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Executive Summary

Introduction to the Department

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

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 safer children, stronger families.
- 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 five adopted core values as guiding principles in the delivery of services:

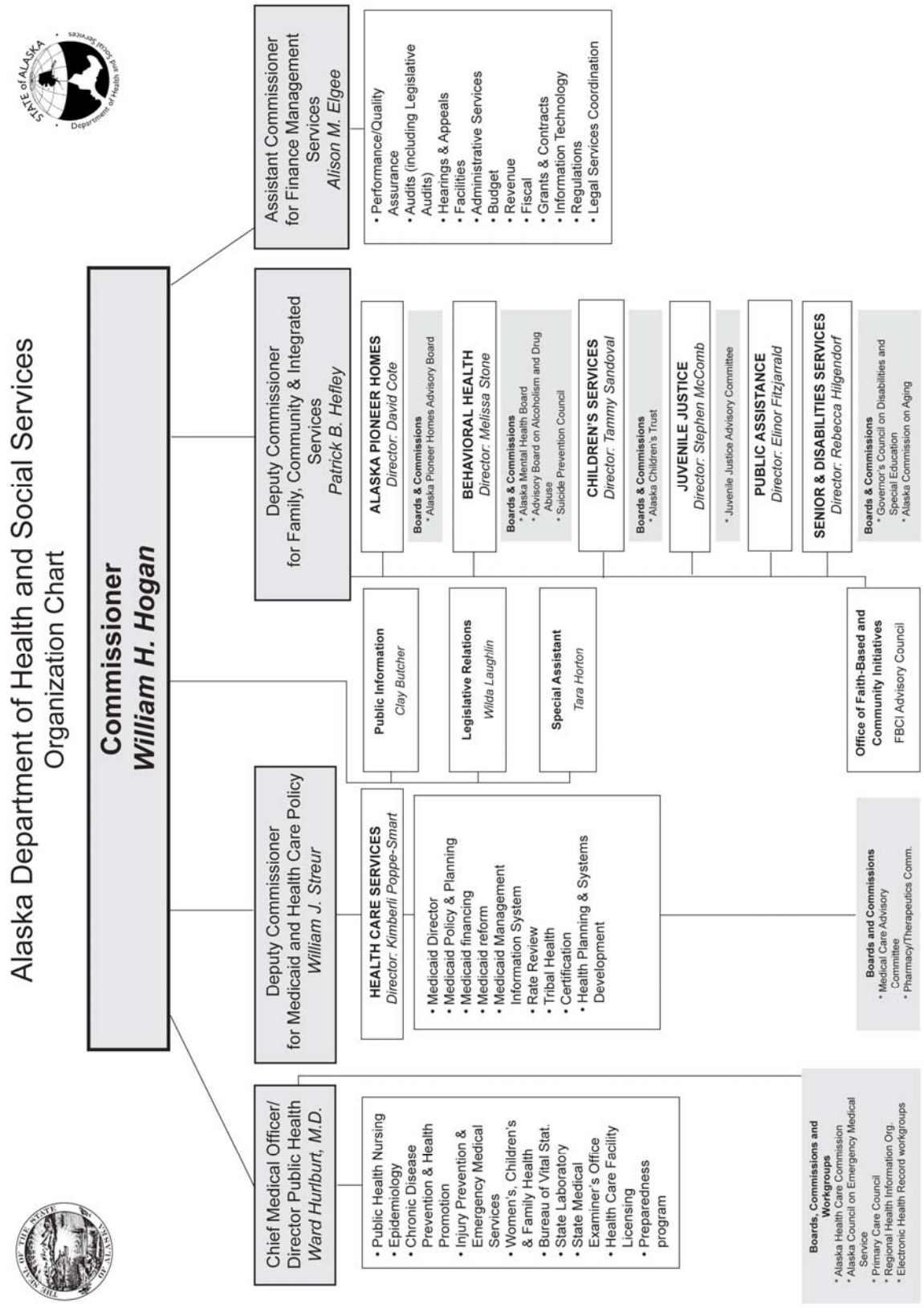
- Collaboration
- Accountability
- Respect
- Empowerment
- Safety

Department Priorities

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

Executive Management Organization

There have been minimal organization changes during FY10 and/or proposed for FY11.



Major Accomplishments in 2009

VULNERABLE POPULATIONS

- The Office of Children's Services (OCS) continued work toward a statewide Family-to-Family (F2F) program. F2F has been very successful in Anchorage in working toward change in the child welfare system through support and resources provided to families, building community partnership, and team decision making that includes not just foster parents and caseworkers but families and community members. The Anne E. Casey Foundation reports that in Alaska, 70% of the children who receive team decision making services are able to stay in their own homes or in a relative's home rather than a foster home. Over the course of the next few years, OCS plans to expand F2F services statewide with expansion to Fairbanks already started.
- A significant accomplishment in Juvenile Justice (DJJ) in 2009 was the development and implementation of a new version of JOMIS, the juvenile offender management information system.
- Rapid development and implementation of the new Alaska Heating Assistance Program (AKHAP) that serves households with incomes between 150% and 225% of the federal poverty guidelines for Alaska.
- The Bring the Kids Home initiative continues to be successful in reducing the number of distinct out-of-state residential psychiatric treatment center (RPTC) recipients served and increasing the number of distinct RPTC recipients who received services in state. Preliminary data indicates that from FY08 to FY09, there was a decrease of about 33.5% in the number of distinct out-of-state RPTC recipients served and an increase of about 2.4% in the number of distinct RPTC recipients who received services in state. Access to in-state non-residential services at lower levels of care has increased significantly.
- During FY09, the Division of Senior and Disabilities Services provided home and community-based services to 7,923 individuals and their families. By providing these services in the community setting, the division was able to delay the entry of these individuals into institutions, thereby reducing costs to the state.
- Worked with AMHTA to plan and implement strategies for the five focus areas (Bring the Kids Home, Housing, Justice, Trust Beneficiary Projects, and Workforce Development).

SUBSTANCE ABUSE

- In 2008, Behavior Health introduced the use of performance based funding. Performance measures hold providers in the state behavioral health system accountable. Further, it is an objective process to determine funding levels for grantees that will reflect an assessment of program and agency performance, utilization, client and community outcomes. Performance was a consideration in grant awards for FY10.

LONG-TERM CARE

- Served 577 Alaska Seniors and Veterans in the Pioneers Homes.
- In FY09 Senior and Disabilities Services (SDS) provided services to approximately 7,600 Medicaid beneficiaries at an average annual cost per person that approached $41,800. Almost 55% of the benefit payments were for disabled adults, about 41% for the elderly, and 4% were disabled children.
- Also, SDS served more than 17,193 seniors (age 60+) through Senior and Disabilities Services programs including direct service grants (17,472), general relief (577), Personal Care Attendant Services (3,552) and Medicaid programs (4,371).

HEALTH AND WELLNESS

- In FY09, the Adult Preventative Dentistry Program was reactivated and 7,336 individual recipients over the age of 21 received services.

HEALTH CARE REFORM

- Work continues with tribal health organizations to improve tribal opportunities to maximize Medicaid revenue, reimbursed at 100% by the federal government.

Key Department Challenges

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

- Work toward more integration of services;
- Maximize resources for effective service delivery;
- Promote rural infrastructure development and standardization of regional structure;
- Promote accountability at all levels of the organization; and
- Use technology in strategic ways to accomplish the department's goals.

Some of the challenges facing priority programs are listed below. Some challenges facing the department affect more than one priority program.

VULNERABLE POPULATIONS

- Development of in-state residential and community-based treatment options for children and youth with an emphasis on minimizing the number and duration of out-of-state placements through the Bring the Kids Home project. Challenges include revision of the system of care while continuing to provide services.
- Improvements to child abuse prevention and protection efforts, particularly with Alaska Native partner agencies.
- Continued challenge in providing needed level of staffing to meet rapidly changing number of Alaskans needing assistance or asking about assistance programs, due to the economic environment.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

SUBSTANCE ABUSE

- Working toward the appropriate capacity levels, especially for secure detoxification.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

LONG-TERM CARE

- Hiring and training staff to complete initial and annual Medicaid Waiver and Personal Care Attendants (PCA) assessments and service plans in order to avoid another backlog, remain in compliance with federal requirements, and complete goals identified in the Corrective Action Plan.
- Continued fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

HEALTH AND WELLNESS

- Preparation and planning with federal, state, and community partners for a potential influenza pandemic.
- Promotion of services that focus on enhancing health and well-being and preventing illness through development of a comprehensive state policy that includes reduction of alcohol and substance abuse.

HEALTH CARE REFORM

Our efforts in this area will depend largely on the results of health care legislation at the national level. However, the department will face the following challenges regardless of those results:

- Development and implementation of a department-wide Quality Management Program incorporating the elements of Program Integrity (fraud detection and audit, with particular emphasis on the Payment Error Rate Measurement project), Quality Assurance (internal controls), and Quality Enhancement (corrective action).
- Identification and implementation of potential solutions to the lack of access to affordable quality health care for Alaskans.
- Identification and implementation of appropriate increases to reimbursement rates for health and social service providers based on results and verifiable costs of service provision.

Medicaid challenges include:

- Development of the Medicaid Management Information System to more effectively use new technology to manage health care in Alaska.
- Development of new comprehensive Medicaid regulations which clarify coverage and payment rules for the program and provide for greater accountability for both the department and health care providers.
- Accurately projecting Medicaid expenses in an environment of rapidly increasing costs and economic uncertainty.

Position Information

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

Direct Field Workers

113	Public Health Nurses
290	Social Workers & Children's Service Specialists
313	Eligibility Determination Staff
289	Youth Detention/Treatment Workers
90	Juvenile Probation Officers
256	API Staff
652	Pioneer Homes Staff
2,003	**TOTAL**

Program Support Services

115	Behavioral Health Programs
150	Senior and Disability Programs
413	Public Health Programs
210	Children's Services
123	Juvenile Programs
10	Facilities Management
372	Benefit Payments/Systems
1,393	**TOTAL**

Administrative/Management Support

130	Information Technology
141	All Other Centralized Admin/Mgmt
271	**TOTAL**

3,667	**FY11 GRAND TOTAL**

The DHSS FY11 Governor's Request includes 3,667 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.

FY11 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,730	26	43	**1,799**
Aniak	2	0	0	**2**
Barrow	9	0	0	**9**
Bethel	95	0	3	**98**
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	9	**375**
Fort Yukon	0	1	0	**1**
Galena	2	1	0	**3**
Glennallen	3	0	0	**3**
Haines	2	0	0	**2**
Homer	15	1	0	**16**
Juneau	577	25	27	**629**
Kenai	86	1	2	**89**
Ketchikan	116	12	10	**138**
King Salmon	2	0	0	**2**
Kodiak	14	2	0	**16**
Kotzebue	10	0	0	**10**
Mat-Su Area-wide	2	0	0	**2**
McGrath	3	0	0	**3**
Nome	39	0	2	**41**
Palmer	121	15	6	**142**
Petersburg	4	0	0	**4**
Saint Mary's	6	0	0	**6**
Seward	3	0	0	**3**
Sitka	101	0	3	**104**
Tok	2	0	0	**2**
Unalaska	1	0	0	**1**
Valdez	4	1	0	**5**
Wasilla	133	0	0	**133**
Wrangell	2	0	0	**2**
Totals	**3,469**	**93**	**105**	**3,667**

Explanation of FY11 Operating 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 FY11 Compared to FY10

	FY10 Management Plan	FY11 Governor's Request
General Fund	**$ 832.5 million**	**$ 882.8 million**
Federal Funds	**1,081.5 million**	**1,109.8 million**
Other Funds	**160.8 million**	**154.8 million**
Total	**$ 2,074.8 million**	**$ 2,147.3 million**
Increased Federal Revenue		**28.3 million**
Increased General Fund		**50.3 million**

The proposed budget for FY11 increases general funds by $50,250.9. Significant changes in GF are due to: Medicaid program growth of approximately $36,400.0, increased resources addressing the department's priorities of Vulnerable Alaskans $7,100.0, Substance Abuse $2,800.0, Long-Term Care $800.0, Health & Wellness $1,900.0, and Health Care Reform $500.0.

To assist in understanding the DHSS budget, we have highlighted budget items addressing the five department initiatives. A complete list of budget items for each division is found in its section of the overview.

Vulnerable Alaskans

The state needs to ensure that both children and communities are safe, that developmentally disabled children 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, Alaska can better meet the needs of the most vulnerable citizens and their families.

The following table compares FY10 Management Plan program capacity for Vulnerable Alaskans to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 403,710.5	$ 416,980.6	$ 13,270.1
Federal Funds	313,875.8	312,573.6	(1,302.2)
Other Funds	73,779.3	74,942.3	1,163.0
Total	**$ 791,365.6**	**$ 804,496.5**	**$ 13,130.9**

Budget requests include:

- Phase 1 of State Medical Examiner's Office reforms - $300.0 GF
- Restoring funding to meet Senior Benefits enrollment and payment projections - $850.0 GF
- Increasing Adult Public Assistance funding due to anticipated enrollment growth - $150.0 GF
- Psychiatric Residency Training at API - $300.0 GF
- Designated Evaluation and Treatment program expansion - $300.0 MHTAAR
- Bring the Kids Home expansion including individualized services, foster parent and parent recruitment training and support, transitional aged youth, expansion of school-based services capacity via grants, and community behavioral health centers outpatient and emergency residential services and training- $1,250.0 GF/MH
- Decreasing unrealizable federal funds (Children's Services Management, Delinquency Prevention) – ($1,250.0) federal
- Replacing unrealizable federal funds with general funds (Front Line Social Workers, Medicaid School Based Admin Claims) - $1,600.0 GF, (1,600.0) federal
- Replacing unrealizable interagency receipts for Medicaid School Based Claims (Children's Services Management, Front Line Social Workers) - $1,120.3 GF, ($1,120.3) Interagency Receipts

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. The state needs to prevent, intervene early, and treat and help people recover from substance abuse through public/private partnerships and long-term strategies.

The following table compares FY10 Management Plan program capacity for Substance Abuse to that requested for FY11:

	FY10 Management Plan	**FY11 Governor's Request**	**FY11 Governor less FY10 Management Plan**
General Fund	$ 19,909.3	$ 22,732.6	$ 2,823.3
Federal Funds	9,955.3	9,731.8	(223.5)
Other Funds	20,298.1	19,903.2	(394.9)
Total	**$ 50,162.7**	**$ 52,367.6**	**$ 2,204.9**

Budget requests include:

- Specialized Treatment Unit at Clitheroe - $1,200.0 GF
- Detox and treatment capacity as alternatives to protective custody holds - $518.3
- Increased access to Fetal Alcohol Spectrum Disorders (FASD) treatment services in rural Alaska - $228.6 GF/MH
- Increased substance abuse treatment services for pregnant women - $500.0 GF/MH
- Disability justice focus group recommendations including pre-development for sleep off alternatives in targeted communities, Alcohol Safety Action Program (ASAP) therapeutic

case management and monitoring treatment, and maintaining treatment capacity for therapeutic court participants with co-occurring disorders - $75.0 GF/MH, 238.0 MHTAAR

Long-Term Care

Seniors represent the fastest growing population in Alaska and it is Alaska's responsibility to determine what kinds of services are wanted for aging parents (and grandparents) to keep them at home in their own communities. The state needs to develop a comprehensive 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.

The following table compares FY10 Management Plan program capacity for Long-Term Care to that requested for FY11:

	FY10 Management Plan	**FY11 Governor's Request**	**FY11 Governor less FY10 Management Plan**
General Fund	$ 170,785.2	$ 184,768.3	$ 13,983.1
Federal Funds	230,990.7	244,587.2	13,596.5
Other Funds	31,526.7	31,439.0	(87.7)
Total	**$ 433,302.6**	**$ 460,794.5**	**$ 27,491.9**

Budget requests include:

- Increased funds for home and community based waiver compliance (split between Long-Term Care and Vulnerable Alaskans) - $500.0 GF Match, $500.0 federal
- Increased capacity for Health Facilities Survey (split between Long-Term Care and Health and Wellness) - $75.0 GF Match, $112.5 federal
- Funds to maintain, improve and design new financial and payment rate systems (split between Long-Term Care and Health and Wellness) - $187.5 GF Match, $187.5 federal
- Funds for traumatic brain injury service coordination (split between Long-Term Care and Vulnerable Alaskans) - $200.0 GF/MH, $150.0 MHTAAR

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. The state and service providers can do a better job of screening, diagnosing and treating these conditions.

The following table compares FY10 Management Plan program capacity for Health and Wellness to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 234,115.2	$ 253,794.9	$ 19,679.7
Federal Funds	522,589.4	540,313.0	17,723.6
Other Funds	34,523.1	27,823.5	(6,699.6)
Total	**$ 791,227.7**	**$ 821,931.4**	**$ 30,703.7**

Budget requests include:

- Maintaining local control of essential public health services by stabilizing funding to public health nursing grantees - $1,000.0 GF
- Increased receipts for the electronic health record system and the Medicaid management information system projects - $1,257.7 CIP Receipts
- Funds to stabilize the Health Facilities Survey budget (split between Long-Term Care and Health and Wellness) - $260.0 GF

Health Care Reform

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

The following table compares FY10 Management Plan program capacity for Health Care Reform to that requested for FY11:

	FY10 Management Plan	FY11 Governor's Request	FY11 Governor less FY10 Management Plan
General Fund	$ 3,392.8	$ 3,887.5	$ 494.7
Federal Funds	4,071.5	2,588.8	(1,482.7)
Other Funds	657.4	652.2	(5.2)
Total	**$ 8,121.7**	**$ 7,128.5**	**$ (993.2)**

Budget related requests include:

- Continuation funding for the comprehensive integrated mental health plan and the loan repayment program - $317.0 MHTAAR
- Decreased federal receipt authority from expired federal grants - ($1,000.0) federal
- Replacing unrealizable federal receipts for core services - $475.1 GF, ($475.1) federal

Expenditure Category Comparisons

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

Formula Programs
This category includes all programs with specific eligibility standards which guarantee a specific level of benefits for any qualified recipient.

Grants
This category 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
This category includes both administration and delivery of direct services, such as public health nursing and social services, and the program management of entitlements and grants.

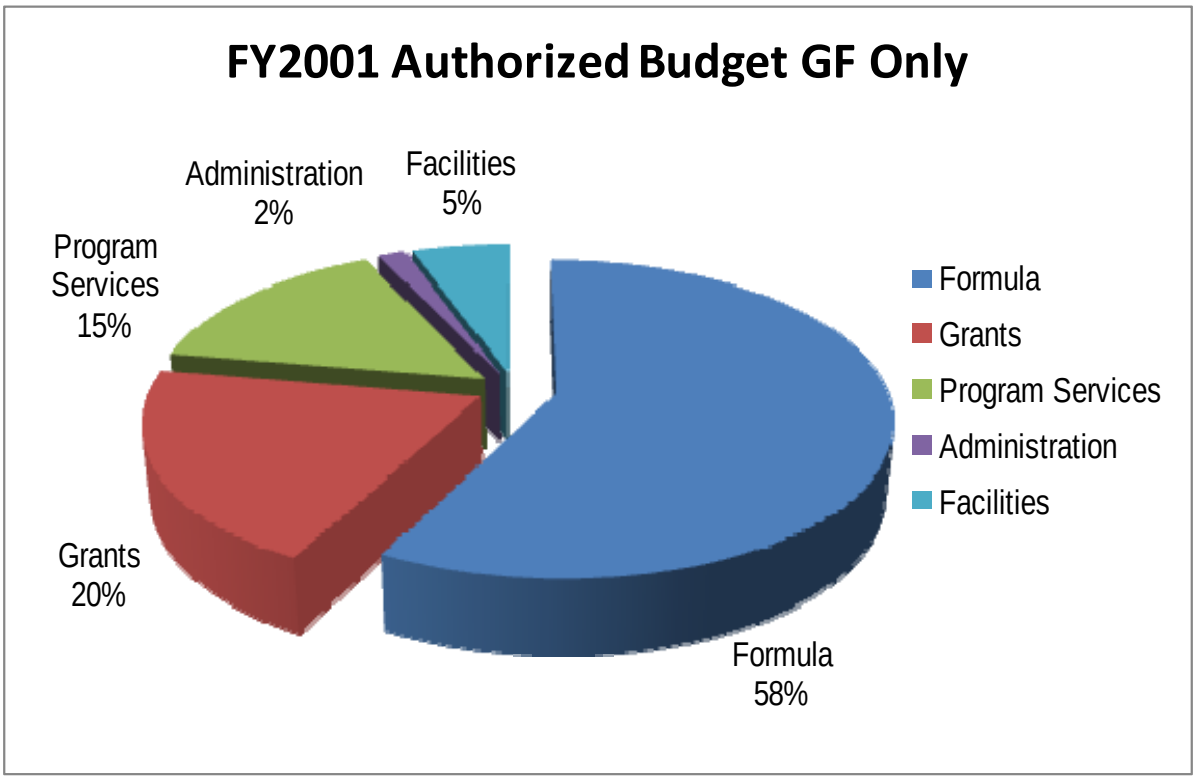
Administration
This category includes departmental administrative oversight and support programs, including the Commissioner's Office, and Administrative Services.

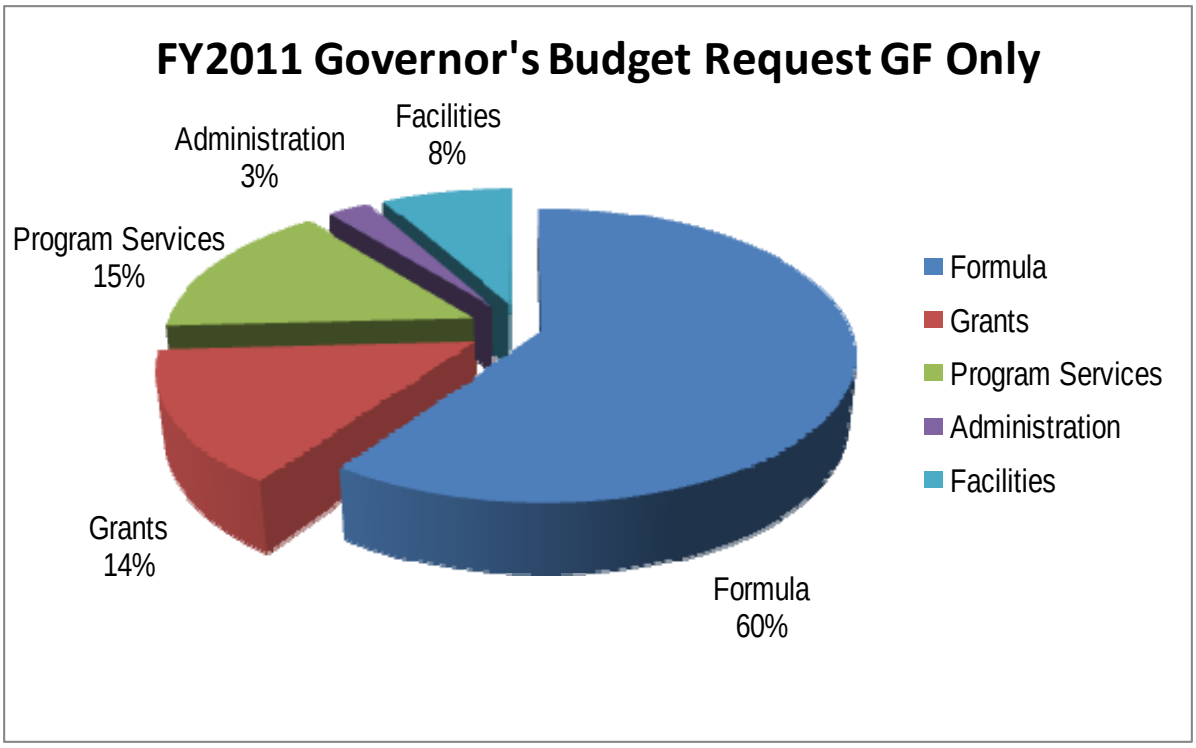
Facilities
The department manages and operates 24-hour facilities and institutions. These include youth correctional facilities, the Alaska Psychiatric Institute, and Pioneer Homes.

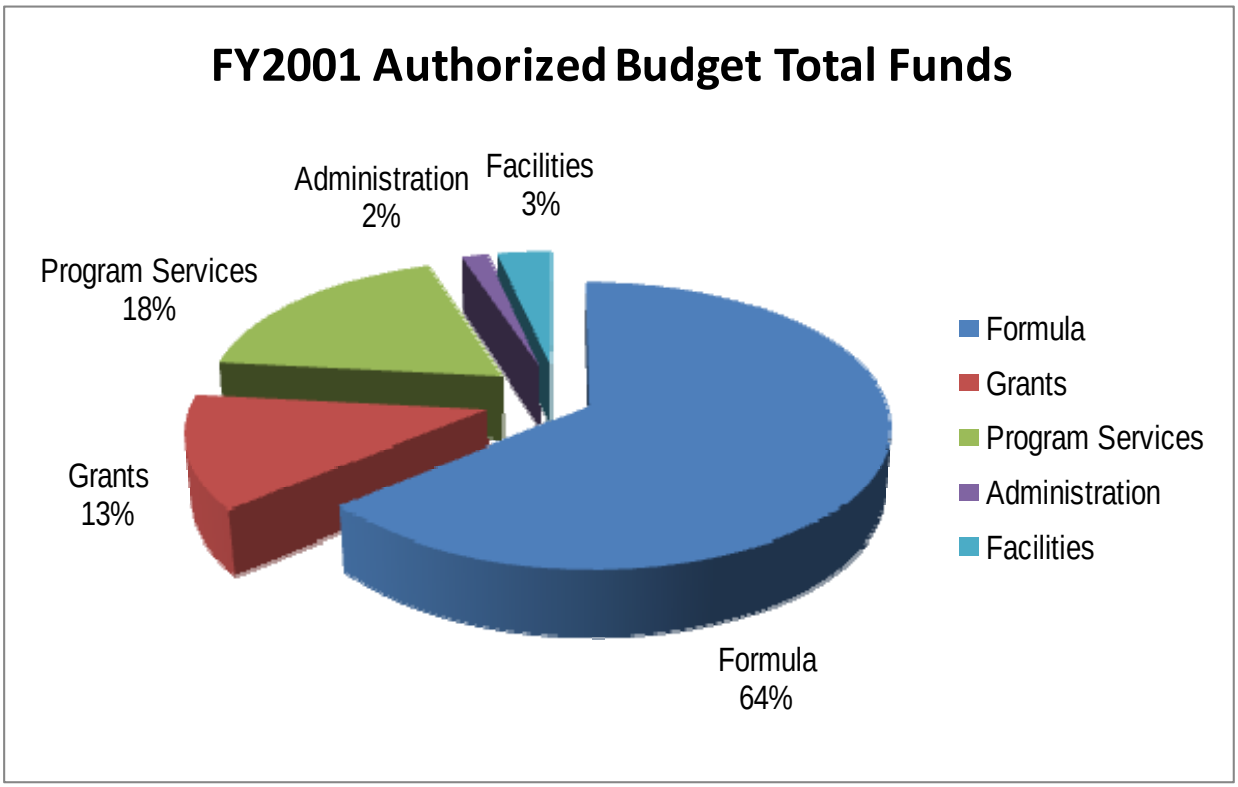
Budget Charts and Graphs

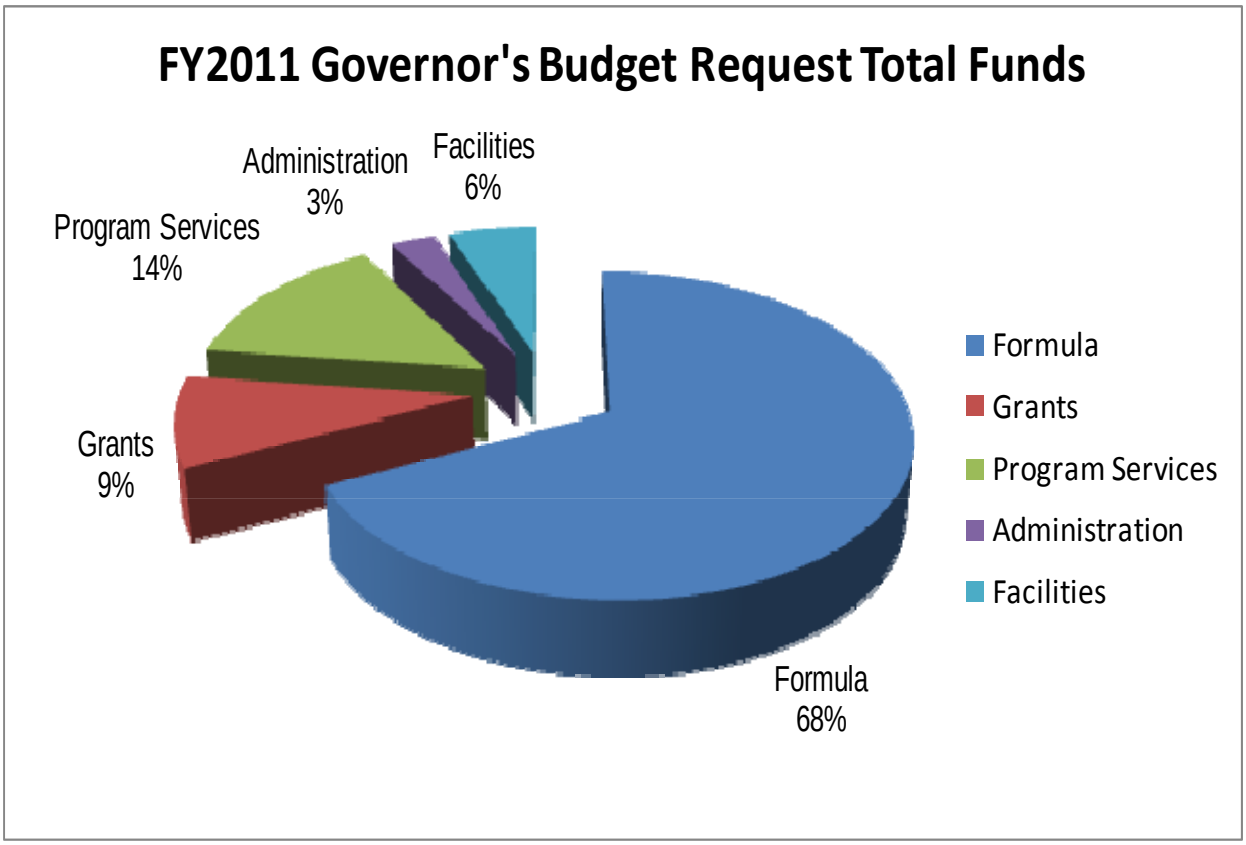
The table below shows the comparison of total funds for FY01 and FY11.

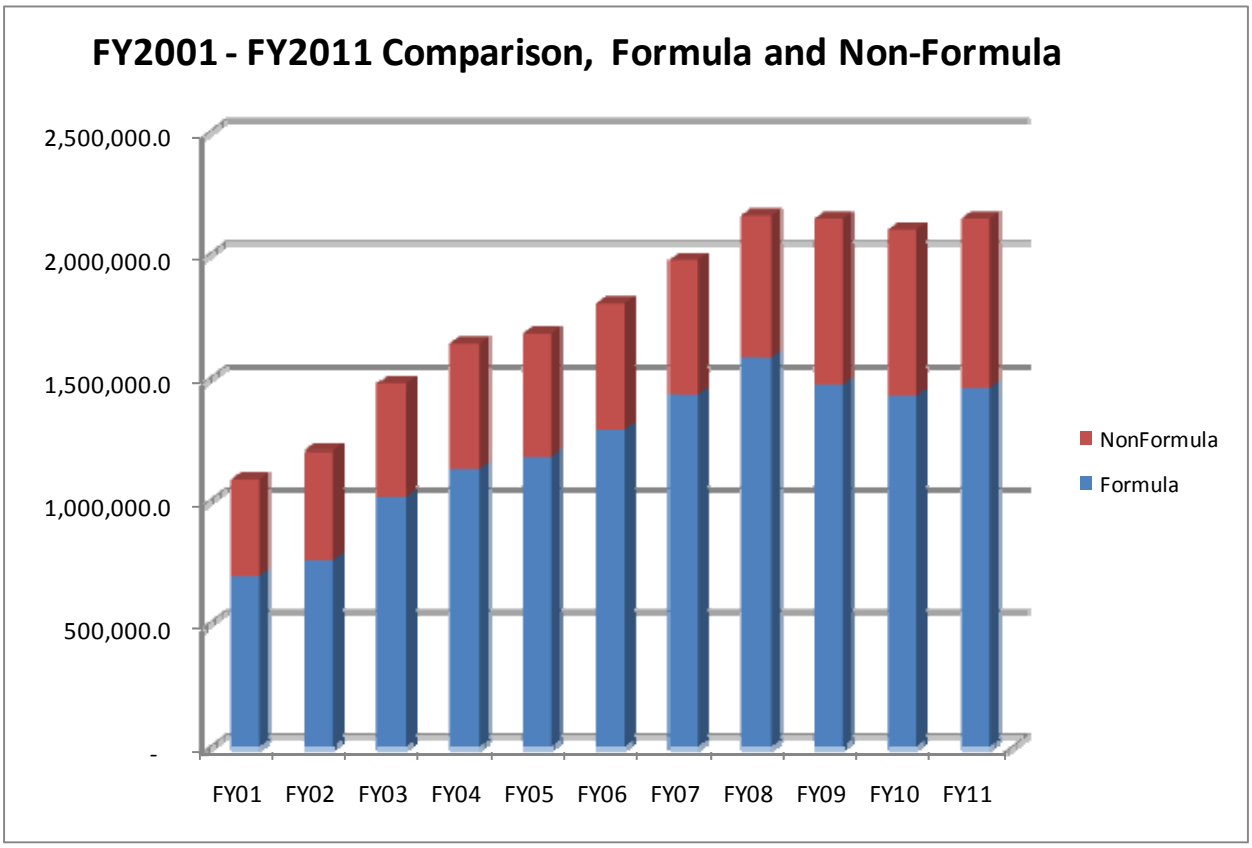
	FY2001 Authorized		FY2011 Governor's		
Category	Total Funds	% of Total	Total Funds	% of Total	2001 to 2010 Change
Formula	696,052.3	63.9%	1,460,290.1	68.0%	109.8%
Grants	139,102.6	12.8%	194,288.3	9.0%	39.7%
Program Services	197,972.2	18.2%	312,732.7	14.6%	58.0%
Administration	17,875.6	1.6%	59,948.2	2.8%	235.4%
Facilities	37,491.4	3.4%	120,059.2	5.6%	220.2%
Total	**1,088,494.1**		**2,147,318.5**		97.3%


FY2001 Authorized Budget GF Only
Administration 2%
Facilities 5%
Program Services 15%
Grants 20%
Formula 58%
Formula
Grants
Program Services
Administration
Facilities


FY2011 Governor's Budget Request GF Only
Administration 3%
Facilities 8%
Program Services 15%
Grants 14%
Formula 60%
Formula
Grants
Program Services
Administration
Facilities


FY2001 Authorized Budget Total Funds
Administration 2%
Facilities 3%
Program Services 18%
Grants 13%
Formula 64%
Formula
Grants
Program Services
Administration
Facilities


FY2011 Governor's Budget Request Total Funds
Administration 3%
Facilities 6%
Program Services 14%
Grants 9%
Formula 68%
Formula
Grants
Program Services
Administration
Facilities



Medicaid is the largest formula program in the department, totaling about 84% of the total formula program category in the proposed FY11 budget.

Formula programs in the Department of Health and Social Services are:

- Behavioral Health Medicaid Services;
- Children's Medicaid Services;
- Foster Care Base Rate;
- Foster Care Augmented Rate;
- Foster Care Special Need;
- Subsidized Adoptions & Guardianship;
- Adult Preventative Dental Medicaid Services;
- HCS Medicaid Services;
- Catastrophic and Chronic Illness Assistance;
- Alaska Temporary Assistance Program;
- Adult Public Assistance;
- Child Care Benefits;
- General Relief Assistance;
- Tribal Assistance Program;
- Senior Benefits Payment Program;
- Permanent Fund Dividend Hold Harmless; and
- Senior and Disabilities Medicaid Services.

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 Adult Preventative Dental Medicaid), 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 Children's Health Insurance Program (CHIP) to children and pregnant women whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance. CHIP 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, Corrections, Education and Early Development, Law, Labor and Workforce Development, and the Court System).

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, Medicaid administrative management, and 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

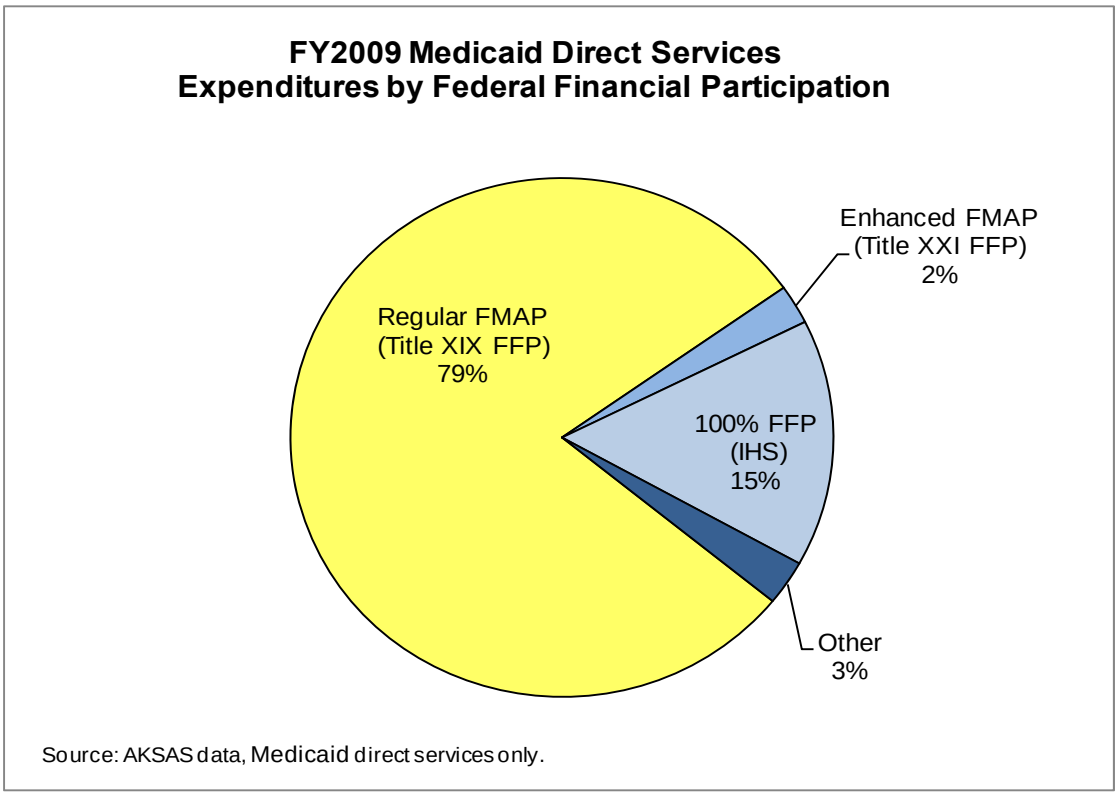
As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and are largely outside of state control. The State's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility 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 (e.g., qualified Indian Health Services claims are reimbursed 100%). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

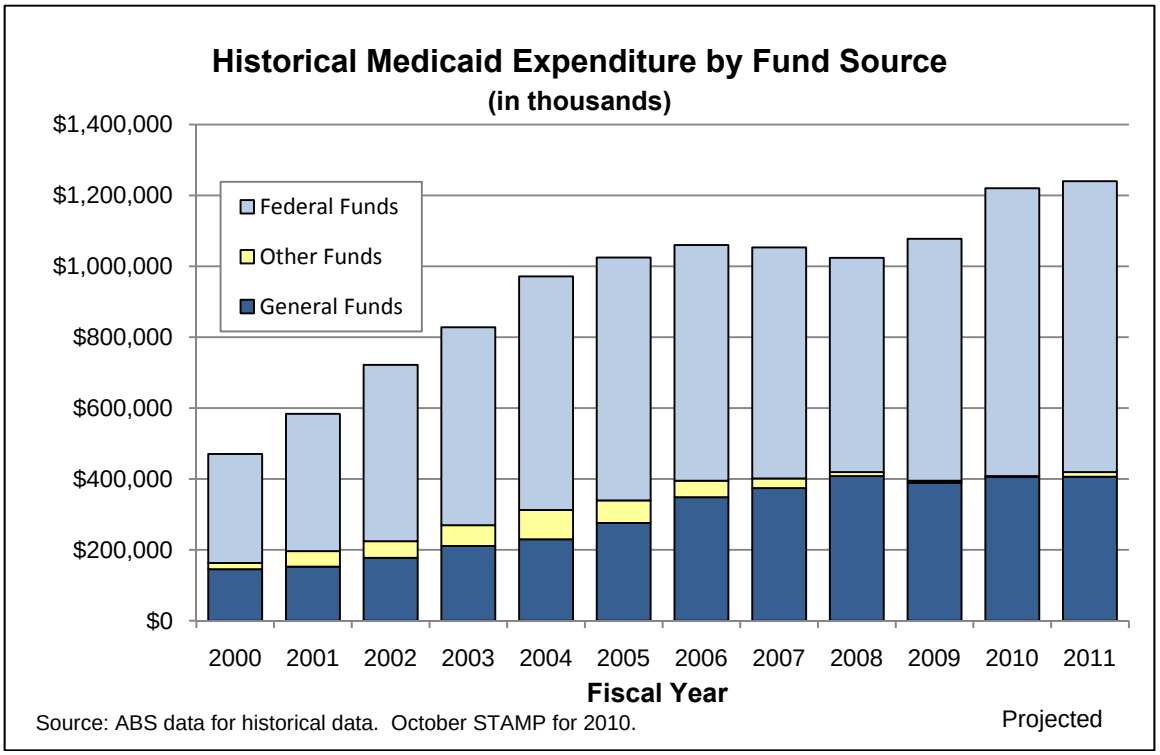
Federal Medical Assistance Percentages for Claim Payments

	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 Q1-Q2	58.68	65.37	57.74	65.71
2009 Q3-Q4	61.12	65.37		
2010 Q1-Q4	61.12	66.00	61.12	65.84
2011 Q1	61.12	65.00	55.56	65.25
2011 Q2-Q4	50.00	65.00		

Source: Medicaid Budget Group and Centers for Medicare and Medicaid Services.
The FMAP prior to 1998 w as 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 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. Due to additional FMAP support provided through ARRA funding, state matching funds required in 2009 for the entire Medicaid program dropped to 36%, from 40% in FY08. State funding is projected to be about 33% of the total program costs in both 2010 and 2011.



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 FFY09, the State saved 40 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 through 2009—mitigating increases in population and payment rates. This trend is not expected to continue in 2010 and 2011 due to enrollment and utilization increases driven by the current general economic climate, as well as provider service rate increases.

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	$389,089	$682,271	$6,123	$1,077,483
2010 *	$405,964	$811,587	$9,462	$1,227,012
2011 **	$408,700	$820,417	$12,939	$1,242,056

Source: Medicaid Budget Group using Alaska Budget System data and STAMP forecast. FY09 and earlier are actual expenditures.
*Projection as of October 2009. **Governor's Budget.

Annual Statistical Summary of Medicaid Services Provided in FY09

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 FY09, one in five Alaskans was enrolled in the state's Medicaid program. After slowing for several years, the annual change in enrollment (enrollment growth) increased by 2% in FY09. The number of persons receiving Medicaid benefits (beneficiaries) also increased in FY09, by over five percent.

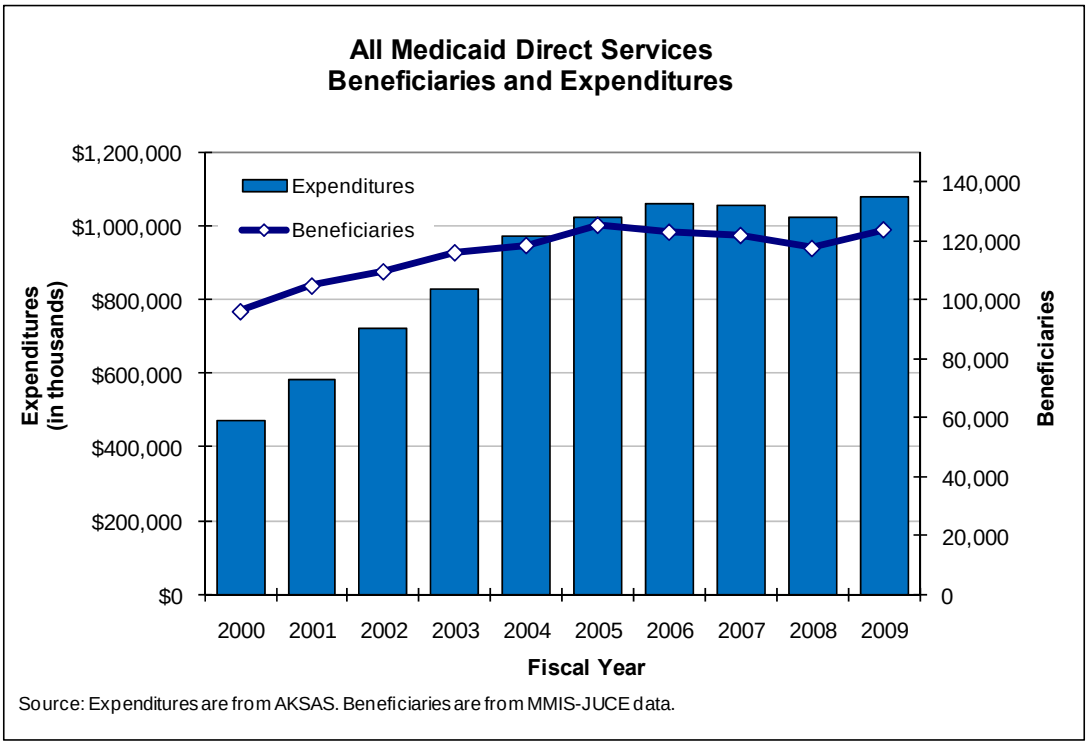
The majority, but not all, of enrollees receive benefits in a fiscal year. The ratio of enrollees to beneficiaries is called the participation rate. The participation rate has increased steadily from 87% in FY00 to 97% in FY09. The participation rate for FY09 is up by 3% from the 94% participation rate in FY08.

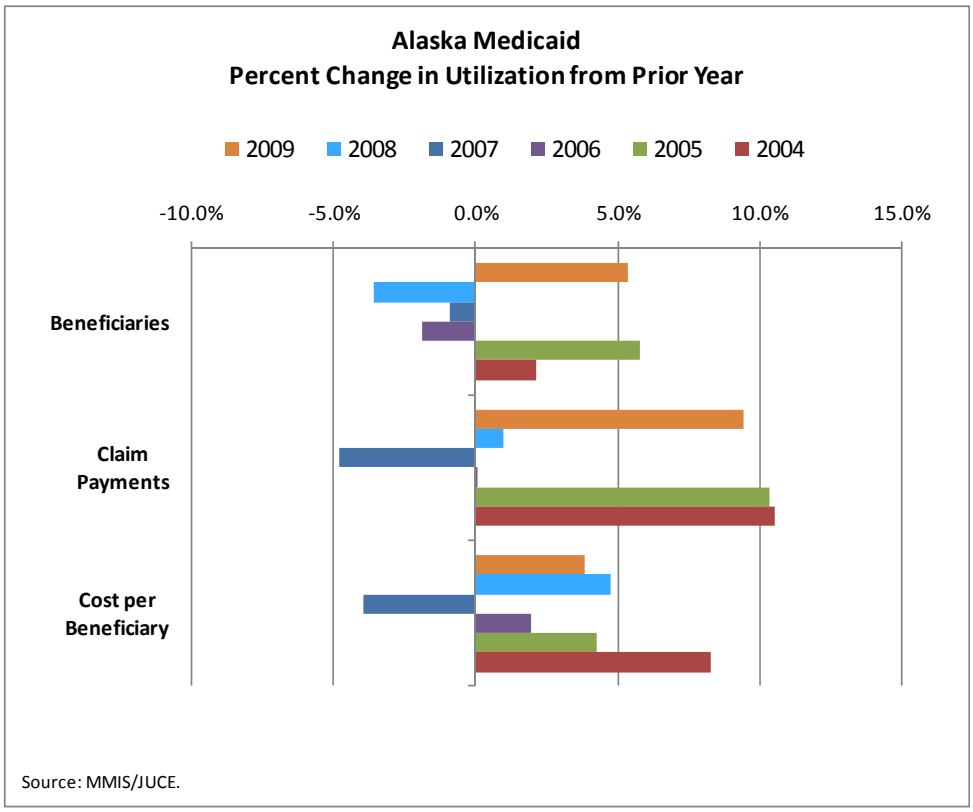
Participation in Medicaid

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	679,720	125,138	117,472	18%	94%
2009 *	691,354	127,944	123,791	19%	97%

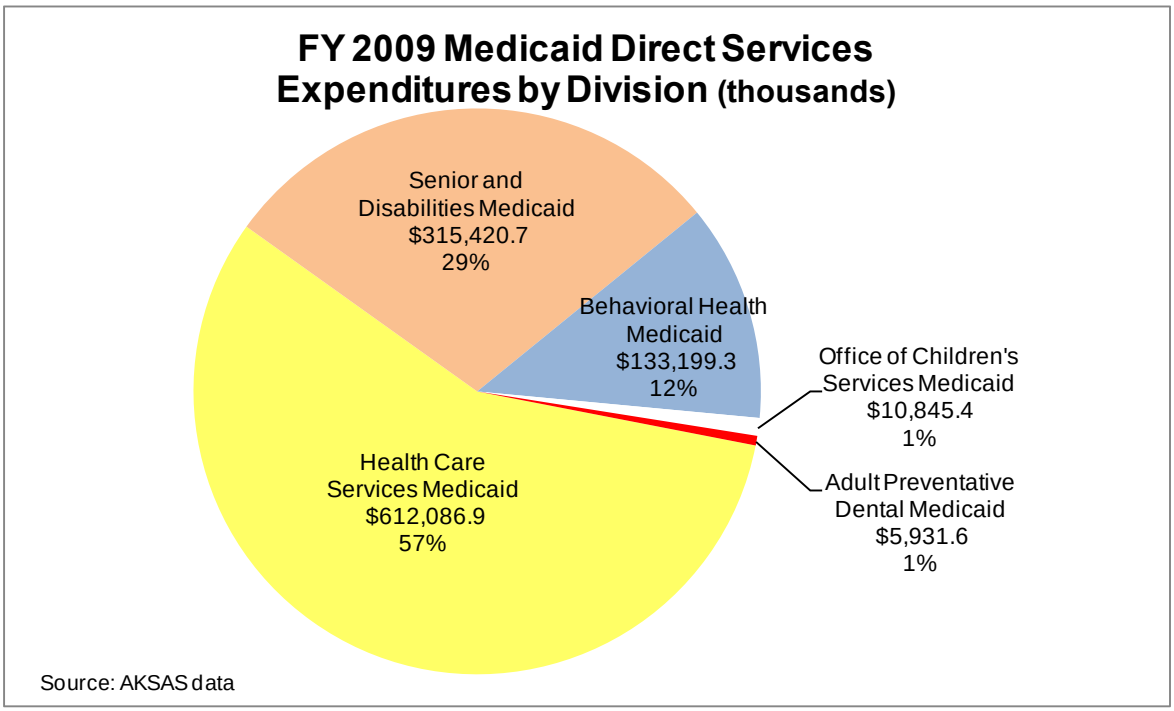
Source: Medicaid Budget Group (MMIS/JUCE) and AK Dept. of Labor and Workforce Development.
*Population is projected.
Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

The total cost of Medicaid direct and indirect services grew by 5% between FY08 and FY09. Costs for direct services (claims paid in FY09) increased by about 9% and the cost of direct services per beneficiary increased by almost 4%. The increase in expenditures from FY08 to FY09 was largely the result of increased enrollment due to the general economic climate and rate increases for some Medicaid services.





The majority of Medicaid expenditures are paid through the Medicaid Services component in the Division of Health Care Services, which funded 57% of the total costs for Medicaid direct services in FY09. The Senior and Disabilities Medicaid Services component provided long-term and home-based care services that accounted for 29% of total Medicaid direct services costs. The remaining 14% of expenditures were paid through the Behavioral Health Medicaid Services budget component (12%), Children's Medicaid Services budget component (1%) and Adult Preventive Dental Medicaid budget component (1%) in the Division of Behavioral Health, Office of Children's Services, and Division of Health Care Services, respectively.


FY 2009 Medicaid Direct Services Expenditures by Division (thousands)
Senior and Disabilities Medicaid $315,420.7 29%
Behavioral Health Medicaid $133,199.3 12%
Office of Children's Services Medicaid $10,845.4 1%
Adult Preventative Dental Medicaid $5,931.6 1%
Health Care Services Medicaid $612,086.9 57%
Source: AKSAS data

Medicaid Direct Services Expenditures by Division, FY09
(in thousands)

Total Medicaid Direct Services	$1,077,483.2
Health Care Services Medicaid	$ 612,086.9
Hospital Services	$ 239,407.3
Physician Services	$ 129,412.7
Pharmacy Services	$ 72,136.2
Dental Services	$ 33,673.7
Transportation	$ 50,445.7
Other Medicaid Direct Services	$ 45,561.9
Non-MMIS Services	$ 40,335.9
Medicaid Financing	$ 557.7
Medicaid (State-only)	$ 555.8
Adult Preventative Dental Medicaid	$ 5,931.6
Adult Preventative Dental	$ 5,931.6
Senior & Disabilities Medicaid	$ 315,420.7
Personal Care Services	$ 76,847.2
Nursing Homes	$ 80,515.6
Adults with Disabilities Waiver	$ 24,756.7
Children with Complex Medical Conditions	$ 9,909.1
Mental Retardation / Developmental Disabilities	$ 84,862.8
Older Alaskans Waiver	$ 38,280.3
Other Services	$ 249.1
Behavioral Health Medicaid	$ 133,199.3
Residential Psychiatric Treatment Centers	$ 44,263.4
Inpatient Psychiatric Hospitals	$ 16,897.2
General Mental Health Services	$ 72,038.8
Office of Children's Services Medicaid	$ 10,845.4
Behavioral Rehabilitation Services	$ 8,088.8
Behavioral Rehabilitation Services - BTKH	$ 2,756.6

Source: Medicaid Budget Group using AKSAS and ABS data.

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.

99% of all persons with paid claims for Medicaid services during FY09 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.

FY 2009 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		COST per ENROLLEE per YEAR
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Medicaid, Department Annual Totals		**123,791**		**$1,032,427,408**	**$8,340**		**127,944**	**$8,069**
Gender								
Female	56.8%	70,312	56.8%	$586,064,938	$8,335	54.9%	70,218	$8,346
Male	43.2%	53,520	43.2%	$446,362,470	$8,340	45.1%	57,777	$7,726
Unknown	0.0%	1	0.0%	$0	$0	0.0%		
Race								
Alaska Native	37.5%	46,770	37.3%	$385,325,840	$8,239	36.9%	47,671	$8,083
American Indian	1.6%	1,953	1.5%	$15,003,114	$7,682	1.6%	2,025	$7,409
Asian	6.0%	7,521	5.3%	$54,308,904	$7,221	6.9%	8,868	$6,124
Pacific Islander	3.1%	3,893	2.2%	$22,489,057	$5,777	3.2%	4,158	$5,409
Black	5.7%	7,065	4.4%	$45,637,560	$6,460	5.6%	7,178	$6,358
Hispanic	3.7%	4,600	2.3%	$23,911,655	$5,198	3.6%	4,709	$5,078
White	39.6%	49,447	44.1%	$455,384,278	$9,210	39.3%	50,812	$8,962
Unknown	2.8%	3,471	2.9%	$30,366,999	$8,749	2.9%	3,716	$8,172
Native	39.0%	48,800	38.8%	$400,432,447	$8,206	38.7%	49,667	$8,062
Non-Native	61.0%	76,460	61.3%	$633,390,430	$8,284	61.3%	78,661	$8,052
Age								
under 1	9.9%	13,535	8.8%	$90,946,051	$6,719	8.4%	11,526	$7,891
1 through 12	35.8%	48,871	15.1%	$155,930,592	$3,191	38.7%	53,021	$2,941
13 through 18	16.2%	22,166	15.3%	$157,753,758	$7,117	17.1%	23,428	$6,734
19 through 20	3.4%	4,587	2.5%	$25,670,113	$5,596	2.9%	4,033	$6,365
21 through 30	10.7%	14,617	11.6%	$119,362,590	$8,166	9.7%	13,288	$8,983
31 through 54	13.7%	18,763	21.4%	$221,011,251	$11,779	13.2%	18,109	$12,204
55 through 64	3.8%	5,233	8.7%	$89,436,641	$17,091	3.6%	5,000	$17,887
65 through 84	5.4%	7,364	12.1%	$125,223,393	$17,005	5.4%	7,444	$16,822
85 or older	1.0%	1,359	4.6%	$47,093,019	$34,653	0.9%	1,294	$36,393
Benefit Group								
Children	61.4%	77,627	34.7%	$357,946,514	$4,611	63.8%	82,516	$4,338
Adults	18.8%	23,812	12.3%	$127,202,503	$5,342	17.0%	21,959	$5,793
Disabled Children	1.9%	2,399	5.5%	$57,146,913	$23,821	1.7%	2,215	$25,800
Disabled Adults	12.0%	15,214	32.6%	$336,494,020	$22,117	11.8%	15,255	$22,058
Elderly	5.9%	7,416	14.9%	$153,637,458	$20,717	5.8%	7,467	$20,576

Payment amounts are net of all claims paid during the fiscal year. Because 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, dollar amounts may not tie exactly to amounts in the state accounting system.

Enrollment: Number of persons eligibile for Medicaid and enrolled for at least 1 month during state fiscal year 2009. 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 2009 (service may have been incurred in a prior year). Grouping is based on status on the date when benefit (service) was provided. 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, 2009. If they obtained dental services again in December 2008, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2009.

Participation: The cost per recipient (the cost per peson actually accessing care) and the cost per enrollee differ due to the percentage of persons eligible and enrolled during the year that also accessed benefits (participation). Participation is typically over 90%. Because claims data is summarized here based on the claims processing cycle rather than on the claim date of service, the recipient count includes some persons that were enrolled and

Explanation of FY11 Medicaid Operating Budget Requests

For FY11, the department request for Medicaid services includes a $34.7 million increase in General Funds, a $32.8 million increase in Federal funds, and a $3.9 million decrease in Other Funds. Enhanced federal participation authorized through the ARRA legislation is projected to continue at current levels through FY11.

		FY10 Mgmt Plan	FY11 Proposed	10 to 11 Change
Total All Medicaid Services	General Funds	$371,805.2	$406,500.0	$34,694.8
	Federal Funds	$787,605.5	$820,417.1	$32,811.6
	Other Funds	$17,041.4	$13,138.9	-$3,902.5
	Total	**$1,176,452.1**	**$1,240,056.0**	**$63,603.9**
Behavioral Health Medicaid Services	General Funds	$49,540.9	$54,974.1	$5,433.2
	Federal Funds	$90,771.4	$95,373.5	$4,602.1
	Other Funds	$2,217.5	$2,217.5	$0.0
	Total	$142,529.8	$152,565.1	$10,035.3
Children's Medicaid Services	General Funds	$7,139.0	$5,396.5	-$1,742.5
	Federal Funds	$8,914.3	$8,165.9	-$748.4
	Other Funds	$0.0	$0.0	$0.0
	Total	$16,053.3	$13,562.4	-$2,490.9
Adult Preventative Dental Medicaid Services	General Funds	$2,416.8	$2,873.2	$456.4
	Federal Funds	$4,871.6	$5,319.6	$448.0
	Other Funds	$0.0	$0.0	$0.0
	Total	$7,288.4	$8,192.8	$904.4
Health Care Medicaid Services	General Funds	$182,938.4	$198,268.6	$15,330.2
	Federal Funds	$460,689.2	$476,055.8	$15,366.6
	Other Funds	$11,071.7	$7,169.2	-$3,902.5
	Total	$654,699.3	$681,493.6	$26,794.3
Senior and Disabilities Medicaid Services	General Funds	$129,770.1	$144,987.6	$15,217.5
	Federal Funds	$222,359.0	$235,502.3	$13,143.3
	Other Funds	$3,752.2	$3,752.2	$0.0
	Total	$355,881.3	$384,242.1	$28,360.8

Source: Medicaid Budget Group Using Alaska Budget System data.

	General Funds	Federal Funds	Other Funds	Total
Total All Change Records for Medicaid Services	**$34,694.8**	**$32,811.6**	**($3,902.5)**	**$63,603.9**

Transfers to Other Components and Reduction of Excess Authority (OCS, HCS)

($3,742.5) ($2,748.4) ($4,000.0) ($10,490.9)

The department can adjust its authorization this year to reflect the current state of the Medicaid program and the services provided. This includes a decrease in interagency receipts authority related to the discontinued ProShare program, the transfer of GF and Federal funds to Public Health Nursing for Medicaid administrative claiming, the removal of excess federal authority from OCS, and the transfer of non-Medicaid eligible costs to Residential Child Care.

Medicaid Growth (DBH, HCS, SDS)

$36,203.5 $35,407.5 $0.0 $71,611.0

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 the 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.

Enhance Medicaid Dental Prevention Benefits (HCS)

$200.0 $0.0 $0.0 $200.0

This increment will support the department's continuing efforts to provide dental care for non-Medicaid covered services. These services include: dentures, crowns, cleanings, routine dental exams, and other preventive services. Outreach to the dental provider community, as well as an increase in dental reimbursement rates in both FY09 and FY10, has resulted in increased participation by dental providers. In addition, both overall costs and the total number of individuals served have increased. The number of beneficiaries utilizing dental services saw an increase during FY09 of 9.3%, and the annual average cost per beneficiary rose by 17.5%.

Improve Medicaid Tobacco Cessation Services (HCS)

$0.0 $152.5 $97.5 $250.0

This increment will be used to modify the Medicaid tobacco cessation service coverage so that Medicaid-covered services are more effectively coordinated with the efforts of the Tobacco Quit Line, the American Lung Association, and tribal efforts. This funding will also be used to assist public education and to partner with other advocacy groups to deter young kids from starting to smoke or chew tobacco products. While quantifiable and standardized measures are still in the discussion phase and have to be agreed upon, they could include reduced Medicaid payments addressing secondary conditions associated with smoking as well as the reduced effects of maternal smoking on newborns.

Transfer General Fund from Alaska Pioneer Homes for Medicaid Match Payment (SDS)

$2,033.8	**$0.0**	**$0.0**	**$2,033.8**

The division currently receives GF match related to Residential Assisted Living Medicaid Waiver receipts as inter-agency receipts through reimbursable service agreements with the Alaska Pioneers Home division. Transferring the GF match to the Senior and Disabilities Medicaid Services component will increase efficiency and reduce paperwork by placing the general fund in the budget of the division responsible for making the match payment.

Vulnerable Populations

- Preliminary data for 2008 indicates an Alaska suicide death rate of 24.6 suicides for all ages per 100,000 population. This rate is more than double the stated target of 10.6.
- The target to decrease the rate of substantiated allegations of child maltreatment in Alaska was not met in FY09, as there was a 1.6% increase in the rate of maltreatment per 1,000 children from FY08 to FY09.

Substance Abuse

Substance abuse affects every family and community in Alaska. Through public/private partnerships and departmental strategies DHSS will help to prevent, intervene, treat and assist recovery from substance abuse among Alaskans. Key indicators are being developed.

Long-Term Care

- In FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent.
- In FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Health and Wellness

- In 2007, 70% of two year olds were fully immunized, which was below the 80% target rate, but slightly above the 67% in FY06. Alaska ranked 45th in the country for fully immunized two year olds.
- In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases.
- The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.
- The adult obesity rate was 27.9% in 2008, below the 28.2% in 2007. However, this was higher than the 26.6% national average and did not meet the 18% target rate.
- The post-neonatal death rate for 2008 was 3.0 per 1,000 live births, above the target of 2.3 per 1,000 live births, but below the rate of 3.3 per 1,000 in 2007.
- There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% target.

Health Care Reform

- From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.
- Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase.

Bring the Kids Home (BTKH)

What is Bring the Kids Home (BTKH)? From 1998-2004, out-of-state placements of children with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800% with no expectation that this trend would change without intervention. The Alaska Mental Health Trust Authority and DHSS organized a stakeholder group to plan, fund, implement and monitor the BTKH initiative. The goal was to develop an in-state system to serve children as close to home as possible and with the family guiding care. Significant progress has been made and FY10 was selected as the target date to end the BTKH initiative, assuming sufficient resources and adequate progress.

How much Progress Has Been Made? Use of out-of-state RPTCs has decreased greatly: admissions are down by 85.4% from 752 to 110 from the high year, FY04. Total yearly recipients are down by 57.6% from 749 to 318.

Use of in-state RPTC has increased: in-state recipients represented only 22.4% of the total RPTC population during FY04 (216 youth) but were 54.3% for FY09 (378 youth). There has been a steady decline in recidivism to RPTC: the recidivism rate dropped from 20% in FY04 to 4% in FY09.

Medicaid expenditures for out-of-state RPTC decreased by 51.3% between FY06 and FY09 ($40 M to $19.48 M). In-state RPTC Medicaid expenditures increased by 739% from FY98 to FY09 ($2.82 M - $20.87M).

What is Working? General funds, MHTAAR and Medicaid have been invested into in-state care. RPTC beds increased from 123 to 186 and lower level beds (residential treatment and therapeutic group/foster homes) went from 530 to 776. These new beds serve youth diverted from out-of-state.

Community behavioral health start-up grants have expanded non-residential services. Examples include sub-acute crisis stabilization, school supports, best practices for children with co-occurring disorders, and expanding mental health Medicaid access to new communities and new providers.

In addition, resource facilitation mechanisms have been established: State staff identify in-state resources and negotiate system gaps while contractors provide gate keeping, peer navigation and coordination. These services help to divert and step children down from residential and RPTC care.

An Individualized Service Agreement (ISA) flexible funding pool was established to pay for services to stabilize a child in the community which are not available through Medicaid, insurance, grants, etc. As ISA use has expanded, RPTC placements have dramatically decreased.

What are the Remaining Priorities? The state needs a system that can serve children with behavioral health problems and their families in communities across Alaska. In order to achieve this, we are *expanding successful strategies* statewide, *addressing funding gaps* and *shifting funding* to programs that reach children and families earlier and prevent severe disturbances.

Expanding Successful Strategies:
BTKH community behavioral health grants are developing in-state capacity to serve children with intensive needs and their families. During FY09 BTKH grantees accepted 41 children from out-of-state RPTC, diverted 129 from out-of-state RPTC and accepted 219 from more restrictive in-state care. However, some communities/regions have not applied for or received BTKH grants yet and have limited behavioral health capacity (Nome, Barrow, Valdez, Petersburg, Wrangell, Aleutians, Pribilofs, etc). Also, some BTKH projects are in a pilot phase and need to be expanded (family therapy, wraparound, etc).

During FY10, DHSS developed training modules and technical assistance targeting behavioral health services to increase revenues and reverse the trend of low billing and reimbursement: between FFY07 and FFY08 tribal Medicaid payments for mental health and substance abuse services decreased by 10.27%. Expansion of tribal behavioral health services will allow increased access to culturally competent care while capturing 100% federal match for services through tribal health organizations. The FY11 budget contains increments for this effort.

Another priority is to improve DHSS capacity to provide technical assistance and training. FY10 MHTAAR funds supported DBH to provide training to providers to expand family therapy services and to improve outcomes. The FY11 budget maintains the MHTAAR funding level for this effort.

Addressing funding gaps:
While ISAs are an effective strategy to divert youth from residential care, 27 eligible providers are not yet using ISA. Also, youth with a primary substance use disorder do not yet have access to ISA. For FY09 less than 1% of ISA recipients were subsequently admitted to an RPTC (5 out of 506). Additional funding is included in the FY11 budget to expand ISA use.

Youth with behavioral disorders transitioning to adulthood encounter service gaps and show poor outcomes: involvement with justice systems, mental health and substance abuse problems, unplanned pregnancy and homelessness. Covenant House Alaska reports that, of 627 youth who completed a FY09 intake assessment, 80% were mental health beneficiaries (501 youth). Within their Crisis Center, 34% of the youth reported a history of residential mental health treatment (65 youth). The FY11 budget contains increments for this effort.

Peer navigation services are limited in Anchorage, Mat-Su, Fairbanks, Juneau and Kotzebue, and are very sparse elsewhere. Peer navigation provides support, parenting classes, and resource facilitation. For FY08 and FY09, over 90% of the youth served who were at risk of out-of-home placement were able to remain in their own communities. Peer navigation can only be partially funded via Medicaid. The FY11 budget maintains the MHTAAR funding level for this effort.

Shifting funding to intervene earlier:
Alaskan stakeholders have identified service gaps for young children with behavioral health problems and their families: few clinicians are qualified to work with young children and early learning settings often expel children with behavioral challenges. The “Adverse Childhood Experiences Study” (which can be found at www.cdc.gov/NCCDPHP/ACE/index.htm) found that children exposed to traumatic experiences were more likely to engage in substance abuse, promiscuity, and suicide attempts and to experience mental illness, heart disease, cancer, and stroke.

Three BTKH projects are aimed at reducing traumatic experiences and intervening earlier. One project provides mental health consultation for young children in early care settings. A second provides a mental health clinician to work with professionals serving young children. Each will reduce the number and impact of traumatic events that impact children's development. A new FY11 project will provide foster parent and parent training and intensive family preservation. Intervening earlier can reduce the need to take children into custody and thus reduce trauma and costs. All three of these projects need FY11 funding to expand beyond the pilot phase and impact families statewide.

BTKH graphs are included in the chapter for the Division of Behavioral Health.

Families First

Families First is a service delivery strategy to increase collaborative services for families who are accessing services from multiple Health and Social Services providers. Families First facilitators are located in Kenai, Sitka, Anchorage, Wasilla, Nome and Fairbanks. These staff are responsible for coordination of efforts within their regions. DHSS offices of Public Assistance, Children's Services, Behavioral Health and Juvenile Justice are partners in Families First and share an abundance of families concurrently accessing many or all of our services. By working as a team, these partners give families a better opportunity to achieve their goal of becoming self-sufficient.

DHSS developed the Families First service delivery strategy to provide collaborative, community-based services, supports, and resources to families to help them become self-sufficient. Employment is the focus of this family-centered approach, and it relies on the creative and efficient use of family, community, and multi-agency resources. In addition to promoting the best possible outcomes for families, these services create opportunities for service providers to work together and work efficiently by making the best use of private and public resources. Many families who will benefit from this approach have complexities in their lives that make it difficult for them to compete in a labor market driven work search.

This approach focuses on solutions to help families be successful. Families frequently find themselves being "shuffled" among and between multiple government, private and non-profit community agencies. Families often report that they have difficulties meeting the expectations of multiple agencies from whom they receive services. This puts families in a difficult situation, because when they can't meet the expectations of an agency, they could very well lose their assistance.

Addressing this problem shines the light on a key aspect of Families First: teams made up of staff from multiple agencies gather in a collaborative meeting with the family to get a holistic view of their needs. The team approach includes learning about the family's daily lives to learn their needs, complexities, strengths and skills. The family is involved in all conversations and decision making. An important facet of this approach is that families engage in this process more strongly when their voice is heard and respected. Gathering this initial information is an important part of creating a family profile, which helps lay the ground work for delivering services and is the beginning of a plan for self-sufficiency.

National studies show that implementing wrap-around services has increased positive outcomes for families. By developing collaborative interdisciplinary service teams to help families identify critical issues and to create plans or strategies to mitigate challenges, families are able to make incremental advances towards self-sufficiency and improved family stability.

The Office of Children's Services' Family-to-Family program exemplifies this course of action as a core program component as the family and natural supports along with agency staff are involved in placement decisions for their children. The use of a coordinated team approach will establish reasonable performance expectations for families.

The primary purpose of Families First is to help families become self-sufficient. DHSS Families First uses "customized employment," a proven employment model for people with significant

disabilities. Customized employment is a blend of services designed to increase employment options for individuals with significant barriers to employment. The process discovers the strengths, skills, needs and interests of the job seeker. The team works with the job seeker to identify potential work sites. The team's Job Developer works with the management at the identified work site to determine if there are unmet needs to which the job seeker can contribute for a mutually beneficial outcome. The parties work together to negotiate a new job description. The goal of this "customization" is a meaningful employment relationship where both parties get their needs met. The model has been successfully implemented in Alaska by the Department of Labor and Workforce Development as part of a national initiative to promote employment for people with disabilities.

Alaska is moving forward to expand the Families First approach, and is hosting Families First trainings across the state for government, non-profit and community partners starting January 2010.

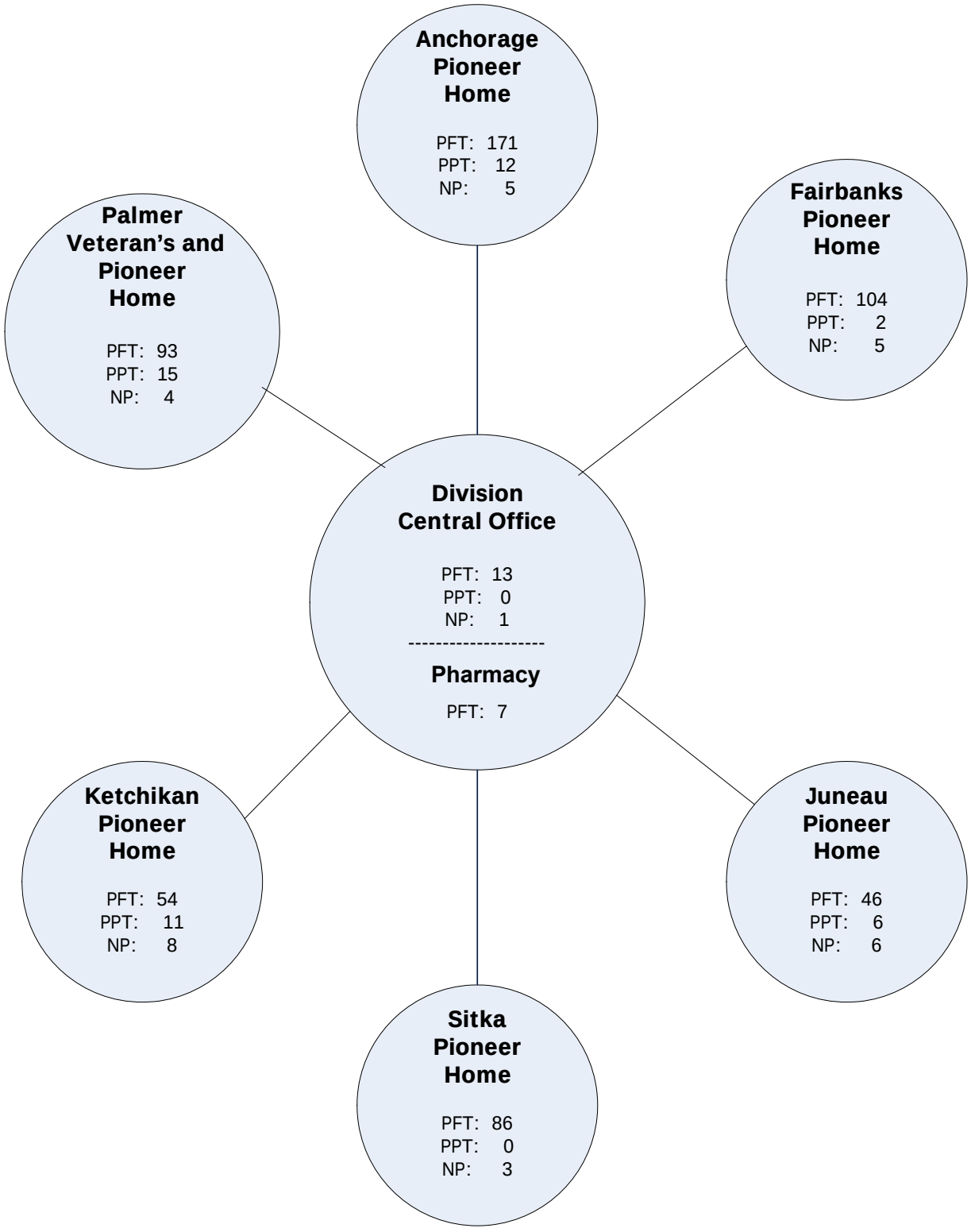
FY11 Capital Project Requests

Capital		FY11 Capital Funding Request (In thousands)			
DHSS Initiatives/ Divisions	***Project Titles***	***GF***	***Fed***	***Other***	***Total***
Vulnerable Alaskans					
Juvenile Justice	Johnson Youth Center Renovation and Remodel to Meet Safety and Security Needs -Phase I	9,880.0			9,880.0
Pioneer Homes	Pioneer Home Deferred Maintenance, Renovation, Repair and Equipment	4,000.0			4,000.0
Department Support Services	Non-Pioneer Home Deferred Maintenance, Renovation, Repairs and Equipment	3,000.0	20.0		3,020.0
	*Mental Health Deferred Maintenance and Accessibility Improvements	500.0			500.0
	*Mental Health Home Modifications and Upgrades to Retain Housing	500.0		550.0	1,050.0
	*Mental Health Housing – Pre-development, Anchorage Assets Building	500.0			500.0
Capital Budget Totals		**18,380.0**	**20.0**	**550.0**	***18,950.0***

****These projects are included in the mental health bill.***

Alaska Pioneer Homes

Functional Organizational Chart



Total Position Count: PFT 574; PPT 46; NP 32

Introduction to the Division

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 577 Alaska seniors during FY09. As of October 31, 2009, 316 Alaska seniors were on the active wait list and 2,747 individuals 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. 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 FY05 allowed for Pioneer Home residents to receive Medicaid benefits. With this change, federal funds (reflected in the budget as inter-agency receipts) also support the operating costs of the Pioneer Homes. The Homes received just over $5.55 million in Medicaid Waiver receipts in FY09 and are budgeted to collect $5.23 million in FY10.

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 Home Advisory Board

There are eight members on the Pioneer Home Advisory Board. Six are appointed by the Governor and one of the six is a Veteran of active military service. The chair of the Alaska Commission on Aging and the chair of the Alaska Veterans Advisory Council make up the remaining two members. Each member serves a staggered four-year term and members may serve a second term. All board members serve at the pleasure of the Governor.

The Board's mission is to conduct annual inspections of the Pioneer Home properties and division procedures and to recommend changes and improvements to the Governor. In addition the board meets at least annually to review admission procedures and to take public testimony from residents and interested parties about the five Pioneer Homes and the Veterans and Pioneer Home.

Pioneer Homes Wait List

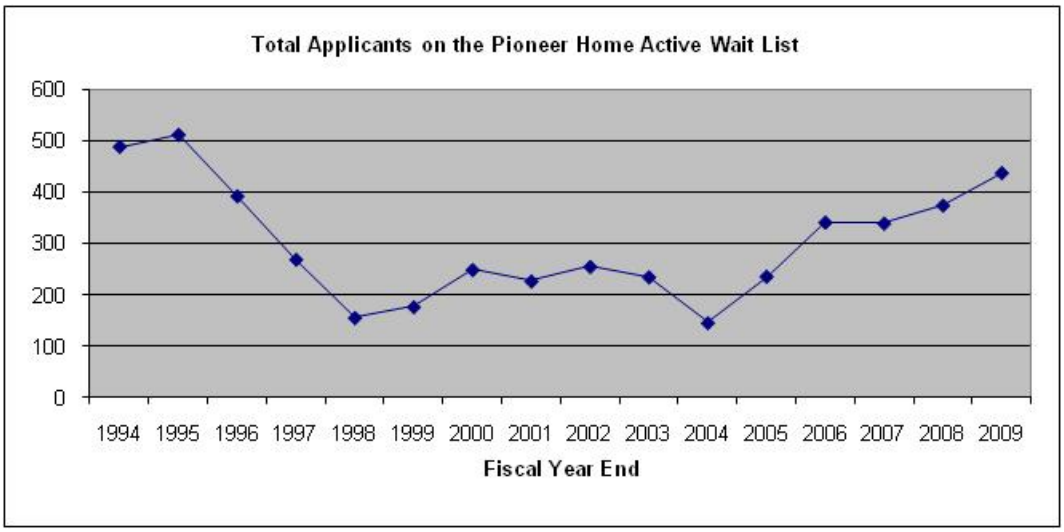
Individuals apply for admission to an Alaska Pioneer Home or the Alaska Veterans and Pioneer Home by completing and submitting an application. An individual who is a resident of the state for at least one year and has reached 65 years of age may submit an application. The date and time of the application's submission determine 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.

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
2009	4	86	122	129	34	62	437

The number of applicants on the active wait list increased over the past few years, 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.



The following table provides the composition of the Pioneer Homes wait list by facility as of October, 31 2009. Since October 2008, the active wait list increased by 2 and the inactive wait list increased by 187 applicants. During this same time period, the Pioneer Homes admitted 120 new residents.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	4	81	121	134	45	74	459
Inactive Branch	701	1,055	983	1,296	492	919	5,446
Total	**705**	**1,136**	**1,104**	**1,430**	**537**	**993**	**5,905**

Number of Applicants Choosing More than One Home (Duplicates)	2,842
Number of Actual Applicants on Active Wait List	316
Number of Actual Applicants on Inactive Wait List	2,747

Pioneer Home Rate History

The next chart shows the history of monthly rates within the Pioneer Home system. The July 1996 rate increase was the first increase in the Pioneer Homes Advisory Board's seven year plan to move towards charging Pioneer Home residents the full cost of care. The final increase of the seven year plan occurred in FY03.

In FY05 the rate structure and service levels were changed to reflect actual utilization. This rate change resulted in a rate decrease for those residents formerly receiving Comprehensive Care Services and an increase for the other levels of service.

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 proposed and implemented a five percent increase in the rates charged for the three levels of care effective July 1, 2009.

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 #1	Level #2	Level #3
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
July 2009	$2,350	$4,260	$6,170

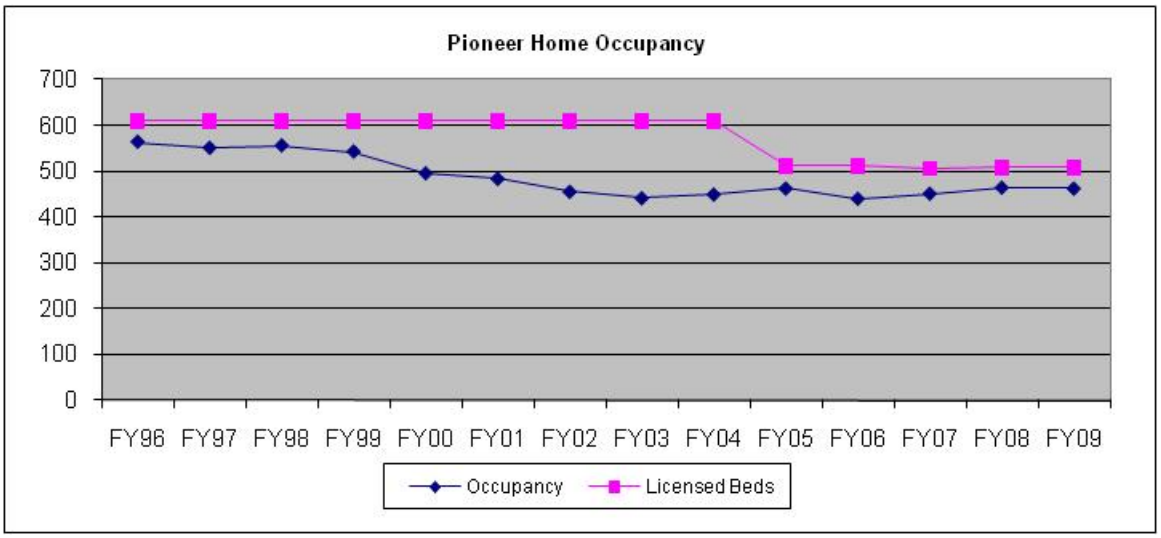
Assistance from the Older Alaskans Medicaid Waiver and the division's Payment Assistance Program are available for residents whose income and resources are insufficient to pay the full monthly rate.

Historical Pioneer Home Occupancy

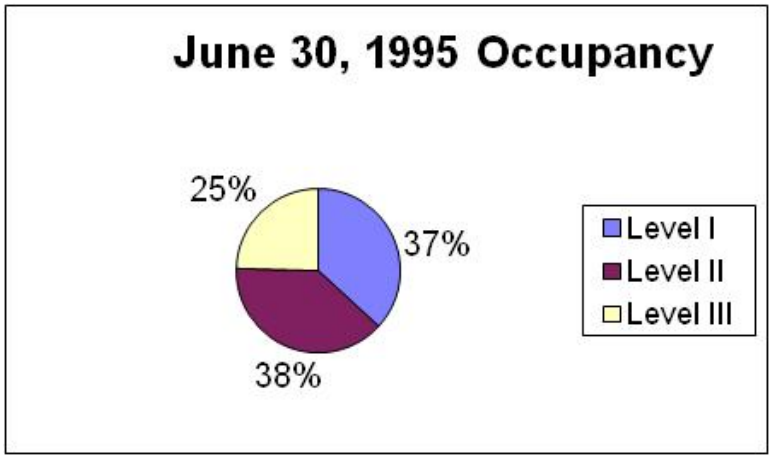
In FY05 the division reduced the number of its licensed beds by 91 to more accurately reflect the number of beds that meet current licensure requirements and are available for occupancy. In FY06 the licensed beds in the Fairbanks and Juneau Homes decreased by three to reflect a safer resident to staff ratio. Early in FY08, 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 for up to 508 Alaskan seniors.

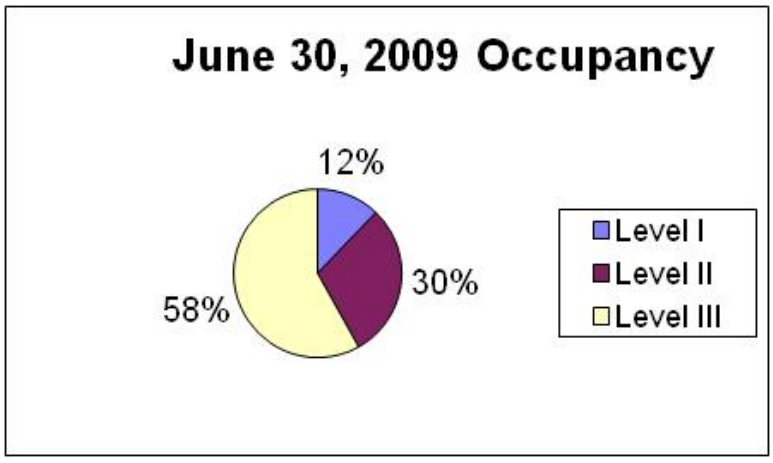
With family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. As of October 31, 2009, there were eleven Level I vacancies, ten Level II vacancies and ten Level III vacancies system wide. Those on the Pioneer Home active wait list tend to require Level II and Level III services and using 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 2009. As mentioned above, the gap between licensed and occupied beds significantly decreased in FY05 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 fourteen 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 58 percent, while those requiring Level I care decreased from 37 to 12 percent.





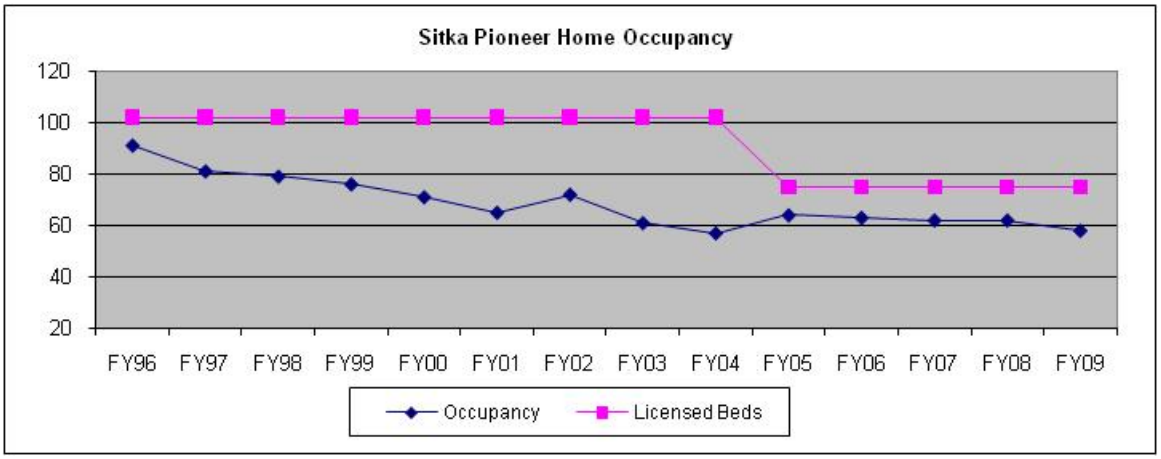
Current Pioneer Homes Occupancy

The table below shows the October 31, 2009 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home by level of service. Totals towards the bottom of the chart compare unoccupied beds, including nine unavailable beds, to licensed beds.

Service Level Occupied/Assigned	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Level I	5	8	5	32	6	1	57
Level II	24	23	14	55	6	17	139
Level III	30	53	53	79	31	26	272
Total	59	84	72	166	43	44	468
Licensed Beds	75	93	79	168	48	45	508
Un-Occupied	16	9	7	2	5	1	40
% Beds Filled	78.7%	90.3%	91.1%	98.8%	89.6%	97.8%	92.1%

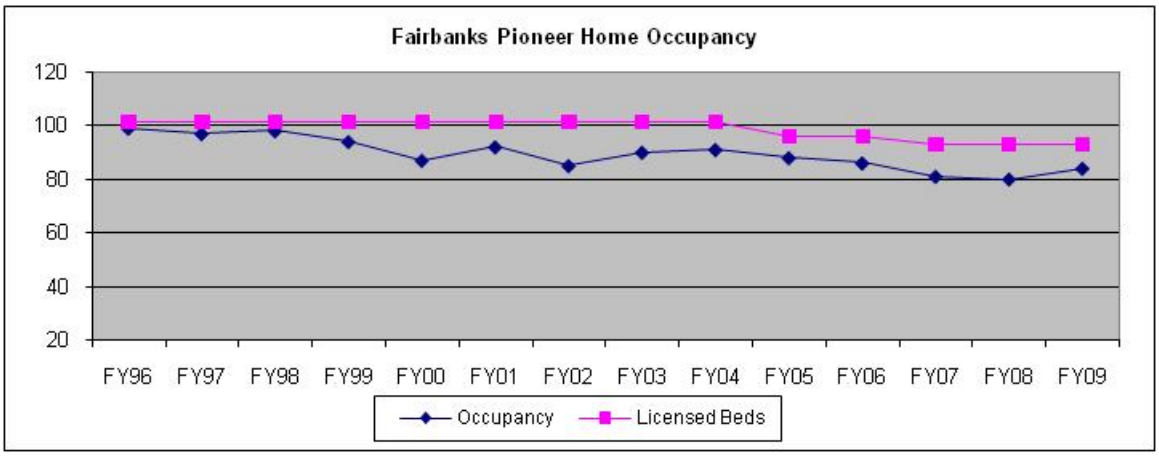
Sitka Pioneer Home

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, 59 were occupied as of October 31, 2009.



Fairbanks Pioneer Home

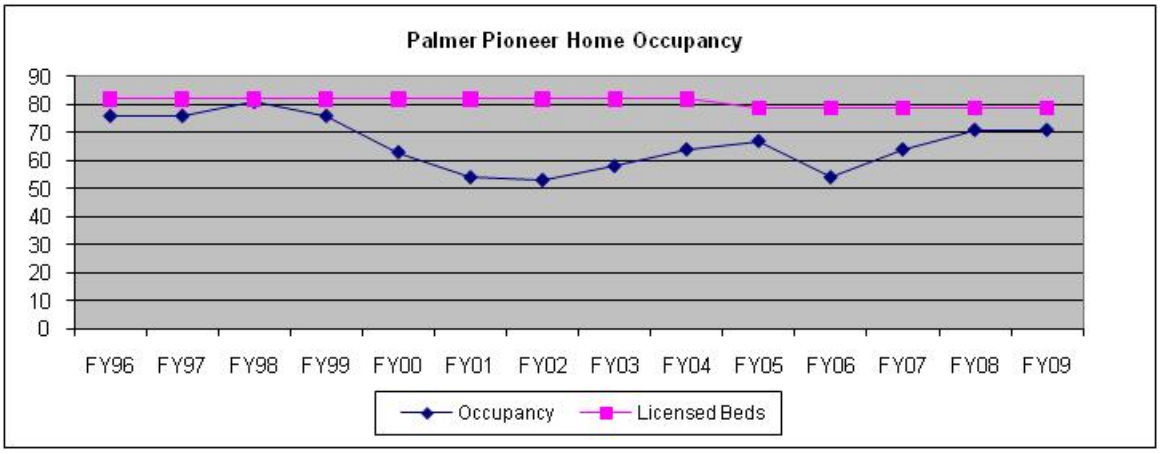
The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. As of October 31, 2009, 84 of the 93 licensed beds were occupied. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93.



Palmer Pioneer Home

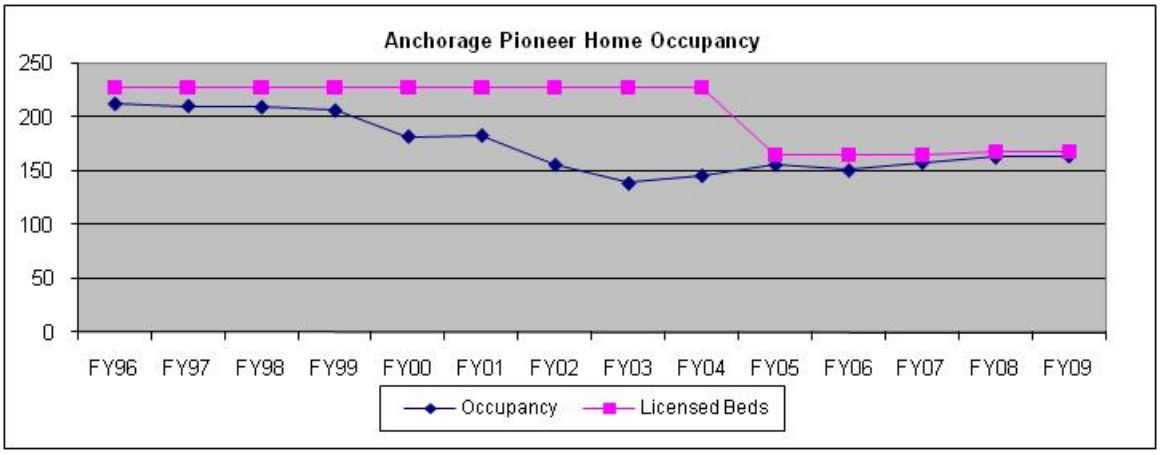
The Palmer Home, located in the Matanuska Valley, was built in 1971. It is a single level, ranch-style building and encompasses 11 acres of lawn and gardens. Within six years of opening, it became apparent more space was needed and an addition was built. As of October 2009, 72 of the 79 licensed beds 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 which is currently $35.84 per day. The Home is now transitioning to fill 60 of its 79 licensed beds with veterans. As of October 2009, 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 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.



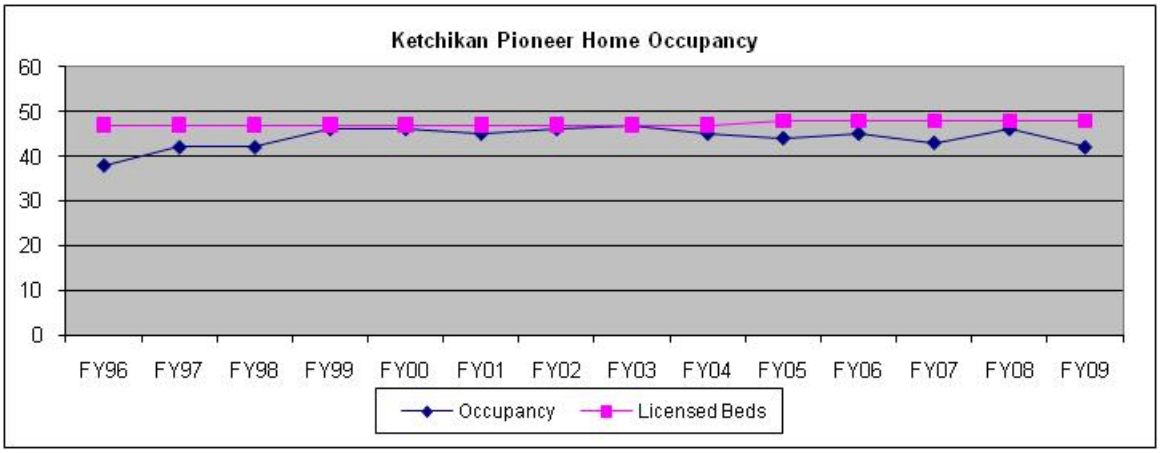
Anchorage Pioneer Home

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 2009, 166 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.



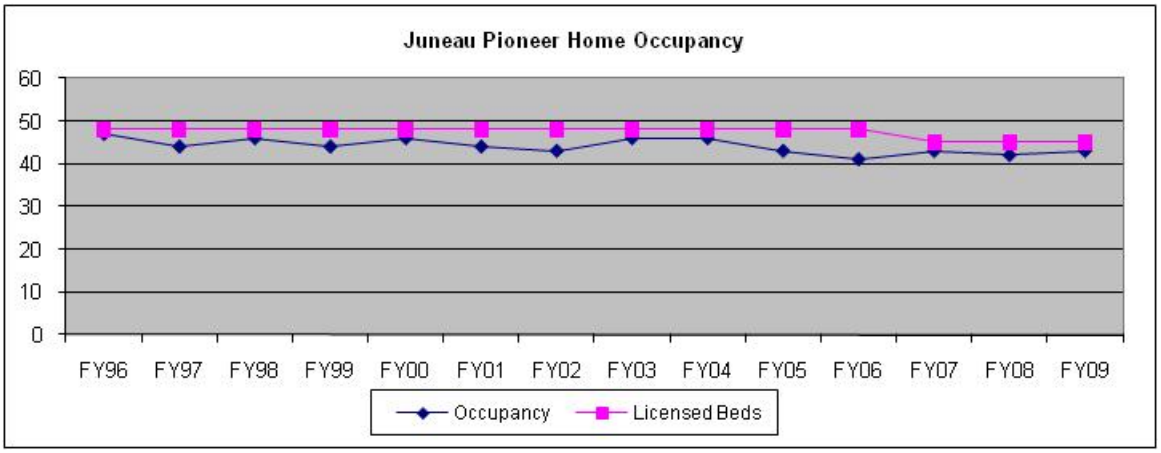
Ketchikan Pioneer Home

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 2009, 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 44 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
AS 44.29.500	Pioneers' Homes Advisory Board
7AAC 74	Pioneers' Homes – Revised August 2004

AK Pioneer Homes	FY10	FY11 Gov	10 to 11 Change
General Funds	33,164.7	30,771.5	(2,393.2)
Federal Funds	297.5	347.9	50.4
Other Funds	23,932.1	23,935.9	3.8
Total	57,394.3	55,055.3	(2,339.0)

Pioneer Homes

Transfer Match to the Division of Senior and Disabilities Services: *($2,033.8) GF*
The division receives Residential Assisted Living Medicaid Waiver receipts as interagency receipts from the Division of Senior and Disabilities Services (DSDS) and then pays the general fund (GF) match back to DSDS through reimbursable service agreements. Transferring the GF match to DSDS will eliminate a significant amount of staff time and paper work and place the match funding in the budget of the division who makes the payment.

Over time the division's interagency receipt authority has increased due to adjustments in personal service costs, health insurance, retirement, and Medicaid Waiver rate increases. However, funding to pay the GF match related to this increased authorization has not been provided and has resulted in the GF match being more than $530.0 underfunded.

Increase Federal Receipts for Veteran Per Diem Payments: *($50.0) GF, $50.0 Fed*
The division has over-collected the Federal receipt authority relating to Veteran per diem payments the past two years and projects an over-collection in FY10. The FY11 budget includes a fund source switch to replace $50.0 GF with Federal Receipts.

Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: *$4,000.0 GF*
This request is for deferred maintenance and renovation projects for the state's six Pioneer Homes. The homes are located in Ketchikan, Sitka, Juneau, Anchorage, Palmer, and Fairbanks, and have a combined replacement value of $310.3 million.

There are six pioneer homes throughout the state with an overall area of 443,354 square feet. The average age of the homes is 45 years with the oldest home (Sitka Pioneer Home) constructed in 1933. 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.

Challenges

Increased Resident Acuity
Level II and III residents in the Homes have increased from 63% in June 1995 to 88% in June 2009. 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. As of September 1, 2009 the average age of a Pioneer Home resident was 82.3. 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 316 applicants as of October 2009, an increase of 130 from the 186 on the active wait list in October 2005. This wait list is expected to grow significantly 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 of injury.

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 keep staff from providing direct care to residents. While we recognize the merits of increased documentation requirements, without additional staff we are unable to meet them and maintain the current level of care we provide our residents.

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 are 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.

Meeting the Veterans and Pioneer Home Goal of 75% Veteran Occupancy in the Veterans and Pioneer Home in Palmer
The Alaska Veterans and Pioneer Home was certified as a state veteran's home in February 2007. A condition of continued certification is that veterans must occupy 75 percent of the 79 licensed beds. During FY07 and FY08 the home continued to use wait list criteria that required offering a vacant bed to the person on the active wait list with the earliest application date. This sometimes meant that non-veterans were admitted for vacancies rather than veterans. In an attempt to increase the Home's veteran population, in FY09 applicants were separated into two wait lists, as either a veteran or a non-veteran and admissions alternated between the lists on a one to one ratio. In FY10 the ratio increased to two veteran admissions for every one non-veteran

admission. In FY11 the ratio will increase to three veteran admissions for every one non-veteran admission and in FY12 the ratio will increase again to four veteran admissions for every one non-veteran admission. Once all 79 beds are occupied, the seventy-five percent veteran to twenty-five percent non-veteran ratio will be maintained by filling the next vacant bed from the list the vacancy occurs in. As of October 31, 2009 there were 25 veterans residing in the Alaska Veterans and Pioneer Home.

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 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 space at the Home that is being used for storage. 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.

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

Target #1: Reduce resident serious injury rate

Status #1: In FY09, the medication error rate decreased to .13% while medications administered increased to an average of 499,366 per fiscal quarter, up from 434,464 in FY06.
In FY09, our sentinel event injury rate from falls decreased to 2.7%, down from 2.9% in FY07.

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.

A1: Strategy - 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 FY09, the medication error rate decreased to .13% comparing favorably with the target medication error rate of less than one percent.

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	0.13%	0	0	0	0
2009	0.15%	0.10%	0.13%	0.14%	0.13%
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 - 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 FY09, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 2.7%, exceeding the 2% target rate, but in line with past performance on this measure.

Fiscal Year Sentinel Event Injury Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2010	2.3%	0	0	0	0
2009	1.3%	2.3%	3.4%	3.8%	2.7%
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 as five times more likely than other injuries to lead to the hospitalization of older adults. 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.

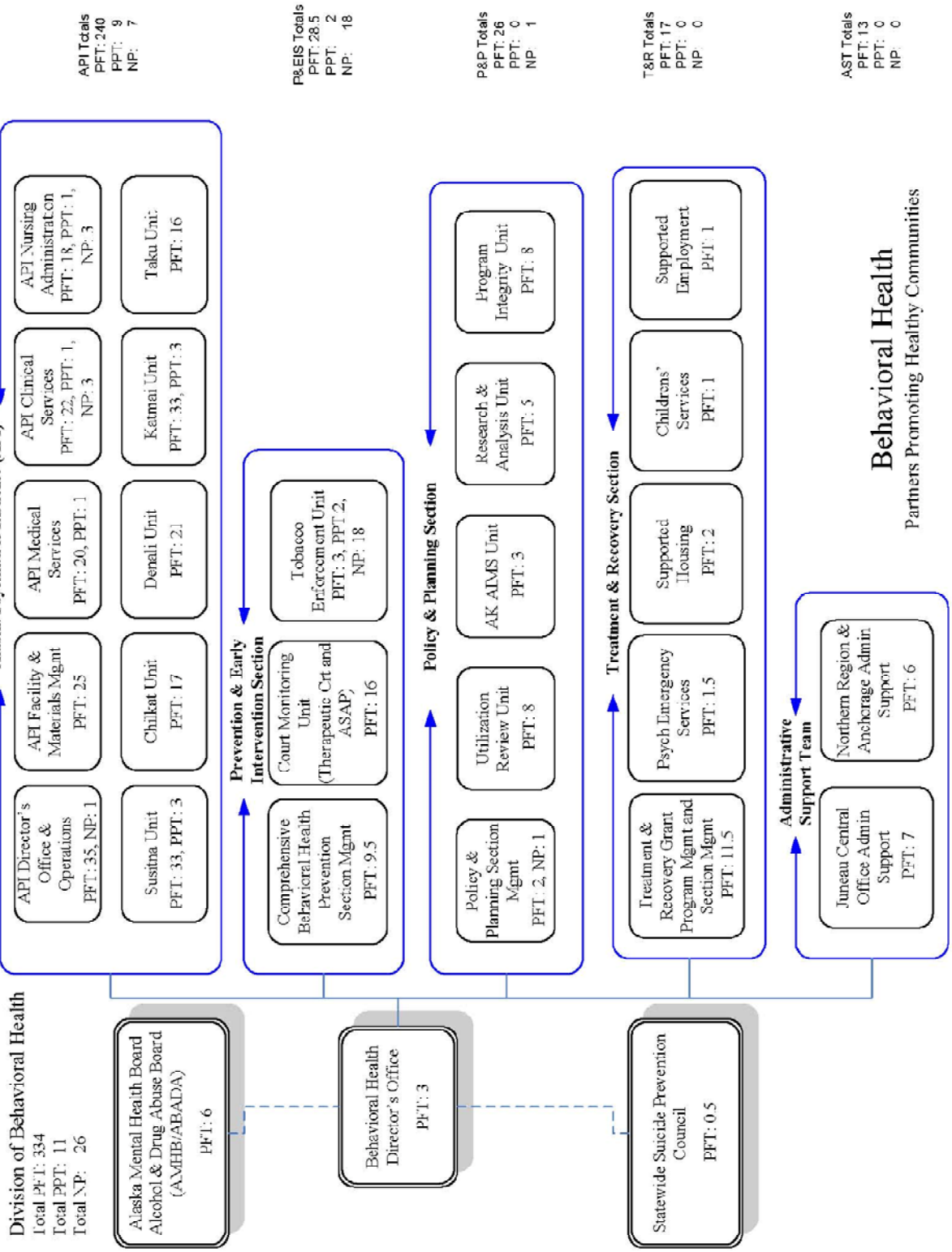
As of September 1, 2009 the average age of Pioneer Homes residents was 82.3, putting them in the highest risk category for suffering a serious injury from a fall that could lead to death.

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

FY11 Governor's Request Increment and Decrement Fund Breakout

Alaska Pioneer Homes FY11 Governor's Request **General and Other Fund Requests** (Increases and Decreases only)				
Item	**GF**	**Federal**	**Other**	**Total**
Federal Receipts for Veteran's Per Diem Payments	$ (50.0)	$ 50.0	$ -	$ -
Reverse August FY2010 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	$ (327.3)	$ -	$ -	$ (327.3)
Alaska Pioneer Homes Total	***$ (377.3)***	***$ 50.0***	***$ -***	***$ (327.3)***

Behavioral Health



Introduction to the Division

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 funds services which insure that Alaskans are afforded access to a statewide continuum of services. The continuum of statewide behavioral health services range from prevention and early intervention through treatment, to inpatient psychiatric hospitalization. Services are provided in community-based outpatient settings, school-based programs, residential/hospital facilities, and involve 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. 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, and coordinates with municipalities, tribal and private providers to ensure Alaskan residents access to comprehensive behavioral health services. In our efforts to maximize the treatment opportunities and access for our citizens, DBH frequently collaborates with the Alaska Mental Health Trust Authority, the Alaska Mental Health Board (AMHB), the Advisory Board for Alcoholism and Drug Abuse, the Statewide Suicide Prevention Council, other divisions within DHSS, other Departments within state government, providers, and advocacy groups.

Core Services

The core service of the Division of Behavioral Health is to provide a continuum of statewide mental health and substance use disorder services ranging from prevention and early intervention to treatment including services for seriously mentally ill adults, services for seriously emotionally disturbed youth, substance use disorder services, and operation of the Alaska Psychiatric Institute.

The long-term outcomes of the Division of Behavioral Health are:

- 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; and,
- All community members are connected, resilient and have basic life skills.

Services Provided

Prevention and Early Intervention Services
The section of Prevention and Early Intervention Services within the Division of Behavioral Health provides an array of comprehensive behavioral health programming.

In alignment with the division's vision of "partners promoting healthy communities", the core services include the following: community-based substance use prevention; fetal alcohol spectrum disorders services; suicide prevention; youth development, resiliency and connectedness; tobacco enforcement and education; Rural Human Services Systems project; and Alcohol Safety Action Program (ASAP). These services are blended to work in partnership toward our common goals.

To carry out these services, four primary grant programs have been established to provide funding to community-based agencies across Alaska:

- Comprehensive Behavioral Health Prevention and Early Intervention Services
- Alcohol Safety Action Program
- Fetal Alcohol Spectrum Disorders Diagnostic Team Provider Agreements
- Rural Human Services Systems Project

Comprehensive Behavioral Health Prevention and Early Intervention Services:
Grant program funds a comprehensive array of promotion, prevention and early intervention approaches that focus on community designed and driven services. These services are based on concepts and program strategies that have proven to be effective in prevention of behavioral health concerns; they have clearly defined qualitative performance outcomes. These grant dollars "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. We want communities to have the freedom to connect these issues, to partner and collaborate with community members working on connected and interrelated issues, and to focus on what it will take to develop overall community health and wellness. Currently 39 community agencies receive funding through this grant program in remote or rural, as well as hub and urban, communities. Each community applying for these funds must use the SAMHSA Center for Substance Abuse Prevention's Strategic Prevention Framework (SPF) planning model to assess, plan, strategize, implement and evaluate community-based services. Prevention strategies must be identified, based on a clear assessment of local/regional data, selecting programs or practices that are data-driven—what does the data tell you are the most important issues the community is facing? This model promotes a better connection between program selection and the critical issues facing the community, as evidenced by the available data.

SAMHSA'S Strategic Prevention Framework (SPF)

Alcohol Safety Action Program (ASAP): Grant funding is made available to communities working in partnership with their local court systems. 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, offering a consistent process for alcohol-related misdemeanant cases in communities served by an ASAP program. ASAP funded programs 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 the courts. ASAP is an integral part of the criminal justice and the behavioral health care service systems, providing invaluable and necessary monitoring and tracking of clients referred to substance abuse services throughout the State. This program requires a close working relationship among all involved agencies, including law enforcement, prosecutors, judges, probation officers, corrections, rehabilitative services, motor vehicle licensing, traffic records, public information/education, and treatment services. Community agencies receiving ASAP grant funds provide early identification of problems or high risk behaviors, and initiate appropriate referrals to substance abuse education and/or treatment providers. Current programs are located in Anchorage, Fairbanks, Juneau, Kenai/Homer, Ketchikan, Kodiak, Kotzebue, Wasilla/Palmer, Dillingham, Seward, Nome, and Bethel. In FY10, the ASAP program incorporated Motivational Interviewing (MI), an evidence-based practice, as a model for increasing the engagement of clients during their first encounter with ASAP staff. Through the use of MI-styled interviews, the expected outcome is that clients will be motivated to change their personal behaviors and attitudes related to alcohol and other drug use, thereby increasing their completion and success rate following the receipt of required services.

Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Team Provider Agreement Program: The FASD Diagnostic Teams provide a system for trained and approved community-based FASD Diagnostic Teams, who receive a Provider Agreement payment following the completion of a FASD diagnosis. Currently nine community-based FASD Diagnostic Teams are registered as State "approved" providers of FASD diagnostic services. Teams are located in Bethel, Kenai, Fairbanks, Anchorage, Juneau, Sitka, Mat-Su Valley and Kodiak. A new team in Anchorage has submitted the paperwork to be considered for Provider Agreement status. With the addition of this new Anchorage team, the Anchorage area will be more broadly served, as the current Anchorage team primarily serves Alaska Native beneficiaries. The new team will provide services to all individuals in the Anchorage area. During FY09, a total of 161 diagnoses were completed, representing a 17.5% increase from FY08 (137 completed diagnoses). 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, such as case management, clinic coordination or parent navigator peer services.

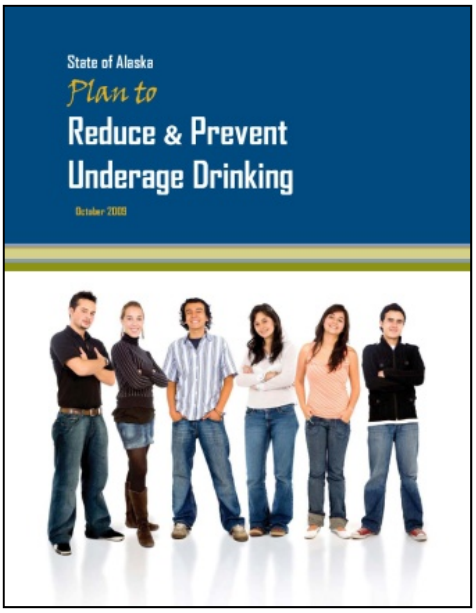
Rural Human Services Systems Project (RHSSP): RHSSP is a partnership between Department of Health and Social Services, Division of Behavioral Health and the University of Alaska Fairbanks (UAF), College of Rural Alaska. The long-term outcome for the RHSSP is to have a trained, culturally competent and stable/sustainable behavioral health workforce in all rural and remote Alaskan villages. The original vision for the Rural Human Services educational program was "a counselor in every village"; the vision remains the same today. 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 or urban agencies serving a significant number of rural clients, and thereby provide funding for educational support, and for part or full-time internships at local agencies for

students taking RHS classes and completing their certification. Through financial support and supervision, these village-based student interns function as behavioral health paraprofessionals 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 rural educational "pipeline" for rural students who can complete a 30-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 RHSSP grants fund students through thirteen regional hub agencies in rural Alaska from Kotzebue to the Eastern Aleutian Islands.

In addition to grant-funded programs, the DBH section of Prevention and Early Intervention Services has a number of other programs and initiatives that complement our grant programs. They include the following:

Alaska's Plan to Reduce and Prevent Underage Drinking

In October 2009, the Division of Behavioral Health, in partnership with the Alaska Interagency Committee to Prevent Underage Drinking (AKPUD), released the State of Alaska Plan to Reduce and Prevent Underage Drinking in response to the 2007 "Call to Action to Prevent and Reduce Underage Drinking" by the Acting Surgeon General. The AKPUD was organized in 2007 to begin looking at Alaska's data and needs related to youth alcohol use. The Committee includes representatives from the following: DHSS Behavioral Health and Juvenile Justice; the Department of Education and Early Development; the DOT/PF Alaska Highway Safety Office; the Alaska Court System; the DPS' Alcoholic Beverage Control Board; and the Alaska Native Justice Center. The plan was developed with input from the interagency committee, 25 Town Hall meetings on Underage Drinking, and public comment from a diverse group of Alaskans. It is organized to provide recommendations on three levels of interaction (national; state; and community) and eight strategy components (media campaign; alcohol advertising; limiting access; youth oriented interventions; community intervention; government assistance and coordination; alcohol excise taxes; and research and evaluation). The AKPUD continues to meet, and is developing a plan for engaging communities in strategies for state and community action. In partnership with the federal Center for Substance Abuse Prevention, the Division of Behavioral Health will be developing a video or a series of public service announcements related to underage drinking. During the spring of 2010, DBH will hold a third series of Town Hall meeting on underage drinking.



Copies of the Plan are available at:
http://www.hss.state.ak.us/dbh/prevention/docs/2009_underagedrinkplan.pdf.

Building Community Coalitions

In an effort to increase community partnerships, coordination and collaboration, the Prevention and Early Intervention Section sponsored a 2-day training called Beyond the Basics: Core Competencies that lead to Successful and Sustainable Coalitions. The training, September 28-29, 2009, was provided by the national Community Anti-Drug Coalitions of America (CADCA), with 200 participants attending from across Alaska. All DBH prevention grantees were required to attend, as our prevention efforts begin moving toward community coalition work. Coalition building is a proactive strategy that promotes coordination and collaboration, and makes efficient use of limited community resources. By connecting multiple and diverse sectors of a community and developing a comprehensive approach to a common issue (such as driving under the influence, domestic violence, or suicide prevention), coalitions can achieve amazing and sustainable outcomes—much more than could ever be achieved alone. This training began preparing community partners to be eligible for new federal funding that will be available through the Strategic Prevention Framework State Incentive Grant. In July 2009, the Division of Behavioral Health received a 5-year, $10.7 million federal SAMHSA prevention infrastructure grant that will award approximately six community grants to prevent substance use across Alaska. Grant solicitation will occur during the summer of FY11.

Therapeutic Court Programs

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. In an extension of the Alcohol Safety Action Program model, DBH Prevention is now working in partnership with the Alaska Court System, to enhance and increase screening, monitoring and case management services, for individuals with felony alcohol convictions who volunteer to engage with one of the many therapeutic court programs across Alaska. 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. Through this partnership, we have Therapeutic Court Probation Officers in Anchorage, Barrow, Fairbanks, Bethel, and Ketchikan. Through this initiative, we work in close partnership with substance abuse treatment providers, to maximize successful outcomes for therapeutic court clients.

Tobacco Enforcement and Education

In addition to our ongoing grant programs, the Prevention section of DBH includes the Tobacco Enforcement and Education program that works directly in communities across Alaska to reduce youth access to tobacco products from retailers. This program monitors the compliance of retail outlets with state-approved Tobacco Endorsements that allow them to legally sell tobacco products. Tobacco investigations work in partnership with student interns (ages 15-17), who are hired and trained to visit retail outlets and attempt to purchase tobacco products while a Tobacco Investigator is in the store. 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 to minors in Alaska have dropped from 34% in 1999, to 9% in 2009. In addition to monitoring and compliance checks, Investigators provide retailers with educational information about the state tobacco laws, training in how to avoid selling tobacco to minors, and signage they can use to denote their policies of not selling tobacco to anyone under the age of 19. The program continues to show improvement and success in reducing access to tobacco products by minors.

Suicide Prevention and the Statewide Suicide Prevention Council

Suicide is a critical issue for the State of Alaska with a 2007 rate per 100,000 population of 23.1 compared to the national rate of 10.8 per 100,000. The DBH Prevention section is working on a number of projects through an ongoing suicide prevention initiative. First, the Statewide Suicide Prevention Council (SSPC) is housed within DBH, with staff support being provided by the section of Prevention and Early Intervention Services. The Council was continued for four more years following last year's Sunset Audit, with some minor changes made to the Council membership and adding one Public member. In partnership with the Council, DBH is working on a number of community planning initiatives, and is coordinating and planning for a Suicide Prevention Summit on January 11-13, 2010. The goal for the Summit is to bring together a diverse group of interested parties, to better coordinate the vast number of current projects related to suicide prevention, and to agree upon a joint "action plan" to reduce the suicide statistics in Alaska. In addition, DBH received a 3-year federal, $1.5 million Youth Suicide Prevention grant in 2009 that has funded three regional programs to work on reducing the incidence of suicide in their regions. Through this grant opportunity, we will participate in a national cross-site evaluation that will provide us with quality outcome information about the success of our regional efforts.

Treatment Services

The Treatment and Recovery Services section of Behavioral Health provides for treatment and recovery services within Alaska's publicly funded 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 affected by 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, and to improve their success and functioning. Services are available on an outpatient basis, residential, and acute care. Specific focus includes employment and housing. Integration of services continues to

better meet the needs of co-occurring disorders. The publicly funded programs primarily serve those Alaskans without insurance or the ability to pay for services.

Services for Substance Use Disorders (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; services 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. DHSS 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 treatment services for adults with severe mental illnesses; effective services at the community level help to control the number of admissions to Alaska Psychiatric Institute (API). Community-based services are intended to keep people with serious mental illness in their home communities as independent as possible in the least restrictive environment. Core services are assessment, psychiatric, pharmacological management, case management, and rehabilitative services. Specialized services include residential services and psycho-social supports.

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

Guiding Principles:

- Kids belong in their homes (least restrictive, most appropriate setting, community based).
- Strengthen families first (strength based, preventative)
- Families and youth are equal partners (family driven, youth driven).
- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Normalize the situation (meet the child where they are, respect normal life cycles, promote normal and healthy development).
- Help is accessible (coordinated and collaborative).
- Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

SEDY 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 to

decrease the number of children moving into out-of-state placements and restrictive in-state environments by increasing the capacity of home and community based services throughout the state.

Designated Evaluation and Treatment: The state, as a payer-of-last resort, makes funds available to designated local community and specialty hospitals, for "designated 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. This intervention is offered regionally in lieu of placement within our state hospital – API.

Using this funding, a local facility provides the level of intervention required to stabilize the patient and return them to their community or home. The service array includes inpatient psychiatric evaluations (0- 72 hours), crisis stabilization (4-7 days), or inpatient psychiatric hospital services (7-40 days) close to the consumer's home, family, and support system. Component funding also supports consumer and escort travel, to designated hospitals and back to their home community.

Alaska Psychiatric Institute: The Alaska Psychiatric Institute (API) provides twenty-four hour acute care inpatient psychiatric treatment to individuals from all regions in the state. Under Title 47 statutes, API serves Alaskans with severe and persistent psychiatric disorders, including adults and adolescents whose need for psychiatric services exceeds the capacity of local service providers. API also provides forensic services under Title 12, with court-ordered competency evaluations, evaluation and observation services, as well as restoration to competency. API has evolved as an inpatient acute care training facility for psychiatry and behavioral health for the University of Alaska Nursing, Social Work and Psychology Programs. Similar training opportunities are provided to third and fourth year WAMI Medical students.

Services provided at API include the following:

- 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.

Effective and Efficient Management and Administrative Services

The management structure within behavioral health administration includes 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.

DHSS Behavioral Health leadership work closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Mental Health Trust Authority, and the Statewide Suicide Prevention Council to determine policy governing the planning and implementation of prevention services and supports, for people who experience mental illness, substance abuse disorders, or both. DBH collaborates in planning and program efforts with other organizations within the department (e.g., 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 Departments of Education, Corrections, and Public Safety.

During FY09, DHSS Behavioral Health applied continuous quality improvement principles to business practice and management philosophy, specifically in relation to these "core functions:

- Monitoring and managing the use of public funds to provide accessible, effective and efficient prevention and treatment services for Alaskans with the following problems: substance use disorders, mental illness, a combination of both; individuals with traumatic brain injury, and/or fetal alcohol spectrum disorders;
- Developing regulations and policies that govern the planning and implementation of services and supports for people who need BH services; and,
- Insuring effective and efficient management and administration of publicly funded behavioral health services.

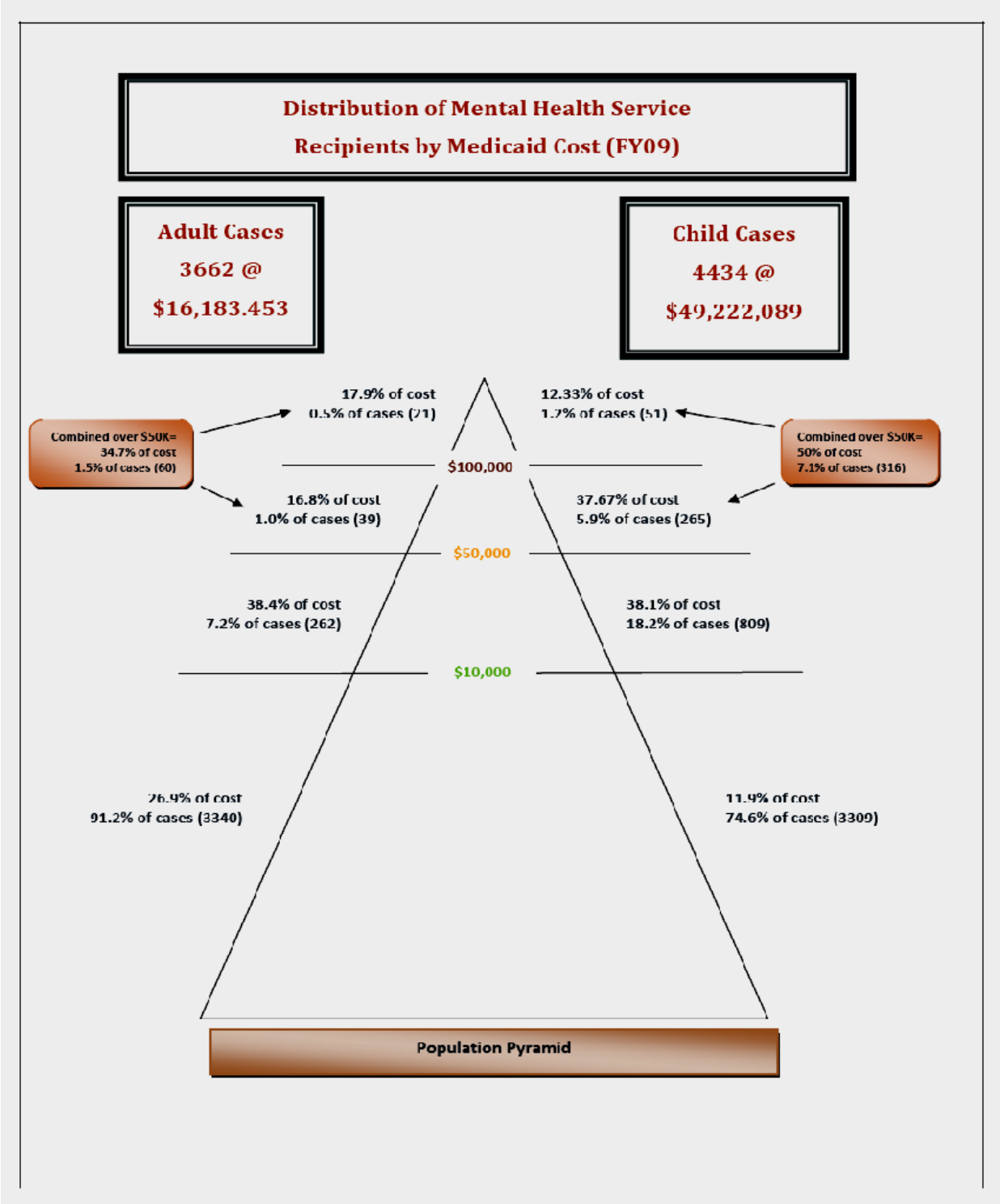
The DHSS Division of Behavioral Health implemented new business practices in an ongoing commitment to the development of a *Performance Management System*, which guide policy and decision-making for improving the behavioral health of Alaskans. The Performance Management System impacts at several levels:

- *The public service delivery system*— The performance measures address the following: how much did we do; how well did we do it; is anybody better off as a result.
- *Population planning*— The performance management system addresses the following questions: are Alaskans who need services getting them, and able to get them conveniently; do Alaskans with behavioral health disorders live with a high quality of life; and are efforts taking place to prevent or lessen problems that result in people needing services.

The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the division's *Performance Management System.* AKAIMS is successfully implemented with 100% of grantee provider agencies submitting data to the division. The grantee provider user network includes 70 agencies, with a combined individual user group membership of 1,965 people. The application of AKAIMS continues expanding to include new user groups. The Office of Children Services (OCS) manages 30 Behavioral Rehabilitation Services (BRS) residential facilities, and has initiated the transition to using AKAIMS as an electronic health record in those programs. Therapeutic courts have initiated two pilot sites (Nome and Anchorage) that interface with the AKAIMS, thereby linking data collection with the courts to access services.

During FY09, the division successfully implemented the AKAIMS "Ad-hoc Reporting" module. This allows a web-based report manager to be available to all grantee providers for accessing existing reports, as well as writing their own. Already, well over 100 reports have been generated that document "data completeness"; clients screened, served, and discharged; treatment outcomes; and specific management productivity reports of staff performance as they deliver services. This encourages collaboration between the division and providers, to insure quantity, quality, and outcomes are a shared value in service delivery.

The following chart illustrates an early staged effort of applying data to inform business practices. By looking at the number of cases and the corresponding Medicaid costs at different cost intervals, the presenting image has provoked further research, analysis and planning, which may justify alternative methods of monitoring and managing service delivery.



A key component of the grant *Performance Management System* is the method of distributing prevention and treatment funding, based on provider performance and outcomes (i.e. "performance based funding"). Alignment of the *Performance Management System* with the financing of the behavioral health system will insure system supportability and life cycle cost-based decisions. This was successfully initiated by the Division of Behavioral Health in 2007. For FY10 grant awards, DBH determined individual grant awards based on the RFP score assigned to each agency's grant application and agency performance as indicated by the Performance Based Funding (PBF) measures. In addition, where applicable, the Proposal Evaluation Committee (PEC) scores were taken into consideration for making final funding decisions. DBH made every effort to minimally impact the existing agencies that have worked so hard to continue providing quality services in a challenging economic environment. Some funds were shifted this year as a result of agencies closing or not reapplying for prior year grants.

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 and substance abuse treatment services for Medicaid eligible youth and adults, in both inpatient and outpatient settings.

Behavioral Health Prevention and Early Intervention Services Statistics

FY09 Alcohol Safety Action Program Case Statistics

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
ASAP New Case Statistics				
Adult ASAP	1,527	1,334	1,837	1,427
Juvenile ASAP	353	529	529	493
Total ASAP	1,880	1,863	2,366	1,920
New ASAP Cases Completed	406	311	525	531
Therapeutic Court Statistics				
Active Therapeutic Court Cases	167	173	187	175
New Therapeutic Court Cases	43	55	51	43
Therapeutic Court Graduates	26	23	15	14

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, which accounts for a greater number of Therapeutic Court Cases. These are felony clients and mental health clients. The case management includes nearly daily contact, urinalyses, group sessions and weekly court sessions. The active Therapeutic Court Case data captures all cases that are being monitored throughout the state. The remaining five Probation Officers handle misdemeanor ASAP referrals.

What is working?

Felony Drug Court (Anchorage) has lowered recidivism:

- 54% of the participants in these courts graduated.
- A 13% rate of re-arrest within 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

FY09 Tobacco Enforcement Statistics

Synar: In 1992, Congress adopted the Synar Amendment, as part of the Alcohol, Drug Abuse and Mental Health Reorganization Act. The Synar Amendment requires states to adopt laws

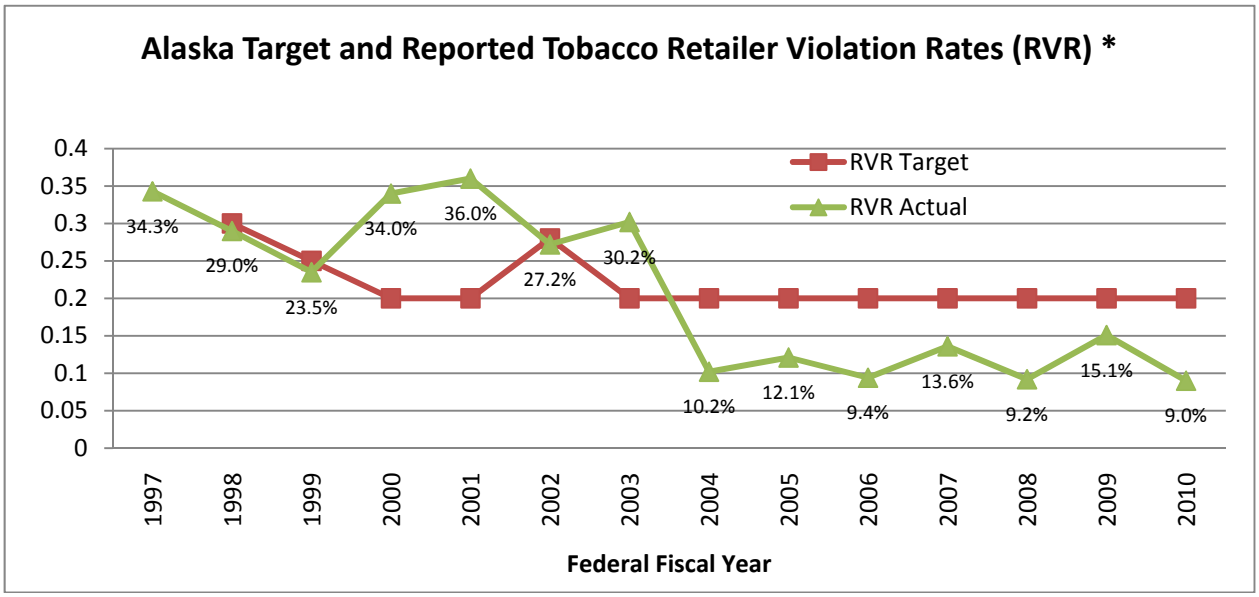
establishing a minimum age for tobacco sales, to enforce the law, and to show progressive reductions in retail availability of tobacco products to minors. To be considered in compliance, states need to maintain a 20% or lower rate of sales to minors.

What is the Synar survey? The Synar survey is an annual, statewide undercover youth tobacco survey, conducted to ascertain the State's compliance with laws that prohibit sales of tobacco products to youth. To be eligible to receive the federal SAMHSA Substance Abuse Prevention & Treatment Block Grant, DBH must complete this survey.

Why is participating in this survey important? States that do not participate in this survey, or whose rates are higher than 20%, may lose their eligibility for the SAMHSA Block Grant and receive reduced funding. These funds are used to support alcohol and other drug treatment and prevention programs and services. It is also important to conduct this survey and conduct tobacco enforcement as a means to decrease youth access to tobacco.

Prior to the State being in compliance:

Data Collection Year (Calendar Year)	Synar Report Year (Federal Fiscal Year)	Illegal Sales Rate	Penalty to Alaska
1999	2000	34%	$481,687
2000	2001	36%	$478,633
2001	2002	27%	Federally negotiated rate, no penalty
2002	2003	30%	$458,230



* Alaska Target and Reported Tobacco Retailer Violation Rates (RVR)

- Retailer Violation Rates (RVR) reported in Federal Fiscal Years (FFY) represent work completed in the previous FFY. For instance, the FFY10 rate represents inspections completed prior to October 1, 2009.
- FFY97 represents a baseline rate. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) negotiated RVR targets between FFY98 and FFY02. SAMHSA required that each state reduce its RVR to 20% or less as of FY03.

- Data source (FFY97 - 08): "State Target and Reported Retailer Violation Rates," SAMHSA, http://prevention.samhsa.gov/tobacco/TobaccoRatesFFY97_08.pdf as accessed on 11/24/09. FY09 RVR approved by SAMHSA on 03/07/09. FFY10 RVR is provisional.

Behavioral Health Treatment and Recovery Services Statistics

Treatment and Recovery Services: Program Enrollments

Access to a comprehensive, integrated service system is critical in order to improve and enhance the quality of life of Alaskans who experience a behavioral health problem. Measuring treatment services through program enrollments is an effective method of documenting accessibility of services.

During FY09, the Division's behavioral health system of care provided 19,144 program enrollments for target populations, and 1,851 program enrollments for non-target populations (total = 20,995 program enrollments). Note: program enrollments are not an unduplicated count of individuals served, as one person may be enrolled in several programs.

FY09 Program Enrollments for Target Populations (total enrollments = 19,144):

- 8,443 enrollments for adults experiencing a serious mental illness (SMI)
- 4,096 enrollments for youth experiencing a serious emotional disturbance (SED)
- 6,605 enrollments for adults and youth experiencing a substance use disorder (SUD)

FY09 Program Enrollments for Non-Target Populations (total = 1,851):

- 1,087 enrollments for adults experiencing a lesser degree of mental illness (Non-SMI)
- 764 enrollments for youth experiencing a lesser degree of emotional disturbance (Non-SED)

FY08 was the first year for reporting program enrollments using the Alaska Automated Information Management System (AKAIMS). During FY08, numerous grantee agencies struggled with data submission requirements, and were not able to enter all client records into AKAIMS. Therefore, FY08 program enrollments are under-reported. The Division's efforts to help grantee providers, with technical assistance and reporting performance-based measures specific to data completeness, has greatly improved the AKAIMS data collection, analysis and reporting capabilities. The number of enrollments reported in FY09 reflects a significant improvement by grantee agencies toward complete electronic health records, and will be considered a baseline year.

Improvements in data collection have resulted in more complete measurement of program enrollments.

- The reported number of SMI program enrollments increased 23.3%, from 6,848 in FY08 to 8,443 in FY09.
- The reported number of SED program enrollments increased 53.0%, from 2,677 in FY08 to 4,096 in FY09.
- The reported number of SUD program enrollments increased 27.5%, from 5,180 in FY08 to 6,605 in FY09.

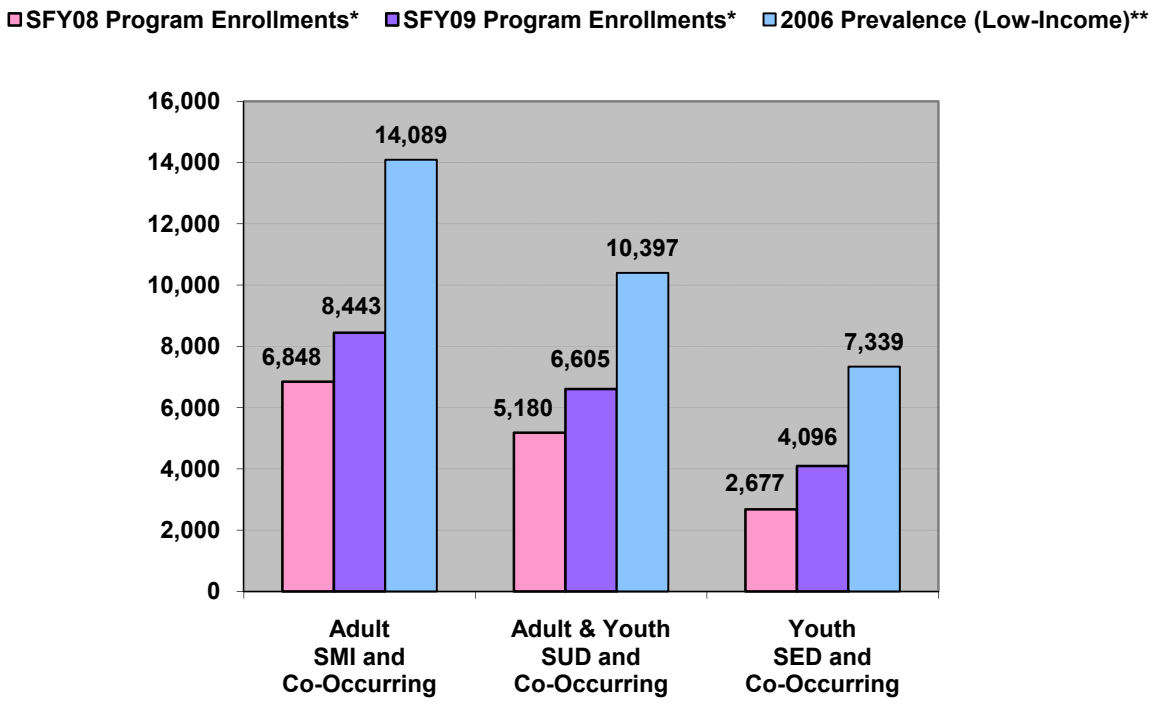
The division, in conjunction with the Mental Health Trust and Advisory Boards, completed the 2006 Alaska Prevalence Estimates of Serious Behavioral Health Disorders. These prevalence estimates can be used as a benchmark, to measure penetration rates of behavioral health services. The estimates, which 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 FY08 and FY09 target population program enrollments. The Division continues to expand AKAIMS reporting capabilities, and will soon be able to report unduplicated client counts. Prevalence estimates can then be used to measure penetration rates of behavioral health services.

Alaska 2006 Prevalence Estimates (Low-Income) and FY08 & FY09 Target Population Program Enrollments			
	FY08 Program Enrollments*	FY09 Program Enrollments*	2006 Prevalence (Low-Income)**
Adult SMI and Co-Occurring	6,848	8,443	14,089
Adult & Youth SUD and Co-Occurring	5,180	6,605	10,397
Youth SED and Co-Occurring	2,677	4,096	7,339

* Program enrollments are for Adult SMI (including Co-Occurring), Adult & Youth SUD (including Co-Occurring), and Youth SED (including Co-Occurring).
FY08 data source date: November 2008; FY09 data source date: August 2009

** 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 SUD prevalence estimates. Prevalence data source: 2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household; 15 January 2008

Alaska 2006 Prevalence Estimates (Low-Income) and FY08 & FY09 Target Population Program Enrollments



Key:
SMI: Serious Mental Illness
SUD: Substance Use Disorder
SED: Serious Emotional Disturbance
Co-Occurring: Mental Health & Substance Use Disorder

The Alaska Screening Tool (AST)

The AST functions as a standardized state-wide screening instrument that is designed to screen for substance abuse, mental illness, dual diagnosis, Fetal Alcohol Spectrum Disorder, and traumatic brain injury (TBI). The AST can produce multiple recommendations which in turn can result in more than one referral for consumers to indicated services. The AST data will assist the DBH and providers:

- to identify the needs of individuals, or families
- to identify the program needs of each agency,
- to ensure that people receive the indicated services, and
- to assist the state in federal reporting requirements.

Alaska Screening Tool Results: FY09						
Agency	Screenings	Screening Outcomes				
		Substance Abuse	Mental Health	TBI	FASD	Dual Diagnosis
Total Counts	12,966	8,295	10,392	4,184	1,155	6,949
Total Percentages		64%	80.1%	32.3%	8.9%	53.6%

Data Source: The Alaska Automated Information Management System (AKAIMS) and five agencies using an electronic data interface. Data source date: August 2009.

Screening is defined as an activity that determines the likelihood a client has presenting signs, symptoms, or behaviors that may be influenced by mental health, substance abuse or co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a process that typically is brief and occurs before or soon after the client presents for services.

For FY09 Alaska Screening Tool results, out of a total of 12,966 screenings, indicate the following:

- 8,295 cases identified with Substance Abuse (SA) needs
- 10,392 cases identified with Mental Health (MH) needs
- 4,184 cases identified as suspected Traumatic Brain Injury
- 1,155 cases identified as suspected Fetal Alcohol Spectrum Disorders
- 6,949 cases identified as suspected dual diagnosis (MH & SA)

Referrals for Assessment:

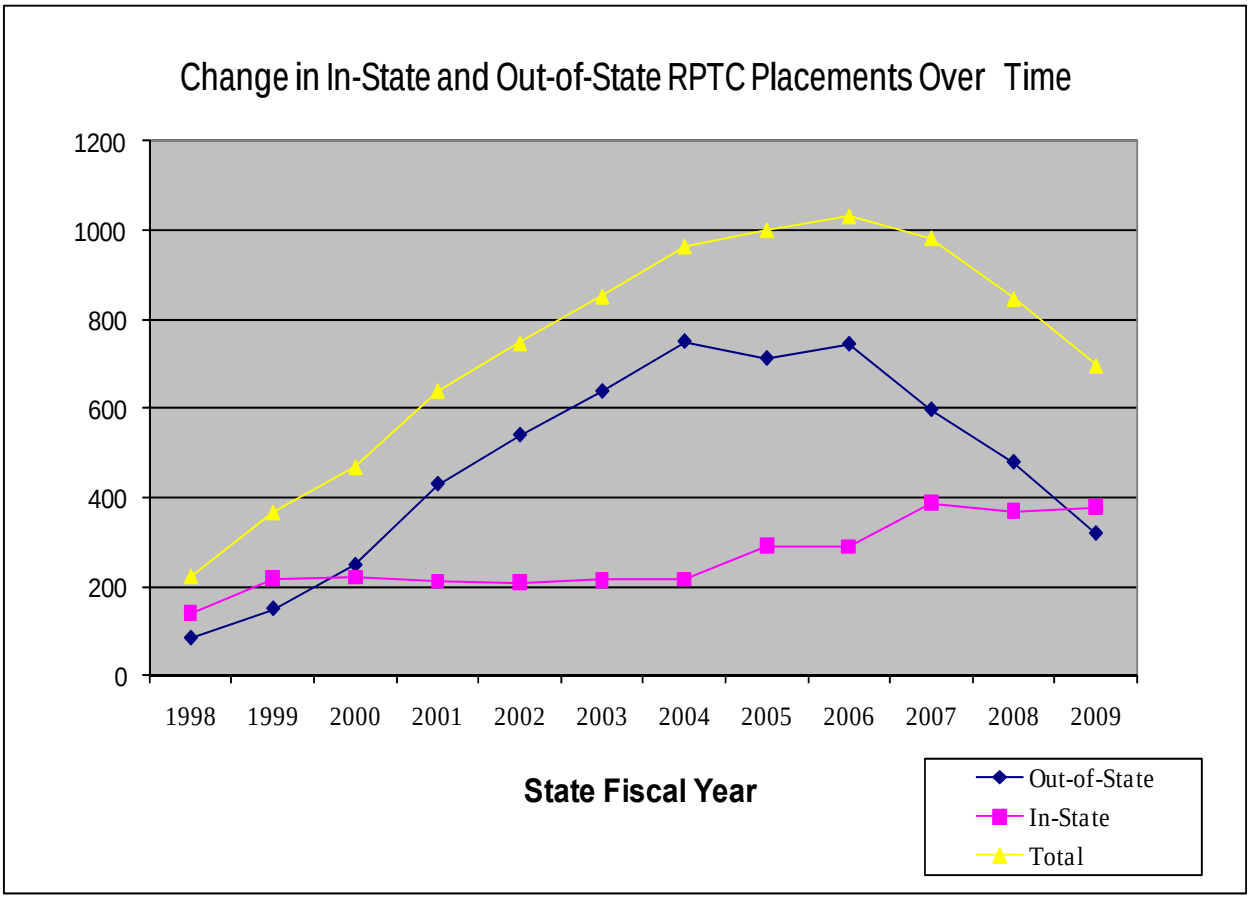
- 8,295 referrals were for SA services
- 10,392 referrals were for MH services

Treatment and Recovery Services Bring the Kids Home (BTKH) Initiative Data Summary
Project Outcome Indicators: Early in BTKH planning, measuring progress was given priority, and BTKH indicators were identified. Below are highlights of FY09 BTKH Indicators Report. For the full final report visit the following website:

http://www.hss.state.ak.us/commissioner/btkh/reports.htm

BTKH Indicator 1: Client Shift
Residential Psychiatric Treatment Center (RPTC) admissions steadily increased from FY98 to FY04. However, from FY05 to the present, there has been a decrease every year. Between FY08 and FY09:

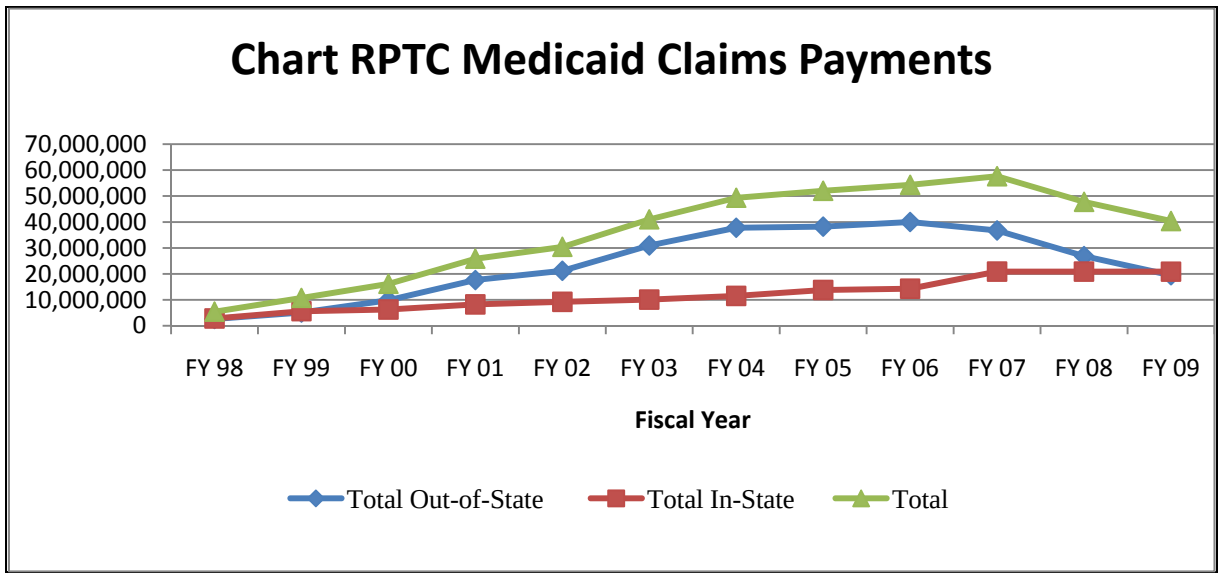
- In-State Custody RPTC "admissions" increased by 29% (61 to 86).
- Out-Of-State Custody RPTC "admissions" decreased by 52.5% (40 to 19).
- In-State Non-Custody RPTC "admissions" increased by 26% (150 to 203).
- Out-of-State Non-Custody RPTC "admissions" decreased by 43.8% (162 to 91).
- Total RPTC admissions decreased by 3.4% (413 to 399).



BTKH Indicator 2: Funding Shift
Between FY98 and FY04, out-of-state RPTC Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. Between FY08 and FY09,

- Out-of-State RPTC Medicaid expenditures decreased by 27%.
- In-State RPTC Medicaid expenditures essentially remained at 2008 levels, in spite of an increase of 36.9% for total instate RPTC admits (from 211 to 289).
- Total RPTC Medicaid expenditures decreased by 15.5%.

Cross-year analysis provides evidence that out-of-State RPTC Medicaid expenditures for FY09 are 51.3% lower than FY06.



BTKH Indicator 3: Length of Stay (LOS)
For FY09, the Average Length of Stay for RPTC:

- In-State Custody: 142 days. Reduction of 12 days (8%) from FY08.
- Custody Out-of State: 476 days. Increase of 174 days (57.6%) from FY08.
- In-State Non-Custody: 157 days. Reduction of 34 days (18%) from FY08
- Out-of-State Non-Custody: 310 days. Reduction of 12 days (3.8%) from FY08.

Percentage of Increase (Decrease) between FY – Average Length of Stay								
	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09
Custody In-State	18.9%	-5.2%	8.2%	7.6%	1.8%	-1.2%	-9.9%	-8.0%
Custody Out-of-State	89.5%	2.4%	-5.9%	25.8%	-2.6%	-0.3%	3.1%	57.9%
Non-Custody In-State	7.4%	6.5%	14.8%	13.7%	46.8%	-31.9%	35.5%	-18.0%
Non-Custody Out-of-State	58.4%	25.0%	0.4%	23.1%	-3.9%	12.8%	-3.9%	-3.8%

BTKH Indicator 4: Service Capacity

In-state residential capacity was lacking for RPTC as well as lower levels of care such as therapeutic group homes, foster care and less restrictive residential care. Increases in bed capacity are tracked in the following table. At this time, BTKH focus is on non-residential service capacity.

	FY03	FY04	FY05	FY06	FY07	FY08	FY09
In-state Bed Capacity (below RPTC)	530	530	530	535	589	716	776
In-state Bed Capacity (RPTC) (Existing	123	123	123	123	183	183	186
TOTAL In-State Beds	653	653	653	658	772	899	962

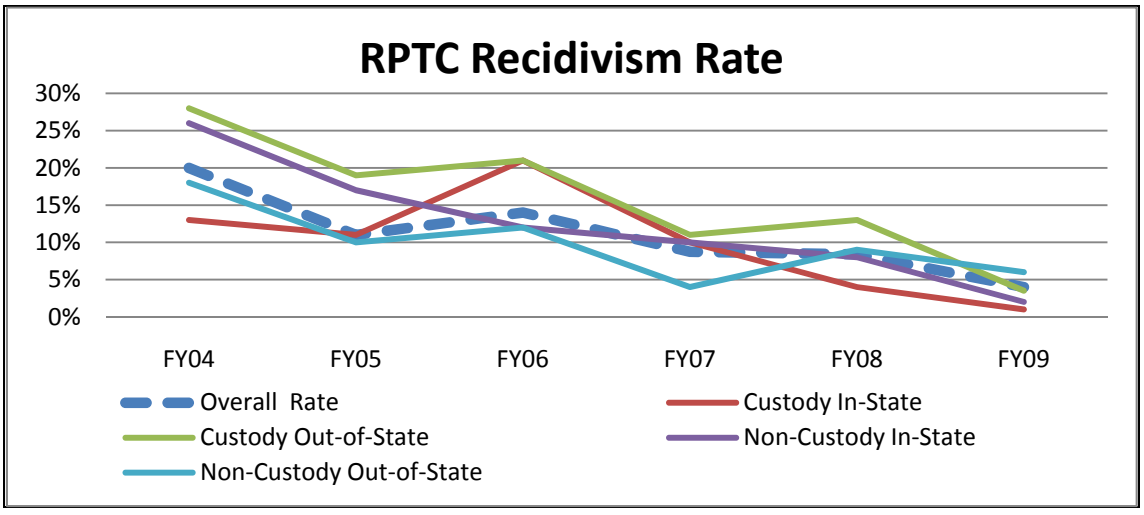
Data Source: Revised data and model, 9/9/09, "used beds" in small treatment resource homes & RPTC

BTKH Indicator 5: Recidivism to RPTC Services

Recidivism to RPTC care is an indicator of the impact of strategies to reduce over-reliance on this level of residential care. As RPTC use decreases, we do not want to see a substantial increase in the need for youth to return to this level of service.

For FY09 the recidivism rates were:

- Custody In-State recidivism was 1%; a 3% decrease from FY08 (4%).
- Custody Out-of-State recidivism was 3.5%, a 9.5% decrease from FY08 (13%).
- Non-Custody In-State recidivism was 2%, a 6% decrease over FY08 (8%).
- Non-Custody Out-of-State recidivism was 6%, a 3% decrease from FY08 (9%).
- The over-all recidivism rate was 3.4% for a readmission to an RPTC within 365 days of the date of discharge. This is a 4.4% decrease from FY08.
- The FY09 over-all recidivism rate of 3.4% (16 cases) is compared to a:
    - FY08 rate of 8.4% (41 cases)
    - FY07 rate of 7.5% (42 cases)
    - FY06 rate of 14% (61 cases)
    - FY05 rate of 12.5% (56 cases)
    - FY04 rate of 20% (93 cases)



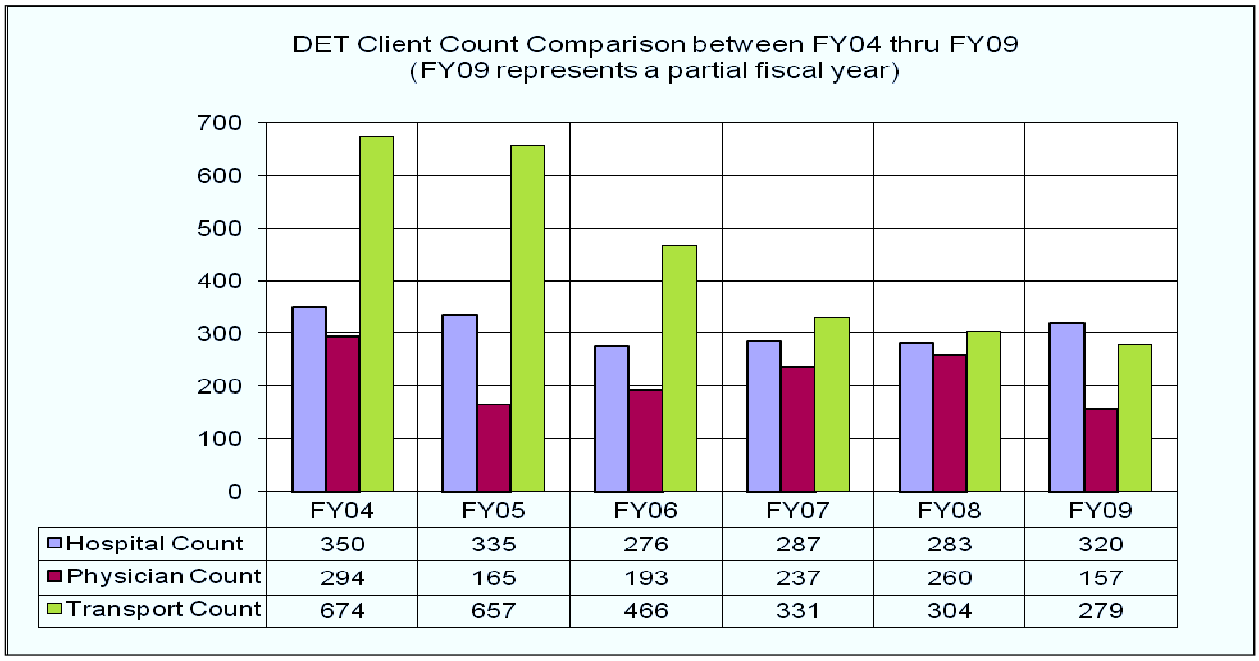
Custody Status	Placement	Discharges by FY		Readmissions Following Discharge within…			Total Readmits	%
				1-30 days	31 – 180 days	81 – 365 days		
Custody	In-State	**FY04**	51	4	2	1	7	13%
		FY05	73	4	2	2	8	11%
		FY06	56	1	8	3	12	21%
		FY07	68	1	4	2	7	10%
		FY08	52	0	1	1	2	4%
		FY09	91	1	--	--	1	1%
Custody	OOS	**FY04**	39	2	7	2	11	28%
		FY05	32	1	4	1	6	19%
		FY06	52	3	4	4	11	21%
		FY07	55	2	4	0	6	11%
		FY08	37	3	1	1	5	13%
		FY09	28	1	--	--	1	3.5%
Non-Custody	In-State	**FY04**	106	12	10	6	28	26%
		FY05	92	10	5	1	16	17%
		FY06	81	2	5	3	10	12%
		FY07	194	12	6	1	19	10%
		FY08	205	10	4	3	17	8%
		FY09	204	--	3	2	5	2%
Non-Custody	OOS	**FY04**	262	12	20	15	47	18%
		FY05	248	6	13	7	26	10%
		FY06	235	8	13	7	28	12%
		FY07	239	4	5	1	10	4%
		FY08	194	5	9	3	17	9%
		FY09	143	5	3	1	9	6%

Designated Evaluation and Treatment Statistics

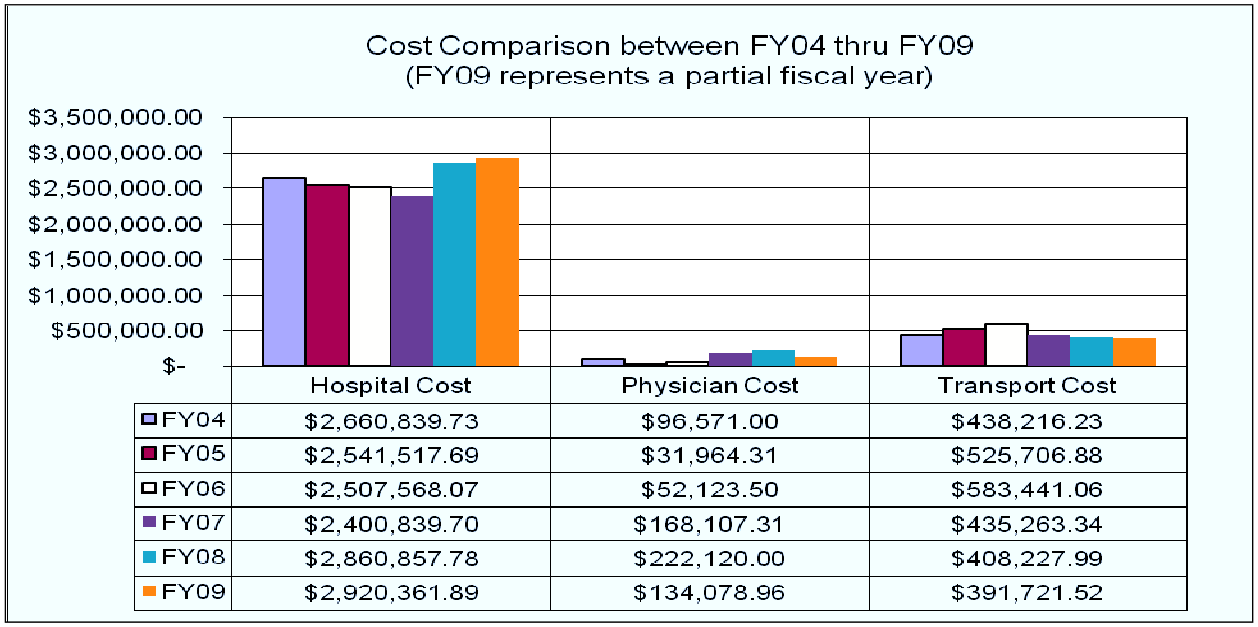
The Designated Evaluation and Treatment component provides fee-for-service funding, as a payer-of-last resort, to designated local community and specialty hospitals. The hospitals provide designated evaluation and treatment services to people in their mental health unit under court-ordered commitment through AS 47.30.655-915, and to people who meet those criteria but have agreed to voluntary services in lieu of commitment. These patients would be transported to API if these services were not available in their own region.

Using this funding, a local facility provides the level of intervention required to stabilize the patient and return them to their community or home. The service array includes inpatient psychiatric evaluations (0- 72 hours), crisis stabilization (4-7 days), or inpatient psychiatric hospital services (7-40 days) close to the consumer's home, family, and support system. Component funding also supports consumer and escort travel, to designated hospitals and back to their home community.

The following charts present the utilization trends for these services in years FY04 to FY09. Hospital Medicaid rates for Acute Psychiatric beds have increased from $1,834.99 per day to $2,234.82 per day in Fairbanks and $1,952.60 per day to $2,651.00 per day in Juneau between FY08 and FY10. There has been an increase in hospital count between FY08 and FY09.

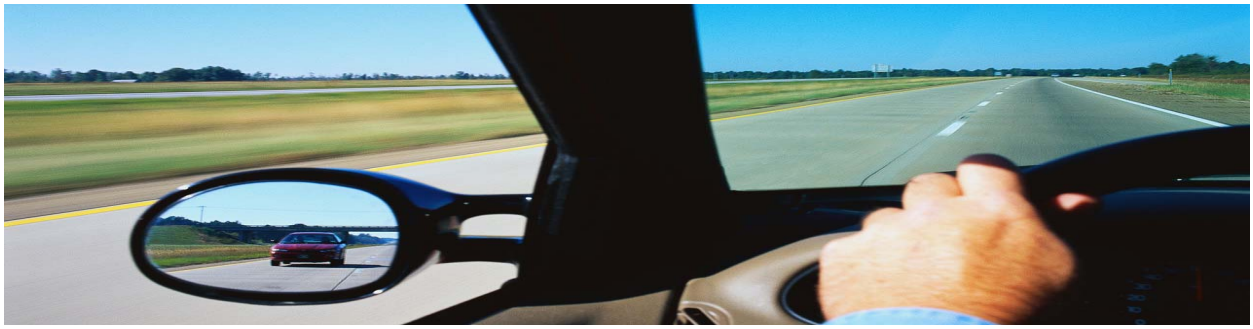


	FY04	FY05	FY06	FY07	FY08	FY09
Hospital Count	350	335	276	287	283	320
Physician Count	294	165	193	237	260	157
Transport Count	674	657	466	331	304	279



	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	$222,120.00	$408,227.99
FY09	$2,920,361.89	$134,078.96	$391,721.52

Alaska Psychiatric Institute "Dashboard" of Key Performance Measures (data as of 11/24/09)



Alaska Psychiatric Institute's "Dashboard" provides an overview of key hospital performance measures used to gauge hospital function and the dynamic relationship with mental health care in Alaska. The measures are broken down into three distinct areas: National Comparison Data, Hospital Measures and Patient Satisfaction. The National Comparison Data choice is driven by the hospital accrediting agency, the Joint Commission, and is a mixture of mandatory and chosen measures. This data provides valuable insight into how API compares nationally to other psychiatric hospitals while providing DHSS and API with important measures related to patient safety and care. These measures are a mix of data that can directly reflect patient care at API (i.e. injury rate, discharge summary) or reflect larger issues relevant to mental health care in Alaska (i.e. Prevalence of COPSD (co-occurring psychiatric and substance abuse disorders), 30 day Re-admit rate).The national data is monitored by the hospital as a measure of response to key quality improvement initiatives internally and for the impact of DHSS system wide changes. Hospital Measures do not have the benefit of national comparison but are picked by API Senior Management to measure hospital function regarding high risk and problem prone areas. Hospital quality improvement efforts seek to affect these measures in a positive manner and provide data driven measure of those efforts. The Patient Satisfaction Measures are derived from the MHSIP (Mental Health Statistical Improvement Project) which is administered upon discharge from the hospital by the Consumer and Family Specialist. API is committed to the use of data to gauge hospital function in an objective way that removes subjective bias. The Dashboard represents what API considers as the most relevant data for hospital function and is openly shared with DHSS and the public as a transparent view of the hospital's operation. It is customary for API to select a hospital-wide quality improvement project based on a measure in which the trending data indicates that a problem exists. These internal 'indicators' along with attention to what is working and not working creates a culture of excellence in the hospital industry.

Alaska Psychiatric Institute "Dashboard" of Key Performance Measures (data as of 11/24/09)

National Comparison Data

Indicator	*API CY 09 2nd Qtr*	*Last Quarter's Comparison to Goal*	*Goal (Annual National Avg.)*	*API CY 08 2nd Qtr*	*API CY 08 3rd Qtr*	*API CY 08 4th Qtr*	*API CY 09 1st Qtr*
Patient Injury Rate	2.16	▲ Nat. Avg.	▼ (0.43)	0.00	0.17	0.53	0.00
Elopement Rate	0.36	▲ Nat. Avg.	▼ (0.21)	0.32	0.17	0.19	0.17
Medication Error Rate	5.56	▲ Nat. Avg.	▼ (2.32)	10.01	7.18	2.92	4.24
Prevalence of COPSD	45.70	▲ Nat. Avg.	▼ (37.80)	50.34	49.08	50.52	48.78
30 Day Re-admit Rate (Discharge Cohort)	14.73	▲ Nat. Avg.	▼ (8.11)	10.35	12.64	12.25	15.47
Patient Seclusion and Restraint							
Hours of Restraint Use	0.14	▼ Nat. Avg.	▼ (0.65)	0.17	0.07	0.07	0.06
% of Patients Restrained	1.56	▼ Nat. Avg.	▼ (3.93)	1.25	0.89	0.69	0.84
Hours of Seclusion Use	0.82	▼ Nat. Avg.	▼ (0.57)	0.14	0.13	0.07	0.21
% of Patients Secluded	0.78	▼ Nat. Avg.	▼ (2.58)	1.67	1.21	0.69	1.50
Patient Discharge Survey			**+/- 5% CI Range**				
Patient Outcome	70.39	▼ (72.82 – 79.33)	▲ (76.08)	73.46	67.20	64.58	73.46
Patient Dignity	79.45	▲ (76.07 – 82.90)	▲ (79.48)	72.96	72.56	79.79	81.99
Patient Rights	61.49	▲ (50.82 – 78.06)	▲ (64.44)	50.42	60.23	63.29	62.66
Patient Participation	72.05	▲ (67.32 – 77.27)	▲ (72.30)	68.38	71.57	75.30	78.56
Hospital Environment	72.22	▲ (62.32 – 71.66)	▲ (66.99)	70.76	67.64	69.43	63.31

Hospital Measures							
Indicator	***API CY 09 2nd Qtr***	***Last Quarter's Comparison to Goal***	***Goal (API's Previous 4 Qtr Avg.)***	***API CY 08 2nd Qtr***	***API CY 08 3rd Qtr***	***API CY 08 4th Qtr***	***API CY 09 1st Qtr***
Seclusion, total number of	20	▲ 4 Qtr. Avg.	▼ (8.50)	9	7	5	13
Seclusion, total time (hrs.)	145:27	▲ 4 Qtr. Avg.	▼ (52:35)	19:55	17:20	4:50	34:57
Restraint, total number of	10	▲ 4 Qtr. Avg.	▼ (6.00)	10	5	5	4
Restraint, total time (hrs.)	19:04	▲ 4 Qtr. Avg.	▼ (10:01)	27:20	10:40	6:44	8:25
Court Ordered Medications	24	▲ 4 Qtr. Avg.	▼ (17.50)	6	18	28	18
180 Day Adult Re-admit Rate %	26.44	▼ 4 Qtr. Avg.	▼ (28.35)	32.36	24.17	34.55	22.30
Nurse Mandatory OT (hr.)	140.25	▲ 4 Qtr. Avg.	▼ (93.50)	139.50	108.00	44.00	82.50
Nurse Voluntary OT (hr.)	1436.75	▼ 4 Qtr. Avg.	▼ (1668.44)	1799.50	1678.50	1535.25	1660.50
Nurse Vacancy Rate (%)	8	▼ 4 Qtr. Avg.	▼ (12.00)	12	14	16	6
Patient Assaults*	33	▼ 4 Qtr. Avg.	▼ (35.00)	25	37	33	45
All Staff Injuries*	35	▲ 4 Qtr. Avg.	▼ (33.00)	26	16	43	47

Key to Icons:

Goal was not met

Goal was met or exceed for the quarter listed

B**ehavioral Health Medicaid Services**

During FY09, Medicaid funded behavioral and mental health services for 11,861 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 services were provided primarily to children under age 21, while community mental health services were distributed more evenly between adults and children.

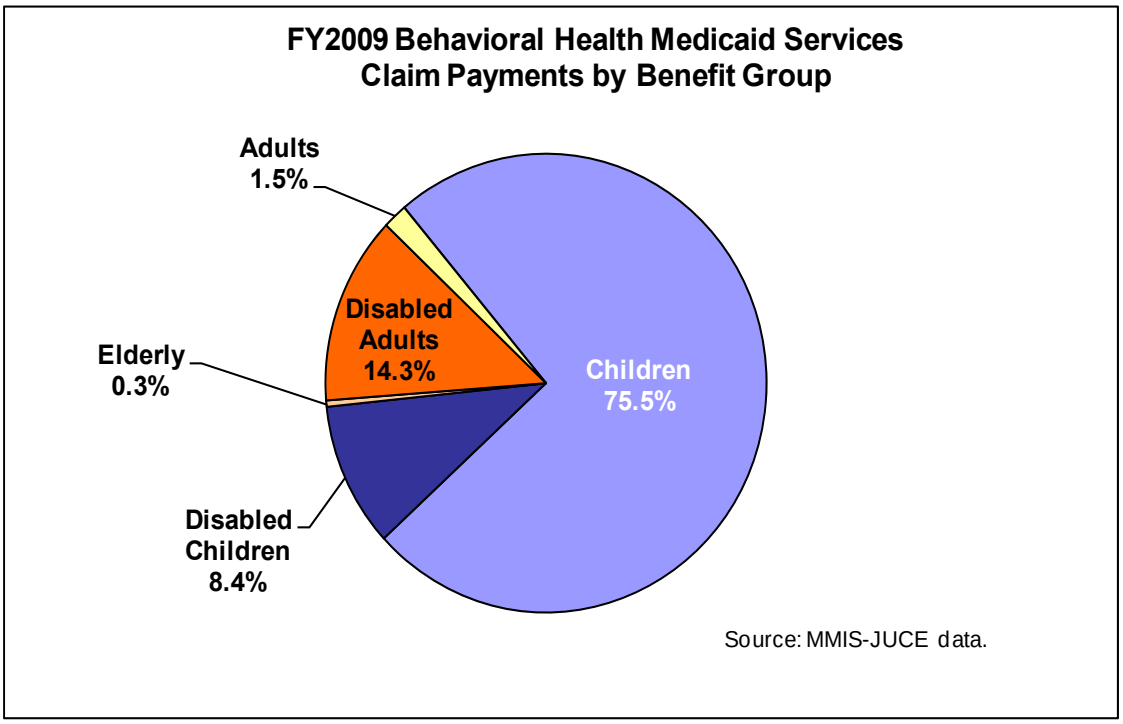
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children	49.6%	5,993	74.3%	$99,227.4	$16,557
Disabled Children	4.1%	495	10.2%	$13,620.8	$27,517
Elderly	2.1%	257	0.4%	$597.5	$2,325
Disabled Adults	29.7%	3,594	13.3%	$17,767.2	$4,944
Adults	14.5%	1,751	1.8%	$2,396.9	$1,369
Unduplicated Annual Clients		**11,861**			
Total Medicaid Claim Payments (thousands)				**$133,609.8**	
Average Annual Medicaid Cost per Beneficiary					**$11,265**

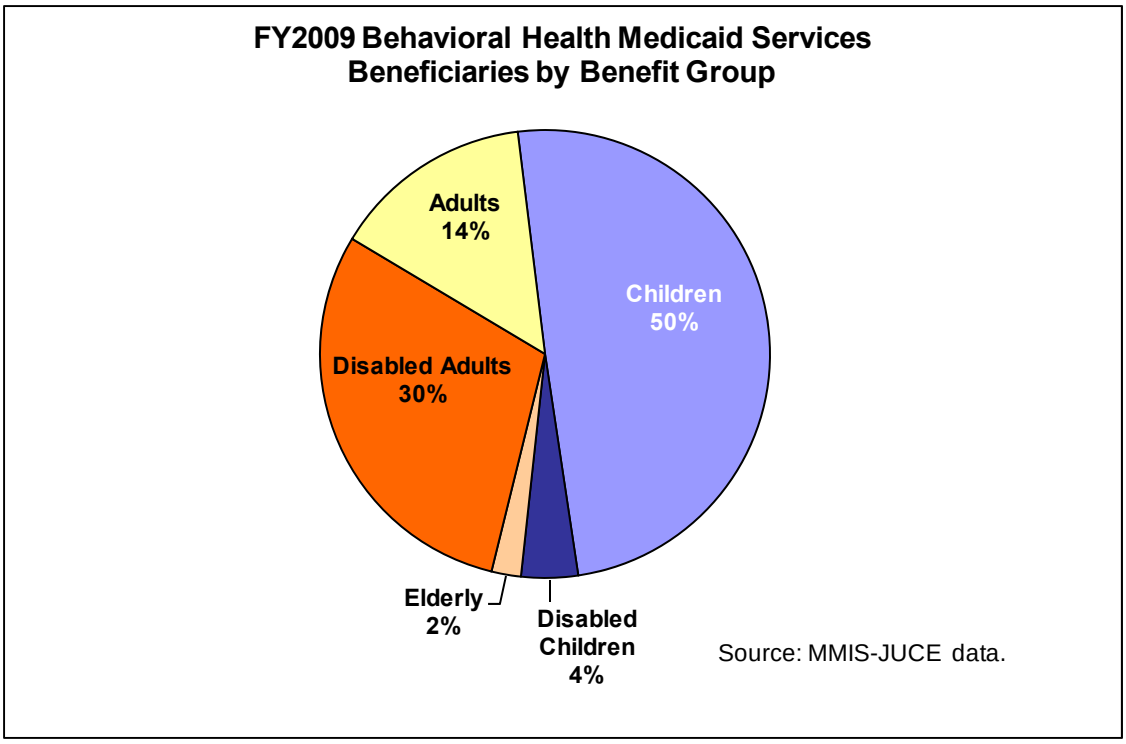
Source: MMIS/JUCE claims paid during FY2009. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
All Behavioral Health Medicaid					
Under 21	54.5%	6,485	85.8%	$114,611.9	$17,673
21 or Older	45.5%	5,422	14.2%	$18,998.0	$3,504
Community Mental Health					
Under age 21	52.8%	6,058	74.0%	$53,409.9	$8,816
21 or Older	47.2%	5,407	26.0%	$18,737.7	$3,465
Inpatient Psychiatric Hospital					
Under 21	89.6%	815	98.8%	$16,476.8	$20,217
21 or Older	10.4%	95	1.2%	$195.6	$2,059
Residential Psychiatric Treatment Centers					
Under 21	99.9%	843	99.9%	$44,725.2	$53,055
21 or Older	0.1%	1	0.1%	$64.7	$64,660

Source: MMIS/JUCE claims paid during FY2009.

Note: Claims and client counts are reported according to the fiscal year in which payments were made, not when services were rendered.

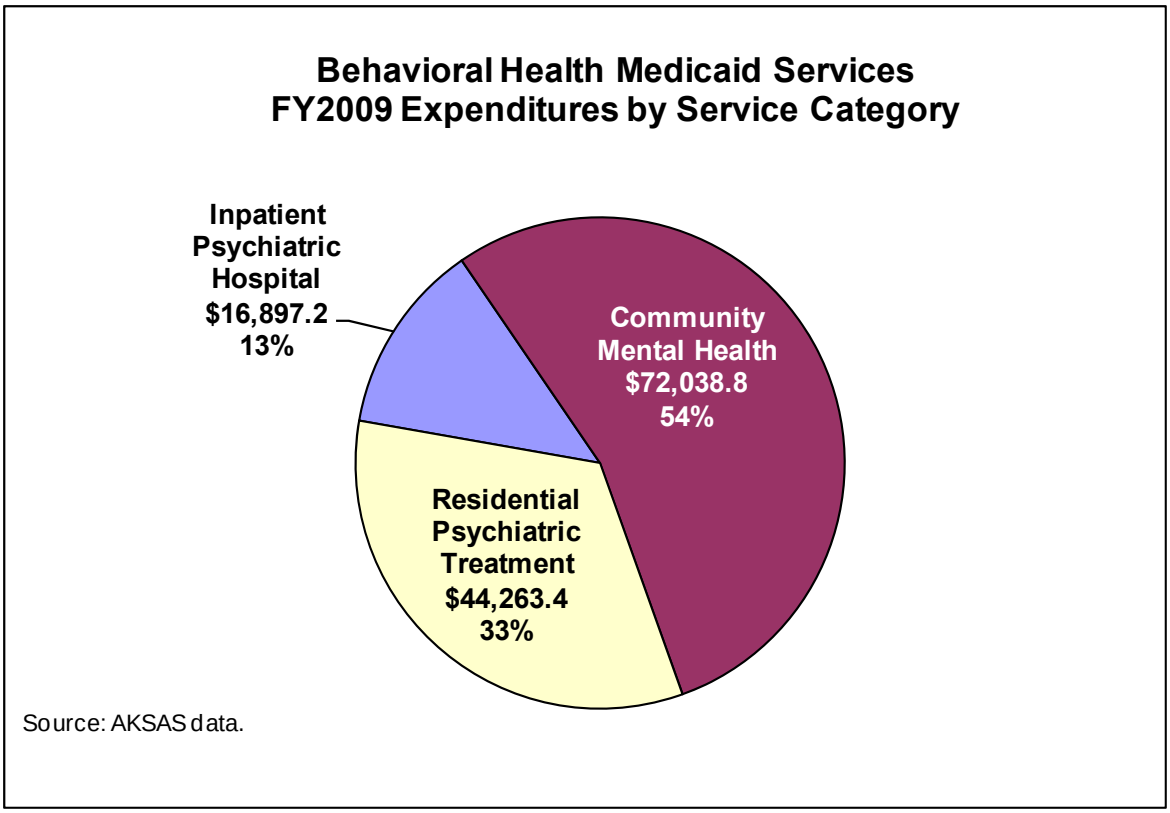

FY2009 Behavioral Health Medicaid Services
Claim Payments by Benefit Group
Adults
1.5%
Disabled
Adults
14.3%
Elderly
0.3%
Children
75.5%
Disabled
Children
8.4%
Source: MMIS-JUCE data.


FY2009 Behavioral Health Medicaid Services
Beneficiaries by Benefit Group
Adults
14%
Children
50%
Disabled Adults
30%
Elderly
2%
Disabled
Children
4%
Source: MMIS-JUCE data.

The majority of services purchased were community mental health services comprising about 54% of total Behavioral Health Medicaid costs in FY09. Inpatient psychiatric hospital and residential psychiatric treatment center (RPTC) claims comprised about 13% and 33% of costs, respectively.

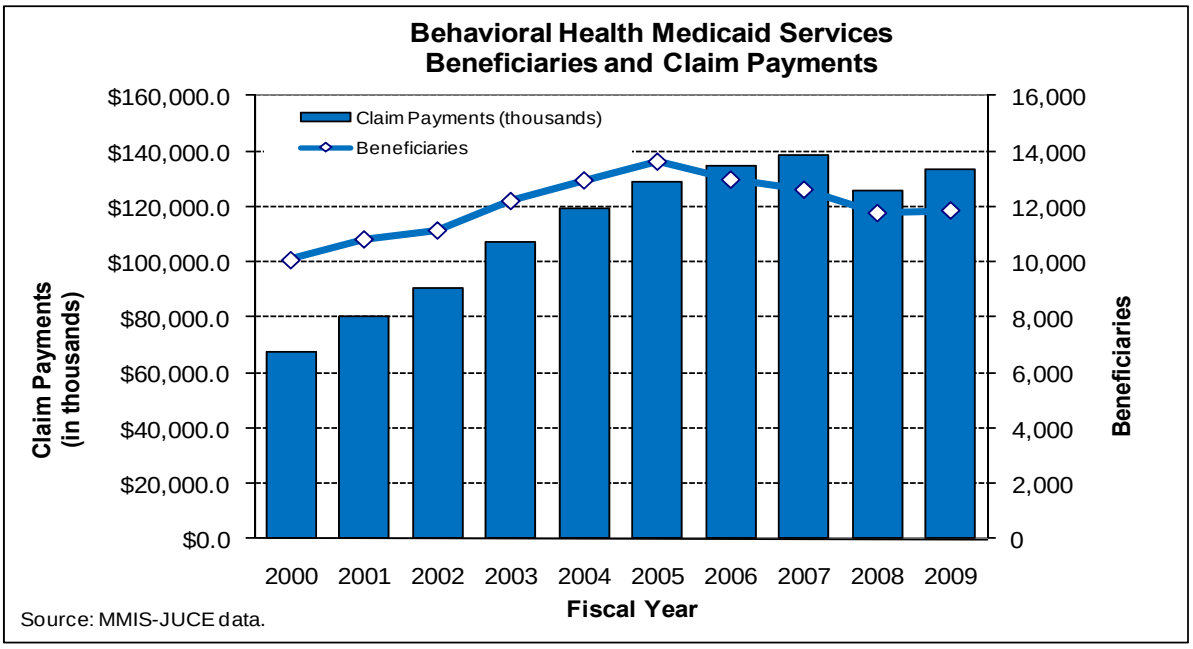
Service Category	Cost per Beneficiary	Percent of Beneficiaries
Inpatient Psych Hospital	$18,300	7.7%
Residential Psych Treatment	$53,100	7.1%
Community Mental Health	$6,300	96.3%
All Behavioral Health Medicaid, cost per recipient per year		$11,265
All Behavioral Health Medicaid, unduplicated annual beneficiaries		11,861

Source: MMIS/JUCE for claims processing duirng fiscal year 2009. Percent of beneficiaries includes individuals receiving services in other categories and will not sum to 100%.

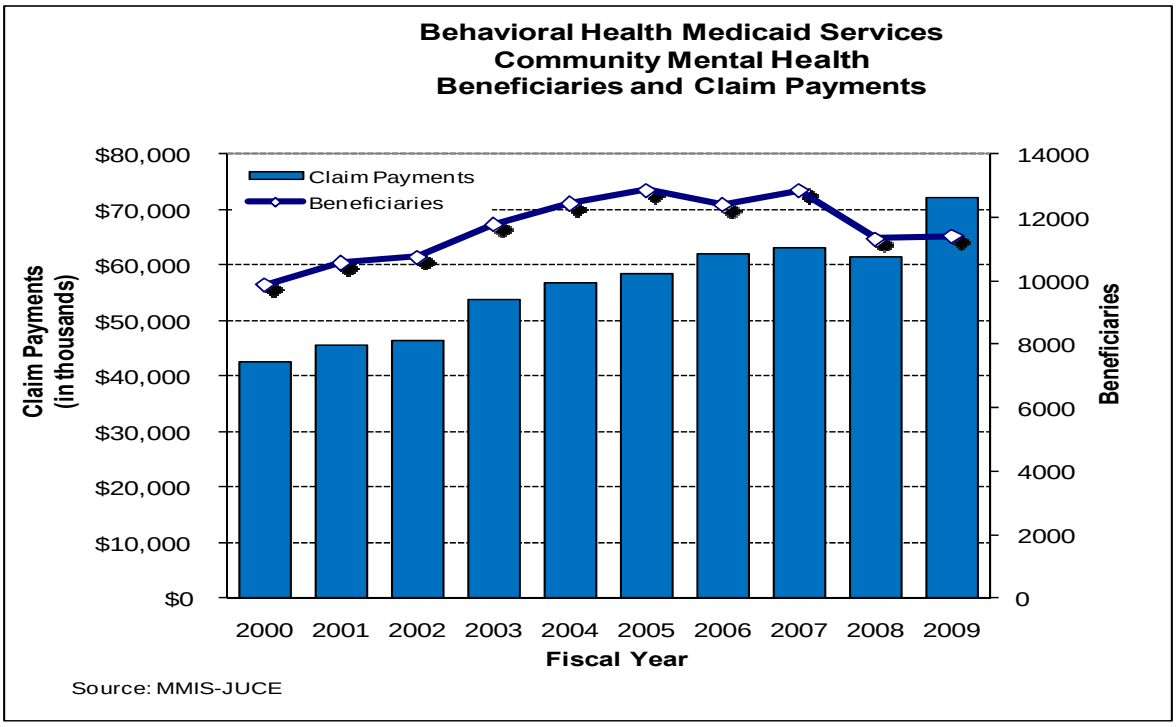


Note: Data is reported on the basis of claims processed in FY09, not services rendered in FY09.

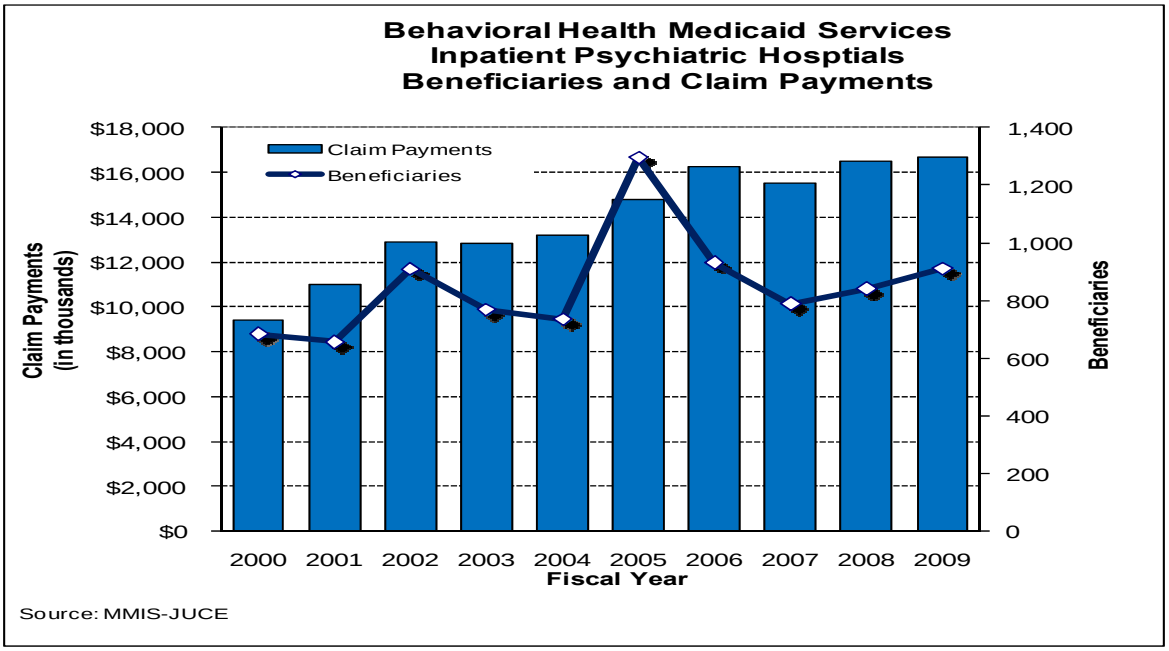
Total claim payments for Behavioral Health Medicaid services in FY09 increased by over 6% from FY08, mostly due to increased Medicaid rates. The number of persons with a paid Behavioral Health Medicaid service increased by less than 1%, while the annual cost per beneficiary increased by almost 6% to nearly $11,300 (documented in supporting data).



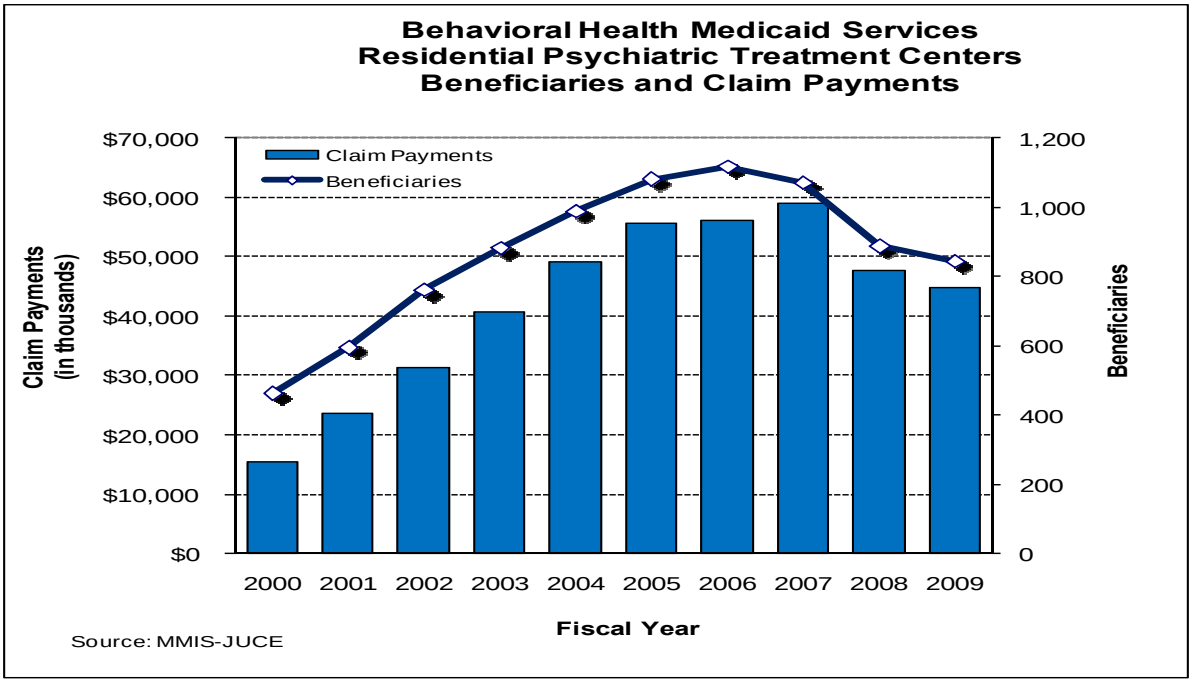
The number of Medicaid beneficiaries with a paid community mental health service increased less than 1%, while the annual cost per beneficiary increased almost 17% to $6,300 (documented in supporting data). Overall, claim payments for community mental health services increased by almost 18% between FY08 and FY09.



Inpatient psychiatric hospital services saw an 8% increase in the number of individuals, but the cost per person decreased by almost 7% to $18,300 (documented in supporting data). Overall, Medicaid claim payments for inpatient psychiatric services increased by about 1% in FY09.



The number of Medicaid beneficiaries with a paid residential psychiatric treatment center service (RPTC) decreased 5% in FY09 after falling 19% the prior year. Medicaid claim payments for RPTC decreased by 6%. The annual cost per RPTC beneficiary decreased by approximately 1% to $53,100 (documented in supporting data).



FY 2009 DIVISION LEVEL SUMMARY: Behavioral Health Medicaid	BEHAVIORAL HEALTH 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		**11,861**		**$133,609,841**	**11,265**	**9.6%**	**12.9%**
Gender							
Female	52.9%	6,276	41.0%	$54,804,529	$8,732	8.9%	9.4%
Male	47.1%	5,585	59.0%	$78,805,311	$14,110	10.4%	17.7%
Unknown	0.0%	0	0.0%	$0	$0	0.0%	0.0%
Race							
Alaska Native	34.0%	4,049	42.0%	$56,105,002	$13,857	8.7%	14.6%
American Indian	1.9%	231	1.2%	$1,573,282	$6,811	11.8%	10.5%
Asian	1.9%	223	1.2%	$1,575,220	$7,064	3.0%	2.9%
Pacific Islander	0.9%	111	0.5%	$718,750	$6,475	2.9%	3.2%
Black	5.1%	606	5.8%	$7,762,597	$12,810	8.6%	17.0%
Hispanic	2.3%	272	1.9%	$2,525,119	$9,284	5.9%	10.6%
White	51.7%	6,156	44.4%	$59,329,159	$9,638	12.4%	13.0%
Unknown	2.1%	250	3.0%	$4,020,712	$16,083	7.2%	13.2%
Native	36.0%	4,280	43.2%	$57,678,284	$13,476	8.8%	14.4%
Non-Native	64.0%	7,597	56.8%	$75,931,569	$9,995	9.9%	12.0%
Age							
under 1	0.0%	4	0.0%	$1,015	$254	0.0%	0.0%
1 through 12	23.3%	2,875	28.2%	$37,630,827	$13,089	5.9%	24.1%
13 through 18	28.7%	3,553	56.3%	$75,250,338	$21,179	16.0%	47.7%
19 through 20	2.9%	363	1.3%	$1,729,694	$4,765	7.9%	6.7%
21 through 30	11.3%	1,399	3.2%	$4,292,034	$3,068	9.6%	3.6%
31 through 54	25.3%	3,128	8.4%	$11,283,912	$3,607	16.7%	5.1%
55 through 64	5.7%	701	1.9%	$2,545,901	$3,632	13.4%	2.8%
65 through 84	2.5%	312	0.6%	$868,317	$2,783	4.2%	0.7%
85 or older	0.2%	29	0.0%	$7,802	$269	2.1%	0.0%
Benefit Group							
Children	49.6%	5,993	74.3%	$99,227,428	$16,557	7.7%	27.7%
Adults	14.5%	1,751	1.8%	$2,396,914	$1,369	7.4%	1.9%
Disabled Children	4.1%	495	10.2%	$13,620,829	$27,517	20.6%	23.8%
Disabled Adults	29.7%	3,594	13.3%	$17,767,159	$4,944	23.6%	5.3%
Elderly	2.1%	257	0.4%	$597,511	$2,325	3.5%	0.4%

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 2009 (service may have been incurred in a prior year). Grouping is based on status on the date the benefit was obtained (service was provided). 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 community mental health clinic 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, 2009. If they used mental health services again in December 2008, they would also be included in the 13 through 18 age subgroup count if the claim was

*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.

Advisory Board on Alcoholism and Drug Abuse
&
Alaska Mental Health Board

Mission

To facilitate ongoing and broad-based public input in the planning, policymaking, and evaluation of the programs, services and systems that promote healthy, independent, productive Alaskans.

Introduction

The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB) were created by statute to assist in planning and coordinating behavioral health services funded by the State of Alaska. The joint mission of ABADA and AMHB is to advocate for programs and services that promote healthy, independent, productive Alaskans.

The work of ABADA and AMHB is established by statute and includes the following functions related to the behavioral health system and the people it serves: planning and coordination, education, advice, evaluation, and advocacy.

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. Like AMHB, ABADA provides an opportunity for public participation in the planning and evaluation of the behavioral health system.

Services Provided

The services provided by ABADA and AMHB fall within the statutory duties: advise, plan and coordinate, educate, evaluate, and advocate.

Advise
ABADA and AMHB work in partnership with state agencies and the Legislature to provide advice and support regarding a variety of behavioral health issues, including funding for services. The boards solicit public input in a variety of ways all over the state, and then communicate that information to the executive and legislative branches. Our staff meets

regularly with agency directors and managers, and works through a variety of workgroups to fulfill this responsibility.

Plan & Coordinate
ABADA and AMHB staff and board members help create and implement the Comprehensive Integrated Mental Health Plan, the Suicide Prevention Plan, the state plans for the Mental Health Block Grant and Substance Abuse Block Grant, and others. We partner with the Department of Health and Social Services, the Alaska Mental Health Trust, and other advisory bodies to help make these various plans work more effectively together. We collaborate with community and consumer organizations, like the Substance Abuse Directors Association, National Alliance on Mental Illness (NAMI), and homeless coalitions throughout the state.

Educate
ABADA and AMHB use a variety of tools to educate citizens, elected officials, and state officers about the issues of substance abuse and mental health. One of our primary goals is to reduce stigma related to addiction and mental illness. We are part of the "You Know Me" campaign. Our own education efforts focus on the fact that "Treatment Works – Recovery Happens!" Board members have participated in legislative caucuses and appeared in television and print ads to help educate all Alaskans about the possibilities that can be realized when the right services are available at the right time and in the right place.

Evaluate
Board members and staff participate in proposal evaluation committees (reviewing grant applications), conduct site visits, complete an annual unduplicated count of clients served, and perform other tasks to help evaluate the effectiveness of policy and programs.

Advocate
Board members and staff are committed to making heard the voices of consumers and their families, as well as service providers and communities as a whole. Using weekly teleconferences, websites, newsletters, and other media, we provide information and support to stakeholders, so that they can better express their views and needs to their elected officials. Board members and staff talk with legislators, legislative staff, the Governor and executive staff, and Alaska's federal delegation to communicate the perspectives of the people on behavioral health issues.

All of the efforts of ABADA and AMHB necessitate close working relationships with the other statutory boards, as well as community organizations, provider associations, state agencies, and consumer groups. No one function stands separate and apart from the other. Each duty is important if we are to see every Alaskan living a healthy and productive life.

List of Primary Programs and Statutory Responsibilities

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 44.29.100-140	Advisory Board on Alcoholism and Drug Abuse
AS 47.30.011-061	Mental Health Trust Authority
AS 47.30.470-500	Welfare, Social Services & Institutions, 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 47.30.661-666	Alaska Mental Health Board
AS 47.37	Welfare, Social Services & Institutions, Uniform Alcoholism and 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
7 AAC 105-160	Medicaid Coverage and Payments

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	FY10	FY11 Gov	10 to 11 Change
General Funds	114,585.4	124,177.0	9,591.6
Federal Funds	102,740.2	107,343.7	4,603.5
Other Funds	48,012.3	51,537.0	3,524.7
Total	**265,337.9**	**283,057.7**	**17,719.8**

Alaska Fetal Alcohol Syndrome Program

MH Trust: AK MH/Alc Bd-Increased Access to FASD Treatment Svcs Rural AK: *$228.6 GF/MH*
Targeted grant funds will build and maintain treatment capacity in those communities with active diagnostic teams, so that children receive appropriate therapies and services as close to home as possible. This recommendation is expected to benefit Alaskan children affected by prenatal alcohol exposure since 1993 (ages 0-18), as well as the 178 children we estimate will be born with some level of effect from prenatal alcohol exposure during each year after 2011. Outcomes are expected to include the following: increased utilization of occupational, physical, and speech therapies; reduction in the number of children diagnosed with FASD who are admitted to RPTCs, including out-of-state placements; and increased clinician competencies to deliver services to children diagnosed with FASD.

Behavioral Health Medicaid Services

Medicaid Growth: *$10,035.3 Total- $4,602.1 Federal, $5,433.2 GF/MH*
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 9% 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. The 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 FY11, Behavioral Health Medicaid costs are projected to grow by 4.4% from FY10. The FY11 forecast (with the 2010 FMAP) is $151,723.2 (96,015.0 Federal / 55,647.2 GF / 61.0 Other). 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 FY04 have successfully reduced the rate of growth from the high of 19.1% for 2001 to 7.5% for 2009. In particular, the Bring the Kids

Home initiative reduced utilization of residential psychiatric treatment centers by 6% from 2008 to 2009. Increased enrollment and utilization will contribute to the approximate 4.4% increase in costs forecast for FY11.

Projections for formula growth are based on historical trends in population, utilization, provider reimbursement, and federal financial participation. 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: AK MH/Alc Bd-Substance Abuse Treatment for Pregnant Women*: $500.0 GF/MH*
Grant funds will expand capacity to provide substance abuse treatment to pregnant women. Providers who shared data reported providing treatment services to 97 pregnant women in FY08. DHSS reports a prevalence rate of 15 children (1.5/1,000 live births) born each year with fetal alcohol syndrome and 163 children (16.3/1,000 live births) born each year affected by prenatal alcohol exposure. Thus, only an estimated 54% of the women needing substance abuse treatment to prevent harm to their children in-utero received care in FY08.

The intent is that funding would be prioritized as follows: expand residential treatment capacity for pregnant women statewide (to alleviate the need to travel to Anchorage/Fairbanks); encourage expansion of existing family-based treatment models where children can reside at the facility with the mother in treatment; expand intensive outpatient treatment capacity for pregnant women statewide so that, when space in a residential or a family-style program is not available, a pregnant woman who needs and seeks treatment can receive it; and expand aftercare.

MH Trust: Disability Justice--Detox and Treatment Capacity as Alternatives to Protective Custody Holds; *$518.3 GF/MH*
Previously funded from the Trust, this project will continue funding efforts towards the development of community detoxification capacity and treatment alternatives in the Bethel region, to avoid the high costs incurred by the use of state correctional institutions for Title 47 substance abuse protective custody holds. This project will be managed by Behavioral Health Grants staff. The funds will be disseminated through either grants, contracts, or a combination of the two, to behavioral health providers. Behavioral Health Grants staff will collect outcome data on how funding is utilized to document correctional and hospital costs.

MH Trust: Disability Justice--Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome): *$100.0 MHTAAR*
There are chronic inebriates in Alaska who are a danger to themselves or others as a result of their chronic alcoholism or abuse of other drugs. While Title 47 of our statutes has long provided for involuntary commitment to treatment, it has been underutilized due to a lack of secure treatment options. The recommendation is to support rural planning in the first year, and then support planning plus implementation in the second year. At least one community (Kotzebue) has begun this process, so capitalizing on existing readiness is key to achieving service delivery within the next two fiscal years. Assisting other regional hub communities to plan for offering secure detox treatment is also important, given the statewide implications of chronic alcoholism and substance abuse. Therefore, support for planning continues into the second year to afford meaningful planning opportunities to other rural communities.

MH Trust: Disability Justice--Specialized Treatment Unit (Clitheroe): *$1,200.0 GF/MH*
This increment will sustain the Secured Treatment Unit (STU) pilot project which was initiated by the 2007 Senate bill 100 and began in Anchorage in FY10. The funding will be used to increase the treatment opportunities for chronic public inebriates within the State, while decreasing the negative impacts that substance abuse has on the lives of the treated individuals, as well as society as a whole. The Secured Treatment Unit at Salvation Army Clitheroe operates in accordance with AS 47.37, the Uniform Alcoholism and Intoxication Treatment Act, specifically AS 47.37.030 (10). The program provides detoxification and residential substance abuse treatment services for adult chronic inebriates who are referred through AS 47.37.180-205 Emergency Commitment, or individuals who are eligible for a non-voluntary commitment to treatment. The detoxification component has four available beds, and the treatment unit has eight beds for clients who have completed detoxification and who are able to begin treatment.

The target populations for this project are individuals whose persistent and continuous use of alcohol has severely restricted their ability to function productively within society over an extended period of time. This group represents a traditionally difficult-to-serve segment of the State, whose disproportionate use of local resources far exceeds that of many other priority populations.

Behavioral Health Administration

Maintain Existing Tobacco Enforcement and Education Program: *$175.0 Tobacco*
The Alaska Tobacco Enforcement and Education program was integrated into DBH in 2003, moving from the Division of Public Health. Since that time, no increase in funding for this program has occurred. At this time, the Tobacco budget component does not fully cover all associated personnel (3.0 FTE investigators, multiple student interns and .5 FTE admin clerk) or the required travel. This program operates throughout the state with just those three investigators; two investigators are located in Anchorage, with a third investigator in Juneau. In addition, training and signage materials for this program have not been updated, revised or reprinted during this time. In researching best-practices related to decreasing sales of tobacco to minors, we plan to implement a system of public and personal recognition of clerks and retailers who do not sell tobacco to minors, via certificates, incentives and public commendation. These funds would be used to fully fund the current positions, update the training and signage materials, and fund required tobacco education and enforcement travel.

Without funding we will be unable to improve our retailer training program, and will be unable to implement a new recognition program to thank our partners in the retail industry. Our goal is to encourage a continuing decrease in the number of Alaska youth who smoke tobacco or use other tobacco products. In addition, if Alaska does not comply with the enforcement stipulated in the Tobacco Regulation for the Substance Abuse Prevention and Treatment (SAPT) Block Grant (45 CFR. 96.130(e)), federal statute (42 USC 300X-26(c)) requires the reduction of the State's SAPT Block Grant allotment for non-compliance. Currently, the SAPT Block Grant supplies a critical funding component to grantee agencies providing substance abuse treatment services.

MH Trust: Workforce Development-DBH/UAA/UAF PhD Student Partnership: *$50.0 MHTAAR*

This project funds Internships for Ph.D. clinical community psychology students with the State of Alaska Division of Behavioral Health. The doctorate program in Clinical Community Psychology at the University of Alaska, with a rural indigenous emphasis, has been designed to prepare doctoral level practitioner-scientists who join theory, practice and research to meet behavioral health needs, and to improve the well-being of Alaskans and their communities. The purpose of the research assistantship is to provide the student with an opportunity to be involved in actual applied research within the field, and to be mentored by researchers involved in the types of applied research that graduates of the program will ultimately do upon completion of the program.

MH Trust: Workforce Development-PhD Internship Consortium (AK-PIC): $*100.0 GF/MH*

This project will fund a grant for technical assistance to support the accreditation of the Alaska Psychology Internship Consortium (AK-PIC). This includes support of the AK-PIC, in the orientation and placement of the first internship cohort during July/August 2010, facilitation of the APA Accreditation application submission and self-study, and application for participation in the national Association of Psychology Postdoctoral and Internship Centers (APPIC). APA accreditation helps ensure that internship programs are setting and achieving high yet reasonable standards in education and service delivery. Additionally, licensure for clinical psychologists in most states requires the completion of an APA-accredited internship. Without licensure, most psychologists cannot be reimbursed for services. At present, no such internship exists in Alaska. The state risks losing students currently in the UAF/UAA program who would leave the state for internship placement because slots are unavailable in Alaska, and who would potentially not return to Alaska for professional practice.

MH Trust: BTKH-Tribal/rural System Development: *$400.0 Total-$200.0 GF/MH, $200.0 MHTAAR*

This request will supplement the $400.0 GF/MH increment from FY10. Funding will assist in establishing serious emotional disturbance (SED) children's services in rural areas. Almost 40% of youth experiencing SED in Residential Psychiatric Treatment Centers (RPTCs) out of state are Alaska Native. This funding will develop services and strategies specific to tribal systems and improve funding mechanisms, such as Medicaid at 100% FMAP. The funding will support tribes to expand health service delivery, as recommended by Senate Bill 61 (Ch 10, SLA 2007) (Medicaid Reform report). Funding may support technical assistance and training from state staff or from contractors and/or adding additional staff functions to DHSS tribal programs. Projects may include developing Medicaid clinical, billing and supervision capacity; technical assistance to link programmatic and finance sections into an effective service delivery/billing revenue

generation; implementing telemedicine, Skype or other distance delivery technology; grant writing; blending funding streams or other projects.

Psychiatric Emergency Services

MH Trust: AMHB/ABADA-Designated Evaluation and Treatment Expansion: *$300.0 MHTAAR*

Through a variety of avenues, public comment to the Alaska Mental Health Board this year has consistently documented that Alaskans experiencing psychiatric emergencies cannot receive adequate services in their community. We have heard that rural hospitals are resistant to providing this acute care, due to the cost, facility requirements, staffing requirements, and perceived obstacles to reimbursement. We have heard that Alaska Psychiatric Institute (API) is often at the limits of its capacity, with the majority of admissions coming from the Kenai Peninsula and Mat-Su areas. We have observed that Alaskans experiencing psychiatric emergencies in rural communities are too often being held in the custody of a village public safety officer or local police, as a way of being kept safe pending transport to API. The system providing acute stabilization and treatment is at risk, as seen by the recent closure of the Designated Evaluation and Treatment (DET) beds at Mt. Edgecombe Hospital in Sitka due to the costs and lack of adequate staffing.

This recommendation includes the use of telemedicine for acute stabilization as a cost-containment measure. API has offered use of its existing telemedicine infrastructure as a basis for this recommendation. Initially, pilot projects with hospitals demonstrating a high degree of readiness are recommended. The goal is for these pilots to demonstrate success and cost-effectiveness.

Services for the Seriously Mentally Ill

MH Trust: Disability Justice-Flexible Forensic Treatment Team (Anchorage Mental Health Court): *$250.0 GF/MH*

This request will fund a Flexible Forensic Treatment Team to provide an immediate array of mental health and substance abuse treatment services for participants of the Anchorage Mental Health Court. Currently, there is a cohort population which cannot access existing community-based treatment services because they are not Medicaid eligible or do not possess the financial resources to access treatment. This population would be the priority for the Flexible Forensic Treatment Team. Payment for these services would be through a voucher and insurance, when billable. This project establishes a treatment program specifically for participants in the Anchorage Mental Health Court program and includes the following:

- Immediate access to screening and assessment
- Intensive outreach, engagement, and case management
- Integrated outpatient treatment that also addresses trauma, criminal behaviors
- Vouchers for housing, medical, transportation and other basic needs
- Close coordination with Court staff

This project fills a gap in the existing treatment system, which cannot provide fast access to services, ongoing outreach and engagement, vouchers for basic services, or close coordination with the Court, all of which are important for treatment success in this population

Services for Severely Emotionally Disturbed Youth

MH Trust: BTKH-Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training: *$950.0 Total- $500.0 GF/MH, $450.0 MHTAAR*
Managed by grants from DHSS/Behavioral Health, funding expands multiple grants to community behavioral health centers, to enhance outpatient services with innovative programs/training so as to reduce the need for residential level services for youth experiencing serious emotional disturbance (SED). It will also emphasize special populations, such as Fetal Alcohol Syndrome, birth to six years, etc. This increase in outpatient care assists in treating youth at the home and community-based level, and avoids utilizing costly residential care. A separate evaluation aspect is funded by the Trust to demonstrate the cost effectiveness of these outpatient services.

MH Trust: BTKH-Individualized Service: *$300.0 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. This project maintains a critical, flexible component of the BTKH Focus Area plan by providing services to avoid costs of much more expensive residential care.

MH Trust: BTKH-Transitional Aged Youth: *$200.0 Total- $100.0 GF/MH, $100.0 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, will help youth access existing resources whenever possible, and will fill service gaps when necessary, to bridge the transition from child services to adulthood.

Alaska Psychiatric Institute (API)

Reflect Interagency Receipts for Medicaid-Eligible Clients: *$3,900.0 I/A*
I/A collections have increased due to increases in the Disproportionate Share Hospital (DSH) allotments and Medicaid rates. In order to utilize these I/A receipts, API expenditures have been recorded under the unbudgeted structure, using I/A authority from Health Care Services via a Reimbursable Service Agreement. The increased authority will allow the division to clean up the budget for API so it accurately reflects operations.

MH Trust: Workforce Development-API Psychiatry Residency Training: *$300.0 GF/MH*
Alaska has a unique opportunity to partner with the University of Washington School of Medicine Department of Psychiatry Residency Program. This will continue the Psychiatric Residency Program which has completed a needs assessment and feasibility analysis. Partnering with an established psychiatry residency would be better than creating an independent free-standing psychiatry residency. The long-term goal is to train psychiatric residents in Alaska, thereby increasing the supply of psychiatric physicians. The longer an individual trains

in a given location, the more likely they are to remain in that location after completing formal training.

MH Trust: BTKH-Child Psychiatrist: *$50.0 MHTAAR*
Funds would hire a child psychiatrist at Alaska Psychiatric Institute (API), to provide doctor-to-doctor consultation to other Residential Psychiatric Treatment Centers (RPTC) around issues of case planning and treatment recommendations. The psychiatrist would provide the state a second opinion for state staff working to divert children from RPTC care, and provide consults to primary care physicians for children at risk of moving into acute or residential care. The goal would be to move youth experiencing serious emotional disturbance (SED) to the lowest level of care possible.

Alaska Mental Health Board and Advisory Board on Alcohol & Drug Abuse (AMHB/ABADA)

MH Trust: BTKH-Strong Family Voice: Parent and Youth Involved via AMHB: *$50.0 MHTAAR*
Managed by the Alaska Mental Health Board (AMHB), this project expands funding for allowing a significant number of parents and youth, including rural families, to attend the Bring the Kids Home (BTKH) quarterly meetings and other advocacy and policy setting meetings. It supports parents who have sons/daughters experiencing serious emotional disturbance (SED).

MH Trust: ABADA/AMHB Joint Staffing: *$418.8 MHTAAR*
This Trust funding provides a supplement to the basic operations of the merged staff of Advisory Board on Alcoholism and Drug Abuse (ABADA) and Alaska Mental Health Board (AMHB), and requires the boards to meet the data, planning and advocacy performance measures negotiated with the Trust.

Challenges

Sustaining an Effective System of Care

The Division of Behavioral Health (DBH) business practice and management philosophy focus on the delivery of high quality services and demonstrated treatment outcomes. Achieving excellent performance expectations for behavioral health service delivery relies on a viable and functional network of service provider organizations. Performance accountability systems require these providers to bear more risk for achieving results, as well as requiring changes of business philosophy, policy and clinical practice, with new resources and skills. However, this changing landscape presents significant challenges that place this service provider network at risk, with negative impact on the quantity, quality, and effectiveness of services, including the potential of agency closure. Our system of care is fragile and requires the following:

- Business modeling that balances fiscal, revenue, and clinical management
- Personnel and workforce management that effectively recruits, trains, and retains (including equitable wages) skilled employees.
- Service provider data infrastructure for adequate equipment, skilled staff, and training.
- Data driven business management that optimizes data collection, reporting, analysis, and application to inform and modify business and clinical practices.

The division's management has developed an innovative "technical assistance" (TA) in response to these increasing challenges faced by the service providers. It has been our experience that our successful outcomes rely heavily on our division staff skills and resources—which are often stretched by ongoing tasks and responsibilities. Building in sufficient room to accommodate periodic insertion into agency-specific improvement efforts given their current workload has been complicated.

Psychiatric Emergency Services

Psychiatric Emergency Services comprise the most basic core services in the community behavioral health system. The fact that we continue to label these services as psychiatric without recognition of the impact of substance use speaks to our need to reassess the service system. These services are part of the larger continuum of care, and are often a partnership among the mental health provider agency, law enforcement, primary care and hospital emergency department. Each community in Alaska, whether large or small, must have some capacity to respond to a psychiatric emergency, and often this psychiatric emergency contains a co-occurring substance abuse component.

Rural-Frontier challenges include the ability for small village communities to coordinate services in such a manner as to respectfully preserve the dignity of the person experiencing the crisis. This necessitates careful liaison with law enforcement, village-based peace officers, primary care practitioners, and health aides. A greater emphasis must be placed on 'hands on' crisis intervention skill development, so that individuals can be stabilized in their own communities, rather than being routinely transported to stabilization and treatment facilities in larger communities including the Alaska Psychiatric Institute (API). Involuntary hospitalization is not only the most restrictive level of care in the service continuum; it is the most costly. Due to a lack of Psychiatric Emergency Services in some areas of the state, admissions to the state hospital, API, have increased. During the first quarter FY10, API has operated with a 'pending admissions' list because of lack of bed availability for acute care.

At the same time, it should be recognized that some individuals will require interventions or a level of care that cannot be provided locally. We must revitalize and expand our behavioral health system of Designated Evaluation and Treatment/Stabilization facilities throughout the state, through increased outreach to the hospitals, and increased support and training. When local hospitals assume these responsibilities, most individuals in crisis (more than half) can be stabilized, and returned home without having to leave their community or region. Successfully stabilizing and treating people close to home also relieves pressure on API, where the census is at or near capacity most of the time.

Prevention

The division's prevention and early intervention services section (CAPI) is striving to develop a clear, comprehensive and integrated approach to prevention of all behavioral health issues, and those influences and causal/contributing factors that surround the behavioral health field (criminal justice, family violence [both child abuse and domestic violence], public health, primary health care, education and others). For too long, we have segregated social and health problems into manageable but isolated parts, missing the powerful effects of a broad combination of interventions that can impact related and intertwined problems. We strongly believe that, by combining our resources, our planning, our data and our efforts, we will create a more flexible, accountable, innovative and measurable program. Issues of community readiness, coalition-building and leveraging critical partnerships, including our Alaska Native tribal health programs/corporations, are key pieces of working to develop a strong and sustainable continuum of care.

Suicide

Suicide in Alaska continues to be a critical concern; everyone in Alaska has been touched by suicide, whether directly or indirectly. It is impacting our citizens, our families, our communities, and our state as a whole. The need for better coordination, strategies, outcome measures, community planning and readiness to deal with issues related to suicide is paramount if we are going to make progress in reducing and preventing suicide in Alaska. One of the first steps is to begin the conversation. In many communities, there is too much pain and loss associated with suicide - many feel it is better to not talk about it. Suicide is an issue that requires community ownership: a commitment to discover and address the underlying influences; and development of positive strategies to change the social norm that allows suicide to be a viable option for too many individuals. A comprehensive, community and data-driven approach is necessary to begin turning the curve on the high rates of suicide across Alaska, especially in rural and remote Alaska and among our Alaska Native populations.

Seriously Mentally Ill Adult Services

Maintaining Seriously Mentally Ill Adults in open community settings, and helping them to become and remain contributing members of the larger community, requires a complicated network of services to be successful. It requires a constellation of safe housing, stable activity or work, individualized treatment supports, pharmacological management services, and crisis intervention that is "wrapped around" the client in the community in a safe, constructive environment. Knowing and accepting that some of these individuals will be long-term clients, our service providers need to have the skills necessary to maintain engagement with this population to prevent relapse and to facilitate recovery, including employment.

Detoxification
Communities around the state struggle with how to decrease the incidence of public inebriation, how to decrease the incidence of substance abuse, and how to increase access to detoxification when people need it. The Alaska Mental Health Trust Authority has been instrumental in promoting the expansion of detox funding in several of our most impacted communities: Barrow, Bethel, Fairbanks and the Mat-Su. We struggle with the issue of readiness in many of these communities, and because detoxification is a service that cannot stand alone, the community must be prepared to commit time and resources to ensure sustainability.

Performance Management System
The division's business practice and management philosophy focuses on the delivery of high quality services and demonstrated treatment outcomes. A core function of DBH is to monitor the service delivery system's performance, in terms of "Quantity" (How much did we do?), "Quality" (How well did we do it?), and "Outcomes" (Did anyone benefit?). Improving service through a results-oriented and performance-based approach requires changes in philosophy, policy and practice, as well as targeted resources.

DBH continues to develop and implement a Performance Management System to insure an efficient, equitable, and effective system of behavioral health care for Alaskans. A performance-oriented system requires a correlated data infrastructure system. Related challenges involve budgeting for appropriately skilled research staff in order to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. In addition, this system realignment absorbs a significant amount of leadership time and energy that, in effect, limits our resources for new program development.

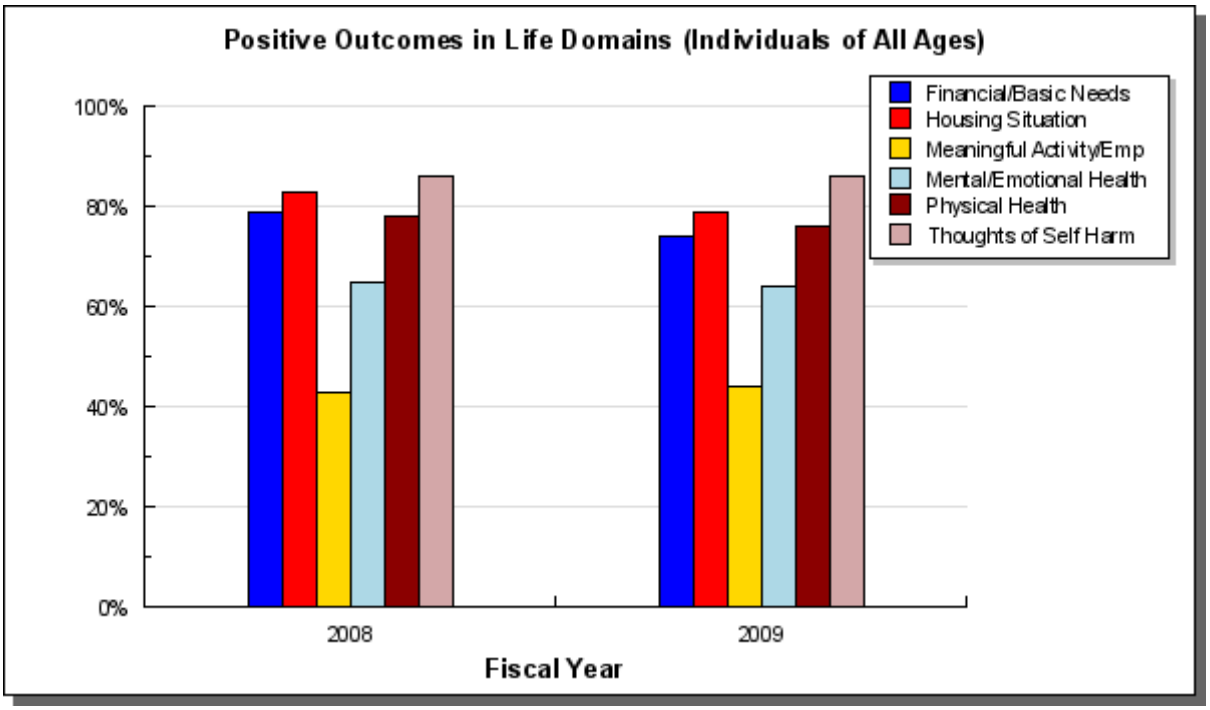
Information Management System Enhancement and Maintenance: The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the division's Performance Management System. System development, enhancements and maintenance of a management information system is standard and accepted business practice. Challenges involve budgeting for the standard life cycle of the MIS system with adequately skilled technical and training staff.

Performance Based Funding (PBF): A key component of the Performance Management System is the method of distributing prevention and treatment funding, based on provider performance and outcomes (i.e. performance based funding). Mandated by the 2007 legislature, PBF was successfully implemented by the DBH, with positive outcomes in the management of the behavioral health system of care. As the sophistication of the PBF effort continues, the workload implications for current and future development is better understood. Challenges involve budgeting for adequately skilled personnel for ongoing development, maintenance and application.

A: Result - The quality of life for Alaskans experiencing a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance use disorder (SUD) is enhanced.

Target #1: For each of six life domains (financial/basic needs, housing situation, meaningful activities/employment, mental/emotional health, physical health, and thoughts of self harm), 75% of individuals will report improvement or maintaining condition.

Status #1: In FY09, for each of three life domains (housing situation, physical health, and thoughts of self harm), more than 75% of individuals who received services through the comprehensive, integrated Behavioral Health Service System reported improvement or maintaining condition. For each of the remaining three life domains (financial/basic needs, meaningful activities/employment, and mental/emotional health), less than 75% of individuals reported improvement or maintaining condition.



Methodology: Grantee agency staff administers the Client Status Review (CSR) to clients at intake, 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: The CSR is not required for clients receiving psychiatric emergency services and/or detoxification services.

Data Source Date: August 2009

Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Financial/ Basic Needs	Housing Situation	Meaningful Activity/Emp	Mental/ Emotional Health	Physical Health	Thoughts of Self Harm
FY09	74%	79%	44%	64%	76%	86%
FY08	79%	83%	43%	65%	78%	86%

Analysis of results and challenges:
FY08 was a baseline year. From FY08 to FY09, the percent of clients who reported improvement or maintaining condition for each of the six life domains changed only slightly. The most significant of these slight changes were in the financial/basic needs and housing situation domains:

-- Positive outcomes in the financial/basic needs domain decreased from 79% in 2008 to 74% in 2009 (this is just below the target value of 75%).

-- Positive outcomes in the housing situation domain decreased from 83% in 2008 to 79% in 2009.

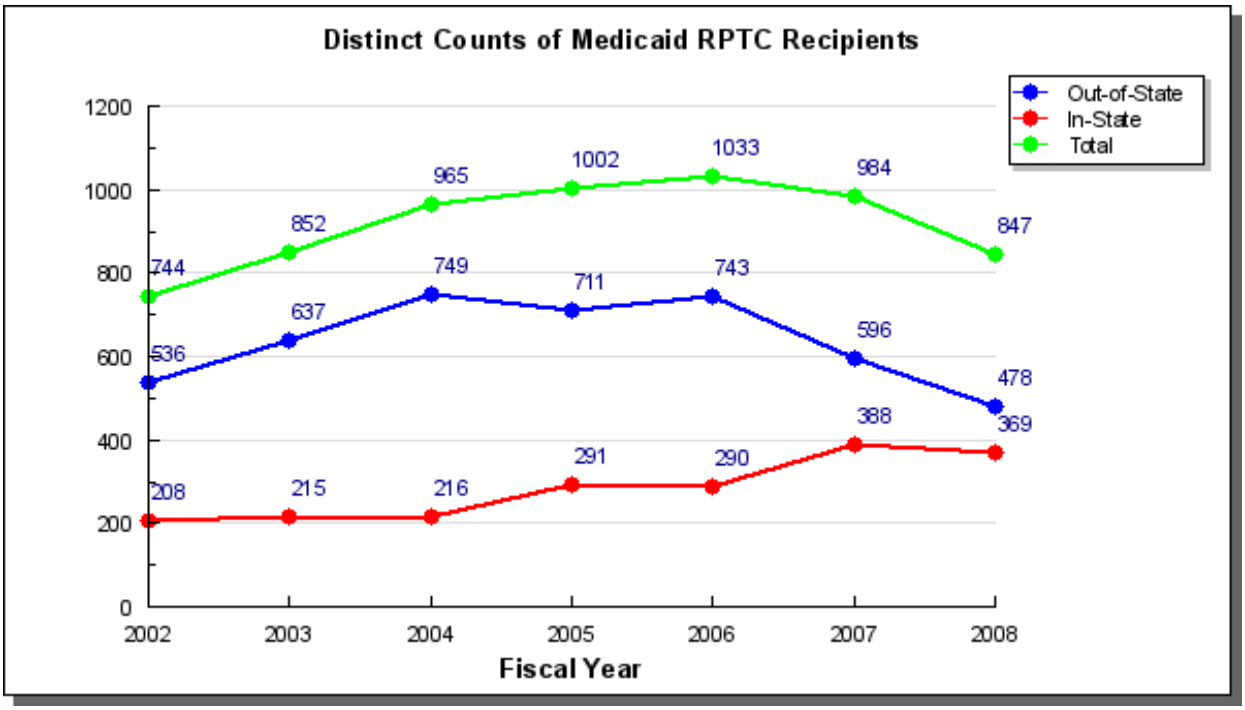
In both FY08 and FY09, the life domains with the lowest percentage of individuals reporting improvement or maintaining condition were meaningful activities/employment (43% in FY08 and 44% in FY09) and mental/emotional health (65% in FY08 and 64% in FY09).

The CSR instrument is currently under revision to improve its usefulness in assessing change over time. This revision will include a child version. The target date for implementing the new CSR instruments (adult and child) is July 1, 2010. In addition, refinements to the CSR reporting procedures are being explored to report change over time for various client groups (e.g., type of services received, duration of services received, and demographic characteristics).

A1: Strategy - 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 residential psychiatric treatment centers (RPTCs) by 10% each year.

Status #1: From FY07 to FY08, there was a 19.8% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care.



Methodology: Data is presented in the "Bring the Kids Home: Indicators for FY08" publication, as provided by the Division of Behavioral Health, Policy and Planning Section (data source: MMIS). The In-State and Out-of-State RPTC recipient counts are each unduplicated; the Total RPTC recipient count is duplicated between In-State and Out-of-State.

* Data for the "Bring the Kids Home: Indicators for FY09" are not yet available.

Distinct Counts of Medicaid RPTC Recipients

Fiscal Year	Out-of-State	In-State	Total
FY08	478	369	847
FY07	596	388	984
FY06	743	290	1033
FY05	711	291	1002
FY04	749	216	965
FY03	637	215	852
FY02	536	208	744

Analysis of results and challenges: The Bring the Kids Home (BTKH) Project was initiated during FY04. 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 as shown by the significant reduction, since FY04, in the number of youth experiencing serious emotional disorders receiving care in out-of-state RPTCs.

From FY04 to FY08, there was a 36.2% decrease in the number of out-of-state RPTC recipients of care (749 in FY04; 478 in FY08) and a 70.8% increase in the number of in-state RPTC recipients of care (216 in FY04; 369 in FY08). In addition, for the same time period, the total RPTC recipient count decreased by 12.2% (965 in FY04; 847 in FY08). The total RPTC recipient count peaked in FY06. Since then, there has been an 18% decrease in the total RPTC recipient count (1,033 in FY06; 847 in FY08). These shifts reflect a number of capital projects initiated to increase the number of beds in-state, some of which became available in FY07. In addition, 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. As more new beds and other programs become available, it is anticipated that there will be further impact on the number of out-of-state RPTC recipients of care.

Annual comparisons from FY06 to FY08:

From FY07 to FY08 there was a:
- 19.8% decrease in the number of distinct out-of-state RPTC recipients of care.
- 4.9% decrease in the number of distinct in-state RPTC recipients of care.
- 13.9% decrease in the total RPTC recipient count.

From FY06 to FY07 there was a:
- 19.8% decrease in the number of distinct out-of-state RPTC recipients of care.
- 33.8% increase in the number of distinct in-state RPTC recipients of care.
- 4.7% decrease in the total RPTC recipient count.

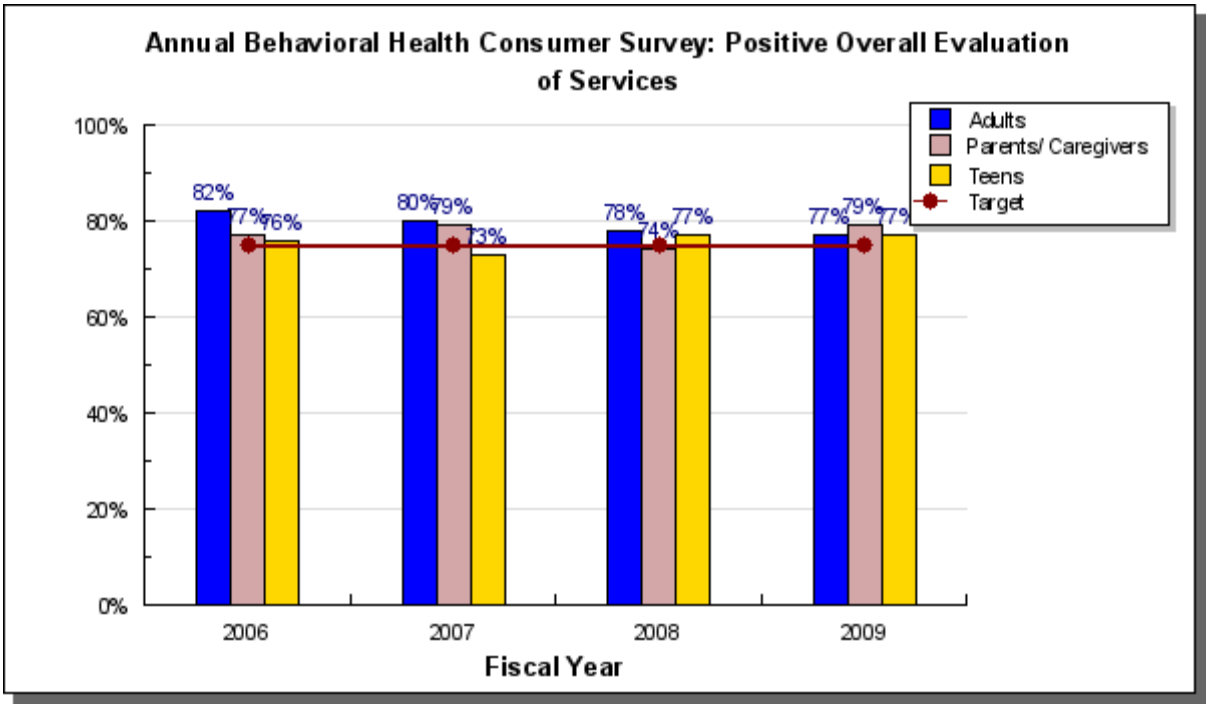
From FY98 to FY04, the number of distinct out-of-state RPTC recipients of care steadily increased – on average, 46.7% per year. Also, for the same time period, the total RPTC recipient count steadily increased - on average 24.8% per year.

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.

A2: Strategy - Improve and enhance the quality of life of Alaskans experiencing a SED, a 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 youth, and teens) who complete the Annual Behavioral Health Consumer Survey will report a positive overall evaluation of services.

Status #1: In FY09, 77% of the Annual Behavioral Health Consumer Survey adult and teen respondents reported a positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services.



Methodology: The Division uses the Behavioral Health Consumer Survey (BHCS) to obtain information on client evaluation of behavioral health services. Grantee agencies mail the Annual BHCS to clients receiving outpatient treatment services; surveys are returned to the Division for processing.

Annual Behavioral Health Consumer Survey: Positive Overall Evaluation of Services

Fiscal Year	Adults	Parents/ Caregivers	Teens
FY09	77%	79%	77%
FY08	78%	74%	77%
FY07	80%	79%	73%
FY06	82%	77%	76%

Analysis of results and challenges: In FY09, 77% of the Annual Behavioral Health Consumer Survey (BHCS) adult and teen respondents reported a positive overall evaluation of services; 79% of parents/caregivers of youth reported a positive overall evaluation of services.

From FY06 to FY09 there was some fluctuation in respondents' evaluation of services. FY08 is considered to be a new baseline year due to survey methodology changes implemented for the FY08 BHCS.

From FY08 to FY09, the percent of adults and teens who reported a positive overall evaluation of services remained almost the same:

--Adults: FY08 = 78%; FY09 = 77%
--Teens: FY08 = 77%; FY09 = 77%

From FY08 to FY09, the percent of parents/caregivers of youth who reported a positive overall evaluation of services increased several percentage points:

--Parents/Caregivers of Youth: FY08 = 74%; FY09 = 79%
(Due to the relatively small sample size of parent/caregiver respondents, this difference is only marginally significant.)

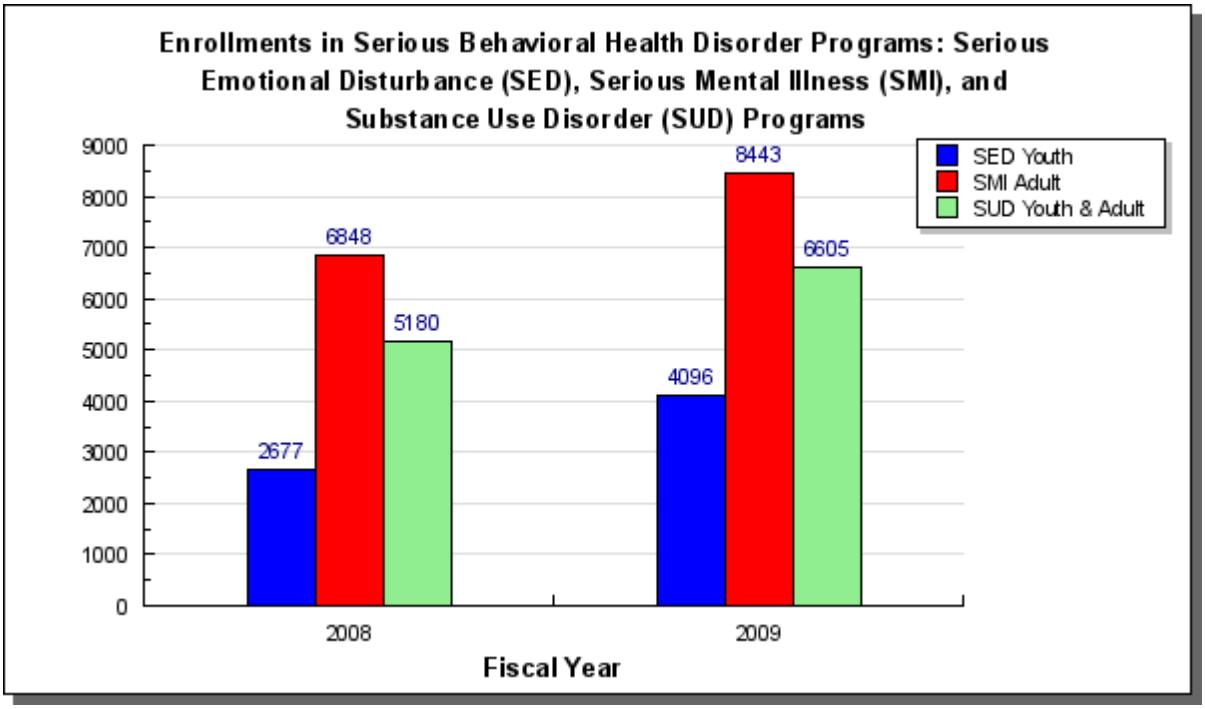
The Division continues to refine the BHCS administration process to improve accuracy, completeness, and response rate.

The Division also is making progress in implementing its Performance Management System. Performance Based Funding measures were developed and applied to funding allocations to service providers for FY09 and FY10. Participation in administering the BHCS was one of several performance measures used to determine funding allocations.

A3: Strategy - Improve and enhance the quality of life of Alaskans experiencing a SED, a SMI and/or a SUD by assuring them access to a comprehensive, integrated Behavioral Health Service System.

Target #1: Increase annually by 2.5% the number of enrollments into serious behavioral health disorder programs (i.e., serious emotional disturbance (SED), serious mental illness (SMI), and substance use disorder (SUD) programs).

Status #1: From FY08 to FY09, the reported number of enrollments into serious behavioral health disorder programs increased more than 20% for SED, SMI, and SUD programs.



Methodology: Data reflects Alaska Automated Information Management System (AKAIMS) FYTD reported number of program enrollments. Program enrollments are not an unduplicated count of individuals served; one person may be enrolled in several programs.

FY08 Data Source Date: November 2008
FY09 Data Source Date: August 2009

Enrollments in Serious Behavioral Health Disorder Programs: Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and Substance Use Disorder (SUD) Programs

Fiscal Year	SED Youth	SMI Adult	SUD Youth & Adult	Total
FY09	4096 +53.01%	8443 +23.29%	6605 +27.51%	19,144 +30.19%
FY08	2677	6848	5180	14,705

Analysis of results and challenges: In order to improve and enhance the quality of life of Alaskans who experience a behavioral health problem, access to a comprehensive, integrated service system is critical. Measuring treatment services through program enrollments is an effective method to measure accessibility of services.

This measurement reports the level at which Alaskans are accessing services, as well as the efforts to improve statewide data collection. FY08 was a baseline year for reporting program enrollments using the Alaska Automated Information Management System (AKAIMS). During FY08, numerous grantee agencies struggled with data submission requirements and were not able to enter all client records into AKAIMS. Therefore, FY08 program enrollments are under-reported. The Division's efforts to assist grantee providers with technical assistance and reporting performance based measures specific to data completeness has greatly improved the AKAIMS data collection, analysis and reporting capabilities. The FY09 reported number of enrollments reflects a significant improvement toward complete electronic health records from grantee agencies.

During FY09, the behavioral health system of care provided 4,096 enrollments in Severely Emotionally Disturbed (SED) programs, 8,443 enrollments in Severely Mentally Ill (SMI) programs, and 6,605 enrollments in substance use disorders (SUD) programs, for a total of 19,144 program enrollments. Program enrollments are not an unduplicated count of individuals served, as one person may be enrolled in several programs.

Improvements in data collection have resulted in greater measurement of program enrollments.
- The reported number of SED program enrollments increased 53.0% from 2677 in FY08 to 4096 in FY09.
- The reported number of SMI program enrollments increased 23.3% from 6848 in FY08 to 8443 in FY09.
- The reported number of SUD program enrollments increased 27.5% from 5180 in FY08 to 6605 in FY09.

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

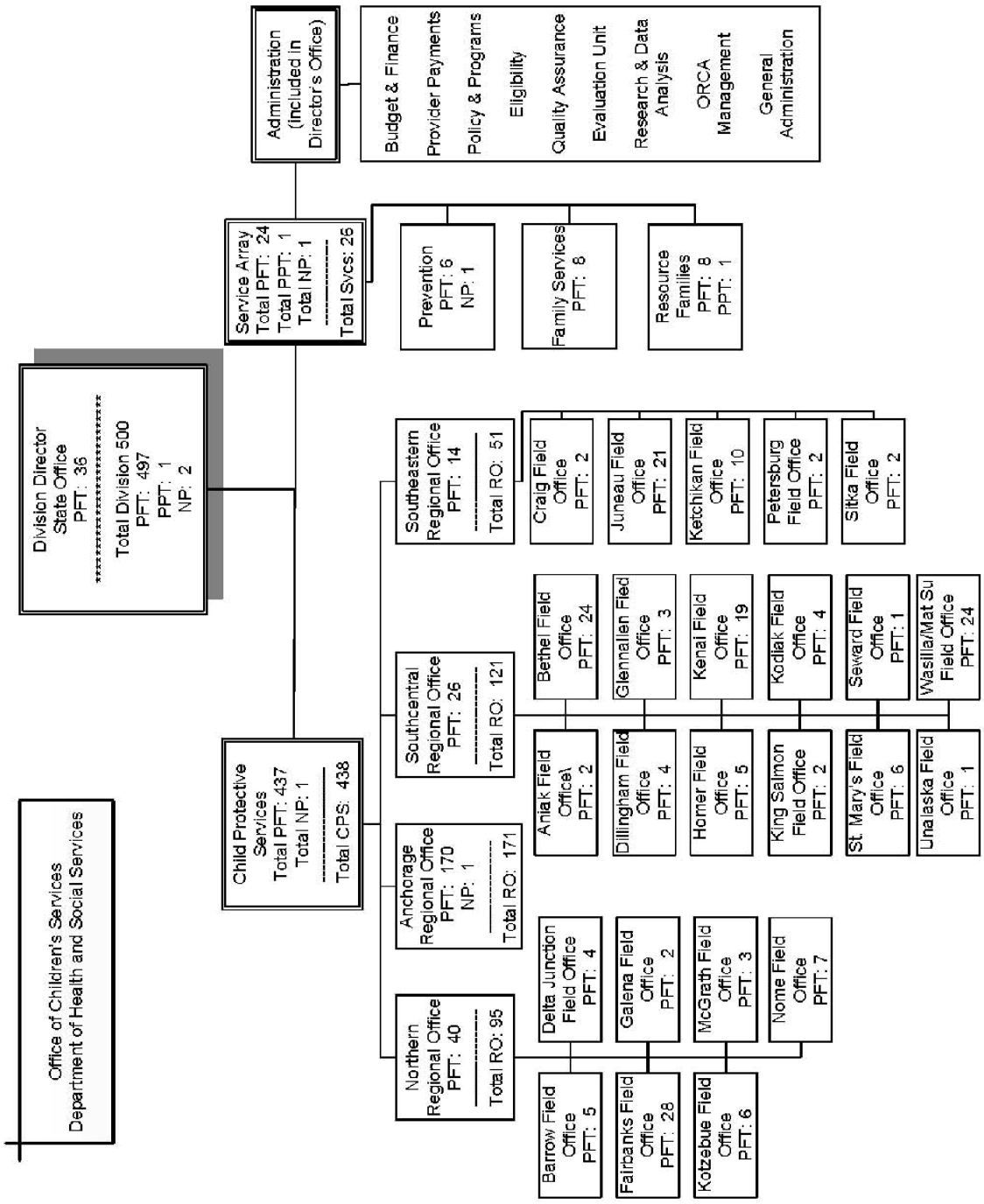
FY11 Governor's Request Increment and Decrement Fund Breakout

Division of Behavioral Health FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
MH Trust: AK MH/Alc Bd-Increased Access to FASD Treatment Svcs Rural AK	$ 228.6	$ -	$ -	$ 228.6
MH Trust: Dis Justice - Grant 569.05 AK Safety Action Pgm Therapeutic Case Management and Monitoring Treatment	$ -	$ -	$ 138.0	$ 138.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (138.0)	$ (138.0)
Medicaid Growth	$ 5,433.2	$ 4,602.1	$ -	$ 10,035.3
MH Trust: AK MH/Alc Bd-Substance Abuse Treatment for Pregnant Women	$ 500.0	$ -	$ -	$ 500.0
MH Trust: Dis Justice - Detox and Treatment Capacity as alternatives to protective custody holds	$ 518.3	$ -	$ -	$ 518.3
MH Trust: Dis Justice - Grant 1380.02 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome)	$ -	$ -	$ 100.0	$ 100.0
MH Trust: Dis Justice - Maintain Treatment Capacity Therapeutic Court Participants w/ Co-occurring Disorders	$ 75.0	$ -	$ -	$ 75.0
MH Trust: Dis Justice - Specialized Treatment Unit (Clitheroe)	$ 1,200.0	$ -	$ -	$ 1,200.0
MH Trust: Housing - Grant 1377.03 Assisted living home training and targeted capacity for development	$ -	$ -	$ 100.0	$ 100.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (725.0)	$ (725.0)
Maintain Existing Tobacco Enforcement and Education Program	$ -	$ -	$ 175.0	$ 175.0
MH Trust Workforce Dev - Grant 2709 DBH/UAA/UAF PhD Student Partnership	$ -	$ -	$ 50.0	$ 50.0
MH Trust Workforce Dev - PhD Internship Consortium (AK-PIC)	$ 100.0	$ -	$ -	$ 100.0
MH Trust: BTKH - Grant 1391.03 Tool kit development and expand school-based services capacity via contract	$ -	$ -	$ 50.0	$ 50.0
MH Trust: BTKH - Grant 2463.01 Technical Assistance	$ -	$ -	$ 100.0	$ 100.0
MH Trust: BTKH - Grant 2465.01 Tribal/rural system development	$ 200.0	$ -	$ -	$ 200.0
MH Trust: BTKH - Grant 2465.01 Tribal/rural system development	$ -	$ -	$ 200.0	$ 200.0
MH Trust: Housing - Grant 383.06 Office of Integrated Housing	$ -	$ -	$ 200.0	$ 200.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (412.0)	$ (412.0)
Transfer BTKH Residential Aide Training and Training Academy to University	$ (305.0)	$ -	$ -	$ (305.0)
MH Trust: AMHB/ABADA - Grant 2464.01 Designated Evaluation and Treatment Expansion	$ -	$ -	$ 300.0	$ 300.0
MH Trust: Dis Justice - Flexible Forensic Treatment Team (Anc MH Court)	$ 250.0	$ -	$ -	$ 250.0
MH Trust: Housing - Grant 575.05 Bridge Home Pilot Project	$ -	$ -	$ 750.0	$ 750.0
MH Trust: Housing - Grant 604.05 Department of Corrections discharge incentive grants	$ -	$ -	$ 350.0	$ 350.0

Division of Behavioral Health FY11 Governor's Request
General and Other Fund Requests cont.
(Increases and Decreases only)

Item	GF	Federal	Other	Total
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (1,300.0)	$ (1,300.0)
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (300.0)	$ (300.0)
MH Trust: BTKH - Individualized Services	$ 300.0	$ -	$ -	$ 300.0
MH Trust: BTKH - 1389.03 Crisis Bed Stabilization - Anchorage and statewide	$ -	$ -	$ 150.0	$ 150.0
MH Trust: BTKH - Grant 1388.03 Peer Navigator Program	$ -	$ -	$ 175.0	$ 175.0
MH Trust: BTKH - Grant 1390.03 Expansion of school-based services capacity via grants	$ -	$ -	$ 200.0	$ 200.0
MH Trust: BTKH - Grant 1390.03 Expansion of school-based services capacity via grants	$ 200.0	$ -	$ -	$ 200.0
MH Trust: BTKH - Grant 2466.01 Transitional Aged Youth	$ 100.0	$ -	$ -	$ 100.0
MH Trust: BTKH - Grant 2466.01 Transitional Aged Youth	$ -	$ -	$ 100.0	$ 100.0
MH Trust: BTKH -Grant 1392.03 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	$ -	$ -	$ 450.0	$ 450.0
MH Trust: BTKH -Grant 1392.03 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	$ 500.0	$ -	$ -	$ 500.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (1,200.0)	$ (1,200.0)
MH Trust Cont - Grant 2467.01 IMPACT model of treating depression	$ -	$ -	$ 70.0	$ 70.0
MH Trust Workforce Dev - API Psychiatry Residency Training	$ 300.0	$ -	$ -	$ 300.0
MH Trust: BTKH - Grant 2708 Child Psychiatrist	$ -	$ -	$ 50.0	$ 50.0
Reflect Interagency Receipts for Medicaid-Eligible Clients	$ -	$ -	$ 3,900.0	$ 3,900.0
Reverse August FY2010 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	$ (19.6)	$ -	$ -	$ (19.6)
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (70.0)	$ (70.0)
MH Trust: BTKH - Grant 606.05 Strong family voice: parent and youth involved via AMHB	$ -	$ -	$ 50.0	$ 50.0
MH Trust: Cont - Grant 605.05 ABADA/AMHB joint staffing	$ -	$ -	$ 418.8	$ 418.8
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (432.0)	$ (432.0)
Behavioral Health Total	***$ 9,580.5***	***$ 4,602.1***	***$ 3,499.8***	***$ 17,682.4***

Children's Services



Introduction to the Division

Mission

The Office of Children's Services (OCS) works in partnership with families and communities to achieve safety, well-being and permanency for children, youth and families.

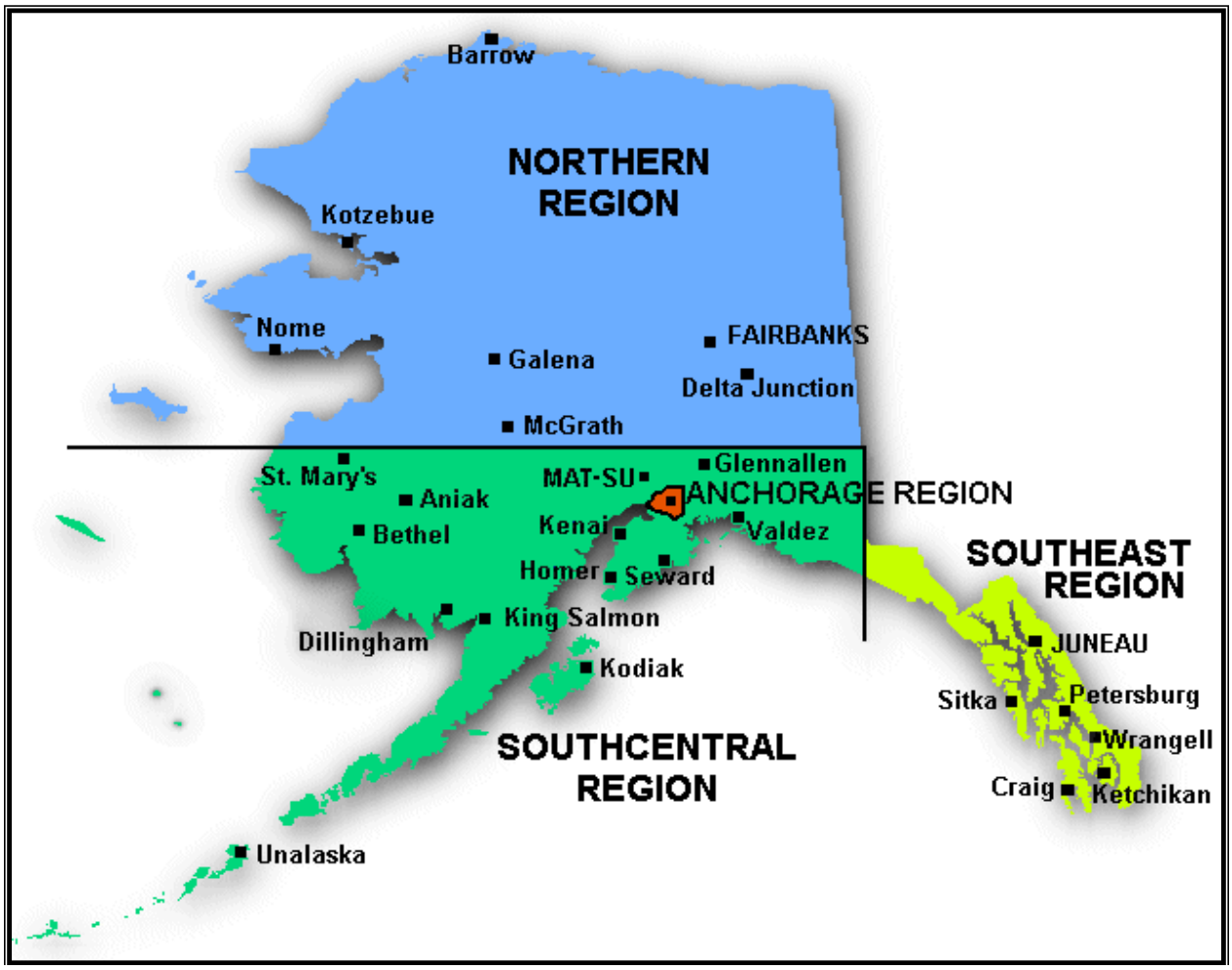
Core Services

Ensure that children are safe and families remain intact whenever possible:

- Prevent and remedy child abuse and neglect.
- Facilitate early intervention and treatment services.
- Initial assessment of protective service reports.
- Ensure services to children and their families when necessary.
- Develop permanency plans for children in out-of-home care.

The OCS supports 26 local offices across 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

Services provided are intended to prevent child abuse and neglect and strengthen families' capacities 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.

Client Services

Prevention and Early Intervention Services

Prevention programs administered by the Office of Children's Services 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.

Infant Learning
The Infant Learning Program provides early childhood special education services (early intervention services) to children with developmental delays and their families, and administers consultant and learning services to providers through 17 regional and two consultant state grantee programs.

The Office of Children's Services 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 to evaluate, assess, develop and implement individualized family services plans. Comprehensive and coordinated early intervention services may include but are not limited to the following:

- Provide child development information to parents;
- Visits to home, child care, or other natural environments to provide consultation and support to best support the child's development;
- Physical, Occupational and Speech therapies as well as mental health and special education services;
- Specialized equipment; and
- Referrals to other services when necessary.

In FY09, more than 2,500 children, birth to three years, received a referral for screening or evaluation for early intervention services through Infant Learning Programs in Alaska. Of these 2,500 children, over 1,767 were eligible for early intervention services funded under Part C of the Individuals with Disabilities Education Act.

In FY09, child outcome summary ratings were collected and analyzed for 244 children exiting the program during the fiscal year. Measures of child outcomes in three primary areas of functioning indicate that most children made significant gains after receiving early intervention services as shown in the tables that follow.

Of those children who entered the program below age expectations in the Outcome Area, the percent that substantially increased their rate of growth by the time they exit the program.

Child Outcome Area	Percent Substantially Increased Rate of Growth
Positive social relationships	67% (104 of 155)
Acquisition of knowledge and skills	78% (146 of 188)
Taking appropriate actions to meet own needs	73% (143 of 195)

The percent of children who are functioning within age expectations in the Outcome Area by the time they exit the program.

Child Outcome Area	Percent within Age Expectations at Exit
Positive social relationships	58% (142 of 244)
Acquisition of knowledge and skills	57% (139 of 244)
Taking appropriate actions to meet own needs	55% (134 of 244)

The Early Childhood Comprehensive Systems Initiative

The Early Childhood Comprehensive Systems Initiative is a project 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.

State agencies and statewide stakeholders worked together to develop an "Early Childhood Comprehensive Systems Plan" that builds on the premise that for children to be ready for school and successful in life, they must be healthy, have their social and emotional needs met, have good opportunities for learning, and need to grow up in families that are supportive and nurturing. This plan is providing guidance on how to improve services for young children and their families.

The Interdepartmental Early Childhood Coordinating Council was formed to support the implementation of the Early Childhood Comprehensive Systems Plan and the development of a comprehensive and integrated early childhood system. The Council is made up of representatives from the Departments of Health and Social Services, Education and Early Development, Commerce and Economic Development, the Alaska Mental Health Trust Authority, the 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.

Work completed over the last year included:

- Establishing three committees of the Interdepartmental Early Childhood Coordinating Council –Finance/Fiscal Strategies, Monitoring & Accountability, and Family Leadership – and beginning a scan of early childhood programs and services provided by the State.
- Working with the State Early Periodic Screening, Diagnosis, and Treatment Workgroup to review that program and identify areas needing improvement.
- Working with Child Protection Services to revise policies and procedures regarding Early Periodic Screening, Diagnosis, and Treatment Well-Child exams for children in custody, identify data needs for monitoring purposes, and develop training for regional offices.
- Sponsoring the third Early Childhood Mental Health Institute focused on building workforce expertise in the area of early childhood mental health.
- Working with the University of Alaska Behavioral Health Alliance to begin development of a cross-disciplinary early childhood mental health certificate for graduate level students.
- Supporting the development of the Early Childhood Mental Health Pyramid Project. This project will provide training, coaching and support to three early care and learning programs that are chosen to become demonstration sites.
- Establishing the use of a more appropriate diagnostic process for children birth to five years with mental health concerns.
- Beginning a grant funded early childhood mental health consultation program for early care and learning programs in the Anchorage area.
- Supporting the work of the Department of Education and Early Development to expand Pre-K programs, the Division of Public Assistance Child Care Program to improve Child Care Assistance rates, and the Office of Children's Services Infant Learning Program to expand services to children birth to three years with special needs.

Strengthening Families Program

The Strengthening Families Initiative is a proven, cost-effective strategy to prevent child abuse and neglect and improve optimal child development. 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
- Social Connections
- Children's social and emotional competence

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 families are engaged.

Strengthening Families efforts included:

- Partnering with United Way of Anchorage and Thread to recruit, train, and support 10 new Anchorage-based early care and learning programs in implementing the Strengthening Families program.
- Sponsoring monthly teleconferences for the "Learning Network" of existing Strengthening Families programs.

- Participating in the National Alliance of Children's Trust and Prevention Funds Early Childhood Initiative. Facilitating a quarterly regional cluster group in partnership with the Alaska Children's Trust.
- Printing and distributing the curriculum entitled, "Engaging with Parents".
- Participating in the Alaska Children's Trust efforts to develop a State Prevention Plan.
- Supporting efforts to expand the use of "Community Cafes" to create local-level dialogue on how families can be strengthened and supported.
- Partnering with Child Protection Services, the Alaska Children's Trust, and the Bristol Bay Native Association to participate in the PREVENT Maltreatment Institute and develop a project to culturally norm the protective factors in rural native villages.

Child Protective Services

Child Protective Services is a specialized social service designed to keep children safe. In 2005, the Office of Children's Services recognized that in order to meet desired outcomes, child protection work in Alaska would need to be restructured. To that goal, restructuring began with the introduction of a safety intervention system and has been formalized with the introduction of a new Office of Children's Services Practice Model that reflects what was learned from the 2004 Child and Family Services Review findings, as well as state-of the-art practice in the field of child welfare.

The Office of Children's Services Practice Model works in concert with the outcomes required by the Federal Child and Family Services Review:

- Children are, first and foremost, protected from abuse and neglect;
- Children are safely maintained in their homes whenever possible and appropriate;
- Children have permanency and stability in their living situations;
- The continuity of family relationships and cultural connections is preserved for children;
- Families have enhanced capacity to provide for their children's needs; and
- Children receive adequate services to meet their physical and mental health needs.

Specific Alaska guidelines have been developed to ground the Practice Model within five core components:

1. Intake - Intake is the critical function of receiving and responding to reports of allegations of child maltreatment. Intake provides the first assessment of child safety, and information gathered determines whether or not a response is required by child protective services.

2. Initial Assessment - Initial Assessment is the essence of the decision-making process once a protective services report is screened in for protective services intervention. Previous practice focused on the alleged maltreatment and the condition of the victim at the time of the report. Practice is now geared to evaluate obvious present danger and overall family functioning. If it is determined that the child is unsafe or at high risk, the worker will work with the family to implement the least intrusive approach to keep the child safe, first with consideration of an in-home safety plan and last, an out-of-home placement.

3. Family Services - Family Services are provided to families with children remaining in their home as well as to families whose children have been placed in out-of-home care.

The Office of Children's Services works first to keep children with their families, and if children must be removed, to reunify children with their parents/caregivers. In collaboration with families, tribes and service providers, case plans are developed and continually reviewed and updated to address the family's changing circumstances.

4. Service Array - The State of Alaska has in place an array of services to meet the needs of children and families that come to the attention of the child protective services system. Services are provided by grantees that are funded by the various divisions within the Department of Health and Social Services. These community providers perform a critical role in their partnership with the Office of Children's Services to keep children safe, enhance parents' protective capacities, and to achieve permanency and child well being.

5. Resource Families - When out-of-home placement is needed to keep the child safe, the Office of Children's Services will make diligent efforts to identify, evaluate and consider relatives, family friends and those culturally tied to the family for placement. When that is not possible, children are placed with licensed resource families that can best meet the child's needs for safety, permanency and well being. The Office of Children's Services will make every effort to place siblings together, to place a child within the same community or in as closest proximity as possible to the child's parents and to assure that the child may continue to go to the same school whenever possible.

Implementation of the practice model is on-going and is in conjunction with the Office of Children's Services Program Improvement Plan in response to findings of the September, 2008 Child and Family Services Review conducted by the Children's Bureau within the U.S. Department of Health and Human Services.

Child Advocacy Centers

Child Advocacy Centers provide alleged child victims of sexual abuse and severe physical abuse and their non-offending caretaker family members a safe, child-friendly environment to assure protective services are administered in a manner that does not re-traumatize the child or the family. This is accomplished through multidisciplinary team member interaction during the assessment and decision-making phases. In the assessment phase, there may be a forensic interview and medical forensic examination to guide the team in the decision as to whether the incident will be referred to the district attorney for prosecution and what services the child victim and non-offending caretakers need for both immediate support and follow-up counseling and medical care. Victims and non-offending family members are assigned a specialized family advocate who remains with them throughout the process.

The foundation of a Child Advocacy Center is a Multidisciplinary Team comprised of law enforcement, community, tribal, medical, social service, and legal representatives. Multidisciplinary Teams, 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 Child Advocacy Center provides the best forum in which an investigation can occur to assure victims are not re-traumatized by repeated interviews and examinations.

The Lake Plaza Multidisciplinary Center in Anchorage where Alaska CARES Child Advocacy Center is located, shares space with a complete Office of Children's Services assessment unit.

The first year in operation the Anchorage center experienced a 13% increase in referrals. The following year, there was an additional 9% increase. The Children's Place Child Advocacy Center and the Copper River Basin Child Advocacy Center are both actively involved with the Office of Children's Services to establish co-location models to include a full child protective services assessment unit.

Child Protective Services Reports Referred to Child Advocacy Centers in FY08					
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%

Child Protective Services Reports Referred to Child Advocacy Centers in FY09					
Region/Area	Sexual Abuse (SA)	Physical Abuse (PA)	SA & PA Totals	Total CAC Referrals	% of Alleged SA & PA Cases Referred to CAC's
Anchorage	679	1003	1682	823	52%
Northern	182	244	426	366	90%
South-central	505	659	1164	410	37%
Southeast	112	233	345	86	26%
TOTALS	1478	2139	3617	1685	49%

During FY09, the Copper River Basin area and the Kenai Peninsula Child Advocacy Centers continued to progress toward full implementation. The Copper River Basin center found a permanent location in Gakona. The Kenai Peninsula center is based in Homer with a fully functioning satellite in Kenai, and they are currently in negotiations to set up a second satellite program in Seward. There are other Alaskan communities in various stages of forming Multidisciplinary Teams and it is expected that some of them will apply for funding when the 2012 grant year is available.

Alaska's Family-to-Family Program

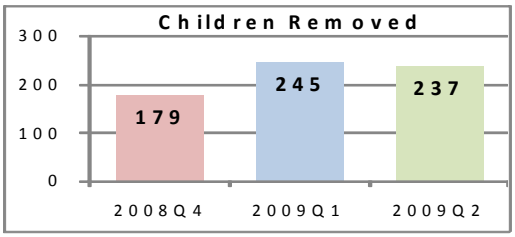
On a national level, Family-to-Family advocates have worked for 15 years to change child welfare systems, most recently by advocating for more children to remain safely with their own families or a family-like connection whenever possible. At its core, Family-to-Family applies four basic principles:

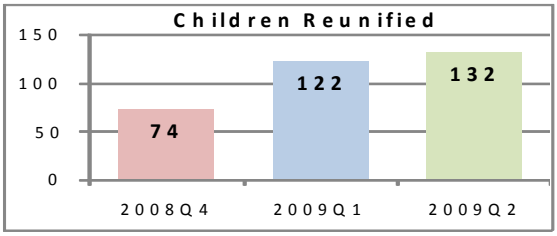
- A child's safety is paramount;
- Children belong in families;
- Families need strong communities; and
- Child Welfare needs to partner with communities and other systems for strong outcomes.

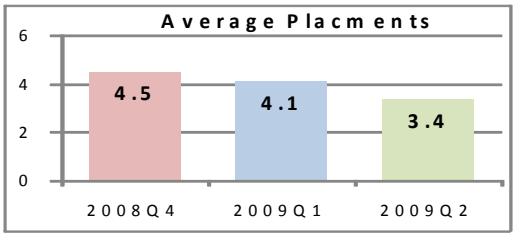
Team Decision Making links active engagement with families, communities, and tribes to Office of Children's Services efforts to improve safety, permanency, and well being of the children. Teams include parents, foster families, youth if appropriate, relatives, supports, service providers, caseworkers, and other involved Office of Children's Services staff. They are convened to decide if a child must be removed from the home in order to ensure safety, if the Office of Children's Services must file for custody and facilitate placement, if the child can remain or return to their home with a safety plan, or if voluntary placement is appropriate.

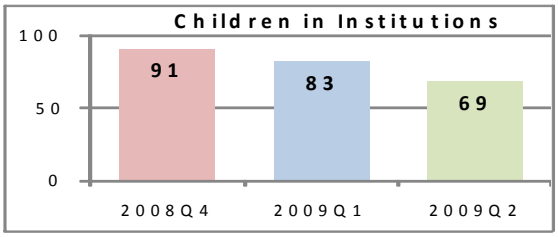
The Family-to-Family team approach provides a network of care that is neighborhood-based, culturally sensitive, and located where the children in need live. Results that benefit the state and its communities and citizens include: less reliance on institutional care such as hospitals, shelters, correctional facilities, and group homes; services to safely preserve the family while understanding the needs of the child; and adequate numbers of foster families for any child who must be removed from their home.

Data collected beginning in October, 2008 shows that progress is being made for children in custody since the implementation of Family-to-Family in Anchorage and Fairbanks. The data indicates increased reunification, decreased placements, and decreases in the number of children under facility care.









The Office of Children's Services has successfully implemented Family-to-Family services in Anchorage and Fairbanks without an increment to appropriated funds. This was possible through resource management and financial assistance from the Anne E. Casey Foundation, but Foundation funds will not be available in the future.

The next steps for the program began this year with the groundwork to bring the Family-to-Family core strategies to the Wasilla field office and surrounding communities. 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

Family preservation continuum grants are awarded through four service models designed to mitigate gaps in available services that help children remain in their homes. Services provided address the diverse and individualized needs of families and children that are involved with the State's child welfare system. This continuum includes:

- Family Support Services,
- Family Preservation Services,
- Time Limited Family Reunification Services, and the
- Rural Social Services Program.

Services provided by our grantees support continued safety for children in their own homes; provide in-home services for families with identified risk factors; and strengthen and support adoptive, foster, and extended families.

Family Preservation is funded through a blending of federal Title IV-B Child Welfare Services and Community-Based Child Abuse Prevention Program grants and state general funds.

Family Support Services
Family Support Service grants are awarded statewide and 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.

The Office of Children's Services will make referrals to Family Support Service providers for families needing support for basic needs and crisis stabilization. The Family Support Program includes the following services:

- Daily in-home support services;
- Facilitated access to resources;
- Service coordination of early childhood services, medical services, and educational/employment services;
- Parent education and support; and
- Transportation services.

Families referred to Family Support Service providers do not have an open child protective services case. Families are referred to these services by other services, such as schools or early education programs, medical services, other community agencies, or clients may self-refer in effort to alleviate the need for a child protective services intervention.

Family Preservation Services
These services are provided to families at risk of having their children removed from their homes due to concerns related to the functioning of the family and the care and safety of children. Services delivered help to prevent the need for out-of-home placements of children and include:

- Ongoing family assessments;
- Safety plan monitoring and service coordination;
- Developing family support teams;
- Parent education and support; and
- Transportation services.

Services are provided to families with children where a determination of high risk or safety threats is present.

Referrals will come exclusively from the Office of Children's Services, and families referred will have a case open for in-home services with a safety plan in place. The Office of Children's Services and its partner grantees and agencies work as a team to provide services to families and children referred to family preservation services. Each member of the family is considered when coordinating services, with special attention given to young children ages birth to three years.

Time Limited Family Reunification Services
These services are provided to families when a child enters the foster care system. They are designed to expedite a reunification of children with their parents as soon as it is safe to do so. Time Limited Family Reunification provides supervised family contact services and transportation services.

Time Limited Family Reunification Services are referred by the Office of Children's Services when it is determined, through an initial assessment, that a child is unsafe or at high risk of maltreatment by a parent or caregiver in the home and removal from the home is necessary.

Independent Living Services

These services support education, vocational training and life skills of youth in foster care as they enter early adulthood. These youth, 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 youth 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 225 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 12-18 participants;
- OCS Independent Living Specialists conduct or arrange classes for youth in custody to address independent living and educational issues. These classes differ by region, but usually have 4-10 youth participating; and
- For youth living in remote areas, DVDs are available regarding a range of Life Skills issues.

In cooperation with the Department of Labor, the Office of Children's Services was able to increase a 2009 transitional living grant to Covenant House Anchorage from $95.0 to $265.0 under the American Recovery and Reinvestment Act. Covenant House provides services to homeless and transitional youth who are both in and out of state custody. Referrals to services provided by Covenant House are made by caseworkers, foster parents, or the youth themselves.

The Independent Living Program hosts Preparation for Adult Living training annually. In 2009, there were 20 youth who attended the weekend-long training in Anchorage and, for the first time, 16 youth attended the training in Juneau. These youth are provided the opportunity to experience such things as life on a college campus, learn about financial aid, and visit Job Corp Centers.

Tribal Title IV-E

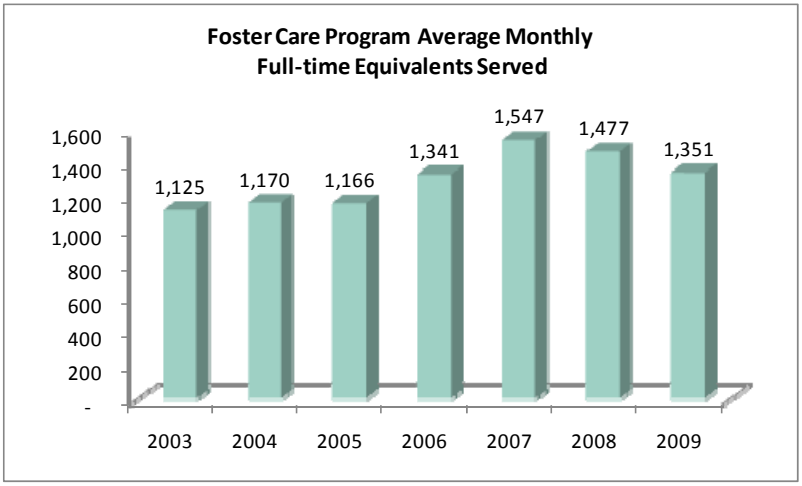
The Office of Children's Services administers the Tribal Title IV-E Reimbursement Program through agreements with Alaskan Tribes and Tribal Organizations. This program passes through as much as $1 million annually of Title IV-E federal funds to participating tribes. In conjunction with the Office of Children's Services, Tribal staff provides child welfare services to Alaskan Native children in out-of-home placements and children at risk of out-of-home placement. In order to claim these federal dollars, Tribal Organizations work closely with Children's Services to provide the federal government with the required, substantial documentation for IV-E determinations.

Foster Care Base Rate, Augmented Rate and Special Needs

Foster Care enables the state to find temporary homes for children who have been maltreated 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 for the days a child is placed in their home. Foster Care Base Rate experienced 15% increases in out-of-home placements in 2006 and 2007 based on full-time equivalents.

For the past two years, those numbers have dropped by 5% in FY08 and 8.5% in FY09. The Office of Children's Services believes the reason for the drop in foster care is related to the increased numbers of adoptions that have been finalized during this same time period.



Note: FY05 data falls within the conversion between the Office of Children's Services old data system, PROBER, and the new data system, ORCA. The resulting disruption in data availability may have caused FY05 numbers to be skewed.

Movement of children on and off the program is a common occurrence. Therefore, the Office of Children's Services calculations are based on full-time equivalents 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. Full-time equivalents are tied to dates of service and are adjusted throughout the fiscal year.

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 physical or cognitive 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 or visitation with biological parents; and other costs associated with the individual needs of each child.

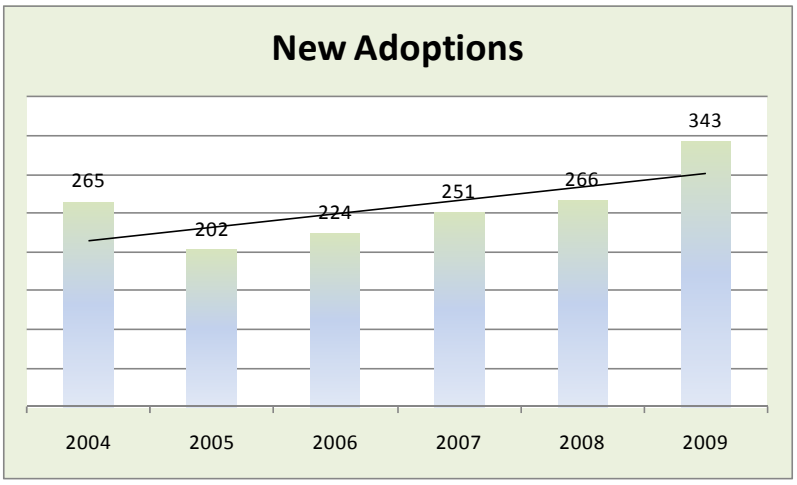
Subsidized Adoption and Guardianship

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.

Many times children, that have been removed from their homes as a result of maltreatment and cannot be returned to their homes safely, have long-lasting disturbances that make it difficult to find permanent adoptive or legal guardianships without a subsidy. Approximately 95% of all children adopted or in guardianships have special needs qualifying them for subsidized support from the state.

For the past two years, the Office of Children's Services has experienced significant increases in the numbers of finalized adoptions. It is expected that those numbers will continue to increase through FY10 with 75 new adoptions completed in the first quarter.



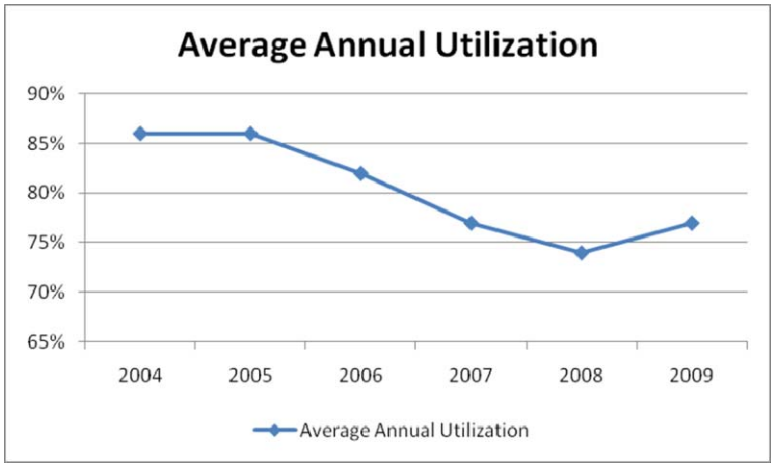
The increase in the numbers of adoptions correlates to the increased numbers in foster care for FY06 and FY07 and decrease in FY08 and FY09 as shown here. Those same children are now being permanently placed.

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 for Children and Youth facilities, such as the Kotzebue and Anchorage facilities shown below, 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 Office of Children's Services 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 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.



In FY10, the Office of Children's Services issued 27 competitive grants for rural and urban residential care resulting in 179 beds available statewide.

While it appears that utilization has declined somewhat in recent years, it is important to ensure that this is due to decreased need (i.e., due to OCS's successful efforts to generate foster homes) rather than anomalous factors that may not remain constant over subsequent years, particularly in light of the Bring the Kids Home project whose prime objectives are to keep children in state and bring them home from out of state facilities.

Additional information for Residential Child Care for Children and Youth system is available at:

http://www.hss.state.ak.us/ocs/ResidentialCare/

Annual Statistical Summary of Services Provided in FY09

Infant Learning Program

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

In FY09, 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:

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

Protective Services Reports

Front Line Workers deliver services to carry out Alaska's legal mandates to address 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.

Protective Services Reports Screened In By State Fiscal Year					
	FY05	FY06	FY07	FY08	FY09
Screened in for OCS Assessment	*5,936*	*6,219*	*6,313*	*6,101*	*6,294*

Protective Services Reports Screened Out By State Fiscal Year					
Screen Out Reason	**FY05**	**FY06**	**FY07**	**FY08**	**FY09**
Differential Response	414	534	324	297	183
Insufficient Information	170	214	582	889	1,078
Law Enforcement Juris. Only	794	740	872	902	1,165
Mult. Ref. on Same Incident	121	238	488	571	798
No Alleged Maltreatment	1,478	1,787	2,289	2,386	3,548
Referred to Another State	17	40	45	35	51
Referred to Military or Tribe	201	254	346	273	324
Total	*3,195*	*3,807*	*4,946*	*5,353*	*7,147*

Total Protective Services Reports Screened By State Fiscal Year					
	FY05	FY06	FY07	FY08	FY08
Total PS Reports Received	*9,131*	*10,026*	*11,259*	*11,454*	*13,441*

Unique Count of Alleged Victims by State Fiscal Year					
	FY05	FY06	FY07	FY08	FY09
Alleged Victims in Screened In Reports	7,964	8,660	8,475	8,631	9,231
Alleged Victims in Screened Out Reports	4,137	4,945	6,101	6,283	7,843
*Total**	*11,114*	*12,436*	*12,867*	*13,094*	*14,692*

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

Unique Count of Children in Out-of-Home (OOH) care for entire FY				
	FY06	FY07	FY08	FY09
Native	1,640	1,768	1,869	1,886
White	758	847	854	819
Other	276	330	300	256
Undetermined	45	44	50	66
No. of Children	*2,719*	*2,989*	*3,073*	*3,027*

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 race identified

Absence of Recurrence of Maltreatment				
	FY06	FY07	FY08	FY09
Anchorage Region	94.9%	95.0%	92.4%	92.5%
Northern Region	90.5%	88.8%	92.6%	93.1%
Southcentral Region	89.1%	89.2%	92.8%	92.4%
Southeast Region	94.8%	87.7%	83.1%	90.2%
Total Alaska	91.6%	91.1%	91.7%	92.4%

Data Source: ORCA, July 27, 2009

Definition of Protective Service Report Screening Outcomes

Screened In—OCS Assessment includes reports that meet the criteria for initial 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.

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

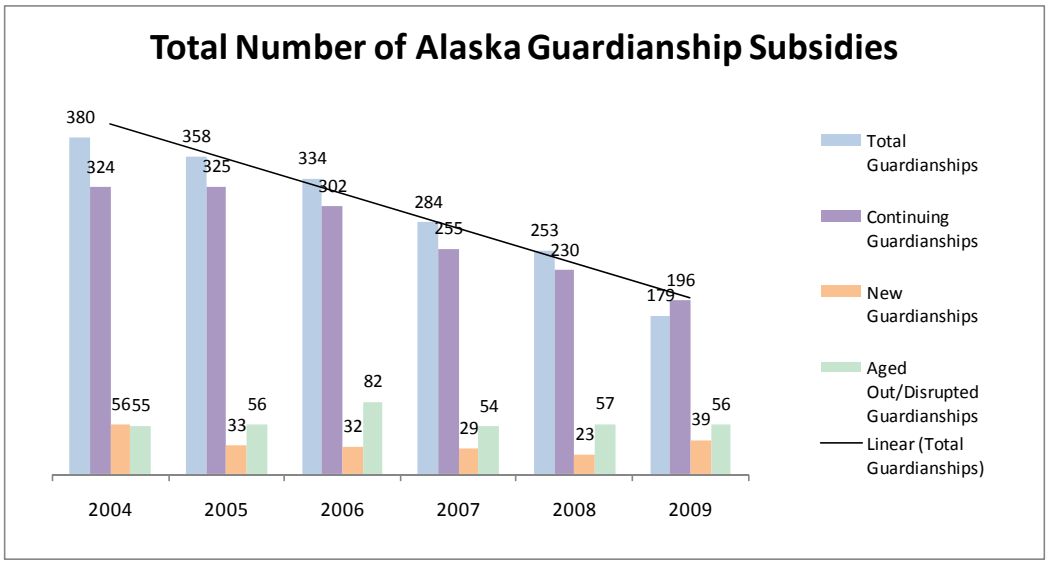
to decrease this disparity through strategic planning with the Tribal State Collaboration Group and local plans between tribal and state partners.

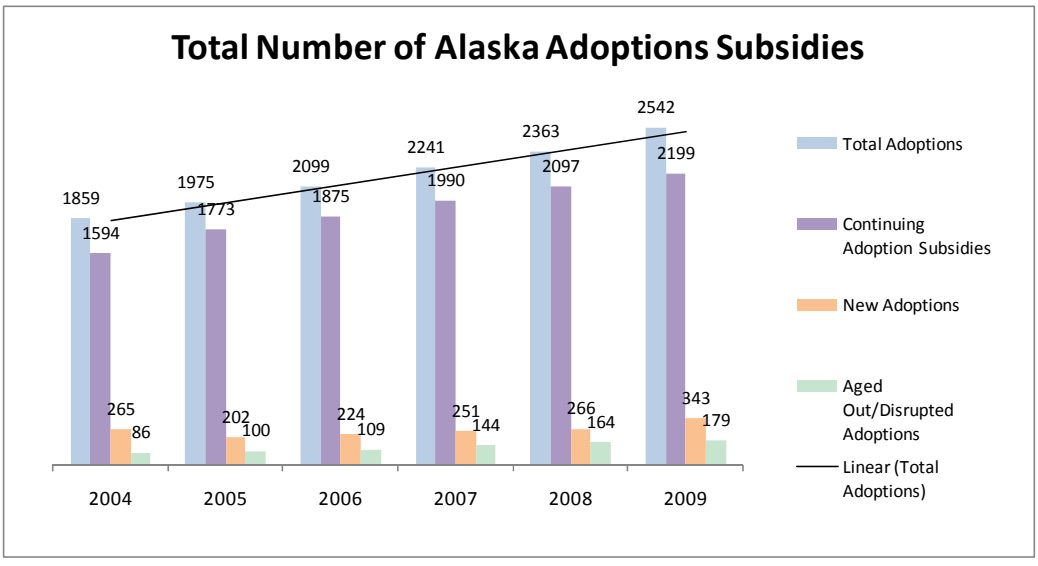
Adoptions and Guardianships

At the end of FY09, 2,542 children were living in permanent homes assisted through the Subsidized Adoption and Guardianship program. At the end of FY07, that number was 2,241. 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 FY04. 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 FY04 through FY09 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	2009
IV-E Continuing Adoptions	1319	1457	1541	1658	1721	1764
IV-E New Adoptions	209	149	190	188	183	262
IV-E Aged Out	49	51	67	102	130	127
IV-E Disrupted	22	29	22	25	10	24
Current=Continuing + New - Aged Out - Disruptions	1457	1526	1642	1719	1764	1875
Adoptions Funded by the State of Alaska						
State Continuing Adoptions	275	316	334	332	376	435
State New Adoptions	56	53	34	63	83	81
State Aged Out	11	15	17	11	21	25
State Disrupted	4	5	3	6	3	3
Current=Continuing + New - Aged Out - Disruptions	316	349	348	378	435	488
Guardianship funded by the State of Alaska						
Guardianships Continuing	324	325	302	255	230	196
Guardianships New	56	33	32	29	23	39
Guardianships Aged Out	40	36	53	42	48	46
Guardianship Disrupted	15	20	26	12	9	13
Current=Continuing + New - Aged Out - Disruptions	325	302	255	230	196	179
TOTALS						
(TTL) YTD New Adoption/Guardianship	321	235	256	280	289	382
plus TTL continuing Adoption/Guardianship	1918	2098	2177	2245	2327	2395
less TTL YTD Aged Out	100	102	137	155	199	195
less TTL Disruptions	41	54	51	43	22	40
Total Children in Active Subsidies at the end of the FY	2098	2177	2245	2327	2395	2542

List of Primary Programs and Statutory Responsibilities

AS 18.05.010-070	Administration of Public Health and Related Laws
AS 25.23	Adoption
AS 25.23.190-240	Subsidy for hard-to-place child
AS 37.14	Alaska Children's Trust
AS 44.29.020 (a)	Duties of Department - Organization
AS 47.05	Administration of Welfare, Social Services, and Institutions,
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 47.32	Centralized Licensing Related to Administrative Procedures

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
7 AAC 110	Medicaid Coverage; Professional Services

42 USC 1305 et seq.	Adoptions and Safe Families Act of 1997
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	FY10	FY11	10 to 11 Change
General funds	80,116.3	83,463.1	3.346.8
Federal Funds	57,709.0	54,670.7	(3,038.3)
Other Funds	9,122.5	6,925.5	(2,197.0)
Total	**146,947.8**	**145,059.3**	**(1,888.5)**

Front Line Social Workers

Replace Disproportionate Level of federal Authorization: *($900) Fed, $900.0 GF*
The Office of Children's Services budget requests with significant impact are specific to realigning budgeted fund sources to reflect the ability of the division to collect federal reimbursements. A fund source change request for $900.0 has been requested to replace disproportionate levels of federal authorization allocated in the FY06 budget. This funding will stabilize the Frontline Social Worker component and allow the division to pay salaries and costs that more closely represents our ability to earn federal revenues.

Other Office of Children's Services FY11 requests are minor program increases through the Mental Health Trust and minor budget cleanup decrements of unrealizable revenue authorization.

Challenges

Federal Child and Family Services Review

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

Specifically, Child and Family Services Reviews 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.

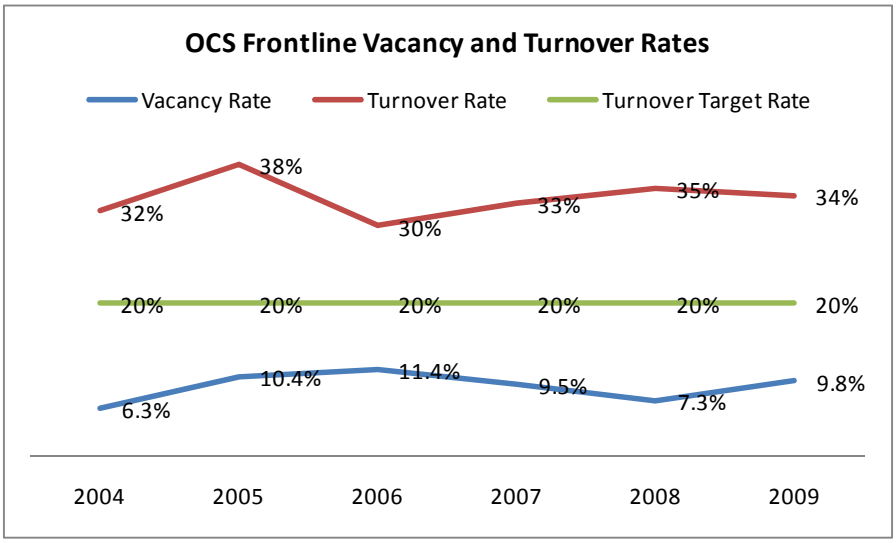
The first round of reviews took place between 2000 and 2004 and all states were required to implement Program Improvement Plans. The second round of reviews began in early spring of 2007. As with the first round of reviews, all states reviewed thus far have been required to implement Program Improvement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

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. The results of Alaska’s review, as anticipated, required a Program Improvement Plan. The plan has been developed and implementation has begun. Ahead, several agencies within the Department of Health and Social Services will face fiscal challenges when addressing some of the requirements included in the federal report. 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.

Approximately 50 percent of the Office of Children's Services front-line caseworkers have been employed with the agency for less than two years, and 20 percent having less than one year of experience.



To institutionalize a mindful and daily focus on combating workforce development, the Office of Children's Services 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 the Department Workforce Development Team.

The agency's internal work group has been instrumental in the development of a video located on the Office of Children's Services website that provides potential applicants the opportunity to hear responses to frequently asked questions from current employees that focus on both the positive and the negative aspects of employment as a frontline worker with the Office of Children's Services. This video can be viewed at:

http://www.hss.state.ak.us/ocs/recruitment/default.htm/.

Efforts to find ways to hire good qualified workers and to, more importantly, retain them will continue even though progress is extremely slow.

Implementation of Public Law 110-351

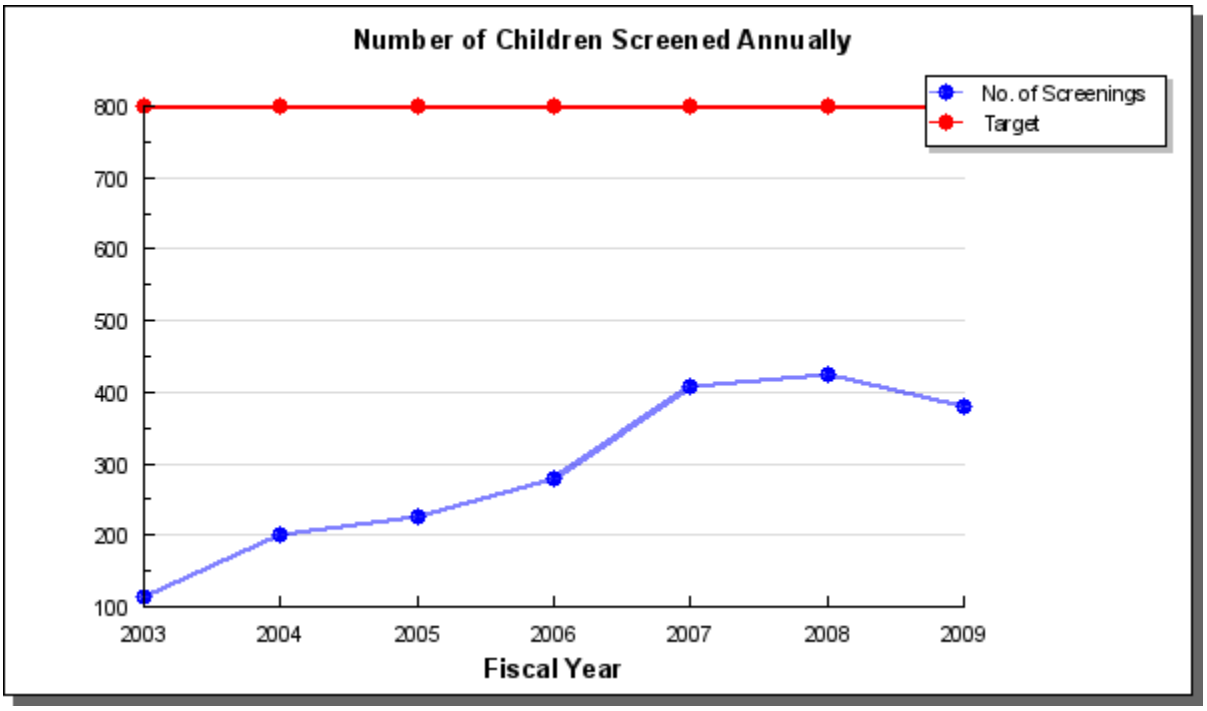
The President signed the Fostering Connections to Success and Increasing Adoptions Act into law October 7, 2008. Generally, the law amends the Social Security Act to extend and expand adoption incentives through 2013; creates an option to provide kinship guardianship assistance payments; creates an option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

Implementation of this Act is expected to be ongoing for at least the next year with consideration given to the time involved to complete new regulation, policy, and state plan specifics. Budgetary impacts are being explored, but thus far, no significant impact is expected within the upcoming budget year.

A: Result - Child abuse and neglect is prevented.

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 FY03, 113 children were screened. In FY08, 425 children were screened. That number decreased by 11% in FY09.



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

Number of Children Screened Annually

Fiscal Year	No. of Screenings	Target
FY09	380	800
FY08	425	800
FY07	408	800
FY06	278	800
FY05	225	800
FY04	200	800
FY03	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, 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.

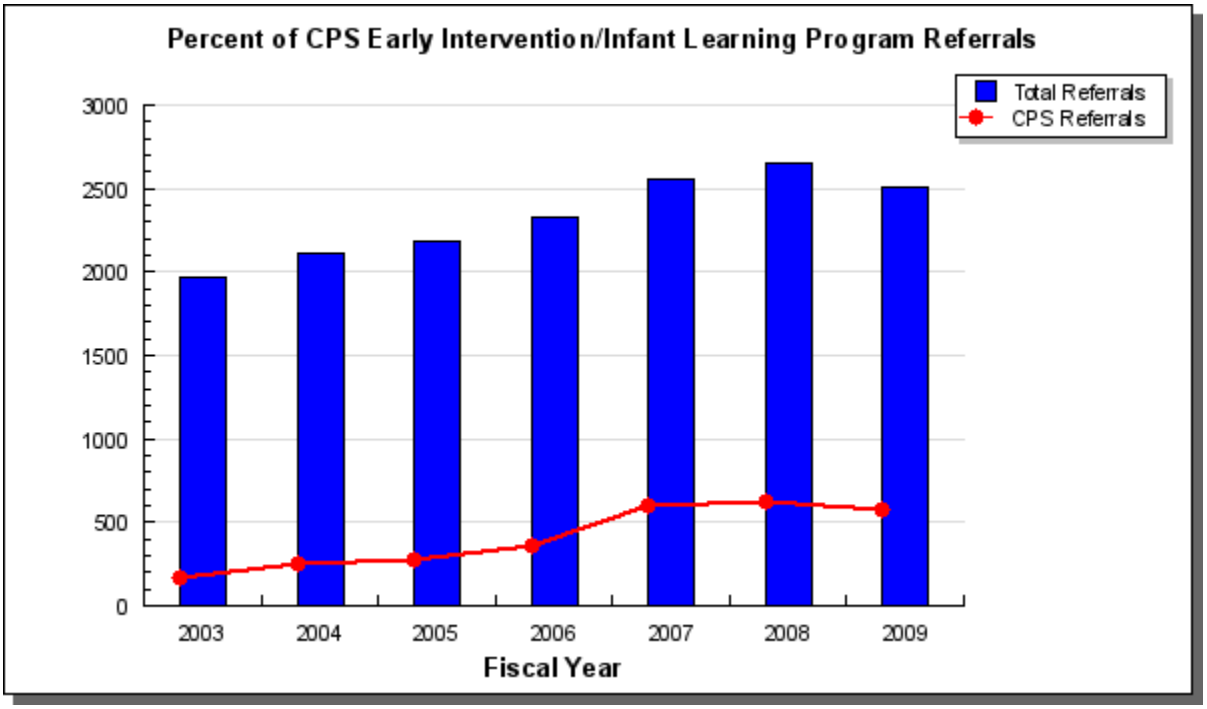
In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Current programs do not have the capacity to provide adequate training and support 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.

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.

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. Numbers fell by only 1% in FY09.



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

Percent of CPS Early Intervention/Infant Learning Program Referrals

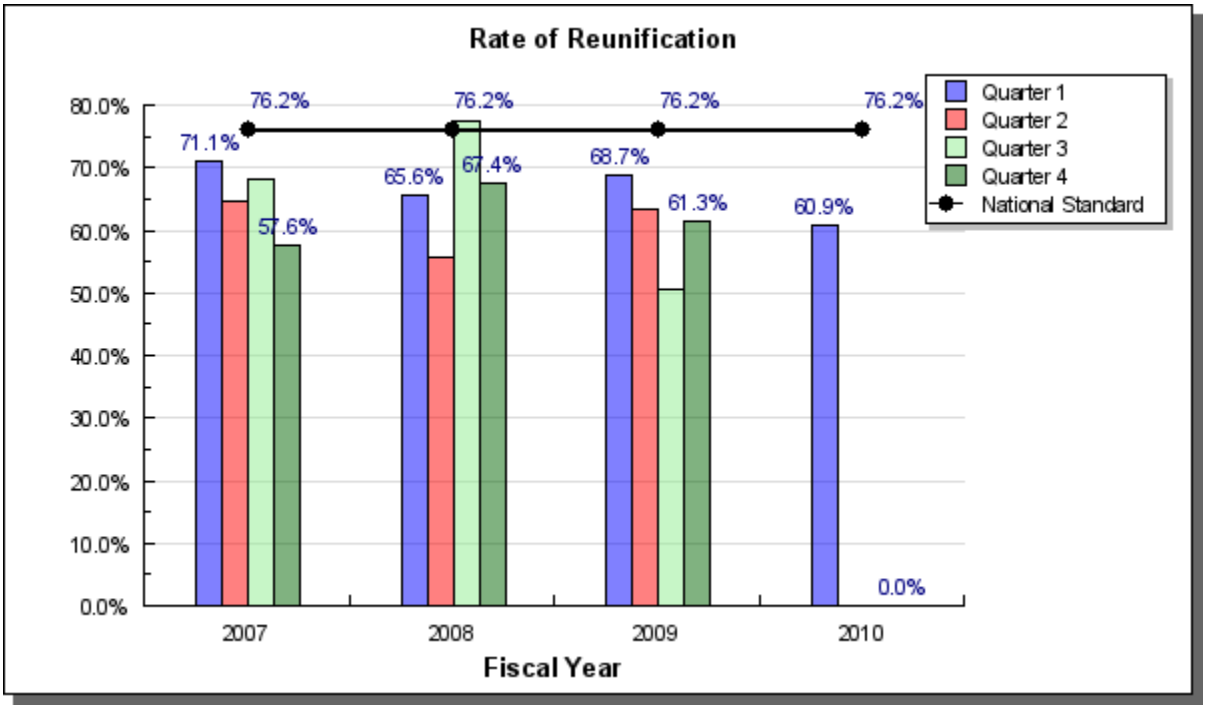
Fiscal Year	Total Referrals	CPS Referrals	Percent	Target
FY09	2503	574	21%	5% increase
FY08	2657	630	22%	
FY07	2557	602	21%	
FY06	2331	363	15%	
FY05	2182	280	13%	
FY04	2107	248	12%	
FY03	1964	169	9%	

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) has seen a significant increase in overall referrals in the past 3 years. The slight decrease in FY09 is related to higher need with no increase in resources. Additional resources are available in FY10 and a stabilization of referrals is anticipated.

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 dropped by 5.5% in FY09. The first quarter of FY10 remains at 61%.



Methodology: This measure is based on children returned to parents or caretakers in less than 12 months from the time of last removal.

The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures back to Quarter 1 of 2007, and will in many cases include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

Data Source: 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).

Rate of Reunification

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National Standard
FY10	60.9%	0	0	0	76.2%
FY09	68.7%	63.4%	50.6%	61.3%	76.2%
FY08	65.6%	55.6%	77.4%	67.4%	76.2%
FY07	71.1%	64.8%	68.1%	57.6%	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.

The Alaska rate of reunification dropped by 5.5% between FY08 and FY09. 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.

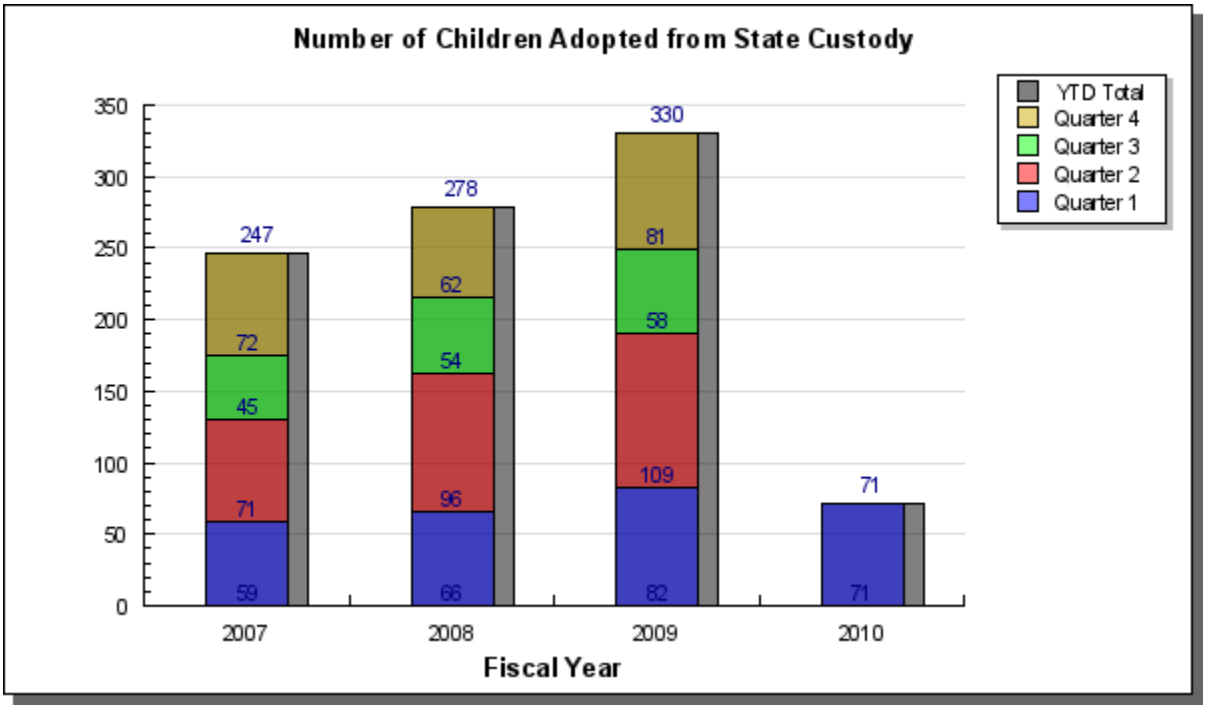
By successfully completing the implementation of the new practice model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new model encourages 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 to 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 31 from 2007 to 2008 and climbed again in FY09 by an additional 52 completed adoptions.



Methodology: The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures and in many cases includes adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

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

Number of Children Adopted from State Custody

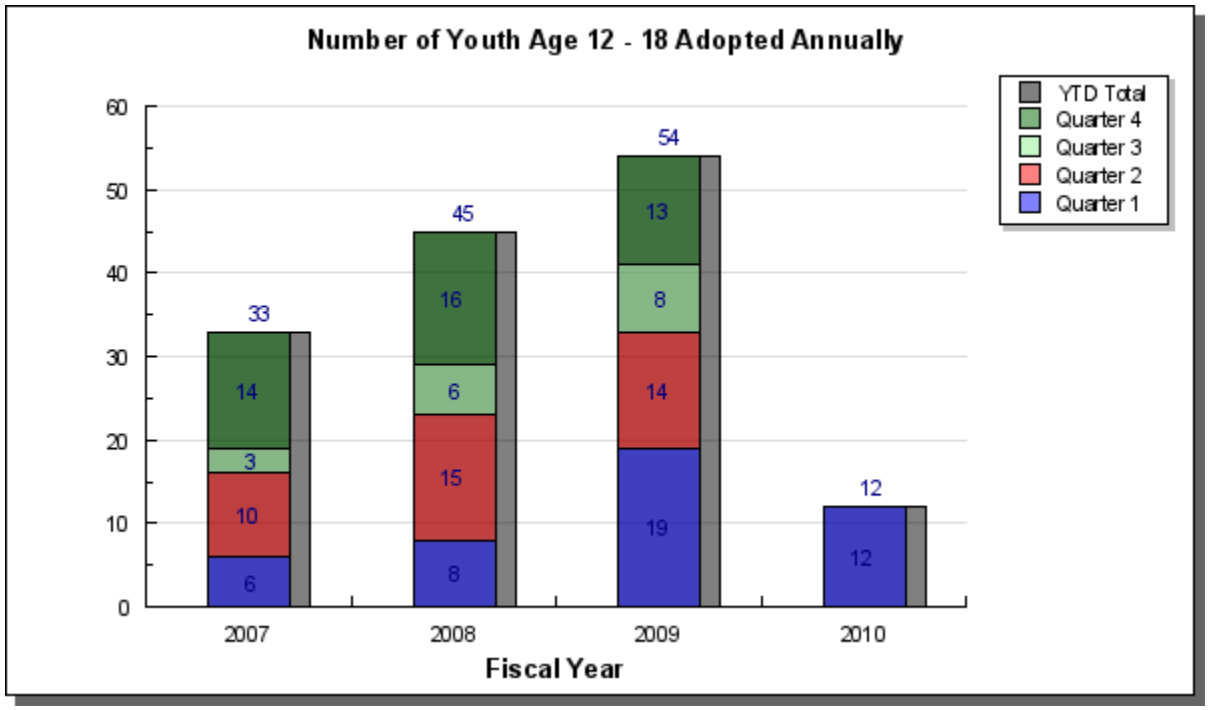
Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY10	71	0	0	0	71
FY09	82	109	58	81	330
FY08	66	96	54	62	278
FY07	59	71	45	72	247

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 in the subsidized adoption program. The number of children who are able to achieve permanency through adoption in the OCS system increased by 19%, from FY08 to FY09. 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 36% from FY07 to FY08 and another 29% in FY09.



Methodology: The Office of Children's Services is bringing state performance measures in line with federal measures and methodologies. Therefore, this chart contains newly calculated measures. In many cases, newly entered date will include adjustments to numbers previously submitted. These adjustments do not represent major changes in outcomes.

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
FY10	12	0	0	0	12
FY09	19	14	8	13	54
FY08	8	15	6	16	45
FY07	6	10	3	14	33

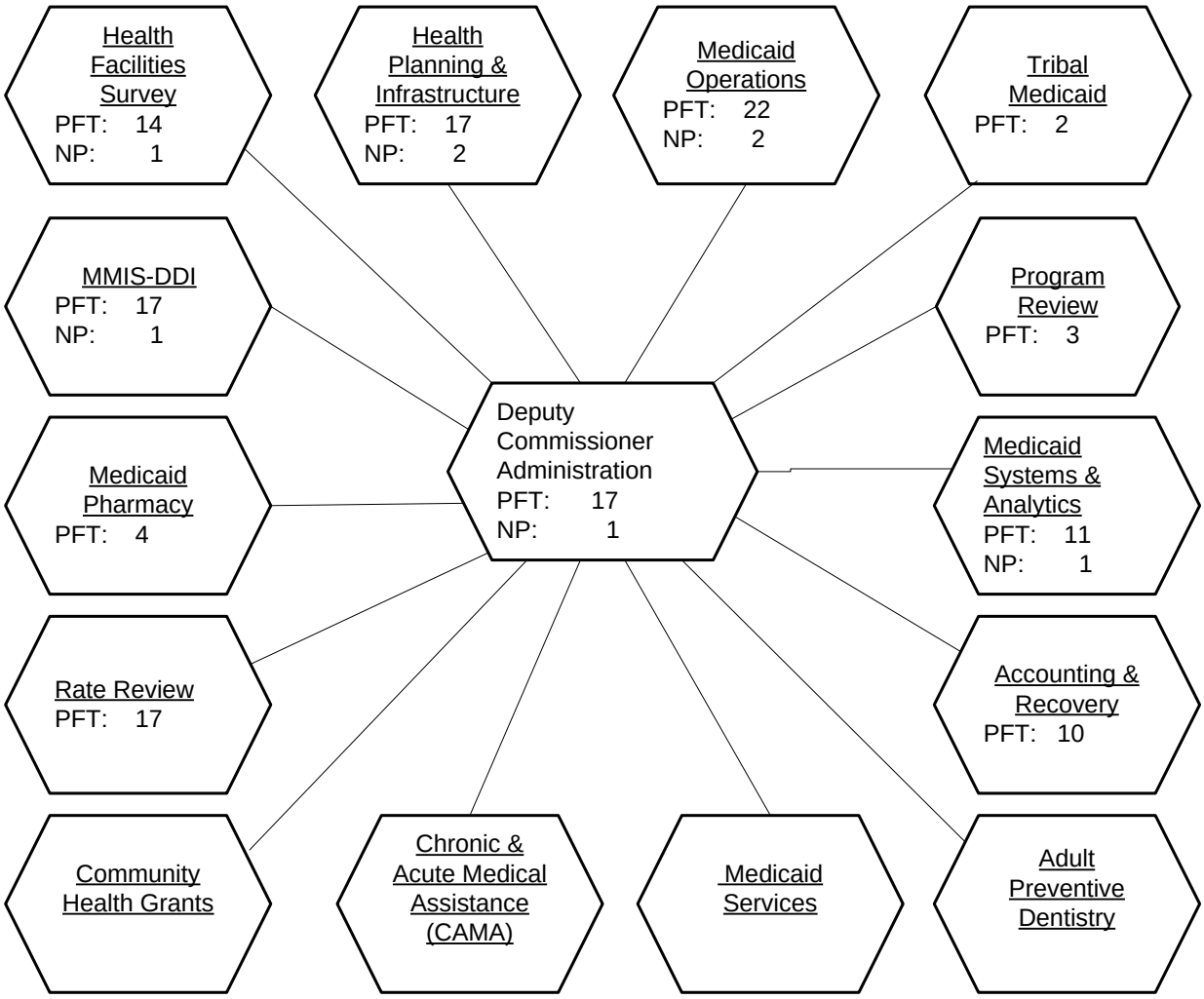
Analysis of results and challenges: In 2006, the national focus for adoption was on the adoption of older youth from the child protection system. In Alaska, the focus on the increase of older youth adoptions (children age 12 - 18 years) has been a specific effort. National research studies have indicated 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.

FY11 Governor's Request Increment and Decrement Fund Breakout

Office of Children's Services FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Delete Excess Federal Authority Based on FY2011 Short Term Alaska Medicaid Projections (STAMP)	$ -	$ (748.4)	$ -	$ (748.4)
Delete Unrealizable Federal Receipts Authority	$ -	$ (750.0)	$ -	$ (750.0)
Delete Unrealizable Interagency Receipt Authority	$ -	$ -	$ (283.5)	$ (283.5)
Replace Unrealizable Interagency Receipts for Medicaid School Based Claims	$ 165.0	$ -	$ (165.0)	$ -
Reverse Television and Radio Public Service Announcements Highlighting the Need for Alaska Foster Homes	$ (30.0)	$ -	$ -	$ (30.0)
Delete Unrealizable Interagency and Statutory Designated Program Receipts	$ -	$ -	$ (953.2)	$ (953.2)
Replace Disproportionate Levels of Federal Authorization	$ 900.0	$ (900.0)	$ -	$ -
Replace Unrealizable Medicaid School Based Claims	$ 955.3	$ -	$ (955.3)	$ -
Judgments and settlements against the state for fiscal year ending June 30, 2011 (Curyung lawsuit)	$ 1,200.0	$ -	$ -	$ 1,200.0
MH Trust: BTKH - 1926.02 Foster Parent & Parent Recruitment training & support	$ -	$ -	$ 275.0	$ 275.0
MH Trust: BTKH - 1926.02 Foster Parent & Parent Recruitment training & support	$ 150.0	$ -	$ -	$ 150.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (75.0)	$ (75.0)
ARRA Individuals with Disabilities Act HB199 CarryFwd	$ -	$ 1,498.3	$ -	$ 1,498.3
MH Trust: BTKH - Grant 1393.03 Early childhood comprehensive system grants	$ -	$ -	$ 75.0	$ 75.0
MH Trust: BTKH - Grant 2550.01 Clinician to work w/ Head Start & Day Care Centers	$ -	$ -	$ 100.0	$ 100.0
MH Trust: Gov Cncl - 1207.03 Behavior Intervention and Supports for Early Childhood System	$ -	$ -	$ 80.0	$ 80.0
Reverse ADN 0609606 ARRA Sec 1, CH 17, SLA 2009, P 3, L 7 (HB 199) Lapse Date 06/30/10	$ -	$ (2,139.8)	$ -	$ (2,139.8)
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (255.0)	$ (255.0)
Delete Unrealizable Interagency Receipt Authority	$ -	$ -	$ (40.0)	$ (40.0)
Office of Children's Services Total	***$ 3,340.3***	***$ (3,039.9)***	***$ (2,197.0)***	***$ (1,896.6)***

Health Care Services

OPERATIONAL STRUCTURE
PFT: 134
PPT: 0
NP: 8



Introduction to the Division

Mission

To manage health care coverage for Alaskans in need.

Introduction

Health Care Services (HCS) oversees and manages all 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.

Core Services

Provide access and oversight 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:

Adult Preventative Dental Medicaid Services
The Adult Preventative Medicaid Dental program was instituted in 2007 to provide restorative and preventative dental services that were previously not available to adults. There is a provision that limits total program costs to fiscal limits set by the legislature, ensuring that total program spending remains within the budgeted amount. A separate Medicaid Services component program continues to pay for children's dental services and for adult emergency dental services.

The program provides restorative and preventative dental services under an annual $1,150 limit per person. Funds support services for improvement of oral health and reduction in emergency dental services. Covered services include most routine restorative dental services, including exams, cleanings, tooth restoration or extraction, and upper or lower full dentures. The program supports the department's mission to manage health care for eligible Alaskans in need. Providing adult preventative dental services through Medicaid improves and enhances the quality of life for Alaskans with dental problems.

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 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 goal of healthy people in healthy communities. These programs support the department's mission to manage health care for eligible Alaskans in need.

Pharmacy and Ancillary Services Unit
This unit provides program management including policy and regulation development utilizing research, analysis, planning, and implementation for the following Medicaid Provider service programs to ensure services are high quality and cost effective treatment: 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. This year the unit offered pharmaceutical advice to facilitate optimal care in other divisions, including the Medicaid Fraud Control Unit, Behavioral Health and the other providers such as the Mary Conrad Center. The pharmacy program provides excellent pharmaceutical care through the following initiatives.

Preferred Drug List (PDL):
A PDL is a list of medications within several therapeutic classes that represents Medicaid's first and last choice when prescribing for Medicaid recipients. This list aligns the patient need, the physicians' knowledge, and the state's purchasing power. The PDL supports cost efficiency when preferred drugs are prescribed and dispensed. Alaska Medicaid PDL participates in the National Medicaid Pooling Initiative to obtain the best rebates.

Pharmacy and Therapeutics Committee (P&T):
- The P&T Committee is 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 health care professionals who prescribe or dispense prescription drugs;
- The committee has statewide representation and includes various physician specialties, pharmacists, dentists, and nurse practitioners.

Drug Utilization Review (DUR):
- Reviews and prevents inappropriate use, adverse reactions and ensures drugs are used safely and appropriately in our Medicaid recipient population;
- 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 many 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 and Disabilities 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, the Estate Recovery Program, and works in

tandem 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 provides program assistance and oversight of Medicaid services at or through tribal facilities statewide. This unit has both policy and operational component responsibilities to act as a support and resource to divisions in maintaining existing tribal functions (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; tracking federal and state legislation and regulations as they pertain to tribal functions; providing technical assistance to improve revenue generation and billing efficiencies at tribal facilities as well as overseeing Continuing Care Agreements and billing manual modifications.

Systems Unit
This unit bears technical responsibility for the Medicaid Management Information System (MMIS) and related systems. Their purpose is to ensure the integrity of the claims payment system, and 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 rate review, accounting and auditing 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’s (HPI) goal is to assure access to health care, especially for underserved and vulnerable populations. The section works with local, regional, statewide and federal health resources and policies to strengthen health services, facilities, and workforce. The section provides data analysis, needs assessments, planning, and technical assistance for hospitals, clinics, and a variety of community organizations. HPI works with the Medicaid program, US DHHS grant programs, and other health care financing structures, including Medicare, to assure availability and sustainability of health care services. HPI manages the Certificate of Need Program (CON), which 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.

Children's Health Insurance Program (CHIP)
Denali KidCare includes Alaska's Children's Health Insurance Program (CHIP) reauthorized for 4.5 years under the Children's Health Insurance Program Reauthorization Act (CHIPRA) in February 2009. The program provides excellent health insurance coverage for children and teens through age 18 who meet income guidelines. Pregnant women may also apply for Medicaid on a streamlined Denali KidCare application. Because Denali KidCare is an expansion of the Federal Poverty Guidelines (FPGs) in Alaska's Medicaid program, rather than a separate CHIP utilizing a benchmark equivalent coverage package, the coverage is the same for children receiving services under both Medicaid and Denali KidCare. Children in both programs receive a Denali KidCare insurance card and the program offers comprehensive prevention and treatment services such as:

- doctor's visits;
- health check-ups and screenings;
- vision exams and eyeglasses;
- dental checkups, cleanings and fillings;
- hearing tests and hearing aids;
- speech therapy;
- physical therapy;
- mental health therapy; and
- substance abuse treatment.

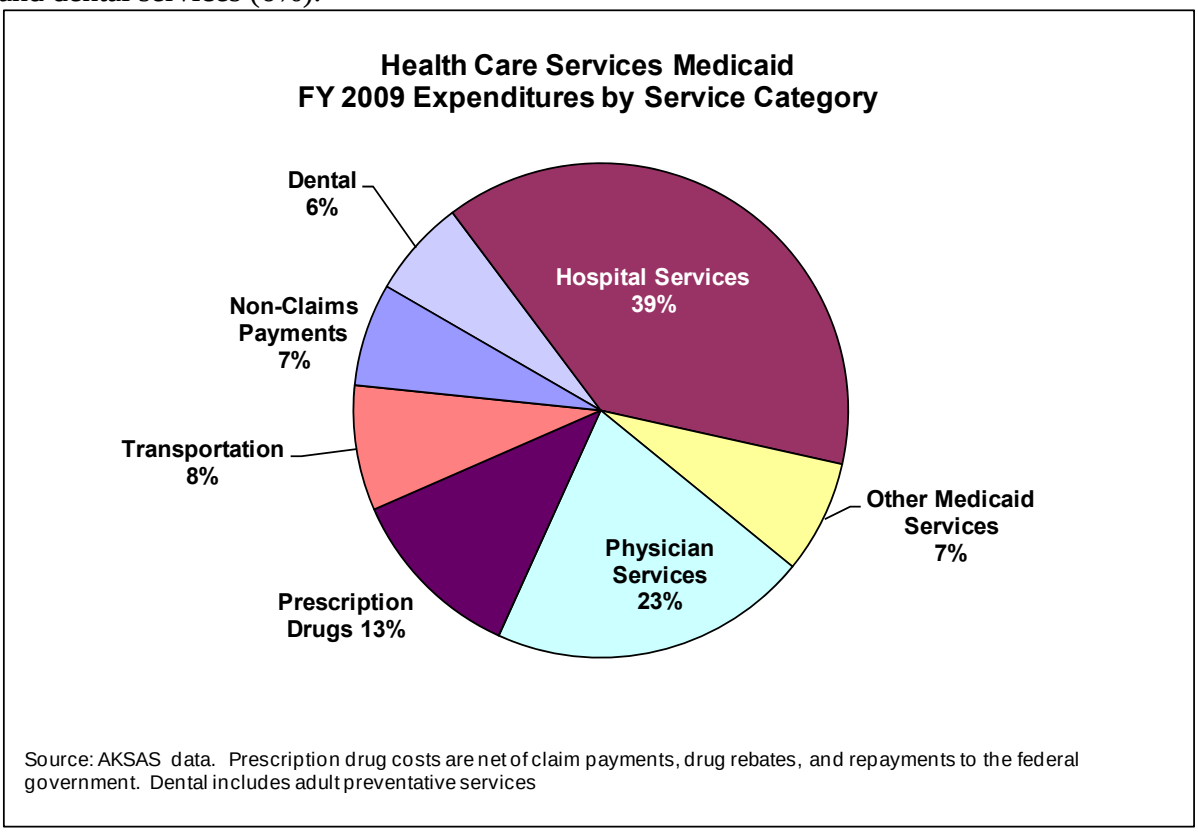
Enhanced Federal Financial Participation (FFP) is received for the children in the expanded Medicaid categories. As an incentive to enroll eligible low-income children into Medicaid, CHIPRA also provides additional financial incentives through contingency funding and performance bonus payments that may equal the enhanced FFP if certain enrollment and eligibility simplification criteria are met.

Health Facilities Survey
Under the State's agreement number 1864 with the Secretary of the Department of Health and Human Services the State Survey Agency's function is to conduct initial surveys (inspections), periodic resurveys, and complaint surveys for 17 different categories of health providers in the State of Alaska. Surveys are conducted to ascertain a health provider's compliance with Medicare and/or Medicaid regulatory requirements and to evaluate the health provider's performance and effectiveness in delivering safe and acceptable quality of care. In addition, the Health Facilities Survey Unit conducts validation surveys of accredited and deemed facilities in order to furnish US DHHS a monitoring of the validity of surveys conducted by accrediting bodies. As mandated by the Social Security Act, the survey agency: conducts periodic educational programs for health facilities; maintains a toll-free telephone hotline to receive complaints; ensures review of Nurse Aide Training and Competency Evaluation Programs; ensures a Nurse Aide Registry is maintained; specifies a specific assessment tool for use in skilled nursing facilities; and maintains pertinent survey, certification and statistical records. The Health Facilities Survey Unit is authorized to renew, and if warranted, deny, suspend, or revoke licenses when there is substantial failure to comply with regulatory 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 FY09, about 93% 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 FY09, 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 (39%) followed by physician services (23%), prescription drugs (13%), transportation services (8%), and dental services (6%).



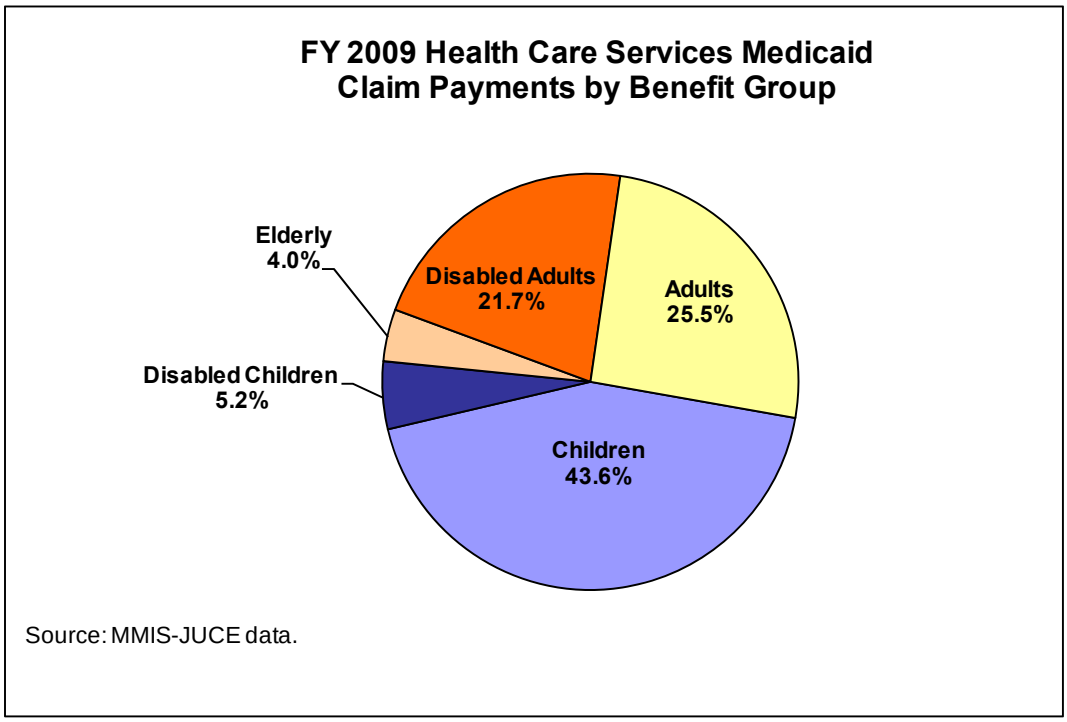
Source: AKSAS data. Prescription drug costs are net of claim payments, drug rebates, and repayments to the federal government. Dental includes adult preventative services

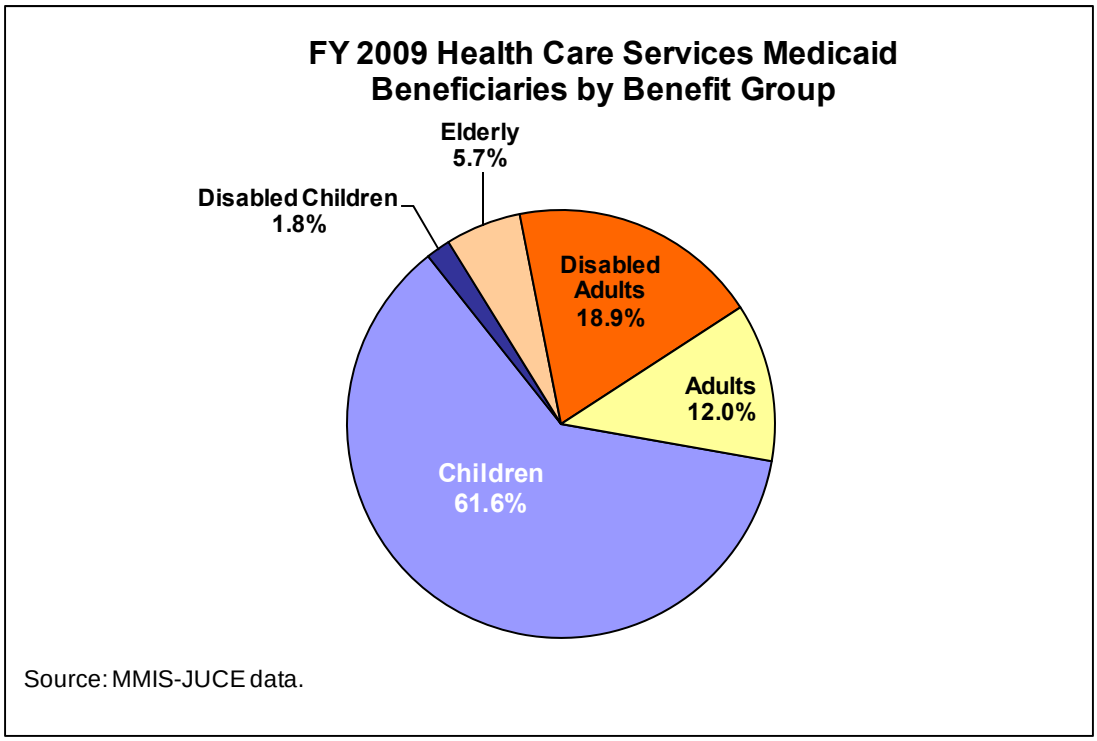
Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost per Beneficiary
All Health Care Services Medicaid					
Under 21	64.0%	79,430	49.8%	$285,740.3	3,597
21 or Older	36.0%	44,588	50.2%	$287,719.5	6,453
Hospital Services					
Under 21	57.0%	41,744	52.6%	$126,164.7	3,022
21 or Older	43.0%	31,434	47.4%	$113,695.1	3,617
Physician Services					
Under 21	63.1%	62,658	48.9%	$63,645.5	1,016
21 or Older	36.9%	36,698	51.1%	$66,591.3	1,815
Prescription Drugs					
Under 21	61.6%	40,128	32.7%	$25,113.8	626
21 or Older	38.4%	25,000	67.3%	$51,573.4	2,063
Transportation					
Under 21	53.4%	13,243	55.7%	$28,129.9	2,124
21 or Older	46.6%	11,576	44.3%	$22,397.6	1,935
Other Medicaid Services					
Under 21	49.6%	24,796	48.6%	$20,797.1	839
21 or Older	50.4%	25,214	51.4%	$21,989.3	872

Source: MMIS/JUCE.

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	CPRPY
Children	61.6%	77,256	43.6%	$249,791.1	$3,233
Disabled Children	1.8%	2,321	5.2%	$30,103.6	$12,970
Elderly	5.7%	7,180	4.0%	$23,206.4	$3,232
Disabled Adults	18.9%	23,741	21.7%	$124,218.1	$5,232
Adults	12.0%	15,006	25.5%	$146,140.7	$9,739
Unduplicated Annual Clients		**122,926**			
Total Medicaid Claim Payments (thousands)				**$573,459.8**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$4,665**

Source: MMIS/JUCE claims paid during FY09. CPRPY is annual cost per beneficiary. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.





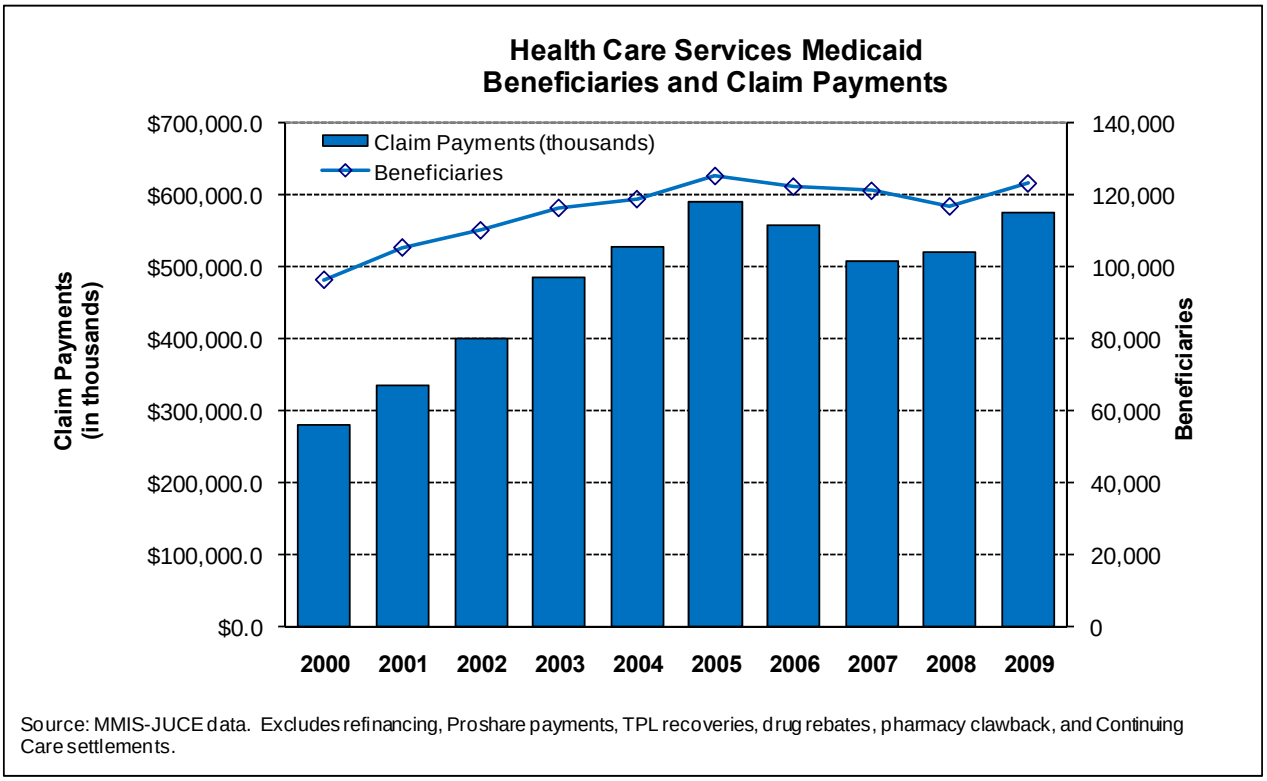
In FY09, the Health Care Services, Medicaid Services component provided direct services to approximately 122,900 Alaskans, about 96% of all persons enrolled in the Alaska Medicaid program. The cost of direct benefits provided to Medicaid enrollees through Health Care Services totaled $573.5 million. Forty-four percent of the claim payments in FY09 were for services provided to children; 21% 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	$3,302	59.1%
Physician Services	$1,318	80.4%
Prescription Drugs	$1,183	52.7%
Transportation Services	$2,043	20.1%
Dental Services	$619	35.3%
All Health Care Medicaid Services, cost per beneficiary		**$4,665**
All Health Care Medicaid Services, unduplicated annual beneficiaries		**122,926**

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 almost 11% from FY08, with claim costs increasing in all major categories of service. This growth was due to a combination of increased enrollment and increased cost of services. The number of beneficiaries utilizing Health Care Services Medicaid services in FY09 increased by 5.5% from FY08 while the annual cost per beneficiary increased 5% to almost $4,700. Cost of services increased due to rate changes associated with the fee for service schedule set by the federal Centers for Medicare and Medicaid Services (CMS). Rate increases affected mostly dental and physician services.

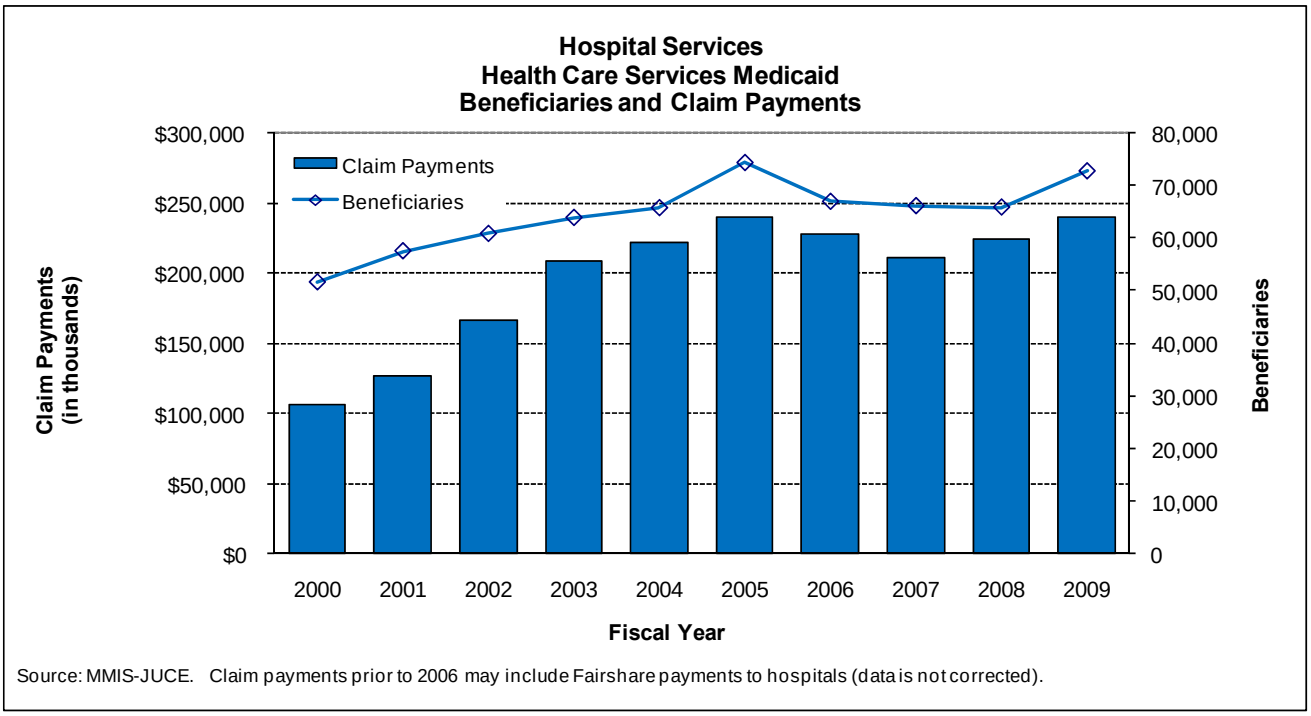


Source: MMIS-JUCE data. Excludes refinancing, Proshare payments, TPL recoveries, drug rebates, pharmacy clawback, and Continuing Care settlements.

Percent Change Between FY2009 and FY2008

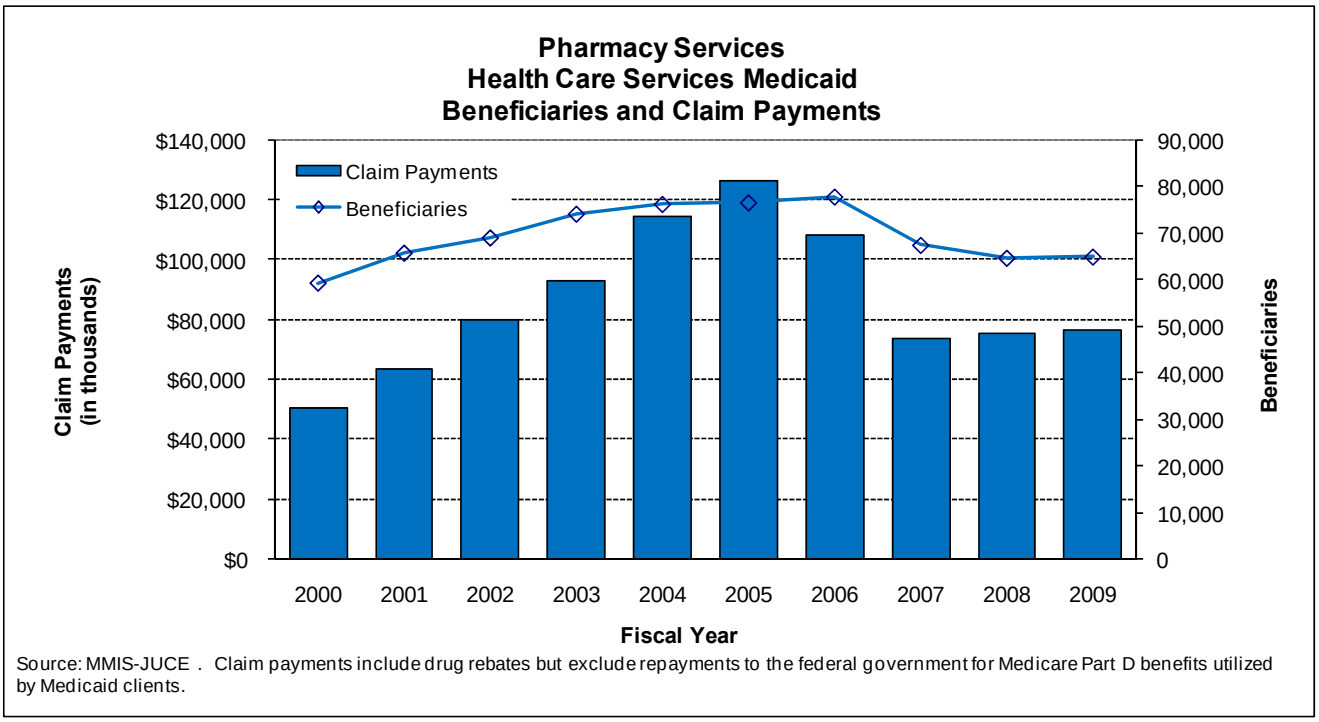
	Beneficiaries	Claim Payments	Cost per Beneficiary
Hospital Services	10.4%	7.0%	-3.0%
Prescription Drugs	0.4%	1.8%	1.4%
Physician Services	3.2%	14.9%	11.4%
Transportation	4.6%	13.4%	8.3%
Dental	9.3%	28.5%	17.5%
Other Medicaid Services	6.9%	13.4%	6.1%

The cost of claims for hospital services increased by 7% due mostly to increased enrollment and utilization of services. The number of beneficiaries in FY09 increased 10%.



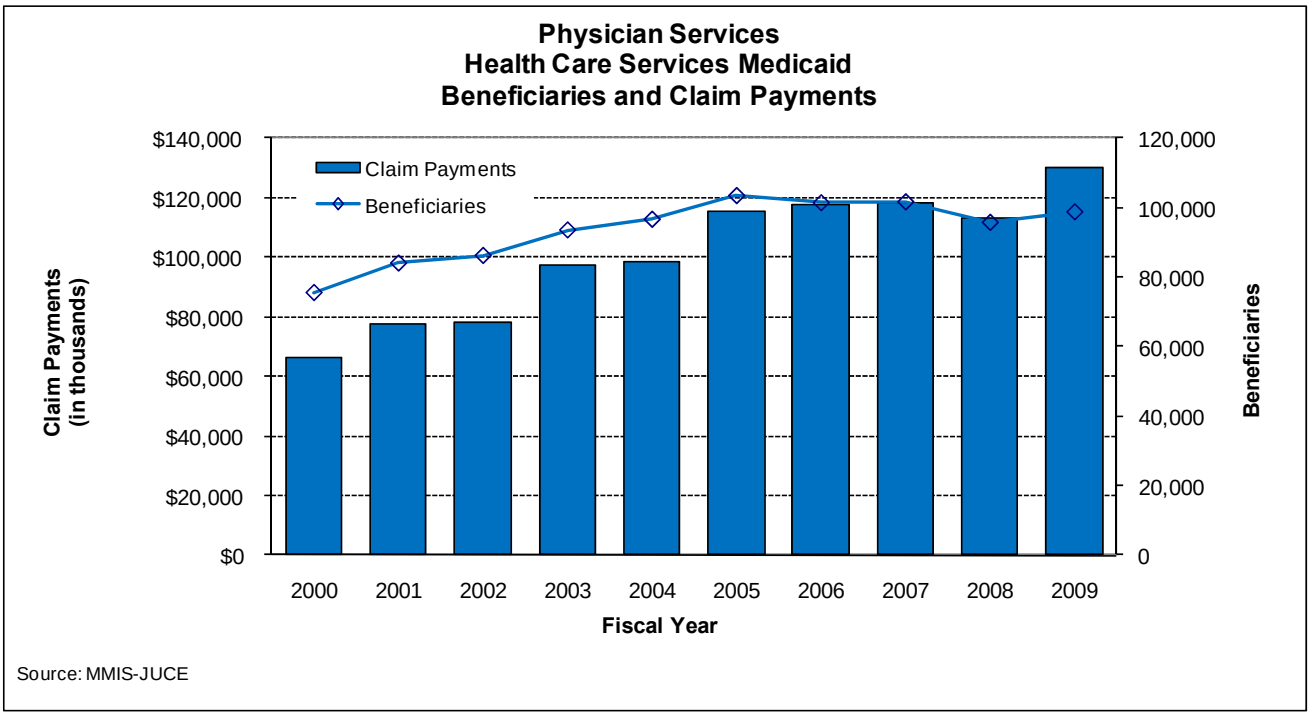
Source: MMIS-JUCE. Claim payments prior to 2006 may include Fairshare payments to hospitals (data is not corrected).

Pharmacy claim payments increased by about 2% for the second year in a row, after falling in FY06 and FY07 due to the implementation of Medicare Part D prescription drug coverage for dual eligible enrollees. The number of beneficiaries changed little from FY08 while the annual average cost per beneficiary rose just over 1%.



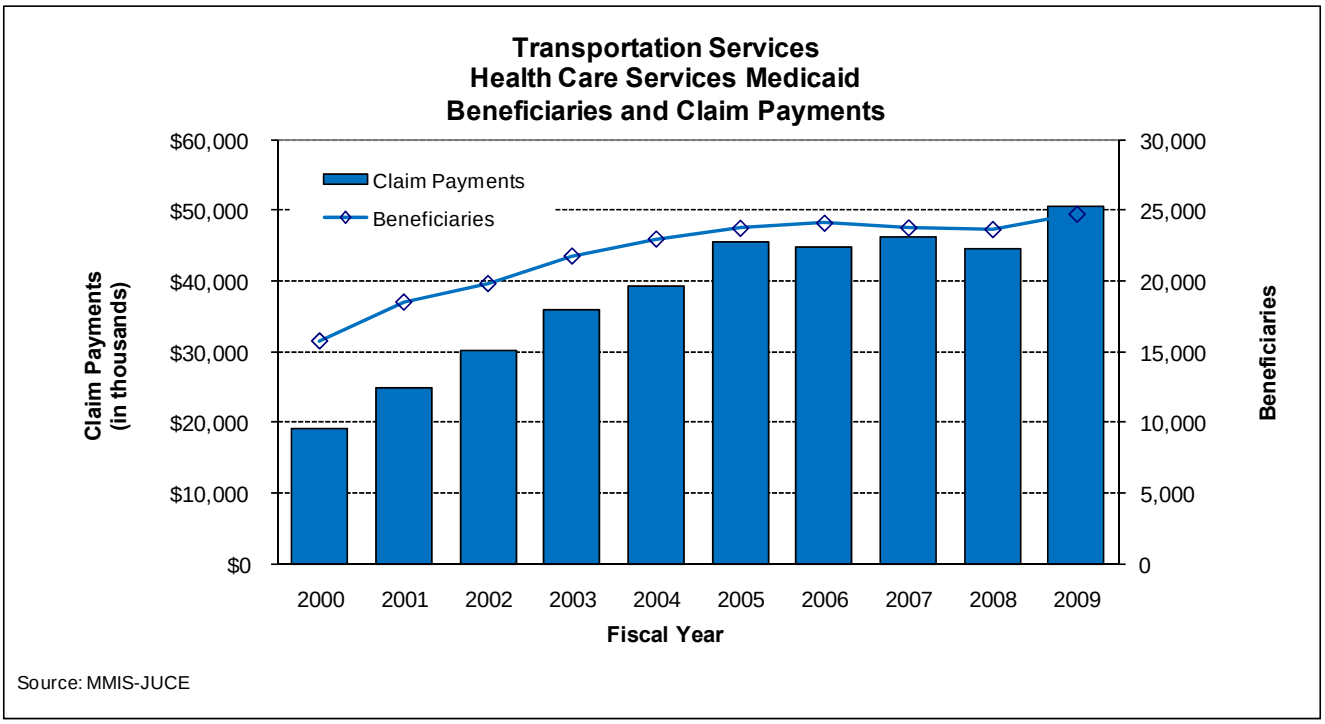
Source: MMIS-JUCE . Claim payments include drug rebates but exclude repayments to the federal government for Medicare Part D benefits utilized by Medicaid clients.

Claim costs for physician services increased almost 15% in FY09. The number of persons using physician services increased by 3% while the cost per beneficiary increased disproportionally, by about 11%, due to physician fee for service rate increases.



Source: MMIS-JUCE

Transportation services costs grew by 13% in FY09, due mostly to increased enrollment and utilization. The number of persons using Medicaid transportation services grew by about 5% and the cost per beneficiary increased by about 8%.

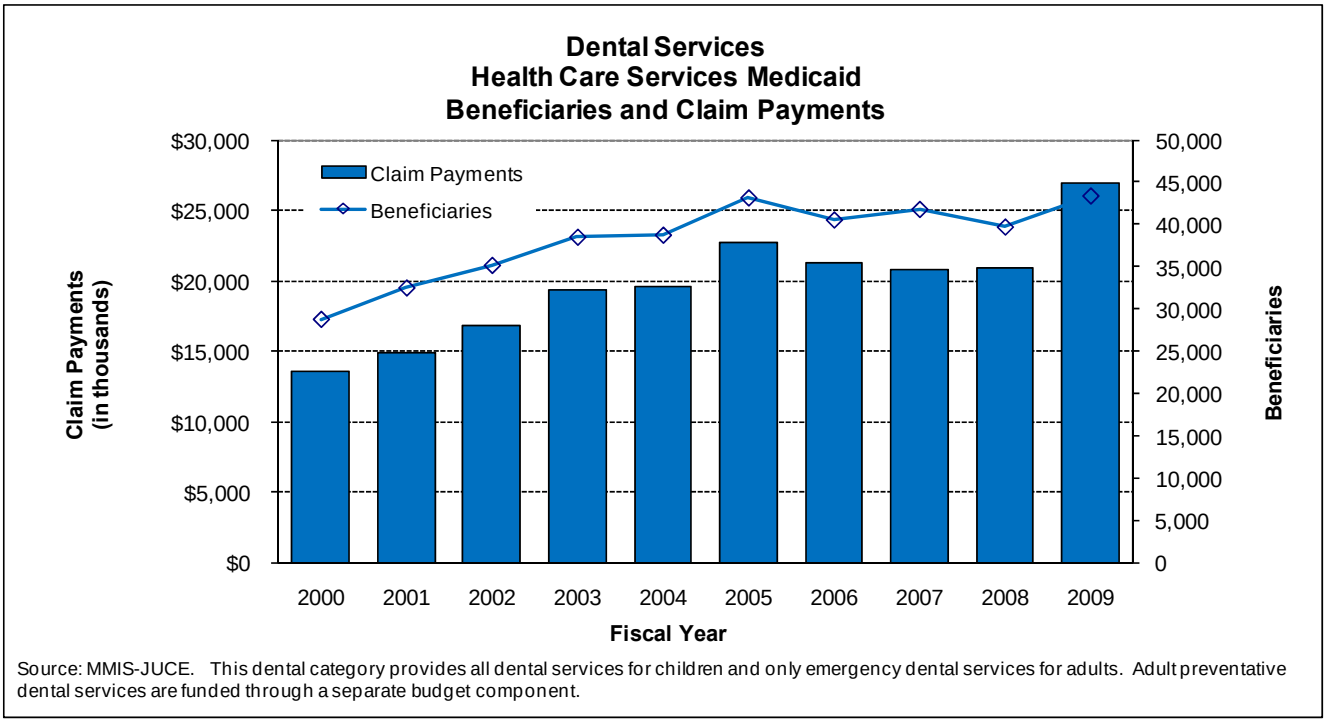


Source: MMIS-JUCE

Health Care Medicaid Services Direct Benefits						
State Fiscal Year	Historic 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%
2009	122,926	$573,459.8	$4,665	5.5%	10.7%	5.0%

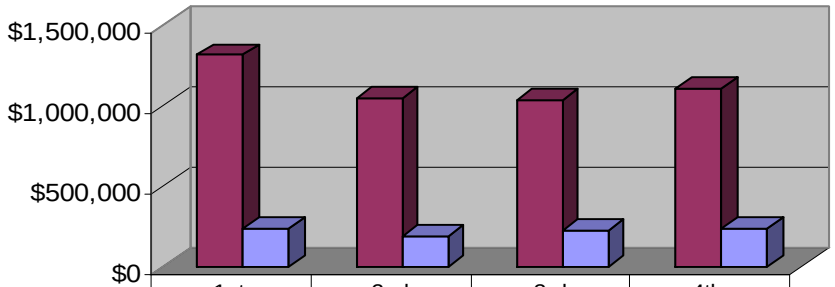
Source: MMIS/JUCE. Paid claims for direct services to Medicaid clients only. Excludes CAMA, Senior Care Drug, and Public Assistance field services benefits. Excludes supplemental payments, premium payments and other services processed outside of the MMIS claims system. 2009 claim payments include Adult Preventative Dental services ($5,931.8). Without preventative dental, the percent increase in claims payments would be 9.6% between 2008 and 2009.

Total claim payments for Dental Services increased by almost 29% in FY09. The number of beneficiaries increased 9%, but dental reimbursement rate increases, begun in FY09 and continuing into FY10, contributed strongly to the overall cost increase. The cost per beneficiary increased by almost 18%. Note that dental services discussed here do not include Medicaid adult preventative dental services.



Source: MMIS-JUCE. This dental category provides all dental services for children and only emergency dental services for adults. Adult preventative dental services are funded through a separate budget component.

Adult Dental Preventive Service Expenditures



	1st Qtr_FY2009	2nd Qtr_FY2009	3rd Qtr_FY2009	4th Qtr_FY2009
Adult Dental Service Expenditures	$1,314,999	$1,045,768	$1,033,152	$1,104,534
IHS Adult Dental Service Expenditures	$238,762	$193,402	$224,406	$237,923

FY 2009 DIVISION LEVEL SUMMARY:Health Care Services Medicaid	HEALTH CARE SERVICES 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		**122,933**		**$573,463,655**	**$4,665**	**99.3%**	**55.5%**
Gender							
Female	56.9%	69,944	60.0%	$343,881,223	$4,917	99.5%	58.7%
Male	43.1%	53,029	40.0%	$229,582,431	$4,329	99.1%	51.4%
Unknown	0.0%	1	0.0%	$0	$0	0.0%	0.0%
Race							
Alaska Native	37.6%	46,591	43.2%	$248,014,860	$5,323	99.6%	64.4%
American Indian	1.6%	1,941	1.7%	$9,492,790	$4,891	99.4%	63.3%
Asian	6.0%	7,493	4.5%	$25,877,732	$3,454	99.6%	47.6%
Pacific Islander	3.1%	3,884	2.3%	$13,242,188	$3,409	99.8%	58.9%
Black	5.7%	7,025	4.4%	$25,184,216	$3,585	99.4%	55.2%
Hispanic	3.7%	4,584	2.6%	$14,843,343	$3,238	99.7%	62.1%
White	39.5%	48,931	38.6%	$221,403,365	$4,525	99.0%	48.6%
Unknown	2.7%	3,405	2.7%	$15,405,160	$4,524	98.1%	50.7%
Native	39.1%	48,609	44.9%	$257,611,143	$5,300	99.6%	64.3%
Non-Native	60.9%	75,789	55.3%	$317,247,968	$4,186	99.1%	50.1%
Age							
under 1	10.0%	13,530	15.8%	$90,879,951	$6,717	100.0%	99.9%
1 through 12	36.0%	48,681	19.1%	$109,662,256	$2,253	99.6%	70.3%
13 through 18	16.1%	21,861	11.7%	$66,828,113	$3,057	98.6%	42.4%
19 through 20	3.3%	4,534	3.2%	$18,369,980	$4,052	98.8%	71.6%
21 through 30	10.7%	14,534	14.1%	$80,888,027	$5,565	99.4%	67.8%
31 through 54	13.8%	18,627	22.9%	$131,200,148	$7,044	99.3%	59.4%
55 through 64	3.8%	5,177	8.4%	$48,063,451	$9,284	98.9%	53.7%
65 through 84	5.3%	7,184	4.3%	$24,547,176	$3,417	97.6%	19.6%
85 or older	0.9%	1,266	0.5%	$3,024,553	$2,389	93.2%	6.4%
Benefit Group							
Children	61.6%	77,256	43.6%	$249,791,071	$3,233	99.5%	69.8%
Adults	18.9%	23,741	21.7%	$124,218,061	$5,232	99.7%	97.7%
Disabled Children	1.8%	2,321	5.2%	$30,103,589	$12,970	96.7%	52.7%
Disabled Adults	12.0%	15,012	25.5%	$146,144,873	$9,735	98.7%	43.4%
Elderly	5.7%	7,181	4.0%	$23,206,061	$3,232	96.8%	15.1%

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 2009 (service may have been incurred in a prior year). Grouping is based on status on the date the benefit was obtained (service was provided). 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, 2009. If they obtained dental services again in December 2008, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2009.

*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.

List of Primary Programs and Statutory Responsibilities

AS 47.07	Medical Assistance for Needy Persons
AS 47.08	Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25	Public Assistance
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
7 AAC 105-160	Medicaid Coverage & Payments

Health Care Services*	FY10	FY11 Gov	10 to 11 Change
General Funds	201,176.6	217,960.8	16,784.2
Federal Funds	495,687.7	510,221.2	14,533.5
Other Funds	13,085.9	10,472.2	(2,613.7)
Total	**709,950.2**	**738,654.2**	**28,704.0**

*Totals include Adult Preventative Dental Medicaid Svcs

Adult Preventative Dental Medicaid Services

Medicaid Program-Formula Growth: *$704.4 Total- $448.0 Fed, $256.4 GF/Match*
This increment is necessary to maintain the current level of Medicaid's Adult Preventative Dental services. For FY11, Adult Preventative Dental Medicaid costs are projected to grow 8.9% from FY10, due to enrollment and utilization increases. Projections for formula growth are based on historical trends in population, utilization, provider reimbursement, and federal financial participation. The formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP). Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget.

Enhance Medicaid Dental Prevention Benefits*: $200.0 GF*
This increment will support the department's continuing efforts to provide dental care for non-Medicaid covered services. These services include: dentures, crowns, cleanings, routine dental exams, and other preventive services. Outreach to the dental provider community, as well as an increase in dental reimbursement rates in both FY09 and FY10, have resulted in increased participation by dental providers. In addition, both overall costs and the total of individuals served have increased. For example, the total claim payments for dental services increased during FY09 by 28.5% over expenditures made during FY08. The number of beneficiaries utilizing dental services also saw an increase during FY09 by 9.3% and the annual average cost per beneficiary rose 17.5%.

Health Care Services Medicaid

Medicaid Program-Formula Growth: *$34,544.3 Total- $17,214.1 Fed, $17,330.2 GF/Match*
This increment is necessary to maintain the current level of quality Medicaid health care services for eligible Alaskans. For FY11, Health Care Services' Medicaid costs are projected to grow 2.1% from FY10. Projections for formula growth are based on historical trends in population, utilization, provider reimbursement, and federal financial participation. The formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP). Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget.

Without this 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.

In recent years the department has implemented Medicaid reforms aimed at improving Medicaid sustainability. Cost containment efforts begun in FY04 have successfully reduced the rate of growth in recent years for direct benefits from a high of 21.5% for FY03. Cost containment has been especially effective in pharmacy services; costs for this category have fallen 27% since the high of $95.7 million in FY05. Additional enrollment and utilization will contribute to the approximate 2.1% increase in costs forecast for FY11.

Transfer GF/Match and Federal Funds From Medicaid Services to Public Health: *($4,000.0) Total- ($2,000.0) Fed, ($2,000.0) GF/Match*
This transfer increases efficiency and reduces paperwork by eliminating a budgeted RSA with Health Care Services/Medicaid Services and allowing Public Health Nursing to make their Medicaid administrative claim directly. Nursing supports administration of the Medicaid State Plan by providing outreach, referral, and education to Medicaid eligible children and adults. Medicaid Services has traditionally made the Medicaid administrative claim on behalf of Nursing through an RSA; however, all other sections in the department that have Medicaid administrative claims make their claim directly. Placing the federal and general fund match in the budget of the section responsible for making the match payment is in more effective, efficient, and transparent. This funding allows Nursing to maintain its current level of administrative support to the Medicaid program. The amount of the transfer is based on the budgeted RSA amount. The federal government reimburses 50% of most administrative costs.

Improve Medicaid Tobacco Cessation Services*: $250.0 Total- $152.5 Fed $97.5 Tobacco*
The division is requesting an increment that will be used to modify Medicaid tobacco cessation service coverage so that Medicaid covered services better coordinate and complement the efforts of the Tobacco Quit Line, American Lung Association, and tribal efforts.

One objective is to expand the provider types allowed to perform and to be reimbursed for tobacco cessation services. More providers would receive payment for tobacco cessation counseling and more recipients will receive better care and this will result in lower tobacco use by Medicaid recipients. This would also result in a lower incidence of Chronic Obstructive Pulmonary Disease, Heart Disease, Hypertension and other Breathing Disorders. Another objective has been to focus on pregnant women in an effort to lower and/or eliminate the effects smoking has on the child, e.g. low birth weight, asthma, etc.

Health Facilities Survey

Stabilize the Health Facilities Survey Budget*: $260.0 GF*
Funding for this increment is needed as a result of increased CMS and State Licensure workloads due to the following health facility survey and reporting requirements:

- Additional regulations and protocols for Skilled Nursing facilities and Ambulatory Surgery Centers including reporting requirements for infection control;
- An increase in serious deficiencies resulting in more time needed for report writing and more frequent monitoring of health facilities;

- An increase in initial surveys (health providers that require a survey in order to open for business).

The benefits of the services provided by this component would assist in meeting agreement number 1864 with the Secretary of the US DHHS; completing State Licensure surveys, including initial surveys for health providers waiting to be approved in order to open for business and become eligible for reimbursement; completing CMS priority surveys, complaints investigations, and new protocols according to congressionally mandated timeframes.

Increase Capacity for Health Facilities Survey: *$187.5 Total- $112.5 Fed, $75.0 GF/Match*
This increment is needed to hire a surveyor assistant who will provide administrative support that will decrease the administrative burden on registered nurses in the health surveyor team. It will also fund an additional surveyor position that will lessen the work load on the State Agency manager so that more time can be devoted to training staff. At this time, only half of the current staff has completed the required 1-2 year training/orientation program required prior to being allowed to survey independently.
The positions will also be needed to meet and complete obligations of the contract under agreement 1864 with the Secretary of the Department of Health and Human Services which includes providing qualified personnel to carry out survey-related functions. State personnel performing functions under this agreement must meet the Federal surveyor qualification standards, successfully pass a national exam, and participate in mandatory programs to develop and maintain their proficiencies. The benefits of funding this increment include:

- Completion of required federal and State survey activities;
- Decreased work-related surveyor burnout and increased retention of registered nurses; and
- Devotion of more time and attention to survey activities rather than administrative assistant duties

Medical Assistance Administration

ARRA Development of State Electronic Health Record System, HB199 Carryforward: *$480.0 Total- $450.0 Fed, $30.0 GF Match*
The division is requesting to carry over expenditure authorization from FY10 to FY11. This request is necessary because it has taken longer than anticipated to get approval of the division's Advanced Planning Document (APD) by the Centers for Medicare and Medicaid Services (CMS). The APD is required before any federal funds are made available for the development of the state's Electronic Health Record System. After approval of this document, the division anticipates that it will hire for all positions needed for the project in early FY10. With such a late staffing date, the division will not be able to expend all funds appropriated in FY10.

Reflect Unbudgeted CIP Receipts for the Medicaid Management MMIS Project: *$970.2 CIP*
The division requests an increase for Capital Improvement Project (CIP) receipts in the amount of $970.2 to match anticipated expenditures for FY11. Receipts for this project have been under-budgeted for the last two budget cycles. This increase will reduce the possibility of preparing an unbudgeted RSA to support the project from the Facilities Management component to the Medical Assistance Administration component.

Rate Review

Maintain, Improve, and Design New Financial Rate Systems: *$375.0 Total- $187.5 Fed, $187.5 GF Match*
This increment will fund three staff positions. The department made significant progress towards improvements in rate setting and enhancing federal financial participation with three temporary positions provided through FY09 under SB61. Those positions were not made permanent for FY10 and beyond. This request is to renew the department's efforts in this area.

This staffing will allow the department to operate and further develop the Medicaid Waiver rate setting processes to alleviate the concerns of CMS and provide for a fairer system of reimbursement with less likelihood of litigation and more efficiently providing services. Without this staffing, federal Medicaid participation in Alaska's home and community based services programs could be in jeopardy.

Health Planning and Infrastructure

Replace Unrealizable Federal Receipts for Core Service: *($457.1) Fed, $457.1 GF*
The Department is requesting $457.1 of GF to fund core services. A previous federal grant request for $1,207.0 was not funded. Sixty percent of the grant-requested funding has been identified from other departmental resources, but this fund source change is needed to cover the remainder. Funding enables the Section of Health Planning and Infrastructure (HPI) to provide core department and state government services including certain statutory requirements (state planning to advise the Commissioner on the need for new or remodeled health care facilities as required by the certificate of need statute AS18.07) and provision and dissemination of data and policy analysis related to access to health care, health insurance coverage, utilization of services, health workforce and industry analysis that the department and other state entities must address.

Decrease Federal Receipts Authority from Expired Grants: *($1,000.0 Fed)*
This decrement of $1,000.0 removes excess federal authority from expired grants. It is not needed to complete the financial budget for this component in FY11.

Challenges

Adult Preventive Dental Medicaid Services
The Adult Preventive Medicaid Dental program was reauthorized in FY09 and repealed the three year sunset provision.

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). DHSS continues to work with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program. The department will continue to cap the dental services for each individual at $1,150 and operate within the budgeted amount.

Medicaid Services
To provide affordable access to quality health care services to eligible Alaskans, a sufficient supply of providers must be enrolled in Medicaid. A strategy to maintain provider participation is for provider reimbursement rates to keep pace with health care costs. Because provider participation in Medicaid is voluntary, if Medicaid's rates are too low, providers may stop seeing Medicaid clients. In FY09, rates paid to hospitals, nursing homes, dentists, and transportation providers were increased. In FY11 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. In response to these concerns, in FY09 Medicaid increased payment rates across the board for all dental services; again in FY10, rates were increased for the most frequently used procedure codes. 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 is looking into an expansion of outpatient nutritional and dietitian services. Services would be available to recipients of all ages with morbid chronic diseases such as diabetes, end stage renal disease, and heart disease.

Health Care Services is also working with the Division of Public Assistance to refer eligible recipients to Social Security and shift these patients to Medicare. A large portion of Medicaid clients receiving end stage renal dialysis treatment are likely eligible for Medicare.

Medicaid is the "payer 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.

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 in FY11, therefore the Department is challenged to determine a new equitable acquisition cost benchmark such as wholesale acquisition cost with an up-charge or another benchmark that has not been developed. Either benchmark will need to fully cover 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 clients' needs.

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, ensuring 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.

Chronic and Acute Medical Assistance (CAMA)
Health Care Services continues to be challenged to use funding appropriately and to stay within CAMA's limited budget. The funding is 100 percent GF and serves about 600 recipients per month. The program primarily pays for prescription drugs.

Health Facilities Survey
The ability to meet CMS survey-related mandates is dependent upon having qualified registered nurse surveyors. Due to the 1-2 year orientation period it is critical for the division to retain qualified surveyors. Another challenge is fulfilling the CMS requirement that every state agency have a State Training Coordinator; OASIS Coordinator (home health); MDS Coordinator (skilled nursing facilities); Complaint Coordinator; and ASPEN Coordinator (for data entry and tracking enforcement). Surveyors are filling these positions and working extra hours to keep up with the CMS requirements in addition to their full survey schedule. Currently, we are attempting to transfer some of these duties to administrative support staff. In addition, Health Facilities Survey staff are identifying and implementing approaches that would improve the efficiency of on-site survey activities as well as decrease the amount of time spent on post-survey report writing. By meeting these challenges, the division helps to ensure Alaskans safe and adequate quality of care, meets CMS mandates, and avoids serious delays in licensing and/or certifying new providers.

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. In FY08 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 MMIS for five years.

The new MMIS, known as Alaska Medicaid Health Enterprise, is a sophisticated, web-enabled solution for administering all Medicaid programs. It was scheduled to be available to providers and recipients who participate in the medical assistance programs in FY11. ACS has informed the HCS MMIS Development Project Management team that delivery of the source code for the Enterprise product will be delayed; therefore, Alaska Medicaid Health Enterprise will be delayed. The cause of the delay is faulty source code for the Enterprise product from one of their subcontractors. ACS has replaced the vendor, and has since brought development in house.

The full extent of the impact to the MMIS Development Project is unknown at this time. The Centers for Medicare and Medicaid Services (CMS) and State leadership have been notified of the delay. Commitment to a new implementation date will not be made until there is more solid data on when the source code for the Enterprise product will be available.

The delay is not a reflection of the work done by the joint state/ACS project team, and the team continues to work to the original schedule to minimize the impact of the Enterprise product delay. Development, also known as construction, of Alaska Medicaid Health Enterprise Alaska-specific requirements will begin as the source code for the Enterprise becomes available. Once we get the source code for the Enterprise product we have nine months of work to build the Alaska-specific requirements and then complete testing. Current estimates show an early to mid FY12 implementation. Our objective is to have the best fully tested MMIS possible. If it takes more time to meet our objective, then it is the right thing to do.

HCS MMIS Development Project Management team is looking at the impact of the delay and what new services can be implemented early, before Alaska Medicaid Health Enterprise is fully operational, including functions like online provider enrollment, document tracking, etc.

Other Challenges

The Division of Health Care Services will be managing the implementation of the replacement MMIS while simultaneously addressing two important federal mandates, one for conversion to HIPAA 5010 standards and the other for a mandate relating to International Classification of Diseases-10 (ICD-10) diagnoses.

HIPAA 5010 Transaction Set Mandate: Federal law requires update to a new version of the Transaction Sets used for electronic commerce between health care providers and payers. This defines the rules for exchange of information on electronic transactions such as claims, eligibility inquiry and response, payment remittances, service authorization and claims status. This is referred to as version 5010 of the HIPAA transaction sets. The mandated compliance date for conversion to these new standards is January 1, 2012. Interim compliance dates for internal and

external testing of these new standards begin January 1, 2011 and continue throughout the calendar year.

ICD-10 Diagnosis and Surgical Procedure Codes Mandate: Federal law requires conversion to a new version of the code sets used for diagnoses and inpatient hospital surgical procedure codes effective October 1, 2013. Planning for the conversion to the International Classification of Diseases-version 10 (ICD-10) will occur during FY11.

Rate Review
Work on the development of a new cost-based rate setting system for Medicaid home- and community-based care will reach completion through the adoption of regulations and implementation of the new methodology. Many challenges still face the process including development of a cost survey instrument and implementation of a very different new system.

Rate Review will begin the process of rebasing hospital and nursing home Medicaid payment rates as part of a four-year cycle. The process involves performing audits of individual facility cost reports as a foundation for rate setting for the next period.

Health Planning and Infrastructure
Health Planning and Infrastructure addresses access to care. Funding for this component is provided through seven federal grants, several awards from the Alaska Mental Health Trust Authority, a Rasmuson Foundation grant, several RSAs, and general funds. At least four of the federal grants have been awarded to HPI for over eight years. The amount of these grant awards has remained level over the past few years. A major challenge for HPI is long-term, stable funding while depending on multiple funding streams.

Community Health Grants
Community Health Grants include the Community Health Aide Training and Supervision (CHATS) grants, the Community Health Center-Senior Access (CHC) grants, and Anchorage Project Access (APA) grant. These grants increase access to health care for underserved, vulnerable and rural populations. Through the CHATS grants, community health aides receive required training and are thus able to provide higher level care to residents of their villages. Through the CHC grants, the health centers are able to provide increased care for the population over 65 that have limited access to providers. Through the APA grant, primary and specialty care for residents of the Anchorage area who are uninsured is provided. The most significant challenge is that the available funding only allows us to address a portion of the need for health care for these populations. A second challenge is that, since there are no administrative funds within the Community Health Grants, technical assistance and site visits to the grantees are limited.

Performance Measure Detail

A: Result - Health care service reductions are mitigated 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 an increase in both Indian Health Services (IHS) billings and adjustments to facility encounter rates the goal of increasing IHS billings was realized, with an increase of approximately 9% from FY08 to FY09.

Health Care Services Actuals - Other Funds (in millions)

Fiscal Year	% Federal	% General	% Other
FY09	58.8%	34.7%	6.5%
FY08	64.6%	32.3%	3.1%
FY07	64.8%	31.0%	4.2%
FY06	65.3%	28.1%	6.6%
FY05	71.5%	17.5%	11.0%
FY04	71.1%	16.6%	12.4%
FY03	67.5%	25.5%	7.1%
FY02	66.6%	27.8%	6.1%
FY01	66.4%	22.7%	10.9%
FY00	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 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 Federal Medical Assistance Percentage (FMAP).

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: Indian Health Services (IHS) Medicaid participation increased by 9% in expenditures from FY08 to FY09. This exceeded the 5% target increase.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY09	$573.4	159.3	28%	9%
FY08	$517.9	$146.3	28%	9%
FY07	$490.2	$134.2	27%	-14%
FY06	$528.9	$155.6	29%	-12%
FY05	$558.2	$177.8	32%	15%
FY04	$503.6	$154.5	31%	15%
FY03	$466.6	$134.9	29%	51%
FY02	$385.9	$89.3	23%	22%
FY01	$323.0	$73.3	23%	48%
FY00	$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 increased from FY08 to FY09 by $13 million. The increase can be attributed to increased IHS claim filing, increased use of IHS facilities, and adjustments in encounter rates following facility rate reviews.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation, whereas non-IHS facility patient costs require a state match of GF funds 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: From FY08 to FY09 the Division of Health Care Services realized an increase in GF recovery of 14%, exceeding the 2% target increase.

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

Year	Drug Rebates	TPL	Total	% Change
2009	24.0	10.2	34.2	14%
2008	21.6	8.4	30.0	0%
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 increased approximately 14% between FY08 and FY09. However, there was no overall increase in collections during FY08. The increase in recoveries experienced during FY09 can be attributed to a number of contributing factors, among them increased receipts recovered by the TPL contractor, increased subrogation recoveries, and more stringent application of Medicare eligibility.

B: Result - Affordable access to quality health care services is provided to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.
Status #1: While there has been mixed success in expanding the number of eligible providers, the greatest gains have been made in ancillary providers and physician extenders. Overall, enrolled providers increased from 8,917 in FY08 to 10,255 in FY09, an increase of approximately 15%.

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2009	2,470 -0.36%	128 +19.63%	2,448 +24.77%	992 -47.12%	10,255 +15.01%
2008	2,479 -0.24%	107 -61.09%	1962 -2.87%	1,876 +22.14%	8,917 -25.16%
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 discontinuing their enrollment.

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 witnessed an increase of approximately 4 days in the average time from claim submission to claim payment, increasing from 11 days in FY08 to 15 days in FY09. This represents an increase of 36% in claims processing time.

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

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY09	7,509,326	15	4
FY08	7,263,956	11	-7
FY07	7,293,304	18	6
FY06	7,721,709	12	-1
FY05	7,903,523	13	3
FY04	6,690,344	10	0
FY03	5,615,072	10	-2
FY02	4,959,864	12	0
FY01	4,409,121	12	2
FY00	3,720,254	10	0

Methodology: Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between FY08 and FY09 increased from 11 days to 15 days.

There may be more than one reason for the increase in time from submission to payment, although the most prominent of these would be the changeover of claims processing contractors from First Health Services to Affiliated Computer Services. As with any change in business practices and personnel, there will be a needed period of adjustment before medical claims processing efficiencies are realized from the completion of employee training and familiarization of employees with practices and procedures.

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 paid without error decreased from 81% during FY08 to 79% in FY09.

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

Year	Medicaid Claims Paid	% No Errors	% Change
2009	5,858,223	79%	-2%
2008	5,550,357	81%	9%
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. This measure is updated quarterly.
2. 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. Affiliated Computer Services, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY06 and FY07 in Pharmacy. During FY06, 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.

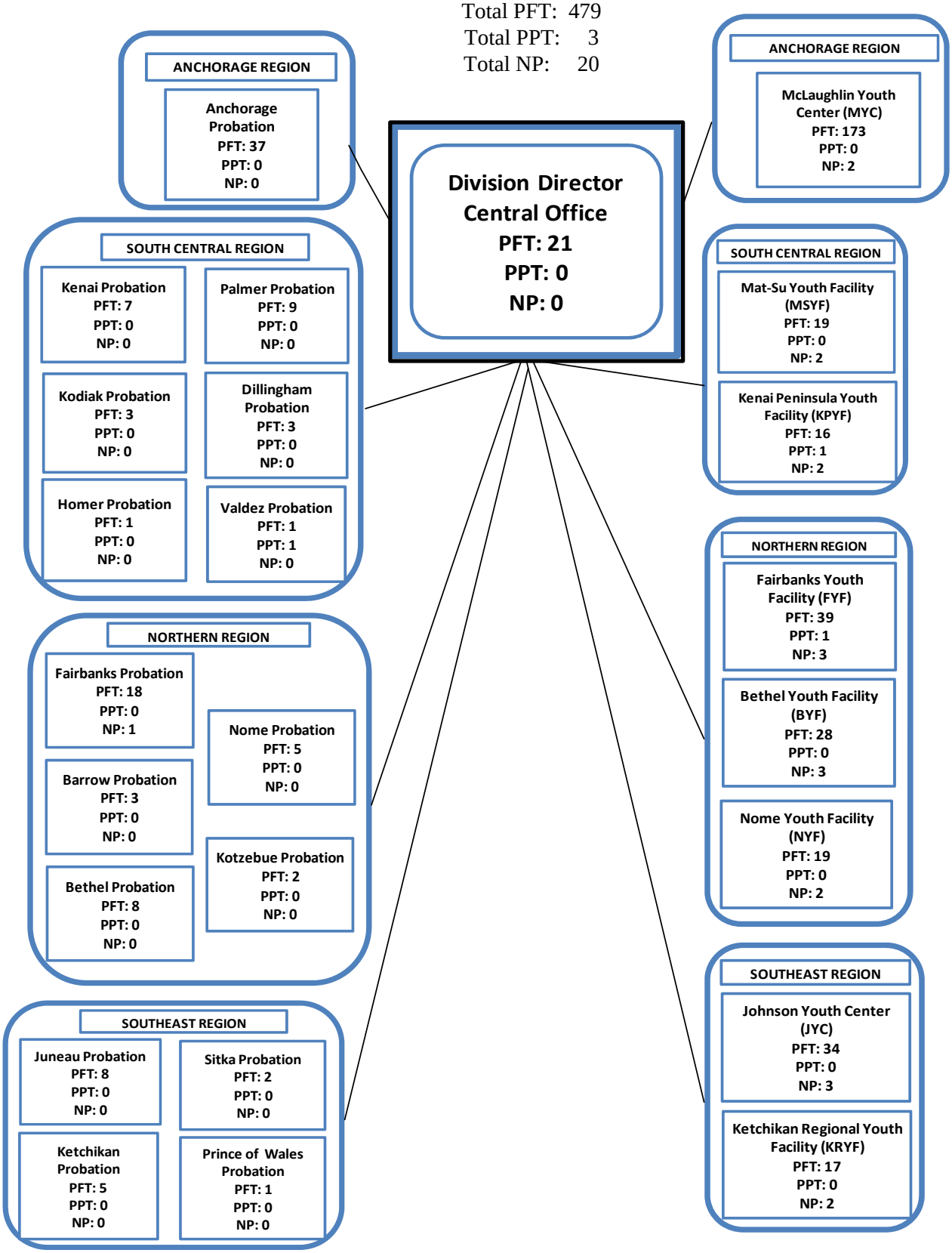
These major changes to the Pharmacy program were noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

FY11 Governor's Request Increment and Decrement Fund Breakout

Health Care Services FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Enhance Medicaid Dental Prevention Benefits	$ 200.0	$ -	$ -	$ 200.0
Medicaid Growth	$ 256.4	$ 448.0	$ -	$ 704.4
Decrease Interagency Receipt Authority for the Discontinued ProShare Program	$ -	$ -	$ (4,000.0)	$ (4,000.0)
Improve Medicaid Tobacco Cessation Services	$ -	$ 152.5	$ 97.5	$ 250.0
Medicaid Growth	$ 17,330.2	$ 17,214.1	$ -	$ 34,544.3
Increased Capacity for Health Facilities Survey	$ 75.0	$ 112.5	$ -	$ 187.5
Stabilize the Health Facility Survey Budget	$ 260.0	$ -	$ -	$ 260.0
2nd Year FN ADN 06-0-0060 Elect Health Info Exchange System, Ch 24 SLA2009 (SB 133)(Sec 2, Ch12, SLA2009, P 47 L 7)	$ (1.5)	$ (13.7)	$ -	$ (15.2)
ARRA Development of State Electronic Health Record System HB199 Carryforward	$ 30.0	$ 450.0	$ -	$ 480.0
Reflect CIP Receipts for the Electronic Health Record System	$ -	$ -	$ 287.5	$ 287.5
Reflect Unbudged CIP Receipts for the Medicaid Management Information System (MMIS) Project	$ -	$ -	$ 970.2	$ 970.2
Reverse ADN 0609607 ARRA Sec 1, CH 17, SLA 2009, P 3, L 10 (HB 199) Lapse Date 06/30/10	$ (40.0)	$ (600.0)	$ -	$ (640.0)
Maintain, Improve, and Design New Financial and Payment Rate Systems	$ 187.5	$ 187.5	$ -	$ 375.0
ARRA Funding for State Primary Care Offices	$ -	$ 36.1	$ -	$ 36.1
Decrease Federal Receipt Authority from Expired Grants	$ -	$ (1,000.0)	$ -	$ (1,000.0)
MH Trust Workforce - Grant 1383.03 Loan Repayment	$ -	$ -	$ 200.0	$ 200.0
MH Trust: Cont - Grant 120.06 Comprehensive Integrated Mental Health Plan	$ -	$ -	$ 117.0	$ 117.0
Replace Unrealizable Federal Receipts for Core Services	$ 475.1	$ (475.1)	$ -	$ -
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (306.0)	$ (306.0)
Health Care Services Total	***$ 18,772.7***	***$ 16,511.9***	***$ (2,633.8)***	***$ 32,650.8***

Division of Juvenile Justice

Total PFT: 479
Total PPT: 3
Total NP: 20



Introduction to the Division

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

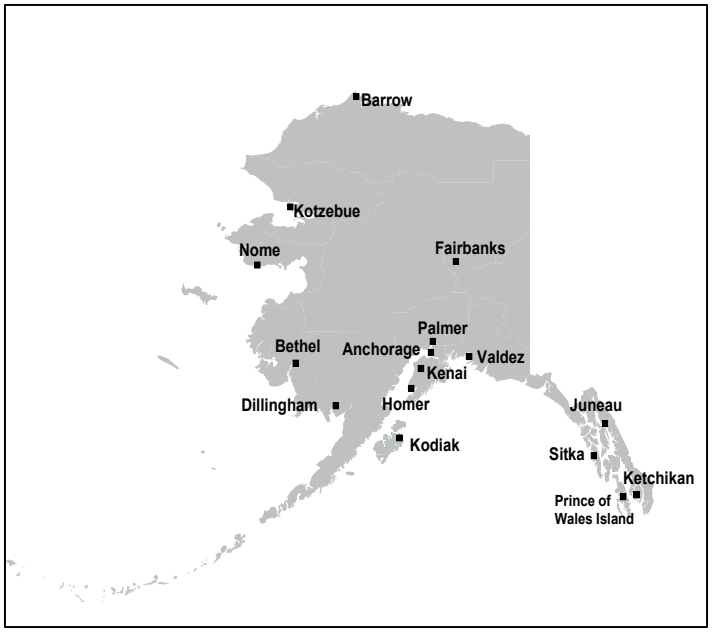
The Division of Juvenile Justice (DJJ) provides services to juveniles who commit delinquent offenses. The division responds to the needs of juvenile offenders in a manner that supports community safety, prevents repeated criminal behavior, restores the community and victims, and helps youth develop into 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

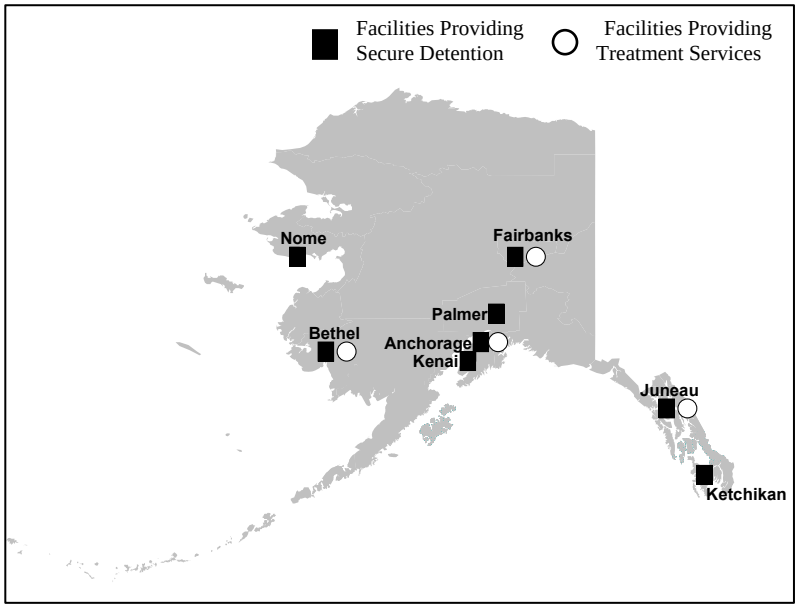
Services provided by the Division of Juvenile Justice can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions.



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 160 beds (60 detention beds and 100 longer-term treatment/training school beds). 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.

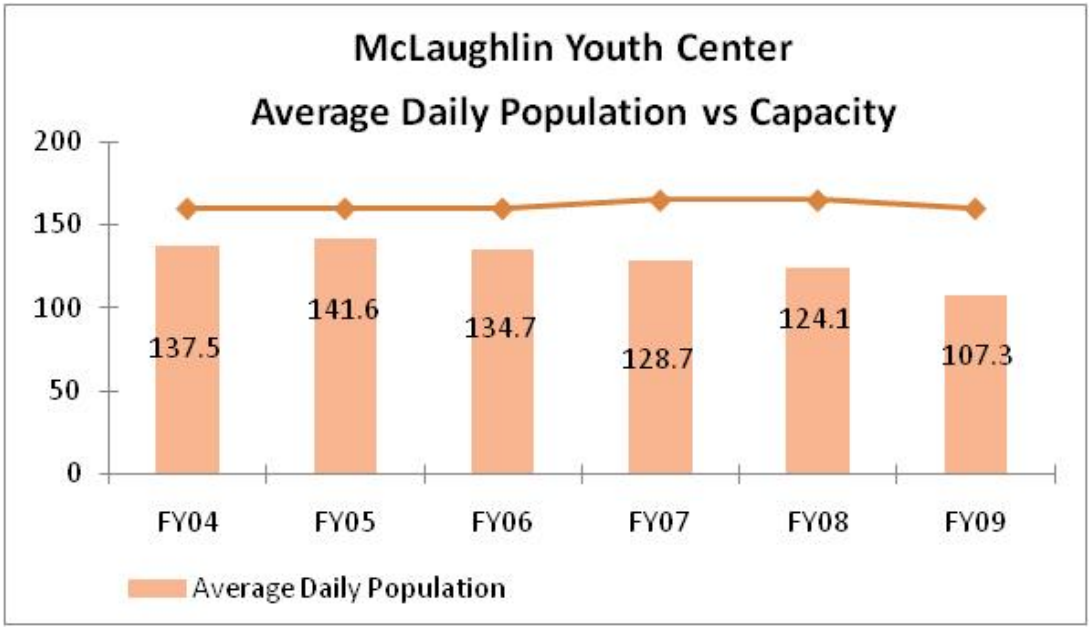
The MYC's Transitional Services Unit (TSU) was created in FY04 and was designed to prepare each institutionalized youth for a gradual and successful re-entry into the community from the time he/she is institutionalized. TSU staff provides monitoring, supervision and support of youth in the community prior to and after release as identified in the Youth Level of Services Case Management Inventory, Aftercare Plan and the youth's overall progress. The TSU is recognized nationally as a promising practice. This program is being replicated in other facilities around the state.

Staff at MYC maintain a large number of very effective collaborations with community members and other agencies. A few of these are 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 Level III Data Certification.

The chart below indicates the average daily population and capacity during several fiscal years. In FY07, the chart shows an increase of five beds from a separate wing that are used "as necessary" (previously designated admission cells) for one of the two detention units. Beginning in FY09, the number is again reduced to 160 as McLaughlin re-evaluated the way they count their beds.

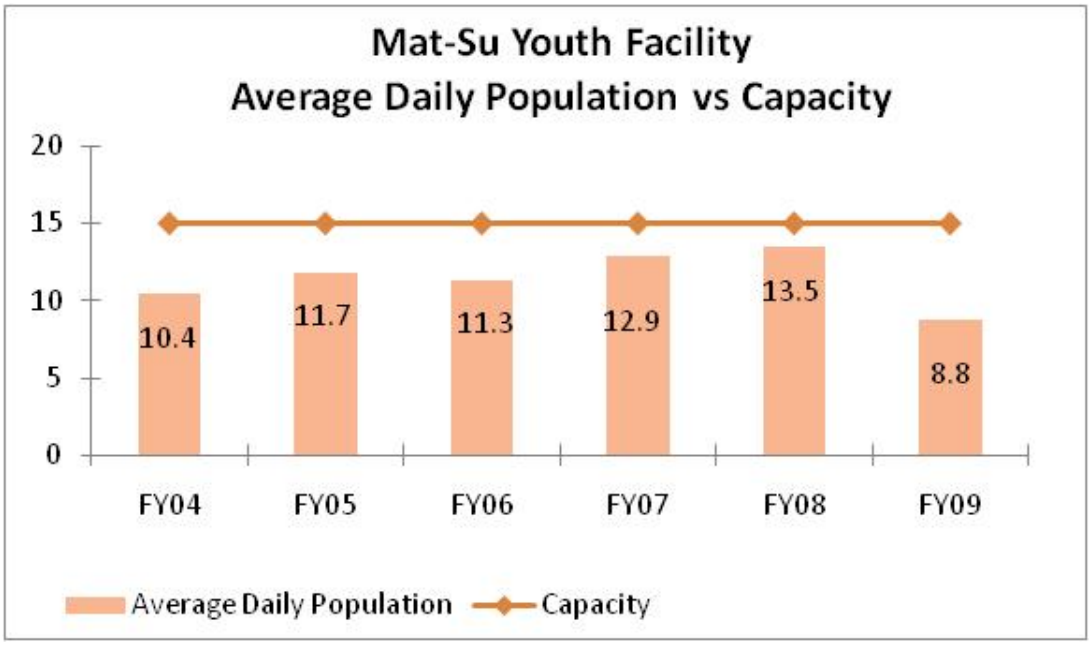


Mat-Su Youth Facility (MSYF)
MSYF is a 15-bed juvenile detention center located in the Palmer serving a population base exceeding 77,000 in addition to the outlying areas of the Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. Services provided to residents of the facility 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 Level III Data Certification.



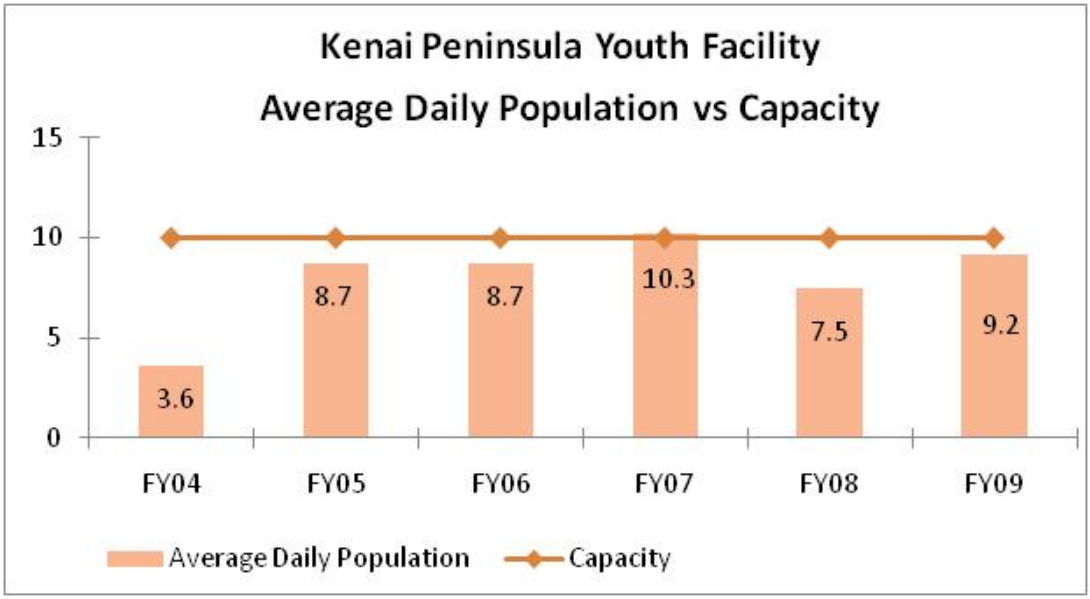
Kenai Peninsula Youth Facility (KPYF)

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 Cottonwood Behavioral Health 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 Level III Data Certification.



The Kenai Peninsula Youth Facility opened in December of 2003. The data collected in FY04 is for 6.5 months.

Fairbanks Youth Facility (FYF)

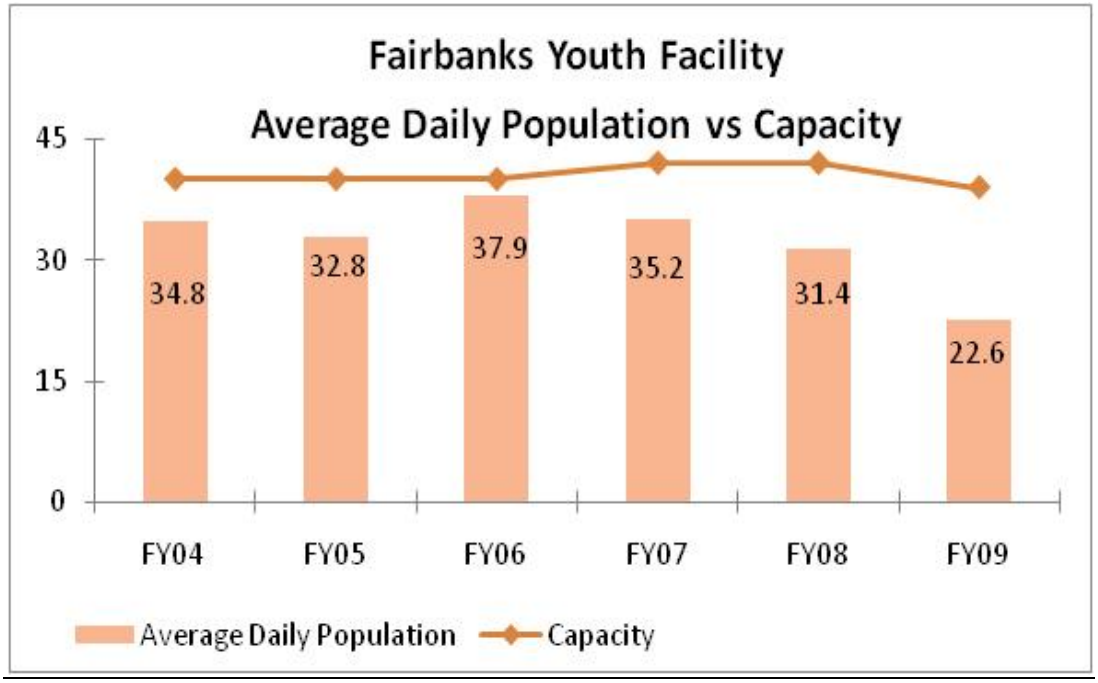
FYF consists of a 22-bed detention unit and a 17-bed treatment unit. The detention unit houses and offers services to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court. The treatment unit houses and makes rehabilitative services available 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 collaborate 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. This past April, the Detention Unit earned the distinction of Level IV, which is the highest level that can be obtained in PbS. FYF Detention is the first site in Alaska to attain Level IV status, and one of only four in the nation. The FYF Treatment Unit is currently working on Level III Data Certification.



In FY07, the detention capacity increased by two, as rooms that were previously used as storage rooms were converted to sleeping rooms. In FY09, the treatment capacity was reduced by 3 to allow for space to run the transitional services program.

Bethel Youth Facility (BYF)

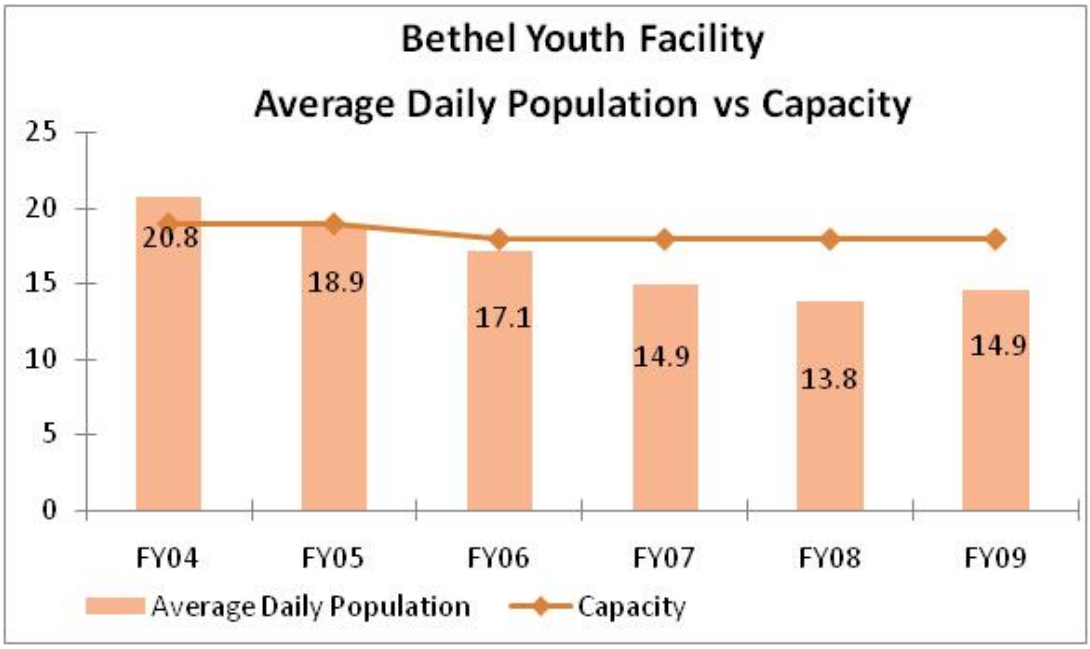
BYF is the only youth facility in the entire Yukon-Kuskokwim Delta, an area the size of Oregon. The facility consists of an 8-bed detention unit and an 11-bed treatment unit. In FY06, one of the treatment rooms was needed for the Mental Health Clinician that was hired, reducing the capacity to ten. This decreased capacity is reflected in the graph below.

The detention unit houses and offers services to alleged and adjudicated offenders who are either involved in the court process or awaiting other placement. The treatment unit houses and provides rehabilitative services to adjudicated offenders who have been institutionalized by the Court. Both units are co-ed; the treatment unit is the only co-ed institutional treatment program in the Northern Region of Alaska. The facility's population is largely Alaska Native, particularly Yupik Eskimo. A significant number of residents have Fetal Alcohol Spectrum Disorders and other mental health needs. Youth come to the facility from a wide geographical area encompassed by the Yukon-Kuskokwim Delta and from other areas of the State as needed. Finding appropriate placements for youth preparing for release from the treatment unit continues to be a substantial challenge. There are currently few alternatives to family placement in the

Yukon-Kuskokwim Delta, and we will need assistance working toward developing other community-based resources such as foster care, therapeutic foster care, and independent living options.

The Bethel Youth Facility 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. The facility is currently working on Levels III and IV Data Certification.



In FY06, 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 FY06.

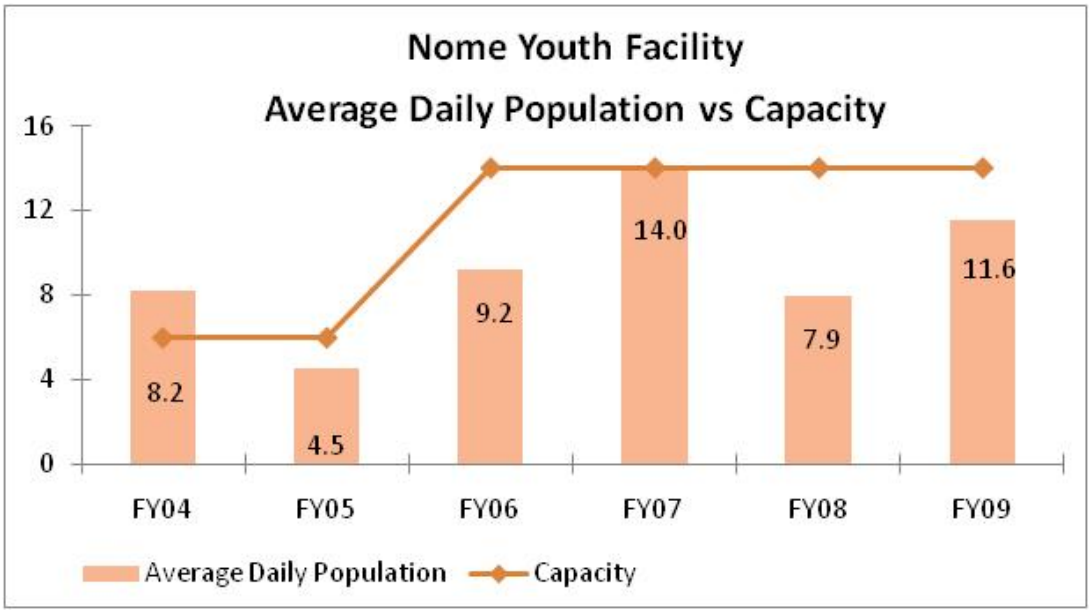
The resident population is primarily male and nearly all Alaska Native. The residents are commonly detained for property crimes, but there has been an increase in the number of residents charged with major assaults and/or sexual crimes. Many of the youth have a history of substance abuse and/or inhalant abuse.

In FY10, 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. FY09 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 Level IV Data Certification.



During FY05, the NYF was partially closed due to the renovation of the building. The renovation was complete at the end of FY05; the increased capacity is reflected on this chart beginning with FY06.

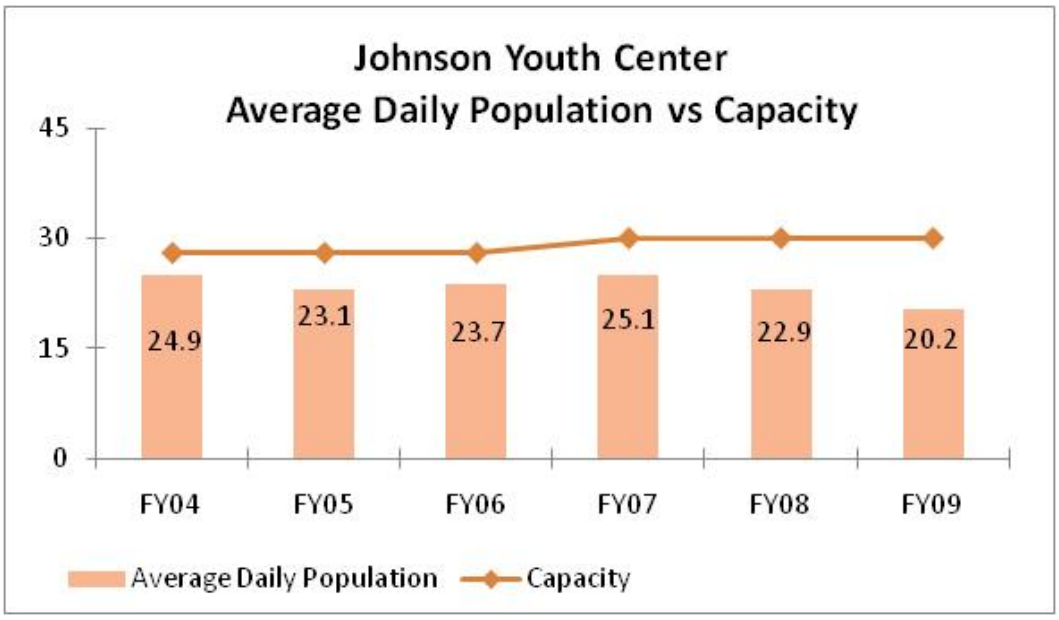
Johnson Youth Center (JYC)

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.

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 Level III Data Certification.



Beginning in FY07, the treatment capacity at the Johnson Youth Center was increased by two beds. Two rooms that had been used as storage rooms were converted to treatment rooms. The increased capacity is reflected in the above chart.

Ketchikan Regional Youth Facility (KRYF)

The Ketchikan Youth facility is a 10-bed facility (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

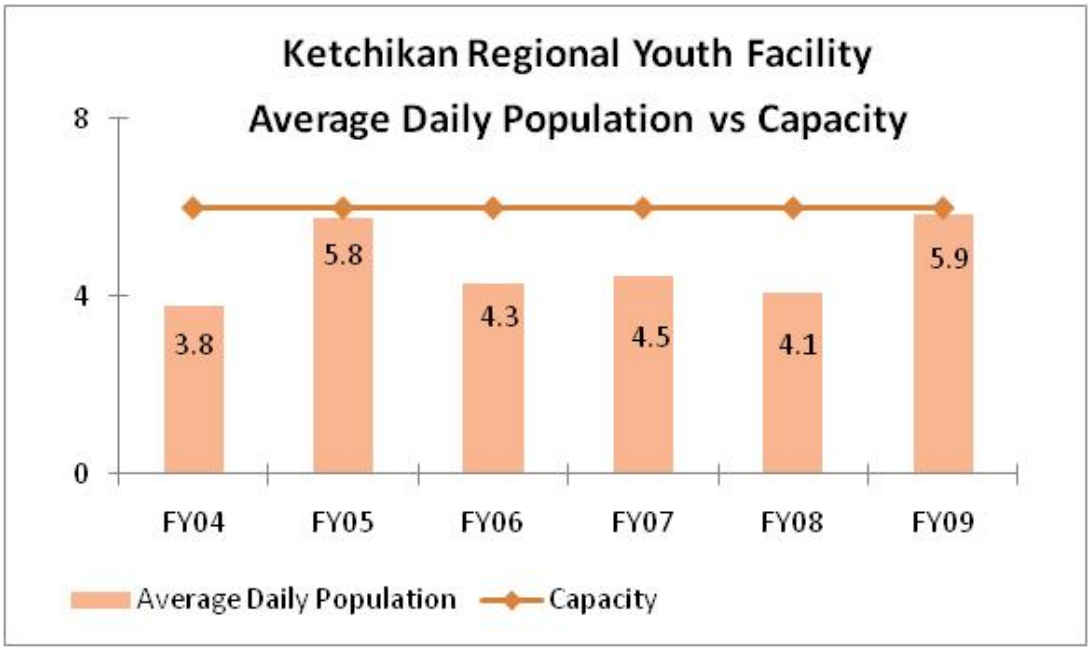
States. To date, the majority of the youth served in detention have been drug-affected and in serious conflict with their community, as evidenced by suspension, expulsion or drop out educational status and a pattern of frequent violations of prior court orders.

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 Level 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, beginning 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. The division also needs 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.

In FY09 financial support from the U.S. Office of Juvenile Justice and Delinquency Prevention was used to commission a study of juvenile probation officers and their ability to meet work and case management expectations. The Justice Center at the University of Alaska Anchorage conducted the study and in early FY10 was finalizing its recommendations, which are expected to help guide the division in management and budget decisions in the coming year.

Director's Office

The division director's office in Juneau oversees a number of functions that 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:

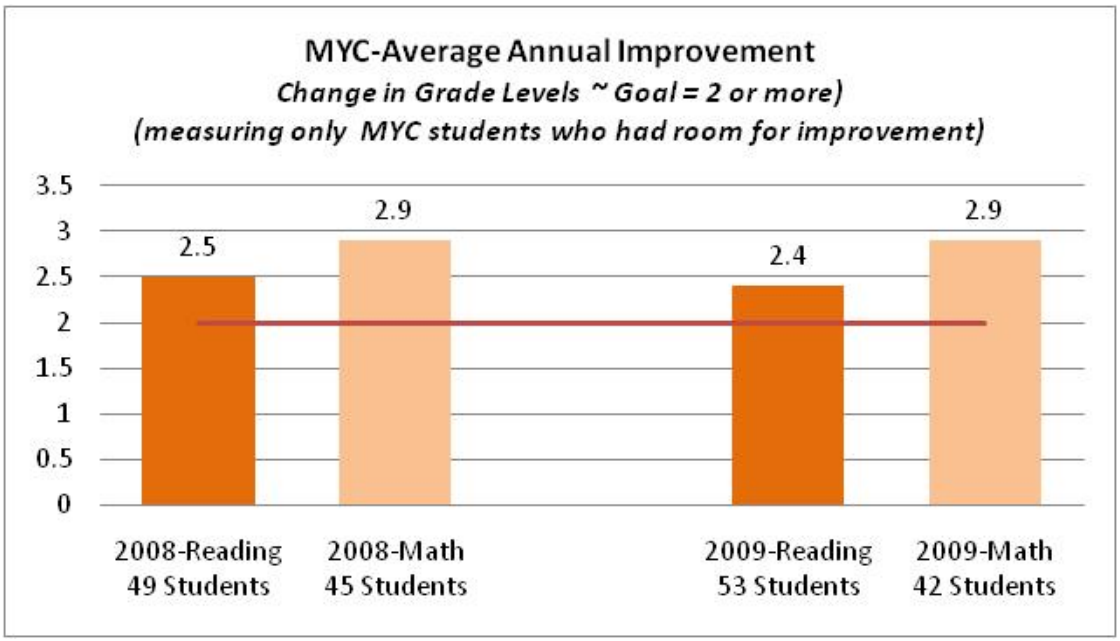
- *Grants Program Management*: Alaska, a participating state in the federal Juvenile Justice and Delinquency Prevention Act, receives approximately $1.3 million in federal funding annually. Each year, these funds help ensure that the state's juvenile justice system abides by the mandates of the Act. 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 by the administrative staff in the Director's Office.

The division is committed to developing partnerships with sister agencies to ensure that the needs of our youth are met and that state resources are fully utilized. 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.
- The division worked with the Anchorage School District and Nine Star Education and Employment Services to create the Step-Up Program, an educational program tailored to the needs of youth who have been previously expelled from school.
- The division's leadership is collaborating with the Department of Corrections to plan for needed renovations to both the Bethel Youth Facility and the Yukon Kuskokwim Correctional Center. Combining both renovations into one construction process will be a more efficient and therefore less expensive prospect for the State.

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 and FY09.



- 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 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 procedure to ensure no child fails to receive needed services because one or the other agency has custody of the child. A joint custody would be developed between the two agencies.
- The division is looking to expand referrals to the Youth Court program to youth involved with the Office of Children's Services. This will allow for a greater number of youth to be diverted from entering our system.
- The Department's Joint Management Team has been expanded to include the Division of Behavioral Health, Office of Children's Services, Division of Public Assistance, and the Division of Juvenile Justice. 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 (DBH) and the Mental Health Trust Authority and other organizations to work on the Comprehensive Integrated Mental Health Plan for the department.
- For the past several years, the DJJ has received funding from DBH to provide services related to Bring the Kids Home project. This has allowed for more family counseling sessions with families and follow-up with youth once they have been released.
- During FY09, DJJ collaborated with the Division of Behavior Health to assess substance abuse services in our juvenile facilities around the state. The resulting report provided observations and recommendations on screening, training, education, planning, and treatment services at the individual facilities and for Alaska's juvenile justice system as a whole.
- The division is part of the Families First program being developed within the department. This program looks at each youth that enters the system and determines if there are other Health and Social Services agencies they may be involved with. Rather than deal with these agencies individually, they will work with a team made up of representatives from each division to ensure the appropriate services are being provided.

- The Reclaiming Futures Project in Anchorage has been a successful collaboration with the court system and Volunteers of America.
- Since FY08, the division has been a part of the Criminal Justice Working Group that is currently co-chaired by The Honorable Supreme Court Justice Walter Carpeneti and Attorney General Dan Sullivan. 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.

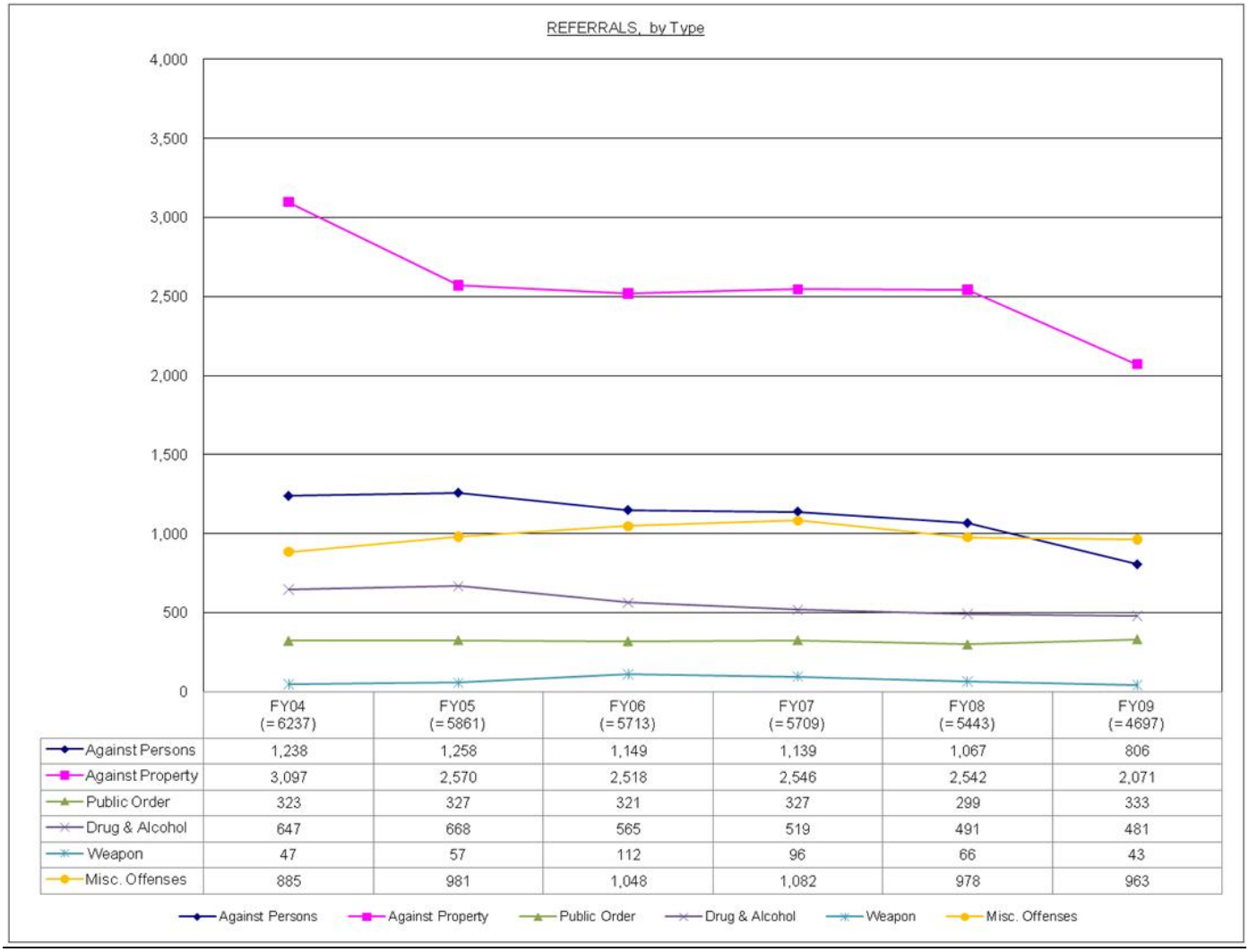
The division continues to incorporate the goals of its FY03 "system improvement initiative" into its routine practice. This initiative was launched to help guarantee that the Alaska juvenile justice system is using its resources effectively and efficiently, that decisions are based on objective criteria, and that the agency is continually using data to improve the quality of services offered. These initiatives include:

- The use of assessment instruments to assist staff in accurately determining a youth's risk of re-offense and need for secure detention;
- A quality assurance process to improve the safety and security of juvenile facilities;
- Improved use of juvenile facilities as a statewide resource for youth receiving secure treatment and those transitioning back to their home communities;
- 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.

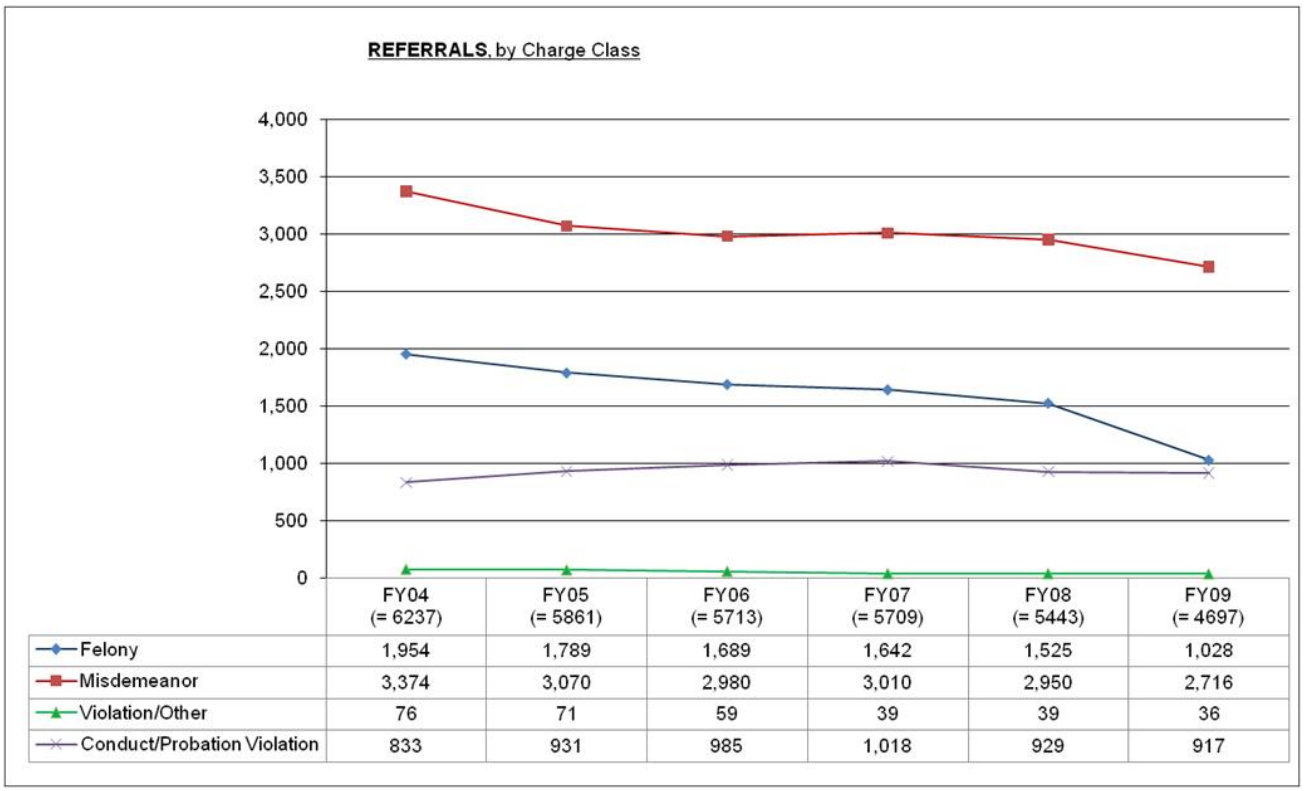
In FY11, the division's leadership will continue to incorporate these system improvement projects into the strategic plan and vision for juvenile justice in Alaska. The system improvement projects will improve public safety, and ensure that victim needs are met and offenders are being held accountable.

FY09 Delinquency Referral Summaries

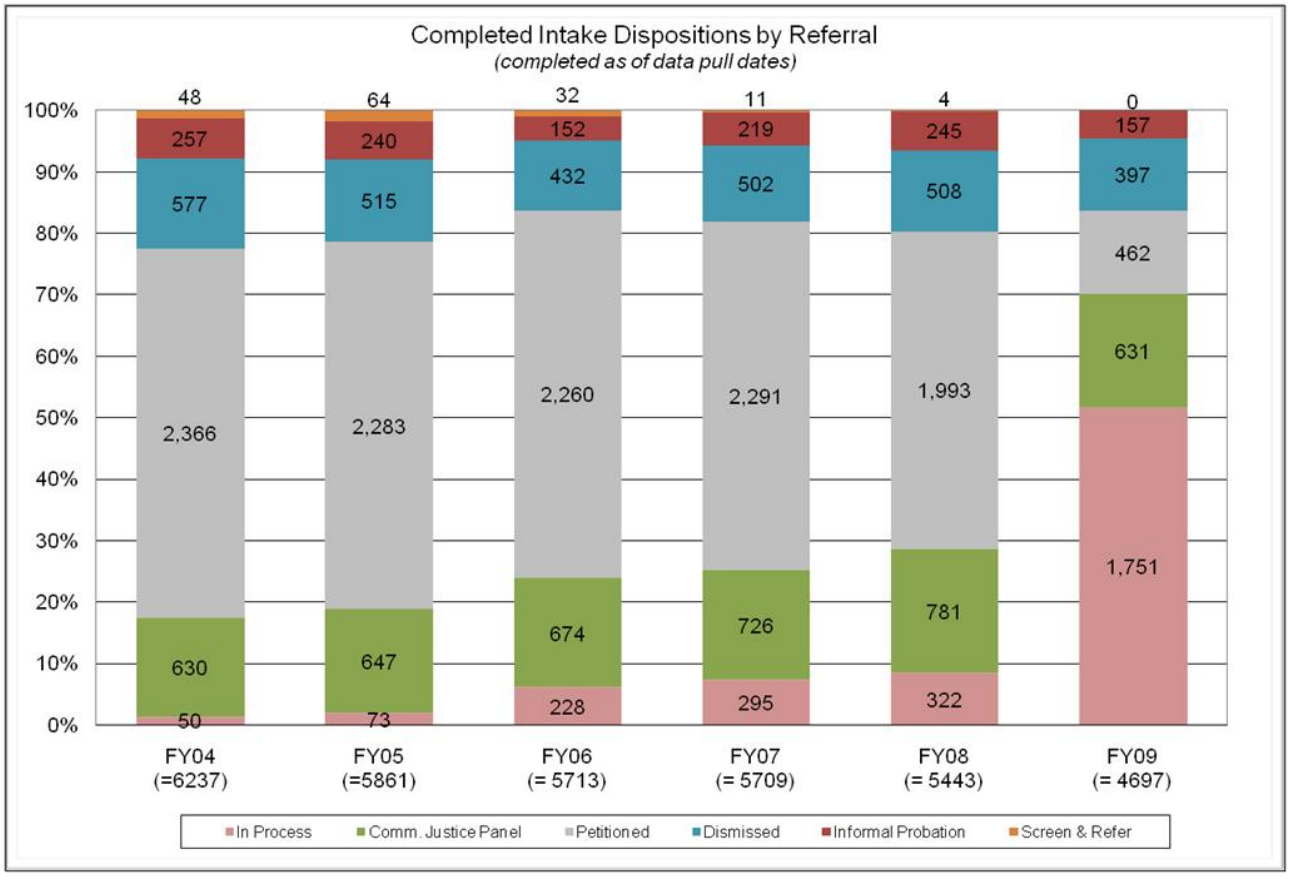
The following charts provide a summary of referrals for FY04 to FY09.

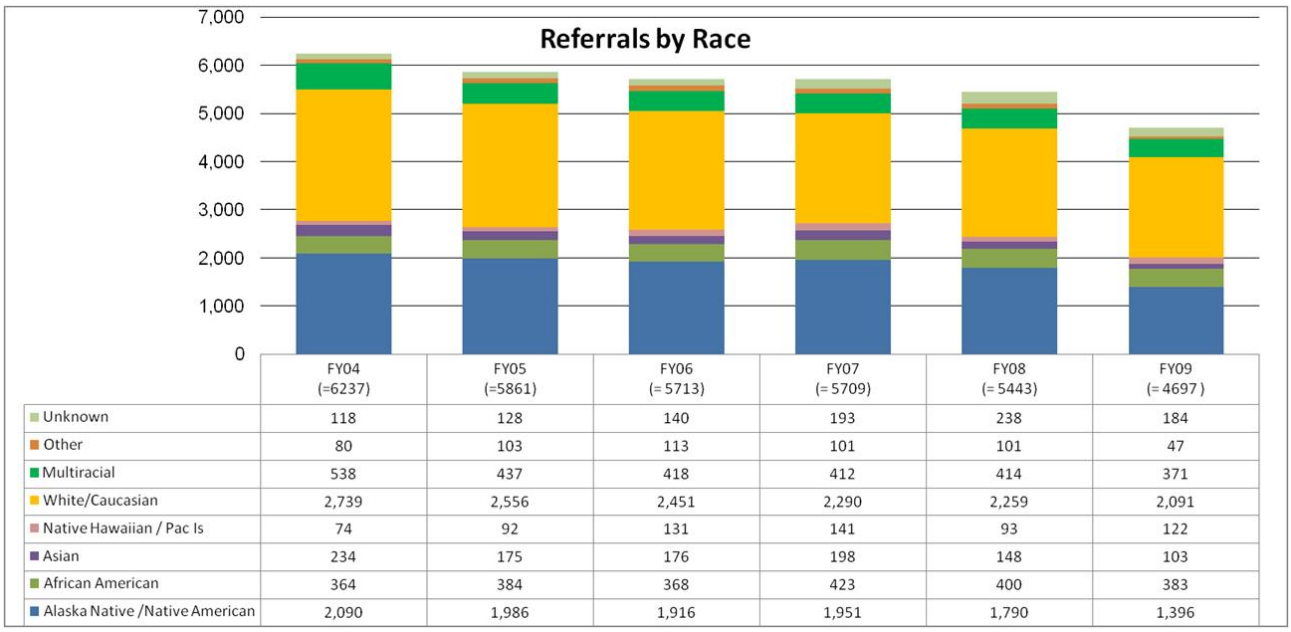


	FY04 (=6237)	FY05 (=5861)	FY06 (=5713)	FY07 (=5709)	FY08 (=5443)	FY09 (=4697)
Against Persons	1,238	1,258	1,149	1,139	1,067	806
Against Property	3,097	2,570	2,518	2,546	2,542	2,071
Public Order	323	327	321	327	299	333
Drug & Alcohol	647	668	565	519	491	481
Weapon	47	57	112	96	66	43
Misc. Offenses	885	981	1,048	1,082	978	963

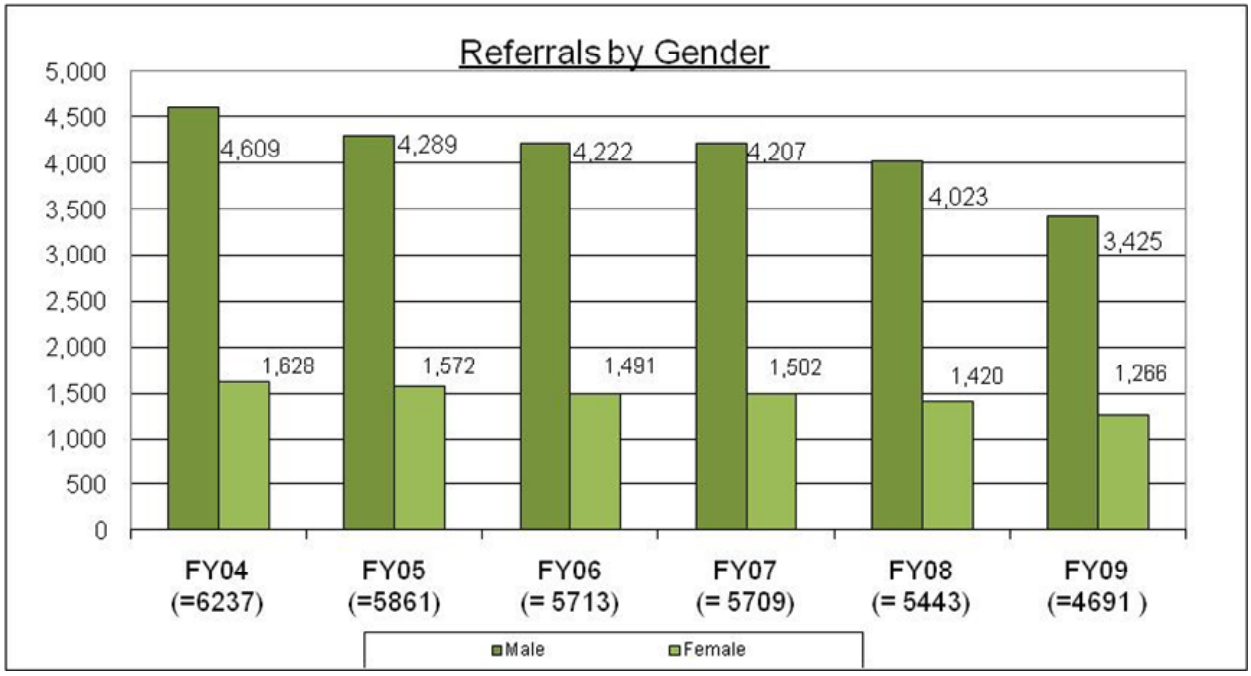


	FY04 (= 6237)	FY05 (= 5861)	FY06 (= 5713)	FY07 (= 5709)	FY08 (= 5443)	FY09 (= 4697)
Felony	1,954	1,789	1,689	1,642	1,525	1,028
Misdemeanor	3,374	3,070	2,980	3,010	2,950	2,716
Violation/Other	76	71	59	39	39	36
Conduct/Probation Violation	833	931	985	1,018	929	917





	FY04 (=6237)	FY05 (=5861)	FY06 (= 5713)	FY07 (= 5709)	FY08 (= 5443)	FY09 (= 4697)
Unknown	118	128	140	193	238	184
Other	80	103	113	101	101	47
Multiracial	538	437	418	412	414	371
White/Caucasian	2,739	2,556	2,451	2,290	2,259	2,091
Native Hawaiian / Pac Is	74	92	131	141	93	122
Asian	234	175	176	198	148	103
African American	364	384	368	423	400	383
Alaska Native /Native American	2,090	1,986	1,916	1,951	1,790	1,396



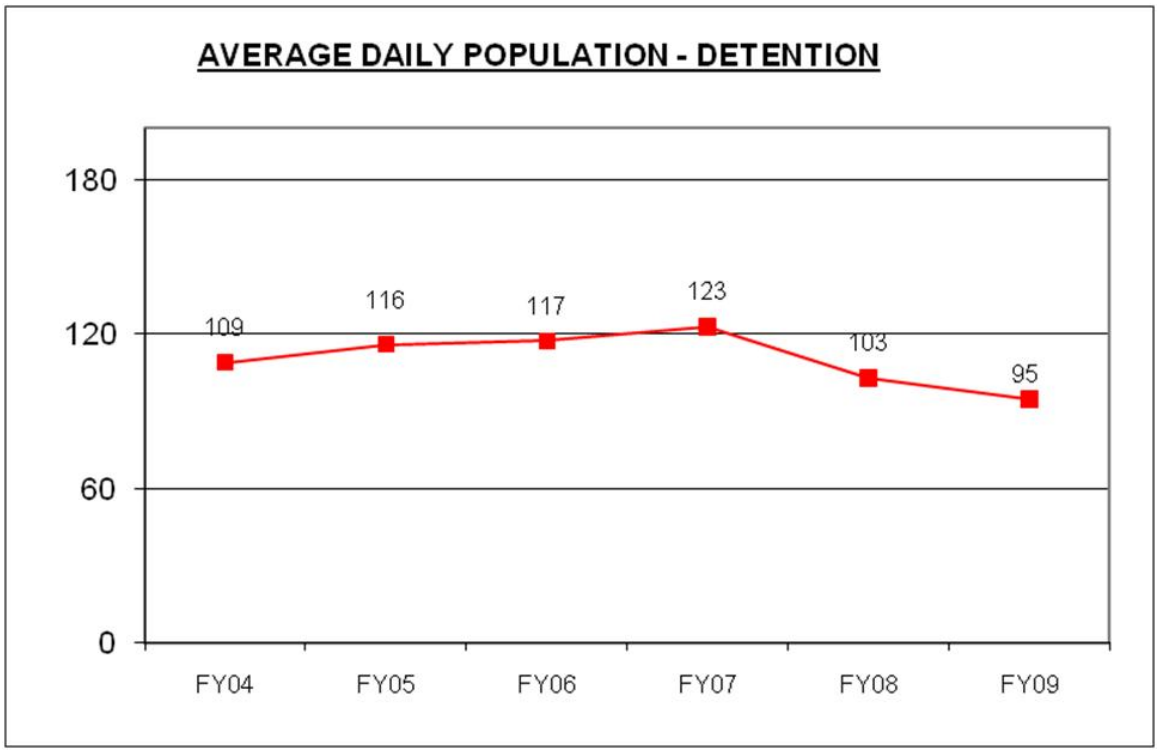
The table below shows the bed capacity at each of the division's secure juvenile facilities. During FY09 McLaughlin Youth Center (MYC) evaluated the way they counted beds. The overall number was reduced by six.

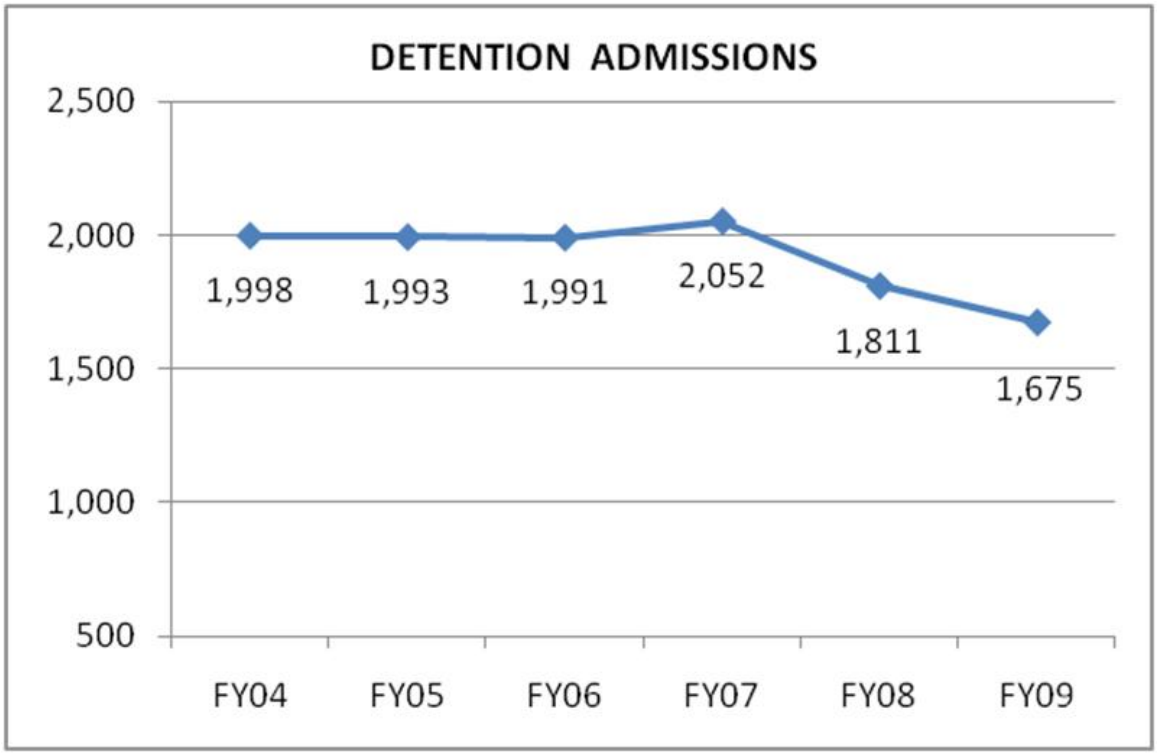
Youth Facility Existing Hard Bed Capacity FY10			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	166	-6	160
Mat-Su Youth Facility	15		15
Kenai Peninsula Youth Facility	10		10
Fairbanks Youth Facility	39		39
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Johnson Youth Center	30		30
Ketchikan Youth Facility	10		10
Total	302		296

Facility Data

Detention Units

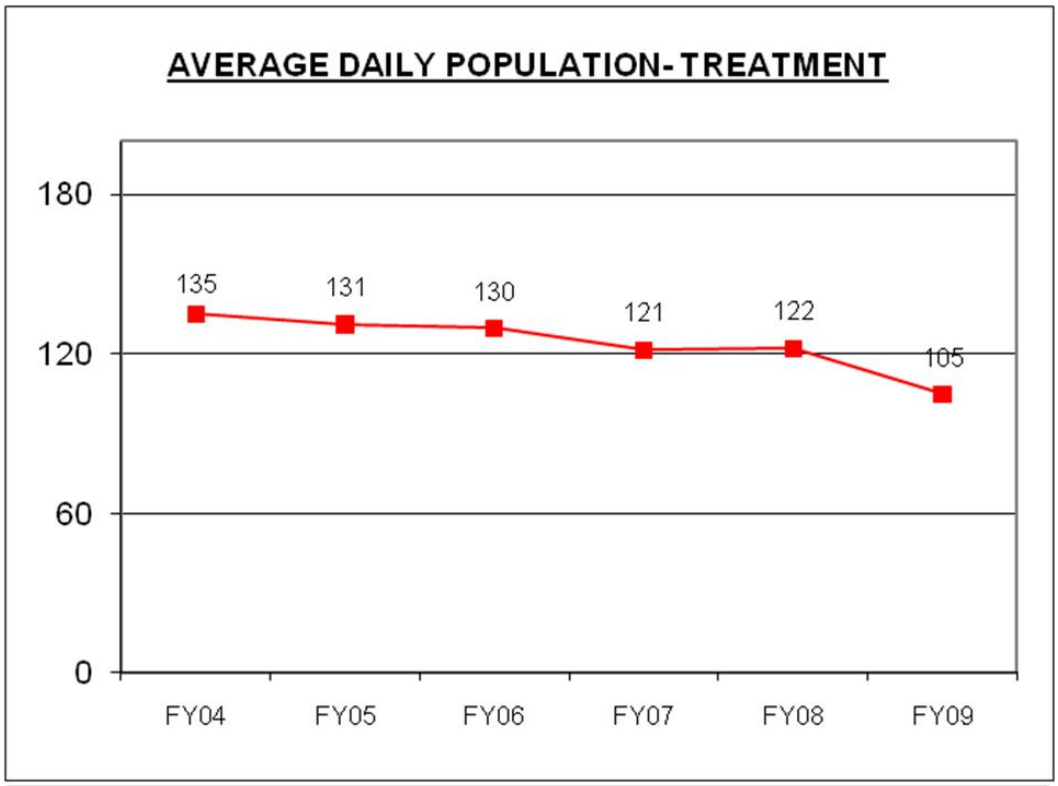
The charts below show juvenile detention average daily population and admissions from FY04 through FY09. Detention units are designed as short-term secure units for youth who are awaiting court hearings and other determinations of outcome on their offenses. Statewide detention capacity in FY09 was 143 beds.

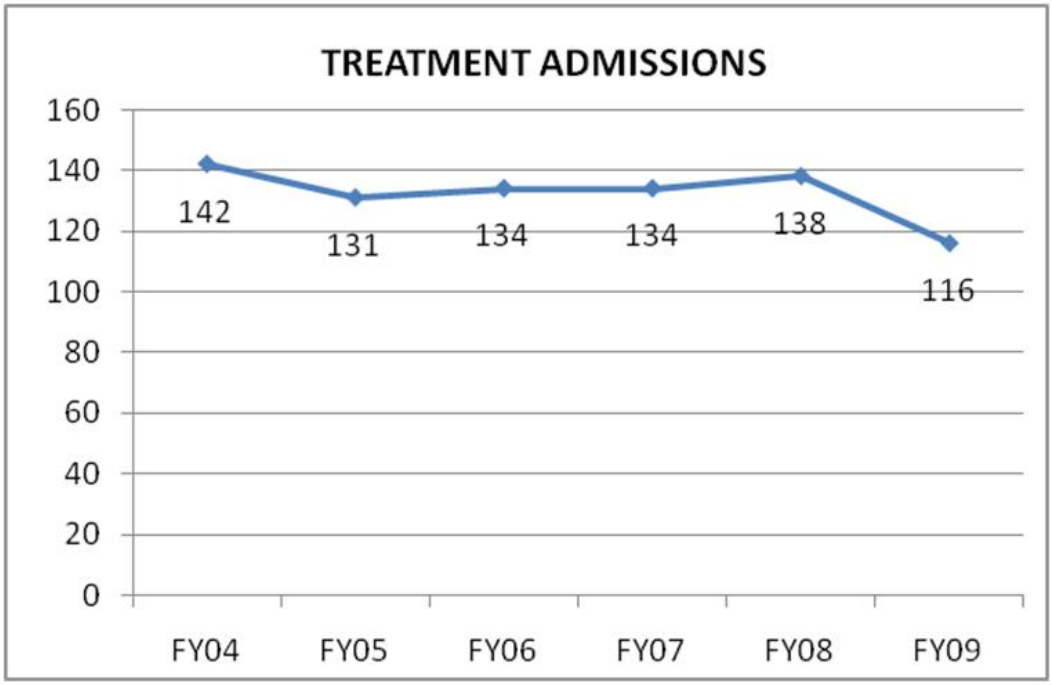



DETENTION ADMISSIONS
2,500
2,000
1,500
1,000
500
1,998
1,993
1,991
2,052
1,811
1,675
FY04
FY05
FY06
FY07
FY08
FY09

Treatment Units

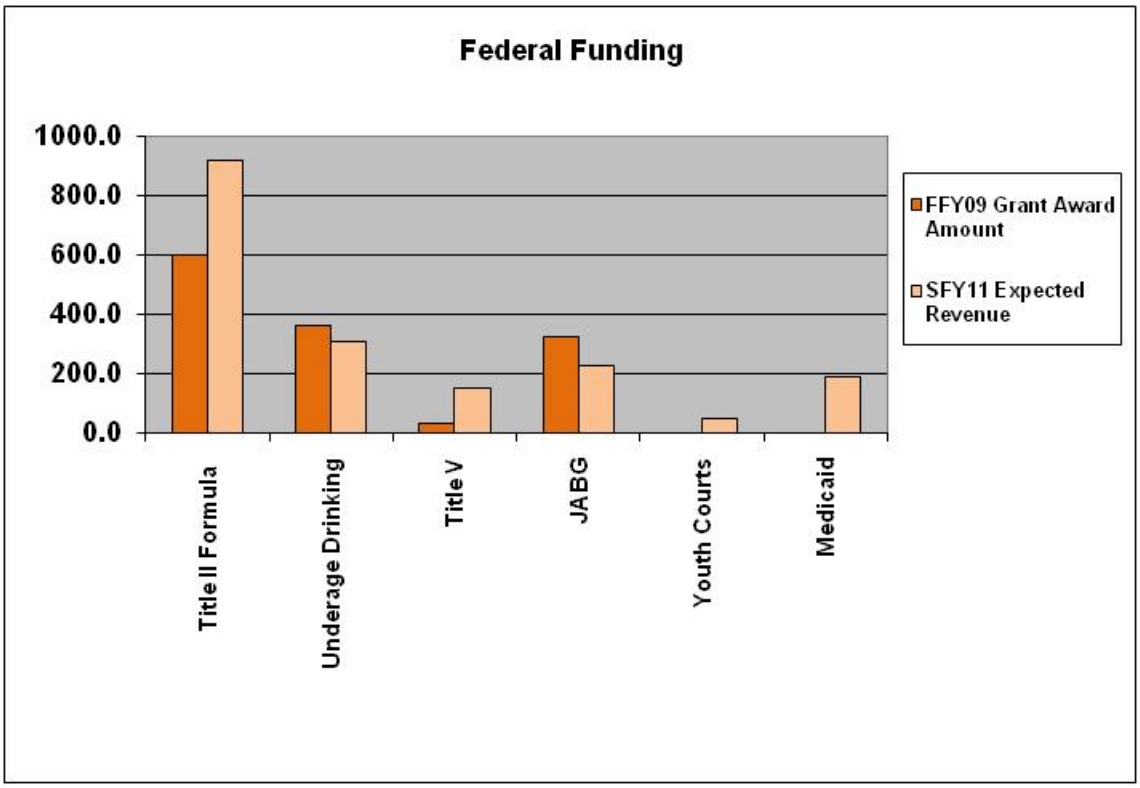
Below are charts showing juvenile program average daily population and admissions from FY04 through FY09. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY09 was 149, excluding the 4 unlocked crisis stabilization 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 the Division of 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 FFY09 grant programs and budgeted revenues for FY11. Note that in some cases the budgeted revenue exceeds the award amounts. This is due to a carry forward from previous years of various grant awards.



List of Primary Programs and Statutory Responsibilities

AS 09.35 Execution
AS 11.81 General Provisions
AS 12.25 Arrests and Citations
AS 12.35 Search and Seizures
AS 25.27 Child Support Enforcement Agency
AS 47.05 Administration of Welfare, Social Services and Institutions
AS 47.10 Children in Need in Aid
AS 47.12 Delinquent Minors
AS 47.14 Juvenile Institutions
AS 47.15 Uniform Interstate Compact on Juveniles
AS 47.17 Child Protection
AS 47.18 Programs and Services Related to Adolescents
AS 47.21 Adventure Based Education
AS 47.30 Mental Health
AS 47.35 Child Care Facilities, Child Placement Agencies, Child Treatment Facilities, Foster Homes, and Maternity Homes
AS 47.37 Uniform Alcoholism and Intoxication Treatment Act

7 AAC 52 Juvenile Correctional Facilities and Juvenile Detention Facilities
7 AAC 53 Social Services
7 AAC 54 Administration
7 AAC 78 Grant Programs

Alaska Delinquency Rules
Alaska Rules of Civil Procedure
Alaska Rules of Criminal Procedure

Juvenile Justice	FY10	FY11 Gov	10 to 11 Change
General Fund	48,470.3	48,481.6	11.3
Federal Fund	3,010.3	2,406.2	(604.1)
Other Funds	1,091.5	1,099.5	8.0
Total	**52,572.1**	**51,987.3**	**(584.8)**

The division is statutorily mandated to protect the public, hold juvenile offenders accountable, restore victims and communities, and develop offender competencies to reduce the likelihood of re-offense. A balanced and restorative justice approach to services and programming ensures that juvenile offenders take personal responsibility for repairing the harm caused to victims and communities.

McLaughlin Youth Center

MH Trust: Disability Justice- 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 Trust's Disability Justice Focus Area plan by ensuring mental health treatment is provided while a youth is in secure custody and ensuring mental health needs are addressed as an important component of each youth's transition back into the community.

The goal for FY11 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.

Fairbanks Youth Facility

Reduce Federal Authority Due to the Completion of the Re-Entry Grant Initiative: *($54.1) Fed*
Reduce federal authority in this component due to the completion of the Re-Entry Initiative federal grant. The non-perm position (06-N08074) funded by this grant will be deleted.

Bethel Youth Facility

New On-Call Nurse II Position (PCN 06-N09180): *$0.0 GF*
This position was created to provide on-call services to the Bethel Youth Facility's nursing position for times the incumbent is on leave or out of the office for other matters. This position (PCN 06-N09180) was approved by the Division of Personnel on 9/29/09.

ADN 06-0-0090 New Juvenile Justice Officer II On-Call Non-Perm (PCN 06-#593): *$0.0 GF*
In accordance with Letter of Grievance Resolution (LGR) 08-G-294, the division was required to add a Juvenile Justice Officer II on-call non-permanent position to each of the facility components to ensure appropriate pay for on-calls that need to be called in to do Juvenile Justice Officer II level of work. Funding for this position is available through savings in premium pay to regular full-time employees that would otherwise be needed to fill the gap.

Nome Youth Facility

Status Change from Part-Time to Full-Time for Nurse II Position: *$0.0 GF*
The Division of Juvenile Justice would like to request a status change for the Nurse position in Nome from part-time to full-time. Nursing needs are not being met through a half-time position. Adequate nurse oversight and review is critical for immediate consultation on injuries and the normal illnesses that afflict adolescents. By making the position full-time, the division can ensure that there is a method of recording entries in the health record and in the formatting of the health record approved by the health authority. The nurse will assist with the management of chronic disease, infirmary care, suicide prevention, assisting staff when a youth comes into the facility intoxicated or going through withdrawals, development of procedures in the event of a sexual assault, management of terminal illness, and management of distribution of medications. This position will assist with health promotion and disease prevention by providing classes on health nutrition, medical diets, exercise, obesity, personal hygiene and tobacco use to clients at the facility.

The division will absorb the increased cost of making this position full-time.

Johnson Youth Center

Reduce Federal Authorization Due to Completion of the Federal Re-Entry Initiative Grant: *($50.0) Fed*

Reduce federal authority in this component due to the completion of the Re-Entry Initiative federal grant. The non-perm position (06-N08089) funded by this grant will be deleted.

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Probation Services

Make Diversion Intake unit Non-Perm Position a Full-Time Permanent Position: *$0.0 GF*
The Division of Juvenile Justice has had a long-term, non-permanent Juvenile Probation Officer position (06-N09090) as part of the Diversion Intake Unit that has worked with the Municpality of Anchorage's Making a Different Program for several years. If the Legislature approves the continuation of this preventive measure that works to keep youth from entering more deply into the juvenile justice system, the non-perm position that has been part of that unit should become

permanent with the secure funding. This change record will make that position, 06-#0684, permanent beginning with the FY11 budget year.

Replace SDPR Receipts from the Municipality of Anchorage: *($142.0) SDPR, $142.0 GF*
Due to budget constraints, the Municipality of Anchorage is no longer able to continue to help fund two Division of Juvenile Justice positions that have been part of the "Making a Difference Program" in that area. Yet it is critical that this program continue because Anchorage needs these services. The “Making A Difference” positions have significantly improved juvenile services in Anchorage through:

~ Faster responses. Before the addition of the three officers through the “Making A Difference” program, the Anchorage office had difficulty responding to reports from law enforcement in a timely fashion. First-time offenders or those committing minor misdemeanors often were not addressed for weeks or until they reoffended with a more serious crime. Thanks to the additional officers, juvenile offenders now typically are brought into the office and interviewed within a week of the report being received from law enforcement.

~ More thorough responses. The Intake Unit at Anchorage Juvenile Probation receives, investigates, and resolves approximately 2,000 law enforcement referrals each year. Before the addition of the “Making A Difference” officers, first-time offenders or those committing minor misdemeanors often were not handled for weeks or until they reoffended with a more serious crime. Now, no legally sufficient behaviors within our scope are overlooked. All offenders can be held accountable and responded to as appropriate, given the seriousness of the offense and the risks and needs of the juvenile.

~ Better public service. Anchorage is the only city in the state where juvenile probation officers are available seven days a week. This is made possible by the “Making A Difference” program; the additional staffing enables supervisors to schedule officers on evenings and weekends to work with police, agency partners, and especially parents and families. Parents can arrange appointments at convenient times, increasing the likelihood that they will be involved in the juvenile justice process and assist in holding juveniles accountable. Having these staff available also means the division is able to provide “courtesy visits” and consultations with parents seeking counsel and assistance in managing children who are posing behavioral challenges but who have not as yet committed any delinquent acts. Probation staff are often able to coordinate these consultations with community-based officers of the Anchorage Police Department, increasing the involvement and investment of families and the community in helping young people succeed.

~Better public safety. The juvenile probation officers of the “Making A Difference” program concentrate their efforts on first-time offenders and those committing less-serious misdemeanors. They work closely with Anchorage Youth Court, the Alaska Native Justice Center, and other community partners to ensure that youth receive the services that will successfully divert them from deeper penetration into the juvenile justice systems. They are able to keep close watch on the youth on their caseloads to ensure that they meet the expectations of their diversion plan (e.g., paying restitution, completing community work service, participating in anger management training). When juveniles don’t follow through on these commitments, our probation officers are able to step in quickly and encourage these youth to get back on track. Without this surveillance and encouragement these juveniles would simply have their cases closed, would meet with no

consequences for failing to repair the harm they've done, and might be encouraged to continue committing offenses.

If this program is not replaced with general fund dollars, these services will no longer be provided in the Anchorage community. Less timely and thorough responses to juvenile offenders in Anchorage could be expected as a result.

Reflect RSA from Department of Labor for Workforce Investment Act Grant: *$150.0 I/A*
Increase I/A authority within the Probation Services component to allow for receipts from the Department of Labor and Workforce Development for the Workforce Investment Act grant the division has received for the past several years. This authority will eliminate the need for an unbudgeted RSA each year.

The Workforce Investment Act (WIA) funds provides the division with resources to prepare youth in the juvenile justice system with job skills so once they leave secure facilities they have tools in hand to obtain and maintain employment. Currently, funds are being used to support a culinary arts program at the Johnson Youth Center in Juneau which includes a job readiness section (job search, interview practice and resume writing). WIA funds also support the staff from the Nome Boys and Girls Club to visit the Nome Youth Facility to conduct three programs including Job Ready (youth also visit the Alaska Job Center Network office), Passport to Manhood and Power Hour to assist youth in completing their education requirements.

Delete Non-Perm Positions at the Nome Probation Office and the Fairbanks Probation Office: *$0.0 GF*
PCN 06-N07038 was created to supplement staff at the Nome Probation office to assist the office with intakes, supervision of clients and escorts while new staff were being training. This non-perm position is no longer needed and should be deleted with the FY11 budget.

PCN 06-N08060 was created when the division received the Gang Prevention Grant from the Office of Juvenile Justice and Delinquency Prevention. Because the grant ends in mid-FY10, the position will no longer be funded and needs to be deleted with the FY11 budget.

Delinquency Prevention

Delete Unrealizable Federal Authorization: *($500.0) Fed*
The Delinquency Prevention Component has excess federal authority that ends up being deferred each year. This change record brings the component more in line with anticipated federal expenditures.

Johnson Youth Center: *$9,880.0 GF*
The current structures on the Johnson Youth Center campus are an eclectic mix of old and new structures. They include an adaptive re-use 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.

The Johnson Youth Center request is part of a long-term plan to address safety and security deficiencies in the division's four oldest youth facilities. The plan was completed in 2008 to address these needs over a six year period, starting with FY09. In FY09, the division received $19.5 million for Phase I of McLaughlin Youth Center renovations. It is the division's goal to acquire the necessary funding over time to address projects at each of the youth facilities.

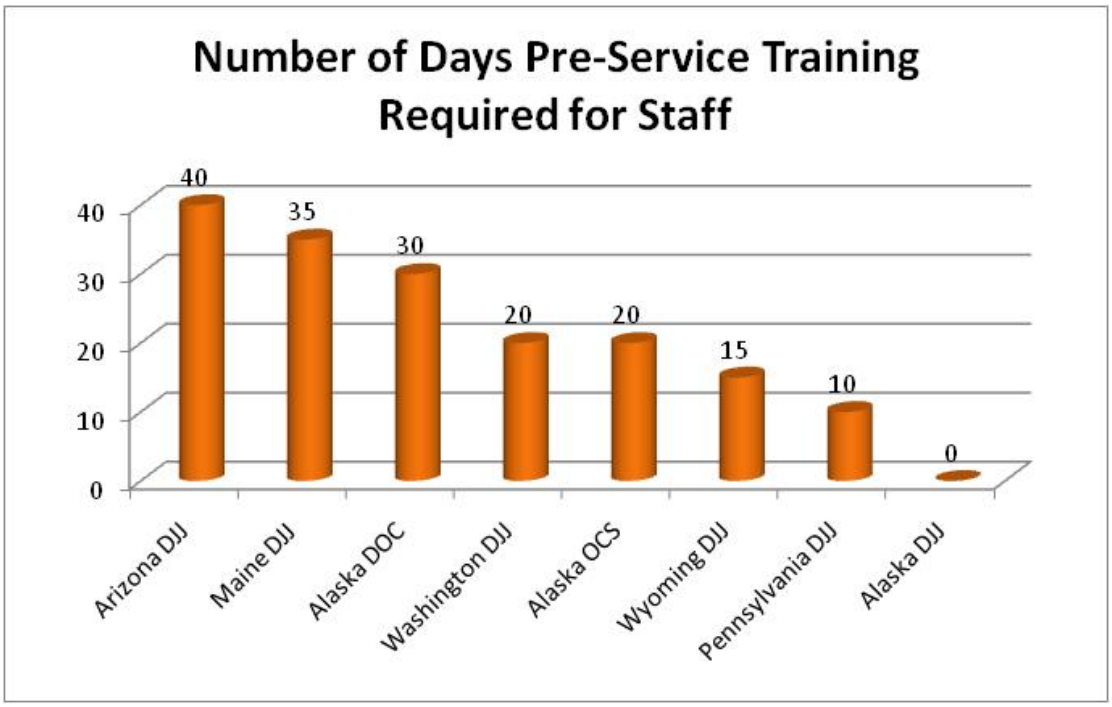
Challenges

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.

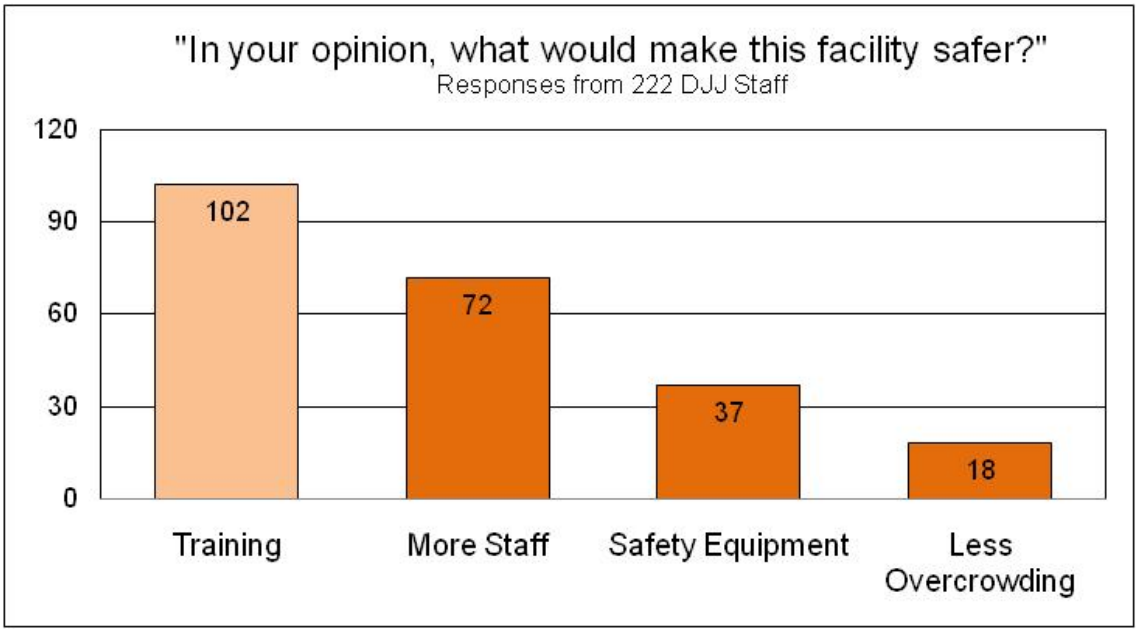
In FY09 the division applied for and received federal technical assistance through the U.S. Office of Juvenile Justice and Delinquency Prevention for national experts in quality assurance and juvenile justice training to look critically at Alaska's juvenile justice system and determine its needs in these areas. In early FY10 these consultants finalized their reports to the division.

The quality assurance technical assistance demonstrated that the division needs to more thoroughly integrate its risk/needs assessment process into the case management of juveniles. The division adopted a new risk/needs assessment instrument in 2005, but has yet to conduct any significant quality assurance review on the tool to make sure it is being used correctly by staff, and that case management efforts are flowing sensibly from the assessment results. The lack of quality assurance surrounding the assessment and quality assurance processes is a significant concern for the division and may be the division's most significant need.

The technical assistance regarding training confirmed what staff have long suspected: that the division's current statewide training capabilities are not adequate to meet the needs of a large agency (approximately 450 employees) charged with both protecting the public and helping youth develop into productive citizens. The Division of Juvenile Justice has just a single employee devoted to statewide training and no formal, statewide pre-service training program for new staff. This contrasts sharply with other agencies and states with regard to the training they offer new staff. 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.



The need for adequate training was further demonstrated in staff responses to a staff climate survey conducted in October 2009 as part of the Performance-based Standards process. The question, "In your opinion, what would make this facility safer?" was posed to our facility staff. Training was the number-one need identified by the 222 employees who responded. The next need identified was more staffing.



A similar survey of 57 staff who work 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.

While the division is very proud of the quality assurance and training that it has been able to do with very little resources, our efforts have not kept pace as the division has adopted higher expectations for quality control, the use of evidence-based practices, and data-driven decisions. As long as the division is unable to conduct adequate quality assurance and provide adequate training for staff we will not be able to ensure that our programs and efforts are effective for the youth, families, and communities we serve.

Recruitment and Retention:
This past year was marked by particularly low turnover among division line staff. Low staff turnover has both costs and benefits for the division. While low staff turnover means that fewer resources and energy need to be devoted to recruiting, training, and closely supervising new staff, low staff turnover also has the effect of costing the division *more* money because long-time staff are not being replaced by lower-paid, new staff. Fewer vacancies mean that there are fewer periods where positions are held open and salaries are not being paid. Increases in pay for longevity, plus increased pay rates for non-permanent employees and those earning premium pay, are forcing our division to make up for its shortfall by no longer budgeting at a zero vacancy rate for its facility components. In the past, the probation component has had enough vacancies to result in savings that could make up for the shortfall in other components, but this year, because probation also is carrying low numbers of vacancies, this is not going to be possible. The division's only recourse is to require any vacancies that do occur remain unfilled still longer to save money. This in turn results in a lack of services, particularly in our rural areas, which jeopardizes public safety and increases the potential for juvenile delinquency to go unaddressed.

While turnover in line staff has been low, retirement of longtime, upper-management staff continues and poses its own set of challenges as institutional knowledge and experience are lost. The division's director and the deputy director of operations, as well as key administrative and maintenance staff in Anchorage, plan to retire by the end of this fiscal year. The division also continues to experience problems recruiting staff in the rural areas. For example, the superintendent position at the Ketchikan Regional Youth Facility has remained vacant for over two years. The position was recruited for several times in FY08, FY09 and again in FY10. We have recently worked with the Department of Administration, Division of Personnel to revise the minimum qualifications with the hope of attracting more qualified candidates to this position.

The division is determined to increase the number of minority staff who work in our agency to better reflect the population that we serve. In particular, we would like to see more individuals from minority groups ascend into management and leadership positions. The division is addressing this issue on several fronts, including leading an inter-departmental work group on work force development and searching out opportunities to encourage minority individuals, particularly Alaska Natives, to take an interest in juvenile justice as a career with the state.

The division also is determined to enhance interest in juvenile justice careers more generally. A recent Youth Court conference in Kenai demonstrated the high degree of interest in justice-related careers among high school-age students. The division would like to maintain its relationships with these young people after they leave high school and pursue their careers, to

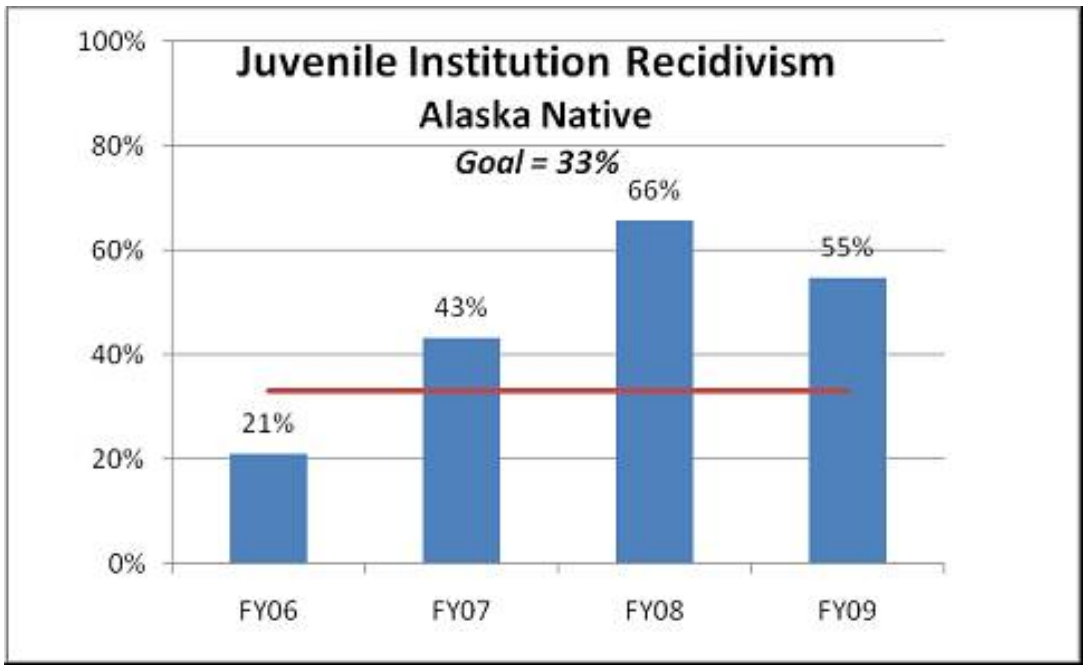
remind them they can combine their interests in public safety, law, justice, and youth development into a satisfying career through juvenile justice.

Alternatives to Detention: The division continues the effort to develop alternatives to detention resources based on local need. This is a critical component of the division's overall system improvement plan, to ensure that sufficient community-based resources are available in order to prevent "default" use of secure detention resources. The division intends to seek technical assistance from the U.S. Office of Juvenile Justice and Delinquency Prevention that will help us better utilize detention and alternatives as effective, graduated responses.

Substance Abuse Data Collection: The division recognizes that there is a high rate of mental health issues that are directly related to substance abuse, and we are continuing to collect data that will help us understand the details behind co-occurring disorders, and in turn make more informed and better decisions on the management of youth who have them. The division has identified the need to work with law enforcement more closely to ensure that substance abuse is identified, when present, in police and trooper reports, and the division needs to do a more thorough job entering this information in case records. Our ultimate goal is for every youth who comes to our attention to be screened for substance abuse and mental health concerns and be referred as indicated to adequate treatment services no matter where they live in Alaska. During FY09, DJJ collaborated with the Division of Behavior Health to assess substance abuse services in our juvenile facilities around the state. The resulting report provided observations and recommendations on screening, training, education, planning, and treatment services at the individual facilities and for Alaska's juvenile justice system as a whole. The division will seek collaboration with other departmental partners and community-based agencies as much as possible to realize the recommendations of this report.

Facility Maintenance and Office Space Shortages: In the summer of 2007, a study was commissioned to identify significant safety and security needs within the four oldest facilities. The study has recommended renovations at each of the four facilities. The department's plan for addressing these safety and security needs spans a six-year period. The first of four phases for the McLaughlin Youth Center renovation was approved with the FY09 capital budget. The division is working to obtain funding for Phase I for Johnson Youth Center in FY11, 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.

Recidivism as a Performance Measure versus a Management Tool: Recidivism—the re-offense rates of juveniles after they've come to our attention and received our services—is a critical indicator of the division's success in meeting its mission. The division has long studied recidivism rates among its juvenile treatment and probation populations and is now witnessing heightened interest in recidivism measures on both the state and national levels. Consistent definitions of recidivism that allow better comparisons between jurisdictions and over successive time periods are likely to be one outcome of this heightened focus.

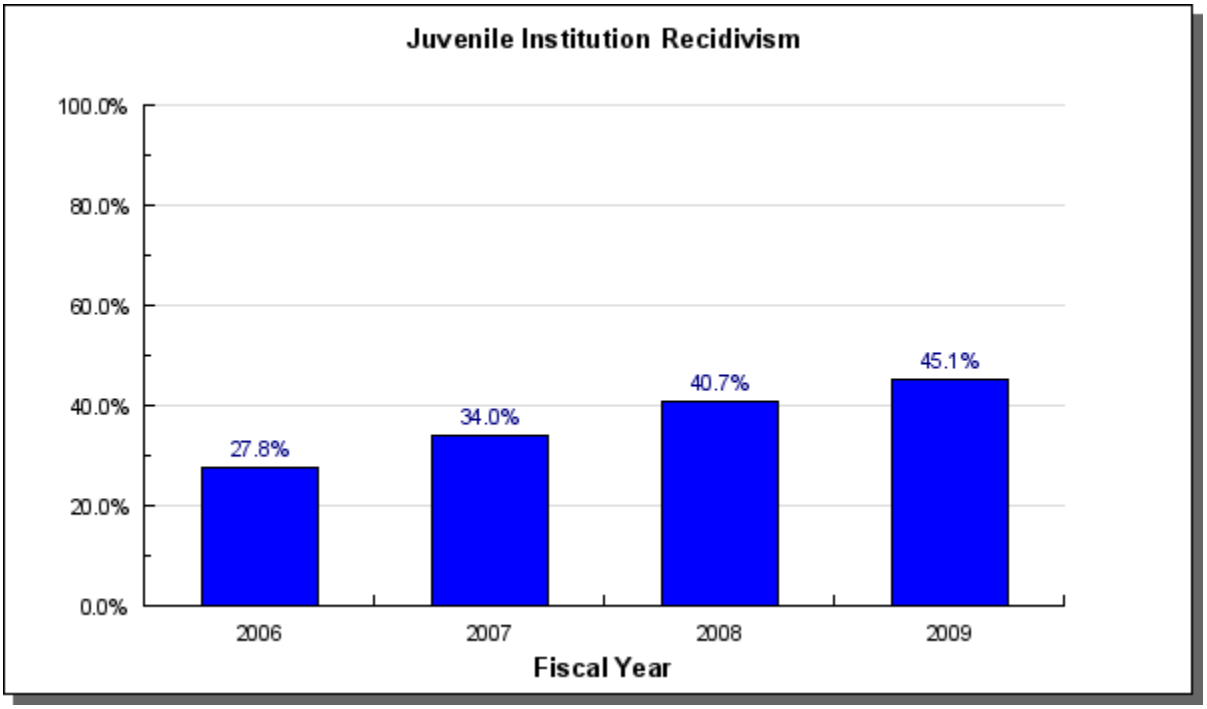


The Division of Juvenile Justice is poised to gain in-depth understanding of the reasons why juveniles succeed or reoffend, thanks to several initiatives which have been launched over the past few years. The division's Juvenile Offender Management Information System was launched in 2003 and significantly renovated in 2009 to better meet the division's need for high quality data. The implementation of programming such as Aggression Replacement Training, Strength-based Practices, and Cognitive-Behavioral Interventions Training promise to help reduce recidivism rates, based on national experience. Most important was the implementation in 2005 of a new assessment tool, the Youth Level of Service/Case Management Inventory (YLS/CMI). This instrument was designed for the very purpose of determining a youth's likelihood to reoffend, and helps guide staff in determining the areas of a youth's life—family circumstances, substance abuse, education, behavior, attitudes, use of leisure, peers—that must be addressed if the youth is to lead a more productive life. On a statewide level, summarizing YLS/CMI results for whole populations of juveniles will help the division better understand its resource needs. For example, if poor family circumstances are a consistent finding among juveniles who reoffend, the division will know that improved family counseling, coaching, and other therapeutic services are a priority need and deserve more effective resources, and will work with its partners in both the nonprofit social services sector as well as within the Department of Health of Social Services to meet this need. Ultimately, the division thinks that the instrument will guide development of resources such that each community will have ways to address and prevent the factors that result in juvenile delinquency and victimization.

A: Result - The ability to hold juvenile offenders accountable for their behavior is improved.

Target #1: Reduce percentage of juveniles who reoffend following release from institutional treatment facilities to less than 33%.

Status #1: The defined recidivism rate for juveniles released from secure treatment in FY07 and followed up in FY09 was 45.1%.



Juvenile Institution Recidivism

Fiscal Year	YTD Total
FY09	45.1%
FY08	40.7%
FY07	34%
FY06	27.8%

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.

The recidivism rate for juveniles released from Alaska's secure treatment institutions has increased over the past few years. The definitions and procedures for measuring recidivism were set by the division in 2006. The increase may not be significant given that the percentage changes in recidivism in fact represent small numbers of youth. For example, in FY07, a total of 113 juveniles were released from secure treatment institutions. Nevertheless, the gradual increase in recidivism among this population is enough cause for concern that the division has formed a work group to closely examine the factors that contribute to recidivism and make recommendations for change. The division is devoting particular attention to the high rate of recidivism noted among Alaska Native juveniles, and is working to improve its understanding of and practices with these youths.

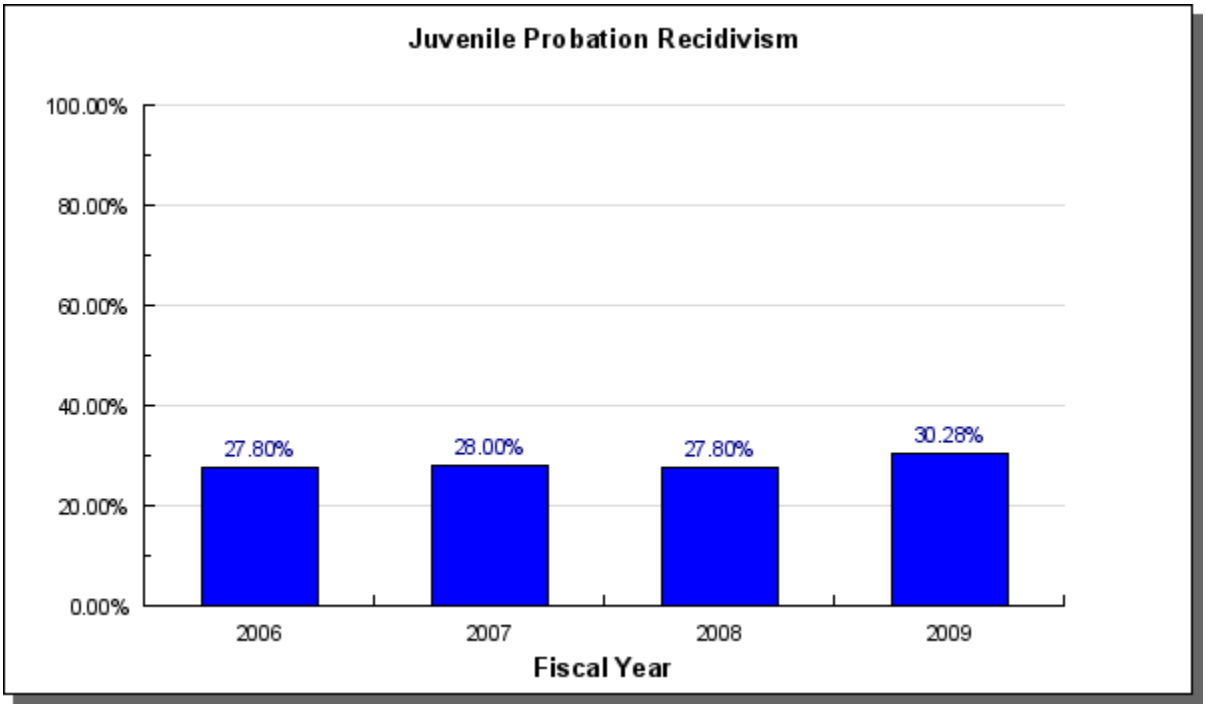
Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. Sixteen of the 32 states that track recidivism, do so on a 12-month basis. Among the eight states (including Alaska) that measure recidivism based on 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, the average recidivism rate was 33% (Source: Juvenile Offenders and Victims: 2006 National Report," National Center for Juvenile Justice, Pittsburgh, page 234). This number serves as the baseline goal from which Alaska works to improve its recidivism rate. This "national" recidivism rate of 33% is very similar to the average recidivism rate over the three prior years in Alaska. In FY09, this average was 34%, based on institutional recidivism rates of 40.7% in FY08; 34.0% in FY07; and 27.8% in FY06.

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

Note: Reoffenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database and the Alaska Public Safety Information Network (APSIN). Juveniles are included in this measure if the reason for their release from the treatment facility is marked in JOMIS as "Completion of Treatment," "Court-Ordered Release," "Order Expired," "Sentence Served," "Transfer (Transitional Services Step Down)," or "Transfer to a Non-DJJ Facility." 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 juvenile institutionalization order. For this FY09 report, adjudication and conviction information on offenses that were committed 12 months after release by juveniles must have been entered in JOMIS or APSIN by August 1, 2009. 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 the average rate in the three prior years (27.9%).

Status #2: The defined recidivism rate for the probation population was 30.28%, a percentage similar to that identified in the previous two years.



Juvenile Probation Recidivism

Fiscal Year	YTD Total
FY09	30.28%
FY08	27.8%
FY07	28%
FY06	27.8%

Analysis of results and challenges: This measure examines reoffense 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.)

The recidivism rate among the population of juveniles released from formal supervision in FY07 appears similar to the rates identified in previous years. Nevertheless, the division is exploring the reasons that some juveniles in Alaska recidivate and will continue to work toward

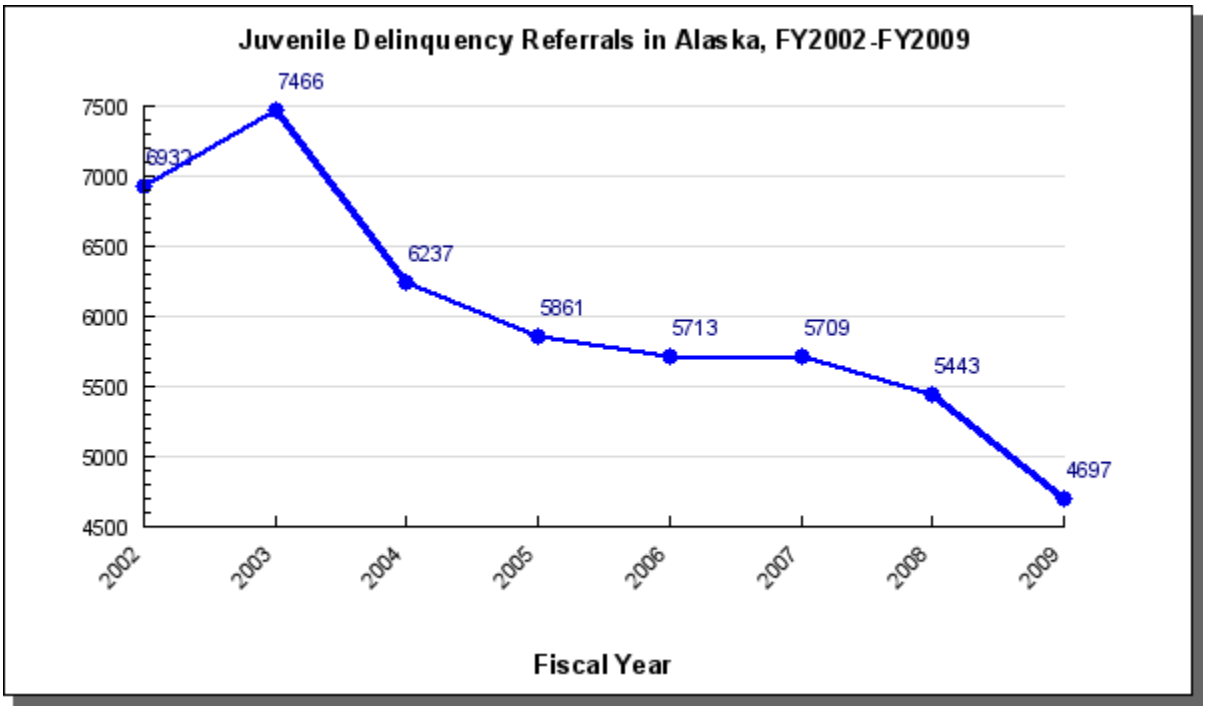
implementing evidence-based practices that will reduce the recidivism rate for the youth released from division probation supervision.

Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. Sixteen of the 32 states reported to track recidivism do so on a 12-month basis. Among the eight states (including Alaska) 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, the average recidivism rate was 33%. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.) In Alaska, the three-year average recidivism rate for youth released from formal probation was 27.9% (27.8% in FY08; 28.0% in FY07; 27.8% in FY06). This number serves as the goal for this year's probation recidivism study.

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 received technical assistance in FY09-FY10 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: Reoffenses for juveniles released from formal probation are determined by checking for entries in the division's Juvenile Offender Management Information System (JOMIS) and the Alaska Public Safety Information Network (APSIN). 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 FY09 study is represented in the graph above by youth who were released from formal probation in FY07, and who re-offended within FY08. For this FY09 report, adjudication and conviction information on offenses that occurred within 12 months of release must have been entered in APSIN or JOMIS by August 1, 2009. Youth are not included who have been reassigned to a formal probation order (with or without custody) within 7 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, above. 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 offense rate will be reduced by 5% over a two-year period.
Status #3: The number of juvenile referrals (reports of juvenile offenses from law enforcement) made to the Division of Juvenile Justice declined 13.7% between FY08 and FY09 and declined 17.7% between FY07 and FY09.



Juvenile Delinquency Referrals in Alaska, FY02-FY09

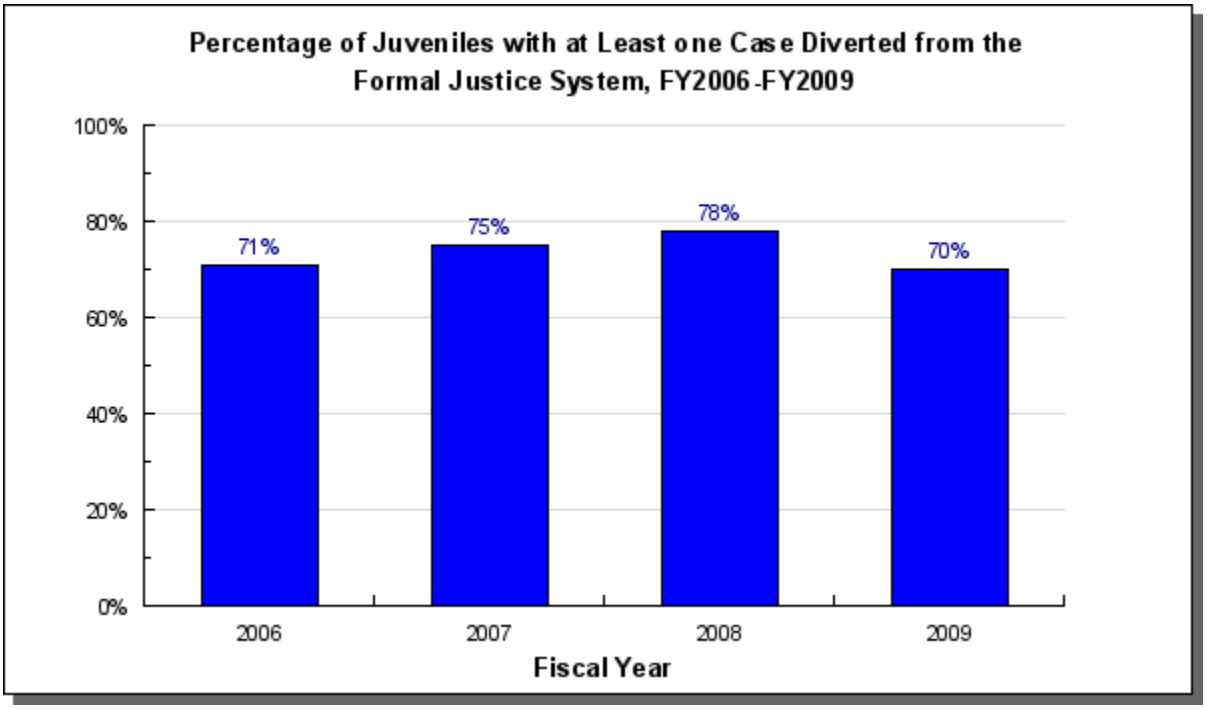
Fiscal Year	YTD Total
FY09	4697 -13.71%
FY08	5443 -4.66%
FY07	5709 -0.07%
FY06	5713 -2.53%
FY05	5861 -6.03%
FY04	6237 -16.46%
FY03	7466 +7.7%
FY02	6932

Analysis of results and challenges: Both the raw number of referrals and the percentage of these referrals per 100,000 youth population declined dramatically in FY09 compared with FY08 and FY07. The decline in referrals surpassed the target of a 5% drop in referrals over a two-year period, reflecting a continued trend of decreased juvenile delinquent 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 2002-2007 is provided by the Alaska Department of Labor and Workforce Development. The population estimate for the year 2008 and 2009 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 21, 2009 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 offense (a criminal charge in a report from law enforcement alleging a juvenile perpetrator) diverted from the formal court process matched the goal of 70%.



Percentage of Juveniles with at Least one Case Diverted from the Formal Justice System, FY06-FY09

Fiscal Year	YTD Total
FY09	70%
FY08	78%
FY07	75%
FY06	71%

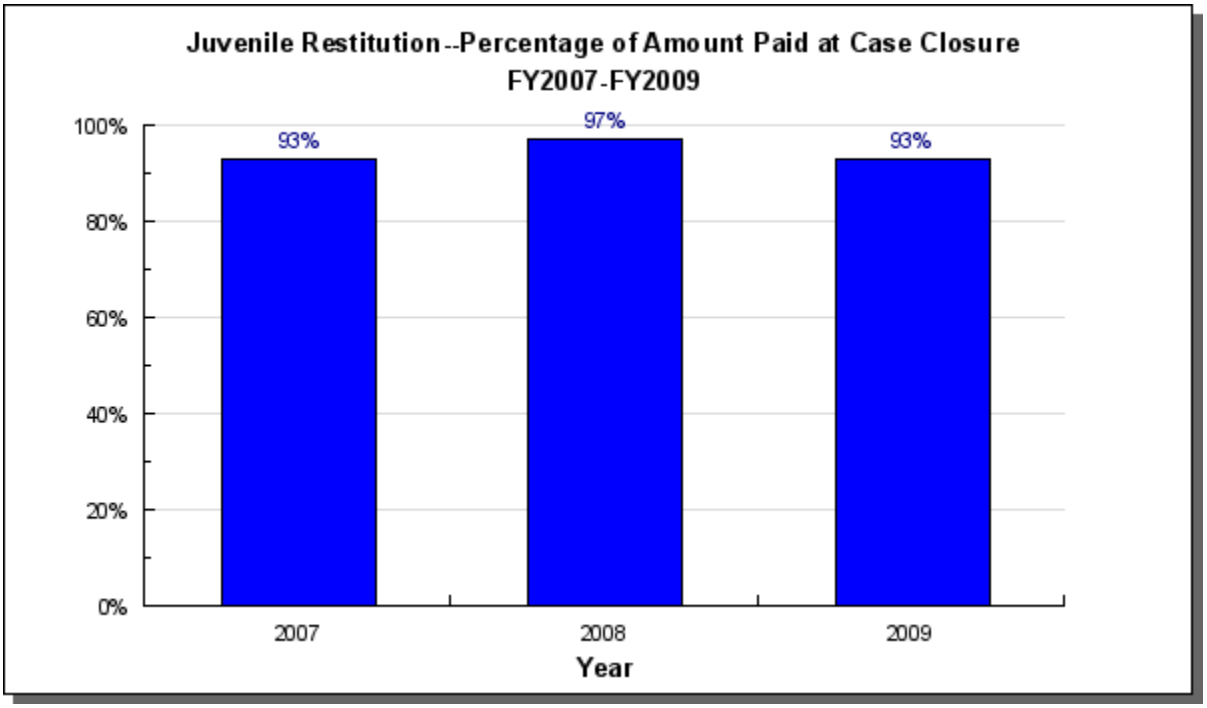
Analysis of results and challenges: "Diversion" refers to the process of managing juveniles cases through non-court processes, such as non-court adjustments; informal probation; referral to community panels such as youth court; or dismissals due to legal insufficiency. Diversion serves a number of important, 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 provides opportunities for community partners and victims to take more active roles in handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to it. Diversion also is considerably less expensive and faster than the formal adversarial process. Diversion processes reduce probation caseloads as well, enabling the division to better allocate resources and staff time to more serious offenders.

In FY09, 2,273 (70%) of 3,233 juveniles referred to the division had at least one of their offenses managed through non-formal-court processes. This percentage was lower than the percentage identified in previous years, but this difference may not be significant. The decrease may be due as much to refinements in record-keeping and data-gathering and analysis as real change in the patterns of managing juveniles. The division will monitor this measure in the future to determine whether the decrease in FY09 represents the beginning of a trend.

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 offense 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 requested or ordered.

Status #5: The amount of restitution paid by juvenile offenders by the time their division supervision ended remained high in FY09, with $36,178.04 (93%) paid by juveniles out of $38,882.84 requested.



Juvenile Restitution--Percentage of Amount Paid at Case Closure FY07-FY09

Year	% of Amt Ordered
2009	93%
2008	97%
2007	93%

Analysis of results and challenges: Restitution provides a means for juvenile offenders to make reparations to their victims and as such is a critical measure of a restorative justice agency's effectiveness. Restitution is typically requested or ordered following property loss or destruction, and provides a clear consequence of misbehavior. Through restitution, juveniles have an opportunity to demonstrate ownership and responsibility for their actions. This measure also provides a gauge of the division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their delinquent behavior, as juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system.

Juveniles may not succeed in completing their restitution expectations for a variety of reasons; they may have aged out of the juvenile system, have had their case transferred to a formal court process, or have moved from Alaska and are difficult to locate. While the division can exercise only limited control over some of these factors, the percentage of restitution paid has nonetheless continued to remain high, indicating that division staff are doing a solid job of identifying

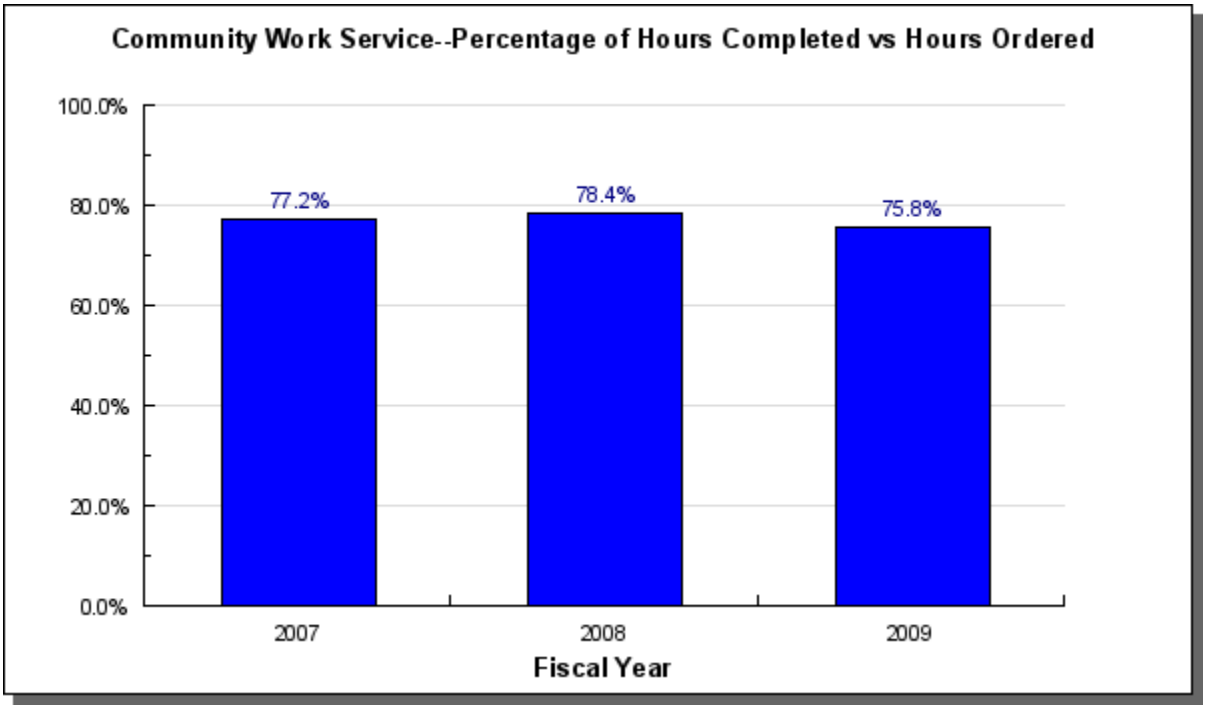
appropriate amounts of restitution and working with youth to see that this expectation is met. The division hopes to provide juvenile probation staff with an analysis of the reasons that youth have failed to complete restitution in the hope that staff can use this information to continue to improve the percentage who successfully complete all expectations of their supervision.

Note: Restitution requests and payments are included in this measure when they are requested by juvenile probation officers through informal (non-court ordered) procedures, including assignments of Alaska Permanent Fund Dividends. Also included are restitution payments ordered by a court to be paid through the Division of Juvenile Justice. Not included in this measure are restitutions formally ordered through a court and monitored by the Department of Law's Collections & Support Unit. Permanent Fund Dividends garnished through formal court processes also are not included. Restitutions tracked and gathered through youth courts and other community diversion programs also are not included in this measure as these agencies track restitution as a measure of their own performance.

The amount of restitution reported as paid is that amount provided by youth whose supervision ended in FY09. The restitution must have been assigned at the same time or after the supervision episode began and closed before or at the same time that the supervision ended in the fiscal year. Data for this measure was retrieved from the Juvenile Offender Management Information System on September 8, 2009. In 2009 the division implemented significant technical changes to its Juvenile Offender Management Information System, and recalculated the restitution figures derived in previous years as well as FY09. Reports of restitution results from previous years therefore may be slightly different from those in this report; as the new information system is refined, numbers in future years also may change slightly.

Target #6: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered or requested.

Status #6: The percentage of hours of community work service completed by juveniles in FY09 remained relatively consistent with that noted in previous years, with 17,052 hours of community work service completed (75.8%) out of the 22,502 hours ordered through a court process or juvenile probation officers in informal, non-court processes.



Community Work Service--Percentage of Hours Completed vs. Hours Ordered

Fiscal Year	Percentage
FY09	75.8%
FY08	78.4%
FY07	77.2%

Analysis of results and challenges: Community work service is an inherent part of a balanced and restorative justice system, providing juveniles with opportunities to: be accountable for delinquent conduct; develop a meaningful sense of self and community; demonstrate responsibility through a tangible act of restoration and contribution. Whether offering assistance to a local nonprofit agency, a government office, or a neighbor, juveniles can gain a sense of investment in their neighborhoods and in their own abilities.

Juveniles may not succeed in completing their expectations for a variety of reasons, similar to the reasons they may not pay their restitution in full: they may have aged out of the juvenile system before their work was completed; they have had their case transferred to a formal court process, or they have moved from Alaska and are difficult to locate. Since the division can exercise only limited control over some of the reasons youth do not complete all their community work service

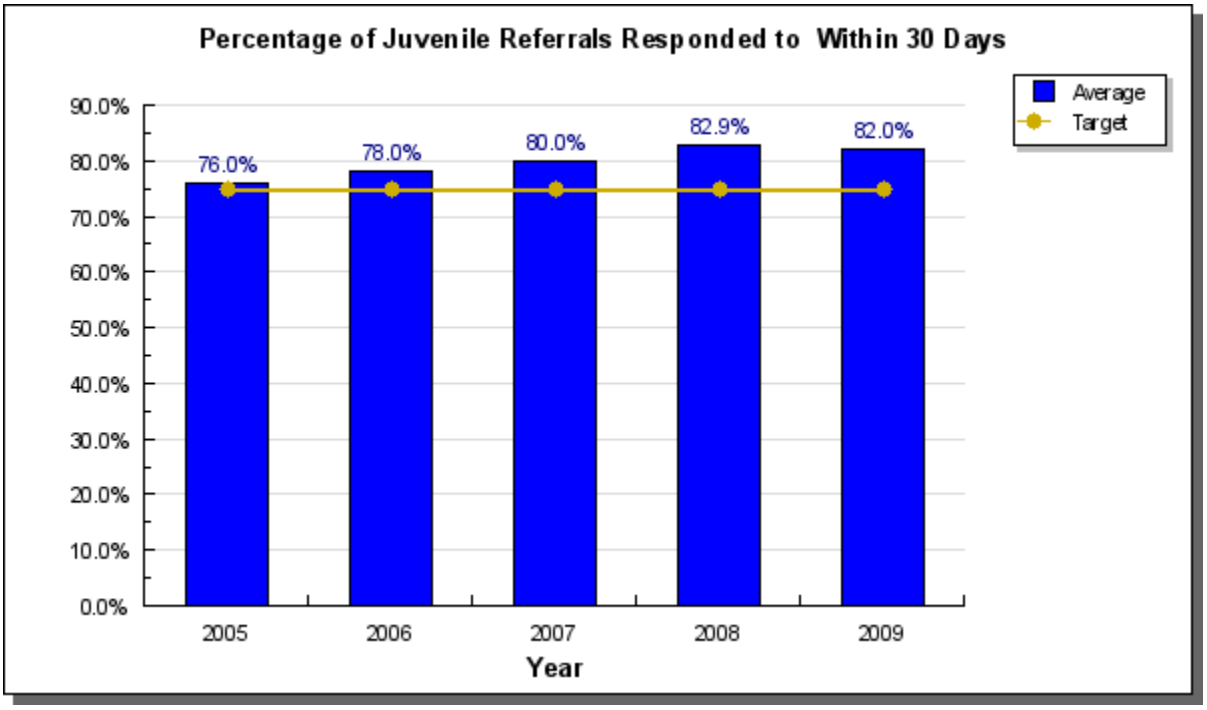
requirements, and community work service is typically a more challenging and involved expectation to fulfill than making restitution payments, the division will explore in the coming year whether a goal of 100% completion of all community work service is realistic. The division also hopes to provide juvenile probation staff with detail on the reasons that youth fail to complete community work service in the hope that staff can use this information to continue to improve the percentage who successfully complete all expectations of their supervision.

Note: 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 as these agencies typically report on community work service as a measure of their own performance. Data for this measure was retrieved from the Juvenile Offender Management Information System on September 8, 2009. The work service must have been assigned at the same time or after the supervision episode began and closed before or at the same time that the supervision ended in the fiscal year. Earlier in 2009 the division implemented significant technical changes to its Juvenile Offender Management Information System, and recalculated the community work service figures derived in previous years as well as FY09. Reports of work service results from previous years therefore may be slightly different from those in this report. As the new information system is refined, numbers in future years also may change slightly.

A1: Strategy - 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 speed with which juvenile justice staff responded to referrals (reports from law enforcement of juvenile activity) remained above the goal, with 82% of reports responded to within 30 days. The average response time for juvenile probation staff to respond to referrals was 16 days.



Percentage of Juvenile Referrals Responded to Within 30 Days

Year	Average	Target
2009	82.0	75.0
2008	82.9%	75%
2007	80%	75%
2006	78%	75%
2005	76%	75%

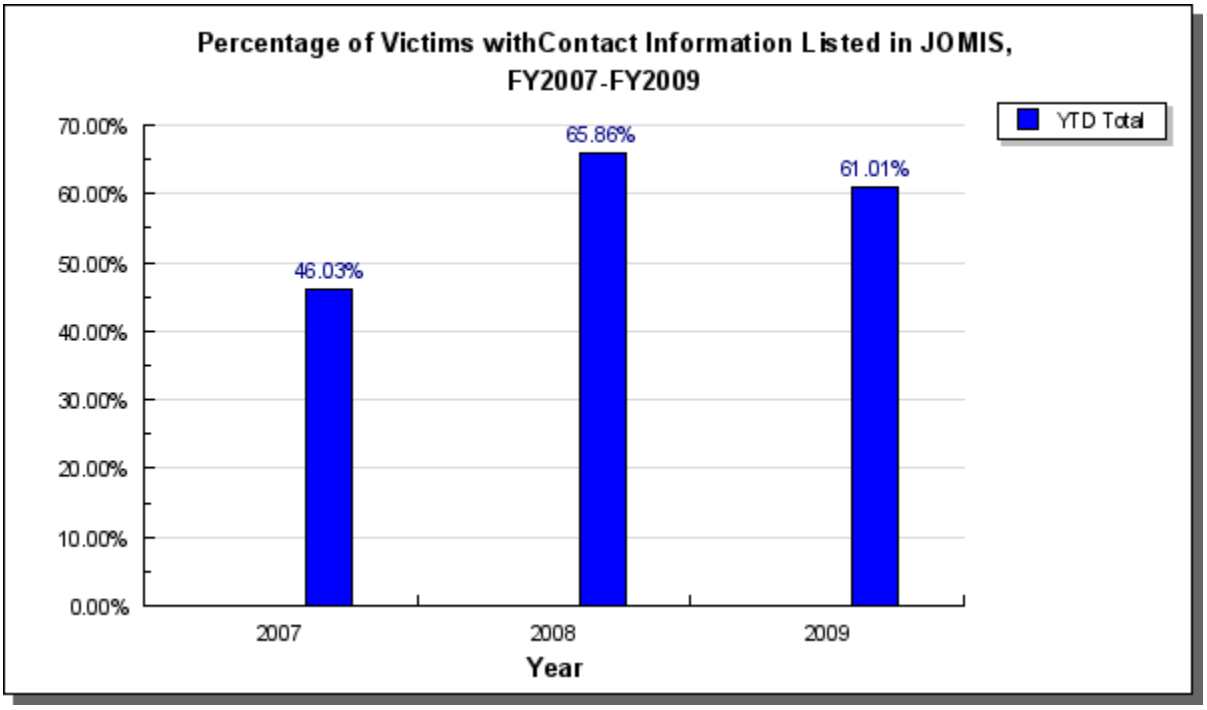
Analysis of results and challenges: Research indicates that responses to juvenile offenses must be timely and appropriate in order to be effective. This measure enables the division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the division as one of three possible actions by staff to deal with the delinquency report (see note below). The statewide average percentage of referrals that received a response within 30 days has been consistently exceeded 75% for the last few years, suggesting that a goal of 80% may be more appropriate. The average length of time it took for juvenile probation officers to respond to referrals also continued to decline. In FY06 the average length of time required to respond to a referral was 22.4 days, while in FY09 the average was

16.02 days—a decrease of 28.5%. The reasons for this decrease are unknown but may be due to the fact that the division's overall referral rate has decreased significantly over the past several years. Fewer referrals may enable officers to respond more quickly when reports from law enforcement are received in their offices.

Note: Delinquency reports or "referrals" included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or it being forwarded to a community accountability program, such as youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

A2: Strategy - Improve the satisfaction of victims of juvenile crime.

Target #1: To monitor and improve victims' satisfaction with juvenile justice services.
Status #1: 61.01% of victims of person and property offenses committed by juveniles adjudicated on those offenses in FY09 had their contact information listed in the Juvenile Offender Management Information System. A sample of 23 of these victims contacted by phone expressed a moderate level of satisfaction with the services they'd received.



Percentage of Victims with Contact Information Listed in JOMIS, FY07-FY09

Year	YTD Total
2009	61.01%
2008	65.86%
2007	46.03%

Analysis of results and challenges: Alaska law and the division's own policies and procedures recognize the importance of treating victims of juvenile delinquency with dignity, respect and fairness, and assuring victim rights is a critical aspect of the division's restorative justice philosophy. The division has sought for several years to determine the best way to measure its effectiveness in working with victims. In 2007 and 2008, attempts were made to determine victim satisfaction through mail-in and web-based surveys, but the number of surveys returned was so low (6-8%) that there was little the division could conclude about the results. One factor undoubtedly contributing to the low response rates was that victim names and addresses often had not been entered accurately or completely in the division's Juvenile Offender Management Information System (JOMIS). The first evidence of this was the large number of surveys that were returned to the division as undeliverable. The division later examined the electronic records of these victims and confirmed that only 46.03% (in FY07) to 65.86% (in FY08) of victims of offenses against persons or property have their names listed in JOMIS.

In July 2009, in an effort to gain some sense of the satisfaction of victims with services, the division conducted brief telephone surveys with a sample of 23 victims of offenses that had been adjudicated in FY09. Victims from each region of the state were contacted regarding the services they'd received; on a scale from 1 (lowest satisfaction) to 5 (highest) their satisfaction averaged 3.86. This small sample size makes it difficult to conclude whether the satisfaction expressed by these victims is representative of the feelings of most victims of juvenile crime, but this result serves as a good baseline for future-year surveys.

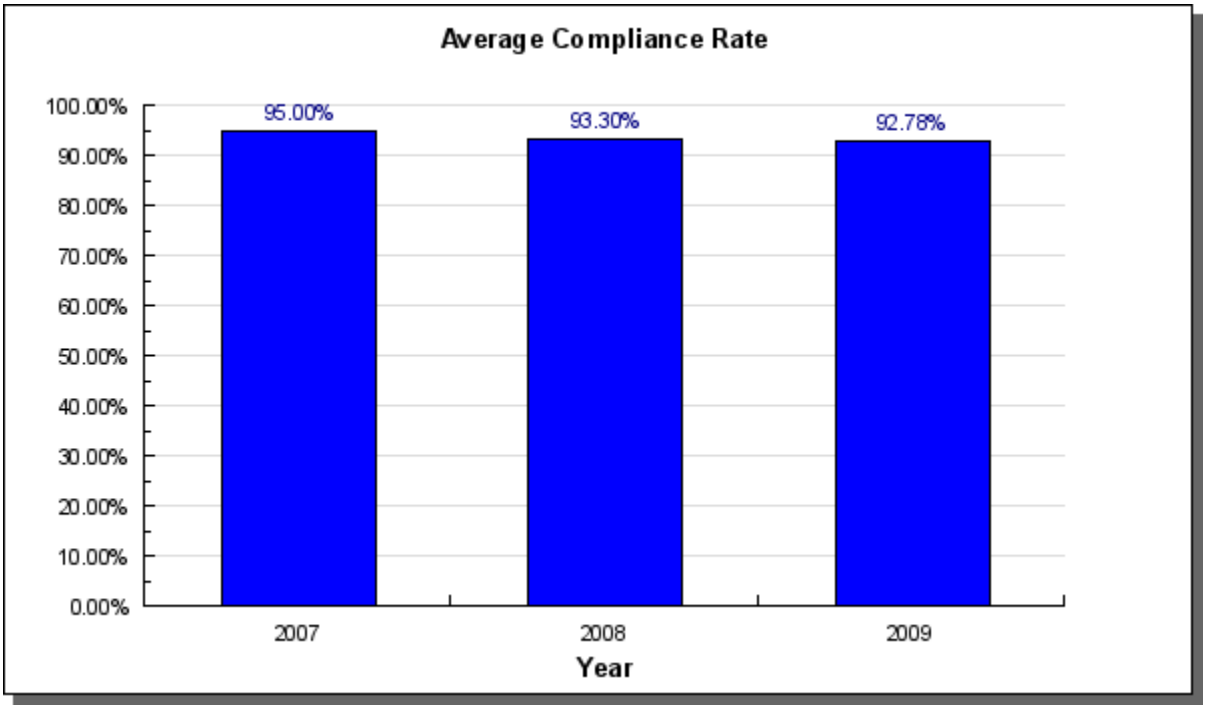
Before the division can get an adequate picture of whether the majority of victims are satisfied with the services they receive, it must first determine whether the contact information it has for victims is complete and accurate. The division therefore will devote attention to improving the completeness of victim contact information in the coming year.

Note: To be counted among the percentage of victims with contact information listed in the Juvenile Offender Management System (JOMIS), names of individuals and organizations who were the victims of property or person offenses, adjudicated in FY07 through FY09, had to be listed in JOMIS by August 21, 2009. Victims of non-property, non-person offenses (i.e., offenses against public order or administration, misconduct involving controlled substances or weapons, etc.) were not included in this measure because a specific victim is often difficult to identify in these cases. Victims were contacted for satisfaction surveys if the offense for which they were listed had resulted in a court-ordered adjudication and disposition for the juvenile who'd committed it in FY09. Juvenile probation supervisors contacted a randomly selected sample of 5-7 victims from their region by telephone and conducted a structured interview.

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 continued to exhibit a high degree of professionalism in conducting casework, as demonstrated by an average 92.78% compliance rate in meeting overall case standards.



Average Compliance Rate

Year	Average
2009	92.78%
2008	93.3%
2007	95%

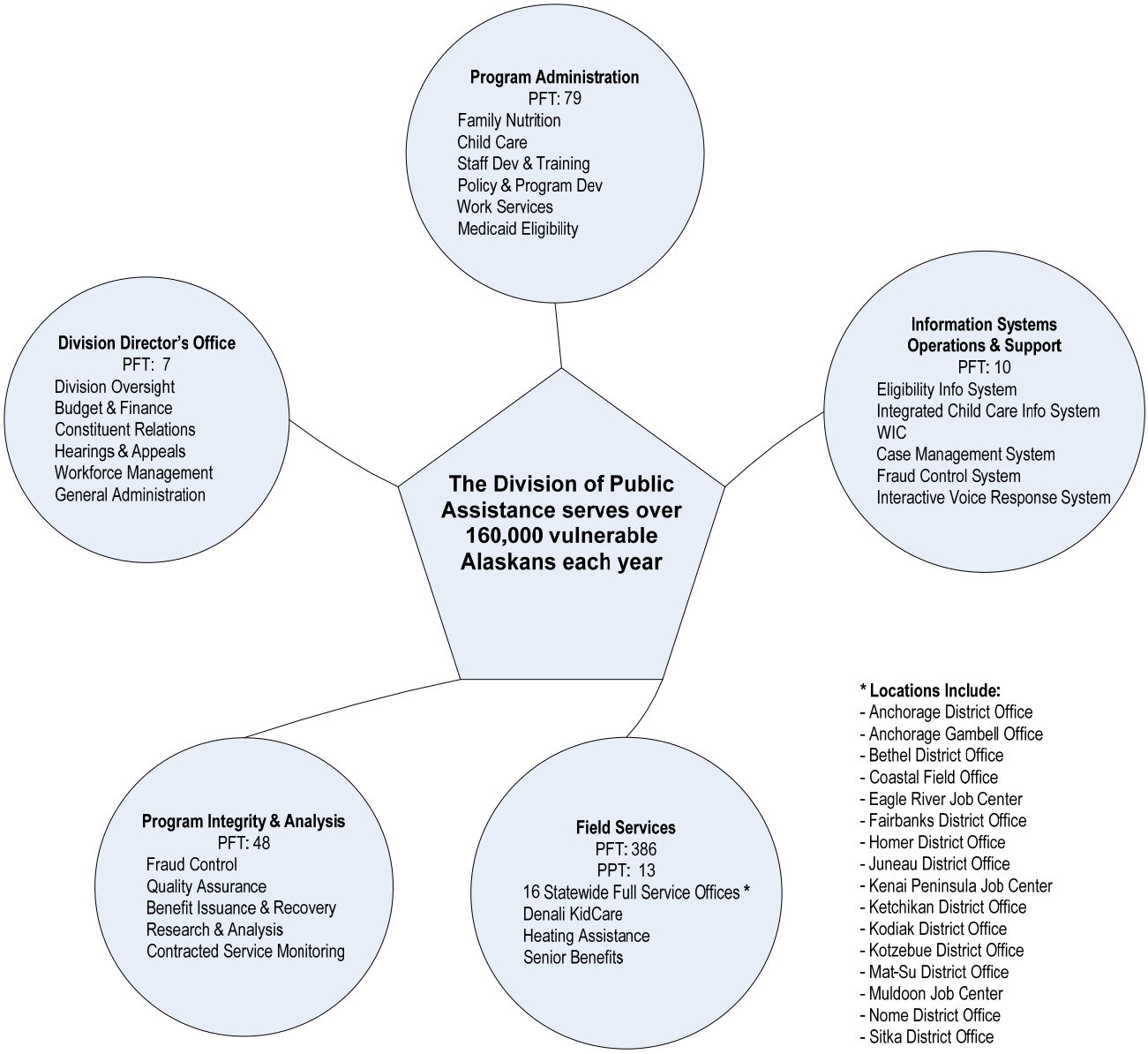
Analysis of results and challenges: This measure monitors the division's success in achieving compliance with casework expectations for juvenile probation officers as specified in the division's Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload are conducted on a trimesterly basis. A representative sample of each officers' caseload is reviewed according to a standardized procedure, 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 continues to refine the format and procedure used to conduct audits of probation to make these audits an ever-more useful tool in determining the quality of juvenile probation officers' work.

FY11 Governor's Request Increment and Decrement Fund Breakout

Division of Juvenile Justice FY11 Governor's Request **General and Other Fund Requests** (Increases and Decreases only) **Item**	**GF**	**Federal**	**Other**	**Total**
MH Trust: Dis Justice -Grant 1386.03 Increase Mental Health Clinical Capacity in Juvenile Justice Facilities	$ -	$ -	$ 189.2	$ 189.2
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (189.2)	$ (189.2)
Reduce Federal Authority Due to the Completion of the Re-Entry Grant Initiative	$ -	$ (54.1)	$ -	$ (54.1)
Reduce Federal Authorization Due to Completion of the Federal Re-Entry Initiative Grant	$ -	$ (50.0)	$ -	$ (50.0)
Reflect Reimbursable Service Agreement from Dept of Labor for the Workforce Investment Act Grant	$ -	$ -	$ 150.0	$ 150.0
Replace Statutorily Designated Program Receipts from Municipality of Anchorage	$ 142.0	$ -	$ (142.0)	$ -
Reverse August FY2010 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	$ (132.7)	$ -	$ -	$ (132.7)
Delete Unrealizable Federal Revenue Authorization	$ -	$ (500.0)	$ -	$ (500.0)
Juvenile Justice Total	***$ 9.3***	***$ (604.1)***	***$ 8.0***	***$ (586.8)***

Public Assistance

Total PFT: 530
Total PPT: 13



*** Locations Include:**
- Anchorage District Office
- Anchorage Gambell Office
- Bethel District Office
- Coastal Field Office
- Eagle River Job Center
- Fairbanks District Office
- Homer District Office
- Juneau District Office
- Kenai Peninsula Job Center
- Ketchikan District Office
- Kodiak District Office
- Kotzebue District Office
- Mat-Su District Office
- Muldoon Job Center
- Nome District Office
- Sitka District Office

Introduction to the Division

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; home heating assistance; child care assistance and work supports that enable and encourage Alaskans to pursue economic independence and self-sufficiency.

Core Services

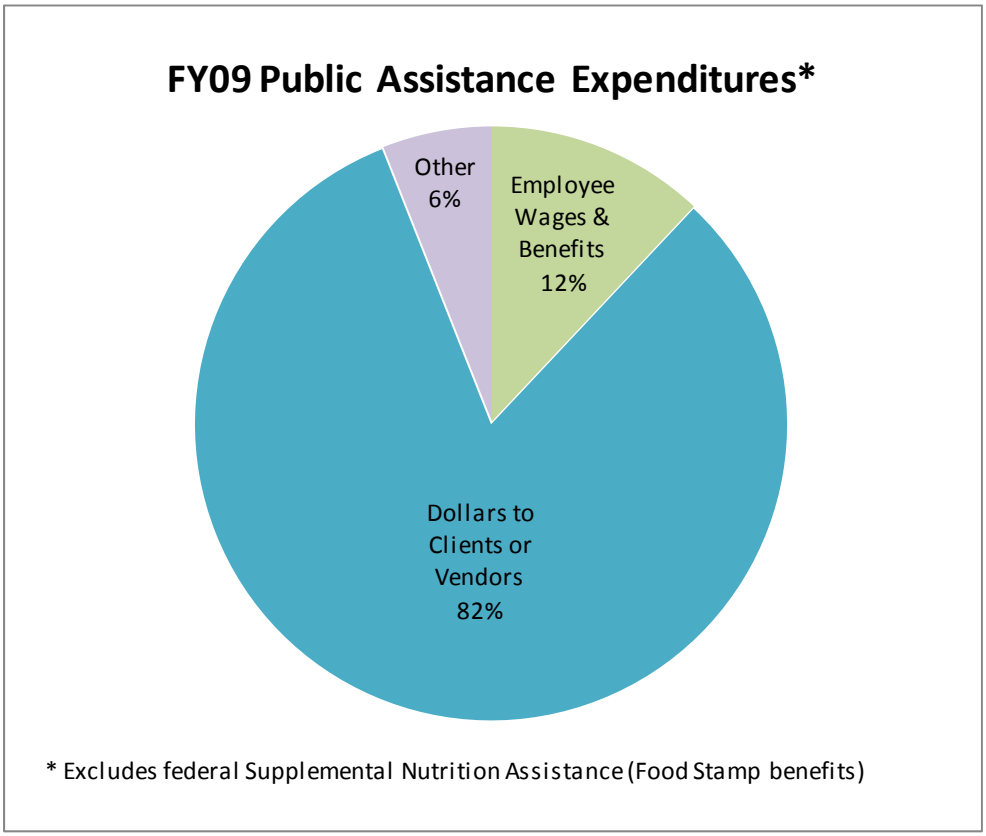
Division staff determine eligibility for benefits and makes services available through a variety of programs that are intended to help Alaskans remain safe and healthy, prevent dependency and provide support for clients as they obtain employment. Public Assistance programs offer:

- Temporary financial assistance to help low-income Alaska families with children meet basic needs and to encourage family self-sufficiency and stability by planning for self-support through employment;
- Employment assistance to promote self-sufficiency;
- Financial and medical assistance to elderly, blind, or disabled Alaskans incapable of self-sufficiency to help meet basic needs and remain as independent as possible in the community;
- Food support and nutrition education to improve health outcomes, and to decrease food insecurity and obesity;
- Help in paying for home heating costs;
- Child care subsidies to families who need child care in order to work or participate in approved work or training activities;
- 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; and
- Administrative accountability and prevention of fraud and program abuse.

To qualify for public assistance, individuals must meet income guidelines in addition to other eligibility requirements which vary by program.

DPA provides direct services in 19 customer service 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

FY09, the division provided cash, food, and medical benefits and services to over 100,000 Alaskan households and 160,000 individuals.



Most DPA funds go directly to clients or to local vendors serving clients. Four of five DPA dollars go directly to clients (e.g. benefit payments or short-term cash assistance for shelter, utilities, food, or clothing and work supports such as child care assistance) or to community-based businesses, vendors and partners who are serving needy individuals and families. Vendor services funded by DPA include contracts and grants with community organizations to provide eligibility services for WIC and Child Care subsidies, Child Care licensing and resource and referral services, nutrition education and outreach, employment and training services and case management to deliver welfare-to-work services. Also included is the support for Alaska Native regional nonprofit organizations that operate Tribal Temporary Assistance for Needy Families programs.

The remaining fifth of the DPA budget is divided between staff costs – direct service and administrative (12%) and all other costs (6%).

Services Provided

Alaska Temporary Assistance Program
The Alaska Temporary Assistance Program (ATAP) provides temporary financial assistance to needy families with children 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 state maintenance of effort funding, based on the amount spent in federal fiscal year 1994 for the AFDC program in Alaska.

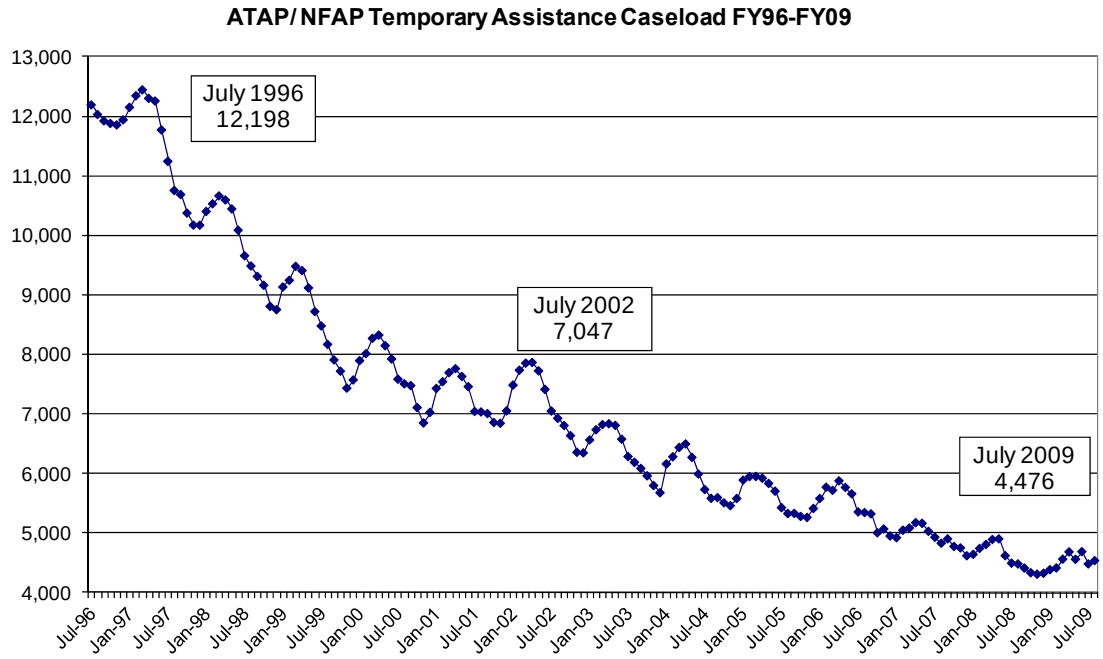
The program provides assistance to nearly 3,100 families throughout the state annually. This assistance is limited to 60 months as a temporary safety net to help families care for children in their own homes by providing for the basic needs of shelter, clothing, transportation and food. ATAP also has 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.

The division continues to invest TANF block grant savings that have accrued as a result of welfare reform to sustain budgets for work services and supports for low income working families such as child care assistance. The division also transfers funds to the Social Services Block Grant for child protection services. The remaining TANF block grant balance is reserved to respond to any potential increases in the ATAP caseload as a result of the weakened economy, and to ensure funds are available to support core business needs in future years such as replacement of the division's eligibility information system.

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 (NFAPs). Funding for NFAPs 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 temporary assistance to eligible families.

While NFAPs must be comparable to the state’s program, the NFAPs 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 receive TANF services and benefits from NFAPs. These programs are operated and administered by the Association of Village Council Presidents, Inc. (AVCP), Bristol Bay Native Association (BBNA), Central Council of Tlingit & Haida Indian Tribes (CCTHITA), Cook Inlet Tribal Council, Inc. (CITCI), Kodiak Area Native Association (KANA), Maniilaq Association, and Tanana Chiefs Conference (TCC).



The sustained efforts of the division since the implementation of ATAP, buoyed by a moderately strong economy, have resulted in thousands of Alaskans achieving economic self-sufficiency through employment. While the Temporary Assistance caseload in Alaska continued to fall in FY09, the rate of decline has slowed and the caseload is beginning to level. Overall, the annual monthly average of families receiving temporary assistance from the State and Native Family Assistance programs has decreased by 63% since FY97, and has generated approximately $80.5 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 helps low-income working families pay for a portion of their child care costs while they are working, looking for work, or attending school or training. Child care benefits pay for part of the child care costs, and parents also pay for a portion (called a co-pay). The parent's share is based on the size of the family and the amount of their income.

Providing access to affordable, safe, healthy, quality child care is a key component in the state's efforts to help families succeed in the work place and attain self-sufficiency. 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 and afforded opportunities to grow and learn in nurturing environments. In addition to child care assistance, the Child Care Assistance Program provides:

- Oversight and approval or 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, such as parent education and support provided by Child Care Resource and Referral agencies, professional development for care providers, and other special initiatives.

Child care assistance programs have 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 and subsequently transferred to the Department of Health and Social Services in 2003. Funding for child care assistance and services comes from the federal Child Care Development Fund (CCDF) and the Temporary Assistance for Needy Families (TANF) block grants, along with a required state general fund match.

Work Services

The Alaska Temporary Assistance Program's (ATAP) 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 ATAP recipients to attain economic self-sufficiency through employment. Employment and training services are also provided to Food Stamp Program participants.

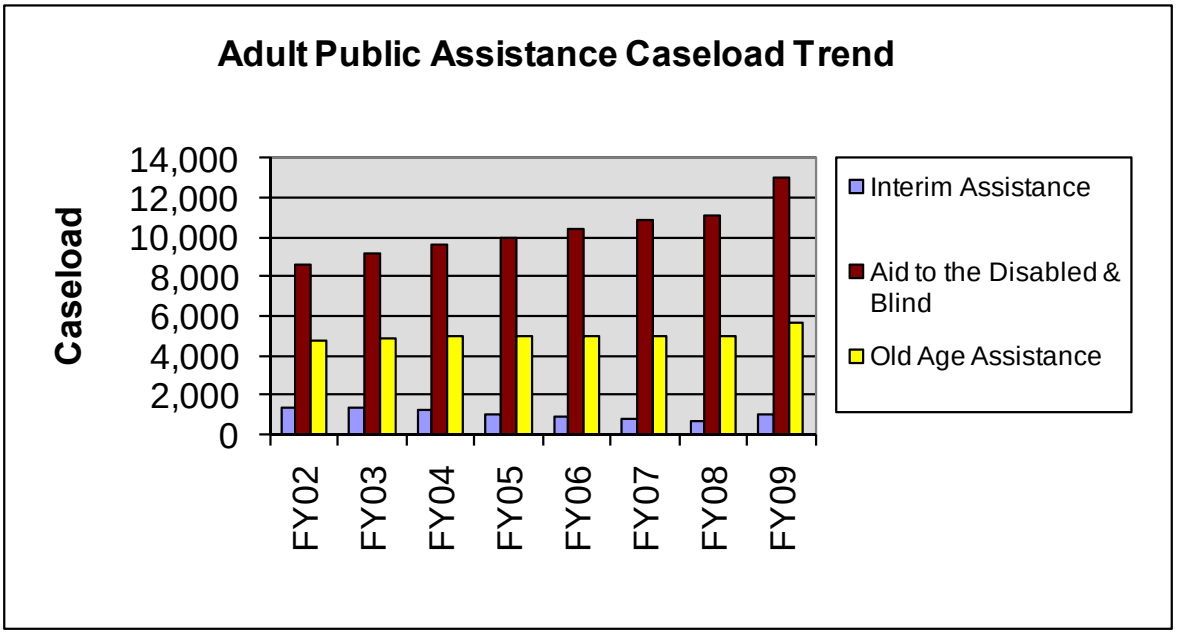
Work Services includes activities and support systems that prepare clients to enter the workforce, help them to retain jobs, advance, and succeed. Work Services also provides wage subsidies to employers who create new jobs and hire recipients to fill them. The majority of Work Services is delivered through 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 12,200 blind and disabled Alaskans annually. The program was created to provide income support to very needy elderly, blind, and disabled persons. APA benefits serve as a supplement to the federal Supplemental Security Income (SSI) program and provide individuals with income sufficient to meet basic needs and to remain as independent as possible in the community. To qualify, an individual must be over age 64, or at least 18 years of age and blind or diagnosed by a physician as permanently disabled or terminally ill. Certain income and asset eligibility standards also apply.

The Adult Public Assistance program includes an Interim Assistance benefit of $280 a month for individuals who appear to meet the SSI disability criteria and have applied for SSI. To qualify for SSI, a person's mental or physical impairment must be severe enough to make him or her temporarily or permanently incapable of self-support through gainful employment. In FY04, 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 FY03.

APA serves the community by promoting the stability and independence of needy individuals. APA benefits help many Alaskans avert problems such as homelessness and avoid higher cost settings such as hospitals and nursing homes or incarceration.

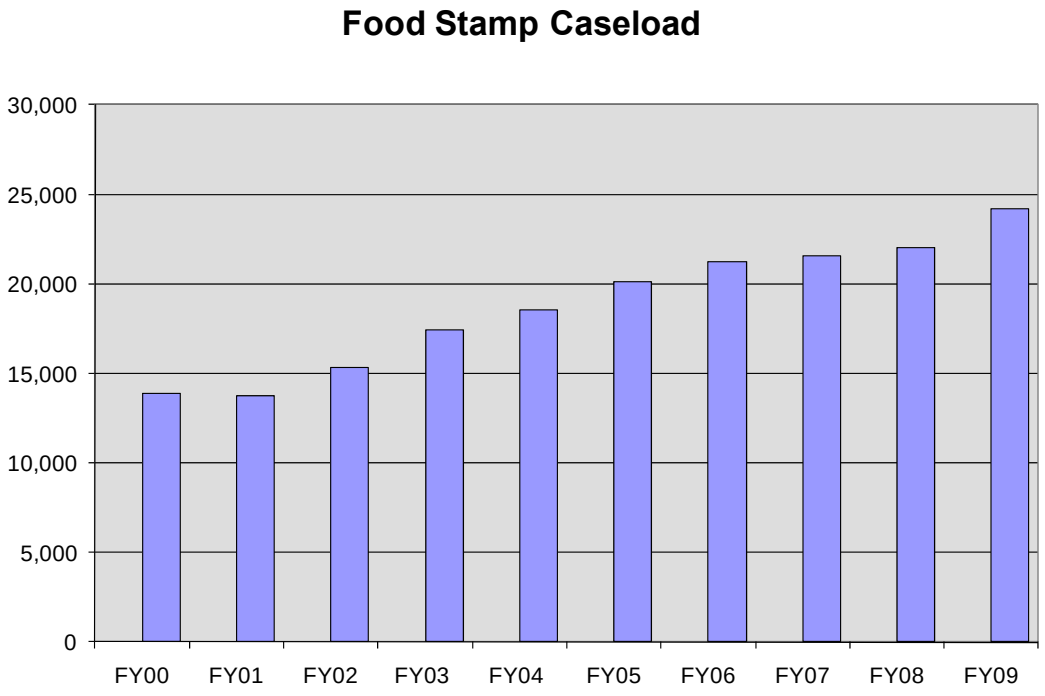


Food Stamp Program

The Food Stamp Program, also known as the Supplemental Nutrition Assistance Program (SNAP), 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 (USDA), Food and Nutrition Service, while costs for the administration of the program are equally shared by the state and federal government. Participation in the Food Stamp Program has other benefits such as: enrollment in free school meals for school-aged children, qualification for low cost phone services, and can be used to show a family meets the Women, Infants and Children's (WIC) income test.

Alaska's Food Stamp caseload continues to climb, with a more dramatic increase over the last year as a result of more households applying for help because of higher energy, food and medical costs, and the weakened economy. In FY09, the program served an average of 24,100 low-income households with about $9.7 million of food stamp benefits issued each month. In October 2009, over 28,000 Alaska households were receiving food stamp benefits, and monthly benefits issued climbed to over $12.5 million dollars. The increase in benefits are due to the higher number of households participating in the program combined with an increase in the monthly benefit allotment that was included in the economic stimulus provisions of the American Recovery and Reinvestment Act (ARRA) of 2009.

The USDA recently awarded DPA with a $273,584 performance bonus award for having the most improved program access for the Food Stamp Program in federal fiscal year 2008 (FFY08). The bonus of $273,584 will be put back into the program to make it even more effective.



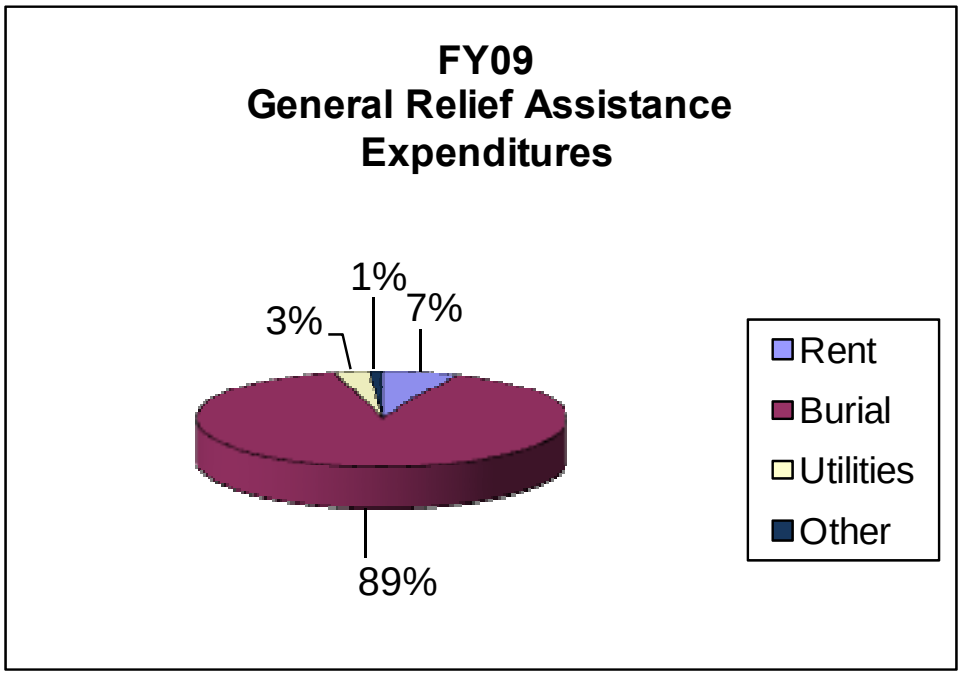
Quality Control

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.

In FY09, the division completed the federally mandated Payment Error Rate Measurement (PERM) eligibility and claims payment reviews for Medicaid. The reviews demonstrated 99.9% of the Medicaid eligibility decisions and related claims payments were accurate.

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. The unit investigates approximately 1,000 allegations of fraud each year.

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-nine 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 FY09 the program covered burial expenses for 596 deceased individuals and met emergency needs by preventing eviction and homelessness for approximately 53 households each month.

Medicaid Program
The Medicaid Program provides medical coverage for basic health and long-term care services for low-income Alaskans. The Division of Health Care Services (HCS) is responsible for managing payments to health care providers. The Division of Public Assistance (DPA) develops and administers policies for the program, ensures access, and determines eligibility of individuals and families, including eligibility for children and pregnant women under the Denali KidCare

Program. The division manages eligibility for Medicaid for nearly 94,000 Alaskans each month. Often, Medicaid recipients participate in other public assistance programs.

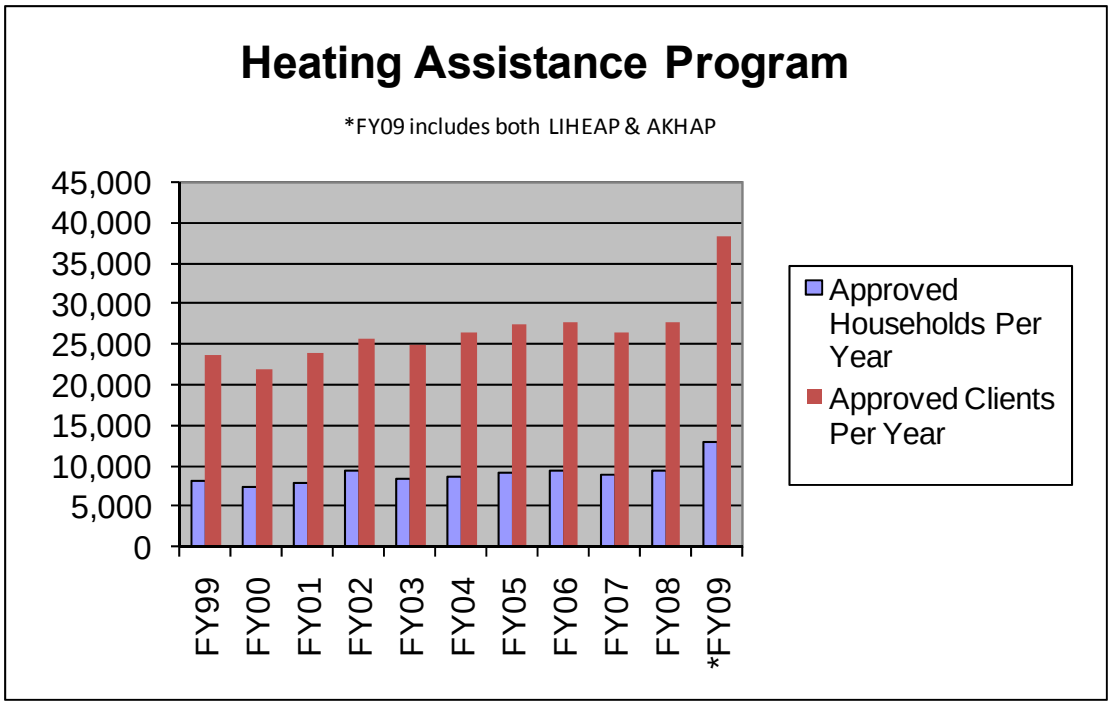
Chronic and Acute Medical Assistance Eligibility

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, 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, have few personal resources and have inadequate or no health care. DPA 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 Programs and funding to support weatherization projects. 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. Until FY09 heating assistance was funded entirely by the federal Low Income Home Energy Assistance Program (LIHEAP) block grant.

Federal LIHEAP funds can be used to serve households with income below 150% of the federal poverty limit for Alaska. The Alaska Heating Assistance Program (AKHAP) which began October 1, 2008, is available for households with income between 151% and 225% of the federal poverty limit.

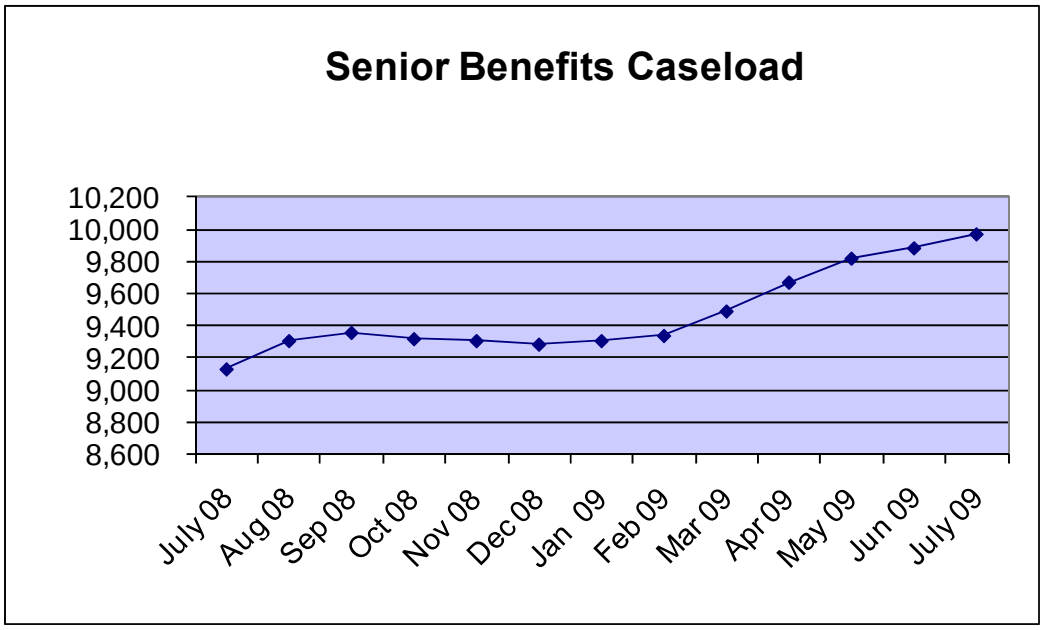


During the 2008-2009 season, over 13,000 households (10,983 LIHEAP and 2,047 AKHAP) received help from the state administered Heating Assistance Program, an increase of 38% over the prior season. Not included in the chart above, an additional, 7,172 households (6,833 LIHEAP and 339 AKHAP) received help from Alaska Native organizations operating 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 payments of $125, $175, or $250 depending on annual income. This program was established in 2007, following the sunset of the SeniorCare program on June 30, 2007.



In July 2009, almost 10,000 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, infants and young children eat well, learn about good nutrition, and stay healthy. Pregnant, postpartum, and breastfeeding women, infants and young children receive nutrition education and counseling, 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 Program, which offers coupons to seniors and WIC participants to purchase locally grown fruits and vegetables at Farmers' Markets during the harvest season. In October 2009, the program changed to offer more variety, healthier foods, and healthier choices for infants, including fresh fruits and vegetables, low-fat milk and a variety of whole grain foods. The WIC program also increased the amount of food provided to mothers who breast-feed their babies' full time to better promote and support breast-feeding.

These programs are primarily federally-funded. In FY09, approximately 25,550 Alaska women, infants and children participated in WIC each month, and approximately 3,000 seniors received food from the commodity program.

Comparison of Public Assistance Programs

	ATAP/NFAP	Adult Public Assistance	General Relief	Food Stamps
FY09 Cases avg. mo.	2,997	16,869	132	24,173
# of clients avg. mo.	8,105	16,869	189	63,159
Race Distribution	White 56% Alaska Native 17% Black 11% Asian 8%	White 50% Alaska Native 30% Asian 9% Black 5%	White N/A Alaska Native N/A Black N/A	White 43% Alaska Native 39% Black 6% Asian 4%
Recipients by Location (District area)	Anch / Mat-Su 64% Northern 10% Southeast 8% Balance of State 18%	Anch / Mat-Su 55% Northern 12% Southeast 11% Balance of State 22%	Anch / Mat-Su 52% Northern 13% Southeast 16% Balance of State 19%	Anch / Mat-Su 49% Northern 13% Southeast 13% Balance of State 25%
Recipients by Age	Children 0 - 18 yrs 5,688 Adults 19 - 59 yrs 2,402 Adults 60 - older 16	Children 0 - 18 yrs 80 Adults 19 - 59 yrs 9,556 Adults 60 - older 7,233		Children 0 - 18 yrs 30,080 Adults 19 - 59 yrs 29,734 Adults 60 - older 3,345
% Expenditure By Category of Service	Single parent 61% Two parent 14% Child only 25%	Disabled 70% Aged 29% Blind 1%	Burial service 87% Rent assistance 7% Other 6%	FS and ATAP 16% FS only 28% FS and APA 9% FS and Med 71%
Total Expenditures	$24,234,135	$55,775,382	$1,548,699	$117,541,100
Federal	$5,912,838	$821,209	$0	$117,541,100
GF	$16,629,846	$50,988,023	$1,548,699	$0
Other	$1,691,451	$3,966,150	$0	$0

Notes:

1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) ATAP/NFAP caseload includes the Alaska Temporary Assistance Program only. Expenditures include the Alaska Temporary Assistance Program and the Native Family Assistance Program.

	Energy Assistance Programs				
	LIHEAP (Federal)	**AKHAP** (State)	**Child Care** (PASS I, II, III)	**Senior Benefits**	**Women, Infants & Children (WIC)**
FY09 Cases avg. mo.	10,983	2,047		9,637	25,550
# of clients avg. mo.	31,851	6,550	4,272 children	9,637	25,550
Race Distribution					
White	54%	58%			39%
Hispanic	2%	2%			9%
Alaska Native/Indian	31%	25%	N/A	N/A	36%
Asian/Pacific Islander	5%	5%			10%
African American	3%	3%			6%
Other	5%	7%			0%
Recipients by Location					
Anch / Mat-Su	42%	38%	N/A	Anch / Mat-Su 48%	Anch / Mat-Su 45%
Northern	16%	17%		Northern 12%	Northern 18%
Southeast	6%	7%		Southeast 11%	Southeast 7%
Balance of State	36%	38%		Balance of State 28%	Balance of State 29%
% Expenditure By Category of Service					
Employed, retired	68%	90%	Pass I 10%	Food Stamp 18%	Food Stamp 3%
or temp unemployed			Pass II 8%	APA 55%	
Receiving ATAP	8%	2%	Pass III 82%	Medicaid 61%	Medicaid 23%
Receiving APA	24%	8%			
Total Expenditures	$29,198,481	$6,261,823	Pass I $4,168,231 Pass II/III $23,238,475	$18,990,108	$28,014,382
Federal	$19,579,501	$0	-$7,726,576	0	$28,004,682
GF	$9,618,980	$6,261,823	$7,726,576	$18,990,108	$9,700
Other	$0	$0	$0	0	0

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.

List of Primary Programs and Statutory Responsibilities

AS 18.05.010-070	Administration of Public Health and Related Laws
AS 43.23.075	Eligibility for Public Assistance
AS 43.23.085	Eligibility for State Programs
AS 44.29.020	Department of Health & Social Services
AS 47.05.010-080	Public Assistance
AS 47.05.300-.390	Criminal History; Registry
AS 47.07.010-900	Medicaid
AS 47.25.001-.095	Day Care Assistance and Child Care Grants
AS 47.25.120-300	General Relief Assistance
AS 47.25.430-615	Adult Public Assistance
AS 47.25.621-626	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
7AAC 10	Licensing, Certification, and Approvals
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 Program
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 AAC 100	Medicaid Assistance Eligibility
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 98	Child Care and Development Fund
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	FY10	FY11 Gov	10 to 11 Change
General Funds	138,909.9	139,985.9	1,076.0
Federal Funds	126,102.7	125,295.5	(807.2)
Other Funds	26,447.0	26,366.2	(80.8)
Total	**291,459.6**	**291,647.6**	**188.0**

The proposed FY11 budget requests reflect funding needed to cover increasing caseloads for programs that provide basic safety net support to Alaska's most needy and vulnerable citizens - low income seniors and people with disabilities, emergency services to destitute individuals, and burial assistance on behalf of deceased persons.

Adult Public Assistance (APA)

Adult Public Assistance Enrollment Growth: *$150.0 GF*
The APA program provides critical financial and medical assistance to low-income seniors and persons with disabilities. While the number of individuals receiving APA has steadily increased, over recent years the rate of growth has slowed. As a result, in the FY10 Governor's request, the division recommended a $500.0 reduction in APA with recognition that an increment would be needed to accommodate projected caseload growth in FY11.

In FY11, the division projects that the number of elderly and disabled Alaskans who rely on APA to meet their basic needs will increase by 1.5 percent from an average of 17,117 in FY10 to 17,370 in FY11. This request for additional funding is needed to meet the projected APA caseload increase in FY11.

General Relief Assistance (GRA)

Increased Burial Costs for Indigent Alaskans*: $100.0 GF*
This increment requests funding to cover increased costs associated with burial-related expenses. Currently about 89% of GRA program expenditures are used to pay for funeral and burial expenses of indigent deceased persons. The remainder is needed to assist individuals and families who need emergency services, such as rental assistance to avoid homelessness or eviction. While the overall number of individuals receiving assistance from the GRA program has remained steady, the needs and average expenditures for burial and emergency assistance have been increasing. In FY11, DPA projects GRA expenditures will increase by approximately 3.5% compared to FY10. This request for additional funding is needed to meet the projected GRA expenditure increases in FY11.

Senior Benefits Payment Program

Funding to Meet Original Senior Benefits Enrollment Projections: *$850.0 GF*
The Senior Benefits Payment Program was established during a special legislative session in June 2007 that was held in response to the impact on senior citizens losing income from the sunset of the SeniorCare program on June 30, 2007.

Initially, approximately 7,000 seniors were enrolled in the new Senior Benefits Program as part of the transition from SeniorCare to Senior Benefits. In July 2009, nearly 9,900 seniors were participating and DPA projects that the number of seniors enrolled in Senior Benefits will increase in FY11 to approximately 10,400.

In the FY10 Governor's request, the division recommended a $500.0 reduction in Senior Benefits because enrollment and associated expenditures were lower than originally projected. This decrement was increased by an additional $221.9 during the 2009 legislative budget deliberations for a total of $721.9, with recognition that funding may need to be restored to meet future caseload projections.

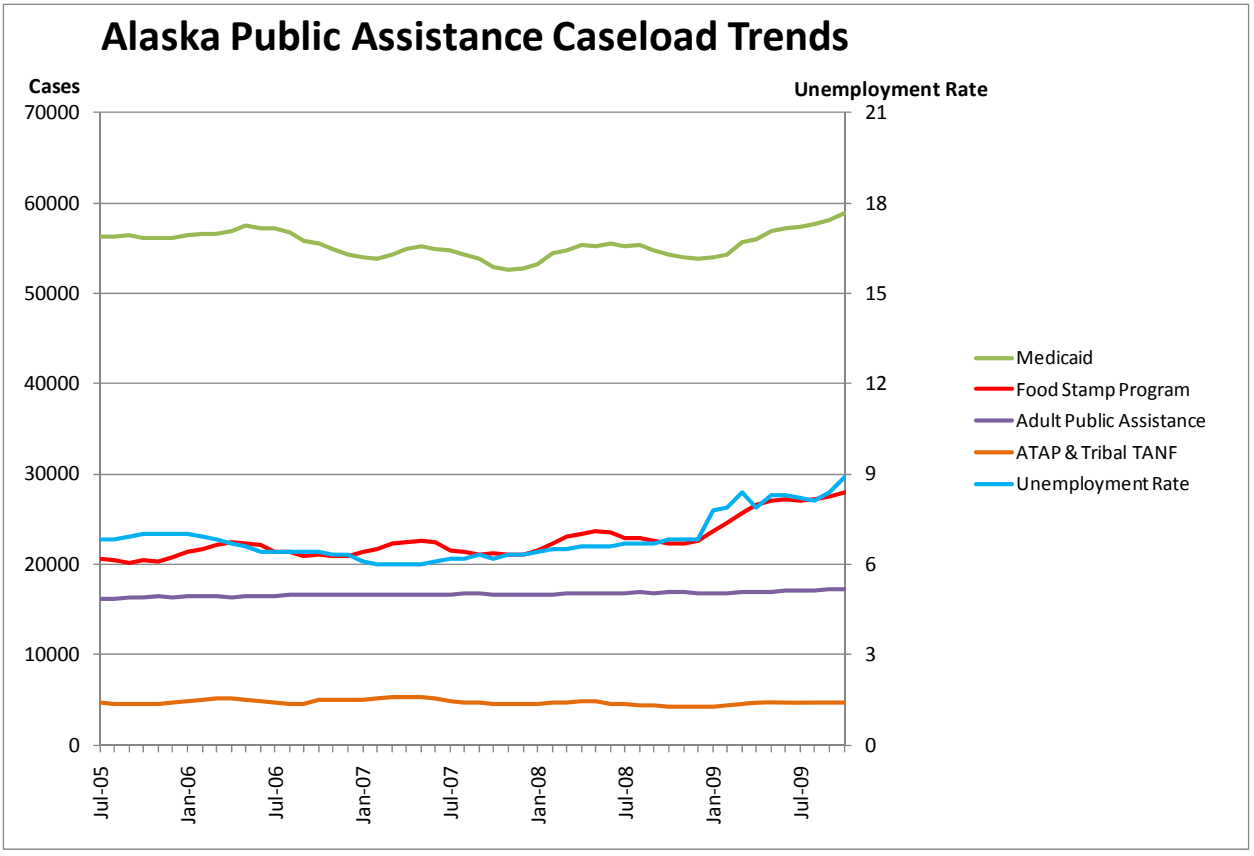
In FY11, the division projects that the number of Alaska's seniors who rely on Senior Benefits to meet their basic needs will increase by 4% percent and reach an average caseload of 10,448 in FY11. This request seeks the additional funding to meet the FY11 forecasted Senior Benefits caseload. This projected estimate falls in line with the caseload estimate that was projected when the new Senior Benefits program was established in June 2007.

Challenges

As the Division of Public Assistance (DPA) continues to make progress on its overall mission to promote self sufficiency and provide for basic living expenses to Alaskans in need, several new and ongoing challenges may affect the division's ability to meet performance objectives in FY11. These include:

Downturn in Economy – Higher Demand for Services

In the midst of difficult economic times, rising rates of unemployment, and increasing costs of gas, food, energy and other vital needs, more households in Alaska are facing economic hardships and turning to the division for assistance. Most noteworthy, individuals and families receiving basic food assistance (food stamps) increased by 26% in October 2009 compared to October 2008, and the Heating Assistance program experienced a 38% increase in the number of households applying for help with home heating costs during the 2008-2009 season. The number of families receiving financial assistance from the Alaska Temporary Assistance Program (ATAP) has leveled; however, it is prudent to expect some increase in the ATAP caseload as a result of the weakened economy. It is also prudent to recognize the significant challenges and pressures the weakened labor market and higher competition for jobs occurring in many communities affect the division's efforts in helping families to become employed and self-sufficient.



Work First Accountability
In August 2009, the Administration for Children and Families (ACF) announced FFY07 state work participation rates for the Temporary Assistance for Needy Families (TANF) program. Alaska successfully met and exceeded its overall (all families) TANF work participation rate set at 32.5% by achieving an overall participation rate of 46.8%. Alaska, however, did not meet the two-parent work participation rate. Alaska's two-parent rate was set at 69.2%, and the state achieved a two-parent rate of 58.6%.

Given the challenges, Alaska achieved the 8th highest two-parent participation rate in the nation. This reflects DPA's commitment to achieve results despite great adversity. The division is pursuing relief from ACF by working through the corrective compliance options allowed under federal law that are intended to avoid application of a financial penalty against the TANF block grant. DPA submitted a reasonable cause claim to ACF in October 2009, and has implemented corrective compliance actions that strive to meet the federally required targets.

ACF acknowledged that many states found it difficult to meet the new TANF work participation rates due to the major changes in the work participation requirements in the Deficit Reduction Act (DRA) of 2005. They also recognized the significant challenges states are facing in the midst of difficult economic times and the substantial pressures on state human service agencies and programs, including TANF.

Every effort is being made through the division's contracts and delivery of work services to keep a focus on a rapid attachment to the workforce and to find innovative ways to increase participation levels for families with mitigating circumstances such as through the division's Families First service initiative. Steps have also been taken to ensure work services contractors are complying with the more stringent policies for documenting, monitoring, and verifying allowable activities, as required under the new rules.

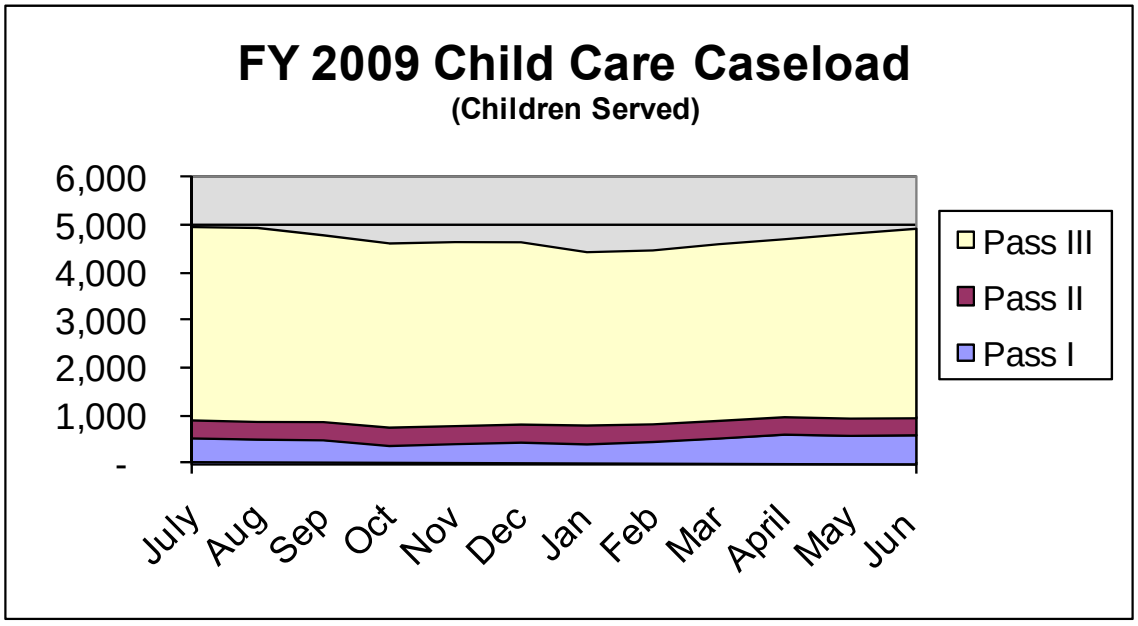
Child Care Assistance - Parents Achieving Self-Sufficiency (PASS)
Children who grow up safe, healthy, and filled with a love of learning are better prepared to succeed in school and life. The Child Care Assistance Program and its initiatives are intended to ensure children in low income working families have access to affordable, safe, quality child care. Child care assistance often provides the support that parents in low paying jobs need in order to stay working.

Over the last two years, the division has been working on strategies to increase the effectiveness of its Child Care Assistance Program by evaluating affordability, quality, and availability of care. Strategies include increases to the child care subsidy rates, which had not been adjusted since 2001. Child care subsidy rate increases were implemented in September of 2008, and additional adjustments are planned for March 2010 that include raising the rates for infant and toddler care and other changes based on the findings of the 2008 market rate survey. In addition, the division is in the process of analyzing the income eligibility standards, the parent contribution (co-pay) scale, and the costs associated with increasing them. The program's income qualifying standards have not been adjusted since 2002. 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 2008 state median income. Alaska's 2008 state median income for a family of three is $6,032 a month. The child care assistance income limit for a family of three is currently set at

$3,854 a month, which is 64% of the 2008 state median income and 202% of the 2009 federal poverty guideline for Alaska.

In FY10, funding for child care increased as a result of the American Recovery and Reinvestment Act (ARRA) of 2009. While ARRA funds are temporary in nature, during the 2009 legislative budget deliberations, it was decided to appropriate ARRA funds to finance the 2010 rate increase, and potentially costs associated with increasing the income qualifying standards for child care assistance, in place of the general fund increment proposed in the Governor's FY10 request. Depending on the cost analysis, additional funding may be needed to implement and sustain changes to the Child Care Subsidy Income Qualifying standards, and future increases in subsidy rates.

ARRA funds are also being used to boost Alaska's ability to improve quality through special one-time initiatives such as professional development and other elements of a Quality Rating Information System (QRIS). The division is working with community partners and the Department of Education and Early Development to develop a system to improve child care and early learning services in Alaska.



Payment Accuracy

The Food Stamp program requires a rigorous quality control process to monitor benefit payment accuracy. The accuracy of monthly benefits is measured by randomly sampling cases and thoroughly reviewing all elements of eligibility. Payment errors occur when a household is overpaid or underpaid. Client and agency caused payment errors are included in the annual error rate calculation. States that perform very well are given bonus payments and States that have error rates above the national average are assessed penalties. Alaska had a higher than average payment error rate in FFY08 and is at risk for incurring a penalty if the FFY09 rate is not below the national average.

DPA has several special initiatives in place to improve food stamp eligibility work quality and payment accuracy and avoid a federal sanction for FFY09. These efforts include: management emphasis on the importance of payment accuracy; intensive review and analysis of casework quality in each office; increased training in targeted areas of error prone policies and practices; and standardization of work processes. The preliminary FFY09 information shows promising results and DPA hopes to avoid a federal sanction, or significantly minimize the amount of any financial penalty.

Quality Workforce

While improved, retaining experienced staff in all sections of the division continues to be a challenge as the workforce ages and dedicated employees with years of knowledge and service retire. This is particularly acute with front-line eligibility staff because of the complex program rules that can take six months or more of experience 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. For a number of years, the division has asked the Department of Administration to conduct a study of the eligibility technician (ET) job class as one strategy that will help the division to hire and retain qualified individuals, strengthening the workforce and improving customer service, timeliness and accuracy of work. The Division of Personnel began the ET classification study in August 2009 and results are expected by the end of FY10.

Service Review Project

In addition to assessing the classification of the eligibility work, the division is also using existing resources to invest in innovative practices to provide better customer service, increase efficiency and streamline service delivery.

The dramatic increase in applications for service and unprecedented growth in the Food Stamp caseload have strained DPA's ability to keep up with adequate levels of customer service, timeliness and accuracy of decisions, and other program performance expectations.

To address this situation, the division started a Service Review Project, using the "LEAN" process management tools and techniques, which look at critical business practices in order to ensure that DPA can sustain a strong customer focus while making certain that every step in the division's core processes is efficient and value added. The project started in October 2009 and the division's vision is to develop and implement a customer-focused, staff empowered, highly efficient and world class service delivery model. DPA's goals are to increase access points for customers, implement efficiencies in work processes, maximize the use of available technology, increase the time available for customers who need more intensive services, and establish and implement the framework for an ongoing culture of continuous improvement. The Service Review Project will take advantage of process improvements including utilizing technology to improve customer service, improve the working environment for staff, and creating capacity to manage increasing caseloads by reducing complex processes.

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 FY11. The division was successful in competing for and securing federal ARRA 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 FY10 with full implementation in FY11. DPA expects 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 FY09 capital budget. A contract for development of the new database has been secured and once implemented will allow better tracking of alleged fraud, status of investigations, and their outcomes.

The division will also be undertaking a comprehensive business needs assessment and feasibility study to evaluate options and the costs for upgrading or replacing the Eligibility Information System (EIS). Initiation of this project was delayed due to turnover of staff and the need for the division to concentrate on other important program and service-related priorities. This delay has had unforeseen benefits, allowing the division to align new system features with refined business processes identified through the service review project, and the future needs stemming from the potential advent of Health Care Reform. DPA expects to have a Project Manager hired and preparation for the business needs assessment and feasibility study to begin in 2010. This is a very large project and the division estimates it will take up to two years to complete. Originally implemented in 1984, EIS is the backbone of Public Assistance operations. Multiple agencies rely on EIS as it is a complex system that supports Alaska's public assistance programs including: Food Stamps, Medicaid, Temporary Assistance, Denali KidCare, Child Care Assistance, Senior Benefits, General Assistance, Adult Public Assistance, Interim Assistance, and Work Services. EIS supports application tracking, eligibility, budgeting, benefit payments and benefit recovery, correspondence, accounting, and federal reporting.

While EIS has been a reliable system for over 25 years, its aging application is costly to maintain and limits DPA's ability to gain efficiencies by using more advanced applications. Many significant changes in public assistance programs, program requirements, and associated 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 support better customer service, timeliness, and accuracy of eligibility decisions.

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Status #1: In FY09, the Alaska Temporary Assistance Program showed a 5% decline in the number of families receiving benefits.

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY09	-10%	-6%	-2%	-5%	-5%
FY08	-7%	-7%	-5%	-6%	-6%
FY07	-5%	-11%	-13%	-10%	-9%
FY06	-23%	-22%	-19%	-20%	-22%
FY05	-6%	-7%	-8%	-6%	-7%
FY04	-12%	-7%	-6%	-9%	-9%
FY03	-1%	-11%	-14%	-13%	-9%
FY02	-16%	6%	4%	3%	-2%

Analysis of results and challenges: Overall, there has been a 61% decline in the caseload since FY96.

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 FY09 percent of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 85% compared to 86% in FY08 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
2010	82%	0	0	0	82%
2009	88%	86%	83%	82%	85%
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 FY09 decreased to 31% from the past four year norm.

Percent of Temporary Assistance Adults with Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2010	31%	0	0	0	31%
2009	34%	31%	28%	31%	31%
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 FFY09, 37% of Alaska Temporary Assistance families met the federal participation requirements, exceeding the federal target of 33%.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2009	38%	36%	36%	36%	37%
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 FY09, 90% 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
FY10	88.5%	0	0	0	88.5%
FY09	89.6%	90.2%	87.2%	89.6%	89.6%
FY08	93.1%	90.4%	86.6%	88.4%	88.4%
FY07	96.5%	96.2%	96.3%	96.4%	96.4%
FY06	95.0%	95.6%	96.0%	95.7%	95.7%
FY05	90.9%	92.3%	92.7%	93.5%	93.5%
FY04	93.2%	93.8%	94.5%	94.7%	94.7%
FY03	94.0%	90.5%	90.8%	92.1%	92.1%
FY02	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 FY09, 86% 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
FY10	86.0%	0	0	0	86.0%
FY09	88.9%	89.2%	86.9%	85.8%	85.8%
FY08	94.8%	92.2%	89.6%	90.3%	90.3%
FY07	97.2%	97.3%	97.2%	97.1%	97.1%
FY06	95.4%	95.9%	96.1%	96.2%	96.2%
FY05	95.2%	95.5%	95.7%	95.9%	95.9%
FY04	96.2%	96.1%	96.3%	96.5%	96.5%
FY03	95.9%	95.1%	95.1%	95.5%	95.5%
FY02	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 FY09, 86% 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
FY10	84.8%	0	0	0	84.8%
FY09	89.9%	89.0%	84.3%	85.8%	85.8%
FY08	94.6%	93.9%	92.6%	92.4%	92.4%
FY07	99.7%	99.5%	99.5%	99.1%	99.1%
FY06	99.4%	99.5%	99.5%	99.5%	99.5%
FY05	99.5%	99.5%	99.5%	99.6%	99.6%
FY04	99.6%	99.6%	99.6%	99.6%	99.6%
FY03	99.5%	99.5%	99.4%	99.4%	99.4%
FY02	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 FY09, 65% 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
FY10	67%	0	0	0	67%
FY09	78%	80%	74%	65%	65%
FY08	83%	82%	81%	81%	81%
FY07	85%	83%	83%	84%	84%
FY06	88%	86%	86%	87%	87%
FY05	85%	84%	85%	85%	85%
FY04	88%	88%	88%	88%	88%
FY03	90%	88%	89%	90%	90%
FY02	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 FY09, 71% of Medicaid applications were processed within 30 days, a 7 percentage point increase from FY08.

Percentage of Medicaid applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY10	74%	0	0	0	74%
FY09	77%	72%	71%	71%	71%
FY08	71%	64%	60%	64%	64%
FY07	88%	84%	78%	78%	78%
FY06	89%	88%	89%	89%	89%
FY05	92%	91%	91%	90%	90%
FY04	88%	91%	91%	91%	91%
FY03	91%	90%	90%	90%	90%
FY02	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 FFY08, 92.6% of food stamp benefits were accurate.

Percentage of accurate food stamp benefits

Federal Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY09	93.8%	94.2%	95.1%	0	95.1%
FFY08	91.1%	93.9%	92.8%	92.6%	92.6%
FFY07	95.1%	96.3%	96.3%	96.1%	96.1%
FFY06	92.3%	93.5%	94.1%	94.3%	94.3%
FFY05	92.2%	93.2%	93.0%	93.8%	93.8%
FFY04	90.8%	94.2%	93.5%	93.3%	93.3%
FFY03	86.2%	84.7%	85.6%	86.4%	86.4%
FFY02	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 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.

Target #2: 95% of temporary assistance benefits are accurate.
Status #2: The FFY07 Alaska Temporary Assistance benefit accuracy is 99%, a 5-year high.

Percentage of accurate temporary assistance benefits.

Federal Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY09	98.8%	97.7%	0	0	97.7%
FFY07	99.4%	99.3%	99.1%	98.8%	98.8%
FFY06	98.1%	96.3%	97.7%	96.3%	96.3%
FFY05	98.5%	95.9%	95.7%	97.1%	97.1%
FFY04	96.7%	97.5%	98.2%	98.1%	98.1%
FFY03	94.4%	93.6%	94.5%	93.6%	93.6%
FFY02	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 FY08 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 FFY09, 99% of the Medicaid eligibility determinations were accurate.

Percentage of accurate Medicaid eligibility determinations

Federal Fiscal Year	YTD Total
FFY09	99%
FFY07	96%
FFY06	95%
FFY05	93%
FFY04	99%
FFY03	99%
FFY02	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 FY09, 71% of children receiving child care assistance were in licensed care, down from 78% in FY06.

Percentage of subsidy children in licensed care

Fiscal Year	September	December	March	June	YTD Total
FY09	74%	74%	72%	71%	71%
FY08	73%	72%	73%	70%	73%
FY07	74%	74%	76%	74%	75%
FY06	80%	84%	75%	72%	78%
FY05	74%	81%	77%	80%	77%
FY04	75%	76%	76%	76%	76%
FY03	65%	66%	68%	75%	75%
FY02	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.

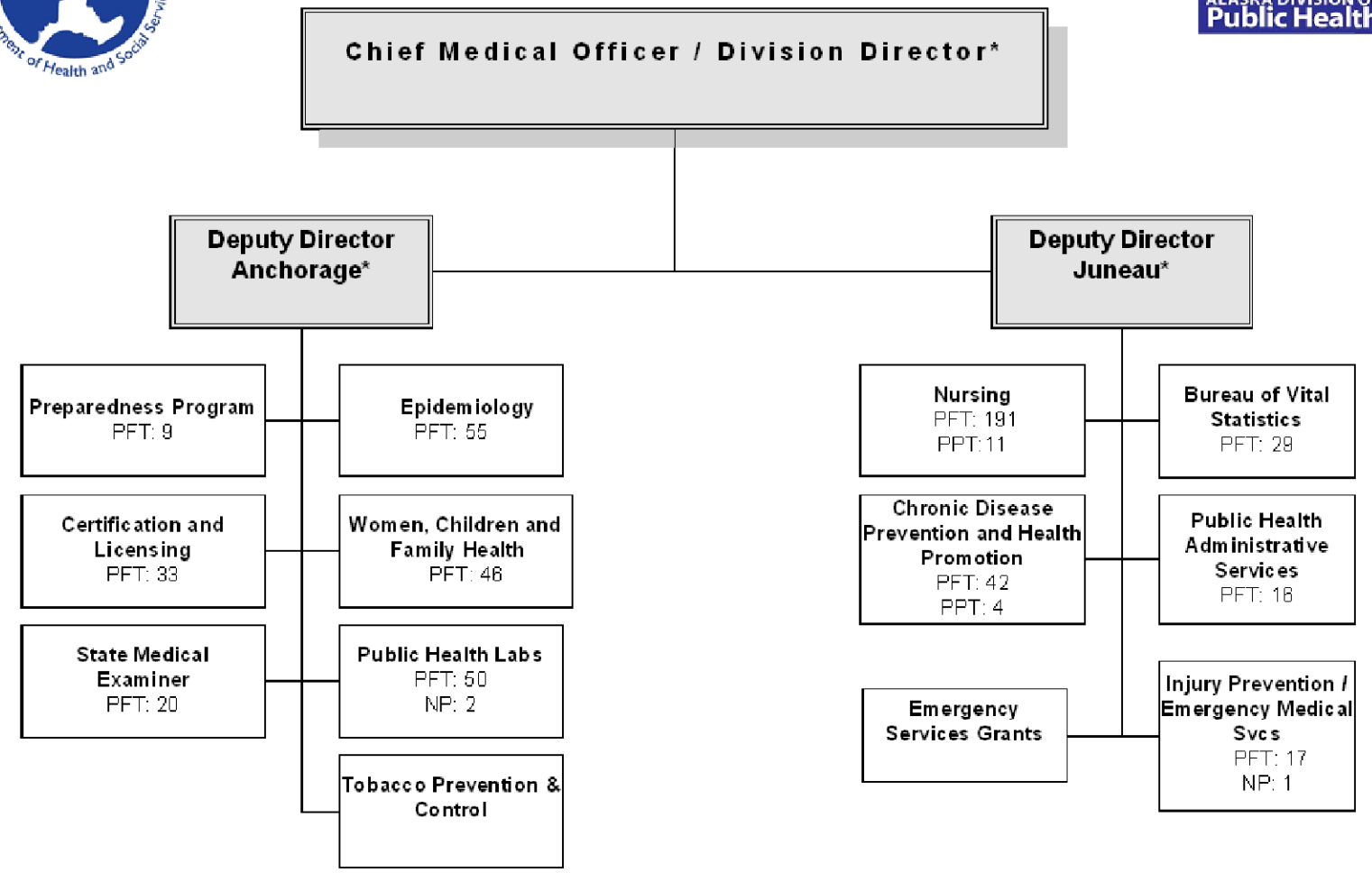
The number of working families participating in the Child Care Assistance Program has decreased over the past year. The decrease is partially attributed to state rates for child care not keeping up with the rates that child care providers charge. As state rates decline in relation to the market rate, 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.

FY11 Governor's Request Increment and Decrement Fund Breakout

Division of Public Assistance FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Adult Public Assistance Enrollment Growth	$ 150.0	$ -	$ -	$ 150.0
ARRA Child Care Program HB199 Carryforward	$ -	$ 3,500.0	$ -	$ 3,500.0
Reverse ADN 0609608 ARRA Sec 1, CH 17, SLA 2009, P 3, L 13 (HB 199) Lapse Date 06/30/10	$ -	$ (4,036.0)	$ -	$ (4,036.0)
Increased Burial Costs for Indigent Alaskans	$ 100.0	$ -	$ -	$ 100.0
Restore Funding to Meet Original Senior Benefits Enrollment Projections	$ 850.0	$ -	$ -	$ 850.0
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 14 (HB 199) Lapse Date 06/30/10	$ -	$ (462.0)	$ -	$ (462.0)
Reverse New positions funded by HB199 (Ch 17, SLA09, P3, L14) for Supplemental Nutrition Assc Program	$ -	$ -	$ -	$ -
Reverse Television Advertising for Denali KidCare	$ (25.0)	$ -	$ -	$ (25.0)
Discontinuation of the Family Self Sufficiency Program	$ -	$ -	$ (90.5)	$ (90.5)
ARRA Funding for State Agency Model (SAM) Management Information System	$ -	$ 961.2	$ -	$ 961.2
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 16 (HB 199) Lapse Date 06/30/10	$ -	$ (777.7)	$ -	$ (777.7)
Public Assistance Total	***$ 1,075.0***	***$ (814.5)***	***$ (90.5)***	***$ 170.0***

Division of Public Health Budget Overview Org Chart

Total PFT:508
Total PPT: 15
Total NP: 9



*These positions are in the Public Health Administrative Services PFT Total

Introduction to the Division

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 six 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

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, gastrointestinal 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 the 2009 H1N1 strain of influenza virus and severe acute respiratory syndrome (SARS).

To prevent and control infectious diseases, 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, rapid identification, and response to outbreaks and epidemics. Staff travel to the site of disease outbreaks to conduct special investigations if necessary, and provide medical consultation to health care providers and information to the public on prevention and control of infectious diseases. 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 limited 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 Control and Emergency Medical Services

The Injury Prevention and Emergency Medical Services section works to prevent injuries by identifying causal factors and implementing prevention policies and strategies. 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 and 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, children's residential facilities, and senior adult and disabled residential facilities.

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, obesity, and tobacco use. The section funds an extensive tobacco counter-marketing media campaign, the Alaska Tobacco Quit Line (a service that provides tobacco cessation coaching and nicotine replacement therapy). In addition, it funds the programs of 36 grantees which focus on tobacco cessation, school-based tobacco prevention, and community-level policy and environmental change. In addition, the section collects, interprets and disseminates population-based data on the health status of youth and adults through the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System. These data are used not only by the section; they are used by many state agencies, local governments, school districts, and other organizations for program planning and tracking progress toward health goals. The section also houses the Cancer Registry and reports cancer data annually to the Centers for Disease Control and Prevention for national surveillance. These data are also used in responding to inquiries about perceived cancer clusters in communities. Finally, the section works with schools and local communities to educate the public and health professionals; collaborates with communities and partners to plan, implement and evaluate evidence-based strategies and interventions; advocates for the prevention and control of chronic diseases; and promotes healthy lifestyles. In addition to improving the quality of life for people with these conditions, these efforts are critical to controlling future health care costs by improving health outcomes.

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 section of Emergency Preparedness works to ensure that Alaskans are protected in the event of a public health emergency – whether natural (such as SARS and pandemic influenza) or manmade. The section's efforts are focused in several key areas, including emergency preparedness planning and readiness assessment; ensuring the capability for disease surveillance through epidemiological, biological, and chemical laboratory services; disseminating health information to the public through effective communications and information technology; providing emergency and disaster training and exercises; and implementing hospital preparedness.

Beginning in FY10, the Preparedness Program established its own budget component within the division. Program staff conduct activities throughout the division, including partnerships with public health nurses who provide leadership and participation 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; and 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 services 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 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 building the health care system infrastructure so Alaska's women, infants, children, and families can achieve their best possible health and well-being. The programs in this section work with other health care and community support service providers to assure that 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. Other programs address improving health outcomes, particularly in areas such as post-neonatal death, teen pregnancy prevention, child abuse prevention and early identification of children with neurodevelopmental conditions.

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, hospitals and clinics; designating trauma centers and recognizing pediatric emergency care centers; and administering state and federal grants that provide operational and capital equipment support for EMS systems across the state.

The Certification and Licensing section works to ensure the safety and quality of Alaska's hospitals, nursing facilities, assisted living homes, child care facilities and other residential and health care facilities by ensuring each of these facilities is properly licensed to provide services to vulnerable populations. The section provides additional safeguards against abuse and neglect of the state's vulnerable populations by providing criminal background checks for employees working in these facilities.

Protecting Human Health from Environmental Hazards

While the Department of Environmental Conservation, Division of Environmental Health, has the primary regulatory role in environmental health protection in the state, DPH works in close partnership with its staff to provide the human health and medical epidemiology expertise to support a common mission. At the local level, public health nurses coordinate community-based environmental hazard identification and response, while at the statewide-level, the Section of Epidemiology operates an Environmental Public Health program to evaluate the possible hazards to human health associated with the presence of hazardous substances in the environment. Program activities include providing medical consultation in response to hazardous substance emergency events; developing studies on subsistence food safety; bio-monitoring of mercury from fish consumption; conducting surveillance and targeted screening for blood lead; providing public health consultation at sites that contain hazardous substances; and providing public information and outreach regarding environmental health hazards. Also, in partnership with the Alaska Department of Natural Resources, the division has begun to develop 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 section, provides leadership and management support to all DPH sections 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

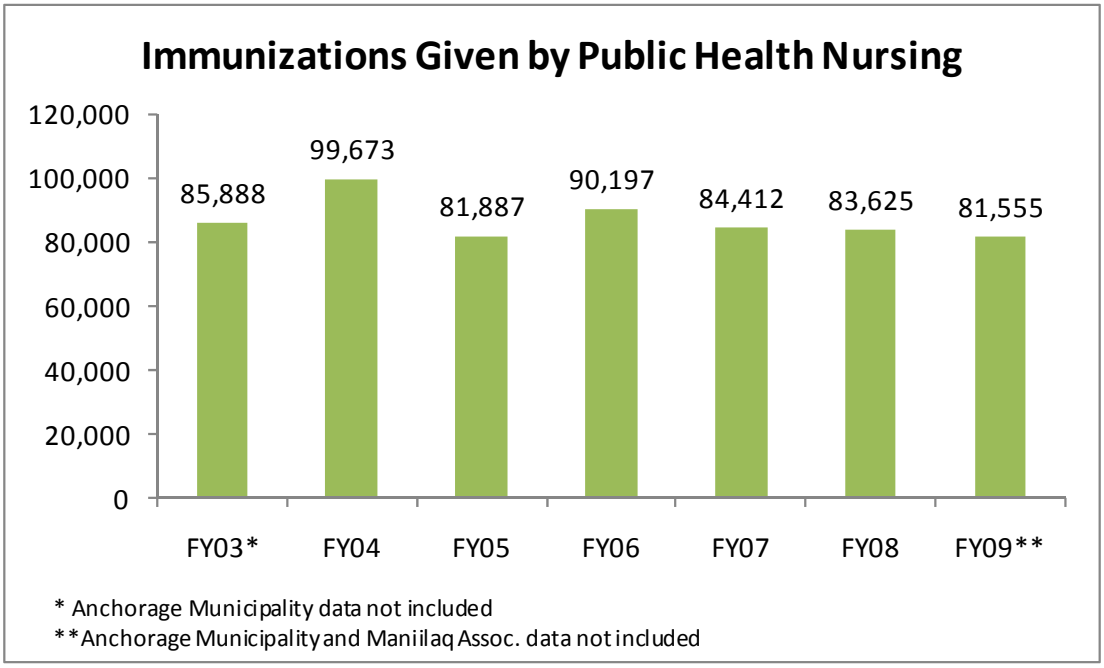
registration and documentation service to all Alaska residents, BVS provides research and analysis of vital events data in support of the development of public health policy.

Another 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 medico-legal investigation of unanticipated, sudden, or violent death. SMEO activities include providing an accurate, legally-defensible determination of the cause and manner of death, and conducting a comprehensive medico-legal death investigation.

Annual Statistical Summary of Services Provided in FY09

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 FY09 are provided below.

Public Health Nursing (PHN)



Public health nursing staff provide 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. PHN provides or assures essential public health services in the absence of local governments with the necessary health powers to serve as local public health authorities.

PHN staff provide public health services to 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. Five expert public health nurses 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.

In FY09, public health nurses*:

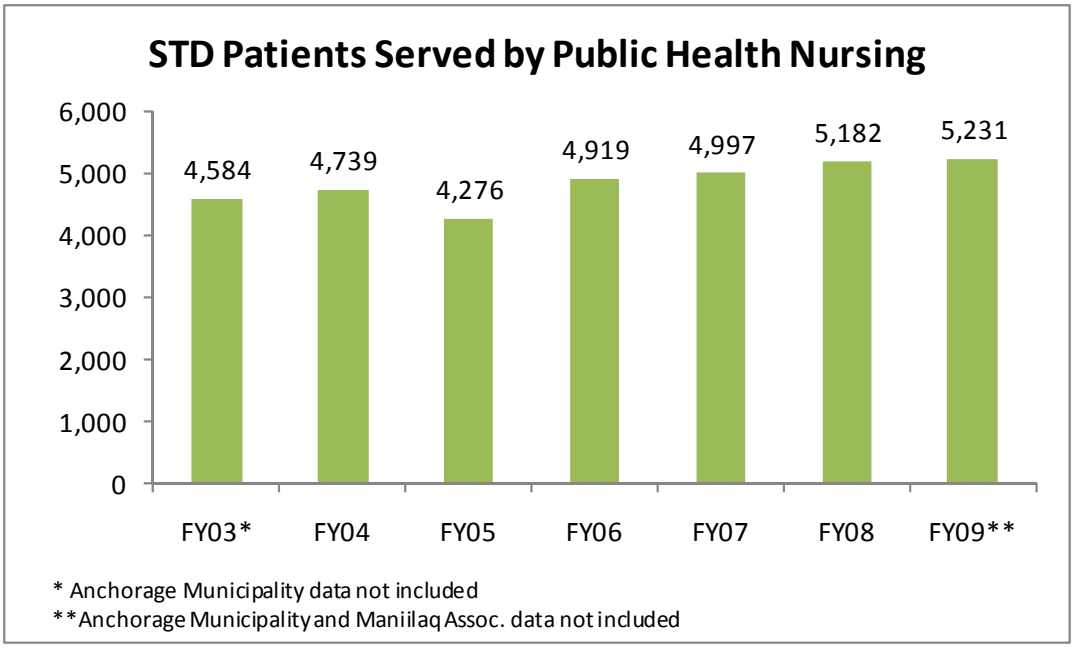
- Provided 104,437 health care visits to 66,772 individual patients.
- Provided 60,769 health care visits to 37,612 children and youth (newborns to 19 years old).
- Made more than 55 referrals to the Office of Children's Services for suspected child abuse, child neglect, or sexual offense against a minor.
- Screened 17,865 individuals for interpersonal/domestic violence; identified 479 individuals with positive or suspect results; these individuals were provided appropriate referral, education and/or counseling regarding protection of self and any children in the household
- Administered 81,555 doses of vaccine.
- Gave and read 14,526 tests for tuberculosis (TB).
- Initiated TB medication therapy for 218 individuals.
- Provided 1,521 Pap Smears for detection of cervical cancer in Alaskan women.
- Provided 11,191 visits for family planning to 5,283 individuals (80% of those visits were to young women ages 24 and younger).
- Provided 1,697 prenatal visits to 1,098 individuals and 1,573 postpartum visits to 1,031 childbearing women and families.
- Administered 103 newborn hearing screenings.
- Provided 9,205 visits to 5,231 patients for Sexually Transmitted Diseases.
- Provided 5,156 visits for HIV/AIDS services including blood testing for 3,038 patients.

**All service data is from the Resource Patient Management System (RPMS) FY09 Reports, 9/14/09. Note: Service data above does not include two of the four Public Health Nursing Services Grantees (Municipality of Anchorage and Maniilaq Association due to difficulties in accessing that data).*

Through the Nursing component in FY09 PHN also:

- Continued to increase 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.

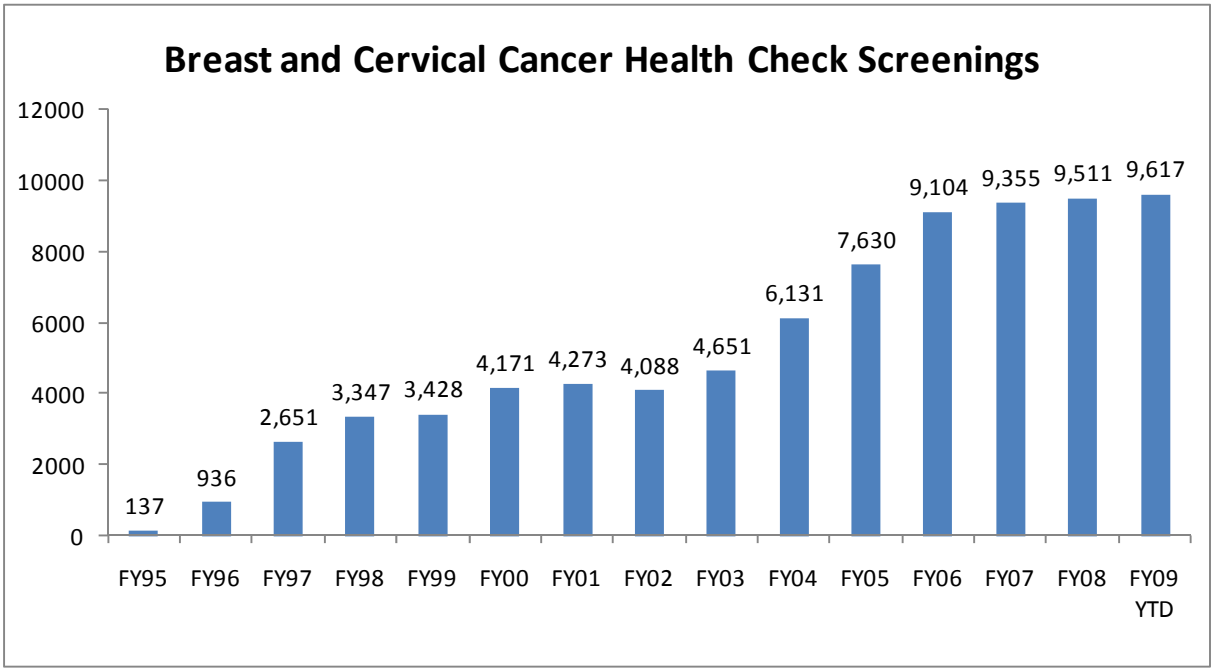
- Continued public health preparedness and response training, planning and exercise activities at both the state and local level:
  - More than 90% of PHN employees have participated in community preparedness exercises or events.
  - An online data collection tool was implemented to facilitate documentation of vulnerable/special needs populations in each community and to identify community mass care sites (including function, location, capacity, and resources). Data was recorded for 86 of the 243 communities in the system.
  - Nine mass-dispensing exercises were conducted (Bethel, Fairbanks Troopers, Fairbanks Airport, Mat-Su Troopers, Kodiak, Anatuvik Pass, Seward, Moose Pass, and Haines)
  - More than 400 nurses enrolled as volunteers in Alaska Nurse Alert System.



- Public Health Nursing focuses on population-based service 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 6,200 work hours focused on community and population-based public health nursing activities in FY09. These activities are broken down by program area: 36% community health improvement; 29% public health preparedness; 19% infectious disease; 11% child health; and 2% family health; and by activity areas including: 47% mobilizing partnerships, 19% community assessment, 18% health teaching, and 7% consultation. Results of partnership mobilization efforts include increases in the numbers and activity of local immunization and domestic violence coalitions to address these health issues sustainably at the local level.
- Continued involvement in community assessments to determine local health care needs and resources, to identify service gaps, and to stimulate community involvement to build a sustainable health services infrastructure and capacity. Approximately 53% of public health nurses are involved in community assessments with their community partners.
- Continued development of a Quality Assurance / Quality Improvement program to 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.
- Focused training on the appropriate use of fee-for-service and how to request payment from clients has resulted in an increase in revenues from $154,190 in FY06 to $190,478 in FY09.
- PHN Practice Guidelines were completed and distributed, articulating the current best practice for public health nursing in preventive services targeted in “Healthy Alaskans 2010.” A comprehensive review and statewide PHN discussion was implemented to assure PHN knowledge in the field.

Women, Children and Family Health (WCFH)
The Mission of the Section of Women, Children, and Family Health 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 in order to develop infrastructure and access to health services, and to deliver preventive, rehabilitative and educational services targeting women, children and families.

Services and programs delivered statewide include Adolescent Health; Breast and Cervical Health Check; Family Planning; Prenatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening; Early Hearing Detection, Treatment and Intervention program (EHDI); Pediatric Specialty Clinics; Genetics and Metabolic clinics; and School Health and School Nursing. In addition, the Maternal and Child Health Epidemiology Unit collects, analyzes and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaska women, children and their families.



Examples of services supported or coordinated by the Section of Women, Children and Family Health in FY09 include:

- The Breast and Cervical Health Check Program continued its lifesaving work. Since its inception, the program has provided 77,000 cancer screenings to 36,000 medically-underserved women. Of the women served, 232 cases of breast cancer, more than 30 cases of cervical cancer, and nearly 1,900 potentially pre-cancerous conditions have been identified.
- In support of the statewide planning for H1N1 and disaster management for children and pregnant women, the School Nurse Consultant participated in developing training and materials for mass flu immunization and kept school nurses informed on up-to-date information regarding H1N1 influenza.

- Through a partnership with the Division of Public Assistance, WCFH continued its statewide efforts 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 public service announcements (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.
- 100 percent of all newborn children were screened for over 30 metabolic conditions, and 95 percent of all newborns were screened for newborn hearing loss. In calendar year 2008, there were 6 confirmed cases of hearing loss in very young children with 19 young children currently being evaluated for hearing loss.
- Through a partnership with the Alaska Mental Health Trust Authority, the number of young children screened for autism and other neurodevelopmental conditions has increased as a result of additional outreach screening clinics held in communities outside of Anchorage, including Kodiak, Fairbanks, Juneau, Ketchikan, Dillingham, Nome, and Barrow. Family planning and reproductive services are offered by two grantees located in the Mat-Su Valley and in Homer. Over 2,285 women were served at these two locations in 2009.

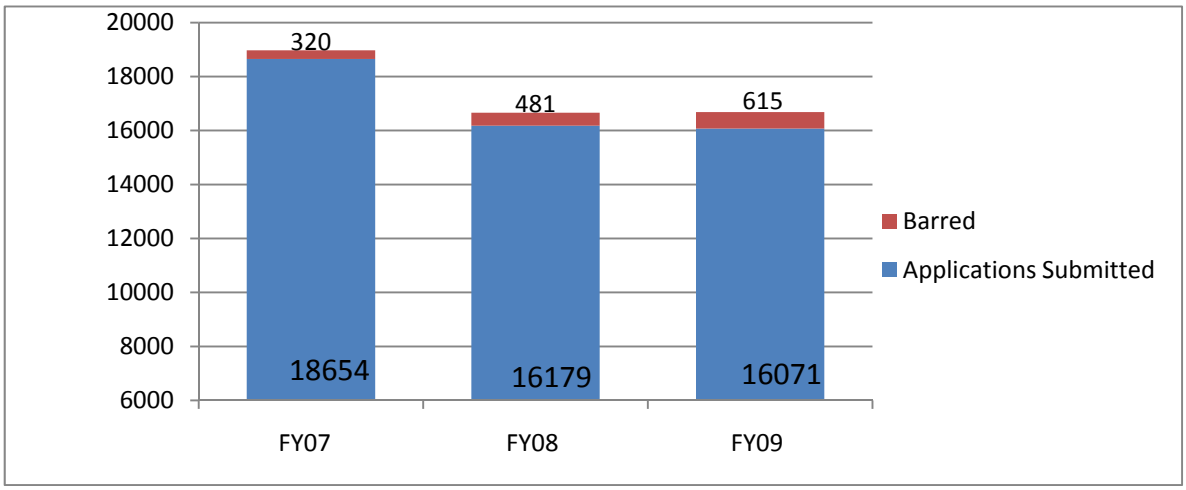
Certification and Licensing

The mission of the Section of Certification and Licensing is to protect and reduce the risk to Alaska's most vulnerable citizens being served, and to ensure that there is public confidence in the health care and community service delivery systems through regulatory, enforcement, and educational activities. This is accomplished by

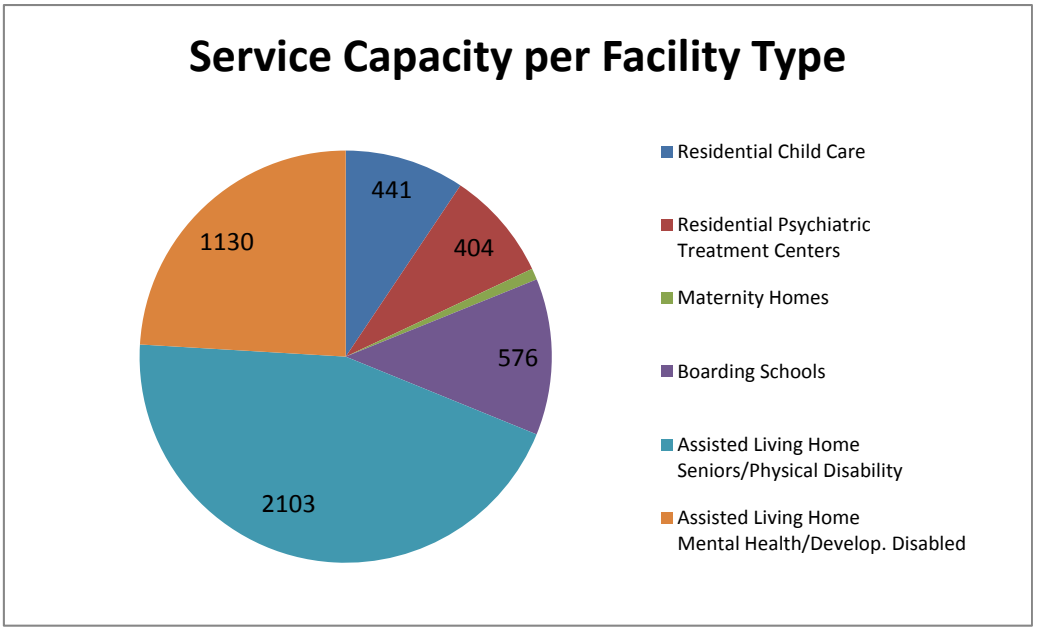
- conducting inspections of senior, disabled adult, and children's residential facilities to ensure compliance with state licensing requirements;
- receiving and investigating complaints involving residents' physical, mental, and sexual abuse; financial exploitation; and safety/sanitation concerns in these residential facilities;
- providing these facilities with a notice of violation, when necessary, and taking appropriate action when facilities fail to come into compliance with state or federal law;
- ensuring a process by which all service providers with direct access to vulnerable populations have a background check.

Continued services provided by Certification and Licensing in 2009 include:

- The processing of over 16,000 background check applications, with over 600 barring conditions identified; ensuring that disqualified individuals do not become service providers. The number of applications with barring conditions has doubled in the past two years.



- Licensing 600 residential facilities in which over 4000 Alaskans reside including: residential child care facilities; residential psychiatric treatment centers; maternity homes; boarding schools; and residential homes for seniors and those with physical and/or mental health disabilities.

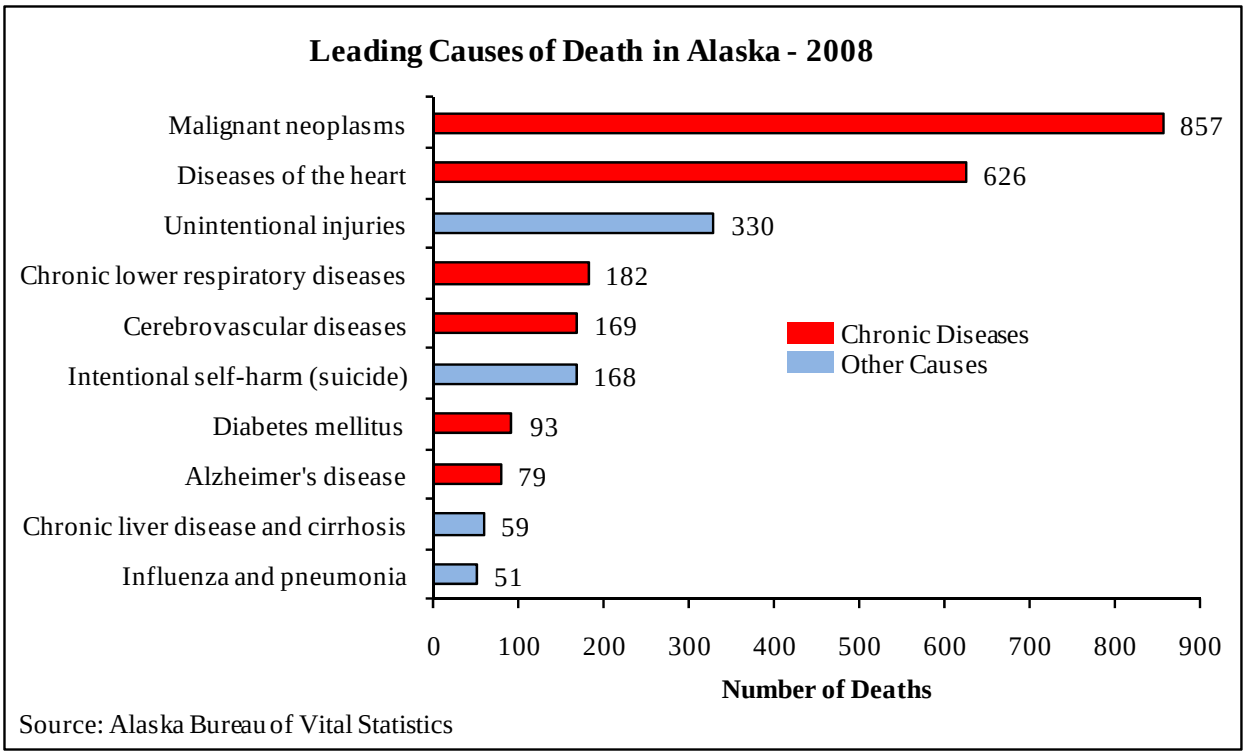


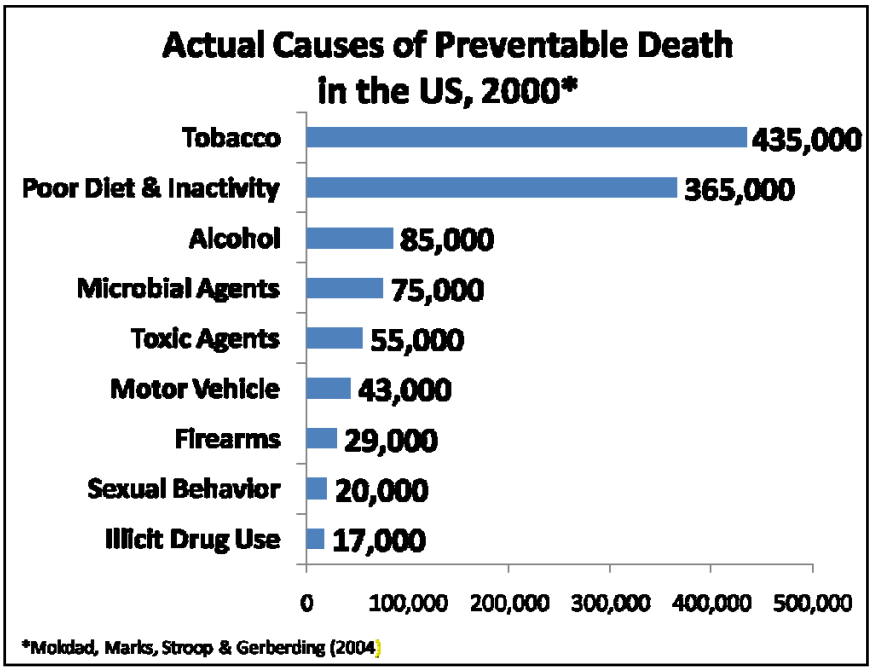
- Responding to 299 licensing complaints statewide.
- Successfully transition to processing background check applications for the Division of Public Assistance child care providers.
- Initial implementation of the Rural Live Scan Project. In conjunction with the Office of Children's Services, electronic transmission of fingerprints will be available for provider use in over 20 Office of Children's Services rural offices. Collaboration continues with the Anchorage Police Department (APD) Dispatch Unit in an effort to increase officer awareness in responding to calls involving a licensed home with vulnerable persons at risk and provide a direct mechanism to notify licensure staff of any unsafe conditions occurring at a licensed home. Updated lists of the Anchorage Homes are routinely forwarded to APD Dispatch.
- The growth of over 1500 entities currently using the Background Check program under the oversight of the divisions of Public Health, Senior and Disabilities Services, Public Assistance, Office of Children's Services, and Behavioral Health.
- Implementation of the Background Check Division Access which provides access to view background information to the divisions of Public Health, Senior and Disabilities Services, Public Assistance, Office of Children's Services, and Behavioral Health. This information may not result in a barring condition but still be a significant factor for licensing agencies that have supporting regulations which allow them to take action against an individual using the supplemental background information.

Chronic Disease Prevention and Health Promotion

The Section of Chronic Disease Prevention and Health Promotion seeks to improve the health and well being of all Alaskans. Programs include: Tobacco Prevention and Control, Health Promotion, Diabetes, Obesity, Heart Disease and Stroke, Cancer Registry, Comprehensive Cancer, School Health, and Data and Evaluation including the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System. These programs work to reduce the social, economic and health impacts of chronic disease by:

- Assessing the chronic disease burden;
- Educating health professionals and the public;
- 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.
- The lifestyle choices we make on a daily basis play a vital role in shaping our health status and lifespan. While heredity and environment play a part, the leading causes of death in Alaska are closely related to behaviors and lifestyle factors such as diet, exercise, tobacco and alcohol use, as well as preventive health practices. Changes in lifestyle could prevent diseases as well as premature death.





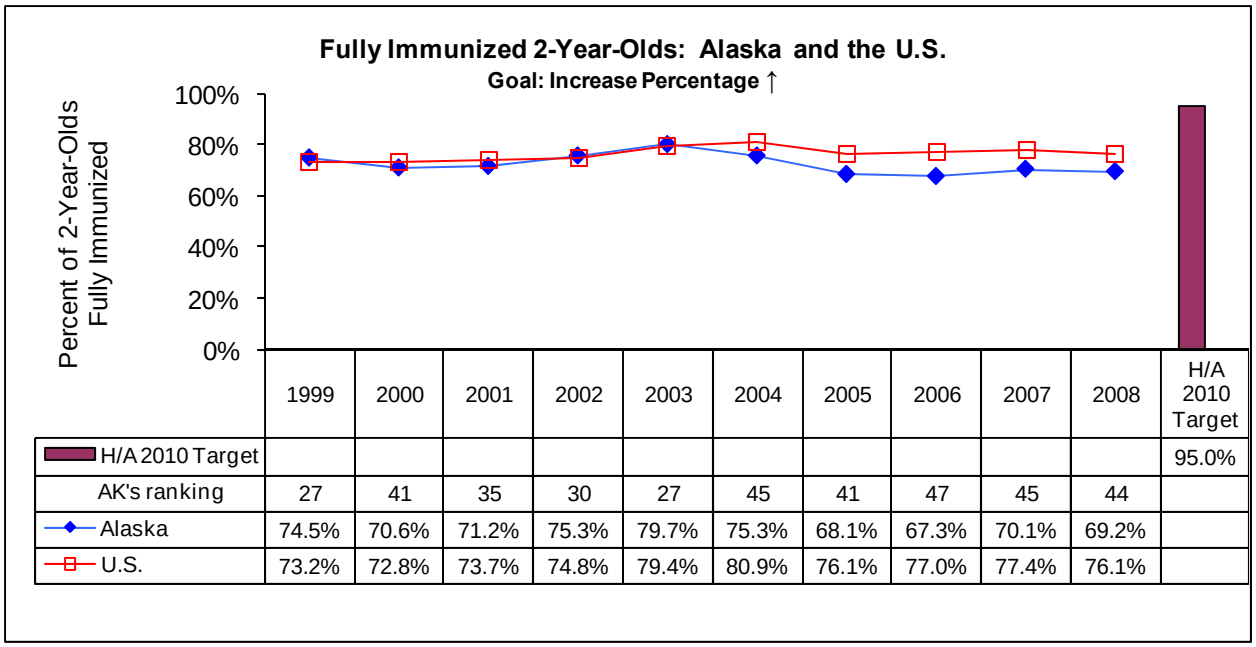
The section works primarily with population-based methods to help Alaskans make healthy choices. An example is tobacco taxes – by raising the cost of tobacco products, youth have more difficulty affording tobacco and are discouraged from initiating smoking or using smokeless tobacco; in addition, the increased cost of tobacco is an incentive for current tobacco users to quit.

Examples of services provided by Chronic Disease Prevention and Health Promotion programs in FY09 include:

- Successfully collected statewide, representative Youth Risk Behavior Survey data involving 30 school districts, 131 schools and 613 classrooms.
- Produced and published numerous documents, including the *AK 2008 Diabetes Burden Report*, the 2009 *AK Diabetes Resource Guide*, the 2007 BRFSS Annual Report *Health Risks in Alaska Among Adults, Childhood Obesity in Alaska, Prevalence of Overweight and Obesity among Anchorage School District Students, 1998-2008 and Cancer Prevention and Control in Alaska: 2009 Overview and Highlights*.
- Developed and coordinated community health status reports for six regions and census areas in Alaska.
- Received an award for the highest level of recognition for the Alaska Cancer Registry in the form of the North American Association of Central Cancer Registries gold certificate for meeting data quality, completeness and timeliness standards.
- Collaborated with DHSS Information Technology Services (ITS) to pilot the use of SharePoint for in-house web page updating with the Take Heart Alaska Coalition's website.
- Developed a website and updated content monthly for Division of Public Health and DHSS employees to promote healthy living through physical activity, healthy eating and elimination of tobacco use.
- Supported policy changes resulting in (but not limited to: 1) passage of a smoke free ordinance in Unalaska, 2) smoke free Aleutian Housing Authority's buildings, 3) pending smoke free workplace ordinances in the North Slope cities of Nuiqsut and Kaktovik, 4) passage of a ballot initiative in Juneau supporting a tax increase on tobacco, and 5) passage of a initiative in Haines for smoke free workplaces.

Epidemiology

The Section of Epidemiology provides surveillance for reportable health conditions to accurately assess the health of Alaskans, to detect disease outbreaks requiring intervention, and to assess the effectiveness of prevention strategies, such as immunization programs. Section staff also 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.



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	H/A 2010 Target
H/A 2010 Target											95.0%
AK's ranking	27	41	35	30	27	45	41	47	45	44	
Alaska	74.5%	70.6%	71.2%	75.3%	79.7%	75.3%	68.1%	67.3%	70.1%	69.2%	
U.S.	73.2%	72.8%	73.7%	74.8%	79.4%	80.9%	76.1%	77.0%	77.4%	76.1%	

Data Source: Alaska – Morbidity Database; U.S. – National Notifiable Diseases Surveillance System; H/A = Healthy Alaskans 2010

Examples of services provided by Epidemiology in FY09 include:

- The section has taken the following aggressive actions to respond to the 2009 H1N1 influenza pandemic in order to reduce the spread and severity of illness and provide timely information to health care providers and the public.
  - *Surveillance:* Influenza activity is being detected and monitored through various surveillance systems, including provider, hospital, and laboratory reporting mechanisms. The collected data are made available to the public on the division's pandemic influenza webpage

www.pandemicflu.alaska.gov

  - *Vaccine:* The section is working with the emergency operations staff to procure and distribute 2009 H1N1 influenza vaccine throughout the state. The 2009 H1N1 vaccinations are being recorded and tracked in VacTrAK, Alaska's new immunization registry.
  - *Clinician guidance:* The section provides updated information and guidance to providers via weekly health care provider teleconferences, creating and posting guidance documents on the panflu webpage, doing media interviews, publishing Epidemiology Bulletins, disseminating public health alerts, giving grand rounds and other lectures, and fielding telephone calls from providers.
  - *Public guidance:* The section provides updated information and guidance to the public by creating and posting guidance documents on the panflu webpage, doing media interviews, publishing Epidemiology Bulletins, giving lectures in the community, and fielding telephone calls from the public.
  - *Stockpile:* The section assists with oversight and distribution of the Strategic National Stockpile of antiviral drugs and other supplies.

- In partnership with the Alaska Department of Natural Resources, assisted with various health

impact assessments on proposed large-scale natural resource development projects.

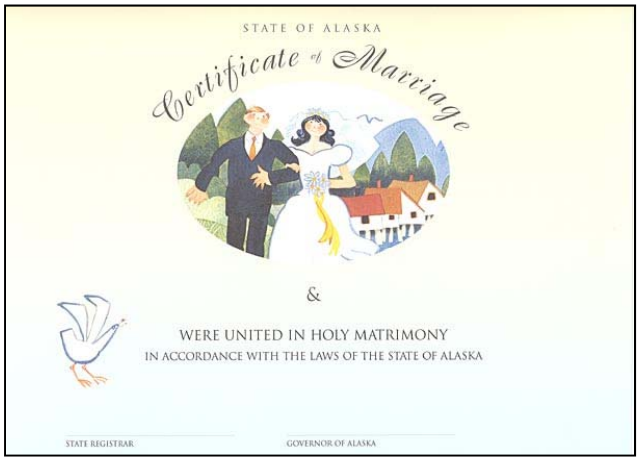
- Investigated an outbreak of *Campylobacter jejuni* infection in collaboration with the Alaska Department of Environmental Conservation (DEC). More than 60 individuals with laboratory-confirmed illness were identified and several required hospitalization. This investigation established a firm linkage 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 Epidemiology 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.
- Investigated an outbreak of norovirus infection associated with consumption of raw oysters.
- Assisted regional providers to control an ongoing response to a tuberculosis outbreak in the Yukon-Kuskokwim Delta region of the state.
- Participated with the Municipality of Anchorage DHHS in control an outbreak of tuberculosis among homeless persons in Anchorage.
- Worked closely with Juneau public and clinical health care providers to control an outbreak of pertussis in Juneau during the fall of 2008. After a community-wide pertussis immunization campaign, cases of pertussis decreased dramatically in 2009.
- Conducted HIV interviews, identifying contacts and additional high-risk individuals meriting follow-up.
- Conducted disease investigation and intervention activities related to HIV, chlamydia and gonorrhea.
- Investigated an outbreak of gonorrhea in the Bethel/Wade Hampton census areas.
- Established emergency regulations for gonorrhea prophylaxis of newborns' eyes to allow DHSS to adopt the recommended alternative medications listed by the CDC and to eliminate recommendations for the use of alternative regimens that are no longer available in pediatric dosages in the United States
- In partnership with the CDC, ANTHC, Region X Infertility Prevention Program, participated in Region X meeting to optimize strategies to reduce morbidity related to gonorrhea infection and developing antimicrobial resistance.
- Implemented *VacTrAK*, a secure Internet-based Immunization Information System (IIS), and a companion Disease Surveillance Management System. Implementation is ongoing.
- Published 22 Epidemiology *Bulletins* from July 1, 2008 - June 30, 2009 to inform health care providers and the public of important investigations, concerns, or alerts regarding health issues.
- Responded to 179 after-hours calls through the 24/7 emergency phone number through June 2009.
- Established new immunization recommendations for pneumococcal polysaccharide vaccine.
- Maintained a Vaccine Depot for distribution of vaccines, including 2009 H1N1 vaccine, to public and private providers throughout the state. Due to changes in vaccine distribution methodologies at the national level, Alaska is the only state that continues to provide vaccines from an in-state location. This is important not only to ensure appropriate vaccine distribution within Alaska's diverse settings, but also to provide an important resource for a

speedy Alaskan response in the event of a public health emergency/bioterrorism event. During FY08, the Vaccine Depot distributed over $10.5 million of vaccine to Alaska providers.

- 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 (BVS)

The Bureau of Vital Statistics 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 FY09, BVS processed 71,905 requests for vital records and recorded these events in Alaska:

- Births: 11,459
- Deaths: 3,529
- Total Registered Marriages: 5,566
- Marriage licenses issued by BVS: 4,294
- Divorces: 2,995
- Adoptions of Alaska-born children processed: 767

- Establishments of paternity of Alaska-born children processed: 3,725
- Funds for the Alaska Children's Trust from heirloom birth and marriage certificates: $20,440
- Applications for the Medical Marijuana Registry processed: 175

With funds approved in the FY09 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.

Injury Prevention and Emergency Medical Services (IPEMS)

The mission of the Section of Injury Prevention and Emergency Medical Services is to reduce the human suffering and economic loss to society from premature death and disability due to sudden illness and injuries through prevention activities and a comprehensive emergency medical care system. The section is responsible for increasing public awareness and actions that promote positive behaviors toward safety and health, and is responsible for development, implementation, and maintenance of a statewide comprehensive medical services system. The section also maintains the Alaska Trauma Registry, EMS Data system (AURORA), 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.

<u>Examples of services provided in FY09 include:</u>

- Fielded more than 10,000 calls to the Alaska Poison Control System and gave critical advice to Alaskans and their health providers.
- Established a web-based EMS and Trauma data system to improve data input and data outputs.
- Established 48 new Kids Don't Float life-jacket loaner sites, bringing the total to 514 active sites statewide.
- Distributed 1,286 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 – 72 rural communities received new equipment.
- Processed 4,562 applications for EMT certification in Alaska.

State Medical Examiner's Office (SMEO)

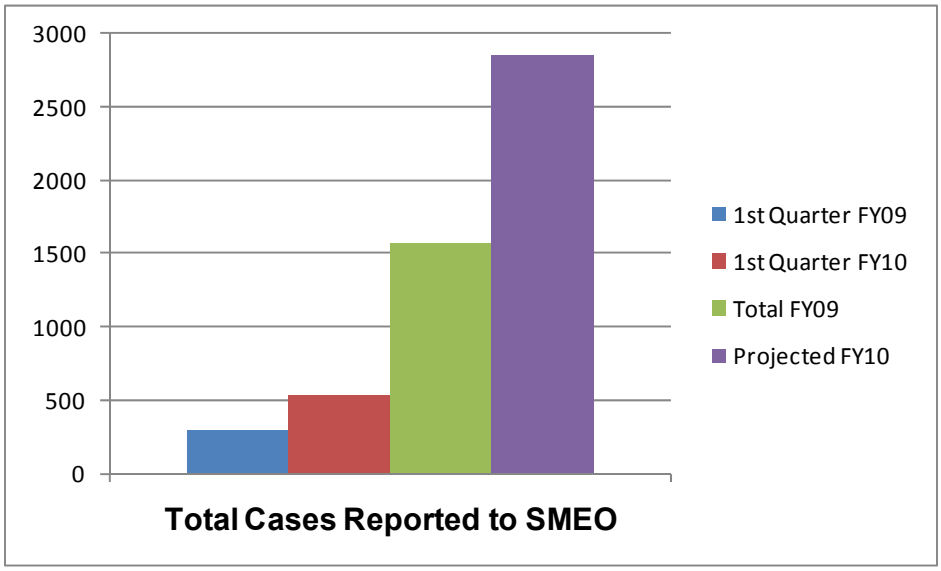
In support of department's mission to promote and protect the health and wellbeing of Alaskans, the State Medical Examiner's Office provides a statewide system for the medico-legal investigation of unanticipated, sudden and violent deaths in Alaska to make accurate, legally-defensible determinations of the cause of death, information to ensure appropriate follow-up on all child deaths in the state, and surveillance to detect new or unexpected infectious diseases.

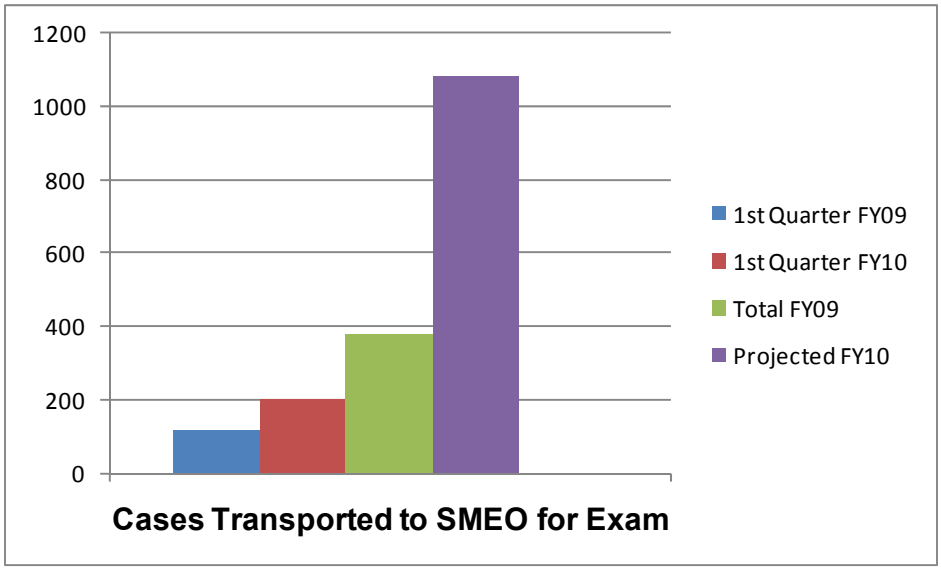
The SMEO investigates and certifies all deaths that occur within the state of Alaska that are a result of violence or suspected violence; deaths due to accidental causes; deaths that occur during incarceration; deaths that are associated with conditions that pose a hazard to public safety or health; and all unattended or unexplained deaths.

The central facility in Anchorage provides postmortem examinations appropriate for each case referred and includes access to state-of-the-art forensic medical services, including forensic pathology and radiology, odontology, anthropology, and the services of Public Health Laboratories and the Department of Public Safety Crime Detection Laboratory. For deaths that are investigated, the SMEO establishes identification of the deceased, if necessary; maintains records and evidence; provides legally defensible determinations of the cause and manner of death; and presents findings of the investigation to courts, law enforcement agencies, and other parties with legitimate interests in the death.

Other services include participating in training personnel involved in death investigations, including forensic medico-legal investigators, local physicians, state and local police, village public safety officers and other authorities, and providing expert testimony in court cases throughout Alaska.

Projected Cases for the State Medical Examiner Office (SMEO) for FY10





Major Accomplishments in FY09

Total Cases Reported:	1556
Cases Autopsied:	253
Cases External Examination (Inspection):	124
Cases with Consult:	719
Cases with Natural Causes:	460

- Continued on the Accreditation track, as recommended by the National Association of Medical Examiners (NAME). This included hiring a Chief Medical Examiner, an additional Deputy Medical Examiner, and an additional Medico-legal Death Investigator. Restructured the SMEO chain of command and created new management positions to include an Operations Administrator, Medico-legal Death Investigations Supervisor, and Forensic Operations Supervisor.
- After several years of research and collaboration with DHSS Information Technology Services (ITS) and various others, the State Medical Examiner's Office now has a state-of-the-art database for all case files, research capabilities, statistical reporting and case-file management in a more comprehensive manner. The web-based database has the potential to allow other division sections and state and federal agencies to extract information needed to complete statistical formulations. The new database went live on December 1, 2008.
- Presented lectures for law enforcement recruits in both Sitka and Fairbanks.
- Collaborated with numerous state and federal agencies to gather statistics. This information was for local and national programs, which may provide information on consumers, work-related accidents, violent deaths, and motor vehicle accidents, to name a few.
- Continued the monthly safety trainings with Public Health Laboratory staff to ensure that employees are updated with Occupational Safety and Health Administration (OSHA) standards.
- Continued equipment upgrades and purchased digital voice recorders and digital transcription software for the use of the forensic pathologists in dictations of their examinations.
- Collaborated with the Public Health Laboratory which provides services to the SMEO for the repository and distribution of toxicology specimens to the toxicology laboratory, and conducts alcohol and carbon monoxide testing at the request of the forensic pathologist.
- Collaborated with the Section of Epidemiology in various epidemiological studies regarding deaths by alcohol, or firearms, as well as occupational deaths.

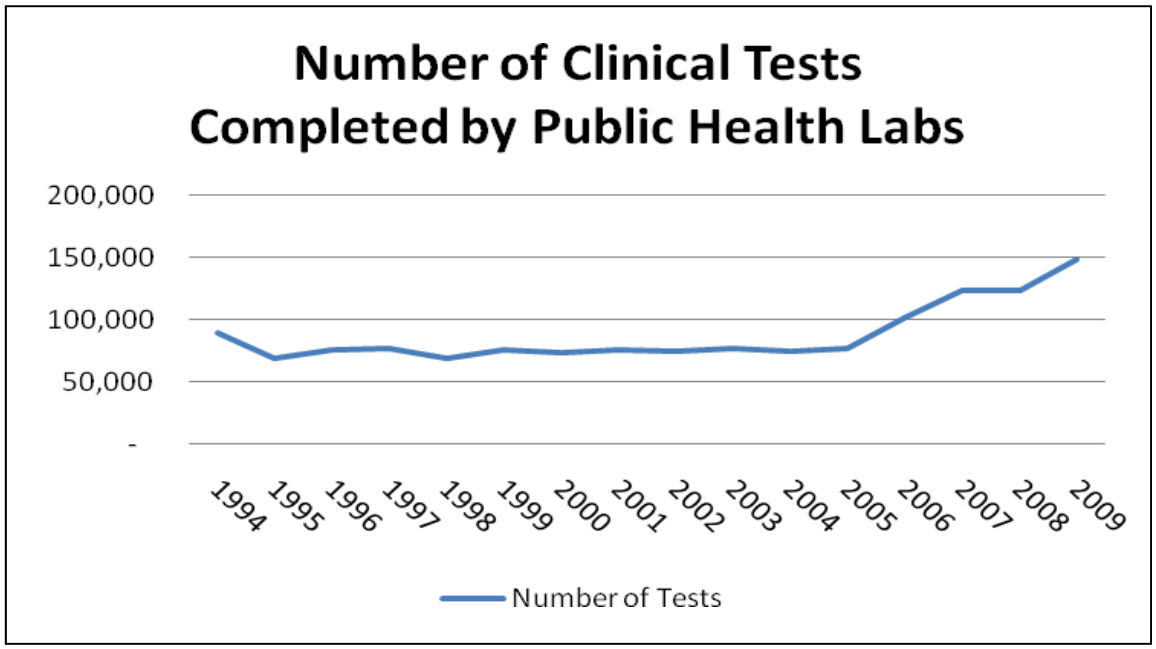
Public Health Laboratories

The laboratories provide 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, the 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 FY09 include:

The laboratory received and processed 148,331 clinical test requests, compared to 123,450 for FY08, representing approximately a 20% increase over the previous fiscal year.

- STD tests: 55,312
- Hepatitis tests: 22,447
- Tuberculosis tests: 23,742
- Toxicology tests: 1,831
- Viral tests: 73,767 (up 12% from FY08 due to many tests for influenza and other respiratory viruses)



The Laboratory also tested 349 samples suspected of containing biological threat agents and 132 samples from botulism outbreaks. Alaska consistently has the highest rate of food-borne botulism in the country.

Preparedness Program
The Preparedness and Response programs focus 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 FY09 include:
H1N1Response and Working Groups - In Spring 2009, the section of Emergency Preparedness opened its Emergency Operation Center (EOC) to respond to the novel H1N1 influenza pandemic. EOC staff coordinated information sharing with local, tribal, state, federal, and private industry partner agencies. Response focused on surveillance, lab testing and shipping antiviral medications and personal protective equipment to 39 locations throughout the state. In June 2009, the section convened multiple working groups with partner agencies to plan H1N1 vaccine distribution and administration, a public information campaign, and community containment strategies. In September 2009, community workshops were conducted to assist in local planning for H1N1.

Mass Vaccination Clinic Exercises – The section conducted 27 Mass or Targeted Vaccination Clinic Exercises around the state in large urban areas and small rural villages. They were designed to test community plans to dispense vaccine to their citizens in a relatively short period of time. They were exercises designed to be relevant in event of a real live pandemic flu epidemic or other large-scale public health emergency. The events tested the community's abilities to plan, coordinate and administer a program in an emergency situation using healthcare staff and volunteers.

Pediatric Rural Medical Surge Exercise - The Pediatric Rural Medical Surge exercise was developed to test the ability of the division to identify, organize and send healthcare resources, including physician, nurses, respiratory therapist and pediatric medical equipment to a rural community to support pediatric medical care The planning team included partner agencies: Samuel Simmonds Hospital, Alaska Native Medical Center, Providence Hospital, Fairbanks Memorial Hospital and the All-Alaska Pediatric Partnership.

Emergency Preparedness Summits – September 08 and January 09 **–** The division partnered with the Alaska Division of Homeland Security & Emergency Management to hold Emergency Preparedness Summits for local emergency management and health care representatives in September (Fairbanks) and January (Juneau). These training summits were held in conjunction

with the State Emergency Response Commission and Local Emergency Planning Committee Association meetings and included training in sheltering for special needs populations and community containment strategies for pandemic influenza.

Healthcare Preparedness Conference – The section of Emergency Preparedness conducted the eighth annual Healthcare Facilities Preparedness Conference at Providence Alaska Medical Center in January 2009. Over 50 attendees heard information on emergency and health care preparedness issues with local, State, and Federal agencies; Healthcare Preparedness Grant requirements for 2009; resources available for planning and conducting exercises; and real life hospital responses to California wildfires.

Special Needs Planning - The Preparedness program began working on Special Needs Sheltering plans and tools to assist local communities to plan and operate special-needs shelter in times of disaster or emergency situation. These shelters are designed for patients who need sheltering and also require care for medical conditions that do not require hospitalization. The section participated in the April 2009 Ketchikan Cruise Ship Exercise that tested the community's ability to open and staff a special needs shelter and triage cruise ship passengers to that facility that could provide appropriate care.

List of Primary Programs and Statutory Responsibilities

Statutes	
AS 08.36.271	Dentist Permits for Isolated Areas
AS 08.64.369	Medicine
AS 08.68	Nursing
AS 09.55	Special Actions & Proceedings
AS 09.65.090, 095, 100	Actions, Immunities, Defenses & Duties
AS 09.65.161	Immunity for Disclosure of Required Health Care Data
AS 11.41.434-.440	Sexual Abuse of a Minor
AS 11.81.430	Use of Force, Special Relationships
AS 12.55.155	Sentencing & Probation
AS 12.65	Death Investigations & Medical Examinations
AS 13.52	Health Care Decisions Act
AS 14.07	Administration of Public Schools
AS 14.07.020	Duties of the Department of Education and Early Development
AS 14.30	Physical Examinations & Screening Examinations
AS 14.30.125	Immunization
AS 17.37	Medical Use of Marijuana
AS 18.05	Administration of Public Health & Related Laws
AS 18.05.042	Access to Healthcare Records
AS 18.07	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 18.20.200	Acceptance of Gifts
AS 18.23	Health Care Services Information & Review Organizations
AS 18.25	Assistance to Hospitals & 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	Parent and Child
AS 25.23.160 - 170	Adoption
AS 26.23	Disasters
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 Record Disclosures
AS 43.70	Alaska Business License Act
AS 44.29	Department of Health & Social Services
AS 44.29.02	Duties of Department
AS 44.62	Administrative Procedure Act
AS 44.62.245	Material Incorporated by Reference
AS 47.05	Criminal History & Registry
AS 47.05.012	Material Incorporated by Reference
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 47.20.300-390	Newborn and Infant Hearing Screening, Tracking and Intervention Program
AS 47.24	Protection of Vulnerable Adults
AS 47.25	Public Assistance
AS 47.30	Mental Health
AS 47.32	Centralized Licensing & Related Administrative Procedures
AS 47.33	Assisted Living Homes
AS 47.35.010	Child Care Facilities, Child Placement Agencies, Child Treatment Facilities, Foster Homes and Maternity Homes
AS 47.40	Purchase of Services
AS 47.2	

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
7 AAC 12.810	Laboratory Safety
7 AAC 16.010 – 090	Do Not Resuscitate Protocol & Identification
7 AAC 18	Radioactive Materials
7 AAC 26.280, 390, 710	Emergency Medical Services
7 AAC 27	Preventative Medical Services
7 AAC 27.011	Reporting of Cancer and Brain Tumors
7 AAC 27.510-590	Screening of Newborn Children for Metabolic Disorders
7 AAC 27.600-629	Newborn Hearing Screening
7 AAC 27.892	Maintaining List and Registries of Immunizations
7 AAC 35	Embalming & Other Post-Mortem Services
7 AAC 37	Public Assistance
7 AAC 41	Childcare Assistance Program
7 AAC 48	Chronic Illness & Chronic & Acute Medical Assistance
7 AAC 50	Community Care Licensing
7 AAC 50.455	Health in Full Time Care Facilities
7 AAC 57.550	Health
7 AAC 75	Assisted Living Homes
7 AAC 78.010 - 320	Grant Programs
7 AAC 80	Fees for Department Services
7 AAC 105-160	Medicaid Coverage & Payment
12 AAC 02.280	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
22 AAC 05	Physical Examination for Children

Federal authority

Title X Family Planning Program
Title XVIII Medicare
Title XIX Medicaid
Title XXI Children's Health Insurance Program
10 CFR Nuclear Regulatory Commission – Authority to Regulate
21 CFR 900 Mammography Quality Standards – Authority to Inspect

Public Health	FY10	FY11 Gov	10 to 11 Change
General Funds	35,662.8	39,294.4	3,631.6
Federal Funds	36,517.0	38,671.4	2,154.4
Other Funds	22,827.4	18,830.0	(3,997.4)
Total	**95,007.2**	**96,795.8**	**1,788.6**

Nursing

Transfer Funds from Health Care Services for Medicaid Administrative Claims: *$4,000.0 Total; $2,000.0 Fed, $2,000.0GF*

This transfer increases efficiency and reduces paperwork by eliminating a budgeted RSA with Health Care Services/Medicaid Services and allowing Public Health Nursing to make their Medicaid administrative claim directly. Nursing supports administration of the Medicaid State Plan by providing outreach, referral, and education to Medicaid eligible children and adults. Medicaid Services has traditionally made the Medicaid administrative claim on behalf of Nursing through an RSA; however, all other sections in the department that have Medicaid administrative claims make their claim directly. Placing the federal and general fund match in the budget of the section responsible for making the match payment is more effective, efficient, and transparent. This funding allows Nursing to maintain its current level of administrative support to the Medicaid program. The amount of the transfer is based on the budgeted RSA amount. The federal government reimburses 50% of most administrative costs.

There is a corresponding change record to reduce I/A authority due to the discontinuation of this RSA.

Maintaining Local Control of Essential Public Health Services: Stabilize Funding to Public Health Nursing Grantees: *$1,000.0 GF*

Four public health nursing grant recipients (the Municipality of Anchorage, Norton Sound Health Corporation, North Slope Borough and Maniilaq Association) assure that parts of the state served by grantees receive essential public health nursing services. These services include prevention, treatment and control of infectious diseases, including low cost, readily accessible immunizations to protect against preventable infectious diseases. The three northern region grantees serve 23,439 people living in 31 villages over 216,000 square miles. The Municipality of Anchorage serves 42% of the state's population.

Local costs and grantee contributions have gone up significantly over the past several years while State funding support has remained stagnant. Grantee public health nursing salaries have not been consistent with state employee salaries and the rural areas suffer from chronic staff shortages due to the inability to attract nurses. As a result, nursing positions among the four grantees have decreased from 48.5 in 2003 to 29 in 2010. A 5% increment was awarded to the grantees for FY09 and maintained for FY10, but this made little impact on the financial gap that has resulted from many years with essentially unchanged grant funding. For example, the State grant funded 38% of the Municipality's public health nursing budget in 2001 and will be funding

25% in 2010. In FY10, the Norton Sound Health Corporation projected total public health nursing services cost of $1,427.6 while the State grant was $749.8.

Basic public health services provided by the grantees have dwindled over the past ten years, while public health concerns are on the rise. The Anchorage tuberculosis rate doubled from 2005 to 2006 with 14.7 cases per 100,000 (U.S. rate was 4.6). The 2008 tuberculosis rate for the Northern Region is 25.4 per 100,000. The 2007 Chlamydia case rate for the Northern Region is 2093 per 100,000 (U.S. rate was 370.2). Immunizations for the Northern Region decreased from 77% in 2000 to 70% in 2009. Due to inadequate funding, the Municipality discontinued its well child and home visiting programs in 2004, removing child rearing education and support for young high risk and high needs families. The North Slope Borough public health nurses no longer can provide prenatal or parenting education, nor offer other health education classes.

In the three northern regions these increased grant monies will primarily be used to stabilize existing operations through support for recruitment and retention of qualified nursing staff and for travel to provide services in 31 northern villages.

If this increment is not funded, services will continue to decrease and in some cases the grantees will discontinue the work and the state will need to resume direct responsibility for providing public health nursing services in those areas. In recent years each of these agencies has expressed some consideration of discontinuing provision of public health nursing services. One of them, Norton Sound Health Corporation, has now given written intent to discontinue acceptance of the public health nursing grant in order to decrease the financial drain on their agency. This would result in elimination of local oversight and contributions to the cost of services and a significant increase in cost to the state. It would cost the state approximately $1,200.0 to take over operation of these public health nursing services in FY10. In comparison, the proposed 40% increase in grant funding would cost approximately $1,050.0 and maintain the local role for public health nursing services.

Women, Children and Family Health

Replace Medicaid School-Based Administrative Claimed: *(347.0) I/A, 347.0 GF*
Keeping children healthy in school supports their learning readiness. The WCFH component uses the school-based administrative claims funds to support school nursing consultation and school health education programs. Children who miss school due to lack of required vaccinations, unstable chronic conditions such as diabetes, asthma, allergies and other ongoing illnesses miss out on important classroom time. Providing the support of school nurses and other health assistants in the school districts through the distribution of current school health guidelines, health information and innovative tools will result in better student performance and less absenteeism. School-based administrative claims have been temporarily suspended by the Centers for Medicare and Medicaid because claims were not being managed correctly by the Department. The Department is working on claiming compliance but needs general funds to maintain this important program in the interim. Personnel supported by this increment also assist in the development of school disaster planning readiness tools and training as WCFH is an active participant in disaster management and a key communicator with school nurses and school health officials. The personnel also reach out to families with children enrolled in Medicaid to assure that well child checks, including dental, vision and hearing screens, are conducted according to the approved schedules. Without this funding the positions and programs will be

limited and will be absorbed into existing federal grants, which are declining. In addition outreach education will be minimal and it is likely that children will miss out on vital health and development assessments, preventive care and earlier intervention for identified problems.

***MH Trust: Workforce Development-1452.02 Autism Capacity Building**: $75.0 MHTAAR*
It is estimated that 60 Alaskan children will be newly diagnosed each year with Autism Spectrum Disorder. Identifying autism in infants or toddlers results in earlier referral to intervention services and assists in more educational success in school leading to improved productivity as an adult. This request provides for ongoing support in sustain the capacity building activities underway at present and to provide for a diagnosis and comprehensive referral system for Autism Spectrum Disorder.

Epidemiology

***ARRA funding for Healthcare-Associated Infections (HAI) Prevention:** $144.0 Federal ARRA*
The Department of Health and Social Services, Division of Public Health, Section of Epidemiology was awarded an American Recovery and Reinvestment Act (ARRA) grant award of $201.8 in September 2009. The division requested and had approved an RPL to expend $57.8 in FY10. This request is for an additional $144.0 of federal authorization needed to receive and spend funds over the next two years (28 months). The grant is to develop a statewide Heathcare-Associated Infections (HAI) prevention program. The main activities supported by these grant funds will be to hire an HAI Prevention Coordinator; to write and submit the State HAI Prevention Plan; and to create a multiagency Advisory Group to assist the Section of Epidemiology in state HAI prevention planning. Grant funds are to be spent by December 31, 2011 (28-month grant period).

The funding will be used to fill an Anchorage-based Nurse Consultant (NC) II position that has been vacant for several years. Funds support 0.5 FTE of a NC II; travel for a training trip in Atlanta, GA sponsored by the Centers for Disease Control (CDC); and some supplies. The remaining 0.5 FTE funding will come from a federal preparedness grant with the expectation that the NC II would also assist with pandemic influenza issues related to hospitals.

The funds awarded to Alaska are for minimal activities, but will allow for Epidemiology to hire staff to create an Alaska HAI Prevention Plan by January 2010. The consequence of not submitting that plan is a 25% cut to the Preventive Health and Human Services (PHHS) Block grant that funds activities in the Section of Chronic Disease Prevention and Health Promotion (CDPHP). Although the PHHS grant does not fund activities related to HAI nor does CDPHP otherwise engage in such activities, the stipulation was part of the 2009 Omnibus spending bill.

State Medical Examiner's Office

***Phase I of State Medical Examiner's Office Reforms:** $300.0 GF*
This increment will provide additional funding for Phase I of III of the Medical Examiner's Office reforms so that all Alaska communities receive the same level of service the Medical Examiner's Office currently provides in Anchorage and the Mat-Su Valley. Phase I funding will allow the Medical Examiner to at least maintain the current levels of investigation and examination for cases statewide and take jurisdiction of more cases.

The purpose of the State Medical Examiner's Office is to bring trained medical evaluation to the investigation of deaths that are of concern to the public health, safety, and welfare of the State of Alaska. The State Medical Examiner's Office investigates sudden, violent, unexpected, and suspicious deaths that occur in the state. In addition to determining the cause and manner of death, the office works to provide accurate identification of decedents under their jurisdiction, and to notify the next of kin.

Historically, with limited available resources, staffing shortages in the Medical Examiner's Office meant only the most controversial deaths are fully investigated. Based on national standards, the State Medical Examiner should be initiating an investigation at some level for 100% of the deaths that fall under their jurisdiction and examine or autopsy approximately 75% of those cases. Of the 3,362 deaths reported in Alaska during FY09, the State Medical Examiner's Office took jurisdiction in 1,556 cases. Autopsy was performed in only 253 cases (16%) and external inspection done in 124 (8%) for a total examination rate of just 24%. Recently, however, the Medical Examiner's Office has become fully staffed with a new Chief Medical Examiner and, for the first time, a third pathologist. New policies and procedures are in effect that mandate investigation and examination of more cases that fit the criteria listed above. These changes will increase the volume of cases examined/autopsied and have a substantial impact to the budget through increased costs of transport and supplies.

With increased caseloads there is also an increased need for investigators and autopsy assistants. This increment includes one additional full-time investigator to adequately staff the office 24/7/365 as recommended by the National Association of State Medical Examiners. The five existing investigators are presently covering the shifts with significant and sustained paid overtime. The increment also funds an autopsy technician to support the increased caseload generated by the new policies/procedures and having three medical examiners on staff.

The consequences of not investigating and examining all cases on scene that fall under the Medical Examiner's jurisdiction are extensive. Homicides may go undetected; suicides may be misdiagnosed; infant deaths may not be classified correctly. The increase in scientific identification would decrease potential liability and aid in possible criminal prosecution. Additionally, by investigating and transporting all appropriate deaths, the office will be able to accurately classify the cause and manner of death, thus providing accurate statistical results for the health department and partner agencies that rely on the data. Expanding services statewide and ensuring the office is practicing and maintaining the highest standards in the profession in which it functions moves the State Medical Examiner's Office closer to its ultimate goal to develop operational standards and obtain accreditation by the National Association of Medical Examiners.

Tobacco Prevention and Control

Empowering Alaskans to Take Personal Responsibility: Sustained Progress in Tobacco Prevention and Control: *$400.0 Tobacco*

This increment will promote and protect the health of Alaskans by reducing death and disability associated with tobacco use.

Funding is needed to build on the progress made by the Tobacco Prevention and Control program to reduce smoking and smokeless tobacco use, with a focus on priority populations. Over the past 12 years, Alaska successfully 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. To realize further reductions in the prevalence of smoking, achieve additional savings in health care costs resulting from reduced tobacco use, and increase quality and length of life, the comprehensive, evidence-based statewide Tobacco Prevention and Control Program must be sustained and efforts to reach disparate populations with higher prevalence rates must be increased.

A smokeless tobacco prevention and cessation project will be piloted in rural Alaska, where nearly a quarter of the population uses smokeless tobacco. Funds will also be made available through established grant programs for expanded tobacco prevention and control work with high prevalence populations. Additional funds will be used to expand the scope and reach of the Cessation Interventions grant program of the Tobacco Prevention and Control program.

Outcomes will be measured in terms of progress toward Healthy Alaskans 2010 tobacco use targets among Alaskan adults and youth of all racial and ethnic backgrounds living in all areas of the state. Key targets are: Adult Smoking Rate (14%), Adult Smokeless Rate (3%), High School Smoking Rate (17%), and High School Smokeless Rate (8%).

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.

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. Stable funding for the section is still elusive as federal grants dwindle.

Nurse Recruitment and Retention
The Section of Public Health Nursing continues to struggle with recruitment and retention of qualified nurses during the current national shortage of people in this profession. The section is utilizing aggressive national and international recruitment strategies through a staff member that is dedicated to this purpose. Recent efforts have been very successful and many new highly qualified staff nurses have been hired. The Section will continue with these current efforts and seek out new strategies to recruit and retain qualified staff to provide nursing services throughout Alaska.

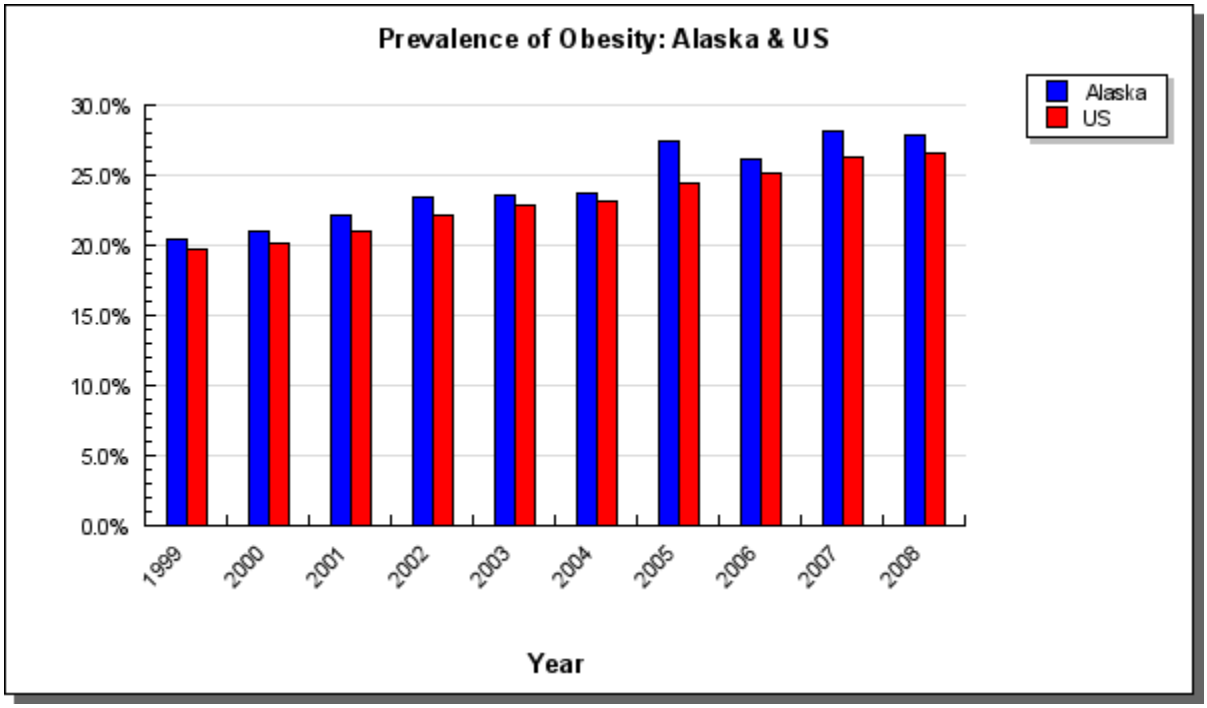
Disaster Preparedness and Response
The Preparedness Program is challenged with statewide disaster preparedness through the Public Health Emergency Operations Center and partnerships with hospitals and other direct care providers throughout Alaska. Timely response to public health disasters and emergencies is difficult in Alaska because of its geographic vastness and the remoteness of rural areas where access to services is limited and challenging. The Section will continue to work with partner agencies to develop infrastructure in Alaska to provide timely response to public health disasters.

Preventing and Controlling Chronic Diseases
The fight against chronic diseases is critical and its importance cannot be overstated. Three risk factors (tobacco, poor diet and lack of physical activity) contribute to the four major chronic diseases (heart disease, type 2 diabetes, lung disease and many cancers) which are responsible for fifty percent of the deaths in the world.

In Alaska, three of every five deaths are linked to chronic diseases. 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, $477 million is spent in Alaska each year 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 FY11, the division plans to tackle this challenge through a comprehensive state-funded approach to preventing and controlling obesity with an emphasis on helping Alaskans take personal responsibility for their own health and well-being.

The trends in Alaska continue to show growing numbers of overweight and obese adults, with obesity prevalence at 27.9% in 2008 - an alarming 30% higher than the 1999 Alaska prevalence level and 55% higher than the Healthy Alaskans 2010 target.



Note: Sources – Alaska and U.S. Behavioral Risk Factor Surveillance System; crude rates.

Being overweight or obese is 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.

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 FY11 increment will increase the emphasis on reducing tobacco use in Alaska's disparate population groups that continue to use tobacco products at high rates.

Controlling Infectious Disease and Reducing the Risk of Epidemics

Fighting infectious disease is increasingly complex and challenging. New diseases are discovered all the time, as evinced by the 2009 H1N1 influenza pandemic, 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 FY09, the Fairbanks Virology Laboratory came on-line. The new laboratory enables the State Public Health Laboratory to efficiently and rapidly detect such new diseases as the 2009 H1N1 influenza virus (a.k.a. swine flu). However, staffing the laboratory with qualified clinical scientists continues to be a challenge. The only remaining classically-trained clinical virologist in the state is planning retirement. Recruitment for this position will be a challenge. The Laboratory is partnering with the University of Alaska-Fairbanks to create a hybrid position (faculty/state employee) which, hopefully, will make the position more attractive.

Customer Service

The Bureau of Vital Statistics has experienced difficulties recruiting and retaining staff to work in the Juneau front office. Chronic turnover of staff, high vacancy factor and the time spent repeatedly recruiting and training new staff has affected the bureau's ability to respond in a timely manner 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.

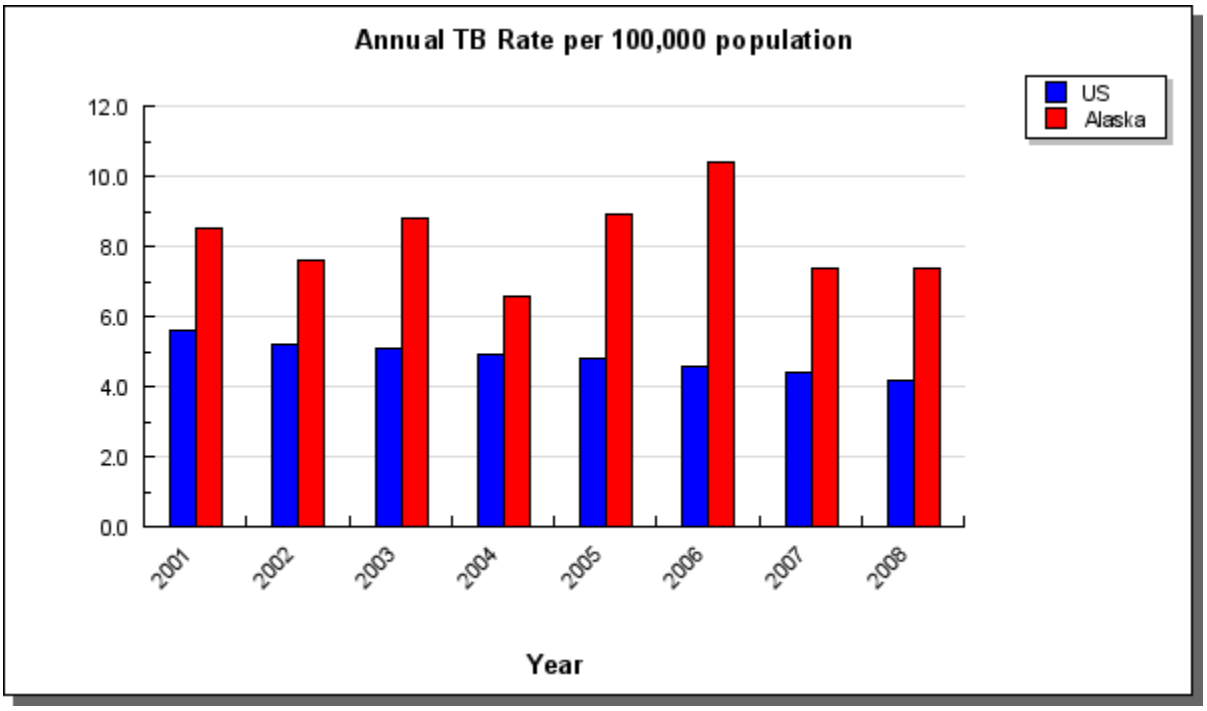
Expand Medical Examiner Services Statewide

The State Medical Examiner's Office is working to expand and standardize death investigation throughout Alaska and give every death the same level of service, including proper investigation, postmortem examination, and confirmation of identification. Providing teaching and required expert testimony for numerous legal cases is difficult without adequate staffing. Other activities include continuing on the prescribed track towards accreditation, following the guidelines of the National Association of Medical Examiners; continuing the revising of SMEO Policies and Procedures Manual to meet the standards of the National Association of Medical Examiners; replacing aging equipment in the autopsy and embalming suites while remaining OSHA-compliant; and replacing aging removal vehicles as funds are made available.

To fulfill SMEO's statewide mandate and bring standardized death investigation to all areas of Alaska will require additional funding in future years. The Phase I increment stabilizes funding for an increased caseload. Phase II (not part of this increment) will expand services to two or three geographic areas with a large number of cases. Phase III (also not part of this increment) will further expand services throughout the state.

A: Result - Healthy people in healthy communities.

Target #1: Alaska's tuberculosis (TB) rate is less than 6.8/100,000 population
Status #1: The rate of TB was unchanged between 2007 and 2008.



Annual TB Rate per 100,000 population

Year	US	Alaska
2008	4.2 -4.55%	7.4 0%
2007	4.4 -4.35%	7.4 -28.85%
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 a small number of 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 held steady in 2008. The state TB rate shows 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 decreased from 725 to 718 or less than 1% decrease in 2008, and increased from 675 to 725 or 7.41% in 2007 per 100,000 population. Alaska ranked second in the nation for chlamydia rates in 2007.

Chlamydia rate per 100,000 of population

Year	Alaska	U.S.
2008	718 -0.97%	N/A
2007	725 +7.41%	370 +6.32%
2006	675 +2.9%	348 +4.5%
2005	656 +7.72%	333 +4.06%
2004	609 +1.16%	320 +5.26%
2003	602 +1.52%	304 +5.19%
2002	593 +36.64%	289 +5.09%
2001	434 +6.11%	275 +9.56%
2000	409 +34.98%	251 +1.62%
1999	303	247

Methodology: National data for CY 2008 will be available from CDC by January 2010. *2008 rates based on 2007 AK Department of Labor & Workforce Development Population Estimates. 2008 Population Estimates will be available in late 2009.

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, such as syphilis, have reemerged in recent years. 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 and sustained over time, these activities have been shown to reduce the reservoir of infected individuals in the population, reducing case numbers and rates. Expanded programmatic efforts stabilized chlamydia rates in 2003-2004 but these efforts 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 six 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.

Age-Adjusted Coronary Heart Disease death rate per 100,000

Year	Alaska	US
2007	84.2 -3.22%	125.2 -7.19%
2006	87.0 -4.29%	134.9 -6.58%
2005	90.9 -4.11%	144.4 -3.86%
2004	94.8 -25.18%	150.2 -7.74%
2003	126.7 +7.28%	162.8 -4.74%
2002	118.1 -13.61%	170.9 -3.88%
2001	136.7 -0.73%	177.8 -4.82%
2000	137.7 +4.71%	186.8 -4.01%
1999	131.5	194.6

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, 652,091 people (50.5% of them women) 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: Cancer rate declined from 2000 through 2005, with a slight increase subsequently. Cancer is still the Number 1 killer in Alaska.

Age-adjusted cancer death rate per 100,000 of population

Year	Alaska	US
2007	183.9 +3.43%	177.5 -1.77%
2006	177.8 +4.77%	180.7 -1.69%
2005	169.7 -7.87%	183.8 -1.08%
2004	184.2 -1.97%	185.8 -2.26%
2003	187.9 -0.9%	190.1 -1.76%
2002	189.6 -1.35%	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

Analysis of results and challenges: Cancer has been the leading cause of death in Alaska since 1993, one of the few states in the United States for which this occurs. There are more than 100 different types of cancer that comprise this group of diseases characterized by the uncontrolled growth and spread of abnormal cells. These abnormal cells can invade surrounding tissues and spread to other parts of the body through the blood and lymph systems. If the spread is not controlled, it can result in death.

In the United States, cancer is the second-leading cause of death after heart disease, accounting for 1 of every 4 deaths. Over the past ten years there has been a declining trend in the cancer death rate in the United States. Alaska has generally mirrored that trend with the exception of the last two years, where an increase was noted. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The most common types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the most common types of cancer deaths are lung, colorectal and prostate. Although some cancer risk factors are not modifiable such as heredity, age and sex, it is estimated that up to two-thirds of cancer deaths may be prevented by changing unhealthy behaviors. These behaviors include tobacco use, excessive alcohol intake, poor diet, lack of exercise, excessive sunlight exposure, and sexual behaviors that increase exposure to certain viruses.

The Alaska Comprehensive Cancer Control Program works collaboratively with communities and partners around the state to positively impact the cancer burden in Alaska. Goals are established that promote cancer prevention, improve early detection, increase access to health

and social services, maximize the quality of life for cancer survivors, and reduce suffering and death from cancer. The Alaska Tobacco Prevention and Control Program works toward "a tobacco-free Alaska" through goals around prevention, cessation, education, advocacy and public policy.

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population
Status #5: The 2007 death rate caused by unintentional injuries was 57.3 per 100,000 population, above the 50/100,000 target and representing a nearly 10% increase from the 2006 rate. The rate dropped by 12% from 2002 to 2006.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
2007	57.3 +9.98%	N/A
2006	52.1 +2.96%	N/A
2005	50.6 -8%	39.7 +4.2%
2004	55.0 -0.54%	38.1 +1.33%
2003	55.3 -6.59%	37.6 +1.62%
2002	59.2 -3.11%	37.0 +3.64%
2001	61.1 -4.38%	35.7 +2.59%
2000	63.9 +11.13%	34.8 -0.85%
1999	57.5	35.1

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 tuberculosis (TB) will complete adequate treatment within one year of beginning treatment

Status #1: In 2007, 90% of persons with tuberculosis (TB) completed adequate treatment; this was in line with prior year performance. This was below the target rate of 95% primarily due to some difficult cases.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2008	N/A*
2007	90%
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

Methodology: *TB treatment requires 6-9 months for completion. Some 2008 cases are still being treated.

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 noncompliant 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: 99.6% of Alaskans diagnosed with chlamydia in calendar year 2008 received adequate treatment, exceeding the 98% target.

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2008	99.6%
2007	99.8%
2006	97.9%
2005	99.8%
2004	99.6%
2003	99.5%

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 4,860 reported chlamydia cases in 2008, compared to 4,911 in 2007. 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: There has been a 51% decline in youth smoking over 12 years, bringing the 2007 prevalence rate of 18% within 1 percentage point of the 17% 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.

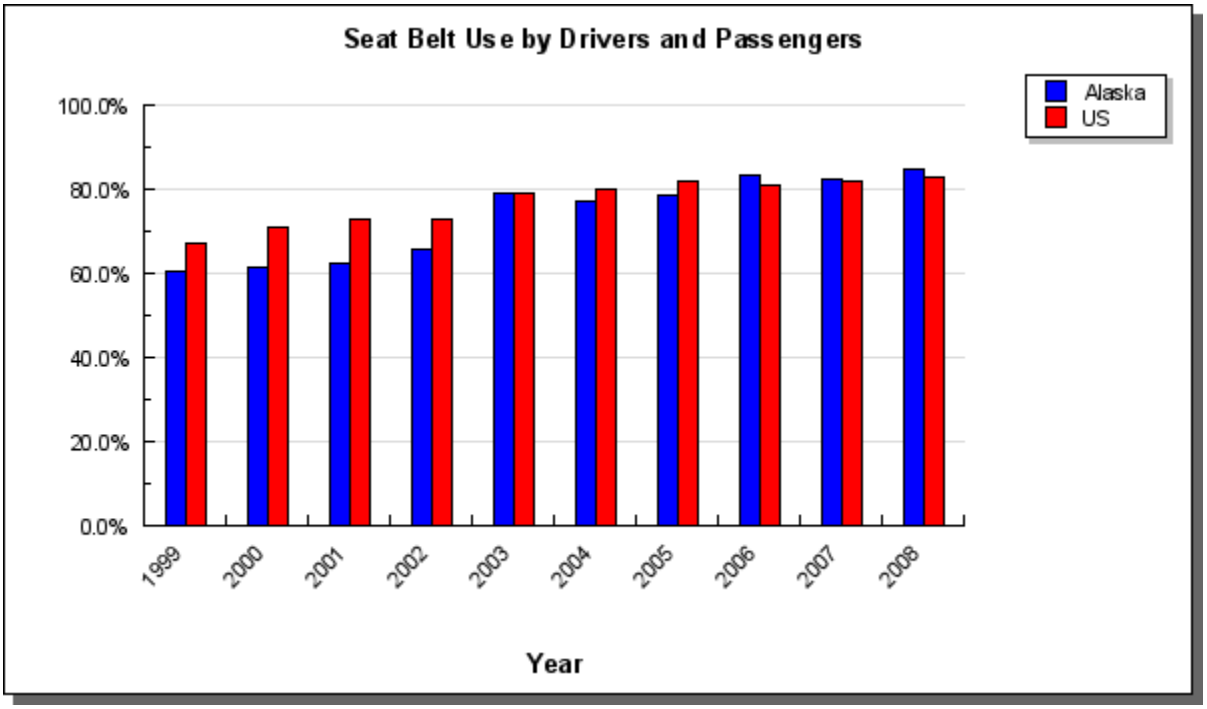
Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, 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 seatbelt 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
2008	84.9%	83%
2007	82.4%	82%
2006	83.2%	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.

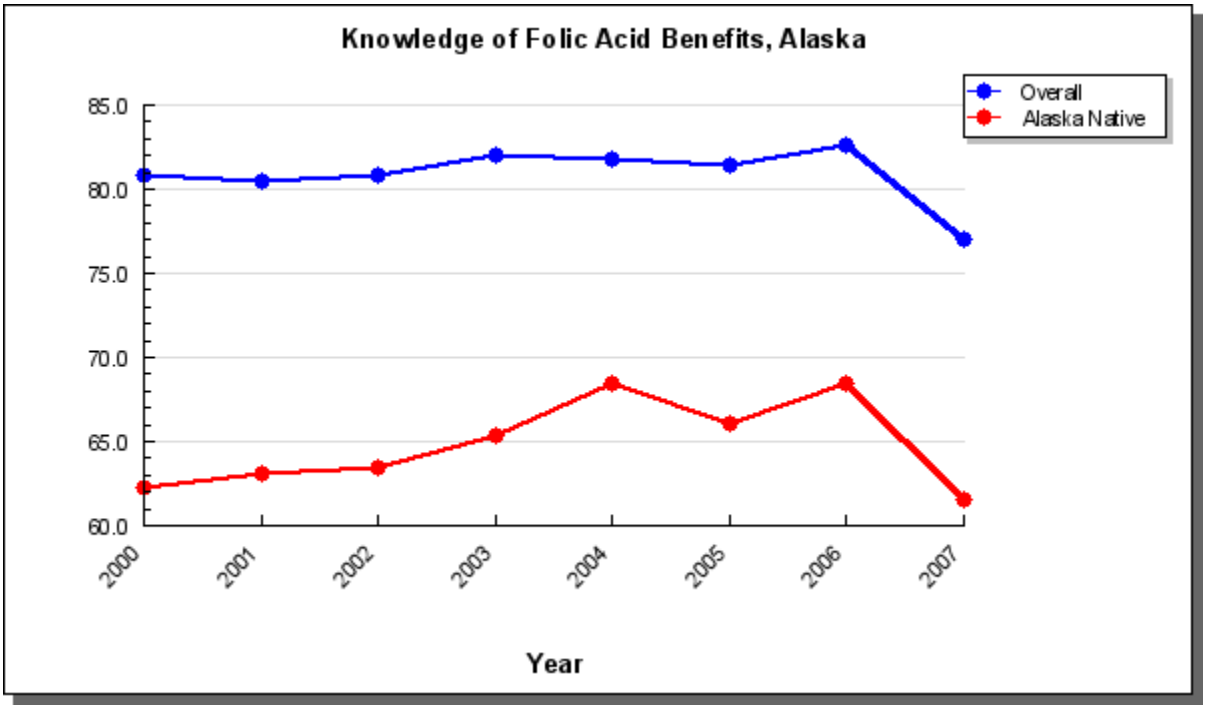
Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance.

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 2007, there was a significant decrease in the knowledge of folic acid benefits.



Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
2007	77.0 -6.78%	61.5 -10.09%
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

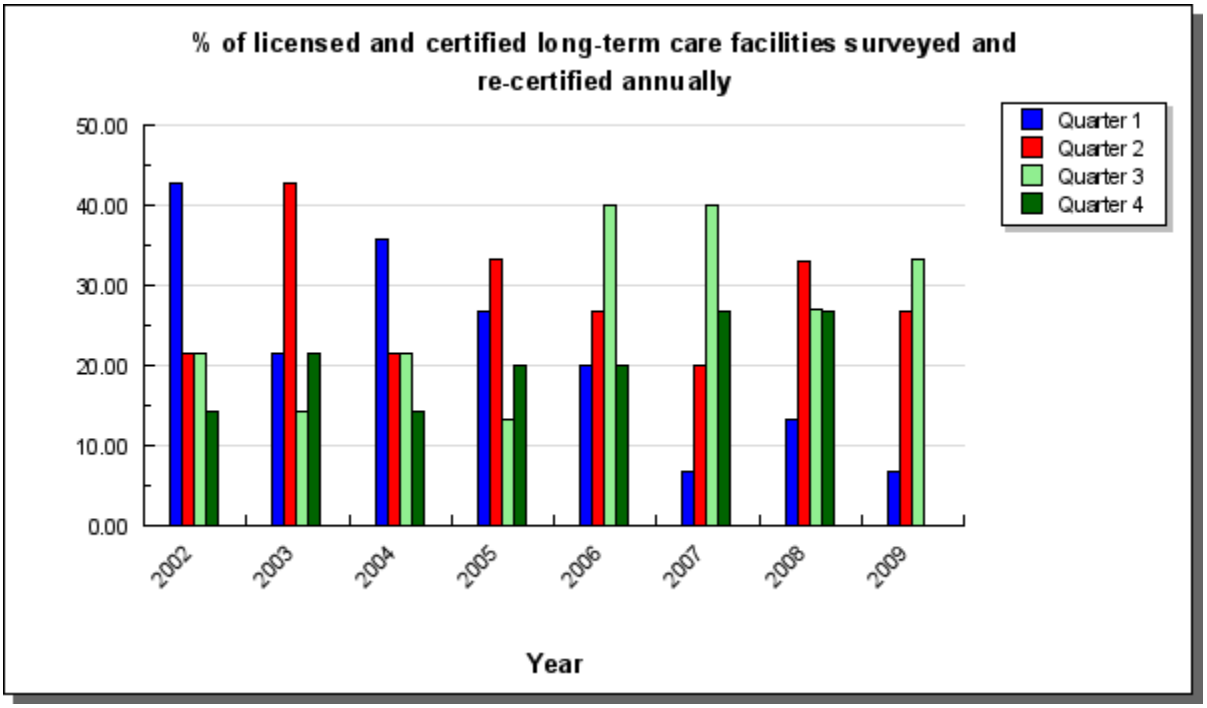
Analysis of results and challenges: From 2000 to 2006, the knowledge of folic acid benefits among Alaska mothers had remained at about the same level, around 81% to 83%. However, in 2007 there was a 7% decline in the proportion of mothers who had folic acid knowledge.

The proportion of Alaska Native mothers who know about the benefits of folic acid steadily increased to a high of 68.4% in 2004, fell slightly following year, and then rose again to 68.4%, only to fall below 2000 levels, to 61.5%. The gap in knowledge between Alaska Natives and Alaskan mothers still exists.

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 FY09, the state is on track to meet 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
2009	6.67	26.67	33.33	0	66.67
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 FY09 29% of all DPH staff received 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
FY09	89	60	0	0	29%
FY08	177				34%
FY07	27	106	17	31	35%
FY06				144*	28%
FY05			70	103	27%

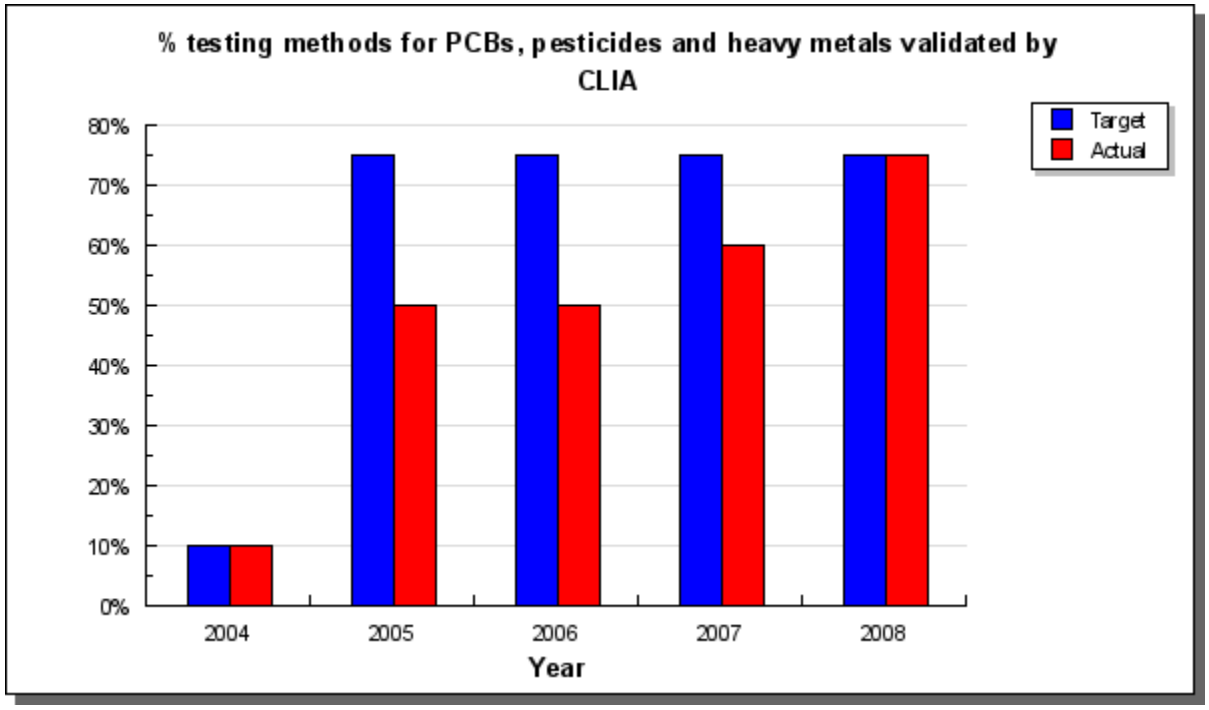
Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action, and permits all concerned to maintain a common knowledge base.

The FY09 percentage reflects the following: 519 permanent full time DPH positions, with an estimated 149 individuals receiving disaster preparedness training, a total of 29 percent trained. This meets the division goal of 25 percent annually.

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: In FY08 100% certification has been maintained for heavy metals; PCB and Pesticides validation is on hold.



Methodology: FY08 data is for metals only

% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2008	75%	75%
2007	75%	60%
2006	75%	50%
2005	75%	50%
2004	10%	10%

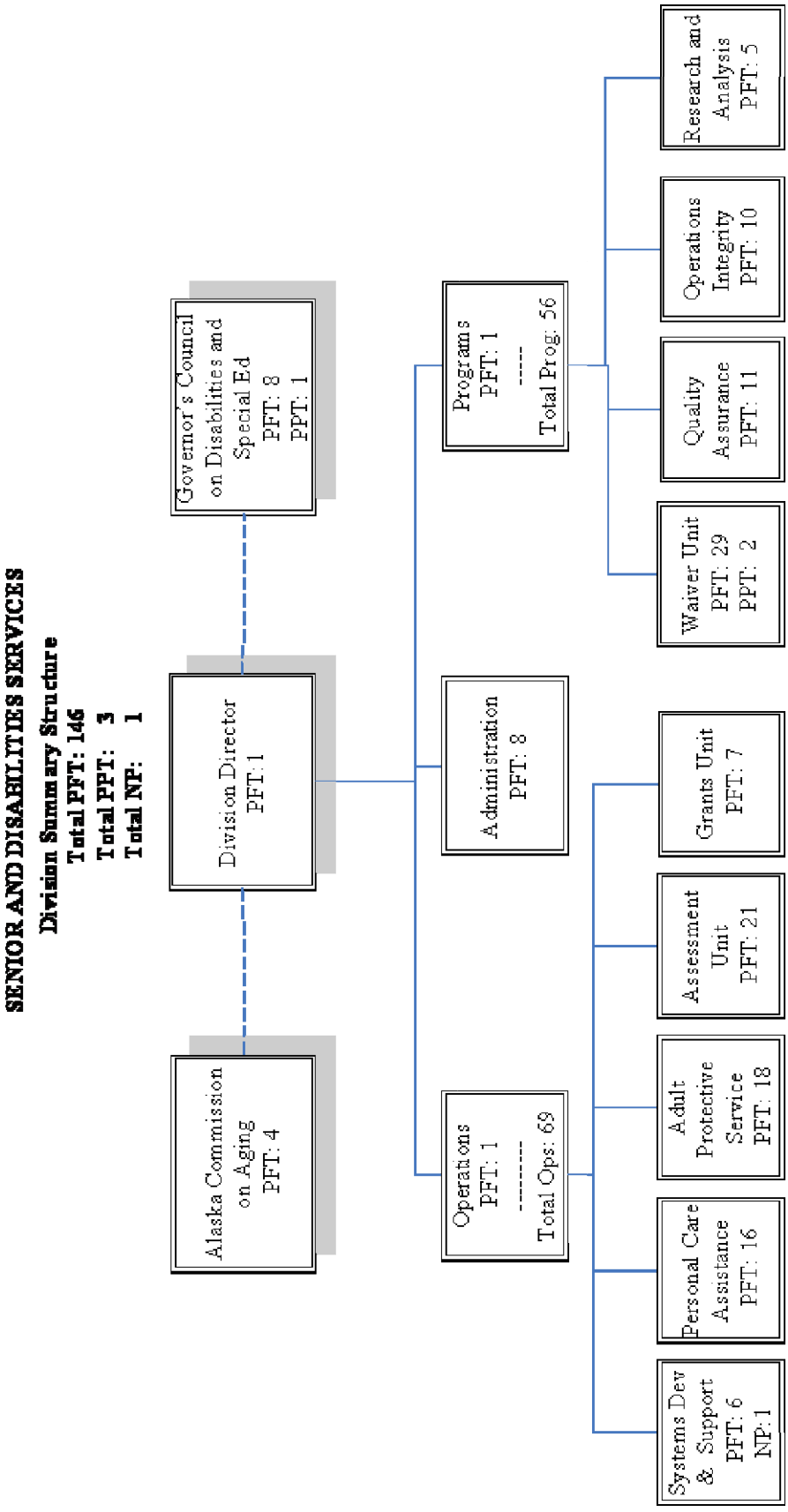
Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus and young children. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. Direct analytical testing of human blood and hair for these compounds provides a real measure of human exposure to contaminants, rather than relying on hypothetical risk models. To date this type of testing has confirmed the safety of traditional foods. Mercury monitoring data has also provided a scientific basis supporting State recommendations regarding a healthy diet for rural and urban Alaskans.

During FY09, the hair mercury testing program will continue and we anticipate increasing throughput capacity for children's blood lead (Pb) testing. As a pilot, capillary blood lead testing was provided to a small subset of Head Start program children. Data from blood lead testing may be useful in identifying communities potentially at risk possibly due to poor practices in handling lead used during subsistence food gathering (i.e. fishing), or improved practices for cleaning lead shot game meats.

Currently there has been little community interest in PCB or pesticides testing conducted by the State. These tests are more expensive to complete, therefore further work on these compounds has been put on hold.

FY11 Governor's Request Increment and Decrement Fund Breakout

Division of Public Health FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Discontinue Medicaid Administrative Claims Reimbursable Service Agreement	$ -	$ -	$ (4,000.0)	$ (4,000.0)
Maintaining Local Control of Essential Public Health Services: Stabilize Funding to Public Health Nursing Grantees	$ 1,000.0	$ -	$ -	$ 1,000.0
Reverse August FY2010 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	$ (29.5)	$ -	$ -	$ (29.5)
MH Trust: Workforce Dev - Grant 1452.02 Autism capacity building	$ -	$ -	$ 75.0	$ 75.0
Replace Medicaid School Based Administrative Claims Funding	$ 347.8	$ -	$ (347.8)	$ -
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (125.0)	$ (125.0)
ARRA funding for Healthcare-Associated Infections (HAI) Prevention	$ -	$ 144.0	$ -	$ 144.0
Phase I of State Medical Examiner's Office Reforms: To Maintain Services	$ 300.0	$ -	$ -	$ 300.0
Empowering Alaskans to Take Personal Responsibility: Sustained Progress in Tobacco Prevention and Control	$ -	$ -	$ 400.0	$ 400.0
Public Health Total	***$ 1,618.3***	***$ 144.0***	***$ (3,997.8)***	***$ (2,235.5)***


SENIOR AND DISABILITIES SERVICES
Division Summary Structure
Total PFT: 146
Total PPT: 3
Total NP: 1
Governor's Council on Disabilities and Special Ed
PFT: 8
PPT: 1
Division Director
PFT: 1
Alaska Commission on Aging
PFT: 4
Administration
PFT: 8
Programs
PFT: 1

Total Prog: 56
Operations
PFT: 1

Total Ops: 69
Research and Analysis
PFT: 5
Operations Integrity
PFT: 10
Quality Assurance
PFT: 11
Waiver Unit
PFT: 29
PPT: 2
Grants Unit
PFT: 7
Assessment Unit
PFT: 21
Adult Protective Service
PFT: 18
Personal Care Assistance
PFT: 16
Systems Dev & Support
PFT: 6
NP: 1

Introduction to the Division

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

- Provide support for institutional and community-based services for older Alaskans and persons with disabilities.
- Provide protection of vulnerable adults.

Services Provided

Medicaid Waiver Services

Home and Community-Based Waiver 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 home- and community-based settings. If determined eligible by meeting specific target population criteria, level of care, and financial guidelines, a person may apply to receive services under one of the four Medicaid waiver programs described below. Reimbursable waiver services include care coordination, chore services, adult day care, day habilitation, environmental modifications, intensive active treatment, meals, respite care, residential care alternatives such as Assisted Living or Group Homes, specialized medical equipment, specialized private duty nursing, supported employment, and transportation to waiver services. The four waivers that the division administers are:

Adults with Physical Disabilities (APD) Waiver
APD provides services to those applicants who meet nursing home level of care but wish to remain in their own homes and communities. The applicant must be at the level of need provided to a client in a nursing home and be financially eligible for Medicaid to access the program. The program serves participants between the ages of 21 and 64 years of age.

Children with Complex Medical Conditions (CCMC) Waiver
CCMC is for children, birth through age 21, having a severe chronic physical condition that is expected to continue for more than 30 days. The physical condition must be life threatening and need extraordinary supervision and observation. The child must be dependent upon medical care or technology and requires the same sort of care delivered in a hospital or nursing home.

Mental Retardation/Developmental Disability (MRDD) Waiver
MRDD is specifically for individuals with mental retardation, autism, cerebral palsy, a seizure disorder, or other related condition. In addition to these diagnoses, the individual 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. Also, the person must require the same level of care provided in an Intermediate Care Facility for the Mentally Retarded.

Older Alaskan (OA) Waiver
OA provides services to those applicants who meet nursing home level of care but wish to remain in their own homes and communities. The applicant must be at the level of need provided to a recipient in a nursing home and be financially eligible for Medicaid to access the program. The program serves recipients who are 65 years and older.

Additional Medicaid Services and Quality Assurance

In addition to the four Medicaid waivers above, the division offers limited Care Coordination and operates the Personal Care Assistance and Nursing Home Authorization Medicaid programs. The division also provides Quality Assurance for these programs and the Medicaid Waivers.

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 participant's needs, ensuring to the greatest extent possible their health, welfare and safety.

Personal Care Assistance
Services are provided statewide in Alaska through Personal Care Assistance (PCA) services. 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, and 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 participant's home by health care paraprofessionals called personal care attendants. These services enable functionally disabled Alaskans of all ages, and frail elderly Alaskans, to live in their own homes, instead of being placed in a more costly and restrictive long-term care setting. Recipients have a choice between two different options of PCA services. The Agency-Based PCA model allows participants to use one of the qualified

agencies that oversee, manage and supervise their care; or, participants 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 applicants to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those participants 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 Alaska. The division is also responsible for authorizing Await & Swing beds for hospitals, in state and out of state. These beds are used while Medicaid applicants 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 2009 average annualized total cost, including Medicaid and other state costs, for a patient in a nursing home was $165,680.

Quality Assurance
Senior and Disabilities Services has a Quality Assurance Unit dedicated to ensuring the quality of services provided to Alaskan seniors, disabled individuals, 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 throughout Alaska. This unit works closely with Adult Protective Services staff and other state agencies to ensure the health and welfare of SDS service participants. This unit also manages and maintains the Quality Improvement Work plan under the direction of the Quality Assurance Steering Committee and Quality Assurance Workgroup.

Non-Medicaid Services

Adult Protective Services (APS) / General Relief
The Adult Protective Services Unit protects vulnerable 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 an intake caseload of 2,043 in FY09.

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 Services (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 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 is awarded to Senior and Disabilities Services from the U.S. Administration on Aging (AOA) to educate older Alaskans about consumer

protection and Medicare fraud, waste and 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 dedicated SDS staff and through a network of statewide volunteers. This program has assisted around 5,000 beneficiaries, or about 10% of eligible Alaskans. While the number of calls that were determined to be uniquely fraud related was 30 for FY09, the staff fielded a much larger number of calls that turned out to be Medicare related, but not fraud.

Aging and Disability Resource Centers (ADRC's)

The Aging and Disability Resource Centers are a federal initiative developed nationwide by the Centers for Medicare and Medicaid Services and the Administration on Aging to provide a viable trusted entity for seniors, individuals with disabilities, and their caregivers to receive information and assistance with accessing both public and private community based long-term care services. This grant is currently funded by the Real Choice Systems Change and ADRC federal grants, state general funds and Mental Health Trust funds, and will be in its third year of development in FY11. During their first year (FY09), three ADRC's served over 4,600 consumers.

Real Choice Systems Change (RCSC) Grant – Person-Centered Planning

This Real Choice Systems Change grant was awarded to SDS from the Centers for Medicare and Medicaid Services (CMS) to develop and implement a person-centered Hospital Discharge Model (HDM) and to enhance and expand Aging and Disability Resource Centers. Participating hospitals in three areas of the state will collaborate with the Aging and Disability Resource Centers to connect seniors and individuals with disabilities of any age with community based programs to provide assistance once they are released from the hospital. The RCSC grant is developing a tool that will increase communication between hospitals and ADRC's to bridge the gap between hospitalization and community-based services.

Community-Based Grants for Seniors

In FY09 over 15,000 seniors received services statewide through these community-based programs. Programs (outlined below) include Nutrition, Transportation and Support services and Home- and Community-Based Care grants for seniors. Programs developed under the Community-Based grants for seniors follow the guidelines of the approved Alaska State Plan on Aging and are supported by state general funds and federal funds provided by Title III of the Older Americans Act.

Nutrition, Transportation, and Support Services Grants for Seniors

The U.S. Department of Health and Human Services, Administration on Aging grants federal funds to SDS 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 on Aging process from a menu of services available under Title III of the Older Americans Act. These services are available to Alaskan seniors who are over age 60 and target populations with the greatest social and economic need. This includes seniors who live in rural areas, are members of minority groups, or 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 funds (GF), GF mental health funds, and the AOA Title III federal grant for National Family Caregiver services.

Home- and Community-Based Care Grants include these programs:

- Adult Day Services
- National Family Caregiver Support
- Senior In-Home Services (Care Coordination, Chore, Respite and Extended Respite Services)

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.

Nursing Facilities Transition Grant

The funds in this program can be used to help an elderly person or individual with a disability transition from a nursing facility back into the community. An eligible person is one who qualifies both medically and financially for the Medicaid Home and Community Based Services Waiver (HCBS) program. The grant is used only for one-time costs associated with the transition; thereafter, the Medicaid program will pay for all other services when the HCBS waiver is approved. The total number of FY09 transitions was 51 at an average cost for transition services between $1,200 and $1,500 per person.

These grants provide one-time funds for:

- Home or environmental modifications that will enable the client to get into the home;
- Travel/room/board to bring caregivers in from a rural community to receive training;
- Trial trips to home or an assisted living home;
- Payment for an appropriate worker for skill level needed for a short period until qualification for other programs;
- Security deposits;
- One-time initial cleaning of home;
- Basic furnishings necessary to set up a livable home;
- Transportation to the new home.
- Other needed items or services may be approved by Program Coordinators.

Community Developmental Disabilities Grants (CDDG)

The Community Developmental Disabilities Grant program minimizes institutionalization and provides care for people with developmental disabilities (DD). In FY09 developmental disabilities grants provided services to nearly 1,000 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. Community DD Grant services are available to individuals with a developmental disability in need of assistance, who are on the Developmental Disabilities Registry, and who do not receive services through any of the four Medicaid Waiver programs.

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 Home- and Community-Based Waiver programs may provide similar services. However, not everyone

having a developmental disability qualifies for Medicaid or meets the threshold for long-term supports that the MRDD Waiver is designed to provide.

Details for other grant programs within the CDDG component follow.

CDDG Core Services Grant - The DD core services grant is a fixed amount of funding that is allocated to individuals who are DD eligible, but not receiving services through the DD Medicaid Waiver program. Funds are individualized and services are based upon the needs identified in the individual's "Core Plan" which is reviewed annually.

Short-Term Assistance and Referral Program (STAR) - In FY09, 12 organizations were awarded funds to operate a STAR program to assist people with developmental disabilities and their families. Services are designed to 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 Developmental Disabilities Registry 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.

Behavioral Risk Management Services - These services address difficult behaviors by providing technical assistance and training for the personnel working in community developmental disability (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.

Disability Law Center - 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 DD community services.

Senior and Disabilities Medicaid and Waiver Services

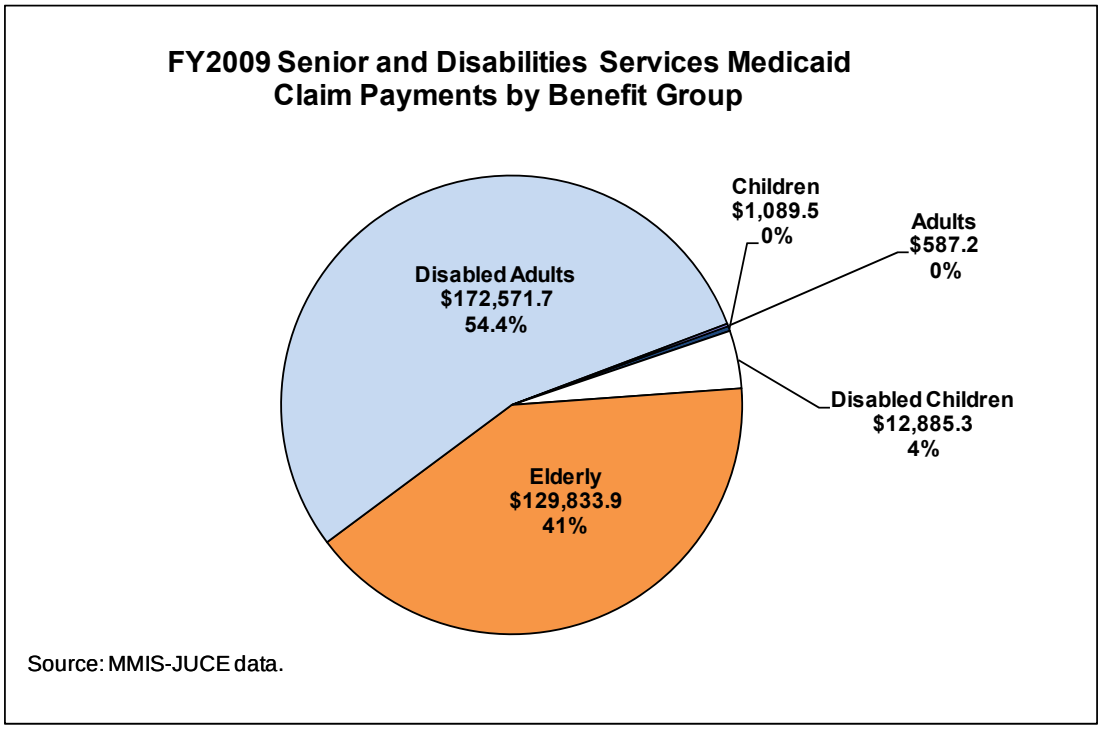
In FY09, Senior and Disabilities Medicaid provided long-term care services to almost 7,600 Alaskans, about 6% of all persons enrolled in the Alaska Medicaid program and about 30% of the seniors and disabled persons enrolled in Alaska Medicaid. The total cost of services funded through Medicaid was about $317 million, or almost $42,000 per person per year.

SDS Medicaid Services by Benefit Group

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost Per Beneficiary
Children	1.2%	93	0.3%	1,089.5	$11,715
Disabled Children	11.1%	860	4.1%	12,885.3	$14,983
Elderly	40.7%	3,159	41.0%	129,833.9	$41,100
Disabled Adults	46.3%	3,596	54.4%	172,571.7	$47,990
Adults	0.8%	60	0.2%	587.2	$9,786
Unduplicated Annual Clients		**7,588**			
Total Medicaid Claim Payments (thousands)				**$316,967.6**	
Average Annual Medicaid Cost per Beneficiary (thousands)					**$41.8**

Source: MMIS/JUCE claims paid during FY2009. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

Over half of the claim payments (58%) were for services provided to disabled individuals. Services provided to the elderly accounted for nearly 41% of claim payments processed in FY09.



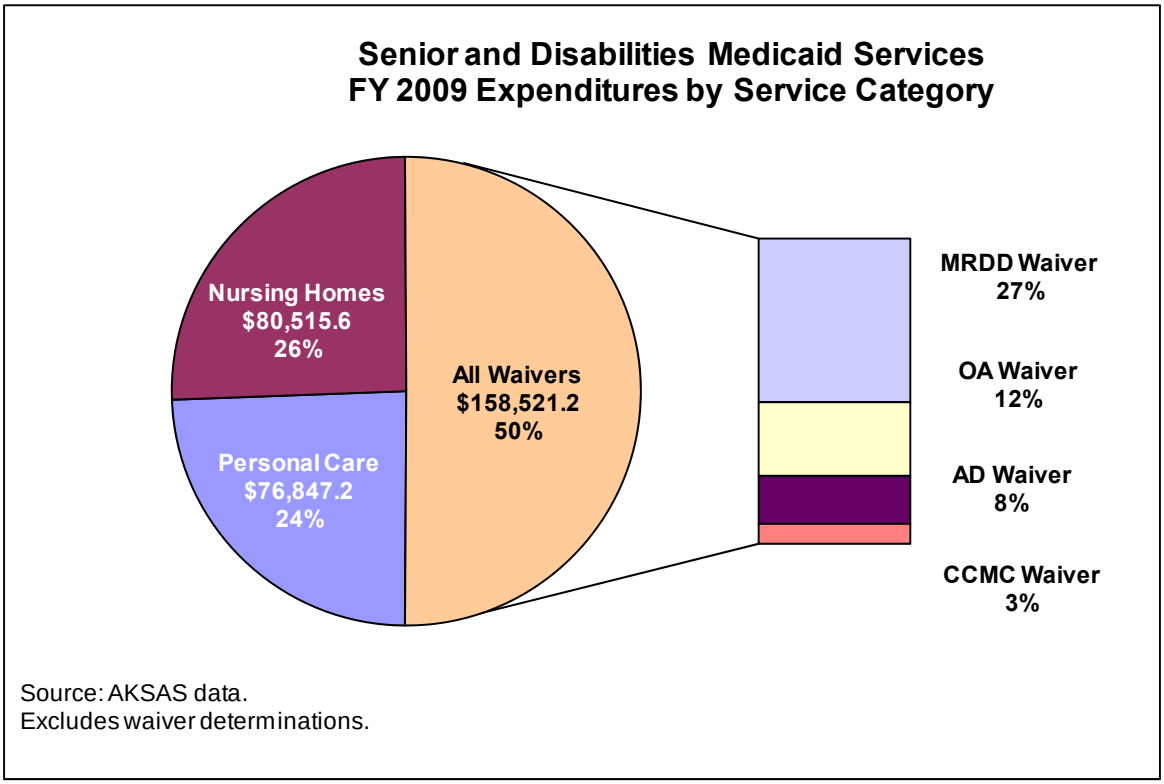
Senior and Disabilities Medicaid provides services to Alaskans of all ages. Ninety-one percent of the Children with Complex Medical Conditions Waiver recipients were under 21 years of age. A large percentage of waivers for Mental Retardation/Developmental Disabilities and other waiver services were also for individuals under 21 years of age.

SDS Medicaid and Waiver Services by Program and Age Group

Age Group	Percent of Benficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost per Beneficiary
All Senior and Disabilities Medicaid					
Under 21	14.0%	1,068	6.8%	$21,562.4	$20,189
21 or Older	86.0%	6,577	93.2%	$295,405.2	$44,915
Nursing Home Services					
Under 21	1.1%	11	0.9%	$762.5	$69,320
21 or Older	98.9%	1,006	99.1%	$80,070.3	$79,593
Personal Care Assistance Services					
Under 21	3.2%	114	3.9%	$3,031.6	$26,593
21 or Older	96.8%	3,461	96.1%	$73,865.2	$21,342
Home and Community Based Waiver Services					
Adults with Disabilities Waiver					
Under 21	3.9%	53	2.7%	$793.1	$14,964
21 or Older	96.1%	1,322	97.3%	$28,454.6	$21,524
Children with Complex Medical Conditions Waiver					
Under 21	90.8%	216	90.4%	$8,643.1	$40,014
21 or Older	9.2%	22	9.6%	$913.6	$41,526
Mental Retardation/Developmental Disability Waiver					
Under 21	23.4%	264	10.0%	$8,167.4	$30,937
21 or Older	76.6%	862	90.0%	$73,200.8	$84,920
Older Alaskans Waiver					
Under 21	0.0%	0	0.0%	$0.0	$0
21 or Older	100.0%	1,651	100.0%	$38,804.1	$23,503
Other Waiver Services					
Under 21	42.4%	542	63.0%	$164.7	$304
21 or Older	57.6%	736	37.0%	$96.7	$131

Source: MMIS/JUCE claims paid during FY 2009.

Of the services managed by the Senior and Disabilities Services Medicaid component, more Medicaid clients used home- and community-based waiver services than nursing home or personal care assistance services. Waiver services comprised half of SDS Medicaid costs in FY09. Nursing home and personal care claim payments accounted for about 26% and 24% of costs, respectively.



Nursing home care is by far the most expensive long-term care service per person at an annual average Medicaid cost of $79,900 per beneficiary. Nursing homes Medicaid costs per beneficiary were more than twice the average for all home- and community-based waiver services and nearly four times the average for personal care assistance services.

SDS Medicaid and Waiver Services Cost per Beneficiary

Service Category	Cost per Beneficiary per Year	Percent of Beneficiaries
Nursing Home Services	$79,900	13.3%
Personal Care Assistance Services	$21,600	47.0%
Home and Community Based Waiver Services	$36,600	57.3%
All Senior and Disabilities Medicaid, cost per beneficiary per year	$41,800	
All Senior and Disabilities Medicaid, unduplicated annual beneficiaries		7,588

Source: MMIS/JUCE for claims paid during fiscal year 2009. Percent of beneficiaries includes individuals receiving services in multiple categories and may not sum to 100%.

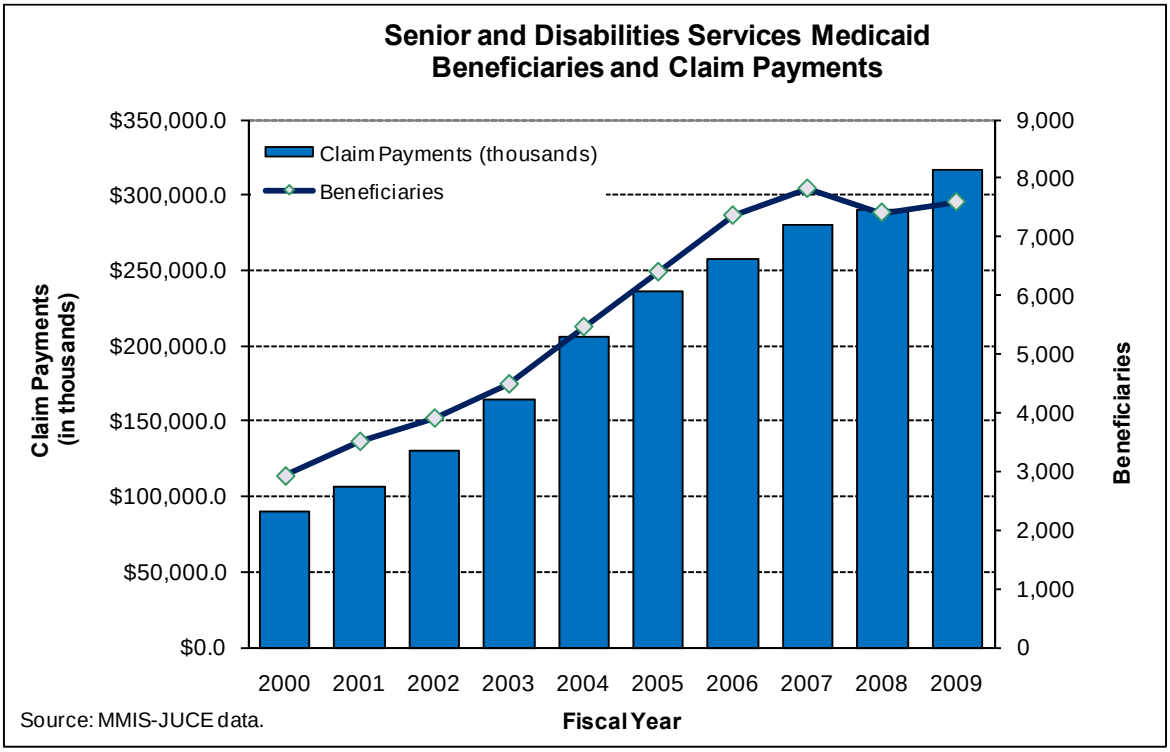
Within all waiver programs, the Older Alaskans waiver served the greatest percentage of waiver beneficiaries (38%) in FY09, followed closely by Adults with Physical Disabilities (32%) and Mental Retardation/Developmental Disabilities (25%). The Children with Complex Medical Conditions waiver had the lowest number of participants with only 5% of waiver beneficiaries. Individuals on the Mental Retardation and Developmental Disabilities waiver were the most expensive to cover, approaching the per-beneficiary cost of nursing home care.

SDS Medicaid Waiver Cost per Beneficiary by Waiver Program

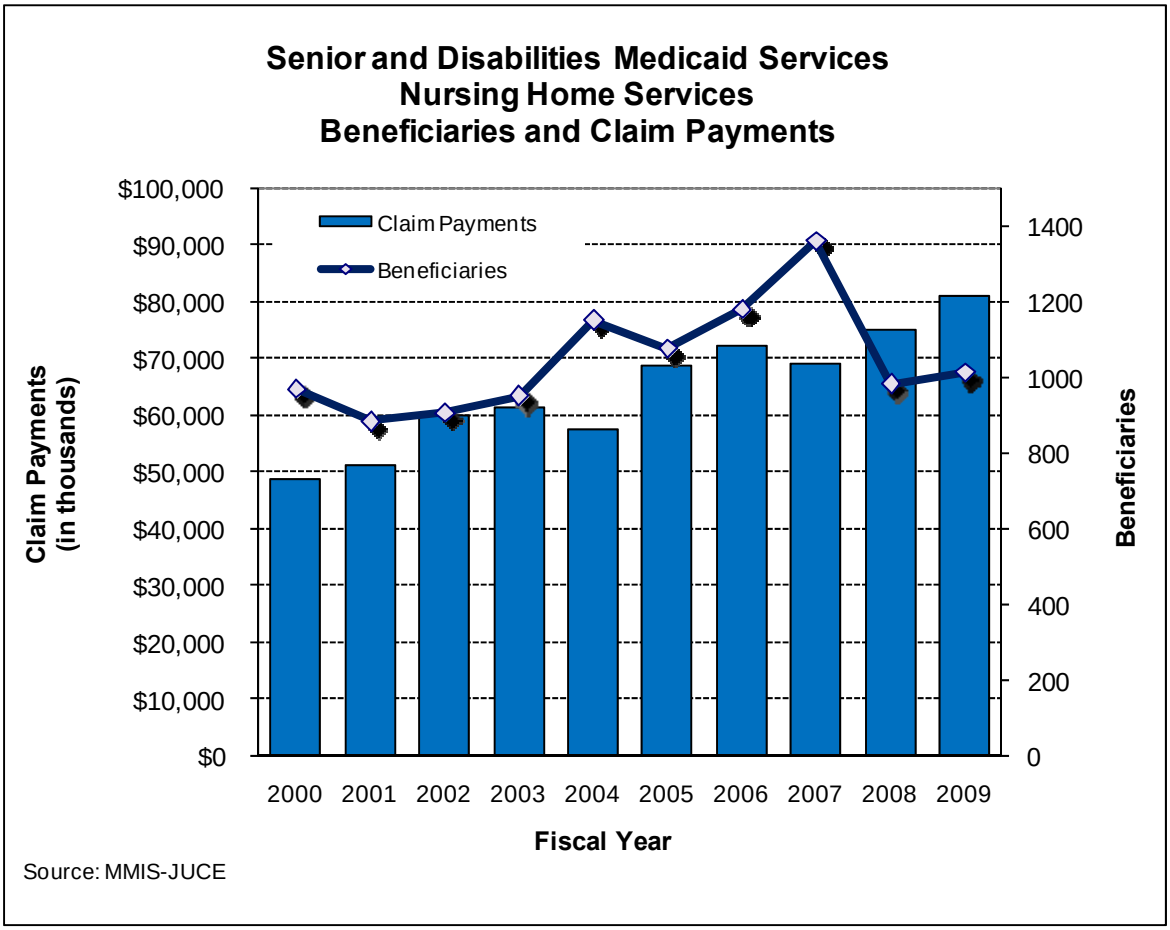
Home and Community Based Waiver	Cost per Beneficiary per Year	Percent of Waiver Beneficiaries
Adults with Disabilities	$21,300	31.6%
Children with Complex Medical Conditions	$42,700	5.3%
Mental Retardation/Developmental Disabilities	$74,400	25.2%
Older Alaskans	$23,500	38.0%
All Home and Community Based Waivers	$36,600	100.0%

Source: MMIS/JUCE for claims paid during fiscal year 2009.

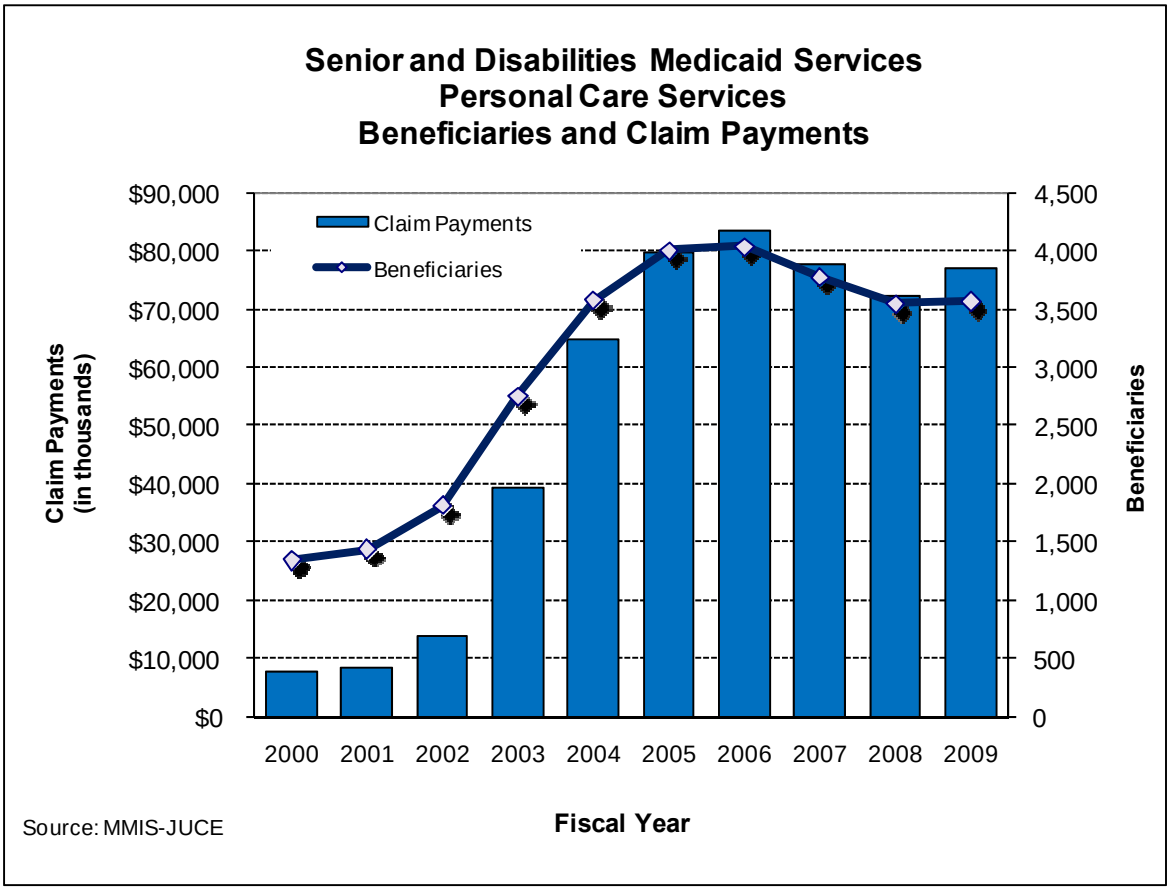
Total claim payments for Senior and Disabilities Medicaid services in FY09 increased by 9% from FY08. The number of beneficiaries using any Senior and Disabilities Medicaid service increased by almost 3% while the annual cost per beneficiary increased by almost 7% to $41,800. Most of the increased cost was due to home- and community-based waiver services ($18 million of the $27 million total cost increase from FY08), but costs for all services increased in FY09.



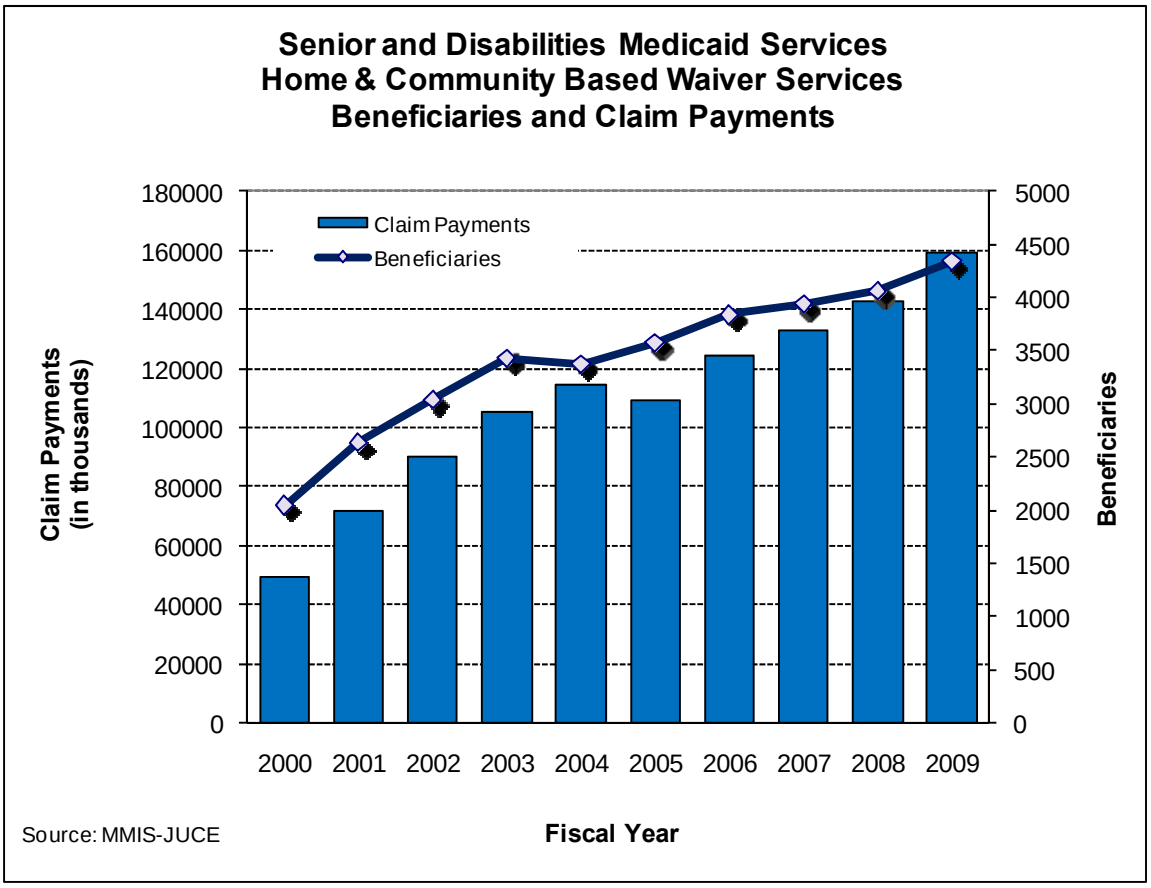
Total nursing home costs increased about 8% in FY09. The number of Medicaid beneficiaries using nursing home services increased by 3% and the annual nursing home Medicaid cost increased by 5% per beneficiary.



Costs for Medicaid personal care assistance decreased annually between FY05 and FY08, but increased by 6% from FY08 to FY09. The number of beneficiaries increased slightly (by less than 1%), while the annual cost per beneficiary increased by about 6%.



Combined claim costs for all home- and community-based waiver services increased by 11% between FY08 and FY09. The number of beneficiaries using any waiver service at some time during the fiscal year increased by about 7%. The annual cost for these waiver services per beneficiary increased by 4%.



Based on beneficiaries served, the fastest growing waiver program was the Mental Retardation and Developmental Disabilities waiver with 12% more Medicaid clients served in FY09, compared to under 8% growth in other waivers. Based on Medicaid expenditures during the year, the waiver program with the most significant growth was the Older Alaskans waiver where costs increased by almost 14%. Medicaid expenditures for the Mental Retardation and Developmental Disabilities waiver and the Adults with Disabilities waiver increased by almost 12%, from FY08 to FY09. Cost per beneficiary increased in both the Older Alaskans and Adults with Physical Disabilities waivers, but decreased in the more expensive Mental Retardation and Developmental Disabilities and Children with Complex Medical conditions waivers.

FY 2009 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		**7,588**		**$316,967,568**	**$41,772**	**6.1%**	**30.7%**
Gender							
Female	58.7%	4,457	58.1%	$184,183,193	$41,324	6.3%	31.4%
Male	41.3%	3,134	41.9%	$132,784,376	$42,369	5.9%	29.7%
Unknown	0.0%	0	0.0%	$0	$0	0.0%	0.0%
Race							
Alaska Native	20.6%	1,566	24.2%	$76,560,310	$48,889	3.3%	19.9%
American Indian	1.4%	108	1.2%	$3,796,105	$35,149	5.5%	25.3%
Asian	11.7%	893	8.5%	$26,807,047	$30,019	11.9%	49.4%
Pacific Islander	3.9%	299	2.7%	$8,452,756	$28,270	7.7%	37.6%
Black	4.1%	311	3.9%	$12,441,997	$40,006	4.4%	27.3%
Hispanic	2.4%	184	2.0%	$6,352,274	$34,523	4.0%	26.6%
White	50.8%	3,866	54.2%	$171,821,460	$44,444	7.8%	37.7%
Unknown	5.0%	381	3.4%	$10,735,619	$28,177	11.0%	35.4%
Native	22.0%	1,674	25.4%	$80,356,415	$48,003	3.4%	20.1%
Non-Native	78.0%	5,922	74.6%	$236,611,153	$39,955	7.7%	37.4%
Age							
under 1	0.3%	27	0.0%	$29,707	$1,100	0.2%	0.0%
1 through 12	7.8%	628	2.4%	$7,740,929	$12,326	1.3%	5.0%
13 through 18	4.2%	335	2.6%	$8,231,573	$24,572	1.5%	5.2%
19 through 20	1.8%	145	1.8%	$5,560,151	$38,346	3.2%	21.7%
21 through 30	6.9%	552	10.8%	$34,182,164	$61,924	3.8%	28.6%
31 through 54	19.7%	1,586	24.8%	$78,527,191	$49,513	8.5%	35.5%
55 through 64	13.8%	1,109	12.2%	$38,827,288	$35,011	21.2%	43.4%
65 through 84	34.0%	2,737	31.5%	$99,807,899	$36,466	37.2%	79.7%
85 or older	11.6%	932	13.9%	$44,060,664	$47,275	68.6%	93.6%
Benefit Group							
Children	1.2%	93	0.3%	$1,089,520	$11,715	0.1%	0.3%
Adults	0.8%	60	0.2%	$587,163	$9,786	0.3%	0.5%
Disabled Children	11.1%	860	4.1%	$12,885,322	$14,983	35.8%	22.5%
Disabled Adults	46.3%	3,596	54.4%	$172,571,677	$47,990	23.6%	51.3%
Elderly	40.7%	3,159	41.0%	$129,833,886	$41,100	42.6%	84.5%

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 2009 (service may have been incurred in a prior year). Grouping is based on status on the date the benefit was obtained (service was provided). 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 64 year old woman with a September birthdate obtained waiver services in August, they would be included in the 55 through 64 age group fiscal year count if that claim was processed for payment anytime before June 30, 2009. If they obtained waiver services again in December 2008, they would also be included in the 65 through 84 age subgroup count if the claim was paid anytime before June 30, 2009.

*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.

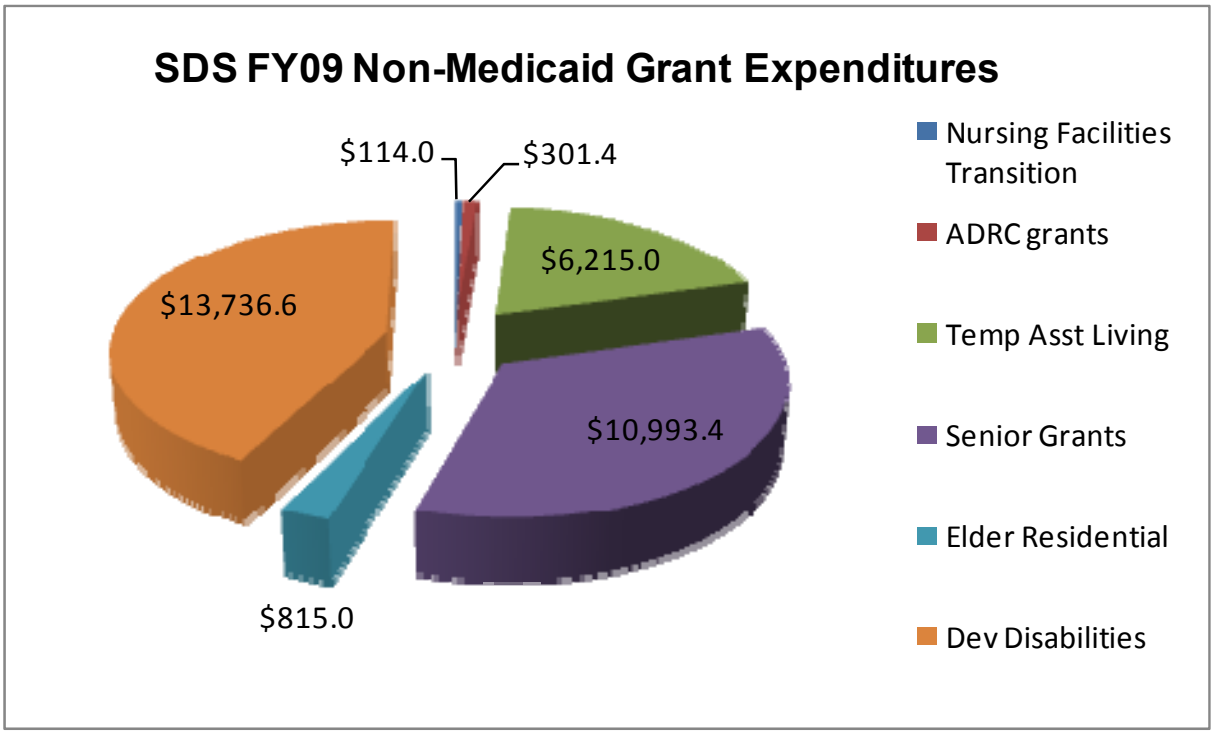
Non-Medicaid Services

FY09 SDS Non-Medicaid Grants/Services Expenditures and Unduplicated Count of Clients Served

Grant Name	Primary Service	# of Clients Served	Client Population	Total Exp:
Nursing Facilities Transition ($114.0)	Nursing Facilities Transition	58	Seniors	$114.0
Aging and Disability Resource Centers	ADRC grants	4,623	Seniors and Dev Disab	$301.4
Gen Relief / Temp Asst Living	Temp Asst Living	877	Adults 18+	$6,215.0
Senior Community Based Grants[1]	Senior Grants	15,590	Seniors	$10,993.4
Senior Residential Grts	Elder Residential	103 (33 FT, 70 PT)	Tribal Elders/Seniors	$815.0
Comm Dev Dis Grts[2]	Dev Disabilities	1,200	Dev Disabled	$13,736.6
	Total Clients Served:	22,451	Total Expenditures:	$32,175.40

[1]Includes these grant programs: Nutrition, Transportation and Support Services, Senior In-Home Services, Adult Day, and ADRE Education and Support.

[2]Includes these grant programs: Community Developmental Disability (DD) Grants, Short-Term Assistance and Referral, DD Min-grants, Protection and Advocacy, and Behavior Risk Management



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	FY10	FY11 Gov	10 to 11 Change
General Funds	160,141.1	176,060.6	15,919.5
Federal Funds	238,162.0	251,322.4	13,160.4
Other Funds	6,636.5	6,351.0	(285.5)
Total	**404,939.6**	**433,734.0**	**28,794.4**

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.

Medicaid Program - Formula Growth: *$26,327.0 Total- $13,183.7 GF Match; $13,143.3 Fed*
This increment is necessary to maintain the current level of long-term health services in Medicaid eligible elderly or disabled Alaskans. For FY11, Senior and Disabilities Medicaid costs are projected to increase 9.8% from FY10, due to increases in rates and utilization. While the Personal Care Assistance 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 cause costs to rise.

Projections for formula growth are based on historical trends in population, utilization, provider reimbursement, and federal financial participation. The formula growth projection does not speculate on future or proposed changes to eligibility, benefits or federal medical assistance percentage (FMAP). Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget.

The Senior and Disabilities Medicaid Services component funds long-term care services: nursing homes, personal care assistance, and home- and community-based services. 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.

Medicaid Program – Transfer Funds from Alaska Pioneer Homes for Medicaid Match Payment: *$2,033.8 GF*
The division currently receives general funds (GF) related to Residential Assisted Living Medicaid Waiver receipts as inter-agency receipts through a reimbursable service agreement with the Alaska Pioneers Homes division. Transferring the GF to Senior and Disabilities Services (SDS) Medicaid Services component will increase efficiency and reduce paperwork by placing the general fund in the budget of the division responsible for making the match payment.

Senior and Disabilities Services Administration

Home and Community Based (HCB) Waiver Compliance: *$1,000.0 Total- $500.0 GF Match; $500.0 Fed*

The Division of Senior and Disabilities Services (SDS) requests funding for seven existing positions transferred into SDS, and one new permanent half-time Office Assistant II position to address the growing demand for services and to implement the Corrective Action Plan required by the Centers for Medicare and Medicaid Services (CMS). These positions will help ensure compliance with federal assurances outlined in the Code of Federal Regulations, CFR 42 441.302(a), designed to ensure the health, safety, and welfare of waiver recipients. In addition to processing applications, completing eligibility determinations, and authorizing services for all four waivers these positions will also be instrumental in achieving goals and objectives outlined in the SDS Quality Improvement Work Plan.

The demand for home- and community-based services continues to grow commensurate with the increased number of seniors moving to and/or retiring in Alaska. Additionally, the nation's current economic problems with a 10% unemployment rate, the highest in 26 years, is anticipated to result in people migrating to Alaska placing additional pressure on the health and human services delivery system.

MH Trust: Housing -Rural Long Term Care Development: *$140.0 MHTAAR*

This project has been a technical assistance resource through Senior and Disabilities Services (SDS) for several years. It has been very successful in working with rural communities to analyze long-term care needs and in locating resources to meet those needs. A staff person will continue to provide outreach, education and intensive community-based work to assist in meeting the needs of people with Alzheimer's Disease and related dementias and other cognitive disability conditions. Activities will include participation in the Aging and Disability Resource Center project and ongoing technical assistance about development and operational issues to ensure successful feasibility analysis of projects and will result in an increase in home- and community-based service delivery capacity in rural Alaska.

MH Trust: Brain Injury - Traumatic Brain Injury Service Coordination: *$200.0 GF/MH*

This GF/MH increment will support the Traumatic Brain Injury (TBI) Care Coordinator program and a Community TBI Grant (CTBIG) program. Based on outcomes in other states, the TBI Care Coordination program has been demonstrated to reduce emergency room visits; deter more costly care by keeping people within their own homes; and along with other program services, increase readiness for vocational rehabilitation/employment. These programs will provide services to individuals that increase independence as well as serve as a benchmark for a Medicaid Waiver or changes to the existing Medicaid program to better serve Alaskans with TBI.

The CTBIG program addresses the needs of individuals with TBI who need rehabilitation and support to re-learn and to maintain activities of daily living and other skills necessary to live independently, to improve capacity and productivity, and to reduce the need for long-term residential care. Services that a person with a TBI may receive from the program vary depending upon the unique needs of each individual.

The TBI Care Coordination program is estimated to serve 70 Alaskans with TBI. The Community TBI Grants program, based on current adult grant program expenditures, could serve an estimated 95 Alaskans based on an estimated annual cost of $3,183/recipient.

MH Trust: Brain Injury - Traumatic Brain Injury Service Coordination: *$150.0 MHTAAR*
This MHTAAR increment will support the Traumatic Brain Injury (TBI) Care Coordinator program and a Community TBI Grant (CTBIG) program. Based on outcomes in other states, the TBI Care Coordination program has been demonstrated to reduce emergency department visits; deter more costly care by keeping people within their own homes; and along with other program services, increase readiness for vocational rehabilitation/employment. These programs will provide services to individuals that increase independence as well as serve as a benchmark for a Medicaid Waiver or changes to the existing Medicaid program to better serve Alaskans with TBI.

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The TBI Care Coordination program is estimated to serve 70 Alaskans with TBI. The Community TBI Grants program, based on current adult grant program expenditures, could serve an estimated 95 Alaskans based on an estimated annual cost of $3,183/recipient.

Senior Community Based Grants

MH Trust: ACoA - Aging and Disability Resource Centers: *$125.0 MHTAAR*
Aging and Disability Resource Centers (ADRC) serve as a visible, trusted place for people to get 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 Senior and Disabilities Services division (SDS) and will unify the referral process for beneficiaries under this service division.

ARDCs provide assistance to seniors and persons with disabilities with completing applications, long-term care options, counseling and decision support. In FY09, management of the ADRCs transitioned from Alaska Housing Finance Corporation and the State Independent Living Council to SDS. Regional ADRCs currently operate in Anchorage, Southeast Alaska and the Kenai Peninsula. ADRCs will evolve into a statewide information resource, accessible to all Alaskans via phone, internet and agency outreach. ADRCs will also be able to pre-screen individuals for Medicaid and other program eligibility.

Full implementation of this program will result in the establishment of two additional ADRCs 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: Benef 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 the Senior and Disabilities Services grantee, Alzheimer's Association of Alaska. Mini-grants provide Trust beneficiaries with a broad range of equipment and services that are essential to directly improving quality of life and increasing independent functioning. These can include, but should not be limited to, therapeutic devices, access to medical, vision, dental, special health-care, and other supplies or services that might remove or reduce barriers to an individual's ability to function in the community and become as self-sufficient as possible. Assistance with basic living needs not covered by current grants, such as transportation and clothing will also be considered. These services help Trust beneficiaries attain and maintain healthy and productive lifestyles. These items support beneficiaries to achieve and maintain a reasonable quality of life and are key supports to maintaining families' self-sufficiency and ability to care for a family member.

Commission on Aging

MH Trust: Cont - ACOA Planner: *$87.3 MHTAAR*
This project funds one of the two Alaska Commission on Aging (ACOA) planner positions (one GF/MH and one MHTAAR funded). The planner is responsible for supporting the Executive Director in coordination between the ACOA and the Alaska Mental Health Trust Authority (Trust), including gathering data for reporting, coordination of advocacy and planning, and preparing on-going grant progress reports to the ACOA and the Trust. The planner also works with staff to maximize other state and federal funding opportunities for MHTAAR projects and to ensure effective use of available dollars. In addition, the planner position acts as liaison with the other beneficiary boards, i.e. participating in the development of state plans, collaborative projects, etc. Outcomes and reporting requirements are negotiated with the Trust annually.

Governor's Council on Disabilities and Special Education

MH Trust: Workforce Dev - "Grow your own" recruitment strategy for youth: *$10.0 MHTAAR*
The Alaska Mental Health Trust Authority (Trust) Workforce Development Focus Area Recruitment Strategy "Grow Your Own" will encourage youth (14-19 years) to participate in career exploratory activities, to increase the long-term availability of direct service professionals in Alaska. These activities include career awareness and exploration that are tied to classroom learning and work-based experiences. Additionally, work will be done with organizations with specific expertise in youth development to further career exploratory experiences and career preparatory activities. The Alaska Alliance for Direct Service workers and the Alaska Health

Education Center will be responsible for leadership on this strategy, working with the appropriate organizations and school districts to achieve outcomes.

MH Trust: Benef Projects - Peer Operated Services: *$50.0 MHTAAR*
Grant funding will be provided to establish family resource services and services to youth with developmental disabilities. Experienced families will help other families whose children are on the waitlist for developmental disability services. An emphasis will be placed on person-centered planning and helping families access generic community resources that will reduce the need for more costly disability-specific services. Also adults with developmental disabilities will provide services to youth with developmental disabilities. An emphasis will be placed on helping youth develop skills needed to secure employment and access to generic community resources, reducing the need for more intensive disability-specific services.

MH Trust: Cont - Research Analyst III: *$103.4 MHTAAR*
The Research Analyst III position supported by this increment provides the Governor's Council on Disabilities and Special Education (Gov Council) with information about the needs of individuals with developmental disabilities. The position and associated travel and operating funds help ensure Gov Council activities are conducted within the framework of the Mental Health Trust Authority's (Trust) guiding principles while still meeting Congressional requirements. The Research Analyst is a staff member of the Gov Council and funds go directly to the Gov Council.

The Gov Council is federally funded to fulfill specific roles mandated by Congress. It is an expectation of the Trust that the Gov Council will participate in planning, implementing and funding a comprehensive integrated mental health program that serves people with developmental disabilities and their families. This position enables the Gov Council to provide up-to-date, valid information to the Trust on consumer issues, identify trends, participate in Trust activities, enhance public awareness, and engage in ongoing collaboration with the Trust and partner boards.

MH Trust: Benef Projects - Microenterprise Capital: *$100.0 MHTAAR*
This project provides resources for small business technical assistance and development of an 'incubator' to provide ongoing support to individuals with a disability establishing small businesses. The Governor's Council on Disabilities and Special Education will administer this grant in collaboration with their federal grant for employment/training. This project is an ongoing part of the Alaska Mental Health Trust Authority's (Trust) asset building projects, emphasizing increases in opportunities for home ownership, small business ventures and higher education. Microenterprise is a component of services being developed under the Trust's Beneficiary Projects Initiative that will provide alternative and innovative resources, and greater options for consumer input and direction in the services they receive.

MH Trust: Workforce Dev - Workforce Dev, Marketing, Recruitment & Conferences: *$175.0 MHTAAR*

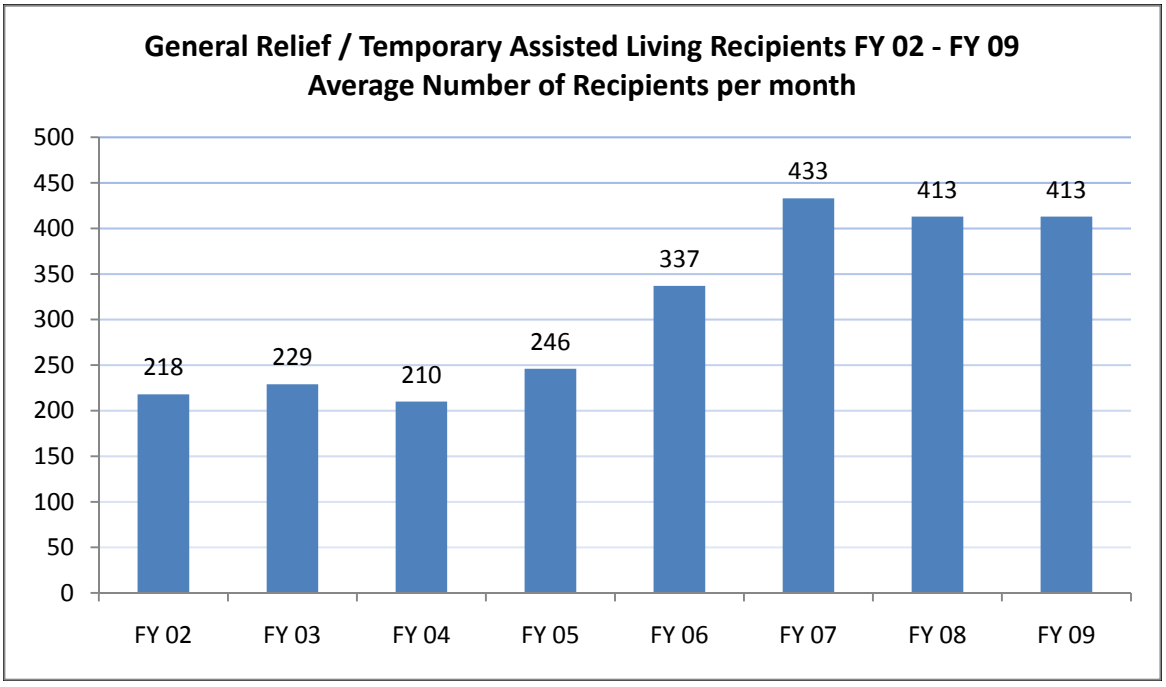
The Alaska Mental Health Trust Authority (Trust) Workforce Development Focus Area is supporting the Alaska Alliance for Direct Service Careers (AADSC) in their work on recruitment and retention strategies. The work will include continued maintenance of the AADSC website for recruitment of direct service workers, training for supervisors, and support for the Full Lives Conference for direct service workers. The AADSC will also continue to provide leadership for the recruitment and retention subcommittees throughout the implementation of the Workforce Development strategies.

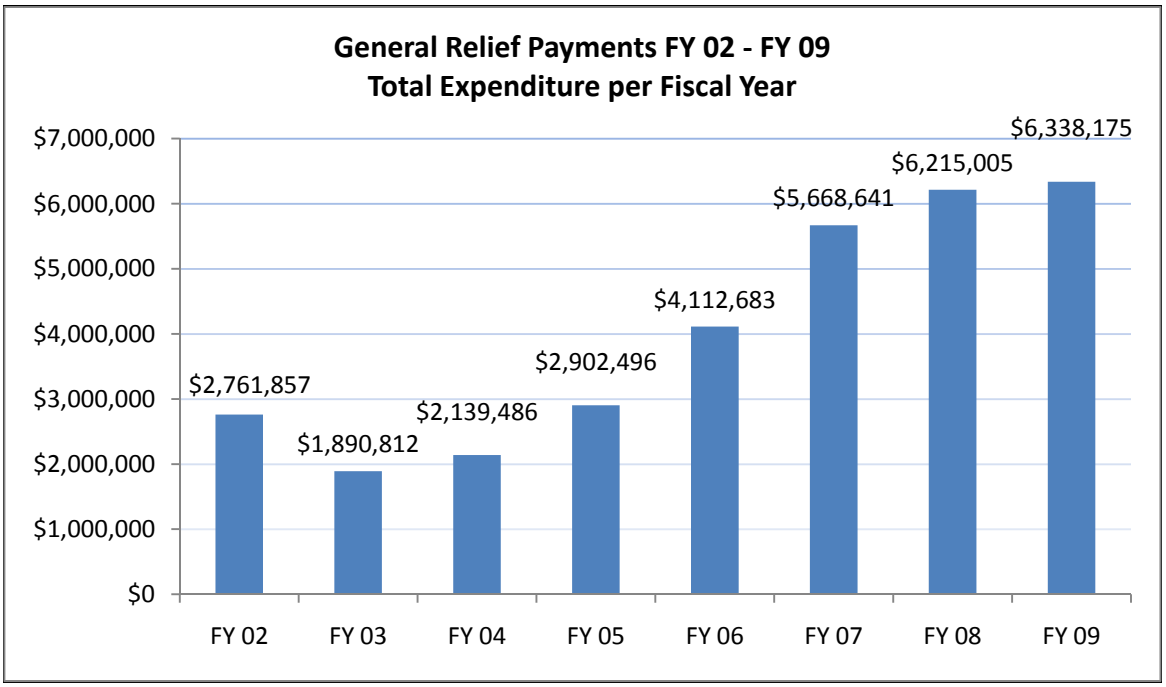
Challenges

The division of Senior and Disabilities Services faces many on-going and new challenges in FY11. Ongoing challenges include eliminating the Developmental Disabilities Waitlist Registry, implementing timely eligibility assessments for Medicaid applicants, and completing activities identified in the Corrective Action Plan.

General Relief / Temporary Assisted Living

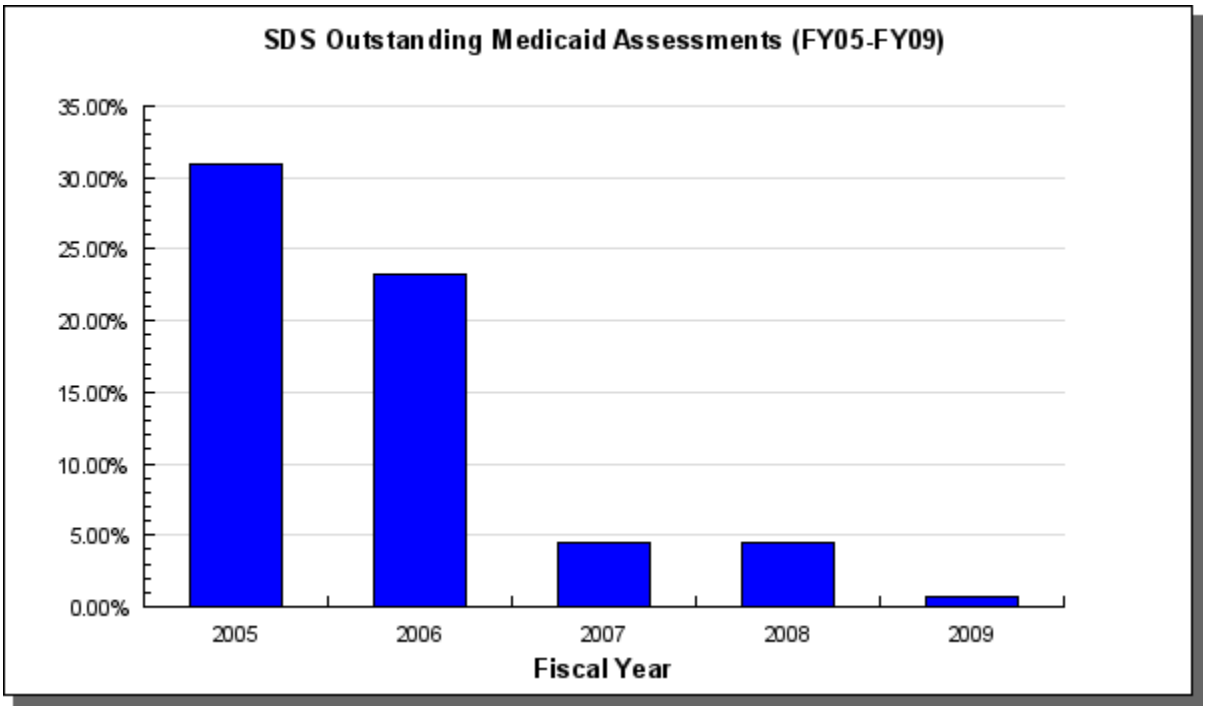
FY10 Legislative Intent Language directs Senior and Disabilities Services (SDS) to review and revise regulations for General Relief / Temporary Assisted Living in order to minimize the length of time that the state provides housing alternatives and to assure the services are provided only to intended beneficiaries who are actually experiencing harm, abuse or neglect. The division educates care coordinators and direct service providers about who should be referred in order that referring agents correctly match consumer needs with the program services intended by the department. Costs to sustain this program have been steadily increasing in recent years. Since FY04, 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 and an increase in the number of vulnerable adults who are victims of abuse and neglect. In addition, an increasing number of adults with severe mental illness are accessing the program. SDS is actively working with the Division of Behavioral Health to determine how many clients served by SDS would be more appropriately served using 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 Payments FY 02 - FY 09
Total Expenditure per Fiscal Year
$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
$6,338,175
FY 02
FY 03
FY 04
FY 05
FY 06
FY 07
FY 08
FY 09

A: Result - The quality of life for seniors and persons with disabilities is enhanced through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipients not receiving medical assessments to less than 5%.
Status #1: The percentage of Medicaid recipients not receiving medical assessments in FY09 was 1%, comparing favorably with the target of less than five percent.



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-FY09.

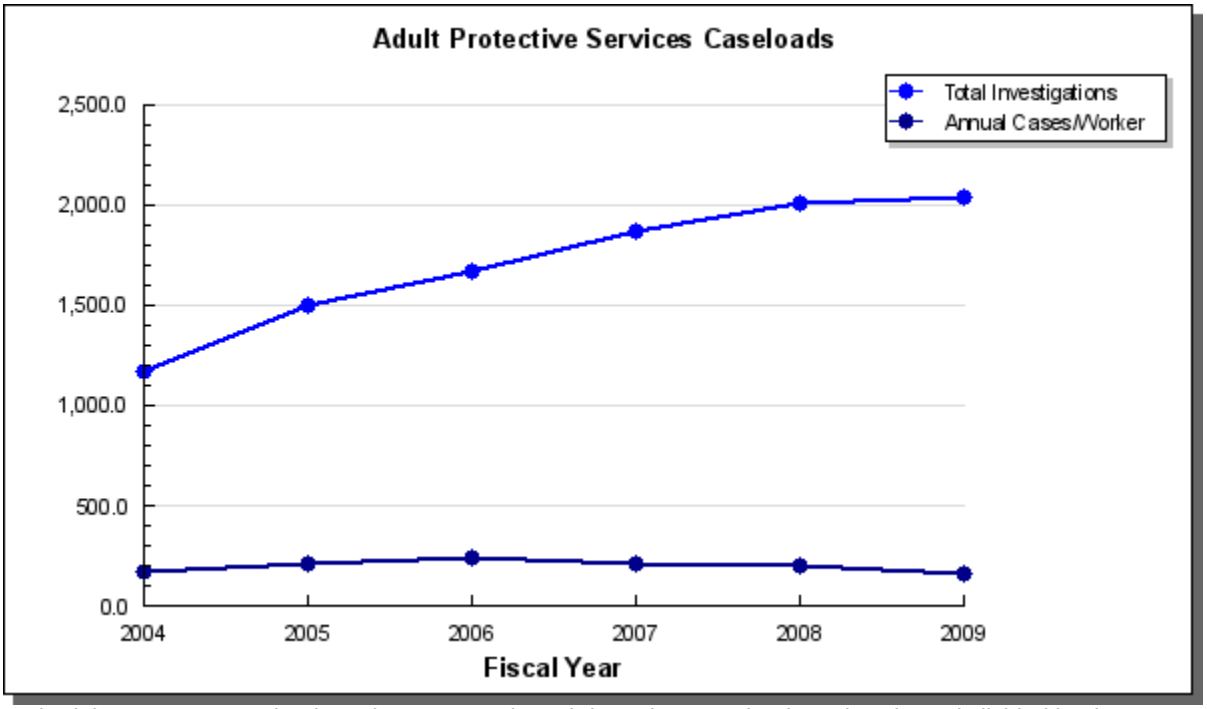
SDS Outstanding Medicaid Assessments (FY05-FY09)

Fiscal Year	% Not Reviewed
FY09	.77%
FY08	4.5%
FY07	4.5%
FY06	23.18%
FY05	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 FY05-2008. 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.

C: Result - A manageable caseload number in Adult Protective Services (APS) and Quality Assurance Units are ensured 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 carry case loads of approximately 78 cases per case investigator, more than 3 times the recommended national average.



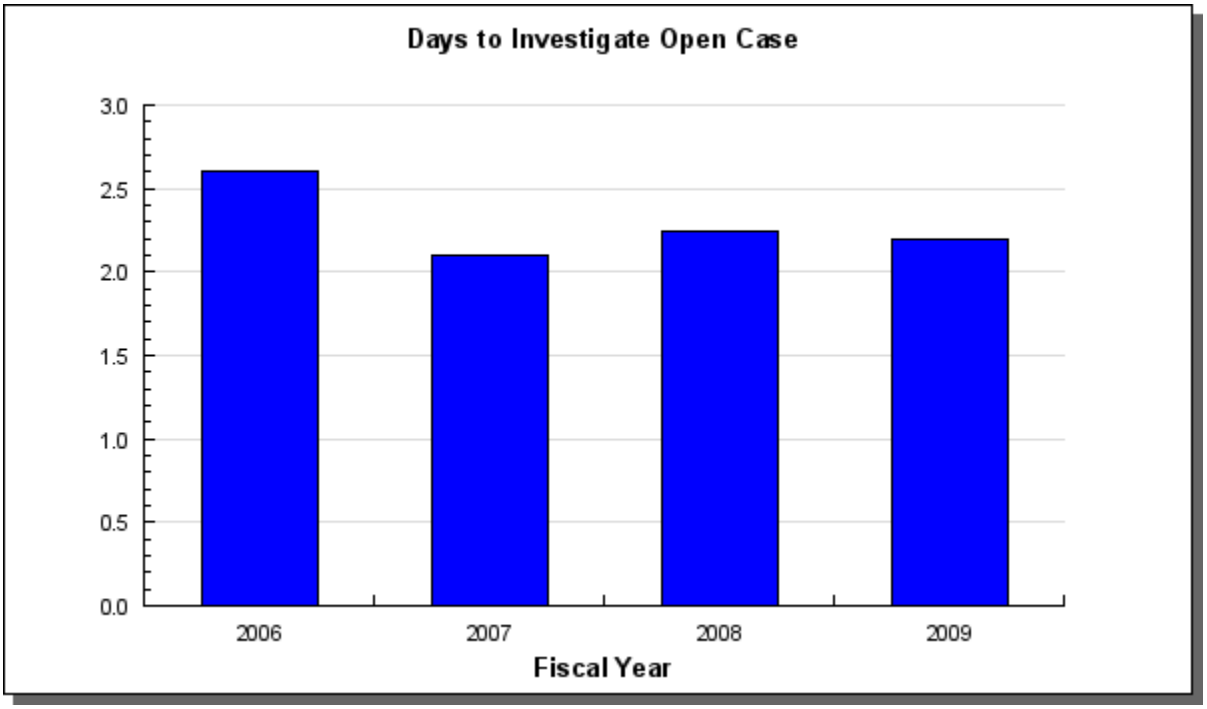
Methodology: *FY09 caseload numbers are "projected" based on caseloads to date (1,362) divided by the number of months that have elapsed in FY09 (8). This number (170) is multiplied by remaining months (4) to project a total number of estimated cases for FY09.

Adult Protective Services Caseloads

Fiscal Year	Total Investigations	Full-Time Workers	Annual Cases per Worker	Days to Investigate
FY09	2043 +1.49%	13 +30%	157.0 -19.9%	2.2 -1.79%
FY08	2013 +7.88%	10 +11.11%	196 -5.31%	2.24 +6.67%
FY07	1866 +12%	9 +28.57%	207 -13.03%	2.1 -19.23%
FY06	1666 +11.29%	7 0%	238 +11.21%	2.6 0%
FY05	1497 +27.62%	7 0%	214 +27.38%	0 0%
FY04	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 FY04 to FY06. From FY04 to FY05, the average caseload increased by more than 27%. From FY05 to FY06, the average caseload increased again, this time by more than 11%. From FY06 to FY07 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 FY09, 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 2.2 days.



Days to Investigate Open Case

Fiscal Year	Days to Investigated	YTD Total
FY09	2.2 -1.79%	2.2 -1.79%
FY08	2.24 +6.67%	2.24 +6.67%
FY07	2.1 -19.23%	2.1 -19.23%
FY06	2.6	2.6

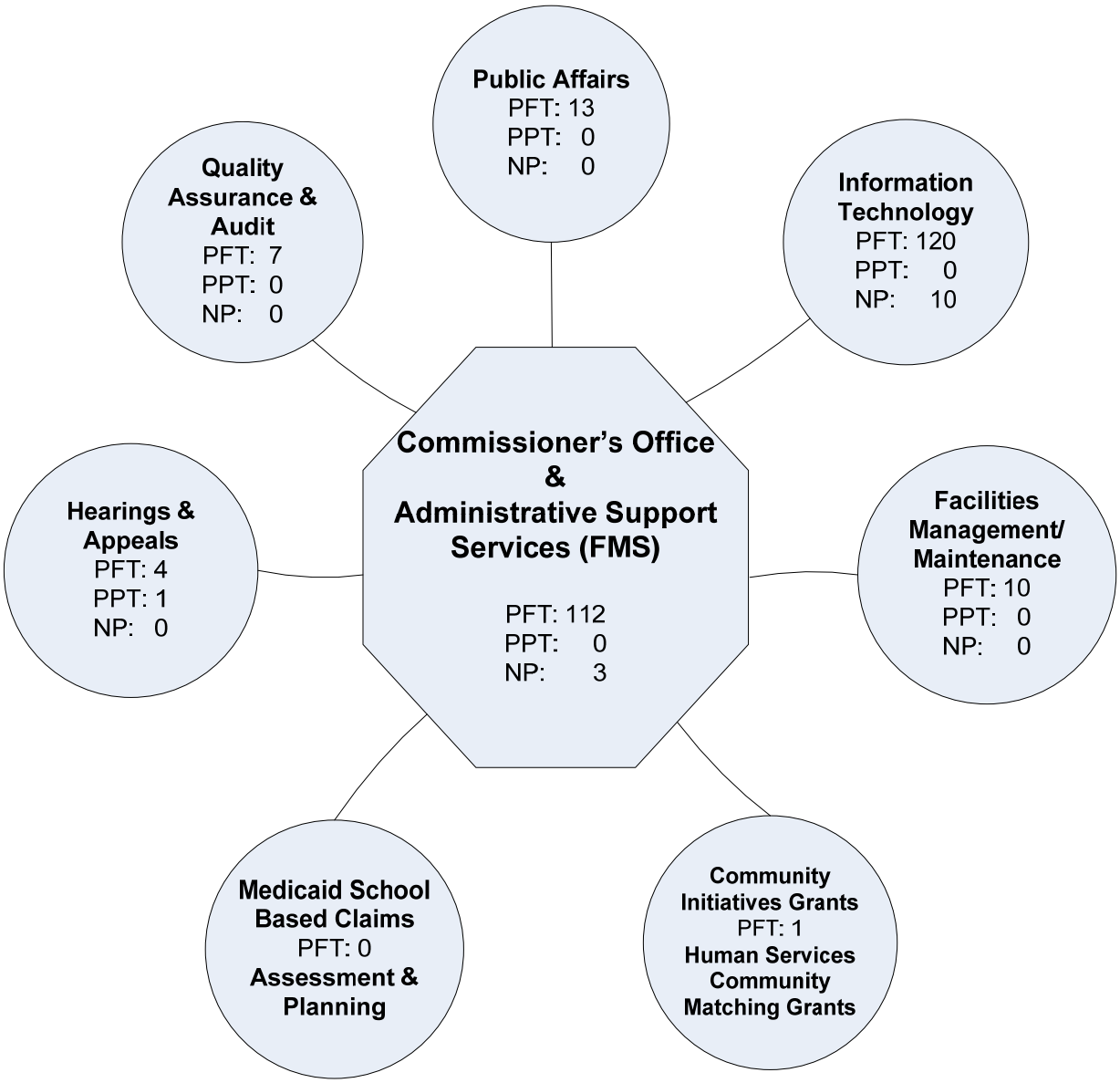
Analysis of results and challenges: The average length of time it took to investigate a new case was approximately 2.6 days in FY06, when there were only seven case workers. In FY07, two additional case worker positions were added, bringing the average length of time to investigate a report of harm down to 2.1 days. In FY08, SDS added three positions, for a total of 12. With these new positions, Senior and Disabilities Services anticipate a decrease to the number of annual cases per worker of more than 13.75%. Senior and Disabilities Services anticipates that, with additional staff in FY09, the number of days it takes to investigate a new case could drop to less than two days.

FY11 Governor's Request Increment and Decrement Fund Breakout

Senior and Disabilities Services FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Medicaid Growth	$ 13,183.7	$ 13,143.3	$ -	$ 26,327.0
Home and Community Based (HCB) Waiver Compliance	$ 500.0	$ 500.0	$ -	$ 1,000.0
MH Trust: Brain Injury - 2468.01 Traumatic Brain Injury Service Coordination	$ -	$ -	$ 150.0	$ 150.0
MH Trust: Brain Injury - 2468.01 Traumatic Brain Injury Service Coordination	$ 200.0	$ -	$ -	$ 200.0
MH Trust: Housing - Grant 68.07 Rural long term care development	$ -	$ -	$ 140.0	$ 140.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (287.5)	$ (287.5)
MH Trust: ACoA - Grant 1927.02 Aging and Disability Resource Centers	$ -	$ -	$ 125.0	$ 125.0
Reverse ADN 0609609 ARRA Sec 1, CH 17, SLA 2009, P 3, L 23 (HB 199) Lapse Date 06/30/10	$ -	$ (485.0)	$ -	$ (485.0)
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (385.3)	$ (385.3)
MH Trust: Benef Projects - Grant 124.06 Mini grants for beneficiaries with disabilities	$ -	$ -	$ 227.5	$ 227.5
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (227.5)	$ (227.5)
MH Trust: Cont - Grant 151.06 ACOA Planner	$ -	$ -	$ 87.3	$ 87.3
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (86.9)	$ (86.9)
MH Trust: Benef Projects - Grant 200.07 Microenterprise capital	$ -	$ -	$ 100.0	$ 100.0
MH Trust: Benef Projects - Grant 2713 Peer operated services	$ -	$ -	$ 50.0	$ 50.0
MH Trust: Cont - Grant 105.06 Research Analyst III	$ -	$ -	$ 103.4	$ 103.4
MH Trust: Workforce Dev - Grant 1381.03 "Grow your own" recruitment strategy for youth	$ -	$ -	$ 10.0	$ 10.0
MH Trust: Workforce Dev - Grant 2344.03 Workforce Dev, Marketing, Recruitment & Conferences	$ -	$ -	$ 175.0	$ 175.0
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (468.6)	$ (468.6)
Senior and Disabilities Svcs Total	***$ 13,883.7***	***$ 13,158.3***	***$ (287.6)***	***$ 26,754.4***

Department Support Services

Total PFT: 267
Total PPT: 1
Total NP: 13



Introduction to the Division

Mission

To provide quality administrative services that support the department's programs.

Introduction

Department Support Services' role is to assist the Department of Health and Social Services divisions in meeting their fiduciary responsibilities. The division serves both external and internal customers by centrally administering the departments' planning, budgetary, financial and management needs.

Core Services

Departmental Support Services (DSS), includes the Commissioner's Office, Public Affairs and Finance and Management Services. DSS is one of nine divisions within the Department of Health and Social Services. DSS provides a varied range of centralized administrative support services to support program efforts across the department. DSS consists of the following components:

- Commissioner's Office;
- Public Affairs;
- Quality Assurance and Audit;
- Hearings and Appeals;
- Medicaid School Based Claims;
- Community Initiative Grants;
- Human Services Community Matching Grants;
- Facilities Management;
- Facilities Maintenance;
- Information Technology Group;
- Administrative Support Services;

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 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 AS 47.05.200, law enforcement contact, and data analysis and problem detection. Unit efforts focus on meeting 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)

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)

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)

Community Initiative Grants
The Community Initiative Grant (CIG) program was created by the legislature to fund grants to areas ineligible for the Human Services Community Matching Grant. (HSCMG). The funds are used to provide essential human services whose unavailability would subject persons in need5 to serious mental or physical hardship. Services provided or supplemented by these grants include: substance abuse treatment, mental health services, food and shelter for families and individuals in need, housing and rehabilitation for the physically and mentally ill, runaway shelters, sexual assault and domestic violence treatment services.

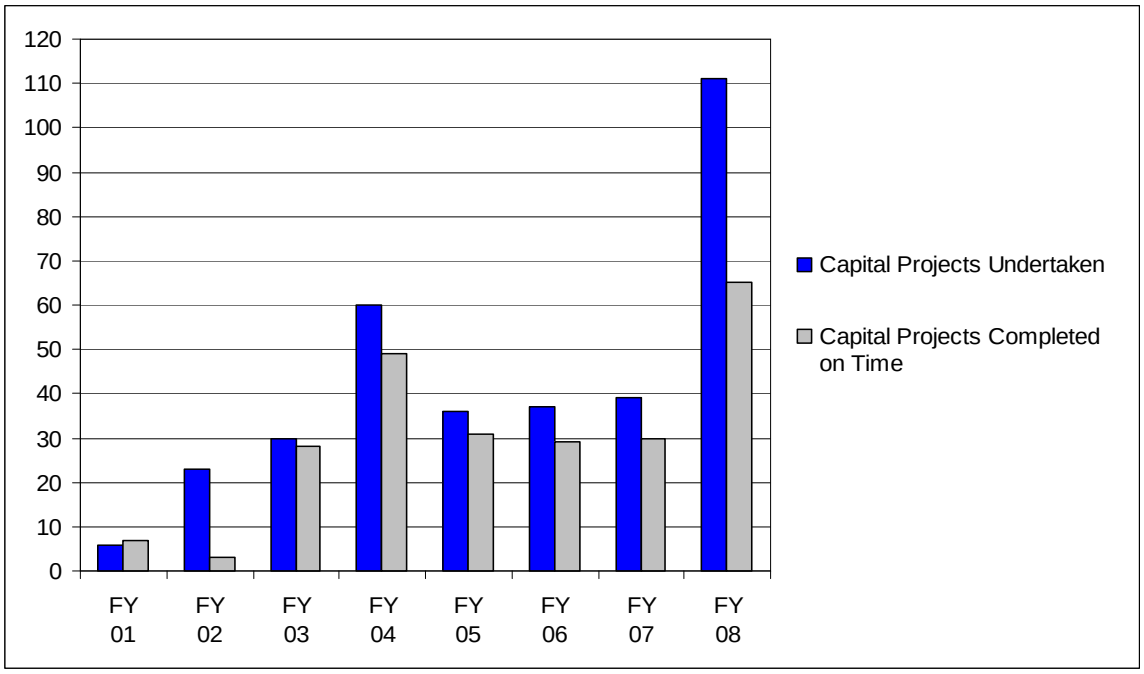
After the competitive RFP process, sixteen agencies were awarded the Community Initiative Grant for FY10. Grantees have completed and submitted first quarter reports that show progress toward their projected outcomes.

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)

Facilities Management
The Facilities Management component manages the department's capital programs. (AS 37.07.062 Capital Projects – Responsible for preparation, submission and competent management of annual capital budget requests.)

The Facilities Management component 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 956,000 square feet throughout Alaska, at a replacement value of $672 million.

The following chart shows the level of activity within Facilities Management for FY01 through FY08.



In addition, Facilities Management administers all capital grants including pass-through federal funds from the Denali Commission. In FY09, 11 new grants were issued valued at $2 million.

Facilities Maintenance
The Facilities Maintenance component, Pioneer Homes Facilities Maintenance, and DHSS 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.

Information Technology
The Information Technology (IT) component's focus is to improve the efficiency and effectiveness of IT services and develop a more agile and capable IT organization to meet the business objectives of the department.

The Information Technology (IT) section provides direct user support, business application development and administration of the department's data centers and network infrastructure. It is comprised of four primary units: Network Services, Customer Services, Business Applications, and Strategic Planning. The IT section supports all aspects of technology needs for the department's employees, as well as providing for specific technology needs of some of the department's grantees. IT provides representation with other organizations and interfaces with other State organizational units regarding 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 and 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. The Strategic Planning unit has three focused areas of responsibility. These areas of responsibility include the department's IT Security Office, the IT Project Management Office (PMO), and IT Strategic Planning. The IT Security Office provides a holistic approach at IT security encompassing general security practices with policy and procedures including department compliance efforts of meeting the HIPAA Privacy and Security rules. The IT Project Management Office (PMO) is responsible for the establishment of standardized and repeatable process for managing IT projects as well as providing department resources for project inception and the management of ongoing projects. IT Strategic Planning is emerging to better align technology services with the business objectives of the department.

FY11 Chart:

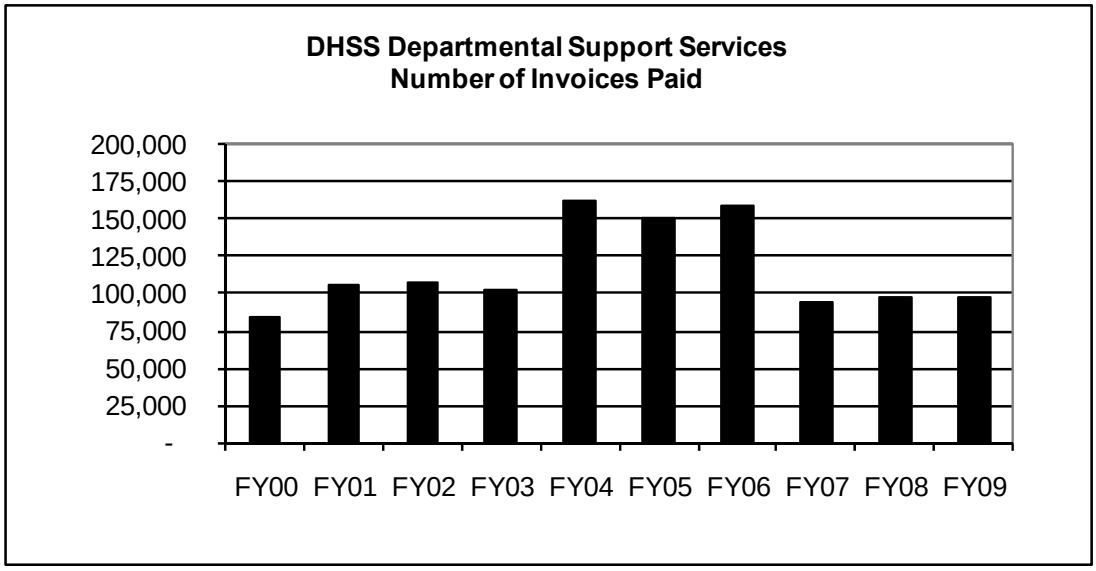
DHSS Computing Environment:	
Number of Desktops:	**3510**
Number of Servers:	**292**
Number of Networks Statewide:	**144**
Number of Facilities Networks are Housed:	**118**
Industry Standard is 125 Customers to 1 Technician **DHSS Ratio: 137 Customers to 1 Technician** **Total Help Calls FY08: 21,628** **Total Help Calls FY09: 19,941** **Average of 78 calls per day in FY08** **Average of 72 calls per day in FY09**	
Number of Communities where IT Infrastructure is Located:	**36**
Number of Business Applications	**238**

Administrative Support Services

The Administrative Support Services component funds financial, budget, procurement, grant and contract administration, and human resource liaison functions. (AS 37.10: Financial Management, OMB Circular A-87; 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.

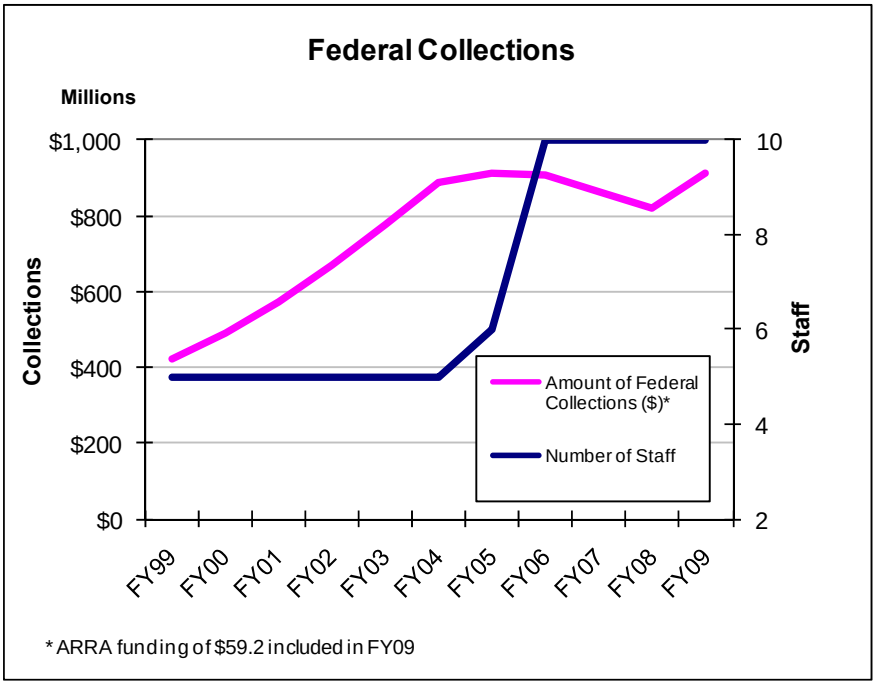
Finance Section

The Finance Section (known internally as Fiscal Services) is responsible for processing financial transactions, management reporting and related accounting services. Finance Section activity from FY00 to FY09 is presented below:



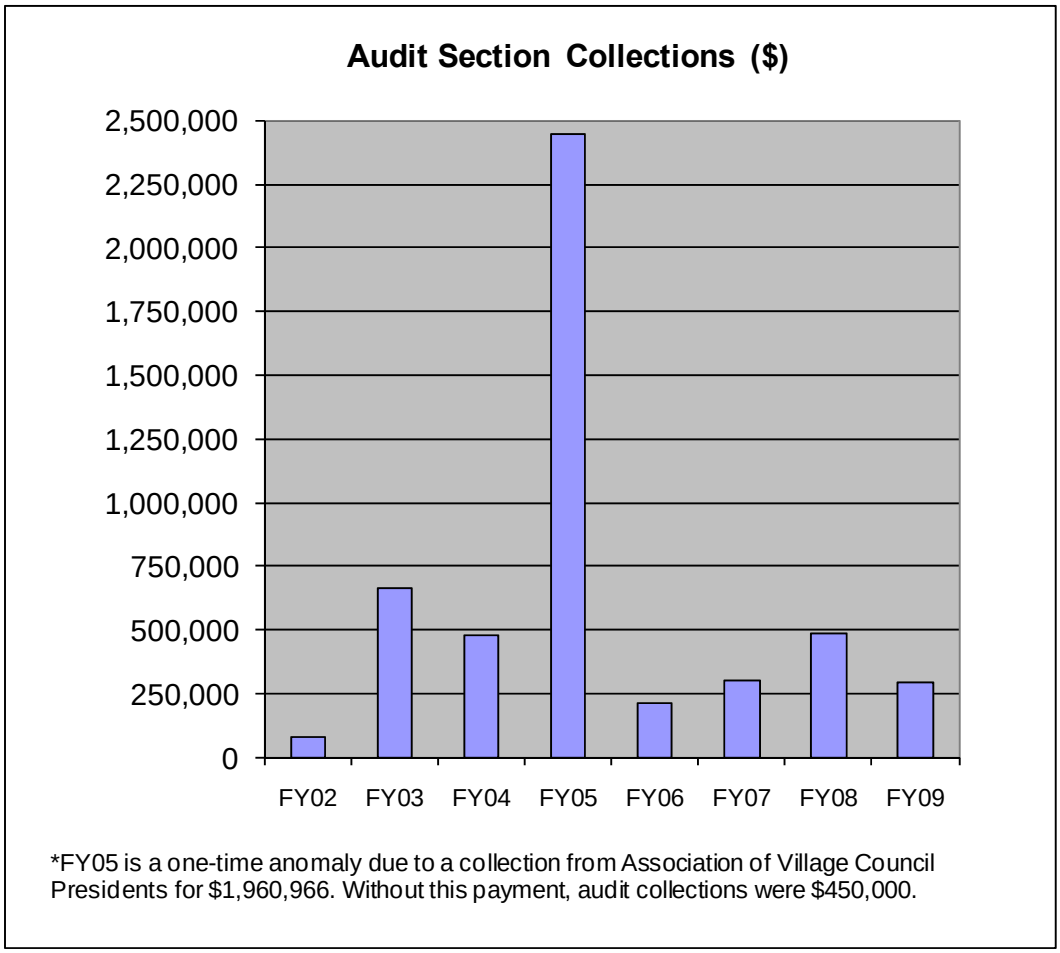
Revenue Section

The Revenue Unit is responsible for federal reporting and revenue collections for the department. Services include the drawdown of cash from Federal sources in compliance with Cash Management Improvement Act (CMIA) regulations, quarterly cost allocations in accordance with the department's Public Assistance Cost Allocation Plan (PACAP) and reporting of federal expenditures. Total FY09 collection of federal funds is presented below.



Audit Section
The Audit Section is responsible for performing single audit reconciliations of DHSS grantees, federal sub-recipient monitoring and special review of department grantees upon request. In addition, the Audit Section coordinates the statewide and federal compliance audits conducted by the Division of Legislative Audit for the Department.

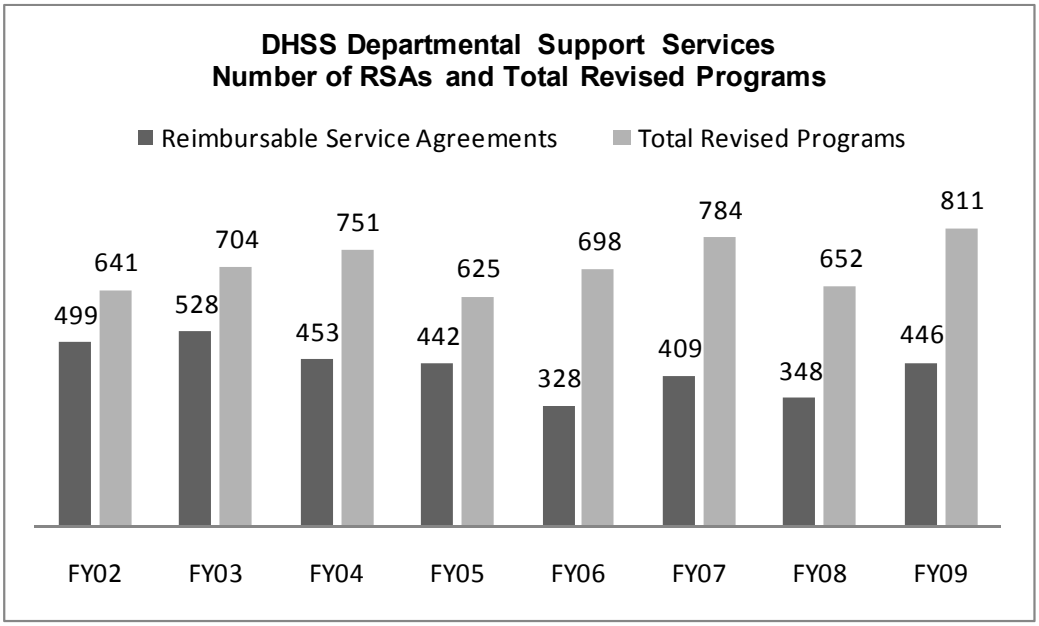
The following chart shows the collection activity of grantee overpayments for FY01 through FY09.

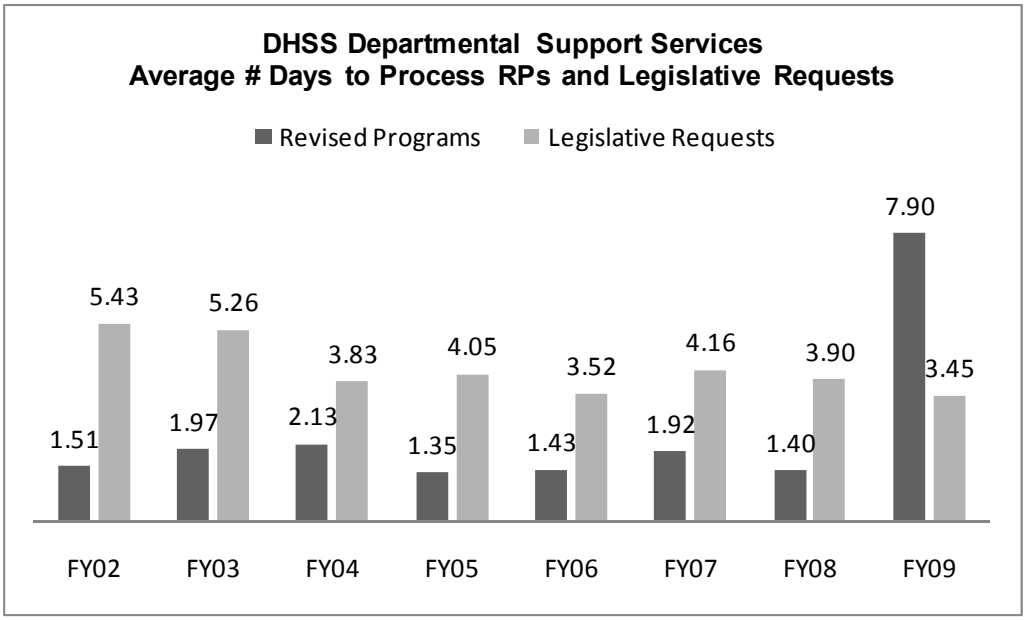


Budget Section
The Budget Section is responsible for analyzing, monitoring, and controlling the Department's annual operating budget, budget amendments, revised programs, supplemental budgets, fiscal notes and legislative requests for information.

FY09 was challenging due to high vacancies and staff turnover. As the charts below show, the unit provided prompt responses to legislative information requests, but processing of revised program requests slowed significantly.

During FY09 the Budget Section developed, presented, and sponsored training for administrative and program staff throughout the department. Training topics included Budget Cycle Overview, Managing Your Budget, How to Prepare RSAs and RPs, Writing for the Workplace, etc. In addition, new SharePoint tools are being developed to simplifying tracking and reporting and to improve intra-department coordination and communication.

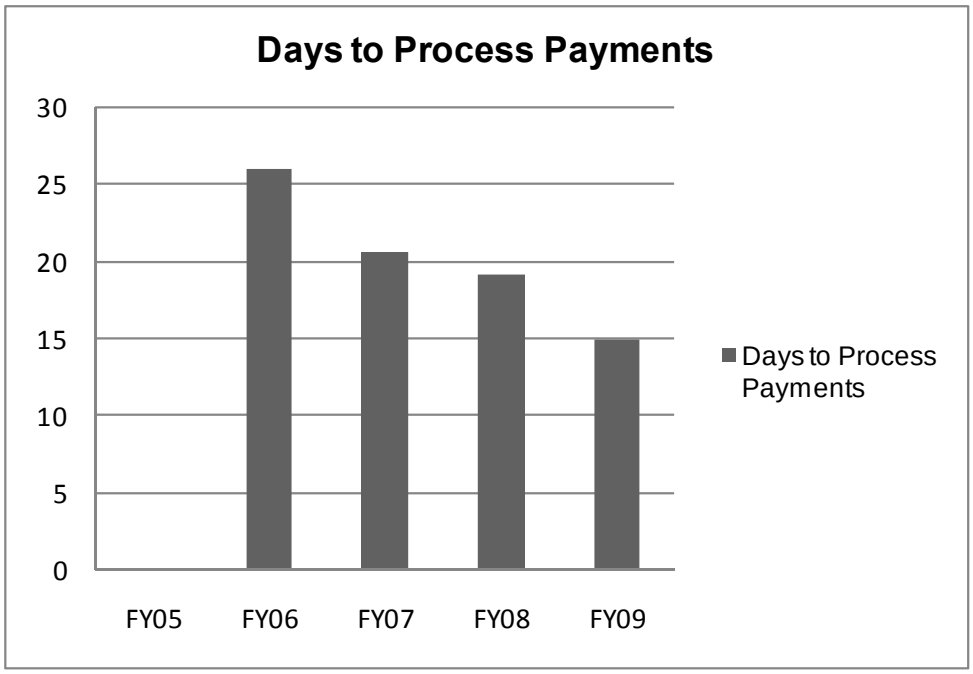




Grant and Contracts Support Team

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.

A significant result of centralizing the administration of department grants into one section, Grants and Contracts Support Team, is a 42% improvement in time needed to process grantee payments. Since FY06 a reduction from an average of 25.93 to 14.93 days to process a payment has been achieved.



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.

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	Hospitals and Nursing Facilities
AS 18.28.010	Community Health Aide Grants
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	Administration of 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	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	Mental Health - Powers and Duties of Department
AS 47.30.661	Welfare, Social Services and Institutions, Mental Health
AS 47.55	Alaska Pioneers' Home and Alaska Veterans' Home
Security Act:	Title XVIII Medicare, Title XIX Medicaid, Title XXI Children's Health Insurance Program
7 AAC 9	Health & Social Services, Design and Construction of Health Facilities
7 AAC 07	Health & Social Services Certificate of Need
7 AAC 13	Health & Social Services, Assistance for Community Health Facilities
7 AAC 26	Emergency Medical Services
7 AAC 43	Medical Assistance
7 AAC 48	Catastrophic Illness and Chronic and Acute Medical Assistance
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	FY10	FY11 Gov	10 to 11 Change
General Funds*	20,285.9	22,569.0	2,283.1
Federal Funds	21,256.3	19,515.4	(1,740.9)
Other Funds	9,629.4	9,242.9	(386.5)
Total	**51,171.6**	**51,327.3**	**155.7**

*Includes Human Services Community Matching Grants, $1,485.3 GF
Community Initiative Matching Grants $673.6 GF, $12.4 Fed, FY10 and $675.7 GF, $12.4 Fed, FY11

Commissioner's Office

Replace Unrealizable Interagency Receipts from Health Care Services: *($175.0) I/A, $175.0 GF*
Replace a reduction in interagency receipts from the division of Health Care Services to maintain core services provided by the Commissioner's Office. A review of the cost allocation plan found Health Care Services was not charged correctly and continuing to charge Health Care Services at this level may result in audit findings, potential federal compliance issues, and the potential return of federal funding. While the additional costs could be borne by the divisions, no additional funding to cover this increase has been requested by the divisions and a reduction in core services provided throughout the department will result.

Information Technology Services

Replace Unrealizable Federal Receipts: *$750.0 GF, ($750.0) Fed*
Uncollectable federal authority was transferred into the centralized Information Technology (IT) unit with positions from the divisions. General Funds (GF) is needed to replace the unrealizable federal revenue to cover the shortfall in personal services.

The continued inability to fund positions in IT hampers efforts to provide for adequate IT services for the department. The divisions will have to absorb sometimes significant costs within their annual operating budgets. Without significant additional funding, the IT section must reduce staffing and/or share the costs with all divisions through an increased RSA approach based upon division PCN counts. As the divisions have received no additional funding with which to cover increased overhead, the end result will be a reduction in core services provided throughout the department.

Replace Unrealizable Interagency Receipts from Health Care Services: *$225.0 GF, ($225.0) I/A*
General Fund (GF) is needed to replace a reduction in interagency receipts from the division of Health Care Services to maintain core services provided by the Information Technology unit. A review of the cost allocation plan found Health Care Services was not charged correctly and, without this fund replacement, continuing to charge Health Care Services at this level may result in audit findings, potential federal compliance issues, and the return of federal funding. While the additional costs could be borne by the divisions, no additional funding to cover this increase

has been requested by the divisions and a reduction in core services provided throughout the department will result.

Increases for Software Maintenance, Systems and Eligibility Information Systems Billings: *$500.0 GF*

DHSS is experiencing increases in department-wide costs for software maintenance and Division of Public Assistance (DPA) Eligibility Information System centralized billings from the Department of Administration. This request for an increment is essential to meet and maintain the level of service this component provides for the department.

Examples of additional annual costs are:
$125.0 JOMIS Maintenance Contract (Juvenile Offender Management Information System)
$140.0 Microsoft Enterprise Licensing (Server Licenses, MS Office)
$235.0 EIS (Public Assistance Eligibility Information System)

Medicaid School Based Admin Claims

Replace Unrealizable Federal Receipts for Medicaid School Based Claims: *$700.0 GF, ($700.0) Fed*
Replace unrealizable interagency receipts for Medicaid School Based Claims. Federal collections will now be remitted to the Public School Foundation program fund. This fund source change is needed to stabilize the Departmental Support Services budget.

Explanation of FY11 Capital Budget Requests

Department Support Services is requesting the following capital funding:

- Johnson Youth Center Renovation to Meet Safety and Security Needs Phase 1 $9,880.0 GF
- Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment $4,000.0 GF
- Non-Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment $3,020.0 ($3,000.0 GF)
- MH Deferred Maintenance and Accessibility Improvements $500.0 GF/MH
- MH Home Modification and Upgrades to Retain Housing $1,050.0 ($500.0 GF/MH)
- MH Housing Pre-development, Anchorage Assets Building $500.0 GF/MH

Total projects: 6
Total amount of Funding Requested: $18,950.0
Total amount of GF Funding Requested: $18,380.0

The Department will also be submitting a FY10 Supplemental for completion of the Department's Medicaid Management Information System.

Brief Description of Major Projects:

Johnson Youth Center Renovation to Meet Safety and Security Needs Phase 1: *$9,880.0 GF*
This request would fund the complete renovation of the existing detention unit, new secure admissions area, and a new medical suite. The existing structure was built in the 1960s to serve as a women's prison. The existing layout is old, inefficient, unsafe, and unsuitable to serve as detention for youth.

Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: *$4,000.0 GF*
This request is for deferred maintenance and renovation projects for the state's six Pioneer Homes. The homes are located in Ketchikan, Sitka, Juneau, Anchorage, Palmer, and Fairbanks, and have a combined replacement value of $310.3 million.

Non-Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: *Total $3,020.0- $3,000.0 GF, 20.0 Fed*
This request is for deferred maintenance and renovation projects for the Department's 43 facilities statewide – which include youth facilities, public health centers, laboratories, and behavioral health buildings. The combined replacement value of these facilities is $343 million.

MH Deferred Maintenance and Accessibility Improvements: *$500.0 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. In FY09, the Department received 28 proposals requesting a total of $4,446.9. We were only able to award a total of $768.0 to seven of these agencies.

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.

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 and department-wide Quality Assurance program: Medicaid program integrity continues to be of high interest from funding agencies, including the federal government and the Department. Review and audit of federal and state programs is anticipated to increase. Efforts are underway to evaluate resources, workflow alignment, and management structure to produce a comprehensive Program Integrity operation that is efficient and effective.

Deferred Maintenance: DHSS has responsibility for an aging infrastructure to support our public health centers and 24-hour facilities, including Youth Facilities 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.

Sitka Public Health Center Crawl Space Repair:
The crawl space vapor barrier needs to be repaired to prevent moisture from the ground building up in this area.

Johnson Youth Facility Core Building Siding Repair:
The siding on the core building is failing and needs to be replaced.

Ketchikan Pioneer Home Grease Trap Replacement:
The kitchen grease trap is rusted and needs to be replaced. Without this trap, the kitchen cannot operate.

Performance Measure Detail

A: Result - Effective and efficient delivery of administrative services facilitate the department's mission.

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 (FY05 - FY09).

Percentage administration personal services is to total department FY budget

Year	YTD Total
2009	1.5%
2008	1.6%
2007	1.6%
2006	1.4%
2005	1.3%

Analysis of results and challenges: It is the goal of the Department of Health and Social Services (DHSS) to keep administrative costs low.

Department administration personnel services equal all of Department Support Services RDU. 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 FY09, the stability of the Facilities Section staff, coupled with the internal changes initiated in FY07 and FY08, contributed to the Section continuing to process reimbursement requests in less than five days.

Number of days to process a grant payment after receiving reports.

Fiscal Year	YTD Total
FY08	1.50 days
FY07	1.50 days
FY06	3.36 days
FY05	3.11 days

Analysis of results and challenges: In FY06, there were 93 capital grant payments, all processing within five days. In FY07, 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 - Management of department budget processes is improved.

Target #1: Improve legislative understanding of the DHSS budget.
Status #1: Due to receiving 87 inquiries, response times to legislative requests have not met 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
FY09	71%
FY08	79%
FY07	72%
FY06	80%
FY05	79%

Analysis of results and challenges: It is important that policy makers working on key budget issues get their information timely in order to make decisions regarding the DHSS budget.

The budget section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY05.

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 FY06 was 3.52 days. 80% were completed within five working days.

In FY07, 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 - Effective and efficient delivery of services facilitate the department's day-to-day operations.

Target #1: Reduce the length of time and number of days to respond and close out service calls.
Status #1: During FY09, IT successfully made great strides on several department-wide desktop deployment and server projects while decreasing the average number of days to complete service and incident calls.

Average Number of Days to Complete Service

Fiscal Year	YTD Total
FY09	6.6 days
FY08	9.9 days
FY07	7.1 days
FY06	4.9 days
FY05	8.2 days

Methodology: FY05 data represents only 3 quarters. This measure began at the start of the 2nd quarter.

Analysis of results and challenges: DHSS uses an incident and project management tool to track and measure IT service delivery to our customers. Approximately 30 service delivery categories are evaluated. Examples of categories include, but are not limited to: hardware and software deployment and upgrades, setting up accounts, application work, password and file maintenance, procurement and relocation of equipment, security, and training.

During FY09, DHSS IT implemented new projects and made steady progress in a number of major department-wide projects, including server consolidation and new desktop deployments and desktop software upgrades, security software deployments, enterprise software procurement and software licensing management. IT staff managed the release of a number of new or upgraded major applications. Refinement of internal incident and project management procedures, improvements in security management, upgrades to network and desktop equipment and increased emphasis on customer training have all contributed to the reduction of time spent in problem resolution.

Target #2: 85% of construction projects completed on time and within budget.
Status #2: Performance percentages fluctuated per quarter from a low of 40% to a high of 90% in FY09.

Percent of Completed Construction Projects On Time and Within Budget.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY09	40%	69%	71%	90%	67.50%
FY08	70%	83%	63%	81%	74.25%
FY07	64%	56%	78%	80%	73.00%
FY06	100%	100%	56%	85%	85.25%

Analysis of results and challenges:
The Department began tracking construction projects in FY06. In FY09, the department completed 68 projects, 42 of which were completed on time and 59 within budget. Due to the continued escalation in construction costs and relatively tight contractor market, the contracting environment continued to be challenging in FY09.

FY11 Governor's Request Increment and Decrement Fund Breakout

Departmental Support Services FY11 Governor's Request General and Other Fund Requests (Increases and Decreases only) Item	GF	Federal	Other	Total
Correct Unrealizable Fund Sources in the Health Insurance increases for Noncovered Employees	$ 11.4	$ -	$ (11.4)	$ -
MH Trust: Workforce Dev - Grant 2347.01 Workforce Development Manager	$ -	$ -	$ 60.0	$ 60.0
Replace Unrealizable Interagency Receipts from Health Care Services	$ 175.0	$ -	$ (175.0)	$ -
Reverse FY2010 MH Trust Recommendation	$ -	$ -	$ (50.0)	$ (50.0)
Delete Grants Administrator (PCNs 06-0023) and Accounting Clerk (PCN 06-0612)	$ -	$ -	$ -	$ -
Reduce Excess Federal Authority	$ -	$ (300.0)	$ -	$ (300.0)
Replace Unrealizable Federal Receipts for Medicaid School Based Claims	$ 700.0	$ (700.0)	$ -	$ -
Cost Increases for Software Maintenance, Systems and Eligibility Information System Billings	$ 500.0	$ -	$ -	$ 500.0
Replace Unrealizable Federal Receipts	$ 750.0	$ (750.0)	$ -	$ -
Replace Unrealizable Interagency Receipts from Health Care Services	$ 225.0	$ -	$ (225.0)	$ -
Reverse August FY2010 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	$ (90.9)	$ -	$ -	$ (90.9)
Departmental Support Services Total	***$ 2,270.5***	***$ (1,750.0)***	***$ (401.4)***	***$ 119.1***

Appendices

RDU/Component Listing FY11

Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Alaska Pioneer Homes	Pioneers Homes Advisory Board
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	AK Mental Health Board & Advisory Board on Alcohol & Drug Abuse
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
Health Care Services	Adult Preventative Dental Medicaid Svcs
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
Health Care Services	Community Health Grants
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	Preparedness Program
Public Health	Certification and Licensing
Public Health	Chronic Disease Prevention and Health Promotion
Public Health	Epidemiology
Public Health	Bureau of Vital Statistics
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
Senior and Disabilities Services	Commission on Aging
Senior and Disabilities Services	Governor's Council on Disabilities and Special Education
Departmental Support Services	Public Affairs
Departmental Support Services	Quality Assurance and Audit
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
Human Services Community Matching Grant	Human Services Community Matching Grant
Community Initiative Matching Grants (non-statutory)	Community Initiative Matching Grants (non-statutory grants)

Glossary of Acronyms

AAC .....Alaska Administrative Code
ABADA .....Advisory Board on Alcoholism and Drug Abuse
ABDR .....Alaska Birth Defects Registry
ABS.....Alaska Budget System
ACOA .....Alaska Commission on Aging
ACS.....Affiliated Computer Services
ACT.....Alaska Children's Trust
ADRC……Aging and Disability Resource Center
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 Access Network
AJJAC.....Alaska Juvenile Justice Advisory Committee
AKAIMS……Alaska Automated Information Management System
AKPH…….Alaska Pioneer Homes
AK-PIC……..Alaska Psychology Internship Consortium
AKPUD……..Alaska Interagency Committee to Prevent Underage Drinking
AKSAP .....Alaska Senior Assistance Program
AKSAS .....Alaska State Accounting System
AMHB.....Alaska Mental Health Board
AMHTA.....Alaska Mental Health Trust Authority
ANHB .....Alaska Native Health Board
ANMC.....Alaska Native Medical Center
ANTHC.....Alaska Native Tribal Health Consortium
AoA……United States Administration on Aging
AORH……Alaska Office of Rural Health
APA.....Adult Public Assistance
APCA.....Alaska Primary Care Association
APCO.....Alaska Primary Care Office
APD.....Advanced Planning Document
APD.....Adults with Physical Disabilities (Waivers)
APHIP.....Alaska Public Health Improvement Process
APHL .....Alaska Public Health Laboratories
API .....Alaska Psychiatric Institute
APPIC…….Association of Psychology Postdoctoral and Internship Centers
APS…….Adult Protective Services
ARND .....Alcohol and Related Neurodevelopmental Disorder
ARBD .....Alcohol Related Birth Defects

ART.....Aggression Replacement Training
AS .....Alaska Statute
ASAP .....Alcohol Safety Action Program
ASPEN.....Automated Survey Processing Environment
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 Bay Native Association
BBAHC.....Bristol Bay Area Health Corporation
BCC.....Breast and Cervical Cancer
BGC……...Boys & Girls Club
BH.....Behavioral Health
BHIP .....Behavioral Health Integration Project
BMI.....Body Mass Index
BRFSS.....Behavioral Risk Factor Surveillance System
BRS.....Behavioral Rehabilitation Services
BTKH.....Bring the Kids Home
BVS.....Bureau of Vital Statistics
BYF……Bethel Youth Facility
CADCA……. Community Anti-Drug Coalitions of America
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 (&/or CDP/HP)....Chronic Disease Prevention and Health Promotion component
CDC .....Center for Disease Control
CDDG .....Community Developmental Disabilities Grants
CFDA.....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
CHC…… ….Community Health Center
CHEMS.....Community Health & Emergency Medical Services

CHG…….. Community Health Grants
CHIP(RA) .....Children's Health Insurance Program (Reauthorization Act)
CIG…….Community Initiative Grants
CIP…….…….Capital Improvement Project
COMP Plan…….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
CON……..…Certificate of Need
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
CTU……Closed Treatment Center
DAI .....Detention Assessment Instrument
DBH .....Division of Behavioral Health
DD.....Developmentally Disabled
DDI .....Design, Development & Implementation
DEED.....Department of Education & Early Development
DET.....Designated Evaluation & Treatment
DES.....Designated Evaluation & Stabilization
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
DOL .....Department of Law
DOT .....Direct Observed Therapy

DOT……Department of Transportation
DOT-PF.....Department of Transportation and Public Facilities
DPA.....Division of Public Assistance
DPH.....Division of Public Health
DPS……Department of Public Safety
DSDS .....Division of Senior and Disabilities Services
DSH.....Disproportionate Share Hospital
DSS .....Department Support Services (aka Finance and Management Services)
DUR .....Drug Utilization Review
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
ER .....Emergency Room
FAE .....Fetal Alcohol Effects
FARS.....Fatal Accident Reporting System
FAS .....Fetal Alcohol Syndrome
FASD .....Fetal Alcohol Spectrum Disorder
FFP.....Federal Financial Participation
FFY .....Federal Fiscal Year
FY……...Fiscal Year
FYF…….Fairbanks Youth Facility
FLEX……..Rural Hospital Flexibility Program
FLSW.....Front Line Social Worker
FMAP.....Federal Medical Assistance Program
FMS.....Finance and Management Services
FPG .....Federal Poverty Guidelines
FQHC.....Federally Qualified Health Centers
FS .....Food Stamps
FTE .....Full Time Equivalent
GCDSE .....Governor's Council on Disabilities and Special Education
GF……...General Fund
GRA .....General Relief Assistance

HAIL.....Healthy Alaskans Information Line
HAN.....Health Alert Network
HAP.....Heating Assistance Program
HB……..House Bill
HCBC.....Home and Community Based Care
HCBW.....Home and Community Based Waivers
HCP.....Health Care Program
HCS.....Health Care Services
HDDS…….Hospital Discharge Data System
HDM……...Hospital Discharge Model
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
HPI…….Health Planning and Infrastructure
HRSA.....Health Resource Services Administration
HSCMG .....Human Services Community Matching Grants
IA .....Interim Assistance
I/A .....Interagency Receipts
ICD-10 .....International Classification of Disease – version 10
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
JUCE.....Juneau Claims and Eligibility
JYC…….Johnson Youth Center
KPYF…….Kenai Peninsula Youth Facility
KRYF…….Ketchikan Regional Youth Facility
LCSW .....Licensed Certified Social Worker
LIHEAP .....Low Income Home Energy Assistance Program
LTC.....Long Term Care
MBU .....Medicaid Budget Unit
MCAC.....Medicaid Care and Advisory Committee
MCFH .....Maternal, Child & Family Health
MCH .....Maternal, Child Health (Block Grant)
MDS.....Minimum Data Set
MH .....Mental Health
MHDD .....Mental Health and Developmental Disabilities
MHSIP .....Mental Health Statistics Improvement Project
MHTAAR .....Mental Health Trust Authority Authorized Receipts
MI……...Motivational Interviewing
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)
MSYF…….Mat-Su Youth Facility
MYC .....McLaughlin Youth Center
NCC……Nome Community Center
NHSC.....National Health Service Corps
NIH .....National Institutes of Health
NPS .....National Pharmaceutical Stockpile
NRO .....Northern Region Office
NSH.....North Star Hospital
NSHC.....Norton Sound Health Corporation
NSIP.....Nutrition Services Incentive Program
NTSS.....Nutrition, Transportation and Support Services
NYF……Nome Youth Facility
OA.....Older Alaskans (Waiver)
OAA.....Older Alaskan's Act
OASIS.....Outcome of Assessment Information Set
OCS.....Office of Children's Services

OEP.....Office of Emergency Preparedness
OOS.....Out of State
ORCA .....Online Resource for the Children of Alaska
ORR .....Office of Rate Review
OSEP.....Office of Special Education Programs
OSHA…….Occupational Safety and Health Association
P&T.....Pharmacy & Therapeutics
PA .....Public Assistance
PASS.....Parents Achieving Self-Sufficiency
PASS Grant.....Personal Assistance, Supports and Services
PbS……..Performance-based Standards
PC.....Personal Computer
PCA.....Personal Care Assistant
PCBs .....Polychlorinated Biphenyls
PCCM .....Primary Care Case Management
PCN.....Position Control Number
PCO……Primary Care Office
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
PL……...Public Law
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
RCSC…….Real Choice System for Change
RDT.....Residential Diagnostic Treatment
RDU .....Results Delivery Unit

RFP .....Request for Proposal
RFR.....Request for Recommendations
RHSS.....Rural Health Services System
RHSSP……Rural Human Services Systems Project
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
SA……...Substance Abuse
SAG.....Subsidized Adoption and Guardianship
SAMHSA.....Substance Abuse and Mental Health Services Administration
SAPT.....Substance Abuse Prevention and Treatment Block Grant
SCF .....Southcentral Foundation
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
SFY……State Fiscal Year
SHIP……...State Health Insurance Assistance Program
SIG/ACT.....State Incentive Grant/Alaskans Collaborating for Teens
SME .....State Medical Examiner
SMI…….Seriously Mentally Ill (aka CMI Chronically Mentally Ill)
SMI .....Supplementary Medical Insurance
SMP……Senior Medicare Error Patrol
SPF…….Strategic Prevention Framework
SPFSIG……...Strategic Prevention Framework State Incentive Grant
SPMP .....Skilled Professional Medical Personnel
SSBG.....Social Services Block Grant
SSI.....Supplemental Security Income
SSPC……...Statewide Suicide Prevention Council
STARS .....Service Tracking Analysis Reporting System (based on MMIS)
STAR Grants.....Short Term Assistance and Referral
STD.....Sexually Transmitted Disease
SUD……Substance Use Dependent

SVCS/SMI .....Services to the Seriously Mentally Ill
TANF .....Temporary Assistance to Needy Families
TB .....Tuberculosis
TBI……..Traumatic Brain Injury
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 IV E
Title V .....Maternal, Child Health Block Grant
Title X .....Family Planning (Federal)
Title XIX.....Medicaid
Title XXI.....SCHIP/Denali KidCare
T&H .....Central Council of Tlingit and Haida Indian Tribes
TPL .....Third Party Liability
TSU…….Transitional Services Unit
TWWIIA.....Ticket to Work and Work Incentives Improvement Act of 1999
UAA……...University of Alaska, Anchorage
UAF……University of Alaska, Fairbanks
USDA.....U. S. Department of Agriculture
USDHHS.....U. S. Department of Health and Human Services
WAS.....Women and Adolescent Services
WIA.....Workforce Investment Act
WIC.....Women, Infants and Children
WISH……..Women in Safe Homes
WSEA .....Western States EBT Alliance
WtW.....Welfare to Work
YCA……...Youth Competency Assessment
YF .....Youth Facility
YKHC .....Yukon-Kuskokwim Regional Health Corporation
YLS/CMI……....Youth Level of Services/Case Management Inventory
YRBS .....Youth Risk Behavior Survey