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Cover Page Acknowledgments: The cover page photographs represent the following communities and facilities:
First Row, Left to Right: Juneau Pioneer Home; Kotzebue; Fairbanks Medical Lab; Prince of Wales; Anchorage Psychiatric Institute; and Kotzebue.
Second Row, Left to Right: Prince of Wales; Ketchikan Youth Facility; Kotzebue-(5K Run) Smokefree Event; Prince of Wales, Kodiak- Families Understanding Nature (Fun) Program; Kodiak- Port Lions Dancers.

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Mission

To promote and protect the health and well-being of all for a strong Alaska.

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 3rd 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.

Core Services

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

Core Values

The Department of Health and Social Services has adopted core values of collaboration,

- Accountability
- Respect
- Empowerment
- Safety as guiding principles in the delivery of services.

Five main outcome goals have been developed to frame the department's efforts:

Substance Abuse: *Decrease the negative impacts of alcohol and substance abuse in Alaska.*
Health and Wellness: *Improve the health status of Alaskans.*
Health Care Reform: *Improve access to quality health care in Alaska.*
Long-Term Care: *Increase the percentage of adults 65 and older living independently in Alaska*
Vulnerable Populations: *Increase the percentage of at risk individuals who are able to live safely in their homes in Alaska.*

Executive Management Organization

The operational structure of the department has undergone modest organizational changes during FY2009. The Assistant Commissioner of Public Affairs has been replaced by a section head for the unit reporting directly to the Commissioner. The Assistant Commissioner position has been transferred back to head up the Finance and Management Services Section replacing a Deputy Commissioner position. Responsibility for legislative affairs has been delegated to a Special Assistant reporting directly to the Commissioner, and the regulations and legal coordination functions have been transferred to the Assistant Commissioner for Finance and Management Services.

Effective January 1, 2009, the department has relocated reporting responsibilities for Boards and Commissions back to the division with which they are most closely aligned. This change will help integrate and strengthen the complementary advocacy efforts that the boards and commissions are engaged in, with the program efforts of the divisions.

Certification and Licensing has been separated, with Certification of Health Facilities moving to the Division of Health Care Services. Licensing of Assisted Living Homes and Residential Child Care Facilities, and the background Check Unit remain in the Division of Public Health. Health Planning and Systems Development has moved from the Division of Public Health to the Division of Health Care Services. These two changes are both designed to provide a more seamless “one-stop shop” for the provider/facility community.

Alaska Department of Health and Social Services
Organization Chart

Commissioner
William H. Hogan

Chief Medical Officer
Jay C. Butler, M.D.

PUBLIC HEALTH
Director: Beverly Wooley

- Public Health Nursing
- Epidemiology
- Chronic Disease Prevention & Health Promotion
- Injury Prevention & Emergency Medical Services
- Women's, Children's & Family Health
- Bureau of Vital Stat.
- State Laboratory
- State Medical Examiner's Office
- Health Care Facility Licensing

Public Health Preparedness Program

Boards, Commissions and Workgroups
* Alaska Health Care Commission
* Alaska Council on Emergency Medical Service
* Primary Care Council
* Regional Health Information Org.
* Electronic Health Record workgroups

Deputy Commissioner for Medicaid and Health Care Policy
William J. Streur

- **HEALTH CARE SERVICES**
- Medicaid Director
- Medicaid Policy & Planning
- Medicaid financing
- Medicaid reform
- Medicaid Management Information System
- Rate Review
- Tribal Health
- Certification
- Health Planning & Systems Development

Boards and Commissions
* Medical Care Advisory Committee
* Pharmacy/Therapeutics Comm.

Public Information
Clay Butcher

Legislative Relations
Wilda Laughlin

Special Assistant
Tara Horton

Office of Faith-Based and Community Initiatives
FBCI Advisory Council

Deputy Commissioner for Family, Community & Integrated Services
Patrick B. Hefley

ALASKA PIONEER HOMES
Director: David Cote

Boards & Commissions
* Alaska Pioneer Homes Advisory Board

BEHAVIORAL HEALTH
Director: Melissa Stone

Boards & Commissions
* Alaska Mental Health Board
* Advisory Board on Alcoholism and Drug Abuse
* Suicide Prevention Council

CHILDREN'S SERVICES
Director: Tammy Sandoval

Boards & Commissions
* Alaska Children's Trust

JUVENILE JUSTICE
Director: Stephen McComb

* Juvenile Justice Advisory Committee

PUBLIC ASSISTANCE
Director: Elinor Fitzjarrald

SENIOR & DISABILITIES SERVICES
Director: Rebecca Hilgendorf

Boards & Commissions
* Governor's Council on Disabilities and Special Education
* Alaska Commission on Aging

Assistant Commissioner for Finance Management Services
Alison M. Elgee

- Performance/Quality Assurance
- Audits (including Legislative Audits)
- Hearings & Appeals
- Facilities
- Administrative Services
- Budget
- Revenue
- Fiscal
- Grants & Contracts
- Information Technology
- Regulations
- Legal Services Coordination

Effective Jan. 1, 2009, Rev. Feb. 13, 2009

Major Accomplishments in 2008

Tobacco and alcohol use and abuse undercut our state goals for health and safety, and drain resources away from other priorities. The State of Alaska has made strides to combat those problems, laid the groundwork to promote healthier lifestyles, and upgraded technology to manage Medicaid, Alaska's social safety net.

Built a Statewide Plan to Prevent Underage Drinking

- Three-quarters of Alaskan youth have tried alcohol. Drinking leads some Alaskan youth to accidents, crime and suicide. With statewide input, the Department of Health and Social Services developed a statewide "Prevention of Underage Drinking Initiative," teaching youth the risks they run and adults that they must take youth drinking seriously.

Cut Tobacco Use

- Alaska has also made strides in cutting our smoking rate. The number of Alaskan adults who smoke has fallen during the past decade. More than 27,000 fewer adults smoke today compared to the number who smoked in 1996.

President's Fitness Award

- Last summer, Alaska won first place among all 50 states in the National President's Challenge. The President's Council on Physical Fitness and Sports sponsored a six-week competition. During that time, more than 2,860 Alaskans signed up to walk, run, even bike their way to at least 30 minutes of physical activity five days a week. We had the highest per capita rate of participation across the country. That shows that many Alaskans are already headed in a healthy direction.

Bring the Kids Home

- The goal of the Bring the Kids Home initiative is to return children with severe emotional disturbances from out-of-state residential facilities to treatment in Alaska. From 1998 to 2004, out of state placements grew by nearly 800 percent. However, we now have fewer than 200 kids out of state at any one time, and are continuing efforts to keep new children from moving into out-of-state care. New programs and facilities in Alaska help youth avoid residential care, or deliver that care here.

Cut Wait for Disability Services

- Fewer Alaskans with disabilities are waiting for services. Senior and Disabilities Services continue to offer services to at least 50 more people with disabilities each quarter.

Bring Medicaid Claims Systems Up-to-Date

- While Alaska's economy remains stronger than those in other states, tight economic times like these may mean more Alaskans with limited incomes will be using Medicaid services, from dental care to delivering a baby, in the future. Alaska recently contracted with a national computer services company to create a new, more efficient Medicaid Management Information System that will improve services to both providers and Alaskans enrolled in Medicaid.

Expanded Financial Assistance for the Low income Heating Assistance Program

- Heating bills throughout Alaska have soared with the price of fuel oil. In rural Alaska, heating oil can run in excess of $8 dollars per gallon. Legislation passed during 2008 expanded the eligibility for financial assistance from 100% of poverty to 175% of poverty.

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.

- Identification and implementation of potential solutions to the lack of access to affordable quality health care for Alaskans.
- Improvements to child abuse prevention and protection efforts, focusing on strengthening families.
- Development of appropriate rate increases for non-profit providers throughout the state, with the needed financing, to enable continuation of the non-profit social services provider network without diminishment of service capacity.
- Increased awareness of the need for prevention strategies to improve physical well-being including education efforts regarding obesity, tobacco use, and alcohol consumption; as well as targeted disease management strategies for individuals with chronic conditions.
- Maintenance of aging facilities for the Pioneers' Homes program and the Division of Juvenile Justice.

Medicaid challenges:

- Development and completion of the Medicaid Management Information System to more effectively use new technology to manage health care in Alaska.
- Projection of Medicaid need. Assumptions for utilization and enrollment continue to be refined while the impacts of rate and other regulatory changes are incorporated into the projection models.
- Changing federal rules and interpretation of financing options using Medicaid
- Continuation of cost containment efforts.
- Expansion of the Denali Kid Care program
- Continuation of the Adult Dental program

Position Information

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

Direct Field Workers	
115	Public Health Nurses
287	Social Workers & Children's Service Specialists
308	Eligibility Determination Staff
283	Youth Detention/Treatment Workers
92	Juvenile Probation Officers
257	API Staff
652	Pioneer Homes Staff
1,994	**TOTAL**
Program Support Services	
108	Behavioral Health Programs
126	Senior and Disability Programs
422	Public Health Programs
223	Children's Services
124	Juvenile Programs
10	Facilities Management
389	Benefit Payments/Systems
1,402	**TOTAL**
Administrative/Management Support	
135	Information Technology
139	All Other Centralized Admin/Mgmt
274	**TOTAL**
3,670	**FY2010 GRAND TOTAL**

The DHSS FY2010 Governor's Request includes 3,670 positions. The details of their budgeted status and geographical location are as follows in the chart below. Select types of employees (i.e. public health nurses, social workers) may be budgeted in one location but provide continual itinerant services to numerous surrounding smaller rural communities.

FY2010 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,711	26	43	**1,780**
Aniak	3	0	0	**3**
Barrow	9	0	0	**9**
Bethel	96	0	1	**97**
Cordova	2	0	0	**2**
Craig	6	0	0	**6**
Delta Junction	6	1	0	**7**
Dillingham	10	1	0	**11**
Eagle River	1	0	0	**1**
Fairbanks	360	6	12	**378**
Fort Yukon	0	1	0	**1**
Galena	2	1	0	**3**
Glenallen	3	0	0	**3**
Haines	2	0	0	**2**
Homer	15	1	1	**17**
Juneau	597	26	34	**657**
Kenai	82	1	1	**84**
Ketchikan	116	12	9	**137**
King Salmon	2	0	0	**2**
Kodiak	14	2	0	**16**
Kotzebue	10	0	0	**10**
Mat-Su Area-wide	14	0	0	**14**
McGrath	3	0	0	**3**
Nome	38	1	2	**41**
Palmer	122	15	5	**142**
Petersburg	4	0	0	**4**
Saint Mary's	5	0	0	**5**
Seward	3	0	0	**3**
Sitka	98	0	3	**101**
Soldotna	1	0	0	**1**
Tok	2	0	0	**2**
Unalaska	1	0	0	**1**
Valdez	4	1	0	**5**
Wasilla	120	0	0	**120**
Wrangell	2	0	0	**2**
Totals	**3,464**	**95**	**111**	**3,670**

FY2010 Budget Requests

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 FY2010 Compared to FY2009

	FY2009 Management Plan	FY2010 Governor's Request
General Fund	**$ 917.2 million**	**$ 950.0 million**
Federal Funds	**1,008.2 million**	**987.4 million**
Other Funds	**171.9 million**	**163.9 million**
Total	**$ 2,097.3 million**	**$ 2,101.3 million**
Decrease Federal Revenue		**(- 20.6) million**
Increased General Fund		**32.8 million**

The proposed budget for FY2010 increases general funds by 32,800.0. Significant changes in GF are due to: Medicaid program growth of approximately 31,000.0, increased rates for providers and grantee increases of 15,800.0, new initiatives that address the department's priorities of Substance Abuse – 1,200.0, Health & Wellness - 2,000.0, Health Care Reform – 1,300.0, and Vulnerable Alaskans 13,400.0. These increases are partially offset by Medicaid savings due to a change in the FMAP rate – (7,700.0), Cost Containment Efforts – (13,500.0) and reduction of (12,000.0) in one-time items, (including the special session $10 million Heating Assistance appropriation).

To assist in understanding the DHSS budget, we have highlighted budget items addressing the five department initiatives. (A complete list of the General fund and Other fund budget items for the department is listed in the Appendices on pages 363-369):

Substance Abuse

Substance abuse affects every family and community in Alaska. It is a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, etc. We need to prevent, intervene early, and treat and help people recover from substance abuse through public/private partnerships and long-term strategies.

Budget related requests include:

- Maintain and enhance the Therapeutic Courts managed by the Alcohol Safety Action Program- *$653.0 GF*;
- Increase access to community-based substance abuse services and specifically increase access to substance abuse treatment- *$1750.0 GF*; and,
- Fairbanks Behavioral Health Enhanced Detox Facility-support the additional capacity for patients not eligible for Medicaid or private insurance- *$500. GF*.

Health and Wellness

Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by tobacco, alcohol abuse, injuries, obesity, diabetes, cancer, heart disease, and sexually transmitted diseases. The economic impact of chronic disease alone in Alaska is staggering: an estimated $600 million is spent annually on direct medical services and $1.9 billion in lost productivity. Most of this is attributable to personal choice involving diet, physical activity and tobacco use — and is preventable. We can do a better job of screening, diagnosing and treating these conditions.

Budget related requests include:

- Enhance a community program that will add treatment, housing and supportive services specifically for mentally ill adults being discharged from Corrections- *$500.0 GF;*
- Establishment of a ten-year initiative to reverse Alaska's childhood obesity trend-*$923.1 GF*
- Staffing to support the Tobacco Prevention and Control program- *$90.0 GF*;
- Retain current staffing levels for the Alaska Cancer Registry- *$179.7 GF*;
- Governor's Initiative- Live Well Alaska- *$498.4 GF*;
- Assuring access to early preventive services and quality health care (CHATS program funding)- *$173.1 GF*
- Increase support to Emergency Medical Service programs in Alaska- *$267.4 GF*
- Preventing, controlling epidemics and the spread of infectious disease- *$256.0 GF*; and,
- Enhance strategies to help Alaskan communities reduce tobacco use by supporting evidence-based community and school grants, while providing expertise in developing and distributing locally targeted communication materials- *$555.0 Other.*

Health Care Reform

Alaska's health care system continues to be fragmented and uncoordinated and doesn't produce the kinds of outcomes we expect. By strategically focusing on care management, reforming Medicaid, creating a Health Care Commission and growing our health care workforce, we can transform our health care system.

Budget related requests include:

- Increase SDPR for Telepsychiatry; revenue enhancement strategies have increased receipts from private insurance and self payors- *$200.0 GF*;
- Implement Phase II reimbursement rate increase for non-Tribal Medicaid dental providers- *$1,000.0 GF, $1000.0 Fed*;
- Provide re-enrollment of providers to CMS- *$800.0 GF, $800.0 Fed*;
- Maintain capacity to provide diagnosis and comprehensive, active referrals for Autism Spectrum Disorder- *$125.0 GF, $125.0 Other*;
- Continuation of the Grantee Partnership Project to increase the efficiency and effectiveness of the DHSS grant making process- *$100.0 GF, $246.1 Other*; and,
- Create an Alaskan Health care Commission per Administrative Order 246- *$500.0 GF*

Long-Term Care

Seniors represent the fastest growing population in Alaska and it is our responsibility to determine what kinds of services we want for our aging parents (and grandparents) in order to keep them at home in their own communities. We need to develop a long-term care plan, improve services to those

with Alzheimer's disease and related disorders, and promote the expansion of aging and disability resource centers.

Budget related requests include:

- Staffing for safety, quality of life and well being of Pioneer Homes residents- *$600.0 Other*;
- Enhance funding for On-Call substitute certified nurse aids- *$55.2 Other*;
- Staffing to perform Eligibility Assessments for Medicaid applicants- *$165.0 GF, $165.0 Fed*; and,
- Continuation of support for Senior Community Based Grants to Aging and Disability Resource Centers- *$125.0 Other*.

Vulnerable Alaskans

We need to ensure that both kids and communities are safe, that developmentally disabled kids and adults have access to quality services and supports, and that individuals and families get the kind of financial and vocational supports they need to be contributing members of society. By focusing on family-centered services and through the use of performance-based standards and funding, we can better meet the needs of our most vulnerable citizens and their families.

Budget related request include:

- Increase funding to all grantee programs within Behavioral Health, where grantees are providing prevention and treatment services for substance abuse and mental health clients, to avoid reduction in capacity due to increased grantee costs - *$588.3 GF*`;
- Enhance funding to community behavioral health services for intensive individualized services- *$1750.0 GF*;
- Enhance the quality of training available to assisted living home providers- *$100.0 Other*;
- Support and expand services for Alaskans experiencing psychiatric emergencies in rural communities- *$950.0 GF, $300.0 Other*;
- Implement and sustain a community-based capacity for BTKH transitional aged youth, which would provide age appropriate services for work and educational activities- *$300.0 Other;*
- Enhancing existing and establishing new BTKH services in Tribal/rural systems, reducing out-of-state services-.*$400.0 GF, $00.0 Other*;
- Enhance BTKH Community Behavioral Health Center Outpatient & Emergency Residential Services and Training, reduce the need for residential level services for youth experiencing serious emotional disturbances- *$1,100.0 G, $250.0 Other;*
- Maintain BTKH services for youth-in-crisis by avoiding crisis stabilization beds in Anchorage and statewide- *$150.0 Other*;
- Maintain funding for BTKH individualized services for additional care of youths experiencing SED who are not Medicaid qualified or who need non-Medicaid eligible services- *$500.0 GF*;
- Continuation of the 2006 OCS workload study recommendation to increase frontline and support staff positions(final phase)- *$310.9 GF, $92.9 Fed*;
- Enhance Children's Services efforts to recruit, screen and train foster homes for children in the custody of the state who have been abused or neglected- *$115.5 GF, $34.5 Fed* ;
- Maintain service levels for Children's Services Family Preservation grantees- *$338.9 GF*;
- Ensure funding for increased numbers of adoptions and guardianships due to growth- *$489.4 GF, $179.0 Fed*;
- Implementation of the final phase to increase adoption subsidies to foster care base rate levels- *$1407.1 GF, $862.4 Fed*;

- Maintain service for adoption and guardianship grantees- *$55.3 GF*;
- Maintain service level levels for Children's Services residential care grantees-*$154.6 GF*
- Sustain and support Early Intervention and Infant Learning program costs due to Congress's authorization of the Child Abuse and Prevention and Treatment Act (from 2003*)- $1,500 GF;*
- Maintain service levels for OCS Infant learning program grantees- *$314.9 GF*;
- Establish an early childhood mental health learning network, coordinator and provides grants for agencies to engage in early childhood screening and intervention services at day care programs- *$100.0 G, $100.0 Other*;
- Continuation of grant funding for early intervention with very young children at risk of becoming youth experiencing serious emotional disturbance- *$100.0 GF*;
- Frontline staffing at five Juvenile Justice facilities for safety and security of resident and staff to meet the National Institute of Corrections recommendation- *$688.2 GF*;
- Maintain existing Mental Health Clinical Capacity in the Juvenile Justice facilities- *$288.4*;
- Staffing for the establishment of aftercare, mental health and support needs for youth transitioning out from long-term institutional treatment programs- *$273.6 GF;*
- Sustain and support cost of operating adjustments for child care grantees- *$305.4 GF*;
- Sustain and support child care rate increases for working families-*$3,000.0 GF*;
- Maintain the Alaska Heating Assistance program beyond FY2009- *$5,000.0 GF*;
- Sustain and support grantees who administer the WIC program during the 3 year phase-in process for new formula funding- *$70.8 GF*;
- Maintain local community services for WIC eligibility determinations- *$247.1 GF*;
- Sustain and support the Birth Defect Registry, current funding level needs do not adequately support this state mandated program- *$280.3 GF*;
- Establish Interagency Receipts to accept funding from the Department of Corrections for behavioral risk management services for sex offenders- *$125.8 Other*; and,
- Establish highly qualified Early Intervention and Infant learning Program staff for children with 25% developmental delay- *$500.0 GF*.

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

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.

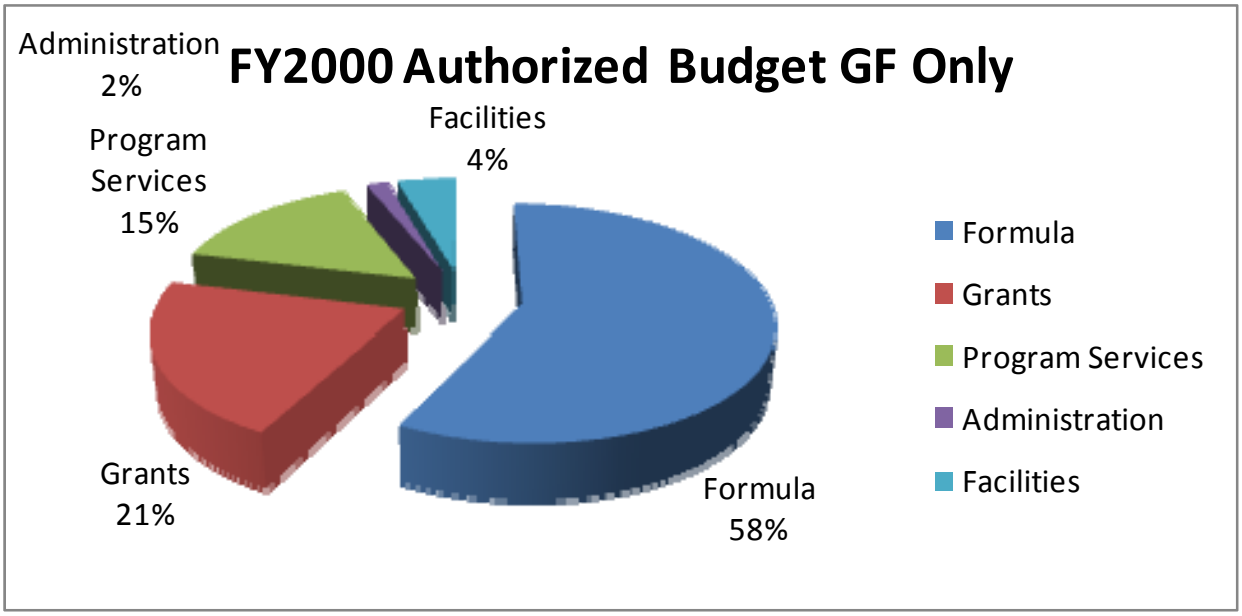
Administration
Administration includes departmental administrative oversight and support programs, including the Commissioner's Office, Administrative Services, and Boards and Commissions.

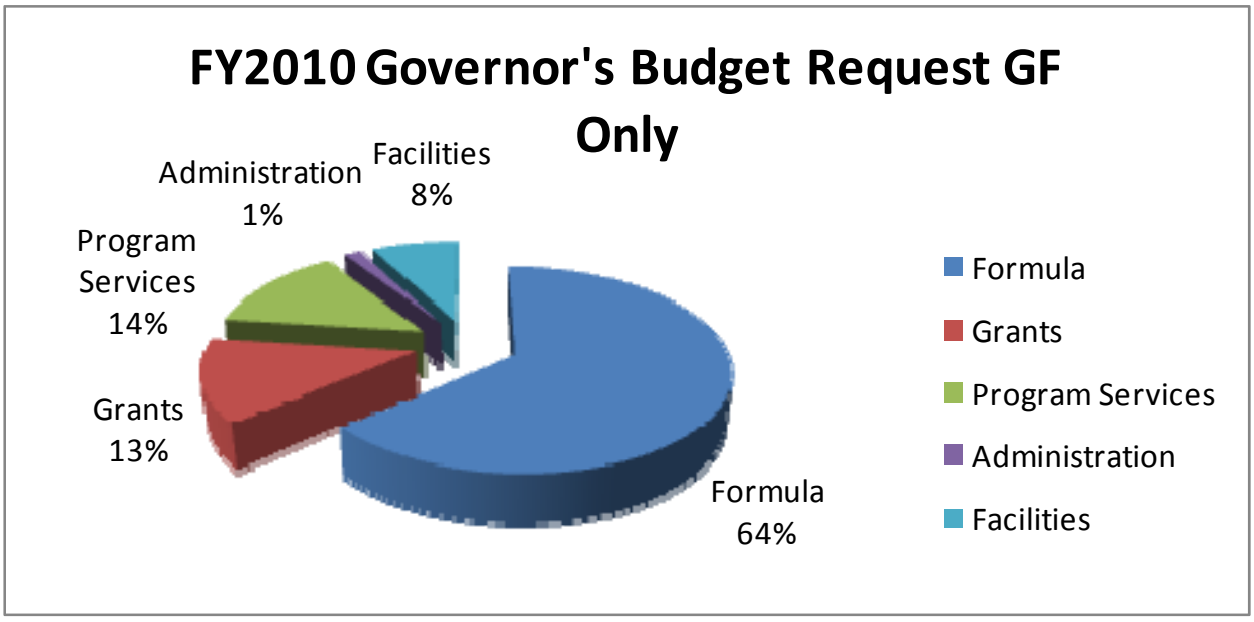
Facilities
The department manages and operates 24-hour facilities and institutions. These include youth correctional facilities, Alaska Psychiatric Institution, and Pioneer Homes.

Budget Charts and Graphs

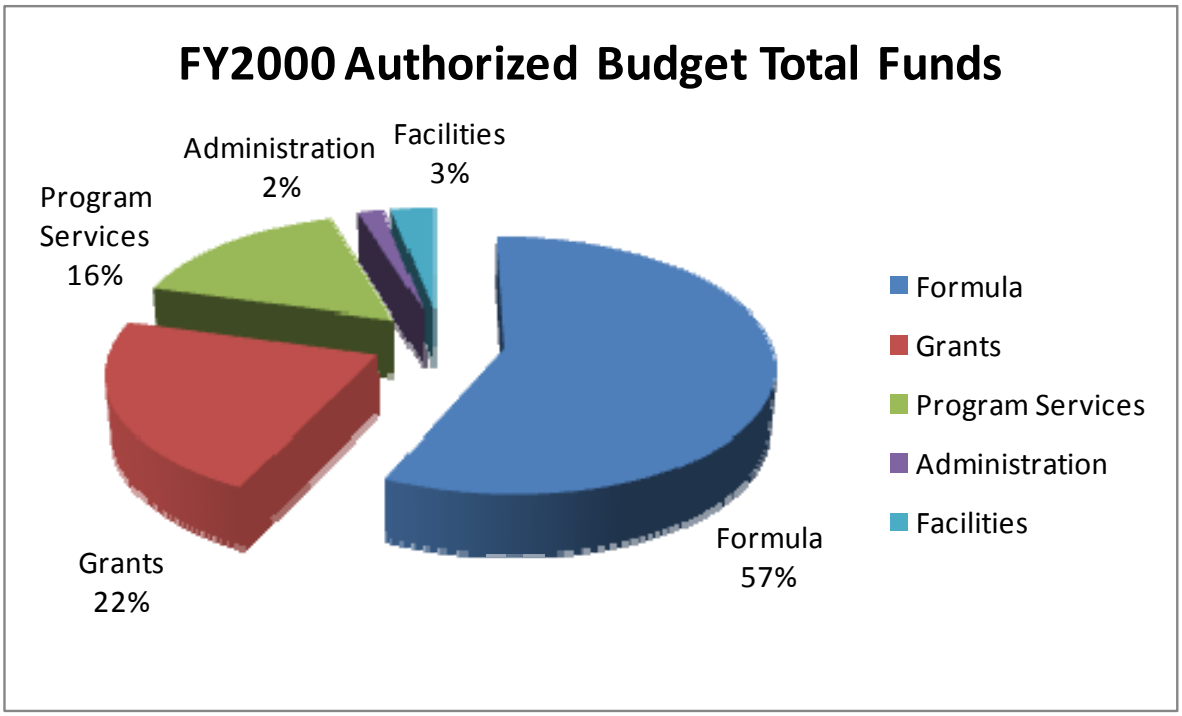
The table below shows the comparison of total funds for FY2000 and FY2010.

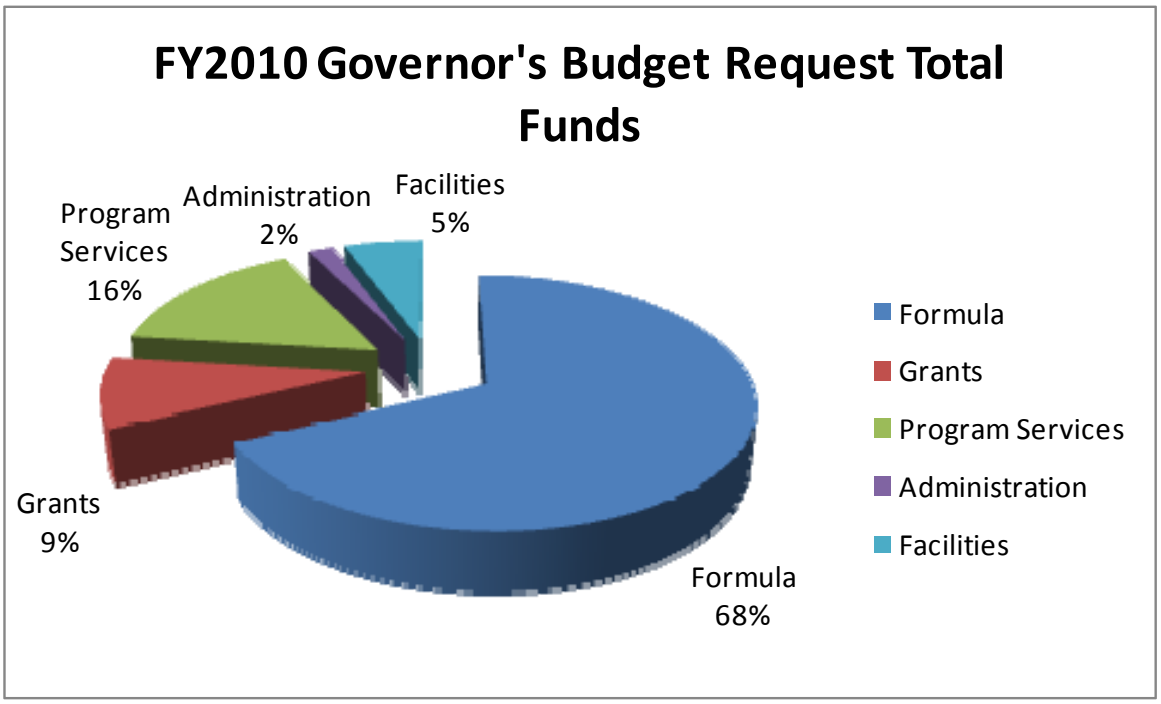
	FY2000 Authorized		FY2010 Governor's		
	Total Funds	% of Total	Total Funds	% of Total	2000 to 2010 Change
Formula	$ 646,517.2	57%	$ 1,427,894.6	68%	221%
Grants	$ 253,650.6	22%	$ 188,782.1	9%	74%
Program Services	$ 181,048.8	16%	$ 329,364.9	16%	182%
Administration	$ 20,301.1	2%	$ 37,280.9	2%	184%
Facilities	$ 33,866.2	3%	$ 118,014.1	6%	348%
Total	**$ 1,135,383.9**		**$ 2,101,336.6**		**185%**





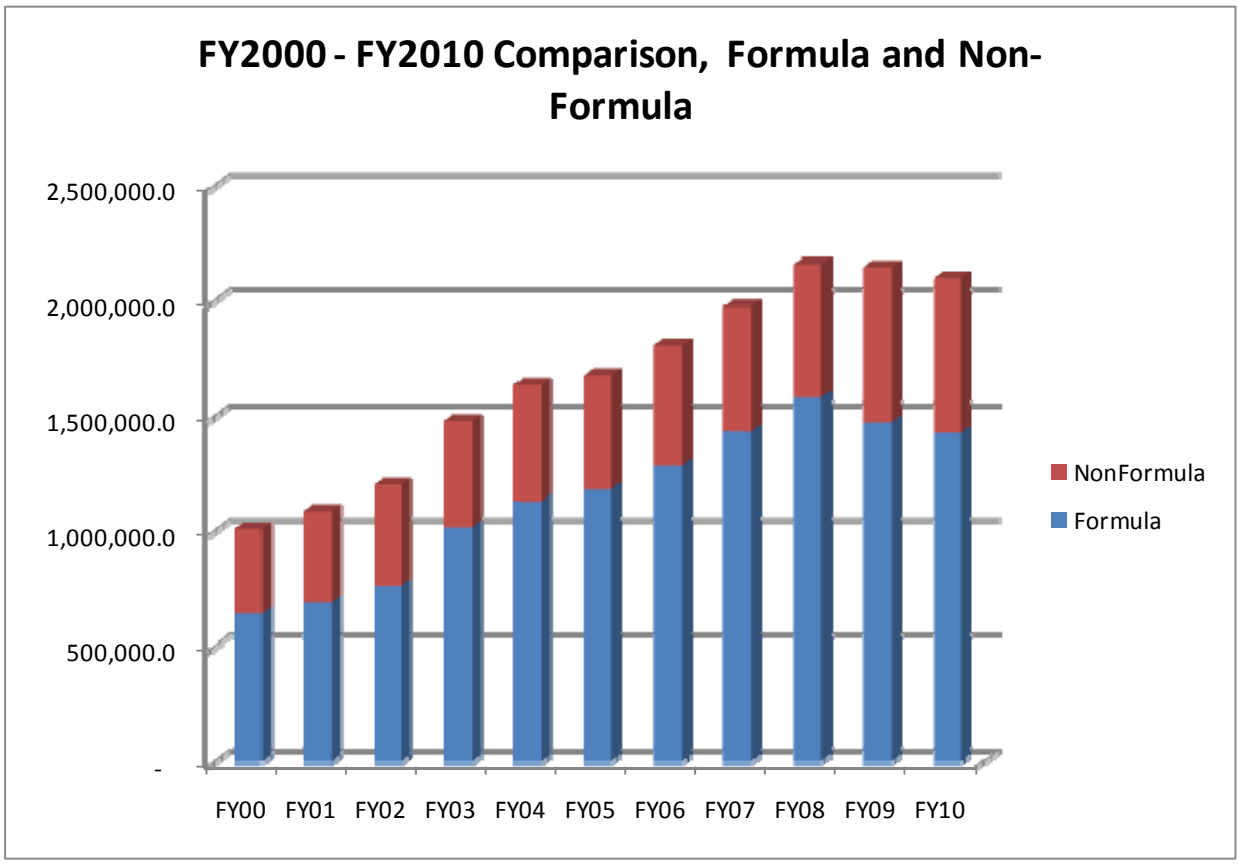
Formula programs comprised approximately 58% of the department's FY2000 general fund budget in comparison to 64% of the FY2010 general fund budget.





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 ten years.



From FY2000 – FY2002 formula programs were fairly consistent between 63% - 65% of the department's overall budget. In FY2003 and FY2004 it was closer to 69%. From there, for the next four years the percentage of formula funding steadily rose to a high of about 73% in FY 2008. Note that for FY2009 – FY2010 we show both a slight reduction in the overall budget and a reduction in the percentage of formula funding, down to about 68%. Medicaid is the largest formula program in the department, totaling about 85% of the total formula program category in the proposed FY2010 budget.

Medicaid

Introduction

This section provides a department-wide review of the Medicaid program. 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 Medicaid 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 persons and single parent families. In addition, Medicaid expanded coverage in 1998 through the State Children's Health Insurance Program (SCHIP) to children and pregnant women whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance. SCHIP enrollment is administered through the Denali KidCare office.

Four main divisions manage benefits: Health Care Services, Behavioral Health Services, Senior and Disabilities Services, and Office of Children's Services. Medicaid administrative activities support the service delivery of every division within the Department of Health and Social Services, as well as six other departments within the state government (Departments of Administration, Courts, Corrections, Education and Early Development, Law, and Labor and Workforce Development).

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

Funding Overview

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

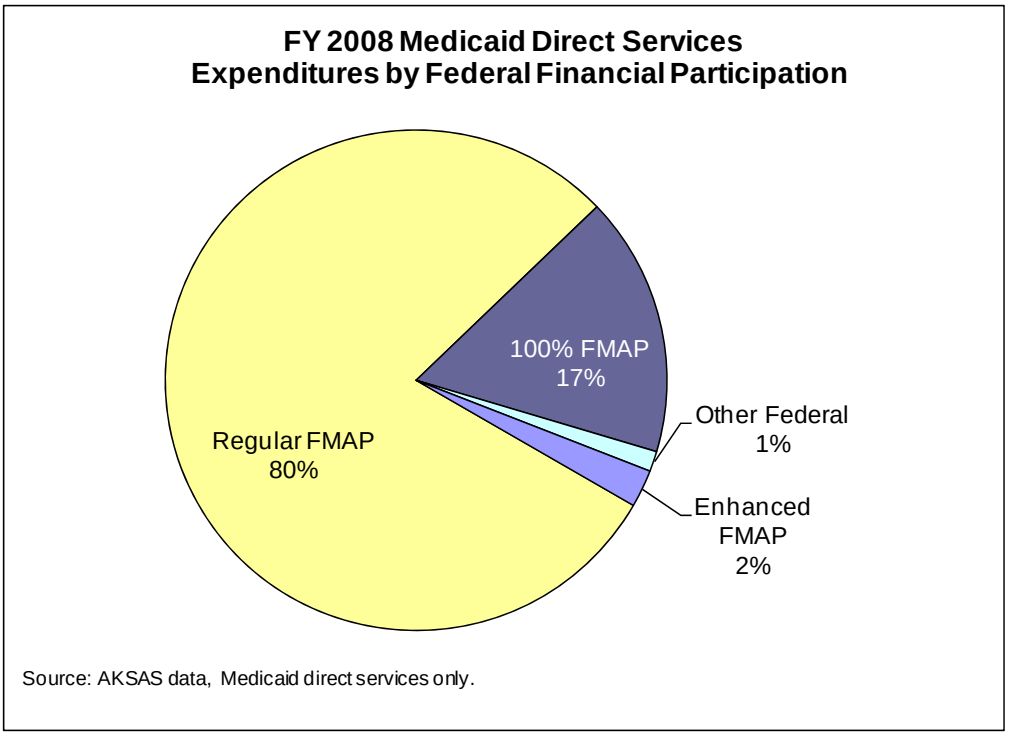
The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50%. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (i.e., qualified Indian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

Federal Medical Assistance Percentages for Claim Payments

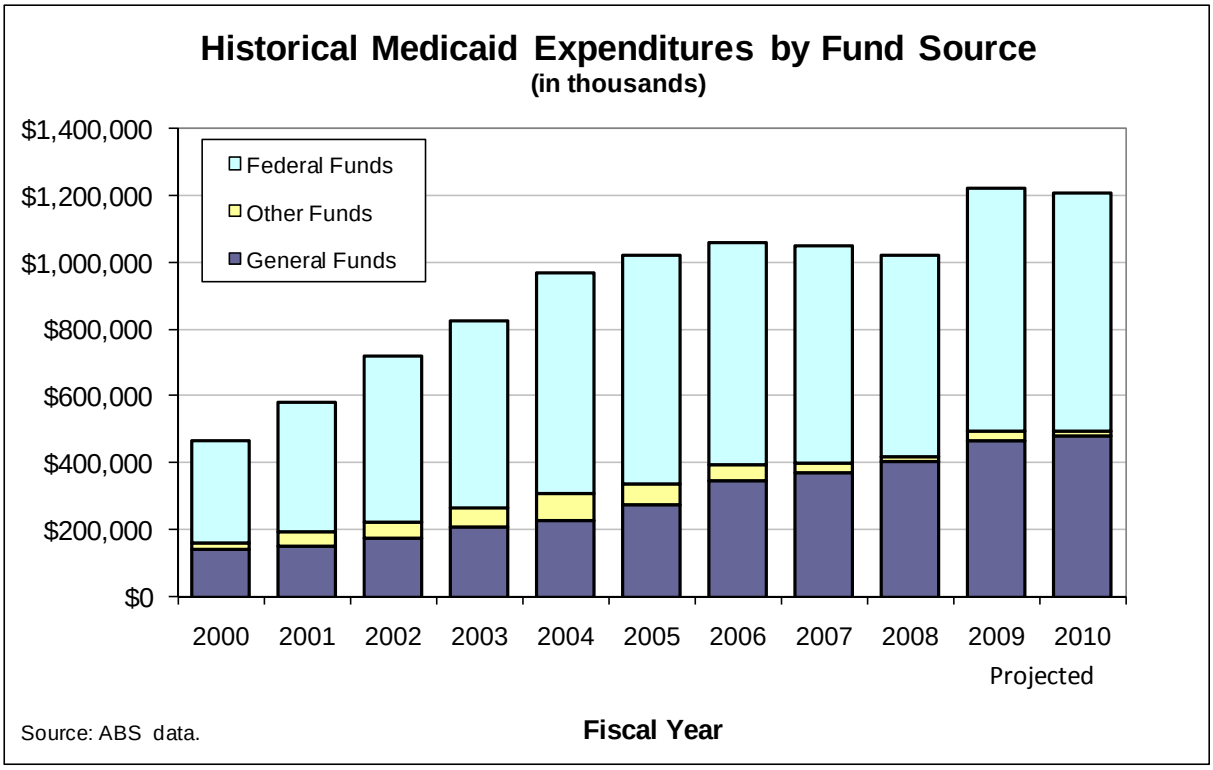
	Federal Fiscal Year Statutory Rate		**State Fiscal Year** Average Rate	
Year	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
Before 1998	50.00	n/a	50.00	n/a
1998	59.80	71.86	57.35	71.86
1999	59.80	71.86	59.80	71.86
2000	59.80	71.86	59.80	71.86
2001	60.13	72.09	60.05	72.03
2002	57.38	70.17	58.07	70.65
2003 Q1-Q2	58.27	70.79	58.79	71.15
2003 Q3-Q4	61.22	72.85		
2004 Q1-Q3	61.34	72.94	61.31	72.92
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
2010	51.43	66.00	51.21	65.84

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

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



The department has successfully minimized the need for additional state general funds while still meeting its mission. Although costs, including 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. Recent changes in the FMAP resulted in State matching funds accounting for 40% of Medicaid funding in FY2008, up from 38% in FY2007.



One of the refinancing measures the Department has implemented is to increase the proportion of Medicaid services eligible for Indian Health Service 100% federal reimbursement. For every dollar shifted to the tribal system from regular FMAP in FFY2008, the State saved 48 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. Growth has been controlled—mitigating other increases in population, enrollment, and the amount and duration of services used. Expenditures decreased in FY2008 for the second consecutive year. This trend is not expected to continue as the Legislature approved increases in provider reimbursements that take effect in FY2009.

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	$408,250	$604,348	$11,189	$1,023,788
2009 *	$451,295	$635,701	$8,579	$1,095,575
2010 **	$481,030	$708,455	$17,224	$1,206,709

Source: Medicaid Budget Group using Alaska Budget System data.
*Forecast as of November 2008. **Governor's Budget.

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

In FY2008, one in five Alaskans was enrolled in the state's Medicaid program. Annual enrollment growth has been slowing. Between FY2000-2003 enrollment growth was 4 to 5% annually; between FY2004 and FY 2006 growth was 2% a year or less; and in FY2007 and FY2008 enrollment declined by about 3% per year.

The number of persons receiving medical assistance benefits (beneficiaries) also decreased, mirroring the drop in enrollment. Beneficiaries declined 1% from the prior year in FY 2007 and 4% for FY2008. This might be due to problems encountered while adjusting enrollment processes to new statutory requirements for citizenship documentation.

The majority, but not all, enrollees receive benefits in a fiscal year. The ratio of enrollees to beneficiaries is called the participation rate. The participation rate has increased from 87% in FY 2000 to 94% in FY2008. So while the number of enrollees has declined, the proportion of those enrollees actually using services has increased.

Participation in Medicaid

Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	627,533	110,219	96,033	18%	87%
2001	632,091	116,226	104,730	18%	90%
2002	640,522	121,582	109,571	19%	90%
2003	647,773	126,632	116,008	20%	92%
2004	657,314	129,528	118,466	20%	91%
2005	664,060	131,136	125,318	20%	96%
2006	670,958	131,996	122,978	20%	93%
2007 *	676,987	128,295	121,864	19%	95%
2008 **	684,232	125,138	117,472	18%	94%

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

* Population is provisional. ** Population is projected.

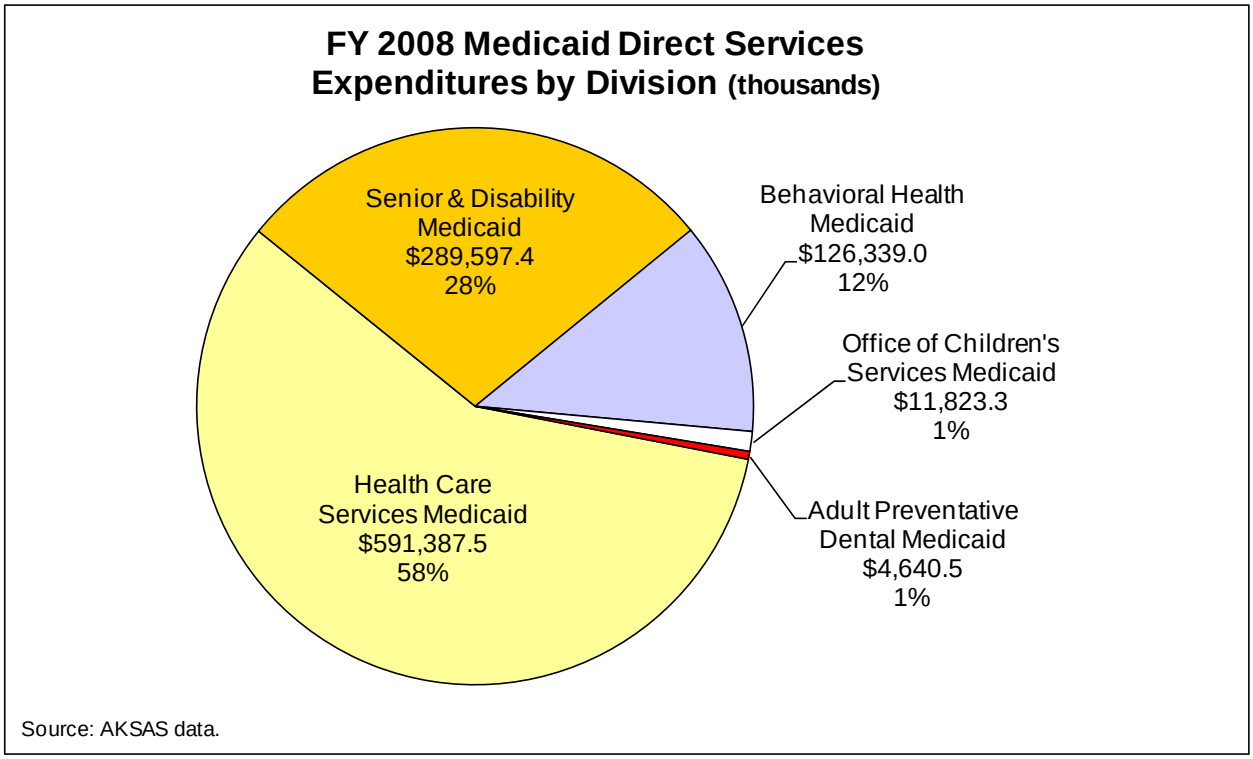
Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

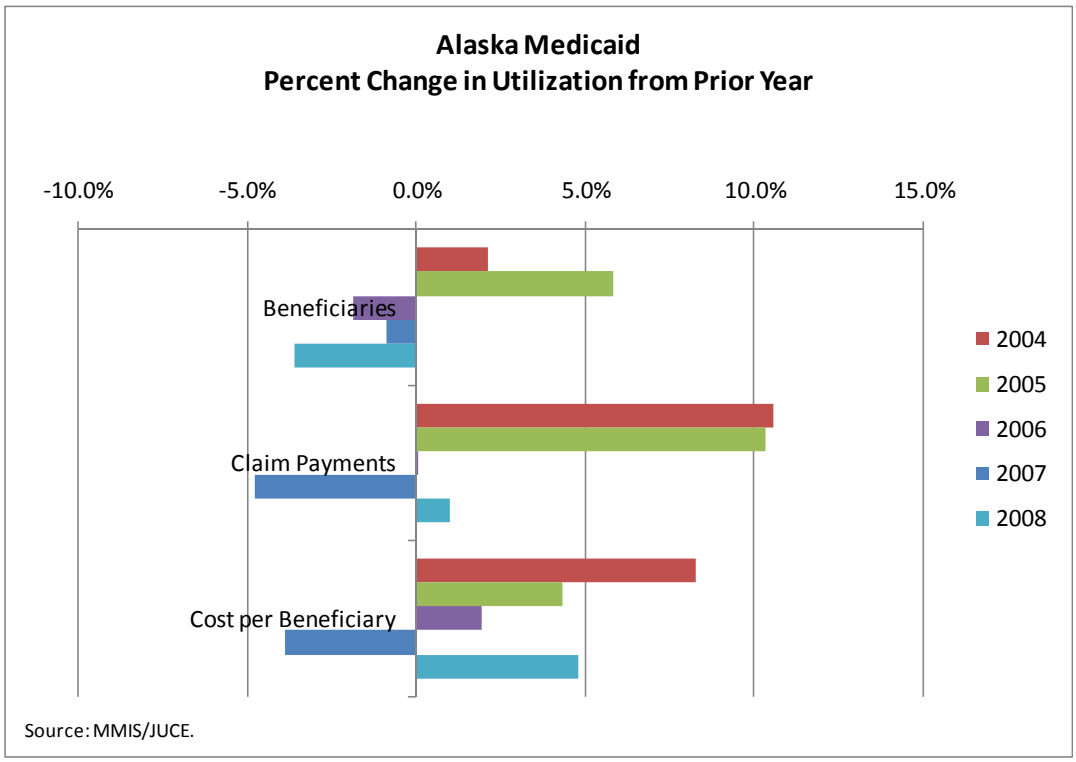
The majority of Medicaid expenditures are in the Health Care Services Medicaid Services component, which accounted for 58% of the costs in SFY2008. Long-term care costs in the Seniors and Disabilities Medicaid Services component comprised 28% of the total. The remaining 14% of expenditures were paid by Behavioral Health Medicaid Services (12%), Office of Children's Services Medicaid (1%) and Adult Preventive Dental Medicaid (1%) components.

Many beneficiaries receive services which are budgeted in more than one component since individuals, once enrolled, can receive any services for which they are eligible. For example, a

beneficiary receiving mental health counseling paid from Behavioral Health Medicaid Services' budget can also get a flu shot paid from Health Care Services' Medicaid budget.

- 93% of all persons with paid claims for Medicaid services during FY 2008 received some benefits funded through Health Care Services Medicaid,
- 10% received benefits through Behavioral Health Medicaid Services,
- 6% received benefits provided by Senior and Disabilities Medicaid Services,
- 1% received benefits provided by Office of Children's Services Medicaid, and
- 1% received benefits provided by Adult Preventative Dental Medicaid.

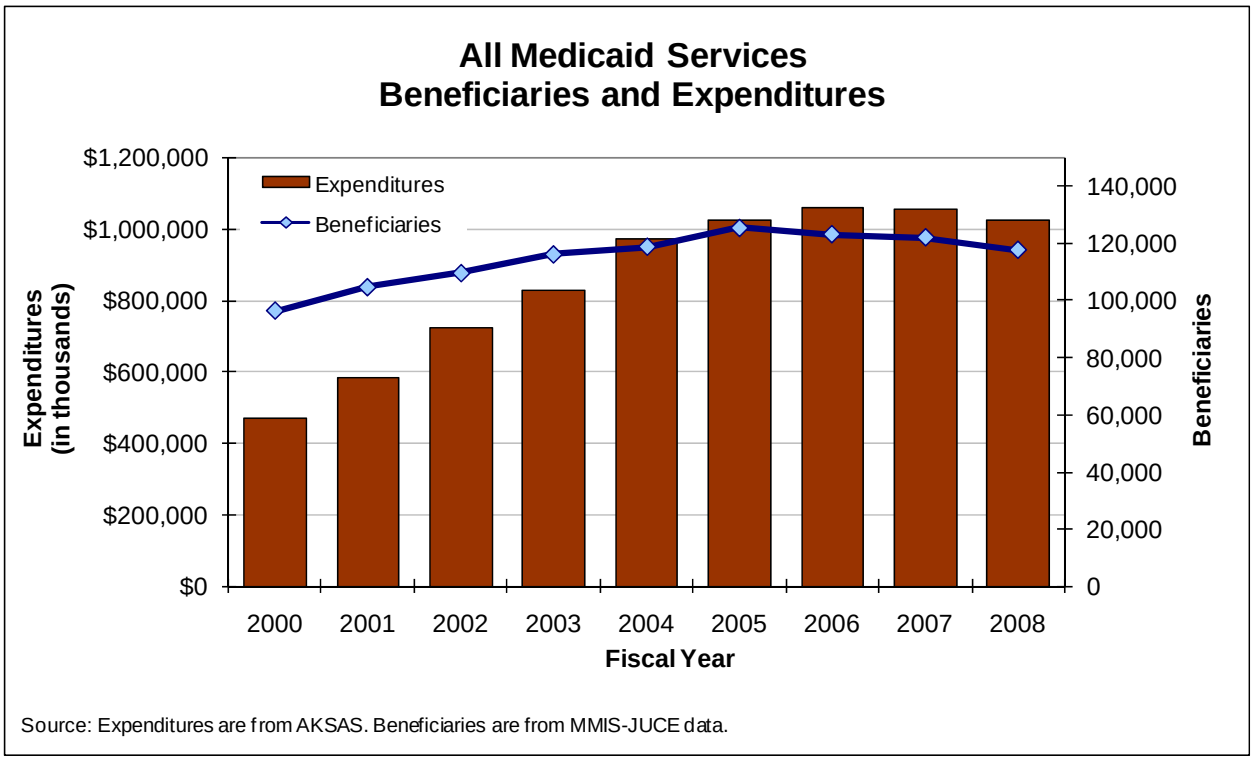



Alaska Medicaid
Percent Change in Utilization from Prior Year
-10.0%
-5.0%
0.0%
5.0%
10.0%
15.0%
Beneficiaries
Claim Payments
Cost per Beneficiary
2004
2005
2006
2007
2008
Source: MMIS/JUCE.

Medicaid Direct Services Expenditures by Division, FY 2008
(in thousands)

Total Medicaid Direct Services	$	1,023,787.7
Health Care Services Medicaid	$	591,387.5
Hospital Services	$	224,313.5
Physician Services	$	112,968.6
Pharmacy Services	$	70,673.9
Dental Services	$	25,095.9
Transportation	$	44,228.7
Other Medicaid Direct Services	$	49,142.1
Non-MMIS Services	$	41,097.2
Medicaid Refinancing	$	23,394.4
Medicaid (State-only)	$	473.2
Adult Preventative Dental Medicaid	$	4,640.5
Adult Preventative Dental	$	4,640.5
Seniors & Disabilities Medicaid	$	289,597.4
Personal Care Services	$	72,272.7
Nursing Homes	$	74,659.0
Adults with Disabilities Waiver	$	21,551.6
Children with Complex Medical Conditions	$	9,618.5
Mental Retardation/Develpmental Disabilities	$	76,806.1
Older Alaskans Waiver	$	33,502.5
Other Services	$	1,187.0
Behavioral Health Medicaid	$	126,339.0
Residential Psychiatric Treatment Centers	$	47,393.5
Inpatient Psychiatric Hospitals	$	16,485.7
General Mental Health Services	$	60,038.7
Other Services	$	2,421.1
Office of Children's Services Medicaid	$	11,823.3
Behavioral Rehabilitation Services	$	10,627.2
Beh. Rehabilitation Services-BTKH	$	1,196.1

Source: Medicaid Budget Group using AKSAS and ABS data.



The decline in expenditures from FY2007 to FY2008 was largely the result of a decline in enrollment and cost containment successes in Personal Care Attendant Services and Residential Psychiatric Treatment Centers, which had been the areas of fastest growth in recent years.

FY 2008 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		PARTICIPATION (Recipients as Percent of Enrollment)
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Medicaid, Department Annual Totals		**117,472**		**$943,714,551**	**$8,034**		**125,138**	**93.9%**
Gender								
Female	57.1%	67,088	56.7%	$535,360,512	$7,980	54.9%	68,770	97.6%
Male	42.9%	50,417	43.3%	$408,354,039	$8,100	45.1%	56,408	89.4%
Unknown	0.0%		0.0%		$0	0.0%	2	-
Race								
Alaska Native	39.3%	46,522	37.1%	$349,902,721	$7,521	37.1%	46,851	99.3%
American Indian	1.6%	1,852	1.4%	$13,422,877	$7,248	1.6%	1,990	93.1%
Asian	5.4%	6,416	4.9%	$45,910,840	$7,156	6.0%	7,555	84.9%
Pacific Islander	2.8%	3,346	2.0%	$19,333,968	$5,778	3.1%	3,903	85.7%
Black	5.2%	6,204	4.5%	$42,040,412	$6,776	5.5%	6,981	88.9%
Hispanic	3.5%	4,183	2.2%	$21,020,284	$5,025	3.6%	4,588	91.2%
White	39.1%	46,281	44.8%	$422,499,475	$9,129	40.1%	50,621	91.4%
Unknown	3.0%	3,553	3.1%	$29,583,974	$8,326	3.1%	3,904	91.0%
Native	41.0%	48,342	38.5%	$363,325,598	$7,516	38.9%	48,802	99.1%
Non-Native	59.0%	69,468	61.5%	$580,388,953	$8,355	61.1%	76,778	90.5%
Age								
under 1	9.4%	12,071	8.4%	$79,343,602	$6,573	8.4%	11,299	106.8%
1 through 12	36.2%	46,391	14.9%	$140,559,693	$3,030	38.6%	51,731	89.7%
13 through 18	16.5%	21,211	16.0%	$151,092,547	$7,123	17.6%	23,610	89.8%
19 through 20	3.2%	4,132	2.6%	$24,450,674	$5,917	2.7%	3,586	115.2%
21 through 30	10.3%	13,249	11.1%	$104,565,753	$7,892	9.3%	12,419	106.7%
31 through 54	13.9%	17,807	21.8%	$205,471,274	$11,539	13.3%	17,786	100.1%
55 through 64	3.8%	4,889	8.6%	$81,192,491	$16,607	3.6%	4,808	101.7%
65 through 84	5.6%	7,247	12.3%	$116,410,139	$16,063	5.5%	7,386	98.1%
85 or older	1.0%	1,321	4.3%	$40,628,378	$30,756	0.9%	1,259	104.9%
Benefit Group								
Children	61.6%	73,773	34.3%	$323,735,337	$4,388	64.2%	81,224	90.8%
Adults	18.1%	21,658	11.9%	$112,401,125	$5,190	16.4%	20,756	104.3%
Disabled Children	1.8%	2,176	6.1%	$57,127,496	$26,253	1.7%	2,114	102.9%
Disabled Adults	12.3%	14,737	32.7%	$308,802,001	$20,954	11.9%	15,001	98.2%
Elderly	6.1%	7,349	15.0%	$141,648,592	$19,275	5.9%	7,429	98.9%

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.

Enrollment: Number of persons eligibile for Medicaid and enrolled for at least 1 month during state fiscal year 2008. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,and benefit group categories). Some duplications may occur between subgroup counts. For example, an infant with a September birthdate would count in the under 1 age subgroup based on enrollment activity between July and September but would also be counted in the 1 through 12 age subgroup based on enrollment activity between October and June.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2008. Service may have been incurred in a prior year. Grouping is based on status on the date the benefit was obtained. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories). Some duplications may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2008. . If they obtained dental services in December, they would also be included in the 13 through 18 age subgroup count if the claim was subsequently paid during SFY08.

Participation: Recipients as a percent of enrollment. An estimate of the percent of enrollees obtaining medical services, based on claims paid or adjusted during the fiscal year. Participation values in this report may exceed 100% because recipient counts include some persons with service incurred in prior years (but paid during the current year).

Department-wide recipient counts are unduplicated across divisions.

Source: MMIS/JUCE.

Explanation of FY2010 Medicaid Budget Requests

For SFY2010, the Department request for Medicaid services includes an $11.1 million increase in General Funds, a $15.2 million reduction in Federal funds, and an $11.3 million decrease in Other Funds.

		2009 Mgmt Plan	2010 Proposed	09 to 10 Change
Total All Medicaid Services	General Funds	469,894.8	481,030.2	11,135.4
	Federal Funds	723,616.6	708,455.3	-15,161.3
	Other Funds	28,569.6	17,223.9	-11,345.7
	Total	**1,222,081.0**	**1,206,709.4**	**-15,371.6**
Behavioral Health Medicaid Services	General Funds	71,075.8	69,693.8	-1,382.0
	Federal Funds	98,984.0	82,418.5	-16,565.5
	Other Funds	2,400.0	2,400.0	0.0
	Total	172,459.8	154,512.3	**-17,947.5**
Children's Medicaid Services	General Funds	7,926.2	7,909.3	-16.9
	Federal Funds	8,219.5	8,236.4	16.9
	Other Funds	0.0	0.0	0.0
	Total	16,145.7	16,145.7	**0.0**
Adult Preventative Dental Medicaid Services	General Funds	1,877.0	2,602.0	725.0
	Federal Funds	6,831.8	3,531.8	-3,300.0
	Other Funds	1,400.0	0.0	-1,400.0
	Total	10,108.8	6,133.8	**-3,975.0**
Health Care Medicaid Services	General Funds	231,744.1	229,212.5	-2,531.6
	Federal Funds	423,593.2	422,052.1	-1,541.1
	Other Funds	21,889.8	11,071.7	-10,818.1
	Total	677,227.1	662,336.3	**-14,890.8**
Senior and Disabilities Medicaid Services	General Funds	157,271.7	171,612.6	14,340.9
	Federal Funds	185,988.1	192,216.5	6,228.4
	Other Funds	2,879.8	3,752.2	872.4
	Total	346,139.6	367,581.3	**21,441.7**

Source: Medicaid Budget Group using Alaska Budget System data.

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

	General Funds	Federal Funds	Other Funds	Total
Total All Change Records for Medicaid Services	**$11,135.4**	**($15,161.3)**	**($11,345.7)**	**($15,371.6)**

Adjust Authorization for Current Trends & Reduce Excess Authority (DBH, HCS, SDS)

($13,500.0) ($61,700.0) ($10,818.1) ($86,018.1)

The department can adjust its authorization this year to reflect current trends by reducing the budget for Medicaid. The long-term trend indicates annual increases in costs driven by inflation and population changes. Short-term projections are influenced mainly by enrollment and utilization of services. The change over a long period is generally smoother and more gradual than the fluctuations experienced in the short term. Recently, the department has been successful in avoiding some costs and in containing growth rates (e.g., pharmacy services, personal care). The result is that authorization is briefly ahead of the current trend.

Medicaid Program- Change in Federal Financial Participation (DBH, OCS, HCS, SDS)

($7,710.8) $7,710.8 $0.0 $0.0

The fund change requests rebalance state and federal funding needs resulting from a 0.9-point increase in the annual rate the federal government reimburses the state for Medicaid benefits. The new federal medical assistance percentage, or FMAP, takes effect on October 1st at the start of the federal fiscal year. The rate for FFY2010 is 51.43%, up from 50.53% in FFY2009.

Medicaid Program-Formula Growth (DBH, HCS, SDS)

$30,903.8 $41,420.3 $0.0 $72,324.1

One in five Alaskans is enrolled in Medicaid in any given year. In an average week, 25,500 Alaskans receive some level of medical care that costs the Medicaid program $17-25 million in benefit payments made to 2,100 health care providers. The Medicaid budget is based on projections of the number of eligible Alaskans who will access Medicaid funded services, the estimates of the quantity of services that may be used and the anticipated changes in the costs of those services.

Increase Dental Rates for non-Tribal Providers (HCS)

$1,000.0 $1,000.0 $0.0 $2,000.0

This increment funds Phase II reimbursement rate increases for non-Tribal Medicaid dental providers. Medicaid pays dental claims for about 42,000 persons a year, mostly children. In FY2009 the department implemented Phase I and increased rates on the most frequently billed codes to about 80% of billed charges. The department intends in FY2010 to review rates for all the remaining Medicaid dental service codes that were not updated in Phase I and increase reimbursement levels to approximately 80% of current billed charges.

Reauthorization of Adult Preventive Dental Medicaid Program & Adjustment of Fund Sources (HCS)

$725.0 ($3,300.0) $0.0 ($2,575.0)

The Adult Preventive Medicaid Dental program was established with a three-year sunset clause, which provides a trial period and an opportunity to evaluate the program. The program will be up for reauthorization at the end of SFY 2009. If not reauthorized, the program will end June 30, 2009. Should the program be reauthorized, to assure the adult preventive dental program's success, the department will continue to cap the dental services for each individual at $1,150 and operate within the budgeted amount. This change record reduces excess federal authority and increases GF to replace Alaska Mental Health Trust Authority Authorized Receipts (MHTAAR).

Other Medicaid Change Records (HCS, SDS)

($282.6) ($292.4) ($527.6) ($1,102.6)

Other change records include: reduced Alaska Mental Health Trust Authority Authorized Receipts (MHTAAR) in Adult Preventive Dental Medicaid; a reversal of one-time funding to increase home and community based waiver rates for assisted living homes from 4% to 6%; a decrement for the second year of a fiscal note for a prescription database (SB196); and additional interagency receipt authority for a previously unbudgeted reimbursable services agreement with the Alaska Pioneer Homes.

Department of Health and Social Services

Mission

To promote and protect the health and well-being of all for a strong Alaska.

Core Services

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

A: Result - Outcome Statement #1: Eligible Alaskans and Veterans will live in a safe environment.

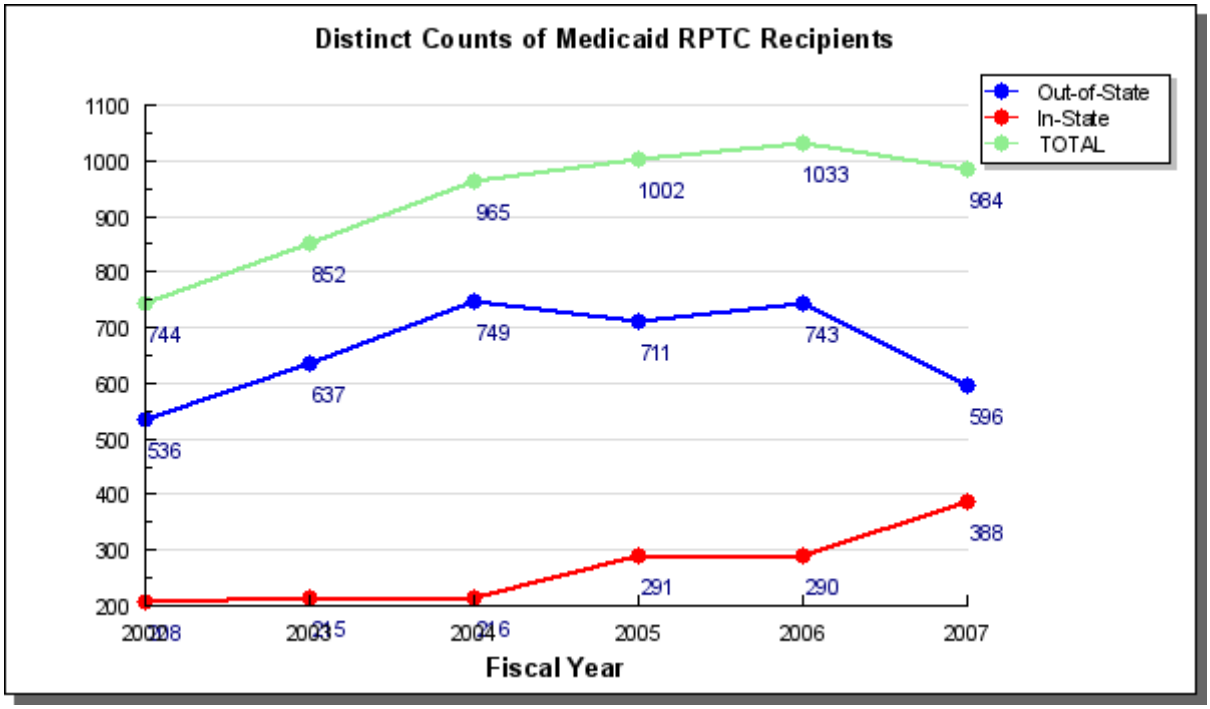
Target #1: Reduce resident serious injury rate

Status #1: In FY2008, the medication error rate decreased to .14% while medications administered increased to an average of 488,184 per fiscal quarter, up from 434,464 in FY2006. In FY2008, our sentinel event injury rate from falls decreased to 1.73%, down from 2.9% in FY 2007.

Analysis of results and challenges: Increasing age and acuity levels of Pioneer Homes residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending and tracking information available in the division's risk analysis program, the Homes are able to identify times, places, 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.

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.
Status #1: From FY2006 to FY2007 the number of children in out of state placement was reduced from 743 to 596.



Methodology: Data appears in the "DHSS BTKH Annual Report 07" (see link below), as provided by the Division of Behavioral Health, Policy and Planning Unit using MMIS-JUCE extracts. Data represents an unduplicated count of RPTC beneficiaries.

Distinct Counts of Medicaid RPTC Recipients

Fiscal Year	Out-of-State	In-State	TOTAL
FY 2007	596	388	984
FY 2006	743	290	1033
FY 2005	711	291	1002
FY 2004	749	216	965
FY 2003	637	215	852
FY 2002	536	208	744

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

The Bring the Kids Home (BTKH) Project was initiated during FY2004. Positive changes are already apparent. Between FY2004 and 2005 there was a 5.1% reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. Between FY2006 and FY2007:

* There was a decrease of 19.8% in the number of distinct out-of-state RPTC recipients served.

* There was an increase of 33.8% in the number of distinct RPTC recipients who received services instate. This reflects increased bed capacity and utilization.

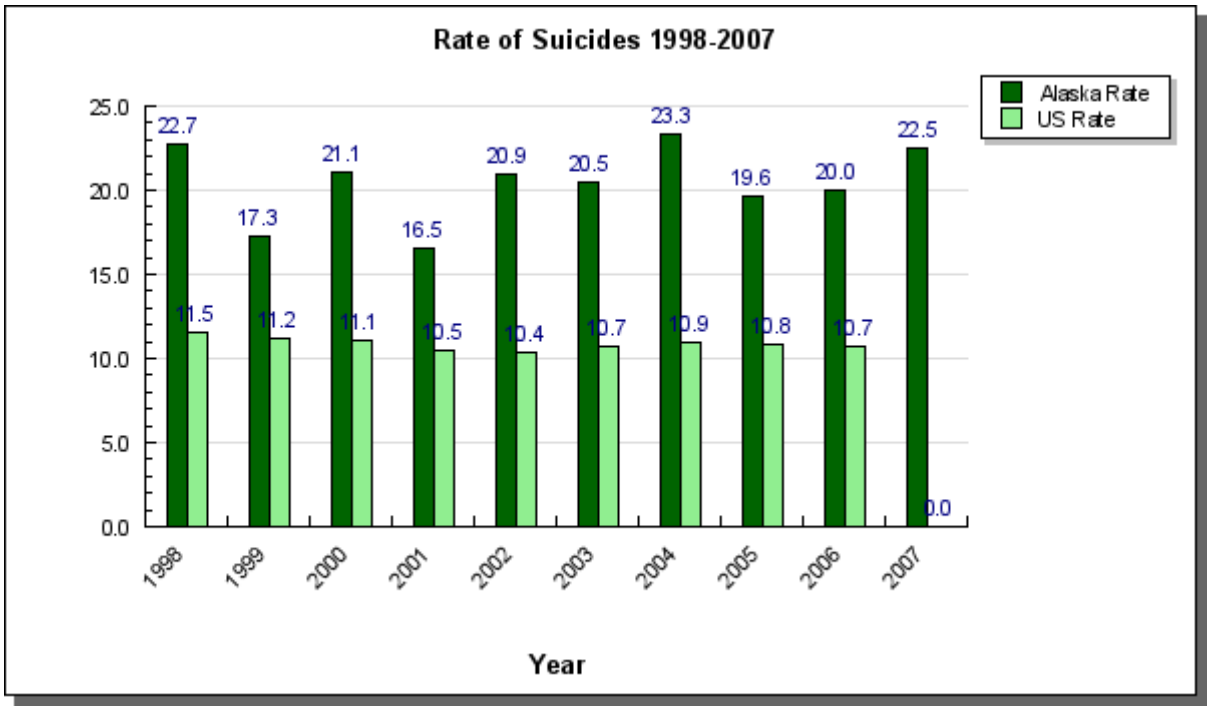
* There was a decrease of 4.8% total RPTC recipients served.

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 FY 07. As more new beds and other programs become available, it is anticipated that there will be further impact on the rate of out-of-state placements.

This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Alaska Mental Health Trust Authority.

Target #2: To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population.
Status #2: In CY2006 there were 20.0 suicides for all ages per 100,000 population, almost double the national average of 10.7.



*Methodology: * Rates are age-adjusted per 100,000 population.*

** The Alaska rate and lives lost count for 2007 are preliminary.*

** US suicide rate for 2006 is preliminary and 2007 data is unavailable at time of publication.*

Rate of Suicides 1998-2007

Year	Alaska Rate	Lives Lost	US Rate
2007	22.5	146	0
2006	20.0	132	10.7
2005	19.6	127	10.8
2004	23.3	154	10.9
2003	20.5	123	10.7
2002	20.9	131	10.4
2001	16.5	103	10.5
2000	21.1	135	11.1
1999	17.3	96	11.2
1998	22.7	131	11.5

Analysis of results and challenges: Alaska averages 125 suicides per year and has a suicide rate of double the national average. The Healthy Alaskan 2010 target is to reduce Alaska's suicide rate to 10.6 per 100,000. The age adjusted suicide rate for Alaska in 2007 was 22.5 per 100,000. Although we have seen a dip in rates since 2004, it appears that Alaska is once again showing a slight increase, which is consistent with rates seen over the past ten years. These measures reflect the need to improve Alaska's ability to provide a comprehensive and coordinated response between state

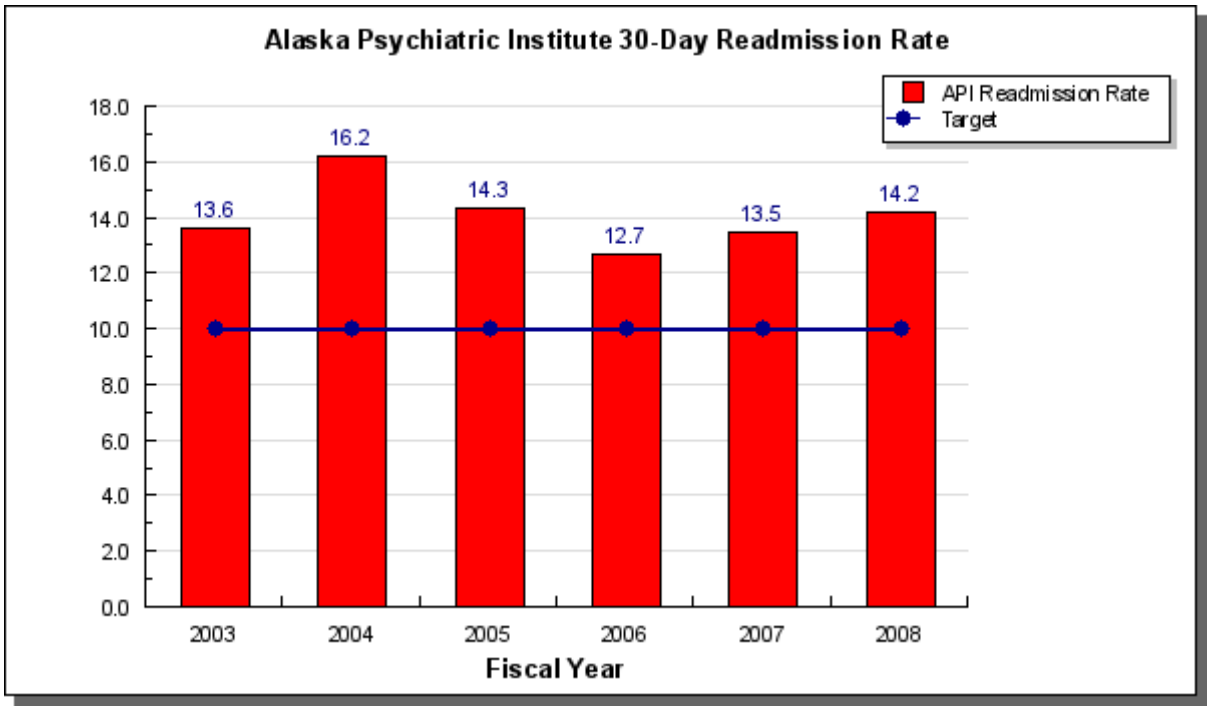
agencies, Tribal entities, community providers, primary health and emergency response systems, school districts and faith-based organizations.

The State Suicide Prevention Council in close working partnership with Behavioral Health has implemented several projects in an attempt to better understand the complex nature of suicide, the underlying causes, and learning prevention-based strategies that support successful outcomes in order to begin to turn the curve away from the problem. Behavioral Health and Prevention and Early Intervention Services administer grants for comprehensive suicide prevention programs and services and provides technical training and assistance. Training topics include the Alaska Suicide Prevention Plan; community-based planning methods including identification of need, resources, readiness and capacity to provide services; understanding risk and protective factors associated with suicide in their respective community; and how to effectively collaborate with state and local partners to create a long term impact that is both sustainable and culturally competent. Behavioral Health has also recently introduced the Alaska Gatekeeper Suicide Prevention Training designed and targeted specifically for Alaska in order to educate and train individuals on the topic of suicide, how to respond to a suicidal person and how to direct resources to reduce risk, promote well being and improve our systems of care.

The Council has also been instrumental in working with the Mental Health Trust beneficiaries to implement the 2007 Alaska Suicide Follow Back Study in an attempt to discover what specific factors in Alaska influence suicide. The study also examined and interviewed family and friends of decedents to learn more about individual characteristics and circumstances that led to suicide. Below is an example of some of the findings.

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.

Target #3: Reduce 30-day readmission rate for API to 10%.
Status #3: API's admission rate increased 3% from 1,231 patients in FY2007 to 1,270 in FY2008 and the readmission rate increased .7%, from 13.5% in FY2007 to 14.2% in FY2008.



*Methodology: * Data is based on an admissions cohort.*

Alaska Psychiatric Institute 30-Day Readmission Rate

Fiscal Year	API Readmission Rate	Target
FY 2008	14.2	10.0
FY 2007	13.5	10.0
FY 2006	12.7	10.0
FY 2005	14.3	10.0
FY 2004	16.2	10.0
FY 2003	13.6	10.0

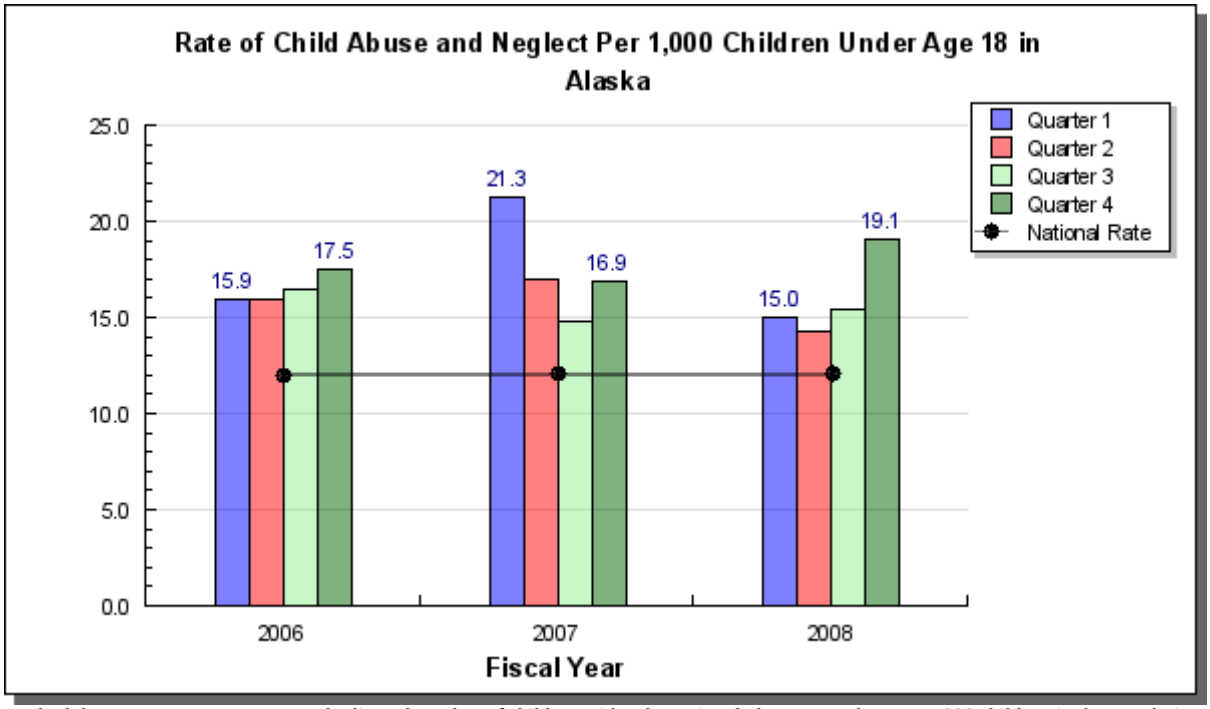
Analysis of results and challenges: This measure tracks the percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8 percent of all admissions were readmissions. This measure is an outcome indicator of continuity of care between the acute care hospital (API) and the behavioral health provider system. The ultimate goal is to have Alaska's rate fall below ten percent.

According to data for the first three quarters of FY2008, 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 case management options.

In FY2007, API admitted 1,231 patients of whom 166 returned within 30 days for a 13.5% readmission rate. In FY2008, API has admitted 1,270 patients with 180 of them returning within 30 days, increasing the rate of return to 14.2%.

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.
Status #1: Alaska experienced an 8% decrease in the rate of child abuse and neglect per 1,000 children from FY2007 to FY2008.



Methodology: Data represents an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. The population equals the number of children under the age of 18 years as of the last day of the reporting period. Data for FY 2006 Quarter 1 and 2 represent pre Office of Children's Services Online Resources for the Children of Alaska (ORCA) data system and is not comparable. It is entered here as 15.9, a pre ORCA calculation, in order to provide 3 full years of statistics.

Source: Current Target of 12.1 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2005. Release date March 30, 2007.

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

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Rate
FY 2008	15.0	14.3	15.4	19.1	12.1
FY 2007	21.3	17	14.8	16.9	12.1
FY 2006	15.9	15.9	16.5	17.5	12

Analysis of results and challenges: The goal of the Office of Children's Services 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 FY2004, national levels of substantiated abuse and neglect per 1,000 children, as determined by the Administration for Children and Families, was 12. New data released for 2005 indicates national levels at 12.1. This increase represents approximately 20,000 victims nationwide.

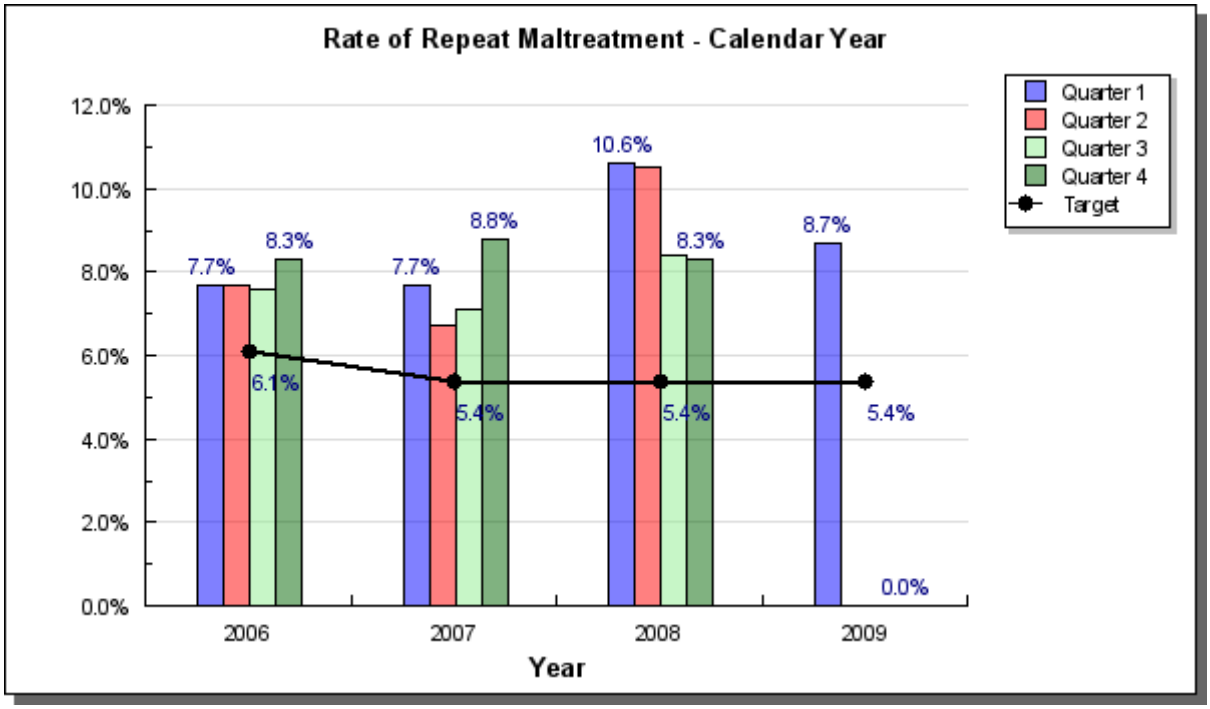
Alaska's rate averaged 15.9 in FY 2008. This is a drop of 1.5 victims from the FY 2007 rate - an 8% decrease.

The Office of Children's Services is continuing to perfect 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 efforts of new practice standards is taking dedicated staff time and training. 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 5.4%.

Status #2: Alaska's rate of repeat maltreatment increased by 3% from FY 2007 to FY 2008. However, both FY2007 and FY2008 represent an approximate 17% decrease in repeat maltreatment from FY2006.



Methodology: Data Source: National Child Abuse and Neglect Data System and Alaska's Online Resources for the Children of Alaska (ORCA). FY 2006 quarters 1 and 2 are pre-ORCA and not perfectly comparable. They are included here to provide 3 full years of data.

Target: National standards set by the Administration for Children an Families of 5.4%.

Rate of Repeat Maltreatment - Calendar Year

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
2009	8.7%	0	0	0	5.4%
2008	10.6%	10.5%	8.4%	8.3%	5.4%
2007	7.7%	6.7%	7.1%	8.8%	5.4%
2006	7.7%	7.7%	7.6%	8.3%	6.1%

Analysis of results and challenges: Alaska's FY 2008 average rate 7.8% for repeat maltreatment is a slight increase from the FY2007 rate of 7.6%. More importantly, FY2007 and FY2008 represent a significant decrease in the rates from the 9.5% recorded in FY2006.

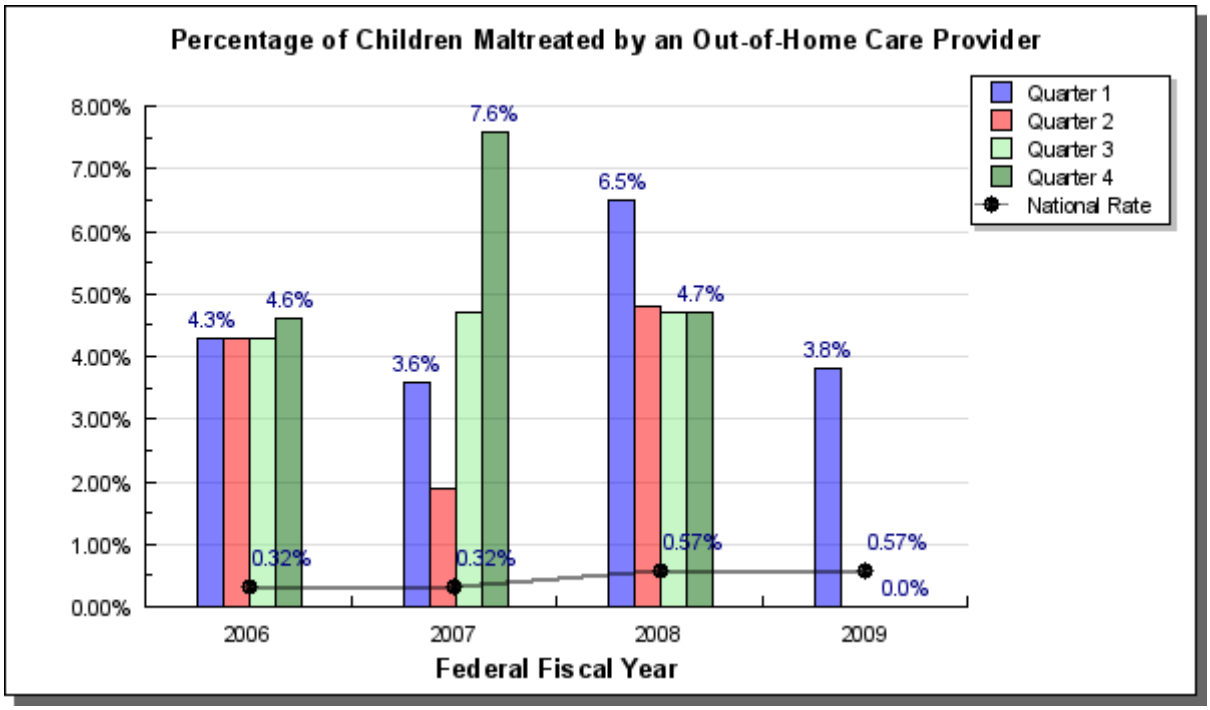
Repeat maltreatment is defined as the percentage of children who were victims of substantiated abuse or neglect during the first 6 months of the reporting year who experienced another substantiated incident within a 6-month period. Alaska's rate of repeat maltreatment, while improving, is still high. A protocol has been 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 is working for continued improvements in the number of repeat maltreatment cases not only due to the improved business practices. Business practices continue to be upgraded as the OCS is receiving technical assistance from the Annie E. Casey Foundation and the Administration for Children and Families to improve the approach to foster care.

In addition, the OCS has implemented 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.
Status #3: The rate of maltreatment in out of home care is above the national rate of .32% in 2008.



Methodology: 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 .32% - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2005.

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

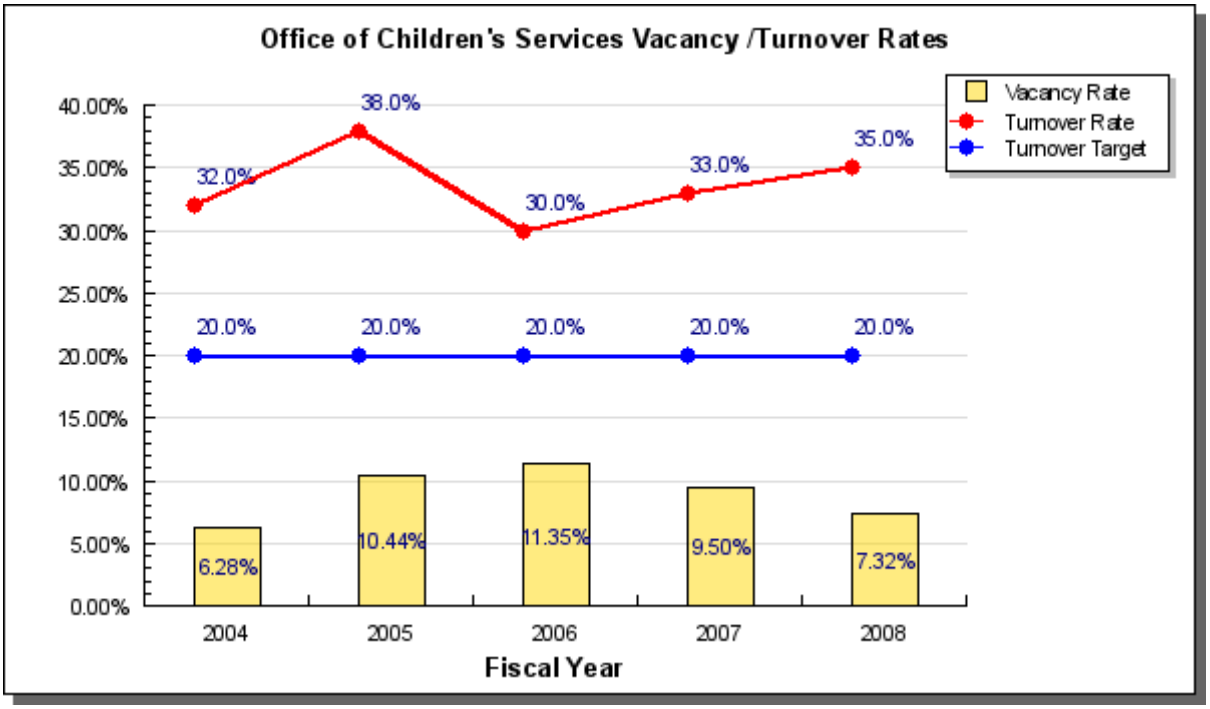
Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Rate
FFY 2009	3.8%	0	0	0	.57%
FFY 2008	6.5%	4.8%	4.7%	4.7%	.57%
FFY 2007	3.6%	1.9%	4.7%	7.6%	.32%
FFY 2006	4.3%	4.3%	4.3%	4.6%	.32%

Analysis of results and challenges: The percentages of maltreatment have averaged 4.6% for the past 3 years. Some improvement was noted in FY 2007 but the percentage increased by .72% in FY 2008.

Maltreatment rates high above national standards in out-of-home care 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. The Office of Children's Services has increased its efforts to obtain and license foster homes across the state with particular efforts in the rural areas.

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.
Status #4: The Office of Children's Services frontline worker vacancy rates have decreased by 4% from FY 2006 to FY 2008 while turnover rates have increased 5% during that same time period.



Methodology: 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 workforce 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 is 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 Frontline 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.

Office of Children's Services Vacancy /Turnover Rates

Fiscal Year	Vacancy Rate	Turnover Rate
FY 2008	7.32%	35%
FY 2007	9.5%	33%
FY 2006	11.35%	30%
FY 2005	10.44%	38%
FY 2004	6.28%	32%

Analysis of results and challenges: Children's Services frontline worker turnover rates are still extremely high and disruptive. It should be noted that rates presented in this measure include transfers within the division, department, or state. Of the 92 employee that turned over in FY 2008, 24% of them were transfers.

Vacancy rates have decreased by 2.2% from FY 2007 to FY 2008 and 5% from FY 2006. This may be indicative of better hiring practices.

Since May of 2006 when the Office of Children's Services received the final Hornsby Zeller Associates, Inc. workload study the OCS had been engaged in gradual, incremental changes to personnel that include transferring positions from overstaffed offices to understaffed offices until such time as data regarding caseload and workload trends could be established.

Of the 17 positions recommended in the study needed to handle the state's entire caseload as mandated by state and federal policy guidelines, the OCS received 6 new frontline positions in FY 2008 and 7 new frontline positions in FY 2009. In addition, 3 administrative staff were requested and approved.

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. In addition, the Governor's Executive Order 287 has shored up OCS efforts with the involvement of state human resource staff.

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.
Status #1: The division has decreased the average time to pay a claim from 18 days to 11 days from FY2007 to FY2008. This represents a 39% reduction.

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

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY 2009	2,047,064	2	-9
FY 2008	7,293,304	11	-7
FY 2007	7,263,956	18	6
FY 2006	7,721,709	12	-1
FY 2005	7,903,523	13	3
FY 2004	6,690,344	10	0
FY 2003	5,615,072	10	-2
FY 2002	4,959,864	12	0
FY 2001	4,409,121	12	2
FY 2000	3,720,254	10	0

Methodology: Chart Notes
1. Between FY02 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data.
2.A word of caution. FY09 numbers are for first quarter only while all other years are based on 12 months of data
Source: MARS MR-0-08-T.
No national average available.

Analysis of results and challenges: Average days to pay between FY2007 and FY2008 decreased from 18 days to 11 days.

Three new initiatives, two in the second half of FY2006 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 FY2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. The decrease from FY2007 to third quarter FY2008 is a result of completion of training and increased staff proficiency.

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

Target #2: Increase the percentage of adjudicated claims paid with no provider errors.
Status #2: The percentage of claims without error and paid within ten days decreased to 70% in FY2008 compared to 72% in FY2007.

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

Fiscal Year	Medicaid Claims Pd	% No Errors	% Change
FY 2009	1,538,356	68%	-2%
FY 2008	5,562,537	70%	-2%
FY 2007	5,606,347	72%	-2%
FY 2006	6,082,318	74%	2%
FY 2005	6,150,027	72%	-4%
FY 2004	5,106,692	76%	3%
FY 2003	4,776,730	73%	-1%
FY 2002	4,202,677	74%	1%
FY 2001	3,670,331	73%	1%
FY 2000	3,076,978	72%	0

Methodology: 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. FY09 numbers are for first quarter of FY09
4. 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 website for providers with information tailored to each provider type.

During FY2006, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

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

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

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

Target #3: Reduce the rate of Medicaid payment errors.
Status #3: Since payment errors are frequently related to lack of appropriate documentation of services, improved provider training and outreach on required documentation for Medicaid payment is underway.

Error Analysis - Percent Claims Paid with No Errors

Year	Total Claims Paid (FY)	% Paid with no Errors
2008	4,127,303	70%
2007	1,363,276	72%
2006	6,082,318	74%
2005	6,150,027	72%
2004	5,106,692	76%
2003	4,776,730	73%

Methodology: FY03 reports were based on six months of data.
Since FY04, reports have been based on annual data.
FY08 numbers are based on claims paid through third quarter of FY2008.

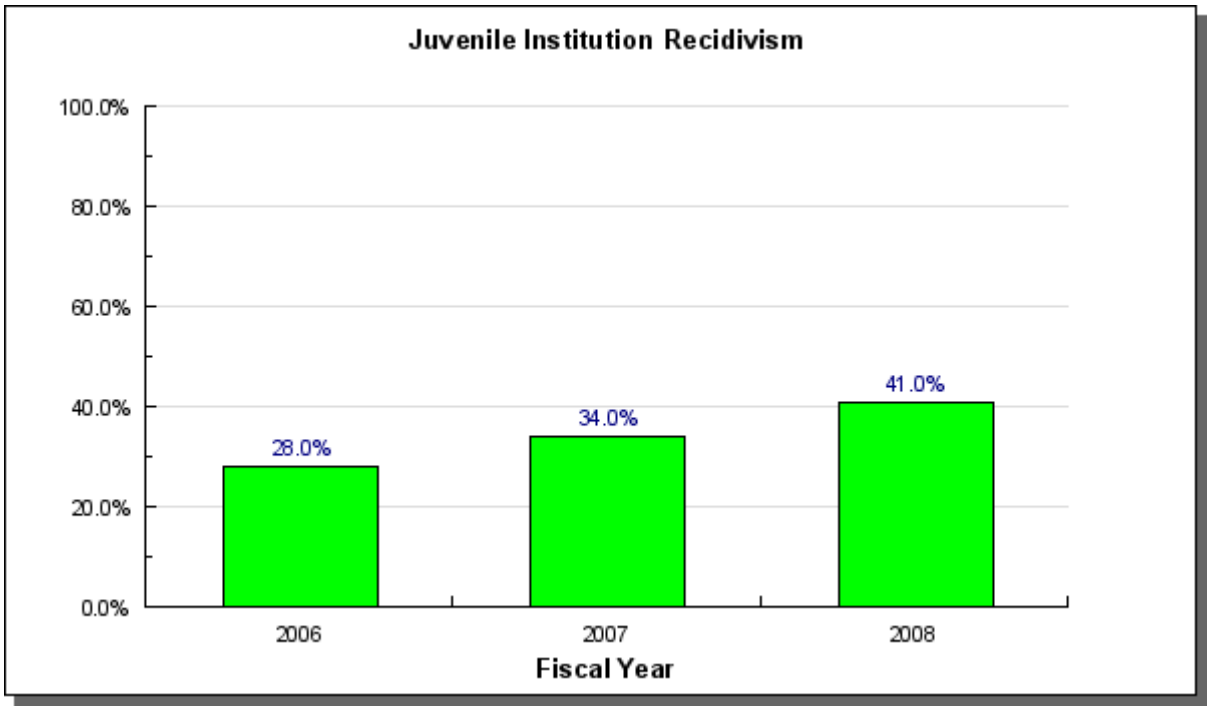
Analysis of results and challenges: The Improper Payments Information Act of 2002 (Public Law 107-300) requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report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

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

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 reoffend following release from institutional treatment facilities to less than 33%.

Status #1: The recidivism rate as defined for youth released from institutional treatment in F06 was 41%, a slight increase in comparison to previous fiscal years.



Juvenile Institution Recidivism

Fiscal Year	YTD Total
FY 2008	41%
FY 2007	34%
FY 2006	28%

Analysis of results and challenges: This measure examines recidivism for youth who have been committed to and released from the Division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the state's more chronic and serious juvenile offenders compared with youth who 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.

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 to work with juveniles to

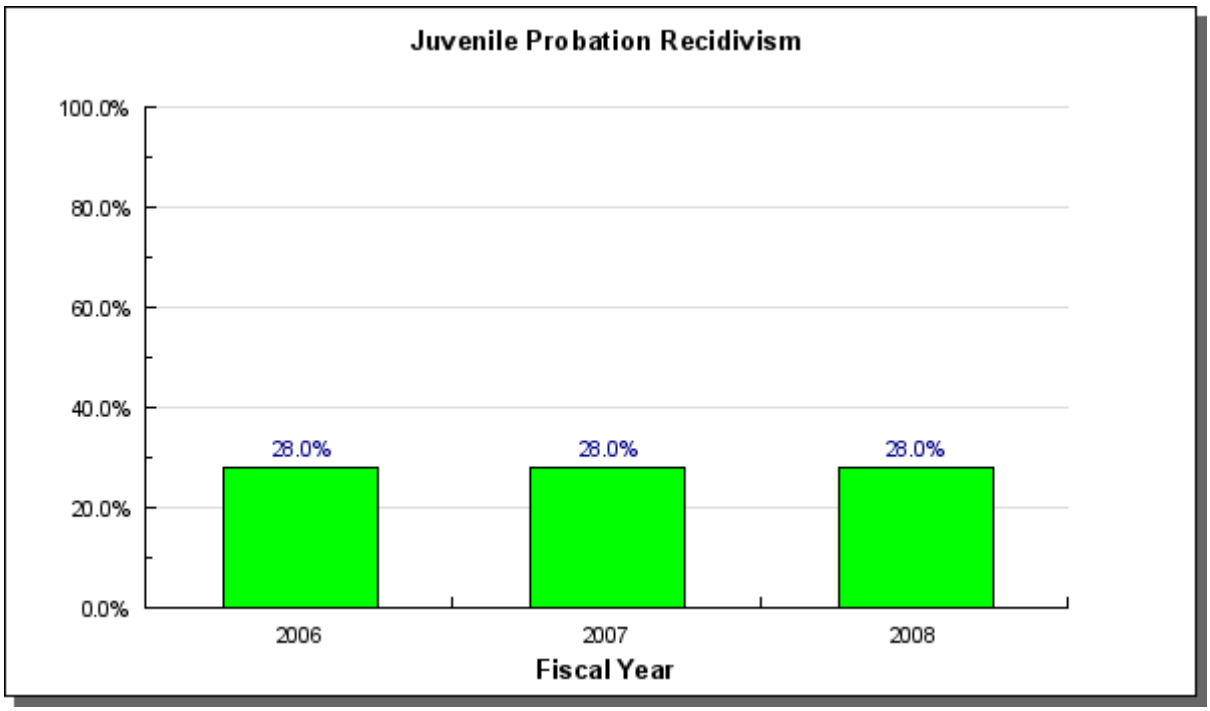
address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

The recidivism rate for juveniles released from Alaska's secure treatment institutions was increased slightly this year compared with the two previous years. The increase may not be significant; the small number of youth released from 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. Any recidivism is cause for concern, and the Division expects to direct additional staffing, training, and other resources at its juvenile facilities in the coming years to limit future re-offending.

Recidivism among juveniles released from treatment is defined, in Alaska, as re-offenses that occurred within a 12-month window. 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%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) This rate serves as the baseline for the juvenile recidivism measure in Alaska.

Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. 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. For this FY08 report, adjudication and conviction information on offenses that occurred in FY06 must have been entered in APSIN or JOMIS by August 15, 2008. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

Target #2: Reduce percentage of juveniles who reoffend following completion of formal court-ordered probation supervision to less than 33%.
Status #2: The recidivism rate as defined for juveniles who completed formal court-ordered probation was 28%, identical to that identified in the previous two years.



Juvenile Probation Recidivism

Fiscal Year	YTD Total
FY 2008	28%
FY 2007	28%
FY 2006	28%

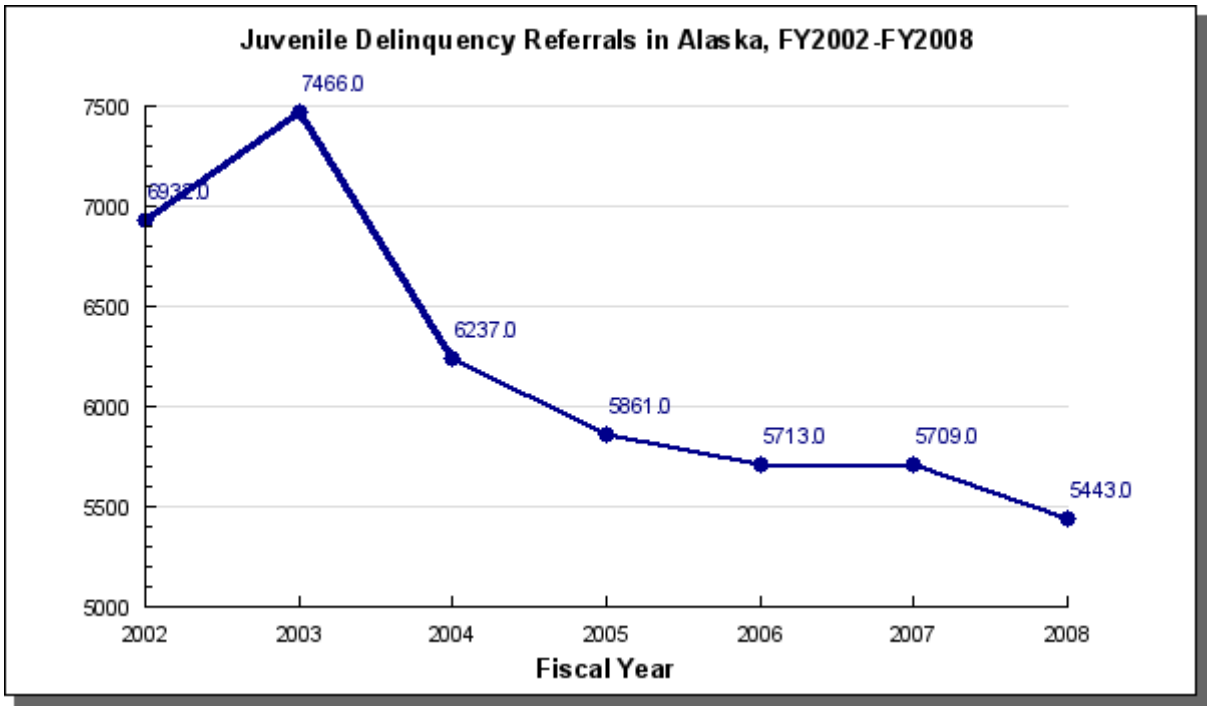
Analysis of results and challenges: This measure examines re-offense rates for juveniles who received probation supervision while either remaining at home or in a non-secure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized. 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%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) This rate serves as the baseline for the juvenile recidivism measure in Alaska. With a 28% rate for its probation population, Alaska compares favorably with this average.

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 is seeking technical assistance in the coming year to assist in understanding its needs for juvenile probation needs more clearly; this information will ultimately be used to improve the Division's ability to incorporate research-based practices into probation work and ultimately improve 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, Court Termination, Non-compliant Closed, or Waived to Adult Status. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, Supervision Transfer, Declared Incompetent, or Deceased are not included. Recidivism for this measure is defined as re-offenses that occurred within 12 months from the time offenders were released from formal probation, and that resulted in a conviction or adjudication. For example, the FY 08 population in the graph above represents youth who were released from formal probation in FY 06, and who re-offended within FY2007. For this FY08 report, adjudication and conviction information on offenses that occurred in FY2006 must have been entered in APSIN or JOMIS by August 15, 2008. Youth 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. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Status #3: The number of reports of juvenile crime made to the Division of Juvenile Justice declined 4.75% between fiscal years 2007 and 2008 and declined 2.6% between fiscal years 2006 and 2008.



Juvenile Delinquency Referrals in Alaska, FY2002-FY2008

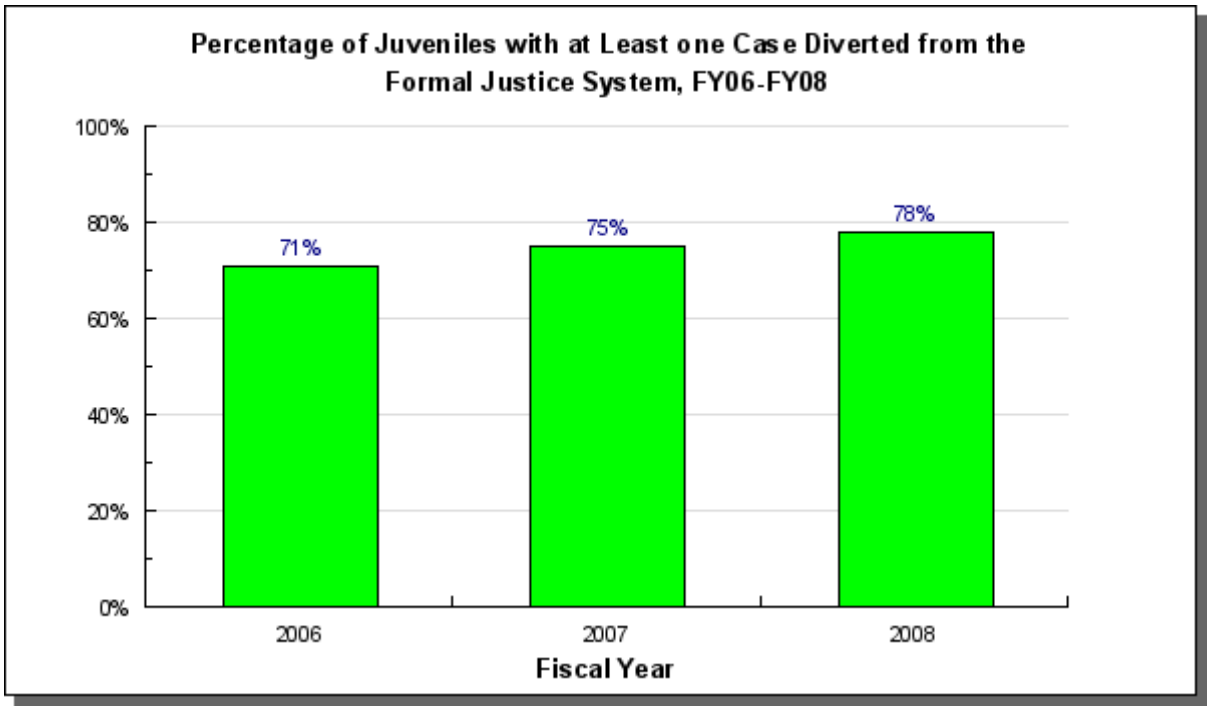
Fiscal Year	YTD Total
FY 2008	5443 -4.66%
FY 2007	5709 -0.07%
FY 2006	5713 -2.53%
FY 2005	5861 -6.03%
FY 2004	6237 -16.46%
FY 2003	7466 +7.7%
FY 2002	6932

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population continued to decrease in FY2008 compared with FY2007 and FY2006. While the change did not meet the target of a 5% decline over a two-year period, the data continued to demonstrate a trend of decreasing juvenile activity that has been noted nationally as well as statewide over the past several years. Definitive reasons for changes in referral levels are unknown. 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 2003-2007 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2008 was derived from the 2007 estimate and the 2010 projection from the report Alaska Population Projections 2007-2030, published by the same Department. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database by on August 18, 2008 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

Status #4: The proportion of juveniles with at least one case (a criminal charge in a report from law enforcement alleging a juvenile perpetrator) diverted from the formal court process remained high, at 78%.



Percentage of Juveniles with at Least one Case Diverted from the Formal Justice System, FY2006-FY2008

Fiscal Year	YTD Total
FY 2008	78%
FY 2007	75%
FY 2006	71%

Analysis of results and challenges: Diversion refers to the process of managing juveniles cases through non-court processes, such as non-court adjustments, informal probation, referral to community panels such as youth court, or dismissals. Diversion 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.

In FY2008 2,922 (78%) of 3,728 juveniles referred to the Division had at least one of their charges managed through non-formal court processes. The percentage increased slightly compared with FY2006 and FY2007 results, but because this is only the third time the Division has considered this measure, the improvement may be due to refinements in recordkeeping, data gathering, and analysis.

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 charge within the 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 this data was collected, are excluded from consideration.

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

Target #1: Increase self-sufficient individuals and families by 10%.
Status #1: In FY2008, the Alaska Temporary Assistance Program showed a 6% decline in the number of families receiving benefits.

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2008	-7%	-7%	-5%	-6%	-6%
FY 2007	-5%	-11%	-13%	-10%	-9%
FY 2006	-23%	-22%	-19%	-20%	-22%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2002	-16%	6%	4%	3%	-2%

Analysis of results and challenges: Overall, there has been a 61% decline in the caseload since FY1996.

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. As the caseload declines, families with more significant challenges 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.

The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

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

Target #1: 80% of all 2 year olds are fully immunized.
Status #1: In 2007, Alaska ranked 45th in the country for fully immunized two year olds at 70.1%.

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

Year	US %	Alaska %	AK US Rank
2007	77.4	70.1*	45
2006	77.0	67.3*	47
2005	76.1	68.1*	41
2004	80.9	75.3	45
2003	79.4	79.7	27
2002	74.8	75.3	30
2001	73.7	71.2	35
2000	72.8	70.6	41
1999	73.2	74.5	27

Methodology: 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 2.3 per 1,000 live births by Healthy Alaskans 2010.
Status #2: Post neonatal death rate for 2007 was 3.0 per 1,000 live births which is above the target of 2.3 per 1,000 live births by Healthy Alaskans 2010.

Post-Neonatal Death Rate - AK and US

Year	Alaska	US
2007	3.0	NA
2006	3.0	2.3
2005	3.2	2.3
2004	3.5	2.3
2003	4.0	2.2
2002	3.8	2.3
2001	3.6	2.3
2000	3.0	2.3
1999	3.3	2.3

Analysis of results and challenges: Chart Note: Rate per 1,000 live births reflects three-year rate, i.e. 2007 represents 2005-2007.

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 1.2 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.
Status #3: 5.7% adult diabetes prevalence for 2005-2007; prevalence has increased 40% since 1998-2000.

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

Year	Alaska	US
2006	5.7%	7.8%
2005	5.3%	7.4%
2004	4.8%	7.0%
2003	4.4%	6.6%
2002	4.2%	6.5%
2001	3.8%	6.4%
2000	3.8%	5.9%
1999	3.4%	5.4%

Methodology: Note: Alaska data are 3-year averages (2006 number is for 2005-2007); U.S. data are single-year values

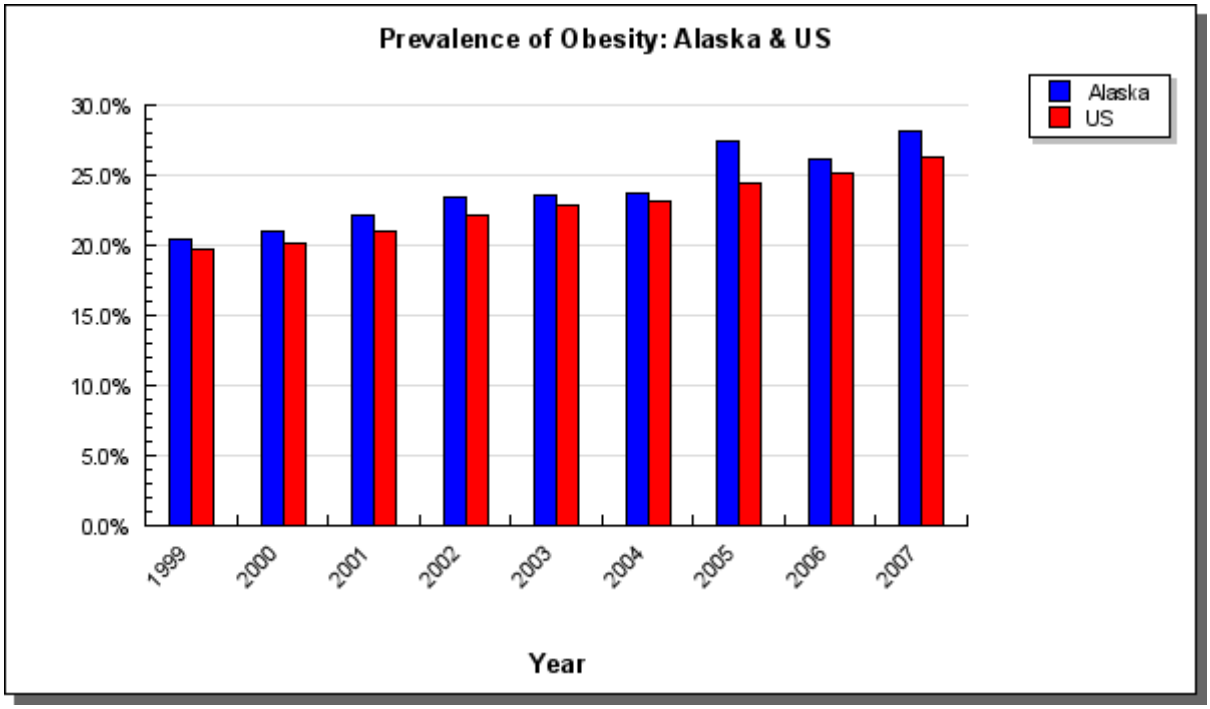
Analysis of results and challenges: Chart Note: Sources - Alaska Behavioral Risk Factor Surveillance System (AK); National Health Interview Survey (U.S.); both are crude rates.

Diabetes is a chronic disease affecting approximately 27,000 adult Alaskans. Over the past decade, an increasing percentage of Alaskan adults have reported being told by a health professional that they have diabetes.

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. 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 prevalence increases with age, and the prevalence of diabetes in Alaska is expected to increase as the population ages.

The DHSS Division of Public Health 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 modifiable risk factors contributing to diabetes and other chronic diseases are tobacco use, physical inactivity, unhealthy eating habits, and resulting obesity. The Division will address all of these factors by providing the information 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%.
Status #4: 28.2% adult obesity prevalence for 2007 continues worsening trend and greater than the national average of 26.3%.



Prevalence of Obesity: Alaska & US

Year	Alaska	US
2007	28.2%	26.3%
2006	26.2%	25.1%
2005	27.4%	24.4%
2004	23.7%	23.2%
2003	23.6%	22.8%
2002	23.4%	22.1%
2001	22.1%	21%
2000	21.0%	20.1%
1999	20.4%	19.7%

Analysis of results and challenges: Chart Note: Sources – Alaska and U.S. Behavioral Risk Factor Surveillance System; crude rates.

The trends in Alaska continue to show growing numbers of overweight and obese adults, with an obesity prevalence at 28.2% in 2007 - an alarming 28% higher than the 1999 Alaska prevalence level and 57% higher than the Healthy Alaskans 2010 target.

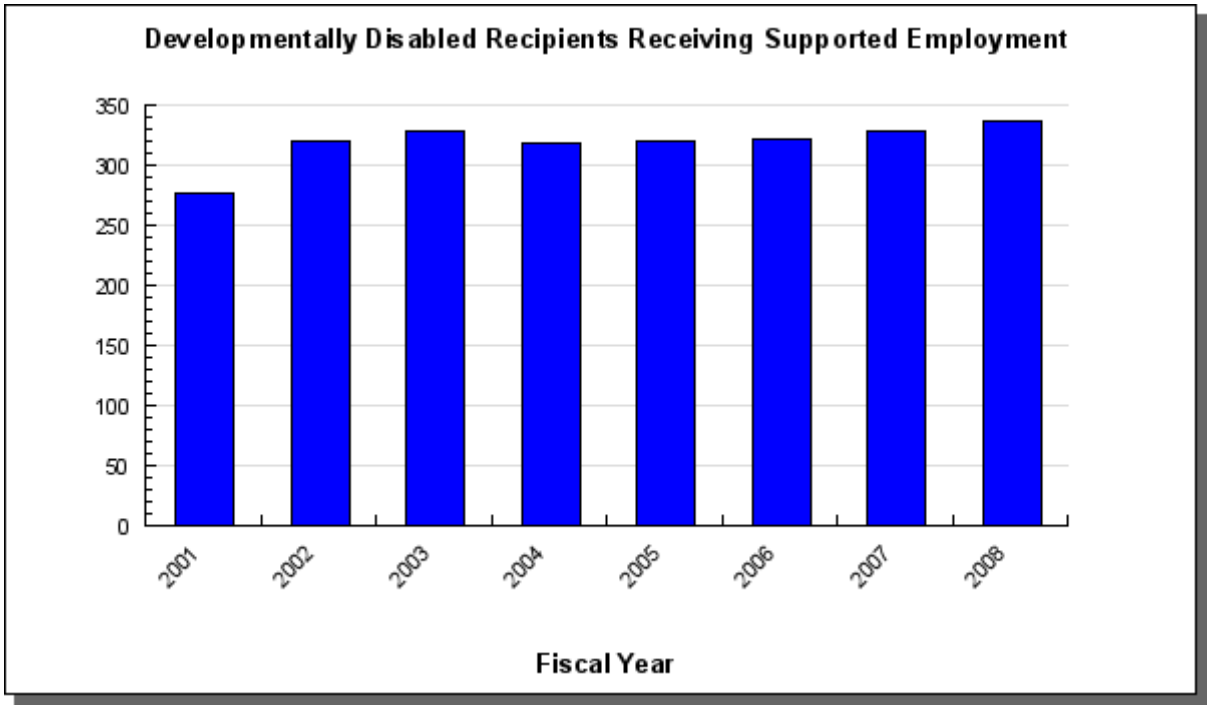
Premature death and disability, increased heath care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with inactivity are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States. Alaskans annually spend $195 million on obesity-related direct medical expenditures, of which $46 million is a Medicare/Medicaid expense.

Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Obesity is a health threat to all generations of Alaskans, and threatens to make this generation the first to live shorter lives than their parents. It increases the risks of chronic diseases and conditions such as heart disease, diabetes, stroke, hypertension, some cancers, and premature 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.

A comprehensive approach, as identified in Alaska in Action: the Statewide Physical Activity and Nutrition Plan, is needed to decrease obesity in Alaska. Through educational, programmatic, policy, and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight or obese.

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

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services.
Status #1: There is a slight increase to utilization of the supported employment Medicaid waiver service in recent years. SDS will encourage increased usage in future years as appropriate.



Developmentally Disabled Recipients Receiving Supported Employment

Fiscal Year	Recipients
FY 2008	336
FY 2007	328
FY 2006	321
FY 2005	320
FY 2004	319
FY 2003	328
FY 2002	320
FY 2001	277

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

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.
Status #1: In FY2008, the HSS Commissioner's office succeeded in meeting the goal of responding within 14 days of receiving a complaint or inquiry.

# of Inquiries/Complaints

Fiscal Year	Opened	Closed	Avg Days to Close
FY 2008	1367	1772	20.06
FY 2007	1495	1224	24.52
FY 2006	1590	1408	25.78
FY 2005	552	503	15.18

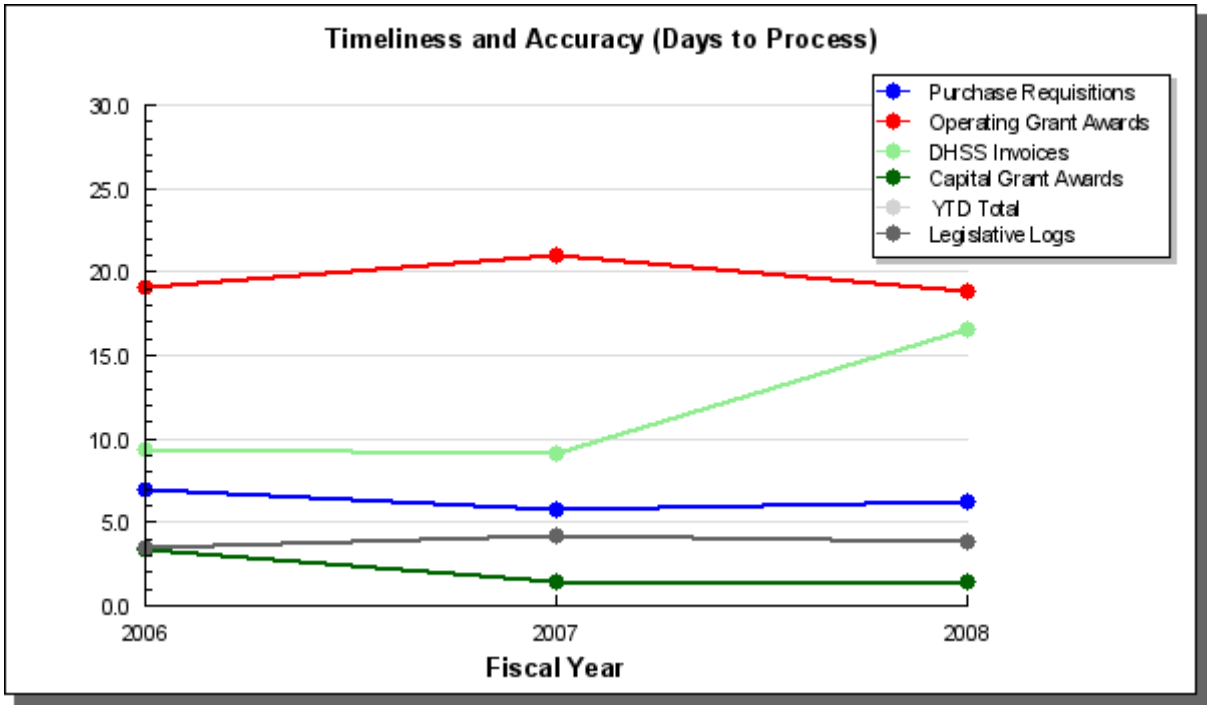
Methodology: This is only done on a yearly basis.

Analysis of results and challenges: The response log "HSS Track" originally included only inquiries or complaints received by the DHSS Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquires, etc). However, in the last few years, other divisions have begun utilizing the HSS Track system for other purposes. For example, SDS tracks for case management purposes. Different employees may enter data on the same client and the log may be left open for longer periods depending on the situation. OCS uses the tracking system to log complaints. First Health, the Medicaid contractor, tracks complaints from Medicaid recipients. Due to the complexity of those issues, the response time has increased overall.

Response time for inquiries and complaints to the Commissioner's Office only (the original intent of this measure), met the response goal with an average of 10 days, half the overall total.

The IT section is working on improvements to the system for tracking and reporting.

Target #2: Reduce by 5% per year processing time for key indicators.
Status #2: In FY2008 the department reduced processing days for grant awards and legislative inquiries. Processing time for purchase requisitions and invoices increased. Capital Grant Awards remained the same.



Timeliness and Accuracy (Days to Process)

Fiscal Year	Purchase Requisitions	Operating Grant Awards	DHSS Invoices	Capital Grant Awards	Legislative Logs
FY 2008	6.3 +8.62%	18.8 -10.35%	16.58 +80.81%	1.5 0%	3.9 -6.25%
FY 2007	5.8 -17.14%	20.97 +9.68%	9.17 -1.71%	1.5 -55.36%	4.16 +18.18%
FY 2006	7.00	19.12	9.33	3.36	3.52

Analysis of results and challenges: This measure was initiated in FY2006 and is updated on an annual basis after year end.

In FY2008 "DHSS invoices" processing time increased significantly. This may be a side effect of turnover in positions in the FMS division and fiscal section but is also impacted by other divisions within the department. If invoices are not promptly submitted or approved, the lag in time counts against this measure as it is calculated based on the invoice date as opposed to the date it was submitted to fiscal. In the coming year, fiscal will encourage divisions to reduce their turnover time.

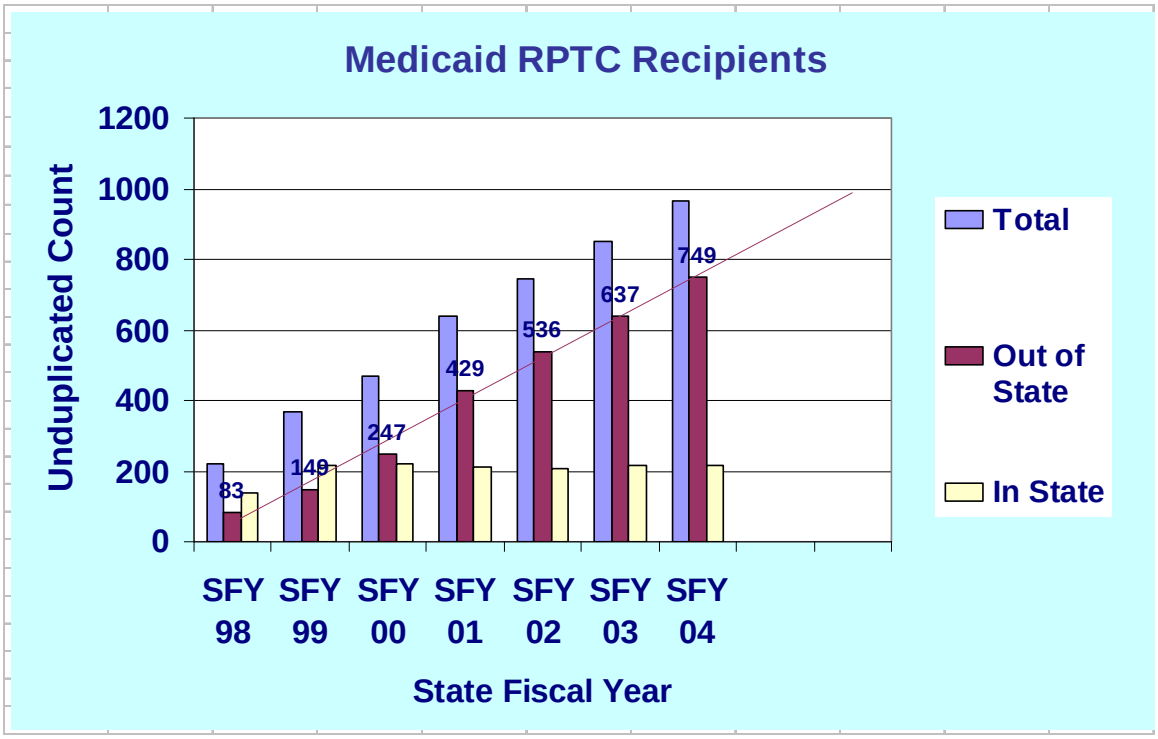
Capital Project Requests

Capital		FY2010 Capital Funding Request (In thousands)			
DHSS Initiatives/ Divisions	***Project Titles***	***GF***	***Fed***	***Other***	***Total***
Health and Wellness					
Public Health	Disaster Preparedness	500.0			500.0
	Emergency Medical Services Ambulances and equipment statewide match for Code Blue project	425.0			425.0
	Emergency Medical Services- Emergency Communications	190.0			190.0
Health and Wellness Total		*1,115.0*			*1,115.0*
Health Care Reform					
Behavioral Health	Data Sharing Partnership	434.2	25.5		*459.7*
	Mental Health Continuing Bring the Kid Home (BTKH) Initiative Denali Match			2,200.0	2,200.0
Department Support Services	E-Grants *	388.0	43.1		431.1
	Personal Information Protection Data Encryption *	736.3	81.8		818.1
	*Health Insurance Portability and Accountability Act Compliance *	668.7	668.7		1,337.4
	Disaster Recovery *	368.2	40.9		409.1
	Contract Management Automation System *	425.5	47.3		472.8
Health Care Reform Total		*3,020.9*	*907.3*	*2,200.0*	*6,128.2*
Vulnerable Alaskans					
Children's Services	Online Resources for the Children of Alaska Enhancements to Meet Federal requirements	242.2	172.1		414.3
	Safety and Support equipment for Probation Officers and Front Line Workers	113.3	20.4		133.7
Juvenile Justice	Johnson Youth Center Renovation and Remodel to Meet Safety and Security Needs Phase I	9,500.0			9,500.0
	Safety and Support Equipment for Probation Officers and Front Line Workers	364.5			364.5
Public Assistance	Production Printer Replacement	299.3	175.0		474.3
	Safety and Support Equipment for Probation Officers and Front Line Workers	222.2	237.0		459.2
Senior Disability Services	Safety and Support Equipment for Probation Officers and Front Line Workers	79.2	79.2		158.4
Department Support Services	Non-Pioneer Home deferred Maintenance, renovation, Repairs and Equipment	2,000.0	203.9		2,203.9
	Pioneer Home Deferred maintenance, Renovation, Repair and Equipment	2,000.0			2,000.0
	Mental Health Deferred Maintenance and Accessibility Improvement	750.0			750.0
	Mental Health Housing- Home Modification and Upgrades to Retain Housing	500.0		550.0	1,050.0
Vulnerable Alaskan Total		*16,265.5*	*858.4*	*550.0*	*17,673.9*
Capital Budget Totals		**20,401.4**	**1,765.7**	**2,750.0**	***24,917.1***

*These projects sums are appropriated to the Office of the Governor and allocated to DHSS.

Between 1998- 2004, out-of-state placements for children's with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800%

What is Bring the Kids Home (BTKH)? BTKH is a response to the over-reliance on out-of-state residential psychiatric treatment center care for Alaskan children with severe emotional disturbances (SED).



To combat this problem, a group consisting of stakeholders, the State of Alaska and the Alaska Mental Health Trust Authority was organized for the purpose of planning, funding, implementing and monitoring the BTKH project.

The goal is development of an in-state system of care that serves children in the least restrictive settings, as close to home as possible, and with the family guiding and participating in care.

BTKH is aimed at system change at multiple levels: statewide, regional, community, and family.

On-going projects at the statewide level include:

- New in-state residential treatment centers will serve statewide populations in Anchorage, Eagle River, Fairbanks, and Juneau.
- Two Statewide projects will expand school behavioral health services: one will improve coordination between schools and out-of-state residential centers and the other will support schools to expand behavioral health best practices.
- Rate increases for the behavioral rehabilitation services (BRS) system, for foster care providers and for community behavioral health services have/will impact the statewide service system.

- A number of regulation changes will have statewide impact. Early childhood regulations are under development as are behavioral health regulations.
- A new resource team process has been established for all children referred to residential psychiatric treatment centers. This will improve access to in-state services.
- A funding stream has been developed to provide individualized services when they will keep children out of residential care or help children move out of residential care into their homes/communities.
- Workforce development initiatives to improve training and availability of BH workforce statewide.

On-going projects at the <u>regional</u> level include:

- New residential group/foster homes in Fairbanks, Ketchikan, Dillingham, Juneau, Prince of Wales and Matsu.
- Pilot project specific to the Matsu area to provide care coordination to children at risk of/moving out of RPTC care.
- Planning is underway to develop a proposal for Federal funding to leverage BTKH funding to system development for children with SED in the Anchorage area.
- Regional BTKH planning summits have been/are being held in: Anchorage, Fairbanks, Seward, Kotzebue, Nome, Bethel, Juneau, Kenai, Kodiak and Dillingham.

On-going projects at the <u>community</u> level include:

- New grant funding to expand outpatient behavioral health services in Anchorage, Metlakatla, Kenai (Soldotna), Maniilaq,
- New grant funding to expand school/early learning delivery of behavioral health services on Prince of Wales Island, Matsu, Juneau, Anchorage and in Sitka.
- Collaborative planning groups between providers to develop services in the community for children in residential psychiatric treatment centers.

On-going projects at the <u>family</u> level include:

- Incorporation of family and youth and their representatives in planning and system development efforts.
- Grants to expand peer navigation: using trained family members to assist parents to identify and access behavioral health resources.
- Increased requirements for RPTC to provide weekly family therapy to children in residential care.
- Technical assistance/training focus for behavioral health providers on improving outpatient in-home service delivery: family driven care that builds on strengths, resources needs and natural supports of the family.
- Technical assistance/training focus to help family/foster family develop skills to support children with SED in their homes.
- Family track at the Children's BH conference to be held in January.

Who is impacted?

- Children in out-of-state RPTC care: in SFY04, almost 800 children were served in out-of-state RPTC care. Adding 2 parents and one sibling for each child, this means that approx 3,200 Alaskans are impacted.

- Children with SED: the 2007 prevalence estimate for children with severe emotional disturbances in Alaska was 6,524. These are children who require services through the Alaska behavioral health system and who are impacted by the availability and quality of in-state services. Adding 2 parents and one sibling for each child, this means that approx 26,000 Alaskans are impacted.

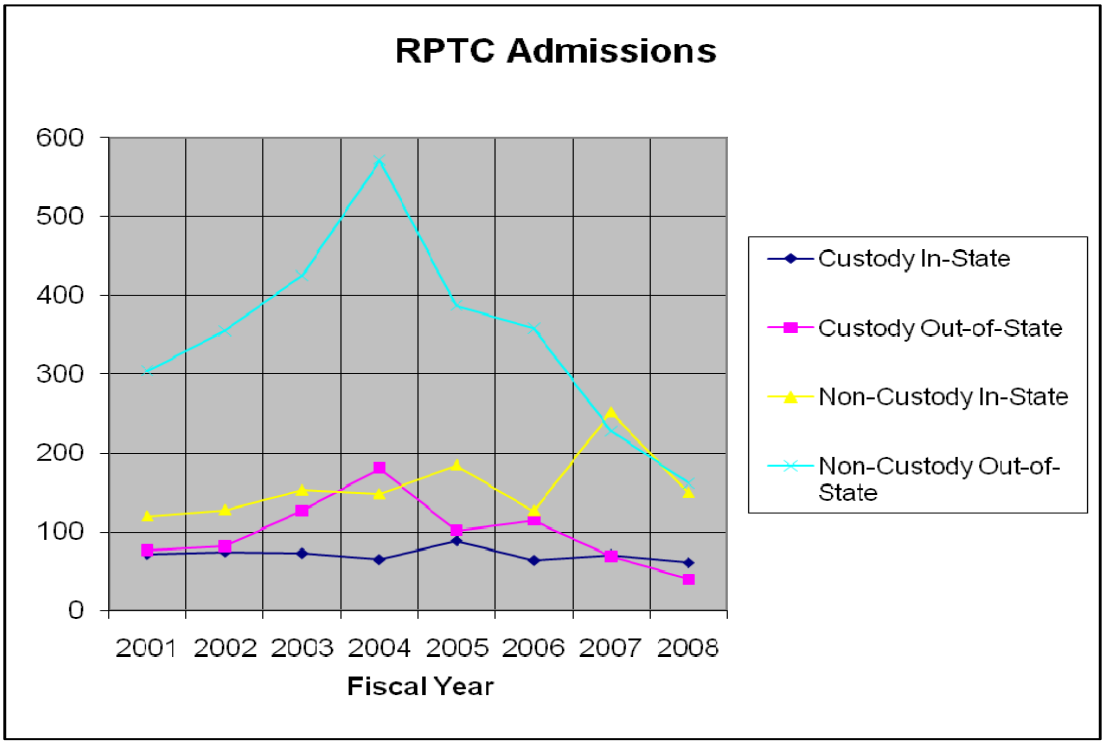
- Difficult to Serve Populations: A number of populations are over-represented in out-of-state residential care and impacted disproportionately by BTKH efforts:

  - Young children, older children
  - Children with difficult presentations (aggressive, runaway, self harming)
  - Children with complex diagnostic profiles: Children with severe emotional disturbances who also experience a developmental disability, a fetal alcohol spectrum disorder, or a substance use disorder.
  - Alaska Native children = 33% of the out-of-state RPTC population are currently Alaska Native children (10/08).

BTKH FY2008 Progress

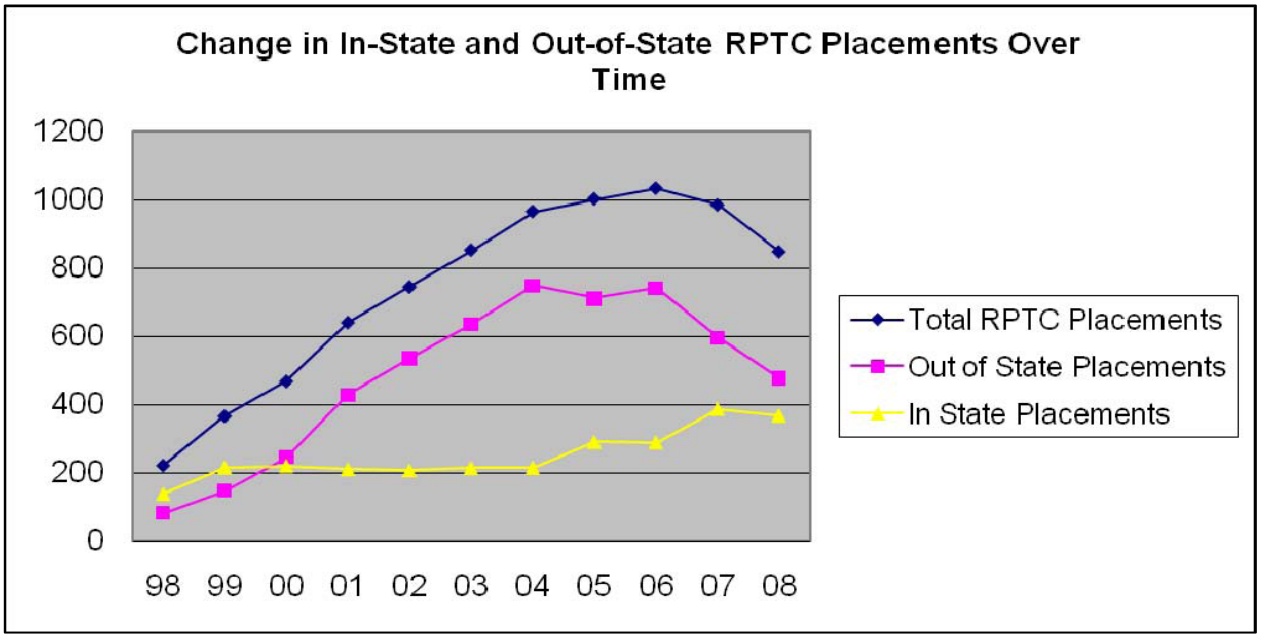
Between 1998 – 2004, out-of-state placements for children with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800%. However, between State fiscal year 2004 and the end of SFY08, the trend went in the other direction:

The number of new admissions to out-of-state RPTC care dropped by 73%.



Data used for this report are from BTKH Indicator report by DHSS/Behavioral Health/Policy & Planning 11/03/08

The number served in out-of-state RPTC care (including those admitted in a previous year) dropped by 36%.



These decreases illustrate the impact of the increased investment in in-state services through BTKH. As a result of BTKH projects, the expenditures for out-of-state RPTC declined significantly:

- Between SFY2007 and SFY2008, there was a 27% decrease in expenditures for out-of-state RPTC (decrease of $9.89 M).
- Between SFY2004 and SFY2008 there was a 29% decrease in expenditures for out-of-state RPTC (decrease of $10.9 M).
- For SFY2008, there was a 57% decrease in actual expenditures from the projected expenditures for out-of-state RPTC care based on the trend prior to BTKH. This represents a "projected savings" of $35.65 M.
- For FY2010 there is a $3.8M GF Medicaid decrement to reflect cost containment efforts in Behavioral Health services, including BTKH.

At the same time, there are on-going efforts to build the in-state continuum of care.

- Between SFY2004 and SFY2008 there was an 81% increase in expenditures for in-state RPTC care from $11.53M to $20.89M. This represents an additional $9.36 M investment into in-state services.
- For SFY2008, there was a 25.7% increase in actual expenditures from the projected expenditures for in-state RPTC care based on the trend prior to BTKH. This represents a "increased in-state investment" of $4.3 M from projected expenditures.
- Between FY2005 and FY2009 DHSS requested/received general funding increments for BTKH of just under $8.M This funding has been invested into new grants, individualized services, care coordination and other system building efforts.
- For FY2010 DHSS is asking for $2.5 million increment for BTKH investment.

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Alaska Pioneer Homes

Mission

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

Introduction

The Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer and Juneau to qualified Alaskan 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 568 Alaska seniors during FY 2008. As of October 31, 2008, 471 Alaska seniors were on the active wait list and 5,136 were on the inactive wait list.

Core Services

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

Services Provided

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

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

The state maintains and operates five Pioneer Homes and the Alaska Veterans and Pioneer 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 FY2005 allowed for Pioneer Home residents to receive Medicaid benefits. With this change, federal funds (reflected in the budget as inter-agency receipts) also support the operating costs of the Pioneer Homes. The Homes received just under $4.94 million in Medicaid Waiver receipts in FY2008 and is budgeted to collect $5.02 million in FY2009.

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

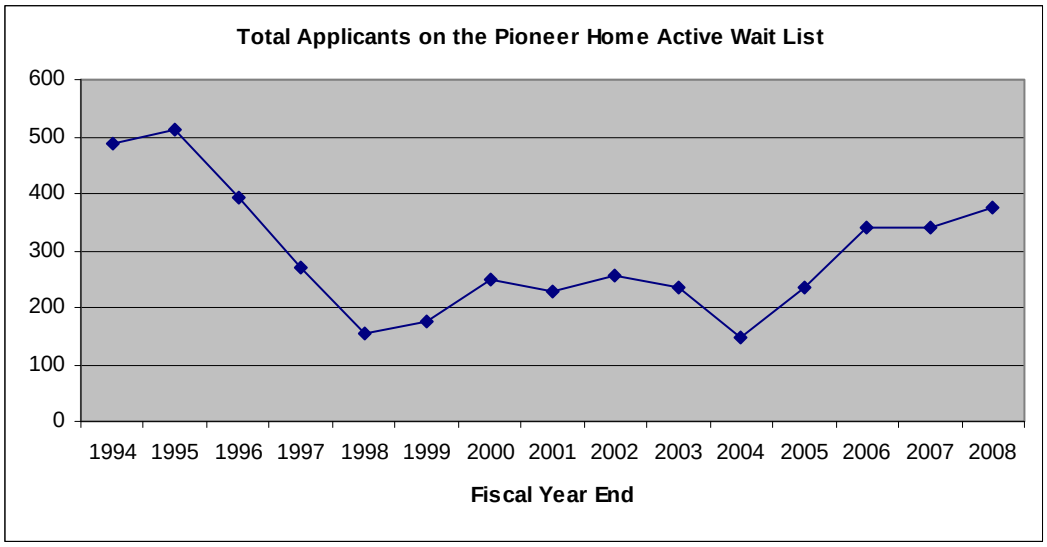
Pioneer Homes Wait List

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

When a bed becomes vacant in a particular level of service, the applicant offered admission is the person whose name is listed on the active branch of the wait list as having the earliest date of application. The applicant is admitted if the level of service the applicant requires matches the level of service of the available bed. At present, most people on the active branch of the wait list require Level II or Level III services and there are few vacancies in those levels. The number of applicants on the active wait list 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
2008	6	90	92	116	23	47	374



The following provides the composition of the Pioneer Homes wait list by facility as of October 2008. Over the past year the active and the inactive wait list increased by 108 and 62 applicants, respectively.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	14	105	113	146	29	64	471
Inactive Branch	678	942	929	1,232	475	880	5,136
Total	**692**	**1,047**	**1,042**	**1,378**	**504**	**944**	**5,607**

Number of Applicants Choosing More than One Home (Duplicates)	2,733
Number of Actual Applicants on Active Wait List	314
Number of Actual Applicants on Inactive Wait List	2,560

Pioneer Home Rate History

The next chart shows the history of monthly rates within the Pioneer Home system. The July 1996 rate increase was the first increase in the Pioneer Homes Advisory Board's seven year plan to move towards charging Pioneer Home residents the full cost of care. The final increase of the seven year plan occurred in FY2003.

In FY2005 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 FY2005.

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

Effective Date	Level I	Level II	Level III
July 2004	$2,240	$4,060	$5,880
July 2005	$2,240	$4,060	$5,880
July 2006	$2,240	$4,060	$5,880
July 2007	$2,240	$4,060	$5,880
July 2008	$2,240	$4,060	$5,880
Proposed Rates			
July 2009	$2,350	$4,260	$6,170

In accordance with the intent language of HB 365 passed by the 24th Legislature and to maximize Medicaid recovery, the Division of Alaska Pioneers Homes proposes a five percent increase in the rates charged for the three levels of care beginning FY2010.

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

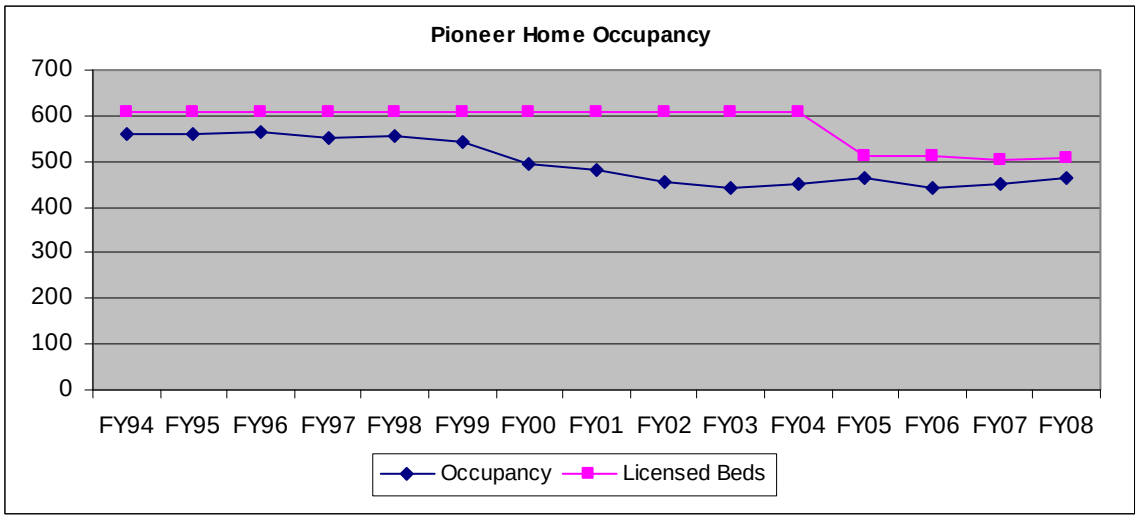
Historical Pioneer Home Occupancy

In FY2005 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 FY2006 the licensed beds in the Fairbanks and Juneau Homes decreased by three to reflect a safer resident to staff ratio. Early in FY2008, the Anchorage Pioneer Home increased their licensed beds to accommodate applicants on the active wait list who required Level I services. The Homes can currently offer assisted living services to 508 Alaskan seniors.

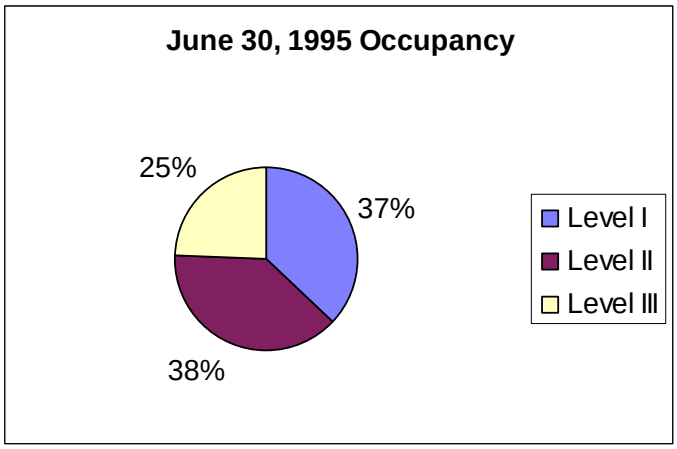
The majority of vacancies are in the Level I care units and there is not a demand for these beds. With family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. Those on the Pioneer Home active wait list require Level II and Level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

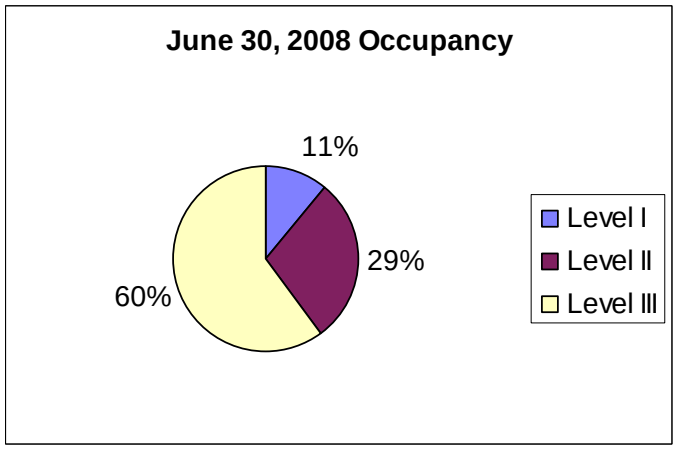
The following two graphs display 1) actual occupancy to the total number of licensed Pioneer Home system beds and 2) the residents and the percentage of residents in each of the three care levels in

1995 and 2008. As mentioned above, the gap between licensed and occupied beds was significantly decreased in FY 2005 when the division decreased the number of licensed beds to more accurately reflect those that are available to fill.



The change in the level of service provided to Pioneer Home residents over the past thirteen years is significant and is shown in the following two pie charts. Those residents requiring the highest level of service, Level III, increased from 25 to 60 percent, while those requiring Level I care decreased from 37 to 11 percent. Additionally, between June 30, 2007 and June 30, 2008 those requiring Level III care increased by four percent.





Current Pioneer Homes Occupancy

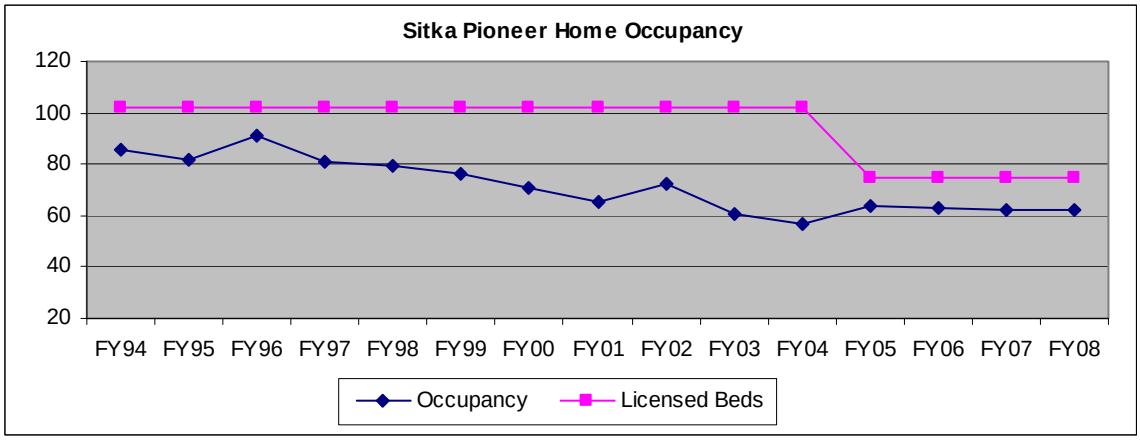
The table below shows the October 31, 2008 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home in Palmer by level of service. Totals towards the bottom of the chart compare unoccupied beds to licensed beds.

Service Level Occupied/Assigned	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Level I	3	7	5	35	5	1	56
Level II	28	21	17	49	8	17	140
Level III	27	55	52	79	30	23	266
Total	58	83	74	163	43	41	462
Licensed Beds	75	93	79	168	48	45	508
Non-Occupied	17	10	5	5	5	4	46
% Beds Filled	77.3%	89.2%	93.7%	97.0%	89.6%	91.1%	90.9%

Sitka Pioneer Home

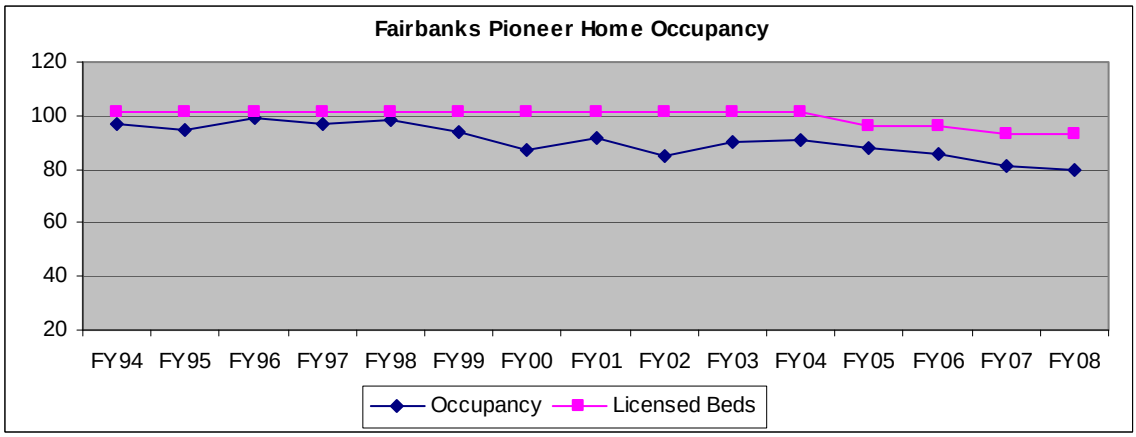
The Sitka Pioneer Home opened in 1913 when Alaska had been a Territory for just one year. The Home was established in the abandoned Sitka Marine Barracks building which was built in 1892. In 1934 a new main building, manager's house and nurses quarters were constructed. An addition was built on the north 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, 58 were occupied as of October 31, 2008.



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, 2008, 83 of the 93 licensed beds were occupied. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93.

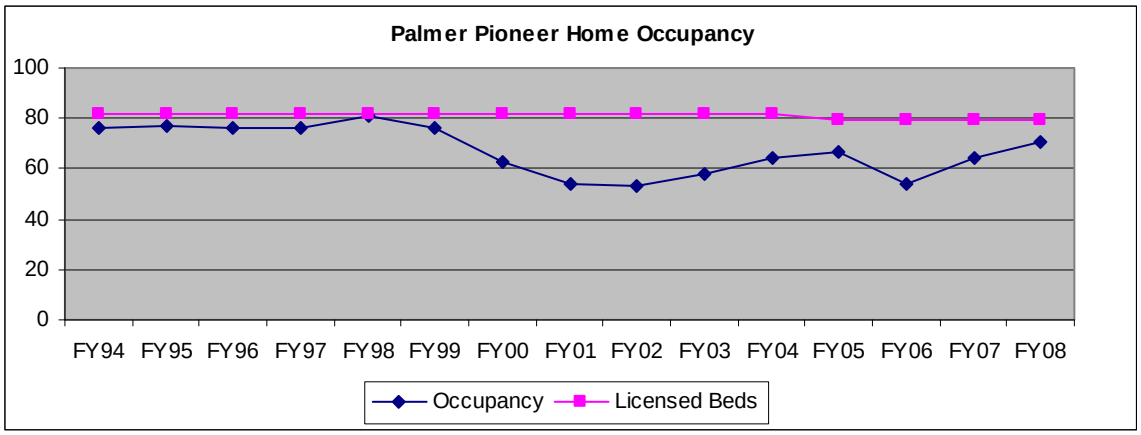


Palmer Pioneer Home

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 2008, 74 of the 79 licensed beds were occupied.

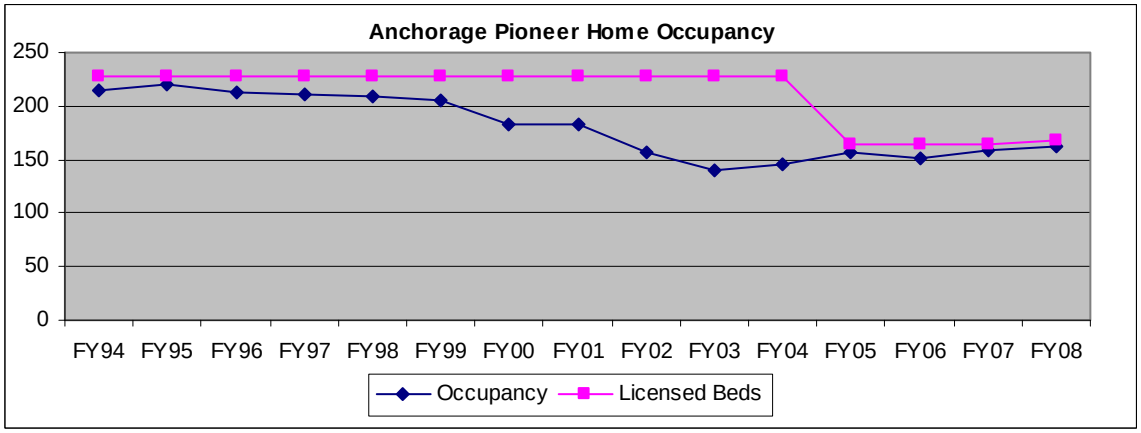
In June 2007, the Palmer Home received final certification from the US Department of Veterans Affairs to become Alaska's first state Veterans Home. Veterans residing in this home are eligible for domiciliary care per diem of $34.40 per day. The Home is now transitioning to fill 60 of its 79 licensed beds with veterans. As of October 2008, 25 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 Pioneer Home in Palmer operates under the same guidelines as the five other Pioneer Homes, requiring one year residency and residents who are 65 years of age or older.

The Legislature authorized ten new positions in FY2007 to serve the needs of 12 additional residents in the Palmer Home. The management of the Palmer Home has used these additional staff to increase occupancy to 96.1%. Two rooms are currently being used for storage and are not available for residents.



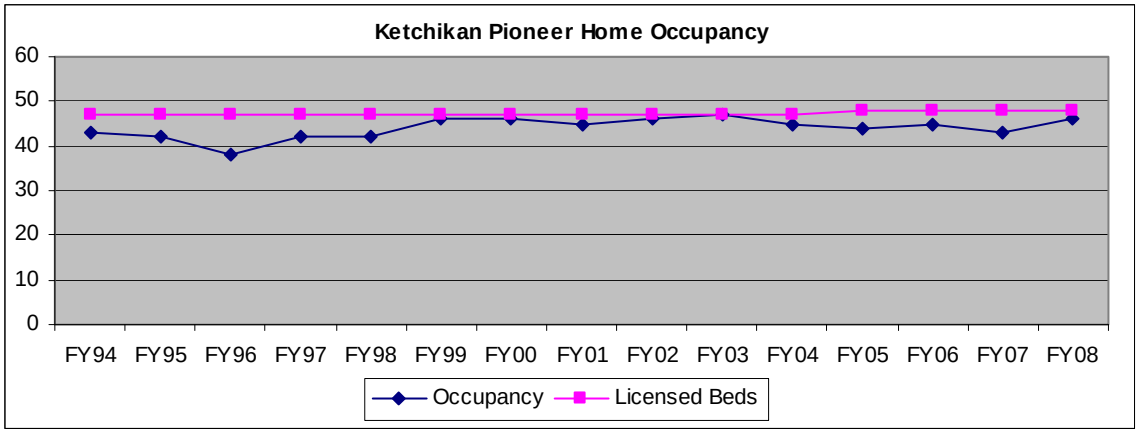
Anchorage Pioneer Home

The Anchorage Home is the largest Pioneer Home with 168 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 2008, 163 of the 168 beds were occupied. Early in FY08 the Anchorage Home increased its licensed beds by three to accommodate Level I residents on the active wait list.



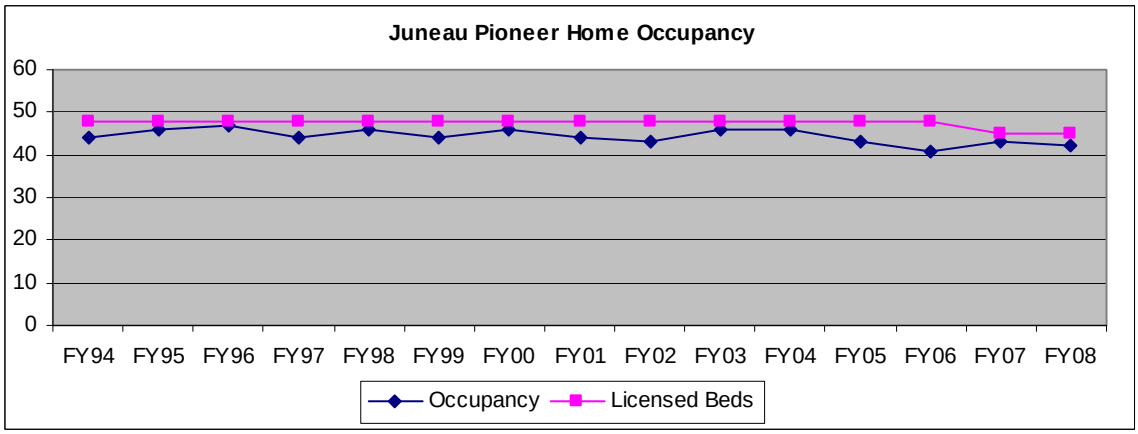
Ketchikan Pioneer Home

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 2008, 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 41 Alaska seniors as an Assisted Living Home and is licensed for 45 beds.



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

AK Pioneer Homes	2009	2010 Gov	09 to 10 Change
General Funds	32,653.8	32,837.4	183.6
Federal Funds	295.6	297.5	1.9
Other Funds	22,972.8	23,918.4	945.6
Total	55,922.2	57,053.3	1,131.1

Pioneer Homes

Additional Direct-Care Staff Funded by a Rate Increase; *$600.0 RSS*
The FY2010 budget includes a request for two nurses and seven certified nurse aides. The Ketchikan Home, which received just one new position in FY2007, requests one nurse and four certified nurse aides. The nurse will primarily perform duties associated with assessments, increased documentation requirements and chart reviews. The certified nurse aides will provide direct care, transportation and restorative services. The Alaska Veterans and Pioneers Home requests three certified nurse aides, to allow for increased resident monitoring and direct care including feeding, bathing, mobility and incontinence care. The Juneau Home requests an additional nurse position to coordinate with physicians in managing complex medical conditions, provide terminal care, monitor and administer medications and provide the documentation and charting necessary to meet the stringent nursing regulations and documentation requirements.

In accordance with intent language passed by the 24th Legislature, the Pioneer Homes proposes a five percent increase in the monthly rates charged to residents. This increase is estimated to result in approximately $600.0 of additional receipts. These additional funds paid by the residents will cover the cost of the additional positions that care for them.

Increase in Medicaid Waiver Residential Assisted Living Rates
The four percent increase provided by the Alaska Legislature is estimated to result in an additional $123.3 inter-agency receipts. The FY2010 budget provides for a general fund decrement equal to this amount.

Increased Funding for On-Call Substitute Certified Nurse Aides; *$55.2 RSS*
In order to enhance recruitment and retain Non-permanent On-Call Substitute certified nurse aides, Letter of Agreement #08-GG-283 increased the pay for these employees by $1.50 for each compensable hour worked. This request is based on the hours worked by such employees between May 1 and July 1, 2008.

Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: *$2,000.0 GF*
There are 5 pioneer homes and the Alaska Veterans and Pioneer Home have an overall area of 443,354 square feet. The average age of the homes is 44 years with the oldest home (Sitka Pioneer Home) constructed in 1934. These homes are open and serving Alaska pioneers 24 hours a day, seven days a week. Do to their use, they receive a higher degree of wear, and require capital funding to address deficiencies that are above and beyond normal maintenance.

This year, the department is requesting $2.0 million in FY2010 to address the documented deficiencies in all the homes. The funding is managed by the department's Facilities Section. The Facilities Section is tasked with the challenge of addressing as many of the identified projects as funding will allow.

Challenges

Increased Resident Acuity
Level II and III residents in the Homes have increased from 63% in June 1995 to 89% in June 2008. Additionally, between 2008 and 2009 fiscal year end, the number of Level I residents decreased from 13% to 11% and the number of Level III residents increased from 56% to 60%. Home and community-based services are enabling seniors to remain in their homes longer and seniors don't request admission to a home until they are much older and in need of Level II or III care. The average age of a Pioneer Home resident was 85.5 in July 2008. These residents often need a great deal of assistance with eating, toileting, bathing, dressing, and mobility which requires increased staff time.

Very few applicants to a Home require Level I service, however we cannot convert level I beds to Level II or III without significant capital improvements to the Homes. The Active Wait List had 314 applicants as of October 2008, an increase from 209 in October 2006. This wait list is expected to grow in the future as demographic data indicates a surge in the number of Alaskan seniors over the next twenty years.

Finding Alternative Placements for Residents Unsuitable for the Pioneer Homes
The Homes are experiencing an increase in residents who manifest assaultive behaviors or mental illness. Residents that are a risk to other residents or staff are to be discharged. The Pioneer Homes are not licensed to care for residents with a mental illness, nor are staff trained to provide such care, yet finding alternative placements for these individuals has been difficult or impossible. Continuing to house these residents places staff and other residents at risk for injury.

Recruiting and retaining Health Care Personnel
Recruiting and retaining adequate health care personnel is an ongoing challenge for the Pioneer Homes. In some locations, the pay and benefits of the Pioneer Homes workforce is not competitive with jobs in the same job class in the private sectors. Allowing employees to attend training and conferences in their area of expertise shows our employees that we value them and allows them to remain up to date with the latest medical advances yet it has always been difficult budgeting adequate funding for training.

Increased Documentation Requirements
Documentation requirements for Medicaid and the Medicaid Waiver, the Veterans Administration, Occupational Safety and Health Association (OSHA), and licensing continue to be a challenge and keeps staff from providing direct care to residents.

Ketchikan Pioneer Home Remodel
The third floor dining area was not designed to accommodate residents in wheelchairs and needs to be expanded. Currently many residents must take their meals in the hallway or in their room where they can't be observed by staff. This creates a safety concern should a resident choke or experience some other medical emergency. The dining area could be expanded by converting one resident room into common space.

Additionally, one neighborhood bathing room cannot accommodate the lift equipment needed to transfer many of the residents and needs to be renovated. The remodel of this area would allow transfers to be accomplished safely and without injury to residents or staff.

Adequate Storage

The Anchorage and Palmer Homes need additional storage space to store supplies, equipment, and disaster preparedness items. Currently the Palmer Home rents three off-site storage units at a cost of $5,000/year and uses two resident rooms for storage. On site storage would save the $5,000 and free up the rooms for additional residents who would bring in the monthly room and board payments. The problem in the Anchorage Home is that there is no room on site to put additional storage so off-site storage is the only option.

Contribution to Department's Mission

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

A: Result - Outcome statement #1 - Eligible Alaskans and Veterans will live in a safe environment.

Target #1: Reduce resident serious injury rate
Status #1: In FY 2008, the medication error rate decreased to .14% while medications administered increased to an average of 488,184 per fiscal quarter, up from 434,464 in FY 2006.
In FY2008, our sentinel event injury rate from falls decreased to 1.73%, down from 2.9% in FY2007.

Analysis of results and challenges: Increasing age and acuity levels of Pioneer Homes residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending and tracking information available in the division's risk analysis program, the Homes are able to identify times, places, 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.

Division Level Measures

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

Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range
Status #1: In FY2008, the medication error rate decreased to .14% while medications administered increased to an average of 488,184 per fiscal quarter, up from 434,464 in FY2006.

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2009	0.15%	0	0	0	0
2008	0.16%	0.13%	0.15%	0.12%	0.14%
2007	0.19%	0.22%	0.15%	0.14%	0.18%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2002	0.07%	0.08%	0.04%	0.05%	0.06%

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

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

The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2008, Pioneer Home staff administered an average of 488,184 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 two percent injury rate, which is the low end of the National Safety Council's range of two to six percent

Status #1: In FY2008, our sentinel event injury rate from falls decreased to 1.73%, down from 2.9% in FY2007.

Fiscal Year Sentinel Event Injury Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2009	0.0%	0	0	0	0
2008	1.5%	1.3%	2.0%	2.1%	1.73%
2007	3.5%	1.2%	2.0%	4.9%	2.9%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2002	2.9%	0.7%	0.0%	0.37%	0.99%

Methodology: 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 85.5, putting them in the highest risk category for suffering a serious injury from a fall that could lead to death. The Pioneer Homes respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

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Mission

The mission of the Division of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open 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 Alaska Board for Substance and Drug Abuse, and providers and advocacy groups.

Core Services

Provide a continuum of statewide mental health and substance use disorder services ranging from prevention and early intervention to treatment, including inpatient psychiatric hospitalization and operation of the Alaska Psychiatric Institute.

Services Provided

Behavioral Heath Continuum of Care

Prevention & Early Intervention Services (Community Based)	Behavioral Health Services (Community & Facility Based)	Residential Services (Mostly Facility Based)	Inpatient Services (Facility Based)
Advocacy	Outreach	Children's Services	Inpatient
Self-Help	Emergency Services	Day Treatment	Acute Psychiatric Care
Community Education	Telephone Screening	Foster Homes	DET/DES
Peer/Consumer Support	Crisis Intervention	Group Homes	
	Assessment	Therapeutic Group Homes	
	Screening	Emergency Stabilization & Assessment (ESA)	
	Evaluation	Long Term Res. Treatment	
	Referrals	Secure Locked Res. Care	
	Outpatient (Clinic Based)	Residential Diagnostic Tx	
	Treatment Planning		
	Counseling		
	Rehabilitation & Recovery	Adult Services	
	Case Management	Crisis Respite	
	Skill Development	Residential Treatment	
	Day Treatment		
	School Based		
	Home Based		
	Supported Living		
	Individualized Services		
	Intensive Outpatient		
	Medical Services		
	Psychiatric Assessment		
	Pharmacological Mgmt		
	Detox Services		
	Social Detox		
	Outpatient Detox		
	Medical Detox		

Prevention and Early Intervention Services

The Prevention and Early Intervention Services section of the Division of Behavioral Health provides for Prevention and Early Intervention Services within Alaska's comprehensive behavioral health system. Using the division's vision of "*partners promoting healthy communities*" the core services of community-based substance abuse prevention, fetal alcohol spectrum disorders services, suicide prevention, youth development and resiliency, tobacco enforcement and education, Rural Human Services Systems project and Alcohol Safety Action Program are blended to work in partnership. To carry out these services, three primary grant programs have been established to provide program funding to community-based agencies.

These prevention and early intervention grant programs are:
Comprehensive Behavioral Health Prevention & Early Intervention Services
Alcohol Safety Action Program
Rural Human Services Systems Project
Fetal Alcohol Spectrum Disorders Diagnostic Team Program

The *Comprehensive Behavioral Health Prevention & Early Intervention Services* grant program funds a comprehensive array of promotion, prevention and early intervention approaches that focus on services that are community designed and driven; based on concepts and program strategies that are proven to be effective in prevention of behavioral health concerns; and with clearly defined qualitative performance outcomes. The intent of these grant dollars are to "blend, braid and pool" resources and programming concepts into an integrated approach to behavioral health prevention. We know that substance abuse, mental health, suicide, fetal alcohol spectrum disorders, underage alcohol use, family violence, juvenile delinquency, and other issues are interrelated and we want communities to have the freedom to connect these issues to partner and collaborate with community members working on connected issues, and to focus on what it will take to develop overall community health and wellness. Currently thirty-seven community agencies have received funding through this grant program in remote, rural, hub and urban communities. Each program uses the Substance Abuse and Mental Health Service Administration (SAMHSA) Strategic Prevention Framework (SPF) planning model to assess, plan, provide and evaluate community-based services.

SAMHSA'S Strategic Prevention Framework (SPF)

The overall goal of this grant program is to promote healthy communities utilizing effective practices and partnerships with a focus on one or more of three long-term outcomes:

- All Alaskan communities, families and individuals are free from the harmful effects of substance use, dependency and addiction.
- Alaska children, youth and adults are mentally healthy and living successfully.
- All community members are connected, resilient and have basic life skills.

The *Alcohol Safety Action Program (ASAP*) grant funding is made available to select communities working in partnership with their local court systems. ASAP funded program provide screening, referral and monitoring to adult and juvenile misdemeanor alcohol offenders to ensure they complete required substance abuse education or treatment programs, as prescribed by the courts. The ASAP program is designed to provide a standardized statewide network of alcohol screening and case management of cases referred by the criminal justice system. ASAP is an integral part of the criminal justice and healthcare delivery systems, providing invaluable and necessary monitoring of clients referred to substance abuse services throughout the State. This program requires a close working relationship among all involved agencies: Enforcement, Prosecution, Judicial, Probation, Corrections, Rehabilitation, Licensing, Traffic Records, Public Information/Education, and Legislatures. Grant funded service providers provide early identification of problems or high risk drinkers, and initiate appropriate referrals to substance abuse educations and/or treatment services. Current programs are located in Anchorage, Fairbanks, Juneau, Kenai/Homer, Ketchikan, Kodiak, Kotzebue, Wasilla/Palmer, Dillingham and Seward. Dillingham and Seward are new programs that began in FY09. Three additional programs will be added during FY09 in Barrow, Bethel and Nome.

The *Rural Human Services Systems Project (RHSSP)* is a partnership between Department Health and Social Services, Division of Behavioral Health and the University of Alaska Fairbanks (UAF), College of Rural Alaska. The long-term outcome for the RHSSP is to have a trained, culturally competent and stable behavioral health workforce in all rural and remote Alaskan villages. The vision is *"a counselor in every village."* First and foremost the RHSSP is a workforce development

and education/training program to build a stable system of well trained and culturally responsive rural behavioral health care providers. Grant dollars are available to rural agencies or urban agencies serving a significant number of rural clients to train, and to provide part or full-time student internships. Through the support and supervision, the village-based student interns will function as behavioral health generalist providing prevention, early intervention and general counseling services to the entire community. The UAF Rural Human Services (RHS) educational program is the first step in the educational "pipeline" for rural students who can complete their 60 hour RHS certification program while living and working in their home community. Following the RHS certificate students can continue in the Human Services Associate degree program and continue into the Intensive Rural Bachelor of Social Work program. Currently RHS grants fund students through thirteen hub agencies in rural Alaska, from Kotzebue to the Eastern Aleutian Islands.

The *Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Team Provider Agreement Program* provides a payment system for approved and trained community-based FASD Diagnostic Teams following the completion of a FASD diagnosis. Currently nine teams are registered as 'approved' Diagnostic Teams located in Bethel, Kenai, Fairbanks, Anchorage, Juneau, Sitka, Mat-Su Valley and Kodiak. During FY08 a total of 137 diagnoses were completed through this community-based process. For each completed diagnosis, teams are allowed to bill the state $3,000 to assist with covering diagnostic costs not allowable through Medicaid or insurance billing. The approximate cost for complete diagnostic testing is $5,000. During FY09 we will be working with two community teams currently on hiatus (Ketchikan and Copper River) to provide technical assistance allowing their local teams to begin operating again. A community FASD committee in Anchorage is working on the development of a second Diagnostic Team in that community, to assist with broadening the coverage and availability of timely diagnostic services in the Anchorage bowl area.

Tobacco Enforcement and Education

In addition to these community grant programs, the Prevention Section includes the Tobacco Enforcement and Education program that does not provide grant funding, but provides a critical component of our prevention efforts and the Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Team Providers Agreements. The Tobacco Enforcement and Education program is responsible for monitoring and compliance of retail outlets with state-approved Tobacco Endorsements, allowing them to legally sell tobacco products. The Tobacco Investigations in partnership with teen workers, visit retail outlets and have teens attempt to purchase tobacco products. From this work, we are able to monitor the "sell rate" of tobacco products to minors under the age of 19 (the legal age to purchase tobacco in Alaska). Due to the consistent and professional work of the Tobacco Enforcement section, sell rates in Alaska have dropped from 34% in 1999 to 9.2% in 2008. In addition to monitoring and compliance checks, Investigators provide retailers with educational information about the state tobacco laws and training in how to avoid selling tobacco to minors.

Therapeutic Courts

Therapeutic courts represent the coordinated efforts of the criminal justice and behavioral health professionals to actively intervene and disrupt the cycle of substance abuse, addiction, and crime. As an alternative to less effective interventions, these courts quickly identify substance abusing offenders and place them under strict court monitoring, community supervision, and long-term behavioral health treatment services.

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 the Department of Health and Social Services Divisions of 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. During FY08 the draft plan was posted for public comment. In addition, 25 Town Hall meetings were held across Alaska focusing on underage drinking and strategies to reduce drinking among our youth and increase the perception of harm by alcohol consumption. The plan has been revised using the comments received through the public comment period and will be finalized by January 2009 and distributed across Alaska to begin a comprehensive approach to reducing teen drinking in Alaska.

Suicide Prevention

Effective July 1, 2008, the Statewide Suicide Prevention Council (SSPC) was relocated from the DHSS Commissioner's Office to the Division of Behavioral Health, section of Prevention & Early Intervention Services. The reason for this change of location was to allow for better coordination of statewide suicide prevention efforts between the SSPC and the Division of Behavioral Health and to promote a more seamless and coordinated approach to suicide prevention in Alaska. While the physical transition is complete, the Council members and the Behavioral Health staff are continuing to define and develop their relationship and structure. Two DBH Prevention staff members are sharing the role of Council support and coordination, working in partnership with the SSPC Council Chair and the Council membership. We are currently working closely with the Office of Boards and Commissions to fill a number of vacant SSPC seats, updating the SSPC Statewide Plan, and completing the annual report to the legislative. In addition, DBH and the SSPC are collaborating on the Statewide Suicide Prevention Initiative.

Suicide Prevention Initiative: In partnership with the Alaska Statewide Suicide Prevention Council, Behavioral Health Prevention staff began working on a suicide prevention initiative in FY2007. The intent of the initiative is to improve mental health and reduce suicidal thoughts and actions among high-risk individuals. In Alaska, those at highest risk are our Alaska Native young men ages 16-24. The initiative, first introduced in the FY09 budget was partially funded for FY09 with a one-time increment of $200,000 to help regions with highest rates of suicide to begin community planning, to evaluation community readiness, examine risk and protective factors and identify strategies for reducing the number of suicides in the identified regions. Seven-month planning grants will be awarded in December 2008, with regional or sub-regional strategic plans being completed in June 2009. A final statewide plan will be developed using the information, data and strategies from the regional plans to establish a 5-year initiative to reduce and prevention suicide in rural Alaska.

Behavioral Treatment & Recovery Services

The Treatment and Recovery Services section of the Division of Behavioral Health provides for treatment and recovery services within Alaska's comprehensive behavioral health system. The core programs include Services for Substance Use Dependent (SUD) Adults and Children, Psychiatric Emergency Services (PES), Services for Seriously Mentally Ill (SMI) Adults, and Services for Seriously Emotionally Disturbed (SED) Youth. Referred to as a "Continuum of Care", these services are networked together to ensure that children and adults (with mental, emotional, substance use and abuse, and behavioral problems) and their families, have access to the services and supports they need to promote recovery and resilience, to improve their success and functioning. The publicly funded programs primarily serve those Alaskans without insurance or the ability to pay for services.

Treatment & Recovery Service Arrays

Services for Substance Use Dependent (SUD) Adults and Children: Grant funding is provided to local non-profit agencies 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 persons 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.

Psychiatric Emergency Services (PES): Community mental health agencies receive funding for services intended to aid people in psychiatric crisis. The service array may include crisis intervention, brief therapeutic interventions for stabilization, and follow-up services. Specialized services such as outreach teams and residential crisis/respite services are also included. Department of Health and Social Services, Division of Behavioral Health will also respond to disasters and seek federal aid for events that qualify as declared disasters.

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

Services for Seriously Emotionally Disturbed (SED) Youth: Competitive grant funding is made available to community mental health agencies to provide a range of services including assessment, psychotherapy, chemotherapy, case management and rehabilitation. Specialized services include individual skill building, day treatment, home-based therapy, residential services and individualized services.

Services for Seriously Emotionally Disturbed (SED) Youth grants prioritize services in the least restrictive environment and as close to home and family as possible. Under the Bring the Kids Home initiative, changes have been made to enhance the in-state service continuum for severely emotionally disturbed children and decrease the number of children moving into out-of-state placements and restrictive in-state environments.

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

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

Effective and Efficient Management and Administrative Services:
- 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 the Office of Children's Services, Division of Juvenile Justice, and the Division of Public Assistance, as well as with other agencies such as the Department of Corrections.
- During FY08 and continuing in FY2009, Department of Health and Social Services, Division of Behavioral Health has been working to improve business practice and management philosophy, resulting in a redefining of its' core functions. Those core functions are:
- Monitors and manages the use of public funds to provide accessible, effective and efficient services of prevention and treatment services for Alaskans with substance use disorders, mental illness, a combination of both; individuals with traumatic brain injury, and/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.
- Insures effective and efficient management and administration of publicly funded behavioral health services.

Related to these functions are the following processes:
Performance Based Funding: Treatment and Recovery staff will continue its successful methodology for applying performance based measures for allocation of treatment grant funds for FY2010. Using the Performance Based Funding (PBF) Work Group, the Division of Behavioral Health has collaborated with grantee providers in establishing the foundation of a PBF methodology for the allocation of grant dollars in FY2009.

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

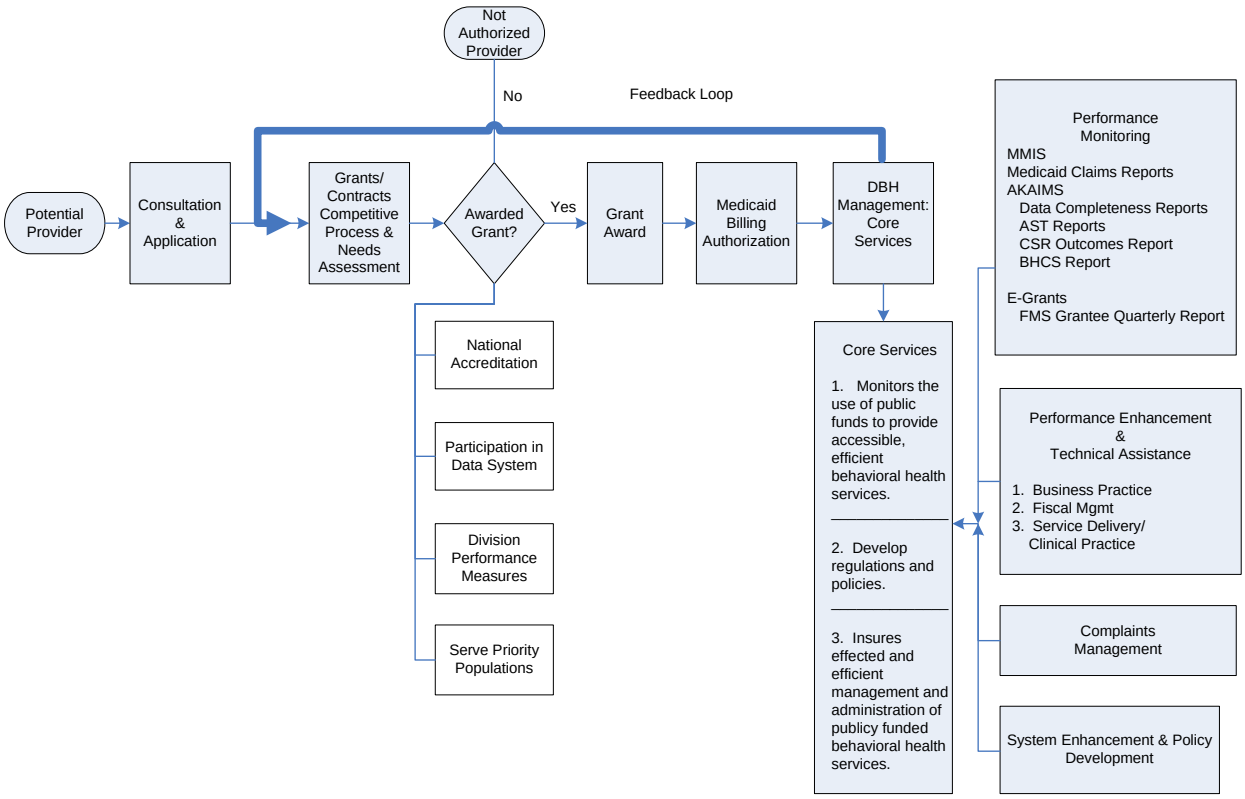
New Business Practices: As the Division of Behavioral Health moves forward in the development of "new business practices" Treatment and Recovery continues to reduce the quarterly reporting requirements of grantee providers—making the administrative footprint of the division on providers smaller.

Technical Assistance Model: Technical Assistance is a major division strategy to shift business practice away from its historical focus on oversight and compliance to a focus on delivery of high quality service and improving treatment outcomes. The new focus will be on performance monitoring and performance enhancement; business practices, fiscal management, service delivery and clinical practice.

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.

The following chart illustrates the vision for the Community Behavioral Health Provider Approval Process resulting from the new business practice and management philosophies.

DHSS / Behavioral Health
Community Behavioral Health Provider Approval Process



Alaska Psychiatric Institute

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

Services provided at API include:

- Screening and referral
- Medication stabilization
- Psychosocial rehabilitation services
- Multidisciplinary assessments
- Individualized and group therapy and counseling
- Patient and family education
- Inpatient psychiatric treatment with an increasing focus on the role recovery approach
- Telepsychiatry services to reach remote areas of the state

API Advisory Council
By Administrative Order dated July 1, 2008, a new interim Alaska Psychiatric Institute Advisory Board was established to provide advice and recommendations to the Commissioner of Health and Social Services on how to meet the needs of API's patients, the patients' families, and the state, including the Alaska Recovery Center and API satellite programs.

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

Behavioral Health Prevention and Early Intervention Services Statistics

FY2008 Alcohol Safety Action Program Case Statistics

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
New Case Statistics				
Adult ASAP New Cases	2074	2231	2298	2604
Juvenile ASAP New Cases	320	288	350	489
Therapeutic Courts Participants	188	185	186	195
	2582	2704	2834	3288
ASAP Compliance				
# New Cases Completed	770	574	653	644
# Clients in Compliance	1504	2002	2037	2510

Seven of the Probation Officers with ASAP work with clients referred from the Therapeutic Court system; each has a small case load of 30 to 40 clients. These are felony clients and mental health clients. The case management includes nearly daily contact, urinalyses, group sessions and weekly court sessions. The remaining five Probation Officers handle misdemeanor ASAP referrals.

What is Working?

Felony Drug Court (Anchorage) lowered recidivism.

- 54% of the participants in these courts graduated.
- 13% rate of re-arrest in one year for program graduates, compared to a 32% re-arrest rate for non-participants.
- "The longer the participants stayed in the program, the less likely they were to recidivate, even if they did not graduate."

Mental Health Court in Anchorage

- The average daily operation cost is less than $20/person; incarceration is more than $120/person.
- The vast majority of participants reported better quality of life from being in the program.
- Participants, especially graduates, re-offended less than others experiencing mental illness in the criminal justice system.

(Sources: 2007 Alaska Judicial Council Study; a recent study of the Mental Health Court in Anchorage commissioned by the Court System and the Mental Health Trust)

Behavioral Health Treatment and Recovery Services Statistics

In FY2008, grantee agencies provided services for 12,612 mental health clients and 5,180 substance use disorder clients as listed below:

Target populations:

- 6,848 adults experiencing a serious mental illness (SMI)
- 2,677 youth experiencing a serious emotional disturbance (SED)

- 5,180 adults and youth experiencing a substance use disorder (SUD)

Non-target populations:

- 1,990 adults experiencing a lesser degree of mental illness (Non-SMI)
- 1,097 youth experiencing a lesser degree of emotional disturbance (Non-SED)

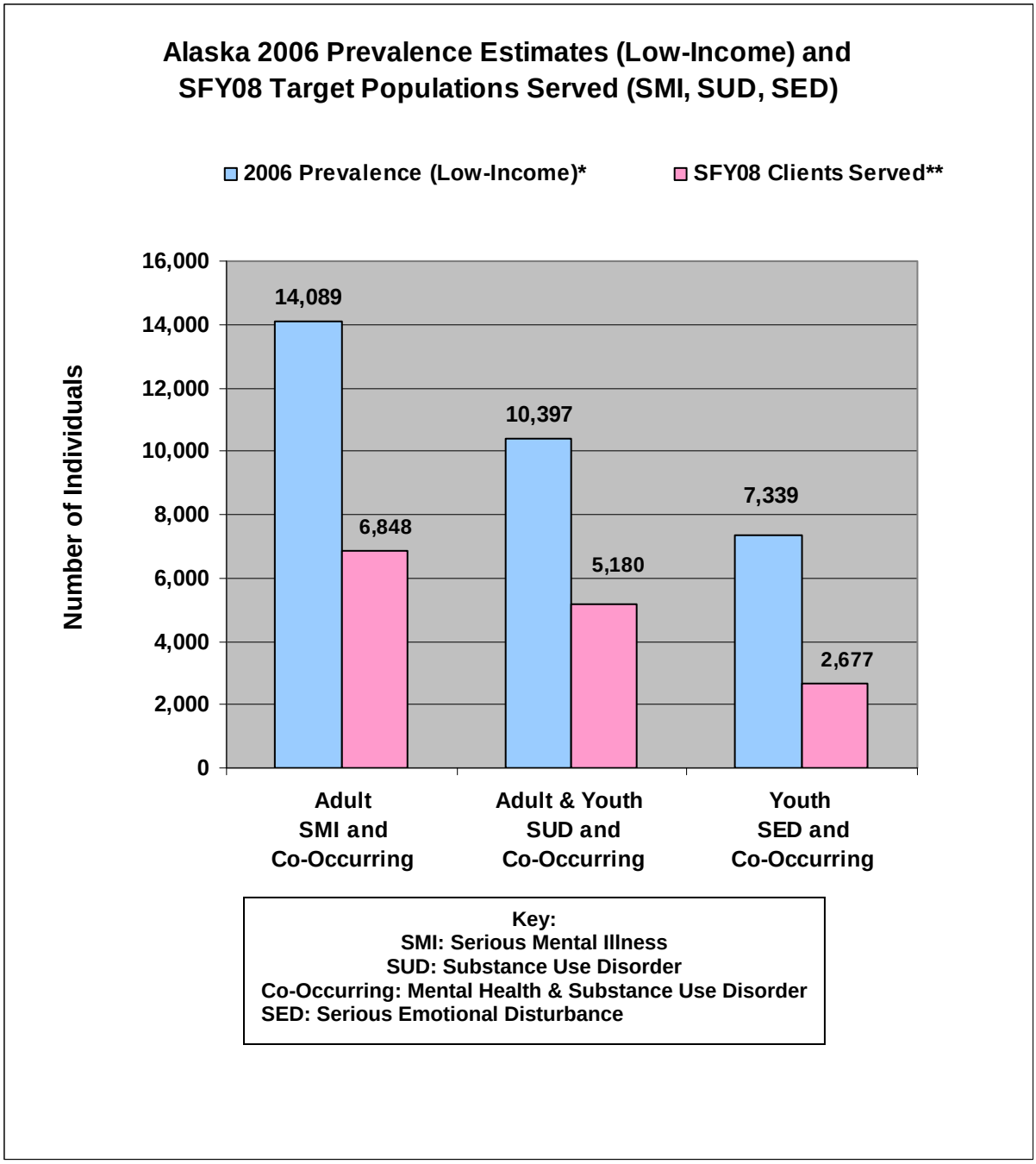
Note: Clients experiencing a co-occurring disorder who were enrolled in mental health and substance abuse programs are included in both the mental health count (SMI or SED) and the substance use disorder count.

FY2008 was a baseline year for reporting client counts using the division's electronic health record system, i.e., the Alaska Automated Information Management System (AKAIMS). The division is continuing to improve AKAIMS data collection, analysis and reporting capabilities. As the division moves forward with this transition, we anticipate more complete electronic health records from grantee agencies and enhanced reporting capabilities.

The division, in conjunction with the Mental Health Trust and Advisory Boards, completed the 2006 Alaska prevalence estimates of serious behavioral health disorders. These prevalence estimates can be used as a benchmark to measure penetration rates of behavioral health services. These estimates, which are considered to be conservative, provide a basis for identifying unmet needs in Alaska's low income and total household population. The table and chart below compare the 2006 prevalence estimates (low-income) with the SFY08 clients served in target populations; estimated penetration rates are also calculated (number of clients served/estimated prevalence).

Alaska 2006 Prevalence Estimates (Low-Income) and SFY08 Target Populations Served (SMI, SUD, SED)

	2006 Prevalence (Low-Income)*	FY08 Clients Served**	Penetration Rate (#Served/Prevalence)
Adult SMI and Co-Occurring	**14,089**	**6,848**	**48.6%**
Adult & Youth SUD and Co-Occurring	**10,397**	**5,180**	**49.8%**
Youth SED and Co-Occurring	**7,339**	**2,677**	**36.5%**

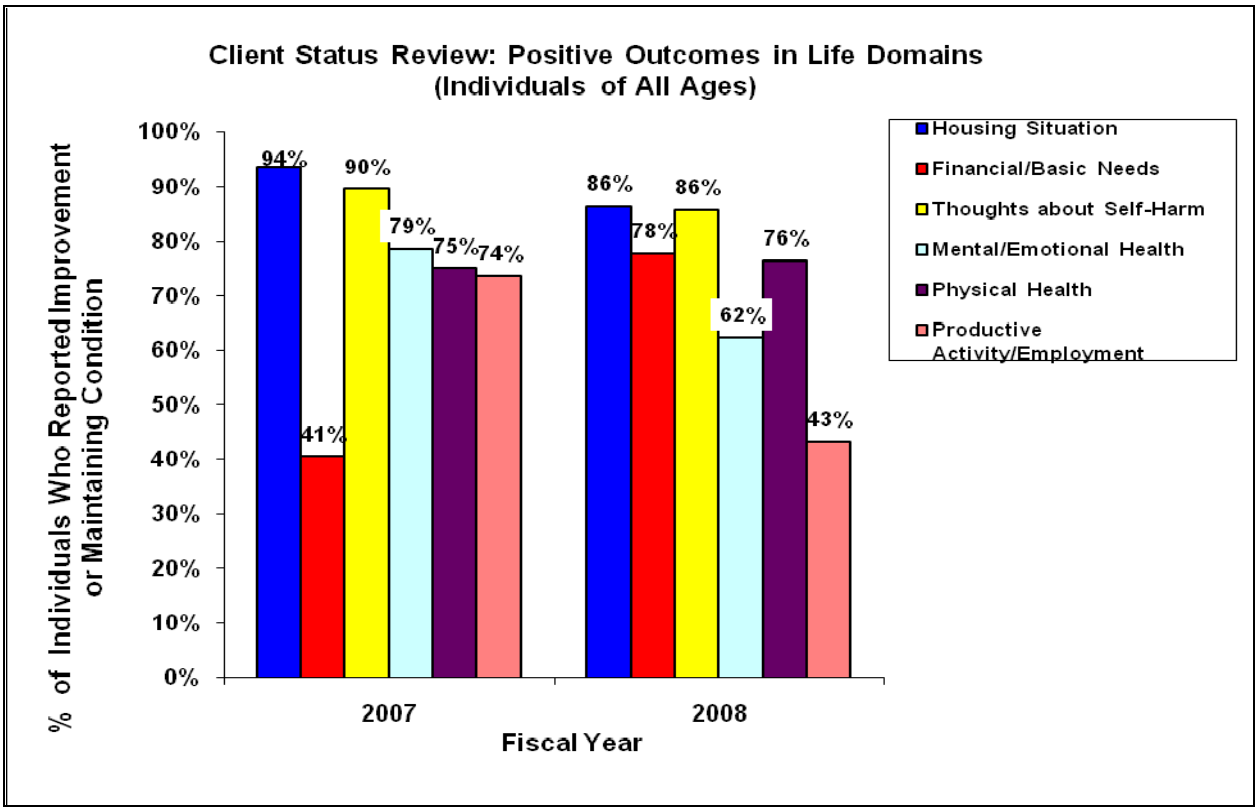


* Prevalence estimates shown here are for Adult SMI (including Co-Occurring), Adult SUD (including Co-Occurring), and Youth SED; the Adult Co-Occurring prevalence estimate is included in both the Adult SMI and Adult prevalence estimates. Prevalence data source: *2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household*, 15 January 2008.

** Client counts are for Adult SMI (including Co-Occurring), Adult & Youth SUD (including Co-Occurring), and Youth SED (including Co-Occurring); a Co-Occurring client is included in both the mental health count (SMI or SED) and the substance use disorder count.

Life Domains

In FY2008, for four life domains (housing situation, financial/basic needs, thoughts about self harm, and physical health), more than 75% of individuals reported improvement or maintaining condition within the specified domain. In two life domains (mental/emotional health and productive activity/employment), less than 75% of individuals reported improvement or maintaining condition within the specified domain.



Methodology: Clients complete a Client Status Review (CSR) form when entering treatment, periodically throughout treatment, and at time of discharge. A client's status of "improvement or maintaining condition" is determined based on comparing CSR scores from the most recent CSR to the intake CSR. Note: Data for both FY07 and FY08 are incomplete - see "Analysis of results and challenges."

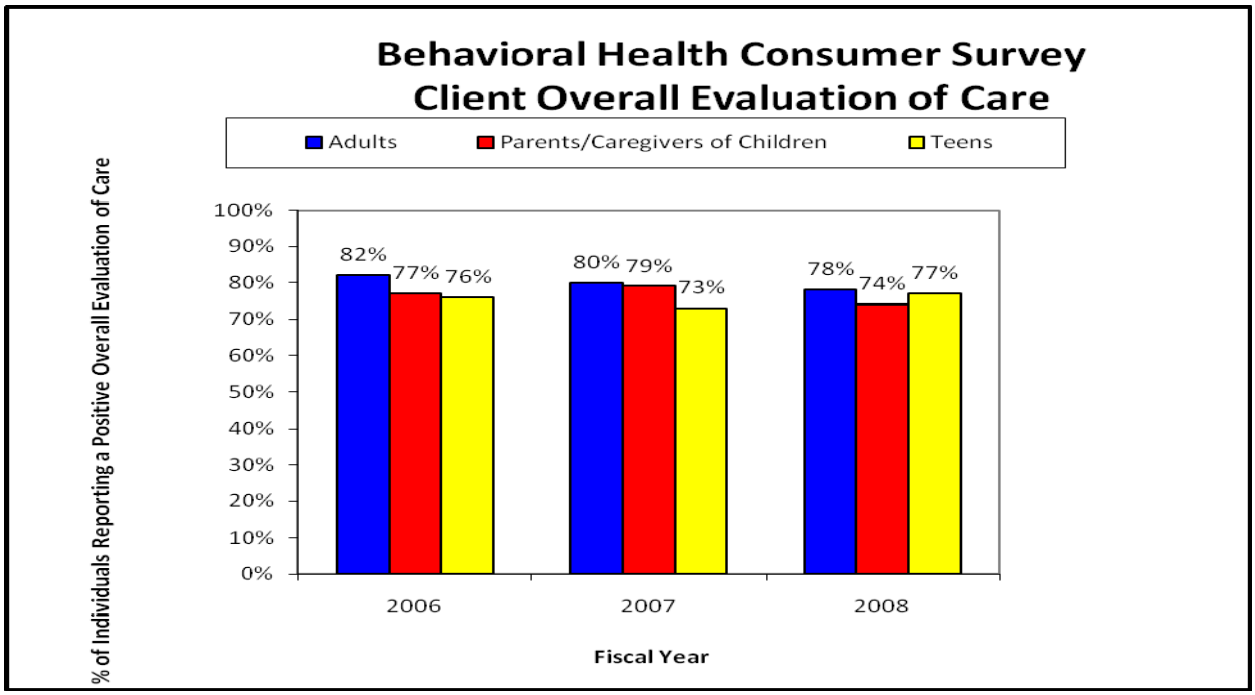
Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Housing Situation	Financial/ Basic Needs	Thoughts about Self-Harm	Mental/ Emotional Health	Physical Health	Productive Activity/ Emp
FY 2008	86%	78%	86%	62%	76%	43%
FY 2007	94%	41%	90%	79%	75%	74%

Due to differences in data collection methodologies and data completeness between FY2007 and FY2008, comparisons between years have limitations. The division is transitioning from a paper record system to an electronic health record system. FY2007 was a peak transition year when some agencies reported CSR data using a paper record system and other agencies used the Alaska Automated Information Management System (AKAIMS) electronic health records system. Combining records from both systems was a challenge and resulted in an incomplete FY2007 data set. Although the FY08 CSR data includes data only through the third quarter, it is considered to be more complete than the FY2007 data. The division intends to use the FY08 data as a baseline for future measurement. As DBH moves forward with transitioning to the AKAIMS electronic health records system, we anticipate more accurate and complete electronic health records from participating agencies.

Refinements to the AKAIMS CSR reporting procedures also are being explored. The life domain analyses do not take into account the length of time that a client may have been in services. Clients receiving services over a long period of time are compared to those who may have just been admitted into services. AKAIMS reporting processes that account for duration of services is one of several refinements being explored.

In FY2008, more than 75% of Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 74% of parents/caregivers of children reported a positive evaluation.

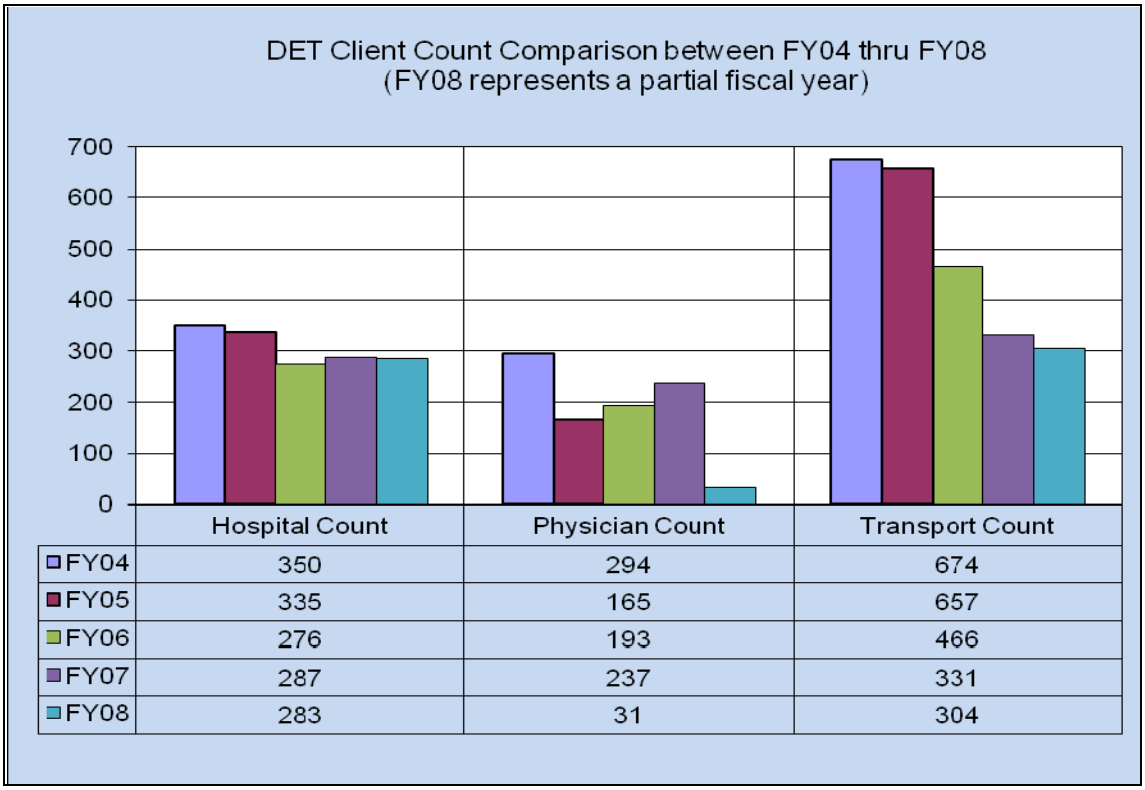


Methodology: The Behavioral Health Consumer Survey (BHCS) is an instrument used by the Division to measure client evaluation of behavioral health services. Grantee agencies providing behavioral health services mail the survey to their clients.

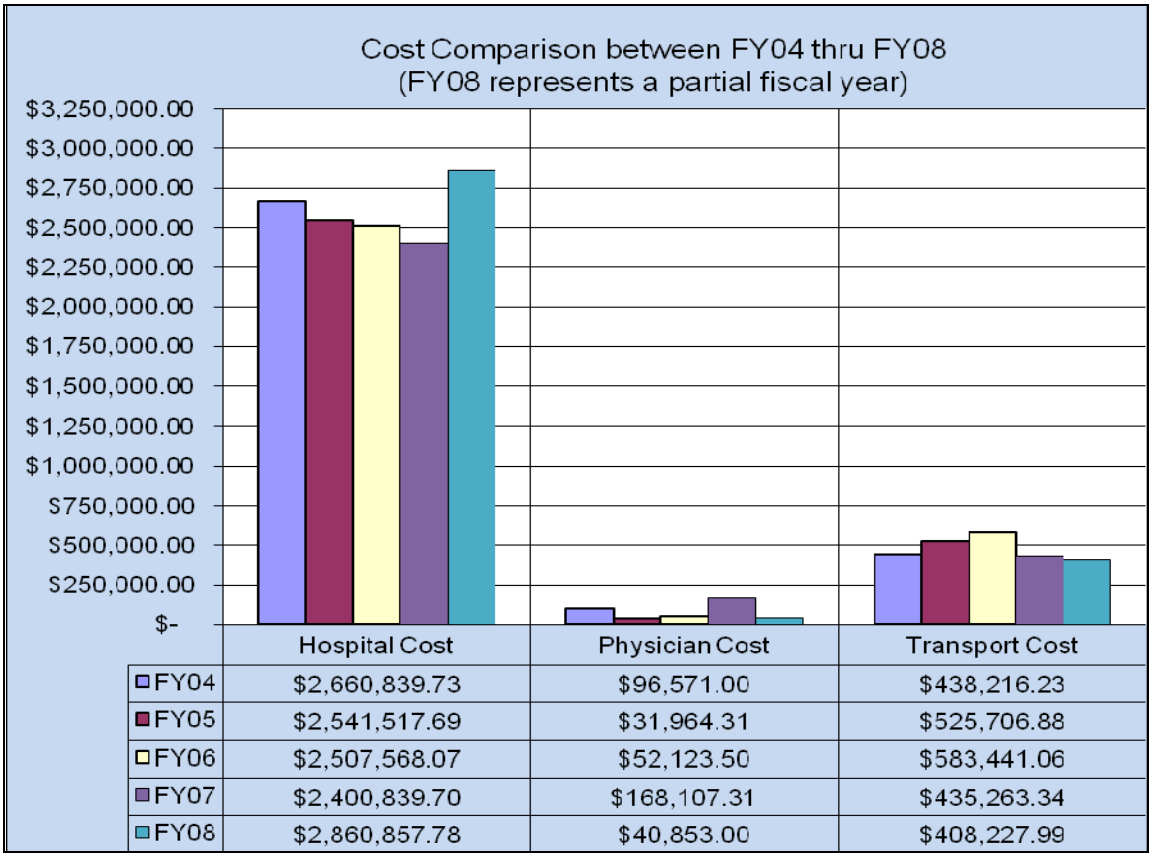
Bring the Kids Home Statistical data is located in the executive Summary Section on pages 62-65.

Designated Evaluation and Treatment (DET) Statistics
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.

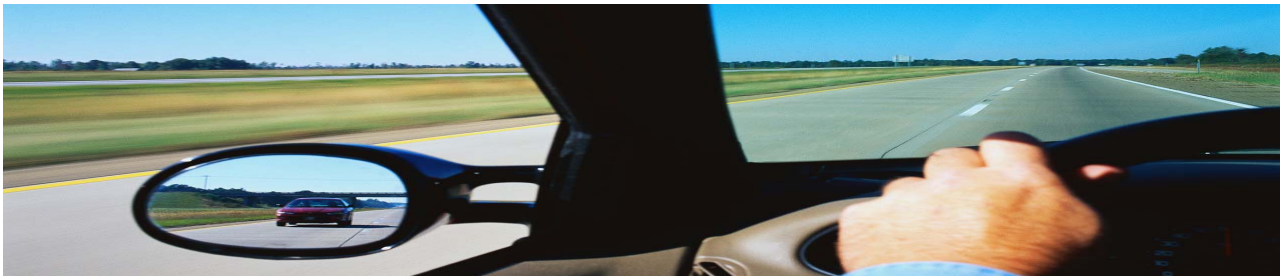
The following charts present the utilization trends for these services in years FY2004-FY2008. During FY08 we have experienced an increase of 17% for the cost of transportation and we anticipate that final FY08 totals will result in a rise to 20%, Hospital Medicaid rates for Acute Psychiatric beds are up 18% in Fairbanks and 31% in Juneau. In FY08 the DET/DES Program served 283 clients who utilized 800 bed days at approved DES/DET facilities, and we paid for 304 transports. The billing remains open for this program for 180 days following the last day in June 2008 so these numbers are likely to grow.



	Hospital Count	Physician Count	Transport Count
FY04	350	294	674
FY05	335	165	657
FY06	276	193	466
FY07	287	237	331
FY08	283	31	304



	Hospital Cost	Physician Cost	Transport Cost
FY04	$2,660,839.73	$96,571.00	$438,216.23
FY05	$2,541,517.69	$31,964.31	$525,706.88
FY06	$2,507,568.07	$52,123.50	$583,441.06
FY07	$2,400,839.70	$168,107.31	$435,263.34
FY08	$2,860,857.78	$40,853.00	$408,227.99



National Comparison Data

Indicator	*API CY 08 2nd Qtr*	*Last Quarter's Comparison to Goal*	*Goal (Annual National Avg.)*	*API CY 07 2nd Qtr*	*API CY 07 3rd Qtr*	*API CY 07 4th Qtr*	*API CY 08 1st Qtr*
Patient Injury Rate	0.00	Nat. Avg.	(0.44)	0.00	0.37	0.42	0.33
Elopement Rate	0.32	Nat. Avg.	(0.38)	0.19	0.18	0.18	0.32
Medication Error Rate	10.01	Nat. Avg.	(2.47)	6.23	7.71	4.27	7.82
Prevalence of COPSD	50.34	Nat. Avg.	(35.53)	49.74	46.71	42.85	47.62
30 Day Re-admit Rate (Discharge Cohort)	10.35	Nat. Avg.	(6.25)	10.19	15.02	17.46	10.11
Patient Seclusion and Restraint							
Hours of Restraint Use	0.17	Nat. Avg.	(0.55)	0.12	0.07	0.01	0.11
% of Patients Restrained	1.25	Nat. Avg.	(4.78)	1.30	0.64	0.25	2.08
Hours of Seclusion Use	0.14	Nat. Avg.	(0.38)	0.27	0.02	0.31	0.12
% of Patients Secluded	1.67	Nat. Avg.	(3.14)	0.66	0.19	1.37	2.08
Patient Discharge Survey		**+/- 5% CI Range**					
Patient Outcome	73.46	(72.39 - 79.05)	(75.29)	69.40	78.33	71.90	69.59
Patient Dignity	72.96	(73.62 - 80.80)	(77.29)	76.30	79.98	79.80	80.61
Patient Rights	50.42	(56.95 - 65.12)	(62.01)	59.28	63.41	60.10	55.65
Patient Participation	68.38	(64.21 - 74.63)	(72.43)	75.54	73.31	73.75	75.84
Hospital Environment	70.76	(61.91 - 71.85)	(68.83)	68.68	78.08	71.89	77.28

9/23/08

Behavioral Health Medicaid Services

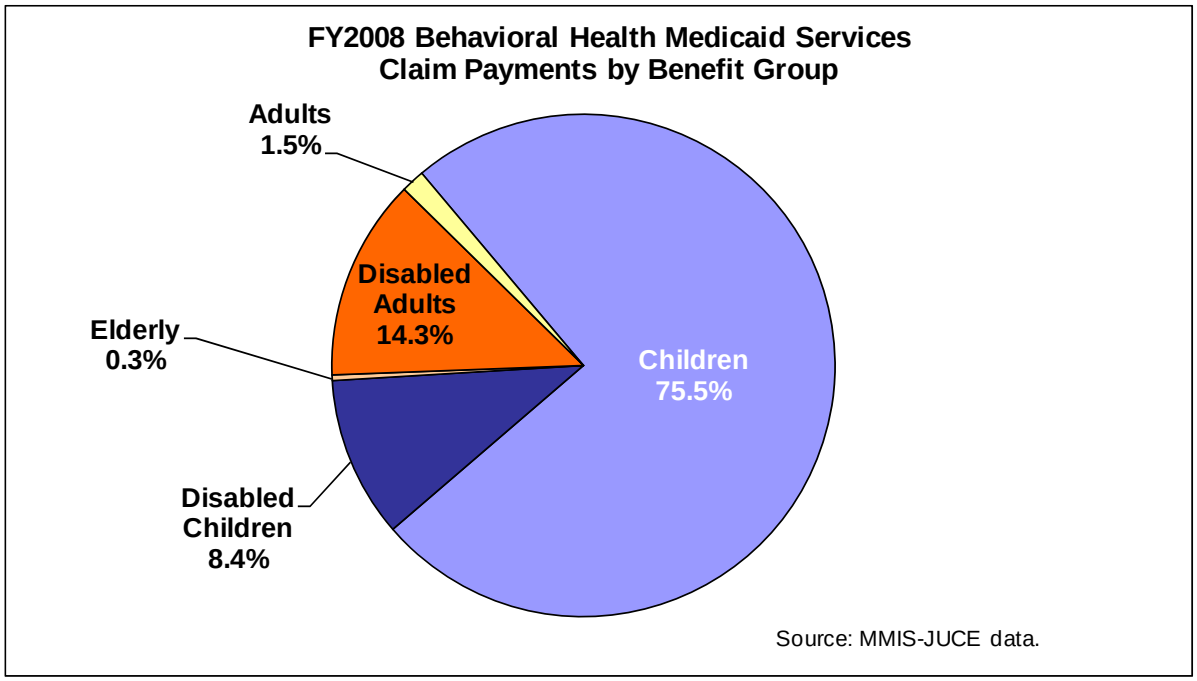
During FY2008 Medicaid funded behavioral and mental health services for 11,800 Alaskans, about 9% of all those enrolled in the Alaska Medicaid program during the year. Most were children or disabled individuals. Residential psychiatric treatment center (RPTC) and inpatient psychiatric hospital Medicaid services are provided primarily to children under age 21 while community mental health Medicaid services are provided to almost as many adults as children.

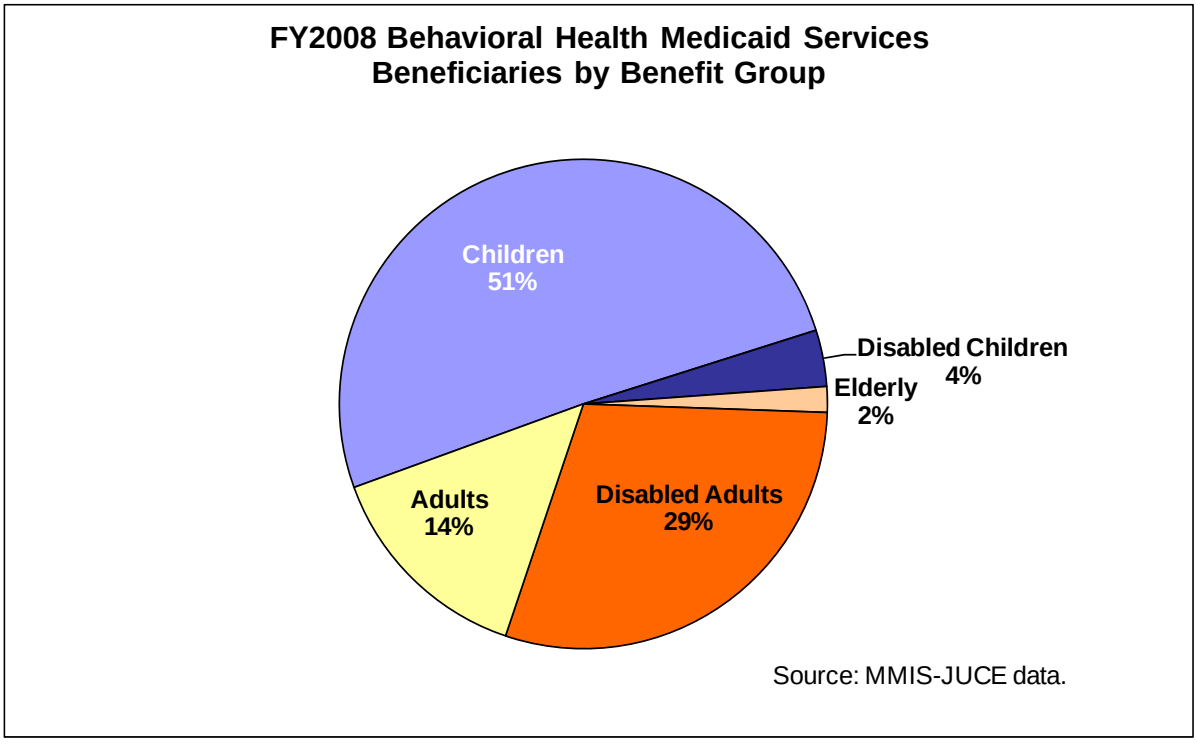
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children	50.7%	6,086	74.8%	$93,914.3	$15,431
Disabled Children	3.7%	449	10.4%	$13,002.7	$28,959
Elderly	1.7%	205	0.4%	$454.6	$2,218
Disabled Adults	29.6%	3,556	13.0%	$16,294.5	$4,582
Adults	14.3%	1,716	1.5%	$1,896.5	$1,105
Unduplicated Annual Clients		**11,767**			
Total Medicaid Claim Payments (thousands)				**$125,562.6**	
Average Annual Medicaid Cost per Beneficiary					**$10,671**

Source: MMIS/JUCE claims paid during FY2008. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
All Behavioral Health Medicaid					
Under 21	55.2%	6,517	86.2%	$108,186.6	$16,601
21 or Older	44.8%	5,299	13.8%	$17,376.0	$3,279
Community Mental Health					
Under age 21	53.6%	6,099	72.3%	$44,364.9	$7,274
21 or Older	46.4%	5,283	27.7%	$16,988.5	$3,216
Inpatient Psychiatric Hospital					
Under 21	87.3%	724	98.5%	$15,519.7	$21,436
21 or Older	12.7%	105	1.5%	$242.9	$2,313
Residential Psychiatric Treatment Centers					
Under 21	99.9%	902	99.7%	$48,302.0	$53,550
21 or Older	0.1%	1	0.3%	$144.6	$144,580

Source: MMIS/JUCE claims paid during FY2008.

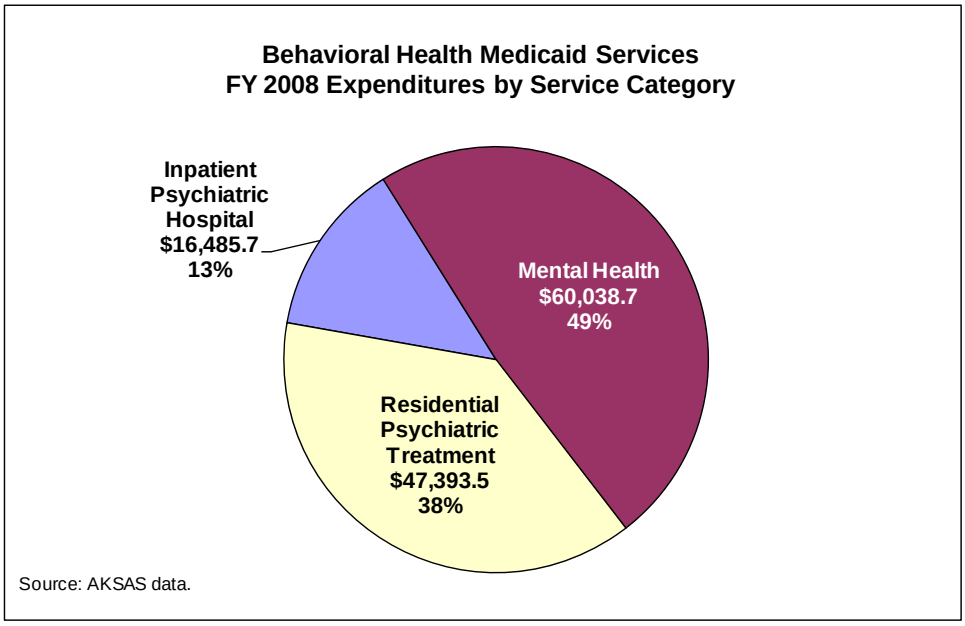


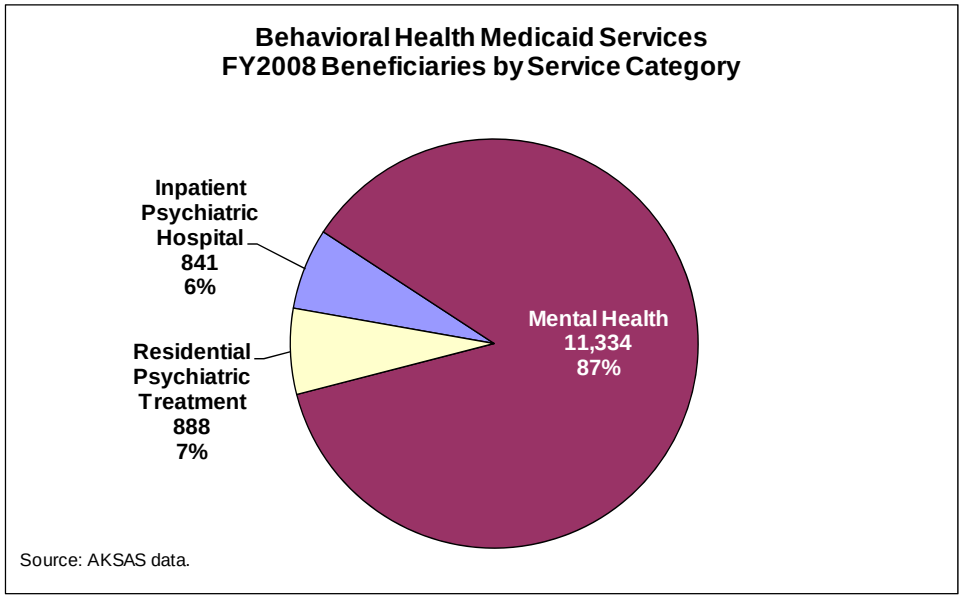


The vast majority of Medicaid clients receiving behavioral health services utilize community mental health services. Community mental health claims comprised about 49% of total Behavioral Health Medicaid costs in FY2008. Inpatient psychiatric hospital and residential psychiatric treatment center (RPTC) claims comprised about 13% and 38% of costs, respectively.

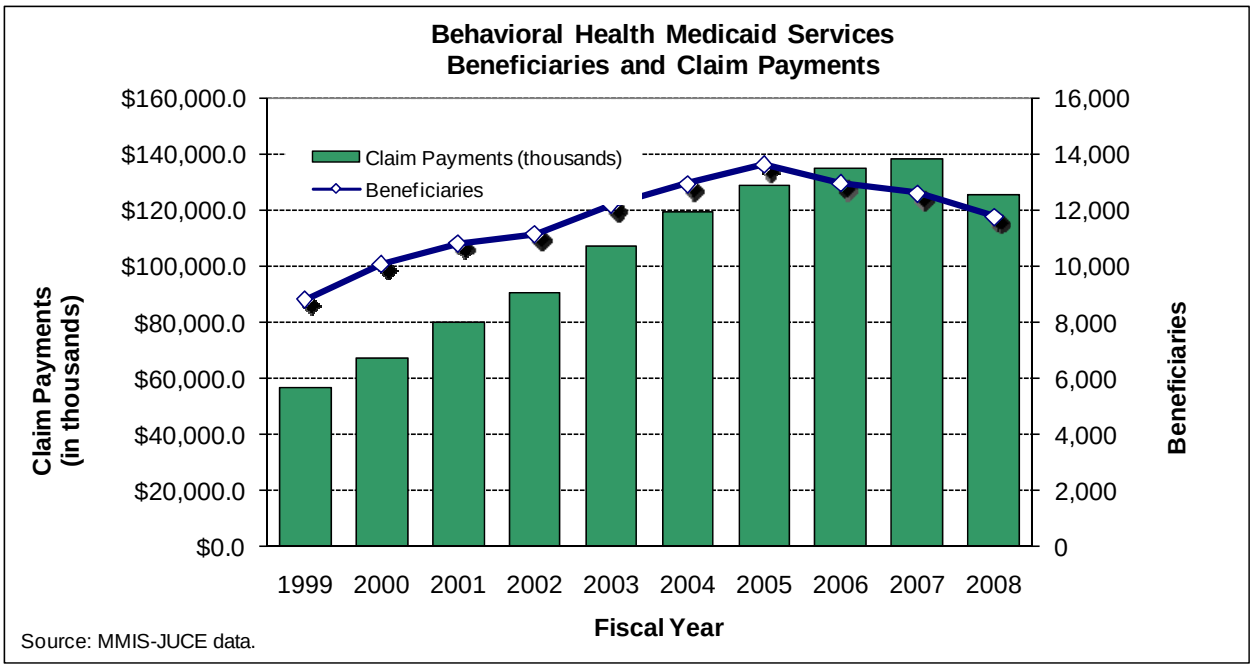
Service Category	Cost per Beneficiary	Percent of Beneficiaries
Inpatient Psych Hospital	$19,600	6.3%
Residential Psych Treatment	$53,700	6.9%
Community Mental Health	$5,400	86.8%
All Behavioral Health Medicaid, cost per recipient per year		$10,700
All Behavioral Health Medicaid, unduplicated annual beneficiaries		11,767

Source: MMIS/JUCE for claims processing duirng fiscal year 2008. Percent of beneficiaries includes individuals receiving services in other categories and will not sum to 100%.

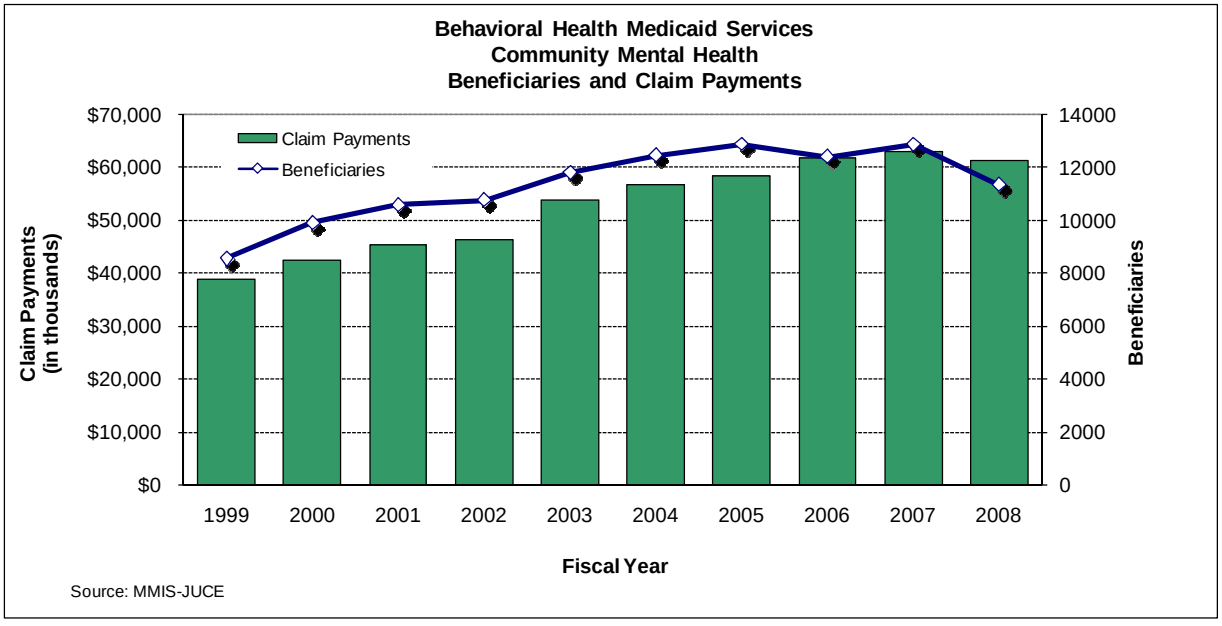




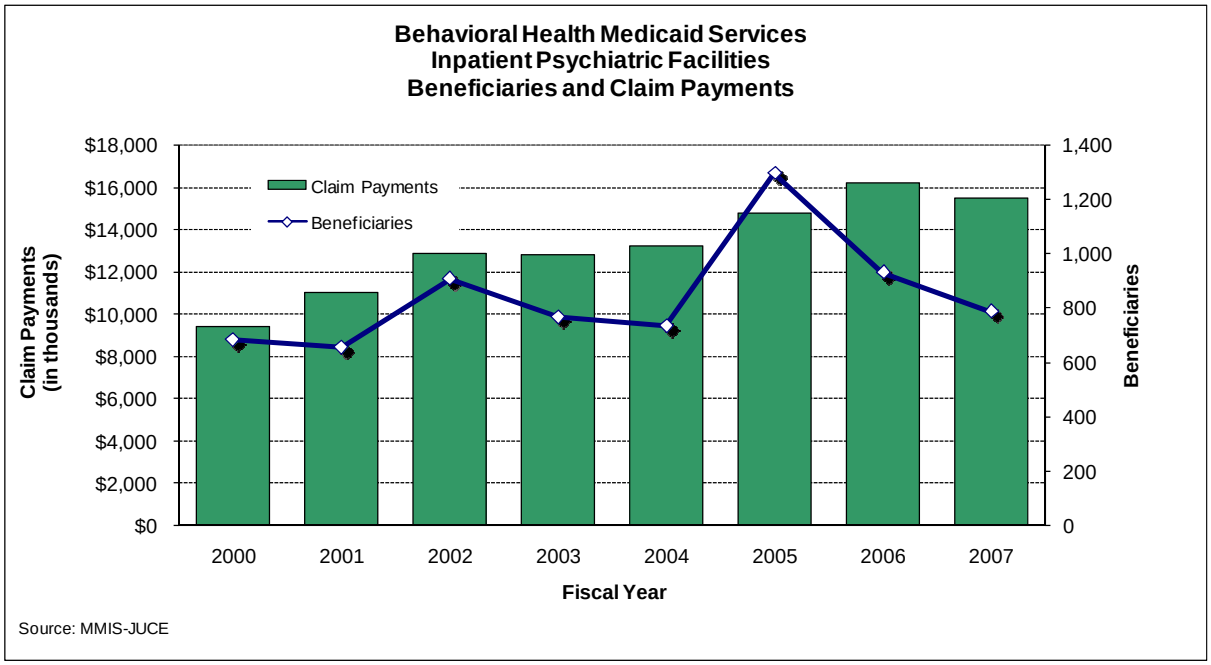
Total claim payments for Behavioral Health Medicaid services in FY08 decreased by 9% from FY2007. The number of persons during FY08 using any Behavioral Health Medicaid service declined by nearly 6% from FY2007 and the average annual cost per beneficiary decreased by 3% to $10,700. The majority of the decrease came from reduced utilization of residential psychiatric treatment center services.



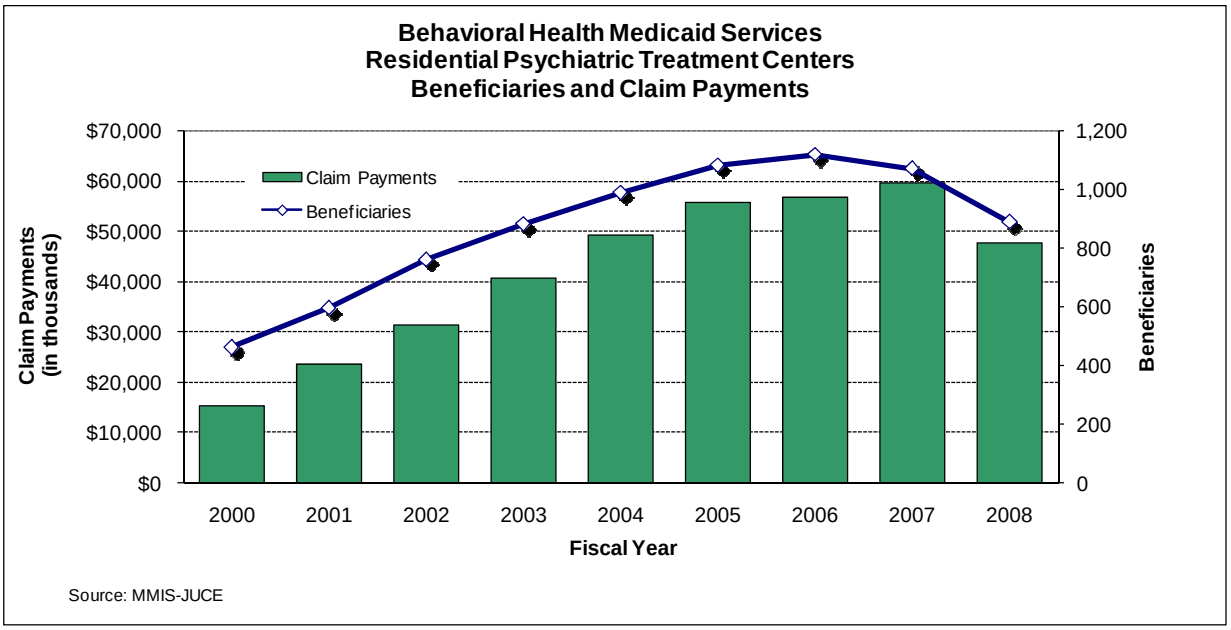
Community mental health Medicaid services saw a decrease in the number of persons using services but the amount of services those persons used increased. Overall, claim payments for community mental health services decreased by $1.7 Million (-3%) between FY2007 and FY2008. The number of beneficiaries using community mental health services at any time during the year decreased by 12%; however, the average annual cost per beneficiary increased by 10% to $5,413.



Inpatient psychiatric hospital services saw an increase in the number of persons using the service but the amount of service used per person decreased. Overall, Medicaid claim payments for inpatient psychiatric services increased by $980 thousand (2%) in FY2008. Although the number of Medicaid beneficiaries utilizing inpatient psychiatric hospital services at some time during the year increased by 4%, the average annual cost per beneficiary decreased by 2% to $19,616.



The number of Medicaid beneficiaries using residential psychiatric treatment center services (RPTC) fell dramatically between FY2007 and FY2008 while the amount of services utilized remained constant. Medicaid claim payments for RPTC decreased $11.3 Million (-19%). The number of Medicaid beneficiaries served in RPTC facilities fell 20% while the average annual cost per beneficiary increased by just 0.4% to $53,730.



SFY 2008 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		**11,767**		**$125,562,600**	**10,671**	**10.0%**	**13.3%**
Gender							
Female	53.2%	6,258	42.4%	$53,191,527	$8,500	9.3%	9.9%
Male	46.8%	5,513	57.6%	$72,371,073	$13,127	10.9%	17.7%
Unknown	0.0%	0	0.0%	$0	$0	0.0%	0.0%
Race							
Alaska Native	34.0%	4,017	40.3%	$50,608,951	$12,599	8.6%	14.5%
American Indian	1.8%	215	1.2%	$1,522,141	$7,080	11.6%	11.3%
Asian	1.7%	198	0.9%	$1,079,146	$5,450	3.1%	2.4%
Pacific Islander	1.0%	122	0.6%	$780,540	$6,398	3.6%	4.0%
Black	5.3%	630	5.2%	$6,538,573	$10,379	10.2%	15.6%
Hispanic	2.4%	281	1.6%	$1,990,819	$7,085	6.7%	9.5%
White	51.7%	6,115	46.2%	$58,046,165	$9,492	13.2%	13.7%
Unknown	2.1%	253	4.0%	$4,996,266	$19,748	7.1%	16.9%
Native	35.9%	4,230	41.5%	$52,131,092	$12,324	8.8%	14.3%
Non-Native	64.1%	7,563	58.5%	$73,431,508	$9,709	10.9%	12.7%
Age							
under 1	0.0%	3	0.0%	$18,031	$6,010	0.0%	0.0%
1 through 12	23.7%	2,904	27.7%	$34,832,010	$11,994	6.3%	24.8%
13 through 18	29.2%	3,574	57.3%	$71,963,116	$20,135	16.8%	47.6%
19 through 20	2.6%	315	1.1%	$1,373,455	$4,360	7.6%	5.6%
21 through 30	10.8%	1,323	3.1%	$3,852,703	$2,912	10.0%	3.7%
31 through 54	26.1%	3,193	8.3%	$10,462,782	$3,277	17.9%	5.1%
55 through 64	5.4%	662	1.8%	$2,201,119	$3,325	13.5%	2.7%
65 through 84	2.1%	253	0.7%	$856,185	$3,384	3.5%	0.7%
85 or older	0.2%	26	0.0%	$3,200	$123	2.0%	0.0%
Benefit Group							
Children	50.7%	6,086	74.8%	$93,914,338	$15,431	8.2%	29.0%
Adults	14.3%	1,716	1.5%	$1,896,463	$1,105	7.9%	1.7%
Disabled Children	3.7%	449	10.4%	$13,002,689	$28,959	20.6%	22.8%
Disabled Adults	29.6%	3,556	13.0%	$16,294,475	$4,582	24.1%	5.3%
Elderly	1.7%	205	0.4%	$454,635	$2,218	2.8%	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 2008. Service may have been incurred in a prior year. Grouping is based on status on the date the benefit was obtained. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories). Some duplications may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2008. . If they obtained dental services in December, they would also be included in the 13 through 18 age subgroup count if the claim was subsequently paid during SFY08.

Because recipients were unduplicated across divisions to obtain the department total, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all 4 divisions may exceed 100%.

Source: MMIS/JUCE.

AS 08.86.010 - 230	Psychologists and Psychological Associates
AS 08.68.010 - 410	Nursing
AS 08.64.010 - 380	State Medical Board
AS 08.95.010 - 990	Clinical Social Workers
AS 08.84.010 - 190	Physical Therapists and Occupational Therapists
AS 12.47.010 - 130	Insanity and Competency to Stand Trial
AS 18.20	Regulation of Hospitals
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 44.29.300-390	DHSS, Statewide Suicide Prevention Council
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 47.30.655 - 915	State Mental Health Policy (Hospitalization of Clients)
AS 47.37	Uniform Alcoholism & Intoxication Treatment Act

7 AAC 29	Uniform Alcoholism & Intoxication Treatment Act
7 AAC 32	Depressant, Hallucinogenic, and Stimulant Drugs
7 AAC 33	Methadone Programs
7 AAC 43	Medicaid
7 AAC 71.010 - 300	Community Mental Health Services
7 AAC 72.010 - 900	Civil Commitments
7 AAC 78	Grant Programs
7 AAC 81	Grant Programs
7 AAC 100	Medicaid Assistance Eligibility

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

PL 102-321	Community Mental Health Services

Code of Federal Regulations: 42 CFR Part 400 to End

Behavioral Health	2009	2010 Gov	09 to 10 Change
General Funds	130,063.5	136,935.1	6,871.6
Federal Funds	110,501.5	94,293.1	-16,208.4
Other Funds	45,302.0	46,725.3	1,423.3
Total	285,867.0	277,953.5	-7,913.5

Alaska Fetal Alcohol Syndrome Program

Increased Grantee Costs: *$59.5 GF*
Department of Health and Social Services, Division of Behavioral Health recommends an annual increase for grant programs providing prevention and treatment services to vulnerable Alaskans with substance abuse problems. Without an increase to offset the effects of inflation, grantee agencies will be unable to hire competitively and the availability of core services will be curtailed.

Alcohol Safety Action Program (ASAP)

Maintain and Enhance Therapeutic Courts: *$653.0 GF*
In FY2009, staffs that provide direct support to the therapeutic courts are funded with grant dollars through the National Highway Traffic Safety Administration. This funding is time-limited, and does not cover the true administrative support costs associated with each of the individual courts. In order to continue the current level of direct ASAP support to the participants in the nine therapeutic courts located throughout the state, the division is requesting a budget increment of $653.0 for FY2010.

Behavioral Health Medicaid Services

The Medicaid budget is based on projections of the number of eligible Alaskans who will access Medicaid funded services, estimates of the quantity of services that may be used and the anticipated changes in the costs of those services. The department uses both long-term and short-term forecasting models to project Medicaid spending. The short-term model is best for budget development and fiscal note analysis while the long-term model is best for strategic planning.

The change over a long period is generally smoother and more gradual than the annual fluctuations experienced in the short term. Since the budget preparation cycle requires projections up to 24 months in the future, often before recent policies have been fully implemented and reflected in the baseline spending data, it is premature to know if recent changes in spending are temporary or will last.

The department's recent success in avoiding some costs and in containing growth rates in the short term has resulted in existing authorization being briefly ahead of the trend. The department has adjusted its authorization to reflect current trends and reduced excess authorization to reestablish a revised authorization base from which to begin FY10. This revised base becomes the foundation for the Medicaid formula growth increment and fund change for federal financial participation.

Behavioral Health Medicaid Services	Total	GF	Federal	Other
SFY 2009 Existing Authorized	**172,412.3**	**70,823.8**	**99,188.5**	**2,400.0**
Adjust Authorization for Current Trends	(8,327.9)	(3,800.0)	(4,527.9)	0.0
Reduce Excess Federal Authorization	(15,472.1)	0.0	(15,472.1)	0.0
SFY 2010 Revised Authorization Base	**148,612.3**	**67,023.8**	**79,188.5**	**2,400.0**
Change in Federal Financial Participation	0.0	(252.5)	252.5	0.0
Formula Growth	5,852.5	2,670.5	3,182.0	0.0
Total	**142,759.8**	**64,605.8**	**75,754.0**	**2,400.0**

Medicaid Program - Adjust Authorization for Current Trends: *($8327.9) Total- ($3,800.0) GF/MH, ($4,527.9) Fed*

One in five Alaskans is enrolled in Medicaid in any given year. In an average week, 25,500 Alaskans receive some level of medical care that costs the Medicaid program $17-25 million for benefit payments made to 2,100 health care providers. Medicaid services are funded through both state general funds and federal matching funds. There must be sufficient state general funds available in order to maximize utilization of federal funds. Good business practice requires the department to maintain adequate funding to ensure that timely payments can be made to service providers.

The Legislature has requested that departments minimize supplemental budget requests through careful budget projections. The department uses both long-term and short-term forecasting models to project Medicaid spending. The long-term trend indicates annual increases in costs driven by inflation and population changes. Short term projections are influenced mainly by enrollment and utilization of services. The change over a long period is generally smoother and more gradual than the annual fluctuations experienced in the short term.

The department has implemented reforms in Medicaid aimed at improving Medicaid sustainability. For example, the department has been successful in avoiding some costs and in containing growth rates that can result in authorization being briefly ahead of the trend. The department can adjust its authorization this year to reflect current trends by reducing the Behavioral Health Medicaid Services component budget by $8.3 million ($3.8 million in state general funds, and $4.5 million in federal Medicaid revenue). This will leave a sufficient amount of funding to continue services at the current level.

Medicaid Program-Formula Growth: *$5,852.5 Total- $2,670.5 GF/MH, $3,182.0 Fed*

This increment is necessary to maintain the current level of behavioral health services in Medicaid for nearly 12,000 Alaskans with serious behavioral health problems, about 10% of all those enrolled in the Alaska Medicaid program during the year.

The Behavioral Health Medicaid Services component funds three types of services: inpatient psychiatric hospitals, residential psychiatric treatment centers, and outpatient behavioral health services. These programs support the department's mission to manage health care for eligible Alaskans in need. Providing behavioral health services through Medicaid improves and enhances the quality of life for Alaskans with serious behavioral health problems. Behavioral Health Medicaid services are also a major component of the department's Bring the Kids Home initiative.

For FY2010, Behavioral Health Medicaid costs are projected to grow 6% from FY2009. Claim payments will rebound from the 9% drop seen between 2007 and 2008, returning to a slightly higher

level than 2007. Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget.

In recent years, the department has implemented Medicaid reforms aimed at improving Medicaid sustainability. Cost containment efforts begun in FY2004 have successfully reduced the rate of growth from the high of 19.1% for 2001 to -9% for 2008. In particular, the Bring the Kids Home initiative reduced utilization of residential psychiatric treatment centers by 19% from 2007 to 2008. Additional capacity expected on completion of new facilities and increases in provider reimbursement approved by the 2008 Legislature will contribute to the approximately 6% increase in costs forecast for FY2010.

Projections for formula growth are based on historical trends in enrollment, utilization, provider reimbursement, and federal financial participation. Projections include recently adopted policy changes that are not yet reflected in the trends, e.g. provider rate increases effective in 2009. However, the formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP).

Behavioral Health Grants

MH Trust: AMHB – Grants for Community Behavioral Health Services: *$1,750.0 GF/MH*
Department of Health and Social Services, Division of Behavioral Health and the Mental Health Trust have identified a core group of adults with severe co-occurring disorders who are especially hard to serve and to house. These consumers require much more intensive services than 90% of their peers, just to keep them out of API, jail, and the shelters. The current level of community mental health center grant and Medicaid funding cannot adequately provide the intensive level of service this population needs; this increment will purchase additional intensive individualized services such as nursing care, 24/hour case manager support, daily medication administration, residential dual diagnosis treatment, and transport to services. At least 107 individuals can be served and expected outcomes for this program include: decreased utilization of hospital emergency rooms, jails, and Alaska Psychiatric Institute (API), as well as increased consumer ability to function in the community and the workplace.

MH Trust: ABADA – Grants for Community Based Substance Abuse Services: *$1,750.0 GF/MH*
Preventing and treating substance abuse is a Department of Health and Social Services priority for FY2010. Department of Health and Social Services, Division of Behavioral Health received an increase in base funding for substance abuse treatment in FY2009, which helped defray rapidly increasing costs. Additional funding in FY2010 will allow Department of Health and Social Services, Division of Behavioral Health to bring the continuum of care closer to meeting the actual demand; faster access to treatment services will reduce the impact of substance abuse disorders on the State's Court system, correctional facilities, hospital emergency rooms, and homeless shelters.

Currently, the continuum of care for substance abuse disorders remains unable to respond to the high demand from the public and Courts for accessible substance abuse treatment services. The State's largest treatment centers all have waiting lists of one to three months. Of particular concern are pregnant women with substance abuse disorders; some centers in Alaska simply cannot find room to accept women on demand.

MH Trust: Expand Treatment Capacity Therapeutic Court Participants with Co-Occurring Disorders: *$150.0 Total- $75.0 GF, $75.0 MHTAAR*

This project will continue providing essential co-occurring assessment and treatment services for participants in the Palmer Mental Health Court. The treatment allows an individual to address the underlying mental health and substance abuse issues that contribute to their contact with the criminal justice system. This project has been funded since FY2007 with $150.0 MHTAAR.

Fairbanks Behavioral Health Enhanced Detox Facility: *$500.0 GF/MH*
Fairbanks is one of only five communities in the state with capacity to provide detoxification services for persons withdrawing from alcohol and drugs; this facility will serve not only Fairbanks, but also the Interior and Northern regions. The requested increment will close the funding gap for the new Detox facility, scheduled to open in January 2009. As a result of this program, Department of Health and Social Services, Division of Behavioral Health expects a dramatic reduction in the number of incapacitated individuals inappropriately (and expensively) held in jails and emergency rooms. Additionally, this project will ensure that Department of Health and Social Services, Division of Behavioral Health meets its statutory responsibility to establish a comprehensive and coordinated continuum of care for alcoholics, intoxicated persons, and drug abusers (AS 47.37.130).

Increased Grantee Costs: *$419.2 GF*
Department of Health and Social Services, Division of Behavioral Health recommends an annual increase for grant programs providing prevention and treatment services to vulnerable Alaskans with substance abuse problems. Without an increase to offset the effects of inflation, grantee agencies will be unable to hire competitively and the availability of core services will be curtailed.

Behavioral Health Administration

Increment for AKAIMS Dedicated Information Technology Staff: *$150.0 GF/MH*
In FY2009, the Division of Behavioral Health received $150.0 MHTAAR as a one-time increment for two AKAIMS dedicated information technology staff. With those funds, the division entered into a Reimbursable Services Agreement with Finance & Management Services for two IT positions that are dedicated to working on AKAIMS programming. The Trust is not requesting additional funding in FY2010. This increment will insure that the minimum staffing requirements are in place for ongoing functionality and usability of the AKAIMS system.

Community Action Prevention & Intervention Grants

Increased Grantee Costs: *$89.1 GF/MH*
Department of Health and Social Services, Division of Behavioral Health recommends an annual increase for grant programs providing prevention and treatment services to vulnerable Alaskans with substance abuse problems. Without an increase to offset the effects of inflation, grantee agencies will be unable to hire competitively and the availability of core services will be curtailed.

Rural Services and Suicide Prevention

Increased Grantee Costs: *$20.5 GF/MH*
Department of Health and Social Services, Division of Behavioral Health recommends an annual increase for grant programs providing prevention and treatment services to vulnerable Alaskans with substance abuse problems. Without an increase to offset the effects of inflation, grantee agencies will be unable to hire competitively and the availability of core services will be curtailed.

Services for the Seriously Mentally Ill

MH Trust: Peer Operated Support Services: *$50.0 GF/M,*
This 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.

Community Mental Health Services Pilot for Department of Corrections: *$500.0 GF/MH*
This increment provides funding to expand an existing community program to add treatment, housing and supportive services for mentally ill adults leaving jail. Funding will provide rental subsidies in order to bridge from Alaska Department of Corrections discharge into the HUD Housing Choice voucher program. A grantee agency will provide intensive, on-site support services and living skills development for participants. For inmates prior to release, this funding will bring mental health services into the jails to provide pre-release planning and linkages with community services. A 2007 study showed that 42% of prisoners in Alaska were Mental Health trust beneficiaries, making the Department of Corrections a "default" provider of mental health services, at great expense. This program will result in a lower rate of re-arrest and incarceration for 50 adults leaving jail, by keeping them stable and productive in the community.

Designated Evaluation and Treatment

MH Trust Request Increase Funding for Designated Evaluation Treatment (DET) Services: ***$****1,250.0 Total- $950.0 GF/MH and $300.0 MHTAAR*
Alaska Statute 47 requires that the Division of Behavioral Health respond to psychiatric emergencies statewide, providing transportation, evaluation, and hospitalization for individuals at imminent risk of harming themselves or others, or gravely disabled by mental illness. Demands for this service have risen dramatically: in FY2008 costs rose 17%; in FY2009 an additional 20% increase is projected. This increment requests $1,250.0 to meet the costs of the DET program.

Services for Severely Emotionally Disturbed Youth

MH Trust BTKH Transitional Aged Youth: *$500.0 Total- $200.0 GF/MH and $300.0 MHTAAR*
This funding will start up and sustain community-based capacity for transitional aged youth to move into adulthood with age appropriate services ensuring productive work or educational activities. The goal of this increment is to target youth who are vulnerable to moving into adult systems such as adult justice, emergency mental health or substance abuse, early pregnancy or hospital based services. This increment will particularly target those youth with few or no family supports. It will seek to coordinate existing service systems and help youth access existing resources whenever possible and will fill service gaps when necessary to bridge the transition from child services to adulthood.

MH Trust BTKH Tribal/Rural System Development: *$800.0 Total- $400.0 GF/MH and $400.0 MHTAAR*
Funding will assist in establishing SED children's services in rural areas. Almost 40% of youth experiencing serious emotional disturbance (SED) in Residential Psychiatric Treatment Centers (RPTC) out of state are Alaska Native. This funding will develop services, improve funding mechanisms such as Medicaid at 100% FMAP and develop strategies specific to tribal systems.

MH Trust BTKH Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training: *$1,350.0 Total- $1,100.0 GF/MH and $250.0 MHTAAR*
Funding expands multiple grants to community behavioral health centers to enhance outpatient services with innovative programs and training to reduce the need for residential level services for youth experiencing serious emotional disturbance (SED). This increase I outpatient care assists in dealing with youth at the home and community-based level and avoids utilizing costly residential care.

MH Trust BTKH Individualized Services: *$500.0 GF/MH*
Bring the Kids Home (BTKH) Individualized Services project will continue funding for additional care for youth experiencing serious emotional 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.

Alaska Psychiatric Institute (API)

Increase SDPR for Telepsychiatry: $200.0 SDPR
This increment would provide additional Statutory Designated Program Receipts to fund psychiatric services that staff the TeleBehavioral Health Program. Approximately 40% of admissions to the Alaska Psychiatric Institute (API) come from rural areas; with an average of 1300 annual admissions per year, this amounts to 520 admissions from rural areas. By increasing access to psychiatric evaluation and medication management services via telepsychiatry, it is determined that over a three year period, API will demonstrate a decrease in the referral rate for involuntary admission to API.

The Division of Behavioral Health will be requesting the following capital funding:

- Behavioral Health Data Sharing Partnership - $434.2 GF, $25.5 Federal
- MH Continuing Bring the Kids Home Initiative Denali Match - $2,200 (GF)

Behavioral Health Data Sharing Partnership *- $459.70 Total- $434.2 GF, $25.5 Fed*
This project will fund a variety of software upgrades and enhancements to existing programs that will allow for shared use among internal and external agencies. The Division of Behavioral Health, working with the Department of Corrections and the Court System, will be able to capture data across various settings and identify need, rate of referral and access to the treatment system, and measure outcomes of services to people who traditionally end up in the legal system.

MH Continuing Bring the Kids Home Initiative Denali Match *- $2,200.0 Other*
This request will provide funding for construction and equipment grants for residential treatment alternatives for severely emotionally disturbed (SED) youth that support the Department's Bring the Kids Home initiative. The Denali Commission has contributed more than $2.3 million for this program. The Denali Commission funds require a 50% cost share match for all construction costs. This request will provide the required matching funds.

Challenges

As the Division of Behavioral Health (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 – several major challenges face its leadership and staff. 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) Effective and efficient management and administration; and (3) The Alaska Psychiatric Institute.

Accessible, Effective and Efficient Continuum of Behavioral Health Services

Sustained Need for Increased Grant Support: The landscape for behavioral health service delivery continues to be challenging to Alaska behavioral health service providers. Service providers must adapt to the changing environment that includes audits and potential "paybacks", which require them to adopt more formalized "risk management" practices in their respective business processes. These changes lead to a costly administrative burden and divert resources from actual service delivery. The grant increases which have been included in the FY2009 budget has helped the targeted agencies to plan for their financial stability. With the implementation of a rate increase for Medicaid services which we will implement December 26, 2008, some of the increased costs based on inflation and the efforts to meet basic risk management requirements will continue. The prevention, early intervention and treatment services continuum is still fragile and at risk. Ongoing funding to support the true cost of service delivery is critical.

Capacity Expansion: We continue to seek alternatives for expanding the treatment capacity for both adults and children within Alaska. All of them are focused on maintaining individuals in (or near) their home community with appropriate services to treat their needs.

For Seriously Mentally Ill (SMI) adults, this is an issue for individuals leaving the correctional system or being discharged from API. They need housing, case management, treatment and medication management services in the community once they leave the more structured settings and providers are struggling to keep pace with the demand for services.

For Seriously Emotionally Disturbed (SED) children, this is an issue for children who may be returning from out-of-state placement, or who require wrap-around services to maintain them in the community. The children need access to a flexible, wrap-around, family driven service array that works in tandem with the school system to maintain them safely—that may not always be available in their home community.

For Substance Use Disorder (SUD) adults and children, this may require intensive out-patient services to keep them outside of the correctional system or to help them maintain custody of their children. The service providers need access to a fuller array of reimbursable services in order to succeed with these clients.

Decrease in Stable Workforce without Budget Increases. The entire state of Alaska is designated as a mental health professional shortage area. An Alaska Center for Rural Health workforce 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% reflecting 1,033 positions. Ongoing funding is needed to address and support the true cost of professional staff providing service delivery.

Effective and Efficient Management and Administration

New Business Practices, Performance Based Funding and AKAIMS: The Division of 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 infusion of new resources for the development, maintenance and support of AKAIMS will assist the Division to meet its goals of new business practice and performance based funding.

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, involving a partnership with Division of 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 State Legislature.

Behavioral Health Integration Project: In October of 2003, Alaska was among several states to receive a Co-occurring State Incentive Grant (COSIG) funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) to address a growing body of research documenting the high prevalence and costs of co-occurring disorders and the barriers to meeting the needs of client in fragmented systems of care. The COSIG funding mechanism was intended to help states build capacity and infrastructure to support national goals of improved screening, assessment, treatment, training and information sharing. To that end, the state of Alaksa adopted the use of the Comprehensive, Continuous, Integrated, System of Care model of Minkoff and Cline. This is a "principle based" model that when implemented build a treatment system that is:

- Welcoming
- Accessible
- Integrated
- Comprehensive
- Continuous

Integration has resulted in the merger of two separate mental health and substance abuse divisions were merged into the Division of Behavioral Health. Internally, we have restructured staff roles, functions, and responsibilities to align with integration. Externally, we have integrated financing through comprehensive service grants to providers. We still hope to complete the *Integrated Behavioral Health Medicaid and Community Behavioral Health Service* regulations for implementation July 1, 2009.

The Alaska Psychiatric Institute

Workforce Challenges: Alaska Psychiatric Institute (API) faces a number of challenges with recruitment and retention for psychiatry, registered nurses and mid-level practitioners. Wage and salary adjustments for nursing positions to market based competition have been established, but workforce 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 psychiatry 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.

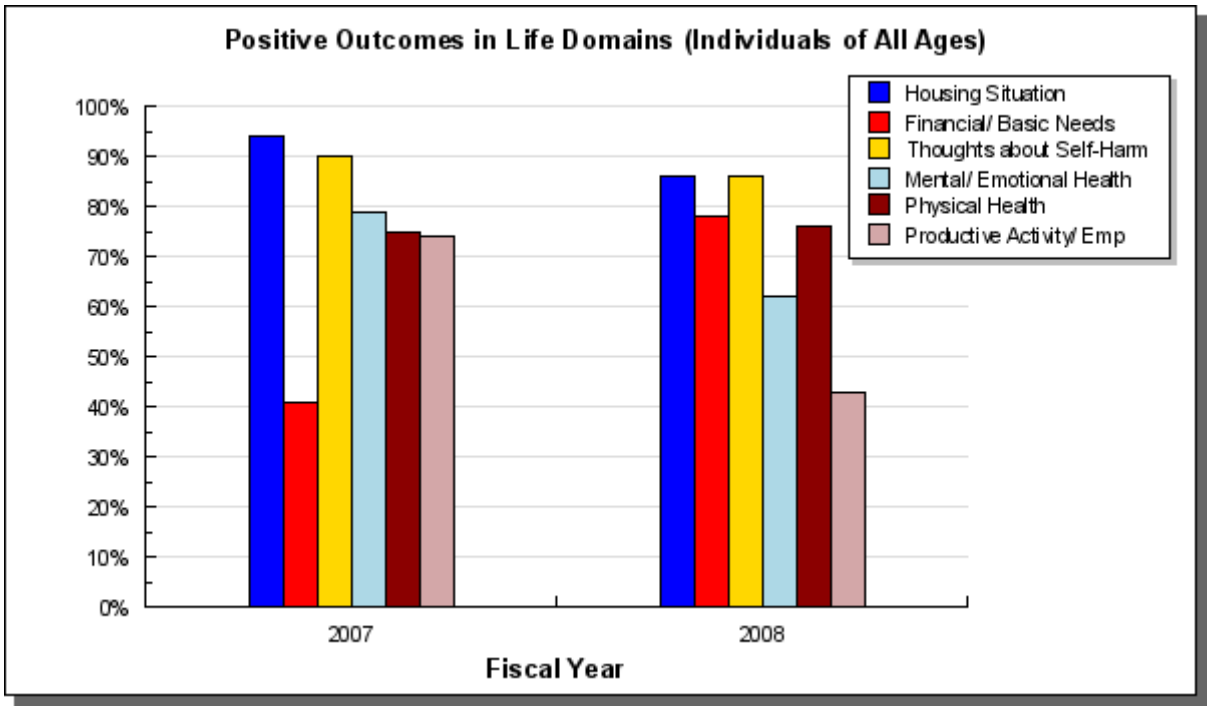
Contribution to Department's Mission

The mission of the Division of Behavioral Health is to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.

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

Target #1: For six life domains (housing, financial/basic needs, thoughts about self-harm, mental/emotional health, physical health, and productive activity/employment), 75% of individuals will report improvement or maintaining condition within four specified domains

Status #1: In FY2008, for four life domains (housing situation, financial/basic needs, thoughts about self harm, and physical health), more than 75% of individuals reported improvement or maintaining condition within the specified domain. In two life domains (mental/emotional health and productive activity/employment), less than 75% of individuals reported improvement or maintaining condition within the specified domain.



Methodology: Clients complete a Client Status Review (CSR) form when entering treatment, periodically throughout treatment, and at time of discharge. A client's status of "improvement or maintaining condition" is determined based on comparing CSR scores from the most recent CSR to the intake CSR. Note: Data for both FY07 and FY08 are incomplete - see "Analysis of results and challenges."

Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Housing Situation	Financial/ Basic Needs	Thoughts about Self-Harm	Mental/ Emotional Health	Physical Health	Productive Activity/ Emp
FY 2008	86%	78%	86%	62%	76%	43%
FY 2007	94%	41%	90%	79%	75%	74%

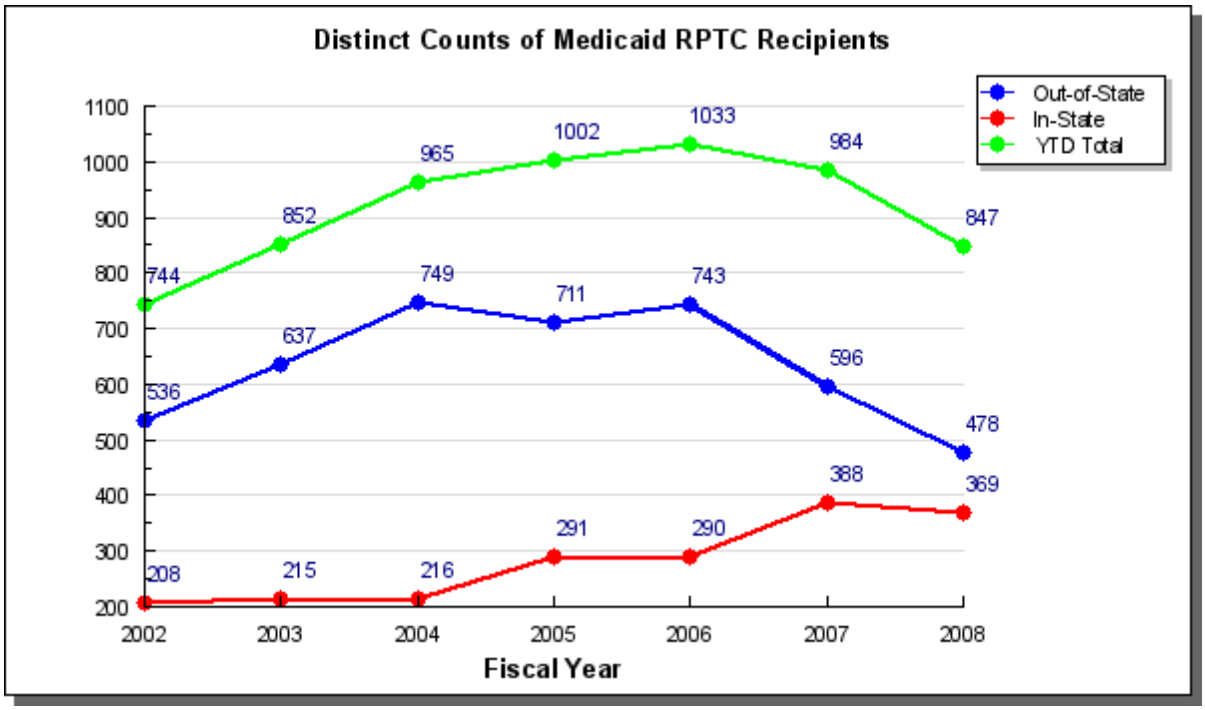
Analysis of results and challenges: In FY08, for four life domains (housing situation, financial/basic needs, thoughts about self harm, and physical health), more than 75% of individuals reported improvement or maintaining condition within the specified domain. In two life domains (mental/emotional health and productive activity/employment), less than 75% of individuals reported improvement or maintaining condition within the specified domain.

Due to differences in data collection methodologies and data completeness between FY07 and FY08, comparisons between years have limitations. The Division is transitioning from a paper record system to an electronic health record system. FY2007 was a peak transition year when some agencies reported CSR data using a paper record system and other agencies used the Alaska Automated Information Management System (AKAIMS) electronic health records system. Combining records from both systems was a challenge and resulted in an incomplete FY2007 data set. Although the FY2008 CSR data includes data only through the third quarter, it is considered to be more complete than the FY2007 data. The Division intends to use the FY08 data as a baseline for future measurement. As DBH moves forward with transitioning to the AKAIMS electronic health records system, we anticipate more accurate and complete electronic health records from participating agencies.

Refinements to the AKAIMS CSR reporting procedures also are being explored. The life domain analyses do not take into account the length of time that a client may have been in services. Clients receiving services over a long period of time are compared to those who may have just been admitted into services. AKAIMS reporting processes that account for duration of services is one of several refinements being explored.

A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children experiencing a serious emotional disturbance through treatment services that meet their clinical needs close to their home communities.

Target #1: Reduce the number of children in out-of-state placement by 10% each year.
Status #1: Preliminary data indicates that from FY2007 to FY2008 there was a decrease of 18% in the number of distinct out-of-state residential psychiatric treatment center (RPTC) recipients served.



Methodology: Data appears in the "DHSS BTKH Annual Report 07" (see link below), as provided by the Division of Behavioral Health, Policy and Planning Unit using MMIS-JUCE extracts. Data represents an unduplicated count of RPTC beneficiaries. This graph will be updated with the FY08 data once the DHSS BTKH FY08 Report is complete.

Distinct Counts of Medicaid RPTC Recipients

Fiscal Year	Out-of-State	In-State	YTD Total
FY 2008	478	369	847
FY 2007	596	388	984
FY 2006	743	290	1033
FY 2005	711	291	1002
FY 2004	749	216	965
FY 2003	637	215	852
FY 2002	536	208	744

Analysis of results and challenges: This measure will be updated with the 2008 data when the "DHSS BTKH Annual Report 08" is complete. However, preliminary data indicates that from FY2007 to FY2008, there was a decrease of about 18% in the number of distinct out-of-state RPTC recipient served. The "Distinct Counts of Medicaid RPTC Recipients" graph below will be updated with the final FY2008 numbers as soon as they are available.

Between FY2006 and FY2007:

- There was a decrease of 19.8% in the number of distinct out-of-state RPTC recipients served.
- There was an increase of 33.8% in the number of distinct RPTC recipients who received services in-state. This reflects increased bed capacity and utilization.
- There was a decrease of 4.8% total RPTC recipients served.

Between FY2004 and FY2005: the number of children receiving out-of-state RPTC care decreased 5.1% from 749 to 711.

Between FY1998 and FY2004: the unduplicated number of youth experiencing serious emotional disorders receiving out-of-state RPTC care steadily increased - on average 46.7% per year. The RPTC population treated in Alaska and outside the state also showed steady increase from FY98-04, an average annual increase of 24.8%.

The Bring the Kids Home (BTKH) Project was initiated during FY2004. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Alaska Mental Health Trust Authority. Positive changes are apparent.

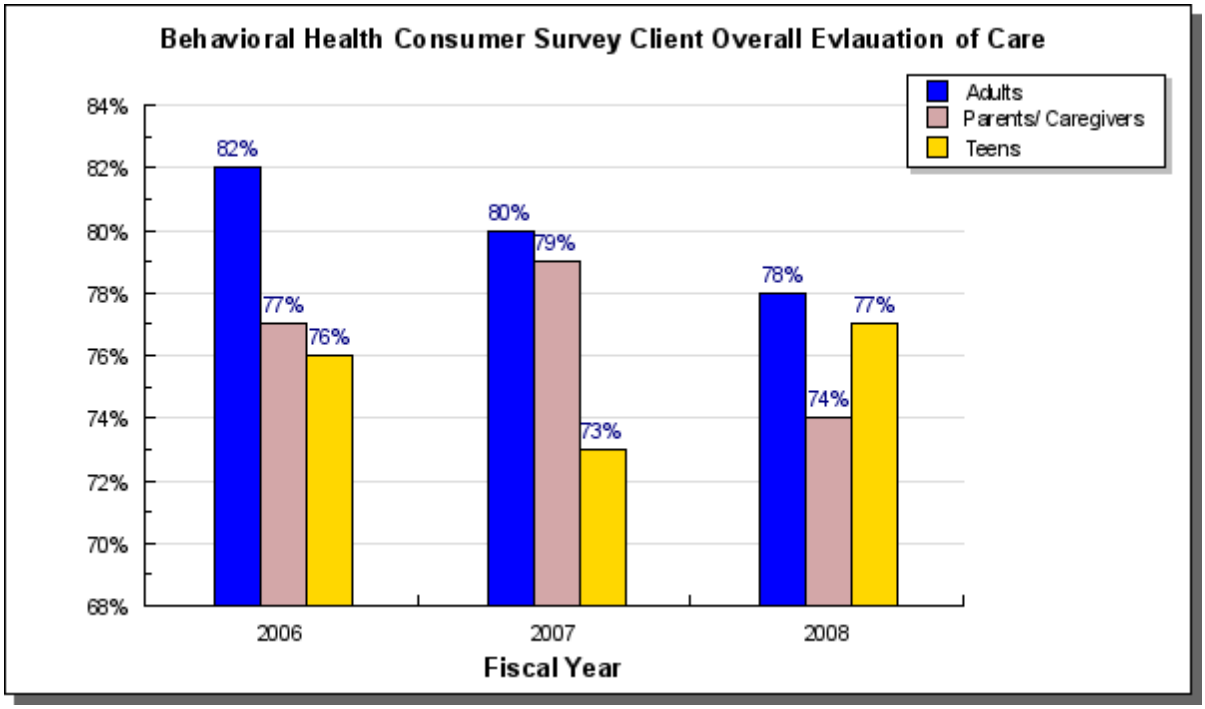
AS47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has developed and implemented "diversion" activities, including aggressive case management services that discharge and 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 assertive case management with Individualized Service Agreements which direct funding to community-based providers who 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. There have been capacity expansion grants to community providers to enhance the service continuum for children and families that provide services at the least restrictive level within a client's home community.

A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans experiencing a SED, SMI and/or a SUD by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided.

Target #1: 75% of individuals (including adults, parents/caregivers of children, and teens) who complete the Behavioral Health Consumer Survey will report a positive overall evaluation of services

Status #1: In FY2008, more than 75% of Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 74% of parents/caregivers of children reported a positive evaluation.



Methodology: The Behavioral Health Consumer Survey (BHCS) is an instrument used by the Division to measure client evaluation of behavioral health services. Grantee agencies providing behavioral health services mail the survey to their clients.

Behavioral Health Consumer Survey Client Overall Evaluation of Care

Fiscal Year	Adults	Parents/ Caregivers	Teens
FY 2008	78%	74%	77%
FY 2007	80%	79%	73%
FY 2006	82%	77%	76%

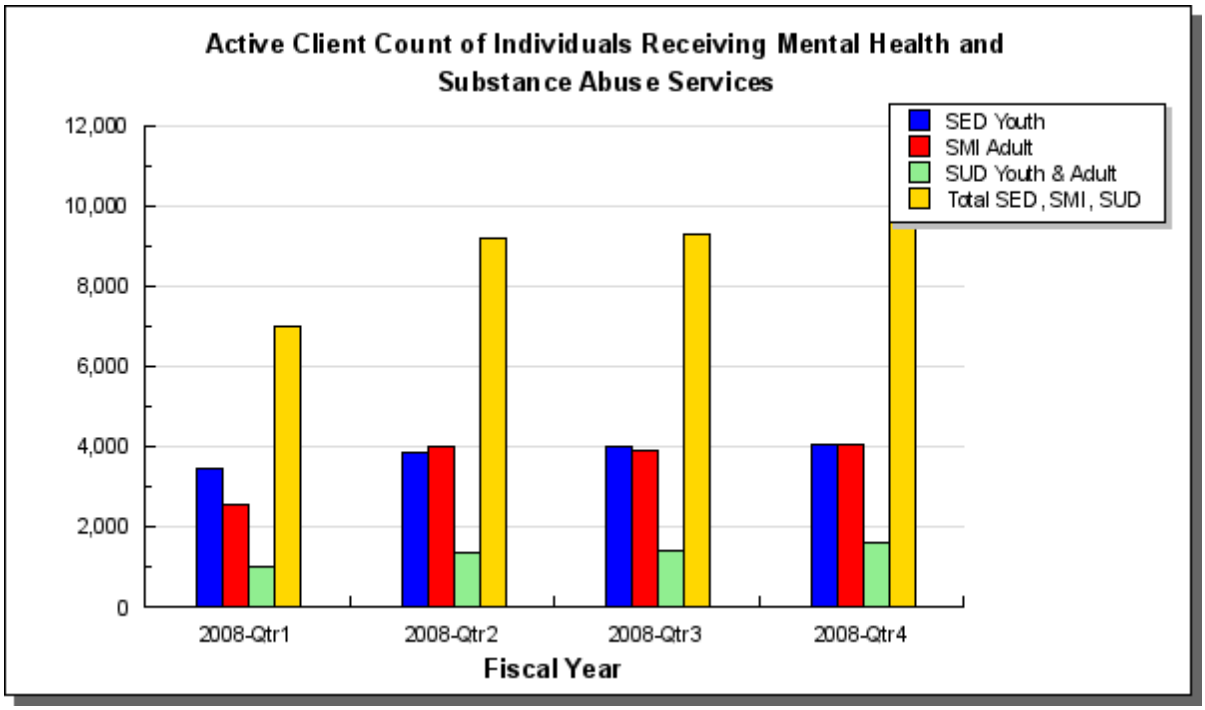
Analysis of results and challenges: In FY2008 more than 75% of Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 74% of parents/caregivers of children reported a positive evaluation. From FY2006 to FY2008 there was some fluctuation in respondents' evaluation of services; however, caution is advised when making comparisons due to changes in survey methodology implemented in FY2008. FY2008 data will be a new baseline. The BHCS administration process is continuing to be refined to improve accuracy, completeness, and response rate.

The Division continues to make progress in implementing performance management measures. Performance Based Funding measures were developed and applied to funding allocations to service providers for FY2009. Participation in administering the BHCS was one of several performance measures used to determine funding allocations.

A3: Strategy - Strategy #1C: Improve/enhance quality of life of Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) by assuring access to a comprehensive, integrated Behavioral Health system.

Target #1: For each category of service (i.e., SED, SMI, and SUD), increase annually by 2.5% the number of individuals experiencing a SED, SMI, and/or SUD who receive comprehensive, integrated behavioral health services.

Status #1: FY2008 is a baseline year.



Methodology: The Division is transitioning from a paper record system to an electronic health record system. FY08 data reflects Alaska Automated Information Management System (AKAIMS) quarterly report active client counts supplemented with paper quarterly report active client counts for Electronic Data Interface (EDI) agencies. Client counts are unduplicated within each quarter.

Active Client Count of Individuals Receiving Mental Health and Substance Abuse Services

Fiscal Year	SED Youth	SMI Adult	SUD Youth & Adult	Total SED, SMI, SUD
FY 2008-Qtr4	4,042 +1.61%	4,063 +3.99%	1,612 +13.36%	9,717 +4.41%
FY 2008-Qtr3	3,978 +2.71%	3,907 -2.4%	1,422 +5.49%	9,307 +0.9%
FY 2008-Qtr2	3,873 +11.45%	4,003 +56.25%	1,348 +36.85%	9,224 +31.36%
FY 2008-Qtr1	3,475	2,562	985	7,022

Analysis of results and challenges: FY08 is a baseline year for reporting active client counts using AKAIMS. Additional development is underway to integrate the AKAIMS and Electronic Data Interface agency data sets. The Division is continuing to improve the methodology for determining active client counts and to improve AKAIMS data collection, analysis and reporting capabilities. As the Division moves forward with this transition, we anticipate more accurate and complete electronic health records from participating agencies.

Initial development efforts to improve the methodology for determining client counts indicates that the reported FY08 numbers are significantly lower than the actual number of clients served. Starting in FY09, the Division will report client counts using the improved methodology.

The Division, in conjunction with the Mental Health Trust and Advisory Boards, completed the 2006 Alaska prevalence estimates of serious behavioral health disorders. These prevalence estimates will be used as a benchmark to measure penetration rates of behavioral health services. Based on the 2006 census data for low income households, there was an estimated 28,684 Alaskans experiencing a serious behavioral health disorder (i.e., SED, SMI, SUD, or both SMI and SUD). In comparison, for all households, there was an estimated 51,430 Alaskans experiencing a serious behavioral health disorder. For details, refer to the Division's "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household" (see link below). These estimates, which are considered to be conservative, provide a basis for identifying unmet needs in Alaska's low income and total household population.

The "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household" is available at the following link in the Document Library:

https://dbh-ssweb.state.ak.us/sites/COSIG/outcomes/default.as

Mission

Promote stronger families, safer children.

Introduction

The Alaska Child Welfare System will continually strive to be a model, effective agency. The National Family Preservation Network describes an effective welfare agency to be one that excels at strengthening families and avoiding unnecessary out-of-home placements with an underlying philosophy of keeping children safely in their homes whenever possible.

To adhere to that philosophy, or any philosophy, takes constant maintenance. As with most welfare systems nationwide, the Office of Children's Services (OCS) must do so within the constraints of high caseloads, high case worker turnover, and mandatory federal Child and Family Services Reviews that no welfare agency has ever passed, and intense scrutiny by the public.

The core principles that guide child welfare practice include:

- Support and Development – staff is supported, valued and receive on-going training;
- Safety – children are safe from abuse and neglect;
- Permanency – children have stable, long-term relationships with healthy, nurturing families; and
- Well-Being – children are successful in family, school, and community.

The OCS partners with other state agencies and community agencies that are dedicated to achieving safety, well-being and permanency for children, youth and families. Core services provided are intended to prevent child abuse and neglect and strengthen the ability of a family to protect and care for their children. When a child's safety is not possible within the family, services focus on providing for a stable, permanent home for a child as quickly as possible.

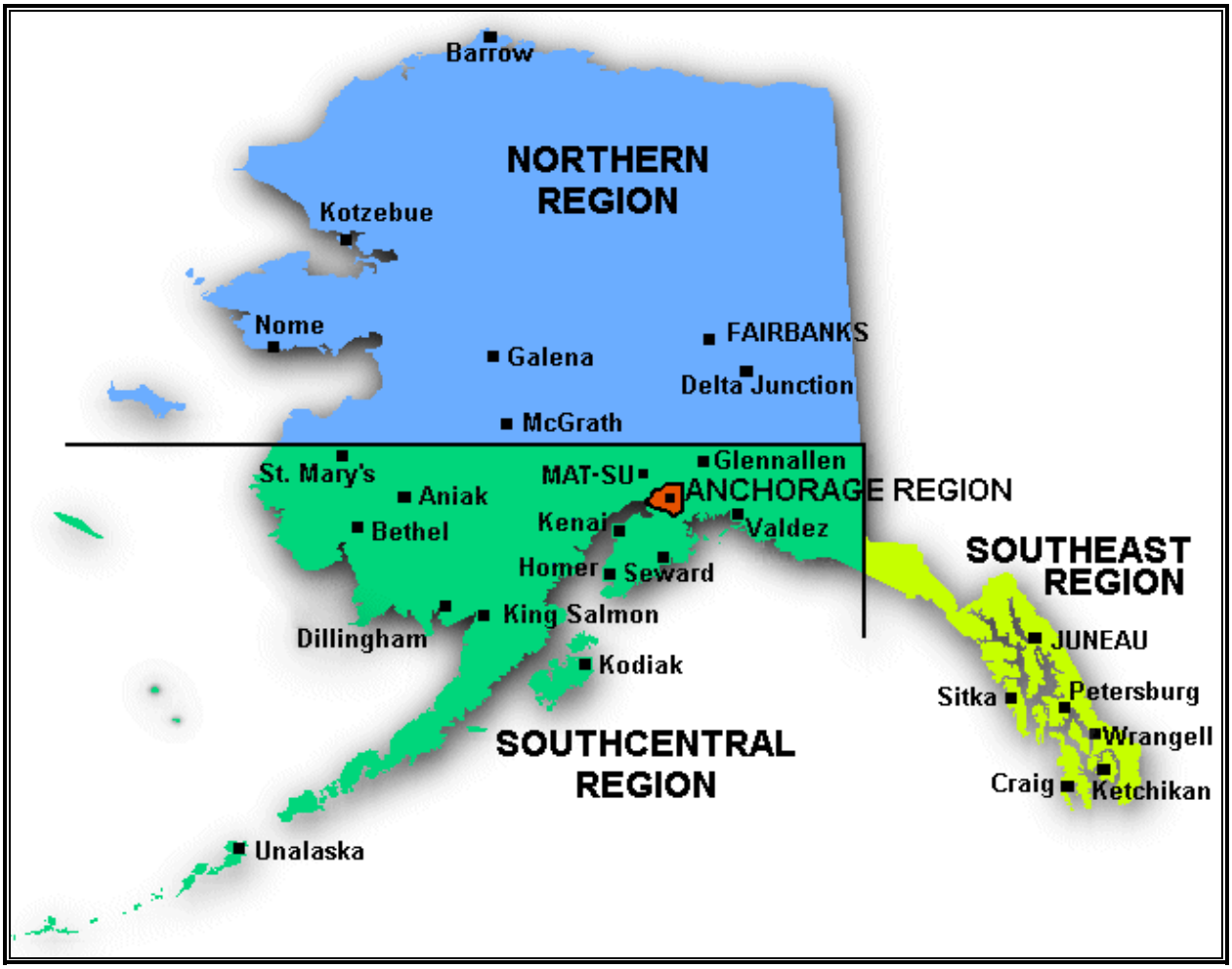
Core Services

Core services provided through the OCS to ensure that children are safe and families remain intact whenever possible currently include the following:

- 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.

The OCS supports 26 local offices in Alaska that deliver child welfare services. These local offices are managed and supported regionally within the OCS:

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

Client Services

Prevention and Early Intervention Services

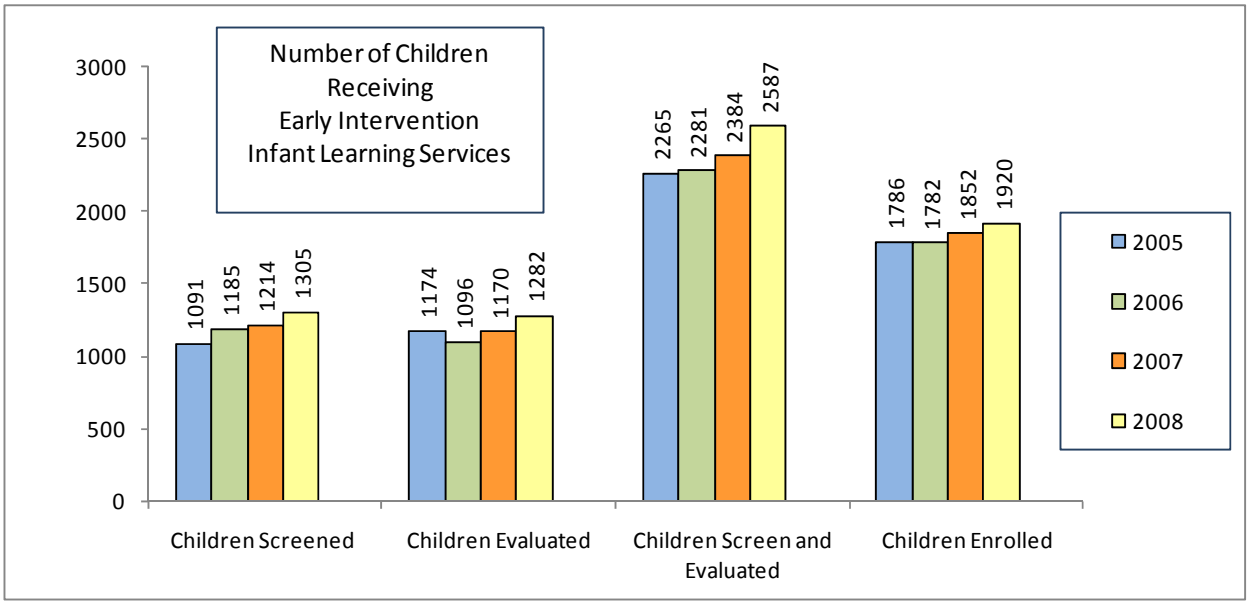
Prevention programs provided through the OCS include a broad perspective and are provided not only to the children served through child protection services, but reach beyond to provide support for all young children in Alaska.

The Early Intervention/ Infant Learning Programs (EI/ILP) provide early childhood special education services to children with significant developmental delays and their families through 20 state grantees. EI/ILP is committed to promoting access to a flexible array of quality services to every Alaskan infant and toddler with special developmental needs and their families.

The EI/ILP program screens, evaluates, and develops individualized family services plans for children identified as having developmental delays or disabilities. Comprehensive, coordinated, home-based early intervention services could include the following:

- Provide 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 necessary services.

In FY 2008, more than 2,600 children, birth to three years, were referred for a screening or evaluation for special education services in Alaska. Of these 2,600 children, over 1,900 were eligible for services - meaning they met the definition of developmental delay.



The Early Childhood Comprehensive Systems (ECCS) Initiative

The Early Childhood Comprehensive Systems (ECCS) Project is an initiative to promote positive development and improved health outcomes for Alaska's children prenatal to age 8 by creating a culturally responsive, comprehensive and accessible service delivery system. Alaska worked with stakeholders all over the state to develop an "Early Childhood Comprehensive Systems Plan." This Plan is providing guidance on how we can improve services for young children and their families. The Plan builds on the knowledge that for children to be ready for school and successful in life they must be healthy, have their social emotional needs met, have good opportunities for learning and need to grow up in families that are supportive and nurturing.

The newly formed Interdepartmental Early Childhood Coordinating Council will work to make sure our young children have access to good health care and quality early childhood programs and that their families will get the kind of information and support that they need to keep their families strong. The Council is made up of representatives from the Departments of Health and Social Services, Education and Early Development, Labor and Workforce Development, Commerce and Economic Development and the Alaska Mental Health Trust Authority, Governor's Council on Disabilities and Special Education, and the Alaska Children's Trust. Through special workgroups, private partners are also engaged in the work. Input from families and consumers is encouraged and welcomed.

Some of the ECCS work over the last year included:

- Conducting a pilot program with primary care providers to implement comprehensive, standardized, developmental screening for young children;
- Working with service agencies and primary care providers to develop an efficient referral system when children are identified with developmental or mental health concerns;
- Building workforce expertise in the area of early childhood mental health by sponsoring the Early Childhood Mental Health Institute and facilitating a "Learning Network" for mental health providers and early interventionists;
- Developing specific recommendations to increase access to mental health services for young children;
- Supporting the work of the Child Care Program Office and Department of Education and Early Development in distributing the Early Learning Guidelines and partnering with other community organizations to improve the quality of early care and learning programs; and
- Embedding family support services in early childhood programs.

Strengthening Families through Early Care and Education Program

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

- Knowledge of parenting and child development
- Concrete support in times of need
- Parental resilience
- A child's health and emotional development
- Social connections

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 five, are served.

We are currently working in partnership with United Way of Alaska, Child Care Connection and the Alaska Children's Trust on a project to expand the approach to additional early childhood programs in Anchorage as well as adapt the Strengthening Families approach and tools to a wide array of family service agencies.

Child Protective Services

Child Protective Services (CPS) is a specialized social service designed to keep children who are determined to be unsafe protected from further harm. This is accomplished by:

- Screening/intake of reports of suspected abuse or neglect;
- Investigation of reports meeting screen in criteria;
- Developing case plans that provide in-home counseling and supportive services to help children remain in their homes;
- Coordinating community and agency services for the family;
- When it is determined that a child cannot remain in his/her own home safely, arranging appropriate placement, with relatives whenever possible;
- Initiating legal action upon involuntary removal of children from their homes;
- Whenever appropriate, developing concurrent permanency planning to expedite permanency, should parents not rehabilitate and a child is unable to return to their home; and
- Exploring all possible alternate permanent homes for children who must be removed from their own homes.

When OCS screens in a child protective service report that contains an allegation of physical, sexual, or emotional abuse; neglect; abandonment; or exploitation; an investigator will conduct an assessment to determine if there is evidence that the allegations are substantiated and whether the child is safe in his home. During an investigation, a CPS worker checks for past allegations, interviews the child, observes the child for signs of abuse and neglect, observes the home and where the alleged abuse or neglect took place, interviews the parents or guardians and any other person alleged to have abused or neglected the child. The worker may also interview people who have knowledge of the child and family such as medical personnel, teachers, or relatives; observe and interview other children in the home; and arrange for a medical or psychological examination of the child if deemed necessary.

If a child is determined to be at high risk for maltreatment or unsafe as a result of the investigation, a CPS worker works closely with the child and the family with a goal toward family preservation through supportive services. If that is not possible and a child cannot remain safely in their own home, CPS workers work toward reunification of the family. If reunification cannot be achieved, other permanency options such as adoptions or guardianships become the goal for the child.

Once a child has been removed from their home, the court system oversees the case to assure that the law and best practice is being followed with regard to the care of the child. There are a myriad of

services provided within the child welfare system to accomplish the goals and objectives applicable to each individual case.

Child Advocacy Centers

Child Advocacy Centers (CAC) provide child sexual abuse and severe physical abuse victims age 0 through 18 and their non-offending parents a safe, child-friendly place to interview, receive forensic medical examinations, and mental health services or referrals. Each victim is assigned a specialized family advocate who will remain with the child and family throughout the investigative process. CAC interviews are legally sound and neutral, and they coordinate fact-finding to avoid duplicative interviews. CACs are in place to assure Alaska children are not re-traumatized after experiencing child sexual or severe physical abuse and that all non-offending family members receive support and treatment when required.

The legal process can be especially intimidating, confusing, and frightening for children. Many aspects of the process (such as providing testimony and multiple interviews) can be overwhelming. It is estimated that a child victim whose case is going through the court system undergoes 11 interviews. During this process, a child can potentially be "re-traumatized." The pre-trial phase can be more distressful for the child than the disclosure phase because the pre-trial phase often involves ongoing investigation, multiple interviews, and protracted fear of perpetrator retaliation.

The foundation of a CAC is the Multidisciplinary Team (MDT) that is comprised of community, tribal, medical, social service, and legal representatives. MDTs, while never working directly with a victim, guide a case through the investigatory process that may lead to prosecution while making certain all non-offending family members receive the appropriate services to help them through the trauma. The CAC provides the best forum in which an investigation can occur to assure victims are not re-traumatized by repeated interviews and examinations.

Since the creation of the Lake Plaza Multidisciplinary Center in Anchorage where Alaska CARES Child Advocacy Center shares space with a complete investigative unit of the Office of Children's Services, referrals to the Anchorage CAC have increased 13%. The Children's Place, Child Advocacy Center located in Wasilla, is in the process of designing a new facility and they are actively involved with the OCS to create a Multidisciplinary Center model where the Office of Children's Services would also like to place a full investigative unit. OCS is committed to continuing their efforts toward supporting multidisciplinary co-location lease funding to place investigative units in Alaskan CACs.

Beginning with SFY2009, the Copper River Basin area and the Kenai Peninsula have begun formation of new Alaskan Child Advocacy Centers. These are located in Homer and Glennallen and increase the number of Alaskan Child Advocacy Centers from seven to nine.

Alaska's Family-to-Family Program

On a national level, Family-to-Family has worked for 14 years to change child welfare systems, most recently by advocating for more children to remain safely with their own families or a family-like connection whenever possible.

At its core, Family-to-Family applies four basic principles:

- A child's safety is paramount;
- Children belong in families;
- Families need strong communities; and
- Child Welfare needs to partner with communities and other systems for strong outcomes.

The Family-to-Family model provides Alaska and our communities with the opportunity and the tools to redesign the child welfare system to establish:

- A network of care that is neighborhood-based, culturally sensitive, and located where the children in need live;
- Less reliance on institutional care, such as hospitals, shelters, correctional facilities, and group homes;
- An adequate number of foster families for any child who must, for safety reasons, be removed from the family home;
- A team approach including foster care families; and
- Screening services to safely preserve the family while understanding the needs of the child.

Family-to-Family relies on a variety of strategies for reforming child welfare systems. Although each of these strategies has proven effective in one or more sites, four strategies are deemed integral to the initiative:

- Building Community Partnerships, which entails building relationships with a wide range of community organizations and leaders in neighborhoods in which child protection referral rates are high, and collaborating to create an environment that supports families involved with the child welfare system.
- Team Decision Making, which involves not just foster parents and caseworkers, but also birth families and community members in all placement decisions to ensure a network of support for children and the adults who care for them.
- Resource Family Support, Development and Recruitment, which involves finding and maintaining foster and kinship homes that can support children and families in their own neighborhoods.
- Self-Evaluation, in which teams of analysts, data managers, frontline managers and staff, and community partners collect, analyze, and interpret data about key Family-to-Family outcomes to assess whether we are making progress and to determine how policy and practice needs to be changed to bring about further improvement.

Each strategy represents good practice on its own, but it is the joint and mutually reinforcing effects of the four strategies that produce the strongest impact. Implemented together, these strategies provide a focus for practice changes that seek to achieve the outcomes emphasized in Family-to-Family.

The OCS Family-to-Family initiative has been fully implemented in Anchorage, and has experienced great success. OCS can truly say that Family-to-Family is no longer considered a "new" initiative, but is the way business is done. It has become fully integrated into practice and is a part of the mainstream culture of the staff and the community.

Fairbanks held a community wide Family-to-Family convening that boasted attendance of well over 100 people in May 2008. This was OCS's first opportunity to educate and inform the community of the efforts to spread the value of Family-to-Family and our plans to fully implement the model. From that convening, OCS has engaged with our stakeholders on a monthly basis to develop local protocol, gather input on development of our standards and how we can improve our relationships. The office began holding TDMs on October 15, 2008.

OCS's next steps will be to begin the groundwork to bring the Family-to-Family practice model to the Wasilla filed office and surrounding communities. Wasilla is ready and eager to improve their practice and to continue their efforts to increase community partnerships and improve the outcomes for the families we serve.

Future roll out locations will be based on the office and community's readiness, resource availability to lead and drive the local efforts, and our continued support and technical assistance from the Anne E. Casey Foundation, the only funding OCS receives for the program.

Family Preservation and Early Intervention Services

Family Preservation and Early Intervention Services awards grants statewide to agencies through three service models, including Family Support Services, Family Preservation Services and Time Limited Family Reunification Services. This service continuum provides services that support continued safety for children in their own homes; provide in-home services for families with indentified risk factors; and strengthen and support adoptive, foster, and extended families. These services help children at risk of foster care placement remain safely with their families and provide after care once a child has been returned from foster care.

Family Support Services, which are awarded statewide, are designed to support young, first-time parents and parents with young children ages birth to 12 years. The focus is on primary and secondary prevention and support for families. Services include care coordination, in-home support and parent education. Referrals for these granted services are accepted from individual families, OCS, local medical providers, school districts, and other community providers.

Family Preservation Services focuses on the tertiary prevention, or service delivery targeting families with identified risk factors that need a higher level of attention and intervention. Services include care coordination, assisting families in caring for their child's safety, in-home support and family education. Service referrals are accepted from the local OCS field office in the grantee's home community.

A significant shift in the service model for this program includes the funding of providers who can implement a Family Group Conferencing/Decision Making service for referral families. This approach will assist families in developing a system of natural supports within their own network of family, friends and community to help keep their children safe and in their own homes.

If there is the need for a child to be removed from his or her home, these teams become potential placement resources through the Resource Family Recruitment efforts also taking place within the team. Members of these teams also become the resource Team Decision Making (TDM) model already utilized by OCS in some service areas. This team approach is well-defined in the Family-to-Family program discussion above.

Time Limited Family Reunification (TLFR) service grants are funded through a blending of federal Title IV-B, SSBG, and state general funds. TLFR services are designed to support the transition of children from out-of-home settings by facilitating the reunification of the children with their biological parents safely and appropriately in a timely fashion. Services include on-going family assessments, visitation planning and active support for Structured Family Time, parent/caregiver support, and Resource Family Licensing Support. Services will have a clinical basis and will be time-intensive, with families having 24-hour access to providers.

A significant change to the service model will be more emphasis on a clinical approach to service delivery with an increase in one-on-one work with reunifying families providing cognitive behavior support and continued active support of visits with parents and children during the reunification stage. Families will receive intensive services during the initial 90 days of reunification, with less intensive services for an additional 60 days. Potential grantees will be expected to propose an evidence-based clinical approach in their service delivery design.

Independent Living Services

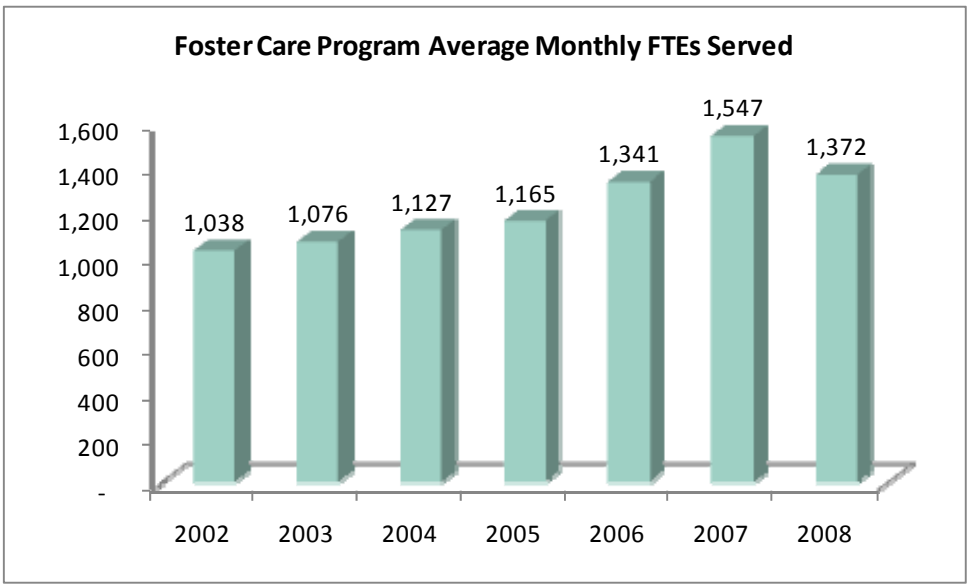
Independent Living services support education, vocational training and life skills of youth in foster care as they enter early adulthood. These youths, 16 years and older, frequently lack the family or financial support and guidance needed to gain self-sufficiency in adulthood. Services provided to help 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.

- The Independent Living services are available to the approximately 240 youth sixteen years old and above that are in state custody. The program also serves approximately 50 youth that are no longer in state custody;
- The Independent Living program supports a youth advisory group of youth in state custody and alumni of the foster care system. This group meets on a quarterly basis and usually has between 12-18 participants;
- OCS Independent Living Specialists conduct or arrange classes for youth in custody to address independent living and educational issues. These classes differ by region, but usually have between 4-10 youth participating;
- 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 as much as $1 million annually of Title IV-E federal funds. In conjunction with OCS, Tribal staff provide child welfare services to Alaskan Native children in out-of-home placement and children at risk of out-of-home placement. Tribal Organizations work closely with OCS to provide the federal government with the required, substantial documentation for IV-E determinations. 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 two Tribes/Tribal Organizations to explore the possibility of joining our 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.

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 the Office of Children's Services and Juvenile Justice. Ongoing efforts in support of the department's Bring the Kids Home (BTKH) initiative allow 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. Individual Service Agreements are available to provide specialized services for children as a funding source of last resort for needed treatment. OCS also provides training and technical support to Residential Child Care Providers through a training grant.

Infant Learning Program

Early Intervention/ Infant Learning Program (EI/ILP) has made significant strides in its ability to provide outcomes and is now equipped to track and analyze data to enhance performance based measures and has implemented a dashboard to track program success across 14 compliance and quality indicators and is currently collecting preliminary data on child outcomes.

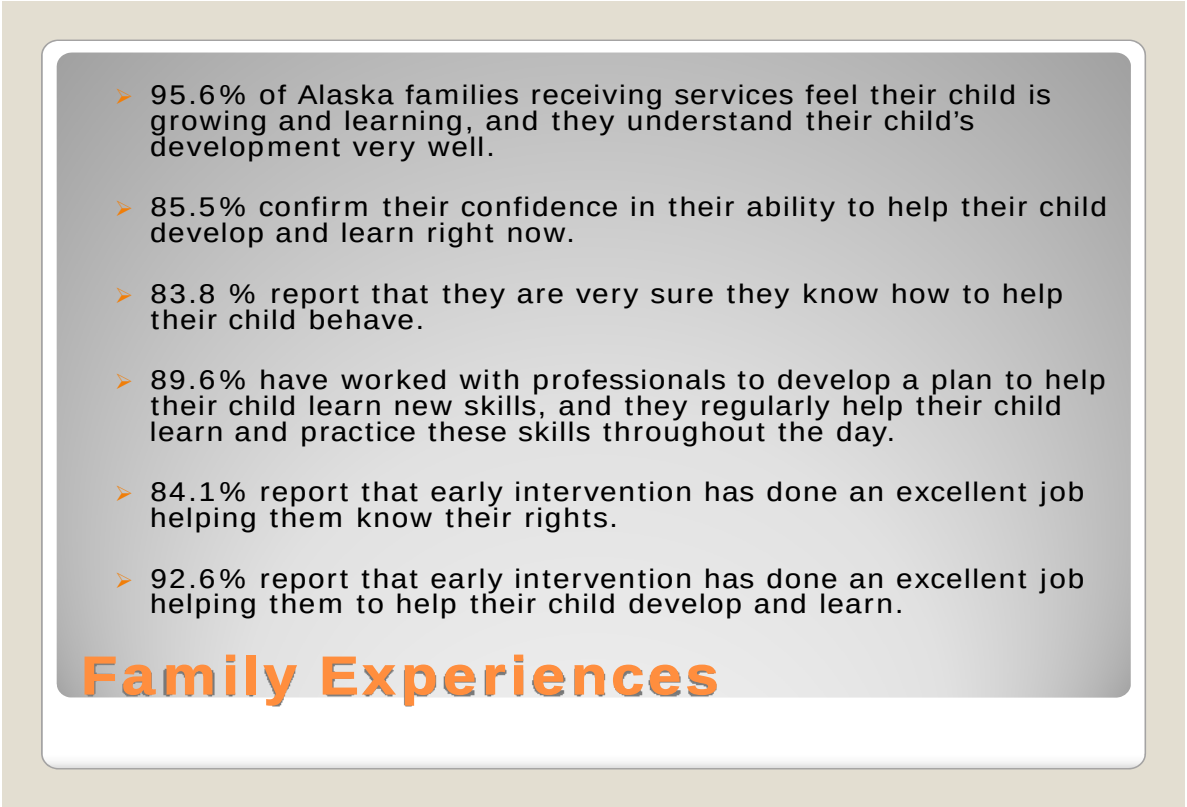
In FY 2008, an Infant Learning Program Family Outcomes Survey was conducted and the results provide important outcome information about family experiences based on the following family outcome areas:

1. Families understand their child's strengths, abilities, and special needs.
2. Families know their rights and advocate effectively for their children.
3. Families help their child develop and learn.
4. Families have support systems.
5. Families access desired services, programs and activities in their community.
6. Families are satisfied with services they received.

The results for Alaska were very good under the current level of funding. The complete survey can been reviewed at:

http://www.hss.state.ak.us/ocs/InfantLearning/resources/pdf/2008FamOutcomes.pdf

and provides the following outcomes, all which fall within survey choices "Most of the time" and "All of the time."



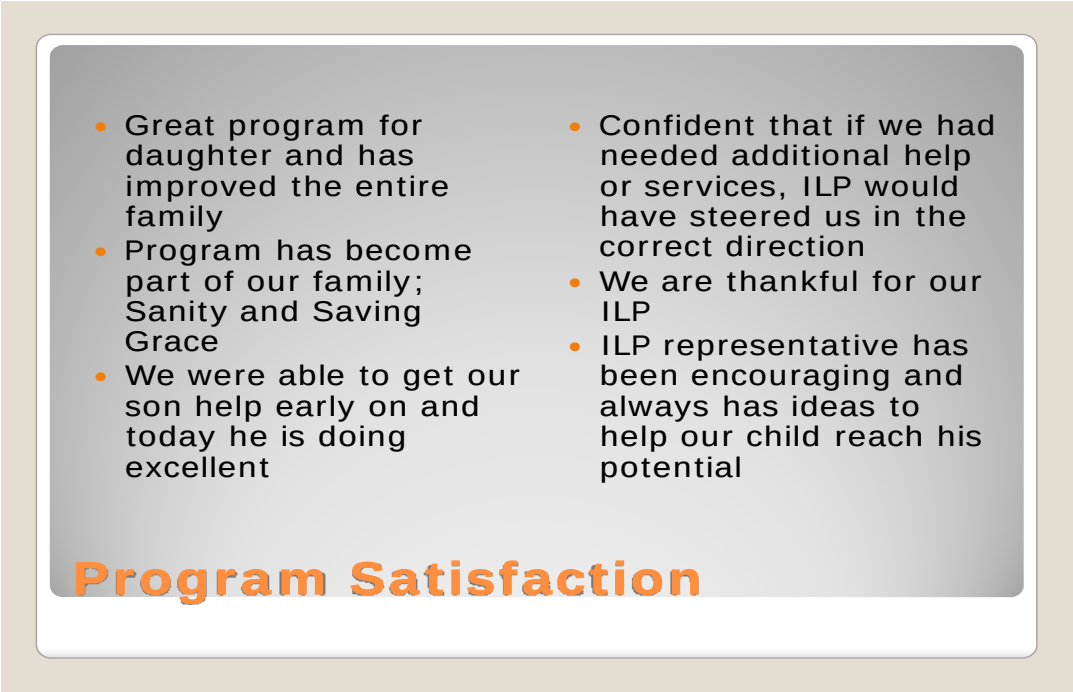
Infant Learning Program (ILP) can report that in 2008 of 90 children who entered the program below age expectations in the outcome area, the percent that substantially increased their rate of growth by exit were:

- 68% Positive social emotional skills
- 66% Acquisition and use of knowledge and skills
- 64% Use of appropriate behaviors to meet their needs

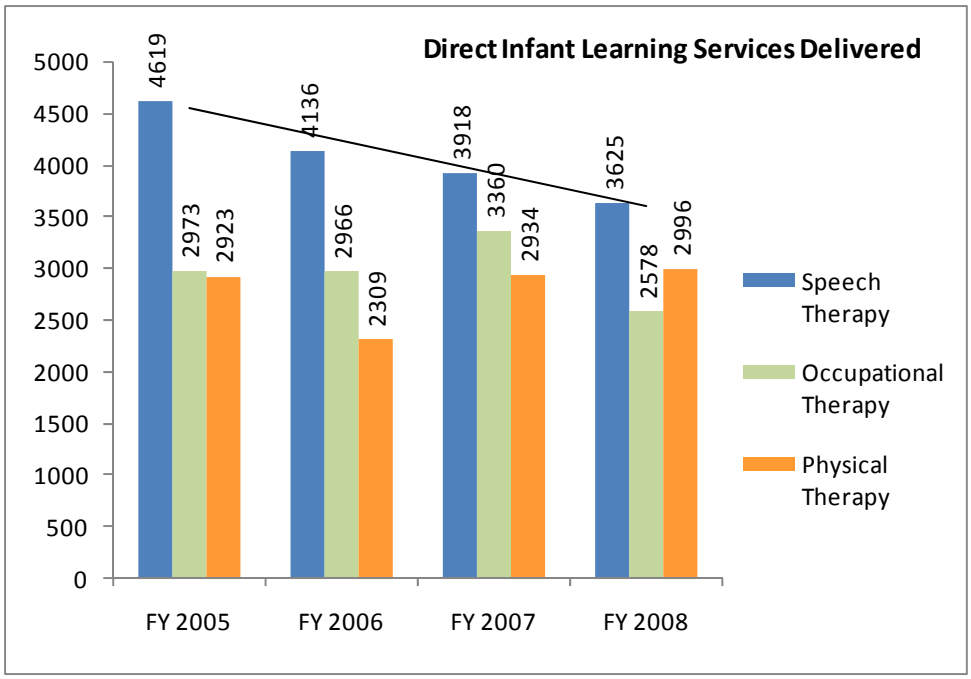
The percent of children who entered the program and exited functioning within age expectations:

- 56% Positive social emotional skills
- 51% Acquisition and use of knowledge and skills
- 49% Use of appropriate behaviors to meet their needs

Sixty-six percent of the survey respondents used the survey as an opportunity to express gratitude and satisfaction:



While the ILP has been successful, program funding has remained flat despite inflation of service costs, resulting in the erosion of available services and a steady loss of personnel. Grantees have had to provide more coordination of care and less direct implementation of home programs. The ability of the grantees to provide services directly to clients through home visits has declined from 2,102 in 2003 to 1,732 in 2007 while children enrolled in the program increased from 1,786 in 2005 to 1,920 in 2008. In particular, speech and occupational therapy services have declined steadily in past 4 years while they remain the most frequently needed service.



The decline in available services is felt most in the school districts when children transition to IDEIA Part B. Part B services provide special education services to children age 3 through 22 years in the schools. At age 3, children are eligible for these services under this law with a 25% delay in development. Estimates suggest that intervening earlier will result in a return on investment between 7% and 16% annually in later years. Additional information is available at:

http://www.hss.state.ak.us/ocs/InfantLearning/resources/pdf/2008FamOutcomes.pdf

Child Advocacy Centers

In July, 2005, Alaska Statute 47.17.033 required that all child sexual abuse interviews be videotaped at a Child Advocacy Center (CAC) whenever possible. In SFY08, OCS Child Protective Services investigated 2,784 reports of child sexual abuse and physical abuse. Of these 2,784 reports, 1,557 or 56% were referred to Alaska's Child Advocacy Centers. This is a 7% increase from SFY07.

Child Protective Services Reports Referred to Child Advocacy Centers in FY 2008					
Region/Area	Sexual Abuse (SA)	Physical Abuse (PA)	SA & PA Totals	Total CAC Referrals	% of Alleged SA & PA Cases Referred to CAC's
Anchorage	290	883	1173	889	76%
Northern	133	334	467	179	38%
South-central	256	613	869	368	42%
Southeast	64	211	275	121	44%
TOTALS	743	2041	2784	1557	56%

Family-to-Family

OCS is confident that the value of family-to-family is understood by most, in particular the Team Decision Making (TDM) efforts. TDMs are utilized to make better placement decisions. A TDM should occur when a child is still at home, and removal is under consideration. A TDM should occur when a child has been taken into emergency care to determine whether the child should remain in care or return home. TDM referrals are made when safety threats are identified in the home and there is not enough information to assess whether parental protective capacities can sufficiently address those safety threats. A TDM should occur:

- To decide if the child must be removed in order to ensure safety;
- To decide if OCS must file for custody and facilitate placement;
- To decide if the child can remain or return home with a safety plan in place; or
- To decide if voluntary placement is appropriate.

The TDM process is working, and the number of meetings occurring and the number of children served have increased steadily since beginning the change in practice in 2005.

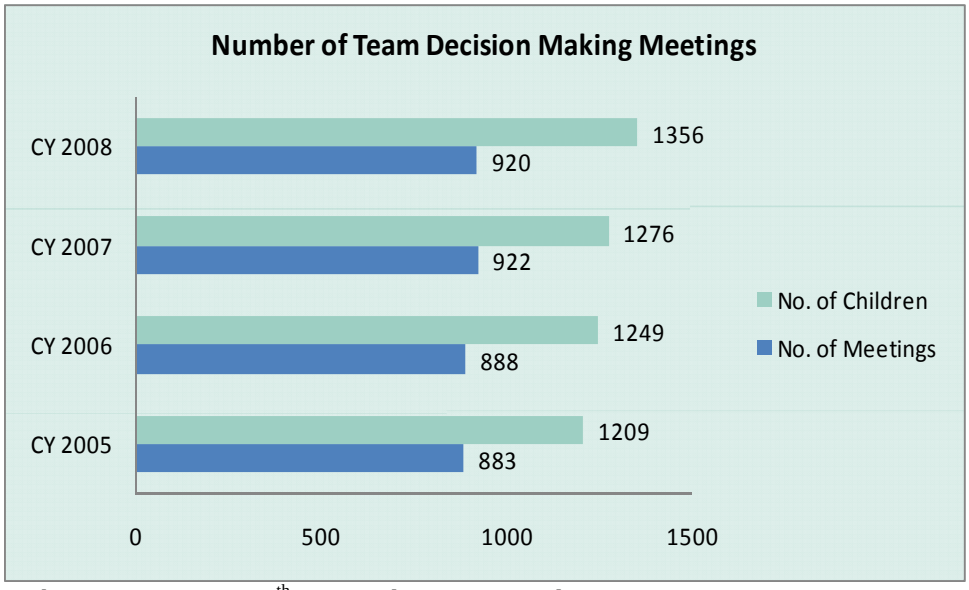
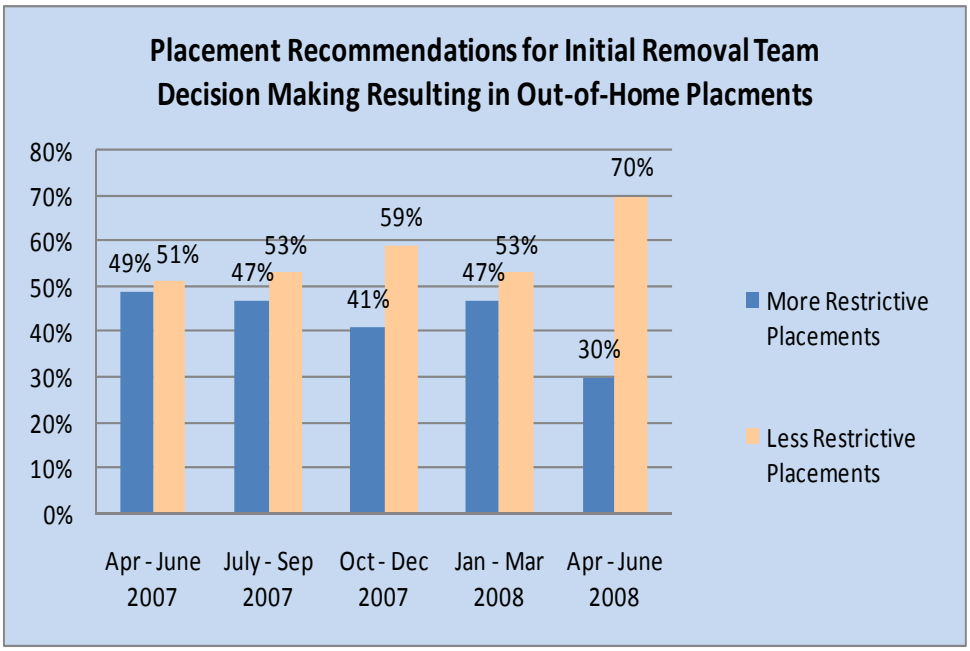


Chart Note: FY 2008 4th Quarter data is an annual average.

Data indicates that in FY 2008, OCS had achieved involving TDM in about 73 percent of placements in the Anchorage area. This data reflects OCS's success in making collaborative decisions when children need to change placements. Every time a placement decision needs to be made, OCS's goal is to bring everyone to the table that may have an interest or information to help the decision-making. Anytime we can open our doors and avoid making decisions in a vacuum, will ultimately produce better outcomes for kids.

The success of TDMs is indicated by the placement decisions made, OCS reached 70 percent for less restrictive placement recommendations during the 3rd calendar year quarter of 2008. These placements include relatives and non-relatives who have a connection with the child.



Having the child's identified Tribe at the table during TDMs is essential and required. OCS has continued to use the data collected to inform what the frequency rate is of Tribal attendance and how then we can partner with them to improve the results. The chart below gives a picture of the success achieved in the first and second quarter of 2008. This is the result of Anchorage's diligent efforts to educate staff, monitor compliance, and be as flexible as the TDM process allows, insuring for increased participation. There was also a significant decline in the number of TDMs overall where there was no Tribe or Alaska Native Community Member in attendance.

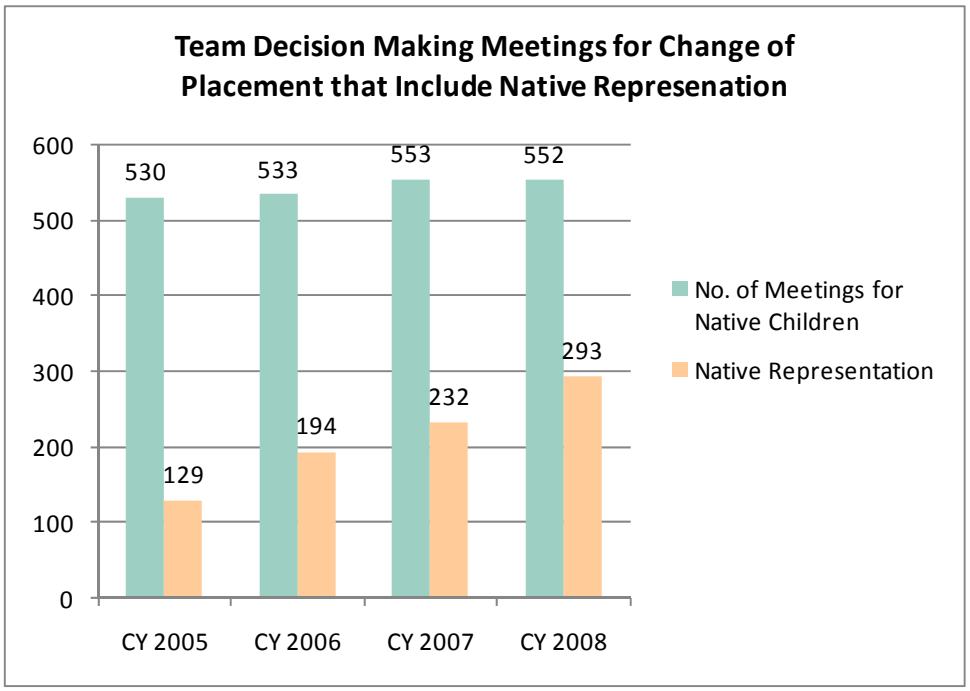


Chart Note: Number of Meetings for Native children is based on the allocation of Native to other children in custody. FY 2008 4th Quarter data is an annual average.

Results of a recent survey conducted of biological parents who had participated in the TDM process as a part of the case activities had this to say about their experience. Over 100 parents were surveyed.

- 83% said the facilitator asked for their input and made sure they had an opportunity to speak.
- 86% felt the facilitator was welcoming and engaged all participants in the TDM process.
- 72% believe it was a worthwhile process.
- 74% felt they were treated with fairness and respect.
- 78% agreed with the decision made in the meeting.

These responses are a testament to the work Alaska has done to improve practice and our work with families. This is at the core of the values of the family-to-family model and is the building blocks to aid OCS in achieving its mission of "stronger families, safe children."

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 FY2008 the Office of Children's Services (OCS) received 11,516 protective services reports. This is 214 more reports in FY 2008 than in FY2007, but 114 fewer of the reports received were screened in for OCS assessment.

Number of Protective Services Reports Screened In By State Fiscal Year				
Screen Reason	**FY05**	**FY06**	**FY07**	**FY08**
Screened in for OCS Assessment	***5,938***	***6,219***	***6,313***	***6,199***
Number of Protective Services Reports Screened Out By State Fiscal Year and Why				
Screen Reason	**FY05**	**FY06**	**FY07**	**FY08**
Screen Out - Law Enforcement Juris. Only	794	740	872	902
Screen Out - No Alleged Maltreatment	1,478	1,787	2,289	2,386
Screened Out - Differential Response	414	534	324	199
Screened Out - Insufficient Information	170	214	582	889
Screened Out - Referred to Military or Tribe	201	254	346	273
Screened Out - Other	370	361	576	668
Total	***3,427***	***3,890***	***4,989***	***5,317***
Total Protective Services Reports Screened By State Fiscal Year				
	FY05	**FY06**	**FY07**	**FY08**
Total PS Reports Received	***9,365***	***10,109***	***11,302***	***11,516***

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 – Law Enforcement Jurisdiction Only includes reports received by OCS that are referred to the appropriate authorities for criminal investigation. In these cases the accused perpetrator is not a caregiver, and there is no indication that the caregiver was neglectful.

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

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

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

Screened Out – Other includes all reports that did not include allegations meeting the criteria for an OCS assessment.

Number of Reported Victims
The number of child alleged victims within Child Protective Services Reports includes reports with more than one alleged victim as well as some victims that will be in both a screened in and screened out report when multiple reports are filed.

Count of Alleged Victims by State Fiscal Year

	FY05	FY06	FY07	FY08
Alleged Victims in Screened In Reports	7,965	8,665	8,475	8,634
Alleged Victims in Screened Out Reports	4,137	4,945	6,105	6,283
*Total**	***11,116***	***12,442***	***12,871***	***13,097***

** Some alleged victims are in both screened in and screened out reports*

This chart indicates that the number of alleged victims reported to OCS in a fiscal year continues to increase, but the rate of growth has fallen from 12 percent in FY2006 to 3 percent in FY2007 and 2 percent in FY2008.

Number of Children in Out-of-Home Care (OOH)
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. 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 and local plans between tribal and state partners. Between FY2006 and FY2008 the number of Native children in custody increased by 209. The increase in the total number of children in OOH care for that same two year period was 306.

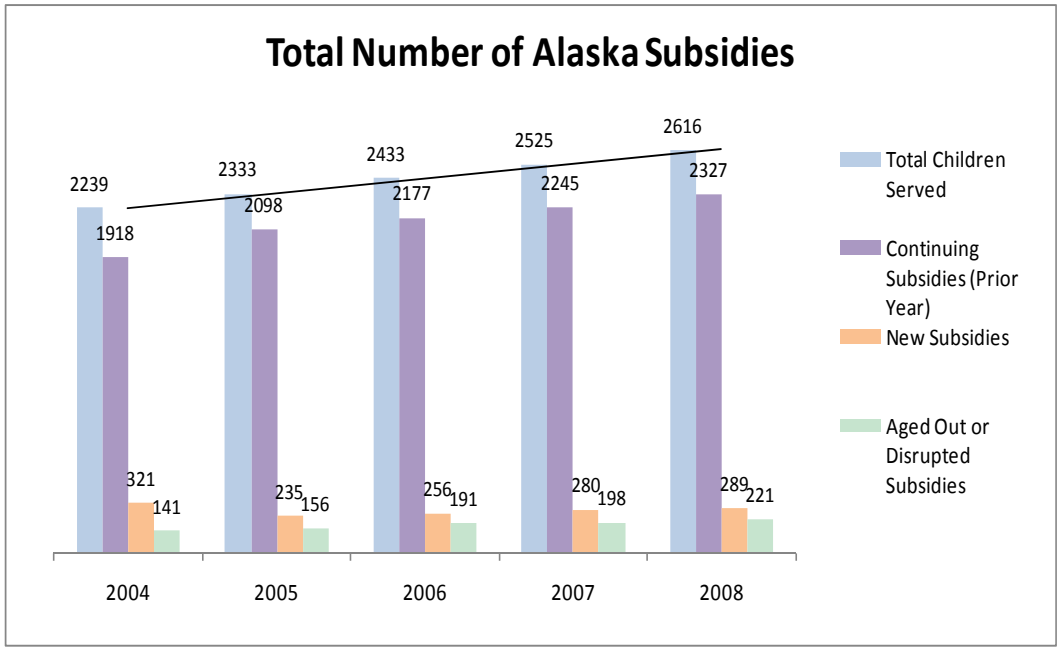
Unique Count of Children in OOH Care

	FY06	FY07	FY08
Native	1,625	1,729	1,834
White	759	832	837
Other	276	329	288
Undetermined	45	39	52
No. of Children	***2,705***	***2,929***	***3,011***

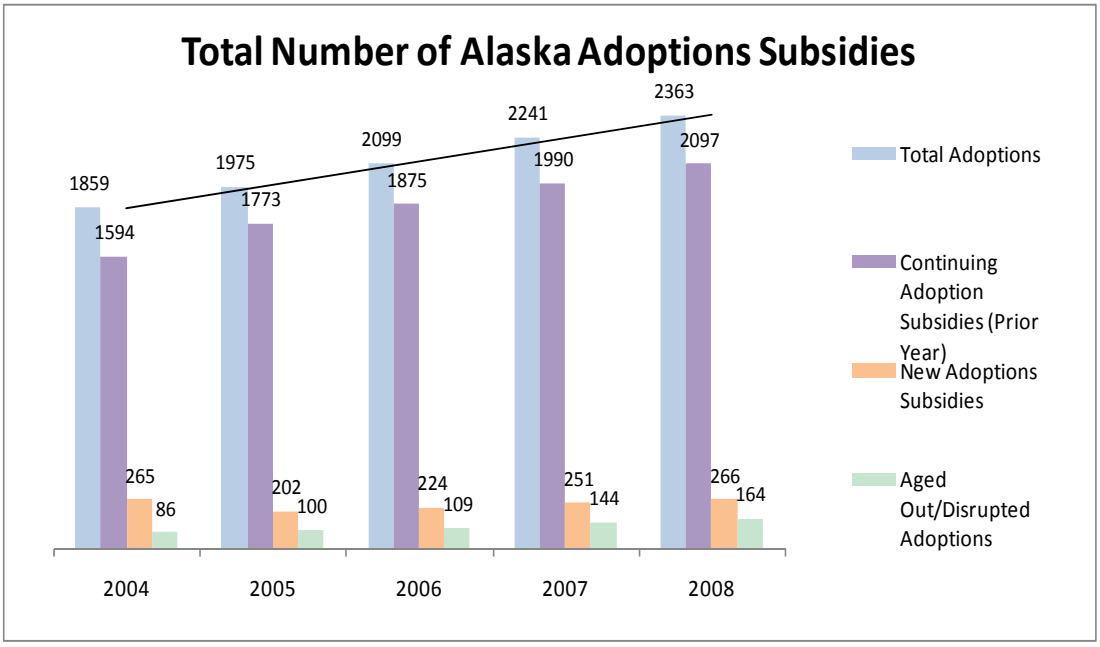
Note: Native- any mention of Alaska Native or American Indian
White- White only, excluding all other races
Other- any combination of non-Native races where White is not a unique raced identified

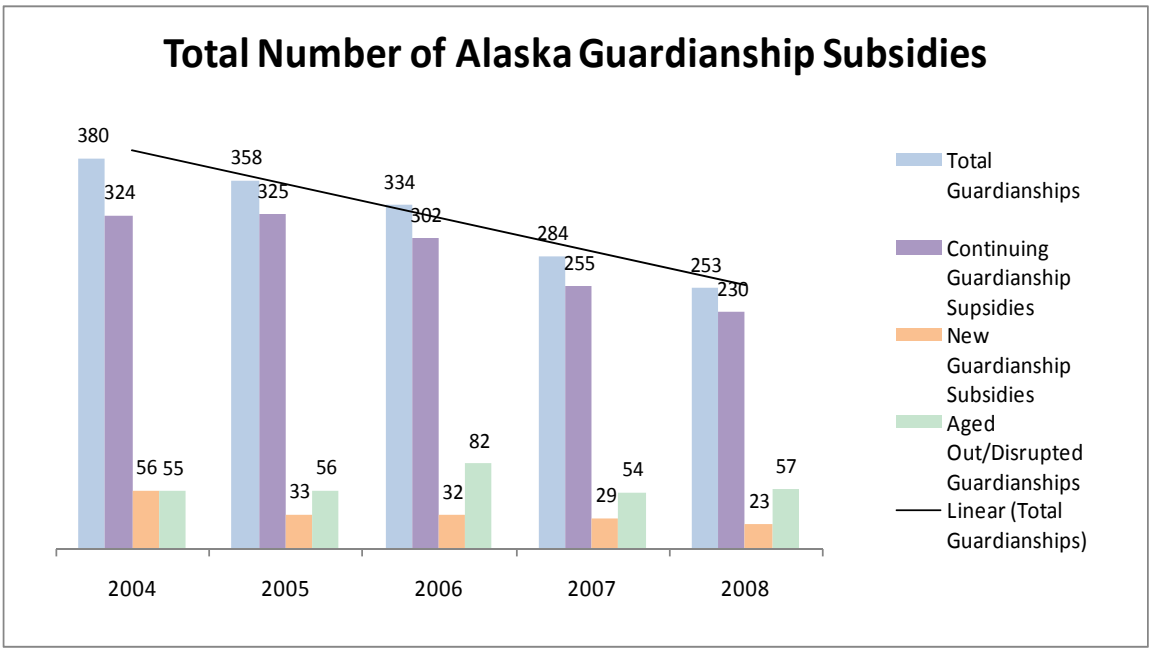
Adoptions and Guardianships

At the end of FY2008, 2,616 children were living in permanent homes assisted through the Subsidized Adoption and Guardianship program. At the end of FY2007, that number was 2,525. The total number of Alaska subsidies for adoptions and guardianships has steadily increased over the past five years.



The following charts outline the continued growth of the Subsidized Adoption and Guardianship since FY2004. The following charts breakdown the adoption and guardianship subsidies by fiscal year. These charts show the increases in adoptions versus guardianships, and the direct impact of policy changes defining guardianships and adoptions.





Data source for all adoptions and guardianships charts: 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 2008 that provides detail on the numbers of subsidies and the funding sources.

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	2008
IV-E Continuing Adoptions	1319	1457	1541	1658	1721
IV-E New Adoptions	209	149	190	188	183
IV-E Aged Out	49	51	67	102	130
IV-E Disrupted	22	29	22	25	10
Current=Continuing + New - Aged Out - Disruptions	1457	1526	1642	1719	1764
Adoptions Funded by the State of Alaska					
State Continuing Adoptions	275	316	334	332	376
State New Adoptions	56	53	34	63	83
State Aged Out	11	15	17	11	21
State Disrupted	4	5	3	6	3
Current=Continuing + New - Aged Out - Disruptions	316	349	348	378	435
Guardianship funded by the State of Alaska					
Guardianships Continuing	324	325	302	255	230
Guardianships New	56	33	32	29	23
Guardianships Aged Out	40	36	53	42	48
Guardianship Disrupted	15	20	26	12	9
Current=Continuing + New - Aged Out - Disruptions	325	302	255	230	196
TOTALS					
(TTL) YTD New Adoption/Guardianship	321	235	256	280	289
plus TTL continuing Adoption/Guardianship	1918	2098	2177	2245	2327
less TTL YTD Aged Out	100	102	137	155	199
less TTL Disruptions	41	54	51	43	22
Total Children in Active Subsidies at the end of the FY	2098	2177	2245	2327	2395

The number of subsidies that are IV-E eligible and receive federal reimbursement are 4.6 times the number of state fund supported subsidies.

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	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

Children's Services	2009	2010 Gov	09 to 10 Change
General funds	76,049.2	88,222.1	12,172.9
Federal Funds	56,893.1	49,157.7	-7,735.4
Other Funds	8,814.5	9,122.5	308.0
Total	141,756.8	146,502.3	4,745.5

Complete Implementation of Front Line Workload Study Recommendations: *$403.8 Total- $310.9 GF Match, $92.9 Fed*
Since the 2006 Workload Study contracted with Hornby Zeller Associates was conducted to determine whether or not front line caseworkers have sufficient time to meet the basic requirements of their jobs, the OCS has been allocated 13 of the 17 recommended additional front line workers required.

OCS is now requesting funding for the final frontline positions and a Social Services Associate (SSA) to help support the frontline by alleviating some of the administrative duties that fall to line workers. SSA's also provide direct services to clients such as transportation or visitation. The workload study revealed that line workers spend an average of 12.4% of their time on administrative tasks.

Continued Support for Child Advocacy Centers: *$1,123.8 GF, ($1,123.8 Fed)*
In 2002, the OCS received federal funds from the United States Department of Justice to establish and operate Child Advocacy Centers in Alaska. Alaska was to receive specific funding for a 5-year period. Those federal funds will be depleted in FY2009, and no additional federal funding has been appropriated.

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. CACs have proven to be very successful in Alaska and are discussed in detail in the OCS Services Provided section of this document. This is Phase II of a two Phase request to replace federal funding that is no longer available for CACs.

Fund Increased Costs forSsubsidized Adoptions and Guardianship Due to Growth: *$677.4 Total- $498.4 GF, $179.0 Fed*
OCS is requesting funding to cover increased numbers of adoptions and guardianships. The program has experienced steady growth each year for the past 7 years. Fiscal year costs have increased by $2,617.1 from 2004 to 2008. The total number of Alaska Adoption and Guardianship subsidies has increase by 377 during that same time period.

The Subsidized Adoption and Guardianship program facilitates permanent placements in adoptive and guardianship homes for an increasing number of children in 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 2008—2,395 children were living in permanent homes assisted through subsidized adoptions and guardianships. Since 2005, subsidized adoptions and guardianships have grown an average of 3.37% annually. This 4-year average growth is the basis for this request. Prior to 2005, adoption and subsidy growth was much higher ranging from 6.5% to 11.66%.

Increased Adoption Subsidies to Foster Care Base Rate Levels – Final Phase: $2,269.5 Total-*$1,407.1 GF, $862.4 Fed*
OCS is requesting funds to complete the final phase of rate increases for Alaska's resource families. This request follows increases for rates in foster care base reimbursements to foster homes for expenditures incurred for the care of state custody children and rate increases for Behavioral Rehabilitative Services for custody children who need facility services 24 hours a day, 7 days a week.

By statute, subsidized adoption rates are negotiated up to foster care base rate levels -- most rates are negotiated at about 85% of the base rate. Rates consider a child's special needs and the circumstance of the adoptive family. When base rate levels increased by 28.9% in FY2009 – the first increase in 8 years – new subsidized adoptions began to be negotiated with the higher starting point of the new base rates as of July 1, 2008. Therefore adoption or guardianship subsidies put into place in FY2009 are capped 28.9% higher than those put into place in prior years. This request allows adoptive parents the same level of increase retroactive to subsidies negotiated in FY2006 forward, and captures most adoption and guardianship subsidies in the pipeline.

MH Trust:Early Intervention/ Infant Learning Program Costs Due to Growth: *$1,500.0 GF/MH*
The Early Intervention/ Infant Learning Program (EI/ILP) request is to maintain preventative services in Alaska. Funds are needed to support services mandated in the Individuals with Disabilities Education Improvement Act that require all children under the age of three, with a substantiated report of abuse and neglect, be referred to the EI/ILP program, increasing the number of referrals, screenings, and enrollment numbers to our grantee providers. The program has not received any increase of funds since prior to 2003.

Services are provided to children with significant developmental delays – a significant developmental delay is defined as a 50% delay in functioning in one or more developmental domains or two standard deviations below normal functioning. More than 2,600 children, birth to three years, were referred for a screening or assessment for special education services in FY 2008. Of these 2,600 children, over 1,900 were eligible for services.

Because EI/ILP funding has remained flat since 2003 and funding sources have shifted there has been an inevitable erosion of available services especially in the therapeutic services of Occupational and Speech Therapy. This lack of services is felt most in the school districts when children transition to special education. Requested funding will restore service levels for children and train professionals to meet federal standards. Services costs: $1,312.5; Training costs: $615.0.

The Office of Children's Services will be requesting the following capital funding:

- Online Resources for the Children of Alaska Enhancements to Meet Federal Requirements - $242.2 GF, $172.1 GF
- Safety and Support Equipment for Probation Officers and Front Line Workers $133.7

Online Resources for the Children of Alaska Enhancements to Meet Federal Requirements: *$414.3 Total- $242.2 GF, $172.1Fed*

This project will enable the Office of Children's Services' Online Resources for Children of Alaska (ORCA) to implement statewide regional intake. Currently all incoming reports of child abuse and neglect are processed by each of the outlying OCS offices. By establishing statewide regional intake, reports will be documented consistently, will maintain regional autonomy, will be responded to more quickly, and will be better monitored. In addition, the project will develop the capability to collect and report information required by the National Youth in Transition federal mandate.

Safety and Support Equipment for Probation Officers and Front Line Workers: *$133.7 Total- $2113.3 GF, $20.4 Fed*

The Office of Children's Services (OCS) will purchase equipment based on the needs identified below to the greatest extent possible. However, actual allocation of funds for particular equipment will depend on a determination of current needs at the time that funds become available.

Funding will be used to replace failing servers in 11 OCS offices statewide. The existing servers are old and extremely difficult to keep operational. Replacement parts are difficult, if not impossible to locate. The ability to store, retrieve, and back up critical files will be enhanced and stabilized with new servers. It is not a question of if any of these servers will stop functioning but when. If a server goes down and a replacement part cannot be obtained, critical, confidential, and irreplaceable data will be permanently lost.

The Office of Children's Services has 29 offices statewide. Many of the OCS offices are in need of replacement furniture and equipment. This request for funds will assure the Ketchikan office can replace desks with drawers taped shut least they fall out, chairs that are no longer stable, and copiers that have far exceeded their usefulness. In order for staff to adequately perform their jobs, employers have an obligation to provide staff with a safe working environment.

The Anchorage office is acquiring eight students for the Multi-Disciplinary Intern Unit and two Mature Alaskans Seeking Skills Training (MASST) work training volunteers through the Department of Labor Nine Star Education and Employment Services. The Department of Labor pays a stipend to these trainees. The only cost to the host agency is equipment. The Multi-Disciplinary Intern Unit will consist of University students from across the behavioral science board (psychology, sociology, counseling, human services, social work). The goal of this unit is to create a pipeline of trained employees to boost recruitment and retention efforts. This request will provide computer equipment for these trainees and other trainees to follow.

With the recent move to the new Anchorage offices, equipment shortages have become evident. Scanners will become a requirement for entry of documentation into the federally mandated computer database, the Online Resources for the Children of Alaska (ORCA). Purchase of four digital scanners is needed for the investigation unit, permanency unit, child protective services unit co-located with AK Cares, and the intake/open for services area of the building.

The availability of safe and reliable vehicles for transporting children and workers in child welfare is a necessity. Children are transported daily as well as all times of the day and night. The circumstance may be a routine transport or a potentially dangerous emergency removal involving violence in the household. The Anchorage regional office needs to replace four vehicles with maintenance costs that are no longer cost effective, or the vehicles are no longer safe or reliable. The vehicles being replaced are model years 1992, 1994, and 1998.

Challenges

Federal Child and Family Services Review

The Child and Family Services Reviews (CFSRs) are conducted by the Children's Bureau, within the U.S. Department of Health and Human Services (HHS), to help states improve safety, permanency, and well-being outcomes for children and families who receive services through the child welfare system. The CFSRs monitor states' conformity with the requirements of Title IV-B of the Social Security Act.

Specifically, the CFSRs measure seven outcomes and seven systemic factors. The outcomes measured include whether children under the care of the state are protected from abuse and neglect; whether children have permanency and stability in their living conditions; whether the continuity of family relationships and connections is preserved for children; whether families have enhanced capacity to provide for their children's needs; and whether children receive adequate services to meet their physical and mental health needs.

The reviews are conducted jointly by federal and state representatives, with federal staff providing overall guidance during the planning and implementation of the review. The Onsite Review Team comprises approximately 65 people. About half of these are federal representatives, and half are state representatives.

The first round of reviews took place between 2000 and 2004 and all states were required to implement Program Improvement Plans (PIPs). The second round of reviews began in early spring of 2007. As with the first round of reviews, all states reviewed thus far have been required to implement Program Improvement Plans (PIP).

The on-site portion of Alaska's second review took place in September of 2008. Sites subject to the review were Anchorage, Juneau, and Bethel. Preliminary results indicate a PIP will be required.

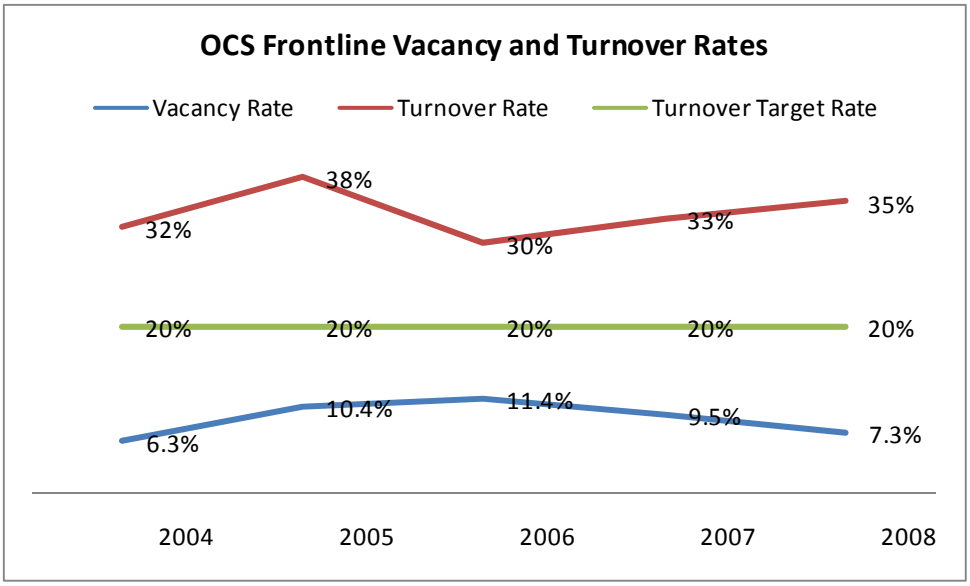
The process for the development of the Program Improvement Plan will take place over a 90-day period and involve both OCS staff and community stakeholders. The Program Improvement Plan will be approved by the federal government and will provide the road map for changes within Alaska's child welfare system. Failure to implement could lead to sanctions – a loss of federal reimbursement.

Alaska may face fiscal challenges when addressing some of the requirements included in the CFSR final report. But budgetary impacts of PIP implementation cannot be determined until the federal final report is received and the PIP is fully developed. Our federal partners do not anticipate providing Alaska's final report until December or later, but have encouraged OCS to work on a PIP based on preliminary findings. Preliminary findings that indicate fiscal impact include a lack of in-home services and mental health and substance abuse treatment.

Frontline Staff Recruitment and Retention

Child Protective Services is an emotionally demanding vocation. Across the nation, compassion, fatigue and vicarious trauma lead to high turnover and vacancy rates among caseworkers.

Fifty percent of the Office of Children's Services (OCS) front-line caseworkers have been employed with the agency for less than two years, and 20 percent having less than one year of experience. While vacancy rates have improved since 2006, turnover rates continue to slowly increase.



To institutionalize a mindful and daily focus on combating workforce development, the OCS formed an internal work group in the fall of 2007 to focus on retention and recruitment strategies. The workgroup includes a representative from the University of Alaska Family and Youth Services Training Academy, the Division of Personnel, several OCS staff, and a member from the Annie E. Casey Foundation that is providing technical assistance.

An executive steering committee was created in July of 2008 to guide the workgroup. Two of the members joined a November-implemented department Workforce Development Team.
The OCS internal work group has been working on development of a realistic job profile DVD, hoping to minimize turnover through recruitment processes that better inform applicants. A candidate for hire is sent a DVD and asked to sign a simple attestation form which state 1) they have watched the video; and 2) they *still* want to be interviewed and considered for the OCS frontline position. While this is a relatively new technique, states 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.

A new employee exit survey was created and protocol implemented to help determine why so many workers leave service; employee incentive technique is being explored; alternative work weeks encouraged and other options related to salaries, student loan forgiveness programs, and licensure are being explored. It is a systemic challenge that many of the options determined viable are unattainable by OCS alone and must be supported at the state level. While work is being done, it is burdened with unavoidable timeframes.

Implementation of Public Law 110-351
The President signed the Fostering Connections to Success and Increasing Adoptions Act into law October 7, 2008. Generally, the law amends the Social Security Act to extend and expand adoption incentives through 2013; create an option to provide kinship guardianship assistance payments; create an option to extend eligibility for Title IV-E Foster Care, adoptions assistance, and kinship guardianship payments to age 21; de-link adoption assistance from Aid to Families with Dependent Children (AFDC) eligibility; and provide federally-recognized Indian Tribes or consortia with the option to operate a Title IV-E program.

The OCS is now tasked with implementation of this significant Act. States must implement some sections of the law and have the option to implement others. OCS is currently working with other states and national organizations to understand the potential impacts of the Act. Detail and direction from the Administration for Children and Families (ACF) is pending.

OCS implementation of this Act is expected to be ongoing for a least the next year. Budgetary impacts have not yet been determined but are being explored.

Children's Services Results Delivery Unit

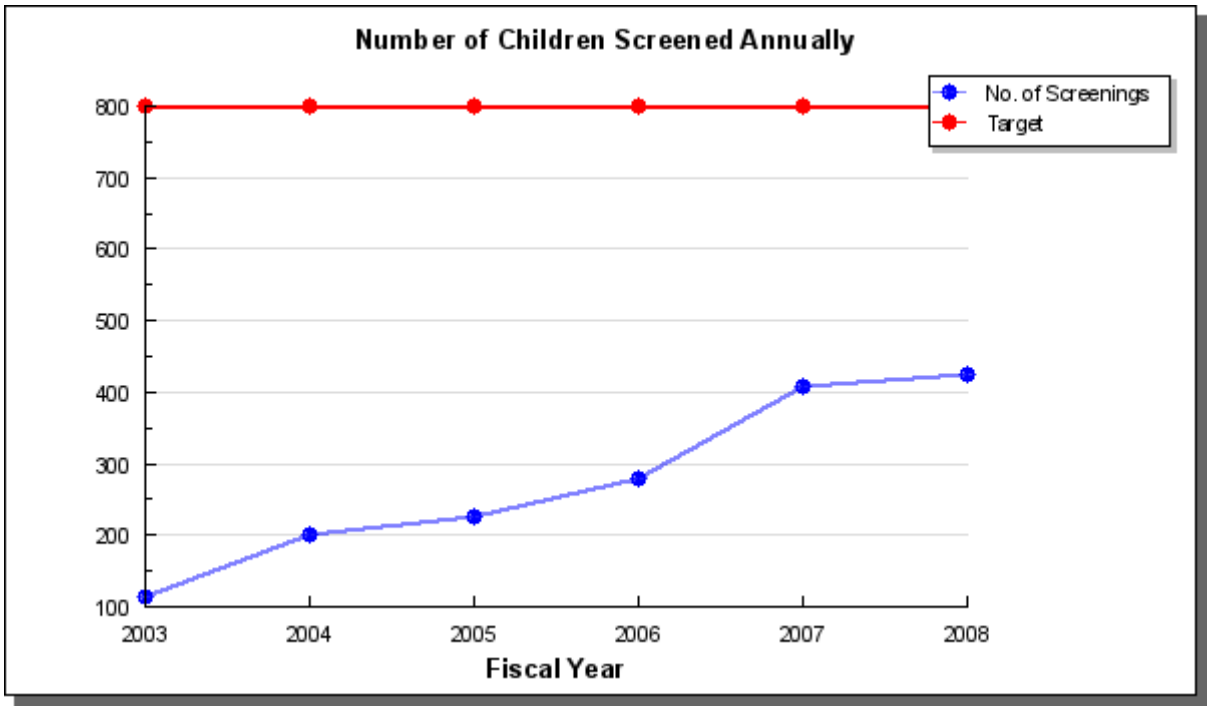
Contribution to Department's Mission

The mission of the Office of Children's Services is to promote stronger families, safer children.

A: Result - To prevent child abuse and neglect.

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

Status #1: The number of children aged 0 - 3 that have been screened through the Early Intervention and Infant Learning Programs has more than tripled in the past 4 years. In 2003, 113 children were screened. In 2008, 425 children were screened.



Methodology: Data Source: Office of Children's Services Prevention Unit.

Number of Children Screened Annually

Fiscal Year	No. of Screenings	Target
FY 2008	425	800
FY 2007	408	800
FY 2006	278	800
FY 2005	225	800
FY 2004	200	800
FY 2003	113	800

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

In 2003 U.S. Congress passed the Strengthening Families Bill requiring all children birth through three years of age who have been abused or neglected to be referred to the Early Intervention/Infant Learning (EI/ILP) program. By referring all 0-3 year old children who have a substantiated finding of abuse or neglect, the EI/ILP program can 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.

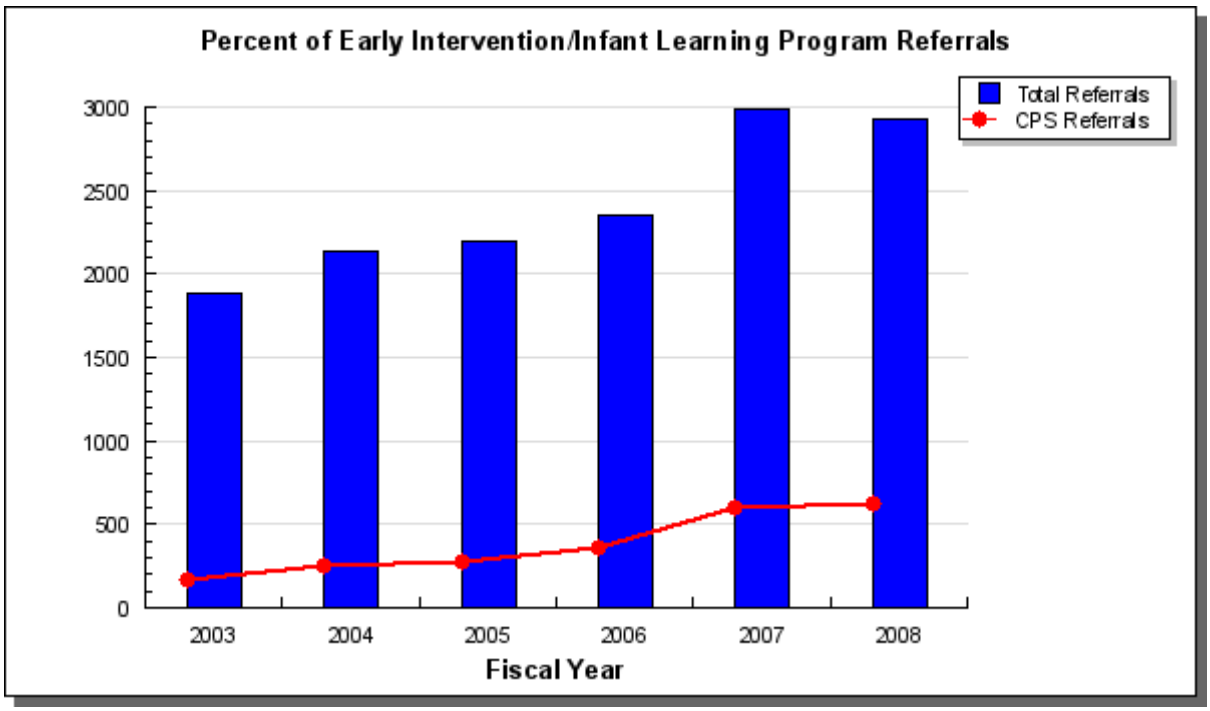
The program, as the number of screenings increase, is improving strategies to meet the 100% goal. This task becomes more complex as increased attention related to the behavioral health needs of very young children increases. In the past, the need for these services and a child's eligibility for these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

In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. 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% 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 2,926 children were referred from all sources in FY2008. Of the total, 630 children were referred specifically from Child Protective Services, a significant increase over 2004 when there were 155 children referred to infant learning from child protective services.

A1: Strategy - Increase the number of referrals 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.
Status #1: Child Protective Services referrals completed by the Early Intervention and Infant Learning programs have increased 55% from 2003 to 2008.



Methodology: Data Source: Office of Children's Services Prevention Unit

Percent of Early Intervention/Infant Learning Program Referrals

Fiscal Year	Total Referrals	CPS Referrals	Percent	Target
FY 2008	2926	630	21.6%	15% increase
FY 2007	2985	602	20.6%	5% increase
FY 2006	2357	363	15.4%	
FY 2005	2201	280	12.7%	
FY 2004	2134	248	11.6%	
FY 2003	1879	169	8.9%	

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).

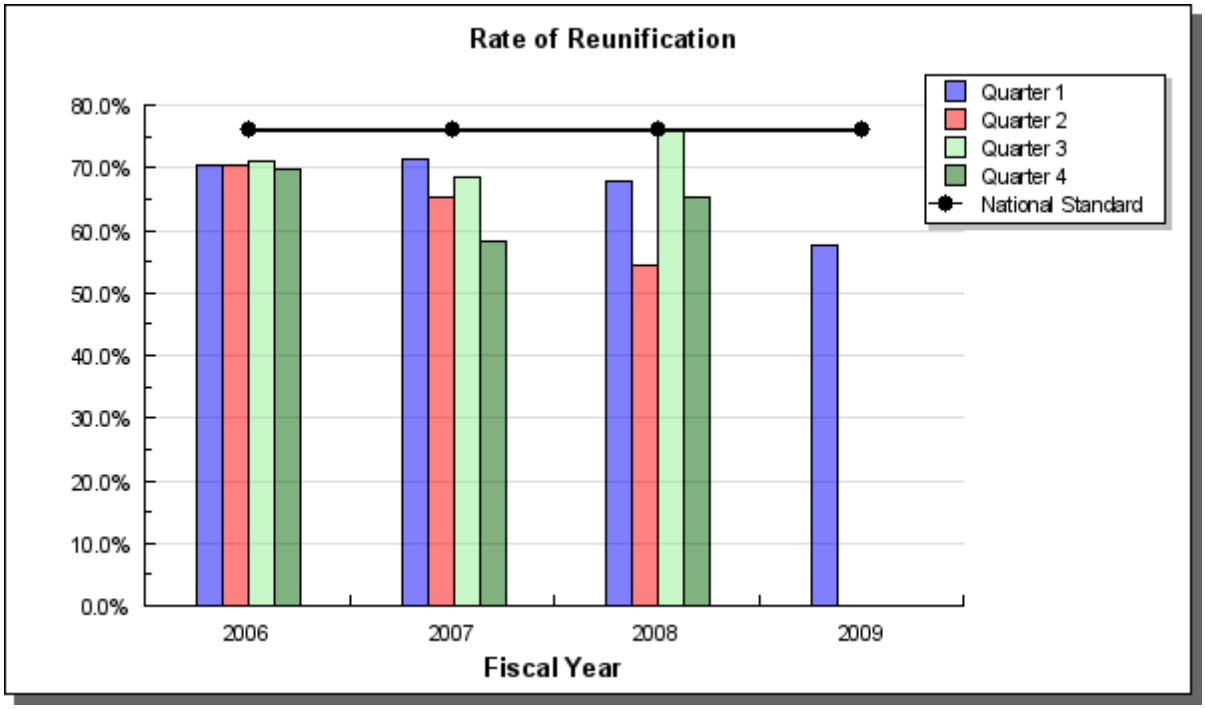
As shown above, the program has made steady progress for the past five years, but still has work to do. Not only do the number of referrals and screenings need to go up, but the availability of services required as a result needs to increase. Currently, programs do not have the capacity to provide adequate 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 safe to do so.

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

Status #1: Annual rates of all children reunified with their parents or caretakers within 12 months of removal has remained steady at 66% for 2007 and 2008. This is 10% lower than the National Standard.



Methodology: This measure is based on children returned to parents or caretakers in less than 12 months from the time of last removal. Data provided for the first two quarters of FY 2006 are static. This data was pre-ORCA and has been annualized for use in this measure in order to provide 3 full years of data. Data Source: Online Resources for the Children of Alaska Data System (ORCA). National Standards are established by the Administration for Children and Families, Children's Bureau. Data Source: Alaska's Online Resources for the Children of Alaska (ORCA) submission to the National Child Abuse and Neglect Data System (NCANDS).

*****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.*

Rate of Reunification

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Standard
FY 2009	57.7%	0	0	0	76.2%
FY 2008	67.8%	54.5%	76%	65.4%	76.2%
FY 2007	71.5%	65.2%	68.5%	58.2%	76.2%
FY 2006	70.5%	70.5%	70.9%	69.9%	76.2%

Analysis of results and challenges: This measure represents the percentage of children that were returned to their parents or caretakers in less than twelve months from the time of the latest removal, known as the rate of reunification. While the Office of Children's Services (OCS) did achieve its goal as mandated by the 2002 Federal Performance Improvement Plan, we have not met national

standards as set by the federal Administration for Children and Families Children's Bureau. There is much room for improvement in reunifying children with their families in a twelve month period.

With so much effort being placed on the new safety assessment business practice implementation, which has proven to be a more lengthy and complicated process than at first anticipated, and more emphasis on the front end of an OCS intervention to keep children safe, outcomes aimed at achieving permanency for children have not increased or decreased for 2007 and 2008.

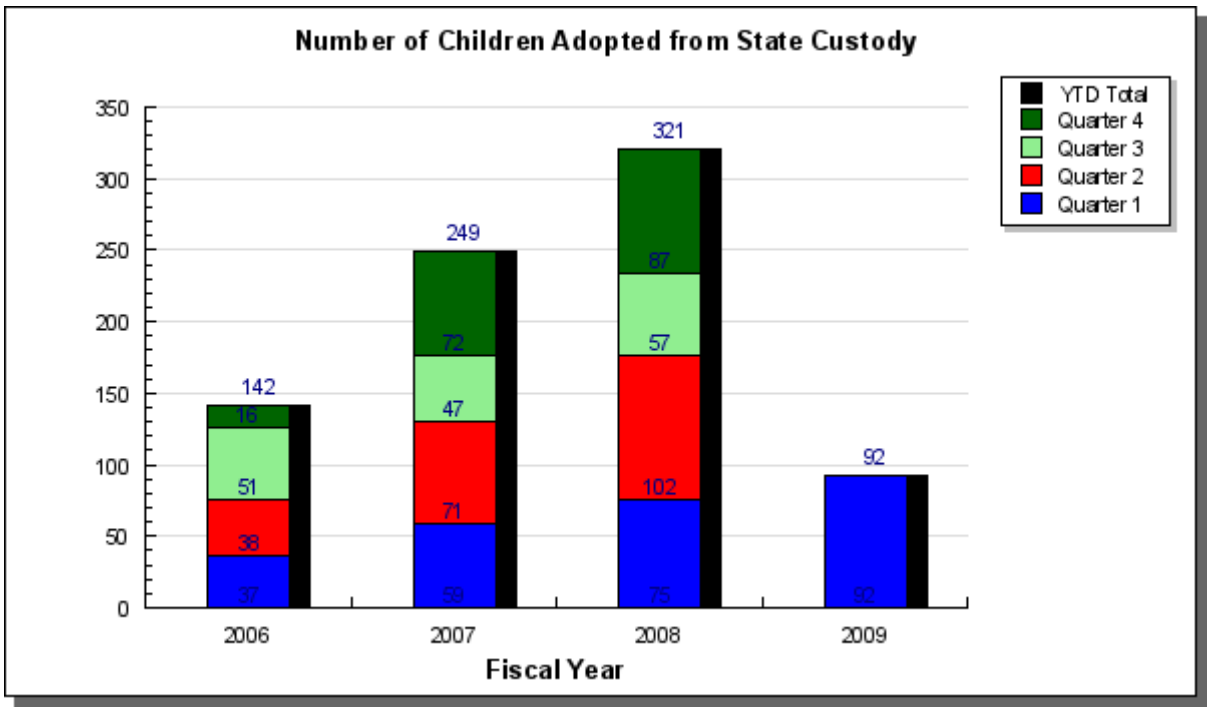
Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorney Generals, Guardians ad Litem, Court Appointed Special Advocates, and judges to assist in helping the OCS to achieve permanency goals more timely.

By successfully completing the implementation of the 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 with children in their homes more easily with the family reunified than by requiring 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.

B: Result - Safe and timely adoptions.

Target #1: Increase the annual number of completed adoptions.
Status #1: The number of children placed in adoptive homes increased by 29% from 2007 to 2008. That is equal to an additional 72 placements in a 12 month period.



Methodology: Data Source: Online Resources for the Children of Alaska (ORCA). The first 2 quarters of FY 2006 predated ORCA. In order to provide 3 full years of data, these quarters are derived from older information and are similar but not 100% comparable.

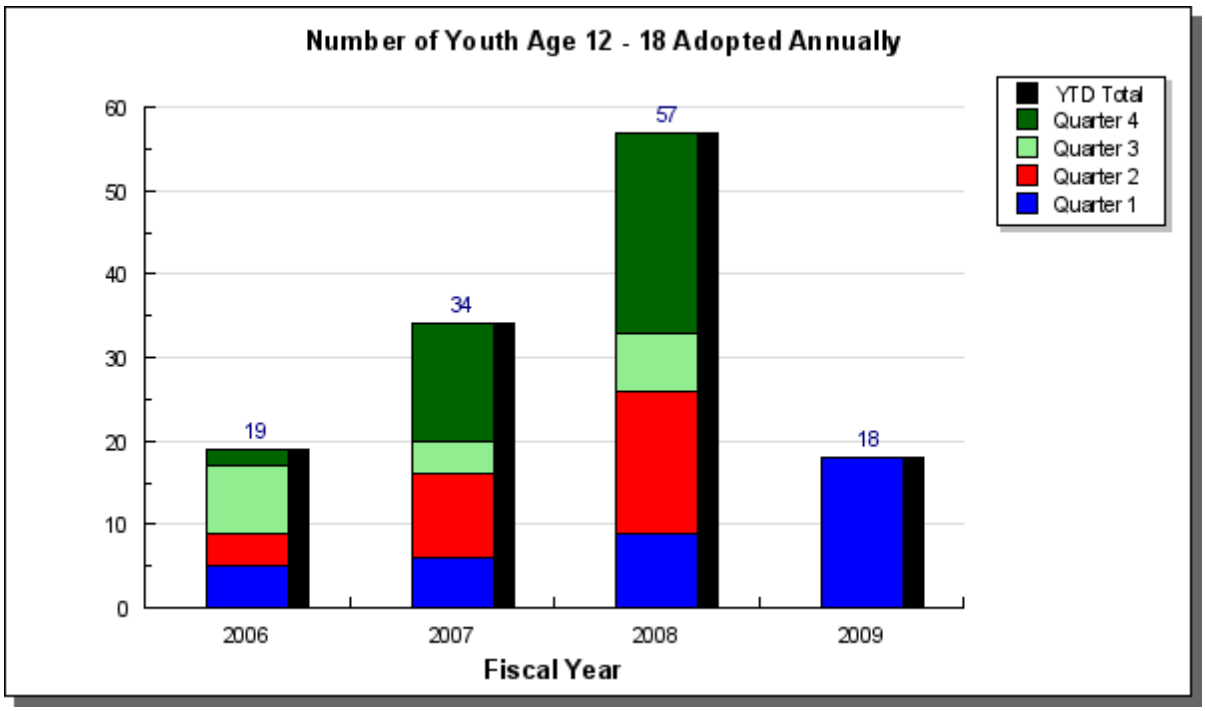
Number of Children Adopted from State Custody

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2009	92	0	0	0	92
FY 2008	75	102	57	87	321
FY 2007	59	71	47	72	249
FY 2006	37	38	51	16	142

Analysis of results and challenges: Since the passage of the Adoption and Safe Families Act of 1997, Alaska has seen an increase in the number of finalized adoptions for children from the Office of Children's Services (OCS) custody. As of June 30, 2008, there were 2,395 children (approximately 77% federally funded and 23% state funded) in the subsidized adoption program. The number of children who are able to achieve permanency through adoption in the OCS system have increased from 249 in 2007 to 321 in 2008. The chart above shows the number of finalized adoptions as reported by State Fiscal Year. As anticipated the adoptions of children in the OCS custody continues to 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 adoption of older youth ages 12 - 18 years.

Target #1: Increase the number of adoptions for youth age 12 - 18 years.
Status #1: The number of adoptions of Alaska youth age 12 through 18 increased by 67.6% from FY 2007 to FY 2008.



Methodology: Count of children aged 12 through 18 years adopted within a state fiscal year by quarter. Data Source: Online Resources for Alaska's Children (ORCA) data system.

Number of Youth Age 12 - 18 Adopted Annually

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2009	18	0	0	0	18
FY 2008	9	17	7	24	57
FY 2007	6	10	4	14	34
FY 2006	5	4	8	2	19

Analysis of results and challenges: In 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 age 12 - 18 years) has been a specific effort. National research studies have indicated that children who leave the foster care system without connections to significant adults (parents, mentors, adoptive parents, guardians) have far greater life challenges. For this reason, the Office of Children's Services has placed emphasis 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.

In 2007, there were 34 children between the ages of 12 and 18 years adopted through the child care system. In 2008, that number rose to 57. We anticipate that number to decrease or level out in upcoming years.

Health Care Services

Mission

To manage health care coverage for Alaskans in need.

Introduction

As a division of the Department of Health and Social Services (DHSS), Health Care Services (HCS) oversees and manages the Medicaid core services, including: 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 the full range of appropriate Medicaid health care services.
Assure the full range of health care services information is available to our customers.

The division's major goal is to provide support services through management efficiencies and the capitalization of Medicaid financing.

Services Provided

The following units or programs provide services in support of Alaska Medicaid:

Pharmacy and Ancillary Services Unit
This unit provides program management including research, analysis, planning, policy and regulation development for the following Medicaid Provider service programs to ensure services are high quality and cost effective: 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 and the practitioner relations provider administered drug program. The unit uses a range of parameters to carry out its responsibilities. This includes:

Preferred Drug List (PDL):

- A PDL is a list of medications within several therapeutic classes that represents Medicaid's first choice when prescribing for Medicaid recipients;
- The PDL allows the state to manage the drug program by improving effectiveness as purchasers of pharmaceuticals;
- This aligns the patient need, the physicians' knowledge, and the state's purchasing **power;**

Alaska Medicaid participates in the National Medicaid Pooling Initiative to obtain the best rebates available for the drugs that are included on the Preferred Drug List.

Pharmacy and Therapeutics Committee (P&T)

- The group of health care providers responsible for determining drug effectiveness for drugs that should/should not be on the PDL;
- The P&T Committee is composed of a group of Alaskan medical professionals who prescribe or dispense prescription drugs;
- The committee has statewide representation and includes various physician specialties, pharmacists, dentists, and a nurse practitioner.

Drug Utilization Review (DUR)

- Ensures drugs are used safely and appropriately in our Medicaid recipient population;
- Required by Federal Law to receive Federal Funding for prescription drugs;
- Complete program including review of prescriptions at the time of filing, retrospective review of drug and medical claims to determine if the prescription was appropriate;
- Committee work provided by a committee of health care professionals.

Operations Unit

The Operations Unit performs program management and oversees policies for the majority of core Medicaid services including those delivered at institutional facilities and by select outpatient providers. It is also responsible for program management of recipient services.

The unit assures compliance with federal Medicaid regulations and related federal and State program policies. It provides Medical Assistance program management for those services performed: (1) at hospitals and ambulatory surgical centers; (2) by end-stage renal disease dialysis centers, federally qualified health centers, and rural health clinics; and, (3) by select outpatient providers including physician services; dental services; transportation; physical, occupational, and speech therapy; laboratory, radiology; durable medical equipment; vision services; hospice, and home health care. The unit ensures that the relationships with consumers and medical providers are maintained at the highest possible level. It works directly with various professional health organizations and seeks their input into policies and programs. The unit assists in answering difficult clinical questions from medical providers, service recipients, and the program's fiscal agent.

The unit has responsibility for contract monitoring, compliance, and oversight of the full-spectrum of fiscal agent services for all of the listed provider types. It also 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.

The unit assists Medicaid recipients and health care providers (acting on behalf of recipients) in appropriately accessing benefits and resolving complaints and grievances. The unit monitors recipient travel under the State Travel Office, manages the statewide Early Prevention, Screening, Diagnosis, and Treatment program, supports the Breast and Cervical Cancer Program, coordinates Fair Hearing requests, represents the agency at Fair Hearings, and monitors the fiscal agent's performance related to recipient services. When necessary, the unit intercedes into recipient and provider disputes regarding eligibility and claims processing.

Finance and Recovery Unit
The Finance and Recovery Unit has two sub-sections, an Accounting section and a Third Party Liability and Recovery (TPL) section.

The Accounting section provides financial services to support the Division of Health Care Services as well as the other Medicaid divisions. The primary responsibilities of the Accounting section 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 & Disability Services, Behavioral Health, and the Office of Children's Services.

The primary responsibilities of the TPL section include pended claims related to TPL, collection of third party payments, Pay and Chase claims, administration of the Medicare Buy-in Program, and the oversight of the post-payment review and cost-avoidance contractor. The TPL section also administers the Working Disabled 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 state general fund only health services to those individuals with covered medical conditions who do not qualify for the Medicaid program. Select outpatient and prescription services are provided to Alaska's indigent for the following covered conditions: terminal illness, chronic diabetes, cancer requiring chemotherapy, chronic seizure disorders, chronic mental illness, and chronic hypertension.

Tribal Unit
The Tribal unit performs program assistance and oversight of Medicaid services at or through tribal facilities statewide. This unit has both policy and operational components that act as a support and resource to divisions in maintaining existing tribal functions (ie waivers, PCA, MH, etc); assisting in expanding tribal refinancing functions by building capacity in the tribal health care system; maintaining successful working relationships internally and externally to the Dept; tracking federal and state legislation and regulations as they pertain to tribal functions; provides technical assistance to improve revenue generation and billing efficiencies at tribal facilities; oversees Continuing Care Agreements; oversees billing manual modifications.

Systems Unit
This unit bears technical responsibility for the MMIS and related systems. Their purpose is to translate Medicaid program business needs into MMIS processing requirements, while operating within the strict confines of all related federal guidelines. They have oversight responsibility for the technical components of the fiscal agent contract. They also have responsibility for claims processing analysis and compliance with federal claims processing reporting requirements.

Rate Review
The Office of Rate Review provides quality accounting, auditing, and rate setting services to support the department's programs. Rate setting, including compliance and ongoing rate setting systems maintenance tasks, is centralized under this component for all services including Medicaid facilities, Medicaid waivers, Medicaid Continuing Care Agreement settlements, foster care, and child care facilities.

Health Policy and Infrastructure
Health Policy and Infrastructure (HPI) works with communities and organizations through needs assessments, planning, and technical assistance to assure access to quality primary and acute health care services in Alaska. Its purpose is to work with the Medicaid program, USDHHS grant programs, and other health care financing structures such as Medicare, to assure sustainability and availability of health care services. The section interacts with local, regional, statewide and federal health resource and policy opportunities to strengthen health services, facilities, and workforce.

HPI Certificate of Need Program (CON) is responsible for receiving applications from health care organizations for certificates of need, and for responding to letters of intent and inquiries about the CON process.

State Children's Health Insurance Program (SCHIP)
Denali KidCare is the State Children's Health Insurance Program (SCHIP) in Alaska.
It provides excellent health insurance coverage for children and teens through age 18, and for pregnant women who meet income guidelines. The program offers the full range of prevention and treatment services such as:

- Doctor's visits
- Health check-ups & screenings
- Vision exams & eyeglasses
- Dental checkups, cleanings & fillings
- Hearing tests & hearing aids
- Speech therapy
- Physical therapy
- Mental health therapy
- Substance abuse treatment

Health Facilities Survey
This unit is new to Health Care Services. It is being transferred from the Division of Public Health in the FY2010 budget and it is funded from the Health Facilities Survey component.

The federal government has established minimum standards for providers who wish to participate in the Medicare or Medicaid programs. Sections 1864 and 1902 of the Social Security Act establish the framework within which state health facility licensure agencies carry out the Medicare and Medicaid certification processes under agreements between the State and the Secretary of Health and Human Services. The Social Security Act stipulates that these same agencies are authorized to set and enforce standards for Medicaid. In addition, the Code of Federal Regulations (CFR) requires the state agency to perform surveys (inspections and investigations) in order to support its certification, both for Medicare and Medicaid. In Alaska, these functions are performed by the Health Facilities Survey Unit.

Health Facilities Survey is also responsible for the survey-related activities necessary for renewing, and if warranted, denying, suspending, or revoking licenses. State and federal governments have long been charged with monitoring health care in the public interest. To promote and maintain quality health care in the State of Alaska, legislation was first enacted in 1949 to provide for development, establishment, and enforcement of standards for the care and treatment of persons in health facilities. Since that time, the Department of Health and Social Services (DHSS) has been given authority to adopt, amend, and enforce regulations and standards to promote safe and adequate treatment for

individuals in health facilities in the interest of public health, safety, and welfare. The department was also given the responsibility to conduct annual inspections and investigations, to issue and renew licenses, and to deny, suspend, or revoke licenses when there is substantial failure to comply with requirements.

Health Care Medicaid Services

The Health Care Services, Medicaid Services component funds both acute medical assistance benefits provided directly to Medicaid enrollees and non-claim payments for other service costs. In FY2008, about 87% of this component's expenditures were for acute medical assistance direct benefits. Direct medical assistance includes claims for hospital, physician, prescription drug, dental, transportation and other acute care services. Non-claim payments for other services include supplemental payment programs (e.g., Disproportionate Share Hospital, Upper Payment Limit) as well as Medicare premium payments and judgments.

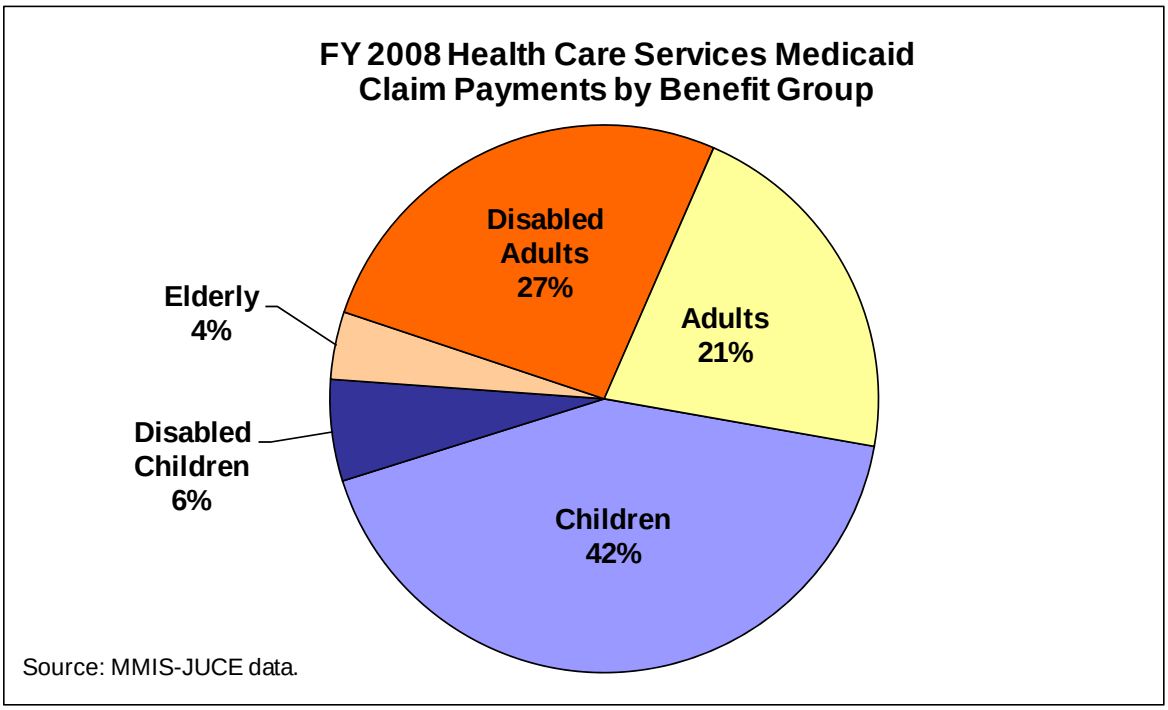
In FY2008, Health Care Services Medicaid comprised over half of the cost of all Alaska Medicaid claim payments. Hospital services accounted for the largest share of expenditures (37%) followed by physician services (19%), prescription drugs (12%), transportation services (7%), and dental services (4%).

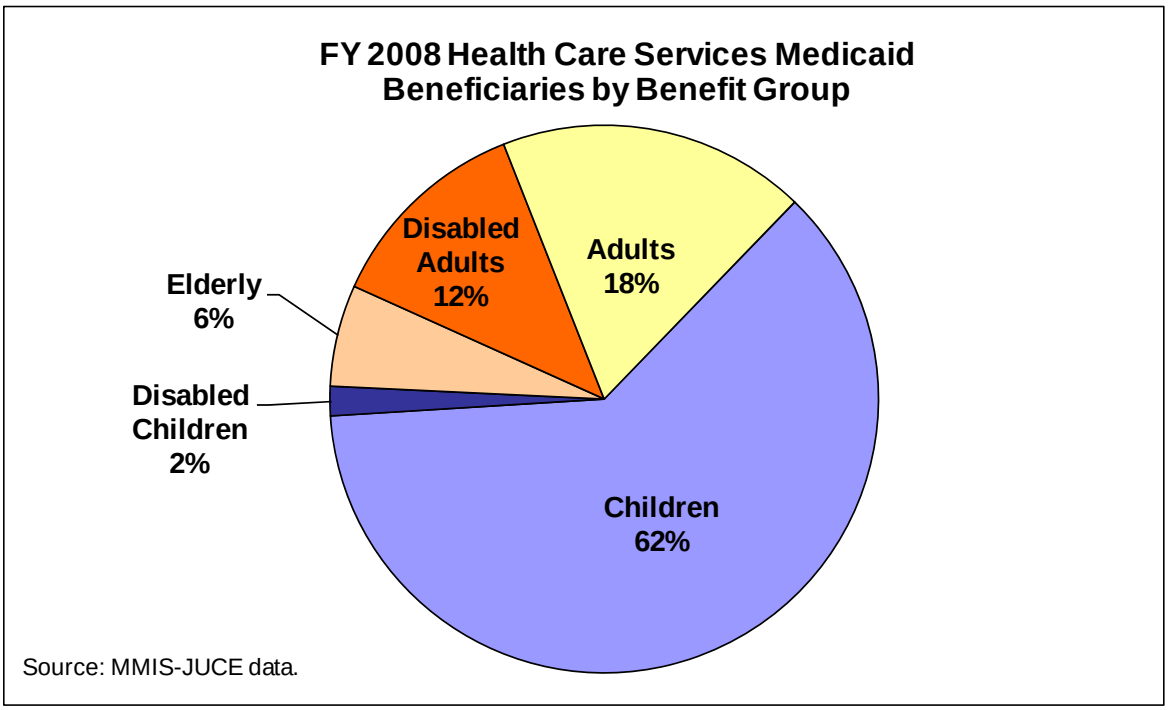
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost per Beneficiary
Children	61.8%	73,343	42.4%	$219,463.1	$2,992
Disabled Children	1.7%	2,061	6.0%	$31,042.8	$15,062
Elderly	6.0%	7,116	4.0%	$20,672.2	$2,905
Disabled Adults	12.3%	14,569	26.4%	$136,749.2	$9,386
Adults	18.2%	21,599	21.2%	$110,018.9	$5,094
Unduplicated Annual Clients		**116,552**			
Total Medicaid Claim Payments (thousands)				**$517,946.2**	
Average Annual Medicaid Cost per Beneficiary					**$4,444**

Source: MMIS/JUCE claims paid during FY2008. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost Per Beneficiary
All Health Care Services Medicaid					
Under 21	64.2%	75,404	49.4%	$256,032.0	$3,395
21 or Older	35.8%	42,079	50.6%	$261,923.8	$6,225
Hospital Services					
Under 21	56.3%	37,318	51.8%	$116,072.0	$3,110
21 or Older	43.7%	28,954	48.2%	$107,993.5	$3,730
Physician Services					
Under 21	63.2%	60,818	49.3%	$55,900.7	$919
21 or Older	36.8%	35,461	50.7%	$57,402.8	$1,619
Prescription Drugs					
Under 21	62.2%	40,301	33.4%	$25,114.5	$623
21 or Older	37.8%	24,533	66.6%	$50,186.0	$2,046
Transportation					
Under 21	53.3%	12,651	56.6%	$25,215.4	$1,993
21 or Older	46.7%	11,069	43.4%	$19,360.6	$1,749
Other Medicaid Services					
Under 21	48.5%	22,664	49.0%	$18,464.2	$815
21 or Older	51.5%	24,066	51.0%	$19,254.1	$800

Source: MMIS/JUCE.

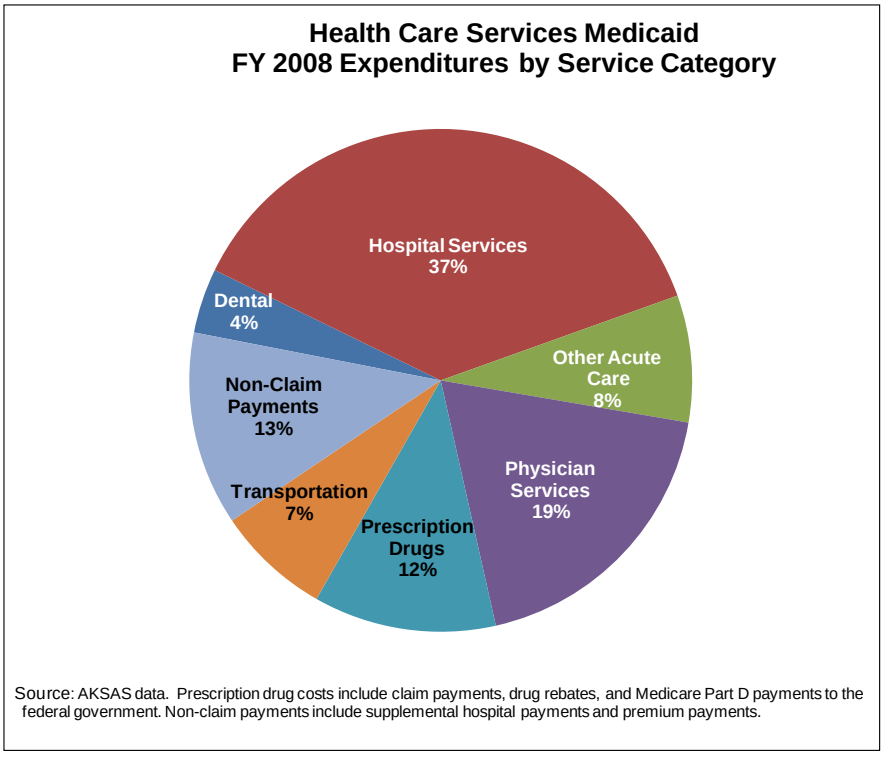

FY 2008 Health Care Services Medicaid
Claim Payments by Benefit Group
Disabled Adults 27%
Adults 21%
Elderly 4%
Disabled Children 6%
Children 42%
Source: MMIS-JUCE data.


FY 2008 Health Care Services Medicaid
Beneficiaries by Benefit Group
Disabled Adults 12%
Adults 18%
Elderly 6%
Disabled Children 2%
Children 62%
Source: MMIS-JUCE data.

In FY2008, the Health Care Services, Medicaid Services component provided direct services to 116,600 Alaskans, about 93% of all persons enrolled in the Alaska Medicaid program. The cost of direct benefits provided to Medicaid enrollees through Health Care Services totaled $518 million. Forty-eight percent of the claim payments in 2008 were for services provided to children; 26% were for services provided to adults; and 4% were for services provided to elderly individuals. Nearly one-third of claim payments in this component were for disabled children and adults.

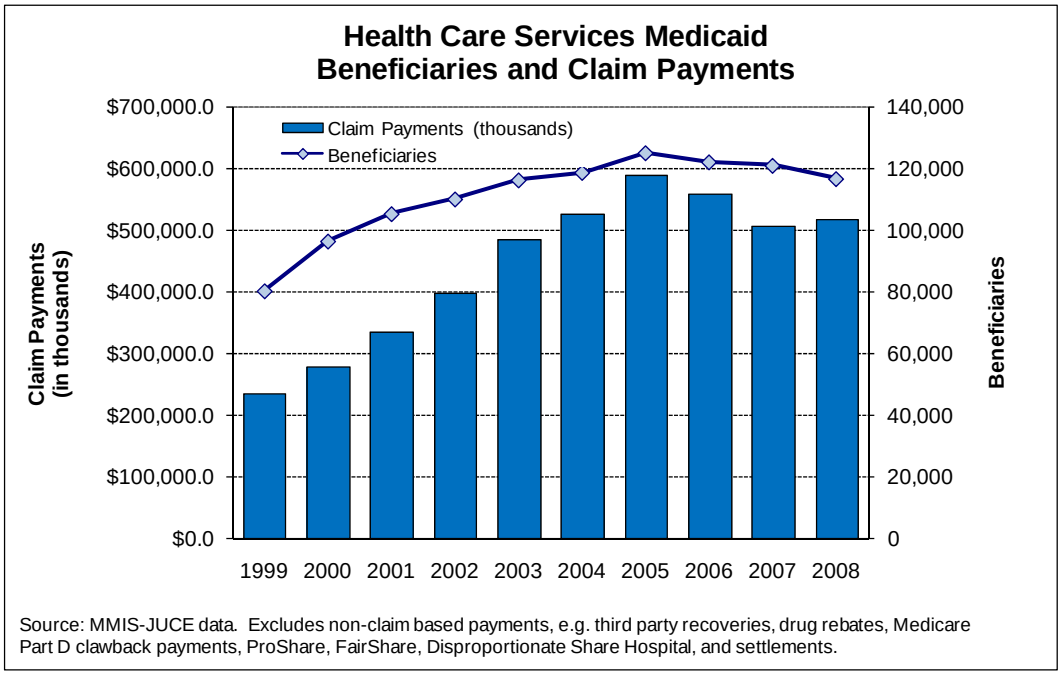
Top 5 Service Categories	Cost per Beneficiary per Year	Percent of Beneficiaries
Hospital Services	$3,400	56.5%
Physician Services	$1,200	82.2%
Prescription Drugs	$1,100	55.4%
Transportation Services	$1,900	20.3%
Dental Services	$500	34.1%
All Health Care Medicaid Services, cost per beneficiary	$4,400	
All Health Care Medicaid Services, unduplicated annual beneficiaries		116,552

Source: MMIS/JUCE. Unduplicated annual number of beneficiaries. Percent of beneficiaries includes individuals receiving services in multiple categories and will not sum to 100%. Likewise, the cost per beneficiary per year for all Health Care Medicaid Services includes multiple services received.



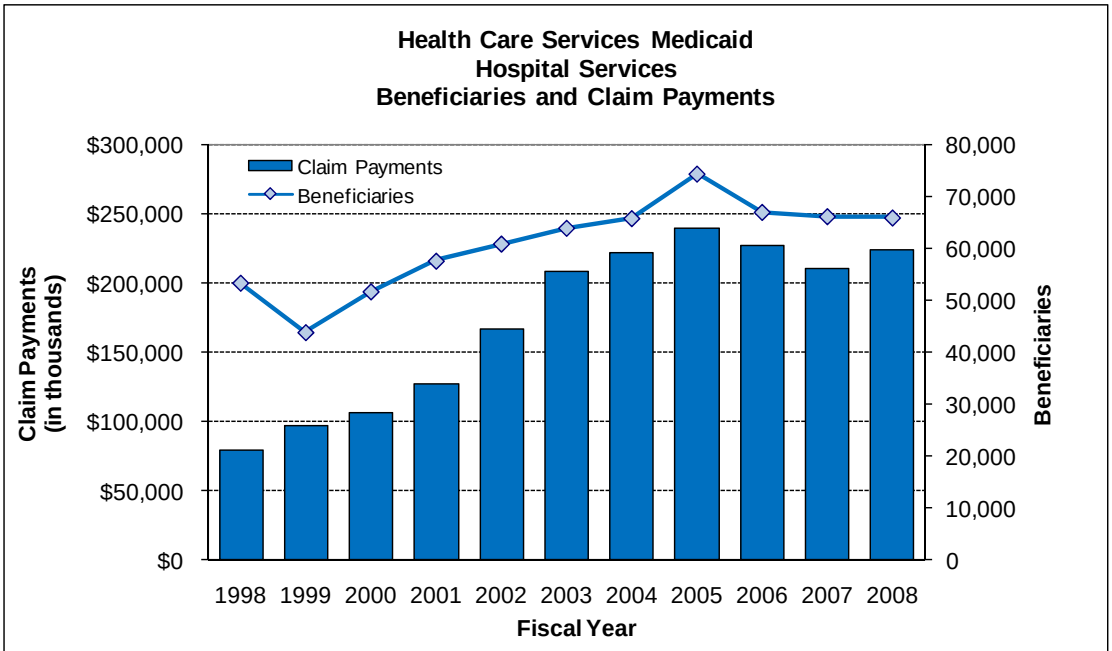
Total claim payments for Health Care Services Medicaid increased by a modest 2% from FY2007. The growth was due mainly to an increase in the cost of services. The number of beneficiaries

utilizing Health Care Services Medicaid services in FY2008 decreased by almost 4% while the average annual cost per beneficiary increased 6% to $4,400. The increase came from hospitals and prescription drug services. Physician and transportation services saw slightly reduced costs from the prior year, possibly a reflection of the decrease in enrollment.



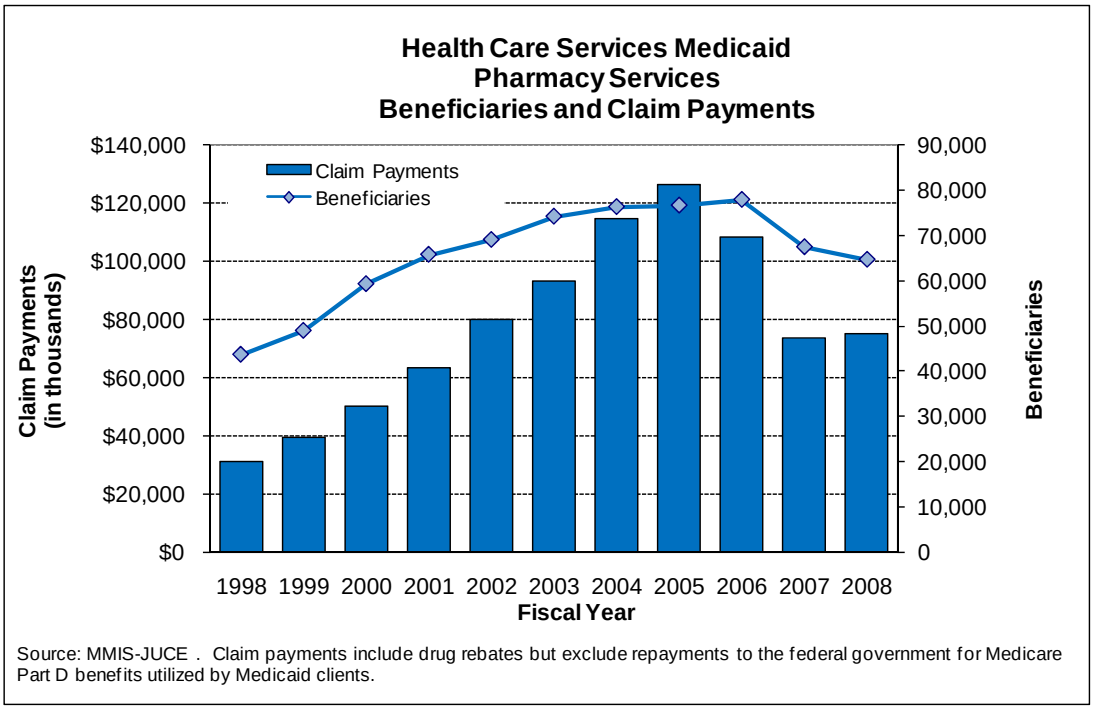
Source: MMIS-JUCE data. Excludes non-claim based payments, e.g. third party recoveries, drug rebates, Medicare Part D clawback payments, ProShare, FairShare, Disproportionate Share Hospital, and settlements.

The cost of claims for hospital services increased by 7% due mainly to changes in reimbursement rates rather than increased utilization of services. The number of beneficiaries decreased slightly (-0.4%).



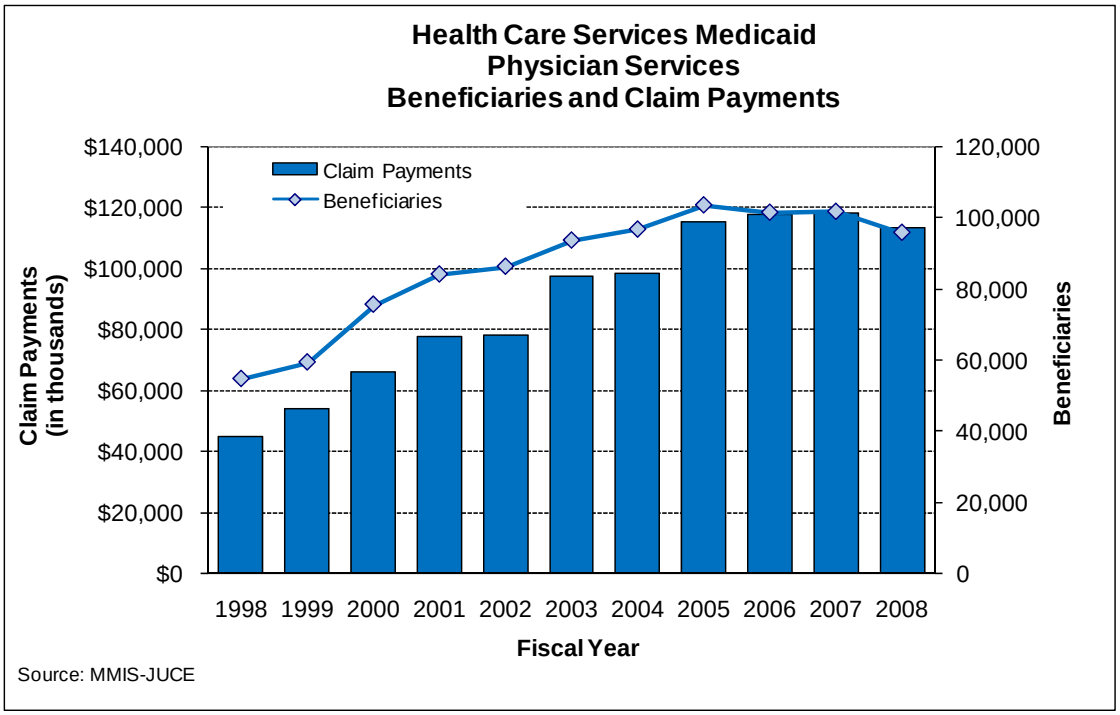
Source: MMIS-JUCE. Claim payments prior to 2006 may include Fairshare payments to hospitals (data is not corrected).

Pharmacy claim payments increased by 2% after falling for several years after the implementation of Medicare Part D prescription drug coverage. The number of beneficiaries decreased by 4% while the annual average cost per beneficiary rose 7%. This is a sign that the steady decline in pharmacy costs may be at an end and inflationary increases will again have an effect.



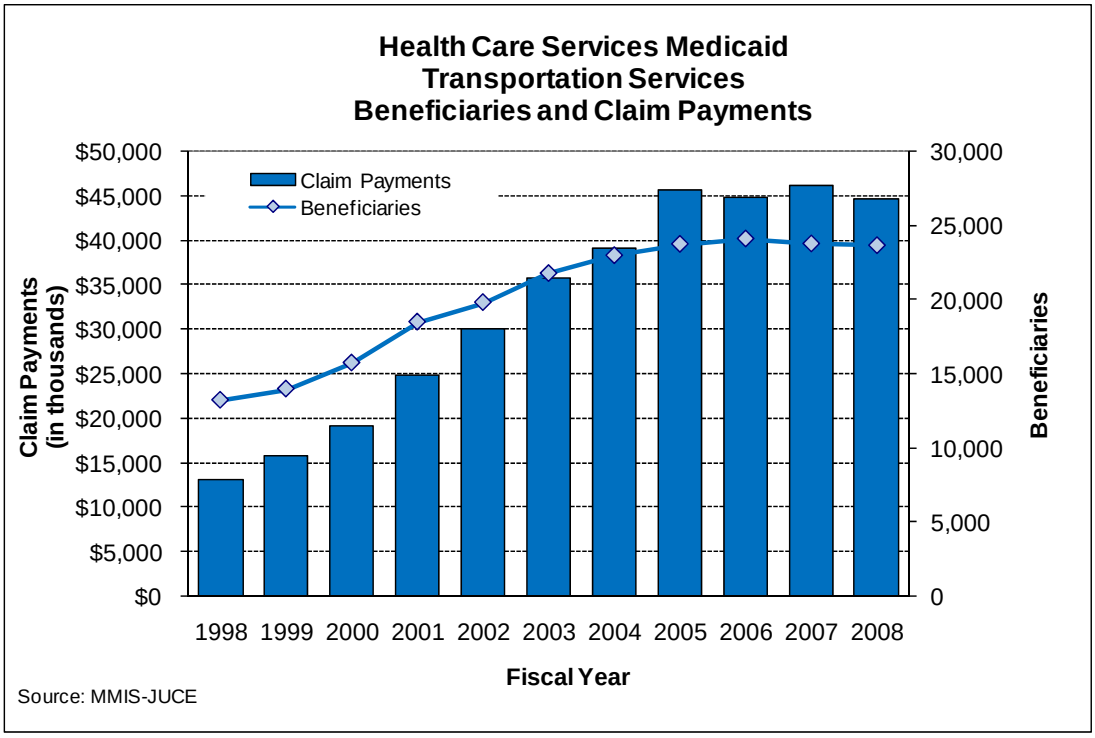
Source: MMIS-JUCE . Claim payments include drug rebates but exclude repayments to the federal government for Medicare Part D benefits utilized by Medicaid clients.

Physician services saw a decrease in total claim payments of 4%. The number of beneficiaries dropped by 6% while the average annual cost per beneficiary increased 2%, again, reflective of inflationary increases.

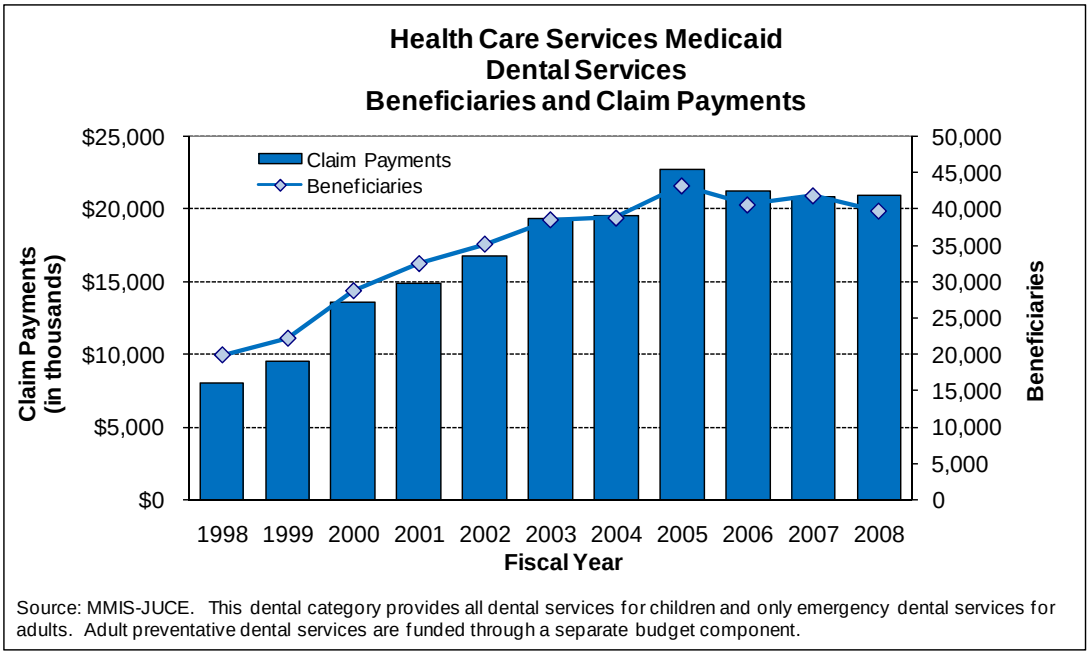


Source: MMIS-JUCE

Transportation service costs saw negative growth of -3%. This was due mostly to a 3% decrease in the annual average cost per beneficiary. Growth in the number of beneficiaries was flat with just a -0.5% change.



Total claim payments for Dental Services were relatively unchanged from FY2007 (0.5%). The number of beneficiaries dropped 5% while the annual average cost per beneficiary rose 6%. (Note: Dental services in Health Care Services do not include adult preventative dental Medicaid services that are in a separate RDU.)



SFY 2008 DIVISION LEVEL SUMMARY:Health Care Services Medicaid	HCS MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent Recipients*	Percent Payments
Medicaid, Division Annual Totals		**116,552**		**$517,946,188**	**$4,444**	**99.2%**	**54.9%**
Gender							
Female	57.2%	66,676	60.1%	$311,120,223	$4,666	99.4%	58.1%
Male	42.8%	49,908	39.9%	$206,825,965	$4,144	99.0%	50.6%
Unknown	0.0%		0.0%		$0	0.0%	0.0%
Race							
Alaska Native	39.4%	46,300	43.0%	$222,537,760	$4,806	99.5%	63.6%
American Indian	1.6%	1,839	1.6%	$8,187,968	$4,452	99.3%	61.0%
Asian	5.4%	6,380	4.2%	$21,985,135	$3,446	99.4%	47.9%
Pacific Islander	2.8%	3,329	2.3%	$11,693,677	$3,513	99.5%	60.5%
Black	5.2%	6,153	4.6%	$24,035,318	$3,906	99.2%	57.2%
Hispanic	3.5%	4,161	2.6%	$13,701,168	$3,293	99.5%	65.2%
White	39.0%	45,787	38.8%	$201,102,585	$4,392	98.9%	47.6%
Unknown	3.0%	3,465	2.8%	$14,702,578	$4,243	97.5%	49.7%
Native	41.2%	48,107	44.5%	$230,725,727	$4,796	99.5%	63.5%
Non-Native	58.8%	68,772	55.5%	$287,220,460	$4,176	99.0%	49.5%
Age							
under 1	9.5%	12,061	15.3%	$79,258,054	$6,571	99.9%	99.9%
1 through 12	36.3%	46,113	18.9%	$97,801,428	$2,121	99.4%	69.6%
13 through 18	16.4%	20,897	11.9%	$61,889,996	$2,962	98.5%	41.0%
19 through 20	3.2%	4,082	3.3%	$17,081,956	$4,185	98.8%	69.9%
21 through 30	10.4%	13,166	13.5%	$69,810,112	$5,302	99.4%	66.8%
31 through 54	13.9%	17,684	23.9%	$123,681,101	$6,994	99.3%	60.2%
55 through 64	3.8%	4,838	8.4%	$43,569,706	$9,006	99.0%	53.7%
65 through 84	5.6%	7,075	4.3%	$22,288,022	$3,150	97.6%	19.1%
85 or older	1.0%	1,217	0.5%	$2,565,812	$2,108	92.1%	6.3%
Benefit Group							
Children	61.8%	73,343	42.4%	$219,463,058	$2,992	99.4%	67.8%
Adults	18.2%	21,599	21.2%	$110,018,941	$5,094	99.7%	97.9%
Disabled Children	1.7%	2,061	6.0%	$31,042,829	$15,062	94.7%	54.3%
Disabled Adults	12.3%	14,569	26.4%	$136,749,159	$9,386	98.9%	44.3%
Elderly	6.0%	7,116	4.0%	$20,672,200	$2,905	96.8%	14.6%

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.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2008. Service may have been incurred in a prior year. Grouping is based on status on the date the benefit was obtained. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories). Some duplications may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2008. . If they obtained dental services in December, they would also be included in the 13 through 18 age subgroup count if the claim was subsequently paid during SFY08.

Because recipients were unduplicated across divisions to obtain the department total, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all 4 divisions may exceed 100%.

Source: MMIS/JUCE.

Adult Preventive Dental Services

The Adult Preventive Medicaid Dental program was established by passage of House Bill 105 in FY2006. It established a three-year trial period for the new program. If the program is not reauthorized, it will cease June 30, 2009.

Adult preventive dental services are prior authorized. An annual cap per person currently limits the cost of preventive dental services that any individual can receive during the year ($1,150 in FY08). HB 105 also contained a provision that limited total program costs to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount
The Medicaid program will continue to pay for adult emergency dental services including pain and infection. However, if the adult preventive dental services are continued, the department anticipates a reduction in the need for emergency dental treatment as some adults get their preventive and restorative work completed and their dental health improves.

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
AS 47.30 Mental Health

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
20 AAC 40 Mental Health Trust Authority

Health Care Services*	2009	2010 Gov	09 to 10 Change
General Funds	244,561.2	244,354.7	-206.5
Federal Funds	453,066.4	454,149.1	1,082.7
Other Funds	24,789.1	12,885.9	-11,903.2
Total	**722,416.7**	**711,389.7**	**-11,027.0**

*Totals include Adult Preventative Dental Medicaid Svcs RDU. Fund source breakdown for FY2009 is $1,877.0 GF/$6,831.8 Fed/$1,400.0 Other; and for FY2010 $2,602.0 GF/$3,531.8 Fed/$0.0 Other.

Health Care Services Medicaid

The Medicaid budget is based on projections of the number of eligible Alaskans who will access Medicaid funded services, estimates of the quantity of services that may be used and the anticipated changes in the costs of those services. The department uses both long-term and short-term forecasting models to project Medicaid spending. The short-term model is best for budget development and fiscal note analysis while the long-term model is best for strategic planning.

The change over a long period is generally smoother and more gradual than the annual fluctuations experienced in the short term. Since the budget-preparation cycle requires projections up to 24 months in the future, often before recent policies have been fully implemented and reflected in the baseline spending data, it is premature to know if recent changes in spending are temporary or will last.

The department's recent successes in avoiding some costs and in containing growth rates in the short term have resulted in existing authorization being briefly ahead of the trend. The department has adjusted its authorization to reflect current trends and reduced excess authorization to reestablish a revised authorization base from which to begin FY2010. This revised base becomes the foundation for the Medicaid formula growth increment and fund change for federal financial participation.

Health Care Medicaid Services	Total	GF	Federal	Other
SFY 2009 Existing Authorized	**675,131.5**	**231,092.4**	**422,149.3**	**21,889.8**
Adjust Authorization for Current Trends	(24,000.0)	(9,000.0)	(15,000.0)	0.0
Reduce Excess Federal & I/A Authorization	(27,000.0)	0.0	(15,000.0)	(12,000.0)
SFY 2010 Revised Authorization	**624,131.5**	**222,092.4**	**392,149.3**	**9,889.8**
Change in Federal Financial Participation	0.0	(6,692.8)	6,692.8	0.0
Formula Growth	34,333.6	12,865.3	21,468.3	0.0
Medicaid Cost Containment in Pharmacy	(1,400.0)	(700.0)	(700.0)	0.0
Increase Dental Rates for non-Tribal Provider	2,000.0	1,000.0	1,000.0	0.0
Total	**659,065.1**	**228,564.9**	**420,610.4**	**9,889.8**

Medicaid Program - Adjust Authorization for Current Trends: *($24,000.0) Total- ($15,000.0) Fed, ($9,000.0) GF/Match*
One in five Alaskans is enrolled in Medicaid in any given year. In an average week, 25,500 Alaskans receive some level of medical care that costs the Medicaid program $17-25 million for benefit payments made to 2,100 health care providers. Medicaid services are funded through both state general funds and federal matching funds. There must be sufficient state general funds available in order to maximize utilization of federal funds. Good business practice requires the department to maintain adequate funding to ensure that timely payments can be made to service providers.

The Legislature has requested that departments minimize supplemental budget requests through careful budget projections. The department uses both long-term and short-term forecasting models to project Medicaid spending. The long-term trend indicates annual increases in costs driven by inflation and population changes. Short-term projections are influenced mainly by enrollment and utilization of services. The change over a long period is generally smoother and more gradual than the annual fluctuations experienced in the short term.

The department has implemented reforms in Medicaid aimed at improving Medicaid sustainability. For example, the department has been successful in avoiding some costs and in containing growth rates that can result in authorization being briefly ahead of the trend. The department can adjust its authorization this year to reflect current trends by reducing the Health Care Services Medicaid component budget by $24 million ($9 million in state general funds, and $15 million in federal Medicaid revenue). This will leave a sufficient amount of funding to continue services at the current level.

Medicaid Program-Reduce Excess Federal & I/A Authorization: *($25,818.1) Total- ($15,000.0) Fed, ($10,818.1) I/A*
The department can adjust its authorization this year to reflect current trends by reducing excess federal and interagency (I/A) authority. This rebalances the funding sources to reflect recent collection rates. This will leave a sufficient amount of funding to continue services at the current level.

Medicaid Program-Formula Growth: *$34,333.6 Total- $21,468.3 Federal, $12,865.3 GF/Match*
This increment is necessary to maintain the current level of quality Medicaid health-care services for nearly 117,000 eligible Alaskans, about 95% of all those enrolled in the Alaska Medicaid program during the year.

The Medicaid Services component funds acute health care services such as hospitals, physicians, prescription drugs, dental, and transportation. Providing acute health services through Medicaid improves the department's success of reaching its goal of healthy people in healthy communities. These programs support the department's mission to manage health care for eligible Alaskans in need. Without the increment, the state would be forced to reduce eligibility or services currently provided to low-income children, pregnant women, persons with disabilities, and the elderly.

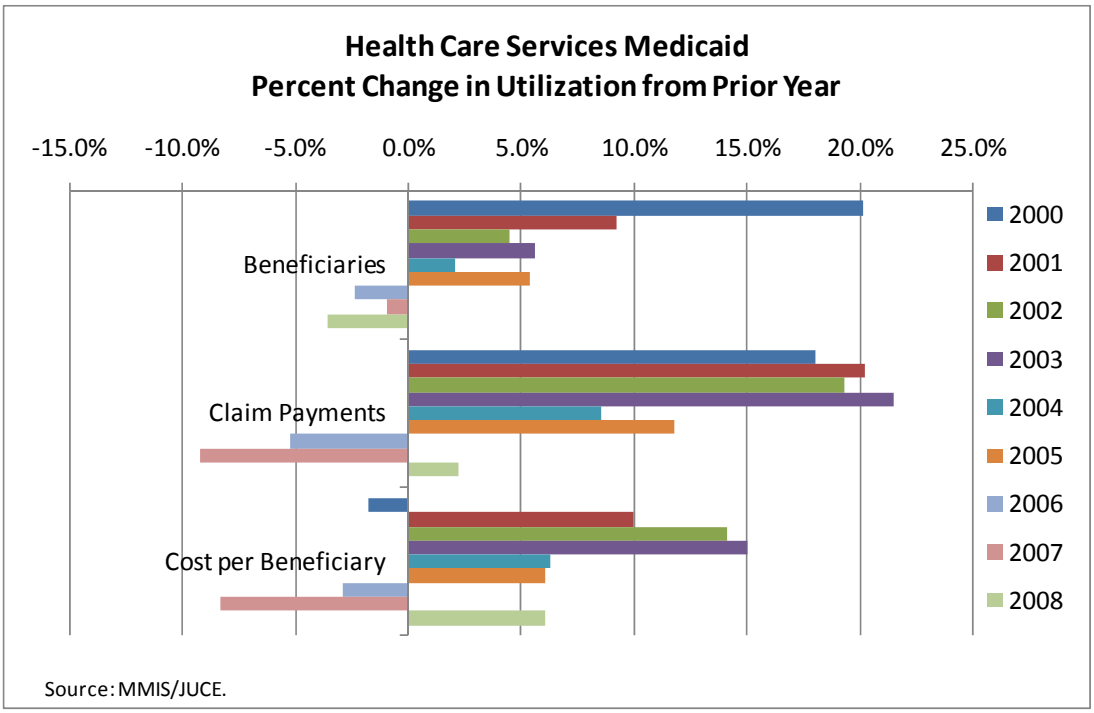
For FY2010, Health Care Services' Medicaid costs are projected to grow 6% from FY2009. Spending will rebound from the 4% drop seen between 2007 and 2008, returning to a slightly higher level than 2007. Cost containment efforts begun in FY2004 have successfully reduced the rate of growth in recent years for direct benefits from a high of 21.5% for 2003. Cost containment has been especially effective in pharmacy services; costs for this category have fallen 28% since the high of $95.7 million in 2005. Additional capacity expected on completion of new facilities and increases in provider

reimbursement approved by the 2008 Legislature will contribute to the approximately 6% increase in costs forecast for FY2010.

Projections for formula growth are based on historical trends in enrollment, utilization, provider reimbursement, and federal financial participation. Projections include recently adopted policy changes that are not yet reflected in the trends, e.g. provider rate increases effective in 2009; however, the formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP).

Health Care Medicaid Services Direct Benefits						
State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	80,099	$235,260.2	$2,937			
2000	96,263	$277,807.6	$2,886	20.2%	18.1%	-1.7%
2001	105,185	$333,979.5	$3,175	9.3%	20.2%	10.0%
2002	109,946	$398,598.1	$3,625	4.5%	19.3%	14.2%
2003	116,151	$484,435.8	$4,171	5.6%	21.5%	15.0%
2004	118,575	$525,882.5	$4,435	2.1%	8.6%	6.3%
2005	124,978	$588,067.1	$4,705	5.4%	11.8%	6.1%
2006	122,023	$557,633.3	$4,570	-2.4%	-5.2%	-2.9%
2007	120,879	$506,497.9	$4,190	-0.9%	-9.2%	-8.3%
2008	116,552	$517,946.2	$4,444	-3.6%	2.3%	6.1%

Source: MMIS/JUCE. Paid claims for direct services to Medicaid clients only. Excludes CAMA, Senor Care Drug, and Public Assistance field services benefits. Excludes supplemental payments, premium payments and other services processed outside of the MMIS claims system. Enrollment is the number of persons ever enrolled during the fiscal year (unduplicated annual enrollment).



Medicaid Program - Change in Federal Financial Participation: *$6,692.8 Fed, ($6,692.8)GF Match*
This fund change request rebalances state and federal funding needs resulting from a 0.9-point increase in the annual rate the federal government reimburses the state for Medicaid benefits.

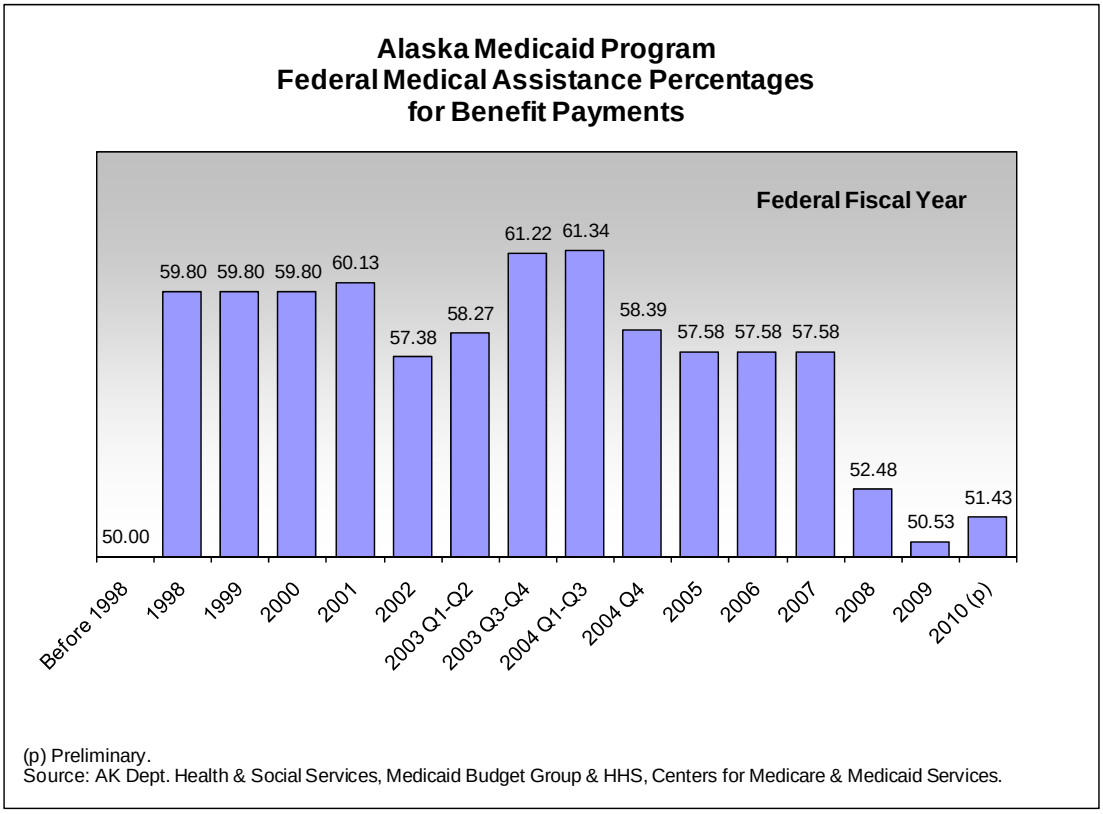
The new federal medical assistance percentage, or FMAP, takes effect on October 1st at the start of the federal fiscal year. The preliminary rate for FFY 2010 is 51.43%, up from 50.53% in FFY2009. For FFY2010 the preliminary enhanced FMAP is 65.37%. The final rates will be published in December but are not expected to change much from the current estimates.

One in five Alaskans is enrolled in Medicaid at some time each year. By approving the change record, the department will be able to continue to meet its mission of managing health-care for Alaskans in need and maintain services at the current level.

The federal and state governments jointly fund Medicaid. The total amount of federal reimbursement for Medicaid depends on a complex array of federal financial participation rates; however, the bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the FMAP rate. The State Children's Health Insurance Program (SCHIP) and the Breast and Cervical Cancer program (BCC), which are part of Alaska's Medicaid program, are reimbursed at an enhanced FMAP rate. (Indian Health Service and family planning service reimbursement rates of 100% and 90%, respectively, are fixed and do not change annually.) U.S. Department of Health and Human Services sets the FMAP rate and it is outside the control of the state government. The FMAP is based on a state's national rank of a three-year average of per capita personal income but can be no less than 50%. The enhanced FMAP reduces the state's share of costs by 30% over the regular FMAP. The enhanced rate can be no lower than 65%.

The average FMAP for the state fiscal year is 51.21% (50.53% from July-September and 51.43% from October-June) and the enhanced FMAP for FY 2010 will average 65.84% (65.37% from July-

September and 66.00% from October -June). Approximately 67% of the Health Care Services/Medicaid Services component's claims are reimbursed at the regular FMAP and another 6% at the enhanced FMAP. The remaining 27% is not affected by the change in FMAP.



(p) Preliminary.
Source: AK Dept. Health & Social Services, Medicaid Budget Group & HHS, Centers for Medicare & Medicaid Services.

Medicaid Cost Containment in Pharmacy One-time Item $-700.0 Federal/$-700.0 GF/Match
The department continues efforts to reform the Medicaid pharmacy program and pursue cost containment endeavors for a sustainable Medicaid program. This one-time decrement reduces authorization for costs avoided in the Medicaid pharmacy program through a variety of cost containment strategies. The actual amount of avoided costs from these efforts is highly uncertain due to the inflationary pressures on the prescription drug market.

One successful cost containment strategy is the Preferred Drug List, which the department continues to expand. The department has reviewed a new class of drugs, the Atypical Antipsychotics, this fall. It is estimated that adding this drug class to the PDL may provide cost containment in FY2009 of $800.0.

Another cost containment strategy employed in the pharmacy program is prior-authorization for proton pump inhibitors. Implementing this change avoided costs of $400.0 over six months in FY2008 and is expected to avoid an additional $400.0 in FY2009.

Another method of counteracting the inflationary pressure on prescription drugs is the supplemental rebate program. In FY2009, the pharmacy program should be able to offset some inflationary cost increases with rebates on the Antipsychotic drugs.

The department is in the process of completing a Fee Survey that may increase reimbursement for dispensing fees; however, this should be mitigated with a corresponding decrease in the Estimated

Acquisition Cost of drugs and adoption of a State Maximum Acquisition Cost. Currently the EAC is 95% of average wholesale price. The net effect of these initiatives will be an anticipated decrease in pharmacy costs of $200.0. This change in reimbursement is contingent on approval of a state plan amendment as required by CMS.

Increase Dental Rates for non-Tribal Providers: *$2,000.0 Total- $1,000.0 Federal/$1,000.0 G/F Match*

This increment funds Phase II reimbursement rate increases for non-Tribal Medicaid dental providers. Medicaid pays dental claims for about 42,000 persons a year, mostly children. In FY2008, the department proposed phasing in updated reimbursement rates for non-Tribal dental providers over a two-year period. (Tribal dental providers have a different reimbursement methodology and are therefore excluded). In FY2009, the department implemented Phase I and increased rates on the most frequently billed codes to about 80% of billed charges. This strategy maximized reimbursement for most, but not all, accessed services. The department intends in FY2010 to review rates for all the remaining Medicaid dental service codes that were not updated in Phase I and increase reimbursement to approximately 80% of current billed charges.

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. This increment will help the department increase the number of providers, which will improve access to quality health care services to eligible Alaskans. The division estimates that it will require an additional $2,000.0 in SFY2010 due to fee-for-service rate increases.

Medical Assistance Administration

Provider Re-enrollment: *$1,600.0 Total- $800.0 GF/MH, $800.0 Fed*

CMS requires periodic re-enrollment of providers to ensure accurate and up to date records of providers are maintained. The State of Alaska last conducted a full enrollment of providers nearly 20 years ago and one will be required prior to go live of the new Medical Management Information System (MMIS). The enrollment was included in the failed 2003 MMIS Procurement, but was not included in the current procurement and contract. Prior to the activation of the new MMIS, an enrollment/re-enrollment must be accomplished. There is some concern that the new MMIS cannot become certified until an enrollment is accomplished. To aid in capturing FMAP for this process, a reenrollment under the current legacy contract will be accomplished and the data imported into the new MMIS upon activation. The efficiencies of the new MMIS enrollment will be utilized to ensure minimal impact on providers.

Challenges

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 FY2009, rates paid to hospitals, nursing homes, dentists, and transportation providers were increased. In FY2010 there remain several challenges related to reimbursement rates:

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% of billed charges for dental services under Medicaid. Payment to dental providers is based on 80% 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% of current billed charges over a 2 or 3 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.

Health Care Services and the Office of Rate Review will work together to establish a rate setting methodology covering recipients with end stage renal disease. The new rates will no longer be based on billed charges, and more costs for eligible recipients will be shifted to Medicare. 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. Medicaid recipients who appear to be eligible for Medicare will now be required to apply for Medicare, enabling Medicaid to avoid the full cost of treatment.

Tribal Medicaid

The Alaska Native Tribal Organizations have requested the State consider changing the reimbursement methodologies available to Tribal behavioral health providers. Tribal behavioral health services are currently reimbursed based on the lesser of billed charge, the provider's lowest billed charge, or a per procedure rate schedule (fee for service) established by the State. Reimbursing Tribal behavioral health at the IHS outpatient hospital encounter rate will provide improved financial stability allowing tribes to expand volume and scope of behavioral health services. The more Medicaid behavioral health services that can be provided in Tribal facilities, the more state general funds Alaska saves by insuring the federal government meets its trust responsibility to native beneficiaries. The challenge to the division of behavioral health is that this option creates tension between tribal and non-tribal providers in hub/urban areas. The non-tribal providers see this as the creation of a dual services delivery system. However, the IHS outpatient hospital encounter rate is closer to the actual costs of delivering services offered at Tribal facilities. Allowing the encounter rate will improve the financial viability of Tribes, insuring access to behavioral health for all residents, both native and non-native, statewide. Local access to health care will reduce the costs for Medicaid clients traveling to receive similar care elsewhere in the state.

Medicaid Pharmacy

The dispensing fee survey suggests higher dispensing fees to pharmacies. It will be necessary to gain CMS approval to implement these. In order to obtain CMS approval it will be necessary to decrease our drug acquisition cost. The benchmark average wholesale price sunsets this year, therefore the Department is challenged to determine a new equitable acquisition cost benchmark such as wholesale acquisition cost with an up-charge that fully covers pharmacy cost of goods. 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. These changes are necessary to continue to efficiently provide quality pharmacy services by maintaining enough local providers to serve client's needs.

Adult Preventive Dental Medicaid Services

The Adult Preventive 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 at the end of SFY 2009. If not reauthorized, the program will end June 30, 2009.

Key to the continued success of the adult preventive 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). If the adult preventive dental program is reauthorized, DHSS will continue to work with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program. Should the program be reauthorized, to assure the adult preventive program's success, the department will continue to cap the dental services for each individual at $1,150 and operate within the budgeted amount.

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. In SFY 2008, the State successfully bid and awarded a contract to Affiliated Computer Services (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. Now 12 months into the development of the new system, it is on schedule and on budget for a June 2010 go-live with a highly interactive, state of the art web based system.

Health Care Services Results Delivery Unit

Contribution to Department's Mission

To manage health care coverage for Alaskans in need.

A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.
Status #1: Due to decreases in IHS billings and FFP rate no success towards target was realized.

Health Care Services Actuals - Other Funds (in millions)

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

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: FY2004 is the first year reported after the reorganization. FY2004 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% in expenditures.

Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures.
Status #1: IHS Medicaid participation continues to decline as IHS providers realign their array of services to respond to continuing decline in IHS support.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2008	$366.6	$94.6	26%	-29%
FY 2007	$490.2	$134.2	27%	-14%
FY 2006	$528.9	$155.6	29%	-12%
FY 2005	$558.2	$177.8	32%	15%
FY 2004	$503.6	$154.5	31%	15%
FY 2003	$466.6	$134.9	29%	51%
FY 2002	$385.9	$89.3	23%	22%
FY 2001	$323.0	$73.3	23%	48%
FY 2000	$268.4	$49.4	18%	32%
FY 1999	$228.6	$37.5	16%	98%

Methodology: Total expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

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

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from FY2006 to FY2007 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% 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% FMAP for service delivery to AI/AN beneficiaries, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system 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 healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long-term system becomes.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Status #1: The division was only able to meet a target of 1% due to a decrease in collections of subrogation, Medicare, and TPL Contractor. The Program Integrity Unit is no longer associated with HCS and its recoveries are not available.

Medicaid Recoveries: Drug Rebates & Third Party Liability (TPL) Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2008	21.9	8.5	30.4	1%
2007	15.5	14.5	30.0	19%
2006	27.5	9.4	36.9	5%
2005	30.2	8.7	38.9	32%
2004	19.4	10.1	29.5	18%
2003	17.0	8.0	25.0	N/A

Analysis of results and challenges: Overall TPL collections for Health Care Services has remained relatively unchanged for fiscal years FY2007 and FY2008. In FY08 there was only a 1% increase over FY07. Most of the leveling off can be attributable to a decline in receipts recovered by the TPL contractor, subrogation, and Medicare.

B: Result - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.
Status #1: While there has been success in expanding provider mix and numbers, the greatest gains have been in the array of services available to be delivered by anciliary providers and physician extenders.

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2007	2,485 +1.22%	275 -30.73%	2,020 -2.93%	1,536 -28.49%	11,915 -4.64%
2006	2,455	397	2,081	2,148	12,495

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 average response time from receiving a claim to paying a claim.
Status #1: The division has decreased the average time to pay a claim from 18 days to 11 days from FY2007 to FY2008. This represents a 39% reduction.

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

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY 2008	7,263,956	11	-7
FY 2007	7,293,304	18	6
FY 2006	7,721,709	12	-1
FY 2005	7,903,523	13	3
FY 2004	6,690,344	10	0
FY 2003	5,615,072	10	-2
FY 2002	4,959,864	12	0
FY 2001	4,409,121	12	2
FY 2000	3,720,254	10	0

Methodology: Note: Between FY02 and FY03 reports were based on six months 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 FY2007 and FY2008 decreased from 18 days to 11 days.

Three new initiatives, two in the second half of FY2006 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 Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry.

The decrease from FY2007 to third quarter FY2008 is a result of completion of training and increased staff proficiency.
All of the above would have had impact on processing time.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the percentage of adjudicated claims paid with no provider errors.
Status #1: The percentage of claims without error and paid within ten days decreased to 70% in FY2008 compared to 72% in FY2007.

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

Year	Medicaid Claims Paid	% No Errors	% Change
2009	1,538,356	68%	-2%
2008	5,562,537	70%	-2%
2007	5,606,347	72%	-2%
2006	6,082,318	74%	2%
2005	6,150,027	72%	-4%
2004	5,106,692	76%	3%
2003	4,776,730	73%	-1%
2002	4,202,677	74%	1%
2001	3,670,331	73%	1%
2000	3,076,978	72%	0%

Methodology: Chart Notes
1. Between FY01 and FY03 reports were based on six months of data. Since FY04 reports have been based on annual data.
2. This measuer was updated annually through FY05; beginning with FY2006, it is being updated quarterly.
3. FY09 numbers are through first quarter of FY09.
4. 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 website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY2006 and FY2007 in Pharmacy. During FY2006, the Department of Health and Social Services (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 noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

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Division of Juvenile Justice

Mission

The mission of the Division of Juvenile Justice is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Introduction

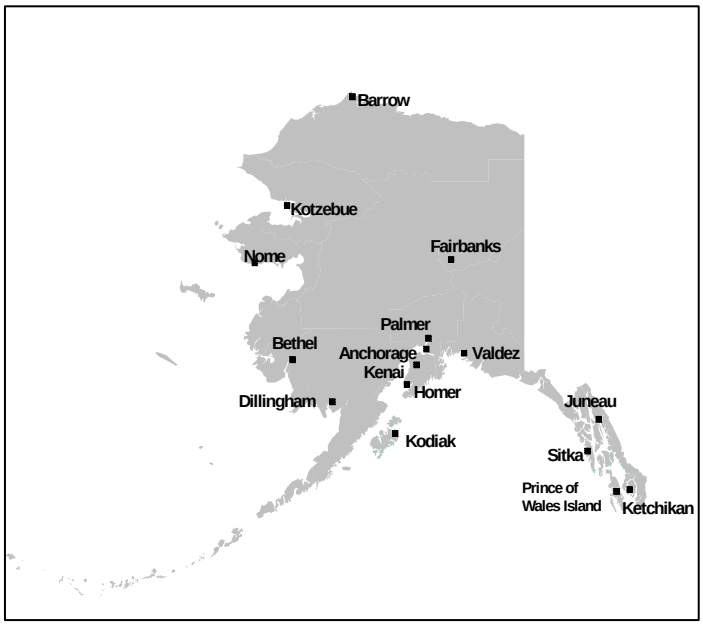
The Division of Juvenile Justice (DJJ) provides services to juveniles who commit a delinquent offense. The division responds to the needs of juvenile offenders in a manner that supports community safety, prevents repeated criminal behavior, restores the community and victims, and helps youth develop into productive citizens. Services are provided in the least restrictive setting that will both ensure community protection and promote the highest likelihood of success for the juvenile offender.

Core Services

- Short-term secure detention
- Court-ordered institutional treatment for juvenile offenders
- Intake investigation and management of informal or formal response
- Probation supervision and monitoring
- Juvenile offender skill development

Services Provided

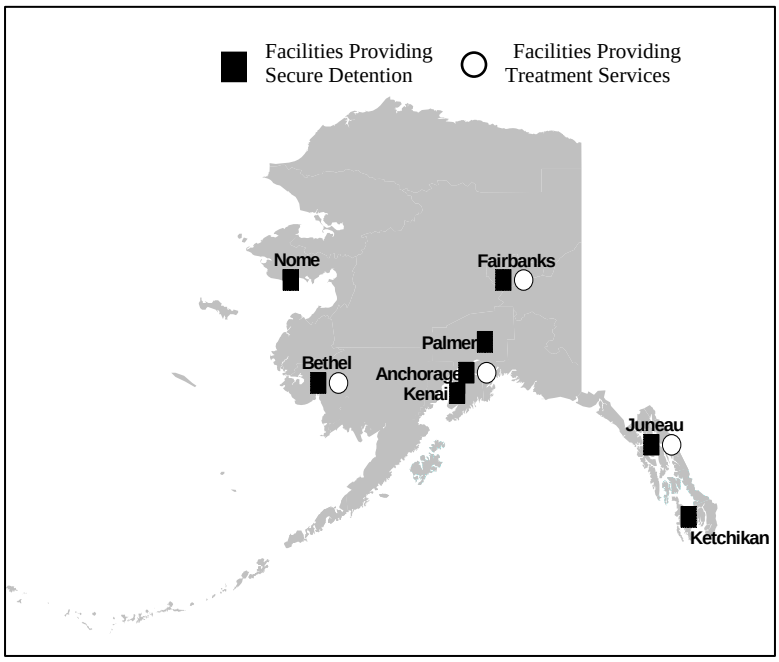
Services provided by the Division of Juvenile Justice can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions.



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 of having 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 166 beds (65 detention beds, 96 longer-term treatment/training school beds and 5 beds which can be used as either detention or treatment). The detention units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Cordova, Valdez, Kodiak, Dillingham and Aleutian/Pribilof Islands. The Training School 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.

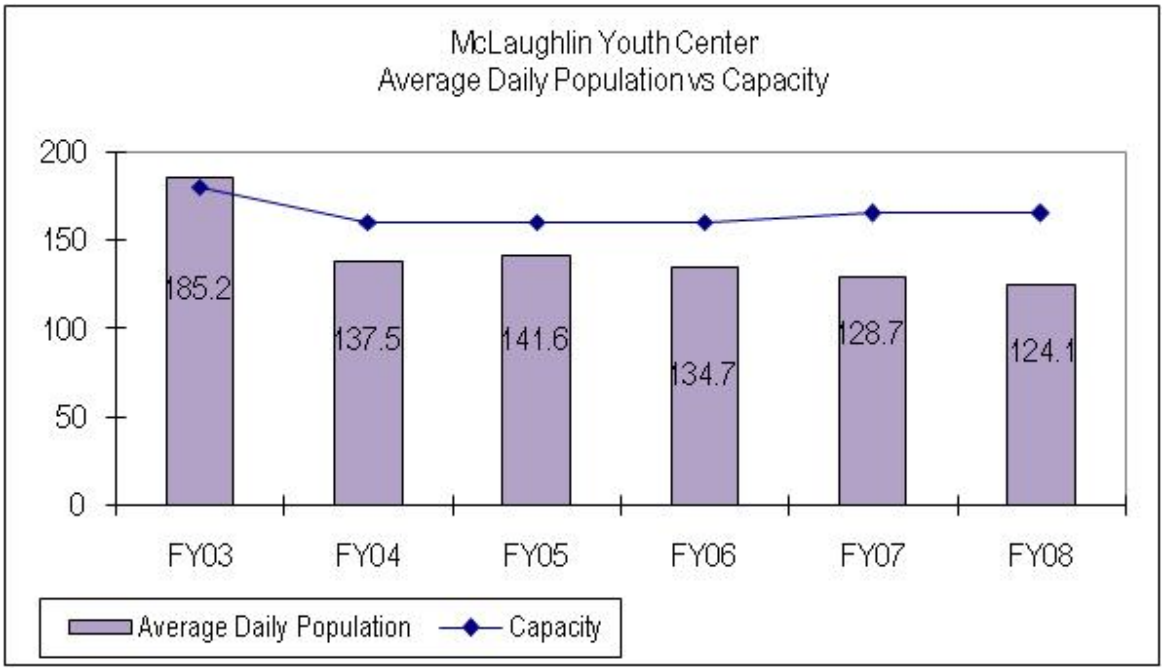
The MYC's Transitional Services Unit (TSU) was created in FY2004 and was designed to prepare each institutionalized youth for a gradual and successful re-entry into the community from the time he/she is institutionalized. TSU staff provides monitoring, supervision and support of youth in the community 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 around the state.

Staff at MYC maintains a large number of very effective collaborations with community members and other agencies. A few of these are Boys and Girls Clubs, City of Anchorage Parks and Recreation, Salvation Army, Alaska Youth Environmental Action group, and Catholic Social Services. Mentoring programs with Big Brothers Big Sisters and UAA's Alaska Mentoring Initiative have resulted in the largest number of mentors working with MYC residents in many years. Through

the Anchorage School District and local employers, our youth have increasing numbers of "real world" work opportunities to help them develop work skills and a positive work ethic.

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 FY2004, the total capacity was reduced to 160 with the closure of Cottage 3 and conversion of the program to the Transitional Services Unit. In FY2007, 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)

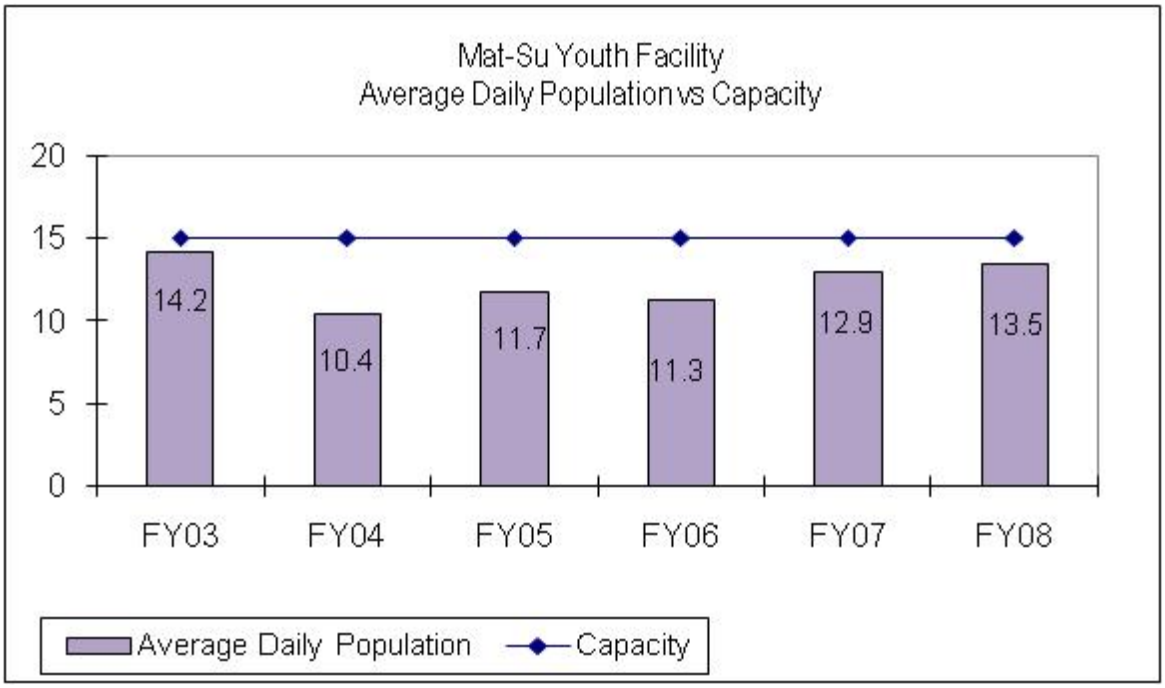
MSYF is a 15-bed juvenile detention center located in the city of Palmer, Alaska, serving a population base exceeding 77,000 in addition to the outlying areas of the Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. Services provided to residents of the facility focus on 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.

MSYF management and staff have exceptional contacts with community agencies and providers. The

staff collaborate extensively to integrate community services into the facility and to support the facility's residents in becoming contributing members of the community. A few of MSYF's many partners are the Mat-Su Community Justice Coalition, Mental Health Court, Substance Abuse Prevention Coalition, and the Mat-Su Food Bank.

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)

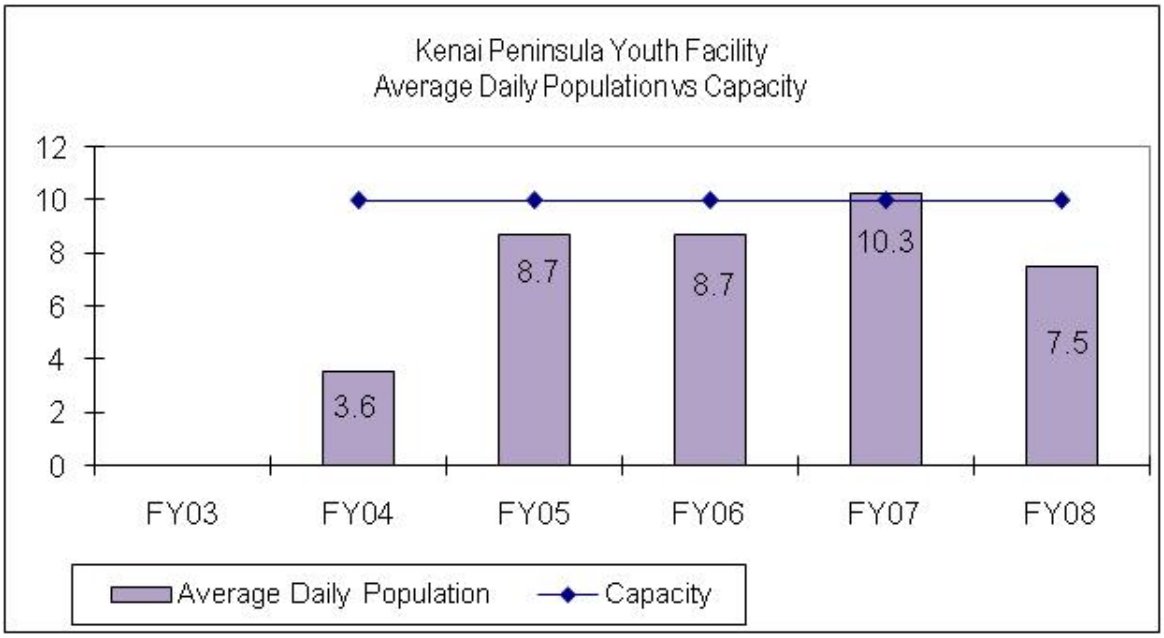
The Kenai Peninsula Youth Facility provides a 10-bed, secure placement setting for youth from the Kenai Peninsula area that are awaiting further court action, or pending transfer to or from another placement or institutional program. The facility also houses the Kenai Juvenile Probation Offices and provides 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 facility maintains close collaborative relationships with a wide range of other state agencies and community partners. These include the Office of Children's Services, the Divisions of Public Health

and Behavioral Health, as well as VISTA, Central Peninsula Counseling Services, the Kenai Fire Department, and numerous others. The Kenai Peninsula Youth Facility participates in the Kenai area Children's Team, which is comprised of managers of various area service agencies. KPYF staff are working with Central Peninsula Counseling Services to develop a memorandum of agreement that will provide for our potential need for Critical Incident Stress Debriefing services.

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 FY2004 is for 6.5 months.

Fairbanks Youth Facility (FYF)

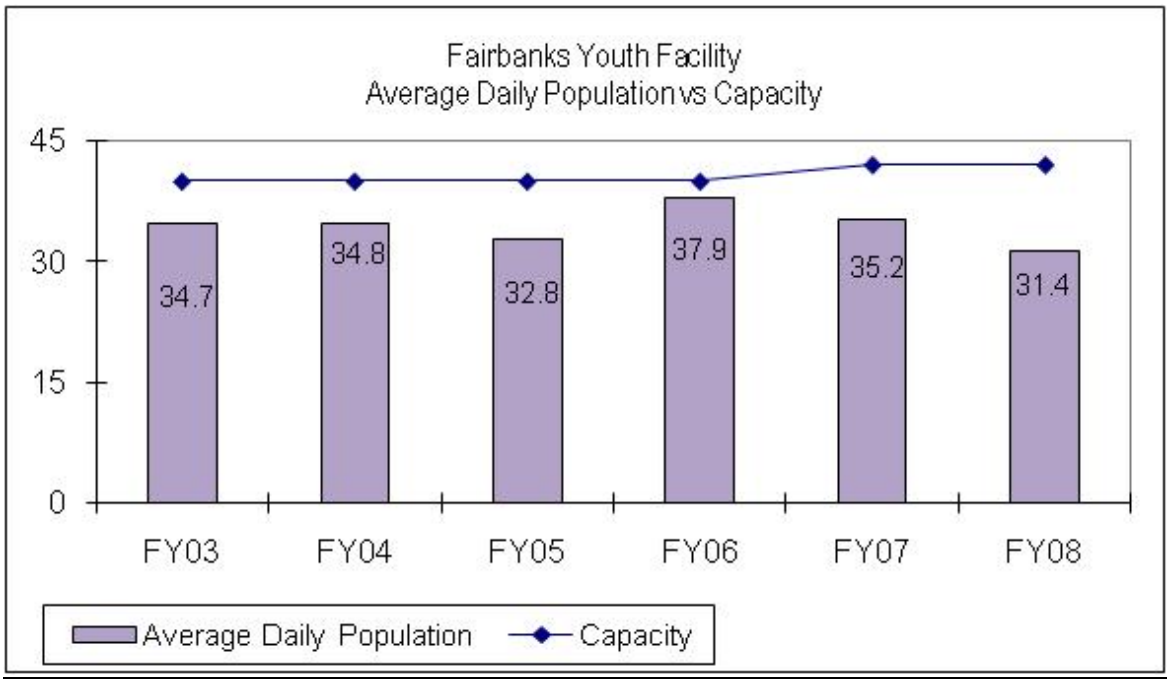
FYF consists of a 22-bed detention unit and a 20-bed treatment unit. The detention unit houses and offers services to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court. The treatment unit houses and makes rehabilitative services available 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 our Northern Region, which is the largest geographical area served by the division in the state.

Residents with intensive mental health or Fetal Alcohol Spectrum Disorders 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.

FYF staff collaborates frequently with the Office of Children's Services, as partners in a diversity effort both divisions are pursuing, and in the sharing of training and other resources. FYF is committed to this endeavor to help us work in unison for the benefit of all of our clients. FYF is also

a member agency of the Compass Coalition, which educates on issues related to substance abuse and advocates for additional resources.

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.



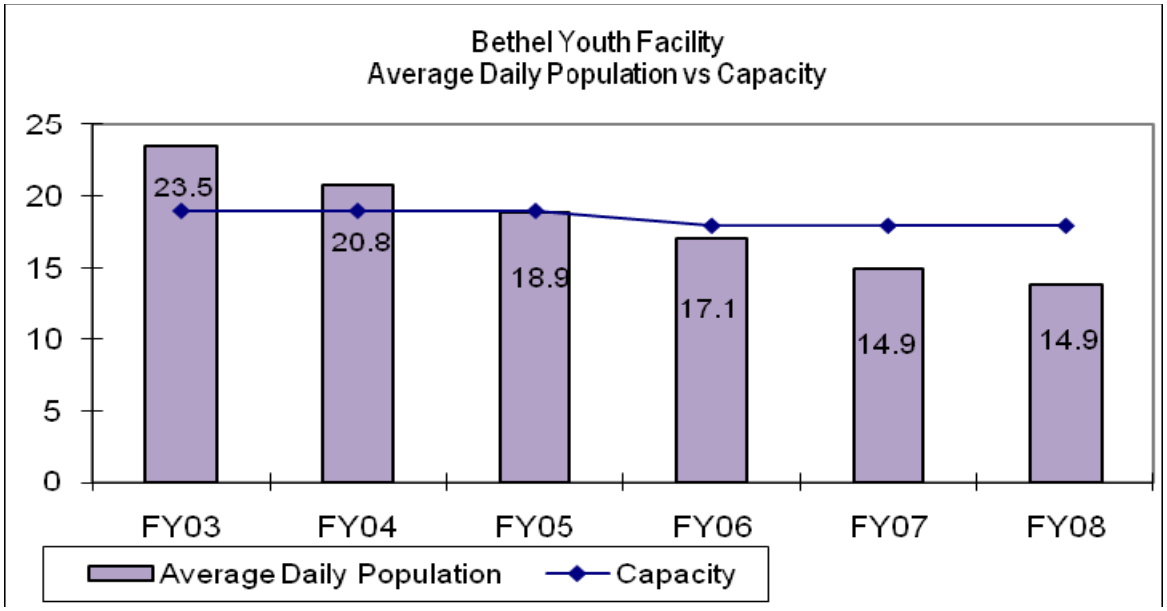
In FY2007, the detention capacity increased by two, as rooms that were previously used as storage rooms were converted to sleeping rooms.

Bethel Youth Facility (BYF)
BYF is the only youth facility in the entire Yukon-Kuskokwim Delta, an area the size of Oregon. The facility consists of an 8-bed detention unit and an 11-bed treatment unit. In FY2006, one of the treatment rooms was needed for the Mental Health Clinician that was hired, reducing the capacity to ten. 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 Yup'ik 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 is working on improving collaboration through the Performance-based Standards Facility Improvement Plan process. One plan focuses on increased involvement with detention residents' families, and the other on increasing the number of volunteers involved with the youth. There has been a significant increase in the frequency of staff contact with families, which the division believes will result in improved relationships between youth and parents. Volunteer contact provides additional opportunities for youth to form positive relationships with adults, and for community members to increase their knowledge of the juvenile justice system.

BYF has been successful in implementing the national quality assurance process of Performance-based Standards (PbS) program, and in FY2007 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.



In FY2006, a treatment room was converted to an office for the Mental Health Clinician, reducing the capacity by one

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 6 to 14 beds in FY2006.

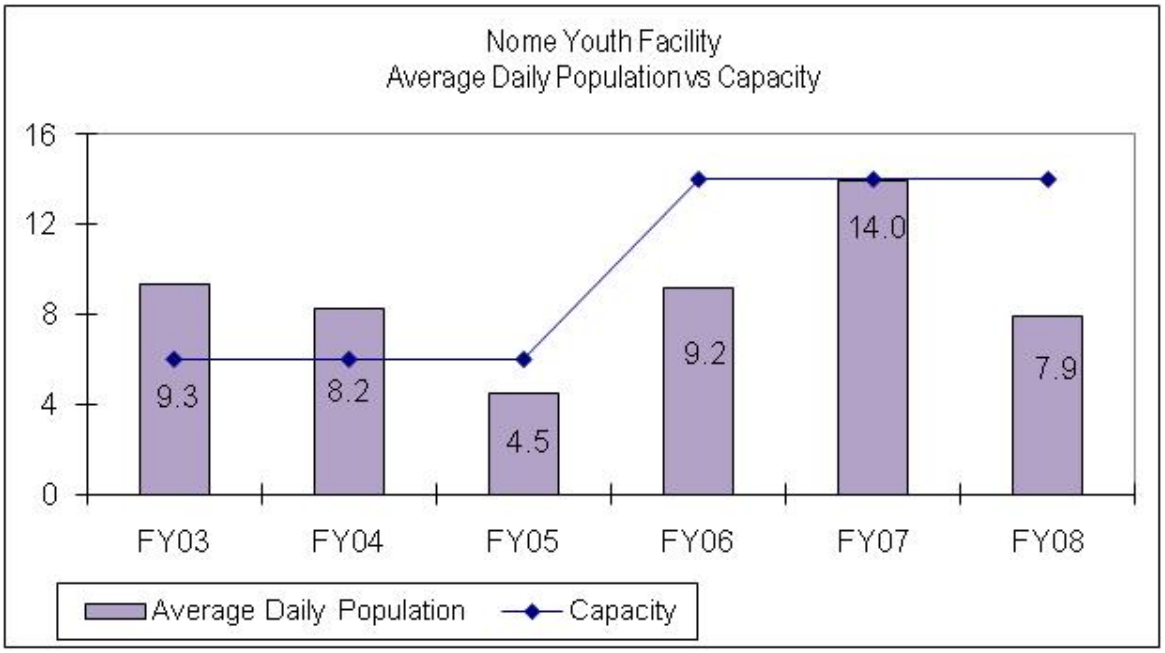
The resident population is primarily male and nearly all Alaska Native. The residents are commonly detained for property crimes, but there has been an increase in the number of residents charged with major assaults and/or sexual crimes. Many of the youth have a history of substance abuse and/or inhalant abuse.

In FY2010, NYF 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. FY2008 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.

NYF has continued and expanded its collaborative and cooperative relationships with a wide variety of agencies in the community. The partnership with Boys and Girls Club (BGC) has expanded, with NYF residents providing them with janitorial service, and BGC providing a series of therapeutic groups to the residents each week. The Nome Community Center (NCC) also provides a variety of services and classes to our residents. NCC donated a greenhouse to the facility that will be used to grow vegetables for the local food bank. In exchange for community work service, UAF Northwest Campus allows the use of their computer lab for training purposes, and provides annual Arctic Winter Survival instruction. The Sitnasuak Native Corporation provides land for NYF residents to use for fish camp. In return NYF residents assist local elders with their camps. All of these partnerships contribute to the excellent relationship that NYF enjoys with the local community.

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 FY2005, the NYF was partially closed due to the renovation of the building. The renovation was complete at the end of FY2005; the increased capacity is not reflected on this chart until FY2006.

Johnson Youth Center (JYC)

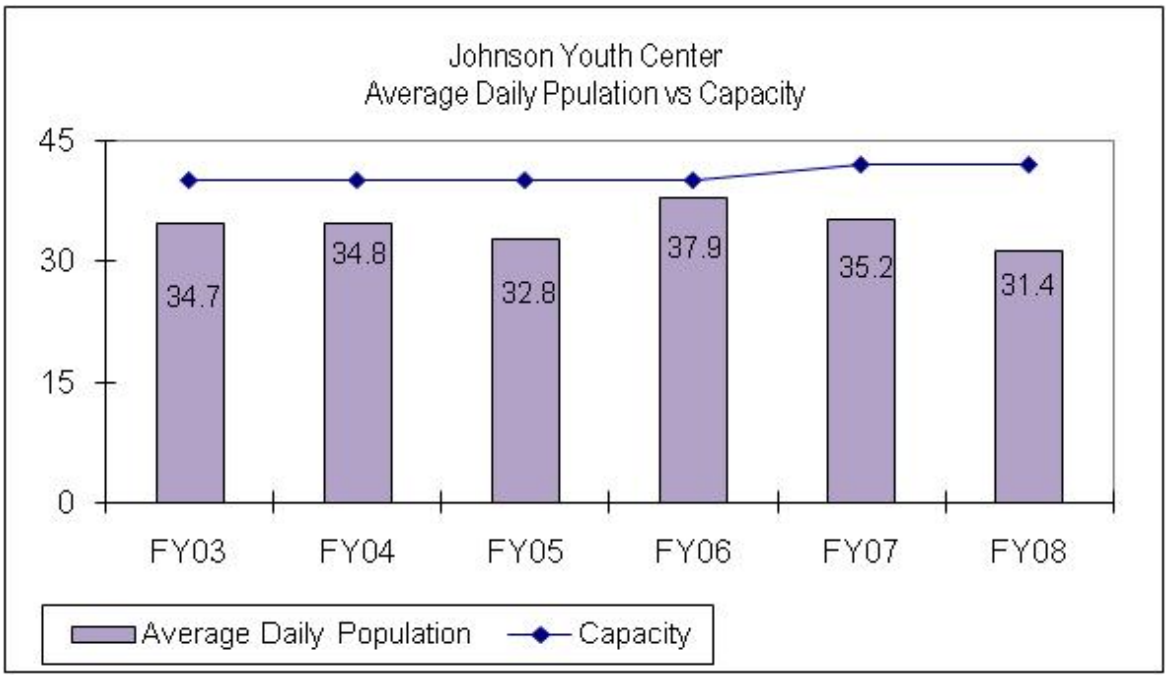
JYC is a 30-bed facility (8-detention and 22-treatment) that provides short-term, pre-trial detention, control and intervention for juveniles who have been ordered confined by the Superior Court due to the danger they present to the public and/or to themselves; and long-term residential and treatment services to youth committed to longer-term secure care. 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.

JYC staff continue to work closely with the Juneau Boys and Girls Club. They have enjoyed a successful partnership since 2007, which supports transition and re-entry services for JYC residents who have completed institutional treatment and are released into Southeast Alaska communities.

The Johnson Youth Center 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 FY2007, 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 (6-bed detention and 4-bed crisis stabilization) that provides detention of youth who are awaiting a court hearing or other placement (six locked detention

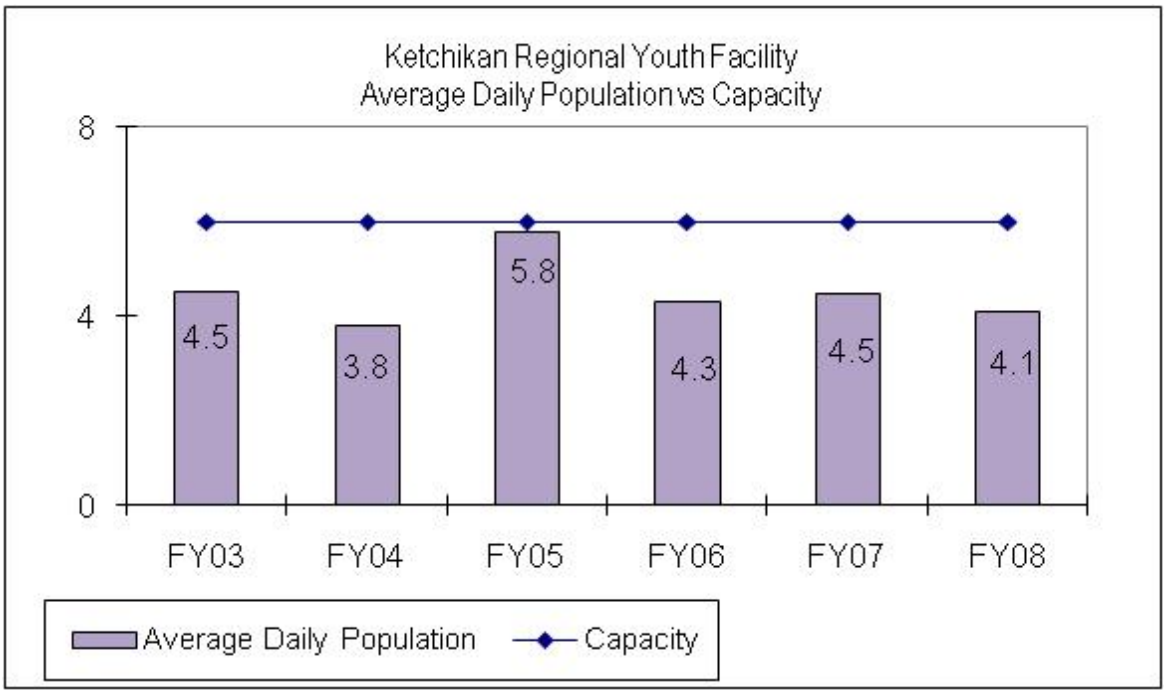
beds), and short-term-crisis respite and stabilization services for youth experiencing a mental illness. The unique combination of a detention unit and a crisis stabilization unit (CSU) in one location is an innovative feature for a youth facility, both in Alaska and in the United States. To date, the 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, Nome, Kenai and Juneau.

The facility continues its strong working relationships with parents, juvenile probation, the local school district and school board and local service agencies including Community Connections, Gateway Human Services Center, Metlakatla Social Services, and the Ketchikan Indian Corporation. KRYF has a strong partnership with the Ketchikan Gateway Borough School District. A school district grant under the Safe Schools and Healthy Students initiative provides valuable services for KRYF residents. As part of that grant program, a school district transition liaison position works with students as they transition into and out of the education program at KRYF.

KRYF's partnership with the Ketchikan agency Women In Safe Homes (WISH) has resulted in a series of groups provided by that agency for KRYF residents. WISH staff and volunteers provided weekly groups on topics such as healthy relationships, domestic violence, bullying and empathy. Additionally, WISH remains a resource for these youth after their release from KRYF.

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, their 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 wrap-around 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 FY2008. 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 FY2007. This new curriculum is web-based and requires extensive experiential learning and mentoring.

Director's Office

The division's director's office in Juneau oversees a number of functions that compliment and support the public, the Legislature, other executive branch agencies, and field staff around the state. They are 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 $1.3 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 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 operations 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 from 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. Some of the collaboration efforts are as follows:

- 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 that may be needed.

- The division has signed 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.

Statewide, the division works closely with school districts to ensure the success of our youth. As demonstrated in the table below, in Anchorage, there has been great improvement in the reading and math skills for youth that were released from the treatment program in FY08. Although there were 61 students released, not all are reflected on this chart because they actually scored at a grade 12 or higher on their pre-test.

Subject	Number of Students	Average Days	Average Annual Improvement	Average Overall Improvement
Reading	49	399.7	2.5 grades	2.8 grades
Math	45	461.7	2.9 grades	3.7 grades

- The division has two memoranda of agreements (MOA) 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 that 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.
- The Department's Joint Management Team has been expanded to include the Division of Behavioral Health, Office of Children's Services and the Division of Juvenile Justice. During

FY2009, the Division of Public Assistance will become part of that team. This team works to ensure the success of the Bring the Kids Home project.

- The division has developed a partnership with the Division of Behavioral Health and the Mental Health Trust Authority and other organizations to work on the Comprehensive Mental Health Integrated Plan for the department.
- The Reclaiming Futures Project in Anchorage has been a successful collaboration with the court system and Volunteers of America.
- The division has become part of the Criminal Justice Working Group that is co-chaired by Chief Justice Dana Fabe and Lieutenant Governor Parnell. The Division Director contributes perspective and insight to this Working Group, and the Division's research analysis team works closely with the Alaska Judicial Council, Department of Public Safety, and other member agencies to develop research questions and generate statistics on juvenile crime, offenders, and recidivism.

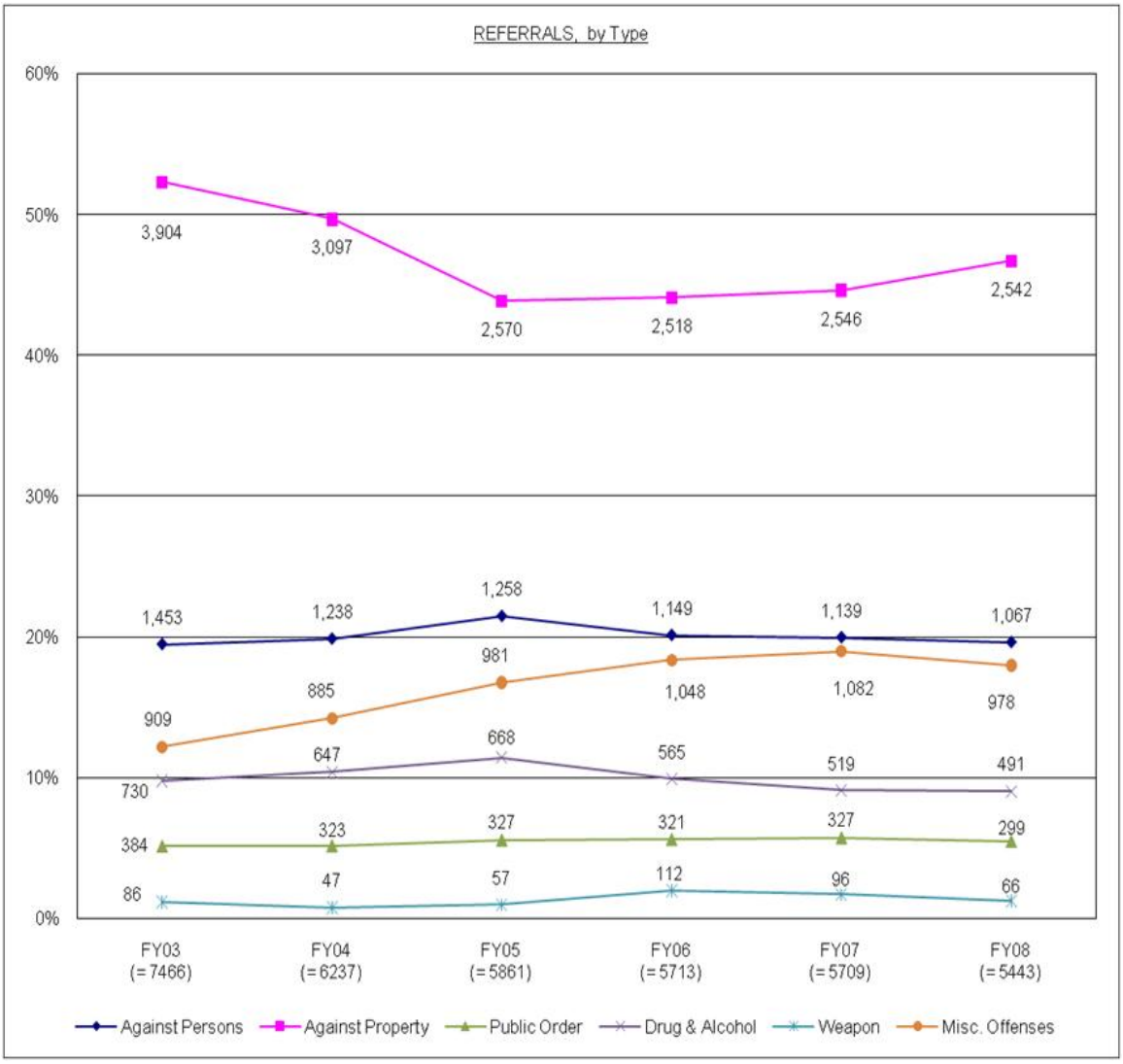
In FY2003, the division launched a "system improvement" effort, resulting in the adoption of several nationally recognized, research-based initiatives. These initiatives help guarantee that the Alaska juvenile justice system is using its resources effectively and efficiently, decisions are based on objective criteria, and that the agency is continually using data to improve the quality of services offered. These initiatives include:

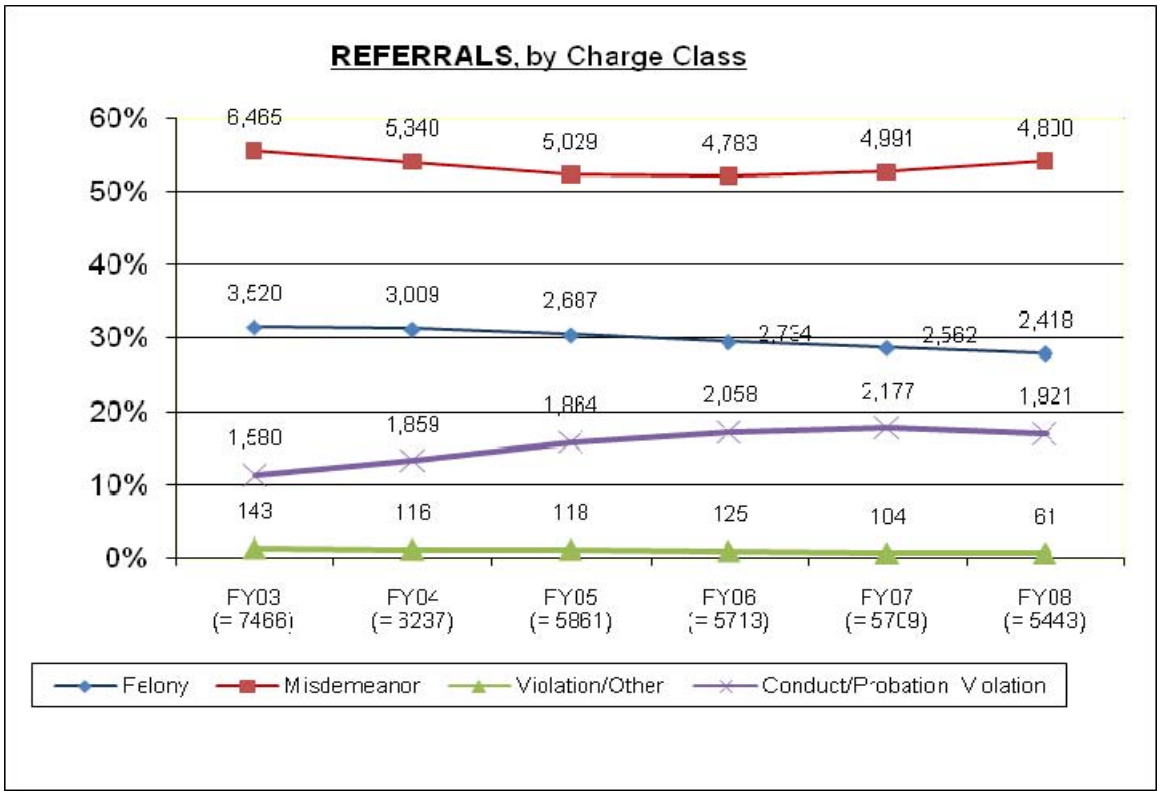
- The use of assessment instruments to assist staff in accurately determining a youth's risk of re-offense and need for secure detention;
- A quality assurance process to improve the safety and security of juvenile facilities;
- Improved use of juvenile facilities as a statewide resource for youth receiving secure treatment and those transitioning back to their home communities;
- 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.

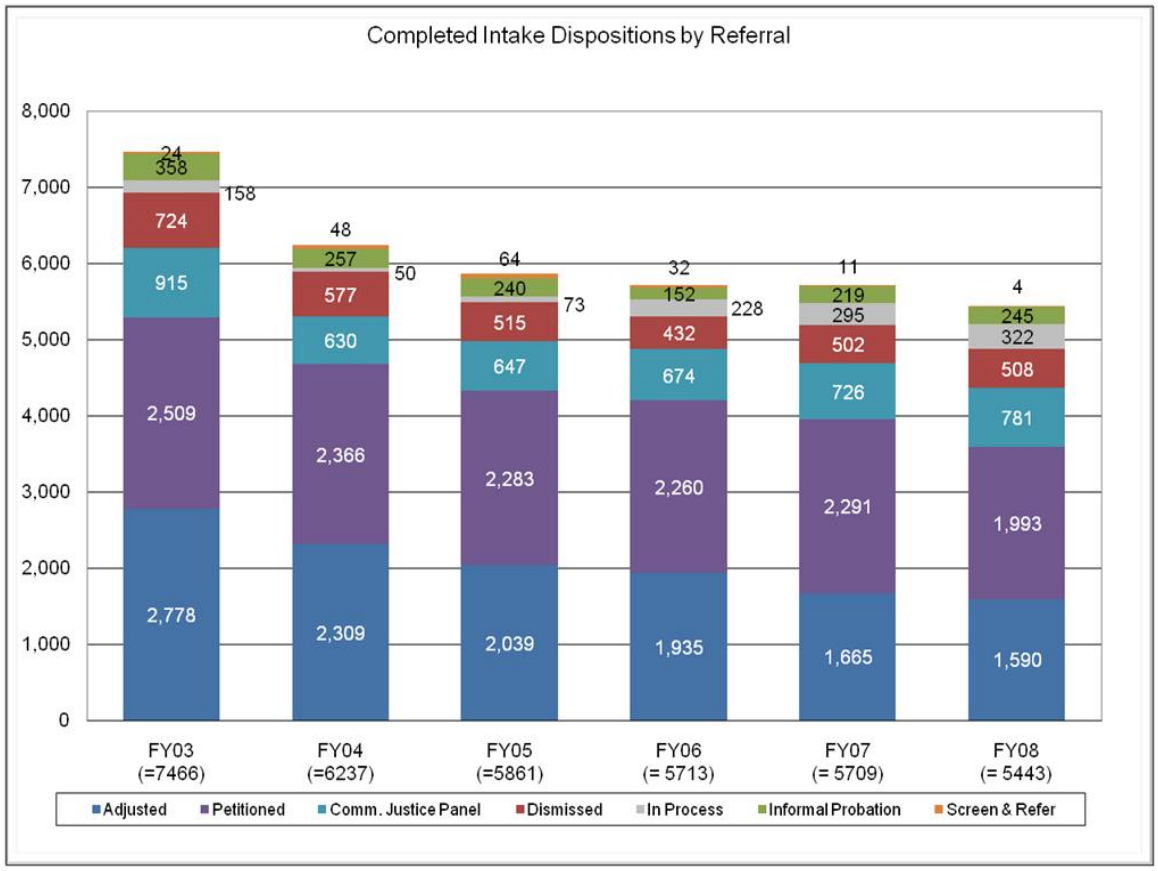
In FY2010, the division's leadership will continue to incorporate these system improvement projects into the strategic plan and vision for juvenile justice in Alaska. The system improvement projects will improve public safety, and ensure that victim needs are met and offenders are being held accountable.

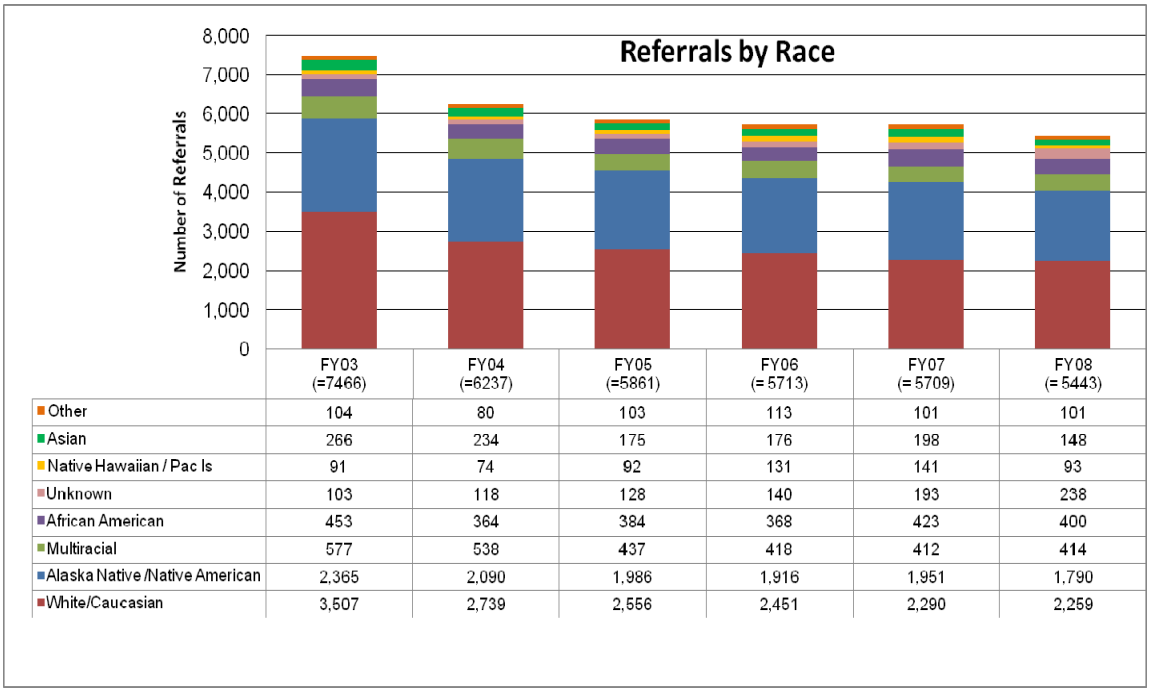
FY2008 Delinquency Referral Summaries

The following charts provide a summary of referrals for fiscal years 2003-2008.

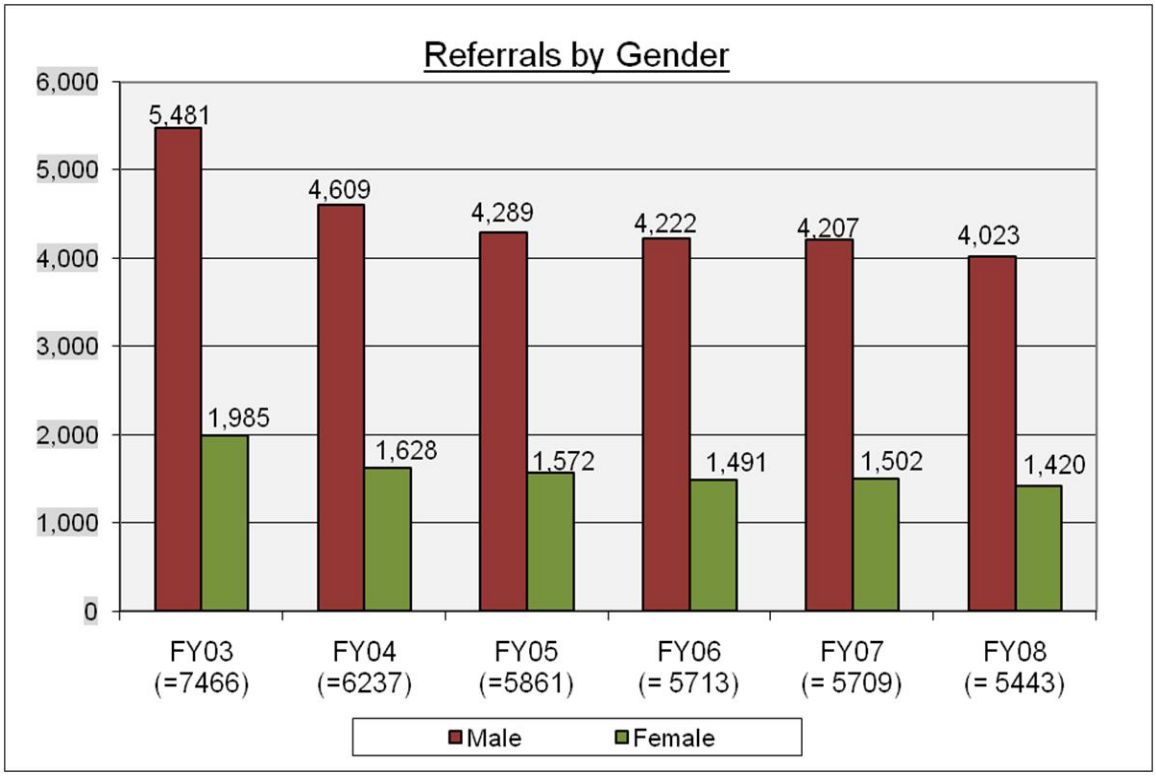



REFERRALS, by Charge Class
60%
50%
40%
30%
20%
10%
0%
6,465
5,340
5,029
4,783
4,991
4,830
3,520
3,009
2,687
2,754
2,562
2,418
1,580
1,859
1,864
2,058
2,177
1,921
143
116
118
125
104
61
FY03 (= 7466)
FY04 (= 3237)
FY05 (= 5861)
FY06 (= 5713)
FY07 (= 5709)
FY08 (= 5443)
Felony
Misdemeanor
Violation/Other
Conduct/Probation Violation


Completed Intake Dispositions by Referral
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
FY03 (=7466)
FY04 (=6237)
FY05 (=5861)
FY06 (= 5713)
FY07 (= 5709)
FY08 (= 5443)
2,778
2,509
915
724
358
24
158
2,309
2,366
630
577
257
50
48
2,039
2,283
647
515
240
73
64
1,935
2,260
674
432
152
228
32
1,665
2,291
726
502
295
219
11
1,590
1,993
781
508
322
245
4
Adjusted
Petitioned
Comm. Justice Panel
Dismissed
In Process
Informal Probation
Screen & Refer



	FY03 (=7466)	FY04 (=6237)	FY05 (=5861)	FY06 (= 5713)	FY07 (= 5709)	FY08 (= 5443)
Other	104	80	103	113	101	101
Asian	266	234	175	176	198	148
Native Hawaiian / Pac Is	91	74	92	131	141	93
Unknown	103	118	128	140	193	238
African American	453	364	384	368	423	400
Multiracial	577	538	437	418	412	414
Alaska Native /Native American	2,365	2,090	1,986	1,916	1,951	1,790
White/Caucasian	3,507	2,739	2,556	2,451	2,290	2,259



The table below shows the bed capacity at each of the division's secure juvenile facilities. In FY2009, capacity increased at the McLaughlin Youth Center (MYC) and decreased at the Fairbanks Youth Facility (FYF). At MYC, a room that had historically been designated an observation room now is counted as a treatment bed since, over time, it has routinely been used as a room for residents

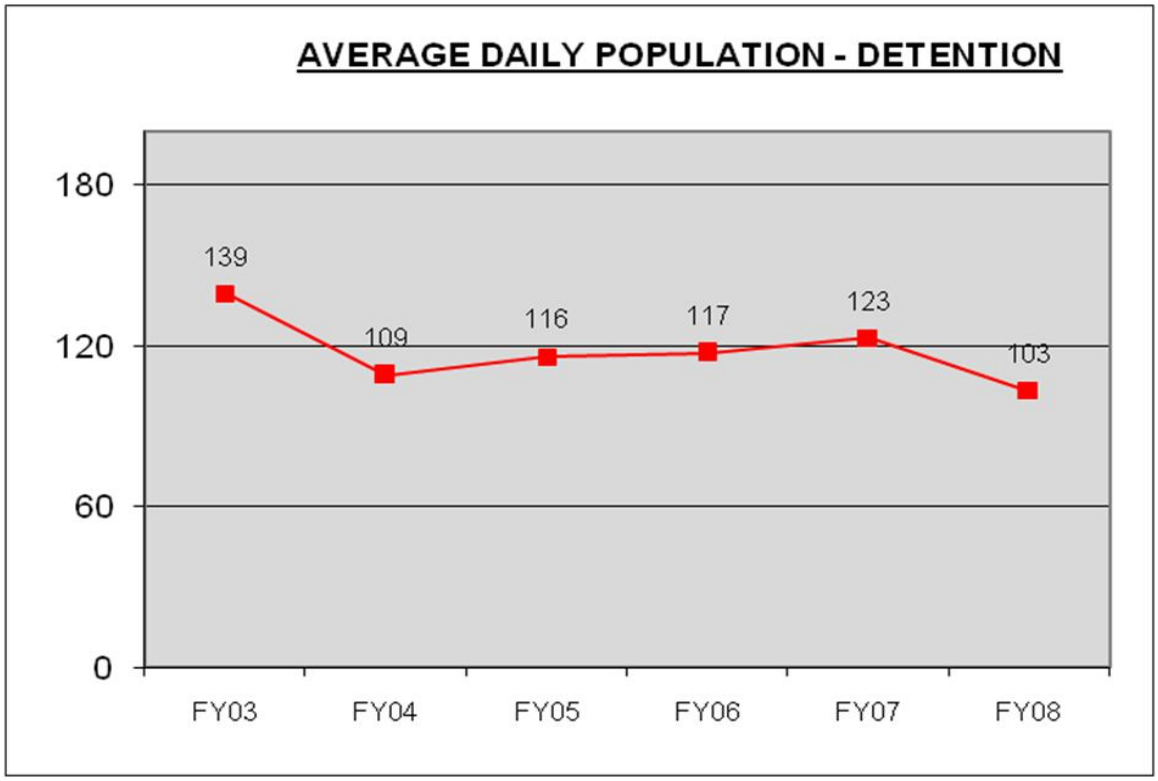
when the facility is at peak. The Fairbanks Treatment Unit's bed count was reduced by three. The facility's re-entry program was in need of office space and so a triple-bed room was converted into a work station that can accommodate the majority of the transitional/re-entry services and staff.

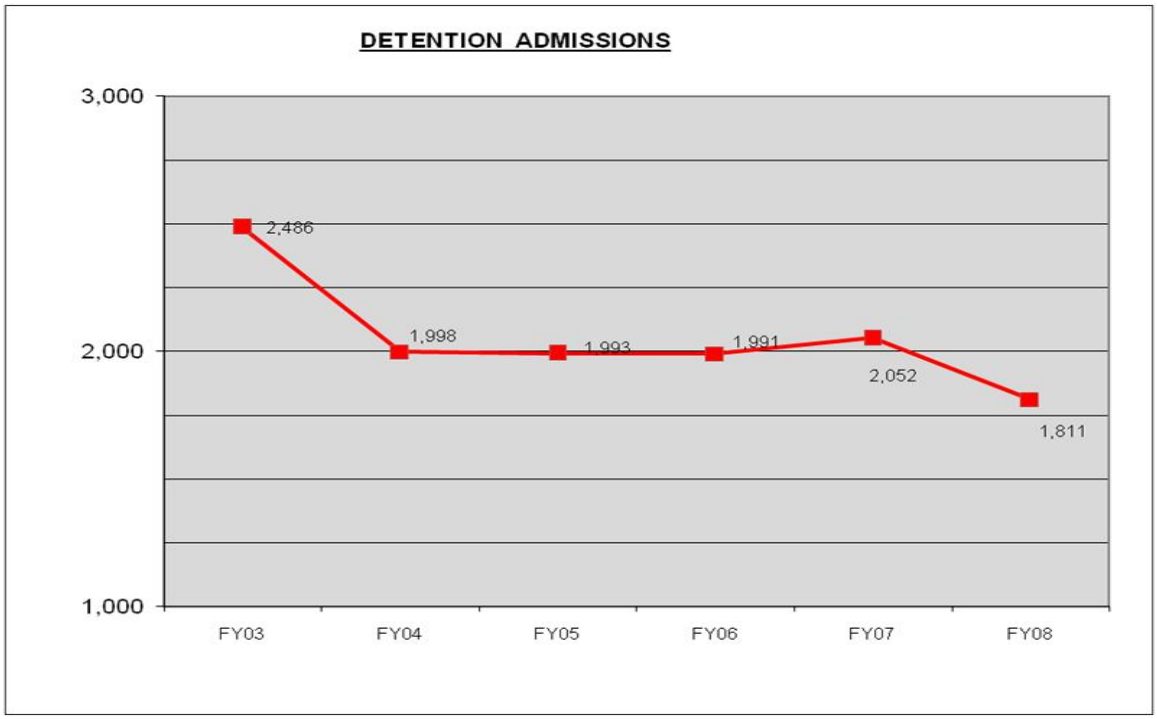
Youth Facility Existing Hard Bed Capacity FY2009			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	165	1	166
Mat-Su Youth Facility	15		15
Kenai Peninsula Youth Facility	10		10
Fairbanks Youth Facility	42	-3	39
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Johnson Youth Center	30		30
Ketchikan Youth Facility	10		10
Total	304		302

Facility Data

Detention Units – Detention and Treatment Units

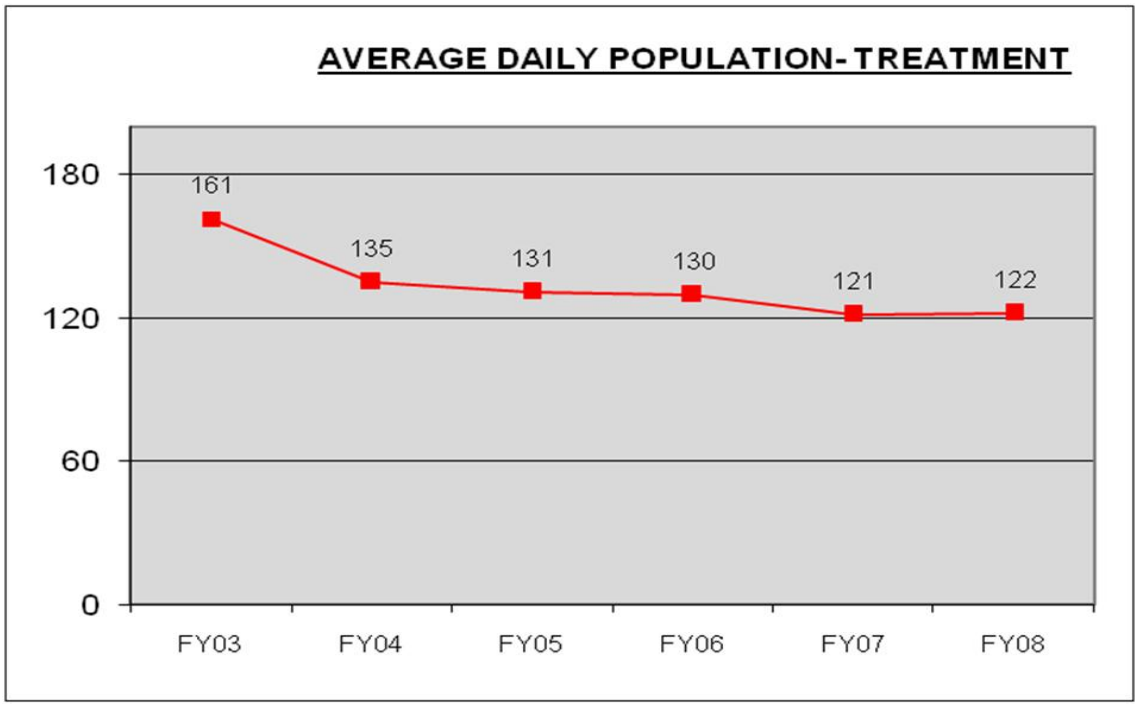
The charts below show juvenile detention average daily population and admissions from FY2003 through FY2008. Detention units are designed as short-term secure units for youth who are awaiting court hearings and other determinations of outcome on their offenses. Statewide detention capacity in FY2008 was 149 beds.

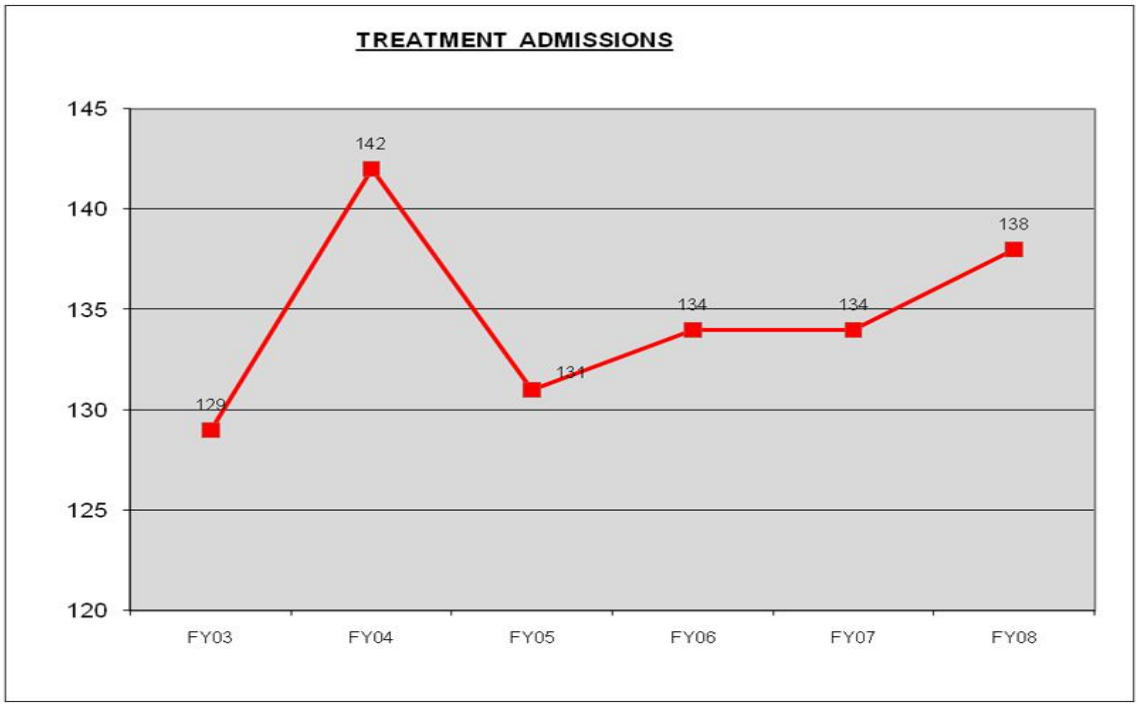

AVERAGE DAILY POPULATION - DETENTION
180
120
60
0
139
109
116
117
123
103
FY03
FY04
FY05
FY06
FY07
FY08



Treatment Units

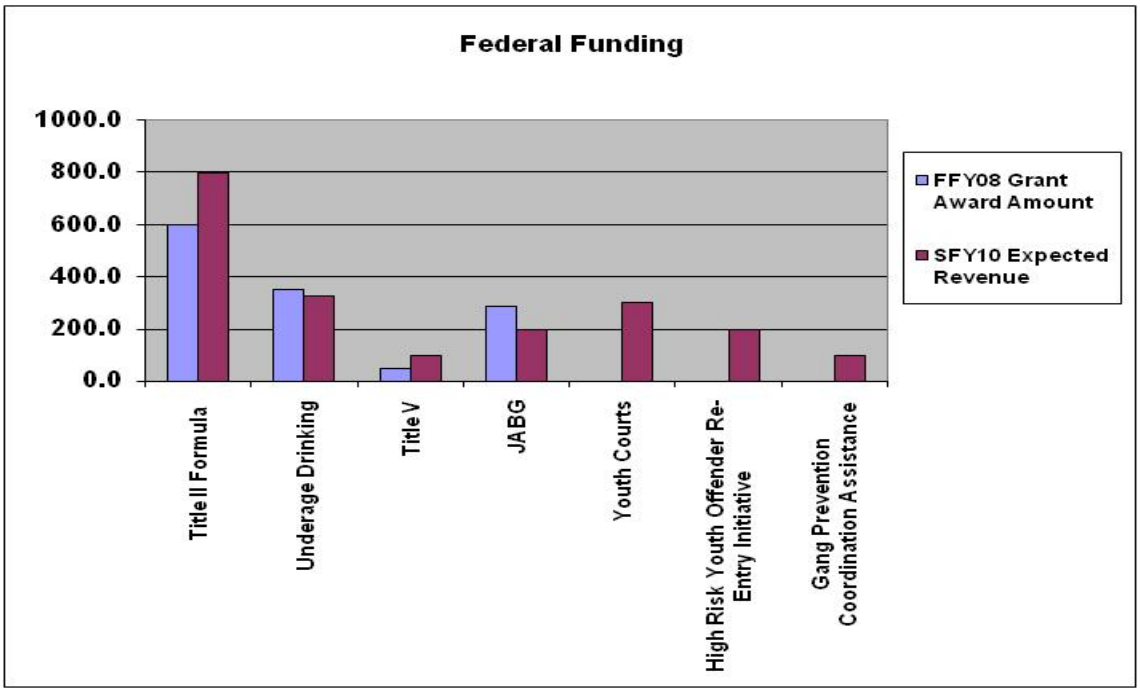
Below are charts showing juvenile program average daily population and admissions from FY2003 through FY2008. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY2008 was 151, excluding the 4 unlocked crisis stabilization beds located at the Ketchikan Regional Youth Facility.





Federal Funding

The Alaska Juvenile Justice Advisory Committee (AJJAC) is 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 with particular emphasis on juvenile justice system improvements. AJJAC also assists the division to ensure compliance with the mandates of the federal Juvenile Justice Delinquency Prevention Act. The following chart provides a breakdown of the FFY2008 grant programs and budgeted revenues for SFY2010. 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.


Federal Funding
1000.0
800.0
600.0
400.0
200.0
0.0
Title II Formula
Underage Drinking
Title V
JABG
Youth Courts
High Risk Youth Offender Re-Entry Initiative
Gang Prevention Coordination Assistance
FFY08 Grant Award Amount
SFY10 Expected Revenue

AS 09.35 Execution
AS 11.81 General Provisions
AS 12.25 Arrests and Citations
AS 12.35 Search and Seizures
AS 25.27 Child Support Enforcement Agency
AS 47.05 Administration of Welfare, Social Services and Institutions
AS 47.10 Children in Need in Aid
AS 47.12 Delinquent Minors
AS 47.14 Juvenile Institutions
AS 47.15 Uniform Interstate Compact on Juveniles
AS 47.17 Child Protection
AS 47.18 Programs and Services Related to Adolescents
AS 47.21 Adventure Based Education
AS 47.30 Mental Health
AS 47.35 Child Care Facilities, Child Placement Agencies, Child Treatment Facilities, Foster Homes, and Maternity Homes
AS 47.37 Uniform Alcoholism and Intoxication Treatment Act

7 AAC 52 Juvenile Correctional Facilities and Juvenile Detention Facilities
7 AAC 53 Social Services
7 AAC 54 Administration
7 AAC 78 Grant Programs

Alaska Delinquency Rules
Alaska Rules of Civil Procedure
Alaska Rules of Criminal Procedure

Juvenile Justice	2009	2010 Gov	09 to 10 Change
General Fund	46,398.9	48,220.3	1,821.4
Federal Fund	3,007.1	3,010.3	3.2
Other Funds	1,202.0	1,091.5	-110.50
Total	**50,608.0**	**52,322.1**	**1,714.10**

The division is statutorily mandated to protect the public, hold juvenile offenders accountable, restore victims and communities, and develop offender competencies to reduce the likelihood of re-offense. A balanced and restorative justice approach to services and programming ensures that juvenile offenders take personal responsibility for repairing the harm caused to victims and communities.

McLaughlin Youth Center

MH Trust: Disability Justice—Grant 1386.02 Increase Mental Health Clinical Capacity in Juvenile Justice Facilities*: $189.2 MHTAAR*

The partnership between the Alaska Mental Health Trust Authority and the Division of Juvenile Justice (DJJ) has enabled the division to provide improved behavioral health services for juveniles statewide, particularly those residing in the division's juvenile justice facilities. Twelve mental health clinicians are now employed by the division, providing mental health assessment, evaluation, and treatment services to juveniles while also working with staff to improve their skills working with juveniles with mental health issues. This project is managed by DJJ staff with funds targeted to those youth facilities with inadequate mental health clinical staff capacity.

This project maintains the momentum of a critical component of the Disability Justice Focus Area plan by ensuring mental health treatment is provided while a youth is detained as well as ensuring treatment is incorporated into each youth's transition plan back into the community.

The goal for FY2010 is to maintain the momentum of this project and use improved mental health staff capacity to demonstrate improvements in outcomes for juveniles with mental health issues. In FY2010 a $189.2 MHTAAR increment is requested to maintain the momentum of effort.

Reverse FY 2009 Mental Health Trust Recommendatio: *($199.7) MHTAAR*

This zero-based adjustment includes all MHTAAR funding for the FY2009 for this component: ($189.2) – 71000 MHTAAR-Disability Justice Mental Health clinical capacity for juvenile in and/or transitioning out of detention. ($10.5) – 71000 MHTAAR FY09 bargaining unit contract terms – GG

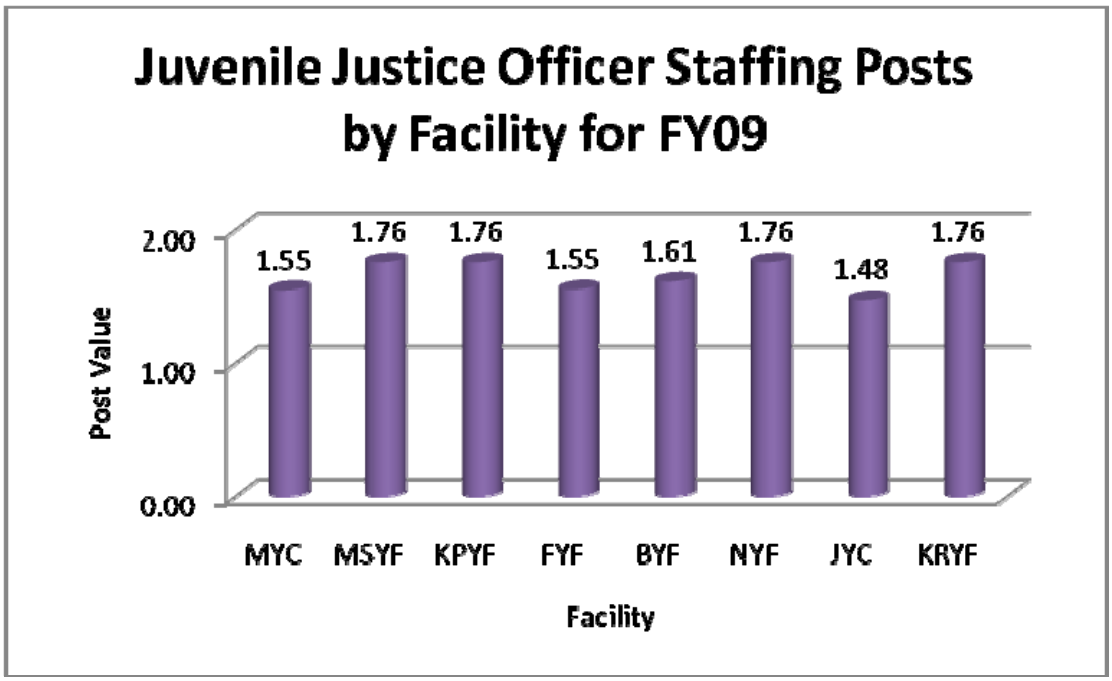
M H Trust: Disability Justice--Grant 1386.02 Increase Mental Health Clinical Capacity in the Division of Juvenile Justice Facilities, Continue FY09 Level: *$288.4 GF/M H*

In The FY2009 budget, a one-time only change record was added that included MHTAAR funding as well as GF/MH funding for several mental health clinicians. The GF/MH funding should not have been included in the one-time only increment. This change record makes that funding a permanent part of the base budget for the McLaughlin Youth Center component.

Reverse FY09 Disability Justice-Mental Clinical Capacity for Juvenile In and/or Transitioning Out of Detention: *($288.4) G Funds/M H*
($255.8) – 71000 General Fund/Mental Health Funds
($17.6) -- 73000 General Fund/Mental Health Funds
($15.0) – 74000 General Funds/Mental Health Funds

Front Line Staffing at the McLaughlin Youth Center: *$150.1 GF*
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, forcing the facility to use non-permanent staff to fill the gaps in supervision levels. For example, 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 them 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 our juvenile justice officer staffing pattern by facility. As can be seen, the McLaughlin Youth Center, The Fairbanks Youth Facility, the Bethel Youth Facility, and the Johnson Youth Center are short staff. The division is in Year 3 of a ten-year plan to bring our facilities in line with staffing needs. This year, DJJ is requesting $150.1 in general funds to support two juvenile justice officers at the McLaughlin Youth Center.



Transfer Out I/A Authority to the Ketchikan Regional Youth Facility Componen: *($5.8) I/A*
This change record moves I/A authority from the McLaughlin Youth Center to the Ketchikan Regional Youth Facility to allow for additional receipts in that component. There is some additional authority in the McLaughlin Youth Center component to allow for the transfer because collections from the Department of Education have been closer to $350,000 for the past several years.

Fairbanks Youth Facility

***Front-Line Staffing for Fairbanks Youth Facility**: $264.2 GF*
As mentioned above in the McLaughlin Youth Center's budget item, the division is in Year 3 of a ten-year plan to bring its facilites in line with staffing needs. The funding for the Fairbanks Youth Facility (FYF) will fund one juvenile justice officer position, one maintenance position and one nurse.

The building has grown in size from 13,850 square feet to 35,043 square feet in recent years due to the addition of a new gymnasium and classroom space. Both these new sections and the older sections of the facility are in constant need of upkeep and require the division to hire an additional maintenance position to keep up with these needs. Currently, only one maintenance position exists at the facility.

The division is also requesting the addition of one full-time nurse position for the FYF. Currently, the facility is forced to have juvenile justice officers distribute medications to the residents as part of their regular duties. Recent regulatory changes by the State Board of Nursing have dictated that only nurses be allowed to distribute certain types of medications such as psychotropics. Having this additional nurse will allow the facility to provide 7 day/week coverage for medication distribution during the day and swing shifts.

Bethel Youth Facility

***Front-Line Staffing for Bethel Youth Facility:** $98.7 G F*
As mentioned above in the McLaughlin Youth Center's budget item, the division is in Year 3 of a ten-year plan to bring its facilities in line with staffing needs. The funding for the Bethel Youth Facility will support one juvenile justice officer position.

Nome Youth Facility

***Funding for Nome's Operating Costs, Phase 2 of 2:** $100.0 G*
When the division requested the new positions for Nome (FY2006), not enough funding for the overhead costs associated with the new building and increased costs for food for the additional youth the facility would serve was requested. Overall, the division was short $150.0 in this component. Phase I in the amount of $50.0 was requested and approved by the Legislature for the FY2009 budget. This is the second and final request to bring this component up to full funding. These funds will be utilized from the contractual line.

Johnson Youth Center

***Front-Line Staffing for the Johnson Youth Center:** $75.2 General Fund*

As mentioned above in the McLaughlin Youth Center's budget item, the division is in Year 3 of a ten-year plan to bring its facilities in line with staffing needs. The funding for the Johnson Youth Center will support one juvenile justice officer position.

Ketchikan Regional Youth Facility

Move I/A Authority from McLaughlin Youth Center Component to the Ketchikan Regional Youth Facility: *$5.8 I/A*
The maintenance position at the Ketchikan Regional Youth Facility will be performing more maintenance duties for the Division of Public Health beginning in FY09 and beyond. This change record moves I/A authority from the McLaughlin Youth Center to this component to allow for enough I/A authority to collect receipts for these services.

Reflect Change in Time Status for Maintenance Position at the Ketchikan Regional Youth Facility
The Division of Juvenile Justice has determined the need to change the part-time maintenance position at this facility from part-time to full-time. This change record reflects the change.

Probation Services

Remove Excess SDPR Authority in Probation Services Component: *($100.0) SDPR*
PCN-06-4949, Juvenile Probation Officer I/II in Ketchikan, was created to work with the school district by providing an opportunity for a probation officer to be in the school. Since this position was created, the school district has decided to use the funding for other needs. This change record deletes the PCN in the budget and the SDPR authority that went with it.

Probation Services Aftercare, Mental Health and Support Needs: *$273.6 GF*
The division is seeking funding for a Juvenile Probation Officer I/II position in the Bethel office, a Mental Health Clinician II position in the Anchorage Probation office, and a part-time Social Services Associate I/II position in the Valdez office.

The Division of Juvenile Justice recognizes the critical importance of effective transition and aftercare services for youth who have been placed by the court in our long-term institutional treatment programs. This program component is essential in our efforts to reduce recidivism by preparing youth to leave secure confinement and adapt successfully to their communities. To effectively carry out this effort, in each of our communities with long-term institutional treatment programs (except Bethel) a Juvenile Probation Officer carries this specialized caseload. Two years ago, due to budget constraints, the Aftercare Probation Officer position in Bethel was eliminated. The remaining probation officers attempted to meet this need to the best of their ability, but unfortunately, there has been a marked decrease in our ability to meet the transition and aftercare needs of the region's most serious and/or repetitive offenders.

As part of a department-wide effort to improve services for families dealing with delinquency, the division is proposing the addition of a Mental Health Clinician for the Anchorage Region Probation Office. This clinician would be specifically trained on the Brief Strategic Family Therapy model and work with Juvenile Justice clients and their families to ensure that youth are returning to a healthy, functional family, thus reducing the possibility of recurring delinquent behavior.

The division currently spends between $20,000-$30,000 each year for mental health assessments in the Anchorage region. Having a mental health clinician on staff will reduce the amount of money the division is paying contractors for these services. Many benefits, including timeliness of receiving an assessment and case management with division staff will be realized.

The division is also seeking funding to support a part-time Social Services Associate (SSA) I/II position at the Valdez Probation Office. The position that had previously been located at that office and provided administrative support to the Division of Juvenile Justice was funded by the Office of Children's Services. That position has recently been moved to another office. Currently, there is no administrative support being provided to Juvenile Justice in this office. The SSA position will provide both administrative and case management support for the juvenile probation office. The juvenile probation officer position in the Valdez office travels to both Glenallen and Cordova leaving the office vacant. This social service associate position will allow for continued interaction with clients by making contacts with the youth, parents and/or school or community agencies when the probation officer is traveling. In addition, the social services associate may also be called on to transport juveniles.

Transfer Admin Positions/Funding from DSS/Administrative Support Services: *$135.9 GF*
The Department of Health and Social Services consolidated administrative functions into a centralized unit beginning in FY2005. Over the last year, management has determined that the consolidation did not achieve the desired results and that the positions should be returned to the originating divisions. A total of 78 administrative staff positions will be transferred from DSS/Administrative Support Services in the FY2010 Governor's Budget. This move will allow Directors and their administrative teams to more efficiently and effectively manage their divisions.

Positions transferred in this request:
06-3573 Administrative Operations Manager I

Delete One-Time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor: *($389.3) GF*
Delete the one-time fuel/utility cost increase funding distribution from the Office of the Governor that was made pursuant to sec. 19(a)-(d), chapter 27, SLA 2008, pages 75-78.

FY2010 Salary Adjustment for Wage and Health Insurance Increases for Bargaining Units with Existing Agreements $1,097.7 General Funds; $15.3 General Funds/Mental Health; $3.2 Federal Funds

An increase for the bargaining units with existing agreement has been added to each of the components. This request totals $1,116.2 for the Division of Juvenile Justice. The breakout is as follows:

McLaughlin Youth Center	$375.2
Mat-Su Youth Facility	44.4
Kenai Peninsula Youth Facility	36.5
Fairbanks Youth Facility	93.6
Bethel Youth Facility	79.4
Nome Youth Facility	53.2
Johnson Youth Center	75.1
Ketchikan Regional Youth Facility	36.7
Probation Services	322.1
Total	**$1,116.2**

Delinquency Prevention

Realign Funding to Meet Operational Needs for Delinquency Prevention

This change record moves authority from the contractual to the grants line to accommodate anticipated grants in FY2010 with grantees. In FY2009, the division had a total of $607.1 in grants with grantees. We expect approximately the same for FY2010.

Explanation of FY2010 Capital Budget Requests

The Division of Juvenile Justice will be requesting the following capital funding:

- Johnson Youth Center Renovations and Remodel to Meet Safety and Security Needs Phase I - $9,500,000 GF
- Safety and Support Equipment for Probation Officer and Front Line Workers - $588.5 GF

The Johnson Youth Center request is part of a long term plan to address safety and security deficiencies in the division's 4 oldest youth facilities. The plan was completed in 2008 to address these needs over a six year period, starting with Fiscal Year 2009. In FY 2009, the division received $19.5 million for phase I of McLaughlin Youth Center.

The funding strategy as laid out in the six year plan below. However, the division understands that not all projects will be included in the Governor's budget according to the time line as reflected below. It is the division's goal to acquire the necessary funding over time to address each of these projects.

Threat to Safety and Security: An Assessment of Security Needs for Alaska's Juvenile Correctional Facilities – Six Year Plan

Facility	FY09	FY10	FY11	FY12	FY13	F14
McLaughlin	$19,503,736	-	-	$18,435,319	$12,081,208	$22,406,641
Johnson		$9,500,000-	$743,856	-	$2,913,655	$4,456,847
Fairbanks	-	-	-	$10,864,547	$14,157,967	-
Bethel	-	$29,271,150	$25,024,993	-	-	-
Total	**$19,503,736**	**$38,868,250**	**$25,768,849**	**$29,299,866**	**$29,152,830**	**$26,863,488**

Johnson Youth Center: *$9,500.0 GF*

The current structures on the Johnson Youth Center campus are an eclectic mix of old and new structures. They include an adaptive reuse of a former adult female jail that was built in the late 1960's, a programs building that was constructed in 1990 and the more recently constructed treatment cottage. The program and treatment facilities are serving the population well and with few exceptions, provide safe and secure environments for the programs they house. The Detention Unit, however, does not support its mission and is the root of the facility's safety and security threats.

If funds are appropriated as requested, the detention unit will be reconstructed, a new medical suite will be constructed adjacent to the admissions area, and a new admissions and police entry will be constructed within the secure perimeter. No new positions will be needed as a result of this project.

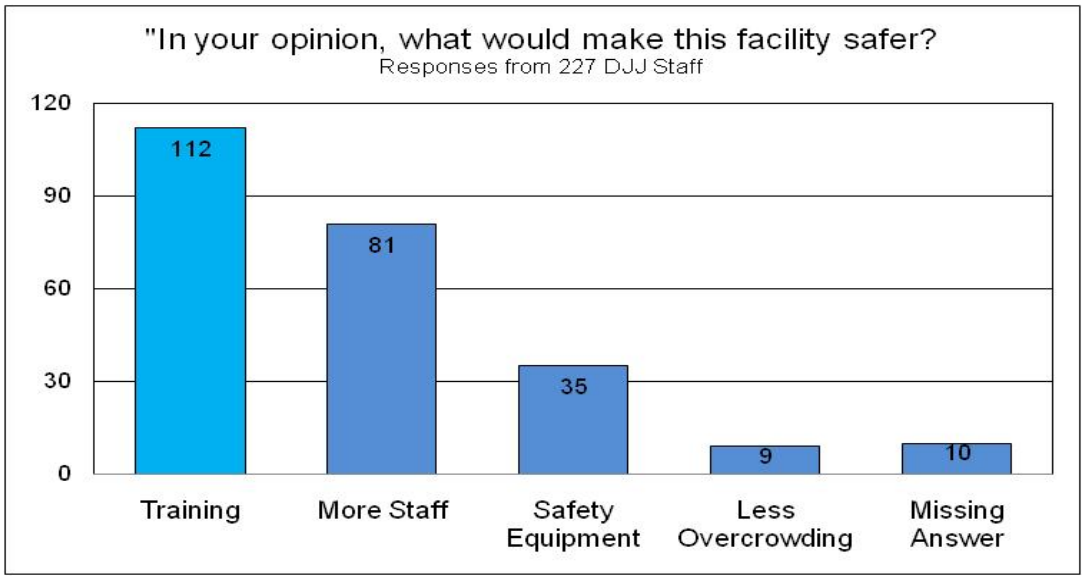
Safety and Support Equipment for Probation Officers and Front Line Workers: *$588.5 GF*
This request will address the need for equipment to protect probation officers and front line workers. Equipment includes soft body armor ballistic vests, ALMR radios, hand cuffs and cases, cuff waist belts, leg irons, and outdated copiers and computers.

Challenges

Quality Assurance and Training Staffing: Over the last several years the Division of 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.

The division has applied for federal technical assistance through the U.S. Office of Juvenile Justice and Delinquency Prevention to develop a comprehensive understanding of our quality assurance and training needs. We anticipate that this consultation will result in a multi-year plan that requires a gradual increase in both quality assurance and training staff as well as other resources.

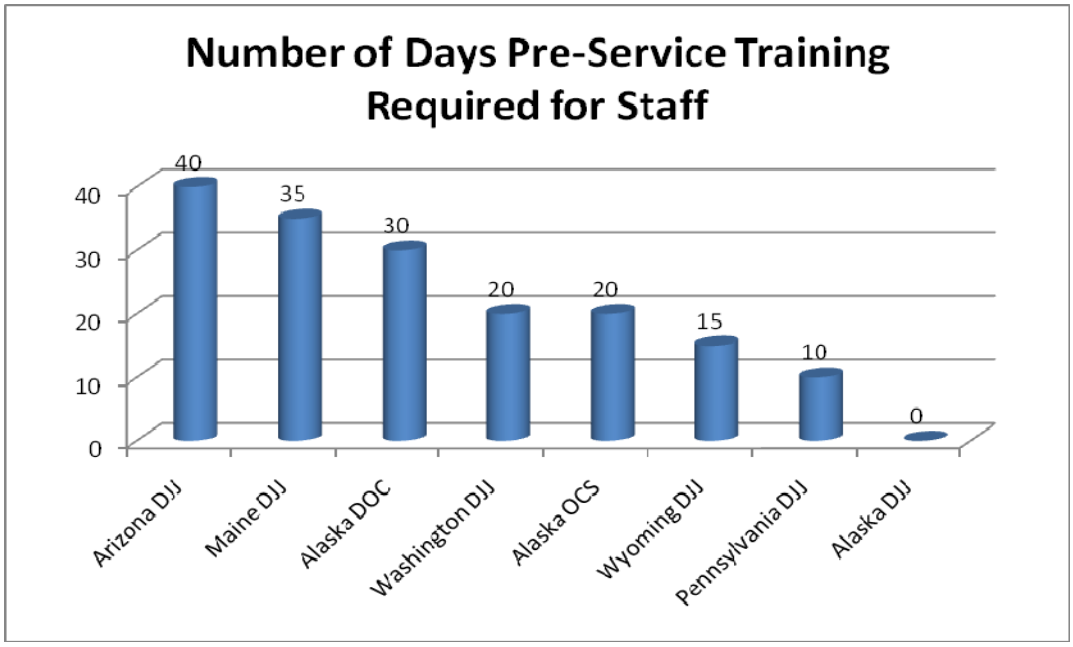
Division staff has recognized the need for adequate training, as demonstrated by responses in a staff climate survey conducted in April 2008 as part of the PbS process. The question, "In your opinion, what would make this facility safer?" was posed to our facility staff. Training was the number one item identified by the 227 employees who responded. The next item was more staffing.



A similar survey of 67 staff who works in the division's juvenile probation offices yielded almost identical results; with "training" again the most commonly identified solution to better officer safety. These results echo the findings of an Alaska Legislative Audit completed in 2005 (Report #06-30020-05) which also noted the need for more comprehensive staff training for Division of Juvenile Justice staff.

Comparing the pre-service training provided to staff that do similar work within and outside Alaska provides additional evidence of this need. The Alaska Division of Juvenile Justice surveyed a

number of jurisdictions around the United States and our sister agencies in Alaska to determine how much pre-service training is required of staff. These findings are outlined in the chart below.



Recruitment and Retention: Recruitment of professional staff has become a key challenge as the division's workforce ages and long-term staff retire from State service. In the past few years, the division has 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. The ability to attract qualified applicants to these positions has become increasingly difficult. This has been a particularly significant issue for rural offices. For example, the superintendent position at the Ketchikan Regional Youth Facility has remained vacant for over a year. The position was recruited for several times in FY2008, including out-of-state. The division is confident that the vacancy will be filled during FY2009.

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.

Substance Abuse Data Collection: The division recognizes that there is a high rate of mental health issues that are directly related to substance abuse. The division hopes to collect data in a more formalized manner to be able to make more informed and better decisions in the future. The division realizes the need to work with the Department of Public Safety to ensure they identify substance abuse in their reports and we need to ensure our own staff is putting this information into the Juvenile Offender Management Information System (JOMIS). Eventually, we want our juvenile probation officers to screen every youth they are working with to identify problem areas and we are hoping to expand the Reclaiming Futures program, which is currently being used in Anchorage, to other communities around the state.

Facility Maintenance and Office Space Shortages:

In the summer of 2007, a study was commissioned to identify significant safety and security breaches within the four oldest facilities. The study has recommended the need to renovate several areas of

each of the four facilities. The department's plan for addressing the safety and security spans a six year period, if funding requests are approved. The first of four phases for the McLaughlin Youth Center renovation was approved with the FY2009 capital budget. The division is working to obtain funding for Phase I for Johnson Youth Center in FY2010, which is discussed in the Capital Funding Request portion of this narrative. Funding for the needed renovations at the Bethel Youth Facility and the Fairbanks Youth Facility will be requested in upcoming years.

Juvenile Justice Results Delivery Unit

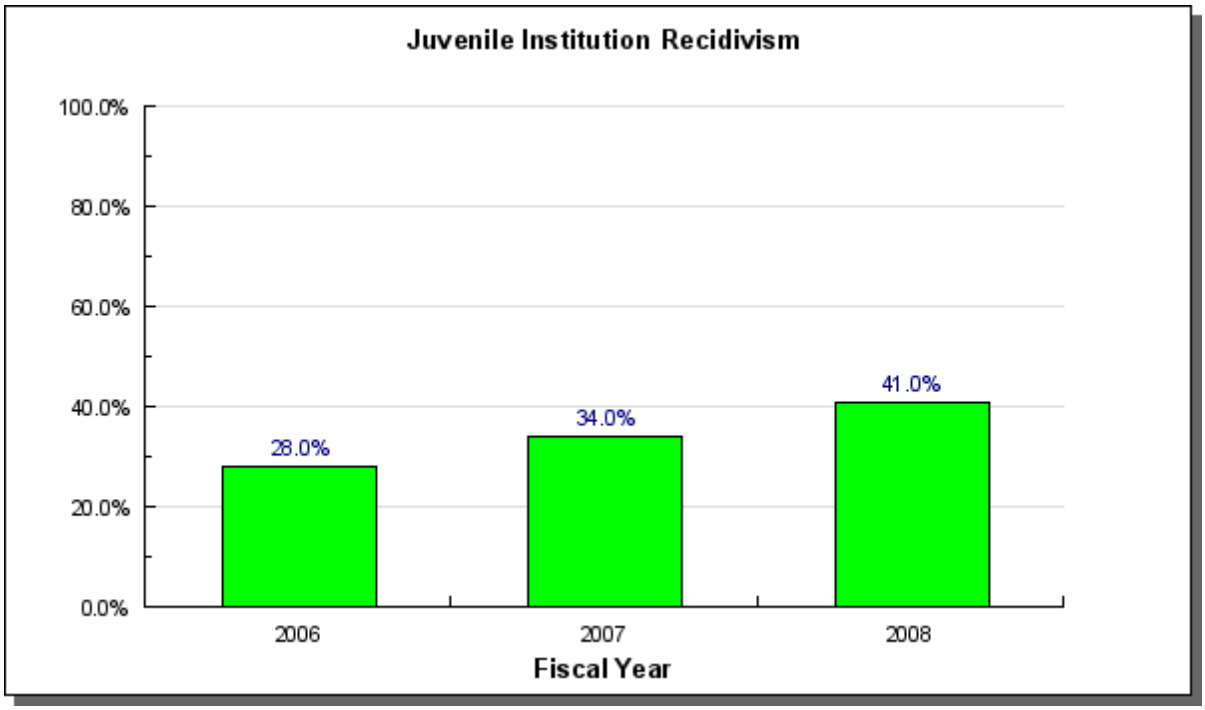
Contribution to Department's Mission

The Division of Juvenile Justice (DJJ) contributes to the department's mission by holding juvenile offenders accountable for their behavior, promoting the safety and restoration of victims and communities, and assisting offenders and their families in developing skills to prevent crime.

A: Result - Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.

Target #1: Reduce percentage of juveniles who reoffend following release from institutional treatment facilities to less than 33%.

Status #1: The recidivism rate as defined for youth released from institutional treatment in FY2006 was 41%, a slight increase in comparison to previous fiscal years.



Juvenile Institution Recidivism

Fiscal Year	YTD Total
FY 2008	41%
FY 2007	34%
FY 2006	28%

Analysis of results and challenges: This measure examines recidivism for youth who have been committed to and released from the Division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the state's more chronic and serious juvenile offenders compared with youth who 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.

Reoffenses, 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 to 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.

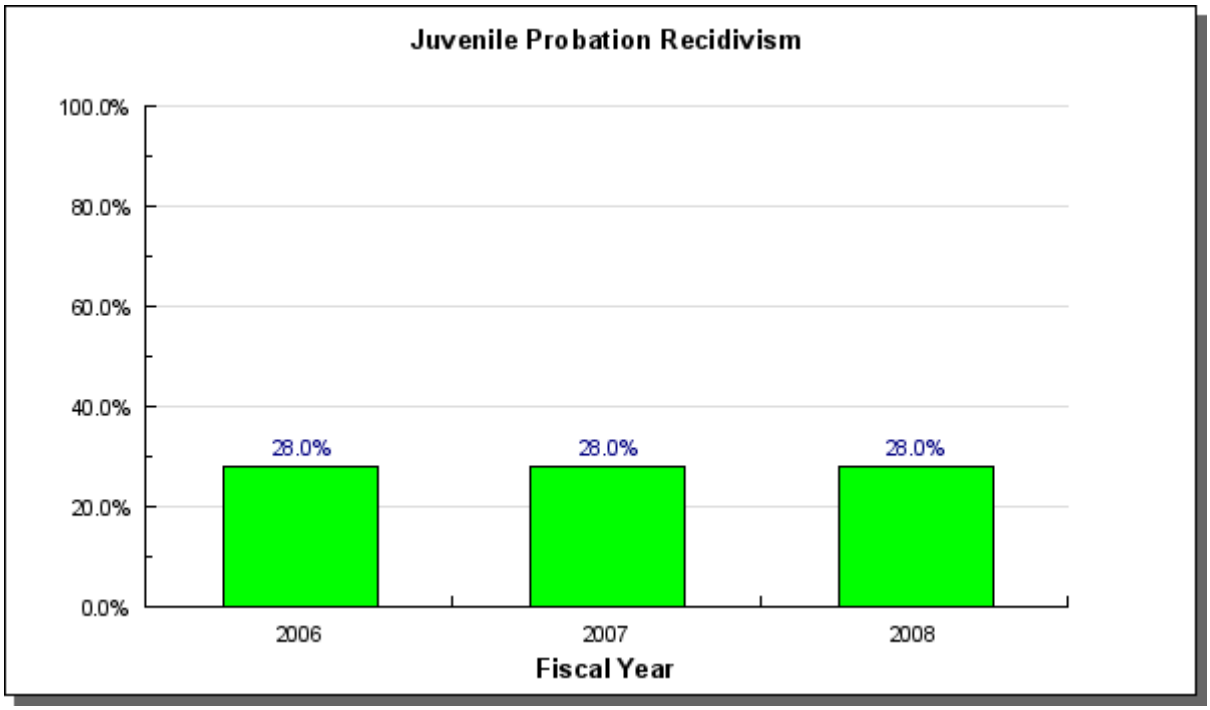
The recidivism rate for juveniles released from Alaska's secure treatment institutions was increased slightly this year compared with the two previous years. The increase may not be significant; the small number of youth released from institutions each year make it difficult to determine whether changes in the recidivism rate from year to year are part of a trend or an anomaly. Any recidivism is cause for concern, and the Division expects to direct additional staffing, training, and other resources at its juvenile facilities in the coming years to limit future re-offending.

Recidivism among juveniles released from treatment is defined, in Alaska, as reoffenses that occurred within a 12-month window. 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%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) This rate serves as the baseline for the juvenile recidivism measure in Alaska.

Note: Reoffenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. 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)." Reoffenses 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. For this FY08 report, adjudication and conviction information on offenses that occurred in FY06 must have been entered in APSIN or JOMIS by August 15, 2008. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska also are excluded from analysis.

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

Status #2: The recidivism rate as defined for juveniles who completed formal court-ordered probation was 28%, identical to that identified in the previous two years.



Juvenile Probation Recidivism

Fiscal Year	YTD Total
FY 2008	28%
FY 2007	28%
FY 2006	28%

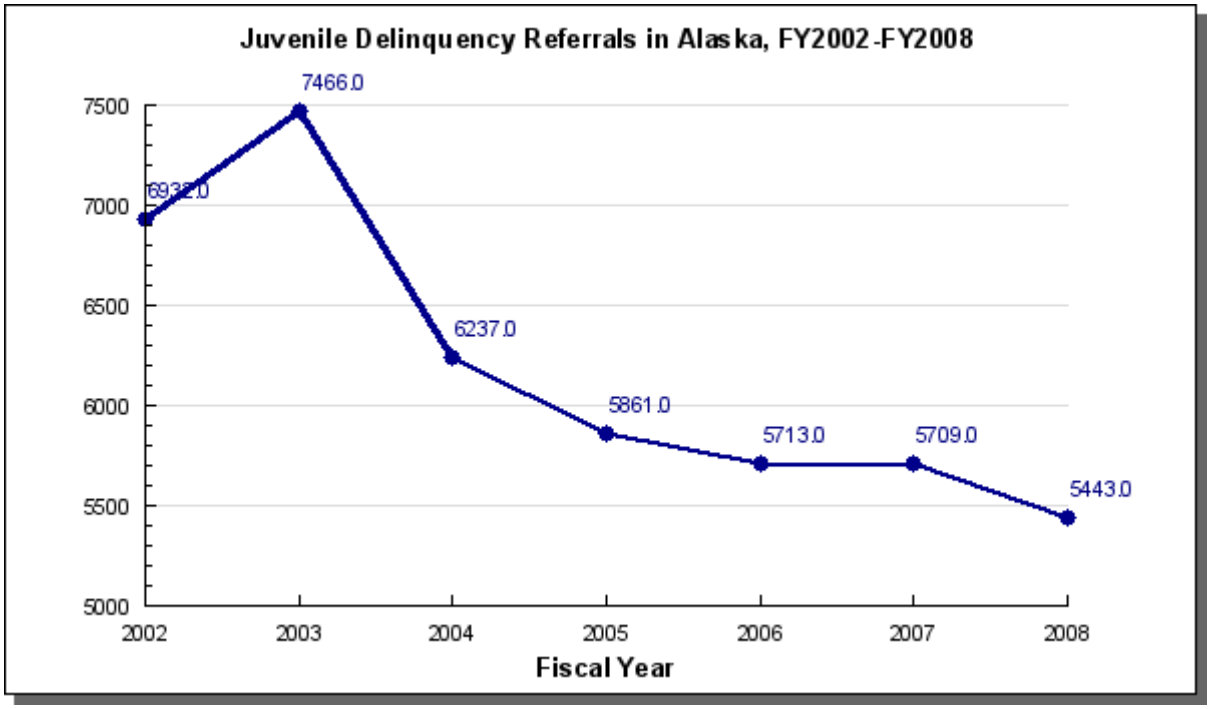
Analysis of results and challenges: This measure examines reoffense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior 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%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) This rate serves as the baseline for the juvenile recidivism measure in Alaska. With a 28% rate for its probation population, Alaska compares favorably with this average.

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 is seeking technical assistance in the coming year to assist in understanding its needs for juvenile probation needs more clearly; this information will ultimately be used to improve the Division's ability to incorporate research-based practices into probation work and ultimately improve 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, Court Termination, Non-compliant Closed, or Waived to Adult Status. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, Supervision Transfer, Declared Incompetent, or Deceased are not included. Recidivism for this measure is is defined as re-offenses that occurred within 12 months from the time offenders were released from formal probation, and that resulted in a conviction or adjudication. For example, the FY 08 population in the graph above represents youth who were released from formal probation in FY 06, and who re-offended within FY2007. For this FY2008 report, adjudication and conviction information on offenses that occurred in FY2006 must have been entered in APSIN or JOMIS by August 15, 2008. Youth 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 any time prior to their supervision end date, as these youth are included in the analysis for our institutional recidivism performance measure. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Status #3: The number of reports of juvenile crime made to the Division of Juvenile Justice declined 4.75% between fiscal years 2007 and 2008 and declined 2.6% between fiscal years 2006 and 2008.



Juvenile Delinquency Referrals in Alaska, FY2002-FY2008

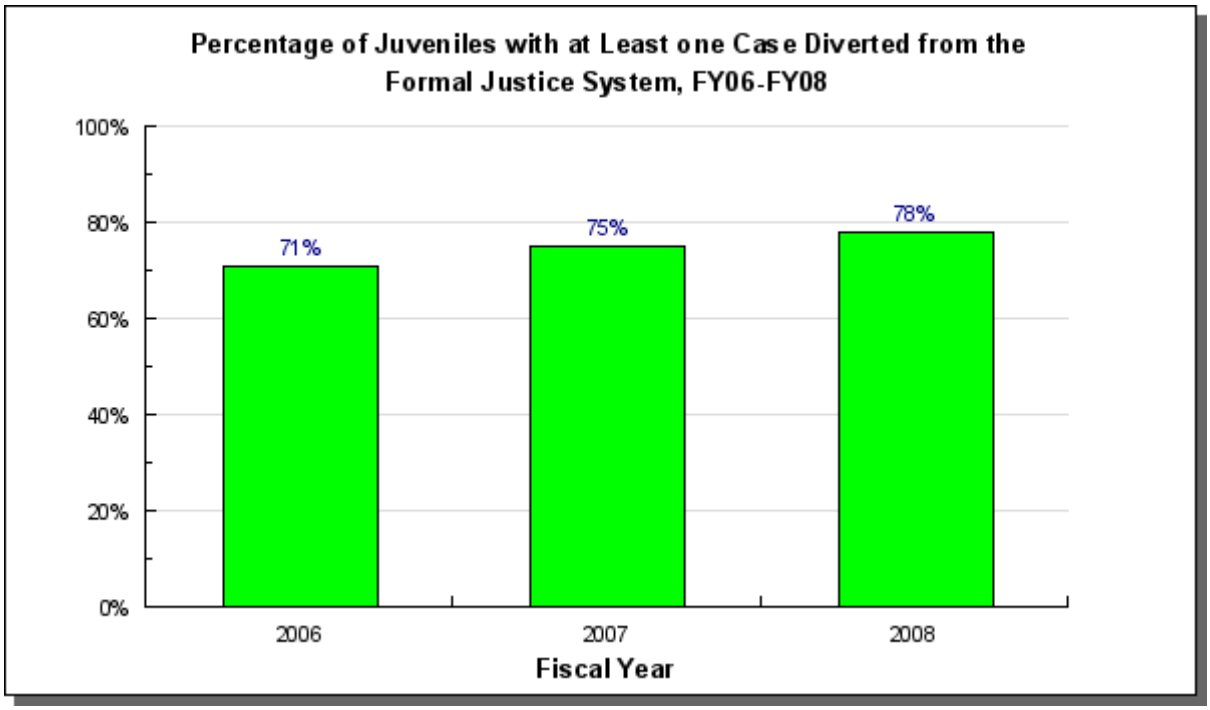
Fiscal Year	YTD Total
FY 2008	5443 -4.66%
FY 2007	5709 -0.07%
FY 2006	5713 -2.53%
FY 2005	5861 -6.03%
FY 2004	6237 -16.46%
FY 2003	7466 +7.7%
FY 2002	6932

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population continued to decrease in FY2008 compared with FY2007 and FY2006. While the change did not meet the target of a 5% decline over a two-year period, the data continued to demonstrate a trend of decreasing juvenile activity that has been noted nationally as well as statewide over the past several years. Definitive reasons for changes in referral levels are unknown. 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 2003-2007 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2008 was derived from the 2007 estimate and the 2010 projection from the report Alaska Population Projections 2007-2030, published by the same Department. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database by on August 18, 2008 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 70% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

Status #4: The proportion of juveniles with at least one case (a criminal charge in a report from law enforcement alleging a juvenile perpetrator) diverted from the formal court process remained high, at 78%.



Percentage of Juveniles with at Least one Case Diverted from the Formal Justice System, FY06-FY08

Fiscal Year	YTD Total
FY 2008	78%
FY 2007	75%
FY 2006	71%

Analysis of results and challenges: Diversion refers to the process of managing juveniles cases through non-court processes, such as non-court adjustments, informal probation, referral to community panels such as youth court, or dismissals. Diversion serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and

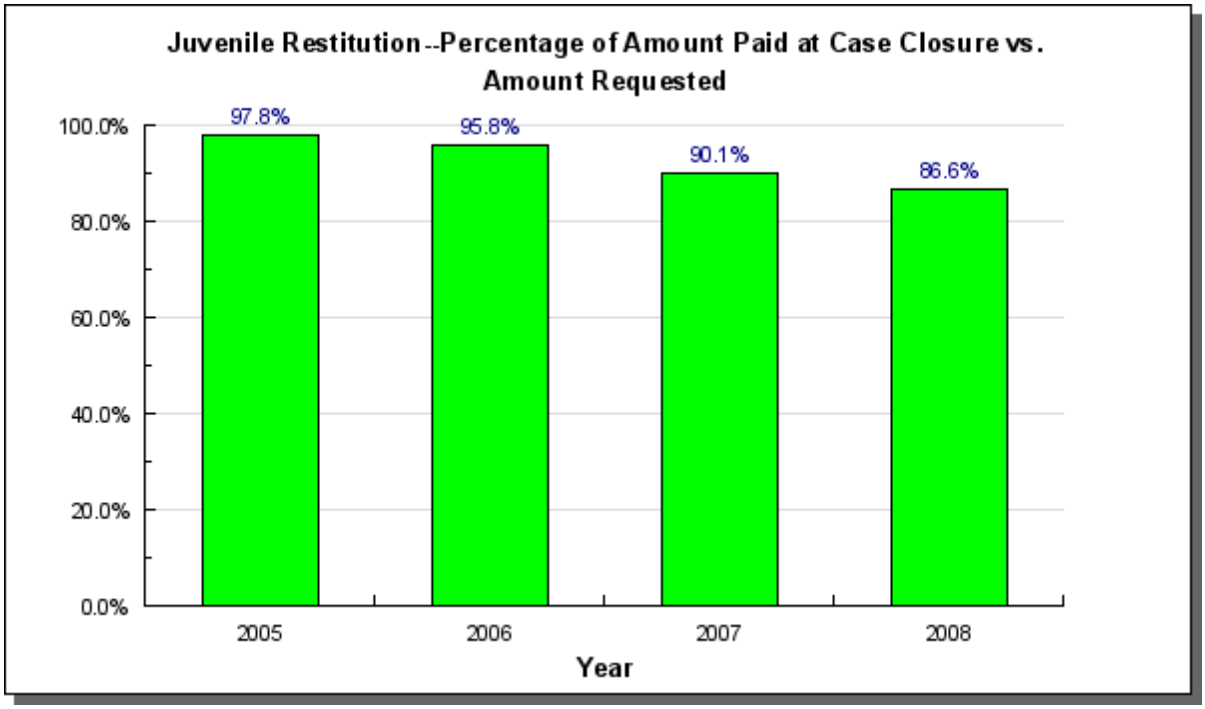
needless harm that can result from delinquency adjudication. Diversion can provide opportunities for community partners and victims to take more active roles in handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, who otherwise would find it impossible to adjudicate 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.

In FY2008 2,922 (78%) of 3,728 juveniles referred to the Division had at least one of their charges managed through non-formal court processes. The percentage increased slightly compared with FY06 and FY07 results, but because this is only the third time the Division has considered this measure, the improvement may be due to refinements in recordkeeping, data gathering, and analysis.

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 charge within the 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 this data was collected, are excluded from consideration.

Target #5: Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered.

Status #5: The amount of restitution paid by juvenile offenders by the time their cases close remained high in FY2008, at 86.6%.



Juvenile Restitution--Percentage of Amount Paid at Case Closure vs. Amount Requested

Year	% of Amt Ordered
2008	86.6%
2007	90.1%
2006	95.8%
2005	97.8%

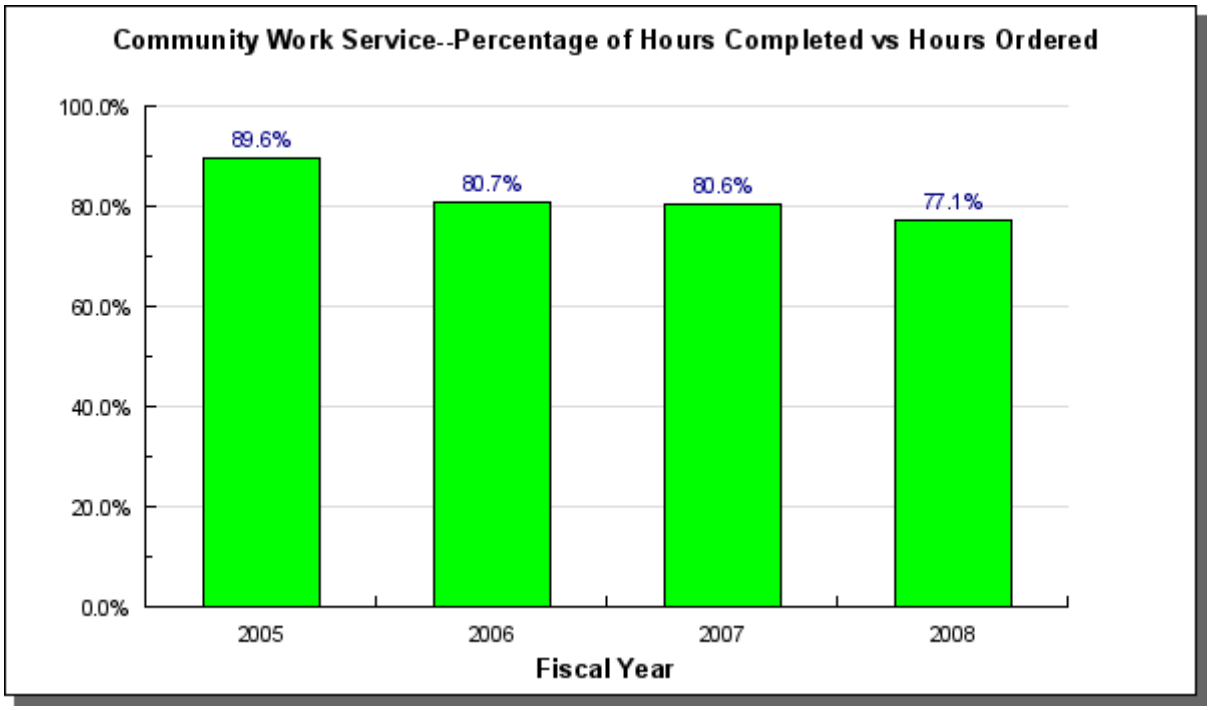
Analysis of results and challenges: This measure provides a gauge of the Division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their criminal behavior. Juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system. Restitutions assigned through informal procedures are included in this measure, as are assignments of Permanent Fund Dividends made by juvenile probation officers. The amount of restitution reported as paid is that amount provided by the youth at the time of case closure. Restitutions tracked and gathered through youth courts and other community diversion programs are not included in this measure. Since January 1, 2002, restitution payments by juveniles who are processed formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections & Support Unit and those restitution payments are also not included in this analysis.

FY08 marked the second full year that staff have used the Division's Juvenile Offender Management Information System (JOMIS) to record restitution data. This year the Division identified a feature of the database which inadvertently led many staff to under-report the amount of restitution paid by clients. While staff attempted to correct this data in time for this report, this issue may be responsible for the slight decrease noted in the restitution collection rates for FY08. This incident has illustrated the need for better quality assurance and training for staff who work with JOMIS, a need the Division hopes to address in the coming fiscal year.

Note: FY2006-2008 data for this measure was retrieved from the JOMIS report, "Statewide Summary Restitution Report," on August 19, 2008. This data is continually refined and corrected and numbers in future reports may change slightly.

Target #6: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.

Status #6: The percentage of hours of community work service completed by juveniles in FY2008 remained relatively consistent with that noted in previous years, at 77.1%.



Community Work Service--Percentage of Hours Completed vs Hours Ordered

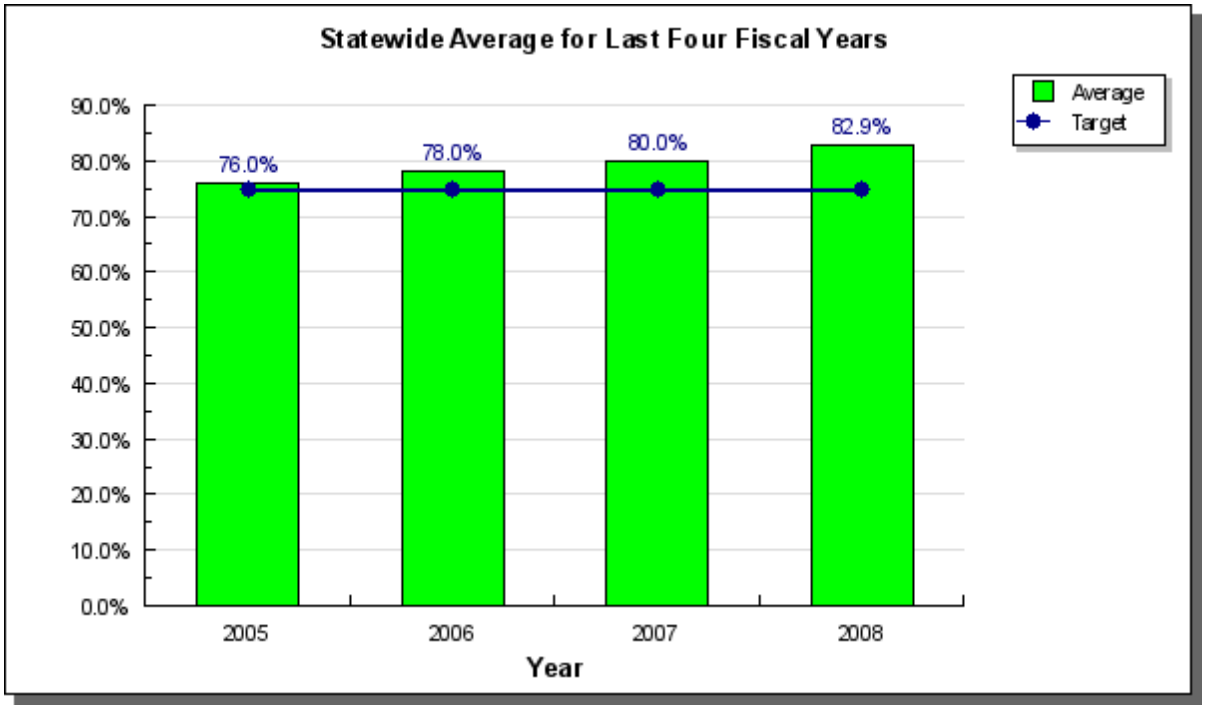
Fiscal Year	Percentage
FY 2008	77.1%
FY 2007	80.6%
FY 2006	80.7%
FY 2005	89.6%

Analysis of results and challenges: 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.

This year the Division identified a feature of the Juvenile Offender Management Information System (JOMIS) which inadvertantly led many staff to under-report the amount of community work service completed by juveniles. While staff worked to correct this data in time for this report, this technical issue may have been responsible for the slight decrease noted in the community work service completion rates for FY08. This incident has illustrated the need for better quality assurance and training for staff who work with JOMIS, a need the Division hopes to address in the coming fiscal year. Note: Data for this measure for FY2006-FY2008 was retrieved from the JOMIS report, "Statewide Summary Community Work Service Report," on August 20, 2008. This data is 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.
Status #1: The average time it took juvenile justice staff to respond to reports from law enforcement of juvenile activity continued to improve, with 82.9% of reports responded to within 30 days.



Statewide Average for Last Four Fiscal Years

Year	Average	Target
2008	82.9%	75%
2007	80%	75%
2006	78%	75%
2005	76%	75%

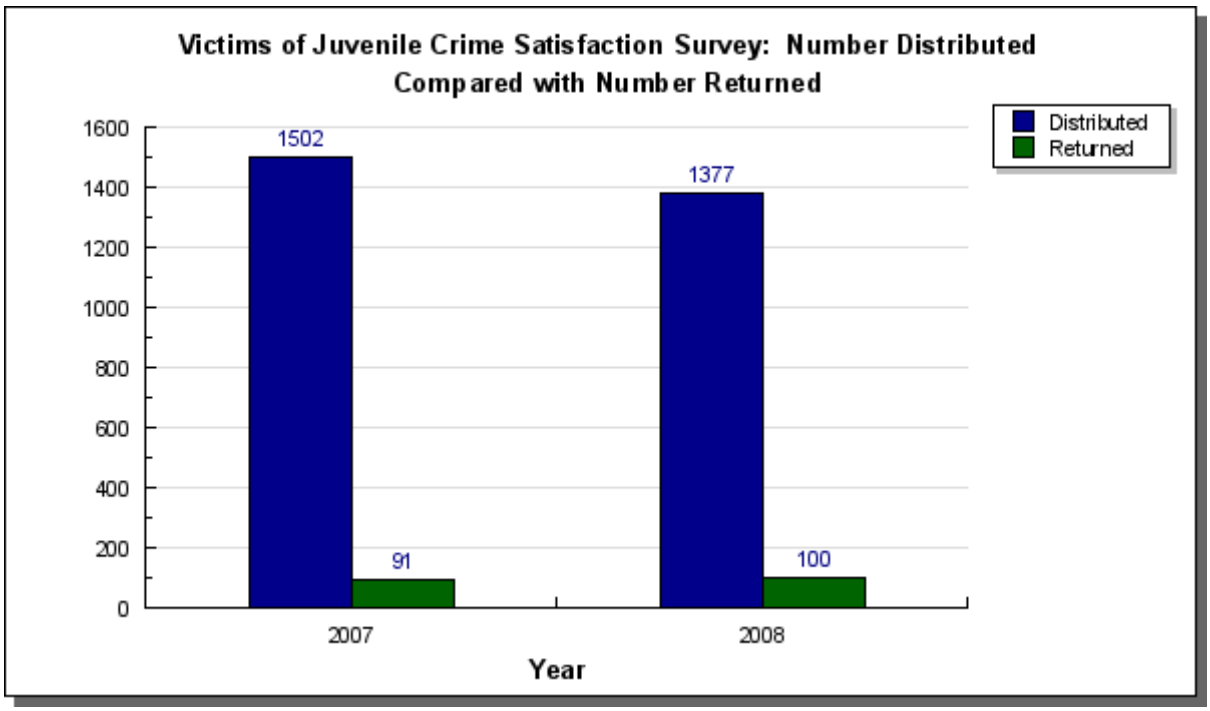
Analysis of results and challenges: This measure enables the Division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An active response is defined by the Division as one of three possible actions by staff to deal with the delinquency report (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 statewide average percentage of referrals that received a response within 30 days was 82.9%, exceeding the goal of 75%, as illustrated in the chart. The average response time in FY08 was 18.2 days, a steady and continuous improvement from prior years. The Division is able to provide information on response time through a streamlined procedure in the Juvenile Offender Management Information System (JOMIS).

Note: Delinquency reports (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: To monitor and improve victims' satisfaction with juvenile justice services.
Status #1: The Division of Juvenile Justice distributed 1,377 surveys to victims of juvenile crime in FY2008 and 100 (7.26%) were returned by August 25, 2008.



Victims of Juvenile Crime Satisfaction Survey: Number Distributed Compared with Number Returned

Year	Distributed	Returned	Percentage Returned
2008	1377	100	7.3%
2007	1502	91	6.1%

Analysis of results and challenges: Promoting the safety and restoration of the victims of juvenile crime is a critical component of the mission of the Division of Juvenile Justice. Division policies, reflecting Alaska statute, afford victims number of rights in the process of handling delinquency cases. Division staff notifies victims when juvenile delinquency matters come to their attention, and they keep victims informed as their cases proceed through the juvenile justice process.

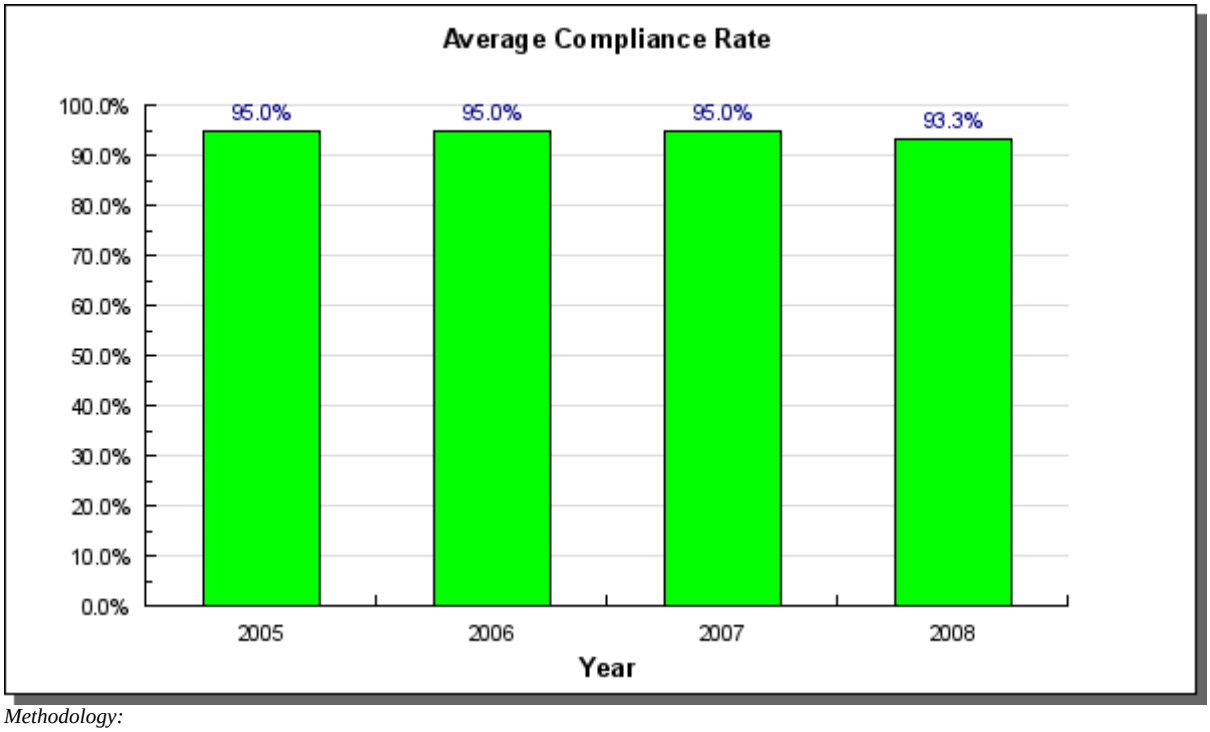
In an effort to determine the Division's effectiveness in providing support and information to victims, the Division worked with the DHSS IT Section to develop a victim's satisfaction survey. The first round of these surveys was distributed in FY2007, with 1502 surveys distributed and 91 returned, for a response rate of 6.06%; the response rate for the 1,377 surveys distributed and returned in FY2008 was 7.26%.

The survey has been valuable in that it has provided, to those who responded to it, a means for the Division to answer additional questions or provide additional information on a case to victims. However, the low response rate prevents the Division from drawing any conclusions about its effectiveness in providing services to victims. The low response rate appears due, in part, to incomplete contact information provided to law enforcement by the victims themselves, resulting in hundreds of the surveys being returned as undeliverable. The survey, which consists of 15 multiple-choice or short-answer questions, may also have been too long for some respondents to take the time to complete. In FY2009 the Division intends to re-examine the survey's format and purposes and anticipates changes to the survey in the coming year.

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: All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

Status #1: Juvenile probation officers in Alaska again demonstrated a high degree of consistency in meeting expectations for thorough case work. Audits of client files demonstrated an average 93.3% compliance rate in FY08, as compared to 95% in previous years.



Methodology:

Average Compliance Rate

Year	Average
2008	93.3
2007	95%
2006	95%
2005	95%

Analysis of results and challenges: 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 trimesterly basis. A representative sample of each officers' 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; child care assistance and work supports that enable and encourage Alaskans to pursue economic independence and self-sufficiency.

Core Services

Division staff determines eligibility for benefits and make 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.
- Child care licensing services 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 meet income guidelines in addition to other eligibility requirements which vary by program.

The division provides direct customer services in 17 offices statewide. In addition, Women, Infants and Children (WIC), Child Care Assistance, and employment case management services are provided through grants and pay-for-performance contracts with community agencies. In FY2008, the division provided cash, food, and medical benefits and services to over 95,000 Alaskan households and 156,000 individuals.

Services Provided

Alaska Temporary Assistance Program

The Alaska Temporary Assistance Program (ATAP) provides temporary financial assistance to needy families with children and while adults work to become self-sufficient. ATAP was created by the state and federal welfare reform laws passed in 1996 and replaced the Aid to Families with Dependent Children (AFDC) Program. The program is funded by the federal Temporary Assistance for Needy Families (TANF) block grant and a required percentage of state expenditures, based on the amount spent in federal fiscal year 1994 for the AFDC program in Alaska.

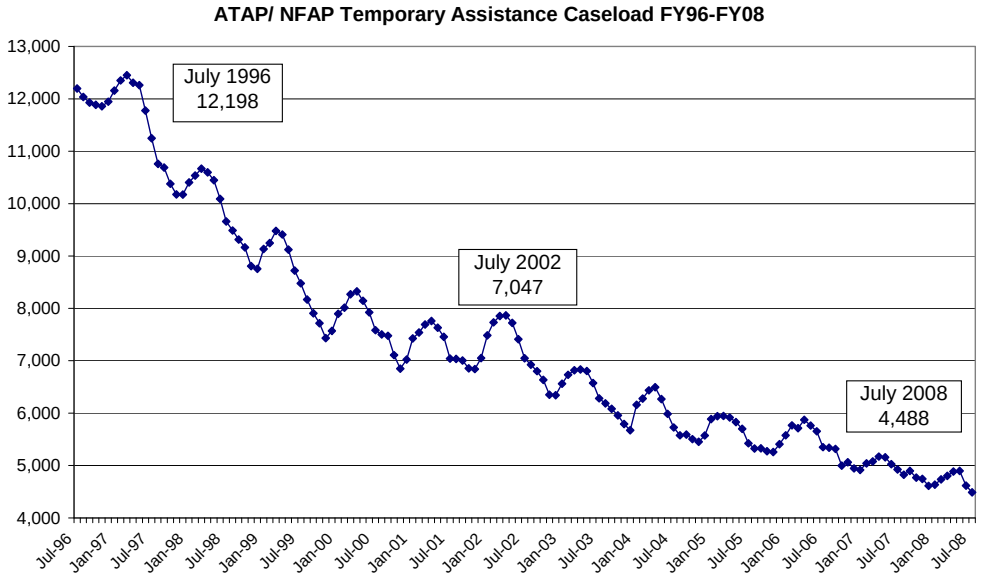
The program provides assistance to nearly 3,100 families throughout the state. This assistance is limited to 60 months as a temporary safety net to help families care for children in their own homes by providing for the basic needs of shelter, clothing, transportation and food. ATAP also has a strong 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 them seek, secure, and retain employment. Case management and employment-related services are provided under a "work first" approach that emphasizes quick entry into the work force. These supports and services are referred to as Work Services.

Tribal Assistance Programs

Federal law allows tribes and Alaska Native regional 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 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 1,500 Alaskan families are receiving TANF services and benefits from 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). Kodiak Area Native Association (KANA) and Maniilaq Association are also planning to implement Native Family Assistance Programs in FY2009.



The sustained efforts of the division since the implementation of ATAP have resulted in thousands of Alaskans achieving economic self-sufficiency through employment. While the Temporary Assistance caseload in Alaska continues to fall, the rate of decline has slowed. Overall, the annual monthly average state and Native Temporary Assistance caseloads have decreased by 61% since FY1997, and have generated approximately $80 million in savings. The decline in the caseload and the decline in the amount of temporary assistance benefits paid to families is a result of the program's emphasis on employment.

Child Care Benefits

The Child Care Assistance Program has been in existence for over 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; in 2003 it became the responsibility Department of Health and Social Services.

Providing access to affordable, safe, child care is a key component in the state's efforts to help families succeed in the work place 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.

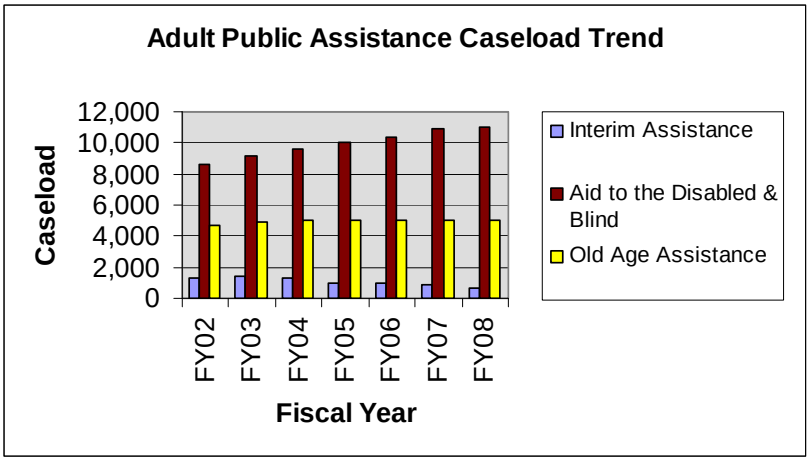
The state's continued commitment to improving the quality, availability, and affordability of child care helps ensure that families can work and move toward economic self-sufficiency while their children are in safe and healthy child care.

Work Services
The Alaska Temporary Assistance Program's time-limited benefits and focus on moving recipients into the workforce require services that assist program participants to gain paid employment quickly. Work Services supports and promotes the efforts of Alaska Temporary Assistance recipients to attain economic self-sufficiency through employment. Employment and training services are also provided to Food Stamp Program participants.

Work Services includes activities and support systems that prepare clients to enter the workforce, 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 non-profit and for-profit organizations, private sector businesses, and Native regional non-profit 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 provide 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.

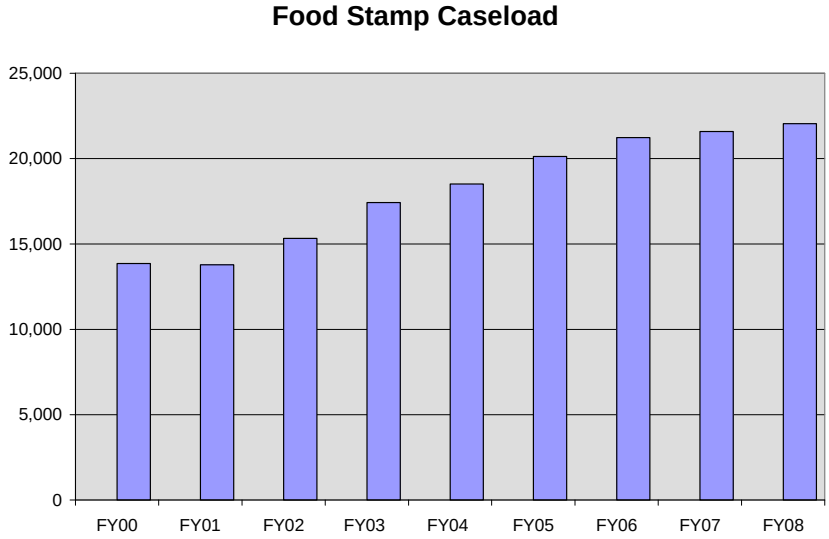
The Adult Public Assistance program also includes an Interim Assistance benefit of $280 a month for individuals who appear to meet the Supplemental Security Income (SSI) disability criteria and have applied for SSI. To qualify for SSI, a person's mental or physical limitations must be severe enough to make him or her temporarily or permanently incapable of self-support through gainful employment. In FY2004, 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 in Interim Assistance and has decreased the caseload by approximately 50% since it reached an all time high at the end of FY2003.



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.

Alaska's Food Stamp caseload has been steadily growing. In FY08, the program served an average of 22,000 low-income households with about $7.9 million of food stamp benefits issued each month.



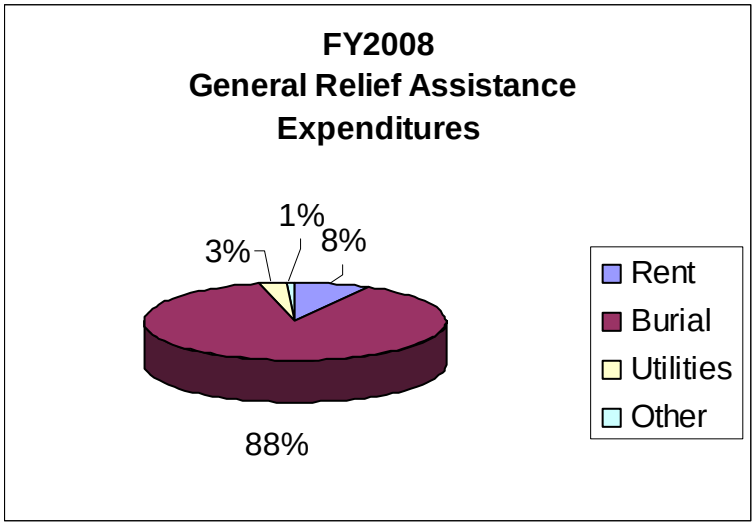
In 2008, Congress passed the Food, Conservation and Energy Act (the 2008 Farm Bill). The Farm Bill changed the name of the federal Food Stamp Program to the Supplemental Nutrition Assistance Program (SNAP) and directs States to also rename the Food Stamp Program. The department will begin this effort in FY2009.

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, program stewardship and accountability. This is a mandated activity for the Food Stamp, Medicaid, and Child Care Assistance programs. The division also conducts payment accuracy reviews for the Alaska Temporary Assistance Program, when Quality Control staff resources are available.

Alaska was among the first 18 states mandated to begin reviewing the accuracy of child care subsidy authorizations, with the federal rules issued only one month prior to the October 1, 2007, effective date. The reviews demonstrated 95.4% of the child care payment authorizations were accurate. The division also started the federally mandated Payment Error Rate Measurement (PERM) eligibility and claims payment reviews for Medicaid and the State Children's Health Insurance Program (SCHIP) in FY2008. The PERM reviews will be completed in FY2009, with a total of 1,416 Medicaid cases reviewed.

Fraud Control
The division maintains 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 FY2008 the unit investigated over 1,300 allegations of 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 indigent Alaskans who have no other resources available. Eighty-eight percent of GRA program expenditures are used to pay for funeral and burial expenses. The remainder is used to meet emergency shelter, food, and clothing needs.



In FY2008 the program covered burial expenses for 594 deceased individuals and met emergency needs by preventing eviction and homelessness for approximately 60 households each month.

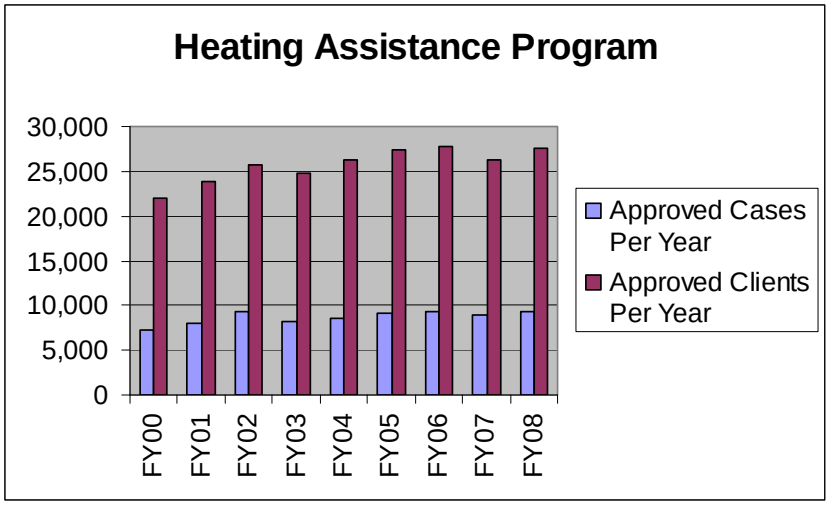
Medicaid Program
The Medicaid Program provides medical coverage for basic health and long-term care service for low-income Alaskans. The Division of Health Care Services (HCS) is responsible for managing payments to health care providers. The division develops and administers policies for the program, 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 89,000 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 provides limited health coverage for individuals who are terminally ill or have chronic conditions, such as cancer requiring chemotherapy, chronic diabetes, seizure disorders, chronic mental illness, or hypertension. It is a state funded program for individuals who do not qualify for Medicaid, have very little income, few personal resources and have inadequate or no health care. 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 funding to support weatherization projects. Until FY2009 Heating Assistance was funded entirely by the federal Low Income Home Energy Assistance Program (LIHEAP) block grant.

The Heating Assistance Program provides seasonal assistance with home heating expenses. Benefits are based on family income, home heating costs, housing type and geographic region. Households apply to receive an annual heating assistance grant. Assistance is normally provided in the form of a credit with the applicant's home energy vendor, and covers a portion of their cost for home heating oil, natural gas, electricity, propane, wood and coal.

Federal LIHEAP funds can be used to serve households with income below 150% of the federal poverty limit for Alaska. The new state-funded Alaska Heating Assistance Program (AKHAP) which began October 1, 2009, is available for households with income between 151% and 225% of the federal poverty limit.



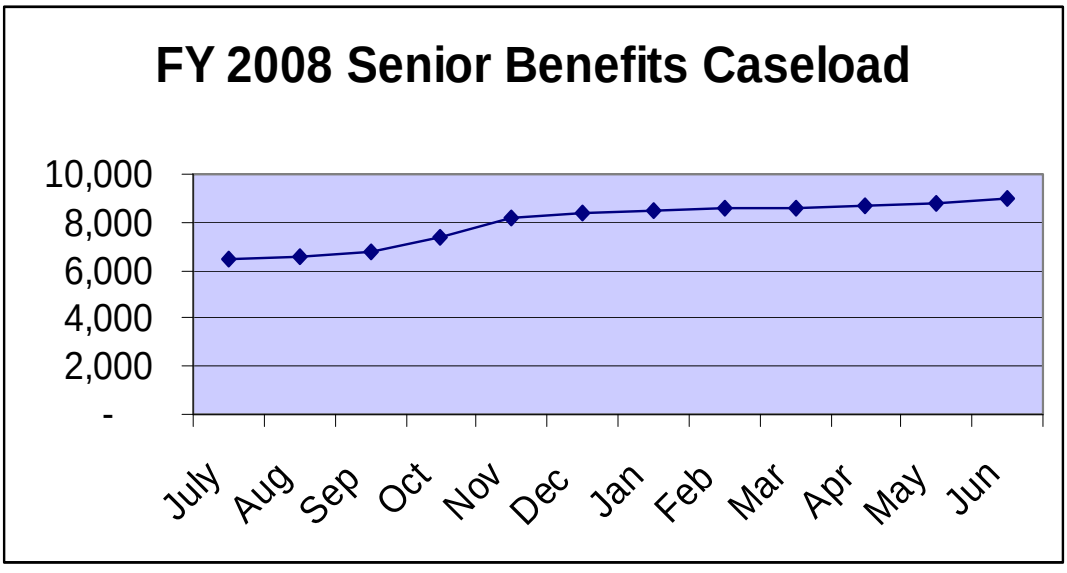
During the 2007-2008 season almost 9,400 households received help from the state administered Heating Assistance Program. In addition, approximately 4,900 households received help from Alaska Native organizations that receive direct federal funding to operate Tribal Energy Assistance Programs.

The Energy Assistance Program also contributes funds to the Alaska Housing Finance Corporation Low Income Home Weatherization Assistance Program for weatherization projects.

Senior Benefits Payment Program

The Senior Benefits Payment program helps low-income seniors who are at least 65 years of age remain independent in the community by providing monthly cash payment of $125, $175, or $250 depending on annual income. This program was established in late June 2007, following the sunset of the SeniorCare program on June 30, 2007.

In August 2008, over 9,300 seniors were enrolled in the Senior Benefits Payment Program compared to approximately 7,000 being 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 infants and young children eat well, learn about good nutrition, and stay healthy. Pregnant, postpartum, and breastfeeding women and children receive nutrition education, referrals, and warrants to purchase food that will improve their health and nutritional status. This component also includes the Commodity Supplemental Food Program, which provides food to low-income seniors, and the Farmers' Market Nutrition Programs, which offers coupons to seniors and WIC participants to purchase locally grown fruits and vegetables at Farmers' Markets during the harvest season.

Program administration for WIC and the family nutrition programs transferred from the Office of Children Services to the Division of Public Assistance effective July 1, 2007. These programs are federally-funded. In FY2008, approximately 25,000 women and children received WIC each month, and 2,000 seniors received food from the commodity program.

Comparison of Public Assistance Programs

	Heating Assistance	Child Care (PASS I, II, III)	Senior Benefits	Women, Infants & Children (WIC)
FY08 Cases	9,360		8,766	25,173
# of clients	9,360	4988 children	8,766	25,173
Race Distribution	White 53% Hispanic 2% Alaska Native/Indian 34% Asian/Pacific Islander 4% African American 3% Other 4%	N/A	N/A	43% 8% 31% 9% 5% 4%
Recipients by Location (District area)	Anch / Mat-Su 38% Northern 13% Southeast 6% Balance of State 43%	N/A	Anch / Mat-Su 47% Northern 13% Southeast 11% Balance of State 29%	43% 10% 8% 29%
Expenditure By Category of Service	Employed, retired or temp unemployed 64% Receiving ATAP 10% Receiving APA 26%	Pass I 10% Pass II 8% Pass III 82%	Food Stamp 17% APA 56% Medicaid 75%	Food Stamp 3% Medicaid 11%
Total Expenditures	$10,392,335	Pass I 3,977,442 Pass II/III 23,742,719	$15,215,794	20,127,900
Federal	$10,392,335	-$7,239,946		20,127,900
GF		$7,239,946	$15,215,794	
Other				

Notes:
1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) Several areas of Alaska receive Heating Assistance through tribal organizations funded directly by the federal government.
3) The Child Care Subsidy information includes PASS I (child care for families also receiving ATAP), PASS II/III child care subsidy and
Child Care Grant Program Expenditures.
4) Caseloads listed for Heating Assistance is an annual number, where the caseloads listed for Child Care are monthly averages.

	ATAP/TANF	Adult Public Assistance	General Relief	Food Stamps
FY08 Cases avg. mo.	3,109	16,704	136	22,055
# of clients avg. mo.	8,185	16,704	190	58,305
Race Distribution	White 56% Alaska Native 19% Black 11% Asian 6%	White 49% Alaska Native 60% Asian 9% Black 5%	White N/A Alaska Native N/A Black N/A	White 43% Alaska Native 40% Black 6% Hispanic 3% Asian 3%
Recipients by Location (District area)	Anch / Mat-Su 61% Northern 11% Southeast 9% Balance of State 19%	Anch / Mat-Su 54% Northern 12% Southeast 12% Balance of State 22%	Anch / Mat-Su 52% Northern 15% Southeast 17% Balance of State 16%	Anch / Mat-Su 47% Northern 13% Southeast 13% Balance of State 27%
Expenditure By Category of Service	Single parent 62% 12% Two parent 26% Child only 29%	Disabled 72% Aged 27% Blind 1%	Burial service 88% Rent assistance 8% Other 4%	FS and ATAP 17% FS only 27% FS and APA 9% FS and Med 92%
Children 0 - 18 yrs	5,734	0		28,105
Adults 19 - 59 yrs	2,436	9,589		27,179
Adults 60 - older	15	7,115		3,021
Total Expenditures	$36,376,868	$53,489,576	$1,445,148	$94,618,467
Federal	$6,303,101	$979,134		$94,618,467
GF	$28,287,299	$48,605,398	$1,445,148	
Other	$1,786,468	$3,905,044		

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.

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 47.25.621-626	Heating Assistance Program
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

Public Assistance	2009	2010 Gov	09 to 10 Change
General Funds	145,634.1	142,120.8	-3,513.3
Federal Funds	119,861.5	120,827.0	965.5
Other Funds	26,405.7	26,447.0	41.30
Total	**291,901.3**	**289,394.8**	**-2,506.5**

Adult Public Assistance (APA)

General Fund Decrement for the Adult Public Assistance Program: *($500.0) GF*
The rate of increase in the number of individuals receiving Adult Public Assistance has slowed over recent years. The division expects the rate of change to begin increasing again in 2009 and that the growth will continue over the next 10 years. The division projects that the Adult Public Assistance Program will have sufficient general funds to offer a $500.0 decrement in F2010; however, the division also projects that the rate of growth will likely result in the need to request an increment in FY2012 of approximately $1,600.0.

Child Care Benefits

Child Care Grantee Support: *$305.4 GF*
This increment requests funding to help offset the rising costs-of-doing business that community grantees are paying as a result of increased energy prices, cost of goods, and maintaining qualified staff. The Child Care Program provides grants to community agencies for Child Care Assistance eligibility determinations, Child Care Resource and Referral services, and Child Care Licensing in the Anchorage area. This funding is needed to avoid a reduction in the availability of child care services for working families due to increased grantee costs.

Child Care Rate Increase for Working Families: *$3,000.0 GF*
The number of working families participating in the Child Care Assistance Program has been steadily declining. The decrease is partially attributed to state rates for child care not keeping pace with the rates that child care providers charge, causing families to choose more affordable, lower quality, and typically unregulated care.

The division received an increment in FY2009, as part of the department's comprehensive rate increase request, to bring child care assistance subsidy rates in line with the 50th percentile of the 2007 Child Care Market Rate Survey. Previously, child care rates had not been increased since 2001. The federal government suggests that states set rates at the 75th percentile of market rates to ensure equal access to child care for families receiving child care assistance.

The division will be completing an enhanced Market Rate Survey in 2009. The results of the 2009 survey will be used in conjunction with the recommendations from the department's comprehensive rate study to develop a standardized methodology for calculating state child care assistance rates. This increment estimates the additional funding needed to implement an increase based on the new formula and bring the state child care subsidy rates closer to the desired 75th percentile, as suggested by the federal government.

Senior Benefits Payment Program

General Fund Decrement for Senior Benefits Payment Program: *$500.0 GF*
The number of seniors enrolled in the Senior Benefits Payment Program is lower than projected when the program began in August 2008.

In FY2010, the division estimates over 10,000 seniors will qualify for Senior Benefits with an estimated cost of $18,926.4 in benefit payments, lower than the $19,917.9 projected when the program was established.

Energy Assistance Program

Alaska Heating Assistance Program: *$5,000.0 GF*
The Alaska Heating Assistance Program was established during the 2008 legislative session, and the Legislature authorized first-year funding for the program (FY09) in Section 64 CH20 SLA2008 P223 L12 (SB221). This increment establishes funding in the operating budget to maintain services for this program beyond FY2009.

The Alaska Heating Assistance Program makes home heating assistance available to households with incomes between 151% and 225% of the federal poverty guidelines for Alaska. Based on current demographic information, the Division estimates that up to 11,000 households could apply for the new program and that as many as 8,800 households could qualify for the this new program in the coming year.

Women, Infants and Children (WIC)

Two increments are included in the FY2010 budget to support WIC. The WIC program is 100% federally-funded, with the exception of $70.0 in general fund. Alaska's federal WIC allocation is not adequate to effectively administer the program. The increments described below are to supplement the federal funding to sustain services to vulnerable pregnant women, infants, and young children.

WIC Local Administrator Support: *$247.1 GF*
This increment requests funding to help offset the rising costs-of-doing business that community grantees are paying as a result of increased energy prices and cost of goods. The WIC Program provides grants to community agencies to administer the WIC program and provide WIC services which include nutrition education, breastfeeding support, risk assessments, and issuing warrants to purchase WIC-approved foods. This funding is needed to avoid a reduction in nutrition services for vulnerable women and children due to increased operating costs.

WIC Formula Funding Implementation: *$70.8 GF*
This request is to provide transitional funding to support the WIC program during implementation of a new funding formula. Eligibility for WIC, nutrition education, and other WIC-related services are provided throughout the state by local grantees. The historic funding methodology used for this community-based service has been inequitable and inconsistent. In FY2009, the division implemented a new standardized funding formula to base funding for grantees and equalize the method of payment for this service. To minimize the negative fiscal impact on grantees that, under the old method, received a disproportionate share of funds the division is phasing-in the new formula over three years. This increment would allow the division to increase grants to grantees that are funded below the new base cost during the phase-in of the funding formula.

Explanation of FY2010 Capital Budget Requests

The Division of Public Assistance will be requesting the following capital funding:

- Production Printer Replacement - $474.3
- Safety and Support Equipment for Probation Officer and Front Line Workers - $459.2

Production Printer Replacement*: $474.3 Total- $299.3 GF, $175.0 Fed*
This capital funding request is to replace Division's Docuprint 92C printer with a newer reliable model that includes the necessary features to meet the division's production printing needs. The existing printer is seven years old and its performance is deteriorating. Equipment breakdowns are frequent and costly to repair and put vulnerable Alaskans and the division at risk when benefits and critical client notifications cannot be issued timely.

The division uses the Xerox Docuprint 92C production printer for issuing program benefits and information to thousands of Alaskans. Each month, DPA's production printer generates approximately 70,000 client notifications, 10,000 Denali KidCare (DKC) identification cards, hundreds of special medical authorizations for Chronic and Acute Medical Assistance (CAMA), and many other types of brochures, forms and materials.

Safety and Support Equipment for Probation Officer and Front Line Workers**:** *$459.2 Total- $222.2 GF, $237.0 Fed*
Adequate workstations, functioning equipment, and security of client records, are crucial to the productivity of staff, efficiency of operations, and acceptable customer service. Budgetary constraints have resulted in a prolonged life cycle of equipment in many Public Assistance offices. The Division is committed to providing a professional and efficient workplace for employees, and ensuring safety and accessibility of services for clients. Funding authorized will be used to begin replacing broken or worn out furniture and equipment.

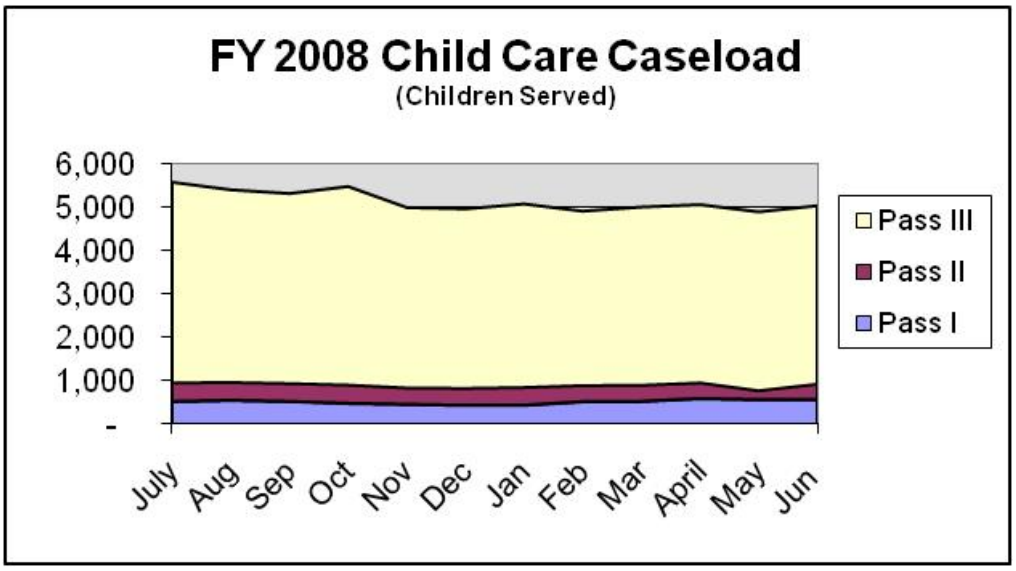
New work stations are needed for the new Gambell Street office in Anchorage. This capital funding request is to secure funding to replace old, well-used, furniture with workstations that are adjustable and can be configured to maximize efficient use of available space and accommodate the needs of the staff and accessibility of services to clientele. In addition, new workstations are needed for division employees because the majority of the furniture is old, well used, and has been in service for ten years or more. Many workstations are no longer functional or able to be adapted or configured to the new space.

Challenges

As the Division of Public Assistance continues to make progress on our overall mission to "promote self sufficiency and provide for basic living expenses to Alaskans in need", several new and ongoing challenges may affect our ability to meet performance objectives in FY2010. These include:

Economic Uncertainty
Rising unemployment and increasing food, medical, and energy costs put vulnerable Alaskans at greater risk. The impact of the economy's downturn on low income individuals and families is already being seen nationally as states begin to have rising participation in safety-net programs such as Supplemental Nutrition Assistance Program (SNAP) (i.e. food stamps). It is likely that, depending on the severity and duration of the recession, more Alaskans will turn to the division for temporary relief. While the number of families receiving financial assistance from the Alaska Temporary Assistance Program (ATAP) continued to decline in FY2008, the viability and the diversity of the state's economy affects our ability to help families become employed and self-sufficient. If there are fewer jobs and other work activities available for welfare participants, it will be increasingly difficult for the division to meet desired employment and self-sufficiency targets. The division needs to preserve savings that have accrued as a result of welfare reform and the reduction in the ATAP caseload to ensure core business needs are supported, such as replacement of the division's eligibility information system in future years, and to prepare for any potential increases in the ATAP caseload due to economic changes.

Child Care Access to affordable, safe, quality child care is imperative for low-income families to be successful. It often provides the support that parents in low paying jobs need in order to stay working. The division is working to increase the effectiveness of its child care assistance program by evaluating quality and availability of provider services, along with more equitable subsidy rates. The number of families participating in the Child Care Assistance Program has been steadily declining. The reasons are two-fold. Costs for child care have risen, but the program's rates have not kept pace with the inflation. In addition, the program's income qualifying standards have not been adjusted since 2002. To begin addressing these issues, the division increased rates on September 1, 2008, closing the gap between the state rate and the amount providers charge for care. The FY2010 increment will allow another rate increase and shrink this gap further. The division is also evaluating the income eligibility standards and the parent contribution (co-pay) scale and will be assessing the costs of increasing them. Federal guidelines allow states to serve families with incomes up to 85% of the state median income. Alaska's child care assistance income limits fall below 70% of the 2007 state median income. For example, Alaska's 2007 state median income for a family of three is $5,785 a month. The child care assistance income limit for a family of three is $3,915 a month, 68 % of the 2007 state median income.



Heating Assistance
The division implemented the new Alaska Heating Assistance Program (AKHAP) that was authorized during the 2008 Legislative Session on September 1, 2008. The newness of the program and lack of solid demographic data, coupled with the current economic condition, makes it difficult to estimate the number of households that will apply for and qualify for AKHAP, and the projected level of funding that will be needed in FY2010.

Women, Infants, and Children (WIC)
New federal rules require Value Enhanced Nutrition Assessments (also known as VENA) be implemented in FY2010. VENA involves using motivational interviewing techniques and critical thinking skills in completing nutrition assessments and providing nutrition education. While these are improved practices, they require significant training and changes to WIC's policies and procedures and computer system (AKWIC) and are resource intensive to implement.

Recruitment and Retention
Retaining staff in all sections of the division continues to be a challenge as the workforce ages and dedicated employees with years of experience retire. This is particularly acute with front-line eligibility staff because of the complex program rules that can take six months of experience or more to effectively administer. The division is expected to deliver timely and accurate benefits and staff takes great pride in ensuring families and individuals receive the best possible service. The turnover rates, however, coupled with increased demand for services, create high caseloads for journey level employees and increase the risk of error. The division is working with the Department of Administration on conducting a study of the eligibility technician job class as one strategy for hiring and retaining qualified individuals and strengthening the workforce. The division is also using existing resources to invest in innovative practices to increase efficiency and streamline service delivery.

Automated System Replacements
The division has three information and management systems under various stages of replacement

The AKWIC system which supports WIC will be replaced in FY2010. The division was successful in securing federal funds to support this project, which includes dedicated project staff and a contract to oversee the transfer of a federally approved WIC system. Development of this system transfer will begin in FY2009 with full implementation in FY2010. We expect transition to the new system will not disrupt services to WIC program participants, vendors, and grantees.

Replacement of the division's Fraud case management system and information database is also underway, using funds appropriated in the FY2009 capital budget. The new database will allow better tracking of alleged of fraud, status of investigations, and their outcomes.

The division is also undertaking a comprehensive business needs assessment and feasibility study to evaluate options and the costs for upgrading or replacing the Eligibility Information System (EIS). This is a very large project and we estimate it will take up to two years to complete. Originally implemented in 1984, EIS is the backbone of Public Assistance operations. EIS supports the application tracking, eligibility, budgeting, benefit issuance, and benefit recovery for Food Stamps, Medicaid, Temporary Assistance, Denali KidCare, Child Care Assistance, Senior Benefits, General Assistance, Adult Public Assistance, Interim Assistance, and Work Services. While EIS has been a reliable system for over 20 years, its aging application is costly to maintain and limits our ability to gain efficiencies by using more advanced applications. Significant changes in programs, program requirements, and public assistance business practices have occurred since EIS was developed. The division needs a more user-friendly and adaptable system to gain efficiencies and keep up with increased service demands, reduce system maintenance costs, and that will better support customer service, timeliness, and accuracy of eligibility decisions.

Public Assistance Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Public Assistance is to provide self-sufficiency and basic living expenses to Alaskans in need.

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Status #1: In FY2008, the Alaska Temporary Assistance Program showed a 6% decline in the number of families receiving benefits.

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2008	-7%	-7%	-5%	-6%	-6%
FY 2007	-5%	-11%	-13%	-10%	-9%
FY 2006	-23%	-22%	-19%	-20%	-22%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2002	-16%	6%	4%	3%	-2%

Analysis of results and challenges: Overall, there has been a 61% decline in the caseload since FY1996.

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. As the caseload declines, families with more significant challenges 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.

The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

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% of temporary assistance families leave with earnings and do not return for six months.

Status #1: The FY2008 percent of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 86% compared to 87% in FY2007 and 81% in FY02.

Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2008	86%	86%	87%	84%	86%
2007	88%	88%	86%	85%	87%
2006	87%	87%	80%	84%	85%
2005	88%	85%	80%	82%	84%
2004	90%	85%	79%	80%	84%
2003	85%	87%	82%	82%	84%
2002	83%	83%	76%	81%	81%

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 who are not in the current caseload by the number of cases that closed with earnings six months ago. 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.

A2: Strategy - Increase the percentage of temporary assistance families with earnings.

Target #1: 40% of temporary assistance families with earnings.

Status #1: The percent of Alaska Temporary Assistance families with earnings for FY2008 held steady for the fourth year in a row at 33% despite a declining caseload with a higher percentage of families experiencing significant challenges.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2008	35%	33%	32%	35%	33%
2007	36%	32%	32%	36%	34%
2006	34%	32%	32%	36%	34%
2005	34%	31%	30%	35%	33%
2004	31%	29%	29%	35%	31%
2003	30%	28%	27%	32%	29%
2002	31%	28%	27%	31%	29%

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.

A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50% of temporary assistance families meet federal work participation rates.
Status #1: In FY2008, 65% of Alaska Temporary Assistance families were engaged in work and training activities, 42% of Alaska Temporary Assistance families met the federal participation requirements, exceeding the federal target of 37%.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2008	44%	42%	41%	45%	42%
2007	47%	46%	46%	50%	47%
2006	42%	43%	44%	44%	44%
2005	39%	37%	39%	40%	40%
2004	36%	36%	36%	37%	37%
2003	32%	33%	33%	34%	34%
2002	38%	37%	36%	36%	36%

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.

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.

A4: Strategy - Improve timeliness of benefit delivery.

Target #1: 95% of food stamp expedited service applications are processed within 5 days.
Status #1: In FY2008, 88% of emergency food stamp applications were processed within 5 days.

Percentage of food stamp expedited service households that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	93.1%	90.4%	86.6%	88.4%	88.4%
FY 2007	96.5%	96.2%	96.3%	96.4%	96.4%
FY 2006	95.0%	95.6%	96.0%	95.7%	95.7%
FY 2005	90.9%	92.3%	92.7%	93.5%	93.5%
FY 2004	93.2%	93.8%	94.5%	94.7%	94.7%
FY 2003	94.0%	90.5%	90.8%	92.1%	92.1%
FY 2002	95.4%	94.5%	93.4%	93.4%	93.4%

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.

Target #2: 96% of new food stamp applications are processed within 30 days.
Status #2: In FY2008, 90% of food stamp initial applications were processed within 30 days with an overall average processing time of 18 days.

Percentage of new food stamp applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	94.8%	92.2%	89.6%	90.3%	90.3%
FY 2007	97.2%	97.3%	97.2%	97.1%	97.1%
FY 2006	95.4%	95.9%	96.1%	96.2%	96.2%
FY 2005	95.2%	95.5%	95.7%	95.9%	95.9%
FY 2004	96.2%	96.1%	96.3%	96.5%	96.5%
FY 2003	95.9%	95.1%	95.1%	95.5%	95.5%
FY 2002	93.0%	94.2%	94.3%	94.7%	94.7%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #3: 99.5% of food stamp recertification applications are processed within 30 days.
Status #3: In FY2008, 92% of food stamp recertification applications were processed within 30 days.

Percentage of food stamp recertification applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	94.6%	93.9%	92.6%	92.4%	92.4%
FY 2007	99.7%	99.5%	99.5%	99.1%	99.1%
FY 2006	99.4%	99.5%	99.5%	99.5%	99.5%
FY 2005	99.5%	99.5%	99.5%	99.6%	99.6%
FY 2004	99.6%	99.6%	99.6%	99.6%	99.6%
FY 2003	99.5%	99.5%	99.4%	99.4%	99.4%
FY 2002	99.8%	99.8%	99.7%	99.6%	99.6%

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.

Target #4: 90% of temporary assistance applications are processed within 30 days.
Status #4: In FY2008, 81% of Alaska Temporary Assistance applications were processed within 30 days with an overall average processing time of 21 days.

Percentage of Temporary Assistance applications that meet time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	83%	82%	81%	81%	81%
FY 2007	85%	83%	83%	84%	84%
FY 2006	88%	86%	86%	87%	87%
FY 2005	85%	84%	85%	85%	85%
FY 2004	88%	88%	88%	88%	88%
FY 2003	90%	88%	89%	90%	90%
FY 2002	83%	86%	85%	86%	86%

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.

Target #5: 90% of Medicaid applications are processed within 30 days.
Status #5: In FY2008, 64% of Medicaid applications were processed within 30 days, a decline of 25% since FY06 due to changes in federal program rules that have greatly increased the complexity and processing time of Medicaid applications.

Percentage of Medicaid applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	71%	64%	60%	64%	64%
FY 2007	88%	84%	78%	78%	78%
FY 2006	89%	88%	89%	89%	89%
FY 2005	92%	91%	91%	90%	90%
FY 2004	88%	91%	91%	91%	91%
FY 2003	91%	90%	90%	90%	90%
FY 2002	89%	90%	89%	89%	89%

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 far exceeded the 30-day standard. 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.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.
Status #1: In FFY2007, 96.1% of food stamp benefits were accurate. This exceeded the national average of 94.7% and reflects a steady increase since FFY03.

Percentage of accurate food stamp benefits

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2008	91.1%	93.9%	0	0	0
FFY 2007	95.1%	96.3%	96.3%	96.1%	96.1%
FFY 2006	92.3%	93.5%	94.1%	94.3%	94.3%
FFY 2005	92.2%	93.2%	93.0%	93.8%	93.8%
FFY 2004	90.8%	94.2%	93.5%	93.3%	93.3%
FFY 2003	86.2%	84.7%	85.6%	86.4%	86.4%
FFY 2002	90.4%	92.4%	90.5%	89.2%	89.2%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits causes 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.

Target #2: 95% of temporary assistance benefits are accurate.
Status #2: The FFY2007 Alaska Temporary Assistance benefit accuracy is 99%, a 5-year high.

Percentage of accurate temporary assistance benefits.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2007	99.4%	99.3%	99.1%	98.8%	98.8%
FFY 2006	98.1%	96.3%	97.7%	96.3%	96.3%
FFY 2005	98.5%	95.9%	95.7%	97.1%	97.1%
FFY 2004	96.7%	97.5%	98.2%	98.1%	98.1%
FFY 2003	94.4%	93.6%	94.5%	93.6%	93.6%
FFY 2002	88.2%	93.7%	93.6%	92.0%	92.0%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The Temporary Assistance accuracy reviews for FY2008 were temporarily suspended due to the additional efforts needed to perform both the federally mandated Medicaid payment accuracy rate and Child Care accuracy measurements.

Target #3: 93% of Medicaid eligibility determinations are accurate.
Status #3: In FFY2007, 96% of the Medicaid eligibility determinations were accurate, an increase over the last two years.

Percentage of accurate Medicaid eligibility determinations

Fiscal Year	YTD Total
FFY 2007	96%
FFY 2006	95%
FFY 2005	93%
FFY 2004	99%
FFY 2003	99%
FFY 2002	96%

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% of subsidy children are in licensed care.
Status #1: In FY2008, 73% of children receiving child care assistance were in licensed care, down from 78% in FY2006.

Percentage of subsidy children in licensed care

Fiscal Year	September	December	March	June	YTD Total
FY 2008	73%	72%	73%	70%	73%
FY 2007	74%	74%	76%	74%	75%
FY 2006	80%	84%	75%	72%	78%
FY 2005	74%	81%	77%	80%	77%
FY 2004	75%	76%	76%	76%	76%
FY 2003	65%	66%	68%	75%	75%
FY 2002	0	60%	58%	64%	64%

Analysis of results and challenges: The first available data regarding this measure is the second quarter in 2002. There is a two month lag in the data.

The 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 not keeping up with the rates that child care providers charge. As state rates decline in relation to the market rate, low income families on child care assistance are faced with an increased financial burden to pay the difference between the state rate and the child care provider's rate (in addition to their required co-

payment) or to 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. State rates for licensed child care providers who accept children on child care assistance were increased effective September 2008 as an initial step to bridge that gap.

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Public Health

Mission

To protect and promote the health of Alaskans.

Introduction

The Division of Public Health (DPH) is the state's lead public health agency. Its work is best described by the "3Ps" – Prevention, Promotion and Protection – because DPH is responsible for operating programs that prevent infections, injuries and chronic diseases; promote healthy living and quality health care; and protect all Alaskans. The division plays a significant role in making sure that Alaska is ready to effectively respond to emergencies, including natural disasters, emerging disease threats, and bioterrorism.

The division's core functions are far-reaching, and focus on a myriad of 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.

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 for many of our partners: local public health agencies, community- and tribal-based organizations, educational institutions and non-profit agencies. Together, we focus on the core services that protect the public's health and advance the health status of individuals and communities. When we do our jobs well together – preventing illness and injury, promoting good health and protecting everyone – Alaska is a better place for all people to live, work and play.

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 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, division employees conduct disease surveillance, and outbreak investigation, and provide treatment consultation, case management and laboratory testing services to control communicable diseases and prevent epidemics. Trained professionals work diligently to

protect health care consumers through facility inspections and complaint investigations of nursing and assisted living facilities. They also protect Alaskans by ensuring that employees who will come in contact with vulnerable populations are first able to clear background checks.

Professional staff 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

The division 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 Epidemiology, Nursing, and Laboratories sections 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 provide medical consultation to health care providers and information to the public on prevention and control of infectious disease. For over 30 years the Alaska Immunization Program has maintained a universal vaccine program, distributing all recommended pediatric and selected adult vaccines at no cost to Alaska health care providers. However, Federal

funding, which has made this service possible, has not kept pace with rapidly rising vaccine costs. Beginning in January 2009 the division will limit availability of selected free vaccines for use only with those children who are eligible for the Vaccines for Children Program, a federally funded entitlement program that covers the cost of vaccines for children through age 18 years who meet certain federal criteria. Prevention and treatment therapies are provided for specific infectious diseases such as tuberculosis and HIV/AIDS. Public health nurses serving as the front line workforce 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

Injury Prevention and Emergency Medical Services section 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 poisoning 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 in communities throughout Alaska to educate residents about injury prevention, screen for domestic violence and provide needed care and referral for identified victims of abuse. 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 Section of Chronic Disease Prevention and Health Promotion focuses on the prevention and control of diabetes, cancer, heart disease and stroke, arthritis, obesity, and tobacco use. In addition to improving the quality of life for persons with these conditions, 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 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.

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 screenings to women who do not have financial access to these services.

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. 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 department's Chief Medical Officer; in FY2010 the program is being established in its own budget component within Public Health. 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 Women, Children and Family Health (WCFH) section contributes to the delivery of population-based services and the building of the 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 Injury Prevention and Emergency Medical Services section works to ensure the availability and quality of the emergency medical services (EMS) in Alaska by: certifying emergency medical technicians (EMTs), EMS instructors, emergency medical dispatchers, and ground and air ambulance services; reviewing and approving emergency trauma technician, EMT, and mobile intensive care paramedic courses; providing training and technical assistance to local EMS agencies; and administering state and federal grants that provide operational and capital equipment support for EMS systems across the state.

The Certification & Licensing section 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.

Protecting Human Health from Environmental Hazards

While the Department of Environmental Conservation (DEC) and 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 division public health nurses at the local level, while 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. Also, in partnership with the Alaska Department of Natural Resources, the division has begun development of procedures to assess the health impacts of proposed large-scale natural resource development projects.

Effective and Efficient Programs and Services

The division 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.

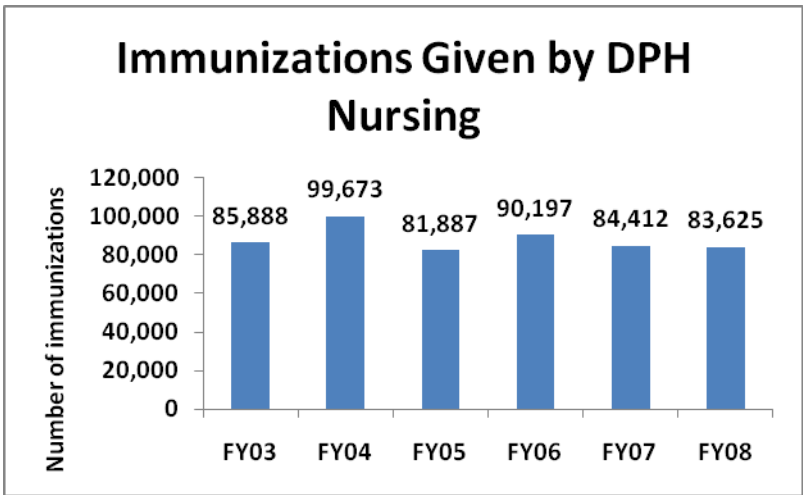
A DPH cross-cutting program that supports all core public health services described above is administered by the Bureau of Vital Statistics (BVS). BVS is responsible for the registration, certification, security, and protection of permanent records of vital events (births, deaths, marriage, divorce, 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 cross-cutting program that supports all core public health services is administered by the State Medical Examiner's Office (SMEO). As a key element of the public health mission to prevent injury, disease and death, the SMEO 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.

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 results from FY08 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.

<u>In FY08, public health nurses statewide*:</u>

- Provided 110,234 health care visits to 66,220 individual patients.
- Provided 61,092 health care visits to 35,101 children and youth (newborn to 19 years).
- Administered 114 newborn hearing screenings.
- Administered 83,625 doses of vaccine.
- Gave and read 17,066 tests for tuberculosis (TB).
- Initiated TB medication therapy for 176 individuals.
- Provided 1,561 Pap Smears for detection of cervical cancer in Alaskan women.
- Provided 12,065 visits for family planning to 5,248 individuals.
- Provided 2,391 prenatal visits to 1,234 individuals and 2,070 postpartum visits to 1,314 childbearing women & families.
- Provided 9,965 visits to 5,182 patients for sexually transmitted diseases.
- Provided 5,572 visits for HIV/AIDS services including blood testing for 3,183 patients.

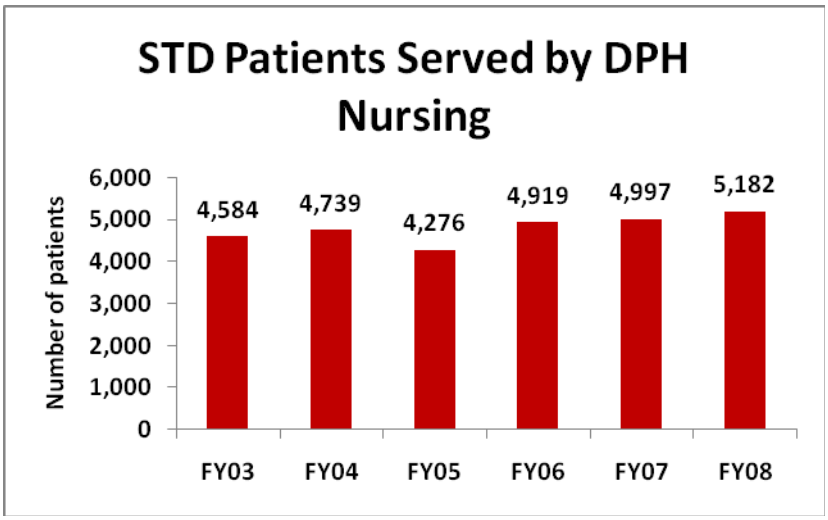
- Screened 15,242 individuals for interpersonal/domestic violence with 468 positive/suspect results.

**All service data is from Resources Patient Management System (RPMS) FY2008 Reports, 9/12/08. 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.*

<u>The Nursing component in FY2008 also:</u>

- Increased implementation of routine, universal screening for domestic/family violence during health encounters at state public health centers. Public health nurses are identifying and providing education, support and referral services to increasing numbers of domestic and family violence victims, as well as improving public awareness and education on this important public health issue.
- Continued public health preparedness and response training, planning and exercise activities at both the state and local level:
  - More than 80% of component employees have participated in community preparedness exercises.
  - An online data collection tool was developed to facilitate documentation of vulnerable/special needs populations in each community and to identify community mass care sites (including function, location, capacity, and resources).
  - Twelve mass dispensing exercises were conducted (Valdez, Delta Junction, Kodiak, Nome, Kivalina, Anchorage, Bethel, Fairbanks, Pelican, Sand Point, and Juneau)
  - More than 350 nurses enrolled as volunteers in Alaska Nurse Alert System.

- Increased public health nursing population-based activities such as mobilizing community partnerships, health teaching, consultation, community assessment, advocacy, social marketing and policy development. Results documented in the Nursing Information Processing System (NIPS) show approximately 6,500 work hours focused on community and population-based public health nursing activities in FY2008. These activities are broken down by program area: 29% community health improvement; 24% public health preparedness; 19% infectious disease; 12% child health; and 7% family health; and by activity areas including:47% mobilizing partnerships, 31% health teaching, and 10% community assessment.

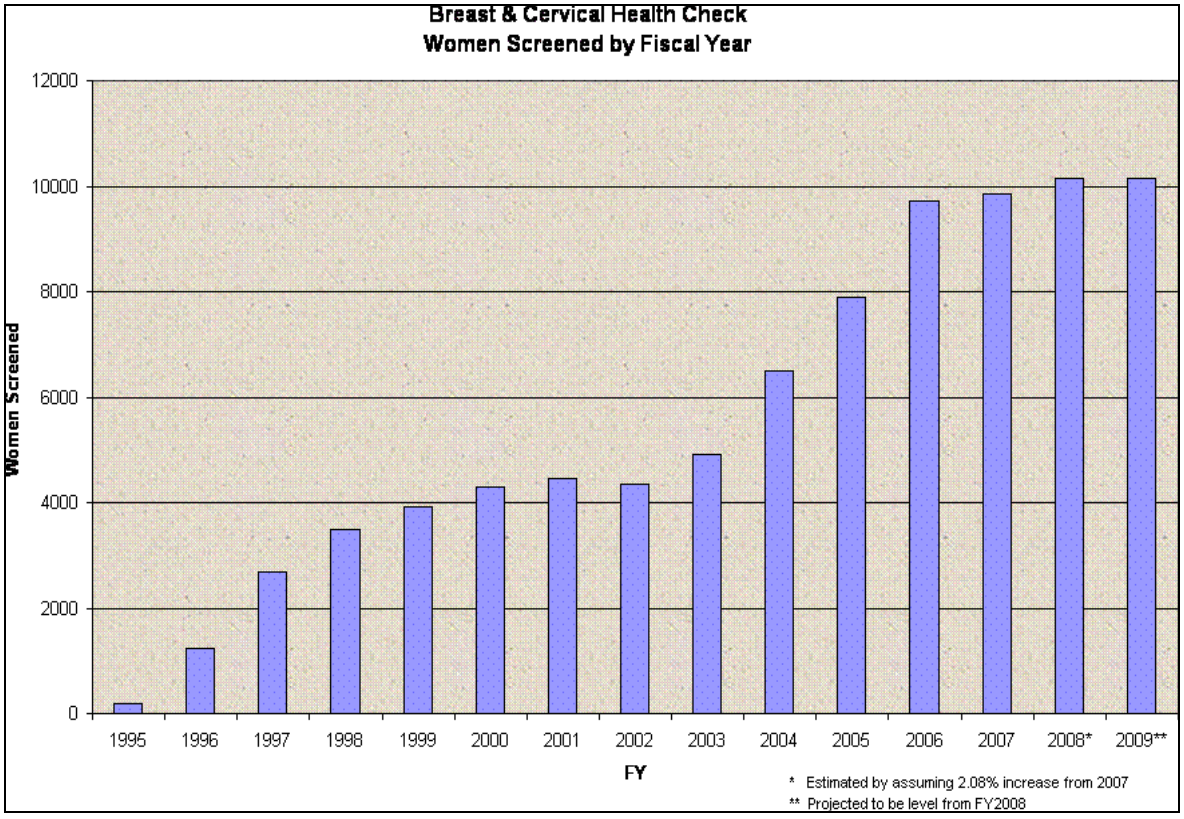


- Initiated a new program to develop and implement statewide record audit tools, satisfaction surveys, and continuous quality improvement processes and procedures. Audit tools have been developed and initiated for sexually transmitted disease and family planning services.

Women, Children and Family Health (WCFH)

The section's mission is to promote optimum health outcomes for all Alaska women, children and their families. This is accomplished by providing leadership and coordination with primary and specialty health care providers and public entities within the state's health care system to develop infrastructure and access to health services; and to deliver preventative, rehabilitative and educational services targeting women, children and families.

Services and programs delivered statewide include Breast and Cervical Health Check; Family Planning; Perinatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening; Early Hearing Detection, Treatment and Intervention program; Pediatric Specialty Clinics; and Genetics and Metabolic clinics. In addition, the Maternal & Child Health Epidemiology Unit collects, analyzes and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaska women, children and their families.



Examples of services supported or coordinated by the Section of Women, Children and Family Health in FY2008 include:

- The Breast and Cervical Health Check Program continued its lifesaving work. Since its inception, the program has provided nearly 77,000 cancer screenings to nearly 36,000 women who are medically underserved. Of those women, 232 cases of breast cancer, more than 30

cases of cervical cancer and nearly 1,900 potentially pre-cancerous conditions have been identified.

- As part of the All Alaska Pediatric Partnership, WCFH participated in the Pediatric Disaster Planning effort that included all four hospitals in Anchorage, Mat-Su Regional, Fairbanks Memorial and Central Peninsula Hospital. Ongoing work continued, including the offering of a two-day maternal-child community disaster planning conference in December 2008.
- Through partnership with the Division of Public Assistance, statewide efforts continued 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 airing of television and radio PSAs, and conducting several training events aimed at helping clinicians and other professionals working with youth to develop counseling and education skills.
- In collaboration with the Alaska Mental Health Trust Authority, the department implemented an Adult Medicaid Dental Program. In addition, a water fluoridation program was developed as was a dental sealant program targeting high-risk school age children.
- Of all newborns, 99.9 percent were screened for metabolic conditions and over 92 percent of all newborns were screened for newborn hearing loss.

Certification and Licensing

The mission of the Section of Certification and Licensing is to protect the life, health and safety of vulnerable populations. Consolidation of certification and licensing functions into the Division of Public Health began in 2003. 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. In FY10 the Health Facilities Licensing and Certification unit of Certification and Licensing, will be moving to Health Care Services and will be known as Health Facilities Survey.

Examples of services provided in FY2008:

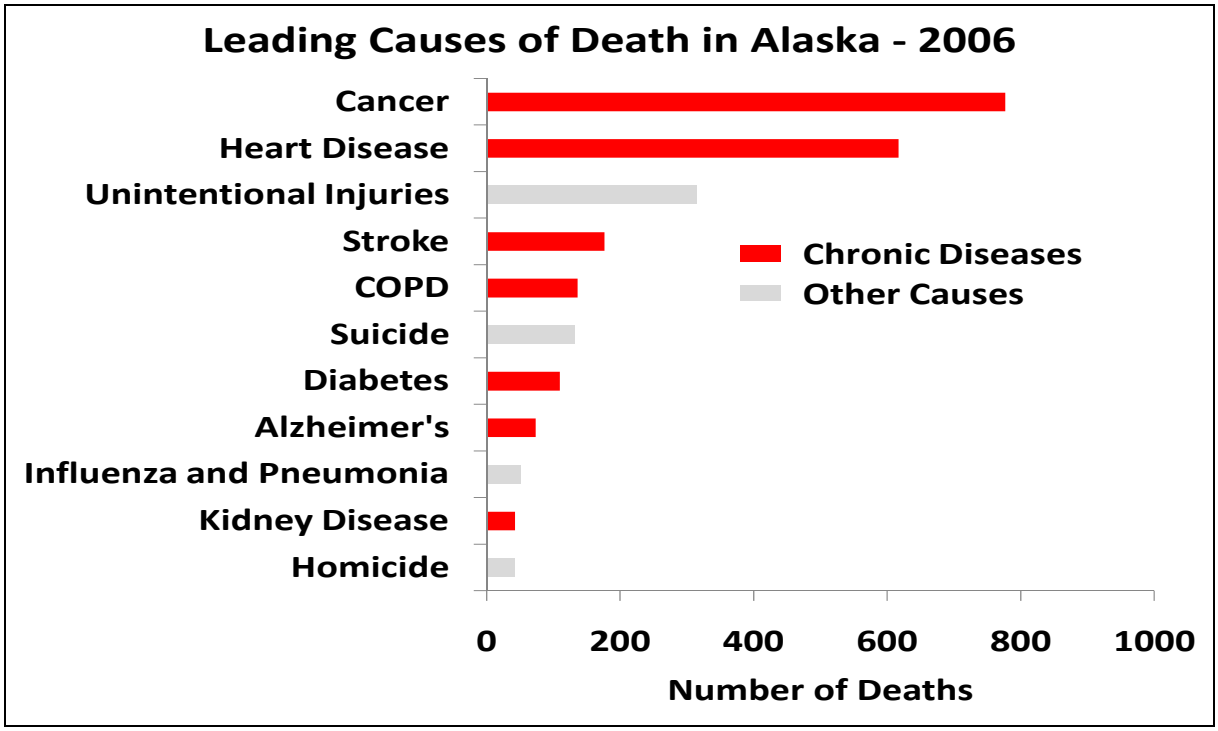
- The Background Check program processed more than 37,000 applications since implementation in March 2006 – and had protected vulnerable Alaskans by disqualifying over 900 individuals from becoming service providers because of barring criminal conditions. In FY2008 alone, approximately 400 people were disqualified from working with vulnerable Alaskans.
- Maintained licensure and inspection for over 750 residential child, assisted living and health care facilities.
- Investigated complaints and took enforcement actions when necessary for more than 530 complaints.
- Staffing for the Background Check program has increased to handle current workload and the anticipated increase of 2,600 additional applications with the transitioning of child care and foster care into the process.
- The Background Check program has continued partnering with local, state, and federal agencies to collaboratively participate in information sharing and development
- Partnerships continue between the Assisted Living Home Program and the Anchorage Municipal Fire Department in an effort to share agency information and also to develop and sustain reasonable and applicable safety standards for both small assisted living homes and large facilities.

- Section partnership with direct care providers and entities grew to over 860 entities currently using the Background Check program under the oversight of the Divisions of Public Health, Senior and Disabilities Services and Behavioral Health.

Chronic Disease Prevention and Health Promotion

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 2007 data still not available

Examples of services provided by Chronic Disease Prevention and Health Promotion programs in FY2008 include:

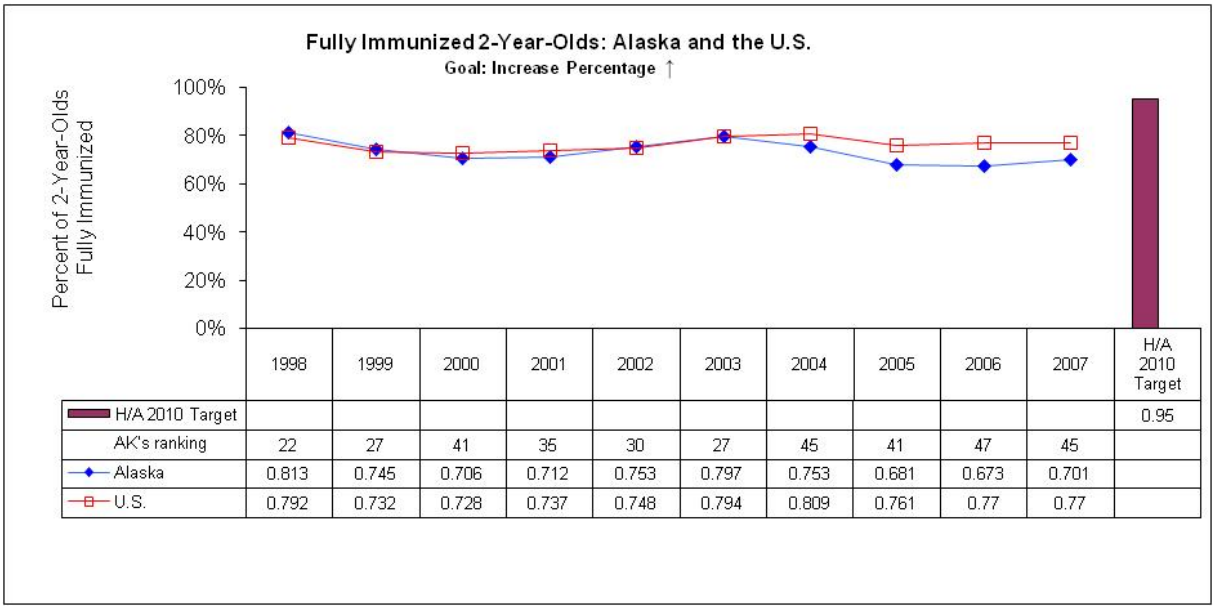
- Documented the success of efforts to reduce cigarette smoking among adults in Alaska. Based on 2007 Behavioral Risk Factor Surveillance System (BRFSS) data, the percentage of adult smokers declined by one-fifth since 1996 to 21.5 percent. This represents more than 27,000 fewer smokers, and is expected to result in almost 8,000 fewer tobacco-related deaths and $300 million in averted medical costs.
- In collaboration with Department of Education and Early Development (DEED), trained over 130 childcare providers to improve physical activity and nutrition for preschool children and families in Juneau, Anchorage, Fairbanks, Nome, Mat-Su, and Homer.
- Offered School Wellness Institute training to more than 90 teachers, principals, school nurses, other school staff, community members representing 28 different school districts and Mt.

Edgecumbe to improve student health, physical education, and nutrition and decrease tobacco use.

- Developed a website and provided regular communication for division employees to promote healthy living.
- Taught chronic disease self-management skills to over 300 Alaskans with chronic disease in 30 communities since April 2006.
- Supported training for parish nurses (registered nurses who serves as a member of the ministry staff of a faith community to promote health and wholeness of the community.) in comprehensive foot assessment and care, and basic diabetes knowledge and standards of care. Forty-six parish nurses attended at least one training session then championed two campaigns: a physical activity promotion that involved 19 churches and in which participants traveled 90,000 miles; a "Know Your Numbers" effort reached more than 1,200 people.
- Partnered with Alaska Native Tribal Health Consortium to develop and produce public service announcements on screening for colorectal cancer titled "Love Your Colon". Colorectal cancer incidence rates in Alaska Natives is double rates in Alaska whites and is the highest ranked cancer by number of cases for Alaska Natives (Alaska Cancer Registry, 1996-2004).

Epidemiology

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 detect, investigate and control 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 persons exposed to tuberculosis, HIV, sexually transmitted diseases, and other infectious diseases; and risk assessment of environmental health threats to Alaskans.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	H/A 2010 Target
H/A 2010 Target											0.95
AK's ranking	22	27	41	35	30	27	45	41	47	45	
Alaska	0.813	0.745	0.706	0.712	0.753	0.797	0.753	0.681	0.673	0.701	
U.S.	0.792	0.732	0.728	0.737	0.748	0.794	0.809	0.761	0.77	0.77	

Data Source: Alaska – Morbidity Database; U.S. – National Notifiable Diseases Surveillance System; H/A = Healthy Alaskans 2010

Examples of services provided by Epidemiology in FY2008 include:

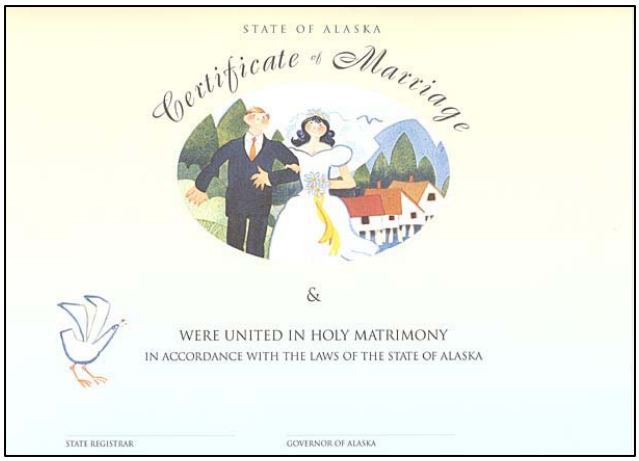
- Investigated an outbreak of *Campylobacter jejuni* infection in collaboration with the Alaska Department of Environmental Conservation (DEC). More than 60 individuals with laboratory-confirmed illness were identified and several required hospitalization. This investigation established a firm linkage between *C. jejuni* infection and consumption of peas grown in Palmer. Based on the molecular analysis of *C. jejuni* isolates from clinical and environmental samples, the source of contamination of the peas appears to be Sandhill Crane feces. Disease notification, treatment, and prevention strategies were communicated to residents and health care providers throughout Alaska via health alert messaging, an Epi Bulletin, and the media.
- Investigated an outbreak of adenovirus 14 that sickened more than 40 people in communities on Prince of Wales Island. Disease notification and prevention strategies were communicated to Prince of Wales Island residents and health care providers throughout Alaska via health alert messaging and the media.
- In partnership with the Alaska Department of Natural Resources, began development of procedures to assess the health impacts of proposed large-scale natural resource development projects. Participated on an interagency workgroup to develop a health impact assessment for the Red Dog mine expansion, excerpts of which will appear in the Supplemental Environmental Impact Statement for the project.
- Implemented *VacTrAK*, a secure Internet-based Immunization Information System (IIS), and a companion Disease Surveillance Management System.
- Published 28 Epidemiology *Bulletins* to inform health care providers and the public of important investigations, concerns, or alerts regarding health issues.
- Responded to 194 after-hours calls through the 24/7 emergency phone number; all were responded to within 10 minutes.
- Published a revision of the booklet, "Conditions Reportable to Public Health." This revision added 14 new conditions that are reportable by health care providers and 16 new pathogens reportable by laboratories. The new booklet includes a laminated insert that lists all reportable conditions, and pathogens and key contact information.
- In partnership with the Municipality of Anchorage, continued work to control an ongoing outbreak of tuberculosis (TB) in the homeless population. This outbreak began in December of 2005 and 39 cases had been identified as of the fall of 2008. The TB program has collaborated with the municipality to provide regular screening events at facilities that support the homeless and provided housing for homeless persons with TB during the course of treatment.
- Established new immunization requirements for protection against varicella (chickenpox) and pertussis (whooping cough) for students enrolled in Alaska schools
- Conducted 85 HIV interviews, identifying 188 contacts plus 92 additional high-risk individuals meriting follow-up. Of those individuals who were identified for testing, 184 of them were located, 153 tested negative and 8 tested newly positive for HIV infection. In addition, follow-up services were provided to 15 individuals living with HIV for referral to medical care or other necessary services.
- Conducted disease investigation and intervention activities. HIV/STD program staff continued to address an extended syphilis outbreak in Southcentral and Interior Alaska. From January 1, 2007 to June 30, 2008, 3,535 individuals with syphilis, gonorrhea, or chlamydia were documented to have been interviewed, identifying 5,520 partners, approximately 72% of whom were located and received appropriate intervention services.
- In partnership with the Vaccinate Alaska Coalition, sponsored the annual "I Did It by TWO!"

childhood immunization campaign, integrating the important message of childhood immunizations with the Iditarod Trail Sled Dog Race. The dog mushers' racing bibs carried the message "Race to Vaccinate". Several mushers were enlisted to speak throughout the year on the importance of immunizations.

- Assisted Head Start providers and Alaska's medical community to provide blood lead screening services for children enrolled in Head Start programs in several communities.

Bureau of Vital Statistics

The Bureau of Vital Statistics (BVS) oversees the registration of vital events (such as births, deaths, and marriages) in Alaska and is responsible for the preservation and security of its 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 continued adding to the number of public health statistics reports that are published on the BVS website. 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**.

In FY2008, BVS processed 69,388 requests for vital records and recorded these events in Alaska:

- Births: 11,281
- Deaths: 3,563
- Marriages: 5,937
- Divorces: 2,736
- Adoptions of Alaska-born children processed: 675
- Establishments of paternity of Alaska-born children processed: 3,889
- Marriage licenses issued: 4,467
- Funds for the Alaska Children's Trust from heirloom birth and marriage certificates: $31,485
- Applications for the Medical Marijuana Registry processed: 148

With funds approved in the FY2009 capital budget, the Bureau has begun the steps to acquire a new information system, replacing an existing system that is more than 20 years old. It will take at least two years to design, test, and fully implement the new birth and death registration system.

The Bureau has experienced difficulties recruiting and retaining staff to work in the Juneau front office. Chronic turnover of staff, the high vacancy factor and the time spent repeatedly recruiting and training new staff has affected the bureau's ability to respond timely to vital record requests. This has resulted in the Bureau changing its standard processing time from two to four weeks. The division is working to identify options to help with staff retention; however any identified solutions will take time to implement.

Injury Prevention and Emergency Medical Services

Injury Prevention & 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.

Examples of services provided in FY2008 include:

- Fielded more than 10,000 calls to the Alaska Poison Control System and gave critical advice to Alaskans and their health providers.
- Established 48 new Kids Don't Float life-jacket loaner sites, bringing the total to 514 active sites statewide.
- Distributed 1,896 new smoke alarms to 13 communities in Alaska.
- With legislative support, received significant funding for essential EMS equipment and vehicles under the Alaska Code Blue project – 35 rural communities received new equipment.
- Processed 2,684 applications for EMT certification in Alaska.

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 prevention of hazardous health problems in the state.

The Medical Examiner's Office has experienced challenges securing and maintaining forensic pathologists. A very limited talent pool – less than 400 certified forensic pathologists nationwide – and a salary schedule that is significantly lower than the marketplace have made recruitment efforts difficult. The office currently employs one full-time staff pathologist and has utilized contract

pathologists to meet critical needs. National recruitment is ongoing for both a Chief and Deputy Chief Medical Examiner. The division has reorganized the staff of the Medical Examiner's Office to create a more efficient management structure that will increase program consistency and improve the chain of command for office operations.

Examples of services provided in FY2008 by the Medical Examiner's Office include:

- Total cases reported: 1,525
- Cases autopsied: 238
- Cases with consult: 974
- Cases with inspection: 27

Other accomplishments:

- Successfully 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). This included hiring one additional investigator and autopsy assistant to bring staff numbers more in tune with the population numbers for case processing.
- The Child Fatality Review Committee continued the review of child death cases. This is a collaborative effort between SMEO, District Attorney's Office, State Troopers, Anchorage Police Department social workers from Child Protective Services (CPS), physicians who specialize in pediatrics and forensic nurses. The Chief Medical Examiner is the chairman of this committee.

Public Health Laboratories

The 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 test for viral infections. 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 FY2008 include:

- The laboratory received and processed 123,450 clinical test requests, compared to 123,284 for FY07.
- STD tests: 61,762
- Hepatitis tests: 30,079
- Tuberculosis tests: 10,119
- Toxicology tests: 697
- Viral serology tests: 10,379 (up 22% from FY07 due to many tests for influenza and other respiratory viruses)

Preparedness Program

The Preparedness and Response Program focuses on coordination and management of public health and emergency medical disaster preparedness activities such as planning, training, exercises and resource development. Preparedness Program staff also comprises the core element of the DHSS disaster response team. This program provides expertise and funding for public health and emergency

medical disaster preparedness to the Municipality of Anchorage, Alaska Native Tribal Health Consortium, all Alaska hospitals, nursing homes and primary care clinics.

Examples of services provided in FY2008 include:

- The Program opened its emergency operation center in February 2008 to respond to children suffering from Respiratory Syncytial Virus (RSV) in the Yukon-Kuskokwim Delta area. Ultimately, 17 children were medevaced from Bethel for treatment, and dozens more were treated locally. There were no deaths and no children had to be transported out of state for treatment.
- Mass dispensing clinic exercises *(photo at right)* were held in Valdez, Fairbanks, Delta Junction, Pelican, Kodiak, Nome, Bethel and Juneau. These exercises, where thousands of people responded to simulated or actual dispensing of vaccines, were developed to test Alaska's capability to distribute mass prophylaxis and to organize citizen preparedness and participation.

- All 22 acute-care hospitals in the state have received an antiviral stockpile. There are currently approximately 88,000 courses of antivirals in the state.
- Seventy ventilators were purchased and distributed to hospitals statewide and in regional stockpiles. The Preparedness Program also arranged for approximately 300 paramedics, nurses, physicians, public health nurses, respiratory therapists and air ambulance crews to be trained in using the new ventilators. In addition, three highly specialized pediatric ventilators were purchased, along with pediatric "Go-Kits" that can be transported anywhere in the state.
- The 6th edition of the pan flu plan was published: **www.pandemicflu.alaska.gov**.

List of Public Health 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 Persons
AS 47.08	Assistance for Catastrophic Illness & Chronic or Acute Medical Conditions
AS 47.17	Child Protection
AS 47.20	Services for Developmentally Delayed or Disabled Children
AS 47.24	Protection for Vulnerable Adults
AS 47.25	Public Records
AS 47.30.660	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

Public Health	FY2009	FY2010	09 to 10 Change
General Funds	32,846.4	35,558.7	2,712.3
Federal Funds	39,262.1	36,042.0	-3,220.1
Other Funds	25,863.8	26,827.4	963.6
Total	97,972.3	98,428.1	455.8

Women, Children and Family Health

Expanded Autism Diagnostic Clinic: *$125.0 GF/MH*
Expanded Autism Diagnostic Clinic will provide comprehensive, active referral for Autism Spectrum Disorders and multidisciplinary diagnostic services. A multidisciplinary team approach assures that children receive an accurate, differential diagnosis that includes the assessment by professionals in the following disciplines: medical, psychological, speech/language, occupational therapy, physical therapy, audiology, and ophthalmology. Children who show signs of having an Autistic Spectrum Disorder (ASD) or who have risk factors on a screening require a comprehensive assessment across developmental and physical domains.

Autism Capacity Building: *$250.0 Total- $125.0 GF/MH, $125.0 MHTAAR*
Approximately 60 Alaskan babies are born each year with Autism Spectrum Disorder (ASD). Delays in diagnosis and intervention result in large medical and special-needs educational costs, and lost productivity. The Legislature agreed to improve autism screening and referral capacity in FY2009. This FY2010 request keeps current funding stable and shifts $125.0 from MHTAAR to GF/MH. This funding will maintain capacity to provide diagnosis and comprehensive, active referral for ASD. A multidisciplinary team approach assures that children receive an accurate diagnosis from a team of specialists (medical, psychology, speech/language, occupational therapy, physical therapy, audiology and ophthalmology) and rules out other possible medical conditions associated with ASD.

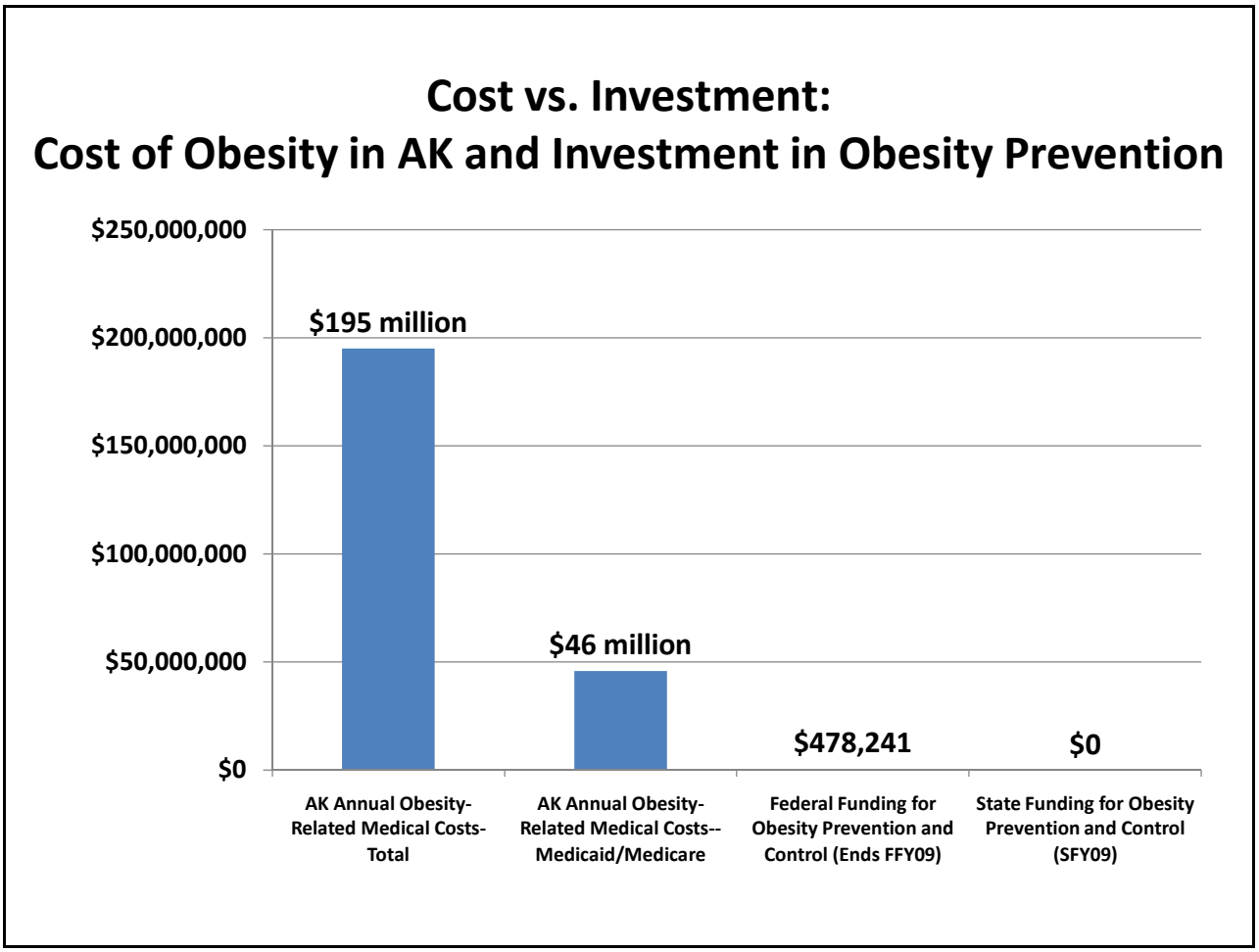
Birth Defects Registry: *$280.3 GF*
The Alaska Birth Defects Registry (ABDR) is a statewide program that collects, analyzes and produces information about the prevalence of congenital anomalies in Alaska. Hospitals, physicians and other health facilities are required by state law to report to ABDR when they have provided services to a child with one of the identified conditions. Accurate information on birth defects in Alaska, including fetal alcohol spectrum disorders, is used to target prevention messages; interventions and health services; define populations at increased risk for birth defects; and identify clusters of conditions that may be related to environmental exposures. This request would fund existing staff with GF to maintain the registry. To date, no state funding has ever been provided to support this basic public health function. Maternal Child Health Block Grant funding can no longer adequately support this registry, which in Alaska has established rates of major congenital anomalies twice that reported nationally. Such findings and other vital information on the status of Alaska's children would not be available without the ABDR.

Chronic Disease Prevention and Health Promotion

Reversing Alaska's Childhood Obesity Trend: **$**923.1 GF

Obesity is a threat to all generations of Alaskans, especially our kids: Health experts predict that, due to obesity, this generation of children will be the first to live shorter lives than their parents. Obesity increases the risks of chronic diseases and conditions such as heart disease, diabetes, stroke, some cancers and premature death. In Alaska, two-thirds of Alaskan adults are considered overweight or obese. One-third of children entering kindergarten in Alaska's largest school district are overweight or obese. Nearly 10,000 Alaska children ages 10 to 17 are considered obese. Reducing childhood and adult obesity will lead to productive lives and it will save money. Currently, Medicaid and Medicare spend $46 million in Alaska annually on obesity-related medical care. One example: In FY2007 Alaska Medicaid paid $379,000 for one client with end-stage renal disease caused by diabetes. That's an extreme example; however, the lifetime cost of any healthcare for people with diabetes is more than double that for people without diabetes. The Partnership for Prevention says obesity even undermines our national security. Military recruits are increasingly overweight and unfit to serve; at least 13% of men and 17% of women age 17-20 years would fail the weight requirements of all four military services, and obesity is the leading cause for medical disqualification for youth applying to the military. Alaska has no comprehensive approach in place to address this epidemic; the state Obesity Prevention and Control Program receives no state GF; a federal earmark for FFY2008 allows the state to run a barebones program – but this funding will end in fall 2009. The Division of Public Health is proposing a long-term comprehensive initiative, based on the successful Tobacco Prevention and Control model, to slow and eventually reverse the growth of childhood obesity rates in Alaska.

In 1 year: Groundwork begins for more community coalitions to address obesity, nutrition and physical activity; obesity media campaign messages tested and on the air; at least 200 school nurses and educators trained; pilot school collects height and weight to establish baseline obesity prevalence. In 5-7 years: At least a dozen obesity coalition grantees have adopted community or school-based policies to promote physical activity and nutrition; media campaign has increased awareness and intentions to adopt healthier lifestyles; trained school nurses and educators support families and community in adopting healthier lifestyles; additional schools collect BMI data, local data catalyzes policy change. In 10 years: Among youth in grantee communities physical activity has increased; more kids are eating healthier foods; childhood obesity rate plateaus and begins to decline.



If we do nothing: Between 2003 and 2007, the percent of children above a normal weight increased by 7.5%. Since 1991, adult obesity rates have risen by approximately 1 percent each year. Without a comprehensive, long-term approach to this problem, Alaska can expect to see an ever-increasing number of Alaskans suffer poor quality of life, disability, chronic illness, and even premature death as a result of obesity-related illnesses. The resulting economic costs in terms of direct medical care and lost productivity are staggering.

Tobacco Prevention and Control Program: *$90.0 Tobacco*
The number one cause of death in Alaska is cancer; tobacco use is the top preventable contributor to cancer. Ninety percent of lung cancer is tobacco related. Many other health conditions are related to tobacco use. Each year, tobacco use and exposure to secondhand smoke cuts short the lives of over 600 Alaskans and costs the State nearly $384 million in direct medical costs and lost productivity due to tobacco related deaths. The tobacco industry spends an annual estimated $28 million in Alaska to promote tobacco use.

The requested $90.0 for program support will boost personal services and travel funding, but result in no new positions. Growth in the TPC program staff necessitates additional administrative assistance. Funds are necessary to change funding sources from GF to Tobacco Funds for one existing Admin Clerk II position so that the TPC program pays for 100% of the position (it currently pays for 25% of the FTE). Travel funds will be used to support participation by statewide partners, stakeholders, and collaborators, including a required minimum of one site visit at least every other year per grantee.

Cancer Registry: *$179.7 GF*

Cancer is the leading cause of death in Alaska; it is in the public health interest of the State to ensure that the Alaska Cancer Registry (ACR) is adequately funded so it can continue to collect data on the ongoing burden and status of this devastating disease. It is this knowledge that will lead to interventions and treatments that will ultimately save lives. State law requires health care providers to report cancer under 7 AAC 27.011. This increment is for $179.7 to retain current staffing levels for the ACR. No new positions are requested. Centers for Disease Control (CDC) funding for the registry has remained flat for many years while costs have risen. CDC requires that the State match $1 for every $3 of federal funds. One administrative position to support the program already has been eliminated; without this request additional reductions will be necessary – and the quality of data will suffer. This in turn will jeopardize further CDC funding, because the state's overall Cancer Program will not meet established reporting standards.

Governor's Health Initiative – Live Well Alaska: *$498.4 GF*

Alaskans wishing to improve their health can benefit greatly from the availability of timely and relevant health information. To encourage people to heed the Governor's call for personal responsibility in the areas of health and wellness, DHSS began work in the fall of 2007 on the development of a healthy living initiative. This work has reached a critical juncture that requires funding if progress is to continue. This request is for $498.4 to build a comprehensive, interactive Website that will encourage and inspire Alaskans to make healthy choices about nutrition, physical activity, tobacco use and other topics. This increment will create 2 new FTEs (Health Program Manager II, Range 19; Project Coordinator, Range 18) and fund portions of 4 other existing positions which would devote part of their expertise to this important project. This increment also would fund necessary research to develop effective health promotion messages in Alaska and pay for a comprehensive communications effort. A comprehensive, interactive, well-advertised "Live Well" Website is not the sole answer to a complex problem. However, this approach can work, and there is strong evidence: Alaska recently finished #1 in the nation in the President's Fitness Challenge – nearly 3,000 Alaskans went to a website and signed up to exercise at least 5 times a week. This request is modest when compared to the nearly $700 million the state spends annually on Medicaid payments for Alaskans with chronic health conditions.

Community Health Grants

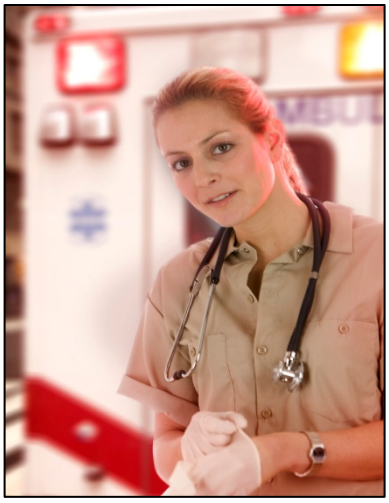
Assuring access to Early Prevention Services and Quality Health care- CHAT Program Funding: *$173.1 GF*

A 10% increase is being requested to assure access to early preventive services and quality health care through the Community Health Aide Training and Supervision Grants (CHATS) program. In FY2009, CHATS grants totaling $1,730.8 were authorized for 16 tribal health organizations. The program provides funds to support the training and supervision of primary community health aides who deliver health care services in rural communities throughout Alaska. Standards for the CHATS program include training, certification, supervision, and instruction requirements for community health aides/practitioners. The purpose of the CHATS grant program is to improve the ability of local and regional health organizations to extend and improve training and supervision of community health aides/practitioners. Grants are for basic, advanced, and continuing education of community

health aides and community health practitioners. The funding level for the CHATS Program is based on a formula established during the 1985 legislative session set out in AS 18.28.020.

Emergency Medical Services Grants

Grant Increase to Support EMS Programs: *$267.4 GF*



The State of Alaska manages emergency medical services technical and training support through grants to the EMS regions above. Rising fuel and health insurance costs directly impact emergency access to health care for the most vulnerable and rural populations served by mostly volunteer services. Yet none of the regions have had increases in their grants since 2006, when they received their first increase after 15 years of flat funding. Administrative costs have risen dramatically and unexpectedly the last two years due primarily to fuel and health insurance, resulting in an increase in overhead, travel, and general operating costs. These additional operating costs are significantly reducing critical services, such as training, recruitment, retention, and technical assistance to EMS services throughout the state. This request would provide for a 10% increase for all grantees.

Public Health Laboratories

Full Operation and Staffing of New Virology Lab: *$256.0 GF*

The new Fairbanks virology lab will open on the University of Alaska Fairbanks campus in January 2009. It's the only lab of its kind in Alaska; it tests for new diseases such as avian flu, SARS, West Nile and re-emerging diseases such as measles and rabies. Additionally, the State of Alaska will be able to respond to emergencies involving exotic diseases such as smallpox and novel influenza in a timely and efficient manner. The virology lab is such an important asset to the State that UAF has contributed over $1.5 million to this project. UAF researchers will have access to both a Biological Safety Level 3 (BSL3) and an Animal BSL3 laboratory for research purposes. UAF will also contribute an estimated additional $400,000 for yearly operational costs. DPH received an increment to heat and light the lab as construction continued in the first half of FY2009. Most of this FY2010 request – $196.0 – adds to current funding and will cover the first full year of operations – heat, lights and other utilities. This request also includes funds for establishing a unique shared position with the UAF Arctic Health Program – a Medical Virologist, a highly trained specialist who plays a vital role in the diagnosis, treatment and study of infectious diseases caused by viruses such as HIV, hepatitis and influenza. DPH's Section of Laboratories will contribute salary and benefits, through an RSA to UAF, $60.0, which represents 50% of the incumbent's compensation. UAF will contribute the remaining 50%.

Tobacco Prevention and Control

Tobacco and Prevention and Control—Grants and Technical Assistance: *$555.0 Tobacco*

The number one cause of death in Alaska is cancer; tobacco use is the top preventable contributor to cancer. Ninety percent of lung cancer is tobacco related. Many other health conditions are related to tobacco use. Each year, tobacco use and exposure to secondhand smoke cuts short the lives of over 600 Alaskans and costs the State nearly $384 million in direct medical costs and lost productivity due to tobacco related deaths. The tobacco industry spends an annual estimated $28 million in Alaska to promote tobacco use. The 555.0 request will fund strategies to help Alaskan communities reduce tobacco use. The funding will pay for $328.0 to enhance successful, evidence-based community and school grants and $227.0 in technical assistance to provide better, more targeted expertise at the local level – including developing and distributing locally-targeted communications materials. This will build on successes achieved over the past 12 years as Alaska developed a statewide, comprehensive, evidence-based tobacco prevention and control program funded through the Tobacco Use and Cessation Fund. As a result of these efforts, the percentage of adults who smoke has dropped from 27.7% in 1996 to 21.5% in 2007. This 20 % decrease means: there are 27,000 fewer smokers in Alaska now than in 1996; nearly 8,000 tobacco-related deaths will be averted; and nearly $300 million in medical costs will be saved. Yet there are still approximately 94,000 adults in Alaska who smoke. More than 65 percent of adult tobacco users in Alaska report that they want to quit. The CDC developed evidence-based guidelines for tobacco prevention and control, including recommended funding levels for states. The Alaska program is funded at $1.6 million below the current CDC recommendation.

Explanation of FY2010 Capital Budget Requests

The Division of Public Health will be requesting the following capital funding:

- Public Health Disaster Preparedness - $500.0 GF
- Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue Project- $425.0
- Emergency Medical Services - Emergency Communications $190.0 GF

Public Health Disaster Preparedness: *$500.0 GF*

The purpose of this project is to protect the health and safety of Alaskans by augmenting existing stockpiles of 1) personal protective equipment (PPE) for use by first responders, public health professionals and citizens during naturally occurring outbreaks of infectious disease or bio-terrorism attacks; 2) portable ventilators to support health care facilities during an emergency or disaster that requires rapid surge of medical resources; 3) antibiotics for rapid dispensing due to widespread outbreak of a naturally occurring communicable disease; and 4) anti-viral medication for protection of the population from an outbreak of pandemic influenza.

Alaska's unique geography demands self-sufficiency during disaster response. Access to in-state stockpiles of pharmaceuticals, supplies and equipment will enable first responders, health care workers and public health professionals to provide life saving support to Alaskans without waiting for outside resources to become available. Over the last five years the Department has strived to establish such stockpiles with federal and state money. The Department currently has Personal Protection Equipment (PPE), portable ventilators and antiviral drugs stockpiled in Alaska. However, the quantity is not adequate and a reliable funding source is needed for long-term maintenance. The federal dollars are rapidly diminishing. Disaster response plans for large numbers of casualties demand immediate deployment of critical medical resources to the impacted area. Without in-state stockpiles located regionally throughout the state the time to deploy those resources is extended and lives are put at risk.

Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue Project**:** *$425.0 GF*

Funds are needed to continue the work of the Code Blue Steering committee. This committee was formed to identify and purchase critical EMS equipment and ambulances for EMS agencies around the state, particularly in rural locations. This year a total of $425,000 is requested to match federal, local and private foundation funds to be allocated for all seven EMS regional offices for such needs as ambulances, heart monitors, training equipment, and communications equipment. One dollar in state general funds can leverage more than four additional dollars in other funds.

Emergency Medical Services - Emergency Communications: *$190.0 GF*

The purpose of this project is to protect the health and safety of Alaskans by maintaining and updating legacy emergency communication systems owned by the state and currently in use by emergency medical responders in rural areas where the Alaska Land Mobile Radio (ALMR) system is not available or where response agencies do not have reliable funding sources for the purchase and maintenance of ALMR radios. This request will fund:

- assessment of the repair and replacement needs of the existing VHF/HB base station/repeater network which supports two-way radio communication using conventional equipment, and completion of the highest priority repair and replacement projects.

Challenges

As the Division of Public Health (DPH) works to achieve its mission – to protect and promote the health of Alaskans – several major challenges face its leadership and staff. These challenges revolve around the division's core services and for FY10 fall into four main categories defined in the division'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 preventing and controlling injuries. The right mix of necessary investments in the division's programs – along with partnerships in the public health community and the recruitment and retention of expert staff – will allow progress in these categories to continue.

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 and controlling vaccine-preventable diseases is an ongoing fight as Alaska's role as a transportation and tourism hub keeps growing. Testing and identification of such diseases is a critical step in treating and controlling them. In FY2010, with requested funding, full operation and staffing of the new Fairbanks virology lab will give Public Health one of the important tools it needs to carry out its mission. In addition, there is an urgent and ever-present need in the division to assure an adequate public health nursing workforce. These nurses are the "foot soldiers" of Alaska's public health system and deliver critical services in every corner of the state. As such, identifying workforce development issues – including lower, non-competitive salaries when compared with similar agencies – and implementing new strategies for improving recruitment, retention and support for qualified staff at all levels statewide is an ongoing and critical challenge.

Preventing and Controlling Chronic Diseases

The fight against chronic diseases is critical; its importance cannot be overstated: three of every five deaths in Alaska are linked to chronic diseases. The primary risk factors for such diseases are obesity, poor diet, lack of exercise and tobacco use. As federal funding shrinks for disease prevention and health promotion programs – and with little commitment of state general fund dollars to these programs to date – a major challenge for the division is to continue its work to prevent chronic diseases and promote good health through better education efforts, especially the important fight to reverse or at least slow Alaska's growing and alarming rates of overweight and obesity. This makes sense financially: Reducing childhood and adult obesity will lead to productive lives and it will save money. Currently, Medicaid and Medicare spend $46 million in Alaska annually on obesity-related medical care. Without a comprehensive, long-term approach to this problem, Alaska can expect to see an ever-increasing number of Alaskans suffer poor quality of life, disability, chronic illness, and even premature death as a result of obesity-related illnesses. In FY2010, the division plans to tackle this challenge through a comprehensive state-funded approach to preventing and controlling obesity – coupled with an initiative to give Alaskans accurate and timely health information they can use to take personal responsibility for their own health and well-being.

In addition, work must continue to reduce tobacco use 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 FY2010 increments will provide grants to communities to increase their work in coalition building, youth prevention, policymaking and counter-marketing, and will shore up staff support for these efforts.

Assuring Access to Early Preventive Services and Quality Health Care
The projected occurrence of Autism Spectrum Disorder (ASD) is about 60 Alaskan babies born each year. Mental Health Trust funding for early diagnosis and treatment referral of ASD babies is phasing out. An FY2010 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.

A related challenge is the division's role in collecting, analyzing and reporting important health data to protect Alaskans. For instance, cancer is the leading cause of death in Alaska and birth defects (including FAS) are disproportionately high. Providers are required by state law to report cancer and birth defects. But without properly funded cancer and birth defects registries, the division's program experts and health care providers around the state will not have the necessary data needed to measure changes in health trends and determine which prevention and intervention programs are the most effective.

Also, without requested funding for FY10, the division will be unable to maintain the current buying power of Community Health Aide Training and Supervision (CHATS) program grants to support training and supervision of community health aides; these aides supply vital health care services in rural communities around the state.

Preventing and Controlling Injuries
The division is working hard 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, including but not limited to communications and training support services. However, soaring costs around the state – especially in rural Alaska – and limited and unstable federal funds directly affect the ability to protect the public and provide adequate emergency medical services statewide. Retaining and recruiting career and volunteer emergency medical services providers and the public health workforce is also a challenge.

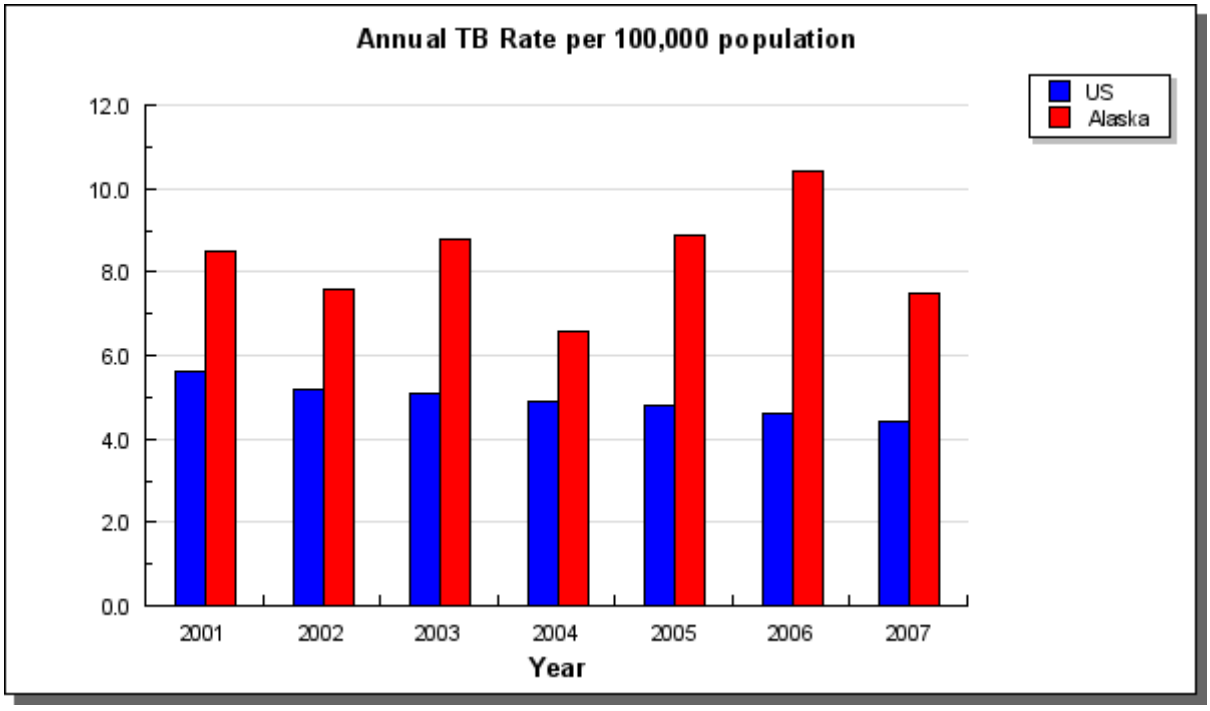
Public Health Results Delivery Unit

Contribution to Department's Mission

To protect and promote the health of Alaskans.

A: Result - Outcome Statement: Healthy people in healthy communities.

Target #1: Alaska's tuberculosis (TB) rate is less than 6.8/100,000 population
Status #1: For 2007, Alaska had third-worst TB rate in the nation



Annual TB Rate per 100,000 population

Year	US	Alaska
2007	4.4 -4.35%	7.5 -27.88%
2006	4.6 -4.17%	10.4 +16.85%
2005	4.8 -2.04%	8.9 +34.85%
2004	4.9 -3.92%	6.6 -25%
2003	5.1 -1.92%	8.8 +15.79%
2002	5.2 -7.14%	7.6 -10.59%
2001	5.6	8.5

Analysis of results and challenges: Tuberculosis (TB) has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment. In 2005 and 2006 Alaska had the highest rate of TB of the 50 states. This was the result of a large outbreak among the homeless in Anchorage. For 2007, Alaska has the third-highest TB rate in the country. 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. Despite the recent outbreaks, the rate of TB in Alaska began to decline again in 2007 and has shown a downward trend over the past 12 months.

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
Status #2: Alaska's chlamydia rate is still on the rise up from 676 to 733 or more than 8% in 2007, and up from 657 to 676 or 2.89% in 2006 per 100,000 population.

Chlamydia rate per 100,000 of population

Year	Alaska	U.S.
2007	733 +8.43%	N/A
2006	676 +2.89%	348 +4.5%
2005	657 +8.77%	333 +4.06%
2004	604 +0.33%	320 +5.26%
2003	602 +1.52%	304 +5.19%
2002	593 +36.95%	289 +5.09%
2001	433 +5.61%	275 +9.56%
2000	410 +35.31%	251 +1.62%
1999	303	247

Methodology: National data for 2007 available from CDC in November

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may cause serious health consequences. Some diseases once under control have recently reemerged, such as syphilis. As well, 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
Status #3: Coronary Heart Disease (CHD) rate is below the target for each year since 2004 which is 120 deaths per 100,000 population.

Coronary Heart Disease death rate per 100,000

Year	Alaska	US
2006	80.9 -10.8%	N/A
2005	90.7 -4.22%	149.8 -0.47%
2004	94.7 -25.2%	150.5 -7.61%
2003	126.6 +7.29%	162.9 -4.68%
2002	118 -13.62%	170.9 -3.88%
2001	136.6 -0.8%	177.8 -4.77%
2000	137.7 +4.71%	186.7 -4.06%
1999	131.5	194.6

Methodology: 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. An estimated 12 million men and women in the U.S. have a history of coronary heart disease, the most common form of heart disease. In 2005, more than 445,000 people died of coronary heart disease in the U.S.. 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 some time in their lives.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (stroke) is the fourth. 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 is 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 162/100,000 population
Status #4: Rate has declined each year since 2000 but cancer still the Number 1 killer in Alaska

Cancer death rate per 100,000 of population

Year	Alaska	US
2006	167.8 -1.12%	N/A
2005	169.7 -7.77%	183.8 -1.08%
2004	184.0 -1.97%	185.8 -2.26%
2003	187.7 -0.9%	190.1 -1.76%
2002	189.4 -1.46%	193.5 -1.28%
2001	192.2 -8.3%	196.0 -1.8%
2000	209.6 +8.88%	199.6 -0.6%
1999	192.5	200.8

Methodology: 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 a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death. Anyone can develop cancer and as the risk of being diagnosed with cancer increases with age, most cases occur in adults who are middle-aged or older. In the United States, cancer accounts for one of every four deaths; half of all men and one-third of all women will develop cancer during their lifetimes.

While cancer is the second-leading cause of death in the United States, it is the leading cause of death in Alaska. Over the past ten years, the overall cancer death rate in Alaska has declined, closely mirroring the decline seen in U.S. cancer mortality rates for the same period. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The leading types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the leading types of cancer deaths are lung, colorectal and prostate. Although some cancer risk factors are not modifiable, such as age, heredity and sex, it is estimated that up to fifty percent of all cancer deaths may be prevented through eliminating and reducing specific unhealthy behaviors. Goals around prevention, early detection and treatment are the focus of the Alaska Comprehensive Cancer Control Plan, a collaboratively-developed roadmap of how statewide partners are “Working Together for a Cancer-Free Alaska.”

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population
Status #5: Death rate caused by unintentional injuries is 52.2 per 100,000 population, above the 50/100,000 target but dropping 12% from 2002 to 2006

Unintentional injury death rate per 100,000 population

Year	Alaska	US
2006	52.2 +3.16%	N/A
2005	50.6 -8.17%	38.1 +4.1%
2004	55.1 -0.36%	36.6 -1.61%
2003	55.3 -6.59%	37.2 +0.81%
2002	59.2 -3.11%	36.9 +3.65%
2001	61.1 -4.38%	35.6 +2.01%
2000	63.9 +11.13%	34.9 -1.13%
1999	57.5	35.3

Methodology: 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 Alaska's high prevalence, the toll 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. Cancer and heart disease are the leading causes of death among the elderly, but 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 programs are two examples of successful activities. DPH's Injury Control program will continue to partner with others and to use data analysis and prevention strategies to understand and target interventions.

A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.

Target #1: 95% of persons with TB will complete adequate treatment within one year of beginning treatment

Status #1: 2006 rate still below target percentage because of some difficult cases

% of Persons with TB Completing Treatment Regimen

Year	Annual
2007	NA*
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

*Methodology: *TB treatment requires 6-9 months for completion. 2007 completion data are still being collected.*

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. However, some TB patients are difficult to locate, are incompliant or have medical complications that don't allow them to receive full treatment within the allotted time period. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Target #2: At least 98% of chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines

Status #2: In 2007, percent of Alaskans getting adequate treatment exceeded target

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2007	99.8%
2006	97.9%
2005	99.8%
2004	99.6%
2003	99.5%

Analysis of results and challenges: 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, the majority of cases are ultimately treated in a manner consistent with the national guidelines. Challenges include maintaining resources necessary to conduct necessary follow up and carefully monitoring disease trends to identify emerging problems.

There were a total of 4,911 reported chlamydia cases in 2007, compared to 4,528 in 2006. A small number of cases don't get adequate treatment, due primarily to individuals refusing treatment or an inability to locate them.

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 17% of high school youth in Alaska smoke
Status #1: 51% decline in youth smoking over 12 years, bringing 2007 prevalence rate within 1 percentage point of target

Prevalence of cigarette smoking in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
2007	17.8	20.0 -13.04%
2005	NA	23.0 +5.02%
2003	19.2	21.9 -23.16%
2001	NA	28.5 -18.1%
1999	NA	34.8

Methodology: Data is collected every other year. Alaska data 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.

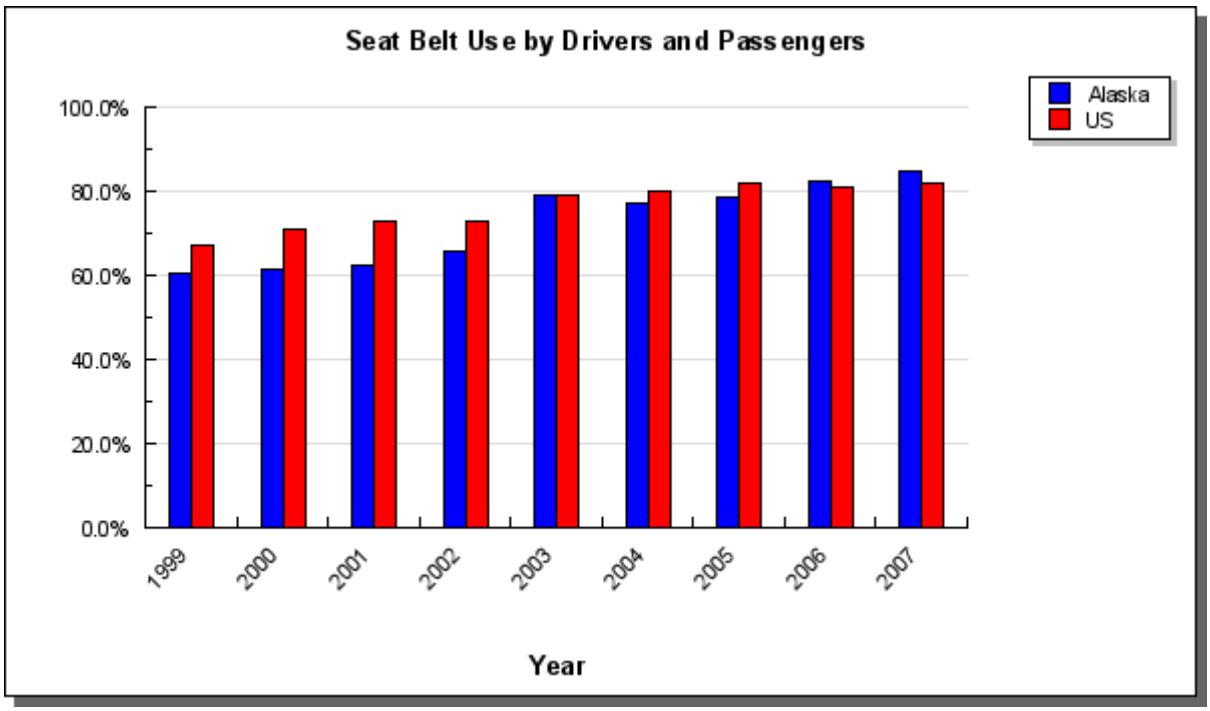
Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2% in 2003 and 17.8% 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.

The Healthy Alaskans 2010 target is 17.0%.

A3: Strategy - Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%
Status #1: Alaska has exceeded target since mandatory law took effect in 2006



Methodology: Alaska Highway Safety Office and U.S. National Occupant Protection Use Survey (NOPUS-2007)

Seat Belt Use by Drivers and Passengers

Year	Alaska	US
2007	85.0%	82%
2006	82.4%	81%
2005	78.4%	82%
2004	77.0%	80%
2003	78.9%	79%
2002	65.8%	73%
2001	62.6%	73%
2000	61.3%	71%
1999	60.6%	67%

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.

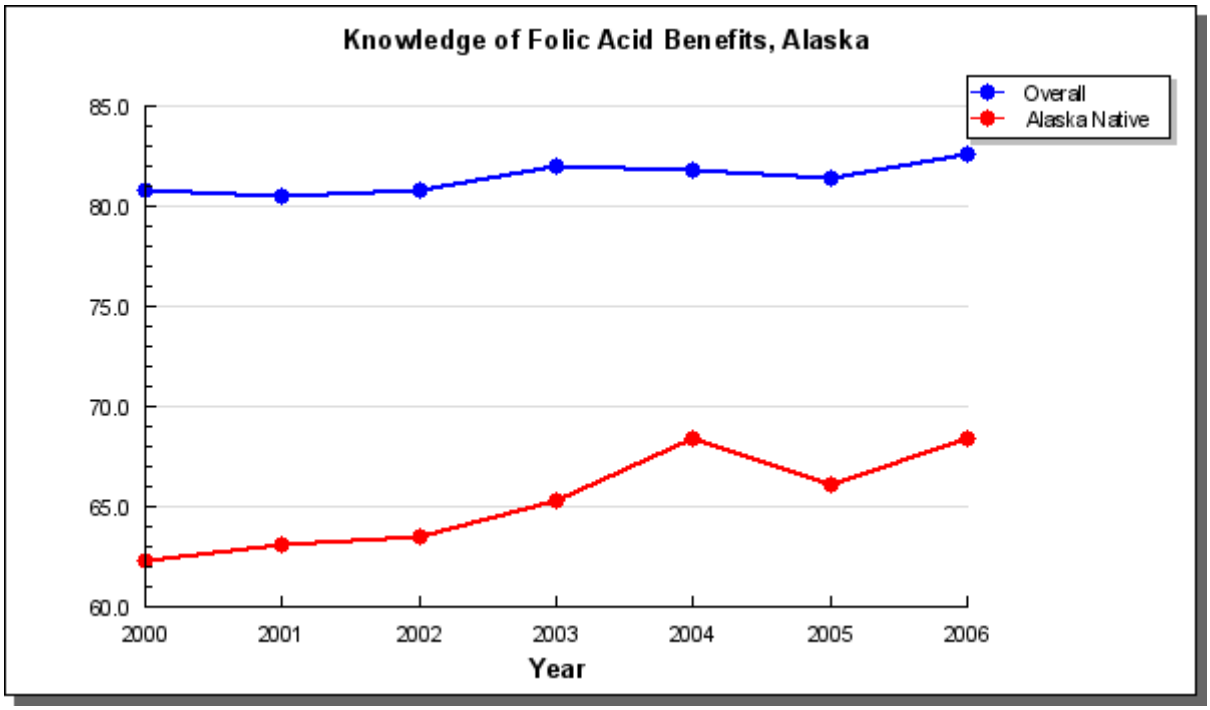
Alaska's mandatory seatbelt law took effect in 2006. In addition, efforts are ongoing to increase seatbelt use through public information messages and other targeted activities.

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% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

Status #1: In 2006, more slow progress in increasing knowledge of folic acid benefits



Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
2006	82.6 +1.47%	68.4 +3.48%
2005	81.4 -0.49%	66.1 -3.36%
2004	81.8 -0.24%	68.4 +4.75%
2003	82.0 +1.49%	65.3 +2.83%
2002	80.8 +0.37%	63.5 +0.63%
2001	80.5 -0.37%	63.1 +1.28%
2000	80.8	62.3

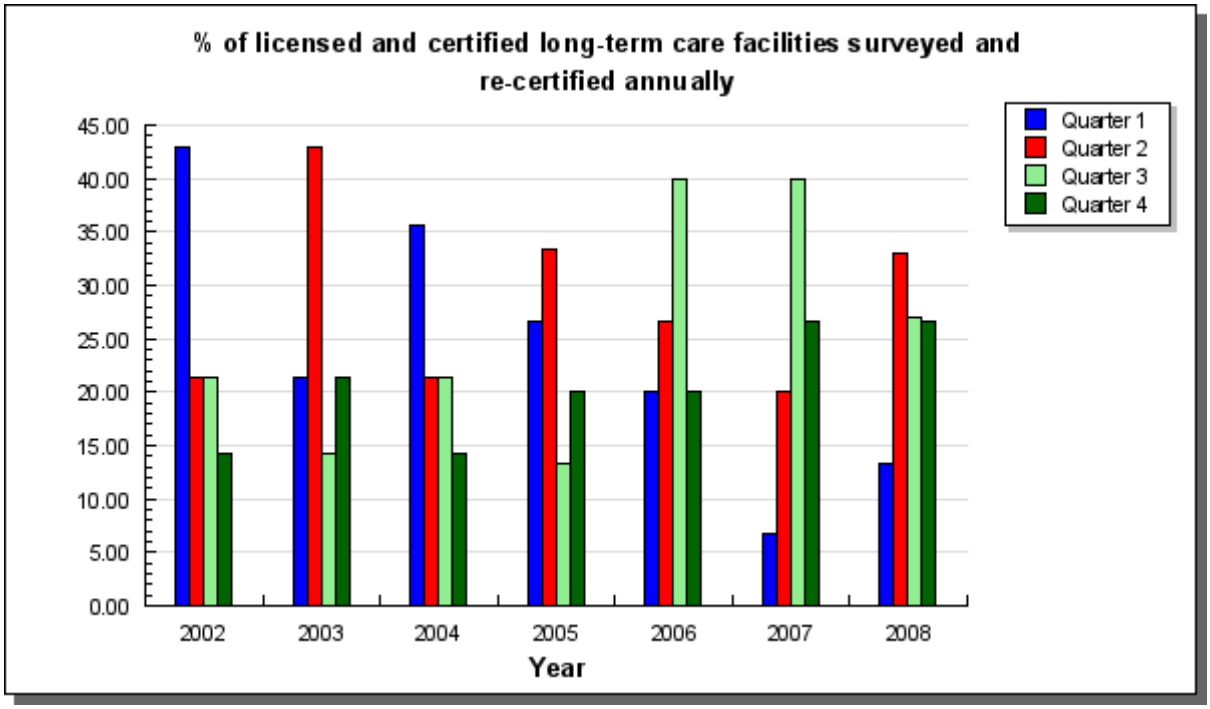
Analysis of results and challenges: Since 2000, the knowledge of folic acid benefits among Alaska mothers has remained at about the same level, around 81% to 83%.

The proportion of Alaska Native mothers who know about the benefits of folic acid steadily increased to 68.4% in 2004, fell slightly to 66.1% the following year, and then rose again to 68.4%. 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% and minimizing racial disparities.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually

Status #2: In FY2008, state consistently met licensure survey timelines



% of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2008	13.33	33	27	26.67	100%
2007	6.67	20	40	26.67	93.34%
2006	20	26.7	40	20	106.7%
2005	26.67	33.33	13.33	20	93.33%
2004	35.71	21.43	21.43	14.29	92.86%
2003	21.43	42.86	14.29	21.43	100%
2002	42.86	21.43	21.43	14.29	100%

Analysis of results and challenges: The annual required schedule for nursing home licensure surveys is driven by the federal Medicare certification survey scheduling mandate. The two surveys are always conducted simultaneously. The Center for Medicare and Medicaid Services (CMS) requires that long-term care (LTC) surveys are to be completed within a 9- to 15-month period with an average not to exceed 12.9 months. The Section of Certification and Licensing has consistently met federal and state certification and licensing LTC survey percentage requirements for licensed and certified long-term care facilities within the 9- to 15-month period. The Section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.

Target #1: 25% of the Division of Public Health (DPH) staff is trained in disaster response techniques and procedures

Status #1: Target exceeded - in FY2008 one-third of all DPH staff receiving preparedness training

 # and % of Division of Public Health staff trained in disaster preparedness

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	177				34%
FY 2007	27	106	17	31	35%
FY 2006				144*	28%
FY 2005			70	103	27%

*Methodology: *177 Division of Public Health staff received disaster preparedness training in FY2008. Quarterly numbers were not available.*

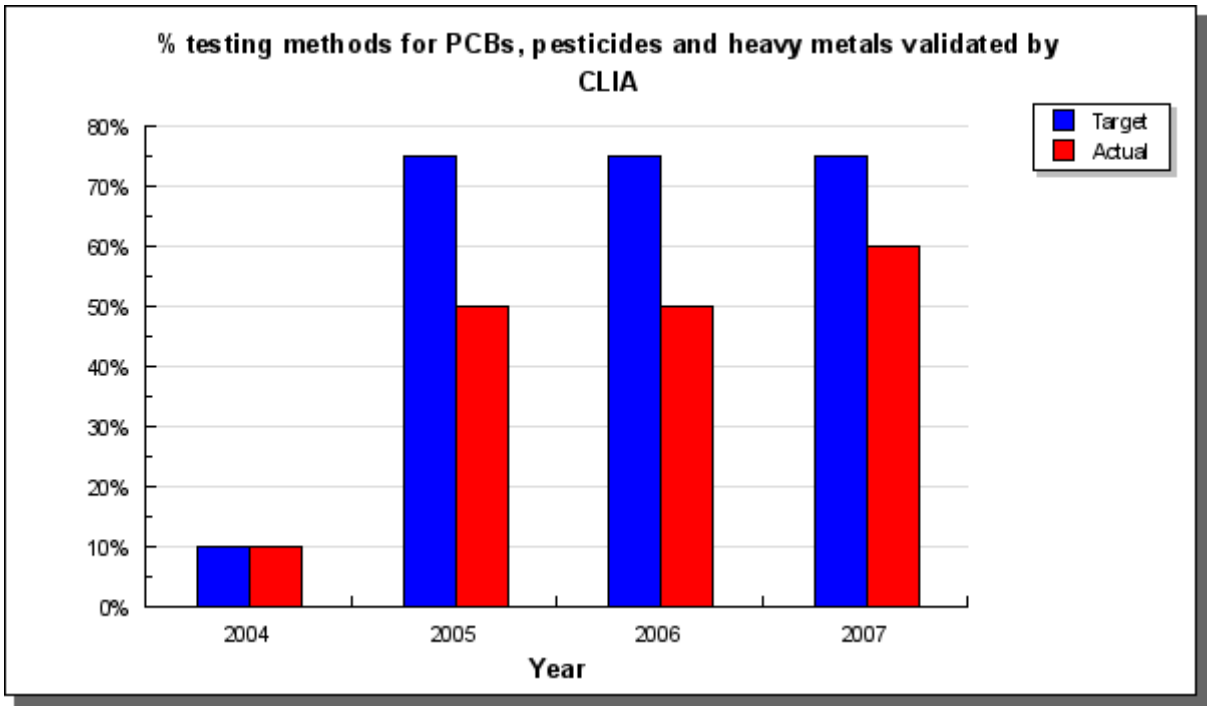
Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action, and permits all concerned to maintain a common knowledge base.

The FY08 percentage reflects the following: 520 total DPH positions, with an estimated 177 individuals receiving disaster preparedness training, a total of 34 percent trained. This meets the division goal of 25 percent annually. However, when only filled positions are considered (approximately 425), then the total of DPH-trained staff for FY2008 to date increases to 42 percent. New tracking software should come online soon.

A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals

Status #1: Target exceeded in 2007, with 75% of testing methods validated by CLIA



% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2007	75%	60%
2006	75%	50%
2005	75%	50%
2004	10%	10%

Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. This testing measures human exposure to contaminants and verifies the safety of traditional foods. For years, the federal government, through the Clinical Laboratory Improvement Amendments (CLIA) process, has certified the state lab. However, no chemical testing (for PCBs, etc.) was offered at the lab until 2004. Now the lab conducts CLIA-certified testing of inorganics, and some testing for Persistent Organic Pollutants (POPs) is underway.

Senior and Disabilities Services

Mission

Promote the independence of Alaskan seniors and persons with physical and developmental disabilities.

Introduction

The Division of Senior and Disabilities Services provides community grants and home and community-based services for older Alaskans and persons with disabilities as well as protection of vulnerable adults. The division administers four Medicaid Waiver programs and Senior Services and Community Developmental Disabilities Grants programs.

Core Services

- Institutional and community based services for older Alaskans and persons with disabilities.
- Protection of vulnerable adults.

Services Provided

Medicaid Services

Home and Community Based Waiver Medicaid Services Programs

In response to the high costs of nursing facility care, Medicaid has evolved into a program that allows the state to provide long-term care in less restrictive, more cost effective services that enable people to live in home and community settings. If determined eligible by meeting specific target population criteria, level of care, and financial guidelines, a person may apply to receive services under one of the 4 Medicaid waiver programs described below. Reimbursable waiver services include care coordination, chore services, adult day care, day habilitation, environmental modifications, intensive active treatment, meals, respite care, residential care in alternatives such as Assisted Living or Group Homes, specialized equipment, specialized private duty nursing, supported employment, and transportation to waiver services. The division manages 4 Medicaid waivers as shown below:

The Adults with Physical Disabilities (APD) Waiver

APD provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home; and, (2) be financially eligible for Medicaid to access the program. The program serves clients between the ages of 21 and 64 years of age.

The Children with Complex Medical Conditions (CCMC) Waiver

CCMC is for children, (1) birth through age 21, (2) having a severe chronic physical condition that is expected to continue for more than 30 days. The condition is (3) life threatening and needs (4) extraordinary supervision and observation. The child is (5) dependent upon medical

care or technology and (6) requires the same sort of care delivered in a hospital or nursing home.

The Mental Retardation/Developmental Disability (MRDD) Waiver
MRDD is specifically for (1) individuals with mental retardation, autism, cerebral palsy, a seizure disorder, or other related condition. In addition to these diagnoses, the individual (2) must have serious limitations 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 direct support. And, (3) the person requires the same level of care provided in an Intermediate Care Facility for the Mentally Retarded.

The Older Alaskan (OA) Waiver
OA provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home and (2) be financially eligible for Medicaid to access the program. The program serves clients who are 65 years and older.

Additional Medicaid Services
In addition to the 4 Medicaid waivers above, the Division offers limited Care Coordination and operates the Personal Care Assistance and Nursing Home Authorization Medicaid programs:

Care Coordination
State care coordinators screen Medicaid Waiver applicants and initiate the eligibility determination process. Once eligibility is determined, the care coordinator helps the applicant create an annual plan of care. This plan is designed to meet the individual recipient's needs, ensuring to the greatest extent possible their health, welfare and safety.

Personal Care Assistance
Services are provided statewide in Alaska through the Personal Care Assistant (PCA) Program. Through division oversight, the level of need for services is determined by assessment, to evaluate functional limitations in the performance of activities of daily living which may include bathing, dressing, grooming and limitations with instrumental activities of daily living such as shopping and cleaning. This assessment and subsequent service plan 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 (2) different options of PCA services. The Agency-Based PCA model allows consumers to use one of the qualified agencies that oversee, manage and supervise their care; or, consumers may choose the Consumer Directed PCA model that allows them to select, train, supervise, and discharge their PCA.

Nursing Home Authorizations
The division is responsible for the initial admitting authorizations of Medicaid eligible consumers to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those consumers staying in these facilities (depending on level of care) throughout the state of Alaska and

in other states if the appropriate care is not available in this state. The division is also responsible for authorizing Await & Swing beds for hospitals, in state and out of state, while Medicaid clients are waiting for admittance to a skilled nursing facility or if a skilled nursing facility is not available in the community. There are 15 skilled nursing facilities around the state with approximately 708 nursing home beds. The average annualized yearly cost of care for a patient in a nursing home in FY2008 was approximately $197,184.

Quality Assurance
Senior and Disabilities Services have a Quality Assurance Unit dedicated to ensuring the quality of services provided to Alaskan seniors and vulnerable adults. This unit oversees the Certification and Licensing staff for Senior and Disabilities, assists with audit activities and investigates complaints reported against licensed service providers (e.g. assisted living homes) throughout Alaska. This unit works closely with Adult Protective Services staff and other state agencies to ensure the quality of services provided to SDS consumers.

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 2,013 new cases in FY08. At present, APS has received an intake caseload of 867 cases (7/1/08 – 11/30/08). If this intake rate continues through the rest of FY09, SDS projects a total intake caseload of 2,080 cases for the year(December through February is typically the highest intake months).

State Health Insurance Assistance Program (SHIP)
The SHIP program is funded by a federal grant that's awarded to Senior and Disabilities Services from the Centers for Medicare and Medicaid (CMS) to help Alaskan seniors better understand their Medicare health insurance benefits and provide Medicare eligible Alaskans with information, counseling and assistance on health insurance matters. Education is provided through two (2) dedicated SDS staff and through a network of statewide volunteers.

Senior Medicare Error Patrol (SMP)
The SMP program is funded by a federal grant that's awarded to Senior and Disabilities Services from the US Administration on Aging (AOA) to educate older Alaskans about consumer protection and Medicare fraud, waste & abuse to reduce erroneous and wasteful Medicare spending. This program also informs Alaskans about changes to Medicare such as changes to Medicare Part D as it relates to the prescription drug program. Education is provided through two (2) dedicated SDS staff and through a network of statewide volunteers.

Real Choice Systems Change Grant – Person-Centered Planning
This Real Choice Systems Change grant was awarded to SDS from the Centers for Medicare and Medicaid (CMS) to develop and implement a person-centered Hospital Discharge Model (HDM) and to enhance and expand Aging and Disability Resource Centers, also known as "Single Entry Point Programs."

Nutrition, Transportation, and Support Services Grants for Seniors
The U.S. Department of Health and Human Services, Administration on Aging grants federal funds to the division each year to provide for Nutrition, Transportation and Support services for Alaskan Seniors.

These grants provide funding for the following services:

- Congregate Meals
- Home Delivered Meals
- Nutrition Services Incentive Program (NSIP)
- Assisted and Unassisted Transportation
- Homemaker Service
- Information and Assistance
- Outreach
- Nutrition Education and Counseling
- Health Education and Counseling
- Health Promotion / Medication Management
- Foster Grandparent / Elder Mentor Program
- Senior Companion Program
- Retired Senior Volunteer Program
- Legal Assistance
- Media Services (provides partial funding for the Senior Voice)

These services are selected through the State Plan process from a menu of services available under Title III of the Older Americans Act. These services are available to Alaskan seniors that are over age 60 and targets populations with the greatest social and economic need. This includes seniors that live in rural areas, are members of minority groups and are physically frail.

Home and Community Based Care Grants for Seniors
Home and Community based services provide a safety net for seniors and their caregivers who wish to remain in their homes and would not otherwise qualify for services under the Older Alaskans Medicaid Waiver program. Grants for these services are provided by State general fund / mental health funds, the AOA Title III federal grant for National Family Caregiver services and MHTAAR funds authorized by the Alaska Mental Health Trust Authority.

Services provided under this grant include:

- Adult Day Services
- National Family Caregiver Support
- Alzheimer's Disease and Related Dementias (ADRD) Education, Support and Mini-Grants
- Senior In-Home Services (Care Coordination, Chore, Respite and Extended Respite Services)
- Geriatric Education Treatment for Seniors with Co-Occurring Substance Abuse and Mental Health Disorders

Senior Residential Services - Through designated funding from the Alaska State Legislature, the Division of Senior and Disabilities Services oversees grants that support assisted living facilities for elders in Tanana and Kotzebue. By definition, assisted living facilities provide meals and assistance with daily activities to enable seniors to remain in or near their community of choice.

Community Developmental Disabilities Grants (CDDG)

The Community Developmental Disabilities Grant Program minimizes institutionalization and provides care for people with developmental disabilities (DD). In FY2008 developmental disabilities grants provided services to nearly 1,200 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 4 Home and Community Based Waiver Programs may provide similar services. However, not everyone having a developmental disability qualifies for Medicaid under a Waiver Program or meets the threshold for long-term residential care that the MRDD Waiver is designed to provide.

Other grant programs in the Community Developmental Disabilities Grant 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 FY2008, 12 organizations were awarded funds to operate a STAR program to assist people with developmental disabilities and their families address short-term needs before a crisis occurs and to defer the need for more expensive residential services or long-term care. Many people who are on the DD Waiting List access STAR services.

Mini-grants for beneficiaries with developmental disabilities—With funds from the Mental Health Trust Authority, mini-grants are a one-time award made to individuals not to exceed $2,500 per recipient for health and safety needs not covered by grants or other programs to help beneficiaries attain and maintain healthy and productive lifestyles. Adult dental care is the most frequently requested service by those who receive mini-grants.

Specific grants that address the severe statewide shortage of qualified direct care staff and assure that critical expertise is available in the state to deliver services required in AS 47.80.130.

Behavioral Risk Management Services—address difficult behaviors by providing technical assistance and training for the personnel working in community DD programs, or family members and guardians. Additionally, funds are used for personal safety training for women with DD.

The ARC of Anchorage Student Living Center for the Deaf –provides students who are deaf living in rural areas of Alaska with residential services and daily support while they attend the Alaska State School for Deaf and Hard-of-Hearing in Anchorage.

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 which help keep seniors in their homes and communities at a cost which is typically far less than paying for a residential nursing home.

Senior and Disabilities Medicaid Services

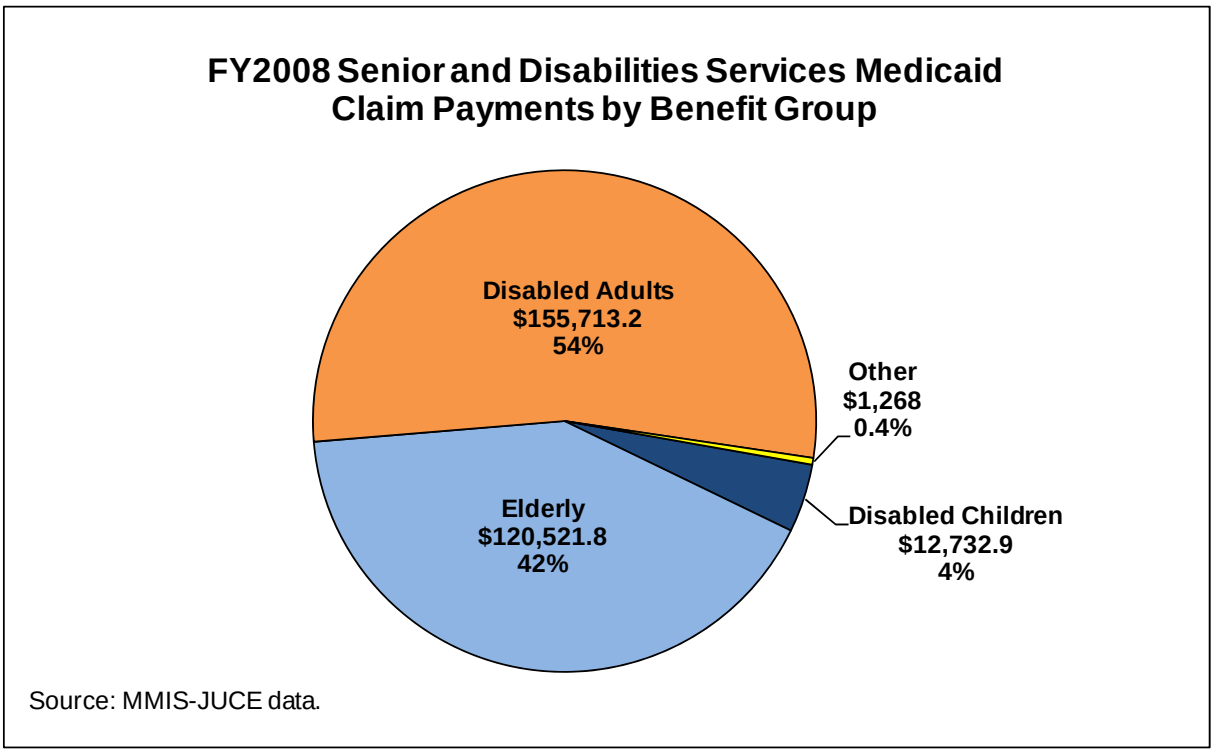
In FY2008, Senior and Disabilities Medicaid provided long-term care services to 7,400 Alaskans, about 6% of all persons enrolled in the Alaska Medicaid program. The total cost of services funded through Medicaid was about $290 million, or about $39,200 per person per year. Over half of the claim payments (58%) were for services provided to disabled individuals. Services provided to the elderly accounted for nearly 42% of claim payments processed in FY2008.

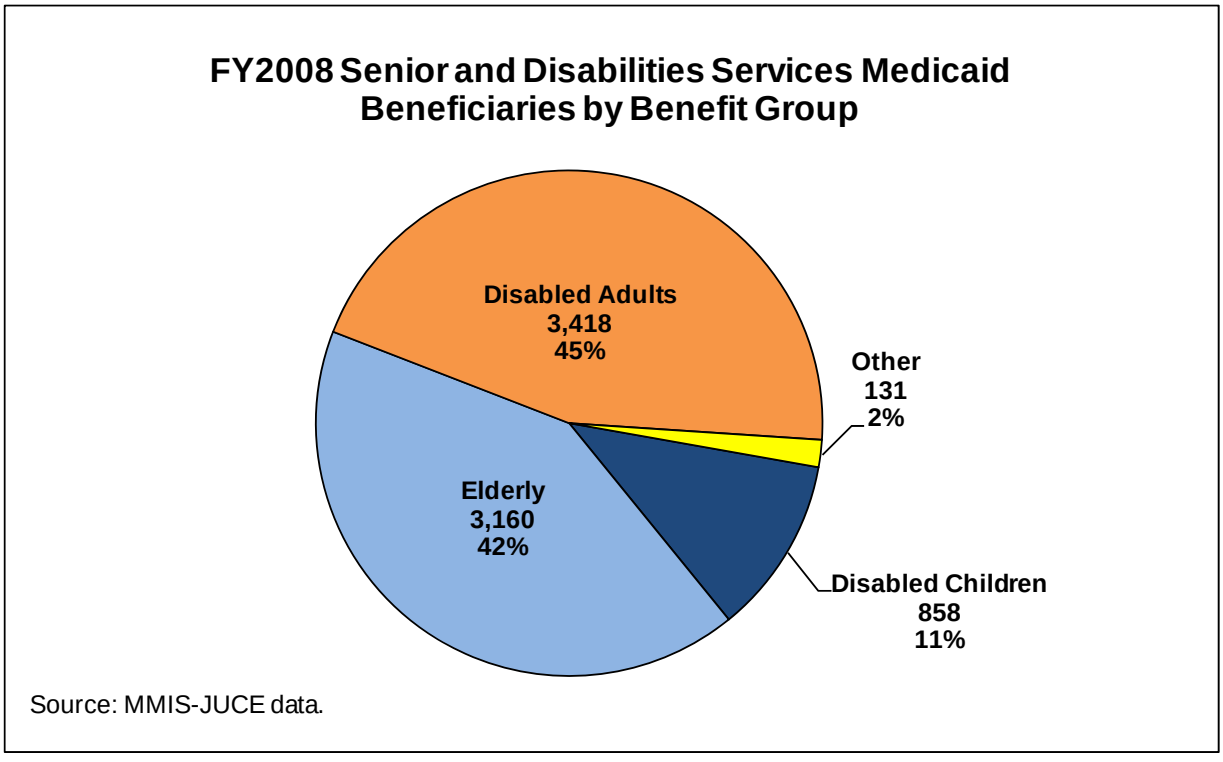
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost Per Beneficiary
Children	1.0%	78	0.3%	$782.9	$10,037
Disabled Children	11.3%	858	4.4%	$12,732.9	$14,840
Elderly	41.8%	3,160	41.5%	$120,521.8	$38,140
Disabled Adults	45.2%	3,418	53.7%	$155,713.2	$45,557
Adults	0.7%	53	0.2%	$485.1	$9,152
Unduplicated Annual Clients		**7,406**			
Total Medicaid Claim Payments (thousands)				**$290,235.9**	
Average Annual Medicaid Cost per Beneficiary					**$39,189**

Source: MMIS/JUCE claims paid during FY2008. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

Age Group	Percent of Benficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost per Beneficiary
All Senior and Disabilities Medicaid					
Under 21	14.1%	1,049	7.3%	$21,259.2	$20,266
21 or Older	85.9%	6,409	92.7%	$268,976.6	$41,969
Nursing Home Services					
Under 21	0.5%	5	0.9%	$707.3	$141,457
21 or Older	99.5%	977	99.1%	$74,283.0	$76,032
Personal Care Attendant Services					
Under 21	3.2%	115	4.0%	$2,870.1	$24,957
21 or Older	96.8%	3,439	96.0%	$69,418.9	$20,186
Home and Community Based Waiver Services					
Adults with Disabilities Waiver					
Under 21	4.1%	55	3.4%	$894.0	$16,254
21 or Older	95.9%	1,280	96.6%	$25,409.4	$19,851
Children with Complex Medical Conditions Waiver					
Under 21	92.1%	209	92.7%	$8,623.4	$41,260
21 or Older	7.9%	18	7.3%	$680.1	$37,783
Mental Retardation/Developmental Disability Waiver					
Under 21	20.6%	208	10.9%	$7,959.6	$38,267
21 or Older	79.4%	801	89.1%	$64,908.4	$81,034
Older Alaskans Waiver					
Under 21	0.0%	0	0.0%	$0.0	$0
21 or Older	100.0%	1,536	100.0%	$34,170.7	$22,247
Other Waiver Services					
Under 21	42.5%	564	65.9%	$205.0	$363
21 or Older	57.5%	764	34.1%	$106.1	$139

Source: MMIS/JUCE claims paid during FY 2008.





Of the services managed by Senior and Disabilities Medicaid, more Medicaid clients used home and community based waiver services than nursing home or personal care attendant services. Waiver services comprised almost half (49%) of Senior and Disabilities Medicaid costs in FY2008. Nursing home and personal care claim payments accounted for about 26% and 25% of costs, respectively.

Nursing home care is by far the most expensive long-term care service per person. At an annual average cost of $76,400 per beneficiary, nursing homes were more than twice the average for all home and community based waiver services and nearly four times the average for personal care attendant services.

Service Category	Cost per Beneficiary per Year	Percent of Beneficiaries
Nursing Home Services	$76,400	13.3%
Personal Care Attendant Services	$20,400	47.9%
Home and Community Based Waiver Services	$35,100	54.8%
All Senior and Disabilities Medicaid, cost per beneficiary per yea	$39,200	
All Senior and Disabilities Medicaid, unduplicated annual beneficiaries		7,406

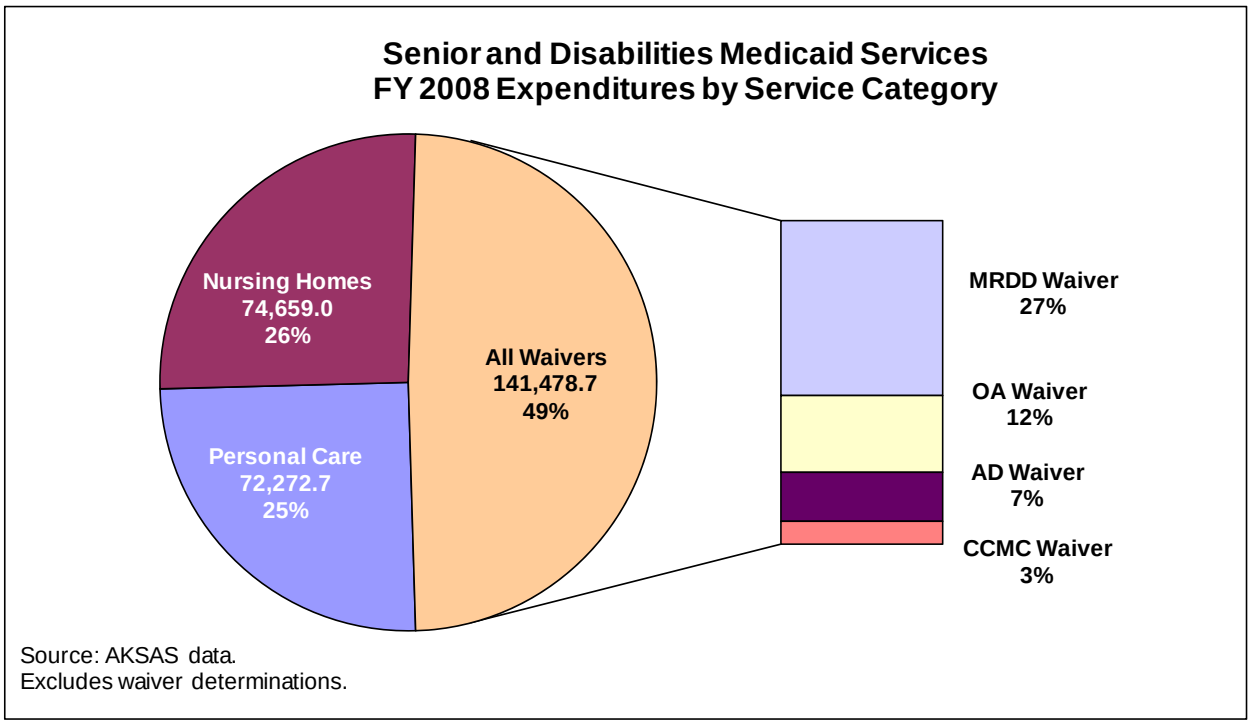
Source: MMIS/JUCE for claims paid during fiscal year 2008. Percent of beneficiaries includes individuals receiving services in multiple categories and may not sum to 100%.

The vast majority of Senior and Disabilities Medicaid clients are over age 21 (93%). Beneficiaries of nursing home and personal care attendant services are almost exclusively over age 21 (99% and 96%, respectively). Participation on the Medicaid home and community-based waivers is split almost evenly between seniors (Older Alaskans), adults (Adults with Disabilities) and children (Mental Retardation/Developmental; Disabilities and Children with Complex Medical Conditions).

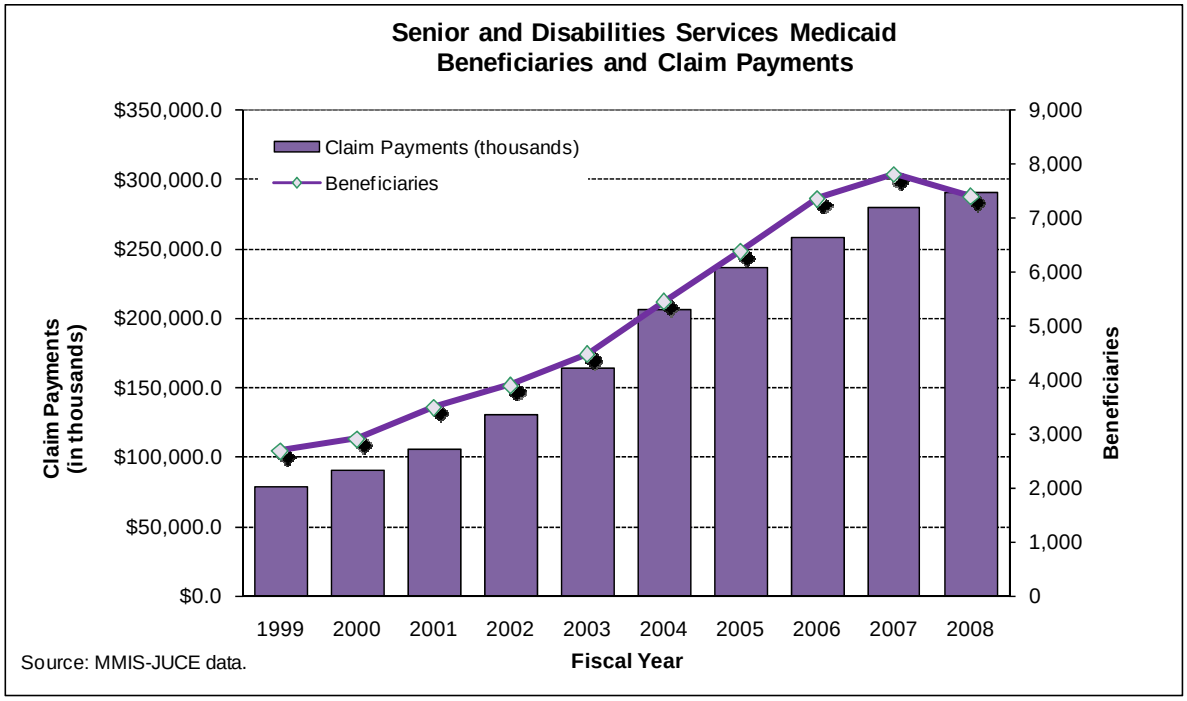
Home and Community Based Waiver	Cost per Beneficiary per Year	Percent of Waiver Beneficiaries
Adults with Disabilities	$19,800	32.7%
Children with Complex Medical Conditions	$42,700	5.4%
Mental Retardation/Developmental Disabilities	$74,500	24.1%
Older Alaskans	$22,200	37.8%
All Home and Community Based Waivers	$35,100	100.0%

Source: MMIS/JUCE for claims paid during fiscal year 2008.

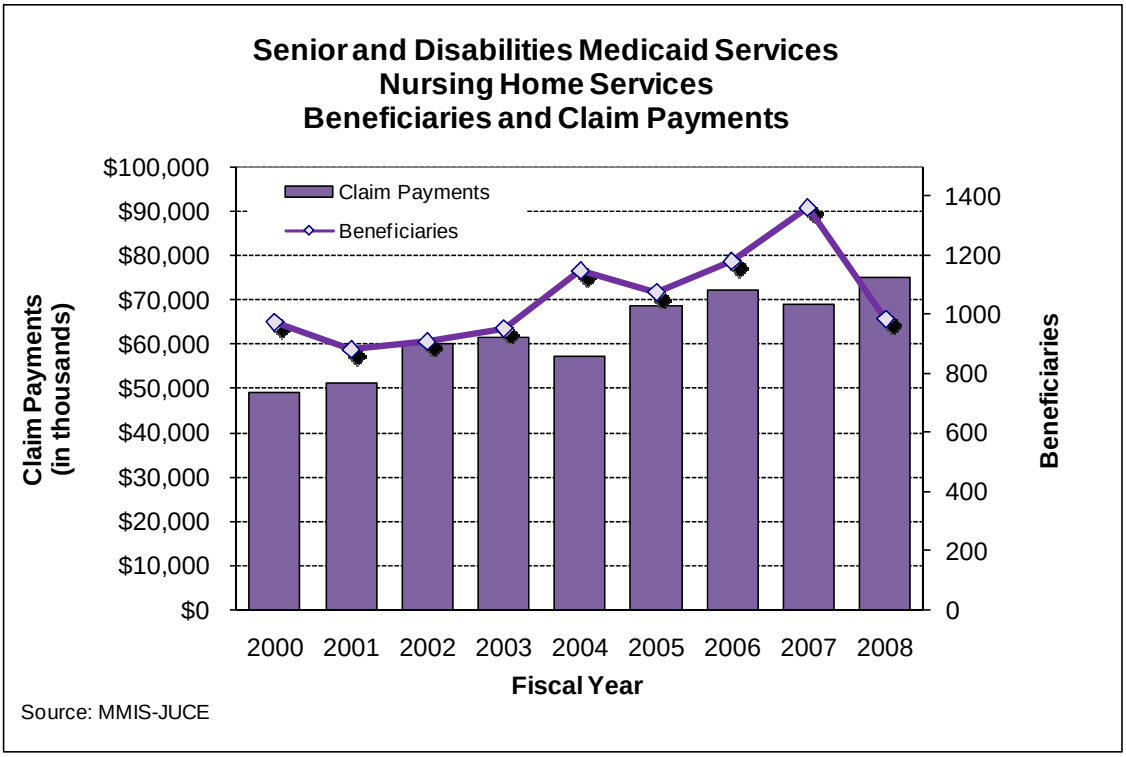
The Older Alaskans waiver has the greatest percentage of waiver beneficiaries (38%) followed closely by Adults with Disabilities (33%) and Mental Retardation/Developmental Disabilities (24%). The Children with Complex Medical Conditions waiver has the least participation with only 5% of waiver clients.



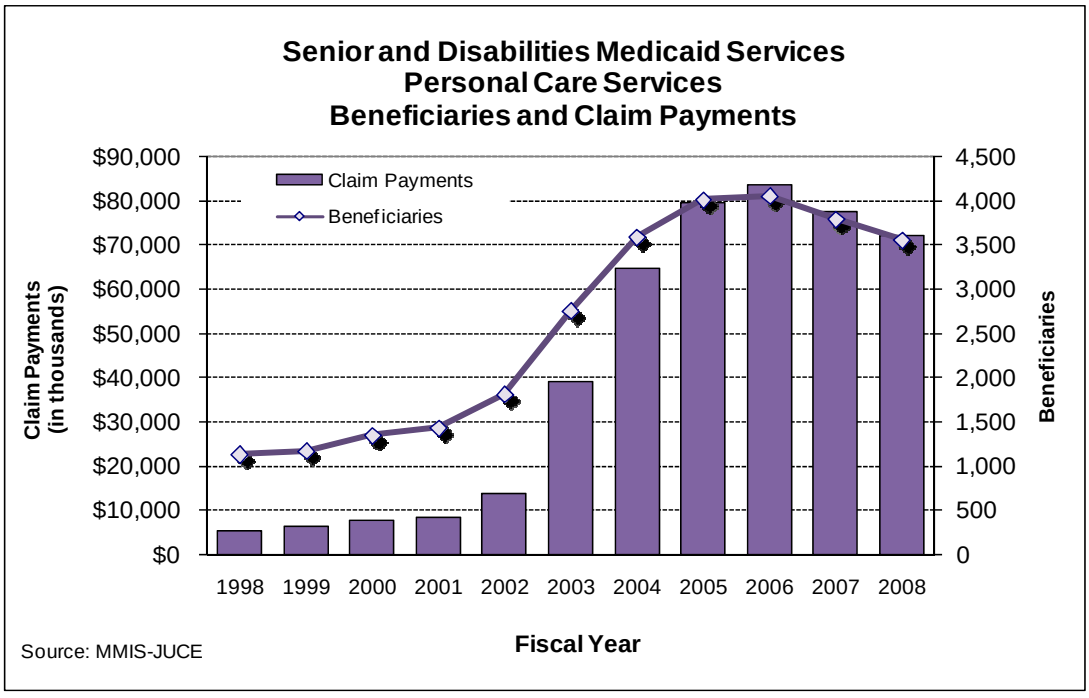
Total claim payments for Senior and Disabilities Medicaid services in FY2008 increased by 4% from FY2007. The number of person during FY2008 using any Senior and Disabilities Medicaid service declined by 5% and the average annual cost per beneficiary increased by 9% to $39,200. The majority of the increase came from nursing home services and home and community based waiver services. Personal care attendant services saw reduced costs for the second consecutive year.

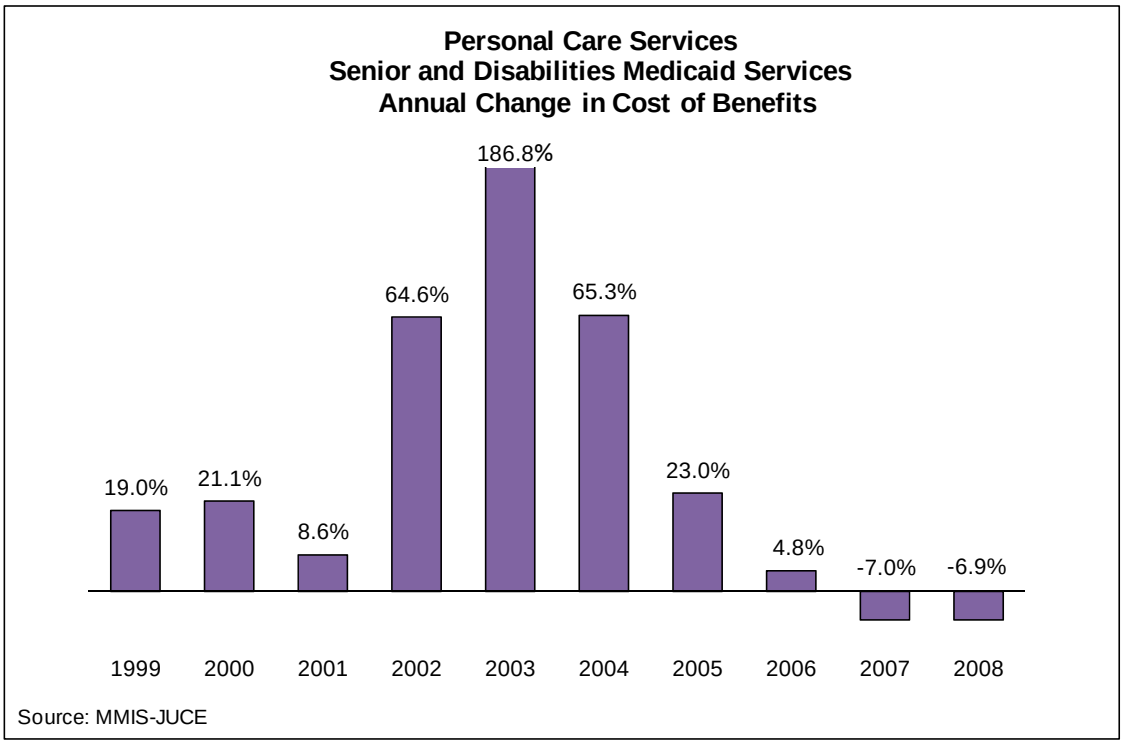


Nursing home costs increased about 9% though the number of persons with nursing home claims paid during the year decreased by almost 30%. This combined for a 50% higher average cost per person.

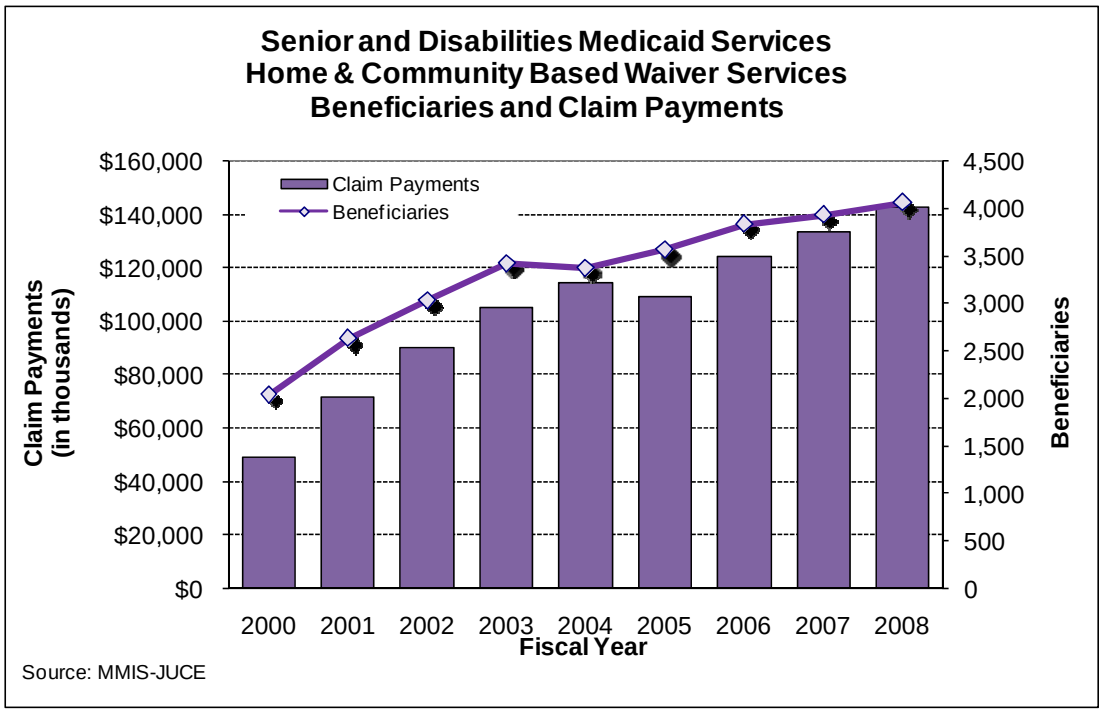


Growth rates for personal care attendant services have been steadily declining since reaching a peak in FY2003. Cost containment has been achieved without a significant reduction in services. Claim payments showed a 7% decline for the second consecutive year. The number of beneficiaries served dropped by about 7% from the previous year while the average cost per person shrank by less than one percent.





Overall, home and community based waiver services increased claim payments by nearly 7%. This was due to increases in both participation in the waivers and utilization of services. The number of beneficiaries using any waiver service at some time during the fiscal year increased by about 3%. The annual cost per beneficiary increased by nearly 4%.



The fastest growing home and community based service in total spending and participation is the Adults with Disabilities waiver. It saw an increase in expenditures of 16% compared to less than 6% for each of the other three waivers. The number of beneficiaries increased by more than 5% in the Adults with Disabilities waiver while the Mental Retardation/Developmental Disabilities waiver increased by slightly less than 5%. The number of beneficiaries increased by 1% in the Older Alaskan waiver and decreased by 2% for the Children with Complex Medical Conditions waiver.

FY 2008 DIVISION LEVEL SUMMARY: Senior and Disabilities Services Medicaid	SENIOR AND DISABILITIES MEDICAID SERVICES						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent Recipients*	Percent Payments
Medicaid, Division Annual Totals		**7,406**		**$290,235,880**	**$39,189**	**6.3%**	**30.8%**
Gender							
Female	59.1%	4,376	57.6%	$167,255,835	$38,221	6.5%	31.2%
Male	40.9%	3,032	42.4%	$122,980,045	$40,561	6.0%	30.1%
Unknown	0.0%	0	0.0%	$0	$0	0.0%	0.0%
Race							
Alaska Native	21.0%	1,558	24.4%	$70,851,807	$45,476	3.3%	20.2%
American Indian	1.3%	93	1.3%	$3,657,249	$39,325	5.0%	27.2%
Asian	11.1%	822	7.8%	$22,672,573	$27,582	12.8%	49.4%
Pacific Islander	3.7%	278	2.3%	$6,756,563	$24,304	8.3%	34.9%
Black	4.1%	304	3.8%	$11,058,730	$36,377	4.9%	26.3%
Hispanic	2.4%	181	1.8%	$5,237,260	$28,935	4.3%	24.9%
White	51.6%	3,838	55.2%	$160,347,014	$41,779	8.3%	38.0%
Unknown	4.9%	361	3.3%	$9,654,685	$26,744	10.2%	32.6%
Native	22.2%	1,649	25.7%	$74,509,056	$45,184	3.4%	20.5%
Non-Native	77.8%	5,764	74.3%	$215,726,824	$37,427	8.3%	37.2%
Age							
under 1	0.4%	34	0.0%	$25,015	$736	0.3%	0.0%
1 through 12	7.9%	622	2.3%	$6,771,775	$10,887	1.3%	4.8%
13 through 18	4.2%	334	2.9%	$8,505,606	$25,466	1.6%	5.6%
19 through 20	1.6%	129	2.1%	$5,956,839	$46,177	3.1%	24.4%
21 through 30	6.4%	509	10.6%	$30,902,938	$60,713	3.8%	29.6%
31 through 54	19.8%	1,566	24.6%	$71,326,743	$45,547	8.8%	34.7%
55 through 64	13.7%	1,081	12.2%	$35,421,666	$32,767	22.1%	43.6%
65 through 84	34.6%	2,738	32.1%	$93,265,932	$34,064	37.8%	80.1%
85 or older	11.4%	899	13.1%	$38,059,365	$42,335	68.1%	93.7%
Benefit Group							
Children	1.0%	78	0.3%	$782,918	$10,037	0.1%	0.2%
Adults	0.7%	53	0.2%	$485,072	$9,152	0.2%	0.4%
Disabled Children	11.3%	858	4.4%	$12,732,940	$14,840	39.4%	22.3%
Disabled Adults	45.2%	3,418	53.7%	$155,713,191	$45,557	23.2%	50.4%
Elderly	41.8%	3,160	41.5%	$120,521,757	$38,140	43.0%	85.1%

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 2008. Service may have been incurred in a prior year. Grouping is based on status on the date the benefit was obtained. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories). Some duplications may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2008. . If they obtained dental services in December, they would also be included in the 13 through 18 age subgroup count if the claim was subsequently paid during SFY08.

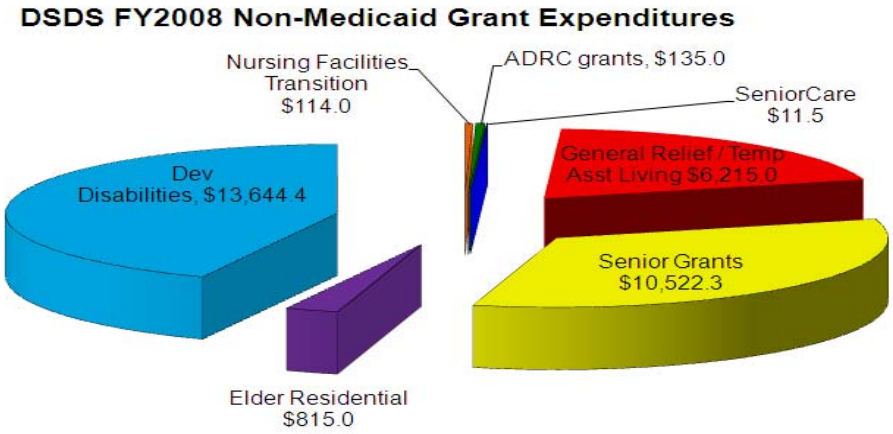
*Because recipients were unduplicated across divisions to obtain the department total, the sum of "Percent Recipients" (Division, Percent of Department Medicaid) for all 4 divisions may exceed 100%.

Source: MMIS/JUCE.

Non-Medicaid Grants/Services

DSDS Non-Medicaid Grant Expenditures in FY2008: ***This chart represents an unduplicated count of service recipients.***				
Grant Name	Primary Service	# of Clients Served	Client Population	Total Exp:
Nursing Facilities Transition ($114.0)	Nursing Facilities Transition	58	Seniors	$114.0
Statewide Independent Living Council (SILC) for Aging and Disability Resource Ctrs (ADRC's)	ADRC grants	3,424*	Seniors and Dev Disab	$135.0
SeniorCare Grants	Medicare Part D		Seniors	$11.5
Gen Relief / Temp Asst Living	Temp Asst Living	877	Adults 18+	$6,215.0
Senior Community Based Grants	Senior Grants	13,404	Seniors	$10,522.3
Senior Residential Grts	Elder Residential	103 (33 FT, 70 PT)	Tribal Elders/Seniors	$815.0
Comm Dev Dis Grts	Dev Disabilities	1,200	Dev Disabled	$13,644.4
(Includes Proshare grant exp.)	Total Clients Served:	15,621	Total Expenditures:	$31,457.2

*ADRC funding was provided by multiple agencies in FY08.



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 Persons
AS 47.24	Protection of Vulnerable Adults
AS 47.25	Public Assistance
AS 47.33	Assisted Living Homes
AS 47.65	Service Programs for Older Alaskans and Other Adults
AS 47.80.010 - 900	Persons with Disabilities
PL89-73	Title III Older Americans Act, as Amended
PL 98-459	Public Law, Title III Older Americans Act, as Amended
PL 100 - 203	Omnibus Budget Reconciliation Act of 1987
Title XVIII	Medicare
Title XIX	Medicaid
7 AAC 43	Medicaid
7 AAC 43.170	Conditions for Payment
7 AAC 43.1000-1110	Home and Community-Based Waiver Services Program
7 AAC 72.010 - 900	Civil Commitment
7 AAC 78.010 - 320	Grant Programs
42 CFR, Part 400 to End	
42 CFR, Part 440	Code of Federal Regulations, Services: General Provisions
45 CFR, Part 1321	Code of federal Regulations

Senior & Disabilities Services	2009	2010 Gov	09 to 10 Change
General Funds	186,601.4	201,344.7	14,743.3
Federal Funds	199,219.7	205,835.8	6,616.10
Other Funds	4,269.9	5,430.7	1,160.8
Total	390,091.0	412,611.2	22,520.2

Senior and Disabilities Medicaid Services

The Medicaid budget is based on projections of the number of eligible Alaskans who will access Medicaid funded services, estimates of the quantity of services that may be used and the anticipated changes in the costs of those services. The department uses both long-term and short-term forecasting models to project Medicaid spending. The short-term model is best for budget development and fiscal note analysis while the long-term model is best for strategic planning.

The change over a long period is generally smoother and more gradual than the annual fluctuations experienced in the short term. Since the budget preparation cycle requires projections up to 24 months in the future, often before recent policies have been fully implemented and reflected in the baseline spending data, it is premature to know if recent changes in spending are temporary or will last.

The department's recent success in avoiding some costs and in containing growth rates in the short term has resulted in existing authorization being briefly ahead of the trend. The department has adjusted its authorization to reflect current trends and reduced excess authorization to reestablish a revised authorization base from which to begin FY2010. This revised base becomes the foundation for the Medicaid formula growth increment and fund change for federal financial participation.

Senior & Disabilties Medicaid Services	Total	GF	Federal	Other
SFY 2009 Existing Authorized	**345,278.6**	**156,410.7**	**185,988.1**	**2,879.8**
Reduce Excess Federal Authorization	(11,000.0)	0.0	(11,000.0)	0.0
SFY 2010 Revised Authorization	**334,278.6**	**156,410.7**	**174,988.1**	**2,879.8**
Change in Federal Financial Participation	0.0	(748.6)	748.6	0.0
Formula Growth	32,138.0	15,368.0	16,770.0	0.0
Total	**366,416.6**	**171,030.1**	**192,506.7**	**2,879.8**

Medicaid Program – Reduce Excess Federal Authority: *($11,000. 0) Fed*
The department can adjust its authorization this year to reflect current trends by reducing excess federal authority. This rebalances the federal/state funding ratio to reflect recent federal collections. This will leave a sufficient amount of funding to continue services at the current level.

Medicaid Program - Formula Growth: *$32,138.0 Total- $16,770.0 Federal, $15,368.0 G/F Match*
This increment is necessary to maintain the current level of long term health services in Medicaid for nearly 7,500 elderly Alaskans or persons with disabilities, about 6% of all those enrolled in the Alaska Medicaid program during the year.

The Senior and Disabilities Medicaid Services component funds long term care services: nursing homes, personal care attendants, and home and community based services. These programs support the department's mission to manage health care for eligible Alaskans in need. Providing long-term care through Medicaid improves and enhances the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

For FY2010, Senior and Disabilities Medicaid costs are projected to increase 10% from FY2009. Spending will grow from the 2% increase seen between 2007 and 2008 after several years of flat growth. While the Personal Care Attendant program has made remarkable progress in controlling costs, the savings from those cost containment efforts have been exhausted. Rate increases and increased utilization by the aging population will raise spending. Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget.

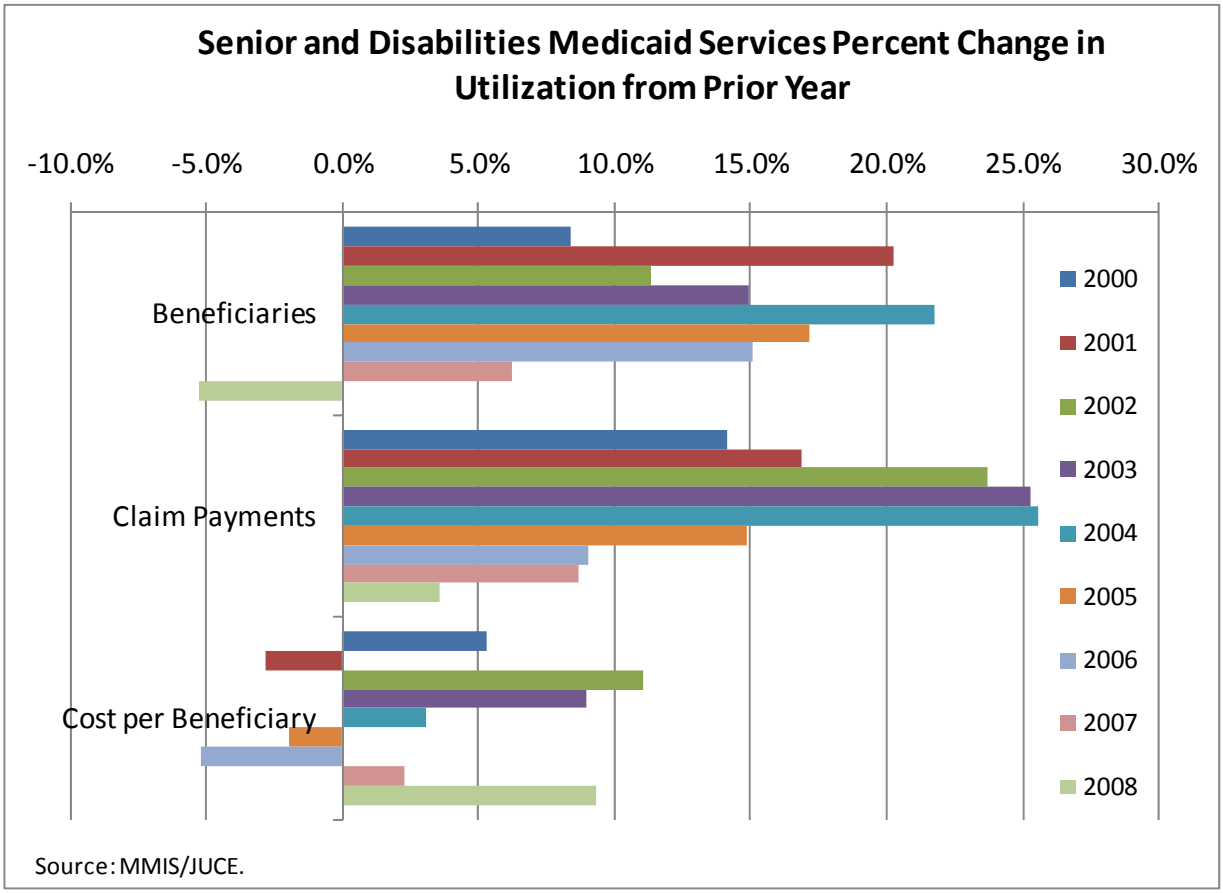
In recent years, the department has implemented Medicaid reforms aimed at improving Medicaid sustainability. Cost containment efforts begun in FY2004 have successfully reduced the rate of growth in recent years. Changes to the Personal Care Attendant program have reduced utilization of these services. Additional capacity expected on completion of new facilities and increases in provider reimbursement approved by the 2008 Legislature will contribute to the approximately 10% increase in costs forecast for FY2010.

Projections for formula growth are based on historical trends in enrollment, utilization, provider reimbursement, and federal financial participation. Projections include recently adopted policy changes that are not yet reflected in the trends, e.g. provider rate increases effective in 2009; however, the formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP).

Seniors and Disabilities Medicaid Services

State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	2,688	$79,351.7	$29,521			
2000	2,914	$90,587.8	$31,087	8.4%	14.2%	5.3%
2001	3,504	$105,834.3	$30,204	20.2%	16.8%	-2.8%
2002	3,902	$130,887.3	$33,544	11.4%	23.7%	11.1%
2003	4,484	$163,925.3	$36,558	14.9%	25.2%	9.0%
2004	5,460	$205,790.8	$37,691	21.8%	25.5%	3.1%
2005	6,395	$236,357.6	$36,960	17.1%	14.9%	-1.9%
2006	7,358	$257,777.8	$35,034	15.1%	9.1%	-5.2%
2007	7,817	$280,164.4	$35,840	6.2%	8.7%	2.3%
2008	7,406	$290,235.9	$39,189	-5.3%	3.6%	9.3%

Source: MMIS/JUCE.



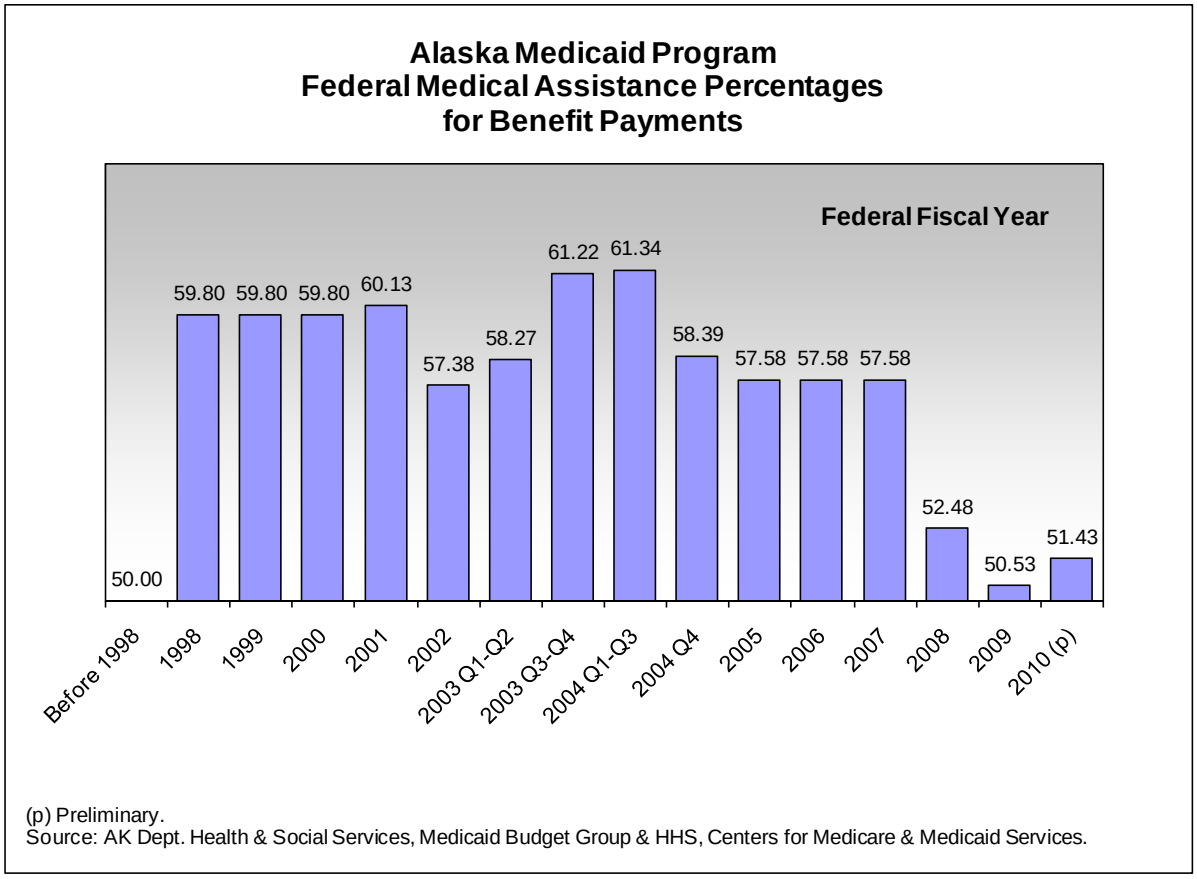
Medicaid Program - Change in Federal Financial Participation: *($748.6) GF/MH, $748.6 Fed*
This fund change request rebalances state and federal funding needs resulting from a 0.9-point increase in the annual rate the federal government reimburses the state for Medicaid benefits.

The new federal medical assistance percentage, or FMAP, takes effect on October 1st at the start of the federal fiscal year. The preliminary rate for FFY2010 is 51.43%, up from 50.53% in FFY 2009. For FFY2010 the preliminary enhanced FMAP is 65.37%. The final rates will be published in December but are not expected to change much from the current estimates.

One in five Alaskans is enrolled in Medicaid at some time each year. By approving the change record, the department will be able to continue to meet its mission of managing health care for Alaskans in need and maintain services at the current level.

The federal and state governments jointly fund Medicaid. The total amount of federal reimbursement for Medicaid depends on a complex array of federal financial participation rates; however, the bulk of the federal funding for Medicaid benefits comes from claims reimbursed at the FMAP rate. (Indian Health Service and family planning service reimbursement rates of 100% and 90%, respectively, are fixed and do not change annually.) U.S. Department of Health and Human Services sets the FMAP rate and it is outside the control of the state government. The FMAP is based on a state's national rank of a three-year average of per capita personal income but can be no less than 50%. The enhanced FMAP reduces the state's share of costs by 30% over the regular FMAP. The enhanced rate can be no lower than 65%.

The average FMAP for the state fiscal year is 51.21% (50.53% from July-September and 51.43% from October-June) and the enhanced FMAP for FY10 will average 65.84% (65.37% from July-September and 66.00% from October -June). Approximately 97% of the Senior and Disabilities Medicaid Services component's claims are reimbursed at the regular FMAP. The remaining 3% is not affected by the change in FMAP.



(p) Preliminary.
Source: AK Dept. Health & Social Services, Medicaid Budget Group & HHS, Centers for Medicare & Medicaid Services.

Add Authorization for Previously Unbudgeted RSA from AK Pioneer Homes: *$872.4 I/A*

This budget increment adds interagency receipt (I/A) authorization to allow Senior and Disabilities Medicaid Services to collect previously unbudgeted receipts from AK Pioneer Homes. This change record budgets for this RSA in full. The Alaska Pioneer Homes gives these receipts to reimburse Medicaid for payments made on behalf of Pioneer Home residents who are eligible for long-term care through one of the Medicaid home and community based waiver programs.

Pioneer home residents who are determined eligible for Medicaid waiver services (i.e. assisted living support) have their Pioneer Home residency paid using federal Medicaid dollars and GF matching funds from the Senior and Disabilities Medicaid Services component budget. The Alaska Pioneer Homes in turn reimburse SDS Medicaid for the GF match portion of these Medicaid payments as I/A. In FY08, SDS Medicaid collected $885.9 I/A in excess of budgeted authorization. This increment would add sufficient I/A authority to meet FY2009 projections.

Senior and Disabilities Services Administration

TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) Level of Care Determinations RSA: *$100.0 I/A*
This change records requests interagency receipts authorization to allow Senior and Disabilities Services (SDS) to spend and collect previously unbudgeted revenue received from Public Assistance. This authorization supports budgeted PCN 06-2380 and related support costs.

Public Assistance provides funding for one position in the Developmental Disabilities/Children With Complex Medical Conditions Waiver unit to make Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Intermediate Care Facility for Mentally Retarded (ICF/MR) level of care decisions for new applicants and renewals. Total case load is approximately 380-400 cases per year and is growing each year. This position will work directly with the Public Assistance Long Term Care Coordinator and any designees in the administration of this part of the TEFRA Medicaid program. This increment allows SDS to collect interagency receipts from Public Assistance to pay for this position.

Transfer PCN 02-1530 to Health Care Svcs, Rate Reveiw: *($109.5) Total- ($82.2) Fed, ($27.3) GF/Match*
PCN 02-1530 has been the only SDS position in charge of establishing or renewing service reimbursement rates for agencies that provide services to SDS beneficiaries. With the creation of a new "Rate-Setting Unit" in the Division of Health Care Services,Rate Review component, this position is being transferred to that unit in the budget effective 7/1/09. This position will be in the process of transitioning to Health Care Services between now and that date, although SDS will pay for this position and its support costs in FY2009. This position has been submitted to the Division of Personnel, Classification Section to be re-classed from a Medical Assistance Administrator II to a Medical Assistance Administrator III (MMA III), this position has been transferred as a MAA III in anticipation of that reclass.

Transfer Administrative positions/funding from Division Support Services/Administrative Support Services: *$296.4Total- $68.9 GF/MH, $194.3 Fed, $33.2 GF/Match*
The Department of Health and Social Services consolidated administrative functions into a centralized unit beginning in FY2005. Over the last year, management has determined that the consolidation did not achieve the desired results and that the positions should be returned to the originating divisions. A total of 78 administrative staff positions will be transferred from DSS/Administrative Support Services in the FY10 Governor's Budget. This move will allow Directors and their administrative teams to function more efficiently and effectively within their divisions.

Positions transferred in this request:
06-1211 Admin Ops Mgr I
02-1818 Admin Asst II
02-7324 Acct Tech III

Add New Positions to Complete Eligibility Assessments: *$330.0 Total- $165.5 Fed; $165.0 GF/Match*
The Division of Senior and Disabilities Services (SDS) is requesting three permanent, full-time positions (PCN 06-#547, 06-#548, 06-#549) to perform eligibility assessments for Medicaid applicants. The demand for eligibility assessments continues to grow commensurate with the

increased number of seniors moving to and/or retiring in Alaska. Without additional staff, the time from when an assessment is requested to when it is completed will continue to increase, causing clients to have to wait longer for the services they need until the assessment is completed. This increased wait time will force clients to move into Assisted Living Homes or Nursing Homes, frequently located outside of their community, away from family and at a much higher cost to the State. The waiver agreements with the Centers for Medicare and Medicaid mandate that assessments will be completed within 90 days of request. For some time the division has been averaging 120 days to complete assessments and is struggling to maintain that timeline with an annual growth in requests for services between 5% and 10%. More problematic is that the division has seven lawsuits related to timeliness of services, assessments and due process. The state's case in these lawsuits becomes weaker as the division falls further behind in timeliness of assessments. Irrespective of the outcomes of the lawsuits, without these positions, SDS estimates that the average number of days from request to assessment will rise to 145+ days by the end of FY2010. If these positions are approved, SDS estimates that the average would drop to 135 days.

Senior Community Based Grants

MH Trust: Aging and Disability Resource Centers: *$125.0 MHTAAR*
The division is requesting $125.0 MHTAAR authorization to distribute to three (3) grantee agencies throughout Alaska that are currently acting as Aging and Disability Resource Centers. These agencies are "no-wrong-door" agencies that can provide valuable information about how to access services to both seniors and persons with developmental disabilities. These agencies provide a valuable community service to vulnerable adults that are seeking Long Term Care either in their home or community based institution.

Aging and Disability Resource Centers (ADRC's) serve as a visible, trusted place for people to go to, for information and assistance with accessing services that support them in the community. The integration of information regarding long term care can reduce the frustration and feelings of being overwhelmed experienced, by people when trying to understand and access available long term care options. ADRC services are unique from other information and referral services because they have the added focus of assisting with streamlining the entrance into long term care services as well as targeted efforts to reach ADRC Users who are able to privately pay for services. The primary target populations are the elderly with Alzheimer ’s disease or related dementia, or people at risk of these conditions, and people with disabilities. However, assistance is provided for anyone who seeks information or referral services on any long-term care issue. The project will be administered by the division, and will unify the referral process for beneficiaries under this service division.

ARDC's provide assistance to seniors and persons with disabilities with completing applications, long-term care options, counseling and decision support. In FY2009, management of the ADRC's is transitioning from Alaska Housing Finance Corporation and the State Independent Living Council to the Division of Senior and Disabilities Services. Regional ADRC's currently operate in Anchorage, Southeast Alaska and the Kenai Peninsula. ADRC's will evolve into a statewide information resource, accessible to all Alaskans via phone, internet and agency outreach. They will also be able to pre-screen individuals for Medicaid and other program eligibility.

The intent is to obtain an annual budget of $750.0 including MHTAAR for this program by the end of FY2011 so additional regional centers may be funded. Full funding of this program will result in the establishment of two additional ADRC's in locations not currently served by the existing centers.

Potential locations include Fairbanks/Interior Alaska, Northwest Alaska region and Southwest Alaska region.

Community Developmental Disabilities Grants

MH Trust: Beneficiaries Projects – Mini Grants for Beneficiaries with disabilities: *$227.5 MHTAAR*

The mini-grants for Alzheimer's Disease and Related Dementia (ADRD) beneficiaries program has been funded by the Alaska Mental Health Trust since FY1999, and is administered through theSenior 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.

Behavioral Risk Management Services for Sex Offenders: *$125.8 I/A*

Add $125.8 I/A receipts to accept funding from the Department of Corrections and grant them out to the Center for Psychosocial Development.

The Department of Corrections provides funding through interagency receipts for specialized sex offender services to individuals that meet the functional definition of developmental disability. These funds are attached to an existing outgoing SDS grant to the Center for Psychosocial Development and will provide behavioral risk management services to include risk assessment, psycho-educational groups, socio-sexual skill training, individual therapy, specialized clinical case management and technical assistance and support.

Explanation of FY2010 Capital Budget Requests

The Division of Senior and Disability Services will be requesting the following capital funding:

- Safety and Support Equipment for Probation Officer and Front Line Workers - $100.0 ($50.0 GF).

Safety and Support Equipment for Probation Officer and Front Line Workers: *$100.0 Total- $50.0 GF, $50.0 Fed*

The furniture (work stations), office equipment, filing cabinets, are needed for new leased space in Anchorage. The number of full-time employees assigned to the Division has more than doubled over the last five years, from approximately 65 positions to 133. The Division has worked hard to maximize existing office space in the Anchorage office by placing two to three employees into single person offices. This solution was less than ideal and now capacity has been reached for any additional utilization of existing space. As a result, we are relocating to a new location. In addition to staff growth, the division has seen, and continues to see, dramatic growth in the number of individuals utilizing the Division's programs, due in large part to the increasing number of seniors in Alaska. This has created a significant need for client file storage, another area where the Division will soon exceed capacity. Moving to larger office space will accommodate existing staff and files and allow room for continued growth. The amount requested is based on 105 employees and approximately 25,000 square feet of space.

Challenges

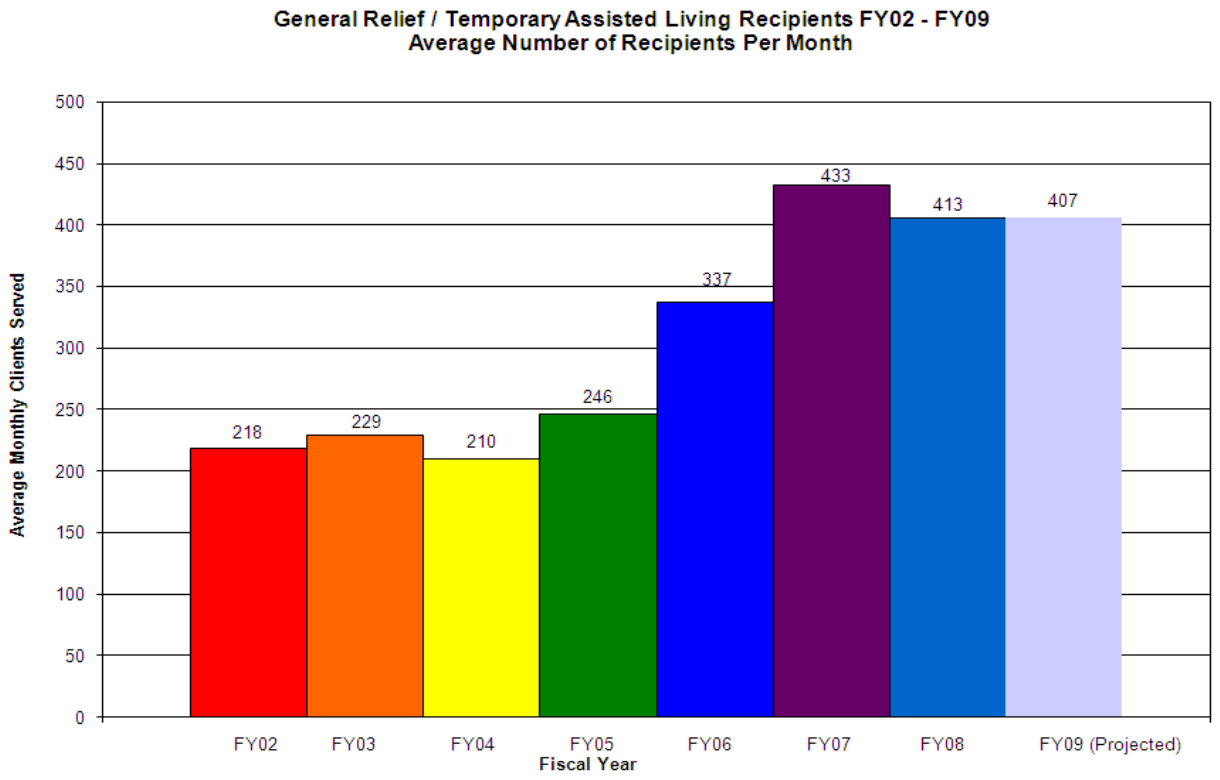
Senior and Disabilities Services face many on-going and new challenges in FY2010.

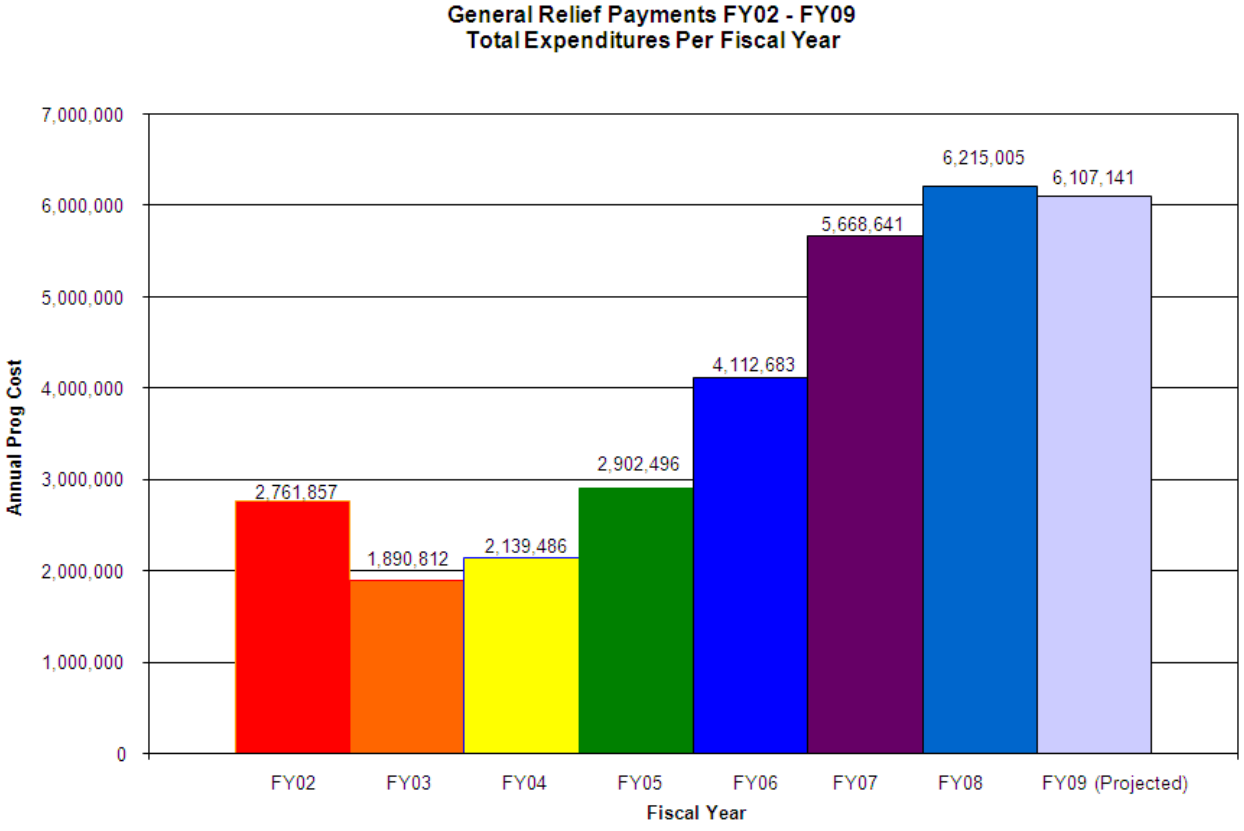
Ongoing challenges include eliminating the Developmental Disabilities Waitlist Registry and implementing timely eligibility assessments for Medicaid applicants.

FY2009 Legislative Intent Language directs Senior and Disabilities Services (SDS) to review and revise regulations for General Relief / Temporary Assisted Living to minimize the length of time that the state provides housing alternatives and assure the services are provided only to intended beneficiaries who are actually experiencing harm, abuse or neglect. The department should educate care coordinators and direct service providers about who should be referred and when they are correctly referred to the program in order that referring agents correctly match consumer needs with the program services intended by the department. The legislature also intends that the $1,000.0 increment in the FY2009 budget for Senior Community Based Grants be used to invest in successful home and community based supports provided by grantees who have demonstrated successful outcomes documented in accordance with the department's performance based evaluation procedures.

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 for this program have nearly doubled. SDS can attribute some of these program cost increases to the rising demographic of older Alaskans. The Adult Protective Services Unit (APS) has also been steadily adding staff positions to this unit since FY04, recent public feedback says that the current APS group is more responsive than it has been for many years. As a result, this program is more readily accessible and APS staff is able to respond to a greater number of reports of harm, abuse and/or neglect. SDS is actively working with Behavioral Health to determine how many clients served by SDS would be more appropriately served used mental health dollars. Behavioral Health grants their General Relief / Temporary Assisted Living funds to the Anchorage Community Mental Health Center. When that agency's grant dollars run out, they have to stop serving clients, at which point they are either referred to the SDS General Relief / Temporary Assisted Living Program by care coordinators, hospital discharge planners, etc., or the person ends up homeless and meets the definition of "vulnerable adult." Once they meet the definition of "vulnerable adult" SDS is mandated to provide temporary assisted living services to them.


General Relief / Temporary Assisted Living Recipients FY02 - FY09
Average Number of Recipients Per Month
Average Monthly Clients Served
500
450
400
350
300
250
200
150
100
50
0
218
229
210
246
337
433
413
407
FY02
FY03
FY04
FY05
FY06
FY07
FY08
FY09 (Projected)
Fiscal Year


General Relief Payments FY02 - FY09
Total Expenditures Per Fiscal Year
Annual Prog Cost
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
2,761,857
1,890,812
2,139,486
2,902,496
4,112,683
5,668,641
6,215,005
6,107,141
FY02
FY03
FY04
FY05
FY06
FY07
FY08
FY09 (Projected)
Fiscal Year

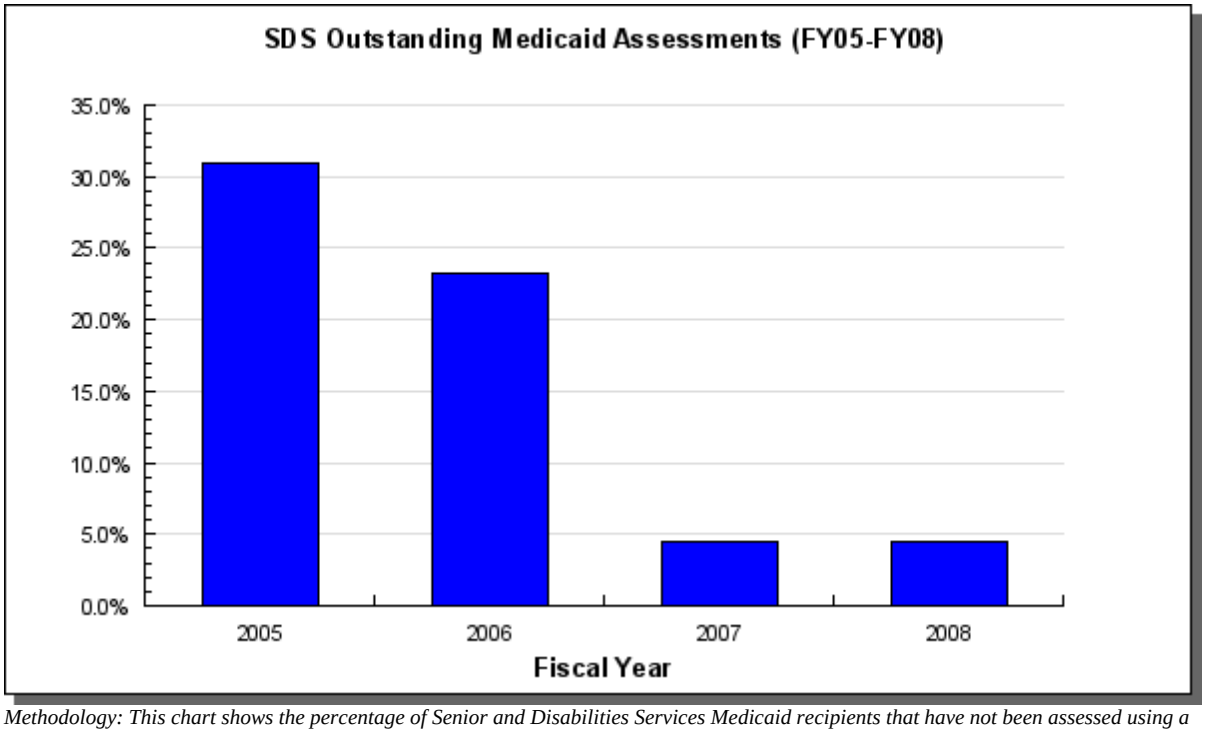
Senior and Disabilities Services Results Delivery Unit

Contribution to Department's Mission

The mission of the Division of Senior and Disabilities Services is to promote the independence of Alaskan seniors and persons with physical and developmental disabilities.

A: Result - Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%.
Status #1: SDS is currently assessing approximately 95.5% of applicants for Medicaid services. There is a small percentage of applicants for CCMC Waiver Services that cannot be easily assessed with a standard assessment tool. These applicants make up the majority of the 4.5% of recipients not being assessed on the chart below.



Methodology: 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-FY08.

SDS Outstanding Medicaid Assessments (FY05-FY08)

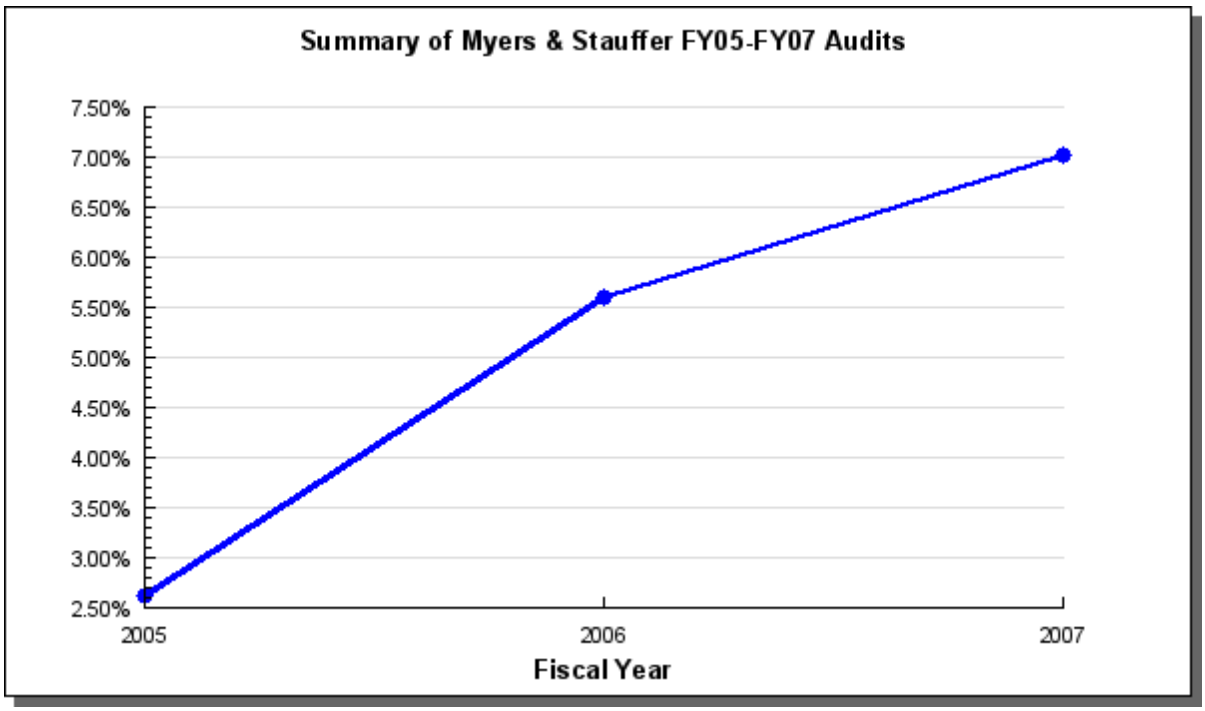
Fiscal Year	% Not Reviewed
FY 2008	4.5%
FY 2007	4.5%
FY 2006	23.18%
FY 2005	30.9%

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 FY2005-2008. 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 back-log but will not be caught up until all recipients receiving PCA services have been assessed. SDS is working hard to get all assessments completed within 30 days of assignment to an assessor.

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% by providing adequate training to provider agencies.

Status #1: Current Medicaid payment error rates are less than 10% each year from FY2005-FY2007. However, SDS is not hitting the target goal of a 10% reduction in error rate from each period year's rate; in fact, error rates have increased. SDS will work towards more provider agency training.



Methodology: Myers & Stauffer presents their audit findings in the early spring each year. FY08 error rate updates should be out at that time.

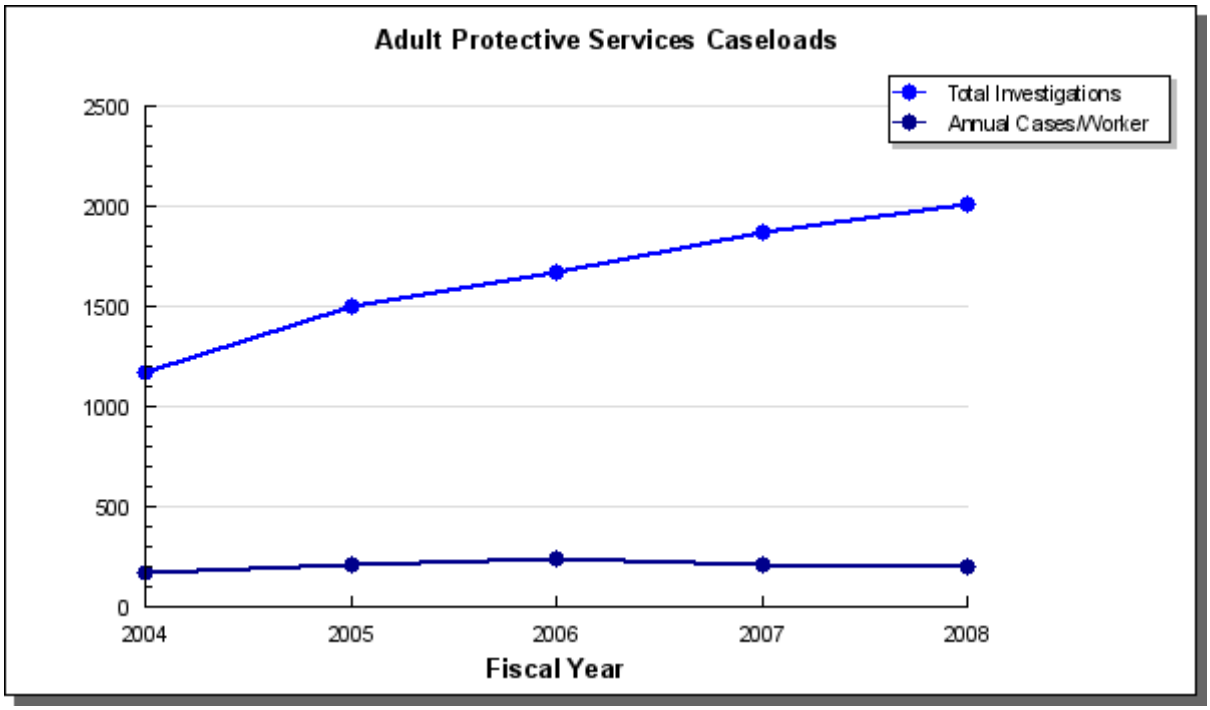
Summary of Myers & Stauffer FY05-FY07 Audits

Fiscal Year	Error Rate
FY 2007	7.03%
FY 2006	5.61%
FY 2005	2.63%

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 after audit findings have been presented to the appropriate agencies and have been given a chance to respond. This process eliminates some initial audit findings. Audits are completed in the spring following the end of each fiscal year. FY2008 audits will be completed in the spring of 2009.

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%.
Status #1: The National Adult Protective Services Association recommends an average case load of 25 cases per worker. The national average is approximately 35 cases per worker. SDS Adult Protective Services staff carries case loads of approximately 78 cases per case investigator, more than 3 times the recommended national average.

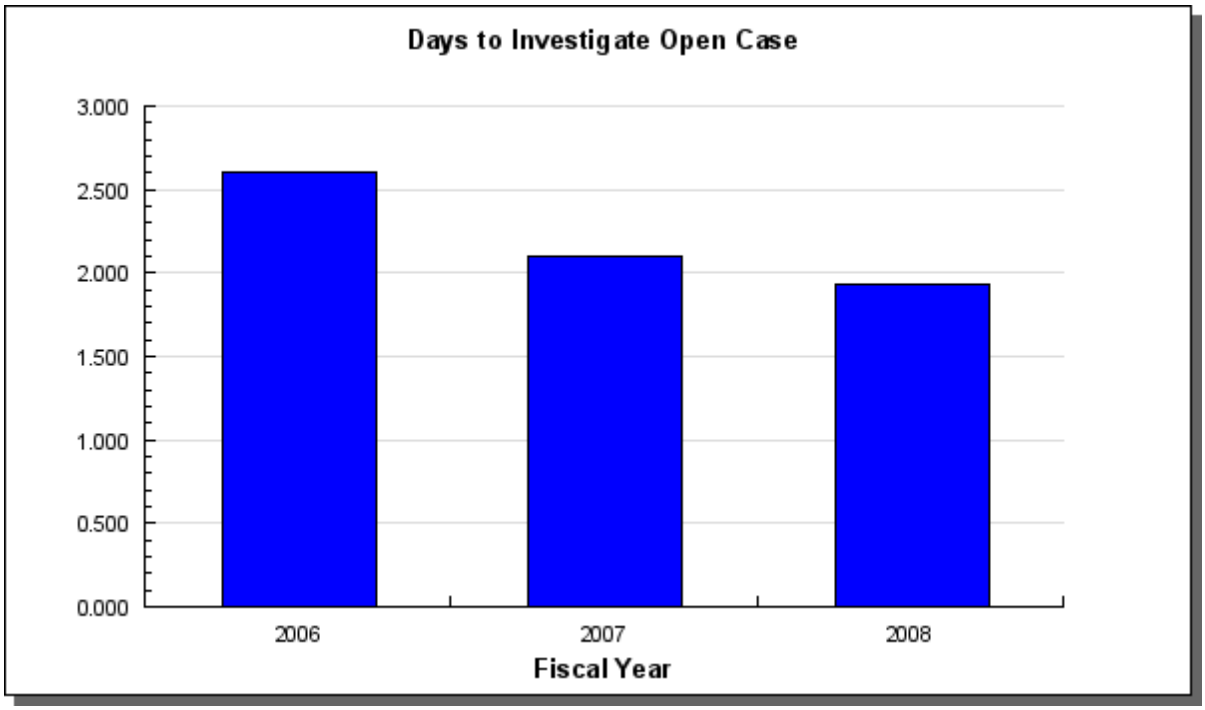


Adult Protective Services Caseloads

Fiscal Year	Total Investigations	Full Time Workers	Annual Cases/Worker	Days to Investigate
FY 2008	2013 +7.88%	10 +11.11%	196 -5.31%	2.24 +6.67%
FY 2007	1866 +12%	9 +28.57%	207 -13.03%	2.1 -19.23%
FY 2006	1666 +11.29%	7 0%	238 +11.21%	2.6 0%
FY 2005	1497 +27.62%	7 0%	214 +27.38%	0 0%
FY 2004	1173	7	168	0

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) case worker was steadily on the rise from FY2004 to FY2006. From FY04 to FY05, the average caseload increased by more than 27%. From FY2005 to FY2006, the average caseload increased again, this time by more than 11%. From FY2006 to FY2007 the average caseload decreased by more than 13% 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 the addition of two new positions in FY2009, Senior and Disabilities Services will expect to see a decrease to the number of annual cases per case worker. The APS Unit received two new case manager positions in the FY09 budget and has just recently filled the last vacant position in the unit. With the new positions, the APS Unit will have four supervisors, seven case investigators, two case managers and two intake workers. With this many staff, SDS is optimistic that case load numbers will decrease to more manageable levels.

Target #2: Reduce length of time a case is open by 10%.
Status #2: Adult Protective Services case investigators have ten days to investigate a report of harm, abuse and/or neglect. The highest average number of days it takes to investigate a new case is 2.6 days.



Days to Investigate Open Case

Fiscal Year	Days to Investigated	YTD Total
FY 2008	1.932 -8%	1.932 -8%
FY 2007	2.1 -19.23%	2.1 -19.23%
FY 2006	2.6	2.6

Analysis of results and challenges: The average length of time it took to investigate a new case was approximately 2.6 days in FY2006, when there were only seven case workers. In FY2007, 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 FY2008, SDS added three additional positions, for a total of 12. With these new positions, Senior and Disabilities Services anticipates a decrease to the number of annual cases per worker of more than 13.75%. Senior and Disabilities Services anticipates that with additional new staff being added in FY2008 that the number of days it takes 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 & 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;
- Community Initiative Grants;
- 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. (AS 18.05: Health, Safety and Housing)

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, and Web-based communication. (AS 18 Health, Safety and Housing; AS 44.29 Department of Health and Social Services)

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. (AS 47.05; AS 47.07; 7 AAC 43.1440-1490)

Community Initiative Grants
The Community Initiative Grants 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. (Administrative Order #221)

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. (AS 37.10: Financial Management; AS 37.07: Budget Section; AS 36.30 Procurement Section, 7 AAC 78 and 81 Grant Regulations; Audit Section PL 98-502 Single Audit Act Amendments of 1996, PL 104-156 and OMB Circular A-133.

Hearings and Appeals
The Hearings and Appeals component conducts appeals for Medicaid, Chronic & Acute Medical Assistance, and Division of Public Assistance regarding rates and recipient benefit appeals. (AS 47.07; AS 47.08 and AS 47.25)

Facilities Management
The Facilities Management component includes the management of the department's capital programs. (AS 37.07.062 Capital Projects – Responsible for preparation, submission and competent management of annual capital budget requests.)

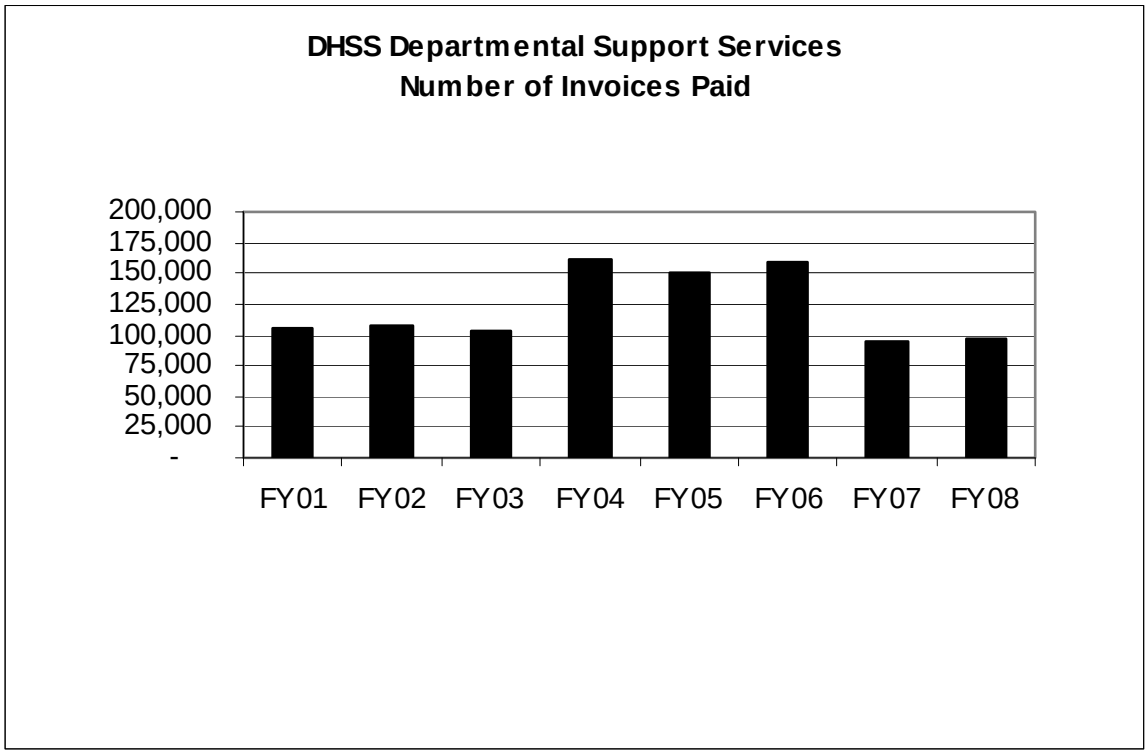
Medicaid School Based Claims
The Medicaid School Based Claims component improves health services access and availability for Medicaid-eligible children and families. (AS 18.05 Health, Safety and Housing)

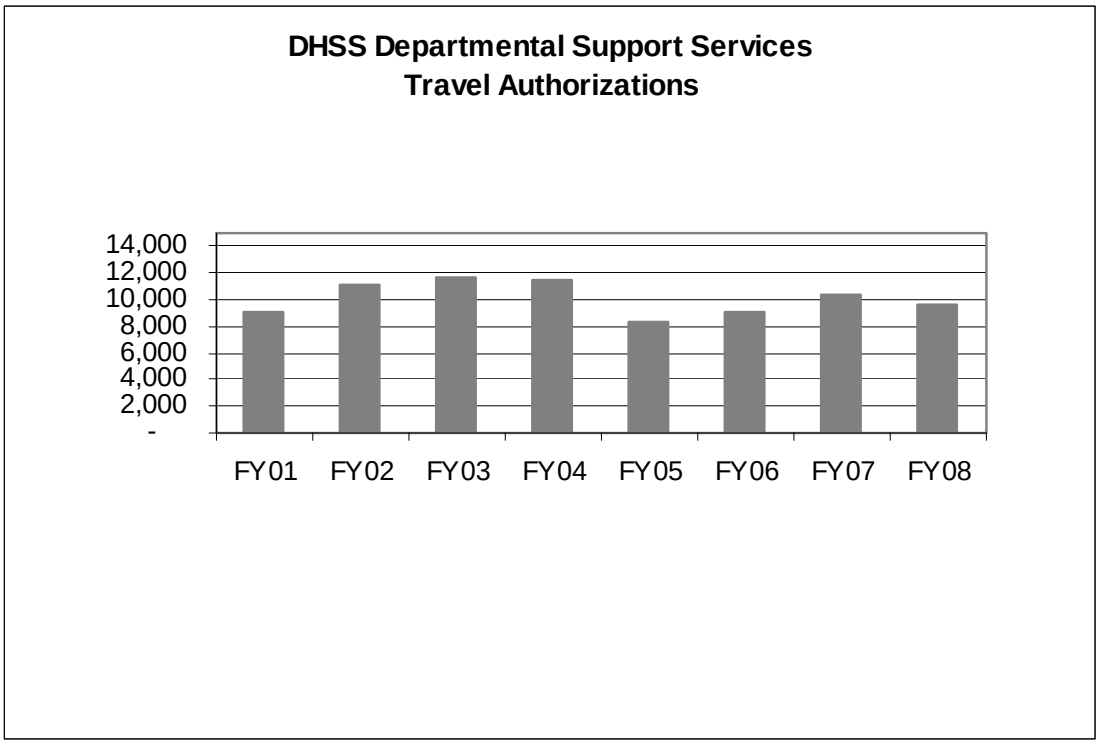
Information Technology
The Information Technology component's focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the department.

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. (AS 29.60.600 Human Services Community Matching Grants)

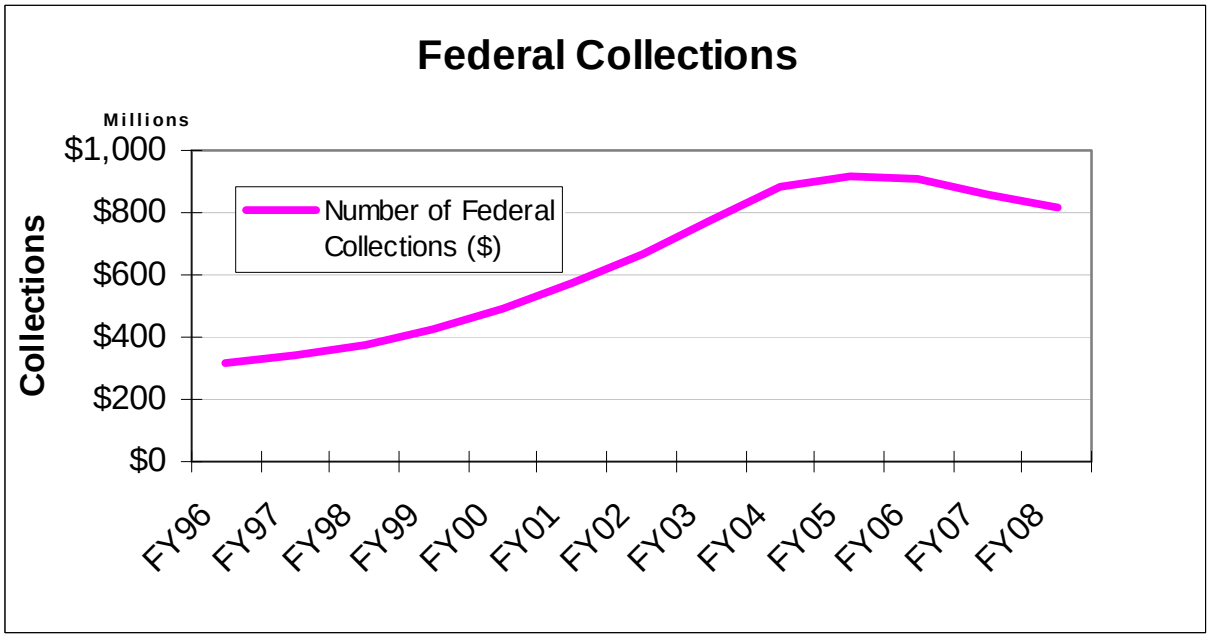
Finance Section
The Finance Section within the Division of Administrative Services supports all the Divisions and programs within Health & Social Services. It is responsible for financial accounting and related support services. Following is the Finance Section Activity from FY2000 to FY2008:





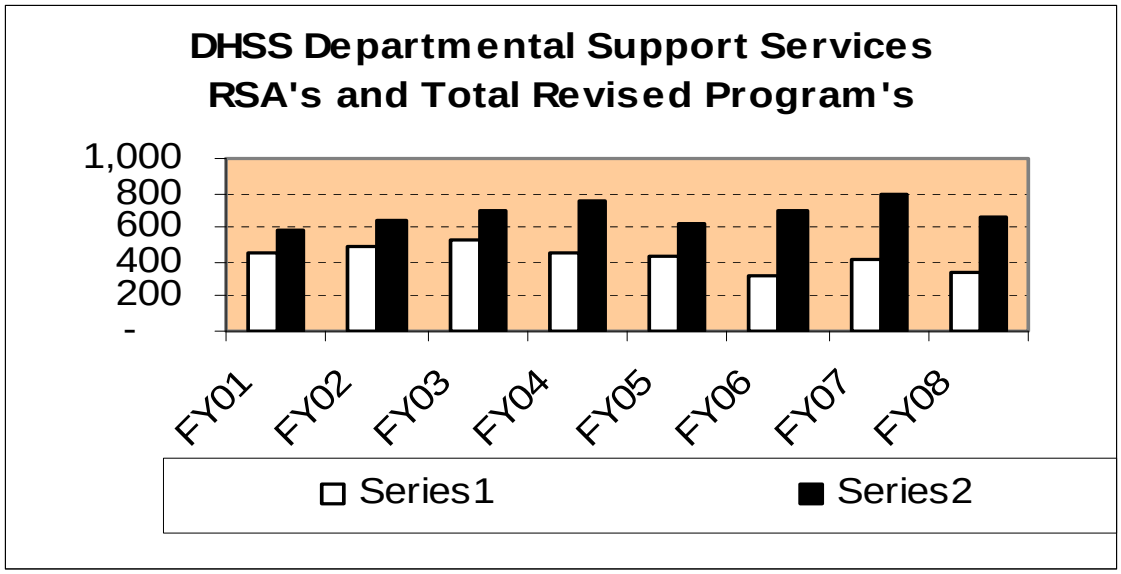
Revenue Section

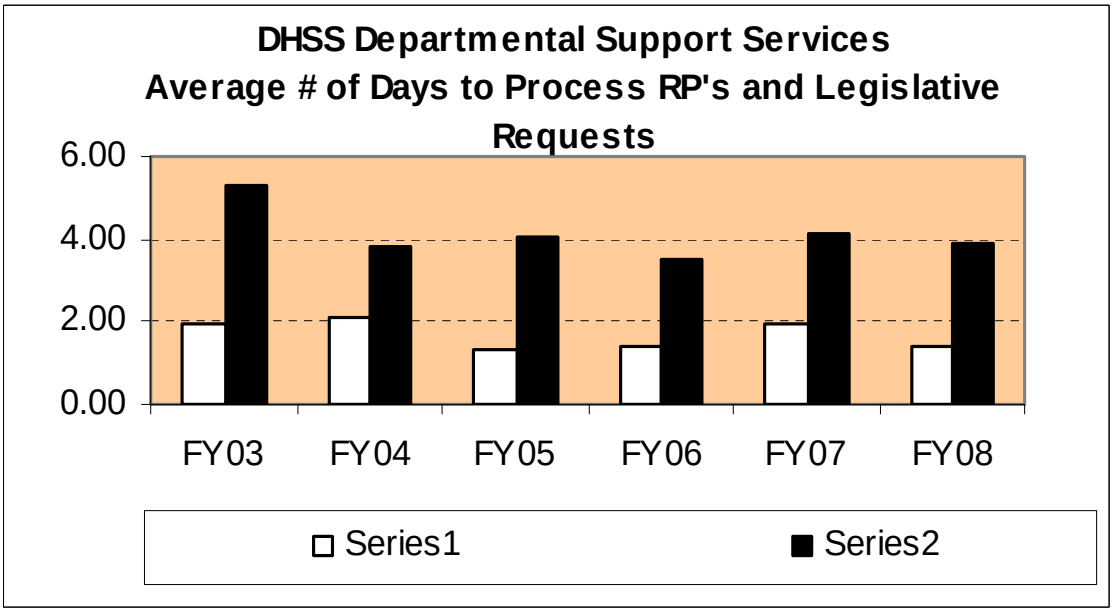
The Revenue Unit is responsible for all federal reporting and revenue collections for the department. The following chart shows a level of activity for the Revenue Unit for collections of federal funds.



Budget Section
The 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 FY2001 through FY2008 and the average number of days to respond to requests for FY2003 to FY2008. 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 5 to 3 days, a decline of 40%.





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 is 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.

In partnership with the Rasmuson Foundation the DHSS Grantee Partnership Project implements process changes to streamline grant management and administration for both DHSS and its grantees. The overall objectives of this project are to reduce the administrative burden for DHSS while ensuring adequate fiduciary control; increase grantee satisfaction and reduce the administrative burden for grantees to interface with DHSS.

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 Strategic Planning. 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.

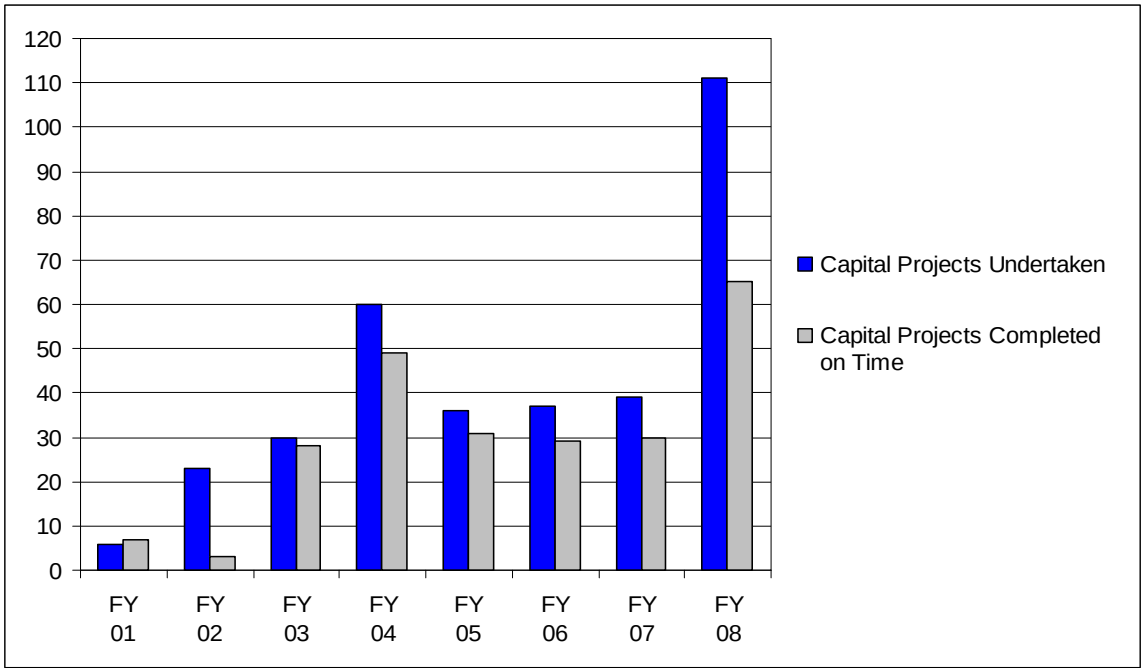
The Network Services unit is responsible for developing and maintaining the wide area and local area network infrastructure for the Department. The Customer Services unit is responsible for providing total computer desktop & laptop support for the Department's staff across the state as well as providing 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.

DHSS Computing Environment:	
Number of Desktops & Laptops:	3510
Number of Servers:	292
Number of Networks Statewide:	144
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 FY08: 21,628 Average of 78 calls per day in FY08	
Number of Communities where IT Infrastructure is Located:	36
Number of Business Applications	238

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 is responsible for maintaining 43 state owned buildings with an estimated area of 903,000 square feet throughout Alaska, at a replacement value of $650.3 million.

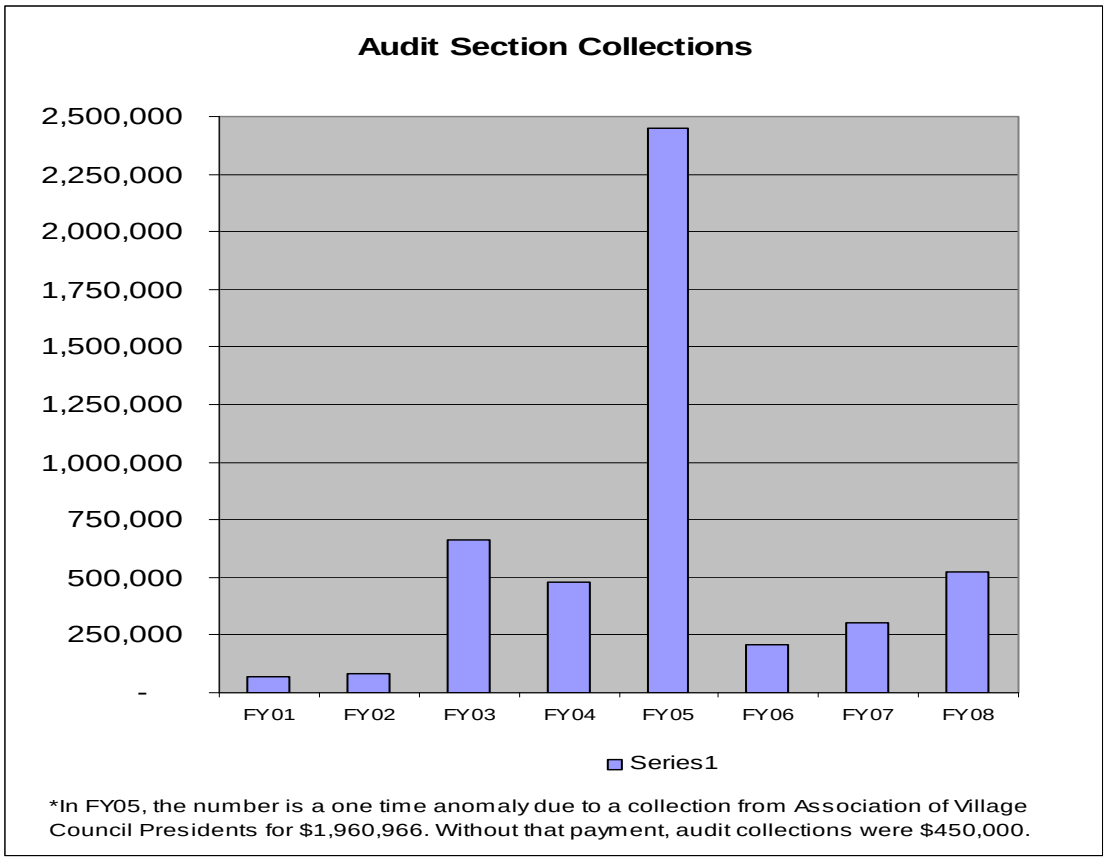
The following chart shows the level of activity within the Facilities Management Section for FY2001 through FY2008.



In addition, the Facilities Management Section administers all capital grants including pass-through federal funds from the Denali Commission. In FY2008, 39 new grants were issued valued at $5.1 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 Section collections for FY2001 through FY2008:



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 Persons
AS 47.08	Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25.001-.095	Day Care Assistance and Child Care Grants
AS 47.25.120 -.300	General Relief Assistance
AS 47.25.430 -.615	Adult Public Assistance
AS 47.25.975 - .990	Food Stamp Program
AS 47.27	Alaska Temporary Assistance Program
AS 47.30.660	DHSS and AMHTA for Comprehensive Integrated Mental Health Plan Social
AS 47.30.660	Welfare, Social Services and Institutions, Mental Health, Alaska Mental Health Board
AS 47.55	Pioneers' Homes
Security Act:	Title XVII Medicare, Title XIX Medicaid, Title XXI Children's Health Insurance Program
7 AAC 9/12	Health & Social Services, Design and Construction of Health Facilities
7 AAC 07.010	Health and Social Services Certificate of Need Aide Training and Supervision Grants
7 AAC 13	Health & Social Services, Assistance for Community Health Facilities
7 AAC 26.950-960	Emergency Medical Services
7 AAC 43	Medical Assistance

7 AAC 43.670-709	Medical Assistance, Health & Social Services
7 AAC 48	Chronic and Acute Medical Assistance
Title 7	CFR Part 270 to End
Title 7	CFR Part 273.15-16
Title 42	CFR Part 400 to End
Title 45	CFR Part 200 to End
Admin Order #221	Governor's Advisory Council on Faith Based & Community Initiatives

Department Support Services	2009	2010 Gov	09 to 10 Change
General Funds*	21,858.2	19,395.0	-2,463.2
Federal Funds	24,331.6	22,017.2	-2,314.4
Other Funds	10,312.6	9,629.4	-683.2
Total	56,502.4	51,041.6	-5,460.8

*Includes Human Services Community Matching Grants $1,485.3 GF
Community Initiative Matching Grants-$671.1 GF, $12.4 Fed, FY2009 and $673.6 GF, $12.4 Fed, FY2010

Commissioner's Office

Mental Health Trust Grantee Partnership Project: *$346.1 Total- $100.0 GF; $196.1 SDPR, $50.0 MHTAAR*

The Grantee Partnership Project will begin by implementing recommendations provided by the partnering group and approved by steering committee. Ongoing efforts will be to:

- Develop policies and procedures for Department internal communication to ensure a timely process of issuing RFP's, RFLOI's, Grant Awards, Payment Advances, and Technical Assistance, while gathering only the appropriate reporting information required for evaluation.
- Improved grantee relations by working together as partners in efforts to provide the highest level of services and to increase the amount of services available to the citizens of Alaska.
- Streamline the grant process to eliminate the administrative inefficiencies that reduce success among programs and limit the amount of direct services to the citizens of Alaska.
- Develop and train grantees and Department staff on how to use Logic Models, which will guide program managers through a strategic planning process.

The Rasmuson Foundation has committed $519,150 over three years to this project and the Mental Health Trust has committed $50,000 for FY2009. Upon review and continued progress, the Mental Health Trust Authority has indicated a willingness to award another $50,000 in FY2010 and again in FY2011. The Mat-Su Health Foundation has partnered with the Foraker Group to provide Logic Model Training to the Department staff as well as non-profit organizations statewide through a direct grant from the Mat-Su Health Foundation to the Foraker Group.

Administrative Support Services

Transfer Administrative Positions out to Divisions

The Department of Health and Social Services consolidated administrative functions into a centralized unit beginning in FY2005. Over the past year management has determined that the consolidation did not achieve the desired results and that the positions should be returned to the originating divisions. A total of 78 administrative staff positions will be transferred from DSS/Administrative Support Services in the FY2010 Governor's Budget. This move will allow Directors and their administrative teams to more efficiently and effectively manage their divisions.

Explanation of FY2010 Capital Budget Requests

Department Support Services will be requesting the following capital funding:

- Non-Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment - $2,203.9 ($2,000.0 GF)
- Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment - $2,000.0 GF
- E-Grants - $431.1 ($388.0 GF)
- Personal Information Protection Data Encryption $818.1 ($736.3 GF)
- Health Insurance Portability and Accountability Act Compliance $1337.4 ($668.7 GF)
- Disaster Recovery $409.1 ($368.2 GF)
- Contract Management Automation System $472.8 ($425.5 GF)
- MH Deferred Maintenance and Accessibility Improvements $750.0 (GF/MH)
- MH Housing – Home Modification and Upgrades to Retain Housing $1,050.0 ($500.0 GF)

Non-Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: *$2,203.9 Total- $2,000.0 GF, $203.9 Fed*

This request is for deferred maintenance and renovation projects for 35 facilities maintained by the Department including health centers, youth facilities and behavioral health facilities statewide with a combined replacement value of $343 million. Funds would be used for immediate and critical renewal, repair, replacement and equipment needs in state-owned facilities

This year, the department is requesting $2.2 million to address the following documented deficiencies. The funding is managed by the Department's Facilities Section. They are tasked with the challenge of addressing as many of these projects as funding will allow. The projects below are listed in priority order.

E-Grants**:** *$431.1 Total- $388.0 GF, 43.1 Fed*

The request is to complete the E-Grant project by providing on-line grant application capability, narrative report document depository, conversion to .NET in compliance with State standards, and the integration of capital and operating grants. eGrants was developed as part of a department-wide effort to improve the Department of Health & Social Services (DHSS) grant process, to simplify and unify procedures, to reduce administrative burdens for both the State and grantees, to enhance communication, and to improve customer (grantee) satisfaction.

Personal Information Protection Data Encryption: *$818.1Total- $736.3 GF, $81.1 Fed*

The Personal Information Protection Data Encryption project is an effort by the Department to comply with the Alaska Personal Information Protection Act (APIPA), as well as 45 CFR § 164.312(a)(2)(iv), a section of the Health Insurance Portability and Accountability Act (HIPAA). The Department's intent is to comply with the legal requirements by encrypting all sensitive data, including electronic protected health information. Data encryption of personal information will safeguard citizens and significantly reduce the risk that a security breach will impact Alaskans.

Health Insurance Portability and Accountability Act Compliance: *$1337.4 Total- $668.7 GF, $668.7 Fed*

The Health Insurance Portability and Accountability Act (HIPAA) compliance project is a multi-year, multi-phased effort to bring the Department into compliance with 45 CFR parts 160, 162, and 164. Major phases of the project include: initiate and complete risk assessment of DHSS IT systems;

implement comprehensive auditing and logging capabilities to track access to Electronic Protected Health Information (EPHI); strengthening department data center defenses to prevent unauthorized access to EPHI; and provide redundant failover for critical IT systems.

Disaster Recovery: *$409.1Total- $368.2 GF, $40.9 Fed*
The Department of Health and Social Services (DHSS) is responsible for housing important data regarding citizen's public health and welfare. During an emergency or crisis situation critical systems in the Department must continue to work. This project will assess these critical systems, and implement a plan for providing continued functionality during an emergency situation. A Continuity of Operations Plan (COOP) will establish guidelines, procedures and contingencies to ensure that important data required for the health and welfare of Alaskans can still be accessed.

Contract Management Automation System: *$472.8 Total- $425.5 GF, $47.3 Fed*
This capital project will create an information management system for contracts and leases, within the Section of Grants and Contracts in the Division of Finance and Management Services. This project will incorporate lease management into the final product for a unified contract/leasing system.

This initiative is intended to streamline the way the Department manages contracts. Currently, a non-compliant database is used to track contracts. There is no way to create contracts in the system, no data safeguards are installed, best practices for database development were not followed, and the system has limited management reporting abilities. The Department's building leases are currently tracked only by a spreadsheet, which has no management reporting capabilities.

MH Deferred Maintenance and Accessibility Improvements: *$750.0 GF/MH*
Funds will be awarded statewide to agencies on a competitive basis for deferred maintenance, including facility renovation, repair, or upgrade and accessibility improvements. The funds are needed to keep program facilities operational and accessible.

The ongoing need for this project has been well documented by the Alaska Mental Health Trust Authority, the beneficiary boards and the Comprehensive Integrated Mental Health Plan, *Moving Forward*. The unmet need for deferred maintenance is also documented by the consistent number of applicants that are left unfunded by each Request for Proposal (RFP) due to the limited funds available for this grant program. Maintenance of buildings housing treatment offices, residential services and administrative offices is a continual problem for providers serving Mental Health Trust beneficiaries. Some agencies have staff working in buildings that are in serious states of deterioration and disrepair. Clients are sometimes housed in residential programs in which maintenance and repair needs are extensive.

MH Housing – Home Modification and Upgrades to Retain Housing: *$1,050.0 Total- $500.0 GF, $300.0 MHTAAR, $250.0 Other*
This capital project provides housing modifications for persons experiencing a disability, allowing them to remain in their homes and potentially reducing the cost of providing supported housing. This project increases the accessibility of current housing so that Trust beneficiaries and other special needs populations can move into or remain in their own homes. Home modifications are available to people wherever they reside, regardless of whether they own or rent and with whom they live. Typical kinds of assistance provided are accessibility modifications or additions (e.g., widening doorways, remodeling bathrooms or kitchens, installing entrance ramps, adding bathrooms or bedrooms) and related equipment.

Challenges

As the administrative and management of the department, FMS and the Commissioner's Office are in a unique position to understand overall department challenges as well as specific impacts on our operations.

Audit requirements & 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.

Fairbanks Youth Facility Siding Replacement:
The T1-11 siding is old, weathered and needs to be replaced.

Fairbanks Youth Facility Condensation pan replacement:
The condensation pan on the heating and ventilation system is rusted and leaking and needs to be replaced.

Sitka Pioneers Home Wall Repair:
The rock wall at the home is deteriorating and needs to be repaired.

Anchorage Pioneer Home Driveway Entrance Repair:
The entrance curb to the home has been damaged over the years by snow plows during the winter and needs to be replaced.

Departmental Support Services Results Delivery Unit

Contribution to Department's Mission

Provide quality administrative services in support of the Department's mission.

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%.
Status #1: DHSS administration overhead costs have met the goal of being under 2% in each of the last four years (FY2005 – FY2008).

Percentage administration personal services is to total department FY budget

Year	YTD Total
2008	1.6%
2007	1.6%
2006	1.4%
2005	1.3%
2004	4.3%
2003	3.6%

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. This number is compared to the total DHSS expenditures. This is done once a year after the year is completed.

Target #2: Process capital grant payments within five days.
Status #2: In FY2007 and 08 the department initiated internal changes in the payment request process. These efficiencies allowed us to exceed our goal of a 5-day turnaround.

Number of days to process a grant payment after receiving reports.

Fiscal Year	YTD Total
FY 2008	1.50 days
FY 2007	1.50 days
FY 2006	3.36 days
FY 2005	3.11 days
FY 2004	4.89 days
FY 2003	5.60 days

Analysis of results and challenges: In FY2006, there were 93 capital grant payments, all processing within five days. In FY2007, there were 101 capital grant payments, all processing within five days. In FY08 there were 131 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.
Status #1: In the most recent years (since FY04) response times to legislative requests have met or exceeded the 80% goal of responding to legislative inquiries within five working days.

% of Responses for Legislative Requests made within five working days

Fiscal Year	YTD Total
FY 2008	79%
FY 2007	72%
FY 2006	80%
FY 2005	79%
FY 2004	78%
FY 2003	83%
FY 2002	83%

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 CY2003, 186 in CY2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported by calendar year, but starting in (2005) the data is collected by fiscal year. The average processing time for the 179 requests in FY 2006 was 3.52 days. 80% were completed within five working days.

In FY 2007, the number of requests increased 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.

In FY08 requests dropped to 148, largely due to the reduced session time of 90 days. The average processing time also dropped to 3.9 working days with 118 of the requests receiving responses in less than 5 days.

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.
Status #1: During FY2008, IT struggled to provide timely response to service calls due to the increased number of applications, increased customers outside HSS and reliance on another department due to email migration.

Average Number of Days to Complete Service

Fiscal Year	YTD Total
FY 2008	9.9 days
FY 2007	7.1 days
FY 2006	4.9 days
FY 2005	8.2 days

Methodology: FY 2005 data represents only 3 quarters. This measure began at the start of the 2nd quarter. FY 2006, FY 2007 and FY2008 contain a full year.

Analysis of results and challenges: In late FY2007, the tool used for measuring performance underwent restructuring and categories measured increased from 13 to 26. Examples of these categories are, but not limited to: setting up accounts, application work, password setup, procurement of equipment, relocation of equipment, security, training, software/web/hardware or file maintenance.

During FY08, ten new applications activated, including applications which incorporated additional customers from outside of the department. Without additional IT support staff, FY08 support incorporated an increase of customers and additional support requirements.

At the beginning of FY2008, DHSS migrated from our internal Exchange email system to the Enterprise Exchange email. During this timeframe, customer call resolution response time increased due to the required interaction with staff outside our department and their response time. The number of days required to create or modify email accounts has increased from 3 days to approximately 7 days.

In addition, FY2008 also saw an increase in long-term security and training projects. When customer service staff was committed to these projects, some delays resulted in routine service call response time.

Target #2: 85% of construction projects completed on time and within budget.
Status #2: Due to a change in the method for managing construction contracts, twice as many projects were completed in FY08 as the previous year.

Percent of Completed Construction Projects On Time and Within Budget.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2008	70%	83%	63%	81%	74.25%
FY 2007	64%	56%	78%	80%	73.00%
FY 2006	100%	100%	56%	85%	85.25%

Analysis of results and challenges: The Department began tracking construction projects in FY2006.

In FY2008 the department completed 81 projects, 65 of which were completed on time and 76 within budget. Twice as many projects were completed as in FY2007. This is due to a change made in the method used internally for construction contract management. Changes made have increased performance, consistency, and quality of work.

Boards and Commissions

Mission

Boards, commissions and councils of the RDU play an important role in government by providing a mechanism for broad-based, on-going 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. AMHB is responsible for participating in the evaluation of the mental health program. AMHB provides a forum for public input about the behavioral health system and advocates for Alaskans affected by mental illness.

The Advisory Board on Alcoholism and Drug Abuse (ABADA) 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) is charged with providing recommendations to the Governor, the Legislature, and the Administration for policies, programs and services that promote the dignity, independence and quality of life for older Alaskans and provide support for their family caregivers; preparing a comprehensive four-year Alaska State Plan for Senior Services in accordance with the provisions of the Older Americans Act for the Department of Health and Social Services and implementing the Plan in collaboration with agency partners; and participating in the ongoing planning and implementation efforts of the Comprehensive Integrated Mental Health Plan.

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 and Advisory Board on Alcoholism and Drug Abuse
The Boards gather information from consumers and families, providers, community members, and other stakeholders in their work to:

- Plan for an integrated, comprehensive behavioral health system;
- Coordinate with other Boards, agencies, and programs to use resources most effectively;
- Educate Alaskans about behavioral health issues, availability of services, possibilities for recovery and the problems of stigma.
- Advise all branches of government on most effective treatment responses to behavioral health conditions;
- 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
The Alaska Commission on Aging (ACoA) plans services for older Alaskans and their caregivers, educates Alaskans about senior issues and concerns, and advocates to improve programs and services that affect the quality of life for older Alaskans and are cost effective. Specifically, the Commission advises the Governor, Legislature, and Administration about the status of Alaska seniors and provides recommendations with respect to legislation, appropriations, and regulations for programs and services benefiting older Alaskans; coordinates the development and implementation of the four-year Alaska State Plan for Senior Services; collaborates with the Department, AMHTA, and other stakeholders on policy development; encourages public input and participation; collaborates and coordinates with other agencies and stakeholders; and participates in community education activities to raise public awareness about senior issues.

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's Home Advisory Board
The Advisory Board holds annual meetings and regular teleconferences to solicit comments and criticisms from Pioneer Home residents, families, friends, staff and the public. They consider all observations in their recommendations to the Governor.

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, Persons with Disabilities
PL 106-402	Programs for Individuals with Developmental Disabilities
PL 105-17 Part B and C	Individuals with Disabilities Education Act

Pioneers Homes Advisory Board

AS 44.29.500	Alaska Pioneers' Homes Advisory Board

Boards and Commissions	2009	2010	09 to 10 Change
General Funds	519.7	1,031.6	511.9
Federal Funds	1,776.4	1.792.9	16.5
Other Funds	1,932.4	1,815.5	-116.9
Total	4,228.5	4,640.0	411.5

The Mental Health Trust Authority Authorized Receipts (MHTAAR) projects will have slight increases.

DHSS FY2010 Governor's Budget--General and Other Fund Requests (Increments and Decrements only)			
Division	**Item**	**GF**	**Other**
AKPH			
	Additional Direct-Care Staff Funded by a Rate Increase		600.0
	Increase Funding for On-Call Substitute Certified Nurse Aides		55.2
	Delete One-time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	(960.1)	
	Alaska Pioneer Home Subtotal	***-$960.1***	***$655.2***
DBH	Community Mental Health Services Pilot for Department of Corrections	500.0	
	Medicaid Program - Adjust Authorization for Current Trends	(3,800.0)	
	Medicaid Program - Formula Growth	2,670.5	
	Add Funding for AKAIMS Dedicated Information Technology Staff	150.0	
	MH Trust: BTKH - Technical Assistance	100.0	
	MH Trust: BTKH - Technical Assistance		100.0
	Increase SDPR for Telepsychiatry		200.0
	MH Trust Cont - IMPACT model of treating depression		70.0
	MH Trust: Dis Justice - Grant 569.04 ASAP Therapeutic Case Management and Monitoring Treatment		135.0
	Reverse FY2009 MH Trust Recommendation		(141.0)
	MH Trust: Dis Justice - Grant 1192.03 Expand Treatment Capacity Therapeutic Court Participants w/ Co-occurring Disorders	75.0	
	MH Trust: Dis Justice - Grant 1192.03 Expand Treatment Capacity Therapeutic Court Participants w/ Co-occurring Disorders		75.0
	MH Trust: Dis Justice - Grant 585.04 Detox and Treatment Capacity as alternatives to protective custody holds		530.0
	Reverse FY2009 MH Trust Recommendation		(965.0)
	MH Trust: BTKH Grant 1391.02 Tool kit development and expand school-based services capacity via contract		100.0
	MH Trust: Dis Justice - 1379.02 Clinical position within Office of Integrated Housing		75.0
	MH Trust: Housing - Grant 383.05 Office of Integrated Housing		185.0
	Reverse FY09 GF for Planning and Design for Clithroe Center Replacement	(500.0)	
	Reverse FY09 One-time GF/MH funding for Suicide Prevention Strategy and Implementation	(200.0)	

Division	Item	GF	Other
DBH	Reverse FY09 OTI - Add funding for Bethel Community Service Patrol	(333.8)	
	Reverse FY09 OTI-Secured Detox and Treatment Involuntary Substance Abuse Commitment	(722.3)	
	Reverse FY2009 MH Trust Recommendation		(625.2)
	MH Trust: Benef Projects - Grant 1396.02 Peer operated support svcs	50.0	
	MH Trust: Housing - Grant 114.05 Flexible special needs housing "rent up"		200.0
	MH Trust: Housing - Grant 575.04 Bridge Home Pilot Project		750.0
	MH Trust: Housing - Grant 604.04 Department of Corrections discharge incentive grants		350.0
	Reverse FY2009 MH Trust Recommendation		(1,100.0)
	MH Trust: BTKH - Grant 1390.02 Expansion of school-based services capacity via grants		200.0
	Reverse FY2009 MH Trust Recommendation		(1,350.0)
	Delete One-time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	(57.5)	
	MH Trust: Workforce Dev - Grant 1434.01 Brain Injury training for providers		50.0
	MH Trust: BTKH - Transitional Aged Youth	200.0	
	Maintain and Enhance Therapeutic Courts	653.0	
	Fairbanks Behavioral Health Enhanced Detox Facility	500.0	
	MH Trust: ABADA - Grants for community based substance abuse services	1,750.0	
	Increased Grantee Costs	59.5	
	Increased Grantee Costs	419.2	
	MH Trust: AMHB - Grants for community behavioral health services	1,750.0	
	MH Trust: Housing - Grant 1377.02 Assisted living home training and targeted capacity for development		100.0
	Increased Grantee Costs	89.1	
	Increased Grantee Costs	20.5	
	MH Trust: AMHB/ABADA - Psychiatric Emergency Services: DES/DET Expansion		300.0
	MH Trust: AMHB/ABADA - Psychiatric Emergency Services: DES/DET Expansion	950.0	
	MH Trust: BTKH - 1389.02 Crisis Bed Stabilization - Anchorage and statewide		150.0
	MH Trust: BTKH - Grant 608.04 Individualized Services	500.0	
	MH Trust: BTKH - Transitional Aged Youth		300.0

Division	Item	GF	Other
	MH Trust: BTKH - Tribal/rural system development	400.0	
	MH Trust: BTKH - Tribal/rural system development		400.0
	MH Trust: BTKH -Grant 1392.02 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	1,100.0	
	MH Trust: BTKH -Grant 1392.02 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training		250.0
	Behavioral Health Subtotal	***$6,323.2***	***$338.8***
OCS	Reverse FY09 OTI - Funding for Federally Mandated Child and Family Services Reviews	(151.7)	
	MH Trust: BTKH - 1926.01 Foster Parent & Parent Recruitment training & support		75.0
	Reverse FY2009 MH Trust Recommendation		(75.0)
	MH Trust: BTKH - Grant 1393.02 Early childhood comprehensive system grants		75.0
	MH Trust: Gov Cncl - 2058 Behavior Intervention and Supports for Early Childhood System		80.0
	Reduce Federal Authorization to Reimbursable Levels		
	Reverse FY2009 MH Trust Recommendation		(155.0)
	Complete Implementation of Front Line Workload Study Recommendations - Final Phase	310.9	
	Foster Parent Recruitment, Screening, and Training	115.5	
	Maintain Service Levels for Children's Services Family Preservation Grantees	338.9	
	Fund Increased Costs for Subsidized Adoptions and Guardianship Due to Growth	498.4	
	Increase Adoption Subsidies to Foster Care Base Rate Levels - Final Phase	1,407.1	
	Maintain Service for Children's Services Adoption/Guardianship Grantees	55.3	
	Maintain Service Levels for Children's Services Residential Care Grantees	154.6	
	Maintain Service Levels for Children's Services Infant Learning Program Grantees	314.9	
	MH Trust: BTKH - Early childhood mental health learning network and coordinator		100.0
	MH Trust: BTKH - Early childhood mental health learning network and coordinator	100.0	
	MH Trust: BTKH - Grant 1393.02 Early childhood comprehensive system grants	100.0	

Division	Item	GF	Other
	MH Trust: Gov Cncl - 2046 Early intervention/Infant Learning Program	1,500.0	
	Office of Children's Services Subtotal	***4,743.9***	***100.0***
Adult Prev. Dental	Reauthorization of Adult Preventative Dental Medicaid Program & Adjustment of Fund Sources	725.0	
	Reverse FY2009 MH Trust Recommendation		(1,400.0)
	Adult Prev. Dental Subtotal	***$725.0***	***-$1,400.0***
HCS	Increase Dental Rates for non-Tribal Providers	1,000.0	
	Medicaid Cost Containment in Pharmacy	(700.0)	
	Medicaid Program - Adjust Authorization for Current Trends	(9,000.0)	
	Medicaid Program - Formula Growth	12,865.3	
	Medicaid Program - Reduce Excess Federal & I/A Authorization		(10,818.1)
	Provider Re-enrollment	800.0	0.0
	MH Trust: Cont - Grant 120.05 Comprehensive Integrated Mental Health Plan		106.0
	Reverse FY2009 MH Trust Recommendation		(80.0)
	Year 2 Fiscal Note (SB 196) Prescription Database	(4.1)	
	Public Health Licensing Activities of Surveyors		80.0
	Reverse FY2009 One-Time Increment for Anchorage Project Access	(250.0)	
	Health Care Services Subtotal	***$4,711.2***	***-$10,712.1***
DJJ	MH Trust: Dis Justice -Grant 1386.02 Increase Mental Health Clinical Capacity in Juvenile Justice Facilities		189.2
	Reverse FY09 Disability Justice-Mental Clinical Capacity for Juveniles In and/or Transitioning Out of Detention	(288.4)	
	Reverse FY2009 MH Trust Recommendation		(199.7)
	Delete One-time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	(389.3)	
	Remove Excess SDPR Authority in Probation Services Component		(100.0)

Division	Item	GF	Other
	Front Line Staffing at the McLaughlin Youth Center	150.1	
	MH Trust: Dis Justice: Grant 1386.02 Increase Mental Health Clinical Capacity in DJJ Facilities. Cont. FY09 Level	288.4	
	Front Line Staffing for Fairbanks Youth Facility	264.2	
	Front-Line Staffing for the Bethel Youth Facility	98.7	
	Nome Operating Costs, Phase 2 of 2	100.0	
	Front Line Staffing for Johnson Youth Center	75.2	
	Probation Services Aftercare, Mental Health and Support Needs	273.6	
	Juvenile Justice Subtotal	***$572.5***	***-$110.5***
DPA	Reverse FY09 Special Session funding added for heating assistance for low income households	(10,000.0)	
	Reverse FY09 Salary Increase for Special Session funding for Resource Rebate (HB 4001) CH 1, 4SSSLA 2008, Sec 3 (P2, L6)	(1.9)	
	Reverse FY09 Special Session funding for Resource Rebate (HB 4001) CH 1, 4SSSLA 2008, Sec 3 (P2, L6)	(1,438.5)	
	Reverse FY09 Special Session funding for Resource Rebate (HB4001) CH 1, 4SSSLA 2008, Sec. 3 (P2, L6)	(400.0)	
	General Fund Decrement for the Adult Public Assistance Program	(500.0)	
	Child Care Grantee Support	305.4	
	Child Care Rate Increase for Working Families	3,000.0	
	General Fund Decrement for Senior Benefits Payment Program	(500.0)	
	Alaska Heating Assistance Program	5,000.0	
	Women, Infants and Children Formula Funding Implementation	70.8	
	Women, Infants and Children Local Administrator Support	247.1	
	Public Assistance Subtotal	***-$4,217.1***	***$0.0***
DPH	Reversing Alaska's childhood obesity trend	923.1	
	Cancer Registry	179.7	
	Governor's Health Initiative - Live Well Alaska	498.4	
	Tobacco Prevention and Control Program		90.0
	Assuring access to early preventive services and quality health care - CHATS Program Funding	173.1	
	Grant increase to support EMS Programs	267.4	

Division	Item	GF	Other
	Preventing and controlling epidemics and the spread of infectious disease - Full operation of new virology lab	256.0	
	Tobacco prevention and control		555.0
	MH Trust: Workforce Dev - Autism capacity building		125.0
	MH Trust: Workforce Dev - Autism capacity building	125.0	
	Delete One-time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	(86.5)	
	MH Trust: Gov Cncl - 2044 Expanded Autism Diagnostic Clinic	125.0	
	Reverse FY2009 MH Trust Recommendation		(250.0)
	Reverse FY09 OTI - One time funding for Community Health centers	(1,000.0)	
	Create Alaska Health Care Commission	500.0	
	Birth Defects Registry	280.3	
	Public Health Subtotal	***$2,241.5***	***$520.0***
SDS	Medicaid Program - Formula Growth	15,368.0	
	Add New Positions for Eligibility Assessments	165.0	
	MH Trust: ACoA - Grant 1927.01 Aging and Disability Resource Centers		125.0
	Add Authorization for Previously Unbudgeted RSA From AK Pioneer Homes		872.4
	Reverse FY09 One-Time Funding to Increase Home & Community Based Waiver Rates (Assisted Living Homes) from 4% to 6%	(278.5)	
	MH Trust: Housing - Grant 68.06 Rural long term care development		200.0
	Reverse FY2009 MH Trust Recommendation		(139.9)
	TEFRA Level of Care Determinations RSA		100.0
	MH Trust: Beneficiary Projects - Grant 74.05 Mini grants for ADRD beneficiaries		260.3
	Reverse FY2009 MH Trust Recommendation		(385.3)
	MH Trust: Beneficiary Projects - Grant 124.05 Mini grants for beneficiaries with disabilities		227.5
	Reverse FY2009 MH Trust Recommendation		(227.5)
	Behavioral Risk Management Services for Sex Offenders		125.8
	Senior Disability Services Subtotal	***$15,254.5***	***$1,158.3***

Division	Item	GF	Other
DSS	Grantee Partnership Project	100.0	196.1
	MH Trust: Grantee Partnership Project		50.0
	Increase Interagency Receipts for Workforce Development Coordinator		97.8
	Delete One-time FY2009 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	(266.6)	
	Department Support Services Subtotal	***($166.6)***	***$343.9***
B&C	MH Trust: Cont - Grant 151.05 ACOA Planner		84.8
	MH Trust: Workforce Dev - Grant 1381.02 "Grow your own" recruitment strategy for youth		180.0
	MH Trust: Workforce Dev - Grant 1382.02 Marketing Strategies for beneficiary area service careers		165.0
	MH Trust: BTKH - Grant 606.04 Strong family voice: parent and youth involved via AMHB		25.0
	MH Trust: Cont - Grant 605.04 ABADA/AMHB joint staffing		403.3
	MH Trust: Benef Projects - Grant 200.06 Microenterprise capital		100.0
	MH Trust: Cont - Grant 105.05 Research Analyst III		100.4
	MH Trust: Workforce Dev - AK Alliance for Direct Service		125.0
	Reverse FY2009 MH Trust Recommendation		(413.7)
	Reverse FY2009 MH Trust Recommendation		(163.5)
	Reverse FY2009 MH Trust Recommendation		(744.7)
	MH Trust: Workforce Dev - Develop Highly Qualified Early Intervention/Infant Learning Program Staff	500.0	
	Boards & Commission Subtotal	***$500.0***	***($138.4)***
	Grand Total FY2010 GF & Other Funds Request	**$ 29,728.0**	**$ (9,245)**

Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Behavioral Health	AK Fetal Alcohol Syndrome Program
Behavioral Health	Alcohol Safety Action Program (ASAP)
Behavioral Health	Behavioral Health Medicaid Services
Behavioral Health	Behavioral Health Grants
Behavioral Health	Behavioral Health Administration
Behavioral Health	Community Action Prevention & Intervention Grants
Behavioral Health	Rural Services and Suicide Prevention
Behavioral Health	Psychiatric Emergency Services
Behavioral Health	Services to the Seriously Mentally Ill
Behavioral Health	Designated Evaluation and Treatment
Behavioral Health	Services for Severely Emotionally Disturbed Youth
Behavioral Health	Alaska Psychiatric Institute
Behavioral Health	Alaska Psychiatric Institute Advisory Board
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
Adult Preventative Dental	Adult Preventative Dental Medicaid Services
Health Care Services	Medicaid Services
Health Care Services	Catastrophic and Chronic Illness Assistance
Health Care Services	Health Facilities Survey
Health Care Services	Medical Assistance Administration
Health Care Services	Rate Review
Health Care Services	Health Planning and Infrastructure
Juvenile Justice	McLaughlin Youth Center
Juvenile Justice	Mat-Su Youth Facility
Juvenile Justice	Kenai Peninsula Youth Facility
Juvenile Justice	Fairbanks Youth Facility
Juvenile Justice	Bethel Youth Facility
Juvenile Justice	Nome Youth Facility

Juvenile Justice	Johnson Youth Center
Juvenile Justice	Ketchikan Regional Youth Facility
Juvenile Justice	Probation Services
Juvenile Justice	Delinquency Prevention
Juvenile Justice	Youth Courts
Public Assistance	Alaska Temporary Assistance Program
Public Assistance	Adult Public Assistance
Public Assistance	Child Care Benefits
Public Assistance	General Relief Assistance
Public Assistance	Tribal Assistance Programs
Public Assistance	Senior Benefits Payment Program
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	Injury Prevention/Emergency Medical Services
Public Health	Nursing
Public Health	Women, Children and Family Health
Public Health	Public Health Administrative Services
Public Health	Certification and Licensing
Public Health	Chronic Disease Prevention and Health Promotion
Public Health	Epidemiology
Public Health	Bureau of Vital Statistics
Public Health	Community Health Grants
Public Health	Emergency Medical Services Grants
Public Health	State Medical Examiner
Public Health	Public Health Laboratories
Public Health	Tobacco Prevention and Control
Senior and Disabilities Services	General Relief/Temporary Assisted Living
Senior and Disabilities Services	Senior and Disabilities Medicaid Services
Senior and Disabilities Services	Senior and Disabilities Services Administration
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	Public Affairs
Departmental Support Services	Quality Assurance and Audit
Departmental Support Services	Unallocated Reduction

Departmental Support Services	Commissioner’s Office
Departmental Support Services	Assessment and Planning
Departmental Support Services	Administrative Support Services
Departmental Support Services	Hearings and Appeals
Departmental Support Services	Medicaid School Based Admin Claims
Departmental Support Services	Facilities Management
Departmental Support Services	Information Technology Services
Departmental Support Services	Facilities Maintenance
Departmental Support Services	Pioneers' Homes Facilities Maintenance
Departmental Support Services	HSS State Facilities Rent
Boards and Commissions	AK Mental Health & Alcohol & Drug Abuse Boards
Boards and Commissions	Commission on Aging
Boards and Commissions	Governor’s Council on Disabilities and Special Education
Boards and Commissions	Pioneers Homes Advisory Board
Human Services Community Matching Grant	Human Services Community Matching Grant
Community Initiative Matching Grants	Community Initiative Matching Grants

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
ASTHO .....Association of State & Territorial Health Officials
ATAP .....Alaska Temporary Assistance Program
ATCA.....Alaska Tobacco Control Alliance
ATSDR .....Agency for Toxic Substances and Disease Registry
AVCP.....Association of Village Council Presidents
BB .....Better Beginnings
BBNA .....Bristol Ban Native Association
BCC.....Breast and Cervical Cancer
BH.....Behavioral Health
BHIP .....Behavioral Health Integration Project
BMI.....Body Mass Index
BRFSS.....Behavioral Risk Factor Surveillance System
BRS.....Behavioral Rehabilitation Services

BTKH.....Bring the Kids Home
BVS.....Bureau of Vital Statistics
CAHPS.....Consumer Assessment of Health Plans Survey
CAMA.....Chronic and Acute Medical Assistance
CAPI .....Community Action, Prevention and Intervention
CCDF .....Child Care Development Fund
CCISC.....Comprehensive, Continuous, Integrated System of Care
CCMC.....Children with Complex Medical Conditions (Waiver)
CCTHITA .....Central Council of Tlingit and Haida Indian Tribes of Alaska
CD.....Chronic Disease Prevention and Health Promotion component
CDC .....Center for Disease Control
CDDG .....Community Developmental Disabilities Grants
CDFA.....Catalogue of Federal Domestic Assistance
CDVSA.....Council on Domestic Violence and Sexual Assault
CFR.....Code of Federal Regulations
CFSR.....Federal Child and Family Services Review
CHATS .....Community Health Aide Training and Supervision
CHEMS.....Community Health & Emergency Medical Services
CHIP .....Children's Health Insurance Program
CIMHP.....Comprehensive Integrated Mental Health Plan
C&L .....Certification & Licensing
CITC .....Cook Inlet Tribal Corporation
CLIA .....Clinical Laboratory Improvement Amendments
CMHC.....Community Mental Health Center
CMHS .....Community Mental Health Services Block Grant
CMI.....Chronically Mentally Ill
CMS .....Center for Medicare and Medicaid Services
COFIT.....Outcome Fidelity and Implementation Tool
COMPASS.....Community Partnership for Access Solutions and Success
COPD.....Chronic Obstructive Pulmonary Disease
COSIG.....Co-Occurring State Inventive Grants
CPS .....Child Protective Services (Office of Children's Services)
CPS .....Child Passenger Safety (Public Health)
CQI.....Continuous Quality Improvement
CSAT .....Center for Substance Abuse Treatment
CSM .....Children's Services Management
CSN.....Children with Special Needs
CSR.....Client Status Review
CSU.....Crisis Stabilization Unit
CTC.....Crisis Treatment Center

DAI .....Detention Assessment Instrument
DBH .....Division of Behavioral Health
DD.....Developmentally Disabled
DE&ED.....Department of Education & Early Development
DET.....Designated Evaluation & Treatment
DHSS .....Department of Health and Social Services
DJJ.....Division of Juvenile Justice
DKC .....Denali KidCare (State Children's Health Insurance Program)
DOL/WD.....Department of Labor and Workforce Development
DOT .....Direct Observed Therapy
DPA.....Division of Public Assistance
DPH.....Division of Public Health
DSDS .....Division of Senior and Disabilities Services
DSH.....Disproportionate Share Hospital
DSS .....Department Support Services (aka Finance and Management Services)
DWI.....Driving While Intoxicated
EAP .....Energy Assistance Program
EBT .....Electronic Benefit Transfer
ECCS.....Early Childhood Comprehensive Systems Project
EI.....Early Intervention
EIEIO .....Early Intervention, Enhancement and Improvement Opportunity
EI/ILP.....Early Intervention/Infant Learning Program
EIS.....Eligibility Information System
EMS .....Emergency Medical Services
EPI.....Epidemiology
EPSDT .....Early & Periodic Screening, Diagnosis and Treatment
FAE .....Fetal Alcohol Effects
FARS.....Fatal Accident Reporting System
FAS .....Fetal Alcohol Syndrome
FASD .....Fetal Alcohol Spectrum Disorder
FBCI.....Faith Based and Community Initiatives
FLSW .....Front Line Social Worker
FMAP.....Federal Medical Assistance Program
FMS.....Finance and Management Services
FS .....Food Stamps
FTE .....Full Time Equivalent
GCDSE .....Governor's Council on Disabilities and Special Education
GRA .....General Relief Assistance
HAIL .....Healthy Alaskans Information Line
HAN .....Health Alert Network

HAP.....Heating Assistance Program
HCBC.....Home and Community Based Care
HCBW.....Home and Community Based Waivers
HCP.....Health Care Program
HCS.....Health Care Services
HF .....Healthy Families
HIFA .....Health Insurance Flexibility and Accountability
HIPP.....Health Insurance Premium Payment (Medicaid)
HIPAA .....Health Insurance Portability and Accountability Act
HIV .....Human Immunodeficiency Virus
HPG.....Health Purchasing Group
HRSA.....Health Resource Services Administration
HSCMG .....Human Services Community Matching Grants
IA .....Interim Assistance
I/A .....Interagency Receipts
IDEA.....Individuals with Disabilities Education Act
IDP .....Institutional Discharge Planning
IEP.....Individualized Education Plan
IFSP.....Individual Family Service Plan
IHS .....Indian Health Services
ILLECP.....Local Law Enforcement & Community
ILP.....Infant Learning Program
IMD.....Institution for Mental Disease
IOP .....Intensive Outpatient Program
IPEAMS.....Injury Prevention & Emergency Medical Services
ISA .....Individualized Service Agreements
IT.....Information Technology
ITG.....Information Technology Group
JAIBG .....Juvenile Accountability and Incentive Block Grant
JCAHO.....Joint Commission on Accreditation of Healthcare Organizations
JJDP .....Office of Juvenile Justice and Delinquency Prevention
JOMIS.....Juvenile Offender Management Information System
JPO.....Juvenile Probation Officer
JTPA .....Job Training Partnership Act
LCSW .....Licensed Certified Social Worker
LIHEAP .....Low Income Home Energy Assistance Program
LTC.....Long Term Care
MBU .....Medicaid Budget Unit
MCAC.....Medicaid Care and Advisory Committee
MCFH .....Maternal, Child & Family Health

MCH .....Maternal, Child Health (Block Grant)
MHDD .....Mental Health and Developmental Disabilities
MHSIP .....Mental Health Statistics Improvement Project
MHTAAR .....Mental Health Trust Authority Authorized Receipts
MIS .....Management Information System
MMIS.....Medicaid Management Information System
MMIS-JUCE.....MMIS – Juneau Claims and Eligibility System
MOA .....Municipality of Anchorage or Memorandum of Agreement
MOE.....Maintenance of Effort
MRDD.....Mental Retardation/Developmental Disability (Waiver)
MYC .....McLaughlin Youth Center
NPS .....National Pharmaceutical Stockpile
NRO .....Northern Region Office
NSH.....North Star Hospital
NSIF.....Nutrition Services Incentive Program
NTSS.....Nutrition, Transportation and Support Services
OA.....Older Alaskans
OAA.....Older Alaskan's Act
OCS.....Office of Children's Services
OEP.....Office of Emergency Preparedness
OOS.....Out of State
OPR.....Office of Program Review
ORCA .....Online Resource for the Children of Alaska
ORR .....Office of Rate Review
OSEP.....Office of Special Education Programs
PA .....Public Assistance
PASS.....Parents Achieving Self-Sufficiency
PASS Grant.....Personal Assistance, Supports and Services
PC.....Personal Computer
PCA.....Personal Care Attendant
PCBs .....Polychlorinated Biphenyls
PCCM .....Primary Care Case Management
PCN.....Position Control Number
PCSA.....Protection, Community Services and Administration
PDL.....Preferred Drug List
PDPs.....Prescription Drug Plans
PEC .....Proposal Evaluation Committee
PERM.....Payment Error Rate Measure
PES.....Psychiatric Emergency Services
PFDHH .....Permanent Fund Dividend Hold Harmless

PFT.....Permanent Full Time
PHAB.....Pioneers' Homes Advisory Board
PHN.....Public Health Nursing
PIC .....Private Industry Council
PIP.....Performance (or Program) Improvement Plan
POP .....Persistent Organic Pollutants
PPC .....Prevention Policy Committee
PPT.....Permanent Part-Time
PRAMS.....Pregnancy Risk Assessment Monitoring System
PRWORA .....Personal Responsibility and Work Opportunity Reconciliation Act
PSR .....Protective Service Reports
RCC.....Residential Child Care
RDT.....Residential Diagnostic Treatment
RDU .....Results Delivery Unit
RFP .....Request for Proposal
RFR.....Request for Recommendations
RHSS.....Rural Health Services System
RPMS.....Resources and Patient Management System
RPTC.....Residential Psychiatric Treatment Center
RSA.....Reimbursable Services Agreement
RSS .....Receipt Supported Services
RSSP .....Rural Services and Suicide Prevention
SAG.....Subsidized Adoption and Guardianship
SAMHSA.....Substance Abuse and Mental Health Services Administration
SAPT.....Substance Abuse Prevention and Treatment Block Grant
SCHIP .....State Children's Health Insurance Program
SCRO .....South Central Region Office
SDPR.....Statutory Designated Program Receipts
SDS .....Senior and Disabilities Services
SECC.....State Emergency Coordination Center
SEARHC.....Southeast Alaska Regional Health Consortium
SEARCH.....Student Experiences & Rotations in Community Health
SED.....Seriously Emotionally Disturbed
SERO .....Southeast Region Office
SIG/ACT.....State Incentive Grant/Alaskans Collaborating for Teens
SME .....State Medical Examiner
SMI .....Supplementary Medical Insurance
SPMP .....Skilled Professional Medical Personnel
SSBG.....Social Services Block Grant
SSI.....Supplemental Security Income

STAR Grants.....Short Term Assistance and Referral
STD.....Sexually Transmitted Disease
SVCS/SMI .....Services to the Seriously Mentally Ill
TANF .....Temporary Assistance to Needy Families
TB .....Tuberculosis
TCC.....Tanana Chiefs Conference
TCM.....Targeted Case Management
TDM.....Team Decision Making
TEFRA.....Tax Equity and Fiscal Responsibility Act of 1982
TFAP.....Tribal Family Assistance Programs
Title V .....Maternal, Child Health Block Grant
Title X .....Family Planning (Federal)
Title XIX.....Medicaid
Title XXI.....SCHIP/Denali KidCare
T&H .....Central Council of Tlingit and Haida Indian Tribes
TPL .....Third Party Liability
TWWIIA.....Ticket to Work and Work Incentives Improvement Act of 1999
USDA.....U. S. Department of Agriculture
WAS.....Women and Adolescent Services
WIA.....Workforce Investment Act
WIC.....Women, Infants and Children
WSEA .....Western States EBT Alliance
WtW.....Welfare to Work
YF .....Youth Facility
YKHC .....Yukon-Kuskokwim Regional Health Corporation
YRBS .....Youth Risk Behavior Survey