



State of Alaska
Department of Health & Social Services

Fiscal Year 2012 Budget Overview



Governor Sean Parnell, State of Alaska
Commissioner Bill Streur, Department of Health & Social Services

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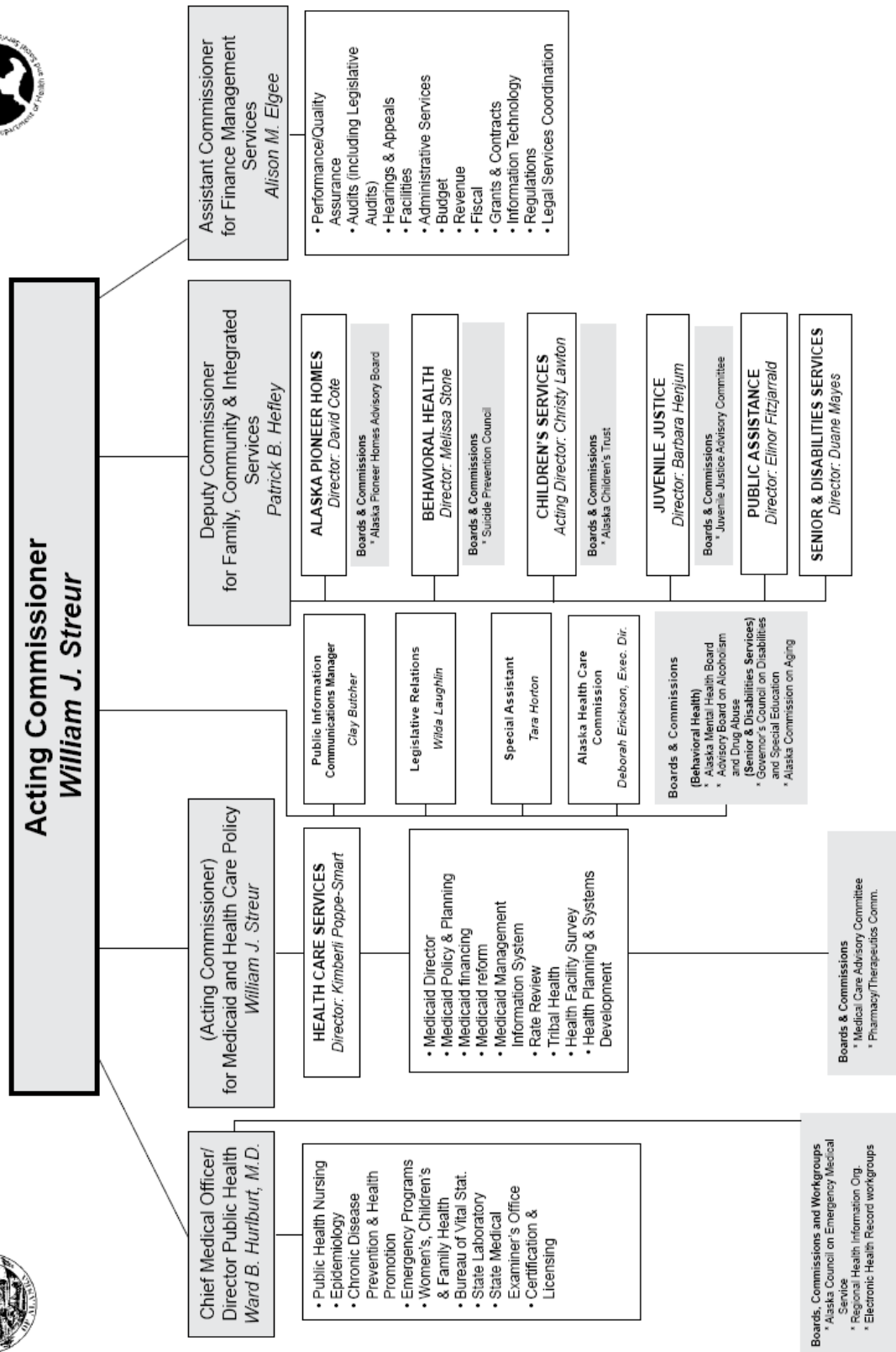
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Department of Health and Social Services



Alaska Department of Health and Social Services Organization Chart



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 Alaskans.

Core Services

- Provide the highest quality of life in a safe home environment for older Alaskans and Veterans.
- Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.
- Promote safe children and strong families.
- Manage health care coverage for Alaskans in need.
- 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.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote the independence of Alaskan seniors and persons 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.

Major Accomplishments in 2010

VULNERABLE POPULATIONS

- The Office of Children's Services (OCS) continued to work toward a statewide Family-to-Family (F2F) program. F2F has been very successful in Anchorage and Fairbanks in working toward change in the child welfare system through support provided to resource 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 home rather than a foster home. Over the course of the next few years, OCS plans to expand F2F services statewide, with the most recent expansion occurring in Wasilla this past spring.
- The Division of Juvenile Justice (DJJ) has increased efforts to turn the curve on the high rate of recidivism of Alaska Native youth offenders through creation of the Alaska Native Recidivism Committee, which now advises division leadership on steps to improve services; increased collaboration with rural communities; improved transitional services; cross-cultural training for staff; development of the DJJ Minority Recruitment and Retention workgroup; and establishment of an interdisciplinary and interdepartmental leadership team to learn how to more effectively support the strengths and diversity of rural communities. Other efforts to address the needs of Alaska Native juveniles include seeking guidance from the Alaska Tribal health Directors; collaborating with the federal Tribal Youth Program (TYP) staff responsible for coordinating TYP services in Alaska and assisting community groups in Fairbanks and Anchorage to directly address Disproportionate Minority Contact in their communities.
- The Division of Juvenile Justice has more fully developed behavioral health services for juveniles within detention and treatment facilities. A very thorough statewide Suicide prevention Policy and Procedure has been integrated into facility work such that all youth in juvenile facilities are screened for suicide risk and related needs are addressed. Clinical services such as crisis intervention, assessment, treatment consultation, staff training, referral, and some family counseling have been integrated into operations. While needs for clinical services are not fully met, each juvenile facility across the state has been able to address many of the immediate behavioral health needs that juveniles present.
- Transitioned the Alaska Heating Assistance Program (AKHAP) to the new Alaska Affordable Heating Program (AAHP). The AAHP connects heating assistance benefit levels to the average price per barrel of oil and will likely result in program funding levels to change from year to year to ensure payments are made at the level set forth in the new law.
- The Bring the Kids Home initiative continues to be successful. The average weekly count of SED children/youth placed in out-of-state Residential Psychiatric Treatment Centers (RPTC) declined 14% (from 167 to 144). The distinct number of total RPTC admissions for FY10 decreased by 26% (from 399 to 295). Out-of-State RPTC Medicaid

expenditures decreased by 22% from \$19,487,410 to \$15,191,809. In-State RPTC Medicaid expenditures decreased by 4%, from \$20,867,295 to \$20,049,751.

- During FY10, the Division of Senior and Disabilities Services provided home and community-based services to 8,282 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.
- Child Advocacy Centers (CACs) have proven successful, through demonstrated cost savings and the Office of Children's Services (OCS) continues to promote co-location with the CACs by OCS staff and other partner agencies. The OCS currently co-locates with the Anchorage Lake Plaza Multidisciplinary Center CAC (Alaska CARES). This center received 839 referrals in FY10, representing a 2% increase. The building remodel for The Children's Place CAC located in Wasilla is nearly complete and will house the Alaska State Trooper Crimes against Children Unit as well as a full OCS investigative unit. The OCS has also co-located staff in the Fairbanks CAC and will be co-located in the Glennallen CAC building before year's end. FY10 referrals to CACs have increased 5% overall.
- 58 Bridge Home Clients with histories of high utilization of the Alaska Psychiatric Institute (API) and Department of Corrections (DOC) resources and history of housing instability were served by the Bridge Home Program. Days of incarceration for this cohort dropped from 1,777 days in the year prior to 338 days for the first year in service, a decrease of 525%.

SUBSTANCE ABUSE

- The Alaska Fetal Alcohol Spectrum Disorder (FASD) Initiative began in January 1998. Since that time many strategies and interventions have been utilized to begin “turning the curve” on the state’s prevalence rates. In February 2010, new Alaska FAS prevalence rates were released showing an overall 32% decrease in FAS births prevalence from 19.9 to 13.5 per 10,000 live births and a 49% decline among Alaska Native births, from 63.1 to 32.4 per 10,000. While there is still much progress to make, as a state, our prevalence numbers are moving in the right direction. A copy of the Epidemiology Bulletin may be found at: http://www.epi.hss.state.ak.us/bulletins/docs/b2010_03.pdf.

LONG-TERM CARE

- Served 580 Alaska Seniors and Veterans in the Pioneers Homes.
- Waiver programs for Alaska Seniors: Served 1,721 Alaskans with the Older Alaskan waiver program and 1,422 with the Adults with Physical Disabilities waiver program.

HEALTH AND WELLNESS

- In FY10, the Adult Preventative Dentistry Program provided services to 10,601 individual recipients over the age of 21.
- Coordinated Health and Social Services' massive surveillance and response to H1N1 Pandemic Influenza including distribution of 228,405 doses of vaccine to providers. Public health nurses vaccinated 68,232 Alaskans against this disease, giving 48% of the vaccine administered by health care providers in Alaska. More than 150 mass and targeted vaccine dispensing clinics were conducted with local communities and partners. Antiviral medications, masks, gowns, gloves and other personal protective equipment from state and federal stockpiles were sent to 38 communities during the response. Public Health laboratories tested more than 5,000 specimens for H1N1 pandemic influenza.
- Alaskans Taking on Childhood Obesity (ATCO) established a Memorandum of Agreement between Health and Social Services and Education and Early Development that identified obesity prevention strategies for the departments to coordinate and implement. A School Nursing Advisory Committee was established and a plan of action was developed and implemented to work on the highest priorities. The School Nursing Consultant contributed significantly to the Department of Education and Early Development's Health and Safety plan and is actively working with school nurses statewide on obesity reduction efforts for school aged children.

HEALTH CARE REFORM

- Legislation was passed during the 2010 Session to establish a Health Care Commission Institute. The Commission serves as the State health planning and coordinating body, responsible for providing recommendations to the Governor and the Legislature on a comprehensive statewide health care policy and on strategies for improving the health of Alaskans.

Key Department Challenges

The Department of Health and Social Services continues its focus on the following overall strategies:

1. Integration of services
2. Maximize resources for effective service delivery
3. Promote rural infrastructure development and standardization of regional structure
4. Promote accountability at all levels of the organization
5. Leveraging 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.
- 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

- 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

- 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.
- Meeting Centers for Medicaid Services (CMS) corrective action plan for waiver administration. All Medicaid waivers must be submitted for renewal effective July 1, 2011.

Health and Wellness

- 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.
- Reduce the prevalence of overweight and obesity in children and adults.

Health Care Reform

- Medicaid challenges include:
 - Development of the Medicaid Management Information System to more effectively use new technology to manage health care in Alaska.
 - Accurately project Medicaid expenses in an environment of rapidly increasing costs and economic uncertainty.
- 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 verifiable costs of service provision.

Position Information

The department has almost 3,700 positions budgeted under the following three types of work:

Direct Field Workers

119	Public Health Nurses
293	Social Workers & Children's Service Specialists
311	Eligibility Determination Staff
289	Youth Detention/Treatment Workers
90	Juvenile Probation Officers
256	API Staff
653	Pioneer Homes Staff
2,011	TOTAL

Program Support Services

117	Behavioral Health Programs
163	Senior and Disability Programs
415	Public Health Programs
208	Children's Services
124	Juvenile Programs
10	Facilities Management
372	Benefit Payments/Systems
1,409	TOTAL

Administrative/Management Support

128	Information Technology
142	All Other Centralized Admin/Mgmt
270	TOTAL

3,690 FY12 GRAND TOTAL

The DHSS Governor's request includes 3,690 positions. The details of their budgeted status and geographical location are shown 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.

FY12 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,740	25	52	1,817
Aniak	2	0	0	2
Barrow	9	0	0	9
Bethel	101	0	3	104
Cordova	2	0	0	2
Craig	5	0	0	5
Delta Junction	7	0	0	7
Dillingham	10	1	0	11
Eagle River	1	0	0	1
Fairbanks	358	6	12	376
Fort Yukon	0	1	0	1
Galena	2	1	0	3
Glennallen	3	0	0	3
Haines	2	0	0	2
Homer	14	1	0	15
Juneau	576	22	26	624
Kenai	84	1	2	87
Ketchikan	120	9	10	139
King Salmon	2	0	0	2
Kodiak	15	1	0	16
Kotzebue	10	0	0	10
Mat-Su Area-wide	1	0	0	1
McGrath	3	0	0	3
Nome	46	0	2	48
Palmer	121	15	6	142
Petersburg	3	0	0	3
Saint Mary's	6	0	0	6
Seward	3	0	0	3
Sitka	102	0	4	106
Tok	2	0	0	2
Valdez	4	1	0	5
Wasilla	133	0	0	133
Wrangell	2	0	0	2
Totals	3,489	84	117	3,690

Explanation of FY12 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 FY12

	FY11 Management Plan	FY12 Governor's Request
Unrestricted General Funds	\$931.1 million	\$1,011.8 million
Designated General Funds	68.2 million	72.7 million
Federal Funds	1,168.4 million	1,261.2 million
Other Funds	94.5 million	99.4 million
Total	\$2,261.2 million	\$2,445.1 million
Increased Federal Revenue		92.8 million
Increased General Fund		85.2 million

The proposed budget for FY12 increases general funds (GF) by \$85,249.3. The changes include Medicaid program growth of \$55,214.4 and increased resources addressing the department's priorities of Vulnerable Alaskans \$12,971.4, Substance Abuse \$268.8, Long-Term Care \$10,950.0, Health & Wellness \$5,567.4, and Health Care Reform \$277.2.

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 FY11 Management Plan program capacity for Vulnerable Alaskans to that requested for FY12.

	FY11 Management Plan	FY12 Governor's Request	FY12 Governor less FY11 Management Plan
Unrestricted GF	\$ 430,756.1	\$ 446,868.0	\$ 16,111.9
Designated GF	22,638.9	25,362.5	2,723.6
Federal Funds	318,215.0	319,706.1	1,491.1
Other Funds	51,564.0	51,556.1	(7.9)
Total	\$ 823,174.0	\$ 843,492.7	\$ 20,318.7

Budget requests include:

- Additional funds to maintain Phase 1 improvements of State Medical Examiner's Office reforms: \$500.0 GF
- Increasing Adult Public Assistance funding due to anticipated enrollment growth: \$1,000.0 federal, \$1,250.0 GF
- Bring the Kids Home expansion including foster parent and parent recruitment training and support, crisis bed stabilization, peer navigator program, a child psychiatrist, expansion of school-based services capacity via grants, and community behavioral health centers outpatient and emergency residential services and training: \$993.0 GF/MH
- Decreasing unrealizable federal funds (Foster Care Special Needs, Probation Services, Delinquency Prevention, Youth Courts): (\$1,053.9) federal

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 FY11 Management Plan program capacity for Substance Abuse to that requested for FY12.

	FY11 Management Plan	FY12 Governor's Request	FY12 Governor less FY11 Management Plan
Unrestricted GF	\$ 21,213.5	\$ 21,462.8	\$ 249.3
Designated GF	16,499.0	16,518.5	19.5
Federal Funds	9,969.9	10,069.8	99.9
Other Funds	4,293.4	6,191.6	1,898.2
Total	\$ 51,975.8	\$ 54,242.7	\$ 2,266.9

Budget requests include:

- Detox and treatment capacity as alternatives to protective custody holds: \$350.0 GF/MH
- Family Wellness Warriors Initiative, multidisciplinary rural community pilot project and trauma informed training as parts of the Governor's focus on domestic violence: \$1,800.0 I/A Receipts
- Behavioral health follow-up survey: \$100.0 MHTAAR
- Disability justice focus group recommendation for pre-development for sleep off alternatives in targeted communities: \$100.0 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 required 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 FY11 Management Plan program capacity for Long-Term Care to that requested for FY12.

	FY11 Management Plan	FY12 Governor's Request	FY12 Governor less FY11 Management Plan
Unrestricted GF	\$ 194,597.6	\$ 226,291.5	\$ 31,693.9
Designated GF	15,554.9	16,260.2	705.3
Federal Funds	258,255.1	294,372.3	36,117.2
Other Funds	17,853.7	18,006.9	153.2
Total	\$ 486,261.3	\$ 554,930.9	\$ 68,669.6

Budget requests include:

- Increased funds to meet Medicaid documentation requirements in the Pioneer Homes: \$400.0 GF/PR
- Medicaid home and community based services provider rate adjustments: \$14,000.0 total - \$7,000.0 GF Match, \$7,000.0 federal
- Funds to stabilize personal care assistance and assessment/waiver units (split between Long-Term Care and Vulnerable Alaskans): \$750.0 GF Match, \$450.0 GF, \$200.0 federal
- Funds to stabilize home and community based waiver programs (split between Long-Term Care and Vulnerable Alaskans): \$750.0 GF Match, \$500.0 federal

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 FY11 Management Plan program capacity for Health and Wellness to that requested for FY12.

	FY11 Management Plan	FY12 Governor's Request	FY12 Governor less FY11 Management Plan
Unrestricted GF	\$ 280,456.8	\$ 312,836.8	\$ 32,380.0
Designated GF	13,346.3	14,434.9	1,088.6
Federal Funds	579,317.4	634,347.7	55,030.3
Other Funds	18,287.8	19,151.5	863.7
Total	\$ 891,408.3	\$ 980,770.9	\$ 89,362.6

Budget requests include:

- Maintaining local control of essential public health services by stabilizing funding to public health nursing grantees: \$750.0 GF
- Replace unrealizable fund sources to maintain public health nursing services: \$1,000.0 GF
- Funds to support cost of transferring public health nursing services from Norton Sound Health Corporation to the Division of Public Health: \$450.0 GF
- Funds for the Alaska family violence prevention project: \$250.0 GF
- Support for medical assistance staffing: \$500.0 GF
- Sustaining progress in tobacco prevention and control: \$950.0 Tobacco Education/Cessation

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 FY11 Management Plan program capacity for Health Care Reform to that requested for FY12.

	FY11 Management Plan	FY12 Governor's Request	FY12 Governor less FY11 Management Plan
Unrestricted GF	\$ 4,052.1	\$ 4,324.5	\$ 272.4
Designated GF	131.3	136.1	4.8
Federal Funds	2,667.1	2,740.2	73.1
Other Funds	2,490.6	4,469.1	1,978.5
Total	\$ 9,341.1	\$ 11,669.9	\$ 2,328.8

Budget related requests include:

- Increased receipts for the health information technology projects: \$2,000.0 CIP Receipts
- Continuation funding for the comprehensive integrated mental health plan and the loan repayment program: \$320.0 MHTAAR

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.

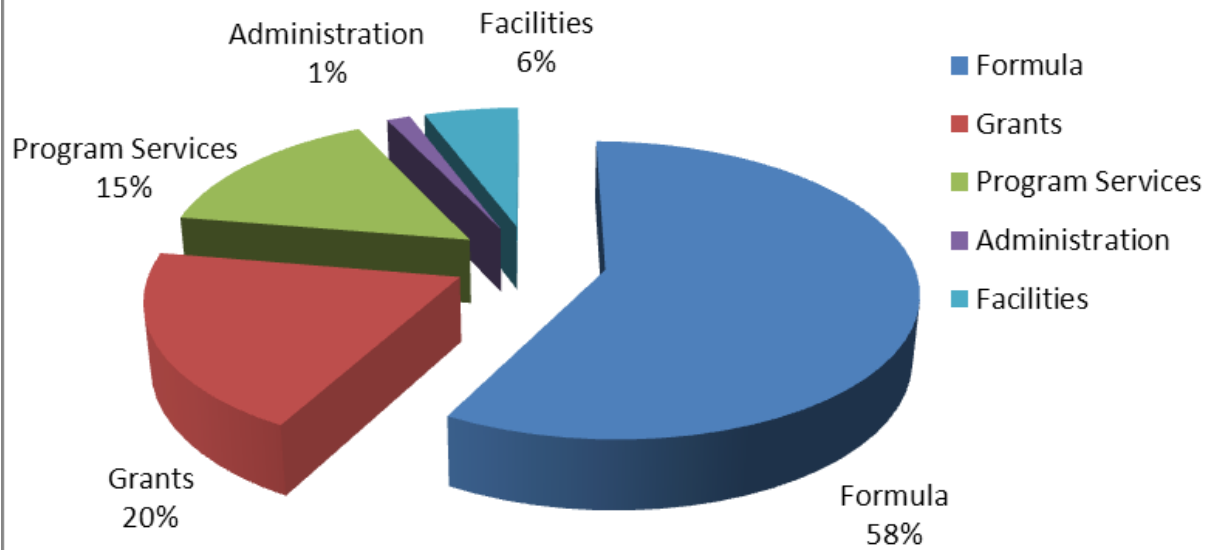
Budget Charts and Graphs

The table below shows the comparison of total funds for FY02 and FY12.

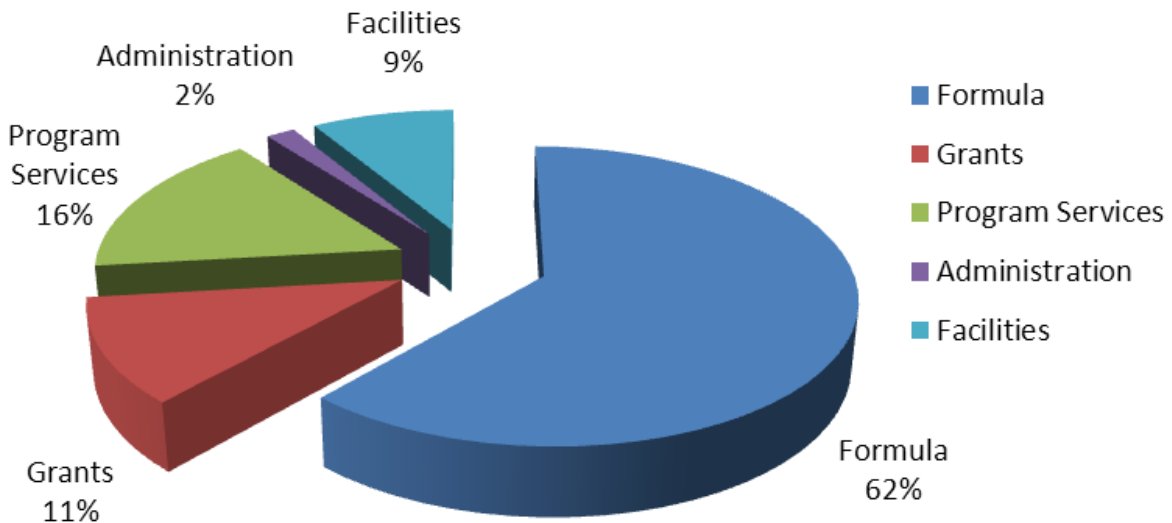
Statewide Medicaid Services Expenditures, FY 2002-12

	FY2002 Authorized		FY2012 Governor's		
Category	Total Funds	% of Total	Total Funds	% of Total	Change: FY02 to FY12
Formula	\$761,226.3	63%	\$1,752,450.3	72%	230%
Grants	167,104.7	14%	169,906.8	7%	102%
Program Services	214,843.8	18%	352,293.0	14%	164%
Administration	18,758.9	2%	41,260.5	2%	220%
Facilities	40,097.7	3%	128,994.5	5%	322%
Total	\$1,202,031.4	100%	\$2,444,905.1	100%	203%

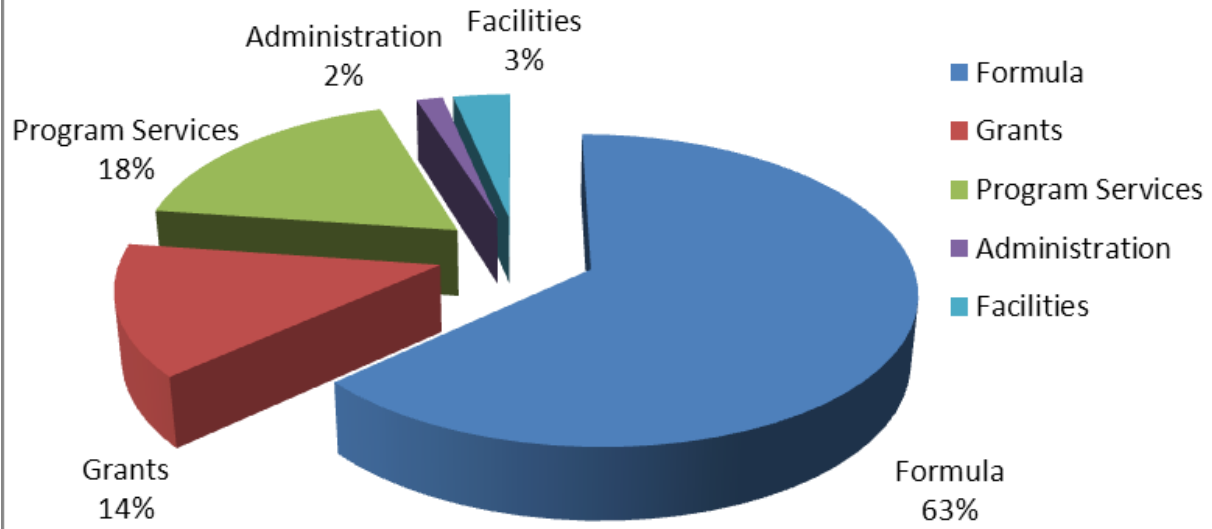
FY2002 Authorized Budget GF Only



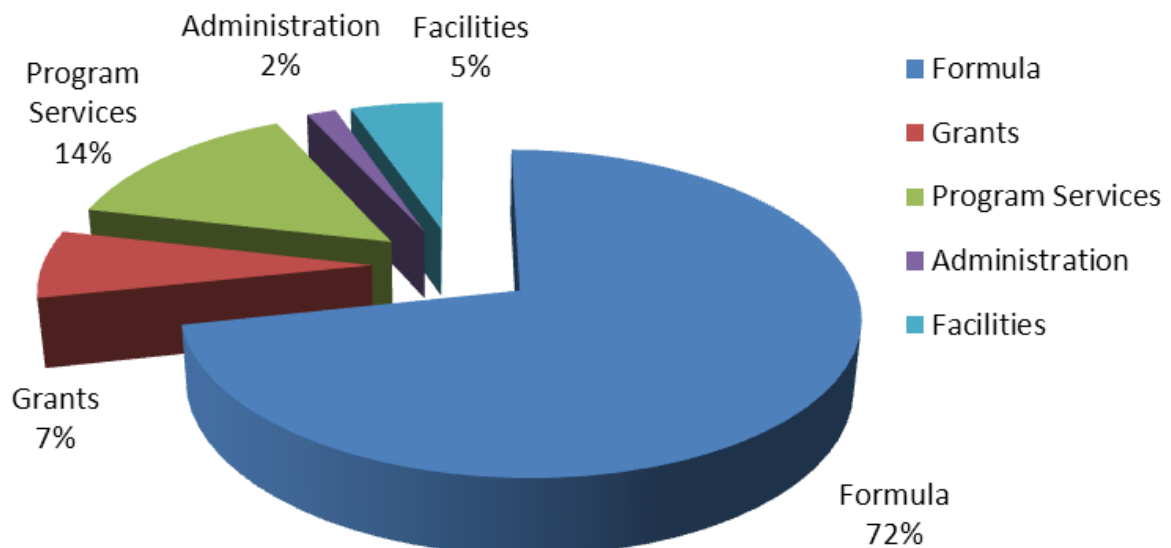
FY2012 Governor's Budget Request GF Only

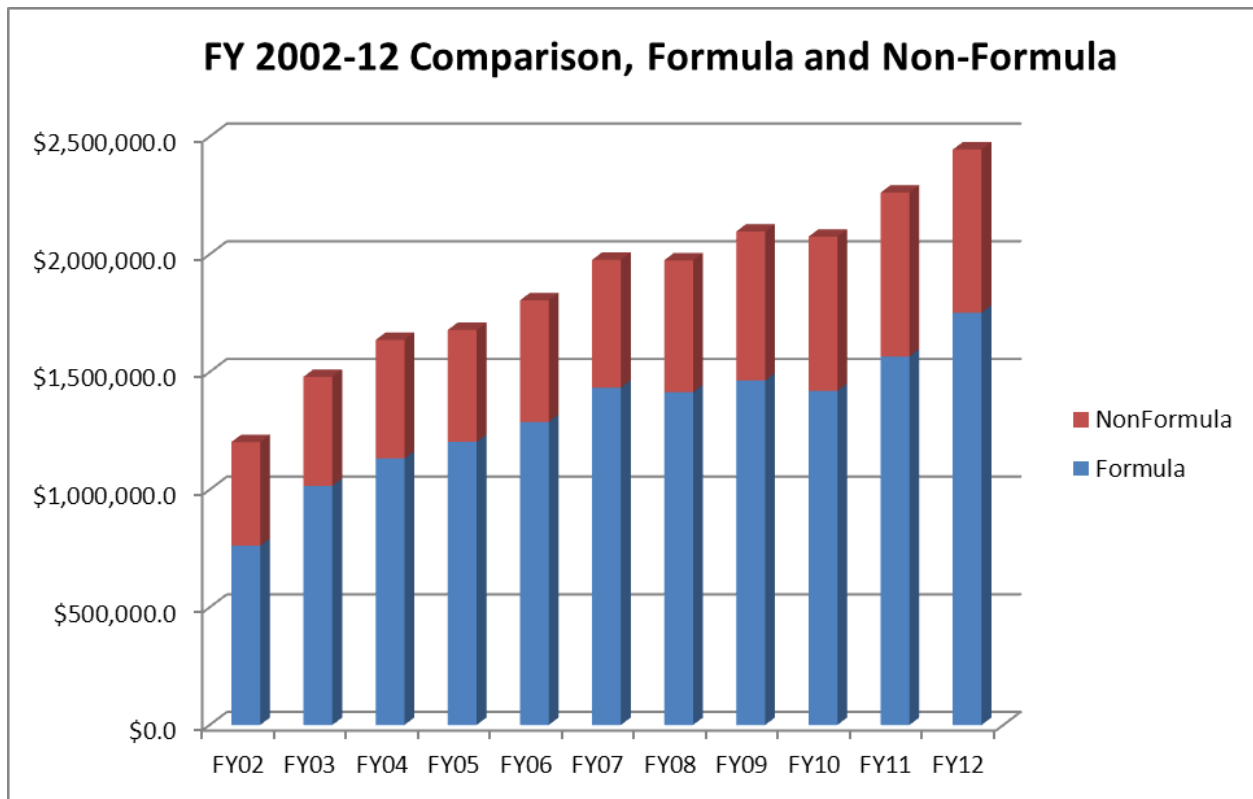


FY2002 Authorized Budget Total Funds



FY2012 Governor's Budget Request Total Funds





Medicaid is the largest formula program in the department, totaling about 87% of the total formula program category in the proposed FY12 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
- Medicaid School Based Admin Claims
- 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
- Senior and Disabilities Medicaid Service.

Department Level Performance Measures

Priority Programs - Key Performance Indicators

(Additional performance information is available on the web at <http://omb.alaska.gov/results>.)

Vulnerable Populations

-  The target to decrease the rate of child abuse and neglect was met in FY10 with a decrease of 4.5% in the rate of child abuse and neglect in Alaska. Source: DHSS ORCA
-  The target to reduce incidents of domestic violence and sexual assault was not met. Most current data: 8,253 incidents which is a 3% increase from the previous year. Source: AK Council on Domestic Violence and Sexual Assault Annual Report to Gov. Palin, 2008

Substance Abuse

-  The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. The rate of FASD among Alaska natives was 32.4 per 10,000 live births in 2002, down 49 percent from a rate of 63.1 per 10,000 live births in 1996 (DHSS DPH Alaska Birth Defects Registry).
-  The target to reduce the rate of alcohol-induced deaths was not met but the trend is maintaining or holding steady. There were 21.1 deaths per 100,000 population in 2007, 22.2 in 2008 and 22.5 in 2009. (DHSS DPH Bureau of Vital Statistics).
-  The target of reducing the risk as measured by the assessment instrument was met. The average substance abuse risk for juveniles completing Division of Juvenile Justice services in FY2010 was 0.82, which is considered medium risk as determined by the Division's juvenile assessment instrument. The rate was 1.11 in FY09 and 0.95 in FY08. The substance abuse risk scale is: 0 - low risk, 1-2 medium risk, 3-5 high risk. (DHSS DJJ)

Long-Term Care

-  In FY10, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 3.4%, exceeding the 2% target, but in line with past performance on this measure. The sentinel injury rate was 2.7% for FY09. For FY 2011 the new target is 2.6%, which coincides with the Joint Commission (JCAHO) standard.
-  The target to reduce the number of nursing home bed days for seniors 65 years and older was met in 2009. Seniors averaged 4.35 bed days per year

down from 6 bed days a year in 2002.

- ↑ In FY10, the medication error rate decreased to 0.11% from 0.14% in FY09 comparing favorably with the CMS target medication error rate of less than 5%. Source: CMS Guidance document 8/10/2007

Health and Wellness

- ➡ In FY08, FY09, and FY10, the target of at least 75% of individuals who received Behavioral Health community-based services and completed a follow-up Client Status Review reported "functioning well" was met for the following four life domains: Financial/Basic Needs, Housing Situation, Physical Health, and Thoughts of Self Harm. Less than 75% of individuals reported "functioning well" for two life domains: Meaningful Activities/Employment and Mental/Emotional Health.
- ↑ Preliminary data for 2009 indicates an Alaska suicide death rate of 20.2 suicides for all ages per 100,000 population. This rate is nearly double the stated target of 10.6, but lower than the 2008 rate of 24.6 suicides. Source: AK DHSS DPH BVS
- ➡ The Department's Healthy Alaskans 2010 target rate of overweight/obese high school students of 17% was not met, registering 26.2% in 2009. However, this was down 1.1% from 27.3% in 2007. The Healthy Alaskans 2010 target rate of overweight/obese adults of 48% was not met, registering 65% in 2008, unchanged from 2007. Source: AK DHSS DPH YRBS
- ➡ The Department's Healthy Alaskans 2010 target rate of high school students using tobacco products of 20% was not met, with the rate at 25.2% in 2009, up from 24.1% in 2007, but below the 25.7% national average (DHSS DPH Alaska Youth Risk Behavior Survey).
- ↓ The target for young children to receive all vaccines was not met as 73% of these children received vaccines in 2009, down from 78% in 2008. Source: AK DHSS DPH Epidemiology, CDC National Immunization Survey

Health Care Reform

- ➡ The target to reduce the rate of uninsured Alaskans to less than 14.6% was not met. In 2009 the rate of uninsured Alaskans grew to 21.1% up from 19.8% in 2008. Source: U.S. Census Bureau, Current Population Survey/AK
- ↑ The target to increase the ratio of active licensed healthcare providers in Alaska in proportion to the population growth has been met. The ratio of active physicians to Alaska residents has shown an increase over the prior CY, with 1 physician per 405 residents in CY10. This is in comparison to 1 per 441 residents during CY09. Source: Alaska Occupational Licensing

FY12 Capital Project Requests

Capital		FY12 Capital Funding Request (In thousands)			
DHSS Division	Project Titles	GF	Fed	Other	Total
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, Repair and Equipment	3,000.0	86.3		3,086.3
Health Care Services	Medicaid Management Information System Completion	1003.4	2,280.4		3,283.8
Juvenile Justice	McLaughlin Youth Center Safety and Security Phase I Completion	4,275.0			4,275.0
Pioneer Homes	Alaska Veterans and Pioneer Home Storage	885.0			885.0
Health Care Services	Health Insurance Portability and Accountability Compliance	1,000.0			1,000.0
Senior and Disabilities Svcs.	Senior and Disabilities Services System Upgrade	1,350.0	1,350.0		2,700.0
Public Health	Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue	425.0			425.0
Public Assistance	Equipment for Electronic Benefit Transfer Connectivity to Alaska's Back-up Data Center	50.0			50.0
Public Assistance	Field Operations Call System for Vulnerable Alaskans	130.2	125.0		255.2
Juvenile Justice	Juvenile Offender management Information System Testing	25.0			25.0
	MH Behavioral Health Data Sharing Partnership *	245.0			245.0
	Mental Health Deferred Maintenance and Accessibility Improvements *	500.0			500.0
	Mental Health Home Modification and Upgrades to Retain Housing *	750.0		300.0	1,050.0
Capital Budget Totals		17,638.6	3,841.7	300.0	21,780.3

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

Major Capital Projects

Pioneer Home 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 Home Deferred Maintenance, Renovation, Repair, and Equipment: \$3,084.9 (\$3,000.0 GF)

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.

Medicaid Management Information System Completion: \$3,283.8 (\$1,003.4 GF)

This request will fund the completion of the department's Medicaid Management Information System (MMIS) through implementation from October 2011 through October 2012. The implementation date has been moved from October 2011 to April 2012. An additional 6 months from April 2012 to October 2012 is required for certification of the new system. This request will fund the costs resulting from this delay.

McLaughlin Youth Center Safety and Security Phase I Completion: \$4,275.0 GF

This request will fund the completion of the McLaughlin Youth Center Safety and Security Phase 1 project. The original appropriation was used for the relocation of the outdoor recreation area, parking for the juvenile justice center, completion of a new 25-bed detention unit, and design of the new medical suite. Insufficient funding remains to complete construction of the new medical suite and the training area, both of which were part of the original appropriation.

Alaska Veterans and Pioneers Home Storage: \$885.0 GF

This request will fund the construction of a storage unit adjacent to the home in Palmer. The storage unit will provide heated and unheated storage space. Currently, off-site units and resident rooms are used for storage, which result in additional operating cost and loss of revenue.

MH Deferred Maintenance and Accessibility Improvements: \$500.0 GF/MH

Funds will be awarded statewide to non-profit 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 Governor's Domestic Violence and Sexual Assault Initiative

Strategic Objectives

In December 2009, Governor Sean Parnell announced a ten-year statewide initiative to end the epidemic of domestic violence and sexual assault. Appropriations in the 2010 legislative session began to address five major strategic objectives:

1. Break the cycle of abuse using a comprehensive public education and prevention campaign to promote a culture of respect that does not tolerate violence against women and children.
2. Deter, segregate, and treat sex offenders so they pose no risk of harm to women and children.
3. Establish a law enforcement presence in every community that desires one to improve public safety.
4. Increase victim services to provide more victims a safe place to go and the services they need to heal.
5. Coordinate and streamline efforts among all stakeholders to more effectively combat violence against women and children.

A Comprehensive Approach

The problems and social harm associated with domestic violence are complex. It has become increasingly evident to law enforcement, service providers, policy makers, and consumers that mental health and substance abuse problems frequently co-occur with domestic violence and sexual assault. A 1997 report by the Research Institute on Addictions found that 80% of women with substance abuse disorders also had a history of domestic violence. Woodhouse (1990) reported that 50% of women in substance abuse treatment also experienced rape or incest. A variety of studies show that over half of women seen in mental health settings are currently experiencing or have experienced abuse by an intimate partner (Briere et al., 1997; Bryer et al., 1997; Jacobson and Richardson, 1987, Schoelle et al, 1998). The Adverse Childhood Experiences (ACE) Study concluded that childhood abuse and household dysfunction can be strong indicators for adult health and risk behaviors, such as smoking, alcohol or drug abuse, overeating, or sexual behaviors (Felitti et al; 1998).

A comprehensive and multi-faceted approach is required to address the public safety, health and behavioral health impacts of domestic violence and sexual assault in Alaska. Prevention and intervention strategies are essential to dramatically reduce future domestic violence and sexual assault of adults and children and to bring healing to those affected. Key elements of the Governor's Initiative included an early recognition of the importance of prevention, which led to increased victim services for recovery and coordination to maximize partnerships.

Providing Critical Services Through Department-wide Efforts

Efforts exist throughout the Department of Health and Social Services (DHSS) to combat domestic abuse, intimate partner sexual violence, and child sexual abuse. State Statute established the Council on Domestic Violence and Sexual Assault, stating that the DHSS Commissioner or designee be a member of the Council. The law directs DHSS to coordinate services and provide technical assistance regarding domestic violence, sexual assault, and crisis prevention and intervention with departments throughout the state. Additionally, the statute requires DHSS to provide consultation for the delivery of services to victims of domestic violence.

Division of Juvenile Justice (DJJ): The division manages several efforts related to family violence.

- Provided to juveniles statewide, Aggression Replacement Training is a highly regarded national curriculum to improve social skills and limit aggressive behavior.
- In Anchorage and Kenai, the Parenting with Love and Limits program gives families tools to effectively discipline and interact with their children, as opposed to reacting with violence or frustration.
- The Division provides other services that address the many facets of family violence, including sex offender treatment, training for staff in substance abuse counseling, and mental health clinical services that help staff and families understand the role that mental illness can have among violent or aggressive youth.

Office of Children's Services (OCS): One primary goal is to keep Alaska's children safe from neglect, physical abuse, sexual abuse, and mental injury. The division provides services through Child Advocacy Centers (CAC) in pursuit of this goal. Funds from the Governor's Initiative budget were allocated to the Kodiak Child Advocacy Center to support expansion and continued services of a center for that region. The Centers:

- See children up to age 18 who have been alleged victims of sexual assault, providing forensic interviews, medical exams, psychosocial evaluation, referral for services needed by the child and family, and coordination of agency interaction and services.
- Avoid duplicative interviewing of the child through carefully organized coordination of services.
- Offer access to health care providers specially trained in treating child abuse, use specialized equipment for exam and documentation and address mental health needs of children and their families, either at the CAC or by referral.

Division of Public Health: Programs support critical efforts to prevent family and intimate partner violence.

- Teen pregnancy prevention efforts include development of education materials about violence in dating and supporting healthy relationships as a prevention strategy.
- Screening for domestic and intimate partner violence is part of the reproductive health services provided to men and women. Portions of two surveys, the *Pregnancy Risk Assessment and Monitoring Survey* (PRAMS) and the *Childhood Understanding Behavior Survey*, collect reports regarding episodes of violence in the home from mothers during their first 6 months postpartum and when their child is three years of age. Also, the Perinatal Nursing consultant works with health care providers on strategies for

screening during the perinatal and postpartum periods as these are times in a woman's life known for escalation of violence.

- The Primary Prevention of Sexual Violence plan, addressing Alaska's social norms by partnering on the *Stand Up, Speak Up* campaign, is supported in part by federal funds. Partners in this effort include the Public Health Section of Women's Children's and Family Health, the Alaska Network on Domestic Violence and Sexual Assault, the Alaska Council on Domestic Violence and Sexual Assault, and the Alaska Native Justice Center.

Also in Public Health, the Alaska Family Violence Prevention Project has developed resources for parents on the effects of violence on children. These resources are disseminated through the Alaska Family Violence Prevention Project Clearinghouse to health care and service providers, educators, and parents. The project, managed by the division's Section of Chronic Disease Prevention and Health Promotion, offers state-of-the-art training on the effects of violence on children and implications for early brain development. Training and technical assistance are also provided on adolescent brain development, dating violence, and substance abuse, with emphasis on prevention and intervention strategies. The Alaska Family Violence Prevention Project has also been developing curricula and training on the relationships between reproductive health, domestic violence, and reproductive coercion—an emerging issue in domestic violence that leads to unintended pregnancies, spreads sexually transmitted diseases, and encourages other high-risk behaviors.

Preventing Problems, Providing Support

Previous to the prevention efforts funded in FY11 through the Governor's DVSA Initiative, no prevention or treatment programs existed in the Division of Behavioral Health specifically targeted to services for victims or perpetrators of domestic or sexual violence. Many of the adult and child recipients of services, such as mental health, substance abuse, and emergency services, are victims of domestic and sexual violence. Likewise, prevention efforts directed toward other activities that exacerbate domestic violence and sexual assault, such as alcohol abuse, underage drinking, and suicide, were previously not emphasized in state program efforts. Three components of the Governor's Initiative help to provide these needed prevention and treatment services.

1) *The Southcentral Foundation's Family Wellness Warrior Initiative (FWWI)* : Funds were provided to complete work in Dillingham and to begin programming in Bethel. The FWWI model works with existing supportive individuals in interested communities to hear the needs of their region, community, or program and to provide tools to work with those who have experienced domestic and sexual violence, child abuse, or child neglect. The core of the FWWI is an intensive education and training program that is culturally centered, faith-based, and consisting of both large group meetings and small group sessions. The initiative is based on the premise that individuals who have been subjected to trauma and abuse themselves have learned coping skills and relational styles that negatively impact or harm others. The desired outcome of the program is for participants to identify and replace harmful relational styles with methods that enhance safe and healthy relationships. The program provides training and support both for those who cause abuse and for recipients of abuse. Funding to continue this effort is included in the Governor's FY12 budget (\$200.0).

2) Combining Community Resources: Effectively dealing with domestic and sexual violence from both prevention and response perspectives requires the collaboration of multiple systems, including the courts, law enforcement, legal services, health care, victims' safety, behavioral health, schools, child protective services, and corrections. Gaps in any of the systems reduce the probability of an effective response. Funds for a community pilot project are intended to identify a rural community interested in developing a multi-disciplinary approach addressing domestic violence and sexual assault from a broad community perspective. The pilot project will use a planning process to conduct a community assessment, including an inventory of community resources and using data to identify relevant community issues. This will lead to a plan to create a comprehensive community model for responding to victims' needs for immediate safety, providing accountability for perpetrators, providing behavioral health services, and implementing strategies for prevention. Funds will be awarded through a competitive request for proposals process that will occur in late winter. A second year of funding for this project is included in the Governor's FY12 budget (\$1,400.0).

3) Helping Behavioral Health Professionals Recognize and Mitigate the Effects of Trauma: Trauma is recognized as a significant factor in a wide range of health, behavioral health, and social problems, including heart disease, cancer, chronic lung disease, mental health challenges, and substance use disorders, violence victimization and perpetration, self-injury, homelessness, prostitution, delinquency, and criminal behavior. Neglecting to address trauma throughout the process of providing services leads to increased caseload levels and increased case severity in the future. Funding of \$200,000 was allocated to develop a specialized trauma-informed curriculum to integrate an understanding of trauma into the programs and therapeutic approaches of community-based behavioral health providers.

As a result of the Governor's Initiative, two forums have taken place that for the first time in memory brought together the Council on Domestic Violence and Sexual Assault victims' services agencies and the behavioral health providers to share expertise, train, identify service barriers, and strategize on ways to collaborate for better outcomes for victims. Relationships are developing and programs are already changing to best serve Alaskans who need these critical services the most. Funding is included in the Governor's FY12 budget to continue this effort (\$200.0).

Bring the Kids Home

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; and through this in-state system, to decrease placements in out-of-state RPTC. Significant progress has been made and FY13 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 RPTC has decreased significantly: yearly *admissions* were down by 88.1% between FY04 and FY10 from 752 to 90 youth. Total yearly *recipients* to out-of-state RPTC during the same period were down by 70.4% from 749 to 221 youth. (Admissions reflect only those youth admitted during each fiscal year, while recipients include youth admitted a previous year and served during the current year.)

Medicaid expenditures for out-of-state RPTC decreased by 62% between FY06 and FY09 (\$40 M to \$15.2 M). Medicaid expenditures for in-state RPTC during the same time period increased by 40% (\$14.3 - \$20.M).

Graphs with BTKH data are included in the chapter for the Division of Behavioral Health.

What is Working?

There has been an increase in in-state capacity. General funds, MHTAAR and Medicaid were invested into in-state residential and outpatient services. Level 5 (RPTC) beds within Alaska increased from 123 to 186. Other beds (residential treatment and therapeutic group/foster homes) went from 530 to 776. These new beds serve youth diverted from out-of-state RPTC.

Community behavioral health start-up grants funded new non-residential service capacity. Examples include sub-acute crisis stabilization, in-home services, school supports, and services for children with co-occurring disorders, fetal alcohol spectrum disorders, low cognitive functioning and other challenging conditions. Grants expanded use of Medicaid, and increased implementation of evidence-supported practices.

Increased oversight, care coordination and support by State staff, contractors and grantees motivate full utilization of in-state resources. State staff identify youth who have not accessed in-state services and link them to in-state care—thus avoiding lengthy outside placements. Contractors provide care coordination to improve discharges and transitions—linking children

and their families to necessary supports within their home community. Grantees provide peer navigation, parenting skills and support to help families keep children at home or to prepare for them to return home. These services divert children from residential care and improve transitions from residential care to homes and communities.

State staff assists in negotiating system gaps. One strategy is use of Individualized Service Agreements (ISA) to pay for services to stabilize a child in the community *when the services cannot be covered by any other funding source*. As ISA use has expanded, RPTC placements have dramatically decreased.

Collaboration has been an important factor: community providers work together to serve children and families with complex needs. Stakeholders work with DHSS and the Trust to identify system gaps and on topic specific work groups including on tribal and rural issues, educational issues, to ensure family voice, to address the needs of transition aged youth and very young children, etc. DHSS divisions work together to address system development and fill identified system gaps to meet the needs of children and families.

What are the Remaining Priorities?

Over the final two years of BTKH (FY12 and FY13), we will focus our attention and resources to prevent severe disturbances and use of high-end services by:

- *Shifting resources to reach families earlier*
- *Expanding successful strategies*
- *Addressing any remaining service gaps*

Shifting Resources to Intervene Earlier

Young children have limited access to mental health services in Alaska. Youth in RPTC may have benefited from an earlier intervention: a FY09 sample of out-of-state RPTC admissions found that 64% had experienced physical abuse, 56% had witnessed domestic violence, 52% were emotionally abused and 50% were neglected. The *Adverse Childhood Experiences Study*¹ described the long-term negative health and mental health outcomes resulting from traumatic early experiences: substance abuse, promiscuity, suicide attempts, mental illness, heart disease, cancer, and stroke. Two FY12 BTKH projects aim to reduce traumatic experiences and to intervene earlier. The first provides foster parent and parent training and intensive family preservation to reduce trauma and costs related to taking children into custody. The second funds a clinician to deliver training and skill development for professionals serving young children.

Expanding Successful Strategies

Over the next two years BTKH will use data to prioritize expansion of successful strategies.

BTKH community behavioral health grants have successfully built in-state capacity to serve children with intensive needs and their families in many communities: 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, gaps remain: a FY09 DBH data sample found that of the youth still admitted to out-of-state RTPC, 56% had a primary referral

¹ www.cdc.gov/NCCDPHP/ACE/index.htm

reason of aggression, and 86% had a risk factor of aggression; 60% had multiple co-morbidities; 68% had a family history of substance abuse and 64% of mental illness – however 66.2% were returning to a parent or relative placement. FY12 grants will be targeted to services for youth who are aggressive and have complex presentations and for families with substance use or mental health disorders.

Sub-acute crisis stabilization beds provide an effective alternative to acute care: a FY09 sample of RPTC admissions found that 78% of youth move into RTPC from acute care. RTPC placement can be precipitated when an acute care placement ends but a community placement is not immediately available. Sub-acute crisis stabilization beds provide an alternative while a long-term placement is developed. However, sub-acute stabilization is only established in Anchorage. During FY12 (and FY13) the goal is to establish sub-acute stabilization in Anchorage, Fairbanks, Matsu, and/or Juneau or other communities depending upon the level of need and the availability of a provider in each community.

Expansion of tribal behavioral health services will increase access to culturally competent care while capturing 100% federal match for services through tribal health organizations. Most tribes are currently not effectively using Medicaid to support behavioral health services. Several BTKH projects have been started which will support tribes to increase use of Medicaid for health and behavioral health services, particularly in rural areas. During FY12, BTKH projects will continue and outcomes will be evaluated.

Another successful strategy is to support evidence-based practices. As noted above, many youth in RTPC come from, and will return to, families with a history of substance abuse and mental health problems. *Parenting with Love and Limits* is a brief family therapy model to decrease recidivism and improve outcomes. Another performance improvement project will provide a child psychiatrist to consult with primary care doctors and State staff to improve use of psychiatric medications. Another will develop a site to monitor in-state bed availability. A last project will train Behavioral Rehabilitation Services providers in Medicaid service delivery and billing. These projects will continue during FY12.

Addressing Service Gaps

Individualized Service Agreements (ISA) are an effective strategy to divert youth from residential care and maintain them in community-based settings. However, during FY10, the ISA fund was significantly overspent. During FY11, ISA use will expand to also include youth with a primary disorder of substance use. During FY12, DHSS will analyze data to refine ISA implementation, target priority use and improve outcomes.

Nationally, 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. A sample of Alaskan RPTC discharges found that 24.5% of the youth were 18 – 21 and 88.1% were 14 – 21. A Covenant House study found that approximately 40% of youth in the crisis center had been in behavioral health residential treatment. During FY09, BTKH funding began to support steps towards statewide implementation of the *Transition to Independence Process (TIP)* to change these outcomes for Alaskan youth. For FY12, technical assistance and provider grants will expand TIP

implementation to additional communities, evaluate outcomes and develop a long-term sustainability plan for a TIP informed system in Alaska.

Another statewide gap is for parent and youth support, skill training and resource facilitation. As noted above, the majority of youth in RPTC have families with complex needs. BTKH is developing a statewide system of peer navigation for these children and their families. Initial outcomes (primarily in Anchorage) are encouraging: the vast majority of youth served were able to remain in their own communities. Peer navigation uses an economical workforce: trained family members and young adults with personal experience in the behavioral health system. During FY12, BTKH will expand peer navigation to additional communities and formalize the model.

School-based services also need additional development: in a FY09 sample of out-of-state RPTC admissions, 84% of the youth had “educational” as a psycho-social factor, 56% had “school suspension” and 41% had an individualized educational plan. School-based services are required to support children with severe disturbances to remain in or return to their homes and communities. Several BTKH strategies address school based services. One strategy is implementing *Positive Behavioral Supports*, an evidence-based practice. Another provides grants for community mental health centers to develop day treatment programs in collaboration with school districts. A grant supports the educational transition of children returning from RPTC. A contract developed a “tool kit” to help schools learn to use Medicaid to support health services. These projects will continue during FY12.

Medicaid Services

Introduction

This section provides a department-wide review of the Medicaid program. Additional detailed descriptions of programs, as well as more in-depth statistical analyses, are found in later chapters of the Budget Overview covering the four divisions that oversee direct delivery of Medicaid services: Behavioral Health, Children's Services, Health Care Services (including Adult Preventative Dental Medicaid), and Senior and Disabilities Services.

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 whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance. The CHIP program is administered through the Denali KidCare Office within the Division of Health Care Services. Enrollment for regular Medicaid and CHIP is managed by the Division of Public Assistance.

Effective FY2011, the five Medicaid direct medical service programs were reorganized and transferred into their own appropriation, Medicaid Services. The four main divisions: Behavioral Health, Children's Services, Health Care Services and Senior Disabilities Services all manage the benefits within this new appropriation. Only benefits are paid out of this new appropriation.

These divisions within their own appropriation structure provide Medicaid administrative activities support for the service delivery of every division within the Department of Health and Social services, as well as six other departments within the state government (Department of Administration, Corrections, Education and Early Development, Law, Labor and Workforce Development and the Court System).

Services Provided

The Medicaid Services Results Delivery Unit Medicaid Benefit Programs (direct services) by Budget Component

Behavioral Health Medicaid	Mental health clinics, substance abuse clinics, psychiatric physicians, residential psychiatric treatment centers, and inpatient psychiatric hospitals.
Children's Medicaid Services	Behavioral rehabilitation services for children.
Health Care Medicaid Services	Inpatient and outpatient hospital services, physician services, pharmacy, transportation, dental, vision, laboratory and X-ray services, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, and state-only Medicaid benefits. Other activities supporting direct services delivery include providing Medicare premium assistance for dual eligibles, recovering third-party liability payments, and making supplemental (disproportional share, or DSH) payments to hospitals.
Adult Preventative Dental Medicaid Services	Preventative and restorative dental services for adults.
Senior and Disabilities Medicaid Services	Nursing home and personal care services. Home and community based waiver programs for children with complex medical conditions (CCMC), children and adults with mental retardation or developmental disabilities (MRDD), adults with disabilities (AD), and older Alaskans (OA).

Funding Overview

Medicaid is a joint federal-state program; the federal government shares the cost of Medicaid with the state. The portion of the cost of Medicaid benefits (direct services) paid by the federal government for most Medicaid eligibility groups and service categories is called the Federal Medical Assistance Percentage (FMAP). Each state has its own FMAP. Federal financial participation rates are set annually at the federal level based on a 50 state ranking of a state's three-year average of per capita personal income. Regardless a state's ranking, its regular FMAP for Title XIX services can be set no lower than 50%.

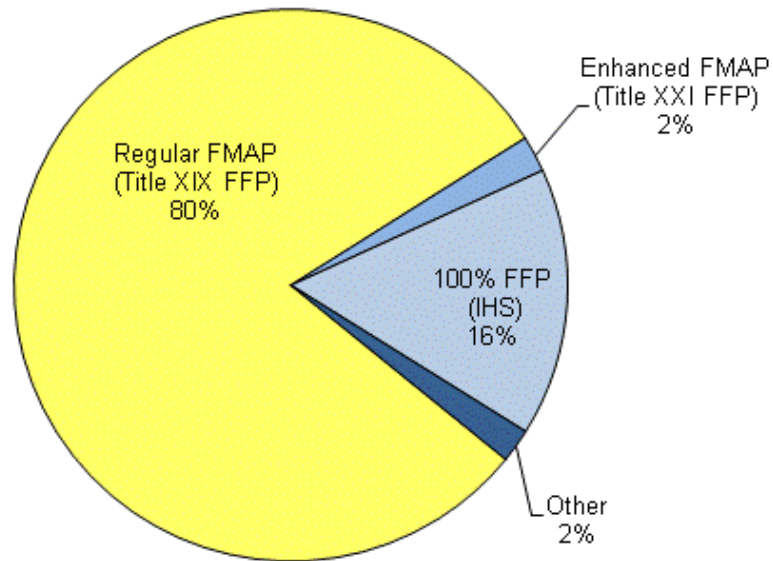
Most benefits costs are reimbursed at this regular FMAP rate for Title XIX services, but some subgroups have higher reimbursement rates. For example, qualified Indian Health Services claims for Medicaid services are reimbursed at 100% federal financial participation (FFP); claims for family planning services are reimbursed at 90% federal financial participation (FFP); and claims for children in the State Children's Health Insurance Program (SCHIP or Title XXI) and women in the Breast and Cervical Cancer program (BCC) are reimbursed at an enhanced FMAP. Where possible, the state takes advantage of these higher reimbursement rates to contain the state's portion of the cost of providing Medicaid services.

The indirect costs of administering the Title XIX Medicaid and Title XXI CHIP programs are shared with the federal government as well, generally at 50% FMAP, though there are some exceptions. For example, CHIP administrative costs and the costs of information technology infrastructure development have higher federal financial participation.

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	61.12	66.00	61.79	65.84
2010 Q2-Q4	62.46	66.00		
2011 Q1	62.46	65.00	60.54	65.25
2011 Q2	59.58	65.00		
2011 Q3	57.67	65.00		
2011 Q4	50.00	65.00		
2012 Q1-Q4	50.00	65.00	50.00	65.00

Source: Medicaid Budget Group and Centers for Medicare and Medicaid Services.
The FMAP prior to 1998 was 50%. The enhanced FMAP started in 1998.

FY2010 Medicaid Direct Services Expenditures by Federal Financial Participation



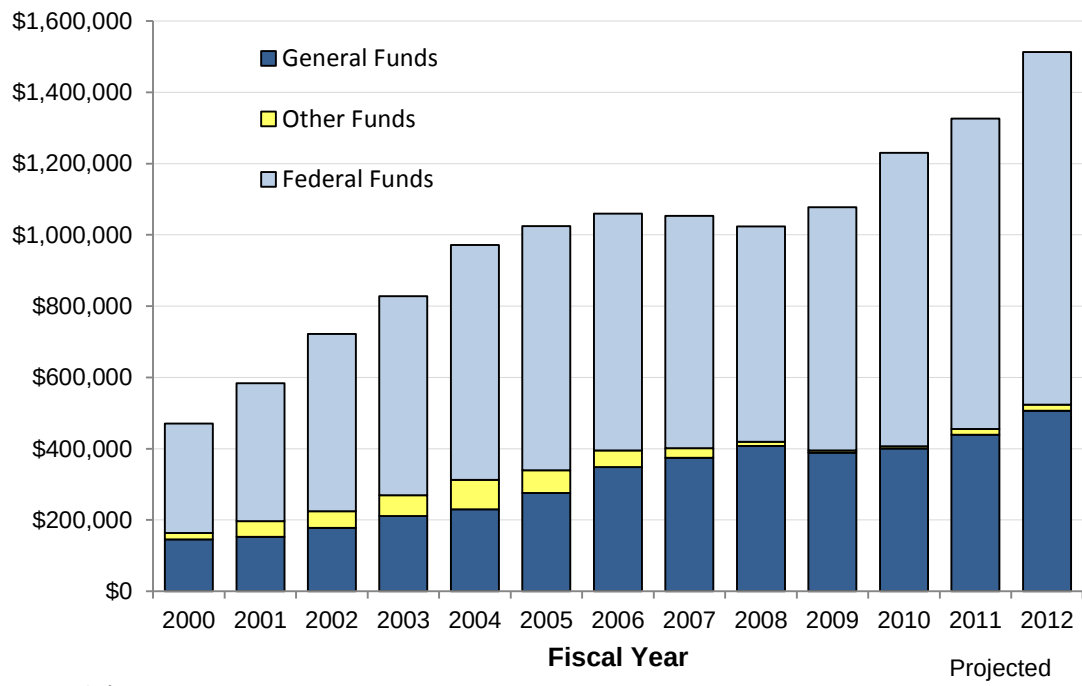
Source: AKSAS data, Medicaid direct services only.

Although total program costs have grown each year, cost containment has helped hold down increases in total Medicaid expenditures. The department's efforts to control costs have generally been successful in mitigating the impacts of increases in population and payment rates, as demonstrated by the slowing rate of growth in Alaska's Medicaid costs between 2007 and 2009. This trend is not expected to continue in 2011 and 2012, due to continued enrollment and utilization increases driven by the current general economic climate, and scheduled provider service rate increases.

The department has successfully minimized the need for additional state general funds while still meeting its mission. When annual costs have increased, federal dollars have covered much of it. Increased Medicaid services costs in late 2009 and in 2010 were largely mitigated by ARRA funding that temporarily increased the regular FMAP. Due to this increased federal financial participation under ARRA, the state matching funds required for the entire Medicaid program dropped from 40% in FY08 to 36% in FY09, then to 33% in FY10. State funding is projected to be about 34% of the total program costs in both 2011 and 2012.

The department has also taken full advantage of federal refinancing programs and strives to maximize services eligible for reimbursement at enhanced match rates. One of the department's refinancing objectives 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, the State saves 40 cents in state matching funds. The department continues to work with tribal health corporations to maximize the benefits of this refinancing strategy.

Historical Medicaid Expenditures by Fund Source (in thousands)



**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	\$389,170	\$682,271	\$6,135	\$1,077,576
2010	\$400,284	\$822,907	\$7,069	\$1,230,260
2011 *	\$438,859	\$871,043	\$16,614	\$1,326,516
2012 **	\$507,030	\$989,848	\$16,614	\$1,513,492

Source: Medicaid Budget Group using Alaska Budget System data and STAMP forecast. FY10 and earlier are actual expenditures.

* FY11 Management Plan ** Governor's Budget

Annual Statistical Summary of Medicaid Services Provided in FY10

The statistics summarized in this section are for the entire Medicaid program, including the CHIP program which is operated as an extension of regular Medicaid. There are additional detailed Medicaid statistics in the division sections for Health Care Services, Behavioral Health Services, and Senior and Disabilities Services.

In FY10, like most years in the past decade, close to one in five Alaskans was enrolled in the state's Medicaid program for at least one month during the year. Most, but not all, used at least one Medicaid service during the year. The ratio of enrollees to beneficiaries (those using services) is called the participation rate. Participation has ranged from 87% in FY00 to 97% in FY09, with a ten year average of 93%.

After slowing between FY04 and FY08, the number of persons enrolled annually increased by over 5% between FY09 and FY10. The number of beneficiaries increased by about 2%.

Participation in Medicaid					
Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	626,931	110,219	96,033	18%	87%
2001	632,200	116,226	104,730	18%	90%
2002	640,643	121,582	109,571	19%	90%
2003	647,884	126,632	116,008	20%	92%
2004	657,483	129,528	118,466	20%	91%
2005	664,334	131,136	125,318	20%	96%
2006	671,202	131,996	122,978	20%	93%
2007	676,056	128,295	121,864	19%	95%
2008	681,977	125,138	117,472	18%	94%
2009	692,314	127,944	123,791	18%	97%
2010*	698,573	135,086	126,127	19%	93%

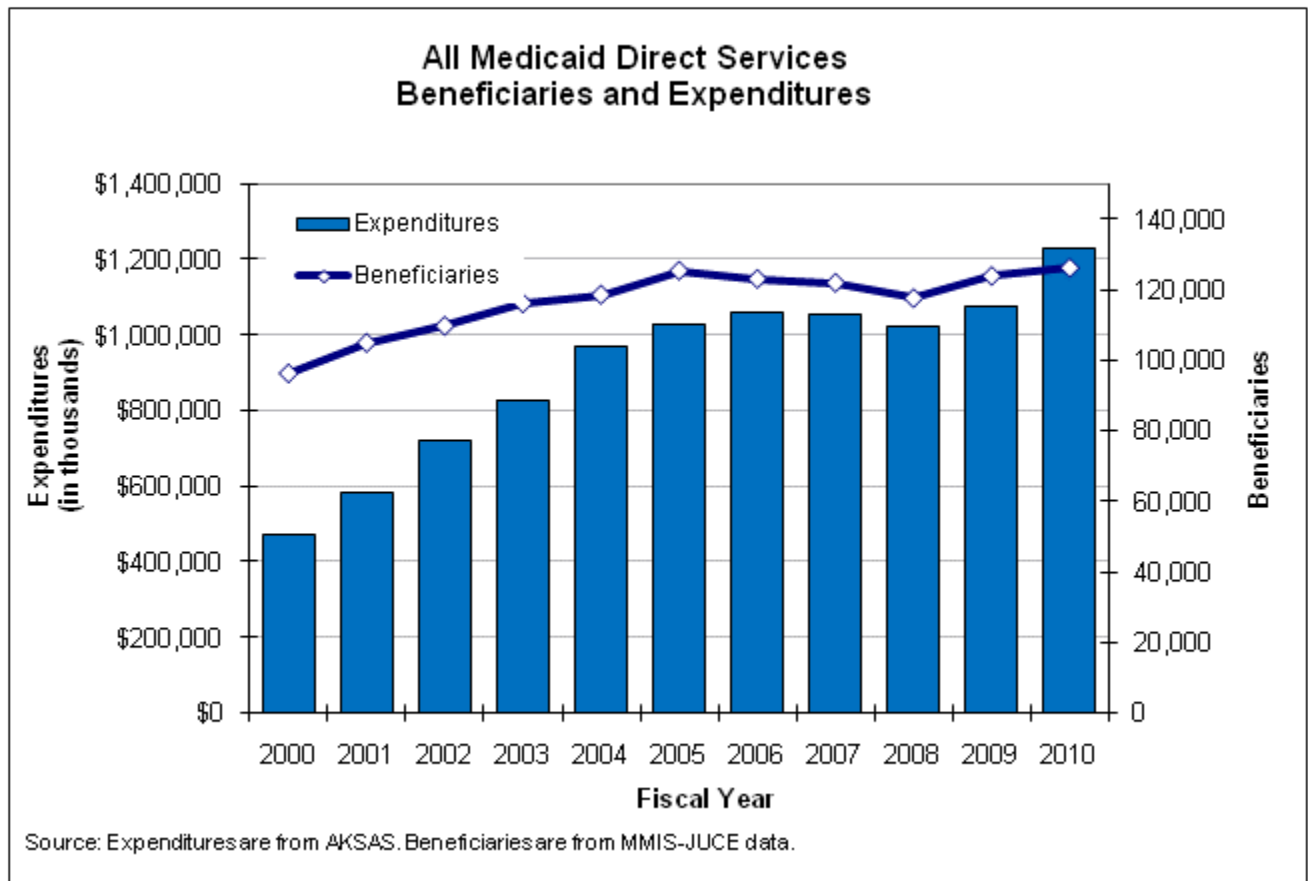
Source: Medicaid Budget Group (MMIS/JUCE) and AK Dept. of Labor and Workforce Development.

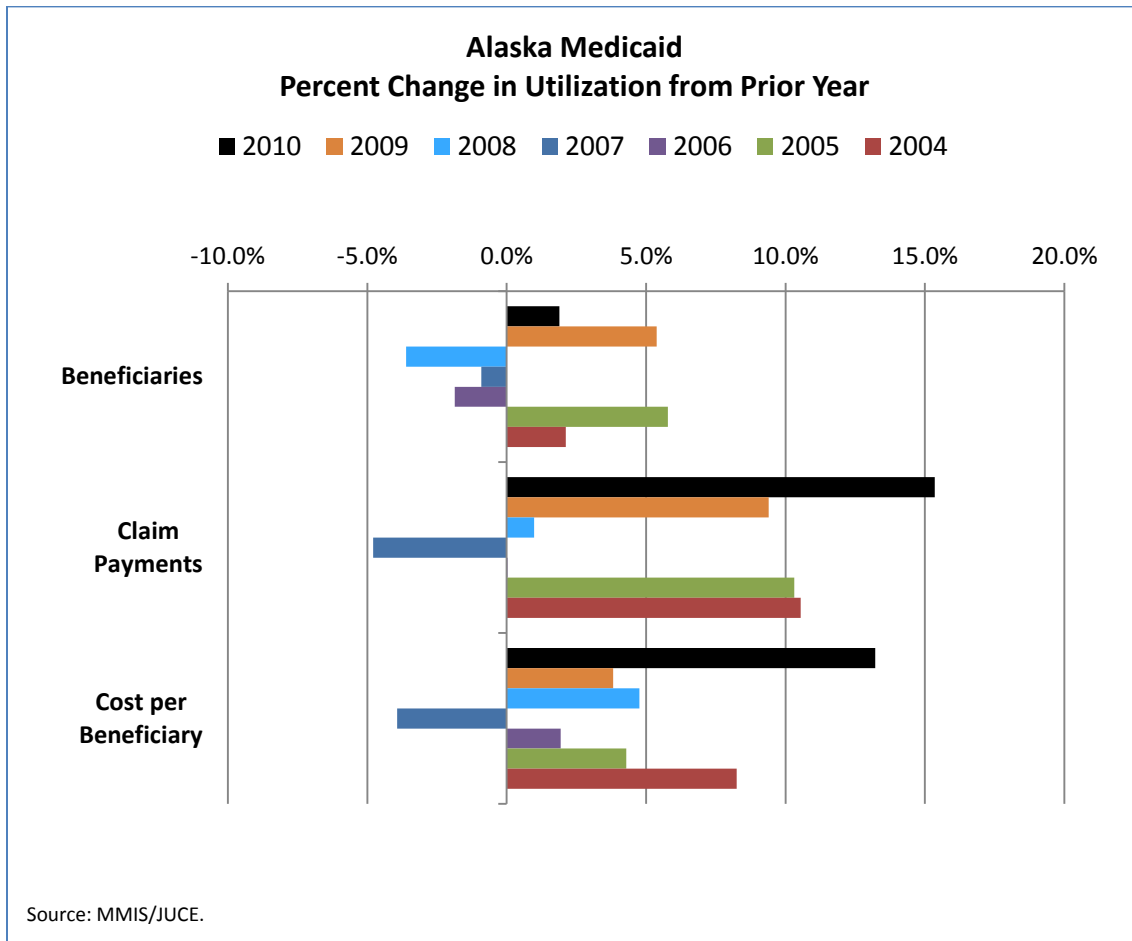
* Population is projected.

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

Total costs for direct services (claims paid in the fiscal year) increased by about 15% between FY09 and FY10 and the cost per beneficiary increased by 13%. The increase in expenditures in

FY10 was largely the result of increased enrollment, due to the general economic climate coupled with a small increase in participation, as well as increases in payment rates for some Medicaid services.

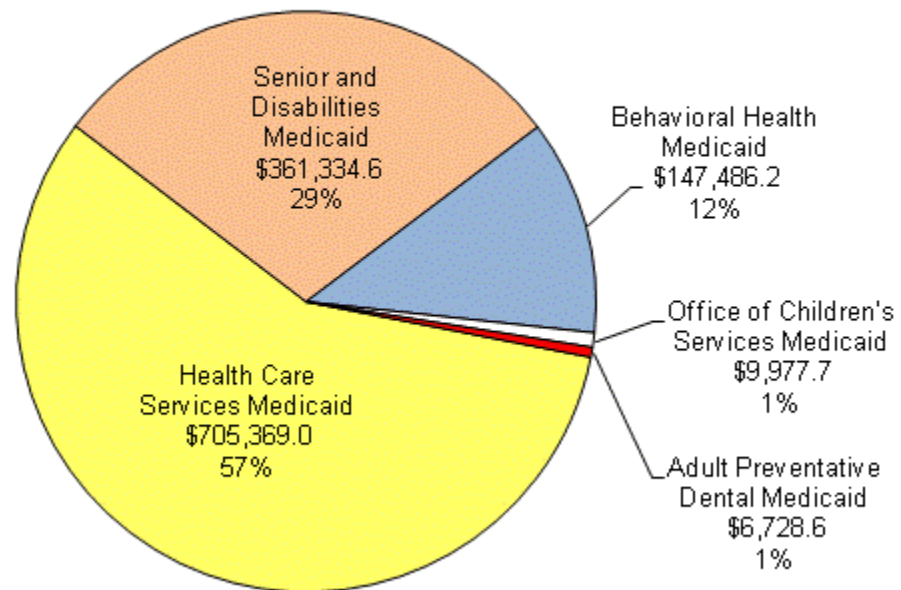




The majority of Medicaid expenditures for direct services in FY10 were paid through the Health Care Medicaid Services component in the Division of Health Care Services, which funded 57% of the total costs for Medicaid direct services. About 96% of that expenditure was for services provided directly to enrolled individuals. The remainder (less than 4%) was net of premium assistance payments, TPL recovery activities, disproportional share hospital payments, and Proshare payments to the state's inpatient psychiatric facility. The Division of Health Care Services also includes the Adult Preventative Dental Medicaid Services component, which funded about 1% of the total Medicaid expenditure for direct services in FY10.

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 in FY10. The remaining 14% of expenditures were paid through the Behavioral Health Medicaid Services (12%), and Children's Medicaid Services (1%) budget components.

**FY 2010 Medicaid Direct Services
Expenditures by Division (thousands)**



Source: AKSAS data

Medicaid Direct Services Expenditures by Division, FY 2010 (in thousands)	
Total Medicaid Direct Services	\$ 1,230,896.0
Health Care Services	
<i>Medicaid Services</i>	\$ 705,369.0
Hospital Services	\$ 281,759.8
Physician Services	\$ 158,617.3
Pharmacy Services	\$ 63,422.3
Dental Services	\$ 42,513.0
Transportation	\$ 55,102.4
Other Medicaid Direct Services	\$ 60,344.8
Non-MMIS Services	\$ 42,354.9
Medicaid Financing	\$ 635.6
Medicaid (State-only)	\$ 619.1
<i>Adult Preventative Dental Medicaid</i>	\$ 6,728.6
Adult Preventative Dental	\$ 6,728.6
Senior and Disabilities Services	
<i>Senior & Disabilities Medicaid Services</i>	\$ 361,334.6
Personal Care Services	\$ 94,812.7
Nursing Homes	\$ 82,648.8
Adults with Disabilities Waiver	\$ 28,834.7
Children with Complex Medical Conditions	\$ 11,264.4
Mental Retardation / Developmental Disabilities	\$ 101,848.0
Older Alaskans Waiver	\$ 41,591.8
Other Services	\$ 334.3
Division of Behavioral Health	
<i>Behavioral Health Medicaid Services</i>	\$ 147,486.2
Residential Psychiatric Treatment Centers	\$ 36,042.5
Inpatient Psychiatric Hospitals	\$ 18,594.8
General Mental Health Services	\$ 92,848.8
Office of Children's Services	
<i>Children's Medicaid Services</i>	\$ 9,977.7
Behavioral Rehabilitation Services	\$ 7,015.0
Behavioral Rehabilitation Services - BTKH	\$ 2,962.7
Source: Medicaid Budget Group using AKSAS data.	

Many beneficiaries receive services that are budgeted in more than one Medicaid component since individuals, once enrolled, can receive any service for which they are eligible under the State Plans for Medicaid and CHIP. For example, a beneficiary receiving mental health counseling from Behavioral Health might also get a flu shot provided by Health Care Services. A child enrolled in Medicaid under the CHIP program might receive vision services provided through Health Care Services, behavioral rehabilitation services provided through Children's Services, as well as drug abuse counseling provided by Behavioral Health. An elderly beneficiary using waiver services under the Older Alaskans waiver program in Senior and Disabilities Services might also need outpatient surgery or dentures provided by Health Care Services.

Based on claims processed for payment during FY10, 99% of Medicaid beneficiaries used at least one Medicaid service that was provided by the Division of Health Care Services. About 10% used Medicaid services provided by Behavioral Health, close to 7% used Medicaid services provided by Senior and Disabilities Services, and less than 1% used Medicaid services provided by the Office of Children's Services.

FY 2010 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		PARTICIPATION (Recipients as Percent of Enrollment)
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Medicaid, Department Annual Totals		126,127		\$1,190,963,312	\$9,443		135,086	93.4%
Gender								
Female	56.4%	71,202	56.2%	\$668,766,333	\$9,393	54.8%	74,047	96.2%
Male	43.6%	54,974	43.8%	\$522,196,988	\$9,499	45.2%	61,111	90.0%
Unknown	0.0%	1	0.0%	(\$9)	\$0	0.0%	1	-
Race								
Alaska Native	38.3%	48,633	36.8%	\$438,665,598	\$9,020	36.5%	49,775	97.7%
American Indian	1.6%	1,997	1.5%	\$17,834,059	\$8,930	1.6%	2,122	94.1%
Asian	6.4%	8,159	5.6%	\$66,771,151	\$8,184	7.0%	9,604	85.0%
Pacific Islander	3.2%	4,026	2.4%	\$28,243,006	\$7,015	3.4%	4,653	86.5%
Black	5.4%	6,887	4.4%	\$52,720,983	\$7,655	5.6%	7,682	89.7%
Hispanic	3.7%	4,646	2.4%	\$29,049,448	\$6,253	3.7%	5,042	92.1%
White	38.7%	49,184	44.0%	\$523,702,297	\$10,648	39.2%	53,433	92.0%
Unknown	2.7%	3,400	2.9%	\$33,976,771	\$9,993	2.9%	3,925	86.6%
Native	40.0%	50,608	38.3%	\$456,499,657	\$9,020	38.3%	51,865	97.6%
Non-Native	60.0%	75,801	61.7%	\$734,463,655	\$9,689	61.7%	83,590	90.7%
Age								
under 1	9.1%	12,532	8.4%	\$99,483,454	\$7,938	8.3%	12,121	103.4%
1 through 12	37.0%	50,921	15.9%	\$189,438,271	\$3,720	38.5%	56,026	90.9%
13 through 18	15.8%	21,744	14.2%	\$168,858,451	\$7,766	16.5%	24,027	90.5%
19 through 20	3.5%	4,817	2.8%	\$33,199,115	\$6,892	3.2%	4,697	102.6%
21 through 30	10.5%	14,498	12.2%	\$145,845,759	\$10,060	10.0%	14,565	99.5%
31 through 54	13.6%	18,758	21.3%	\$253,276,323	\$13,502	13.4%	19,462	96.4%
55 through 64	4.0%	5,454	9.3%	\$110,507,239	\$20,262	3.8%	5,542	98.4%
65 through 84	5.4%	7,497	11.7%	\$139,803,439	\$18,648	5.3%	7,715	97.2%
85 or older	1.0%	1,429	4.2%	\$50,551,261	\$35,375	0.9%	1,350	105.9%
Benefit Group								
Children	61.6%	79,076	34.2%	\$407,579,137	\$5,154	63.1%	86,227	91.7%
Adults	18.5%	23,741	12.8%	\$152,264,932	\$6,414	17.7%	24,173	98.2%
Disabled Children	1.8%	2,363	5.4%	\$64,766,615	\$27,409	1.7%	2,315	102.1%
Disabled Adults	12.2%	15,603	33.3%	\$396,934,142	\$25,440	11.9%	16,236	96.1%
Elderly	5.9%	7,516	14.2%	\$169,418,485	\$22,541	5.6%	7,687	97.8%
Location (DHSS Region)								
Anchorage/Mat-Su	44.7%	63,146	51.6%	\$614,314,598	\$9,728	49.8%	68,946	91.6%
SouthCentral	12.5%	17,735	14.5%	\$172,205,097	\$9,710	13.5%	18,611	95.3%
Northern	11.3%	16,030	10.8%	\$128,826,938	\$8,037	12.7%	17,515	91.5%
Western	13.8%	19,577	11.3%	\$135,163,029	\$6,904	14.3%	19,815	98.8%
SouthEast	8.5%	11,967	11.1%	\$132,481,804	\$11,071	9.3%	12,917	92.6%
Out of State or Unknown	1.5%	2,170	0.7%	\$7,971,846	\$3,674	0.4%	548	

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 and may therefore not equal expenditure totals in the state accounting or budget systems.

Enrollment: Number of persons eligible for Medicaid and enrolled for at least 1 month during state fiscal year 2010. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group, and region 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 2010 (service may have been incurred in a prior year). Grouping is based on status on the date when service was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories) but some duplication 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, 2010. If they later obtained dental services in December 2009, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2010.

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

Department-wide recipient counts are unduplicated across divisions.

Location is based on residence of the recipient or enrollee, not the location where service was provided.

Source: MMIS/JUCE.

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	Department of Health and Social Services
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 47.05	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 47.30	Mental Health
AS 47.30.011-061	Mental Health Trust Authority
AS 47.30.470-500	Mental Health
AS 47.30.520 - 620	Community Mental Health Services Act
AS 47.30.655 - 915	State Mental Health Policy
AS 47.30.655 - 915	State Mental Health Policy (Hospitalization of Clients)
AS 47.33	Assisted Living Homes
AS 47.37	Uniform Alcoholism & Intoxication Treatment Act
AS 47.65	Service Programs for Older Alaskans and Other Adults
AS 47.80.010 – 900	Persons with Disabilities
PL 89-73	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
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 43.170	Conditions for Payment
7 AAC 43.1000-1110	Home- and Community-Based Waiver Services Program
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
20 AAC 40	Mental Health Trust Authority

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

PL 102-321 Community Mental Health Services

Code of Federal Regulations: 42 CFR Part 400 to End

Explanation of FY12 Operating Budget Requests

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 and mix 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.

Home and Community Based Waiver and Personal Care Attendant Service Rates

Cost based rate determination processes have been applicable for health facilities including hospitals, long term care facilities, and rural health clinics for many years. For these providers historical costs are reviewed for compliance with Medicare cost reporting principles. The department has utilized that experience in developing the new Waiver cost based system.

Cost based waiver and personal care attendant (PCA) service rates methodology calculates payment rates utilizing reported provider costs of providing Waiver and PCA services to Medicaid recipients. Changes to the rate methodology are anticipated to have an effective date in late FY11.

The new cost based rate system sets up a link between the actual costs of providing services to the rates of payment.

For SFY 2011, 2012 and 2013 this new payment system relies on a combination of costs provided through a cost survey and historical payment rates. A phase-in period will allow providers an opportunity to adjust to the new structure, and provide an opportunity for providers to collect and report to the department the costs of providing the various services. A rebasing will occur in SFY 2014.

Key elements are:

- Establishes accounting and reporting requirements (effective SFY 2011)
- Establishes a cost survey methodology.
- Rates developed from cost survey at least every 4 years (first rebasing in SFY 2014)
- Annual reporting of financial and statistical data

Waiver service providers will be required to track and account for costs in a manner adequate to complete the cost survey in accordance with regulatory requirements and Cost Survey instructions. Small providers receiving under \$200,000 in Medicaid payments may choose to not maintain the accounting requirements or complete a cost survey.

The new rate determination process applies to services and equipment supplied to recipients on the Adults with Physical Disabilities (APD), Children with Complex Medical Conditions

(CCMC), individuals with Mental Retardation and Developmental Disabilities (MR/DD) and Older Alaskans (OA) Waiver programs. Providers report the cost of providing services at least every four years, by use of a cost survey tool that collects the actual cost of providing services. Based upon the accumulated cost data, a statewide rate is determined for each individual waiver service, and is then adjusted for geographic area.

Example - Chore services² are available to all four waiver programs. Providers offering Chore services report costs on the cost survey. The department reviews the costs for compliance with regulatory and reporting standards. Costs for Chore services are accumulated and divided by the related units of service. Accumulated costs include both direct and overhead. The resulting historical cost is inflated from the report year to the payment year. If applicable a geographic differential is added to the payment rate.

Senior and Disabilities Services (SDS) provide access to support low-income seniors and people with physical, intellectual and developmental disabilities. Services are funded through Medicaid, the federal Older Americans Act and state general funds (GF). Services range from modest supports which allow an individual to maintain independence in their own home to nursing home care.

Medicaid waivers provide the majority of long-term care services and supports to needy Alaskans. Waiver programs allow the state to “waive” some of the federal rules governing Medicaid, while allowing Alaskans to receive the services in their own homes and communities. Currently, waivers serve over 3,500 individuals with a variety of home and community-based services (HCBS), including care coordination, home health care, chore service, habilitation and respite. Financial assistance is provided to qualified individuals (as an alternative to care in a nursing home) through purchase of home and community-based services that allow the individual to remain in their home and community for as long as possible. To be eligible for an OA or APD waiver, an individual must be both Medicaid-eligible and be found to need the level of care available in a nursing home.

This new rate methodology was developed to replace the previous rate determination method, which relied on projected (budgeted) costs submitted by the individual provider. Under the previous system, providers frequently found themselves providing similar services at very different rates of reimbursement. In the early 2000’s, the department experienced rapidly rising expenditures and instituted a rate freeze for Medicaid waiver services which was in effect for several years. The legislature, provider community, and recipients and their advocates voiced concern over the lack of relationship between rates of payment and the cost of the service.

The department engaged the Kansas accounting firm of Myers and Stauffer (M&S) to assist in developing a new approach to rate setting. Myers and Stauffer held several community meetings with providers. Utilizing recommendations from those meetings, as well as previous work done to review rate setting approaches, the department decided to look at the potential of provider costs as a basis for possible reimbursement methodologies.

² These are services or tasks performed for recipients in the waiver programs.

Payment system development steps included:

- 1) M&S developed a simplified cost report template and piloted it with 10 Alaskan HCBS and PCA providers. Out of that pilot some changes were made to the template and it then became the basis for the larger cost collection process with the HCBS and PCA providers. That cost survey was wrapped up in October and November of 2008. The results of that work was evaluated by Myers and Stauffer and reviewed by the state.
- 2) Four meetings were held in Anchorage, Fairbanks and Juneau in November and December of 2008 to present and discuss with the providers and the public M&S's recommendations to the state.
- 3) The cost survey tool used by M&S to gather cost information received multiple comments on its difficulty and un-workability. The department put together a workgroup to discuss options and to provide the department with important input on the development of a cost survey tool that will provide information necessary to calculate appropriate payment rates for Waiver services. The department decided to keep the survey tool as simple as possible, while creating an acceptable cost basis for determining rates of payment for Waiver services. The last of these meetings were held in the summer of 2009.
- 4) The department began the regulation process in September of 2009, M&S recommendations were incorporated as adjusted by the department, based on provider comments and internal deliberations.
- 5) At least three public work sessions were conducted by the department to present, discuss, and receive valuable community, provider, and recipient input into cost reporting and rate calculation processes.
- 6) Significant elements of the new system include accounting requirements; allowable cost definitions; cost reporting requirements; new chart of payment rates; annual adjustments with periodic rebasing to include current cost data; and an updated specialized medical equipment rate chart. These improvements provide a solid and predictable basis for calculating rates related to the provision of Waiver and PCA services.

Budget Overview Table

Behavioral Health Medicaid Services

Behavioral Health	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$57,944.0	\$63,808.0	\$5,864.0
Designated General funds	1,500	1,500	0.0
Federal Funds	100,408.9	109,720.2	9,311.3
Other Funds	717.5	717.5	0.0
Total	\$160,570.4	\$175,745.7	\$15,175.3

Behavioral Health Medicaid Services Funding Needs Table

Behavioral Health Medicaid Services	Total	GF	Federal	Other
FY11 Authorized Base	160,570.4	57,944.0	100,408.9	2,217.5
Growth in FY11	4,202.4	267.8	3,934.6	0.0
Growth from FY11 to FY12	10,972.9	5,596.2	5,376.7	0.0
Replace ARRA funds	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
Total	175,745.7	63,808.0	109,720.2	2,217.5

Budget Requests

Behavioral Health Medicaid Services

Growth in FY11: \$4,202.4 Total:
\$267.8 GF/MH, \$2,402.9 Fed, \$1,531.7 Fed ARRA

This increment is necessary to increase the FY11 base before making further adjustments for FY12. Total spending for FY10 was at the upper range of our estimates. Total spending for FY11 has been projected again, using more up-to-date data than was available when the Governor's Amended Budget for FY11 was created. This increment will help maintain the current level of Behavioral Health Services.

Growth from FY11 to FY12: \$10,972.9 Total - \$5,596.2 GF/MH, \$5,376.7 Fed

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

The Behavioral Health Medicaid Services component funds three types of services: inpatient psychiatric hospitals, residential psychiatric treatment centers, and outpatient behavioral health services. 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 FY12, Behavioral Health Medicaid costs are projected to grow 6.7% from FY11. Projections are revised monthly and this increment request will be revisited for the Governor's Amended budget. Increased enrollment and utilization will contribute to the 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).

Replace ARRA funds: \$0.0 Total – \$16,883.8 Fed, (\$16,883.8) Fed ARRA

ARRA Medicaid funding will end in 2011. This fund change converts ARRA authorization to federal authorization in anticipation of a potential continuation of the increased FMAP.

Behavioral Health Medicaid Services						
State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	8,821	\$56,771.4	\$6,436			
2000	10,082	\$67,281.0	\$6,673	14.3%	18.5%	3.7%
2001	10,823	\$80,101.2	\$7,401	7.3%	19.1%	10.9%
2002	11,143	\$90,655.0	\$8,136	3.0%	13.2%	9.9%
2003	12,199	\$107,215.7	\$8,789	9.5%	18.3%	8.0%
2004	12,935	\$119,349.9	\$9,227	6.0%	11.3%	5.0%
2005	13,606	\$129,057.1	\$9,485	5.2%	8.1%	2.8%
2006	12,962	\$134,799.0	\$10,400	-4.7%	4.4%	9.6%
2007	12,604	\$138,242.0	\$10,968	-2.8%	2.6%	5.5%
2008	11,767	\$125,562.6	\$10,671	-6.6%	-9.2%	-2.7%
2009	11,861	\$133,609.8	\$11,265	0.8%	6.4%	5.6%
2010	12,083	\$148,331.5	\$12,276	1.9%	11.0%	9.0%

Source: MMIS/JUCE.

Budget Overview Table
Children's Medicaid Services

Children's Medicaid Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$5,396.5	\$5,584.0	\$187.5
Federal Funds	8,165.9	8,353.4	187.5
Other Funds	0.0	0.0	0.0
Total	\$13,562.4	\$13,937.4	\$375.0

Orthodontic Services and ARRA Funding Needs Table

Children's Medicaid Services	Total	GF	Federal	Other
FY11 Authorized Base	13,562.4	5,396.5	8,165.9	0.0
Orthodontic Services for Children	375.0	187.5	187.5	0.0
Replace ARRA funds	0.0	0.0	0.0	0.0
Total	13,937.4	5,584.0	8,353.4	0.0

Budget Requests

Orthodontic Services for Children: \$375.0 Total - \$187.5 GF/Match, \$187.5 Fed

A state court order was made relating to orthodontic services for children. As a consequence of this court order, the state is required to revise the regulations used for approving orthodontic services for children. The revised standards will increase the utilization and spending associated with these services.

Replace ARRA funds: \$0.0 Total – \$724.1 Fed, (\$724.1) Fed ARRA

ARRA Medicaid funding will end in 2011. This fund change converts ARRA authorization to federal authorization in anticipation of a potential continuation of the increased FMAP.

Budget Overview Table
Adult Preventive Medicaid Services

Adult Preventive Dental	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$2,981.8	\$3,038.4	\$56.6
Federal Funds	6,231.7	5,957.1	-274.6
Other Funds	0.0	0.0	0.0
Total	\$9,213.5	\$8,995.5	-\$218.0

Adult Preventive Medicaid Funding Needs Table

Adult Preventive Dental Medicaid Services	Total	GF	Federal	Other
FY11 Authorized Base	9,213.4	2,981.7	6,231.7	0.0
Growth from FY11 to FY12	249.6	164.2	85.4	0.0
Replace ARRA funds	0.0	0.0	0.0	0.0
Previous fiscal notes	<u>-467.5</u>	<u>-107.5</u>	<u>-360.0</u>	<u>0.0</u>
Total	8,995.5	3,038.4	5,957.1	0.0

Budget Requests

Growth from FY11 to FY12: \$249.6 Total - \$164.2 GF/Match, \$85.4 Fed

This increment is necessary to maintain the current level of services for Adult Preventive Dental Medicaid. Costs are projected to grow 9.4% from FY11 to FY12, due to enrollment and utilization increase. Projections for formula growth are based on historical trends in spending and federal financial participation.

Replace ARRA funds: \$0.0 Total – \$765.7 Fed, (\$765.7) Fed ARRA

ARRA Medicaid funding will end in 2011. This fund change converts ARRA authorization to federal authorization in anticipation of a potential continuation of the increased FMAP.

Previous fiscal notes: (\$467.5) Total – (\$107.5) G/F Match, (\$360.0) Fed

There is a decrease in funding in the fiscal note for SB199, Medicaid Coverage for Dentures.

Budget Overview Table

Health Care Medicaid Services

Health Care Medicaid Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$222,537.7	\$256,035.4	\$33,497.7
Designated General Funds	847.5	847.5	0.0
Federal Funds	509,947.0	584,313.7	74,366.7
Other Funds	9,796.7	9,796.7	0.0
Total	\$743,128.9	\$850,993.3	\$107,864.4

Health Care Medicaid Services Funding Needs Table

Health Care Medicaid Services	Total	GF	Federal	Other
FY11 Authorized Base	743,128.9	222,537.7	509,947.0	10,644.2
Growth in FY11	43,549.0	5,775.7	37,773.3	0.0
Growth from FY11 to FY12	43,243.2	21,961.3	21,281.9	0.0
Replace ARRA funds	0.0	0.0	0.0	0.0
Transfer out funding for Eye Care	-165.0	-165.0	0.0	0.0
Transfer in funding for Contractual Services	21,244.0	5,929.1	15,314.9	0.0
Previous fiscal notes	-6.8	-3.4	-3.4	0.0
Total	850,993.3	256,035.4	584,313.7	10,644.2

Budget Requests

Growth in FY11: \$43,549.0 Total- \$5,775.7 G/F Match, \$33,359.6 Fed, \$4,413.7 Fed ARRA

This increment is necessary to increase the FY11 base before making further adjustments for FY12. Total spending for FY10 was at the upper range of our estimates. Total spending for FY11 has been projected again, using more up-to-date data than was available when the Governor's Amended Budget for FY11 was created. This increment will help maintain the current level of Health Care Medicaid Services.

Growth from FY11 to FY12: \$43,243.2 Total - \$21,961.3 G/F Match, \$21,281.9 Fed

This increment is necessary to maintain the current level of quality Medicaid health care services for eligible Alaskans. Health Care Medicaid Services' costs are projected to grow 5.5% from 2011 to 2012, due to growth in enrollment, growth in utilization, and rate increases. Projections are revised monthly, and this increment request will be revisited for the Governor's Amended Budget.

In recent years the department has implemented 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 2003. Cost containment has been especially effective in pharmacy services; costs for this category have fallen 34% since the high of \$95.7 million in 2005.

The Health Care Medicaid Services component funds acute health care services, such as hospitals, physicians, prescription drugs, dental services, and transportation. Providing acute health services through Medicaid improves the department's mission to manage health care for eligible Alaskans in need.

Replace ARRA funds: \$0.0 Total – \$59,556.9 Fed, (\$59,556.9) Fed ARRA

ARRA Medicaid funding will end in 2011. This fund change converts ARRA authorization to federal authorization in anticipation of a potential continuation of the increased FMAP.

Transfer out funding for Primary Eye Care: (\$165.0) Total – (\$165.0) Gen Fund

These funds will be transferred from the Health Care Medicaid Services component to the Health Care Services, Health Planning and Systems Development component so appropriate distributions can be made to rural Alaskan communities.

Transfer in funding for Contractual Medicaid Services: \$21,244.0 Total – \$5,929.1 G/F Match, \$15,314.9 Fed

These funds will be transferred from the Health Care Services, Medical Assistance Administration component to the Health Care Medicaid Services component in order to streamline Medicaid funding by placing contractual items that directly affect Medicaid Services into the Medicaid Services RDU.

Included in this transfer are the following items:

Funding for MMIS Legacy Contract: \$17,400.1 Total – \$4,768.1 G/F Match, \$12,632.0 Fed

This transfer supports funding that pays the Medicaid contractor that processes provider claims for Medicaid Services.

Funding for Medical Necessity Reviews: \$2,240.7 Total – \$560.2 G/F Match, \$1,680.5 Fed

This transfer supports funding that pays an independent contractor to conduct medical necessity reviews for Medicaid services. These reviews are required under 42 CFR 456.50.

Funding for Provider Re-enrollment: \$800.0 Total – \$400.0 G/F Match, \$400.0 Fed

This transfer supports funding that pays for Medicaid provider re-enrollment. This is a required and on-going process as the department prepares to transition from the old MMIS legacy system to the new MMIS.

Funding for Medical Provider Audits: \$803.2 – \$200.8 G/F Match, \$602.4 Fed

This transfer supports funding that pays an independent auditing firm to conduct Medicaid audits. These audits are required under AS 47.05.200 to substantiate the services rendered, that the diagnoses recorded on the claim forms reconcile with the medical charts.

Previous fiscal notes: (\$6.8) Total – (\$3.4) G/F Match, (\$3.4) Fed

There is a decrease in funding in the fiscal note for SB196, Prescription Drug Database.

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%
2010	125,191	\$671,547.4	\$5,364	1.8%	17.1%	15.0%

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.

Budget Overview Table
Senior and Disabilities Medicaid Services

Senior and Disabilities Medicaid Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$149,998.9	\$178,564.0	\$28,565.1
Federal Funds	246,289.3	281,503.8	35,214.5
Other Funds	3,752.2	3,752.2	0.0
Total	\$400,040.4	\$463,820.0	\$63,779.6

Senior and Disabilities Medicaid Services Funding Needs Table

Senior and Disabilities Medicaid Services	Total	GF	Federal	Other
FY11 Authorized Base	400,040.4	149,998.9	246,289.3	3,752.2
Growth in FY11	15,270.5	3,346.2	11,924.3	0.0
Growth from FY11 to FY12	34,560.1	18,103.0	16,457.1	0.0
Replace ARRA funds	0.0	0.0	0.0	0.0
HCBS provider rate increases	14,000.0	7,000.0	7,000.0	0.0
Previous fiscal notes	-51.0	115.9	-166.9	0.0
Total	463,820.0	178,564.0	281,503.8	3,752.2

Budget Requests

Growth in FY11: \$15,270.5 Total- \$3,346.2 G/F Match, \$7,528.8 Fed, \$4,395.5 Fed ARRA

This increment is necessary to increase the FY11 base before making further adjustments for FY12. Total spending for FY10 was at the upper range of our estimates. Total spending for FY11 has been projected again, using more up-to-date data than was available when the Governor's Amended Budget for FY11 was created. This increment will help maintain the current level of services for Senior and Disabilities Medicaid.

Growth from FY11 to FY12: \$34,560.1 Total - \$18,103.0 G/F Match, \$16,457.1 Fed

This increment is necessary to maintain the current level of quality Medicaid services for eligible Alaskans. Senior and Disabilities Medicaid Services' costs are projected to grow 8.4% from 2011 to 2012, due to growth in enrollment, growth in utilization, and rate increases. 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 attendants, and home- and community-based services. These programs support the department's mission to manage health care for eligible Alaskans in need. Providing long-term care through Medicaid improves and enhances the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

Replace ARRA funds: \$0.0 Total – 45,855.7 Fed, (45,855.7) Fed ARRA

ARRA Medicaid funding will end in 2011. This fund change converts ARRA authorization to federal authorization in anticipation of a potential continuation of the increased FMAP.

HCBS provider rate increases: \$14,000.0 Total – \$7,000.0 G/F Match, \$7,000.0 Fed

These funds will pay for provider rate increases for the providers of Home- and Community-Based Services.

Previous fiscal notes: (\$51.0) Total – \$115.9 G/F Match, (\$166.9) Fed

There is a decrease in funding in the fiscal note for SB219, Traumatic Brain Injury.

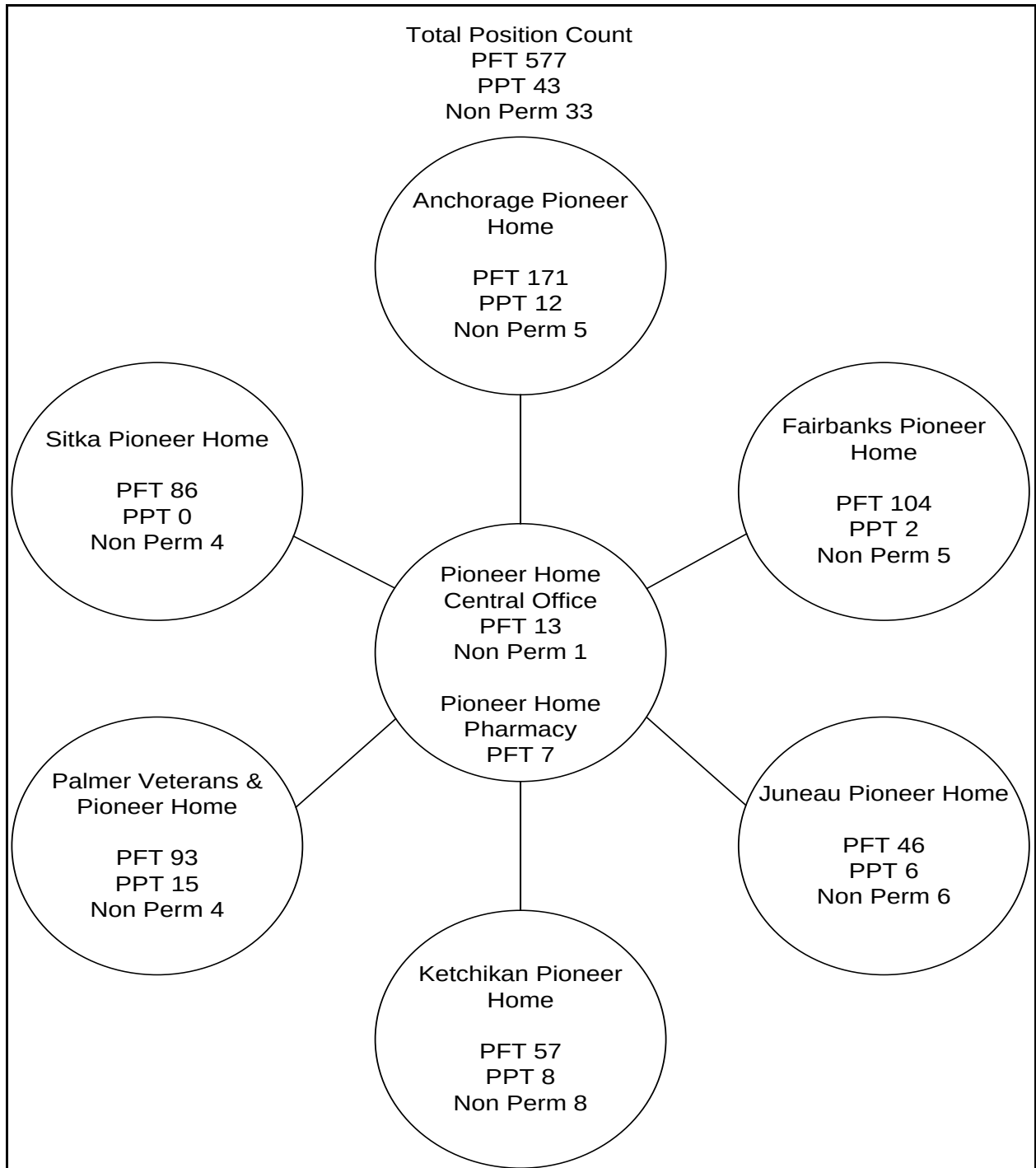
Seniors and Disabilities Medicaid Services						
State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	2,688	\$79,351.7	\$29,521			
2000	2,914	\$90,587.8	\$31,087	8.4%	14.2%	5.3%
2001	3,504	\$105,834.3	\$30,204	20.2%	16.8%	-2.8%
2002	3,902	\$130,887.3	\$33,544	11.4%	23.7%	11.1%
2003	4,484	\$163,925.3	\$36,558	14.9%	25.2%	9.0%
2004	5,460	\$205,790.8	\$37,691	21.8%	25.5%	3.1%
2005	6,395	\$236,357.6	\$36,960	17.1%	14.9%	-1.9%
2006	7,358	\$257,777.8	\$35,034	15.1%	9.1%	-5.2%
2007	7,817	\$280,164.4	\$35,840	6.2%	8.7%	2.3%
2008	7,406	\$290,235.9	\$39,189	-5.3%	3.6%	9.3%
2009	7,588	\$316,967.6	\$41,772	2.5%	9.2%	6.6%
2010	8,282	\$362,733.3	\$43,798	9.1%	14.4%	4.9%

Source: MMIS/JUCE.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Growth from FY11 to FY12	\$ 5,596.2	\$ -	\$ 5,376.7	\$ -	\$ 10,972.9
Growth in FY11	\$ 267.8	\$ -	\$ 3,934.6	\$ -	\$ 4,202.4
Orthodontic Services for Children	\$ 187.5	\$ -	\$ 187.5	\$ -	\$ 375.0
Replace ARRA funds	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Coverage for Dentures (SB 199)	\$ (107.5)	\$ -	\$ (360.0)	\$ -	\$ (467.5)
Growth from FY11 to FY12	\$ 164.2	\$ -	\$ 85.4	\$ -	\$ 249.6
Growth from FY11 to FY12	\$ 21,961.3	\$ -	\$ 21,281.9	\$ -	\$ 43,243.2
Growth in FY11	\$ 5,775.7	\$ -	\$ 37,773.3	\$ -	\$ 43,549.0
Provide Primary Eye Care and Vision Rehabilitation to Rural Alaskan Communities - Xfr to Health Planning/Systems Dev	\$ (165.0)	\$ -	\$ -	\$ -	\$ (165.0)
4th Yr Prescription Drug Database (SB196)	\$ (3.4)	\$ -	\$ (3.4)	\$ -	\$ (6.8)
Transfer Funding From MAA to Support Contractual HCS Medicaid Services	\$ 5,929.1	\$ -	\$ 15,314.9	\$ -	\$ 21,244.0
2nd Year Traumatic Brain Injury Fiscal Note (SB 219)	\$ 115.9	\$ -	\$ (166.9)	\$ -	\$ (51.0)
Growth from FY11 to FY12	\$ 18,103.0	\$ -	\$ 16,457.1	\$ -	\$ 34,560.1
Growth in FY11	\$ 3,346.2	\$ -	\$ 11,924.3	\$ -	\$ 15,270.5
Medicaid Home and Community Based Services Provider Rate Adjustments	\$ 7,000.0	\$ -	\$ 7,000.0	\$ -	\$ 14,000.0
Medicaid Svs Total	\$ 68,171.0	\$ -	\$ 118,805.4	\$ -	\$ 186,976.4

Alaska Pioneer Homes



Introduction to the Alaska Pioneer Homes

Mission

To 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 580 Alaska seniors during FY10. As of September 30, 2010, 367 Alaska seniors were on the active wait list and 3,168 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, including 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 (general fund/program receipts). 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 interagency receipts) also support the operating costs of the Pioneer Homes. The Homes received \$5.14 million in Medicaid Waiver receipts in FY10 and are budgeted to collect \$5.23 million in FY11.

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.

Annual Statistical Summary of Services Provided

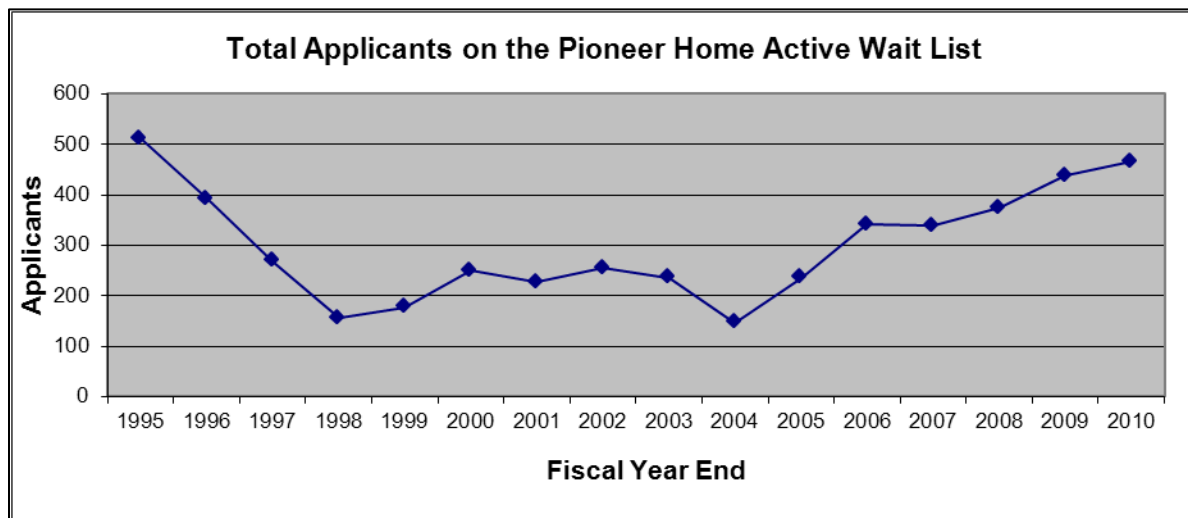
Pioneer Homes Wait List

Individuals apply for admission to an Alaska Pioneer Home or the Alaska Veterans and Pioneer Home by completing and submitting an application. An individual who is a resident of the state 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
2010	10	87	112	129	53	75	466

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, 2010. Since October 2009, the number of actual applicants on the active wait list increased by 43 and the number of actual applicants on the inactive wait list increased by 221. During this same time period, the Pioneer Homes admitted 106 new residents.

Pioneer Homes Wait List Composition							
	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	7	104	118	144	54	87	514
Inactive Branch	773	1,132	1,082	1,407	563	1,042	5,999
Total	780	1,236	1,200	1,551	617	1,129	6,513
Number of Applicants Choosing More than One Home (Duplicates)							3,186
Number of Actual Applicants on Active Wait List							359
Number of Actual Applicants on Inactive Wait List							2,968

Pioneer Home Monthly 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.

Alaska Pioneer Home Rate History Tables

Effective Date	Residential	Assisted Living	Skilled Nursing
1954	\$150		\$195
July 1966	\$180		\$225
July 1976	\$225		\$275
October 1983	\$425		\$525
December 1989	\$525	\$630	\$800
February 1993	\$600	\$700	\$880
February 1994	\$665	\$780	\$975
February 1995	\$735	\$860	\$1100

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
July 2010	\$2,350	\$4,260	\$6,170

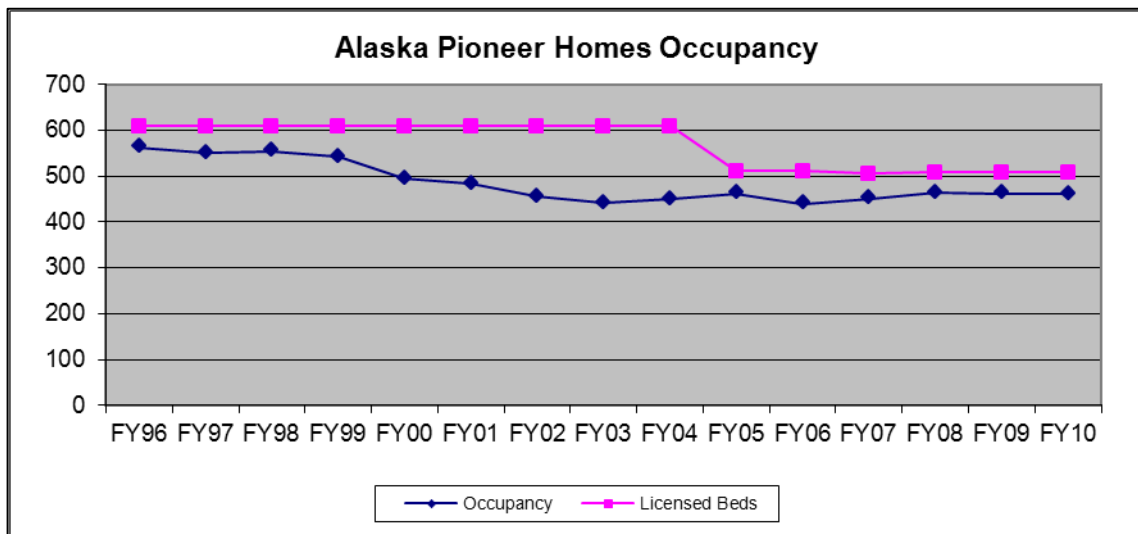
Assistance from the Older Alaskans Medicaid Waiver and the division's Payment Assistance Program are available for residents whose income and resources are insufficient to pay the full monthly rate.

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.

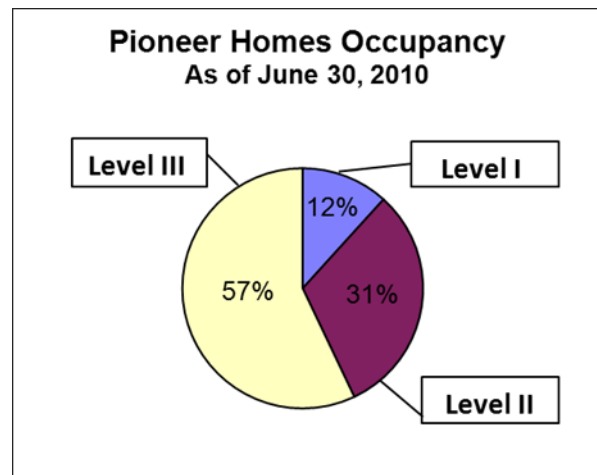
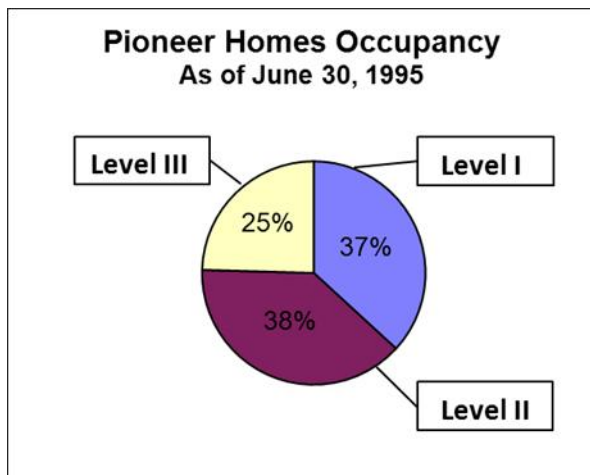
With family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. As of October 31, 2010, there were six Level I vacancies, five Level II vacancies and sixteen Level III vacancies system wide. Those on the Pioneer Home active wait 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 2010. As mentioned above, the gap between licensed and occupied beds decreased significantly 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 fifteen 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 57 percent, while those requiring Level I care decreased from 37 to 12 percent.

Alaska Pioneer Homes Level of Service Breakdowns: 1995 and 2010



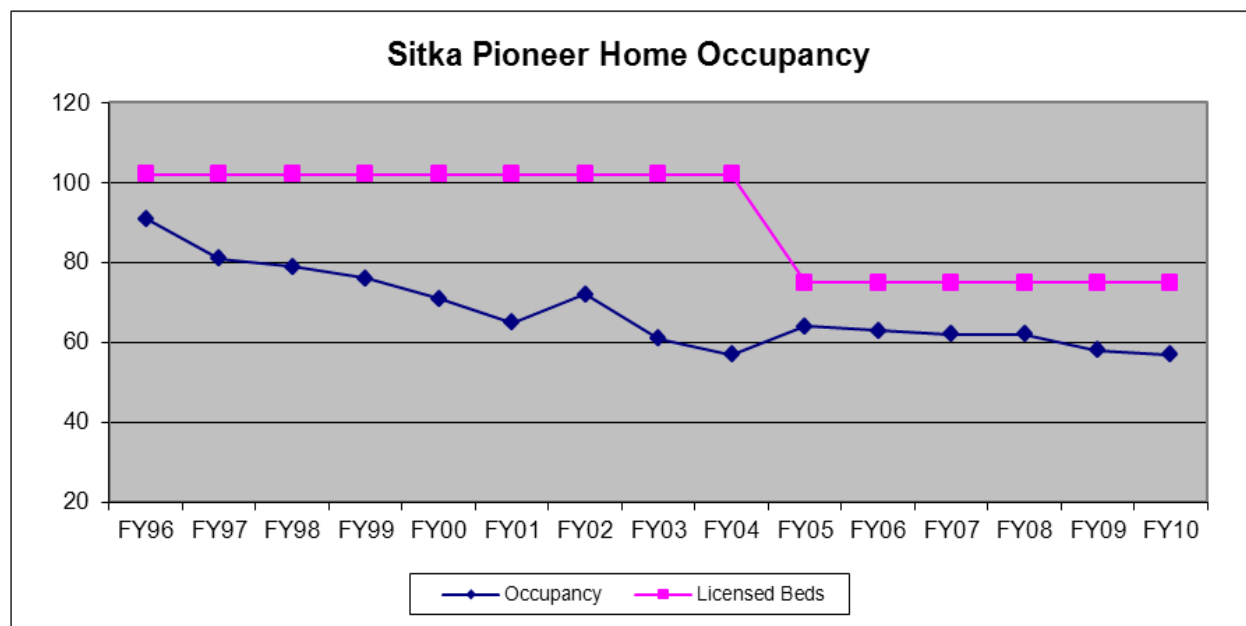
Current Pioneer Homes Occupancy

The table below shows the October 31, 2010 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home by level of service.

Alaska Pioneer Homes Occupancy by Home and Level of Service							
Service Level							
Occupied/Assigned	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Level I	4	8	4	34	6	2	58
Level II	26	17	18	53	8	19	141
Level III	31	53	48	80	27	22	261
Total	61	78	70	167	41	43	460
Licensed Beds	75	93	79	168	48	45	508
Non-Occupied	14	15	9	1	7	2	48
Unavailable	3	15	0	0	3	0	21
% Avail. Beds Filled	84.7%	100.0%	88.6%	99.4%	91.1%	95.6%	94.5%

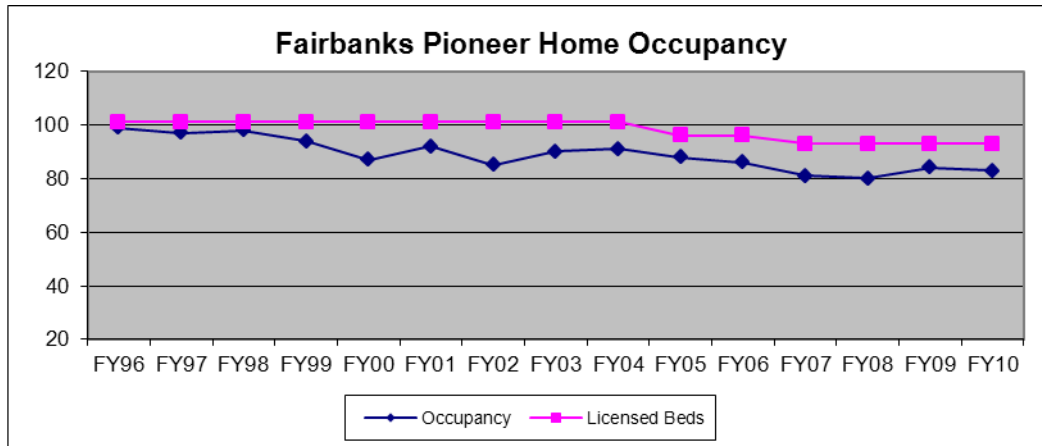
Sitka Pioneer Home

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 adhere to stringent federal guidelines. Of the 75 licensed beds in the Sitka Pioneer Home, 61 were occupied as of October 31, 2010.



Fairbanks Pioneer Home

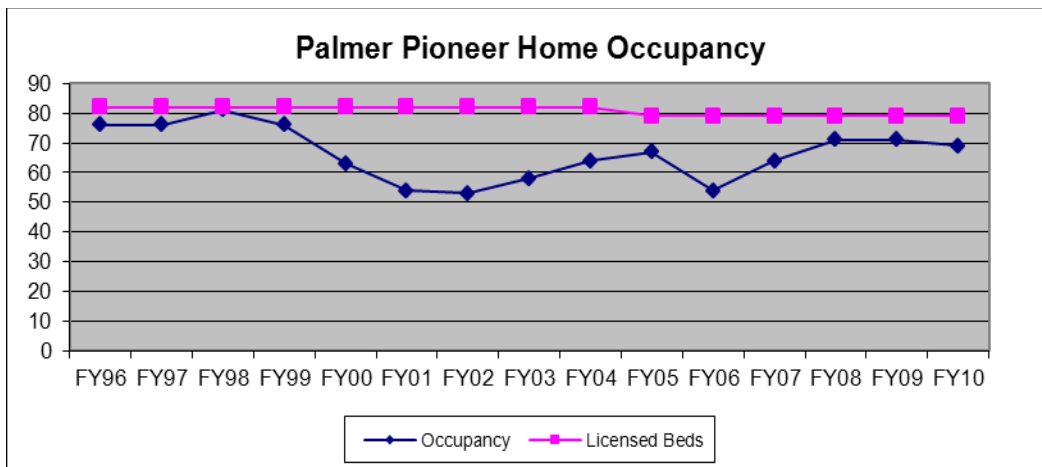
The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. As of October 31, 2010, 78 of the 93 licensed beds were occupied. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93.



Palmer Pioneer Home

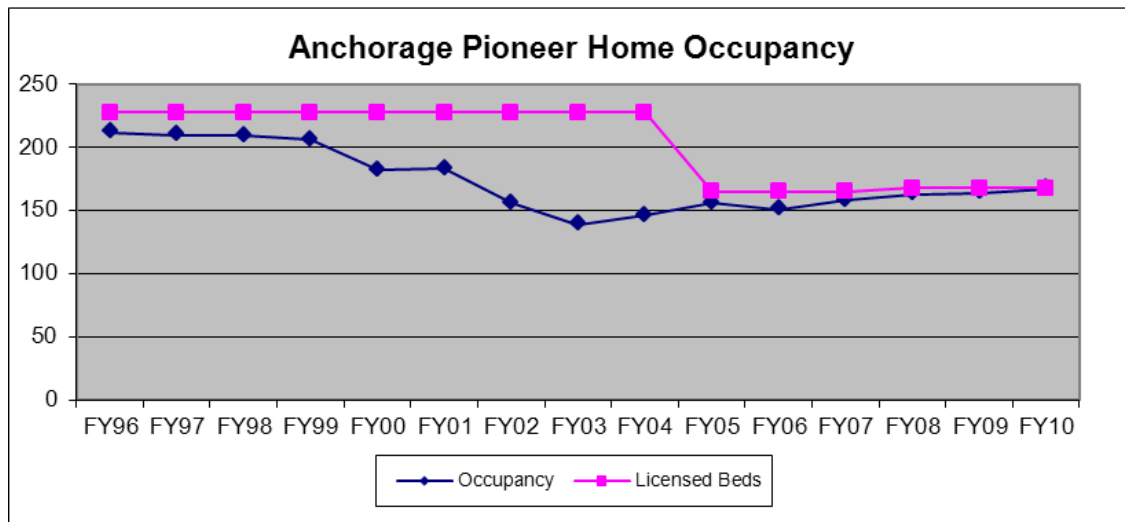
The Palmer Home, located in the Matanuska Valley, was built in 1971. It is a single level, ranch-style building and encompasses 11 acres of lawn and gardens. Within six years of opening, it became apparent more space was needed and an addition was built. As of October 2010, 70 of the 79 licensed beds were occupied.

Effective February 2007, the Palmer Home was certified by the US Department of Veterans Affairs to become Alaska's first state Veterans Home. Veterans residing in this home are eligible to receive the federal domiciliary care per diem payment, which is currently \$38.90 per day. The Home is transitioning to fill 60 of its 79 licensed beds with veterans. As of October 2010, 29 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.



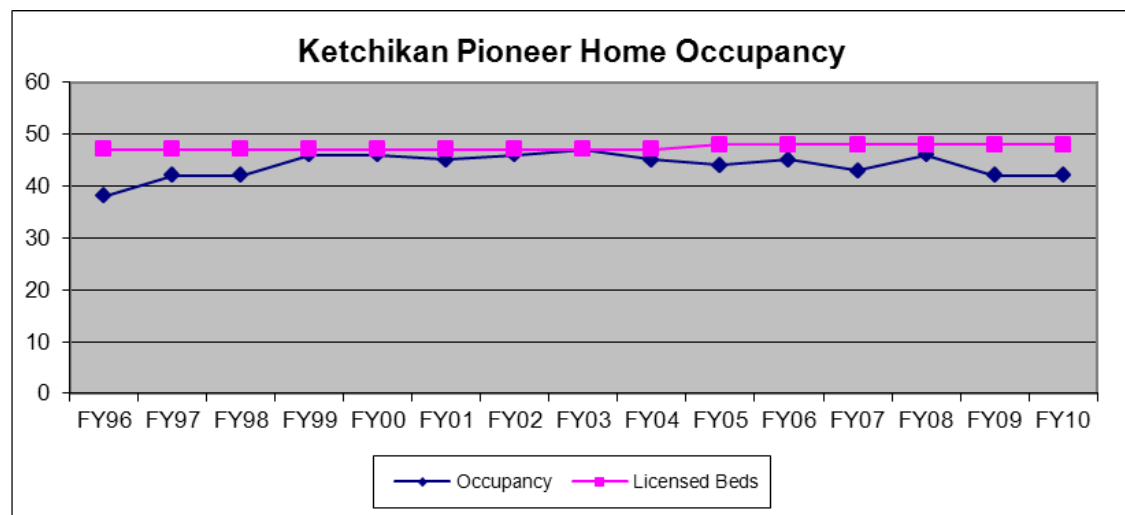
Anchorage Pioneer Home

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 2010, 167 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.



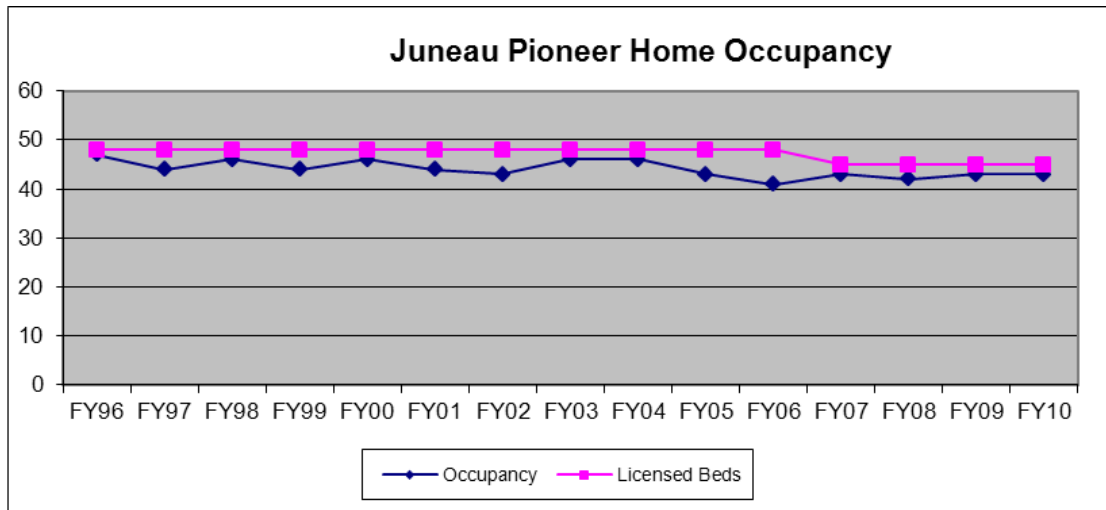
Ketchikan Pioneer Home

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 2010, 41 of the 48 licensed beds were occupied.



Juneau Pioneer Home

The newest Pioneer Home opened in Juneau in 1988 as a skilled nursing facility. Today, it is home to 43 Alaska seniors as an Assisted Living Home and is licensed for 45 beds.



List of Primary Programs and Statutory Responsibilities

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

Explanation of FY12 Operating Budget Requests

Alaska Pioneer Homes

Budget Overview Table

Alaska Pioneer Homes	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Fund	\$32,770.9	\$33,980.2	\$1,209.3
Designated General Fund	15,554.3	16,259.6	705.3
Federal Funds	349.9	353.4	3.5
Other Funds	8,881.7	9,078.7	197.0
Total	\$57,556.8	\$59,671.9	\$2,115.1

Budget Requests

Pioneer Homes – Additional Funding to Meet Medicaid Documentation Requirements: **\$400.0 GF/Prgm**

The division is at risk of losing Medicaid revenue.

The FY12 budget includes an increment of \$400.0 general fund/designated program receipts to meet Medicaid documentation requirements. This funding will provide approximately 18,500 additional staff hours and will allow the division to utilize part time positions, nonpermanent positions and overtime to meet the documentation requirements. This request does not include additional positions.

The additional staff hours are funded with resident payments or general fund/designated program receipts. The division's collection of resident payments continues to exceed authorization, and we believe future receipts will be sufficient to fund this increment. We request that the Pioneer Home resident payments be used to fund staff that serves them.

A previous Medicaid audit found deficiencies in documentation and the division had to repay \$329.4 of the receipts received during the 2006 audit period. With Medicaid Waiver receipts increasing from \$2.8 million in FY06 to \$5.1 million in FY10, the Pioneer Homes are at risk of additional audits and lost Medicaid receipts.

This increment is a good investment for the state. It will ensure Medicaid funding will continue and will allow the Pioneer Homes to meet the documentation requirements, while maintaining the current level of care and service provided to Pioneer Home residents.

Transfer to Keep Pioneer Home Advisory Board and Pioneer Homes in One Component:
\$13.1 RSS

The Pioneer Home Advisory Board's \$13.1 authorization was transferred to the Pioneer Home component as a FY11 Management Plan adjustment. The Board will continue to meet and tour the Homes, but the expenditures will be paid from the Pioneer Home component. With such a small amount of funding, it is unnecessary to have a separate component for the Board.

All other FY12 operations budget transactions are technical position and salary adjustments.

Explanation of FY12 Capital Budget Requests

Alaska Pioneer Homes

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.

Alaska Veterans and Pioneers Home Storage: \$885.0 GF

This request will fund the construction of a storage unit adjacent to the home in Palmer. The storage unit will provide heated and unheated storage space. Currently, resident rooms and off-site units are used for storage, which result in additional operating cost and loss of revenue.

Challenges

Increased Resident Acuity

Level II and III residents in the Homes have increased from 63% in June 1995 to 88% in June 2010. 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 367 applicants as of September 2010, an increase of 181 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 the number of 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. Finding alternative placements for these individuals has been difficult or impossible, while 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. Additionally, we are at risk of losing Medicaid revenue if the documentation requirements are not met.

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 sector. Allowing employees to attend training and conferences in their area of expertise shows our employees that we value them and also allows them to remain up to date with the latest medical advances, yet it has always been difficult to adequately budget 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,(59), 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, 2010 there were 29 veterans residing in the Alaska Veterans and Pioneer Home. This is an increase of four over the past year.

Ketchikan Pioneer Home Remodel

The third floor dining area was not designed to accommodate residents in wheelchairs and also 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.

This project is included in the FY12 capital budget as a Pioneer Home deferred maintenance project.

Adequate Storage

The Anchorage and Palmer Homes need additional storage space to store supplies, equipment, and disaster preparedness items. Currently the Palmer Home rents off-site storage units at a cost of \$5,000/year and uses three resident rooms for storage. On-site storage would save the \$5,000 and free up the rooms at the Home that are being used for storage. The rooms currently used for storage could generate up to \$222.1 in room and board receipts. 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.

The FY12 capital budget includes a request for \$885.0 to build a storage facility at the Palmer Veterans and Pioneer Home.

Performance Measure Detail

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

Target #1: Sentinel Event Injuries attributed to falls will not increase.

Status #1: In FY10, the rate of Pioneer Homes resident falls resulting in a major injury (sentinel event injury rate) was 3.4%, exceeding the 2% target, but in line with past performance on this measure. The sentinel injury rate was 1.85% for FY09.

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.

Target #2: Reduce number of elders on Alaska Pioneer Homes waiting list.

Status #2: The Pioneer Homes maintain an active and inactive waitlist. In order to enter a Pioneer Home, an elder Alaskan must first make application to be placed on our waitlist. For the last several years the Pioneer Homes have experienced an annual increase in the number of elder Alaskans being placed on the waitlist and waiting to enter the pioneer Homes. The Pioneer Homes endeavor to decrease the waitlist by offering additional beds to Alaskan elders.

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

Target #1: The medication error rate for the Pioneer Homes will not increase.

Status #1: In FY10, the medication error rate decreased to 0.11% from 0.14% in FY09 comparing favorably with the target medication error rate of less than one percent. Source: DHSS AK Pioneer Homes

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2011	0.10	0	0	0	0
2010	0.13%	0.10%	0.12%	0.09%	0.11%
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.

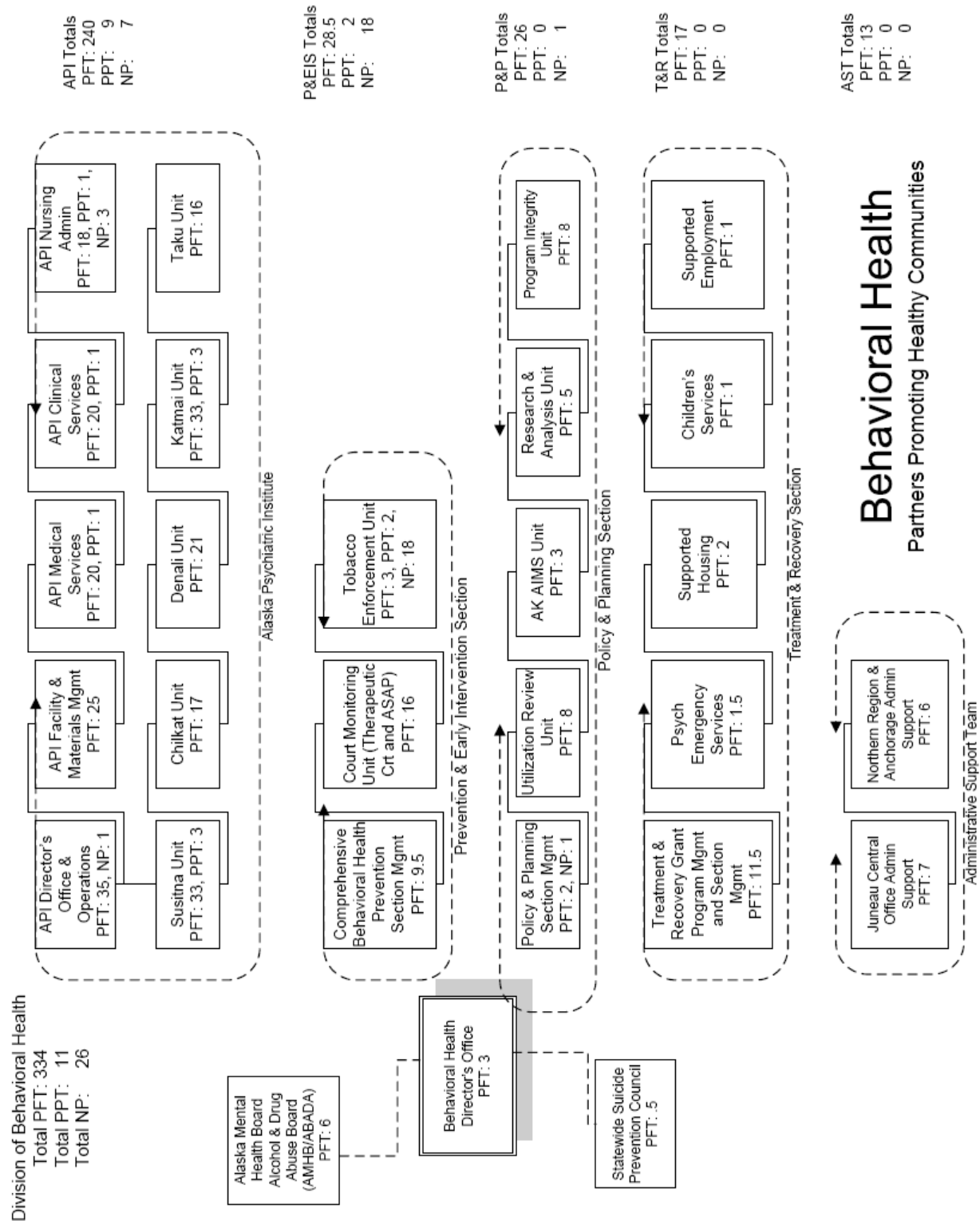
The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2008, Pioneer Home staff administered an average of 488,184 individual medications each quarter.

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.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Additional Funding to Meet Medicaid Documentation Requirements	\$ -	\$ 400.0	\$ -	\$ -	\$ 400.0
Reverse August FY2011 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (294.6)	\$ -	\$ -	\$ -	\$ (294.6)
<i>Alaska Pioneer Homes Total</i>	<i>\$ (294.6)</i>	<i>\$ 400.0</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ 105.4</i>

Division of Behavioral Health



Introduction to the Division of Behavioral Health

Mission

To promote wellness and recovery to assure behavioral health for all Alaskans.

Overview

The Division of Behavioral Health (DBH) operates and manages behavioral health programs and funds services which ensure that Alaskans have access to a statewide continuum of services. The array of behavioral health services crosses the lifespan of individuals who need and use these services. Services range from prevention and early intervention through treatment, to inpatient psychiatric hospitalization. Services support recovery and resilience and are provided in convenient locations and various settings to reduce barriers, support collaboration, and address level of severity. Settings include community-based outpatient settings, school-based programs, residential facilities, hospital facilities, and also involve tobacco enforcement activities. Services are located in bush villages, rural communities, 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 access for Alaskan residents to comprehensive behavioral health services. Funding decisions are based on provider performance, and client outcomes are measured to determine effectiveness of care. Behavioral health needs arise in various settings and circumstances. Community hospitals, Designated Evaluation and Stabilization/Treatment contracted hospitals, community behavioral health centers, physician clinics, primary care practitioners, child advocacy centers, Department of Corrections, juvenile justice facilities, opioid treatment providers, domestic violence and sexual assault victim services agencies, recovery and peer organizations all have a role in providing and or collaborating in the delivery of mental health and substance use services. In our efforts to maximize the treatment opportunities and access for our citizens, DBH frequently works 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, the Governor's Council on Disabilities and Special Education, Alaska Pioneer Homes, Children's Services, Juvenile Justice, Public Assistance, Public Health, other Departments within state government, providers, and advocacy groups.

Core Services

To provide a continuum of statewide mental health and substance use disorder services ranging from prevention and early intervention to emergency care and treatment. Included are services for seriously mentally ill adults, services for seriously emotionally disturbed youth, substance use disorder services, and operation of the Alaska Psychiatric Institute.

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

Through grants to agencies, the division 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.



SAMHSA'S Strategic Prevention Framework (SPF)

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 Substance Abuse and Mental Health Services Administration (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 indicate 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.

Alcohol Safety Action Program (ASAP)

ASAP is an integral part of the criminal justice and behavioral health care service systems, providing monitoring and tracking of clients referred to substance abuse services throughout the State. Five Probation Officers and five community grantees handle traditional adult misdemeanor ASAP referrals in Anchorage. There are an additional seven community grantees that are funded to handle just juvenile cases. In addition to the Anchorage office, adult and juvenile grant programs are located in Fairbanks, Juneau, Kenai/Homer, Kotzebue, Wasilla/Palmer. Juvenile-only programs are located in Anchorage, Dillingham, Ketchikan, Kodiak, Seward, Nome, and Bethel.

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. It offers a consistent process to ensure clients complete required substance abuse education or treatment programs, as prescribed by the courts. The ASAP programs, including the Anchorage office, monitors these cases to confirm with the court and the Department of Motor Vehicles (DMV) when clients have completed court ordered assignments. 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.

There are approximately 1,500 adult court-ordered referrals made to the six adult community programs quarterly. An additional 500 juvenile referrals are made to the twelve grantees. 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. Grantees are also responsible for engaging their community prevention coalition and to be involved in ASAP program outreach and education efforts in schools, community forums, and other appropriate venues.

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. In order to qualify for a Provider Agreement, diagnostic teams must demonstrate that they have the organizational infrastructure, the required staff training and licensing and that they are an interdisciplinary team composed of a variety of professional and paraprofessional disciplines.

Currently, ten community-based FASD Diagnostic Teams are registered as State “approved” providers of FASD diagnostic services. Teams are located in Bethel, Kenai, Fairbanks,

Anchorage (SouthCentral Foundation), Anchorage (ASSETS), Juneau, Sitka, Mat-Su Valley, Copper Center and Kodiak. Two new teams were added in FY11: Anchorage ASSETS and Copper Center. The diagnostic capacity of Alaska has significantly increased with the addition of these new teams, particularly with the addition of the Anchorage ASSETS team. The Anchorage area is now more broadly supported due to the fact that the Anchorage ASSETS team serves all individuals in the Anchorage area; previously the only other Anchorage team was limited to providing services to Native Health Service beneficiaries. At this time, there is interest in developing diagnostic teams in Dillingham and Barrow, both of which are communities that offer few options for individuals seeking FASD diagnostic services beyond urban travel.

During FY10, a total of 131 diagnoses were completed. 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 providing funding for educational support and for part-time 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.

Prevention Programs and Initiatives

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.

The prevention programs and initiatives are described below and include:

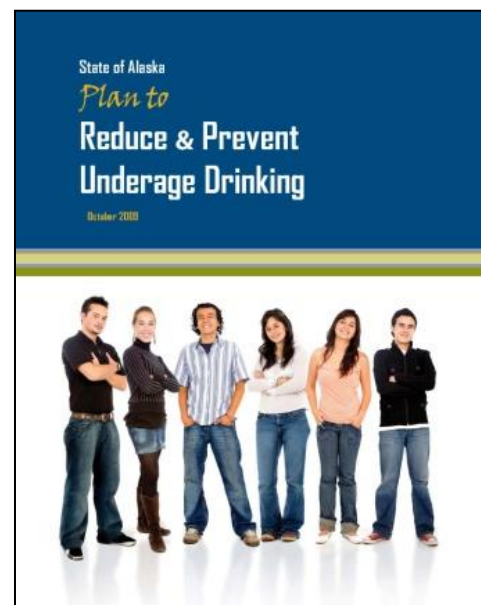
- Alaska's Plan to Reduce and Prevent Underage Drinking
- Building Community Coalitions
- Therapeutic Court Programs
- Tobacco Enforcement and Education
- Suicide Prevention and the Statewide Suicide Prevention Council

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 look 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 Department of Transportation and Public Facilities, Alaska Highway Safety Office; the Alaska Court System; the Department of Public Safety 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. Currently DBH is conducting focused conversations with Alaskans (providers, youth and grantees) in order to determine changes needed in the plan. Those recommendations will be incorporated into the update of this plan.

In partnership with the federal Center for Substance Abuse Prevention, the Division of Behavioral Health has developed a video related to underage drinking in Alaska. The focus of the video is a showcase Alaskans across the state working together to decrease the negative impacts of youth alcohol use. Specifically the video highlights efforts in Barrow, Nome, Kodiak and Anchorage in the areas of limiting access, youth oriented interventions and community intervention.



Prevention efforts are showing results in statewide population level indicators. On some measures, Alaska is doing better than the national average on youth consumption patterns. Most importantly, we're moving in the right direction. Between 2003 and 2009, the following benchmarks were reported by high school students:

- Students who had at least one drink **decreased** from 75 percent to 67 percent.
- Students who had their first drink before age 13 **decreased** from 23 percent to 17 percent.
- Students who drank in the past 30 days **decreased** from 39 percent to 33 percent.

Utilizing the strength-based approach of the strategic prevention framework, community coalitions and inter-departmental collaboration, we will continue to have an impact on the negative consequences related to underage drinking.

Copies of the Plan are available at:

http://www.hss.state.ak.us/dbh/prevention/docs/2009_underagedrinkplan.pdf.

Building Community Coalitions and Regional Infrastructure

Coalition building is a proactive strategy that promotes coordination and collaboration, and makes efficient use of 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. In July 2009 the Division of Behavioral Health received a 5-year, \$10.7 million infrastructure grant from SAMHSA that will build community-based foundations for promotion, prevention and early intervention of behavioral health conditions across Alaska. Funds will target the two top consumption patterns that impact Alaska in a significant way:

1. Youth alcohol abuse (ages 12-18)
2. Adult heavy and binge drinking (ages 12-44)

In addition to selecting alcohol use as the focus for the funding, six consequences were identified as the most serious in Alaskan communities, with the worst outcomes: alcohol related deaths; alcohol-related crashes/collisions; drinking under the influence arrests; minors consuming alcohol citations; alcohol-related suicides; and alcohol-related interpersonal violence.

Therapeutic Court Programs

Therapeutic courts represent an intensive, coordinated effort of DBH, in partnership with the Alaska Court System and behavioral health professionals, to actively intervene and disrupt the cycle of substance abuse, addiction and crime. Seven of the Probation Officers with ASAP work with clients referred through the Therapeutic Court system with a case load of 30 to 40 clients. Through this partnership there are Therapeutic Court Probation Officers in Anchorage, Barrow, Fairbanks, Bethel, and Ketchikan.

Individuals assigned to the misdemeanor program must complete their court ordered requirements mostly independently. Non-compliance with the ASAP misdemeanor program may lead to a referral to the therapeutic court program. Those who wish to participate in one of the therapeutic court programs must be referred by the District Attorney's office and enter the program voluntarily. Individuals referred to these programs have substance abuse and lifestyle

challenges that prevent them from succeeding in the traditional criminal justice and substance abuse treatment settings such as the misdemeanor court. These are felony clients and mental health clients with multiple substance abuse related arrests and convictions. By entering the program, they plead guilty through a process called a Rule Eleven. By so doing, they are given an opportunity to earn a reduced sentence that can include removing a conviction from their record if they successfully complete the program. By entering the program, they receive intensive case management, up to daily contact, urinalyses, group sessions and weekly court sessions. As an alternative to less effective interventions, these courts are ideal for motivated individuals who are at high risk due to their substance abuse. The active Therapeutic Court Case data captures all cases that are being monitored throughout the state. Data shows that with the strict court monitoring, community supervision, intensive case-management, and long-term behavioral health treatment services of the therapeutic court programs, even individuals with felony alcohol and drug convictions are able to reenter the community and be successful.

Tobacco Enforcement and Education

In addition to the 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, the “sell rate” of tobacco products to minors under the age of 19 (the legal age to purchase tobacco in Alaska) is monitored. The consistent work of the Tobacco Enforcement section has resulted in sell rates to minors in Alaska dropping 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. In 2007 Alaska had the highest suicide rate in the country, with a rate of 23.1 suicides per 100,000 population, compared to the national rate of 10.8 per 100,000. In 2009 there was a small drop in the suicide rate to 20.2 per 100,000, but this is equivalent to an alarming 140 suicides.

Alaska Division of Behavioral Health is working to strengthen partnerships with the Statewide Suicide Prevention Council, the Alaska Mental Health Trust and partner boards, Alaska schools, Alaska Native groups and organizations, as well Alaska’s Veterans organizations. Doing a better job of monitoring higher risk populations and developing proper and adequate early identification, screening and referral resources including gatekeeper training are necessary to avert suicide crises.



Through the Garrett Lee Smith federal grant awarded for FY09 – FY11, Behavioral Health funded three regional programs to work on reducing the incidence of suicide in their regions. Regional Suicide Prevention Teams are implementing projects and services in Southeast Alaska

and the Central Kuskokwim area villages. Grantees and partners are working on raising awareness, providing Alaska Suicide Prevention Gatekeeper trainings, conducting social marketing campaigns, working with the media on “safe-messaging” and also developing postvention plans to help prepare communities to respond after a suicide occurs.

The division funds the Alaska Careline that provides the only statewide suicide crisis hotline in Alaska. Recent reports indicate that suicide calls have increased over 50% over the past year. Careline has also recently created a web site and a chat line function which gives greater access to those at risk. Plans are underway to create a stronger link between Careline, individuals at risk and local community health care centers to broaden the safety net community by community.

Last year the division launched a new suicide prevention web-portal, www.stopsuicidealaska.org, designed to connect individuals, groups and organizations around the state to bring resources together. This resource will allow partners to better communicate, inform, educate and empower each other in their work.

Behavioral Health has formed a stakeholder advisory group to help guide the development of suicide postvention resources including a comprehensive postvention guide, technical assistance to communities for postvention planning and responding to behavioral health emergencies, web based training and resources, and expanding Critical Incident Stress Management team training and development.

These initiatives and strategies are aimed at balancing identified needs and resources with the understanding that:

- Suicide prevention requires a multi-faceted approach, integrated into Alaska’s continuum of care.
- Efforts must be targeted simultaneously at the community, family and individual level.
- Community involvement is necessary for any effort to succeed.

Treatment and Recovery Services

Recovery is the goal of treatment for people with mental illness, substance use disorders, or both conditions (co-occurring). 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 provide effective treatment and support services that range from the least intensive outpatient services to the most intensive level of care in an inpatient acute care hospital, and span healthcare, employment, housing and educational sectors. Effective services support shared decision making with adults, youth and families and promote independence and resilience. Behavioral health services form a linkage with primary care, child welfare, criminal and juvenile justice, education, aging, and domestic violence and sexual assault systems to maximize collaboration and improve outcomes for the people served. The provider system must achieve high quality standards and results and produce measurable outcomes. Services are provided in a manner to promote community integration and social inclusion, and also support families who are critical to achieving recovery and resiliency.

Services for Substance Use Disorders (SUD) Adults and Children

Grant funding is provided to local non-profit agencies approved by DBH to deliver specific levels of alcohol and drug treatment services. The Division's funding is primarily targeted to provide 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, as well as services for injection drug users at risk for infectious disease.

Psychiatric Emergency Services (PES)

Community behavioral health agencies receive funding for services intended to aid people in psychiatric crisis. Acknowledging that many people in crisis are under the influence of alcohol or other drugs, response incorporates assessment, stabilization and treatment to impact psychiatric and substance use symptoms. The service array may include crisis intervention, brief therapeutic interventions for stabilization, family, consumer and community wrap-around support, and follow-up services. Specialized services, such as outreach teams and residential crisis/respite services are also included. DHSS Behavioral Health also responds to disasters and seeks federal aid for events that qualify as officially 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, psychiatry, medication management, case management, and rehabilitative services. Specialized services include residential and acute intensive services.

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, psychiatry, medication 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, as close to home as possible, and include family as a critical element to recovery. Under the Bring the Kids Home initiative stakeholders work together to plan, develop in-state home and community-based services, change policy and invest resources to reduce the number of Alaskan youth in out-of-state residential psychiatric treatment centers and decrease out-of-state Medicaid expenditures.

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, stabilization 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 the Alaska Psychiatric Institute.

Using this funding, a local hospital provides the level of intervention required to stabilize the patient and return them to their community or home or to refer to the next higher level of care if needed. The service array includes inpatient psychiatric evaluation (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 then 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 as well as the Oregon Health Sciences University, Department of Psychiatry Residency Training Program.

Services provided at API include the following:

- Psychiatric 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 a recovery orientation
- Telepsychiatry services to reach remote areas of the state
- Metabolic clinic to screen for obesity, diabetes and other health risk related factors with a focus on wellness and prevention

API Advisory Board

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. This is a 'consumer-driven' advisory board with active participation in the API Quality Improvement process.

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
- Medicaid management

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.

The Division applies continuous quality improvement principles to business practice and management philosophy in relation to the **three core functions**, which are:

1. 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, co-occurring disorders, individuals with traumatic brain injury, and/or fetal alcohol spectrum disorders
2. Developing regulations and policies that govern the planning and implementation of services and supports for people who need behavioral health services
3. Promoting program standards, utilization management measures, quality requirements, provider performance expectations and client outcomes

The Division continues to implement new business practices in an ongoing commitment to the development of a performance management system, which guides policy and decision-making for improving the behavioral health of Alaskans. The performance management system impacts at several levels:

- Public service delivery system — the performance measures address the questions: 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 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? 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. The AKAIMS is an evolving web-based application and database that serves the dual purpose of a management information system (MIS) and an electronic medical record (EMR). As an MIS reporting tool, the system allows the division to meet current and emerging state and federal reporting requirements, such as state Quarterly Reporting, Treatment Episode Data Set (TEDS),

Government Performance and Results Act (GPRA), both Mental Health and Substance Abuse Block Grants and National Outcome Measurements (NOMs).

AKAIMS provides an agency the ability to create an EMR compliant with HIPAA and 42-CFR part II standards. Furthermore, the system gives providers a management tool which allows them to screen and assess clients, administer facilities, manage waitlists, measure data completeness, and measure staff productivity and collect outcome data in real-time via a secure, web-based framework.

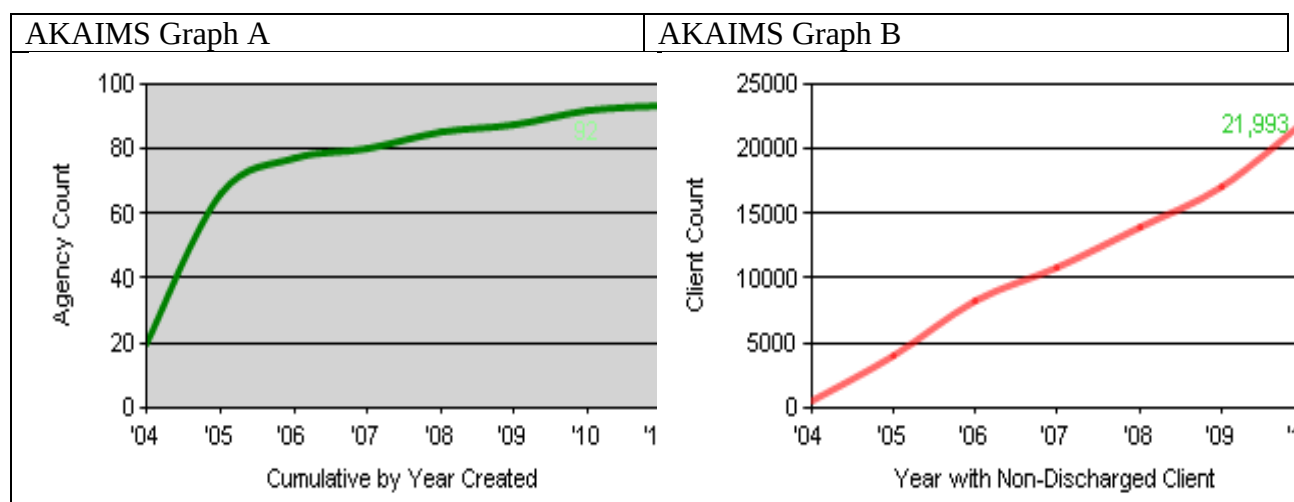
AKAIMS has been successfully implemented with 100% of grantee provider agencies now submitting data to the division. The grantee provider user network includes 96 service provider organizations, with a combined individual user group membership of over 2,000 individuals. The AKAIMS serves community-based outpatient behavioral health programs, residential, detox and Opioid treatment facilities. The scope of AKAIMS users has expanded and includes:

- The Office of Children Services (OCS) using AKAIMS as the electronic health record for the 35 Behavioral Rehabilitation Services (BRS) residential programs
- Therapeutic Courts initiating the “e-courts” module that will use the AKAIMS platform to manage court-referred clients to the treatment system
- The Alcohol Safety Action Program laying the groundwork for migrating its data collection system to the AKAIMS
- Division grantees who also provide Department of Corrections substance abuse services
- FASD Diagnostic Teams
- API interfacing with AKAIMS for coordination of discharge planning for clients re-entering services back in their community of origin

The accelerated utilization of AKAIMS is illustrated in with AKAIMS graphs “A and B” below. AKAIMS Graph B shows that from 2004 to 2010, there has been a 4,589% increase of client cases entered. Another measure of growth is in the volume of transactions that reflect data modifications performed over time. AKAIMS Table A immediately below shows that from FY08 to FY010, there has been an increase of 215% in such transactions.

AKAIMS Table A: Transaction Rates

FY05	FY06	FY07	FY08	FY09	FY10
16,634	327,417	421,445	698,486	1,151,702	2,199,353



The division successfully implemented the AKAIMS “Ad-hoc Reporting” module that allows all grantee agencies access to existing reports, as well as allowing them the ability to write their own. 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 help ensure quantity, quality, and outcomes are a shared value in 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. Alignment of the performance management system with the financing of the behavioral health system will ensure 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 performance-based funding 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.

Behavioral Health Medicaid Services

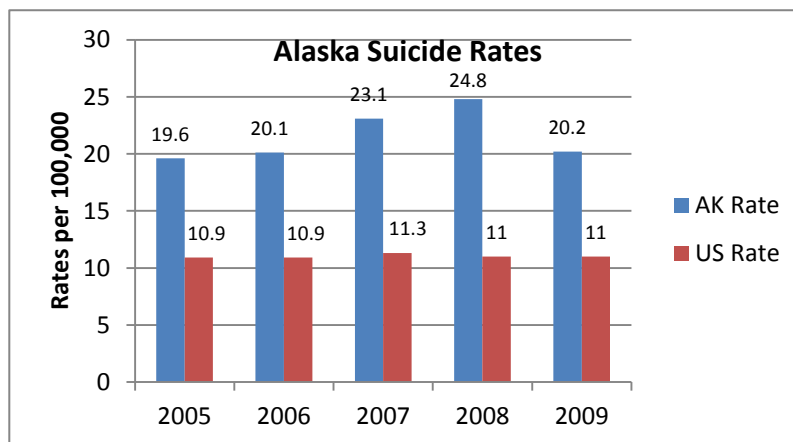
A combination of federal and matching state Medicaid funds support behavioral health services to Medicaid eligible individuals with a mental disorder or illness and/or a substance abuse disorder. These funds are managed by the division to maximize financial support for mental health and substance abuse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

Annual Statistical Summary of Services Provided in FY10

Prevention and Early Intervention Services Statistics

Alaska Suicide Data

Suicide is the second leading cause of death among Alaskans under age 50. According to the 2009 Youth Risk Behavior Survey, approximately 9 percent of high school students had attempted suicide in the past 12 months. Historically, most suicides occur among our young people ages 20-29 years and are equally represented in rural and urban communities. Alaska also has a high number of suicides among veterans. Seniors also have significantly higher rates of suicide.



Rates are per 100,000. 2009 AK rate is provisional. The Alaska Bureau of Vital Statistics, Last updated 8-20-10
*2008 and 2009 US rates are projected

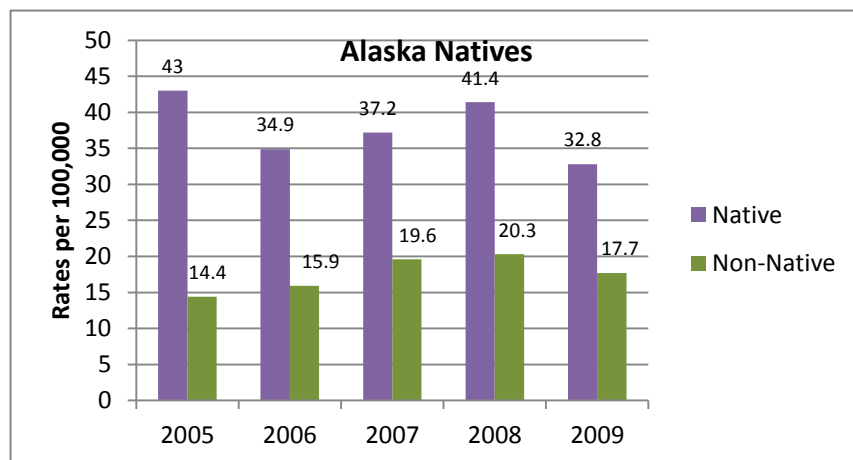
The distribution of suicide by ethnicity shows Alaska Natives comprise 16% of the population, however they account for 39% of the suicides. The highest rate of suicide in Alaska is among Alaska Native male teens and young adults between 15 – 29 years of age. Older adults and gay, lesbian, and transgender youth are also at an increased risk - as well as those with chronic medical illness, trauma, past sexual abuse, substance abuse and mental illness, the most common of which is depression.

♦ *Alaska Natives have rates more than double that of non-Native Alaskans.*

♦ *Non-Natives have a rate of 1 ½ - 2 times the U.S. rate.*

♦ *Rates also showed a drop in 2009.*

Alaska Bureau of Vital Statistics



Alaska Bureau of Vital Statistics, Last updated 8-20-10. *2009 rates are provisional.

Alcohol Safety Action Program Case Statistics

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
ASAP New Case Statistics				
Adult ASAP	2,018	2,049	1,776	1,327
Juvenile ASAP	549	517	488	386
Total ASAP	2,567	2,566	2,264	1,713
Adult Cases Completed & Closed	756	704	535	769
Juvenile Cases Completed & Closed	243	250	254	211
Therapeutic Court Statistics				
Point in Time Caseload (# participants at end of quarter)	72	73	78	101
New Admissions	17	18	14	19
Therapeutic Court Graduates	7	5	10	22

Eight of the probation officers with ASAP work with clients referred from the Therapeutic Court system. These are felony clients and mental health clients. Case management includes nearly daily contact, urinalyses, group sessions and weekly court sessions. The remaining five probation officers handle misdemeanor ASAP referrals.

Treatment and Recovery Services Statistics

As Behavioral Health moves forward in the development of new business practices the role of meaningful data increases in value and usefulness. In this respect, a performance management system becomes a valuable mechanism that supports and serves new business practices that are data driven and focus on outcomes. The goal of this performance management system is: To develop a continuous quality improvement process to guide policy development and decision making in improving the behavioral health of Alaskans.

Related questions to be answered by a performance management system include:

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

The DBH uses certain information and instruments to answer these critical questions.

- Access to Community Based Treatment Services
- The Alaska Screening Tool (AST)
- The Behavioral Health Consumer Survey (BHCS)
- The Client Status Review of Life Domains (CSR)

Access to Community-Based Treatment Services

In order to improve and enhance the quality of life of Alaskans who experience a behavioral health disorder, access to a comprehensive, integrated service system is critical. A measure of the number of individuals receiving community-based Behavioral Health services is; accessibility of services.

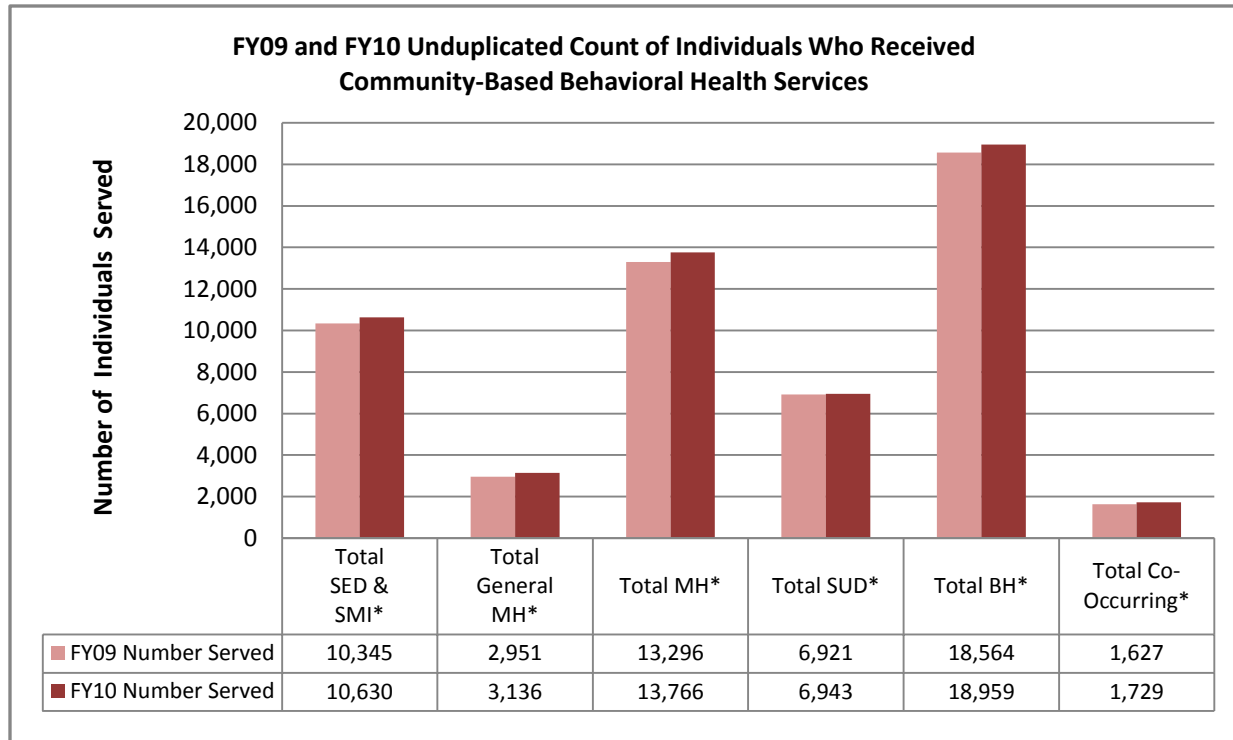
In FY10, the Division created a series of AKAIMS Uniform Reporting (UR) Tables for reporting client profile data. These tables were generated on October 20, 2010 and include data from all division grantee providers. Charts 1-4 below show the FY09 and FY10 unduplicated counts of individuals who received community-based Behavioral Health services. Highlights follow below.

Total Served: All Behavioral Health Disorders, including Mental Health, Substance Use, and / or Co-occurring (see Chart 1)

From FY09 to FY10 we find a:

- 2.1% increase in the total number of individuals who received Behavioral Health services (18,564 in FY09; 18,959 in FY10).
- 6.3% increase in the total number of individuals who received services for co-occurring disorders (1,627 in FY09; 1,729 in FY10).
- 3.5% increase in the total number of individuals who received mental health services (13,296 in FY09; 13,766 in FY10).
- 2.8% increase in the total number of SED Youth and SMI Adults who received mental health services (10,345 in FY09; 10,630 in FY10).
- 0.3% increase in the total number of individuals who received substance use disorder services (6,921 in FY09; 6,943 in FY10).
- 6.3% increase in the total number of Non-SED Youth and Non-SMI Adults who received mental health services (2,951 in FY09; 3,136 in FY10).

Chart 1



*** Key:**

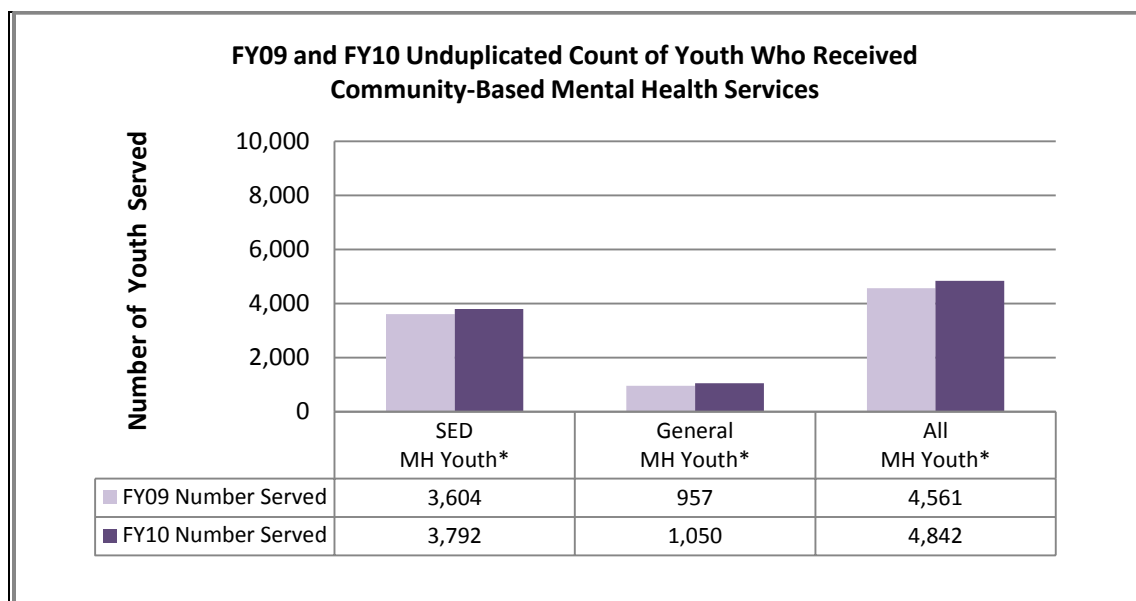
- **Total SED & SMI:** Youth with Serious Emotional Disturbance (SED) and Adults with Serious Mental Illness (SMI) receiving Mental Health (MH) services; includes individuals with Co-Occurring disorders (i.e., mental health and substance use disorders).
- **Total General MH:** Non-SED Youth and Non-SMI Adults receiving General Mental Health services; includes individuals with Co-Occurring disorders.
- **Total MH:** All Youth (SED and Non-SED) and All Adults (SMI and Non-SMI) receiving Mental Health services; includes individuals with co-occurring disorders.
- **Total SUD:** Youth and Adults receiving Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders.
- **Total BH:** All Youth and All Adults receiving Behavioral Health (BH) services (i.e., mental health and/or substance use disorder services); includes individuals with Co-Occurring disorders.
- **Total Co-Occurring:** Youth and Adults receiving services for Co-Occurring disorders.

Youth Served: Community-Based Mental Health Services (see Chart 2)

From FY09 to FY10 we find a:

- 5.2% increase in the number of SED Youth who received mental health services (3,604 in FY09; 3,792 in FY10).
- 6.2% increase in the number of all Youth who received mental health services (4,561 in FY09; 4,842 in FY10).
- 5.2% increase in the number of SED Youth who received mental health services (3,604 in FY09; 3,792 in FY10).
- 9.7% increase in the number of Non-SED Youth who received mental health services (957 in FY09; 1,050 in FY10).

Chart 2



*** Key:**

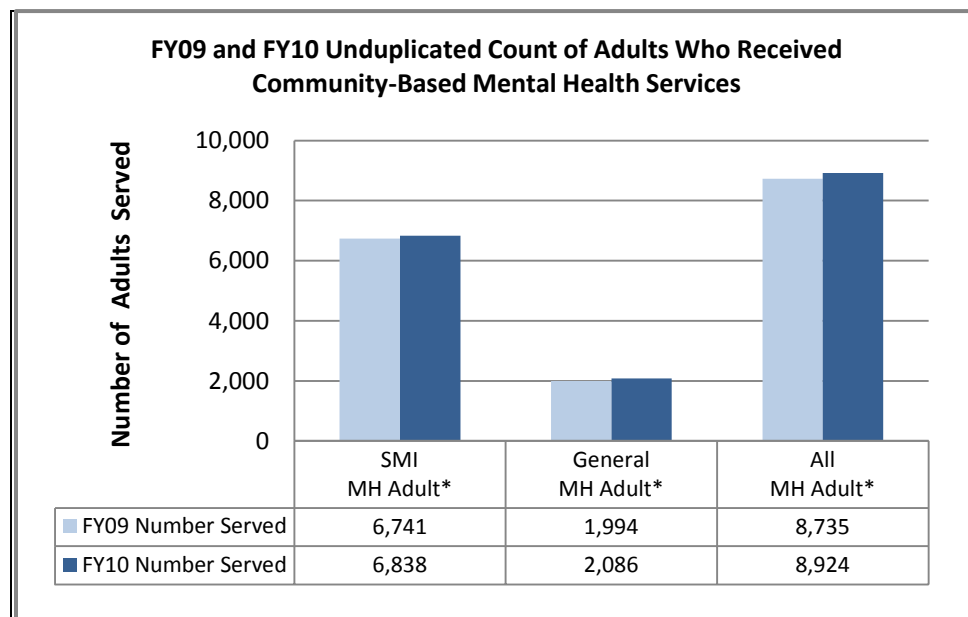
- **SED MH Youth:** Youth with Serious Emotional Disturbance (SED) receiving Mental Health (MH) services; includes individuals with co-occurring disorders (i.e., mental health and substance use disorders).
- **General MH Youth:** Non-SED Youth receiving General Mental Health services; includes individuals with Co-Occurring disorders.
- **All MH Youth:** All Youth (SED and Non-SED) receiving Mental Health services; includes individuals with Co-Occurring disorders.

Adults Served: Community-Based Mental Health Services (see Chart 3)

From FY09 to FY10 there was a:

- 1.4% increase in the number of SMI Adults who received mental health services (6,741 in FY09; 6,838 in FY10).
- 2.2% increase in the number of all Adults who received mental health services (8,735 in FY09; 8,924 in FY10).
- 4.6% increase in the number of Non-SMI Adults who received mental health services (1,994 in FY09; 2,086 in FY10).

Chart 3



*** Key:**

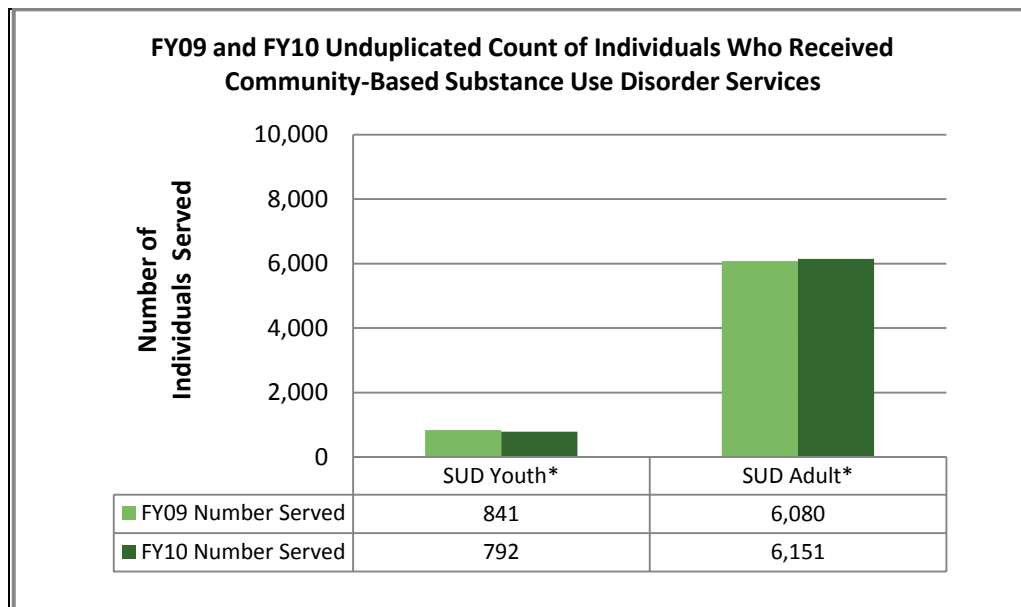
- **SMI MH Adult:** Adults with Serious Mental Illness (SMI) receiving Mental Health (MH) services; includes individuals with co-occurring disorders (i.e., mental health and substance use disorders).
- **General MH Adult:** Non-SMI Adults receiving General Mental Health services; includes individuals with co-occurring disorders.
- **All MH Adult:** All Adults (SMI and Non-SMI) receiving Mental Health services; includes individuals with co-occurring disorders.

Total Served: All Substance Use Disorders for Youth and Adults (see Chart 4)

From FY09 to FY10 we find a:

- 5.8% decrease in the number of SUD Youth who received substance use disorder services (841 in FY09; 792 in FY10).
- 1.2% increase in the number of SUD Adults who received substance use disorder services (6,080 in FY09; 6,151 in FY10).

Chart 4



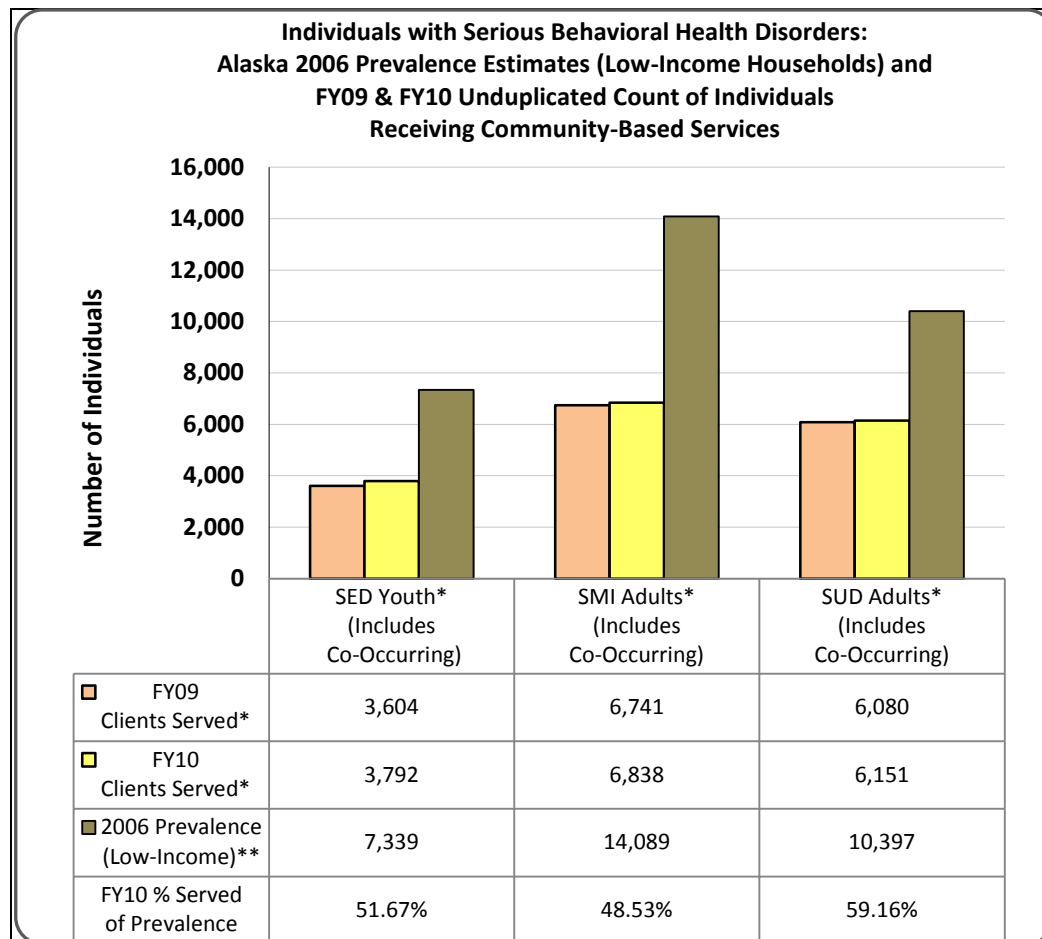
*** Key:**

- **SUD Youth:** Youth receiving Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders (i.e., mental health and substance use disorders).
- **SUD Adult:** Adults receiving SUD services; includes individuals with Co-Occurring disorders.

The Division, in collaboration with the Mental Health Trust and Advisory Boards, developed an Alaska-specific estimated prevalence of serious behavioral health disorders. However, estimated prevalence can only serve as a proxy in determining the level of need for treatment services. Not all individuals with severe behavioral health disorders necessarily desire or seek services. Therefore estimated prevalence is only an estimation of “true” need for services. There are different methods of estimating prevalence and a more conservative estimation is representative of true need.

Prevalence estimates can be used as a benchmark to measure penetration rates of behavioral health services. Chart 5 below compares the prevalence estimates (for low-income households) with the FY09 and FY10 unduplicated counts of individuals who received community-based services for serious behavioral health disorders. These prevalence estimates provide a basis for identifying unmet needs in Alaska’s low-income household population. Based on the 2006 prevalence estimates, the Division’s FY10 penetration rate for community-based services was 51.7% for SED Youth, 48.5% for SMI Adults, and 59.2% for SUD Adults. The Division is currently in the process of updating the Alaska prevalence estimates to reflect the 2007 census data.

Chart 5



* Clients served include individuals who received Behavioral Health community-based services for serious behavioral health disorders: Youth with Serious Emotional Disturbance (SED), Adults with Serious Mental Illness (SMI), and Adults with Substance Use Disorders (SUD). Counts for each category include individuals receiving services for co-occurring Disorders (i.e., mental health and substance use disorders). Data Source: AKAIMS DBH Uniform Reporting Tables (includes AKAIMS and EDI agencies); Data Source Date: October 20, 2010.

** Prevalence estimates are for SED Youth, SMI Adults, and SUD Adults. Prevalence for each category includes the co-occurring prevalence. Prevalence data source: 2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household; 15 January 2008.

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 is required of all clients prior to entering treatment services. 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
- identify the program needs of each agency
- ensure that people receive the indicated services
- assist the state in federal reporting requirements

Alaska Screening Tool Results FY10

	Screenings	Screening Outcomes				
		Substance Abuse	Mental Health	TBI	FASD	Dual Diagnosis
Total Counts	14261	9083	11514	4667	1393	7706
Total Percentages		63.6%	80.7%	32.7%	9.7%	54.0%

Data Source: The Alaska Automated Information Management System (AKAIMS) and five agencies using an electronic data interface. Data source date: November 2010.

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 FY10 Alaska Screening Tool results, out of a total of 14,261 screenings, indicate the following:

- 9,083 cases identified with Substance Abuse (SA) needs
- 11,514 cases identified with Mental Health (MH) needs
- 4,667 cases identified as suspected Traumatic Brain Injury
- 1,393 cases identified as suspected Fetal Alcohol Spectrum Disorders
- 7,706 cases identified as suspected dual diagnosis (MH & SA)

The Division of Behavioral Health initiated an upgrade of the Alaska Screening Tool (AST) during FY 2010 to improve the reliability and validity to screen for presenting need of service. The primary goal for the AST modification was to incorporate a brief screening for adverse experiences (trauma) and domestic violence, as well as a brief depression scale.

The Behavioral Health Consumer Survey (BHCS)

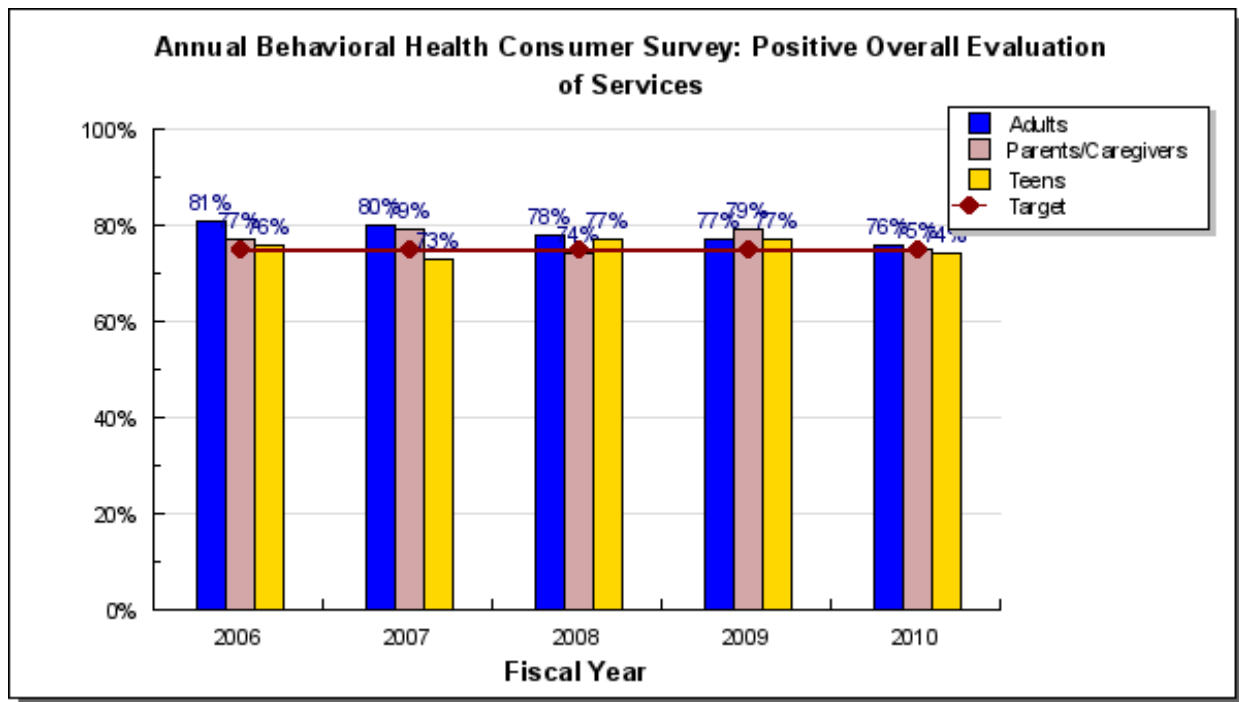
The BHCS is used to obtain information on client evaluation of Behavioral Health services. The survey includes questions about: access to services, quality and appropriateness of treatment, participation in treatment planning, general satisfaction, positive outcomes, improved functioning, and social connectedness. The Division initiated the BHCS for mental health providers in FY03. The application of the BHCS was expanded in FY06 to include substance abuse providers. Stakeholders are asked to assess the validity and reliability of the data, confirming with other data sources, and identifying ways to use the data to improve service delivery.

The survey questions regarding services focus on access, appropriateness, and outcome. Stakeholders are asked to assess the validity and reliability of the data, confirming with other data sources, and identifying ways to use the data to improve service delivery.

For the FY10 Annual BHCS, survey results for adults, parents/caregivers of youth, and teens are as follows:

- 76% of adults reported a positive overall evaluation of services.
- 75% of parents/caregivers of youth reported a positive overall evaluation of services.
- 74% of teens reported a positive overall evaluation of services.

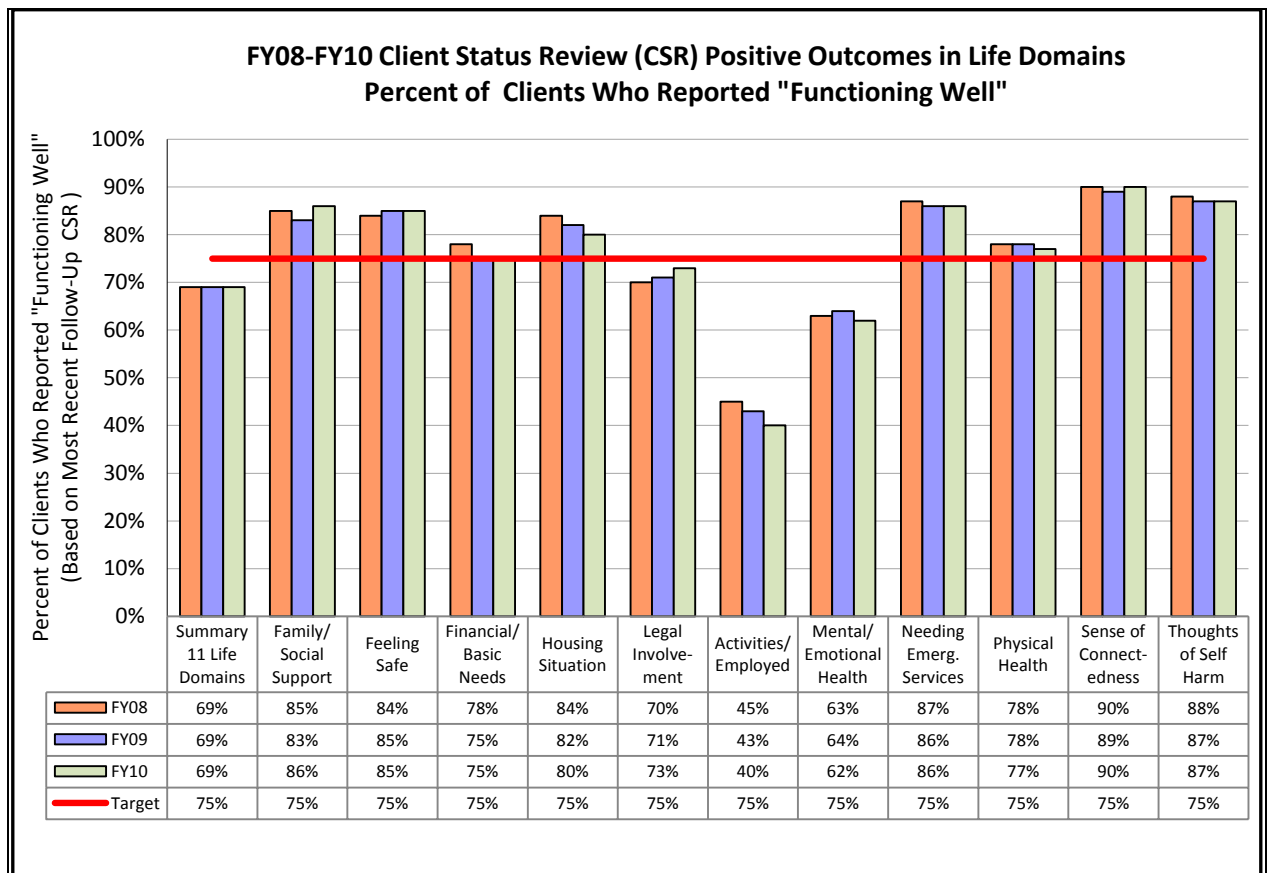
From FY06 to FY10 (for adults, parents/caregivers of youth, and teens), there were only small changes in respondents' evaluations of services. For adults, the percent reporting positive overall evaluation decreased slightly each year. For parents/caregivers of youth and for teens, there were small fluctuations from year to year. Generally, a higher percentage of adults reported positive evaluation of services than did parents/caregivers of youth and teens. Generally, a higher percentage of parents/caregivers of youth reported positive evaluation of services than did teens.



Methodology: The Division uses the Behavioral Health Consumer Survey (BHCS) to obtain information on client evaluation of behavioral health services. Grantees providing community-based services mail the Annual BHCS to clients who receive outpatient treatment services; surveys are returned to the Division for processing.

The Client Status Review (CSR)

The Client Status Review (CSR) is administered to clients at intake, periodically throughout treatment, and at time of discharge to assess functioning in eleven life domains and change-in - functioning over time. The chart below shows (for FY08, FY09, and FY10) the percentage of clients who reported “functioning well” on their most recent follow-up CSR. Note: The CSR is not required for clients receiving psychiatric emergency services and/or detoxification services.



Source: AKAIMS (includes AKAIMS and EDI agencies)

FY08 Report Date: December 2008

FY09 Report Date: August 2009

FY10 Report Date: August 2010

In FY08, FY09, and FY10, at least 75% of individuals who received community-based Behavioral Health services and completed a follow-up Client Status Review reported "functioning well" for the following eight life domains:

- Family Social Support
- Financial/Basic Needs
- Needing Emergency Services
- Sense of Connectedness
- Feeling Safe
- Housing Situation
- Physical Health
- Thoughts of Self Harm

In FY08, FY09, and FY10, less than 75% of individuals reported "functioning well" for the following three life domains:

- Legal Involvement (70%, 71%, and 73%, respectively)
- Meaningful Activities/Employment (45%, 43%, and 40%, respectively)
- Mental/Emotional Health (63%, 64%, and 62%, respectively)

The Division is making the following efforts to improve outcomes in these three life domains:

Legal Involvement

The Division will continue to work closely with the Trust's Disability Law group in the following areas:

- Therapeutic court treatment programs (Anchorage, Fairbanks, Palmer, and Bethel).
- Housing programs for adults with serious mental illness who have repeated episodes of incarceration. Programs include the Bridge Home (the "housing first" model places SMI adults in housing first and provides supportive services to keep them stable) and DOC's housing program for offenders exiting institutions.
- Encourage state grantees to contract with DOC on its APIC (Assess, Plan, Intervene, Coordinate) program to make sure that consumers leaving correctional facilities get the services to avoid relapse and incarceration.

Meaningful Activities/Employment

- DBH signed a MOA with the Division of Vocational Rehab to maximize collaboration to impact service delivery.
- DBH funds three supported employment programs.
- DBH participates in the Families' First initiative to provide services to families who are trying to get off public assistance and find employment.

Mental/Emotional Health

- DBH grantee treatment programs provide clinical services to help consumers improve their mental and emotional wellbeing.
- DBH funds three grants for consumer operated services, all of which help consumers take control of their own recovery, reduce their isolation, and increase their participation in meaningful activities.
- DBH started an Individualized Services Agreement program for seriously mentally ill (SMI) adults to help consumers with no or few resources get the service they need to function independently out of institutional care.

The Division's efforts to improve outcomes in all life domains include Enhanced Technical Assistance to grantees. This assistance is available to grantees experiencing programmatic or administrative difficulties. The Division works with grantees to develop quality assurance mechanisms by which program adjustments can be made based on CSR results.

The Division initiated an upgrade of the CSR during FY10 to improve the ability to assess change over time. The revised CSR instrument was implemented in AKAIMS in October, 2010. Specific focus was placed on the scoring methodology, the language used to ask questions, the number of questions necessary to measure change, and aligning questions with national data requirements (i.e., Block Grants reporting requirements for substance abuse and mental health, including National Outcome Measures). 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).

Bring the Kids Home (BTKH) Initiative Statistics

Early in the planning process of the BTKH Initiative, measuring progress was valued and given priority in the development of strategies for project implementation. Seven indicators were defined by identified priority areas of the service delivery system in order to measure progress of the BTKH Initiative. The indicators are presented in their original form, with modification as indicated.

Below are highlights of FY10 BTKH Indicators Report.

Indicator 1: Client Shift - A reduction in the total number of SED children / youth admitted to out-of-state RPTC care by 90 percent by FY12 (15% per year) ³

Findings: (Reference Table 1-4b)

Residential Psychiatric Treatment Center (RPTC) admissions, as a whole, steadily increased from FY98 through FY04. From FY05 to the present, there has been a decrease every year. For FY09:

- The distinct number of In-State Custody RPTC recipients “admitted” during FY10 **decreased** by 66% (from 86 to 29).
- The distinct number of Out-Of-State Custody RPTC recipients “admitted during FY10 **increased** by 53% (from 19 to 29).
- The distinct number of In-State Non-Custody RPTC recipients “admitted” during FY10, **decreased** by 13% (from 203 to 176).
- The distinct number of Out-of-State Non-Custody RPTC recipients “admitted” during FY10, **decreased** by 33% (from 91 to 61).
- The distinct number of total RPTC admissions for FY10 **decreased** by 26% (from 399 to 295).

Cross-year analysis targeting the year with the highest admission rates, and comparing with FY10 indicates that:

- The total RPTC admissions for FY10 are 69.4% **lower** than FY04 (from 965 to 295)
- The In-State Custody RPTC recipients “admitted” during FY10 are 67% **lower** than FY05 (from 86 to 29).
- The Out-Of-State Custody RPTC recipients “admitted” during FY10 are 84% **lower** than FY04 (from 181 to 29).
- The In-State Non-Custody RPTC recipients “admitted” during FY10 are 30% **lower** than FY07 (from 252 to 176).
- Out-of-State Non-Custody RPTC recipients “admitted” during FY10 is 89% **lower** than FY04 (from 571 to 61).

³ This indicator has been modified during this reporting period. The previous indicator #1 read: Client Shift- A reduction in the total number of SED children / youth placed in out-of-state RPTC care by 90 percent by SFY 2012 (15% per year)

Table 1

Unduplicated Count of Medicaid RPTC Recipients "Admitted"										
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Custody In-State	72	75	73	65	89	64	71	61	86	29
Custody Out-of-State	77	82	127	181	102	115	69	40	19	29
Non-Custody In-State	120	128	153	148	185	127	252	150	203	176
Non-Custody Out-of-State	304	355	425	571	387	358	228	162	91	61
Total	573	640	778	965	763	664	620	413	399	295

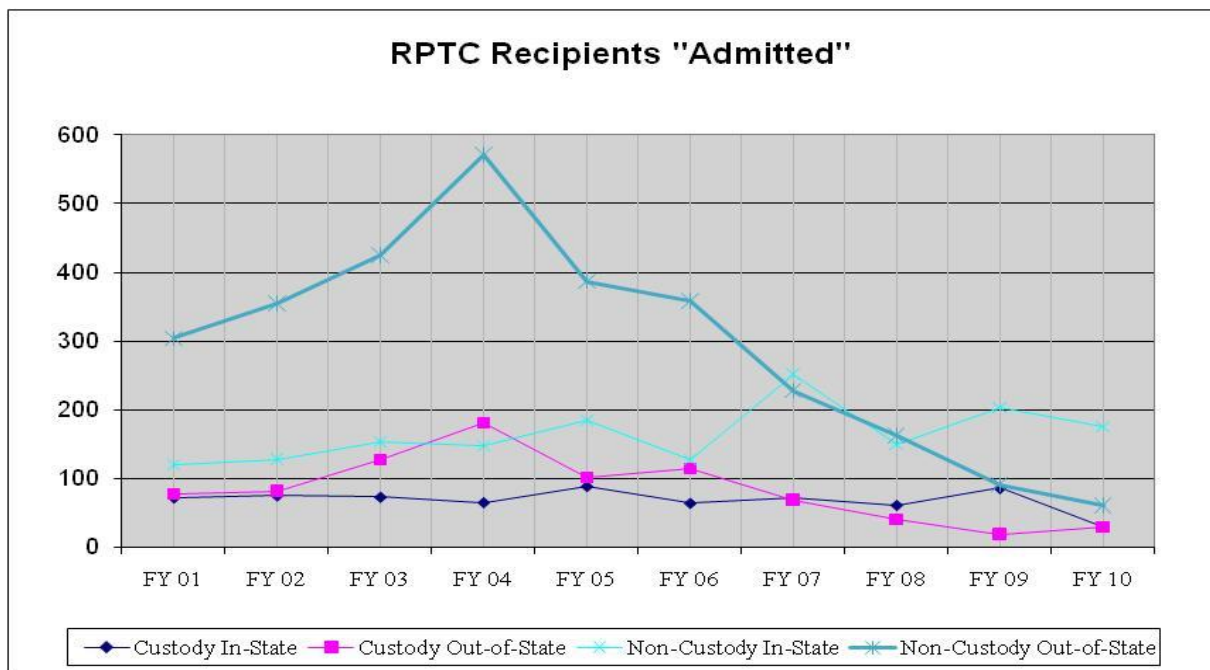
Data Source: MMIS SFY 10

Table 2

Percentage of Increase /Decrease) between FYs - Distinct RPTC Medicaid Recipients "Admitted"										
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Custody In-State		4.0%	-2.7%	-11.0%	27.0%	-28.1%	9.9%	-14.1%	29.1%	-66%
Custody Out-of-State		6.1%	35.4%	29.8%	-43.6%	11.3%	-40.0%	-42.0%	-52.5%	53%
Non-Custody In-State		6.3%	16.3%	-3.3%	20.0%	-31.4%	49.6%	-40.5%	26.1%	-13%
Non-Custody Out-of-State		14.4%	16.5%	25.6%	-32.2%	-7.5%	-36.3%	-28.9%	-43.8%	-33%
Total		10.5%	17.7%	19.4%	-20.9%	-13.0%	-6.6%	-33.4%	-3.4%	-26%

Data Source: MMIS SFY 10

Graph 1



The distinct number of SED youth receiving RPTC treatment, as a whole, has steadily increased – on average of 24.8% per year during FY98 through FY04 (ranging from 13-65%). Between FY98 and FY04 the distinct number of SED youth receiving out-of-state RPTC care has steadily increased- on average 46.7% per year (ranging from 17-80%).

For FY10, for the distinct number of (Reference Table 3 – 4):

- Out-Of-State RPTC recipients during FY10 **decreased** by 31% (from 318 to 221).
- In-State RPTC recipients during FY10 **increased** by 1.2% (from 378 to 384).
- Total RPTC recipients during FY10 **decreased** by 13% (from 696 to 605).

Cross-year analysis targeting the year with the highest and/or lowest utilization rates, and comparing with FY 10 indicates that:

- The number of Out-Of-State RPTC recipients during FY10 is 70.4% **lower** than FY 04 (from 749 to 221).
- The number of In-State RPTC recipients during FY10 are 1% **lower** than FY07 (from 388 to 384) and **increased** 176% over FY98.
- The distinct number of all RPTC recipients during FY10 is 41.4% **lower** than FY06 (from 1033 to 605).

Table 3a

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY04 - FY10)							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Out-of-State	749	711	743	596	478	318	221
In-State	216	291	290	388	369	378	384
Total	965	1002	1033	984	847	696	605

Table 3b

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY98 - FY03)						
	FY98	FY99	FY00	FY01	FY02	FY03
Out-of-State	83	149	247	429	539	637
In-State	139	217	221	211	208	215
Total	222	366	468	640	747	852

Data Source: MMIS SFY 10

Table 4a

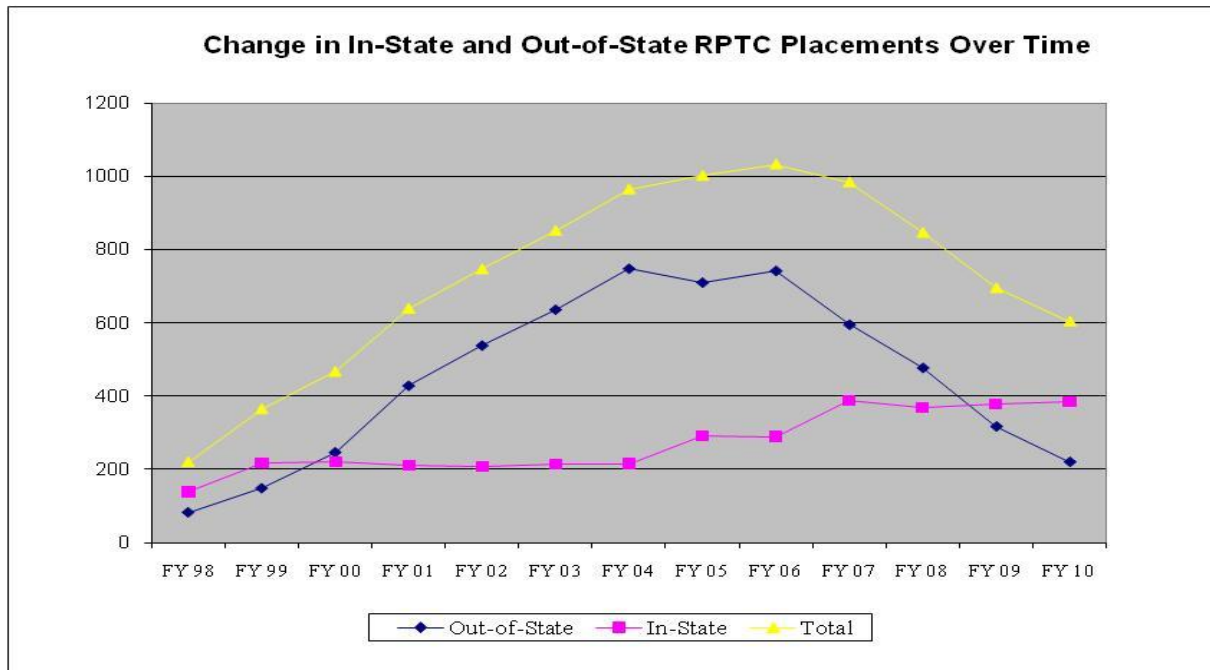
Percentage of Increase (Decrease) between FYs - Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY04 - FY10)							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Out-of-State	17.60%	-5.10%	4.50%	-19.80%	-19.80%	-33.50%	-31%
In-State	0.50%	34.70%	-0.30%	33.80%	-4.90%	2.40%	1.20%
Total	13.30%	3.80%	3.10%	-4.70%	-13.90%	-17.80%	-13%

Table 4b

Percentage of Increase (Decrease) between FYs - Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY98 - FY03)						
	FY98	FY99	FY00	FY01	FY02	FY03
Out-of-State		79.50%	65.80%	73.70%	25.60%	18.20%
In-State		56.10%	1.80%	-4.50%	-1.40%	3.40%
Total		64.90%	27.90%	36.80%	16.70%	14.10%

Data Source: MMIS SFY 10

Graph 2



Indicator 2: Funding Shift- Ninety percent reduction in Medicaid / General Fund match dollars from out-of-state services to SED children / youth with a corresponding increase in Medicaid / General Fund match dollars for in-state services by FY 12 (15 percent per year).

Findings: (Reference Table 5a – 6b)

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%. During the same time period in-state RPTC Medicaid expenditures increase a little more than 300% and realized smaller average annual increases of 29.6%.

For FY10, in comparison to FY09:

- Out-of-State RPTC Medicaid expenditures **decreased** by 22%.
- In-State RPTC Medicaid expenditures **decreased** by 4%.
- Total RPTC Medicaid expenditures **decreased** by 13%.

Cross-year analysis targeting the year with the highest and/or lowest utilization rates, and comparing with FY10 indicates that:

- Out-of-State RPTC Medicaid expenditures for FY10 are 62% lower than FY06.
- Total RPTC Medicaid expenditures for FY10 are 38.8% lower than FY07.

Table 5a

RPTC Medicaid Claims Payments by Fiscal Year (FY04 - FY09)							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Out-of-State	37,794,039	38,202,707	40,008,891	36,745,804	26,848,252	19,487,410	15,191,809
In-State	11,532,083	13,812,640	14,297,112	20,888,007	20,896,822	20,867,295	20,049,751
Total	49,326,122	52,015,347	54,306,003	57,633,811	47,745,074	40,354,705	35,251,550

Data Source: MMIS SFY 10

Table 5b

RPTC Medicaid Claims Payments by Fiscal Year (FY98 - FY03)						
	FY98	FY99	FY00	FY01	FY02	FY03
Out-of-State	2,609,857	5,098,189	9,873,606	17,609,108	21,175,228	30,915,287
In-State	2,823,582	5,623,348	6,286,219	8,242,948	9,229,970	10,093,200
Total	5,433,439	10,721,537	16,159,825	25,852,056	30,405,198	41,008,487

Table 6a

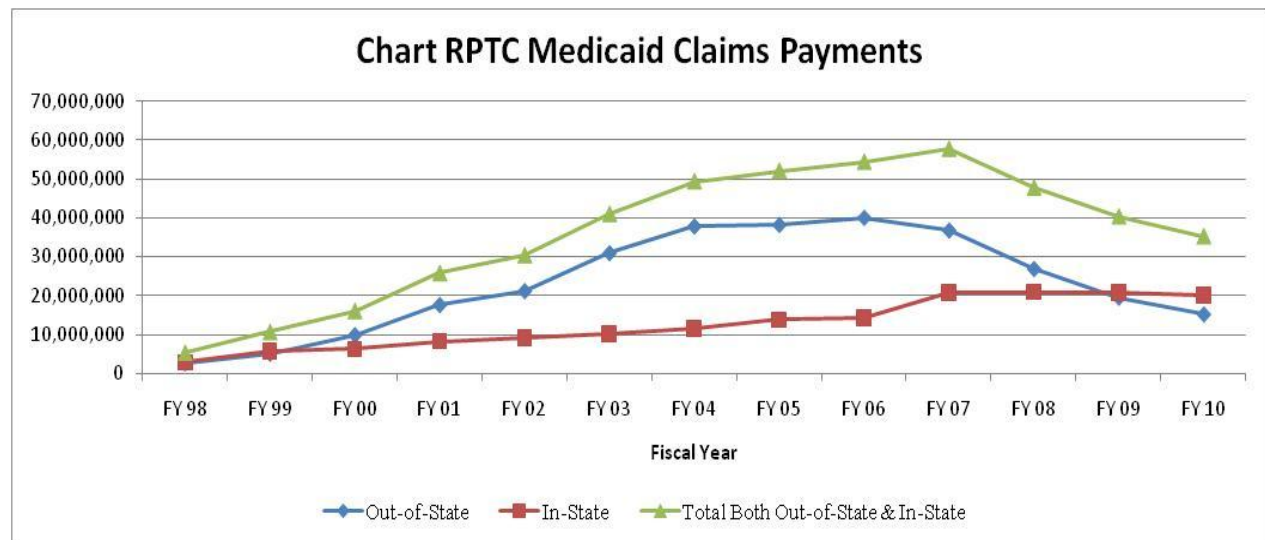
Percentage of Increase (Decrease) between FYs - Medicaid RPTC Claims Payments (FY04 - FY10)							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Out-of-State	18.2%	1.1%	4.5%	-8.2%	-26.9%	-27.4%	-22%
In-State	12.5%	16.5%	3.4%	31.6%	0.0%	-0.1%	-4%
Total	16.9%	5.2%	4.2%	5.8%	-17.2%	-15.5%	-13%

Data Source: MMIS SYF 10

Table 6b

Percentage of Increase (Decrease) between FYs - Medicaid RPTC Claims Payments (FY98 - FY03)						
	FY98	FY99	FY00	FY01	FY02	FY03
Out-of-State		48.8%	48.4%	43.9%	16.8%	31.5%
In-State		49.8%	10.5%	23.7%	10.7%	8.6%
Total		49.3%	33.7%	37.5%	15.0%	25.9%

Graph 3



Indicator 3: Length of Stay - Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by FY12.

Findings: (Reference Table 7 – 8)

For FY10, the Average Length of Stay for RPTC:

- Custody In-State: 161 days. **Increase** of 22 days (14%) from FY09.
- Custody Out-of-State: 512 days. **Increase** of 23 days (4%) from FY09.
- Non-Custody In-State: 169 days. **Increase** of 7 days (5%) from FY09.
- Non-Custody Out-of-State: 366 days. **Increase** of 30 days (3.8%) from FY09.

Table 7

Average Length of Stay (in days)										
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Custody In-State	140	160	150	170	156	167	181	156	139	161
Custody Out-of-State	255	325	293	331	414	323	316	337	489	512
Non-Custody In-State	133	111	121	135	146.5	227	145	197	161	169
Non-Custody Out-of-State	196	223	269	272	322	304	353	323	336	366

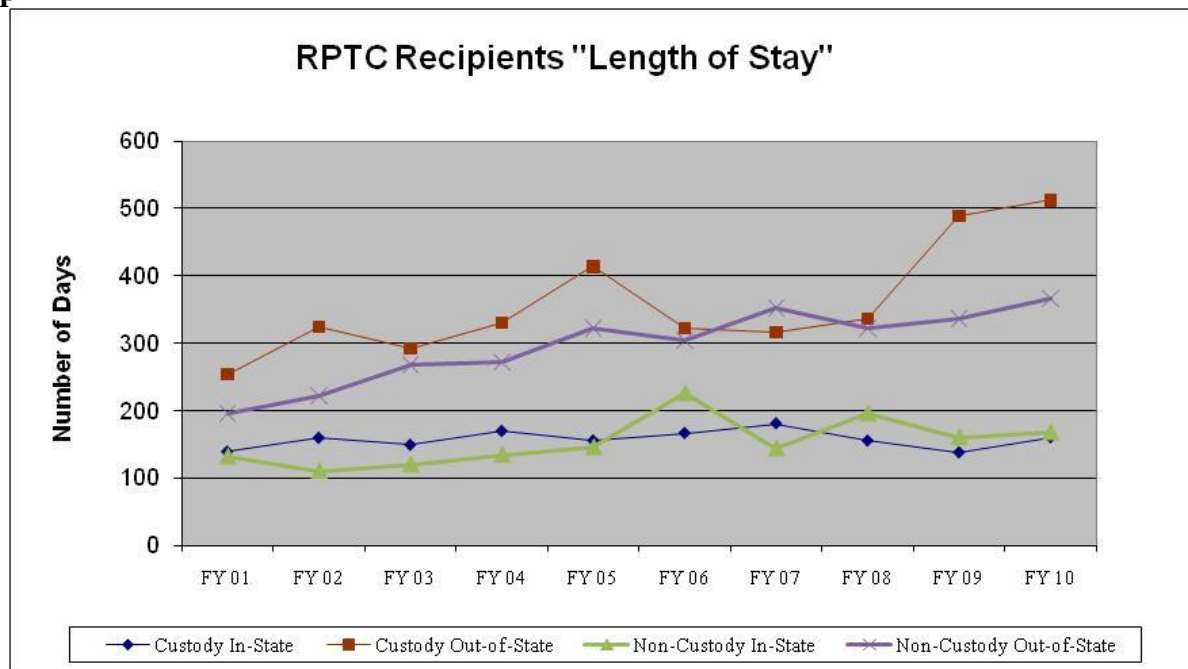
Data Source: MMIS SFY 10

Note: This data were re-calculated over the 10 year period using a methodology that reflects a more precise length of stay over time.

Table 8

Percentage of Increase (Decrease) between FYs – Average Length of Stay										
	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Custody In-State		13%	-6%	12%	-8%	7%	8%	-14%	-11%	14%
Custody Out-of-State		22%	-10%	11%	20%	-22%	-2%	6%	31%	4%
Non-Custody In-State		-17%	8%	10%	8%	35%	-36%	26%	-18%	5%
Non-Custody Out-of-State		12%	17%	1%	16%	-6%	14%	-8%	4%	8%

Data Source: MMIS SFY 10

Graph 4

Indicator 4: Service Capacity – Increase in the number of in-state residential beds for children/youth by 60 percent by FY12 (10 percent per year).⁴

Findings: (Reference Table 9)

Table 9

	FY00	FY01	FY02	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 and RPTC's.

Note: Estimates show a 15% increase in bed capacity for FY10 for an estimated total 1,020 beds.

⁴ This indicator has been modified during this reporting period. The previous indicator #4 read: *Service Capacity – Increase in the number of children /youth receiving home and community based services in communities or regions.*

Indicator 5: Recidivism: Decrease in the number of children/youth returning to RPTC and acute hospitalization care by 75% by FY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year).⁵

Findings: (Reference Table 10)

For FY10,

- Custody In-State recidivism rate was 2%.
- Custody Out-of-State recidivism rate was 19%
- Non-Custody In-State recidivism rate was 9%.
- Non-Custody Out-of-State recidivism rate was 9%.
- For FY10, the over-all recidivism rate was 8.6% (35 cases) for readmission to an RPTC within 365 days of the discharge date.
- Of the 35 cases that experienced a readmission to an RPTC within 365 days of discharge:
 - 13 cases were readmitted in 1-30 days of discharge
 - 17 cases were readmitted in 31-180 days of discharge
 - 5 cases were readmitted in 181-365 days of discharge
- The FY10 over-all recidivism rate of 8.6% (35 cases) is compared to:
 - FY09 rate of 3.4% (16 cases)
 - 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)

Table 10

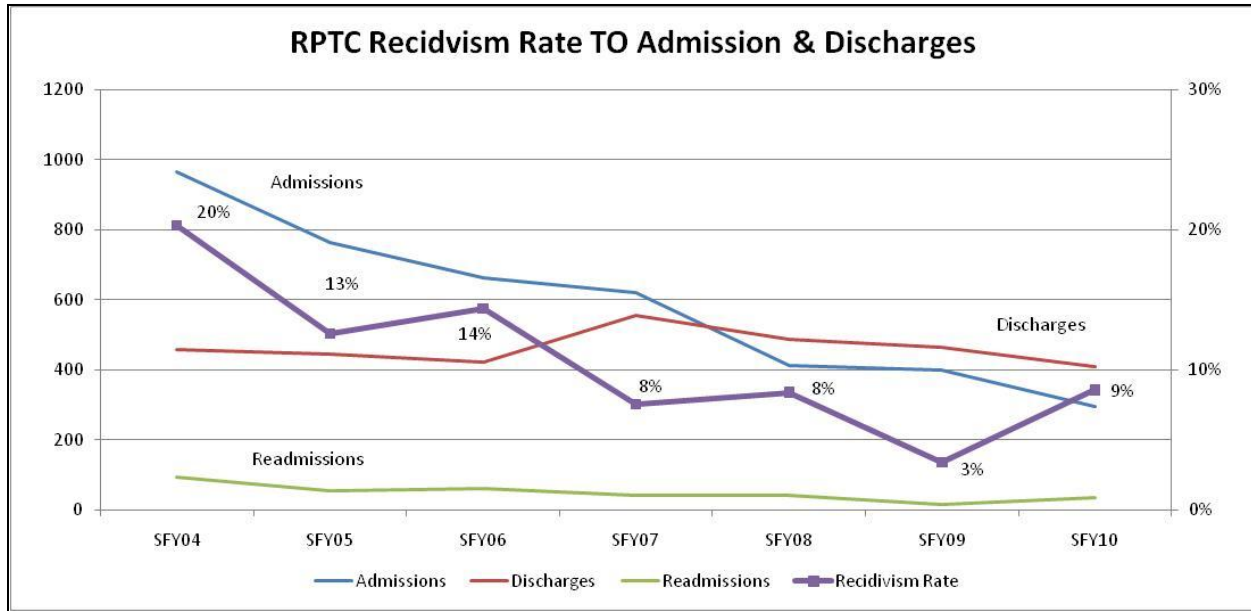
RPTC Recidivism Rates								
Custody Status	Placement	Discharges by FY		Readmissions Following Discharge within...			Total Readmits	%
				1-30 days	31 – 180 days	81 – 365 days		
Custody	In-State	FY 04	51	4	2	1	7	13%
		FY 05	73	4	2	2	8	11%
		FY 06	56	1	8	3	12	21%
		FY 07	68	1	4	2	7	10%
		FY 08	52	0	1	1	2	4%
		FY 09	91	1	--	--	1	1%
		FY 10	59	--	1	--	1	2%
Custody	OOS	FY 04	39	2	7	2	11	28%
		FY 05	32	1	4	1	6	19%

⁵ This indicator has been modified during this reporting period. The previous indicator #5 read: *Effectiveness: Decrease in the number of children/youth returning to residential care by 75% by FY12. Defined as children/youth returning within one year to the same or higher level of residential care.*

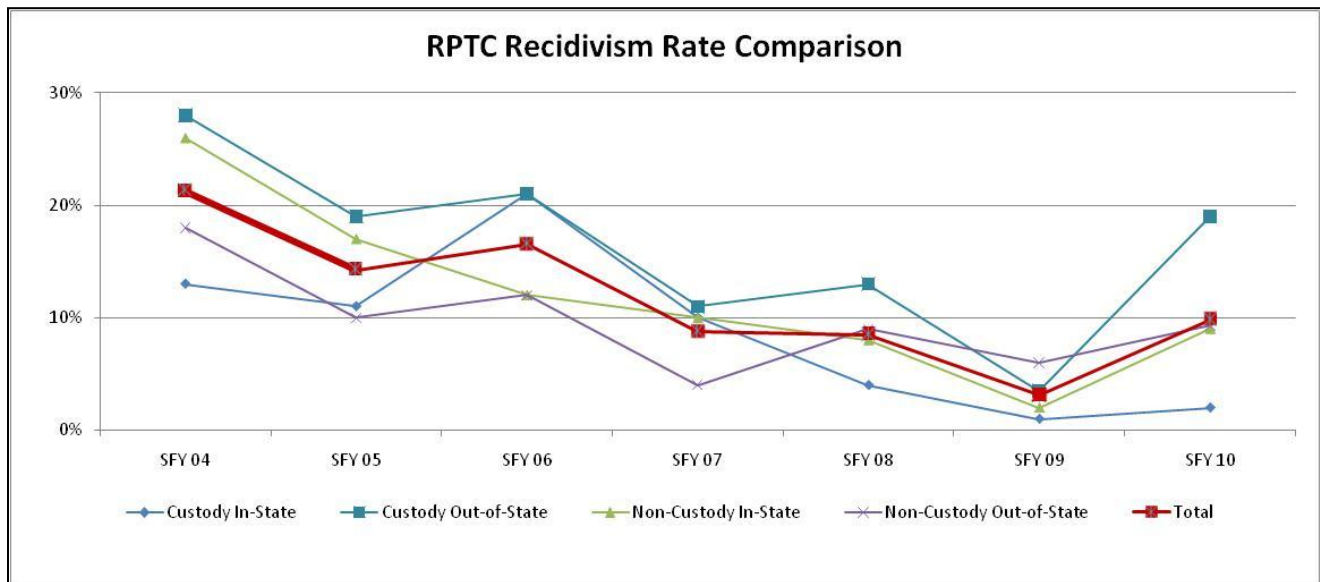
RPTC Recidivism Rates								
Custody Status	Placement	Discharges by FY		Readmissions Following Discharge within...			Total Readmits	%
				1-30 days	31 – 180 days	81 – 365 days		
		FY 06	52	3	4	4	11	21%
		FY 07	55	2	4	0	6	11%
		FY 08	37	3	1	1	5	13%
		FY 09	28	1	--	--	1	3.5%
		FY 10	16	3	--	--	3	19%
Non-Custody	In-State	FY 04	106	12	10	6	28	26%
		FY 05	92	10	5	1	16	17%
		FY 06	81	2	5	3	10	12%
		FY 07	194	12	6	1	19	10%
		FY 08	205	10	4	3	17	8%
		FY 09	204	--	3	2	5	2%
		FY 10	236	3	14	5	22	9%
Non-Custody	OOS	FY 04	262	12	20	15	47	18%
		FY 05	248	6	13	7	26	10%
		FY 06	235	8	13	7	28	12%
		FY 07	239	4	5	1	10	4%
		FY 08	194	5	9	3	17	9%
		FY 09	143	5	3	1	9	6%
		FY 10	97	7	2	--	9	9%

Data Source: MMIS SFY 10

Graph 5



Graph 6



*** NOTE:**

- The data for Indicator #5 reflects RPTC re-admissions, and does not include admits to acute level of care.
- This data does not include lateral transfers from one RPTC facility to another.

Indicator 6: Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered.⁶

Behavioral Health has implemented a performance management system.⁷ The goal is to develop an outcomes measurement and management capacity that will provide accountability and consistency in the evaluation and effectiveness of behavioral health services. It is the intent of the BTKH planning effort to include residential services into the Performance Management System.

July FY10, Behavioral Health implemented the residential version of the Behavioral Health Consumer Survey (BHCS)⁸ as the instrument to measure the client satisfaction of RPTC services. The administration and management of this process will follow the administration and implementation schedule as defined in the current Performance Measures System Policy (located at: http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm).

Methodology: The month after client discharge UR staff makes a collective effort to contact clients' discharge placement to gather correct mailing addresses. Clients over the age of 18 and Client guardians are informed that they will receive an RPTC BHCS to be completed and returned in the paid postage envelop. When the data are received by DBH they are entered and will be reported and analyzed with the same methodology as the Community-Based BHCS.

Alaska Psychiatric Institute “Dashboard” of Key Performance Measures

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 co-occurring psychiatric and substance abuse disorders (COPSD), 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

⁶ This indicator has been modified during this reporting period. The previous indicator #6 read: *Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered*

⁷ http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm

⁸ As part of a statewide effort to evaluate and improve behavioral health services, the Division of Behavioral Health (DBH), The Alaska Mental Health Trust Authority (AMHTA), and the Alaska Mental Health Board (AMHB) developed the *Performance Measures Project* initiated July 1, 2002. The Mental Health Statistics Improvement Program (MHSIP) was selected as the consumer survey. In 2006, the MHSIP was adapted into the *Behavioral Health Consumer Survey* (BHCS).

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 08/09/10)
National Comparison Data



<i>Indicator</i>	<i>API CY 09 4th Qtr</i>	<i>Last Quarter's Comparison to Goal</i>			<i>Goal (Annual National Avg.)</i>	<i>API CY 08 4th Qtr</i>	<i>API CY 09 1st Qtr</i>	<i>API CY 09 2nd Qtr</i>	<i>API CY 09 3rd Qtr</i>
Patient Injury Rate	0.84		▲	Nat. Avg.	▼ (0.44)	0.53	0.00	2.16	0.83
Elopement Rate	0.35		▲	Nat. Avg.	▼ (0.20)	0.19	0.17	0.36	0.17
Medication Error Rate	7.64		▲	Nat. Avg.	▼ (2.42)	2.92	4.24	5.56	6.07
Prevalence of COPSD	48.76		▲	Nat. Avg.	▼ (38.04)	50.52	48.78	45.70	53.07
30 Day Re-admit Rate (Discharge Cohort)	14.47		▲	Nat. Avg.	▼ (7.97)	12.25	15.47	14.73	12.64

Patient Seclusion and Restraint

Hours of Restraint Use	0.24		▼	Nat. Avg.	▼ (0.57)	0.07	0.06	0.14	0.03
% of Patients Restrained	1.18		▼	Nat. Avg.	▼ (3.84)	0.69	0.84	1.56	0.37
Hours of Seclusion Use	0.08		▼	Nat. Avg.	▼ (0.55)	0.07	0.21	0.82	0.00
% of Patients Secluded	1.20		▼	Nat. Avg.	▼ (2.58)	0.69	1.50	0.78	0.18

Patient Seclusion and Restraint

				(CI Range)						
Patient Outcome	68.16		▲	(61.44 – 84.92)	▲	(76.50)	64.58	73.46	70.39	72.40
Patient Dignity	84.41		▲	(70.85 – 92.25)	▲	(80.17)	79.79	81.99	79.45	82.61
Patient Rights	75.63		▲	(52.26 – 80.19)	▲	(64.94)	63.29	62.66	61.49	66.49
Patient Participation	76.54		▲	(64.39 – 90.92)	▲	(73.62)	75.30	78.56	72.05	78.89
Hospital Environment	77.25		▲	(61.54 – 90.25)	▲	(68.13)	69.43	63.31	72.22	76.50

Hospital Measures										
Indicator	API CY 09 4 th Qtr	Last Quarter's Comparison to Goal			Goal (API's Previous 4 Qtr Avg.)	API CY 08 4th Qtr	API CY 09 1 st Qtr	API CY 09 2 nd Qtr	API CY 09 3 rd Qtr	
Seclusion, total number of	6		▼	4 Qtr. Avg.	▼ (9.75)	5	13	20	1	
Seclusion, total time (hrs.)	10:47		▼	4 Qtr. Avg.	▼ (47:44)	4:50	34:57	145:27	5:40	
Restraint, total number of	11		▲	4 Qtr. Avg.	▼ (6.75)	5	4	10	8	
Restraint, total time (hrs.)	33:26		▲	4 Qtr. Avg.	▼ (13:35)	6:44	8:25	19:04	20:06	
Court Ordered Medications	17		▼	4 Qtr. Avg.	▼ (24.00)	28	18	24	26	
180 Day Adult Re-admit Rate %	29.44		▲	4 Qtr. Avg.	▼ (27.68)	34.55	22.30	26.44	27.42	
Nurse Mandatory OT (hr.)	34.00		▼	4 Qtr. Avg.	▼ (84.69)	44.00	82.50	140.25	72.00	
Nurse Voluntary OT (hr.)	1388.75		▼	4 Qtr. Avg.	▼ (1485.19)	1535.25	1660.50	1436.75	1308.25	
Nurse Vacancy Rate (%)	2		▼	4 Qtr. Avg.	▼ (10.00)	16	6	8	10	
Patient Assaults*	46		▲	4 Qtr. Avg.	▼ (38.25)	33	45	34	42	
All Staff Injuries*	47		▲	4 Qtr. Avg.	▼ (39.75)	43	47	35	34	

Key to Icons:  Goal was not met  Goal was met or exceeded for the quarter listed

Behavioral Health Medicaid Service Statistics

During FY10, Medicaid funded behavioral and mental health services for 12,083 Alaskans, 9.6% of all those enrolled in the Alaska Medicaid program during the year. Most were children or disabled individuals. Residential psychiatric treatment center (RPTC) services are restricted to children who have a documented psychiatric need that cannot be treated in a community setting. Inpatient psychiatric hospital services are limited to children and adults over 65 who have a documented psychiatric need for acute services. The numbers of beneficiaries served in these categories largely reflect these service limitations. Community mental health services were distributed evenly between adults and children; however, the cost of providing community services to children who suffer from a severe emotional disturbance is significantly greater than adult services. Please note that one beneficiary over 21 was served in an RPTC as program rules allow beneficiaries to continue this service until their 22nd birthday if the individual was receiving services in an RPTC on their 21st birthday.

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
Children	51.0%	6,284	72.1%	\$107,000.6	\$17,027
Disabled Children	4.0%	489	9.7%	\$14,381.2	\$29,409
Elderly	1.5%	190	0.6%	\$902.6	\$4,751
Disabled Adults	27.9%	3,438	15.2%	\$22,613.3	\$6,577
Adults	15.5%	1,914	2.3%	\$3,433.8	\$1,794
Unduplicated Annual Clients		12,083			
Total Medicaid Claim Payments (thousands)				\$148,331.5	
Average Annual Medicaid Cost per Beneficiary					\$12,276

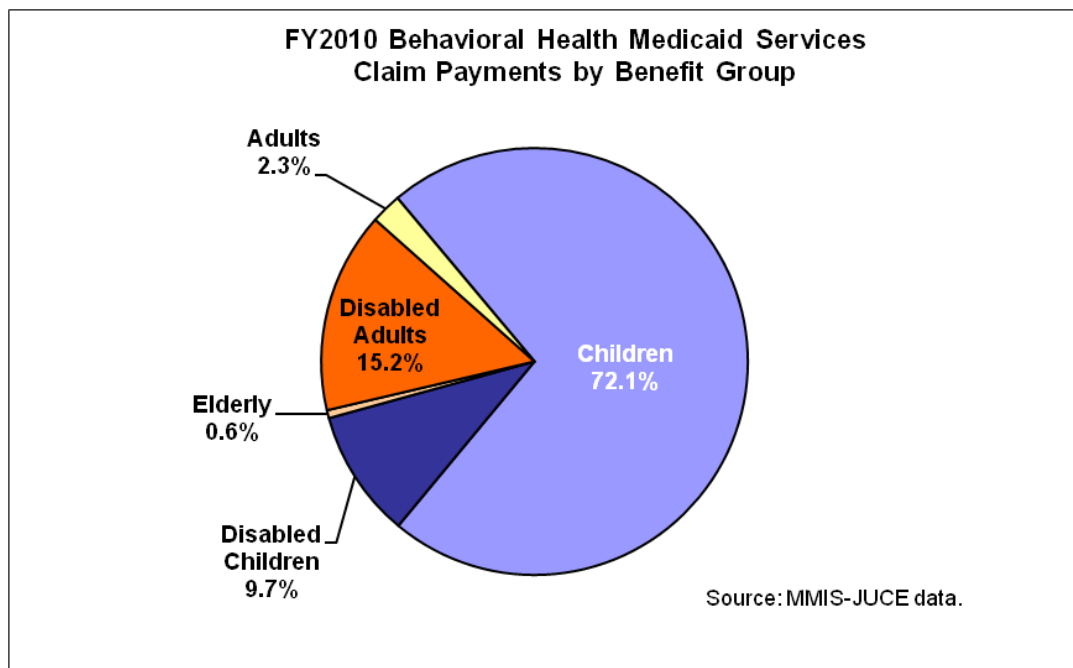
Source: MMIS/JUCE claims paid during FY2010. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

This reflects a 2% increase (or 222) in Number of Beneficiaries from FY 2009. In addition, the Average Annual Medicaid Cost per Beneficiary increased by \$1,011.

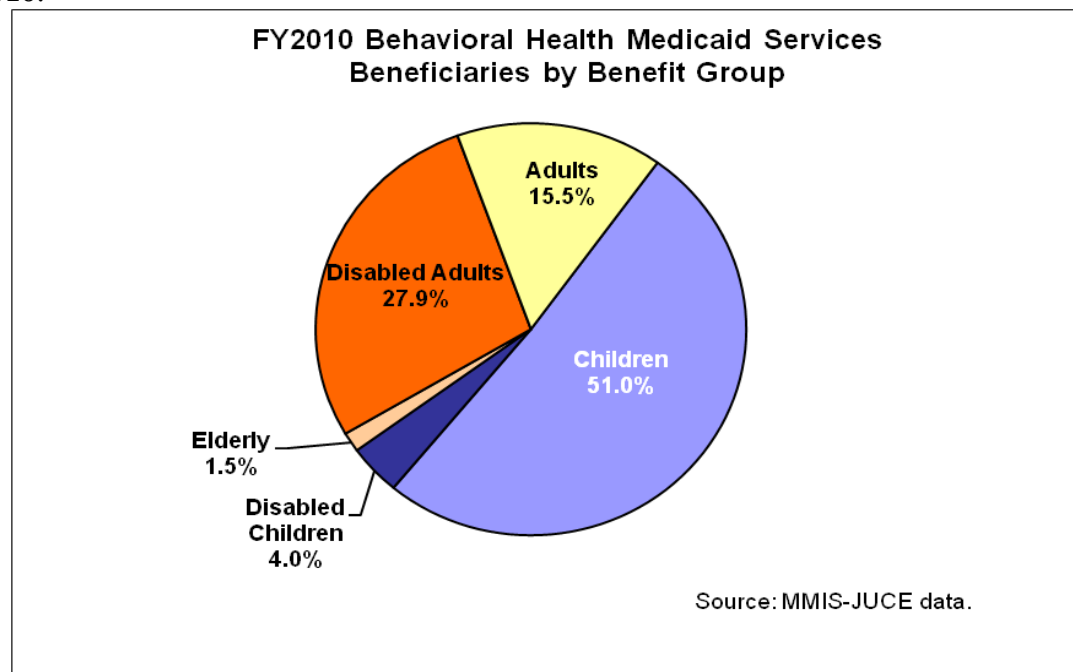
Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	Cost per Beneficiary
All Behavioral Health Medicaid					
Under 21	56.0%	6,794	83.6%	\$123,945.6	\$18,243
21 or Older	44.0%	5,339	16.4%	\$24,385.8	\$4,567
Community Mental Health					
Under age 21	54.9%	6,468	74.0%	\$68,916.3	\$10,655
21 or Older	45.1%	5,323	26.0%	\$24,174.9	\$4,542
Inpatient Psychiatric Hospital				\$0.0	
Under 21	87.9%	808	99.1%	\$18,228.0	\$22,559
21 or Older	12.1%	111	0.9%	\$160.6	\$1,447
Residential Psychiatric Treatment Centers				\$0.0	
Under 21	99.9%	724	99.9%	\$36,801.3	\$50,831
21 or Older	0.1%	1	0.1%	\$50.3	\$50,310

Source: MMIS/JUCE claims paid during FY2010.

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

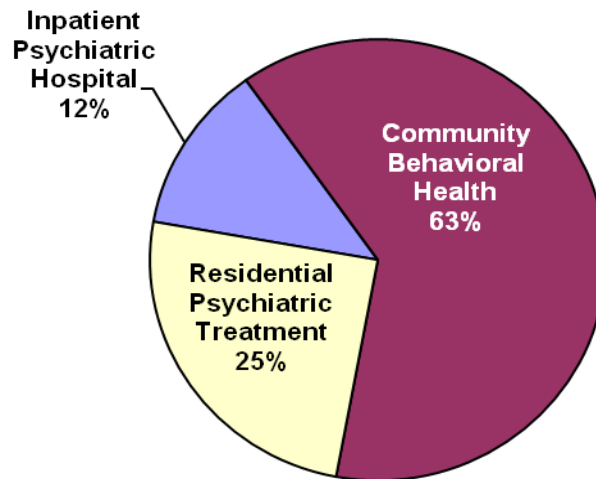


The system experienced a slight increase in the adults served by Medicaid between FY 2009 and FY 2010.



The majority of services purchased were community behavioral health services, comprising about 63% of total Behavioral Health Medicaid costs in FY10. However over 97% of the beneficiaries were provided at some level of community service. Community behavioral health services are provided by psychologists, mental health clinics and substance abuse agencies. This reflects the change we are attempting to bring about by serving people close to home, with locally operated, community behavioral health services. Inpatient psychiatric hospital and residential psychiatric treatment center (RPTC) claims comprised about 12% and 25% of costs, respectively.

**Behavioral Health Medicaid Services
FY2010 Claim Payments by Service Category**



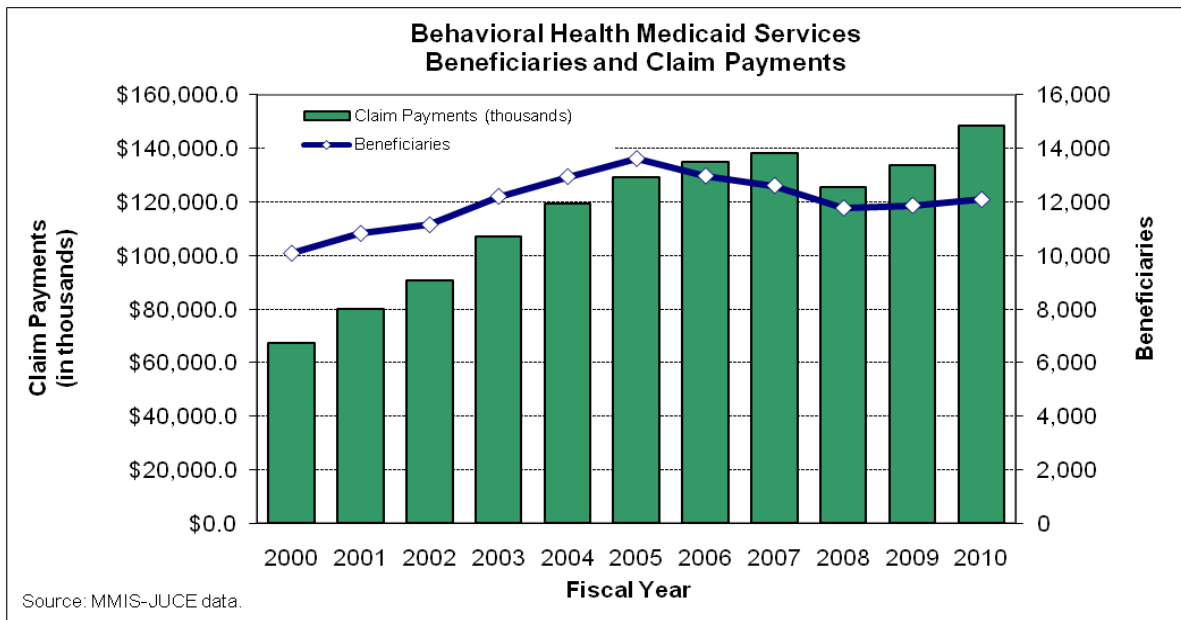
Source: MMIS/JUCE data.

Service Category	Cost per Beneficiary	Percent of Beneficiaries
Inpatient Psych Hospital	\$20,009	7.6%
Residential Psych Treatment	\$50,900	6.0%
Community Behavioral Health Health	\$7,927	97.2%
All Behavioral Health Medicaid, cost per recipient per year		\$12,276
All Behavioral Health Medicaid, unduplicated annual beneficiaries		12,083

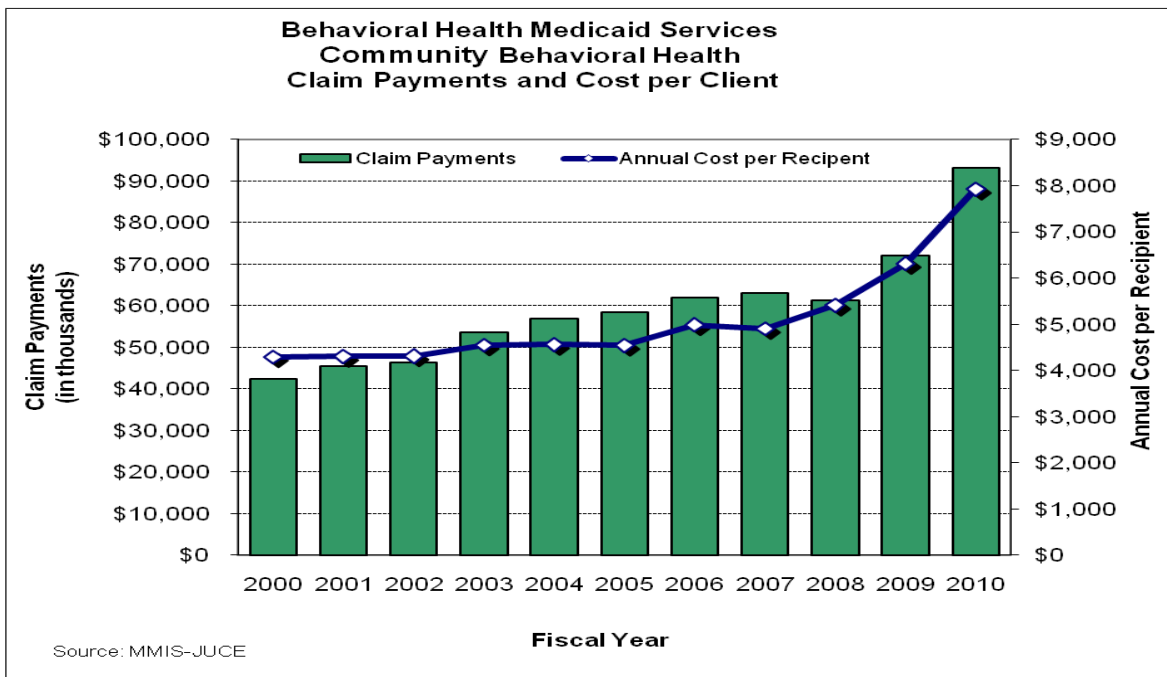
Source: MMIS/JUCE for claims processing during fiscal year 2010. Percent of beneficiaries includes individuals receiving services in other categories and will not sum to 100%.

Note: Data is reported on the basis of claims processed in FY10, not services rendered in FY10.

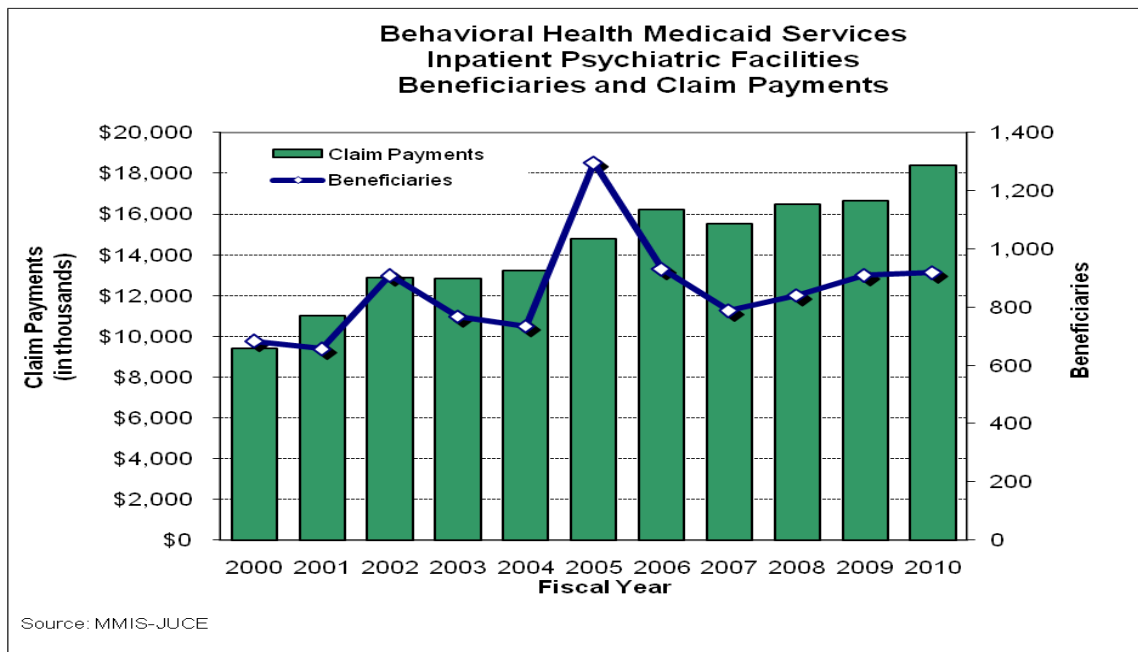
Total claim payments for Behavioral Health Medicaid services in FY10 increased by 11% from FY09, mostly due to an increase in the beneficiaries receiving services and in the rate increased for reimbursed services within the community behavioral health service system. The number of persons with a paid Behavioral Health Medicaid service increased by almost 2%, while the annual cost per beneficiary increased by 9% to nearly \$12,276 (documented in supporting data).



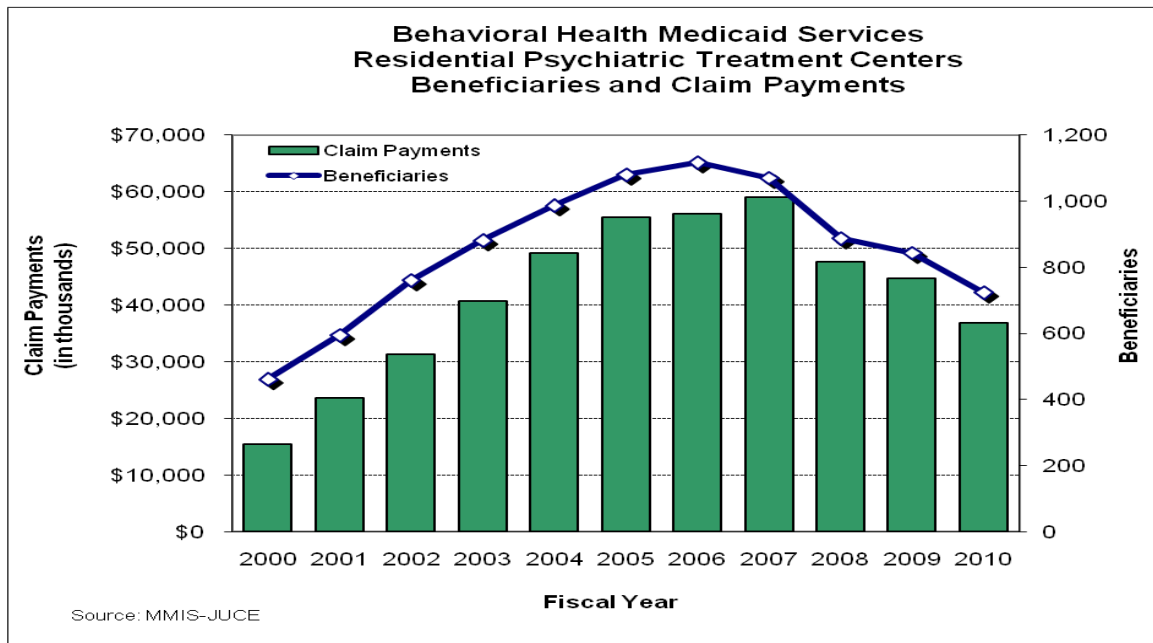
The number of Medicaid beneficiaries with a paid community behavioral health service increased less than 1%, while the annual cost per beneficiary increased 25.5% to \$7,927 (documented in supporting data). Overall, claim payments for community behavioral health services increased by 29% between FY09 and FY10. The community behavioral health category is comprised of psychologist services, mental health clinic services and substance abuse rehabilitation services.



Inpatient psychiatric hospital services saw a 1% increase in the number of individuals as compared to 8% increase from FY08 to FY09. The cost per person increased by approximately 9% to \$20,009 (documented in supporting data). Overall, Medicaid claim payments for inpatient psychiatric services increased by about 10.3% in FY10.



The number of Medicaid beneficiaries with a paid residential psychiatric treatment center service (RPTC) decreased 14.2% in FY10 after falling nearly 23% since FY08. Medicaid claim payments for RPTC decreased by 17.7%. The annual cost per RPTC beneficiary decreased by 4.1% in FY10 to \$50,900 (documented in supporting data).



FY 2010 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		12,083		\$148,331,488	\$12,276	9.6%	12.5%
Gender							
Female	52.9%	6,389	41.4%	\$61,369,927	\$9,606	9.0%	9.2%
Male	47.1%	5,698	58.6%	\$86,961,560	\$15,262	10.4%	16.7%
Unknown	0.0%	0	0.0%	\$0	\$0	0.0%	0.0%
Race							
Alaska Native	35.8%	4,338	41.5%	\$61,559,193	\$14,191	8.9%	14.0%
American Indian	1.9%	234	1.5%	\$2,277,178	\$9,732	11.7%	12.8%
Asian	1.9%	229	1.6%	\$2,444,492	\$10,675	2.8%	3.7%
Pacific Islander	0.9%	109	0.4%	\$636,320	\$5,838	2.7%	2.3%
Black	5.3%	638	5.7%	\$8,408,229	\$13,179	9.3%	15.9%
Hispanic	2.6%	313	2.1%	\$3,090,479	\$9,874	6.7%	10.6%
White	49.6%	6,010	44.4%	\$65,852,131	\$10,957	12.2%	12.6%
Unknown	2.0%	246	2.7%	\$4,063,466	\$16,518	7.2%	12.0%
Native	37.8%	4,571	43.0%	\$63,836,371	\$13,966	9.0%	14.0%
Non-Native	62.2%	7,529	57.0%	\$84,495,117	\$11,223	9.9%	11.5%
Age							
under 1	0.0%	4	0.0%	\$1,797	\$449	0.0%	0.0%
1 through 12	24.3%	3,064	30.1%	\$44,581,180	\$14,550	6.0%	23.5%
13 through 18	28.6%	3,606	51.5%	\$76,463,670	\$21,205	16.6%	45.3%
19 through 20	3.4%	432	2.0%	\$2,898,994	\$6,711	9.0%	8.7%
21 through 30	11.6%	1,469	3.8%	\$5,580,770	\$3,799	10.1%	3.8%
31 through 54	24.4%	3,074	9.6%	\$14,189,172	\$4,616	16.4%	5.6%
55 through 64	5.7%	718	2.3%	\$3,441,727	\$4,793	13.2%	3.1%
65 through 84	1.9%	236	0.8%	\$1,155,423	\$4,896	3.1%	0.8%
85 or older	0.1%	9	0.0%	\$18,754	\$2,084	0.6%	0.0%
Benefit Group							
Children	51.0%	6,284	72.1%	\$107,000,586	\$17,027	7.9%	26.3%
Adults	15.5%	1,914	2.3%	\$3,433,790	\$1,794	8.1%	2.3%
Disabled Children	4.0%	489	9.7%	\$14,381,225	\$29,409	20.7%	22.2%
Disabled Adults	27.9%	3,438	15.2%	\$22,613,261	\$6,577	22.0%	5.7%
Elderly	1.5%	190	0.6%	\$902,626	\$4,751	2.5%	0.5%
Location (DHSS Region)							
Anchorage/Mat-Su	52.2%	6519	58.8%	\$81,338,635	\$12,477	10.3%	13.2%
SouthCentral	14.7%	1834	15.1%	\$20,877,208	\$11,383	10.3%	12.1%
Northern	11.0%	1371	12.2%	\$16,841,479	\$12,284	8.6%	13.1%
Western	7.1%	884	6.2%	\$8,591,076	\$9,718	4.5%	6.4%
SouthEast	13.9%	1740	14.7%	\$20,264,125	\$11,646	14.5%	15.3%
Out of State or Unknown	1.2%	146	0.1%	\$105,508	\$723	6.7%	1.3%

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

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2010 (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 2009, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2010.

Location is based on residence of the recipient or enrollee, not the location where service was provided.

*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

Explanation of FY12 Operating Budget Requests

Division of Behavioral Health

Budget Overview Table

Division of Behavioral Health	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$69,537.3	\$71,550.2	\$2,012.9
Designated General Funds	19,533.7	19,566.8	33.1
Federal Funds	12,043.6	12,100.4	56.8
Other Funds	31,570.5	33,434.0	1,863.5
Total	\$132,685.1	\$136,651.4	\$3,966.3

Budget Requests

Behavioral Health Grants

MH Trust: Cont – Behavioral Health Follow-up Survey: \$100.0 MHTAAR

This MHTAAR funding request to the Division of Behavioral Health (DBH) for \$100.0 in FY12 and would be used to conduct a behavioral health survey of client recovery levels at one year after treatment. DBH would utilize an experienced contractor to ensure a sufficient response rate for statistical validity. This survey has important policy implications for improving treatment and could also help to document important cost savings from good treatment. The Trust has approved \$25.0 MHTAAR in FY13 to finish the survey. If survey information is found to be helpful, it is the intent to repeat this survey every 4 to 5 years.

MH Trust: Dis Justice – Grant 1380.03 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome): \$100.0 MHTAAR

FY12 funds will be used to support the Division of Behavioral Health staff in pre-development & planning activities for a system of service alternatives to incarcerating persons requiring protective custody under AS 47.37.170 in Nome, AK. Activities may include but are not limited to (1) assessing the level and nature of need for substance abuse treatment services, (2) assessing the service capacity of existing programs & facilities within the community and (3) developing an implementation plan for the needed identified treatment services.

MH Trust: DIS Justice – Sobering Center Operations-alternatives to T47 protective custody holds (Bethel): \$350.0 GF/MH

Originally targeted for FY12, the construction of the Sobering Center is ahead of schedule and is anticipated to be complete by December 2010. Thus, operations of the new facility are projected to begin in early 2011. The FY12 GF/MH increment (\$350.0) is required for annualized operations of the Sobering Center itself and maintains the current momentum of effort.

MH Trust: Housing – Grant 1377.04 Assisted living home training and targeted capacity for development: \$100.0 MHTAAR

The Assisted Living Home training and targeted capacity development project continues a Trust project to improve the quality of training available for assisted living home providers. The DHSS Behavioral Health General Relief Adult Residential Care (ARC) program funds assisted living costs for approximately 142 indigent individuals with severe mental health disabilities statewide. In addition, AMHTA funds assisted living care for approximately 10-12 high needs individuals exiting correctional facilities. Both of these programs are intended to prevent homelessness and to improve daily functioning for very impaired beneficiaries. This project supports these goals by providing training to assisted living home caregivers, which increases the capacity of these providers to house individuals with intensive behavioral health needs. The project will be administered by DHSS Behavioral Health through a qualified grantee to provide the prescribed training program.

Family Wellness Warriors Initiative – Year 2 –RSA from GOV: \$200.0 I/A

Family Wellness Warriors Initiative seeks to address the devastating problems of domestic violence, abuse, and neglect in the Alaska Native community. The purpose of the project is to equip organizations and individuals to efficiently address the spiritual, emotional, mental and physical effects of domestic violence, abuse, and neglect.

Trauma Informed Training – Year 2 – RSA from GOV: \$200.0 I/A

The Trauma Informed Training project will implement a specialized trauma-informed curriculum to assure that the community-based behavioral health providers integrate an understanding of trauma into their programs and therapeutic approaches.

Behavioral Health Administration

MH Trust: BTKH – Grant 2463.02 Technical Assistance: \$330.0 MHTAAR

This funding will allow DBH to streamline business practices among Bring the Kids Home providers with an emphasis on performance based funding and outcomes. It will support technical assistance, training and on-going mentoring to improve delivery of integrated, family-driven, recovery oriented services. Training and technical assistance may be from state staff, contractors, or other providers. Services may be on-site, via telephone and/or via video-conferencing. Focus will include business practices such as: a) developing Medicaid service delivery, documentation and billing capacity or partnerships to achieve administrative

economies; b) performance improvement and outcomes monitoring; c) PERM related preparation ,or; d) Improving and implementing fiscal systems and will also include clinical performance improvement projects such as: a) developing wraparound facilitation, planning and implementation; b) implementing evidence-based or be-best practices; c) developing FASD waiver services; d) expanding in-home and family therapy service models, and; e) implementing models for sub-populations of children and their facilities for whom in-state services are limited (children with aggression, for example).

MH Trust: BTKH – Grant 2465.01 Tribal/rural system development: \$100.0 MHTAAR

Funding will assist in establishing SED children's services in rural areas. Almost 40% of youth experiencing serious emotional disturbance (SED) in Residential Psychiatric Treatment Centers (RPTCs) out of state are Alaska Native. This funding will develop services and improve funding mechanisms such as Medicaid at 100% FMAP and strategies specific to tribal systems. The funding will support tribes to expand health service delivery as recommended by Senate Bill 61 (Ch10, 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; blinding funding streams or other projects.

MH Trust: Housing – Grant 383.07 Office of Integrated Housing: \$225.0 MHTAAR

This is an ongoing project through DHSS Behavioral Health for technical assistance to develop supported housing for Trust beneficiaries. Recognizing the affordable and supported housing crisis in Alaska, the Trust and Behavioral Health advocated for the integration of supported housing – now the Supported Housing Office – to develop housing and support opportunities for consumers struggling with mental illness and/or substance abuse. The stated mission of this office is to aggressively develop the expansion and sustainability of supported housing opportunities statewide for Behavioral Health consumers in safe, decent and affordable housing in the least restrictive environment of their choice that is supportive of their rehabilitation process and to receive individualized community services and supports. This project has been funded with Trust and GF/MH funds dating back to FY01. FY11 is \$200.0 MHTAAR with a match through a joint Trust /state position for clinical technical assistance in the Supported Housing Office (presumably GF/MH base funding).

Community Action Prevention and Intervention Grants

Multidisciplinary Rural Community Pilot Project – Year 2 – RSA from GOV: \$1,400.0 I/A

In an effort to reduce domestic violence, sexual assault, and substance abuse in rural Alaska, the intent of these funds is to establish one or more rural community pilot projects to develop innovative, multi-disciplinary, collaborative approaches to domestic violence and sexual assault early intervention and prevention.

Services to the Seriously Mentally Ill

MH Trust: AK MH BD – Alaska Complex Behavior Collaborative: \$150.0 MHTAAR

Alaska's current system of care does not include appropriate services for individuals with cognitive disabilities and complex behaviors. Because of this, many of these individuals are served by API, where they languish in an unnecessarily restrictive environment for extended periods of time, or they are inappropriately held in places such as jails and emergency rooms. Many are ultimately sent out of State for care, where in many cases they remain indefinitely. Risk for out of state placement typically occurs when the individual exhibits behaviors that are so complex that they are outside the range and expertise of local caregivers and providers, or the available treatment options in State have been exhausted without resultant success for the individual. The result of the lack of appropriate services in Alaska is a cost to the individuals and their families.

MH Trust: Housing – Grant 575.06 Bridge Home Program & Expansion: \$750.0 MHTAAR

This project replicates successful transition programs in other states for individuals 'cycling' through emergency and institutional setting. The focus locations for the project will ultimately expand to include Anchorage, Juneau and possibly other locations where Alaska Housing Finance Corporation administers rental subsidies. Institutions targeted for re-entry include: Alaska Psychiatric Institution, Department of Corrections facilities, hospital emergency services and other high-cost social service and health programs. The project allows for up to 100 individuals to receive less expensive, continuous services, including a rental subsidy (estimate based on charging the tenant 30% of income) in order to bridge from institutional discharge onto the HUD Housing Choice voucher program (formerly known as the Section 8 housing voucher program), paired with intensive in-home support services. This pairing of resources for beneficiaries has proven successful in other states in reducing recidivism and impacts on service systems. Alaska's success rates have been demonstrated in reduction of return to Corrections and in use of emergency level services in the initial years of the project.

MH Trust: Housing – Grant 604.06 Department of Corrections discharge incentive grants: \$150.0 GF/MH - \$250.0 MHTAAR

This project is a strategy in the Trust's Affordable Housing Initiative and the Disability Justice work groups. It is consistent with the Housing focus on 'community re-entry' by targeting beneficiaries exiting Department of Corrections settings who are challenging to serve and who require extended supervision public safety concern. These funds will be administered by the Division of Behavioral Health as Assisted Living Home vouchers or support service resources. Resources will also increase the skill level and capacity for assisted living providers to successfully house this population.

Services for Severely Emotionally Disturbed Youth

MH Trust: BTKH-Crisis Bed Stabilization – Anchorage and statewide: \$150.0 GF/MH

This program maintains services in Anchorage and begins to expand services beyond Anchorage for youth-in-crisis by avoiding higher placements via crisis stabilization beds. Managed by DHSS/BH, it provides multiple grants to assist both custody (Juvenile Justice and Children's Services) and non-custody (Division of Behavioral Health) youth. Some youth will be Medicaid eligible; some will not (non-resourced), hence the proposed mixture of grant funds and GF/MH Medicaid match for operations of the facilities. This critical component of the BTKH overall plan is expected to save Medicaid funds for acute hospitalizations and eventual referrals to Residential Psychiatric Treatment Centers.

MH Trust: BTKH-Grant 1388.04 Peer Navigator Program: \$100.0 GF/MH, \$100.0 MHTAAR

The Parent and Youth Navigator project continues funding to allow parents (predominantly) but also youth, to be hired to assist their peers in navigating the service delivery system for youth experiencing serious emotional disturbance (SED). Grant funding would also be available for volunteer coordination to develop a volunteer youth advisory group, with grant funding for travel and per diem for volunteer youth and volunteer chaperones. This group would meet to educate various groups about issues from their perspective. Parent/peer navigation and parent/youth input in policymaking has always been a critical part of the BTKH Initiative, to ensure the increased in-state capacity that is developed is as responsive to the needs of youth and parents as possible. Grantees will be required to report outcomes such as number of parents involved, results of the interaction, and effectiveness of services.

MH Trust: BTKH-Grant 1390.04 Expansion of school-based services capacity via grants: \$175.0 GF/MH, \$125.0 MHTAAR

Bring The Kids Home Expansion of School-Based Services Capacity via Grants Support project provides educational tracking for youth returning from Residential Psychiatric Treatment Centers (RPTCs) to ensure their educational success upon return. It also pilots positive behavioral supports in four school districts: Ketchikan, Juneau, Sitka and Dillingham. This program encourages an environment of support and connection to local behavioral health providers for these youth experiencing serious emotional disturbance (SED). DHSS/BH manages these funds via multiple grants.

MH Trust: BTKH-Grant 2466.02 Transitional Aged Youth: \$250.0 MHTAAR

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

MH Trust: BTKH-Grant 1392.04 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training: \$380.0 GF/MH, \$400.0 MHTAAR

Managed by grants from DHSS/Behavioral Health, funding expands multiple grants to Community Behavioral Health Centers (CBHC) to enhance outpatient services with innovative programs/training 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 dealing with youth at the home and community-based level and avoids utilizing costly residential care. A separate evaluation component is funded by the Trust to demonstrate the cost effectiveness of these outpatient services.

Alaska Psychiatric Institute (API)

MH Trust: BTKH-Grant 2708.01 Child Psychiatrist: \$50.0 GF/MH

Funds would hire a child psychiatrist at Alaska Psychiatric Institute (API) to provide doctor-to-doctor consultation to other Residential Psychiatric Treatment Centers (RPTCs) 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 that is appropriately possible.

MH Trust: Grant 2467.02 IMPACT model of treating depression: \$75.0 MHTAAR

The Alaskan IMPACT project is using the IMPACT model (Improving Mood – Promoting Access to Collaborative Treatment), a collaborative model for treating depression in adults, to establish protocols for identifying and intervening with depressed Alaskans within the primary care setting, where people feel most comfortable. This tested model relies on regular contact with a depression care manager and psychiatrist, with an emphasis on identifying manageable steps toward positive lifestyle changes, and working closely with primary care physicians providing patient education and support for the antidepressant medication when needed.

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

**MH Trust: BTKH-Grant 606.06 Strong Family Voice: Parent and Youth Involved via
AMHB: \$25.0 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: \$430.0 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.

Explanation of FY12 Capital Budget Requests

Capital Budget Request

Behavioral Health Data Sharing Partnership: \$245.0 GF

This project will fund a variety of software upgrades and enhancements to existing programs that will allow for shared use among internal and external agencies. The Division of Behavioral Health, working with the Department of Corrections and the Court System, will be able to capture data across various settings and identify need, rate of referral and access to the treatment system, and measure outcomes of services to people who traditionally end up in the legal system. This increment will fund year 2 of the project.

Challenges

Alaskan Beneficiaries with Cognitive Disabilities and Complex, Challenging Behaviors

Alaskan beneficiaries with cognitive disabilities and complex, challenging behaviors are at risk for institutional and/or out-of-state placement, due to the lack of intensive intervention services in the State of Alaska. Risk for out-of-state placement, for both adults and youth, typically occurs when the individual exhibits behaviors that are so complex that they are outside the range of expertise of local caregivers and providers, present safety issues for themselves and/or others or the available intervention options in-state have been exhausted without success for the individual. Because of the gap in the Alaska service system to meet their needs, these individuals have inappropriate and lengthy stays at API, are admitted to out-of-state Intermediate Care Facilities for the Mentally Retarded(ICF/MR), incur inappropriate, expensive hospital emergency room costs, and are admitted to out-of-state residential psychiatric treatment facilities.

Psychiatric Emergency Services

Each community in Alaska, be it village or urban center, must have some capacity to respond to a psychiatric emergency. Often the person in crisis is under the influence of alcohol or other drugs and services must be able to manage these symptoms as well. In the event behavioral health options are not available at the local level, the emergency response must be coordinated by primary care, with behavioral health backup, sometimes via technology. Local challenges and solutions are as diverse as the geography and cultures. The ability for communities to coordinate services in such a manner as to preserve the dignity and respect of the person experiencing the crisis is essential yet sometimes lacking. Successful crisis response requires 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 instead of immediately sending the individual to an urban setting for stabilization.

Emergency response is a part of the continuum of care of behavioral health services and is often a partnership between the mental health provider agency, law enforcement, primary care and hospital emergency department. The level of coordination and attention to clinically appropriate intervention strategies requires standardization across the state, and the disparity in resources requires correction. The development of quality local behavioral health emergency response services throughout the state, including additional Designated Evaluation and Treatment and Designated Evaluation and Stabilization (DET/DES) facilities, improved ability to respond to co-occurring substance use intoxication, and alternatives to hospitalization such as crisis respite beds, is needed to minimize admissions to the state hospital, Alaska Psychiatric Institute (API), which has limited capacity and has experienced significant census increases in recent years.

Designated Evaluation and Stabilization/Treatment (DES/T)

Over time, the number of hospitals that have contracted with the Division of Behavioral Health to provide DES/T has declined, while there has been a corresponding increase in admissions to the Alaska Psychiatric Institute. Hospitals need to be recruited, policies and procedures need to be reviewed, revised and simplified, ongoing training developed and implemented, performance expectations defined, and a system for total quality management implemented.

Suicide

Prevalence rates for suicide in Alaska are unacceptable, be it in urban, rural or ‘bush’ Alaska. Public safety and emergency medical providers are often the first responders in these crisis situations. It requires concerned citizens and the community at large to recognize warning signs and there exists a need to train first responders in effectively handling such situations.

Rural Human Services System (RHSS)

We currently fund 14 rural and Alaska Native service agencies to provide RHSS training to their staff. The University of Alaska/Fairbanks receives approximately 20 additional requests per year for RHSS scholarship funding from individuals not associated with one of the currently funded agencies. RHSS does not have the funds to enroll these interested individuals in the program. The ability to increase the number of people who enroll and complete RHSS would positively impact the workforce problem by increasing the number of entry level human services workers.

Treatment Capacity for Criminal Justice Clients

Increasing the availability and access of treatment services throughout the state for therapeutic court and other criminal justice clients continues to be a major challenge. Therapeutic courts represent the coordinated efforts of the criminal justice and behavioral health professionals to actively intervene and disrupt the cycle of substance abuse, addiction, and crime. As an alternative to less effective interventions, these courts quickly identify substance abusing offenders and place them under strict court monitoring, community supervision, and long-term behavioral health treatment services.

Continuing Enhancements and Maintenance of the Alaska Automated Information Management System (AKAIMS)

The e-courts module of AKAIMS for Therapeutic Courts was implemented in FY11. We continue to work out problems, and the initial results are very promising. Once fully implemented, the system will track all substance abuse related cases from the initial referral from the Court, Division of Motor Vehicles (DMV) and/or the Division of Juvenile Justice to final disposition of the case. The AKAIMS system will also allow ASAP to be directly linked to treatment providers and the treatment information of ASAP participants. It will allow: 1) consistent data entry availability at all ASAP sites statewide; 2) seamless data access for the

purposes of increasing efficiency of client services both at the ASAP program level as well as case management and statistical analyses; 3) identification and provision of intensive services to high-risk clients; and 4) increased efficiency in the overall processing of these cases.

Performance Management System

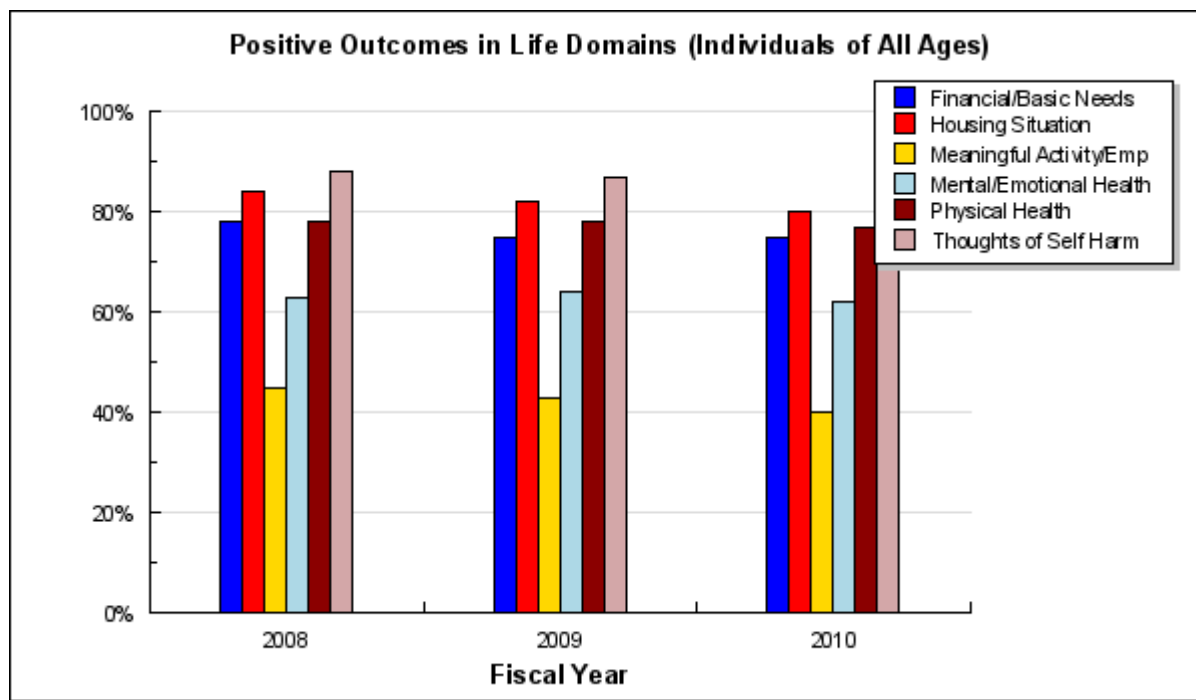
The Division of Behavioral Health continues to develop and implement a performance management system, to ensure an efficient, equitable, and effective system of behavioral health care for Alaskans. A performance-oriented system requires an integrated data infrastructure system. Related challenges involve budgeting for appropriately skilled research staff in order to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. This system realignment absorbs a significant amount of leadership time and energy that limits our resources for emerging issues analysis.

Performance Measure Detail

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: 75% of individuals who receive Behavioral Health community-based services will report “functioning well” for each of six life domains (Financial/Basic Needs, Housing, Activities/Employed, Mental/Emotional Health, Physical Health, & Thoughts of Self Harm)

Status #1: In FY08, FY09, and FY10, the target of at least 75% of individuals who received Behavioral Health community-based services and completed a follow-up Client Status Review reported "functioning well" was met for the following four life domains: Financial/Basic Needs, Housing Situation, Physical Health, and Thoughts of Self Harm. Less than 75% of individuals reported “functioning well” for two life domains: Meaningful Activities/Employment and Mental/Emotional Health.



Methodology: Grantee agency staff administer the Client Status Review (CSR) to clients at intake, periodically throughout treatment, and at time of discharge. A client's status of "functioning well" is determined based on the client's most recent follow-up CSR during the reporting period. Data is entered in the Alaska Automated Information Management System (AKAIMS). Note: The CSR is not required for clients receiving psychiatric emergency services and/or detoxification services.

FY08 Data Source Date: December 2008

FY09 Data Source Date: August 2009

FY10 Data Source Date: August 2010

Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Financial /Basic Needs	Housing Situation	Meaningful Activity/ Emp	Mental/ Emotl Health	Phys Health	Thoughts of Self Harm
FY 2010	75%	80%	40%	62%	77%	87%
FY 2009	75%	82%	43%	64%	78%	87%
FY 2008	78%	84%	45%	63%	78%	88%

Analysis of results and challenges: FY08 was a baseline year for reporting Client Status Review (CSR) data from the Alaska Automated Information Management System (AKAIMS). During FY08, some grantees struggled with data submission requirements and were not able to enter all client records into AKAIMS. Consequently, the FY08 data is not reflective of the entire population served by the Behavioral Health System. The Division's efforts to provide grantees with technical assistance and to hold grantees accountable for entering required data elements into AKAIMS (i.e., through performance based funding) have greatly improved the extent of data completeness in AKAIMS.

In FY08, FY09, and FY10, at least 75% of individuals who received Behavioral Health community-based services and completed a follow-up Client Status Review reported "functioning well" for the following four life domains: Financial/Basic Needs, Housing Situation, Physical Health, and Thoughts of Self Harm. Less than 75% of individuals reported "functioning well" for two life domains: Meaningful Activities/Employment and Mental/Emotional Health. The Division's (DBH) efforts to improve outcomes in these two life domains include:

Meaningful Activities/Employment life domain:

- DBH signed a MOA with the Division of Vocational Rehab to maximize collaboration to impact service delivery.
- DBH funds three supported employment programs.
- DBH participates in the Families' First initiative to provide services to families who are trying to get off public assistance and find employment.

Mental/Emotional Health life domain:

- DBH grantee treatment programs provide clinical services to help consumers improve their mental and emotional well being.
- DBH funds three grants for consumer operated services, all of which help consumers take control of their own recovery, reduce their isolation, and increase their participation in meaningful activities.
- DBH is starting an Individualized Services Agreement program for SMI adults, which ensures that consumers with no or few resources still get all the service they need to function at their highest capacity.

The Division's efforts to improve outcomes in all life domains include Enhanced Technical Assistance to grantees. This assistance is available to grantees experiencing programmatic or administrative difficulties. The Division works with grantees to

develop quality assurance mechanisms by which program adjustments can be made based on CSR results.

Annual Comparisons

From FY08 to FY10, there were only slight changes in the percent of clients who reported “functioning well” in life domains; overall, the data reflects a general trend towards slight decreases in the percent “functioning well.” Annual comparisons are listed below for each of the six life domains:

- Financial/Basic Needs:
Slight decrease from FY08 (78%) to FY09 (75%); no change from FY09 to FY10 (75%).
- Housing Situation:
Slight decrease from FY08 (84%) to FY09 (82%); continued slight decrease from FY09 to FY10 (80%).
- Meaningful Activities/Employment:
Slight decrease from FY08 (45%) to FY09 (43%); continued slight decrease from FY09 to FY10 (40%).
- Mental/Emotional Health:
Slight increase from FY08 (63%) to FY09 (64%); slight decrease from FY09 to FY10 (62%).
- Physical Health:
No change from FY08 (78%) to FY09 (78%); slight decrease from FY09 to FY10 (77%).
- Thoughts of Self Harm:
Slight decrease from FY08 (88%) to FY09 (87%); no change from FY09 to FY10 (87%).

Across all three years (FY08, FY09, and FY10), the life domain with the highest percentage of individuals reporting “functioning well” was:

- Thoughts of Self Harm: (88%, 87%, and 87%, respectively).

Across all three years (FY08, FY09, and FY10), the life domains with the lowest percentage of individuals reporting “functioning well” were:

- Meaningful Activities/Employment (45%, 43%, and 40%, respectively)
- Mental/Emotional Health (63%, 64%, and 62%, respectively).

From FY08 to FY10, the most significant changes in percent “functioning well” were for the following life domains:

- Meaningful Activities/Employment: decreased 5 percentage points (FY08 = 45%; FY10 = 40%).
- Housing Situation: decreased 4 percentage points (FY08 = 84%; FY10 = 80%).
- Financial/Basic Needs: decreased 3 percentage points (FY08 = 78%; FY10 = 75%).

From FY09 to FY10, the most significant change in percent “functioning well” was for the following life domain:

- Meaningful Activities/Employment: decreased 3 percentage points (FY09 = 43%; FY10 = 40%).

From FY08 to FY09, the most significant change in percent “functioning well” was for the following life domain:

- Financial/Basic Needs: decreased 3 percentage points (FY08 = 78%; FY09 = 75%).

The CSR instrument is currently under revision to improve its usefulness in assessing change over time. The target date for implementing the new CSR instrument in AKAIMS is October, 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).

Target #2: Reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children.

Status #2: The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. The rate of FASD among Alaska natives was 32.4 per 10,000 live births in 2002, down 49 percent from a rate of 63.1 per 10,000 live births in 1996 (DHSS DPH Alaska Birth Defects Registry).

Target #3: Reduce the rate of suicides in Alaska to 10.6 deaths per 100,000.

Status #3: Preliminary data for 2009 indicates an Alaska suicide death rate of 20.2 suicides for all ages per 100,000 population. This rate is nearly double the stated target of 10.6, but lower than the 2008 rate of 24.6 suicides. Source: AK DHSS DPH BVS

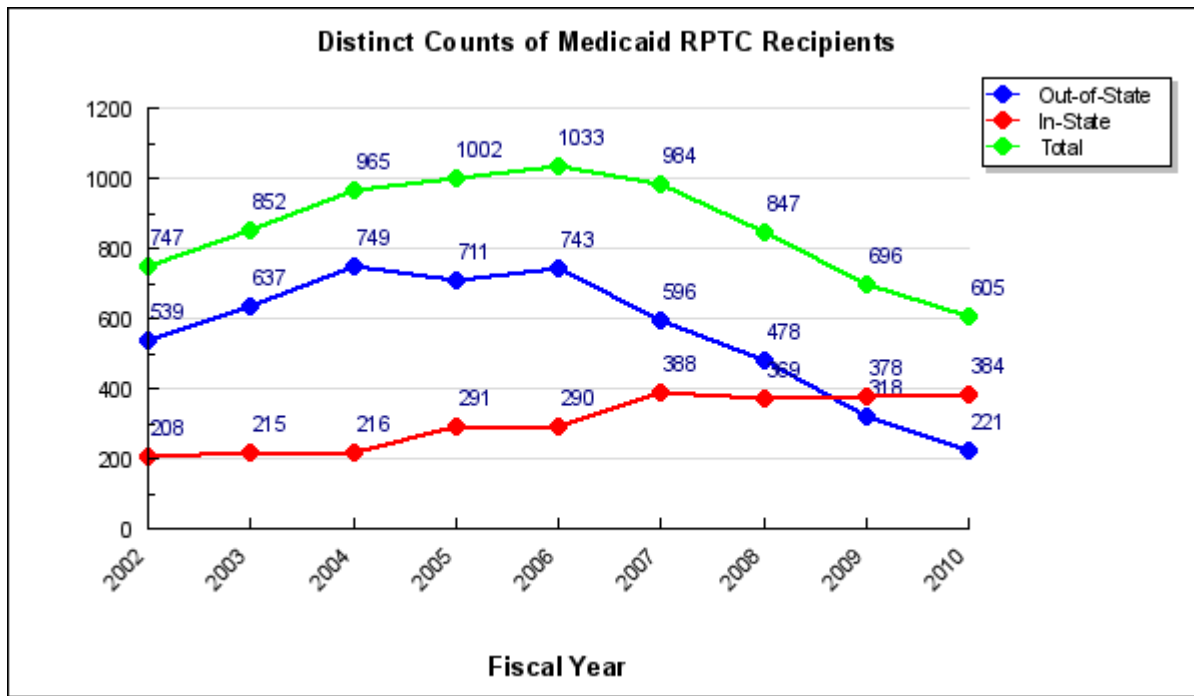
Target #4: Reduce the rate of alcohol-induced deaths.

Status #4: The target to reduce the rate of alcohol-induced deaths was not met but the trend is maintaining or holding steady. There were 21.1 deaths per 100,000 population in 2007, 22.2 in 2008 and 22.5 in 2009. (DHSS DPH Bureau of Vital Statistics).

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 FY09 to FY10, there was a 30.5% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care (318 in FY09; 221 in FY10).



Methodology: The Bring the Kids Home indicator data for SFY10 is preliminary. Data is provided by the Division of Behavioral Health, Policy and Planning Section (data source: MMIS). RPTC recipient counts are unduplicated.

Distinct Counts of Medicaid RPTC Recipients

Fiscal Year	Out-of-State	In-State	Total
FY 2010	221	384	605
FY 2009	318	378	696
FY 2008	478	369	847
FY 2007	596	388	984
FY 2006	743	290	1033
FY 2005	711	291	1002
FY 2004	749	216	965
FY 2003	637	215	852
FY 2002	539	208	747

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 FY10, there was a 70.5% decrease in the number of out-of-state RPTC recipients of care (749 in FY04; 221 in FY10) and a 77.8% increase in the number of in-state RPTC recipients of care (216 in FY04; 384 in FY10). In addition, for the same time period, the total RPTC recipient count decreased by 37.3% (965 in FY04; 605 in FY10). The total RPTC recipient count peaked in FY06. Since then, there has been a 41.4% decrease in the total RPTC recipient count (1,033 in FY06; 605 in FY10). 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 FY10:

-- From FY09 to FY10 there was a:

- 30.5% decrease in the number of distinct out-of-state RPTC recipients of care.
- 1.6% increase in the number of distinct in-state RPTC recipients of care.
- 13.1% decrease in the total RPTC recipient count.

-- From FY08 to FY09 there was a:

- 33.5% decrease in the number of distinct out-of-state RPTC recipients of care.
- 2.4% increase in the number of distinct in-state RPTC recipients of care.
- 17.8% decrease in the total RPTC recipient count.

-- 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.

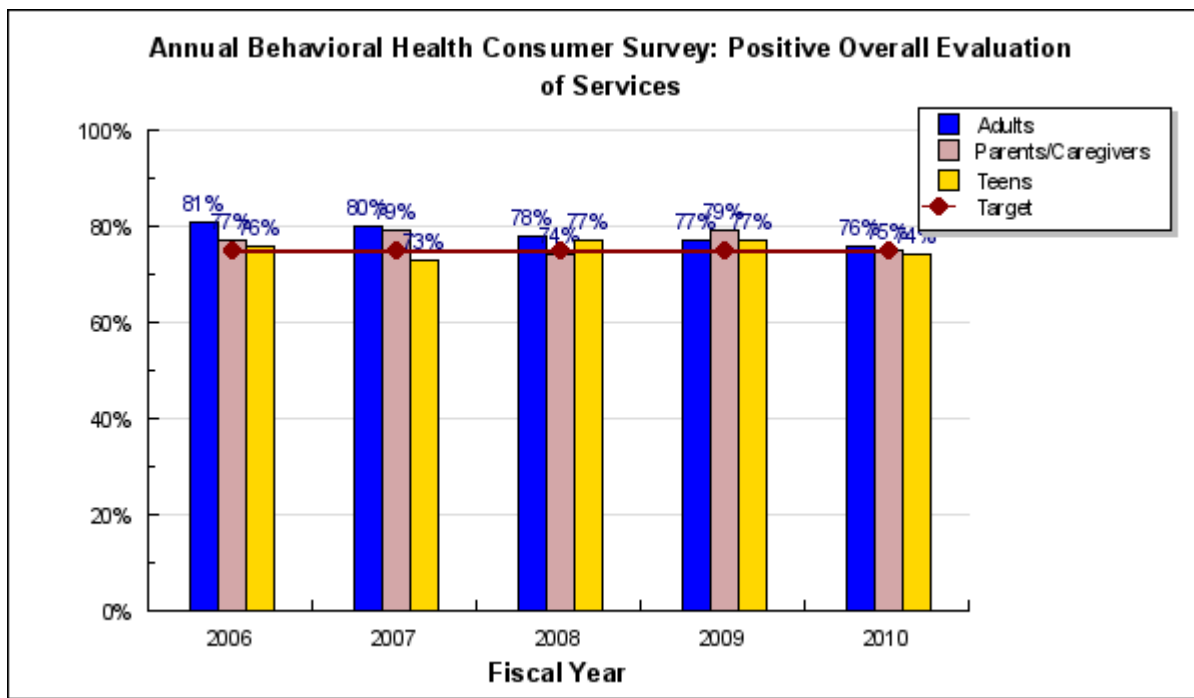
AS47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has

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 FY10, 76% of adults and 75% of parents/caregivers of youth who completed the Annual Behavioral Health Consumer Survey reported a positive overall evaluation of services; 74% of teens 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. Grantees providing community-based services mail the Annual BHCS to clients who receive 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
FY 2010	76%	75%	74%
FY 2009	77%	79%	77%
FY 2008	78%	74%	77%
FY 2007	80%	79%	73%
FY 2006	81%	77%	76%

Analysis of results and challenges: In FY10, 76% of adults and 75% of parents/caregivers of youth who completed the Annual Behavioral Health Consumer Survey reported a positive overall evaluation of services; 74% of teens reported a positive overall evaluation of services.

From FY06 to FY10 (for adults, parents/caregivers of youth, and teens), there were only small changes in respondents' evaluation of services. For adults, the percent reporting positive overall evaluation decreased slightly each year. For parents/caregivers of youth and for teens, there were small fluctuations from year to year. Generally, a higher percentage of adults reported positive evaluation of services than did parents/caregivers of youth or teens. Generally, a higher percentage of parents/caregivers of youth reported positive evaluation of services than did teens.

FY08 is considered to be a new baseline year due to survey methodology changes implemented for the FY08 BHCS. FY08 to FY10 annual comparisons of the percent positive overall evaluation of services are listed below.

Annual Comparisons (FY08 to FY10):

-- Adults:

Slight decrease from FY08 (78%) to FY09 (77%); continued slight decrease from FY09 to FY10 (76%).

-- Parents/Caregivers of Youth:

Small increase from FY08 (74%) to FY09 (79%); small decrease from FY09 to FY10 (75%).

-- Teens:

No change from FY08 (77%) to FY09 (77%); small decrease from FY09 to FY10 (74%).

The Division's efforts to improve service delivery include Enhanced Technical Assistance to grantees. This assistance is available to grantees experiencing programmatic or administrative difficulties. The Division works with grantees to develop quality assurance mechanisms by which program adjustments can be made based on Client Status Review (CSR) and BHCS results.

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, FY10 and FY11. Participation in

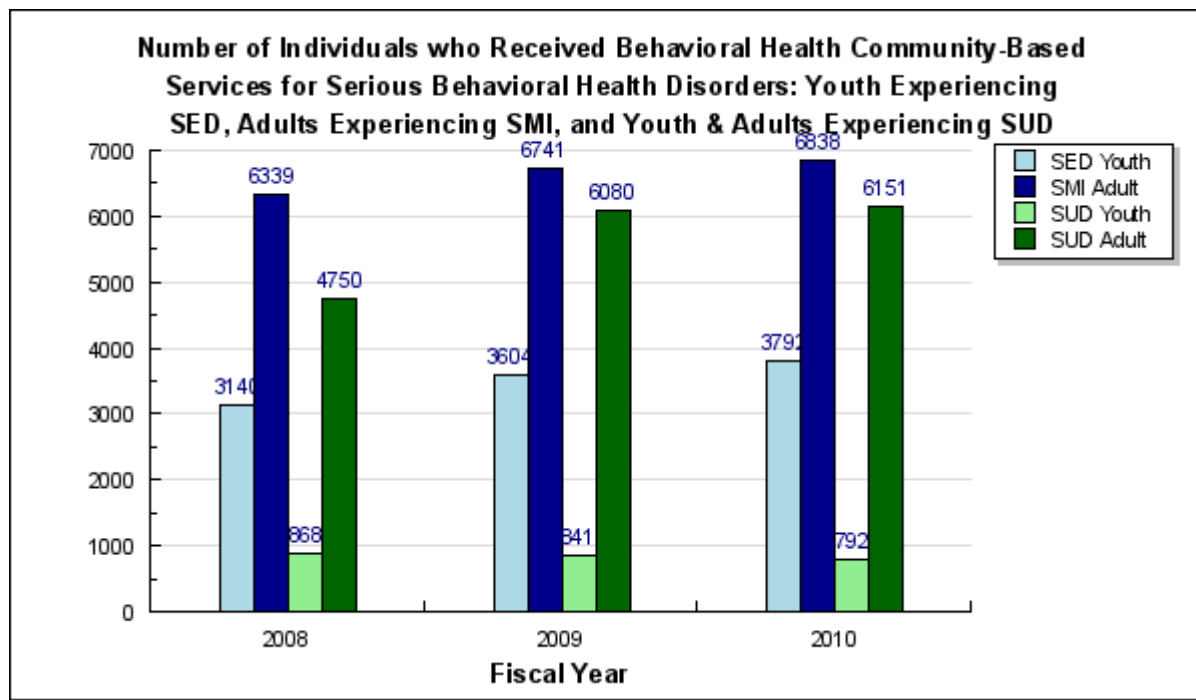
administering the BHCS is one of several performance measures used to determine funding allocations.

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

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 individuals who receive Behavioral Health community-based services for serious behavioral health disorders: serious emotional disturbances (SED), serious mental illness (SMI), and substance use disorders (SUD).

Status #1: From FY09 to FY10, the number of individuals who received Behavioral Health community-based services increased 5.2% for youth experiencing SED, increased 1.4% for adults experiencing SMI, decreased 5.8% for youth experiencing SUD, and increased 1.2% for adults experiencing SUD.



Methodology: Data reflects the Alaska Automated Information Management System (AKAIMS) DBH Uniform Reporting (UR) Client Profile Tables, FYTD number of clients served. Client counts are unduplicated within each group but duplicated across mental health (SED/SMI) and substance abuse (SUD). Clients who received services for mental health and substance abuse are counted in both the SED/SMI and SUD groups.

Data Source Date for all three years: October 20, 2010.

Number of Individuals who Received Behavioral Health Community-Based Services for Serious Behavioral Health Disorders: Youth Experiencing SED, Adults Experiencing SMI, and Youth & Adults Experiencing SUD

Fiscal Year	SED Youth	SMI Adult	SUD Youth	SUD Adult	Total
FY 2010	3,792 +5.22%	6,838 +1.44%	792 -5.83%	6,151 +1.17%	17,573 +1.78%
FY 2009	3,604 +14.78%	6,741 +6.34%	841 -3.11%	6,080 +28%	17,266 +14.37%
FY 2008	3,140	6,339	868	4,750	15,097

Analysis of results and challenges: In order to improve and enhance the quality of life for Alaskans who experience a behavioral health disorder, access to a comprehensive, integrated service system is critical. A measure of the number of individuals receiving Behavioral Health community-based services is reflective of accessibility of services.

FY08 was a baseline year for reporting client counts from the Alaska Automated Information Management System (AKAIMS). During FY08, some grantees struggled with data submission requirements and were not able to enter all client records into AKAIMS. Consequently, the FY08 data is not reflective of the entire population served by the Behavioral Health community-based system. The Division's efforts to provide grantees with technical assistance and to hold grantees accountable for entering required data elements into AKAIMS (i.e., through performance based funding) have greatly improved the extent of data completeness in AKAIMS. There was a significant improvement in AKAIMS data completeness from FY08 to FY09, which is reflected in the annual comparisons listed below.

The increase in the number of SED Youth served (from FY08 through FY10) reflects the ongoing efforts of the Bring/Keep The Kids Home (BTKH) Project. Alaska currently has an over reliance on use of long term residential treatment centers outside of the State to serve children with SED. Alaska has addressed this issue through the BTKH Project, which includes efforts to increase in-state service capacity at lower levels of care, manage acute care discharge and out of state referrals more effectively, and develop in-state residential resources that meet the needs of Alaskan children. DBH is working with a large stakeholder group on these issues and has formed several work groups, including Care Coordination, Data Management, Home and Community Based Services, and Workforce Development. Funding for these efforts has been provided through the Alaska Mental Health Trust Authority and through DHSS general funds and Medicaid match. A complimentary effort is on-going through the Alaska Denali Commission to provide funding for BTKH capital projects ranging from residential care to in-home services. The long term goal of these efforts is to develop an instate service system that can meet the needs of Alaskan children.

Annual Comparisons

FY09 to FY10

For Serious Mental Health Disorders (SED and SMI), there was a:

- 5.2% increase in the number of SED Youth who received services (3,604 in FY09; 3,792 in FY10).
- 1.4% increase in the number of SMI Adults who received services (6,741 in FY09; 6,838 in FY10).
- 2.8% increase in the number of SED Youth & SMI Adults who received services (10,345 in FY09; 10,630 in FY10).

For Substance Use Disorders (SUD), there was a:

- 5.8% decrease in the number of SUD Youth who received services (841 in FY09; 792 in FY10).
- 1.2% increase in the number of SUD Adults who received services (6,080 in FY09; 6,151 in FY10).
- 0.3% increase in the number of SUD Youth & Adults who received services (6,921 in FY09; 6,943 in FY10).

For Serious Mental Health and Substance Use Disorders combined (SED, SMI, and SUD), there was a:

- 1.8% increase in the number of SED Youth, SMI Adults, and SUD Youth & Adults who received services (17,266 in FY09 to 17,573 in FY10).

From FY08 to FY09:

For Serious Mental Health Disorders (SED and SMI), there was a:

- 14.8% increase in the number of SED Youth who received services (3,140 in FY08; 3,604 in FY09).
- 6.3% increase in the number of SMI Adults who received services (6,339 in FY08; 6,741 in FY09).
- 9.1% increase in the number of SED Youth & SMI Adults who received services (9,479 in FY08; 10,345 in FY09).

For Substance Use Disorders (SUD), there was a:

- 3.1% decrease in the number of SUD Youth who received services (868 in FY08; 841 in FY09).
- 28.0% increase in the number of SUD Adults who received services (4,750 in FY08; 6,080 in FY09).
- 23.2% increase in the number of SUD Youth & Adults who received services (5,618 in FY08; 6,921 in FY09).

For Serious Mental Health and Substance Use Disorders combined (SED, SMI, and SUD), there was a:

- 14.4% increase in the number of SED Youth, SMI Adults, and SUD Youth & Adults who received services (15,097 in FY08; 17,266 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:

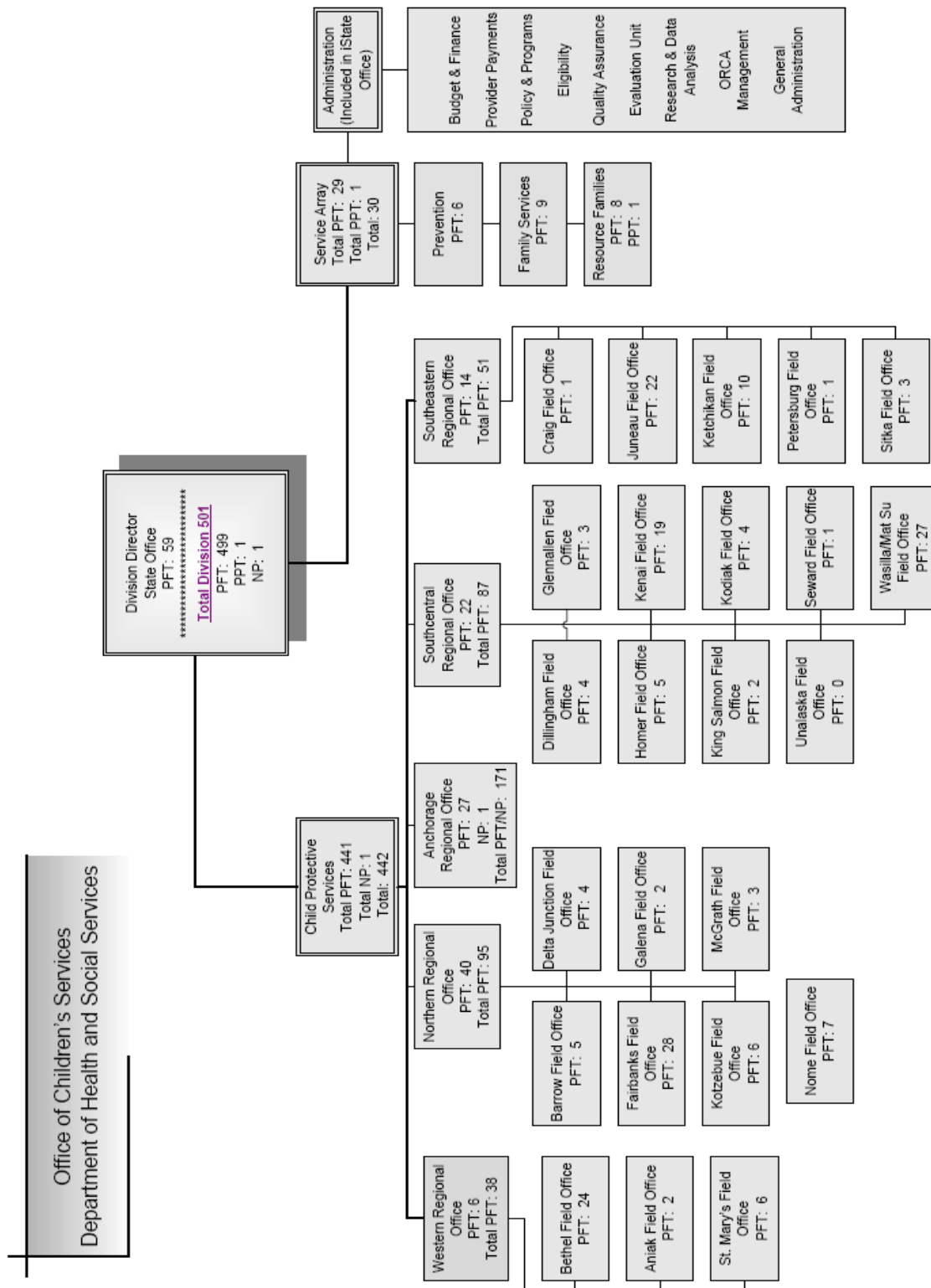
<https://dbh-ssweb.state.ak.us/sites/COSIG/outcomes/default.as>

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Delete MHTAAR funding from FY2011 Over/Understated GGU/SU salary adjustment	\$ -	\$ -	\$ -	\$ (1.3)	\$ (1.3)
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (1.9)	\$ (1.9)
MH Trust: Cont - Behavioral Health Follow-up Survey	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: Dis Justice - Grant 1380.03 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: Dis Justice- Sobering Center Operations-alternatives to T47 protective custody holds (Bethel)	\$ 350.0	\$ -	\$ -	\$ -	\$ 350.0
MH Trust: Housing - Grant 1377.04 Assisted living home training and targeted capacity for development	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
Family Wellness Warriors Initiative - Year Two - RSA from Gov	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
Trauma Informed Training - Year Two - RSA from Gov	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
Transfer authority to Seriously Emotionally Disturbed Youth to align funding with service priorities	\$ (213.0)	\$ -	\$ -	\$ -	\$ (213.0)
Transfer Authority to Behavioral Health Administration Component for AKAIMS Maintenance Contract	\$ (300.0)	\$ -	\$ -	\$ -	\$ (300.0)
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (200.0)	\$ (200.0)
MH Trust: BTKH - Grant 2463.02 Technical Assistance	\$ -	\$ -	\$ -	\$ 330.0	\$ 330.0
MH Trust: BTKH - Grant 2465.01 Tribal/rural system development	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: Housing - Grant 383.07 Office of Integrated Housing	\$ -	\$ -	\$ -	\$ 225.0	\$ 225.0
Transfer authority from Behavioral Health Grant component for AKAIMS maintenance contract	\$ 300.0	\$ -	\$ -	\$ -	\$ 300.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (803.1)	\$ (803.1)
Multidisciplinary Rural Community Pilot Project - Year Two - RSA from Gov	\$ -	\$ -	\$ -	\$ 1,400.0	\$ 1,400.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (300.0)	\$ (300.0)
MH Trust: AK Alc Bd - Alaska Complex Behavior Collaborative	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
MH Trust: AK MH Bd - Alaska Complex Behavior Collaborative	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
MH Trust: Housing - Grant 575.06 Bridge Home Program & Expansion	\$ -	\$ -	\$ -	\$ 750.0	\$ 750.0
MH Trust: Housing - Grant 604.06 Department of Corrections discharge incentive grants	\$ 150.0	\$ -	\$ -	\$ -	\$ 150.0
MH Trust: Housing - Grant 604.06 Department of Corrections discharge incentive grants	\$ -	\$ -	\$ -	\$ 250.0	\$ 250.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (1,100.0)	\$ (1,100.0)
MH Trust: BTKH - Crisis Bed Stabilization - Anchorage and statewide	\$ 150.0	\$ -	\$ -	\$ -	\$ 150.0
MH Trust: BTKH - Grant 1388.04 Peer Navigator Program	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
MH Trust: BTKH - Grant 1388.04 Peer Navigator Program	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: BTKH - Grant 1390.04 Expansion of school-based services capacity via grants	\$ 175.0	\$ -	\$ -	\$ -	\$ 175.0
MH Trust: BTKH - Grant 1390.04 Expansion of school-based services capacity via grants	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
MH Trust: BTKH - Grant 2466.02 Transitional Aged Youth	\$ -	\$ -	\$ -	\$ 250.0	\$ 250.0
MH Trust: BTKH -Grant 1392.04 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	\$ 380.0	\$ -	\$ -	\$ -	\$ 380.0
MH Trust: BTKH -Grant 1392.04 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	\$ -	\$ -	\$ -	\$ 400.0	\$ 400.0
Transfer authority from BH Grants to align funding with service priorities	\$ 213.0	\$ -	\$ -	\$ -	\$ 213.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (1,075.0)	\$ (1,075.0)
MH Trust: BTKH - Grant 2708.01 Child Psychiatrist	\$ 50.0	\$ -	\$ -	\$ -	\$ 50.0
MH Trust Cont - Grant 2467.02 IMPACT model of treating depression	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (121.8)	\$ (121.8)
Reverse August FY2011 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (17.7)	\$ -	\$ -	\$ -	\$ (17.7)
MH Trust: BTKH - Grant 606.06 Strong family voice: parent and youth involved via AMHB	\$ -	\$ -	\$ -	\$ 25.0	\$ 25.0
MH Trust: Cont - Grant 605.06 ABADA/AMHB joint staffing	\$ -	\$ -	\$ -	\$ 430.0	\$ 430.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (476.1)	\$ (476.1)
MH Trust Workforce Dev - AK Psychiatric Residency	\$ 202.0	\$ -	\$ -	\$ -	\$ 202.0
Behavioral Health Total	\$ 1,539.3	\$ -	\$ -	\$ 1,230.8	\$ 2,770.1

Office of Children's Services



Introduction to the Office of Children's Services



Mission

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

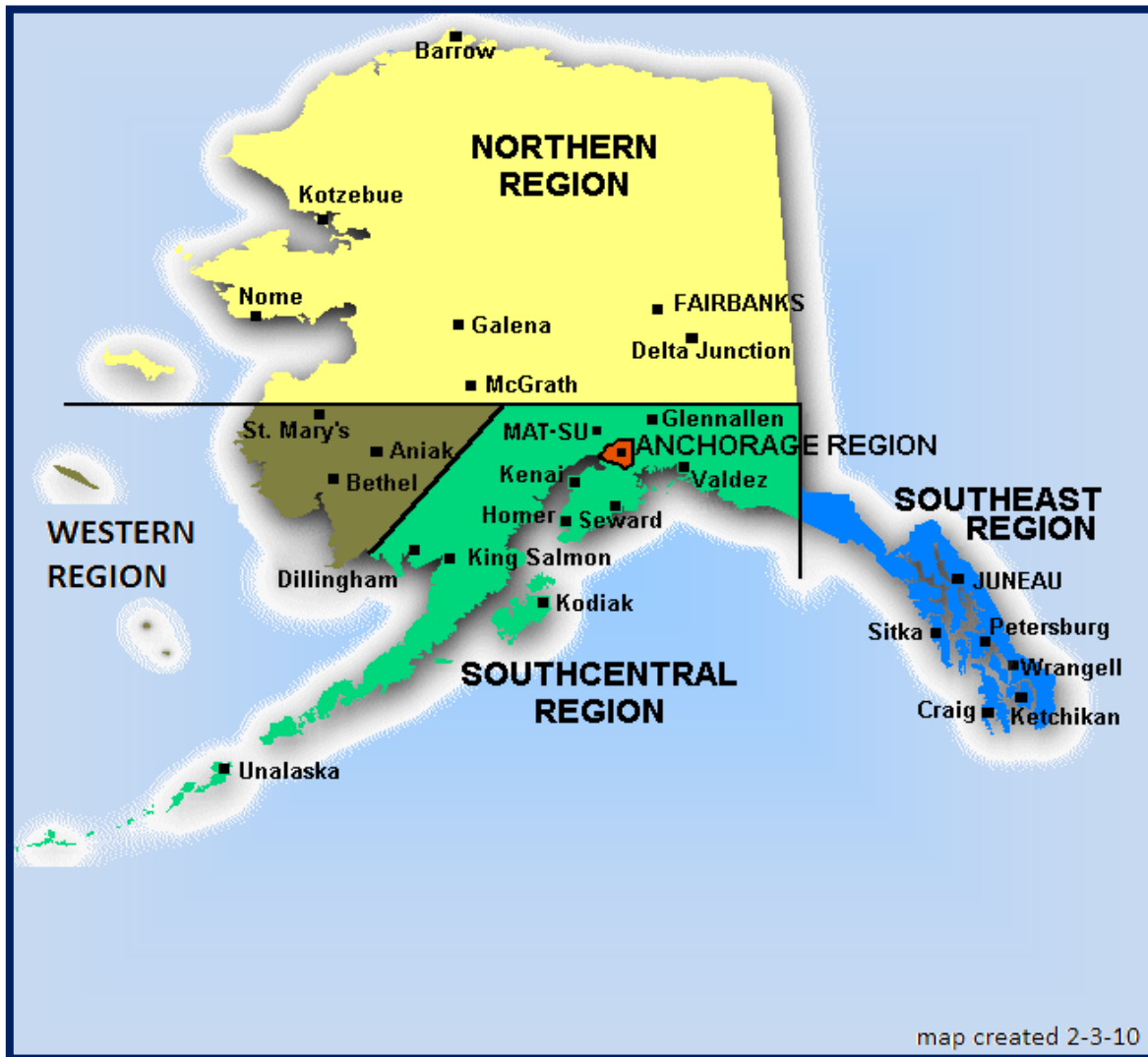
The OCS supports 26 local offices across Alaska that deliver child welfare services. These local offices are managed and supported regionally within the OCS:

- 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, Valdez, Kodiak, Dillingham, Aleutian Islands, and surrounding areas
- Anchorage Regional Office (ARO) is responsible for Anchorage
- Southeastern Regional Office (SERO) in Juneau: Sitka, Petersburg, Ketchikan, Craig and surrounding communities
- Western Regional Office (WRO) in Bethel: Aniak, St. Mary's and surrounding villages

The Western Region is new to the OCS and is still in the implementation stage. New staff has been hired to provide the same management structure to the WRO as the other four regions; office equipment improvements have been purchased including updates to computers and office furniture; and area bandwidth has been expanded to increase ORCA (Online Resources for the Children of Alaska) performance.

In FY2011 final staffing changes will occur and the transfer of regional management duties and responsibilities will be completed.

ALASKA CHILDREN'S SERVICES REGIONAL AND OFFICE COVERAGE



Services Provided

Services 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 :

- 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 as appropriate.

In FY2010, approximately 2,550 children, from birth to three years of age, received a referral for screening or evaluation for early intervention services through Infant Learning Programs in Alaska. Of these 2,550 children, over 1,785 were eligible for early intervention services funded under Part C of the Individuals with Disabilities Education Act.

The Infant Learning Program procured the online Ages and Stages Developmental Screening system in FY2010 to ensure parents have easy access to a high quality, parent completed, and developmental screening tool kit. Parent reports of their child's skills are accurate predictors of developmental delays, and this parent-completed screening tool helps to identify children in need of further evaluation, enabling early intervention.

FY2010 child outcome summary ratings were collected and analyzed for children exiting the program during the fiscal year who were enrolled in the program for at least six months. 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.

Infant Learning Measures of Child Outcomes - Emotional, Knowledge, and Action

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.

Summary Statement 1	FY2009	FY2010
<i>Child Outcome Area</i>	<i>Percent Substantially Increased Rate of Growth</i>	<i>Percent Substantially Increased Rate of Growth</i>
Emotional: Positive social relationships	67% (104 of 155)	66% (154 of 234)
Knowledge: Acquisition of knowledge and skills	78% (146 of 188)	71% (191 of 271)
Action: Taking appropriate actions to meet own needs	73% (143 of 195)	72% (185 of 258)

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

Summary Statement 2	FY2009	FY2010
<i>Child Outcome Area</i>	<i>Percent within Age Expectations at Exit</i>	<i>Percent within Age Expectations at Exit</i>
Emotional: Positive social relationships	58% (142 of 244)	58% (142 of 244)
Knowledge: Acquisition of knowledge and skills	57% (139 of 244)	57% (139 of 244)
Action: Taking appropriate actions to meet own needs	55% (134 of 244)	55% (134 of 244)

The Early Childhood Comprehensive Systems Initiative

The Early Childhood Comprehensive Systems (ECCS) Initiative is a project to promote positive development and improved health outcomes for Alaska's children prenatal to age eight years 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.

Alaska has an Interdepartmental Early Childhood Coordinating Council (IECCC) that currently guides the work of ECCS. The IECCC includes a representative from the Governor's Office; the Commissioner of Health and Social Services; and a cross-section of Division Directors, Deputy Directors and Program Managers from the Department of Education and Early Development and the Department of Health and Social services, as well as representatives from the Alaska Mental Health Trust Authority, the Governor's Council on Disabilities and Special Education, and the Alaska Children's Trust. An Administrative Order had been signed by the Governor, formally acknowledging this group as the "early childhood advisory council" required by the Head Start Act of 2007. With this new designation, the membership will expand to include the Commissioners of Education and Early Development, Labor and Workforce Development and Public Safety as well as private sector members and parents.

ECCS work over the last year included:

- The IECCC Monitoring & Accountability Committee began addressing issues of monitoring and continual quality improvement. This committee identified several areas of focus for their work: 1) to develop a list of indicators that could be tracked over time and indicate the “status of Alaska’s children”; 2) to use these indicators to drive system/service improvements; and 3) to design a process for monitoring the impact of the ECCS systems work that is being done. The Committee established a list of 60 plus indicators. These indicators can now be used for systems to guide decision making and systems improvements.
- The State Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Workgroup met to review the EPSDT program and identify areas needing improvement. The ECCS Plan recommendation for incorporating standardized developmental screening during EPSDT well-child visits was included in the work of this Committee. The EPSDT Committee held meetings with the Community Health Aide Program Directors in each of the Tribal Health Corporations to discuss their efforts to improve exam rates and improve practices. This information is being used to develop recommendations to improve the EPSDT program.
- The ECCS Coordinator worked 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.
- In related work, a Memorandum of Understanding template was developed to enable OCS offices and school districts to exchange information on children in the state’s custody. One of the prompts for this work was the need to exchange information more readily so that school districts could provide developmental screening to 3-5 yr olds who come into the State’s custody.
- The Regulations Sub-Committee of the Early Childhood Mental Health Workgroup made final changes to the recommendations for new early childhood mental health services and delivery systems. These new services, if implemented, will support earlier access and be more developmentally appropriate for this age group.
- The fourth Early Childhood Mental Health Institute focused on building workforce expertise in the area of early childhood mental health was held. This three-day conference included a special focus on trauma in early childhood and engaging/supporting families.
- A policy supporting a more appropriate diagnostic process for children birth to five years with mental health concerns was developed and implemented.
- Continued support was provided for the “Early Childhood Mental Health Learning Network”. Through this project, workshops on the diagnostic policy and process and Early Childhood Mental Health Principles and Practices were provided in several areas of the state. Monthly consultation/training conference calls are being facilitated for mental health clinicians; family support workers, early interventionists, etc. This long-distance delivery format is especially important for those providers in rural and remote portions of the state where staff with early childhood mental health expertise are rare or non-existent.
- Continued support was provided for an early childhood mental health consultation program for early care and learning programs in the Anchorage area. Mental health providers are available to assist programs and parents who have identified children with challenging behaviors. One of the goals of the project is to stabilize children in their early care and learning programs so that parents can maintain their employment.
- Support continues for the Professional Development Committee charged with updating the EC Professional Development Plan for the early care and learning workforce.

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 the United Way of Anchorage and “*thread* connecting early child care & education to Alaska”, to train and supporting Anchorage-based early care and learning programs in implementing the Strengthening Families program. Additionally, Pre-K programs in the Anchorage School District committed to implementing Strengthening Families.
- Sponsoring monthly teleconferences for the “Learning Network” of existing Strengthening Families programs.
- Presenting at state at conferences on the Strengthening Families protective factors.
- 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.
- Collaborating with the Alaska Children's Trust to expand the use of “Community Cafes” to create local-level dialogue on how families can be strengthened and supported.

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 2008 Child and Family Services Review findings.

Throughout FY2009 and FY2010, the OCS has worked with stakeholders to develop and implement a Program Improvement Plan (PIP). The PIP was approved in December of 2009 with the first year of the two-year time frame for implementation focused on defining and publishing the Office of Children's Services Practice Model, increasing timeliness of investigations, enhancing initial assessment practices, developing and supporting field supervision, increasing the quality of case worker visits, working with Tribes to reduce the disproportionate number of Alaska Native children in care, and working with other state agencies

to increase the availability and accessibility of service delivery to children and families. These changes and enhancements to OCS practice work 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.

During the first year of the PIP, OCS substantially met required goals for safety and permanency standards. During the upcoming year the focus will be to integrate and extend the practice model through the life of the case, update remaining policy and procedures, further develop training curriculum in line with the PIP and establish quality controls. The statewide assessment leading to the PIP and detailed information and plans for 2010 through 2014 are available at:

<http://www.hss.state.ak.us/ocs/Publications/default.htm>.

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 a 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 deciding whether the incident will be referred to the district attorney for prosecution, and also determining 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, within a co-location of services model, provides the best forum in which an investigation can occur to assure victims are not re-traumatized by repeated interviews and examinations.

During FY2010, the Copper River Basin area and the Kenai Peninsula Child Advocacy Centers became fully operational. The Kenai Peninsula center is based in Homer with fully functioning satellites in Kenai, and Seward, and Kodiak is in the process of forming a Multidisciplinary Teams. It is expected that other interested communities may apply for start-up funding for planning activities when the 2012 grant year is available.

There are a total of nine Centers statewide in Alaska with a tenth in the planning stages around full Multidisciplinary Team implementation. Situated in both rural and urban centers, the fully

operating CACs include locations in Nome, Bethel, Dillingham, Fairbanks, Mat-Su Valley, Copper River Basin, Anchorage, Kenai and Juneau, with Kodiak planning for full Center implementation in FY2012. Anchorage and Mat-Su attained full re-accreditation through the National Children's Alliance in FY2011 and all other Centers are focused on retaining or attaining accredited status in the near future, so that Alaska's Child Advocacy Centers represent a fully standardized approach to child abuse investigations utilizing best practices statewide.

Alaska's Family-to-Family Program

During the past year, the Annie E. Casey Foundation (which oversaw Family-to-Family nationwide) completed their Family-to-Family Initiative. In Alaska, Family-to-Family focus has continued to be Team Decision Making efforts and Support, Development and Recruitment of resource families.

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 Office of Children's Services has implemented Team Decision Making and Support, Development and Recruitment services in Anchorage, Fairbanks and Wasilla at no additional cost to the state.

Family Preservation

Family preservation services grants are awarded through four service areas designed to support families and 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. Service areas include:

- Family Support Services;
- Family Preservation Services;
- Time-Limited-Family Reunification Services; and
- Family Contact Services Center.

Services provided by our grantees support continued safety monitoring services aimed at increasing parental capacities for children and their families; In-home services are the primary focus of services, ensuring modeling, coaching and guidance in parenting, life skills and understanding child development.

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 the children. Services delivered help to prevent the need for out-of-home placements of children and include:

- Ongoing family assessments;
- Safety 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 and removal from the home is necessary.

Family Contact Services Center

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.

Currently, only one Family Contact Services Center is being funded in Anchorage.

Data collected from grantees over the past year has provided some insight into the services being provided. While OCS is still working toward measures that will indicate positive outcomes, this data does provide us with insight into grantee/client contacts.

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Family Preservation Services Provided	
Families Served	337
Adults Served	470
Children Served	734
Client Transports	4,210
Supervised Child Visits	5,537
Average Cost Per Visit	\$143
Hours of Direct Services to Families	18,490
Total Investment in Direct Services	\$2.2 Million
Average Direct Service Cost/Family	\$6,375
Average Direct Service Cost/Hour	\$116

Independent Living Services

The Independent Living program provides services to foster youth ages 16 to 21, both in custody and those who have exited OCS custody, to prepare them for self-sufficiency in adulthood. Research suggests that without the extended support most families provide young people in the transition to adulthood, youth leaving foster care face enormous challenges in building successful lives.

Independent Living Services are offered to all eligible youth and include independent living needs assessment, academic support, post-secondary education support, career preparation, vocational and job training, budgeting and financial management training, mentorship, health education and risk prevention training, life skills assessments, transition planning and housing education and home management training.

FY 2010 Independent Living Youth Participants by Region			
Region	In Custody	Out of Custody	Total Youth
Anchorage	56	100	156
Northern	30	54	84
South Central	46	92	138
Southeast	22	50	72
Western	17	30	47
Total	171	326	497

The Independent Living services are available to the approximately 171 youth sixteen years old and above that are in state custody. The program also serves approximately 326 youth that are no longer in state custody

As part of the Independent Living Program, an Education Training Voucher (ETV) is awarded to current and former foster youth. ETV funds are used to assist foster youth to reach their education/ training goals and make a successful transition to self-sufficiency by providing financial support for post-secondary education and training.

The Independent Living Program hosts the annual Education Conference which took place in July 2010, at the University of Alaska, Fairbanks campus, and 30 youth from throughout Alaska attended.

Rural Social Services

The Rural Social Services Program is designed to help children and families living in rural Alaska who are at risk for out-of-home placement and children who have been removed from their home setting. The Rural Social Service Program provides child abuse prevention and support services to families at risk of entering into OCS custody and coordinated case management services to families and children who are involved in the OCS system.

The priorities for service are families and children living in rural Alaska who are at risk of out-of-home placement due to allegations of child abuse or neglect and children who are in out-of-home placement needing services to reunify with their families. Because of the disproportionate number of Alaska Native/American Indian children involved in the OCS system, special consideration will be given to proposals that prioritize services to Alaska Native/American Indian children and families.

Services include both Family Preservation, and Time Limited Reunification. These services are identical to those described in the Family Preservation, and Time Limited Reunification sections.

Tribal Title IV-E

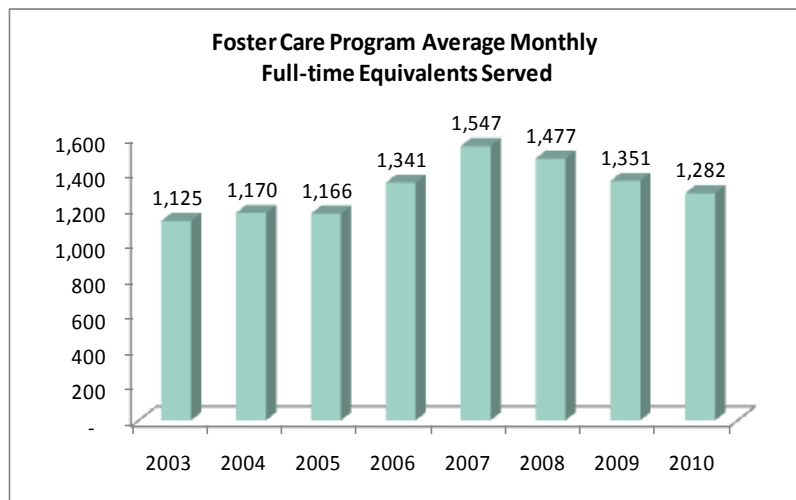
The Office of Children's Services administers the Tribal Title IV-E Reimbursement Program through agreements with Alaskan Tribes and Tribal Organizations. This program passes through as much as \$1 million annually of Title IV-E federal funds to participating tribes. In conjunction with the Office of 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, Foster Care numbers dropped by 8.5% from FY08 to FY09 and 5% from FY09 to FY10. The Office of Children's Services believes more children are remaining in their homes as a result of practice changes such as safety assessment and the increased numbers of adoptions that have been finalized during this same time period.



Note: FY2005 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.

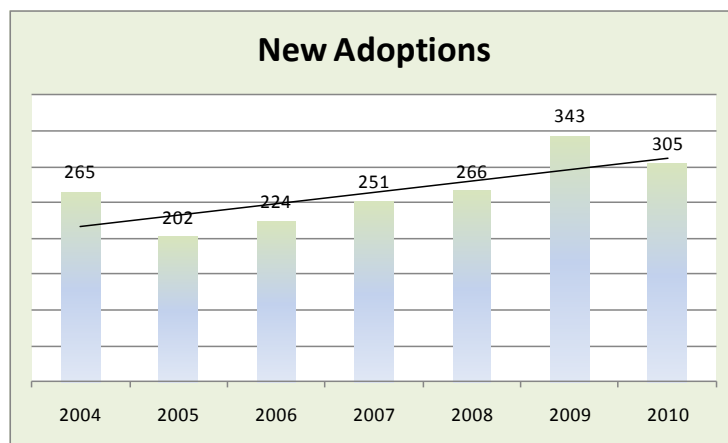
Subsidized Adoption and Guardianship

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 three 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 FY2011 with 95 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 the decreases in foster care from FY08 – FY10 as shown here. Those same children are now being permanently placed.

Residential Child Care

Residential Child Care facilities deliver high quality, time-limited residential treatment services and 24-hour care for abused, neglected, and delinquent children who are unable to remain in their own home or who need structured treatment. These children may be in the custody of the Office of Children's Services and Juvenile Justice or recipients of service through the Bring the Kids Home (BTKH) initiative that allows non-custody youth to access Residential Child Care services with prior OCS approval.



Residential Child Care facilities (like those pictured above) deliver emergency stabilization and assessment, as well as increasingly intensive levels of residential diagnostic treatment based on the needs of the individual child. OCS provides grants for core services to ensure capacity. The Behavioral Rehabilitation Service Medicaid program provides funding for eligible treatment and care. Individual Service Agreements provide unique services for children as funding of last resort to meet specialized needs. OCS also provides training and technical support specific to residential care to providers through a training grant.

In FY2011, the Office of Children's Services issued 25 competitive grants for rural and urban residential care resulting in 175 beds available statewide. Five facilities operate outside Alaska's three urban hubs and three of those rural facilities are piloting flexible levels of service to ensure children receive the services needed as close to their home communities as possible.

Residential bed capacity has decreased nominally in the last few years and utilization of beds has remained fairly stable at around 70%. Not all facilities enjoyed stability. Between FY2009 and FY2010, four Emergency Shelters closed due to financial difficulty and only one community has recouped those services: Yukon Kuskokwim Keyes in Bethel, Safe and Free in Dillingham, Salvation Army Cares for Kids in Anchorage, and Kawerak's Jacob's House that was replaced by Nome Children's Home. Despite sharply increasing costs, particularly in rural areas, payment for services has not increased since 2005. Nonetheless, all children served were retained in-state with a focus on maintaining ties to their families and communities when appropriate.

Additional information as well as an interactive map of the Residential Child Care for Children and Youth system are available at:



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

Annual Statistical Summary of Services Provided in FY10

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.

In FY2010, 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.
-
- Over 90% of families reported that ILP did an excellent job helping them know their rights;
 - Over 90% of families reported that ILP did an excellent job helping them effectively communicate their child's needs;
 - Over 92% of families reported that ILP did an excellent job helping them help their child develop and learn.

Early Childhood Comprehensive Systems

While the ECCS Program is primarily focused on improving "systems" and "policies" to support early childhood programs, two projects are funded directly- the Early Childhood Mental Health Consultation Project and the Early Childhood Mental Health Learning Network.

The Early Childhood Mental Health Consultation Project provided consultation and training to 48 classrooms with over 400 children. All of the children needing individual consultation maintained child care as a result.

The Early Childhood Mental Health Learning Network provided training to 104 practitioners, 92% of whom reported that their skills and knowledge improved.

Strengthening Families Program

Strengthening Families builds protective factors around children by supporting family strengths and resiliency in early childhood and family support programs, the program provided 2,232 hours of training to 416 participants in FY 2010.

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.

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 alleged child 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 into 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% of children in state custody are Alaska Native. A collaborative effort between the OCS and tribal child welfare leaders is working to decrease this disparity through strategic planning with the Tribal State Collaboration Group and local plans between tribal and state partners.

Protective Services Reports Screened In By State Fiscal Year						
	FY05	FY06	FY07	FY08	FY09	FY10
Screened in for OCS Assessment	5,936	6,219	6,313	6,101	6,294	5,918
Protective Services Reports Screened Out By State Fiscal Year						
Screen Out Reason	FY05	FY06	FY07	FY08	FY09	FY10
Differential Response	414	534	324	297	183	0
Does not Meet IA Criteria	1,478	1,787	2,289	2,386	3,548	4,630
Insuf. Info. To Locate	170	214	582	889	1,078	1,740
Law Enforcement Juris. Only	794	740	872	902	1,165	1,157
Mult. Ref. on Same Incident	121	238	488	571	798	881
Referred to Another State	17	40	45	35	51	64
Referred to Military or Tribe	201	254	346	273	324	185
<i>Total</i>	3,195	3,807	4,946	5,353	7,147	8,657
Total Protective Services Reports Screened By State Fiscal Year						
	FY05	FY06	FY07	FY08	FY09	FY10
<i>Total PS Reports Received</i>	9,131	10,026	11,259	11,454	13,441	14,575

Unique Count of Alleged Victims by State Fiscal Year						
	FY05	FY06	FY07	FY08	FY09	FY10
Alleged Victims in Screened In Reports	7,959	8,654	8,470	8,482	9,012	8,326
Alleged Victims in Screened Out Reports	3,861	4,798	6,006	6,275	8,007	9,459
<i>Total*</i>	10,933	12,320	12,797	12,988	14,640	15,218
<i>* Some alleged victims are in both screened in and screened out reports</i>						

Unique Count of Children in OOH care for entire FY						
	FY06	FY07	FY08	FY09	FY10	
Native	1,622	1,757	1,887	1,919	1,822	
White	751	850	857	853	791	
Other	271	332	298	263	234	
Undetermined	27	33	26	34	46	
<i>No. of Children</i>	2,671	2,972	3,068	3,027	2,893	

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						
	FY06	FY07	FY08	FY09	FY10	
Anchorage Region	94.9%	95.0%	92.4%	92.5%	94.4%	
Northern Region	90.5%	88.8%	92.6%	93.1%	90.1%	
Southcentral Region	89.1%	89.2%	92.8%	92.4%	90.5%	
Southeast Region	94.8%	87.7%	83.1%	90.2%	83.1%	
<i>Total Alaska</i>	91.6%	91.1%	91.7%	92.4%	91.7%	

Data Source: allallegs; CPS_REPORT; spell_in; and Absence of Recurrence report

Program used to tabulate statistics: SR10378.sas

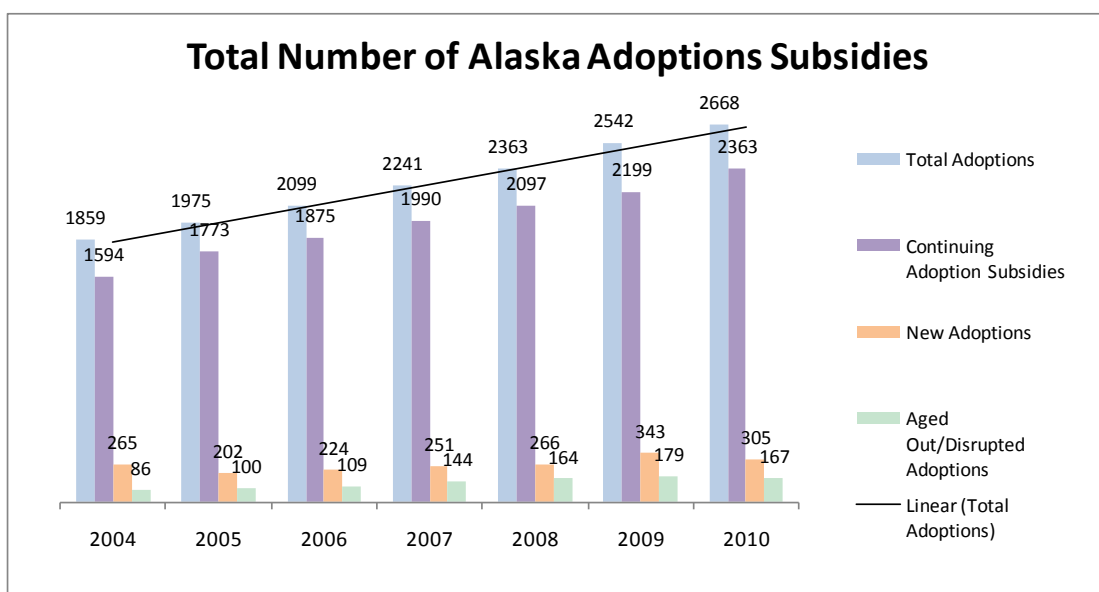
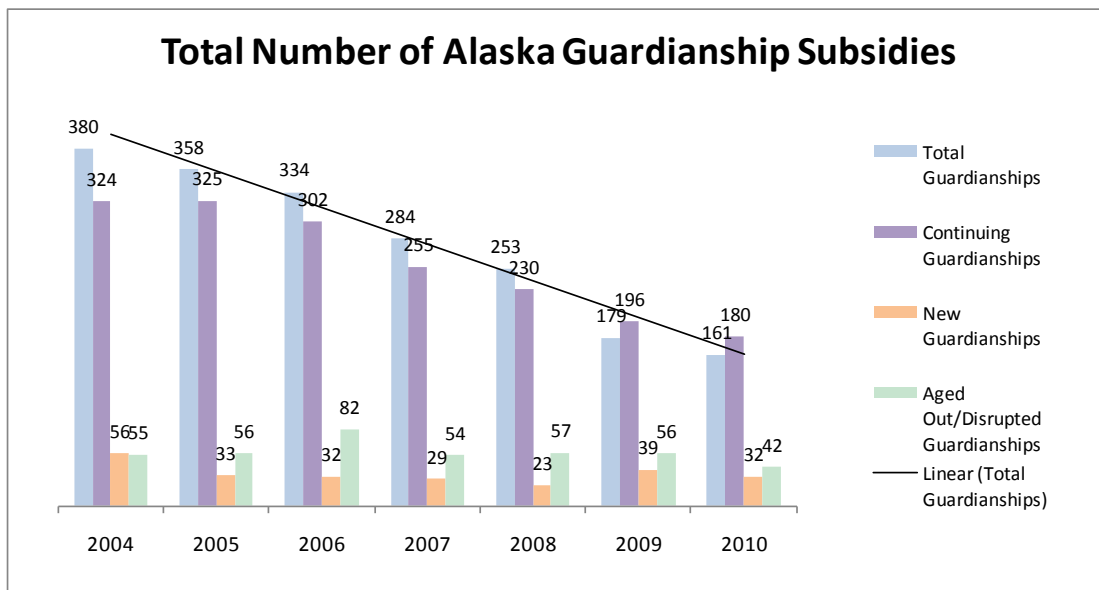
Date of data: October 29, 2010

Adoptions and Guardianships

At the end of FY2007, 2,241 children were living in permanent homes assisted through the Subsidized Adoption and Guardianship program. At the end of FY2010, that number was 2,662. The total number of Alaska subsidies for adoptions and guardianships has steadily increased over the past five years and early FY2011 numbers indicate that trend will continue.

The following charts outline the continued growth of the Subsidized Adoption and Guardianship since FY2004. 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 FY2004 through FY2010 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	2010
IV-E Continuing Adoptions	1319	1457	1541	1658	1721	1764	1875
IV-E New Adoptions	209	149	190	188	183	262	219
IV-E Aged Out	49	51	67	102	130	127	124
IV-E Disrupted	22	29	22	25	10	24	9
Current=Continuing + New - Aged Out - Disruptions	1457	1526	1642	1719	1764	1875	1961
Adoptions Funded by the State of Alaska							
State Continuing Adoptions	275	316	334	332	376	435	488
State New Adoptions	56	53	34	63	83	81	86
State Aged Out	11	15	17	11	21	25	30
State Disrupted	4	5	3	6	3	3	4
Current=Continuing + New - Aged Out - Disruptions	316	349	348	378	435	488	540
Guardianship funded by the State of Alaska							
Guardianships Continuing	324	325	302	255	230	196	180
Guardianships New	56	33	32	29	23	39	32
Guardianships Aged Out	40	36	53	42	48	46	42
Guardianship Disrupted	15	20	26	12	9	13	9
Current=Continuing + New - Aged Out - Disruptions	325	302	255	230	196	179	161
TOTALS							
(TTL) YTD New Adoption/Guardianship	321	235	256	280	289	382	337
plus TTL continuing Adoption/Guardianship	1918	2098	2177	2245	2327	2395	2543
less TTL YTD Aged Out	100	102	137	155	199	195	196
less TTL Disruptions	41	54	51	43	22	40	22
Total Children in Active Subsidies at the end of the FY	2098	2177	2245	2327	2395	2542	2662

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 (PRWORA)	
Social Security Act, Title IV-A	
Social Security Act, Title IV-B	
Social Security Act, Title IV-E	
Social Security Act, Title XIX	
Title XIX Grants to States for Medical Assistance Programs	
Title XXI State Children's Health Insurance Program	

Explanation of FY12 Operating Budget Requests

Office of Children's Services

Budget Overview Table

Office of Children's Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$80,171.2	\$81,927.6	\$1,756.4
Designated General Funds	2,649.2	2,649.3	0.1
Federal Funds	47,760.8	45,119.6	(2,641.2)
Other Funds	3,833.1	3,621.1	(212)
Total	\$134,414.3	\$133,317.6	\$(1,096.7)

Budget Requests

Foster Parent & Parent Recruitment Training & Support: \$138.0 MHTAAR

The FY12 operating budget requests include a one-time \$138.0 MHTAAR increment to recruit and screen potential foster parents and provide training and technical assistance for parents and foster parents of youth experiencing serious emotional disturbances. This request is a part of the Bring the Kids Home project. The OCS will manage the funds and contract to recruit and screen foster parents and provide technical assistance to retain these parents. Training will also be available to biological parents as available. If not funded, training will not occur and advancement toward appropriate foster homes for individual children in custody will continue to be in shortfall.

Sustain Operations of the Kodiak Child Advocacy Center: \$250.0 GF

This is to support and sustain operations of a Child Advocacy Center (CAC) in Kodiak. The Kodiak Area Native Association has been serving as the lead agency to establish a regional CAC on Kodiak Island. They have formed a multidisciplinary team; the foundation of each CAC's success, adopting evidence based practices, received training from the National and Alaska Children's Alliance and is moving toward successful implementation and national accreditation.

If this request is denied, the Office of Children's Services will need to decide whether to fund Kodiak by decreasing grants to other successful CACs or to exclude the Kodiak CAC from state support. Current funding available to existing CACs cannot meet requested amounts resulting in reduced capacity as demand continues to rise. Reports of sexual abuse referred to CACs in FY08 totaled 743. In FY09 that number increased to 1,478. Reports of physical abuse referred increased by 98 during that same time period. Referral amounts for FY10 are not yet available. For Kodiak, no additional funding to sustain their program will most likely mean failure.

Early Intervention/Infant Learning Pgm Positive Parenting Training: \$80.0 MHTAAR

The Early Intervention/Infant Learning Programs will utilize one-time MHTAAR funds to support three demonstration sites to fully implement the “Teaching Pyramid” to support social competence and prevent challenging behavior in young children. These parent teaching modules are designed to help fill the gap between families who are in need of intervention supports, but whose provider agencies have not yet adopted these strategies. Foster and biological families will be provided training for intervention based on positive relationship building, home and classroom preventative practices, social and emotional teaching strategies, and individualized interventions. Without this funding the demonstration project will not move forward and families will not receive the training they need to support social competence and prevent challenging behavior in children in their care.

Clinician to work w/Head Start and Day Care Centers: \$100.0 MHTAAR

An additional \$100.0 in one-time MHTAAR funding will help to fund a clinician and some provider grants to establish an early childhood mental health learning network to provide early childhood screening and intervention services at day care and Headstart programs. Data strongly supports that infants and toddlers not meeting developmental milestones, who live in high risk families or are born into aversive life situations, have a higher probability of developing severe emotional or behavioral disturbances. This funding will support the Bring the Kids Home project focus to intervene early. If the funding is not available, the mental health learning network will not be fully developed and Headstart program children may not receive screening and intervention services.

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.

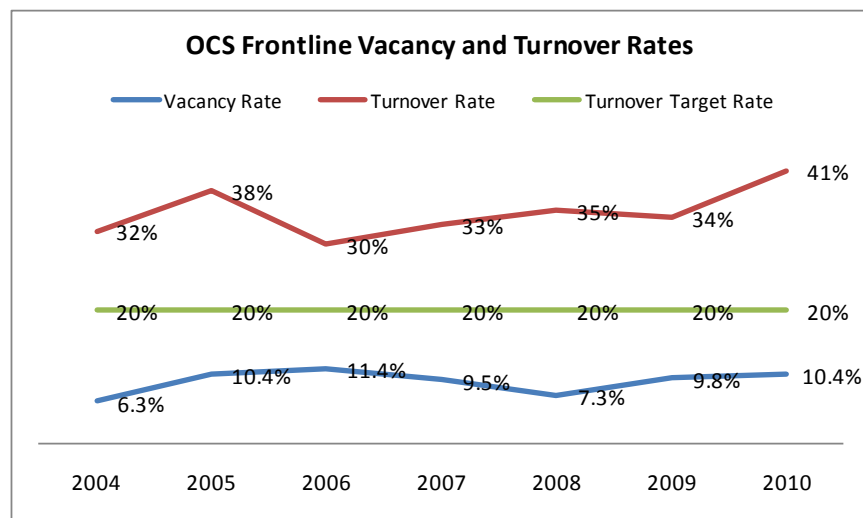
The on-site portion of Alaska's second review took place in September of 2008. Sites subject to the review were Anchorage, Juneau, and Bethel. The results of Alaska's review, as anticipated, required a Program Improvement Plan. The plan was developed and implementation has occurred over the past year and will continue over the next year. Implementation efforts require concentrated resources, leaving the division struggling to develop, train, implement, and maintain specific portions of the plan while continuing to provide services to children and families.

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.

Last year the OCS reported the results of the 2008 staff survey indicating approximately 50% of the Office of Children's Services front-line caseworkers had been employed in their current positions with the agency for less than two years. The 2009 survey indicates that that percent increased to 60% with 25% having less than one year of experience.

Despite specific efforts to combat high vacancy and turnover at the OCS, FY2010 closed with rates at their highest in 7 years.



The 2009 OCS Staff Survey, when compared to the 2008 results, indicate that the majority of OCS staff still believe that in order to retain staff, salaries and benefits need to be increased, workloads reduced, work accomplishments should be better recognized, and support staff are needed.

In an effort to improve OCS's ability to attract and retain qualified staff through workforce development, the OCS continues to work internally to focus on retention and recruitment strategies through a workgroup that 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 available to provide technical assistance.

The agency's internal work group has maintained a web page for career opportunities and current openings at the address provided below. The web site includes a video that provides potential applicants the opportunity to view a realistic job preview and hear responses to frequently asked questions from current employees that focus on both the positive and the negative aspects of employment as a front line 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 competent, qualified workers and to, more importantly, retain them will continue even though progress is extremely slow.

Implementation of Public Law 110-351 and HB126

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.

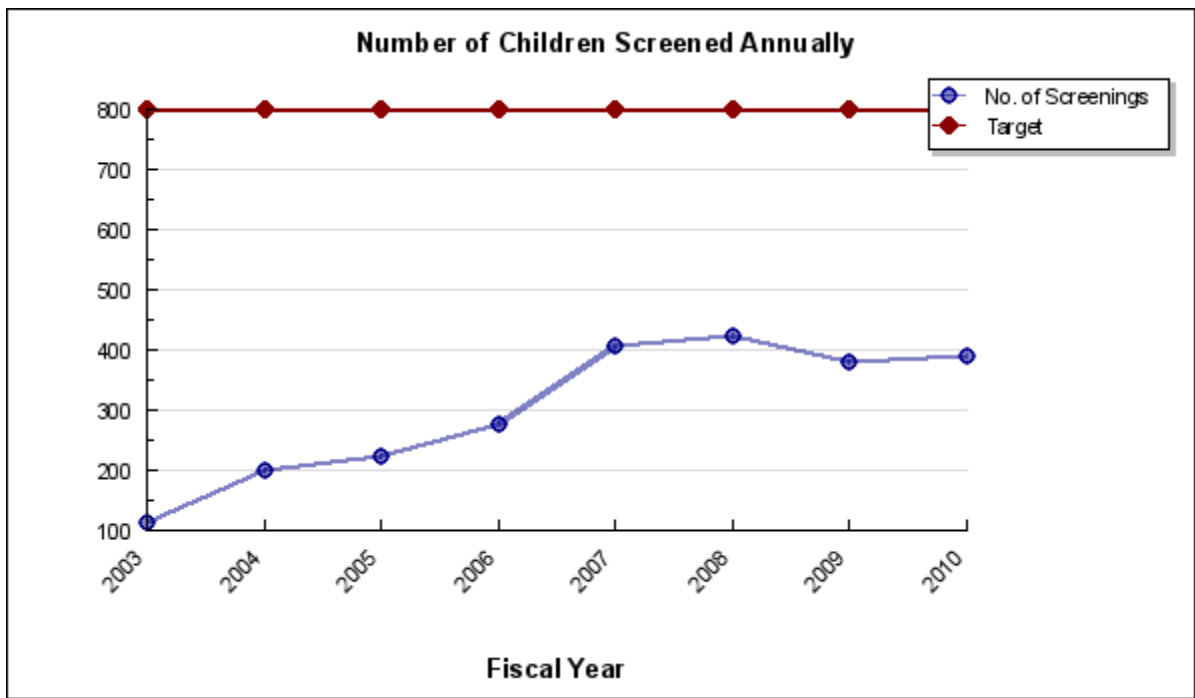
HB126 provided the OCS with the legal authority and funding to expand eligibility for foster care to age 21 years. The bill, however, did not include the same authorization for adoptions and guardianships. Until OCS can support increased subsidy payments for adoptions and guardianships to age 21, claiming Title IV-E reimbursement for extended foster care will not be allowed by the federal Administration for Children and Families. Implementation of HB126 will occur after January 1, 2011, when regulations can be adopted. Federal reimbursement for those costs will not be claimed. At this time, the OCS does not intend to request additional funding to cover the lost reimbursement.

Performance Measure Detail

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 five years. In FY2003, 113 children were screened. In FY2010, 389 children were screened.



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

Number of Children Screened Annually

Fiscal Year	No. of Screenings	Target
FY 2010	389	800
FY 2009	380	800
FY 2008	425	800
FY 2007	408	800
FY 2006	278	800
FY 2005	225	800
FY 2004	200	800
FY 2003	113	800

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

In 2003, 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.

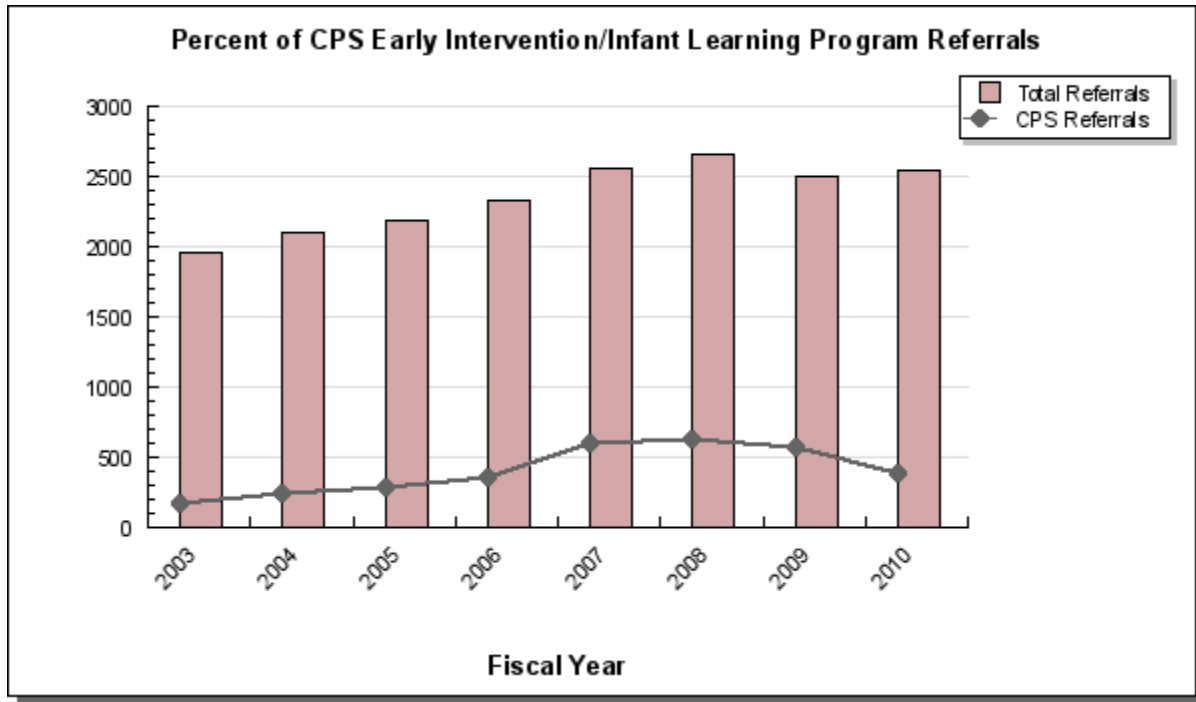
In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Current programs do not have the capacity to provide adequate training and support 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 steady increases 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 decreased by only 1% in FY2009, but fell by 6% in FY2010.



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

Percent of CPS Early Intervention/Infant Learning Program Referrals

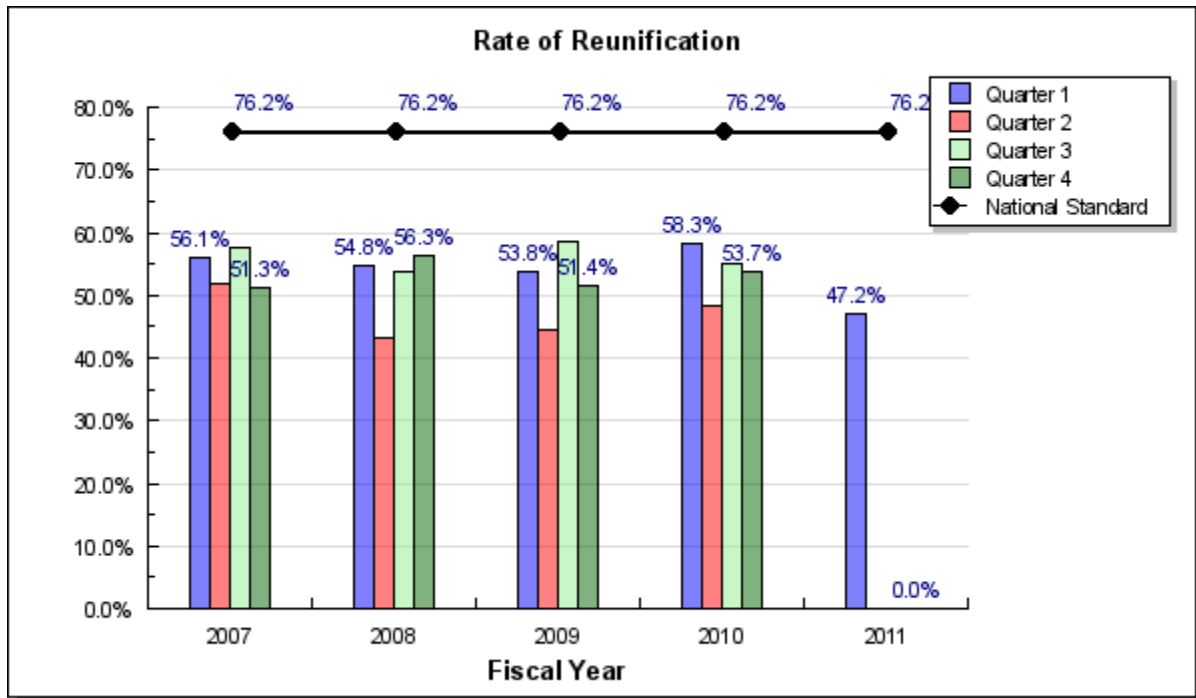
Fiscal Year	Total Referrals	CPS Referrals	Percent	Target
FY 2010	2548	389	15%	5% increase
FY 2009	2503	574	21%	
FY 2008	2657	630	22%	
FY 2007	2557	602	21%	
FY 2006	2331	363	15%	
FY 2005	2182	280	13%	
FY 2004	2107	248	12%	
FY 2003	1964	169	9%	

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) saw significant increase in overall referrals from 2006 to 2009. The decreases noted in FY2009 and FY2010 may be related to higher need with no net increase in resources.

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 increased by 1.7% in FY10.



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
FY 2011	47.2%	0	0	0	76.2%
FY 2010	58.3%	48.4%	55.0%	53.7%	76.2%
FY 2009	53.8%	44.6%	58.6%	51.4%	76.2%
FY 2008	54.8%	43.2%	53.9%	56.3%	76.2%
FY 2007	56.1%	51.9%	57.7%	51.3%	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 FY 2008 and FY 2009 but has increased by 1.7% in FY 2010. 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.

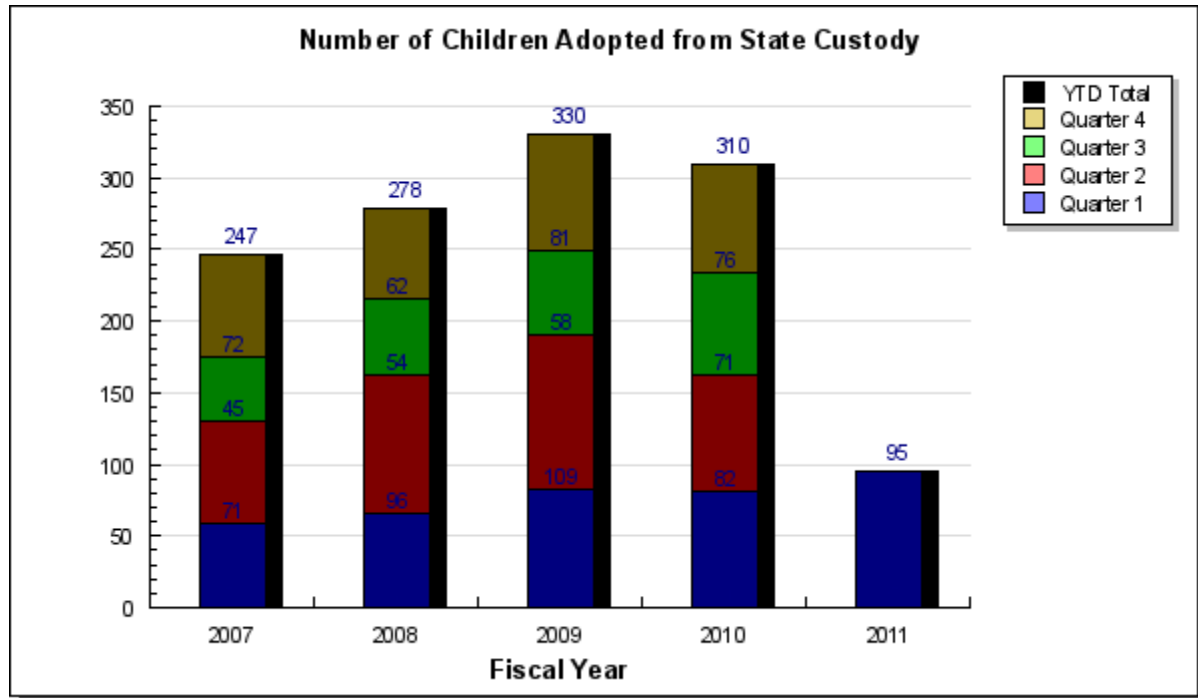
By successfully completing the implementation of the new practice model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new model encourages 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 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. In FY 10, 20 fewer adoptions were completed which still represents an increase of 32 from 2008.



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 include 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
FY 2011	95	0	0	0	95
FY 2010	81	82	71	76	310
FY 2009	82	109	58	81	330
FY 2008	66	96	54	62	278
FY 2007	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 FY 2008 to FY 2009. 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.

Target #2: Decrease the rate of child abuse and neglect per 1,000 childer ages 0-17.

Status #2: The target to decrease the rate of child abuse and neglect was met in FY10 with a decrease of 4.5 in the rate of child abuse and neglect in Alaska. Source: DHSS ORCA

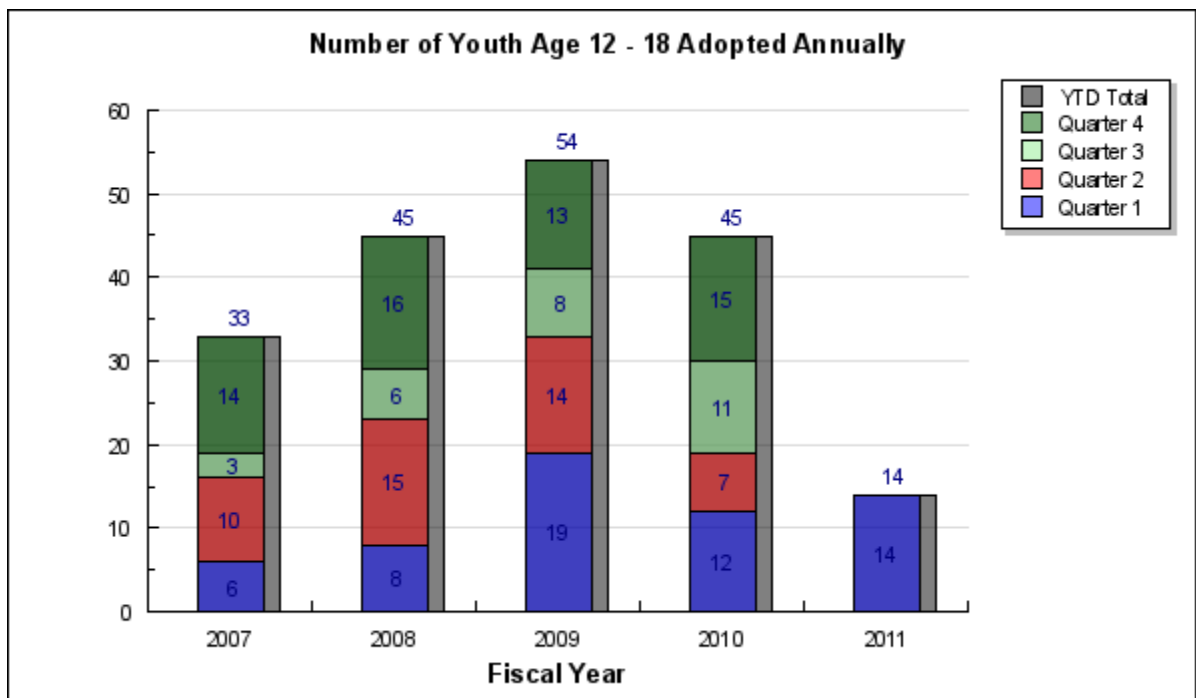
Target #3: Reduce incidents of domestic violence and sexual assault.

Status #3: The target to reduce incidents of domestic violence and sexual assault was not met. Most current data: 8,253 incidents which is a 3% increase from the previous year. Source: AK Council on Domestic Violence and Sexual Assault Annual Report to Gov. Palin, 2008

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 20% in FY09. In FY10, the number decreased by 17%.



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 data 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
FY 2011	14	0	0	0	14
FY 2010	12	7	11	15	45
FY 2009	19	14	8	13	54
FY 2008	8	15	6	16	45
FY 2007	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.

Target #2: Percent of children in Infant Learning Program (ILP) receiving service coordination.

Status #2: 100% of children in the Infant Learning Program received service coordination in FY10.

Target #3: Increase the retention rate of the DHSS social services workforce, primarily social workers, nurses and eligibility technicians.

Status #3: In FY10, DHSS had a 28% turnover rate with a 9% vacancy rate in the social services workforce.

Target #4: Increase the percentage of child protection assessments completed in 45 days.

Status #4: In FY10, 23.4% of child protection assessments were completed within 45 days.

Target #5: Increase the percentage of children referred to Infant Learning Program from Child Protective Services.

Status #5: In FY10, 42% of children were referred to the Infant Learning Program from Child Protective Services.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
FOSTER CARE/CINA/EDUCATION OF HOMELESS (HB 126)	\$ (130.7)	\$ -	\$ (73.5)	\$ -	\$ (204.2)
FY 2011 Over/Understated GGU/SU salary adjustments	\$ (19.1)	\$ -	\$ (17.6)	\$ -	\$ (36.7)
FY 2012 Personal Services increases	\$ 167.8	\$ -	\$ 91.0	\$ -	\$ 258.8
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 10.3	\$ -	\$ (10.3)	\$ -	\$ -
MH Trust: BTKH - 1926.03 Foster Parent & Parent Recruitment training & support	\$ -	\$ -	\$ -	\$ 138.0	\$ 138.0
MH Trust: BTKH - 1926.03 Foster Parent & Parent Recruitment training & support	\$ 138.0	\$ -	\$ -	\$ -	\$ 138.0
Judgments and settlements against the state for fiscal year ending June 30, 2012 (Curyung lawsuit)	\$ 1,200.0	\$ -	\$ -	\$ -	\$ 1,200.0
Sustain Operations of the Kodiak Child Advocacy Center	\$ 250.0	\$ -	\$ -	\$ -	\$ 250.0
Reverse OTI - Judgments and settlements against the state for fiscal year ending June 30, 2011 (Curyung lawsuit)	\$ (1,200.0)	\$ -	\$ -	\$ -	\$ (1,200.0)
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (275.0)	\$ (275.0)
Delete ARRA funding for enhanced FMAP of 6.2%	\$ -	\$ -	\$ (243.6)	\$ -	\$ (243.6)
Extending State Custody of Children; Ch. 80 SLA 10 (HB 126)	\$ 184.0	\$ -	\$ 36.5	\$ -	\$ 220.5
Delete Excess Federal Authority	\$ -	\$ -	\$ (400.0)	\$ -	\$ (400.0)
Extending State Custody of Children; Ch. 80 SLA 10 (HB 126)	\$ 38.7	\$ -	\$ 2.2	\$ -	\$ 40.9
Delete ARRA Funding for Enhanced FMAP of 6.2%	\$ -	\$ -	\$ (780.0)	\$ -	\$ (780.0)
MH Trust: Gov Cncl - 1207.04 Early Intervention/Infant Learning Pgm Positive Parenting Training	\$ -	\$ -	\$ -	\$ 80.0	\$ 80.0
MH Trust: BTKH - Grant 2550.02 Clinician to work w/ Head Start & Day Care Centers	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 7 (HB 199) Lapse Date 06/30/11	\$ -	\$ -	\$ (1,712.2)	\$ -	\$ (1,712.2)
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (255.0)	\$ (255.0)
Conversion from the Earnings Funds to POMV	\$ -	\$ 399.3	\$ -	\$ -	\$ 399.3
Decrease Authority to the Earning Funds to Reflect changes to POMV	\$ -	\$ (399.3)	\$ -	\$ -	\$ (399.3)
Restore operational funding to the amount allowable under statutes	\$ -	\$ 0.1	\$ -	\$ -	\$ 0.1
Children's Services Total	\$ 639.0	\$ 0.1	\$ (3,107.5)	\$ (212.0)	\$ (2,680.4)

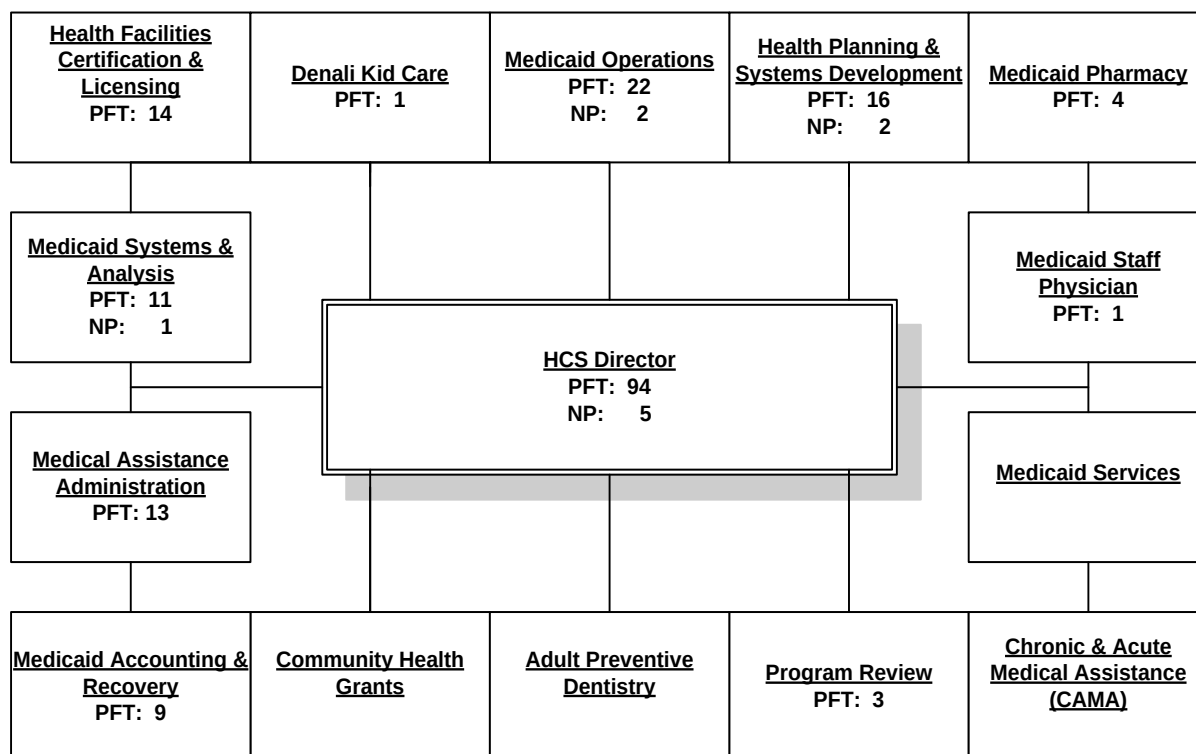
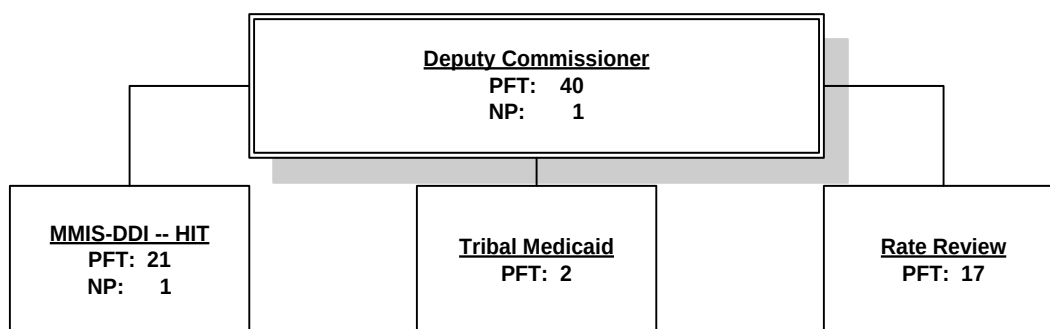
Division of Health Care Services

Operational Structure

PFT: 134

PPT: 0

NP: 6



Introduction to the Division of Health Care Services

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 health care services such as hospitals, physicians, prescription drugs, dental, and transportation. Providing 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 manages the following provider types: Pharmacy, Private Duty Nursing, Hearing and Audiology, Home Infusion Therapy, and Respiratory Therapy. The unit manages these provider

types through policy and regulation development. The unit completes research, analysis, planning, and implementation for the preceding providers. The unit ensures services to vulnerable Alaskans are high quality and cost effective treatment. The unit also provides support for the Chronic and Acute Medical Assistance (CAMA) program, the provider-administered drug program, the Department's Program Integrity Unit, the Medicaid Fraud Unit and the Commercial and Fair Business Section of the Department of Law.

This year the unit presented regulations which were adopted to improve tamper resistant prescriptions, allow immunization of adults and change pharmacy reimbursement. The unit initiatives provide excellent pharmaceutical care through the following initiatives:

Preferred Drug List (PDL):

The PDL is a list of medications that contains classes representing 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 which drugs are effective whether these 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):

- DUR is responsible for maintaining appropriate use of medications and to prevent inappropriate use, and adverse reactions. This sub-program ensures drugs are used safely and appropriately by our Medicaid recipient population.
- Prospective DUR provides immediate review of prescriptions at the time of filing, to determine if the medication is appropriate.
- The DUR Committee oversight is provided by a committee of health care professionals.

Medicaid 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 also oversees provider enrollment, education, and outreach efforts.

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 health care facilities statewide. This unit has both policy development and operational components. It functions as a liaison and technical assistance resource to each of the divisions within the Department to maintain and enhance existing tribal functions (waivers, , BH, DPA EIS access, hospital and clinic based services, administrative claiming efforts, etc); assist with expansion of tribal refinance efforts through data analysis to promote capacity building in the tribal health care system; maintain successful and proactive working relationships internally and externally; tracks federal and state legislation and regulations pertaining to tribal functions; provides technical assistance to improve revenue generation and billing efficiencies at tribal facilities as well as oversees Continuing Care Agreements, billing manual modifications, training efforts, and other duties related to tribal health care services.

Medicaid Systems and Analysis 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 also have responsibility for claims processing analysis and compliance with federal claims processing reporting requirements.

The unit has responsibility for contract monitoring and oversight of all technical components, including the claims processor, the decision support system (DSS), and all interfaces to and from the MMIS and DSS.

The unit also has responsibility for preparing planning documents to secure federal funding related to the MMIS and fiscal agent services. This includes standard weekly MMIS services as well as federal mandates for changes in standards. The unit coordinates this action with HSS Grants and Contracts.

The unit also provides research and analysis with regard to MMIS processing outcomes, as well as decision support system training and support to H&SS users.

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 Planning and Systems Development

Health Planning and Systems Development (HPSD) 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. HPSD 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. HPSD 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.

This section is also responsible for Medicaid State Plan amendments.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP), known in Alaska as Denali KidCare, was reauthorized for 4.5 years under the Children's Health Insurance Program Reauthorization Act (CHIPRA) in February 2009. Under the Affordable Care Act (ACA) 2010 CHIP funding was extended an additional two years through 2015 with program authorization through 2019. The Children's Health Insurance Program provides excellent health insurance coverage for children 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 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
- Substance abuse treatment

Health Facilities Licensing and Certification

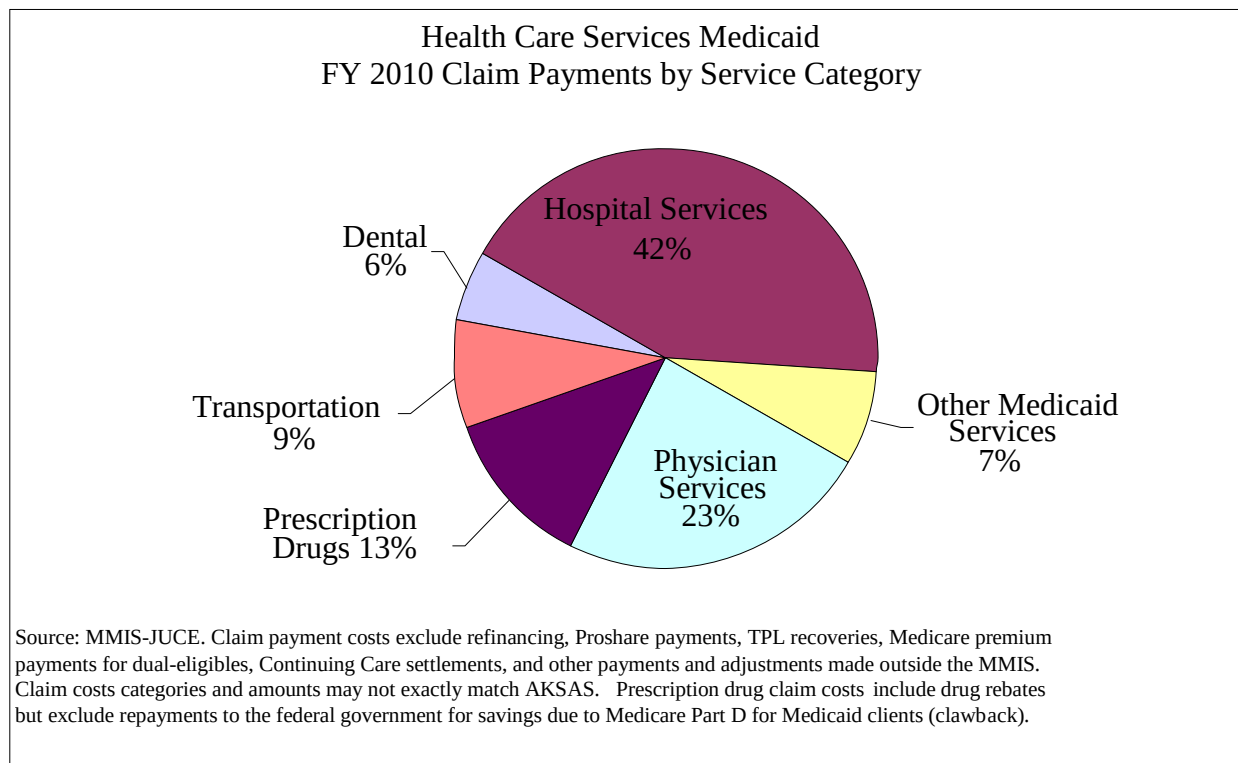
Under the State's agreement number 1864 with the Secretary of the Department of Health and Human Services the State Survey Agency's function is to conduct initial surveys (inspections), periodic resurveys, and complaint surveys for 17 different categories of health providers in the State of Alaska. Surveys 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 Licensing and Certification Unit conduct 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 Licensing and Certification Unit is authorized to renew, and if warranted, deny, suspend, or revoke licenses when there is substantial failure to comply with regulatory requirements.

Annual Statistical Summary of Medicaid Services Provided in FY10

Health Care Medicaid Services

The Health Care Services, Medicaid Services component funds both medical assistance benefits for services provided directly to Medicaid enrollees and non-claim payments for other service costs. In FY 2010, approximately 93% of this component's expenditures were made for Medicaid medical assistance recipient benefits. Direct medical assistance includes claims for hospitals, physicians, prescription drugs, dental services, transportation, and other acute care services. Non-claim payments for services include supplemental payment programs (e.g., Disproportionate Share Hospital, Upper Payment Limit) as well as Medicare premium payments and judgment restitution.

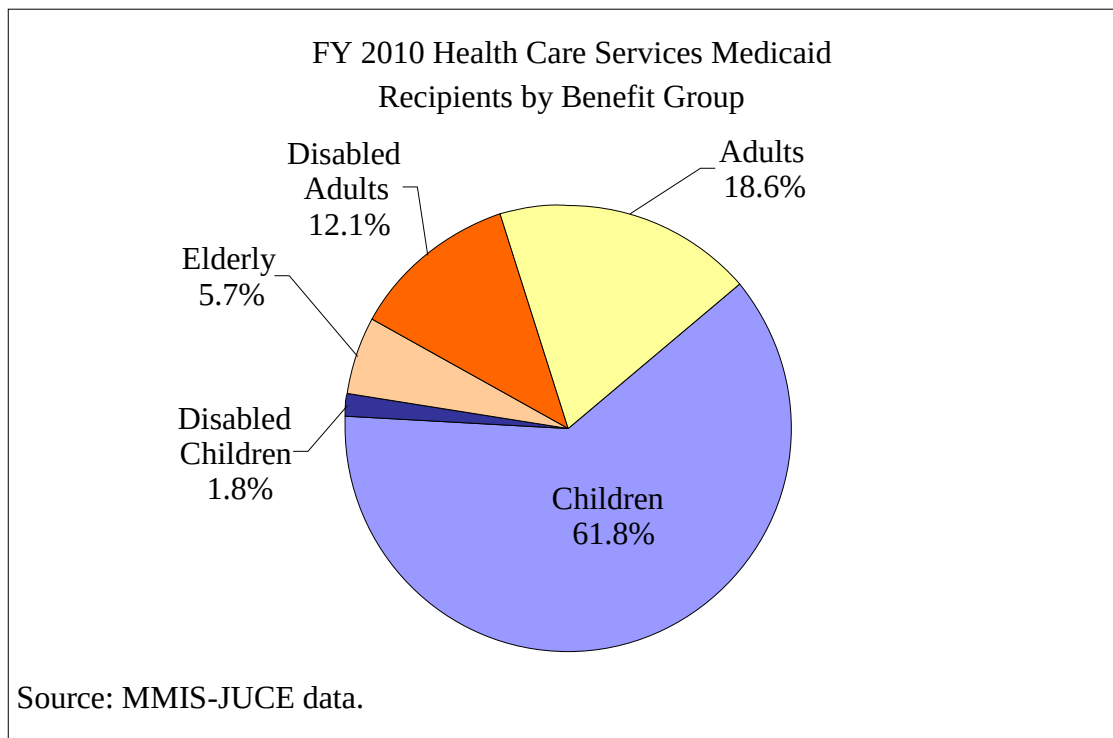
In FY 2010, Health Care Services Medicaid expenditures comprised over half of the cost of all Alaska Medicaid claim payments. Hospital services accounted for the largest share of Medicaid expenditures (42%) followed by physician services (23%), prescription drugs (13%), transportation services (9%), dental services (6%), and other services (7%).



In FY 2010, the Alaska Health Care Medicaid Services component provided direct services to 126,062 Alaskans, approximately 93.3% of all individuals enrolled in the Alaska Medicaid program. The total cost of direct medical benefits provided to Medicaid enrollees through Health Care Services totaled \$671.8 million dollars during FY 2010. 63.6% of 2010 claim payments provided medical services to children; 30.7% of expenditures provided services for adults; and 3.9% provided medical care to elderly individuals. Over 2/3 of Medicaid claim expenditures made during FY 2010 provided medical care for children and the elderly.

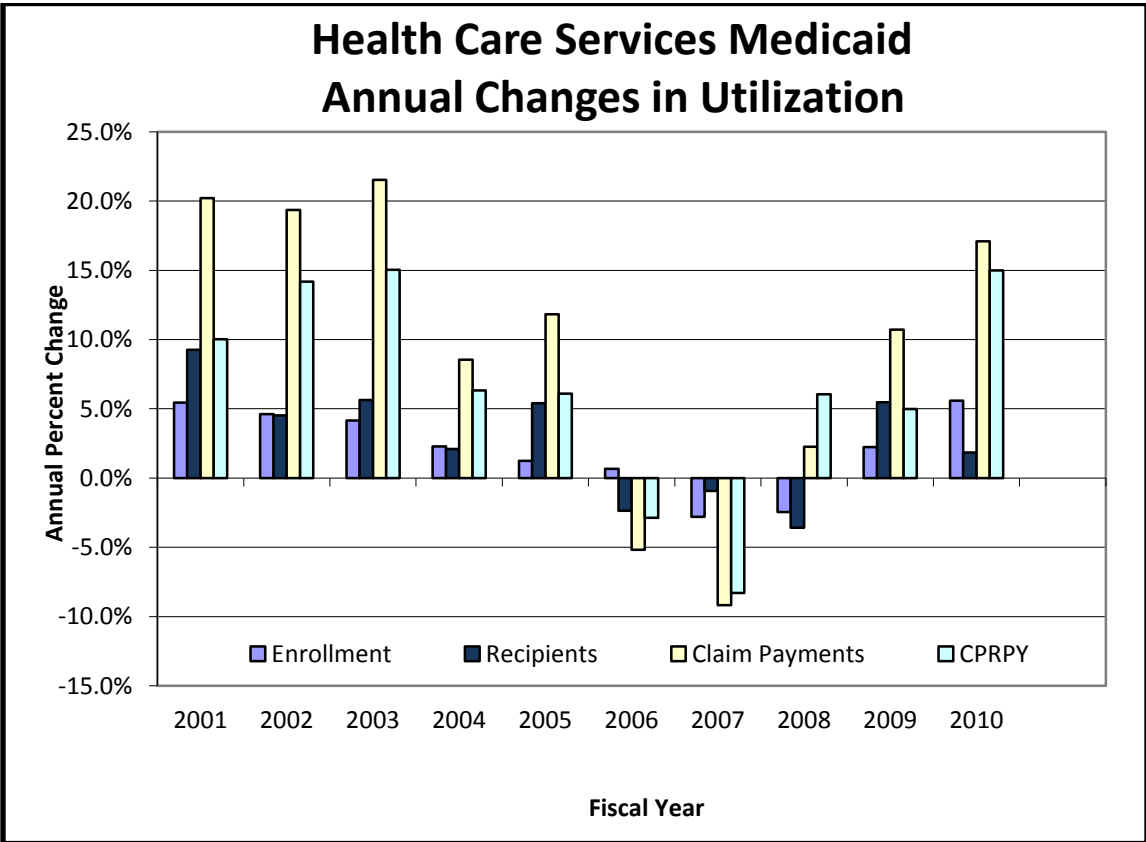
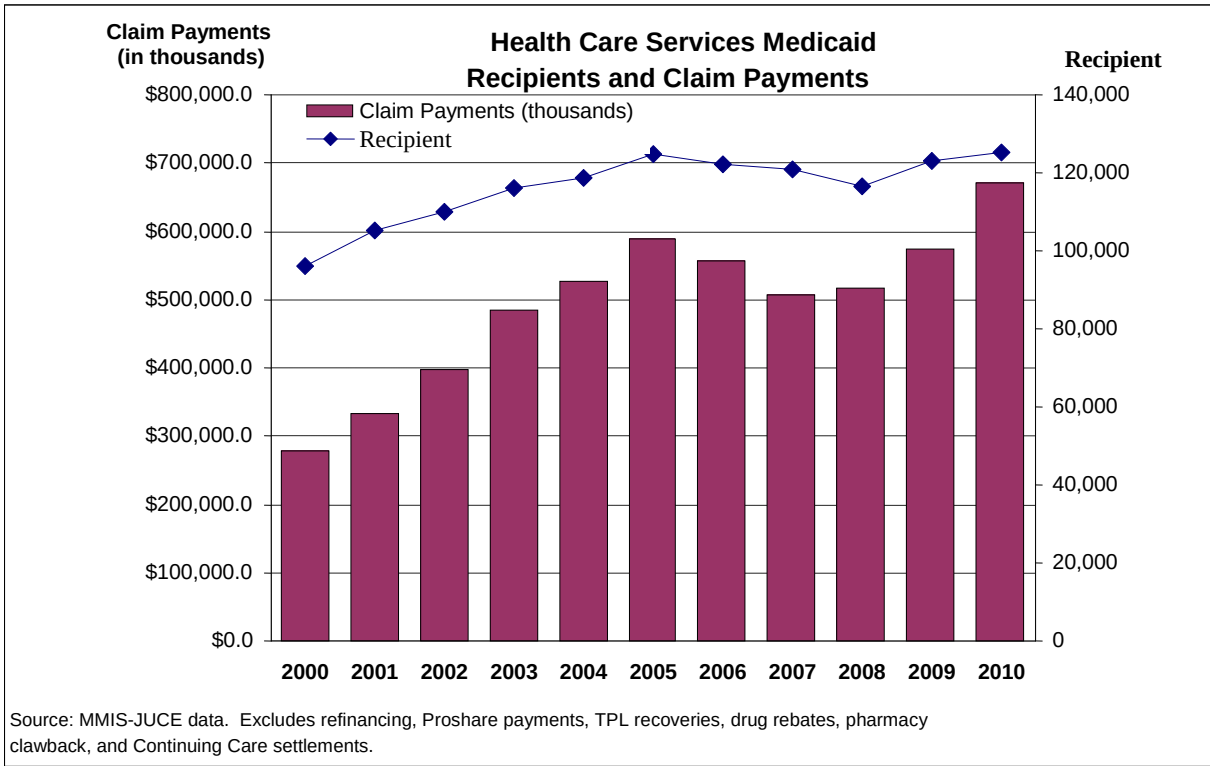
Benefit Group	Percent of Recipients	Number of Recipients	Percent of Payments	Payments (thousands)	CPRPY
Children	61.8%	77,479	43.4%	\$291,574.2	\$3,707
Disabled Children	1.8%	2,272	5.1%	\$34,032.5	\$14,979
Elderly	5.7%	7,251	3.9%	\$26,473.4	\$3,651
Disabled Adults	12.1%	15,394	25.5%	\$171,439.1	\$11,137
Adults	18.6%	23,666	22.1%	\$148,264.1	\$6,265
Unduplicated Annual Recipients 126,062					
Total Medicaid Claim Payments (thousands)				\$671,783.2	
Average Annual Medicaid Cost per Recipient (CPRPY)					\$5,329

Source: MMIS/JUCE claims paid during FY10. CPRPY is annual cost per recipient. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.



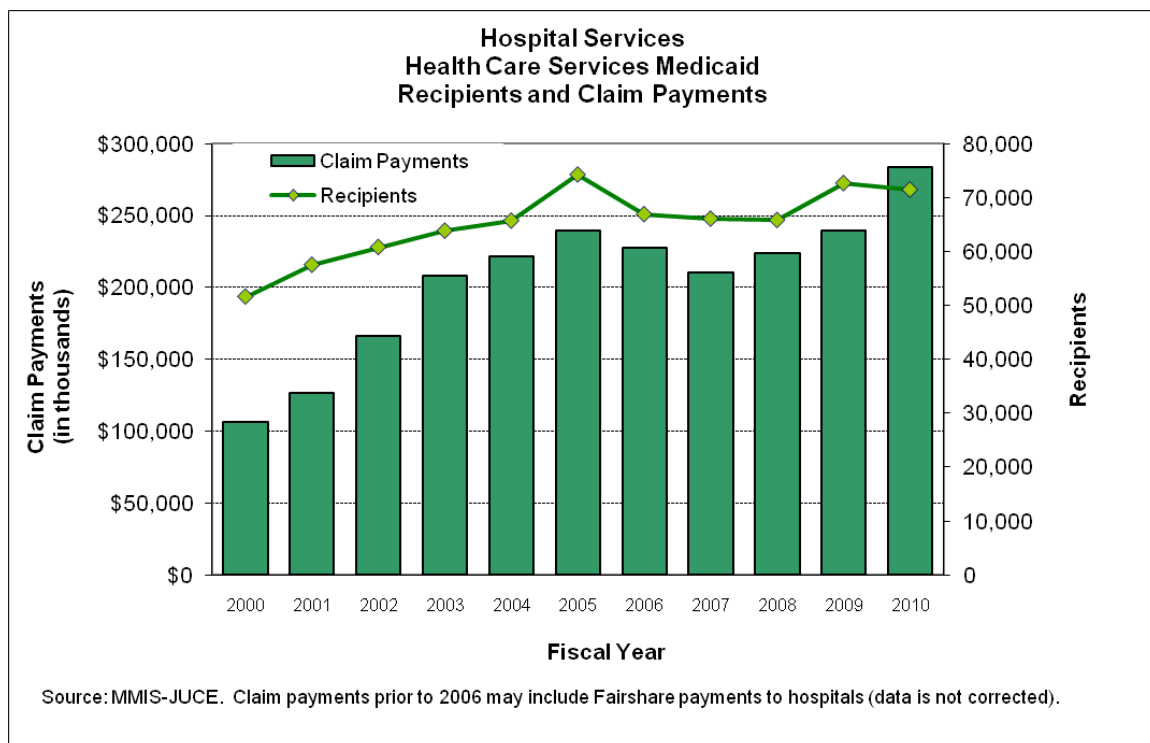
Total claim expenditures for Health Care Services Medicaid increased by 17.1% between FY 2009 and FY 2010, with increased reimbursements noticeable across many categories of service. This growth in expenditures can be attributed to a combination of both increased recipient enrollment and increased service costs. The number of recipients utilizing Health Care Services Medicaid services in FY 2010 increased by 1.8% from FY 2009. During this same period, the annual cost per recipient increased 11.8%, from an average cost of \$4,700 per recipient in FY 2009 to \$5,329 in FY 2010. Increases in medical service costs can be directly linked to rate changes associated with the yearly fee-for-service schedule set by the Federal Centers for Medicare and Medicaid Services.

ALL Medicaid Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	64.3%	80,995	49.5%	\$332,207.6	\$4,102
Over 21	35.7%	45,067	50.5%	\$339,575.5	\$7,535
Unduplicated Annual Recipients		126,062			
Total Medicaid Claim Payments (thousands)		\$671,783.2			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$5,329			
Hospital Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	56.8%	40,787	50.4%	\$142,983.1	\$3,506
Over 21	43.2%	30,995	49.6%	\$140,834.3	\$4,544
Unduplicated Annual Recipients		71,782			
Total Medicaid Claim Payments (thousands)		\$283,817.4			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$3,953			
Physician Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	63.4%	68,463	49.9%	\$80,000.0	\$1,169
21 or Older	36.6%	39,538	50.1%	\$80,216.7	\$2,029
Unduplicated Annual Recipients		108,001			
Total Medicaid Claim Payments (thousands)		\$160,216.7			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$1,483			
Pharmacy	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	61.9%	44,585	31.3%	\$25,046.1	\$562
21 or Older	38.1%	27,493	68.7%	\$55,066.1	\$2,003
Unduplicated Annual Recipients		72,078			
Total Medicaid Claim Payments (thousands)		\$80,112.2			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$1,111			
Transportation	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	53.0%	13,403	54.9%	\$30,609.1	\$2,284
21 or Older	47.0%	11,874	45.1%	\$25,187.5	\$2,121
Unduplicated Annual Recipients		25,277			
Total Medicaid Claim Payments (thousands)		\$55,796.6			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$2,207			
Other Medicaid Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	50.2%	26,817	49.3%	\$23,263.1	\$867
21 or Older	49.8%	26,649	50.7%	\$23,940.5	\$898
Unduplicated Annual Recipients		53,466			
Total Medicaid Claim Payments (thousands)		\$47,203.6			
Average Annual Medicaid Cost per Recipient (CPRPY)		\$882			
Source: MMIS-JUCE					

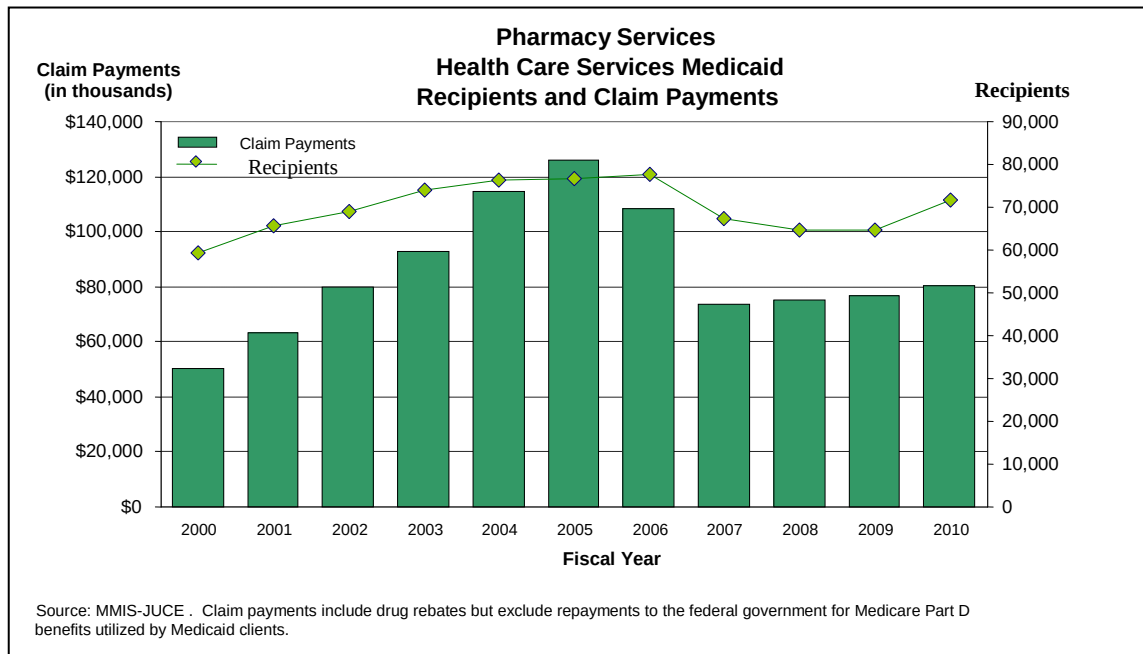


HCS Medicaid Services – Percentage Change Between Funding Years				
SFY	Annual Percent Change			
	Enrollment	Recipients	Claim Payments	Cost per Recipient per Year
2000	15.0%	20.2%	18.1%	-1.7%
2001	5.5%	9.3%	20.2%	10.0%
2002	4.6%	4.5%	19.3%	14.2%
2003	4.2%	5.6%	21.5%	15.0%
2004	2.3%	2.1%	8.6%	6.3%
2005	1.2%	5.4%	11.8%	6.1%
2006	0.7%	-2.4%	-5.2%	-2.9%
2007	-2.8%	-0.9%	-9.2%	-8.3%
2008	-2.5%	-3.6%	2.3%	6.1%
2009	2.2%	5.5%	10.7%	5.0%
2010	5.6%	1.8%	17.1%	15.0%

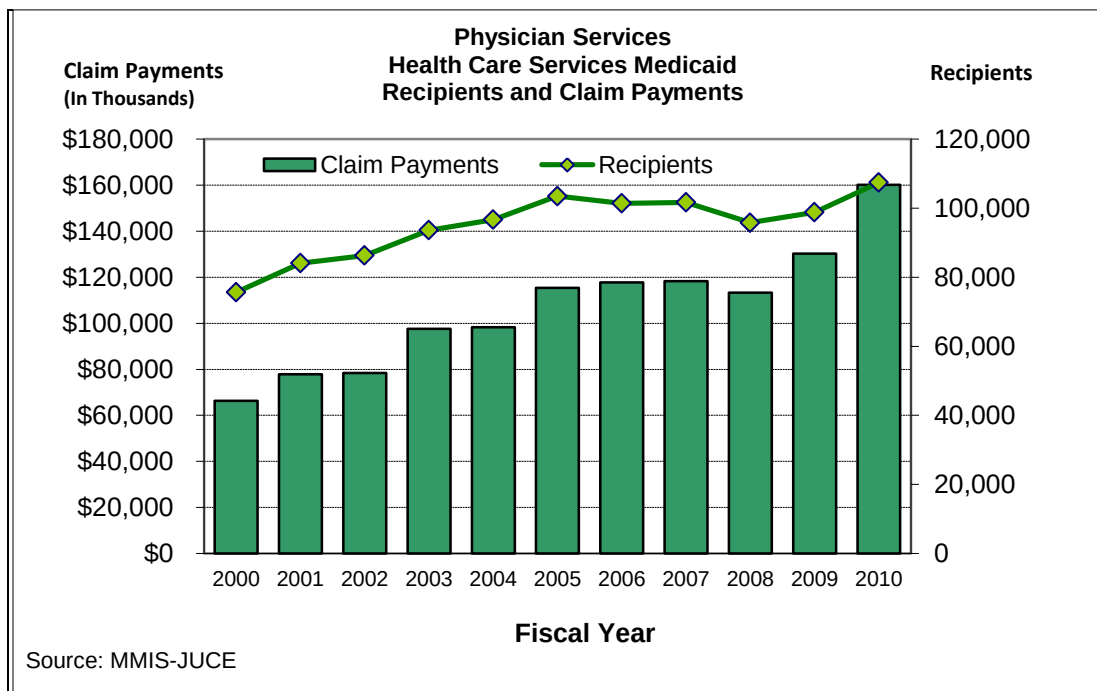
Overall claims expenditures for Medicaid hospital services increased by 18.3% between FY 2009 and FY 2010. This increase can be attributed to a number of factors, which include, but are not limited to, increases in recipient enrollment and higher levels of service utilization by recipients. The number of Medicaid recipients utilizing Medicaid hospital services increased by 1.8% between FY 2009 and FY 2010.



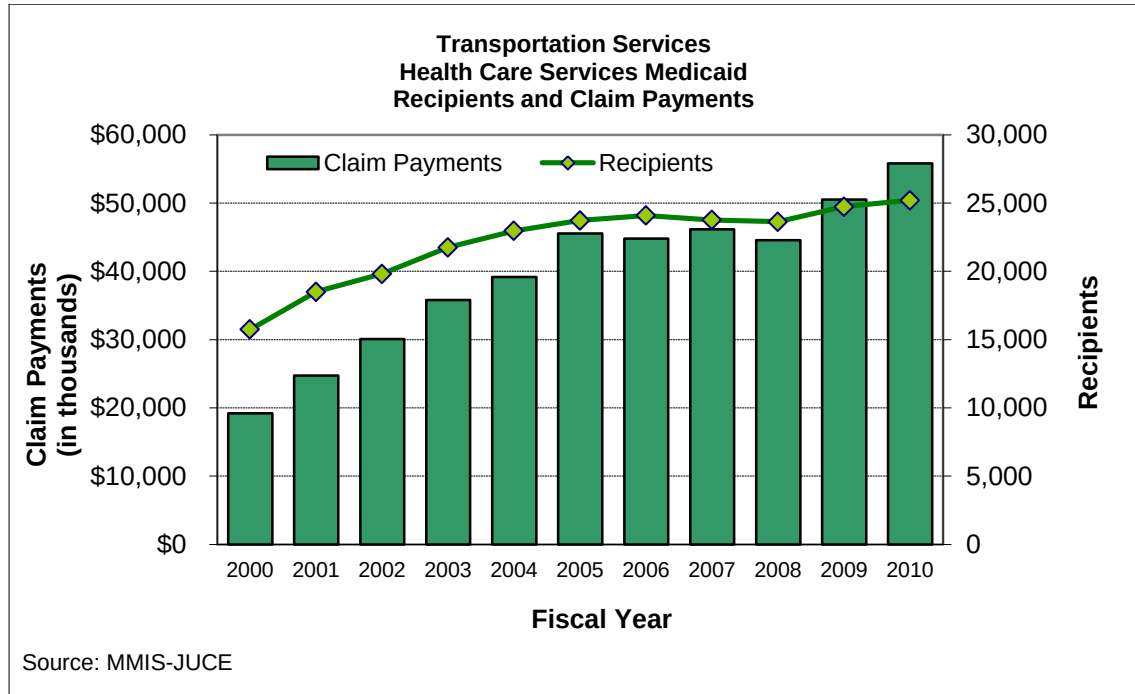
Pharmacy claim payments increased by 4.5% from FY 2009 to FY 2010. Pharmacy expenditures fell during FY 2006 and FY 2007 due to the implementation of Medicare Part D prescription drug coverage for dual eligible enrollees. The number of Medicaid recipients receiving pharmaceuticals increased by 10.7% between FY 2009 and FY 2010, while the annual average cost per recipient rose during this period by 13.1%.



Overall, claims payments for Medicaid physician services increased nearly 23% between FY 2009 and FY 2010. The number of Medicaid recipients utilizing physician services during this period increased by 10.7%, while the average cost per recipient decreased by \$66.00, or approximately 5.6%.

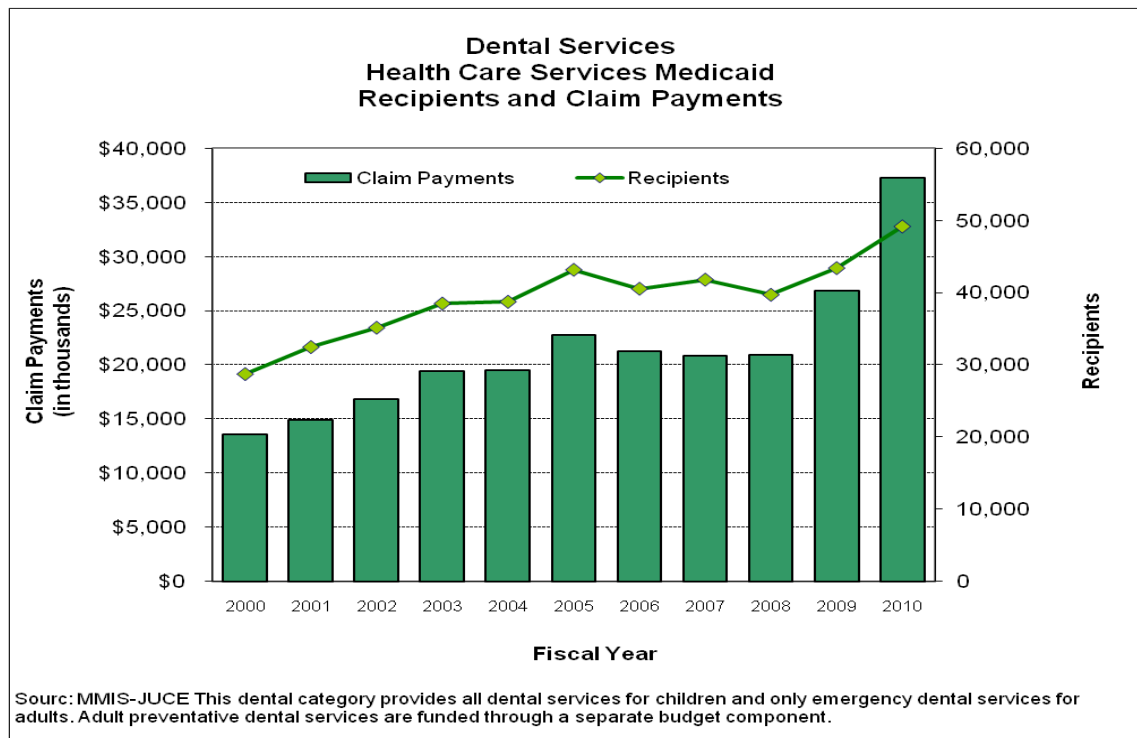


Expenditures for Medicaid transportation services grew by 10.4% during FY 2010, due in large part to increases in reimbursement rates. The number of Medicaid recipients utilizing Medicaid transportation services increased by 1.9%, while the average cost per recipient rose by 8.4%.

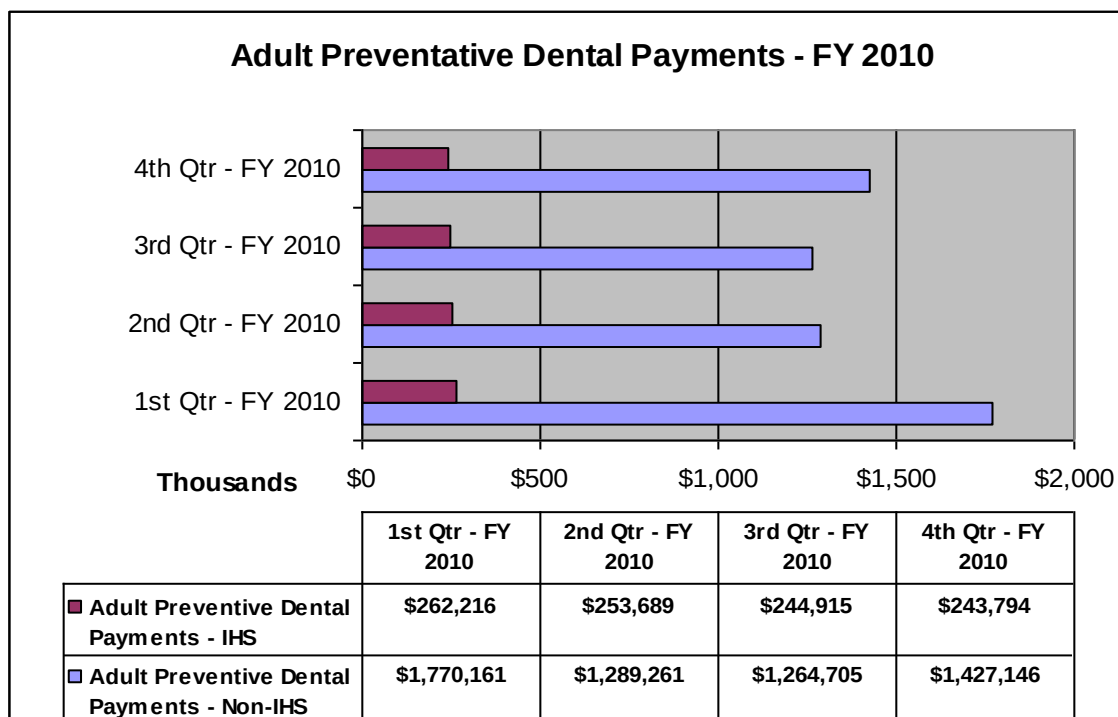
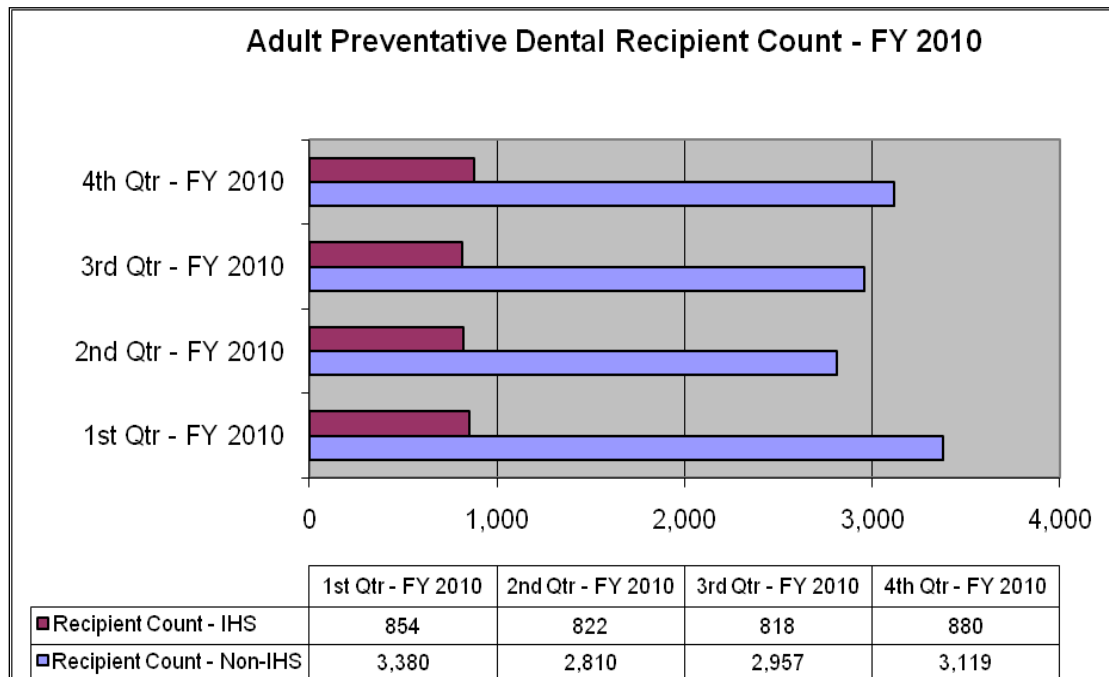


Total Medicaid expenditures for dental services increased by 38.7% between FY 2009 and FY 2010, while the number of Medicaid recipients utilizing dental services increased by 13.3%. The average cost per recipient increased by 22.4% between FY 2009 and FY 2010.

(Note: Dental services discussed here do not include Medicaid adult preventative dental services.)



The Adult Preventative Medicaid Dental program was established with the passage of House Bill 105 in FY 2006. Its implementation in April 2007 began a three-year trial period for the program. House Bill 26 (passed into law during the 2009 session) repealed the sunset clause in the original bill, and reauthorized the program to continue beyond June 30, 2009. The preauthorization requirement and annual cap per individual remains the same (\$1,150 per year). The total program costs are subject 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.)



2010 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		PARTICIPATION (Recipients as Percent of Enrollment)
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Annual Medicaid Department Totals		126,062		\$1,190,963,303	\$9,447		135,159	93.3%
Gender								
Female	56.3%	71,087	56.2%	\$668,766,333	\$9,408	54.8%	74,047	96.0%
Male	43.7%	54,974	43.8%	\$522,196,970	\$9,499	45.2%	61,111	90.0%
Unknown	0.0%	1	0.0%	(\$9)	\$0	0.0%	1	-
Race								
Alaska Native	38.3%	48,633	36.8%	\$438,665,598	\$9,020	36.5%	49,775	97.7%
American Indian	1.6%	1,997	1.5%	\$17,834,059	\$8,930	1.6%	2,122	94.1%
Asian	6.4%	8,159	5.6%	\$66,771,151	\$8,184	7.0%	9,604	85.0%
Pacific Islander	3.2%	4,026	2.4%	\$28,243,006	\$7,015	3.4%	4,653	86.5%
Black	5.4%	6,887	4.4%	\$52,720,983	\$7,655	5.6%	7,682	89.7%
Hispanic	3.7%	4,646	2.4%	\$29,049,448	\$6,253	3.7%	5,042	92.1%
White	38.7%	49,184	44.0%	\$523,702,297	\$10,648	39.2%	53,433	92.0%
Unknown	2.7%	3,400	2.9%	\$33,976,761	\$9,993	2.9%	3,925	86.6%
Native	40.0%	50,434	38.3%	\$456,499,648	\$9,051	38.4%	51,865	97.2%
Non-Native	60.0%	75,628	61.7%	\$734,463,655	\$9,711	61.6%	83,294	90.8%
Age								
under 1	9.1%	12,532	8.4%	\$99,483,454	\$7,938	8.3%	12,121	103.4%
1 through 12	37.0%	50,921	15.9%	\$189,438,271	\$3,720	38.5%	56,026	90.9%
13 through 18	15.8%	21,744	14.2%	\$168,858,451	\$7,766	16.5%	24,027	90.5%
19 through 20	3.5%	4,817	2.8%	\$33,199,115	\$6,892	3.2%	4,697	102.6%
21 through 30	10.5%	14,498	12.2%	\$145,845,759	\$10,060	10.0%	14,565	99.5%
31 through 54	13.6%	18,758	21.3%	\$253,276,313	\$13,502	13.4%	19,462	96.4%
55 through 64	4.0%	5,454	9.3%	\$110,507,239	\$20,262	3.8%	5,542	98.4%
65 through 84	5.4%	7,497	11.7%	\$139,803,439	\$18,648	5.3%	7,715	97.2%
85 or older	1.0%	1,429	4.2%	\$50,551,261	\$35,375	0.9%	1,350	105.9%
Benefit Group								
Children	61.6%	79,076	34.2%	\$407,579,137	\$5,154	63.1%	86,227	91.7%
Adults	18.5%	23,741	12.8%	\$152,264,932	\$6,414	17.7%	24,173	98.2%
Disabled Children	1.8%	2,363	5.4%	\$64,766,615	\$27,409	1.7%	2,315	102.1%
Disabled Adults	12.2%	15,603	33.3%	\$396,934,132	\$25,440	11.9%	16,236	96.1%
Elderly	5.9%	7,516	14.2%	\$169,418,485	\$22,541	5.6%	7,687	97.8%

Location (DHSS Region)								
Anchorage/Mat-Su	44.7%	63,146	51.6%	\$614,314,598	\$9,728	49.8%	68,946	91.6%
SouthCentral	12.5%	17,735	14.5%	\$172,205,097	\$9,710	13.5%	18,611	95.3%
Northern	11.3%	16,030	10.8%	\$128,826,928	\$8,037	12.7%	17,515	91.5%
Western	13.8%	19,577	11.3%	\$135,163,029	\$6,904	14.3%	19,815	98.8%
SouthEast	8.5%	11,967	11.1%	\$132,481,804	\$11,071	9.3%	12,917	92.6%
Out of State or Unknown	1.5%	2,170	0.7%	\$7,971,846	\$3,674	0.4%	548	

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 and may therefore not equal expenditure totals in the state accounting or budget systems.

Enrollment: Number of persons eligible for Medicaid and enrolled for at least 1 month during state FY 2010. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group, and region categories). Some duplication may occur between subgroup counts. For example, an infant with a September birth date would count in the less than 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 FY 2010 (service may have been incurred in a prior year). Grouping is based on status on the date when service was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories) but some duplication may occur between subgroup counts. For example, if a 12 year old child with a September birth date 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, 2010. If they later obtained dental services in December 2009, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2010.

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

Department-wide recipient counts are unduplicated across divisions.
Location is based on residence of the recipient or enrollee, not the location where service was provided.

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	Medical Assistance
7 AAC 48	Chronic and Acute Medical Assistance
7 AAC 100	Medicaid Assistance Eligibility
7 AAC 105-160	Medicaid Coverage and Payment
20 AAC 40	Mental Health Trust Authority

Explanation of FY12 Operating Budget Requests

Division of Health Care Services

Budget Overview Table

Health Care Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds*	\$17,077.9	\$11,932.1	(\$5,145.8)
Designated General Funds	131.3	136.1	4.8
Federal Funds	29,335.1	13,510.4	(15,824.7)
Other Funds	5,185.6	7,988.9	2,803.3
Total	\$51,729.9	\$33,567.5	(\$18,162.4)

*Totals include Adult Preventative Dental Medicaid Services

Budget Requests

Medical Assistance Administration

Increase CIP Authorization to Fund Health Information Technology Projects: **\$2,000.0 Total - \$2,000.0 CIP**

The Division of Health Care Services has insufficient CIP receipts authority to fully implement provisions of the Health Information Technology program as referenced in SB133 and HB199.

In the 2009 legislative session, the legislature passed SB133 and HB199 which authorizes the state to develop the capacity for Health Information Exchange network. This legislation provided funding through a combination of ARRA federal receipts and general funds in both the capital and operating budgets. Most of the funding is in the capital budget. Administratively, to accomplish many of the proposed tasks, funding is needed in the operating budget. The division will fund those tasks through a RSA to the operating budget to the capital budget. In order to do this most efficiently, it needs CIP receipts authority.

Therefore, the division is requesting \$2,000.0 in CIP receipts authority to accomplish the establishment of the RSA's to fund those operating costs that should not be funded from the capital budget.

Support for Medical Assistance Staffing: \$500.0 Total - \$500.0 GF

The Division of Health Care Services has insufficient funding for support staff who administer the Medicaid program. In the past, during the re-appropriation period, the division has relied upon transfers from the Medicaid Services component to cover shortfalls in the MAA component. As of FY 11, these transfers are no longer an option since Medicaid Services funding is in a separate BRU.

The MAA component funds support for administrative staff working with providers and the State's Medicaid contractor to carry out the various programs and services outlined in the Medicaid State Plan. Some of these services include pharmacy, hospital services, dental services, and transportation. Working with providers and the contractor, MAA staff are necessary for carrying out an effective and efficient Medicaid Services delivery system.

The Division of Health Care Services would like to request a \$500.0 general fund increment to bridge a projected shortfall in the FY12 budget. The division has been able to keep its year end deficit below this requested amount by liquidating large encumbrances. However, this is not an acceptable long term budget strategy. As mentioned above, the division has relied upon transfers from the Medicaid Services component to bridge the shortfall. The requested increment will pay for salary support for existing staff who work to administer the Medicaid program. Funding support for MAA staff has been inadequate for a number of years. The true scope of this inadequacy is very apparent with the elimination of funding transfers between the two components.

Interagency Receipt Authorization to manage HCS RDU: \$750.0 Total - \$750.0 I/A

Health Care Services requests an increment for interagency receipts authority to manage financial transactions between the various components within the RDU. The Medical Assistance Administration component is the primary component within the RDU for coordinating and ensuring that other components have adequate interagency receipts authorization to receive funding via reimbursable services agreements both inter-departmentally and intra-departmentally.

Transfer Funding From MAA to Support Contractual HCS Medicaid Services: \$21,244.0 Total - -\$15,314.9 Federal/ -\$5,929.1 GF/Match

Health Care Services requests to make the following transfers from the Health Care Services RDU, MAA component, to the Medicaid Services RDU, HCS Medicaid Services component:

Transfer MMIS Legacy Contract Funding to Medicaid Services (-\$12,632.0 Fed/- \$4,768.1 GF Match). This transfer supports funding that pays the Medicaid contractor that processes provider claims for Medicaid Services.

Transfer Funding for Medical Necessity Reviews to Medicaid Services (-\$1,680.5 Fed/- \$560.2 GF/Match). This transfer supports funding that pays an independent contractor to conduct medical necessity reviews for Medicaid services. These reviews are required under 42 CFR 456.50.

Transfer Provider Re-enrollment Funding to Medicaid Services: (\$800.0 Total)
(-\$400.0 Fed/- \$400.0 GF/Match)

This transfer supports funding that pays for Medicaid provider re-enrollment. This is a required and on-going process as the department prepares to transition from the old MMIS legacy system to the new MMIS.

Transfer Funding for Medical Provider Audits to Medicaid Services: (803.2) Total
(-\$602.4 Fed/- \$200.8 GF/Match)

This transfer supports funding that pays for an independent auditing firm to conduct Medicaid audits. These audits are required under AS 47.05.200 to substantiate the services rendered and that the diagnoses recorded on the claim forms reconcile with the medical charts.

Health Planning and Systems Development

Mental Health Trust Grant: \$120.07

Comprehensive Integrated Mental Health Plan: \$120.0 Total \$120.0 MH/Trust

The Comprehensive Integrated Mental Health Program Plan (Comprehensive Plan) is the outcome of a legislatively mandated planning process between the Department of Health and Social Services, the Trust and the four recipient advisory boards. The Trust currently provides funding to DHSS for the development of the Comprehensive Plan, Moving Forward 2006-2011, and annual updates to the indicators in the plan. The plan is used to measure status of recipient-related indicators, guide program evolution and service delivery and contributes significantly to the establishment of funding priorities. The Comprehensive Plan is developed within a results-based framework that will assist policymakers in identifying recipient needs and determining service effectiveness.

Mental Health Trust Workforce Development: Grant 1383.04 Loan Repayment
\$200.0 Total \$200.0 MH/Trust

This request for \$200.0 is for use as one component of the required “non-federal match-funding.” For FY12, this proposed continuation of SHARP will field another estimated 16-22 program practitioners, via the following resources - DHSS \$200.0; AMHTA \$200.0; and federal HRSA, \$400.0, with resulting total of \$800.0. The entire \$800.0 is for practitioner loan repayments, with none requested for administration.

Increase CIP Authorization to Fund DOT RSA's: \$115.0 Total - \$115.0 CIP

Health Planning and Infrastructure has insufficient CIP receipts authority. To appropriately accomplish the tasks of the DOT RSA, increased funding is needed in the operating budget. In order to do this most efficiently, it needs CIP receipts authority.

Challenges

Adult Preventative Dental Medicaid Services

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

Key to the continued success of the adult preventative Medicaid dental program is adequate provider capacity (the extent of dental access through tribal and community health center dental programs, and the extent of private dental participation in the Medicaid program). 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 considering 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. This proposed expansion is still in the conceptual stage. Projected cost is not yet available, but will be assessed as part of the division's feasibility study.

Health Care Services is also working with the Division of Public Assistance to refer eligible recipients to Social Security so that they may enroll in 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 Department completed a dispensing fee survey that suggests paying higher dispensing fees and lower ingredient costs. 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 Tribal unit of DHCS is responsible to CMS for the creation of a Tribal consultation process required prior to all future Medicaid State Plan Amendment (SPA) submissions. The challenge in crafting this document is to meet the requirements of CMS while balancing/reducing the request of the Tribes for complete sovereignty. The goal is to ensure both parties are successful. The other change being considered is cost based reimbursement for Community Health Aide Practitioners (CHAP's). This effort follows the reimbursement request process through CMS as was done for tribal dental and behavioral health services. The cost based reimbursement of CHAP's would provide improved financial stability allowing tribes to expand infrastructure and scope of CHAP services. The more Medicaid services CHAP's provide in village based tribal health care facilities, the more state general funds Alaska saves by insuring the federal government meets its trust responsibility to native Recipients. The challenge is that this creates tension between tribal and non-tribal providers. The non-tribal providers continue to see this as the creation of a dual services delivery system. However, a separate rate would be closer to the actual costs of delivering services offered at Tribal facilities. Additionally, local access to health care reduces the cost of 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 Licensing and Certification

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 Licensing and Certification 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 (DDI) 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 Centers for Medicare and Medicaid Services (CMS) and State leadership have been notified of the delay.

The MMIS DDI project team has received an initial version of the Enterprise source code and has begun construction of the Alaska specific requirements. Alaska Medicaid Health Enterprise continues to progress and is expected to be available to state staff, providers and recipients' spring 2012.

The MMIS DDI project team has begun to analyze and develop services that can be implemented early before Alaska Medicaid Health Enterprise is fully operational, such as ePrescribe, Smart Non-Emergency Transportation (NEMT) and possible web enablement of some legacy transactions.

Additionally, DHSS will be prepared to receive and send HIPAA X12N 5010 transactions and code sets by the mandated effective date of January 1, 2012. Alaska Medicaid Health Enterprise will be compliant with 5010.

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. Work efforts to develop solutions for the conversion to the International Classification of Diseases-version 10 (ICD-10) will occur during FY12.

During FY12 HCS will respond to anticipated federal regulations relating to Medicaid payments for health-care acquired (HCA) conditions, and for National Health Plan numbers. The federal HHS Centers for Medicare and Medicaid Services (CMS) has given early indications of their plans to release regulations regarding these two initiatives during SFY 12.

In addition, HCS will implement changes in pharmacy claims processing rules to replace the current average wholesale price (AWP) basis of pharmacy payment. HCS will also implement provider enrollment and claims processing rule changes resulting from the integrated behavioral health services regulations developed by Division of Behavioral Health.

Rate Review

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.

Rate Review has been working with the Division Senior and Disabilities Services to implement a new rate setting process for Medicaid Waiver Services. Fiscal year 2012 will be the first full year of operation of the new system, and that first year of operations will require significant attention to provider needs and related system refinements.

Health Planning and Systems Development

Health Planning and Systems Development (HPSD) 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 HPSD for over eight years. The amount of these grant awards has remained level over the past few years. A major challenge for HPSD is long-term, stable funding while depending on multiple funding streams. Ongoing efforts are underway to monitor and apply for ongoing and new federal grants, as well as manage HPSD general funds that support the mission of DHSS.

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

Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.

Status #1: Due to an increase in both Indian Health Services (IHS) billings and encounter rates, the target strategy of increasing IHS billings was realized, with an increase of approximately 21% from SFY 2009 to SFY 2010.

In addition, the division exceeded the target of a 2% increase in GF recovery. Recovered GF increased by approximately 27% in SFY 2010 when compared to SFY 2009.

*Note: The large increase in recovered GF during SFY 2010 can be attributed to an expanded focus on estate recoveries during this period. THIS INCREASE IN RECOVERED GF MAY NOT BE NOTICED IN FUTURE FUNDING CYCLES.

Health Care Services Actuals - Other Funds (in millions)

Fiscal Year	% Federal	% General	% Other
FY 2010	69.2%	30.0%	.8%
FY 2009	58.8%	34.7%	6.5%
FY 2008	64.6%	32.3%	3.1%
FY 2007	64.8%	31.0%	4.2%
FY 2006	65.3%	28.1%	6.6%
FY 2005	71.5%	17.5%	11.0%
FY 2004	71.1%	16.6%	12.4%
FY 2003	67.5%	25.5%	7.1%
FY 2002	66.6%	27.8%	6.1%
FY 2001	66.4%	22.7%	10.9%
FY 2000	65.3%	25.5%	9.2%
FY 1999	66.0%	34.7%	.8%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in the Alaska Budget System (ABS) as percentages.

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

A1: Strategy - Increase Indian Health Services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian Health Services (IHS) Medicaid participation by 5% in expenditures.

Status #1: IHS Medicaid participation increased from SFY 2008 to SFY 2009. Total IHS expenditures were \$193 million in SFY10, compared to \$159 million in SFY09, a 21% increase.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2010	\$671.5	\$192.7	29%	21%
FY 2009	\$573.4	\$159.3	28%	9%
FY 2008	\$517.9	\$146.3	28%	9%
FY 2007	\$490.2	\$134.2	27%	-14%
FY 2006	\$528.9	\$155.6	29%	-12%
FY 2005	\$558.2	\$177.8	32%	15%
FY 2004	\$503.6	\$154.5	31%	15%
FY 2003	\$466.6	\$134.9	29%	51%
FY 2002	\$385.9	\$89.3	23%	22%
FY 2001	\$323.0	\$73.3	23%	48%
FY 2000	\$268.4	\$49.4	18%	32%
FY 1999	\$228.6	\$37.5	16%	98%

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

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

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

Analysis of results and challenges: Indian Health Service (IHS) expenditures 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: The division exceeded the 2% target for increasing GF recovery during SFY2010.

The division experienced an increase in recovered funds of approximately 27%.

*Note: The large increase in recovered GF during SFY2010 can be attributed to an expanded focus on estate recoveries during this period. THIS INCREASE IN RECOVERED GF MAY NOT BE NOTICED IN FUTURE FUNDING CYCLES.

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

Year	Drug Rebates	TPL	Total	% Change
2010	28.9	42.0	70.9	107%
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 - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.

Status #1: While there has been 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 10,255 in FY09 to 10,841 in FY10. This was an increase of approximately 5%, exceeding the 2% target.

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2010	2,760 +11.74%	173 +35.16%	2,760 +12.75%	1,525 +53.73%	10,821 +5.52%
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

Methodology: source: Affiliated Computer Systems, Provider Enrollment Subsystem SFY2010.

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.

Target #2: Reduce the rate of uninsured Alaskans to less than 14.6%.

Status #2: The target to reduce the rate of uninsured Alaskans to less than 14.6% was not met. In 2009 the rate of uninsured Alaskans grew to 21.1% up from 19.8% in 2008. Source: U.S. Census Bureau, Current Population Survey/AK

Target #3: Increase the number of active, licensed health care providers in Alaska in proportion to population growth.

Status #3: The target to increase the ratio of active licensed healthcare providers in Alaska in proportion to the population growth has been met. The ratio of active physicians to Alaska residents has shown an increase over the prior CY, with 1 physician per 405 residents in CY10. This is in comparison to 1 per 441 residents during CY09. Source: Alaska Occupational Licensing

Target #4: Increase number of adults who visited a dentist in the last year.

Status #4: The number of adults who visited a dentist in CY08 was 66% of the Alaska population. During CY 2009 this percentage increased slightly to 66.3% of the Alaskan population. However, this percentage is still far below the target of 80% for CY 2010. Source: Kaiser Statehealthfacts.org

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 a decrease of approximately 5 days in the average time from receipt of a claim to final claim payment, decreasing from 15 days in SFY09 to 10 days in SFY10. This represents a decrease of approximately 33% in processing time.

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

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY 2010	8,215,221	10	5
FY 2009	7,509,326	15	4
FY 2008	7,263,956	11	-7
FY 2007	7,293,304	18	6
FY 2006	7,721,709	12	-1
FY 2005	7,903,523	13	3
FY 2004	6,690,344	10	0
FY 2003	5,615,072	10	-2
FY 2002	4,959,864	12	0
FY 2001	4,409,121	12	2
FY 2000	3,720,254	10	0

Methodology: 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 79% during SFY09 to 75% in SFY10.

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

Year	Medicaid Claims Paid	% No Errors	% Change
2010	6,648,011	75%	-4%
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 measurer 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.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Increase CIP Authorization to Fund Health Information Technology Projects	\$ -	\$ -	\$ -	\$ 2,000.0	\$ 2,000.0
Support for Medical Assistance Staffing	\$ 500.0	\$ -	\$ -	\$ -	\$ 500.0
Interagency Receipt Authorization to Manage HCS RDU	\$ -	\$ -	\$ -	\$ 750.0	\$ 750.0
Transfer Funding from MAA to HPI to Support HSS Planner II Position	\$ (48.2)	\$ -	\$ (48.2)	\$ -	\$ (96.4)
2nd Year MEDICAID COVERAGE FOR DENTURES (SB 199)	\$ (61.5)	\$ -	\$ (86.4)	\$ -	\$ (147.9)
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 10 (HB 199) Lapse Date 06/30/11	\$ -	\$ -	\$ (625.1)	\$ -	\$ (625.1)
Transfer Funding From MAA to Support Contractual HCS Medicaid Services	\$ (5,929.1)	\$ -	\$ (15,314.9)	\$ -	\$ (21,244.0)
MH Trust: Cont - Grant 120.07 Comprehensive Integrated Mental Health Plan	\$ -	\$ -	\$ -	\$ 120.0	\$ 120.0
MH Trust Workforce Dev - Grant 1383.04 Loan Repayment	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
Increase CIP Authorization to Fund DOT RSA's	\$ -	\$ -	\$ -	\$ 115.0	\$ 115.0
Transfer Funding from MAA to HPI to Support HSS Planner II Position	\$ 48.2	\$ -	\$ 48.2	\$ -	\$ 96.4
Reverse one-time ARRA Funding for State PrimaryCare Offices	\$ -	\$ -	\$ (36.1)	\$ -	\$ (36.1)
Provide Primary Eye Care and Vision Rehabilitation to Rural Alaskan Communities - transfer from HCS Medicaid	\$ 165.0	\$ -	\$ -	\$ -	\$ 165.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (470.1)	\$ (470.1)
Health Care Services Total	\$ (5,325.6)	\$ -	\$ (16,062.5)	\$ 2,714.9	\$ (18,673.2)

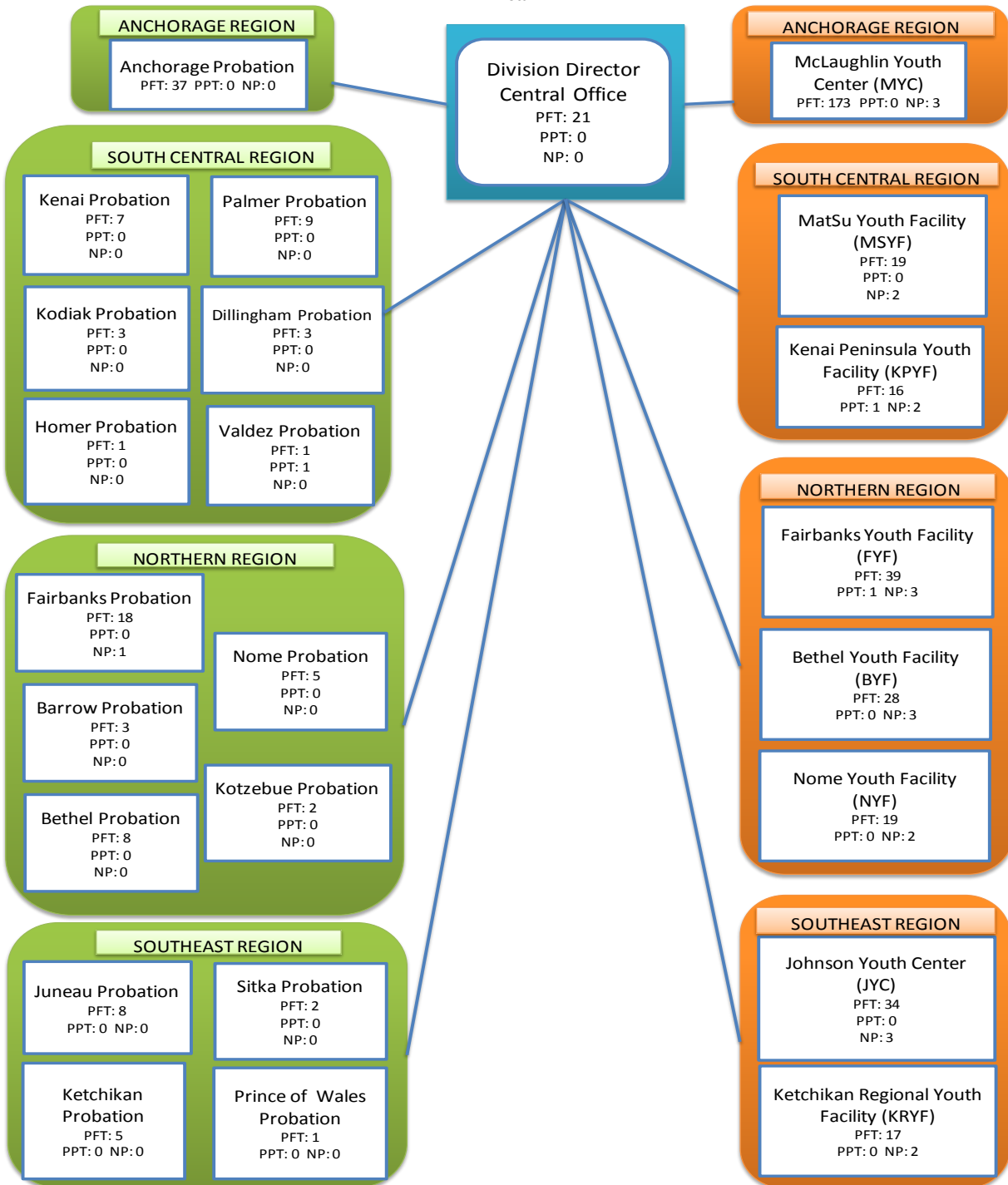
Division of Juvenile Justice

State of Alaska
Department of Health and Social Services
Division of Juvenile Justice

Total PFT: 479

Total PPT: 3

Total NP: 21



Introduction to the Division of Juvenile Justice

Mission

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

Introduction

The Division of Juvenile Justice (DJJ) provides supervision and 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 the offending youth develop into productive citizens. Services are provided in the least restrictive and most appropriate 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 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 district offices based in 16 communities around

Alaska; these comprise four Juvenile Probation Regions. The Juvenile Probation districts operate under the supervision of district supervisors who are, in turn, supervised by the Chief Probation Officer of the specific region.

Juvenile Probation services involve much more than the community supervision of delinquent youth. One key responsibility is to determine the legitimacy of a delinquency referral from law enforcement and then to determine the most effective way to hold the juvenile accountable while working to address the causes of the behavior. Once the division's jurisdiction has been established, the probation officer meets with the juvenile and their family to decide if the matter can be handled informally (through a community diversion plan), or if it requires formal court intervention.

Probation officers also 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. If detention is requested by an arresting officer, the probation officer will assess the request based on three (3) statutory criteria: if the youth is a danger to the community, a danger to him/herself, or if the probation officer believes the youth will not appear for a court hearing if released.

Whenever feasible, the probation officer will attempt to "divert" the young offender from becoming more entrenched into the juvenile justice system. The probation officer will use an array of graduated responses which may include restitution, community work service, youth court, or informal probation. If a diversion strategy is not practicable or fails, the probation officer may initiate formal court proceedings and may detain or ask the court to detain the juvenile in one of the division's secure detention facilities.

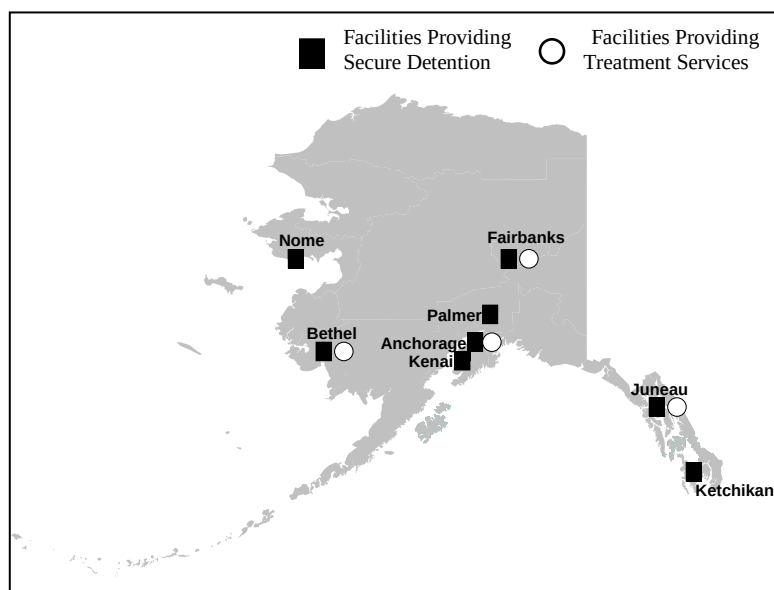
The result of the formal court proceeding will be a dismissal, placement in a division treatment facility, placement in division custody, or most commonly, placement under the supervision of the division but the youth will be allowed to remain in their home under court-ordered Conditions of Probation. This last category of youth will be involved with an individual treatment strategy which is designed to hold them accountable, restore their victim, and to build competencies to help them avoid continued law-breaking activities. These youth are supervised at a level commensurate with the findings of a risk/needs assessment performed by the probation officer. Failure to abide by their conditions of probation may require the probation officer to exercise their “peace officer” authority and arrest the youth for a new court appearance.

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. Probation Services are based not only in the actions of the court and probation officers, but also in the extensive and vital collaborations that the division maintains with community resources and providers. 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.

A study was conducted in FY2009, with financial support from the U.S. Office of Juvenile Justice and Delinquency Prevention, to assess the workload of juvenile probation officers and determine their ability to meet work and case management expectations. The Justice Center at the University of Alaska Anchorage conducted the study and in early FY2010 presented the results to the division. This information is expected to help guide the division in management and budgeting decisions in the coming years.

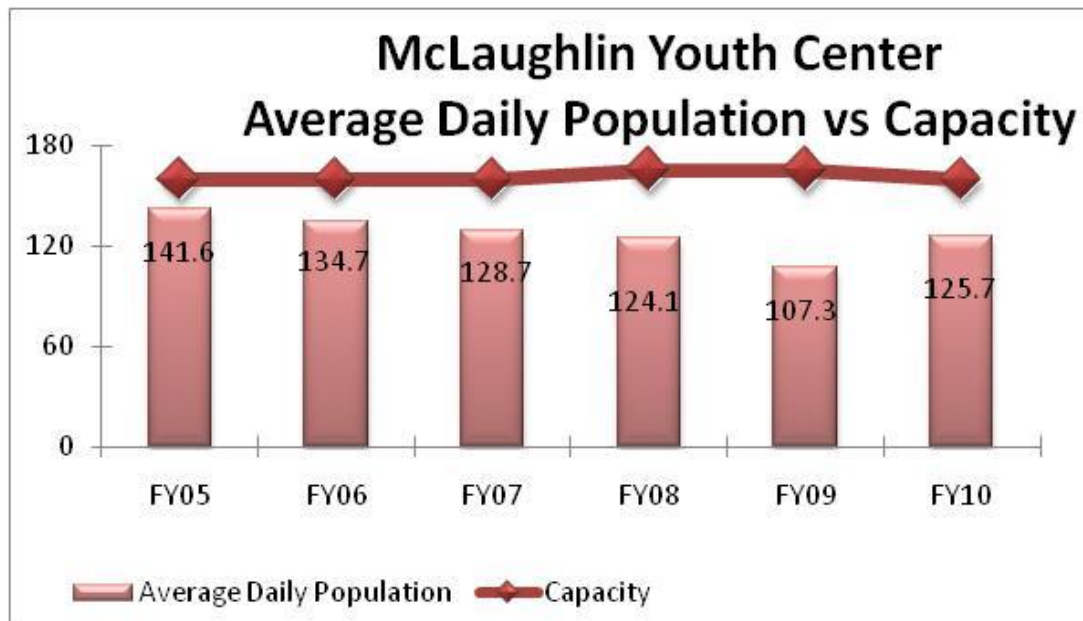
Juvenile Detention and Youth Treatment Facilities in Alaska perform two primary functions:

- 1) Detention Units are designed as short-term secure units for youth awaiting a court hearing or a court determination regarding a delinquency petition; and
- 2) Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment. DJJ operates four secure facilities that offer both detention and treatment services and four which provide detention services only.



The division is continuing the process of having stand-alone detention facilities develop a continuum of detention services that will include facility staff providing alternatives to detention programming, and transitional/re-integration services for youth returning to the community from treatment in a DJJ institution.

McLaughlin Youth Center (MYC)



MYC currently has 156 beds (60 detention beds and 96 longer-term treatment beds). The detention units primarily serve the Third Judicial District but will often contain juveniles from every part of Alaska. The treatment component consists of: institutional programs for delinquent males, delinquent females, and male sex offenders; an intensive services treatment unit for particularly difficult-to-manage youth; and a transitional services unit for youth leaving the facility. MYC, because of its size and its history as the state's first youth facility, has developed a range of program options that do not exist in most of the smaller facilities.

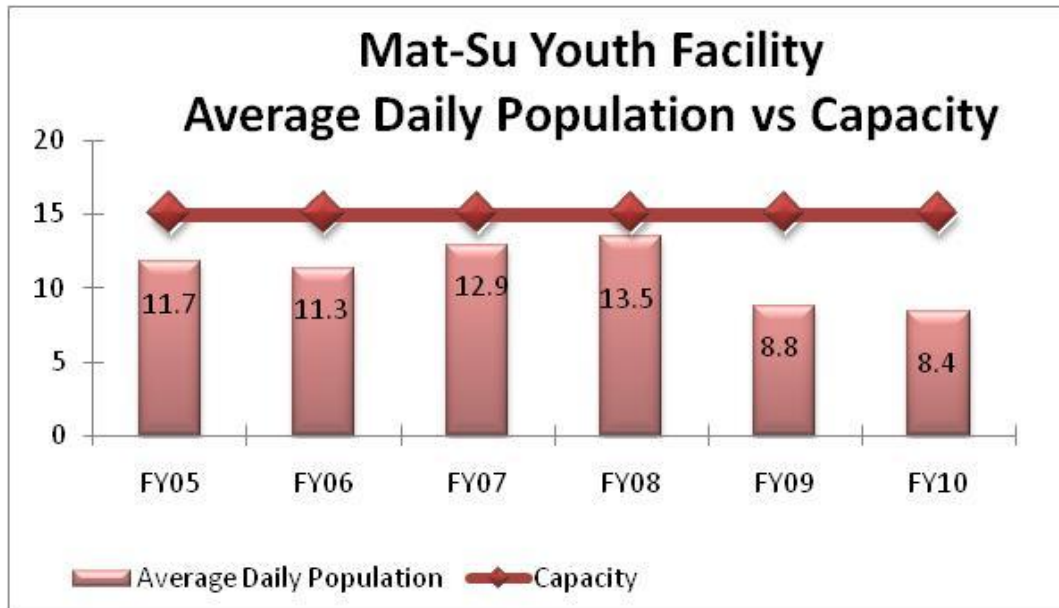
The MYC's full-time Transitional Services Unit (TSU) was created in FY2004 following an established evidence-based "re-entry" philosophy called "intensive aftercare". It was designed to prepare each institutionalized youth for a gradual and successful re-entry back into the community from the time he/she is initially institutionalized. TSU staff works with a youth's assigned juvenile probation officer to provide monitoring, supervision and support of youth in the community prior to, and after release. An individualized aftercare plan is established using information from the Youth Level of Services Case Management Inventory and the youth's overall progress within the institution. 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 Boys and Girls Club, Municipality 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 over the course of several fiscal years. In FY2007, the chart shows an increase of five beds (from a separate wing) that are used “as necessary” (previously designated admission cells) for one of the two detention units. Beginning in FY2009, the number is again reduced to 160 as McLaughlin re-evaluated the way they designated their bed usage. For FY2011, the number of beds has been reduced by four. Two beds due to the construction project that is currently taking place at the facility, and one bed in each of two rooms that are now strictly used as observation rooms.

Mat-Su Youth Facility (MSYF)



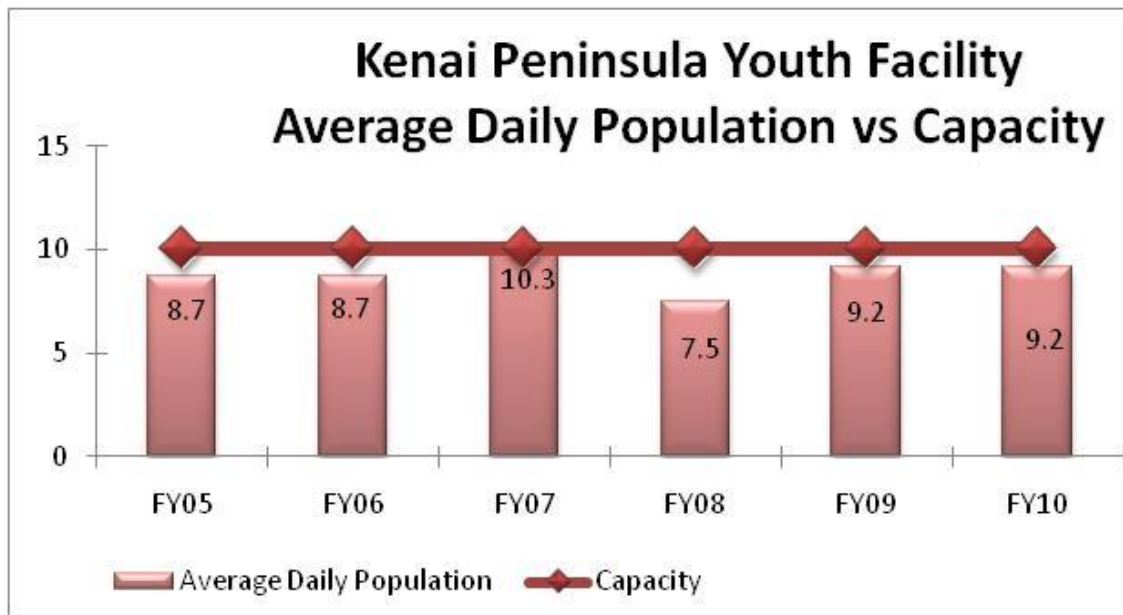
MSYF is a 15-bed juvenile detention center located in Palmer serving a South Central Alaska population base exceeding 77,000, as well as other areas served by South Central Probation Services including: the Copper River Basin, Valdez, Cordova, Kodiak, Dillingham, and a portion of the Aleutian Chain. 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 long-term plan of intervention, rehabilitation or treatment that is appropriate for 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 collaborates extensively to integrate community services into the facility and to support the facility's residents in becoming contributing members of the community and society. 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 the Performance-based Standards (PbS) program. The facility is currently working on Level III Data Certification.

Kenai Peninsula Youth Facility (KPYF)



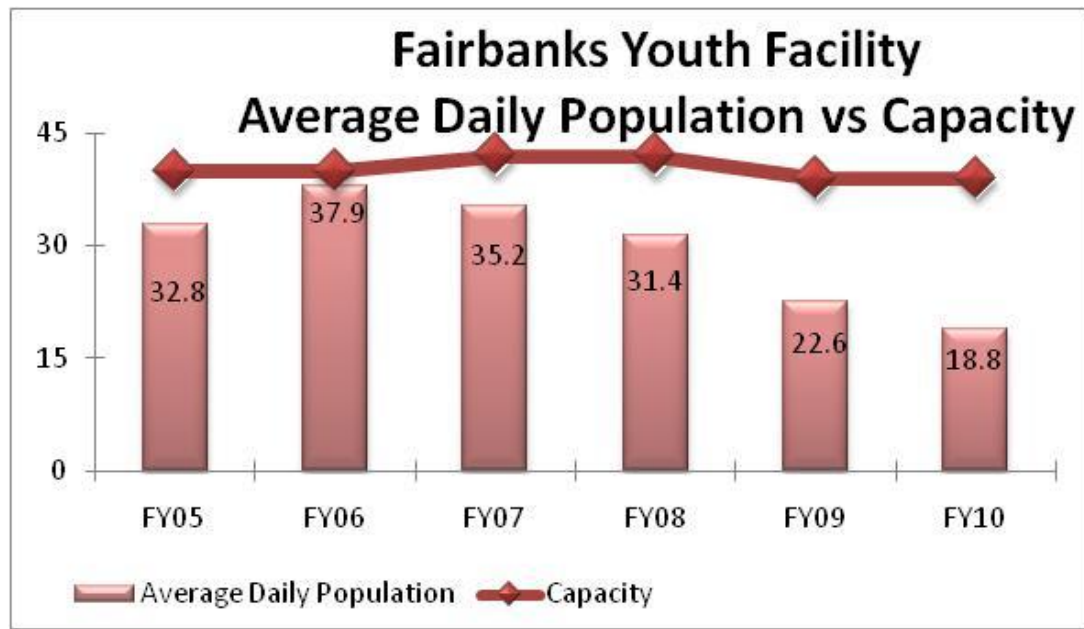
The Kenai Peninsula Youth Facility provides a 10-bed, secure placement setting for youth from the Kenai Peninsula area awaiting further court action, or pending transfer to or from another placement or institutional program. The facility provides educational services in partnership with the local school 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 offices of Kenai Juvenile Probation are co-located within the facility.

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 works with local service providers to appropriately place youth, 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 is 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.

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 this division in the state. The offices of Fairbanks Juvenile Probation and Northern Region Probation are co-located with the facility.

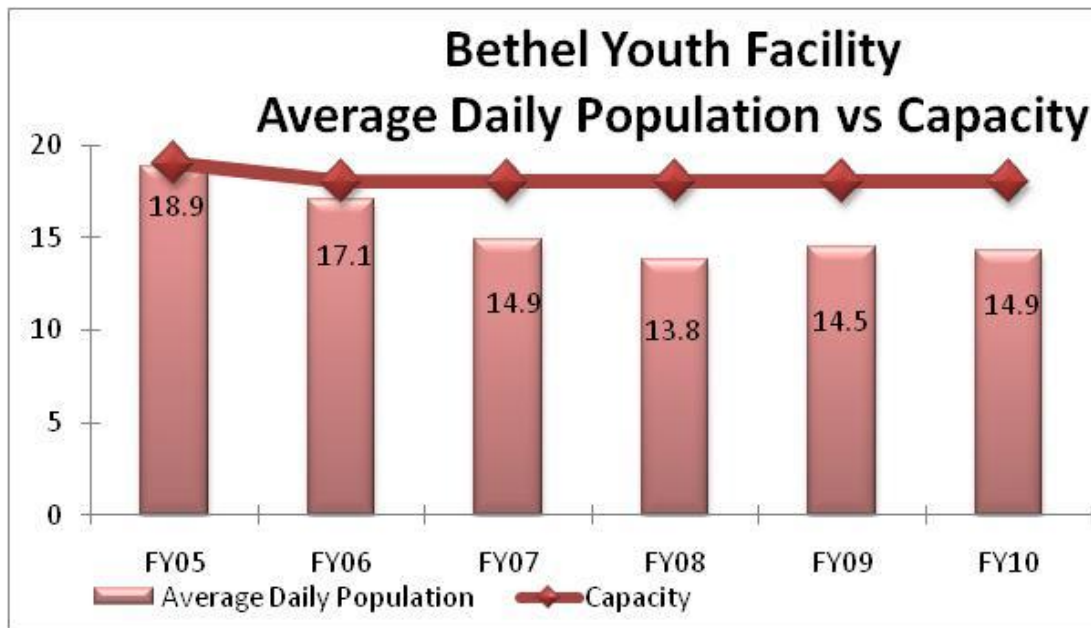
Residents with intensive mental health or Fetal Alcohol Spectrum Disorders continue to challenge the facility's ability to operate safely and securely. Increasingly, special needs offenders demonstrate clinical needs that require one-on-one supervision and care, which significantly impacts the availability of staff for the rest of the facilities clients.

FYF staff collaborates frequently with the Office of Children's Services, as partners in a diversity effort that 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 with the OCS 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 FY2007, the detention capacity increased by two, as rooms that were previously used as storage rooms were converted to sleeping rooms. In FY2009, 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. The offices of Bethel Juvenile Probation are co-located with the facility.

In FY2006, one of the treatment rooms was needed for the Mental Health Clinician that was hired, reducing the capacity to 10. This decreased capacity is reflected in the graph above.

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 of these 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 considerable 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.

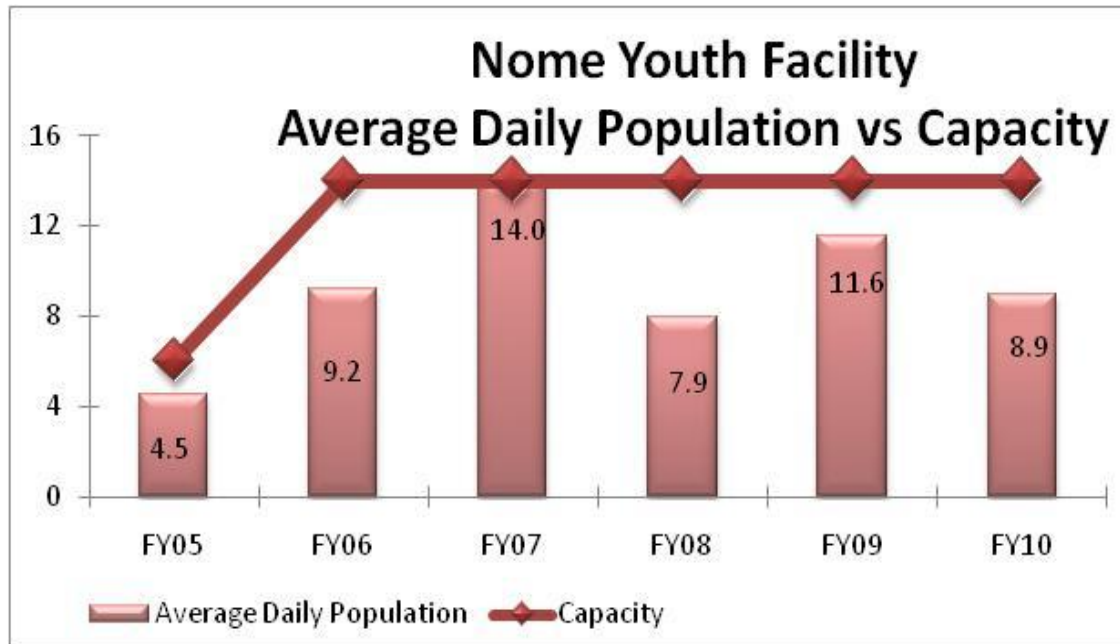
The Bethel Youth Facility is working on improving collaboration through the Performance-based Standards Facility Improvement Plan process. One plan focuses on increased involvement with families of the detention facility residents', and the other plan focuses on increasing the number of volunteers involved 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 the institutionalized youth and their 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 FY2006, a treatment room was converted to an office for the Mental Health Clinician, reducing bed 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 six to 14 beds in FY2006. The offices of Nome Juvenile Probation are co-located with the facility.

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

In FY2012, 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. FY2009 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.

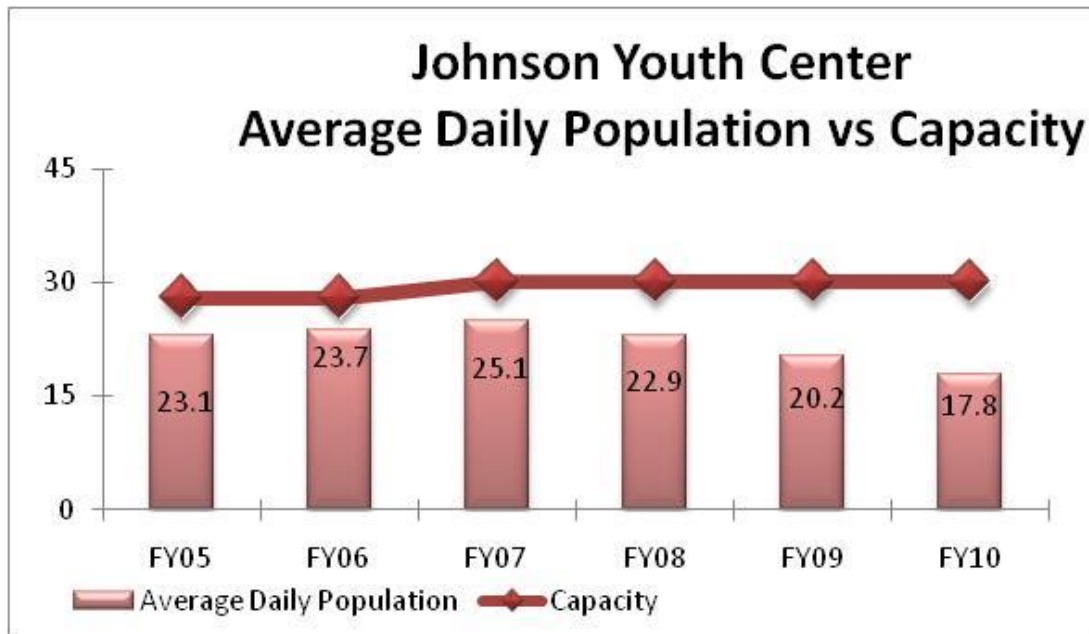
NYF has continued and expanded its collaborative and cooperative relationships with a wide variety of agencies in the community. The partnership with Boys and Girls Club (BGC) has expanded, with NYF residents providing janitorial service, and BGC providing a series of therapeutic groups to the residents 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 exceptional 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 FY2005, the NYF was partially closed due to renovation of the building. The renovation was complete at the end of FY2005; the increased capacity is reflected on the above chart beginning with FY2006.

Johnson Youth Center (JYC)



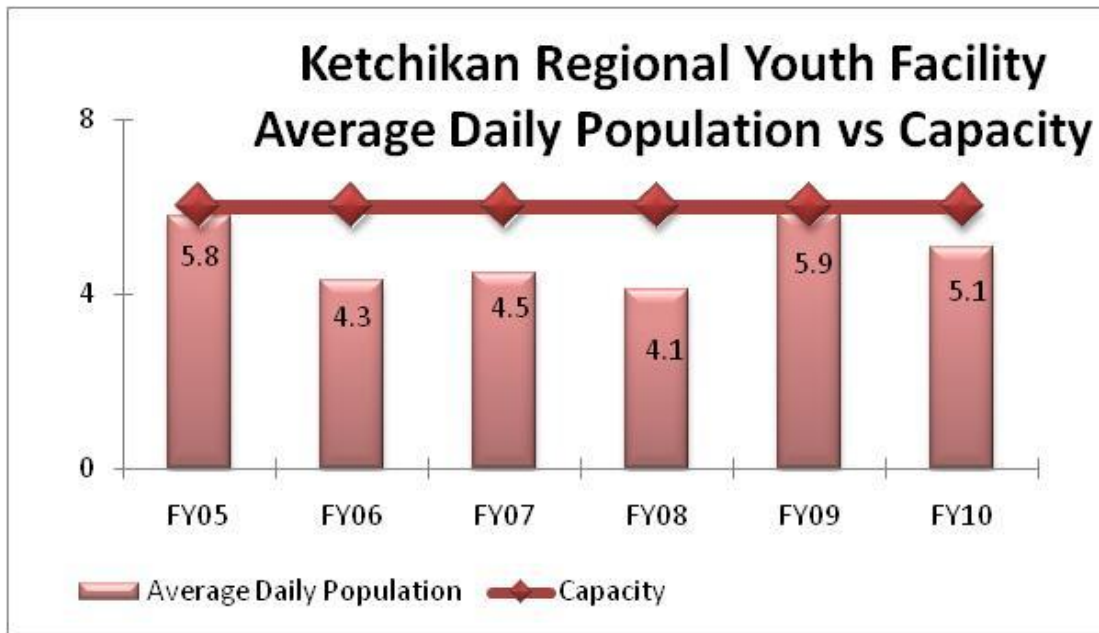
JYC is a 30-bed (8-detention and 22-treatment) facility that provides short-term, pre-trial detention, control, and intervention for juveniles who have been ordered confined by the Superior Court due to the danger they present to the public and/or to themselves; and long-term residential and treatment 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 offices of Juneau Juvenile Probation and Southeast Region Probation are co-located with the facility.

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 fundamental skill building, 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 FY2007, the treatment capacity at the Johnson Youth Center was increased by two beds. Two rooms that had been used as storage rooms were converted to treatment rooms. The increased capacity is reflected in the above chart.

Ketchikan Regional Youth Facility (KRYF)



*The capacity for KRYF includes only the six locked detention beds.

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 needing assessment or evaluation to assist in treatment planning. Services provided are short-term and voluntary, with a maximum stay of up to 30 days. The presence of this program allows local youth to stay in the community during sub-acute mental health 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 (EM) has always been a program favored by the Ketchikan courts as an alternative to detention. Youth on EM 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 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 staff member 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 provide 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.

Director's Office

The Division Director's office in Juneau oversees a number of administrative functions that support the public, the Legislature, other executive branch agencies, as well as field staff around the state. The staff is responsible for statewide policy development and implementation; coordinated service delivery between field probation and the youth facilities; statewide staff training; quality assurance for both field probation and juvenile institutions; research and statistical analysis of juvenile justice data and development and administration of federal grant programs. This office ensures ongoing operation and quality assurance for the division's automated offender database, the Juvenile Offender Management Information System (JOMIS), 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:

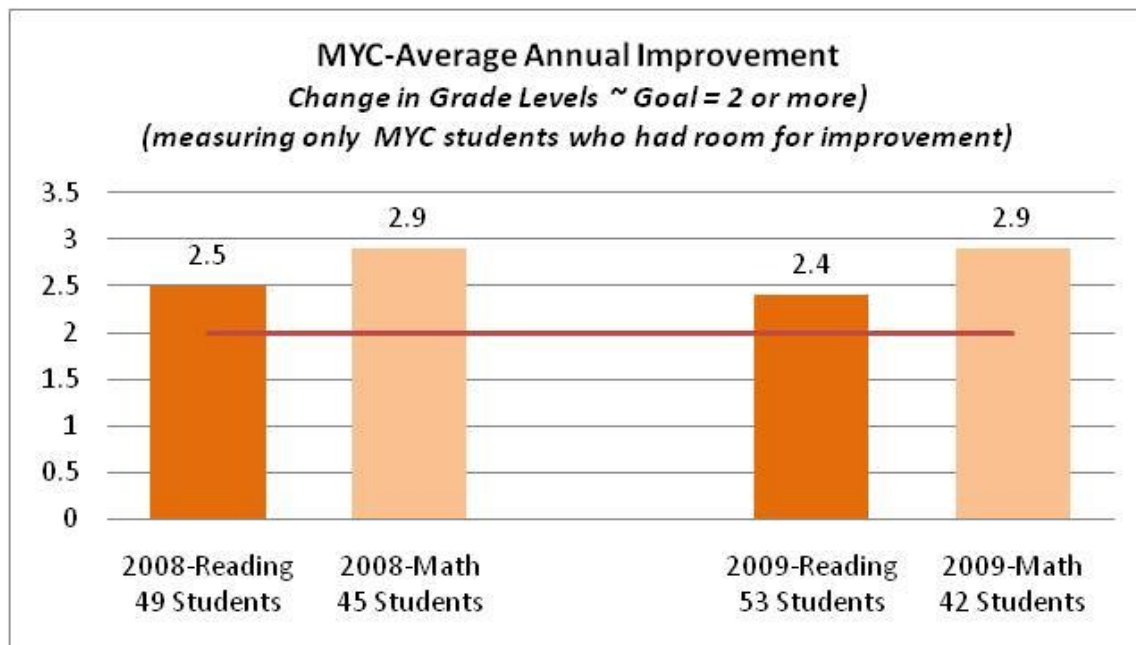
- *Grants Program Management:* Alaska, a participating state in the federal Juvenile Justice and Delinquency Prevention Act, receives approximately \$1.3 million in federal grant funding annually. Each year these funds help ensure that the state's juvenile justice system abides by the mandates of the Delinquency Prevention Act. Federal grant funds are also used to improve juvenile programming, and build community partnerships throughout the state.
- *Data and Research Analysis:* The division provides statewide and local juvenile crime statistics, analyses of juvenile delinquency policies and legislation, and other information to the Legislature, agencies and partners, and the public as needed. This team ensures the smooth functioning of the Juvenile Offender Management Information System (JOMIS) and develops JOMIS to address current data collection and extraction needs of the division and the department. This team partners with department and other justice agencies to collectively improve information sharing mechanisms.
- *Quality Assurance and Training:* The division is directing limited QA resources toward key areas such as facility safety and programming, residential service review and risk/need assessment, and case planning. 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 facilitation of Aggression Replacement Training classes for juveniles and training new employees in the principles of restorative justice. Adequate quality assurance and training that ensures the success of the division's system improvement efforts remains a key need.
- *Policy Development:* The Director's Office policy staff develops and monitors legislative proposals, facilitate regulation revisions, coordinate development and review of policies and procedures that enhance operation of probation, facility and state office services, and assist with performance-related reporting. Policy staff serves as the liaison to division staff and the Department of Law to address policy questions that affect youth and services. Case-specific questions or complaints that come to the division through the Governor or Commissioner's Office, or legislators, are addressed. Policy staff writes reports regarding agency activities.
- *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 other state agencies to ensure that the needs of our youth are met and that state resources are fully utilized. Some of the collaboration efforts are outlined below.

- The division has an agreement with the Alaska Psychiatric Institute (API) that establishes a protocol for juvenile admissions to API, and transfers from API to Juvenile Justice Facilities to ensure that youth who are in a crisis situation receive the mental health services they need.
- 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.

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 FY2008 and FY2009.



- The division has two MOA's 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 the statewide Youth Court Program by collaborating with community partners to establish new courts where an interest in that community exists. The already existing Youth Courts reflect a primary diversion resource that presents a pro-social and restorative alternative to low-level first time offenders.
- The Department's Joint Management Team includes 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.
- The division continues to receive funding from DBH to provide services related to Bring the Kids Home project. This has allowed for more family counseling sessions with follow-ups for families and youth and once they have been released.
- During FY2009, DJJ collaborated with DBH to assess substance abuse services and treatment 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 FY2008, 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 former 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 offenders, crime, and recidivism.

The division continues to incorporate the goals of its FY2003 “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 current data to improve the quality of services offered. These initiatives include:

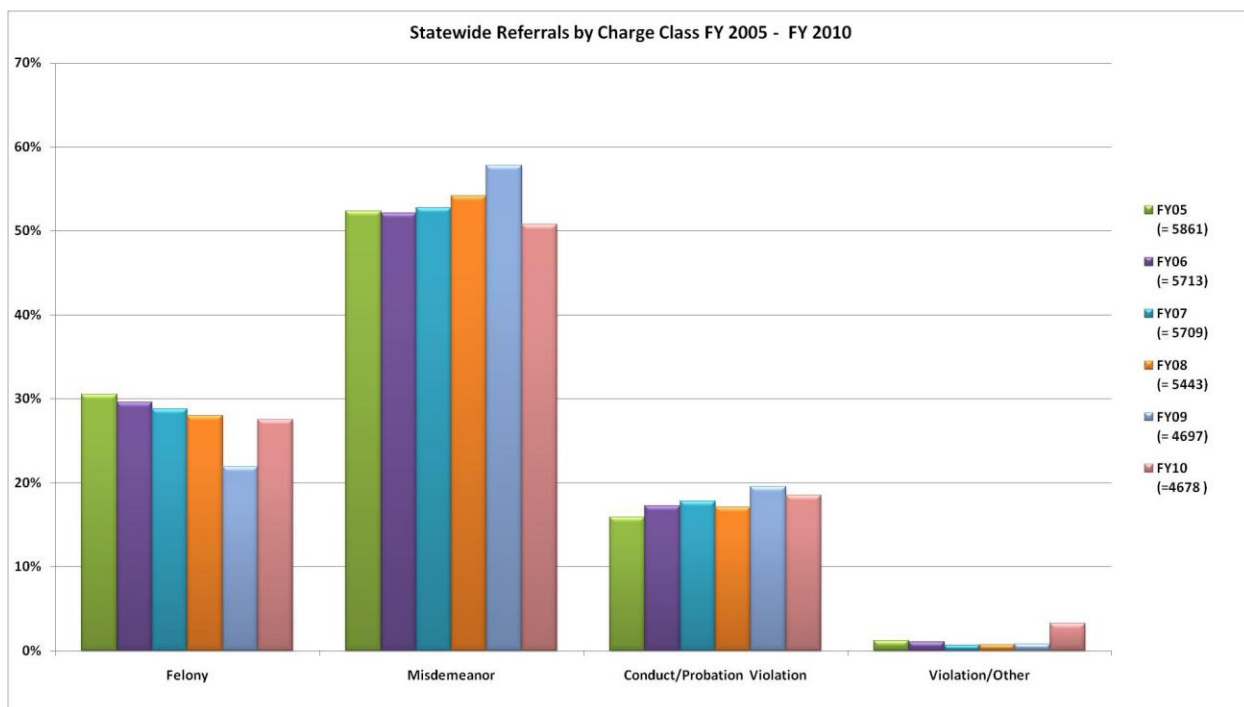
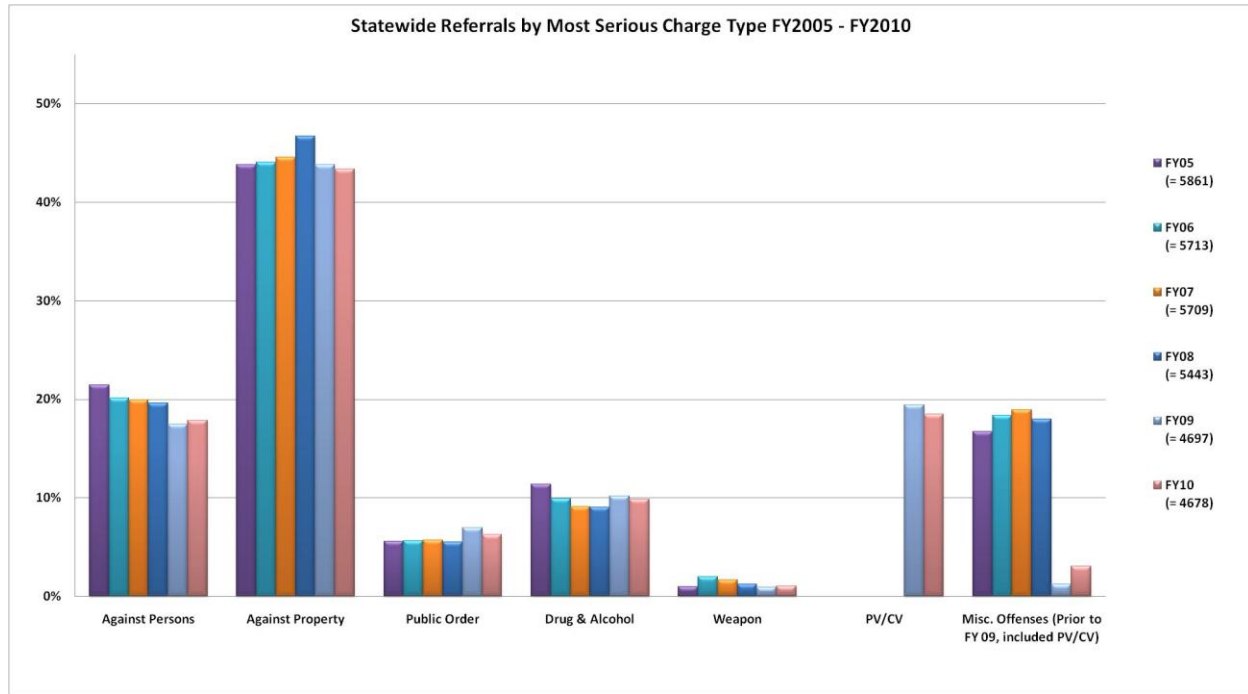
- The use of assessment instruments to assist staff in accurately determining a youth’s risk of re-offense and need for secure detention;
- A quality assurance process to improve the safety and security of juvenile facilities;
- Improved use of juvenile facilities as a statewide resource for youth receiving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

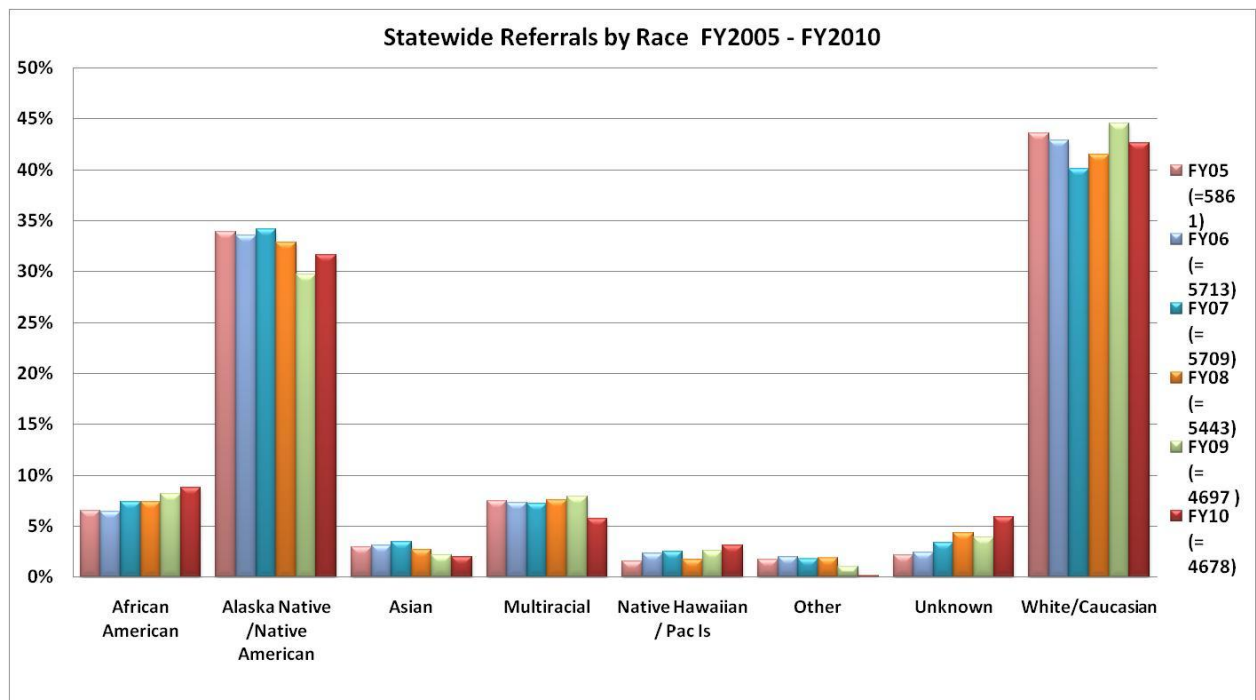
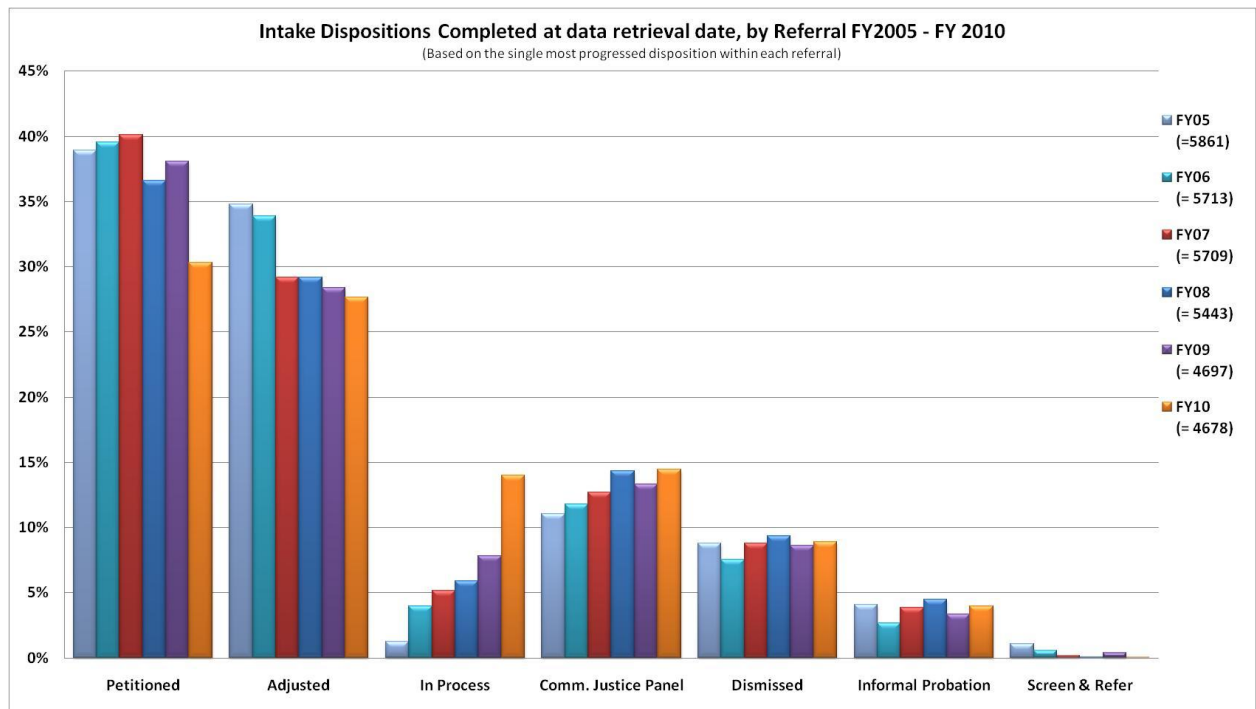
In FY2012, the division’s leadership will continue to incorporate these system improvement projects into the strategic plan and vision for juvenile justice in Alaska. The system improvement projects will impact public safety, and ensure that victim needs are met and offenders are being held accountable. Areas of focus for the Division will include substance abuse services, mental health services, services for youth from rural Alaska and improved educational and vocational services for DJJ involved youth, in addition to remaining focused on reducing recidivism rates for all youth served within the Division.

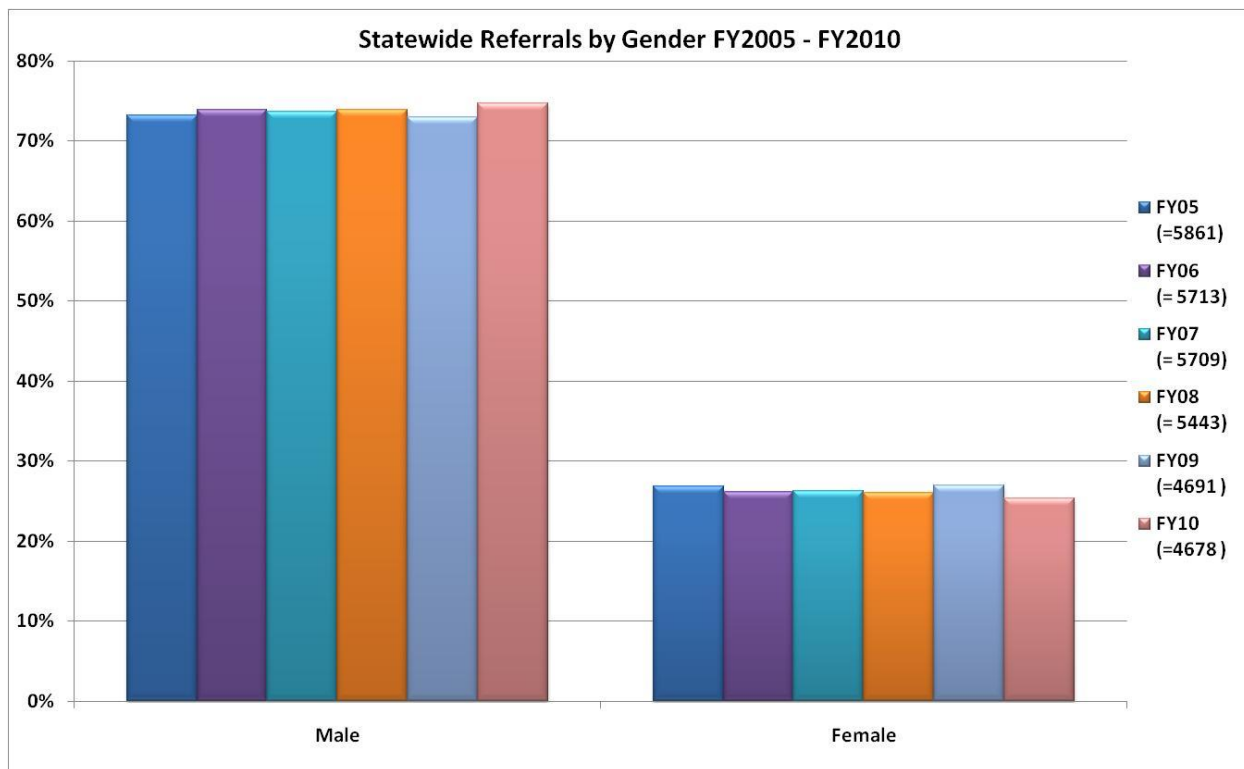
Annual Statistical Summary of Services Provided in FY10

FY10 Delinquency Referral Summaries

The following charts provide a summary of referrals for FY2005 through FY2010.







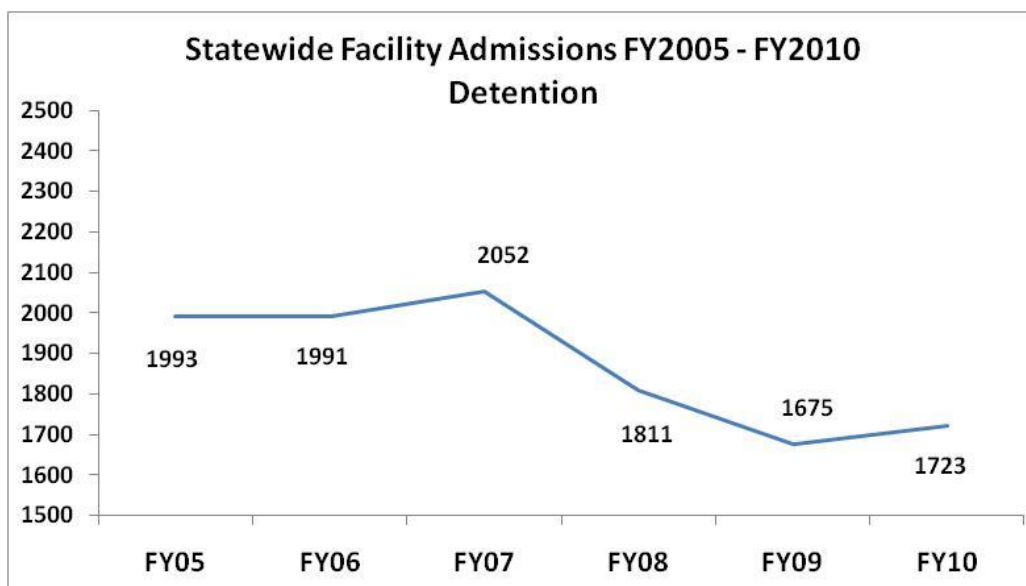
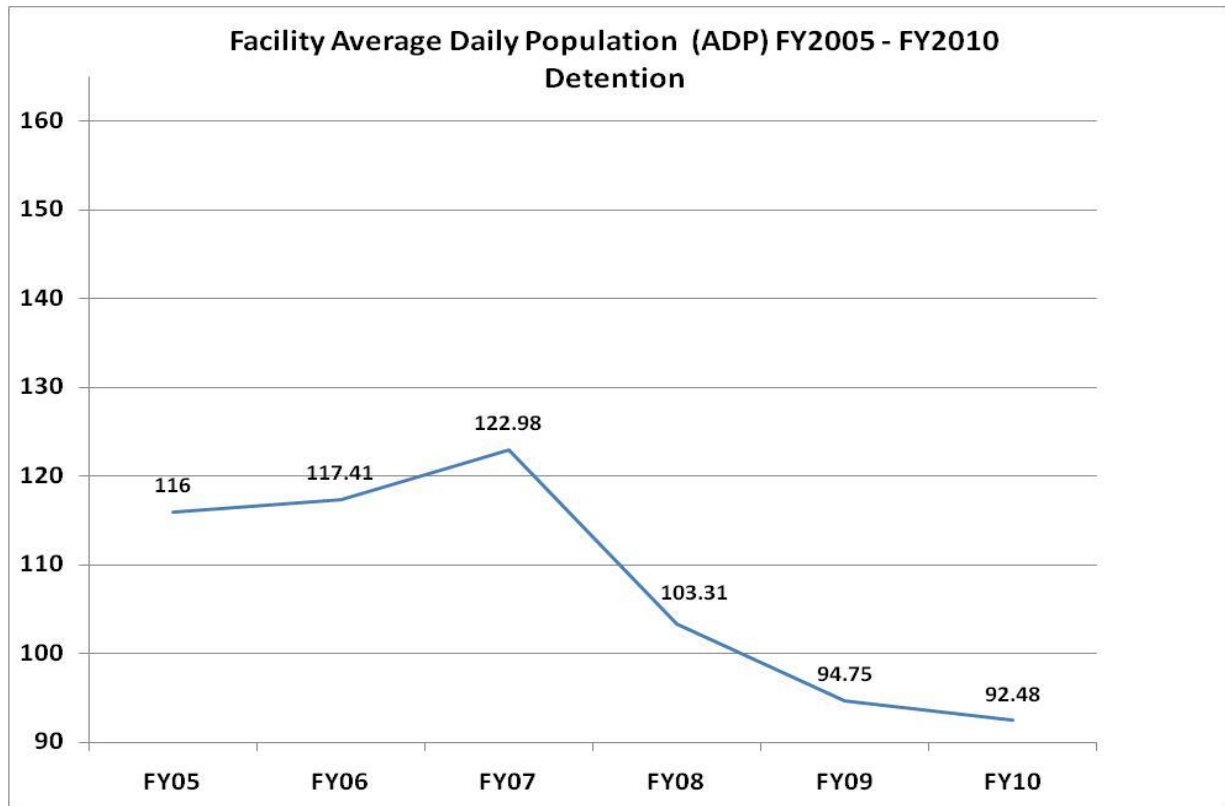
The table below shows the bed capacity at each of the division's secure juvenile facilities. For FY2011, the number of beds for the McLaughlin Youth Center has been reduced by four: two due to the construction project that is currently taking place at the facility, and two because the rooms are strictly used as observation rooms and do not have beds in them. At the Fairbanks Youth Facility, two of the beds are also being used strictly for observation rooms.

Youth Facility Existing Hard Bed Capacity FY2011			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	160	-4	156
Mat-Su Youth Facility	15		15
Kenai Peninsula Youth Facility	10		10
Fairbanks Youth Facility	39	-2	37
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Johnson Youth Center	30		30
Ketchikan Youth Facility	10		10
Total	296	-6	290

Facility Data

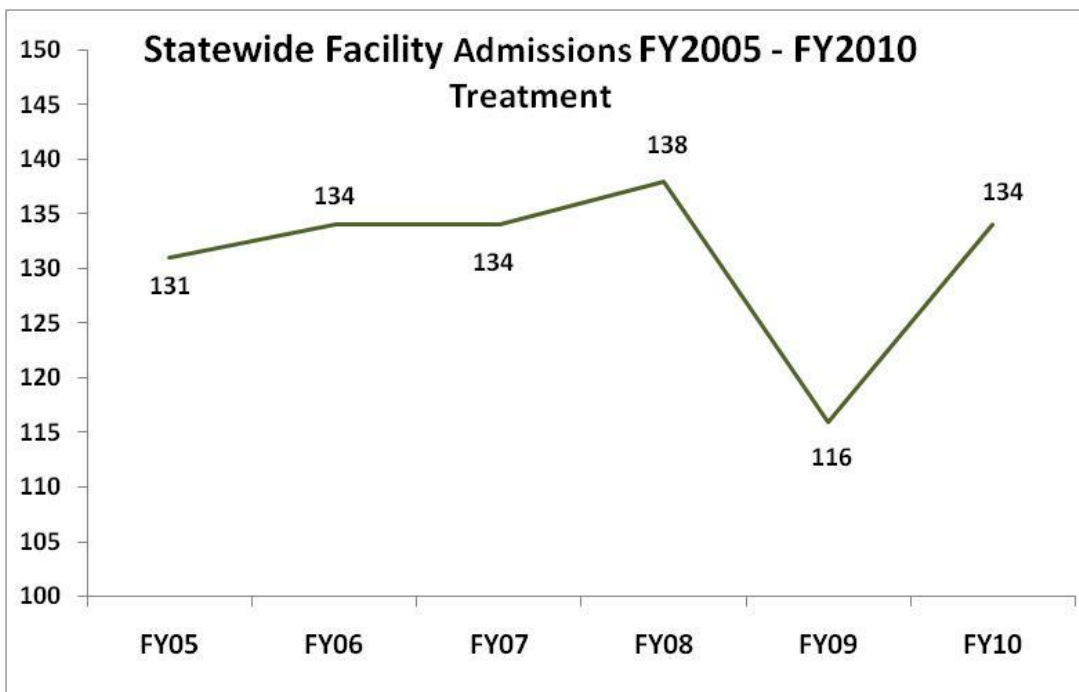
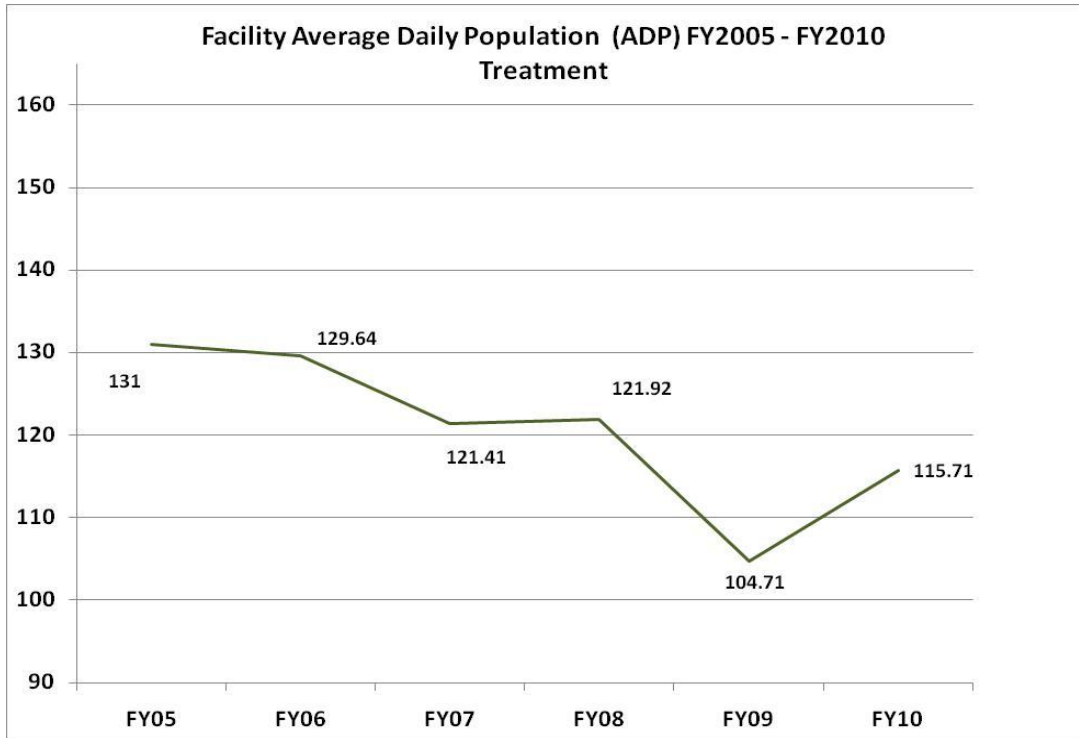
Detention Units

The charts below show juvenile detention average daily population and admissions from FY2005 through FY2010. 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 FY2010 was 143.



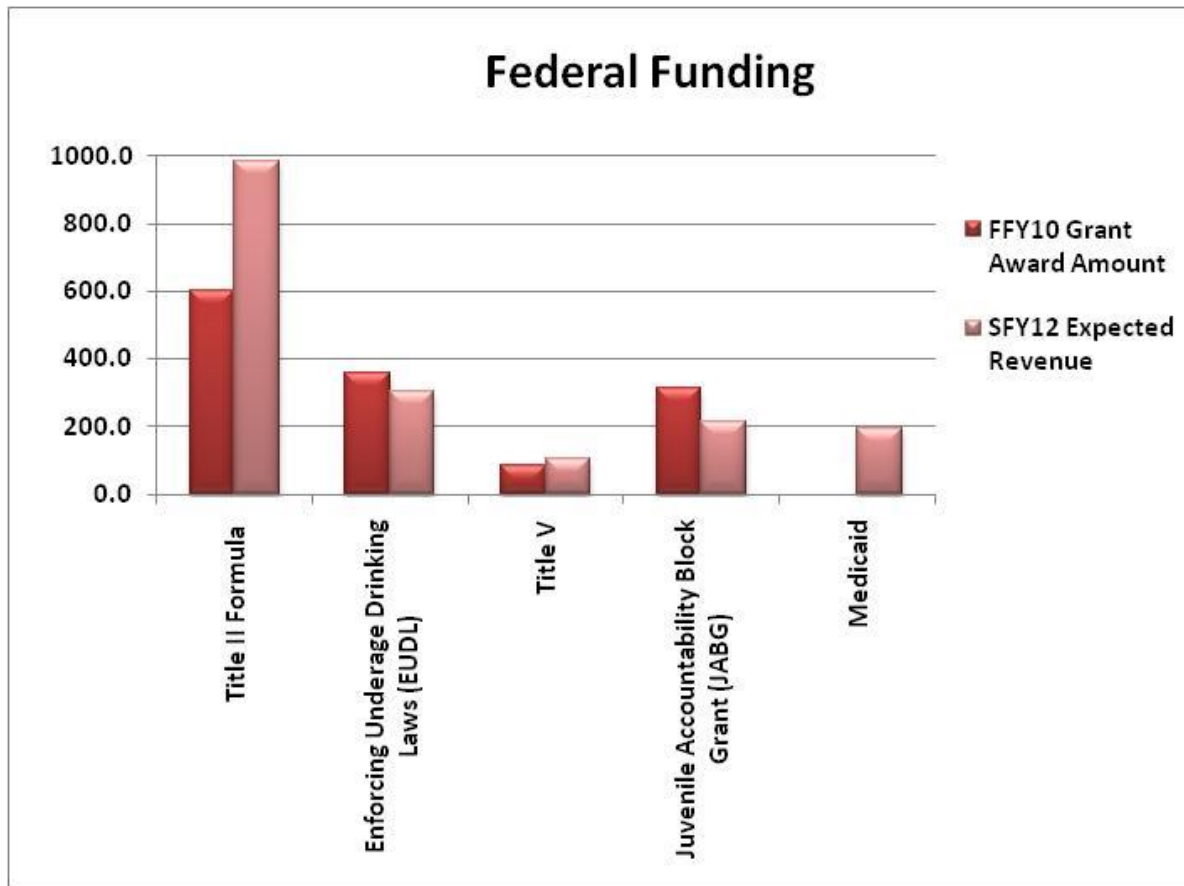
Treatment Units

The charts below show juvenile program average daily population and admissions from FY2005 through FY2010. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY2010 was 149, excluding the four 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 FFY2010 grant programs and budgeted revenues for FY2012. Note that in some cases the budgeted revenue exceeds the award amounts. This is due to a carry forward from previous years of various grant awards.



List of Primary Programs and Statutory Responsibilities

AS 09.35	Execution
AS 11.81	General Provisions
AS 12.25	Arrests and Citations
AS 12.35	Search and Seizures
AS 25.27	Child Support Enforcement Agency
AS 47.05	Administration of Welfare, Social Services and Institutions
AS 47.10	Children in Need in Aid
AS 47.12	Delinquent Minors
AS 47.14	Juvenile Institutions
AS 47.15	Uniform Interstate Compact on Juveniles
AS 47.17	Child Protection
AS 47.18	Programs and Services Related to Adolescents
AS 47.21	Adventure Based Education
AS 47.30	Mental Health
AS 47.35	Child Care Facilities, Child Placement Agencies, Child Treatment Facilities, Foster Homes, and Maternity Homes
AS 47.37	Uniform Alcoholism and Intoxication Treatment Act
7 AAC 52	Juvenile Correctional Facilities and Juvenile Detention Facilities
7 AAC 53	Social Services
7 AAC 54	Administration
7 AAC 78	Grant Programs
Alaska Delinquency Rules	
Alaska Rules of Civil Procedure	
Alaska Rules of Criminal Procedure	

Explanation of FY12 Operating Budget Requests

Division of Juvenile Justice

Budget Overview Table

Juvenile Justice	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$50,439.1	\$52,794.7	\$2,355.6
Designated General Funds	0.0	0.0	0.0
Federal Funds	2,424.4	1,796.1	(628.3)
Other Funds	1,105.2	1,028.4	(76.8)
Total	\$53,968.7	\$55,619.2	\$1,650.5

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.

Budget Requests

McLaughlin Youth Center

Safety and Security Funding for Juvenile Justice Facilities: \$500.0 GF

Juvenile justice facilities require adequate minimum staffing at all times to keep the youth, the facility, and the staff safe. Hiring non-permanent staff and requiring permanent staff to work overtime is necessary in order to maintain adequate staffing levels when a vacancy occurs or employees are not available for shift coverage. This necessary practice does not allow the division to realize the savings a vacancy factor implies. Low or no staff turnover, which is a good thing programmatically, causes a hardship on a budget when a vacancy factor has to be made up. In the Division of Juvenile Justice, the vacancy factors are made up by holding some positions open for months, but filling others in order to meet the required staff to client ratio. This practice impacts clients and services that the division provides to the youth that are served within and outside of our institutions. Fully funding all authorized positions within the facility components would help resolve this issue.

In the FY2011 management plan, the McLaughlin Youth Center needs to make up \$400.8, because of the 2.74% vacancy factor, to stay within the budget. With the low number of staff turnover, this will be impossible to do, thus requiring a supplemental request to cover the excess costs for maintaining adequate staffing.

In FY2010, the McLaughlin Youth Center had 173 full-time positions, no vacancies for two months, and four or fewer vacancies for eight months. This component still incurred non-perm and overtime costs to cover shifts while staff attended training and staff meetings, as well as for staff that were out sick, on personal leave, on FMLA, or on military leave.

Although the goal is to have all of the division's facility components at a zero vacancy, the increment request will get the McLaughlin Youth Center closer to that goal. The \$500.0 increment brings the McLaughlin Youth Center component to 1.15% vacancy, closer than the 4.42% vacancy that would be required if the funds were not received. If this increment is not funded, the division will be requesting supplemental increments to cover the cost for staff time, or, programs will have to be shut down because of lack of funding. Our facility staff positions need to be filled to provide safety and security for both clients and staff.

MH Trust: Increase Mental Health Clinical Capacity in Juvenile Justice Facilities:
\$189.2 General Fund/Mental Health

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. Thirteen 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 in 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 FY2012 and beyond 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.

DHSS Increment to Mental Health Trust Recommendation – Mental Health Trust:
Increase Mental Health Clinical Capacity in Juvenile Justice Facilities:
\$10.8 General Funds/Mental Health

The Trust-recommended increment only replaced FY2011 MHTAAR funding for the positions. This request funds the remaining personal services costs for the mental health clinicians.

Add On-Call Non-Perm Nurse Position (PCN 06-N10020): Position Adjustment
In December 2009, an on-call non-perm nurse position was approved to support the nursing staff at the McLaughlin Youth Center. This request adds the position to the budget component.

All Facility and Probation Services Components

FY2012 Personal Services Increases: \$1936.8, which is comprised of \$1889.2 General Fund; \$23.9 General Fund/Mental Health; and \$23.7 Federal Receipts

These salary adjustments are for various contract requirements for increased health insurance costs and cost of living allowances. The funding is made up of the following:

Component	GF	GF/MH	Federal	Total
McLaughlin Youth Center	\$571.6	\$14.9		\$586.5
Mat-Su Youth Facility	\$66.0			\$66.0
Kenai Peninsula Youth Facility	\$55.4			\$55.4
Fairbanks Youth Facility	\$109.6	\$2.5		\$112.1
Bethel Youth Facility	\$224.9	\$1.2		\$226.1
Nome Youth Facility	\$111.3			\$111.3
Johnson Youth Center	\$159.6			\$159.6
Ketchikan Regional Youth Facility	\$56.1			\$56.1
Probation Services	\$532.2	\$5.3	\$23.7	\$561.2
Total	\$1,886.7	\$23.9	\$23.7	\$1,934.3

Probation Services

MH Trust: Disability Justice; Division of Juvenile Justice Rural Specialist: \$110.9 MHTAAR

This project maintains a key component of the Disability Justice Focus Area by proactively engaging the local communities, treatment providers and natural supports in rural communities in a planning process to assist youth returning to their rural home communities. The position will assist rural communities in developing prevention and/or early intervention activities, make recommendations for training efforts, etc. to reduce the risk of local youth contact with the juvenile justice system, which in turn will decrease the risk of recidivism and the associated high costs of care within the juvenile justice system or out-of-home placement.

Reduce Federal Authority for Expired Re-Entry Grant and for the Unrealized Revenue for the Juvenile Accountability Block Grant: (\$25.0) Federal

The High Risk Youth Offender Re-Entry grant expired September 30, 2010. This change record reduces by \$5.0 the authority in this component that was tied to the High Risk Youth Offender grant that expired on 9/30/10. It also reduces the amount to be collected for administration of the Juvenile Accountability Block Grant (JABG) by \$20.0. The amount that has been awarded to the division for JABG has decreased, allowing fewer expenditures that can be charged to the administration of the grant.

Transfer of Funds Needed to Bring Personal Services within Vacancy Factor Guidelines: \$0.0
This line items transfer moves \$16.6 authority from the travel line, \$122.4 from the contractual line, \$35.0 from the equipment line, and \$36.0 from the grants line of this component to balance personal services within the vacancy factor guidelines. Historically, funds from the equipment line have not been spent and the division will see some savings within the contractual line in FY2012 for services, including teleconferences. In addition, the division has experienced a small drop in total expenses from the grants line of this component.

Delinquency Prevention

Reduce Federal Revenue Authority by \$50.0 Due to Expiration of Re-Entry Grant: (\$50.0) Fed
The High Risk Youth Offender Re-Entry federal grant ended on September 30, 2010. This change record reduces the federal authority for this component by the \$50.0 that was identified to be collected.

Youth Courts

Remove Federal Authority for Expired Earmark Grant: (\$568.5) Fed
The federal earmark grant for the Alaska Youth Courts and Community Panel Programs ended August 31, 2010. No federal funding supports this component. This decrement removes all the federal authority.

Explanation of FY12 Capital Budget Requests

McLaughlin Youth Center: \$4,275.0 General Funds

This request will fund the completion of the McLaughlin Youth Center Safety and Security Phase I project. The original appropriation was used to relocate the outdoor recreation area, parking for the juvenile justice center, completion of a new 25 bed detention unit, and design of the new medical suite. There is insufficient funding to complete construction of the new medical suite and training area, which is part of this project.

There are three components that lead to the shortfall on this project:

1. Medical Suite Space Calculation Error: As part of this project, the vacated Detention 2 will be renovated into the new medical suite and training area. There was a miscalculation in the original budget as to the size for the new space. The original budget included 5,000 SF for the medical suite and training room. The actual space needed is 20,000 SF, which is a 15,000 SF discrepancy. The space will be used for training space, offices, dentist office, mental health clinicians, nurse's office, and storage for confidential files. This error is the primary reason for the overall shortfall in the budget.

2. Duration: The original budget was based on a 1.5 year construction time line. It did not account for the necessary time for all the components within phase 1. The actual time line is 3.5 years, which requires more time to manage the overall project.

3. Asbestos Abatement: During the investigation of the Intensive Treatment Unit, it was determined that asbestos in the crawl area will need to be abated. The cost is estimated at \$500.0 to complete. This abatement was not anticipated with the original budget.

This request will address all these items and complete all the components of Phase 1. If this request is not funded, the contractor will need to demobilize and the medical suite and training space will need to be re-bid. The cost of rebidding the project would substantially increase the amount of the request. Also, if a different contractor completes the project, they will not be familiar with the existing conditions to the extent the current contractor is. This could further inflate the overall cost. The funding is needed now to complete this project at the lowest possible cost. In the construction world, a delay in completion translates to an increased cost. The State has been fortunate lately to experience overall lower construction costs. This eventually will change, and when it does, we will experience increased costs to the State to make these needed changes.

Juvenile Offender Management Information System (JOMIS) Testing: \$25.0 General Funds
The Juvenile Offender Management Information System (JOMIS) is a large and complex system. Testing of new releases of the application is time-consuming and done manually by probation and other staff who are fully allocated to other duties. Even though Division of Juvenile Justice staff manually test this application, the division is unable to catch all possible problems. Periodically new problems are introduced to the system as a direct result of the process to fix or upgrade JOMIS, but if the testing were automated, the process would be faster and more accurate, which in turn would save both money and staff time.

Challenges

Facilities Safety and Security Master Plan: The division's aging youth facilities are becoming increasingly difficult to maintain as these buildings sustain hard use 24/7 in challenging climates, ranging from the cold arctic climate at the Bethel Facility to the damp Southeast climate at Juneau's Johnson Youth Center. Severe overcrowding for probation staff remains a serious concern in most probation offices but especially in those offices co-located with a DJJ facility. In Bethel and Anchorage, numerous probation officers often share a single person office, making it extremely challenging to meet with clients or families, conduct thorough and confidential risk/need assessments, or interface with service providers to ensure appropriate services to promote positive juvenile outcomes. Both the Johnson Youth Center and the Fairbanks Youth Facility are plagued with structural and utilization problems that need to be addressed if these facilities are to offer secure, safe services.

In the summer of 2007, a study was commissioned to identify significant safety and security breaches within the four oldest facilities. The study has recommended the need to renovate several areas of each of the four facilities. The first of four phases for the McLaughlin Youth Center renovation was funded and is underway. The division was able to obtain funding for Phase I for the Johnson Youth Center in FY2011. The current challenge is to receive funding for the remaining projects at the Bethel Youth Facility, Fairbanks Youth Facility and at McLaughlin Youth Center. Funding for the Bethel Youth Facility renovation is presently the top capital priority for the division.

Recruitment: Recruitment of professional staff has become a key challenge as the division's workforce ages and long-term staff retires from State service. In the past few years, the division has experienced a significant turnover in several key leadership positions, including facility superintendents, regional probation managers, district probation supervisory positions, several long-time probation officers and critical positions in the director's office. This trend will continue into FY2011. The ability to attract qualified applicants to these positions has become increasingly difficult, especially for rural offices and facilities. The superintendent position at the Ketchikan Regional Youth Facility has remained vacant for over two years. The division is working with the Division of Personnel to revise the minimum qualifications for this job series and is committed to the process of finding viable candidates.

Safety and Security: The Division of Juvenile Justice is working with other Federal, State, and local emergency services as part of the development of an Alaska Land Mobile Radio (ALMR) communication system that can be shared among appropriate entities. The division's involvement will allow for better communication between DJJ Probation and Facilities at all times, but especially during emergencies. The division has received some capital funds to bring sites on-line, but we continue to work with the department to find funding to provide Anchorage with the necessary radios.

Quality Assurance: Although the division has re-allocated positions to help provide some measure of quality assurance, resources to provide the oversight necessary to assure that DJJ facilities and probation services are contributing to public safety and positive outcomes for youth remain inadequate. The most effective way the division can reduce recidivism and assure public safety is by accurately identifying juveniles' needs then providing the appropriate quality services to ensure the needs are met. The most pressing need is oversight of the division's use of

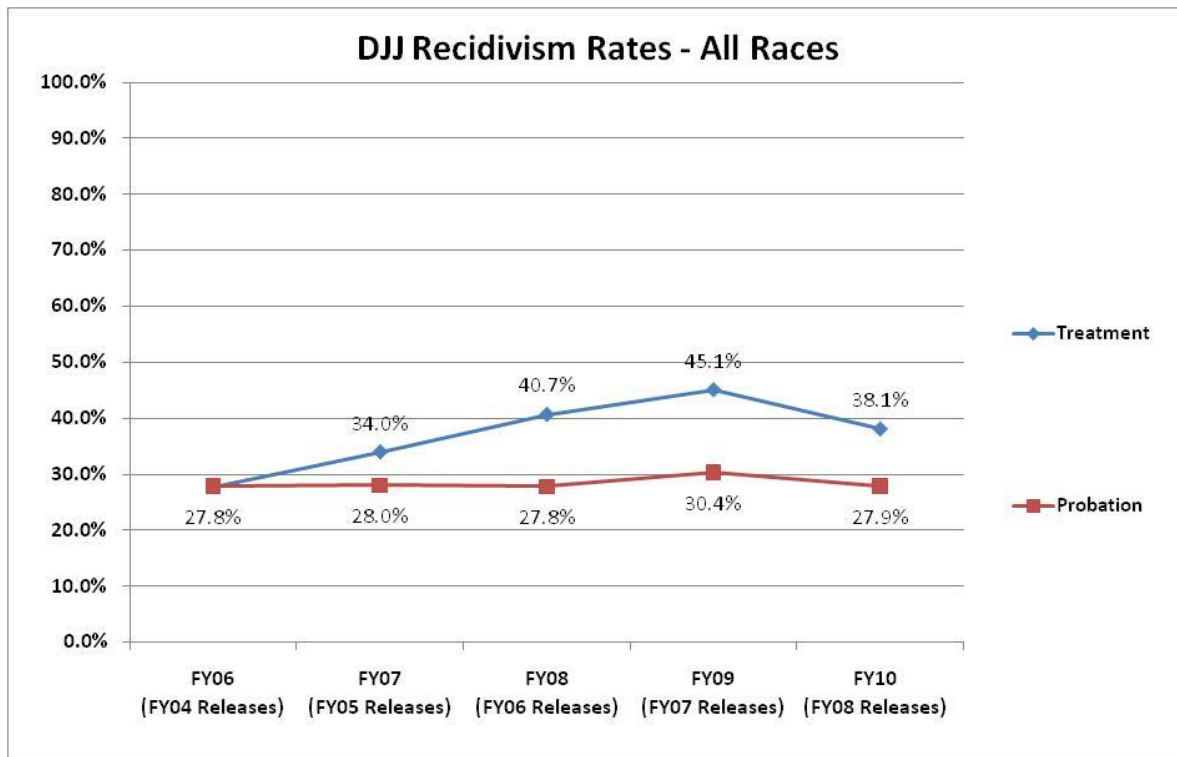
the Youth Level of Services/Case Management Inventory (YLS/CMI), a highly regarded, extensively researched instrument adopted by the division in 2005; and for oversight of Aggression Replacement Training (ART), a nationally recognized program proven to reduce aggression and social skills problems in youth. Both initiatives require that staff maintain fidelity to the prescribed implementation and delivery model. Correct implementation of the YLS assessment and the ART program can be expected to reduce recidivism among youth; improper implementation could lead to youth being incorrectly assessed and trained, and has been demonstrated to lead to more delinquent behaviors among juveniles. Other quality assurance priorities include ensuring substance abuse and mental health services provided to DJJ youth are appropriate and consistently delivered.

Training: Adequate staff training remains a critical need for the division. This need has received attention in past years', however given the daunting logistical challenges of training a 500 member workforce spread out over the entire state with only one staff dedicated to the effort remains a huge challenge. With increased emphasis on best practices at all levels of the division (particularly with regards to arrest procedures, client behavioral management, legal issues, gang issues), the need to provide adequate training to all employees is paramount. Even veteran staff report a need for improved training, and recent staff climate surveys and exit interviews further document this need. The situation is exacerbated by staff turnover. The division is eager to explore ways to deliver effective training in a cost-effective manner to employees that takes full advantage of technology and collaboration with other agencies offering similar services. The division received assistance on this issue by way of federal technical assistance. The recommendations included expanding our current one person training unit, taking advantage of skills already present within the division, and making use of cost effective training methods such as online training and training through video conference.

Workload for Juvenile Probation Officers: A federally funded study of the division's juvenile probation staffing, completed in early FY2010, demonstrated that probation offices statewide are significantly under-resourced, and recommended increased staffing at almost all of the division's 16 probation offices. The division is reviewing these results and will be making recommendations on how staffing patterns can be changed and staffing levels increased as necessary to meet the State's goals for public safety, victim support, and skill development for delinquent youth.

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.

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 time, peers—that must be addressed if the youth is to lead a more productive life.

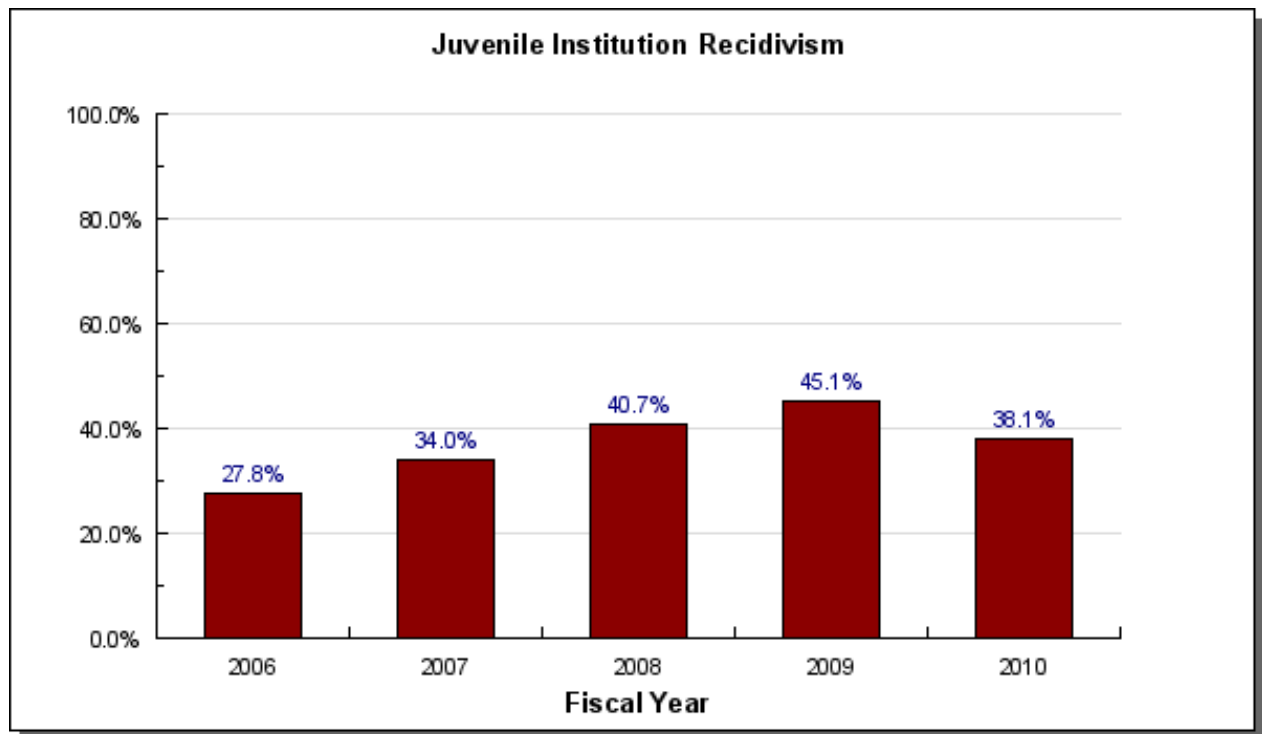
On a statewide level, summarizing YLS/CMI results for whole populations of juveniles will help the division better understand its resource needs. For example, if poor family circumstances are a consistent finding among juveniles who reoffend, the division will know that improved family counseling, coaching, and other therapeutic services are a priority need and deserve more effective resources, and will work with its partners in both the non-profit 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.

Performance Measure Detail

A: Result - Improve the ability to hold juvenile offenders accountable for their behavior.

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

Status #1: The defined recidivism rate for juveniles released from secure treatment in FY2008 and followed up in FY2010 was 38.1%, a decrease from last year but still higher than the target of 33%.



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 among juvenile offenders, and have been institutionalized because they have demonstrated particular violent behavior or have failed to meet requirements of probation supervision or less-restrictive placements.

This year, a decrease in the recidivism rate for juveniles released from Alaska's secure treatment institutions occurred for the first time since this measure has been tracked by the Division on a 12-month basis. (The definitions and procedures for measuring recidivism were set by the Division in 2006.) Prior to this year the recidivism rate for this population had been edging upward. The decrease may not be significant given that the percentage changes in recidivism in fact represent small numbers of youth. (In FY2008, a total of 105 juveniles were released from secure treatment institutions.) Nevertheless, the decrease is positive and the Division is eager to discuss possible contributing factors. The Division recognizes that the recidivism rate for Alaska Native youth released from its facilities remains particularly high. A work group of Division staff created to look more closely at this specific concern has developed a set of recommendations that the Division will be working to realize in the coming year.

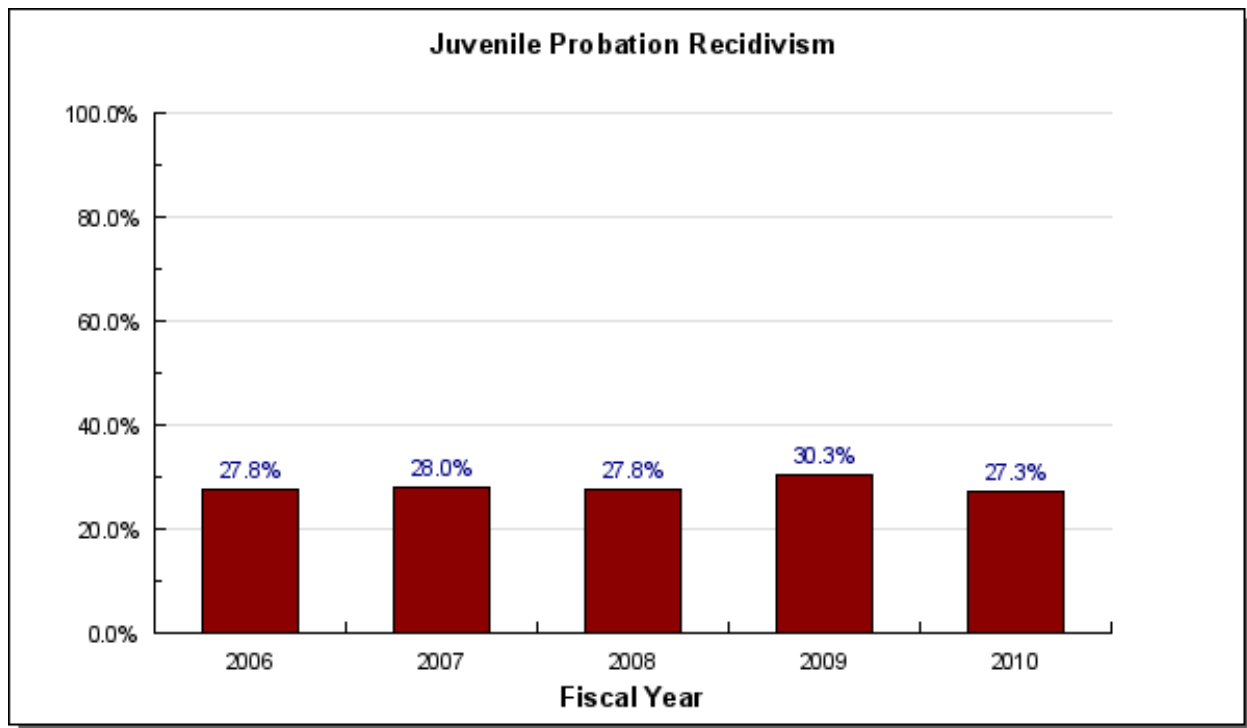
Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. Sixteen of the 32 states that track recidivism do so on a 12-month basis. Among the eight states (including Alaska) that measure recidivism based on a 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 current baseline goal from which Alaska works to improve its recidivism rate. An effort to create a more consistent nationwide definition of recidivism among state juvenile justice agencies, led by the national Council of Juvenile Correctional Administrators, currently is underway. The Division will likely be changing the way it gathers and reports recidivism data in the coming year to better understand how Alaska's juvenile recidivism rates compare with those of other states.

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 a goal this year to closely examine the role of substance abuse risk in delinquent behavior and our success in reducing substance risk among youth who receive Division services. Reducing substance abuse risk and the other factors that contribute to delinquent behavior will reduce the recidivism rate among Alaska's juveniles.

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). 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 FY2010 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, 2010. 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 27.3%, a rate similar to that identified in the previous four years.



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 juveniles released from formal supervision has consistently been in the 27-30% range each year since 2006, when the Division adopted its current procedures for tracking re-offenses for this population. 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. Particular attention is being paid to the high rate of recidivism noted among Alaska Native youth. The Division has recently received the recommendations of an internal workgroup in ways to better understand and meet the needs of this population and will be working to enact these recommendations in the next fiscal year and beyond.

Differences in the way states manage juvenile delinquency referrals make it challenging to compare Alaska's recidivism rate with that of other states. In the coming year the Division

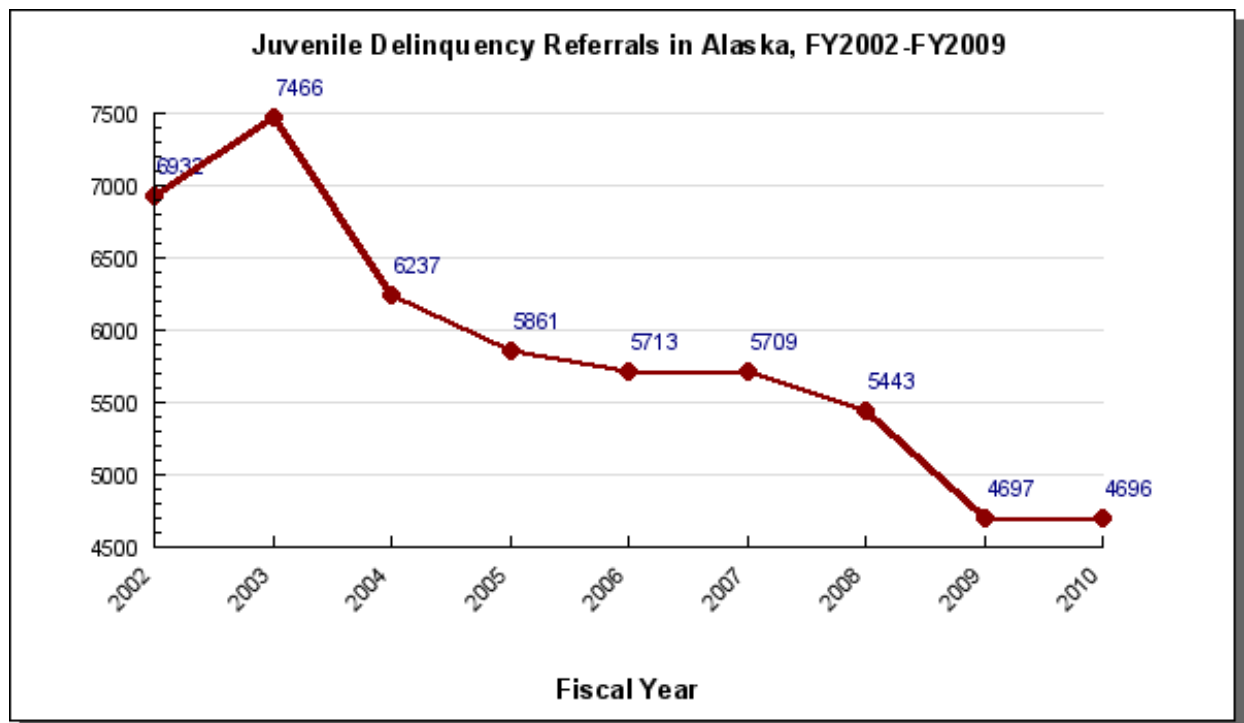
intends to participate in the national dialogue being led by the Council of Juvenile Correctional Administrators to better enable states to compare themselves with each other on their juvenile recidivism rates. This participation may require the Division to adjust its procedures for gathering and reporting on recidivism rates so that Alaska is in closer alignment with the way other states report this information.

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 a goal this year to closely examine the role of substance abuse risk in delinquent behavior and our success in reducing substance risk among youth who receive Division services. Reducing substance abuse risk and the other factors that contribute to delinquent behavior will reduce the recidivism rate among Alaska's juveniles.

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). 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 FY2010 study is represented in the graph above by youth who were released from formal probation in FY2008 and who re-offended within FY2009. For this FY2010 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, 2010.) 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 rate of juvenile referrals (reports of juvenile offenses from law enforcement) per 100,000 youth declined 11.8% compared with the rate two years ago but remained virtually unchanged compared with the number received last year.



**Juvenile Delinquency Referrals in Alaska
FY2002-FY2009**

Fiscal Year	Delinquency Referrals	% Change Over Previous Year
FY 2010	4696	-0.02%
FY 2009	4697	-13.7%
FY 2008	5443	-4.66%
FY 2007	5709	-0.07%
FY 2006	5713	-2.53%
FY 2005	5861	-6.03%
FY 2004	6237	-16.46%
FY 2003	7466	7.7%
FY 2002	6932	--

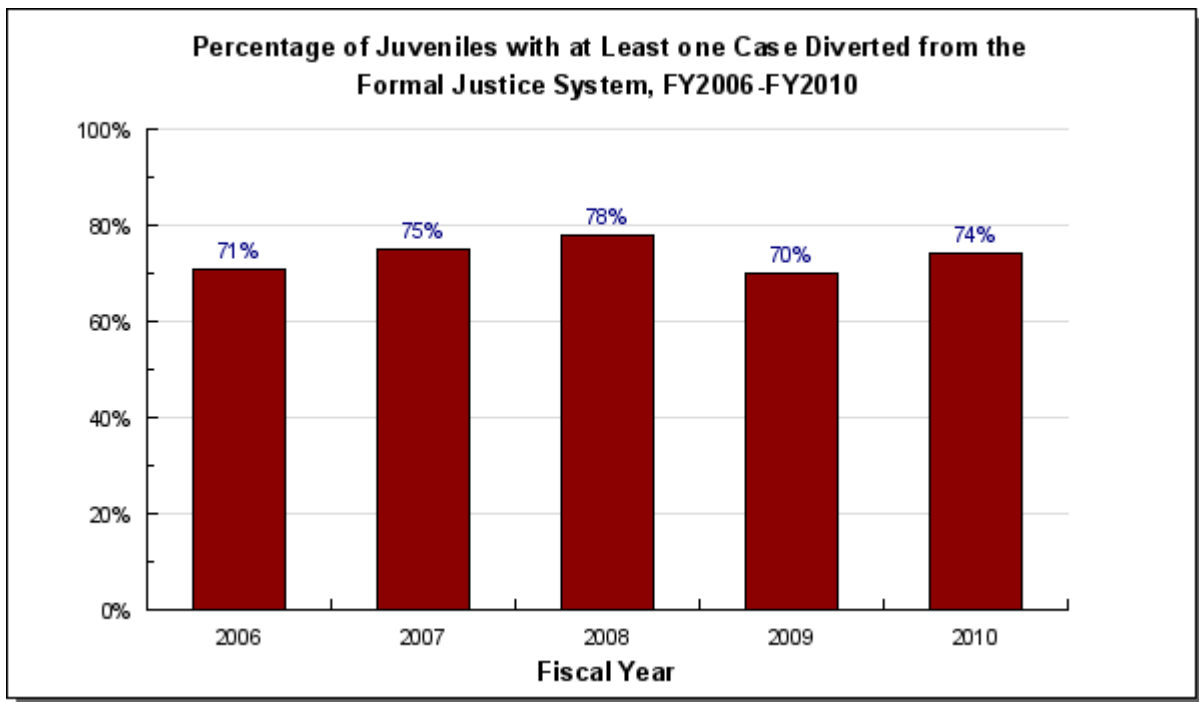
Analysis of results and challenges: The declines in juvenile delinquency activity that have been witnessed in Alaska over the past several years are similar to trends witnessed nationally. (See the Statistical Briefing Book web site sponsored by the U.S. Office of Juvenile Justice and

Delinquency Prevention at the web site noted below.) It is unknown at this time whether the almost identical rate of referrals received in FY2009 and FY2010 represents the beginnings of a trend or potential change in the number of reports of juvenile activity. 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 estimates for youth aged 10-17 are provided by the report Alaska Population Projections 2007-2030, published by the Alaska Department of Labor and Workforce Development. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database on August 20, 2010 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 was 74%, exceeding the goal of 70%.



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 and valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and stress that can result from delinquency adjudication. Diversion

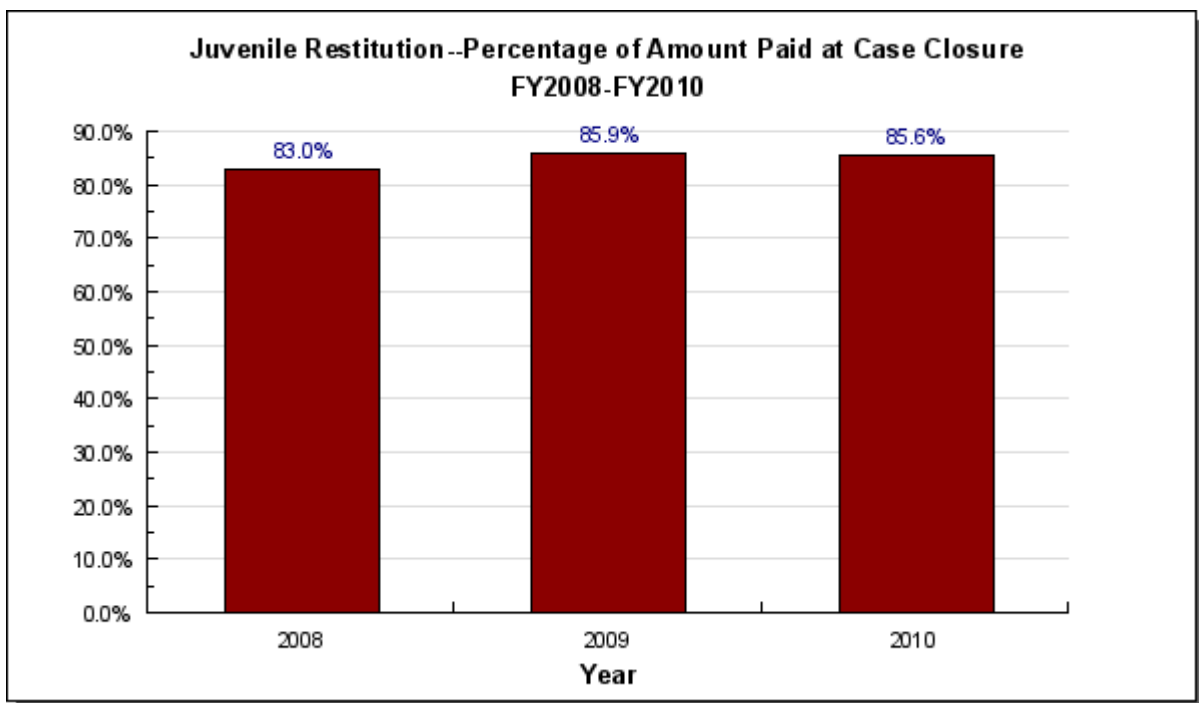
provides opportunities for community partners and victims to take more active roles in handling low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to it. Diversion also is considerably less 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 FY2010, 2,224 (74%) of 2,994 juveniles referred to the Division had at least one of their offenses managed through non-formal-court processes. This percentage matches findings for this measure in previous years; since this measure was first established in FY2006 the percentage of juveniles with at least one offense diverted from the formal justice system has consistently been in the 70-80% range. In the coming year the Division hopes to refine this measure to better determine when juveniles are appropriately referred for diversion and when more intensive services are warranted.

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 amount of restitution paid at the time of case closure to 100% of what was requested or ordered.

Status #5: The percentage of restitution orders and requests completed successfully in FY2010 was 85.6%, a percentage similar to previous years. A total of 140 orders or requests for restitution were closed in FY2010 and of these 120 were completed successfully.



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.

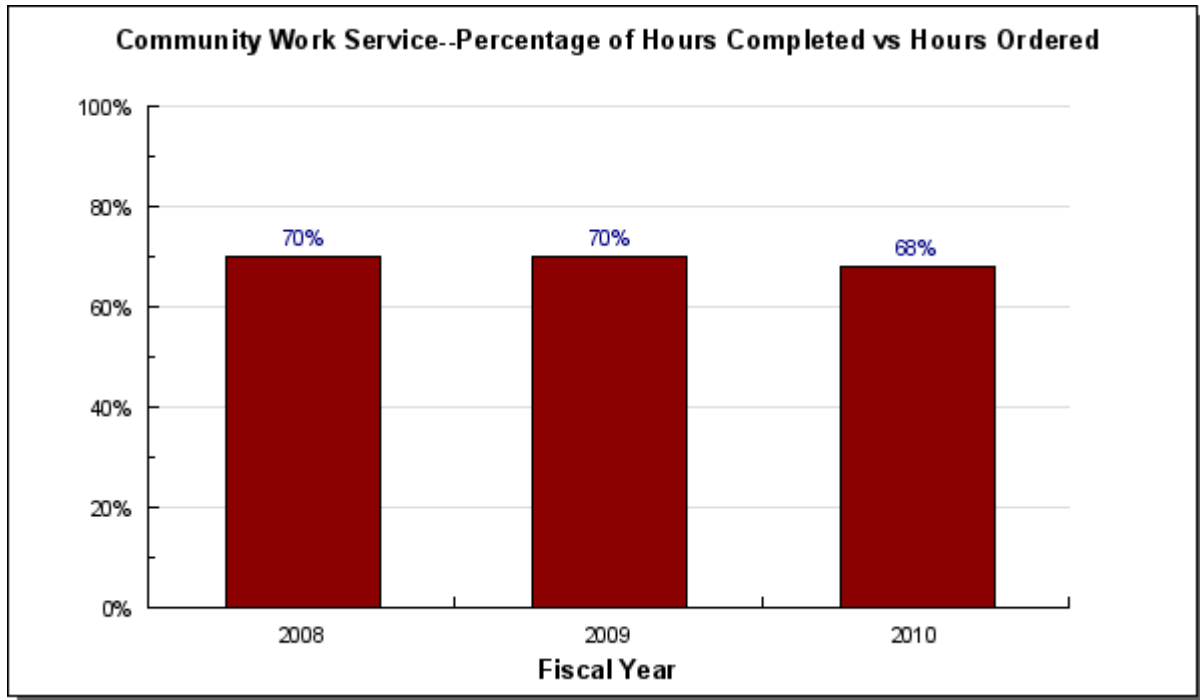
Toward the end of FY2009 the Division made significant changes to its electronic records management system, the Juvenile Offender Management Information System. Among these changes were a move from a server-based application to a web-based platform. This appears to have affected the accuracy of records of restitution, specifically the amount of money Division staff reported as paid. (The total amount ordered or requested appears accurate.) The Division therefore has changed slightly the way in which it determines its success in fulfilling restitution orders and requests compared with previous years. Previously, the Division reported the percentage of dollars of restitution paid out of the total amount ordered or requested. This year we report the number of episodes of restitution completed out of the total number of episodes—successful or not—closed in each fiscal year. We believe this provides an accurate sense of juveniles' success in meeting restitution requirements and expectations despite the technical challenges in understanding the actual dollar amounts paid.

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 number of restitution episodes that are successfully completed has remained consistently 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 more closely analyze the reasons youth fail to complete restitution requirements in order to improve the expectations of their supervision. The Division also will be clarifying the requirements for entering information on restitution to ensure that we present the most accurate information possible, in a way that is most meaningful toward helping us improve performance.

Note: Restitution is included in this measure when it is 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. Data for this measure was retrieved from the Juvenile Offender Management Information System on August 31, 2010.

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 community work service episodes completed successfully during FY2010 was 68%, a percentage similar to previous years. A total of 584 episodes of community work service episodes were closed in FY2010 and of these 395 were completed successfully.



Analysis of results and challenges: Community work service (CWS) 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.

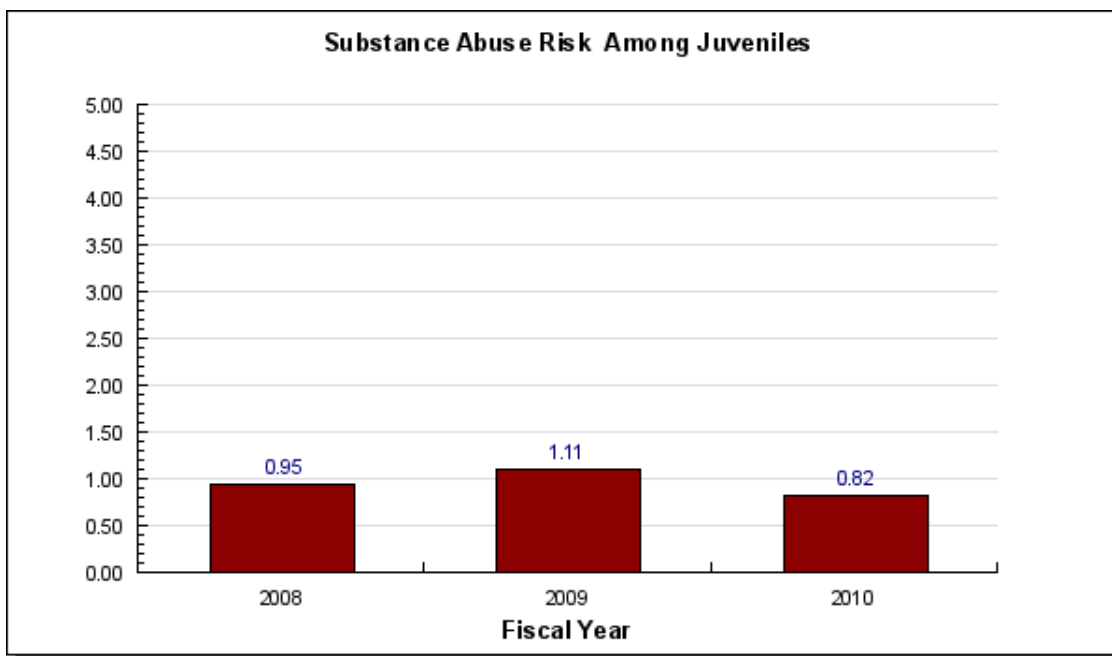
Toward the end of FY2009 the Division made significant changes to the Juvenile Offender Management Information System, which included moving the database from a server-based application to a web-based application. The changes to the database appear to have affected the accuracy of records of CWS, specifically the number of hours Division staff report as completed. (The number of hours ordered appears to be accurate.) The Division therefore has changed slightly the way in which it determines the amount of CWS compared with previous years. Previously, the Division reported the percentage of hours of CWS completed out of the total number of hours ordered. This year we report the number of episodes of CWS completed as a percentage of the total number of episodes—completed or not—that closed in each year. We believe this provides us with an accurate picture of the amount of CWS completed despite the technical challenges of understanding the number of hours completed.

Episodes of CWS are assigned to juveniles by a judge or probation officer, and may range from assignments that last just a few hours to one hundred hours or more. 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 CWS requirements, and CWS is typically a more challenging and involved expectation to fulfill than making restitution payments, in the coming year the Division will examine the utility of CWS as a performance measure, and the appropriate baseline expectation for juveniles fulfilling CWS requirements. The Division also will be clarifying the requirements for entering information on CWS to ensure we are presenting the most accurate information possible, in a way that is most meaningful toward helping us improve performance.

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 August 31, 2010.

Target #7: Reduce substance abuse risk among juveniles as measured by the Division's assessment instrument.

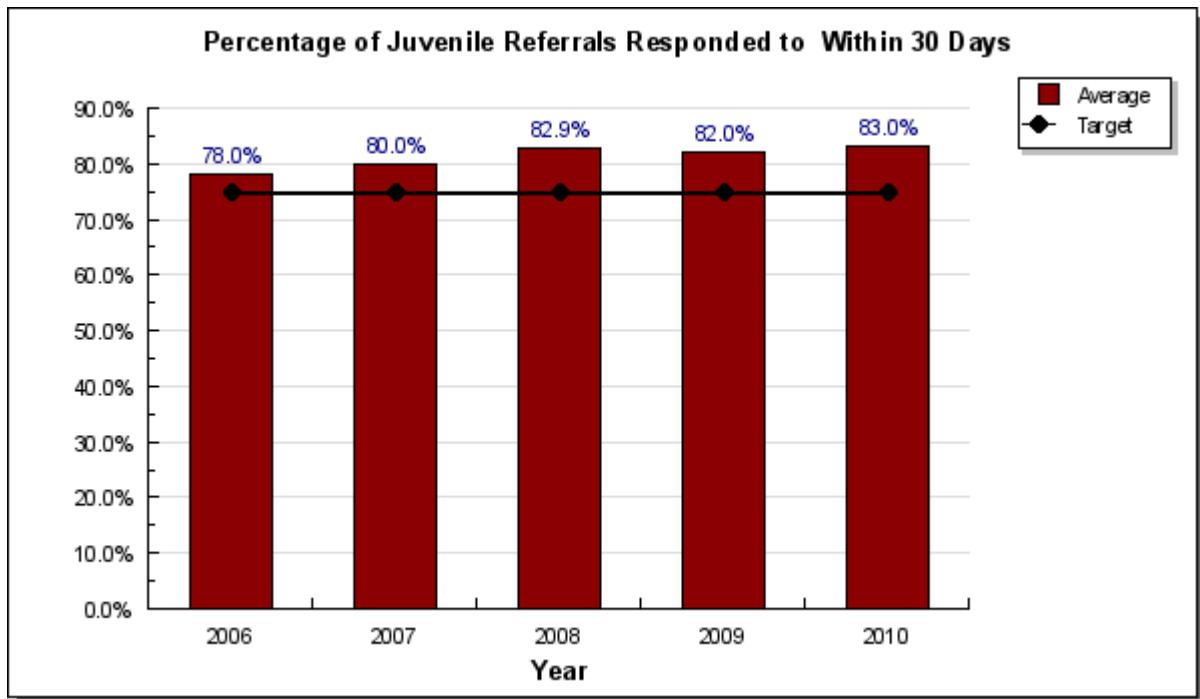
Status #7: The target of reducing the risk as measured by the assessment instrument was met. The average substance abuse risk for juveniles completing Division of Juvenile Justice services in FY2010 was 0.82, which is considered medium risk as determined by the Division's juvenile assessment instrument. The rate was 1.11 in FY09 and 0.95 in FY08. The substance abuse risk scale is: 0 - low risk, 1-2 medium risk, 3-5 high risk. (DHSS DJJ)



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 83% of reports responded to within 30 days. The average response time for juvenile probation staff to respond to referrals was 17.9 days.



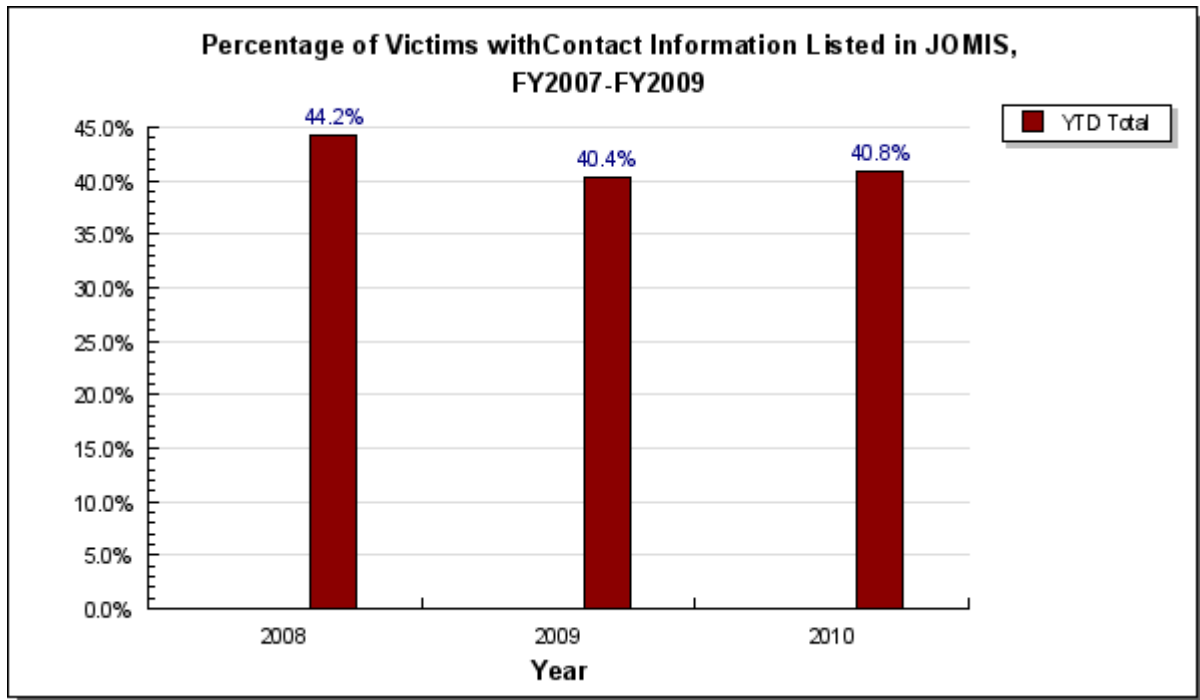
Analysis of results and challenges: Research indicates that responses to juvenile offenses must be timely and appropriate in order to be effective. This measure monitors the percentage of cases that receive an active response within the target response time of 30 days. An “active response” is defined 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 consistently exceeded 75% since this measure was developed in FY2004, suggesting that a goal of 80-90% may be more appropriate. The number of days that it took, on average, for probation officers to respond to referrals remained consistent with previous years’ results at 17.9 days.

Note: Delinquency reports (“referrals”) included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or 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 improve victim participation in juvenile justice processes.

Status #1: 40.8% of victims of person and property offenses committed by juveniles who were adjudicated on those offenses in FY2010 had contact information listed in the Juvenile Offender Management Information System. This percentage was similar to that identified for previous years.



Analysis of results and challenges: Alaska law and the Division's own policies recognize the importance of treating victims of juvenile delinquency with dignity, respect and fairness. 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 previous years attempts were made to determine victim satisfaction through mail-in, web-based, and phone surveys, but response rates were so poor there was little the Division could conclude from the results. One factor determined to contribute to the low response rates was that victim names and addresses often had not been entered accurately or completely into the Division's Juvenile Offender Management Information System (JOMIS). A high percentage of the surveys were returned as undeliverable, and a high percentage of the phone calls made went unanswered, because zip codes were missing, post office box numbers were non-existent, or phone numbers were incomplete.

Before the Division can get an adequate picture of whether the majority of victims are satisfied with the services they receive, we must first determine whether the contact information for these victims is complete and accurate. This is the second year the Division has examined the completeness of victim records in JOMIS as a performance measure. The process through which victim information is entered and was gathered has changed, however, due to technical changes that the Division made to JOMIS late in FY2009. In order to get a consistent comparison with

FY2010, the Division has re-calculated victim information for FY2008 and FY2009. The percentages of complete victim information presented for these years therefore are different from those reported previously.

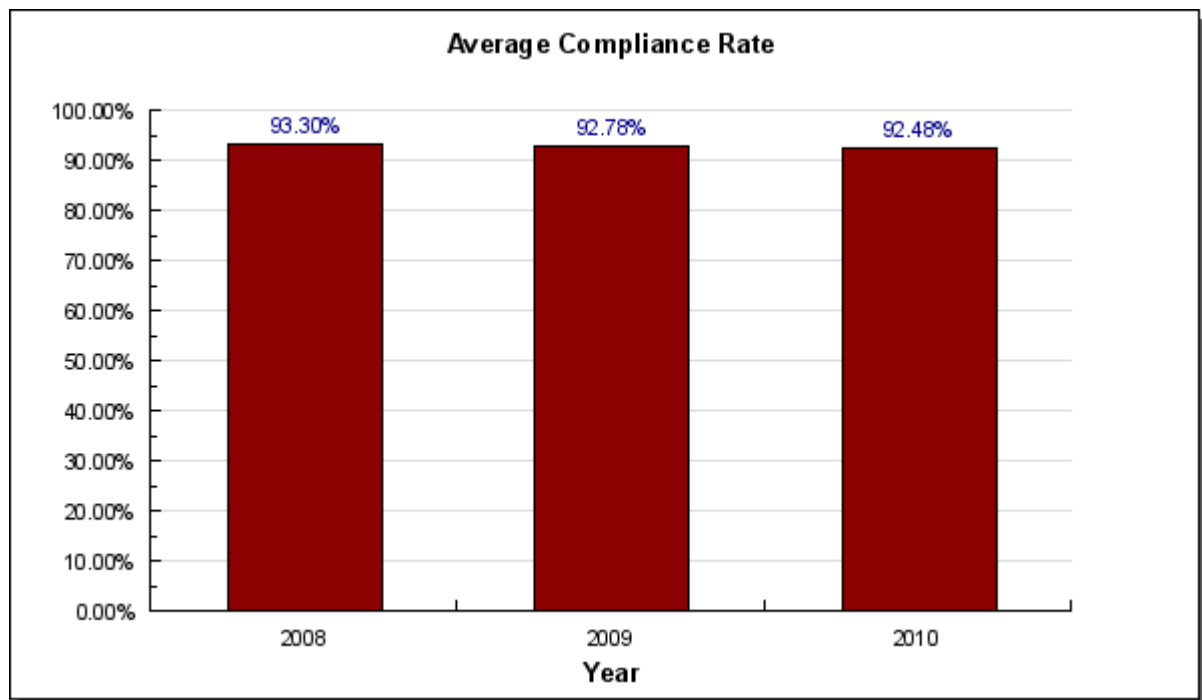
In the coming year the Division will be exploring the reasons why it has contact information on only 40% of the victims of offenses that are adjudicated through the formal court process. Some reasons might be: challenges in getting complete victim information from police reports; cumbersome data entry procedures; technical problems with the database; or a need for improved staff training. Once the Division understands how to improve the completeness of victim records we will then be able to address their satisfaction with our services.

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 FY2008 through FY2010, had to be listed in JOMIS by August 31, 2010. 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.

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 92.48% compliance rate in meeting overall case standards.



Methodology:

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 every trimester. 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 case files to make these audits an ever-more useful tool in determining the quality of juvenile probation officers' work.

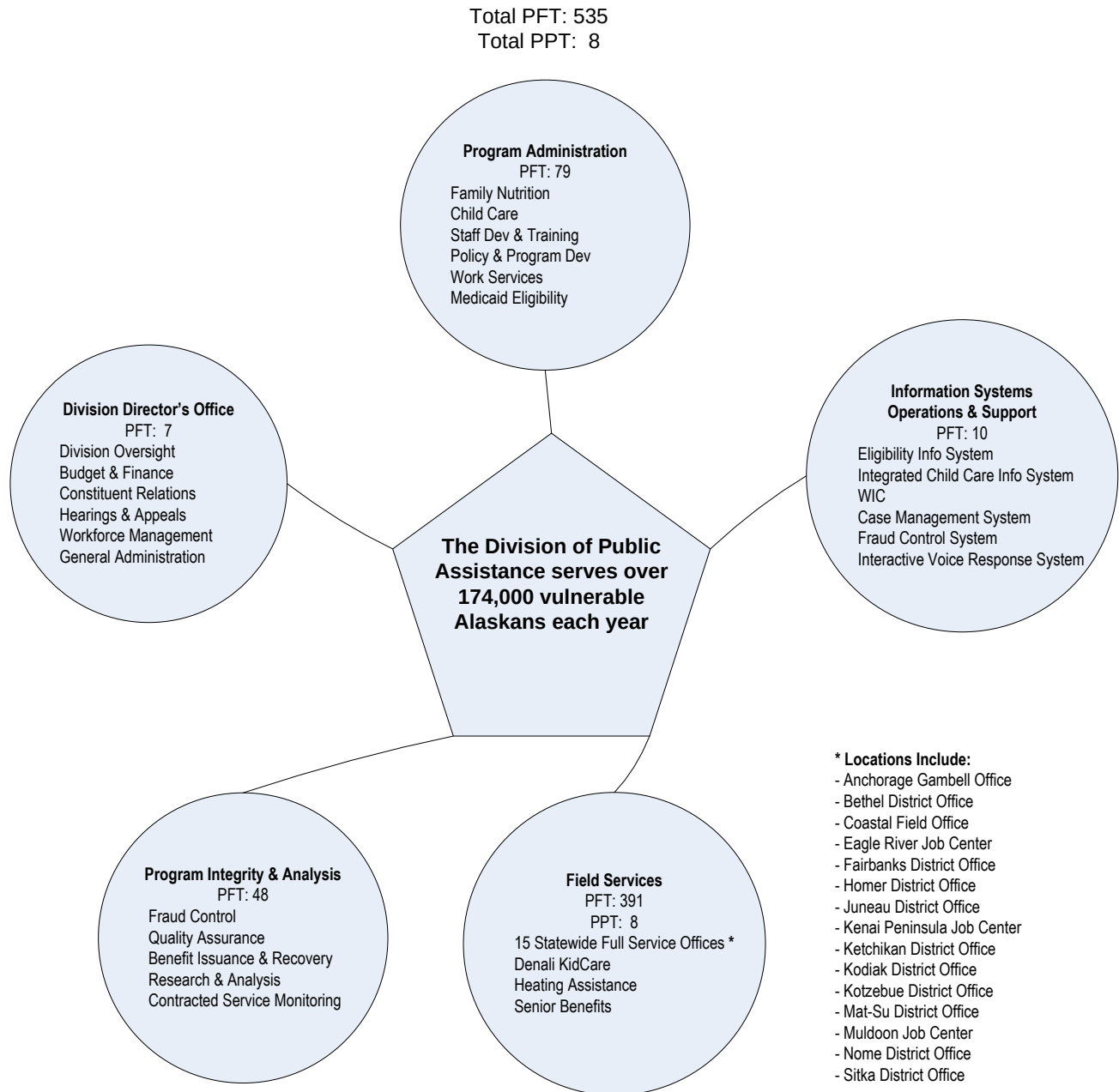
Target #2: Increase the percentage of juveniles assessed for substance abuse risk to 100%.

Status #2: Not Available

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Safety and Security Funding for Juvenile Justice Facilities	\$ 500.0	\$ -	\$ -	\$ -	\$ 500.0
MH Trust: Dis Justice - Increase Mental Health Clinical Capacity in Juvenile Justice Facilities	\$ 189.2	\$ -	\$ -	\$ -	\$ 189.2
DHSS inc to MHT Rec - MH Trust: Dis Justice - Increase Mental Health Clinical Capacity in Juvenile Justice Facilities	\$ 10.8	\$ -	\$ -	\$ -	\$ 10.8
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (194.9)	\$ (194.9)
MH Trust: Dis Justice- Div Juvenile Justice Rural Specialist	\$ -	\$ -	\$ -	\$ 110.9	\$ 110.9
Reduce Federal Authority for Expired Re-Entry Grant and for Unrealized Revenue for the JABG Grant	\$ -	\$ -	\$ (25.0)	\$ -	\$ (25.0)
Reverse August FY2011 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (119.4)	\$ -	\$ -	\$ -	\$ (119.4)
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 6.3	\$ -	\$ (6.3)	\$ -	\$ -
Reduce Federal Revenue Authority Due to Expiration of Re-Entry Grant	\$ -	\$ -	\$ (50.0)	\$ -	\$ (50.0)
Remove Federal Authority for Expired Earmark Grant	\$ -	\$ -	\$ (568.5)	\$ -	\$ (568.5)
Juvenile Justice Total	\$ 586.9	\$ -	\$ (649.8)	\$ (84.0)	\$ (146.9)

Division of Public Assistance



Introduction to the Division of Public Assistance

Mission

To promote self-sufficiency and provide for basic living expenses to Alaskans in need.

Overview

DPA provides essential services to meet many of the basic and urgent needs of Alaska's most vulnerable families and individuals. 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 provides accurate and timely program benefits and make services available through a variety of programs that are intended to help Alaskans remain safe and healthy, prevent dependency, and support Alaskans as they work toward family stability and economic independence. Public Assistance programs offer:

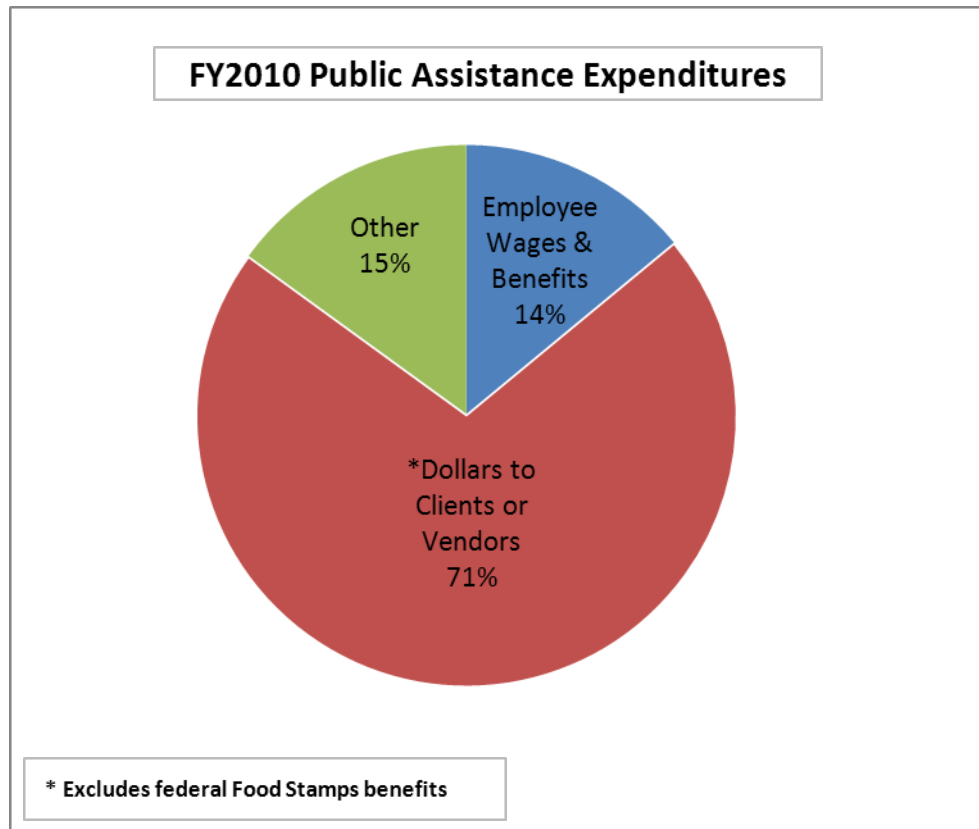
- Temporary financial assistance to help low-income Alaska families with children meet basic needs and to encourage family self-sufficiency and stability by planning for self-support through employment;
- Employment assistance to help individuals find and keep jobs and advance to better employment;
- 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, to increase food security, and reduce 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 the 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.

Every day hundreds of thousands of Alaskans rely on DPA to meet their most basic needs and to support their efforts to achieve economic independence. DPA services are a significant element of the Department's larger effort in Alaska to keep children safe and families strong. DPA's success as a partner in that effort depends upon over 500 employees located across the state, as well as many

community partners, all of whom are dedicated to supporting and improving the lives of children, adults and families in Alaska.

The division provides direct services in 18 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 FY10, the division provided cash, food, and medical benefits and services to nearly 115,000 Alaskan households and 174,000 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 Native Temporary Assistance for Needy Families programs.

The remaining fifth of the DPA budget is divided between staff costs – direct service and administrative (14%) and all other costs (15%).

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 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 about 3,500 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.

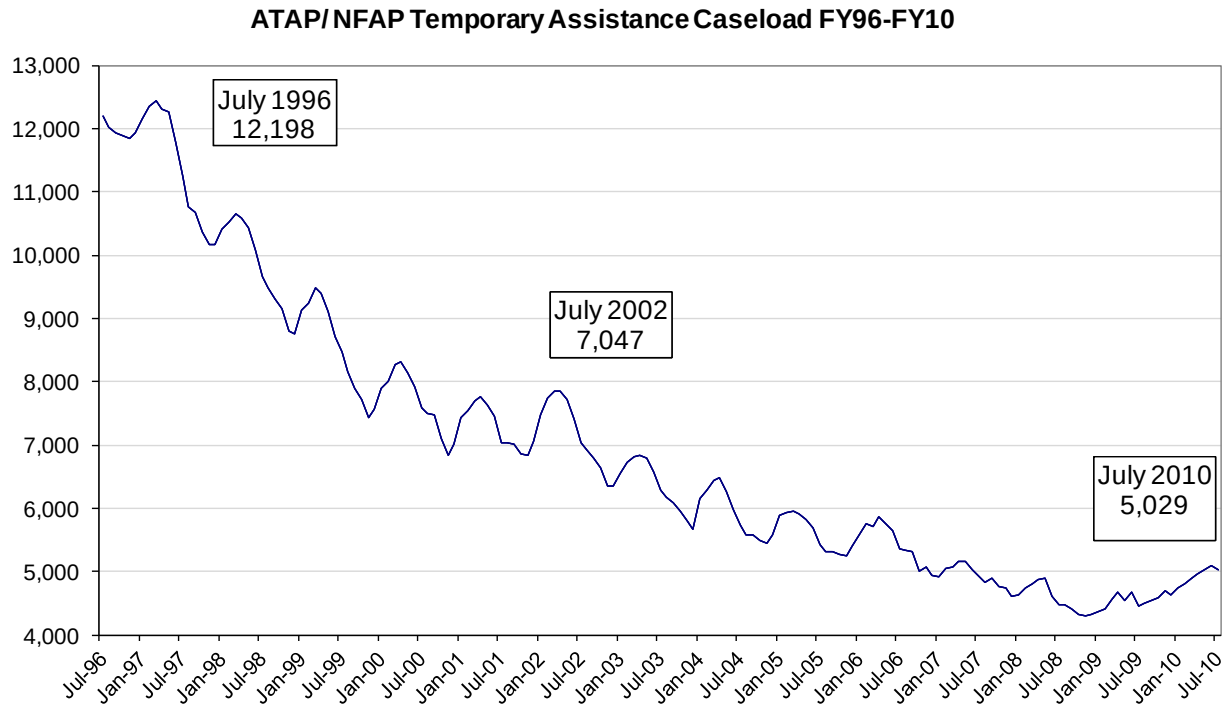
The division continues to invest TANF block grant savings that accrued as a result of welfare reform to sustain budgets for work services and supports for low income working families such as child care assistance. The division also transfers funds to the Social Services Block Grant for child protection services. The remaining TANF block grant balance is reserved to respond to increases in the ATAP caseload, such as the increase that began to occur in FY09 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.

Native 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 1,600 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, (CITC), 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 Alaska's moderately strong economy, have resulted in thousands of Alaskans achieving economic self-sufficiency through employment. Alaska began to see an increase in the number of families seeking help from the Temporary Assistance program in FY10 as a result of higher unemployment rates and the troubled economy.

Overall, the annual monthly average of families receiving temporary assistance from the State and Native Family Assistance programs has decreased significantly and has generated millions of dollars in savings. The decline in the caseload and the decline in the amount of temporary assistance benefits paid to families are a result of the program's continued 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, 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.

During FY10, DPA either directly or through its partners supported child care services for over 2,800 low-income working families, serving nearly 4,700 children in the Child Care Assistance Program, and licensed and monitored 1,870 child care facilities.

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.

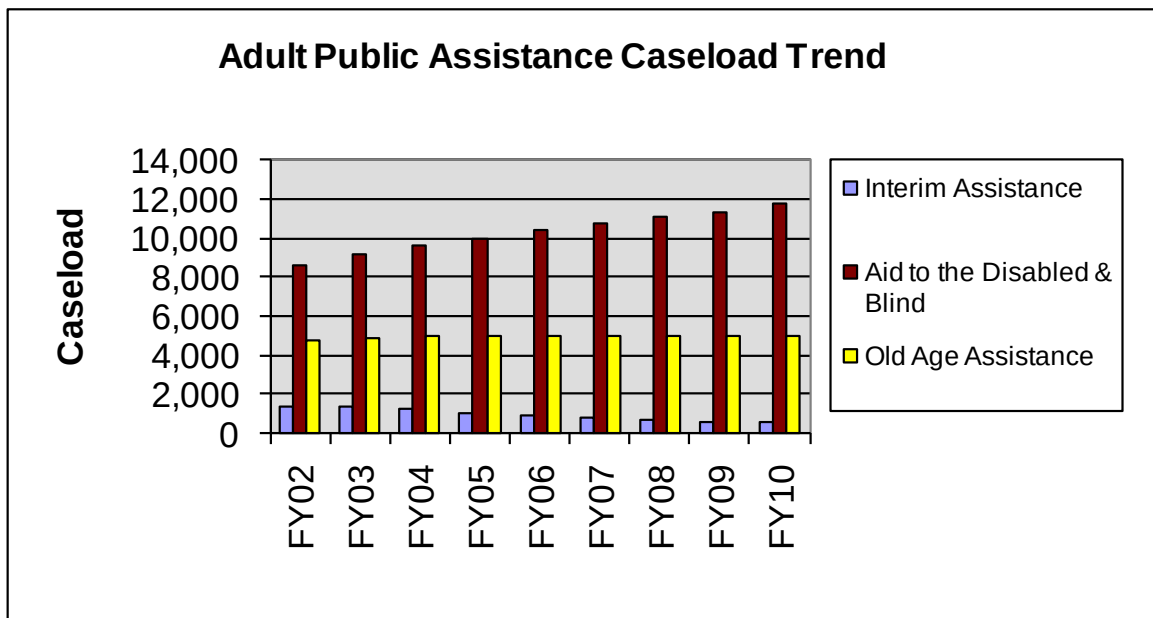
Work Services includes activities and support systems that prepare clients to enter the workforce, help them to retain jobs, advance, and succeed. Work Services also provides wage subsidies to employers who create new jobs and hire recipients to fill them. The majority of Work Services is delivered through 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 over 5,000 elderly and nearly 12,000 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 provides 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. Nearly 550 individuals receive Interim Assistance each month while they wait for their SSI decision. 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 65% 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 achieve well-being through opportunities for community living, promoting independence, and averting problems such as homelessness and avoiding higher cost settings such as hospitals and nursing homes or incarceration.



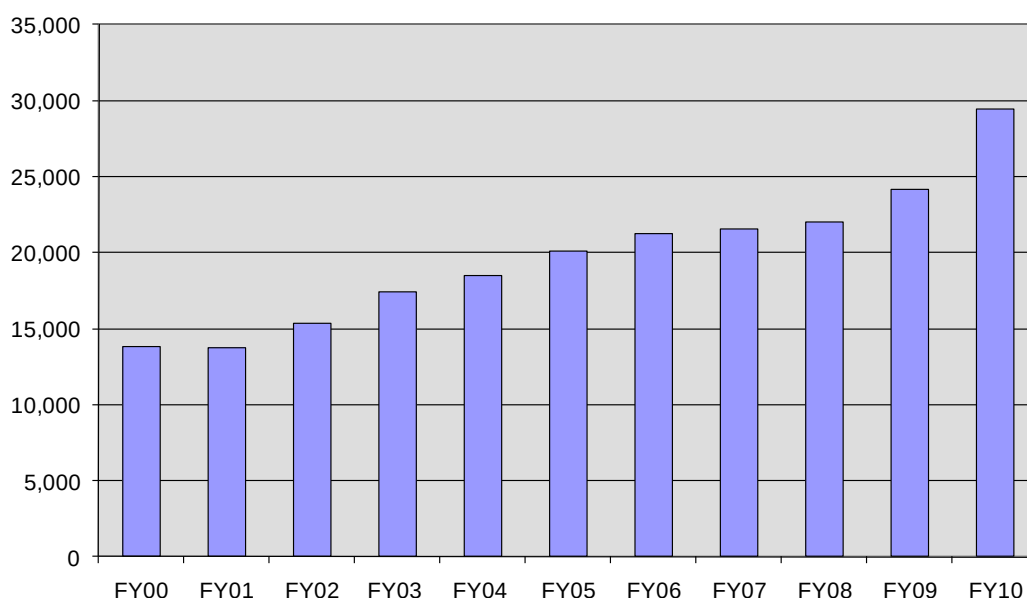
Food Stamp Program

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% federally funded by the U.S. Department of Agriculture (USDA), Food and Nutrition Service. Costs for the administration of the Food Stamp Program are shared equally by the state and federal government, and USDA estimates that for every \$5.00 in food stamp benefits used to purchase food in local stores, \$9.50 is contributed to the economy. Participation in the program has other benefits as well, such as: education about healthful nutrition, enrollment in free and reduced-price school meals for school-aged children, qualification for low cost phone services, and for conferring financial eligibility for the Supplemental Women, Infants and Children's Program (WIC).

Alaska's Food Stamp caseload continues to climb, with a more dramatic increase in participation over the last two years with more households applying for help as a result of the weakened economy. In FY10 the program served an average of 29,471 eligible households, a 22% increase compared to the number of households served in FY09. In September 2010, over 32,400 Alaska households were receiving food stamp benefits. Monthly benefit issuances climbed from \$9.0 million a month in FY09 to over \$13.0 million dollars a month in FY10. 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 its second Food Stamp Program performance bonus award for having the Best Program Access and increasing participation of eligible low-income Alaskans, and for its leadership in service to communities. The bonus of \$295,630 for federal fiscal year 2009 (FFY09) will be invested into the program to make it even more effective for participants.

Food Stamp Caseload



Quality Control

The division conducts rigorous quality control case reviews to ensure the accuracy of individual eligibility and benefit payment decisions. The quality assessment effort helps the division focus on work quality, improved performance outcomes, 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, Senior Benefits, and Adult Public Assistance when Quality Control staff resources are available.

Alaska's Food Stamp payment accuracy rate for FFY 10 is anticipated to be around 98%, and among the top five states in the nation. DPA was successful in making significant progress in raising Alaska's food stamp accuracy rate to 96.19% in FFY 09 and avoiding a fiscal sanction for having an accuracy rate below the national average in FFY 08.

In FY11, the division will complete the second cycle of the federally mandated Medicaid Payment Error Rate Measurement (PERM) eligibility and claims payment reviews. The division will also complete the second cycle of the federally required Child Care Assistance Improper Authorization of Payment reviews.

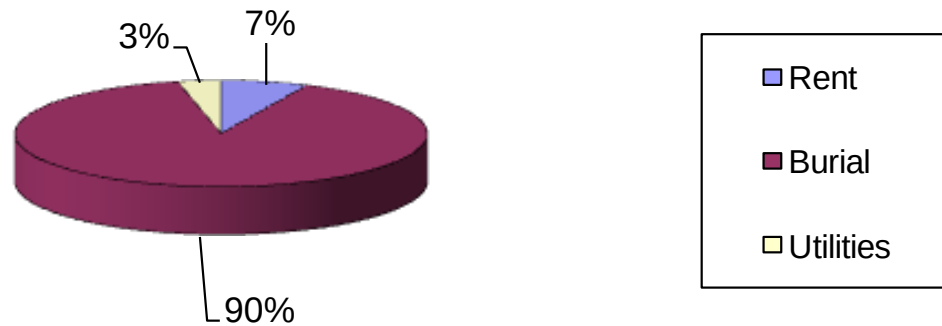
Fraud Control

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. 90% 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.

FY10 General Relief Assistance Expenditures



In FY10 the program covered burial expenses for 706 deceased individuals and met emergency shelter needs to prevent eviction and homelessness for approximately 94 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 over 104,000 Alaskans each month. Often, Medicaid recipients participate in other public assistance programs.

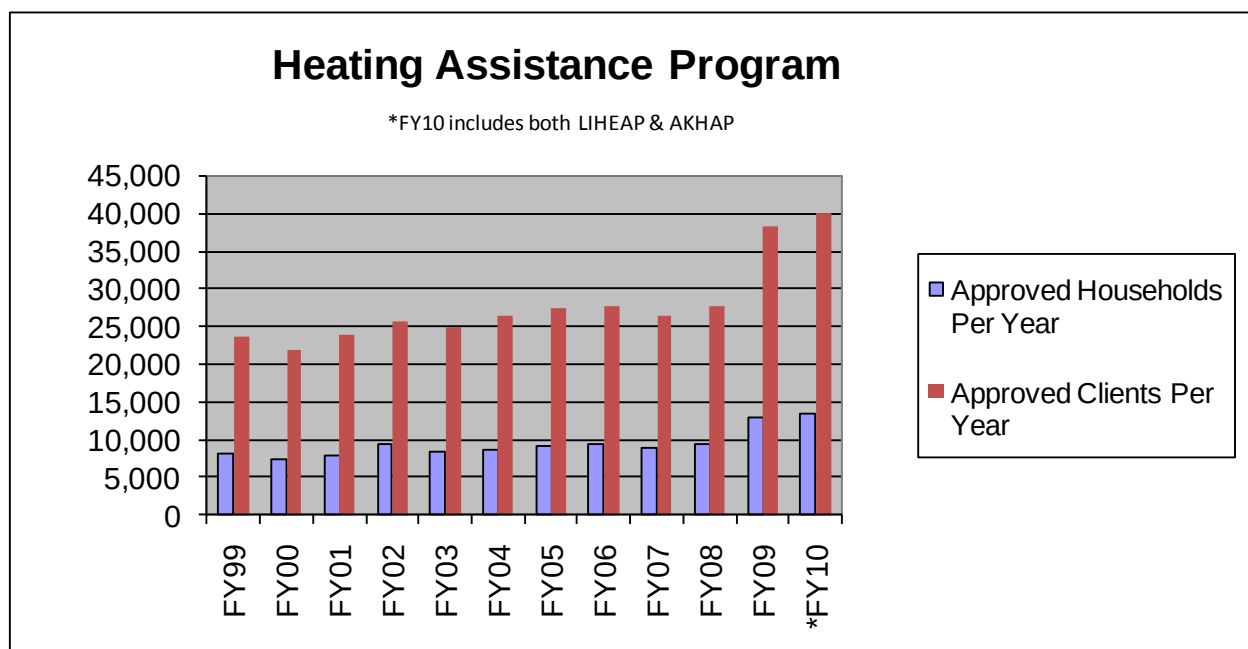
Chronic and Acute Medical Assistance

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. In October 2008, DPA began operating the state-funded Alaska Heating Assistance Program (AKHAP). In October 2010, AKHAP transitioned to the new Alaska Affordable Heating Program (AAHP).

While federal LIHEAP funds can only be used to serve households with income below 150% of the federal poverty limit for Alaska, AAHP connects the income eligibility standards and the annual benefit levels to the average price per barrel of North Slope crude oil. The Alaska Affordable Heating Program (AAHP) is available for households with income between 151% and 225%, and increases to 250% of the federal poverty limit if the average price per barrel of oil reaches \$150 a barrel.

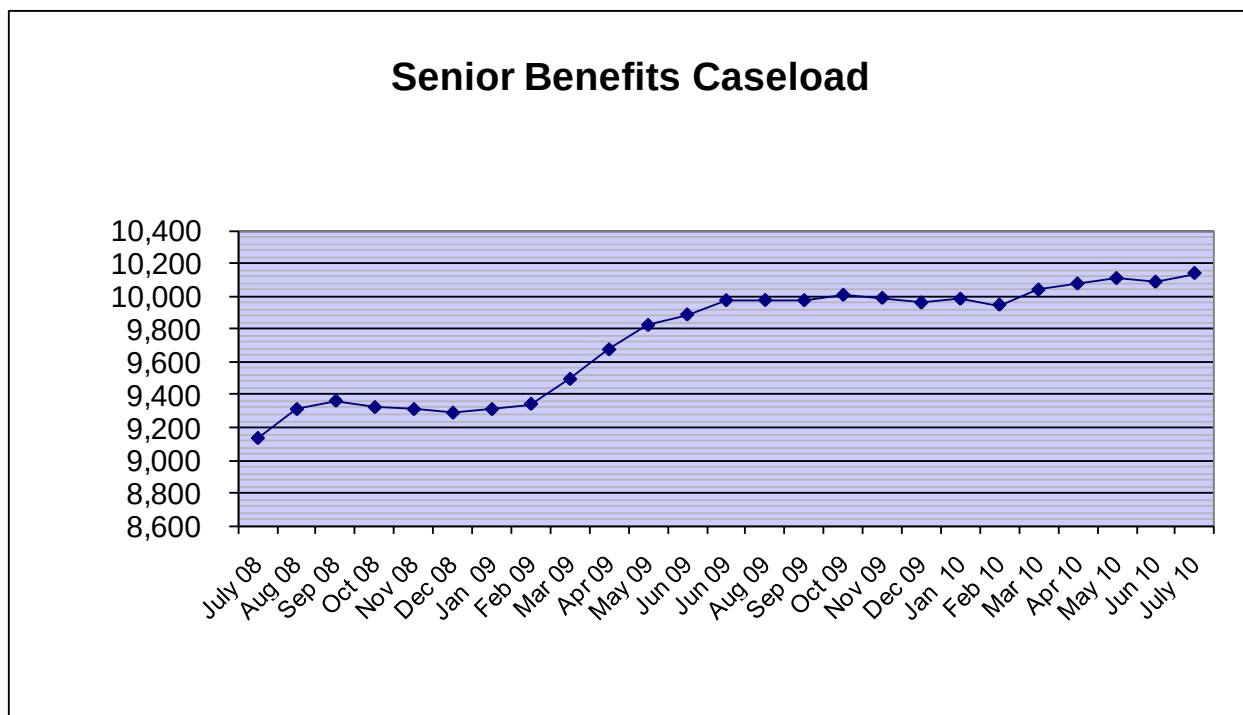


During the 2009-2010 heating season, over 13,000 households (11,124 LIHEAP and 2261 AKHAP) received help from the State administered heating assistance programs. Not included in the chart above, an additional 5,867 households (5510 LIHEAP and 357 AKHAP) received help from Alaska Native organizations 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.



During the first few months of FY11 the number of seniors enrolled in Senior Benefit reached over 10,150, compared to approximately 7,000 being served under the former SeniorCare program. The Senior Benefits Payment Program, which was authorized by the Alaska Legislature in August 2007, has a sunset date of June 2011. The program must be reauthorized to continue. The division projects continued growth through the year that will reach an estimated enrollment of 10,500 cases by the end of FY11.

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. In FY10, the division received a U.S. Department of Agriculture performance award for an exceptional job promoting and supporting breast feeding among mothers participating in WIC. The \$75,515 bonus is being used to promote the importance of breast feeding through Alaska's breast feeding program.

The WIC, Farmer's Markets, and Commodity Supplemental Food Programs are primarily federally-funded. In FY10, nearly 28,000 Alaska women, infants and children participated in WIC each month, and approximately 2,100 seniors received food from the Commodity Supplemental Food Program. Over 15,100 WIC participants were issued \$25 worth of vouchers for the Farmer's Market Nutrition Program (FMNP) that runs from June 2010 through October 2010 harvest season. The value of redeemed FMNP vouchers for the 2010 season is expected to be \$179,445; the Senior Farmer's Market Nutrition Program (SFMNP) provided more than 3,400 coupon books valued at \$85,050 and were distributed at 32 senior agencies.

Annual Statistical Summary of Services Provided in FY10

Comparison of Public Assistance Programs

	ATAP/NFAP	Adult Public Assistance	General Relief	Food Stamps
FY10 Cases avg. mo.	3,198	17,374	153	29,471
# of clients avg. mo.	8,890	17,374	189	75,352
Race Distribution	White 53% Alaska Native 18% Black 13% Asian 11%	White 55% Alaska Native 28% Asian 5% Black 9%	White N/A Alaska Native N/A Black N/A	White 41% Alaska Native 44% Black 7% Asian 6%
Recipients by Location (District area)	Anch / Mat-Su 66% Northern 10% Southeast 8% Balance of State 16%	Anch / Mat-Su 55% Northern 12% Southeast 11% Balance of State 22%	Anch / Mat-Su 48% Northern 13% Southeast 12% Balance of State 28%	Anch / Mat-Su 47% Northern 13% Southeast 10% Balance of State 30%
Recipients by Age	Children 0 - 18 yrs 11,518 Adults 19 - 59 yrs 5,897 Adults 60 - older 26	Children 0 - 18 yrs 211 Adults 19 - 59 yrs 11,804 Adults 60 - older 8,232		Children 0 - 18 yrs 33,975 Adults 19 - 59 yrs 37,964 Adults 60 - older 3,413
% Expenditure By Category of Service	Single parent 65% Two parent 13% Child only 22%	Disabled 71% Aged 29% Blind <1%	Burial service 90% Rent assistance 7% Other 3%	FS and ATAP 11% FS only 34% FS and APA 23% FS and Med 66%
Total Expenditures	\$38,061,537	\$56,340,629	\$1,760,919	\$157,777,100
Federal	\$8,300,400	\$1,102,700	\$0	\$157,777,100
GF	\$27,712,037	\$51,174,929	\$1,760,919	\$0
Other	\$2,049,100	\$4,063,000	\$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)
FY10 Cases avg. mo.	11,124	2,261			27,025
# of clients avg. mo.	33,372	6,783	4,698 children	10,009	27,025
Race Distribution					
White	58%	64%	N/A	N/A	39%
Hispanic	2%	2%			9%
Alaska Native/Indian	24%	19%			36%
Asian/Pacific Islander	6%	5%			10%
African American	3%	3%			6%
Other	7%	7%			0%
Recipients by Location					
Anch / Mat-Su	46%	39%	N/A	Anch / Mat-Su 48%	Anch / Mat-Su 46%
Northern	17%	22%		Northern 12%	Northern 8%
Southeast	6%	7%		Southeast 11%	Southeast 7%
Balance of State	31%	32%		Balance of State 28%	Balance of State 39%
% Expenditure By Category of Service					
Employed, retired or temp unemployed	68%	92%	Pass I 16%	Food Stamp 14%	Food Stamp 3%
Receiving ATAP	9%	2%	Pass II 7%	APA 36%	
Receiving APA	23%	6%	Pass III 77%	Medicaid 41%	Medicaid 23%
Total Expenditures					
	\$14,533,964	\$1,609,842	Pass I \$4,879,849 Pass II/III \$22,829,103	\$19,147,892	\$29,312,628
Federal	\$14,533,964	\$0	\$23,663,410	0	\$24,990,128
GF	\$0	\$1,609,842	\$4,045,542	\$19,147,892	\$57,900
Other	\$0	\$0	\$0	0	\$4,264,600

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	Alaska Affordable Heating 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

Explanation of FY12 Operating Budget Requests

Division of Public Assistance

Budget Overview Table

Division of Public Assistance	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$142,218.1	\$144,879.9	\$2,661.8
Designated General Funds	13,752.7	16,452.7	2,700.0
Federal Funds	129,290.0	124,066.6	-5,223.4
Other Funds	12,563.8	13,100.1	446.3
Total	\$297,914.6	\$298,499.3	\$584.7

Budget Requests

The proposed FY12 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 indigent deceased persons.

Adult Public Assistance (APA)

Adult Public Assistance Enrollment GF brings in additional FF with a total Growth of: \$1,000.00 FED, 1,250.00 GF

The APA program provides critical financial and medical assistance to low-income seniors and persons with disabilities. Enrollment in APA is increasing, particularly in the Aid to the Disabled and Blind category. This growth is similar to the increase in enrollment experienced by the Social Security Administration's Supplemental Security Income (SSI) program. Alaska's APA and SSI programs have seen a 4% increase in applicants who are disabled or blind. As a result, expenditures for the APA program are expected to increase.

The division projects that the number of elderly and disabled Alaskans who rely on APA to meet their basic needs will increase from an average of 18,000 individuals enrolled per month in FY11 to an average of 18,700 enrolled in FY12. In FY12, DPA projects GRA expenditures will increase by approximately 4% compared to FY11. This request for additional funding is needed to meet the projected APA caseload increase in FY12.

General Relief Assistance (GRA)

Increased Burial Costs for Indigent Alaskans: \$250.0 GF

The costs of the GRA program has grown due to a significant increase in the number of families requesting help in paying for the burial expenses of deceased relatives that lack the means to pay for such services. There has also been more demand for assistance to individuals and families who need emergency services as a result of economic changes.

90% 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.

In FY12, the division projects GRA expenditures will increase by approximately 4% compared to FY11. This request for additional funding is needed to meet the projected GRA expenditure increases in FY12.

Permanent Fund Hold Harmless (PFD-HH) Funding: \$2,700.0 PFD-HH

Alaska law provides that recipients of public assistance programs not lose benefits due to receipt of the Alaska Permanent Fund Dividend. These benefit replacements are referred to as Permanent Fund Dividend Hold Harmless payments. As public assistance caseloads increase, there is increased need for PFD-HH payments. Current PFD-HH funding is not sufficient to cover the amount of hold harmless payments needed due to the growth of the Supplemental Security Income (SSI), Food Stamp, and the Adult Public Assistance (APA) programs. The SSI and APA programs have grown by over 3% in recent years, and this trend is expected to continue. The Food Stamp program caseload grew over 20% between FY 2009 and FY 2010 and we expect the program to continue to grow at a rate between 9% and 10% in FY 2012.

Eligibility Technician Personal Service Funding: \$700.0 (\$350.0 Fed/\$350.0 GF)

The Eligibility Technician job class study was completed by the Department of Administration in June 2010. Field service eligibility work is the backbone of the division, and the majority of positions in DPA fall under the Eligibility Technician job class series. The salary analysis based on the study resulted in range and step increases for approximately 60 positions effective July 2010. Personal service allocations are insufficient to cover the salary changes, which are needed to fully implement the study. This request for additional funding is needed to fully implement the salary changes resulting from the Eligibility Technician job classification study.

WIC Rebate Funds: \$400.0 Statutory Designated Program Receipts (SDPR)

Additional SDPR authority is needed to collect the anticipated revenue from manufacturer's rebates for specific infant formula products that are included in Women, Infants, and Children (WIC) food packages. Federal regulations require that infant formula rebate revenues be expended on WIC foods only. The current SDPR authority is inadequate to receive the anticipated level of rebates in FY12. Without increased SDPR authority, WIC will be unable to receive earnable levels of rebates while still being bound by federal law to provide the same level of services, and would require general fund expenditures to remain compliant with the program.

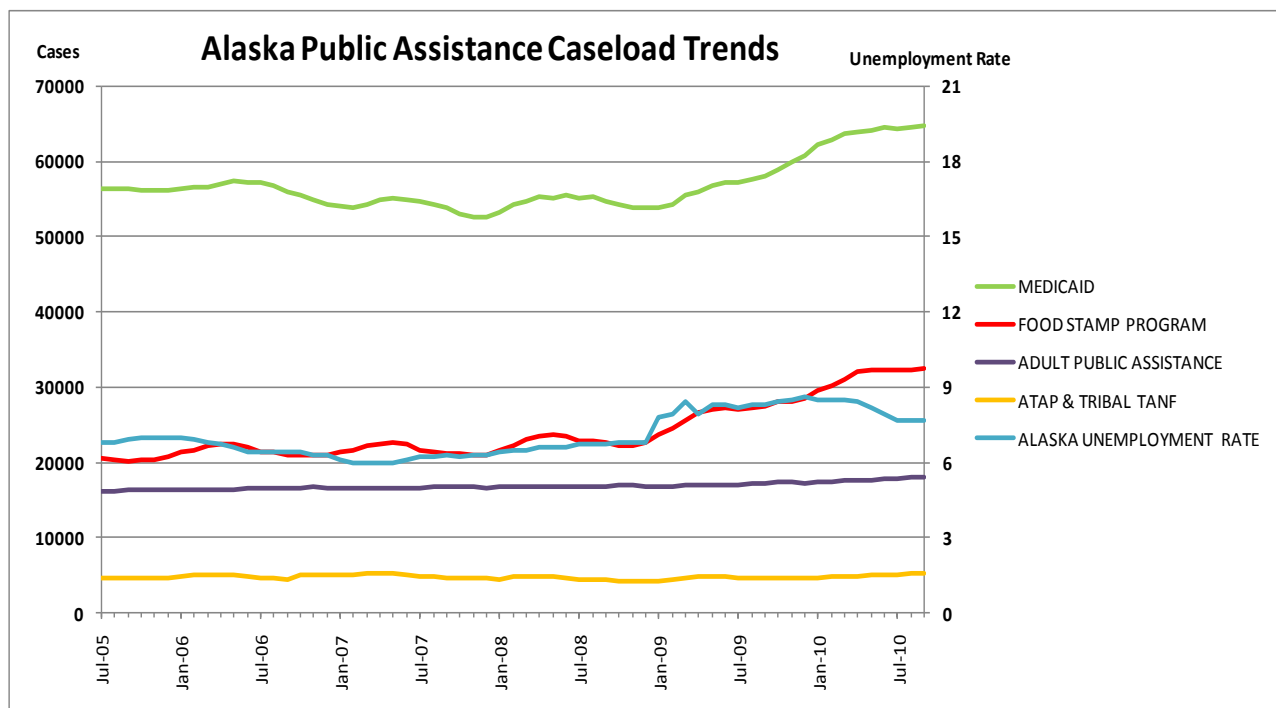
Challenges

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, listed below, may affect the division's ability to meet performance objectives in FY12.

Rising Need, Workload Challenges, and Continuous Improvement

The rise and fall of Alaska's unemployment rates over the past two years, and the costs of gas, food, energy and other vital needs has put immense stress on low-income households, amplifying the employment and family economic stability needs of parents and children throughout the State. As a result, requests for help from programs designed to meet the most basic needs of individuals and families who are economically challenged have increased dramatically.

The number of families receiving Alaska Temporary Assistance Program (ATAP) benefits grew by 6.7% between FY09 and FY10. The increased caseload reflects the pressures that the weakened labor market and higher competition for jobs have on the division's efforts in helping families to become employed and self-sufficient. The number of households receiving food stamp benefits grew by another 22% in FY10, with an overall increase of 32% over the past two fiscal years.



Work First Accountability

In March 2010, the Administration for Children and Families (ACF) announced FFY08 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 25.8% by achieving an overall participation rate of 42.8%. Alaska, however, did not meet the two-parent work participation rate. Alaska's two-parent rate was set at 59.4%, and the state achieved a two-parent rate of 47.0%.

Despite the challenges, Alaska achieved the 10th 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 May 2010 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. 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 by federal rules.

Despite the weakened economy, DPA continues to keep a focus on a rapid attachment to the workforce. Work services pay-for-performance contracts ensure the services provided to families focus on work first. Innovative ways to increase work participation levels have been implemented through new partnerships. DPA has provided grants to Native Employment Work Services Programs for development of work and work experience activities in remote areas. DPA is working with the Department of Labor and Workforce Development (DOLWD) on enhancing wage subsidy and targeted job development opportunities for ATAP parents to increase employment and training opportunities for ATAP youth and young parents between the ages of 16 – 24 through the Summer Youth Employment Program. The division's Families First! initiative and renewed partnerships with other DHSS division and community social service providers across the state allow for better service coordination and employment planning for families with profound challenges to move to work and self-sufficiency.

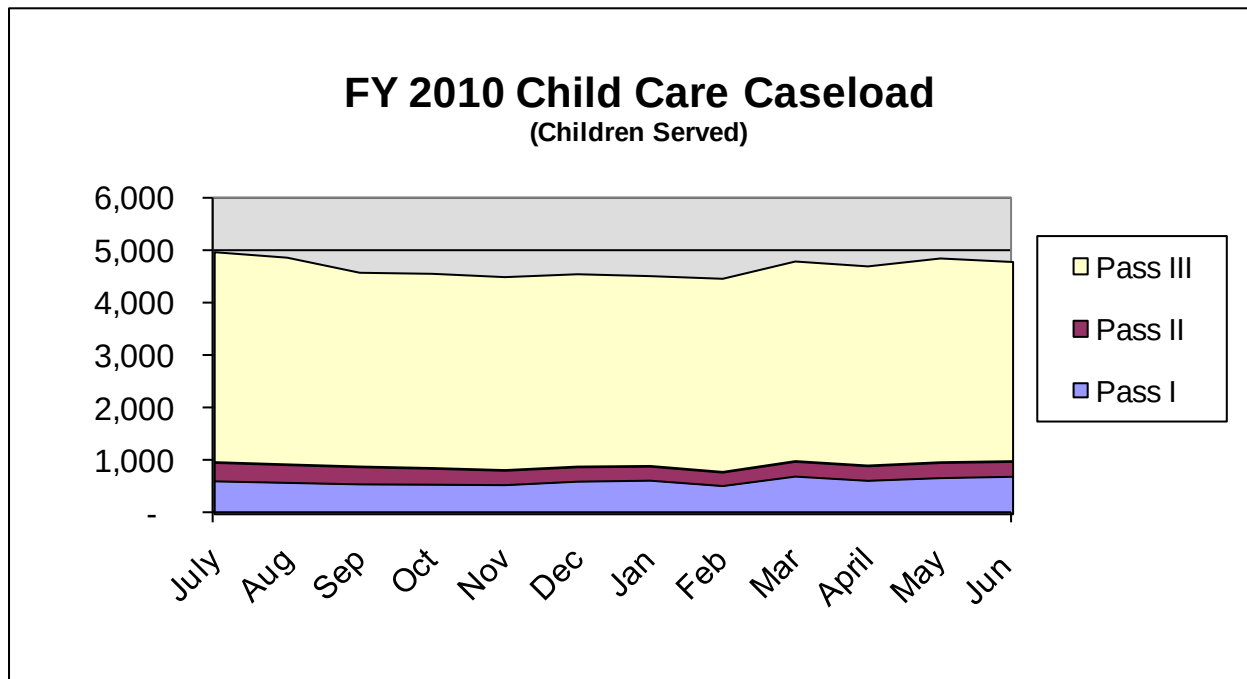
Child Care Assistance - Parents Achieving Self-Sufficiency (PASS)

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 need in order to stay working.

Over the last three years, the division has been working on strategies to increase the effectiveness of its Child Care Assistance Program to enable low-income working parents to find and afford safe, stable quality child care. Strategies include increasing access and raising child care subsidy

rates closer to actual market levels. Prior to 2008, child care subsidy rates had not increased since 2001. Rate adjustments were implemented in September of 2008, and again in March 2010 based on the findings of the 2009 market rate survey (market price study). In addition, the division completed a comprehensive analysis of the program's income eligibility standards and the parent contribution (co-pay) levels. As a result, changes to the income qualifying standards and family co-payment amounts were implemented on November 1, 2010. These standards were last adjusted in 2002. Federal guidelines allow states to serve families with incomes up to 85% of the state median income. The new standards set Alaska's child care assistance income limits at 75% of Alaska's state median income.

In FY10 and FY11, funding for child care increased as a result of additional one-time program funding available through 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 potential 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 program enrollment, additional funding may be needed in future years to keep the Child Care Subsidy Income Qualifying standards current with the State median income levels, and child care subsidy rates current with the market rates being charged for child care services.



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. 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 division is using mentoring and other learning opportunities as a means of retaining and strengthening its workforce.

Service Review Project

Despite the dramatic increase in applications for service and unprecedented growth in the Food Stamp caseload, DPA is committed to high quality customer service, timely processing and benefit accuracy, and other program performance expectations.

To fulfill those commitments, the division is using existing resources to invest in innovative practices to provide better customer service, increase efficiency and streamline service delivery, and make other significant business process improvements.

In FY 2010, 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 with the division’s vision 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 takes 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 – the most significant changes being focused on streamlining the eligibility intake processes.

The business process improvement initiative was first implemented in DPA offices in the Central Region (the division’s largest region covering the Municipality of Anchorage, Eagle River, and Matanuska and Susitna Borough), and the added capacity generated by this work has dramatically improved customer service and staff morale, decreased application processing timeframes, increased program benefit accuracy, and reduced employee turnover. It inevitably eliminated what would have otherwise been an ongoing need for additional staff resources. The division is implementing this work statewide in all direct service and administrative offices over the next twelve to eighteen months. The Southeast Region began their work in October 2010; Northern Region is scheduled to begin in December 2010, followed by the Child Care Assistance Program Office in January 2011, and the Coastal Region in February 2011.

Automated System Replacements

The division has three information and management systems under various stages of replacement.

Alaska Women Infant and Children (AKWIC) system: This computer system, which supports WIC, was scheduled to be replaced in FY11; however, implementation has been delayed due to unforeseen complications in securing a vendor for the transfer of a federally certified WIC system. The division has been continually successful in competing for and securing federal funds to support this project, which includes dedicated project staff and a contract to oversee the transfer of a federally approved WIC system. Development of this system transfer is now anticipated to begin in FY11 with full implementation in FY12. DPA expects transition to the new system will not disrupt services to WIC program participants, vendors, and grantees.

Fraud Case Management System: Replacement of this system and its information database is underway using funds appropriated in the FY09 capital budget. A contract for development of the new database has been awarded and development of the new system began in FY11. The new system will allow better tracking of alleged fraud, status of investigations, and their outcomes.

Upgrading or replacing the Eligibility Information System (EIS): The division has also launched the comprehensive business needs assessment and feasibility study to evaluate options and the costs for replacing the EIS. Initiation of this project was delayed until FY11 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 advent of Health Care Reform. The Planning Advanced Planning Document (PAPD) needed to draw federal funding for programs supported by EIS has been submitted and is awaiting approval. The business gaps analysis and business needs assessment is scheduled to begin in the spring 2011. This is a very large project and the division estimates it will take up more than a year 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, mission-critical system for over 25 years, its aging application is costly to maintain and its use limits DPA's ability to gain efficiencies if it used 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.

Health Care Reform

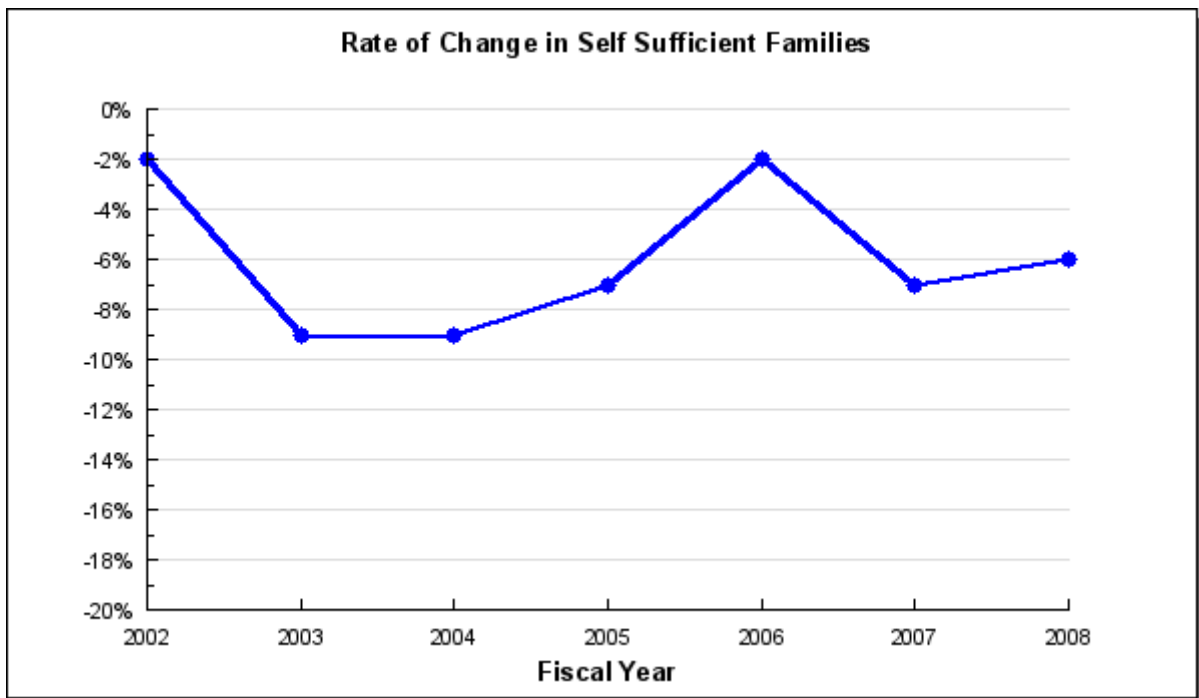
The federal Affordable Care Act, also referred to as Health Care Reform, includes a number of requirements related to Medicaid eligibility that are mandatory for state programs, as well as offering optional provisions that the state may implement. One of the most significant provisions of the health care reform legislation is an expansion of Medicaid. Beginning January, 1, 2014, states must implement a new Medicaid category for persons (including childless adults) with income that is equal to or less than 133% of the federal poverty guidelines. Eligibility for this new Medicaid category must be based on a person's modified adjusted gross income, which is based on the Internal Revenue Code definition of adjusted gross income. This mandatory provision, as well as others and any options that the state may select, will require research and policy development as well as computer system changes to implement. As necessary, division resources will be redirected from other projects and programs to support this planning effort.

Performance Measure Detail

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase the rate of self-sufficient individuals and families by 10%.

Status #1: In FY10, the Alaska Temporary Assistance Program (including the Native Temporary Assistance for Needy Families Program) showed a 7.5% increase in the number of families receiving benefits.



Methodology: *YTD Total Column represents the average annual monthly caseload rate change.

Rate of Change in Self Sufficient Families

Fiscal Year	AFDC/ATAP Caseload	YTD Total
FY 2008	9,000	-6%
FY 2007	10,100	-7%
FY 2006	11,000	-2%
FY 2005	12,000	-7%
FY 2004	12,000	-9%
FY 2003	14,000	-9%
FY 2002	16,000	-2%

Analysis of results and challenges: As shown in the YTD Total column, FY 2007 had a 7% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to FY 2006. The other four monthly columns show a snapshot of caseload rate change

compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

Target #2: Reduce the proportion of the population that lives in impoverishment.

Status #2: In calendar year 2008, the percentage of food stamp families with incomes below the poverty threshold was reduced by 18% after receiving food supports.

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 FY10 percent of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 85%, identical to FY09.

**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%	87%	84%	84%	85%
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 FY10 decreased to 29% from 31% in FY09.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2010	31%	31%	27%	27%	29%
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 FFY10, 33% of Alaska Temporary Assistance families met the federal participation requirements, meeting the federal target of 33% compared to 37% in FFY09.

Percentage of temporary assistance families meeting federal work participation rates

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2010	36%	33%	31%	33%	33%
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 FY10, 90% of emergency food stamp applications were processed within 5 days which is an increase from 89.6% in FY09.

Percentage of food stamp expedited service households that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	88.5%	90.1%	89.6%	90.2%	90.2%
FY 2009	89.6%	90.2%	87.2%	89.6%	89.6%
FY 2008	93.1%	90.4%	86.6%	88.4%	88.4%
FY 2007	96.5%	96.2%	96.3%	96.4%	96.4%
FY 2006	95.0%	95.6%	96.0%	95.7%	95.7%
FY 2005	90.9%	92.3%	92.7%	93.5%	93.5%
FY 2004	93.2%	93.8%	94.5%	94.7%	94.7%
FY 2003	94.0%	90.5%	90.8%	92.1%	92.1%
FY 2002	95.4%	94.5%	93.4%	93.4%	93.4%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures.

Target #2: 96% of new food stamp applications are processed within 30 days.

Status #2: In FY10, 89% of food stamp initial applications were processed within 30 days with an overall average processing time of 18 days.

Percentage of new food stamp applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	86.0%	86.8%	87.3%	89.3%	89.3%
FY 2009	88.9%	89.2%	86.9%	85.8%	85.8%
FY 2008	94.8%	92.2%	89.6%	90.3%	90.3%
FY 2007	97.2%	97.3%	97.2%	97.1%	97.1%
FY 2006	95.4%	95.9%	96.1%	96.2%	96.2%
FY 2005	95.2%	95.5%	95.7%	95.9%	95.9%
FY 2004	96.2%	96.1%	96.3%	96.5%	96.5%
FY 2003	95.9%	95.1%	95.1%	95.5%	95.5%
FY 2002	93.0%	94.2%	94.3%	94.7%	94.7%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #3: 99.5% of food stamp recertification applications are processed within 30 days.

Status #3: In FY10, 87% of food stamp recertification applications were processed within 30 days compared to 86% in FY09.

Percentage of food stamp recertification applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	84.8%	85.4%	85.5%	87.4%	87.4%
FY 2009	89.9%	89.0%	84.3%	85.8%	85.8%
FY 2008	94.6%	93.9%	92.6%	92.4%	92.4%
FY 2007	99.7%	99.5%	99.5%	99.1%	99.1%
FY 2006	99.4%	99.5%	99.5%	99.5%	99.5%
FY 2005	99.5%	99.5%	99.5%	99.6%	99.6%
FY 2004	99.6%	99.6%	99.6%	99.6%	99.6%
FY 2003	99.5%	99.5%	99.4%	99.4%	99.4%
FY 2002	99.8%	99.8%	99.7%	99.6%	99.6%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #4: 90% of temporary assistance applications are processed within 30 days.

Status #4: In FY10, 75% of Alaska Temporary Assistance applications were processed within 30 days with an overall average processing time of 23 days. This is an increase from 65% in FY09 with an overall average processing time of 21 days.

Percentage of Temporary Assistance applications that meet time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	67%	69%	71%	75%	75%
FY 2009	78%	80%	74%	65%	65%
FY 2008	83%	82%	81%	81%	81%
FY 2007	85%	83%	83%	84%	84%
FY 2006	88%	86%	86%	87%	87%
FY 2005	85%	84%	85%	85%	85%
FY 2004	88%	88%	88%	88%	88%
FY 2003	90%	88%	89%	90%	90%
FY 2002	83%	86%	85%	86%	86%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Target #5: 90% of Medicaid applications are processed within 30 days.

Status #5: In FY10, 80% of Medicaid applications were processed within 30 days, a 9 percentage point increase from FY09.

Percentage of Medicaid applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	74%	74%	77%	80%	80%
FY 2009	77%	72%	71%	71%	71%
FY 2008	71%	64%	60%	64%	64%
FY 2007	88%	84%	78%	78%	78%
FY 2006	89%	88%	89%	89%	89%
FY 2005	92%	91%	91%	90%	90%
FY 2004	88%	91%	91%	91%	91%
FY 2003	91%	90%	90%	90%	90%
FY 2002	89%	90%	89%	89%	89%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

Recent changes in federal eligibility requirements, such as verification of citizenship, have greatly increased the complexity and processing time for each Medicaid application handled. During the first half of FY08 processing times far exceeded the 30-day standard. As a result, children have not received timely medical care, and payments to vendors and medical care

providers have been delayed. The implementation of the federal Payment Error Rate Measurement (PERM) requirements further impacts processing timeframes by establishing higher expectations for program accountability and payment accuracy.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.

Status #1: In FFY09, 96% of food stamp benefits were accurate compared to 93% in FFY08.

Percentage of accurate food stamp benefits

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2010	99.7%	99.0%	0	0	0
FFY 2009	93.8%	94.2%	95.1%	96.3%	96.3%
FFY 2008	91.1%	93.9%	92.8%	92.6%	92.6%
FFY 2007	95.1%	96.3%	96.3%	96.1%	96.1%
FFY 2006	92.3%	93.5%	94.1%	94.3%	94.3%
FFY 2005	92.2%	93.2%	93.0%	93.8%	93.8%
FFY 2004	90.8%	94.2%	93.5%	93.3%	93.3%
FFY 2003	86.2%	84.7%	85.6%	86.4%	86.4%
FFY 2002	90.4%	92.4%	90.5%	89.2%	89.2%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits 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 four-month lag.

Target #2: 95% of temporary assistance benefits are accurate.

Status #2: The FFY09 Alaska Temporary Assistance benefit accuracy is 98%, compared to 99% in FFY07.

Percentage of accurate temporary assistance benefits

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2010	98.2%	97.7%	0	0	97.7%
FFY 2009	98.8%	98.2%	97.7%	97.7%	97.7%
FFY 2007	99.4%	99.3%	99.1%	98.8%	98.8%
FFY 2006	98.1%	96.3%	97.7%	96.3%	96.3%
FFY 2005	98.5%	95.9%	95.7%	97.1%	97.1%
FFY 2004	96.7%	97.5%	98.2%	98.1%	98.1%
FFY 2003	94.4%	93.6%	94.5%	93.6%	93.6%
FFY 2002	88.2%	93.7%	93.6%	92.0%	92.0%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a four-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 FFY10, 96% of the Medicaid eligibility determinations were accurate compared to 90% in FFY09.

Percentage of accurate Medicaid eligibility determinations

Fiscal Year	YTD Total
FFY 2010	96%
FFY 2009	90%
FFY 2008	98%
FFY 2007	96%
FFY 2006	95%
FFY 2005	93%
FFY 2004	99%
FFY 2003	99%
FFY 2002	96%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities. Reviews in FFY 2009 were targeted to only high risk cases.

Target #4: Food Stamp Program, Temporary Assistance and Medicaid eligibility benefits are accurate.

Status #4: In FFY09, 96% of Food Stamp Program benefits, 98% of Temporary Assistance benefits and 90% of Medicaid eligibility determinations were accurate.

A6: Strategy - Increase the percentage of subsidy children in licensed care.

Target #1: 76% of subsidy children are in licensed care.

Status #1: In FY10, 76% of children receiving child care assistance were in licensed care; meeting the target for the first year since FY 2006, an increase from 71% in FY09.

Percentage of subsidy children in licensed care

Fiscal Year	September	December	March	June	YTD Total
FY 2010	73%	77%	77%	77%	76%
FY 2009	74%	74%	72%	71%	71%
FY 2008	73%	72%	73%	70%	73%
FY 2007	74%	74%	76%	74%	75%
FY 2006	80%	84%	75%	72%	78%
FY 2005	74%	81%	77%	80%	77%
FY 2004	75%	76%	76%	76%	76%
FY 2003	65%	66%	68%	75%	75%
FY 2002	0	60%	58%	64%	64%

Analysis of results and challenges: The first available data regarding this measure is the second quarter in 2002. There is a two month lag in the data.

The number of working families participating in the Child Care Assistance Program has decreased over the past year. The decrease is partially attributed to State rates for child care not keeping up with the rates that child care providers charge. As state rates decline in relation to the market rate, low income families on child care assistance are faced with an increased financial burden to pay the difference between the state rate and the child care provider's rate (in addition to their required co-payment) or to choose lower priced and usually lower-quality child care. The decline in state rates in relation to the market rate has resulted in fewer families being assisted by the Child Care Assistance Program and child care providers being less able to provide care at state payment levels. State rates for licensed child care providers who accept children on child care assistance were increased effective September 2008 as an initial step to bridge that gap.

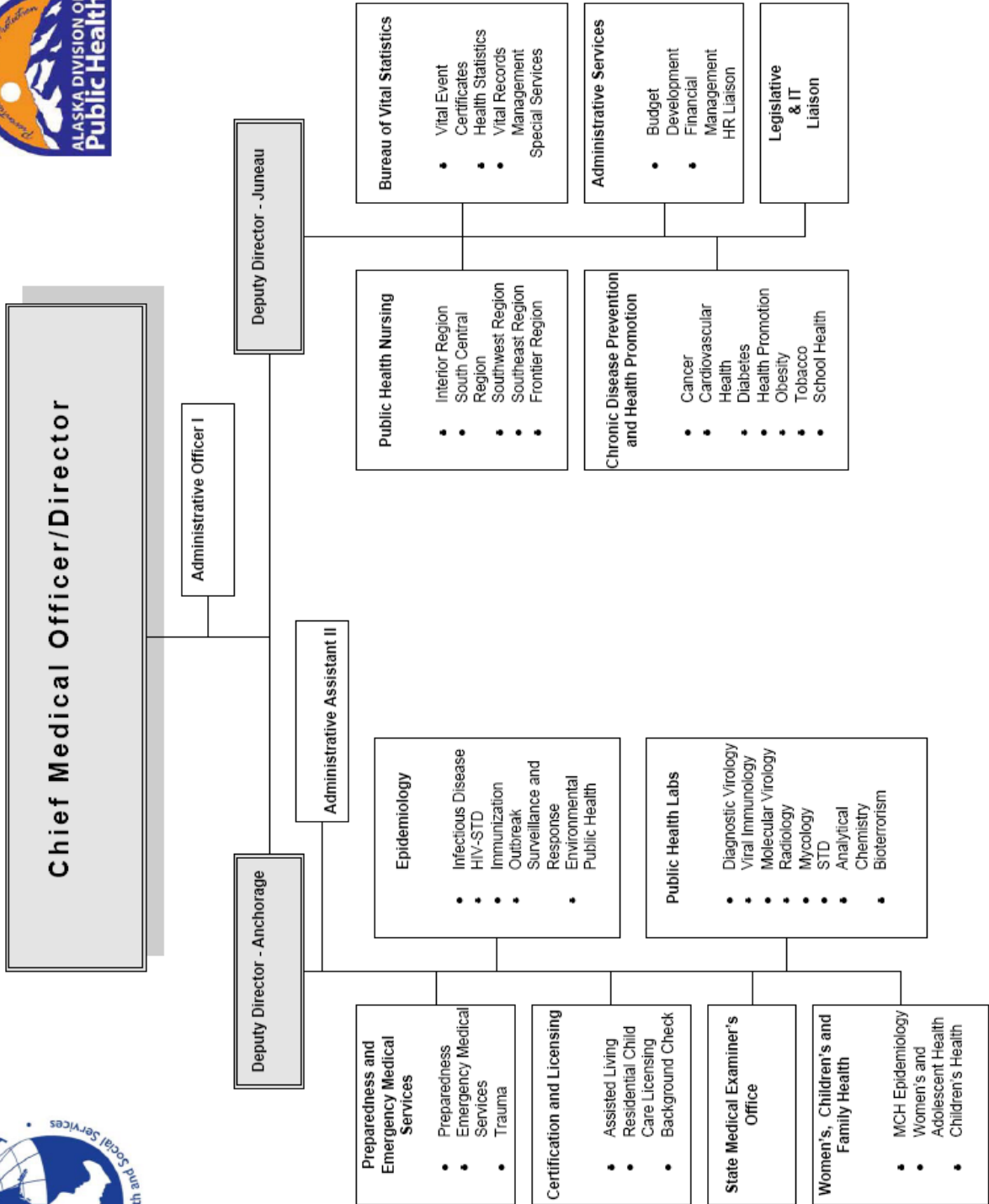
The YTD total is the average for the year.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Formula Program Funding Increase Due to Caseload Growth	\$ 1,250.0	\$ -	\$ 1,000.0	\$ -	\$ 2,250.0
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 13 (HB 199) Lapse Date 06/30/11	\$ -	\$ -	\$ (4,036.0)	\$ -	\$ (4,036.0)
Program Funding Increase Due to Caseload Growth	\$ 250.0	\$ -	\$ -	\$ -	\$ 250.0
Program Funding Increase Due to Caseload Growth	\$ -	\$ 2,700.0	\$ -	\$ -	\$ 2,700.0
Reverse ARRA Sec 1, CH 17, SLA 2009, P 3, L 14 (HB 199) Lapse Date 06/30/11	\$ -	\$ -	\$ (91.1)	\$ -	\$ (91.1)
Funding Increase Due to Eligibility Technician Salary Study	\$ 350.0	\$ -	\$ 350.0	\$ -	\$ 700.0
Formula Program Funding Increase Due to Rebate Growth	\$ -	\$ -	\$ -	\$ 400.0	\$ 400.0
Reverse ARRA SAM Mgt Info system & Sec 1, CH 17, SLA 2009, P 3, L 16 (HB 199) Lapse Date 06/30/11	\$ -	\$ -	\$ (3,440.0)	\$ -	\$ (3,440.0)
Public Assistance Total	\$ 1,850.0	\$ 2,700.0	\$ (6,217.1)	\$ 400.0	\$ (1,267.1)



Department of Health and Social Services - Division of Public Health
Organization Chart



Introduction to the Division of Public Health

Mission

To protect and promote the health of Alaskans.

Overview

The Division of Public Health is the state's lead public health agency. Its work is best described by the "3Ps" – Prevention, Promotion and Protection – because Public Health 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 primarily focus on the health of all of Alaska's residents and visitors ("population-based").



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, the Division of Public Health fulfills both state and local public health functions. To assist in meeting this challenge, division 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.

Public Health 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 and legal investigative work related to unanticipated, sudden or violent death is also provided by Public Health.

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. In an effort to control communicable diseases and prevent epidemics, the division provides treatment consultation, case management and laboratory testing services. 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 monitors and assesses health status through the collection and analysis of: vital statistics; behavioral risk factor, disease, and injury data; and 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 services that help achieve its mission of protecting and promoting the health of the public. The six core public health priorities are:

- Infectious Disease and Epidemic Prevention and Control
- Injury Prevention Control and Emergency Medical Services
- Chronic Disease Prevention and Control
- Public Health Emergency Preparedness and Response
- Access to Early Preventive Services and Quality Health Care
- Protecting Human Health from Environmental Hazards

Public Health is organized into 10 sections:

○ Administrative Services	○ Epidemiology
○ Bureau of Vital Statistics	○ Public Health Laboratories
○ Certification and Licensing	○ Public Health Nursing
○ Chronic Disease Prevention and Health Promotion	○ State Medical Examiner's Office
○ Emergency Programs (formerly Preparedness Program)	○ Women's, Children's and Family Health

In FY2010, the Section of Injury Prevention and EMS was reorganized, allocating programs to the sections of Epidemiology, Emergency Programs, and Chronic Disease Prevention and Health Promotion.

Services Provided

The Bureau of Vital Statistics supports all core public health services. The Bureau 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, the Bureau provides research and analysis of vital events data in support of the development of public health policy.



The State Medical Examiner's Office is another program that supports all core public health services. As a key element of the public health mission to prevent injury, disease and death, the State Medical Examiner's Office investigates unanticipated, sudden, or violent death. Office activities include providing an accurate, legally-defensible determination of the cause and manner of death, and conducting a comprehensive medico-legal death investigation.

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.

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. For over 30 years the Alaska Immunization Program has maintained a universal vaccine program. Public health nurses serve as the front line workforce of public health within local communities to identify the presence and source of disease, respond 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 Emergency Programs (formerly Preparedness Program), Epidemiology, and Chronic Disease Prevention and Health Promotion sections work 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, fire-related

injury prevention, fall prevention, and family violence prevention. The Emergency Medical Services unit ensures that qualified and properly-equipped emergency medical services personnel are available to respond to emergency medical needs throughout our state.



Other sections of Public Health contribute to injury prevention 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 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 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. The Tobacco Prevention and Control unit funds an extensive tobacco counter-marketing media campaign, the Alaska Tobacco Quit Line (a service that provides tobacco cessation coaching and nicotine replacement therapy), and grantees which focus on tobacco cessation, school-based tobacco prevention, and community-level policy and environmental change. The Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System collect, interpret, and disseminate population-based data on the health status of youth and adults. The data are used not only by the section, but also



by many state agencies, local governments, school districts, and other organizations for program planning and tracking progress toward health goals.

Other Public Health sections contribute to chronic disease prevention and control as well. For example, public health nurses organize and staff local senior clinics to help seniors monitor their weight and care for a variety of chronic conditions. The section of Women, Children and Family Health administers the Alaska Breast and Cervical Health Check program to provide breast and cervical cancer screenings to women who do not have financial access to these services.

Public Health Emergency Preparedness and Response



The division works to ensure that Alaskans are protected in the event of a public health emergency – whether natural (such as pandemic influenza) or manmade. The section of Emergency Programs (formerly Preparedness Program) collaborates with Alaska’s emergency medical services system and hospitals to ensure they are prepared to respond to a medical disaster or public health emergency. Public health nurses provide leadership in community disaster and bioterrorism response activities;

medical epidemiologists develop policies and plans for improved detection and control of a wide range of possible public health emergencies; and laboratory scientists ensure timely detection and diagnosis of epidemic, biological, or chemical agents of terror.

Access to Early Preventive Services and Quality Health Care

Alaska public health nurses deliver 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 250 communities statewide. Services include well-child exams, tuberculosis screening, sexually transmitted disease 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's, Children's and Family Health section works with health care and community support service providers to improve health outcomes and assure that the health care system infrastructure meets the needs of families. Access to preventive and other health care services is provided through breast and cervical cancer screening, family planning, genetic and specialty clinics, newborn metabolic and hearing screening, and oral health.

The Emergency Programs section works to ensure the availability and quality of the emergency medical services (EMS) in Alaska by certifying emergency medical personnel and ambulance services, designating trauma 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 protects the safety and quality of Alaska's vulnerable populations in residential and healthcare facilities by ensuring each of these facilities is properly licensed; providing criminal background checks for employees working in these facilities; and investigating complaints.

Protecting Human Health from Environmental Hazards



Public Health works in close partnership with the Department of Environmental Conservation's Division of Environmental Health, which has the primary regulatory role in environmental health protection in the state. Also, in collaboration with the Department of Natural Resources, the division has a program to assess the health impacts of proposed large-scale natural resource development projects. At the local level, public health nurses coordinate community-based environmental hazard identification and response, while at

the statewide-level, the Section of Epidemiology evaluates the possible hazards to human health associated with the presence of hazardous substances in the environment. Activities include providing medical consultation in response to hazardous substance emergency events and at sites that contain hazardous substances; developing studies on subsistence food safety; bio-monitoring of mercury from fish consumption; screening for lead; and providing public information and outreach regarding environmental health hazards.

Annual Statistical Summary of Services Provided in FY10

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 always reflect an accurate 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 Public Health efforts to protect, promote and improve the health of hundreds of thousands of Alaskans every day. Some of the results from FY10 are provided below.

Infectious Disease and Epidemic Prevention and Control

- Administered 129,999 doses of vaccine.
- Gave and read 17,673 tests for tuberculosis (TB).
- Initiated TB medication therapy for 520 individuals.
- Provided 15,792 visits to 10,458 patients for sexually transmitted diseases.
- Provided 14,693 visits for HIV/AIDS services, including blood testing for 6,340 patients.
- The laboratory received and processed:
 - STD tests: 97,005
 - Hepatitis tests: 22,710
 - Tuberculosis tests: 5,291
 - Toxicology tests: 890
 - Viral tests: 55,159
- Published 31 Epidemiology Bulletins informing health care providers and the public of important investigations, concerns, and alerts regarding health issues.



Major Accomplishments

- Alaska led the nation with the highest rate of seasonal influenza vaccination coverage among residents age 65 and older. An estimated 82 percent of Alaskans age 65 and older had received the seasonal flu vaccine by the end of January 2010, according to the CDC.
- Investigated an ongoing, large-scale outbreak of gonorrhea infection that has already affected more than 1,000 individuals across the state. Provided disease notification and prevention strategies; collaborated with public and private health providers; and evaluated ways to control sexually transmitted infections, including the use of expedited partner therapy to reduce transmission of gonorrhea and other sexually transmitted diseases.
- Investigated numerous smaller infectious disease outbreaks, including outbreaks of paralytic shellfish poisoning, botulism, meningococcal disease, and a restaurant-

- associated outbreak of salmonella infection that sickened at least seven people and resulted in two hospitalizations.
- Started a health care-associated infections prevention program, created an Advisory Group, and completed an Alaska health care-associated infection Prevention Plan to reduce hospital-acquired infections (HAIs).
- The state's immunization registry, VacTrAK, has 112 providers participating; 45% of Alaska residents had at least one vaccine recorded in VacTrAK.

Injury Prevention Control and Emergency Medical Services

- Eighteen different communities in Alaska received 1,450 smoke alarms. More than 500 child safety seats and booster seats were distributed to moderate- and low-income families. The Poison Prevention and Control Program reported 9,006 calls to the Alaska Poison Control System. Kids Don't Float drowning prevention program added 87 sites, totaling 580 active sites and education centers statewide.



- Certified 2,790 emergency medical personnel, 284 instructors, and 50 ambulance services. Provided 544 emergency medical training courses throughout the state.
- The Alaska Family Violence Prevention Project provided training and technical assistance to more than 500 service providers on the health effects of domestic violence on women and children and best practices for assessment, intervention, and prevention.
- 20,319 screenings by Public Health Nursing for interpersonal/domestic violence identified 500 clients with positive or suspected screening results. These individuals were provided appropriate referral, education and counseling regarding protection of themselves and any children in the household. In addition,

Nursing made more than 78 referrals to the Office of Children's Services for suspected child abuse, child neglect, or sexual offense against a minor.

Major Accomplishments

- Nineteen lives have been saved to date by direct use of personal floatation devices from Kids Don't Float.
- The Trauma Care Fund bill was signed into law on June 22 by Governor Parnell, funding designated trauma centers for uncompensated care of trauma patients.
 - Because of the passage of this law, currently more than 15 facilities have expressed interest in the trauma designation process.
 - 3 facilities have requested trauma care training for next year. A rural trauma team development course was held in Dillingham in June.
 - The state re-designated Yukon-Kuskokwim Health Corporation as a Level IV trauma center in June. There are 3 re-verification visits scheduled in December for the current Level IV centers.

Chronic Disease Prevention and Control

- Alaskans Taking on Childhood Obesity (ATCO) established a Memorandum of Agreement between Health and Social Services and Education and Early Development that identified obesity prevention strategies for the departments to coordinate and implement. A School Nursing Advisory Committee was established, and a plan of action was developed and implemented to work on the highest priorities. The School Nursing Consultant contributed significantly to the Department of Education and Early Development's Health and Safety plan and is actively working with school nurses statewide on obesity reduction efforts for school aged children.
- Provided more than 1,221 Pap Smears for detection of cervical cancer in Alaska women.
- Disseminated results of the 2009 Statewide Youth Risk Behavior Survey and the first Alternative School Youth Risk Behavior Survey, as well as local results from 20 school districts in Alaska.
- Coordinated the statewide Alaska School Health and Wellness Institute, which was attended by 100 participants and representatives from over 20 school districts.
- Facilitated the development of the Alaska School Health and Safety Plan, in partnership with the Department of Education & Early Development.



Major Accomplishments

- The Alaska Cancer Registry participated in two separate projects providing data for studies that will advance clinical, epidemiologic, and health services research which may ultimately reduce the burden of this disease on Alaskans.
- The Alaska Family Violence Prevention Project (AFVPP) developed new training modules on reproductive coercion and dating violence that were launched in Anchorage, Fairbanks, Kodiak, Sitka, and Homer. The AFVPP is participating in a community initiative to integrate assessment and services for domestic violence, substance abuse and mental health.
- Overall youth tobacco use is at an all-time low of 16%, significantly lower than the US average for the first time. Historically, tobacco use among Alaska natives was four times higher than the non-native average; now it is only twice as high.
- Produced and published *The Burden of Overweight and Obesity in Alaska*, and an update to the Tobacco Annual Report.

Public Health Emergency Preparedness and Response

- Coordinated Health and Social Services' massive surveillance and response to H1N1 pandemic influenza. Alaska had 832 hospitalizations and 12 deaths related to H1N1 influenza.
 - Distributed 228,405 doses of vaccine to providers.
 - Public health nurses vaccinated 68,232 Alaskans against this disease, giving 48% of the vaccine administered by health care providers in Alaska.
 - Conducted more than 150 mass and targeted vaccine dispensing clinics with local communities and partners.
 - Sent 78,680 doses of antiviral medications, 680,000 masks, 133,676 pairs of surgical gloves, 118 ventilators, and 50,000 bottles of hand sanitizer, among other personal protective equipment, to 38 hub communities during the response.
 - Public Health laboratories tested more than 5,000 specimens for H1N1 pandemic influenza.
- Conducted community outreach workshops in 19 communities in preparation for the fall flu response with an additional 21 outreach events scheduled through December 2010.
- The Laboratory tested 23 samples suspected of containing biological threat agents and 6 samples from botulism outbreaks. Alaska consistently has the highest rate of food-borne botulism in the country.



Major Accomplishments

- Participated in 2010 Alaska Shield Exercise (scenario of South-central earthquake) with local, state and federal partners, including hospitals, Blood Bank of Alaska, Valdez, Cordova, Anchorage, and Division of Homeland Security and Emergency Management.
- Successfully passed three federal inspections (CLIA, Select Agent, & Animal Welfare) with no deficiencies in either the Anchorage or Fairbanks laboratories.
- More than 400 nurses are enrolled as volunteers in Alaska Nurse Alert System.
- More than 90% of Public Health Nursing employees have participated in community preparedness exercises or events.

Access to Early Preventive Services and Quality Health Care

- Alaska's public health nurses provided more than 136,000 health care visits; 81,073 of these were to children and youth ages birth to 19 years.
- 100 percent of all newborn children were screened for over 30 metabolic conditions, and 97 percent of all babies born in a hospital were screened for newborn hearing loss. Public Health nurses administered 85 newborn hearing screenings. In calendar year 2009, there were 18 confirmed cases of hearing loss in very young children.
- 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, Homer, Bethel, Kotzebue, Valdez, and Barrow.
- Performed 8,200 child health exams, including 1,250 complete Medicaid early, periodic, screening, diagnosis and treatment (EPSDT) exams.
- 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.
- Provided more than 10,500 visits for family planning to 4,800 individuals (80% of those visits were to young women ages 24 and younger).
- 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.
- Provided 1,100 prenatal visits to 825 individuals and more than 1,300 postpartum visits to 950 childbearing women and families.
- Administered 6,270 pregnancy tests.
- Residential care licensing staff investigated complaints and took enforcement actions when necessary for more than 525 complaints, as compared to 299 complaints in FY09.
- The Background Check program has processed over 71,000 background check applications since implementation on March 31, 2006, with more than 2,200 applications identified as having barring criminal conditions.



Major Accomplishments

- Analysis of FY10 data from the Alaska Birth Defects/Fetal Alcohol Spectrum Disorder Registry showed a declining trend among Alaska Native infants in the birth prevalence of neural tube defects and fetal alcohol syndrome.

- The Oral Health Program worked with the Division of Health Care Services to provide Medicaid reimbursement for fluoride varnish application and oral evaluation by medical providers as a means to address the prevalence of early childhood cavities.
- Reduced the time to receive fingerprint results to three weeks, a significant improvement from the four months in previous years, speeding up the background check process.
- The Background Check Program implemented the Rural Live Scan electronic fingerprinting system in all the Office of Children's Services rural offices and successfully completed the transition of the Child Care Program Office providers.

Protecting Human Health from Environmental Hazards

- Provided blood lead testing for 36 children at a daycare center potentially exposed to lead in artificial turf.
- In collaboration with the U.S. Fish and Wildlife Service, developed targeted fish consumption advice for villages located near six National Wildlife Refuges that consume pike.

Major Accomplishments

- Successfully implemented childhood blood lead testing for the Head Start Program.
- Started the Alaska Health Impact Assessment (HIA) Program.
- Completed the Point Thompson HIA;
- Initiated the Donlin Creek Mine and Chuitna Coal Mine HIAs.
- Addressed community health concerns about potential exposure to the chemical sulfolane detected in hundreds of private drinking wells in the North Pole area.



Other Division of Public Health Statistical Information

- The Office of the State Medical Examiner has seen a dramatic increase in case load. Eighty percent of cases were transported to the Office for further examination, as compared to 24 percent in FY09. The Office performed 484 autopsies, up from 253, and 265 inspections, up from 124, in FY09.

- In FY10, the Bureau of Vital Statistics processed:
 - Births: 11,521
 - Deaths: 3,642
 - Total Registered Marriages: 5,591
 - Marriage licenses issued: 4,328
 - Divorces: 3,088
 - Adoptions of Alaska-born children processed: 808
 - Establishments of paternity of Alaska-born children processed: 3,725
 - Funds for the Alaska Children's Trust from heirloom birth and marriage certificates: \$23,200
 - Applications for the Medical Marijuana Registry processed: 65

Major Accomplishments

- The Bureau of Vital Statistics completed two major information management projects: 1) a five year project to enter all deaths into its information system; and 2) a project to image and then conduct optical character recognition on the historical marriage and divorce paper-based index files used to locate these records. The information from the index files was subsequently uploaded into the Bureau's information system. The completion of these projects allows staff to search for records electronically, saving considerable time by eliminating the need to manually search paper index files. Each record that can be located electronically saves staff three to five minutes per search.
- The State Medical Examiner's Office collaborated with the U.S. Consumer Product Safety Commission to publish a warning on infant sleep-positioners to help reduce the number of cases of Sudden Infant Death Syndrome (SIDS).
- The Chief Medical Examiner, Investigator Supervisor and Operations Administrator presented lectures to law enforcement, hospital staff, fire department, and paramedics in Kodiak, Valdez, Fairbanks, Bethel, and Juneau regarding the changes that have occurred within the Medical Examiner's Office since the addition of the third pathologist. Presented lectures at the state Emergency Medical Services symposium and the child maltreatment conference as well.



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

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

Explanation of FY12 Operating Budget Requests

Division of Public Health

Budget Overview Table

Division of Public Health	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$40,968.7	\$45,690.1	\$4,721.4
Designated General Funds	14,198.9	15,297.4	1,098.5
Federal Funds	42,244.1	38,976.3	(3,267.8)
Other Funds	4,907.0	4,918.2	11.2
Total	\$102,318.7	\$104,882.0	\$2,563.3

Budget Requests

Stabilize Funding to Public Health Nursing Grantees-Phase II: \$750.0 GF

This increment is the second phase in an effort to stabilize funding for the public health nursing grantees. Current grants are inadequate to support services at a level consistent with the rest of the state. Phase II will provide the three public health nursing grant program recipients with about 43% of the state grant funding needed to maintain services at the current level. Even with an increment of \$1 million for FY2011 (Phase I) and a 5% budget increase in FY2009, grantees still must subsidize operations with \$1,750.0 of local funding. The remainder of the state receives services without the requirement of locally subsidized funding. Despite an increase for FY2011 the Norton Sound Health Corporation returned responsibility for provision of public health nursing services to the State beginning in FY2012. Another grantee has likewise expressed an interest in discontinuing these services.

The Division of Public Health provides direct public health nursing services to all communities



in Alaska except those served by three grantees (Maniilaq Association, North Slope Borough and the Municipality of Anchorage). These grantees are part of the essential public health safety net for Alaska. Maniilaq and North Slope Borough serve a combined 14,160 people in 16 villages covering more than 125,000 square miles. The Municipality of Anchorage serves 42% of the State's population.

Stabilizing grantee funding will maintain public health nursing services by helping to strengthen families and maintain local economies. Public health nurses support and strengthen families by screening for domestic/family violence, linking families to needed health and social services, and providing child health and parenting education and support. They help people get and stay employed by providing job-required TB and other infectious disease screening and treatment, and by helping people stay healthy enough to work. In the longer term, the child health screening and parent support services they provide detect health conditions early and help keep children in school, thus giving the child the best opportunity to grow into a productive member of the community. In addition, by supporting the grantees, these jobs are kept in the communities, helping to indirectly provide other local jobs that support these staff positions and keeping the income from these jobs in the local economy as well.

Basic public health services in areas served by the grantees have dwindled over the past ten years. The Municipality of Anchorage discontinued its well-child and home visiting programs in 2004, removing child rearing education and support for young, high needs families, and the overall public health nursing service level of Anchorage is much less than the level supported for the rest of the state. The North Slope Borough public health nurses no longer can focus on pregnancy prevention in the schools, provide prenatal or parenting education, nor offer other health education classes. The Maniilaq Association has been unable to fill vacant public health nurse positions due to low salaries and, as a result, has been unable to provide adequate basic public health nursing services to the people in that area. A fourth grantee, Norton Sound Health Corporation, will return public health nursing services to the State beginning in FY2012.

The grantees have gone decades with little or no increased funding for public health nursing services to these areas while local costs and grantee contributions have risen steadily. For example, the State funded 38% of the Municipality's public health nursing services' budget in 2001- which dropped to 25% in 2010. Costs for travel, facility operations, and supplies have increased significantly, burdening the grantees with additional expenses. Grantee public health nurse salaries have not kept pace



with State salaries and the rural areas suffer from chronic public health nurse shortages.

The grantees' inability to meet basic public health needs impacts the health of all Alaskans. If not funded, trends are expected to continue in reduced public health service delivery in these regions accompanied by a rise in public health problems. This proposal assures that the three remaining grantees continue to provide mandated public health nursing services for their geographic areas including the prevention, control and treatment of infectious diseases such as tuberculosis, sexually transmitted diseases and vaccine preventable diseases; public health preparedness and response to pandemic flu, new emerging infectious disease, and other public health disasters; preventing injury and chronic disease, and accessing care for children and vulnerable adults.

Maintain Phase I Improvements of State Medical Examiner's Office Reforms: \$500.0 GF

This increment will ensure that the present level of service in the State Medical Examiner's Office can be maintained. A drastic increase in caseload resulted in a shortfall for FY10, primarily for freight costs to transport cases. The Office received \$300.0 GF supplemental funding in FY10 and a \$300.0 GF increase to the base budget in FY11. However, this still leaves a projected deficit of \$300.0 to simply maintain services in FY11, for which the Division will again request supplemental funding. The shortfall related to Phase I improvements is expected to rise to \$500.0 in FY12, driven by caseload increases.

- Phase I, begun in FY10, helped stabilize funding for an increased caseload. However, actual cost increases exceeded estimates, resulting in a \$500.0 projected shortfall for FY12.
- Phase II will expand services to 3 geographic areas with a large number of cases and provide additional stabilization funds for the increasing caseload.
- Phase III will further expand services throughout the state; maintain funding for the increasing caseload; and move the Office closer to national accreditation.



These reforms are needed because the present Medical Examiner's Office is completely centralized in the city of Anchorage. When a death occurs in Anchorage, a full investigation into the death occurs, including a trained Medical Examiner's investigator attending the scene of death and initiating an investigation independent of law enforcement. Currently no independent death investigation takes place in communities outside of the Anchorage/Mat-Su area.

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 Medical Examiner's Office investigates sudden, violent, unexpected, and suspicious deaths that occur in the state 24/7/365. The Office's independent investigator makes the determination whether a body should be transported to the office for further medical examination by a pathologist. 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.

Phase I reforms have already improved services to Alaska families and communities. Death certificates are signed in a more timely manner, within 48 hours after examination, and autopsy report requests are being mailed more quickly, as well. Cases are released to next of kin for final disposition (i.e. funeral home, back to next of kin) within 24 hours after examination and authorization from family. Outreach to communities (such as Bethel, Valdez, Kodiak, Juneau, and Fairbanks) informed stakeholders about changes in the Medical Examiner's Office policies and procedures and provided valuable information on the increase in cases.

In FY10, the Medical Examiner's Office experienced a marked increase in the volume of cases that were examined and autopsied. The number of cases under the Medical Examiner's Office jurisdiction increased 28% from FY09 to FY10. Of the 3,300 deaths reported in Alaska during FY10, the Medical Examiner's Office took jurisdiction in 60% of the cases (1,989), up from 46% in FY09 (1,556). The number of cases examined or autopsied doubled from 377 (24%) to 754 (38%) cases. This trend is expected to continue.

The increased work load in the central office was possible because the Office became 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 transportation of all cases that warrant an examination by a forensic pathologist, regardless of their location of death. However, the increased caseload is presently being done with significant overtime to cover all shifts and creates potential for exhaustion, burn out, and injury.

The consequences of not investigating and examining all cases on scene that fall under the Medical Examiner's jurisdiction are extensive, creating a liability for the State of Alaska. Without additional stabilizing funds, the Office will remain understaffed. Understaffing results in transportation and death investigations of human remains being delayed or abandoned, causing possible decomposition or worse, an undetermined cause of death. Homicides may go undetected; suicides may be misdiagnosed; misidentification may abet identity theft, cause undue hardship on families, or result in inaccurate statistics.

Transfer Public Health Nursing Services from Norton Sound Health Corp to Div of Public Health: \$450.0 GF

This change record is one of two that will provide the funding necessary for the Division of Public Health to assume provision of all public health services for the inhabitants of the Nome/Bering Strait region on July 1, 2011. The total cost to transfer public health services from Norton Sound Health Corporation (NSHC) to the State will be \$1,452.4 GF in FY12. These costs will be offset by the \$1,002.4 grant monies NSHC receives from the Section of Public Health Nursing (in a separate change record). This increment will supply the remaining \$450.0 GF needed to maintain services for the inhabitants of the Bering Strait area. No new services will be added. Staffing levels will be slightly decreased from the ten current NSHC positions to seven.

The Norton Sound Health Corporation (NSHC) provided essential public health nursing services to the region as one of four grantees of the Section of Public Health Nursing. NSHC gave the Department notice in June 2010 that they will return responsibility for public health nursing services to the State of Alaska on July 1, 2011 despite a \$250,000 increase to their grant funding for FY11.



Assuming direct provision of these services comes at a significant cost to the state, the most notable being that salaries and benefits for state public health nurses are higher than what NSHC pays. Requested funds will support hiring staff, leasing clinic and office space, traveling to the villages to provide itinerant public health nursing services, purchasing supplies and equipment, and paying overhead costs, such as utilities and phone service. This includes a one-time \$30.0 purchase of computers, office supplies and medical equipment for the facility.

Staffing levels will be decreased from the ten current NSHC positions to eight permanent positions: 3 full-time and 1 part-time Public Health Nurse IIIs, 2 full-time Public Health Nurse IIs, and 2 full-time Office Assistant IIs. This is one fewer nurse and two fewer office assistants than NHSC employed.

The state has a constitutional mandate to provide for the public's health and must take over provision of public health nursing services for the inhabitants of this area in order to assure the integrity of Alaska's public health safety net. The NSHC public health nursing region covers 88,000 square miles. The service area has a total population of approximately 9,275 inhabitants. Nome (pop. 3,502) is the hub community from which itinerant public health nurses serve 15 villages with 5,773 additional inhabitants. Services provided include tuberculosis screening for school children; treatment and follow-up of persons with tuberculosis; child health exams; pregnancy testing; prenatal education and counseling; sexually transmitted disease prevention, control and treatment; response and investigation of disease outbreaks that may be caused by food, water, or other environmental hazards; public health emergency preparedness & response activities; development of community partnerships to address local public health problems such as injury, obesity, and family violence; and immunizations, among many others.

This increment will assist in strengthening families and maintaining the local economy. Public health nurses support and strengthen families by screening for domestic/family violence, linking families to needed health and social services, and providing child health and parenting education and support. They help people get and stay employed by providing job required TB and other infectious disease screening and treatment, and by helping people stay healthy enough to work. In the longer term the child health screening and parent support services they provide detect health conditions early and help keep children in school, thus giving the child the best opportunity to grow into a productive member of the community. In addition, this increment will



assure the seven jobs that are responsible for performing this work stay in Nome and keeps the income from these jobs in the local Nome economy.

If this proposal is not implemented, public health services for both the inhabitants of the Bering Strait area and across the state will be severely compromised. There will be eight jobs lost in Nome, six of which are high paying public health nurses. Existing resources in the rest of the

state will have to be stretched to provide necessary services to this area. Public health nurses will need to travel from Anchorage, and other parts of the state, to Nome and the Bering Strait villages to provide services; other services will no longer be available at all. A hole will be opened in our public health safety net, weakening our ability to assure access to care for the vulnerable and to prepare and respond to public health threats such as pandemics, and natural and manmade disasters.

Sustaining Progress in Tobacco Prevention and Control: \$950.0 Tob Ed/Cess

There are two requests for the Tobacco Prevention and Control program to expand tobacco cessation efforts. The majority, \$750.0, will go towards grants in the Tobacco Prevention and Control component, while the remaining \$200.0 will support program infrastructure and oversight in Chronic Disease Prevention and Health Promotion.

Every \$1 spent on tobacco prevention and control saves \$3 in health care related costs.

The \$750.0 portion of the increment supports an expanded network of health care professionals trained to address tobacco use with their patients. This funding will broaden outreach throughout Alaska to inform the public on the dangers of tobacco use and increase the number of providers who are referring tobacco users for cessation services. The contract is expected to directly fund four to six local private sector jobs.

The \$200.0 portion of the increment will enhance a key database and support the grantees. The Behavioral Risk Factor Surveillance System (BRFSS), used for planning and assessment of tobacco prevention and control efforts, will contract for a data collection system to augment the Alaska Health Survey Lab. There are increasing calls from partners and stakeholders for community-level prevalence data, as well as more detailed information on various aspects of tobacco use and cessation, including barriers to successful quitting, reasons for relapse to tobacco use, and utilization of cessation services. To date, the majority of these needs have been met by the Alaska Health Survey Lab; however, the Health Survey Lab no longer has the capacity to meet the increased demand for tobacco-related data.

Funds will also be used to conduct cessation outreach activities and site visits for grantees; purchase supplies for cessation outreach activities for local communities; and partially fund (0.1 FTE) an existing position to oversee and manage the BRFSS contract.

Tobacco remains a significant public health problem in Alaska, killing nearly 600 people annually and generating almost \$380 million in medical costs and lost productivity each year. Alaska has made considerable progress in reducing the burden of tobacco use by implementing a sustained, comprehensive tobacco prevention and control program that includes a tobacco Quit Line, media, community programs, and grants to schools



and healthcare organizations. Since the inception of the program, adult smoking rates have declined significantly and youth smoking rates have been cut in half.

Providers, facilities, agencies, and tribal health entities statewide rely on the Tobacco Prevention and Control Program to provide them the established, coordinated provision of resources to effectively implement systems that have been demonstrated to improve tobacco cessation. Without this funding, tobacco use will continue to disproportionately affect Alaska Natives, individuals of low socioeconomic status, and rural residents. Fewer Alaskan adults and youth will be free from the harmful effects of tobacco. The financial burden to the Alaskan public of the cost of tobacco-related morbidity and mortality will not be reduced.

Alaska Family Violence Prevention Project: the Connection between Dating Violence, Substance Abuse and Brain Development: \$250.0 GF

This proposal would stabilize funding for the Division of Public Health's Alaska Family Violence Prevention Project (AFVPP) which provides prevention activities for domestic violence and sexual assault. The AFVPP's Project Director and Project Coordinator budgeted positions are funded on a year-to-year basis and there is only enough funding for the Project Director to work part-time (0.8 FTE). There is no funding to develop materials or travel to work with service providers on prevention strategies except for a few trips a year possible through the generosity of third parties.



Alaska has the highest domestic violence homicide rate in the U.S., nearly twice the national rate. Nearly 1 in 4 (22%) Alaskans have experienced domestic violence in their lifetime. Dating violence is a precursor of domestic violence, the focus of a current initiative by Governor Parnell. Dating violence is associated with substance abuse among youth, and both are predictors of additional risk behaviors, as well as a host of negative health outcomes—including those affecting brain development. Levels of both dating violence and substance abuse are high in Alaska youth:

- 13% of Alaskan teens have been hit, slapped or physically hurt by a dating partner.
- 21% of high school students had 5 or more drinks of alcohol in a row in the past 30 days.
- 44.5% of high school students have used marijuana 1+ times; 7.4% have used cocaine.

Preventing dating violence and substance abuse promotes optimal brain development, improves adolescent health and wellness, and interrupts the cycle of relationship violence. By abstaining

from violence in relationships and substance abuse Alaska youth maximize their brain potential. Disseminating state-of-the-art information to service providers and youth can lead to earlier detection of emerging problems, more effective intervention, and scientifically informed policies and practices.



The Alaska Family Violence Prevention Project, a nationally recognized best practice program for violence prevention, uses a train-the-trainers (TTT) program to efficiently create and support multidisciplinary teams of educators, health care providers, public health nurses, and behavioral health/substance abuse professionals. These individuals become local training resources and community change agents. By supporting regional teams with training, technical assistance, and resources, prevention can be initiated and sustained at the local level in the most economical, yet effective way.

This increment will allow full funding for the two existing positions, a train-the-trainer conference (travel/ per diem, speakers, conference coordinator & site), provide professional development and technical assistance (includes travel to sites); purchase prevention curricula and tools; and print and disseminate resource materials for providers.

Funding will enable the AFVPP to provide these services to support the TTT teams:

- Disseminate integrated curriculum on dating violence, substance abuse, and adolescent brain development with prevention strategies.
- Integrated assessment tools for dating violence and substance abuse that can be used in health care settings including school health.
- Technical assistance and site visits to teams to facilitate local training, policy development, and implementation of prevention strategies.
- Educational resources for service providers and parents.
- AFVPP Clearinghouse and website with the latest resources on adolescent brain development and evidence-based prevention for dating violence and substance abuse.
- Evaluation of the train-the-trainer program to assess changes in participants' knowledge, practices, and policies.

Without stabilized funding, both dating violence and substance abuse levels will likely remain high in Alaska youth. Communities will not have the opportunity to coordinate efforts to address related risk factors with the most effective prevention strategies.

Replace Unrealizable Fund Sources to Maintain Public Health Nursing Services:
\$1,000.0 GF

This increment will stabilize the Public Health Nursing budget and allow them to provide essential public health services. In FY11 Public Health Nursing reduced services and is maintaining an 12.5% vacancy factor, yet projects a GF shortfall of \$1,750.0. It has only been possible to continue to meet budget within recent years due to difficulty recruiting nurses, which resulted in a high vacancy factor. A recent effort to strengthen recruitment of public health nurses has resulted in a decrease in vacancy factor from 16% in July 2006 to 11% by May 2010. Use of generic drugs, purchasing pools and increased fee collections have helped but cannot make up the deficit. Layoffs and a 17% vacancy factor would be required to stay within budget. There is sufficient personal services authority in this component; however, the federal funds that support these positions are unrealizable. The requested funds will reduce the vacancy factor to 9.8%.



Public health nurses serve all Alaskans through 23 state-operated public health centers located around the state. Public health nurses travel to reach over 250 communities in Alaska; support and strengthen families by screening for domestic and family violence, linking families to needed health and social services, and providing child health and parenting education and support; help people get jobs and stay employed by providing job required TB and other infectious disease screening and treatment, and by helping people stay healthy enough to work; detect health conditions early and help keep children in school through child health screenings and parent support services, thus giving the child the best opportunity to grow into a productive member of the community; optimize the physical health of Alaskans through direct clinical services and community based prevention and health education activities; prevent, control and treat infectious diseases such as tuberculosis, sexually transmitted and vaccine preventable diseases; prepare for and respond to public health disasters such as pandemic flu, floods, fires, and new emerging infectious diseases; perform health screenings and injury prevention activities; reduce chronic diseases due to obesity and tobacco use by promoting healthy lifestyles; improve oral health through education; and provide clinical services for children and vulnerable adults without access to other health care providers.

This increment will allow Public Health to restore services that have been reduced or eliminated.

- Restore approximately 35 trips to communities & villages
- Immunizations to children and adults
- Child health exams to children age 0-5 who have no primary care provider
- Home visits for high risk newborns and young families at social and economic risk
- Follow-up on persons who have been exposed to sexually transmitted diseases and who may not be aware of their exposure
- TB screenings in school
- Mass vaccination and emergency shelter exercises for communities
- Family planning services and birth control options
- Pediatric Tylenol when children receive immunizations
- Head lice treatment
- Health prevention and promotion activities
- Dissemination of public health information to communities



If this request is denied public health centers may need to be closed, public health staff positions may have to be cut, and core public health services further reduced or eliminated. This will result in direct public health impacts including: decreased immunization rates, increases in rates of tuberculosis and sexually transmitted infections, and other preventable diseases could also increase. For example, Alaska is currently in the midst of a gonorrhea outbreak and consistently has one of the highest chlamydia rates in the nation; however, funds are stretched too thin to respond adequately to the demand.

Public Health Laboratory Financial Sustainability: \$100.0 GF/Prgm



This increment would increase receipt supported services authority to maintain services. During the past five years, the number of tests performed by the Laboratories has nearly doubled from 77,000 to over 148,000. The complexity and cost of these tests have increased exponentially while the budget has remained flat. Additionally, overhead costs have increased more than 25% during the same period. To keep up with rising costs while maintaining services, the Public, Health Laboratories are increasing fees for services.

If approved, it is proposed that \$30.0 be used to pay for contractual services such as maintenance contracts for scientific instruments (required under 42 CFR 493) and \$70.0 for personnel costs associated with on-call requirements of operating a 24/7/365 facility.

More and more scientific data indicates that persons abusing drugs, diabetics, the young, elderly, native Alaskans, rural and subsistence-dependent populations are more at risk of contracting infectious diseases. It is prudent that early and accurate diagnostics be made available to prevent, mitigate and treat these morbidities. The programs and laboratory testing offered by the Public Health Laboratories are of such vital importance to the State of Alaska that the Toxicology unit received the Governor's Award of Excellence in 2008.

Without the receipt supported services authority, vital and life-saving testing for diseases such as tuberculosis, hepatitis, botulism, and rabies may have to be curtailed or eliminated.

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 sustaining the current capacity-building efforts and to provide for a diagnosis and comprehensive referral system for Autism Spectrum Disorder.



Challenges

As the Division of Public Health works to protect and promote the health of Alaskans, challenges abound in the general categories of preventing chronic disease and promoting good health, fighting infectious disease, preventing injuries, improving outcomes for children and protecting vulnerable Alaskans. In each of these categories, progress will continue through the right mix of necessary investments in the division's programs, expanded partnerships with the entire public health community and the recruitment and retention of expert, dedicated staff.

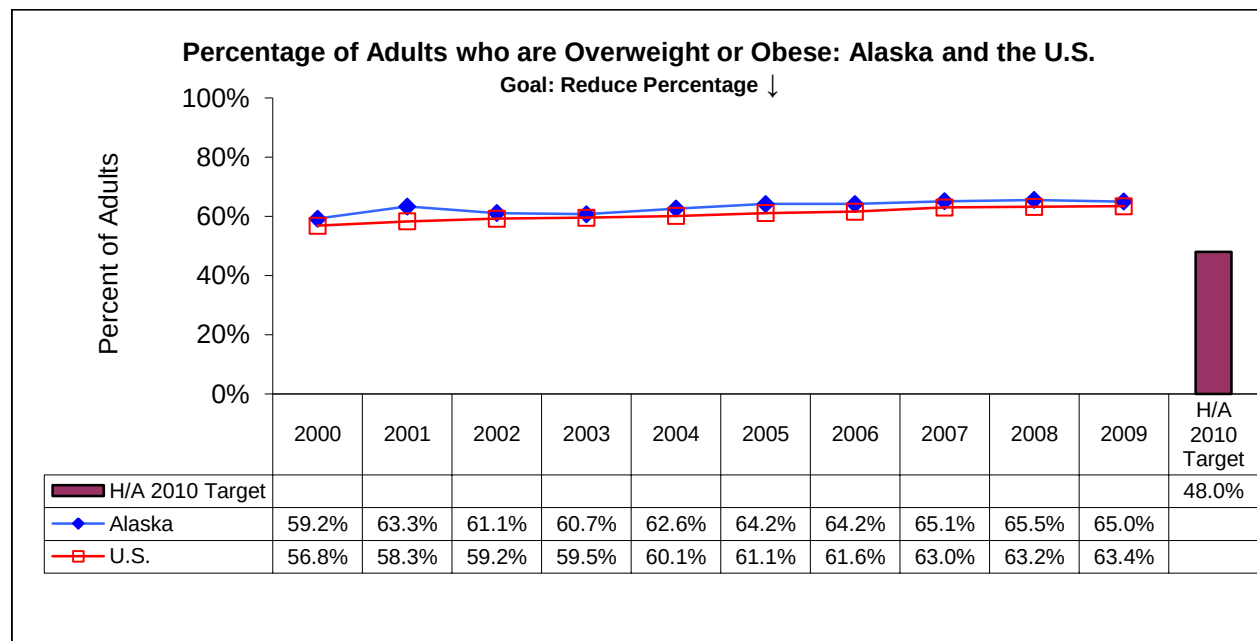
Chronic Disease Prevention

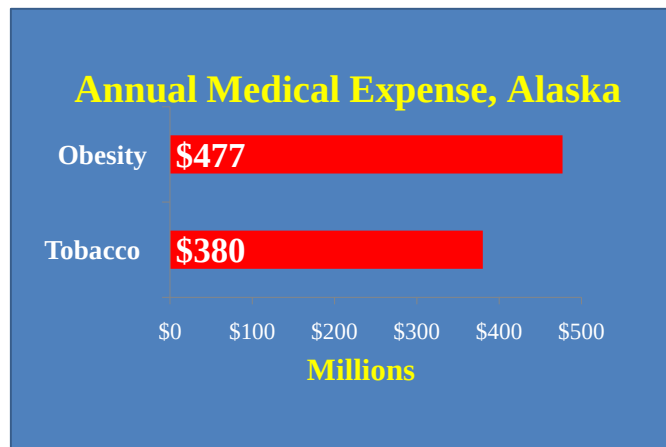
The fight against chronic diseases is critical, especially the important fight to reverse or at least slow Alaska's growing and alarming rates of overweight and obesity. Three of every five deaths in Alaska are linked to chronic diseases. The primary risk factors for such diseases are obesity, poor diet, lack of exercise and tobacco use.



Strategies

- Expand efforts to combat Alaska's epidemic of childhood overweight and obesity through better education efforts.
- Continuing to build on progress made by reducing adult and youth smoking in Alaska, efforts must continue to lessen the negative impact of tobacco on all Alaskans.





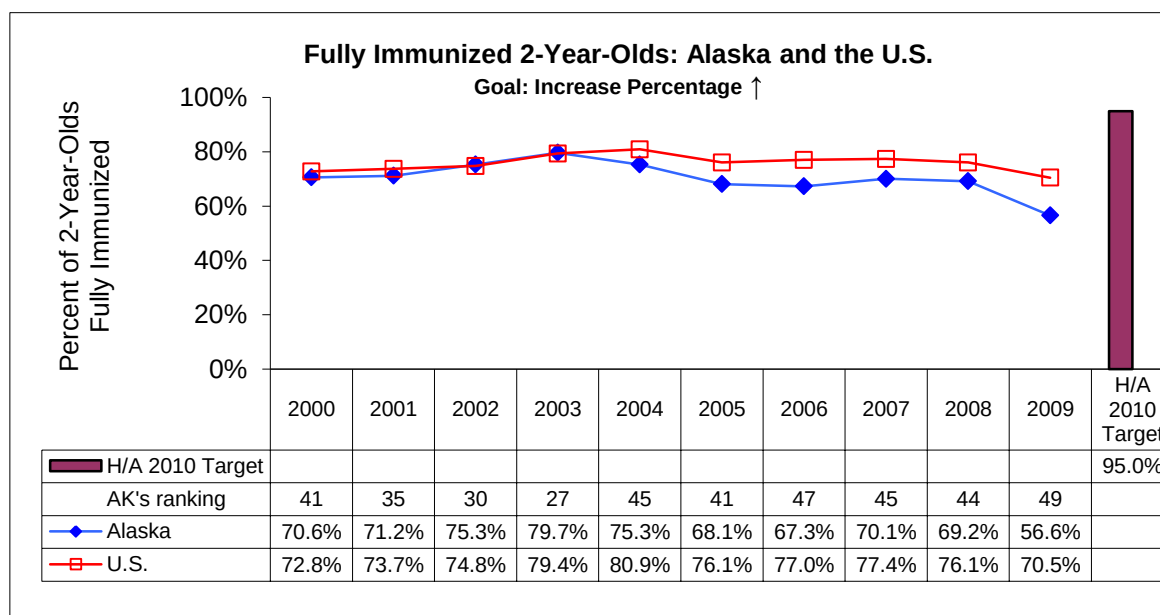
Infectious Disease

Another major challenge is the fight against infectious disease, with new diseases discovered all the time and old scourges still lingering. Alaska must remain prepared for the threat of avian influenza while continuing to battle long-familiar diseases such as tuberculosis. Alaska's role as a transportation and tourism crossroads exacerbates the challenge as people from around the world come to our state. Of particular concern is the low rate of immunization for children under age two.



Strategies

- Expand efforts to improve Alaska's childhood immunization rates by working within the division and with health partners around the state to increase the number of children who are fully immunized.
- Provide effective public (parent) education and promotional programs for childhood vaccination.



Public Health Workforce

There is an urgent and ever-present need in the division to assure an adequate public health nursing workforce around the state. These nurses serve as the “foot soldiers” of Alaska’s public health system and deliver critical services in every corner of Alaska. Public Health Nursing provides critical services in Alaska through 23 state-operated public health centers located around the state. Itinerant Public Health Nurses deliver critical services to over 250 communities in Alaska.



- The national standard for the ratio of public health nurses to the population is 1 to 5,000.
- Given the vast distances between communities, it is appropriate for the ratio to be much lower in less densely populated regions.
- The Municipality of Anchorage’s staffing levels are just 25% of what is recommended – 1 to 20,000.
- As of December 2010, Public Health Nursing has 30 vacancies, or nearly 15% of 202 authorized positions.

Strategies

- Maintain a 5-7% vacancy level for state public health nurses.
- Improve the ratio of public health nurses to population in the Municipality of Anchorage to 1:10,000.

NATIONAL STANDARD	1 : 5,000
ALASKA DIVISION OF PUBLIC HEALTH	
Interior Region	1 : 4,246
South Central Region	1 : 5,677
Southwest Region	1 : 2,159
Southeast Region	1 : 2,914
GRANTEES	
Municipality of Anchorage	1 : 20,000
Maniilaq Association	1 : 2,690
North Slope Borough	1 : 1,427
Norton Sound Corporation	1 : 2,090

Public Health Infrastructure

As federal funding shrinks – and with little commitment of GF for these programs to date – a major challenge for the division is to continue its work to protect and promote the health of Alaskans with existing resources. Investing in Public Health’s infrastructure makes sense financially because investments in a healthier Alaska now will save healthcare dollars in the years to come.

Strategies

- Stabilize funding for essential public health services:
 - Infectious Disease and Epidemic Prevention and Control
 - Injury Prevention Control and Emergency Medical Services
 - Chronic Disease Prevention and Control
 - Public Health Emergency Preparedness and Response
 - Access to Early Preventive Services and Quality Health Care
 - Protecting Human Health from Environmental Hazards
- Improve public health information technology to provide recommendations for and foster the development of comprehensive statewide health care policies and strategies for improving the health of Alaskans. Aging data systems, such as the electronic vital records system, need to be replaced. New systems need be developed where no infrastructure exists (such as a database for residential care facility licensing). Current databases need to be reconfigured for electronic health records and the statewide health information exchange.
- Continue leadership with the Alaska Health Care Commission to improve the quality, accessibility, and affordability of health care for Alaskans.
- Expand the number of Alaska hospitals that undergo trauma system certification and designation.
- Continue with Phase II of expanding the State Medical Examiner’s Office function to better serve statewide needs.

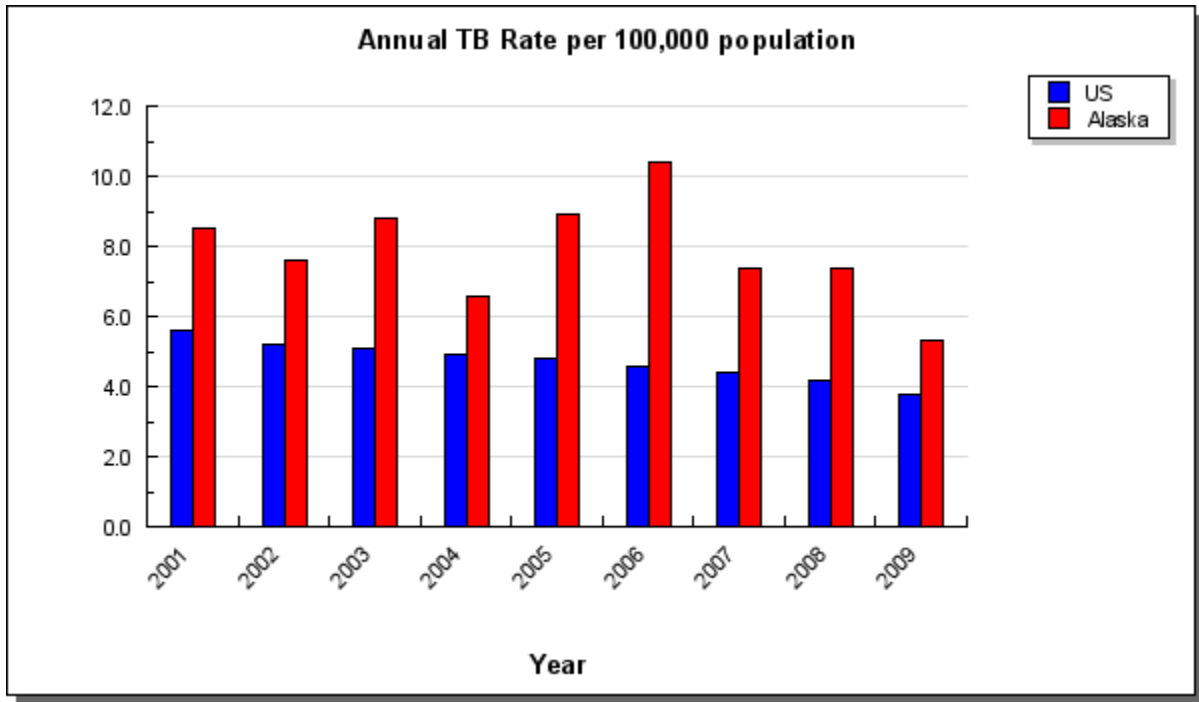


Performance Measure Detail

A: Result - Healthy people in healthy communities.

Target #1: Reduce Alaska's tuberculosis (TB) rate.

Status #1: The rate of tuberculosis was 5.3 cases/100,000 population in 2009, a 29% decrease from 2008.



Methodology: U.S. TB rates come from the Centers for Disease Control and Prevention. (CDC)

Alaska TB rates are tracked in the Alaska TB program. Data is kept in the AK Stars and Infectious Disease Electronic Data System. This data was reported in the 2009 Annual TB report. (See Website below)

Annual TB Rate per 100,000 Population

Year	US	Alaska
2009	3.8 -9.52%	5.3 -28.38%
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 listed as the cause of death for 36% of all Alaskan Natives who died from 1926-1930. Major efforts, utilizing 10% of the entire 1946 territorial 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 has been in decline since 1970 and was the lowest ever reported in 2009.

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: Reduce Alaska's unintentional injury death rate.

Status #2: The 2008 death rate caused by unintentional injuries was 55 per 100,000 population, below the 57/100,000 rate in 2007; however it did not meet the Healthy Alaskans 2010 target of 31/100,000. Source: AK DHSS DPH BVS

Unintentional injury death rate per 100,000 Population

Year	Alaska	US
2008	54.9 -4.19%	N/A
2007	57.3 +9.35%	39.9 +0.25%
2006	52.4 +3.35%	39.8 +1.79%
2005	50.7 -7.99%	39.1 +3.71%
2004	55.1 -0.54%	37.7 +1.07%
2003	55.4 -6.42%	37.3 +1.08%
2002	59.2 -3.11%	36.9 +3.65%
2001	61.1 -4.38%	35.6 +2.01%
2000	63.9 +11.13%	34.9 -0.57%
1999	57.5	35.1

Methodology: Age-Adjusted Rate.

Source: Alaska Bureau of Vital Statistics; U.S. Center for Disease Control and Prevention, National Center for Health Statistics, Web-Based Injury Statistics Query and Reporting System.

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 injury prevention programs and will keep working towards a reduction of injury-related deaths. Public Health injury prevention programs such as "Kids Don't Float," "Child Passenger Safety," "Helmet Safety" and "Poison Prevention" are a few examples of successful injury-prevention

activities in Alaska. Injury Surveillance and Prevention Programs, working collaboratively with its statewide network of prevention partners, continue to use data and proven data driven prevention strategies to sustain a progressively downward trend to meet and maintain its goal to reduce unintentional injury-related deaths.

Target #3: Alaska's overall cancer death rate is less than 162/100,000 population

Status #3: 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
2009	183.8 +1.6%	0 0%
2008	180.9 -1.63%	0 -100%
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

Methodology: Statistics are copied from the following data sources:

Alaska Bureau of Vital Statistics (Alaska Data)

National Center for Health Statistics (US Data)

Mortality statistics for 2008 and 2009 for the United States have not yet been released.

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 until 2005 where an

increase was noted 2005-2007 and no significant change was noted 2007-2009. 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 #4: Alaska's coronary heart disease death rate is less than 120/100,000 population

Status #4: Coronary Heart Disease (CHD) death rate continues to be below the target rate of 120 deaths per 100,000 people. Alaska has been below the target death rate since 2004.

Age-Adjusted Coronary Heart Disease death rate per 100,000

Year	Alaska	US
2009	93.3 +9.64%	0 0%
2008	85.1 +1.07%	0 -100%
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

Methodology: Statistics are copied from the following data sources:

Alaska Bureau of Vital Statistics (Alaska Data)
National Center for Health Statistics (US Data)

Mortality statistics for 2008 and 2009 for the United States have not yet been released.

Analysis of results and challenges: Nationally, heart disease is the leading cause of death. An estimated 18 million men and women in the U.S. over the age of 20 have a history of coronary heart disease, the most common form of heart disease. In 2006, 425,425 people (52.8% of them men) 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 fifth. Between 1999 and 2007, Alaska's age-adjusted mortality rate for coronary heart disease declined. The last two years have seen a small increase in the mortality rate. Nationally, the mortality rate for coronary heart disease has declined, and despite the increase in the last two years, 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 of 120 deaths per 100,000 people.

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 #5: Alaska's chlamydia rate is less than 590/100,000 population

Status #5: Alaska's chlamydia rate increased from 715 cases per 100,000 in 2008 to 755 cases per 100,000 in 2009. This was approximately a 6% increase. Alaska ranked second in the nation for chlamydia rates in 2008. The 2009 ranking is not yet available.

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 have, in recent years reemerged, such as syphilis. As well, evolving antimicrobial resistance is rendering certain antibiotics ineffective.

Many challenges remain. More sensitive diagnostic technologies, targeted screening, and increased disease investigation activities have detected more infections, increasing the total numbers of chlamydia cases diagnosed. Rapid identification, notification, testing, and treatment of sexual contacts of individuals with chlamydia can make it possible to treat exposed individuals before they develop symptoms or further transmit infection. Conducted with sufficient intensity and sustained overtime, these activities have been shown to reduce the reservoir of infected individuals in the population, reducing case numbers and rates over time. Expanded programmatic efforts 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 #6: Reduce prevalence of overweight and obesity.

Status #6: The Department's Healthy Alaskans 2010 target of 17% was not met. The rate of overweight/obese high school students in 2009 was 26.2%, down from 27.3% in 2007.

The Department's Healthy Alaskans 2010 target of 48% was not met. The rate of overweight/obese adults in 2008 was 65%, unchanged from 2007. Source: AK DHSS DPH YRBS

Target #7: Increase the prevalence of pregnant women who receive adequate prenatal care to at least 75%.

Status #7: The 75% target for pregnant women receiving adequate prenatal care was met in FY2008, the last year data is available. Source: DHSS DPH BVS

Target #8: Reduce cases of vaccine-preventable disease in Alaska.

Status #8: The number of reportable conditions that are vaccine-preventable in 2009 was 149, a decrease from 395 in 2008. However, it did not meet the Healthy Alaskans 2010 target of zero cases. Source: AK DHSS DPH Epidemiology Bulletin

Target #9: Less than 20% of children aged 2 to 5 served by WIC are overweight or obese.

Status #9: In 2009, 20% of children aged 2 to 5 served by WIC were overweight or obese. This meets the Healthy Alaskans 2010 target.

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 2008, 87% of persons with tuberculosis (TB) completed adequate treatment within one year; this was a slight decrease from the previous year and was below the target rate of 95%, primarily due to some difficult cases.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2009	NA *
2008	87%
2007	90%
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

*Methodology: *TB treatment requires 6-9 months for completion. Some 2009 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: 98.1% of Alaskans diagnosed with Chlamydia in calendar year 2009 received adequate treatment, slightly exceeding the 98% target.

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2009	98.1%
2008	99.6%
2007	99.8%
2006	97.9%
2005	99.8%
2004	99.6%
2003	99.5%

*Methodology: Chlamydia morbidity data comes from the AK Stars morbidity database.
The percentage of individuals that are treated for Chlamydia comes from the STD*MIS database.*

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 5,253 reported chlamydia cases in 2009 compared to 4,869 reported chlamydia cases in 2008.. A very small number of cases don't get adequate treatment, due primarily to individuals refusing treatment or an inability to locate them.

Target #3: Young children, aged 19 months to 35 months, received all vaccines recommended by the Centers for Disease Control and Prevention (CDC).

Status #3: The target for young children to receive all vaccines was not met as 73% of these children received vaccines in 2009, down from 78% in 2008. Source: AK DHSS DPH Epidemiology, CDC National Immunization Survey

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Reduce the percentage of of high school students in Alaska who use any tobacco products.

Status #1: The Department's Healthy Alaskans 2010 target of 20% was not met. 25.2% of high school students used tobacco products in 2009, up from 24.1% in 2007 but below the 25.7% national average; (DHSS DPH Alaska Youth Risk Behavior Survey).

Prevalence of Tobacco Use in Alaska Youth in Past 30 Days (Per YRBS Survey)

Year	Alaska	US
2009	25.2 +41.57%	25.7 +28.5%
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,

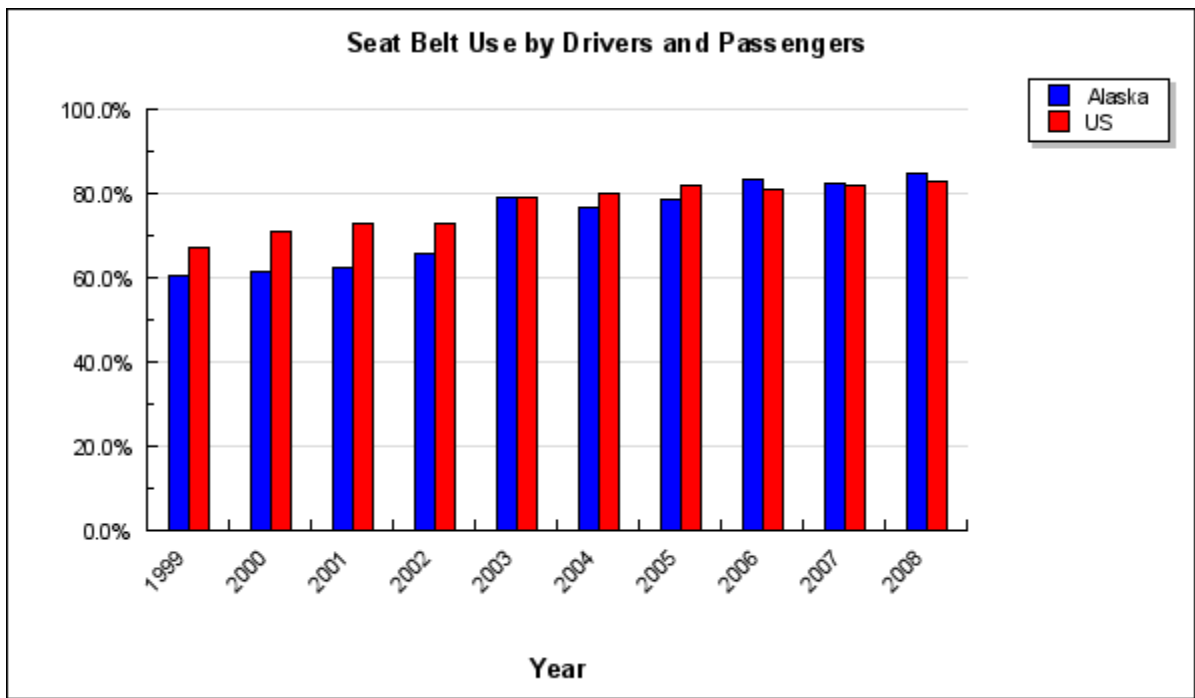
education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.2% in 2003, 17.8% in 2007, and 15.7% in 2009. The Healthy Alaskans 2010 target for youth cigarette smoking is 17.0%. 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, 2007, and 2009. 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.

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: Source data provided by: Alaska Highway Safety Office and the 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	76.7	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: Since 2006, Alaska has been able to attain and exceed its goal to increase seat belt use (Healthy Alaskans 2010 target — 80% seat belt usage by driver and passengers in a motor vehicle) and surpass national seatbelt use percentages from 2006-2008.

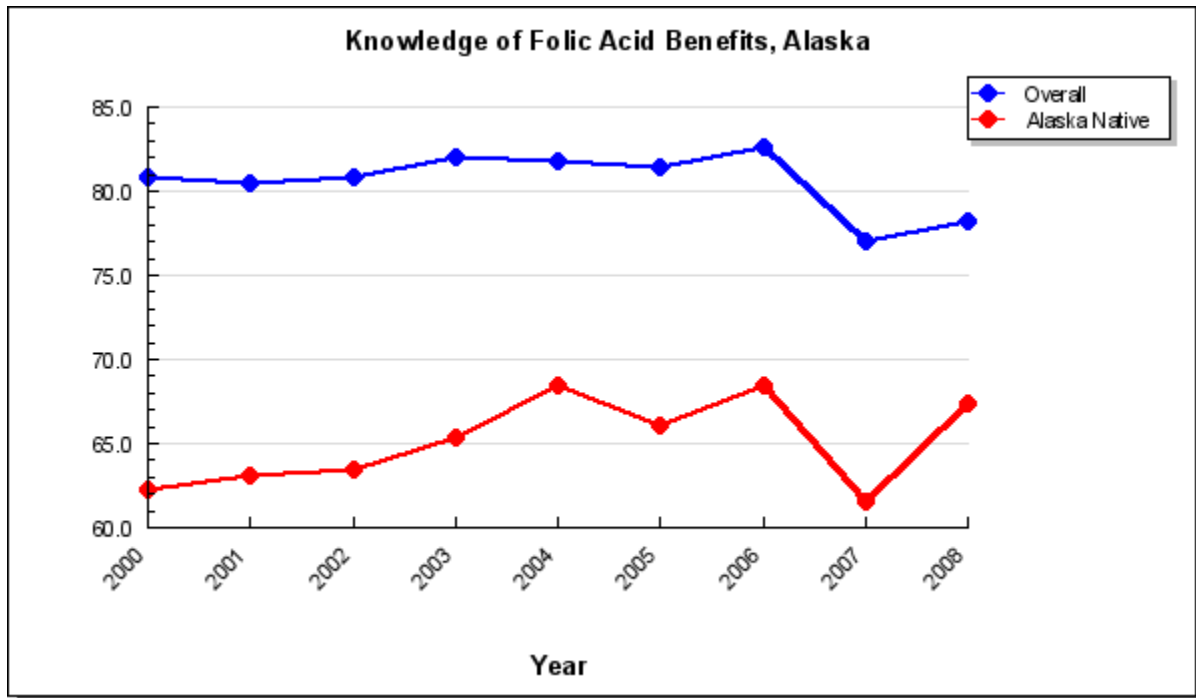
Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is the most effective strategy to increase the level of seatbelt use compliance.

While seat belt usage was improving, Alaska's mandatory seatbelt law, which took effect in 2006, significantly impacted compliance, helping to save lives and reduce serious injury. The annual number of fatalities among drivers and passengers not wearing a seat belt decrease 63%, from 46 deaths in 2000 to 17 deaths in 2006. The efforts by Alaska's prevention partners continue to provide education and awareness through public information messages and other targeted activities to foster long-term behavior changes

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: Alaska has achieved this target since 2000. From 2007 to 2008, there was a slight increase in the knowledge of folic acid benefits. The increase in knowledge among Alaska Native women erased the apparent decline from 2006 to 2007



Methodology: Source: The Alaska Pregnancy Risk Assessment Monitoring System (PRAMS)

Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
2008	78.2 +1.56%	67.4 +9.59%
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 2008, the knowledge of folic acid benefits among Alaska mothers has remained at about 80%.

The proportion of Alaska Native mothers who know about the benefits of folic acid has remained fairly constant from 2000 to 2008, at about 62% - 68%. This is a significantly lower proportion than for non-Native mothers.

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).

Increasing comprehensive preconception and inter-conception care and addressing unplanned pregnancies should be part of the overall strategy for preventative services and quality health care.

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 FY10, 32% of all full-time, permanent DPH staff received preparedness training.

**Division of Public Health staff trained in disaster preparedness
Number and Percentage**

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2010	164 +84.27%	0 -100%	0 0%	0 0%	164
FY 2009	89 -49.72%	60	0	0	29%
FY 2008	177 +555.56%				34%
FY 2007	27	106	17	31	35%
FY 2006				144*	28%
FY 2005			70	103	27%

Methodology: The FY10 percentage reflects the following: 510 permanent full time DPH positions, with an estimated 164 individuals receiving disaster preparedness training, a total of 32 percent trained.

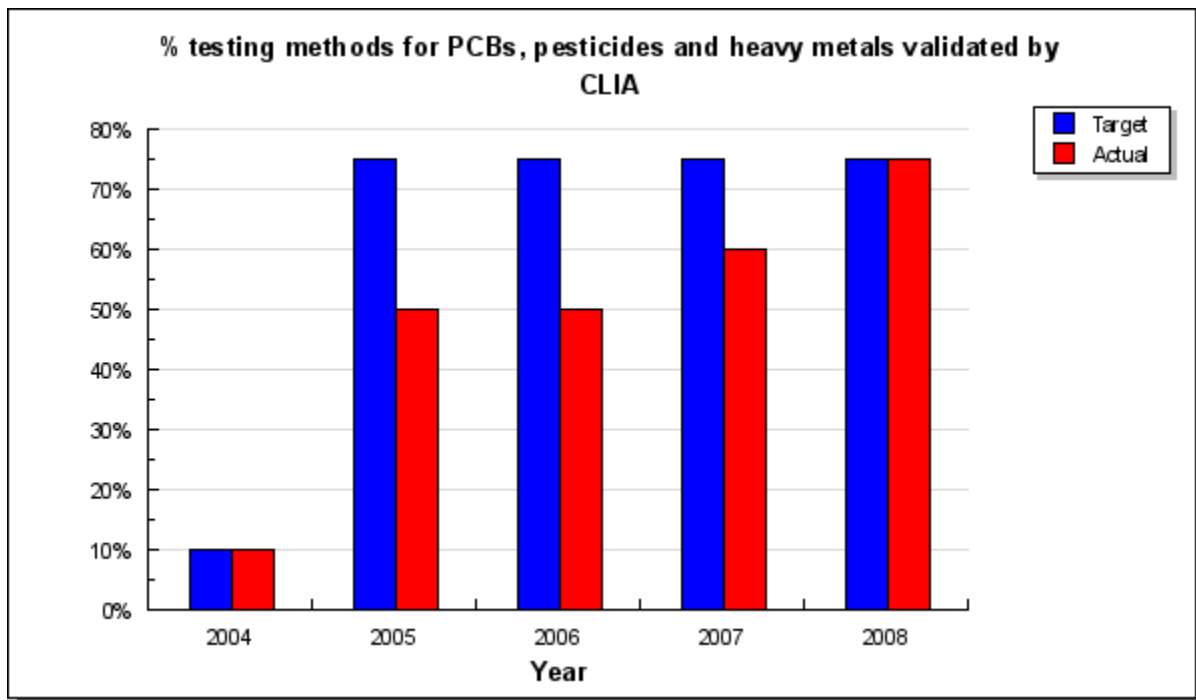
Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action, and permits all concerned to maintain a common knowledge base.

32% disaster-trained staff exceeds the Division's goal of 25%.

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 polychlorinated biphenyls (PCBs), pesticides and trace heavy metals

Status #1: In FY10, 100% certification has been maintained for heavy metals; PCB and pesticides validation is on hold. State lab testing for environmental contaminants in clinical specimens now focuses on high sample throughput for contaminants of primary concern (lead and mercury) rather than on method development.



Methodology: FY2008 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 FY11, the hair mercury testing program will continue.

Over the past two years, the Division of Public Health has greatly increased throughput capacity for children's blood lead (Pb) testing in Alaska. As a pilot in FY 2009, capillary blood lead testing was provided to a small subset (148) of Head Start program children. The pilot was highly successful; Head Start participation continues to increase and a total of 809 children received blood lead tests in FY2010. Data from blood lead testing is used to identify families and communities at risk for elevated lead exposures. Follow-up investigations conducted by the Section of Epidemiology identify the sources of lead exposure, and we work with providers and parents to reduce or eliminate those exposure sources.

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.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Stabilize Funding to Public Health Nursing Grantees-Phase II	\$ 750.0	\$ -	\$ -	\$ -	\$ 750.0
Transfer Public Health Nursing Services from Norton Sound Health Corp to Div of Public Health	\$ 450.0	\$ -	\$ -	\$ -	\$ 450.0
Transfer Public Health Nursing Services from Norton Sound Health Corp to Div of Public Health	\$ -	\$ -	\$ -	\$ -	\$ -
Stabilize Funding to Maintain Public Health Nursing Services	\$ 1,000.0	\$ -	\$ -	\$ -	\$ 1,000.0
Reverse August FY2011 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (26.5)	\$ -	\$ -	\$ -	\$ (26.5)
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 153.5	\$ -	\$ (150.5)	\$ (3.0)	\$ -
MH Trust: Gov Cncl - Grant 1452.03 Autism Workforce Capacity Building	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (75.0)	\$ (75.0)
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 116.9	\$ -	\$ (110.1)	\$ (6.8)	\$ 0.0
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 44.2	\$ -	\$ (44.2)	\$ -	\$ -
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 50.5	\$ -	\$ (50.2)	\$ (0.3)	\$ (0.0)
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 54.4	\$ -	\$ (54.4)	\$ -	\$ -
Alaska Family Violence Prevention Project: the Connection between Dating Violence, Substance Abuse and Brain Development	\$ 250.0	\$ -	\$ -	\$ -	\$ 250.0
Sustaining Progress in Tobacco Prevention and Control	\$ -	\$ 200.0	\$ -	\$ -	\$ 200.0
Reverse ARRA funding for Prevention and Wellness and Communities Putting Prevention to Work	\$ -	\$ -	\$ (3,276.4)	\$ -	\$ (3,276.4)
Continuation of ARRA Funding for Prevention and Wellness	\$ -	\$ -	\$ 129.3	\$ -	\$ 129.3
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 113.4	\$ -	\$ (116.3)	\$ 2.9	\$ 0.0
Reverse Unrealizable ARRA authority	\$ -	\$ -	\$ (144.0)	\$ -	\$ (144.0)
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 149.5	\$ -	\$ (136.7)	\$ (12.8)	\$ -
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 108.5	\$ (85.4)	\$ (10.0)	\$ (13.1)	\$ -
Maintain Phase I Improvements of State Medical Examiner's Office Reforms	\$ 500.0	\$ -	\$ -	\$ -	\$ 500.0
Public Health Laboratory Financial Sustainability	\$ -	\$ 100.0	\$ -	\$ -	\$ 100.0
Correct Unrealizable Fund Sources for Personal Services Increases	\$ 50.3	\$ -	\$ (50.3)	\$ -	\$ -
Sustaining Progress in Tobacco Prevention and Control	\$ -	\$ 750.0	\$ -	\$ -	\$ 750.0
Public Health Total	\$ 3,764.7	\$ 964.6	\$ (4,013.8)	\$ (33.1)	\$ 682.4

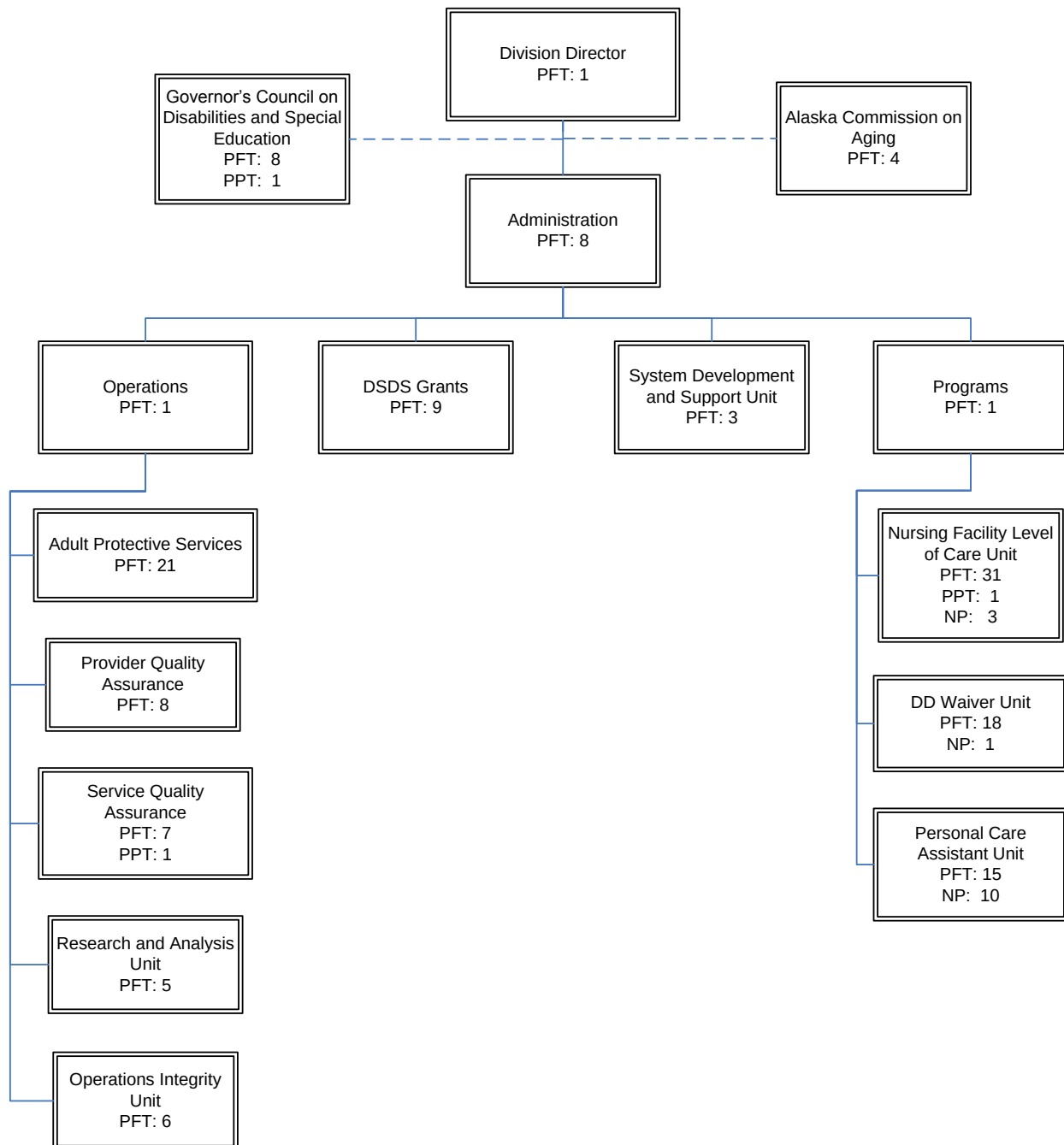
Division of Senior and Disabilities Services

Division Summary Structure

Total PFT: 146

Total PPT: 3

Total NP: 14



Introduction to the Division of Senior and Disabilities Services

Mission

To promote the independence of Alaskan seniors and persons with physical and developmental disabilities.

Overview

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, Personal Care Assistance, Traumatic Brain Injury services, Senior Services and Community Developmental Disabilities grants programs.

Core Services

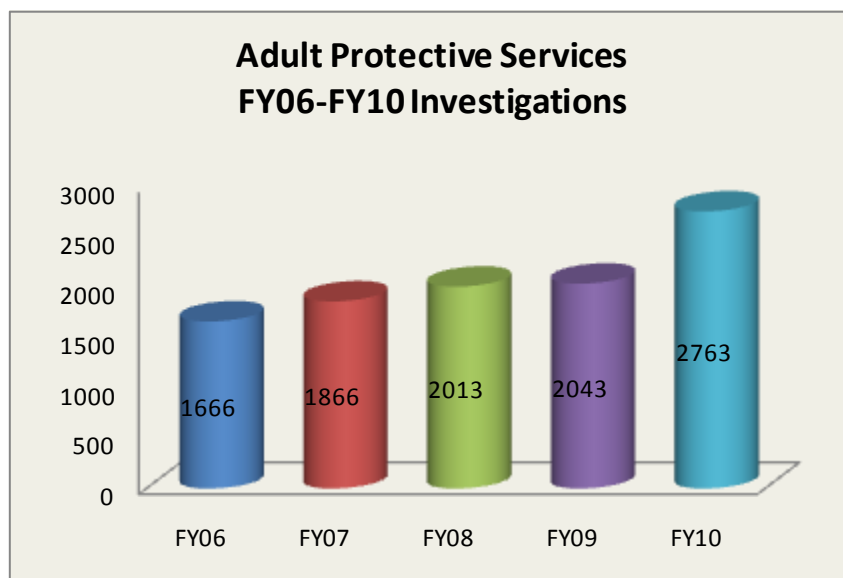
- Provide protection of vulnerable adults.
- Provide Nursing Facility Services that include placement in a nursing institution which provides either an intermediate or skilled level of nursing care.
- Provide Personal Care Services that support non-technical, hands-on assistance with activities of daily living (such as bathing, dressing, or grooming) and related instrumental activities of daily living (such as shopping or cooking) necessary to maintain the health and safety of the client in a home setting.
- Medicaid services include care coordination, chore services, adult day services, day habilitation, environmental modifications, meals, respite care, residential care in alternatives such as assisted living or group homes, specialized medical equipment, specialized private duty nursing, supported employment, and transportation.
- Provide Older Alaskan Waiver Services to Medicaid eligible persons aged 65 and older that need the level of care provided in a nursing home.
- Provide Adults with Physical Disabilities Waiver services to Medicaid eligible persons between the ages of 21 and 64 who need the level of care provided in a nursing home.
- Provide Mental Retardation/Developmental Disability Waiver services to Medicaid eligible persons with mental retardation, autism, cerebral palsy, seizure disorder, or a condition that means the person functions as if having mental retardation.
- Provide Children with Complex Medical Conditions Waiver services to Medicaid eligible persons age 21 or younger having a severe, life threatening, chronic physical condition that is expected to continue for more than 30 days. The child also must be dependent upon medical care or technology and need the level of care provided in a nursing home or hospital.

- Provide temporary assisted living for vulnerable adults over the age of 18, as referred by Adult Protective Services investigators or community health professionals.
- Provide grants to a statewide network of local agencies that provide a range of community based services to individuals 60 and over who are at risk of institutionalization due to declining health, disability, social isolation, poverty, or self-neglect. Services provide vulnerable seniors with basic necessities that dramatically increase their quality of life and allow them to “age in place.”
- Provide grants to rural-remote providers for supported residential living services to frail elders who do not have access to Pioneer Homes or other Long Term Care facilities in their community or region.
- Certification, monitoring and oversight of qualified Home and Community based service providers.
- Investigation of critical incidents and provider complaints related to the delivery of Home and Community based services.

Services Provided

Adult Protective Services (APS)/General Relief Temporary Assisted Living Program

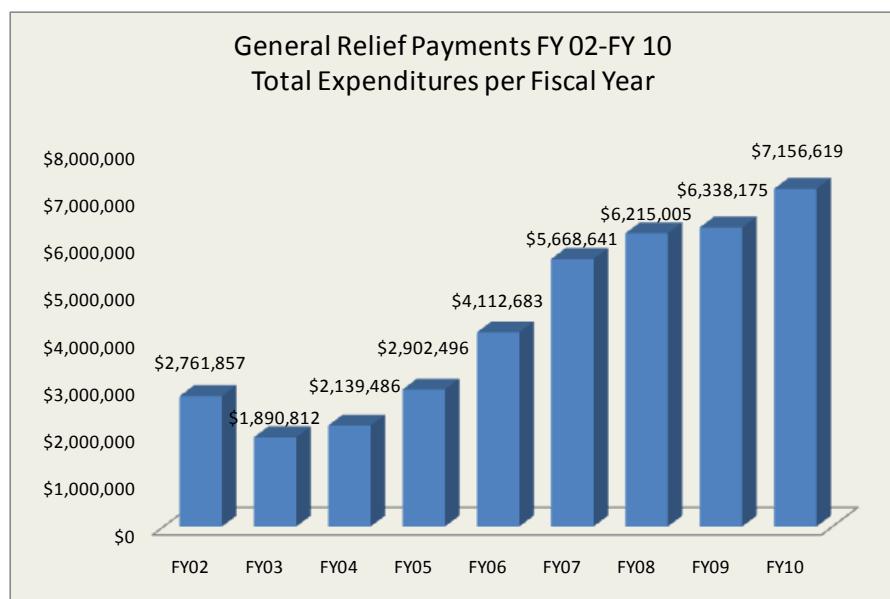
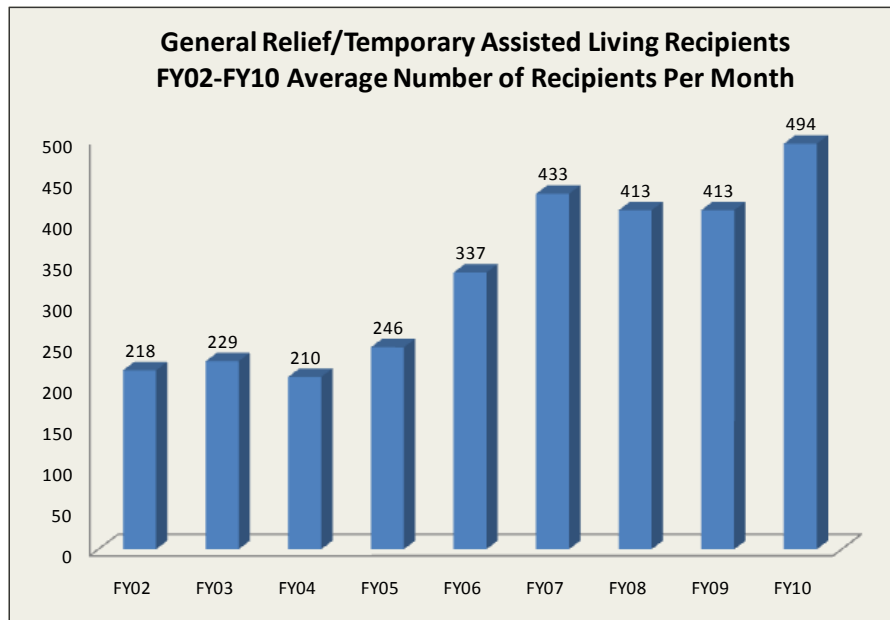
The Adult Protective Services Unit protects vulnerable adults over the age of 18 from abuse, neglect, and exploitation. APS staff investigate incidents in which a vulnerable adult suffers harm from abandonment, abuse, exploitation, neglect or self-neglect. Upon investigation of reports of harm, APS staff take appropriate action (up to and including removal from the client's home) to ensure that vulnerable adults are safe. The SDS APS Unit has responded to an increased number of reports over the past several years. APS investigations increased 12% from FY06 to FY07 and an additional 8% to FY08. The number of investigations increased another 1% in FY09 and 35% in FY10. The substantial increase in FY10 is attributed to SDS policies requiring reporting by Home and Community Based waiver providers and enhanced education to mandatory reporters.



The APS unit administers the General Relief/Temporary Assisted Living program to provide assisted living care to adults who need protective services, under the authority granted by AS 47.24.017. The General Relief program is intended to meet the most basic needs of many Alaskans who lack the personal resources to meet an emergent need and who are ineligible for assistance from other programs. The program provides residential care and financial assistance to needy adults who require the protective oversight of an assisted living home. The overall objective of the program is to enable these adults to obtain the level of care they would otherwise receive in their own home from friends or relatives and to live in the least restrictive setting possible.

In FY2010, SDS served an average of 494 individuals monthly through the General Relief / Temporary Assisted Living Program. The net expenditure, after recoupment efforts, was \$7,156,619. In total, 961 unique individuals were served throughout the year for an average expenditure of \$7,447 per individual. The average cost per recipient in FY2009 for 898 unique recipients was \$7,058. The increased utilization is reflective of longer lengths of stay and higher

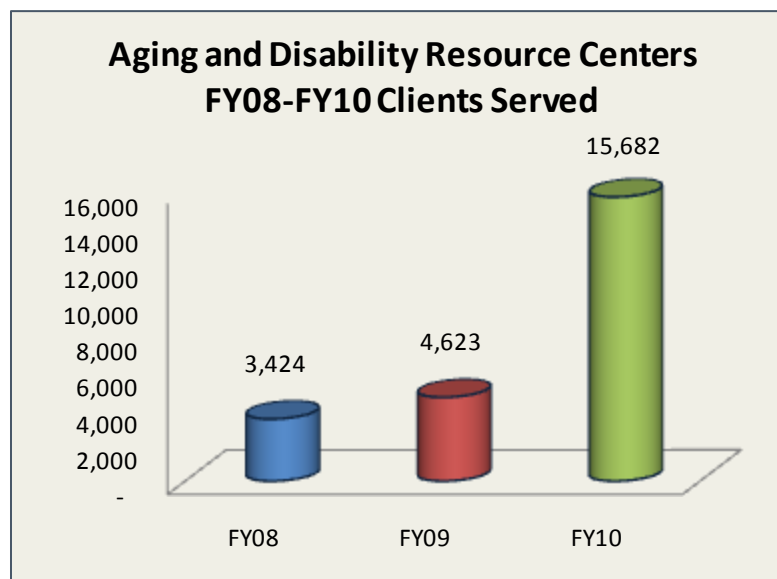
compensation to providers necessitated by increased medical and behavioral needs of recipients. The 7% increase in unique participants served in FY2010 is consistent with growth seen in other state benefits programs.



Aging and Disability Resource Centers (ADRCs)

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, ADRC federal grants, state general funds and Mental Health Trust funds, and will be in its third year of development in FY11.

The Alaska ADRCs continue to coordinate and collaborate within their communities and with statewide partners to build a strong network of providers, agencies, consumers, and caregivers so consumers can access long term support services through multiple entry points. The ultimate long term goal of the ADRCs is to centralize eligibility screening, comprehensive assessment, programmatic eligibility, financial eligibility determination, and access to long-term support services for private-pay consumers. The number of individuals ADRCs has provided information and assistance regarding long term care services to increased 35% between FY08 and FY09. In FY10 the number of clients ADRCs served jumped approximately 240% over FY09 from 3,424 to 15,682 individuals. The rapid growth in the number of clients served is attributed to a number of factors including additional staffing for existing ADRCs, increased outreach and networking to providers and community members and coordination with other community-based services. SDS anticipates the number of clients served in FY11 to increase but at a less significant rate.



Real Choice Systems Change (RCSC) Grant – Person-Centered Planning

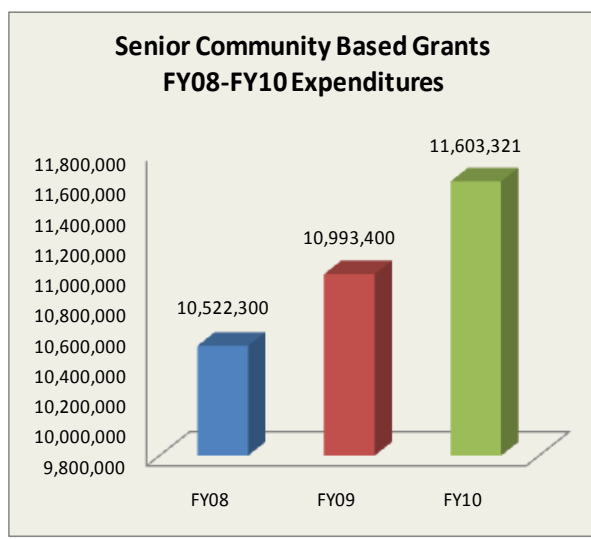
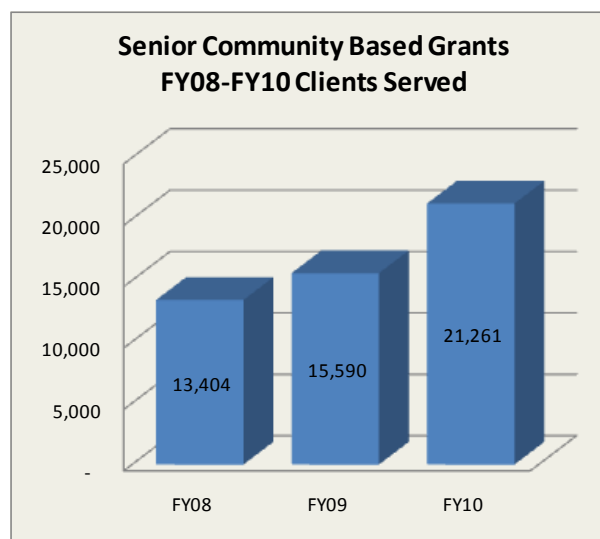
This Real Choice Systems Change grant was awarded to SDS in FY08 from the Centers for Medicare and Medicaid Services to develop and implement a person-centered Hospital Discharge Model and to enhance and expand Aging and Disability Resource Centers. Participating hospitals in three areas of the state are collaborating 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 Real Choice Systems Change grant is increasing communication between hospitals and Aging and Disability Resource Centers to bridge the gap between hospitalization and community-based services. The RCSC project has begun implementation of the Coleman Model, an evidence-based Care Transitions Intervention utilized at discharge that is shown to improve patient health outcomes and reduce hospital readmission rates. This pilot project will run through the end of 2011 with study results to be released in the Spring of 2012.

Senior Community-Based Grants

Programs funded through Senior Community Based Grants provide supportive services that assist individuals age 60 and older and their caregivers to remain independent in their homes and communities for as long as possible. These grant programs are developed under the Community-Based grants umbrella for seniors and follow the guidelines of the approved Alaska State Plan on Aging. Services 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.

Through the U.S. Department of Health and Human Services, Administration on Aging, SDS purchases Nutrition, Transportation and Support grant services for Alaskan seniors. With these grants community agencies provide a variety of needed services and supports to include congregate meals, homemaker services, and information and assistance. Grantees deliver nutritious meals to groups and to seniors in private homes, assist with transportation to enable seniors to maintain mobility and independence and promote health, nutrition and medication management. Foster Grandparent/Elder Mentor, Senior Companion, and Retired and the Senior Volunteer Programs further provide critical resources to Alaska's seniors and youth. Without these services many older adults would not be able to continue living at home and would need more expensive, less personal care.

The Senior and Community Based Grants programs have seen a steady increase in the number of clients served over past three years while the average funds available per client for the same time period has decreased. In FY08, over 13,400 seniors and caregivers received services statewide through these community-based programs at a total funding level of \$10,522,300 or approximately \$785 per client. The number of clients served in FY09 increased over 13% to 15,590. During this same period the total funding rose less than 5% to \$10,993,400, for a per client funding level of \$705. The number of clients served through the Senior and Community Based Grants program rose again from FY09 to FY10. This increase was over 36% to 21,261 clients served at a total cost of \$11,603,300 for the lowest per client funding level of \$546. This lower cost is a reflection of lesser services being delivered per client due to the increase in the number of seniors in need.



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 mental health funds, and the Administration on Aging Title III federal award for National Family Caregiver services.

Among Home- and Community-Based Care Grants program are Adult Day Services, which are furnished at a center for adults with impairments, primarily Alzheimer's disease or related disorders, and provided in a protective group setting that is facility-based. Therapeutic and social activities are designed to meet and promote the client's level of functioning through individual plans of care. Adult Day services provide support, respite and education for families and other caregivers, provide opportunities for social interaction and serve as an integral part of the aging network.

National Family Caregiver Support Program's services are available to the caregiver of anyone 60 and over or grandparents who are 55 and over raising grandchildren. Services include information and assistance accessing services, respite, caregiver support groups, caregiver training and supplemental services.

Senior In-Home Services include care coordination, chore, respite, extended respite and supplemental services.

The Alzheimer Disease and Related Disorders (ADRD) Education and Support Program provides outreach, information and referral, education, consultation and support provided to individuals with ADRD, their family caregivers, professionals in the field and the general public about ADRD.

Senior Residential Services

Through designated funding from the Alaska State Legislature, the division of Senior and Disabilities Services oversees two grants to rural-remote provider in Kotzebue (Maniilaq Association) and Tanana (Tanana Tribal Association), for supported residential living services to frail elders who do not have access to Pioneer Homes or other Long Term Care facilities in their community or region. Senior Residential facilities supported by these funds served 96 individuals in FY10. 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 Program

The Nursing Facilities Transition program provides support for services to elderly persons or individuals with a disability to transition from a nursing facility back into the community. Funds are available for one-time costs associated with the transition and may include items such as home or environmental modifications that will enable the client to get into their home; travel including room and board for caregivers to receive training, and the cost of trial trips home or to an assisted living home. The program also funds security deposits, the initial cleaning of a home, basic furnishings and other items that may be approved by the program's coordinator. In FY10, 42 transitions occurred at an average cost that ranged between \$1,200 and \$1,500 per person.

Community Developmental Disabilities Grants (CDDG)

The Community Developmental Disabilities Grant program minimizes institutionalization and provides care for people with developmental disabilities (DD). In FY10 developmental disabilities grants provided services to nearly 1,200 recipients across the state with conditions such as mental retardation, autism, or cerebral palsy. Services funded by these grants result in the acquisition or maintenance of skills to live with independence and improved capacity and reduce the need for long-term residential care. 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 supported employment, respite care, care coordination, day habilitation, case management, specialized adaptive equipment and independent living along with in-home supports. Behavioral training, intensive active treatment and vocational services may be provided through the program.

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 Mental Retardation/Mental Disability (MRDD) Waiver is designed to provide.

Other grant programs under the Community Developmental Disabilities Grant umbrella include The Short-Term Assistance and Referral Program (STAR). In FY10, 12 organizations were awarded funds to operate a STAR program to assist people with developmental disabilities and their families. Services were 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.

With funds from the Mental Health Trust Authority, mini-grants for beneficiaries with developmental disabilities are a one-time award made to individuals. The awards, not to exceed \$2,500 per recipient, are for health and safety needs not covered by grants or other programs to help beneficiaries attain and maintain healthy and productive lifestyles.

In the Community Developmental Disabilities Grant component, Behavioral Risk Management Services address difficult behaviors through technical assistance and training. These services are designed 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.

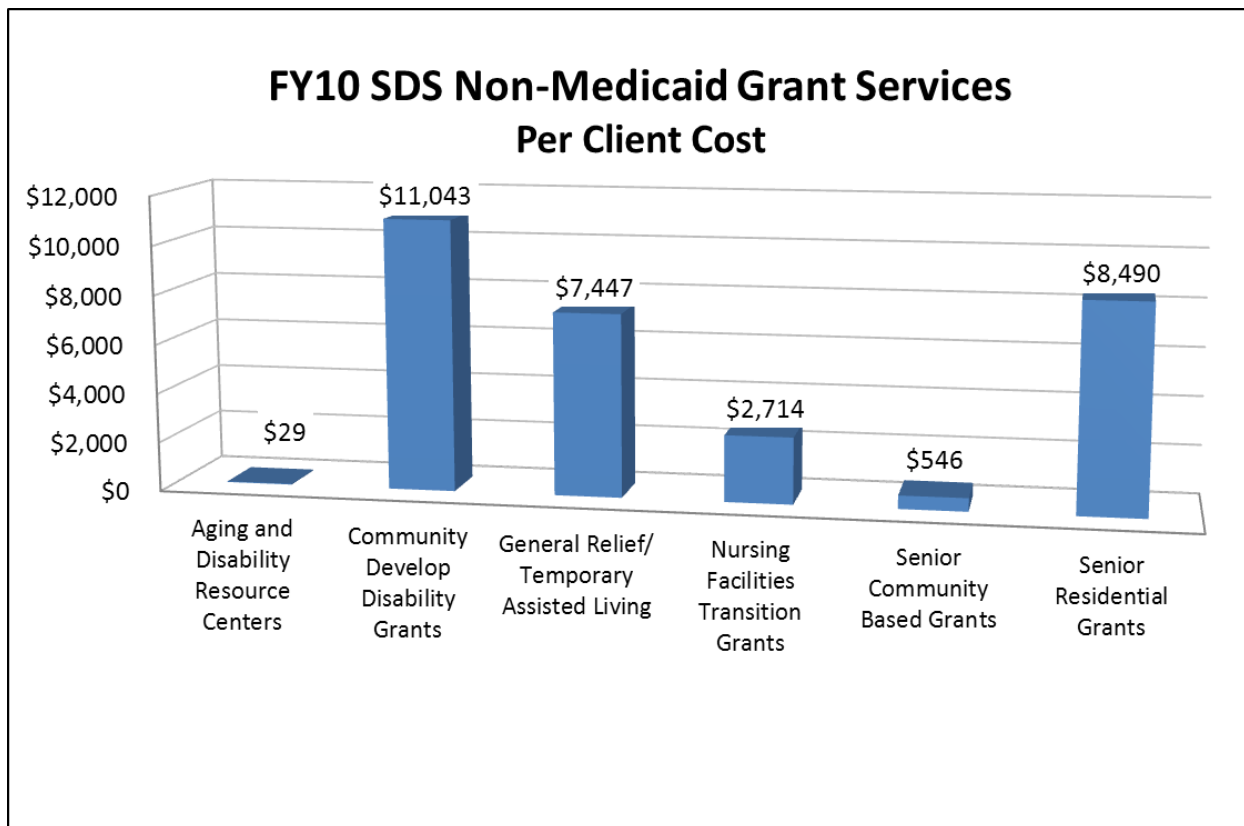
State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program, or SHIP, offers one-on-one counseling and assistance to people with Medicare and their families. Through a federal grant from the Centers for Medicare and Medicaid Services, the SHIP program provides free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. The program also offers one-on-one counseling on enrolling and navigating the various parts of Medicare. Public outreach and education about Medicare services are provided through two Senior and Disabilities staff and a network of statewide Medicare volunteers working in the aging network. There were 7612 encounters with individuals during FY10.

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). These funds support a variety of outreach strategies used by SDS staff to educate and empower Alaskans to identify, prevent and report health care fraud. The SMP program empowers seniors through increased awareness and understanding of healthcare programs. This knowledge helps seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error and abuse. These activities support AOA and the division's goals of promoting increased choice and greater independence among older adults. The activities of the SMP program also serve to enhance the financial, emotional, physical and mental well-being of older adults — thereby increasing their capacity to maintain security and independence in retirement, and to make better financial and healthcare choices. This program has assisted around 5,000 beneficiaries, or about 10% of eligible Alaskans.

FY10 SDS Non-Medicaid Grant Services		
Grant	Clients Served	Total Expenditure
Aging and Disability Resource Centers	15,682	460,719
Community Develop Disability Grants	1,200	13,251,165
General Relief/Temporary Assisted Living	961	7,156,619
Nursing Facilities Transition Grant	42	114,000
Senior Community Based Grants	21,261	11,603,321
Senior Residential Grants	96	815,000
Total	39,242	33,400,824



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

The APD waiver 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

The CCMC waiver is for children, birth through age 21, who have a severe chronic physical condition that is expected to continue for more than 30 days. The 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

The MRDD waiver 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

The OA waiver 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.

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

There are two division care coordinators who each carry an assigned case load of about 25 of the most difficult to serve waiver recipients. 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 assessment and service plan are both completed by division staff. 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 of Senior and Disabilities Services is responsible for the initial admission 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 Administrative Wait days & 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.

Quality Assurance

In the Division of Senior and Disabilities Services, the Quality Assurance Unit ensures the quality of services provided to Alaskan seniors, disabled individuals, and vulnerable adults. This unit oversees the Certification staff for Senior and Disabilities, evaluates program performance through audits and surveys, and provides technical assistance. The Quality Assurance Unit, collects feedback on the quality of services provided as well as responds to and investigates complaints of inappropriate service provisions and/or noncompliance with program guidelines.

This unit works closely with division's Adult Protective Services staff and other state agencies to ensure the health and welfare of SDS service participants and manages the critical incident reporting system. The Quality Assurance Program also manages and maintains the Quality Improvement Work plan under the direction of the Quality Assurance Steering Committee and Quality Assurance Workgroup.

Annual Statistical Summary of Services Provided in FY10

Senior and Disabilities Medicaid and Waiver Services

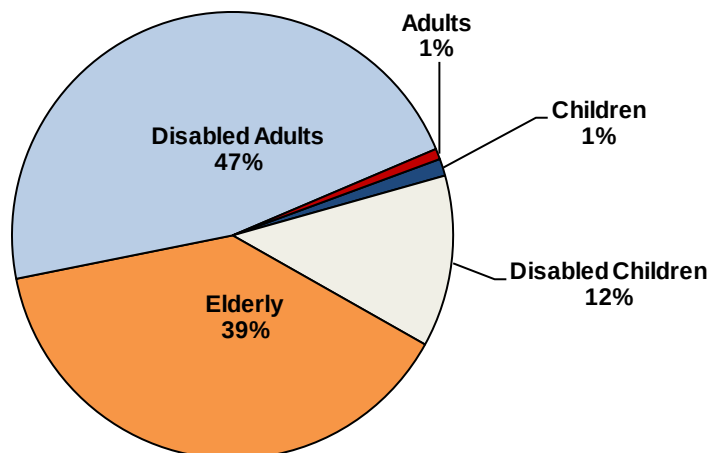
The Senior and Disabilities Services Medicaid program funded benefits for 8,282 Medicaid beneficiaries during FY2010, with total expenditures of \$362,733.0. This equates to an average annual claim cost of approximately \$44,000 per recipient during FY10.

FY10 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%	105	377.7%	\$1,370.0	\$13,048
Disabled Children	12.4%	1055	4319.3%	\$15,667.6	\$14,851
Elderly	38.8%	3,287	39159.0%	\$142,042.9	\$43,214
Disabled Adults	46.8%	3,968	55987.7%	\$203,086.1	\$51,181
Adults	0.8%	65	156.2%	\$566.7	\$8,718
Unduplicated Annual Clients		8,282			
Total Medicaid Claim Payments (thousands)				\$362,733	
Average Annual Medicaid Cost per Beneficiary					\$44

In FY10 in excess of 85% of Medicaid services were provided to adults, with 47% of those beneficiaries disabled and 39% elderly. The division provided 13% of Medicaid services in FY10 to children. 12% of those children were disabled.

FY2010 Senior and Disabilities Services Medicaid Beneficiaries by Benefit Group



Source: MMIS-JUCE data.

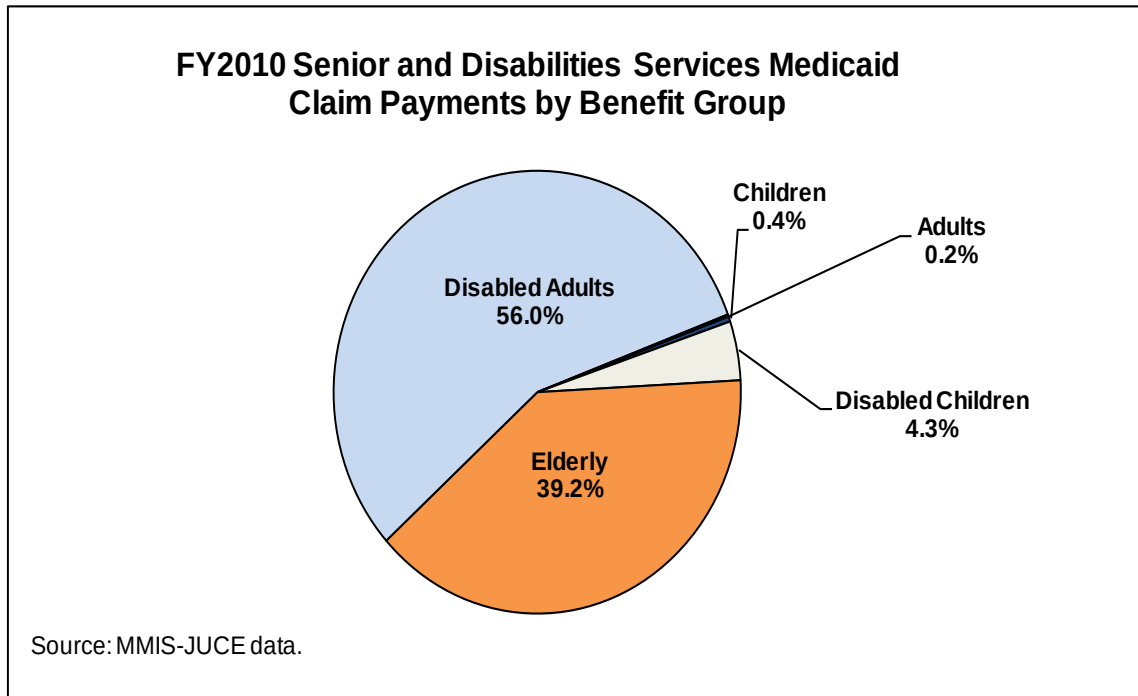
Senior and Disabilities Medicaid provides services to Alaskans of all ages. For all programs, close to 85% of all beneficiaries were 21 years of age or older and served at a total cost of \$336,256.3 or \$44,915 per beneficiary. In FY10, 15% of all beneficiaries were under 21 years of age. These clients were served at a total cost of \$26,477.0 for a per-beneficiary cost of \$20,189.

FY10 SDS Medicaid and Waiver Services by Program and Age Group

Age Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost per Beneficiary
All Senior and Disabilities Medicaid					
Under 21	15.8%	1,315	7.3%	\$26,477.0	\$20,189
21 or Older	84.2%	7,028	92.7%	\$336,256.3	\$44,915
Nursing Home Services					
Under 21	0.7%	7	0.9%	\$716.6	\$69,320
21 or Older	99.3%	961	99.1%	\$82,752.4	\$79,593
Personal Care Attendant Services					
Under 21	3.0%	120	3.7%	\$3,496.5	\$26,593
21 or Older	97.0%	3,886	96.3%	\$91,389.1	\$21,342
Home and Community Based Waiver Services					
Adults with Disabilities Waiver					
Under 21	3.0%	44	2.9%	\$973.4	\$14,964
21 or Older	97.0%	1,422	97.1%	\$32,346.0	\$21,524
Children with Complex Medical Conditions Waiver					
Under 21	91.5%	236	84.4%	\$9,174.6	\$40,014
21 or Older	8.5%	22	15.6%	\$1,690.2	\$41,526
Mental Retardation/Developmental Disability Waiver					
Under 21	29.1%	384	12.1%	\$11,855.0	\$30,937
21 or Older	70.9%	935	87.9%	\$86,306.8	\$84,920
Older Alaskans Waiver					
Under 21	0.0%	0	0.0%	\$0.0	\$0
21 or Older	100.0%	1,721	100.0%	\$41,687.5	\$23,503
Other Waiver Services					
Under 21	51.6%	690	75.5%	\$260.8	\$304
21 or Older	48.4%	647	24.5%	\$84.4	\$131

Source: MMIS/JUCE claims paid during FY 2010. Waiver data not corrected for the IHS waivers journal entries.

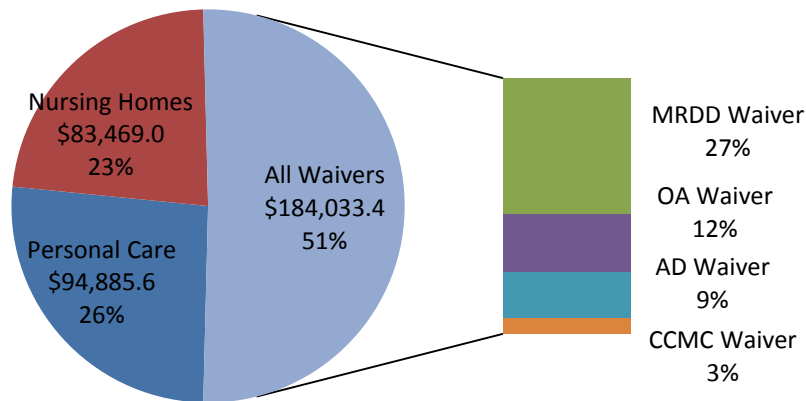
Benefits provided to children comprised 4.7% of claim payments while benefits provided to adults comprised 56.1%. Services provided to the elderly were 39.2% of the Senior and Disabilities Services Medicaid claim payments.



The Division of Senior and Disabilities Services served 1,246 recipients through the Adult with Physical Disabilities Waiver program at a cost of \$23,200 per recipient. Approximately 250 participants were served through the Children with Complex Medical Conditions Waiver program at a cost of \$45,000 per participant. Through the Mental Retardation/ Developmental Disabilities Waiver program, 1,363 recipients were served at a cost of \$74,700 per recipient. SDS also served 1,737 seniors through the Older Alaskans Waiver program at a cost of \$24,200 per senior.

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 51% of SDS Medicaid costs in FY10. Nursing home and personal care claim payments accounted for about 23% and 26% of costs, respectively.

Senior and Disabilities Medicaid Services FY 2010 Claim Payments by Service Category



.Source: MMIS/JUCE data
Excludes waiver

Nursing home care is by far the most expensive long-term care service per person at an annual average Medicaid cost of \$86,200 per beneficiary. This increase is approximately 8% over FY09, when the average Medicaid cost was \$79,900 per beneficiary. Medicaid costs per beneficiary for Skilled Nursing beds were more than four times the average costs for Adults with Disabilities, Children with Complex Medical Conditions and Older Alaskans waiver services combined and also nearly four times the average for personal care assistance services. The per beneficiary cost for personal care assistance services grew from an average of \$21,600 in FY09 to an average of \$23,750 in FY10. The increase equates to not quite 10%. The division also saw a rise in the per-beneficiary cost of Home and Community Based Waiver Services. In FY09 these services averaged \$36,600 per beneficiary. In FY10 the services reached \$41,800 per beneficiary, an increase of approximately 14.2%. The average cost of all Senior and Disabilities Medicaid services per beneficiary also increased from FY09 to FY10. In FY09 average cost per beneficiary of \$41,800 jumped to \$43,800 in FY10, or approximately 5%.

SDS Medicaid and Waiver Services Cost per Beneficiary

Service Category	Cost per Beneficiary per Year	Percent of Beneficiaries
Nursing Home Services	\$86,200	10.0%
Personal Care Assistance Services	\$23,750	41.0%
Home and Community Based Waiver Services	\$41,800	49.0%
All Senior and Disabilities Medicaid, cost per beneficiary per year	\$43,800	
All Senior and Disabilities Medicaid, unduplicated annual beneficiaries		8,282

Source: MMIS/JUCE for claims paid during fiscal year 2010. 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, 36%, in FY10, followed closely by Adults with Physical Disabilities, 31% and Mental Retardation/Developmental Disabilities, 27%. The Children with Complex Medical Conditions waiver had the lowest number of participants with only 5% of waiver beneficiaries.

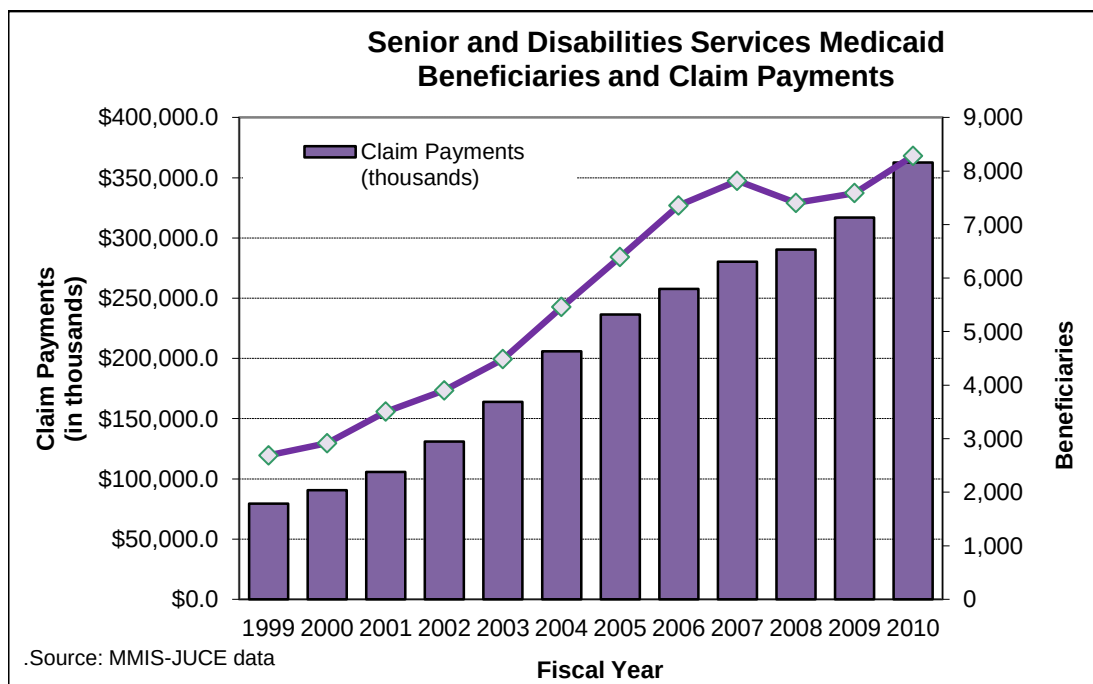
The Home and Community Based Waiver program costs per beneficiary ranged from \$22,800 for Adults with Physical Disabilities Waiver services to \$76,700 for Mental Retardation and Developmental Disabilities Waiver services.

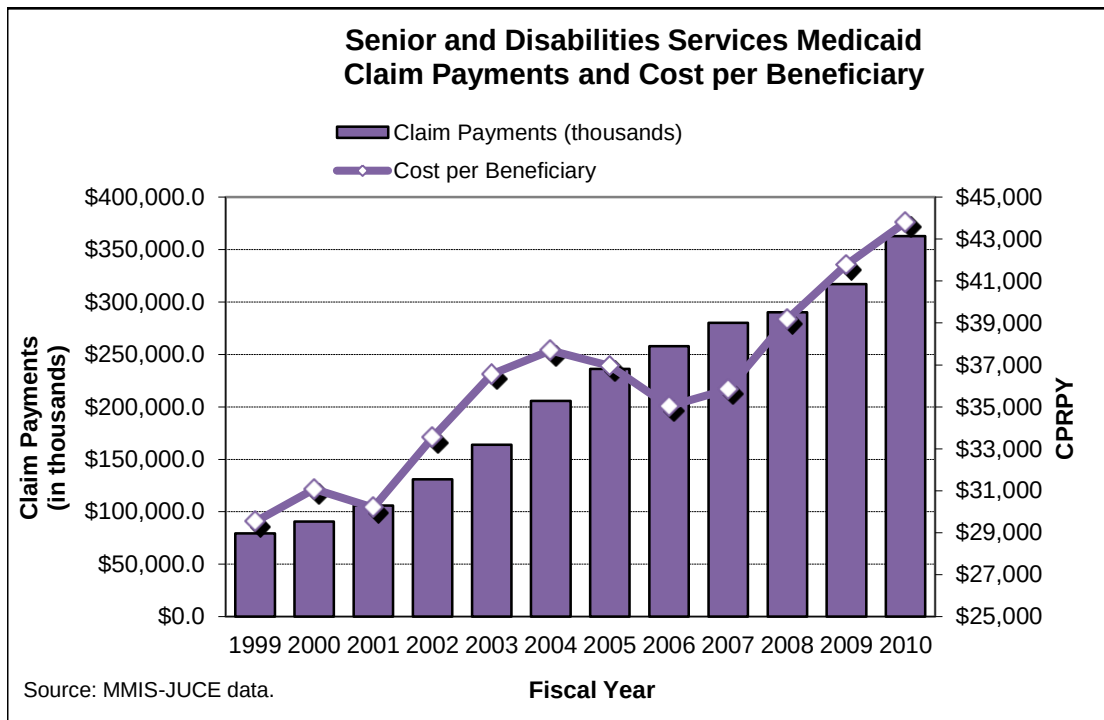
SDS Medicaid Waiver Cost per Beneficiary by Waiver Program

Home and Community Based Waiver	Cost per Beneficiary per Year	Percent of Waiver Beneficiaries
Adults with Physical Disabilities	\$22,800	31.0%
Children with Complex Medical Conditions	\$43,600	5.3%
Mental Retardation/Developmental Disabilities	\$76,700	27.2%
Older Alaskans	\$24,200	36.5%
All Home and Community Based Waivers	\$43,800	100.0%

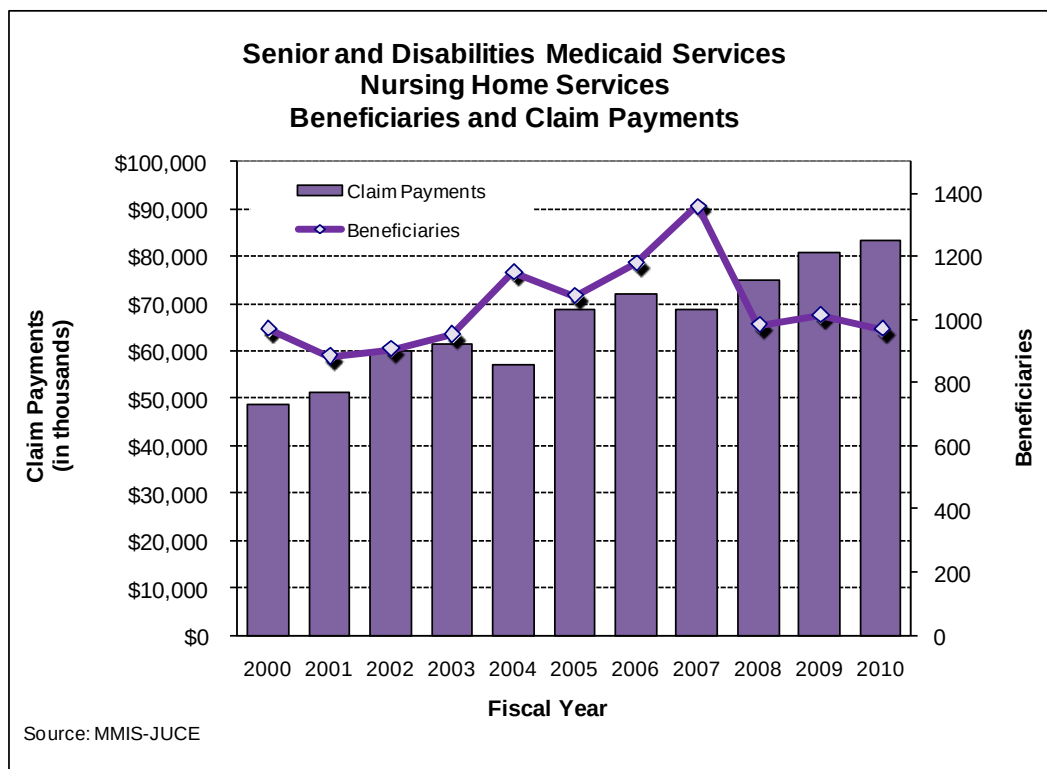
Source: MMIS/JUCE for claims paid during fiscal year 2010.

Total claim payments for Senior and Disabilities Medicaid services in FY10 increased by 14.2% from FY09. The number of beneficiaries using any Senior and Disabilities Medicaid service increased in excess of 9% while the annual cost per beneficiary increased by almost 5% to \$43,800. The division saw an increase in all services in FY10.

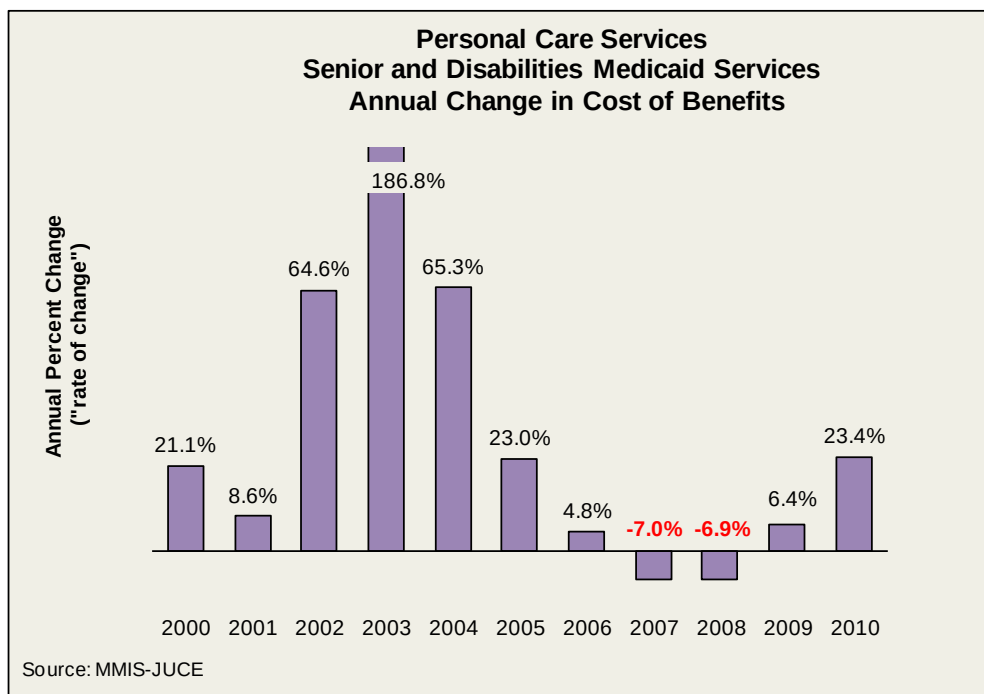
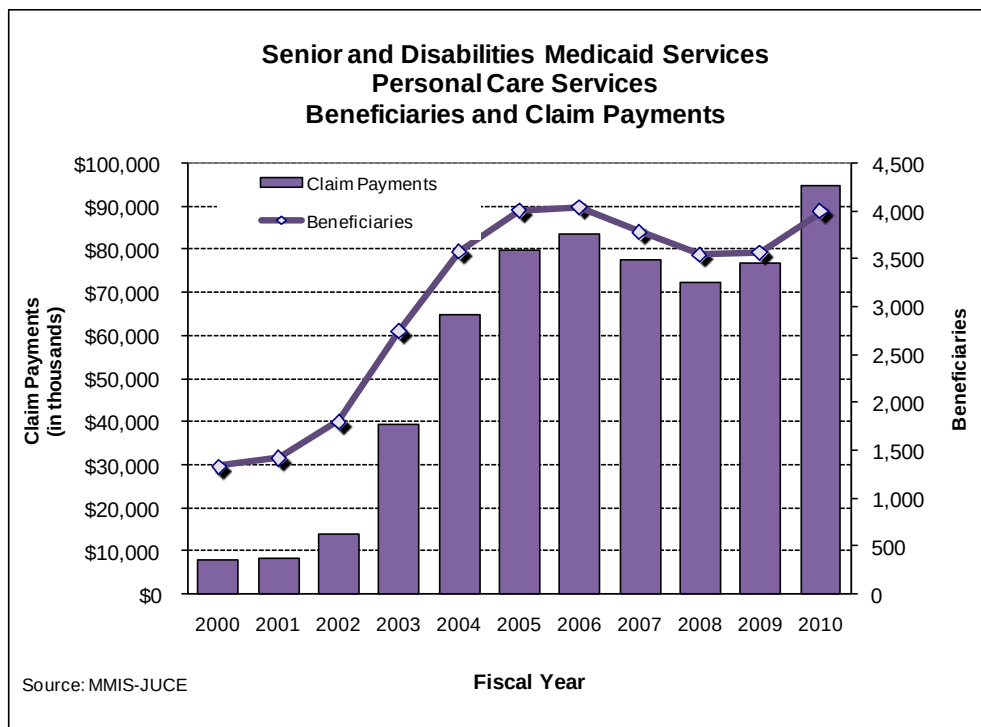




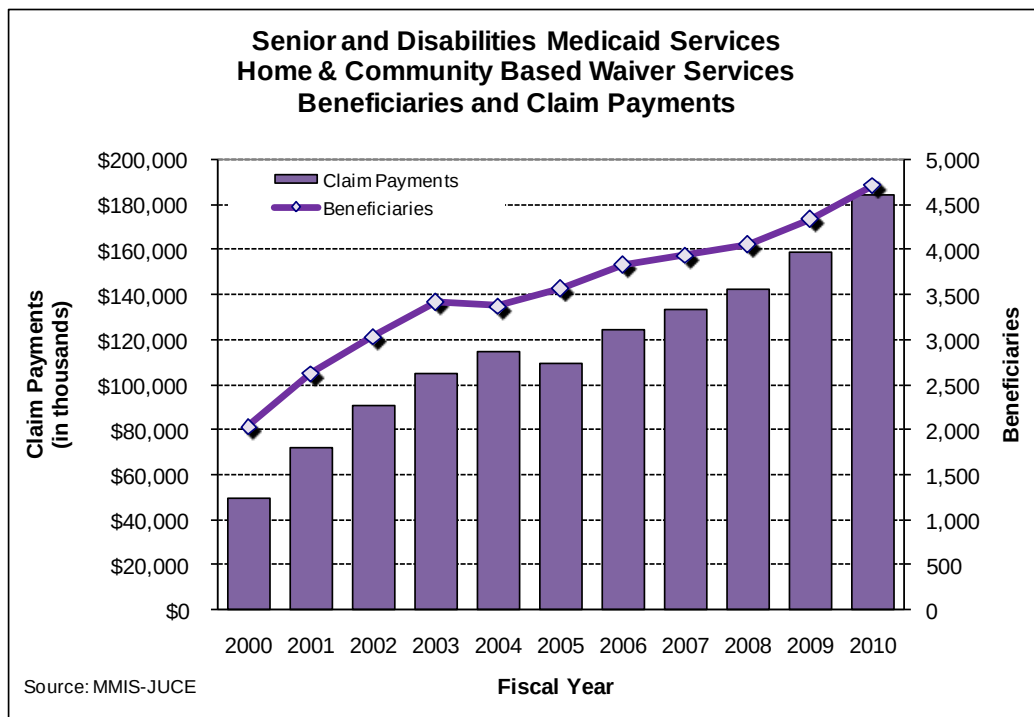
Total nursing home costs increased about 3% in FY10. The number of Medicaid beneficiaries using nursing home services decreased slightly by 4% and the annual nursing home Medicaid cost increased by 8% per beneficiary.



Between FY2009 and FY2010 the number of PCA recipients increased by 12.1%. The average utilization per recipient in FY2010 increased by 10.1% over FY2009. SDS, in collaboration with Health Care Services (HCS), is instituting PCA renderer enrollment. Enrollment of individual Personal Care Attendants will allow improved oversight by SDS and HCS in the areas of qualified providers and utilization of services. The combined effect of the increased average utilization per recipient and the increased number of recipients had the net effect of a 23% increase in paid claims.



Combined claim costs for all home- and community-based waiver services increased by 11% between FY08 and FY09. These waiver services increased over 13% between FY09 and FY10. The number of beneficiaries using any waiver service at some time during the fiscal year increased by about 4%.



FY 2010 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		8,282		\$362,733,288	\$43,798	6.6%	30.5%
Gender							
Female	58.1%	4,815	57.7%	\$209,386,908	\$43,486	6.8%	31.3%
Male	41.9%	3,475	42.3%	\$153,346,380	\$44,128	6.3%	29.4%
Unknown	0.0%	0	0.0%	\$0	\$0	0.0%	0.0%
Race							
Alaska Native	19.7%	1,635	23.4%	\$84,749,232	\$51,834	3.4%	19.3%
American Indian	1.3%	112	1.2%	\$4,277,783	\$38,194	5.6%	24.0%
Asian	12.8%	1,065	9.3%	\$33,625,531	\$31,573	13.1%	50.4%
Pacific Islander	4.3%	354	3.1%	\$11,365,553	\$32,106	8.8%	40.2%
Black	4.3%	354	4.0%	\$14,441,421	\$40,795	5.1%	27.4%
Hispanic	2.7%	222	2.1%	\$7,755,797	\$34,936	4.8%	26.7%
White	49.5%	4,118	53.1%	\$192,744,860	\$46,805	8.4%	36.8%
Unknown	5.5%	455	3.8%	\$13,773,111	\$30,271	13.4%	40.5%
Native	21.1%	1,747	24.5%	\$89,027,015	\$50,960	3.5%	19.5%
Non-Native	78.9%	6,542	75.5%	\$273,706,273	\$41,838	8.6%	37.3%
Age							
under 1	0.3%	27	0.0%	\$48,383	\$1,792	0.2%	0.0%
1 through 12	9.0%	798	2.6%	\$9,338,967	\$11,703	1.6%	4.9%
13 through 18	4.8%	425	2.9%	\$10,510,454	\$24,730	2.0%	6.2%
19 through 20	2.0%	176	1.8%	\$6,579,163	\$37,382	3.7%	19.8%
21 through 30	6.9%	612	12.2%	\$44,075,166	\$72,018	4.2%	30.2%
31 through 54	19.0%	1,674	24.3%	\$88,229,518	\$52,706	8.9%	34.8%
55 through 64	14.1%	1,248	12.7%	\$46,128,340	\$36,962	22.9%	41.7%
65 through 84	32.4%	2,862	30.5%	\$110,732,577	\$38,691	38.2%	79.2%
85 or older	11.3%	998	13.0%	\$47,090,720	\$47,185	69.8%	93.2%
Benefit Group							
Children	1.2%	105	0.4%	\$1,370,039	\$13,048	0.1%	0.3%
Adults	0.8%	65	0.2%	\$566,686	\$8,718	0.3%	0.4%
Disabled Children	12.4%	1,055	4.3%	\$15,667,601	\$14,851	44.6%	24.2%
Disabled Adults	46.8%	3,968	56.0%	\$203,086,078	\$51,181	25.4%	51.2%
Elderly	38.8%	3,287	39.2%	\$142,042,883	\$43,214	43.7%	83.8%
Location (DHSS Region)							
Anchorage/Mat-Su	64.6%	5473	75.6%	\$211,753,473	\$38,691	8.7%	34.5%
SouthCentral	13.8%	1173	23.0%	\$64,465,094	\$54,957	6.6%	37.4%
Northern	8.1%	689	11.4%	\$31,847,261	\$46,222	4.3%	24.7%
Western	3.2%	269	3.6%	\$10,209,046	\$37,952	1.4%	7.6%
SouthEast	8.9%	750	15.6%	\$43,642,502	\$58,190	6.3%	32.9%
Out of State or Unknown	1.4%	119	0.3%	\$815,911	\$6,856	5.5%	10.2%

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 2010 (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 2009, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2010.

Location is based on residence of the recipient or enrollee, not the location where service was provided.

*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.

Introduction to the Alaska Commission on Aging

Mission

To ensure the dignity and independence of all older Alaskans, and to assist them through planning, advocacy, education, and interagency cooperation to lead useful and meaningful lives.

Overview

The Alaska Commission on Aging (ACoA) was established in 1982. The ACoA plans services for older Alaskans and their caregivers, educates Alaskans about senior issues and advocates for the needs of older Alaskans. The Department of Health and Social Services is the federally designated State Unit on Aging. The responsibilities that come with this designation are carried out by the Division of Senior and Disabilities Services (DSDS) with the Alaska Commission on Aging.

The ACoA consists of eleven members, seven of whom are public members, (with six members being 60 years and older), appointed by the Governor to serve four-year terms. Two seats are filled by the Commissioners of the Departments of Health and Social Services (DHSS) and Commerce, Community and Economic Development, or their designees. The remaining seats are reserved for the Chair of the Alaska Pioneer Homes Advisory Board and a senior services provider, regardless of age. The Commission is supported by an office staff of four, including the Executive Director, two Planners, and an Administrative Assistant.

Core Services

The ACoA provides five core services to help older Alaskans retain their dignity and independence while living in their homes and communities for as long as possible. These core services include:

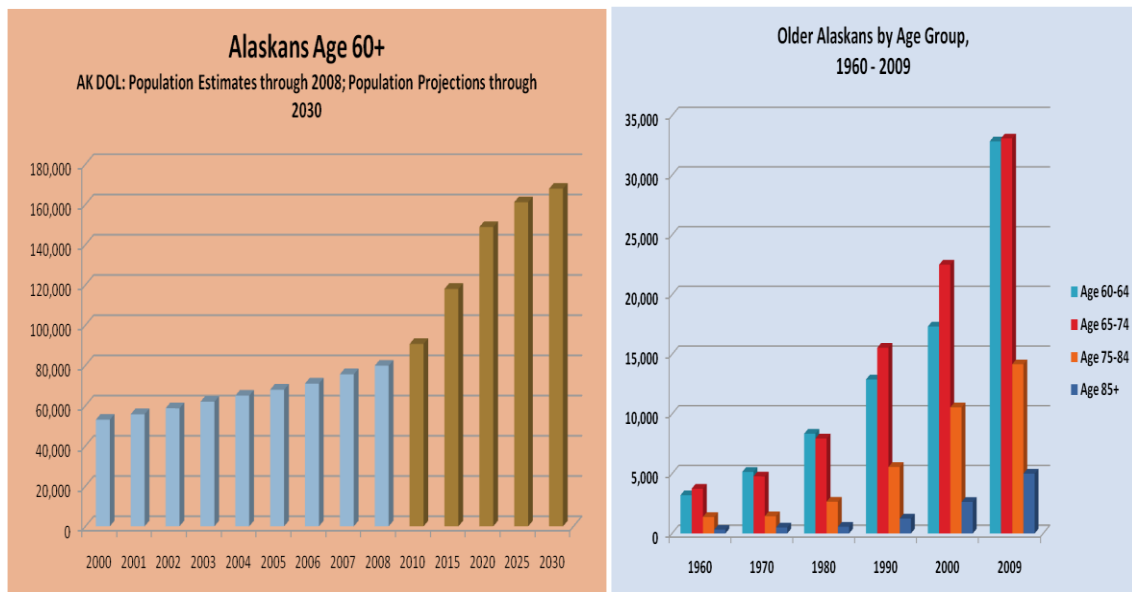
- Providing advisory recommendations to the Governor, the Legislature, and Administration for policies, programs and services that serve the needs of older Alaskans and their family caregivers.
- Preparing a comprehensive four-year state plan for senior services in accordance with the Older Americans Act, implementing the Plan in collaboration with agency partners as well as participating in the ongoing planning and implementation of the Comprehensive Integrated Mental Health Plan.
- Collaborating with the DHSS, the Alaska Mental Health Trust Authority (AMHTA) and other stakeholders on policy development.
- Advocating for laws, policies and programs to improve services for all older Alaskans.
- Promoting public awareness of aging issues and trends and providing information to the public and policy makers on senior issues including health, financial security, and housing.

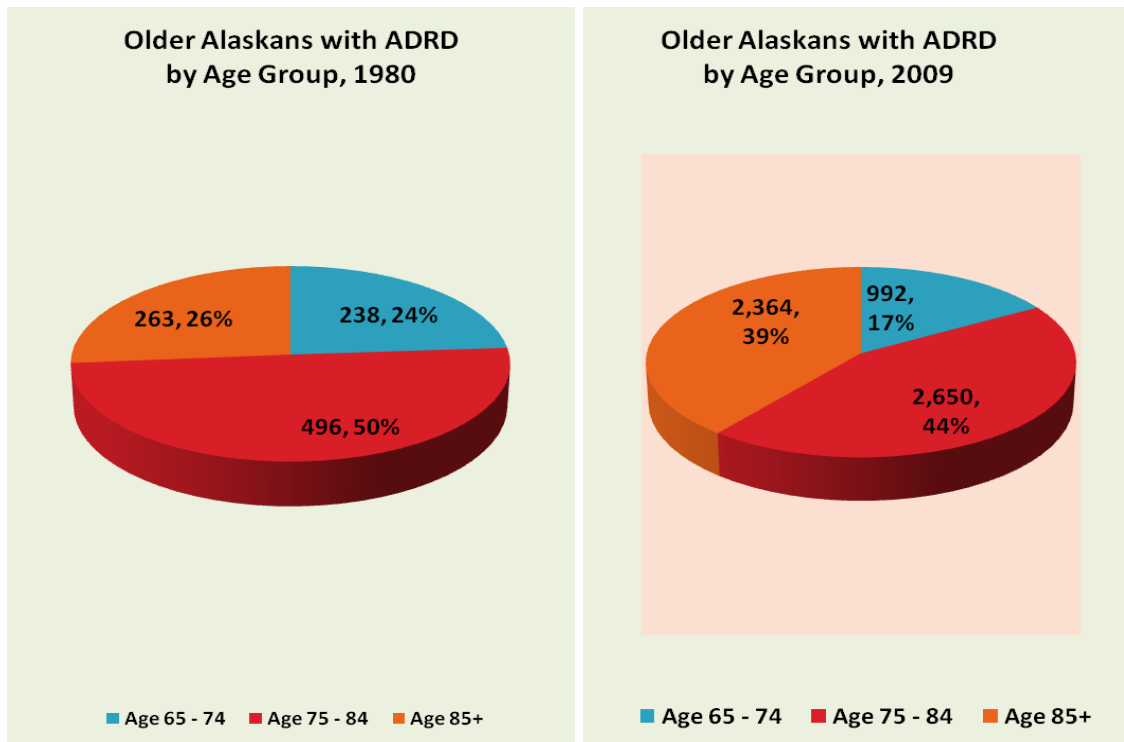
Services Provided

ACoA's services are organized under its mission areas of planning, advocacy, public awareness/community education, and inter-agency collaboration.

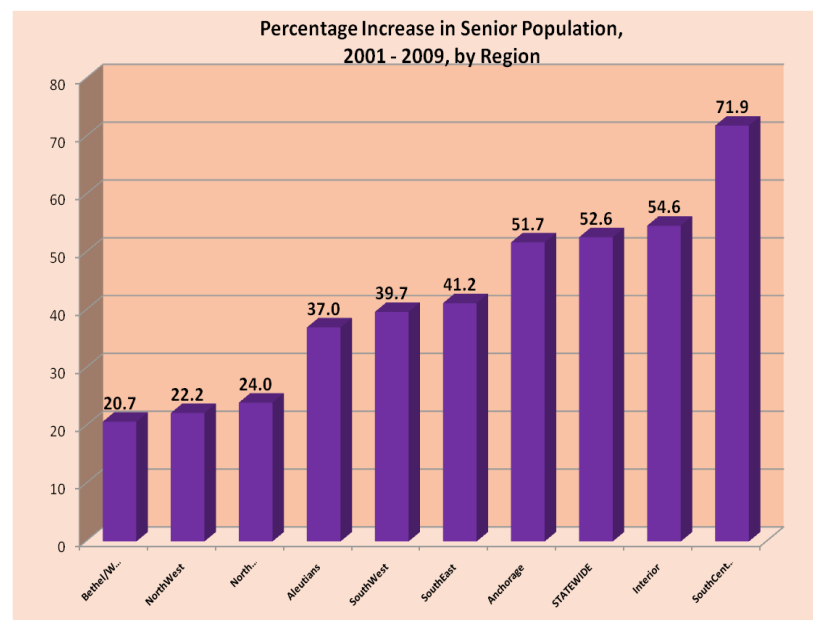
Planning

For the second year in a row, Alaska has the fastest-growing senior population, (persons age 60 years and older) of all states. While in the past, Alaskans chose to leave the state after retirement, more retirees are choosing to remain in Alaska close to their family, friends, and preferred lifestyle. The Alaska senior population has grown by over 60% in the last 10 years due to aging of the baby boomers (persons born between 1946-1964 who comprise about one-third of Alaska's population), increased life expectancy, and changes in migration patterns (although more seniors move out of the state than move in, out-migration is slowing). By 2030, the proportion of seniors 65+ will double to comprise 13% of the Alaska population with those of age 60+ making up 17% of the population. The oldest group of seniors, those age 85 and older, is expected to almost triple during the next 25 years, significantly increasing the number of Alaskans with Alzheimer's disease and related dementias (ADRD).





Rates of senior growth have increased significantly for DHSS's nine regions with all regions experiencing double-digit growth in the last eight years.



The ACoA is currently developing the new four-year state plan for senior services, FY 2012-2015, in coordination with agency partners and consumers as required by the U.S. Administration on Aging for states receiving federal funds under the Older Americans Act. The ACoA also advises the AMHTA on policy and funding for programs that serve individuals with Alzheimer's disease and related dementias (ADRD), seniors with behavioral health needs, and older adults with chronic mental illness.

Advocacy

ACoA advocates on behalf of older Alaskans and their caregivers to ensure that they have access to services when they need them and where they need them so that Alaska seniors may live with dignity and independence for as long as possible. The ACoA works in partnership with state agencies, the Legislature, and the Governor to provide resources, recommendations, and support on behalf of Alaska seniors. We also work closely with local senior advisory commissions and stakeholder groups to ensure that the voices of older Alaskans and their caregivers are heard.

The Commission is committed to representing the interests of and promoting well-being for all older Alaskans. Board members and staff testify at legislative hearings, prepare letters of support, and communicate regularly with legislators, legislative staff, the Governor and executive staff, as well as Alaska's federal delegation to convey the perspectives of older Alaskans and their caregivers throughout the year. Through ACoA's legislative teleconferences, newsletters, website, and other media, the Commission provides information and support to seniors, family caregivers, and senior advocates so that they may have the tools to effectively communicate their points of view to their elected officials.

Inter-Agency Coordination

The ACoA partners with the DHSS, the AMHTA, divisions, and other advisory bodies in preparing and implementing the state plan for senior services, developing projects to promote disease prevention and healthy lifestyles that encourage senior participation, participating in long-term care planning efforts, and implementing evidence-based strategies to address senior behavioral health conditions.

Public Awareness/Community Education

The ACoA uses a variety of methods to educate the public, the administration, and elected officials about the needs of Alaska's elderly citizens and the social and economic resources that older Alaskans bring to improve the communities where they live. Our vision for older Alaskans is based on the belief that older people should have the opportunity to fully participate in all aspects of society and community life, be able to maintain their health and independence, and live in their own homes and communities for as long as possible in the least restrictive setting. The Healthy Body/Healthy Brain Campaign and the Senior Fall Prevention Campaign are examples of public awareness efforts that focus on ways to promote health and reduce injury for Alaska seniors. ACoA collaborates annually with senior advisory commissions to celebrate May as "Older Alaskans Month" and with the Mature Alaskans Seeking Skills Training Program to recognize "Employ Older Alaskan Workers Week." We also participate in the "You Know Me Campaign" with the AMHTA and advisory boards to reduce stigma associated with ADRD, mental illness, and substance abuse and to encourage all Alaskans to seek treatment and services.

On the Horizon: Challenges & Opportunities

Alaska and Alaska seniors are confronting a range of challenges in the near-term and long-range future that require comprehensive and thoughtful planning to provide services in a respectful manner to uphold the dignity and independence of older Alaskans. Alaska seniors are culturally, ethnically, and socio-economically diverse reflecting the wide range of Alaskan lifestyles. As we prepare to meet the demands of a growing aging population, some of the challenges before us as a state are access to quality health care and long-term care supports, a system to help consumers make informed decisions about long-term care, sufficient funding for programs and services, efforts to promote elder safety against exploitation and abuse, income security for seniors, workforce development in all health care and supportive service industries, transportation, and housing.

Alaska is one of the most advanced states to emphasize a balance between home- and community-based services and institutionalized care for older persons. While other states built nursing homes and other institutional care facilities to care for their elderly, Alaska has been in the forefront, investing in a continuum of long-term support services, ranging from community services and in-home support measures to assisted living and nursing home facilities. This approach is not only less costly but most desired by older Alaskans and their families who want access to services close to home. An increasing emphasis on health promotion, chronic disease prevention, and management of chronic diseases provides the opportunity to help older Alaskans enhance their physical, mental, and emotional health while avoiding, delaying, or minimizing the effects of chronic disease and higher-cost health care services. Additionally, healthy eating, physical exercise, social involvement, and information on ways to prevent falls strongly support seniors' health.

The aging of the Baby Boomer generation, which has now entered its senior years, is expected to bring new energy, intensity, and models of support into senior services. While the population surge created by this will be a challenge to the long-term care infrastructure, it is also likely to prompt more innovative approaches to senior needs.

Older Alaskans enrich the lives of all Alaskans and their communities. Alaska seniors provide a wealth of experience, wisdom, caregiving, volunteer time, and cash contribution to the state that totaled almost \$1.7 billion in 2009 from retirement income, health care spending, and other income sources. While public policy often focuses on the cost of services for seniors, their social and economic contributions should not be overlooked.

Introduction to The Governor's Council on Disabilities and Special Education

Mission

To create change that improves the lives of Alaskans with disabilities

Overview

The Governor's Council on Disabilities and Special Education (Council) conducts capacity building, systems change and advocacy activities that help Alaskans with developmental and other severe disabilities, students receiving special education services and infants and toddlers with disabilities live safe, healthy and productive lives in their local communities. The Council is comprised of 28 members appointed by the Governor; of these 28, a minimum of 60% must be individuals with developmental disabilities and/or family members. The remaining 40% are policymakers or representatives of entities designated in federal law.

Core Services

- Advocate the needs of individuals with disabilities before the executive and legislative branches of state government, the congressional delegation and the public.
- Advise the executive and legislative branches of state government, the congressional delegation and the private sector on programs and policies pertaining to current and potential services to individuals with disabilities and their families and the development of appropriate early intervention and special education programs and services for children with disabilities.
- Review and comment on, prior to adoption, state plans and proposed regulations relating to programs and services for persons with disabilities.
- Provide recommendations to the Alaska Mental Health Trust Authority for the integrated comprehensive mental health program and the use of funds on the mental health trust settlement income account; and submit budget recommendations for services provided to individuals with disabilities.
- Implement the capacity building, systems change and advocacy activities outlined in the Council's five-year strategic plan to improve services for Alaskans with disabilities and their families.
- Monitor and evaluate budgets or other implementation plans and programs for individuals with disabilities to assure non-duplication of services and encourage efficient and coordinated use of federal, state and private resources in the provision of services.
- Collect and analyze data about programs and services impacting the quality of life of people with developmental and other severe disabilities, students receiving special education services, and infants and toddlers with disabilities.
- Evaluate programs for consumer satisfaction, efficiency and effectiveness.
- Assist individuals with disabilities and their families to speak on their own behalf and on behalf of others in the development of regulations and legislation.
- Provide support to assist individuals with developmental disabilities to become leaders and to participate in cross-disability coalitions.

Services Provided

Services provided by the Council can be grouped into three main categories: Capacity Building, Systems Change and Advocacy.

Capacity Building

Capacity building is activity that seeks to enhance or increase the ability and skills of individuals, organizations, service providers and communities to support Alaskans with disabilities to live safe, healthy and productive lives in their local communities.

Major accomplishments in FY10 include helping plan and/or co-sponsor the Alaska State Special Education Conference, the Early Childhood Mental Health Conference, the Early Childhood Networking Forum, the Healthcare and Human Services Career Fair, the Full Lives Conference, Career X – A Career Exploration Day (formerly Disability Mentoring Day); and helping coordinate the Real Economic Impact Tour (578 individuals with disabilities received free tax return assistance and 115 people claimed the Earned Income Tax Credit, resulting in \$128,549 in Earned Income Tax Credits and \$581,302 in total refunds).

Systems Change

Systems change is activity focused on creating sustainable, permanent change across systems (i.e., developmental disabilities, early intervention/infant learning program, special education, vocational rehabilitation) to better meet the needs of Alaskans with disabilities.

Major accomplishments in FY10 include holding a Self-Employment Policy Summit where participating agencies and entities agreed to sustain successful component of the StartUp Alaska project through policy development, continued capacity building and resource leveraging; and co-sponsoring six community forums with Senior & Disabilities Services and the Alaska Commission on Aging to secure input from individuals with disabilities, seniors, families and service providers about ways to improve quality assurance, monitor health and wellness of service recipients, conduct provider oversight and prevent conflicts of interest.

Advocacy

Advocacy is activity focused on informing policymakers about the needs of Alaskans with disabilities, proposing policy solutions and mobilizing stakeholders to participate in the democratic process.

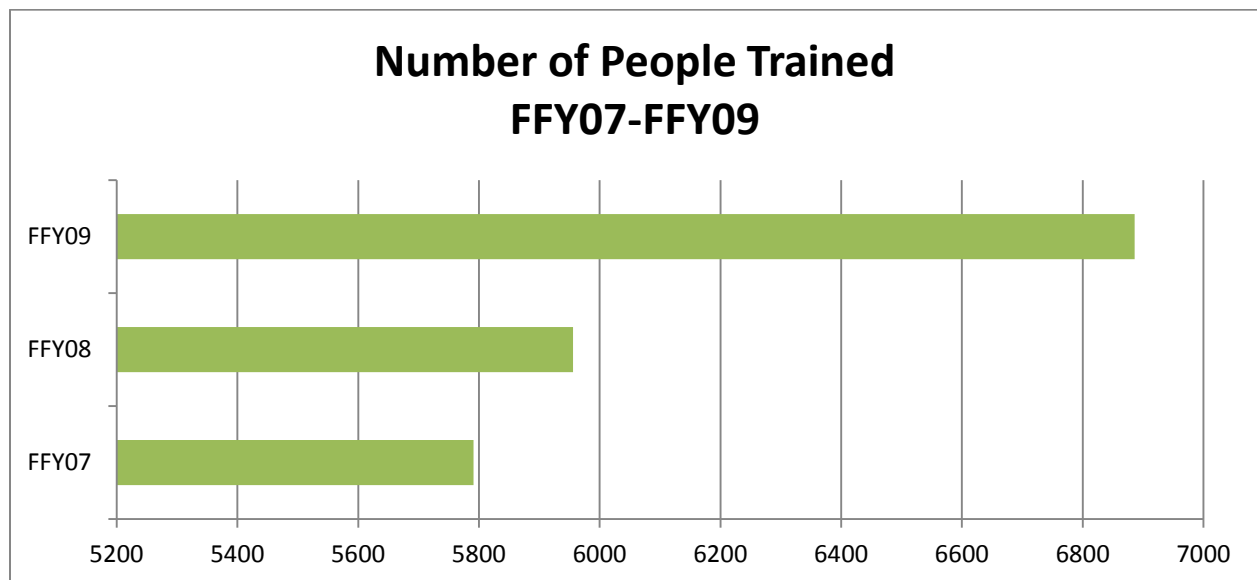
Major accomplishments in FY10 include providing public comment to the State Board of Education & Early Development and coordinating testimony by self-advocates with developmental disabilities, resulting in the replacement of “Mental Retardation” with “Cognitive Disabilities”, and the installation of videophones for the deaf in state government offices, thereby ensuring they have the same access to state resources as hearing Alaskans.

Annual Statistical Summary of Services Provided in FY10

The Council collects and reports data on a federal fiscal year (October 1 – September 30) for the federal Administration on Developmental Disabilities (ADD); an annual Performance Program Report is submitted by January 1 of each year.

Capacity Building

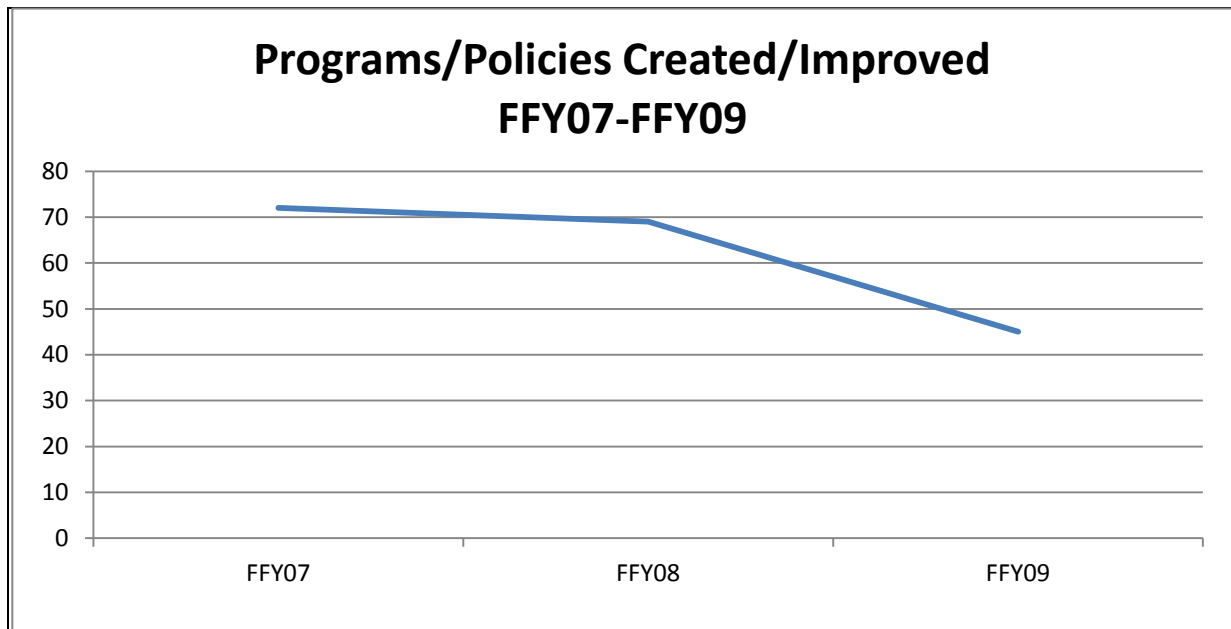
The following graph reports the number of people who received training as a result of Council activities. The Council works with a variety of different entities and organizations to plan, sponsor or co-sponsor, and/or provide training across a number of life domain areas, including employment, housing, health care, early intervention, education, health, community participation, transportation, workforce development, self-determination and advocacy.



As can be seen, the number of people trained has increased significantly over the past three years. This has most likely occurred because of new partnerships the Council has entered into to increase the number of people with disabilities who are self-employed, better meet the needs of Alaskans with Autism Spectrum Disorder, increase access to assistive devices and services that will enable people with disabilities and seniors live more independently at less cost in the community and better meet the needs of women with disabilities who are the victims of sexual or physical assault or stalking.

Systems Change and Advocacy

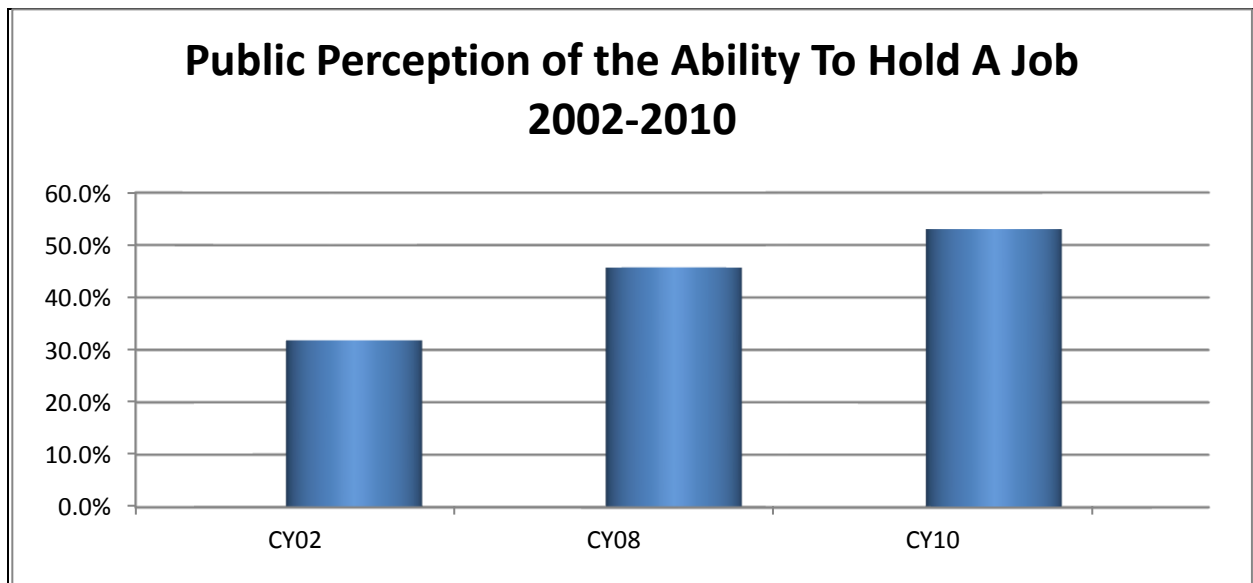
The next graph reports the number of programs and/or policies created or improved as a result of Council's systems change and advocacy activities. The Council works with a variety of stakeholders to improve service delivery systems for people with disabilities, including systems designed specifically for people with disabilities as well as those available to all Alaskans, including but not limited to employment, housing, health care, early intervention, education, health, community participation and transportation.



As can be seen, the number of programs and policies created or improved has decreased considerably over the past three years. This may reflect the significant amount of time and advanced preparation it takes to make systems change. Advocacy alone is not enough to make systems change; viable solutions to barriers must also be identified so they can be presented to policymakers for consideration and hopefully, adoption. The Council anticipates that the number of programs and policies created or improved will increase in state fiscal years 2011 and 2012. Several initiatives and projects that Council has spearheaded over the past several years such as the StartUp Alaska project, the Five-Part Autism Initiative, the Alaska Works Initiative and the Alaska Safety Planning Empowerment Network are shifting from a focus on capacity building to a focus on sustainable systems change.

Public Awareness

The following graph show changes in attitudes toward Alaskans with developmental disabilities. The Alaska Mental Health Trust Authority commissioned several studies by Hellenthal & Associates in 2002 and 2010 (a different contractor was used in 2008) to measure public attitudes toward its beneficiaries, which include people with developmental disabilities, mental illness, Alzheimer's disease or other dementias, brain injury or alcoholism. The surveys were conducted through random telephone surveys.



As can be seen, the public perception of the ability of Alaskans with developmental disabilities to hold down a job improved considerably since 2002. Although part of this change is most likely due to the Alaska Mental Health Trust Authority's media campaign, some is also attributable to the Council's capacity building, systems change and advocacy work. One of the Council's major initiatives over the past 10 years has been focused on increasing the employment rate of Alaskans with disabilities and increasing the awareness of the ability of people with disabilities to work.

Explanation of FY12 Operating Budget Requests

The Council currently has several projects or initiatives that are funded with “soft” federal grants or Mental Health Trust Authority Authorized Receipts (MHTAAR), which will end in FY12 and result in less funding for Council activities. Unless other funds are secured, the loss of these funds will severely impact the ability of the Council to implement its capacity building, systems change and advocacy agenda, particularly in the area of employment, justice for crime victims and the recruitment and retention of direct service staff who assist individuals with disabilities to live more independent and productive lives in the community. The consequences of the Council’s inability to adequately address these issues means that the high unemployment rate of Alaskans with disabilities compared to the general population is unlikely to continue to decrease as it has in recent years. Additionally, disability providers and victim services providers are less likely to meet the needs of victims with disabilities, and individuals with disabilities will not receive the services and supports they need to be independent, productive members of their communities at the right time, which may result in the need for higher cost services.

The Council will receive a \$25,000 increase in MHTAAR funding for the microenterprise program, which will result in an additional 3-5 individuals with disabilities receiving start-up funds to launch their own businesses.

Challenges

In FY12, the Council will be implementing a new strategic plan that outlines its capacity building, systems change and advocacy agenda for the next five years. The goals, objectives and strategies will be based on input received directly from Alaskans with disabilities and their families, advocates, service providers, state agencies and other stakeholders. Although the State of Alaska can be justifiably proud of its commitment to serving people with disabilities in their homes and communities rather than in costly institutions, more remains to be done.

According to the new survey sponsored by Kessler Foundation and National Organization on Disability, lifestyle and economic gaps still remain between Americans with and without disabilities. Although there have been substantial improvement reported in education attainment and political participation since 1986, large gaps still exist between people with and without disabilities with regard to employment, household income, transportation, health care, socializing, going to restaurants and satisfaction with life. Although the size of the gaps may be different in Alaska, the same gaps likely exist between Alaskans with and without disabilities. The major challenge not only for the Council, but also for the State of Alaska, is translating these findings into actions and policies that will improve the lives of thousands of Alaskans with disabilities in the future. Emphasis needs to be placed on properly equipping Alaskans with disabilities with tools, skills and opportunities they need to succeed and live the same everyday lives as Alaskans without disabilities. As Rodger DeRose, President and Chief Executive Office of Kessler Foundation stated, “A great deal of innovation and passion exists, but we have yet to come together as a community to talk through these issues and deliver solutions for the largest minority group in the nation.”

List of Primary Programs and Statutory Responsibilities

AS 14.30.231	Education, Libraries and Museums, Advisory Panel
AS 14.30.610	Education, Libraries and Museums, Governing Board
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 47.45.200-290	Alaska Commission on Aging
AS 47.65	Service Programs for Older Alaskans and Other Adults
AS 47.65.100	Adult Day Care and Family Respite Care
AS 47.80.010 – 900	Persons with Disabilities
AS 47.80.030-090	Welfare, Social Services & Institutions, 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
PL105-17	Part B and C Individuals with Disabilities Education Act
PL106-402	Administration on Developmental Disabilities Act
Title XVIII	Medicare
Title XIX	Medicaid
7 AAC 100	Medicaid Eligibility
7 AAC 105	Medicaid Provider and Recipient Participation
7 AAC 43.125.010-199	Personal Care Services
7 AAC 130.200-319	Home and Community-Based Waiver Services
7 AAC 72.010 – 900	Civil Commitment
7 AAC 78.010 – 320	Grant Programs
42 CFR, Part 400 to End	
42 CFR, Part 440 Code of Federal Regulations, Services: General Provisions	
45 CFR, Part 1321 Code of federal Regulations	

Explanation of FY12 Operating Budget Requests

Division of Senior and Disabilities Services

Budget Overview Table

Senior and Disabilities Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds	\$35,598.3	\$37,765.8	\$2,167.5
Designated General Funds	0.0	0.0	0.0
Federal Funds	16,512.4	17,452.3	939.9
Other Funds	2,729.3	2,439.5	(289.8)
Total	\$54,840.0	\$57,657.6	\$2,817.6

Budget Requests

Senior and Disabilities Services Administration

Waiver Corrective Action Plan Recovery and Program Stabilization:

\$1,250.0 Total - \$750.0 GF Match; \$500.0 Federal Receipts

The Division of Senior and Disabilities Services (SDS) requests \$1,250.0 towards the projected \$1.8-\$2.2 million budget shortfall resulting from ongoing operating expenses required to meet program needs. SDS utilizes long-term, non-permanent employees to complete essential job functions, required by state and federal laws, to operate and manage the Home and Community Based Waiver programs. SDS is required to conduct face-to-face assessments annually for all Waiver participants (approximately 3,000) in their homes, to review and approve annual care plans and any amendment presented throughout the year.

Failure to provide this funding will mean SDS will have to dismiss staff in an effort to balance the budget, leaving the required work undone and recipients/waiver participants at risk. In addition, consequences will include an inability to access the programs for new applicants and non-compliance with Federal waiver requirements resulting in the Centers for Medicare and Medicaid Services potentially not renewing the waivers and civil litigants taking SDS back to court for failing to meet our court-mandated timeline obligations for conducting critical elements of waiver management.

Personal Care Assistance Staff Conversion and Program Stabilization:

\$950.0 Total - \$750.0 GF Match; \$200.0 Federal Receipts

The division requests \$950.0 to ensure compliance with initial assessment and annual reassessment requirements for the personal care attendant program. This will allow funding for employees to address assessment and reassessment needs and the burgeoning document management of the program that has grown 16% in the last fiscal year.

Approximately 3,000 individuals are currently on the Personal Care Assistance Program and are not also on a Waiver program. They must be reassessed face-to-face in their homes annually. Failure to provide this funding means that those beneficiaries currently eligible for services based on their functional limitations and vulnerability without assistance will not be assessed annually for eligibility for continued benefits. Additionally, for the more than 100 new applicants for services each month, an assessor will not be able to timely assess individuals for their eligibility for the benefit. Failure to conduct timely annual assessments and timely initial eligibility determinations may jeopardize the health and welfare of this vulnerable population.

Senior and Disabilities Services Assessment/Waiver Units Stabilization and Expansion: \$450.0 GF

This increment ensures staffing needs are met for employees to conduct and manage the documentation/paperwork requirements, prior authorization and overutilization management for the waiver initial assessments and annual reassessments for the Older Alaskans and Adults with Physical Disabilities waiver programs. This increment will allow staff in the Assessment Unit to manage the required paperwork, including the assessments, level of care determinations and completed plans of care that must be mailed to each participant pursuant to timelines established in Superior Court.

Failure to fund this increment will result in the inability of the Assessment and Waiver units to process prior authorizations, analyze services overutilization, manage the paperwork requirements, and cause SDS to be out of compliance with federal and state requirements, potentially leading to the loss of the waiver programs and a return to Superior Court for breach of settlement terms.

MH Trust: Housing - Rural Long Term Care Development: \$140.0 MHTAAR

This project has been a technical assistance resource through Senior and Disabilities Services for several years. It has successfully worked with rural communities to analyze long-term care needs and locate 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 include participation in the Aging and Disability Resource Center project and ongoing technical assistance for development and operational issues, in order to ensure successful feasibility analysis of projects and to result in an increase in home- and community-based service delivery capacity in rural Alaska.

MH Trust: Brain Injury - Traumatic Brain Injury Program Research Analyst: \$136.0 MHTAAR

There are more than 10,000 Alaskans living with disability due to brain injury. There are currently 262 Alaskans with Acquired Traumatic Brain Injury each year that qualify for medical assistance. The current State of Alaska and statewide resources available to best prevent, treat, and support (long-term) Alaskans after brain injury are extremely scarce; they do not meet the current needs or the increasing demand. Without the proper resources Alaskans with brain injury are at risk of job loss, divorce, substance abuse, bankruptcy, and homelessness; often negatively impacting many State of Alaska departments and service systems. The passage of SB 219 (an

act establishing an Acquired/ Traumatic Brain Injury Program and Registry within the Department of Health and Social Services; and relating to medical assistance coverage for traumatic and acquired brain injury service) has given DHSS statutory and regulatory authority to address the many service gaps. Funding, staffing, planning infrastructure, and development expertise, are imperative to successfully meet the requirements of SB 219. These requirements will provide the foundation to then work (collaboratively) to reduce the incidence of brain injury and minimize the disabling conditions through the expansion of services and supports for TBI survivors and their families.

Senior Community Based Grants

MH Trust: ACoA - Aging and Disability Resource Centers: \$125.0 MHTAAR

Older Alaskans, persons with disabilities, and family caregivers require a reliable source for information and referral on how to access a wide range of services (related to health, home care, financial support, housing, transportation, equipment and other needs) which is critical to help individuals through a crisis or change in circumstance. With the rapidly increasing number of older Alaskans, demand for access to this information is growing, while the current ADRCs are minimally funded and staffed. ADRCs are federally mandated as the entrance into the state's long-term care services delivery system and are identified as a strategy under the Department of Health and Social Services' priority for long-term care. ACoA recommends an increment to SDS's budget to continue the ADRCs and to build their capacity to provide formalized options counseling, eligibility screening, assessment procedures, and to expand services into an area not covered by the existing ADRCs.

Community Developmental Disabilities Grants

MH Trust: Benef Projects - Mini Grants for Beneficiaries with Disabilities: \$227.5 MHTAAR

The Mini-grants for Beneficiaries with Disabilities program has been funded by the Trust since FY99 and is administered through Senior and Disabilities Services grantees under the Short Term Assistance and Referral projects. 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 and dental, and 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.

The FY12 MHTAAR increment (\$227.5) maintains the FY11 funding level & momentum of effort.

Commission on Aging

MH Trust: Cont - ACOA Planner: \$91.0 MHTAAR

This project funds one of the two Alaska Commission on Aging (ACOA) planner positions. The planner is responsible for supporting the Executive Director in coordination between the ACOA and the 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: Cont - Research Analyst III: \$110.0 MHTAAR

The Research Analyst III is a continuing project to provide the Governor's Council on Disabilities & Special Education with information about the needs of individuals with developmental disabilities. The position and associated travel and operating funds help ensure Council activities are conducted within the framework of the Mental Health Trust Authority's guiding principles while still meeting Congressional requirements. The Research Analyst is a staff member of the Governor's Council and funds go directly to the Council.

The Council is federally funded to fulfill specific roles mandated by Congress. It is an expectation of the Trust that the Council will participate in planning, implementing and funding a comprehensive integrated mental health program that serves people with developmental disabilities and their families. The position enables the 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.

The FY12 MHTAAR increment (\$110.0) maintains the FY11 funding level & momentum of effort.

MH Trust: Benef Projects - Microenterprise Capital: \$125.0 MHTAAR

The Trust Microenterprise fund has provided beneficiaries with a unique avenue to access startup funding for microenterprises. The fund was designed to provide an option for beneficiaries that might not be eligible for startup funding assistance through traditional paths including banks, credit unions and other traditional lending sources. This project provides resources for small business technical assistance and development to provide ongoing support to individuals with a disability establishing small businesses and self-employment. The Governor's Council on Disabilities and Special Education will administer this grant. 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 beneficiary self-employment and economic independence. Due to the success of this program, FY12 funding recommendation is increasing to allow for more beneficiary small business start-up grants.

Challenges

The Division of Senior and Disabilities Services faces many on-going and new challenges in FY12. 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.

Capacity development is a key need for many Alaskan communities. The U.S. Census Bureau predicts that the senior population in Alaska will increase from 26,000 in 1993 to over 90,000 by the year 2015, an average annual increase of 11%. The fraction of this population that requires significant assistance from the state will grow proportionately to the overall senior population. The rapid growth in the Alaskan senior population results in the increased need for long-term care services; however, the current service provider capacity is insufficient to meet these needs. The division will continue its work with Alaskan communities to help ensure that an adequate number of service providers are available to provide services required in each community.

The Division of Senior and Disabilities Services endeavors to conduct timely Personal Care Assistance assessments to get vulnerable Alaskans on the program initially and conduct the annual assessment to ensure the recipients continue to meet program requirements and receive the care that meets their health and welfare needs.

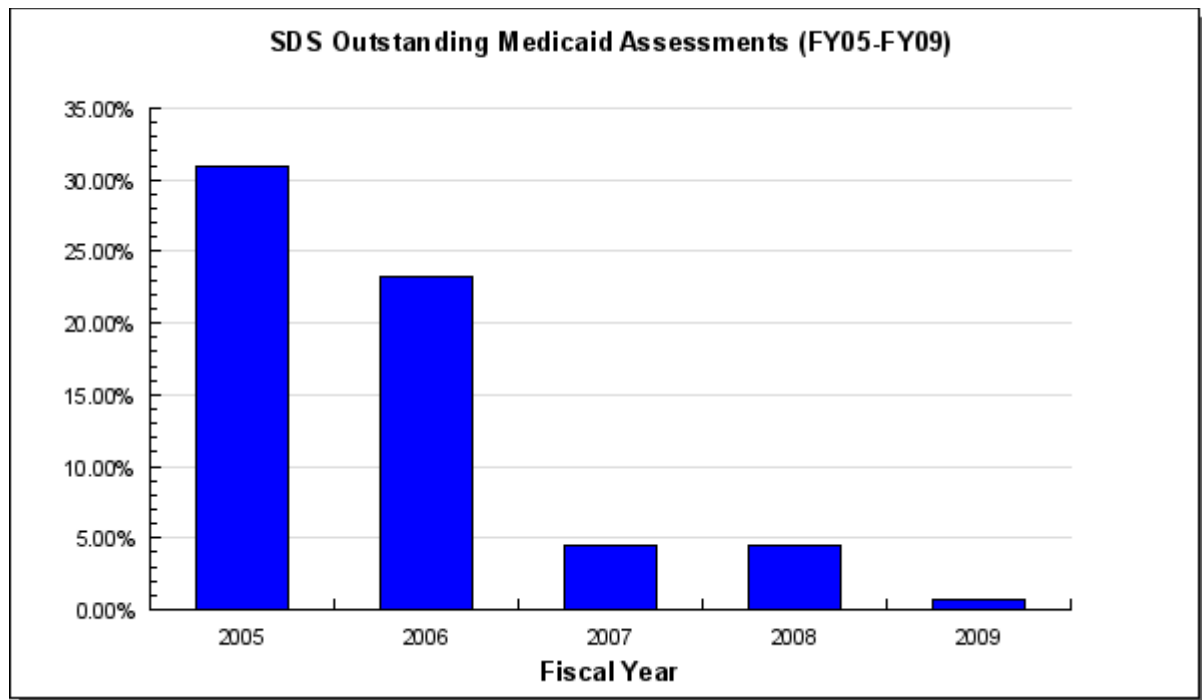
Maintain compliance with federal and state requirements to manage the Older Alaskans and Adults with Physical Disabilities waiver programs and meet documentation and timeline requirements. This includes the required paperwork including the assessments, level of care determinations and completed plans of care that must be mailed to each participant.

Performance Measure Detail

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
FY 2009	.77
FY 2008	4.5%
FY 2007	4.5%
FY 2006	23.18%
FY 2005	30.9%

Analysis of results and challenges: The Personal Care Attendant (PCA) program was the only Medicaid program that did not require a state-approved medical assessment to receive services until implementation of new regulations in April of 2006. These new regulations began requiring a state-approved medical assessment and prior authorization of Medicaid benefits to ensure that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from FY2005-2008. Senior and

Disabilities Services (SDS) has worked hard to catch up on back-logged Medicaid Waiver assessments through a contractor, state staff authorized to perform assessments and through agencies with staff on-site that have the appropriate credentials to complete assessments. In spite of these efforts, there were too many pending assessments required when new regulations went into effect in April of 2006 for the Personal Care Attendant program. SDS has dramatically decreased the assessment back-log but will not be caught up until all recipients receiving PCA services have been assessed. SDS is working hard to get all assessments completed within 30 days of assignment to an assessor.

Target #2: The use rate of nursing home bed days per year for seniors 65 years and older in skilled nursing facilities will not increase.

Status #2: The target to reduce the number of nursing home bed days for seniors 65 years and older was met in 2009. Seniors averaged 4.35 bed days per year down from 6 bed days a year in 2002.

A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.

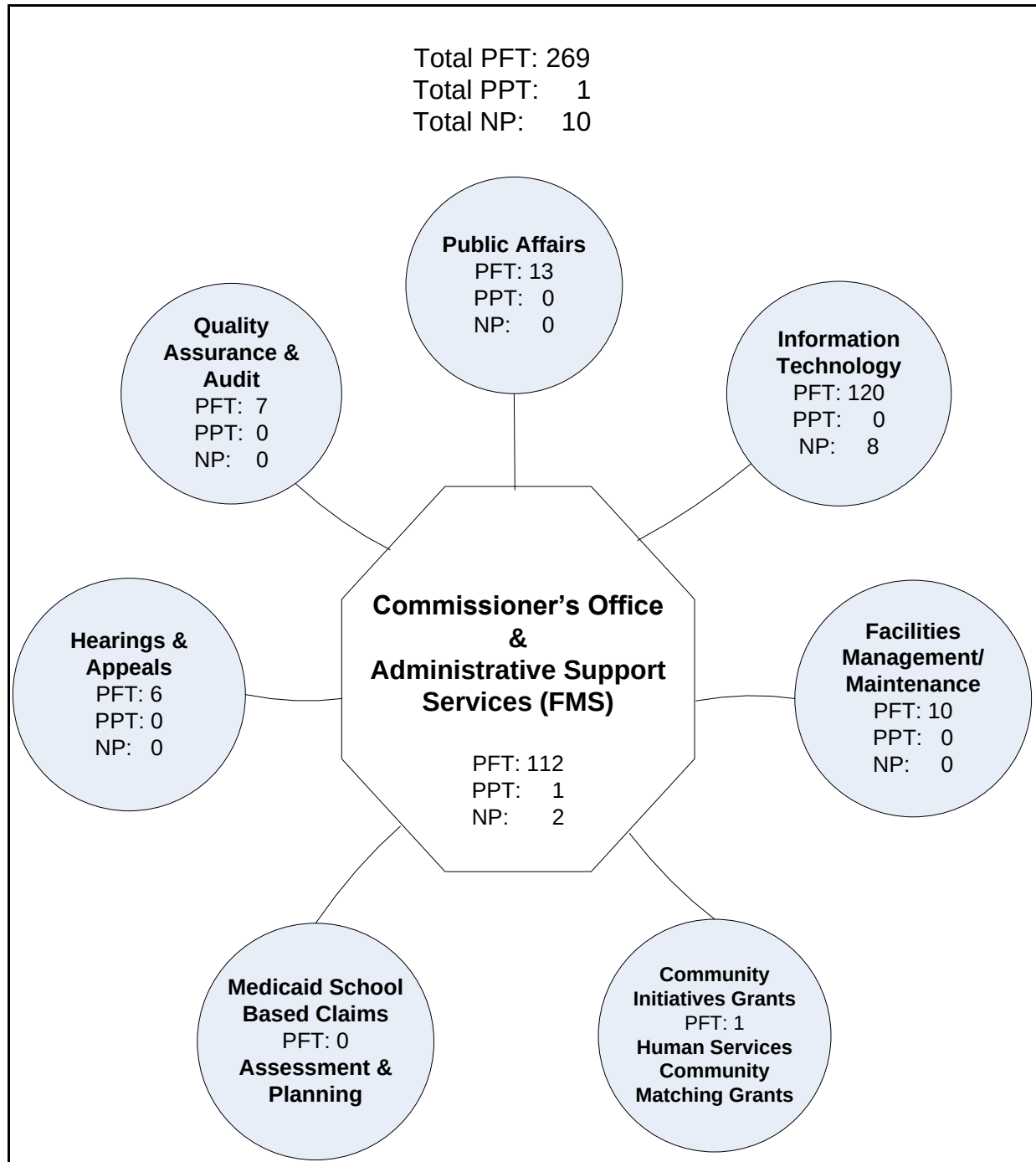
Target #1: Increase by 10% the number of disabled and elderly Alaskans utilizing Aging and Disability Resource Centers (ADRC).

Status #1: In FY10, 15,000 individuals used ADRCs to access information and to apply for long-term services and supports.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Waiver Corrective Action Plan Recovery and Program Stabilization	\$ 750.0	\$ -	\$ 500.0	\$ -	\$ 1,250.0
MH Trust: Brain Injury - Acquired & Traumatic Brain Injury Pgm Research Analyst & Registry Support	\$ -	\$ -	\$ -	\$ 136.0	\$ 136.0
MH Trust: Housing - Grant 68.08 Rural long term care development	\$ -	\$ -	\$ -	\$ 140.0	\$ 140.0
Personal Care Assistance Staff Conversion and Program Stabilization	\$ 750.0	\$ -	\$ 200.0	\$ -	\$ 950.0
Senior and Disabilities Services Assessment/Waiver Units Stabilization & Expansion	\$ 450.0	\$ -	\$ -	\$ -	\$ 450.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (395.7)	\$ (395.7)
MH Trust: ACoA - Grant 1927.03 Aging and Disability Resource Centers	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (125.0)	\$ (125.0)
MH Trust: Benef Projects - Grant 124.07 Mini grants for beneficiaries with disabilities	\$ -	\$ -	\$ -	\$ 227.5	\$ 227.5
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (227.5)	\$ (227.5)
MH Trust: Cont - Grant 151.07 ACOA Planner	\$ -	\$ -	\$ -	\$ 91.0	\$ 91.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (89.9)	\$ (89.9)
MH Trust: Cont - Grant 105.07 Research Analyst III	\$ -	\$ -	\$ -	\$ 110.0	\$ 110.0
MH Trust: Benef Projects - Grant 200.08 Microenterprise capital	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (440.9)	\$ (440.9)
Senior and Disabilities Svcs Total	\$ 1,950.0	\$ -	\$ 700.0	\$ (324.5)	\$ 2,325.5

Department Support Services



Introduction to Department Support Services

Mission

To provide quality administrative services that supports the department's programs.

Overview

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 department's 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

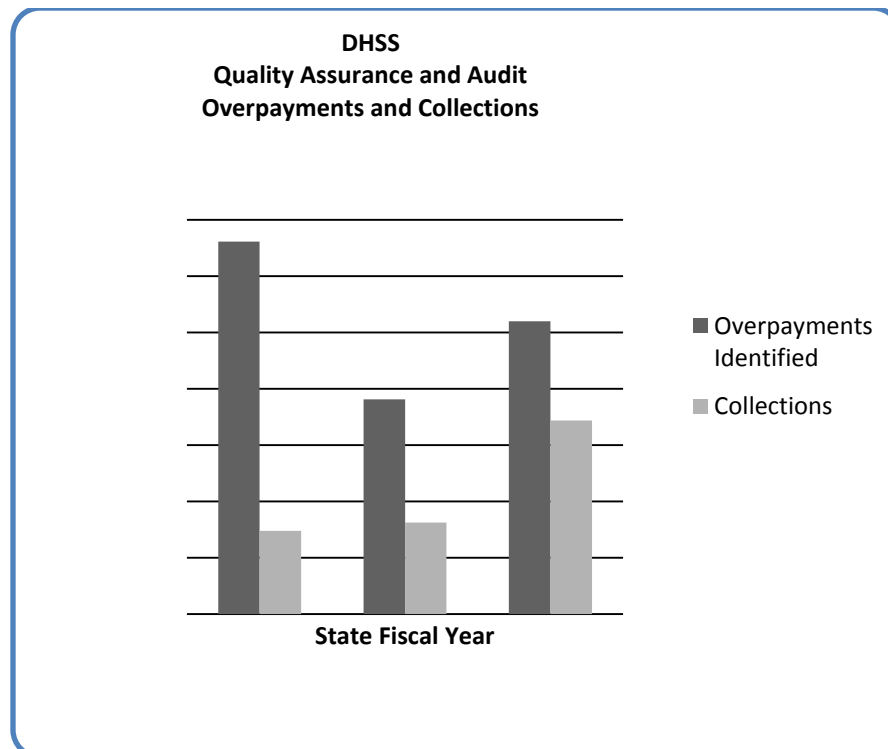
The Commissioner's Office component funds upper-level management and policy development for the entire department. (AS 18.05: Health, Safety and Housing)

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 an example of the component's work, the chart below shows identified Medicaid provider overpayments and related collections. (AS 47.05; AS 47.07; 7 AAC 160.100 - 140.)



Hearings and Appeals

The Hearings and Appeals component is responsible for adjudicating claims or disputes between clients/grantees/providers and the offices/divisions of the department. To accomplish this mission, this office conducts hearings and issues impartial decisions that comply with due process requirements. Ultimately, all issued decisions can be appealed to the state Superior Court. In addition, a mediation process is provided for the resolution of claims or disputes.

The department administers and regularly issues decisions regarding at least 42 programs, some of which include: Medicaid, Food Stamps, Alaska Temporary Assistance, Person Care Assistance, and Home and Community Based Waiver Services. (AS 47.07; AS 47.08 and AS 47.25 and AS 47.27)

Medicaid School Based Claims

The Medicaid School Based Claims component provides federal reimbursement to participating school districts for performing medical activities within the schools. (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 need to serious mental or physical hardship. Related services 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.

Human Services Community Matching Grants

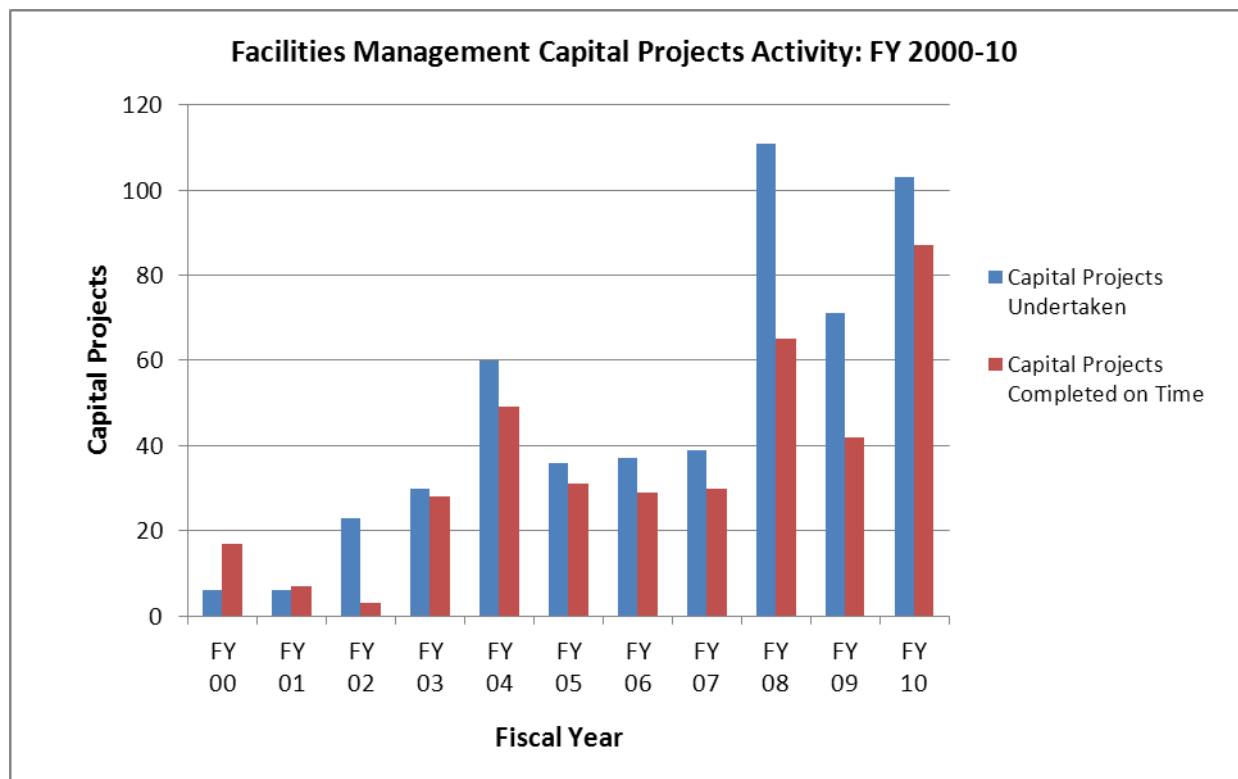
The Human Services Community Matching Grants component makes grants to qualified municipalities. (AS 29.60.600 Human Services Community Matching Grants)

Facilities Management

The Facilities Management component manages the department's capital programs and by law is responsible for preparation, submission and competent management of annual capital budget requests. (AS 37.07.062 Capital Projects)

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 FY00 through FY10.



In addition, Facilities Management administers all capital grants including pass through federal funds from the Denali Commission. In FY10, Facilities managed 9 Denali Commission grants with a value of \$6.6 million and an additional 64 state capital grants with a value of \$8.3 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 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 not only supports all aspects of technology needs for the department's employees, but also provides for specific technology needs of some of the department's grantees, as well. The Department's need for information technology support extends throughout the state to 82 separate communities. IT provides representation 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 and the deployment and support for an extensive server 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 and also serves 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, and includes department compliance efforts of meeting the HIPAA Privacy and Security rules. The IT 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.

DHSS Computing Environment	
(Statewide Totals)	
Desktops	3,269
Servers (physical)	186
Servers (virtual)	88
Networks	139
Housed Facilities Networks	113
FY08 Help Calls	21,628
FY09 Help Calls	19,941
FY10 Help Calls	20,596
FY08 Average Calls per Day	78
FY09 Average Calls per Day	72
FY10 Average Calls per Day	74
Communities with IT Infrastructure	82
Number of Business Applications	78

Administrative Support Services

The Administrative Support Services component is responsible for financial, budget, grant and contract administration, and procurement. Administrative Support provides key liaison services to other state departments in the areas of personnel, travel, finance, procurement and legislative audit issues. For the second year in a row, Administrative Support staff coordinated the Finance & Management Services Training Academy for DHSS employees in Anchorage, Fairbanks and Juneau. Training topics ranged from supervision and cost allocation basics to ALDER workshops and Excel labs. Classes provide key information to both administrative and program personnel. 500 - 775 departmental employees received training in core state administrative processes over the past two years. (AS 37.10: Financial Management, OMB Circulars A-87, A-89, A-102, A-122, Code of Federal Regulations and Federal Register; 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 centralized processing, audit and certification of expenditure and non-federal revenue transactions, coordination of year end activities, specialized management reporting and accounting services.

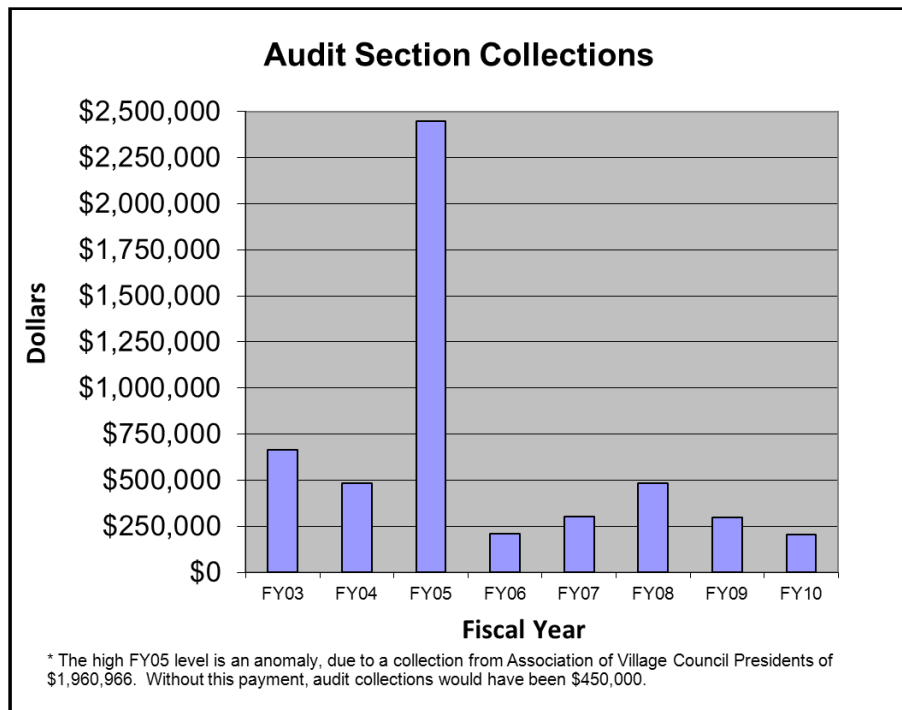
Revenue Section

The Revenue Unit is responsible for reporting of expenditures and federal revenue collections for the department. Core services include weekly and quarterly drawdown of cash from the federal treasury in compliance with the Cash Management Improvement Act (CMIA), quarterly cost allocation processing in accordance with the department's federally approved Public Assistance Cost Allocation Plan (PACAP) and filing of multiple federal financial reports for departmental programs, grants and contracts. Total collection of revenues exceeded \$1.061 Billion in FY10 for 101 federal programs.

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 chart on the following page shows the collection activity of grantee overpayments for FY03 through FY10.



Budget Section

The Budget Section is responsible for analyzing, monitoring, and controlling the Department's annual 2.2 billion dollar operating budget, budget amendments, revised programs, supplemental budgets, fiscal notes and legislative requests for information for each of our nine divisions.

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 Reimbursable Service Agreements, Revised Programs and Writing for the Workplace.

In addition, new SharePoint tools were developed to simplify tracking and reporting and to improve intra-department coordination and communication. For example, Division personnel can now track the status of their Revised Program or Reimbursable Service Agreements on SharePoint. The Budget Section led the effort with all nine divisions to revise the Department's Strategic Performance Measures, incorporating the Strategic Plan and our Department Priorities into the process.

The Medicaid Budget Unit updated the 20-year long-term forecast of Medicaid enrollment and spending in Alaska (MESA) and responded to information requests and fiscal notes.

Grant and Contracts Support Team

In 2004 the Division of Finance & Management Services established the Grants & Contracts Support Team in an effort to better manage grants and contracts through a centralized process. Prior to the centralization, the individual divisions were responsible for the issuance of all grant solicitations and awards in unlimited dollar amounts, and professional service contracts in amounts less than \$50,000. Contracts in excess of \$50,000 were solicited, awarded, and administered by the procurement staff. Presently, the Grant and Contracts Support Team manages all grants and contract awards.

The results of the establishment of a centralized approach have been well received. The department has benefited by providing a more streamlined method for vendors and grantees to work with trained and certified professional staff to ensure a fair and open process. This approach appears to have contributed to fewer protests of solicitations and awards for both grants and contracts. Due to these changes, there has been an increase in grantee/customer satisfaction by having a single point of contact. In addition, our grants reporting database, eGrants, has reduced the administrative burden for grantees to interface with the department and has served to standardize the application and reporting requirements, therefore contributing to a positive partnership and professional environment.

During the past two fiscal years, there has been an increase in the establishment of professional service contracts, largely due to federally mandated projects, limited resources, and an obligation to comply. In FY09, contracts staff processed 120 contracts, in FY10, contracts staff processed 156 contracts. Currently, it appears as though FY11 will be no exception to the increasing number of contract needs, due to the adherence of federally mandated obligations. During the past two grant cycles, grants staff has witnessed an increase of operating grants awarded from 645 grants in FY10 to 655 grants in FY11, a difference of \$8,867,378. All in all, this transition has been successful and embraced by many both inside and outside of the Department, especially our partners in the non-profit community.

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

Explanation of FY12 Operating Budget Requests

Department Support Services

Budget Overview Table

Department Support Services	FY11	FY12 Gov	11 to 12 Change
Unrestricted General Funds*	\$23,435.8	\$24,233.2	\$797.4
Designated General Funds	2.8	2.8	0.0
Federal Funds	17,421.4	18,012.8	591.4
Other Funds	9,356.9	9,499.9	143.0
Total	\$50,216.9	\$51,748.7	\$1,531.8

*Includes Human Services Community Matching Grants, \$1,685.3 (MP), \$1,485.3 (Gov) GF
Community Initiative Matching Grants \$676.9 GF, \$12.4 Fed, FY11 and \$680.4 GF, \$12.4 Fed, FY12

Budget Requests

Information Technology Services

Creation of DS3 Information Technology Support Team: **\$655.0 (\$197.0 Federal/\$458.0 GF)**

The Division of Senior and Disabilities Services is in development stage of a comprehensive case management system to support service delivery and address corrective action as required by the Center for Medicaid and Medicare Services (CMS). Ongoing system modification and maintenance will require a service team in Business Applications Information Technology section. This increment will allow the division to establish the business applications team necessary to maintain the case management system being developed for the Division of Senior and Disability Services.

Without institutionalized support for the DS3 case management system, the division puts continued compliance with CMS directives at risk. Required information may not be retrievable for CMS reporting requirements and/or personnel will not have the management tools needed to meet CMS work performance deadlines. This will put continued approval of the long term care waiver programs operated by the division at risk of being disapproved at the federal level. Without the waiver program alternatives, all long term care will be delivered through institutional settings, such as nursing homes, at 4 to 5 times the cost of waived services.

Explanation of FY12 Capital Budget Requests

Department Support Services

Capital Budget Request Overview

- 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 (MMIS).

Capital Budget Requests

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, a 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, including 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 applicants.

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. Also, clients are sometimes housed in residential programs in which maintenance and repair needs are extensive.

Challenges

As the administrative and management undertakers 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 are 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 without risk to public employees, facility inhabitants, and visitors.

Changes in program operations over time necessitate the need for building renovation and expansion. Unlike 20 years ago, when pioneer homes primarily served level one residents, today they primarily serve level 3 residents. This is coupled with the fact that the active and inactive waitlists continue to grow because of the need for renovations and expansions at pioneer homes. Increased capacity is needed to address the eligible resident population growth and the related increased service needs of Alaska's aging citizens. This is an ongoing challenge.

Similarly, juvenile justice programs change over time to provide safer and more appropriate treatment for Alaska's youth. A study completed in 2007 identified \$170 million in safety and security deficiencies at the department's four oldest youth facilities. Securing the necessary funding is a challenge. To assist with this, the department has outlined a 10 year funding plan.

Juneau Pioneer Home Kitchen Floor Replacement

This is a sample of how floors deteriorate over time. They delaminate, become tripping hazards, and are unsanitary. The pioneer homes operate 24 hours a day. Replacing a floor requires tremendous coordination in order to not interrupt meal service for the residents.





Dillingham Health Center Heating and Ventilation Duct Replacement

Problems with building in rural Alaska are more challenging for project managers. Often, problems go un-noticed due to the lack of qualified maintenance staff located on site. In this case, the heating duct is falling apart and was not detected for months.

FY12 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2012 Governor's Request General and Other Fund Increases (Increases and Decreases Only)					
Item	UGF	DGF	Federal	Other	Total
Mental Health Trust Grant 2347.02 for Workforce Development Coordinator Position	\$ -	\$ -	\$ -	\$ 115.0	\$ 115.0
Reverse FY2011 MH Trust Recommendation	\$ -	\$ -	\$ -	\$ (60.0)	\$ (60.0)
Create DS3 Info Tech Support Team for Case Management System	\$ 400.0	\$ -	\$ 255.0	\$ -	\$ 655.0
Reverse August FY2011 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (81.8)	\$ -	\$ -	\$ -	\$ (81.8)
Departmental Support Services Total	\$ 318.2	\$ -	\$ 255.0	\$ 55.0	\$ 628.2
Reverse one-time funding for fiscal year 2011	\$ (200.0)	\$ -	\$ -	\$ -	\$ (200.0)
Human Svcs Comm Matching Grant Total	\$ (200.0)	\$ -	\$ -	\$ -	\$ (200.0)

Appendices

RDU/Component Listing FY12

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 Planning and Infrastructure

Community Health Grants

McLaughlin Youth Center

Mat-Su Youth Facility

Kenai Peninsula Youth Facility

Fairbanks Youth Facility

Bethel Youth Facility

Nome Youth Facility

Johnson Youth Center

Ketchikan Regional Youth Facility

Probation Services

Delinquency Prevention

Youth Courts

Alaska Temporary Assistance Program

Adult Public Assistance

Child Care Benefits

General Relief Assistance

Tribal Assistance Programs

Senior Benefits Payment Program

Permanent Fund Dividend Hold Harmless

Energy Assistance Program

Public Assistance Administration

Public Assistance Field Services

Fraud Investigation

Quality Control

Work Services

Women, Infants and Children

Nursing

Women, Children and Family Health

Public Health Administrative Services

Emergency Programs

Certification and Licensing

Chronic Disease Prevention and Health

Promotion

Epidemiology

Bureau of Vital Statistics

Emergency Medical Services Grants

State Medical Examiner

Public Health Laboratories

Tobacco Prevention and Control

General Relief/Temporary Assisted Living

Senior and Disabilities Medicaid Services

Senior and Disabilities Services Administration

Senior Community Based Grants

Senior Residential Services

Community Developmental Disabilities Grants

Commission on Aging

Senior and Disabilities Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Departmental Support Services

Human Services Community Matching Grant

Community Initiative Matching Grants (non-statutory)

Governor's Council on Disabilities and Special Education

Public Affairs

Quality Assurance and Audit

Commissioner's Office

Assessment and Planning

Administrative Support Services

Hearings and Appeals

Medicaid School Based Admin Claims

Facilities Management

Information Technology Services

Facilities Maintenance

Pioneers' Homes Facilities Maintenance

HSS State Facilities Rent

Human Services Community Matching Grant

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
AKHAP	Alaska Heating Assistance Program
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

ARBD Alcohol Related Birth Defects
 ARND Alcohol and Related Neurodevelopmental Disorder
 ARRA.....American Recovery and Reinvestment Act of 2009
 AS Alaska Statute
 ASAP Alcohol Safety Action Program
 ASPEN.....Automated Survey Processing Environment
 AST.....Alaska Screening Tool
 ASTHO Association of State & Territorial Health Officials
 ATAP Alaska Temporary Assistance Program
 ATCA.....Alaska Tobacco Control Alliance
 ATCO.....Alaskans Taking on Childhood Obesity
 ATSDR Agency for Toxic Substances and Disease Registry
 AVCP.....Association of Village Council Presidents
 BBNA Bristol Bay Native Association
 BBAHC.....Bristol Bay Area Health Corporation
 BCC.....Breast and Cervical Cancer
 BH.....Behavioral Health
 BHCS.....Behavioral Health Consumer Survey
 BHIP Behavioral Health Integration Project
 BRFSS.....Behavioral Risk Factor Surveillance System
 BRS.....Behavioral Rehabilitation Services
 BTKH.....Bring the Kids Home
 BVS.....Bureau of Vital Statistics
 BYF.....Bethel Youth Facility
 CAC.....Child Advocacy Center
 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, 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)
 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)
 DOC.....Department of Corrections

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 Initiative
EI.....Early Intervention
EIEIO Early Intervention, Enhancement and Improvement Opportunity
EI/ILP.....Early Intervention/Infant Learning Program
EIS.....Eligibility Information System
EMR.....Electronic Medical Record
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
 GPRA.....Government Performance and Results Act
 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
 HIPPI 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
 IECCC.....Interdepartmental Childhood Coordinating Council
 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
 ISA Individualized Service Agreements
 IT Information Technology
 ITG.....Information Technology Group

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
 KPYP.....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
 NOMs.....National Outcome Measurements
 NPS National Pharmaceutical Stockpile
 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
 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
SCHIP	State Children's Health Insurance Program
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
SEDY.....	Seriously Emotionally Disturbed Youth
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, Substance Use Disorder
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
 TEDS Treatment Episode Data Sets
 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
 TYP Tribal Youth Program
 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
 YF Youth Facility
 YKHC Yukon-Kuskokwim Regional Health Corporation
 YRBS Youth Risk Behavior Survey