

State of Alaska Department of Health and Social Services

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



Fiscal Year 2009 Budget Overview



Sarah Palin
Governor

Karleen Jackson
Commissioner



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Introduction to Department

Mission

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

The Department of Health and Social Services (DHSS) was originally established in 1919 as the Alaska Territorial Health Department. With the formal proclamation of statehood on January 3, 1959, the department's 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.

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 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 vulnerable 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.

While the core services serve as the basis for the department's service delivery system the Department has three main guiding principles: self sufficiency for Alaskans, a strong safety net for those who cannot provide for themselves, and local access to care.

We create public value by:

- ensuring Alaska children are healthy;
- ensuring Alaska children are safe;
- assisting low-income Alaskans to become as economically self-sufficient as possible;
- keeping children with mental health issues close to their community support networks;
- preventing and mitigating threats to public health; and
- providing access to health care for eligible Alaskans.

In carrying out these services, we provide the following contributions to the economy of Alaska:

- Benefit payments to over 120,000 Alaskans in the upcoming year
- Health Coverage for approximately 132,000 eligible individuals
- Management of 43 buildings statewide, including six pioneer homes, with a total square footage exceeding 928,000 square feet for all buildings, and use of 70 leased spaces that the department is responsible for equipping and configuring

- Management of approximately \$140 million in grants to communities and nonprofit entities throughout Alaska
- Oversight of over \$1 billion in federal funds, which flow through the department on an annual basis every year, for Medicaid, Temporary Assistance, Title IV-E Child Welfare funds as examples

Executive Management Organization

Effective September 2007, the DHSS leadership team revised portions of the department's organizational structure to better articulate the functions of the Commissioner's Office and how those functions relate to the work of the department. A new Chief Medical Officer position was created to oversee Public Health and provide medical advice to the leadership team and the Governor's cabinet. The Assistant Commissioner of Public Affairs role oversees both the Public Information Team and the department's legislative and regulatory work. Finally, the former DHSS Deputy and Assistant Commissioner roles were realigned to better distribute the span of responsibility for the department under the authority of three Deputy Commissioners: Deputy Commissioner for Medicaid and Health Care Policy, to oversee Medicaid operations; Deputy Commissioner for Finance and Accountability, to oversee all aspects of the department's administrative infrastructure; and Deputy Commissioner for Family, Community and Integrated Services, which oversees social services programs.

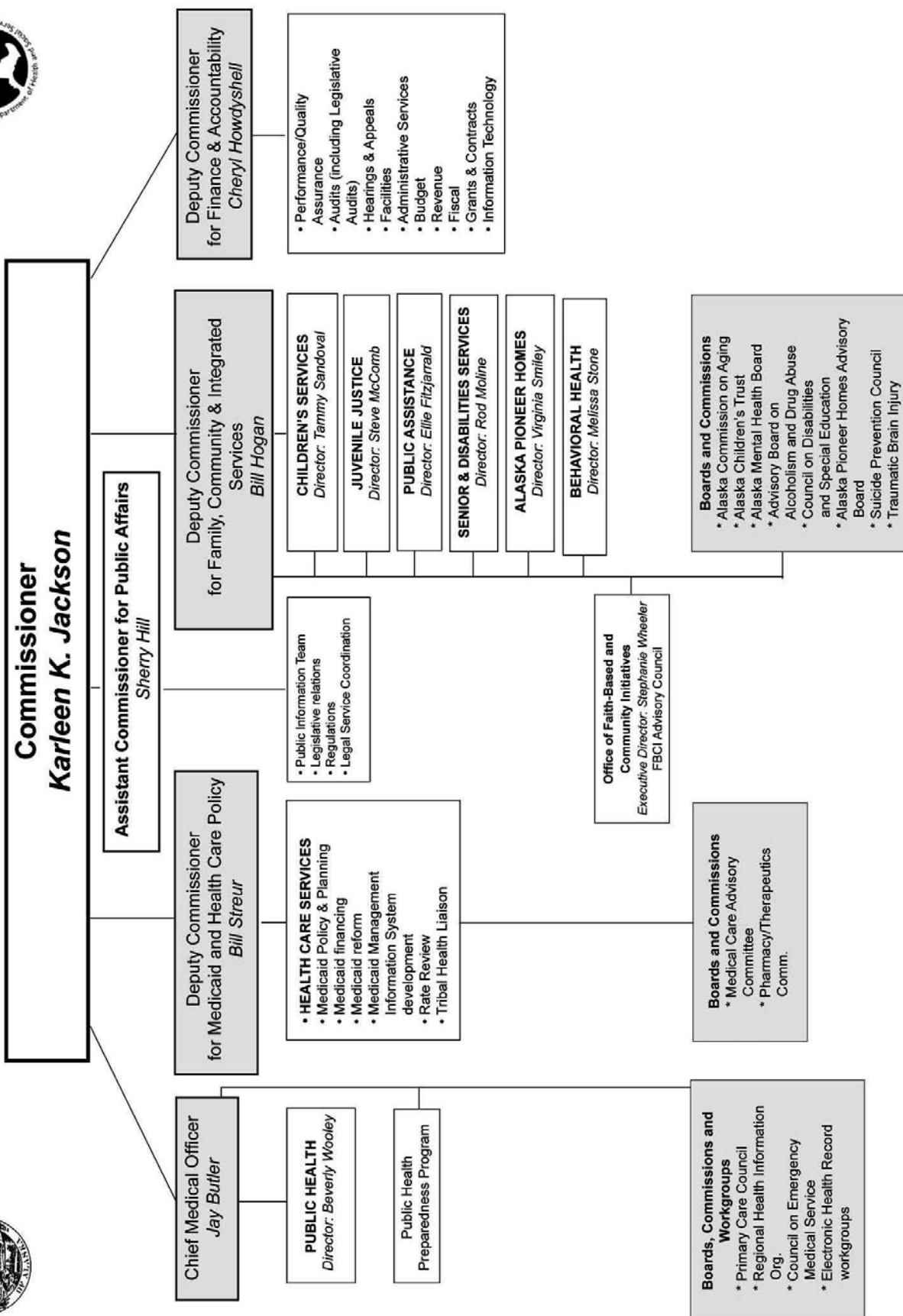
The updated Organizational Structure for the department is provided on the next page.

The FY09 budget structure includes the following Result Delivery Units (RDUs):

- Alaska Pioneer Homes
- Behavioral Health
- Children's Services
- Health Care Services
- Adult Preventative Dental Medicaid Services
- Juvenile Justice
- Public Assistance
- Public Health
- Senior and Disabilities Services
- Department Support Services (includes Commissioner's Office)
- Boards and Commissions



Alaska Department of Health and Social Services Realignment September 2007



Major Accomplishments in 2007

- Secured passage of new legislation and promulgated new regulations creating the Senior Benefits Program to provide cash assistance to low-income Alaska seniors.
- Continued to work with providers through the Bring the Kids Home project to develop in-state residential and community based treatment options for children and youth with an emphasis on minimizing the number and duration of out of state placements. As of June 30, 2007 there were 287 children in out-of-state placement, compared to 429 out of state in spring 2006. In fall 2007, implemented a home and community-based waiver program for Severely Emotionally Disturbed Children diagnosed with Fetal Alcohol Spectrum Disorder.
- Established new Medicaid eligibility regulations that promote efficient program administration by both the department and providers of Medicaid services, and provide Medicaid clients with clear guidance as to their rights and responsibilities.
- Provided leadership and staffing for the Alaska Health Care Strategies Planning Council established through Administrative Order 232 to complete an action plan for submission to the Governor and Legislature with long- and short-term strategies to effectively provide access to quality health care and help reduce the costs of health care for Alaskans.
- Broke ground and began construction of a new virology lab in Fairbanks.
- Dedicated and received Certification by the U.S. Department of Veterans Affairs to begin operation of the first state Veterans Home: the Alaska Veterans and Pioneers Home.
- The Office of Children's Services evaluated operations and, based on recommendations, continued systems improvement to better serve and protect the children of the state.
- The Office of Faith-Based and Community Initiatives used a \$500,000 grant 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.
- Behavioral Health continued integrating the two former systems that provided community mental health and community drug and alcohol treatment into a single behavioral health system.
- Expanded dental coverage to include adult preventative services.
- Supported tobacco enforcement legislation that reinforced the state's commitment to keeping tobacco products out of the hands of youth under the age of 19.
- Appointed a Negotiated Rulemaking committee to bring together various stakeholders for the purpose of reaching consensus on recommended improvements to the Certificate of Need program statutes, regulations, and policies so that the program functions as an effective tool to help ensure that affordable quality health care is accessible to all Alaskans.

Key Department Challenges

The Department of Health and Social Services continues to make progress on the following overall strategies:

1. Work toward more integration of services;
 2. Maximize resources for effective service delivery;
 3. Promote rural infrastructure development and standardization of regional structure;
 4. Promote accountability at all levels of the organization; and
 5. Use technology in strategic ways to accomplish the department's goals.
- Development of in-state residential and community based treatment options for children and youth with an emphasis on minimizing the number and duration of out of state placements, in a project named, Bring the Kids Home. Challenges include:
 - Revision of the system of care while continuing to provide services
 - Implementation of a home and community-based waiver program for Severely Emotionally Disturbed Children diagnosed with Fetal Alcohol Spectrum Disorder
 - Medicaid challenges include:
 - Maximization of Medicaid refinancing opportunities, implementation of legislation passed in 2006 including Medicaid Adult Dental program and reforms to Medicaid and child protection programs; implementation of legislation passed in 2007 for increasing eligibility for Denali KidCare.
 - Development of the Medicaid Management Information System to more effectively use new technology to manage health care in Alaska.
 - Development of new comprehensive Medicaid regulations (these may be filed in the spring of 2008) which will clarify coverage and payment rules for the program and will provide for greater accountability for both the department and health care providers.
 - Continuation of cost containment of the Medicaid Waiver and Personal Care Attendant programs.
 - Preparation and planning with federal, state, and community partners for a potential influenza pandemic.
 - Development and implementation of a department wide Quality Management Program through the Commissioner's Office that incorporates the elements of Program Integrity (fraud detection and audit, with particular emphasis on the Payment Error Rate Measurement project), Quality Assurance (internal controls), and Quality Enhancement (corrective action).
 - Construction of a new virology lab in Fairbanks.
 - Identification and implementation of potential solutions to the lack of access to affordable quality health care for Alaskans.
 - Promotion of services that focus on enhancing health and well-being and preventing illness through development of a comprehensive state policy that includes reduction of alcohol and substance abuse.
 - Improvements to child abuse prevention and protection efforts, particularly with Alaska Native partner agencies.

- Continuation of development of new regulations to implement statutory revisions to the department's various licensing functions including fine-tuning requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.
- Replacement of approximately \$16 million in federal funds DHSS had anticipated receiving for FY08 that will be lost due to a decision by the Centers for Medicare and Medicaid Services that the Private Hospital Proportionate Share Program (ProShare) must be discontinued.
- Identification and implementation of appropriate increases to reimbursement rates for health and social service providers based on results of comprehensive analysis conducted by external contractor.
- Identification and implementation of potential changes to statutes, regulations and/or policies recommendations from the Governor's Alaska Health Care Strategies Planning Council report and the Certificate of Need Negotiated Regulations Committee report that will help ensure that affordable quality health care is accessible to all Alaskans.

Position Information

The department has more than 3,600 positions budgeted under the following three types of work:

Direct Field Workers

111	Public Health Nurses
285	Social Workers & Children's Services Spec
300	Eligibility/Work Services
245	API staff
646	Pioneer Homes Staffing
253	Youth Detention/Treatment Workers
97	Juvenile Probation Officers
1,937	TOTAL

Program Support Services

101	Mental Health and Substance Abuse
123	Senior and Disability Programs
439	Public Health
199	Children and Family Services
146	Juvenile Programs
10	Facilities Management
335	Benefit Payments/Systems
1,353	TOTAL

Administrative/Management Support

181	Division Support Services
134	Information Technology
75	Quality Assurance / Program Oversight
390	TOTAL

3,680 FY 2009 GRAND TOTAL

Recruitment and retention issues create significant challenges to maintaining an adequate work force as the following two tables of position vacancy rates and position turnover rates demonstrate. These statistics were obtained from the Division of Personnel and Labor Relations' CY 2006 Employee Movement reports.

Examining the data first by location, 20 communities have fewer than 10 DHSS positions, but those jobs are highly valued; in 2006, only three of the 20 communities experienced any ongoing vacancies. By contrast, in the state's three largest communities there existed a combined total of 359 ongoing vacant positions. Regardless of community size, in most cases in 2006 DHSS was successful in replacing employees who left their positions (851 left, 836 were hired).

Calendar Year 2006 DHSS Vacancy/Turnover by Location

	Vacancy Rate	Turnover Rate
State of Alaska Executive Branch	9%	29%
Health and Social Services	13%	29%

Location	Vacancy Rate	Turnover Rate
Anchorage	14%	28%
Aniak	33%	100%
Barrow	38%	80%
Bethel	19%	42%
Cordova	0%	0%
Craig	0%	0%
Delta Junction	0%	0%
Dillingham	25%	22%
Eagle River	0%	100%
Fairbanks	8%	24%
Fort Yukon	0%	0%
Galena	0%	0%
Glennallen	0%	100%
Haines	0%	0%
Homer	0%	14%
Juneau	18%	40%
Kenai	2%	13%
Ketchikan	13%	27%
King Salmon	0%	0%
Kodiak	0%	13%
Kotzebue	20%	25%
Matanuska	7%	15%
McGrath	0%	33%
Nome	21%	33%
Palmer	7%	26%
Petersburg	0%	0%
Saint Mary's	20%	100%
Seward	0%	0%
Sitka	5%	15%
Soldotna	0%	100%
Tok	0%	0%
Unalaska	0%	100%
Valdez	0%	0%
Wasilla	11%	24%
Wrangell	0%	0%

Examining the same CY 2006 data instead by job class, across DHSS those classes experiencing the highest count of ongoing vacant positions were Administrative Clerk II (29), Eligibility Technician I (23), and Certified Nurse Aide (19). Job classes of at least 10 positions that experienced the highest ongoing vacancy rates were Psychiatric Nursing Assistant I (73 percent), Nurse I (67 percent) and Public Health Nurse I (50 percent).

Calendar Year 2006 DHSS Vacancy/Turnover by Job Class

	Vacancy Rate	Turnover Rate
State of Alaska Executive Branch	9%	29%
Health and Social Services	13%	29%

Job Class Title	Vacancy Rate	Turnover Rate
Accountant II	0%	0%
Accountant III	17%	50%
Accountant IV	20%	25%
Accountant V	33%	50%
Accounting Clerk I	25%	67%
Accounting Clerk II	14%	50%
Accounting Supervisor II	0%	100%
Accounting Technician I	6%	33%
Accounting Technician II	10%	22%
Accounting Technician III	0%	17%
Administrative Assistant	7%	26%
Administrative Clerk I	25%	133%
Administrative Clerk II	17%	60%
Administrative Clerk III	10%	47%
Administrative Manager I	0%	50%
Administrative Manager II	8%	25%
Administrative Manager III	0%	40%
Administrative Manager IV	0%	17%
Administrative Services Manager I	0%	0%
Administrative Services Manager II	67%	0%
Administrative Supervisor	6%	18%
Adult Probation Officer II, Alcohol Safety Action Program (ASAP)	8%	0%
Analyst/Programmer II	45%	33%
ANALYST/PROGRAMMER III	0%	0%
ANALYST/PROGRAMMER IV	15%	9%
Analyst/Programmer V	31%	44%
Assistant Administrator, Anchorage Pioneers' Home	0%	100%
Assistant Chief, Public Health Nursing	0%	0%
Assistant Commissioner	0%	0%
ASSISTANT MEDICAL DIRECTOR	0%	0%
Assistant Nursing Director	0%	100%
Assisted Living Aide	0%	11%
Assisted Living Care Coordinator	0%	20%
Associate Coordinator	21%	13%
Autopsy Assistant	33%	100%
Building Management Specialist	33%	50%
Certification & Licensing Administrator	0%	0%
Certification & Licensing Consultant	0%	0%
Certified Nurse Aide I	7%	23%
Certified Nurse Aide II	0%	0%
Chemist III	0%	0%
Chemist IV	0%	0%
Chemist V	0%	0%

Chief, Emergency Medical Services	0%	0%
Chief, Health Research And Vital Statistics	0%	0%
Chief, Public Assistance Field Operations	0%	0%
Chief, Public Health Laboratories	0%	0%
Chief, Public Health Nursing	0%	0%
Children's Services Manager	0%	25%
Children's Services Specialist I	17%	66%
Children's Services Specialist II	9%	31%
Children's Services Specialist III	0%	0%
Clinical Pharmacist*	100%	n/a
COMMISSIONER	0%	0%
Community Care Licensing Specialist I	4%	20%
Community Care Licensing Specialist II	8%	18%
Community Care Licensing Specialist III	0%	0%
Community Mental Health Services Program Administrator	0%	0%
COORDINATOR	33%	50%
Coordinator, Suicide Prevention Council*	100%	n/a
Correspondence Secretary III	0%	33%
Criminal Justice Technician I	0%	75%
Criminal Justice Technician II	0%	50%
Custodial Services Supervisor	0%	0%
Data Processing Manager I	40%	33%
Data Processing Manager II	0%	0%
Data Processing Manager III	40%	33%
Data Processing Manager IV	0%	0%
Data Processing Technician I	0%	0%
Data Processing Technician III	0%	0%
Database Specialist III*	100%	n/a
Deputy Commissioner	0%	0%
Developmental Disabilities Program Specialist I	0%	0%
Developmental Disabilities Program Specialist II	0%	0%
Developmental Disabilities Program Specialist III	20%	0%
DIRECTOR OF API	0%	0%
Division Director – Px	71%	150%
Education Specialist I*	100%	n/a
Eligibility Quality Control Technician I	15%	500%
Eligibility Quality Control Technician II	0%	1600%
Eligibility Technician I	26%	0%
Eligibility Technician II	8%	0%
Eligibility Technician III	11%	15%
Eligibility Technician IV	19%	41%
Embalmer	0%	0%
Environmental Services, Foreman	0%	0%
Environmental Services, Journey I	8%	38%
Environmental Services, Journey II	7%	19%
Environmental Services, Lead	0%	0%
EXECUTIVE DIRECTOR	0%	0%
Executive Director, Alaska Commission On Aging	0%	100%
Executive Director, DH&SS Boards*	100%	n/a
Executive Director, Governor's Council on Disabilities and Special Education	0%	0%
Executive Secretary III	0%	300%
Facilities Manager I	0%	33%

Food Service Supervisor	0%	0%
Food Service, Journey	4%	13%
Food Service, Lead	0%	0%
Food Service, Sub-Journey	5%	46%
Grand Total	13%	29%
Grants Administrator I	0%	67%
Grants Administrator II	0%	25%
Grants Administrator III	0%	60%
Grants Administrator IV	0%	0%
Health And Social Services Planner I	67%	300%
Health And Social Services Planner II	15%	36%
Health And Social Services Planner III	25%	33%
Health Facilities Surveyor I	23%	60%
Health Facilities Surveyor II	0%	0%
Health Practitioner I	8%	18%
Health Program Associate	16%	19%
Health Program Manager I	17%	10%
Health Program Manager II	27%	32%
Health Program Manager III	14%	6%
Health Program Manager IV	17%	0%
HEARING EXAMINER	0%	0%
Hearing Officer	0%	0%
Hospital Administrator*	100%	n/a
Human Resource Assistant	0%	100%
Human Resource Technician I	0%	0%
Industrial Therapist	0%	0%
Information Officer I	0%	100%
Information Officer II	67%	100%
Information Officer III	50%	100%
Internal Auditor I	50%	0%
Internal Auditor III	33%	33%
Internal Auditor IV	0%	50%
Investigator I	60%	100%
Investigator II	24%	8%
Investigator III	0%	0%
Investigator IV	0%	0%
Juvenile Justice Officer I	16%	110%
Juvenile Justice Officer II	3%	13%
Juvenile Justice Officer III	4%	17%
Juvenile Justice Superintendent I	0%	13%
Juvenile Justice Superintendent II	0%	0%
Juvenile Justice Superintendent III	0%	0%
Juvenile Justice Unit Supervisor	0%	24%
Juvenile Probation Officer I	31%	67%
Juvenile Probation Officer II	7%	8%
Juvenile Probation Officer III	6%	31%
Juvenile Probation Officer IV	0%	25%
Laboratory Technician	14%	17%
Law Office Assistant I	0%	0%
Licensed Practical Nurse	0%	21%
Mail Services Courier	0%	100%
Maintenance Generalist, Foreman	0%	0%
Maintenance Generalist, Journey	11%	17%

Maintenance Generalist, Sub-Journey I	33%	0%
Maintenance Generalist, Sub-Journey II	0%	0%
Maintenance Specialist, Building/Facility/System, Journey I	0%	0%
Maintenance Specialist, Building/Facility/System, Journey II/Lead	0%	0%
Maintenance Specialist, Plumbing, Journey II/Lead	0%	0%
Medicaid Pharmacy Program Manager*	100%	n/a
Medical Assistance Administrator I	20%	25%
Medical Assistance Administrator II	33%	20%
Medical Assistance Administrator III	15%	27%
Medical Assistance Administrator IV	10%	33%
Medical Officer	50%	0%
Medical Records Administrator	0%	200%
Medical Records Assistant	0%	0%
Mental Health Clinician II	17%	20%
Mental Health Clinician III	13%	20%
Mental Health Clinician IV	0%	0%
Microcomputer/Network Specialist I	17%	20%
Microcomputer/Network Specialist II	17%	30%
Microcomputer/Network Technician I	20%	75%
Microcomputer/Network Technician II	6%	20%
Nurse Consultant I	29%	20%
Nurse Consultant II	10%	0%
Nurse I	67%	200%
Nurse II	11%	21%
Nurse II (Psychiatric)	17%	12%
Nurse III	6%	13%
Nurse III (Psychiatric)	8%	18%
Nurse IV	0%	50%
Nurse IV (Psychiatric)	29%	40%
Nursing Director	0%	0%
Occupational Therapist I	0%	0%
Occupational Therapist II	0%	0%
Oral Transliteration Interpreter*	100%	n/a
Paralegal II	0%	0%
Pharmacist	36%	14%
Pharmacy Technician	0%	0%
Physical Therapist	0%	0%
Pioneers' Home Administrator I	0%	0%
Pioneers' Home Administrator II	0%	0%
Planner IV	0%	0%
Procurement Specialist I	0%	0%
Procurement Specialist II	0%	0%
Program Budget Analyst I*	100%	n/a
Program Budget Analyst III	0%	50%
Program Budget Analyst IV	0%	0%
Program Budget Manager	0%	0%
Program Coordinator	27%	36%
Project Assistant	23%	30%
Project Coordinator	38%	46%
Psychiatric Nursing Assistant I	73%	33%
Psychiatric Nursing Assistant II	0%	13%
Psychiatric Nursing Assistant III	0%	4%
Psychiatric Nursing Assistant IV	0%	15%

Psychiatric Safety and Security Officer I	0%	20%
Public Assistance Analyst I	12%	7%
Public Assistance Analyst II	17%	20%
Public Assistance Field Services Manager I	0%	0%
Public Assistance Field Services Manager II	25%	33%
Public Assistance Programs Officer	0%	0%
Public Health Medical Specialist*	100%	n/a
Public Health Microbiologist I	17%	20%
Public Health Microbiologist II	14%	0%
Public Health Microbiologist III	0%	0%
Public Health Nurse Aide	14%	50%
Public Health Nurse I	50%	140%
Public Health Nurse II	11%	9%
Public Health Nurse III	21%	14%
Public Health Nurse IV	0%	13%
Public Health Nurse V	33%	25%
Public Health Specialist I	8%	8%
Public Health Specialist II	26%	23%
Publications Specialist II	0%	40%
Publications Specialist III	0%	33%
Publications Technician II	0%	100%
Radiological Health Specialist I*	100%	n/a
Radiological Health Specialist II	0%	0%
Records And Licensing Supervisor	0%	0%
Recreation Assistant	0%	0%
Recreation Therapist I	0%	33%
Recreation Therapist II	0%	13%
Regional Alcoholism Program Coordinator	0%	0%
Research Analyst I	25%	67%
Research Analyst II	0%	40%
Research Analyst III	28%	69%
Research Analyst IV	0%	50%
Safety Officer	0%	0%
Secretary	33%	100%
Senior Services Technician	0%	100%
Social Services Associate I	7%	85%
Social Services Associate II	12%	13%
Social Services Program Administrator	0%	25%
Social Services Program Coordinator	22%	24%
Social Services Program Officer	0%	38%
Social Services Specialist I	0%	100%
Social Services Specialist II	13%	29%
Social Services Specialist III	0%	0%
Social Worker I (Children's Services)	29%	100%
Social Worker II	9%	0%
Social Worker II (Children's Services)	11%	28%
Social Worker III	0%	0%
Social Worker III (Children's Services)	33%	50%
Social Worker IV (Children's Services)	8%	23%
Social Worker V (Children's Services)	0%	25%
Special Assistant To The Commissioner II	0%	0%
SPECIAL STAFF ASSISTANT*	100%	n/a
STAFF PHYSICIAN	33%	0%

STAFF PSYCHIATRIST	50%	20%
STATE MEDICAL EXAMINER/CHIEF	50%	0%
Statistical Clerk	0%	0%
Statistical Technician I	33%	50%
STIPEND RECIPIENT	33%	600%
Stock & Parts Services, Sub-Journey	0%	0%
Supply Technician I	0%	100%
Supply Technician II	0%	14%
SYSTEM REFORM ADMINISTRATOR	0%	0%
TOBACCO ENFORCEMENT WORKER*	100%	n/a
Training Specialist I	0%	0%
Training Specialist II	38%	0%
Training Specialist III	50%	0%
VETERINARY EPIDEMIOLOGIST	0%	0%
Visual Information Specialist	0%	0%
Word Processing Center Supervisor	0%	0%
Work force Development Specialist I	22%	29%
Work force Development Specialist II	0%	0%
Work force Development Specialist III	0%	0%
Work force Development Specialist IV	0%	0%

*At the time information was pulled there were no employees in this Job Class.

Professional nursing positions have been a particular challenge to the department, especially when in the majority of cases, nurses work in environments with required staff-to-patient ratios; when vacancies exist, the remaining nursing staff must work overtime to maintain safe ratios for the patients. Examining the DHSS data on those positions within the Professional Group03 (PG03) Nursing, Professional job family in the Classification Outline reveals that in 2006, this subgroup experienced a 17-percent ongoing vacancy rate (49 of 294 positions), although the department was able to make more hires (59) than the number of employees who left their positions (54).

Calendar Year 2006 DHSS Vacancy/Turnover, PROFESSIONAL Nursing

Job Class	Total Positions	Total Employees	# Vacant Positions	Vacancy Rate	Outgoing Employee Count	Incoming Employee Count	Turnover Rate
Assistant Chief, Public Health Nursing	1	1	-	0%	-	-	0%
Assistant Nursing Director	1	1	-	0%	1	1	100%
Chief, Public Health Nursing	1	1	-	0%	-	-	0%
Licensed Practical Nurse	24	24	-	0%	5	8	21%
Nurse Consultant I	7	5	2	29%	1	-	20%
Nurse Consultant II	20	18	2	10%	-	1	0%
Nurse I	15	5	10	67%	10	10	200%
Nurse II	47	42	5	11%	9	12	21%
Nurse II (Psychiatric)	30	25	5	17%	3	-	12%
Nurse III	16	15	1	6%	2	3	13%
Nurse III (Psychiatric)	12	11	1	8%	2	4	18%
Nurse IV	4	4	-	0%	2	2	50%
Nurse IV (Psychiatric)	7	5	2	29%	2	-	40%
Nursing Director	1	1	-	0%	-	1	0%
Public Health Nurse I	10	5	5	50%	7	6	140%
Public Health Nurse II	37	33	4	11%	3	4	9%
Public Health Nurse III	47	37	10	21%	5	4	14%
Public Health Nurse IV	8	8	-	0%	1	3	13%
Public Health Nurse V	6	4	2	33%	1	-	25%

***Total, DH&SS
PROFESSIONAL
Nursing***

294 245 49 17% 54 59 22%

State of Alaska Executive Branch	17,274	14,640	2,634	9%	4,223	4,434	29%
Health and Social Services	3,403	2,964	439	13%	851	836	29%

The DHSS FY 2009 Governor's Request includes 3,680 positions. The details of their budgeted status and geographical location are as follows in the chart below. Select types of employees (e.g., public health nurses, social workers) may be budgeted in one location but provide continual itinerant services to numerous surrounding smaller rural communities.

FY2009 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,707	29	56	1,792
Aniak	3	0	0	3
Barrow	9	0	0	9
Bethel	94	0	1	95
Cordova	2	0	0	2
Craig	6	0	0	6
Delta Junction	6	1	0	7
Dillingham	10	1	1	12
Eagle River	1	0	0	1
Fairbanks	361	6	13	380
Fort Yukon	0	1	0	1
Galena	2	1	0	3
Glennallen	1	0	0	1
Haines	2	0	0	2
Homer	15	1	0	16
Juneau	605	22	37	664
Kenai	84	1	2	87
Ketchikan	111	13	10	134
King Salmon	2	0	0	2
Kodiak	14	2	0	16
Kotzebue	11	0	0	11
Mat-Su Area-wide	16	0	0	16
McGrath	3	0	0	3
Nome	36	1	2	39
Palmer	119	18	5	142
Petersburg	4	0	0	4
Saint Mary's	5	0	0	5
Seward	3	0	0	3
Sitka	99	0	7	106
Soldotna	1	0	0	1
Tok	2	0	0	2
Unalaska	1	0	0	1
Valdez	5	0	0	5
Wasilla	105	1	1	107
Wrangell	2	0	0	2
Totals	3,447	98	135	3,680

Program Prioritization

Statutory Reference AS 37.07.050(a) (13)

Prioritization of program resources is based on four key factors:

- Relevance of the activity to the department's mission.
- The Department has sole responsibility for providing service.
- Protection of vulnerable Alaskans.
- Provision of direct services to clients.

1. Alaska Psychiatric Institute	51. Youth Courts
2. GRA/Temporary Assisted Living (Senior & Disabilities Services)	52. Certification and Licensing
3. Epidemiology	53. State Medical Examiner
4. Alaska Temporary Assistance Program (ATAP)	54. Senior Residential Services
5. Tribal Assistance Programs	55. General Relief Assistance (Public Assistance)
6. Pioneer Homes	56. Community Health Grants
7. HCS Medicaid Services	57. Community Action Prevention & Intervention Grants
8. Senior and Disabilities Medicaid Services	58. Designated Evaluation and Treatment
9. Behavioral Health Medicaid Services	59. Commissioner's Office
10. Children's Medicaid Services	60. Administrative Support Services
11. Senior Benefits Program	61. Facilities Management
12. Probation Services	62. Quality Assurance and Audit
13. Adult Public Assistance	63. Health Strategies Council
14. Community Developmental Disabilities Grants	64. Information Technology Services
15. Foster Care Base Rate	65. Public Affairs
16. Foster Care Augmented Rate	66. Rate Review
17. Foster Care Special Need	67. Quality Control (Public Assistance)
18. McLaughlin Youth Center	68. Fraud Investigation
19. Delinquency Prevention	69. Hearings and Appeals
20. Fairbanks Youth Facility	70. Office/Faith-Based and Community Initiatives
21. Johnson Youth Center	71. Health Planning & Infrastructure
22. Bethel Youth Facility	72. Facilities Maintenance
23. Nome Youth Facility	73. Pioneers Homes Facilities Maintenance
24. Ketchikan Regional Youth Facility	74. Children's Services Training
25. Mat-Su Youth Facility	75. Public Assistance Field Services
26. Kenai Peninsula Youth Facility	76. Child Protection Legal Services
27. Public Health Laboratories	77. Injury Prev/Emerg Med Services
28. Residential Child Care	78. Preparedness Program
29. Psychiatric Emergency Services	79. Tobacco Prevention and Control
30. Behavioral Health Grants	80. Assessment and Planning (Medicaid)
31. Rural Services and Suicide Prevention	81. Women, Children & Family Health
32. Services for Severely Emotionally Disturbed Youth	82. Medicaid School Based Administrative Claims
33. Alaska Fetal Alcohol Syndrome Program	83. HSS State Facilities Rent
34. Services to the Seriously Mentally Ill	84. Alaskan Pioneer Homes Management
35. Catastrophic and Chronic Illness Assistance	85. Behavioral Health Administration
36. Nursing	86. Children's Services Management
37. Front line Social Workers	87. Medical Assistance Administration
38. Adult Preventative Dental Medicaid Services	88. Public Assistance Administration
39. Subsidized Adoptions & Guardianship	89. Public Health Administrative Services
40. Child Care Benefits	

41.	Work Services	90.	Senior and Disabilities Services
42.	Chronic Disease Prevention/Health Promotion		Administration
43.	Energy Assistance Program	91.	Permanent Fund Dividend Hold Harmless
44.	Bureau of Vital Statistics	92.	Council on Faith Based & Community
45.	Emergency Medical Services Grants		Initiatives
46.	Human Services Community Matching Grant	93.	Children's Trust Programs
47.	Senior Community Based Grants	94.	Alcohol Safety Action Program (ASAP)
48.	Women, Infants and Children	95.	Alaska Mental Health/Alcohol & Drug
49.	Family Preservation		Abuse Boards
50.	Infant Learning Program Grants	96.	Commission on Aging
		97.	Governor's Council on Disabilities
		98.	Pioneer Homes Advisory Board
		99.	Suicide Prevention Council

FY2009 Budget Changes

The Department of Health and Social Services 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 FY 2009 compared to FY 2008

	FY 2008 Management Plan	FY 2009 Governor's Request
General Fund	\$ 794.6 million	\$ 938.5 million
Federal Funds	1,023.8 million	1,040.3 million
Other Funds	156.2 million	168.4 million
Total	\$ 1,974.6 million	\$ 2,147.2 million
Increased Federal Revenue		16.5 million
Increased General Fund		143.9 million

While the proposed budget for FY2009 increases by \$143.9 million in general funds, the department has identified five main causes of the increase: (1) the anticipated reduction in the federal medical assistance percentage (FMAP) accounts for \$29.1 million of the GF increase, paired with equal reductions in federal revenues; (2) projected growth in the Medicaid program requires another \$26.4 million in GF; (3) discontinuation of the private ProShare refinancing process will cost the department \$16.2 million GF; (4) establishment of the Senior Benefits program following the sunset of the SeniorCare program will run \$20.3 million; and (5) the comprehensive rate increase across all programs accounts for another \$24.4 million GF increase. Together, these five items account for about 80 percent 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:

Maintain Services

Many DHSS programs costs are based on caseload, mandated cost increases, or cost increases that are unavoidable. Without additional investment, the department would not be able to maintain services. Investments to maintain services include the need to:

- Establish the budget for the Senior Benefits program as outlined by Ch. 1, FSSLA 2007 (SB4);
- Replace federal funds from a reduced Medicaid Federal Medicaid Assistance Percentage (FMAP) rate (drops from 52.48% to 50.53%);
- Increase rates paid to providers for a variety of programs, based on recommendations from the Comprehensive Rate Increase analysis;
- Maintain the Denali KidCare program despite reduced federal allotments for State Child Health Insurance Program (SCHIP);
- Maintain grant levels to providers impacted by the elimination of Private ProShare due to adverse federal decision;
- Maintain Medicaid services to vulnerable Alaskans despite program and caseload growth;
- Ensure safety and security in Juvenile facilities by implementing phase two of necessary funding enhancements;
- Sustain and support behavioral health treatment services;
- Support secure detoxification and treatment for involuntary substance abuse commitments;

- Ensure appropriate funding for the new Fairbanks Virology Lab;
- Maintain Child Advocacy Centers services by replacing declining federal funds with state support;
- Enhance funding for the Aging and Disability Resource Centers (ADRC);
- Maintain ability to lease space and train staff for Office of Children's Services;
- Sustain services for Public Health Nursing grant program;
- Enhance funding for behavioral health prior authorization and accreditation contracts to ensure appropriate service delivery.

Increase Prevention Services

Investing resources in prevention activities is expected to improve the health and well being of Alaskans by improving outcome measures in several areas. Investments in prevention services will support:

- Use of best and promising practices to improve efforts in Suicide Prevention;
- Efforts by Alaska's schools to address Childhood Overweight and Obesity;
- Continuation of phased implementation of the Front Line Social Worker Workload Study in the Office of Children's Services;
- Implementation Youth Gang and Violence Reduction project strategies;
- Continuation of efforts to improve Tobacco Cessation and Prevention programs;
- Enhancement of the Senior Outreach, Assessment and Referral project (SOAR);
- Staffing for the Medicaid FASD demonstration project;
- Implementation of the Prevention of Underage Drinking Initiative program;
- Continuation of enhanced Behavioral Health Services for youth in Juvenile Justice;
- Implementation of Year 3 of the Adult Dental Preventative program;
- Implementation of appropriate strategies from the action plan developed by the Governor's Health Care Strategies Planning Council.

Review Privatization Options

In FY09 the department will conduct feasibility studies regarding potential privatization of:

- the Alaska Pioneer Homes;
- the Alaska Psychiatric Institute (API).

Cost Savings/Efficiencies

DHSS reviewed current programs for potential cost savings to offset a portion of the additional resources requested in the FY09 budget, and/or investments which could be made in FY09 to help contain future costs. Areas identified for potential cost savings/efficiencies include:

- Medicaid Cost Containment for Pharmacy and End Stage Renal Dialysis;
- Medicaid rate reductions for some durable medical equipment;
- Additional projected savings in Personal Care Attendant program costs;
- Investments in recommended strategies associated with the Pacific Health Policy Group's Medicaid Program Review report.

Mental Health Trust Recommendations

The Alaska Mental Health Trust Authority has recommended a series of investments in the DHSS budget to improve conditions for their beneficiaries. The investments are for a wide variety of

programs including housing, justice, support of Board initiatives and the Bring the Kids Home program.

**DHSS FY2009 Governor's Request
General Fund Requests**

<i>Division</i>	<i>Item</i>	<i>GF Only Amount</i>
<i>Cost Savings and Efficiencies</i>		
HCS	Medicaid Cost Containment in End Stage Renal Dialysis	(244.9)
HCS	Medicaid Cost Containment in Pharmacy	(500.0)
HCS	Reduce Medicaid Rates for Durable Medical Equipment	(49.0)
HCS	Review/Implement Medicaid Report Recommendations	1,224.5
SDS	Decrement PCA Cost Containment	(3,000.0)
DSS	Review/Implement Health Care Strategies Council Recommendations	100.0
<i>Cost Savings and Efficiencies Subtotal</i>		<u><u>\$ (2,469.4)</u></u>
<i>Increase Prevention Services</i>		
DBH	New Positions for Medicaid FASD Demonstration Project	287.0
DBH	Senior Outreach, Assessment, and Referral Project	300.0
DBH	Suicide Prevention Statewide Initiative	1,000.0
DBH	Prevention of Underage Drinking Initiative	823.4
OCS	Implementation of Front line Workload Study Recommendations — Phase 2	600.0
DJJ	Behavioral Health Services for Juvenile Justice Youth	361.9
DJJ	Youth Gang and Violence Reduction Project	513.1
DPH	Helping Alaska's Schools Address Childhood Overweight and Obesity	596.7
<i>Increase Prevention Services Subtotal</i>		<u><u>\$ 4,482.1</u></u>
<i>Mental Health Trust Authority Recommendations</i>		
DBH	MH Trust: Brain Injury Training for Providers	100.0
DBH	MH Trust: BTKH — Anchorage Crisis Stabilization, 15 Beds and Develop Single Point of Entry	200.0
DBH	MH Trust: BTKH — individualized Services	250.0
DBH	MH Trust: Department of Corrections Discharge Incentive Grants	100.0
DBH	MH Trust: Operations Support for Sober House Recovery	300.0
DBH	MH Trust: Oxford House Adaptation	75.0
DBH	MH Trust: Peer Operated Support Services	50.0
OCS	MH Trust: BTKH — Early Childhood Mental Health Learning Network and Coordinator	100.0
OCS	MH Trust: BTKH — Foster Parent and Parent Services: Recruit, Train, Support	75.0
DPH	MH Trust: AB-Gov Council — Center for Human Development Capacity Building on Autism	125.0
DPH	MH Trust: AB-Gov Council — Multidisciplinary Diagnostic Team and Comprehensive Referral for Autism Spectrum Disorder	125.0

SDS	MH Trust: AB-ACoA — Primary Care Clinics	350.0

<i>Mental Health Trust Authority Recommendations Subtotal</i>		<u>\$ 1,850.0</u>

Maintain Services

AK PH	Increment for Reduced FMAP	214.4
DBH	Community Prevention & Early Intervention for Behavioral Health Programs	1,000.0
DPH	Human Biomonitoring for Chemical Contaminants	300.0
DBH	Designated Evaluation and Treatment Increment	700.0
DBH	Discontinue Private ProShare Refinancing	9,306.7
DBH	FFY2009 Federal Medicaid Assistance Percentage Rate Change for Medicaid	4,918.6
DBH	FY2009 Medicaid SCHIP Allotment Shortfall	900.0
DBH	FY2009 Projected Medicaid Formula Growth	2,959.9
DBH	Medicaid Mental Health Prior Authorization Contract Increase	200.0
DBH	National Accreditation Contract — Phase I of V Increment	200.0
DBH	Secured Detoxification & Treatment for Involuntary Substance Abuse Commitment	1,989.7
DBH	Services for Substance Use Disorders Comprehensive System of Care	1,750.0
DBH	Treatment and Wrap Around Services for Clients with Severe Mental Illness and Co-occurring Disorders	1,750.0
OCS	Basic Staff Training and Development	369.1
OCS	Continued Support for Child Advocacy Centers	1,300.0
OCS	Discontinue Private Refinancing	322.4
OCS	FFY2009 Federal Medicaid Assistance Percentage Rate Change for Medicaid	355.6
OCS	Increased Lease Costs — Anchorage	440.0
OCS	IV-E Federal Fund Participation Decrease	90.7
HCS	FFY2009 Federal Medicaid Assistance Percentage Rate Change for Medicaid	14,566.6
HCS	FY2009 Medicaid Program Fund Change	1,717.5
HCS	FY2009 Medicaid SCHIP Allotment Shortfall	1,000.0
HCS	FY2009 Projected Medicaid Formula Growth	14,793.9
DJJ	Discontinue Private ProShare Refinancing	555.4
DJJ	FFY2009 Federal Medicaid Assistance Percentage Rate Change for Medicaid	32.9
DJJ	Funding for Nome's Operating Costs	50.0
DJJ	Funding for Performance Based Standards	115.0
DJJ	Safety and Security Funding for Juvenile Justice Facilities	1,690.5

DPA	Child Care Program Performance Measures	45.8
DPA	Denali KidCare Performance Improvement	197.9
DPA	Senior Benefits Program	20,345.4
DPH	Discontinue Private ProShare Refinancing	1,172.0
DPH	Fairbanks Virology Lab Pro-rated for Lab Opening	395.0
DPH	Public Health Nursing Grant Program	120.7
DPH	Tuberculosis Control Program	150.0
SDS	Discontinue Private ProShare Refinancing	4,815.7
SDS	FFY2009 Federal Medicaid Assistance Percentage Rate Change for Medicaid	9,004.9
SDS	Funding for Aging and Disability Resource Centers	125.0
SDS	FY2009 Projected Medicaid Formula Growth	8,601.9
DSS	Comprehensive Rate Increase Across All Programs	24,417.5
Maintain Services Subtotal		\$ 132,980.7
Review Privatization Options		
AKPH	FUTURE: Cost of Feasibility Study Related to Privatizing Pioneer Homes or Services	50.0
DBH	LONG TERM: Feasibility Study on Privatization of API	50.0
Privatization Subtotal		\$ 100.0
Miscellaneous Items		
Atrin	Dept ETS Chargeback Transfer from DOA	190.5
OTI	Dept Delete One-Time-authorization for First FY2008 Fuel/Utility Cost Increase Funding Distribution	(480.0)
OTI	DSS Delete Legislative Medicaid Review Report Appropriation (Ch. 10, SLA 2007 (SB 61))	(1,132.5)
Miscellaneous Subtotal		\$ (1,422.0)
Subtotal w/o Salary Adjustments		\$ 135,521.4
Salary Adjustments		
Dept	FY2009 Health Insurance Increases for Exempt Employees	7.4
Dept	FY2009 Bargaining Unit Contract Terms: GGU	7,796.8
Dept	FY2009 Bargaining Unit Contract Terms: LTC	188.5
Dept	FY2009 Bargaining Unit Contract Terms: CEA	2.1
Dept	Correct Unrealizable Fund Sources for Salary Adjustments: GGU	363.8
Salary Adjustments Subtotal		\$ 8,358.6
GRAND TOTAL FY2009 GF REQUESTS		\$ 143,880.0

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; Permanent Fund Dividend Hold Harmless; 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.

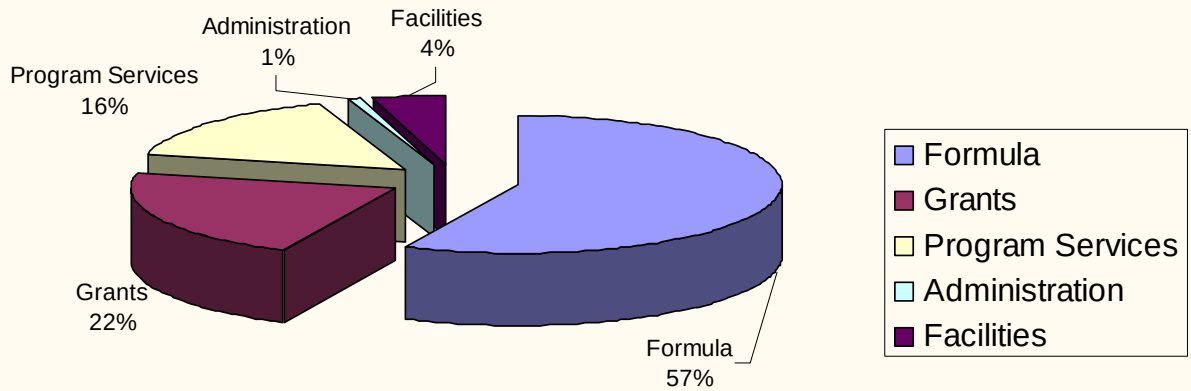
Budget Charts and Graphs

The table below shows the comparison of total funds for FY 1999 and FY 2009.

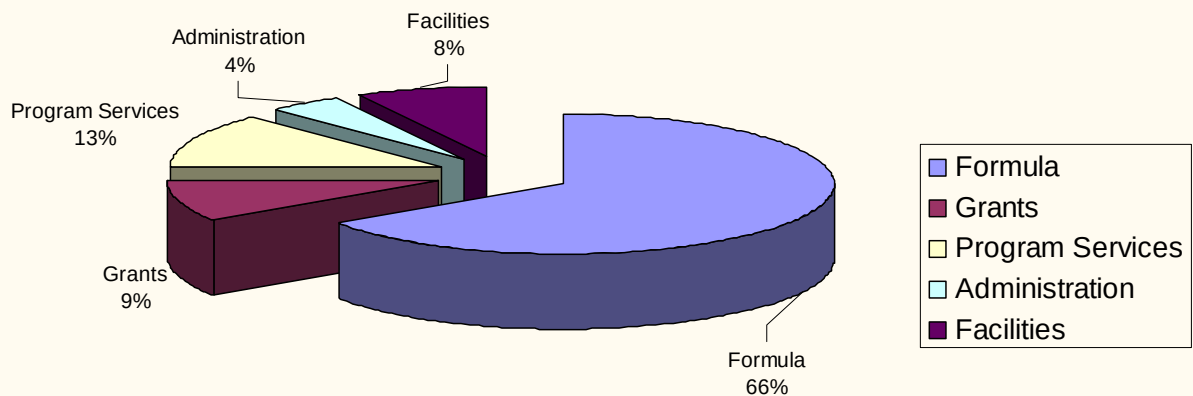
	FY 1999 Authorized		FY 2009 Governor's		
	Total Funds	% of Total	Total Funds	% of Total	99 to 09 Change
Formula	606,143.4	64.6%	1,474,256	68.7%	143%
Grants	116,491.2	12.4%	151,956.1	7.1%	30%
Program Services	175,773.2	18.7%	315,130.2	14.7%	79%
Administration	7,335.5	0.8%	91,683.5	4.3%	1,150%
Facilities	32,273.0	3.4%	114,161.2	5.3%	254%
Total	938,016.3		2,147,187.0		130%

Expenditure Category Comparisons of General Fund Authorization

FY1999 Authorized Budget GF Only



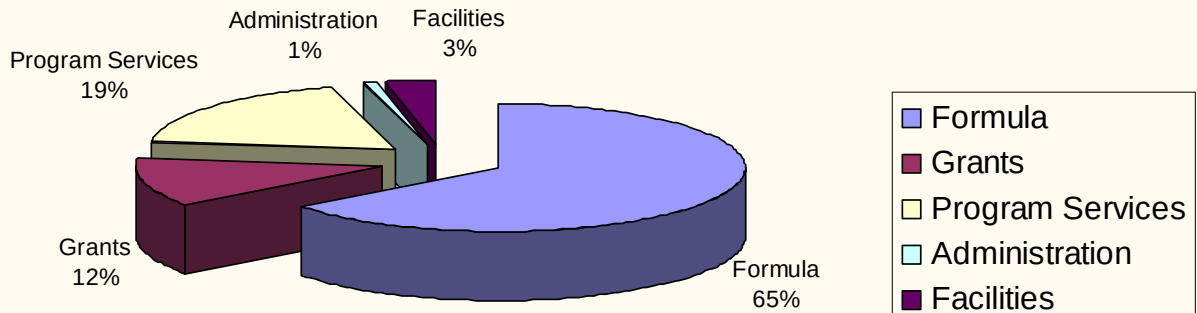
FY2009 Governor's Budget Request GF Only



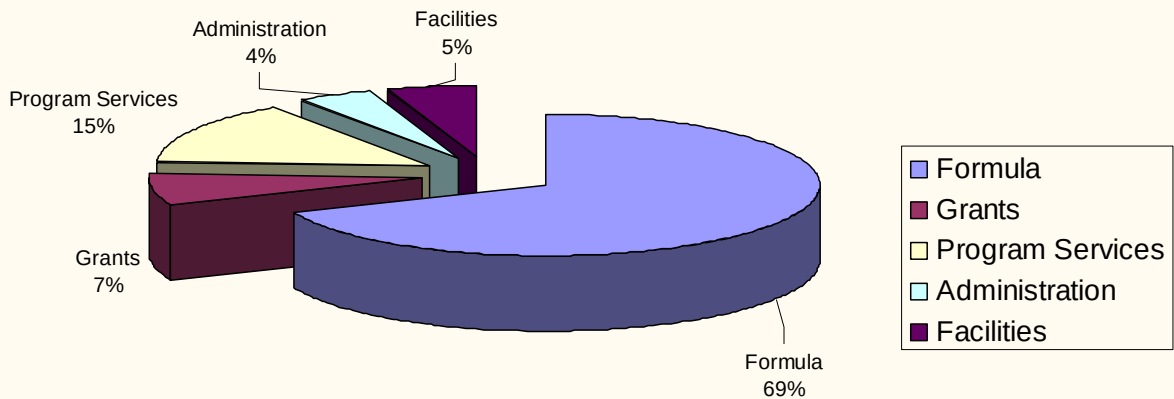
Formula programs comprised approximately 57 percent of the department's FY 1999 general fund budget in comparison to 66 percent of the FY 2009 general fund budget.

Expenditure Category Comparisons of Total Funds Authorization

FY1999 Authorized Budget Total Funds

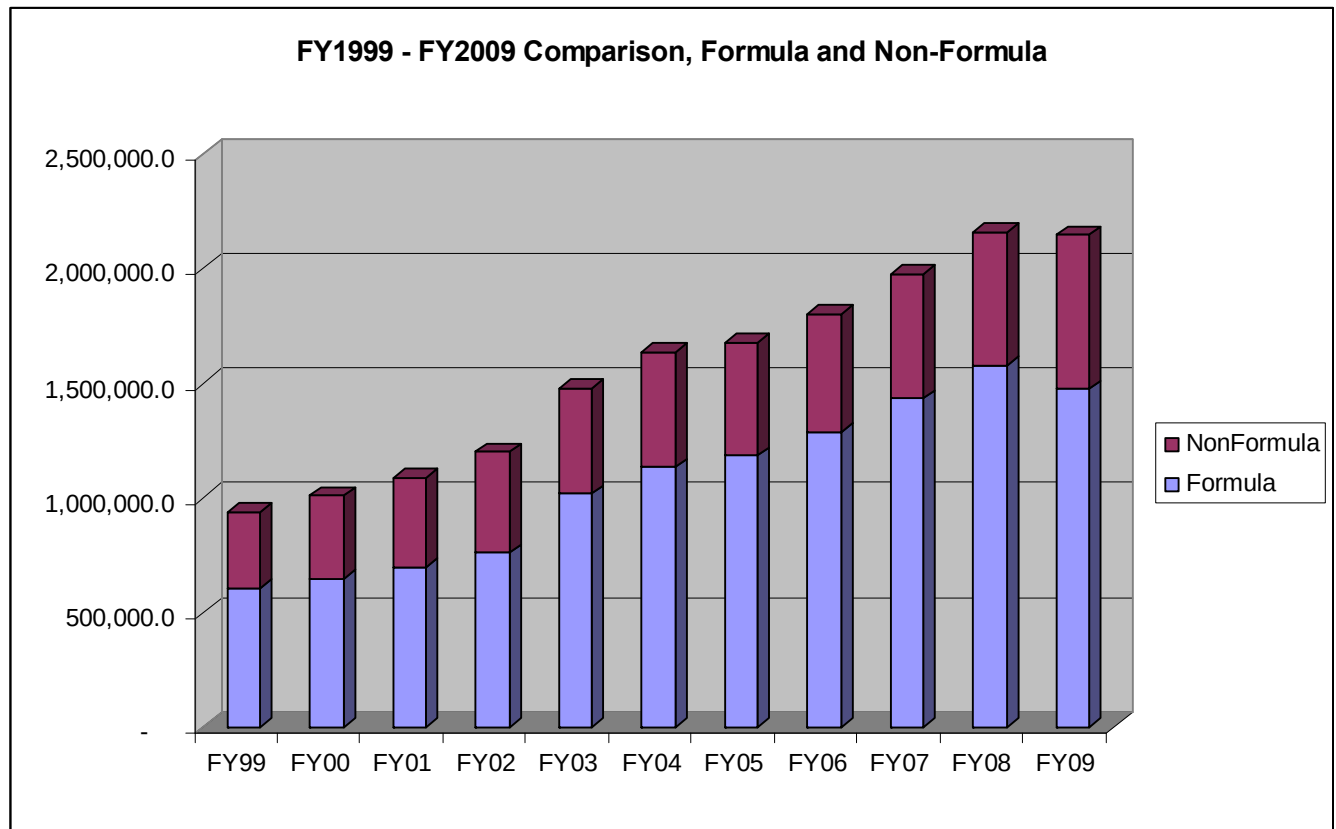


FY2009 Governor's Budget Request Total Funds



Formula programs have fairly steadily represented considerably more than half the department's total budget. A breakout by fiscal year follows.

The chart below details the formula and non-formula categories of budget for the last 10 years.



From FY 1999–FY 2002, formula programs were fairly consistent between 63 percent–65 percent of the department’s overall budget. In FY 2003 and FY 2004 it was closer to 69 percent. From there, for the next four years the percentage of formula funding steadily rose to a high of about 73 percent in FY 2008. Note that for FY 2009 we show both a slight reduction in the overall budget and a reduction in the percentage of formula funding, down to about 69 percent. Medicaid is the largest formula program in the department, totaling about 85 percent of the total formula program category in the proposed FY 2009 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 (including the Adult Preventative Dental RDU), 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 individuals 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 six¹ 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 Results Delivery Unit

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
Adult Preventative Dental Medicaid Services	Routine restorative dental services including exams, cleanings, tooth restoration or extraction, and upper or lower full dentures.
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.

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

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 percent. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (e.g., qualified Indian Health Services claims are reimbursed 100 percent). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

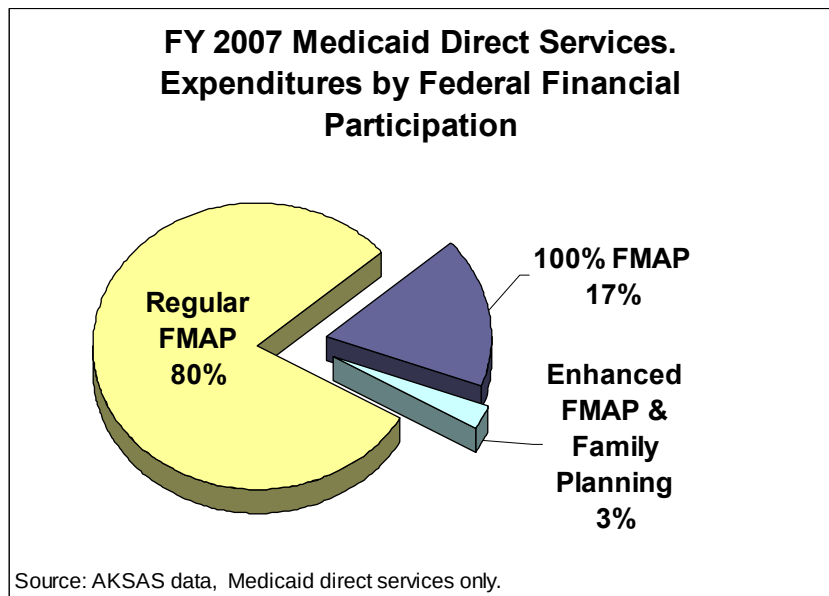
Federal Medical Assistance Percentages for Claim Payments

Year	Federal Fiscal Year		State Fiscal Year	
	Statutory Rate		Average Annual Rate	
	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
1998	59.80	71.86	57.35	71.86
1999	59.80	71.86		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 Q1-Q2	58.27	70.79	59.74	71.82
2003 Q3-Q4	61.22	72.85		
2004 Q1-Q3	61.34	72.94	60.60	72.42
2004 Q4	58.39	70.87		
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
2009	50.53	65.37	51.02	65.71

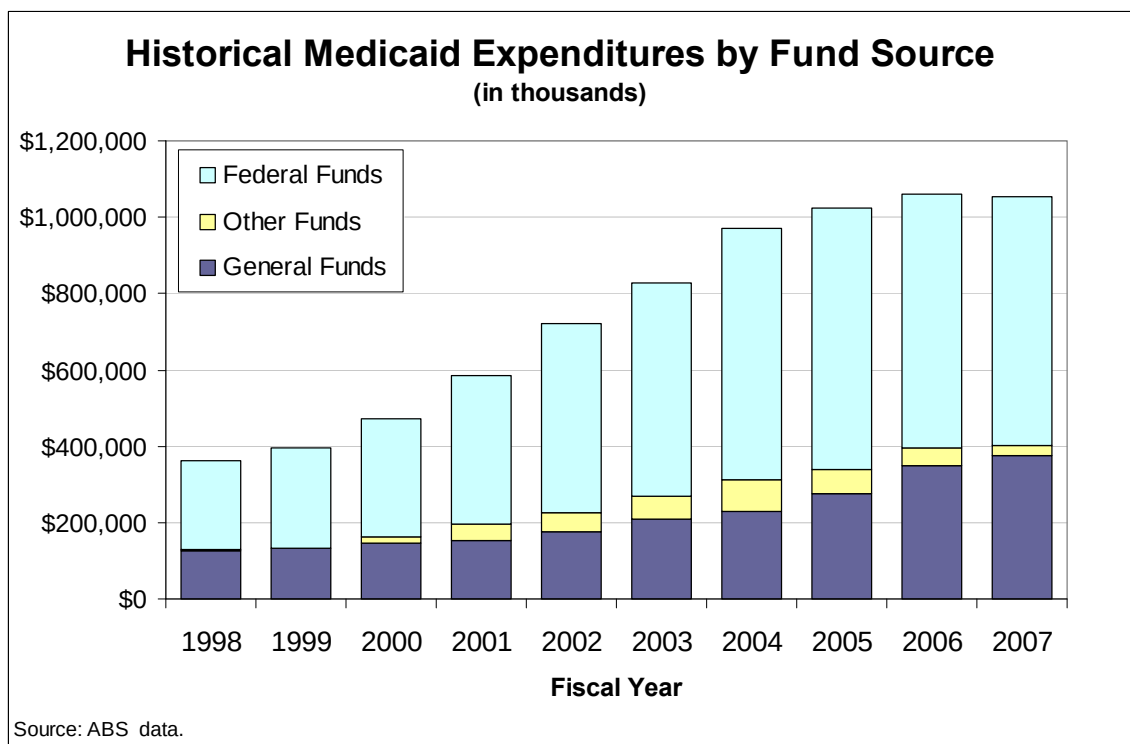
Source: Medicaid Budget Group and Centers for Medicare and Medicaid Services.

The FMAP prior to 1998 was 50%. The enhanced FMAP started in 1998.

In recent years, Alaska benefited 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 percent for FFY 2006 and 2007. This special rate expired October 1, 2007, at which time Alaska's FMAP dropped to 50.53 percent. The FFY09 change in FMAP will require an estimated \$28,487.7 increase in GF to replace the lost federal funds and maintain services at the current level.



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. State matching funds accounted for 45 percent of Medicaid funding in SFY 1997. In SFY 2007, state matching funds supported only 38 percent 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-percent federal reimbursement. For every dollar shifted to the tribal system from regular FMAP in FFY 2007, the state saved 42 cents in state

matching funds. The department continues to work with tribal health corporations to maximize the benefits of this refinancing program.

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 from 16.6 percent in the period from 1998–2004 to about 4 percent for 2009. Growth has been controlled to a rate less than medical inflation — mitigating other increases in population, enrollment, and the amount and duration of services used.

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	\$374,492	\$651,908	\$26,976	\$1,053,376
2008 *	\$433,594	\$743,399	\$28,290	\$1,205,283
2009 **	\$484,149	\$735,401	\$28,570	\$1,248,120

Source: Medicaid Budget Group using Alaska Budget System data.

*Management Plan. **Governor's Budget.

Annual Statistical Summary of Services Provided in FY 2007

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, and Senior and Disabilities Services.

In FY 2007, one in five Alaskans was enrolled in the state's Medicaid program. Annual enrollment has remained relatively stable, growing by 2 percent a year or less between FY 2004 and FY 2006; however, enrollment declined by almost 3 percent in FY07. The number of people receiving benefits (beneficiaries) also declined slightly from 2006, mirroring the drop in enrollment. A recent Kaiser Family Foundation study shows Medicaid enrollment declined for the first time in nearly a decade with a .5 percent decrease across the nation in FY 2007. The Kaiser study attributes this decrease in Medicaid enrollment to a better economy, lower unemployment rates and new federal documentation requirements which are causing delays in processing applications.

The proportion of Alaska enrollees actually utilizing services, 95 percent, rose two percentage points from FY 2006.

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 *	670,053	131,996	122,978	20%	93%
2007 **	677,108	128,295	121,864	19%	95%

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

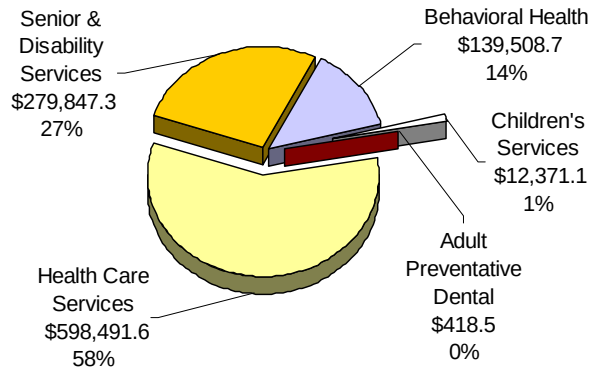
* Population for 2006 is provisional. ** Population for 2007 is projected.

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

Many individuals 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 Behavioral Health can also get a flu shot through Health Care Services. Ninety-eight percent of people with paid claims for Medicaid services during FY07 received benefits funded through Health Care Services, 10 percent received benefits through Behavioral Health, 6 percent received benefits provided by Senior and Disabilities Services, and 1 percent received benefits provided by Children's Services.

The majority of expenditures are in Health Care Services, which accounted for 58 percent of the costs in SFY 2007. Costs for long-term care for seniors and individuals with disabilities comprised 27 percent of the total. The remaining 15 percent of expenditures were incurred by Behavioral Health (14 percent) and Children's Services (1 percent).

**FY 2007 Medicaid Direct Services
Expenditures by Division (thousands)**

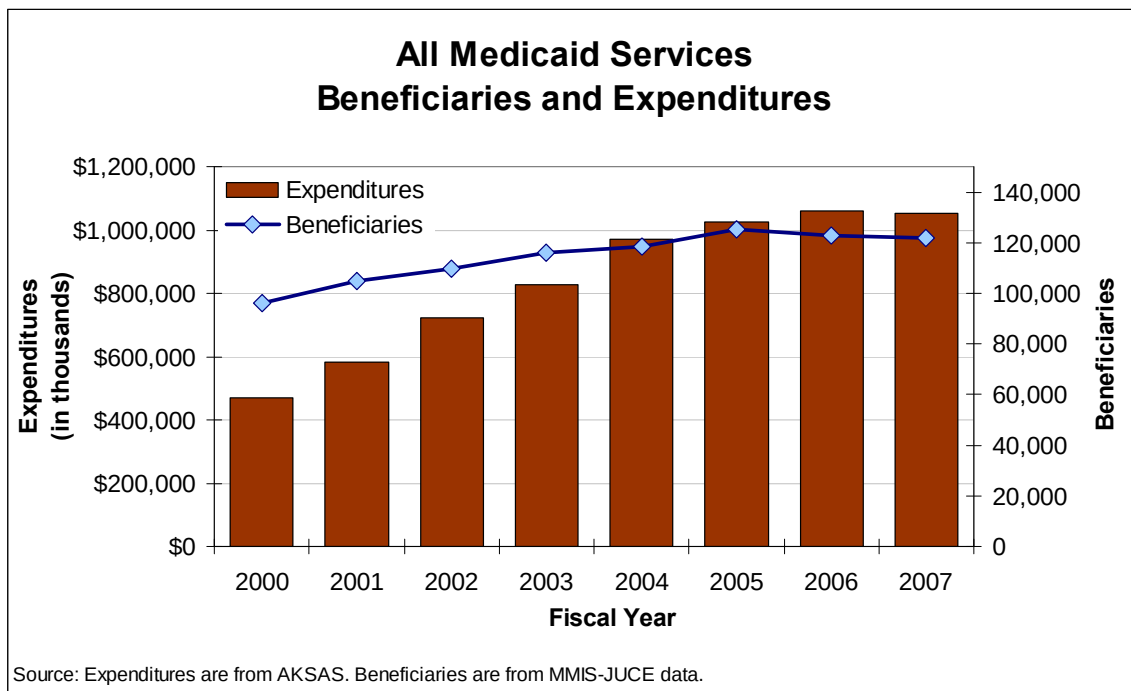


Source: AKSAS data, Medicaid direct services only.

**Medicaid Direct Services Expenditures by Division, FY 2007
(in thousands)**

Total Medicaid Direct Services	\$ 1,030,218.7
Division of Health Care Services	\$ 598,491.6
Pharmacy	\$ 68,432.7
Physician Services	\$ 117,267.6
Hospital Services	\$ 218,737.9
Transportation	\$ 45,526.2
Dental	\$ 20,669.0
Medicaid (State-only)	\$ 608.0
Other Medicaid Direct Services	\$ 46,446.7
Non-MMIS Services	\$ 42,046.5
Medicaid Refinancing	\$ 38,757.0
Adult Preventative Dental	\$ 418.5
Adult Preventative Dental	\$ 418.5
Division of Seniors & Disabilities Svcs	\$ 279,847.3
Personal Care Services	\$ 77,575.0
Nursing Homes	\$ 68,583.4
AD Waiver	\$ 18,581.1
CCMC Waiver	\$ 9,461.6
MRDD Waiver	\$ 72,663.3
OA Waiver	\$ 32,732.8
Other LTC	\$ 250.1
Division of Behavioral Health	\$ 139,508.7
Res. Psych. Treatment Center	\$ 59,010.3
Inpatient Psychiatric Facilities	\$ 16,143.4
General Mental Health	\$ 64,355.0
Office of Children's Services	\$ 12,371.1
Behavioral Rehabilitation	\$ 11,058.6
BTKH	\$ 1,312.5

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. Demand for medical services has also climbed as the proportion of enrollees utilizing services has increased. Growth has been greatest in two categories: residential psychiatric treatment centers costs for youths, and home and community based waiver services for the elderly and disabled.

SFY2007 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR (CPRPY)	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		121,864		\$934,547,745	\$7,669		128,295	95.0%
Gender								
Female	57.0%	69,537	56.3%	\$525,961,988	\$7,564	55.1%	70,745	98.3%
Male	43.0%	52,386	43.7%	\$408,585,983	\$7,800	44.9%	57,630	90.9%
Unknown	0.0%	2	0.0%	(\$226)	(\$113)	0.0%	1	-
Race								
Alaska Native	38.3%	46,979	37.9%	\$353,818,597	\$7,531	36.8%	47,738	98.4%
American Indian	1.5%	1,891	1.3%	\$12,379,883	\$6,547	1.5%	1,993	94.9%
Asian	5.3%	6,535	4.7%	\$43,527,460	\$6,661	5.7%	7,452	87.7%
Pacific Islander	2.7%	3,284	2.2%	\$20,486,243	\$6,238	3.0%	3,899	84.2%
Black	5.2%	6,406	4.2%	\$39,677,811	\$6,194	5.4%	7,031	91.1%
Hispanic	3.5%	4,268	2.2%	\$20,379,005	\$4,775	3.6%	4,655	91.7%
White	40.5%	49,769	44.7%	\$417,883,854	\$8,396	40.8%	52,818	94.2%
Unknown	3.0%	3,655	2.8%	\$26,394,892	\$7,222	3.1%	4,025	90.8%
Native	40.0%	48,833	39.2%	\$366,198,480	\$7,499	38.6%	49,689	98.3%
Non-Native	60.0%	73,371	60.8%	\$568,349,264	\$7,746	61.4%	79,060	92.8%
Age								
under 1	9.1%	12,136	8.0%	\$74,701,481	\$6,155	8.5%	11,722	103.5%
1 through 12	36.1%	48,074	15.4%	\$143,830,256	\$2,992	38.4%	52,830	91.0%
13 through 18	17.1%	22,750	17.5%	\$163,711,333	\$7,196	18.0%	24,794	91.8%
19 through 20	3.4%	4,490	2.7%	\$25,218,339	\$5,617	2.8%	3,834	117.1%
21 through 30	10.3%	13,760	10.5%	\$97,662,922	\$7,098	9.2%	12,704	108.3%
31 through 54	14.1%	18,771	21.6%	\$202,059,242	\$10,764	13.4%	18,418	101.9%
55 through 64	3.5%	4,682	8.0%	\$75,015,014	\$16,022	3.3%	4,562	102.6%
65 through 84	5.5%	7,295	12.3%	\$114,583,154	\$15,707	5.4%	7,434	98.1%
85 or older	1.0%	1,270	4.0%	\$37,766,006	\$29,737	0.9%	1,216	104.4%
Benefit Group								
Children	62.1%	77,157	36.2%	\$338,017,657	\$4,381	64.6%	83,857	92.0%
Adults	18.5%	22,967	11.9%	\$111,103,946	\$4,838	16.7%	21,659	106.0%
Disabled Children	1.7%	2,094	5.9%	\$54,985,777	\$26,259	1.5%	1,998	104.8%
Disabled Adults	11.8%	14,641	31.0%	\$290,068,353	\$19,812	11.4%	14,747	99.3%
Elderly	6.0%	7,465	15.0%	\$140,372,012	\$18,804	5.8%	7,573	98.6%

Payment amounts are net of all claims paid during the fiscal year. Amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments. Payment amounts may not tie exactly to amounts in AKSAS or ABS.

Enrollment: Number of persons eligible for Medicaid and enrolled at some time during state fiscal year 2007. 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 2007. 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

Participation: Recipients as a percent of eligible persons (as a percent of enrollment). The percent of eligible persons using Medicaid services.

Source: MMIS/JUCE.

Explanation of FY09 Budget Changes

		2008	2009 Gov	08 to 09 Change
Total All Medicaid Services	General Funds	433,594.1	484,149.1	50,555.0
	Federal Funds	743,399.4	735,400.9	-7,998.5
	Other Funds	28,289.8	28,569.6	279.8
	Total	1,205,283.3	1,248,119.6	42,836.3
Behavioral Health Medicaid Services	General Funds	65,179.5	72,790.0	7,610.5
	Federal Funds	102,961.8	100,552.9	-2,408.9
	Other Funds	2,400.0	2,400.0	0.0
	Total	170,541.3	175,742.9	5,201.6
Children's Medicaid Services	General Funds	7,570.6	7,926.2	355.6
	Federal Funds	8,575.1	8,219.5	-355.6
	Other Funds	0.0	0.0	0.0
	Total	16,145.7	16,145.7	0.0
Adult Preventative Dental Medicaid Services	General Funds	1,543.1	3,518.7	1,975.6
	Federal Funds	7,323.9	5,348.3	-1,975.6
	Other Funds	1,425.0	1,400.0	-25.0
	Total	10,292.0	10,267.0	-25.0
Health Care Medicaid Services	General Funds	222,055.0	248,544.0	26,489.0
	Federal Funds	445,749.5	441,463.8	-4,285.7
	Other Funds	21,889.8	21,889.8	0.0
	Total	689,694.3	711,897.6	22,203.3
Senior and Disabilities Medicaid Services	General Funds	137,245.9	151,370.2	14,124.3
	Federal Funds	178,789.1	179,816.4	1,027.3
	Other Funds	2,575.0	2,879.8	304.8
	Total	318,610.0	334,066.4	15,456.4

Source: Medicaid Budget Group using Alaska Budget System data.

For SFY 2009, the department is requesting an increase of \$42.8 million from SFY 2008 management plan authorization for Medicaid services, department-wide. From 1998 to 2004 the rate of growth for Medicaid costs was 16.6 percent. In contrast, the SFY 2009 request represents an increase of only 3.6 percent from SFY 2008 management plan authorization.

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	\$50,555.0	(\$7,998.5)	279.8	\$42,836.3
Cost Containment (HCS, SDS)	(\$3,793.9)	(\$826.5)		(\$4,620.4)
Savings are anticipated from cost containment efforts in Medicaid pharmacy services, end stage renal dialysis, and personal care attendant services.				
SFY09 Projected Medicaid Growth (DBH, HCS, SDS)	\$26,355.7	\$40,964.1	\$0.0	\$67,319.8
For SFY09, the Department projects growth of approximately 5.6% above the FY08 authorized amount. This increment request is necessary to maintain the current level of Medicaid services. The requested FY09 growth increment is based on the change between the FY08 and the FY09 forecasts of spending and enrollment. Most of the increase can be attributed to hospital services, community mental health and home and community based waiver services.				
FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid (HCS, DBH, SDS, OCS)	\$28,487.7	(\$28,487.7)	\$0.0	\$0.0
The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid and is largely outside the control of the state government. The regular FMAP will drop from 52.48% to 50.53% in FFY09 and the enhanced FMAP from 66.74% to 65.37%. The regular FMAP for SFY09 will average 51.02% across two federal fiscal years (52.48% from July-Sept. 2008 and 50.53% from Oct. 2008-June 2009). The enhanced FMAP for SFY09 will average 65.71% (66.74% from July-Sept. 2008 and 65.37% from Oct. 2008-June 2009). This will result in a 1.95 percentage-point decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008.				
FFY09 Medicaid SCHIP Allotment Shortfall (DBH, HCS)	\$1,900.0	(\$1,900.0)	\$0.0	\$0.0
Alaska's annual allotment has fluctuated between \$7 and \$11 million. Since Alaska's annual allotment represents only about 30% of our costs, we have relied heavily on unspent funds from other states that were redistributed to Alaska to maintain our access to the enhanced federal rate for SCHIP. Once the state exhausts the enhanced funding claims are reimbursed at the lower, regular rate and increasing our GF need.				
Upper Payment Limit Decline-ProShare (HCS)	(\$4,044.0)	(\$16,013.9)	\$0.0	(\$20,057.9)
The ProShare program allowed the state to make payments to qualifying hospitals for the difference between Medicare and Medicaid rates. The department received notice July 31, 2007 from the Centers for Medicare & Medicaid Services (CMS) that the State must discontinue the ProShare program resulting in a \$16 million decrease in federal funding. In FY08, a GF increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program due to a change in the formula. This transfer of the general funds is necessary to provide the divisions the funding needed to continue these services.				

Other Change Records (HCS, APD, DBH, SDS)

\$1,649.5	(\$1,734.5)	\$279.8	194.8

Other major change records include Adult Preventative Dental fund changes for reduced Alaska Mental Health Trust Authority Authorized Receipts (MHTAAR) and federal financial participation. Rebalancing the fund source amounts is necessary to reflect changes in projected participation by the Trust and for lower utilization by Indian Health Service (IHS) recipients served by tribal dental programs (1,717.5 GF/-1,717.5 federal). An increment of \$2,500.0 (1,224.5 GF/1,275.5 federal) is requested for continued implementation of recommendations for improvement from the Pacific Health Policy Group's Medicaid Program Review study and the Governor's Alaska Health Care Planning Strategies Council.

Department Level Performance Measures

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.
- Promote self-sufficiency and provide basic living expenses to vulnerable Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.

A: Result — Outcome Statement #1: Provide a safe living environment for elderly pioneers and veterans.

Target #1: Injury rate below half the national standard, which is 2 to 6 percent.

Measure #1: Pioneer Homes sentinel event injury rate.

Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.126%	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	3.5%	1.2%	2.0%	2.1%	2.2%
2008	1.5%	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 as 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.

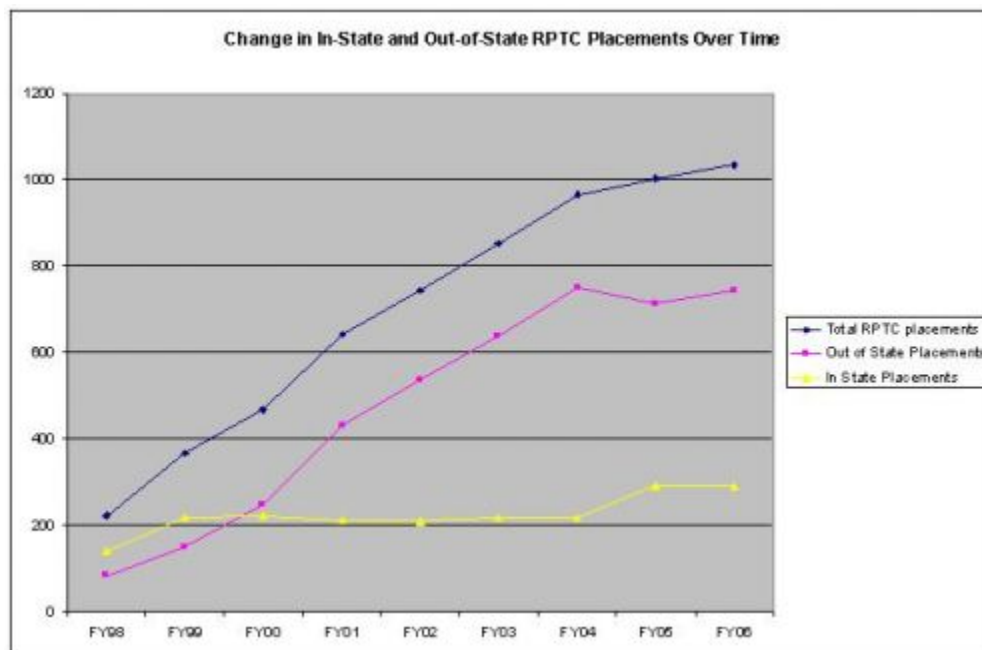
See Alaska Pioneer Homes Division Level Strategy A2: Target 1: Measure 1 for additional explanation.

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 RTPC beneficiaries.

Analysis of results and challenges: For the past eight years there has been a steady increase in the number of children receiving Residential Psychiatric Treatment Center (RPTC) services. Between FY 1998 and 2004, the unduplicated number of youth with Serious Emotional Disorders (SED) receiving

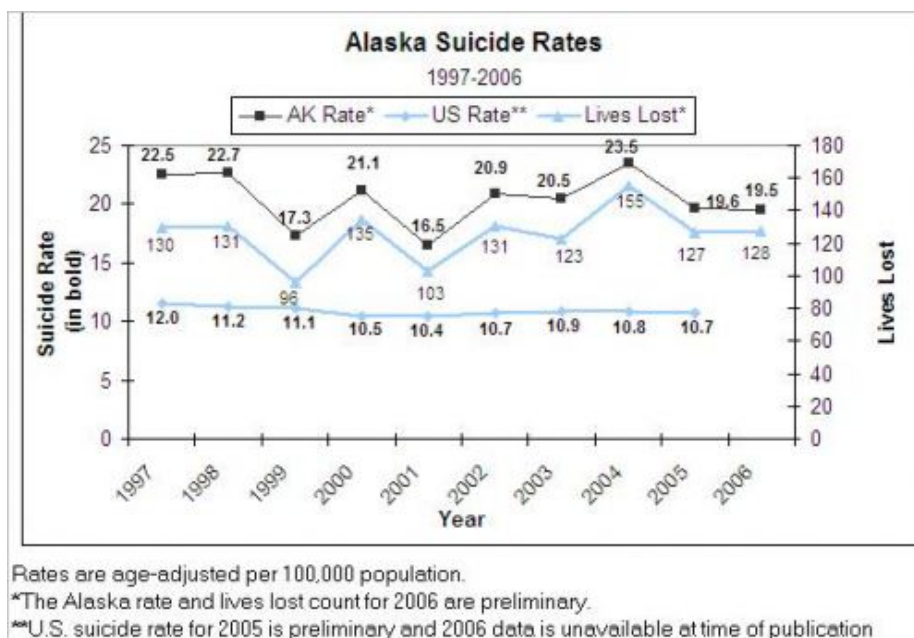
out-of-state RPTC care steadily increased — on average 46.7 percent per year. The RPTC population as a whole also showed steady increase from FY98–04, an average annual increase of 24.8 percent.

The Bring the Kids Home Project was initiated during FY 2004. Positive changes are already apparent. Between FY 2004 and 2005 there was a 5.1-percent reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. However, between FY 2005 and 2006, there was again an increase in out-of-state placement, of 5 percent, from 711 to 743. In FY 2006, there was a 3-percent increase in total RPTC placements. The historical average increase of 46.7 percent 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 ensures 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 became available in FY07. 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 divisions of Behavioral Health and Juvenile Justice and Office of Children's Services, in partnership with the Alaska 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.



Rate of Suicides 1998-2006

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.2
1999	17.3	96	11.1
2000	21.1	135	10.5
2001	16.5	103	10.4
2002	20.9	131	10.7
2003	20.5	123	10.9
2004	23.5	155	10.8
2005	19.6	127	10.7
2006	19.5	128	N/A

**Rate is number per 100,000 standard population and accounts for differences in population distribution.*

**CY 2006 Alaska data are preliminary; U.S. data for 2006 are not available.*

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 2006 shows a slight decline in rate, however is 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 assess community readiness for decreasing suicide and non-lethal suicidal behaviors. 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.

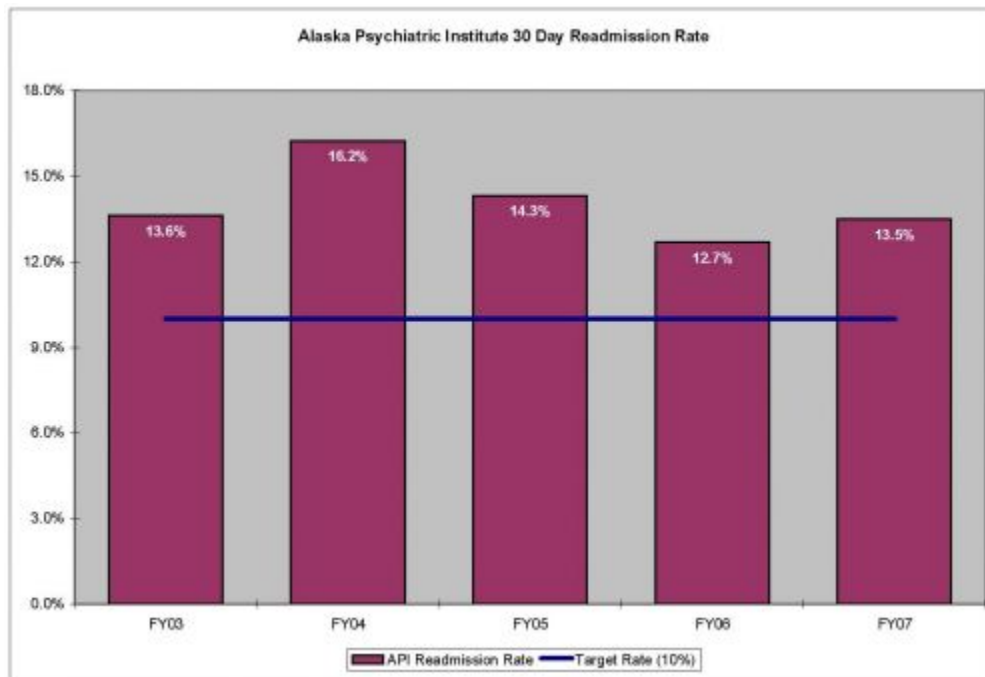
An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to or close to those who had died by suicide:

- 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 fathers;
- 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.

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 Alaska Psychiatric Institute (API) to 10 percent.

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 percent 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 percent.

According to data for FY07, 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. In FY07, API admitted 1,231 patients of whom 166 returned within 30 days for a 13.5-percent readmission rate.

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 and Neglect Per 1,000 Children Under Age 18 in Alaska

Fiscal Year	Rate Per 1,000	National Rate
FY 2006	23.8	11.9
FY 2007	24.1 +1.26%	11.9 0%

FY 2006 measures forward 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 estimated by the Department of Labor and Work force Development during the year prior to reporting.

Source: Target of 11.9 — U.S. 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' (OCS) 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.

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-percent higher than the national average.

The Office of Children's Services is continuing to implement its new safety decision-making practice. The new model has proved to be more of a paradigm shift than was previously anticipated; therefore the implementation of new practice standards is taking longer than originally anticipated. The new model of working with families will lead to improved outcomes for the children and families needing OCS intervention. New practice standards have revealed that additional specialized training is necessary and is being pursued through the University of Alaska.

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.

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.

Rate of Repeat Maltreatment		
Year	YTD	Target
2005	10.6%	6.1%
2006	10.4%	6.1%
2007	11.4%	6.1%

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

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.

The OCS anticipates improvements in the number of repeat maltreatment cases due to the improved business practices set out above.

Business practices continue to be upgraded as the OCS is receiving technical assistance from the Annie E. Casey Foundation to improve foster care and the approach to foster care. In addition, the OCS is restructuring the administration of foster care and adoptions by moving all of the work to one section and moving the supervision and decision-making from the field up through state office to alleviate any conflicts of interest.

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

Year	FFY % Rate	National Rate
2005	1.10%	0
2006	1.16%	.57%
2007	1.55%	.57%

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 percent — U. S. Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: Steady increases are believed to be an indicator that there are not enough foster homes. The pool of resources from which to make the best possible match for children needing placement and foster parents best able to meet the needs of a particular child is too small.

OCS continues to work toward improved business practices through the use of technical assistance and increased foster and child care rates to assure foster parents will not need to continue to absorb the cost of care for foster children.

Target #4: Reduce the rate of 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	Turnover Target
FY 2004	6.28%	32%	218	0
FY 2005	10.44%	38%	249	0
FY 2006	11.35%	30%	261	0
FY 2007	9.5%	33%	261	20%

This vacancy and turnover analysis is an update of past analysis and is based on the same methodology used by the Department of Administration, Division of Personnel in compiling their work force analysis. Vacancy and turnover analyses are based on vacancies in the Children's Services Specialist I, II, and III and the Social Worker (CS) I, II, III, and IV job class series. Data are collected from the state of Alaska Payroll System. This analysis compiles complete fiscal year data.

Turnover rate represents the number of times a position becomes vacant in the Front line Social Worker component due to an incumbent leaving the position. Reasons for leaving include, but are not limited to, resignation, separation, termination, voluntary demotion, promotion, retirement, or non-retention.

Vacancy rate represents the total number of positions vacant divided by the number of positions in the job class series. The analysis compiles data from the fiscal year and records the length of time a position is vacant so that multiple vacancies for any one position are counted.

Analysis of results and challenges: The Office of Children's Services (OCS) received the final report in May 2006 for a workload study completed by Hornsby Zeller Associates, Inc. One of the recommendations was that OCS not engage in wide-scale changes to personnel that would include transferring positions from overstaffed offices to understaffed offices until such time as data regarding caseload and workload trends could be established. However, the contractor did conclude that in order to meet the workload of the state, OCS needed an additional 17 positions to handle the state's entire caseload as mandated by state and federal policy guidelines. The OCS received authorization for six new positions in FY 2008:

- 2 Community Care Licensing Specialists
- 3 Children's Services Specialists
- 1 Social Worker

No administrative staff has been added, which has caused a burden to front line staff having to pick up administrative tasks.

Work on a comprehensive plan to address retention, recruitment and selection of front line staff continues. OCS has not yet realized the kind of success needed from retention and recruitment efforts. There are a number of efforts currently underway and the plan is constantly evaluated and revised as new ideas and efforts are explored.

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 work force.

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	Medicaid 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	7,263,956	18	6

Note: Between FY02 and FY03 reports were based on six months of data. Since FY04, 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 FY 2006 and FY 2007 increased from 12 days to 18 days.

Three new initiatives, two in the second half of FY 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 FY 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 DHSS 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 FY 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	Medicaid 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	5,606,347	72%	-2%

Chart Notes

1. Between FY 2001 and FY 2003, reports were based on six months of data. Since FY04, reports are based on annual data.

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

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

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 Web site for providers with information tailored to each provider type.

During FY 2006, DHSS had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, 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 DHSS 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 Centers 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 Payment Error Rate Measurement (PERM) program commenced nationally on July 1, 2005, with Phase I and one-third of the states participated. Alaska is a year-three cycle state and will be required to participate with calendar year 2007 data. 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).

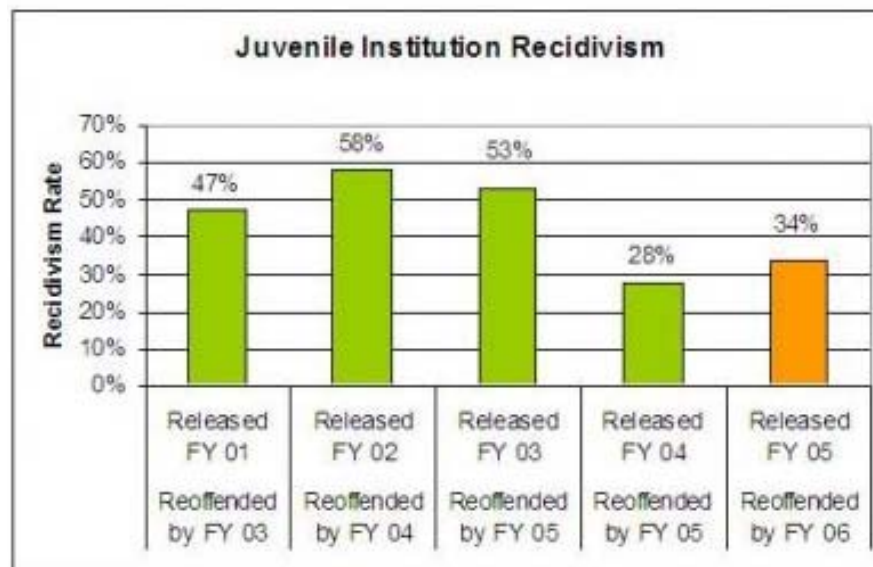
E: Result — Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 33 percent.

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

Facility	Number released in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Bethel Youth Facility	9	4	44%
Fairbanks Youth Facility	18	8	44%
Johnson Youth Center	10	3	30%
McLaughlin Youth Center	66	20	30%
Total	103	35	34%

Race	Number released in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Caucasian	39	12	31%
African American	4	1	25%
Native Alaskan/American Indian	37	16	43%
Asian	3	1	33%
Pacific Islander	1	0	0%
Multiple Races	18	5	28%
Other	1	0	0%
Total	103	35	34%



Analysis of results and challenges: The recidivism rate for juveniles released from Alaska's secure treatment institutions increased slightly this year. The increase may not be significant; the small number of youth released from these institutions each year makes it difficult to determine whether

changes in the recidivism rate from year to year are part of a trend or an anomaly. The change in recidivism rate for this population also may be due to the fact that, for the first time, this information was gathered and analyzed at the division director's office using the statewide Juvenile Offender Management Information System (JOMIS) instead of being submitted by individual facilities. Researching this measure at the statewide level ensured consistent application of the definitions that determine whether juveniles should be included in this measure, and whether or not they had committed re-offenses.

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 states more chronic and serious juvenile offenders, compared with youth who receive only 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.

Recidivism among juveniles released in FY04 and FY05 is defined as re-offenses that occurred within a 12-month window. For youth released prior to these years, recidivism had to occur within 24 months. This change likely explains the demonstrated drop in recidivism for youth released in FY04 and FY05 compared with youth released in prior years; youth released later had a smaller window of time in which to re-offend. 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 it results in a conviction or adjudication in the juvenile or adult systems (eight states, including Alaska), the average recidivism rate was 33 percent. Alaska, at a 34-percent rate, closely reflects 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 assessment tools, both for juveniles and the facilities that house them, that 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.

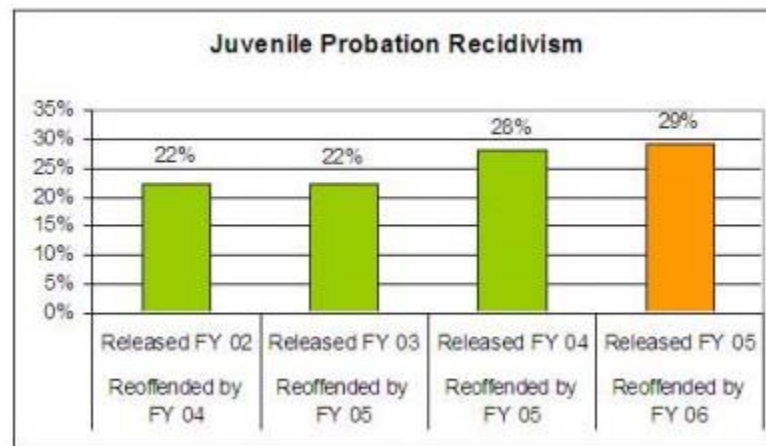
Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in Juvenile Justice's database and the Alaska Public Safety Information Network. Juveniles are included in this measure if the reason for their release from the treatment facility is marked in JOMIS as "Completion of Treatment," "Sentence Served," "Court-Ordered Release," "Transfer to a Non-DJJ Facility," "Order Expired," or "Transfer (Transitional Services Step Down)." Re-offenses are defined as: any offenses that occurred within 12 months of release and that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new institutionalization order, by Aug. 1, 2007. Adjudications and convictions for motor vehicle, Fish and Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

Target #2: Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 33 percent.

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

Region	Number of offenders released from formal probation in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Anchorage	99	27	27%
Northern Region	107	34	32%
Southcentral Region	80	22	28%
Southeast Region	42	12	29%
Total	328	95	29%

Race	Number released from formal probation in FY 05	Number of Reoffenders 12 months after release	Percentage of offenders who reoffended
Asian	11	3	27%
African-American	13	4	31%
Multi-race	36	5	14%
Alaska Native/American Indian	130	47	36%
Pacific Islander	5	2	40%
Other	2	1	50%
Caucasian	131	33	25%
Total	328	95	29%



Analysis of results and challenges: The defined recidivism rate for this population was 29 percent, a small and likely insignificant increase compared with the previous year's rate.

FY07 was the second year that recidivism was defined as a re-offense that occurred within 12 months from the time offenders were released from formal probation. In years prior to FY06, re-offenses were counted if they occurred within 24 months of release from formal probation. The change to a 12-month window was made to better align Alaska with other states' definitions of recidivism. 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 FY04 and FY05 is likely 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.

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. (Recidivism rates for institutionalized youth are analyzed in a separate performance measure, above, and are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.)

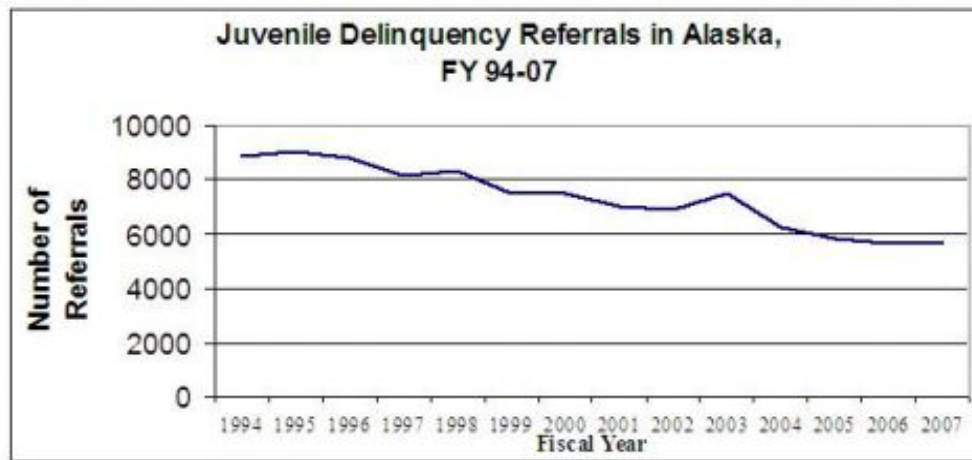
Sixteen of the 32 states reported to track recidivism do so on a 12-month basis. Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (eight states), the average recidivism rate was 33 percent. Alaska, at a 29-percent rate for its probation population, 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. Youth also are not included who have been reassigned to a formal probation order (with or without custody) within seven days of release, as this typically reflects a modification of probation status or custodial placement rather than true completion of supervision. This analysis also excludes youth who were ordered to an Alaska treatment institution anytime prior to their supervision end date, as these youth are included in the analysis for our institutional recidivism performance measure, above. Adjudications and convictions for Motor Vehicle, Fish and 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 probation end date in FY 2005, and the offense must have resulted in an adult conviction or new juvenile adjudication by Aug. 1, 2007.

Target #3: Alaska's juvenile crime rate will be reduced by 5 percent over a two-year period.

Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



Target Fiscal Year	2004		2005		2006		2007	
Number of Referrals per 100,000 population aged 10-17	6893		6512		6345		6490	
Comparison Year	2002	2003	2003	2004	2004	2005	2005	2006
Percentage Increase (or Decrease) between Target Year and Comparison Year	(10.5%)	(16.7%)	(21.3%)	(5.5%)	(8.0%)	(2.6%)	(0.3%)	2.3%

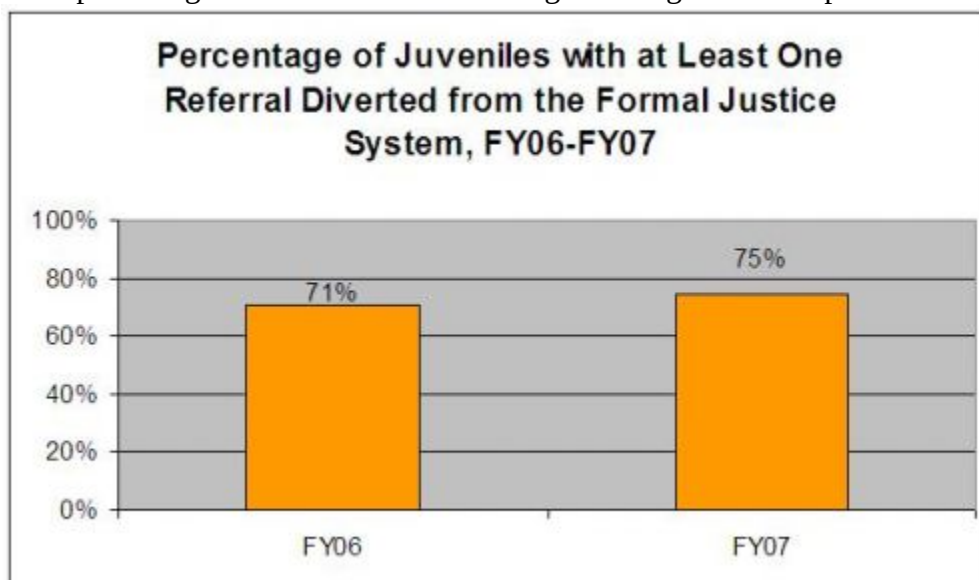
Region	Office	Juveniles	Percent of State	Referrals	Percent of State	Charges	Percent of State
Anch.	Anchorage	1,537	40%	2,200	39%	3,532	36%
NRO	Barrow	128	3%	230	4%	318	3%
	Bethel	202	5%	290	5%	602	6%
	Fairbanks	428	11%	592	10%	1026	10%
	Kotzebue	86	2%	136	2%	245	2%
	Nome	126	3%	242	4%	452	5%
	NRO Total	970	25%	1,490	26%	2,643	27%
SCRO	Dillingham	66	2%	91	2%	147	1%
	Homer	45	1%	61	1%	82	1%
	Kenai	286	7%	384	7%	695	7%
	Kodiak	95	2%	160	3%	241	2%
	Mat-Su	368	9%	467	8%	900	9%
	Valdez	54	1%	81	1%	179	2%
	SCRO Total	914	24%	1244	22%	2244	23%

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population were virtually unchanged in FY07 compared with FY06, with a slight but insignificant increase in both measures noted. 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 for youth aged 10–17 during the years 2003–2006 are provided by the Alaska Department of Labor and Work force Development. The population estimate for the year 2007 was derived from the report Alaska Population Projections 2007–2030, published by the Alaska Department of Labor and Work force Development. Juvenile referral data were extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database by Aug. 10, 2007, and include referrals for youth who are under 10 years old (these referrals make up less than 1 percent of the total). These data are continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70 percent 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 FY07 the proportion of juveniles with at least one referral (a report from law enforcement alleging a juvenile perpetrator) who were diverted from the formal court process remained high, at 75 percent. This means that 2,891 of the 3,876 juveniles referred in FY07 had one of those cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed. The percentage increased compared with FY06 results, but because this is only the second time the division has considered this measure, the improvement may be due to refinements in our record-keeping, data-gathering, and analysis.

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 handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, who otherwise would find it impossible to adjudicate every offender referred to them. Diversion also is considerably less expensive and faster than the formal adversarial

process. Diversion processes reduce probation caseloads as well, enabling the division to better allocate resources and staff time to more serious offenders.

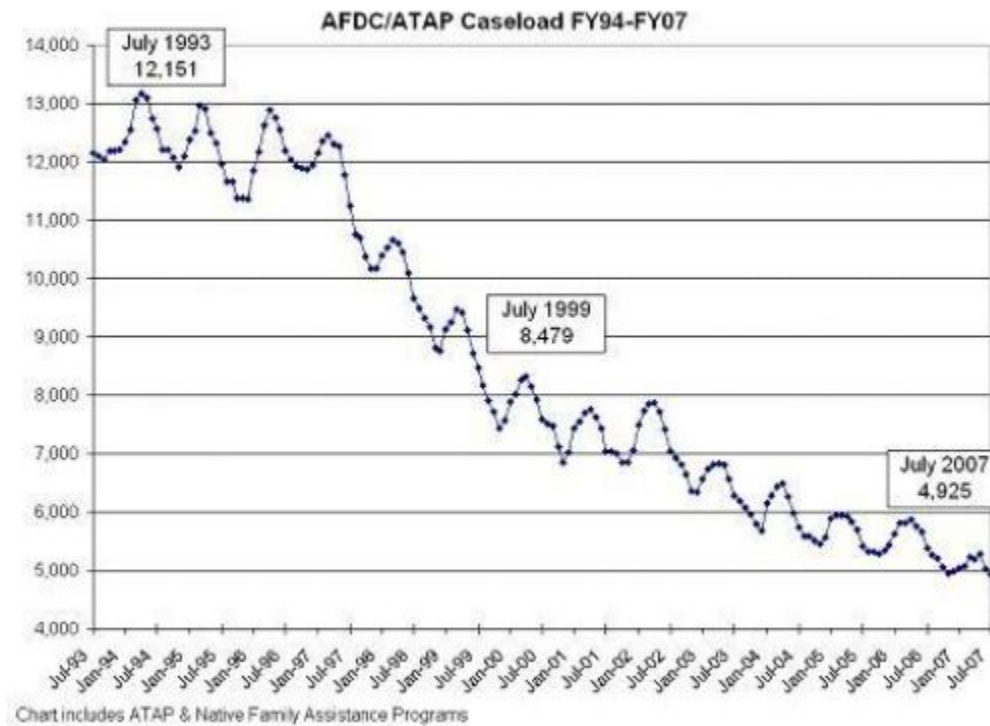
Note: For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referrals resulted in at least one referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Referrals that are screened and referred elsewhere, such as back to law enforcement for further information, and those that were still in process at the time these data were collected are excluded from consideration. These data are continually refined and corrected and numbers in future reports may change slightly.

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

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

Target #1: Increase self-sufficient individuals and families by 10 percent annually.

Measure #1: Rate of change in self-sufficient families.



Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD
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	-2%	-8%	-10%	-10%	-7%
FY 2008	-7%	0 0%	0 0%	0 0%	0 0%

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

Analysis of results and challenges: As shown in the YTD Total column, FY 2007 had a 7-percent decline in the number of families receiving Alaska Temporary Assistance program benefits compared to FY 2006. The other four 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

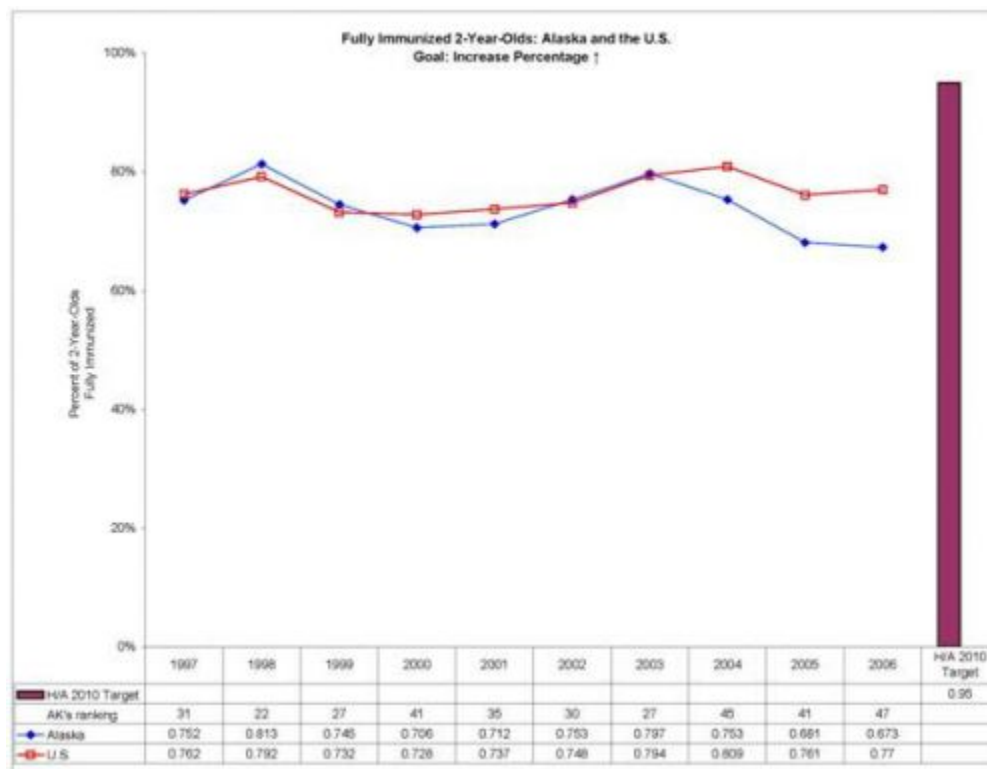
a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

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 percent of all 2-year-olds are fully immunized.

Measure #1: percent of all Alaska 2-year-olds fully immunized.



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
2006	77.0	67.3*	47

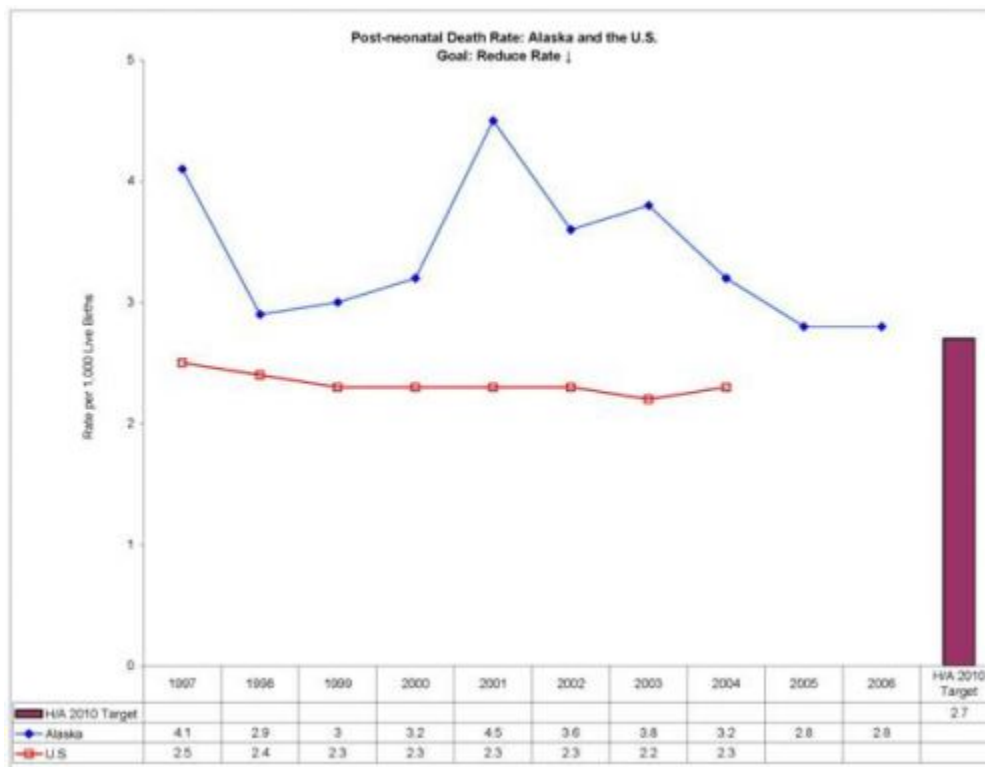
In 2005, CDC began using a new six-dose standard for its recommended basic immunization series.

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 2-year-olds dropped considerably, as did Alaska's rate. 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 one 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
2006	2.8	N/A

Note: The National Center for Health Statistics has not yet released U.S. death rates for 2005 and 2006.

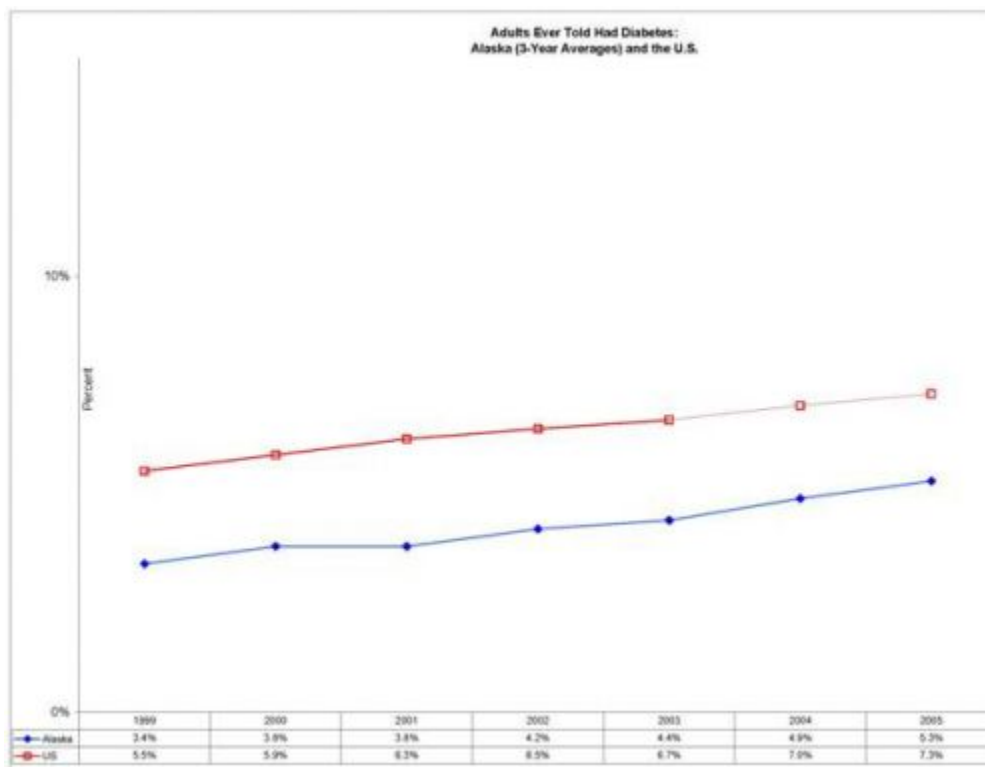
Analysis of results and challenges: Chart Note: Rate per 1,000 live births and reflects three-year rate, i.e., 2006 represents 2004–2006.

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%	7.0%
2005	5.3%	7.3%

Note: 2005 Alaska data are based on a three-year average of 2004–2006.

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 percent 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.

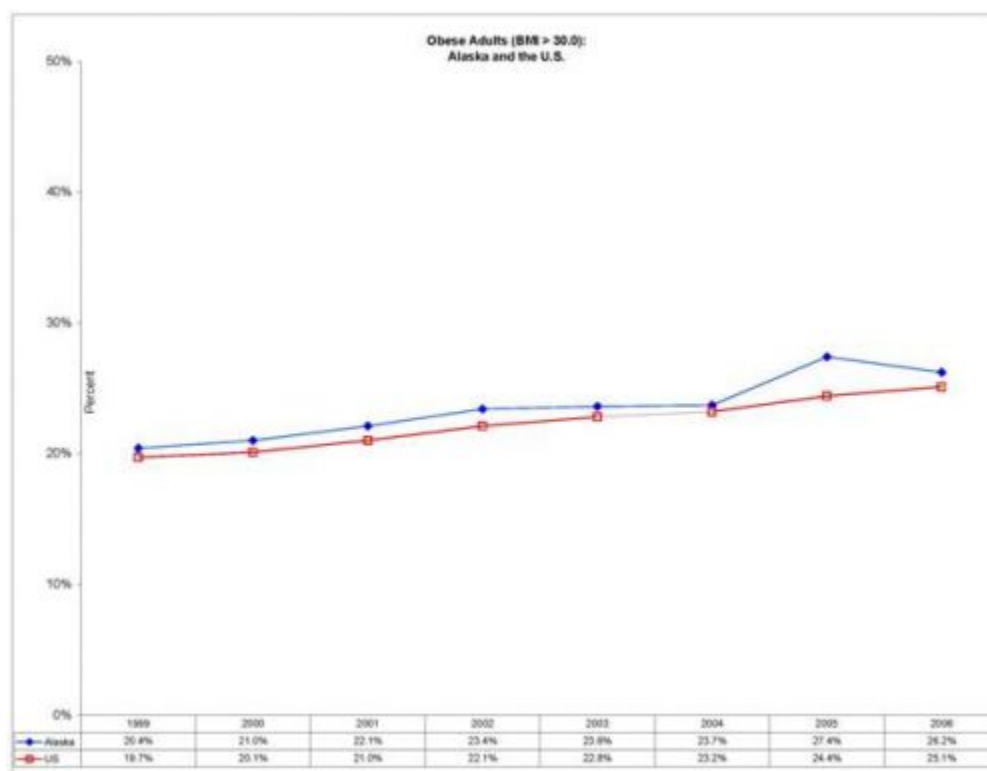
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence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

Over the past decade, an increasing number of Alaska adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29 percent 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 our community partners. 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 providing the knowledge and tools needed 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 percent.

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%
2006	26.2%	25.1%

Analysis of results and challenges: Analysis of results and challenges: The trends in Alaska continue to show growing numbers of overweight and obese adults, with an obesity rate of 26.2 percent in 2006. By comparison, the Healthy Alaskans 2010 target for obesity is 18 percent.

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 10 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.

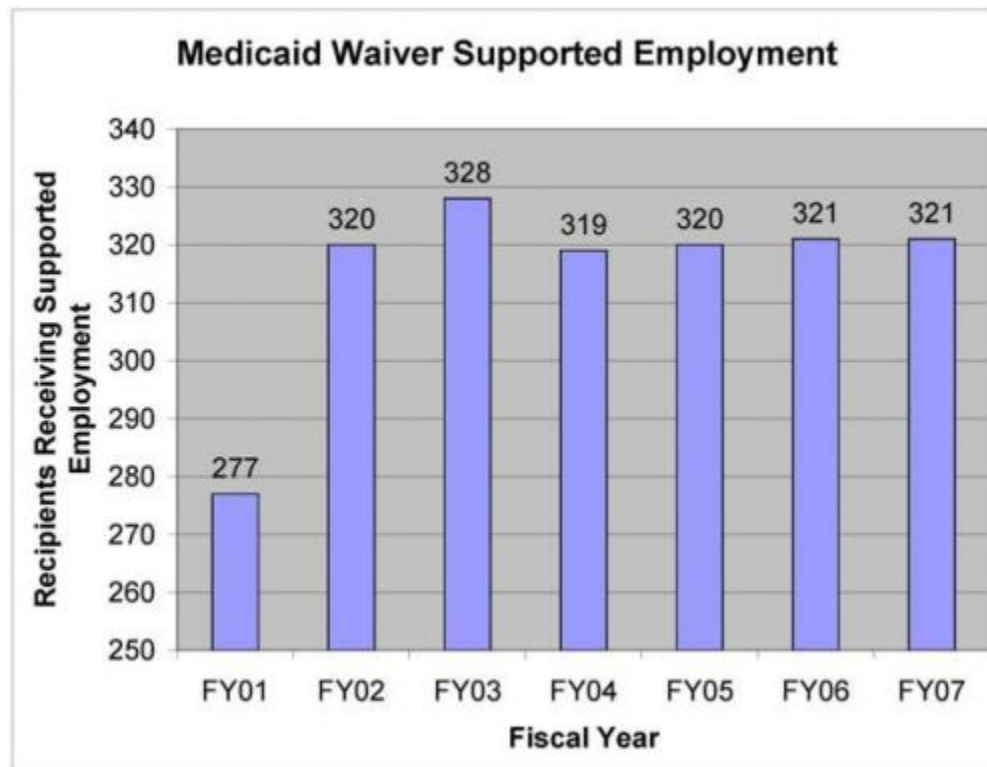
Through educational, programmatic, policy and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight, obese or at risk for being overweight, and to promote healthy food choices and exercise. A comprehensive approach is needed to reduce the trend of 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, targeting the promotion of healthy behaviors in communities: 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 Developmental Disabilities (DD) Waiver recipients receiving Supported Employment Services.

Measure #1: percent 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%
FY 2007	0.0%

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. Senior and Disabilities Services has determined that the reason the number of Developmental Disabilities (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.

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

Target #1: Reduce the average response time for complaints/inquiries to 14 days.

Measure #1: 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	1495	1224	24.52

Analysis of results and challenges: The response log "HSS Track" includes all inquiries or complaints that are received by the Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquiries, 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, 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 #2: Reduce by 5 percent per year processing time for key indicators.

Measure #2: 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	
DHSS Invoices	158,281	9.33	
Capital Grant Awards	93	3.36	
Legislative Logs	172	3.52	

Timeliness and Accuracy			
Fiscal Year 2007			
	# Processed	Days to Process	
Purchase Requisitions	459	5.80	
Operating Grant Awards	628	20.97	
DHSS Invoices	94,050	9.17	
Capital Grant Awards	101	1.50	
Legislative Logs	191	4.16	

Analysis of results and challenges: This is a new indicator with new data for FY 2006. The data will develop a baseline for future comparisons.

In FY 2007, the number of requests increased in several of the categories, resulting in an overall increase to the average response time. Although there was increased processing time and increased number of requests, the sections remained under the standard response time in FY 2007.

Alaska Pioneer Homes

Mission

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

Introduction

Alaska Pioneer Homes provide 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. Effective February 2007, the Palmer Home was certified as the Alaska Veterans and Pioneer Home. The six Homes served 560 Alaska seniors during FY 2007. As of October 31, 2007, 241 Alaska seniors were on the active waitlist and 2,494 were on the inactive waitlist.

Core Services

To provide residential assisted living and pharmaceutical services to Alaska seniors residing in the six statewide Pioneer Homes, including the Alaska Veterans and Pioneers 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	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 Veterans and Pioneers Home. The services provided over time have 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 at least 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 over \$3.0 million in Medicaid Waiver receipts in FY 2007 and is budgeted to collect about \$3.3 million in FY 2008.

Pioneer Homes 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 Dec. 31, 2005, all residents receiving state assistance, must also apply for other public benefit programs for which they may be eligible. The Homes now have three categories of residents for payment purposes: private pay, those on the Older Alaskans Medicaid Waiver and those on the Pioneer Home Payment Assistance program. The portion of the monthly rent not paid by the resident and/or the Medicaid Waiver is the state assistance provided.

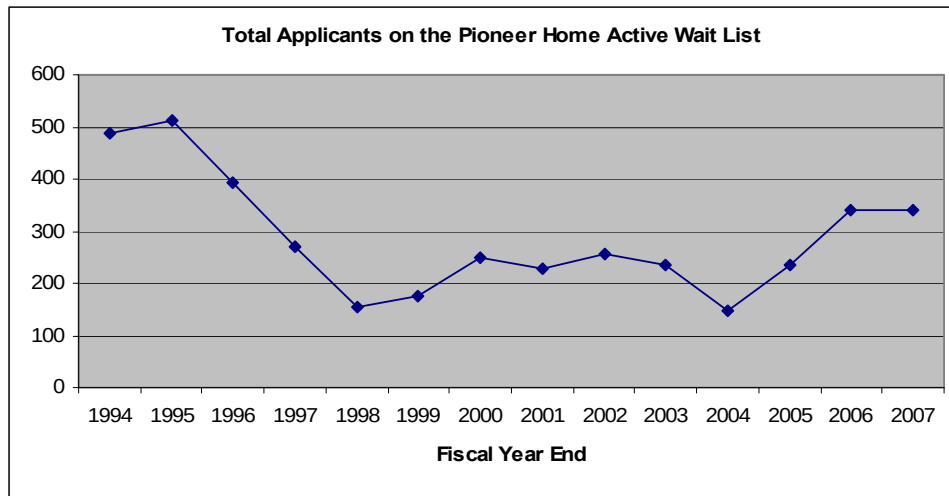
Annual Statistical Summary of Services Provided in FY2007

Pioneer Homes Wait List

Individuals apply for admission to an Alaska Pioneer Home or the Alaska Veterans and Pioneers 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 Homes 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 number of seniors on the Pioneer Homes active wait lists over the years is shown in the table and graph 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
2007	9	87	74	91	33	45	339
Oct-07	11	94	72	100	29	57	363



The following provides the composition of the Pioneer Homes wait list by facility as of October 2007. Over the past year the active and inactive wait lists increased by 23 and 63 applicants, respectively.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	11	94	72	100	29	57	363
Inactive Branch	688	897	909	1,239	491	850	5,074
Total	699	991	981	1,339	520	907	5,437
Number of Applicants Choosing More than One Home (Duplicates)							2,702
Number of Actual Applicants on Active Wait List (Not Duplicated)							241
Number of Actual Applicants on Inactive Wait List							2,494

Pioneer Homes Rate History

The next chart shows the history of monthly rates within the Pioneer Homes system. The July 1996 rate increase was the first increase in the Pioneer Homes Advisory Board's seven-year plan to move toward charging Pioneer Homes' residents the full cost of care. The final increase of the seven-year plan occurred in FY 2003.

In FY 2005 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. The rates have not changed since FY 2005 and the department is not proposing a rate adjustment for FY 2009.

The division continues to address the following FY 2007 legislative intent language:

It is the intent of the Legislature that the Pioneer Homes program administration review the actual full cost of care for services provided at the Pioneer Homes and develop a proposal to increase rates to reflect the system wide average of full cost of care at the three different levels.

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

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 2007 costs. 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, 2009.

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
July 2007	\$2,240	\$4,060	\$5,880

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.

Historical Pioneer Home Occupancy

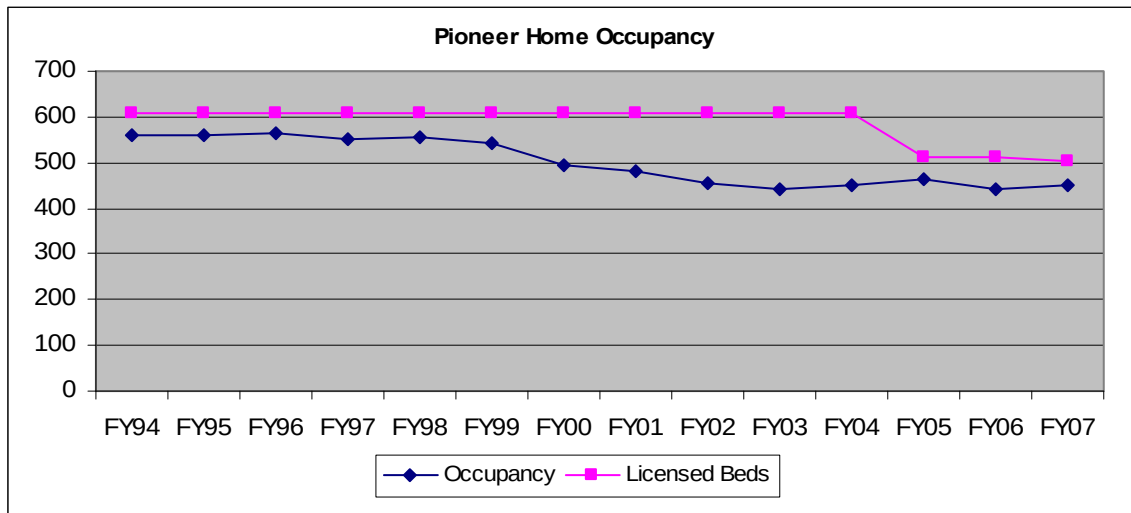
In FY 2005 the division reduced the number of its licensed beds by 91 to more accurately reflect the number of beds that meet current licensure requirements and are available for occupancy. In FY 2006 the licensed beds in the Fairbanks and Juneau homes decreased by three to reflect a safer resident-to-staff ratio. The homes can currently offer assisted living services to 505 Alaska seniors.

The majority of vacancies are in the Level I care units and there is not a demand for these beds. With 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 Homes 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.

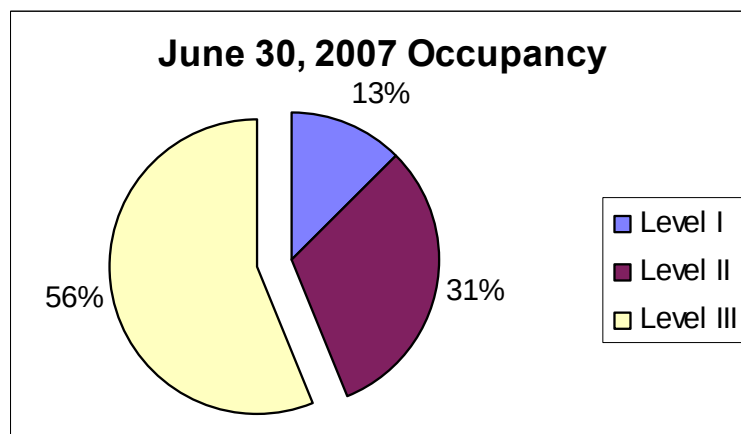
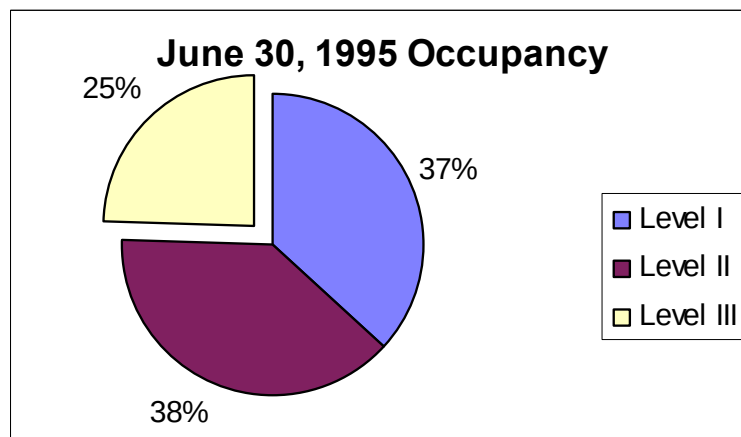
In FY07 the Legislature authorized additional staff to fill 10 and 12 vacant beds in the Sitka and Palmer homes, respectively. These positions are filled and the homes continue to work their active wait lists to admit residents as quickly as possible.

The following two graphs display 1) actual occupancy to the total number of licensed Pioneer Homes system beds and 2) the residents and the percentage of residents in each of the three care levels in 1995 and 2007. 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 Homes' residents over the past 12 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 percent to 56 percent, while those requiring Level I care decreased from 37 percent to 13 percent.



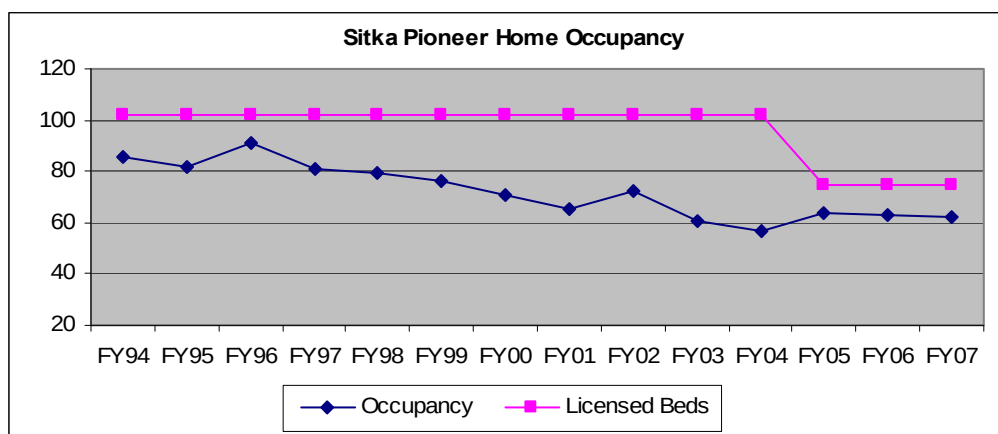
Current Pioneer Homes Occupancy

The table below shows the October 31, 2007, occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneers Home in Palmer by level of service. Totals toward the bottom of the chart compare occupied beds and available beds to the licensed beds.

Service Level	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Occupied/Assigned							
Level I	4	8	3	33	5	2	55
Level II	29	12	19	51	10	18	139
Level III	32	60	50	79	22	23	272
Total	65	80	72	163	43	43	466
Licensed Beds	75	93	79	165	48	45	505
Non-Occupied	10	13	8	2	4	2	39
% Licensed Beds Filled	86.6 %	86.0%	91.1%	98.8%	89.6%	95.6%	92.3%

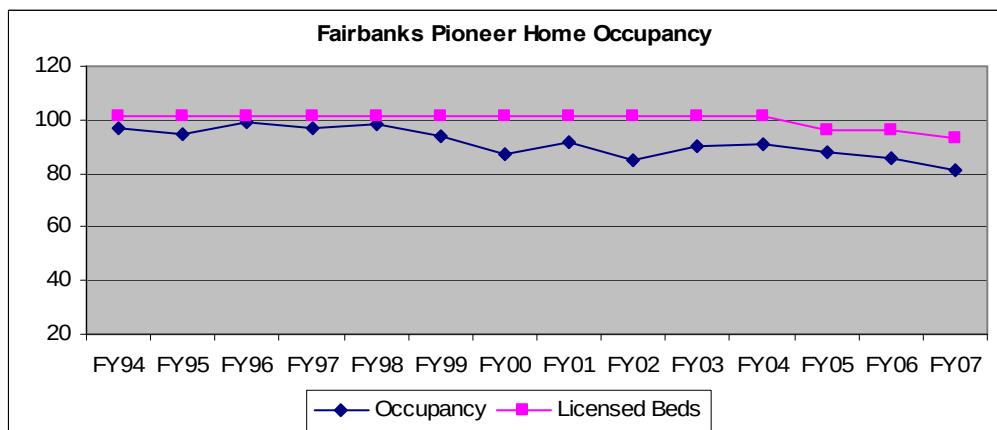
Sitka Pioneer Home

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, 65 were occupied as of Oct. 31, 2007. With the increase in staff authorized in FY 2007, the social worker is actively working to fill the additional 10 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 October 31, 2007, 80 of the 93 licensed beds were occupied. In November 2006, the Fairbanks home decreased the number of its licensed beds from 96 to 93.

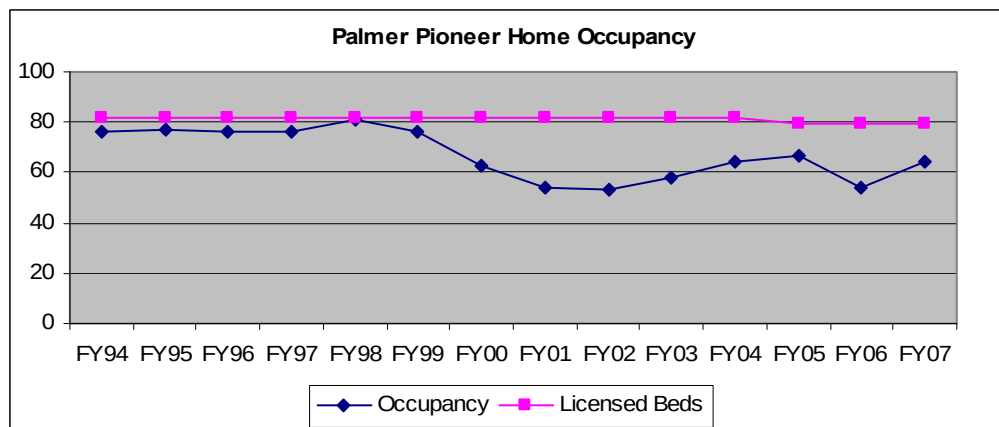


Palmer Pioneer Home

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 October 2007, 72 of the 79 licensed beds were occupied.

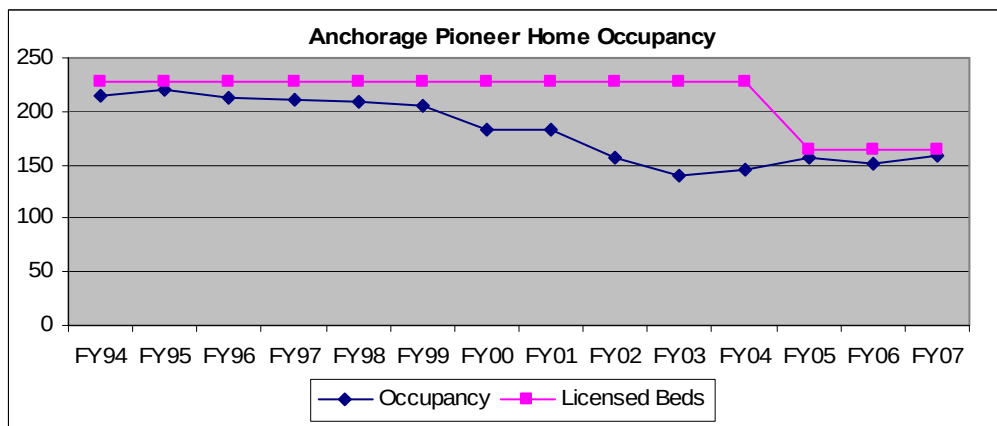
In June 2007, the Palmer home received final certification from the U.S. Department of Veterans Affairs to become Alaska's first state Veterans home. The home will now transition to fill 60 of its 79 licensed beds with veterans. As of Oct. 2007, 23 veterans resided in the Home. Nineteen of the beds are reserved for spouses of veterans, children of veterans, and all non-veteran related pioneers. The state Veterans and Pioneers Home in Palmer operates 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 10 new positions in FY07 to serve the needs of 12 additional residents in the Palmer Home. The staff of the Palmer Home continues to actively work the wait list to fill these beds.



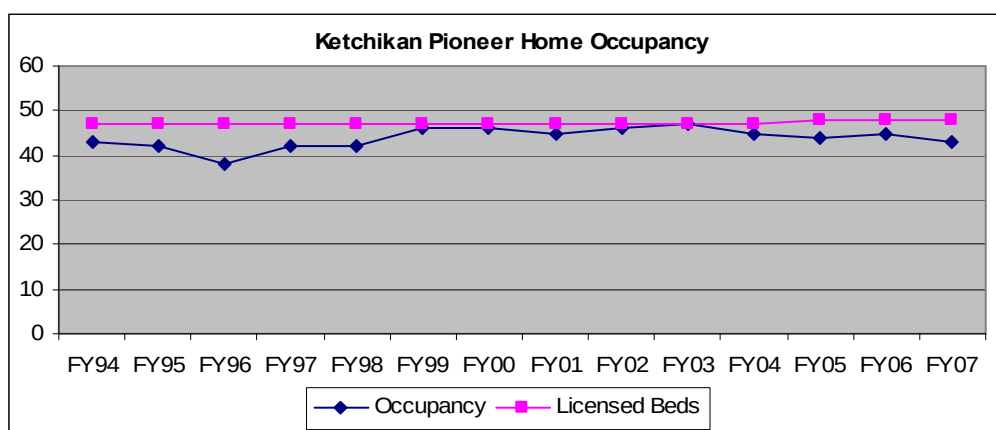
Anchorage Pioneer Home

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 October 2007, 163 of the 165 beds were occupied.



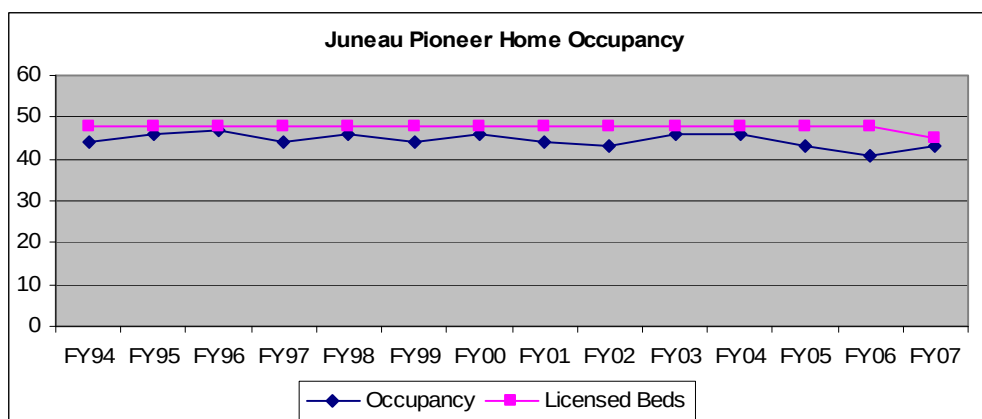
Ketchikan Pioneer Home

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. The Ketchikan home continually maintains a high census. In October 2007, 43 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 43 Alaska seniors as an Assisted Living Home and is licensed for 45 beds.



List of Primary Programs and Statutory Responsibilities

Ch 59, SLA04	Pioneers' Homes/Veterans' Homes: SB 301
AS 44.29.020(1) (16)	Duties of HSS 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

Explanation of FY2009 Budget Changes

AK Pioneer Homes	2008	2009 Gov	08 to 09 Change
General Funds	30,426.1	32,249.7	1,823.6
Federal Funds	314.7	291.0	-23.7
Other Funds	20,396.6	21,411.0	1,014.4
Total	51,137.4	53,951.7	2,814.3

Pioneer Homes

Increase Base Budget for Equipment Purchases: \$500.0 Receipt Supported Services

In prior years, the Pioneer Homes received legislative approval to transfer unexpended resident payments (receipt supported services) and those collected in excess of the amount authorized to the capital budget for equipment needs. This funding is used to purchase equipment for the residents and the homes and includes items such as special resident beds, resident safety lift equipment, unique bathing tubs appropriate for the frail elderly, industrial kitchen equipment for bulk food preparation, and commercial capacity washers and dryers.

Although the FY 2008 Governor's budget did not include this language, in lieu of a supplemental request, the Legislature authorized any unexpended and unobligated balance of FY 2007 support receipts collected to be appropriated for Pioneer Homes equipment and supply needs. Rather than relying on the inclusion of this language in the operating budget or supplemental budget request to pay for the equipment the Pioneer Homes need, this change record builds the equipment needs into the base budget.

Increment for Feasibility Study Related to Privatizing the Pioneer Homes or Services: \$50.0 General Funds

The question is often asked if the state of Alaska should be in the assisted living business, owning and operating the Pioneer Homes. Because the Alaska Veterans and Pioneers Home in Palmer has a different status as a state veteran's home, it must be viewed differently.

In an effort to ensure that the state's funds are most efficiently utilized and to identify cost-saving opportunities, the division will hire a contractor to undertake a feasibility study to assist in the determination of whether the state should continue under statutory authority to operate the Pioneer Homes, or if it is feasible to privatize the homes or contract out some of the services currently provided by state employees, such as food, housekeeping and laundry services, or management functions currently handled by administrators in Juneau and each of the homes.

Increment for Reduced FMAP: \$214.4 General Fund

The Pioneer Homes bill for and receive Residential Supported Living Medicaid Waiver receipts. Both the federal and general fund match is received as interagency receipts. The interagency receipts are a funding source for the Pioneer Homes and the general fund match is a contractual expense paid by the Pioneer Homes to Senior and Disabilities Services.

The current FMAP of 57.58 percent decreases to 52.48 percent Oct. 1, 2008, and averages 51.02 percent during FY2009. This decrease results in a 6.6-percent increase in the general fund match expenditure.

The FY 2009 budget includes \$3,268.5 of Medicaid waiver receipts. The first quarter and remaining three quarters' FY 2009 general fund match are 42.42 percent and 48.98 percent, respectively. The increased general fund match will cost the Pioneer Homes \$214.4.

This increment increases as the interagency receipt authority increases from pay, retirement or other funding changes made to the FY 2008 and FY 2009 budget.

Increase Interagency Receipts for Providing Food Service to Youth Facilities: \$113.0 Interagency Receipts

With the new food service contract, effective July 1, 2007, the Juneau Home began providing meals to clients and staff of Johnson Youth Center. Under this contract the Fairbanks, Ketchikan and Palmer Homes also provide meals to the youth facilities located in their areas. For a number of years Juvenile Justice paid the Pioneer Homes \$67.0 (for two part-time food service workers) for these services.

Alaska Pioneer Homes and Juvenile Justice increased the amount to be paid to the Pioneer Homes for the use of its employees and kitchens to provide meals to the youth facilities to \$180.0. This amount funds three food service workers at \$45.0 each and provides \$45.0 for kitchen supplies and equipment related to the increased number of meals that the homes prepare.

Challenges

Pioneer Homes' Advisory Board (PHAB) Concerns

After touring the three northern 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 recommendations. The following are issues brought to the Governor's attention by the board:

Operating

On both a statewide and department level, the services provided by the Human Resources, Information Technology and State Travel office have declined since these functions were centralized. Additionally, these services continue to become more costly. The PHAB recommended that the Governor provide funding for a review of these consolidated functions to determine how to make them more efficient.

Capital

The Pioneer Home facilities range from 19 to 73 years old and continue to deteriorate due to the lack of funding for deferred maintenance. The PHAB recommended that the Governor approve the inclusion of the deferred maintenance projects, including the Sitka Pioneer Home Roof and the Zero Lift program, in the DHSS FY 2009 budget request.

The Sitka Pioneer Home now uses 41 five-gallon buckets (17 buckets were used last year) in its attic to deal with the numerous and 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.

The Zero Lift program will address the needs of small framed certified nurse aides (CNA) who are unable to lift or transport residents properly, decrease worker's compensation claims for shoulder and back injuries, decrease employee absenteeism and allow the homes to safely serve the residents. This equipment does not add to the need for storage space as the lifts are affixed to the ceiling.

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

Increased Documentation Requirements

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, and social workers notify new admissions of the need to apply for other benefit programs, and included supplemental funding paperwork in the Pioneer Homes admission packets. Social workers continue to assist residents and/or responsible parties with the forms and initial application for benefits as well as with follow-up paperwork.

The following table shows the number of residents receiving state assistance through the Pioneer Home Payment Assistance program and those eligible for the Older Alaskans Medicaid Waiver as of November 21, 2007.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total	% of Total
Residents Receiving Assistance through the division's Payment Assistance Program	24	25	23	63	13	15	163	34.80%
Residents Approved for the Older Alaskans Medicaid Waiver	19	9	20	26	12	6	92	19.70%
Total Residents	65	81	73	165	41	43	468	

The Pioneer Homes system billed and collected over \$3.0 million in Medicaid Waiver receipts in FY 2007 and is budgeted to collect nearly \$3.3 million in FY 2008. Beginning in FY 2006, all receipts for pharmaceuticals are posted as statutory designated program receipts (SDPR).

Recruiting and Maintaining Health Care Personnel

Recruiting and maintaining adequate health care personnel in a time of national and state work force shortages is an ongoing challenge for the Pioneer Homes. The pay and benefits of the Pioneer Homes work force is not competitive with jobs in the same job class in the private sectors.

Governor Palin's Executive Proclamation of October 19, 2007, recognizing November 2007 as Apprenticeship Awareness Month, illustrates the Governor's acknowledgement of the important role that apprenticeships offer the work force. The apprenticeship model is one of the most effective means of maintaining a well-trained and skilled work force. Beginning in FY 2008 the Pioneer Homes is partnering with the University of Alaska Statewide Health Program, the U.S. Department of Labor, Alaska Mental Health Trust Authority Work force Initiative, and the Alaska Department of Labor Job Center Network in the Long-Term Care Apprenticeship program for Certified Nursing Assistants (LTCAP). The purpose of the LTCAP is to implement industry-driven training solutions that address the long-term care sector's critical work force challenges for recruitment and retention by using the on-the-job training apprenticeship model.

Through the LTCAP for Certified Nursing Assistants, the Pioneer Homes is endeavoring to better prepare its workers and increase health-care personnel retention. The first phase of the LTCAP implemented in FY 2008 is designed for certified nursing assistants (CNAs) working in the Pioneer Homes. These CNAs can specialize in dementia care, restorative care, geriatrics, and leadership and earn college credit for both the class time and on-the-job training time.

Implementing the Continuity of Operations and Disaster Preparedness Plan

In FY 2007 the Pioneer Homes began implementing the Continuity of Operations and Disaster Preparedness plan and during FY 2008 the Pioneer Homes finished the implementation for the entire Pioneer Homes system. The plan contains worksheets that guide the individual homes through the process of crafting home-specific Disaster Preparedness Plans. During FY 2008 the individual Pioneer Homes will update the individual homes' COOP and Disaster Preparedness Plan.

Developing a Training and Disaster Drill Preparedness Plan

Through Alaska State Hospital and Nursing Home Association (ASHNHA), the Pioneer Homes staff participated in the PREPARE train-the-trainer disaster preparedness training. PREPARE is a federal grant funding program to equip long-term care professionals with the core competencies to address the medical and psychosocial consequences of natural disasters and other public health emergency preparedness and response concerns. The Pioneer Homes staff continue with train-the-trainer PREPARE learning modules in disaster preparedness within the Pioneer Homes system.

Challenges remain for the Pioneer Homes to exercise and drill in preparedness activities such as full evacuation, and IT, personnel and fiscal preparedness.

Processing Background Checks Timely

The Pioneer Homes transitioned to the Alaska Background Check program in FY 2007. For FY 2008 the division transitioned back to Department of Public Safety (DPS) for the fingerprint/FBI check portion of the background check. The Pioneer Homes is continuing to process the determination and provisional authorizations portion of the background check through the Alaska Background Check program.

There have been several challenges for the Pioneer Homes to use the Alaska Background Check program. The Alaska Background Check program cannot supply the Pioneer Homes with the billing information that is required by Finance and Management Support Services (FMS). This prompted the Pioneer Homes to transition back to DPS for the processing of the FBI background checks.

In addition, processing the provisional approval and determinations is not being done in a timely manner. Pioneer Homes typically employs people who do not have completed FBI background checks because of the length of time it takes for the Alaska Background Check program to process a background check. However, all employees have received provisional approval from the Alaska Background Check program.

Performance Measures — Alaska Pioneer Homes

Contribution to the 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 living environment for elderly pioneers and veterans.

Target #1: Injury rate below half the national standard, which is 2 percent to 6 percent.

Measure #1: Pioneer Homes sentinel event injury rate.

Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.126%	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	3.5%	1.2%	2.0%	2.1%	2.2%
2008	1.5%	0	0	0	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 as 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 Homes residents create 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, individual 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 explanation and tables.

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

Target #1: Less than 1-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
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%	0.22%	0.15%	0.14%	0.18%
2008	0.16%	0	0	0	0
		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 5-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 risks. Trending the cause of the error tends to provide the most useful information in designing strategies for preventing future errors.

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

Target #1: Less than 2-percent injury rate, which is the low end of the National Safety Council's range of 2 percent to 6 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
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	3.5%	1.2%	2.0%	2.1%	2.2%
2008	1.5%	0	0	0	1.5
		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 for suffering a serious injury from a fall that could lead to death.

Pioneer Homes respond 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 falls are reported as "found on floor," and the sequence of events leading up to the fall is reconstructed by staff depending on the time of day with some supposition about 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%

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

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Behavioral Health

Mission

To manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships.

Introduction

The Division of Behavioral Health (DBH) operates and manages behavioral health programs and services, and seeks to insure that Alaskans are afforded access to a continuum of statewide services. This continuum of statewide behavioral health services ranges from prevention, early intervention through treatment services, to inpatient psychiatric hospitalization. The array of services is provided in community-based outpatient settings, school-based programs, residential facilities, and settings involving tobacco enforcement activities. Additionally, the division provides a strong housing component to assist individuals who have been homeless or are in need of assisted living. These services are located in small villages, regional centers and urban communities throughout the state.

The division administers grants to the state's network of service providers, coordinates with municipalities, tribal and private providers, to ensure comprehensive behavioral health services to Alaska residents. Frequently, DBH collaborates with the Alaska Mental Health Trust Authority, the Alaska Mental Health Board (AMHB), the Advisory Board on Alcohol and Drug Abuse (ABADA), and providers and advocacy groups.

Core Services

Behavioral Health provides core services that help achieve its mission to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships.

- Insures effective, efficient management and administration of publicly funded behavioral health services. These include prevention and treatment services for Alaskans with substance use disorders, mental illness, a combination of both, individuals with traumatic brain injury, or fetal alcohol spectrum disorders.
- Develops regulations and policies that govern the planning and implementation of services and supports for people who need Behavioral Health services.
- Operates the Alaska Psychiatric Institute, the state's only 24-hour psychiatric hospital which receives patients on a voluntary and involuntary basis, and which also provides rural Alaska with telemedicine/psychiatric services.

The Alaska behavioral health system is defined by its mission to ensure that children and adults with mental, emotional, substance use and abuse, behavioral problems, and their families, have access to the services and supports they need to succeed. This continuum of behavioral health services is designed to meet the unique strengths of each individual, is culturally sensitive, and is delivered in the most normative environment that is clinically appropriate. At its best the system is designed to acknowledge the diversity of communities across the state of Alaska and to maximize quality of service and economies of scale. The continuum of services reflects the importance of relationship between providers in smaller and larger communities.

Services Provided

Treatment & Recovery Section

The Treatment and Recovery administration section administers the Behavioral Health Grant Services, Psychiatric Emergency Services, Designated Evaluation and Treatment Services, and Services for Severely Emotionally Disturbed Youth,

Performance Based Funding: Treatment and Recovery staff will continue its successful methodology to applying performance-based measures for allocation of treatment grant funds for FY09.

New Business Practices: As Behavioral Health moves forward in the development of “new business practices,” Treatment and Recovery continues to reduce the quarterly reporting requirements of grantee providers — making the administrative footprint of the division on providers smaller.

Community Planning: Implement an improved local community planning process to increase the collaboration between grantee and allied care providers within the 29 local community planning and services areas that cover the state, and to base those interactions on specific service deliverables.

Outcome Indicators: Partnering with the Research and Planning section will increase data collection from grantees. This process will allow the division to assess program effectiveness, and implement Performance Based Funding measures through a fully implemented Alaska Automated Information Management System (AKAIMS).

Service Provider System and Numbers Served in FY07

- 103 behavioral health treatment & recovery providers
- 64 prevention & early intervention grantees
- 1 staff supported psychiatric hospital licensed for 80 beds

- 5,413 persons received substance abuse services
- 9,034 seriously emotionally disturbed youth were served
- 15,384 adults with serious mental illness were served
- 42,030 emergency contacts were made
- 1,231 persons were admitted to API

(NOTE: these numbers may include duplicated counts)

Behavioral Health: Program Integrity Section

Program Integrity (PI) evaluates all behavioral health programs to ensure that treatment services are effective, collaborative and protect the health, safety and well-being of its consumers. PI works with providers to reduce their Medicaid error rate through medical necessity reviews and technical assistance. Additionally, PI is responsible for providing formal program certification (or approval), for substance use disorder treatment services to operate in Alaska, which is a requirement of Alaska law.

- Program Integrity will certify substance use disorder treatment providers and conduct medical necessity reviews for Medicaid providers. In response to review findings, PI will provide technical assistance to improve client care to providers. Technical assistance includes: 1) reduction of Medicaid error rates; 2) common Medicaid audit findings — mistakes in billing and documentation; 3) Medicaid regulations, billing and provider agreements; 4) creating effective assessment and treatment plans; and, 5) Criminal Background Check regulations.
- PI continues to work closely with the Medicaid Fraud Unit and the Surveillance unit at First Health, as well as Health Care Services. When First Health identifies irregularities in provider billing patterns, it requests clinical records from the provider, PI reviews these records to confirm suspicions or eliminate doubt about the provider's billing practices. The supervisor of the PI unit sits on the department's audit committee and assists in the preparation for Medicaid audit appeals, working closely with Health Care Services.
- The supervisor of the PI unit sits on the Criminal Background Variance Committee appointed by the Commissioner. The Variance Committee was established in early April 2007, and by the end of the fiscal year had made approximately 28 recommendations to the Commissioner to approve, approve with conditions, or deny the requested variance. The PI unit assists the public in processing variance requests. After a behavioral health entity submits a request, it is then reviewed and recommendations are routed to the Variance Committee.

Prevention & Early Intervention Section

The Prevention and Early Intervention administration section provides management and support for Alaska's behavioral health system. This involves the core services of Community Action Prevention & Intervention Grant Services, Alcohol Safety Action Program, and Fetal Alcohol Syndrome Services.

Suicide Follow-Back Study: In March 2007, DHSS, in partnership with the Alaska Statewide Suicide Prevention Council and the Alaska Mental Health Trust Authority, released a new study on suicide in Alaska. The three-year study, completed by the Alaska Injury Prevention Center, documents the circumstances and family perceptions surrounding the 426 suicides that occurred in Alaska from 2003–2006. Of the 426 suicides during this time period, follow-back interviews were conducted for 56 cases.

This study, the first of its kind in Alaska, is a critical step to better understand the underlying behavioral risk factors leading to suicide. The information that will be analyzed in FY09 includes the issues facing Alaskans that lead to suicidal thoughts, or completed suicides. It will guide the development of better interventions, strategies, and services, to both prevent suicide, and to intervene earlier in the lives of individuals that feel suicide is their only choice.

Alaska Epidemiological Profile of Substance Use: Beginning in FY06, Alaska received a contract from SAMHSA to develop a statewide epidemiological (EPI) profile of substance use in Alaska. The full report will be completed in FY08, and will be used to guide development of effective community intervention strategies in FY09.

Alaska's Plan to Reduce and Prevent Underage Drinking: In response to the Acting Surgeon General's "Call to Action to Prevent and Reduce Underage Drinking" Alaska developed an interagency coordinating committee to prevent underage drinking (AKPUD). Agencies participating on the committee include Behavioral Health and Juvenile Justice; Department of Education and Early Development; Department of Transportation, Highway Safety Office; Alaska Court System; Department of Public Safety, ABC Board; and, the Alaska Native Justice Center. The plan is in final draft form and was posted for public comment on Dec. 3, 2007, for final publication in early 2008.

The plan defines clear recommendations and the responsibility of the state, as well as local communities, in accomplishing the identified tasks for application in FY09.

Suicide Prevention Initiative: In partnership with the Alaska Statewide Suicide Prevention Council, Behavioral Health Prevention staff began working on a suicide prevention initiative, using the recently completed Alaska Follow-back Study and its findings. The study forms a basis for new strategies to better partner with communities and community agencies, to focus their efforts on improved mental health, and reduced suicidal thoughts and actions. DBH will continue to work on developing the initiative and incorporating the strategies into its new FY09 Request for Proposals, including a strong focus on community planning, readiness and evaluation of program efforts. DBH is also working closely with its national partners to increase Alaska's capacity to respond to suicide crisis calls, and provide evidence-based programming specifically aimed at suicide prevention.

Strategic Prevention Framework (SPF): All behavioral health program grantees have been trained in the five-step strategic prevention framework, and are required to utilize this planning model in their program development, evaluation and revisions, as needed. This overall change in philosophy has helped to embed DBH's vision into everything its grantees do: partners promoting healthy communities. The SPF encourages communities to develop a continuum of services across the spectrum from promotion of prevention ideas, to prevention, to early intervention, to treatment and to recovery. DBH will continue to use this planning tool and incorporate it into its new FY09 grant programs.

Substance Abuse and Mental Health Service Administration (SAMHSA) center for Substance Abuse Prevention System Review: Every three years, state prevention programs receive a system site review from the SAMHSA Center for Substance Abuse Prevention (CSAP). The review is an opportunity for CSAP and its site review contractors to visit the state, meet with state prevention staff, and review the programs and prevention system/strategies in place. Although Alaska reporting systems provide a more comprehensive overview of prevention efforts, this review specifically analyzes the use of the prevention set-aside funding in the Substance Abuse Prevention and Treatment Block Grant. The review was very positive and the federal staff gave the division "high marks" for implementation of the SPF evaluation tools, outcome measures, and its tobacco enforcement (Synar) efforts.

Behavioral Health: Policy & Planning Section

The Policy and Planning section's responsibilities involve the planning, development, implementation, monitoring and updating of statewide policies, procedures and regulations, as well as the application of project management in program and systems development. In response to a growing focus on a business practice that is data-driven and based on outcomes, the Policy and Planning section provides oversight to research staff and the Alaska Automated Information Management System (AKAIMS). In addition, the section is responsible for "policy and regulation development". The following programs are key proprieties of FY08 and moving into FY09: behavioral health "new business practices"; Integrated Regulations; Program Approval; National Accreditation; Performance Management System/Performance-Based Funding, the Behavioral Health Integration Project; the Bring the Kids Home Initiative; and Fetal Alcohol Spectrum Disorder (FASD) Demonstration Waiver.

The Behavioral Health Integration Project: The Behavioral Health Integration Project has challenged all aspects of the service system. Significant progress has been made in the development of capacity to serve clients with co-occurring disorders. The most recent evaluation report highlights this progress, including:

- increased staff capability in Dual Diagnosis Capability;

- improvements in integrated screening and assessments;
- integrating mental health and substance abuse staff;
- improved staff competency;
- collaboration with other provider agencies;
- integrated treatment planning; and
- identifying individuals with Co-occurring Disorders.

This project will result in new integrated regulations, with an anticipated date of implementation in FY09.

Performance Management System/Performance-Based Funding: Behavioral Health has invested significant resources into the ongoing development of a Performance Based Funding system (PBF) for the allocation of prevention and early intervention and treatment grants. Outcomes for prevention programs are very different than treatment programs. The indicators of “success” for prevention grants are defined in the categories of “documented project outcomes,” “agency performance,” and “documentation of behavioral health conditions for the target population(s).” The indicators of “success” for treatment grants are defined in the categories of “documented project outcomes,” “agency performance,” as well as data quantity and quality submitted by providers (minimal data set) and outcomes, using the Client Status Review of Life Domains (CSR). Additionally, by using prevalence estimations, indicators will also be focused on identified needs of services, cost of service delivery, and the degree to which services meet or do not meet the local need.

The Alaska Automated Information Management System (AKAIMS): Significant redesign and technical support is necessary to fully implement AKAIMS to the level necessary for use in the performance-based funding protocols. DBH will work closely with agencies to get their data into the system, prepare for quarterly reports, and the application of performance-based funding measures for FY09.

DBH anticipates expanded participation in the AKAIMS user group, and improved utilization by its agencies and division staff of production reports as quality assurance and management tools. This process will insure quality data available for the application of performance measures for FY09 funding.

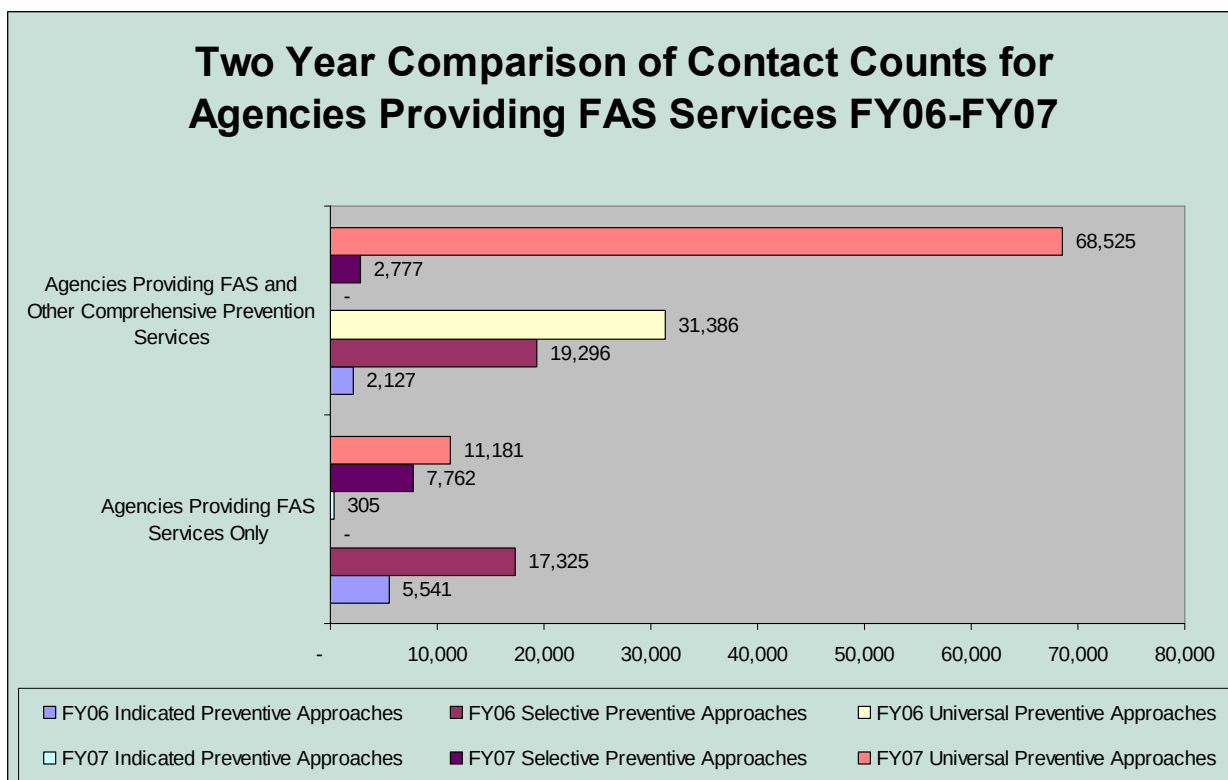
Alaska Fetal Alcohol Syndrome (FAS) Services

FAS goals are to reduce alcoholism and substance use among pregnant women and women of child bearing age. The expected outcomes of this program are to prevent alcohol-related birth defects; to increase diagnostic services in Alaska; to improve the delivery of community-based services to individuals already affected by fetal alcohol spectrum disorders (FASD); and to evaluate the outcomes of the statewide project.

Services include training, public education, coordination of statewide diagnostic services, and community support through grants and contracts. To decrease the presence of fetal alcohol spectrum disorders, FAS services continues to develop partnerships with other divisions, departments, community agencies, Native health corporations and parents/caregivers. This service is administered and managed through the Behavioral Health Administration component, Prevention and Early Intervention section.

- FASD curriculum development project continues to be used across the state through two curricula: FASD 101 is titled “Disabilities of Discovery: Insights into Brain-Based Disabilities”; and FASD 201 is titled “Developing Successful Interventions and Supports.” More than 1,000 individuals have received the FASD 101 training with an aggregate increase in FASD knowledge of 31 percent, as indicated by the post-training test. The FASD 101 for Educators is an online four-hour course specifically developed to meet the needs of Alaska educators, and the statutory requirement that all educators must be trained in FASD.
- Fourteen (14) FASD community-based grant programs are funded by the division across the state. These projects include the following: prevention programs aimed at middle- and high-school-age youth; prenatal programs working with expectant moms and dads; training programs for school personnel working with children and youth with FASD; and life-skills development programs for adolescents and young adults with FASD. Through these grant programs, community coalitions work on the many issues related to FASD, increasing community awareness, education and activities aimed at reducing prenatal exposure to alcohol.
- The Alaska FASD community-based diagnostic team network currently has 12 community-based diagnostic teams across Alaska, and one specialized team located at the Alaska Psychiatric Institute (API). Behavioral Health hosts a monthly teleconference with all diagnostic team coordinators, which provides an opportunity for sharing information, discussing cases, and provides new resources, research and data that may be helpful in their work. Since 2000, when the division first began diagnosing FASD, 1,130 individuals have been diagnosed using the University of Washington-developed 4-Digit Diagnostic Process. Of those who completed a diagnosis, approximately 10 percent have full FAS (with the facial features and growth deficiencies); 86 percent received a diagnosis indicating significant brain damage; approximately 4 percent did not show signs of an alcohol-related disability. The average age at diagnosis is between 9 and 13 years of age.
- In December 2006, the department received notification that a Medicaid Waiver Demonstration Project was awarded to serve youth ages 14–21 with co-occurring diagnoses of an FASD and a seriously emotionally disturbed (SED). The first nine months of the project were for planning and project design and services will be offered starting in December 2007. This project will complement and strengthen the FASD Program and the

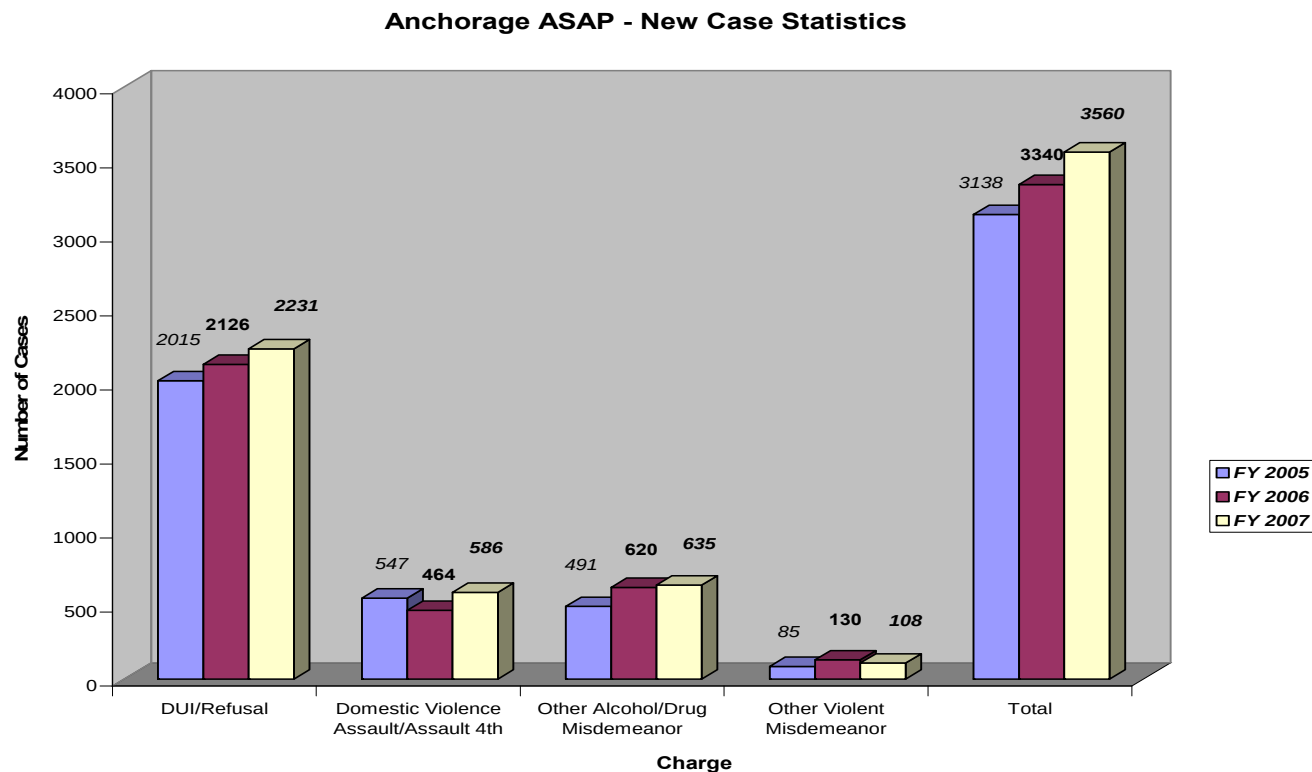
Bring the Kids Home initiative in keeping children in Alaska for treatment, by maintaining them through wraparound services within their home community.



Alcohol Safety Action Program (ASAP)

The goal of this program is to reduce alcoholism and substance abuse. ASAP is both a direct service provider in the Anchorage area and the oversight office for the division's statewide ASAP grant programs. The program facilitates entry of all misdemeanor defendants ordered by the court, the Division of Motor Vehicles, or Juvenile Justice, into substance abuse education or treatment. The program also monitors court requirements, and provides data regarding those defendants. In its grants management role, ASAP provides training to qualify administrators for ASAP grant programs throughout the state, and provides quality control and monitoring functions on all state-approved ASAP programs.

Examples of services provided and accomplishments for FY07 include the results of the “New Case Statistics” for the Anchorage ASAP:



Behavioral Health Grants

The goal of this service is to mitigate the impact of behavioral health issues on individual Alaskans who experience severe mental health, alcoholism and other substance abuse impairments. The grants provide treatment services through local grantee organizations and services to individuals to achieve recovery and attain their highest possible functioning level.

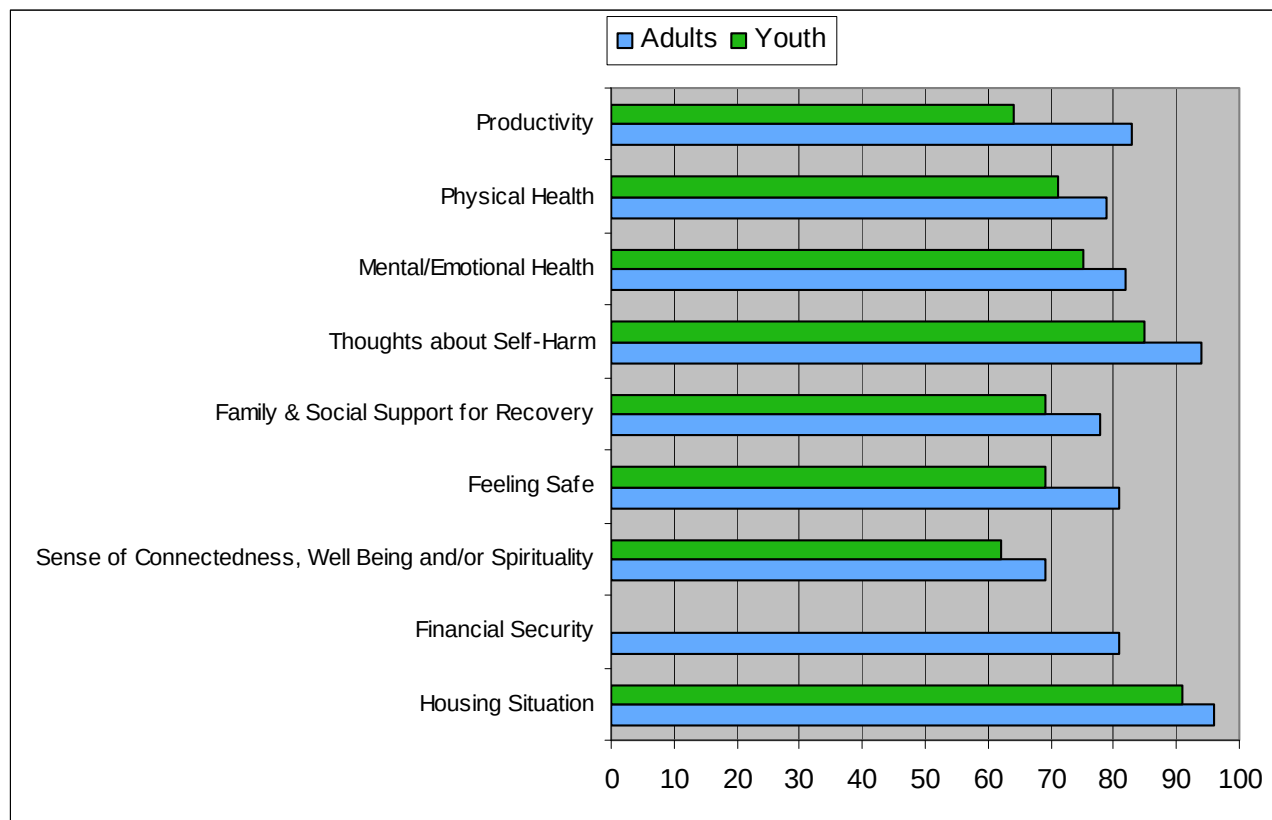
Behavioral Health grant-funded community-based treatment services include: emergency detoxification; residential treatment (adult, adolescent, family, gender specific for women with children) and intensive therapeutic communities; and outpatient treatment (adult, gender-specific for women with children, opioid treatment programs, youth and families).

The Behavioral Health grants component contains grant funding to local nonprofit agencies to support the comprehensive, statewide mental health and substance abuse treatment system, as required by law. These publicly funded programs primarily serve Alaskans without insurance or the ability to pay for services. This component also supports personal skills development and general support services for people with traumatic brain injury, and maintenance of state-owned community mental health facilities.

A key outcome for behavioral health grants is a positive report on the Client Status Review of Life Domains — Youth & Adult. This is reported by individuals served within behavioral health treatment system funded through grants.

2007 Treatment Outcomes

Client Status Review: Youth & Adult



Substance abuse treatment services are provided through grants to community not-for-profit organizations that were approved by the division to deliver specific levels of alcohol and drug treatment services. The division's funding is primarily targeted to provide the following: substance abuse services to individuals with no other means of paying for treatment; support for targeted populations with special needs, including pregnant women, women with dependent children, individuals at risk of harming themselves, and others; and services for injection drug users at risk for infectious disease.

Behavioral Health Administration

The mission of this component is to direct and administer the statewide behavioral health programs and services, which spans the continuum from prevention and early intervention through treatment and recovery.

This component provides the overall administrative and organizational structure for Behavioral Health. More than \$230 million is granted, contracted, or otherwise utilized by the division, and is managed through this component, to accomplish the identified mission. All of the division's staff, except for those employed by the Alaska Psychiatric Institute, is funded in this component.

The Behavioral Health Administration component provides centralized administration of the grant-funded, community-based behavioral health prevention and treatment services/programs, and the Alaska Psychiatric Institute. Sections within behavioral health administration include the following: service system planning and policy development; programmatic oversight of behavioral health grantees; general administration; budget development and fiscal management; program and systems integrity; and Medicaid management. The leadership in this component 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. The division collaborates regularly in planning and program efforts with other components within the department, such as Children's Services, Juvenile Justice, and Public Assistance, as well as with other agencies such as the Department of Corrections.

Changing Business Practice: Behavioral Health has initiated a policy change to overhaul its business practices and management philosophy. This will involve a shift away from its historical focus on oversight and compliance, and move forward to develop business and management practices that focus on delivery of high quality service and improving treatment outcomes. The expectation is that the grantee-provider's administrative burden associated with periodic reporting and operational oversight will be reduced; the expectation of accountability and a results-orientation will be refined. The desired result will realign and redefine the division's efforts toward providing high quality services to Alaskans efficiently and effectively.

Integrated Medicaid Regulations: The division has engaged in a major effort to address the issue of integrating regulations for mental health and substance abuse services. The "integrated" Medicaid regulations will replace the current portions of 7 AAC 43 that addresses reimbursement of substance abuse services and mental health services. The "integrated" Community Behavioral Health Services regulations will replace 7 AAC 29 (Uniform Substance Abuse Treatment), and 7 AAC 71 (Community Mental Health Services). The purpose and intent of these integrated regulations is to: insure state compliance with federal regulations; maintain system accountability and system integrity; remove unnecessary "industry standards" from reimbursement regulations; clarify the role of Behavioral Health and its expectations of grantees; reduce administrative burden, where possible, for both department and behavioral health grantees; adopt a national accreditation policy to ensure industry standards are embodied within provider business practices; link quality services and outcomes to priority populations; and increase both consumer and grantee satisfaction.

National Certification: A standardized process is being developed that allows the division to "authorize" or "approve" behavioral health providers. Once issued by the division, each provider can obtain a Medicaid enrollment and be eligible to receive grant funds. The intent is to develop an objective standardized method of decision-making to approve a provider for a specific geographical area. The decision to approve a provider for a particular community service area or region would be based on matching identified need, history of level of effort, and available resources that match with the level of services that can be supported by state funds.

Smaller Administrative Footprint: The expectation is that the grantee's administrative burden, associated with periodic reporting and operational oversight, will be reduced, and the expectation of accountability and a results-orientation will increase. Ultimately, program standards will be embodied in national accreditation, which will be required for all providers. Reaching this goal will take several years of preparation involving a partnership with Behavioral Health, the provider organizations, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska

Mental Health Trust Association. The intent is that, with the assistance of necessary financial and technical resources, all providers will succeed in this endeavor.

Performance-based Funding: The division continues to progress in the development of a “Performance Management System”. The goal of this performance based system is as follows: **To develop a continuous quality improvement process, to guide policy development and decision-making in improving the behavioral health of Alaskans.** Important questions to be answered include:

- Are Alaskans who need services getting them, and able to get them conveniently?
- Are the services of high quality?
- Is the behavioral health system efficient, productive, and effective?
- Do services produce the desired impact on the quality of life of consumers?
- Are efforts taking place to prevent or lessen problems that result in consumers needing services?
- Do Alaskans with serious behavioral health disorders live with a high quality of life?

A key component of the “Performance Management System” is the method of distributing treatment funding, based on provider performance and outcomes. The development of Performance-Based Funding (PBF) has several phases. Phase I of PBF for Treatment and Recovery Services has focused on addressing an immediate \$1-million shortfall for FY08. The table below represent, PBF cuts made to 63 grantees for the third and fourth quarter of FY08.

Performance based Funding Cuts Comprehnesive Treatment Behavioral Health Grants FY2008 3rd and 4th Quarters	
Types of cuts	Total Dollars
Across the Board Cuts (1.17% of Total FY07 Grant)	498,991
Grant Performance Cuts (3.51% of Total FY07 Grant)	367,176
Excessive Unit Cost Cuts (1.5% of Total FY07 Grant)	178,132
Residential Care Utilization Forgiveness (1.5% of Total FY07 Grant)	45,471
Total	\$ 1,089,770

Phase II of the PBF effort is looking ahead to FY09. Using the Performance-Based Funding Work Group, Behavioral Health has collaborated with grantee providers in establishing the foundation of a PBF methodology for the allocation of grant dollars in FY09.

Community Action Prevention & Intervention Grant Service

The goal of this service is to reduce alcoholism and other drug abuse, especially among youth. The mission of this component is to ensure that effective community-based prevention services are available statewide. These prevention services strive to incorporate community readiness, planning, partnerships and coalitions, and evidence-based strategies that demonstrate positive outcomes for individuals, families and communities.

In FY07, the division funded 22 agencies through grant awards, totaling \$2,042.1. Agencies made a total of 128,107 contacts in FY07. The intent is to provide the foundation funding for Alaska's effort to

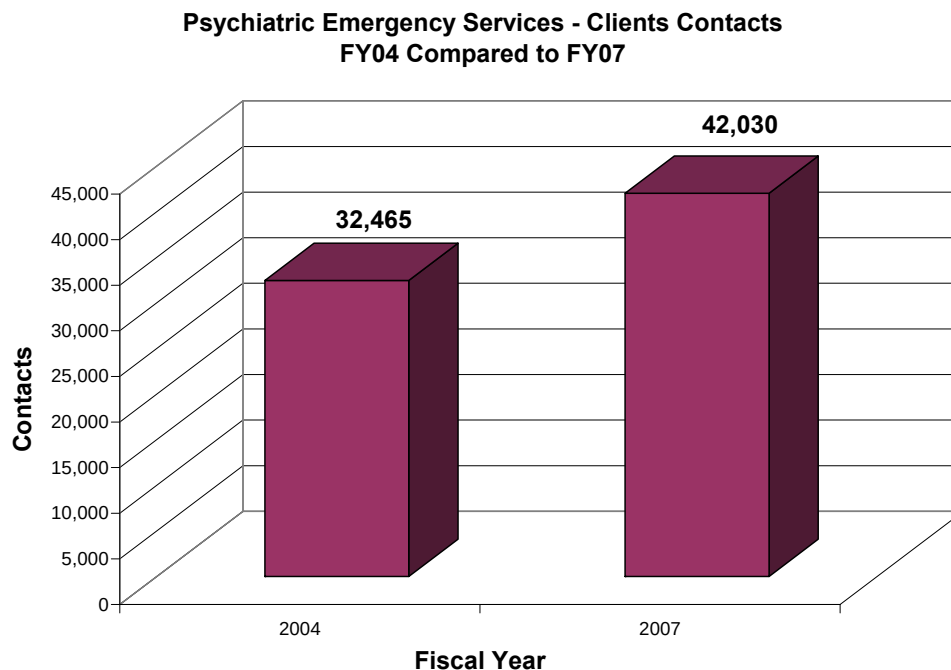
prevent substance abuse within the state, with a special focus on preventing youth from experimenting with and becoming addicted to alcohol and other drugs. Funds are granted to support community-based substance abuse prevention programs that utilize “Best Practices” (as defined by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention). Prevention services delivered by the local providers can include a variety of prevention strategies, including information dissemination, general education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. In addition, programs utilize the three Institute of Medicine (IOM) prevention categories: 1) universal (direct and indirect); 2) selected; and 3) indicated. These services reach a broad spectrum of individuals, with promotion and early prevention activities, and work with individuals who have already experienced problems and services to decrease the likelihood of relapse or recidivism. Specific strategies for service will be selected by the community providers working within the context of the Strategic Prevention Framework, which include capacity, planning, implementation, and evaluation, while incorporating sustainability and cultural competency.

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). RHSSP 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 goal of this service is to protect and improve the quality of life for consumers impacted by mental disorders or illness. The Psychiatric Emergency Services component provides competitive grant funding to community mental health agencies for services intended to aid people in psychiatric crisis. The service may include crisis intervention, brief therapeutic interventions to help stabilize the client, and follow-up services. Specialized services, such as mobile outreach teams, residential crisis/respite services and disaster assistance services, may include federally declared disaster situations. Psychiatric Emergency Services have increased in 2004, from 32,645 events of service to 42,030 events of service in 2007.



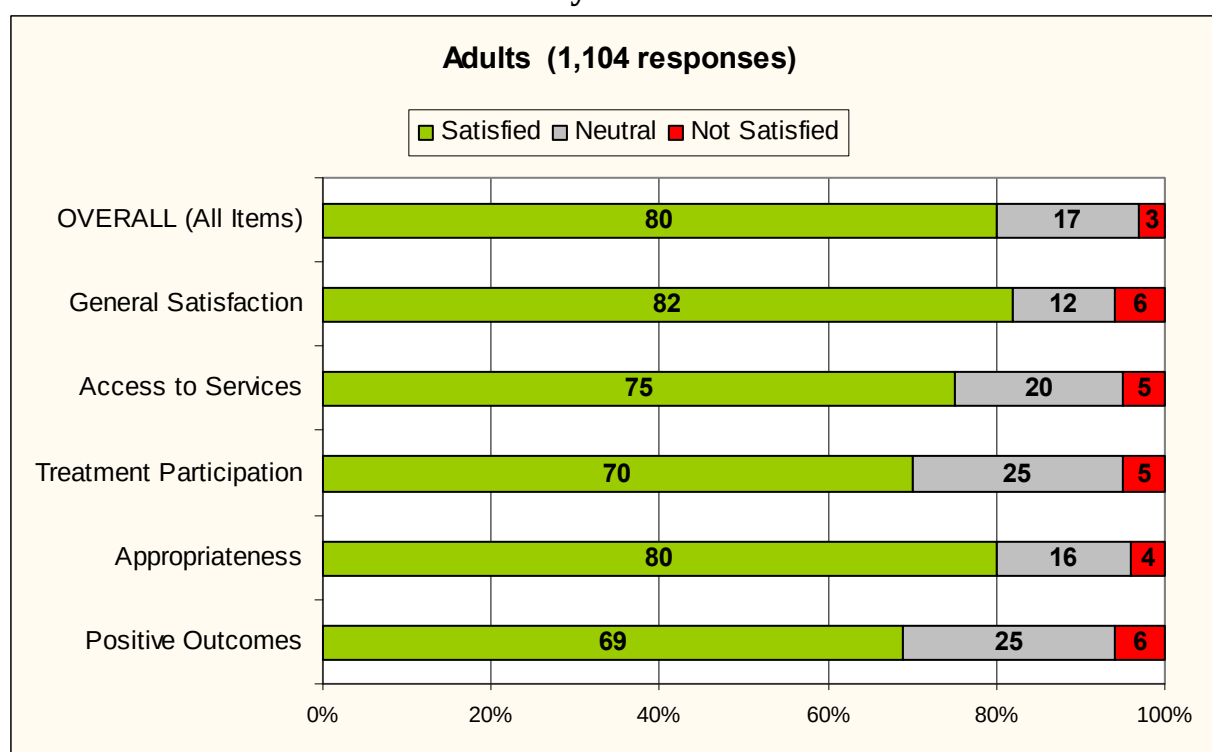
Services for the Seriously Mentally Ill

The goal of this service is to protect and improve the quality of life for consumers impacted by mental disorders. The Services for the Seriously Mentally Ill component provides competitive grant funding to community mental health agencies to support services for adults with severe mental illnesses. Core services are assessment, psychotherapy, case management and rehabilitative services. Specialized services include residential services, vocational services, and drop-in centers. These services are necessary to maintain seriously mentally ill adults in a community-based setting, without requiring referral to an inpatient psychiatric hospital or being inappropriately housed in our correctional system.

A key indicator of success for this population is reflected in the results of the Behavioral Health Consumer Survey — Adults:

2007 Treatment Outcomes

Behavioral Health Consumer Survey - Adults



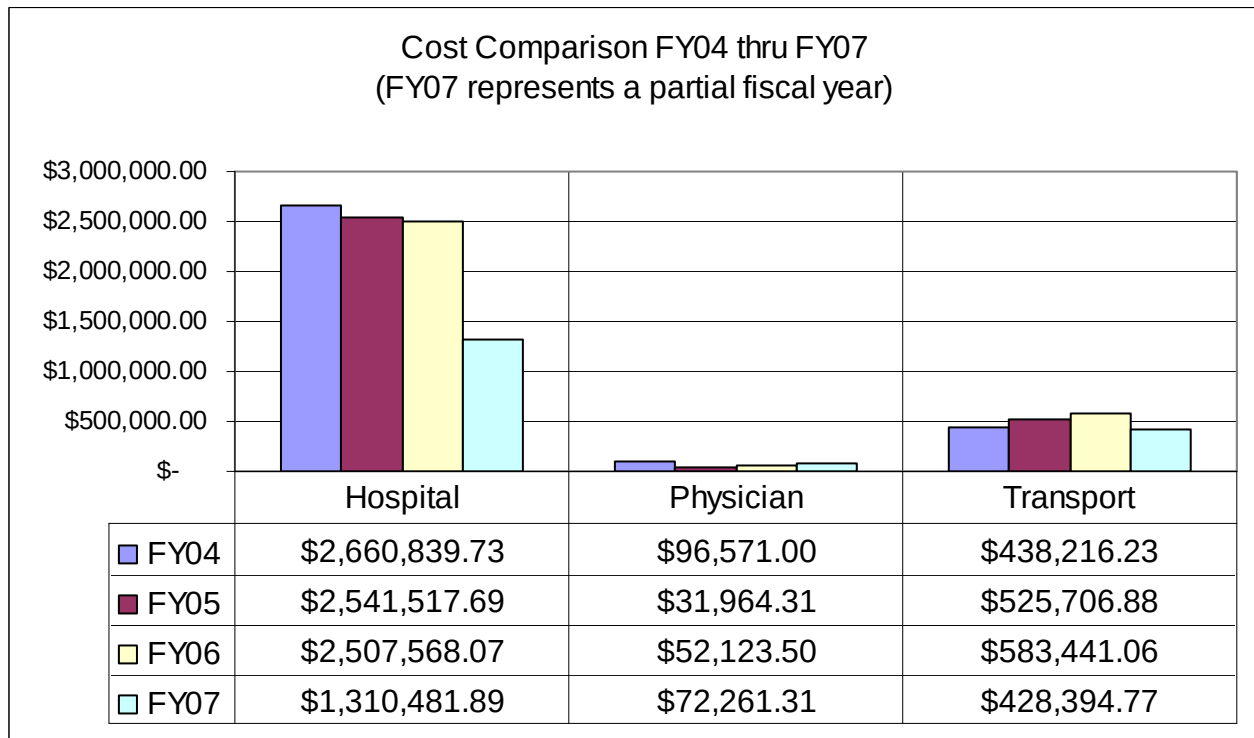
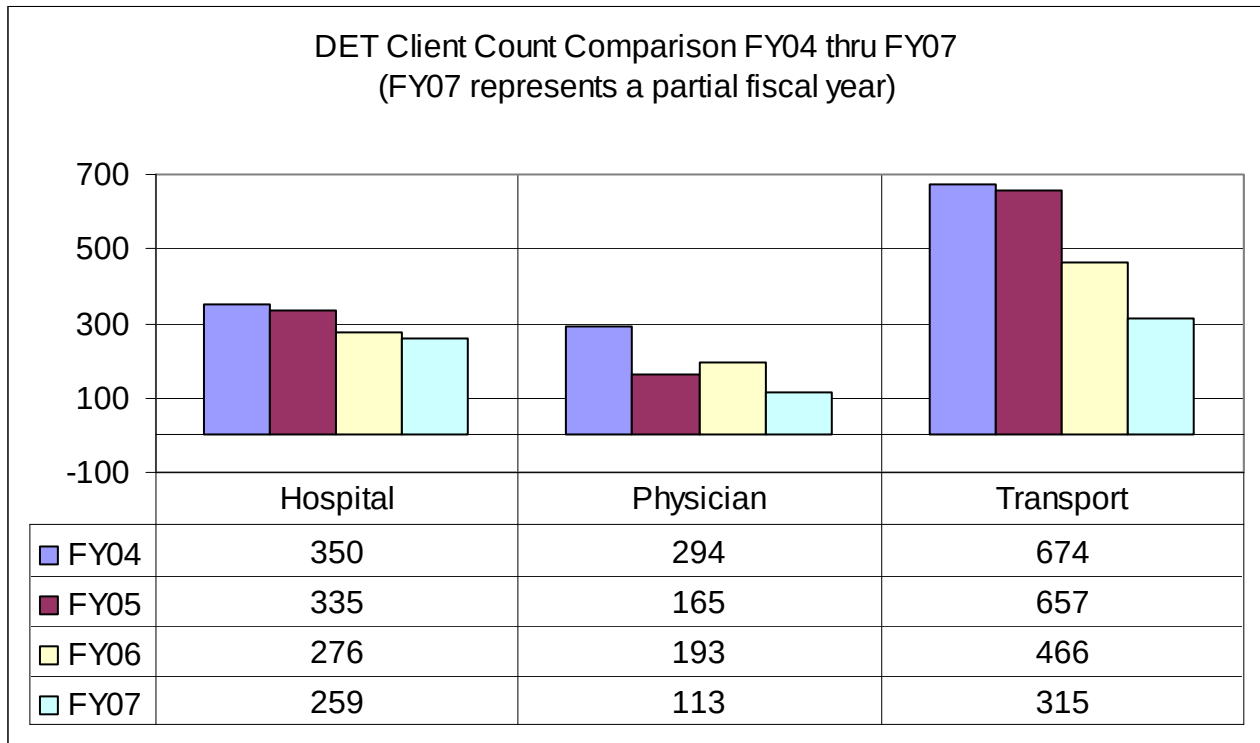
Designated Evaluation and Treatment (DET)

The goal of this service is to protect and improve the quality of life for consumers impacted by mental disorders or illness. DET services apply when consumers are experiencing a psychiatric crisis that requires hospitalization to stabilize them, and to maintain their or another individual's safety.

Core Services provides fee-for-service funding, on a payer-of-last resort basis, to designated local community and specialty hospitals. Evaluation and treatment services are provided to people under court-ordered commitment through AS 47.30.655-915, and to those individuals who meet the criteria, but have agreed to voluntary services in lieu of commitment. Through this program, a designated facility may provide up to 72-hour inpatient psychiatric evaluations, up to seven days of crisis stabilization, or up to 40 days of inpatient hospital services close to the consumer's home, family and

support system. Component funding also supports consumer and escort travel to designated hospitals, and back to their home community.

The following charts present the utilization trends for these services in years FY04–FY07.

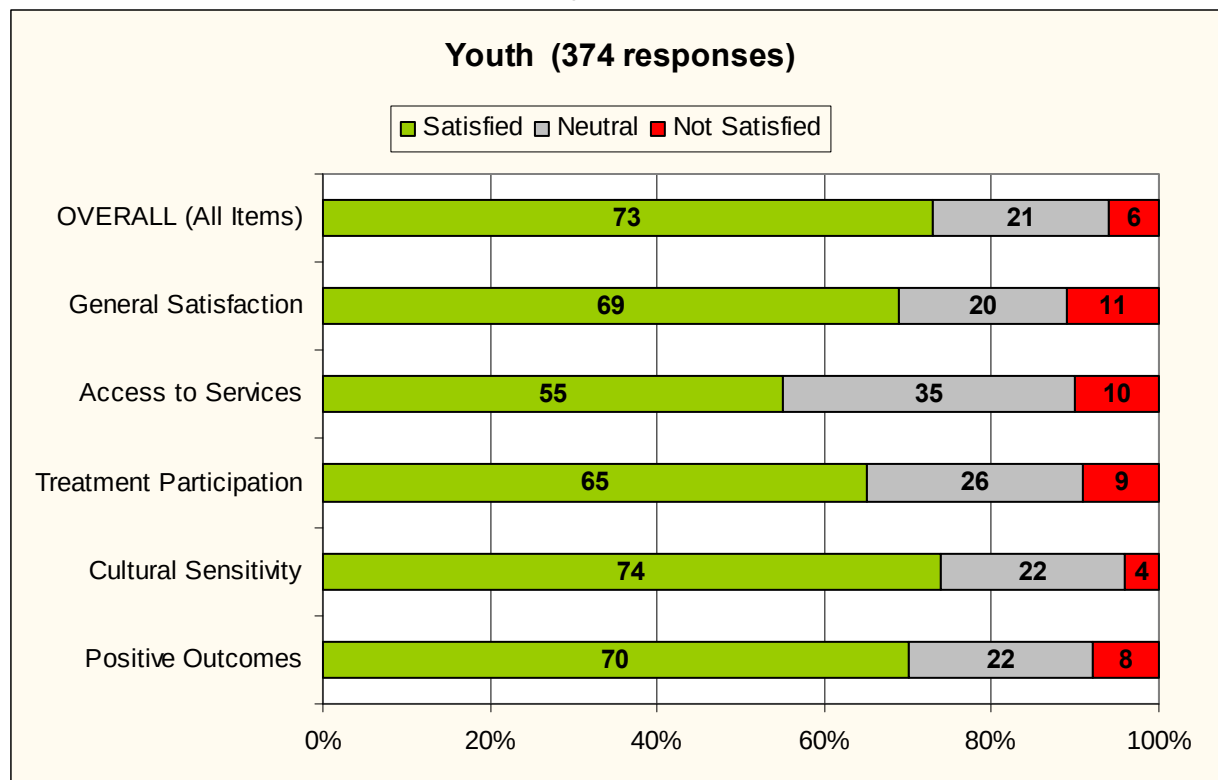


Services for Severely Emotionally Disturbed Youth

The goal of this service is to protect and improve the quality of life for consumers impacted by mental disorders or illness. Severely Emotionally Disturbed Youth component provides competitive grant funding to community mental health agencies for a range of services for severely emotionally disturbed youth and their families and for those youth who are at risk of becoming severely emotionally disturbed. The core services provided are assessment, psychotherapy, chemotherapy, case management and rehabilitation. Specialized services include individual skill building, day treatment, home-based therapy and residential services.

A key indicator for this component is clients' satisfaction with their services, as demonstrated by the 73 percent Overall Score in the Behavioral Health Consumer Survey – Youth:

2007 Treatment Outcomes Behavioral Health Consumer Survey - Youth



The Bring—and Keep—the Kids Home Initiative is operated within this component. The state is beginning to see tangible improvements in the system of care for children, as a result of the major redesign caused by Bring the Kids Home (BTKH) initiative. Such results are already measured by a reduction of children in out-of-state placements. In April of 2006, 429 children were in out-of-state care; in October of 2007, 260 children were in out-of-state care (a 39-percent decrease).

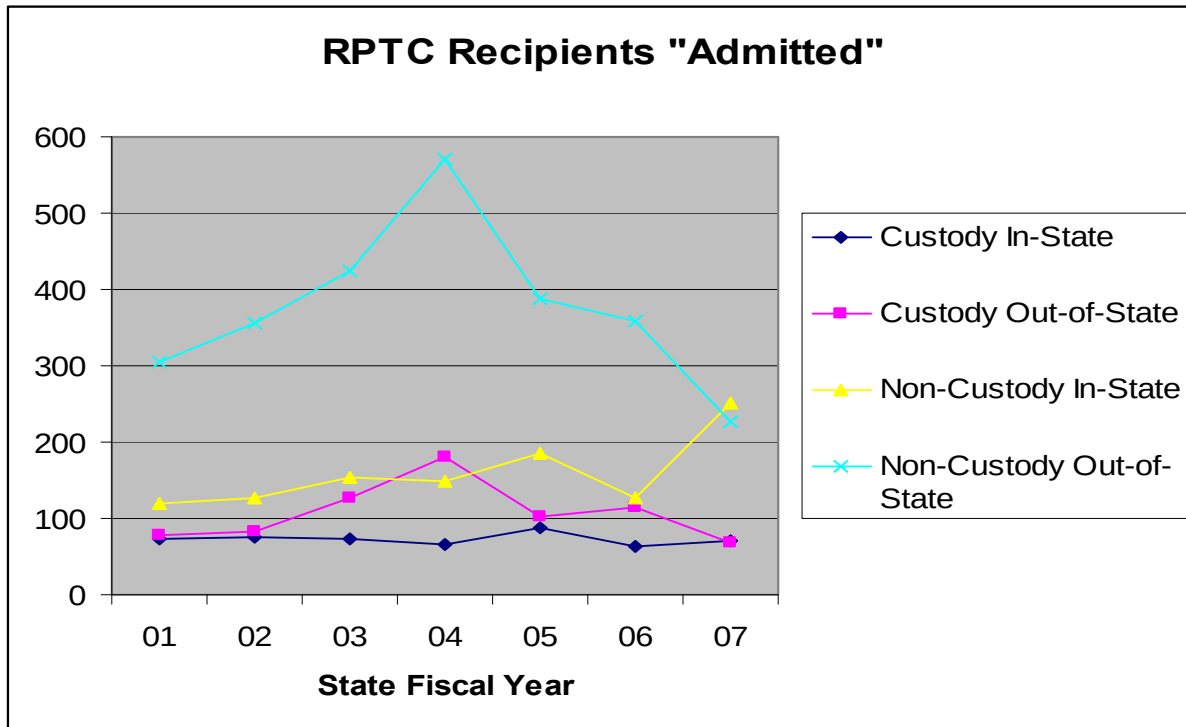
Through this initiative, grants from federal, state, and Alaska Mental Health Trust Authority funding are providing the bridge needed to start new programs and to develop new processes. Previous funding used to cover out-of-state care is being reinvested into the in-state service delivery system, allowing it to expand to meet the needs of our children.

The Bring the Kids Home Initiative: Between FY98 and FY04 the total number² of SED youth in out-of-state Residential Psychiatric Treatment Center (RPTC) care per year steadily increased — on average 46.7 percent per year. However between FY06 and FY07, there was:

- a decrease of 19.8 percent in out-of-state RPTC recipients;
- an increase of 33.8 percent in in-state RPTC recipients; and
- a decrease of 4.8 percent in total RPTC recipients.

Overall admissions³ also showed a significant decrease between FY06 and FY07:

- a decrease of 36.3 percent in out-of-state non-Custody RPTC admissions;
- a decrease of 37 percent in out-of-state RPTC admissions; and
- a decrease of 6.6 percent in total RPTC admissions.



Alaska Psychiatric Institute

In partnership with patients, families and their communities, Alaska Psychiatric Institute (API) will provide appropriate, quality, and individualized treatment that helps patients achieve their goals and become successful in their communities.

API is the only publicly operated state psychiatric facility in Alaska. API provides 24-hour, seven-days per week acute care in accordance with state law (Alaska Statutes 47 and 12). The hospital is fully accredited by the Joint Commission and the Centers for Medicare and Medicaid Services (CMS), and serves adults and adolescents from all regions in Alaska. API is predominately an acute care facility. API also provides longer term care for organic or highly complex and difficult-to-place patients; forensic services, including court-ordered competency evaluations; treatment for patients found incompetent to stand trial or individuals found not guilty by reason of insanity.

The Alaska Psychiatric Institute opened in September 1962 as a 50 bed psychiatric hospital, and quickly grew to a more than a 250-bed facility. During the past 15 years, the hospital has been

² Unduplicated total youth served in RTPC during fiscal year, including those admitted a previous fiscal year.

³ Unduplicated total youth admitted to RTPC during fiscal year, not including those admitted a previous fiscal year.

systematically downsized, to accommodate the department's vision of community-based treatment in the least restrictive settings.

In July 2005, API migrated to a new, state-of-the-art 80-bed facility with a focus on recovery from mental illness. An array of therapeutic modalities is utilized to treat the 'whole' person, and teach a variety of life skills and coping mechanisms to enhance the patient's ability to live within the community.

The hospital has developed an innovative TeleBehavioral Health program, which extends the clinical infrastructure to rural and remote regions within the state. A transparent Quality Improvement component maintains the API Quality Improvement Dashboard Indicators, and tracks important changes in quality outcomes throughout the hospital.

Successful initiatives over the past year include the following: the transition to a 'smoke free' campus on July 1, 2007; Joint Commission and CMS Accreditation unannounced surveys in 2007; and procurement of an electronic medical record system which will increase quality of care and enhance operating efficiencies.

Examples of services provided and accomplishments for FY07 highlighted in the "API Dashboard of Key Performance Measures."

API "Dashboard" Key Performance Measures 10/19/2007						
National Comparison Data						
	<i>CY 06</i>	<i>CY 06</i>	<i>CY 06</i>	<i>CY 07</i>	<i>CY 07</i>	<i>Goal</i>
Indicator	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	(Annual National Average)
Client Injury Rate	0.82	0.33	0.63	0.2	0	▼ Nat. Avg. (0.43)
Elopement Rate	0.17	0.62	0	0	0.19	▼ Nat. Avg. (0.27)
Medication Error Rate	8.3	10.78	8.32	5.41	6.23	▼ Nat. Avg. (2.28)
Prevalence of COPSD	44.72	42.86	45.05	50.93	49.74	▼ Nat. Avg. (34.73)
30 day Readmit Rate	16.15	18.11	12.17	13.96	10.19	▼ Nat. Avg. (5.96)
Patient Seclusion and Restraint						
Hours of Restraint Use	0.13	0.06	0.04	0.03	0.12	▼ Nat. Avg. (0.53)
% of Clients Restrained	0.71	0.39	0.61	0.41	1.3	▼ Nat. Avg. (4.86)
Hrs of Seclusion Use	0.03	0.09	0	0.07	0.27	▼ Nat. Avg. (0.34)
% of Clients Secluded	0.69	1.01	0	0.89	0.66	▼ Nat. Avg. (1.68)
Patient Discharge Survey						
Patient Outcome	70.12	76.58	67.72	68.73	69.4	▲ Nat. Avg. (75.17)
Patient Dignity	77.07	79.27	75.83	77.81	76.3	▲ Nat. Avg. (76.65)
Patient Rights	62.72	61.9	58.78	62.24	59.28	▲ Nat. Avg. (61.16)
Patient Participation	76.91	73.66	66.72	73.03	75.54	▲ Nat. Avg. (69.11)
Hospital Environment	76.13	77.61	67.35	69.91	68.68	▼ Nat. Avg. (65.21)

Behavioral Health Medicaid Services

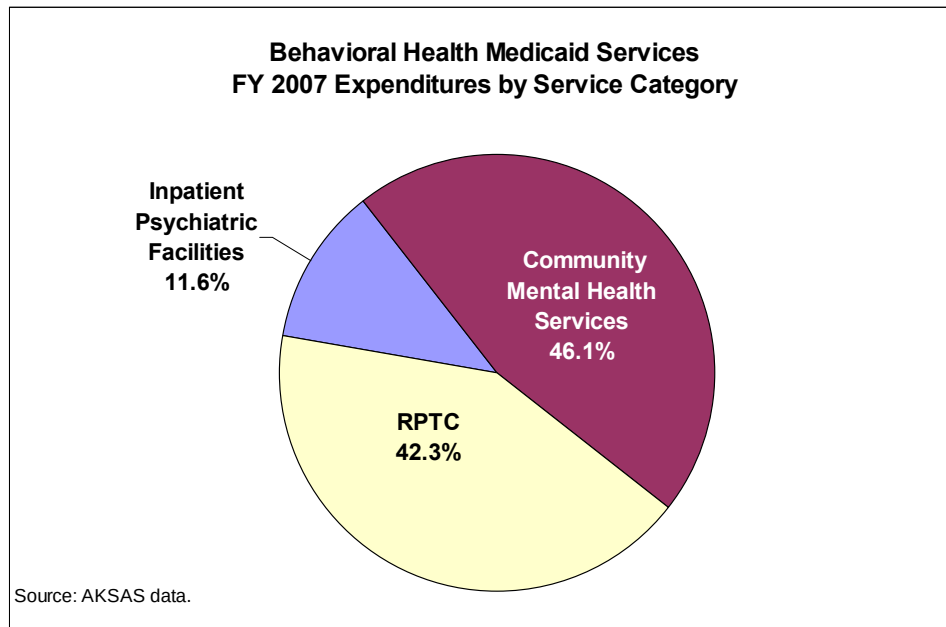
During FY 2007 Medicaid funded behavioral and mental health services for 12,600 Alaskans, about 10 percent of all those enrolled in the Alaska Medicaid program during the year. Most were children or disabled individuals. Residential Psychiatric Treatment Center (RPTC) Medicaid services are available only to children under 21 years of age, and inpatient psychiatric hospital Medicaid services are also provided primarily to children (88 percent in FY07). Community mental health Medicaid services are provided to almost as many adults as children (45 percent adults, 55 percent children under age 21 in FY07).

Benefit Group	Beneficiaries	Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children	52.90%	6,804	75.50%	\$104,432.30	\$15,349
Disabled Children	3.40%	438	8.40%	\$11,550.60	\$26,371
Elderly	1.50%	190	0.30%	\$391.50	\$2,060
Disabled Adults	27.30%	3,510	14.30%	\$19,751.00	\$5,627
Adults	15.00%	1,925	1.50%	\$2,116.70	\$1,100
Unduplicated Annual Clients		12,604			
Total Medicaid Claim Payments (thousands)				\$138,242.00	
Average Annual Medicaid Cost per Beneficiary					\$10,968

Source: MMIS/JUCE claims paid during FY07.

Age Group	Beneficiaries	Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
All Behavioral Health Medicaid Services					
Under 21	57.20%	7,247	85.30%	\$117,924.50	\$16,272
21 or Older	42.80%	5,424	14.70%	\$20,318.10	\$3,746
Community Mental Health					
Under age 21	56.00%	6,793	68.00%	\$42,928.70	\$6,320
21 or Older	44.60%	5,413	32.00%	\$20,167.20	\$3,726
Inpatient Psychiatric Hospital Services					
Under 21	87.60%	698	99.10%	\$15,993.10	\$22,913
21 or Older	12.40%	99	0.90%	\$150.30	\$1,518
Residential Psychiatric Treatment Centers					
Under 21	100.00%	1,060	100.00%	\$59,002.70	\$55,663
21 or Older	0.00%	0	0.00%	\$0.00	\$0

Source: MMIS/JUCE claims paid during FY07.

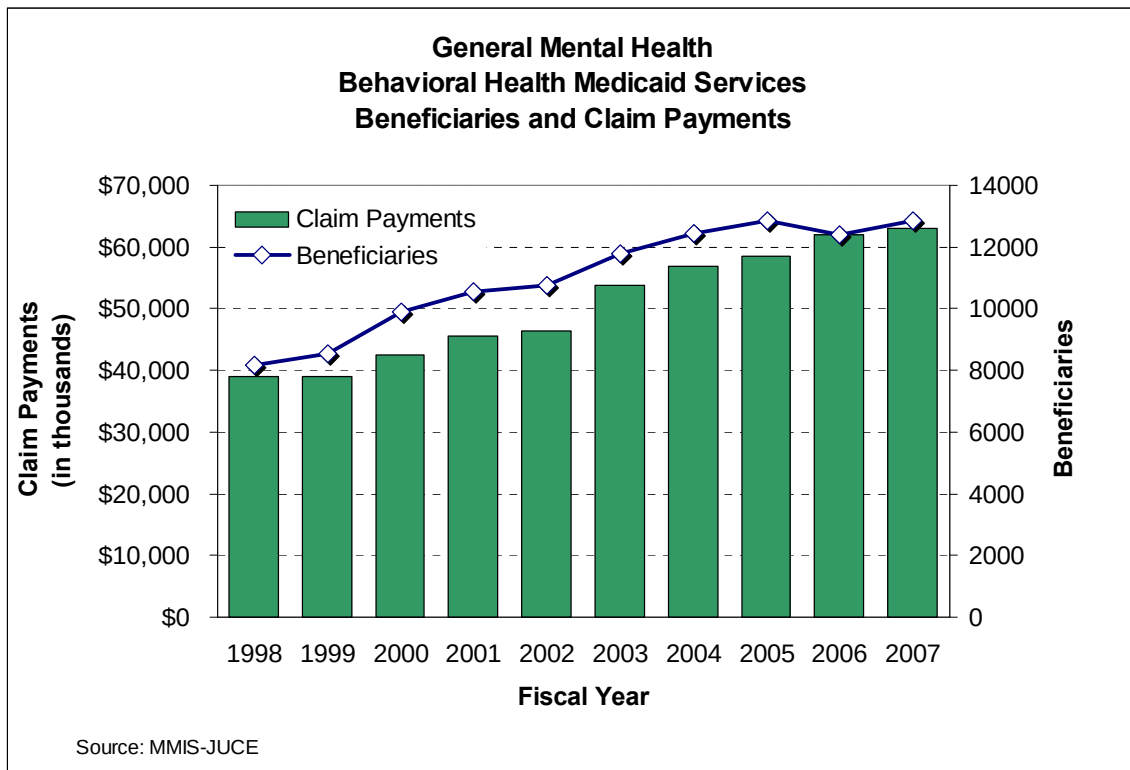


More than 90 percent of all Behavioral Health Medicaid clients utilized community mental health services in FY07; however, their claims comprised only about 46 percent of costs for the component. Fewer than 6 percent of clients utilized inpatient psychiatric hospital services with their claims representing about 12 percent of costs. Eight percent of clients received residential psychiatric treatment center (RPTC) benefits, which comprised about 42 percent of costs.

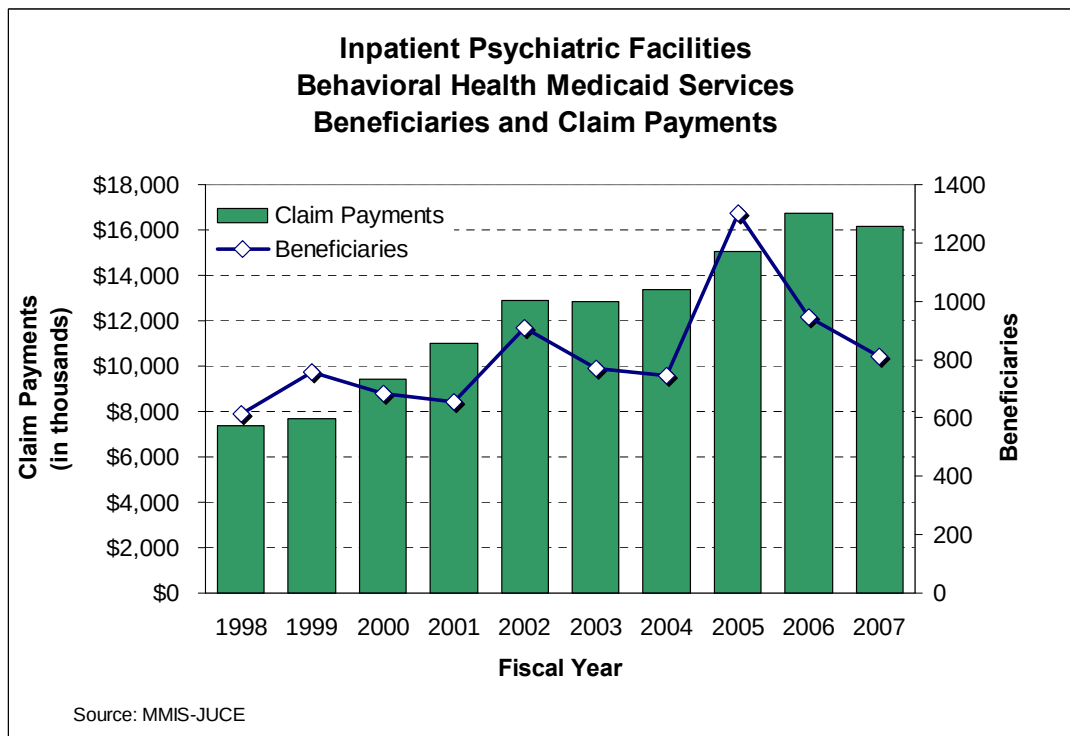
	Cost per Beneficiary	Percent of Beneficiaries
Inpatient Psych Hospital	\$20,200	5.70%
Residential Psych Treatment	\$55,600	8.00%
Community Mental Health	\$5,200	92.00%
All Behavioral Health Medicaid, cost per recipient per year		\$11,000
All Behavioral Health Medicaid, unduplicated annual beneficiar		12,604

Source: MMIS/JUCE claims processed during fiscal year 2007. Percent of beneficiaries includes individuals receiving services in multiple categories and will not sum to 100%.

Medicaid costs for community mental health services increased by \$3 million (2 percent) between FY06 and FY07. The number of individuals using community mental health services during the year increased by about 4 percent. The annual cost per person decreased slightly (\$4,990 to \$4,908).

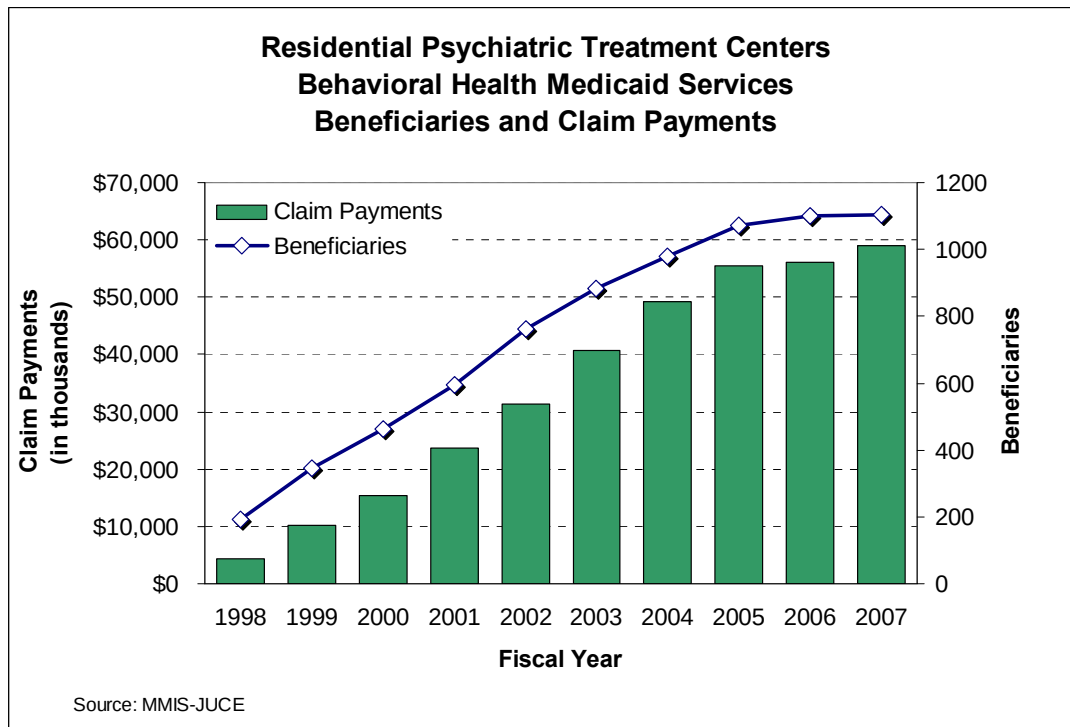


Medicaid costs for inpatient psychiatric services overall decreased by almost \$0.8 million (-3 percent) in FY07. Although the number of Medicaid clients served in inpatient psychiatric hospitals decreased by 14 percent, the average annual cost per client increased by almost 13 percent to \$19,800 per person.

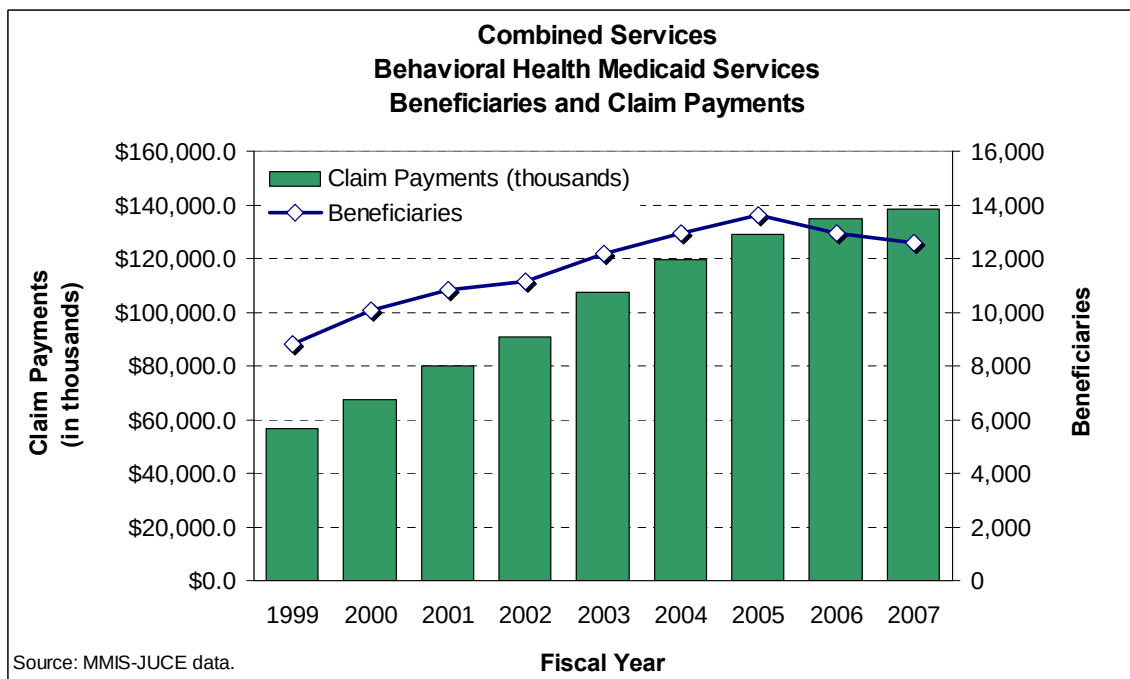


Medicaid costs for residential psychiatric treatment increased \$2.5 million (5 percent) in FY07. The number of Medicaid clients served in RPTC facilities changed minimally (0.5 percent-increase) but the annual cost per person increased by 10 percent to \$55,600. Increased costs were due in part to

scheduled rate increases for in-state facilities and to increased capacity in-state. The department's efforts to reduce out-of-state institutionalization resulted in more children receiving RTPC services in-state during FY07.



The number of individuals using any Behavioral Health Medicaid service during FY07 dropped by nearly 3 percent from FY06, while the annual cost per beneficiary increased by more than 5 percent to almost \$11,000 per person (on average, about \$914 per person per month during FY07). Total Behavioral Health Medicaid annual costs grew by less than 3 percent between FY06 and FY07.



SFY 2007 DIVISION LEVEL SUMMARY: Behavioral Health Medicaid	DBH MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR (CPRPY)	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent Recipients	Percent Payments
Medicaid, Division Annual Totals		12,604		\$138,242,020	\$10,968	10.3%	14.8%
Gender							
Female	53.3%	6,722	41.3%	\$57,109,881	\$8,496	9.7%	10.9%
Male	46.7%	5,884	58.7%	\$81,132,138	\$13,789	11.2%	19.9%
Unknown						0.0%	0.0%
Race							
Alaska Native	35.6%	4,507	40.8%	\$56,430,523	\$12,521	9.6%	15.9%
American Indian	1.9%	235	1.1%	\$1,523,392	\$6,483	12.4%	12.3%
Asian	1.8%	229	1.0%	\$1,411,811	\$6,165	3.5%	3.2%
Pacific Islander	0.8%	106	0.6%	\$813,534	\$7,675	3.2%	4.0%
Black	5.3%	671	5.1%	\$7,096,265	\$10,576	10.5%	17.9%
Hispanic	2.1%	261	1.7%	\$2,297,863	\$8,804	6.1%	11.3%
White	50.4%	6,378	46.4%	\$64,105,053	\$10,051	12.8%	15.3%
Unknown	2.1%	266	3.3%	\$4,563,578	\$17,156	7.3%	17.3%
Native	37.5%	4,739	41.9%	\$57,953,915	\$12,229	9.7%	15.8%
Non-Native	62.5%	7,885	58.1%	\$80,288,104	\$10,182	10.7%	14.1%
Age							
under 1	0.0%	6	0.0%	\$14,095	\$2,349	0.0%	0.0%
1 through 12	23.9%	3,166	25.1%	\$34,723,035	\$10,967	6.6%	24.1%
13 through 18	31.0%	4,102	58.8%	\$81,253,664	\$19,808	18.0%	49.6%
19 through 20	2.8%	372	1.4%	\$1,933,690	\$5,198	8.3%	7.7%
21 through 30	10.7%	1,418	3.4%	\$4,753,932	\$3,353	10.3%	4.9%
31 through 54	25.3%	3,355	8.9%	\$12,258,560	\$3,654	17.9%	6.1%
55 through 64	4.3%	574	1.9%	\$2,642,445	\$4,604	12.3%	3.5%
65 through 84	1.8%	239	0.5%	\$660,979	\$2,766	3.3%	0.6%
85 or older	0.1%	14	0.0%	\$1,621	\$116	1.1%	0.0%
Benefit Group							
Children	52.9%	6,804	75.5%	\$104,432,251	\$15,349	8.8%	30.9%
Adults	15.0%	1,925	1.5%	\$2,116,674	\$1,100	8.4%	1.9%
Disabled Children	3.4%	438	8.4%	\$11,550,617	\$26,371	20.9%	21.0%
Disabled Adults	27.3%	3,510	14.3%	\$19,751,021	\$5,627	24.0%	6.8%
Elderly	1.5%	190	0.3%	\$391,457	\$2,060	2.5%	0.3%

Payment amounts are net of all claims paid during the fiscal year. Amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments. Payment amounts may not tie exactly to amounts in AKSAS or ABS.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2007. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the division and group level (gender, race, age, and benefit group). Some duplications may occur in subgroup counts.

Because department-wide recipient counts are unduplicated across divisions, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all divisions will exceed 100%.

Source: MMIS/JUCE.

List of Primary Programs and Statutory Responsibilities

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

Explanation of FY2009 Budget Changes

Behavioral Health	2008	2009 Gov	08 to 09 Change
General Funds	104,854.4	136,996.6	32,142.2
Federal Funds	113,853.9	112,026.7	-1,827.2
Other Funds	42,832.0	44,849.3	2,017.3
Total	261,540.3	293,872.6	32,332.3

Alaska Fetal Alcohol Syndrome Program

Reduction of excess Federal Funds: \$803.2 Federal

Federal earmark funding for the Alaska five-year Fetal Alcohol Spectrum Project ended.

Alcohol Safety Action Program (ASAP)

Underage Drinking Initiative Increment: \$823.4 General Fund

Behavioral Health is requesting an increment of \$823.4 General Fund. The increment is part of a comprehensive initiative to reduce and prevent underage drinking among Alaska's youth.

This funding will allow a coordinated response by the Alaska Court System, Juvenile Justice, Department of Motor Vehicles, local law enforcement and school districts to respond more effectively in addressing and reducing underage drinking in the state.

The funding will allow for the following: for one Adult Probation Officer II to help identify and track habitual minor consuming offenders; increase funding to eight existing juvenile ASAP programs in Anchorage, Fairbanks, Juneau, Kenai, Ketchikan, Kotzebue, Kodiak and Mat-Su; and, expanded juvenile ASAP grants to five new communities in Bethel, Barrow, Dillingham, Nome and Seward.

Fund Source Change from Interagency Receipts to Capital Improvement Project: (\$950.0 Interagency Receipts); \$950.0 Capital Improvement Project

ASAP has two annual Reimbursable Services Agreements (RSA) where funding is budgeted as CIP rather than IA. \$750.0 is awarded from the Highway Safety Planning Agency in DOTPF, for substance abuse screening, case management and accountability for DUI and other alcohol and drug related misdemeanor cases for adults, juveniles and therapeutic court. \$200.0 is awarded from the court system in the Department of Law for therapeutic court case probation officers.

MH: Therapeutic Case Management — Barrow Project: \$135.0 MHTAAR

This project was funded in FY08 with \$120.0 MHTAAR and is being maintained in FY09 with \$135.0 MHTAAR. The Barrow project provides a therapeutic court alternative in rural/remote Alaska.

Therapeutic court addresses the underlying disorders that contributed to the individual's contact with the justice system. 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, and due to a diminished cognitive capacity, not volitional intent. Potentially, this program has the capacity to decrease future costs associated with the criminal justice system, care within correctional settings, or psychiatric institutions.

The FY09 increment allows for travel, services and supplies to support the existing Adult Probation Officer position located in Barrow. The project is a partnership between the Alaska Mental Health Trust and the Alaska Court System.

Behavioral Health Medicaid Services

FY09 Projected Medicaid Formula Growth: \$6,821.6 Total \$3,861.7 Federal, \$2,959.9 GF/Mental Health

For SFY09, Behavioral Health Medicaid component costs are projected to grow 4 percent over the SFY08 authorized amount of \$170,541.3. Cost containment efforts begun in SFY04 have successfully reduced the rate of growth in recent years. Although growth has been relatively slow for the past five years, increased capacity expected on completion of approved Certificate of Need (CON) projects, changes in residential psychiatric treatment center (RPTC) provider rates, and revision of income criteria for children and pregnant women (Senate Bill 27, effective July 2007) will contribute to the approximately 15-percent increase in costs forecast for FY08. Growth is expected to slow in FY09 after these changes have been implemented.

Behavioral Health Medicaid Services Historical Utilization				
SFY	Enrollment	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary per Year
1999	94,500	8,821	\$56,771.40	\$6,436
2000	110,219	10,082	\$67,281.00	\$6,673
2001	116,226	10,823	\$80,101.20	\$7,401
2002	121,582	11,143	\$90,655.00	\$8,136
2003	126,632	12,199	\$107,215.70	\$8,789
2004	129,528	12,935	\$119,349.90	\$9,227
2005	131,136	13,606	\$129,057.10	\$9,485
2006	131,996	12,962	\$134,799.00	\$10,400
2007	128,295	12,604	\$138,242.00	\$10,968

FY09 Medicaid SCHIP Allotment Shortfall: \$1,800.0 Total \$900.0 Federal, \$900.0 GF/Mental Health

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.

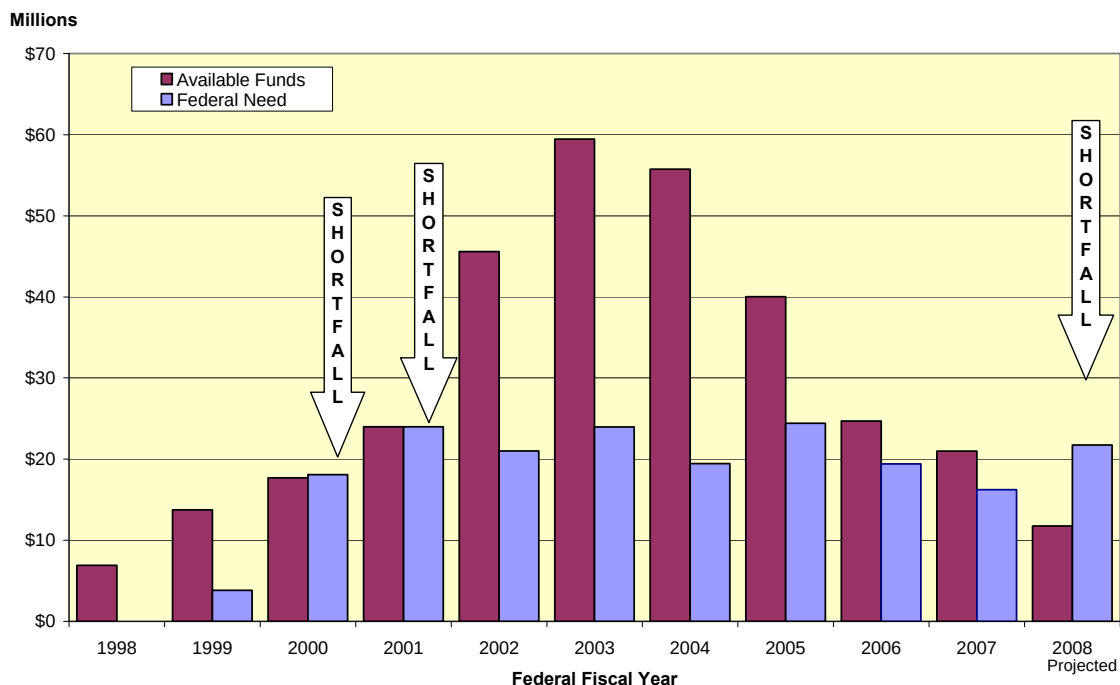
SCHIP helps reach uninsured children whose families earn too much to qualify for regular Medicaid but not enough to afford private coverage. Each month, SCHIP provides health coverage for about 9,000 uninsured children under age 19. Without this funding, low-income children now enrolled in Denali KidCare 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 49 percent of the federal SCHIP funding needed to cover program expenditures in 2009, exhausting its SCHIP funds in the second quarter. When it reverts to regular Medicaid, the difference in federal reimbursement rates means that Behavioral Health Medicaid Services component will need an additional \$900.0 GF in 2009.

Alaska's annual allotment has fluctuated between \$7 million and \$11 million. Since Alaska's annual allotment represents only about 30 percent of costs, Alaska has 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 Alaska does not anticipate any further redistributions.



Denali KidCare M-SCHIP Federal Funds Available and Federal Need



FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: (\$4,560.6 Federal), \$4,560.6 GF/Mental Health

This request replaces lost federal revenues resulting from a 1.95-percent decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008.

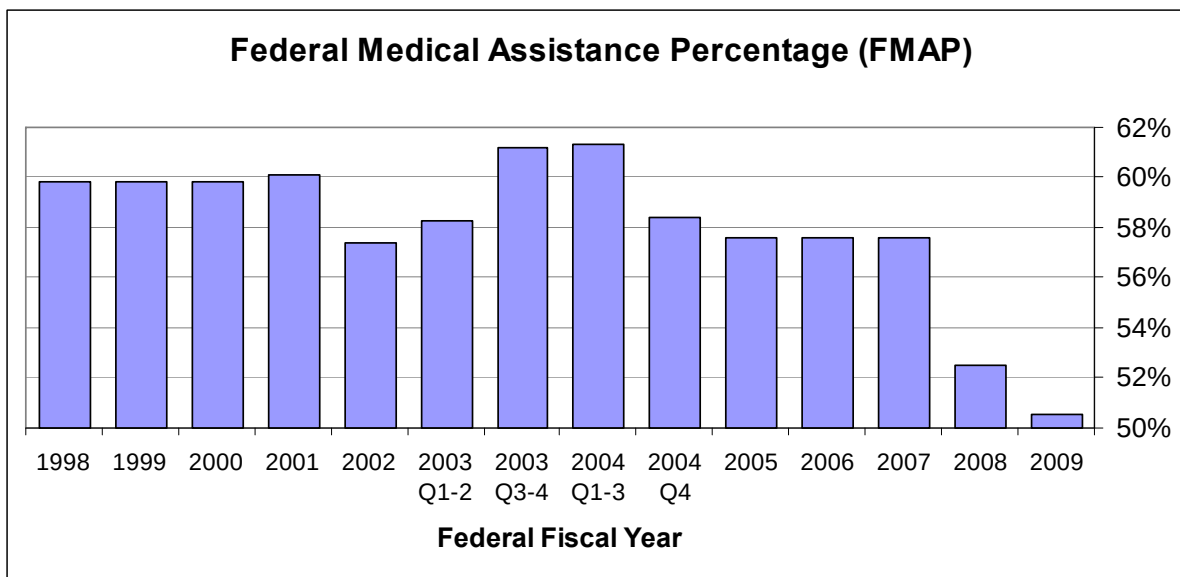
The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid and is outside the control of the state government. One in five Alaskans is enrolled in Medicaid at some time each year. Without the increment the state would be forced to reduce eligibility or services currently provided to low-income children, pregnant women,

individuals with disabilities, and the elderly. By approving this change record, the department will be able to continue to meet its mission of managing health care for Alaskans in need.

The amount of federal funds the state receives for its Medicaid program depends on a complex array of reimbursement rates, some of which change each Oct. 1 with the start of a new federal fiscal year. The bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the federal medical assistance percentage or FMAP. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50 percent. Also affected is the State Children's Health Insurance Program (SCHIP), which is reimbursed at an enhanced FMAP rate that reduces the state share of costs by 30 percent over the regular FMAP.

The regular FMAP is projected to drop from 52.48 percent to 50.53 percent in FFY09 and the enhanced FMAP from 66.74 percent to 65.37 percent. The regular FMAP for SFY09 will average 51.02 percent across two federal fiscal years (52.48 percent from July–September 2008 and 50.53 percent from October 2008–June 2009). The enhanced FMAP for SFY09 will average 65.71 percent (66.74 percent from July–September 2008 and 65.37 percent from October 2008–June 2009).

Approximately 91 percent of the Behavioral Health Medicaid Services component's claims are reimbursed at the regular FMAP and another 4 percent at the enhanced FMAP (the remaining 5 percent is IHS and is not affected by the change in FMAP). Based on current estimated expenditures for Medicaid, the FFY09 change in FMAP will require an estimated \$4,560.6 increase in GF/MH to replace the lost federal funds and maintain services at the current level.



Transfer Out Medicaid Mental Health Prior Authorization Contract to Behavioral Health

Administration: (\$1,620.0 Total) \$810.0 Federal—\$810 GF/Match

This request transfers the authorization for the Medicaid mental health utilization review and care coordination contract out of the Behavioral Health Medicaid Services component and into the Behavioral Health Administration component. This contract is an administrative cost, not a direct medical service, and should not be in the Medicaid services component. The contract will continue to be eligible for 50 percent federal reimbursement once it has been moved to the administrative component.

This contract is for federally required behavioral health utilization review and care coordination services. Federal utilization control regulations for mental hospitals (42 CFR 456.150-456.245) require that medical and other professional personnel must evaluate each applicant's or recipient's need for admission to behavioral health facilities.

Behavioral Health Grants

Discontinue Private ProShare Refinancing: \$4,448.2 General Fund

This increment replaces federal funding with general funds, due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

The department is committed to continue funding these services at the current level to support its mission to provide health care for Alaskans in need. In order to maintain current service levels, the department is requesting additional GF in the divisions that refinanced grants and services to replace this lost federal money.

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$820.9 General Fund

In FY08 a general fund increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services. However, these services are provided by other divisions. Behavioral Health grants provide grant funding to local nonprofit agencies in order to provide statewide integrated mental health and substance abuse treatment services. This transfer of \$820.9 is necessary to give the division the funding needed to continue these services.

Senior Outreach, Assessment, and Referral Project (SOAR): \$300.0 GF/Mental Health

Senior service providers report a growing number of clients experiencing serious behavioral health needs. A lack of appropriate behavioral health services for seniors, fear of social stigma, insufficient prevention and intervention programs, and shortage of trained geriatric providers are some of the barriers to delivering services appropriate for seniors. Behavioral Health is requesting funding for this project to provide a statewide structure for developing senior-friendly forms of outreach and assessment, and where necessary, will invest in the development of appropriate local treatment options. Advocacy partners include the Alaska Mental Health Board/Alaska Board on Alcohol and Drug Abuse.

Community Prevention & Early Intervention for Behavioral Health Programs: \$1,000.0 GF/Mental Health

The division needs to prevent behavioral health problems. This will in turn decrease secondary problems in communities, such as criminal behaviors, suicidal thought and actions, traumatic brain injuries, and fetal alcohol disorders. This increment will be used to expand the community-based programs that offer prevention and early intervention evidence-based services, and the administrative support services for these programs within the division.

Services for Substance Use Disorders Comprehensive System of Care: \$1,750.0 GF/Mental Health

Alaskans in large urban communities currently must wait one to three months to receive treatment, if they do not present a danger to themselves or others. Available detoxification services are at maximum capacity, and failure to meet the need leads to more costly hospital admissions, inappropriate incarceration, public inebriation, and placement into the correctional system. In addition, there is a failure to appropriately serve dual-disordered clients, such as those with traumatic brain injury and a substance use disorder. This increment will fund grants to create an enhanced continuum of care, from the least restrictive to the most intensive.

Treatment and Wraparound Services for Clients with Severe Mental Illness and Co-occurring Disorders: \$1,750.0 GF/Mental Health

This project provides case management and wraparound services for individuals experiencing long-term chronic behavioral illnesses who have been unsuccessful in the current system. It will target people with severe mental illness and dual diagnoses, such as chronic mentally ill substance abusers, seriously mentally ill people discharged from Department of Corrections with multiple problems, and clients with low cognitive functioning or traumatic brain injury who also have a second diagnosis. Assuring that a person is safely housed, fed, involved in gainful activity through connection with their family, friends and community, and receiving appropriate medical and behavioral treatment, will prepare him or her for increasing independence.

MH Trust: MHTAAR Funding Discontinued in FY09: (\$70.0 MHTAAR)

The following MH Trust project was discontinued: Convene a Biennial Summit .

MH Trust Brain Injury Training for Providers: \$100.0 MHTAAR

The traumatic brain injury (TBI) training program includes three separate components: 1) contracted brain injury specialists for case consultation; 2) regional workshops specific to needs of the area utilizing multidisciplinary hub and spoke model; and 3) development of training material that will include self study modules.

This increment will ensure that every provider serving Alaskans with a brain injury will have access to brain injury specialists for consultation, will have a road map on how to address the screening, assessment, referral, and treatment planning, and will feel confident in their service capabilities.

MH Trust Transition to Full-Time Work Project: \$85.0 MHTAAR

This project was funded in FY08 with \$85.0 MHTAAR and is maintained at that level in FY09 with \$85.0 MHTAAR. The Transition to Full-Time Work Project provides grant funding to provider(s) to enhance work skills of those experiencing behavioral health problems. Temporary employment can give skill sets, which are needed in a variety of industries. The project offers clients a chance to develop work skills and habits that may then lead to permanent employment. Many people need initial support and mentoring to stay on the job. This includes help in managing activities of daily living and other employment logistics, such as child care and housing. It also includes support for developing work attitudes and competencies.

MH Trust Expand Treatment Capacity for Therapeutic Court Participants with Co-occurring Disorders: \$150.0 MHTAAR

This project was funded in FY08 with \$150.0 MHTAAR and is maintained at that level in FY09 with \$150.0 MHTAAR. This project provides access for Palmer Mental Health Court participants to community co-occurring treatment services, so individuals can address the underlying mental health and

substance abuse issues that contributed to their contact with the criminal justice system. This increases public safety and decreases the potential for future high costs, incurred by contacts with the criminal justice system, and care within correctional settings or psychiatric institutions. Funds will be disseminated to a behavioral health provider. The Behavioral Health grants staff, in collaboration with the behavioral health grantee and the court system, will collect outcome data on participants accessing this treatment.

MH Trust Assess Sleep-Off Alternatives: \$50.0 MHTAAR

This project was funded in FY08 with \$25.0 MHTAAR and is increased in FY09 with \$50.0 MHTAAR. This request will fund the continuation of the MH Trust Assess Sleep-Off Alternatives Project, to support Behavioral Health (BH) staff and targeted communities in the pre-development and planning process, for a community system of service alternatives to incarcerating individuals under Title 47 substance abuse protective custody holds. This project will be managed by Behavioral Health grants staff, with funds disseminated to behavioral health providers through grant agreements.

MH Trust Oxford House Adaptation: \$75.0 GF/Mental Health

The division proposes this increment for a new MH Trust housing project in FY09. Nationally, recovery homes offer a self-help program for alcoholics and drug users that provide low-cost, high-quality group-home living in a supportive environment free of drugs and alcohol. Residents must be employed, pay their share of expenses, complete their chores, and stay free of drugs and alcohol. The Oxford House is one example of such a self-help recovery program, and offers a template for replication of the program in Alaska.

MH Trust Operations Support for Sober Housing for Recovery: \$300.0 GF/Mental Health

The division proposes this increment for a new MH Trust housing project in FY09. This request supports several years of capital resources to develop viable options for long-term supported housing to maintain sobriety. On-site and case management supports are vital to maintenance of sobriety for Alaskans. This request will match capital resources available with operations support to maintain safe, stable sober housing for Alaskans.

MH Trust Detox and Treatment Capacity Project: \$480.0 MHTAAR

This project was funded in FY08 with \$480.0 MHTAAR and is maintained at that level in FY09 with \$480.0 MHTAAR. This request will provide continuation funding of the Alaska Mental Health Trust, Detox and Treatment Capacity Project. The project will continue development of community detoxification capacity and treatment alternatives, to avoid the high costs incurred by the use of state correctional institutions for Title 47 substance abuse protective custody holds. Funds will be disseminated through grants, contracts or a combination of the two, to behavioral health providers. This project is critical to developing alternative community detoxification and treatment services, to avoid the higher costs incurred in the correctional or hospital emergency room setting. Behavioral Health will collect outcome data on how the funding is utilized to save correctional and hospital costs.

MH Trust Assisted Living Home Training & Targeted Capacity for Development: \$100.0 MHTAAR
This project was funded in FY08 with \$100.0 MHTAAR and is maintained at that level in FY09 with \$100.0 MHTAAR. The Assisted Living home training and targeted capacity development project is a continuation project to improve the quality of training available to assisted living home providers. The goal is to increase the capacity of these providers to house individuals with intensive behavioral health needs. The project will be administered by Behavioral Health; a grantee will provide the prescribed training program.

Behavioral Health Administration

Suicide Prevention Statewide Initiative: \$1,000.0 General Fund

Behavioral Health, in partnership with the Statewide Suicide Prevention Council, is proposing a Suicide Prevention Initiative to begin in FY09. Alaska's vision is that all children, youth, and adults are mentally healthy, connected, resilient and living successfully. Alaska continues to have the highest rate of suicide in the nation — the suicide rate for Alaska is 23.4 per 100,000 population, more than double the U.S. rate of 11 per 100,000. The proposed initiative will develop a cross-disciplinary, community-driven and research-based approach to reducing the number of suicides in Alaska.

Secured Detoxification & Treatment for Involuntary Substance Abuse Commitment: \$1,989.7 General Fund

The division will select and fund a nonprofit or municipal agency with a regional and accessible support network, to operate a secure 24-hour detoxification and treatment center, for individuals who are involuntarily committed under AS 47.37.190. The facility would employ clinical staff who have been trained in integrated and comprehensive screening and assessment practices, and would provide intensive case management services for individuals who have been incapacitated by alcohol or drugs, including those diagnosed with co-occurring disorders. The pilot project would terminate no later than July 1, 2012, and would include an evaluation report with outcome measures, including baseline data. Long-term impacts include reduced emergency room costs, lower acute care medical costs, decreased incarcerations and reduced emergency responder costs.

Transfer in Medicaid Mental health Prior Authorization Contract from Behavioral Health Medicaid: \$1,620 Total \$810.0 Federal, \$810.0 GF/Mental Health

This request transfers the authorization for the Medicaid mental health utilization review and care coordination contract, out of the Behavioral Health Medicaid Services component, into the Behavioral Health Administration component.

Medicaid Mental Health Prior Authorization Contract Increase: \$400.0 Total \$200.0 Federal, \$200.0 GF/Mental Health

This increment covers cost increases anticipated for the contract for federally required behavioral health utilization review services, which goes out for bid in SFY08. Utilization control requirements for mental hospitals (42 CFR 456.150-456.245) require that medical and other professional personnel must evaluate each applicant's or recipient's need for admission to behavioral health facilities.

National Accreditation Contract — Phase I of V Increment: \$200.0 GF/Mental Health

Behavioral Health has initiated a process to evaluate and overhaul its business practices and management philosophy. The division is shifting its focus from oversight and compliance toward delivering a higher quality of service and improving treatment outcomes. The purpose is to reduce the grantee's administrative burden associated with periodic reporting and operational oversight, to increase accountability and results based orientation. Strategy linked with changing to a business practice that is

outcomes-based includes national accreditation. Ultimately program standards will be embodied in national accreditation that will be required for all providers.

New Positions for Medicaid FASD Demonstration Project: \$574.0 Total \$287.0 Federal, \$287.0 GF/Mental Health

This increment funds the following: a new Mental Health Clinician III position; a new Medical Assistance Administrator IV position for a Medicaid demonstration project for children with fetal alcohol spectrum disorder; and contractual services for provider training. These costs are eligible for 50-percent federal reimbursement from Medicaid.

The Mental Health Clinician will deal with the following: approve individual plans for waiver clients twice a year; identify system issues, such as duplicative service delivery, barriers to collaboration, or other service delivery; and present these issues to the waiver project manager for resolution. The Medical Assistance Administrator oversees the implementation of the demonstration project, and functions as a coordinator between divisions by interfacing with appropriate division directors to ensure compliant and effective policy development for children in the target group. Contractual services will be used to procure required training services.

MH Trust Develop Credentialing and Quality Standards Steering Committee: \$49.0 MHTAAR

The division proposes this increment for a new MH Trust project in FY09. The Trust Work force Development Focus Area is supporting the formation of a credentialing and quality standards steering committee. This committee will support the development and coordination of competencies, credentialing and standardization processes for certificate level programs to increase consistency and decrease duplication across programs.

MH Trust BTKH Southcentral Foundation Eklutna Residential Psychiatric Treatment Center Training Site: \$50.0 MHTAAR

The division proposes this increment for a new MH Trust project in FY09. This funding, managed by Behavioral Health, provides grants for planning and implementation of a training site within the new Southcentral Foundation (SCF), Eklutna Residential Treatment Facility, which is expected to be completed in the fall of 2008. Forty percent of youth experiencing serious emotional disturbance (SED) are Alaska Native. SCF's Eklutna program will focus on those youth to ensure services are provided in a way that supports cultural differences.

MH Trust Clinical position within the Office of Integrated Housing: \$75.0 MHTAAR

This project was funded in FY08 with \$75.0 MHTAAR under the title "Policy Level Planning & Implementation" and is maintained at that level in FY09 with \$75.0 MHTAAR. This position within the Office of Integrating Housing ensures that clinical and treatment needs are considered and incorporated into Alaska's housing inventory. It will also aim to prevent incidences of incarceration or institutionalization of Trust beneficiaries, by convening key state and community treatment experts to problem solve specific cases that have exhausted available community treatment and housing resources.

MH Trust BTKH Tool Kit Development and Expansion of School-Based Services Capacity via Contract: \$100.0 MHTAAR

This project was funded in FY08 with \$100.0 MHTAAR and is maintained at that level in FY09 with \$100.0 MHTAAR. The project started in FY08 and will continue in FY09. Funding will support a contract to develop a tool kit to disseminate best practices. This will include teaching schools to access Medicaid for school based mental health service delivery, and will increase supports for children with an Individual Education Plan (IEP) and behavioral health problems that interfere with their school performance. Other best or evidence-based practices that have been found effective nationally or in Alaska schools may also be disseminated via this contract.

MH Trust Office of Integrated Housing: \$185.0 MHTAAR

This project was funded in FY08 with \$185.0 MHTAAR and is maintained at that level in FY09 with \$185.0 MHTAAR. The request is for an ongoing project through Behavioral Health for technical assistance to develop supported housing. The stated mission of this office is to aggressively develop the expansion and sustainability of supported housing opportunities statewide for Behavioral Health consumers in safe, decent, and affordable housing, in the least restrictive environment of their choice, which is supportive of their rehabilitation process and allows them to receive individualized community services and supports.

Psychiatric Emergency Services

Discontinue Private ProShare Refinancing: \$1,631.60 General Fund

This increment replaces federal funding with general funds due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$614.4 General Fund

In SFY08 a general fund increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services component. However, these services are provided by other divisions. The transfer of \$614.4 is necessary to give the division the funding needed to continue these services.

FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: (\$158.0 Federal), \$158.0 General Fund

This request is for additional GF needed to match federal revenues for the Single Point of Entry Psychiatric services funded through the Medicaid ProShare program. The annual rate the federal government reimburses the state for Medicaid benefits will decline on October 1, 2008, requiring additional GF to maintain services at the current level.

Services to the Seriously Mentally Ill

Discontinue Private ProShare Refinancing: \$3,324.9 General Fund

This increment replaces federal funding with general funds due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$798.7 General Fund

In SFY08 a general increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services component. However, these services are provided by other divisions. This transfer of \$798.7 is necessary to give the division the funding needed to continue these services.

MH Trust Bridge Home Pilot Project: \$750.0 MHTAAR

This project was funded in FY08 with \$750.0 MHTAAR and is maintained at that level in FY09 with \$750.0 MHTAAR. The focus location for this transition project is Anchorage. Institutions targeted for re-entry include Alaska Psychiatric Institute, Department of Corrections' facilities, Providence Hospital emergency rooms, and other high-cost social service and health programs. The project will allow for up to 60 individuals to receive less expensive, continuous services, including a rental subsidy in order to 'bridge' from institutional discharge onto the HUD Housing Choice voucher program, paired with intensive in-home support services. This pairing of resources has proven successful in other states in reducing recidivism and impacts on service systems. Alaska's efforts have reduced the number of returns to Corrections and in the use of emergency level services in the first full year of the project.

MH Trust Flexible Special needs Housing "Rent Up": \$300.0 MHTAAR

This project was funded in FY08 with \$300.0 MHTAAR and is maintained at this level in FY09 with \$300.0 MHTAAR. Since FY01 the project is an ongoing collaboration between the department, the Trust and Alaska Housing Finance Corporation, to provide capital-related operations funding for special needs housing projects. Behavioral Health allocates the funds as a component of technical assistance provided to successful applicants.

MH Trust Department of Corrections Discharge Incentive Grants: \$300.0 Total \$100.0 GF/Mental Health, \$200.0 MHTAAR

This project was funded in FY08 with \$300.0 MHTAAR, and in FY09 with \$100.0 GF/MH and \$200.0 MHTAAR. The project targets those exiting Department of Corrections settings who are challenging to serve, and who require extended supervision and support services to avoid becoming repeat offenders or public safety concerns. The funds are administered as Assisted Living vouchers or support service resources.

MH Trust Peer Operated Support Services: \$100.0 Total \$50.0 GF/Mental Health, \$50.0 MHTAAR

This project was funded in FY08 with \$50.0 GF/MH and \$50.0 MHTAAR; in FY09 a \$50.0 GF/MH increment is requested with continued \$50.0 MHTAAR funding. Including base funding, this project totals \$150.0: \$100.0 GF/MH and \$50.0 MHTAAR. The project targets the development of consumer-operated programs, such as drop-in centers, case management programs, outreach programs, businesses, employment, housing programs, and crisis services. The incorporation of these programs into the service delivery system provides cost-effective services that are preferred by a sector of consumers.

Designated Evaluation and Treatment

Designated Evaluation and Treatment (DET) Increment: \$700.0 General Fund

This state mandated program has continued to be under-funded each year for the last six years; budgets have usually been short between \$500,000 and \$750,000 each year. As payor-of-last resort, the DET program funds are made available to designated local community and specialty hospitals for evaluation, stabilization and treatment services, inpatient physician services and transportation for people under

court-ordered commitment. Also, it is available to people who meet those criteria, but have agreed to accept services voluntarily in lieu of commitment, and who would otherwise go to the Alaska Psychiatric Institute.

FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: \$200.0 General Fund

This request is for additional GF needed to match federal revenues for the Designated Evaluation and Treatment services funded through the Medicaid ProShare program. The annual rate the federal government reimburses the state for Medicaid benefits will decline on Oct. 1, 2008, requiring additional GF to maintain services at the current level.

Services for Severely Emotionally Disturbed Youth (SED Youth)

Discontinue Private ProShare Refinancing: \$902.0 General Fund

This increment replaces federal funding with general funds, due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$211.0 General Fund

In SFY 08 a general fund increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services component. However, these services are provided by other divisions. This transfer of \$211.0 is necessary to give the division the funding to continue these services.

MH Trust: MHTAAR Funding Discontinued in FY09: (\$1,350.0 MHTAAR)

BTKH Outpatient and Emergency Residential Services & Training —\$500.0 MHTAAR

The project is maintained in FY09 with \$500.0 GF/MH baseline funding from FY08.

BTKH Parent and Youth Navigator Program - \$150.0 MHTAAR

The project is maintained in FY09 with \$200.0 GF/MH baseline funding from FY08.

MH Trust BTKH Anchorage Crisis Stabilization Grant, 15 Beds and Develop Single Point of Entry: \$300.0 Total \$200.0 GF/Mental Health, \$100.0 MHTAAR

This project was funded in FY08 with \$184.0 GF/MH and \$100.0 MHTAAR; in FY09 a \$200.0 GF increment is requested with continued \$100.0 MHTAAR funding. Including base funding, this project totals \$484.0: \$384.0 GF/MH and \$100.0 MHTAAR.

Anchorage Crisis Stabilization program and Single Point of Entry project expands services to youth in crisis for higher placements via 15 crisis stabilization beds, and develops a new single point of entry for children's services: assessment, service coordination and placement in community stabilization and/or into acute care as appropriate.

MH Trust BTKH Individualized Services: \$500.0 Total \$250.0 GF/Mental Health, \$250.0 MHTAAR
This project was funded in FY08 with \$700.0 GF/MH and \$500.0 MHTAAR; in FY09 a \$250.0 GF increment is requested with \$250.0 MHTAAR funding. Including base funding, the total for this project is \$1,200.0: \$950.0 GF/MH and \$250.0 MHTAAR. The project funds additional care for youth experiencing serious emotion disturbance (SED), who are not qualified under Medicaid or who need non-Medicaid eligible services to stay at lower levels of care and avoid Residential Psychiatric Treatment Center (RPTC) placement.

MH Trust BTKH Expansion of School-Based Services Capacity via Grants: \$200.0 MHTAAR
This project was funded in FY08 with \$250.0 GF/MH and \$200.0 MHTAAR and is maintained at that level in FY09. The project funds Evidence-Based Practice (EBP) in schools and collaborations between schools and community behavioral health centers. It also tracks the educational needs of Seriously Emotionally Disturbed Youth (SED Youth) transitioning to and from residential care.

MH Trust BTKH Home and Community Based Start up Grants: \$500.0 MHTAAR
This project was funded in FY08 with \$250.0 GF/MH and \$400.0 MHTAAR; in FY09 a \$500.0 MHTAAR increment is requested. Including base funding, the total for this project is \$750.0: \$250.0 GF/MH and \$500.0 MHTAAR. This project funds grants to providers to expand services within Alaska at the outpatient and residential level for SED Youth.

Alaska Psychiatric Institute

Feasibility Study on Privatization of Alaska Psychiatric Institute (API): \$50.0 GF/Mental Health
This funding supports a feasibility study on privatizing services or operations of API.

SDPR Authorization Increase: \$2,200.0 Statutory Designated Program Receipts
Statutory Designated Program Receipts (SDPR) collections have increased, due to the following changes: new Medicare regulations effective July 2, 2006, which allowed reimbursement for Diagnosis Related Group activities at the institution; billing for Medicare Part B (Physician Services) identified by consultants in October 2006; billing for Medicare Part D (Pharmaceutical) as identified by consultants in October 2006; and scheduled increases in the Medicaid daily rate that impacts the amount billed to Medicare and other third-party payers.

The SDPR funding will be used to improve and implement the following API activities: Currently, API has a new care concept that allows patients to receive disease-related education and psychiatric treatment in a setting that will promote recovery for chronic and acute patients. This program educates and encourages patients to learn to function more independently in their daily life, and become less dependent on the structures provided by a hospital setting. It is anticipated that this system of care will reduce recidivism.

Tele-Behavioral Health (TBH) is emerging as a new technique across the United States, and has been piloted in Alaska with a federal grant, which expired August 2007. This program will allow for psychiatric evaluation and treatment of patients from remote villages. The development of this infrastructure allows for rapid treatment in the patients home setting, without requiring transport to API.

The U.S. Department of Veterans Affairs has limited resources to assist Alaska veterans returning from active duty in Iraq and Afghanistan. These services will be provided as inpatient treatment, as well as outpatient treatment through TeleBehavioral Health.

MH Trust MHTAAR Funding Discontinued in FY09: Tele-psychiatry project: (\$67.6 MHTAAR)

Challenges

Several major challenges face leadership and staff, as DBH continues work on achieving its overall mission — to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships. In general terms, these challenges fall into the four categories of the core services: (1) accessible, effective and efficient continuum of behavioral health services; (2) policy and regulation development; (3) the Alaska Psychiatric Institute; and (4) effective and efficient management and administration.

Accessible, Effective and Efficient Continuum of Behavioral Health Services

Stagnant /or Declining Grant Support: The landscape for behavioral health service delivery continues to be challenging to Alaska behavioral health service providers. As service providers adapt to the changing environment that includes audits and potential “paybacks,” the implementation of “risk management” practices is becoming more formalized in their respective business processes. This has resulted in increased levels of costly administrative burden and diverted resources from actual service delivery. Since reimbursement rates have not kept up — at a minimum with the increased cost of inflation — the efforts to meet basic risk management requirements are resulting in diminishing services, and challenging service providers to meet basic fiscal needs within their organizations. The treatment services network is becoming increasingly fragile and at risk. Ongoing funding to support the true cost of service delivery is critical.

Policy and Regulation Development

Decrease in Stable Work force without Budget Increases: The entire state of Alaska is designated as a mental health professional shortage area. An Alaska Center for Rural Health work force study in 2007 noted that the behavioral health occupational group had the most acute shortages — with both extremely high vacancy numbers and high vacancy rates. The overall vacancy rate was 29 percent, reflecting 1,033 positions. Ongoing funding is needed to address and support the true cost of professional staff providing service delivery.

The Alaska Psychiatric Institute

Work force Challenges: Alaska Psychiatric Institute (API) faces a number of challenges with recruitment and retention for psychiatric registered nurses and mid-level practitioners. Wage and salary adjustments for nursing positions to market-based competition have been established, but work force shortages in API continue to be an issue. The API has made nursing recruitment one of its six organizational priorities for the year. A nursing vacancy rate had been established as an ‘API Key Performance Indicator.’

Lack of Capacity to meet the Need: Perhaps the most significant challenge for API is the increased demand for inpatient acute psychiatric services. This past year the hospital recorded 1,231 acute care admissions. Quite often the hospital is at 'peak' census for the 50 available acute care beds. During periods of high utilization there is a waiting list for admissions. The consequences are serious. Patients often back up in rural areas and require overnight stays in less desirable alternatives, such as jails. Even worse, they may be discharged from a local emergency department and fail to achieve appropriate intensive outpatient services.

Effective and Efficient Management and Administration

New Business Practices, Performance Based Funding and AKAIMS: Behavioral Health is shifting its business practice and management philosophy away from its historical focus on oversight and compliance to a focus on delivery of high quality services and demonstrated treatment outcomes. The

Performance-Based Funding effort plays a critical role in this new business practice. With the new business practices and performance-based funding, the ability to collect, analyze and report on data has become an urgent priority. The lack of resources for the development, maintenance and support of AKAIMS puts the division at risk of falling short of its goals of new business practices and performance-based funding. Current analysis indicates that the AKAIMS project requires two new program analysts (lead developer and maintenance) and one information technology business analyst. Funding is needed to support the necessary staffing levels to meet the existing and anticipated workload. In addition, this will insure successful implementation of the Legislature's instructions to institute Performance-Based granting in FY08, outlined in intent language included in House Bill 95, FY08 operating budget.

National Accreditation: The grantee's administrative burden associated with periodic reporting and operational oversight will be reduced; an expectation of accountability and a results-orientation will be established. Ultimately, program standards will be embodied in national accreditation, which will be required for all providers. Reaching this goal will take five years of preparation, and will involve a partnership with Behavioral Health, provider organizations, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Mental Health Trust Association and the Alaska Legislature.

Behavioral Health Medicaid Services

Payment Error Rate Measurement (PERM): DBH conducted a vigorous Payment Error Rate Measurement (PERM) effort between Aug. 6–Oct. 31, 2007. All 58 DBH Medicaid providers were educated to the PERM process via a PowerPoint presentation and a simulated audit exercise. An audit preparation checklist was used during the simulated audit exercise, one each for mental health and substance abuse, which was based on the Behavioral Health Medicaid regulations and provider billing manual.

The checklists were designed to help the provider compile supporting documentation for audit requests on paid Medicaid claims. When a provider had difficulty with this exercise, technical assistance was rendered immediately. If the provider performance was particularly deficient, more in-depth training was scheduled for a later date.

The PowerPoint presentations and simulated audit exercises along with provider evaluations constituted Phase I of the DBH PERM efforts. A total of 478 individuals were educated about PERM. As a side benefit, DBH was also able to assist providers in preparation for any audit, including state contract audits.

Phase II of the PERM effort consists of follow-up training for those providers who performed poorly in Phase I and provider assistance for individual providers when federal auditors request paid Medicaid claim documentation. Federal audit requests for Medicaid-paid claim histories will begin in early 2008 and continue throughout the federal fiscal year. DBH staff will also intensify Medicaid documentation training efforts as part of a two-pronged approach to ensure a low payment error rate measurement for DBH providers and ultimately contribute to a low Medicaid error rate statewide. The PERM efforts are evolving in response to provider evaluations of every phase of these efforts.

The landscape for behavioral health service delivery continues to be challenging to Alaska behavioral health service providers. As service providers adapt to the changing environment that includes audits and potential "paybacks," the implementation of "risk management" practices is becoming more formalized in their respective business processes. This has resulted in increased levels of costly

administrative burden and diverted resources from actual service delivery. Since reimbursement rates have not kept up, at a minimum with the increased cost of inflation, the efforts to meet basic risk management requirements are resulting in diminishing services, and challenging service providers to meet basic fiscal needs within their organizations. The treatment services network is becoming increasingly more fragile and at risk.

Senate Bill 61 legislative intent language authorizes Behavioral Health to examine whether expanding Medicaid coverage for behavioral health treatment may provide a cost-effective method to partially address the need for increased, effective treatment. Currently Medicaid eligibility categories exclude from coverage most men and women between ages 22 and 64, even if they meet the income and resource requirements. Substance abuse treatment for these Alaskans, if available at all, is funded with local funds or state general funds. Federal Medicaid funds are simply not available under the current Medicaid eligibility criteria unless waived or somehow incorporated into a Deficit Reduction Act state plan for a unique benefit package. However, this segment of the population costs Alaska hundreds of millions of dollars in lost work, increased health care, education and criminal justice costs. Additional populations to be considered for coverage include parents of children receiving Medicaid behavioral health services and uninsured children in need of behavioral health services who do not meet current eligibility criteria for Medicaid or Denali KidCare. DBH propose that all Alaskans seeking, but unable to afford behavioral health treatment could be covered for appropriate services. The department anticipates hiring a contractor familiar with Medicaid waiver law and policy to evaluate the feasibility of expanding the Medicaid program to provide services to this targeted group of Alaskans in need of behavioral health services.

The former divisions of Alcoholism and Drug Abuse and Mental Health and Developmental Disabilities were merged into the current Division of Behavioral Health. Subsequent to that time a primary focus of Behavioral Health has largely been that of “integrating” the two former service systems into one. Currently, Behavioral Health is engaged in promoting system integration and business practice improvement through the development of integrated behavioral health regulations. This regulation package consists of the development of new “integrated” (substance abuse/mental health) regulations. The goals for these new regulations include:

- insuring state compliance with federal regulations;
- maintaining system accountability and system integrity;
- removing unnecessary “industry standards” from reimbursement regulations;
- clarifying the role of Behavioral Health and its expectations of grantees;
- reducing administrative burden where possible for both department and behavioral health grantees;
- adopting a national accreditation policy to ensure industry standards are embodied within provider business practices;
- linking quality services and outcomes to priority populations; and
- increasing both consumer and grantee satisfaction

Performance Measures — Division of Behavioral Health

Contribution to the Department's Mission

Provide an integrated behavioral health system.

Core Services

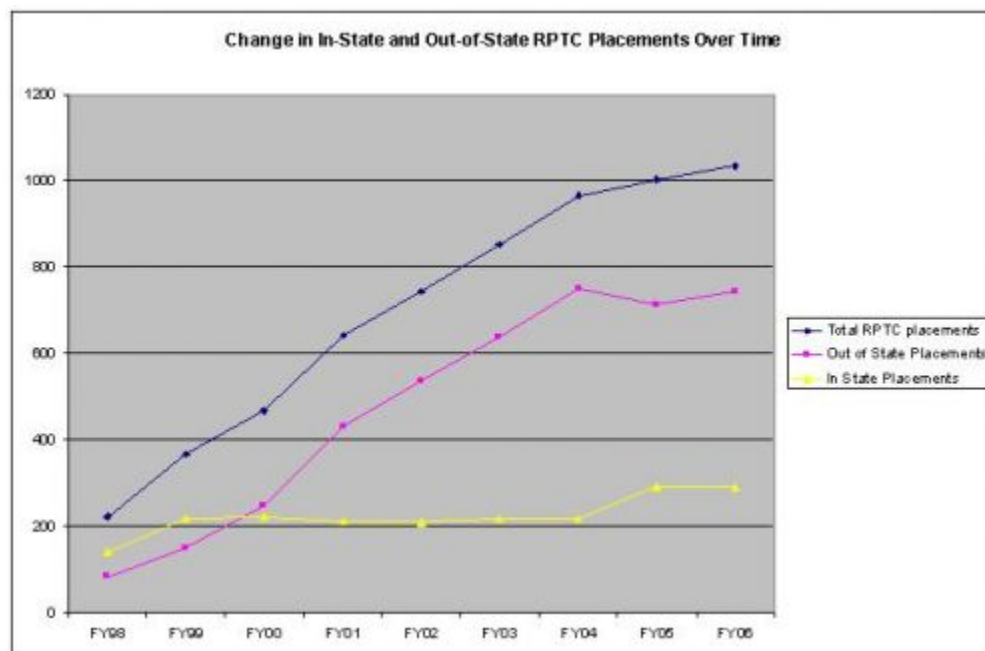
Provide treatment and prevention services for Alaskans with substance use disorders, mental illness, or a combination of both.

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 Residential Psychiatric Treatment Center (RPTC) services. Between FY 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 percent per year. The RPTC population as a whole showed steady increase from FY98–04, an average annual increase of 24.8 percent.

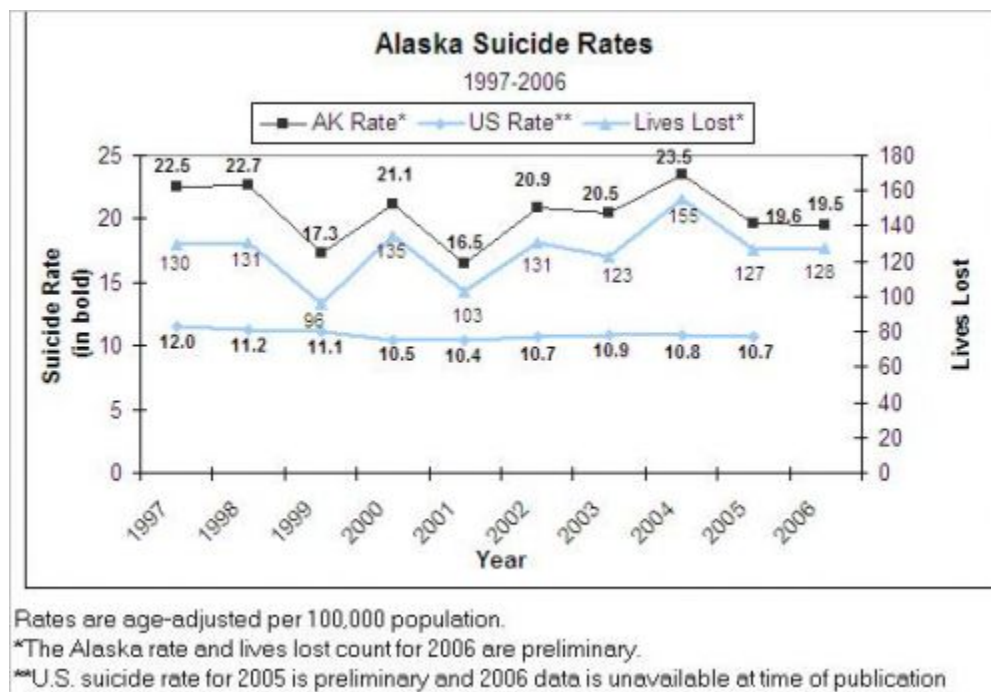
The Bring the Kids Home Project was initiated during FY 2004. Positive changes are already apparent. Between FY 2004 and 2005 a 5.1-percent reduction in the number of children receiving out-of-state

RPTC care, from 749 to 711. However, between FY 2005 and 2006, there was again an increase in out-of-state placement, of 5 percent, from 711 to 743. In FY 2006, there was a 3-percent increase in total RPTC placements. The historical average increase of 46.7 percent 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 ensures 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 became available in FY07. 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 Behavioral Health, Juvenile Justice and Office of Children's Services, in partnership with the Alaska 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.



Rate of Suicides 1998–2006

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.2
1999	17.3	96	11.1
2000	21.1	135	10.5
2001	16.5	103	10.4
2002	20.9	131	10.7
2003	20.5	123	10.9
2004	23.5	155	10.8
2005	19.6	127	10.7
2006	19.5	128	N/A

**Rate is number per 100,000 standard population and accounts for differences in population distribution.*

**CY 2006 Alaska data are preliminary; U.S. Data for 2006 is not available.*

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 2006 shows a slight decline in rate, however is 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 Behavioral Health to provide training on the statewide Suicide Prevention Plan and assessing community readiness for decreasing suicide and non-lethal suicidal behaviors. 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.

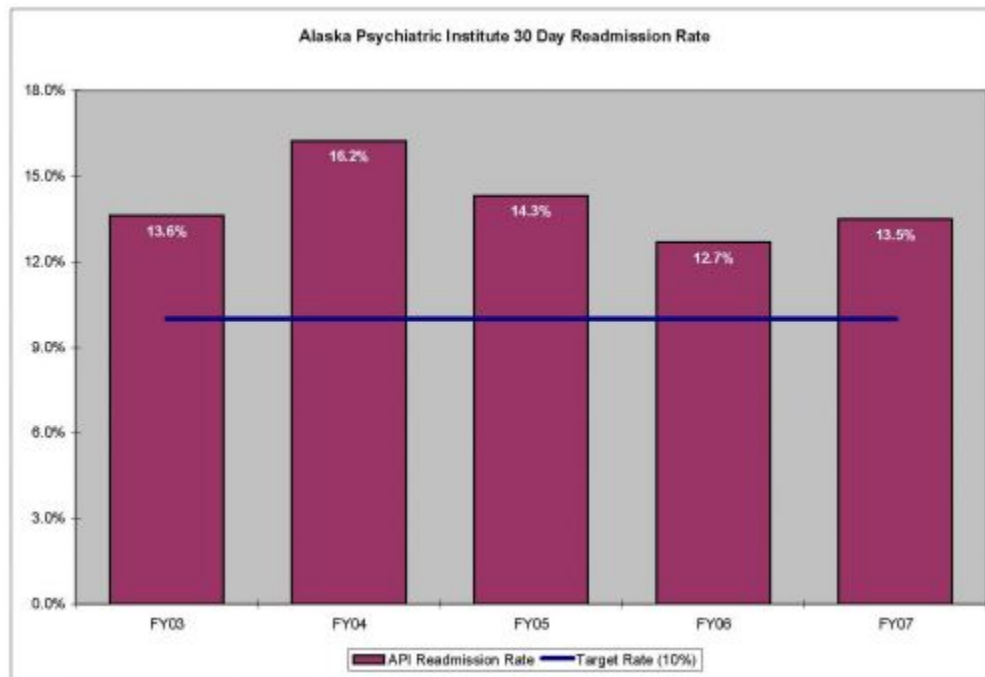
An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to or close to those who had died by suicide:

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

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 Alaska Psychiatric Institute to 10 percent.

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 percent 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 percent.

According to data for FY07, 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. In FY07, API admitted 1,231 patients of whom 166 returned within 30 days for a 13.5-percent readmission rate.

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 percent 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 affect all areas of a person's life, so does recovery affect more than just a single variable. Therefore, clients are asked questions at entry, discharge, and at various points post-discharge, concerning a variety of "life domains." By comparing these responses, DBH is 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 children in out-of-state placement by 25 percent 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 Department of Health and Social Services Tribal Agenda.

Target #1: Increase the number of tribal entities providing behavioral health services to Alaska Natives by 10 percent 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, 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 eight. These eight were: Bristol Bay Area Health Corporation, Copper River Native Association, Kenaitze Indian Tribe, Maniilaq Association, Norton Sound Health Corporation, Southcentral Foundation, Tanana Chiefs Conference, Yukon-Kuskokwim Health Corporation.

In 2006, 14 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 Council, 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 Alaska 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-percent improvement in service outcomes and consumer satisfaction.

Measure #1: Treatment satisfaction data from Behavioral Health Consumer Survey (BHCS; formerly called the Mental Health Statistics Improvement Program Consumer Survey, or MHSIP).

Percentage of BHCS Respondents Satisfied with Services					
Table 1.					
Adults					
DOMAIN	FY04	FY05	FY06	FY07	% increased between FY2004 and FY 2007
Participation in Treatment Planning	67%	71%	70%	70%	2%
Quality and Appropriateness	69%	77%	82%	80%	16%
Positive Outcomes of Services	55%	61%	73%	69%	26%
Access to Services	68%	70%	74%	75%	10%
General Satisfaction	77%	82%	82%	82%	6%
FY06 and FY07: Both Substance abuse and mental health consumers submitted surveys.					
Percentage increase column calculated as follows: (FY07-FY04)/FY04.					
Table 2.					
Families with Children					
DOMAIN		FY05	FY06	FY07	% change between FY2004 and FY 2007
Access to Services		71%	72%	72%	1%
Satisfaction with Services		68%	74%	69%	2%
Participation in Treatment		84%	81%	82%	-2%
Cultural Sensitivity		87%	86%	85%	-2%
Positive Outcomes of Services		58%	64%	65%	12%
FY06 and FY07: Both Substance abuse and mental health consumers submitted surveys.					
Percentage increase column calculated as follows: (FY07-FY05)/FY05.					
Family with Children surveys do not have sufficient response rates for FY04 to use as the base year.					
Table 3.					
Youth					
DOMAIN		FY05	FY06	FY07	% change between FY2004 and FY 2007
Access to Services		70%	65%	55%	-21%
Satisfaction with Services		77%	74%	69%	-10%
Participation in Treatment		68%	67%	65%	-4%
Cultural Sensitivity		84%	86%	74%	-12%
Positive Outcomes of Services		73%	64%	70%	-4%
FY06 and FY07: Both Substance abuse and mental health consumers submitted surveys.					
Percentage increase column calculated as follows: (FY07-FY05)/FY05.					
Youth surveys do not have sufficient response rates for FY04 to use as the base year.					

Analysis of results and challenges: The Behavioral Health Consumer Survey (BHCS) 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 Behavioral Health for processing.

This Performance Improvement Process improves survey validity each year. Early in the implementation of the BHCS, 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 FY04 and FY05 is questionable due to the poor response rates.

For FY08, the following changes have been implemented as part of the improvement process: the division has improved oversight of the implementation of the consumer survey and developed a formal procedure to establish consistent implementation (timelines and methods) of the survey. These changes in the consumer survey process will result in a continued improvement in the sampling size and validity of survey findings.

Clearly, adult clients of our programs have become more satisfied over the last several years, while children and their families are less satisfied with certain aspects of treatment. The division is exploring these results with providers and consumers in order to increase their levels of satisfaction and the positive outcomes of treatment.

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, permanency planning and adoption and guardianship. 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.

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 three programs that support children, youth, and families:

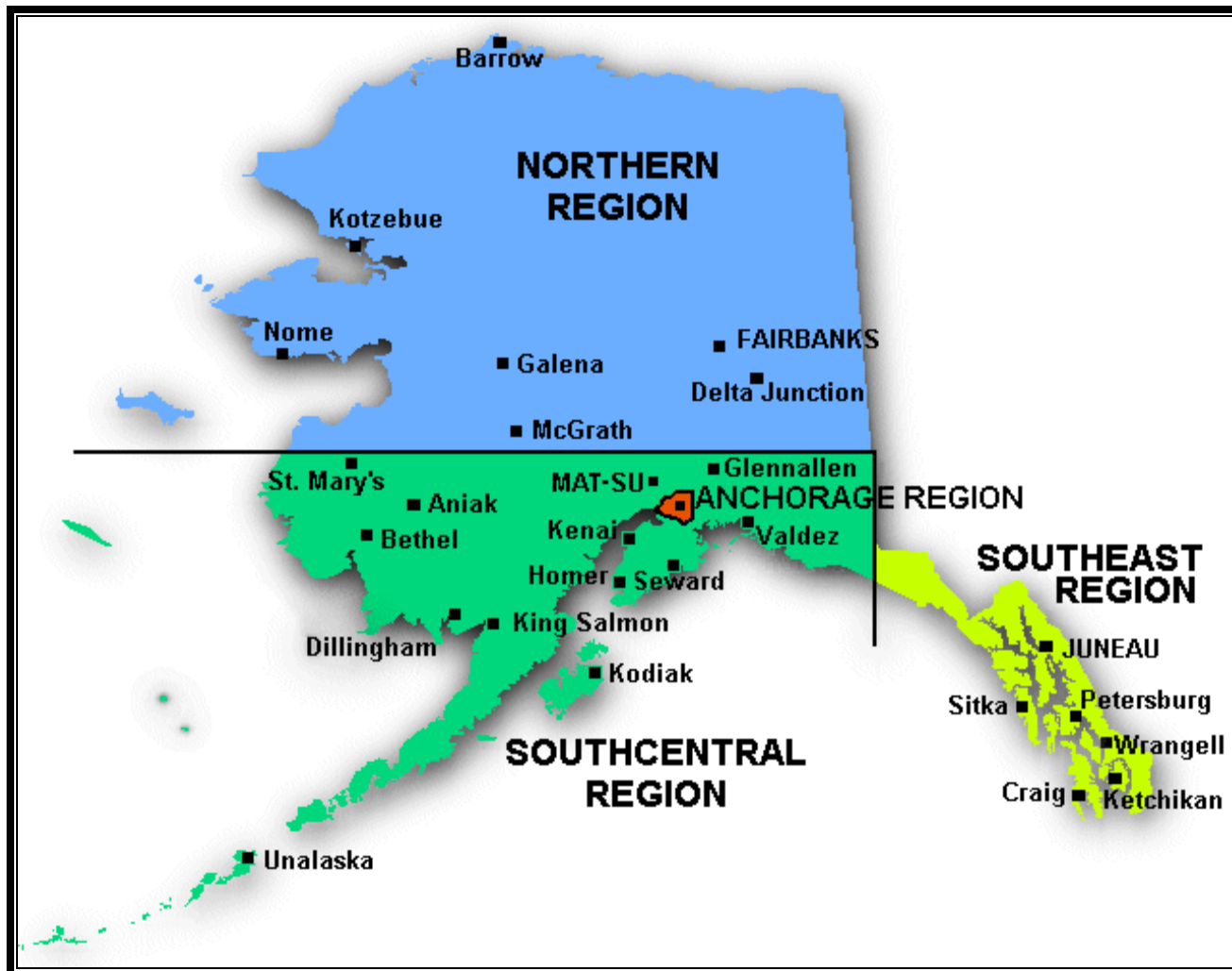
1. Child Protection and Permanency
2. Early Childhood Comprehensive Systems Planning
3. Infant Learning Program

Core Services

- Investigate Child Protective Services Reports and ensure that children are safe in their own homes and provide services when necessary;
- 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, children 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;
- 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.

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;
- South-central 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

In addition to the core services identified earlier, OCS has the following services and new programs.

Native Family Preservation Unit

Three agencies, including OCS, have joined forces to address disproportionate numbers of Alaska Native children in state care. (Alaska Native children in Anchorage are 14 times more likely than non-Native children to be involved with the state's child protection agency.)

Funding has been secured for the next five years for the new Alaska Native Family Preservation Unit, comprised jointly of OCS-Anchorage, Cook Inlet Tribal Council and the Native Village of Eklutna. The unit, which will share authority and decision-making, will consist of two staff members from each agency, along with a supervisor.

On behalf of the group, Cook Inlet Tribal Council applied for a \$2.5 million, five-year grant from the U.S. Department of Health and Human Services. The funding was granted in late 2007 and hiring for the unit has begun. It is expected to be operational in January 2008.

The unit may be the first of its kind in the United States and will work exclusively with Alaska Native families. The unit plans to serve 180 families its first year, and 240 for each of the following four years.

University Lake Multi-Disciplinary Center

As of late August 2007, five Anchorage OCS investigators and one supervisor are located in the new Multi-Disciplinary Center of University Lake Plaza. They are part of a specialized unit that is investigating all sexual abuse and physical abuse allegations for the Anchorage region. The unit includes OCS staff; the Anchorage Police Department's Crimes Against Children's Unit and the Special Victim's Unit; Alaska State Troopers (Alaska Bureau of Investigations unit); S.A.R.T (Sexual Assault Response Team) Center; and the Alaska C.A.R.E.S (Anchorage's child advocacy center) Child Abuse Response and Evaluation Services.

The vision is a one-stop facility that ensures children and families receive the most efficient and supportive care possible. With the primary goal of ensuring that children are not further victimized by the intervention systems designed to protect them, the unit will collaborate to conduct joint forensic interviews and make team decisions about the investigation, treatment, management and prosecution of child abuse cases. Additionally, co-location is expected to enhance coordination efforts resulting in time savings for everyone involved.

Family Preservation

Family Preservation awards grants statewide to nonprofit 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, aftercare 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

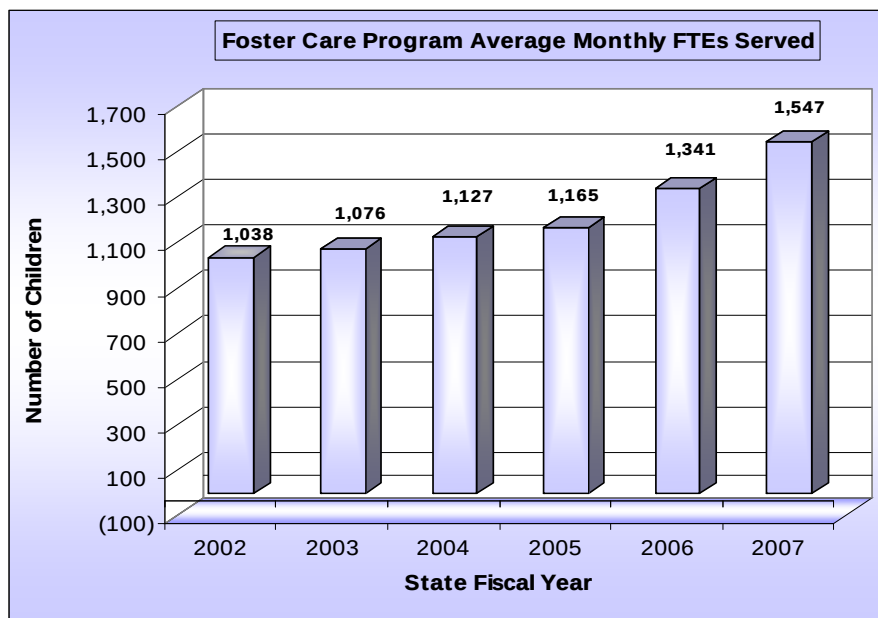
family/community connections; financial assistance, and identification of additional resources the youth may require.

- Eighteen youth were approved for funding for college in the University of Alaska system in fall of 2007.
- Three youth were approved for funding at the states AVTEC program.
- Four youth received funds to attend vocational training.
- Approximately 31 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 services are available to the approximately 238 youth 16 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 4–10 youth participating.
- For youth living in remote areas, DVDs are available regarding a range of Life Skills issues.
- In Anchorage, Independent Living funds are used to fund a grant with Covenant House 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

The 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.



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.

Tribal Title IV-E

OCS administers the Tribal Title IV-E Reimbursement Program. OCS, through agreements with Alaskan Tribes and Tribal Organizations, passes through more than \$1 million annually of Title IV-E federal funds annually. In conjunction with OCS, Tribal staff provide child welfare services to Alaska 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. Tribes are also working with OCS to develop a foster care information packet to be used for recruitment of Native Foster Homes. OCS is currently working with three Tribes/Tribal Organizations to explore the possibility of joining its Tribal Title IV-E Partners.

OCS Subsidized Adoption and Guardianship

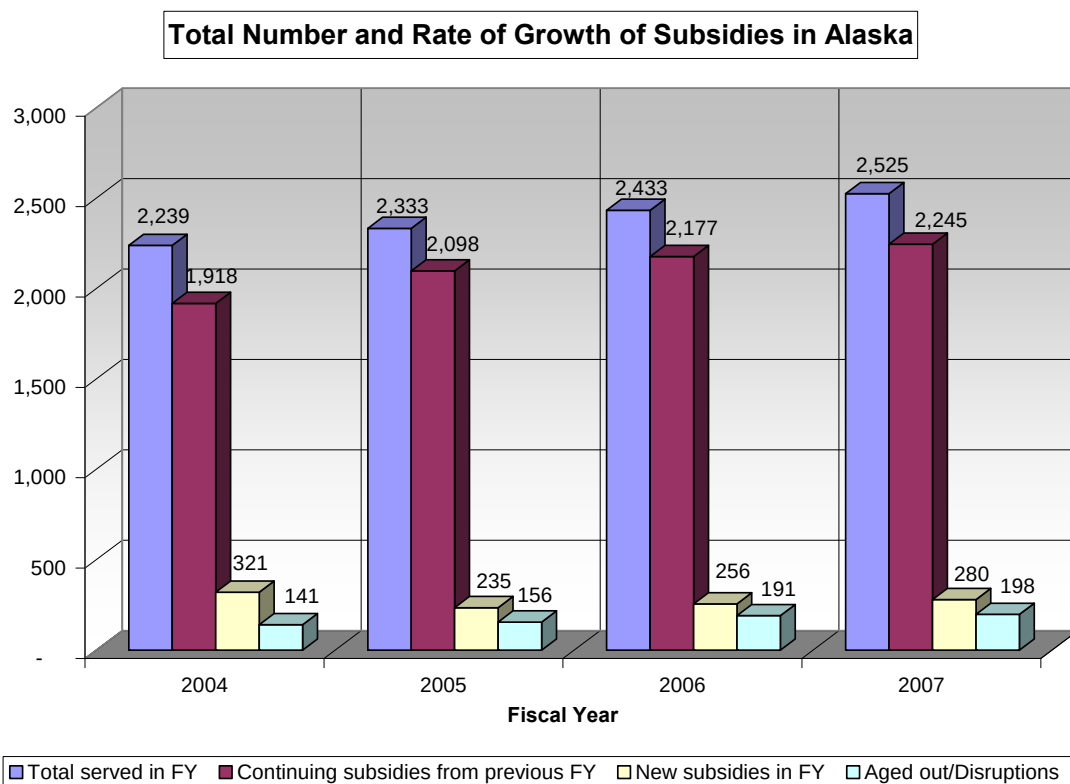
The Subsidized Adoption and Guardianship program facilitates permanent placements in adoptive and guardianship homes for an increasing number of children in state custody whose special needs make them hard-to-place. Adoption is viewed as the most permanent and preferable option for children who cannot return to their own homes.

Guardianships are considered for children who cannot be freed for adoption, but for whom a reasonably permanent home is 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 to their families that should not be severed.

By the end of FY 2007, 2,525 children are currently living in permanent homes assisted through the Subsidized Adoption and Guardianship program.

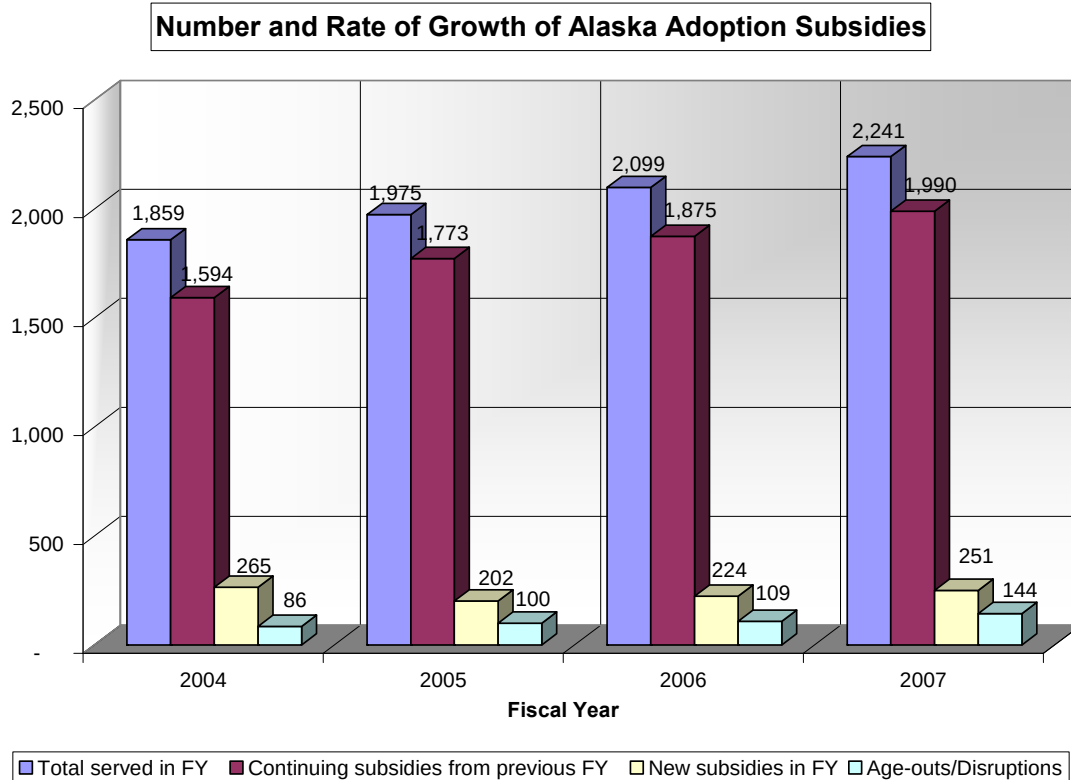
The following charts outline the continued growth of the Subsidized Adoption and Guardianship program at the Office of Children's Services since FY 2004. The Office of Children's Services has implemented policy changes to the subsidy program that further define the parameters of legal guardianship versus adoption for children in the 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:

NOTE: Previously submitted DHSS Budget Overviews underreported subsidy numbers. Those numbers have been updated here. New methodology implemented in FY 2008 provides better detail to actual services provided through the Subsidized Adoption and Guardianship Programs for the reported fiscal years.

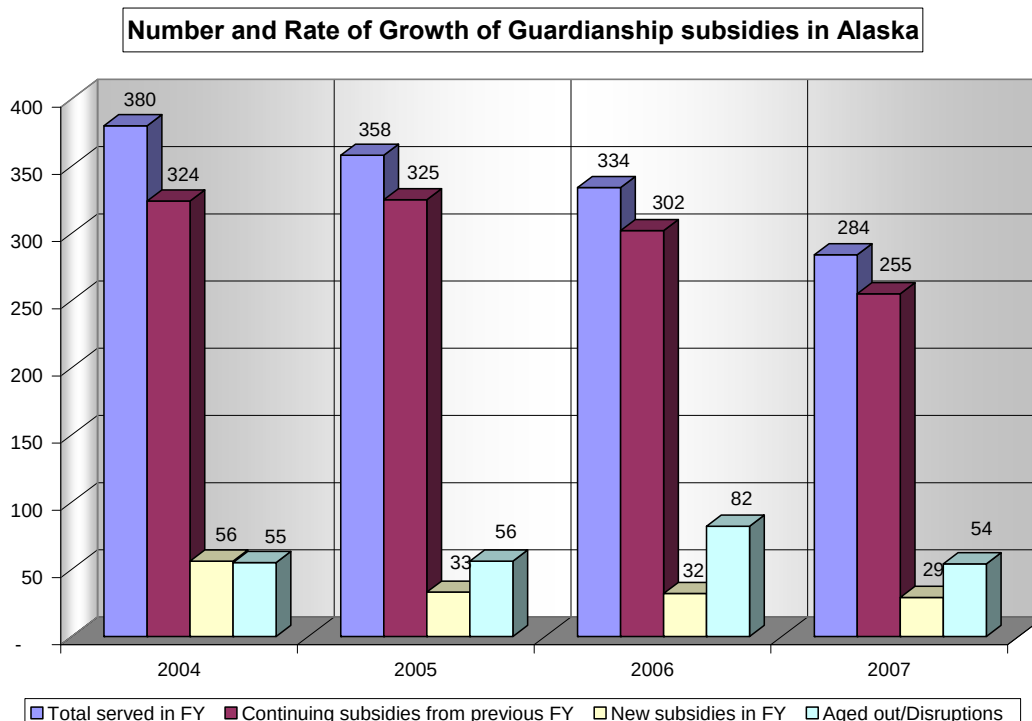


Data source: AK DHSS, Office of Children's Services Subsidized Adoption and Guardianship Program.

The following charts break down the adoption and guardianship subsidies by fiscal year. These charts show the increases in adoptions versus guardianships, and the direct impacts of the policy changes regarding permanency for children in the OCS.



Data source: AK DHSS, Office of Children's Services Subsidized Adoption and Guardianship Program.



Data source: AK DHSS, Office of Children's Services Subsidized Adoption and Guardianship Program.

The following table is a breakdown of Adoption and Guardianship Subsidy numbers for fiscal years 2004 through 2007.

Adoptions and Guardianship Subsidies by State Fiscal Year				
Totals by Subsidy Type	Fiscal Year			
Adoptions funded through Title IV-E funds	2004	2005	2006	2007
IVE Continuing Adoptions	1319	1457	1541	1658
IVE New Adoptions	209	149	190	188
IVE Aged Out	49	51	67	102
IVE Disrupted	22	29	22	25
Current = Continuing + New — Aged Out — Disrupted	1457	1526	1642	1719
Adoptions funded by the State of Alaska				
State Continuing Adoptions	275	316	334	332
State New Adoptions	56	53	34	63
State Aged Out	11	15	17	11
State Disrupted	4	5	3	6
Current = Continuing + New — Aged Out — Disrupted	316	349	348	378
Guardianships funded by State of Alaska				
Guardianships Continuing	324	325	302	255
Guardianships New	56	33	32	29
Guardianships Aged Out	40	36	53	42
Guardianships Disrupted	15	20	26	12
Current = Continuing + New — Aged Out — Disrupted	325	302	255	230
TOTALS				
(TTL)YTD NEW ADOPTION/GUARDIAN	321	235	256	280
plus TTL continuing ADOPTION/GUARDIAN	1918	2098	2177	2245
less TTL YTD AGED OUT	100	102	137	155
less TTL YTD DISRUPTIONS	41	54	51	43
Total Children with active subsidies at the end of the FY	2098	2177	2245	2327

Data source: AK DHSS, Office of Children's Services Subsidized Adoption and Guardianship Program.

Residential Child Care

Residential Child Care facilities provide high quality, time-limited residential treatment services for abused, neglected, and delinquent children in the custody of Children's Services and Juvenile Justice. Ongoing efforts in support of the department's Bring The Kids Home (BTKH) initiative now allows non-custody youth to access Residential Child Care services upon prior approval by OCS. Residential Child Care 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 Behavioral Rehabilitation Service (BRS) Medicaid program provides funding for eligible treatment and care while the state pays for core services to ensure capacity. Core services support each program by funding room and board.

Residential Care Facilities and Utilized Bed Days				
State Fiscal Year	FY04	FY05	FY06	FY07
Number of Facilities	29	28	28	28
Utilized Bed Days	57,041	58,606	56,857	55,034

Lower numbers of utilized bed days in FY 2007 can, at least in part, be attributed to low numbers of referrals. It is anticipated that numbers will increase as children return to Alaska under the BTKH program.

Early Childhood Programs

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. If significant problems are identified in the evaluation, an individualized family service plans is developed that outlines goals for the family and the child. Comprehensive, coordinated, home-based early intervention services could include the following services based upon the child and family's needs:

- providing child development information to parents;
- home visits to provide early intervention services in a natural environment;
- physical, occupational, and speech therapy;
- specialized equipment; and
- referrals to other needed services

The Early Childhood Comprehensive Systems (ECCS) Project is a federally funded project whose purpose is to promote positive development and improved health outcomes for Alaska's prenatal to 8-year-old children by creating a culturally responsive, comprehensive and accessible service delivery system.

The ECCS project brought together more than 100 public and private partners from around the state in a collaborative effort to review existing systems for young children and plan for their improvement. A statewide Early Childhood Comprehensive Systems Plan was developed which included the following target areas:

- access to health insurance and medical homes;
- family support and parent education;
- early care and education; and
- social-emotional development of young children.

Some of the recommendations that are currently being focused on include:

- promoting comprehensive, developmental screening for young children;
- providing greater access to mental health services for young children;
- improving quality in early care and learning programs; and
- embedding family support services in early care and learning programs.

The Strengthening Families Initiative (SFI) is a proven, cost-effective strategy to prevent child abuse and neglect. The strategy involves early childhood centers working to build protective factors around children by supporting family strengths and resiliency. Protective Factors include:

- parental resilience;
- social connections;
- knowledge of parenting and child development;
- concrete support in times of need; and
- children’s health, social and emotional development.

The Strengthening Families framework can be adapted to any early childhood setting — child care centers, Head Start programs, preschools, and home visiting programs. Family support is offered to all families, not just those identified as “at risk”. It is a population-based approach that puts family support in natural settings where approximately one-third of Alaska’s children, from birth to 5, are served. OCS is currently working with several early childhood programs to implement this model.

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 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 increases funds by soliciting contributions through fund-raising activities, gifts and bequests, and applies for private and federal grants consistent with the purpose of the Trust.

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 OCS Director’s Office
- The Family Services Unit
- The Program Eligibility Unit
- Tribal Relations Unit

Other administrative functions provided for OCS are located in Finance and Management Services under the DHSS Commissioner’s Office.

The Online Resources for the Children of Alaska (ORCA) is Alaska’s child protection services case management and provider payment system.

- ORCA is a federally mandated system required to support child protective services case management and federal reporting.
- Since inception and ongoing , ORCA staff will be continuously modifying Alaska's SACWIS system to reflect changing federal reporting requirements and Alaska’s ever-changing needs.

- The ORCA system is updated by a series of releases that occur approximately four times per year.
- ORCA has recently produced reports that have been very useful to OCS field managers including:
 - number of Protective Services Reports received and Investigations completed;
 - number of Protective Services reports per priority level in each region; and
 - provider Vacancy Report that helps the field identify available foster homes.

ORCA is now the child protection system of record and must respond to a service environment that is in continuous change and growth.

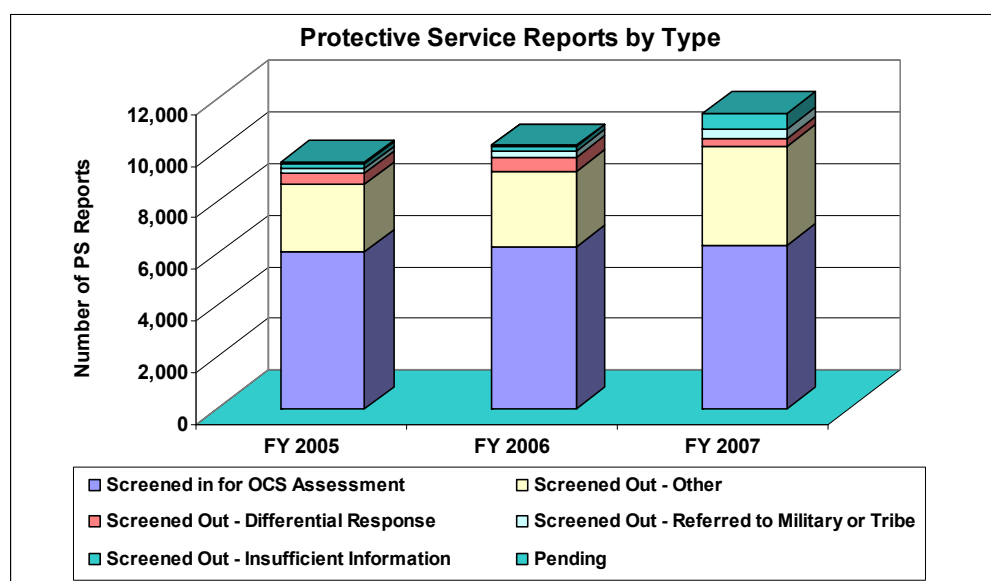
Annual Statistical Summary of Services Provided in FY 2007

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 2007 OCS received approximately 11,400 protective services reports — roughly 1,200 more than received in FY 2006.

The table below illustrates that in FY07, 6,613 (55.4 percent) of the 11,399 protective service reports received by OCS were assigned to OCS staff for assessment. There were 3,808 protective services reports that were “Screened Out — Other”, meaning they did not contain allegations that would necessitate an investigation. To ensure that all protective services reports that necessitate an assessment receive a response, those reports not assigned to OCS staff are referred to a Differential Response program (community-based agencies in Wasilla, Anchorage and Nome), a Tribal organization, or a Military agency.



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 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 includes 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 were pulled.

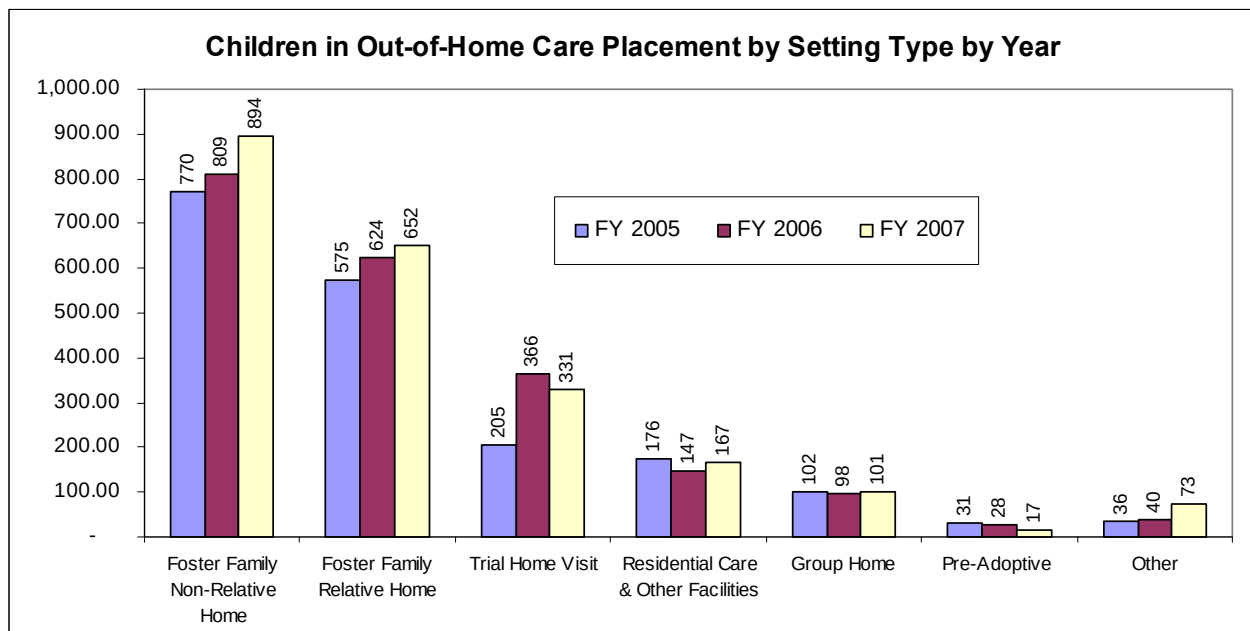
Protective Services Reports Screened In by State Fiscal Year			
	FY 2005	FY 2006	FY 2007
Screened in for OCS Assessment	6,086	6,225	6,313
Protective Services Reports Screened Out by State Fiscal Year			
	FY 2005	FY 2006	FY 2007
Screened Out - Other	2,598	2,929	3,808
Screened Out - Differential Response	419	536	326
Screened Out - Referred to Military or Tribe	198	254	353
Screened Out - Insufficient Information	172	219	588
Pending	70	6	11
Total	3,457	3,944	5,086
Total Protective Services Reports Received by State Fiscal Year			
	FY 2005	FY 2006	FY 2007
Total PS Reports Received	9,543	10,169	11,399

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

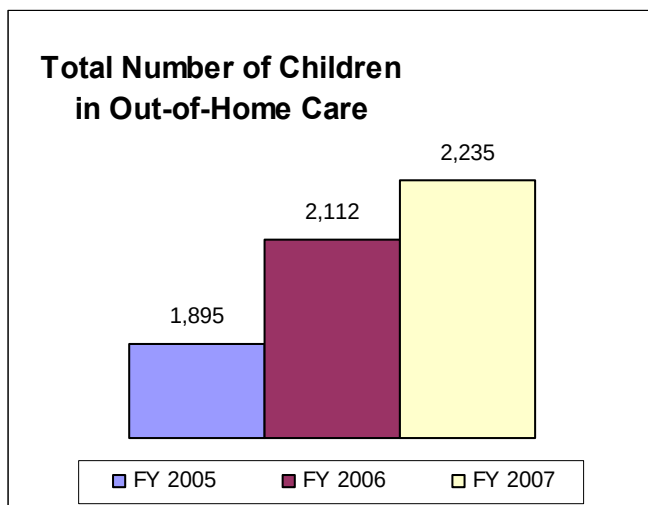
Number of Children in Out-of-Home Care

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.

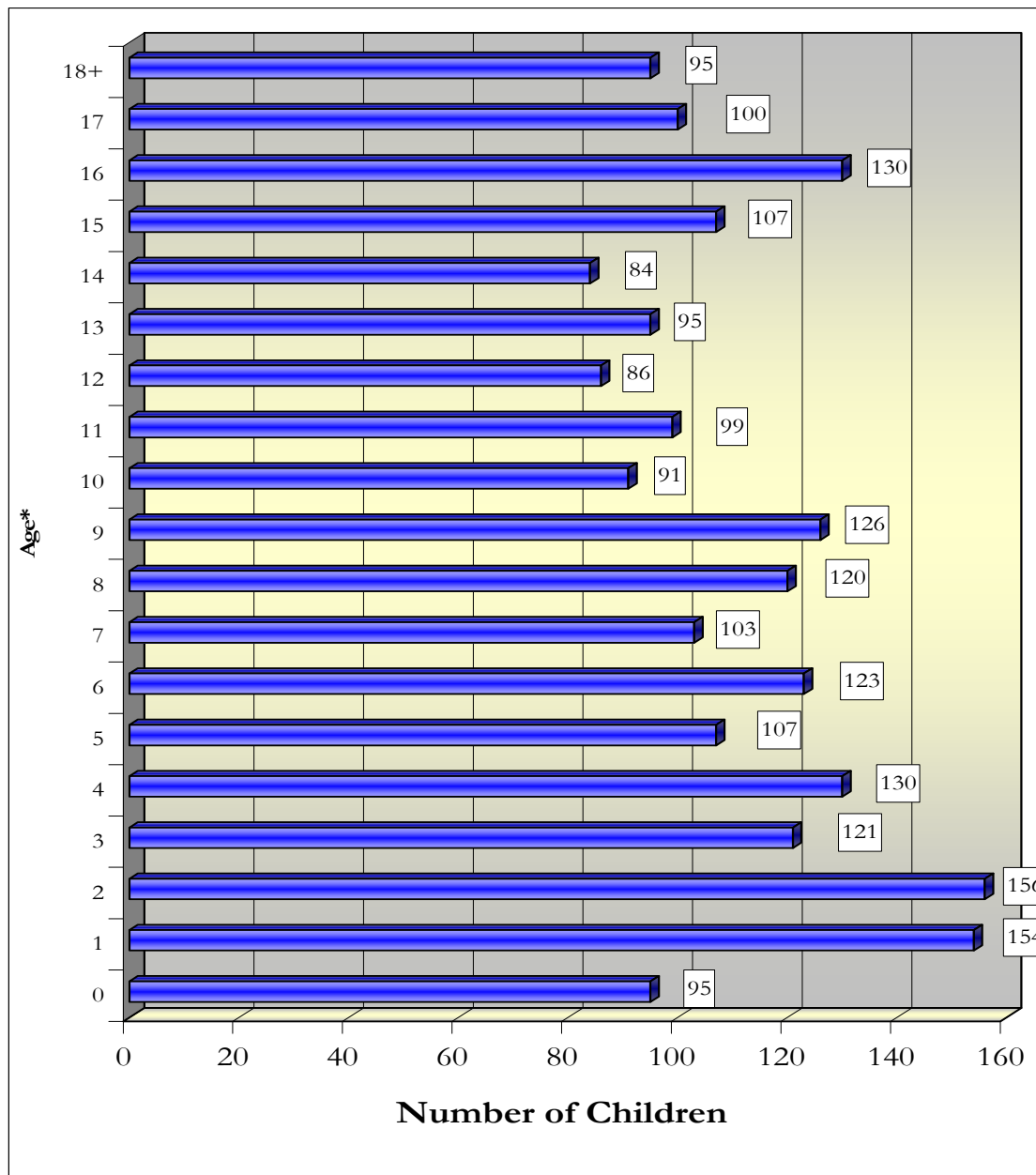


Other includes Supervised Independent Living and Runaways



Data Source: AK DHSS, Office of Children's Services Online Resource for the Children of Alaska (ORCA) case management. Other includes Supervised Independent Living and Runaways. The total number of children is based on data from the last month of the fiscal year.

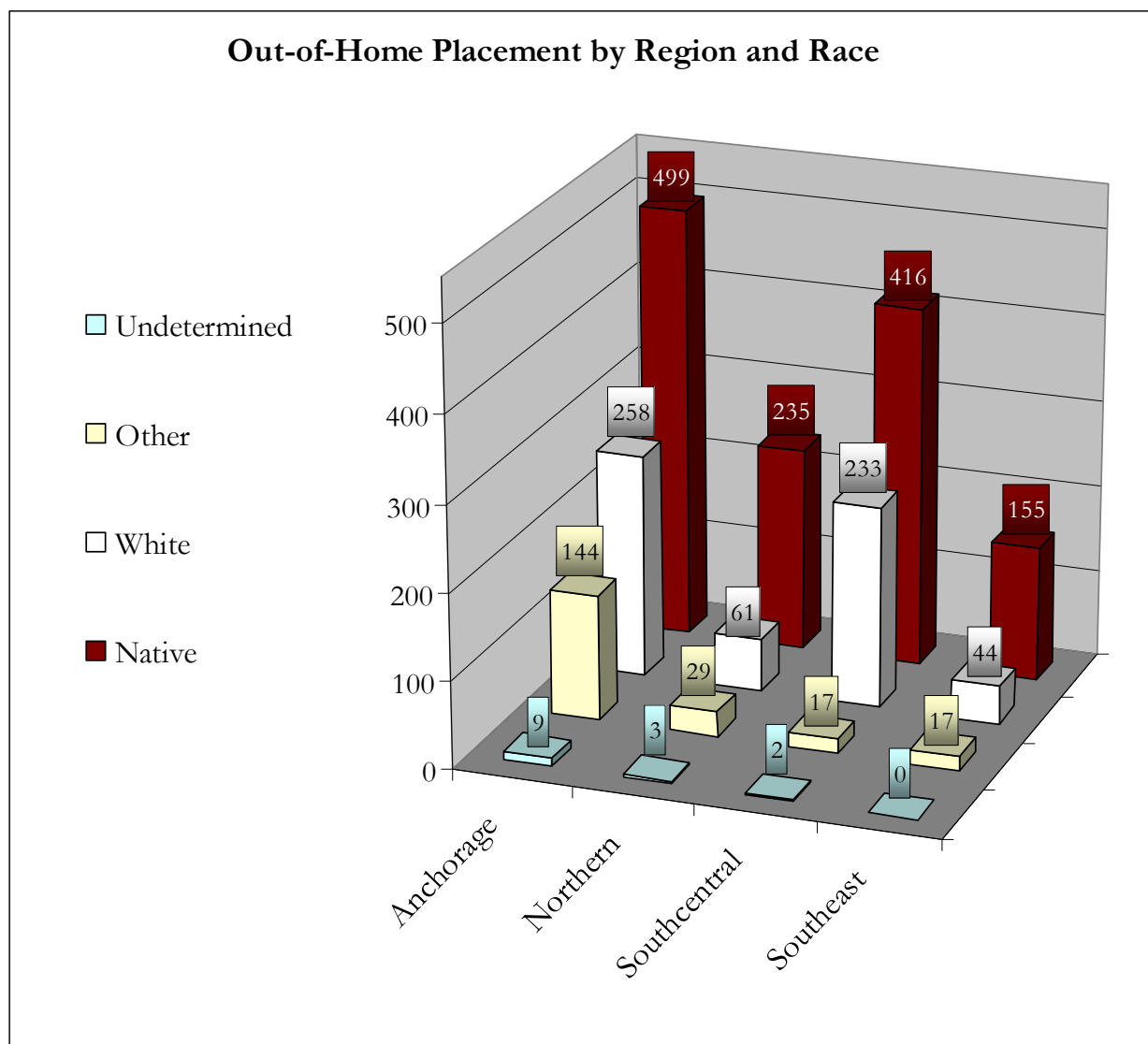
Children in Out of Home Care for November 1, 2007, by Age



* age of child as of November 1, 2007

Out-of-home placement is the last option considered when reasonable efforts to protect a child in his or her own home have been exhausted. The first preference considered in all out-of-home placements for a child is a relative's home. When it is not possible to place a child with a relative, it is necessary to place the child in a foster home. Residential care facilities may offer short-term emergency shelter as well as more long-term residential treatment if required.

Throughout the National child welfare system, children of ethnic backgrounds other than Caucasian are represented in numbers that exceed their relative proportion of the population. In Alaska, approximately 60 percent of children in state custody are Alaska Native. A collaborative effort between the OCS and tribal child welfare leaders and Casey Family Programs is working to decrease this disparity through strategic planning with the Tribal State Collaboration Group, local plans between tribal and state partners, Undoing Racism Training, and the Kinship Care initiative, among other things.



Recurrence of Maltreatment

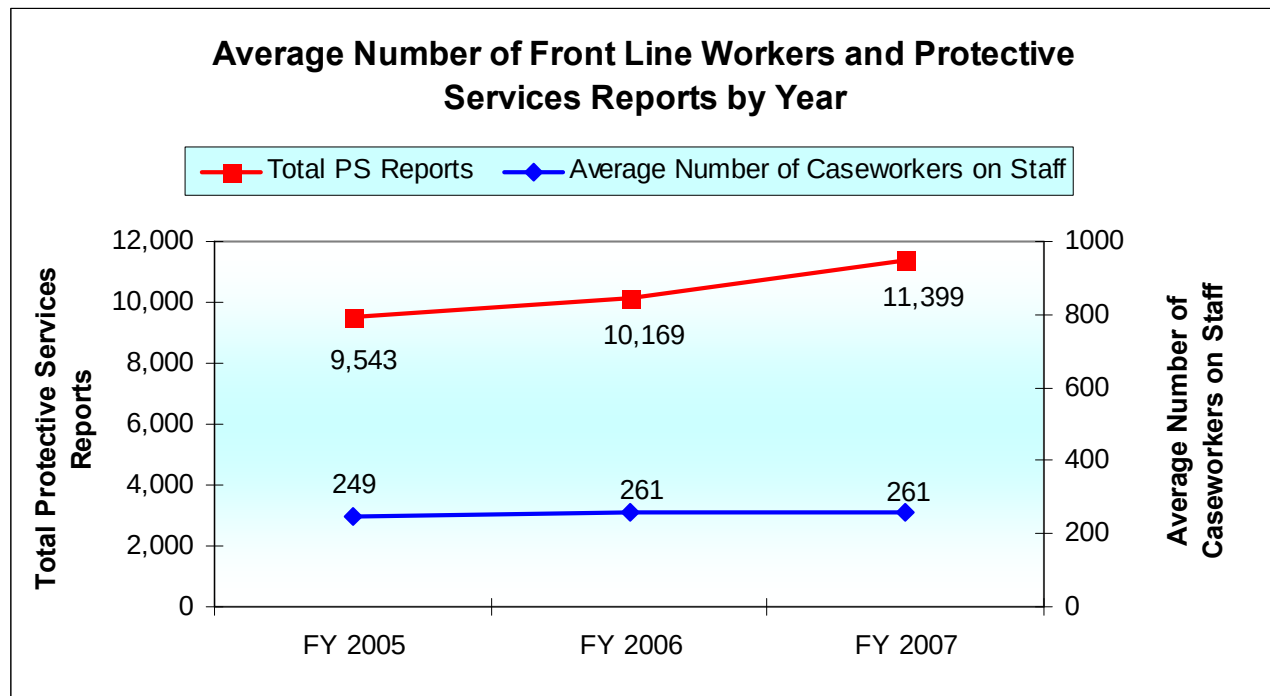
A child is considered to have a recurrence of maltreatment if two or more protective services reports are substantiated within a six-month period.

In 2002, the baseline for substantial compliance with federal criteria was set at 74 percent of cases with no recurrence of maltreatment. The current performance measure goal is 93.9 percent. For Federal Fiscal Year 2007, there was no recurrence of maltreatment in 90.4 percent of the cases. Progress in this area will continue as OCS continues to achieve manageable caseloads, builds a well-trained stable work force, 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 work force turns over. While turnover rates are a current performance measure, this chart provides a good picture of the continuing struggle to maintain a stable work force. While staff numbers have increased over the past three years, the number of protective service reports has outpaced increased staffing significantly.



List of Primary Programs and Statutory Responsibilities

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	

Explanation of FY2009 Budget Changes

Office of Children's Services	2008	2009 Gov	08 to 09 Change
General Funds	63,843.2	68,713.4	4,870.2
Federal Funds	54,912.0	55,629.1	717.1
Other Funds	6,545.5	8,648.4	2,102.9
Total	125,300.7	132,990.9	7,690.2

Children's Services Medicaid Services

FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid (\$355.6 Federal), \$355.6 General Fund

This request replaces lost federal revenues resulting from a 1.95% decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008. The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid Services and is outside the control of the state government. Without the increment the state would be forced to reduce eligibility or services currently provided to low income children. By approving this change record the department will be able to continue to meet its mission of purchasing health care for Alaskans in need.

The amount of federal funds the state receives for its Medicaid program depends on a complex array of reimbursement rates, some of which change each October 1st with the start of a new federal fiscal year. The bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the federal medical assistance percentage or FMAP. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50%. Also affected is the State Children's Health Insurance Program (SCHIP) which is part of Alaska's Medicaid program. Eligible claims for SCHIP are reimbursed at an enhanced FMAP rate which reduces the state share of costs by 30% over the regular FMAP.

The regular FMAP is projected to drop from 52.48% to 50.53% in FFY09 and the enhanced FMAP from 66.74% to 65.37%. The regular FMAP for SFY09 will average 51.02% across two federal fiscal years (52.48% from July-Sept. 2008 and 50.53% from Oct. 2008-June 2009). The enhanced FMAP for SFY09 will average 65.71% (66.74% from July-Sept. 2008 and 65.37% from Oct. 2008-June 2009). Approximately 75% of the Children's Medicaid component's claims are reimbursed at the regular FMAP and another 2% at the enhanced FMAP. The remaining 23% is Indian Health Service (IHS) or non-reimbursable and is not affected by the change in FMAP. Based on current estimated expenditures for Medicaid, the FFY09 change in FMAP will require an estimated \$355.6 increase in GF to replace the lost federal funds and maintain services at the current level.

Children's Services Training

Basic Staff Training and Development: \$ \$427.0 Total \$57.9 Federal, \$369.1 General Fund

OCS intends to implement improved employee training for front-line workers by extending the length of training so that it is in line with other child welfare agencies nationwide and by enhancing the curriculum to provide new employees with all of the tools necessary to achieve OCS system improvements. OCS also intends to provide all OCS staff the opportunity for continued education that is not only on point with their specific job class but beneficial to the state. The planned, improved full spectrum of training is in keeping with recommendations by national experts, University of Alaska Anchorage professionals, Tribal partners, and OCS staff.

Alaska's children and their families deserve caseworkers that have been given the tools and training necessary to provide exemplary services. These improvements are expected to positively impact annual employee turnover rates, the numbers of positions available to provide direct services, and worker effectiveness.

In addition, the OCS intends to offer all OCS staff continued education opportunities. Any Internet search or walk through a local bookstore will lead the researcher to a sea of findings related to the importance of staff training. Simply put, training is critical in helping staff develop skills and knowledge; perform their job effectively and efficiently; perform their job safely; feel confident and professional; and feel valued and motivated. OCS recognizes that while education for new front-line workers is the priority, continued education for front line and all other OCS workers is extremely important as well.

Front Line Social Workers

Implement Front-line Worker Study Recommendations — Phase 2: \$860.9 Total \$260.9 Federal, \$600.0 GF/Match

In FY 2008, the OCS was given six additional case workers in response to a Workload Study contracted with Hornby Zeller Associates. The study was conducted in response to legislative concerns and Citizen's Review Panel findings. The primary purpose of the study was to determine whether or not front-line caseworkers have sufficient time to meet the basic requirements of their jobs — protecting children and serving families.

The outcome of this six-month study was based on the time needed to handle a case appropriately, the time available for case-specific work, and caseload per worker. The results indicated a need for 17 additional workers.

The OCS is now requesting funding for an additional seven front-line positions and three administrative staff workers. Support positions are necessary to help alleviate some of the administrative duties that fall on line workers. The workload study revealed that line workers spend an average of 12.4 percent of their time on administrative tasks. OCS has increased its front-line staff by 63 positions over the last four fiscal years with no additional administrative staff hires.

Increased Lease Costs – Anchorage: \$583.3 Total \$143.3 Federal, \$440.0 General Fund

This increment provides the additional funding for adequate office space for staff in Anchorage. Staff are currently housed in three different buildings.

Transfer out I/A Receipts to Infant Learning Program: (\$425.0 Interagency Receipt)

Excess Interagency Receipt authorization is being transferred to the Infant Learning Program.

Family Preservation

Discontinue Private Proshare Refinancing: \$322.4 General Funds

This increment replaces federal funding with general funds, due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$76.9 General Fund

In SFY 08 a general fund increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services component. However, these services are provided by other divisions. This transfer of \$76.9 is necessary to give the division the funding to continue these services.

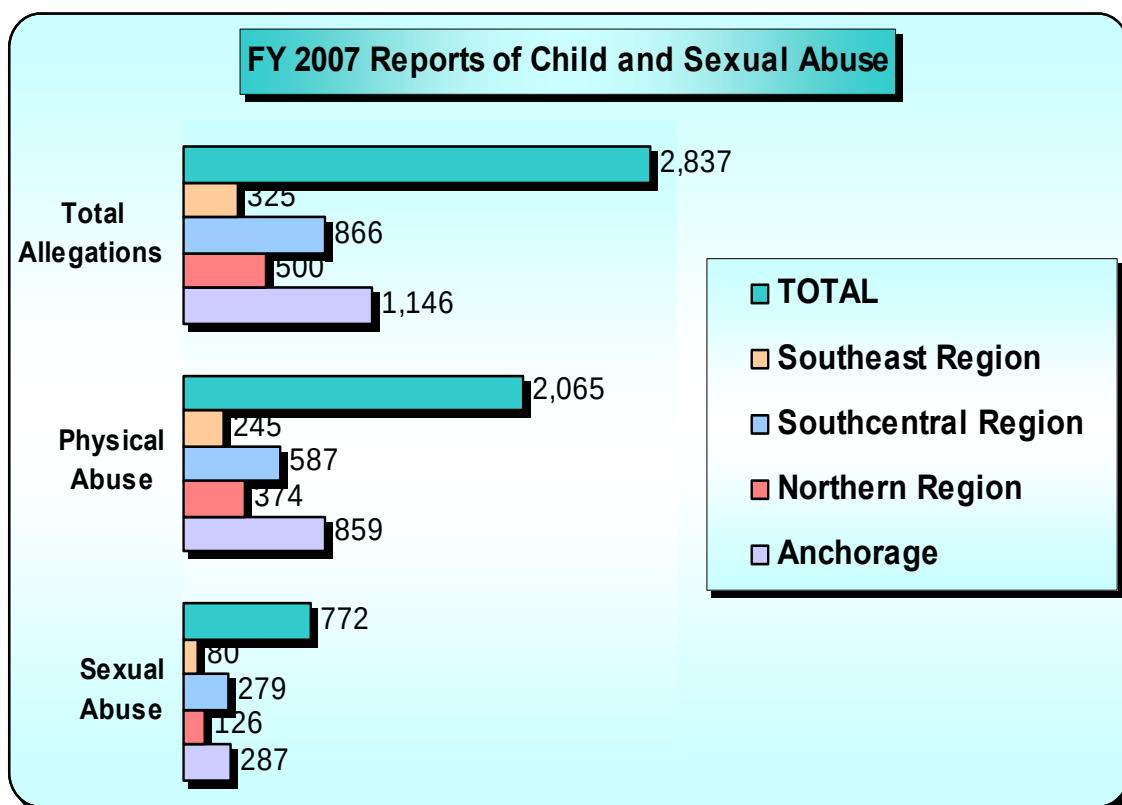
Continued Support for Child Advocacy Centers: \$1,300.0 General Fund

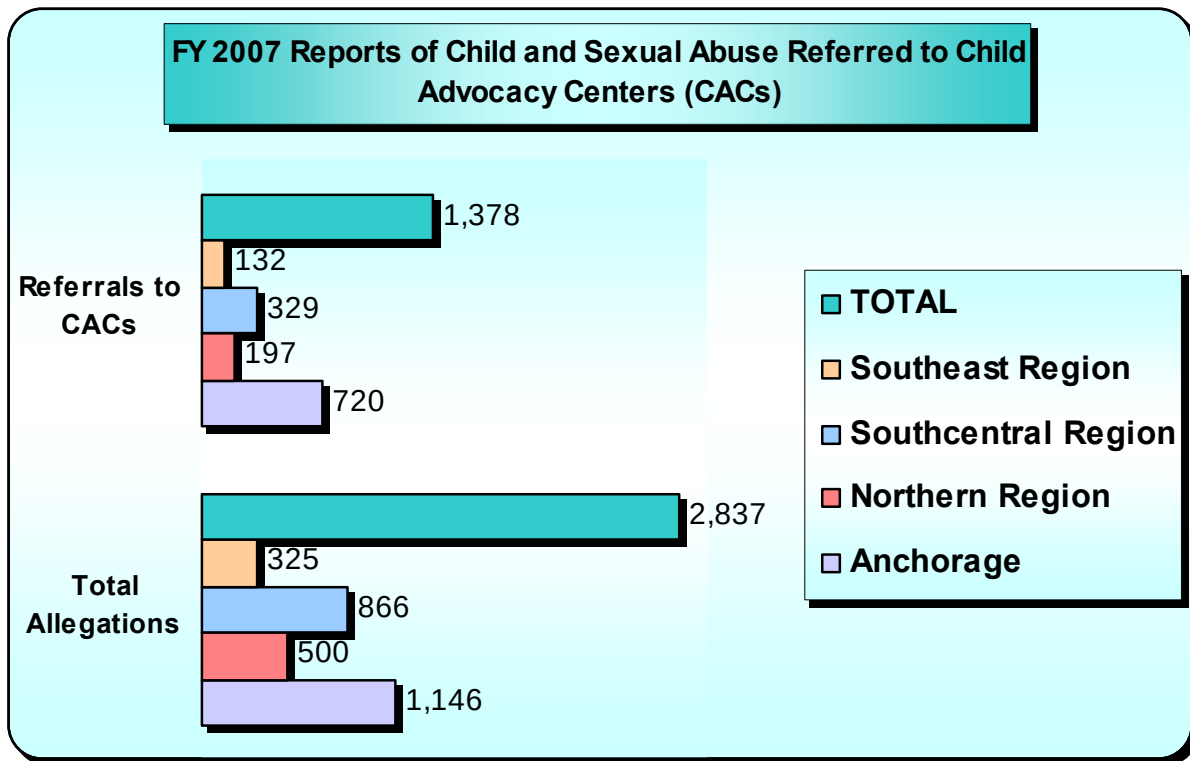
In 2002, OCS received federal funds from the United State Department of Justice to establish and operate Child Advocacy Centers (CAC) in Alaska. Alaska was to receive specific funding for a five-year period.

Child Advocacy Centers provide child sexual abuse and severe physical abuse victims a safe, child-friendly place to be interviewed, receive forensic medical examinations, and mental health services or referrals. CAC interviews are legally sound, neutral, and prevent the need for duplicative interviews that re-traumatize already abused children.

AS 47.17.033 requires that all child sexual abuse interviews be videotaped at a Child Advocacy Center “whenever possible.” OCS believes legislative intent strongly encourages utilization of the Centers, and the permissive language “whenever possible” was indicative of the fact that there were few centers available in 2005 when the law was enacted.

CACs are in place to assure Alaska children are not re-traumatized after experiencing child sexual or severe physical abuse and support OCS’s mission to promote stronger families, safer children. CAC measures indicate they are being utilized and they are successful:





Unfortunately, only enough one-time federal funds remain to allow OCS to continue the second stage of the project — establishing new CACs in Kotzebue and Homer/Kenai while bringing CACs in Galena, Glennallen, and Ketchikan on line as they are ready, leaving no available funds to support existing CACs. OCS is requesting legislative support to maintain the current level of CACs in FY 2009.

MH Trust: BTKH – Foster Parent and Parent Services: recruit, train, support: \$150.0 Total

This is new funding for FY09 at \$75.0 MHTAAR and \$75.0 GF/MH. Project provides resources to recruit and screen potential foster parents, and provide training and technical assistance for parents and foster parents. Therapeutic Foster Homes are recognized in BTKH planning as an economical and effective alternative to costlier types of residential care for youth experiencing serious emotional disturbance (SED).

Foster Care Base Rate

IV-E Federal Fund Participation Fund Change – (\$57.1 Federal), \$57.1 General Funds

This request replaces lost federal revenues resulting from a 1.95% decrease in the annual Federal Medical Assistance Percentage rate. This statutory rate is used for Title IV-E funded programs that reimburse foster parents and providers for services provided to children in state custody. This decreased rate will take effect on October 1, 2008.

The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid and is outside the control of the state government. The amount of federal funds the state receives depends on a complex array of reimbursement rates, some of which change each October 1st with the start of a new federal fiscal year. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50%.

The regular FMAP is projected to drop from 52.48% to 50.53% in FFY09 and the enhanced FMAP from 66.74% to 65.37%.

Increase Receipt Support Services for Child Support Enforcement Collections: \$600.0 RSS

This request assures the OCS can collect all child support enforcements reimbursements collected for child welfare recipients. Under Title VI-D and VI-E of the Social Security Act, states must pursue the collection of child support for children in state custody.

Foster Care Augmented Rate

IV-E Federal Fund Participation Fund Change – (\$7.7 Federal), \$7.7 General Funds

See earlier write-up under Foster Care Base Rate.

Foster Care Special Need

Increase Child Care Benefits for Child Protective Services: \$1,295.1 Interagency Receipts

This request for funding will: (1) allow OCS to provide reimbursement to working foster parents, unlicensed relatives, and biological parents needing child protective services child care at the DPA child care assistance rate; (2) provide additional funds to cover the balance of the child care costs (not covered by the DPA child care assistance rate) when a quality child care program cannot be found for that amount; (3) allow funding to process child care applications in one location for foster parents and unlicensed relatives; and (4) will provide adequate funding for child care utilization by foster parents and relatives.

IV-E Federal Fund Participation Fund Change – (13.7 Federal), \$13.7 General Funds

See earlier write-up under Foster Care Base Rate.

Subsidized Adoptions/Guardianships

Transfer in Permanency Funding from Child Protection Legal Services: \$277.5 General Funds

This funding represents a portion of the cost for legal services related to adoptions. The division proposes to transfer this funding from the Child Protection Legal Services component into Subsidized Adoptions/Guardianships component where other funding for this purpose is budgeted.

Residential Child Care

IV-E Federal Fund Participation Fund Change – (12.2 Federal), \$12.2 General Funds

See earlier write-up under Foster Care Base Rate.

Infant Learning Program

Mental Health Trust Projects:

MH Trust: Behavior Intervention and supports for early childhood system: \$80.0 MHTAAR

MH Trust: BTKH – Early Childhood comprehensive grant system grants: \$75.0 MHTAAR

MH Trust: BTKH – Early childhood mental health learning network and coordinator \$200.0 Total

This project is new project funded with \$100.0 GF/MH and \$100.0 MHTAAR funds. Project provides funding to create a learning network as a short-term approach to developing knowledge and skills in practicing mental health clinicians and advanced early interventionists. Managed by the DHSS/Office of

Children's Services, the project would fund meetings, travel and distance communication to support this learning. It also provides for a state coordinator who would lead this effort. This position would also be responsible for working with complementary systems to ensure that young children with mental health concerns are being identified and directed to developmentally appropriate services. Data strongly supports that infants and toddlers not meeting developmental milestones, who live in high risk families or who are born into otherwise adverse life situations, have a substantially higher probability of developing severe emotional or behavioral disturbances.

Child Protection Legal Services

Transfer out Permanency Funding to Subsidized Adoption for Legal Services to Adoptions: (\$227.5 General Funds)

This transfer realigns funding to Subsidized Adoption/Guardianships component where other similar funding is budgeted. No change in services result from this transfer.

Challenges

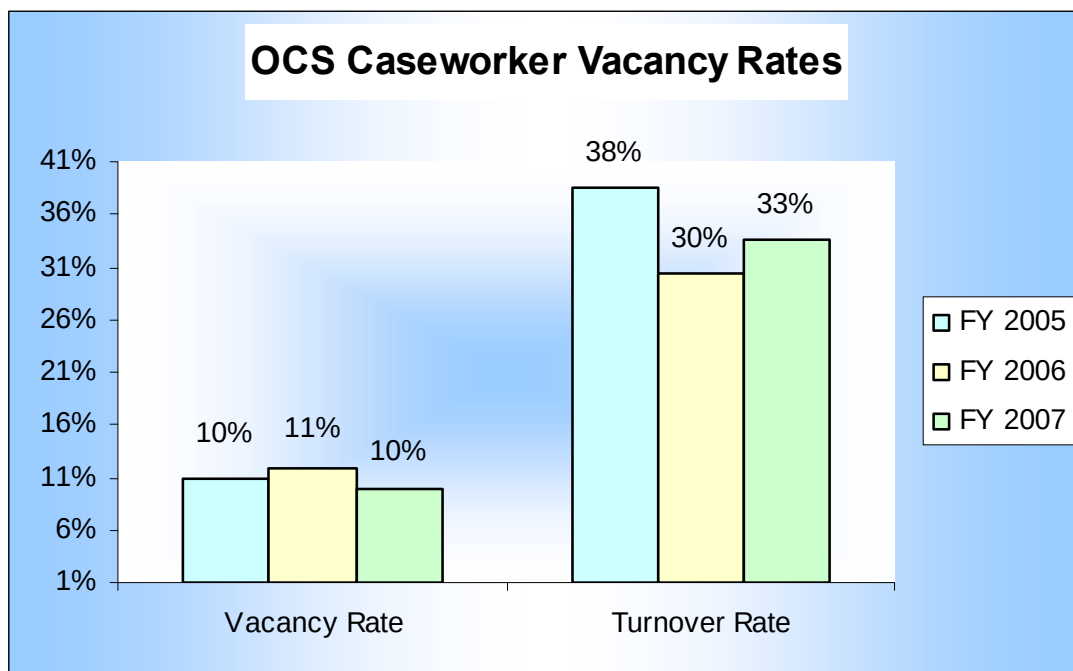
Recruitment and Retention

Child protective services are an emotionally demanding vocation. Across the nation, compassion, fatigue and vicarious trauma lead to high turnover and vacancy rates among caseworkers.

- 50 percent of OCS front-line caseworkers have been employed with the agency for less than two years, and
- 20 percent have less than one year of experience.

The OCS has been experiencing consistently similar vacancy and turnover rates since 2000. It has been an ongoing challenge to maintain full staffing levels, train staff to proficient levels of competency and institutionalize the agency's core mission and standard practice model.

The ending turnover rate for FY07 was 33 percent. The vacancy rate at the end of FY07 was 9.5 percent.



Funds requested in FY 2009, and discussed in the Explanation of FY2008 Budget Changes section previously, will allow OCS to expand new caseworker training by two weeks to offer and provide staff the full spectrum of training recommended by national experts, UAA professionals, Tribal partners, and OCS management and staff.

OCS is working toward solutions to address retention and recruitment issues and has formed a workgroup that includes a representative from the UAA Family and Youth Services Training Academy and is receiving technical assistance from the Annie E. Casey Foundation. Work has begun on establishing a realistic job profile DVD to be provided to each candidate upon application, prior to an interview. The applicant is asked to sign a simple attestation form that 1) they've watched the video, and 2) they still want to be interviewed and considered for the opening. States using this technique are seeing an increase of new employees that truly have the competencies and the heart to do child protective services work, and a decrease of early resignations/dismissals.

The OCS also holds hope for several of the short- and long-term tools for recruitment and retention that were presented in October by Commissioner Karleen K. Jackson to the Executive Branch Working Group assigned to Administrative Order 237.

Other recruitment and retention challenges rotate around the question that initiated the workload study also discussed in the Explanation of FY2008 Budget Changes above: Does the Office of Children's Services have an adequate number of social workers to keep Alaska's children safe, and do some geographical areas have excess staff that could be diverted to geographical areas that need additional staff?

The continuing effort to completely implement the Hornby Zeller Associates Inc. time study remains a challenge. The study found that OCS needed 17 more positions to meet the demands of its workload and recommended regular updates to caseload distribution. Subsequent use of the workload study data set indicates that the data are confounded by a large number of cases that are not being worked and are awaiting closure. OCS is making a concerted effort to close all cases that qualify for closure, and will continue using the workload study data until it is confident that the number of caseworkers needed is as accurate as possible.

OCS has explored the option of relocating positions to Anchorage, an area of high need. A review of existing positions (PCNS) by the regional case managers indicated that the study had misidentified some positions as front-line caseworker positions that were actually supportive positions. Consequently, there is only minimal and transitory excess capacity in any field office and no significant gains would occur by transferring positions to Anchorage.

Foster Care Reimbursement Rates Have Not Been Increased In Nine 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 16 years and that was nine years ago. Rates paid to the people of Alaska willing to bring into their homes children who have had to be removed from their own 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 have 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.

Performance Measures — Office of Children's Services

Contribution of the Department's Mission

Promote stronger families, safer children.

Core Services

- Investigate protective service reports and ensure services to children and their families when necessary.
- Develop permanency plans for children in out-of-home care.
- Facilitate early intervention and treatment 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 and Neglect Per 1,000 Children Under Age 18 in Alaska

Fiscal Year	Rate Per 1,000	National Rate
FY 2006	23.8	11.9
FY 2007	24.1 +1.26%	11.9 0%

FY 2006 measures forward 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 estimated by the Department of Labor and Workforce Development during the year prior to reporting.

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: OCS's 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.

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-percent higher than the national average.

The Office of Children's Services is continuing to implement our new safety decision making practice. The new model has proved to be more of a paradigm shift than was previously anticipated; therefore the implementation of new practice standards is taking longer than originally anticipated. The new model of working with families will lead to improved outcomes for the children and families needing OCS

intervention. New practice standards have revealed that additional specialized training is necessary and is being pursued through the University of Alaska.

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.

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.

Rate of Repeat Maltreatment		
Year	YTD	Target
2005	10.6%	6.1%
2006	10.4%	6.1%
2007	11.4%	6.1%

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

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.

OCS anticipates improvements in the number of repeat maltreatment cases not only due to the improved business practices set out above.

Business practices continue to be upgraded as OCS is receiving technical assistance from the Annie E. Casey Foundation to improve foster care and the approach to foster care. In addition, the OCS is restructuring the administration of foster care and adoptions by moving all of the work to one section and moving the supervision and decision making from the field up through state office to alleviate any conflicts of interest.

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

Year	FFY % Rate	National Rate
2005	1.10%	0
2006	1.16%	.57%
2007	1.55%	.57%

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 percent — United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: Steady increases are believed to be an indicator that there are not enough foster homes. The pool of resources from which to make the best possible match for children needing placement and foster parents best able to meet the needs of a particular child is too small.

OCS continues to work toward improved business practices through the use of technical assistance and increased foster and child care rates to assure foster parents will not need to continue to absorb the cost of care for foster children.

Target #4: Reduce the rate of 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	Turnover Target
FY 2004	6.28%	32%	218	0
FY 2005	10.44%	38%	249	0
FY 2006	11.35%	30%	261	0
FY 2007	9.5%	33%	261	20%

This vacancy and turnover analysis is an update of past analysis and is based on the same methodology used by the Department of Administration, Division of Personnel in compiling its work force analysis. Vacancy and turnover analyses are based on vacancies in the Children's Services Specialist I, II, and III and the Social Worker (CS) I, II, III, and IV job class series. Data are collected from the state of Alaska Payroll System. This analysis compiles complete fiscal year data.

Turnover rate represents the number of times a position becomes vacant in the Front-line Social Worker component due to an incumbent leaving the position. Reasons for leaving include, but are not limited to, resignation, separation, termination, voluntary demotion, promotion, retirement, or non-retention.

Vacancy rate represents the total number of positions vacant divided by the number of positions in the job class series. The analysis compiles data from the fiscal year and records the length of time a position is vacant so that multiple vacancies for any one position are counted.

Analysis of results and challenges: OCS received the final report in May 2006 for a workload study completed by Hornsby Zeller Associates, Inc. One of the recommendations was that OCS not engage in wide-scale changes to personnel that would include transferring positions from overstaffed offices to understaffed offices until such time as data regarding caseload and workload trends could be established. However, the contractor did conclude that in order to meet the workload of the state, OCS needed an additional 17 positions to handle the state's entire caseload as mandated by state and federal policy guidelines. The OCS received authorization for six new positions in FY 2008:

- 2 Community Care Licensing Specialists
- 3 Children's Services Specialists
- 1 Social Worker

No administrative staff has been added, which has caused a burden to front-line staff having to pick up administrative tasks.

Work on a comprehensive plan to address retention, recruitment and selection of front-line staff continues. OCS has not yet realized the kind of success needed from retention and recruitment efforts. A number of efforts are currently underway and the plan is constantly evaluated and revised as new ideas and efforts are explored.

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 work force.

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
2007	352	800

2007 data represents ONLY the first three quarters of FY 2007, which already exceed prior year screening numbers.

Analysis of results and challenges: The Early Intervention/Infant Learning program (EI/ILP) goal is to have every child under the age of 3 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, the U.S. Congress passed the Strengthening Families Bill requiring all children birth through 3 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 conduct 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-percent 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 percent of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15 percent. 182 children (10 percent) had social and emotional delays greater than 50 percent. Current 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-percent 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.

In 2007 EI/ILP continues to identify an increase in children demonstrating delays in social and emotional development and continues to promote resource development in the area of identification and

appropriate treatment training for staff to address the issue. EI/ILP currently has a cohort of six providers receiving training in the treatment of social and emotional delays.

A total of 2,552 children were referred from all sources in FY 2007. Of the total, 525 children were referred specifically from Child Protective Services — 21 percent of all referrals, whereas in 2004 there were 155 children referred to infant learning from child protective services. This represents a significant increase of close to 240 percent in referrals over a three-year period with 2007 representing only three-quarters of data.

Of 90 referrals in Fairbanks in FY 2007, 10 children were enrolled in the program. This was an increase of 2 percent enrolled, over FY 2006 that showed 71 referrals and seven enrollments. In Mat-Su six children were enrolled out of 30 referred in FY 2007, compared to 11 referrals and no enrollments in the program in FY 2006. Anchorage referred 178 children and enrolled 26 of those children in FY 2007. In FY 2006, Anchorage referred 128 children and enrolled 23 in the program.

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

Target #1: Increase the percentage of child protection services referrals 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	Total Referrals	CPS Referrals	Percent	Target
FY 2003	1879	169	8.9%	
FY 2004	2134	248	11.6%	
FY 2005	2201	280	12.7%	
FY 2006	2357	363	15.4%	
FY 2007	2552	525	20.6%	5% increase

Data Source: OCS Early Intervention/Infant Learning Unit

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) goal is to continue to increase the percentage of referrals of children who come to the attention of Child Protection Services (CPS).

As shown above, the program has made steady progress for the past five years, but still has work to do. Not only does the number of referrals and screenings need to go up, but the availability of services required as a result 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. Provider training is currently ongoing.

The significant increase in the number of CPS referrals is a good indicator of increased understanding and communication.

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		
Year	Alaska Rate	National Standard
2001	62.4%	76.2%
2002	53.3%	76.2%
2003	54.7%	76.2%
2004	54.7%	76.2%
2005	53.3%****	76.2%
2006	61.5%	76.2%
2007	50.7%	76.2%

This measure is based on children returned to parents or caretakers in less than 12 months from the time of the latest removal and is calculated annually.

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 12 months from the time of the latest removal, known as the rate of reunification. While 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 12-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.

Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorneys General, 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, then the threshold for their return ought to be the same. Ongoing case plans can

be monitored more easily with children in their homes, with the family reunified, than by requiring that the family achieve success by reducing all the risk factors as well.

This model provides 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 grantees also provide 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 are being captured from quarterly narrative reports and results should be available in January 2008.

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

Year	Children Adopted	Annual Change
2001	278	75
2001	222	-56
2003	201	-21
2004	179	-22
2005	191	12
2006	197	6
2007	221	24

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

These data are provided through the federal Administration for Children and Families (ACF).

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 OCS custody. As of June 30, 2006, there were 1,989 children (approximately 87 percent federally funded and 13 percent state funded) in the subsidized adoption program. Each year 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 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 — 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%
2007	to come	to come	to come

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

FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

Analysis of results and challenges: OCS participates in a state, regional, and national adoption exchange to assist with the identification of potential adoptive families for children in 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 OCS for information on becoming a licensed resource family with the OCS. Of these 102 families, 63 families (60 percent 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 percent of the total number of initial inquiries during the next fiscal year.

B2: Strategy — Promote the adoption of older youth ages 12–8.

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

Year	# Adopted	Change
2005	36	0
2006	36	0
2007	35	0

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

ORCA data are provided to the federal Administration for Children and Families (ACF) biannually. The data are processed by the ACF and results are returned to the state.

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. There was only one fewer child between the ages of 12 and 18 that was adopted in FY 2007.

In FY 2007 nearly 14 percent of the total new adoptions were of children age 12–18.

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Health Care Services

Mission

To provide health coverage to Alaskans in need.

Introduction

The Division of Health Care Services (HCS) manages the Medicaid core services: hospitals; physician services; pharmacy; dental services; transportation; 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

- Provide access to appropriate health care services
- Assure access to a full range of health care services information to our customers

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

Services Provided

Policy Units

The three Medicaid policy units share a common purpose to monitor for the appropriate provision of and reimbursement for Medical Assistance services. These units assure compliance with federal Medicaid regulations and related federal and state program policies, and may identify the need for and initiate changes to the state's implementation of the Medicaid program. These groups set policy pertaining to Medicaid coverage of services and rates of payment to service providers.

While the purpose of the policy units is the same, the focus of each is unique:

Pharmacy and Ancillary Services Unit

This unit provides research and analysis, planning, and policy and regulations development for the following Medicaid Provider service programs: Pharmacy, Private Duty Nursing, Hearing and Audiology, Home Infusion Therapy, and Respiratory Therapy. The group also provides similar support for the Chronic and Acute Medical Assistance (CAMA) program.

Facility Relations Unit (FRU)

The FRU performs program management for Medical Assistance services performed at institutional facilities such as hospitals and ambulatory surgical centers, and for services performed by end-stage renal disease dialysis centers, federally qualified health centers, and rural health clinics. 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 organization 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 maintains connection with various professional organizations and seeks their professional input into policies and programs. The PRU assists in answering difficult clinical questions from medical providers, service recipients, and the program's fiscal agent.

Recipient Services Unit (RSU)

This unit bears some similarity to the functioning of the policy units, but does not set policy for service coverage or payment rates. It monitors the functioning of the Medicaid management Information System (MMIS) to be sure that it is paying service providers in the intended manner. The unit assists Medicaid recipients and health-care providers (acting on behalf of recipients) in appropriately accessing benefits and resolving complaints and 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 Hearings, and monitors the fiscal agent's performance. When necessary, the RSU intercedes into recipient and provider disputes regarding eligibility and claims processing.

Program Integrity (PI) Unit

The PI Unit acts upon federal and state Medicaid program audit requirements, analyzing claims and making determinations about the appropriateness of service provided. Program integrity processes and activities are designed to provide for methods and procedures to safeguard against unnecessary utilization of care and services 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 Finance and Accountability, Program Integrity, which in turn may be referred to the Medicaid Fraud Control Unit or Occupational Licensing. The unit assures that complaints are received and investigated. Complaints may involve either recipient conduct or a provider's 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 has two sub-sections, an Accounting unit and a Third Party Liability and Recovery (TPL) unit. The Accounting and Recovery section provides financial services to support Health Care Services as well as the other Medicaid divisions.

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. Accounting functions are provided for the divisions of Health Care Services, Senior and Disabilities Services, and Behavioral Health. The unit also provides financial oversight for the State Pharmaceutical Assistance Program (SPAP).

The primary responsibilities of the TPL sub-unit include pending claims related to TPL, collection of third-party payments, Pay and Chase claims, administration of the Medicare buy-in and Drug Rebate programs, and the oversight of the post-payment review and cost-avoidance contractor. The TPL unit also administers the disabled working program and the estate recovery program, and works with the Department of Law on Subrogation cases. TPL cost recovery activities cover all Medicaid services.

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. 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.

Systems Unit

This unit bears technical responsibility for the MMIS. Its purpose is to translate Medicaid program business needs into MMIS processing requirements, while operating within the strict confines of all related federal guidelines.

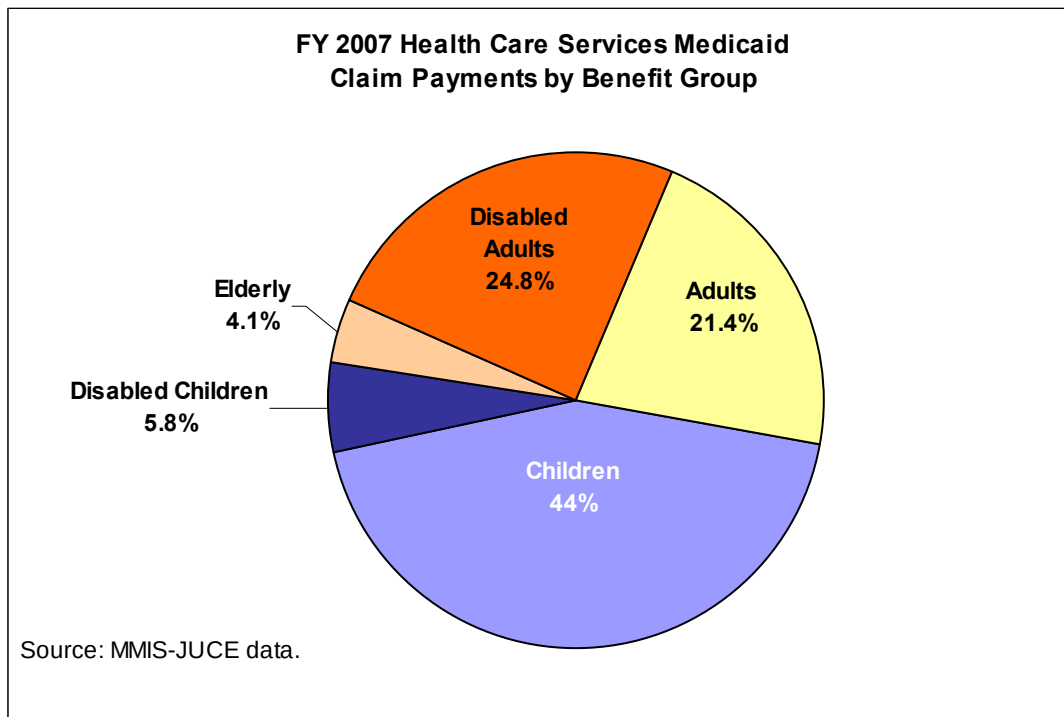
Annual Statistical Summary of Services Provided in FY2007

Health Care Medicaid Services

In FY07 Health Care Services Medicaid provided services to 120,900 Alaskans, about 94 percent of all individuals enrolled in the Alaska Medicaid program. The cost of benefits provided to Medicaid enrollees through Health Care Services totaled \$507 million, or about \$4,200 per person (beneficiary) per year. Forty-four percent of the cost of claims in 2007 was for services provided to children, 30 percent was for services provided to disabled individuals, and about 25 percent was for services provided to adults and elderly individuals.

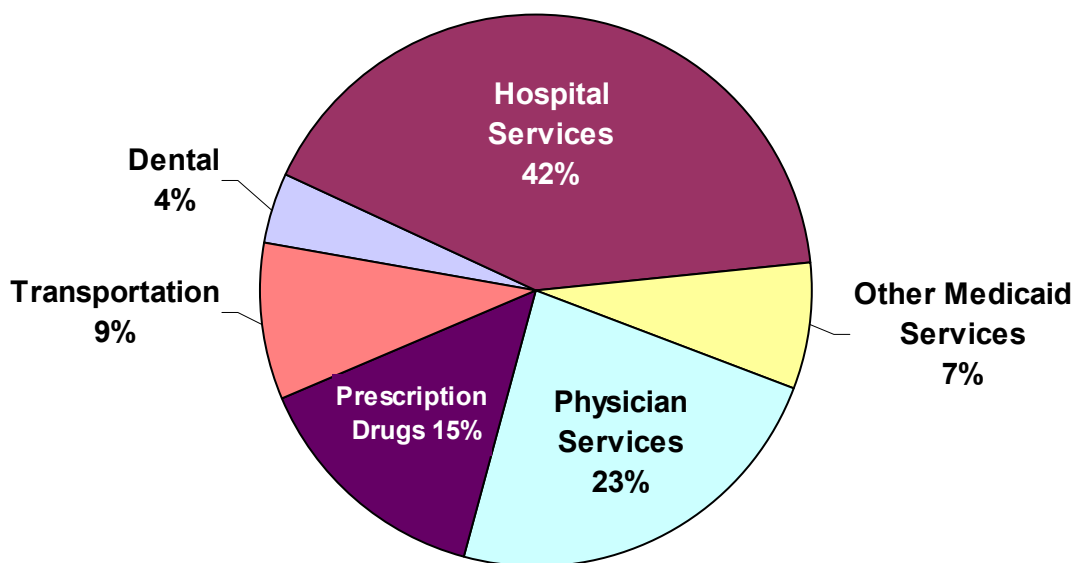
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children	62.3%	76,725	44.0%	\$222,971.1	\$2,906
Disabled Children	1.6%	1,995	5.8%	\$29,178.0	\$14,626
Elderly	5.8%	7,157	4.1%	\$20,774.5	\$2,903
Disabled Adults	11.7%	14,464	24.8%	\$125,372.8	\$8,668
Adults	18.6%	22,891	21.4%	\$108,201.5	\$4,727
Unduplicated Annual Clients		120,879			
Total Medicaid Claim Payments (thousands)				\$506,497.9	
Average Annual Medicaid Cost per Beneficiary					\$4,190

Source: MMIS/JUCE claims paid during FY07. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.



In FY07, 98 percent of all Medicaid beneficiaries used at least one service funded through the Health Care Services Medicaid budget component. Health Care Services Medicaid funded 52 percent of the cost of all Alaska Medicaid claims processed in FY07. Physician services, hospital services (combined inpatient and outpatient hospitals, including outpatient surgery centers), transportation services, and prescription drugs continue to be the categories of HCS Medicaid services that are the most expensive, per person and in total claim costs.

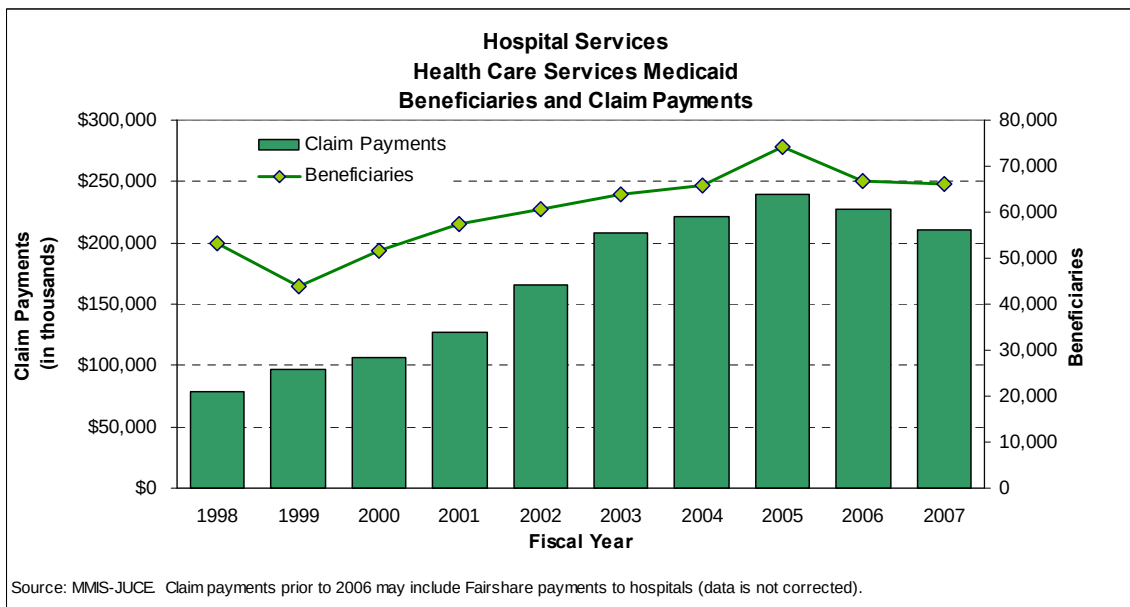
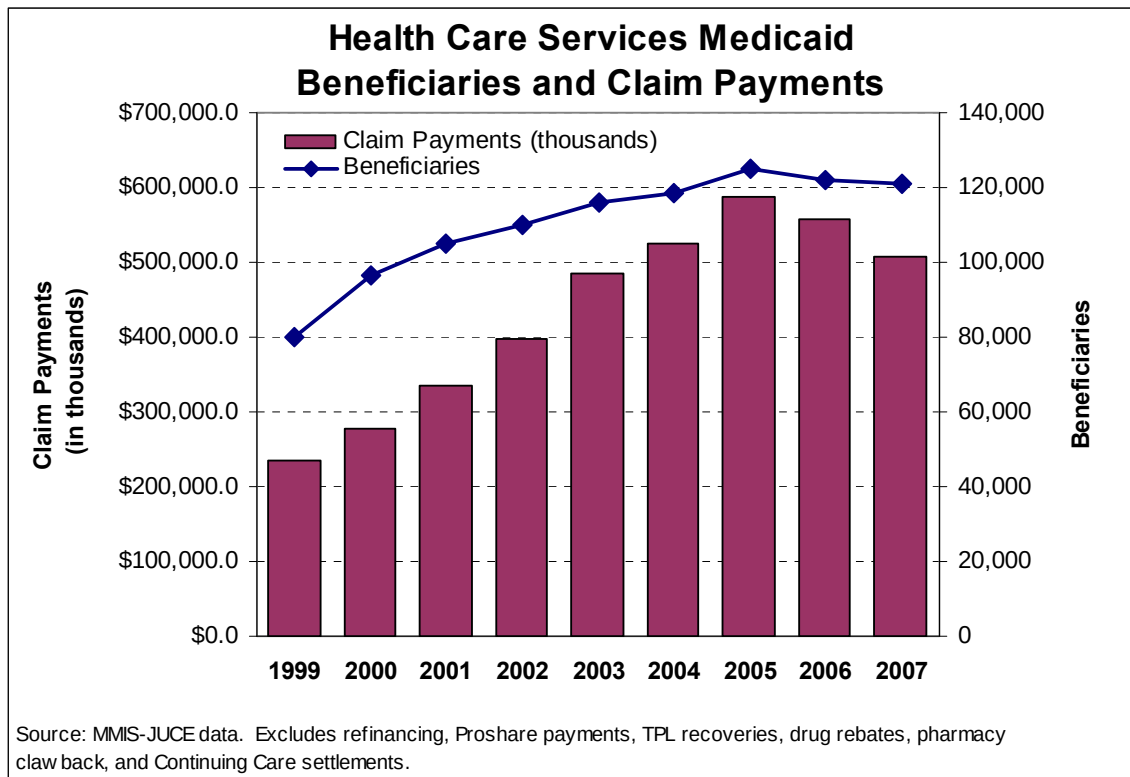
Health Care Services Medicaid FY 2007 Claim Payments by Service Category

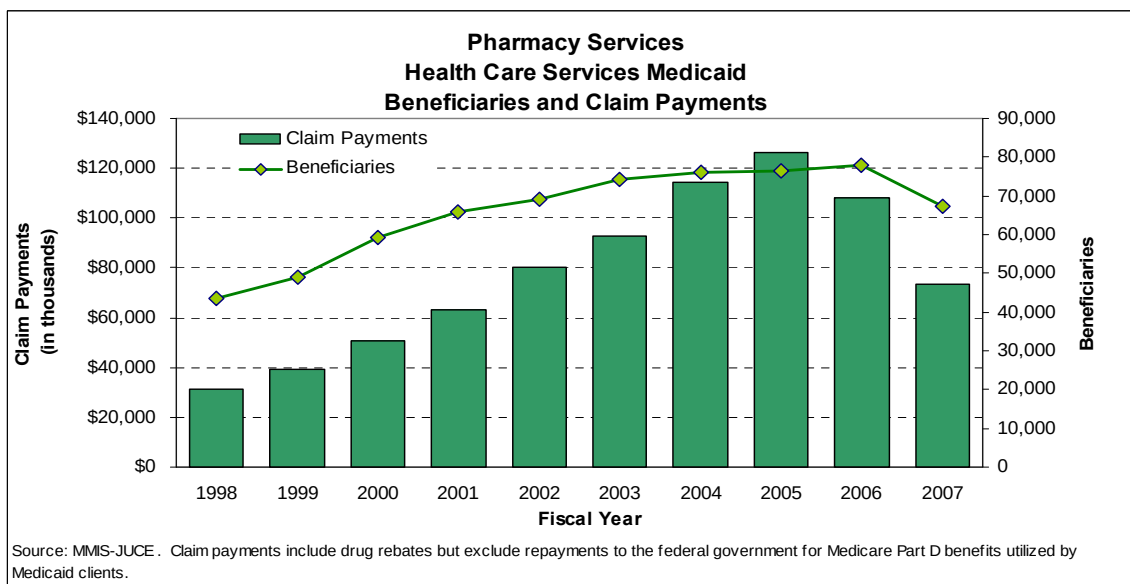
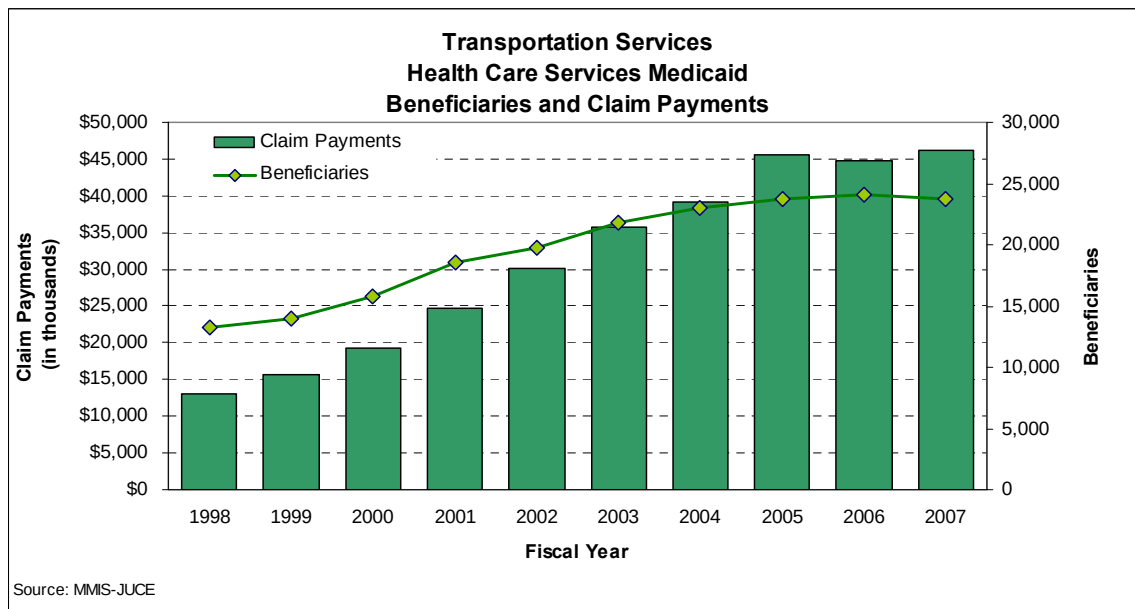
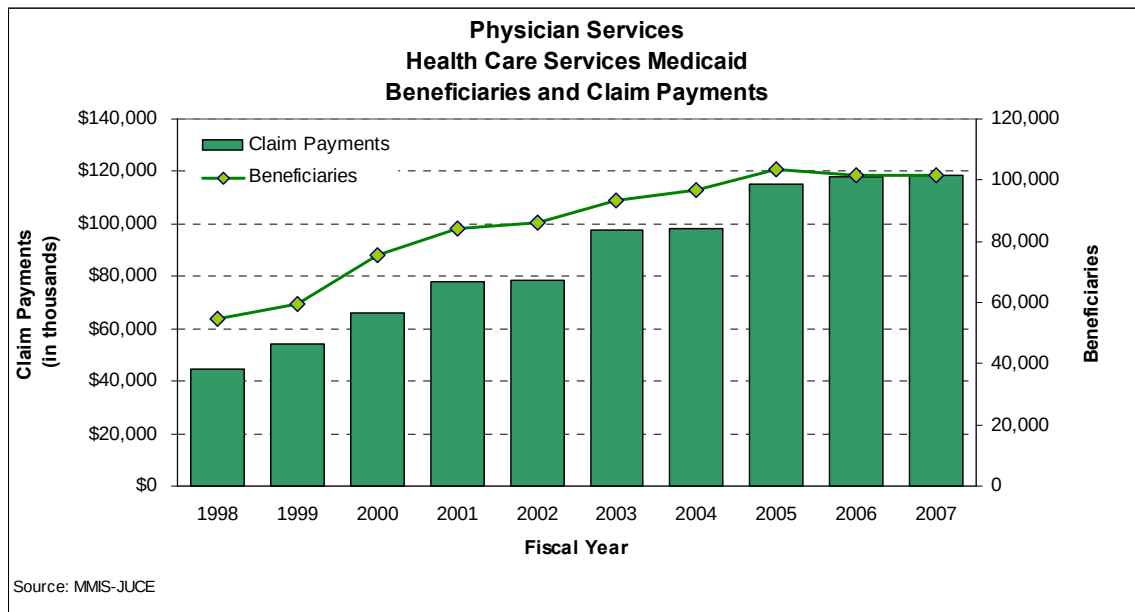


Source: MMIS-JUCE. Claim payment costs exclude refinancing, Proshare payments, TPL recoveries, Medicare premium payments for dual eligibles, Continuing Care settlements, and other payments and adjustments made outside the MMIS. Claim costs categories and amounts may not exactly match AKSAS. Prescription drug claim costs include drug rebates but exclude repayments to the federal government for savings due to Medicare Part D for Medicaid clients (claw back).

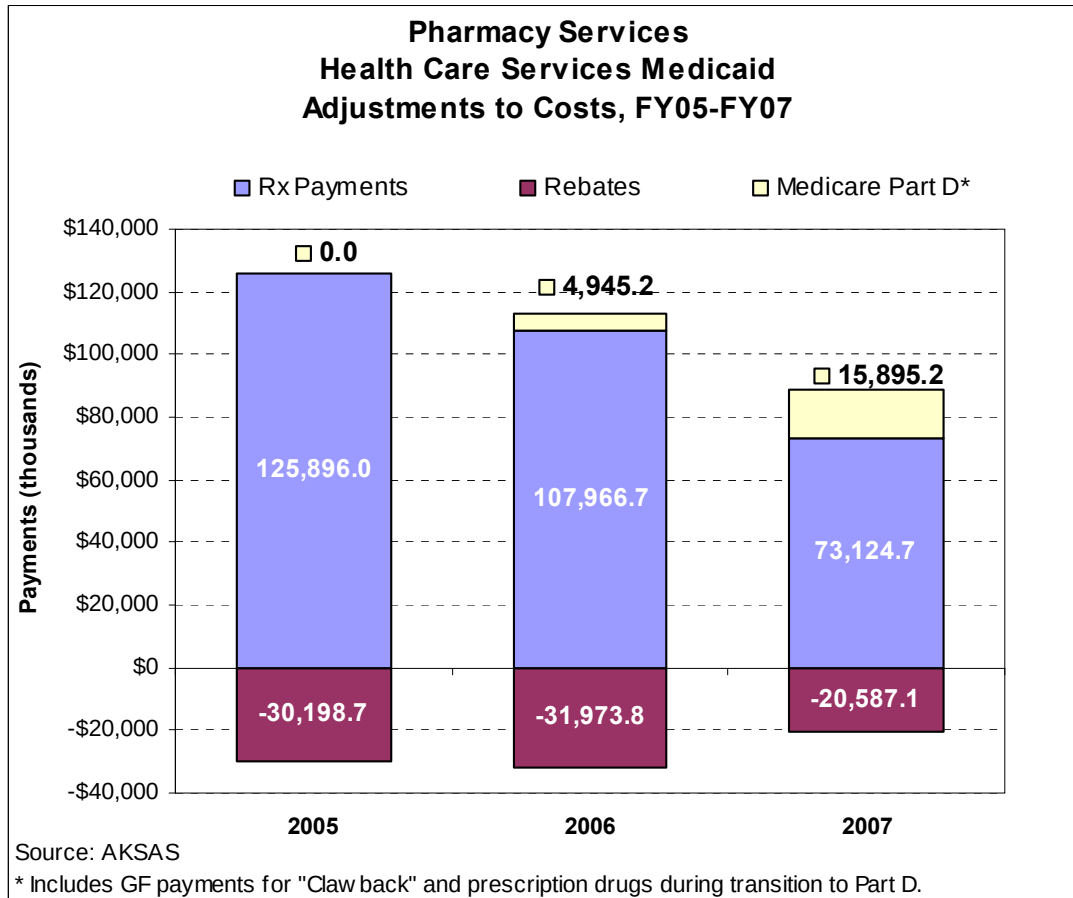
Top 4 Service Categories in Health Care Services Medicaid	Cost per Beneficiary	Number of Beneficiaries
Hospital Services	\$3,200	66,000
Physician Services	\$1,150	101,700
Prescription Drugs	\$1,100	67,400
Transportation	\$1,950	23,800
Source: MMIS/JUCE. Unduplicated annual number of beneficiaries.		

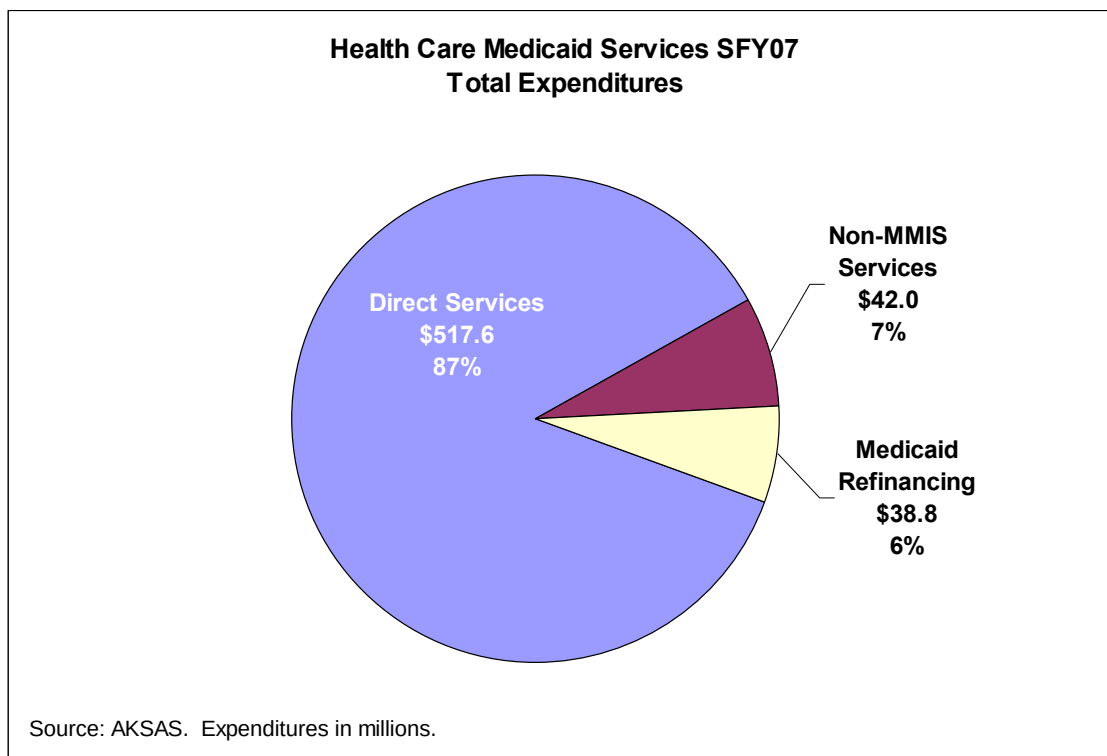
The number of beneficiaries utilizing Health Care Services Medicaid benefits in FY07 decreased by nearly 1 percent between FY06 and FY07, while the total cost of claim payments decreased by about 9 percent, and the annual cost per person decreased by about 8 percent. Much of the decrease in costs may be due to saving in prescription drug services. Pharmacy claim payments decreased by 32 percent between FY06 and FY07 and the number of individuals with prescription drug claims paid by Medicaid decreased by more than 13 percent. The cost of claims for hospital services between FY06 and FY07 decreased by nearly 8 percent though the number of individuals using hospital services changed little. The number of individuals using physician services and costs of claims for physician services changed little between FY06 and FY07. Transportation claim costs increased by about 3 percent though the number of individuals using transportation services decreased slightly (less than 1 percent).





The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a new Medicare Part D prescription drug benefit available to all Medicare recipients, effective January 1, 2006. Now Medicaid recipients who also qualify for Medicare (called dual eligibles) receive prescription drug coverage through Medicare instead of Medicaid. This has had a profound impact on Medicaid pharmacy services. The state forecasted last year that pharmacy-direct costs in FY07 (adjusted by the cost of Part D premiums paid by the state for dual eligibles and by drug rebates paid to the state) would be about \$70 million. The actual net cost in FY07 was \$68,432.7. The unadjusted cost of prescription drugs claims to the Medicaid program declined about 32 percent between FY06 and FY07.





Health Care Services Medicaid funds more than just medical services provided directly to Medicaid enrollees. Funds are also used for payments for services not compensated through claim payments and for refinancing programs that leverage federal funds. The total Medicaid expenditure for the Health Care Services Medicaid budget component in FY07 was \$598.4 million, a decrease of about 6 percent between FY06 and FY07.

Direct services comprised 87 percent of Medicaid expenditures in FY07. In addition to the cost of claims for services provided directly to beneficiaries, direct services include third-party liability (TPL) recoveries, drug rebates and pharmacy clawback, Part D premiums for dual eligibles, and Continuing Care settlements. Refinancing (Proshare payments) comprised 6 percent of total expenditures and non-MMIS services (including Disproportionate Share Hospital payments, and Part A and Part B premium assistance for Medicare dual eligibles) comprised about 7 percent of total expenditures.

SFY 2007 DIVISION LEVEL SUMMARY:Health Care Services Medicaid	DHCS MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR (CPRPY)	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent Recipients	Percent Payments
Medicaid, Division Annual Totals		120,879		\$506,497,889	\$4,190	98.3%	51.7%
Gender							
Female	57.1%	69,096	54.5%	\$302,258,246	\$4,374	99.4%	57.5%
Male	42.9%	51,842	36.8%	\$204,239,869	\$3,940	99.0%	50.0%
Unknown	0	2	0.0%	-\$226	-	-	-
Race							
Alaska Native	38.4%	46,726	40.6%	\$225,444,409	\$4,825	99.5%	63.7%
American Indian	1.5%	1,885	1.3%	\$7,044,938	\$3,737	99.7%	56.9%
Asian	5.3%	6,505	3.5%	\$19,332,002	\$2,972	99.5%	44.4%
Pacific Islander	2.7%	3,264	2.2%	\$12,431,703	\$3,809	99.4%	60.7%
Black	5.2%	6,348	3.8%	\$20,937,881	\$3,298	99.1%	52.8%
Hispanic	3.5%	4,246	2.2%	\$12,141,903	\$2,860	99.5%	59.6%
White	40.4%	49,217	35.5%	\$197,150,738	\$4,006	98.9%	47.2%
Unknown	2.9%	3,589	2.2%	\$12,014,316	\$3,348	98.2%	45.5%
Native	40.1%	48,574	41.9%	\$232,489,348	\$4,786	99.5%	63.5%
Non-Native	59.9%	72,638	49.4%	\$274,008,542	\$3,772	99.0%	48.2%
Age							
under 1	9.2%	12,129	13.4%	\$74,524,309	\$6,144	99.9%	99.8%
1 through 12	36.2%	47,795	18.1%	\$100,265,394	\$2,098	99.4%	69.7%
13 through 18	17.0%	22,417	11.7%	\$64,786,888	\$2,890	98.5%	39.6%
19 through 20	3.4%	4,430	3.2%	\$17,983,378	\$4,059	98.7%	71.3%
21 through 30	10.4%	13,677	11.6%	\$64,135,149	\$4,689	99.4%	65.7%
31 through 54	14.1%	18,630	22.0%	\$121,805,881	\$6,538	99.2%	60.3%
55 through 64	3.5%	4,638	7.0%	\$39,019,610	\$8,413	99.1%	52.0%
65 through 84	5.3%	7,050	3.9%	\$21,831,003	\$3,097	96.6%	19.1%
85 or older	0.9%	1,166	0.4%	\$2,146,278	\$1,841	91.8%	5.7%
Benefit Group							
Children	62.3%	76,725	40.2%	\$222,971,146	\$2,906	99.4%	66.0%
Adults	18.6%	22,891	19.5%	\$108,201,458	\$4,727	99.7%	97.4%
Disabled Children	1.6%	1,995	5.3%	\$29,177,976	\$14,626	95.3%	53.1%
Disabled Adults	11.7%	14,464	22.6%	\$125,372,787	\$8,668	98.8%	43.2%
Elderly	5.8%	7,157	3.7%	\$20,774,523	\$2,903	95.9%	14.8%

Payment amounts are net of all claims paid during the fiscal year. Amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments. Payment amounts may not tie exactly to amounts in AKSAS or ABS.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2007. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the division and group level (gender, race, age, and benefit group). Some duplications may occur in subgroup counts.

Because department-wide recipient counts are unduplicated across divisions, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all divisions will exceed 100%.

Source: MMIS/JUCE.

Adult Preventative Dental Services

The Adult Preventative Medicaid Dental program was established by passage of House Bill 105 in FY06 and services were implemented in April 2007. HB 105 established a three-year trial period to evaluate the new program. The Adult Preventative Medicaid Dental program will be up for reauthorization in SFY 2009 and, if not reauthorized, will end June 30, 2009.

Enhanced dental services must be preauthorized. An annual cap per person currently limits the cost of preventative dental services that any individual can receive during the year (\$1,150 in FY08). HB 105 also contained a provision that limits total program costs to fiscal limits set by the Legislature, ensuring that total program spending remains within the budgeted amount. The FY08 authorization for preventative dental services would support about 8,950 clients if all fully utilized their annual benefits limit in FY08. The department will review FY08 preventative dental costs before the start of FY09 and adjust the annual limit per person for FY09 in order to meet that requirement.

In the long term, the department anticipates reducing the need for emergency dental treatment as some adults get preventative and restorative work completed and their dental health improves. In the short term, Medicaid transportation costs may increase slightly if clients in rural areas cannot obtain preventative and restorative dental services locally. Both emergency dental and transportation services are funded through a separate Medicaid budget component (Health Care Services Medicaid). Program staff will be monitoring both emergency dental and transportation services costs to assess the impact of the new Adult Preventative Dental program on overall Medicaid expenditures.

List of Primary Programs and Statutory Responsibilities

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

7 AAC 100	Medicaid Assistance Eligibility

Explanation of FY2009 Budget Changes

Health Care Services	2008	2009 Gov	08 to 09 Change
General Funds	233,293.1	262,946.4	29,653.3
Federal Funds	473,732.9	468,738.9	-4,994.0
Other Funds	23,318.2	24,418.2	1,100.0
Total	730,344.2	756,403.5	25,759.3

**Totals include Adult Preventative Dental Medicaid Services RDU. Fund source breakdown for FY2008 is \$1,543.17 GF/\$7,323.9 Fed/\$1,425.0 Other; and for FY2009 \$3,518.7 GFM/\$5,348.3 Fed/\$1,400.0 Other.*

Health Care Services Medicaid

FY09 Medicaid SCHIP Allotment Shortfall: \$2,000.0 Total \$1,000.0 Federal, \$1,000.0 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.

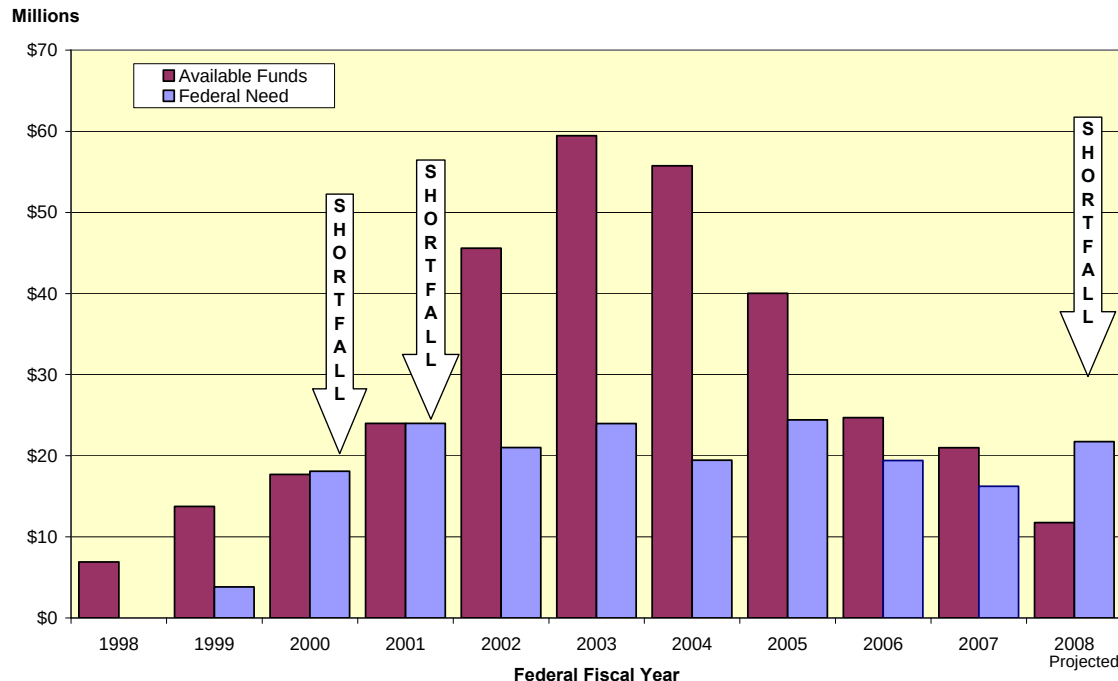
SCHIP helps reach uninsured children whose families earn too much to qualify for regular Medicaid but not enough to afford private coverage. Each month, SCHIP provides health coverage for about 9,000 uninsured children under age 19. Without this funding, low-income children now enrolled in Denali KidCare 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 43 percent of the federal SCHIP funding needed to cover program expenditures in 2009, 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 \$1,000.0 GF in 2009.

Alaska's annual allotment has fluctuated between \$7 million and \$11 million. Since Alaska's annual allotment represents only about 30 percent 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.



Denali KidCare M-SCHIP Federal Funds Available and Federal Need



FY09 Projected Medicaid Formula Growth: \$41.381.6 \$25,587.7 Federal, \$14,793.9 GF/Match

For FY09, Health Care Services' Medicaid costs are projected to grow 6 percent over the FY08 authorized amount of \$689,694.3. 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.

In FY07 Health Care Services contracted approximately 6 percent from the previous fiscal year. Growth in FY08 is expected to be 9-percent higher than FY07. The requested FY09 growth increment, 6 percent, is based on the FY08 projection and the FY09 baseline forecast from the short term forecasting model.

Most of the increase can be attributed to hospital services which are expected to grow at approximately 11 percent between FY07 and FY08 and 6 percent between FY08 and FY09. Hospital and physician services were both affected by rate rebasing in FY08. Transportation and Pharmacy also contributed to the overall growth with growth rates between 6 percent and 7 percent.

The fund source projection is based on the actual amount of federal revenue collected in SFY07 in this component, 68.2 percent, and assumes that the proportion of expenditures eligible for each type of federal reimbursement remains the same. It also assumes that the SFY09 average federal medical assistance percentage remains at 53.76 percent for regular Medicaid and 67.63 percent for enhanced FMAP.

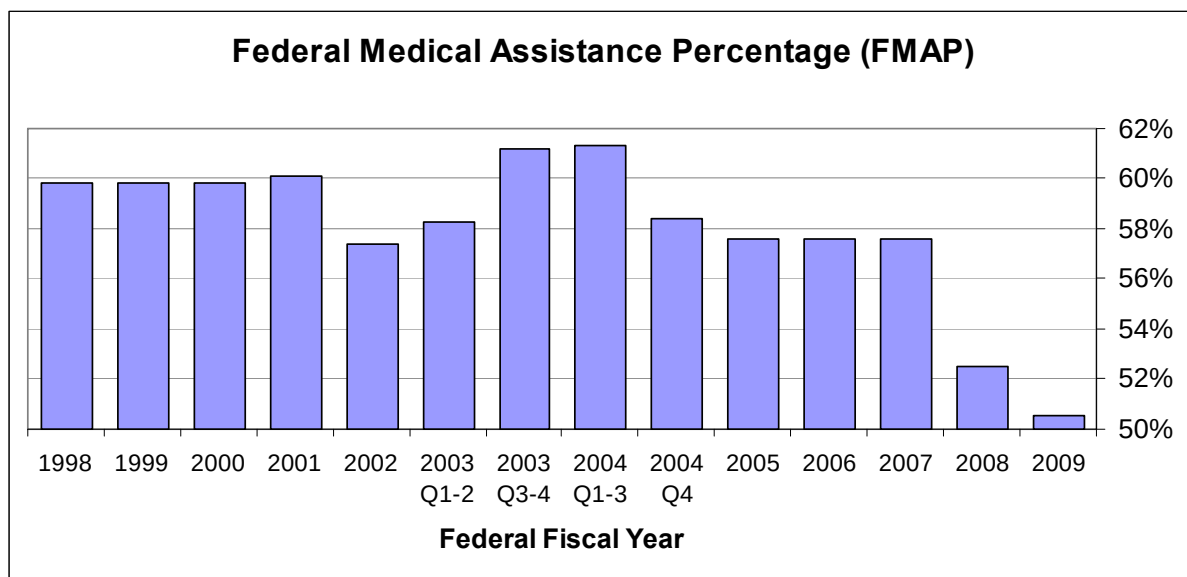
FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: (\$14,308.5 Federal), \$14,308.5 GF/Match

This request replaces lost federal revenues resulting from a 1.95-percent decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008.

The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid and is outside the control of the state government. One in five Alaskans is enrolled in Medicaid at some time each year. Without the increment the state would be forced to reduce eligibility or services currently provided to low income children, pregnant women, individuals with disabilities, and the elderly. By approving this change record, the department will be able to continue to meet its mission of managing health care for Alaskans in need.

The amount of federal funds the state receives for its Medicaid program depends on a complex array of reimbursement rates, some of which change each October 1st with the start of a new federal fiscal year. The bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the federal medical assistance percentage or FMAP. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50 percent. Also affected are the State Children's Health Insurance Program (SCHIP) and the Breast and Cervical Cancer program (BCC) which are part of Alaska's Medicaid program. Eligible claims for SCHIP and BCC are reimbursed at an enhanced FMAP rate which reduces the state share of costs by 30 percent over the regular FMAP.

The regular FMAP is projected to drop from 52.48 percent to 50.53 percent in FFY09 and the enhanced FMAP from 66.74 percent to 65.37 percent. The regular FMAP for SFY09 will average 51.02 percent across two federal fiscal years (52.48 percent from July–September 2008 and 50.53 percent from October 2008–June 2009). The enhanced FMAP for SFY09 will average 65.71 percent (66.74 percent from July–September 2008 and 65.37 percent from October 2008–June 2009).



Approximately 67 percent of the Medicaid Services component's claims are reimbursed at the regular FMAP and another 6 percent at the enhanced FMAP (the remaining 27 percent is Indian Health Service, family planning, or non-reimbursable and is not affected by the change in FMAP). Based on current estimated expenditures for Medicaid, the FFY09 change in FMAP will require an estimated \$14,308.5 increase in GF to replace the lost federal funds and maintain services at the current level.

Discontinue Private ProShare Refinancing: (\$16,013.9 Federal)

This change record reduces the federal authorization no longer needed because the Private ProShare Medicaid program has been discontinued by the federal Medicaid agency.

The department has made payments to hospitals and community health care providers for several years under this program, and ProShare was 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. Without ProShare the same services would have to be funded through grant programs that are totally GF.

ProShare came about in SFY 2004 when the Division of Medical Assistance (now Health Care Services) proposed an innovative move to optimize use of Medicaid funding through the Private Hospital Proportionate Share Program. ProShare made payments for certain medical assistance services to qualified private hospitals. The hospital in turn grants funds to qualified community service providers to secure services in rural, remote areas. ProShare funds also were used to refinance medical care for children in juvenile justice facilities. Health Care Services paid the hospitals the ProShare payments and the divisions provided Health Care Services with the matching GF through reimbursable services agreements. The general funds saved through refinancing these grants/services were removed from the divisions' budgets and replaced with federal funds in Health Care Services' budget. The Legislature supported this cost containment effort and about \$16 million in general funds was replaced with federal funds in that first year. Since 2004, the state has saved approximately \$36 million in GF through ProShare refinancing.

In 2006 the Centers for Medicare and Medicaid Services (CMS) decided that Alaska's ProShare program was not allowed and denied reimbursement for these payments. The department appealed this decision, and with the agreement of the Legislature, decided to continue the program until the case was resolved. CMS again disallowed the ProShare claim for 2007. On July 31, 2007, the department learned that it had lost the appeal when the U.S. Department of Health and Human Services Department Appeals Board upheld the disallowed claim.

The department is committed to continue funding these services at the same level in support of its mission to manage health care for Alaskans in need. While the federal authority is no longer needed in Health Care Services, in order to maintain current service levels, the department is requesting additional GF in the divisions with refinanced grants/services to replace this lost federal money.

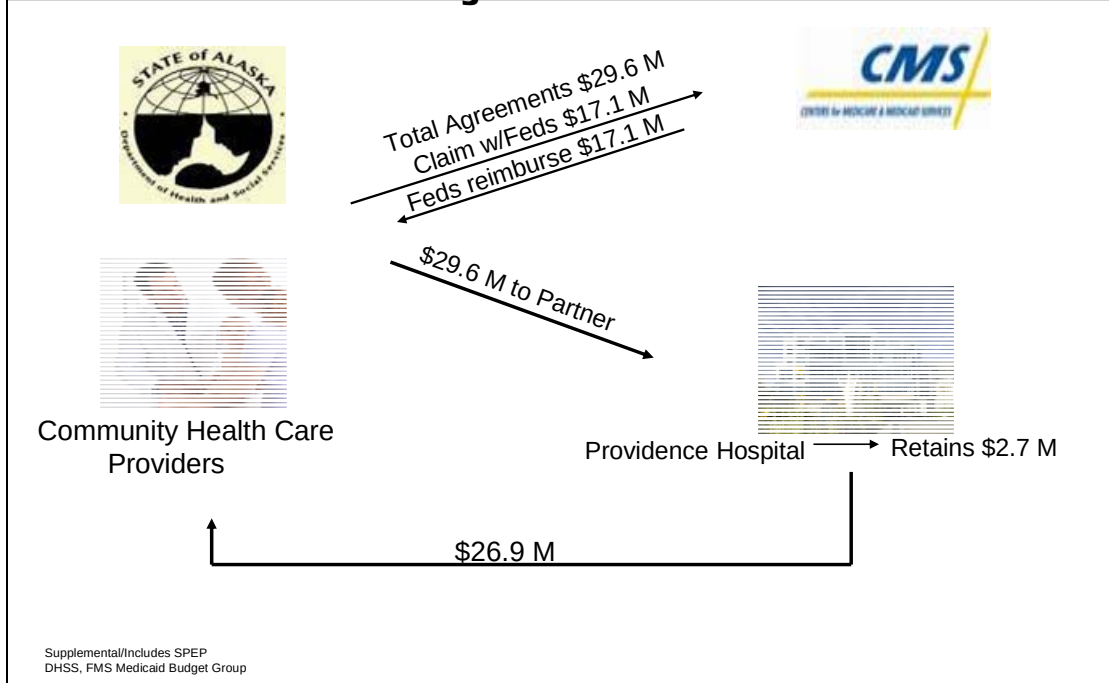
Behavioral Health Grants \$3,448.2
Psychiatric Emergency Services \$1,631.6
Services to the Seriously Mentally Ill \$3,324.9
Seriously Emotionally Disturbed Youth \$902.0
Office of Children's Services/Family Preservation \$322.4
Public Health/Community Health \$1,172.0
Senior & Disabilities Services/Community DD Grants \$4,815.7
Juvenile Justice-McLaughlin YF \$191.1
Juvenile Justice-Mat-Su YF \$25.1
Juvenile Justice-Kenai YF \$21.4
Juvenile Justice-Fairbanks YF \$46.5
Juvenile Justice-Bethel YF \$33.9
Juvenile Justice-Nome YF \$22.6

Juvenile Justice-Johnson YF \$38.9
Juvenile Justice-Ketchikan Regional \$17.6

Provided on the next page is a demonstration of how the ProShare Financing was originally planned for SFY08, followed by the view for FY08 and FY09 based on federal disallowance of financing mechanism.

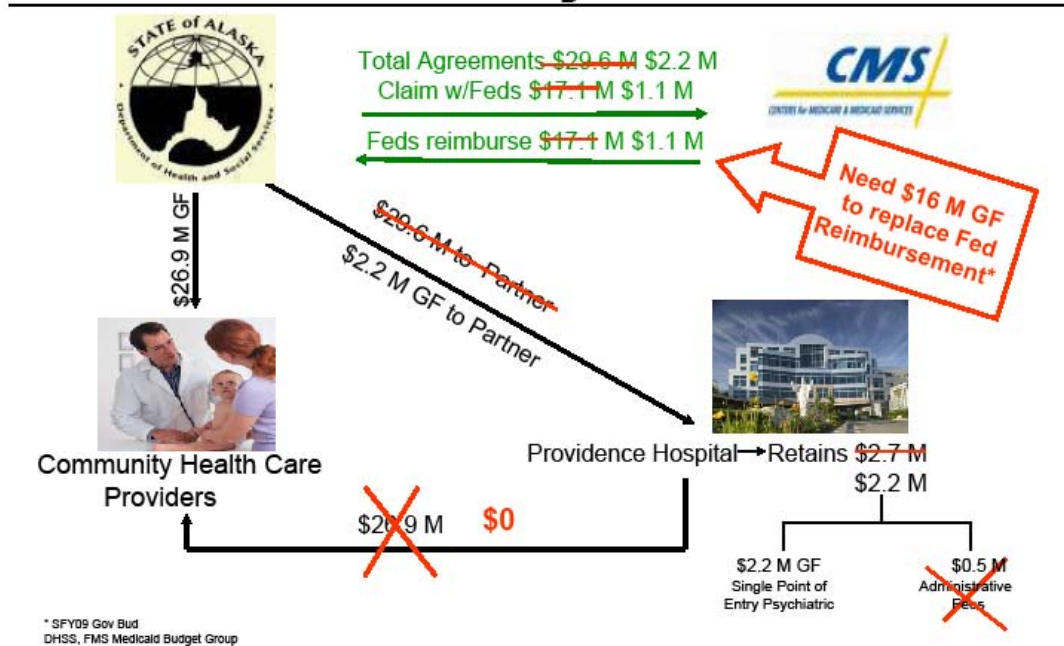
ALASKA'S PROSHARE PROGRAM

The Original Plan for SFY08



ALASKA'S PROSHARE PROGRAM

Governor's Budget for SFY09



Transfer out General Funds to Programs due to Elimination of ProShare Financing: (\$4,044.0 General Fund)

In SFY 08 a GF increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. The ProShare program allowed 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. That entire increment was placed in Health Care Services / Medicaid Services. This transfer of the general funds is necessary to provide the divisions the funding needed to continue these services.

- Behavioral Health Grants \$820.9
- Psychiatric Emergency Services \$614.4
- Services to the Seriously Mentally Ill \$798.7
- Services for Severely Emotionally Disturbed Youth \$211.0
- Office of Children's Services \$76.9
- Public Health \$279.4
- Senior and Disability Services \$1,148.1
- Juvenile Justice- McLaughlin YF \$45.5
- Juvenile Justice-Mat-Su YF \$6.0
- Juvenile Justice-Kenai YF \$5.0
- Juvenile Justice-Fairbanks YF \$11.1
- Juvenile Justice-Bethel YF \$8.1
- Juvenile Justice-Nome YF \$5.4
- Juvenile Justice-Johnson YF \$9.3
- Juvenile Justice-Ketchikan Regional YF \$4.2

Medicaid Cost Containment in Pharmacy: (\$1,020.4 Total) (\$520.4 Federal, \$500.0 GF/Match)

Savings are anticipated from cost containment efforts in Medicaid pharmacy services. These efforts include expanding the list of drugs requiring prior authorization, using tamper resistant prescription pads, implementing a drug dose optimization program, and adoption of federal upper limit average manufacturer's price (AMP) for generic drugs effective January 2008. This is a conservative estimate. Actual savings possible from these initiatives could be higher but are highly uncertain at this time as most of the savings could be wiped out by the anticipated increase in pharmacy dispensing fees.

Medicaid Cost Containment in End Stage Renal Dialysis: (\$500.0 Total) (\$255.1 Federal, \$244.9 GF/Match)

This proposal would reduce costs for end stage renal dialysis (ESRD) through a change to the rate structure and by shifting eligible costs to Medicare. These changes are anticipated to save \$500.0 in FY 2009 (1/2 year); annually \$1 million could be saved.

Currently Medicaid pays providers 100 percent of their billed charges for each procedure and different providers can charge different rates for the same service. The new rate would be an inclusive composite rate so that all providers are paid the same rate for the same group of services. A comparison of the current rate to the Medicare rate found that in some cases Medicaid is paying as much as 10 times what Medicare pays.

A large portion of Medicaid clients receiving end stage renal dialysis treatment are over age 65 and are likely eligible for Medicare. Medicaid is the "payor of last resort" so if a client is eligible for both Medicare and Medicaid, Medicare will be billed first. By making sure that dually eligible clients are enrolled in Medicare, Medicaid will be able to avoid the full cost of treatment.

Savings for SFY 2009 are estimated for 1/2 year due to the need to change regulations regarding the rate structure.

Review/Implement Medicaid Report recommendations (Stat Chg (SB 61)) — Pacific Health Study: \$2,500.0 Total \$1,275.5 Federal, \$1,224.5 GF/Match

The Senate Finance Committee's Medicaid Program Review report (PHPG Report), a report by the Pacific Health Policy Group that was completed January 2007, details inefficiencies in the Medicaid system that result in large general fund expenditures and addresses money currently paid by Medicaid to non-tribal providers on behalf of American Indians and Alaska Natives. The department and the Governor's Alaska Health Care Strategies Planning Council are currently considering many of the report's recommended changes to Alaska's Medicaid program. Most of the report recommendations, such as creation of new waiver programs and changes to rate methodologies, are long-term changes that require regulatory or statutory changes, or changes to the Medicaid State Plan. The Health Care Strategies Planning Council will provide the Legislature a summary of its recommendations for implementing PHPG Report recommendations, and other changes the Planning Council recommends, in January 2008.

Health Care Services (HCS) is potentially impacted by PHPG Report recommendations. These include altering the methodology for setting drug dispensing fees in rural versus urban settings and increasing the number of drugs requiring prior authorization; implementing a disease management program; and seeking federal reimbursement for services currently provided under the CAMA program. Implementation of PHPG recommendations for increasing tribal reimbursements would also affect HCS funding.

Adult Preventative Dental Services

FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: (\$258.1 Federal), \$258.1 GF/Match

This request replaces lost federal revenues resulting from a 1.95-percent decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on Oct. 1, 2008.

The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid and is outside the control of the state government. One in five Alaskans is enrolled in Medicaid at some time each year. Without the increment, the state would be forced to reduce eligibility or services currently provided to low-income children, pregnant women, individuals with disabilities, and the elderly. By approving this change record the department will be able to continue to meet its mission of managing health care for Alaskans in need.

The amount of federal funds the state receives for its Medicaid program depends on a complex array of reimbursement rates, some of which change each October 1 with the start of a new federal fiscal year. The bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the federal medical assistance percentage, or FMAP. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50 percent.

The regular FMAP is projected to drop from 52.48 percent to 50.53 percent in FFY09 and the enhanced FMAP from 66.74 percent to 65.37 percent. The regular FMAP for SFY09 will average 51.02 percent across two federal fiscal years (52.48 percent from July–September 2008 and 50.53 percent from

October 2008–June 2009). The enhanced FMAP for SFY09 will average 65.71 percent (66.74 percent from July–September 2008 and 65.37 percent from October 2008–June 2009).

FY09 Medicaid Program Fund Change: (\$1,717.5 Federal), \$1,715.5 GF/Match

This change record seeks to rebalance the fund source amounts for Adult Dental Preventative Dental (APD) Medicaid Services based on projections for increased recipients served by private dental providers and a reduction from previous estimates for Indian Health Service (IHS) recipients served by tribal dental programs. These enhanced dental services include preventative and enhanced restorative dental services as well as periodontal maintenance and denture services. The forecast is based on limited claims experience and should be updated for the Governor's amended budget.

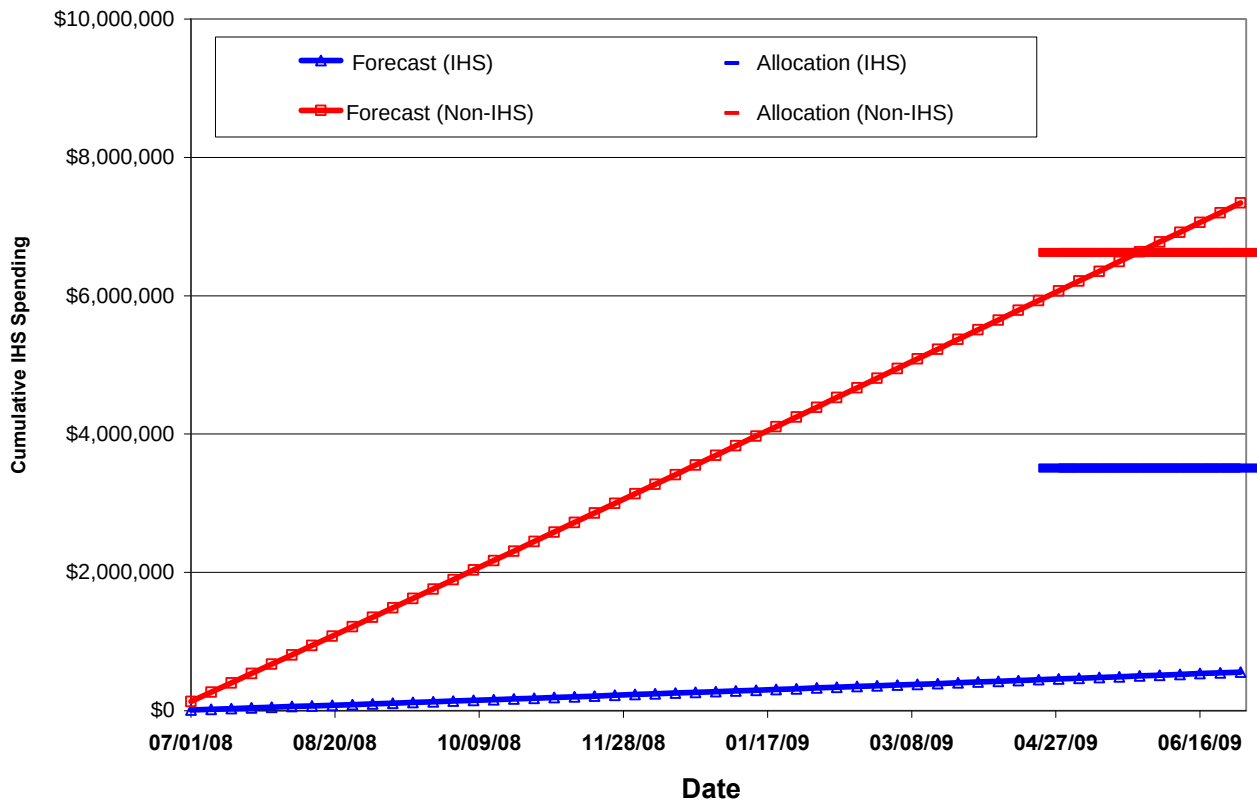
The forecasted spending for SFY09 (upper bound as of Sept. 13, 2007) is for \$9,088.9 (\$5,183.8 Fed/3.905.1 match). The FY08 authorized amount of \$10,292.0 is adequate, but the expected 40-percent IHS participation has not materialized, which has led to a surplus of federal authorization and a shortfall of state match. This change record seeks to balance the fund sources by increasing GF match by \$1,717.5 and decreasing federal by an equal amount.

IHS billings have been lower than anticipated. While some of this may be the longer lag time for Medicaid billing from tribal programs as compared with private dental offices, tribal programs also may lack adequate provider capacity to fully meet dental service demands from their adult beneficiaries. Tribal dental work force capacity typically results in prioritization for children's dental services. To the extent tribal dental programs refer Alaska Native adults to private dental offices; estimated federal funding for the services will decrease. Correspondingly, general fund match funding for the services will increase. The prior authorization process for the enhanced dental services has been a frequent complaint of private and some tribal programs and could be restricting provider participation in the adult dental Medicaid services. Additionally, there are some indications that the new dental services have not fully been appreciated by tribal beneficiaries in remote areas of the state.

Based on the claims experience and preliminary analysis at this time, it is unlikely tribal programs will meet the level of participation in the enhanced dental services that was estimated in the fiscal note for the services.

The department will evaluate claims experience and revise the forecast before the end of the third-quarter of FY 2008 to address the need to lower the annual cap in FY 2009 and remain within overall expenditures estimated in the fiscal note for these dental services.

FY 2009 Adult Enhanced Dental Forecasted Spending



Medical Assistance Administration

Transfer in Positions and Funding from Office of Program Review for Medicaid Policy Unit: \$768.8 Total \$384.4 General Fund/Match, \$384.4 Federal

This transfer is part of the realignment plan for the Department of Health and Social Services which coordinates the functions of OPR with the Medicaid and Health Care Policy Component. The Medicaid and Health Care Policy component includes Medicaid health care policy and operations within DHSS, which encompasses Medicaid policy and financing, Health Care Services, tribal health agreements, rate review; and design, development, and implementation of the new Medicaid Management Information System (MMIS).

Capital Improvement Projects (CIP) Receipts for Medicaid Management Information System (MMIS) Project Personnel: \$1,415.2 CIP Receipts

This increment is being added to be able to receive funds from the capital project for the new Medicaid Management Information System Design Development and Implementation (MMIS-DDI) positions that have been added to staff the MMIS-DDI project.

Challenges

Health Care Medicaid Services

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. Because provider participation in Medicaid is voluntary, if Medicaid's rates are too low providers may stop seeing Medicaid clients. In FY09 there are several challenges related to reimbursement rates:

Health-care facility rates will be recalculated beginning in FY08. By regulation, payment rates for most health-care facilities must be recalculated at least every four years [7 AAC 43.685(a) (6) (B)]. Facilities were last re-based in FY04. For Health Care Services' Medicaid, this means that non-tribal inpatient hospital payment rates for FY09 will be adjusted. The new rate for each facility will become effective at the start of that facility's 2009 fiscal cycle. The department estimates that the average adjustment will be 8.5 percent. Less than a third (29 percent) of payments for non-tribal hospital services will be impacted by re-based rates in FY09.

Many dentists choose not to participate in Medicaid because of the low reimbursement rates. According to a study published by the Alaska dental provider community, Medicaid offers the lowest reimbursement rates for dental services in the state. Medicaid is currently paying 60 percent of billed charges for dental services under Medicaid. Payment to dental providers is based on 80 percent of what was usual and customary for dental procedures in 1995. Except for dental services billed at physician rates (oral surgeries) and dental services with codes developed after 1997, rates for most dental services have not been updated since February 1997. The division proposes to update reimbursement rates to approximately 80 percent of current billed charges over a two or three year process. Dental services provided at federally qualified health centers (FQHC) are billed at an encounter rate and will not be affected by any fee for service rate changes.

Alaska Native Tribal organizations have asked the state to consider changing the reimbursement methodologies available to tribal dental providers. Tribal dental services are currently reimbursed based on the lesser of the billed charges, the provider's lowest billed charge, or a per-procedure rate schedule (fee for service) established by the state. Reimbursing tribal dental providers at the Indian Health Service outpatient hospital encounter rate will provide improved financial stability and allow tribal organizations to expand the volume and scope of dental services they offer. The more Medicaid dental services that can be provided in tribal facilities, the more state general funds Alaska will save by insuring that the federal government meets its trust responsibility to native beneficiaries. The IHS outpatient hospital encounter rate is also closer to the actual costs of delivering the broad range of health services offered at tribal facilities, including dental services. Allowing tribal dental providers to bill at the encounter rate may improve the financial viability of the tribal health care infrastructure, insuring access to dental health care for all the residents, both Native and non-Native, in many areas of the state. Local access to dental health care will reduce the costs for Medicaid clients traveling to receive similar care elsewhere in the state.

The federal government has cut the rates for prescription drugs. Without an increase in dispensing fees, many of the small "Mom & Pop" pharmacies that Alaskans rely on will not be able to make a profit anymore. One of the tenets of Medicaid is to pay providers rates that are consistent with economy, efficiency, and quality of care and sufficient to enlist enough providers. This increase is necessary to continue to efficiently provide quality pharmacy services by maintaining enough local providers to serve client's needs.

Reduce costs for end stage renal dialysis (ESRD) through a change to the rate structure and by shifting eligible costs to Medicare. Currently Medicaid pays providers 100 percent of their billed charges for each procedure and different providers can charge different rates for the same service. The new rate would be an inclusive composite rate so that all providers are paid the same rate for the same group of services. A comparison of the current rate to the Medicare rate found that in some cases Medicaid is paying as much as ten times what Medicare pays. A large portion of Medicaid clients receiving end stage renal dialysis treatment are over age 65 and are likely eligible for Medicare.

Medicaid is the "payor of last resort," so if a client is eligible for both Medicare and Medicaid, Medicare will be billed first. By making sure that dually eligible clients are enrolled in Medicare, Medicaid will be able to avoid the full cost of treatment.

Other reimbursement rate challenges include increasing rates for emergency transportation providers to bring them up to Medicare rates, and reducing Medicaid rates for high cost durable medical equipment items by changing the current pricing methodology and requiring documentation of manufacturer's suggested retail price or true cost before establishing a rate of reimbursement.

General hospitals are required to see patients regardless of their income or insurance coverage. The Alaska Medicaid Upper Payment Limit program (ProShare) has allowed the state to make payments to qualifying hospitals to compensate these hospitals for the cost of providing care to individuals who are publicly insured. As a result of a negative court decision, the department's ProShare program has been ended. Without the Medicaid ProShare program, many of the services will be funded through grant programs that are totally GF.

The department wishes 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 individuals who are uninsured or underinsured may qualify for DSH payments to help offset their loss of revenue for uncompensated charity care. The state has had plans to negotiate agreements with qualifying hospitals to preserve or expand health care services that will benefit the state or local community. Alaska's allotment of federal DSH funds increases by 16 percent each federal fiscal year; however, the level of funding in the state's budget for DSH has not increased in many years. The department does not currently have sufficient funding to expend the full allotment.

Adult Preventative Dental Medicaid Services

A key to the successful implementation of the adult preventative Medicaid dental program is adequate provider capacity (the extent of dental access through tribal and community health center dental programs, and the extent of private dental participation in the Medicaid program). Because of the limited number of dentists and available appointments for new clients, it is expected that some adults will only be able to visit the dentist once or twice in a year. DHSS is meeting with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program.

This RDU was established by passage of HB 105 in FY2006. 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. Total spending must remain within the budgeted amount. If costs will exceed the budget, the annual cap must be adjusted.

The Adult Preventative Medicaid Dental program was established with a three-year sunset which provides a trial period and an opportunity to evaluate the program. The program will be up for reauthorization in SFY 2009. If not reauthorized, the program will end June 30, 2009.

Medical Assistance Administration

Medicaid Management Information System (MMIS) Development Project

Federal law requires all states participating in the Medicaid program to operate an automated claims processing system that must be certified by the federal government as a Medicaid Management Information System (MMIS). Federal rules also require these fiscal agent contracts be competitively bid. The contract for HCS's current fiscal agent was negotiated and awarded in May 1987.

A priority goal for the division is to transition to a new MMIS system with minimum disruption to its service providers and clients. The new system must satisfy the needs of the state, medical service providers and the clients they serve.

The department has awarded a contract to Affiliated Computer Systems (ACS). The contract includes: design, development and implementation of a new claims payment system; a claims data warehouse information system; and operations of the new system for five years. The department has set up a project management office to manage the state's responsibilities for this effort.

Performance Measures — Health Care Services

Contribution to Department's Mission

To provide health coverage to Alaskans in need.

Core Services

Manage health care coverage for Alaskans in need.

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	Medicaid 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	7,263,956	18	6

Note: Between FY02 and FY03 reports were based on six months of data. Since FY04 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 FY 2006 and FY 2007 increased from 12 days to 18 days.

Three new initiatives, two in the second half of FY 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 FY 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 DHSS contractor experienced a data entry backlog as it 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 FY 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	Medicaid 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	5,606,347	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 FY 2005; beginning with FY 2006, it is being updated quarterly.
3. Source: MARS MR-0-11-T.

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 Web site for providers with information tailored to each provider type.

During FY 2006, DHSS had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, 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 DHSS 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 Centers 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 Payment Error Rate Measurement (PERM) program commenced nationally on July 1, 2005, with Phase I and one-third of the states participated. Alaska is a year-three 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 percent the GF expenses and replace them with alternate funds.

Measure #1: Percent of general funds replaced with alternate funding.

Health Care Services Actuals — Other Funds (in millions)

Fiscal Year	% Federal	% General	% Other
FY 1999	66.0%	34.7%	.8%
FY 2000	65.3%	25.5%	9.2%
FY 2001	66.4%	22.7%	10.9%
FY 2002	66.6%	27.8%	6.1%
FY 2003	67.5%	25.5%	7.1%
FY 2004	71.1%	16.6%	12.4%
FY 2005	71.5%	17.5%	11.0%
FY 2006	65.3%	28.1%	6.6%
FY 2007	64.8%	31.0%	4.2%

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 the Alaska Budget System (ABS) as percentages.

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 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 Federal Medical Assistance Percentage (FMAP).

Note: FY 2004 is the first year reported after the reorganization. FY 2004 and earlier actuals will include the complete Medicaid program (not just Health Care Services) and therefore do not provide exact comparisons between fiscal years.

A1: Strategy — Increase Indian health services (IHS) participation by 5 percent in expenditures.

Target #1: Increase Indian health services (IHS) Medicaid participation by 5 percent 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%	98%
2000	\$268.4	\$49.4	18%	32%
2001	\$323.0	\$73.3	23%	48%
2002	\$385.9	\$89.3	23%	22%
2003	\$466.6	\$134.9	29%	51%
2004	\$503.6	\$154.5	31%	15%
2005	\$627.4	\$187.2	30%	21%
2006	\$628.4	\$155.3	25%	-17%
2007	\$594.3	\$153.0	26%	-1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS direct services claim payments, including FairShare claims, for 1999 - 2004 are from MMIS-JUCE. 2005-2007 are from AKSAS. The drug rebate offset is from AKSAS.

The % Increase is the percent change in IHS expenditures from the prior year.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from FY06 to FY07 by \$2.3 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 percent 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. Certain tribal entities with 638 status receive 100 percent 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, 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 percent FMAP vs. the standard match for non-Native.

Once an AI/AN beneficiary is connected to a tribal health-care delivery system that is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door beneficiaries enter, for example, whether it's behavioral health, clinic, or dental, they become a part of the larger tribal health-care 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 percent.

Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability (TPL) 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%
2007	19.2	3.5	22.7	-28%

Analysis of results and challenges: Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 28 percent from FY06 to FY07. 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 percent 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	YTD FY2006	YTD FY2007
Physicians	6,440	7,076	6,486	6,406	5,553
Dentists	587	597	578	553	482
Pharmacies	359	356	287	224	198
Hospitals	734	841	739	751	602
Nursing Facilities	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	6,870
Source: DHSS, Finance & Mgmt Services					
Medicaid Budget Group, MARS-MR-0-06-T					

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 percent 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.

	FY02	FY03	FY04	FY05	FY06	FY07
Total Claims Paid (fiscal year)	4,202,677	4,776,730	5,106,692	6,150,027	6,082,318	5,606,347
Percent Paid with No Errors	74%	73%	76%	72%	74%	72%
Hospitals	60%	65%	64%	65%	64%	73%
Physicians	67%	65%	64%	63%	65%	63%
Dentists	73%	74%	74%	73%	74%	74%
Nursing Home Facilities	65%	62%	62%	49%	60%	65%
Pharmacy	83%	80%	77%	77%	79%	64%
Mental Health	73%	76%	77%	74%	75%	79%
Transportation	88%	86%	86%	75%	84%	85%
HCBC	77%	78%	81%	87%	81%	87%
Vision	80%	77%	69%	76%	75%	69%
Psych	71%	42%	47%	55%	54%	60%
Clinics	71%	58%	49%	65%	61%	62%
BRS	91%	86%	84%	87%	87%	92%
Chiropractic	60%	49%	51%	53%	53%	50%

*Note: Prior year reports were based on six months of data. This report is based on annual data.
FY04 data is actual through May.*

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 Web site 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 in Pharmacy. During FY06, DHSS had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, 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. Therefore, the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required DHSS 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.

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 management of informal or formal response
- Probation supervision and monitoring
- Juvenile offender skill development

Services Provided

Juvenile Justice services can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions.



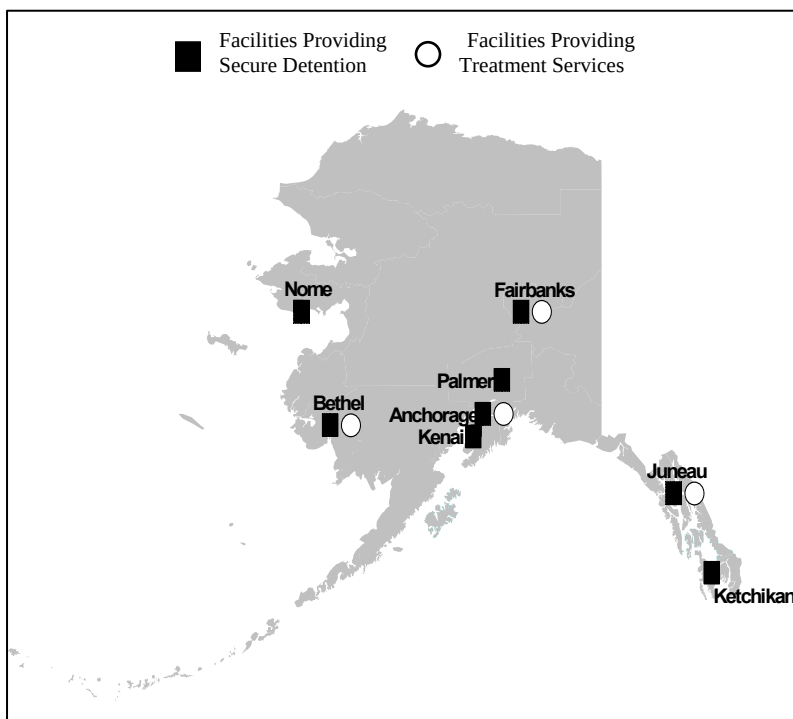
Probation Services

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; and, 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 a determination on an outcome for their offense; 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 to have the 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)

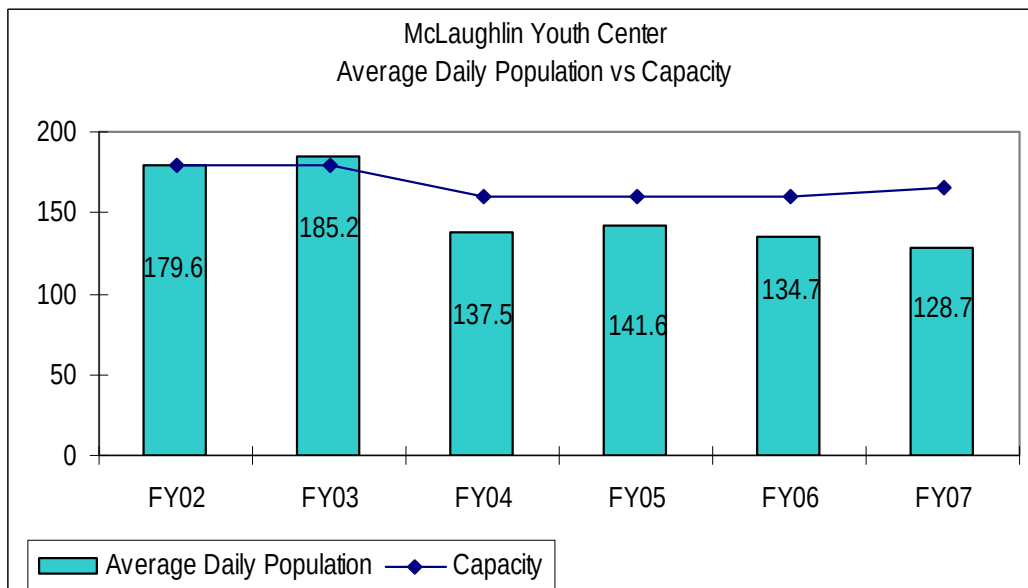
MYC currently has 165 beds (65 detention beds, 95 longer-term treatment/training school beds and five beds which can be used as either detention or treatment). The detention units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Cordova, Valdez, Kodiak, Dillingham and Aleutian/Pribilof Islands. The Training School consists of residential treatment programs for delinquent males, delinquent females, and male sex offenders; a specialized treatment unit; an intensive services treatment unit for particularly difficult-to-manage youth; a transitional services unit for youth leaving the facility; and an intensive community supervision program. 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.

The McLaughlin Youth Center's Transitional Services Unit (TSU) was created in FY04 and was designed to prepare each institutionalized youth for a gradual and successful re-entry into the community from the time he/she is institutionalized. TSU staff provides monitoring, supervision and support of youth in the community prior to and after release as identified in the Youth Level of Services Case Management Inventory, Aftercare Plan and the youth's overall progress. The TSU is recognized nationally as a promising practice. This program is being replicated in other facilities in the state.

McLaughlin Youth Center (MYC) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. McLaughlin is currently working on Levels II and III Data Certification.

The chart below indicates the average daily population and capacity during several fiscal years. 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. In FY07, the chart shows an increase of five beds from a separate wing that are used “as necessary” (previously designated admission cells) for one of the two detention units.

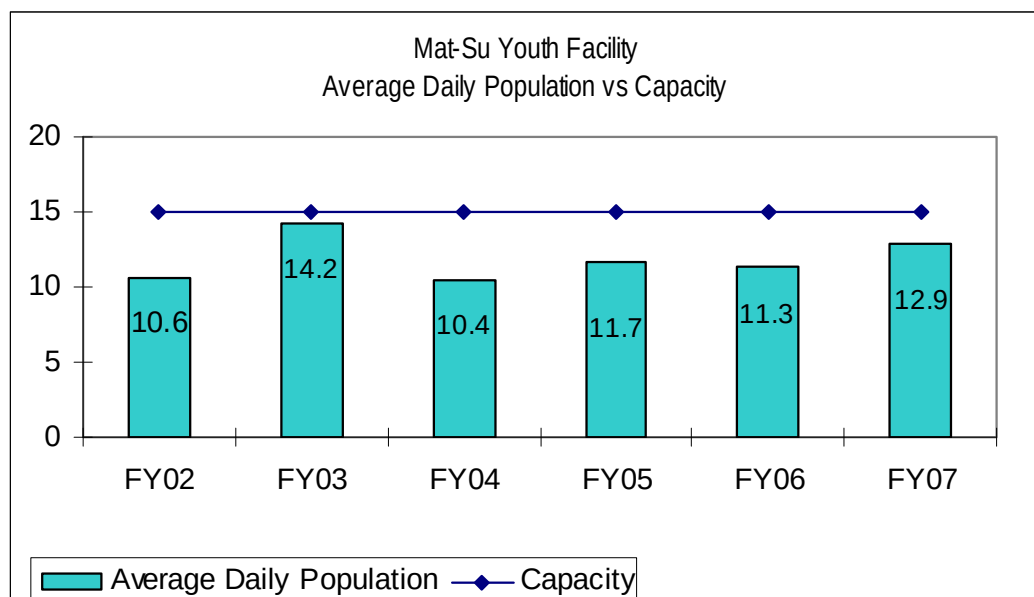


Mat-Su Youth Facility (MSYF)

The Mat-Su Youth Facility is a 15-bed juvenile detention center located in the city of Palmer, Alaska, serving a population base exceeding 77,000 in addition to the outlying areas of the Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. Services provided to residents of the facility focus on education, physical and mental health, substance abuse and a variety of related activities geared toward competency development and the restoration of victims of juvenile crime and the communities in which these crimes occur. Juvenile offenders are housed at the facility while

awaiting trial, adjudication, disposition, placement or diagnostic evaluation to help determine a longer term plan of intervention, habilitation or treatment that is appropriate to their needs. The facility also houses the Mat-Su Juvenile Probation offices.

Youth returning to the Mat-Su area after a period of commitment in one of the other juvenile treatment facilities within the state work with the Transitional Services Unit and community-based service providers. This requires active participation by community partners inside the facility as they assess the immediate and long-term treatment needs of juveniles.



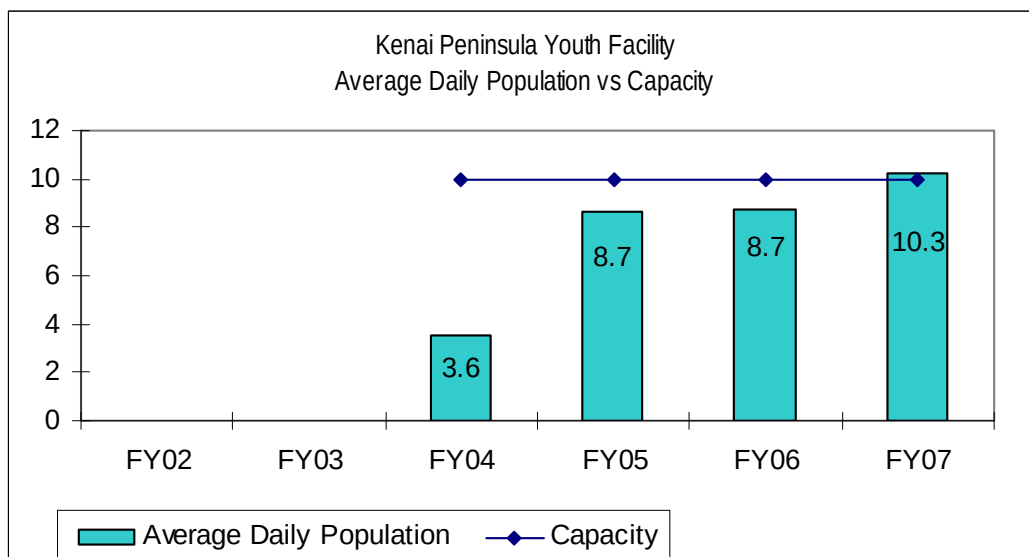
The Mat-Su Youth Facility (MSYF) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.

Kenai Peninsula Youth Facility (KPYF)

The Kenai Peninsula Youth Facility provides a 10-bed, secure placement setting for youth from the Kenai Peninsula area that are awaiting further court action, or pending transfer to or from another placement or 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.

The facility provides core services that focus on promoting social and moral growth, and the acceptance of personal responsibility for behavior while meeting the youth's basic physical needs for food, shelter and clothing in a safe and secure environment. The facility provides educational services, daily activities and recreational programming that focus on promoting psychological and behavioral growth, including life skills education, victim empathy, substance abuse education, increased self awareness, healthy lifestyle choices and improved decision making. When youth are returned to the community, probation and facility staff work with local service providers to appropriately place youth leaving the facility, and to provide community outreach services to encourage victim and community restoration.

The Kenai Peninsula Youth Facility (KPYF) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.



The Kenai Peninsula Youth Facility opened in December of 2003. The data collected in FY04 are for 6.5 months.

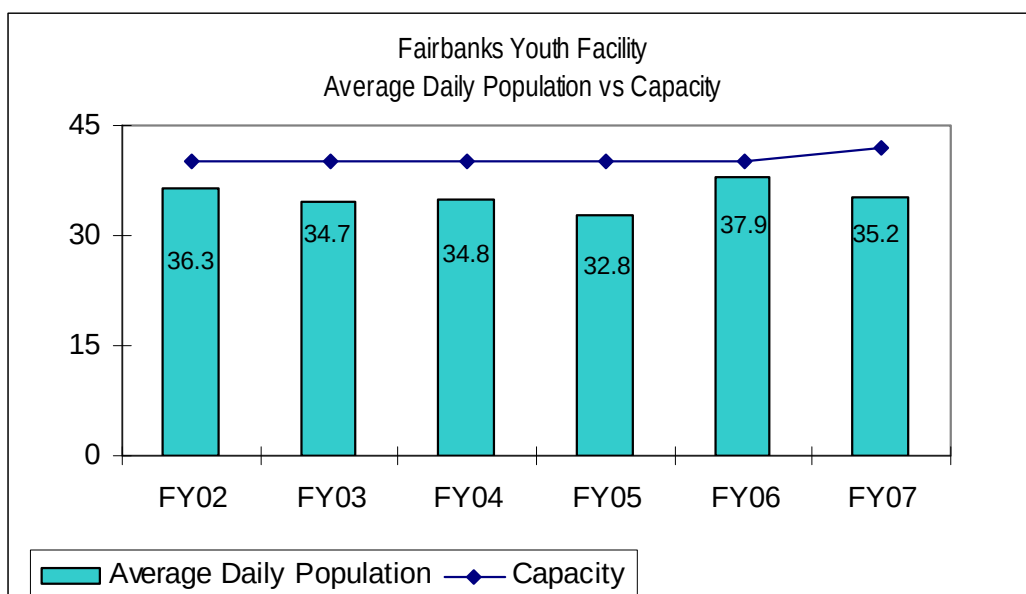
Fairbanks Youth Facility (FYF)

FYF consists of a 22-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. This facility is located in DJJ's Northern Region, which is the largest geographical area served by the division in the state.

FY09 will demonstrate continued improvement in the treatment services provided in Fairbanks. Expanding the training in Aggression Replacement Training (ART) during FY09 will continue to develop treatment competencies of the facility staff. Residents with intensive mental health or Fetal Alcohol Spectrum Disorders (FASD) continue to challenge the facility's ability to operate safely and securely. Increasingly, special needs offenders demonstrate clinical needs that require one-on-one supervision and care, which significantly impacts the staff resources available.

The Fairbanks Youth Facility (FYF) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.

In FY07, the detention capacity increased by two, as rooms that were previously used as storage rooms were converted to sleeping rooms.



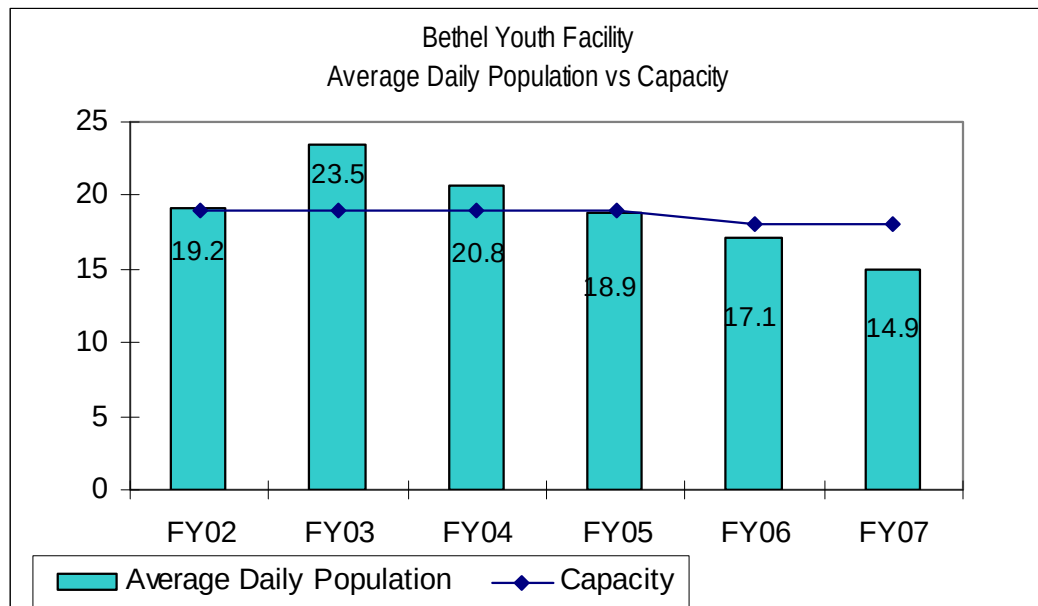
Bethel Youth Facility (BYF)

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 following graph.

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 Yupik Eskimo. A significant number of residents have Fetal Alcohol Spectrum Disorders and other mental health needs. 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. Finding appropriate placements for youth preparing for release from the treatment unit continues to be a substantial challenge. There are currently few alternatives to family

placement in the Yukon-Kuskokwim Delta, and we will need assistance working toward developing other community-based resources such as foster care, therapeutic foster care, and independent living options.

The Bethel Youth Facility (BYF) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program and in FY07 was awarded the prestigious Barbara Allen-Hagen Award for Excellence by the Council of Juvenile Corrections Administrators for its effective implementation of this program in the detention unit. The facility is currently working on Levels II and III Data Certification.



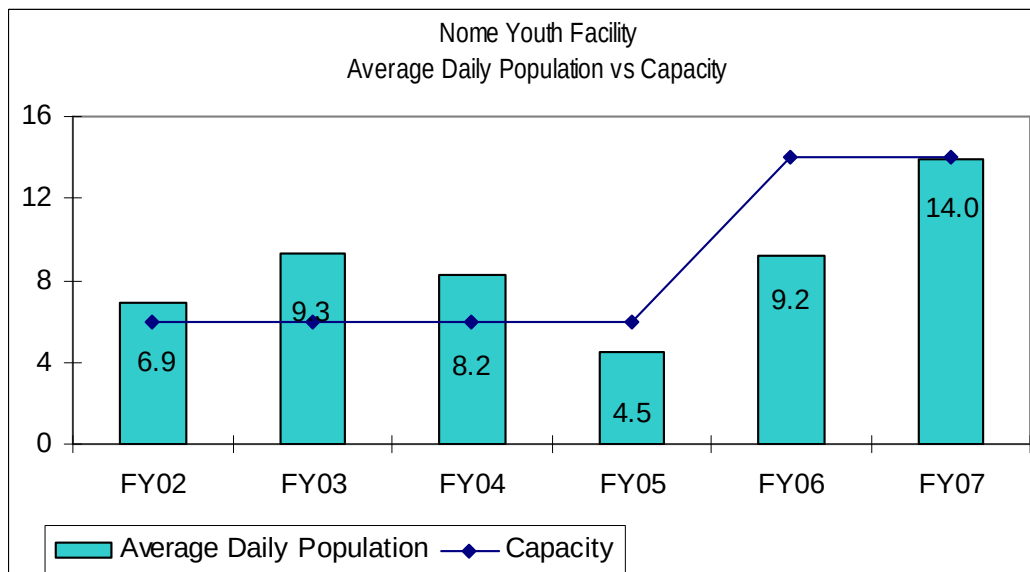
Nome Youth Facility (NYF)

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 expanded from six to 14 beds in FY06.

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 FY09, the Nome Youth Facility will continue to train and maintain staff in the provision of long-term treatment services including: Aggression Replacement Training, building relationships with families, and the new Aftercare/Transitional Services program. FY07 demonstrated continued improvement in the services provided at the Nome Youth Facility, providing longer-term treatment services for youths in the region. The expanded 14-bed capacity allows a greater opportunity for the program to meet the needs of the youth in the region. Through a partnership with Boys and Girls Club the therapeutic intervention classes for substance abuse prevention, smoking cessation and responsible sexual behavior will be increased. A suicide prevention curriculum will be added as well as comprehensive job skills training

The Nome Youth Facility (NYF) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.

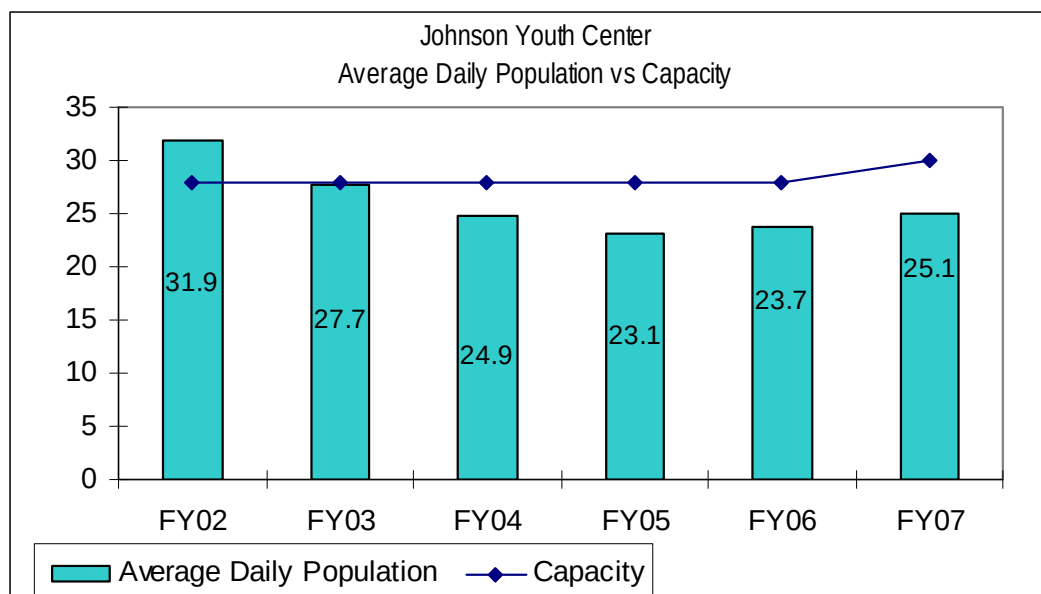


During FY05, the NYF was partially closed due to the renovation of the building. The renovation was complete at the end of FY05; the increased capacity is not reflected on this chart until FY06.

Johnson Youth Center (JYC)

JYC is a 30-bed facility (eight, detention; 22, 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. Johnson Youth Center is the largest of the division's southeast youth facilities, providing specialized programs for non-adjudicated sex offenders, female offenders held in detention and violent offenders from other areas of the southeast region. The facility also provides support services for the Ketchikan Regional Youth Facility in Ketchikan and administrative support for Juneau Probation and the Southeast Region Probation Department.

The Johnson Youth Center detention unit provides an array of basic and specialized delinquency intervention services. A 22-bed Cognitive Behavioral Treatment Program focuses on skill streaming, appropriate anger management, moral reasoning, intensive substance abuse assessment/treatment, family support, and life skill development for male residents. Transitional services are incorporated in all initial treatment/release plans, and are designed to begin preparing each institutionalized youth for a gradual and successful re-entry into the community. The Youth



Competency Assessment (YCA) and Youth Level of Services/Case Management Inventory (YLS/CMI) instruments are utilized to identify specific individual strengths, needs and risk of each resident.

The Johnson Youth Center (JYC) has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.

Beginning in FY07, the treatment capacity at the Johnson Youth Center was increased by two beds. Two rooms that had been used as storage rooms were converted to treatment rooms. The increased capacity is reflected in the above chart.

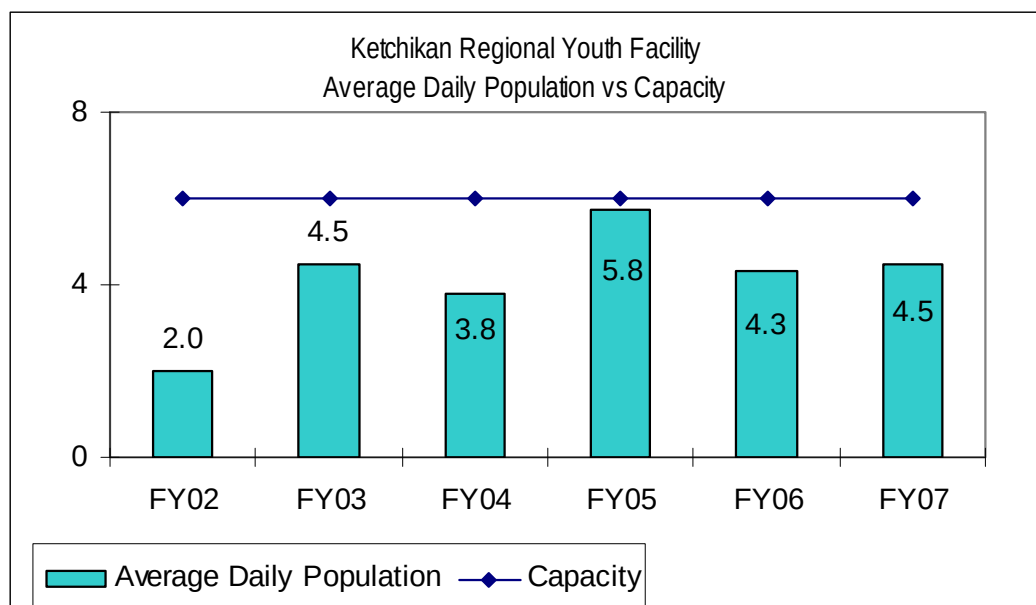
Ketchikan Regional Youth Facility (KRYF)

The Ketchikan Youth facility is a 10-bed facility (six, detention; four, crisis stabilization) that provides detention of youth who are awaiting a court hearing or other placement (six locked detention beds), and short-term-crisis respite and stabilization services for youth experiencing a mental illness. 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 Crisis Stabilization Unit (CSU) provides a safe environment for up to four youth in crisis and needing assessment or evaluation to assist in treatment planning. Services provided are short-term, with a maximum stay of up to 30 days. Youth are permitted to stay in the community during sub-acute episodes, while still receiving the structure and support necessary for them to succeed. Staffing for the CSU includes a mental health clinician who works closely with community mental health providers to ensure continuity of care and to effectively plan for each youth's return to the community. 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 responds 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, including Fairbanks, Mat-Su, Kenai and Juneau, and soon to be Nome and Bethel.

The Ketchikan Regional Youth Facility (KRYF)



has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program. The facility is currently working on Levels II and III Data Certification.

The capacity for KRYF includes only the six locked detention beds.

Probation Services

Probation officers perform a number of functions and responsibilities, from the point a juvenile is arrested or identified by law enforcement as the perpetrator of a delinquent offense. Probation officers evaluate a police officer's request to detain a juvenile following an arrest, and make a decision about whether the juvenile should remain at home, be held in a secure facility, or be placed outside of the home. When police refer a juvenile for having committed a delinquent offense, probation officers review the reports to determine if the charges are legally sufficient to take further action against the juvenile. Once jurisdiction has been established, the probation officer meets with the juvenile, his or her family, and the victim(s) involved in the case, to decide if the matter can be handled informally (through a community diversion plan), or if it requires formal court intervention.

The need to develop a broader array of community-based services for juveniles, both at the front end of the service continuum, as well as for youth transitioning to their home communities from a long-term institutional placement, remains a significant priority for this component. The division needs additional foster homes and therapeutic placements for juveniles, with particular emphasis on rural areas. A comprehensive and systemic approach to services for transitioning youth, including the ability to provide step-down therapeutic group homes with wraparound services, and additional and targeted services for juveniles with mental health issues, particularly those with low cognitive functioning or Fetal Alcohol Spectrum Disorder.

A significant revision of the Policy and Procedure Manual for Juvenile Probation staff was completed in FY08. This 450-page manual provides the juvenile probation officer with every aspect of juvenile probation practices, from intake through discharges, supervision and court processes to case management. A second training aid, the Juvenile Probation Officer Pre-Orientation Training curriculum, received a significant renovation in FY07. This curriculum previously consisted only of a workbook handed to new probation staff upon their hire. The new curriculum is Web-based and requires extensive experiential learning and mentoring. The new curriculum was piloted by several new probation staff; new supervisors were trained in the delivery of the new curriculum in early FY08. Juvenile probation officers around the state continue to collect a high percentage of restitution on behalf of victims of juvenile crime.

Director's Office

The division's Director's Office in Juneau oversees a number of functions that complement and support the public, the Legislature, other executive branch agencies, and field staff around the state. The Director's Office is responsible for statewide policy development and implementation; coordinated service delivery between field probation and the youth facilities; statewide staff training; quality assurance for both field probation and juvenile institutions; research and statistical analysis of juvenile justice data; and development and administration of federal grant programs. This office ensures ongoing operation and quality assurance for the division's automated offender database JOMIS (Juvenile Offender Management Information System), as well as focusing on continued refinements to the system, including integration with all facets of the juvenile justice service and delivery process.

The director's office functions include:

- *Grants Program Management:* Alaska, a participating state in the federal Juvenile Justice and Delinquency Prevention Act, receives approximately \$1.7 million in federal funding annually. Each year, these funds 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/Quality Assurance:* 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. Adequate quality assurance that will ensure the success of the division's system improvement efforts remains a key need.
- *Training:* The division's statewide Training Specialist works with staff to develop and implement staff training programs, including the development of specific competencies for probation and institutional field staff such as the ability to facilitate Aggression Replacement Training classes for juveniles or train new employees in the principles of restorative justice.
- *Administrative Support:* The division's administrative manager and staff prepare the division's budget, make monthly projections on spending, and approve grant payments and service agreements. In addition, full spectrum professional and administrative services to the division, including human resources, financial and procurement services, are monitored and/or performed by the administrative staff in the Director's Office.

The division is committed to developing partnerships with sister agencies to ensure that the needs of our youth are met and that state resources are fully utilized. The division has signed a Memorandum of Agreement (MOA) with the Department of Public Safety to increase opportunities for transportation of departmental staff to Alaska's rural communities, by meeting regularly to determine availability of flights and schedule travel. The division has an agreement with the Alaska Psychiatric Institute (API) that outlines a protocol for juvenile admissions to API, and transfers to Juvenile Justice facilities to ensure that youths who are in a crisis situation receive the mental health services they may need. The division is working to generate an MOA with the Department of Education and Early Development to ensure youth within Juvenile Justice's facilities continue to receive required educational services. This is mandated through the Individualized Education Plan that is generated for special needs students in the event of a teacher's strike in any of the school districts. The division has two MOAs with the Office of Children's Services; one outlines programmatic responsibility for shared resource areas, such as foster care and residential services; the second MOA describes guidelines for the management of shared cases. In addition, the division is working with the Office of Children's Services to develop a specific policy and procedures to ensure no child fails to receive needed services because one or the other agency has custody of the child.

In FY03 the division launched a "system improvement" effort, resulting in the adoption of several nationally recognized, research-based initiatives. These initiatives help guarantee that the Alaska juvenile justice system is using its resources effectively and efficiently, 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; and
- the Aggression Replacement Training curriculum serves aggressive offenders housed in its secure facilities, and some juveniles who are supervised in the community. The division has

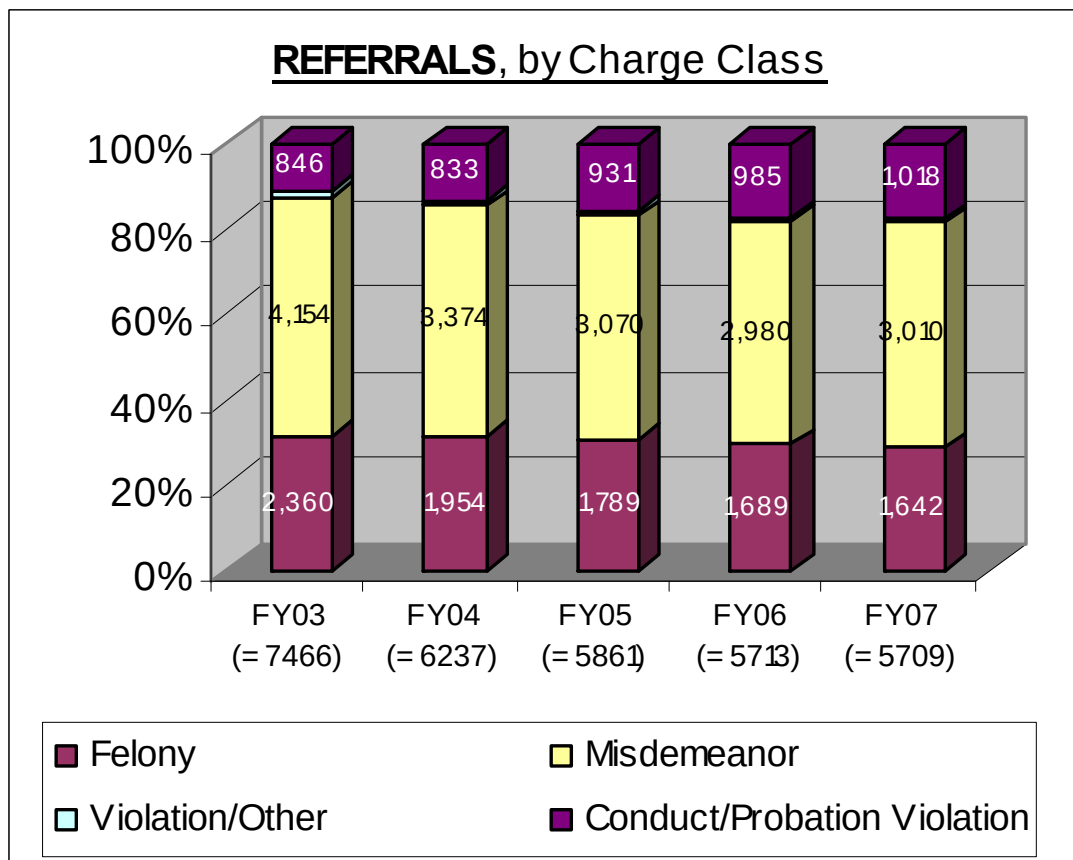
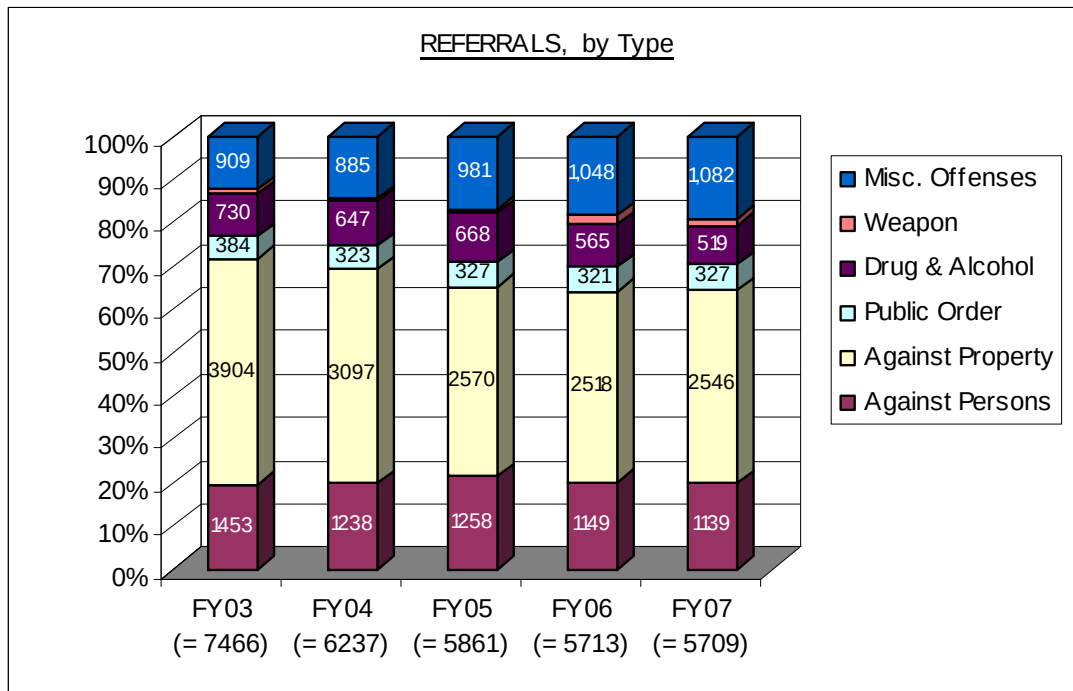
identified the need to expand this program in more communities, and through partnerships with schools and other agencies.

In FY09, the division's leadership will continue to incorporate these system improvement projects into a strategic plan and vision for juvenile justice in Alaska. The system improvement projects will improve public safety, and ensure that victim needs are met, and offenders are being held accountable.

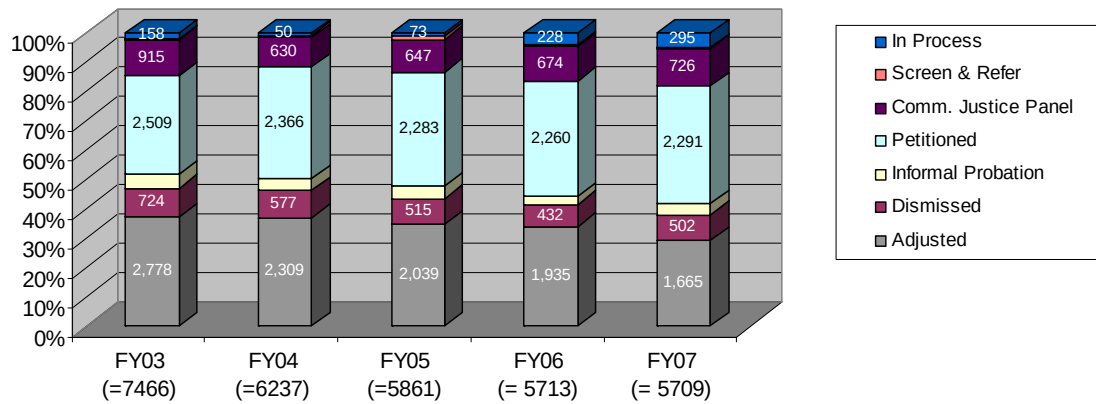
Annual Statistical Summary of Services Provided in FY 2007

FY 2007 Delinquency Referral Summaries

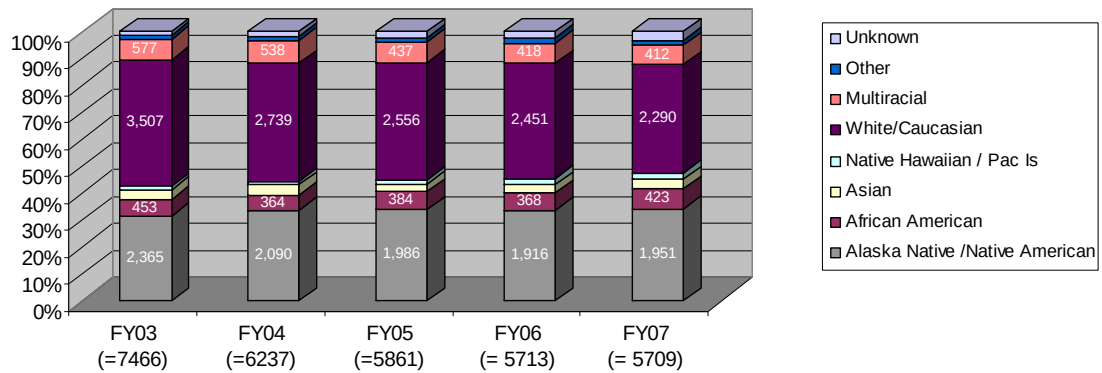
The following charts provide a summary of referrals for fiscal years 2003–2007.



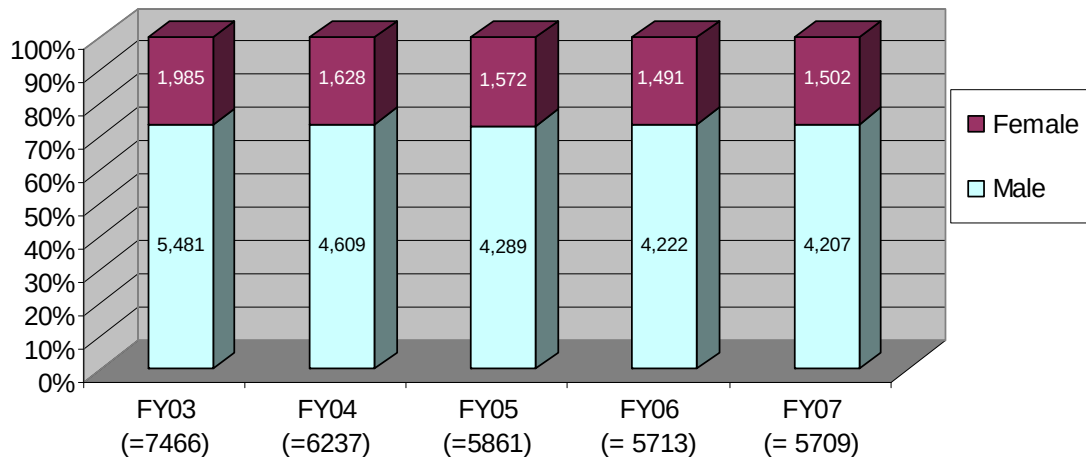
Completed Intake Dispositions



Referrals by Race



Referrals by Gender



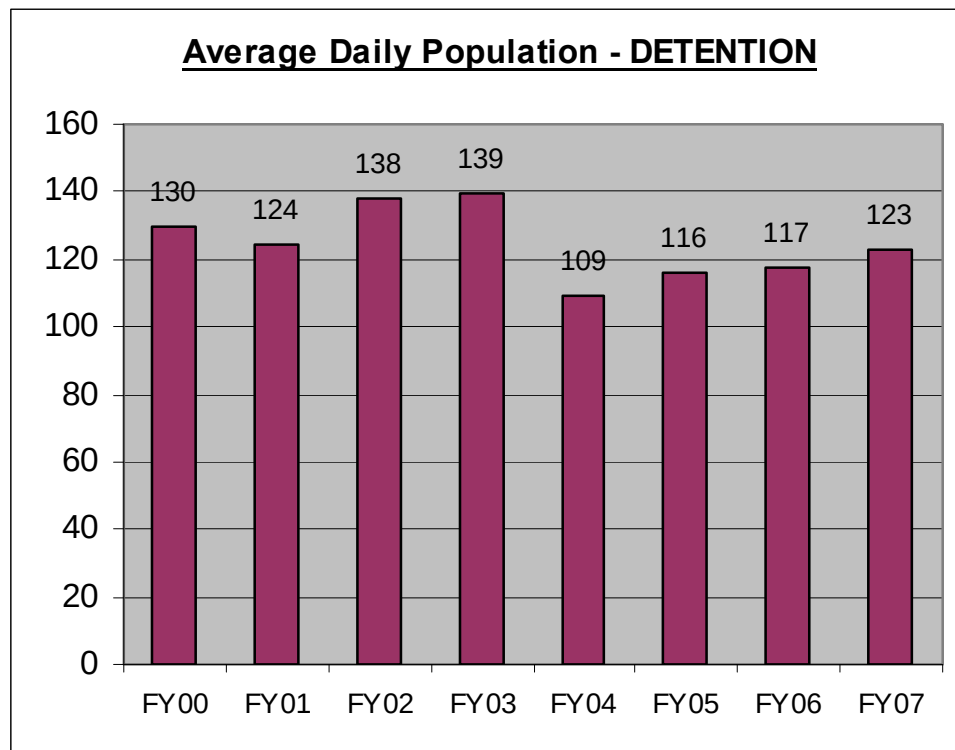
The table below shows increased bed capacity at the McLaughlin Youth Center (MYC), Fairbanks Youth Facility (FYF) and the Johnson Youth Center (JYC). One of MYC's detention units uses five beds from a different wing that were considered admission cells. These five admission cell beds are included in the capacity count because they are used for detention purposes. For both the FYF and JYC, rooms that had previously been used as storage rooms are now used as rooms on the detention unit in Fairbanks and the treatment unit in Juneau.

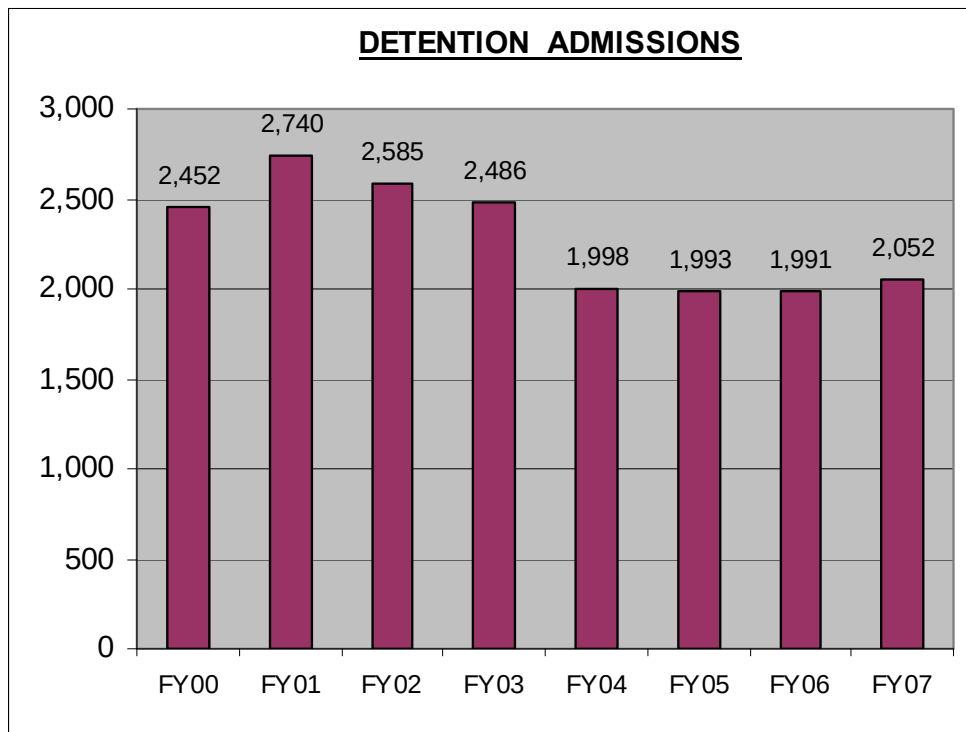
Youth Facility Existing Hard Bed Capacity FY07			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	160	5	165
Fairbanks Youth Facility	40	2	42
Johnson Youth Center	28	2	30
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Mat-Su Youth Facility	15		15
Ketchikan Youth Facility	10		10
Kenai Peninsula Youth Facility	10		10
Total	295		304

Facility Data

Detention Units — Detention and Treatment Units

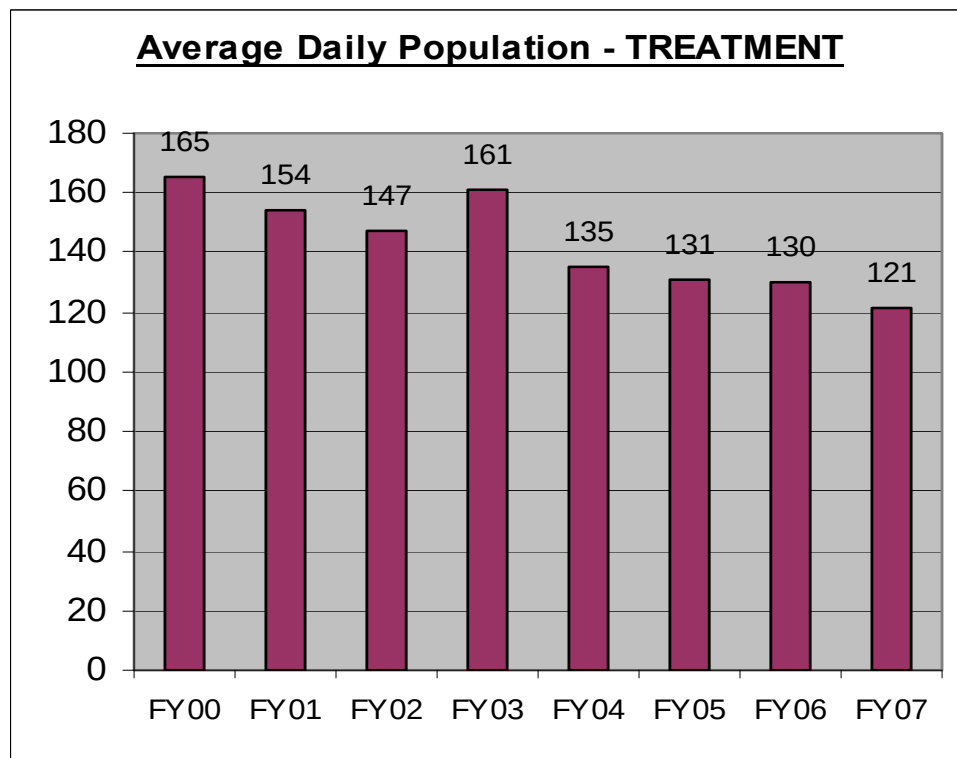
Below are charts showing juvenile detention average daily population and admissions from FY00 through FY07. Detention units are designed as short-term secure units for youth who are awaiting court hearings. Statewide detention capacity in FY07 was 149 beds.

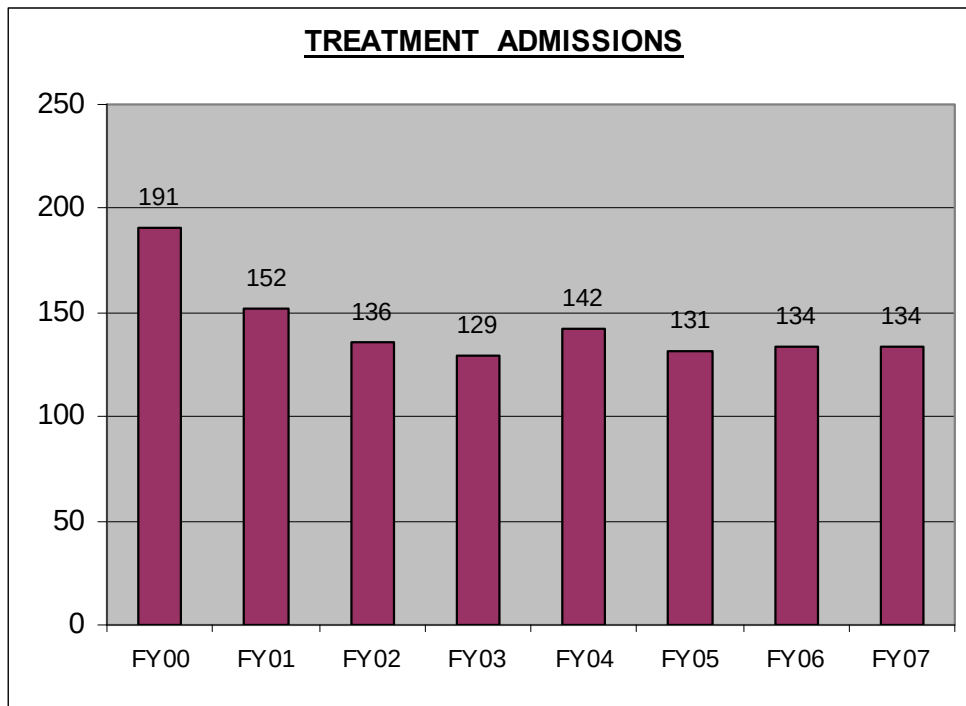




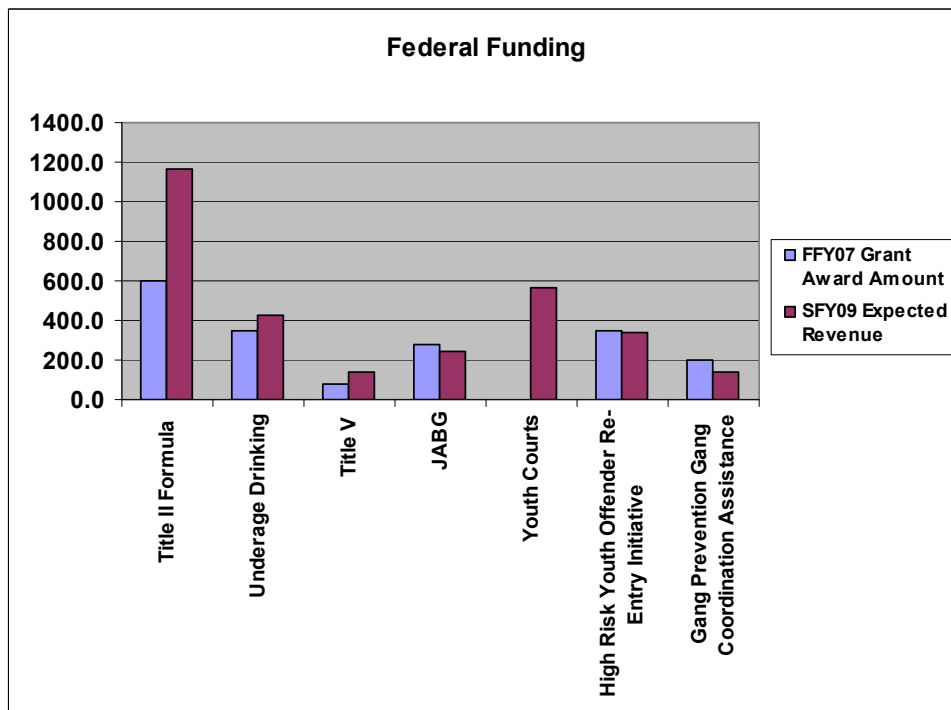
Treatment Units

Below are charts showing juvenile program average daily population and admissions from FY00 through FY07. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY07 was 151, excluding the four unlocked crisis stabilization beds located at the Ketchikan Regional Youth Facility.





The Alaska Juvenile Justice Advisory Committee (AJJAC) serves as the congressionally mandated state advisory group to the division. The committee collaborates with Juvenile Justice in the distribution of federal funds and juvenile justice programming focused on juvenile justice system improvements and assists the division to ensure compliance with the four core mandates of the Juvenile Justice Delinquency Prevention Act. The following chart provides a breakdown of the FFY07 grant programs and budgeted revenues for SFY09. Note that in some cases the budgeted revenue exceeds the award amounts. This is due to a carry forward from previous years of various grant awards.



List of Primary Programs and Statutory Responsibilities

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

Explanation of FY2009 Budget Changes

Juvenile Justice	2008	2009 Gov	08 to 09 Change
General Funds	39,973.5	45,438.6	5,465.1
Federal Funds	3,569.8	3,569.8	0.0
Other Funds	1,184.2	1,194.7	10.5
Total	44,727.5	50,203.1	5,475.6

McLaughlin Youth Center

Safety and Security Funding for Juvenile Justice Facilities: \$1,016.5 General Fund

Authorized youth facility positions have historically not been fully funded based on the assumption that during the course of a year positions will become vacant and budget "savings" will therefore naturally occur. In order to generate the required amount of "savings," vacant positions are held open for a minimum of 30 days. However, juvenile facilities require adequate staffing at all times to keep both the youth and the facility staff safe. Hiring non-permanent staff and requiring permanent staff to work overtime have been necessary in order to maintain adequate staffing levels. This practice has not allowed the division to realize the savings a vacancy factor implies, and may be contributing to staff turnover and further vacancies. The lack of consistent staff during shifts and staff turnover is not conducive to effective treatment. Fully funding all authorized positions would resolve this issue.

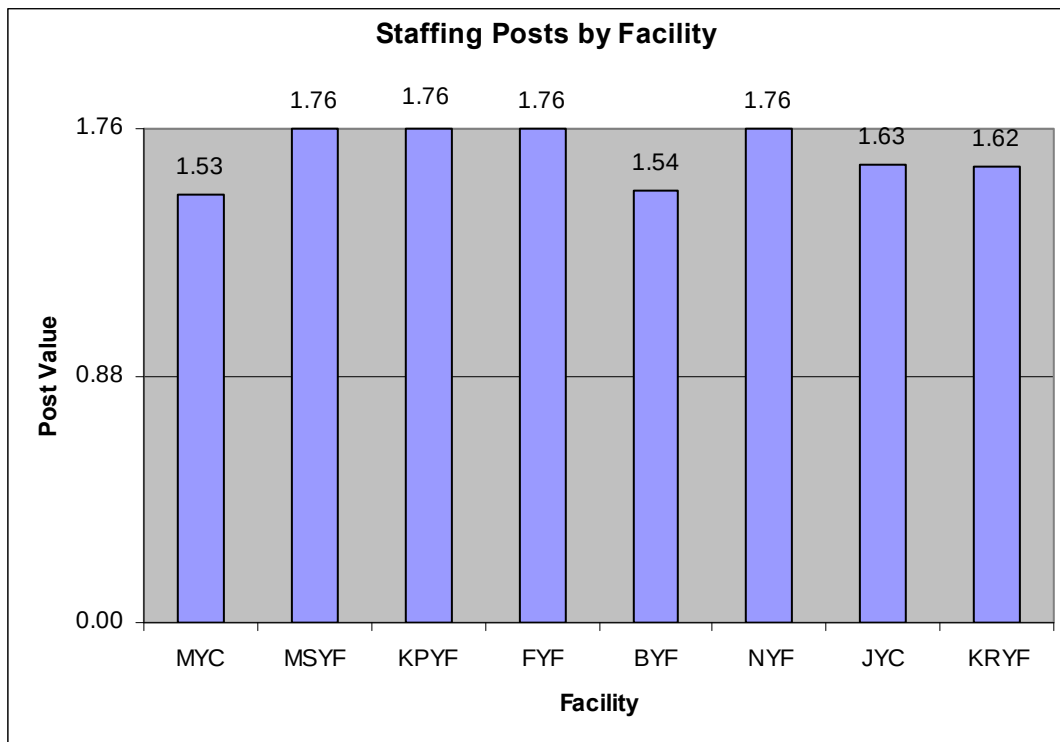
Front Line Staffing at McLaughlin Youth Center: Year 2 of Division Plan \$439.0 General Funds

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, because they lack permanent staff, 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. 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 chart below identifies juvenile justice officer staffing pattern by facility. As can be seen, the McLaughlin Youth Center, the Bethel Youth Facility, the Johnson Youth Center and the Ketchikan Regional Youth Facility are short staff.

The division is in Year 2 of a five-year plan to bring its facilities in line with staffing needs. This year, DJJ is requesting \$439.0 in general funds to support five juvenile justice officers and 1 nurse at the McLaughlin Youth Center.

The McLaughlin Youth Center has far fewer nurses per resident than any other juvenile facility in Alaska. Currently, all youth facilities in Alaska except McLaughlin are staffed with nurses at a rate of one full-time nurse for every 10–20 juveniles. McLaughlin Youth Center, with 165 beds, employs three nurses, resulting in a ratio of one nurse for every 55 juveniles.



Fairbanks Juvenile Treatment Court Support: \$73.5 General Funds

This request includes funding for one specialized Mental Health Juvenile Probation Officer (JPO) located in Fairbanks. See more information under Fairbanks Youth Facility.

This increment request is part of the Division's plan to increase behavioral health services for youth in state custody. It is closely tied to the Trust recommendation for Mental Health Clinicians. Since the Trust did not recommend funding for this position, it was placed in a separate change record.

(Note: As it was split out, this part of the increment should have been pointed to the Fairbanks Youth Facility component.)

MH Trust: Disability Justice – Mental Health Clinical capacity for juveniles in and/or transitioning out of detention: \$477.6 Total \$288.4 GF/Mental Health, \$189.2 MHTAAR

The state of Alaska is responsible for ensuring that the basic health needs of juveniles who are placed within its 24-hour secure institutions are met. These health needs include screening, evaluation and treatment for behavioral health disorders. The Department of Justice has found that constitutionally-mandated, reasonably safe conditions of confinement include the right to adequate medical care, and behavioral health treatment has been identified as part of that medical care. Several states that have not provided basic access to behavioral health services within its 24-hour secure institutions have been found to be in violation of the federal Civil Rights of Institutionalized Individuals Act (CRIPA).

Nationally, the trend to address the behavioral health needs in juvenile detention and treatment facilities is moving in the following two directions: either construction of separate units at secure facilities to treat residents with these problems, or hiring clinical staff to work within existing secure facilities. The latter is the route Juvenile Justice is taking. It is recommended that one Mental Health Clinician (MHC) be on board for every 20 residents. Currently, the McLaughlin Youth Center (MYC) has three MHC positions for the entire facility (165 beds); no MHC for either the Kenai Peninsula Youth Facility (KPYF) or the Mat-Su Youth Facility (MSYF).

The state has a responsibility to ensure appropriate probation services are provided for youth who have behavioral health disorders. Demonstrated best practice indicates that treatment courts are the most appropriate course for many juveniles who have a primary behavioral health disorder, and who have broken the law. The goal of the treatment court is to ensure the youth receives adequate treatment, while at the same time does not violate any conditions of probation, including committing another offense. Juvenile Justice is a key partner with the Alaska Court System and other community stakeholders in the creation of the newly-developing Fairbanks Juvenile Treatment Court, the first juvenile court in Alaska.

Data for FY07 have shown that 46 percent of youth formally involved with the Alaska juvenile justice system had at least one primary behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders. Of those youth, 40 percent also had a co-occurring substance-related disorder. This is consistent with the first juvenile justice behavioral health data, review conducted in 2001. On Oct. 9, 2007, facility data demonstrated that 69 percent of youths, securely confined in either a detention or treatment institution in Alaska, had an existing behavioral health disorder. With 2,186 admissions to secure detention and treatment in 2007, it is imperative that the state fulfill its responsibility to provide adequate access to behavioral health screening, evaluation, treatment and community referral for continued care.

Short-term outcomes are anticipated to include a decrease in the number of episodes of client behavioral management that include the use of physical restraints or room confinement, improved crisis intervention, and a decrease in the length of stay in treatment facilities for youth with DSM-IV diagnoses. Longer-term outcomes of having an appropriate staffing level of Mental Health Clinicians (MHCs) and a specialized Juvenile Treatment Court may include a shorter length of stay in detention, reduced recidivism in the juvenile system and a lowered risk of contact with the adult criminal system.

Transfer out General Fund Authority to Mat-Su Youth Facility

This change record moves authority from McLaughlin Youth Center to the Mat-Su Youth Facility. Beginning in FY08, the RSA with the Alaska Pioneers' Home and the Mat-Su Youth Facility was increased to cover the cost for the use of their equipment to prepare food for residents of the facility. This transfer will help to cover the increase to that RSA.

Mat-Su Youth Facility

Transfer in General Funds from McLaughlin Youth Center: \$21.0 General Funds

This change record reflects the transfer in of general funds from McLaughlin that was discussed above.

Bethel Youth Facility

Front-Line Staffing for Bethel Youth Facility, Year 2 of Division Plan: \$95.0 General Funds

As mentioned earlier with McLaughlin Youth Center budget items, DJJ is in Year 2 of a five-year plan to bring its facilities in line with staffing needs. The funding for Bethel will support one Juvenile Justice Officer.

Nome Youth Facility

Funding for Nome's Operating Costs: \$50.0 General Fund

When the division requested the new positions for Nome (FY06), funding was not requested for the overhead costs associated with the new building and increased costs for food for the additional youth the facility would serve. Overall, the division is short \$150.0 in this component. The division would like to bring this component in line with its needs over a three-year period. In FY09, the division will utilize these needed funds from the contractual line. To date, DJJ has been able to cover these expenses because of vacancies in this component and in other components within the division.

Johnson Youth Center

Front-Line Staffing for Johnson Youth Center, Year 2 of Division Plan: \$70.0 General Funds

As mentioned earlier with McLaughlin Youth Center budget items, DJJ is in Year 2 of a five-year plan to bring its facilities in line with staffing needs. The funding for the Johnson Youth Center in Juneau will support one Juvenile Justice Officer.

Ketchikan Regional Youth Facility

Front-Line Staffing for Ketchikan Regional Youth Facility, Year 2 of Division Plan: \$70.0 General Funds

As mentioned earlier with McLaughlin Youth Center budget items, DJJ is in Year 2 of a five-year plan to bring its facilities in line with staffing needs. The funding for the Ketchikan Regional Youth Facility will support one Juvenile Justice Officer.

Multiple Youth Facilities

General Funds Required Due to the Elimination of ProShare Funding; \$555.4 General Fund

The department has made payments to hospitals and community health care providers for several years under the ProShare program as 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. Without ProShare the same services would have to be funded through grant programs that are funded entirely with general funds.

ProShare funding for Juvenile Justice was initiated in SFY04, when the Division of Medical Assistance (now Health Care Services) proposed an innovative strategy to optimize Medicaid funding through the Private Hospital Proportionate Share program. Juvenile Justice began utilizing ProShare funds in late FY04. Medical costs that would normally have been paid directly to a provider for medical needs were submitted to Providence Hospital for payment. These medical needs included everything from prescriptions, psychiatric evaluations, dental work, to any necessary surgeries or hospital stays.

The general funds saved through refinancing these grants/services were removed from the divisions' budgets and replaced with federal funds in Health Care Services' budget. The Legislature supported this cost containment effort and about \$16 million in general funds was replaced with federal funds in that first year. Since 2004, the state has saved approximately \$36 million in GF through ProShare refinancing.

In 2006 the Centers for Medicare and Medicaid Services (CMS) decided that Alaska's ProShare program was not allowed under federal law, and denied reimbursement for these payments. The department

appealed this decision, and with the agreement of the Legislature, decided to continue the program until the case was resolved. CMS again disallowed the ProShare claim for 2007. On July 31, 2007, the department learned that it had lost its appeal with the U.S. Department of Health and Human Services Department Appeals Board.

The department is committed to continue funding these services at the current level to support its mission to provide health care for Alaskans in need. In order to maintain current service levels, the department is requesting additional GF in the divisions that refinanced grants/services to replace this lost federal money. Juvenile Justice is required by Alaska statute to provide necessary medical services to clients that are housed in our Juvenile Justice facilities (AS 47.12.150, AS 47.14.020).

An increment request has been added to each component. The breakdown is as follows:

McLaughlin Youth Center	\$349.4
Mat-Su Youth Facility	\$25.1
Kenai Peninsula Youth Facility	\$21.4
Fairbanks Youth Facility	\$46.5
Bethel Youth Facility	\$33.9
Nome Youth Facility	\$22.6
Johnson Youth Center	\$38.9
Ketchikan Regional Youth Facility	\$17.6
TOTAL	\$555.4

Transfer in General Funds from Health Care Services / Medicaid Services Due to Elimination of ProShare Financing: \$94.6 General Fund

In SFY 08 a general fund increment of \$4,044.0 was authorized to replace a federal funding reduction in the Medicaid ProShare program. That entire increment was placed in Health Care Services / Medicaid Services component. However, these services are provided by other divisions. This transfer of \$94.6 is necessary to give the division the funding to continue current operations.

Following is a breakdown of the transfers in:

McLaughlin Youth Center	\$45.5
Mat-Su Youth Facility	\$6.0
Kenai Peninsula Youth Facility	\$5.0
Fairbanks Youth Facility	\$11.1
Bethel Youth Facility	\$8.1
Nome Youth Facility	\$5.4
Johnson Youth Center	\$9.3
Ketchikan Regional Youth Facility	\$4.2

Probation Services

Youth Gang and Violence Reduction Project: \$513.1 General Fund

Crime by young people is a top safety and security concern for Alaskans. High-profile shootings have occurred in public places and the number of violent, gun-related, and drug-related crimes involving youth remains unacceptably high. The City of Anchorage has formed a task force to find solutions to the problem. The City of Fairbanks has developed a partnership among local stakeholders to try and head off gangs before they're established in the Interior. Legislators report that, as they meet with their constituents, youth crime in their neighborhoods heads their list of concerns.

It's time for the state of Alaska to provide a more focused response to these concerns. Juvenile Justice proposes implementation of Aggression Replacement Training® for youth displaying signs of bullying, aggression, and violence, as well as those who are fully entrenched in criminal and delinquent behavior. Aggression Replacement Training® is a nationally recognized curriculum for juveniles that has been proven, by research, to be effective in reducing recidivism. The U.S. Office of Juvenile Justice and Delinquency Prevention awarded "Model Program" status to the Aggression Replacement Training®.

In one study, young people in several Brooklyn gangs — without Aggression Replacement Training® services — had four times the number of arrests of similar young gang members who participated in the curriculum (Goldstein, Glick, Carthan, and Blancero, 1994). A major study by the Washington State Institute for Public Policy measured a 24-percent reduction in felony recidivism when Aggression Replacement Training® was delivered according to the standardized model (Barnoski, 2004).

In a 1998 study, Professor Mark A. Cohen of Vanderbilt University found that preventing one teen from adopting a life of crime would save the country between \$1.7 million and \$2.3 million. Aggression Replacement Training® has been proven by research to be cost-effective and save money for crime victims and taxpayers. In the Washington State study (Barnoski, 2004); the cost-benefit analysis demonstrated that when Aggression Replacement Training® is delivered competently, it generates \$11.66 in benefits (avoided crime costs) for each \$1 spent on the program.

The Youth Gang and Violence Reduction Project will provide an effective intervention to reduce gang activities and prevent crime, while providing a cost savings to victims of crime and the general public.

Performance-based Standards Funding: \$115.0 General Fund

All of the facilities will continue to participate in the Performance-based Standards (PbS) program to improve program efficiency and quality. PbS is a critical component of the system improvement project undertaken by the division approximately five years ago, in its movement toward a system based on research, data, and demonstrated best practice. Aside from DJJ's own internal commitment to research-based programs and processes, PbS is consistent with the direction it received from the Legislature regarding research and data-driven decision-making. The division has now been involved with PbS for three years. During that time it has committed extensive staff time and other resources to developing policies consistent with Performance-based Standards, training staff, and implementing procedures in its facilities statewide. In that time, the division also has achieved demonstrable results in data collection and ongoing progress via the Facility Improvement Plan (FIP) process. In determining where to target its efforts in the FIP process, the critical areas of safety and security are considered priorities. Concerns related to rates of resident injuries, physical restraints, suicidal behavior and medical care, for example, are expected to be addressed before other important but less critical areas such as resident education, vocational services, and targeted treatment programs. Climate surveys administered to residents and

staff allows DJJ to identify and focus on areas of concern, such as employee job satisfaction, adequacy of staff training, and staff and resident fear for safety.

Unfortunately, the vendor that provides DJJ access to the PbS program lost its federal funding, so the costs to the clients rose dramatically. Although the increment for funding of the PbS shows up in the Probation Services component, the funding affects all of the facility components.

General Funds Required Due to Decrease in Federal Medicaid Percentage (FMAP) Rate for Targeted Case Management Billing \$32.9 General Funds

This request replaces lost federal revenues resulting from a 1.95-percent decrease in the annual rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008.

Challenges

Recruitment and Retention

Recruitment of professional staff has become a key challenge for the agency. The division's work force is aging, and long-term dedicated staff, many with 20–30 years of quality service, are retiring. 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 inability to compete with salaries offered for similar positions across the country. This has been a significant issue for all rural offices and for some of the more urban areas.

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.

Quality Assurance Staffing

Over the last three years, Juvenile Justice has successfully introduced a number of system improvement initiatives designed to ensure quality service delivery, appropriate resource allocation, and adherence to best-practice standards. The division's system improvement initiatives require data analysis and ongoing integration in operations in order to ensure that the sought-after outcomes of improved public safety, more effective services for juveniles and victims, and more efficient resource allocation are being realized. Without adequate quality assurance oversight, these initiatives will simply result in extra work with no evidence of effectiveness. Worse, Alaskans will not reap the benefits of reduced criminal activity and improved outcomes for juvenile offenders and their victims that can result from these system initiatives. Adequate quality assurance staffing is particularly critical if the division is to expand Aggression Replacement Training® to help prevent and reduce gang activity. The division currently employs only one statewide training coordinator to oversee all of the training needs of the division. It anticipates there will be a need for additional staff to help with this function, particularly if Aggression Replacement Training® is to be performed by community partners.

Facility Maintenance and Office Space Shortages

During this past year, the department commissioned an assessment study to be performed on Juvenile Justice's four oldest facilities. The intent of the study was to identify safety and security breaches within these facilities. Site information for the McLaughlin Youth Center, Bethel Youth Facility, Fairbanks Youth Facility and the Johnson Youth Center was gathered by the contractor during site visits, interviews with the administrators and staff, by reviewing record drawings and studying current mapping and other property descriptions.

McLaughlin Youth Center

McLaughlin Youth Center (MYC) is the state's oldest and largest facility for juvenile incarceration. As such, the staff is able to offer programs, counseling and controlled environments that are not cost-effective in smaller facilities. In this way MYC provides a central resource for the detained and adjudicated youngsters from Southcentral Alaska, as well as specialized services for other regions of the state. Some of the youth housed at MYC are transferred here because of their difficult-to-manage behavior at the smaller facilities that lack staffing for one-on-one supervision. Such an intense group of young offenders requires a particularly high level of health, safety and security precautions to protect the residents, staff and surrounding neighborhood. Specific concerns include: the high rate of adolescent suicides, particularly among those suffering from mental illness; the aggressive behavior of some residents toward staff and other residents; the potential for gang activity and its associated violence among residents; and the constant threat of violent acts against residents outside the fence.

The 40-year-old MYC structures pose the greatest safety threat; the structures are simply worn out and need significant upgrade. In some cases security components do not consistently lock cell doors, release emergency exit doors, or view isolated corners. There are cases where pipes and light fixtures are accessible to residents who could tie off clothing or sheets and hurt themselves. Some of the oldest housing units are not able to maintain temperatures that are habitable in the winter or at temperatures below 90° F in the summer. In these same units, raw sewage regularly backs up and floods the area, which is extremely unhealthy.

For the first 30 years, MYC served the state without a perimeter fence. It was felt the risk of flight was less serious than the emotional impact of committing children to live within a secure compound. Gradually the community has expanded to surround the MYC campus. This encroachment, coupled with the increase in violence and severe mental health issues facing our youth, required greater security. Ultimately the 12-foot-tall security fence was installed. The fence system was designed to enclose and secure the obvious and major escape routes. The fence has fulfilled its intended purpose. However, there continues to be a number of key locations that need enhancements to the original system, to prevent potentially dangerous individuals from escaping into the surrounding neighborhoods and campuses.

The staff working at the McLaughlin Youth Center has a deep and finely honed understanding of adolescent behavior. This resource, coupled with the well-developed programs available at MYC, provides a solid platform for other organizations and departments to offer their services on the MYC campus. These programs are provided daily at MYC to non-adjudicated youngsters. Providing non-adjudicated youth counseling and direction is definitely providing the community with a critically needed service. Unfortunately, there are influences brought onto the campus by youths who are outside the system most of the day and who introduce contraband materials and a host of problems onto the secure campus. In addition to drugs, a pistol was recently found hidden in a space that is accessible to residents. This serious security breach clearly must be curtailed. Establishment of a new structure outside the secure perimeter at MYC for these services is recommended. The Juvenile Justice Center would be occupied by programs delivered in conjunction with nonprofit agencies, such as the Boys and Girls Club, the Anchorage School District, and other McLaughlin Youth Center programs, for counseling after probation.

Below: This photo shows a recent leak on one of the detention units. This type of occurrence is not uncommon.



Above: This is a photograph of a shared Probation office. There is very little room for staff. Meeting with clients and families is difficult.

Johnson Youth Center

The Johnson Youth Center (JYC) is the largest and oldest of southeast Alaska's youth facilities. Programs offered at the JYC include detention, treatment and probation services. The detention program is provided for up to eight boys and girls. Boys are the principle residents with girls making up a small percentage of the population. Typically, girls with longer detention stays are transported to Anchorage and held in the MYC facility. JYC also provides a 22-resident treatment program for boys.

As with those in all Alaska's youth facilities, JYC's residents demonstrate a significant level of mental health concerns and issues. Violent, aggressive behavior among residents increases the threat of physical violence against staff and other residents. Southeast Alaska also is plagued with a high level of adjudicated youngsters with substance abuse problems, again leading to more seemingly irrational and often aggressive behavior toward the residents and staff.

The current structures on the JYC campus are an eclectic mix of old and new. They include an adaptive reuse of a former adult female jail/prison that was built in the late 1960s, a program building that was constructed 15 years ago, and a recently constructed treatment living facility. The program and treatment facilities are serving the population well and with few exceptions provide safe and secure environments for the clients and programs they house.

The detention unit building does not support its mission and poses the root of the facility's safety and security concerns. The building that houses the detention program also provides office space for probation offices, police admissions and the JYC campus administration offices. The semi-secure

administration and probation spaces are utilized above their capacity, in violation of building code and occupancy requirements.

The secure detention areas are divided into multiple incongruous rooms and spaces, creating an awkward separation of the eight resident cells and two dayrooms. This leads to an inordinate amount of time spent monitoring and checking on resident location, instead of mentoring and counseling youth. The detention building also is poorly designed to withstand the abuse to which it is routinely subjected by residents. The large cell windows are not glazed with appropriate security glass, and the single doors leading from the secure unit to the yards and offices are secured with commercial grade doors and locks without the recommended sally ports. In sum, the detention unit is clearly not adequately secured for the current population.

The facility's perimeter security system does not adequately assist staff in monitoring arrivals and departures from the facility; the security system provides virtually no assistance in preventing escapes, altercations among residents, or in controlling the introduction of contraband into the facility. The Johnson Youth Center is clearly in need of an extensive renovated detention unit and an upgrade to the perimeter security system.

Right: The hallway that leads to the second unit presents a security threat to staff and residents because of a blocked line of site.



Above: Staff has an obstructed view from the control station into the day room. This puts staff as well as residents at risk for assaults. It also creates opportunities for residents to engage in illicit behaviors.

Bethel Youth Facility

The Bethel Youth Facility (BYF) provides western Alaska with an 18-bed detention and treatment facility, and houses the region's probation offices. The existing building was constructed in 1984–1985 and the division assumed occupancy in 1988. The 20+-year-old facility serves the City of Bethel and 56 surrounding villages (Yukon-Kuskokwim area).

The majority of the residents at the Bethel Youth Facility suffer from some level of mental health and/or socialization issues. The rate of serious crime among juveniles in the Yukon-Kuskokwim area is not disproportionately higher than other regions of the state. Historically the facility has housed offenders with a wide range of offenses, including murder, assault, and kidnapping charges. The level of the physical security systems and barriers must be adequate to keep these offenders contained within the building. The departmental assessment of this facility, conducted this year, revealed several weaknesses in containment that need to be addressed, to improve both the holding capability of the security lines and internal safety within the facility.

BYF capacity is inadequate to meet the needs of both staff and residents. Multiple probation officers share the same space and have difficulty meeting the expectations for private and confidential management of client, victim, and family information. The detention program experiences frequent and severe overcrowding of residents. In previous years as many as 22 residents were frequently occupying the eight-bed detention facility. While this overcrowding has recently been alleviated by transporting residents to other facilities with available room, this approach does not represent a cost-effective, long-term solution to client management.

Detention and treatment are managed from one centralized and enclosed control room. The spaces are separated by an island containing two holding cells that are accessible from either program or toilet/shower facilities.

The detention unit has steel doors and security locks with lock-down capabilities, but the treatment unit has hotel-style locking wood doors with commercial locks. There is little acoustic separation between the spaces. Therefore, little separation between the detention and treatment programs exists. Large cell windows are not security glazed. There are few interlocking doors to close off direct access from program areas to unprotected free space.

The Bethel Youth Facility site is negatively affected by closely surrounding structures. The adult prison shares the southern property line with BYF. A children's receiving home, operated by Kuskokwim Emergency Youth Services (YKHC), is less than 30 feet away from the treatment unit, along the north property line. There is no fence defining the property boundary; casual trespassing onto the well-cared-for BYF grounds is common. Visual access onto the site is unimpeded and conformance to child protection and confidentiality requirements are difficult to provide since the only outdoor recreation area is in full view of these neighboring facilities.

The Bethel Youth Facility is in serious need of additional detention housing, increased perimeter security and adequate space for probation services.



Left: This is a photo of a two-person probation office in Bethel.

Right: 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.



Fairbanks Youth Facility

The Fairbanks Youth Facility (FYF) serves as Alaska's northern and interior youth facility. The facility's capacity is for 42 residents in its detention and treatment units. The facility was constructed and expanded in several increments, beginning in the 1970s with the current treatment wing. In the 1980s, the current detention unit was constructed; the new gymnasium and program space were added in 2002.

Mental health and socialization issues plague many of the facility's residents, resulting in impulsive, irrational behavior requiring intensive staff involvement. Residents that require continuous and precisely dosed psychotropic medications, as well as constant individualized counseling and attention, limit the attention other residents are able to receive. Even with these interventions, disruptions, violent outbursts and aggressive behaviors are common, placing staff and other residents at risk of physical injury.

The 20-bed male treatment unit occupies a portion of the building that originally held the secure detention unit. The current configuration of space is difficult to monitor and manage, since the program is divided into two areas: an eight-cell secure room with wet cells (contains toilet fixtures), and a 13-room free egress space that has dry cells (no toilet fixtures). The mixture of living conditions and separation of space makes the unit difficult to supervise. This condition becomes particularly dangerous due to the free egress on one side of the unit.

The 22-bed detention unit is located in a two-tier space that offers good visual access from the staff workstation. However, the space is inadequate. The unit was constructed in the 1970s when the predominant point of view was for staff to be stationed in a secure control room. Juvenile justice experts since the 1980s have advised that residents are more secure and safely served when staff is stationed with them in the day room. To accommodate this approach, the workstation has been precariously positioned at the top of the dayroom stairs, outside of the currently unused control room. This arrangement still falls short of expectations and need for adequate monitoring and counseling of juveniles.

The FYF currently has no campus-wide enclosed fence, and casual trespassing occurs on a regular basis. This open campus condition led to an event that could have proved tragic when several young men walked up to the detention unit with the intent of burning through the security glazed window with a torch. Fortunately, the security glazing withstood the attack and the offenders were prosecuted. Containment of the facility with perimeter fencing would eliminate such activity, and reduce escapes and the introduction of contraband on the site.

Portions of the 2002/2003 gymnasium and classroom project were never completed due to unexpected contractor cost overruns. Nevertheless, the secure outdoor recreation yard and expansion of the staff and visitor parking lots, which were supposed to be completed, are clearly needed to support the program, keep fire lanes clear of obstructing vehicles, and conform to industry standards for the minimum recommended sizes for outdoor activity space.

The intake area of the facility is not secure, well-lit, covered or heated. An arresting officer is required to escort the arrestee through a narrow passage between a secured yard and the building to the intake door. This winding walkway is clearly not secure and does not provide the officer with safe accommodations. With Fairbanks' long cold winters, providing an interior vehicle sally port is an important safety measure.

There is currently no secure screening station in the facility. Weapons or contraband items could easily be carried into the facility by visitors. By establishing a secure screening area, all visitors could be met, interviewed, checked through a metal detector and directed to their contact person in a safe and controlled environment that is outside the security line.

The Fairbanks Youth Facility is clearly in need of an infrastructure upgrade to improve the safety of those living and working in the building. The improvements described in this report would lead to improvements in the level of care, service, safety, and security for staff, residents, and visitors.

Right: This is a door that leads directly from the detention unit to the outside. It is never opened, but if it gets opened inadvertently, the lack of a fence could free the entire unit.



Below: This is a photograph of the nurse's office, which also doubles as an examination room.



Right: This photograph depicts unmonitored and underutilized front entrance area.



the

Performance Measures — Division of Juvenile Justice

Contribution to Department's Mission

Provide a comprehensive array of services for juveniles who have committed delinquent offenses, beginning at the point that law enforcement officers identify or apprehend juvenile offenders.

Core Services

Address juvenile crime by promoting accountability, public safety and skill development.

Department Level Measures

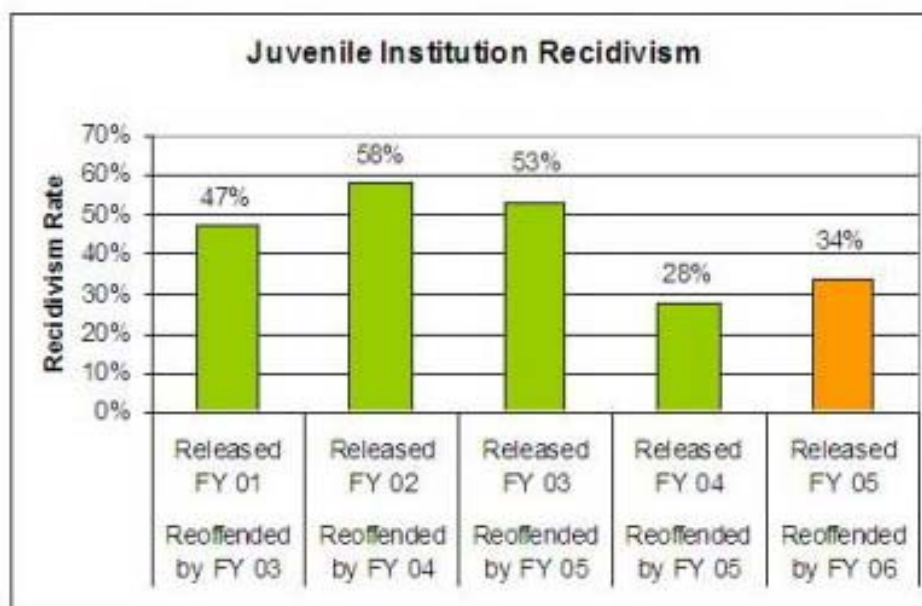
E: Result — Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 33 percent.

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

Facility	Number released in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Bethel Youth Facility	9	4	44%
Fairbanks Youth Facility	18	8	44%
Johnson Youth Center	10	3	30%
McLaughlin Youth Center	66	20	30%
Total	103	35	34%

Race	Number released in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Caucasian	39	12	31%
African American	4	1	25%
Native Alaskan/American Indian	37	16	43%
Asian	3	1	33%
Pacific Islander	1	0	0%
Multiple Races	18	5	28%
Other	1	0	0%
Total	103	35	34%



Analysis of results and challenges: The recidivism rate for juveniles released from Alaska's secure treatment institutions was increased slightly this year. The increase may not be significant; the small number of youth released from these institutions each year make it difficult to determine whether changes in the recidivism rate from year to year are part of a trend or an anomaly. The change in recidivism rate for this population also may be due to the fact that, for the first time, this information was gathered and analyzed at the division director's office using the statewide Juvenile Offender Management Information System (JOMIS) instead of being submitted by individual facilities. Researching this measure at the statewide level ensured consistent application of the definitions that determine whether juveniles should be included in this measure, and whether or not they had committed re-offenses.

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 states more chronic and serious juvenile offenders compared with youth who receive only 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.

Recidivism among juveniles released in FY04 and FY05 is defined as re-offenses that occurred within a 12-month window. For youth released prior to these years, recidivism had to occur within 24 months. This change likely explains the demonstrated drop in recidivism for youth released in FY04 and FY05 compared with youth released in prior years; youth released later had a smaller window of time in which to re-offend. 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 (eight states, including Alaska), the average recidivism rate was 33 percent. Alaska, at a 34-percent rate, closely reflects 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 assessment tools, both for juveniles and the facilities that house them, that 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.

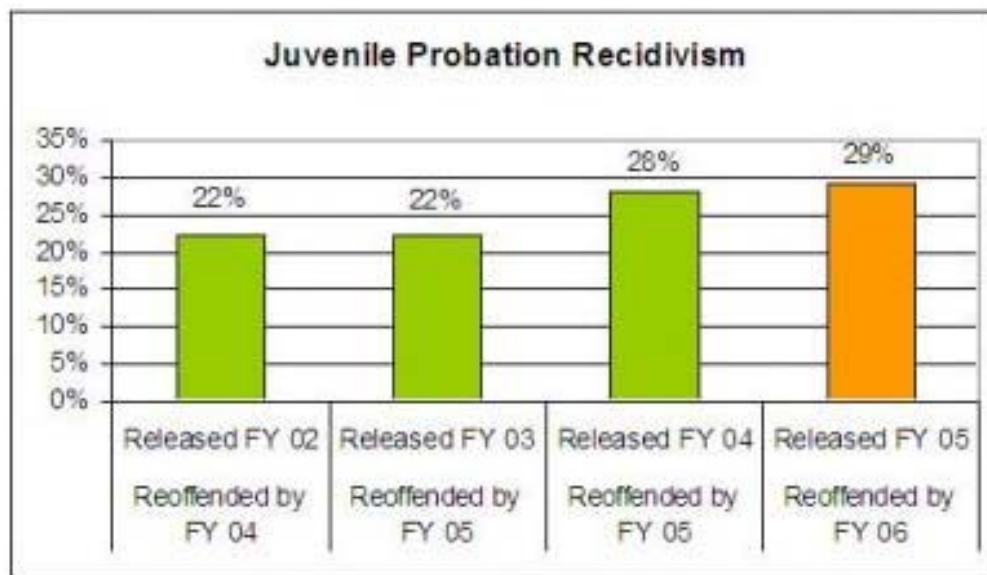
Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in Juvenile Justice's database and the Alaska Public Safety Information Network. Juveniles are included in this measure if the reason for their release from the treatment facility is marked in JOMIS as "Completion of Treatment," "Sentence Served," "Court-Ordered Release," "Transfer to a Non-DJJ Facility," "Order Expired," or "Transfer (Transitional Services Step Down)." Re-offenses are defined as: any offenses that occurred within 12 months of release and that resulted in a new juvenile adjudication or adult conviction, or a probation violation resulting in a new institutionalization order, by Aug. 1, 2007. Adjudications and convictions for motor vehicle, Fish and Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

Target #2: Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 33 percent.

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

Region	Number of offenders released from formal probation in FY 05	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Anchorage	99	27	27%
Northern Region	107	34	32%
Southcentral Region	80	22	28%
Southeast Region	42	12	29%
Total	328	95	29%

Race	Number released from formal probation in FY 05	Number of Reoffenders 12 months after release	Percentage of offenders who reoffended
Asian	11	3	27%
African-American	13	4	31%
Multi-race	36	5	14%
Alaska Native/American Indian	130	47	36%
Pacific Islander	5	2	40%
Other	2	1	50%
Caucasian	131	33	25%
Total	328	95	29%



Analysis of results and challenges: The defined recidivism rate for this population was 29 percent, a small and likely insignificant increase compared with the previous year's rate.

FY07 was the second year that recidivism was defined as a re-offense that occurred within 12 months from the time offenders were released from formal probation. In years prior to FY06, re-offenses were counted if they occurred within 24 months of release from formal probation. The change to a 12-month window was made to better align Alaska with other states' definitions of recidivism. 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 FY04 and FY05 is likely 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.

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. (Recidivism rates for institutionalized youth are analyzed in a separate performance measure, above, and are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.)

Sixteen of the 32 states reported to 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 (eight states), the average recidivism rate was 33 percent. Alaska, at a 29-percent rate for its probation population, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

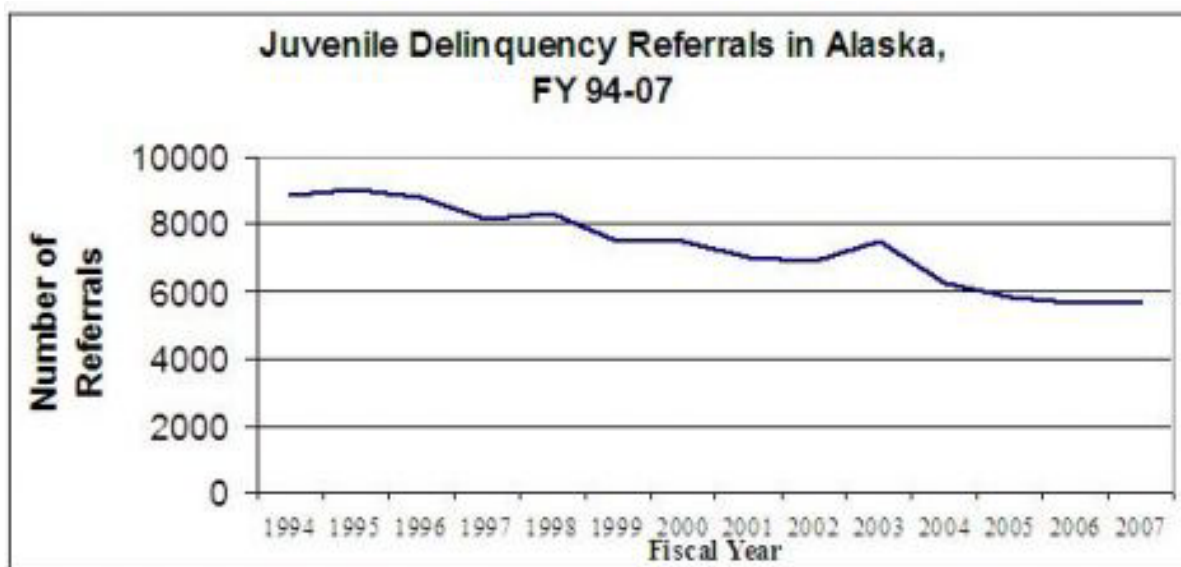
Re-offenses, like the original offenses that brought the juveniles to the division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence 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. Youth also are not included who have been reassigned to a formal probation order (with or without custody) within seven days of release, as this typically reflects a modification of probation status or custodial placement rather than true completion of supervision. This analysis also excludes youth who were ordered to an Alaska treatment institution anytime prior to their supervision end date, as these youth are included in the analysis for our institutional recidivism performance measure, above. Adjudications and convictions for Motor Vehicle, Fish and 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 probation end date in FY 2005, and the offense must have resulted in an adult conviction or new juvenile adjudication by Aug. 1, 2007.

Target #3: Alaska's juvenile crime rate will be reduced by 5 percent over a two-year period.

Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



Target Fiscal Year	2004		2005		2006		2007	
Number of Referrals per 100,000 population aged 10-17	6893		6512		6345		6490	
Comparison Year	2002	2003	2003	2004	2004	2005	2005	2006
Percentage Increase (or Decrease) between Target Year and Comparison Year	(10.5%)	(16.7%)	(21.3%)	(5.5%)	(8.0%)	(2.6%)	(0.3%)	2.3%

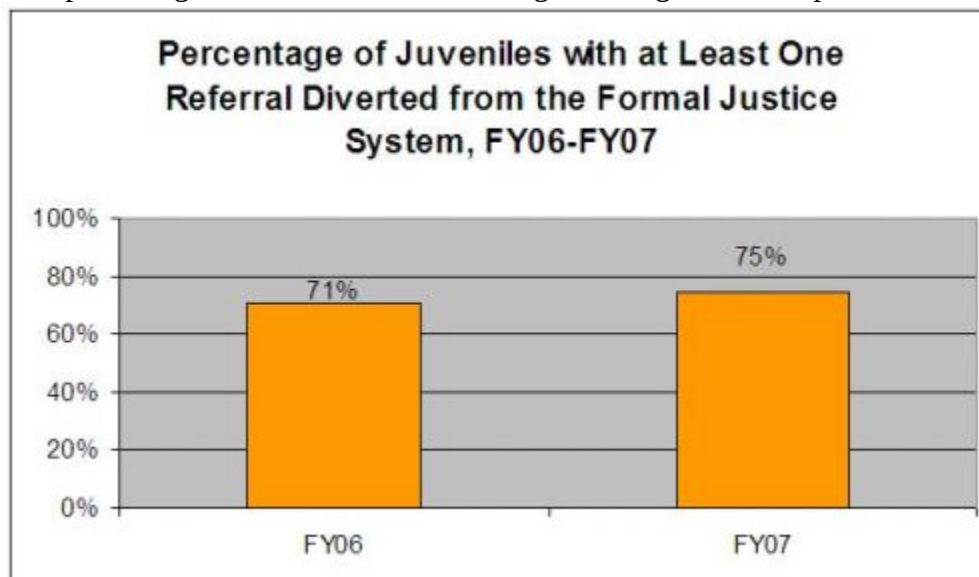
Region	Office	Juveniles	Percent of State	Referrals	Percent of State	Charges	Percent of State
Anch.	Anchorage	1,537	40%	2,200	39%	3,532	36%
NRO	Barrow	128	3%	230	4%	318	3%
	Bethel	202	5%	290	5%	602	6%
	Fairbanks	428	11%	592	10%	1026	10%
	Kotzebue	86	2%	136	2%	245	2%
	Nome	126	3%	242	4%	452	5%
	NRO Total	970	25%	1,490	26%	2,643	27%
SCRO	Dillingham	66	2%	91	2%	147	1%
	Homer	45	1%	61	1%	82	1%
	Kenai	286	7%	384	7%	695	7%
	Kodiak	95	2%	160	3%	241	2%
	Mat-Su	368	9%	467	8%	900	9%
	Valdez	54	1%	81	1%	179	2%
	SCRO Total	914	24%	1244	22%	2244	23%

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population were virtually unchanged in FY07 compared with FY06, with a slight but insignificant increase in both measures noted. 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 for youth 10–17 during the years 2003–2006 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2007 was derived from the report Alaska Population Projections 2007–2030, published by the Alaska Department of Labor and Workforce Development. Juvenile referral data were extracted from Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database by Aug. 10, 2007, and includes referrals for youth who are under 10 years old (these referrals make up less than 1 percent of the total). These data are continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70 percent 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 FY07 the proportion of juveniles with at least one referral (a report from law enforcement alleging a juvenile perpetrator) who were diverted from the formal court process remained high, at 75 percent. This means that 2,891 of the 3,876 juveniles referred in FY07 had one of those cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed. The percentage increased compared with FY06 results, but because this is only the second time the division has considered this measure, the improvement may be due to refinements in our record-keeping, data-gathering and analysis.

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 handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to it. Diversion also is considerably less expensive and faster than the formal adversarial process. Diversion processes reduce 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 referrals resulted in at least one referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Referrals that are screened and referred elsewhere, such as back to law enforcement for further information, and those that were still in process at the time these data were collected, are excluded from consideration. These data are continually refined and corrected and numbers in future reports may change slightly.

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 percent 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
2005	\$70,911.28	\$69,343.23	97%	100%
2006	\$58,576.80	\$55,821.90	95%	100%
2007	\$92,785.90	\$83,158.30	90%	100%

Amount completed is amount at case closure.

Analysis of results and challenges: While the percentage of restitution completed at case closure appears to have decreased between FY06 and FY07, the overall amount of restitution recorded as requested and paid increased, indicating that division staff are doing a thorough job of entering restitution information in the division's Juvenile Offender Management Information System (JOMIS). FY07 marked the first full year that staff has used JOMIS to record restitution information. It is believed that this change has resulted in more thorough and accurate reporting of restitution than in years past. The percentage collected indicates that the Division of Juvenile Justice (DJJ) staff continues to demonstrate a high degree of effectiveness in collecting restitution payments.

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 FY06 and FY07. Since Jan. 1, 2002, restitution payments by juveniles who are adjudicated formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections and Support Unit, and those restitution payments are also not included in this analysis.

Note: FY06 and FY07 data for this measure were retrieved from the JOMIS report, "Statewide Summary Restitution Report," on Aug. 13, 2007. These data are continually refined and corrected and numbers in future reports may change slightly.

Target #2: Improve the amount of community work service performed by juvenile offenders to 100 percent 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	Hours Ordered	Hours Completed	Percentage	Goal
FY 2005	34,167	30,642	90%	100%
FY 2006	35,059	28,730	81%	100%
FY 2007	32,141	25,979	81%	100%

Hours completed are at closure of service record.

Analysis of results and challenges: The percentage of community work service completed compared to what was ordered held steady through FY07, the second full year that the division tracked this measure through its Juvenile Offender Management Information System. This is an encouraging finding because it indicates that the data entry procedures for staff are being used consistently, and that the division can next devote its attention to improving community work service completion rates.

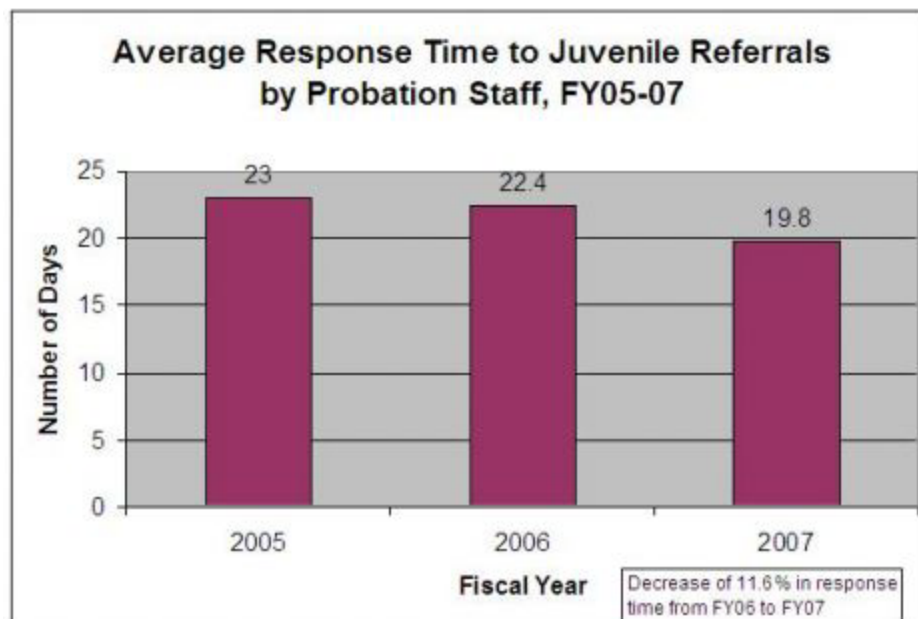
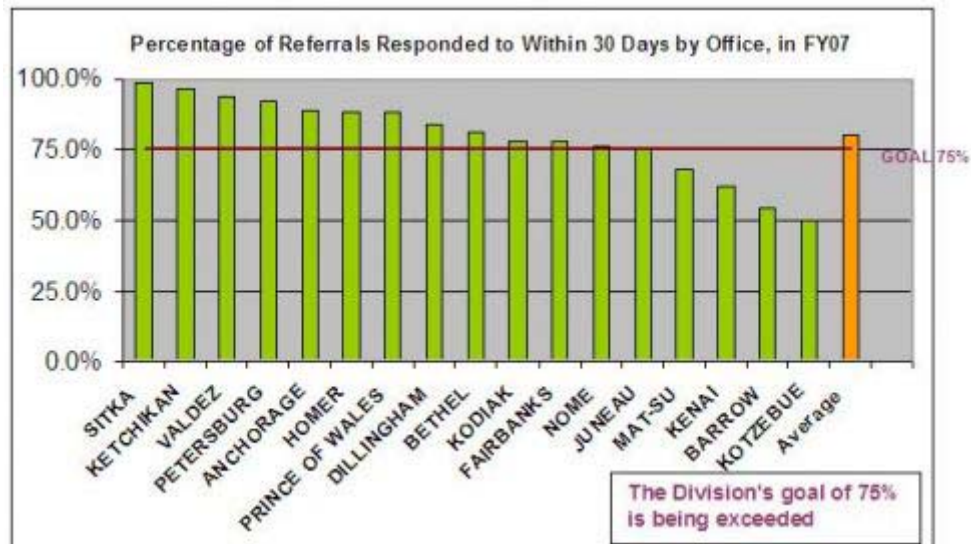
Like restitution, community work service is a way for juveniles to repair harm caused to those impacted by juvenile crime. The record of community work service must have been closed in the target fiscal year to be included in this measure. Community work service ordered both through formal, court-ordered processes or informal processes directed by a juvenile probation officer are included in this measure. Community work service ordered through youth courts or other alternative justice processes are not included.

Note: Data for this measure for FY06 and FY07 were retrieved from the JOMIS report, "Statewide Summary Community Work Service Report," on Aug. 13, 2007. These data are continually refined and corrected and numbers in future reports may change slightly.

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.

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.



Statewide Average for Last Three Fiscal Years

Year	Average	Target
2005	76%	75%
2006	78%	75%
2007	80%	75%

Over the last three years, the division has exceeded the goal of 75 percent and has continuously improved.

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 was 80 percent, exceeding the goal of 75 percent. The second chart illustrates the average number of days it took to actually respond to all referrals. The average response time in FY07 was 19.8 days, an improvement from prior years. Response time information is provided through 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 forwarding it 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).

A2: Strategy — Strategy 1b: Improve the satisfaction of victims of juvenile crime.

Target #1: In FY07 the division will 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 was successful in meeting this qualitative goal this year, thanks to close collaboration with the department's Information Technology Section. By the end of FY07 several hundred surveys had been generated through an application that interfaced with the division's Juvenile Offender Management Information System, and these were distributed to recent victims of juvenile crime. The surveys were sent out so late in the fiscal year that less than 15 were returned by fiscal year end. During FY08, we will review all surveys and gather information from them to help us gain better perspectives.

The survey is designed as a tri-fold mailing that can be completed on paper and returned to the division Director's Office, or that can be completed online. The division's goals for FY08 will be to refine and improve the application that generates this survey, and to generate at least 100 responses. The responses should provide a clear understanding of victim perceptions of the division and its success in helping them recover from the damage caused by juvenile crime.

A3: Strategy — Improve the division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the Division of Juvenile Justice (DJJ) field probation policy and procedure manual.

Target #1: Juvenile Probation Officers will achieve an average of 95-percent compliance with all probation audit standards for each one-year period measured.

Measure #1: Average percent of all probation audit standards met by probation officers over the course of the fiscal year.

Juvenile Probation Region	# of Officers Audited	Average Audit Compliance Rate	Goal
Anchorage	26	97.1%	95%
Southcentral	18	93.3%	95%
Southeast	11	96.2%	95%
Northern	16	91.5%	95%
TOTAL	71	95%	95%

Note: 95 percent in the middle column above represents the overall audit compliance rate for officers audited, rather than the average of the four regional averages.

Average Compliance Rate for Last Three Fiscal Years

Year	Average	Target
2005	95%	95%
2006	95%	95%
2007	95%	95%

The division continues to meet the 95-percent target.

Analysis of results and challenges: The data indicate that juvenile probation officers have been successful in meeting the goal of 95-percent audit compliance. This measure monitors the division's success in achieving compliance with casework expectations for juvenile probation officers as specified in the DJJ Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload were conducted on a quarterly or trimester basis. (The division adopted a policy to conduct audits on a trimester basis partway through the year.) A representative sample of each officer's caseload is audited, and the results 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. The division is continuing to examine 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

To promote self-sufficiency and provide for basic living expenses to Alaskans in need.

Introduction

The Division of Public Assistance (DPA) provides temporary economic support to needy families; financial assistance to elderly, blind and disabled individuals; food support and nutrition education; medical benefits; and supportive services that enable and encourage Alaskans to pursue economic independence and self-sufficiency.

Core Services

Division staff determines eligibility for benefits and makes services available through a variety of programs that are intended to help Alaskans remain safe and healthy, prevent dependency and provide support for clients as they obtain employment. Public Assistance programs offer:

- Temporary financial assistance to help low-income Alaska families with children meet basic needs and to encourage family self sufficiency and stability by planning for self-support through employment.
- Employment assistance to promote self-sufficiency.
- Financial and medical assistance to elderly, blind, or disabled Alaskans incapable of self-sufficiency to help meet basic needs and remain as independent as possible in the community.
- Food support and nutrition education to improve health outcomes, and to decrease food insecurity and obesity.
- Help in paying for home heating costs.
- Child care subsidies to families who need child care in order to work or participate in approved work or training activities.
- Licensed child care providers to promote safety and quality of child care in Alaska.
- Access to health care by determining eligibility for Medicaid, Denali KidCare, and Chronic and Acute Medical Assistance.

To qualify for public assistance, individuals must have income below certain levels and also meet a number of specific eligibility requirements that vary by program.

DPA provides direct customer services in 17 offices statewide. In FY07, the division provided cash, food, and medical benefits and services to over 94,000 Alaskan households and 155,000 individuals.

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 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 3,400 families throughout the state. This assistance is limited to 60 months as a temporary safety net to help families care for 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 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.

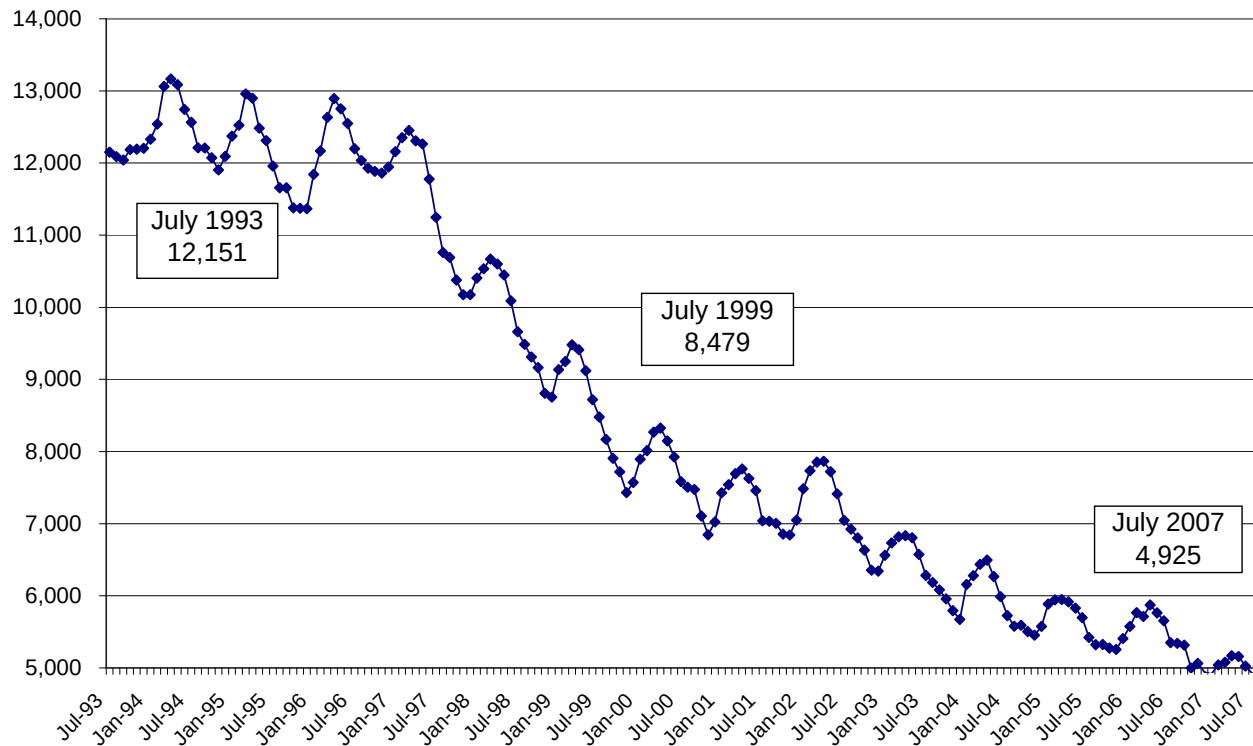
Tribal Assistance Programs

Federal law allows tribes and Alaska regional Native nonprofit 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 is 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 Native Family Assistance programs must be comparable to the state's program, they 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 1,800 Alaska 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).

ATAP/ NFAP Temporary Assistance Caseload FY93-FY07



Eleven years of welfare reform has resulted in thousands of Alaskans achieving economic self-sufficiency through employment, and the number of families receiving Temporary Assistance in Alaska is still declining. The annual monthly average state and Native Temporary Assistance caseloads have decreased by 59% between FY 07 and FY 94, and have generated almost \$80 million in savings since FY 97.

Child Care Benefits

The Child Care Assistance program has been in existence for more than 30 years. Initially administered by the Department of Community and Regional Affairs, it was moved to the Department of Education and Early Development in 2001, and to the Department of Health and Social Services in 2003.

Providing access to child care is a key component in the state's efforts to help families 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;
- oversight and 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 work and move toward economic 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 work force 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.

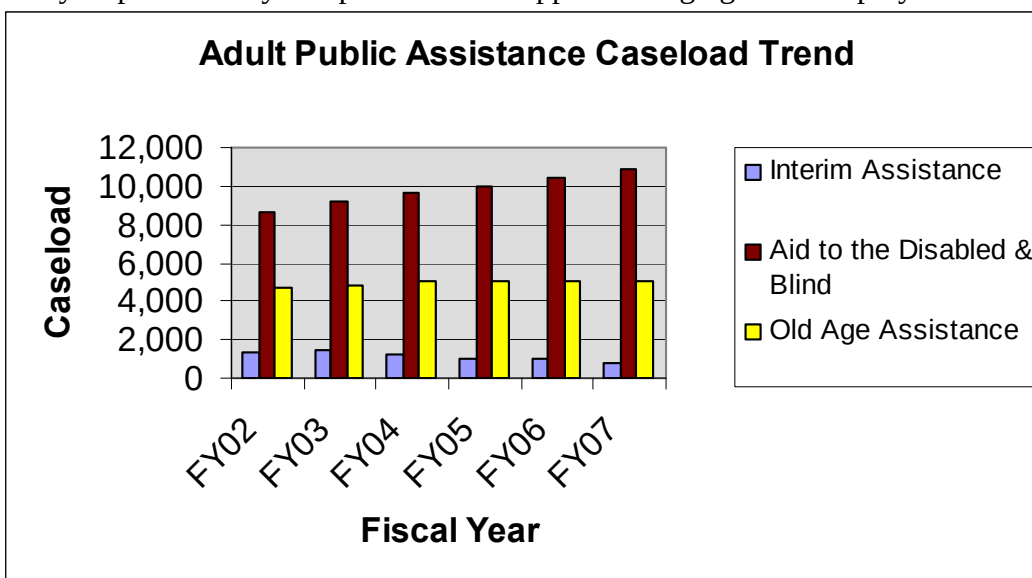
Work Services includes activities and support systems that not only prepare clients to enter the work force, but help them to retain jobs, advance and succeed. Work Services also provides wage subsidies to employers who create new jobs and hire recipients to fill them. The majority of Work Services is 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. Grants and contracts are issued to nonprofit and for-profit organizations, private sector businesses, and Native regional nonprofit organizations to assist recipients in their communities to move from welfare to work.

Adult Public Assistance

The Adult Public Assistance (APA) program provides financial assistance and access to medical care for 5,000 elderly and 11,700 disabled Alaskans. 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. An individual must have low income and be over age 64, or at least 18 years of age and blind or diagnosed by a physician as permanently disabled or terminally ill. APA benefits help many Alaskans avert problems such as homelessness and avoid higher cost settings such as hospitals and nursing homes.

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. To qualify for SSI, a person's mental or physical limitations must be severe enough to make him or her temporarily or permanently incapable of self-support through gainful employment. In FY 04, DPA

implemented a rigorous medical review process to determine if a person will likely meet the SSI disability criteria. This change has slowed the rate of growth of the Interim Assistance caseload and resulted in significant cost containment savings.

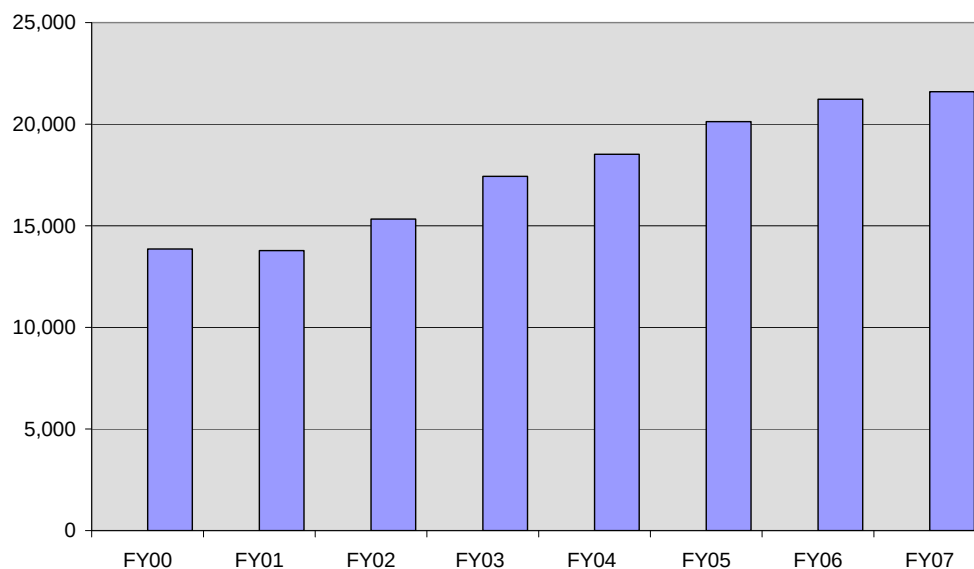


Food Stamp Program

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, and may use the card 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 remote communities receive 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,

while costs for the administration of the program are equally shared by the state and federal government. The Food Stamp caseload has been steadily growing. In FFY 2007, the program served almost 22,000 low-income households with about \$7.4 million of food stamp benefits each month.

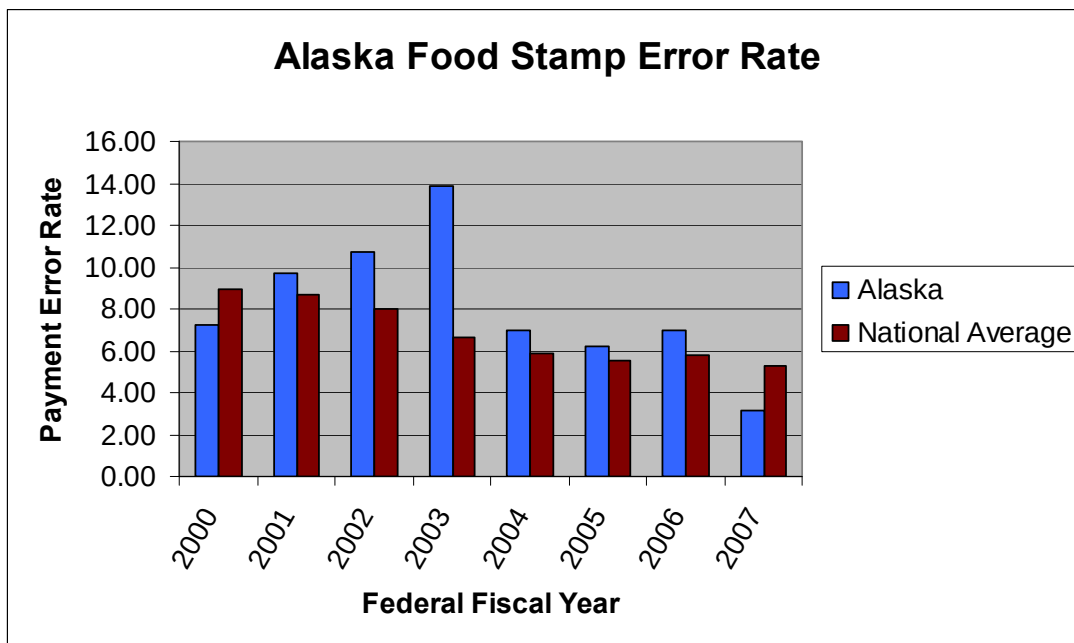
Food Stamp Caseload



Quality Control

The division conducts rigorous quality control case reviews to ensure the accuracy of individual eligibility and benefit payment decisions. The quality assessment effort helps the division focus on work quality, improved performance outcomes and program accountability. This is a mandated activity for the Food Stamp and Medicaid programs. States can receive Food Stamp program performance bonuses for superior performance and financial penalties for poor results.

In 2003 Alaska was identified as having a food stamp payment error rate of more than 14 percent, the worst in the nation. The division's Food Stamp Program Payment Accuracy campaign and emphasis on work quality has shown significant results.



(2007 = Preliminary Average)

The division also conducts regular payment accuracy reviews for the Alaska Temporary Assistance program, and, in FY 08, will begin conducting accuracy reviews of Child Care Assistance determinations.

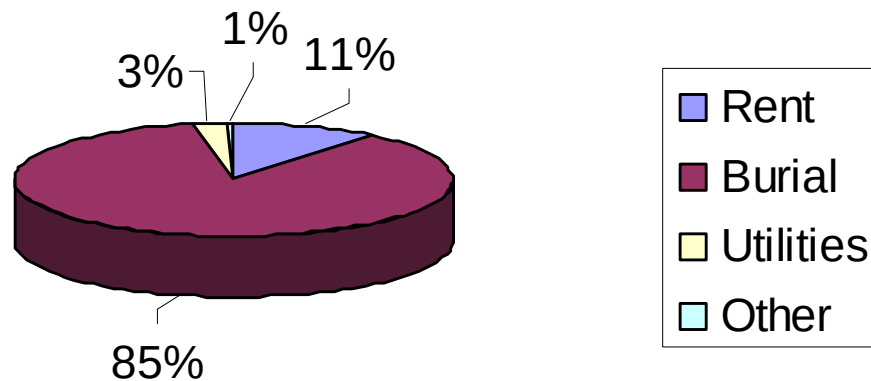
Fraud Control

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 FY07 the unit investigated nearly 1,200 cases of alleged fraud.

General Relief Assistance

Alaska's General Relief Assistance (GRA) program is a safety net program for very low-income individuals who lack the 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. Eighty-five percent of GRA program expenditures are used to pay for funeral and burial expenses of indigent deceased individuals. The remainder is used to meet emergency shelter, food and clothing needs.

FY2007 General Relief Assistance Expenditures



In FY 2007 the program covered burial expenses for 520 deceased individuals and met emergency needs by preventing eviction and homelessness for approximately 70 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 95,000 Alaskans each month. Often, Medicaid recipients participate in other public assistance programs.

Chronic and Acute Medical Assistance Eligibility

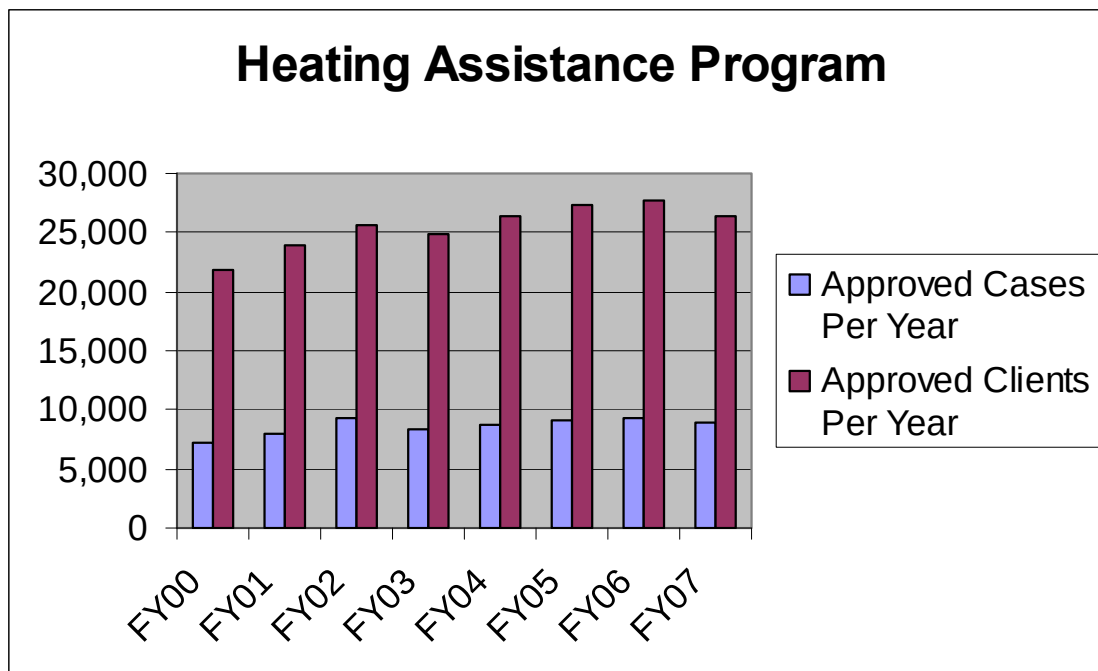
The Chronic and Acute Medical Assistance (CAMA) program is state funded and designed to help needy Alaskans with specific illnesses receive the medical care they need to manage those illnesses. The program is for people who do not qualify for Medicaid, have very little income, few personal resources and have inadequate or no health care. Recipients 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 generating payments to health care providers.

Energy Assistance Program

The Energy Assistance Program component includes the Heating Assistance Program and weatherization projects, and is 100% federally funded through the Low Income Home Energy Assistance Program (LIHEAP) Block Grant.

The Heating Assistance program provides seasonal financial assistance with home heating expenses for low-income households. 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 a portion of costs for home heating oil, natural gas, electricity, propane, wood and coal.

Last season nearly 9,000 households received help from the state's Heating Assistance program. In addition, approximately 4,800 households received help from Alaska Native organizations that receive direct federal funding to operate Tribal Energy Assistance programs.



**Cases=Number of Households, Clients=Number of Individuals*

The Energy 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 its Low Income Home Weatherization Assistance program.

Senior Benefits Payment Program

The new Senior Benefits Payment program helps low-income seniors who are at least 65 years of age remain independent in the community by providing a monthly cash benefit.

During a special session in late June 2007, the Alaska Legislature passed legislation to create a new program to benefit low-income seniors, which followed the sunset and end of the SeniorCare program on June 30.

For FY08, the department temporarily transferred funds from the Adult Public Assistance program to the General Relief Assistance program to pay for the benefit and administrative costs of the new Senior Benefits Payment program.

The department successfully transitioned almost 7,000 seniors from the former SeniorCare program to the new Senior Benefits program, and continues to process applications for individuals newly eligible under the income limits.

By FY09, the division expects 11,000 seniors will qualify for assistance under this new program, a significant increase from the almost 7,000 seniors served under the former SeniorCare program.

Women, Infants, and Children (WIC)

The Women, Infants and Children (WIC) component includes family nutrition programs designed 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 warrants to purchase food that will improve their health and nutritional status.

Program administration for the WIC program transferred from the Office of Children Services to the Division of Public Assistance effective July 1, 2007 without any interruption in services to program participants.

Annual Statistical Summary of Services Provided in FY2007

Comparison of Public Assistance Programs

	ATAP/TANF	Adult Public Assistance	General Relief	Food Stamps
FY07 Cases avg. mo.	3,318	16,594	84	21,594
# of clients avg. mo.	8,847	16,594	132	57,896
Race Distribution	White 79% Alaska Native 24% Black 9% Asian 7%	White 49% Alaska Native 29% Asian 9% Black 5%	White N/A Alaska Native N/A Black N/A	White 33% Alaska Native 47% Black 5% Hispanic 3% Asian 4%
Recipients by Location (District area)	Anch / Mat-Su 59% Northern 11% Southeast 8% Balance of State 22%	Anch / Mat-Su 54% Northern 13% Southeast 11% Balance of State 22%	Anch / Mat-Su 51% Northern 14% Southeast 13% Balance of State 22%	Anch / Mat-Su 47% Northern 13% Southeast 13% Balance of State 27%
Expenditure By Category of Service	Single parent 58% Two parent 13% Child only 29%	Disabled 69% Aged 30% Blind 1%	Burial service 86% Rent assistance 11% Other 3%	FS and ATAP 19% FS only 29% FS and APA 22% FS and Med 69%
Children 0 - 18 yrs	6,243	0		29,104
Adults 19 - 59 yrs	2,587	9,565		25,951
Adults 60 - older	12	7,029		2,842
Total Expenditures	\$38,601,977	\$55,098,207	\$1,261,997	\$88,262,866
Federal	\$8,557,723	\$1,433,203		\$88,262,866
GF	\$28,150,336	\$49,731,224	\$1,261,997	
Other	\$1,893,918	\$3,933,780		

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

	Energy Assistance	Child Care (Pass I, II, III)	SeniorCare
FY07 Cases	8,896		6,918
# of clients	26,334	5,622	6,918
Race Distribution	White 53% Hispanic 1% Alaska Native/Indian 34% Asian/Pacific Islander 4% African American 3% Other 5%	N/A	N/A
Recipients by Location (District area)	Anch / Mat-Su 37% Northern 12% Southeast 5% Balance of State 46%	N/A	Anch / Mat-Su 46% Northern 13% Southeast 11% Balance of State 30%
Expenditure By Category of Service	Employed, retired 61% or temp unemployed Receiving ATAP 11% Receiving APA 28%	Pass I 10% Pass II 8% Pass III 82%	Food Stamps 19% APA 67% Medicaid 75%
Total Expenditures	\$6,606,955	Pass I \$4,269,062 Pass II/III \$24,482,641	\$9,910,168
Federal	\$6,606,955	\$22,661,903	
GF		\$6,089,800	\$9,910,168
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 Energy 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 Energy Assistance is an annual number, where the caseloads listed for Child Care are monthly averages.

List of Primary Programs and Statutory Responsibilities

AS 18.05.010-070	Administration of Public Health and Related Laws
AS 43.23.075	Eligibility for Public Assistance
AS 43.23.085	Eligibility for State Programs
AS 44.29.020	Department of Health & Social Services
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 47.45.301-.309	Senior Benefits Payment 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 47.545-599	Senior Benefits Payment Program
7 AAC 57	Child Care Facilities Licensing
7 AAC 78.010-320	Grant Programs
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

Explanation of FY2009 Budget Changes

Public Assistance	2008	2009 Gov	08 to 09 Change
General Funds	110,622.9	132,262.6	21,639.7
Federal Funds	120,315.6	116,868.9	-3,446.7
Other Funds	24,712.5	25,675.3	962.8
Total	255,651.0	274,806.8	19,155.8

Child Care Benefits

Eligibility Services Grants for Child Care Assistance Programs: \$185.7 Federal

This request includes funding to support eligibility determinations for the Child Care Assistance Program, provided throughout the state by local community grantees. Historically, the methodology used to support this community-based service was inequitable and inconsistent, and the department is in the second year of a three-year plan to standardize funding among grantees for this service.

In year one of the plan (FY08) an increment of \$248.1 was authorized to increase grants to grantees that were funded below the targeted unit cost. In year two (FY09), an increment of \$185.7 is needed to increase the average unit cost from \$520 to \$580. This increment will also be used to minimize the negative fiscal impact on grantees that have experienced a drop in the number of children served, by sustaining funding at the FY08 levels and setting goals to increase the number of children in licensed care.

Reduction of Excess Federal Authorization for Child Care Programs: \$-5,000.0 Federal

Reducing the excess federal authority located in the Child Care Benefits Component.

General Relief Assistance

Senior Benefits Payment Program: \$20,345.4 General Fund

This increment requests funding for the new Senior Benefits Payment program, which provides financial assistance to Alaska's needy seniors. In FY09, the division estimates nearly 11,000 seniors will qualify for assistance under the Senior Benefits Payment program for an annual cost of \$20,345.4. This request includes \$19,662.3 for cash payments to seniors and \$683.1 for the administrative costs of operating the program, which includes 6 FTE's needed to support the initial and ongoing determination of eligibility.

In FY08, the department temporarily transferred funds from the Adult Public Assistance program to the General Relief Assistance program to pay for the benefit and administrative costs of the new Senior Benefits Payment program.

Tribal Assistance Programs

Transfer in General Fund match from Alaska Temporary Assistance Program: \$400.0 General Fund Match

Bristol Bay Native Association has fully implemented their administration of Temporary Assistance for Needy Families (TANF) benefits in their region. With this fifth Native Organization in place, we are transferring the balance of General Fund Match needed to fully administer grants for the approximately 107 families and more than 30 Bristol Bay villages of Southwestern Alaska, from the Alaska Temporary Assistance Program (ATAP) Component to the Tribal Assistance Program Component.

Public Assistance Administration

Eligibility Information System Alternatives, Phase II operating costs: \$264.0 Capital Improvement Project (CIP) Receipts

The Division of Public Assistance's automated Eligibility Information System (EIS) is an aging, inflexible application. It is difficult to adapt to the states 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.

This request provides the CIP Receipt authorization for FY09 estimated operating costs for the initial project team supporting the capital Eligibility Information System Alternatives project. Phase I of the capital project was funded in FY08, with project team hires planned for February 2008. FY08 project operating costs will be handled via an unbudgeted Reimbursable Services Agreement (RSA), with budgeted continuing operating costs represented by this increment.

Public Assistance Field Services

Denali KidCare Performance Improvement: \$395.7 Total \$197.8 Federal, \$197.9 GF/Match

Each month, the Denali KidCare (DKC) office provides essential medical coverage for approximately 30,000 children and 3,000 pregnant women. The effective and efficient delivery of services provided by the DKC office is central to the department's mission to promote and protect the health and well-being of Alaskans. Recent changes in federal eligibility requirements, such as the verification of citizenship coupled with higher expectations for program accountability and payment accuracy, have greatly increased the complexity and processing time for each case handled by the office. Over the past year, processing timeframes have greatly exceeded the 30-day standard for processing applications. Consequently, children have not received timely medical care, and payments to vendors and medical providers have been delayed. The Governor's FY09 budget request includes an increment of \$395.7 to add 6 full-time staff to provide adequate resources to sustain effective quality services in the Denali KidCare office and increase program accountability.

Quality Control

Child Care Program Performance Measures: \$91.5 Total \$45.8 Federal, \$45.8 GF/Match

The Administration for Children and Families (ACF) issued new rules that require states to review a random sample of cases to establish error rates in the expenditure of Child Care Development Funds (CCDF). Under the new rules, states are required to conduct reviews once every three years, prepare error rate reports, develop corrective action plan and frequently measure the impact of their corrective action plans. An increment of \$91.6 is needed to increase DPA's Quality Control staff by one FTE to comply with the new federal performance error rate measurement requirements.

Transfer in Funds from Office of Program Review: \$78.1 Total \$39.0 General Funds, \$39.1 Federal

These funds are transferred from the Office of Program Review to support a position that was transferred in the FY08 Management Plan.

Women, Infants and Children

Increased Statutory Designated Program Receipts (SDPR): \$650.0 SDPR

Increased Statutory Designated Program Receipts authority is needed to allow for higher collections of manufacturer's rebates received for specific infant formula products in Women, Infant and Children (WIC) food packages. Federal Regulations require that infant formula rebate revenues be expended on WIC foods only. The current SDPR authority is inadequate to receive the anticipated level of rebates in FY09. Without increased Statutory Designated Program Receipts, WIC will be unable to receive earnable levels of rebates and will still be bound by federal law to provide the same level of services, which will require general fund expenditures.

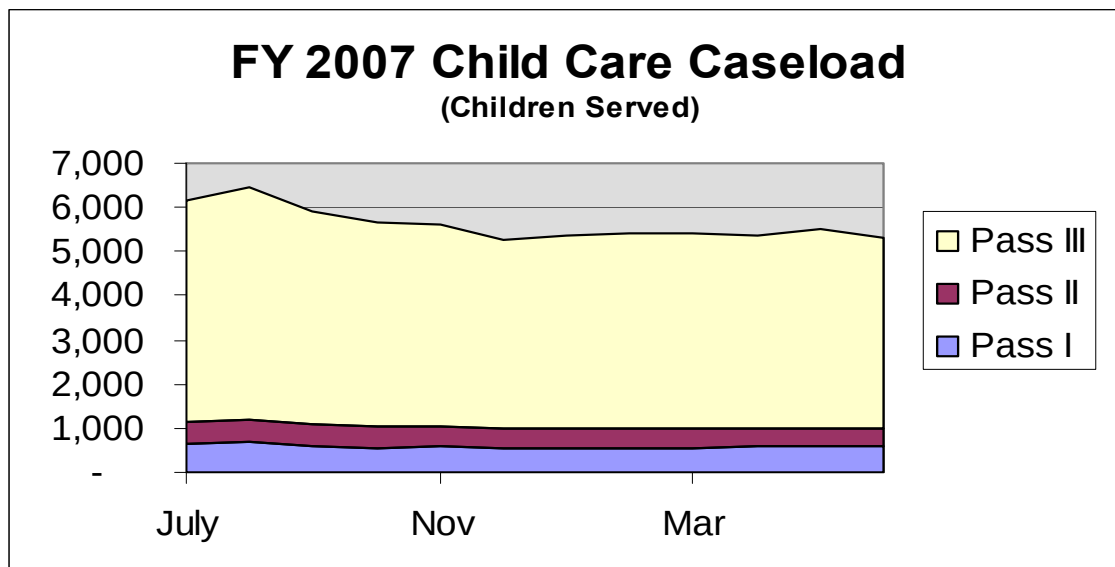
Challenges

Alaska Temporary Assistance Program

- Sustaining and building on the success of Alaska's welfare reform efforts is critical. The 2006 federal reauthorization of TANF includes a wide range of impacts on Alaska's Temporary Assistance program. It increases performance expectations, sets stricter work requirements for adults on welfare, and invokes penalties against states that fail to meet the new standards. It also eliminated some past sources of revenue, such as the High Performance Bonus. Alaska earned over \$12 million from this source over the last four years. Reauthorization also only ensured the continuation of supplemental grants to states with high population growth until 2008. Alaska's "High Pop" grant has been almost \$7 million a year.
- Meeting the new federal work participation requirements and providing opportunities for families to achieve lasting self-sufficiency while maintaining basic safety net services remains a challenge. The FY07 monthly average caseload for the Alaska Temporary Assistance program has decreased by 59 percent compared to FY94. Even though the number of families on assistance continues to decline, those remaining on assistance face greater challenges with employment. These families need more intensive services and alternative activities that are often not allowed or hours of participation are extremely limited under the federal work requirements, such as work search, substance abuse and mental health treatment.
- In FY08, DPA amended its outcome-based pay-for-performance work service contracts to implement the new standards, and will strive to ensure that Alaska complies with the new requirements while concentrating on the best possible outcomes for families. Conservation of Alaska's TANF balance resulting from declining caseloads since the beginning of the Temporary Assistance is also essential to ensure that core business needs and efforts to support self-sufficiency through employment can be sustained.

Child Care Benefits

- Accessible, affordable, quality child care is an important aspect of supporting working parents. The number of working families participating in the Child Care Assistance program has decreased over the past year. The decrease is partially attributed to state rates for child care falling behind the rates that child care providers charge. State rates for child care assistance have not increased since 2001, except for the Fairbanks area, where rates were increased in 2006 to match rates in Southeast and Anchorage. As state rates decline in relation to the market rate, low-income families on child care assistance must either absorb the increased difference between the state rate and the child care provider's rate (in addition to their required co-payment) or choose lower priced and usually lower quality child care. The decline in state rates in relation to the market rate has resulted in fewer families being assisted by the Child Care Assistance program and child care providers being less able to provide care at state payment levels. To better understand this issue, the division completed a Market Rate Survey in 2007 and is in the process of analyzing its results. The division is also participating in the department's rate study that is under way.



- Eligibility determinations for the Child Care Assistance program are provided throughout the state by local grantees. Historically, the methodology used to support this community-based service was inequitable and inconsistent, and the incremental funding authorized by the 2007 Legislature is being used to standardize the funding for grantees by establishing a unit cost structure. The unanticipated decrease in the number of children participating in the program in the past year, however, would negatively impact some grantees and the division would like to hold grantees harmless from these reductions as we move forward into the second year of the three-year plan.

General Relief Assistance

- The new Senior Benefits program offers important assistance to Alaska seniors. In FY08, the department temporarily transferred funds from the Adult Public Assistance program to the General Relief Assistance program to pay for the benefit and administrative costs of the new Senior Benefits Payment program until February 2008. Supplemental funding is needed to ensure adequate funding is in place to pay APA and Senior Benefits for the remainder of FY08.

Energy Assistance Program

- FFY08 funding for the Energy Assistance Program is still uncertain, so FY09 funding is projected at the FY07 level. Uncertainty over the federal LIHEAP block grant funding continues to contribute to challenges in planning and administering the program. The funding allocation is frequently determined after the beginning of the federal fiscal year. This means the state must set heating benefit levels, hire eligibility staff, and issue requests for proposals for low-income weatherization in the absence of a funding allocation. In addition, the increasing cost of home heating oil continues to create great difficulties for low-income households as heating assistance grants do not adequately cover increased costs. Based upon spot market prices from communities around the state and information from the federal Energy Information Administration (EIA), most Alaskans are paying much more than the national average of \$2.88 per gallon anticipated for the coming winter. The EIA is anticipating a 6 percent increase in the cost of heating fuel in 2008, which will create even greater difficulties for low-income Alaskans when household heating assistance grants do not adequately cover the increased costs.

Field Services

- The Denali KidCare office lacks sufficient staffing to satisfy customer service needs and meet performance expectations. Funding is needed to provide adequate resources to sustain effective quality services in the Denali KidCare office and increase program accountability.
- Recruitment of staff in all sections of the division has become a key challenge as the agency's work force ages and long-term, dedicated staff, many with 20 to 30 years of quality service, retires. Public assistance programs have complex rules and on average a new eligibility worker needs six months of practice to effectively manage a caseload for one program. The loss of experienced staff causes gaps in service delivery as new employees are hired and trained.

Quality Control

- In FY08 the Quality Control unit is charged with implementing the federally mandated Child Care Development Fund Error Rate Reporting, and the Payment Error Rate Measurement (PERM) eligibility reviews for Medicaid and the State Children's Health Insurance Program (SCHIP), while completing Food Stamp and Medicaid Eligibility Quality Control (MEQC) reviews.
- Insufficient lead time between the release of the federal rules and supporting guidance for implementing these new requirements has hampered effective planning. The division is developing strategies for performing the reviews. Authority is needed to increase DPA's Quality Control staff by one FTE to comply with the new federal performance error rate measurement requirements.

Women, Infants and Children

- Eligibility for WIC, nutrition education, and other WIC-related services are provided throughout the state by local grantees. Similar to the child care assistance program, the historic funding methodology used for this community-based service is inequitable and inconsistent. In FY09, WIC grants will begin a new grant cycle at which time the division will use a new funding formula to base funding for grantees and equalize the method of payment for this service.
- WIC's automated eligibility and information management system lacks essential internal controls and requires intensive programming and technical support to maintain connectivity for grantees. Efforts are under way to secure federal funds to hire project staff to begin planning for the transfer of a new federally approved management information system.

Performance Measures – Division of Public Assistance

Contribution to Department's Mission

Promote self-sufficiency and provide for basic living expenses to Alaskans in need.

Core Services

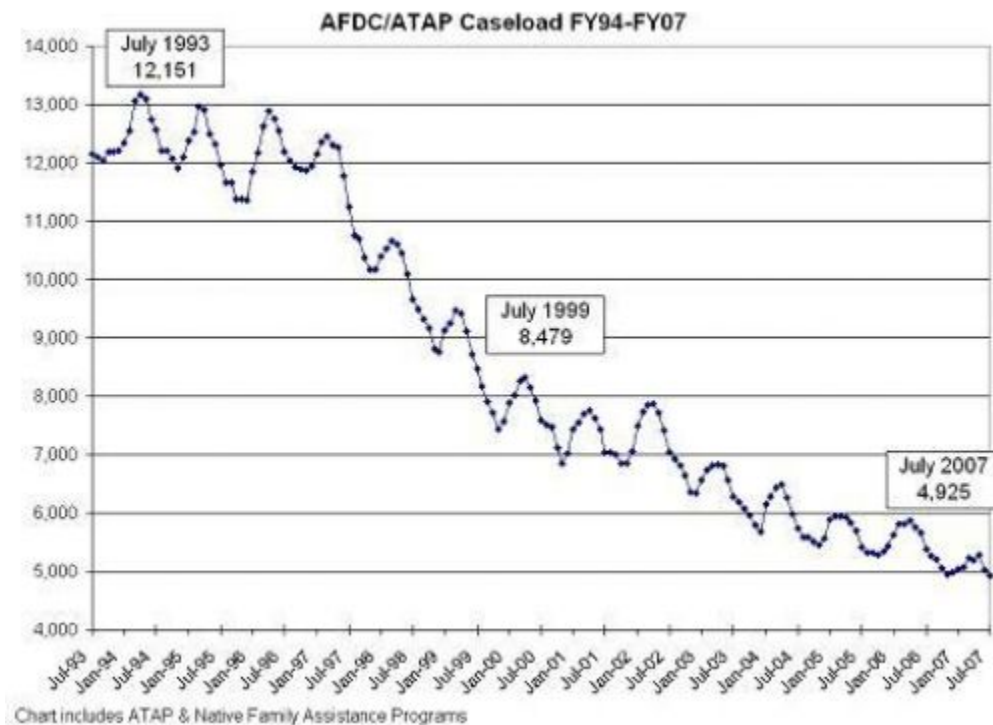
Administer programs that provide temporary economic support to needy families and individuals; financial assistance to the elderly, blind and disabled; food support and nutrition education; medical benefits; and supportive services that enable and encourage Alaskans to pursue economic independence and self-sufficiency.

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 percent annually.

Measure #1: Rate of change in self-sufficient families.



Changes in Self-Sufficiency

Fiscal Year	September	December	March	June	YTD
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	-2%	-8%	-10%	-10%	-7%
FY 2008	-7%	0	0	0	0
		0%	0%	0%	0%

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

Analysis of results and challenges: As shown in the YTD Total column, FY 2007 had a 7 percent decline in the number of families receiving Alaska Temporary Assistance program benefits compared to FY 2006. The other four 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 percent.

Measure #1: Rate of change in self-sufficient families.

This is reported at the Department level. See above.

A1: Strategy — Increase the percentage of temporary assistance families who leave the program with earnings and do not return for six months.

Target #1: 90 percent of temporary assistance families leave with earnings and do not return for six months.

Measure #1: Percentage of families that leave temporary assistance with earned income and do not return for six 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
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%	88%	86%	85%	87%
2008	86%	0 0%	0 0%	0 0%	0 0%

Analysis of results and challenges: The goal is for clients to move off 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 six months ago by the number of cases that closed with earnings six months ago who are not in the current caseload. The calculation for the quarterly figures is a weighted average of the three months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY08 target is 90 percent.

A2: Strategy — Increase the percentage of temporary assistance families with earnings.

Target #1: 40 percent 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
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%	32%	32%	36%	34%
2008	35%	0	0	0	0

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 three months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY08 target is 40 percent.

A3: Strategy — Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50 percent 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
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%	46%	46%	50%	47%
2008	44%	0 0%	0 0%	0 0%	0 0%

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 FY08 target is 50 percent.

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, the Division of Public Assistance (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 assess 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 percent of food stamp expedited service applications meet federal time requirements.

Measure #1: Percentage of food stamp expedited service households that meet federal time requirements.

Percentage of food stamp expedited service households that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
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%	96.2%	96.3%	96.4%	96.4%
2008	93.1%	0 0%	0 0%	0 0%	0 0%

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 FY08 target is 95 percent.

Target #2: 96 percent of new food stamp applications meet federal time requirements.

Measure #2: Percentage of new food stamp applications that meet federal time requirements.

Percentage of new food stamp applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
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%	97.3%	97.2%	97.1%	97.1%
2008	94.8%	0	0	0	0
		0%	0%	0%	0%

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 FY08 target is 96 percent.

Target #3: 99.5 percent of food stamp recertification applications meet federal time requirements.

Measure #3: Percentage of food stamp recertification applications that meet federal time requirements.

Percentage of food stamp recertification applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
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%	99.5%	99.5%	99.1%	99.1%
2008	94.6%	0	0	0	0
		0%	0%	0%	0%

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 FY08 target is 99.5 percent.

Target #4: 90 percent 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
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%	83%	83%	84%	84%

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 FY08 target is percent.

Target #5: 90 percent 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
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%	84%	78%	78%	78%
2008	71%	0	0	0	0
		0%	0%	0%	0%

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.

Recent changes in federal eligibility requirements, such as verification of citizenship, have greatly increased the complexity and processing time for each Medicaid application handled. During the first half of FY08 processing times have far exceeded the 30-day standard and as a result, children have not received timely medical care, and payments to vendors and medical care providers have been delayed. The implementation of the federal Payment Error Rate Measurement (PERM) requirements further impacts processing timeframes by establishing higher expectations for program accountability and payment accuracy.

The FY08 target is 90 percent.

A5: Strategy — Improve accuracy of benefit delivery.

Target #1: 93 percent 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
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%	94.3%	94.3%
2007	95.1%	96.3%	0 0%	0 0%	96.3%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits because 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 FFY08 target is 95%.

Target #2: 95 percent 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
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%	96.3%	96.3%
2007	99.4%	99.3%	0 0%	0 0%	99.3%

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.

Based on successes to date, the target percentage is revised to 98 percent for FFY08.

Target #3: 93 percent of Medicaid eligibility determinations are accurate.

Measure #3: Percentage of accurate Medicaid eligibility determinations.

Percentage of accurate Medicaid eligibility determinations

Year	YTD
2002	96%
2003	99%
2004	99%
2005	93%
2006	95%

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.

A6: Strategy — Increase the percentage of subsidy children in licensed care.

Target #1: 76 percent 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
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%	72%	78%
2007	74%	74%	76%	74%	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.

Although the Child Care Assistance program subsidizes the cost of child care for eligible working families, there is a gradually widening gap between current market rates for child care services, and the state subsidy rate. State rates for child care assistance have not been increased since 2001, except for the Fairbanks area, where rates were increased in 2006 to match rates in Southeast and Anchorage. 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 child care provider's rate (in addition to their required co-payment) or choosing lower priced and usually lower-quality child care.

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Public Health

Mission

To protect and promote the health of Alaskans.

Introduction

The work of the Division of Public Health (DPH) is best described by the “3Ps”: Prevention, Promotion and Protection. DPH is the state’s lead public health agency, responsible for operating programs that prevent injury, infections and chronic diseases while promoting healthy living and quality health care. The division also plays a significant role in making sure that Alaska is ready to effectively respond to serious emergencies, such as natural disasters, emerging disease threats, and bioterrorism.

In Alaska, the public health system is largely the responsibility of the state. The Municipality of Anchorage assumes some direct health powers and, to a lesser extent, so does the North Slope Borough. However, throughout the remainder of the state DPH fulfills both state and local public health functions. To assist in meeting this challenge, DPH provides funding through grants and contracts to many of our partners: local public health agencies, community- and tribal-based organizations, educational institutions and nonprofit agencies. Together, we focus on the core services that protect the public’s health and advance the health status of individuals and communities. This makes Alaska a better place for all people to live, work and play by preventing illness and injury, promoting good health and protecting all of us.

While DPH is perhaps best known for responding to disease outbreaks, the division’s core functions are much more diverse and far-reaching, and focus on myriad services and activities as part of the overall continuum of health in Alaska. The division carries out its functions through programs that are primarily population-based and focused on the health of all Alaska’s residents and visitors.

DPH employees actively work with communities and organizations to build capacity and sustainability among health systems, and assure access to quality health care services; often acting as a liaison between federal, state and private organizations in the areas of health planning and service delivery. In addition, the division engages in countless activities to ensure emergency medical services personnel are qualified and properly equipped. Medical/legal investigative work related to unanticipated, sudden or violent death is also provided by DPH.

The division also works with a variety of organizations and individuals across the state to develop and implement health promotion strategies and community action plans for preventing and reducing the burden of chronic diseases. Promoting healthy behaviors by educating the public and supporting community actions to reduce health risks and injuries has proven effective. In an effort to eliminate health disparities, outreach activities are conducted to link high-risk and disadvantaged people to needed services.

To protect people from disease, 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. Trained staff also work diligently to protect health care consumers through facility inspections and complaint investigations of nursing and assisted living facilities, and to ensure that employees clear background checks.

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. This information along with other scientific information and expertise is used to improve program services, develop health recommendations and inform future policy decisions.

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 and 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 infections, 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 of and response to outbreaks and epidemics. Staff travels to the site of disease outbreaks to conduct special investigations if necessary, and provides medical consultation to health care providers and information to the public on prevention and control of infectious disease. Through federal funds, vaccines for vaccine-preventable diseases are provided at no charge for all Alaskan children to health care providers around the state. Prevention and treatment therapies are provided for specific infectious diseases such as tuberculosis and HIV/AIDS. Public health nurses serving as the front line work force of public health, work within local communities 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, conduct partner notification and investigation services for sexually transmitted infection, 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.

Injury Prevention and Control



The DPH Section of Injury Prevention and Emergency Medical Services work to prevent injuries 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 throughout 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 safeguards the quality of health care in the state by regulating many people and institutions that provide care to vulnerable Alaskans, including

hospitals and assisted living homes.

Chronic Disease Prevention and Control

The DPH Chronic Disease Prevention and Health Promotion Section strives to improve the health and well-being of all Alaskans. In addition to improving the quality of life for individuals, these efforts are critical to controlling future health care costs through improved health outcomes. Services provided include 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, Children 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.

Public Health Emergency Preparedness and 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; ensuring capacity of disease surveillance, epidemiology, and biological and chemical laboratory services; communications and information technology, health information dissemination to the public; emergency and disaster training and exercises; and hospital preparedness.

The emergency preparedness program reports to the DHSS Chief Medical Officer and is housed in the DPH Administrative budget component. Activities are conducted by staff throughout the division, including: 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, biological, or chemical agents of terror. The division works collaboratively with Alaska's emergency medical system and hospitals to ensure they are prepared to respond to a medical disaster or public health emergency.

Access to Early Preventive Services and 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. Services provided include well child exams, tuberculosis screening, Sexually Transmitted Disease (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, Children 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. Using federal funds WCFH administers grants and contracts to support access to preventive and other health care services through the following programs: 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 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.

The DPH Section of Health Planning and Infrastructure works with communities and organizations to assure access to quality primary and acute health care services in Alaska by focusing on services, facilities, work force and financing. The section works with primary care clinics, hospitals, and other health facilities to address their long term sustainability. By providing technical assistance and data to document needs, the section guides communities in matching resources to needs. Health Planning and Infrastructure works extensively with other sections in DHSS and as well as state-wide health care organizations.

Environmental Hazard Protection

While the Department of Environmental Conservation (DEC), particularly its Division of Environmental Health, play the primary role in environmental health protection in the state, DPH works in close partnership to provide the human health and medical epidemiology expertise in support of a common mission. Community-based environmental hazard identification and response is coordinated with DPH public health nurses at the local level, while 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, biomonitoring of mercury from fish consumption, 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 and Efficient Programs and 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.

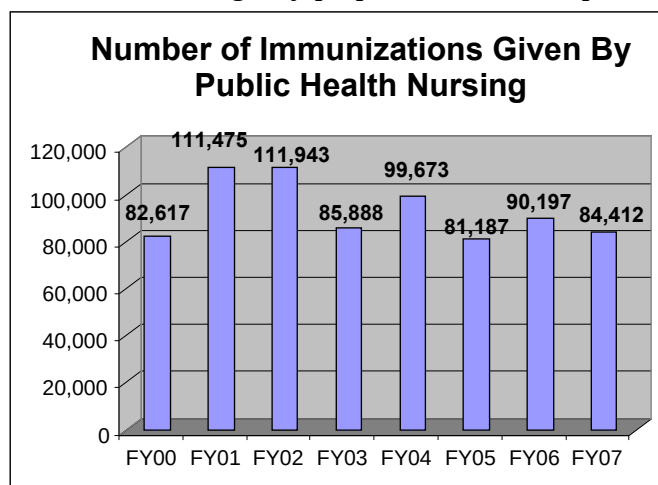
Another DPH cross-cutting program that supports all core public health services is administered by the Office of the State Medical Examiner (SME). As a key element of the public health mission to prevent injury disease and death, the SME designs and manages a statewide system of medical legal investigation 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.

Annual Statistical Summary of Services Provided in FY2007

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 prevention 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 FY07 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 FY07 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 FY07, public health nurses statewide*:

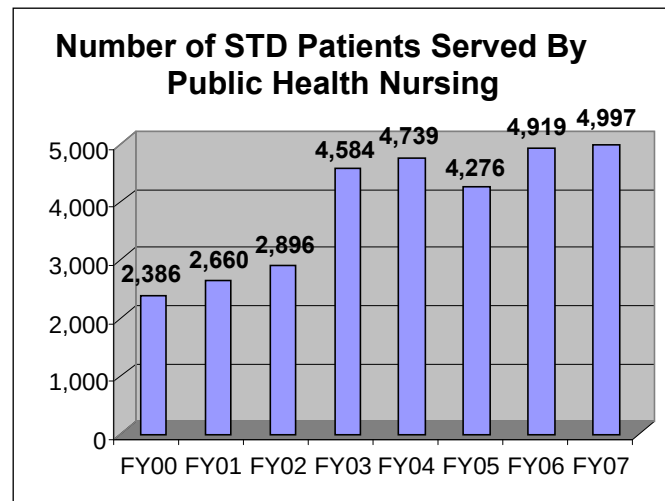
- provided 126,672 health care visits to 75,691 patients;
- provided 64,308 health care visits to 36,069 children and youth (ages birth-19 years);
- administered 84,412 doses of vaccine;
- gave and read 18,638 tests for tuberculosis (TB);
- provided 1,779 Pap Smears for detection of cervical cancer in Alaskan women;
- provided 14,287 visits for family planning to 5,756 individuals;
- provided 9,280 visits to 4,997 patients for Sexually Transmitted Diseases;
- provided 4,815 visits for HIV/AIDS services including blood testing for 2,593 patients.

*Note: All service data are from Resources Patient Management System (RPMS) FY 2007 Reports, 8/21/07. Note: Service data above does not include the Municipality of Anchorage, a Public Health

Nursing grantee, except doses of vaccine administered. The Municipality uses a different data system for all but immunizations.

In addition, public health nurses in FY07, increased implementation of routine, universal screening for domestic/family violence during health encounters at state public health centers. There were 10,093 clients screened for domestic/family violence, and positive/suspect screening results increased by approximately 45%. Public health nurses are identifying and providing educational, support and referral services to increasing numbers of domestic and family violence victims, as well as improving public awareness and education on this issue. Also, public health nurses continued public health preparedness and response training, planning, and exercise activities at both the state and local level.

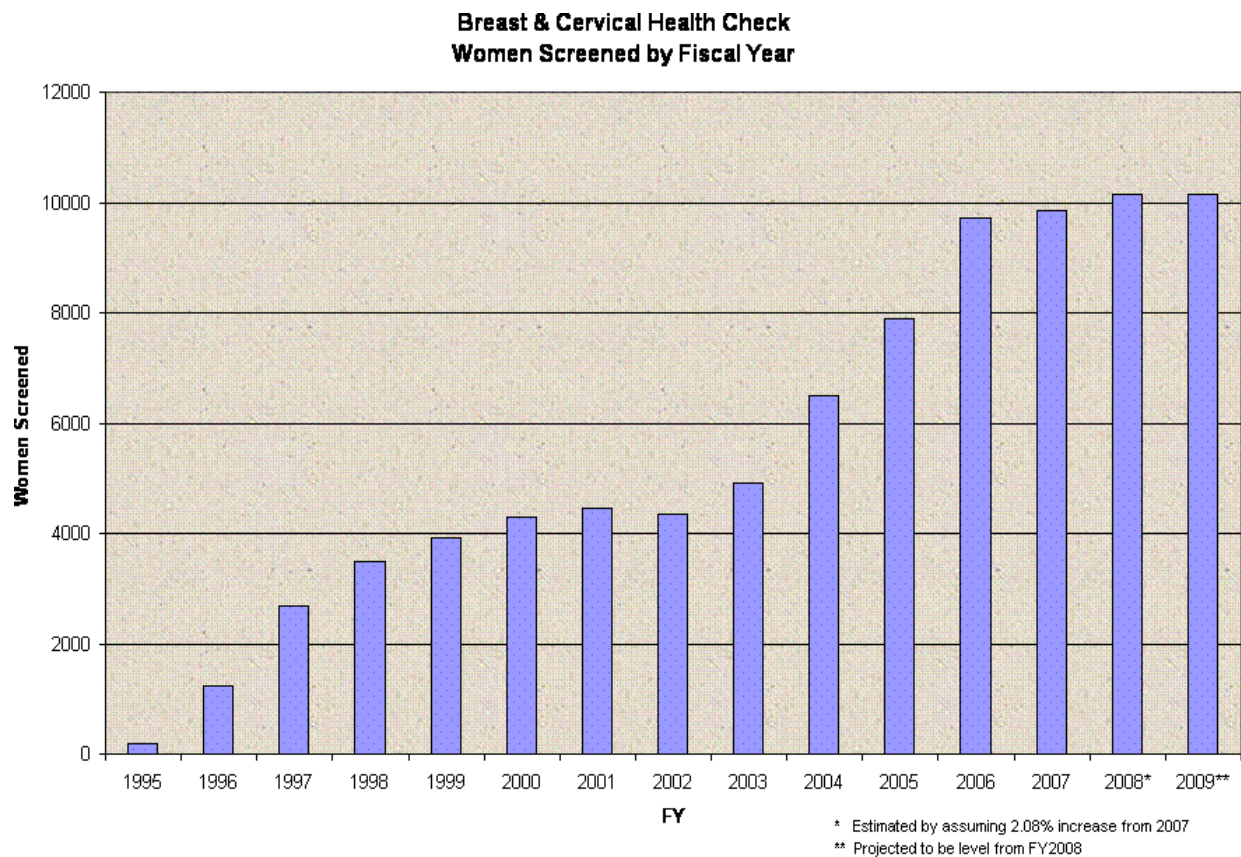
Nurses worked in partnership with eight communities (Fairbanks, Ketchikan, Bethel, Unalaska, Juneau, Hooper Bay, Mat-Su and Kenai) to plan, coordinate, and carry out mass prophylaxis exercises with 9,000 participants screened and vaccinated, and 780 volunteers recruited and trained. Additional mass dispensing exercises were conducted by grantee agencies in Anchorage and Kotzebue.



Women, Children 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 and 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, Children and Family Health in FY07 include:

- The Breast and Cervical Health Check program continued its lifesaving work. Since its inception in 1995, the program has provided nearly 71,000 cancer screenings to more than 33,000 individual women who are medically underserved. Of those women, 211 cases of breast cancer, 30 cases of cervical cancer and 1,825 pre-cancerous conditions have been diagnosed.
- Through partnership with the Division of Public Assistance, statewide efforts were launched to raise public awareness of the need to help teens engage in healthy relationships and avoid the life-limiting challenges posed by unintended pregnancy, sexually-transmitted infections, relationship violence and sexual coercion. These efforts included production and airing of television and radio PSAs, and several training events aimed at helping clinicians and other professionals working with youth to develop counseling and education skills.
- Of all newborns, 99.9 percent were screened for metabolic conditions.

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 four years ago; even today, this significant change is still 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.

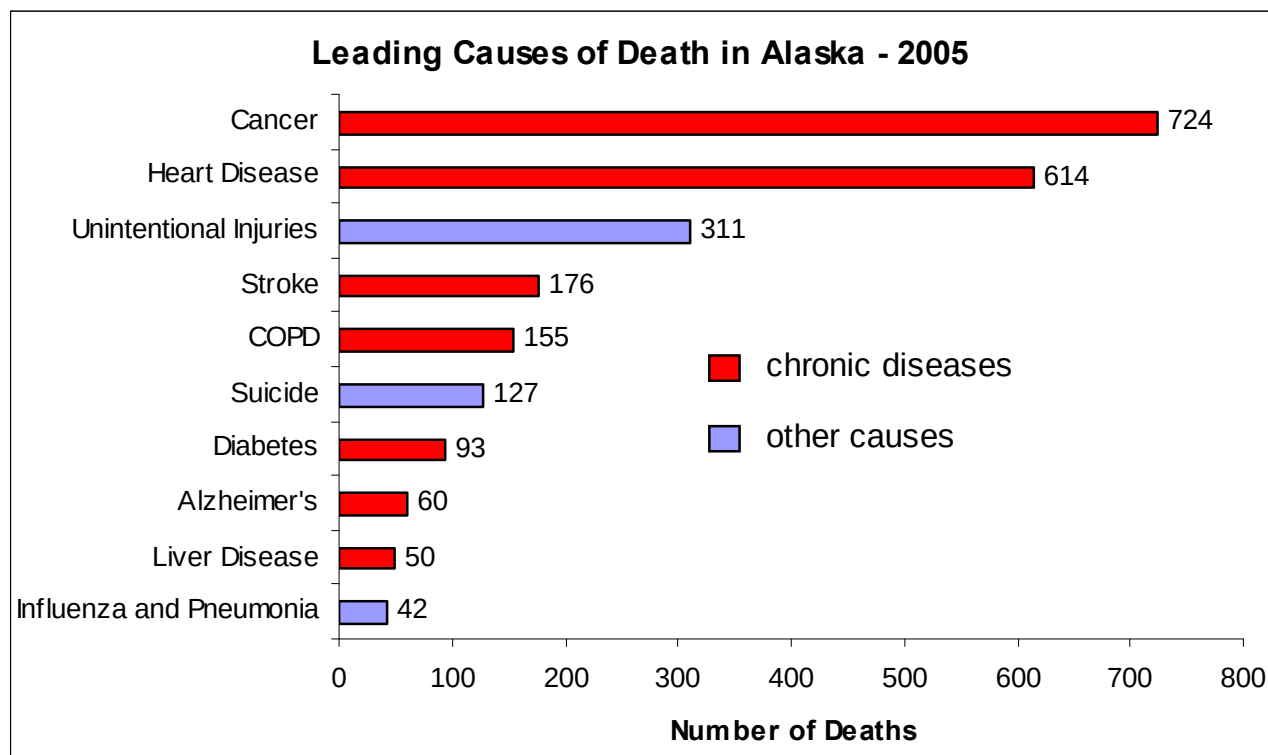
Examples of services provided in FY07:

- The Background Check program has processed 23,712 applications since implementation on March 31, 2006; 505 individuals were disqualified from becoming service providers due to barring criminal conditions.
- The Background Check program instituted an online web-based application for background checks, and obtained approval and federal funding for a Rural Live Scan electronic fingerprinting system.
- The Assisted Living Home program began working with Anchorage Police Department's officer dispatch unit. This partnership will increase an officer's awareness that he or she is responding to a call involving a licensed home with vulnerable individuals at risk and also provide a direct mechanism to notify licensure staff of any unsafe conditions occurring at a licensed home.
- Maintenance of licensure and inspection for over 600 facilities.
- Complaint investigation and at times enforcement actions for more than 250 complaints.

Chronic Disease Prevention and Health Promotion

The Section of Chronic Disease Prevention and Health Promotion, established in FY06, unifies many programs into one component: 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.



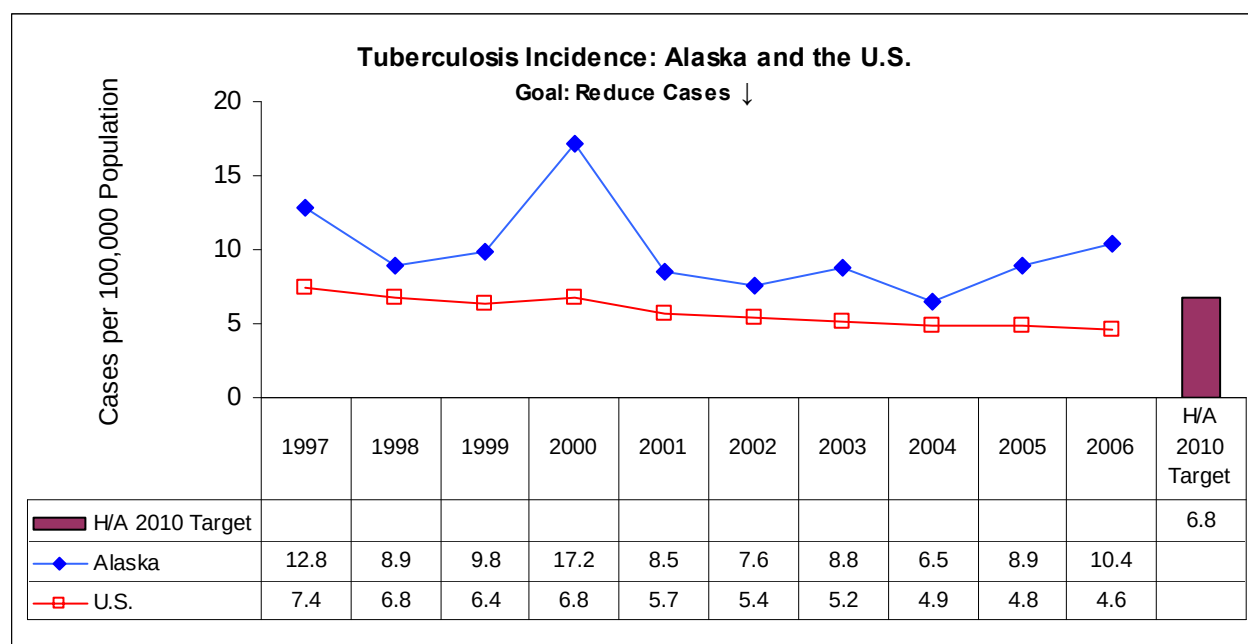
Notes: COPD = Chronic Obstructive Pulmonary Disease; some 2006 data still not available

Examples of services provided by Chronic Disease Prevention and Health Promotion programs in FY07 include:

- Having attained both (a) CDC-recommended minimum funding level and (b) full staffing for the first time, the Alaska Tobacco Prevention and Control program expanded the reach of its prevention and cessation grantee program, resulting in more coverage of the state than ever. Importantly, this coverage now includes the first ever K-12 School Comprehensive Tobacco program, currently implemented in six districts throughout Alaska.
- Successful collection of statewide, representative Youth Risk Behavior Survey (YRBS) data, which is used to help school officials, health experts and policy-makers track risky behaviors among young people and identify successful interventions. The YRBS, designed by the CDC and modified for Alaska issues and schools, is anonymous and voluntary. It is administered every other year at the local, state and national level.
- Working with the Alaska Heart Institute to improve outcomes for heart-attack patients through better tracking and follow-up procedures.

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 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 individuals exposed to tuberculosis, HIV, sexually transmitted diseases, and other infectious diseases; and risk assessment of environmental health threats to Alaskans.



Data Source: Alaska – Morbidity Database; U.S. – National Notifiable Diseases Surveillance System; H/A = Healthy Alaskans 2010

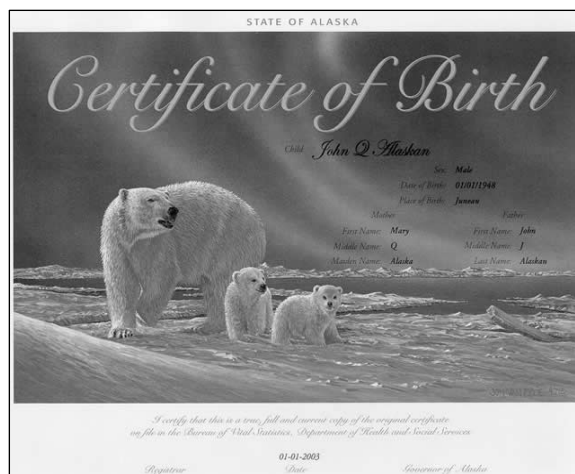
Examples of services provided by Epidemiology in FY07 include:

- In partnership with the Municipality of Anchorage, worked to control an ongoing outbreak of tuberculosis (TB) in the homeless population. This outbreak began in December 2005; more than 30 cases have been identified.

- Established new fish consumption guidelines for the state of Alaska that balance the health benefits of fish consumption against the potential risks from mercury exposure. The section established an Alaska Scientific Advisory Committee for Fish Consumption, developed consensus recommendations, engaged stakeholders, presented at the National Fish Forum sponsored by the U.S. Environmental Protection Agency, and published a scientific monograph to document the guidelines.
- Published 41 Epidemiology *Bulletins* to inform health care providers and the public of important investigations, concerns, or alerts regarding health issues.
- Responded to 213 after-hours calls; all were responded to within 10 minutes.
- Completed a multi-million dollar contract award for a secure Internet-based Immunization Information System (IIS) and Disease Surveillance Management System. The contract was awarded to Scientific Technologies Corporation; the IIS should be up and running in the spring of 2008.
- Incorporated rapid HIV testing into HIV disease intervention activities conducted by HIV/STD program staff, and broadened these activities to include people in related social/sexual networks. From January 2006 through June 2007, 74 cases of HIV were newly identified. During this same period, 89 individuals with HIV were interviewed, identifying 215 contacts plus 107 additional individuals meriting follow-up.
- Responded to an epizootic (>35 cases) of animal rabies in northern and western Alaska, ensuring that any and all individuals potentially exposed to this fatal virus received appropriate post-exposure prophylaxis. This response involved close working partnerships with the State Virology Laboratory, Offices of Environmental Health for various Native health corporations, the North Slope Borough, and the Department of Fish and Game.
- Published an Epidemiology *Bulletin* and worked with state librarians to remove lead-tainted toys from circulation after they were disseminated through a statewide reading program.

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 FY07 include:

- processed 68,887 requests for vital records;
- recorded these events in Alaska:
 - o Births: 10,990
 - o Deaths: 3,444
 - o Marriages: 5,430
 - o Divorces: 2,883
- processed 682 adoptions of Alaska-born children;
- processed 3,496 establishments of paternity of Alaska-born children;
- issued 4,393 marriage licenses;
- collected \$34,970 in funds for the Alaska Children's Trust from heirloom birth and marriage certificates;
- processed 113 applications for the Medical Marijuana Registry.

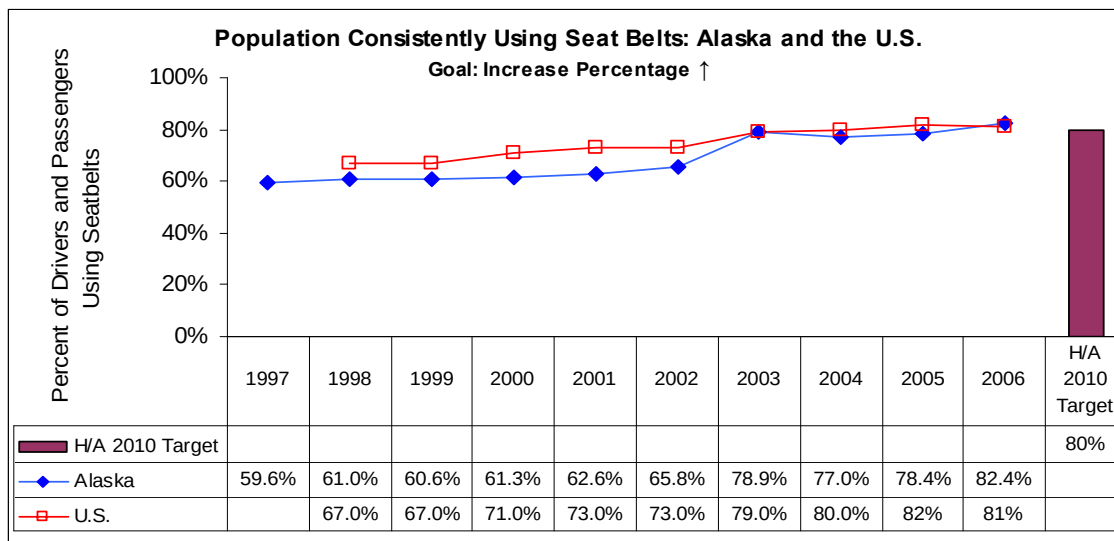
Despite an increased workload and technology challenges, the bureau worked hard to maintain customer service improvements achieved in the previous year. The year began with a significant increase in requests for birth records, mainly due to changes in passport requirements. Additionally, the bureau's information system was inoperable for over two weeks due to repeated hardware failures, and recurring problems with the bureau's auto-attendant phone system impacted staff's ability to process vital record requests. Processing time for vital record requests increased from an average of two days in 2006 to about two weeks in 2007.

The bureau continued adding to the number of public health statistics reports that are published on the BVS Web site. Detailed information on injury deaths, leading causes of death, chronic disease deaths, infant mortality, birth rates, causes of death, and health profiles is readily available at:

<http://www.hss.state.ak.us/dph/bvs/data/default.htm>.

Injury Prevention and Emergency Medical Services

The Section of Injury Prevention and Emergency Medical Services 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.



Data Sources: Alaska Highway Safety Office and National Highway Transportation Safety Administration

Examples of services provided in FY07 include:

- Reviewed application materials and issued certification credentials for over 3,800 Emergency Medical Technicians (EMT), Emergency Medical Services (EMS) Instructors, and Emergency Medical Dispatchers, approximately 83 ground emergency medical services, 19 air medical services, and five hospital trauma centers.
- Distributed and installed smoke alarms in residences throughout the state to help prevent deaths from house fires; enrolled rural and low-income households in the Fire Prevention/Smoke Alarm Installation program, with the potential of seven lives saved in 2007.
- Provided support for the installation and maintenance of approximately 466 "Kids Don't Float" life jacket loaner sites in all regions of Alaska by providing personal flotation devices. Since 1998, this program has resulted in 14 documented cases of prevented drowning.
- Supported Alaska Poison Control activities, including support of a statewide triage phone hotline and educational requests. The Poison Control Center received approximately 9,300 calls, of which over 7,000 were human exposures resulting in medical treatment for over 1,000 people. The poison control center provided statewide technical and educational support to caregivers on all calls.

State Medical Examiner

The State Medical Examiner's Office (SMEO) 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 preventing hazardous health problems in the state.

Examples of services provided in FY07 by the Medical Examiner's Office include:

- total cases reported: 1,457
- cases autopsied: 288
- cases with consult: 79
- cases with inspection: 19
- cases with natural cause: 360

Also, the office:

- Completed the upgrade of aging X-ray equipment to a state-of-the-art digital system.
- Continued on the accreditation track, as recommended by the National Association of Medical Examiners (NAME).
- The Child Fatality Review Committee, chaired by the Chief Medical Examiner, reviewed 90 child death cases, of which eight were prosecuted as homicides. This is a collaborative effort between District Attorneys, Alaska State Troopers, Anchorage Police Department, state social workers, pediatric physicians, forensic nurses and an investigator from the SMEO.
- In collaboration with anthropological staff at the University of Alaska and a forensic odontologist, SMEO identified 10 John or Jane Doe decedents. Working with the Cold Case Unit, Alaska State Troopers, FBI and other investigators, cases are being solved and missing individuals identified.

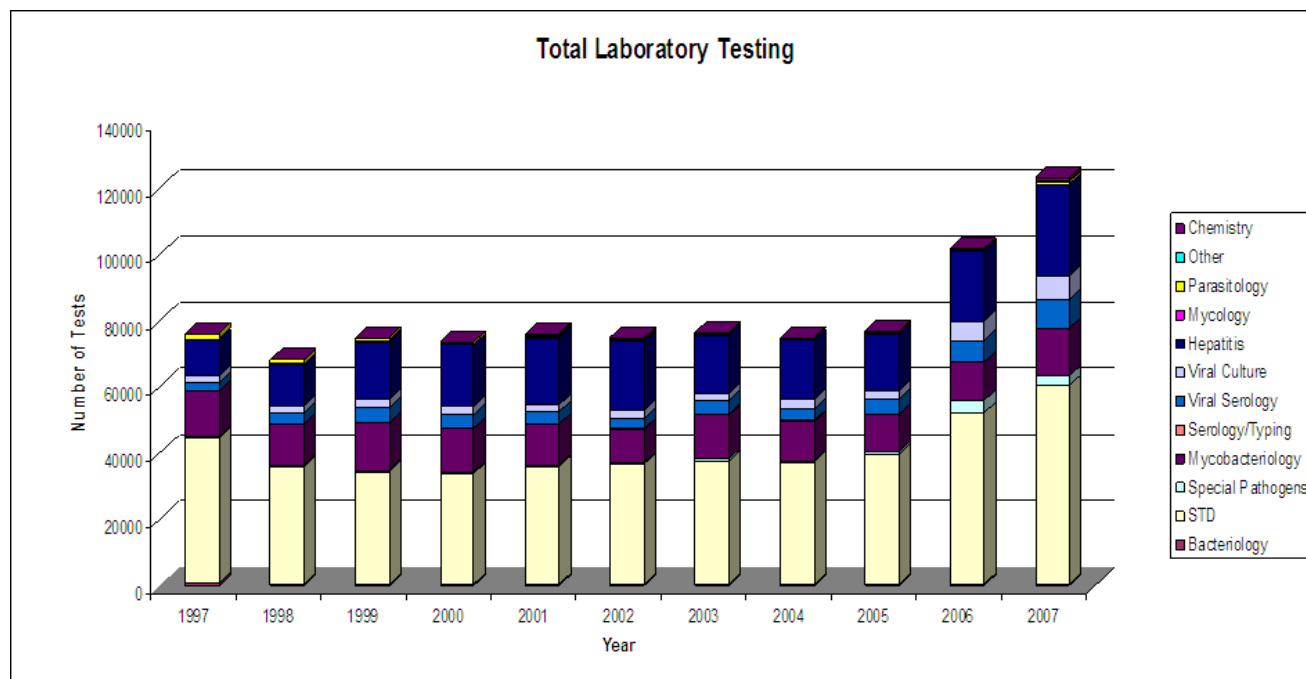
Public Health Laboratories

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 FY07 include:

- The laboratory received and processed 123,284 (21% increase over FY06) 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: 60,058 (+16%; highest since 1994)
- Total number of hepatitis tests: 27,920 (+31%; all-time record high)
- Total number of tuberculosis tests: 14,584 (+24%; highest since 1996)

- Total toxicology tests: 787 (+272%)



Health Planning and Infrastructure

Health Planning and Infrastructure core services include community health needs assessments, health indicators tracking, data analyses and reports, technical assistance, health plan development, community health grants, health service design, and health care reimbursement and sustainability strategies monitoring. These core services focus on needs in health care services, facilities, funding strategies, and health professions work force.

Examples of services provided by Health Planning and Infrastructure in FY07 include:

- Technical assistance on health care services and funding to over 90 communities, including 16 Community Health Aide Training and Supervision grants totaling 1.7 million.
- Technical assistance to HRSA “New Access Point” Community Health Center Applicants resulting in eight additional new Community Health Center sites receiving an additional \$1,536,653 in recurring federal funds.
- Review of all Certificate of Need (CON) applications that were submitted.
- Completion of health assessments, plans and reports including: (1) the Comprehensive Integrated Mental Health Plan (*Moving Forward*) with additional tables and data sources, (2) federal health professional shortage area designation requests; (3) the Alaska Physician Supply Task Force report; and (4) a household survey, employer survey, key informant interviews, focus groups and other activities related to lack of health insurance in Alaska.
- Implementation of health care work force programs that resulted in rotations for 57 health professions students and residents in 26 underserved sites throughout Alaska.
- Strategic planning for the Medicare Rural Hospital Flexibility program resulting in a \$100K increase in grant funds to address critical access hospitals’ performance and sustainability.
- Technical assistance to small rural hospitals that resulted in commitments by hospitals to participate in Centers for Medicare and Medicaid Services quality measures; and submission of critical access hospital applications by tribally managed hospitals.

List of Primary Programs and Statutory Responsibilities

Statutes

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 18.07	Health, Safety and Housing, Certificate of Need Program
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
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 Individuals
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 47.30.660	Comprehensive Integrated Mental Health Plan
AS 47.32	Centralized Licensing & Related Administrative Procedures
AS 47.35.010	Child Care Facilities, Child Placement Agencies, Child Treatment

Regulations

4 AAC 06.055	Immunizations
7 AAC 05.110 - 990	Vital Records

7 AAC 05.976	Heirloom Marriage Certificates
7 AAC 07.010	Health and Social Services Certificate of Need
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

Federal authority

Title XVIII Medicare

Title XIX Medicaid

Title XXI Children's Health Insurance Program

Explanation of FY2009 Budget Changes

Public Health	2008	2009 Gov	08 to 09 Change
General Funds	28,711.4	32,960.0	4,248.6
Federal Funds	34,657.0	38,777.6	4,120.6
Other Funds	22,092.6	25,705.1	3,612.5
Total	85,461.0	97,442.7	11,981.7

Nursing

Public Health Nursing Grant Program: \$120.7 General Fund

This funding increment will provide the four public health nursing grant program recipients (Maniilaq Association, Norton Sound Health Corporation, North Slope Borough, and the Municipality of Anchorage) with a 5 percent increase in state grant funding. These entities provide public health nursing services to the residents of these four geographical areas of the state not served by State Public Health Nursing. This investment will allow the grantees to continue to provide basic public health nursing services such as infectious disease prevention and control services including immunizations, and screening, treatment and contact investigation for infectious diseases such as tuberculosis and sexually transmitted diseases. Services also include preparation and response to public health threats and emergencies. In FY07 state public health nursing grantees provided more than 28,000 client visits to more than 17,000 individual clients, and administered almost 25,000 immunizations to prevent potential disease. This increment will allow our grantees to continue to provide these critical services locally rather than pass the responsibilities back to the state. Due to increased travel and other costs, it would be more expensive if the state had to provide these services directly.

Women, Children and Family Health

Diagnostic Team and Referral for Autism Spectrum Disorder: \$250.0 Total \$125.0 GF/Mental Health, \$125.0 MHTAAR

This request begins to phase out FY08 Mental Health Trust Authority Authorized Receipts with General Fund/Mental Health (GF/MH) funding in FY09. This investment will enhance the capacity to provide diagnosis and comprehensive, active referral for Autism Spectrum Disorders (ASD). A multidisciplinary-team approach assures that children receive an accurate diagnosis from a team of specialists and rules out other possible medical conditions that may be associated with ASD. Autism is a spectrum disorder that is neurologically based and affects social skills, communication, play and behavior. Nationally, the disorder occurs in approximately one in 166 children – more than three times the number with Juvenile (Type 1) diabetes (CDC, 2005). About 60 Alaska babies born each year are expected to have an autism spectrum disorder. It is estimated that the cost nationally of this disorder is \$35 billion annually, with even more spent on the loss of productivity of untreated individuals.

MH Trust: AB-Gov Cncl – Center for Human Development Capacity building for autism intervention: \$250.0 Total \$125.0 GF/Mental Health, \$125.0 MHTAAR

The FY09 funding request is \$125.0 MHTAAR and \$125.0 GF/MH, maintaining momentum of effort to include the treatment of autism in our state's continuum of care. CHD Capacity Building for Autism Intervention is a component of the overall autism initiative and will provide funding to train individuals to offer effective early autism intervention services. As a result, a cadre of professionals and paraprofessionals will be available to deliver intensive autism intervention soon after a child is diagnosed, and early in a child's life when research shows intervention has the greatest impact. The Department of Health and Social Services, Section of Women's Children's and Family Health will

transfer funds to the University of Alaska Center for Human Development through a Reimbursable Services Agreement.

Certification and Licensing

Incremental Funding to Support Growth Demand for Background Check Unit: \$1,000.0 Receipt Support Services

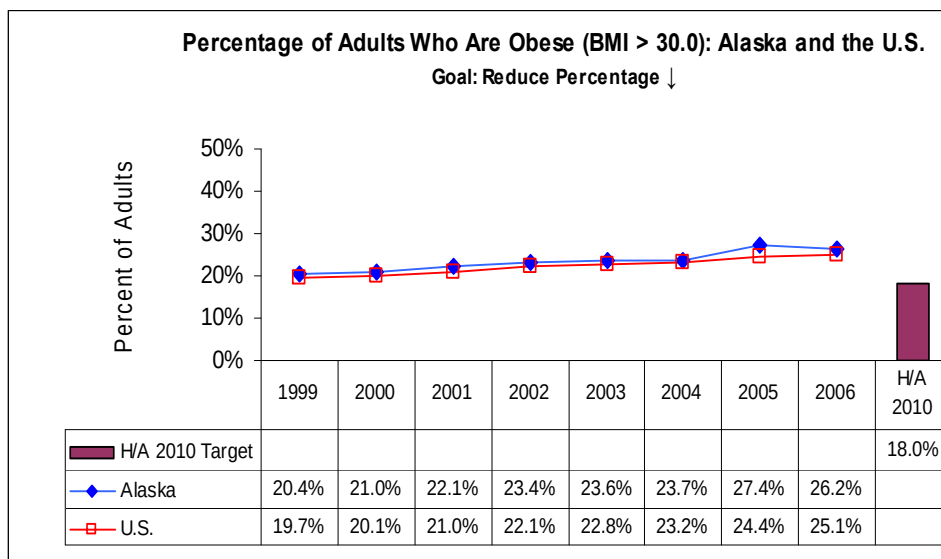
In the past year, services within the Section of Certification and Licensing (C&L) have been greatly impacted by both regulatory and statutory changes – especially its Background Check Unit (BCU). Certification and Licensing estimated it would receive roughly 14,000 background check applications in the first year from hospitals, nursing homes, residential child care, assisted living homes and all health-related service providers. However, in the first 17 months, nearly 24,000 applications were processed. This is a significant workload increase; the good news is that this program is also generating more fees. The cost of processing one application and set of fingerprints is \$79.85; of this, C&L/BCU collects \$25 RSS for the application fee and \$54.25 RSS pass-through to process fingerprints. At the end of the first quarter of FY08, C&L had collected 87.4% of its authorized RSS. This request is to increase RSS authority by 1,000.0 in FY09.

Chronic Disease Prevention and Health Promotion

Helping Alaska's Schools Address Childhood Overweight and Obesity: \$596.7 General Fund

With this increment, the Physical Activity and Nutrition Promotion (PAN Promotion) program will provide resources to six grantee schools to improve policies and practices that support healthy eating and physical activity, thus empowering Alaska's youth to make informed decisions and ultimately take responsibility for their own health.

Childhood overweight is becoming a crisis in Alaska, with dire health, social and economic consequences. Forty percent of premature deaths are due to behavioral choices that lead to obesity. We know youth overweight and inactivity leads to adult obesity. The Rand Corporation, a leading national think tank that focuses on health economics research, says that one of every five health care dollars spent by older members of our families will be for conditions related to their obesity. The numbers in Alaska are staggering: 32 percent of Anchorage students entering kindergarten or first grade are overweight or at risk of becoming overweight. Less than one-fourth of Alaska high school students attend daily physical education classes. A 2007 report from the Trust for America's Health ranked Alaska – a young and supposedly active state – 16th worst in the nation for adult obesity at nearly 26 percent of the population. According to another study, nearly two-thirds of adult Alaskans are overweight or obese. We must act now to prevent more of our children from growing up to become obese adults.



Tobacco Systems Cessation Grant Program: \$187.0 Tobacco Tobacco Prevention and Control: \$813.0 Tobacco

Tobacco use is the number one cause of preventable death in Alaska. Of the adult Alaskan population: 24 percent of all adults, 48 percent of low income adults, 44 percent of Alaska Native adults, and 45 percent of adults with less than a high school education use tobacco. More than 77 percent of adult tobacco users in Alaska report that they want to quit. Each year, tobacco cuts short the lives of nearly 600 Alaskans and costs the state over \$329 million in direct medical costs and lost productivity due to tobacco-related deaths.



The \$187.0 increment will go to planning and support of different training opportunities. A series of trainings centered on capacity building and readiness geared toward communities not yet prepared to apply for the Community-Based Tobacco Prevention Grants – but ready to begin addressing tobacco issues – will be provided. In addition, the increment will provide more tobacco prevention training opportunities for school districts who were new FY08 grantees, including training and in-service days on: curriculum, policy, capacity building, information and training for parent and

community groups, and enforcement issues. To increase awareness of effective strategies and challenges, funding is needed for printing and greater dissemination of published reports and findings from the Alaska Tobacco Prevention and Control program (TPC), including poster presentations, and audiovisual displays.

The \$813.0 request is needed to provide:

Additional technical assistance for the successful Community-Based Tobacco Prevention Grant program, including: a statewide tobacco media library and mail-out center, to be housed on the web, and to provide media created by TPC to Alaskans statewide; a new statewide youth prevention pilot project to provide training to adults and teens interested in starting youth action groups in their communities focused on tobacco prevention, as well as small grants to these groups to fund locally developed projects and activities.

Grants to communities to increase their work in coalition building, youth prevention, policymaking and/or counter-marketing; and to provide new Community-Based Tobacco Prevention Grant awards to communities and regions that have not received funding before, including communities focusing on special populations. This grant program has a proven record of success, and these additional funds will allow us to continue using nationally-recognized, evidence-based strategies.

Epidemiology

Human Biomonitoring for Chemical Contaminants and Fish Consumption Advice for Alaskans: \$300.0 General Fund

Alaskans are bombarded with conflicting and confusing messages about the safety of fish consumption. On the one hand, health and nutrition professionals tout the significant health benefits of fish consumption, including cardiovascular benefits and optimal fetal brain development. On the other hand, advisories to limit fish consumption because of contaminant concerns are ubiquitous. Two federal agencies have jointly issued a



national fish advisory recommending that children and women of childbearing age should limit their consumption of fish and seafood to 12 ounces a week. However, based on local human biomonitoring, DPH has documented its disagreement with the national fish advisory, which has been shown to be inappropriate for Alaska. This increment request is the sole source of funding to continue this program. It consists of two key components:

- An ongoing Hair Mercury Monitoring program to document mercury exposures in Alaska. Data from this program, which has tested over 500 women to date, are used to successfully defend the state's position that fish from Alaska is safe to eat in quantities far exceeding 12 ounces a week (the national, generic advisory level).
- A toxicologist within Epidemiology to interpret fish chemistry data, prepare public health recommendations and reports, coordinate the Alaska Scientific Advisory Committee for Fish Consumption, and promote Alaska's balanced risk vs. benefit approach to fish consumption advice at a national level.

Tuberculosis Control Program Fund Source Change: (\$150.0 Federal), \$150.0 General Fund

The tuberculosis (TB) rate in Alaska is more than twice the national average. Each confirmed case requires screening and testing of 16 to 18 people who are identified contacts to the case to determine if the TB germ has been spread. Some people with suspected or actual TB are hard to locate; this requires labor-intensive, gumshoe detective work. For those who do contract the disease, the treatment regimen requires as many as 62 doses of medication administered over six to nine months. Each dose can consist of as many as 15 pills and must be given under direct observation to be sure that the pills are actually swallowed. This standard of care is essential to prevent treatment failures that can lead to multi- and extensively-drug resistant TB. Without this increment, the state's ability to undertake these necessary contact investigations and to assure each patient completes the required therapy will be seriously jeopardized.

This request is critical if the state is to successfully maintain control and treatment of TB in Alaska. Since 2000, base federal funding from CDC has remained relatively constant (\$426.1 in 2000 to a peak of \$495.8 in 2004 to the 2008 projection of \$431.1). But actual purchasing power has been lost to inflation and other costs, such as the soaring price of TB medications. However, the biggest impact on the TB Control program is the loss of additional funding from federal earmarks, totaling about \$1.4 million since 2000. The last earmark – \$496.0 in addition to base CDC funding – was expended in SFY07. A new federal earmark of \$487.0 was approved in December 2007 and runs through September 30, 2008. The \$150.0 GF is still needed for SFY09 to keep pace with rising costs and make sure treatment and prevention efforts are maintained.

Community Health Grants

Discontinue Private ProShare Refinancing: \$1,172.0 General Funds

This increment replaces federal funding with general funds due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Medicaid Services Due to Elimination of ProShare Financing: \$279.4 General Fund

In SFY08 a GF increment of \$4,044.0 was authorized to replace 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. That entire increment was placed in Health Care Services / Medicaid Services. However, these services are provided by other divisions. Senior and Disabilities Services/Community

Developmental Grants Used the ProShare program to provide services that include but are not limited to: Care Coordination, Chore Services, Day Habilitation, Independent Living Support, Behavioral Training, Intensive Active Treatment, Residential Services, Respite Care, Specialized Adaptive Equipment and Vocational Services. This transfer of \$279.4 is necessary to give the division the funding needed to continue these services.

Injury Prevention/Emergency Medical Services

This is a new component for FY09. The component Health Planning and Infrastructure (HPI) was realigned and added to the RDU Public Health in FY09. HPI had two Reimbursable Service Agreements (RSA) with the Division of Public Health, Section of Injury Prevention/Emergency Medical Services (IPEMS). This record transfers the funding directly to IPEMS to continue supporting the Rural Medical Services program.

Public Health Laboratories

Pro-Rated, Half-Year Funding for Opening of New Fairbanks Virology Lab: \$395.0 General Fund

The Legislature provided funding to replace the aging Fairbanks virology laboratory of the Alaska Public Health Laboratories; that project is expected to be completed in December 2008. This increment is for half-year, pro-rated costs to support operating the new laboratory (utilities, janitorial, snow removal, parking, heat, electricity, natural gas, etc.).

Challenges

As the Division of Public Health (DPH) works to achieve its overall mission – to protect and promote the health of Alaskans – several major challenges face its leadership and staff. In general terms, and not surprisingly, these challenges revolve around the division’s core services and for FY09 fall into four main categories defined in DPH’s performance measurements: reducing the risk of epidemics and infectious disease; reducing suffering, death and disability due to chronic disease; assuring access to early preventive services and quality health care, and reducing exposure to environmental human health risks. In each of these categories, progress will continue through the right mix of necessary investments in the division’s programs, partnerships within the public health community and the recruitment and retention of expert, dedicated staff.

Controlling Infectious Disease and Reducing the Risk of Epidemics

Fighting infectious disease is increasingly complex and challenging: New diseases are discovered all the time, the threat of pandemic influenza still looms, controlling tuberculosis and vaccine-preventable diseases is an ongoing challenge, and Alaska’s role as a transportation and tourism hub is still growing. In FY09, additional funding for TB control is required because the disease, once called the “Scourge of Alaska,” can still kill our citizens. Four Alaskans died with TB in 2004 because of delayed diagnosis and treatment. TB is an equal opportunity disease. It is transmitted through the air and can infect anyone at any time. The TB rate in Alaska is more than twice the national average. In 2006 in Anchorage alone, 41 cases of TB were reported. Despite hard work and strong coordination between the Section of Epidemiology and the Municipality of Anchorage, that outbreak is continuing.



Also, an additional investment for Public Health Nursing grantees will help assure the continuation of basic services such as infectious disease prevention and control, including immunizations, screening, treatment and contact investigation for infectious diseases such as tuberculosis and sexually transmitted diseases.

Preventing Chronic Diseases

Chronic diseases are responsible for three of every five deaths in Alaska. The primary risk factors for chronic diseases are obesity, lack of exercise, poor diet and tobacco use. 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 health care dollars in the years to come. Childhood overweight is becoming a crisis in Alaska and will lead to dire health, social and economic consequences. Additional funding is required to provide Alaskans with the knowledge and tools they need to make healthy choices, and to create healthy communities – especially through support of physical activity and nutrition programming in schools. The FY09 increment will allow six grantee schools to improve policies and practices that support healthy eating and physical activity.

In addition, more work must be done to reduce the use of tobacco in Alaska. Tobacco continues to be the top 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. The

FY09 increment will provide grants to communities to increase their work in coalition building, youth prevention, policymaking and counter-marketing and, will provide new grants to communities and regions that have not received funding before. A related increment will also provide technical assistance including the development of a statewide tobacco media library and mail-out center, and fund a statewide youth prevention pilot project to facilitate the start-up of youth action groups focused on tobacco prevention.

Assuring Access to Early Preventive Services and Quality Health Care

The still relatively new Section of Certification and Licensing (C&L) was formed to ensure that Alaska's vulnerable seniors and children in need of residential services will always receive safe and appropriate care. Continued investment in the ongoing consolidation of these functions into DPH is critical to ensure that facilities are inspected in a timely manner, licensing paperwork is quickly reviewed and state and federal safety mandates are met. Staff is now responsible for safety in nearly 700 facilities statewide, from hospitals to nursing homes to children's residential facilities. Within C&L, the Background Check Unit (BCU) provides the critical service of ensuring that employees of licensed residential facilities have not committed barrier crimes, making them potentially dangerous caretakers of vulnerable people. During its first year of operation, the BCU projected it would process 14,000 applications but actually processed 24,000 in 17 months. It is important to complete this work without significant backlogs, and although staff have managed this through the use of overtime, it is equally important to avoid staff burnout. A budget change in FY09 will allow an increase in Receipt Supported Services (RSS), thus allowing the collection of background check fees to cover the cost of needed new staff.

There are a number of alarming trends in Alaska related to birth outcomes, including the projected occurrence of Autism Spectrum Disorder (ASD) in about 60 Alaskan babies each year. Mental Health Trust funding for early diagnosis and treatment referral of ASD babies will be phasing out, beginning in FY09. An increment to replace some MTAAR funding with General Funds will allow important early diagnosis and referral activities to continue, ensuring that the affected children have an opportunity to achieve their potential.

Reducing Human Exposure to Environmental Health Hazards

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. DPH has documented its disagreement with a national fish advisory that recommends children and women of childbearing age should limit their consumption of fish and seafood to 12 ounces per week. An ongoing Hair Mercury Monitoring program in DPH's Section of Epidemiology shows that this national recommendation is inappropriate in Alaska, where it is safe to eat locally caught fish and seafood in much larger quantities. The FY09 increment for Human Biomonitoring for Chemical Contaminants and Fish Consumption Advice for Alaskans will provide the sole funding for the continuation of this important program.

Besides providing testing data on fish consumption, 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). Additional funding is necessary to keep the state labs operating effectively and efficiently by preparing for the opening of a new virology laboratory in Fairbanks. It is scheduled for completion in December 2008 – halfway into FY09.

Performance Measures — Division of Public Health

Contribution to Department's Mission

To protect and promote the health of Alaskans.

Core Services

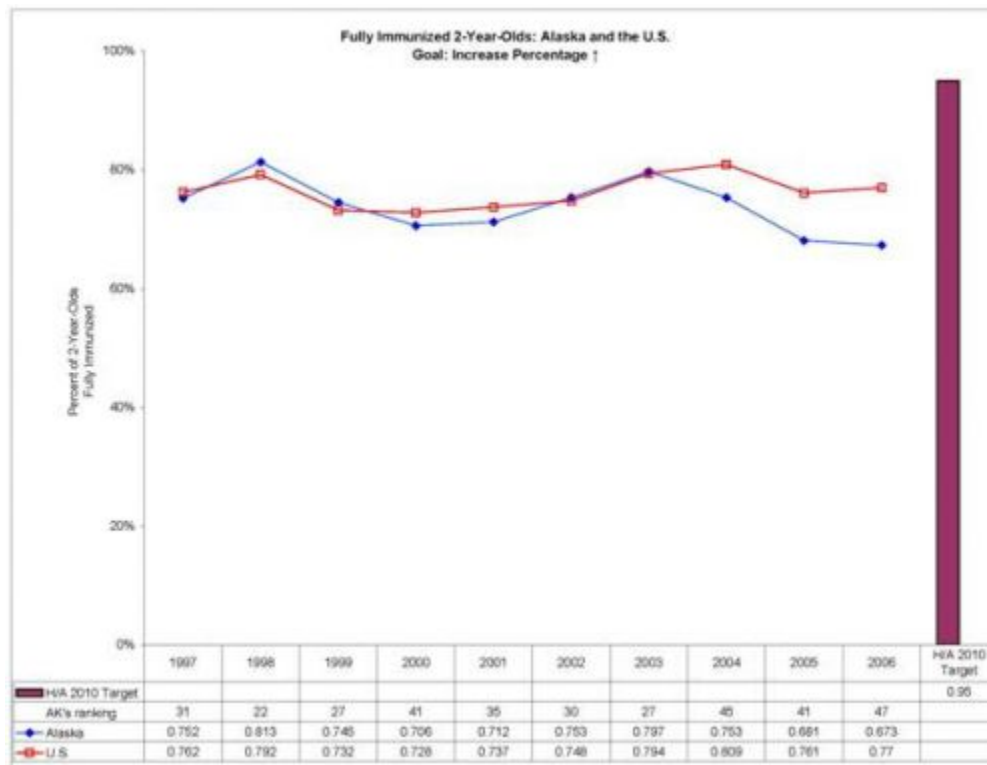
- Prevent and control epidemics and the spread of infectious disease.
- Prevent and control injuries.
- Prevent and control chronic disease and disabilities.
- Respond to public health emergencies, disasters and terrorist attacks.
- Assure access to early preventative services and quality health care.
- 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 percent of all two year olds are fully immunized.

Measure #1: percent of all Alaskan two year olds fully immunized.



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
2006	77.0	67.3*	47

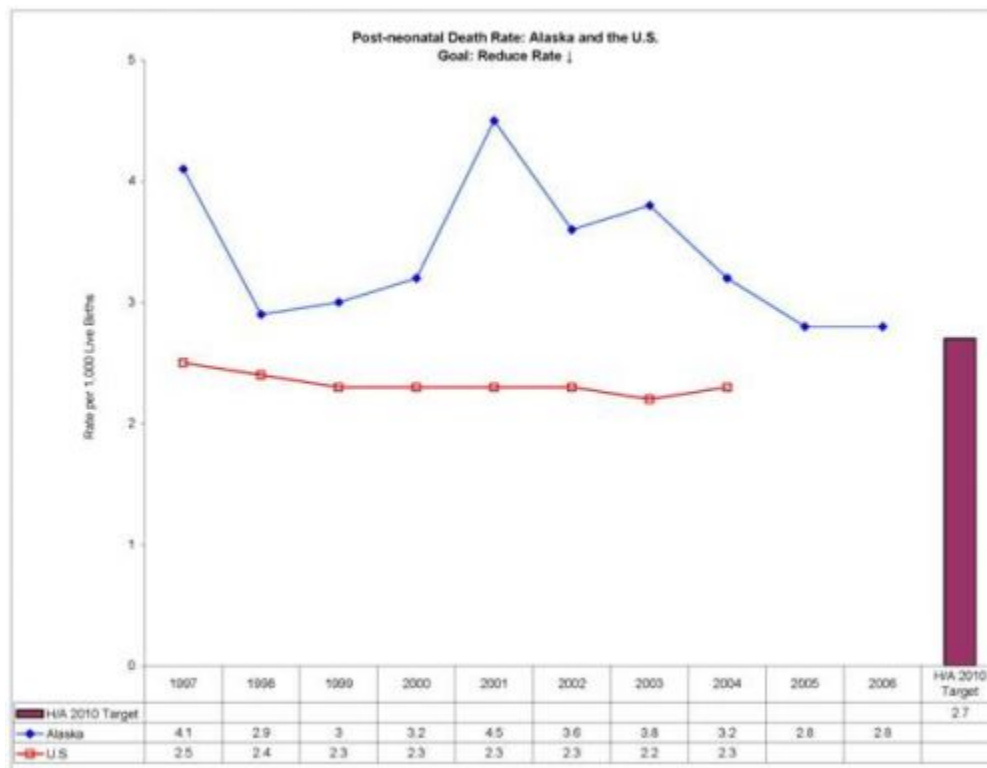
In 2005, CDC began using a new six-dose standard for its recommended basic immunization series.

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. 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 one 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
2006	2.8	N/A

Note: The National Center for Health Statistics has not yet released US death rates for 2005 and 2006.

Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects three-year rate, i.e. 2006 represents 2004-2006.

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 Department of Health and Social Services is under way 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%	7.0%
2005	5.3%	7.3%

Note: 2005 Alaska data are based on a 3-year average of 2004-2006.

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.

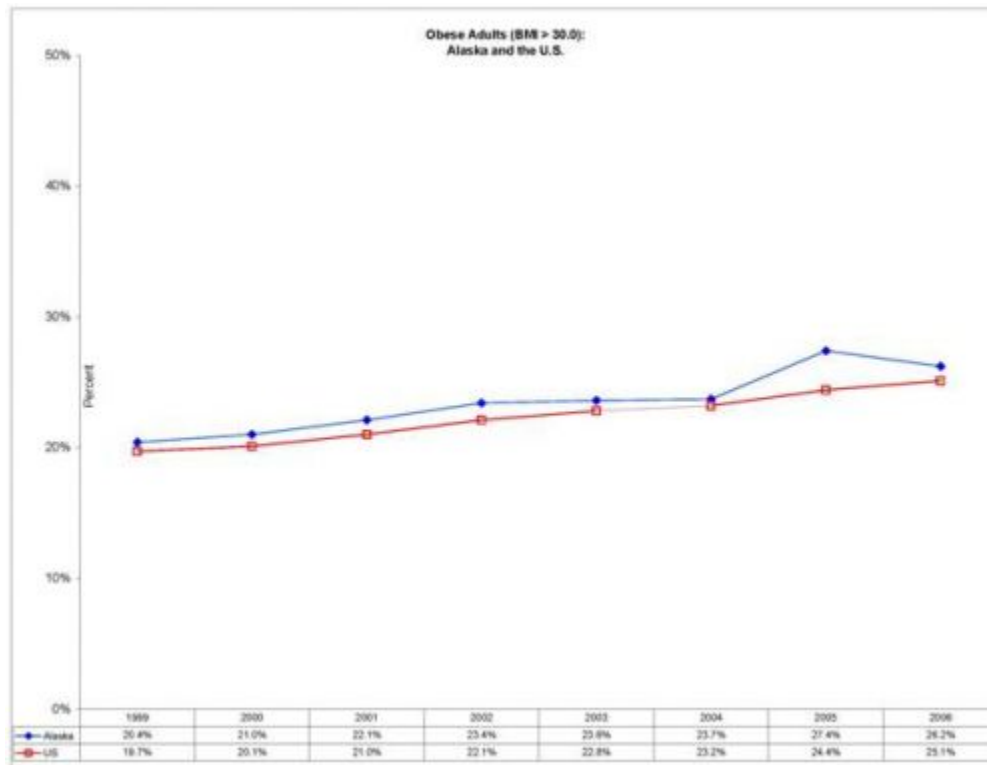
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence 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 percent 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 our community partners. 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 providing the knowledge and tools needed 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 percent.

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%
2006	26.2%	25.1%

Analysis of results and challenges: Analysis of results and challenges: The trends in Alaska continue to show growing numbers of overweight and obese adults, with an obesity rate of 26.2 percent in 2006. By comparison, the Healthy Alaskans 2010 target for obesity is 18 percent.

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, targeting the promotion of 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 -25.00%
2005	4.8 -2.04%	8.9 +34.85%
2006	4.6 -4.17%	10.4 +16.85%

Analysis of results and challenges: Tuberculosis has been a longstanding problem in Alaska and was the cause of death for 46 percent of all Alaskans who died in 1946. Major efforts, utilizing 10 percent 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. In 2005 and 2006 Alaska again had the highest rate of TB of the 50 states. This was the result of a large outbreak among the homeless in Anchorage that has continued into 2007. On an ongoing 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.

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 11 cases – 59 in 2005 up to 70 in 2006. Despite the recent outbreaks, the rate of TB in Alaska has shown a downward trend over the past 12 years.

Because of a high rate of latent TB infection among residents, and Alaska's location as a global crossroads that attracts travelers, seasonal workers and new families, rates of TB 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 ongoing challenge of TB, the department needs a strong and multi-pronged public health team of professionals knowledgeable about current issues of TB control as well as a strong public health nursing force. 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	657 +8.77%	333 +4.06%
2006	676 +2.89%	348 +4.50%

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may cause serious health consequences. Additionally, new infectious organisms and diseases are being detected, some diseases once under control have recently reemerged, and evolving antimicrobial resistance is rendering certain antibiotics ineffective.

Many challenges remain. More sensitive diagnostic technologies, targeted screening, and increased disease investigation activities have detected more infections, increasing the total numbers of Chlamydia cases diagnosed. Rapid identification, notification, testing, and treatment of sexual contacts of individuals with Chlamydia can make it possible to treat exposed individuals before they develop symptoms or further transmit infection. Conducted with sufficient intensity, these activities have been shown to reduce the reservoir of infected individuals in the population, reducing case numbers and rates

over time. Expanded programmatic efforts reduced Chlamydia rates in 2003-2004, but could not be sustained; rates have increased since that time.

The basic public health infrastructure for sexually transmitted disease (STD) and HIV prevention and control is in place: public health expertise for patient follow up and partner notification; high quality public health laboratory services; and capacity for epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure, especially trained personnel to conduct partner notification services, currently require additional resources to strengthen and expand them to a level sufficient to address needs. All elements require ongoing maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal and have declined over the past five years. Buying power has been eroded by increased costs of living and increased Department of Health and Social Services indirect costs. New resources are needed to expand program efforts.

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 -0.80%	177.8 -4.77%
2002	118 -13.62%	170.9 -3.88%
2003	126.6 +7.29%	162.9 -4.68%
2004	94.7 -25.20%	150.5 -7.61%
2005	90.7 -4.22%	149.8 -0.47%
2006	80.9 -10.80%	N/A

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

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 2003, more than 480,000 people died of coronary heart disease. 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 heart disease sometime in their life.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease, or 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. Since 2004, Alaska's coronary heart disease

death rates have been 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 -0.60%
2001	192.2 -8.30%	196.0 -1.80%
2002	189.4 -1.46%	193.5 -1.28%
2003	187.7 -0.90%	190.1 -1.76%
2004	184.0 -1.97%	185.8 -2.26%
2005	169.7 -7.77%	183.8 -1.08%
2006	167.8 -1.12%	N/A

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

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. However, unlike in most other states, in Alaska cancer is the number one cause of mortality. 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	50.6 -7.83%	38.1 +4.10%
2006	48.5 -4.15%	N/A

U.S. data will be updated once it is approved and released by the CDC's National Center for Health Statistics.

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 are the third leading cause of death in Alaska. Unlike cancer and heart disease, 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 percent of individuals with TB will complete adequate treatment within one year of beginning treatment.

Measure #1: Percent of individuals with TB completing treatment regimen.

Percentage of Individuals with TB Completing Treatment Regimen

Year	Annual
2002	93%
2003	93%
2004	86%
2005	92%
2006	50%*

**TB treatment requires 6-9 months for completion.
2006 completion data are still being collected.*

Analysis of results and challenges: The highest priority for TB control is to ensure that individuals 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 percent of Chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines.

Measure #2: Percent of individuals with Chlamydia prescribed adequate treatment regimen.

Percentage of Chlamydia cases prescribed adequate treatment

Year	Annual
2003	99.5%
2004	99.6%
2005	99.8%
2006	97.9%

Analysis of results and challenges: HIV/STD program staff follow up to assure adequate treatment is prescribed for all reported Chlamydia cases. Given such follow up, few cases are ultimately treated in a manner inconsistent with the national guidelines. Challenges include maintaining resources necessary to conduct necessary follow up and carefully monitoring disease trends to identify emerging problems.

The proportion of Chlamydia cases prescribed adequate treatment dropped slightly in 2006, due primarily to individuals refusing treatment or an inability to locate them. There were a total of 4,528 reported Chlamydia cases in 2006, compared to 4,356 in 2005.

A2: Strategy — Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 17 percent of high school youth in Alaska smoke.

Measure #1: Prevalence of smoking among 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 -18.10%
2003	19.2	21.9 -23.16%
2005	0 -100.00%	23.0 +5.02%
2007	17.8 0%	0 -100.00%

Data are collected every other year. Alaska data are not released in years when a statistically valid sample is not available. U.S. data will be reported when released by the CDC.

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking; being 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 percent) 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, educating young people, enforcing laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37 percent of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2 percent in 2003 and 17.8 percent in 2007. Data are 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 only in 1995, 2003 and 2007. Surveys occurred in other years; however, schools did not have enough participants to provide statewide results. 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 17 percent.

A3: Strategy — Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80 percent.

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%
2000	61.3%	71%
2001	62.6%	73%
2002	65.8%	73%
2003	78.9%	79%
2004	77.0%	80%
2005	78.4%	82%
2006	82.4%	81%

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 passing such a law, which took effect May 1, 2006. In addition, efforts are ongoing 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 percent 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
2000	80.8	62.3
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%
2004	81.8 -0.24%	68.4 +4.75%
2005	81.4 -0.49%	66.1 -3.36%

Analysis of results and challenges: Since 2000, the knowledge of folic acid benefits among Alaska mothers has remained at about the same level, around 81percent to 82 percent.

The proportion of Alaska Native mothers who know about the benefits of folic acid steadily increased to 68.4 percent in 2004, then fell slightly to 66.1 percent the following year. Numbers for 2006 still are not available. 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 in recent years.

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 percent and minimizing racial disparities.

Target #2: 100 percent 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.

Percentage of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
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%
2007	6.67	20	40	26.67	93.34

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 percent. 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 percent of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures.

Measure #1: Percent of DPH staff trained.

Number and percentage of Division of Public Health staff trained in disaster preparedness

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD
FY 2005			70	103	27%
FY 2006				144*	28%
FY 2007	27	106	17	31 0%	35%
FY 2008	69 +155.56%	0 -100.00%	0 -100.00%	0 -100.00%	69 0%

*144 Division of Public Health staff received disaster preparedness training in FY 2006. Quarterly numbers were 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 FY07 percentage reflects the following: 520 total DPH positions, with an estimated 181 individuals receiving disaster preparedness training — for a total of 35 percent trained. This meets the division goal of 25 percent annually. However, when only filled positions are considered (approximately 425 at the end of FY07), then the total of DPH-trained staff for FY07 to date increases to 42 percent.

A6: Strategy — Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100 percent of the important PCBs, pesticides and trace heavy metals.

Measure #1: Each new testing method validated as required by Clinical Laboratory Improvement Amendments (CLIA).

Percentage testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2004	10%	10%
2005	75%	50%
2006	75%	50%
2007	75%	60%

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 some testing for Persistent Organic Pollutants (POPs) is underway.

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Senior and Disabilities Services

Mission

Promote the independence of Alaskan seniors and individuals 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 individuals 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 individuals 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 through 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 four 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 four 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 be at the level of need provided to a client in a nursing home and 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 birth through age 21 who have a severe chronic physical condition that is expected to continue for more than 30 days. The condition must be life threatening and need careful all-day monitoring every day. The child must be dependent upon medical care or technology and require the same sort of care usually found in a hospital or nursing home.

The Mental Retardation/Developmental Disability (MRDD) Waiver

MRDD is specifically for 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 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, the person must require 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 be at the level of need provided to a client in a nursing home and 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 four 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. The division assesses the need for services by evaluating functional limitations in the performance of daily living activities including bathing, dressing and grooming; and “instrumental” daily living activities such as shopping and cleaning. This assessment and subsequent plan of care determines which services a recipient is eligible to receive and “prior authorizes” them to receive these services. The division certifies qualified agencies as PCA providers.

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 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, both in 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 15 skilled nursing facilities around the state. The average annualized yearly cost of care for a patient in a nursing home in FY07 was approximately \$176,351.

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 1,982 new cases in FY07. Between August 1, 2007 and Nov. 30, 2007, the intake caseload was 756 cases. If this intake rate continues through the rest of FY08, the division projects a total caseload intake of 2,000 cases in FY08. (December through February are typically the highest intake months)

Nutrition, Transportation, and Support Services Grants for Seniors

The U.S. Department of Health and Human Services, Administration on Aging (AoA) grants federal funds to the division each year to provide for Nutrition, Transportation and Support services for Alaska 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 Alaska seniors who 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 Mental Health Trust Authority Authorized Receipts (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 FY07 developmental disabilities grants provided services to nearly 1,468 recipients 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 four 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 SFY07, 15 organizations were awarded funds to operate a STAR program to help 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.

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—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, are 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 help keep seniors in their homes and communities at a cost that is typically far less than paying for a residential nursing home.

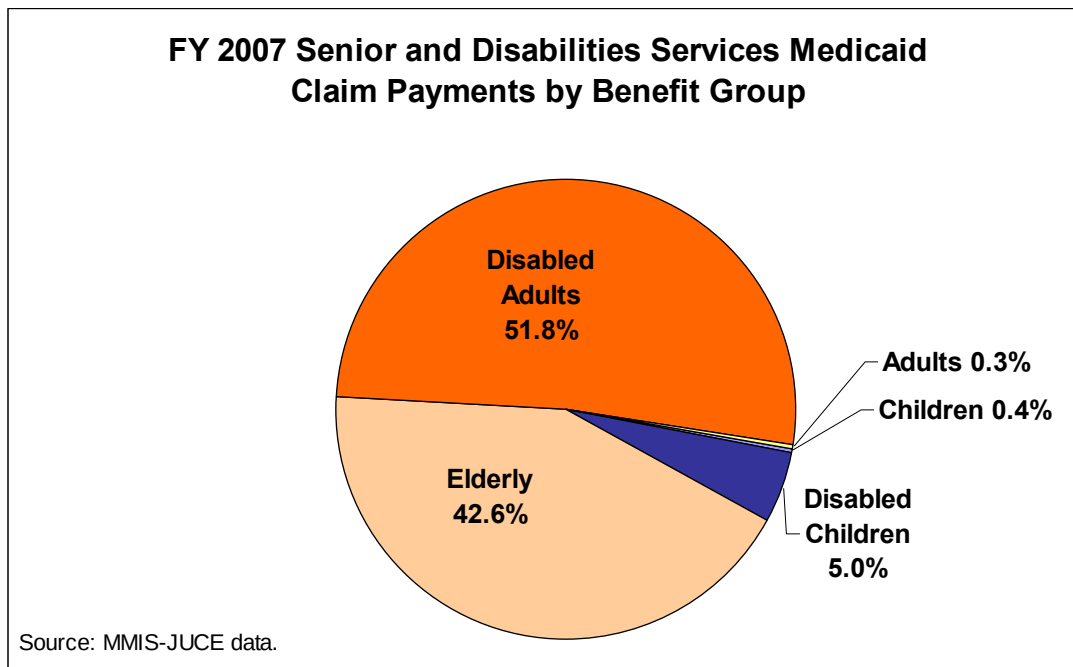
Annual Statistical Summary of Services Provided in FY2007

Senior and Disabilities Medicaid Services

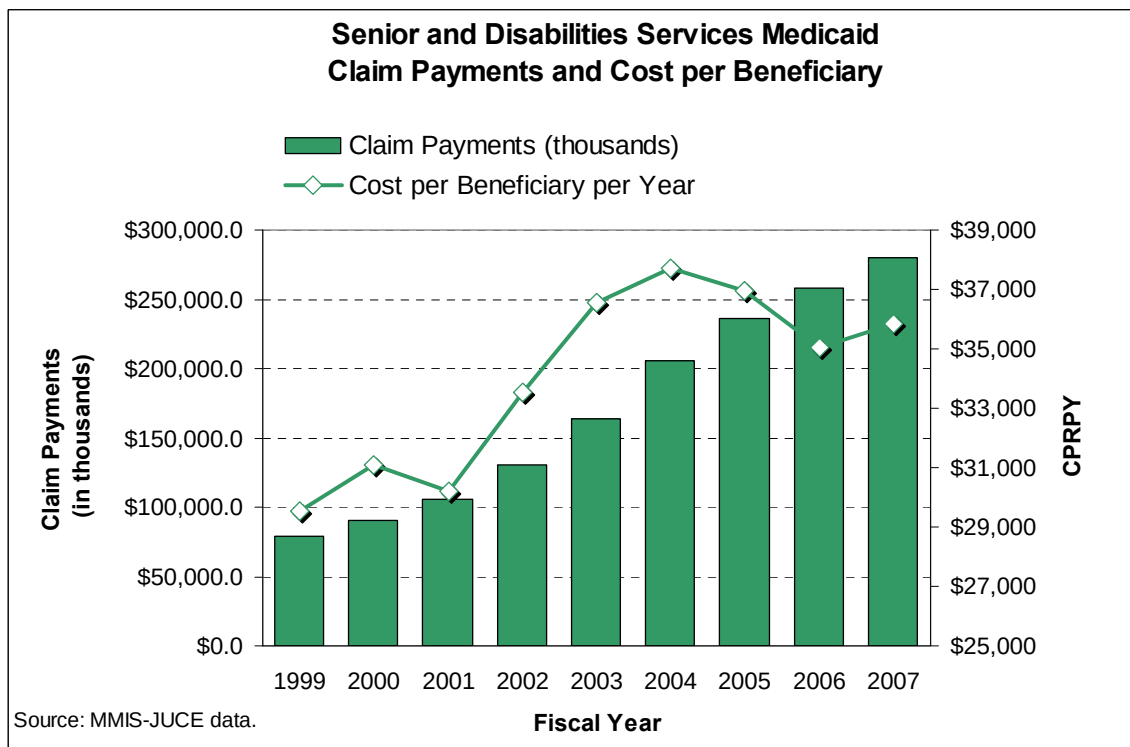
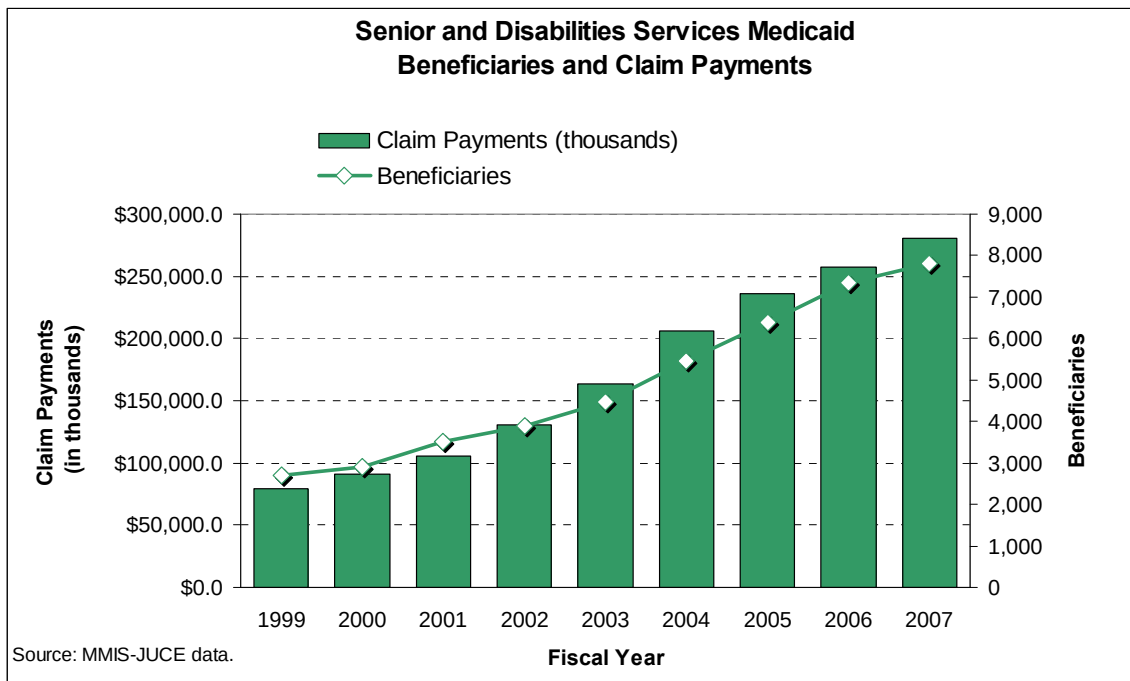
In FY07 Senior and Disabilities Medicaid provided services to over 7,800 Alaskans, about 6 percent of all individuals enrolled in the Alaska Medicaid program (nearly 33 percent of all elderly and disabled enrollees). The total cost of services funded through Medicaid was about \$280 million, or about \$35,800 per person (beneficiary) per year. More than half of the claim costs (57 percent) were for services provided to disabled individuals. Services provided to the elderly accounted for nearly 43 percent of claim payments processed in FY07.

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children Disabled	1.0%	79	0.4%	1,138.5	\$14,411
Children	10.7%	852	5.0%	13,966.1	\$16,392
Elderly	43.7%	3,487	42.6%	119,206.0	\$34,186
Disabled Adults	43.8%	3,494	51.8%	144,922.5	\$41,478
Adults	0.9%	73	0.3%	785.8	\$10,765
Unduplicated Annual Clients		7,817			
Total Medicaid Claim Payments (thousands)				\$280,018.9	
Average Annual Medicaid Cost per Beneficiary					\$35,822

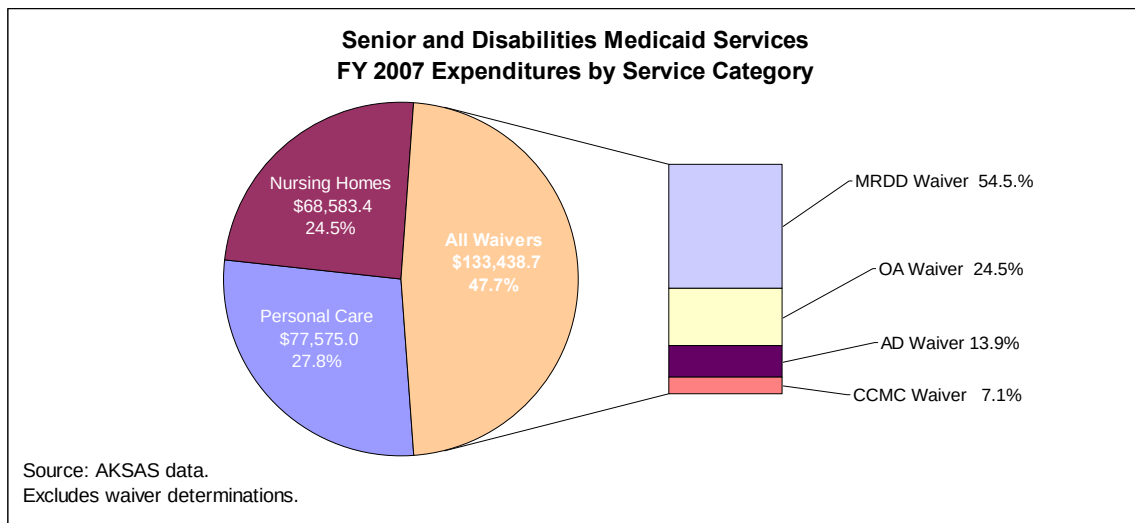
Source: MMIS/JUCE claims paid during FY07. The benefit category "disabled adults" includes disabled individuals between 19 and 20 years of age as well as adults.



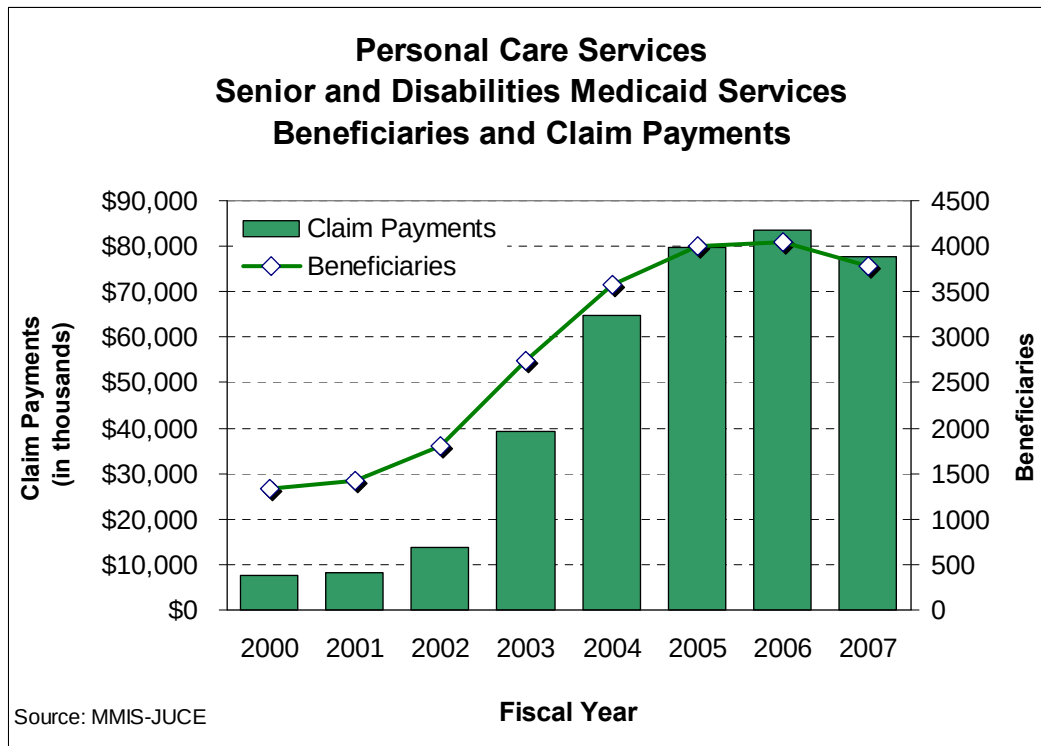
Although overall Medicaid enrollment dropped by almost 3 percent in FY07, enrollment of disabled and elderly individuals actually increased by about 4 percent. The number of beneficiaries utilizing Senior and Disabilities Medicaid services in FY07 increased by 6 percent while the total cost of services increased by nearly 9 percent. The annual cost per beneficiary increased by about 2 percent, but remained lower than annual costs per beneficiary between 2003 and 2006.



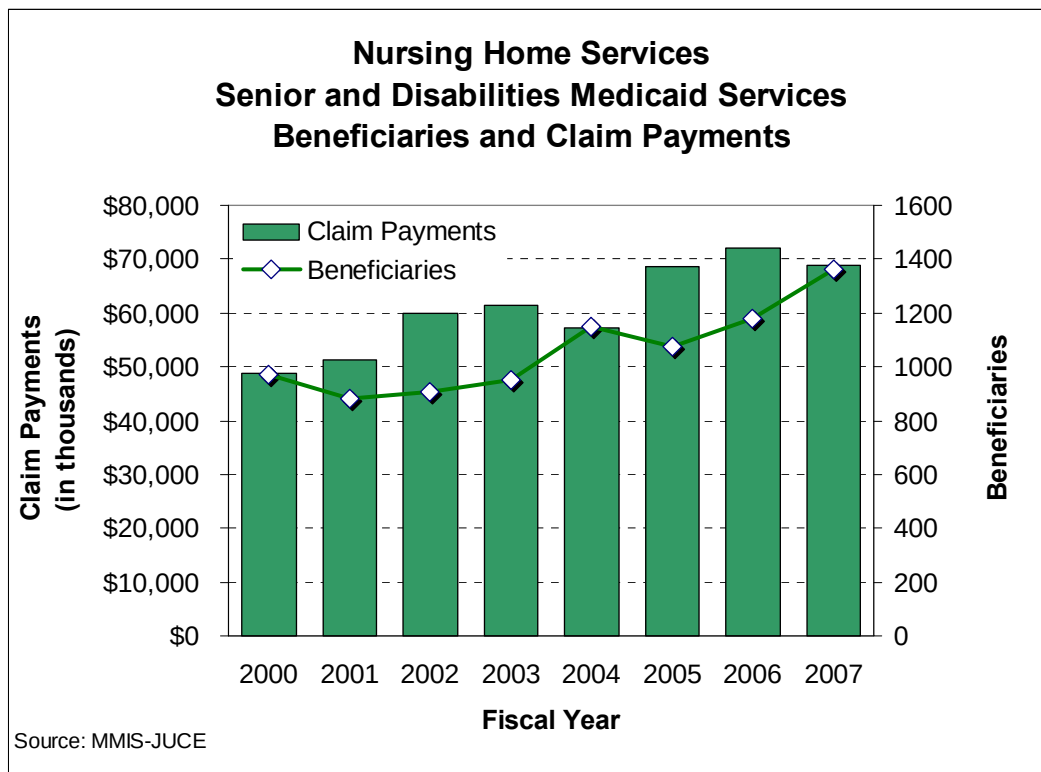
Waiver services comprised almost half (48 percent) of Senior and Disabilities Medicaid costs in FY07. Nursing home and personal care claim payments accounted for about 24 percent and 28 percent of costs.



Personal care services costs decreased by about 7 percent from the previous year, and the number of individuals served dropped by a similar amount.



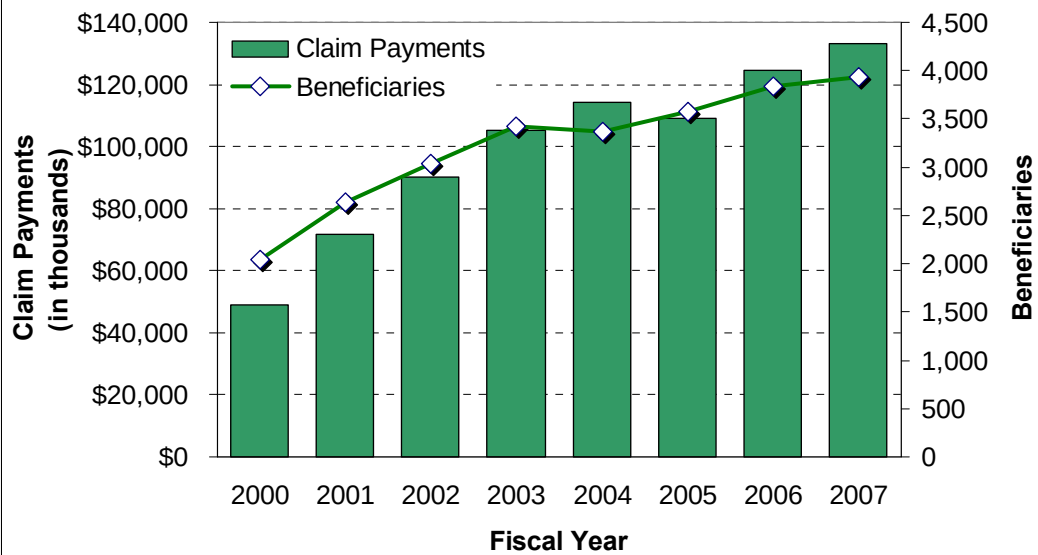
Total nursing home costs decreased (about 4 percent), though the number of individuals with nursing home claims processed during the year appeared to increase by almost 15 percent. This may be the result of late claim processing (counting claims that should have processed in the prior year) or may be due to a higher number of individuals receiving services during the year but, on average, for a shorter period of time.



Overall waiver services costs increased by nearly 7 percent (12 percent for adult disabled waiver services but less than 7 percent for each of the other three waivers). The number of beneficiaries using any waiver service increased by less than 3 percent (number of beneficiaries increased by about 6 percent in the adult disabled waiver but was unchanged in the other three). The annual cost per beneficiary increased for each waiver: 4 percent for Older Alaskan (OA), 5 percent for Adult Disabled (AD), 6 percent for Children with Chronic Medical Conditions (CCMC), and about 5 percent for Mentally Retarded and Developmentally Disabled (MRDD) waivers.

Waiver	Claim Payments (thousands)	Percent of Waiver Beneficiaries	Cost per Beneficiary
AD Waiver	\$21,891.9	32.1%	\$17,300
CCMC Waiver	\$9,209.4	5.7%	\$41,300
MRDD Waiver	\$69,489.7	23.7%	\$74,500
OA Waiver	\$32,574.8	38.6%	\$21,500
All Waivers	\$133,165.8	100.0%	\$33,800

Waiver Services Senior and Disabilities Medicaid Services Beneficiaries and Claim Payments



Source: MMIS-JUCE

SFY 2007 DIVISION LEVEL SUMMARY: Senior and Disabilities Services Medicaid	DSDS MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR (CPRPY)	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent Recipients	Percent Payments
Medicaid, Division Annual Totals		7,817		\$280,018,887	\$35,822	6.4%	28.6%
Gender							
Female	59.5%	4,650	58.2%	\$163,034,158	\$35,061	6.7%	31.0%
Male	40.5%	3,169	41.8%	\$116,984,729	\$36,915	6.0%	28.6%
Unknown						0.0%	0.0%
Race							
Alaska Native	21.6%	1,698	23.5%	\$65,967,177	\$38,850	3.6%	18.6%
American Indian	1.2%	92	1.3%	\$3,696,738	\$40,182	4.9%	29.9%
Asian	10.8%	850	8.1%	\$22,714,221	\$26,723	13.0%	52.2%
Pacific Islander	3.4%	267	2.5%	\$7,053,254	\$26,417	8.1%	34.4%
Black	4.2%	333	4.0%	\$11,271,699	\$33,849	5.2%	28.4%
Hispanic	2.7%	209	2.1%	\$5,813,438	\$27,815	4.9%	28.5%
White	51.9%	4,069	54.9%	\$153,749,863	\$37,786	8.2%	36.8%
Unknown	4.2%	328	3.5%	\$9,752,497	\$29,733	9.0%	36.9%
Native	22.9%	1,789	24.9%	\$69,663,915	\$38,940	3.7%	19.0%
Non-Native	77.1%	6,035	75.1%	\$210,354,972	\$34,856	8.2%	37.0%
Age							
under 1	0.3%	29	0.0%	\$47,331	\$1,632	0.2%	0.1%
1 through 12	7.3%	604	2.7%	\$7,695,460	\$12,741	1.3%	5.4%
13 through 18	4.4%	365	3.3%	\$9,162,544	\$25,103	1.6%	5.6%
19 through 20	1.6%	131	1.9%	\$5,282,673	\$40,326	2.9%	20.9%
21 through 30	5.9%	487	10.3%	\$28,773,841	\$59,084	3.5%	29.5%
31 through 54	19.8%	1,647	24.3%	\$67,994,801	\$41,284	8.8%	33.7%
55 through 64	13.6%	1,132	11.9%	\$33,352,959	\$29,464	24.2%	44.5%
65 through 84	36.3%	3,018	32.9%	\$92,091,172	\$30,514	41.4%	80.4%
85 or older	10.7%	891	12.7%	\$35,618,106	\$39,975	70.2%	94.3%
Benefit Group							
Children	1.0%	79	0.4%	\$1,138,505	\$14,411	0.1%	0.3%
Adults	0.9%	73	0.3%	\$785,814	\$10,765	0.3%	0.7%
Disabled Children	10.7%	852	5.0%	\$13,966,079	\$16,392	40.7%	25.4%
Disabled Adults	43.8%	3,494	51.7%	\$144,922,457	\$41,478	23.9%	50.0%
Elderly	43.7%	3,487	42.5%	\$119,206,032	\$34,186	46.7%	84.9%

Payment amounts are net of all claims paid during the fiscal year. Amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments. Payment amounts may not tie exactly to amounts in AKSAS or ABS.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2007. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the division and group level (gender, race, age, and benefit group). Some duplications may occur in subgroup counts.

Because department-wide recipient counts are unduplicated across divisions, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all divisions will exceed 100%.

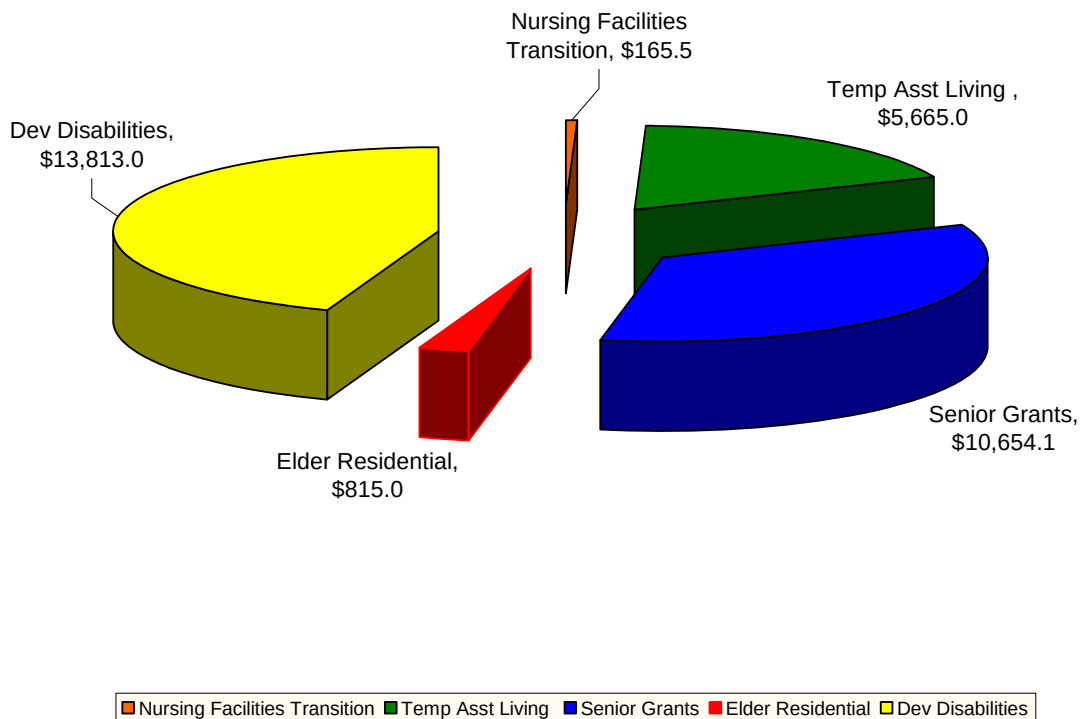
Source: MMIS/JUCE.

Non-Medicaid Grants/Services

DSDS Non-Medicaid Grant Expenditures in FY2007*				
Grant Name	Primary Service	# of Clients Served	Client Population	Total Exp:
Nursing Facilities Transition (\$92.3); Provider Agreements for CAT/PCAT Assessments (\$73.2)	Nursing Facilities Transition	37	Seniors	\$165.5
Gen Relief / Temp Asst Living	Temp Asst Living	845	Adults 18+	\$5,665.0
Senior Community Based Grants	Senior Grants	15,548	Seniors	\$10,654.1
Senior Residential Grts	Elder Residential	116 (30 FT, 86 PT)	Tribal Elders/Seniors	\$815.0
Comm Dev Dis Grts	Dev Disabilities	1,468	Dev Disabled	\$13,813.0
(Includes Proshare grant exp.)	Total Clients Served:	17,861	Total Expenditures:	\$31,112.6

This chart represents an unduplicated count of service recipients.

DSDS FY2007 Non-Medicaid Grant Expenditures



List of Primary Programs and Statutory Responsibilities

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 Individuals
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	Individuals 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 Program	Eligibility for the Home and Community-Based Waiver Services
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

Explanation of FY2009 Budget Changes

Senior & Disabilities Services	2008	2009 Gov	08 to 09 Change
General Funds	158,368.4	179,590.3	21,221.9
Federal Funds	191,246.8	192,932.8	1,686.0
Other Funds	3,960.2	4,269.9	309.7
Total	353,575.4	376,793.0	23,217.6

Senior and Disabilities Medicaid Services

FY09 Projected Medicaid Formula Growth: \$19,116.6 Total \$10,514.7 Federal, \$8,601.9 General Fund

In FY09, services for seniors and the developmentally disabled are expected to grow 6 percent over the FY08 authorized amount of \$318, 610.0. This increment request is necessary to maintain the current level of Medicaid long term health services. The Senior and Disabilities Medicaid Services component funds three types of services: nursing homes, personal care attendants, and home and community based services.

Seniors and Disabilities Medicaid Services Historical Utilization				
SFY	Enrollment	Beneficiaries	Claim Payments (thousands)	Cost per Recipient per Year
1999	16,718	2,688	\$79,351.7	\$29,521
2000	17,657	2,914	\$90,587.8	\$31,087
2001	18,455	3,504	\$105,834.3	\$30,204
2002	19,602	3,902	\$130,887.3	\$33,544
2003	20,731	4,484	\$163,925.3	\$36,558
2004	21,525	5,460	\$205,790.8	\$37,691
2005	22,275	6,395	\$236,357.6	\$36,960
2006	23,038	7,358	\$257,777.8	\$35,034
2007	23,944	7,817	\$280,164.4	\$35,840

Source: MMIS/JUCE

Enrollment stated for disabled and elderly individuals only. 98% of DSDS beneficiaries are from these benefit groups.

In FY07, total growth was affected by the Mentally Retarded and Developmentally Disabled Waiver, which grew approximately 4 percent from FY06 and is expected to grow again in FY08 by approximately 9 percent. Personal Care Services is a large portion of Senior and Disabilities Services, but its growth has been slowing due to cost containment measures. The Older Alaskan Waiver, another major contributor to overall growth, is expected to grow by 9 percent in FY08 and 7 percent in FY09.

The fund source projection is based on the actual amount of federal revenue collected in SFY07 in this component, 59 percent, and assumes that the proportion of expenditures eligible for each type of federal reimbursement remains the same. It also assumes that the SFY09 average federal medical assistance percentage remains at the SFY08 level of 53.76 percent for regular Medicaid and 67.63 percent for enhanced Medicaid.

FFY09 Federal Medical Assistance Percentage (FMAP) Rate Change for Medicaid: (\$9,004.9 Federal), \$9,004.9 GF/Match

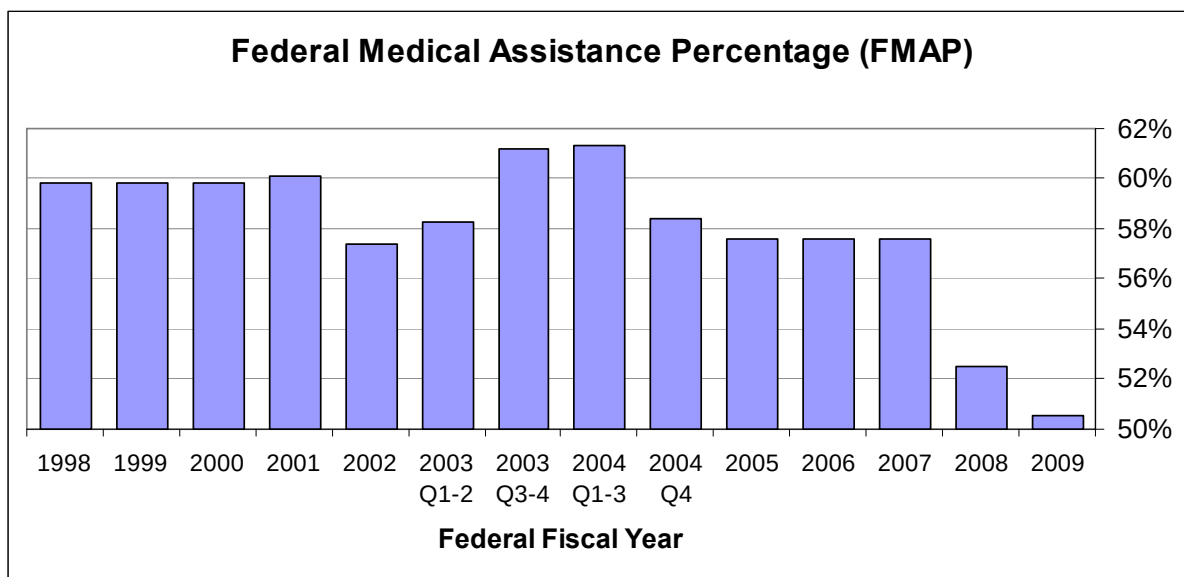
This request replaces lost federal revenues resulting from a 1.95 percent decrease in the rate the federal government reimburses the state for Medicaid benefits that will take effect on October 1, 2008.

The federal and state governments jointly fund Medicaid. The federal fund reimbursement rate is set by the Centers for Medicare and Medicaid Services and is outside the control of the state government. One in five Alaskans is enrolled in Medicaid at some time each year. Without the increment the state would be forced to reduce eligibility or services currently provided to low income children, pregnant women, individuals with disabilities, and the elderly. By approving this fund source change, the department will be able to continue to meet its mission of purchasing health care for Alaskans in need.

The amount of federal funds the state receives for its Medicaid program depends on a complex array of reimbursement rates, some of which change each October with the start of a new federal fiscal year. The bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the federal medical assistance percentage, or FMAP. The FMAP rate is based on the state's national rank of per capita personal income but can be no less than 50 percent.

The regular FMAP is projected to drop from 52.48 percent to 50.53 percent in FFY09. The regular FMAP for SFY09 will average 51.02 percent across two federal fiscal years (52.48 percent from July-Sept. 2008 and 50.53 percent from Oct. 2008-June 2009).

Approximately 97 percent of the Senior and Disabilities Medicaid Services component's claims are reimbursed at the regular FMAP (the remaining 3 percent is Indian Health Service). Based on current estimated expenditures for Medicaid, the FFY09 change in FMAP will require an estimated \$9,004.9 increase in GF to replace the lost federal funds and maintain services at the current level.



Transfer out Funding to Senior and Disabilities Services Administration (\$965.0) Total (\$482.5 Federal), (\$482.5 GF/M)

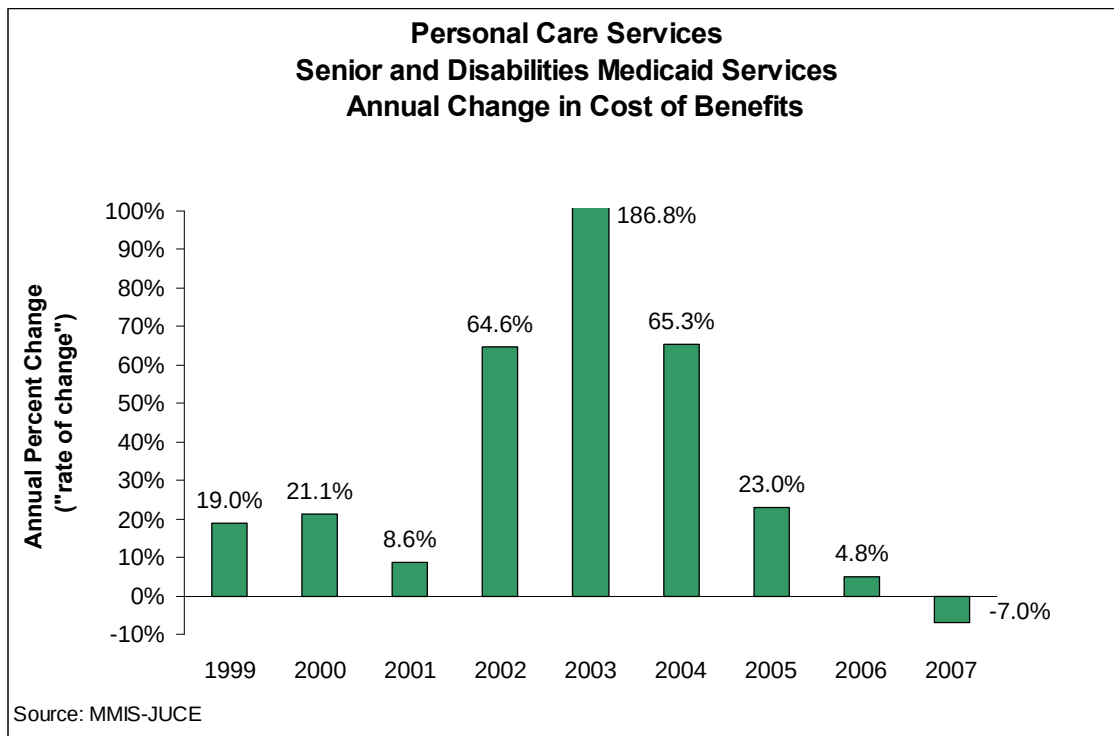
This funding transfer is for care coordinator services previously provided by private agency care coordinators and paid from the SDS Medicaid component, which will now be provided by state care coordinators through the SDS Administrative component.

Decrement PCA cost containment: \$3,000.0 GF/Match

Medicaid spending for personal care attendant (PCA) services grew by 42.2 percent per year between 1998 and 2004. The personal care cost containment initiatives for the program have been some of the most successful implemented by the department to date. Between FY00 and FY05, the PCA program grew from \$8 million to \$80 million. Since implementing regulation changes in FY06, the department succeeded in slowing the growth of the program and for FY07 spending actually decreased from the prior year by 7 percent. The department estimates that an additional \$3 million in cost containment can be realized in FY09.

State Fiscal Year	Beneficiaries	Payments for PCA Claims (in thousands)			Cost per Client
		Federal	State Match	Total Cost	
2000	1,339	\$5,072.4	\$2,572.1	\$7,644.6	\$5,709
2001	1,425	\$5,323.5	\$2,977.2	\$8,300.7	\$5,825
2002	1,804	\$8,146.5	\$5,518.2	\$13,664.8	\$7,575
2003	2,747	\$23,272.4	\$15,916.2	\$39,188.6	\$14,266
2004	3,577	\$39,795.2	\$24,858.1	\$64,653.3	\$18,075
2005	4,003	\$46,291.8	\$33,392.5	\$79,684.3	\$19,906
2006	4,039	\$48,238.9	\$35,300.1	\$83,539.0	\$20,683
2007	3,778	\$45,254.9	\$32,320.1	\$77,654.2	\$20,554

Source: Data from MMIS-JUCE claims database, with fund source totals based on the match rate for individual claim records at time of adjudication. Fund source amounts may not exactly match AKSAS data after adjustments.



Increase RSA from AKPH for Assisted Living Home Payments to Pioneer Home Residents: \$304.8 Interagency Receipts

This increment request matches anticipated increases to general fund match requirements associated with the RSA between AKPH (Requesting) and SDS (Servicing.) This increase reflects additional funding required because of changes to the FMAP rate, which requires greater GF match from AKPH.

This increment reflects an increase to the GF/M portion paid by the Pioneer Homes to SDS Medicaid for Assisted Living Services provided to Medicaid eligible Pioneer Homes residents. The increase is due to both higher Medicaid receipts to the Homes and to increased GF/M due to reduced FMAP.

Senior and Disabilities Services Administration

Transfer In Funding From Senior and Disabilities Medicaid Services: \$965.0 Total \$482.5 General Funds; \$482.5 Federal

Senior and Disabilities Services has been steadily adding new staff positions in each budget cycle in order to more effectively manage programs as programmatic growth occurs. At present, one of the most direct needs for additional staff (and support costs) exists in the Adult Protective Services unit, which investigates reports of harm, abuse and neglect of vulnerable adults and in the new care coordination unit to give recipients the choice between private agency or state care coordination. The influx of people needing care coordination will be steadily on the rise as SDS follows legislative intent language to eliminate the Developmental Disabilities Waitlist by 2010.

New positions will be added as follows:

- Adult Protective Services – 2 new investigators
- Care Coordination – 6 new care coordinators
- Administrative Support – 2 new positions

General Relief/Temporary Assisted Living

Transfer Authorization to General Relief / Temporary Assisted Living: \$2,748.4 General Fund, \$740.3 GF/Mental Health

This change record transfers authorization from the Protection and Community Services Component to a newly created component called General Relief/Temporary Assisted Living. The Protection and Community Services Component was originally created when the Division of Senior Services and the Department of Health and Social Services/Developmental Disabilities program merged to become The Division of Senior and Disabilities Services (SDS). As SDS evolved, all of the "administrative funding" and positions that were allocated to this component were transferred to the main administrative component for SDS called Senior and Disabilities Services Administration. At this point in time, the only funding left in the Protection and Community Services component funds the General Relief / Temporary Assisted Living program. SDS would like to transfer this funding to a new component with this name to better identify what these funds are used for.

There is no change in service as this is a technical change.

Senior Community Based Grants

Funding for Aging and Disability Resource Centers – Phased: \$250.0 Total \$125.0 GF/Mental Health, \$125.0 MHTAAR

Aging and Disability Resource Centers (ADRCs) will work with local senior and disability providers to create and maintain a comprehensive list of services (with eligibility requirements) available in that region and will distribute that information to all providers. Professional ADRC staff in each region will work with the state to develop and implement a general intake process and screening tool that will streamline access to appropriate and available assistance and will refer the individual to the next step of assessment and eligibility determination when appropriate. The Aging and Disability Resource Centers will be developed using the No-Wrong-Door concept in which consumers will be able to enter the system through multiple access points.

The Aging and Disability Resource Center concept was developed and implemented through a joint venture between the federal Centers for Medicare and Medicaid Services and the Administration on Aging in order to streamline access to long term care. The state of Alaska implemented this model in 2004 through its Independent Living Centers and has made a commitment in the 2007-2011 State Plan on Aging to continue to expand this concept. Current funding for this program ends June 30, 2008.

Funding for this project will be granted to private agencies that will establish and administer the ADRCs.

MH Trust: AB-ACOA – Primary Care Clinics: \$350.0 GF/Mental Health

Grant 1448: This project will provide funding to Alaska's Community Health Centers (CHCs) to augment the low rates of Medicare reimbursement for services, and to provide access to care for Alaska's seniors. The funding will help alleviate the strain on the CHCs resulting from their providing a medical home to many seniors statewide who have been refused care by physicians in private practice due to low Medicare reimbursement rates. These individuals can be served at the CHCs in their area. Alaska is one of 36 states that does not currently provide direct funding for Community Health Centers. During the current primary care crisis for seniors who have Medicare as their primary insurer, a growing number are being refused care by physicians due to Medicare's low reimbursement rate. CHCs may be the only providers willing to see Medicare patients in some parts of the state. In 2005, the CHCs served 5,468 Alaskans age 65 and over — more than 13 percent of Alaskans in that age group enrolled in Medicare (and also a 12 percent increase over 2004). The Senior and Disabilities Services grants section will determine an allocation formula to distribute funds to Community Health Centers according to population.

MH Trust: Benef Projects – Mini Grants for ADRD Beneficiaries: \$260.3 MHTAAR

Grant 74.04: The mini-grants for Alzheimer's Disease and Related Dementia (ADRD) beneficiaries program has been funded by the Alaska Mental Health Trust since FY99 and is administered through the DHSS Senior and Disabilities Services grantee, Alzheimer's Association of Alaska. Mini-grants provide Trust beneficiaries with a broad range of equipment and services that are essential to directly improving quality of life and increasing independent functioning. These can include, but should not be limited to, therapeutic devices, access to medical, vision, dental, special health-care, and other supplies or services that might remove or reduce barriers to an individual's ability to function in the community and become as self-sufficient as possible. Assistance with basic living needs not covered by current grants, such as transportation and clothing, will also be considered. These services help Trust beneficiaries attain and maintain healthy and productive lifestyles. These items support beneficiaries to

achieve and maintain a reasonable quality of life and are key supports to maintaining families' self-sufficiency and ability to care for a family member.

Community Developmental Disabilities Grants

Discontinue Private ProShare Refinancing: \$4,815.7 General Fund

This increment replaces federal funding with general funds due to the discontinuation of the Private ProShare Medicaid program by the federal Medicaid agency.

Transfer in General Funds from Medicaid Services Due to Elimination of ProShare Financing: \$1,148.1 General Fund

In SFY08 a GF increment of \$4,044.0 was authorized to replace 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. That entire increment was placed in Health Care Services / Medicaid Services. However, these services are provided by other divisions. Senior and Disabilities Services/Community Developmental Grants Used the ProShare program to provide services that include but are not limited to: Care Coordination, Chore Services, Day Habilitation, Independent Living Support, Behavioral Training, Intensive Active Treatment, Residential Services, Respite Care, Specialized Adaptive Equipment and Vocational Services. This transfer of \$1,148.1 is necessary to give the division the funding needed to continue these services.

Challenges

Elimination of the Developmental Disabilities Waitlist

Senior and Disabilities Services (SDS) faces many new and ongoing challenges in FY09. FY08 Legislative Intent Language directs SDS to work toward eliminating the Developmental Disabilities Waitlist. SDS has developed methodology to remove 50 consumers from the DD Waitlist each quarter (200 per year) and place them into permanent services under a Medicaid Waiver. At this rate, SDS will eliminate the DD Waitlist by 2010. The 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. SDS 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 care coordinator positions were established and filled in early FY2007. SDS has received a positive response to these new "State Care Coordinators" from consumers. As a result, SDS is committed to creating more care coordinator positions to give consumers a choice between agency based and state care coordination. In addition to giving service recipients a choice of who will be their care coordinator, these new positions will help take on case loads for people being removed from the DD Waitlist. SDS estimates that approximately \$7.8 million is currently billed to the Medicaid program by provider agencies to perform care coordination activities for Medicaid recipients. SDS believes that creating new positions and assigning them case loads will mostly be a "cost shift" from funding that was going to agencies as part of their Medicaid billing, to SDS to fund these new positions.

Medicaid Assessments

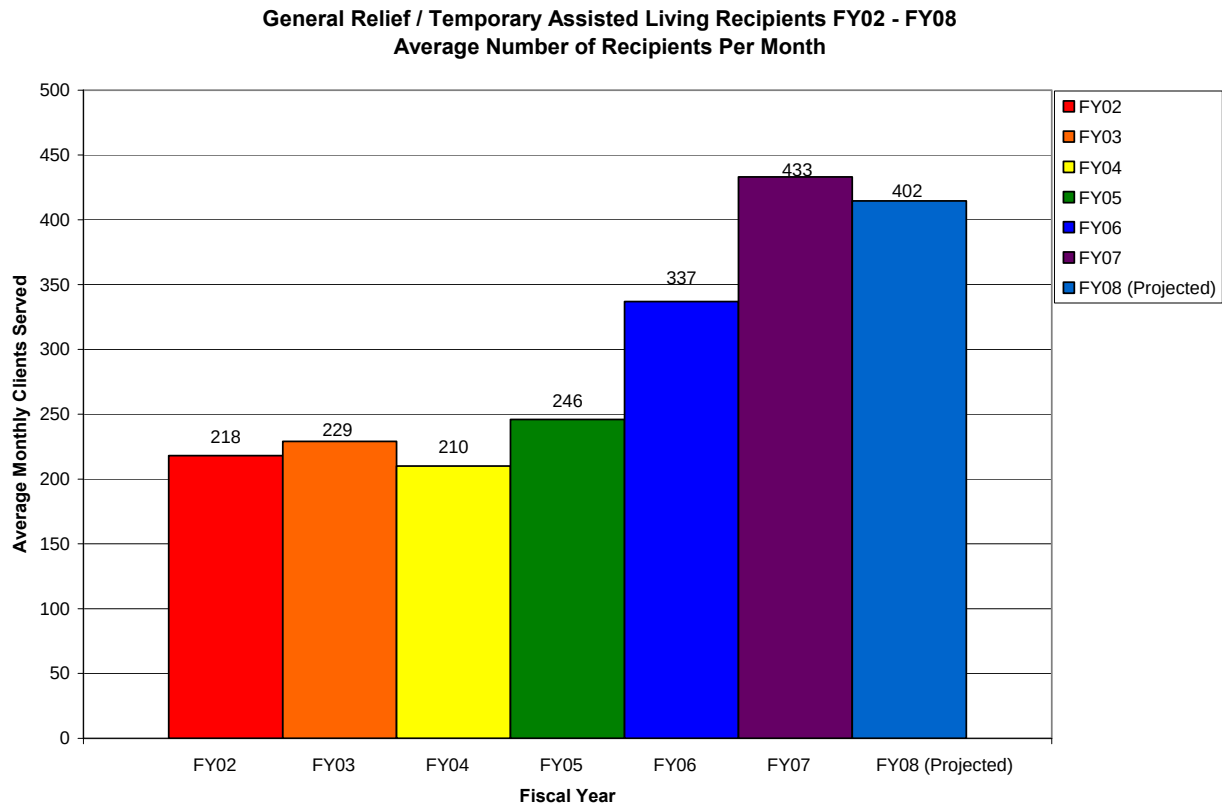
All Medicaid programs administered by SDS require consumers to receive a medical assessment to determine the services they are eligible to receive and prior authorization of those services by staff. SDS has been contracting out for the medical assessment portion of this process. On Oct. 31, 2007, the SDS contractor hired to complete these assessments ran out their contracts and chose not to reapply for a new contract. As a result, SDS has hired 20 new non-permanent employees to complete Medicaid assessments as state employees. SDS is challenged with recruiting and retaining qualified staff, creating new policies and procedures to guide the actions of these employees, and catching up on a significant backlog of assessments that are due and were not completed by the contractor before their contracts expired.

General Relief / Temporary Assisted Living

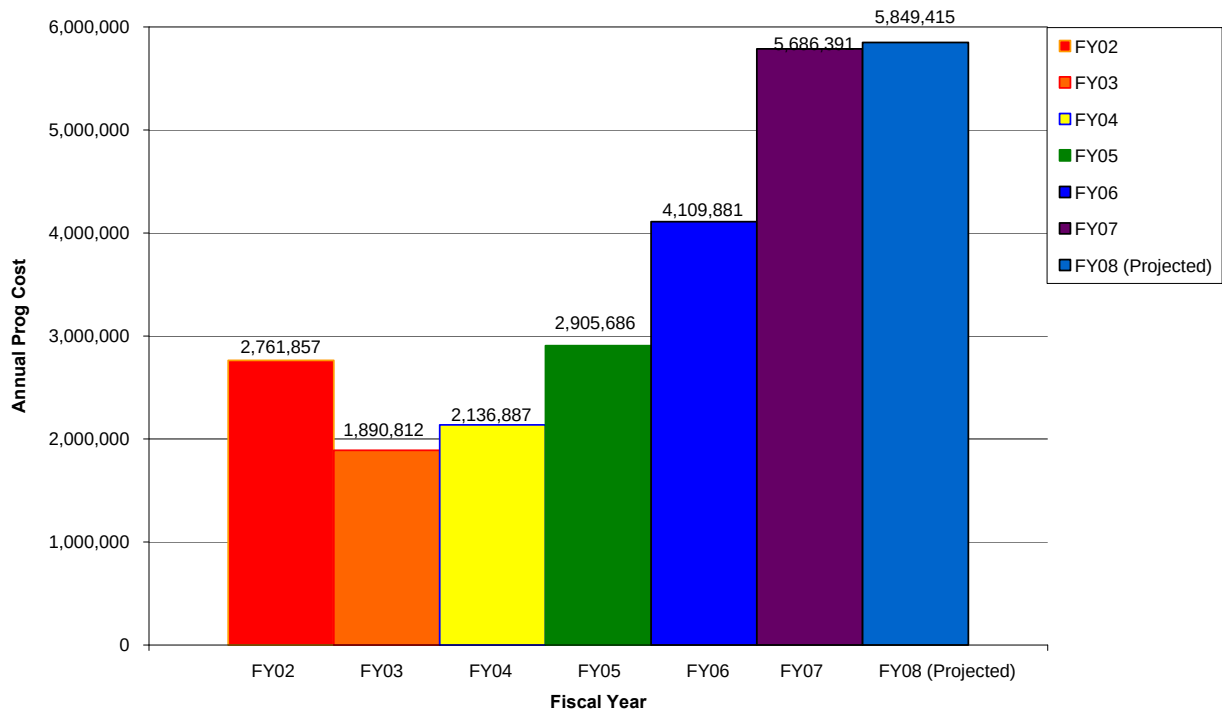
Program costs to sustain this program have been steadily increasing in recent years, while requests to increase funding have been denied. Since FY2004, when SDS was created and inherited this program, the number of clients served and the cost to maintain this program has more than doubled. In FY04, \$2,136.8 was spent for this program, with an average of 210 clients served each month. In FY07, SDS spent \$5,665.0 with an average monthly client base of 433. (Client counts for FY07 are projected until final payments are made in July of 2007). SDS 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 mean that more vulnerable adults are placed in temporary assisted living homes.

SDS is actively working with Division of Behavioral Health and the Department of Corrections to tighten up current regulations governing this program to ensure that only the most vulnerable populations will qualify for services using these funds.



**General Relief Payments FY02 - FY08
Total Expenditures Per Fiscal Year**



Data Integration

SDS has made great strides toward creating an integrated database to track service recipients across all SDS programs. In recent months, SDS has made significant progress in creating the new DS3 database. This database now allows all work units within SDS to access client data electronically in an expedient manner. Additionally, the database is continuing to evolve to meet more technological needs within SDS. For example, the DS3 database is being expanded to allow Adult Protective Services workers to track their cases from intake to resolution. It is also being expanded to take over the cost sheet interface process that allows provider agencies to bill for prior authorized services through First Health. The challenge will be maintaining momentum and continuing to adequately fund the evolution of this database.

Performance Measures – Senior and Disabilities Services

Contribution to the Department's Mission

Promote independence of Alaska Seniors and people with physical and developmental disabilities.

Core Services

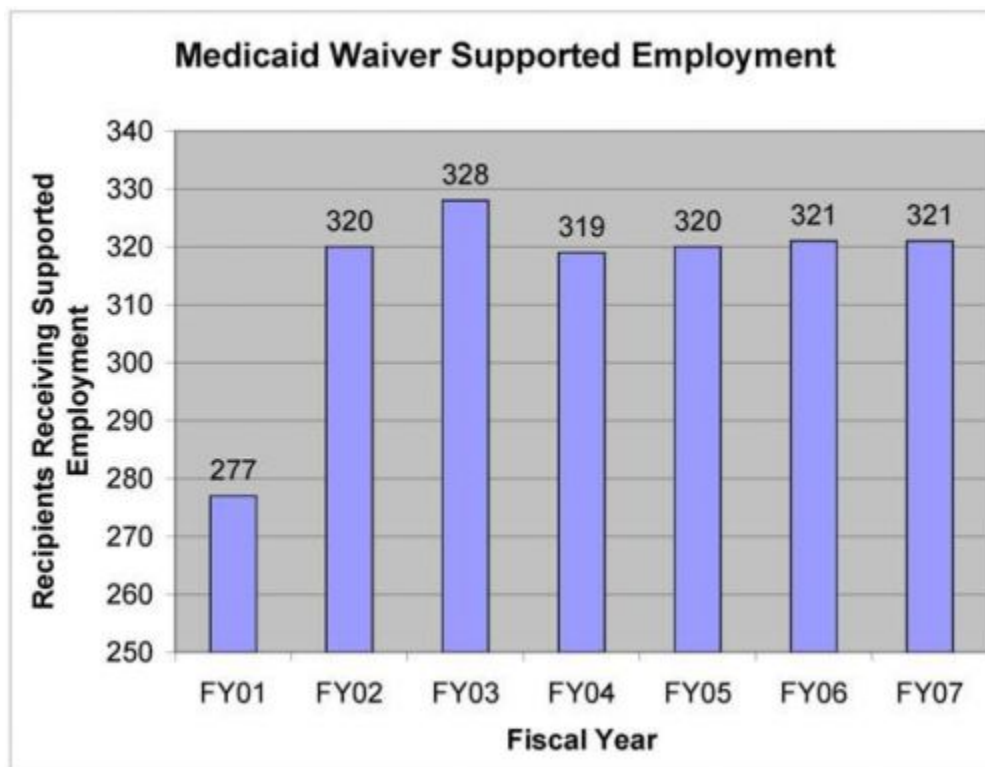
- Institutional and community-based services for older Alaskans and individuals with disabilities.
- Protection of vulnerable adults.

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 Developmental Disabilities (DD) Waiver recipients receiving Supported Employment Services.

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



Percent 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%
FY 2007	0.0%

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 Developmental Disabilities (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 individuals with disabilities through cost-effective delivery of services.

Target #1: Reduce percentage of Medicaid recipients not receiving medical assessments to less than 5 percent.

Measure #1: Percent of clients not receiving medical review.

SDS Outstanding Medicaid Assessments (FY05-FY07)

Fiscal Year	% Not Reviewed
FY 2005	30.9%
FY 2006	23.18%
FY 2007	4.50%

This chart shows the percentage of Senior and Disabilities Services Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY07.

Analysis of results and challenges: The Personal Care Attendant (PCA) program was the only Medicaid program that did not require a state-approved medical assessment to receive services until implementation of new regulations in April of 2006. These new regulations began requiring a state-approved medical assessment and prior authorization of Medicaid benefits to ensure that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from FY 2005-2007. Senior and Disabilities Services (SDS) has worked hard to catch up on back-logged Medicaid Waiver assessments through a contractor, state staff authorized to perform assessments, and through agencies with staff on site that have the appropriate credentials to complete assessments. In spite of these efforts, there were too many pending assessments required when new regulations went into effect in April of 2006 for the Personal Care

Attendant program. SDS has dramatically decreased the assessment backlog, but will not be caught up until all recipients receiving PCA services have been assessed. SDS will strive to be fully caught up with all pending assessments by the end of FY08.

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.

Target #1: Reduce incidence and severity of errors resulting in audit findings by 10 percent by providing adequate training to provider agencies.

Measure #1: Show an overall reduction in error rates from audit findings from current rate by 10 percent.

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%
SDS Total	15.83%	6.43%

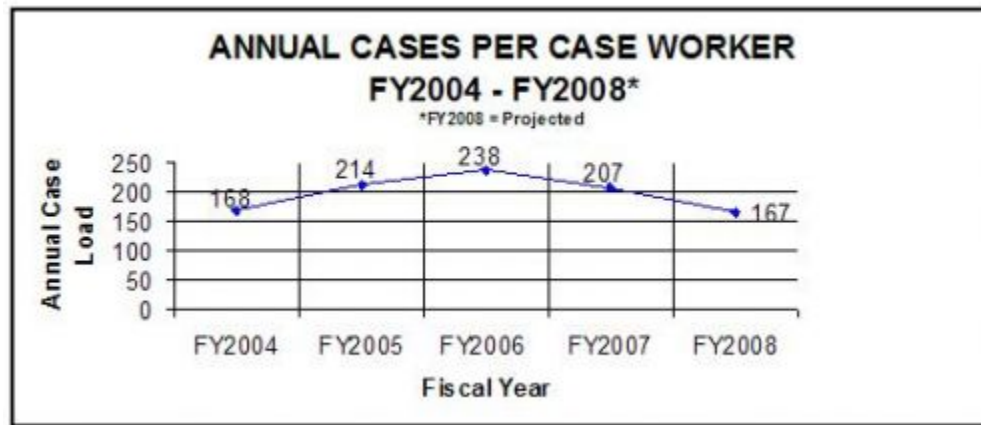
Analysis of results and challenges: The chart shows SDS Medicaid programs that have been audited by Myers and Stauffer and the percentage of audit exceptions that have been assigned to each program. These audit numbers are preliminary until the provider agencies have had a chance to respond, so these numbers should decrease as providers respond to the findings. However, it does show that significant improvement was made in the error rates across SDS programs from FY05 to FY06. In FY07 and FY08, Senior and Disabilities Services has been working with provider agencies to help provide them with the training and support they need to improve their error rates noted in FY05 and FY06.

B1: Strategy — Develop, implement and maintain an ongoing system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide eight care coordination training sessions each year in Alaskan communities.

C: Result — Ensure manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units to provide timely investigations.

Target #1: Reduce APS staff assigned case loads by 10 percent

Measure #1: Annual cases assigned to each case worker.



Adult Protective Services Caseloads

Fiscal Year	Total Investigations	Full Time Workers	Annual Cases/Worker	Days to Investigate
FY 2004	1173	7	168	0
FY 2005	1497 +27.62%	7 0%	214 +27.38%	0 0%
FY 2006	1666 +11.29%	7 0%	238 +11.21%	2.6 0%
FY 2007	1866 +12.00%	9 +28.57%	207 -13.03%	2.1 -19.23%
FY 2008	2000 +7.18%	12 +33.33%	167 -19.32%	1.932 -8.00%

**FY08 = projected numbers based on addition of new case worker staff and current estimated case load decrease of 8 percent.*

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) case worker was steadily on the rise from FY04 to FY06. From FY04 to FY05, the average caseload increased by more than 27 percent. From FY05 to FY06, the average caseload increased again, this time by more than 11 percent. From FY06 to FY07 the average caseload decreased by more than 13 percent after two new case workers were hired. Based on this unexpected growth, Senior and Disabilities Services has added five new positions since FY06. Because of these new positions, FY07 finally saw a decrease in the number of open cases per case worker. With additional new position in FY08, Senior and Disabilities Services expects to see a decrease to the number of annual cases per case worker. Senior and Disabilities Services will keep adding new positions until case loads for Alaska Adult Protective Services case workers are at a more manageable level.

Target #2: Reduce length of time a case is "open" by 10 percent.

Measure #2: Length of days required to close an "open" case.

Days to Investigate Open Case		
Year	Days to Investigated	YTD
2006	2.6	2.6
2007	2.1 -19.23%	2.1 -19.23%
2008	1.932 -8.00%	1.932 -8.00%

FY08 = Projected

Analysis of results and challenges: The average length of time to investigate a new case was approximately 2.6 days in FY06, when there were only seven case workers. In FY07, two additional case worker positions were added, bringing the average length of time to investigate a report of harm down to 2.1 days. In FY08, SDS added three additional positions, for a total of 12. With these new positions, Senior and Disabilities Services anticipates a decrease in the number of annual cases per worker of more 13.75 percent. Senior and Disabilities Services anticipates that with the addition of new staff in FY08, the number of days to investigate a new case could drop to less than two days.

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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 nine divisions within the Department of Health and 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;
- Public Affairs;
- Quality Assurance and Audit;
- Office of Faith Based and Community Initiatives;
- Health Strategies Planning Council;
- Assessment and Planning;
- Administrative Support Services;
- Hearings and Appeals;
- Medicaid School Based Administrative Claims;
- Facilities Management;
- Information Technology Group;
- Facilities Maintenance;
- Pioneer Homes Facilities Maintenance; and
- HSS State Facilities Rent

Services Provided

Commissioner's Office

The Commissioner's Office component funds upper-level management and policy development for the entire department.

Public Affairs

The Public Affairs component is tasked with ensuring consistency and continuity in department communication with stakeholders helps promote health communications; and ensures responsiveness to media, legislative and constituent inquiries. The Public Affairs component includes the functions of public information management, publications design, web-based communication, legislative management and regulatory development.

Quality Assurance and Audit

The Quality Assurance and Audit component is responsible for conducting and coordinating Medicaid program integrity efforts to meet both state and federal requirements. These efforts include provider auditing activity, contract audit processes under 47.05.200, law enforcement contact, and data analysis and problem detection. Unit efforts focus on meeting and exceed department and federal standards and requirements related to protecting program assets and assuring quality services.

Office of Faith Based and Community Initiatives (FBCI)

The Office of FBCI was created in 2005. The Office is supported by a statewide advisory council (22 members). The mission of the Office is to improve the well-being of Alaskans by strengthening and expanding the contributions of faith-based and community initiatives through fostering partnerships, building capacity and expanding awareness.

Health Strategies Planning Council

The Health Care Strategies Planning Council (HCSPC) is to develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

Assessment and Planning

The Assessment and Planning component is tasked with planning, assessment and forecasting improvements for the Medicaid program.

Administrative Support Services

The Administrative Support Services component funds financial, budget, procurement, grant and professional service contract administration, and information services as well as human resource liaison functions.

Hearings and Appeals

The Hearings and Appeals component conducts appeals for Medicaid, Chronic and Acute Medical Assistance, and Division of Public Assistance regarding rates and recipient benefit appeals.

Facilities Management

The Facilities Management component includes the management of the department's capital programs.

Medicaid School-Based Claims

The Medicaid School-Based Claims component improves health services access and availability for Medicaid-eligible children and families.

Information Technology

The Information Technology component's focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the department.

Facilities Maintenance

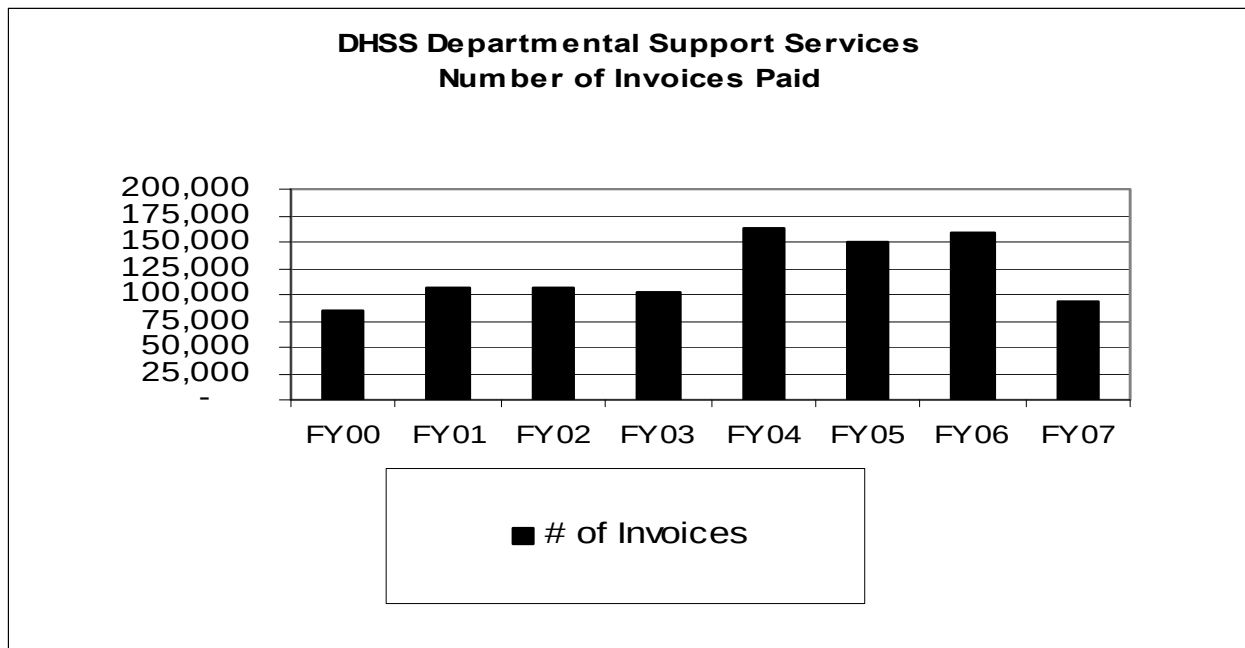
The Facilities Maintenance component, Pioneer Homes Facilities Maintenance, and HSS State Facilities Rent component record dollars spent to operate state facilities. These units collect costs for facilities operations, maintenance and repair, renewal and replacement as defined in Chapter 90, SLA 98 and pay rent fees for Rent Project.

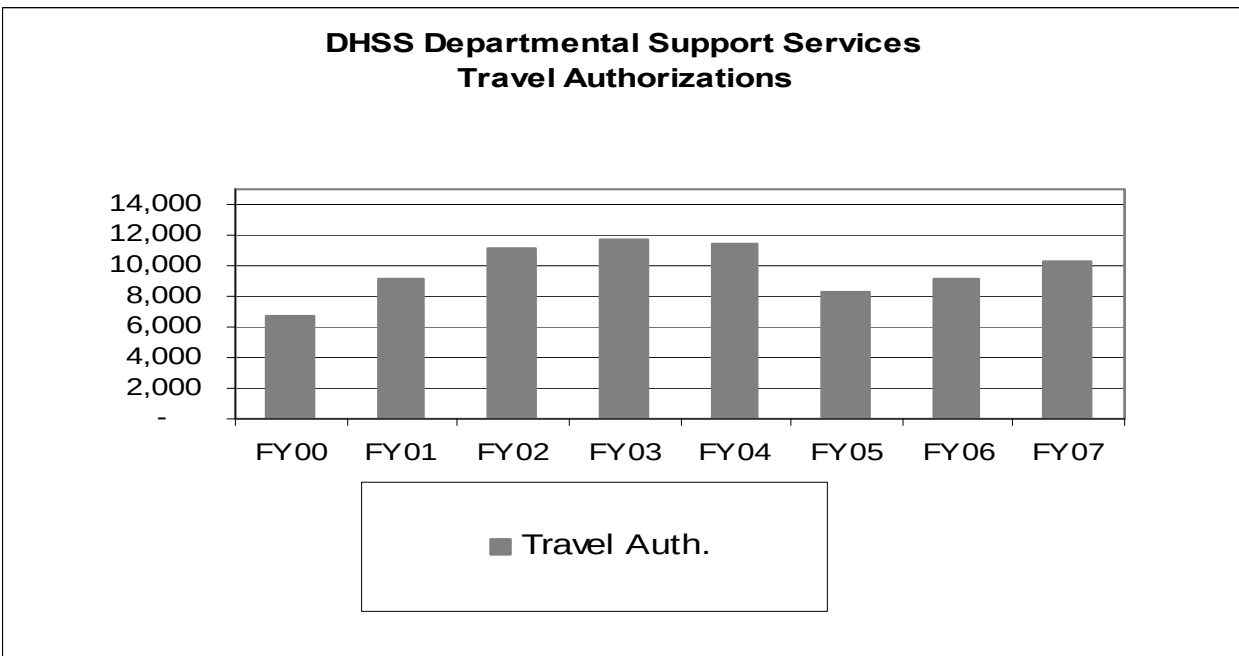
Human Services Community Matching Grants

The Human Services Community Matching Grants component makes grants to qualified municipalities.

Finance Section

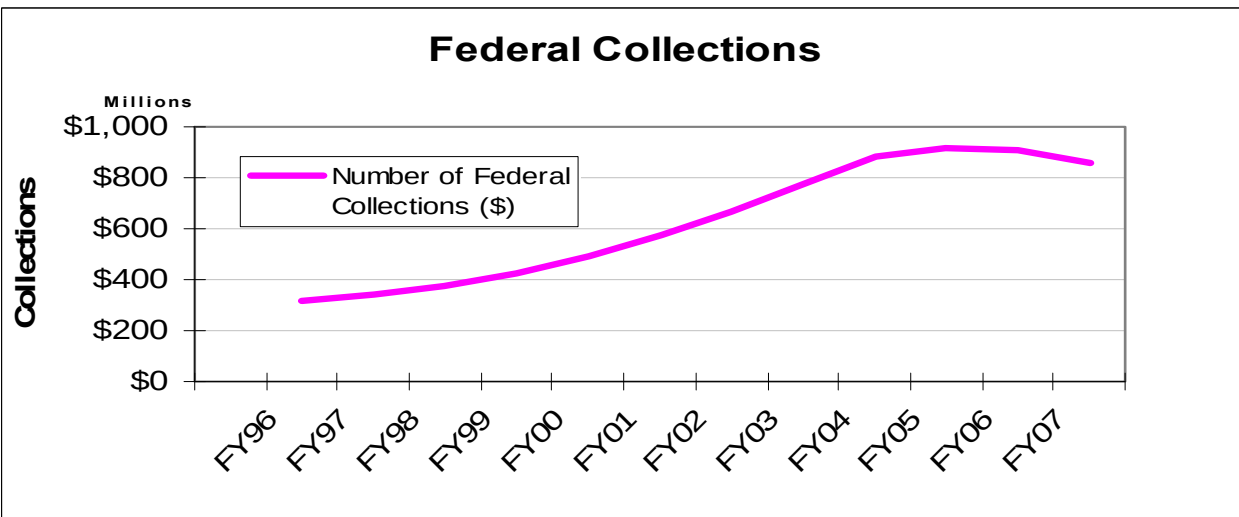
The Finance section within the Division of Administrative Services supports all the divisions and programs within Health and Social Services. It is responsible for financial accounting and related support services. Following is the Finance Section Activity from FY2000 to FY2007:





Revenue Section

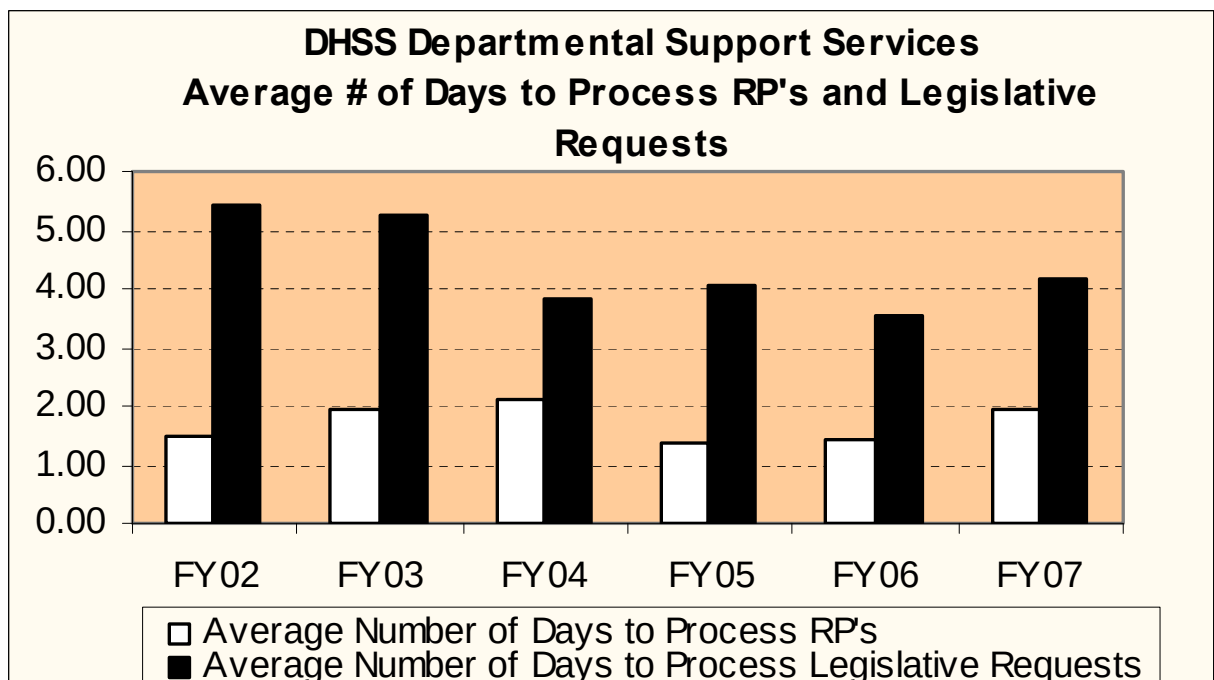
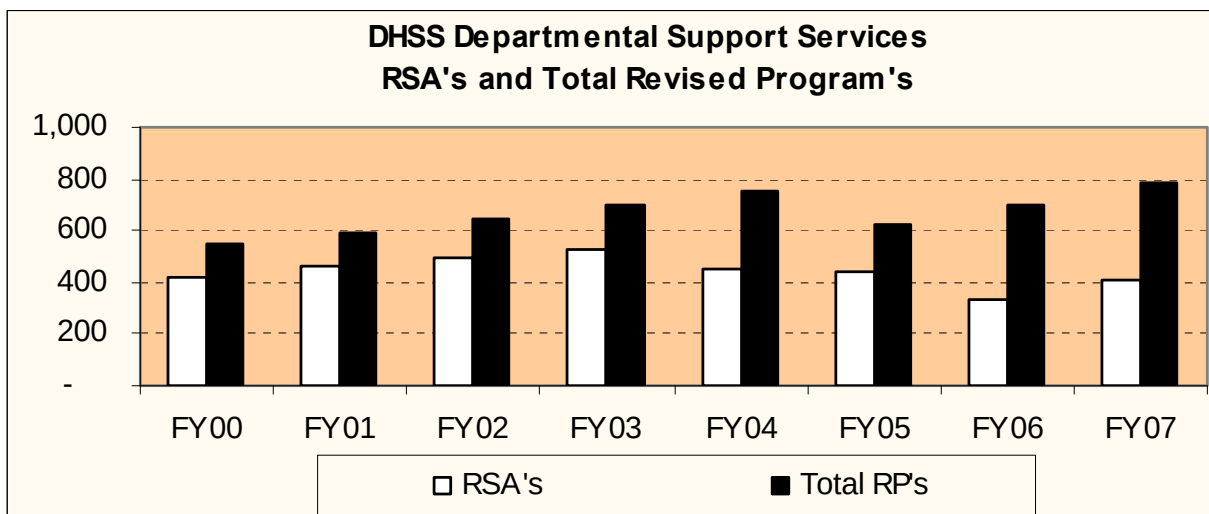
The Revenue unit is responsible for all federal reporting and revenue collections for the department. The following chart shows a level of activity for the Revenue unit for collections of federal funds.



Budget Section

Budget 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.

The following charts shows the level of activity within the Budget section for RSA's and Total RP's for FY 2000 through FY 2007 and the average number of days to respond to requests for FY 2002 to FY 2007. The charts demonstrate that while the level of activity (number processed) has remained steady, the Budget section has been able to improve response time and have dropped them for the Legislative Requests from five to three days, a decline of 40 percent.



Grant and Contracts Support Team

The Contracts and Grants Support Team manages all aspects of procurement for the Department of Health and Social Services. It is comprised of four areas: Grants, Professional Services Contracts, Procurement and Leasing.

The Grants and Contracts unit performs the administrative tasks associated with the procurement of professional services for the department, whether it be through professional services contract or operating grant. The Procurement and Leasing unit is responsible for commodities and non-professional services purchases, construction contracting, mail service, property control, space allocation and leasing. This team provides 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 the goals of the Grants and Contracts unit is to reduce the number of grants and consolidate where possible. The unit also strives to improve processes, most notably with the implementation of eGrants, the department's electronic grant management system.

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	Actual Number of Grant Awards in FY 07	Number of Grant Awards Reduced between FY04 and FY05	Number of Grant Awards Reduced between FY05 and FY06	Number of Grant Awards Reduced between FY06 and FY07
DPH	112	88	77	87	-24	-11	10
DBH	289	248	184	193	-41	-64	9
OCS	181	208	147	137	27	-61	-10
DPA	34	44	48	45	10	4	-3
FMS	9	12	14	12	3	2	-2
HCS	7	0	0	0	-7	0	0
DSDS	193	153	113	119	-40	-40	6
DJJ	45	25	29	35	-20	4	6
Totals	870	778	612	628	-92	-166	16

Information Systems Section

The Information Technology 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 and Publications. The IT section supports all aspects of the computational needs of the departments approximately 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 all department 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.



<u>DHSS Computing Environment:</u>	
Number of Desktops:	3412
Number of Servers:	275
Number of Networks Statewide:	161
Number of Facilities Networks are Housed:	118
Industry Standard is 125 customers to 1 Technician	
DHSS Ratio: 137 Customers to 1 Technician	
Total Help Calls FY07: 22,295	
Average of 98 calls per day in FY07	
Number of Communities where IT Infrastructure is Located:	36
Number of Business Applications	252
Number of DHSS Publications Produced in FY07	215
Number of Web Changes and Updates in FY07	663
Number of Coordinated Media Inquiries in FY07	696
Number of News Stories for DHSS in FY07	1000

IT Server Consolidation - The department has been able to significantly reduce the number of servers from 450 to 275. This has helped reduce the maintenance and support costs of the distributed hardware across the state. In addition, the department has been successful in consolidating a number of key applications into servers that are housed in datacenters both in Anchorage and Juneau as well. HSS plans to further reduce the number of servers by implementing a technology called Server Virtualization. This technology allows administrators to host a number of *virtual* servers on one *physical* server. We anticipate that this will further reduce the number of physical servers to under 200. As part of the department's HIPAA compliance effort this will better support moving confidential data from servers that have been placed in inadequate environmental locations to more secure locations with proper power and air conditioning support.

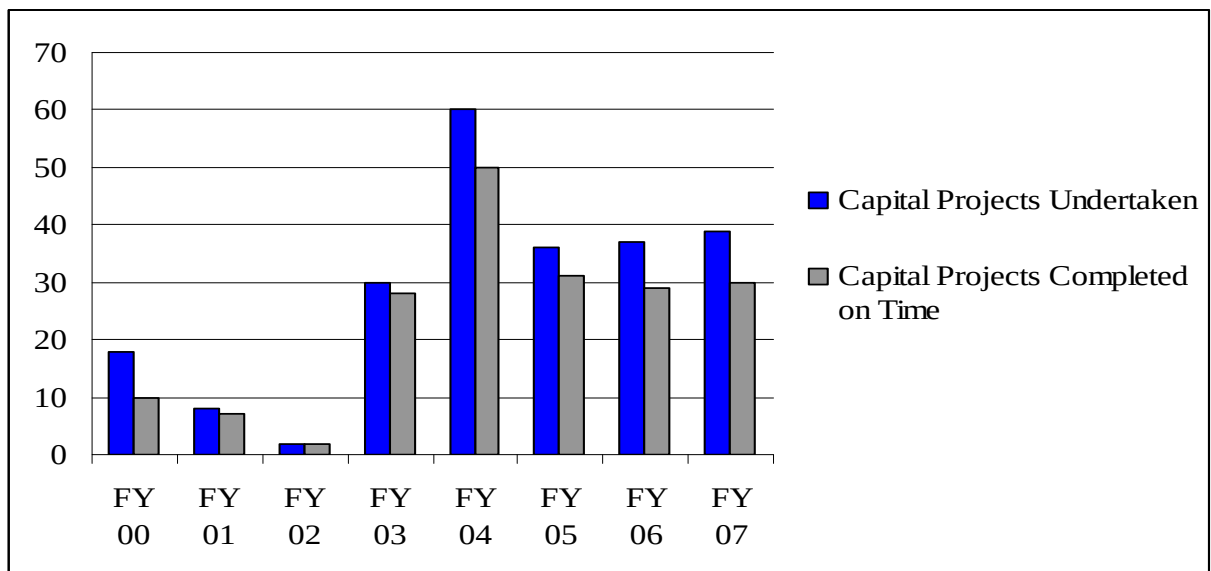
IT Success - Desktop deployment: 2,200 desktop workstations were replaced or received operating system upgrades in 2006-2007 allowing for more complete department-wide desktop standardization and improved Help Desk support. Standardization of hardware operating systems improved procedures for procurement, management and tracking for a number of network hardware and software products and provides department staff with a stable environment to perform their daily work. This also brings the department into compliance with statewide standards. This project required four months of intensive planning and preparation and six months to execute. Customer Services traveled to 23 remote and metropolitan cities and villages and deployed computers to more than 40 individual building locations. In addition to replacing desktops, Customer Services worked closely with Dell to coordinate the pickup and environmentally-friendly disposal of more than 2,800 pieces of equipment.

Desktop and Server Security and IT Security Policy implementation - Consolidated department's ability to address attacks and security breaches and identified and corrected a number of high-risk security problems. The ability to address security as a department instead of small IT groups has allowed DHSS to resolve attacks and security events — which have become increasingly complex — in a more efficient manner. The State Security Office now gives high ratings to DHSS' department-wide security efforts in particular.

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 \$650.3 million.

The following chart shows the level of activity within the Facilities Management section for FY2000 through FY2007:

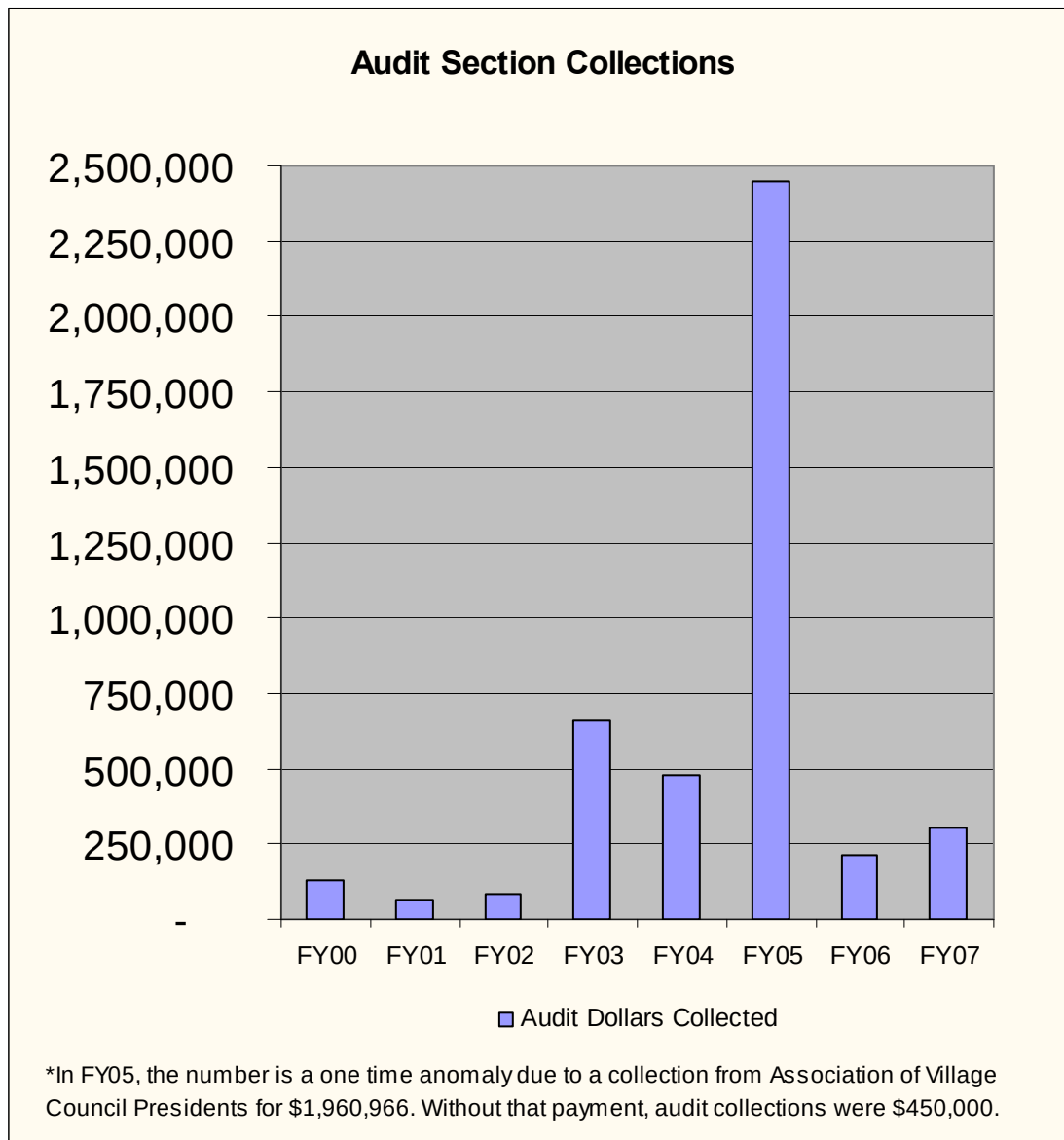


In addition, the Facilities section administers all capital grants including pass-through federal funds from the Denali Commission. In FY07, 20 new grants were issued valued at \$7.9 million

Audit Section

The Audit unit is responsible for performing single audit reconciliations of DHSS grantees, federal sub-recipient monitoring and special reviews of department grantees upon request.

The following chart shows the level of Audit unit collections for FY2000 through FY2007:



List of Primary Programs and Statutory Responsibilities

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 Individuals
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

Explanation of FY2009 Budget Changes

Department Support Services	2008	2009 Gov	08 to 09 Change
General Funds	23,894.4	46,813.3	22,918.9
Federal Funds	29,563.9	49,701.8	20,137.9
Other Funds	9,535.8	10,174.7	638.9
Total	62,994.1	106,689.8	43,695.7

**Includes Human Services Community Matching Grants \$1,485.3 GF.*

Commissioner's Office

Comprehensive Rate Proposal: \$49,852.0 Total \$25,435.5 Federal; \$24,417.5 General Fund

Based on concerns from legislators, providers, and the public that many rates paid to providers were too low and had not been adjusted in a number of years, DHSS contracted with Myers and Stauffer to develop a rate study. The purpose of the rate study is to analyze rates and to establish a uniform rate setting methodology for various programs.

This request for \$49.9 million is a reasonable estimate or placeholder to implement rate increases and potentially new methodologies for programs within DHSS. Final recommendations for changes to rates will not be complete until January 2008, so the specific information on what changes will be proposed for individual programs will be available at that time. Results of the rate study will provide department decision makers data, including:

- How long has it been since a particular rate has been adjusted?
- What is a reasonable rate?
- How will the department best equalize rates across programs?

Programs for which rates could require adjustments include child-care programs, assisted living homes, foster care providers, home and community based waivers, personal care and other medical providers.

Transfer in Positions and Funding from Information Technology, Office of Program Review, and Commissioner's Office: \$2,283.2 Total \$1,028.6 Federal, \$932.9 General Funds, and \$321.7 other funds

This is a new component to reflect the department's realignment. The Public Affairs unit has been functioning as a team since the department organized IT functions in FY 2005 (as the Public Information Team), consolidating department communication functions to achieve consistency in communication efforts and to better serve the department as a unit that serves all divisions and programs. The legislative and regulations function were added to the team, thus renaming the group to the Public Affairs unit in September 2007. The Public Affairs unit includes the functions of Public Information, Publications and web-based communication (Public Information Team), legislative management and regulatory development.

The Public Affairs unit ensures consistency and continuity in communication with stakeholders, helps promote health communications; and ensures transparency to the public regarding department activities, as well as ensures responsiveness to media, legislative and constituent inquiries.

Office of Program Review

This budget component is eliminated in the FY09 budget. Positions and funding have been transferred out as follows:

Transfer to Medical Assistance Administration: \$768.8 Total (\$384.4 GF/Match, \$384.4 Federal)

Transfer to Commissioner's Office: \$550.0 Total (\$369.3 GF, \$181.2 Federal)

Transfer to Public Affairs: \$108.0 Total (\$44.8 GF, \$5.0 Federal, \$58.2 Other Funds)

Transfer to new Quality Assurance and Audit component: \$1,087.7 Total (\$544.9 GF, \$542.8 Federal)

Transfer to Public Assistance Quality Control: \$78.1 Total (\$39.0 GF, \$39.1 Federal)

Quality Assurance and Audit

Transfer in positions and funding from Office of Program Review: \$1,087.7 Total \$542.8 Federal; \$544.9 General Fund

This is a new component to reflect the department's realignment. The Quality Assurance and Audit component is responsible for conducting and coordinating Medicaid program integrity efforts to meet both state and federal requirements. These efforts include provider auditing activity, contract audit processes under 47.05.200, law enforcement contact, and data analysis and problem detection. Unit efforts focus on meeting and exceeding department and federal standards and requirements related to protecting program assets and assuring quality services.

Health Care Strategies Planning Council

Review/Implement Health Care Strategies Planning Council recommendations: \$200.0 Total \$100.0 Federal; \$100.0 General Fund

This is a new component to reflect the department's realignment. The objective of the Health Care Strategies Planning Council (HCSPC) is to develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

Administrative Services Support

Transfer out two PCNs and funding to Public Affairs: (\$263.5 Other Fund)

This transfer is part of the realignment plan for the Department of Health and Social Services which coordinates the functions of regulation development with the Public Affairs component. The Public Affairs component includes combining the functions of department communications, legislative relations, and oversight and development of department regulations.

DEPARTMENT WIDE SALARY ADJUSTMENTS

FY09 Salary adjustments in the DHSS budget include health insurance increases for Exempt Employees, and bargaining unit contract terms for the General Government Unit, Confidential Employees Association, and Labor, Trades and Crafts bargaining units.

A summary of salary adjustments is provided below.

DHSS FY09 Salary Adjustments

RDU	Component	General Funds	Federal Funds	Other Funds	Total
Alaska Pioneer Homes	Pioneer Homes Management	14.7	0.1	0.0	14.8
Alaska Pioneer Homes	Pioneer Homes	1,656.1	0.0	401.4	2,057.5
	Subtotal AKPH	1,670.8	0.1	401.4	2,072.3
Behavioral Health	ASAP	0.0	0.0	82.6	82.6
Behavioral Health	Behavioral Health Admin.	103.0	83.8	50.1	236.9
Behavioral Health	Alaska Psychiatric Institute	388.0	4.1	729.5	1,121.6
Behavioral Health	Suicide Prevention council	0.1	0.0	0.0	0.1
	Subtotal DBH	491.1	87.9	862.2	1,441.2
Children's Services	Children's Services Mgt.	35.1	95.1	7.1	137.3
Children's Services	Front Line Social Workers	1,070.0	591.8	50.7	1,712.5
Children's Services	Infant Learning Programs	8.7	14.4	0.0	23.1
Children's Services	Children's Trust Programs	0.0	0.0	2.0	2.0
	Subtotal OCS	1,113.8	701.3	59.8	1,874.9
Health Care Services	Medical Assistance Admin.	104.4	113.3	9.8	227.5
Health Care Services	Rate Review	34.4	34.4	0.0	68.8
	Subtotal HCS	138.8	147.7	9.8	296.3
Juvenile Justice	McLaughlin Youth Center	758.7	0.0	10.5	769.2
Juvenile Justice	Mat-Su Youth Facility	106.0	0.0	0.0	106.0
Juvenile Justice	Kenai Peninsula Youth Facility	78.0	0.0	0.0	78.0
Juvenile Justice	Fairbanks Youth Facility	183.4	0.0	0.0	183.4
Juvenile Justice	Bethel Youth Facility	158.5	0.0	0.0	158.5
Juvenile Justice	Nome Youth Facility	108.1	0.0	0.0	108.1
Juvenile Justice	Johnson Youth Center	140.2	0.0	0.0	140.2
Juvenile Justice	Ketchikan Regional Yth Facility	71.7	0.0	0.0	71.7
Juvenile Justice	Probation Services*	484.7	0.0	0.0	484.7
	Subtotal DJJ	2,089.3	0.0	10.5	2,099.8
Public Assistance	Child Care Benefits	19.9	122.4	0.0	142.3
Public Assistance	Energy Assistance	0.0	27.1	0.0	27.1
Public Assistance	Public Assistance Admin.	34.9	40.1	0.0	75.0
Public Assistance	Public Assistance Field Svcs	789.8	761.7	48.8	1,600.3
Public Assistance	Fraud Investigation	37.1	41.9	0.0	79.0
Public Assistance	Quality Control	40.1	40.4	0.0	80.5
Public Assistance	Work Services	17.1	52.2	0.0	69.3
Public Assistance	Women, Infants and Children*	45.1	0.0	0.0	45.1
	Subtotal DPA	984.0	1,085.8	48.8	2,118.6
Public Health	Nursing	579.6	85.1	410.0	1,074.7
Public Health	Women, Children and Family Hlth	7.4	125.2	43.2	175.8
Public Health	Public Health Adm Svcs	3.2	49.5	0.0	52.7
Public Health	Certification and Licensing	41.6	118.4	0.0	160.0
Public Health	Chronic Disease Prev/Hlth Promotion	20.5	140.5	26.3	187.3
Public Health	Epidemiology	36.8	192.2	0.0	229.0
Public Health	Bureau of Vital Statistics	0.0	0.0	76.2	76.2

DHSS FY09 Salary Adjustments

RDU	Component	General Funds	Federal Funds	Other Funds	Total
Public Health	Public Health Laboratories	125.8	64.9	4.4	195.1
Public Health	Health Planning & Infrastructure	2.0	68.9	7.0	77.9
	Subtotal DPH	906.4	902.5	570.5	2,379.4
Sr. and Disabilities Svcs	Sr. and Disabilities Svcs Admin	170.6	176.2	4.9	351.7
	Subtotal SDS	170.6	176.2	4.9	351.7
Dept Support Svcs	Commissioner's Office	11.0	4.4	1.4	16.8
Dept Support Svcs	Quality Assurance and Audit	12.2	12.1	0.0	24.3
Dept Support Svcs	Public Affairs	1.0	0.1	0.1	1.2
Dept Support Svcs	Ofc/Faith Based&Comm Initiatives	2.8	3.0	0.0	5.8
Dept Support Svcs	Administrative Support Svcs*	322.1	111.7	73.8	507.6
Dept Support Svcs	Hearings and Appeals	18.1	9.0	0.0	27.1
Dept Support Svcs	Facilities Management	0.0	0.0	32.8	32.8
Dept Support Svcs	Information Tech Services	404.6	171.5	46.8	622.9
	Subtotal DSS	771.8	311.8	154.9	1,238.5
Boards and Commissions	AK MH/Alc & Drug Abuse Brds	22.0	1.5	10.1	33.6
Boards and Commissions	Commission on Aging	0.0	0.0	15.9	15.9
Boards and Commissions	Governor's Cncl/Disabilities	0.0	14.5	15.7	30.2
	Subtotal B&C	22.0	16.0	41.7	79.7
Department Total		8,358.6	3,429.3	2,164.5	13,952.4

* Includes Fund source change: Probation Services \$27.9 Federal and \$7.3 Other switched to \$35.2 GF; WIC Switch \$26.6 Fed and \$18.5 Other Funds to \$45.1 GF; Admin Support Svcs \$112.0 from Fed to GF; IT \$171.5 from Fed to GF.

Challenges

As the administrative and management units of the department, Department Support 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 DHSS as a whole for 2005 had a 22 percent turnover rate and a vacancy rate of 13 percent and in 2006 had a 29 percent turnover rate and a vacancy of 13 percent. In 2005, 708 new employees were hired compared to 836 in 2006. While those are averages, you can see from the table below we have wide variations in turnover with rates varying from 24 percent to 61 percent in 2006.

DHSS Employee Movement Report								
	2006 Total Positions	2006 Total Employees	2005 Vacancy Rate	2005 Turnover Rate	2005 Hire Rate	2006 Vacancy Rate	2006 Turnover Rate	2006 Hire Rate
State of Alaska Executive Branch	17,274	14,640	15%	24%	22%	9%	29%	26%
Department of Health and Social Services	3,403	2,964	13%	22%	21%	13%	29%	25%
Division								
Pioneer's Homes	597	562	7%	16%	15%	6%	24%	20%
Behavioral Health	326	267	21%	18%	15%	18%	23%	19%
Children's Services	470	421	10%	32%	35%	10%	39%	33%
Office of the Commissioner/Boards	73	56	10%	14%	24%	23%	43%	33%
Finance and Management Services	321	278	17%	32%	29%	13%	30%	33%
Health Care Services	52	38	22%	8%	6%	27%	61%	37%
Juvenile Justice	453	420	7%	15%	16%	7%	22%	17%
Public Assistance	507	428	11%	24%	22%	16%	32%	23%
Public Health	519	421	19%	25%	21%	19%	27%	25%
Senior and Disability Services	85	73	22%	15%	22%	14%	23%	36%

Audit Requirements and Department-wide Quality Assurance program

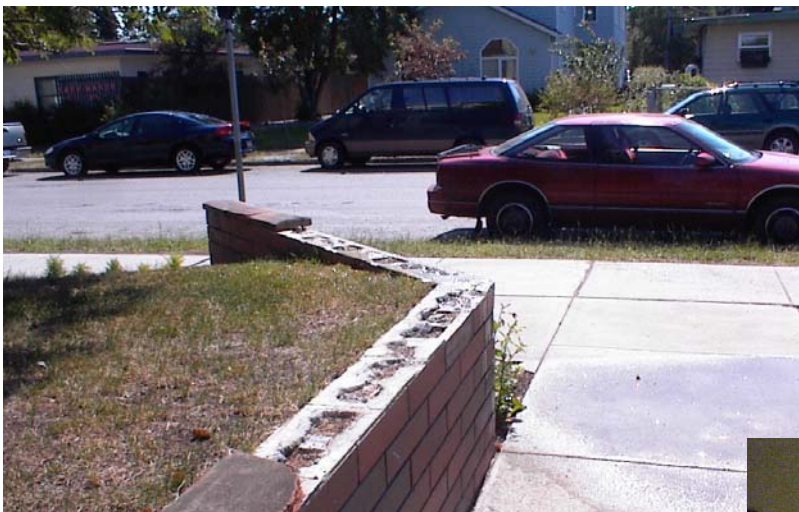
Medicaid program integrity continues to be of high interest from funding agencies, including the federal government and the department. Review and audit of federal and state programs is anticipated to increase. Efforts are underway to evaluate resources, workflow alignment, and management structure to produce a comprehensive Program Integrity operation that is efficient and effective.

Deferred Maintenance

DHSS 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.

This year, the department has prepared a six year plan to address the safety and security issues surrounding the four oldest youth facilities. These include McLaughlin Youth Center, Johnson Youth Center, Bethel Youth Facility, and the Fairbanks Youth Facility. This plan systematically addresses the safety and security deficiencies for these facilities in a prioritized manner.

Below: Broken Brick Retaining Wall at the Anchorage Pioneer Home.



Right: McLaughlin Youth Center Detention 2 Door Frame – Corrosion from Leaking Roof.



Above: Leaking Roof at Sitka Pioneer Home.

Performance Measures – Department Support Services

Contribution to Department's Mission

To provide quality administrative services that support the department's programs.

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 Department of Health and Social Services staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.
- Provide efficient centralized administrative support to nine DHSS divisions; maintain offices in Juneau and Anchorage.

Department Level Measures

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

Target #1: Reduce the average response time for complaints/inquiries to 14 days.

Measure #1: 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	1495	1224	24.52

Analysis of results and challenges: The response log "HSS Track" includes all inquiries or complaints that are received by the 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 #2: Reduce by 5 percent per year processing time for key indicators.

Measure #2: 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
DHSS Invoices	158,281	9.33
Capital Grant Awards	93	3.36
Legislative Logs	172	3.52

Timeliness and Accuracy		
Fiscal Year 2007		
	# Processed	Days to Process
Purchase Requisitions	459	5.80
Operating Grant Awards	628	20.97
DHSS Invoices	94,050	9.17
Capital Grant Awards	101	1.50
Legislative Logs	191	4.16

Analysis of results and challenges: This is a new indicator with new data for FY 2006. The data will develop a baseline for future comparisons.

In FY 2007, the number of requests increased in several of the categories, resulting in an overall increase to the average response time. Although there was increased processing time and increased number of requests, the sections remained under the standard response time in FY 2007.

Division Level Measures

A: Result — Facilitate the department's mission through superior (effective and efficient) delivery of administrative services.

Target #1: The Department of Health and Social Services (DHSS) administration as a percentage of department overhead should be below 2 percent.

Measure #1: Percentage administration personal services is to total department budget.

Percentage administration personal services is to total department budget

Year	YTD
2003	3.6%
2004	4.3%
2005	1.3%
2006	1.4%
2007	1.6%

Analysis of results and challenges: It is the goal of the Department of Health and Social Services (DHSS) 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 five 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
FY 2003	5.60 days
FY 2004	4.89 days
FY 2005	3.11 days
FY 2006	3.36 days
FY 2007	1.50 days
FY 2008	0.43 days

2008 only reflects first quarter.

Analysis of results and challenges: For FY06, there were 93 capital grant payments, all processing within five days. For FY07, there were 101 capital grant payments, all processing within five days.

B: Result — Improve overall management of DHSS budget processes.

Target #1: Improve legislative understanding of the DHSS budget.

Measure #1: Respond to 80 percent of legislative inquiries by budget section within five working days.

Percent of Responses for Legislative Requests made within five working days

Fiscal Year	YTD
FY 2002	83%
FY 2003	83%
FY 2004	78%
FY 2005	79%
FY 2006	80%
FY 2007	72%
FY 2008	81%

2008 only reflects first quarter.

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 were reported by calendar year, but starting in (2005) the data are collected by fiscal year. The average processing time in FY 2006 was 3.52 days and 80 percent were completed within five working days.

In FY 2007, the number of requests increased from 179 to 191, and there were a number of complex requests that required a week or more to complete, resulting in an overall increase to the average number of days to respond. With the increased processing time and increased number of requests, the budget section still averaged a 4.16 day turnaround in responding to legislative budget requests even though the percentage of those responded to within five working days went down.

C: 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
FY 2005	8.2 days
FY 2006	4.9 days
FY 2007	7.1 days

FY 2005 data represents only three quarters. This measure began at the start of the 2nd quarter FY 2006 contains a full year.

Analysis of results and challenges: This measure was developed at the start of the second 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 were consistent and showed a 50 percent 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 second 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.

In FY07, although the days to respond to a service request increased nearly 50 percent, the number of service calls went from 4,843 in FY06 to 7,334 for FY07. Additionally, during this past year the department underwent a major statewide, from Ketchikan to Barrow, desktop refresh within the department. While customer service staff was deployed to this priority project, some delays resulted in routine service call response times.

Target #2: 85 percent 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
FY 2006	100%	100%	56%	85%	85.25%
FY 2007	64%	56%	78%	80%	73.00%
FY 2008	70%	0	0	0	70.00%

Analysis of results and challenges: The department began tracking construction projects in FY06.

In FY07, although the overall percentage of completed construction projects was lower than FY06, these projects were still completed in a timely manner. The timeline on these dropped due to staffing shortages and the inability to recruit and fill needed professional positions.

Boards and Commissions

Mission

Boards, commissions and councils of the RDU play an important role in government by providing a mechanism for broad-based, ongoing public input to planning, policy development and program evaluation.

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 disease and other related dementias, developmental and other severe disabilities, special education, infant learning program/early intervention, and mental health.

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 Alaska Mental Health Board is responsible for evaluating the mental health program and provides a policy forum for and advocates 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 healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.

The Alaska Commission on Aging (ACoA) advocates for policies, programs and services that promote the dignity and independence of Alaska's seniors and helps them maintain a meaningful quality of life. ACoA is authorized by Alaska Statute (AS 47.45.240) to prepare the Alaska State Plan for Senior Services in accordance with the provisions of the Older Americans Act. In collaboration with our agency partners, the ACoA has begun a structured process to implement the goals and strategies related to the State Plan. The ACoA advocates for the needs of seniors and conducts education and public awareness activities on behalf of the issues of older Alaskans. ACoA participates in the planning of the comprehensive integrated mental health plan, and is available to provide recommendations when the department develops other health or service plans that impact the quality of life of older Alaskans.

The Governor's Council on Disabilities and Special Education (GCDSE) is charged with creating change that improves the lives of people with developmental and other severe disabilities, students receiving special education, and infants and toddlers with disabilities and their families. The council serves as the State Council on Developmental Disabilities, the Special Education Advisory Panel and the Interagency Coordinating Council for Infants and Toddlers with Disabilities.

The Pioneer Homes Advisory Board is charged with conducting annual inspections of the Alaska Pioneer Homes property and procedures and making recommendations for changes and improvements. The board meets on an annual basis to review admission procedures and consider complaints.

Services Provided:

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse

The boards gather information 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.
- Advocate for continued support for effective, efficient behavioral health programs.

Alaska Commission on Aging

Services provided by the Alaska Commission on Aging (ACoA) are 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, health care needs and other 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.

Pioneer Homes Advisory Board

The advisory board holds annual meetings and regular teleconferences to solicit comments and criticisms from Pioneer Homes' residents, families, friends, staff and the public. They consider all observations in their recommendations to the Governor.

List of Primary Program and Statutory Responsibilities

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 47.65.010-290	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, Individuals with Disabilities

PL 106-402	Programs for Individuals with Developmental Disabilities
PL 105-17	Individuals with Disabilities Education Act
Part B and C	

Pioneers' Homes Advisory Board

AS 44.29.500	Alaska Pioneers' Homes Advisory Board

Explanation of FY2009 Budget Changes

Boards and Commissions	2008	2009 Gov	08 to 09 Change
General Funds	617.8	514.3	-103.5
Federal Funds	1,647.3	1,752.8	105.5
Other Funds	1,622.6	1,765.8	143.2
Total	3,887.7	4,032.9	145.2

There are no significant budget changes in FY2009.

Appendices

RDU/Component Listing FY2009

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
	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
Behavioral Health	Suicide Prevention Council
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	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
	Catastrophic and Chronic Illness Assistance (AS
Health Care Services	47.08)
Health Care Services	Medical Assistance Administration
Health Care Services	Rate Review
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	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 Assistance	Women, Infants and Children
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	Injury Prevention/Emergency Medical Services
Public Health	Emergency Medical Services Grants
Public Health	State Medical Examiner
Public Health	Public Health Laboratories
Public Health	Tobacco Prevention and Control
Public Health	Preparedness Program
Public Health	Health Planning and Infrastructure
Senior and Disabilities Services	Senior and Disabilities Medicaid Services
Senior and Disabilities Services	Senior and Disabilities Services Administration
Senior and Disabilities Services	General Relief/Temporary Assisted Living
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	Commissioner's Office

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Boards and Commissions
Boards and Commissions

Boards and Commissions
Boards and Commissions
Human Services Community Matching
Grant

Public Affairs
Office of Program Review
Quality Assurance and Audit
Office of Faith Based & Community Initiatives
Health Strategies Planning Council
Assessment and Planning
Administrative Support Services
Hearings and Appeals
Medicaid School Based Admin Claims
Facilities Management
Information Technology Services
Facilities Maintenance
Pioneers' Homes Facilities Maintenance
HSS State Facilities Rent
AK Mental Health & Alcohol & Drug Abuse Boards
Commission on Aging
Governor's Council on Disabilities and Special
Education
Pioneers Homes Advisory Board

Human Services Community Matching Grant

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Glossary of Acronyms

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
ASHNHA.....	Alaska State Hospital & Nursing Home Association
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
BYF.....	Bethel Youth Facility
CAHPS.....	Consumer Assessment of Health Plans Survey
CAMA.....	Chronic and Acute Medical Assistance
CAPI	Community Action, Prevention and Intervention
CBSPP.....	Community-Based Suicide Prevention Program
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
CJCA.....	Council of Juvenile Correctional Administrators
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	Centers 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 Incentive Grants
CPS	Child Protective Services (Office of Children's Services)
CPS	Child Passenger Safety (Public Health)
CQI.....	Continuous Quality Improvement
CRIPA.....	Civil Rights for Institutionalized Person Act
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
CTU.....	Closed Treatment Unit
DAI	Detention Assessment Instrument
DBH.....	Division of Behavioral Health
DD.....	Developmentally Disabled
DEED.....	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 Work force 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)
DWL.....	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
FHSC.....	First health Services Corporation
FLSW.....	Front line Social Worker
FMAP.....	Federal Medical Assistance Program
FMS.....	Finance and Management Services
FS	Food Stamps
FTE	Full Time Equivalent

FYF	Fairbanks Youth Facility
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
IMO.....	Institute of Medicine
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 Health care Organizations
JJDP	Office of Juvenile Justice and Delinquency Prevention
JOMIS	Juvenile Offender Management Information System
JPO	Juvenile Probation Officer
JTPA	Job Training Partnership Act
JYC	Johnson Youth Facility

KPYF	Kenai Peninsula Youth Facility
KRYF	Ketchikan Regional Youth Facility
LCSW	Licensed Certified Social Worker
LIHEAP	Low Income Home Energy Assistance Program
LTC	Long Term Care
MAA	Medical Assistance Administration
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-DDI	Medical Management Information System-Design Development & Implementation
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)
MSYF.....	Mat-Su Youth Facility
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
NYF.....	Nome Youth Facility
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
PACAP.....	Public Assistance Cost Allocation Plan
PASS.....	Parents Achieving Self-Sufficiency

PASS Grant.....	Personal Assistance, Supports and Services
PBF	Performance Based Funding
PbS	Performance-based Standards
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
PFDDH	Permanent Fund Dividend Hold Harmless
PFT.....	Permanent Full Time
PHAB.....	Pioneers' Homes Advisory Board
PHN.....	Public Health Nursing
RHSSP	Rural Human Services System Project
PI.....	Program Integrity
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
SPF	Strategic Planning Framework
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
SUR.....	Surveillance Utilization and Review
SURS.....	Surveillance Utilization and Review Subsystem
SERVICES/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
TSU.....	Transitional Services Unit
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999
USDA.....	U. S. Department of Agriculture
WAS.....	Women and Adolescent Services
WIA.....	Work force Investment Act
WIC.....	Women, Infants and Children

WSEA Western States EBT Alliance
WtW Welfare to Work
WWAMI Washington, Wyoming, Alaska, Montana, Idaho
YCA Youth Competency Assessment
YF Youth Facility
YKHC Yukon-Kuskokwim Regional Health Corporation
YLS/CMI Youth Level of Services/Case Management Inventory
YRBS..... Youth Risk Behavior Survey