

State of Alaska
**Department of
Health & Social Services**

Fiscal Year 2013 Budget Overview

Governor Sean Parnell, State of Alaska
Commissioner William J. Streur,
Department of Health & Social Services



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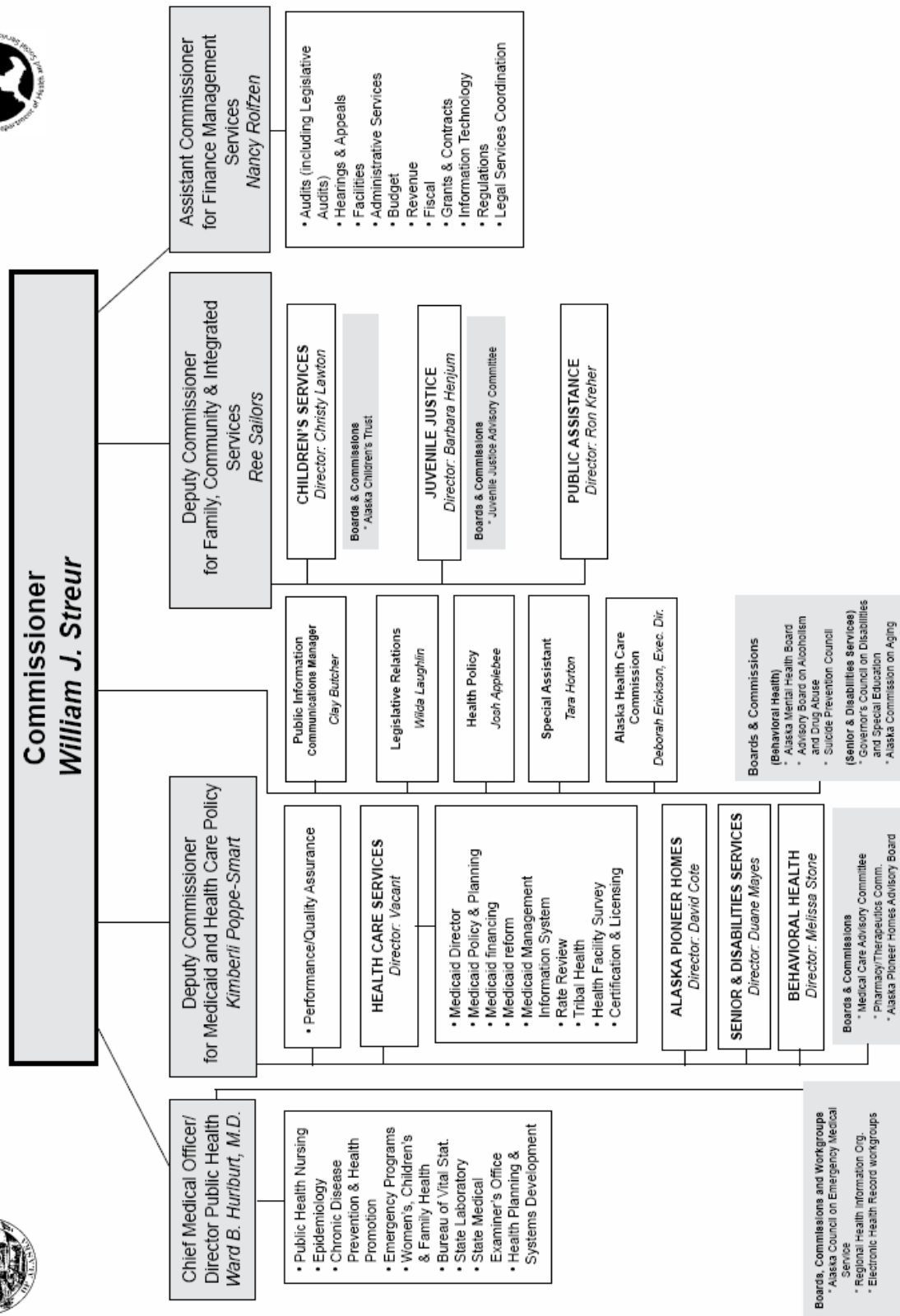
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Alaska Department of Health and Social Services Organization Chart



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, which include Collaboration, Accountability, Respect, Empowerment, and Safety.

Department Priorities

- Integrated Health and Wellness
- Health Care Access and Delivery
- Sustainable Long-Term Care Delivery System
- Safe and Responsible Families and Communities

Major Accomplishments in FY2011

INTEGRATED HEALTH AND WELLNESS

- In FY2011, the Adult Preventative Dentistry Program provided services to 14,821 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.
- 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.

HEALTH CARE ACCESS AND DELIVERY

The final Medicaid Task Force report was forwarded to Governor Parnell for approval in May 2011. With his approval, he instructed the DHSS to begin with planning and if appropriate, commence with implementation.

Options

Patient-centered medical homes. A Request-for-Proposal was released December 28, 2011 to provide consulting services to the DHSS on the development of medical homes, with proposals due January 19, 2012. The consultant will assist the DHSS in evaluating models of medical homes suited to Alaska's unique circumstances, a plan for establishing criteria for pilot projects and recruitment of at least 4 pilot sites: urban, rural, tribal, and non-tribal. Integrated mental health services will be a part of the pilots.

Care management. Chronic care management through the Health Home model of reimbursement through Medicaid providing for enhanced Federal Medical Assistance Percentages (FMAP) is anticipated to be integrated into Medical Homes once data is available from operational Medical Homes to identify participants with qualifying conditions.

Community First Choice. A consultant has been retained to evaluate this option and develop an implementation plan. Activities have begun with state participation. Community stakeholders will be engaged in the near future as is required in this Medicaid program option that provides for an enhanced FMAP. The consultant's work is expected to wrap up mid-summer when implementation will be underway.

Increase substitution of generic medications. Implementation is delayed until FY2013 due to competing federal requirements.

Increase generic medication utilization. Two elements were implemented on May 25, 2011. There has been a savings of roughly \$1,280,000 over six months when compared to the six-month period before implementation.

Enhanced preferred drug list. Community input has been received.

State Maximum Allowable Cost. Implemented in September 2011. The State's contractor, Magellan, estimates the state maximum allowable cost savings is roughly \$500,000 per month based on October 2011 data.

Psychiatric medications policy. The divisions within DHSS continue to collaborate and draft the department's proposed policy. Claims processing edits are anticipated to be discussed with PhRMA during the second half of FY2012 with implementation of the components of the policy anticipated in FY2013.

SUSTAINABLE LONG-TERM CARE DELIVERY SYSTEM

- Served 570 Alaska Seniors and Veterans in the Pioneers Homes.
- Serviced close to 30,000 recipients through Senior and Disabilities Services programs including direct service grants (17,400), general relief (1,066), Personal Care Attendant services (4,632) and Medicaid programs (6,482).

SAFE AND RESPONSIBLE FAMILIES AND COMMUNITIES

- The Office of Children's Services (OCS) continued to support Child Advocacy Centers (CACs) that have proven successful through demonstrated cost savings. OCS supports co-location with CACs by OCS and other partner agencies. The OCS currently co-locates with the Anchorage Lake Plaza Multidisciplinary Center CAC (Alaska CARES). This center received 853 referrals in FY2011 representing a 2% increase per year for the past three years. The building remodel for The Children's Place CAC located in Wasilla is nearly complete and houses the Alaska State Trooper Crimes against Children Unit as well as two OCS investigators. The OCS has also co-located staff in the Glennallen CAC building. Referrals to CACs have increased by 5% overall again in FY2011.
- The Division of Juvenile Justice (DJJ) has increased efforts to reduce the high rate of recidivism of Alaska Native youth through creation of the Alaska Native Recidivism Committee. This committee 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.
- Provided over 14,500 heating assistance grants to qualifying low-income households during the 2010-2011 heating season. Payments for LIHEAP eligible households average \$1,522 and Alaska Heating Assistance payments averaged \$586 per household. Many other households received heating assistance grants through LIHEAP and AKHAP programs administered by Alaska tribal organizations including the Cook Inlet Tribal Council.
- During FY2011, the Division of Senior and Disabilities Services provided home and community-based services to 9,169 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.

- The Bring the Kids Home initiative continues to be successful.
 - The overall recidivism rate within one year to the same level of care for RPTC (Residential Psychiatric Treatment Centers) decreased from 9% to 7%.
 - The distinct number of total RPTC admissions for FY2011 increased by 30% (from 295 to 386).
 - Out-of-State RPTC Medicaid expenditures decreased by 18%, from \$15,191,809 to \$12,506,885.
 - In-state RPTC Medicaid expenditures increased by 10%, from \$20,049,751 to \$22,171,482.

- The Office of Children's Services (OCS) continued work toward a statewide Family-to-Family (F2F) program, expanding the program into Wasilla this past spring. F2F works 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. F2F has been very successful in Anchorage and Fairbanks. 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 a relative's home, rather than being placed in a foster home.

- Fifty 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. Those admitted to the Bridge Home since July 1, 2010 spent 766 days in jail and 78 days in API in the year preceding their involvement. Through the end of FY2011, those individuals had spent 35 days in jail and no time in API.

Key Department Challenges

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

1. Integrate 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. Leverage 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.

Integrated 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.
- Reduction in the prevalence of overweight and obesity in children and adults.
- Responding to the national movement to broaden the vision of prevention to include promotion of mental health, physical health and wellness in addition to the traditional prevention strategies, recognizing the need to act earlier and to incorporate all aspects of health into our state and community health planning.
- Fine-tuning of statutory and regulatory requirements relating to employment of persons with criminal histories.
- Identification and resolution of issues relating to the recruitment and retention of qualified employees to allow the department to fulfill its ongoing mission in a time of national and state workforce shortages.

Health Care Access and Delivery

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

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

Sustainable Long-Term Care Delivery System

- 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 were submitted for renewal effective July 1, 2011.

Safe and Responsible Families and Communities

- 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. A stronger focus is needed on developing community based services for those aggressive youth who represent the majority of the target population returning from acute care placements, both in and out-of-state.
- 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.

Position Information

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

Direct Field Workers

118	Public Health Nurses
290	Social Workers & Children's Service Specialists
304	Eligibility Determination Staff
304	Youth Detention/Treatment Workers
80	Juvenile Probation Officers
254	API Staff
648	Pioneer Homes Staff
1,998	TOTAL

Program Support Services

117	Behavioral Health Programs
161	Senior and Disability Programs
385	Public Health Programs
209	Children's Services
123	Juvenile Programs
9	Facilities Management
374	Benefit Payments/Systems
1,378	TOTAL

Administrative/Management Support

123	Information Technology
134	All Other Centralized Admin/Mgmt
257	TOTAL

3,633 FY2013 GRAND TOTAL

The DHSS Governor's request includes 3,633 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.

FY2013 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,745	14	40	1,799
Aniak	1	0	0	1
Barrow	9	0	0	9
Bethel	102	0	3	105
Cordova	2	0	0	2
Craig	5	0	0	5
Delta Junction	7	0	0	7
Dillingham	9	1	0	10
Eagle River	1	0	0	1
Fairbanks	358	4	11	373
Fort Yukon	0	1	0	1
Gakona	2	0	0	2
Galena	2	1	0	3
Haines	2	0	0	2
Homer	14	0	0	14
Juneau	554	17	25	596
Kenai	83	1	2	86
Ketchikan	120	9	10	139
King Salmon	2	0	0	2
Kodiak	15	1	0	16
Kotzebue	10	0	0	10
McGrath	3	0	0	3
Nome	45	0	2	47
Palmer	121	15	6	142
Petersburg	3	0	0	3
Saint Mary's	5	0	0	5
Seward	3	0	0	3
Sitka	99	0	4	103
Tok	2	0	0	2
Valdez	4	1	0	5
Wasilla	134	0	1	135
Wrangell	2	0	0	2
Totals	3,464	65	104	3,633

Explanation of FY2013 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 FY2013 Compared to FY2012

	FY2012 Management Plan	FY2013 Governor's Request
Unrestricted General Funds	\$1,150.1 million	\$1,214.5 million
Designated General Funds	72.2 million	73.0 million
Federal Funds	1,148.4 million	1,229.1 million
Other Funds	99.5 million	101.0 million
Total	\$2,470.2 million	\$2,617.7 million
Increased Federal Revenue		80.7 million
Increased General Fund		65.2 million

The proposed budget for FY2013 increases general funds (GF) by \$65,208.4. The changes include Medicaid program growth of \$46,031.6 and non-Medicaid resources addressing the department's priorities of Integrated Health and Wellness \$4,016.0, Health Care Access and Delivery \$265.8, Sustainable Long-Term Care Delivery System \$1,042.2, and Safe and Responsible Families and Communities \$13,852.8.

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.

Integrated 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.

Additionally, 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 FY2012 Management Plan program capacity for Integrated Health and Wellness to that requested for FY2013.

	FY2012 Management Plan	FY2013 Governor's Request	Difference
Unrestricted GF	\$ 394,370.0	\$ 418,303.5	\$ 23,933.5
Designated GF	31,038.8	31,219.2	180.4
Federal Funds	584,428.7	619,284.4	34,885.7
Other Funds	25,852.5	25,913.5	61.0
Total	\$ 1,035,690.0	\$ 1,094,720.6	\$ 59,030.6

Budget requests include:

- Medicaid growth from FY2012 to FY2013: \$53,272.3 total - \$18,130.4 GF Match, \$35,141.9 federal
- Maintaining local control of essential public health services by stabilizing funding to public health nursing grantees: \$1,100.0 total - \$990.0 GF, \$110.0 federal
- Delete excess authorization: (-\$2,000.0) federal, (-\$250.0) Interagency receipts
- Immunization for children and seniors: \$700.0 total - \$630.0 GF, \$70.0 federal
- Substance abuse treatment for un-resourced individuals: \$450.0 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: \$75.0 MHTAAR
- Disability justice focus group recommendation for pre-development for sleep off alternatives in targeted communities: \$100.0 MHTAAR
- Tele-health strategic capacity expansion: \$100.0 GF

Health Care Access and Delivery

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 FY2012 Management Plan program capacity for Health Care Access and Delivery to that requested for FY2013.

	FY2012 Management Plan	FY2013 Governor's Request	Difference
Unrestricted GF	\$ 4,198.9	\$ 4,464.7	\$ 265.8
Designated GF	136.1	136.1	0.0
Federal Funds	2,774.5	2,953.2	178.7
Other Funds	3,969.4	3,964.2	(5.2)
Total	\$ 11,078.9	\$ 11,518.2	\$ 439.3

Budget related requests include:

- Continuation funding for the comprehensive integrated mental health plan and the loan repayment program: \$320.0 MHTAAR
- Increased support for the loan repayment program: \$200.0 GF/MH

Sustainable Long-Term Care Delivery System

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 FY2012 Management Plan program capacity for Sustainable Long-Term Care Delivery System to that requested for FY2013.

	FY2012 Management Plan	FY2013 Governor's Request	Difference
Unrestricted GF	\$ 273,831.0	\$ 297,660.0	\$ 23,829.0
Designated GF	16,101.8	16,276.7	174.9
Federal Funds	248,806.1	272,708.9	23,902.8
Other Funds	18,009.6	18,080.2	70.6
Total	\$ 556,748.5	\$ 604,725.8	\$ 47,977.3

Budget requests include:

- Rate setting and acuity measurement systems (split between Long-Term Care and Health and Wellness): \$640.0 total - \$320.0 GF Match, \$320.0 federal
- Medicaid growth from FY2012 to FY2013: \$46,004.7 total - \$22,786.8 GF Match, \$23,217.9 federal
- Adult protective services and provider quality assurance split between Long-Term Care and Vulnerable Alaskans): \$550.0 total - \$275.0 GF Match, \$275.0 federal

Safe and Responsible Families and Communities

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.

Additionally, 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 FY2012 Management Plan program capacity for Safe and Responsible Families and Communities to that requested for FY2013.

	FY2012 Management Plan	FY2013 Governor's Request	Difference
Unrestricted GF	\$ 477,688.8	\$ 494,103.7	\$ 16,414.9
Designated GF	24,963.2	25,373.1	409.9
Federal Funds	312,390.6	334,180.0	21,789.4
Other Funds	51,628.7	53,070.8	1,442.1
Total	\$ 866,671.3	\$ 906,727.6	\$ 40,056.3

Budget requests include:

- Additional funds to cover grave shifts at McLaughlin and Johnson Youth Centers: \$500.0 GF
- Increasing Adult Public Assistance funding due to anticipated enrollment growth: \$5,665.5 GF, \$409.5 Interagency Receipts
- Medicaid growth from FY2012 to FY2013: \$27,638.4 total - \$2,562.1 GF/MH, \$25,076.3 federal
- Support for school based suicide prevention: \$450.0 GF/MH
- Bring the Kids Home expansion including foster parent and parent recruitment training and support, evidence based family therapy models, transitional aged youth, early intervention for young children, peer navigator program, and community behavioral health centers outpatient and emergency residential services and training: \$1,133.0 total - \$1,008.0 GF/MH, \$125.0 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.

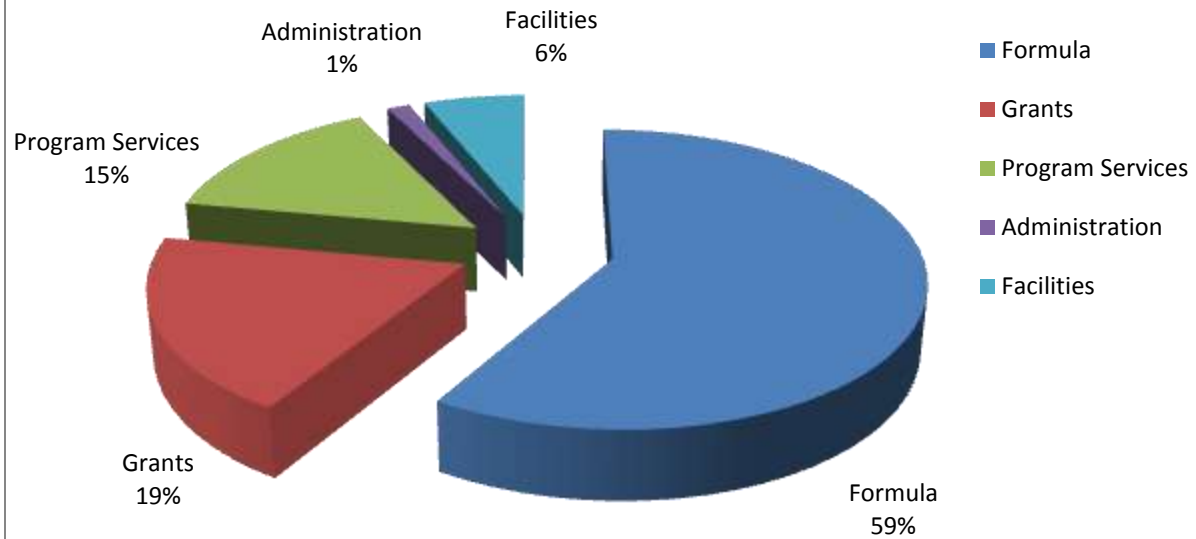
Budget Charts and Graphs

The table below shows the comparison of total funds for FY2003 and FY2013.

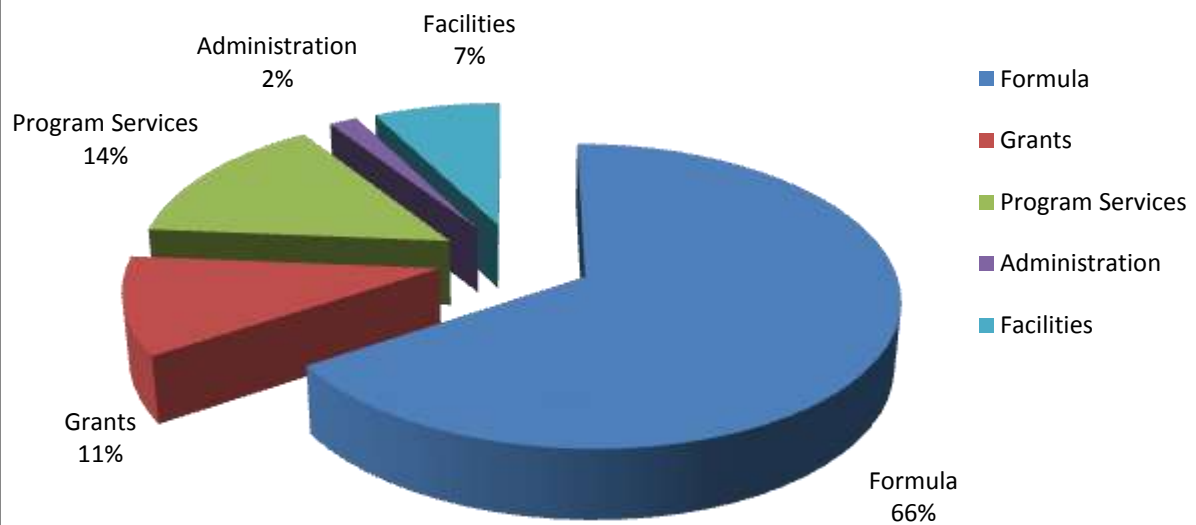
Department of Health and Social Services Expenditures by Category, FY2003-FY2013

	FY2003 Authorized		FY2013 Governor's		
Category	Total Funds	% of Total	Total Funds	% of Total	Change: FY02 to FY12
Formula	\$1,016,103.6	69%	\$1,893,974.5	72%	186%
Grants	167,285.2	11%	185,896.7	7%	111%
Program Services	234,660.9	16%	360,483.7	14%	154%
Administration	19,205.9	1%	44,987.3	2%	234%
Facilities	42,322.4	3%	132,350.0	5%	313%
Total	\$1,479,578.0	100%	\$2,617,692.2	100%	177%

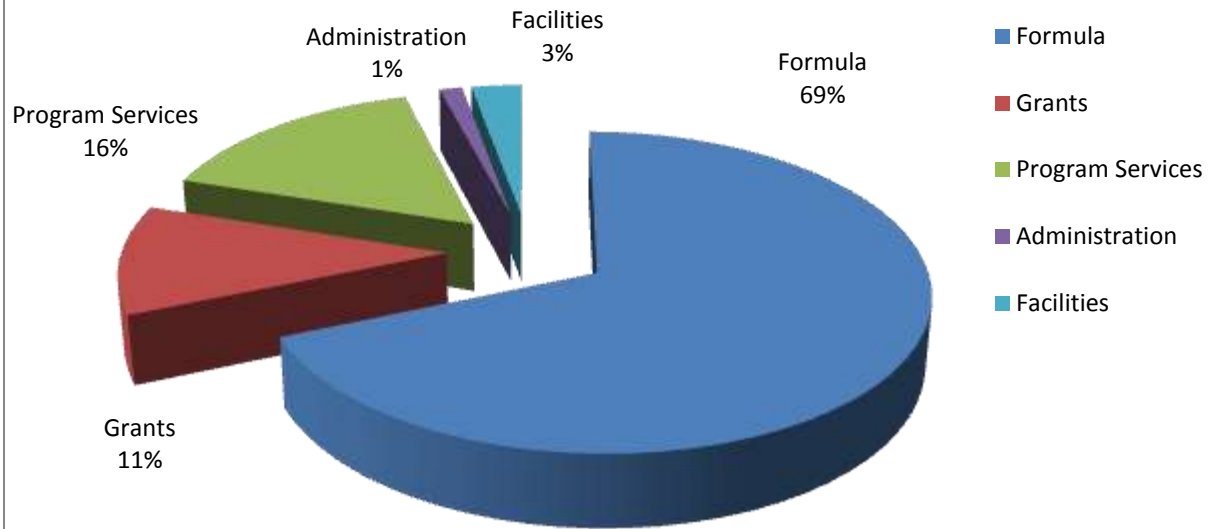
FY2003 Authorized Budget GF Only



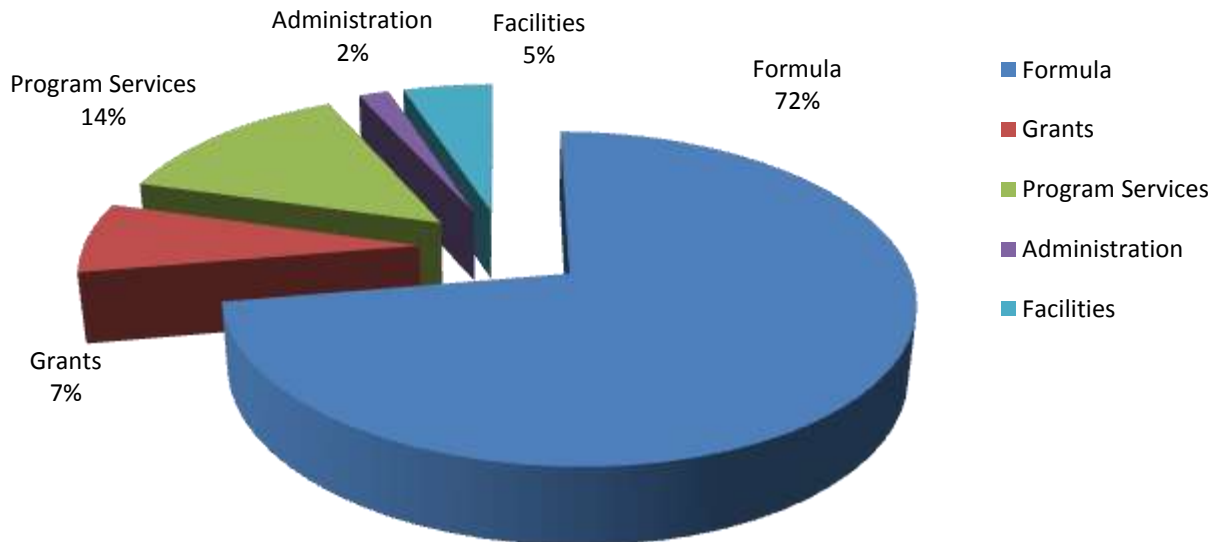
FY2013 Governor's Budget Request GF Only

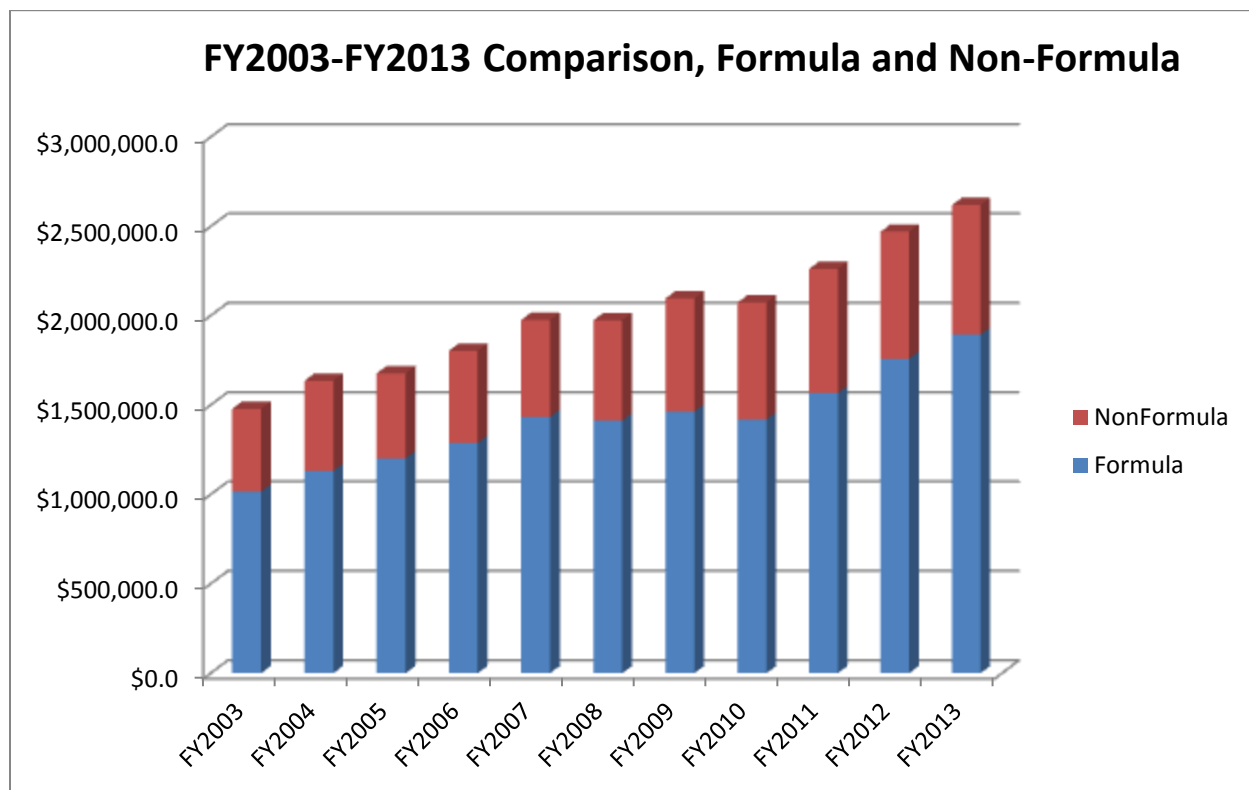


FY2003 Authorized Budget Total Funds



FY2013 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 FY2013 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 Services

Department Level Performance Measures

Priority Programs - Key Performance Indicators

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

Integrated Health and Wellness

- ➔ The target of at least 75% of individuals who receive Behavioral Health community-based services will report "functioning well" in life domains was met for four of six domains. In FY2008, FY2009, and FY2010, 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 target to reduce the rate of suicide deaths to 10.6 deaths per 100,000 population was not met; however, from 2008 to 2009, the rate did decrease from 24 to 19.6 deaths per 100,000 population.
- ⬇ The target to reduce Alaska's tuberculosis (TB) rate was not met. The 2010 rate of tuberculosis was 8.0 cases/100,000 population, a 51% increase from 2009.
- ➔ The overall target to reduce prevalence of overweight and obesity was not met. The rate of overweight/obese high school students in 2009 was 26.2%, down from 27.3% in 2007; however, the Department's Healthy Alaskans 2010 target of 17% for high school students was not met. The rate of overweight/obese adults in 2010 was 66.7%, up from 65.02% in 2009. The Department's Healthy Alaskans 2010 target of 48% for adults was not met.
- ➔ The target to reduce the percentage of high school students in Alaska who use any tobacco products was not met. Also, 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.
- ⬇ The target of at least 95% of children 0-18 years of age have continuous health insurance coverage during the year was not met. In 2009, 88% of children 0-18 years of age had continuous health insurance coverage. At least 17% of three-year old toddlers had experienced a gap in health insurance coverage since they were born.
- ⬇ The target for young children to receive all vaccines was not met, as 56.6% of these children received vaccines in 2009, down from 69.2% in 2008.
- ⬆ The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. From 2002 to 2003, the prevalence of FASD decreased 23%, from 128.7 per 10,000 live births in 2002 to 99.1 per 10,000 live births in 2003.

- ➡ The target to reduce the rate of alcohol-induced deaths was not met. From 2008 to 2009, the number of alcohol-induced deaths per 100,000 population remained relatively steady at 21.7 in 2008 and 21.9 in 2009.
- ⬇ The target to reduce substance abuse risk among juveniles as a percentage of those assessed as low risk for substance abuse upon the completion of Division of Juvenile Justice services was not met. The percentage of juveniles assessed as low risk decreased from 56% in FY2010 to 50% in FY2011. The number assessed as moderate risk increased from 32% to 38%, and the percentage of youth assessed as high risk remained unchanged at 12% between FY2010 and FY2011.

Health Care Access and Delivery

- ⬆ The target to reduce the rate of uninsured Alaskans to less than 14.6% was not met but is improving. In 2009, the rate of uninsured Alaskans was 17.7%, down from 19.8% in 2008. (Source: U.S. Census Bureau, Current Population Survey for Alaska)
- ➡ The target to increase the ratio of active licensed healthcare providers in Alaska in proportion to the population growth has not been met. The ratio of active physicians to Alaska residents decreased slightly, with 1 physician per 424 residents as of July 1, 2011, as compared to 1 per 405 residents during 2010.

Sustainable Long-Term Care Delivery System

- ⬆ 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.
- ⬆ The target to reduce the medication error rate for the Pioneer Homes was met. The medication error rate decreased to 0.10% in FY2011, from 0.11% in FY2010, and 0.13% in FY2009, comparing favorably with the CMS target medication error rate of less than 5% (CMS Guidance Memo S&C-07-39, 9/28/2007). The Pioneer Homes has continually decreased its medication error rate since FY2006. The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications dispensed in the same quarter x 100. (Source: The Alaska Pioneer Homes)
- ⬆ The target to reduce the number falls resulting in a major injury (sentinel event injuries) was met. In FY2011, the NEW sentinel injury rate was 0.030%, which is well below the 2.6% target. In FY2010, the rate of Pioneer Homes resident 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 FY2009. For FY2011 the new target of 2.6%, coincides with the Joint Commission (JCAHO) standard.

Safe and Responsible Families and Communities

- ↓ The target to reduce incidents of domestic violence and sexual assault was not met. In FY2010, 10,657 incidents were reported, which is a 25% increase from the 8,550 incidents reported in FY2009, and a 26% increase from the 8,476 incidents reported in FY2008. (Source: AK Council on Domestic Violence and Sexual Assault Annual Report to Gov. Parnell, 2010, page 10.)
- ↑ The target to decrease the rate of child abuse and neglect was met. In FY2010 that rate equaled 17.4 victims per 1,000 children. In FY2011 that rate dropped slightly to 17.1. (Source: DHSS ORCA)

FY2013 Capital Project Requests

Capital		FY2013 Capital Funding Request			
		(In thousands)			
DHSS Division	Project Titles	GF	Fed	Other	Total
Juvenile Justice	Bethel Youth Facility Expansion, Phase 1	10,000.0			10,000.0
Health Care Services	International Classification of Diseases Version 10, Phase 2	901.6	3,805.4		4,707.0
Public Health	Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue	450.0			450.0
Pioneer Homes	Deferred Maintenance, Renewal, Repair and Equipment – Pioneer Homes	4,000.0			4,000.0
Public Health, Juvenile Justice, Behavioral Health	Deferred Maintenance, Renewal, Repair and Equipment – Non-Pioneer Homes	3,000.0	15.7		3,015.7
	MH - Essential Program Equipment*	475.0			475.0
	MH - Aging and Disability Resource Centers Pilot to Improve Screening and Services	425.0			425.0
	MH – Assistive Technology*	125.0			125.0
	MH – Home Modification and Upgrades to Retain Housing*	750.0		300.0	1,050.0
Capital Budget Totals		20,126.6	3,821.1	300.0	24,247.7

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

Major Capital Projects

Bethel Youth Facility Expansion, Phase 1: \$10,000.0 GF

Bethel Youth Facility (BYF) is in need of extensive renovation and construction. This capital request will provide for the pre-construction work of four new detention beds for a total of twelve, upgraded treatment beds, additional probation space, expanded medical space, a vehicle sally port, a small gymnasium and a secure outdoor recreation area. This first phase will complete the design, address site issues and will assist in the removal of the Yukon Kuskokwim Health Corporation's Keyes Building that is in too close proximity to Bethel Youth Facility.

International Classification of Diseases Version 10, Phase 2: \$4,707.0 (\$901.6 GF)

This request is to fund phase two of a Center for Medicare and Medicaid Services (CMS) approved project in the amount of \$9,714,712 to comply with federal standards for electronic health interactions with the provider community. This establishes standardized formats for exchange of data between computer systems. By using this updated standard, Alaska Medicaid eliminates the risk of federal penalties for failure to comply with the law. The International Classification of Diseases-10 (ICD-10) code sets provide a standard coding convention that is flexible, providing unique codes for all substantially different health conditions.

Emergency Medical Services – Match for Code Blue Project: \$450.0 GF

The Code Blue Steering Committee was formed to identify need for and purchase critical Emergency Medical Services (EMS) equipment and ambulances for EMS agencies around the state, particularly in rural locations. This year a total of \$450,000 is required to match federal, local and private funds to be allocated for all seven EMS regional offices for such needs as ambulances, heart monitors, training equipment, and communications equipment. One dollar in state general funds leverages more than four additional dollars in other funds.

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: \$3,015.7 (\$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.

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 and 2011 legislative sessions 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 cities and regions across the state - including Anchorage, Kenai Peninsula, Kodiak, Juneau, Ketchikan, Mat-Su and Fairbanks - 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.
- Trauma Informed Care training has been provided to all mid-level and senior managers in the Division to help staff better understand how trauma, and especially family violence, has impacted the youth receiving DJJ services. Two locked units at McLaughlin Youth Center are piloting a Trauma Informed Care model for their programs. Youth admitted to detention units are screened for trauma issues.

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 develop a Multi-Disciplinary Team in the community and continue the development of a CAC for that region. The Child Advocacy Centers:

- Serve children up to age 18 and developmentally disabled adults who are alleged victims of sexual assault by providing forensic interviews, medical exams, psychosocial evaluation, referral for other services needed by the child and family, and the coordination of agency interaction and services.
- Work to avoid duplicative interviewing of the child through carefully organized coordination of services.
- Offer access to health care providers specially trained in treating child abuse.
- Provide services with specialized equipment for exams 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 six 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, 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.

In Public Health, the Alaska Family Violence Prevention Project has developed resources, assessment tools, and training for parents on the effects of violence on children. These resources are disseminated through the Alaska Family Violence Prevention Project Clearinghouse to health care providers, behavioral health providers, educators, judges, lawyers, foster parents, child protection workers, 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 and sexual coercion—an emerging issue in the field of family violence that leads to rapid repeat, and unintended pregnancies, spreads sexually transmitted diseases, and encourages other high-risk behaviors.

In addition to the Stand-Up, Speak-Up Initiative, the Division of Public Health is working to prevent intimate partner and sexual violence through a variety of evidence-based and promising practice efforts. Teachers across Alaska are being trained on the 4th R, a curriculum originally developed in Canada to introduce information and skills to teens for healthy relationships. The developers are working with Alaska to modify the program to Alaska's specific populations. Coaching Boys to Men is another initiative that is training coaches to work with their athletes to eliminate violence in relationships by making non-violence the norm. Additionally, a series of monthly webinars are being conducted across Alaska to teach communities how to develop and implement primary prevention programs related to sexual violence.

Domestic Violence and Sexual Assault (DV & SA) Prevention Initiative

Beginning in state FY2011, the Division of Behavioral Health (DBH) began working in partnership with the Office of the Governor in the statewide initiative to end domestic violence and sexual assault within a decade. DBH took the lead on three primary DV & SA prevention projects: Rural DV & SA Prevention Pilot Projects; Trauma Informed Care Training for Service Providers; and Expansion of the Family Wellness Warriors Initiative.

1) Rural DV & SA Prevention Pilot Projects

The Rural DV & SA Prevention Pilot Project has funded a total of four programs for a three-year grant cycle; one implementation grant (\$800,000 per year) and three building capacity grants (\$200,000 per year). The DV & SA Implementation grant is providing service to the Bristol Bay area, primarily Dillingham with some outreach to other communities. They are focusing heavily on impacting the youth of the Bristol Bay region, recognizing the need to begin generational change that can continue. In addition, they are utilizing the *Green Dot* concept to increase by-stander involvement in recognizing and saying no to DV and SA. The three Building Capacity grants are located in Bethel and the YK region; Kodiak and surrounding island communities; and Sitka, Angoon and Kake. Each of these programs has identified region-specific needs to focus their efforts. Sitka is focusing on youth and community involvement and completed a community *Choose Respect* mural that was mounted on the outside of a local school. Kodiak is working to bring the whole community into the effort through public education, awareness and using *Green Dot* by-stander awareness programming, making appropriate regional and cultural revisions to be most useful. Bethel has identified historical trauma and racism as the primary root cause for DV & SA in their region and is focusing on these two critical issues, as well as bringing back traditional cultural values, practices and strategies to combat domestic violence, sexual assault and alcohol abuse.

Each of the four grantees is partnering with the Council on Domestic Violence and Sexual Assault and the University of Alaska Anchorage in conducting regional versions of the Alaska Victimization Survey, a phone survey to begin collecting data on the incidence of sexual assault across Alaska. Dillingham conducted the survey in FY2011 and the other three communities will begin the survey in their regions in January 2012.

2) Trauma Informed Training

DBH worked with the Anchorage Community Mental Health Center to develop the Trauma 101 curriculum. The development committee included five trauma content experts, a lead curriculum developer and curriculum designer. Eighteen trainings reaching 600 providers have been provided to date. These trainings have ranged from brief (two to four hour) trainings aimed at building basic trauma awareness and knowledge for broad audiences (Annual School on Addictions and Early Childhood Mental Health Institute) to more intensive multi-day trainings aimed at systematic trauma informed care implementation (four days of training on evidence-based trauma informed care for Division of Juvenile Justice staff, two days of training in Anchorage for teachers and school nurses, and two days of training for 12 agencies in Haines)

and blended trainings that are aimed at building foundational knowledge for a targeted audience (on-site training for Covenant house staff).

In FY2012 DBH will work with partners to conduct a series of regional trauma institutes aimed at bringing information on trauma informed care to service systems and launching trauma informed organizational self-assessment processes and trauma informed care learning collaborative. We have been working with the National Child Traumatic Stress Network on adapting trauma informed organizational self-assessment tools for such purposes.

3) Family Wellness Warriors Initiative

FY2012 is year two of the Family Wellness Warriors Initiative. This project is part of the Governor's Initiative to end domestic violence and sexual assault in Alaska and is being implemented by Southcentral Foundation in the Bethel region. Year one included a project in Dillingham. The Bethel project has a community-based steering committee that works to enhance community readiness and develop tribal leadership to change the norms regarding interpersonal violence, including child abuse and neglect. Phase two of the project will focus on engaging more community leaders in the change process.

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 percent 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.

How much Progress Has Been Made?

Use of out-of-state RPTC has decreased significantly: yearly *admissions* were down by 87.2 percent between FY2004 and FY2011 from 752 to 96 youth.

Medicaid expenditures for out-of-state RPTC decreased by 69 percent between FY2006 and FY2011 (\$40 M to \$12.5 M). Medicaid expenditures for in-state RPTC during the same time period increased by 55.1 percent (\$14.3 - \$22.2.M).

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

What is Working?

New residential capacity in the community has expanded options for children including therapeutic foster and group homes, and transitional living settings.

Increased oversight, care coordination and support by State staff, contractors and grantees have increased utilization of in-state resources.

Community providers work together to serve children and families with complex needs. Stakeholders work with DHSS and the Alaska Mental Health Trust Authority to identify system gaps and on topic-specific work groups including on tribal and rural issues and education issues.

What are the Remaining Priorities?

There are currently two primary challenges to the long-term success of BTKH:

- *Addressing service gaps which result in children with complex presentations continuing to leave the State for residential care.*
- *Shifting resources to intervene earlier with children and with families in order to prevent development of more severe problems.*

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 for specified eligibility categories. Medicaid covers aged, blind, or disabled persons and single parent families. In addition, Medicaid coverage was expanded 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 benefit, not administrative costs 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

Medicaid Program	Covered Services
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	Preventive 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 are 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%.

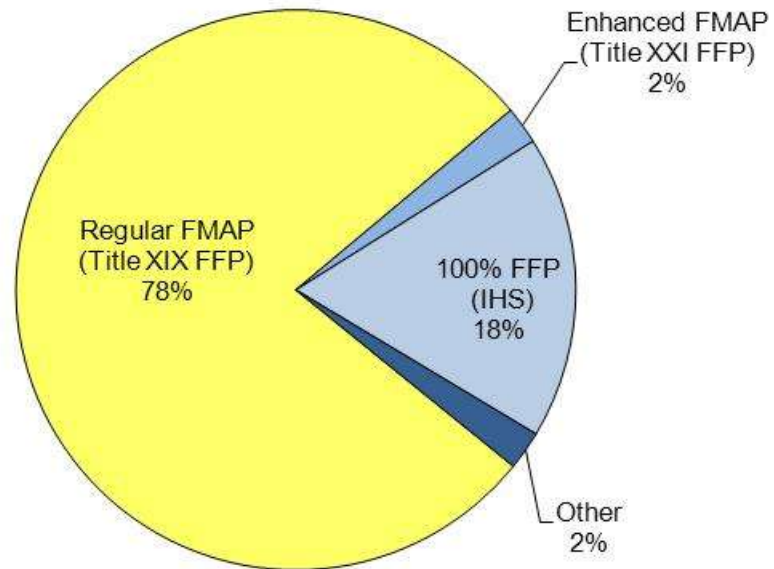
Most benefits costs are reimbursed at this regular FMAP rate for Title XIX services, but some subgroups have higher reimbursement rates. For example, qualified Indian Health Services claims for Medicaid services are reimbursed at 100% federal financial participation (FFP); claims for family planning 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 rates.

Federal Medical Assistance Percentages for Claim Payments				
Year	Federal Fiscal Year Statutory Rate		State Fiscal Year Average Rate	
	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
2013 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.

**FY2011 Medicaid Direct Services
Expenditures by Federal Financial Participation**

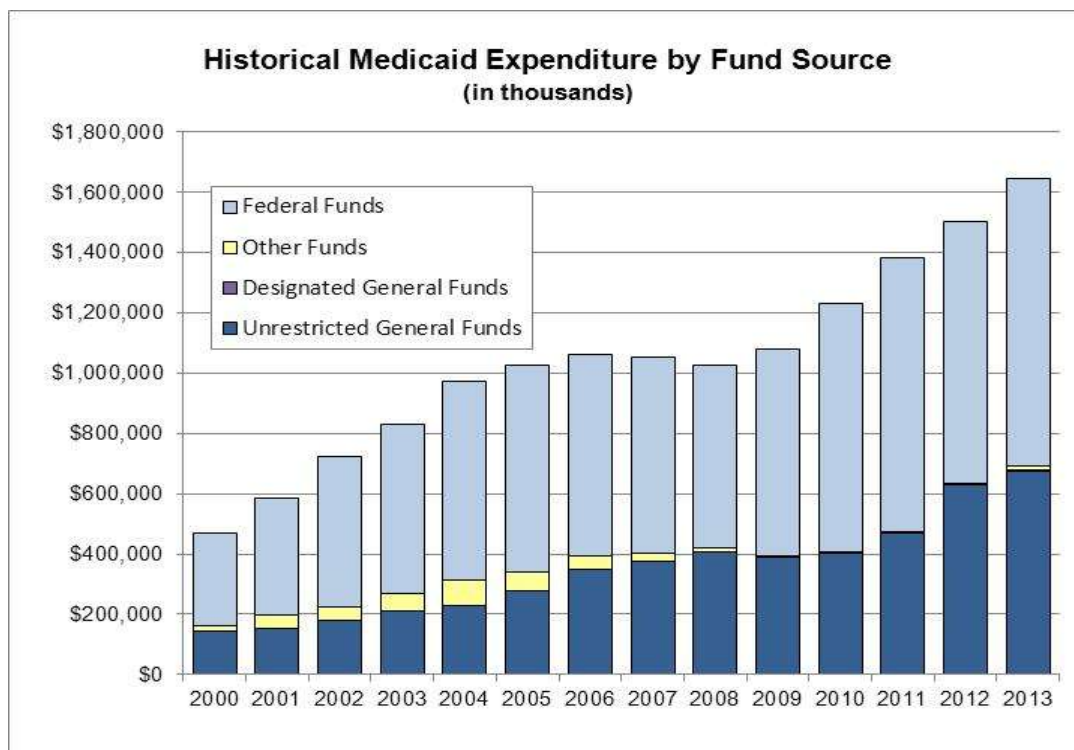


Source: AKSAS data, Medicaid direct services only.

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 2012 and 2013, 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, 2010 and in 2011 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 FY2008 to 36% in FY2009, in FY2010 to 33% in FY10, then to 37% in FY2011. State funding is projected to be about 41% of the total program costs in both 2012 and FY2013.

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 (IHS) 100% federal reimbursement. In FY2011 we have increased our IHS percentage from 16% in prior years to 18% in FY2011. For every dollar shifted to the tribal system from regular FMAP, the State saves on average, 40 cents in state matching funds. The department continues to work with tribal health providers to maximize the benefits of this refinancing strategy.



Source: Actual reporting in AKSAS; FY2012& 2013 figures are based September 2012 STAMP Projections.

Medicaid Expenditures by Fund Source
(in thousands)

Fiscal Year	Unrestricted General Funds	Designated 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	\$1,023,787
2009	\$389,170		\$682,271	\$6,135	\$1,077,576
2010	\$400,284		\$822,907	\$7,069	\$1,230,260
2011	\$457,813	\$192	\$900,851	\$4,528	\$1,363,383
2012*	\$630,914	\$2,348	\$867,486	\$14,266	\$1,515,014
2013**	\$675,981	\$2,348	\$952,875	\$14,266	\$1,645,469

Source: ABS (Alaska Budget System), STAMP forecast, and FY2011 and earlier are actual expenditures. * FY2012 management Plan ** FY2013 Governor's Budget

Annual Statistical Summary of Medicaid Services Provided in FY2011

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. Health Care Services, Behavioral Health Services, and Senior and Disabilities Services each have detailed Medicaid statistics in the respective division sections.

In FY2011, 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. An estimated 92% of Medicaid enrollees 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 FY2000 to 97% in FY09, with a ten year average of 93%.

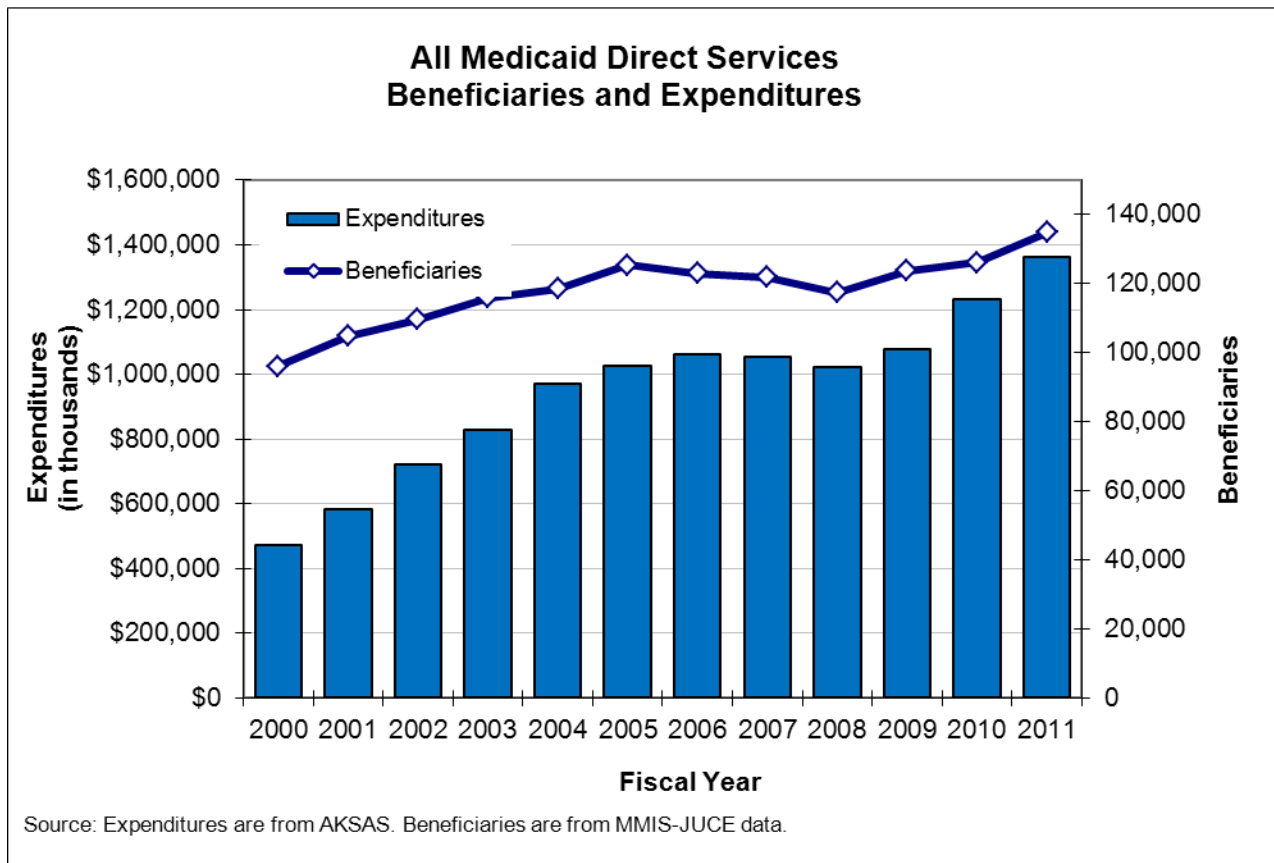
After slowing between FY2004 and FY2008, the number of persons enrolled annually increased by over 8.3% between FY2010 and FY2011. The number of beneficiaries increased by about 6.9%.

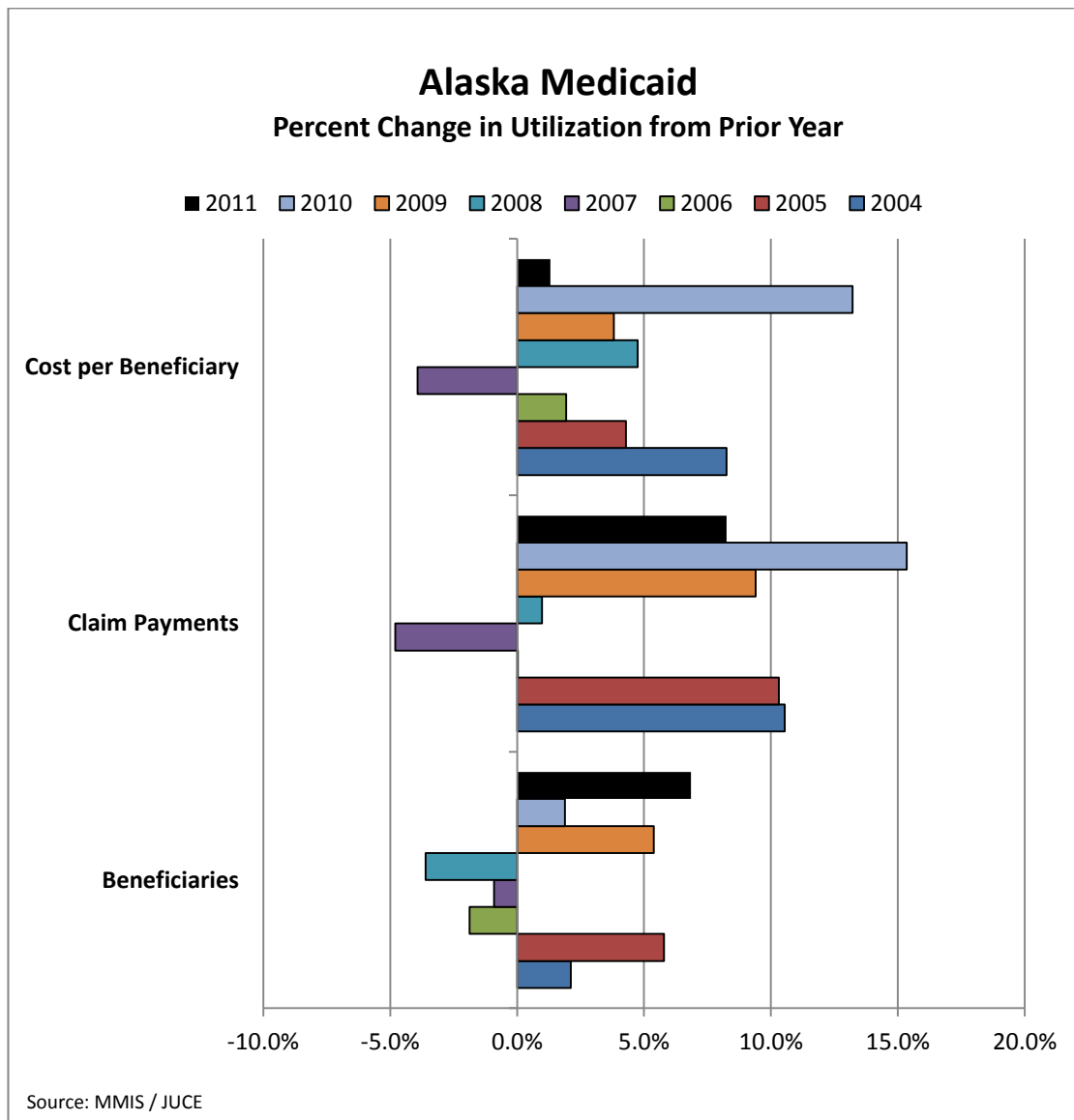
Participation in Medicaid					
Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	626,931	110,219	96,033	18%	87%
2001	632,200	116,226	104,730	18%	90%
2002	640,643	121,582	109,571	19%	90%
2003	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	710,231	135,086	126,127	19%	93%
2011*	704,419	146,244	134,768	21%	92%

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 8.2% between FY2010 and FY2011. The cost per beneficiary increased by 1.3%. The increase in expenditures in FY2011 was largely the result of increased enrollment, due to the general economic climate coupled with a small increase in participation. Additionally, there were increases in payment rates for some Medicaid services.

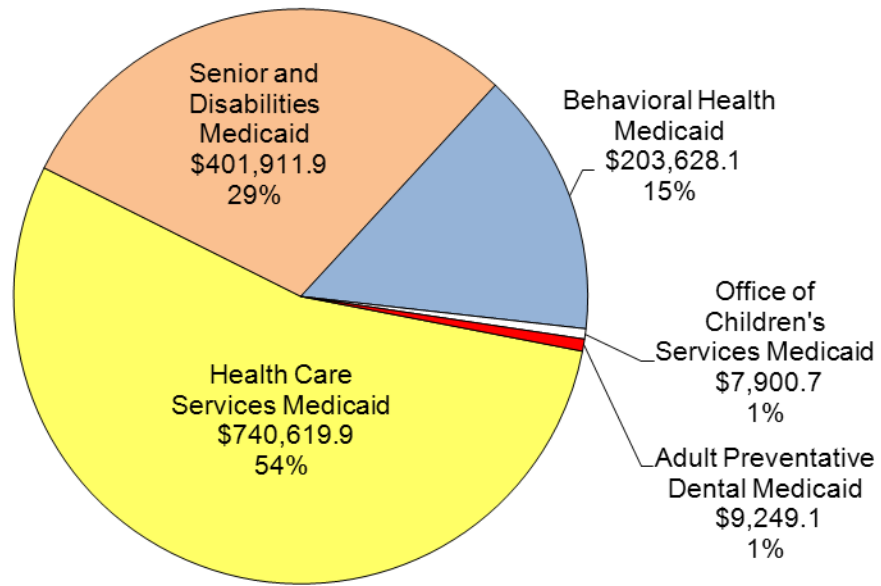




The majority of Medicaid expenditures for direct services in FY2011 were paid through the Health Care Medicaid Services component in the Division of Health Care Services, which funded 54% of the total costs for Medicaid direct services. About 96% of that expenditure was for services provided directly to enrolled individuals. The remainder (less than 4%) was the net of premium assistance payments, third party liability recovery activities (TPL), disproportional share hospital payments (DSH), and Proshare payments to the state's inpatient psychiatric facility.

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 FY2011. The remaining 16% of expenditures were paid through the Behavioral Health Medicaid Services (15%), and Children's Medicaid Services (1%) budget components.

**FY 2011 Medicaid Direct Services
Expenditures by Division (thousands)**



Source: AKSAS data

Medicaid Direct Services Expenditures by Division, FY 2011
(in thousands)

Total Medicaid Direct Services	\$ 1,363,309.5
Health Care Services	
<i>Medicaid Services</i>	\$ 740,619.9
Hospital Services	\$ 303,002.4
Physician Services	\$ 168,039.8
Pharmacy Services	\$ 60,393.6
Dental Services	\$ 51,820.2
Transportation	\$ 61,560.2
Other Medicaid Direct Services	\$ 51,634.5
Non-MMIS Services	\$ 43,041.0
Medicaid Financing	\$ 586.1
Medicaid (State-only)	\$ 542.1
<i>Adult Preventative Dental Medicaid</i>	\$ 9,249.1
Adult Preventative Dental	\$ 9,249.1
Senior and Disabilities Services	
<i>Senior & Disabilities Medicaid Services</i>	\$ 401,911.9
Personal Care Services	\$ 107,801.5
Nursing Homes	\$ 92,511.4
Adults with Disabilities Waiver	\$ 33,929.1
Children with Complex Medical Conditions	\$ 11,125.1
Mental Retardation / Developmental Disabilities	\$ 109,281.4
Older Alaskans Waiver	\$ 43,907.6
Other Services	\$ 3,355.7
Division of Behavioral Health	
<i>Behavioral Health Medicaid Services</i>	\$ 203,628.1
Residential Psychiatric Treatment Centers	\$ 34,652.5
Inpatient Psychiatric Hospitals	\$ 19,046.6
General Mental Health Services	\$ 149,928.9
Office of Children's Services	
<i>Children's Medicaid Services</i>	\$ 7,900.7
Behavioral Rehabilitation Services	\$ 4,819.7
Behavioral Rehabilitation Services - BTKH	\$ 3,081.0

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 Plan for Medicaid and CHIP. For example, a beneficiary receiving mental health counseling through Behavioral Health Medicaid Services might also get a flu shot that was paid through Health Care Medicaid Services. A child enrolled in Medicaid under the CHIP program might receive vision services funded through Health Care Medicaid Services budget, behavioral rehabilitation services provided through Children's Medicaid Services, as well as drug abuse counseling funded through the Behavioral Health Medicaid services budget. An elderly beneficiary using waiver services under the Older Alaskans waiver program is funded through Health Care Medicaid Services.

Based on claims processed for payment during FY2011, 99% of Medicaid beneficiaries used at least one Medicaid service that was funded through Health Care Medicaid Services component. About 10% used Medicaid services funded through Behavioral Health Medicaid Services component. Nearly, 7% used Medicaid services funded through Senior and Disabilities Medicaid Services component, and less than 1% used Medicaid services funded through the Children's Medicaid Services component.

FY 2011 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		134,768		\$1,289,178,587	\$9,566		146,244	92.2%
Gender								
Female	56.2%	75,719	56.1%	\$723,267,776	\$9,552	54.5%	79,722	95.0%
Male	43.8%	59,083	43.9%	\$565,910,811	\$9,578	45.5%	66,575	88.7%
Unknown	0.0%	0	0.0%	\$0	\$0	0.0%	1	-
Race								
Alaska Native	38.3%	51,925	36.2%	\$466,333,962	\$8,981	36.8%	54,296	95.6%
American Indian	1.6%	2,145	1.5%	\$19,737,780	\$9,202	1.6%	2,327	92.2%
Asian	6.4%	8,722	6.3%	\$80,920,056	\$9,278	7.0%	10,259	85.0%
Pacific Islander	3.3%	4,517	2.6%	\$33,831,703	\$7,490	3.6%	5,298	85.3%
Black	5.5%	7,492	4.5%	\$58,596,768	\$7,821	5.7%	8,388	89.3%
Hispanic	3.6%	4,850	2.5%	\$31,819,189	\$6,561	3.6%	5,356	90.6%
White	38.7%	52,491	43.5%	\$560,204,096	\$10,672	39.0%	57,538	91.2%
Unknown	2.6%	3,543	2.9%	\$37,735,035	\$10,651	2.7%	4,033	87.9%
Native	40.0%	54,050	37.7%	\$486,071,741	\$8,993	38.6%	56,597	95.5%
Non-Native	60.0%	81,126	62.3%	\$803,106,846	\$9,900	61.4%	90,161	90.0%
Age								
under 1	8.5%	12,508	7.5%	\$96,179,566	\$7,689	7.9%	12,485	100.2%
1 through 12	36.7%	53,840	15.3%	\$197,115,494	\$3,661	38.3%	60,447	89.1%
13 through 18	15.5%	22,810	13.7%	\$177,248,879	\$7,771	16.3%	25,647	88.9%
19 through 20	3.7%	5,443	2.9%	\$37,251,278	\$6,844	3.5%	5,553	98.0%
21 through 30	10.9%	16,005	12.8%	\$164,694,567	\$10,290	10.2%	16,138	99.2%
31 through 54	14.1%	20,778	21.8%	\$280,491,524	\$13,499	13.7%	21,618	96.1%
55 through 64	4.2%	6,119	9.7%	\$124,530,724	\$20,351	3.9%	6,184	98.9%
65 through 84	5.4%	7,891	12.2%	\$157,780,833	\$19,995	5.2%	8,171	96.6%
85 or older	1.0%	1,486	4.2%	\$53,885,722	\$36,262	0.9%	1,411	105.3%
Benefit Group								
Children	60.8%	83,394	32.6%	\$420,453,912	\$5,042	62.6%	92,699	90.0%
Adults	19.4%	26,592	13.6%	\$175,540,497	\$6,601	18.4%	27,289	97.4%
Disabled Children	1.8%	2,507	5.2%	\$67,322,843	\$26,854	1.7%	2,495	100.5%
Disabled Adults	12.3%	16,859	34.1%	\$440,081,549	\$26,104	11.8%	17,480	96.4%
Elderly	5.8%	7,918	14.4%	\$185,779,785	\$23,463	5.5%	8,154	97.1%
Location (DHSS Region)								
Anchorage/Mat-Su	48.8%	67,874	51.5%	\$664,291,121	\$9,787	50.0%	74,979	90.5%
SouthCentral	13.2%	18,410	15.3%	\$196,716,973	\$10,685	13.3%	19,891	92.6%
Northern	12.3%	17,073	10.5%	\$134,808,494	\$7,896	12.6%	18,907	90.3%
Western	15.1%	20,969	10.9%	\$139,956,394	\$6,674	14.3%	21,474	97.6%
SouthEast	9.3%	12,892	11.3%	\$145,153,791	\$11,259	9.4%	14,148	91.1%
Out of State or Unknown	1.4%	1,880	0.6%	\$8,251,814	\$4,389	0.4%	633	

Source: MMIS/JUCE.

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. 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.

Enrollment: Number of persons eligible for Medicaid and enrolled for at least 1 month during state fiscal year 2011. 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 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 2011 (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 any time before June 30, 2011. If they later obtained dental services in December 2010, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2011.

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.

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 FY2013 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 most useful for budget development and fiscal note analysis while the long-term model is indicated for strategic planning.

The change over a long period is generally more smooth and more gradual than the annual fluctuations experienced in the short term.

Budget Overview Table

Behavioral Health Medicaid Services

Behavioral Health Medicaid	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$81,079.6	\$83,641.7	\$2,562.1
Designated General funds	1,500	1,500	0.0
Federal Funds	94,000.5	119,076.8	25,076.3
Other Funds	717.5	717.5	0.0
Total	\$177,297.6	\$204,936.0	\$27,638.4

Behavioral Health Medicaid Services Funding Needs Table

Behavioral Health Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2012 Authorized Base	177,297.6	63,437.7	1,500.0	111,642.4	717.5
Restore Medicaid GF for Fed	0.0	17,641.9	0.0	-17,641.9	0.0
Medicaid Growth from FY2012 to FY2013	27,638.4	2,562.1	0.0	25,076.3	0.0
Total	204,936.0	83,641.7	1,500.0	119,076.8	717.5

Budget Requests

Behavioral Health Medicaid Services

Restore Medicaid GF/MH in FY2013 due to FMAP Reduction to 50%: \$17,641.9 Total: \$1,7641.9 GF/MH, \$(17,641.9) Fed

The FY2012 budget assumed the continuation of the ARRA FMAP. Congress did not extend the ARRA FMAP past June 30, 2011, so the base budget has excess federal authorization and inadequate GF authorization. This request makes adjustments to the fund source authorization that will reflect Alaska's 50.0% FMAP in FY2013 and assist to maintain the current level of spending in Behavioral Health Services.

Growth from FY2012 to FY2013: \$27,638.4 Total - \$2,562.1 GF/MH, \$25,076.3 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 FY2013, Behavioral Health Medicaid costs are projected to grow 13.6% from FY2012. 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 FY2012.

Projections for formula growth are based on historic trends in population, utilization, provider reimbursement, and federal financial participation. The formula growth projection does not speculate on future or proposed changes to eligibility, benefits, or federal medical assistance percentage (FMAP).

Behavioral Health 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%
2011	12,798	\$154,099.8	\$12,041	5.9%	3.9%	-1.9%

Source: MMIS/JUCE

Budget Overview Table
Children's Medicaid Services

Children's Medicaid Services	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$6,308.1	\$6,308.1	\$0.0
Federal Funds	7,629.3	7,629.3	0.0
Other Funds	0.0	0.0	0.0
Total	\$13,937.4	\$13,937.4	\$0.0

Children's Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2012 Authorized Base	13,937.4	5,584.0	0.0	8,353.4	0.0
Restore Medicaid GF for Fed	0.0	724.1	0.0	-724.1	0.0
Total	13,937.4	6,308.1	0.0	7,629.3	0.0

Budget Requests

Restore Medicaid GF/Match in FY2013 due to FMAP Reduction to 50%: \$724.1 Total: \$724.1 GF/Match, \$(724.1) Fed

The FY2012 budget assumed the continuation of the ARRA FMAP. Congress did not extend the ARRA FMAP past June 30, 2011, so the base budget has excess federal authorization and inadequate GF authorization. This change record makes adjustments to the fund source authorization that will reflect Alaska's 50.0% FMAP in FY2013.

Budget Overview Table

Adult Preventative Dental Medicaid Services

Adult Preventive Dental Medicaid	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$3,804.1	\$5390.2	\$1,586.1
Federal Funds	5,191.4	7,146.5	1,955.1
Other Funds	0.0	0.0	0.0
Total	\$8995.5	\$12,536.7	\$3,541.2

Adult Preventative Dental Medicaid Funding Needs Table

Adult Preventive Dental	Total	Unrestricted GF	Designated GF	Federal	Other
FY2012 Authorized Base	8,995.5	3,022.2	0.0	5,973.3	0.0
Restore Medicaid GF for Fed	0.0	781.9	0.0	-781.9	0.0
Medicaid Growth from FY2012 to FY2013	4,008.7	1,787.1	0.0	2,221.6	0.0
Previous fiscal notes	-467.5	-201.0	0.0	-266.5	0.0
Total	12,536.7	5,390.2	0.0	7,146.5	0.0

Budget Requests

Restore Medicaid GF/Match in FY2013 due to FMAP Reduction to 50%: \$781.9 Total: \$781.9 GF/MH, \$(781.9) Fed

The FY2012 budget assumed the continuation of the ARRA FMAP. Congress did not extend the ARRA FMAP past June 30, 2011, so the base budget has excess federal authorization and inadequate GF authorization. This change record makes adjustments to the fund source authorization that will reflect Alaska's 50.0% FMAP in FY2013.

Growth from FY2012 to FY2013: \$4,008.7 Total - \$1,787.1 GF/Match, \$2,221.6 Fed

Spending for Adult Preventive Dental grew by 13.4% from FY2009 to FY2010, but by 37.5% from FY2010 to FY2011, so spending was at the upper end of our estimates. Total spending for FY2012 has been projected again, using more up-to-date data than was available when the budget was being created. This level of funding would allow for 19.8% growth from FY2011 to FY2012. Growth from FY2012 to FY2013 is projected to be 17.2%, based on the July 2011 projections.

Previous fiscal notes: (\$467.5) Total – (\$201.0) G/F Match, (\$266.5) Fed

SB 199 authorizes the department to allow for provision of both an upper and lower denture within the same fiscal year. However, when these services are provided, the adult recipient would not be eligible for additional services under the Adult Preventative Dental program for a two-year period.

The fiscal note for this legislation contained \$935.0 in funding for FY2011, \$467.5 for FY2012, and \$0 for FY2013. This transaction reflects the decrease in funding from \$467.5 to \$0 in FY2013.

Budget Overview Table

Health Care Medicaid Services

Health Care Medicaid Services	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$315,043.3	\$333,170.0	\$18,126.7
Designated General Funds	847.5	847.5	0.0
Federal Funds	524,756.8	559,894.9	35,138.1
Other Funds	9,796.7	9,796.7	0.0
Total	\$850,444.3	\$903,709.1	\$53,264.8

Health Care Medicaid Services Funding Needs Table

Health Care Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2012 Authorized Base	850,444.3	253,280.8	847.5	586,519.3	9,796.7
Restore Medicaid GF for Fed	0.0	61,762.5	0.0	-61,762.5	0.0
Medicaid Growth from FY2012 to FY2013	53,272.3	18,130.4	0.0	35,141.9	0.0
Previous fiscal notes	-7.5	-3.7	0.0	-3.8	0.0
Total	903,709.1	333,170.0	847.5	559,894.9	9,796.7

Budget Requests

Restore Medicaid GF/Match in FY2013 due to FMAP Reduction to 50%: \$61,762.5 Total-\$61,762.5 GF/Match, (\$61,762.5) Fed

The FY2012 budget assumed the continuation of the ARRA FMAP. Congress did not extend the ARRA FMAP past June 30, 2011, so the base budget has excess federal authorization and inadequate GF authorization. This change record makes adjustments to the fund source authorization that will reflect Alaska's 50.0% FMAP in FY2013.

Growth from FY2012 to FY2013: \$53,272.3 Total - \$18,130.4 G/F Match, \$35,141.9 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 5.9% from 2012 to 2013, 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 37% since the high of \$95.7 million in 2005, spending in FY2011 was \$60.4 million.

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.

Prescription Drug Database Ch84 SLA 2008 (SB196 fiscal note): (\$7.5) Total – (\$3.7) G/F Match, (\$3.8) 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	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	80,099	\$235,260.2	\$2,937			
2000	96,263	\$277,807.6	\$2,886	20.2%	18.1%	-1.7%
2001	105,185	\$333,979.5	\$3,175	9.3%	20.2%	10.0%
2002	109,946	\$398,598.1	\$3,625	4.5%	19.3%	14.2%
2003	116,151	\$484,435.8	\$4,171	5.6%	21.5%	15.1%
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%
2011	133,773	\$726,131.7	\$5,428	6.9%	8.1%	1.2%

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	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$224,679.2	\$247,470.5	\$22,791.3
Federal Funds	235,907.6	259,130.0	23,222.4
Other Funds	3,752.2	3,752.2	0.0
Total	\$462,305.2	\$510,352.7	\$46,013.7

Senior and Disabilities Medicaid Services Funding Needs Table

Senior and Disabilities Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2012 Authorized Base	464,339.0	176,233.7	0.0	284,353.1	3,752.2
Restore Medicaid GF for Fed	0.0	48,445.5	0.0	-48,445.5	0.0
Medicaid Growth from FY2012 to FY2013	46,004.7	22,786.8	0.0	23,217.9	0.0
Previous fiscal notes	9.0	4.5	0.0	4.5	0.0
Total	510,352.7	247,470.5	0.0	259,130.0	3,752.2

Budget Requests

Restore Medicaid GF/match in FY2013 due to FMAP Reduction to 50%: \$48,445.5 Total-\$48,445.5 GF/Match, (\$48,445.5) Fed

The FY2012 budget assumed the continuation of the ARRA FMAP. Congress did not extend the ARRA FMAP past June 30, 2011, so the base budget has excess federal authorization and inadequate GF authorization. This change record makes adjustments to the fund source authorization that will reflect Alaska's 50.0% FMAP in FY2013.

Growth from FY2012 to FY2013: \$46,004.7 Total - \$22,786.8 G/F Match, \$23,217.9 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 9.0% from FY2012 to FY2013, 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.

Traumatic Brain Injury fiscal note Ch 109 SLA 2011 (SB129): \$9.0 Total – \$4.5 G/F Match, \$4.5 Fed

This is to account for an increase in funding in the fiscal note for SB219, Traumatic Brain Injury.

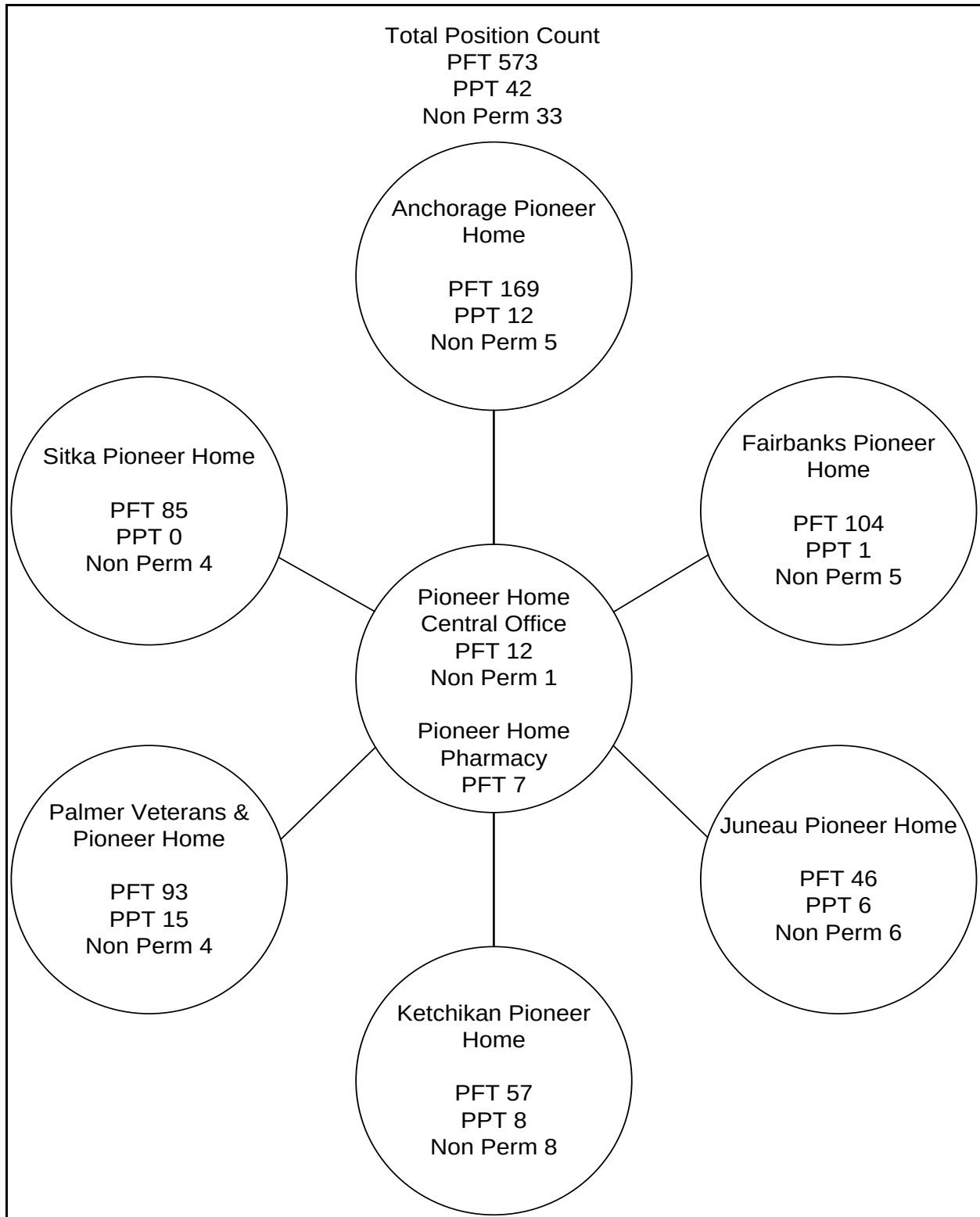
Senior and Disabilities Medicaid Services						
State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	2,688	\$79,351.7	\$29,521			
2000	2,914	\$90,587.8	\$31,087	8.4%	14.2%	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%
2011	9,169	\$400,248.7	\$43,652	10.7%	10.3%	-0.3%

Source: MMIS / JUCE

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Medicaid Services</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Medicaid GF for Fed in FY2013 due to Federal Medical Assistance Percentage (FMAP) Reduction to 50% (BH)	\$ 17,641.9	\$ -	\$ (17,641.9)	\$ -	\$ -
Medicaid GF for Fed in FY2013 due to Federal Medical Assistance Percentage (FMAP) Reduction to 50% (OCS)	\$ 724.1	\$ -	\$ (724.1)	\$ -	\$ -
Medicaid GF for Fed in FY2013 due to Federal Medical Assistance Percentage (FMAP) Reduction to 50% (Adult Dental)	\$ 781.9	\$ -	\$ (781.9)	\$ -	\$ -
Medicaid GF for Fed in FY2013 due to Federal Medical Assistance Percentage (FMAP) Reduction to 50% (HCS)	\$ 61,762.5	\$ -	\$ (61,762.5)	\$ -	\$ -
Medicaid GF for Fed in FY2013 due to Federal Medical Assistance Percentage (FMAP) Reduction to 50% (SDS)	\$ 48,445.5	\$ -	\$ (48,445.5)	\$ -	\$ -
Medicaid Growth from FY2012 to FY2013 (BH)	\$ 2,562.1	\$ -	\$ 25,076.3	\$ -	\$ 27,638.4
Medicaid Growth from FY2012 to FY2013 (Adult Dental)	\$ 1,787.1	\$ -	\$ 2,221.6	\$ -	\$ 4,008.7
Medicaid Growth from FY2012 to FY2013 (HCS)	\$ 18,130.4	\$ -	\$ 35,141.9	\$ -	\$ 53,272.3
Medicaid Growth from FY2012 to FY2013 (SDS)	\$ 22,786.8	\$ -	\$ 23,217.9	\$ -	\$ 46,004.7
Traumatic Brain Injury Fiscal Note CH109 SLA2010 (SB219 FN year 3)	\$ 4.5	\$ -	\$ 4.5	\$ -	\$ 9.0
Reduce Medicaid Coverage for Dentures CH60 SLA2010 (SB199 FN year 3)	\$ (201.0)	\$ -	\$ (266.5)	\$ -	\$ (467.5)
Reduce Prescription Drug Database CH84 SLA2008 (SB196 FN year 5)	\$ (3.7)	\$ -	\$ (3.8)	\$ -	\$ (7.5)
Reverse Medicaid Contingency Language Sec15(b) CH3 FSSLA2011 P73 L22-28 (HB108)	\$ (17,641.9)	\$ -	\$ 17,641.9	\$ -	\$ -
Reverse Medicaid Contingency Language Sec15(b) CH3 FSSLA2011 P73 L22-28 (HB108)	\$ (724.1)	\$ -	\$ 724.1	\$ -	\$ -
Reverse Medicaid Contingency Language Sec15(b) CH3 FSSLA2011 P73 L22-28 (HB108)	\$ (781.9)	\$ -	\$ 781.9	\$ -	\$ -
Reverse Medicaid Contingency Language Sec15(b) CH3 FSSLA2011 P73 L22-28 (HB108)	\$ (61,762.5)	\$ -	\$ 61,762.5	\$ -	\$ -
Reverse Medicaid Contingency Language Sec15(b) CH3 FSSLA2011 P73 L22-28 (HB108)	\$ (48,445.5)	\$ -	\$ 48,445.5	\$ -	\$ -
Medicaid Services Total	\$ 45,066.2	\$ -	\$ 85,391.9	\$ -	\$ 130,458.1

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 571 Alaska seniors during FY2011. As of October 31, 2011, 342 Alaska seniors were on the active wait list and 3,326 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 FY2005 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 \$5.52 million in Medicaid Waiver receipts in FY2011 and are budgeted to collect \$5.42 million in FY2012.

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, with one of the six being 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

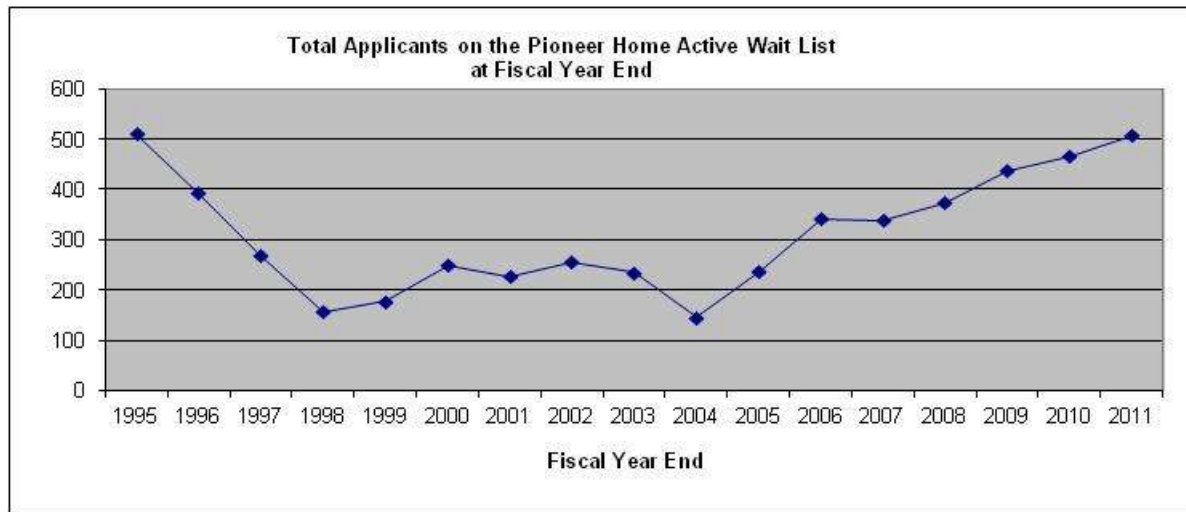
Pioneer Homes Wait List

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
2011	16	77	113	153	56	93	508

The number of applicants on the active wait list increased over the past number of 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, 2011. Since October 2010, the number of actual applicants on the active wait list decreased by 17 and the number of actual applicants on the inactive wait list increased by 358. During this same time period, the Pioneer Homes admitted 115 new residents.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	27	80	94	148	55	97	501
Inactive Branch	913	1,259	1,195	1,530	665	1,169	6,731
Total	940	1,339	1,289	1,678	720	1,266	7,232
Number of Applicants Choosing More than One Home (Duplicates)							3,564
Number of Actual Applicants on Active Wait List							342
Number of Actual Applicants on Inactive Wait List							3,326

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 FY2003.

In FY2005 the rate structure and service levels were changed to reflect actual utilization. This rate change resulted in a rate decrease for those residents formerly receiving Comprehensive Care Services and an increase for the other levels of service.

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
July 2011	\$2,350	\$4,260	\$6,170

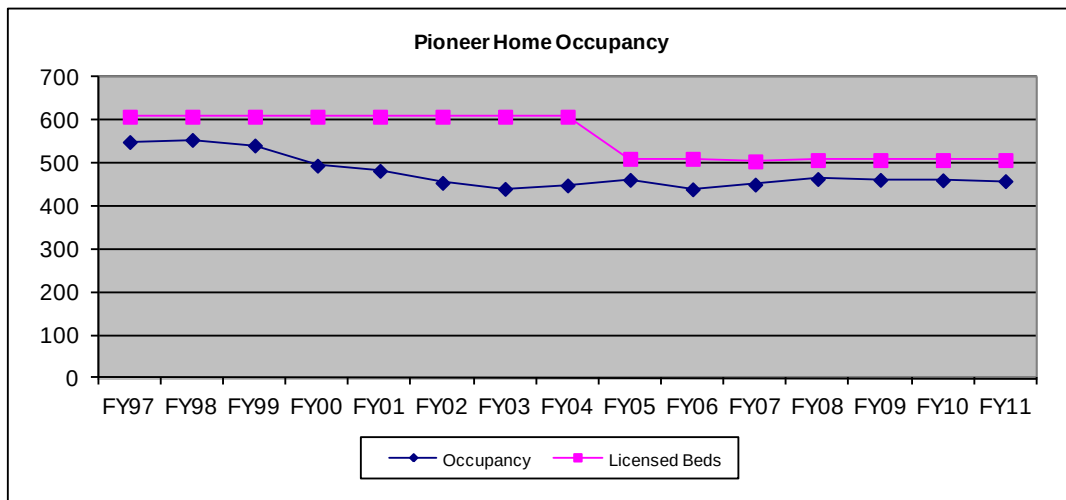
Assistance from the Older Alaskans Medicaid Waiver and the division's Payment Assistance Program are available for residents whose income and resources are insufficient to pay the full monthly rate.

Historical Pioneer Home Occupancy

In FY2005, the division reduced the number of its licensed beds by 91 to more accurately reflect the number of beds that met current licensure requirements and were available for occupancy. In FY2006 the licensed beds in the Fairbanks and Juneau Homes decreased by three to reflect a safer resident-to-staff ratio. Early in FY2008, the Anchorage Pioneer Home increased their licensed beds to accommodate applicants on the active wait list who required Level I services. The Homes can currently offer assisted living services for up to 508 Alaskan seniors.

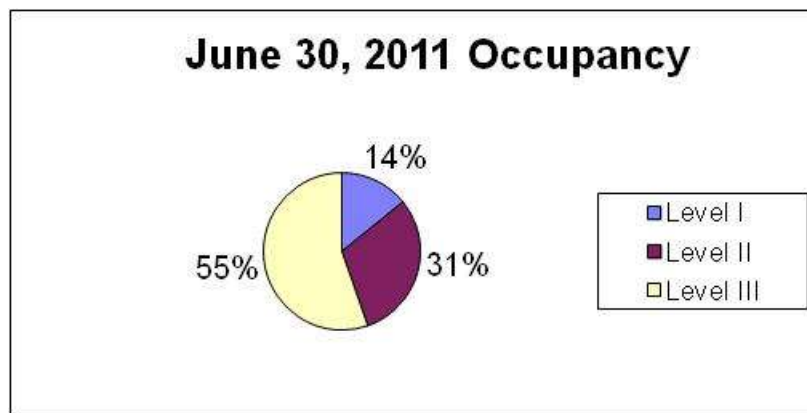
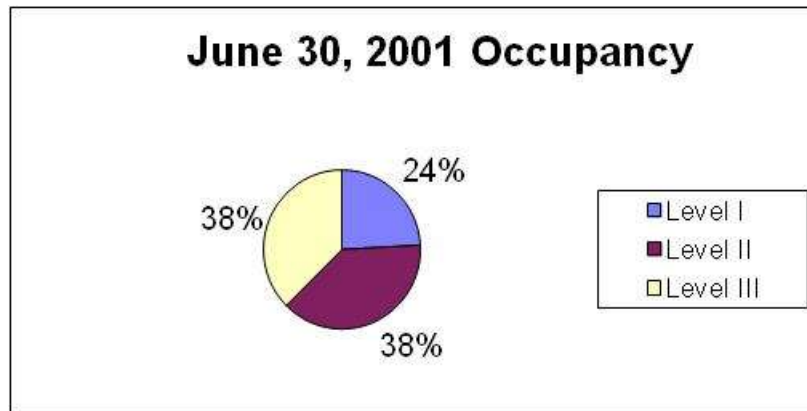
With family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. As of October 31, 2011, there were 12 Level I vacancies, 18 Level II vacancies and 15 Level III vacancies system wide. Those on the Pioneer Home active wait list tend 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 those 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 1996 and 2011. As mentioned above, the gap between licensed and occupied beds decreased significantly in FY2005 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 ten years is significant and is shown in the following two pie charts. Those residents requiring the highest level of service, Level III, increased from 38 to 55 percent, while those requiring Level I care decreased from 38 to 31 percent.

Alaska Pioneer Homes Level of Service Breakdowns: 2001 and 2011

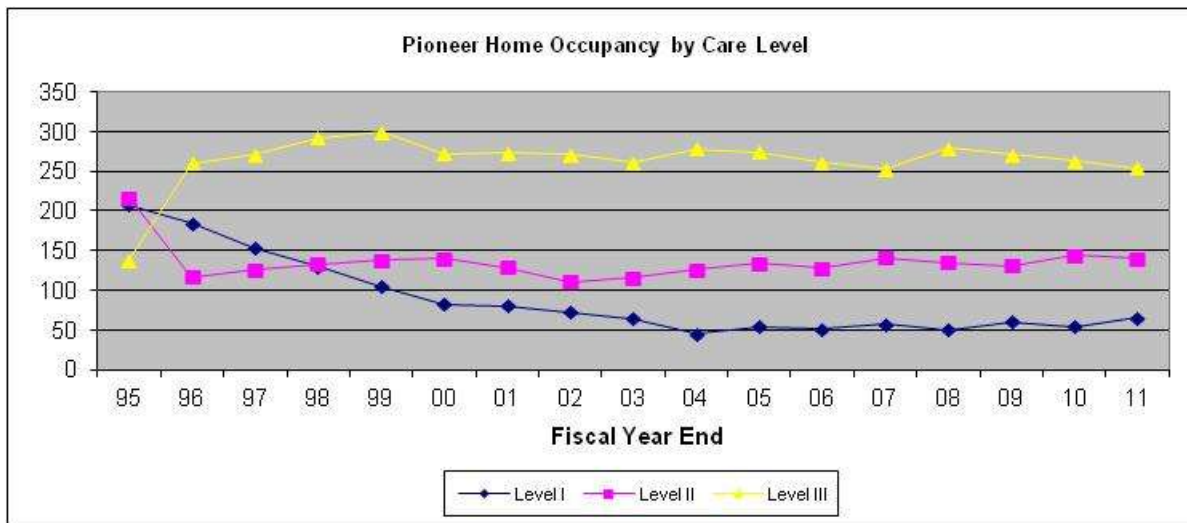


Current Pioneer Homes Occupancy

The table below shows the October 31, 2011 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home located in Palmer by level of service.

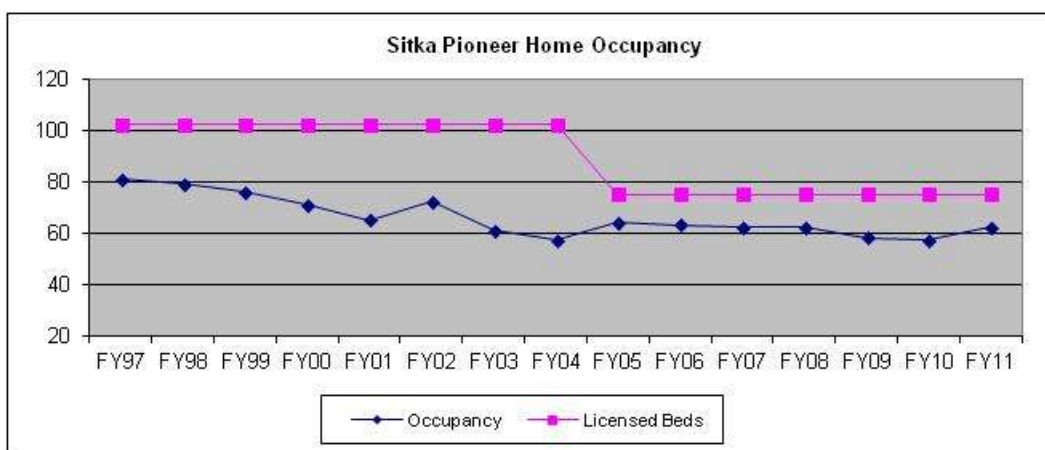
Alaska Pioneer Homes Occupancy by Home and Level of Service							
Service Level	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Level I	4	8	5	35	7	6	65
Level II	23	22	17	50	6	22	140
Level III	36	51	47	77	28	15	254
Total	63	81	69	162	41	43	459
Licensed Beds	75	93	79	168	48	45	508
Non-Occupied	12	12	10	6	7	2	49
Unavailable	2	0	0	0	2	0	4
% Avail. Beds Filled	86.3%	87.1%	87.3%	96.4%	89.1%	95.6%	91.1%

The following graph shows the Pioneer Home occupancy by level of care from FY1995 through FY2011. As you can see, the care levels of the residents served over the past few years has remained relatively stable.



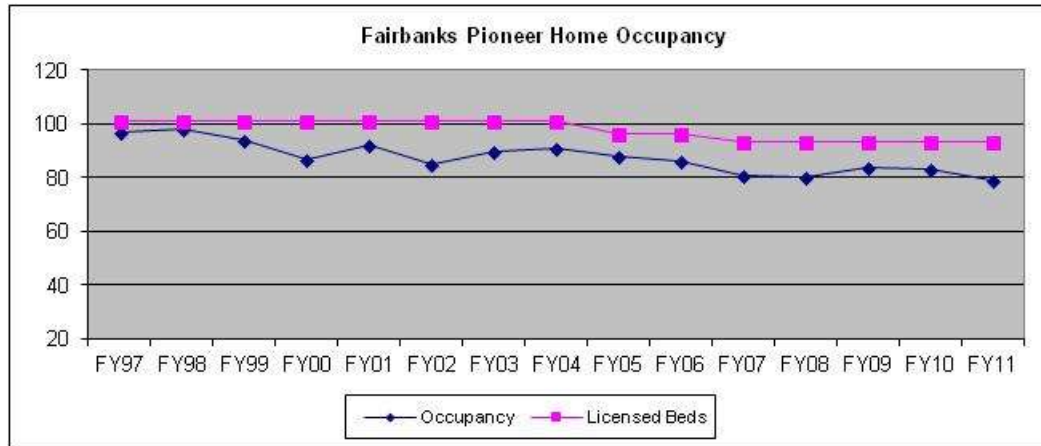
Sitka Pioneer Home

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, 63 were occupied as of October 31, 2011.



Fairbanks Pioneer Home

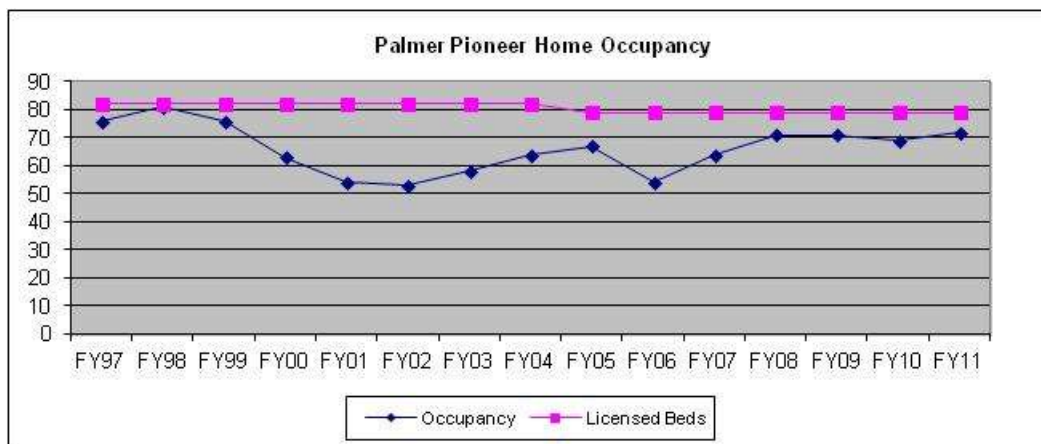
The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93. As of October 31, 2011, 81 of the 93 licensed beds were occupied.



Alaska Veterans and Pioneer Home

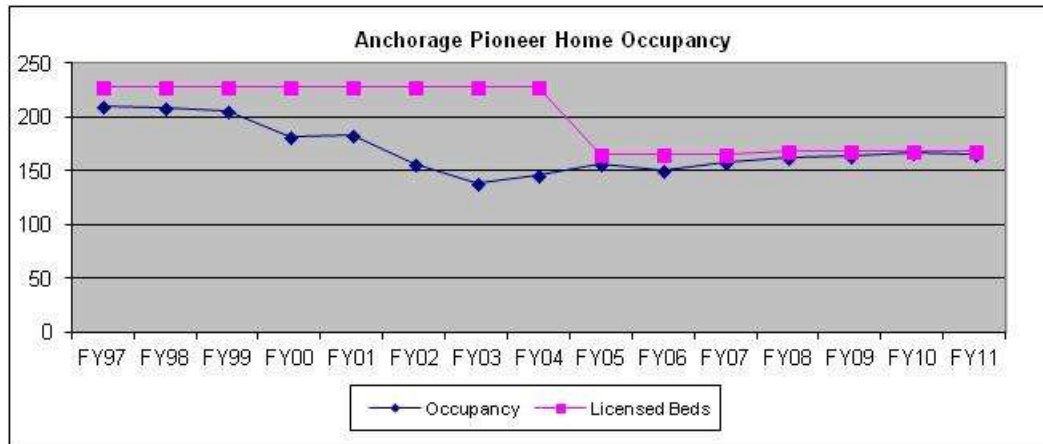
The Alaska Veterans and Pioneer Home, located in the Matanuska Valley, was built in 1971. It is a single level, ranch-style building and encompasses 11 acres of lawn and gardens. Within six years of opening, it became apparent more rooms were needed, and an addition was built. As of October 2011, 69 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 \$39.90 per day. The Home is transitioning to fill 59 of its 79 licensed beds with veterans. As of October 2011, 35 veterans resided in the Home. Nineteen of the beds are reserved for spouses of veterans, children of veterans, and all non-veteran related Alaska pioneers. The state Veterans and Pioneer Home operates under the same guidelines as the five other Pioneer Homes, requiring one-year residency and a minimum resident age of 65 years.



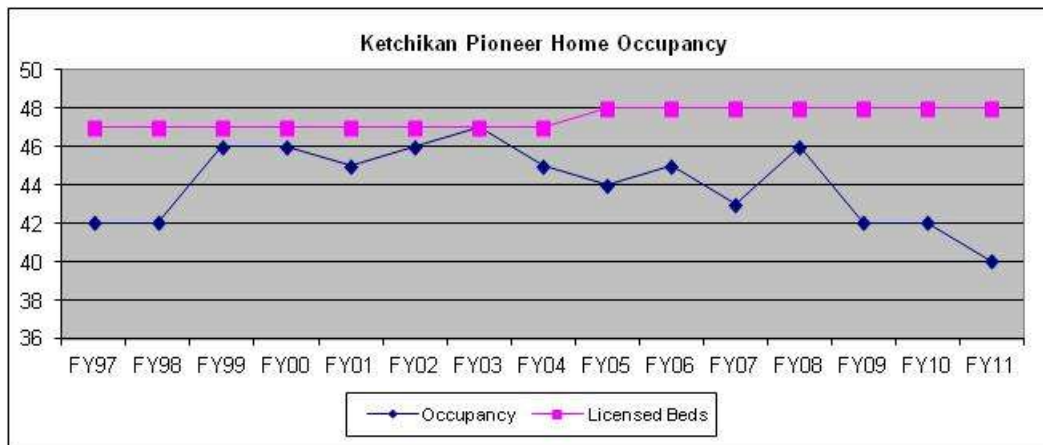
Anchorage Pioneer Home

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 2011, 162 of the 168 beds were occupied. Early in FY2008 the Anchorage Home increased its licensed beds by three to accommodate Level I residents on the active wait list.



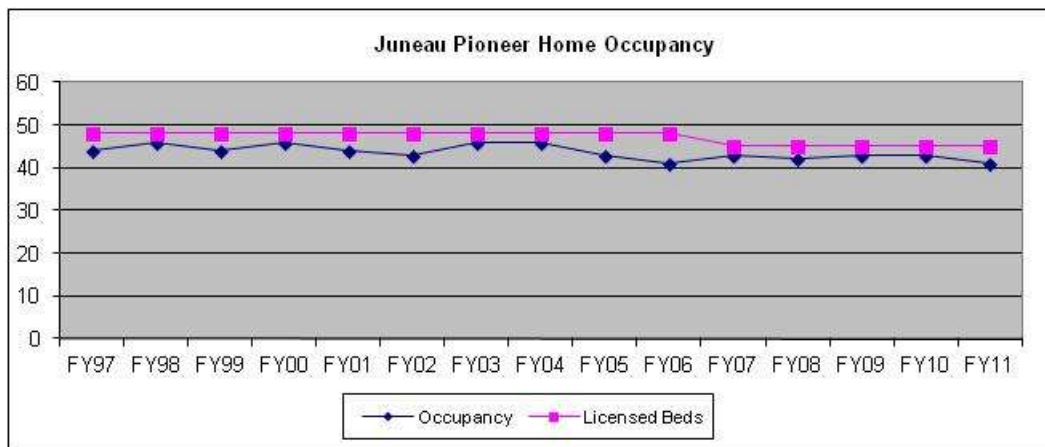
Ketchikan Pioneer Home

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 2011, 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' Home/Veterans' Home: SB 301
AS 44.29.020(1)(16)	Duties of DHSS-Amended by Ex Order 108, Sec 4; Ch 59, SLA 2004
AS 44.29.400	State Veterans' Home Facilities – Amended by Ex Order 108, Sec. 4; Ch 59, SLA04
AS 47.55	Pioneers' Home – Amended by Exec Order 108, Sec 4; Ch 59, SLA04
AS 44.29.500	Pioneers' Home Advisory Board
7AAC 74	Pioneers' Home – Revised August 2004

Explanation of FY2013 Operating Budget Requests

Alaska Pioneer Homes

Budget Overview Table

Alaska Pioneer Homes	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$34,852.9	\$35,276.2	\$423.3
Designated General Funds	16,101.2	16,276.1	174.9
Federal Funds	353.4	342.0	-11.4
Other Funds	9,078.7	9,167.1	88.4
Total	\$60,386.2	\$61,061.4	\$675.2

Budget Requests

Pioneer Homes Management and Pioneer Homes: Transfer of Personal Services Funding \$81.2

In the FY2012 Management Plan, \$81.2 GF was transferred to the Alaska Pioneer Management component from the Pioneer Home component along with the transfer of the Procurement Specialist II position. Since that time, two vacant positions, PCN 06-0610 and PCN 06-9500 were deleted from the Pioneer Home Management component, but the funding for the positions remained. Because the \$81.2 is not needed to fund the Procurement Specialist II position in the Management component, it is returned to the Pioneer Home component.

Pioneer Homes Management Component: Reduce Unrealizable Federal Receipts \$15.0

The Pioneer Homes Management component is unable to collect the full federal receipt authorization. This request decreases the authorization to the amount of projected collections.

Explanation of FY2013 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 Anchorage, Fairbanks, Juneau, Ketchikan, Palmer, and Sitka and have a combined replacement value of \$310.3 million.

Challenges

Increased Resident Acuity

Level II and III residents in the Homes have increased from 63% in June 1995 to 76% in June 2011. 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 November 22, 2011 the average age of a Pioneer Home resident was 86.4. 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 342 applicants as of October 2011, an increase of 156 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.

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 similar jobs 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, and yet it has always been difficult to adequately budget funding for such 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, or 59, of the 79 licensed beds. During FY2007 and FY2008 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 FY2009 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 FY2010 the ratio increased to two veteran admissions for every one non-veteran admission. In FY2011 the ratio increased to three veteran admissions for every one non-veteran admission. The FY2012 ratio increased 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, 2011 there were 35 veterans residing in the Alaska Veterans and Pioneer Home. This is an increase of six over the same date last year.

Adequate Storage

The Anchorage Pioneer Home needs additional storage space to store supplies, equipment, and disaster preparedness items. There is no room on-site at the Anchorage Pioneer Home to place additional storage, so off-site storage is the only option.

Performance Measure Detail

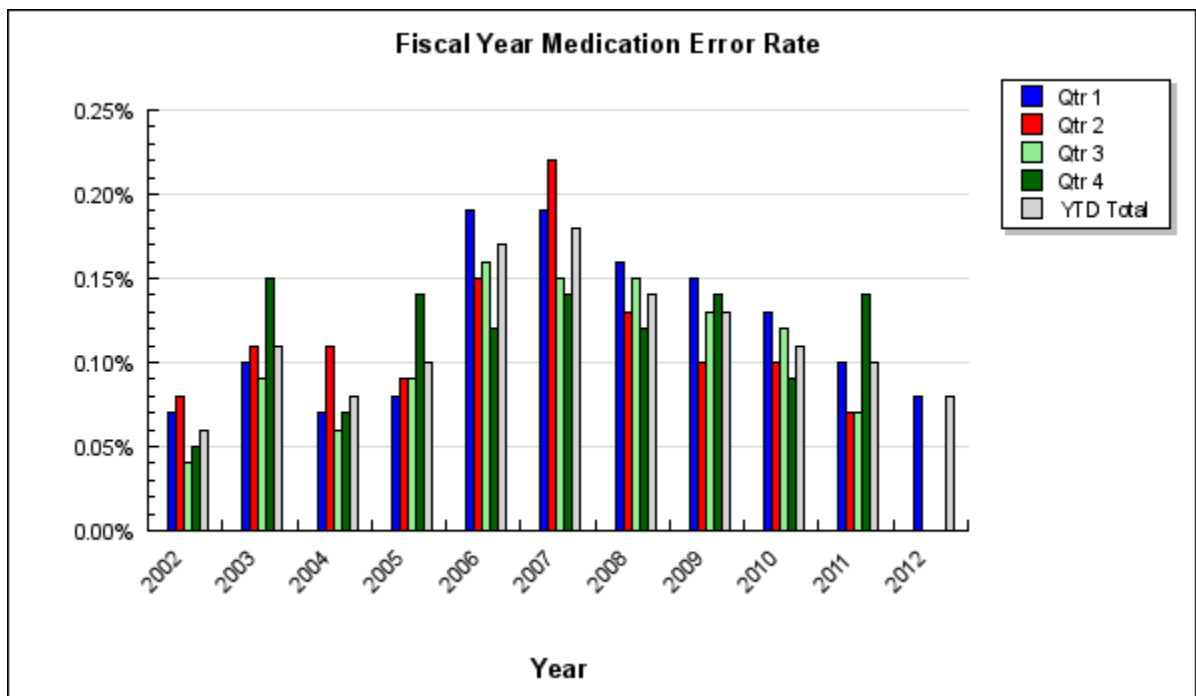
Performance Detail

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

A1: Strategy - The Alaska Pioneer Homes will maintain a safe environment for residents by improving the medication dispensing and administration system.

Target #1: The medication error rate for the Pioneer Homes will be less than 5%.

Status #1: The target to reduce the medication error rate for the Pioneer Homes was met. The medication error rate decreased to 0.10% in FY2011, from 0.11% in FY2010, and 0.13% in FY2009, comparing favorably with the CMS target medication error rate of less than 5% (CMS Guidance Memo S&C-07-39, 9/28/2007). The Pioneer Homes has continually decreased its medication error rate since FY2006. The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications dispensed in the same quarter x 100. (Source: The Alaska Pioneer Homes)



*Methodology: The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications dispensed in the same quarter x 100.
(data source: The Alaska Pioneer Homes)*

Fiscal Year Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2012	0.08%	0	0	0	0.08%
2011	0.10%	0.07%	0.07%	0.14%	0.10%
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%

Analysis of results and challenges: The Centers for Medicare and Medicaid Services (CMS), which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable. (CMS Guidance Document, August 31, 2007)

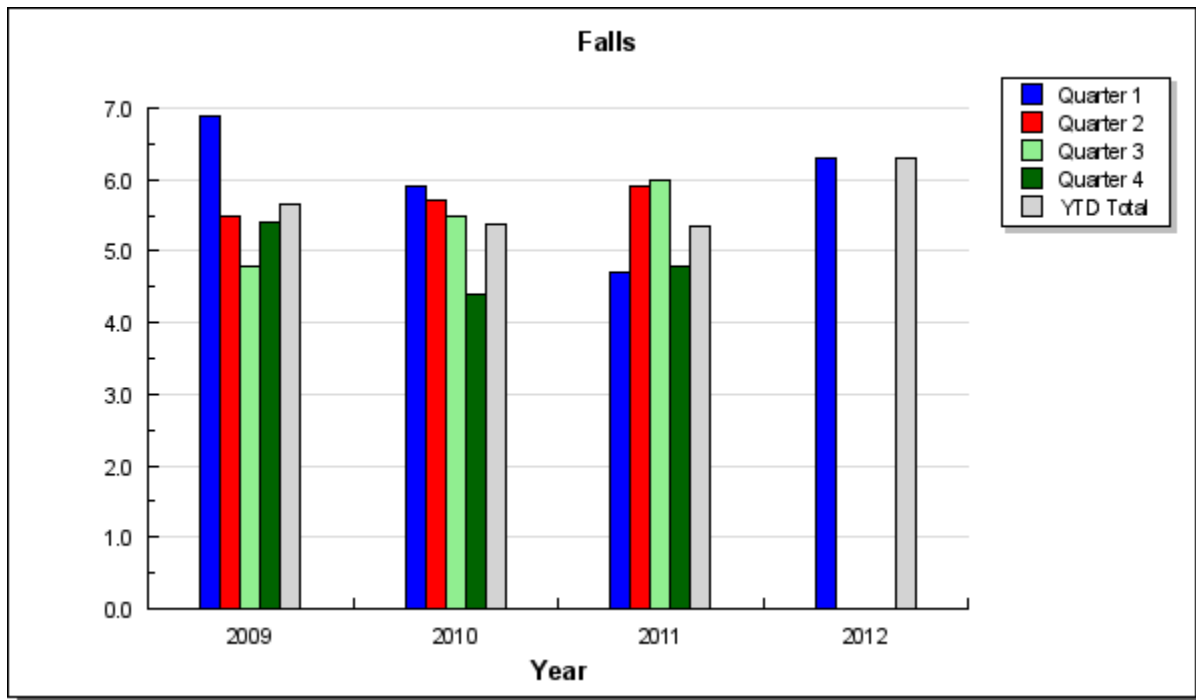
The Alaska Pioneer Home system collects medication information at the individual Alaska Pioneer Home level and aggregates the numbers for reporting at the division level. All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent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

A2: Strategy - The Alaska Pioneer Homes will create a safe environment for elders by reducing the number of resident falls and sentinel events.

Target #1: The Pioneer Homes will keep the resident fall rate below 6.0 for every 1000 bed days of care. (Rate=#Falls/bed daysX1000)

Status #1: The Alaska Pioneer Homes has achieved its target to keep resident fall rates below 6.0 for every 1000 bed-days of care. (Rate= #Falls/bed-daysX1000) From FY2009 to FY2011; the Pioneer Homes has continued to slightly decrease the average resident fall rate: 5.65 in FY2009, 5.37 in FY2010, and 5.35 in FY2011.

Comparing fall rates among different Long Term Care programs is difficult because of varying fall definitions, data reporting methods, differences in settings and resident populations, and the lack of risk adjustment. The most reliable and useful approach for any organization is an examination of its own quality indicator data over time, with the ultimate goal of reducing and eliminating all preventable falls. (Source: Alaska Pioneer Homes)



Methodology: The fall rate is a measurement of risk and indicates how many falls can be expected for every 1000 bed days of care. (Falls/bed daysX1000=rate)

Comparing fall rates among different Long Term Care programs is difficult because of varying fall definitions, methods to report data and differences in settings and resident populations, and the lack of risk adjustment. The most reliable and useful approach for any organization is an examination of its own quality indicator data over time -- with the ultimate goal of reducing and eliminating all preventable falls.

(Data source: Alaska Pioneer Homes)

Falls

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2012	6.3	0	0	0	6.3
2011	4.7	5.9	6.0	4.8	5.35
2010	5.9	5.7	5.5	4.4	5.37
2009	6.9	5.5	4.8	5.4	5.65

Target #2: Sentinel event injuries will not increase.

Status #2: The target to reduce the number falls resulting in a major injury (sentinel event injuries) was met. In FY11, the NEW sentinel injury rate was 0.030%, which is well below the 2.6% target. In FY10, the rate of Pioneer Homes resident 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 FY11 the new target of 2.6%, coincides with the Joint Commission (JCAHO) standard.

Sentinel Event Rate

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2012	0.000	0	0	0	0
FY 2011	0.066	0.053	0.023	0.000	0.036
FY 2010	0.175	0.154	0.058	0.209	0.149
FY 2009	1.3%	2.3%	3.4%	3.8%	2.7%
FY 2008	1.5%	1.3%	2.0%	2.1%	1.7%
FY 2007	3.5%	1.2%	2.0%	4.9%	2.9%
FY 2006	0.6%	2.7%	1.3%	1.1%	1.4%

Methodology: Beginning with FY 2010 the Pioneer Homes changed its methodology. The new sentinel event rate is determined by dividing the number of sentinel events by the number of resident bed days x 1000 (expected sentinel events for every 1000 bed days of care). Previously, the sentinel event rate was the percentage of sentinel events in relation to falls (sentinel events/falls x 100 = %). The new rate enables the Alaska Pioneer Homes to compare our rates to the the Joint Commission (JCAHO) standard of 2.6.

There is no national standard for sentinel events due to falls. JCAHO does not track sentinel events based on a percent of falls. JCAHO tracks sentinel events compared to the population of a Home. The JCAHO average is 2.6 for sentinel events compared to the total bed days/population of a Home.

Sentinel events are tracked by the Pioneer Homes to ensure that sentinel events are adequately analyzed and undesirable trends or decreases in performance are addressed and mitigated.

(Data Source: Alaska Pioneer Homes)

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.

A3: Strategy - The Alaska Pioneer Homes will keep residents safe by the retention of experienced direct care givers.

Target #1: CNAs workforce retention is increased in the Pioneer Homes per fiscal year

Status #1: The CNA turnover rate for the Division of Alaska Pioneer Homes for FY2011 was 30.0%. Turnover of CNA staff is costly to the Alaska Pioneer Home (costs associated with hiring, training and for a person to be proficient at the job). In addition, there is a disruption to the resident when experienced primary care providers (CNAs) leave Alaska Pioneer Home's employment.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2011	10.5%	4.8%	6.2%	8.0%	29.5%

Methodology: Turnover percentage rate is the total of Certified Nursing Assistants (CNA) terminated divided by the total number of CNAs (274) times 100.

(Data Source: Dept. Labor, Alaska Pioneer Homes, H&SS personnel)

A4: Strategy - The Alaska Pioneer Homes will keep elderly eligible Veterans and Alaskans safe by working to reduce the number of elders on the Alaska Pioneer Homes waitlist.

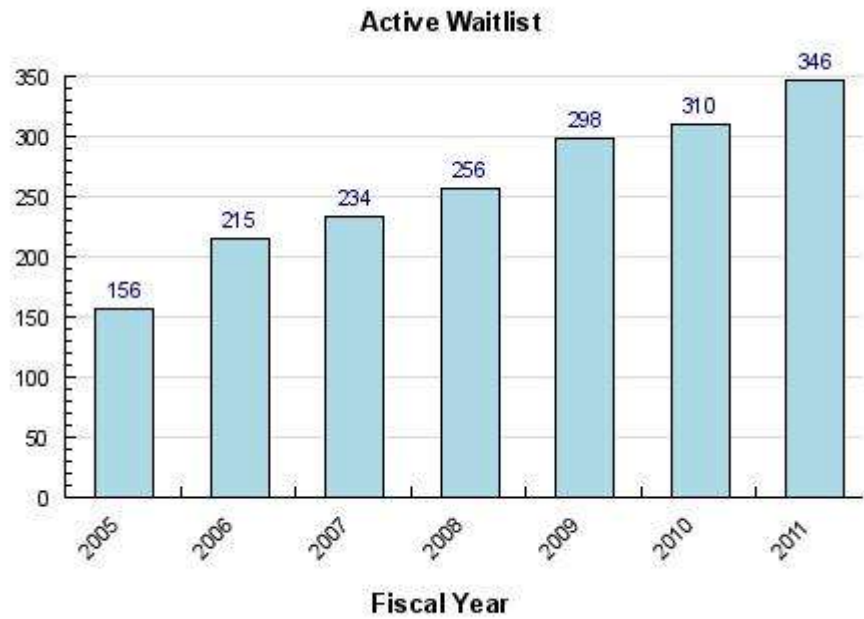
Target #1: Alaska Pioneer Homes will reduce the active waitlist by expanding and providing more assisted living home beds for Alaska elders.

Status #1: The Alaska Pioneer Homes maintains an active and inactive waitlist. In order to enter a Pioneer Home an elder Alaskan must be a resident of Alaska and first submit an application to be placed on the Alaska Pioneer Home waitlist. For the last several years the Alaska Pioneer Homes has experienced an annual increase in the number of elder Alaskans being placed on the waitlist. An elder on the active waitlist may remain there for several years before a vacant bed that meets their needs becomes available and they can enter a Pioneer Home.

The Pioneer Homes endeavors to decrease the waitlist by offering additional beds to eligible Alaskan and Veteran elders.

Increase in total waitlist was 279 elders as of 7/30/11 over the prior year.

Increase in total waitlist was 317 elders as of 7/30/10 over the prior year.



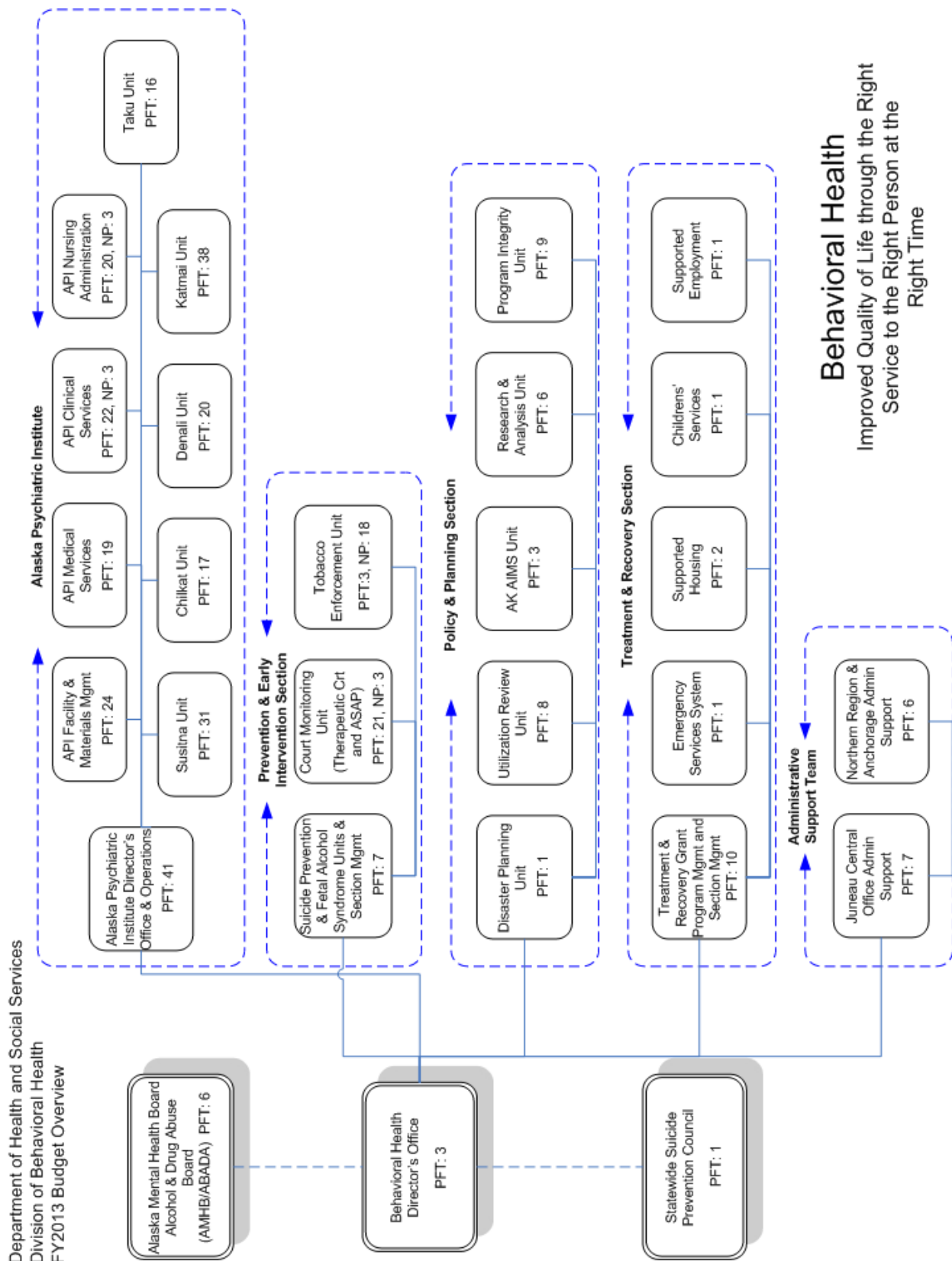
Methodology: Total increase of elders on the Active Waitlist for a fiscal year taken in a point in time on June 30th compared to the previous fiscal years.

(Data source: DHSS AK Pioneer Homes)

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Alaska Pioneer Homes</u> Alaska Pioneer Homes - General and Other Funds (Increase, Decrease and OTI Items Only)								
Item	PFT	PPT	NP	UGF	DGF	Federal	Other	Total
Unrealized Authority	0	0	0	\$ -	\$ -	\$ (15.0)	\$ -	\$ (15.0)
Reverse August FY2012 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	0	0	0	\$ (392.8)	\$ -	\$ -	\$ -	\$ (392.8)
Alaska Pioneer Homes Total				\$ (392.8)	\$ -	\$ (15.0)	\$ -	\$ (407.8)

Division of Behavioral Health



Introduction to the Division of Behavioral Health

Mission

Improved quality of life through the right service to the right person at the right time.

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 mental health and substance use disorder 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 urban and rural 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

The central purpose of the Division is 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 inpatient psychiatric hospitalization 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 behavioral health promotion and prevention programming. These services, in conjunction with the DBH Treatment and Recovery programs, provide a comprehensive continuum of care for Alaska's communities.

In alignment with the division's vision of *partners promoting healthy communities*, the core components include: 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.

Four primary grant programs have been established in alignment with the core components, 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)

Fiscal year 2012 is the first year in a new 3-year grant cycle. A Request for Proposals was issued in February 2011; 46 proposals were received requesting over \$11 million in program funding. Available funding equaled just over \$4.1 million, making funding decisions very difficult. Clearly, there is a need for more behavioral health funding to provide support to communities working to prevent substance use/abuse; suicide; and fetal alcohol spectrum disorders; as well as

funding to promote overall mental health and wellness. Proposals were divided into three categories:

1. Building Capacity: eligible to apply for up to \$150,000
2. Implementation with populations under 20,000; eligible to apply for up to \$150,000
3. Implementation with populations over 20,000; eligible to apply for up to \$500,000

Each category held a separate Proposal Evaluation Committee (PEC) to make sure like grants competed against like grants (comparing apples to apples). In addition to PEC scores, additional selection criteria included:

1. Service type
2. Regional distribution
3. Urban v. rural distribution
4. Areas with unmet needs or un-served populations
5. State staff scores/past grantee performance

A total of twenty five proposals were selected for funding: seven were Building Capacity grants; ten were Implementation grants for under \$20,000; and eight were Implementation grants for over \$20,000. Funded proposals represented remote/rural communities, as well as hub and urban communities. Each community applying for these funds was required to 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. Each funded proposal was required to develop an evaluation plan with baseline data to show the impact each selected strategy is having on the outcome for those communities being served. Outcome data reporting is required bi-annually in January and again in July.

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. ASAP programs are also key partners in their community prevention coalition doing outreach and education efforts in schools, community forums, and other appropriate venues. Five Probation Officers and five community grantees handle traditional adult misdemeanor ASAP referrals in Alaska. 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, Glenallen Ketchikan, Kodiak, Seward, Nome, and Bethel. Anchorage has also developed a "fast track" court which enables ASAP and the courts to more closely monitor those offenders who are at greater risk of falling through the cracks. Those offenders who are in the fast track court are required to have more frequent contact with the court while the ASAP POs monitor the participant's involvement in treatment and any additional requirements.

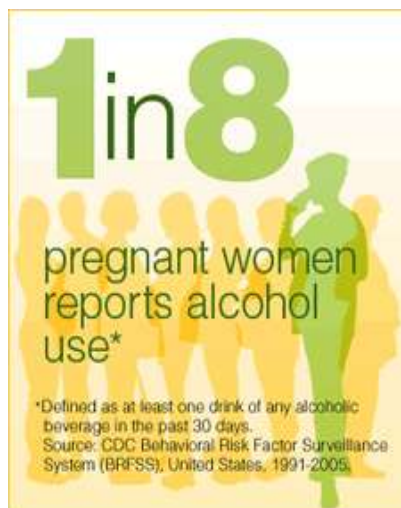
The ASAP program is designed to provide a standardized statewide network of alcohol screening and case management of cases referred by the criminal justice system. It offers a consistent

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.

Unlike the therapeutic court, most offenders assigned to the misdemeanor program must complete their court ordered requirements mostly independently. Because chronic non-compliance with the ASAP misdemeanor program substantially increases costs to public safety, the judicial system, prisons, and of lost lives, the ASAP program has been exploring a hybrid court for high risk offenders who have failed their first try through the ASAP program. Short of a referral to the therapeutic court program, the high risk court requires many of the same elements such as increased contacts with a judge and probation officer, shortened timelines, and higher expectations to get through court ordered treatment. Although this process is only slightly more expensive than the standard process, the cost savings are expected to be well worth the effort.

In FY2010, the ASAP program incorporated Motivational Interviewing (MI), an evidence-based practice, as a mechanism for increasing the engagement of clients during their first encounter with ASAP staff. Best practices suggest that best outcomes for engaging offenders through treatment is getting them enrolled quickly. Using MI-styled interviews at the ASAP level is expected to improve outcomes for program completion in the short- and long-term. Although funding is limited, there are additional efforts to integrate screening and assessment processes within the ASAP office in order to further facilitate offenders enrollment into education or treatment.

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, eight 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, and Mat-Su Valley. FY2010 saw the addition of

two new diagnostic teams in Anchorage housed at ASSETS, and in Copper Basin. The diagnostic capacity of Alaska significantly increased with the addition of these two teams. The Copper Basin Team voluntarily ended their provider agreement with the State after a year of diagnostic service. 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 Alaska Native Health Service beneficiaries. At this time, there is interest in developing diagnostic teams in Dillingham, Nome, and Barrow, all of which are communities that offer few options for individuals seeking FASD diagnostic services beyond travel to an urban area with a certified team.

During FY2011 a total of 179 diagnoses were completed, an increase of 34% from the 133 diagnoses completed in FY2010. For each completed diagnosis, teams 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. In FY2012, the provider agreement will be revised to ensure higher accountability of teams. There is also an initiative to study both the short term and long-term outcomes of the diagnostic teams to confirm their efficacy and modify the program in response to the data and its analysis.

In FY2012, the state will implement a new initiative to provide case management services to individuals who have been diagnosed with a FASD by one of the diagnostic teams located in Kenai, Bethel, Juneau, or Sitka. This new effort will provide the services needed to link people with FASD to necessary community resources. Support for individuals seeking services, interventions and accommodations for FASD are a great need in Alaska, especially rural Alaska, and this initiative is the first of its kind to address this need. By the end of fiscal year 2012, we expect to have at least one case manager working in each of the aforementioned communities.

The most current Alaska FAS prevalence rates show 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. These data were released in 2009; new prevalence data is currently being collected and analyzed.

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 RHS certification, 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
- Alaska's Strategic Prevention Framework: Building Community Coalitions
- Therapeutic Court Programs
- Tobacco Enforcement and Education
- Suicide Prevention and the Statewide Suicide Prevention Council
- Domestic Violence & Sexual Assault Prevention Initiative
- Broadening the Vision of Prevention

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 (ACPUD), 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 ACPUD 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).

In 2011, the Alaska Committee to Prevent Underage Drinking (ACPUD) began to reconvene as an advisory group to the Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory Committee. This was a logical next step for the ACPUD since the SPF SIG will be focusing on preventing underage drinking as part of their focus. The ACPUD will be focused on developing a draft revision of the plan in order to have it available for reissue in the fall of 2012. In keeping with the tradition of the original plan, the plan will be revised based on public input. In the first part of 2012, SAMSHA will be supporting town hall events around the country. The section of Prevention and Early Intervention will be assisting communities interested in conducting these town halls. The ACPUD hopes to have a draft of the revisions available for communities to review at these events, if so desired. In addition to the town hall feedback, we will also include the information collected in 2010 and 2011 from Alaskans (providers, youth and grantees). Those recommendations will be incorporated into the final revision. The current version of the 2009 Plan is available at:

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



In 2010, in partnership with the federal Center for Substance Abuse Prevention, the Division of Behavioral Health developed a video related to underage drinking in Alaska. The focus of the video is to 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. This year the video is available to stream online or in DVD format. For viewing the Alaska video *Underage Drinking Prevention in Alaska: A Collective Responsibility* go to <http://www.stopalcoholabuse.gov/statevideos.aspx>.

Alaska's Strategic Prevention Framework State Incentive Grant: 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. Grant funds are targeting the two (2) priority consumption patterns that impact Alaska in a significant way:

- Youth alcohol abuse (ages 12-20)
- Adult heavy and binge drinking (ages 21-44)

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

Six grantees from across the state have received SPF Community grant funds to address these priority areas.

1. Rural Alaska Community Action Program (RurAL CAP): \$318,810. RurAL CAP is based in Anchorage, but is serving three villages surrounding Nome: Teller, Savoonga and Shishmareff. RurAL CAP has partnered with agencies in the Nome region, including Kawerak and Norton Sound Health Corporation. Although each of these villages will have its own coalition to address unique community needs regarding the priority areas, it will also utilize its existing regional coalition—the Regional Wellness Forum comprised of representative from outlying communities.
2. Alaska Island Community Services: \$316,716. Alaska Island Community Services is working with the Southeast communities of Petersburg and Wrangell. Alaska Island Community Services has engaged Petersburg Mental Health Services as a key stakeholder in the SPF project, and is utilizing the existing Central Southeast Prevention Coalition as the operating coalition for this project. The coalition leadership team is the identified group who will oversee the SPF to ensure key stakeholders and members stay on track.
3. Fairbanks Native Association: \$345,961. Fairbanks Native Association is serving the Fairbanks North Star Borough—they are working with the largest service area of these six grantees. Fairbanks Native Association has recently become the recipient of the federal Drug Free

Communities (DFC) grant, the Fairbanks Prevention Coalition, which the SPF will be operating under.

4. Cook Inlet Council on Alcohol and Drug Abuse (CICADA): \$350,000. CICADA is serving the community of Homer. CICADA has strong partnerships with key stakeholders, who include Haven House and The Center, non-profit agencies in their service area. The Homer community serves a unique blend of communities—some are Caucasian fishing communities, others are isolated Native villages only accessible by boat or plane, while others are called “Old Believers” or Russian communities. CICADA is utilizing their local coalition, Mobilizing for Action through Planning and Partnership (MAPP), which was created in 2008. The steering committee, which will play a key role in the management of this grant, has a focus of domestic violence and substance abuse.
5. Yakutat Tlingit Tribe: \$350,000. Yakutat Tlingit Tribe is serving Yakutat, and is utilizing their Drug Free Communities coalition, the Yakutat Healthy Community Coalition, to serve the SPF. They have been in operation since 2001 and have strong community engagement from parents, students, tribal leaders, the City and Borough and counseling service providers. Yakutat is addressing the need to expand their workforce to meet the needs of this grant and are having staff participating in RADACT training as well as the Rural Human Services program to increase their ability to provide prevention services to their community.
6. Southeast Alaska Regional Health Corporation (SEARHC): \$350,000. SEARHC is serving three (3) communities across Southeast Alaska: Angoon, Kake and Klukwan. Each of these communities has unique needs and conditions, and this grantee is committed to serving each of the villages by having a direct service provider based in each community. SEARHC is utilizing their established coalition, the Suicide Prevention Taskforce, to address the priority areas of adult heavy and binge drinking and underage drinking in each of these communities.

Each grantee is currently in the first stages of the Strategic Prevention Framework (SPF): Step 1: Assessment and Step 2: Capacity Building. Grantees are identifying key stakeholders in the SPF, developing their coalition, gathering local level data and hiring on key staff, such as their evaluators. Only then will they continue to the next three Steps of the SPF: 3: Planning, 4: Implementation, and 5: Evaluation.

Domestic Violence & Sexual Assault Prevention Initiative

Beginning in state fiscal year 2011, the Division of Behavioral Health began working in partnership with the Office of the Governor in the statewide initiative to end domestic violence (DV) and sexual assault (SA) within a decade. DBH took the lead in three primary DV & SA prevention projects: Rural DV & SA Prevention Pilot Projects; Trauma Informed Care Training for Service Providers; and Expansion of the Family Wellness Warriors Initiative.

The Rural DV & SA Prevention Pilot Project has funded a total of four programs for a 3-year grant cycle; one implementation grant (\$800,000 per year) and three building capacity grants (\$200,000 per year).

The DV & SA Implementation grant is providing service to the Bristol Bay area, primarily Dillingham with some outreach to other communities. They are focusing heavily on impacting the youth of the Bristol Bay region, recognizing the need to begin generational change that can continue. In addition, they are utilizing the *Green Dot* concept to increase by-stander involvement in recognizing and saying no to DV and SA.

The three Building Capacity grants are located in Bethel and the YK region; Kodiak and surrounding island communities; and Sitka, Angoon and Kake. Each of these programs has

identified region-specific needs to focus their efforts—Sitka is focusing on youth and community involvement and completed a community *Choose Respect Mural* that was mounted on the outside of a local school. Kodiak is working to bring the whole community into the effort through public education, awareness and using *Green Dot* by-stander awareness programming, making appropriate regional and cultural revisions to be most useful. Bethel has identified historical trauma and racism as the primary root cause for DV & SA in their region and is focusing on these two critical issues, as well as bringing back traditional cultural values, practices and strategies to combat domestic violence, sexual assault and alcohol abuse.

Each of the four grantees is partnering with the Council on Domestic Violence and Sexual Assault and the University of Alaska Anchorage in conducting regional versions of the Alaska Victimization Survey—a phone survey to begin collecting data on the incidence of sexual assault across Alaska. Dillingham conducted the survey in FY2011 and the other three communities will begin the survey in their regions in January 2012.

Broadening the Vision of Prevention

Nationwide, as well as locally, there is a movement to broaden the vision of prevention to include; promotion of mental health, physical health and wellness; in addition to the traditional prevention strategies; recognizing the need to act earlier and to incorporate all aspects of health into our state and community health planning. Within the Division of Behavioral Health we oversee a continuum of care that includes prevention of substance abuse, early intervention services for those at risk for substance use or mental health concerns, treatment of both substance use disorders and mental health disorders, and recovery and maintenance following specific treatment services. The piece that has been missing is promotion of good mental health, physical health and overall individual, family and community wellness that can stop the need for future interventions along the continuum of care. In addition, mental health has never been part of the “prevention” services and we are now recognizing there are many strategies and interventions that can be employed to delay the onset of, and reduce the severity of many mental health conditions. The Division of Behavioral Health is committed to expanding our vision of prevention. The climate is right for change, as the value of prevention, across disciplines, is gaining momentum. There is now a clear recognition that the social and health problems we are working to minimize are all interconnected, and our efforts across the continuum of care must start earlier, be broader in our reach, and be coordinated across disciplines and service types.

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 with a case load of 30 to 40 clients work with these clients referred through the Therapeutic Court system. 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, such as 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 re-enter 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 with 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 investigators 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 36% in 2001, to 7.6% in 2011. 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 promote 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. The Alaska Division of Behavioral Health is continuing its work 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 as Alaska’s Veterans organizations. We are working to better monitor higher risk populations and develop proper and adequate early identification, screening and referral resources, including gatekeeper suicide prevention trainings as necessary to avert suicide crises.



The council has recently released, for public review, the newly revised Alaska Suicide Prevention Plan 2012-2017: *Casting the Net Upstream*. The Plan will be final in January of 2012. In the plan is a call to action to prevent and reduce suicide in our state by working further upstream, looking beyond just the rates and seeking prevention oriented solutions to underlying issues, problems and conditions that pave the way for suicides to occur. Traditionally, we have isolated and treated individual factors that contribute to suicide, i.e. alcohol, domestic violence, sexual abuse, that exhausts our resources of limited emergency care that is often a crisis driven system. The plan will allow us to develop a more comprehensive view of suicide and promote

new strategies that help to reveal the underpinning issues that increase the likelihood of suicide among our youth, adults, Veterans, LGBT community, and other vulnerable populations.

Suicide Prevention Initiatives

Behavioral Health received a no-cost extension of the Garrett Lee Smith federal grant awarded for Federal FY2009 – 2011, to continue funding 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, Fairbanks Northstar Borough 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 post-vention plans to help prepare communities to respond after a suicide occurs.

A critical and key piece of suicide prevention work is the Alaska CareLine, providing the only statewide suicide crisis hotline in Alaska. Recent reports indicate that suicide calls have increased incrementally over the past several years. CareLine has 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.

On International Suicide Prevention Awareness Day, September 10th of 2009, the division in partnership with the Council, 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 continues to be developed and will allow more partners to better communicate, inform, educate and empower each other in their work. Plans are underway to create a formal network of members to the site that will target ongoing projects and developments around the state.

Behavioral Health has formed a stakeholder advisory group to help guide the development of suicide postvention resources including a comprehensive postvention resource 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. A Postvention Training and Healing Conference was held in June of 2011, with approximately 80 people attending from around the state. The goal of the conference was to develop further the postvention plans for Alaska.

Through this process, the division recognized its lack of a formal policy that directed treatment providers in how to respond consistently to suicides. Current efforts are underway to finalize a statewide policy for all community-based behavioral health centers to implement during this fiscal year. In addition, the division will provide technical assistance and training to all behavioral health providers and Community Action Planning teams who require further support.

These initiatives and strategies aim to balance 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 must produce measurable outcomes. Services are provided in a manner that promotes community integration, social inclusion, and also supports families which 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/or other drug treatment services. The levels of care may include outpatient, intensive outpatient, residential treatment, opioid maintenance therapy, and adult detoxification services. The Division's funding is primarily targeted to provide substance abuse services to persons with no other means of paying for treatment, and 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 experiencing a behavioral health crisis. Acknowledging that many people in crisis are under the influence of alcohol or other drugs, Alaska's behavioral health crisis response system 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 supports; 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 and in the least restrictive environment. Core services include assessment, psychiatry, medication management, case management, and rehabilitative services. Specialized services include supported living, supported employment and intensive services necessary to maintain community placements.

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 in-home family services as a critical element to recovery. Under the Bring the Kids Home initiative, stakeholders work together to plan and 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 specially designated local community hospitals to pay for evaluation, stabilization, and / or treatment services for persons experiencing a behavioral health crisis who meet statutorily-defined involuntary mental health commitment criteria and who have been court-ordered to receive appropriate evaluation and / or treatment services but who have agreed to accept such services voluntarily in lieu of formal commitment procedures. This intervention is offered regionally in Juneau for Southeast Alaskans and in Fairbanks for Interior and Northern Alaskans instead of treatment at Alaska Psychiatric Institute in Anchorage.

Using this unique funding program (the Mental Health Assistance Program, or MHAP), certain designated local hospitals provide the level of intervention required to appropriately stabilize and treat patients experiencing behavioral health crises and return them to their home or refer them to the next higher level of care, if needed. The MHAP service array includes inpatient psychiatric evaluation (0- 72 hours), crisis stabilization (up to 7 days), or inpatient psychiatric treatment services (up to 40 days) closer to the consumer's home, family, and support system. Component funding also supports consumer and escort travel between the designated hospitals and their home community.

Alaska Psychiatric Institute (API)

Census Management and Transition to an Acute Care Model

Over the past year and half, Alaska Psychiatric Institute - Alaska Recovery Center (API) has transitioned to an acute care psychiatric inpatient treatment center. This brings the hospital into alignment with the initial Certificate of Need to establish short-term psychiatric inpatient hospitalization for mentally ill adults and seriously emotionally disturbed youth. It also achieves the following:

- Alignment with healthcare reform to limit long and unnecessary hospitalizations
- Alignment with the state's vision of home and community based treatment services
- Greater access to available psychiatric inpatient acute care beds

In order to transition hospital operations to an acute care model and effectively manage the daily utilization of hospital beds, API has set the following objectives for FY2012:

- With a staffing effectiveness analysis, provide adequate professional staffing to assure active treatment, admissions and discharges seven days a week;
- Re-align the API admissions to coordinate incoming admissions from rural areas and minimize mentally ill adults pending civil admissions from jail;
- Optimize functionality with the API Electronic Health Record (EHR) demonstrating meaningful use of the system (reducing paperwork and inefficiency in clinical and administrative departments); link basic patient demographic information in AKAIMS.
- Refine the current utilization review and quality improvement management system to meet the needs of an acute care hospital and provide data to Behavioral Health for systems planning;
- Prompt screening and referral of substance induced psychiatric conditions to other treatment resources;
- Complete Quality Improvement plan for forensic population;
- Continue to provide a safety net for exceptional, difficult-to-treat individuals who meet level of care criteria for psychiatric hospitalization;
- Work in conjunction with the Behavioral Health Emergency Services Steering Committee to make improvements to the gate keeping system for psychiatric urgent/emergent treatment.

API treats the most acute phase of a psychiatric illness when hospitalization is medically necessary. The treatment focus is on the resolution of acute symptoms which interfere with daily functioning and the precipitating psychosocial stressors that preceded the need for hospitalization. As the individual has optimized treatment, proactive discharge planning assures the return to community living and treatment.

The hospital is staffed seven days a week to provide acute care. Active treatment with admissions and discharges occurring on a daily basis presents numerous challenges for the leadership team at the hospital, as well as to the community behavioral health system. The workforce shortage of qualified psychiatrists in the state, and at API, requires the hospital to contract with Locum Tenens agencies costing **twice as much as** a state employed physician. This creates budgetary as well as continuity of care issues. Another challenge is the role of API within the greater Anchorage metropolitan area including the Palmer-Wasilla region. As the only hospital with psychiatric acute care inpatient capacity serving a metropolitan area greater than 425,000 people, demand for bed utilization sometimes exceeds capacity. The system is challenged to create additional capacity in the private sector. Finally, working collaboratively with behavioral health's Emergency Services Steering Committee, it will be critical to revitalize crisis services and emergency services around the state and integrate substance abuse treatment into the system.

API Advisory Board

By Administrative Order dated July 1, 2008, the 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 works 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 Department of Education, Department of Corrections, and Department of Public Safety.

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

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 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 being made to prevent or lessen problems that result in people needing services?

The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the division's performance management system. AKAIMS is 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 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, 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 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. AKAIMS serves community-based outpatient behavioral health programs, residential, detox and Opioid treatment facilities. The scope of AKAIMS users has expanded to include:

- The Office of Children Services (OCS) using AKAIMS as the electronic health record for the 35 Behavioral Rehabilitation Services (BRS) residential programs;
- Therapeutic Courts is expanding the “e-courts” module state-wide, that will use the AKAIMS platform to manage court-referred clients to the treatment system;
- The DBH Alcohol Safety Action Program is migrating its data collection system to the AKAIMS;
- Department of Corrections, Substance Abuse Services (mental health services are under consideration);
- State-wide Division FASD Diagnostic Teams;
- API interfacing with AKAIMS for coordination of discharge planning for clients re-entering services back in their community of origin.

Future development and enhancements of the AKAIMS include:

- The implementation of a Prevention/Early Intervention Module to collect related data from grantee providers;
- The implementation of a Homeless Management Information System (HMIS) module that is compliant with HUD’s National Data and Technical Standards, and captures client-level information on program characteristics and services provided to adults, families, and children experiencing homelessness
- The AKAIMS is scheduled for complete Stage One Meaningful Use certification by the end of calendar year 2011. This will allow individual grantee providers to interface with the Alaska Health Information Network.

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.

Behavioral Health Medicaid Services

Medicaid behavioral health services are available to Medicaid eligible individuals experiencing an emotional disturbance and/or a substance abuse disorder. These services 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.

Medicaid Behavioral Health service providers include Community Behavioral Health Providers, Physician Mental Health Clinics, Independent Psychologists, Residential Behavioral Rehabilitation Services, Inpatient Psychiatric Hospitals, and Residential Psychiatric Treatment Centers.

Medicaid outpatient services include clinic services and rehab services. Eligibility for the services is based on the needs of the Medicaid recipient. Clinic services may be provided to:

- A child experiencing an emotional disturbance
- A child experiencing a severe emotional disturbance
- An adult experiencing an emotional disturbance;
- An adult experiencing a serious mental illness

Medicaid Rehabilitation Services may be provided to:

- An individual experiencing a substance use disorder
- A child experiencing a severe emotional disturbance
- An adult experiencing a serious mental illness

Behavioral Health Clinic services may be provided by Community Behavioral Health grantees approved by the division or physician mental health clinics operating under the supervision of a psychiatrist. Behavioral Health Rehabilitation services may be provided only by Community Behavioral Health grantees approved by the division. Medicaid enrolls independent psychologists to provide psychological assessment and testing services to Medicaid recipients who are referred.

Inpatient Psychiatric Services provided in a Specialized Psychiatric Hospital are a covered Medicaid benefit only for children under 21 years of age and adults over 65 years of age. Inpatient Psychiatric Services provided in a Residential Psychiatric Treatment Center (RPTC) are a covered benefit only for children under age 21.

Residential Behavioral Rehabilitation services may be provided to children experiencing a severe emotional disturbance by providers operating under a residential child care facility grant. Management of this program will be fully transitioned from the Office of Children's Services to DBH on July 1, 2012 - including Medicaid administration, grant management and program operations.

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 Prevention and Treatment Block Grant, and others. We partner with the Department of Health and Social Services, the Alaska Mental Health Trust Authority, and other advisory bodies to help make these various plans work more effectively together. We collaborate with community and consumer organizations, like the Alaska Behavioral Health Association, Alaska Addiction Professionals Association, National Alliance on Mental Illness (NAMI), and homeless coalitions throughout the state. AMHB and ABADA helped establish the Alaska FASD Partnership, a volunteer coalition of individuals experiencing FASD and their families, providers and community members. AMHB and ABADA host a page for the Alaska FASD Partnership on their website. This close partnership with the statewide FASD coalition ensures better coordination of policymaking and planning related to improving FASD prevention, treatment and support services.

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 and, with the Alaska Mental Health Trust Authority, have developed a “We Are All Alaskans!” anti-stigma campaign. Our own education efforts focus on the fact that “Treatment Works – Recovery Happens!” ABADA partners with Alaska CHARR, the restaurant and hospitality industry organization, in an annual FASD prevention campaign in September. Board members participate in legislative caucuses and appear 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, review and analyze quantitative and qualitative data on state-funded behavioral health services, 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, advocacy training, social media, 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 Alaskans 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.

Statewide Suicide Prevention Council (SSPC)

Mission

To reduce the impact of suicide on Alaskans by improving the health and wellness of our communities and increasing awareness that suicide is preventable.

Introduction

The SSPC was created by statute in 2001 to advise legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, improving public awareness of suicide and risk factors, enhancing suicide prevention efforts, working with partners and faith-based organizations to develop healthier communities, creating a statewide suicide prevention plan and putting it in action, and building and strengthening partnerships to prevent suicide.

Core Services

The SSPC engages in advising, planning, public education and awareness building, coordination of suicide prevention efforts, and relationship building in order to fulfill its statutory duties.

Services Provided

The SSPC provides policymaking and programmatic advice to both the executive and legislative branches. Council members and staff serve as members of and advisors to suicide prevention and wellness coalitions in several communities, as well as to recipients of federal suicide prevention grants.

The SSPC is responsible for creating a state suicide prevention plan and putting it into action. *Casting the Net Upstream: Promoting Wellness to Prevent Suicide in Alaska* is the 2012-2017 state suicide prevention plan. It was created over an 18 month period with input and expertise from hundreds of Alaskans statewide. This plan reflects the SSPC's statutory responsibility to "improve Alaskans' health and wellness" by looking beyond the immediate risk factors for suicide (depression, alcohol and drug use, isolation). The plan addresses broader issues that impair health and wellness in order to provide a comprehensive suicide prevention plan. To begin implementation of this plan, the SSPC, the DHSS, and other partners hosted a training summit to educate regional suicide prevention teams from all over Alaska on the plan, its goals and strategies. This training included helping regional teams develop *Casting the Net Upstream* implementation plans be tailored to their communities.

The SSPC engages in large and small public education/awareness campaigns. The Alaska Mental Health Trust Authority funds a limited statewide education campaign for the SSPC through its coordinated communications. Partnering with non-profit and private organizations, like Iron Dog and the Alaska Community Foundation, has expanded the reach of prevention messages and increased awareness of CareLine, Alaska's statewide crisis hotline. Council members and staff provide presentations to large conferences, such as the BIA Tribal Providers Conference, as well as smaller groups like the Southeast Episcopal Deanery and local high schools.

The SSPC works with its partners to coordinate state and federally funded suicide prevention programs, as well as community driven efforts. Examples include:

- The promotion of CareLine, the statewide crisis hotline, through SSPC and partner activities (the Division of Behavioral Health, Alaska Mental Health Board, community behavioral health organizations, etc.).
- Connecting community coalitions for resource sharing and mentoring.
- Combining education efforts with tribal and non-profit organizations.
- Partnering with advocacy organizations to further the goals of the state plan.

This coordination depends heavily on healthy relationships with organizations and individuals involved in preventing suicide. Council members and staff are active in communities all over the state connecting with individuals, churches, non-profits, schools, local governments, and state agencies to support diverse and creative ways to prevent suicide. Council members and staff serve in the local chapter of the American Foundation for Suicide Prevention, community coalitions, state agencies, and non-profit providers. This ensures that the SSPC's activities complement and enhance those of other suicide prevention providers – and that the Council's activities are themselves enhanced and informed by the experiences and knowledge of our partners.

The SSPC and Alaska Mental Health Board maintain www.StopSuicideAlaska.org, the state suicide prevention portal. This tool was created with one-time funding from the Alaska Mental Health Trust Authority in partnership with the Department of Health and Social Services. More than a website, StopSuicideAlaska.org is a clearinghouse for information, research, data, and programmatic information related to suicide prevention. A statewide event calendar, training resources, and community group sites are all available through the portal. StopSuicideAlaska.org has become the keystone of the SSPC's outreach and continues to evolve as an important tool for the Council as well as community suicide prevention providers.

Annual Statistical Summary of Services Provided in FY2011

Prevention and Early Intervention Services Statistics

Underage Drinking Data

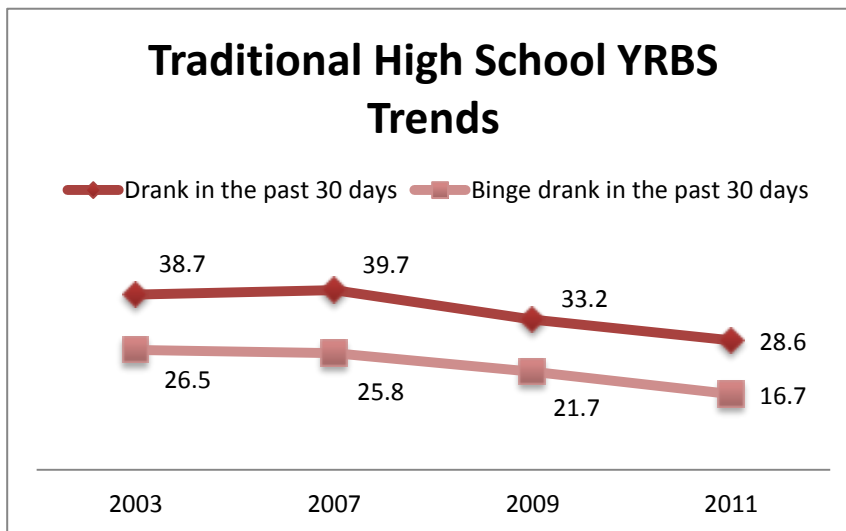
Prevention efforts are showing results in statewide population level indicators. On some measures, Alaska is doing better than the national average on youth consumption patterns. Most importantly, we're moving in the right direction. Between 2003 and 2011, the following benchmarks were reported by traditional high school students:

- Students who drank in the past 30 days **decreased** from 39.7 percent to 28.6 percent.
- Students who binge drank in the past thirty days **decreased** from 25.8 percent to 16.7 percent.

A population of emerging concern is the Alternative High School Students. In 2009 and 2011 the alternative schools were surveyed in a separate YRBS (Youth Risk Behavior Survey). The data collected at these two points in time highlight areas of interest. First, the youth in alternative schools are at **higher risk** for negative drinking behaviors than their traditional school counterparts and second, between 2009 and 2011 there has been a **decrease** in these drinking behaviors. Between 2009 and 2011, the following benchmarks were reported by alternative high school students:

- Students who drank in the past 30 days **decreased** from 57 percent to 49.1 percent.
- Students who binge drank in the past thirty days **decreased** from 42.7 percent to 37.9 percent

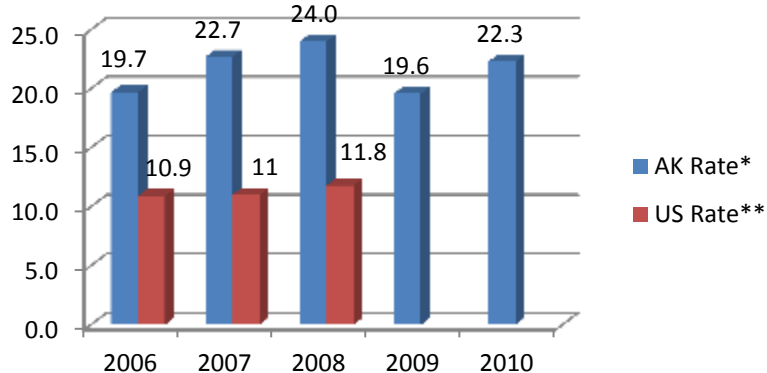
These data points help to show successful movement on Strategy B1: Prevent and reduce substance use and abuse, particularly target #4: Reduce the percentage of high school students who use alcohol. For both traditional and alternative high school populations, the trends for current alcohol use and binge drinking are on a downward trend. In 2011 we have also included a special focus on alternative school environments with the SPF SIG funds. Continuing to utilize the strength-based approach of the strategic prevention framework, community coalitions, and inter-departmental collaboration, we will continue to have a positive impact on the behavior of underage drinking.



Alaska Suicide Data

According to a 2008 national report of suicides in the United States¹, Alaska ranks first with the highest suicide rate in the country. Suicide is the second leading cause of death among Alaskans under age 50. In 2010, Alaska had approximately 160 suicides. (*This preliminary finding does not yet include deaths of Alaskans dying out of state.)

Chart 1
Alaska Suicide Rates 2006 to 2010



Between 2005 - 2008, Alaska saw a yearly increase in suicide rates.

In 2009, there was a small 17% drop of reported suicides in Alaska but had again increased in 2010.

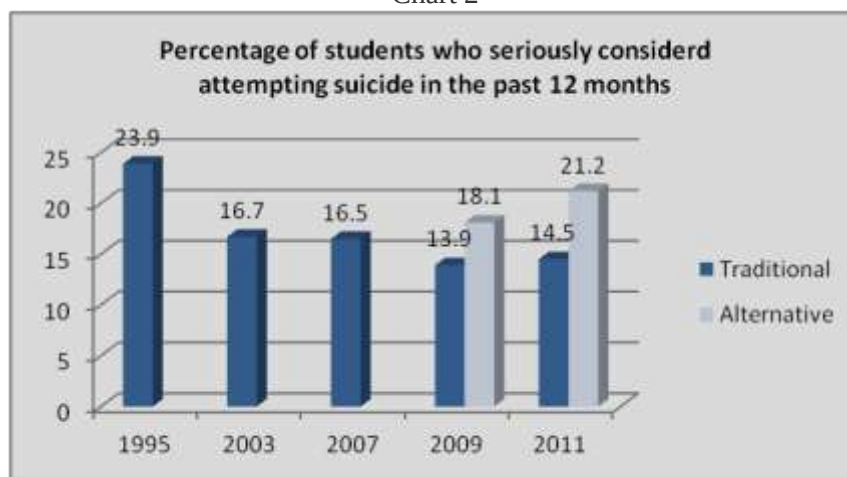
Alaska
Bureau of Vital Statistics

Rates are per 100,000. The Alaska Bureau of Vital Statistics, Last updated 9-14-11

* 2010 AK rates are preliminary; **2009 US rates are preliminary.

According to the [2011 Youth Risk Behavior Survey](#), approximately 9 % of high school students attempted suicide in the past 12 months. In addition, 14.5% considered attempting suicide (Chart 2). Historically, we have seen a decreasing trend in suicides and suicide attempts among teens, however, the last few years show a slight increase. We have yet to determine the reason for this trend, but will continue to monitor this data, as well as recent data on alternative high schools that are showing higher risk factors associated with suicide for this unique population.

Chart 2



Alaska Youth Risk Behavior Survey Results, US Center for Disease Control

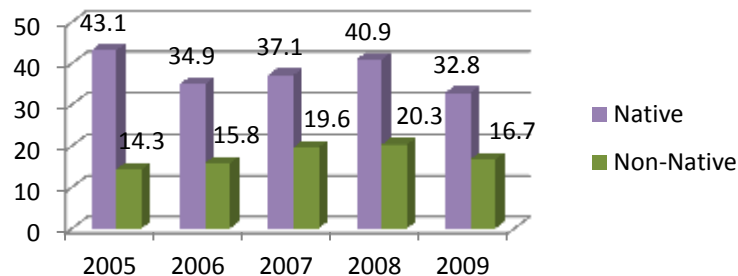
¹ McIntosh, J. L. (for the American Association of Suicidology). (2011). U.S.A. suicide 2008: Official final data. Washington, DC: American Association of Suicidology, dated 24 October 2011, downloaded from <http://www.suicidology.org>.

The highest rates, and numbers of suicides, occur among 20 – 24, and 25 - 29 year olds respectively, with the majority of suicides occurring among males. In addition, according to a 2007 report of suicides that occurred between 2003 and 2006, Alaska Natives comprise 16% of the overall state population, however, they account for 39% of all suicides (Alaska Suicide Follow-back Study 2007). The highest rate of suicide in Alaska is among Alaska Native teen and young adult males between 15 – 29 years of age. According to the American Association of Suicidology, 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 - most commonly depression.

Alaska Native

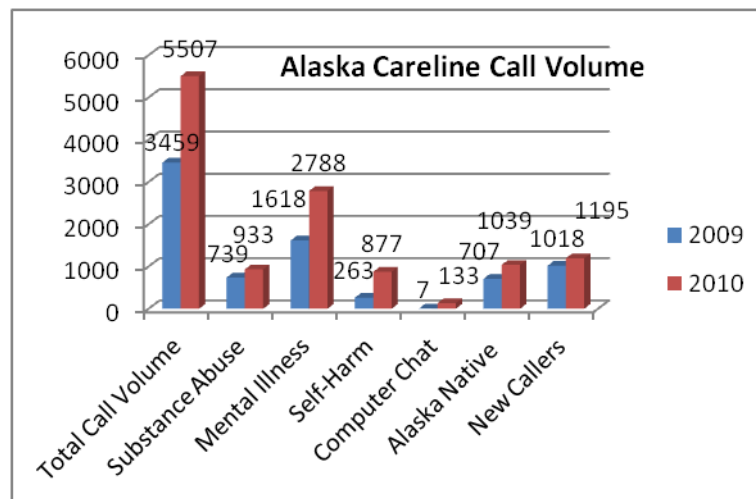
Alaska Natives have rates more than double that of non-Natives in Alaska. Non-Natives have a rate of 1 ½ - 2 times the U.S. rate.

Alaska Bureau
of Vital Statistics

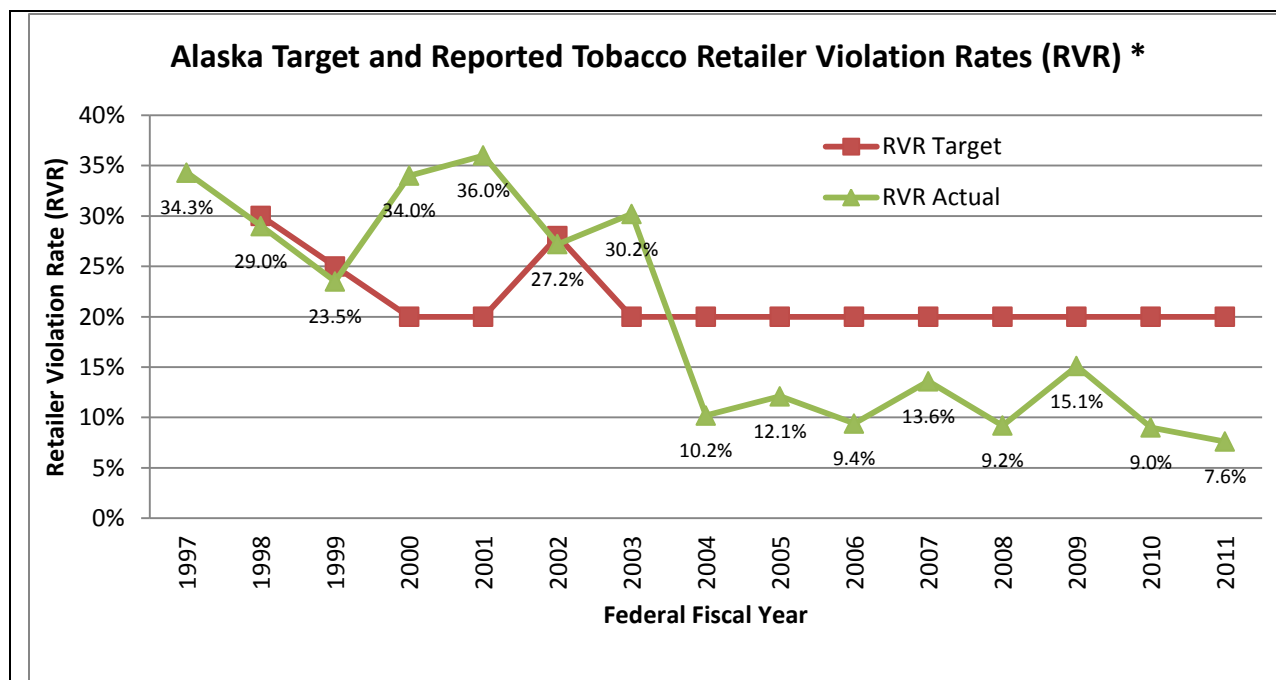


Alaska Bureau of Vital Statistics, Last updated Nov. 17th, 2009.

According to Alaska CareLine data, Alaska has been seeing an increase in call volume associated with suicidal calls. However, they have also seen an increase in all calls related to drugs and alcohol, domestic violence, self-harm, and mental illness. Computer chat, an online CareLine service, was added in late 2009 and is showing an increase in its use as well as an increase in first-time callers. New data is being collected in 2011 to show if callers are experiencing a reduction in suicidality and an increase in accepted follow-back calls and referrals for services.



Tobacco Enforcement Data



The consistent work of the Tobacco Enforcement section has resulted in sell rates to minors in Alaska dropping from 36% in 2001, to 7.6% in 2011. 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.

Alcohol Safety Action Program (ASAP) Case Statistics

	FY2010	FY2011
*ASAP New Case Statistics		
Adult ASAP	7170	7829
Juvenile ASAP	1940	2038
Total ASAP	9110	9867
Adult Cases Completed & Closed	*6751	*4122
Juvenile Cases Completed & Closed	958	975
**Therapeutic Court Statistics		
Point in Time Caseload (# participants at end of quarter)	253	398
New Admissions	68	172
Therapeutic Court Graduates	44	103

*ASAP Misdemeanor Court: When an ASAP case is complete, it means the client has participated in a screening and/or assessments and has then followed-up with completing the recommended educational and/or treatment requirements.

At this time, we do not have standardized treatment program or participant outcome evaluations for those completing substance use treatment programming. We are developing a plan to conduct follow-up with clients by reviewing our ASAP Misdemeanor graduates via Courtview records, checking for any new offenses over time (1yr, 2yr, 5yr periods).

For those who are involved in one of our standardized Alcohol Drug Information Schools or educational programs, participant evaluations indicate that 98% of those who complete ADIS believe that the course was either helpful or very helpful, and 85% report that the ADIS program helped them make changes in the behaviors that caused their problems in the first place.

**Anchorage Wellness Court (AWC) Exit Data October 1, 2006-September 30, 2011:

Two hundred seventy one (271) participants exited the AWC between 10-1-06 and 9-30-11. Of those who exited the AWC, two hundred forty three (243) or 89% have had no further substance related vehicular incidents .

Behavioral Health 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 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 taking place to prevent or lessen problems that result in consumers needing services?
- Do Alaskans with serious behavioral health disorders live with a high quality of life?

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

1. Access to treatment Services
2. The Alaska Screening Tool (AST)
3. The Behavioral Health Consumer Survey (BHCS)
4. The Client Status Review of Life Domains (CSR)

1. Access to Treatment Services

Treatment and Recovery Services: Individuals who Received Community-Based 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 services reflects accessibility and capacity of the behavioral health service system.

FY2009 was a baseline year for using the Alaska Automated Information Management System (AKAIMS) to report the total number of individuals who received community-based behavioral health services. From FY2009 to FY2011, the number of individuals who received community-based behavioral health services has continued to increase. A summary of the FY2009 to FY2011 unduplicated counts of individuals who received services, by service population, is presented in Chart 1. Highlights are as follows:

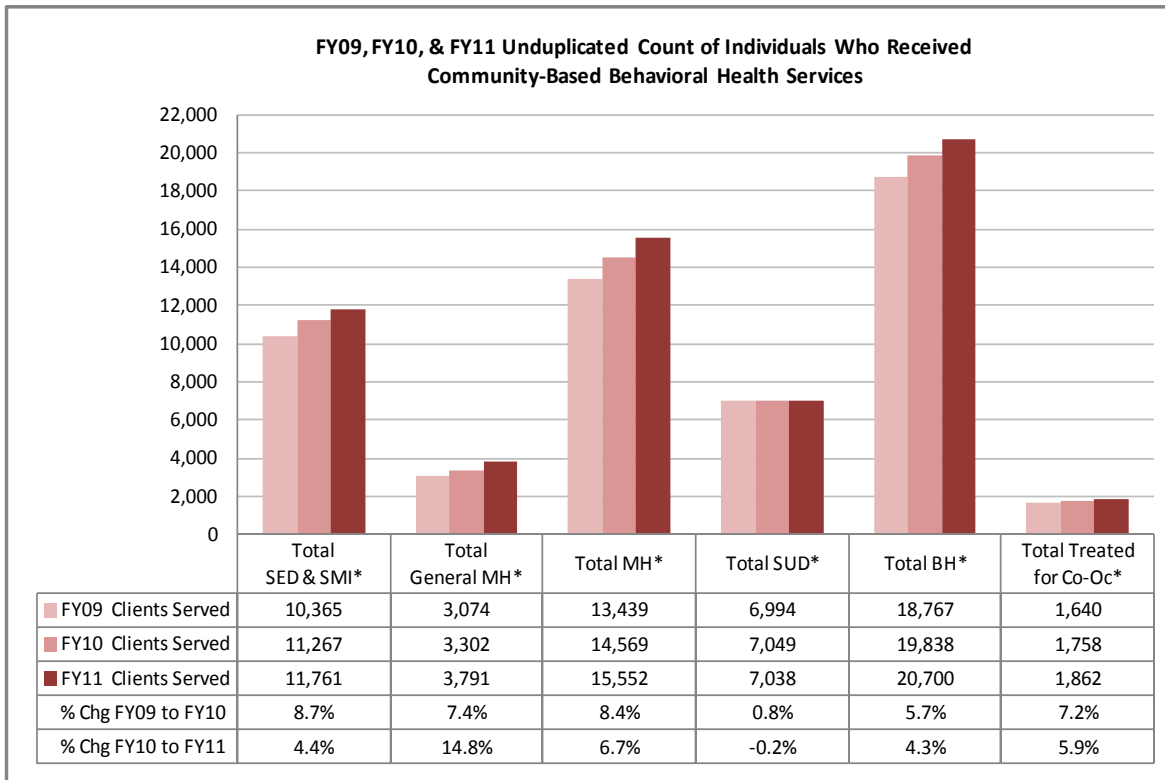
- The general trend from 2009 through 2011 indicates a 10.3% increase (from 18,767 in FY2009 to 20,700 in FY2011) in the **total number** of individuals who received community-based behavioral health services;
- The largest area of growth is found in “general mental health services” (23% increase from 2009 to 2011);
- The priority populations of youth with severe emotional disturbance (SED) and adults with severe mental illness increased (13.5% from 2009 to 2011);
- The service category with the least amount of change, or declining amount of services was “substance use disorder “ (SUD) services (see Chart 2):
 - Youth SUD Services: From 2009 through 2011 the trend indicates a 17.3% decrease (from 845 in FY2009 to 694 in FY2011) in the **total number** of youth who received community-based SUD services;
 - Adult SUD Services: From 2009 through 2011 the trend indicates a 3% increase (from 6,149 in FY2009 to 6,344 in FY2011) in the **total number** of adults who received community-based SUD services.

The Division recognizes that in general, the behavioral health system of care continues to improve overall accessibility and service capacity. However, the area of SUD services requires analysis and strategic development.

As defined in the “Challenges” section of this budget document, DBH intends to address these service capacity issues in the following manner:

- Establishment of a methodology to determine the capacity of the behavioral health system.
- Identification of system gaps and recommendations for improvement including a review of payment systems to insure a reasonable reimbursement for quality services.
- Changes in infrastructure, coverage, workforce, and information exchanges.
- Develop continuous improvements to the performance management system that optimize data collection, reporting, and analysis that informs and modifies program and clinical practice for improved outcome measurement.

Chart 1



*** Key:**

Total SED & SMI: Youth with Serious Emotional Disturbances (SED) and Adults with Serious Mental Illness (SMI) who received Mental Health (MH) services; includes individuals with Co-Occurring disorders.

Total General MH: Non-SED Youth and Non-SMI Adults who received 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) who received Mental Health services; includes individuals with Co-Occurring disorders.

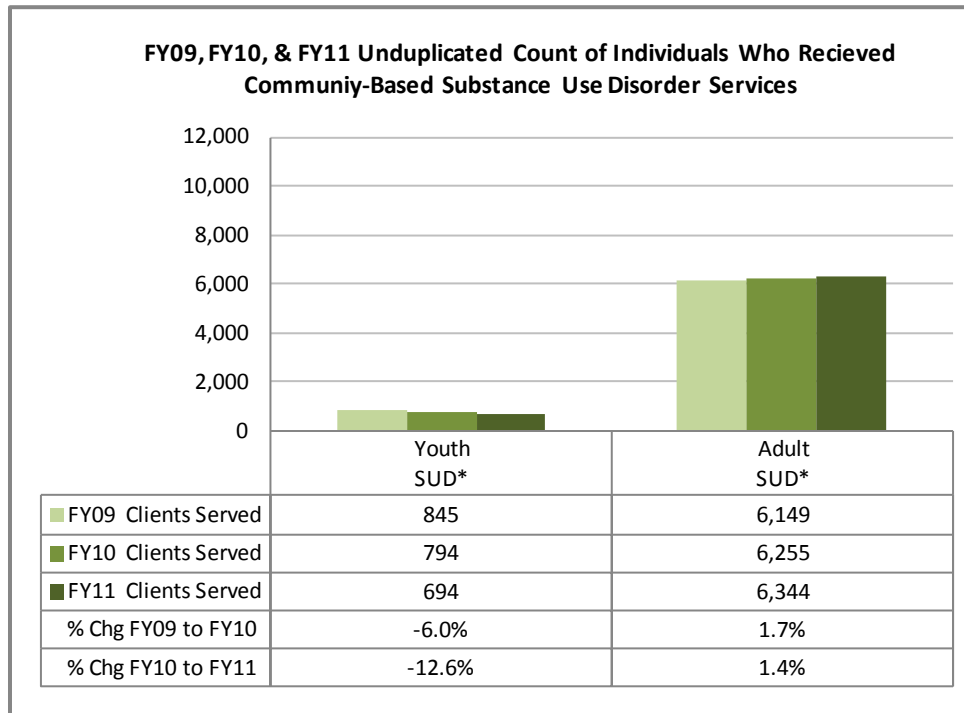
Total SUD: Youth and Adults who received Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders.

Total BH: All Youth and All Adults who received Behavioral Health (BH) services (i.e., mental health and/or substance use disorder services); includes individuals with Co-Occurring disorders.

Total Treated for Co-Occurring: Youth and Adults who received services for Co-Occurring disorders (i.e., co-occurring mental health and substance use disorders).

Data Source: Alaska Automated Information Management System (AKAIMS), DBH Uniform Reporting (UR) Client Profile Tables. **Source Date:** October 5, 2011 with adjustments made November 4, 2011.

Chart 2



*** Key:**

Youth - SUD: Youth who received Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders.

Adult - SUD: Adults who received SUD services; includes individuals with Co-Occurring disorders.

Data Source: Alaska Automated Information Management System (AKAIMS), DBH Uniform Reporting (UR) Client Profile Tables. **Source Date:** October 5, 2011 with adjustments made November 4, 2011.

Serious Behavior Health Disorders: Prevalence and Penetration Rate

The Division, in conjunction with the Mental Health Trust and Advisory Boards, completed the 2006 Alaska prevalence estimates of serious behavioral health disorders. Prevalence estimates can be used as a benchmark to measure penetration rates of behavioral health services. Chart 3 below compares the 2006 prevalence estimates (for low-income households) with the FY2009, FY2010, and FY2011 unduplicated count of individuals who received community-based services for serious behavioral health disorders. These prevalence estimates, which are considered to be conservative, provide a basis for identifying unmet needs in Alaska's low-income household population.

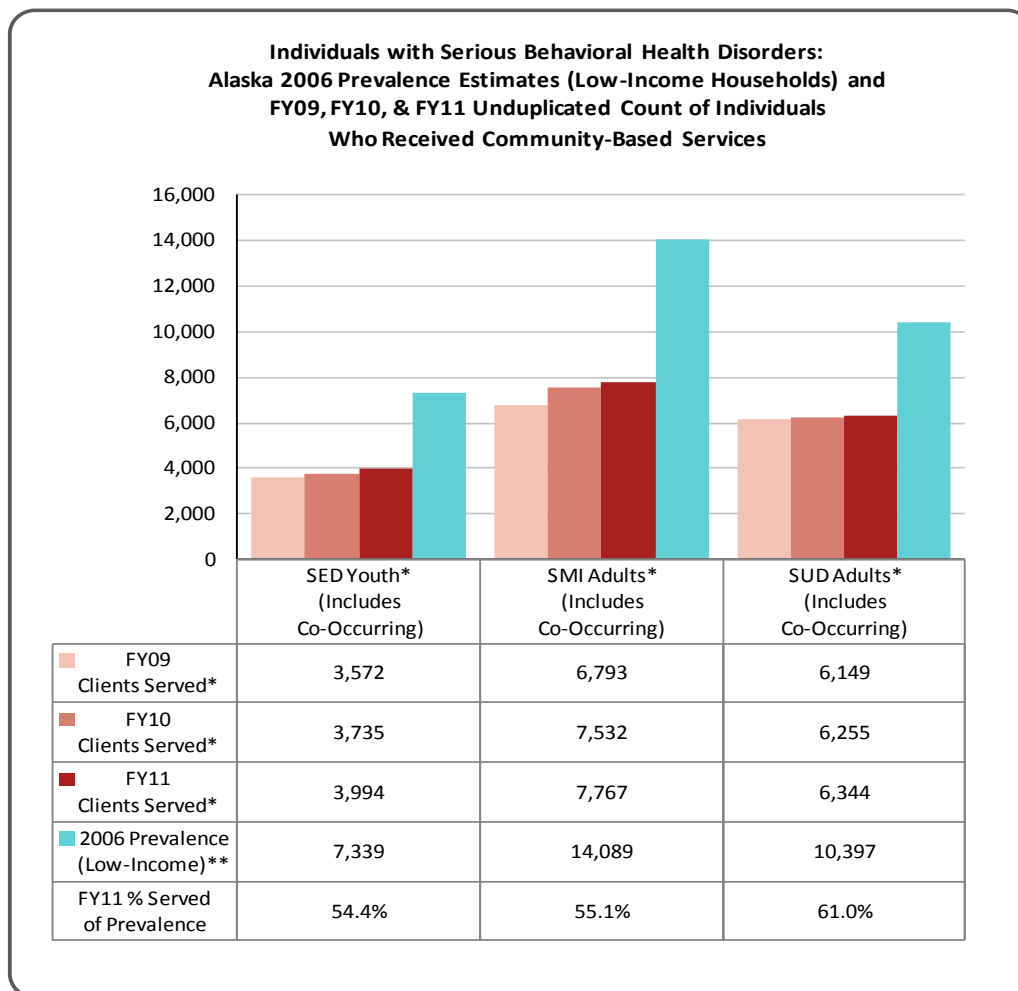
Based on the 2006 prevalence estimates, the Division's FY2011 penetration rate for community-based services was:

- 54.4% for SED Youth
- 55.1% for SMI Adults
- 61.0% for SUD Adults

The Division is currently in the process of updating the Alaska prevalence estimates to reflect the 2007 census data.

Treatment and Recovery Chart 3

2006 Prevalence Estimates and FY2009, FY2010, and FY2011 Clients Served



* Clients served include individuals who received community-based behavioral health services for serious behavioral health disorders: Youth with Serious Emotional Disturbances (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., co-occurring mental health and substance use disorders).

Data Source: Alaska Automated Information Management System (AKAIMS) DBH Uniform Reporting (UR) Client Profile Tables. **Source Date:** October 5, 2011 with adjustments made November 4, 2011.

** 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.

2. 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 for 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 assists 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

Screening is defined as an activity that determines the likelihood a client has presenting indicators, 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 FY2011, 14,932 AST screenings were conducted with the results displayed in Chart 4. In order to maximize the clinical utility of the AST, the Division developed and deployed the AST Clinical Guidance Document. This guidance document provides the most recent research literature that assists clinicians in the identification of individual and combined AST indicators that further inform assessments to meet the individual needs of clients seeking services.

Chart 4

Alaska Screening Tool (AST FY2011)												
Agency	ASTs	Screening Outcomes										
		Substance	Mental Health				Dual	TBI	FASD	Adverse	Major	Intimate
		Abuse	Depression	Anxiety	Risk Self/Others	Trauma Symptoms	Diagnosis			Experience	Life Change	Partner Violence
Total	14,932	9,396	8,943	8,687	4,438	9,170	8,510	4,887	1,128	10,261	8,747	2,624
Total %		63%	60%	58%	30%	61%	57%	33%	7%	69%	59%	18%

Data Source: The Alaska Automated Information Management System (AKAIMS) and five agencies using an electronic data interface. Data source date: November 2011

The Alaska Screening Tool is located at the following:

<http://www.hss.state.ak.us/dbh/PDF/Training/Resources/AST%202010.pdf>

The AST Clinical Guidance Document is located at the following:

<http://www.hss.state.ak.us/dbh/PDF/Training/Resources/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf>

3. The Behavioral Health Consumer Survey

Treatment and Recovery Services: Annual Behavioral Health Consumer Survey (BHCS)

The Annual BHCS is used to obtain information on client evaluation of behavioral health outpatient services. The survey includes questions pertaining to the following domains:

- access to services
- general satisfaction
- improved functioning
- social connectedness
- participation in treatment planning
- positive outcomes
- quality and appropriateness
- cultural sensitivity

The Division initiated the BHCS for mental health providers in FY2003. In FY2006, the BHCS process was expanded to include substance abuse providers. In FY2008, a new baseline year was established due to changes in the survey questions and survey methodology. The Division continues to work with stakeholders to refine the BHCS process in efforts to improve accuracy, completeness, and response rate.

There are three Annual BHCS survey instruments:

- Adult BHCS (for clients ages 18 and older; see Charts 5 and 8),
- Parent/Caregiver of Youth BHCS (for parents/caregivers of youth all ages younger than 18; see Charts 6 and 9), and,
- Adolescent BHCS (self-report for youth ages 13-17; see Charts 7 and 10).

Survey results for FY2008 through FY2011, for each instrument and primary reason for receiving services (i.e., mental health or substance abuse), are summarized in the charts below. The sample size was considerably smaller for the substance abuse group than the mental health group; for both of these groups, the Parent/Caregiver of Youth and the Adolescent BHCS sample sizes were considerably smaller than the Adult BHCS sample sizes. The small sample sizes contribute toward relatively wide confidence intervals, and therefore, caution should be exercised in extrapolating interpretation and assumption of findings.

The primary focus of the summary presented in the charts below is to show patterns and trends across the four-year period relative to respondents' evaluation of services in the different domains. General conclusions are as follows:

- **For mental health outpatient services:**
 - Adult BHCS:
 - a relatively high percent of respondents reported positively about general satisfaction and quality & appropriateness of services;
 - a relatively low percent of respondents reported positively about improved functioning and positive outcomes.
 - Parent/Caregiver of Youth BHCS:
 - A relatively high percent of respondents reported positively about cultural sensitivity, social connectedness, and participation in treatment planning.
 - A relatively low percent of respondents reported positively about access to services, improved functioning, and positive outcomes.
 - Adolescent BHCS:
 - A relatively high percent of respondents reported positively about cultural sensitivity and social connectedness.
 - A relatively low percent of respondents reported positively about access to services, improved functioning, and positive outcomes.

- **For substance abuse outpatient services:**
 - Adult BHCS,
 - a relatively high percent of respondents reported positively about general satisfaction, quality & appropriateness, and social connectedness;
 - a relatively low percent of respondents reported positively about participation in treatment planning
 - Parent/Caregiver of Youth BHCS,
 - a relatively high percent of respondents reported positively about social connectedness; in addition,
 - A relatively high percent of parent/caregiver respondents reported positively about cultural sensitivity.
 - A relatively low percent of respondents reported positively about improved functioning and positive outcomes.
 - Adolescent BHCS,
 - a relatively high percent of respondents reported positively about social connectedness
 - a relatively low percent of respondents reported positively about access to services.
 - A relatively low percent of respondents reported positively about access to services, improved functioning, and positive outcomes.
- **Common Themes below Target Goals:**
 - Common issues falling below targets, for both Mental Health and Substance Abuse services, identified across multiple years include:
 - Access to services
 - Improved Functioning
 - Positive Outcomes
 - Predominately for Substance Abuse Services, common to most client types, participation in treatment planning was also reported negatively.

The Division works with grantees to develop quality assurance mechanisms by which program adjustments can be made based on the BHCS results. The Division's efforts to improve service delivery include Enhanced Technical Assistance that is made available to grantees experiencing programmatic or administrative difficulties. The following are specific areas of focus for the Division, in each area:

- **Access to services:** As defined in the "Challenges" section of this budget document, DBH intends to address these service capacity issues in the following manner:
 - Establishment of a methodology to determine the capacity of the behavioral health system.
 - Identification of system gaps and recommendations for improvement including a review of payment systems to insure a reasonable reimbursement for quality services.
 - Changes in infrastructure, coverage, workforce, and information exchanges.
 - Develop continuous improvements to the performance management system that optimize data collection, reporting, and analysis that informs and modifies program and clinical practice for improved outcome measurement.
- **Improved Functioning, Positive Outcomes; Participation in Treatment Planning:** The Division has adopted a primary focus on measuring treatment services that result in improved functioning and positive outcomes. In particular, the Division has invested resources into the structures that will further support a primary focus on treatment outcomes.
 - As described in the Client Status Review (Section 4) of this document, the CSR has been updated to more accurately measure change over time.
 - The CSR includes multiple life domains, as well as, the clients perception of the quality of care received.

- The new Integrated Regulations mandate the standardized implementation of the CSR to inform assessments and measuring for positive treatment outcomes has been mandated to all providers
- The Divisions' implementation of Performance-Based Funding has specific measures that focus on client outcomes.
- Enhanced Outcomes reporting will occur during FY2011, and used to inform Division technical assistance.

Chart 5
FY2008 - FY2011 Annual Adult Behavioral Health Consumer Survey
Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services

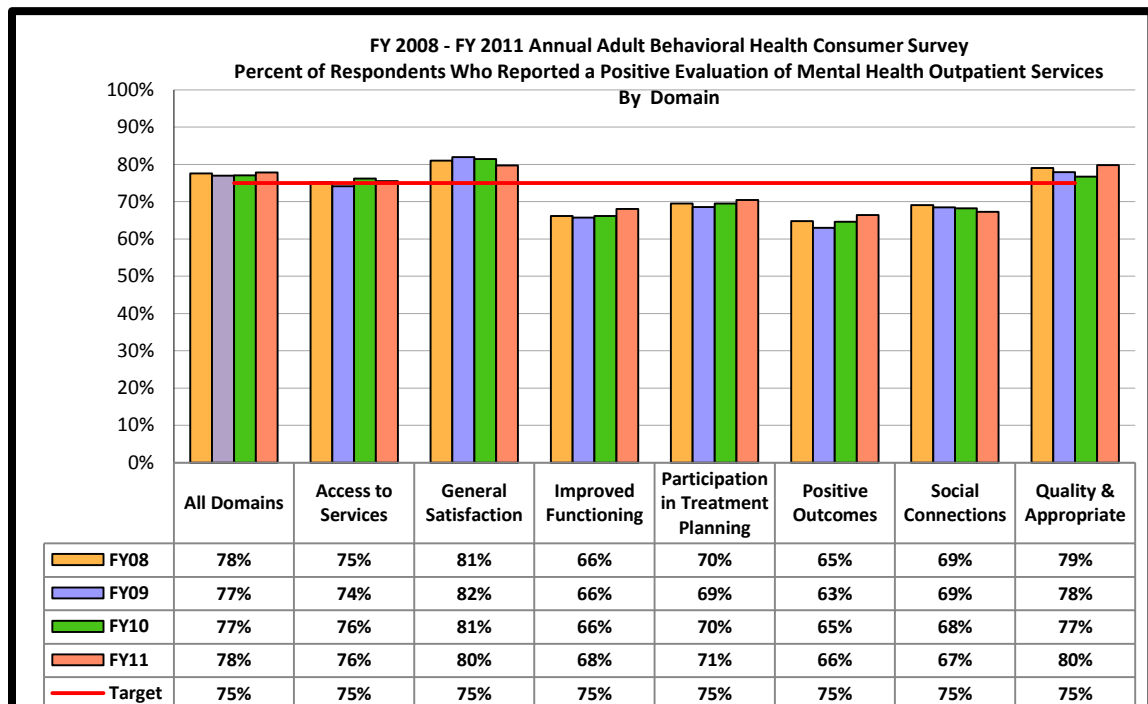


Chart 6
FY2008 - FY2011 Annual Parent/Caregiver of Youth Behavioral Health Consumer Survey
Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services

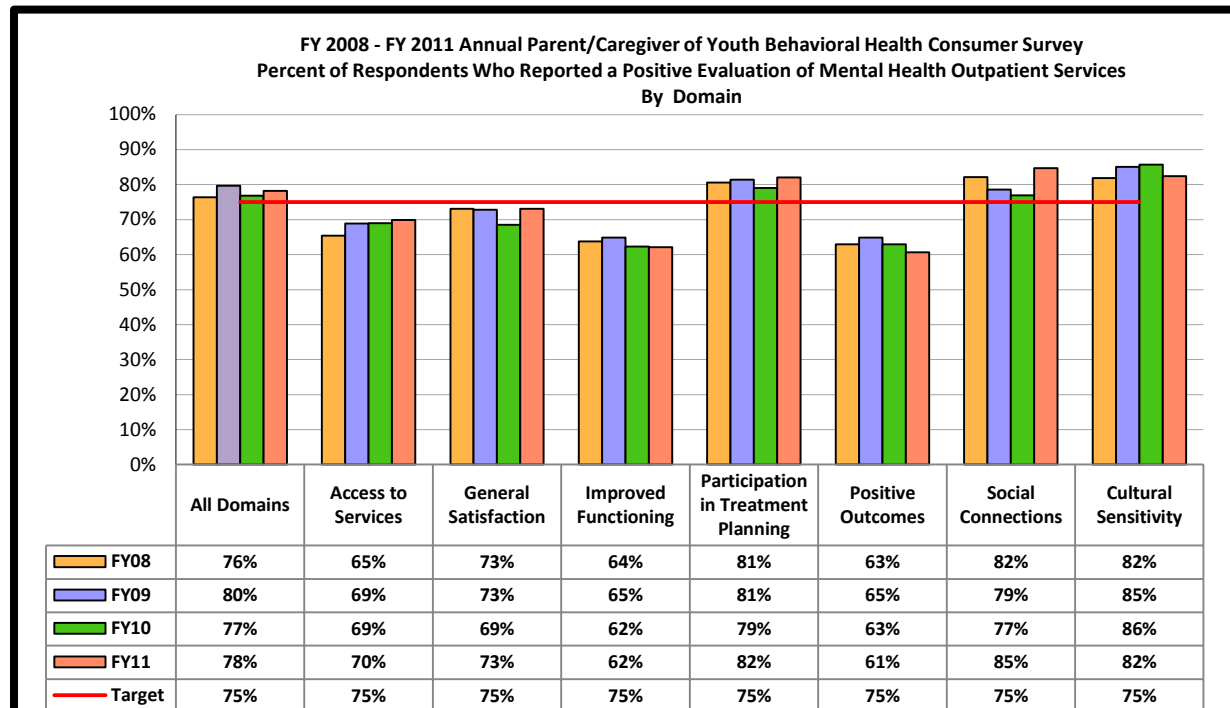


Chart 7
FY2008 - FY2011 Annual Adolescent Behavioral Health Consumer Survey
Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services

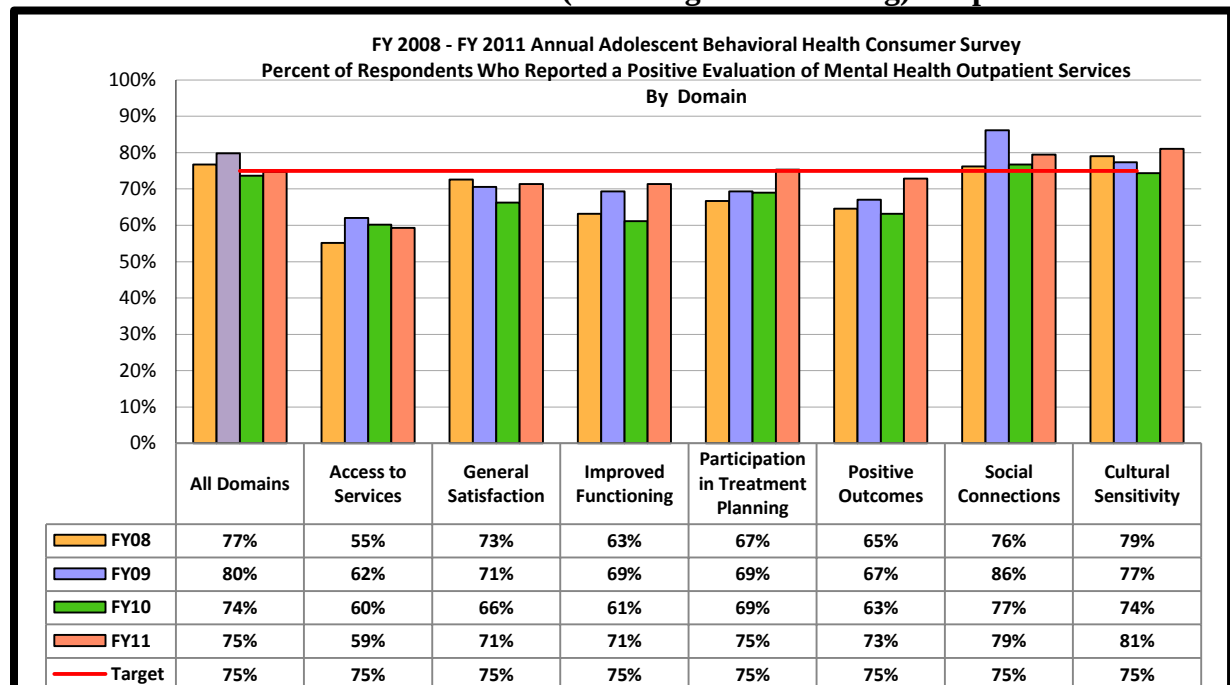


Chart 8
FY2008 - FY2011 Annual Adult Behavioral Health Consumer Survey
Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services

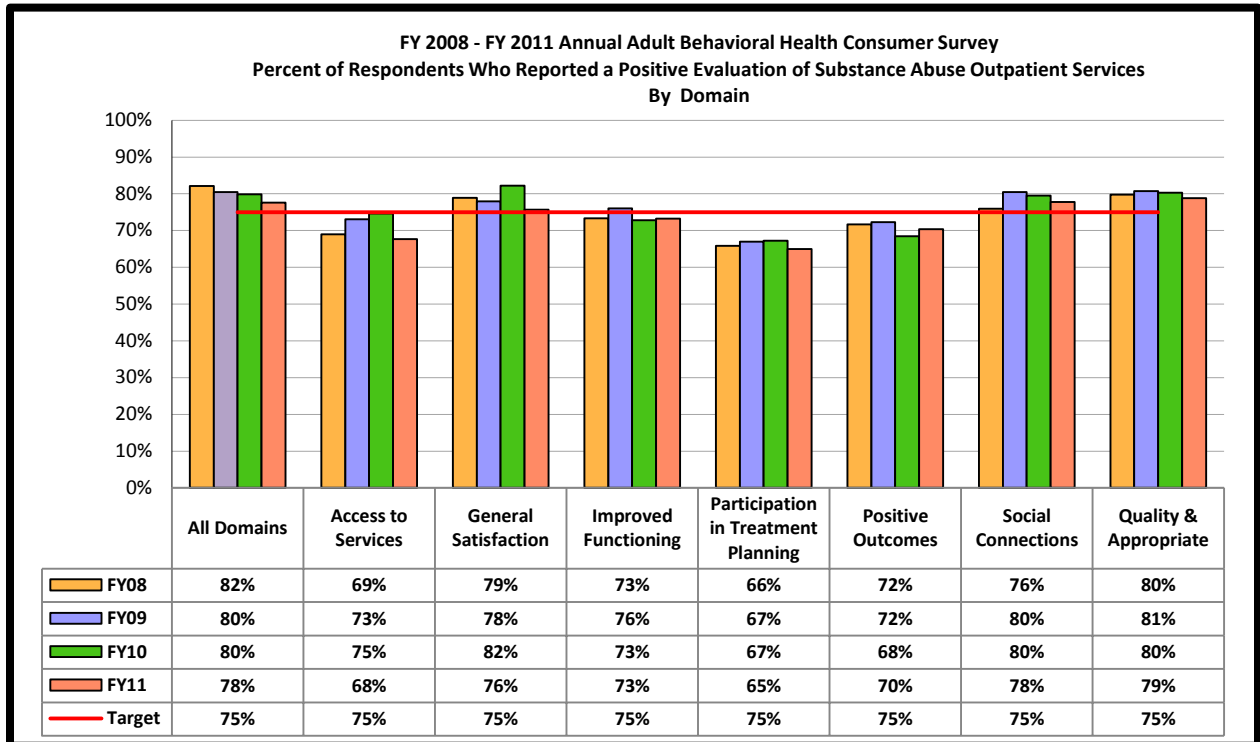


Chart 9
FY2008 - FY2011 Annual Parent/Caregiver of Youth Behavioral Health Consumer Survey
Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services

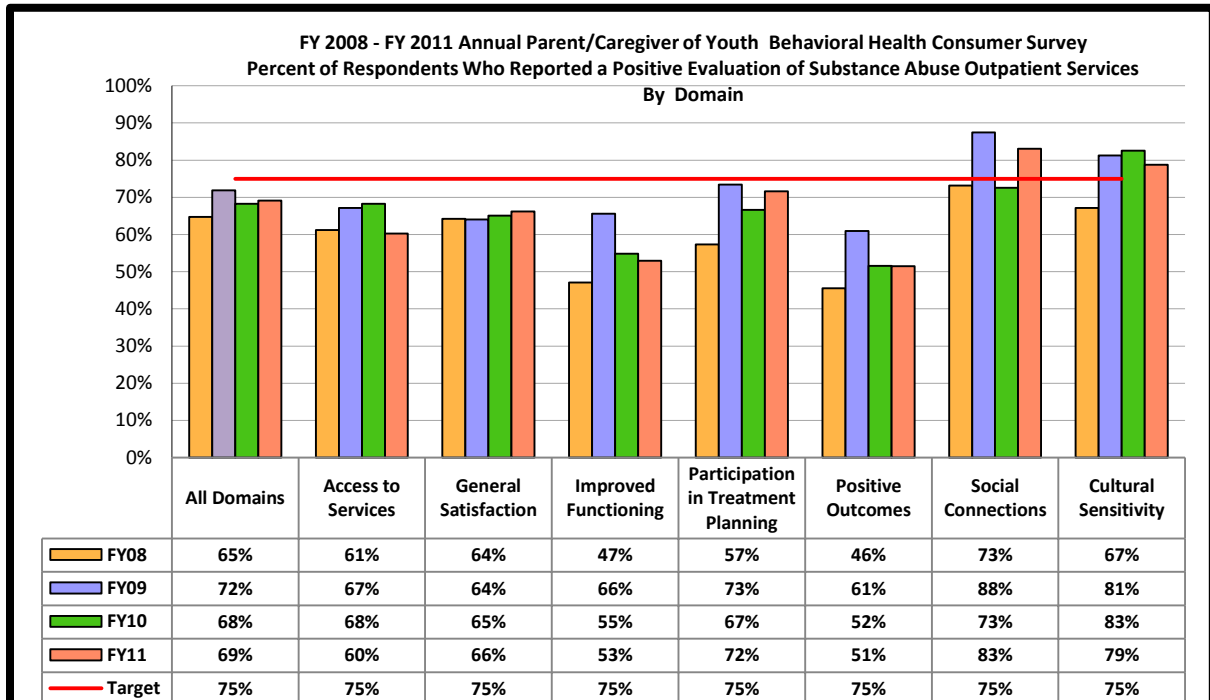
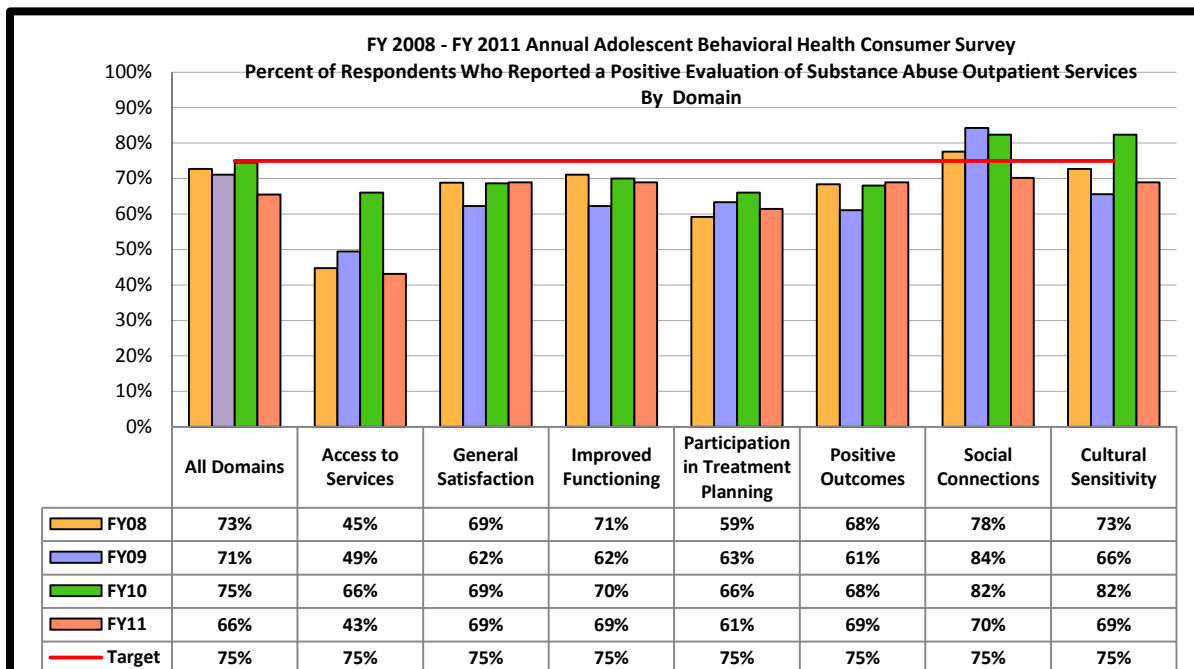


Chart 10
FY2008 - FY2011 Annual Adolescent Behavioral Health Consumer Survey
Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services



4. The Client Status Review

The Client Status Review of Life Domains (CSR) is a self-report instrument developed by the department that is used to measure a recipient's quality of life at the time of intake and at subsequent 4-month intervals during treatment, and at discharge from services. Information from the CSR is used in multiple ways: 1) the initial CSR conducted prior or during the intake assessment process supplements screening information obtained in the Alaska Screening Tool (AST) to inform the assessment and treatment plan. 2) The initial CSR functions as a baseline measure of a persons' quality of life prior to an assessment and entry into services. This initial CSR can be compared with subsequent CSR's to monitor change over time and outcomes. (3) The CSR is used to revise a client's behavioral health treatment plan.

The CSR measures multiple life domains. These include:

Physical health	Mental health
Substance use	Harm to self
Emergency services	Legal involvement
Domestic violence	Safety
Employment/school	Productive activities
Housing	Supports for recovery
Quality of life	Quality of services received

The CSR results are entered into the Alaska Automated Information Management System (AKAIMS) or through an agency's Electronic Data Interface (EDI). The CSR instrument can be

located at the following:

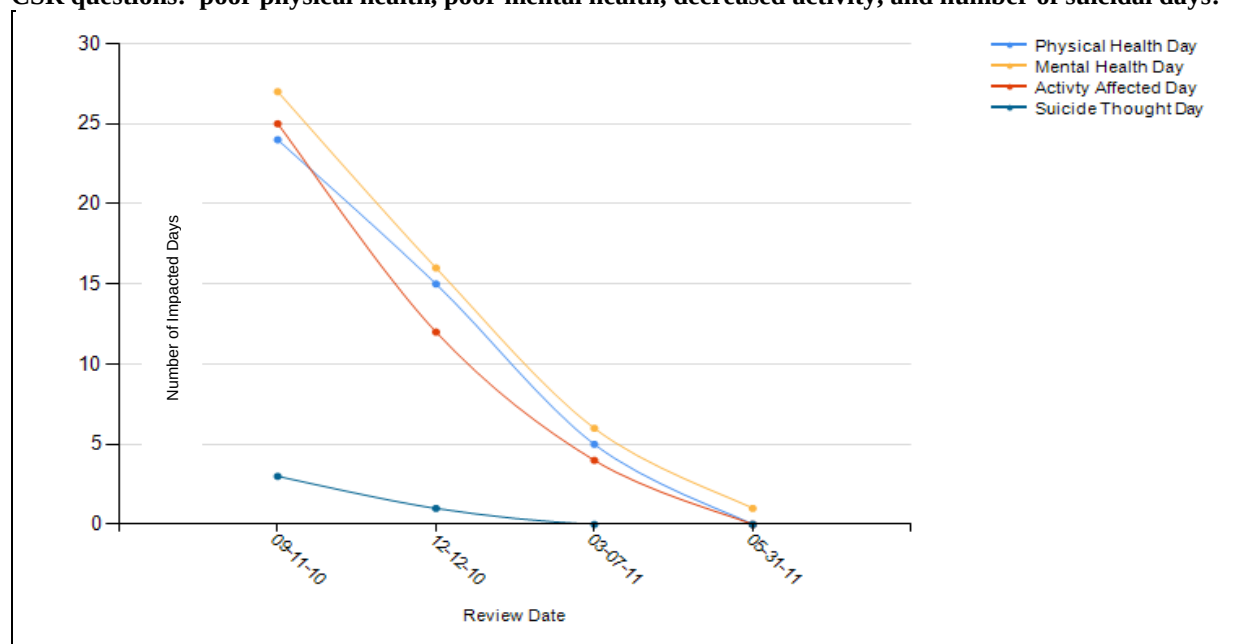
<http://www.hss.state.ak.us/dbh/PDF/Training/Resources/CSR%202010.pdf>

The Division initiated an upgrade of the CSR during FY2010 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 Grant reporting requirements for substance abuse and mental health, including National Outcome Measures). In addition, refinements to the CSR reporting procedures are being developed to report change over time for various client groups: general mental health, child/youth with severe emotional disturbance, and adults with severe mental illness. A full year of data will allow the Division to move forward in the enhancement of reporting outcomes.

The following chart (Chart 11) is an example of developing reporting capability at an individual client level. Future reporting will also include aggregate outcomes measurement at multiple levels: client, program, agency, regional, and statewide.

The CSR Chart below depicts an individual client's change over time, specific to the number of days in a month (0-30 days) that are negatively impacted by poor physical health, poor mental health, decreased activity, and number of suicidal days. A review date from 90-135 days (and at discharge) are now the Division standard by which every client receiving services completes a CSR to review impact of treatment and make adjustments to improve outcomes.

Chart 11 CSR Change over Time
CSR questions: poor physical health, poor mental health, decreased activity, and number of suicidal days.



Data Source: AKAIMS Report Manager

Bring the Kids Home (BTKH) Initiative: Indicators for FY2011

Early in the planning process of the BTKH Initiative, measuring progress was valued and given priority in the development of strategies for project implementation. This priority was defined in *Strategy 4s: Performance and QA Measures*. From this strategy, 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.

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 SFY 2012 (15% per year)

Findings: (Reference Table 1-4b)

The RPTC admissions, as a whole, steady increased from SFY 98-04. From SFY 05 to the present, there has been a decrease every year. For SFY 2011 there is a slight increase.

- The distinct number of In-State Custody RPTC recipients “admitted” during SFY 11 **increased** by 110% (from 29 to 61).
- The distinct number of Out-Of-State Custody RPTC recipients “admitted during SFY 11 **increased** by 10% (from 29 to 32).
- The distinct number of In-State Non-Custody RPTC recipients “admitted” during SFY 11, **increased** by 30% (from 176 to 229).
- The distinct number of Out-of-State Non-Custody RPTC recipients “admitted” during SFY 11, **increased** by 5% (from 61 to 64).
- The distinct number of total RPTC admissions for SFY 11 **increased** by 30% (from 295 to 386).

Cross-year analysis targeting the year with the highest admission rates, and comparing with SFY 11 indicates that:

- The total RPTC admissions for SFY '11 are 60% **lower** than SFY 04 (from 965 to 386)
- The In-State Custody RPTC recipients “admitted” during SFY 11 are 31% **lower** than SFY 05 (from 89 to 61).
- The Out-Of-State Custody RPTC recipients “admitted” during SFY 11 are 82% **lower** than SFY 04 (from 181 to 32).
- The In-State Non-Custody RPTC recipients “admitted” during SFY 11 are 9% **lower** than SFY 07 (from 252 to 229).
- Out-of-State Non-Custody RPTC recipients “admitted” during SFY 11 are 89% **lower** than SFY 04 (from 571 to 64).

Table 1a

Unduplicated Count of Medicaid RPTC Recipients "Admitted" (FY 06 - FY 11)						
	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
Custody In-State	64	71	61	86	29	61
Custody Out-of-State	115	69	40	19	29	32
Non-Custody In-State	127	252	150	203	176	229
Non-Custody Out-of-State	358	228	162	91	61	64
Total	664	620	413	399	295	386

Table 1b

Unduplicated Count of Medicaid RPTC Recipients "Admitted" (FY 01 - FY 05)					
	FY 01	FY 02	FY 03	FY 04	FY 05
Custody In-State	72	75	73	65	89
Custody Out-of-State	77	82	127	181	102
Non-Custody In-State	120	128	153	148	185
Non-Custody Out-of-State	304	355	425	571	387
Total	573	640	778	965	763

Data Source: MMIS SYF 11

Table 2a

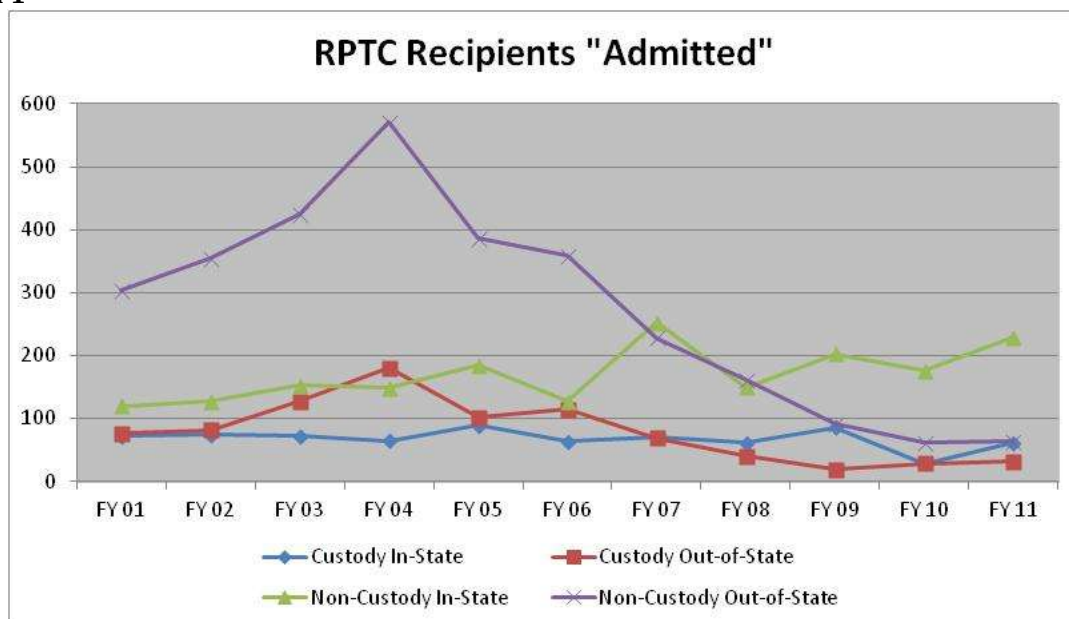
Percentage of Increase (Decrease) between SFY - Distinct RPTC Medicaid Recipients "Admitted" (FY 06 - FY 11)						
	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
Custody In-State	-28.1%	10.9%	-14.1%	41.0%	-66.3%	110.3%
Custody Out-of-State	12.7%	-40.0%	-42.0%	-52.5%	52.6%	10.3%
Non-Custody In-State	-31.4%	98.4%	-40.5%	35.3%	-13.3%	30.1%
Non-Custody Out-of-State	-7.5%	-36.3%	-28.9%	-43.8%	-33.0%	4.9%
Total	-13.0%	-6.6%	-33.4%	-3.4%	-26.1%	30.8%

Table 2b

Percentage of Increase (Decrease) between SFY - Distinct RPTC Medicaid Recipients "Admitted" (FY 01 - FY 05)					
	FY 01	FY 02	FY 03	FY 04	FY 05
Custody In-State		4.2%	-2.7%	-11.0%	36.9%
Custody Out-of-State		6.5%	54.9%	42.5%	-43.6%
Non-Custody In-State		6.7%	19.5%	-3.3%	25.0%
Non-Custody Out-of-State		16.8%	19.7%	34.4%	-32.2%
Total		11.7%	21.6%	24.0%	-20.9%

Data Source: MMIS SYF 11

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 SFY 98-04 (ranging from 13-65%). Between SFY 1998 and 2004 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 SFY 2011, for the distinct number of (Reference Table 3 – 4):

- Out-Of-State RPTC recipients during SFY 11 **decreased** by 13% (from 221 to 192).
- In-State RPTC recipients during SFY 11 **increased** by 12% (from 384 to 431).
- Total RPTC recipients during SFY 11 **increased** by 3% (from 605 to 623).

Cross-year analysis targeting the year with the highest and/or lowest utilization rates, and comparing with SFY 11 indicates that:

- The number of Out-Of-State RPTC recipients during SFY 11 are
 - 74% **lower** than SFY 04 (from 749 to 192).
- The number of In-State RPTC recipients during SFY 11 are
 - 11% **higher** than SFY 07 (from 388 to 431).
 - 210% **increase** over SFY 1998
- The distinct number of all RPTC recipients during SFY 11 are
 - 40% **lower** than FY 06 (from 1033 to 623)

Table 3a

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY 05 - 11)							
	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
Out-of-State	711	743	596	478	318	221	192
In-State	291	290	388	369	378	384	431
Total	1002	1033	984	847	696	605	623

Table 3b

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY 98 - 04)							
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Out-of-State	83	149	247	429	539	637	749
In-State	139	217	221	211	208	215	216
Total	222	366	468	640	747	852	965

Data Source: MMIS SYF 11

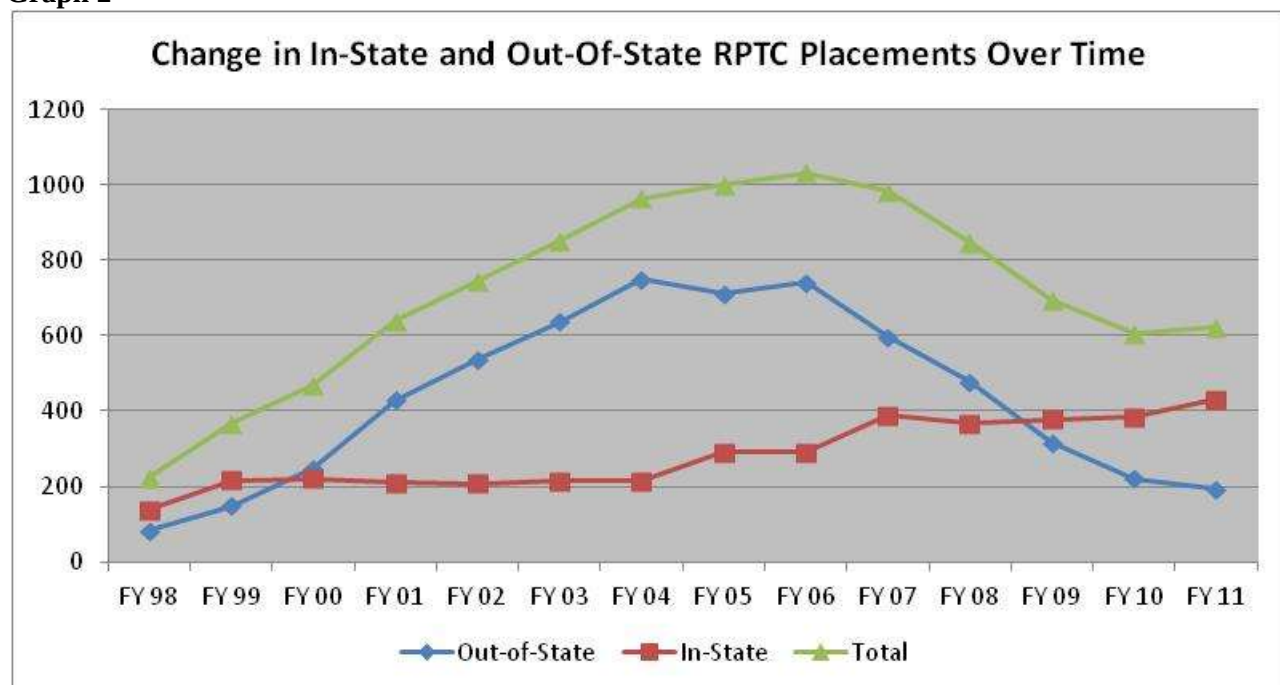
Table 4a

Percentage of Increase (Decrease) between SFY - Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY 05 - 11)							
	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
Out-of-State	-5.1%	4.5%	-19.8%	-19.8%	-33.5%	-30.5%	-13.1%
In-State	34.7%	-0.3%	33.8%	-4.9%	2.4%	1.6%	12.2%
Total	3.8%	3.1%	-4.7%	-13.9%	-17.8%	-13.1%	3.0%

Table 4b

Percentage of Increase (Decrease) between SFY - Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year (FY 98 - 04)							
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Out-of-State		79.5%	65.8%	73.7%	25.6%	18.2%	17.6%
In-State		56.1%	1.8%	-4.5%	-1.4%	3.4%	0.5%
Total		64.9%	27.9%	36.8%	16.7%	14.1%	13.3%

Data Source: MMIS SYF 11

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 SFY 12. (15 percent per year)

Findings:

(Reference Table 5a – 6b)

Between SFY 1998 and 2004 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 SFY2011, in comparison to SFY2010:

- Out-of-State RPTC Medicaid expenditures **decreased** by 18%
- In-State RPTC Medicaid expenditures **increased** by 10%
- Total RPTC Medicaid expenditures **decreased** by 2%.

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

- Out-of-State RPTC Medicaid expenditures for SFY '11 are 69% **lower** than SFY 06.
- Total RPTC Medicaid expenditures for SFY '11 are 40% **lower** than SFY 07.

Table 5a

RPTC Medicaid Claims Payments by Fiscal Year (FY 05 -FY 11)							
	FY 05	FY 06	FY 07	FY 08	FY 09	FY2010	FY 11
Out-of-State	38,202,707	40,008,891	36,745,804	26,848,252	19,487,410	15,191,809	12,506,885
In-State	13,812,640	14,297,112	20,888,007	20,896,822	20,867,295	20,049,751	22,171,482
Total	52,015,347	54,306,003	57,633,811	47,745,074	40,354,705	35,251,550	34,678,367

Data Source: MMIS SYF 11

Table 5b

RPTC Medicaid Claims Payments by Fiscal Year (FY 98 -FY 04)							
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Out-of-State	2,609,857	5,098,189	9,873,606	17,609,108	21,175,228	30,915,287	37,794,039
In-State	2,823,582	5,623,348	6,286,219	8,242,948	9,229,970	10,093,200	11,532,083
Total	5,433,439	10,721,537	16,159,825	25,852,056	30,405,198	41,008,487	49,326,122

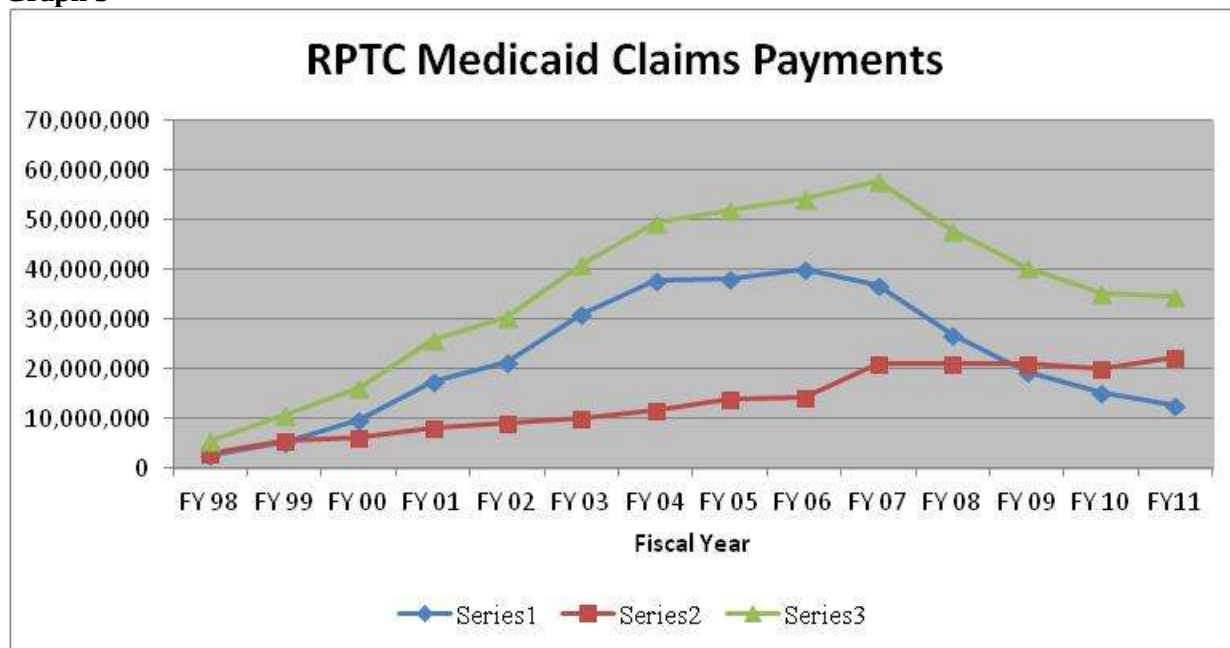
Table 6a

Percentage of Increase (Decrease) between SFY - Medicaid RPTC Claims Payments (FY 05 - FY 11)							
	FY 05	FY 06	FY 07	FY 08	FY 09	FY10	FY 11
Out-of-State	1.1%	4.5%	-8.2%	-26.9%	-27.4%	-22.0%	-17.7%
In-State	16.5%	3.4%	31.6%	0.0%	-0.1%	-3.9%	9.6%
Total	5.2%	4.2%	5.8%	-17.2%	-15.5%	-12.6%	-1.6%

Data Source: MMIS SYF 11

Table 6b

Percentage of Increase (Decrease) between SFY - Medicaid RPTC Claims Payments (FY 98 - FY 04)							
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Out-of-State		48.8%	48.4%	43.9%	16.8%	31.5%	18.2%
In-State		49.8%	10.5%	23.7%	10.7%	8.6%	12.5%
Total		49.3%	33.7%	37.5%	15.0%	25.9%	16.9%

Graph 3

Series 1: Out of State Expenditures; Series 2: In-State Expenditures; Series 3: Total Expenditures for RPTC

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 SFY 2012.*

Findings: (Reference Table 7 – 8)

For SFY 2010, the Average Length of Stay for RPTC:

- Custody In-State: 161 days. **Increase** of 22 days (14%) from FY 09.
- Custody Out-of State: 512 days. **Increase** of 23 days (4%) from FY 09.
- Non-Custody In-State: 169 days. **Increase** of 7 days (5%) from FY 09.
- Non-Custody Out-of-State: 366 days. **Increase** of 30 days (3.8%) from FY 09.

Table 7

Average Length of Stay (in days)										
	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10
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 SYF 11

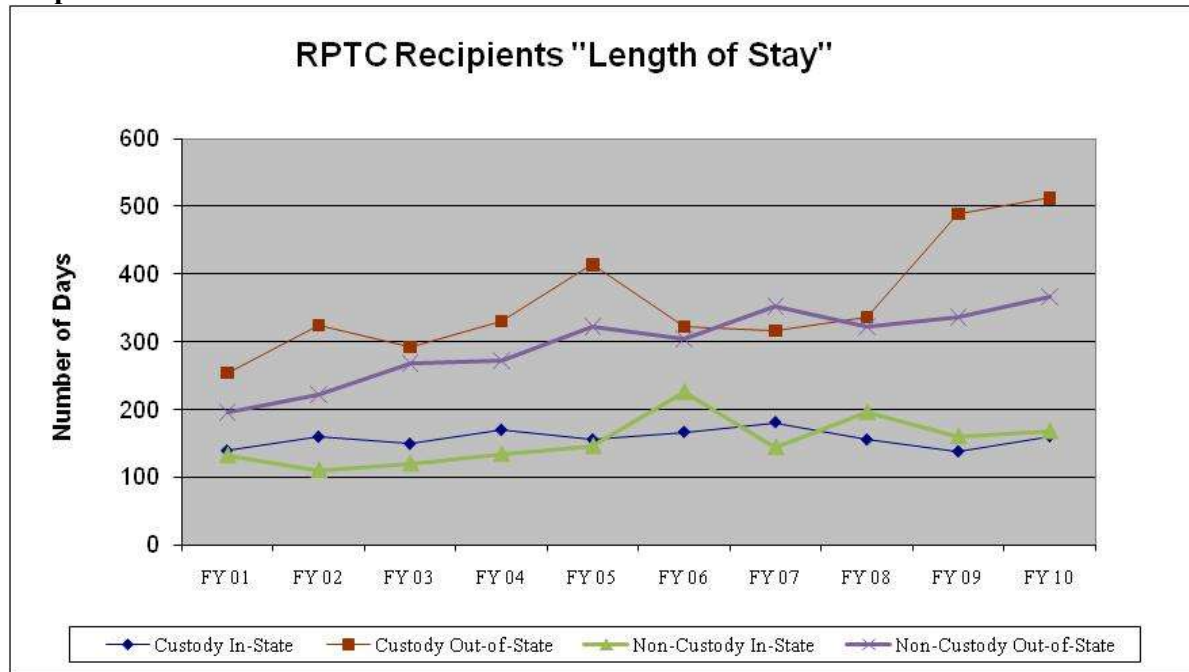
Note: Data re-calculated over the 10 year period using a methodology that reflects a more precise LOS over time.

Table 8

Percentage of Increase (Decrease) between SFY – Average Length of Stay										
	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10
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 SYF 11

Graph 4



Indicator 4: Service Capacity – Increase in the number of instate residential beds for children/youth by 60 percent by SFY 12. (10 percent per year).²

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 SFY '10 for an estimated total 1,020 beds.

Indicator 5: Recidivism: Decrease in the number of children/youth returning to RPTC and acute hospitalization care by 75% by SFY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)³

Findings: (Reference Table 10)

For SFY 2010,

- Custody In-State recidivism rate was 2%.

² 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 of meaningful ties by 60 percent by SFY 12 (10 percent per year).*

³ 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 SFY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)*

- 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 SFY '10, 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 SFY '10 over-all recidivism rate of 8.6% (35 cases) is compare to:
 - a SFY '09 rate of 3.4% (16 cases)
 - a SFY '08 rate of 8.4% (41 cases)
 - a SFY '07 rate of 7.5% (42 cases)
 - a SFY '06 rate of 14% (61 cases)
 - a SFY '05 rate of 12.5% (56 cases)
 - a SFY '04 rate of 20% (93 cases)

Table 10

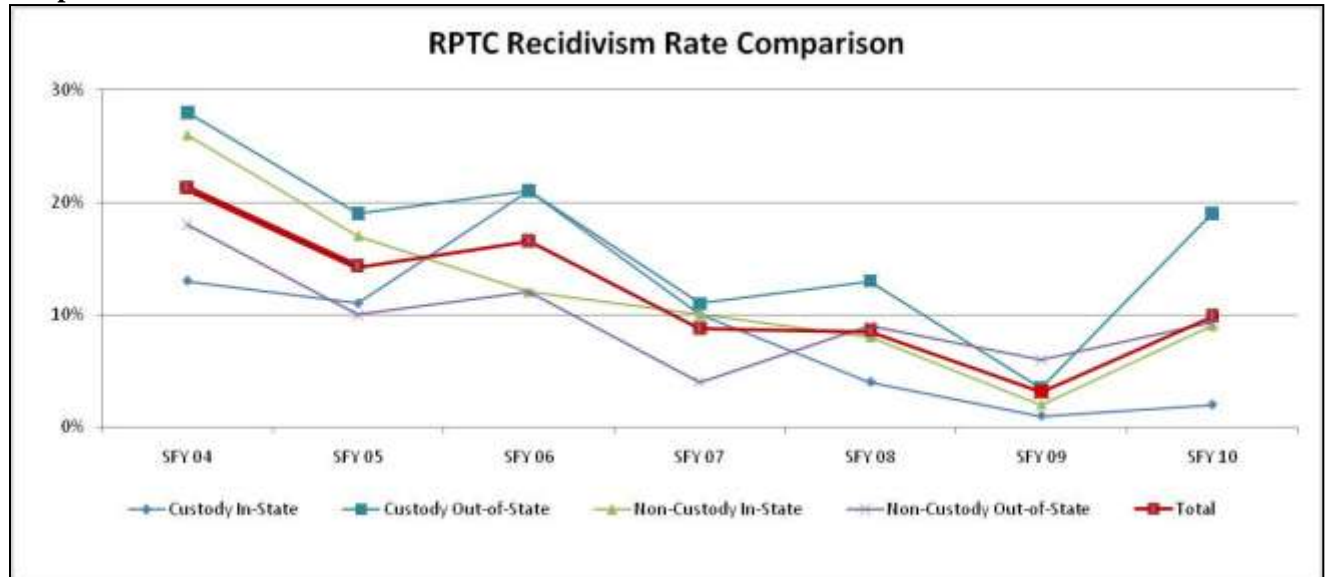
RPTC Recidivism Rates								
Custody Status	Placement	Discharges by SFY		Readmissions Following Discharge within...			Total Readmits	%
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	SFY 04	51	4	2	1	7	13%
		SFY 05	73	4	2	2	8	11%
		SFY 06	56	1	8	3	12	21%
		SFY 07	68	1	4	2	7	10%
		SFY 08	52	0	1	1	2	4%
		SFY 09	91	1	--	--	1	1%
		SFY 10	59	--	1	--	1	2%
Custody	OOS	SFY 04	39	2	7	2	11	28%
		SFY 05	32	1	4	1	6	19%
		SFY 06	52	3	4	4	11	21%
		SFY 07	55	2	4	0	6	11%
		SFY 08	37	3	1	1	5	13%
		SFY 09	28	1	--	--	1	3.5%
		SFY 10	16	3	--	--	3	19%
Non-Custody	In-State	SFY 04	106	12	10	6	28	26%
		SFY 05	92	10	5	1	16	17%
		SFY 06	81	2	5	3	10	12%
		SFY 07	194	12	6	1	19	10%
		SFY 08	205	10	4	3	17	8%
		SFY 09	204	--	3	2	5	2%
		SFY 10	236	3	14	5	22	9%
Non-Custody	OOS	SFY 04	262	12	20	15	47	18%
		SFY 05	248	6	13	7	26	10%
		SFY 06	235	8	13	7	28	12%
		SFY 07	239	4	5	1	10	4%
		SFY 08	194	5	9	3	17	9%
		SFY 09	143	5	3	1	9	6%
		SFY 10	97	7	2	--	9	9%

Data Source: MMIS SYF 11

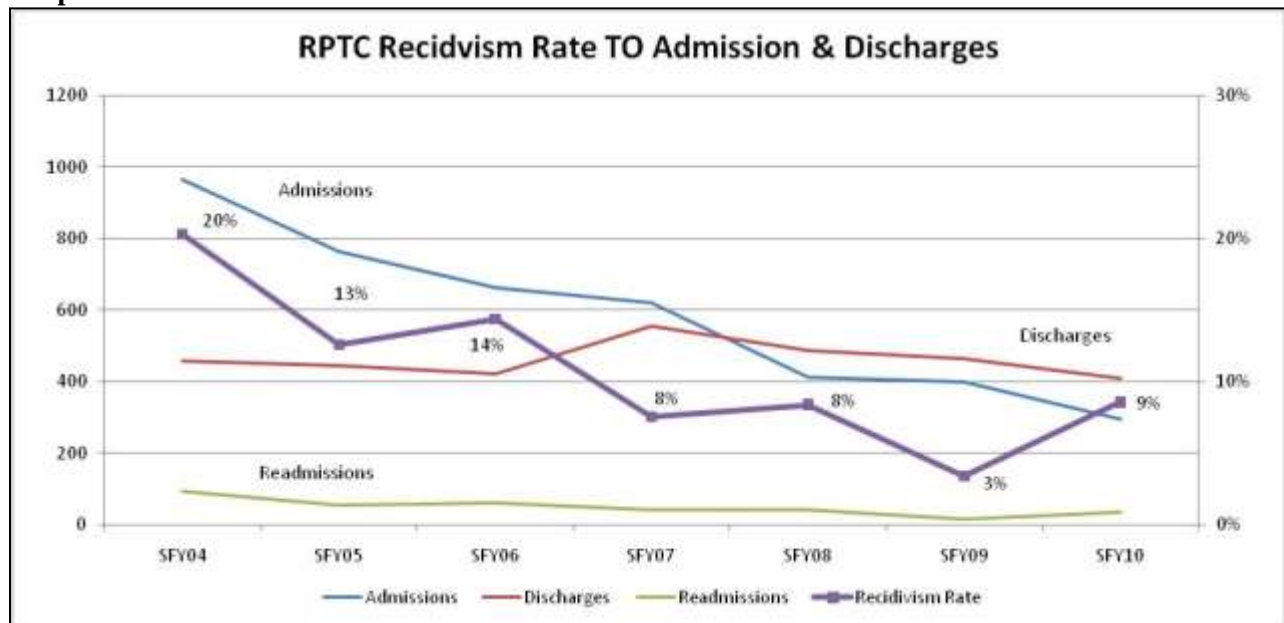
Table 10: NOTE:

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

Graph 5



Graph 6



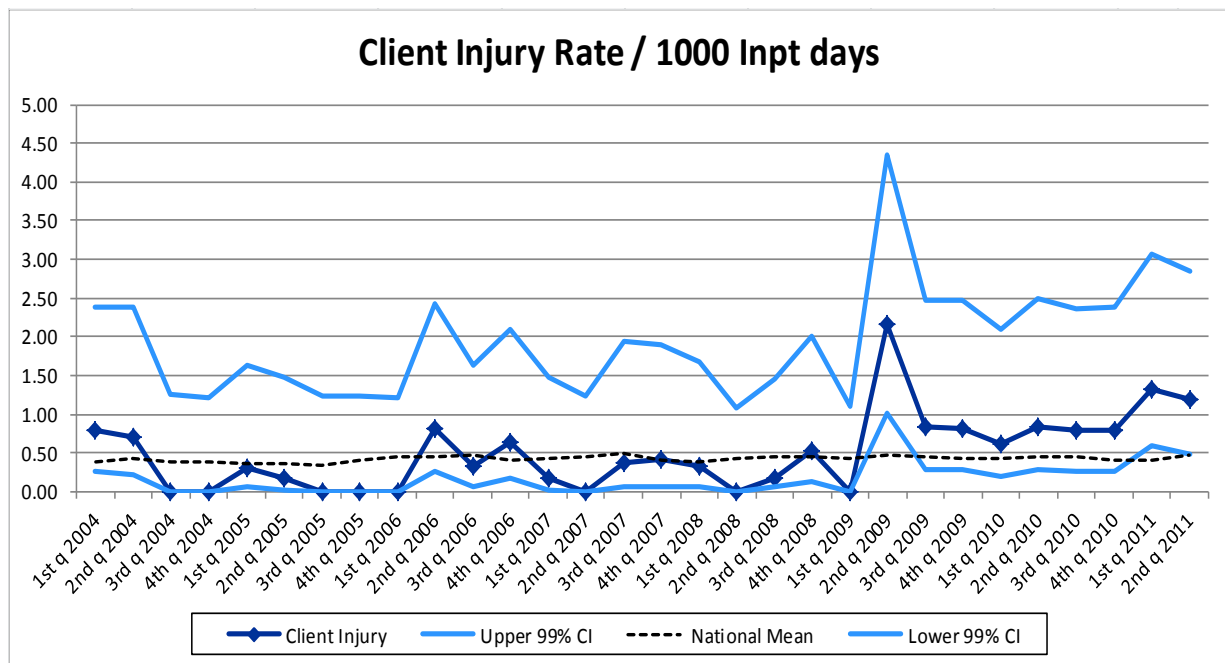
Alaska Psychiatric Institute “Dashboard” of Key Performance Measures



Welcome to API's Dashboard

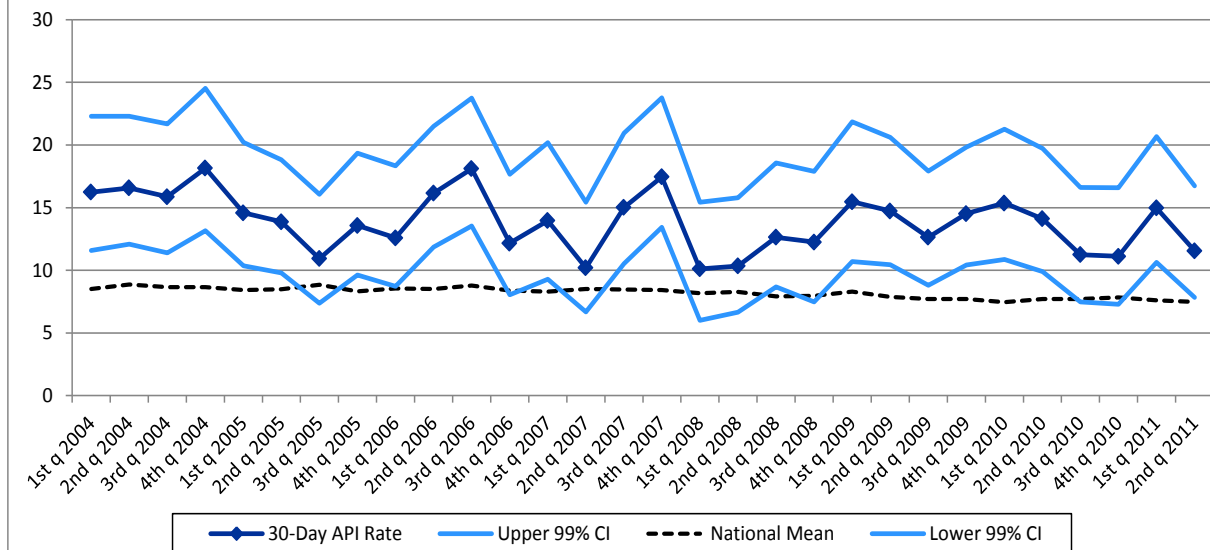
API has changed the format of the dashboard. The following graphs provide a review of our data over time. This allows us to look back at the road traveled. Evaluate the course we have taken, anticipate the future, and evaluate how well our effects are meeting the challenges we face.

Thank you for taking the time to review our data.



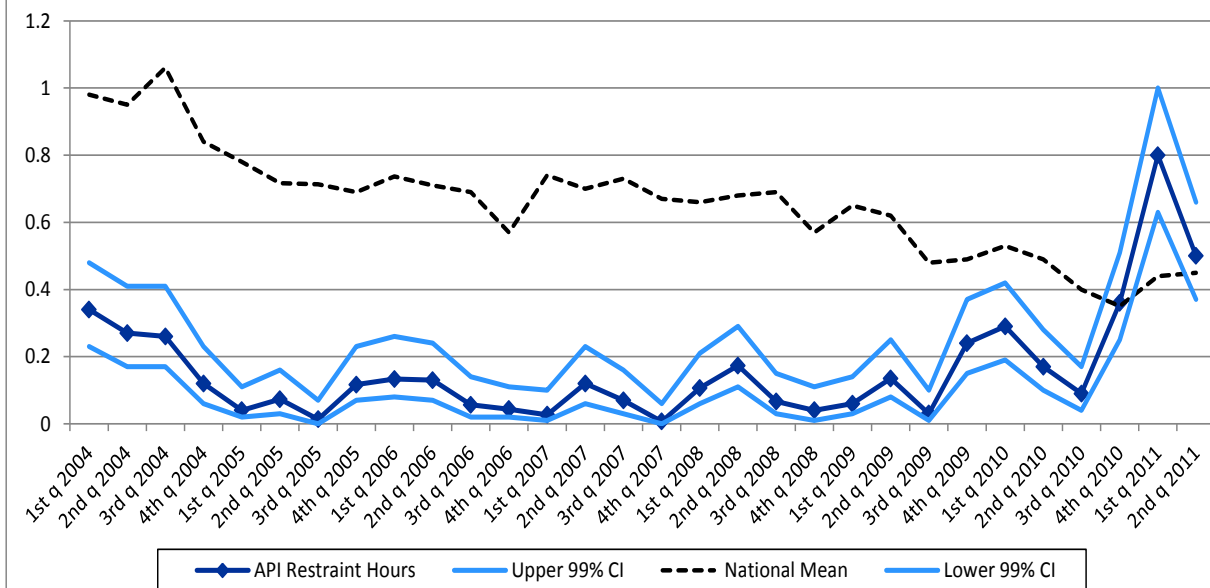
The upsurge for the second quarter of 2009 is the result of a confluence of multiple patient issues including; patient seizures, patient falls, and peer to peer assaults. The sustained rise above the national mean from the second quarter 2009 through the second quarter 2011 is significant and could point to a trend change. API has initiated efforts to evaluate our care environment, utilization of program and staff training to identify effective ways to mitigate the trend.

30-Day Readmission Rate (Discharge Cohort)

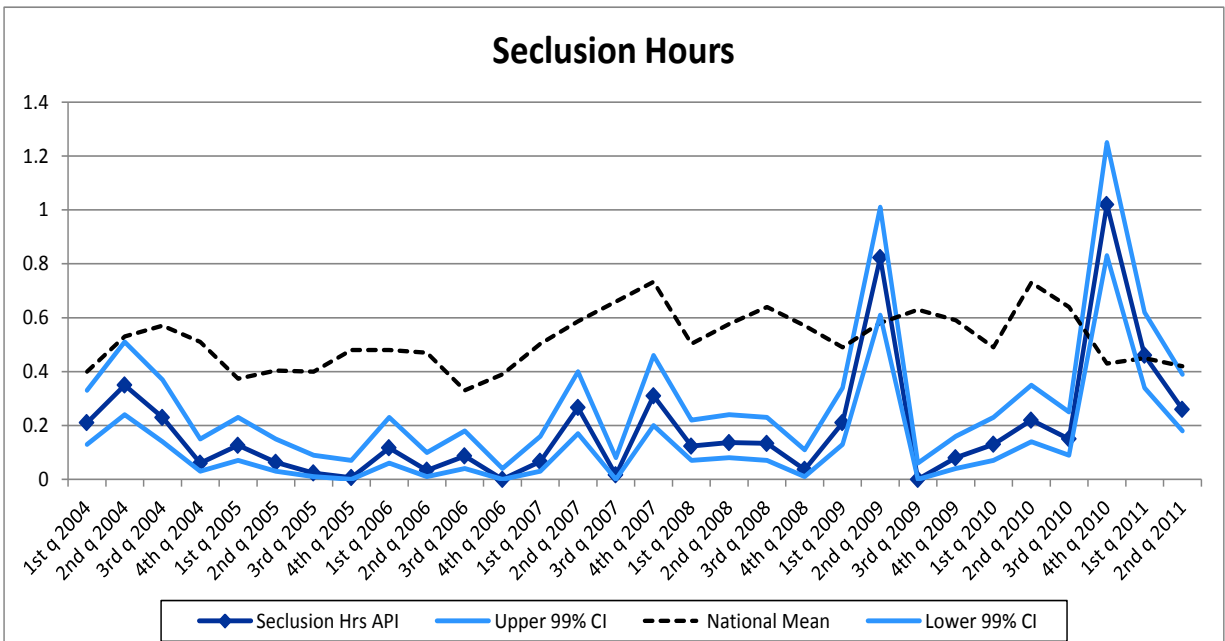


The 30-Day re-admission rate at API has been consistently above the National Mean over the last 5 years. The difference between the 30-day re-admission rate at API and the National mean is statistically significant at each point where the lower 99% confidence interval is above the (black dashed) National Mean line. API is working to improve outcomes through evaluation of its discharge process, collaboration with DBH and community providers in the goal of improving client outcomes post discharge.

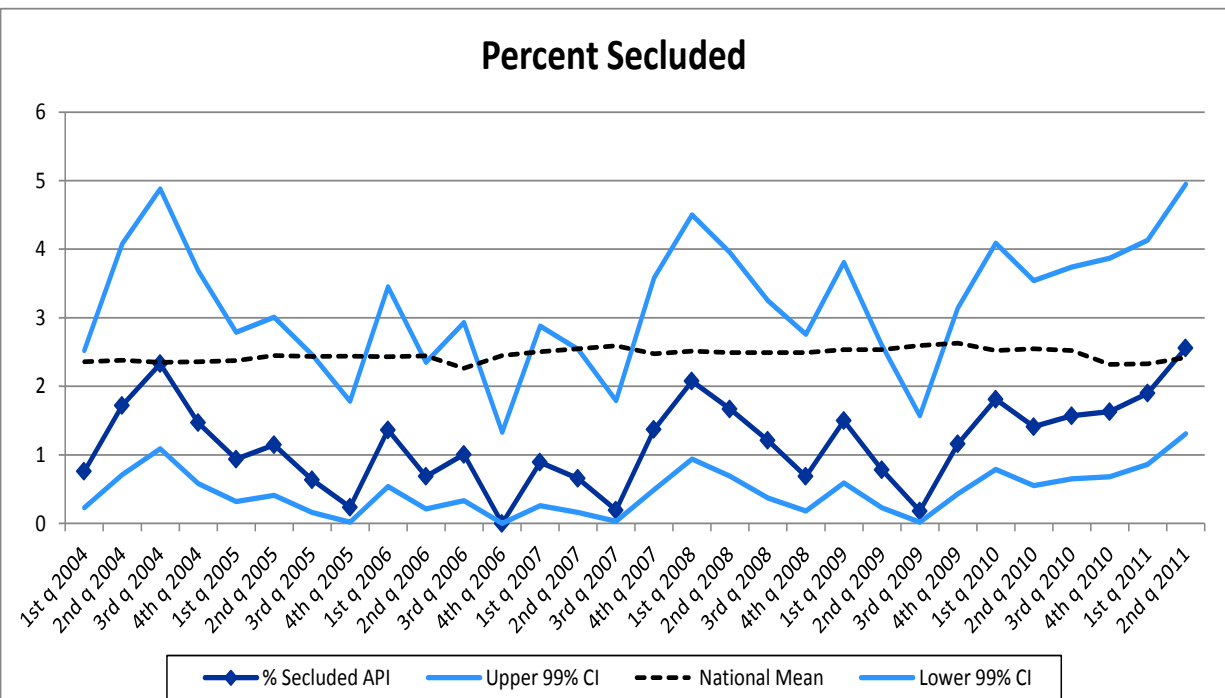
Restraint Hours



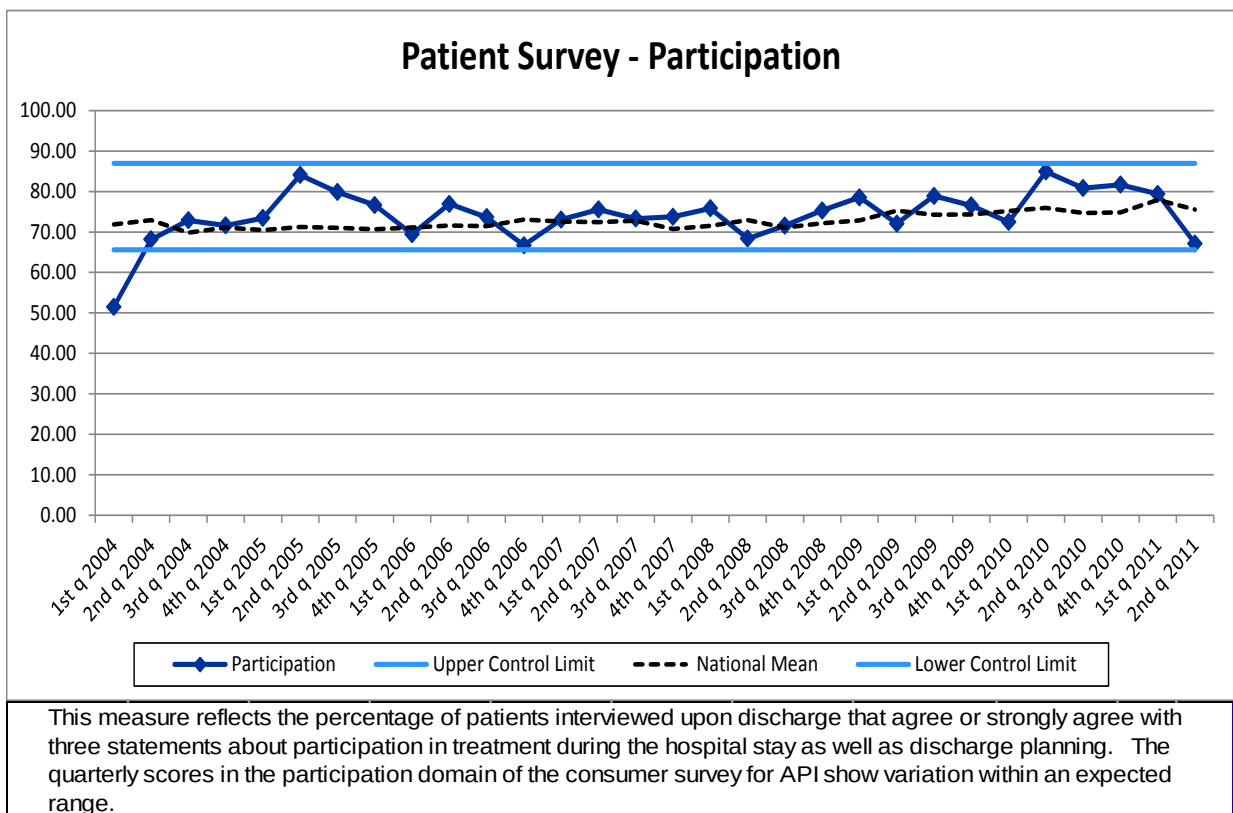
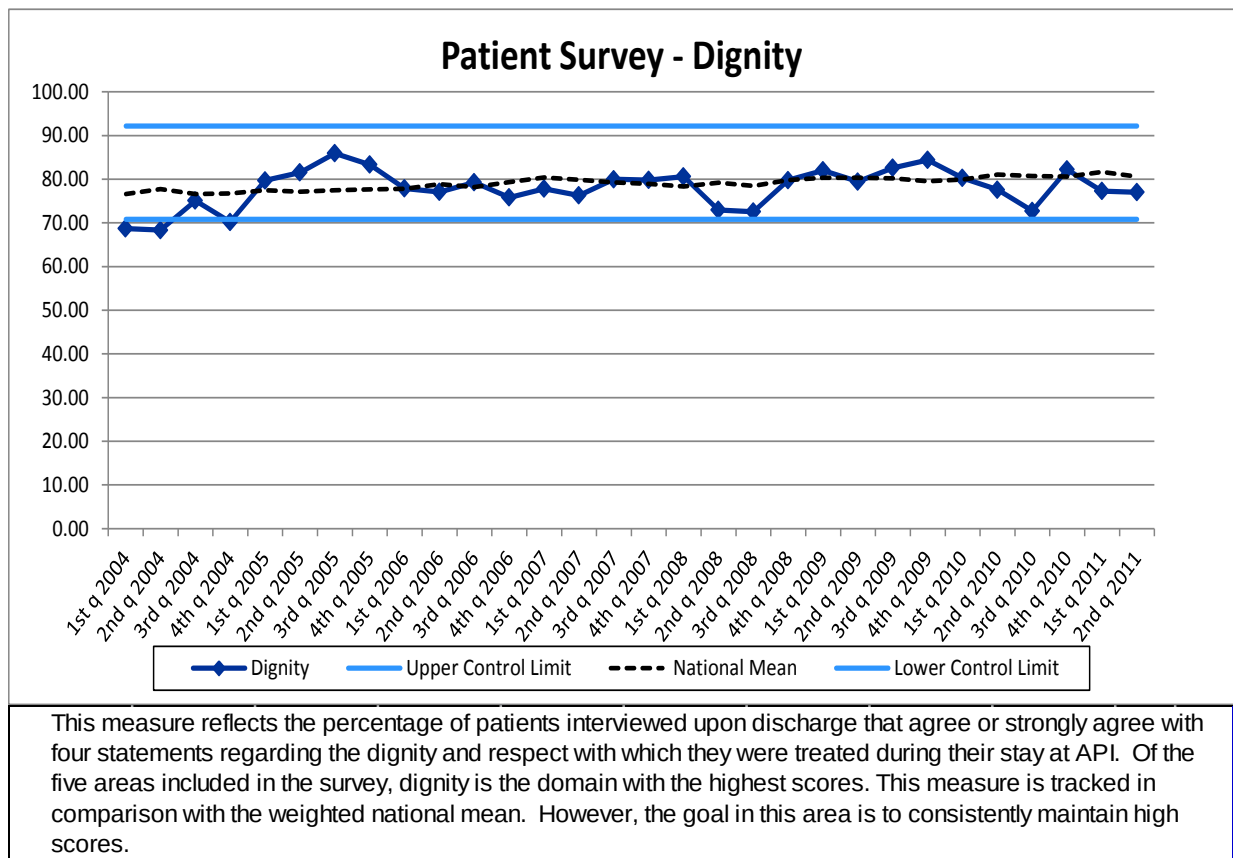
API has traditionally maintained restraint hours per 1000 inpatient hours well below the national mean for this measure. Over the last three quarters API has seen a marked increase in restraint hours. API continues to monitor this important indicator as part of its commitment to providing the best possible care for our clients. API has identified objectives to improve treatment programming, client engagement, and other best practice measures to work toward a reduction in restraint and seclusion use in the hospital.

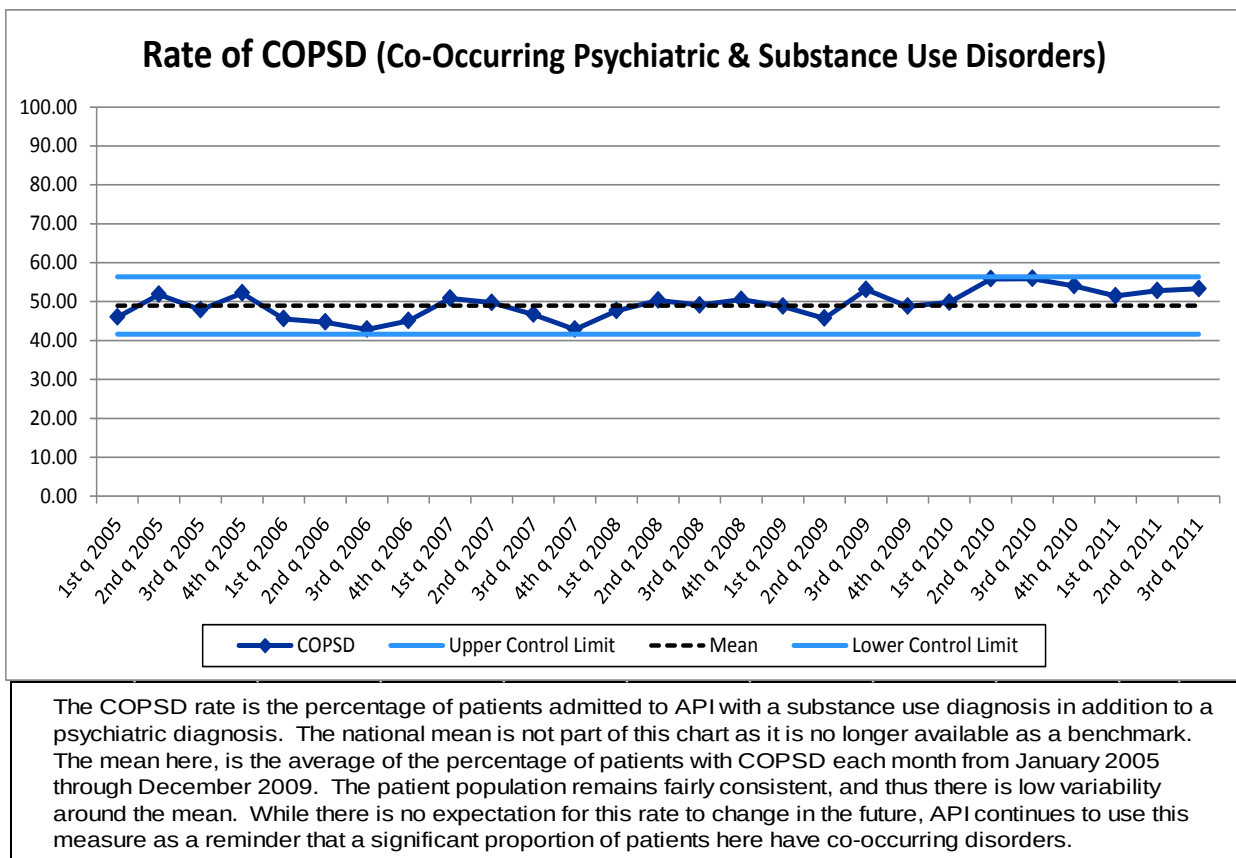
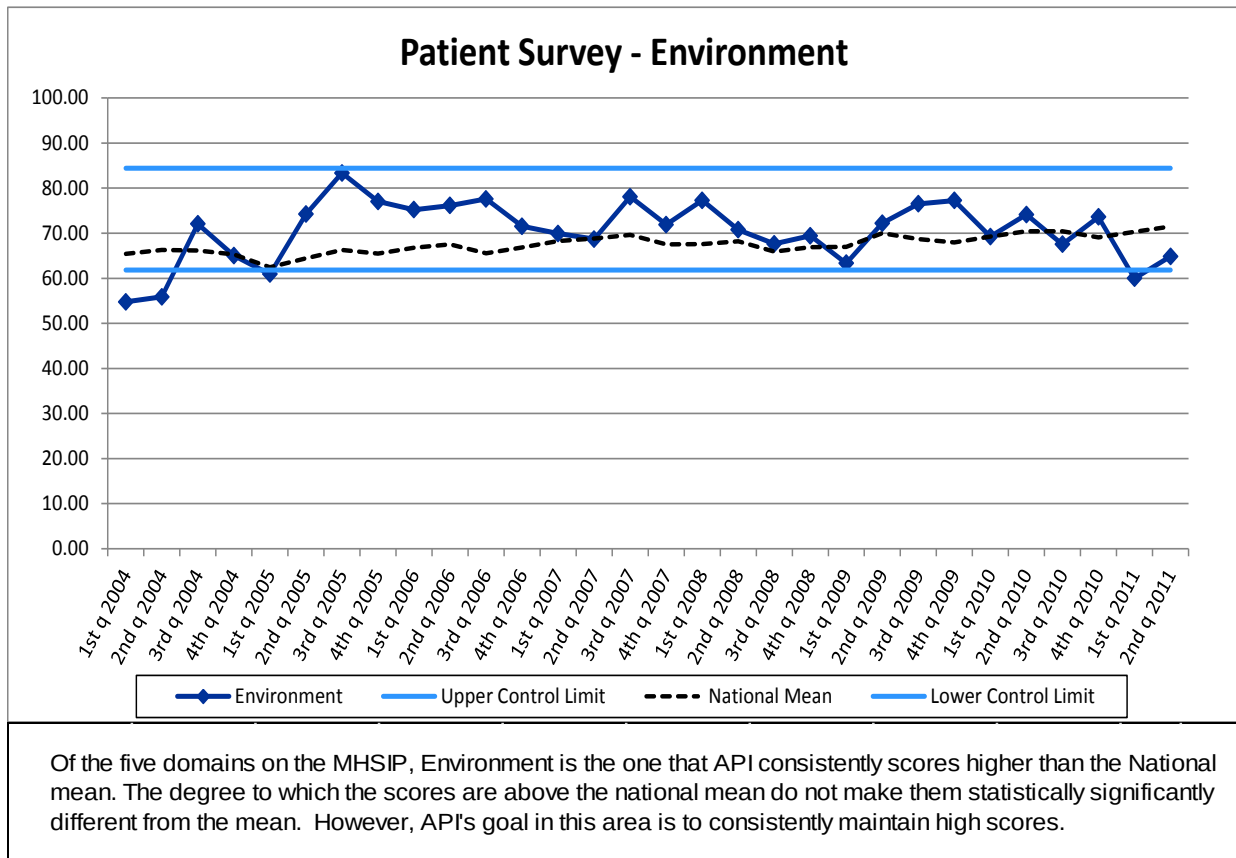


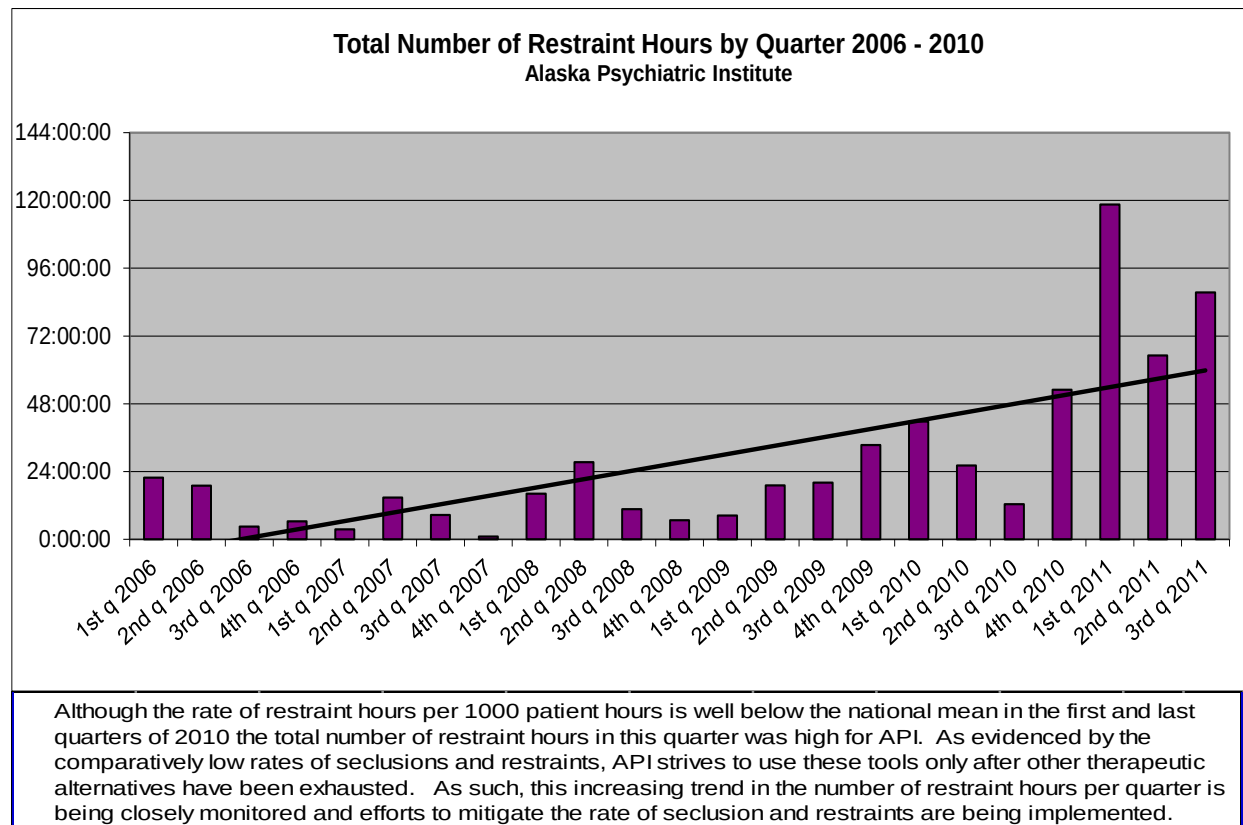
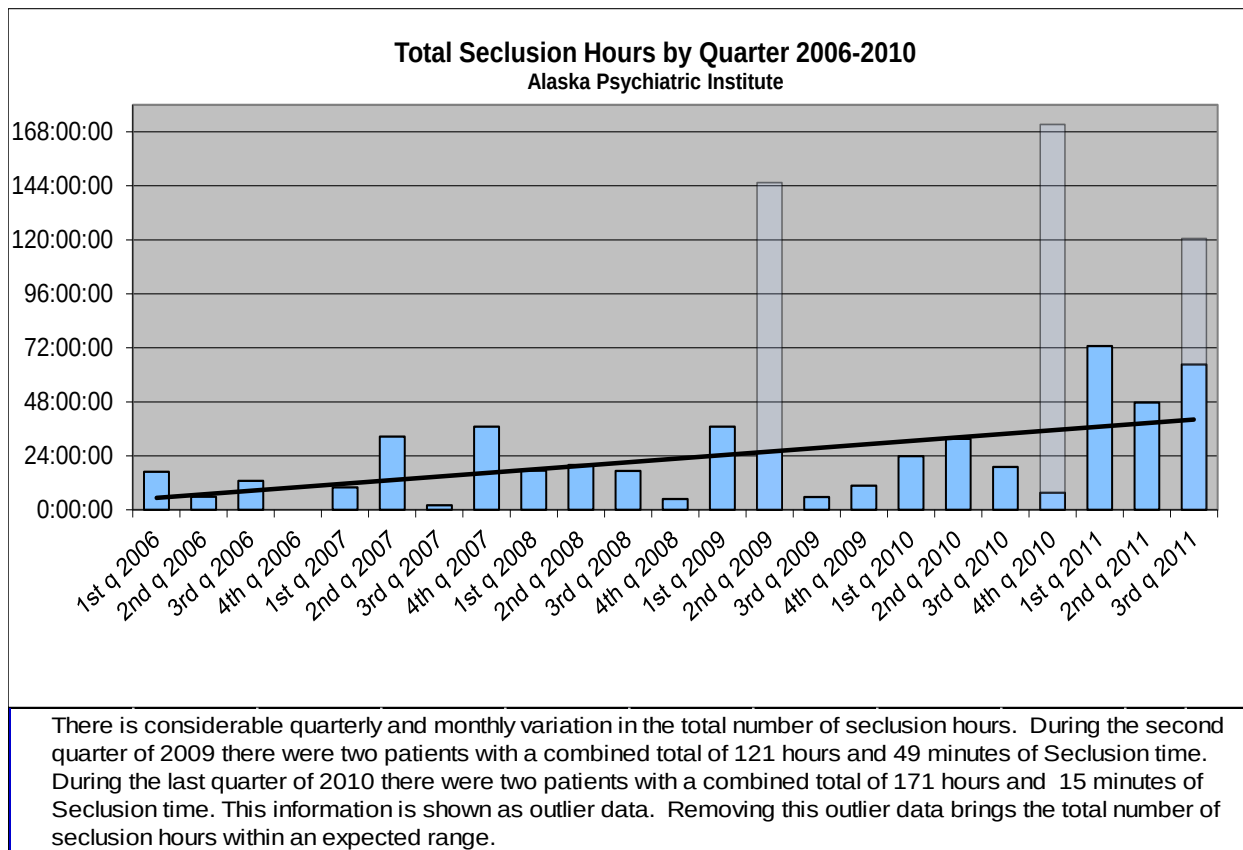
Seclusion hours per 1000 inpatient hours at API is fairly consistent, and for the most part this trend has remained well below the national mean for the past five years with the obvious exceptions of the second quarter of 2009 and the last quarter in 2010. Ninety percent of the Seclusion incidents during the second quarter of 2009 were divided equally between three patients. Ninety five percent of the seclusion hours in the last quarter of 2010 was accounted for by two patients.



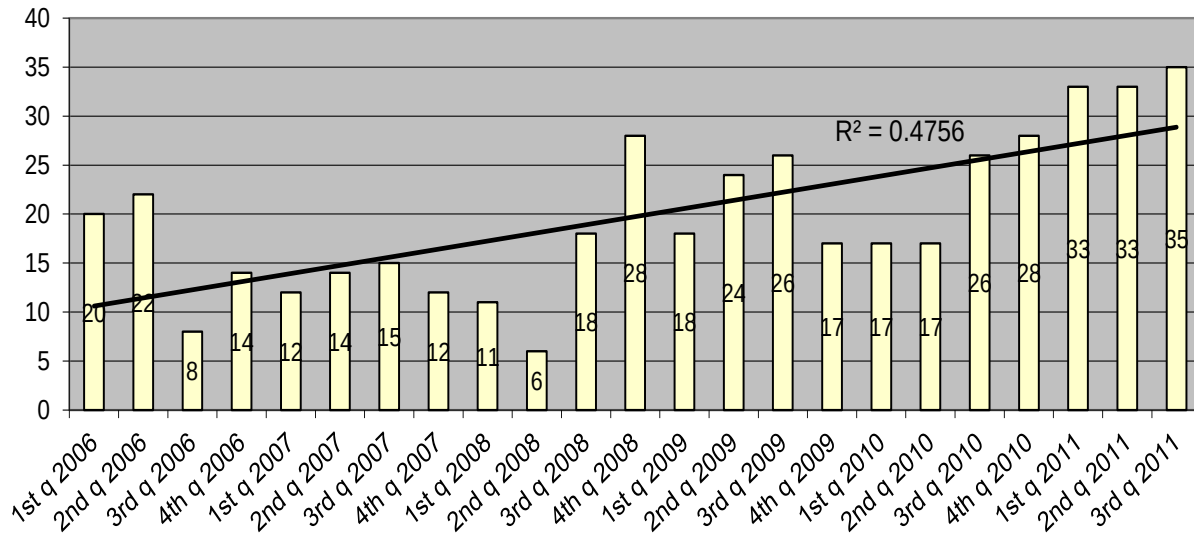
As identified in the Restraint Hours measure; API has identified objectives to improve treatment programming, client engagement, and other best practice measures to work toward a reduction in restraint and seclusion use in the hospital.





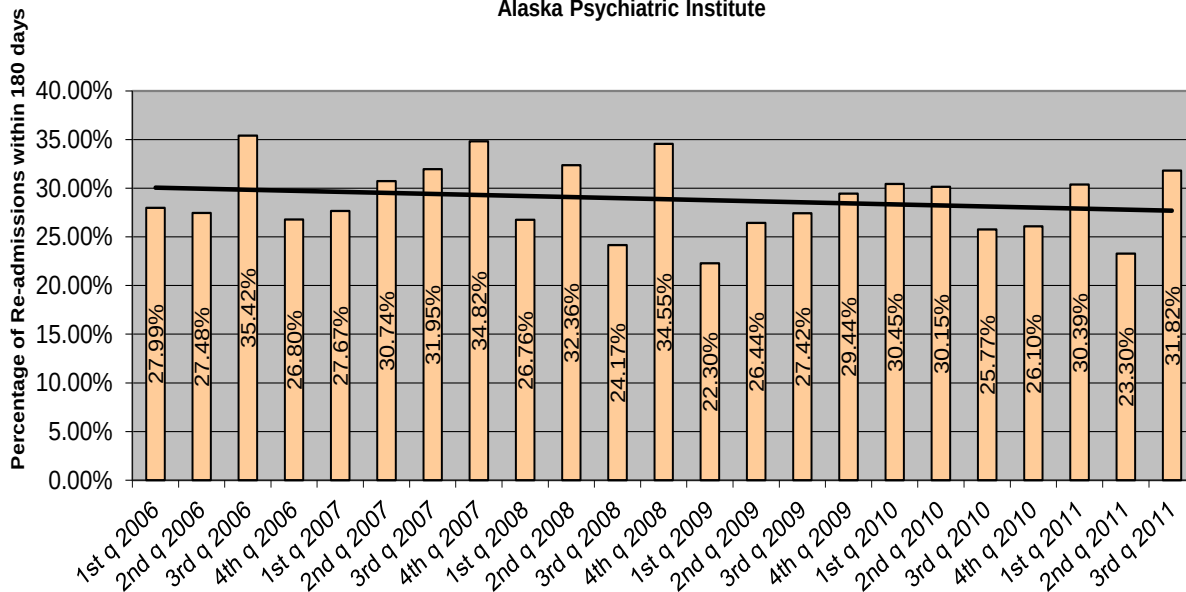


Quarterly Trend of Court Approved Medications Alaska Psychiatric Institute

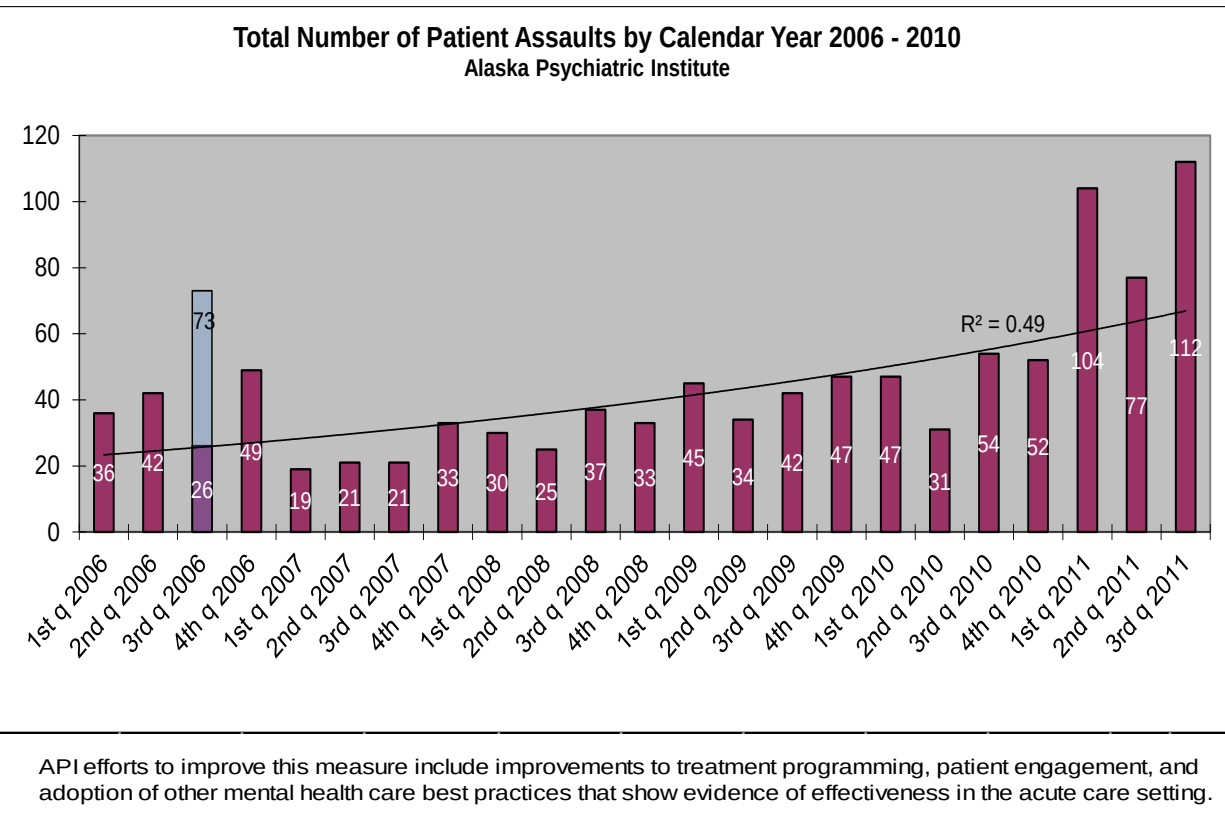
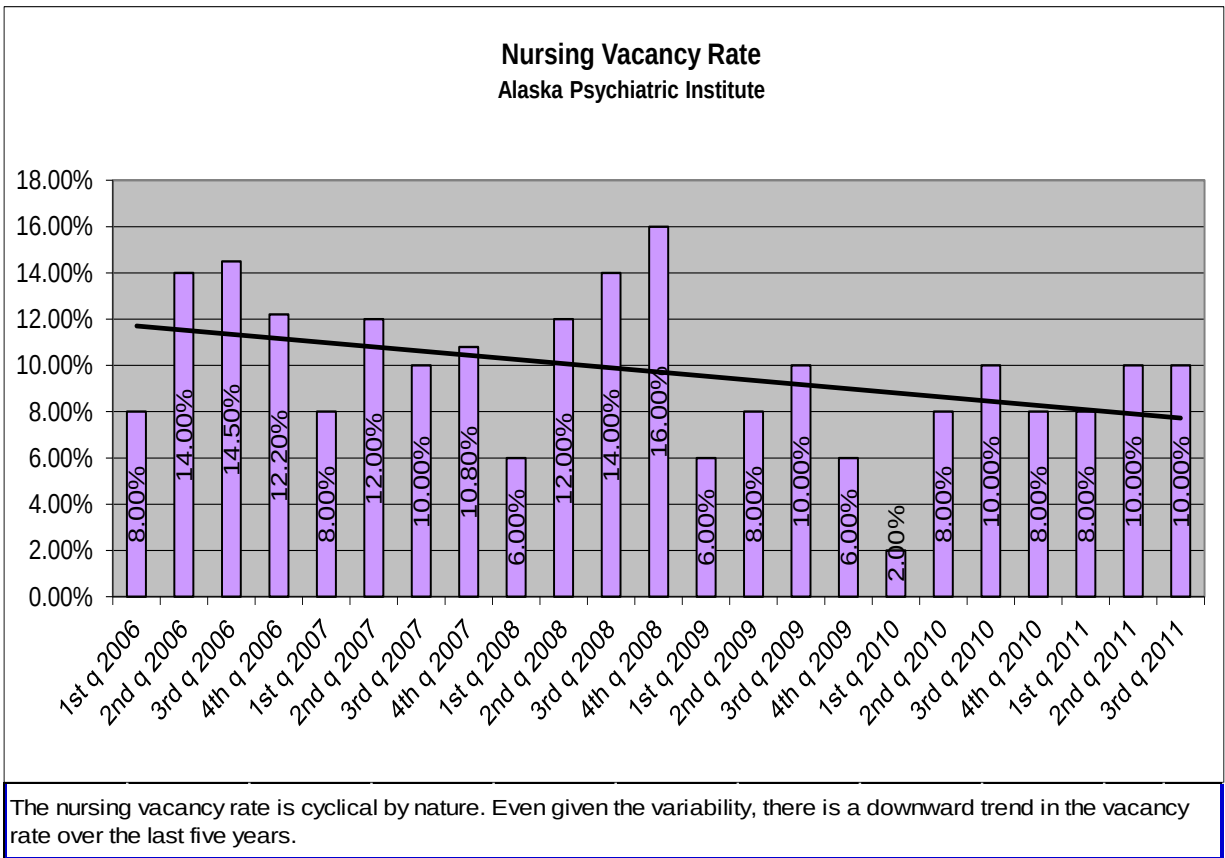


The trend line has remained relatively constant over the reporting period. Many factors effect the quarter by quarter variations in court ordered medications, including but not limited to: severity of acute illness, effects of census on individual patients, type of illness, etc..

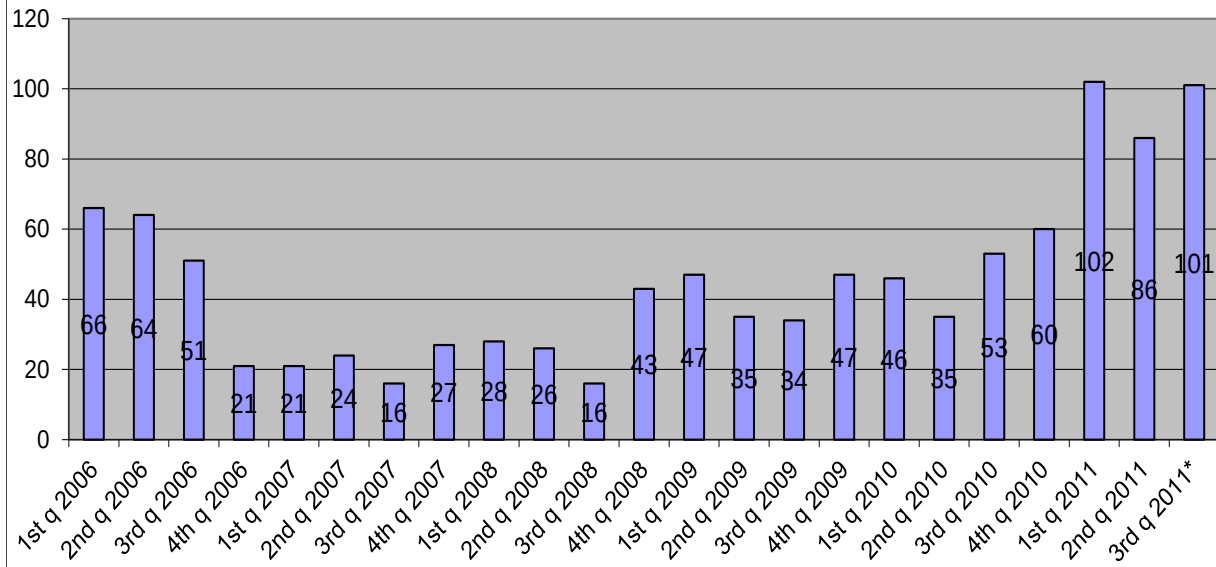
180 Day (Adult) Re-admits by Quarter 2006 - 2010 Alaska Psychiatric Institute



The quarterly average number of 180 Day Re-Admits over the past four years has a gradually declining trend line. This declining trend matches the declining rate of 30 day re-admits.



Total Number of Staff Injuries by Quarter for the 2006 - 2010 Calendar Years
Alaska Psychiatric Institute

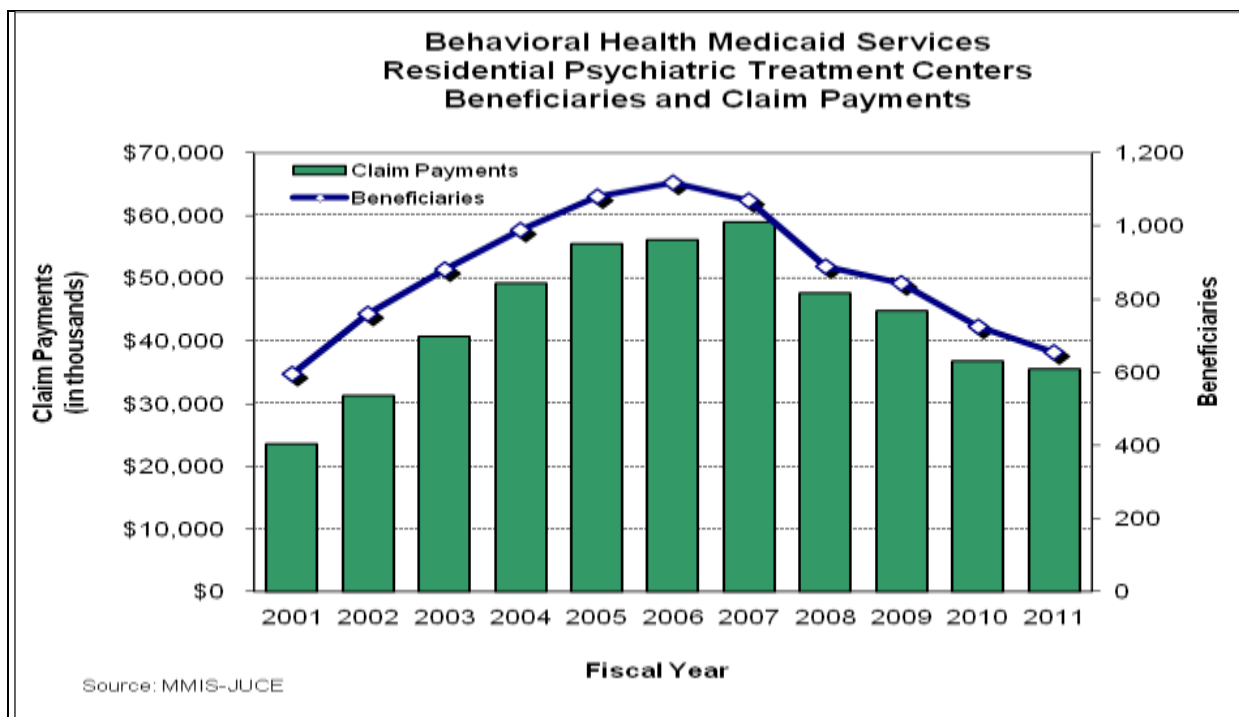
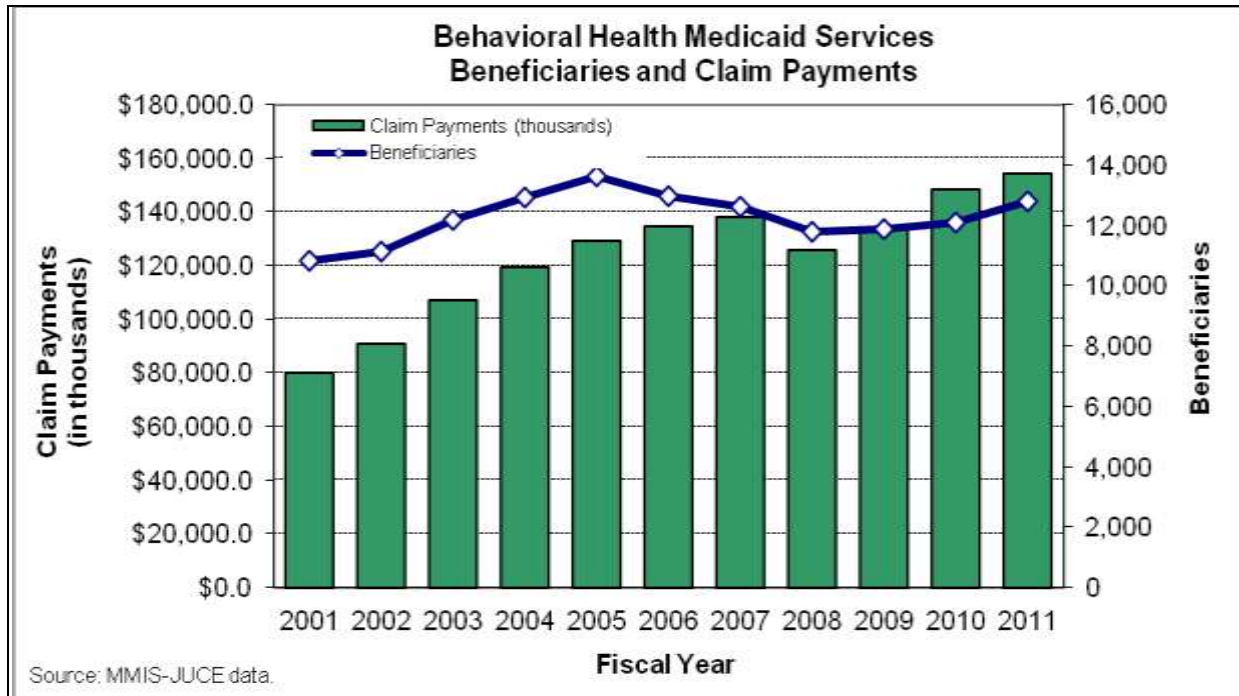


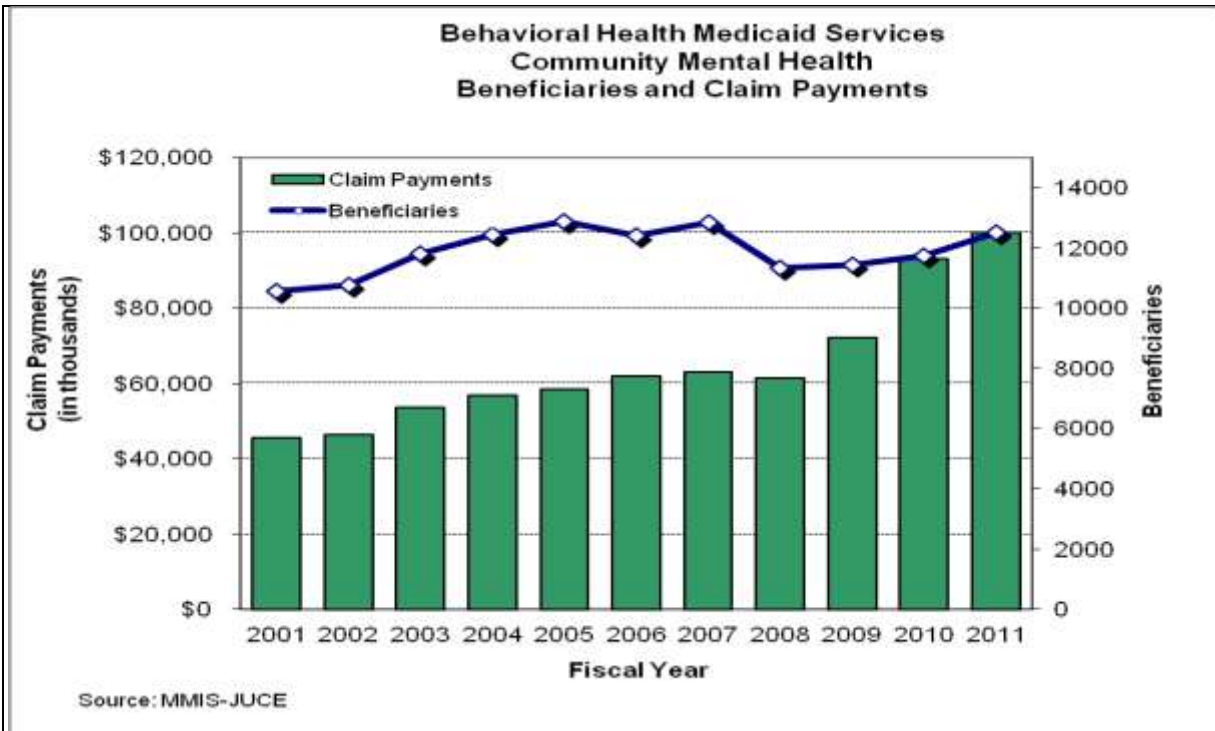
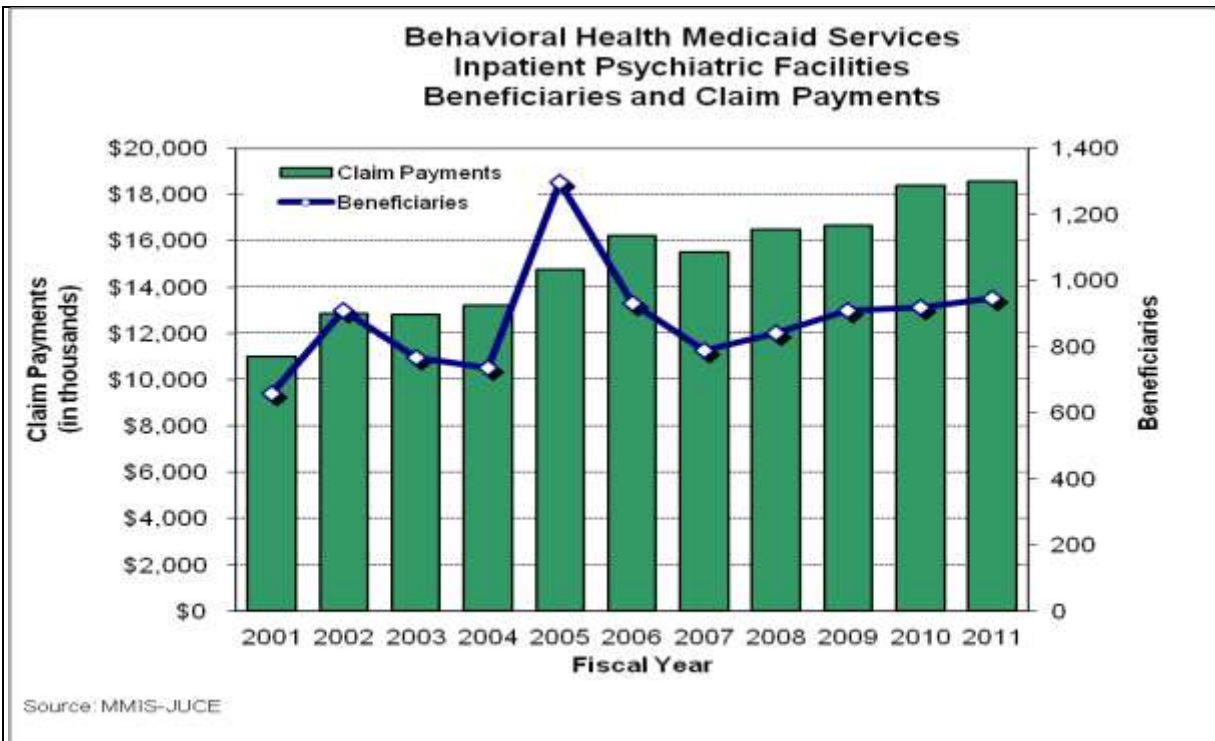
As noted in 'Patient Assaults' API has several objectives underway to improve the outcome of this measure.

Behavioral Health Medicaid Service Statistics

Health Medicaid Services Beneficiaries and Claim Payments

In FY2011, the Behavioral Health Medicaid component provided services to 12,798 persons at an average annual cost of \$12,041 per beneficiary. This represents a 5.9% increase in the number of beneficiaries and a 1.9% decrease in the cost per beneficiary from FY2010 to FY2011.

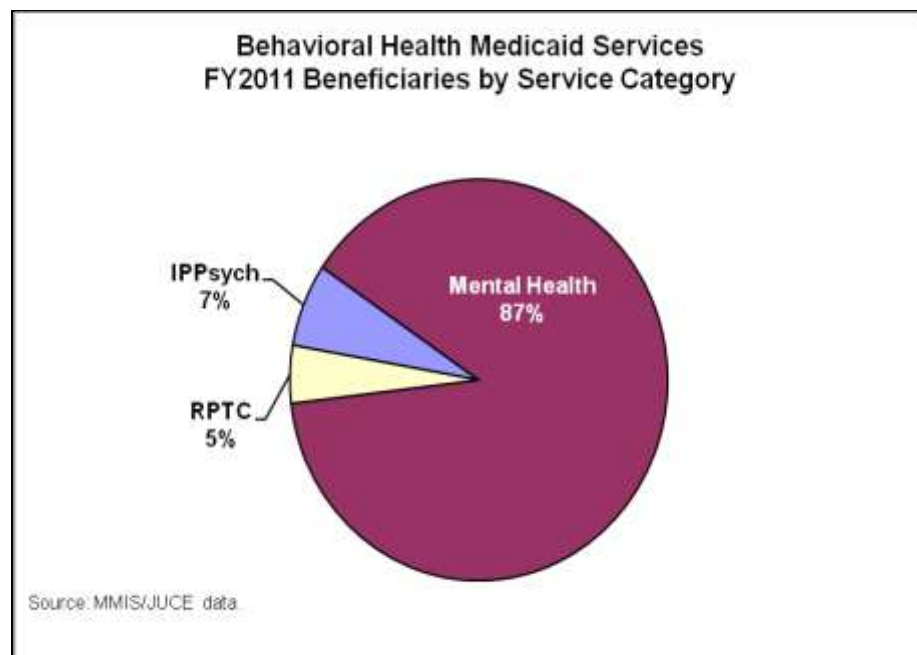
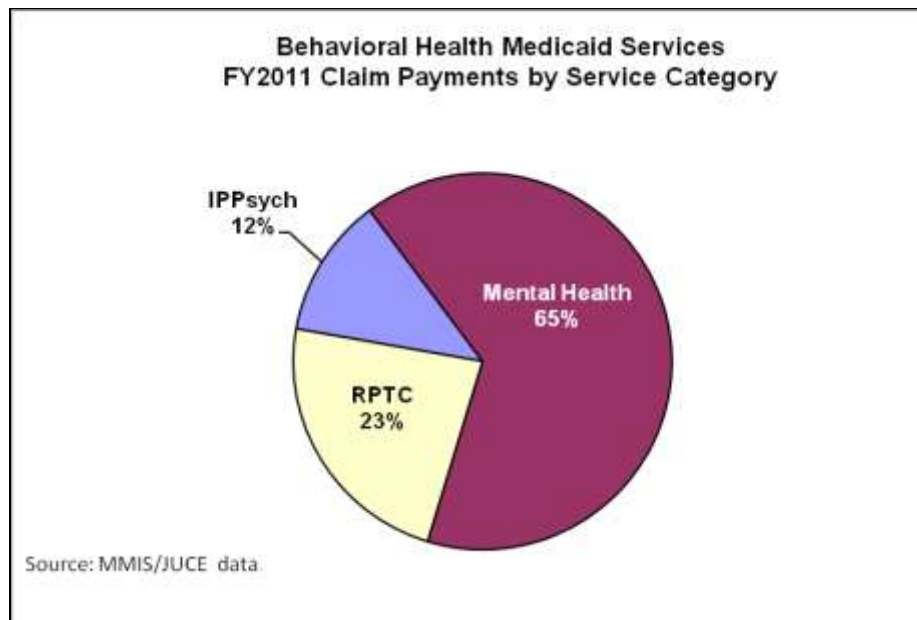




Behavioral Health Medicaid Services FY2011 Claim Payments by Service Category

The Behavioral Health Medicaid Services component funds three types of services: inpatient psychiatric hospital services, residential psychiatric treatment center (RTPC) services, and community behavioral health services.

Inpatient psychiatric hospital claims account for 12% of total FY2011 Behavioral Health Medicaid claim payments. The inpatient psychiatric hospital category is comprised of psychiatric services delivered at non-state hospitals, at the Alaska Psychiatric Institute and at Indian Health Service psychiatric hospitals. RTPC claims account for 23% of total Medicaid claim payments in FY2011. The community behavioral health category is comprised of psychologist services, mental health clinic services and substance abuse rehabilitation services. Claims submitted for community behavioral health services account for 65% of claim payments in FY2011.



FY 2011 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		12,798		\$154,099,768	\$12,041	9.5%	12.0%
Gender							
Female	52.2%	6,679	41.0%	\$63,226,903	\$9,467	8.8%	8.7%
Male	47.8%	6,119	59.0%	\$90,872,866	\$14,851	10.4%	16.1%
Unknown	0.0%	0	0.0%	\$0	\$0	0.0%	0.0%
Race							
Alaska Native	37.0%	4,749	42.3%	\$65,115,706	\$13,711	9.1%	14.0%
American Indian	2.2%	285	2.0%	\$3,045,171	\$10,685	13.3%	15.4%
Asian	1.9%	246	1.5%	\$2,335,869	\$9,495	2.8%	2.9%
Pacific Islander	1.1%	141	0.5%	\$711,856	\$5,049	3.1%	2.1%
Black	5.5%	705	5.4%	\$8,247,175	\$11,698	9.4%	14.1%
Hispanic	2.8%	355	2.1%	\$3,213,049	\$9,051	7.3%	10.1%
White	47.4%	6,082	43.4%	\$66,853,800	\$10,992	11.6%	11.9%
Unknown	2.2%	278	3.0%	\$4,577,143	\$16,465	7.8%	12.1%
Native	39.2%	5,033	44.2%	\$68,160,876	\$13,543	9.3%	14.0%
Non-Native	60.8%	7,792	55.8%	\$85,938,892	\$11,029	9.6%	10.7%
Age							
under 1	0.1%	7	0.0%	\$2,261	\$323	0.1%	0.0%
1 through 12	23.4%	3,127	28.9%	\$44,513,373	\$14,235	5.8%	22.6%
13 through 18	28.3%	3,782	51.8%	\$79,879,837	\$21,121	16.6%	45.1%
19 through 20	3.7%	498	2.0%	\$3,078,223	\$6,181	9.1%	8.3%
21 through 30	12.5%	1,679	4.2%	\$6,434,904	\$3,833	10.5%	3.9%
31 through 54	24.6%	3,291	9.7%	\$14,882,250	\$4,522	15.8%	5.3%
55 through 64	5.8%	770	2.6%	\$3,941,829	\$5,119	12.6%	3.2%
65 through 84	1.7%	226	0.9%	\$1,344,643	\$5,950	2.9%	0.9%
85 or older	0.1%	7	0.0%	\$22,449	\$3,207	0.5%	0.0%
Benefit Group							
Children	49.8%	6,512	72.1%	\$111,092,295	\$17,060	7.8%	26.4%
Adults	16.7%	2,183	2.7%	\$4,099,624	\$1,878	8.2%	2.3%
Disabled Children	4.1%	531	8.8%	\$13,577,404	\$25,569	21.2%	20.2%
Disabled Adults	28.1%	3,670	15.8%	\$24,343,604	\$6,633	21.8%	5.5%
Elderly	1.3%	171	0.6%	\$986,840	\$5,771	2.2%	0.5%
Location (DHSS Region)							
Anchorage/Mat-Su	52.6%	6956	59.8%	\$82,719,879	\$11,892	10.2%	12.5%
SouthCentral	13.7%	1814	16.6%	\$22,997,623	\$12,678	9.9%	11.7%
Northern	10.3%	1368	12.2%	\$16,835,095	\$12,306	8.0%	12.5%
Western	7.3%	961	6.0%	\$8,306,838	\$8,644	4.6%	5.9%
SouthEast	15.0%	1980	16.6%	\$22,906,051	\$11,569	15.4%	15.8%
Out of State or Unknown	1.1%	144	0.2%	\$334,282	\$2,321	7.7%	4.1%

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

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2011 (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, 2011. If they obtained dental services again in December 2010, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before June 30, 2011.

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.

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 FY2013 Operating Budget Requests

Division of Behavioral Health

Budget Overview Table

Division of Behavioral Health	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$71,569.7	\$74,643.0	\$3,073.3
Designated General Funds	19,566.8	19,593.6	26.8
Federal Funds	10,936.5	10,985.8	49.3
Other Funds	33,488.9	33,713.2	224.3
Total	\$135,561.9	\$138,935.6	\$3,373.7

Budget Requests

Alcohol Safety Action Program (ASAP)

Restore Probation Officer for Anchorage Municipal Wellness Court with Fund Switch: \$85.0 I/A, (\$85.0 CIP)

In a FY2012 legislative add-on, a PFT Adult Probation Officer II and 79.9 budgeted I/A was added to the ASAP component for the Anchorage Wellness Court as a one-time increment. It is the intent of the Alaska Court System to continue this function so this increment restores the position and I/A funding at current costs.

Behavioral Health Grants

MH Trust: AK MH Bd- Trauma Informed Care: \$400.0 GF/MH

This recommendation ensures access to trauma-informed behavioral health services for victims of domestic violence, sexual assault, and other forms of interpersonal violence. It builds upon DBH efforts in the previous two fiscal years to train behavioral health providers in trauma-informed care practices by supporting direct services for adult victims of violence.

For a victim of domestic violence experiencing a generalized mental health issue or moderate alcohol dependence, treatment services are out of reach unless the person has private insurance. Rather than wait until that person's condition worsens to become one of the Medicaid priorities for treatment services, this increment will increase access to treatment and early intervention services to address the behavioral health issue before it become a serious, incapacitating (and expensive) disorder.

MH Trust: Housing - Grant 1337.05 Assisted Living Home Training and Targeted Capacity for Development: \$100.0 GF/MH and \$100.0 MHTAAR

The Assisted Living Home training project improves the quality of training available for assisted living home providers which increases the capacity of these providers to house individuals with intensive behavioral health needs. 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, the Alaska Mental Health Trust Authority provides funds for 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.

MH Trust: Dis Justice - Grant 2819.03 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome): \$100.0 MHTAAR

FY2013 funds will be used to support the Division of Behavioral Health staff in pre-development and 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 and facilities within the community; and (3) developing an implementation plan for the needed identified treatment services. This project was started with MHTAAR funding in FY2010. This FY2013 MHTAAR increment maintains the FY2012 funding level and momentum of effort.

MH Trust: Cont - Grant 3736.01 Behavioral Health Follow-up Survey: \$75.0 MHTAAR

This increment will be used to complete a behavioral health survey of client recovery levels at one year after treatment that was initiated in FY2012. DBH will 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 costs savings related to more efficient efforts. If survey information is found to be helpful, it is the intent to repeat this survey every four-to-five years.

AMHB/ABADA: Substance Abuse Treatment for Unresourced Individuals: \$450.0 GF/MH

The current substance abuse treatment system cannot meet the present demand for services. The current reported wait for substance abuse assessment in Fairbanks is two-to-three weeks, and several weeks longer for a residential treatment bed. The same is true for residential programs in the Southeast that employ a cohort model (rather than rolling admission). This experience is also reported by rural behavioral health aides and village based counselors – long waits and costs of service discourage clients from going to detox or residential treatment. Given the limited detox capacity in Fairbanks and Anchorage, beds in those facilities go first to clients with the most immediate needs; this often results in long waits for those needing medically-monitored withdrawal.

This increment makes grant funds available to expand capacity to provide medical detox, residential, and/or intensive outpatient substance abuse treatment – followed by aftercare – to unresourced adults. It addresses the fact that demand for residential treatment, intensive outpatient, and aftercare continues to exceed the substance abuse treatment system's capacity. It is also designed to reinforce the existing treatment capacity in the face of a potential increase in demand for services. If the 141,000 uninsured Alaskans living at or below 250% of the federal poverty index become eligible for publicly-funded health insurance after 2014, (based on 2006

prevalence estimates) at least 2,800 of these adults can be expected to experience a substance use disorder requiring treatment.

Trauma Informed Training – Year Three: \$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. This project is funded by Reimbursable Service Agreement with the Office of the Governor.

DVSA: Telehealth Strategic Capacity Expansion: \$100.0 GF

The entire state of Alaska is a Workforce Shortage Area for Behavioral Health Professionals. There are a limited number of psychiatrists in Alaska. Most of our communities have no psychiatric coverage and have shortages of behavioral health clinicians and direct service workers resulting in inadequate access to behavioral health services. Lack of availability results in costly travel to access care, and the care is often at higher, more costly levels than necessary. One of the strategies we have used in the private, tribal and public sectors is implementation of tele-health solutions. However, the current tele-health solutions focus on agency to hub area connectivity using high end equipment and expensive T-1 line connectivity. With advances in technology, recent solutions include a personal computer-based application of tele-health in a home-based model that is less expensive and has more comprehensive application.

This increment requests funding to: (1) assess readiness of the DBH provider network to pilot such a demonstration project; (2) review potential vendors and telecommunications carriers to work collaboratively with the Division for a custom application; (3) identify specific hub areas for linkage to appropriate services for home-based treatment.

Behavioral Health Administration

MH Trust Continuing – Sustaining Alaska 2-1-1: \$25.0 GF/MH

Alaska 2-1-1 is an information and referral system for health and human services resources throughout Alaska. The call center is staffed weekdays from 8:30am - 5pm for callers to receive personalized attention and a website available to all 24/7.

MH Trust Workforce Dev – Committee on Workforce Competency-Curriculum Development: \$50.0 GF/MH

Direct care health and social service workers are often the primary caregivers for Trust beneficiary groups. However, these workers typically have little formal training and receive minimal support while on the job. Strengthening their skills is a priority among the Trust's workforce activities, leading to the development and release of the Alaskan Core Competencies (FY2009), tools to assess worker competency (FY2010), and curriculum development (FY2011 and FY2012).

In FY2013, the project will employ a strategy similar to the Institute for Healthcare Improvement (IHI) quality improvement collaborative model. This model tests changes in real work settings to determine if the change is an improvement. The project consultants, with guidance from the Committee on Workforce Competency (CWC), will identify and work in partnership with five organizations, one from each of the Trust's beneficiary groups (i.e., service sectors) on

implementing the competencies and assessment. A one and a half day technical assistance meeting between project consultants and all five sites will be conducted at one point during the fiscal year, with follow-up consultation provided via phone.

At the conclusion of the year, a broad dissemination of the findings and tools from this process will be accomplished using electronic means and through the varied activities of the Trust Training Cooperative. Each of the five agencies in the improvement collaborative would, as a requirement of participation, agree to present their work at a minimum of two professional meetings in Alaska where agencies serving similar Beneficiary Groups will be present. The proposed level of funding covers the cost of the consultants from WICHE and the Annapolis Coalition, meeting materials, and teleconference costs. The estimate is exclusive of travel and lodging costs for the five participating agencies.

MH Trust: BTKH - Grant 2465.03 Tribal/Rural System Development: \$100.0 MHTAAR

This increment will assist in expanding SED children's services in rural areas. Alaska Native youth are over-represented in behavioral health services, including in out-of-state services. This funding will develop services; 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 (Ch 10, SLA 2007) (Medicaid Reform report). Funding may support technical assistance and training from state staff or from contractors and/or adding additional staff functions to DHSS tribal programs. Projects may include developing Medicaid clinical, billing and supervision capacity; technical assistance to link programmatic and finance sections into an effective service delivery/billing revenue generation; implementing telemedicine, Skype or other distance delivery technology; grant writing; blending funding streams or other projects.

MH Trust: Housing - Grant 383.08 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 FY2001.

Community Action Prevention and Intervention Grants

DVSA: Multidisciplinary Rural Community Pilot Project - Year Three: \$1,400 I/A

In an effort to reduce domestic violence, sexual assault, and substance abuse in rural Alaska, these funds will be used 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. This project is funded through a Reimbursable Service Agreement with the Office of the Governor.

DVSA: Family Wellness Warriors Initiative - Year Three: \$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 empower organizations and individuals to effectively address the spiritual, emotional, mental and physical effects of domestic violence, abuse, and neglect. This project is funded through a Reimbursable Service Agreement with the Office of the Governor.

Services to the Seriously Mentally Ill

MH Trust: Housing - Grant 575.07 Bridge Home Program & Expansion: \$750.0

MHTAAR and \$300.0 GF/MH

This project replicates successful transition programs in other states for individuals 'cycling' through emergency and institutional settings. 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. This request allows for expansion of the program in other critical parts of the state outside of Anchorage and assists in increasing the intensity of services for people with more complex service delivery needs.

MH Trust: Housing - Grant 604.07 Department of Corrections Discharge Incentive

Grants: \$200.0 MHTAAR and \$50.0 GF/MH

This project is a joint strategy in the Trust's Affordable Housing Initiative and the Disability Justice workgroups. 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 and support services to prevent repeat incarceration and becoming a 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 be targeted to increase the skill level and capacity for assisted living providers to successfully house this population.

Services for Severely Emotionally Disturbed Youth

MH Trust: BTKH - Grant 2466.03 Transitional Aged Youth: \$200.0 MHTAAR and \$250.0 GF/MH

This increment will provide funding to start-up and sustain the Transition to Independence Process (TIP). TIP is an evidence-supported process to assist transitional aged youth to move into adulthood with age-appropriate services ensuring productive work or educational activities. TIP targets youth with severe behavioral health problems who are vulnerable to poor outcomes such as involvement with adult justice, emergency mental health or substance abuse, early pregnancy or hospital-based services. Youth with behavioral health problems often have few

skills and little social or family support to help them succeed. TIP engages youth, provides support to access existing service systems and helps youth to bridge the transition from child services to adulthood.

MH Trust: BTKH -Grant 1392.05 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training: \$450.0 MHTAAR

This increment will provide funding to continue a Bring the Kids Home project that uses grants to enhance and expand outpatient services with innovative programs/training to reduce the need for residential level services for youth experiencing serious emotional disturbance (SED). This increment will be used to address gaps in community-based services and to support start-up of evidence-based and best practices. This increase in outpatient care assists in dealing with youth at the home and community-based level and avoids utilizing costly residential care.

MH Trust: BTKH - Grant 1390.05 Expansion of School-Based Services Capacity via Grants: \$125.0 MHTAAR

This increment will provide funding to continue a Bring the Kids Home project to expand school-based services treatment capacity through grants and contracts. The project provides educational tracking for youth returning from Residential Psychiatric Treatment Centers (RPTCs) to ensure their educational success upon return. It also has funded development of training and implementation pilot projects for an evidence-based practice, Positive Behavioral Intervention and Supports (PBIS). PBIS develops support and connection between schools and behavioral health providers to better serve youth experiencing serious emotional disturbance. PBIS also establishes a school-wide culture which research shows reduces behavioral problems and improves learning across the school setting.

MH Trust: BTKH - Grant 3051.02 Peer Navigator Program: \$100.0 MHTAAR and \$100.0 GF/MH

This increment will fund grants to expand Parent and Youth Navigation services to additional communities in Alaska. Peer Navigation allows trained parents and young adults to be hired to assist their peers in navigating the service delivery system, learning parenting skills and practicing self-help strategies. The priority population is youth with severe emotional disturbances and their families, however, services are also available to youth and families who are at-risk due to other issues such as child protection or juvenile justice. Grant funding also supports involvement of family members and youth in planning and policymaking. Parent/peer navigation and parent/youth input 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.

MH Trust: AK MH Bd- Early Childhood Screening & Brief Behavioral Services: \$400.0 GF/MH

This increment will fund “Brief Behavioral Services” for young children and their families in primary care offices and community mental health centers. These services will be effective interventions for children and families experiencing the consequences of domestic violence. By encouraging providers to perform early and regular screenings for developmental and social-emotional delays/disabilities, we can ensure that Alaskan children who have witnessed or suffered domestic violence receive the services they need to grow up healthy.

The increment would fund outreach, training, and technical assistance to encourage more providers to administer Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings, to use a standardized screening tool, to inform them about services available and to provide information necessary for meaningful referral to services. This increment would also fund education and outreach to parents about the EPSDT program and the services available to them – while also stressing how important it is that children not only be kept safe from harm, but also to be able to receive services early to address the harm that results from living in a violent household.

MH Trust: BTKH - BTKH In-Home Intensive Support: \$200.0 MHTAAR

This increment will provide funding for grants to implement a new service model which will divert children with severe emotional disturbances and complex behaviors from residential psychiatric treatment centers (RPTC) through intensive in-home supports and crisis management.

FY2011 Bring the Kids Home (BTKH) data shows that an increasing percentage of children placed in out-of-state RPTC have complex behaviors due to co-occurring conditions, and that most have experienced profound trauma. These issues result in an array of difficult behaviors such as aggression, suicidality, and risk taking, which in-state providers are challenged to respond to. Continued BTKH progress at reducing out-of-state RPTC placements requires effectively serving these youth in-state, however, the long-term nature of co-occurring issues such as fetal alcohol spectrum disorders, autism and developmental disabilities requires a new model of developing intensive behavioral health services in a community setting. This increment will support start-up of this model.

MH Trust: BTKH - Grant 2463.03 Evidence Based Family Therapy Models: \$330.0 MHTAAR and \$170.0 GF/MH

This increment will provide funding for contracts to implement evidence-based family treatment models in Alaska. For FY2013, funds will support a contract with Dr. Scott Sells to implement Parenting with Love and Limits (PLL) for children with severe emotional disturbances and their families. MHTAAR/MH funds will support expansion to new communities and GF/MH funds will be required to sustain training, supervision, quality assurance and system development over time. Additional family therapy models may be selected for future years, based on system gaps and needs. This enhancement of outpatient behavioral health services is required to ensure that severely disturbed children are able to remain in their homes and communities.

Alaska Psychiatric Institute (API)

MH Trust Cont - Grant 2467.03 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. This increment will support use of tele-health equipment for a psychiatrist from API to provide weekly consultation to three demonstration projects in urban and rural Alaska.

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

MH Trust: Cont - Grant 605.07 ABADA/AMHB Joint Staffing: \$435.0 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.

MH Trust: BTKH - Strong Family Voice: Parent and Youth Involved via AMHB: \$50.0 MHTAAR

This increment will provide funding to continue the Alaska Mental Health Board (AMHB) Family Voice project long-term. The AMHB allocates staff time for planning and Family Voice funding pays for costs associated with bringing family and youth to events and activities. Family Voice funds for costs associated with providing orientation and training to youth and family members to participate effectively in policy meetings, bringing parents and youth, including rural families, to the Bring the Kids Home (BTKH) quarterly meetings, and to other advocacy and policy-setting meetings, and gathering feedback and information from stakeholders. Family and youth are key partners in BTKH planning. In order to sustain long-term system change, it is important to maintain stakeholder feedback by allocating long-term funding for Family Voice.

Suicide Prevention Council

MH Trust: ABADA/AMHB School Based Suicide Prevention: \$450.0 GF/MH

With adolescents and young adults being the age group with the highest rate of suicide, school-based prevention efforts have the greatest likelihood of impact. By providing funding for grants to school districts to implement evidence and research based training and intervention models tailored to the unique needs of their student and teacher populations, such as Signs of Suicide (effectively implemented in MatSu schools) and youth peer leadership/mentoring (implemented successfully in the Northwest Arctic Borough schools), we can reach youth when they are the most vulnerable. To ensure successful outcomes, additional training for secondary school teachers and staff is critical. This increment would also fund statewide on-demand training (Kognito At-Risk, an evidence-based and rigorously evaluated best practice) for all high school educators and staff.

Challenges

- **Alaska Psychiatric Institute (API) Transition to an Acute Care Model**

Over the past year and half, Alaska Psychiatric Institute - Alaska Recovery Center (API) has transitioned to an acute care psychiatric inpatient treatment center. This brings the hospital into alignment with the initial Certificate of Need to establish short-term psychiatric inpatient hospitalization for mentally ill adults and seriously/emotionally disturbed youth. It also achieves the following:

- Alignment with healthcare reform to limit long and unnecessary hospitalizations
- Alignment with the state's vision of home and community based treatment services
- Greater access to available psychiatric inpatient acute care beds

API treats the most acute phase of a psychiatric illness when hospitalization is medically necessary. The treatment focus is on the resolution of acute symptoms which interfere with daily functioning and the precipitating psychosocial stressors that preceded the need for hospitalization. As the individual has optimized treatment, proactive discharge planning assures the return to community living and treatment.

The hospital is staffed seven days a week to provide acute care. Active treatment with admissions and discharges occurring on a daily basis presents numerous challenges for the leadership team at the hospital, as well as to the community behavioral health system. The workforce shortage of qualified psychiatrists in the state and at API, requires the hospital to contract with Locum Tenens agencies at a cost **twice as much as** a state employed physician. This creates budgetary as well as continuity of care issues. Another challenge is the role of API with the greater Anchorage metropolitan area including the Palmer-Wasilla region. As the only hospital with psychiatric acute care inpatient capacity serving a metropolitan area greater than 425,000 people, demand for bed utilization sometimes exceeds capacity. The system is challenged to create additional capacity in the private sector. Finally, working collaboratively with behavioral health's Emergency Services Steering Committee, it will be critical to revitalize crisis services and emergency services around the state and integrate substance abuse into the system.

- **Broadening the Vision of Prevention**

Nationwide, as well as locally, there is a movement to broaden the vision of prevention to include promotion of mental health, physical health and wellness; in addition to the traditional prevention strategies, recognizing the need to act earlier and to incorporate all aspects of health into our state and community health planning. Within the Division of Behavioral Health, we oversee a continuum of care that includes prevention of substance abuse, early intervention services for those at risk for substance use or mental health concerns, treatment of both substance use disorders and mental health disorders, and recovery and maintenance following specific treatment services. The piece that has been missing is promotion of good mental health, physical health and overall individual, family and community wellness that can stop the need for future interventions along the continuum of care. In addition, mental health has never been part of the "prevention" services and we are now recognizing there are many strategies and interventions that can be employed to delay onset and reduce severity of many mental health conditions. The Division of Behavioral Health is committed to expanding our vision of prevention. The climate is right for change, as the value of prevention, across disciplines, is gaining momentum. There is

now a clear recognition that the social and health problems we are working to minimize are all interconnected, and our efforts across the continuum of care must start earlier, be broader in our reach, and be coordinated across disciplines and service types.

- **Affordable Housing**

There is a deepening crisis in Anchorage and statewide due to the freeze in subsidized housing vouchers through AHFC. This is a hardship for hundreds of individuals with serious mental illness. It can potentially cause destabilization, a risk of movement to higher levels of care, preventing transitions to independence from Assisted Living Homes, and an inability to transition out of homelessness.

- **Grant Streamlining**

The treatment and recovery section for DBH currently has multiple grant programs to fund behavioral health treatment for SMI adults, SED children and SUD adults and adolescents. The reasons for this relate to service expansion that has occurred through new funding coming into the system to promote change: BTKH initiative, disability justice initiatives, housing initiatives, and peer services to name a few. In order to track these services as they were implemented, we kept them separate. Now we have an overwhelming burden of small grant programs that are hard for us to manage and create additional administrative burden for our grantees.

We will be developing a new model to align all adult services and all children/youth services into two distinct programs that will encompass all behavioral health (integrated MH and SA) treatment services with responsibilities for emergency crisis support for people within Community Service Planning Areas. This will provide the opportunity to blend all of the outlier grant programs into a cohesive system. The additional intent of streamlining is to integrate Medicaid and grant oversight to be better able to verify that the expansion of services we anticipate in 2014 will be targeted effectively to those individuals who are joining the system. We anticipate additional coordination with our BH treatment providers and their primary care providers to partner in development of medical home models for our BH clientele.

- **Service Capacity**

Insuring access to appropriate services and determining sufficient treatment capacity is a complex responsibility. While we anticipate an increase in need for services due to the expansion of Medicaid, we also anticipate decreased federal financial support. These changes highlight the need for program management strategies necessary to control the system. Projects addressing these multifaceted issues include: establishment of a methodology to determine the capacity of the behavioral health system; identification of system gaps and recommendations for improvement including a review of payment systems to insure a reasonable reimbursement for quality services; changes in infrastructure, coverage, workforce, and information exchanges; development of continuous improvements to the performance management system that optimize data collection, reporting, and analysis that informs and modifies program and clinical practice for improved outcome measurement.

- **Regulations – Ongoing Improvement**

In support of on-going program improvement, Behavioral Health has identified several areas where regulation changes are required or should be considered. These include: revise Medicaid RPTC coverage regulations to ensure standardization in licensure and national accreditation requirements for out-of-state facilities; revise regulations covering methadone programs to align with current national coverage standards; adopt a standardized level of care instrument to support continuum of behavioral health services; define standards outlining mandatory critical incident reporting requirements; add specialized early childhood Medicaid services; revise authorization criteria for admission to psychiatric hospital and RPTC services; define coverage for behavioral health aides; consider revision services included in the daily rate for RPTC services; revise Medicaid service coverage for psychologists; expand disenrollment and sanction authorities; and consider reimbursement for prevention.

- The national landscape includes emerging issues that will have significant implications and challenges for the Division of Behavioral Health. These include:
 - **The Affordable Care Act** will have major impact on the current behavioral health system of care. For example, by 2014, Alaska's Medicaid eligibility criterion will expand to include all citizens, including children, who fall under 133% of the federal poverty rate. Additionally, foster care children will be covered up to age 26. This will result in a significant increase in enrollment. Previously uninsured citizens will obtain access to care through insurance reform and coverage expansion. Demand for behavioral health services is estimated to increase by as much as 30%. This has significant implications for the manner of access to services, service delivery, workforce development, and challenges to the management and oversight of multiple service systems. This expansion of coverage and the anticipated increased demand in access to services will challenge and strain the current behavioral health treatment system.
 - **HITECH Act:** The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is rapidly reshaping the arena of electronic health records (EHR) requiring an interoperable health IT network. At the core of interoperability is the requirement for EHR applications to meet certification standards of "meaningful use." The arena of behavioral health was excluded from federal legislation that would have assisted in accessing financial resources to support the expense of achieving meaningful use certification. The Division functions as a vendor of an EHR application, i.e. the AKAIMS system, and must absorb this additional programming expense, and obligations for long term future maintenance costs, as well. Behavioral health treatment service providers will be challenged to reevaluate current clinical and business practices to align with EHR applications.
 - **ICD & 5010:** Most world healthcare systems follow the World Health Organization (WHO) International Classification of Diseases (ICD). This coding scheme is used to classify morbidity and mortality data for vital statistics tracking and for health insurance claim reimbursement. The Federal government mandates the move from the ICD-9 system to an expanded ICD-10 version to be implemented by October 1, 2013. In addition, the government has also mandated an upgrade of the nine HIPAA transaction formats for electronic data transmission from the initial 4010 version to version 5010. The deadline for this implementation is January 1, 2012 to accommodate the expanded ICD-10 codes. In order to develop an effective consecutive implementation for these two major changes will require strategic planning to include training, interaction with vendor systems, changes to internal legacy systems, benefit and provider contractual changes, and testing to ensure a transparent changeover.

- **Integrating Behavioral Health and Primary Care Services**

Over the past twenty-five years many studies have found correlations between physical and behavioral health-related problems. Individuals with serious physical health problems often have co-morbid mental health and substance abuse problems. While patients typically present with a physical health complaint, data suggest that underlying mental health or substance abuse issues often trigger these visits. These realities explain why increased integration of behavioral health and healthcare services is a priority amongst policymakers, planners, and providers of physical and behavioral health care across the United States. The challenges we face in Alaska include:

- Identification, facilitation and support of behavioral health providers and primary care providers that are willing to enter into partnerships to develop and operate a full continuum of healthcare services. The implications for system-wide duplication and competition for scarce resources are significant.
- Development of new ancillary resources such as healthcare homes to support the integrated services.
- Monitoring and oversight to assure that behavioral health services are not diminished or overshadowed as a result of integration.

Performance Measure Detail

End Result	Strategies to Achieve End Result
A: 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. <u>Target #1:</u> At least 75% of individuals who receive Behavioral Health community-based services will report "functioning well" for each of six life domains (Basic Needs, Housing, Activities/Employed, Mental Health, Physical Health, & Thoughts of Self Harm). <u>Status #1:</u> The target of at least 75% of individuals who receive Behavioral Health community-based services will report "functioning well" in life domains was met for four of six domains. In FY2008, FY2009, and FY2010, 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. <u>Target #2:</u> Maintain or increase successful treatment completion by individuals who receive substance abuse treatment services. <u>Status #2:</u> From FY2009 to FY2011, the percent of individuals who were disenrolled from substance abuse treatment services who successfully completed treatment has remained steady at approximately 50%.	A1: 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. <u>Target #1:</u> Reduce the number of children in out-of-state residential psychiatric treatment centers (RPTCs) by 10% each year. <u>Status #1:</u> Status: From FY2010 to FY2011, there was a 13% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care (from 221 in FY2010 to 192 in FY2011). A2: Improve and enhance the quality of life of Alaskans who experience serious behavioral health disorders by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided. <u>Target #1:</u> At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for mental health outpatient services will report a positive overall evaluation of services. <u>Status #1:</u> In FY2011, 78% of adults, 78% of parents/caregivers of youth, and 75% of adolescents who completed the Annual Behavioral Health Consumer Survey for mental health outpatient services reported a positive overall evaluation of services. <u>Target #2:</u> At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services will report a positive overall evaluation of services. <u>Status #2:</u> In FY2011, 78% of adults, 69% of parents/caregivers of youth, and 66% of adolescents who completed the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services reported a positive overall evaluation of services. A3: Improve and enhance the quality of life of Alaskans who experience serious behavioral health disorders by assuring them access to a comprehensive, integrated Behavioral Health

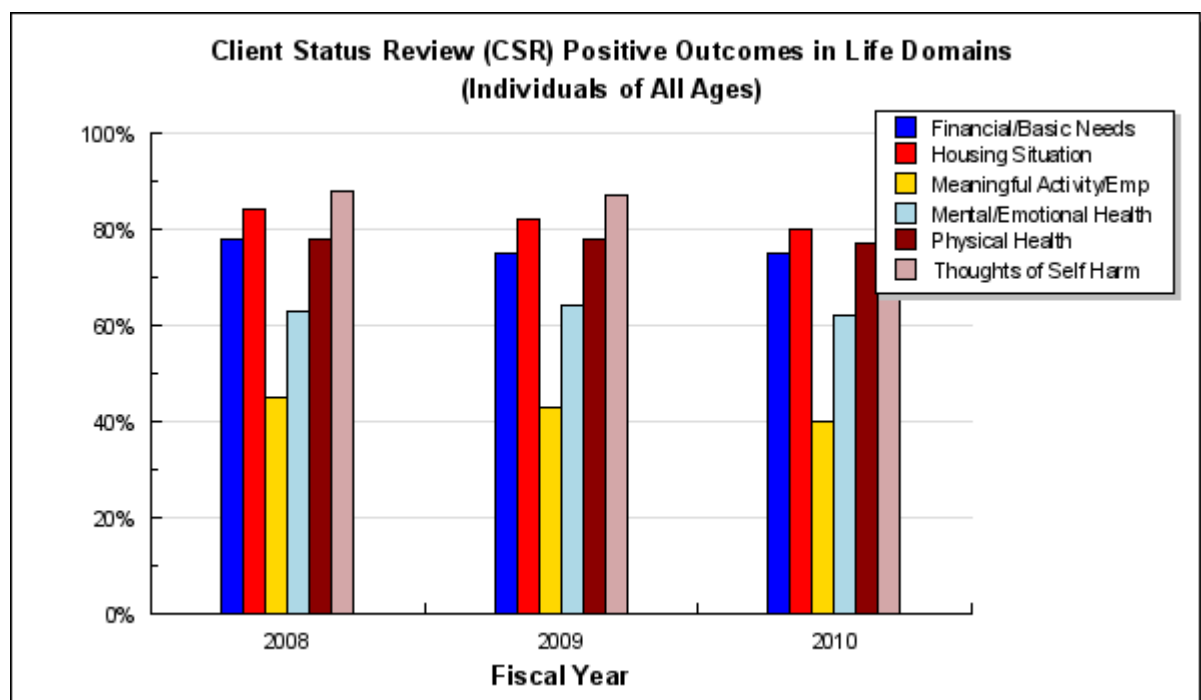
	Service System. <u>Target #1:</u> Increase the number of youth experiencing serious emotional disturbances (SED) and adults experiencing serious mental illness (SMI) who receive community-based mental health services. <u>Status #1:</u> From FY2010 to FY2011, the number of youth experiencing serious emotional disturbances (SED) who received community-based mental health services increased 6.9%, from 3,735 in FY2010 to 3,994 in FY2011. The number of adults experiencing serious mental illness (SMI) who received community-based mental health services increased 3.1%, from 7,532 in FY2010 to 7,767 in FY2011. <u>Target #2:</u> Increase the number of adults experiencing a substance use disorder who receive community-based substance abuse treatment services. <u>Status #2:</u> From FY2010 to FY2011, the number of adults experiencing a substance use disorder who received community-based substance abuse treatment services increased 1.4%, from 6,255 in FY2010 to 6,344 in FY2011.
End Result	Strategies to Achieve End Result
B: Alaskans live free from the negative impacts of alcohol and drug use. <u>Target #1:</u> Reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children. <u>Status #1:</u> The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. From 2002 to 2003, the prevalence of FASD decreased 23%, from 128.7 per 10,000 live births in 2002 to 99.1 per 10,000 live births in 2003. <u>Target #2:</u> Reduce the rate of alcohol-induced deaths. <u>Status #2:</u> The target to reduce the rate of alcohol-induced deaths was not met. From 2008 to 2009, the number of alcohol-induced deaths per 100,000 population remained relatively steady at 21.7 in 2008 and 21.9 in 2009. <u>Target #3:</u> Reduce the number of alcohol-related motor vehicle fatal crashes. <u>Status #3:</u> From 2009 to 2010, the number of alcohol-related motor vehicle fatal crashes decreased 22.7%, from 22 in 2009 to 17 in 2010.	B1: Prevent and reduce substance use and abuse. <u>Target #1:</u> Reduce the percent of women consuming alcohol during pregnancy. <u>Status #1:</u> From 2007 to 2008, the percent of women consuming alcohol during the last three months of pregnancy increased slightly from 5.1% to 6.1%. <u>Target #2:</u> Reduce the percent of male and female adults ages 21-64 who engage in binge drinking. <u>Status #2:</u> From 2009 to 2010, the percent of adult males ages 21-64 who engaged in binge drinking during the past 30 days increased from 26.6% to 30.5%; the percent of adult females ages 21-64 who engaged in binge drinking during the past 30 days remained steady at 13.5% both years. <u>Target #3:</u> Reduce the percent of male and female adults ages 21-64 who engage in heavy drinking. <u>Status #3:</u> From 2009 to 2010, the percent of adult males ages 21-64 who engaged in heavy drinking during the past 30 days increased slightly from 6.8% to 7.7%; the percent of adult females ages 21-64 who engaged in heavy drinking during the past 30 days decreased from 7.0% to 4.5%. <u>Target #4:</u> Reduce the percent of high school students who use alcohol. <u>Status #4:</u> From 2007 to 2009, the percent of high

	school students who used alcohol during the past 30 days decreased from 39.7% to 33.2%.
End Result	Strategies to Achieve End Result
C: The mental health of Alaskans is optimized. <u>Target #1:</u> Reduce the rate of suicide deaths to 10.6 deaths per 100,000 population. <u>Status #1:</u> The target to reduce the rate of suicide deaths to 10.6 deaths per 100,000 population was not met; however, from 2008 to 2009, the rate did decrease from 24 to 19.6 deaths per 100,000 population. <u>Target #2:</u> Reduce the percent of adults who experience poor mental health. <u>Status #2:</u> From 2009 to 2010, the percent of adults who experienced poor mental health during the past 30 days increased slightly from 7.4% to 8.6%. <u>Target #3:</u> Reduce the percent of teens who experience depression. <u>Status #3:</u> During 2003, 2007, and 2009, between 25% and 27% of high school students experienced depression during the past 12 months.	C1: Incorporate mental health promotion into the Division's Prevention and Treatment continuum of care.

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

Status #1: The target of at least 75% of individuals who receive Behavioral Health community-based services will report "functioning well" in life domains was met for four of six domains. In FY2008, FY2009, and FY2010, 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.



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.

FY2008 Data Source Date: December 2008

FY2009 Data Source Date: August 2009

FY2010 Data Source Date: August 2010

FY2011 Data Not Available (see note below)

Note: FY2011 was a major transition year in implementing modifications to the CSR outcomes instrument. These modifications were implemented in AKAIMS during the middle of FY2011, which resulted in a significant change of agency practice and impacted the availability of CSR data for FY2011 reporting.

Client Status Review (CSR) Positive Outcomes in Life Domains (Individuals of All Ages)

Fiscal Year	Financial/Basic Needs	Housing Situation	Meaningful Activity/Emp	Mental/Emotional Health	Physical Health	Thoughts of Self Harm
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: FY2008 was a baseline year for reporting Client Status Review (CSR) data from the Alaska Automated Information Management System (AKAIMS). During FY2008, some grantees struggled with data submission requirements and were not able to enter all client records into AKAIMS. Consequently, the FY2008 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 FY2008, FY2009, and FY2010, 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 FY2008 to FY2010, 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 FY2008 (78%) to FY2009 (75%); no change from FY2009 to FY2010 (75%).
- Housing Situation: Slight decrease from FY2008 (84%) to FY2009 (82%); continued slight decrease from FY2009 to FY2010 (80%).
- Meaningful Activities/Employment: Slight decrease from FY2008 (45%) to FY2009 (43%); continued slight decrease from FY2009 to FY2010 (40%).
- Mental/Emotional Health: Slight increase from FY2008 (63%) to FY2009 (64%); slight decrease from FY2009 to FY2010 (62%).
- Physical Health: No change from FY2008 (78%) to FY2009 (78%); slight decrease from FY2009 to FY2010 (77%).
- Thoughts of Self Harm: Slight decrease from FY2008 (88%) to FY2009 (87%); no change from FY2009 to FY2010 (87%).

Across all three years (FY2008, FY2009, and FY2010), 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 (FY2008, FY2009, and FY2010), 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 FY2008 to FY2010, the most significant changes in percent “functioning well” were for the following life domains:

- Meaningful Activities/Employment: decreased 5 percentage points (FY2008 = 45%; FY2010 = 40%).
- Housing Situation: decreased 4 percentage points (FY2008 = 84%; FY2010 = 80%).
- Financial/Basic Needs: decreased 3 percentage points (FY2008 = 78%; FY2010 = 75%).

From FY2009 to FY2010, the most significant change in percent “functioning well” was for the following life domain:

- Meaningful Activities/Employment: decreased 3 percentage points (FY2009 = 43%; FY2010 = 40%).

From FY2008 to FY2009, the most significant change in percent “functioning well” was for the following life domain:

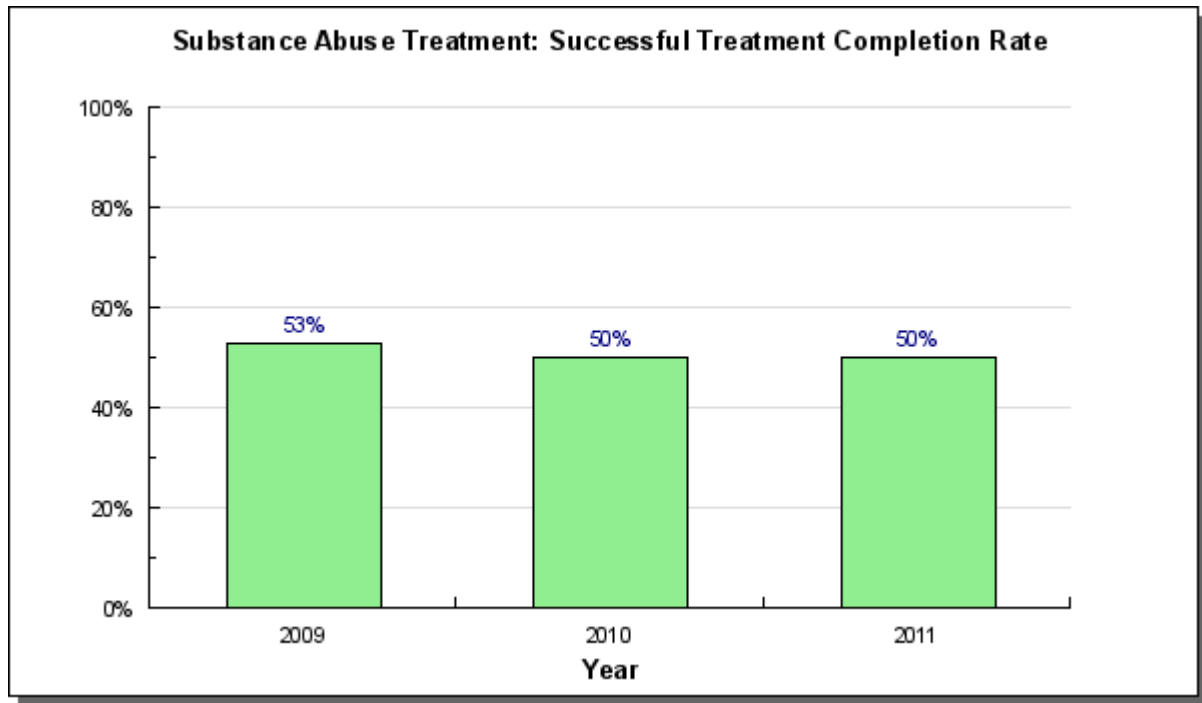
- Financial/Basic Needs: decreased 3 percentage points (FY2008 = 78%; FY2009 = 75%).

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: Maintain or increase successful treatment completion by individuals who receive substance abuse treatment services.

Status #2: From FY2009 to FY2011, the percent of individuals who were disenrolled from substance abuse treatment services who successfully completed treatment has remained steady at approximately 50%.



Methodology: Successful treatment completion rate is defined as the percent of individuals who were disenrolled from substance abuse treatment services (excluding detox services) whose reason for program disenrollment was "Successfully Completed Treatment" or "Referred to Another Program or Other Services with Satisfactory Progress" (these clients are assumed to have successfully completed the treatment services for the program in which they were enrolled).

Data source: Alaska Automated Information Management System (AKAIMS): "Agency Disenrollment by Modalities" report. Data Source Date: October 4, 2011. Completion rate reports are not available for providers who submit data via electronic data interchange (EDI).

Substance Abuse Treatment: Successful Treatment Completion Rate

Year	Completion Rate
2011	50%
2010	50%
2009	53%

Analysis of results and challenges: From FY2009 to FY2011, the percent of individuals who were disenrolled from substance abuse treatment services who successfully completed treatment has remained steady at approximately 50%.

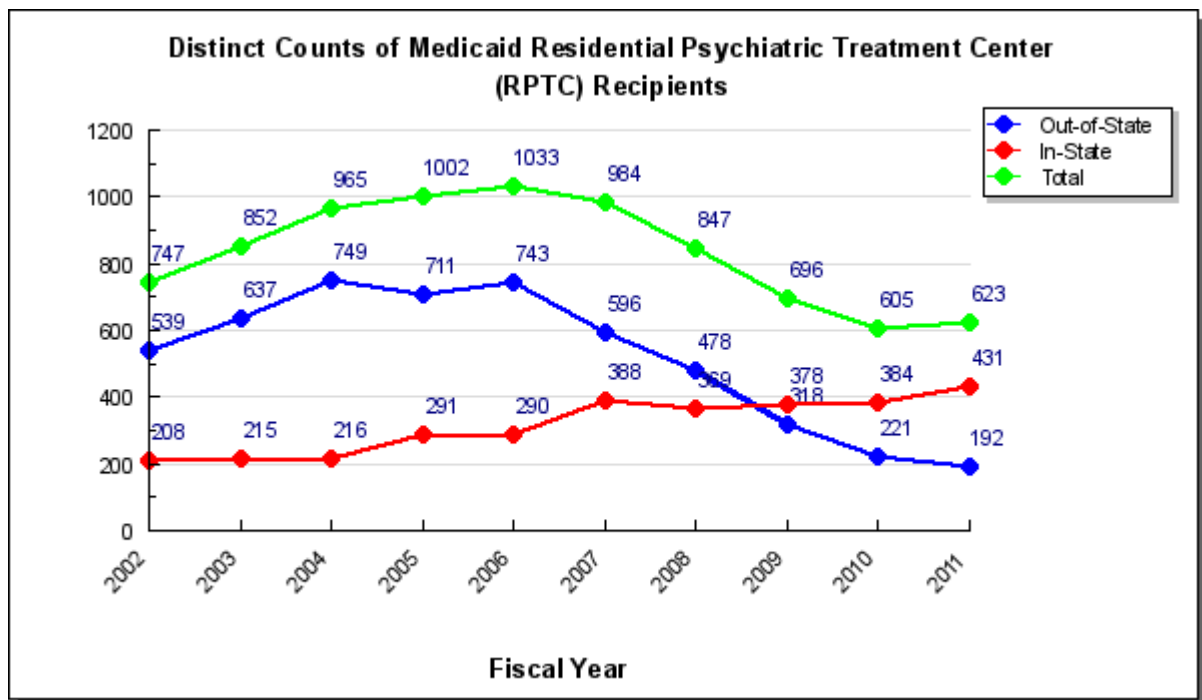
The Division plans to engage in general and targeted discussions with treatment providers to explore reasons why clients are or are not completing treatment. Through a collaborative effort with providers, the Division intends to develop strategies to improve treatment completion rates, promote best practices associated with successful treatment completion, and develop

partnerships to provide technical assistance and training for those agencies that demonstrate low treatment completion rates.

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: Status: From FY2010 to FY2011, there was a 13% decrease in the number of distinct out-of-state residential psychiatric treatment centers (RPTC) recipients of care (from 221 in FY2010 to 192 in FY2011).



Methodology: Residential psychiatric treatment center (RPTC) recipient counts are from the Bring the Kids Home Indicator Report; data source is the MMIS. RPTC recipient counts are unduplicated. Data is provided by the Division of Behavioral Health, Policy and Planning Section.

Data for FY2011 is preliminary.

Distinct Counts of Medicaid Residential Psychiatric Treatment Center (RPTC) Recipients

Fiscal Year	Out-of-State	In-State	Total
FY 2011	192	431	623
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 FY2004. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice, and Office of Children's Services, in partnership with the Alaska Mental Health Trust Authority. Positive changes are apparent as shown by the significant reduction, since FY2004, in the number of youth experiencing serious emotional disorders receiving care in out-of-state RPTCs.

From FY2004 to FY2011, there was a 74.4% decrease in the number of out-of-state RPTC recipients of care (749 in FY2004; 192 in FY2011) and a nearly 100% increase in the number of in-state RPTC recipients of care (216 in FY2004; 431 in FY2011). In addition, for the same time period, the total RPTC recipient count decreased by 35.4% (965 in FY2004; 623 in FY2011). The total RPTC recipient count peaked in FY2006. Since then, there has been a 39.7% decrease in the total RPTC recipient count (1,033 in FY2006; 623 in FY2011). These shifts reflect a number of capital projects initiated to increase the number of beds in-state, some of which became available in FY2007. 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 FY2006 to FY2011:

-- From FY2010 to FY2011 there was a:

- 13.1% decrease in the number of distinct out-of-state RPTC recipients of care.
- 12.2% increase in the number of distinct in-state RPTC recipients of care.
- 3.0% increase in the total RPTC recipient count.

-- From FY2009 to FY2010 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 FY2008 to FY2009 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 FY2007 to FY2008 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 FY2006 to FY2007 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.

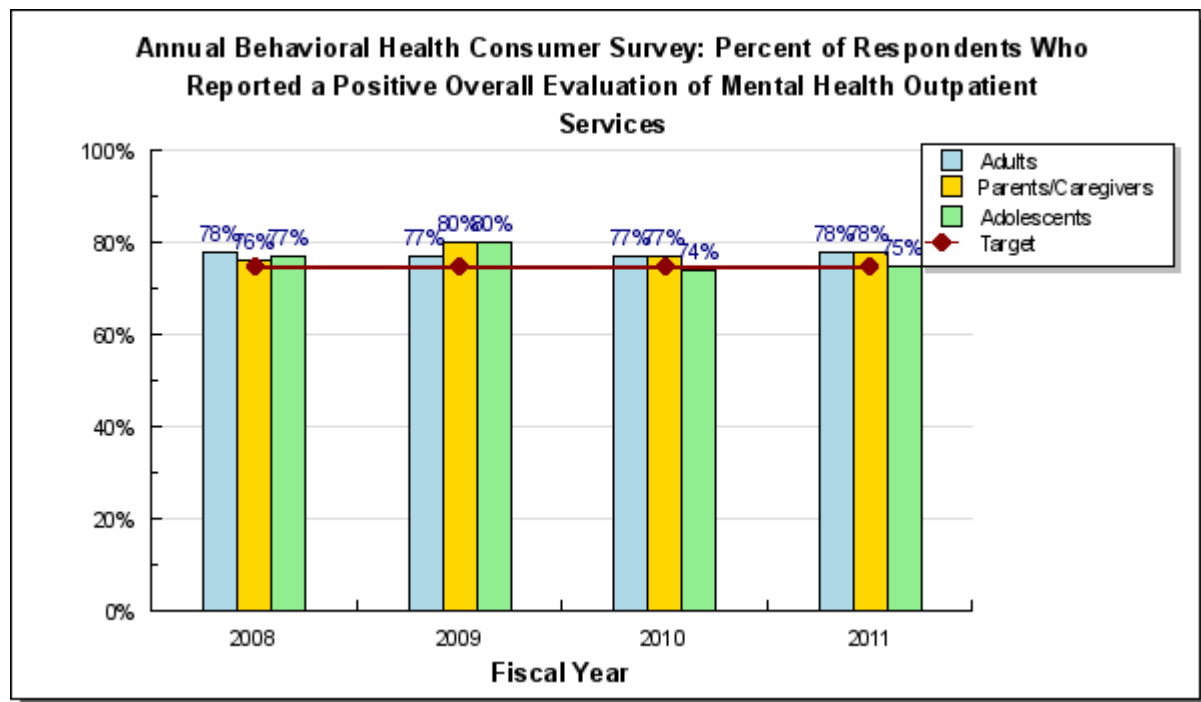
From FY1998 to FY2004, the number of distinct out-of-state RPTC recipients of care steadily increased – on average, 46.7% per year. Also, for the same time period, the total RPTC recipient count steadily increased - on average 24.8% per year.

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 who experience serious behavioral health disorders by implementing a Performance Management System that promotes process improvement and fosters partnerships to improve the quality of services provided.

Target #1: At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for mental health outpatient services will report a positive overall evaluation of services.

Status #1: In FY2011, 78% of adults, 78% of parents/caregivers of youth, and 75% of adolescents who completed the Annual Behavioral Health Consumer Survey for mental health outpatient services reported a positive overall evaluation of services.



Methodology: The Division utilizes 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 and recovery services; surveys are returned to the Division for processing. The results shown above reflect survey data for clients who received mental health services or services for co-occurring disorders.

Annual Behavioral Health Consumer Survey: Percent of Respondents Who Reported a Positive Overall Evaluation of Mental Health Outpatient Services

Fiscal Year	Adults	Parents/Caregivers	Adolescents	Target
FY 2011	78%	78%	75%	75%
FY 2010	77%	77%	74%	75%
FY 2009	77%	80%	80%	75%
FY 2008	78%	76%	77%	75%

Analysis of results and challenges: In FY2011, 78% of adults, 78% of parents/caregivers of youth, and 75% of adolescents who completed the Annual Behavioral Health Consumer Survey for mental health outpatient services reported a positive overall evaluation of services.

FY2008 was a new baseline year due to changes in the survey questions and survey methodology. From FY2008 to FY2011, generally, there were small changes from year to year in the percent of respondents who reported a positive overall evaluation of mental health outpatient services. Annual comparisons for each respondent group (i.e., adults, parents/caregivers of youth, and adolescents) are listed below:

-- Adults (the target of 75% was exceeded each year):

FY2010 to FY2011: Increase of 1 percentage point, from 77% to 78%

FY2009 to FY2010: No change (77% both years)

FY2008 to FY2009: Decrease of 1 percentage point, from 78% to 77%

-- Parents/Caregivers of Youth (the target of 75% was exceeded each year):

FY2010 to FY2011: Increase of 1 percentage point, from 77% to 78%

FY2009 to FY2010: Decrease of 3 percentage points, from 80% to 77%

FY2008 to FY2009: Increase of 4 percentage points, from 76% to 80%

-- Adolescents- Self Report (the target of 75% was met or exceeded each year except for FY2010):

FY2010 to FY2011: Increase of 1 percentage point, from 74% to 75%

FY2009 to FY2010: Decrease of 6 percentage points, from 80% to 74%

FY2008 to FY2009: Increase of 3 percentage points, from 77% to 80%

Within each year, the respondent group (i.e., adults, parents/caregivers of youth, or adolescents) with the highest and the lowest percent that reported a positive overall evaluation of mental health outpatient services is listed below:

-- FY2011

Highest % Positive Evaluation: Adults and Parents/Caregivers of Youth

Lowest % Positive Evaluation: Adolescents

-- FY2010

Highest % Positive Evaluation: Adults and Parents/Caregivers of Youth

Lowest % Positive Evaluation: Adolescents

-- FY2009

Highest % Positive Evaluation: Parents/Caregivers of Youth and Adolescents

Lowest % Positive Evaluation: Adults

-- FY2008

Highest % Positive Evaluation: Adults

Lowest % Positive Evaluation: Parents/Caregivers of Youth

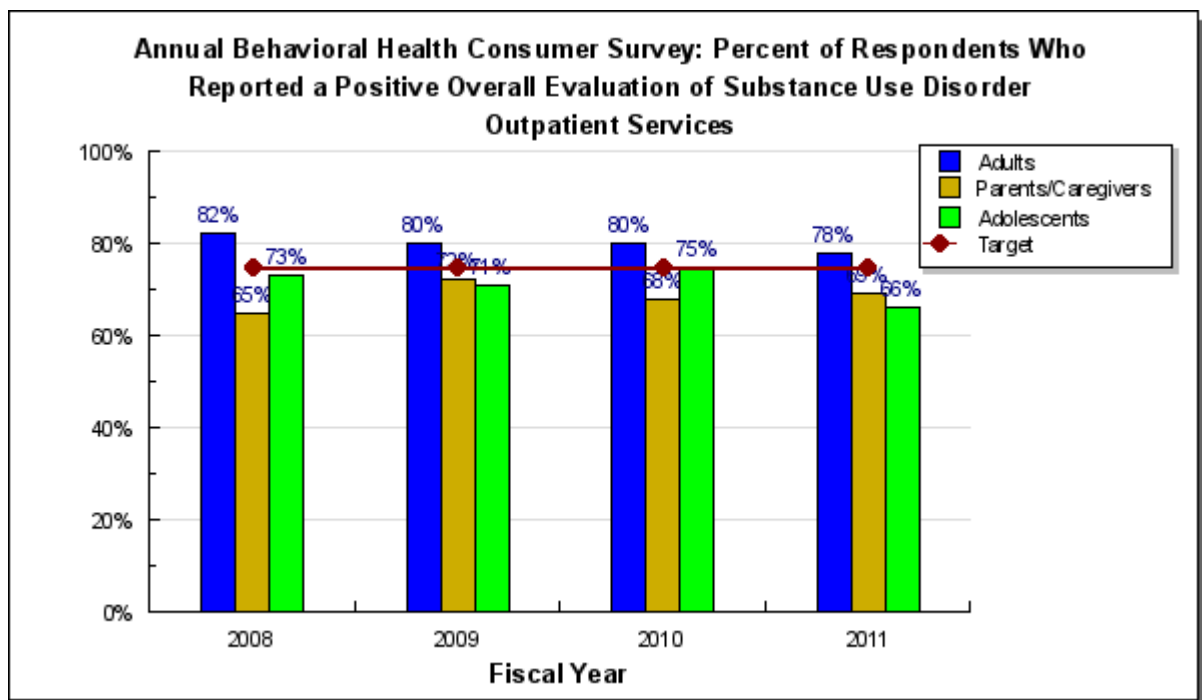
The Division's efforts to improve service delivery include Enhanced Technical Assistance to grantees. This assistance is available to grantees experiencing programmatic or administrative difficulties. The Division works with grantees to develop quality assurance mechanisms by which program adjustments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

The Division continues to make progress in implementing its Performance Management System. Performance measures of quantity, quality, and outcomes are utilized in the Performance Based Funding process for determining funding allocations to service providers. Participation in administering the BHCS is one of several performance measures used to determine funding allocations.

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

Target #2: At least 75% of individuals (including adults, parents/caregivers of youth, and adolescents) who complete the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services will report a positive overall evaluation of services.

Status #2: In FY2011, 78% of adults, 69% of parents/caregivers of youth, and 66% of adolescents who completed the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services reported a positive overall evaluation of services.



Methodology: The Division utilizes 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 and recovery services; surveys are returned to the Division for processing. The results shown above reflect survey data for clients who received substance use disorder services or services for co-occurring disorders.

Annual Behavioral Health Consumer Survey: Percent of Respondents Who Reported a Positive Overall Evaluation of Substance Use Disorder Outpatient Services

Fiscal Year	Adults	Parents/Caregivers	Adolescents
FY 2011	78%	69%	66%
FY 2010	80%	68%	75%
FY 2009	80%	72%	71%
FY 2008	82%	65%	73%

Analysis of results and challenges: In FY2011, 78% of adults, 69% of parents/caregivers of youth, and 66% of adolescents who completed the Annual Behavioral Health Consumer Survey for substance use disorder outpatient services reported a positive overall evaluation of services.

FY2008 was a new baseline year due to changes in the survey questions and survey methodology. From FY2008 to FY2011, generally, there were small changes from year to year in the percent of respondents who reported a positive overall evaluation of substance use disorder outpatient services. Annual comparisons for each respondent group (i.e., adults, parents/caregivers of youth, and adolescents) are listed below:

- Adults (the target of 75% was exceeded each year):
FY2010 to FY2011: Decrease of 2 percentage points, from 80% to 78%
FY2009 to FY2010: No change (80% both years)
FY2008 to FY2009: Decrease of 2 percentage points, from 82% to 80%
- Parents/Caregivers of Youth (the target of 75% was not met for any of the four years):
FY2010 to FY2011: Increase of 1 percentage point, from 68% to 69%
FY2009 to FY2010: Decrease of 4 percentage points, from 72% to 68%
FY2008 to FY2009: Increase of 7 percentage points, from 65% to 72%
- Adolescents - Self Report (the target of 75% was met only for FY2010):
FY2010 to FY2011: Decrease of 9 percentage points, from 75% to 66%
FY2009 to FY2010: Increase of 4 percentage points, from 71% to 75%
FY2008 to FY2009: Decrease of 2 percentage points, from 73% to 71%

Within each year, the respondent group (i.e., adults, parents/caregivers of youth, or adolescents) with the highest and the lowest percent that reported a positive overall evaluation of substance use disorder outpatient services is listed below:

- FY2011
Highest % Positive Evaluation: Adults
Lowest % Positive Evaluation: Adolescents
- FY2010
Highest % Positive Evaluation: Adults
Lowest % Positive Evaluation: Parents/Caregivers of Youth

-- FY2009

Highest % Positive Evaluation: Adults

Lowest % Positive Evaluation: Adolescents

-- FY2008

Highest % Positive Evaluation: Adults

Lowest % Positive Evaluation: Parents/Caregivers of Youth

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.

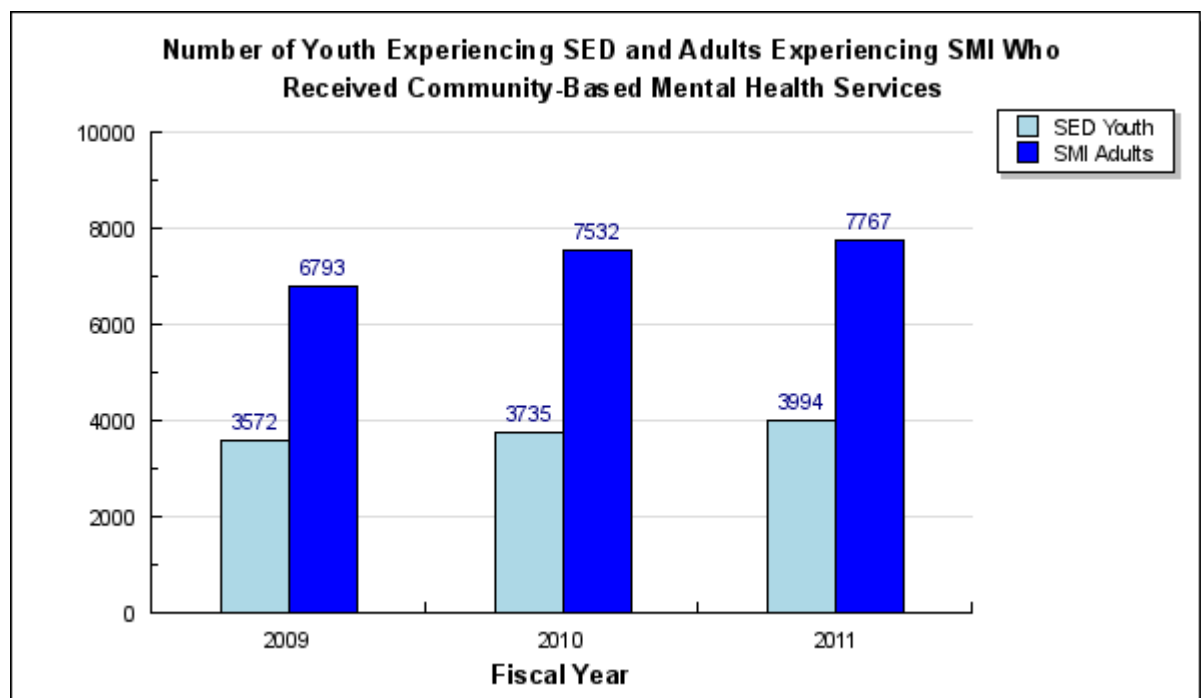
The Division continues to make progress in implementing its Performance Management System. Performance measures of quantity, quality, and outcomes are utilized in the Performance Based Funding process for determining funding allocations to service providers. Participation in administering the BHCS is one of several performance measures used to determine funding allocations.

The Division also 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 who experience serious behavioral health disorders by assuring them access to a comprehensive, integrated Behavioral Health Service System.

Target #1: Increase the number of youth experiencing serious emotional disturbances (SED) and adults experiencing serious mental illness (SMI) who receive community-based mental health services.

Status #1: From FY2010 to FY2011, the number of youth experiencing serious emotional disturbances (SED) who received community-based mental health services increased 6.9%, from 3,735 in FY2010 to 3,994 in FY2011. The number of adults experiencing serious mental illness (SMI) who received community-based mental health services increased 3.1%, from 7,532 in FY2010 to 7,767 in FY2011.



Methodology: Data reflects the Alaska Automated Information Management System (AKAIMS) DBH Uniform Reporting (UR) Client Profile Tables, FYTD unduplicated count of clients served. Counts include clients who received services for co-occurring disorders.

Data Source Date for FY2009, FY2010, and FY2011: October 5, 2011 (adjusted November 4, 2011)

Number of Youth Experiencing SED and Adults Experiencing SMI Who Received Community-Based Mental Health Services

Fiscal Year	SED Youth	SMI Adults
FY 2011	3994 +6.93%	7767 +3.12%
FY 2010	3735 +4.56%	7532 +10.88%
FY 2009	3572	6793

Analysis of results and challenges: 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 services is reflective of accessibility to the behavioral health service system.

FY2009 was a baseline year for using the Alaska Automated Information Management System (AKAIMS) to report the total number of individuals who received community-based behavioral health services. From FY2009 to FY2011, the number of youth experiencing SED and the number of adults experiencing SMI who received community-based mental health services has continued to increase. Annual comparisons are listed below.

-- Annual comparisons in the number of youth experiencing SED who received community-based mental health services:

FY2010 to FY2011: 6.9% increase (from 3,735 in FY2010 to 3,994 in FY2011).

FY2009 to FY2010: 4.6% increase (from 3,572 in FY2009 to 3,735 in FY2010).

-- Annual Comparisons in the number of adults experiencing SMI who received community-based mental health services:

FY2010 to FY2011: 3.1% increase (from 7,532 in FY2010 to 7,767 in FY2011).

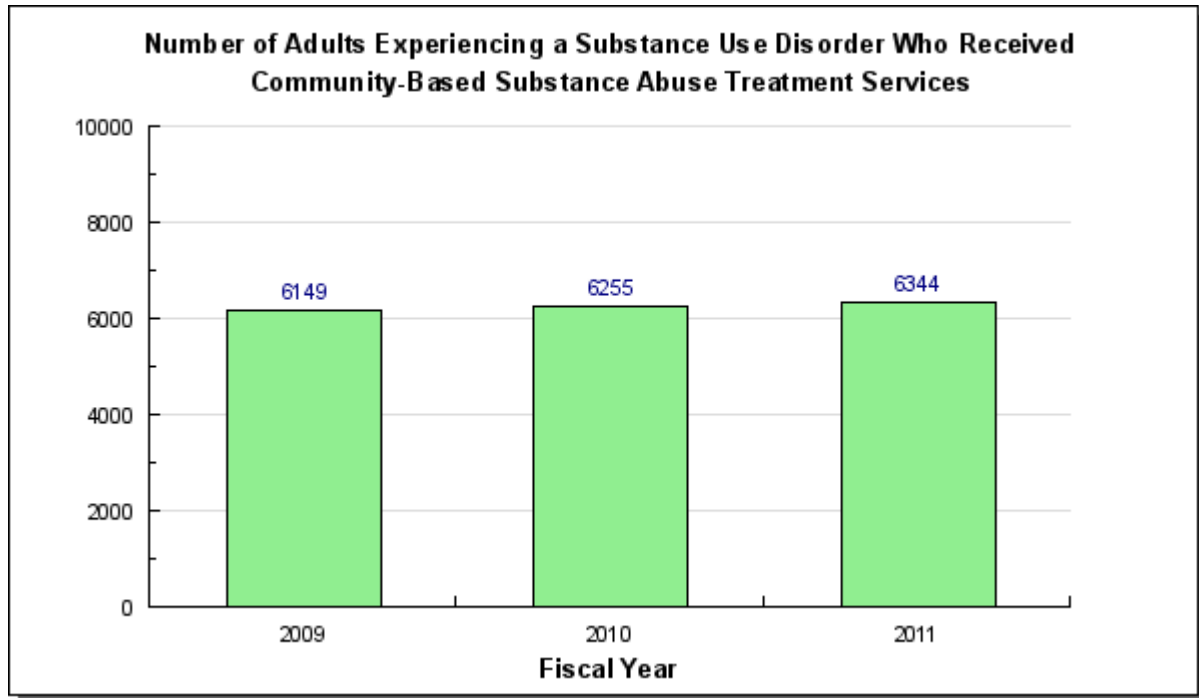
FY2009 to FY2010: 10.9% increase (from 6,793 in FY2009 to 7,532 in FY2010).

The continued increase in the number of youth experiencing SED who received community-based services reflects the ongoing efforts of the Bring/Keep The Kids Home (BTKH) Project. Alaska has had an over reliance on the use of long term residential treatment centers outside of the State to serve children experiencing 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 in-state service system that can meet the needs of Alaskan children.

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, the prevalence estimate for youth experiencing SED is 7,339; the estimate for adults experiencing SMI is 14,089 (prevalence estimates include the co-occurring prevalence). These prevalence estimates, which are considered to be conservative, provide a basis for identifying gaps and unmet needs in Alaska's low income population. For details, refer to the Division's "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household."

Target #2: Increase the number of adults experiencing a substance use disorder who receive community-based substance abuse treatment services.

Status #2: From FY2010 to FY2011, the number of adults experiencing a substance use disorder who received community-based substance abuse treatment services increased 1.4%, from 6,255 in FY2010 to 6,344 in FY2011.



Methodology: Data reflects the Alaska Automated Information Management System (AKAIMS) DBH Uniform Reporting (UR) Client Profile Tables, FYTD unduplicated count of clients served. Counts include clients who received services for co-occurring disorders.

Data Source Date for FY2009, FY2010, and FY2011: October 5, 2011

Number of Adults Experiencing a Substance Use Disorder Who Received Community-Based Substance Abuse Treatment Services

Fiscal Year	Number of Adults
FY 2011	6344 +1.42%
FY 2010	6255 +1.72%
FY 2009	6149

Analysis of results and challenges: 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 services is reflective of accessibility to the behavioral health service system.

FY2009 was a baseline year for using the Alaska Automated Information Management System (AKAIMS) to report the total number of individuals who received community-based behavioral health services. From FY2009 to FY2011, the number of adults experiencing a substance use

disorder who received community-based substance abuse treatment services has continued to increase. Annual comparisons are listed below.

Annual comparisons in the number of adults experiencing a substance use disorder who received community-based substance abuse treatment services:

FY2010 to FY2011: 1.4% increase (from 6,255 in FY2010 to 6,344 in FY2011).

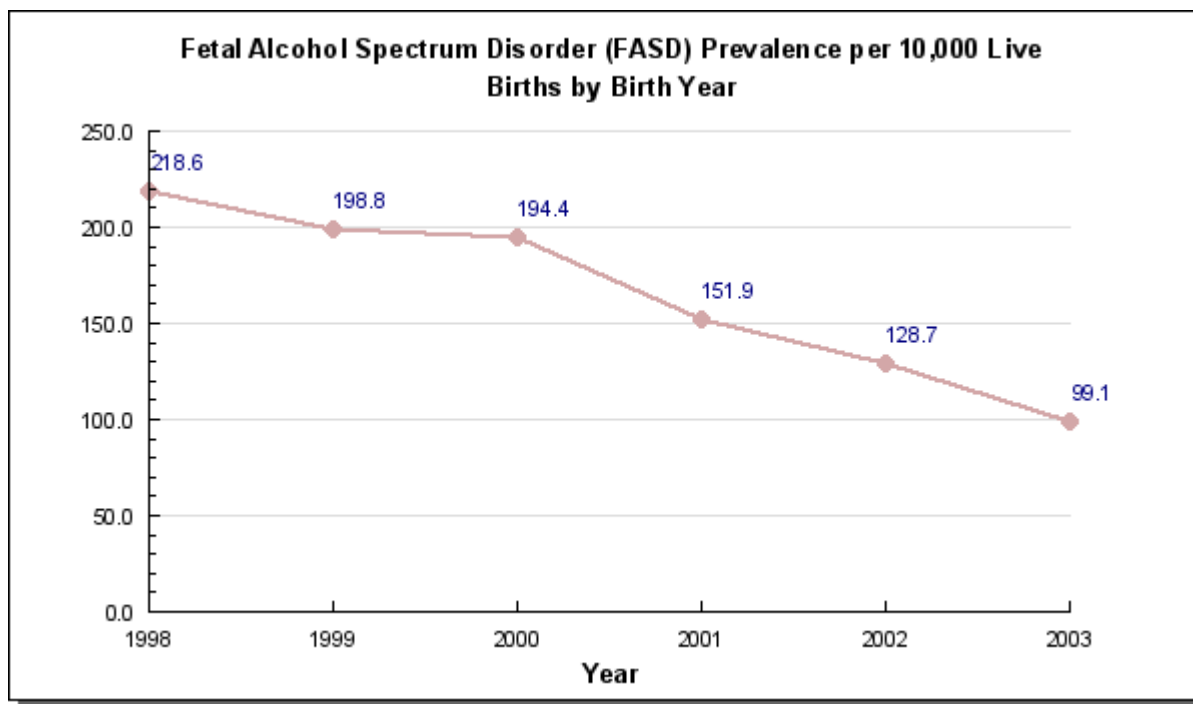
FY2009 to FY2010: 1.7% increase (from 6,149 in FY2009 to 6,255 in FY2010).

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, the prevalence estimate for adults experiencing a substance use disorder is 10,397 (prevalence estimate includes the co-occurring prevalence). This prevalence estimate, which is considered to be conservative, provides a basis for identifying gaps and unmet needs in Alaska's low income population. For details, refer to the Division's "2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders by Household."

B: Result - Alaskans live free from the negative impacts of alcohol and drug use.

Target #1: Reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children.

Status #1: The target to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) in Alaskan children was met. From 2002 to 2003, the prevalence of FASD decreased 23%, from 128.7 per 10,000 live births in 2002 to 99.1 per 10,000 live births in 2003.



Methodology: Fetal Alcohol Spectrum Disorder prevalence is the unduplicated number of children per 10,000 live births reported to the Alaska Birth Defects Registry with ICD9 code 760.71 (fetus or newborn affected by maternal alcohol use) by their 6th birthday and matched to an Alaska birth certificate.

DHSS, DPH, Section of Women's, Children's and Family Health, Alaska Birth Defects Registry. As of November 2011, the most current year for which data is available is 2003.

Fetal Alcohol Spectrum Disorder (FASD) Prevalence per 10,000 Live Births by Birth Year

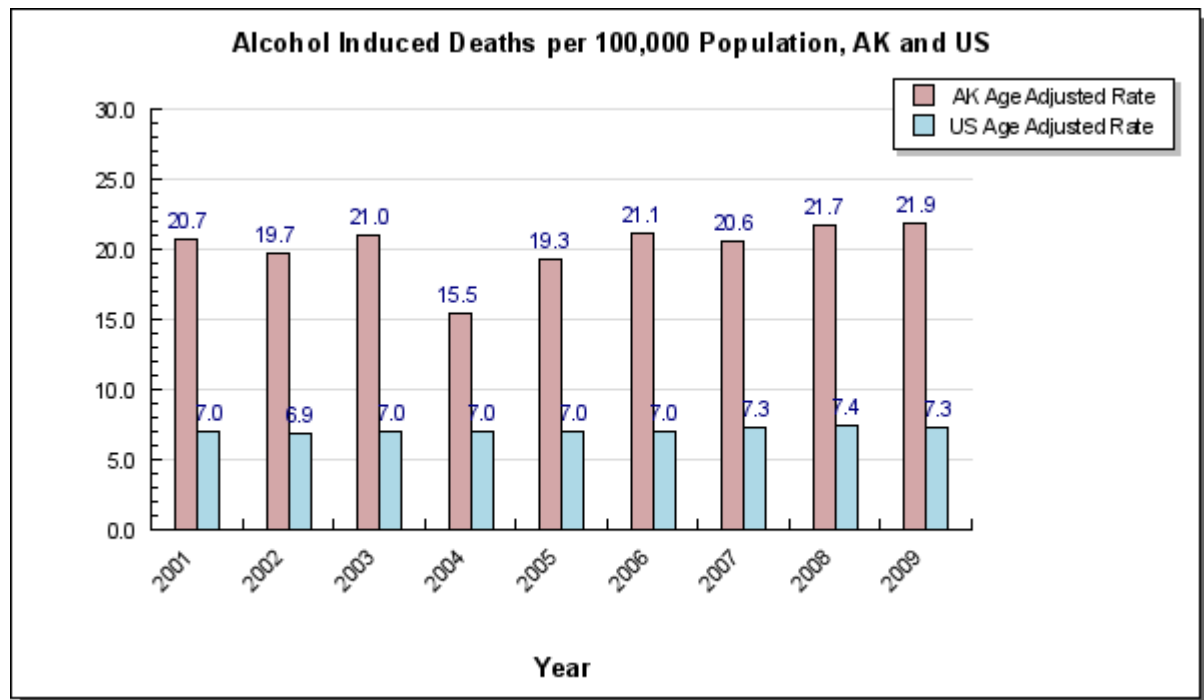
Year	Prevalence
2003	99.1 -23%
2002	128.7 -15.27%
2001	151.9 -21.86%
2000	194.4 -2.21%
1999	198.8 -9.06%
1998	218.6

Analysis of results and challenges: Since 1998, the prevalence of FASD among Alaskan children has continued to decline. From 2002 to 2003, the prevalence of FASD decreased 23%, from 128.7 per 10,000 live births in 2002 to 99.1 per 10,000 live births in 2003.

Children are often not identified and reported as having FASD until around age six, when they are entering school; this is why 2003 is the most recent birth year reported. Challenges in the diagnosis of fetal alcohol syndrome and related conditions include the lack of specificity related to the ICD9 code and variations in the age at which the characteristics become evident.

Target #2: Reduce the rate of alcohol-induced deaths.

Status #2: The target to reduce the rate of alcohol-induced deaths was not met. From 2008 to 2009, the number of alcohol-induced deaths per 100,000 population remained relatively steady at 21.7 in 2008 and 21.9 in 2009.



Methodology: Alcohol-induced deaths include fatalities from causes such as degeneration of the nervous system due to alcohol, alcoholic liver disease, gastritis, myopathy, pancreatitis, poisoning, and more. It does not include accidents, homicides, and other causes indirectly related to alcohol use.

Data source: DHSS, DPH, Bureau of Vital Statistics. In September 2011, the Alaska alcohol-induced death rates for the period 2001 through 2009 were updated to reflect modified population estimates. As of November 2011, the most current year for which data is available is 2009.

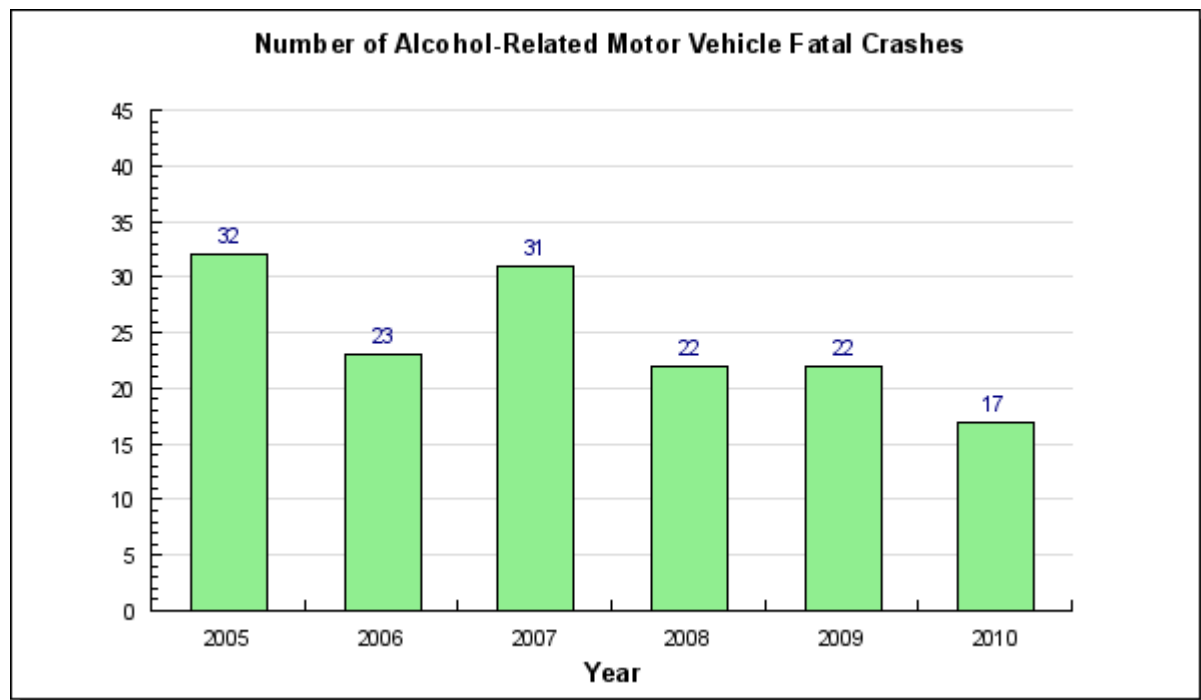
Alcohol Induced Deaths per 100,000 Population, AK and US

Year	AK Age Adjusted Rate	US Age Adjusted Rate
2009	21.9	7.3
2008	21.7	7.4
2007	20.6	7.3
2006	21.1	7.0
2005	19.3	7.0
2004	15.5	7.0
2003	21.0	7.0
2002	19.7	6.9
2001	20.7	7.0

Analysis of results and challenges: From 2008 to 2009, the number of alcohol-induced deaths per 100,000 population remained relatively steady at 21.7 in 2008 and 21.9 in 2009. Between 2001 and 2007, the rate of alcohol-induced deaths ranged between 15.5 and 21.1 deaths per 100,000 population.

Target #3: Reduce the number of alcohol-related motor vehicle fatal crashes.

Status #3: From 2009 to 2010, the number of alcohol-related motor vehicle fatal crashes decreased 22.7%, from 22 in 2009 to 17 in 2010.



Methodology: Data source: DOT&PF, Alaska Highway Safety Office, Fatality Analysis Reporting System (FARS). FARS is a national data collection system that contains information on all known motor vehicle traffic crashes in which there was at least one fatality. For the purposes of the FARS program, a reportable fatality is a death that occurs within 30 days of the motor vehicle traffic crash and is a direct result of the crash. Numbers for 2010 are preliminary and subject to change.

Number of Alcohol-Related Motor Vehicle Fatal Crashes

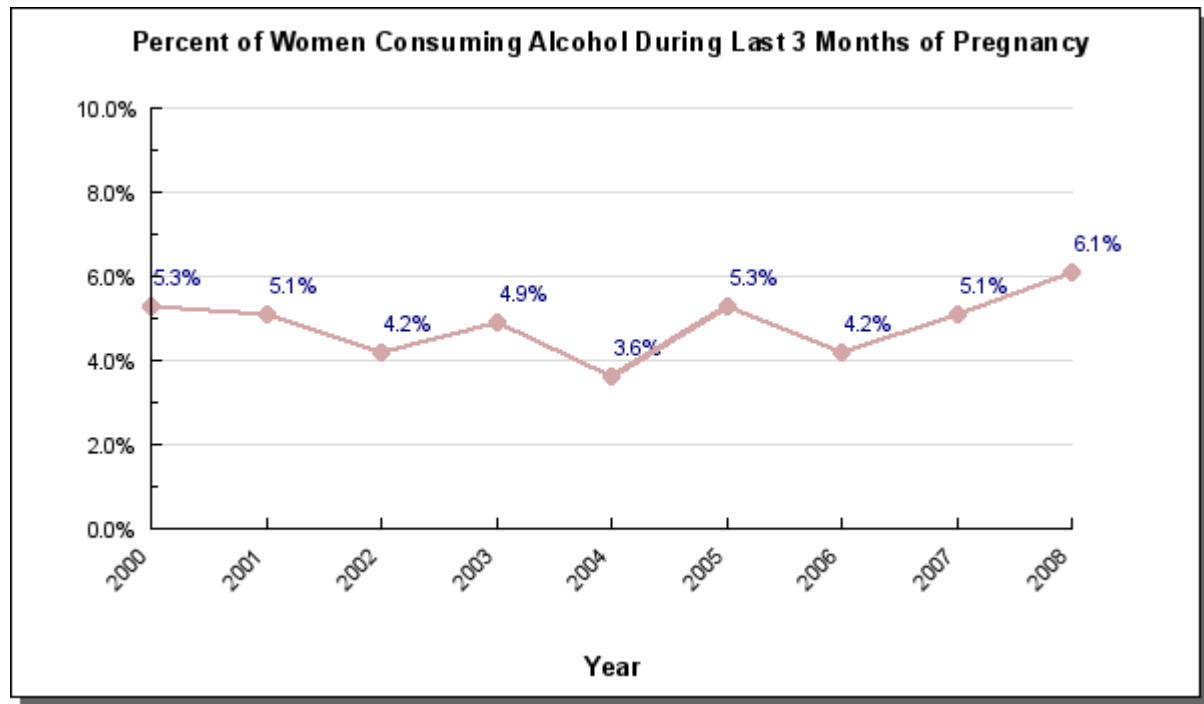
Year	Fatal Crashes
2010	17 -22.73%
2009	22 0%
2008	22 -29.03%
2007	31 +34.78%
2006	23 -28.13%
2005	32

Analysis of results and challenges: From 2009 to 2010, the number of alcohol-related motor vehicle fatal crashes decreased 22.7 %, from 22 in 2009 to 17 in 2010. Since 2005, the number of alcohol-related motor vehicle fatal crashes has decreased by 46.9%, from 32 in 2005 to 17 in 2010. This decline may be attributed to a number of campaigns to promote safe driving habits and awareness of enforcement action.

B1: Strategy - Prevent and reduce substance use and abuse.

Target #1: Reduce the percent of women consuming alcohol during pregnancy.

Status #1: From 2007 to 2008, the percent of women consuming alcohol during the last three months of pregnancy increased slightly from 5.1% to 6.1%.



Methodology: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS). As of November 2011, the most current year for which data is available is 2008.

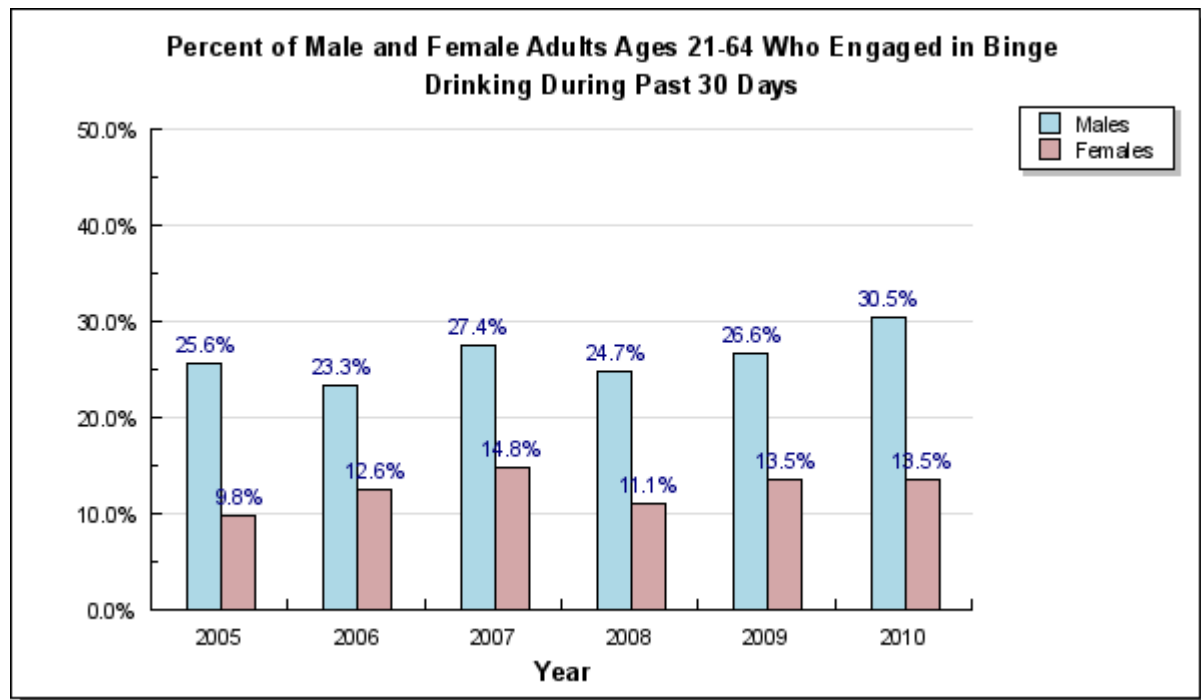
Percent of Women Consuming Alcohol During Last 3 Months of Pregnancy

Year	Percent
2008	6.1%
2007	5.1%
2006	4.2%
2005	5.3%
2004	3.6%
2003	4.9%
2002	4.2%
2001	5.1%
2000	5.3%

Analysis of results and challenges: From 2007 to 2008, the percent of women consuming alcohol during the last three months of pregnancy increased slightly from 5.1% to 6.1%. Between 2000 and 2006, the prevalence of alcohol use during the last three months of pregnancy ranged from 3.6% to 5.3%.

Target #2: Reduce the percent of male and female adults ages 21-64 who engage in binge drinking.

Status #2: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in binge drinking during the past 30 days increased from 26.6% to 30.5%; the percent of adult females ages 21-64 who engaged in binge drinking during the past 30 days remained steady at 13.5% both years.



Methodology: Binge drinking is defined as having 5 or more drinks (for males) or 4 or more drinks (for females) on at least one occasion in the past 30 days. Note: prior to 2006, the threshold for binge drinking was 5 drinks for both men and women.

Data source: Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

Percent of Male and Female Adults Ages 21-64 Who Engaged in Binge Drinking During Past 30 Days

Year	Males	Females
2010	30.5%	13.5%
2009	26.6%	13.5%
2008	24.7%	11.1%
2007	27.4%	14.8%
2006	23.3%	12.6%
2005	25.6%	9.8%

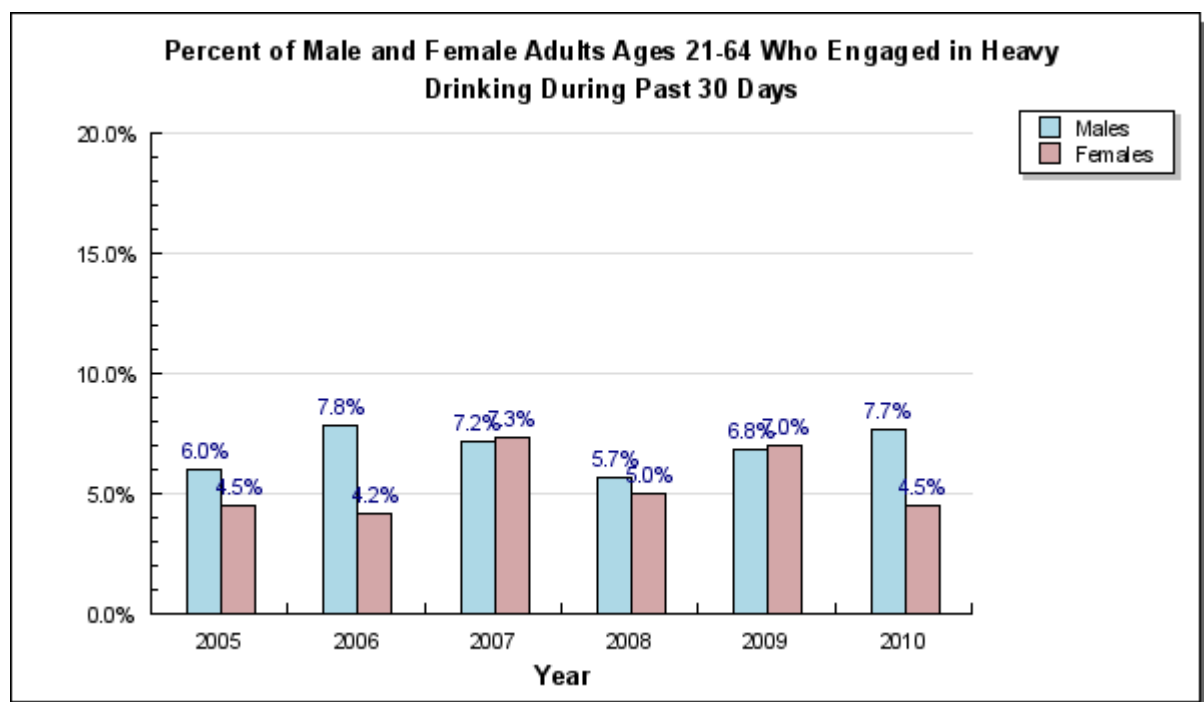
Analysis of results and challenges: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in binge drinking during the past 30 days increased from 26.6% to 30.5%. Between 2005 and 2008, the prevalence of binge drinking among males ages 21-64 ranged from 23.3% to 27.4%.

From 2009 to 2010, the percent of adult females ages 21-64 who engaged in binge drinking during the past 30 days remained steady at 13.5% both years. Between 2005 and 2008, the prevalence of binge drinking among females ages 21-64 ranged from 9.8% to 14.8%.

Through the work of the Alaska Strategic Prevention Framework State Incentive Grant (SPF SIG) assessment process, two priority consumption patterns rose to the top: youth alcohol use and adult heavy and binge drinking. Through the combined efforts of the SPF SIG funded community grantees (6 regional areas), the Comprehensive Prevention community grantees, and agencies receiving Alcohol Safety Action Program grants, Alaska is promoting a multidisciplinary, coordinated and comprehensive approach to the reduction and prevention of alcohol use and abuse. Strategies will include a combination of environmental strategies to affect change at the population level, as well as programs focused on individuals or groups of individuals that may be at risk for alcohol use or individuals who are already using alcohol in an unacceptable way.

Target #3: Reduce the percent of male and female adults ages 21-64 who engage in heavy drinking.

Status #3: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in heavy drinking during the past 30 days increased slightly from 6.8% to 7.7%; the percent of adult females ages 21-64 who engaged in heavy drinking during the past 30 days decreased from 7.0% to 4.5%.



Methodology: Heavy drinking is defined as having more than 2 drinks per day (for males) or more than 1 drink per day (for females) in the past 30 days.

Data source: Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

Percent of Male and Female Adults Ages 21-64 Who Engaged in Heavy Drinking During Past 30 Days

Year	Males	Females
2010	7.7%	4.5%
2009	6.8%	7.0%
2008	5.7%	5.0%
2007	7.2%	7.3%
2006	7.8%	4.2%
2005	6.0%	4.5%

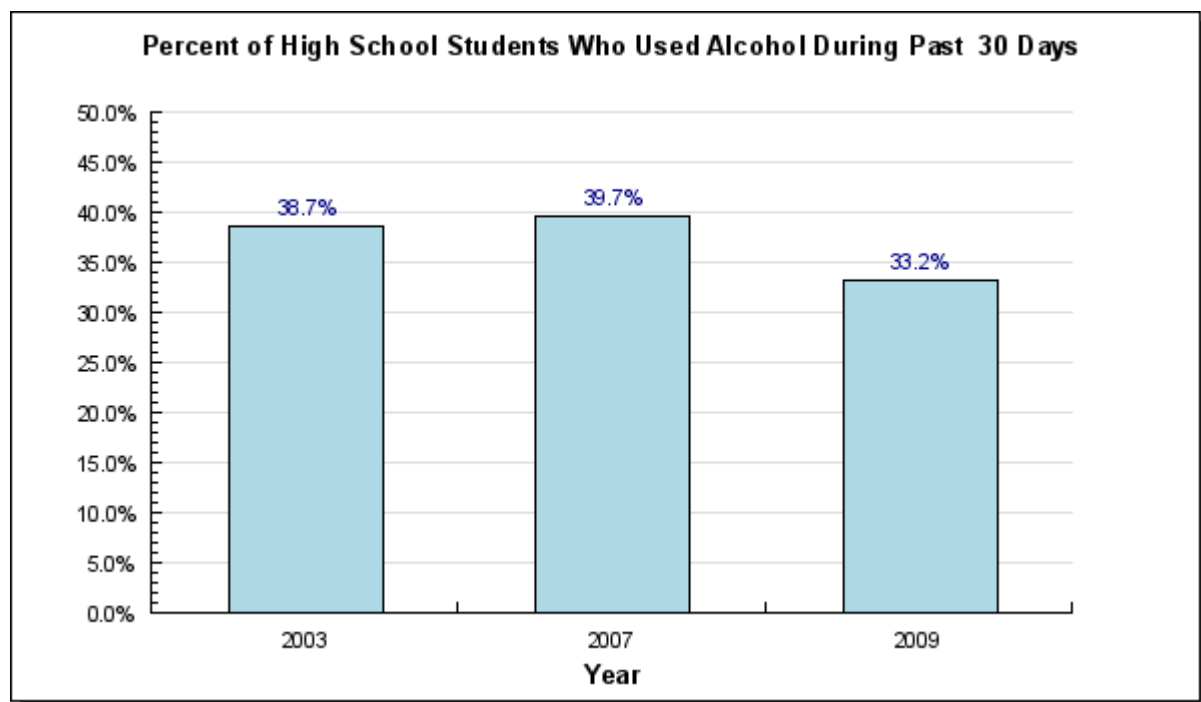
Analysis of results and challenges: From 2009 to 2010, the percent of adult males ages 21-64 who engaged in heavy drinking during the past 30 days increased slightly from 6.8% to 7.7%. Between 2005 and 2008, the prevalence of heavy drinking among males ages 21-64 ranged from 5.7% to 7.8%.

From 2009 to 2010, the percent of adult females ages 21-64 who engaged in heavy drinking during the past 30 days decreased from 7.0% to 4.5%. Between 2005 and 2008, the prevalence of heavy drinking among females ages 21-64 ranged from 4.2% to 7.3%.

Through the work of the Alaska Strategic Prevention Framework State Incentive Grant (SPF SIG) assessment process, two priority consumption patterns rose to the top: youth alcohol use and adult heavy and binge drinking. Through the combined efforts of the SPF SIG funded community grantees (6 regional areas), the Comprehensive Prevention community grantees, and agencies receiving Alcohol Safety Action Program grants, Alaska is promoting a multidisciplinary, coordinated and comprehensive approach to the reduction and prevention of alcohol use and abuse. Strategies will include a combination of environmental strategies to affect change at the population level, as well as programs focused on individuals or groups of individuals that may be at risk for alcohol use or individuals who are already using alcohol in an unacceptable way.

Target #4: Reduce the percent of high school students who use alcohol.

Status #4: From 2007 to 2009, the percent of high school students who used alcohol during the past 30 days decreased from 39.7% to 33.2%.



Methodology: Alcohol use is defined as having at least one drink of alcohol on at least 1 day in the past 30 days.

Data Source: DHSS, Division of Public Health - Youth Risk Behavior Survey (YRBS) - Traditional School. As of November 2011, the most current year for which data is available is 2009.

Percent of High School Students Who Used Alcohol During Past 30 Days

Year	Percent of Students
2009	33.2%
2007	39.7%
2003	38.7%

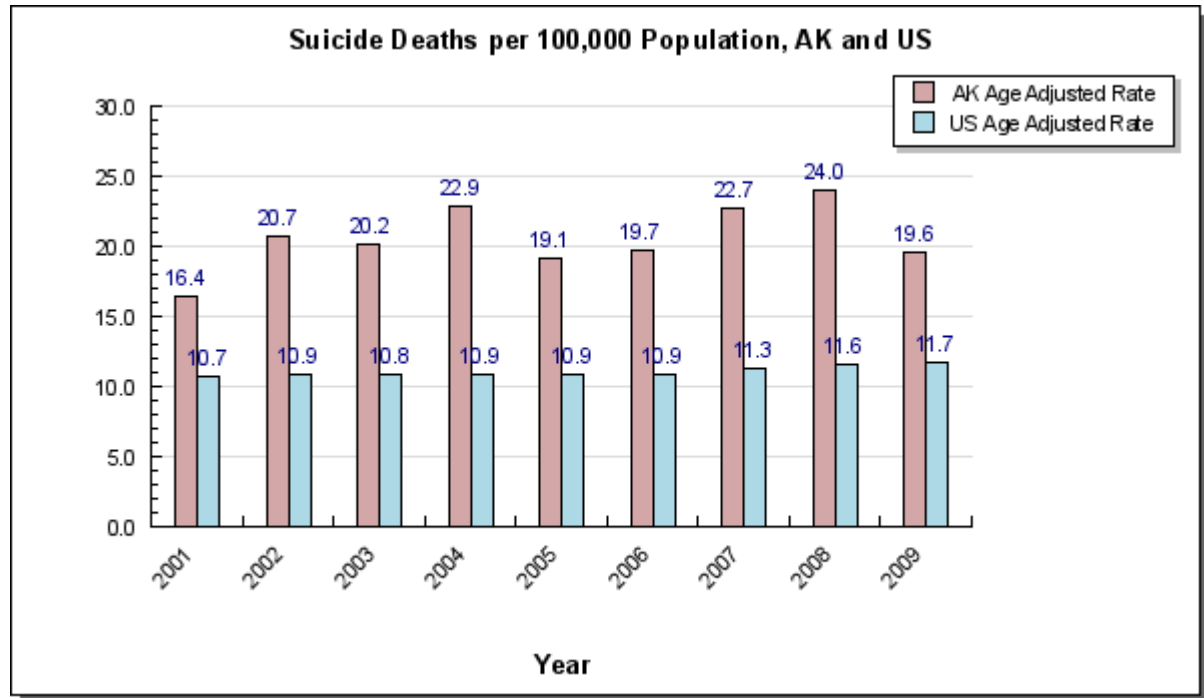
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C: Result - The mental health of Alaskans is optimized.

Target #1: Reduce the rate of suicide deaths to 10.6 deaths per 100,000 population.

Status #1: The target to reduce the rate of suicide deaths to 10.6 deaths per 100,000 population was not met; however, from 2008 to 2009, the rate did decrease from 24 to 19.6 deaths per 100,000 population.



Methodology: In the fall of 2011, the Alaska suicide death rates for the period 2001 through 2009 were updated to reflect modified population estimates. The US suicide death rates for 2008 and 2009 are preliminary and subject to change. As of November 2011, the most current year for which data is available is 2009.

Data source: AK DHSS, Division of Public Health, Bureau of Vital Statistics, (9/14/2011).

Suicide Deaths per 100,000 Population, AK and US

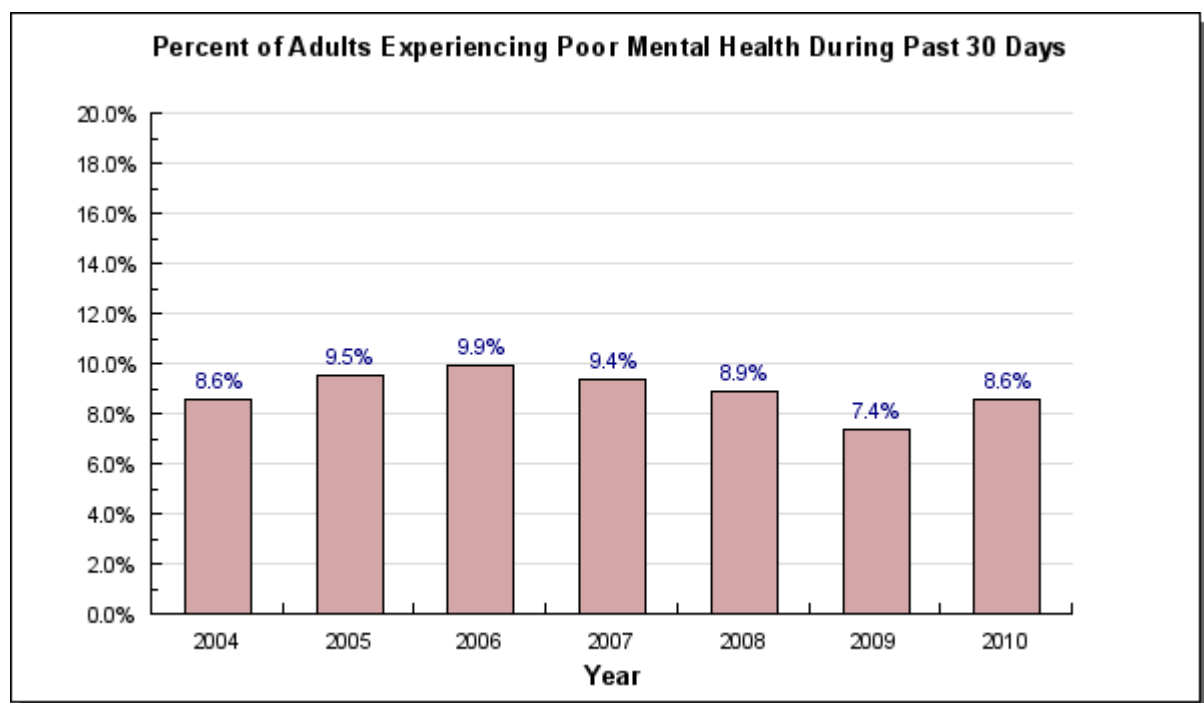
Year	AK Age Adjusted Rate	US Age Adjusted Rate
2009	19.6	11.7
2008	24.0	11.6
2007	22.7	11.3
2006	19.7	10.9
2005	19.1	10.9
2004	22.9	10.9
2003	20.2	10.8
2002	20.7	10.9
2001	16.4	10.7

Analysis of results and challenges: From 2008 to 2009, the rate of suicide deaths decreased from 24 to 19.6 deaths per 100,000 population. Between 2001 and 2007, the rate of suicide deaths ranged from 16.4 to 22.9 deaths per 100,000 population.

Alaska's suicide rates continue to rank among the top one or two states nationally. In many parts of Alaska, suicide is an epidemic. The state has a number of strategies and efforts in place to better address this continuing problem, but most important is the need for a comprehensive, coordinated and aggressive approach to ending this epidemic. In partnership with the State Suicide Prevention Council and community based suicide prevention coalitions and community behavioral health grant programs, the state will continue to refine and focus its suicide prevention efforts to increase early access to support, assessment and early identification of suicidal thoughts, depression and other related conditions, and referral to services by enhancing and expanding the statewide CareLine, 24-hour phone line for Alaskans in crisis or needing assistance and support. The CareLine is a nationally accredited program, serving all of Alaska, with referral sources across Alaska. The strategy for enhancing this service includes better rural outreach and awareness of the service, increased staffing to maximize coverage, development of MOUs between the CareLine and all DBH funded community behavioral health centers, and expanding the CareLine technology and range of services to better utilize social networking opportunities.

Target #2: Reduce the percent of adults who experience poor mental health.

Status #2: From 2009 to 2010, the percent of adults who experienced poor mental health during the past 30 days increased slightly from 7.4% to 8.6%.



Methodology: Poor mental health is defined as experiencing frequent mental distress. Frequent mental distress is defined as 14 or more days during the past 30 days when a person's mental health was not good.

Data source: DHSS, Division of Public Health, Alaska's Behavioral Risk Factor Surveillance System (BRFSS). Note: The BRFSS survey does not collect data from individuals living in an institutional setting.

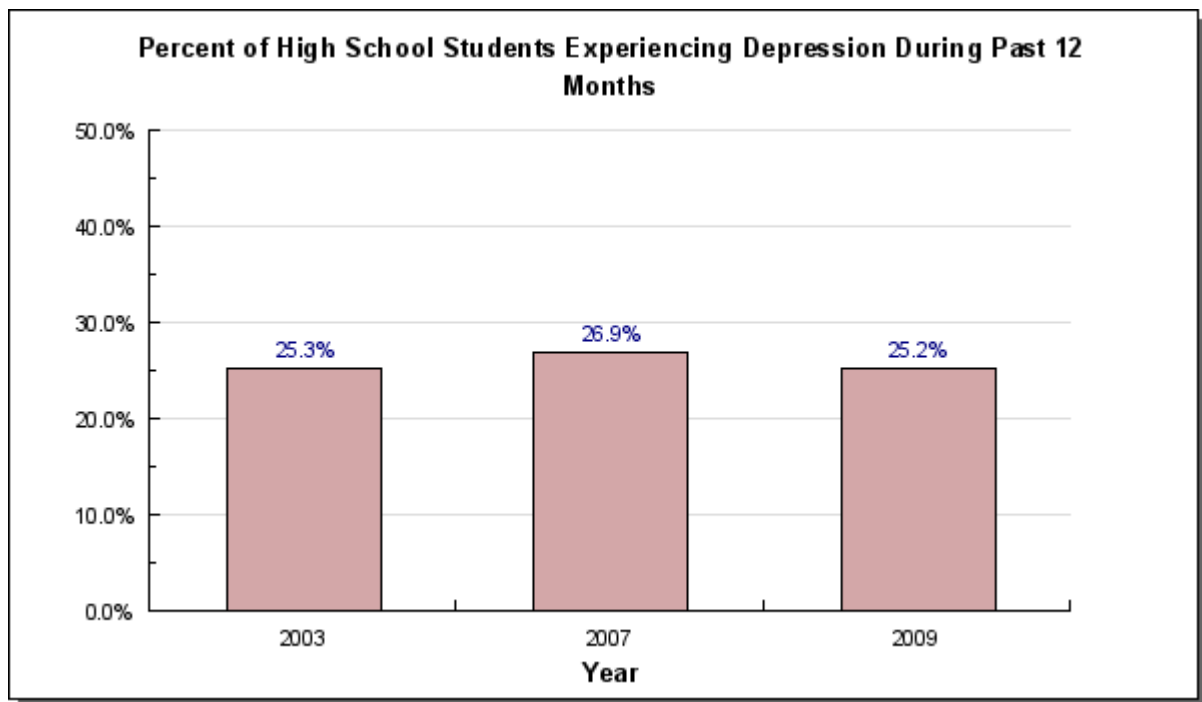
Percent of Adults Experiencing Poor Mental Health During Past 30 Days

Year	Percent of Adults
2010	8.6%
2009	7.4%
2008	8.9%
2007	9.4%
2006	9.9%
2005	9.5%
2004	8.6%

Analysis of results and challenges: From 2009 to 2010, the percent of adults who experienced poor mental health during the past 30 days increased slightly from 7.4% to 8.6%. From 2006 to 2009, the percent of adults who experienced poor mental health decreased slightly each year, from 9.9% in 2006 to 7.4% in 2009.

Target #3: Reduce the percent of teens who experience depression.

Status #3: During 2003, 2007, and 2009, between 25% and 27% of high school students experienced depression during the past 12 months.



Methodology: Experiencing depression is defined as feeling so sad or hopeless almost every day for two weeks or more in a row that the student stopped doing some usual activities.

Data Source: DHSS, Division of Public Health - Youth Risk Behavior Survey (YRBS) - Traditional School. As of November 2011, the most current year for which data is available is 2009.

Percent of High School Students Experiencing Depression During Past 12 Months

Year	Percent of Students
2009	25.2%
2007	26.9%
2003	25.3%

Analysis of results and challenges: During 2003, 2007, and 2009, between 25% and 27% of high school students experienced depression during the past 12 months.

The 2009 Youth Risk Behavior Survey of Alaska high school students also reported the following:

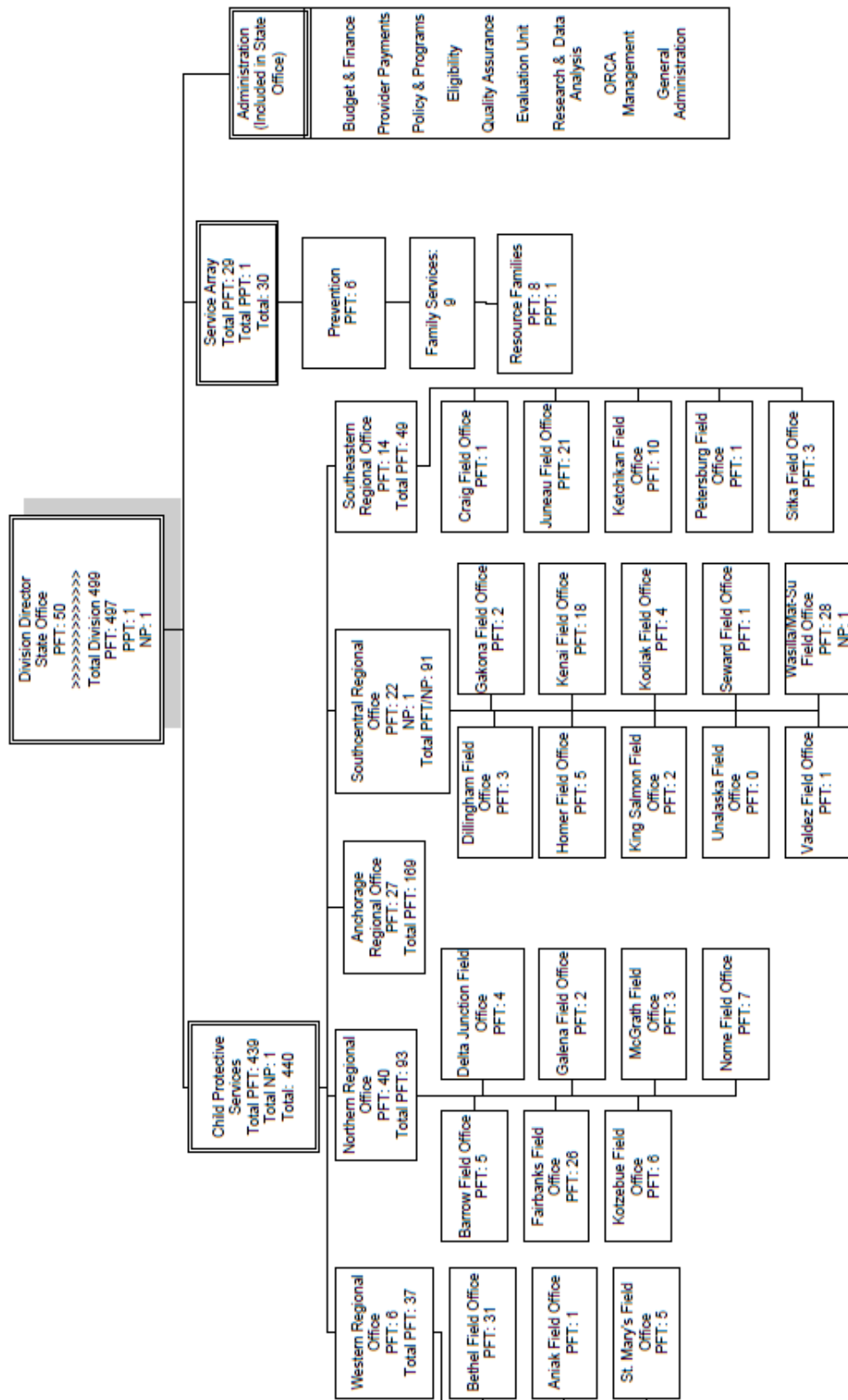
- 11.7% had made a plan about how they would attempt suicide in the previous 12 months
- 21% had been bullied on school property during the past 12 months
- 13% had been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend

C1: Strategy - Incorporate mental health promotion into the Division's Prevention and Treatment continuum of care.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for Behavioral Health General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Unrealized Authority	\$ -	\$ -	\$ -	\$ (85.0)	\$ (85.0)
Domestic Violence and Sexual Assault: Telehealth Strategic Capacity Expansion	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
MH Trust Continuing - Sustaining Alaska 2-1-1	\$ 25.0	\$ -	\$ -	\$ -	\$ 25.0
MH Trust Workforce Dev – Committee on Workforce Competency-Curriculum Development	\$ 50.0	\$ -	\$ -	\$ -	\$ 50.0
MH Trust: ABADA/AMHB School Based Suicide Prevention	\$ 450.0	\$ -	\$ -	\$ -	\$ 450.0
MH Trust: AK Alc Bd - Substance Abuse Treatment for Unresourced Individuals	\$ 450.0	\$ -	\$ -	\$ -	\$ 450.0
MH Trust: AK MH Bd - Early Childhood Screening & Brief Behavioral Services	\$ 400.0	\$ -	\$ -	\$ -	\$ 400.0
MH Trust: AK MH Bd - Trauma Informed Care	\$ 400.0	\$ -	\$ -	\$ -	\$ 400.0
MH Trust: BTKH - BTKH In-Home Intensive Support	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
MH Trust: BTKH - Strong Family Voice: Parent and Youth Involved via AMHB	\$ 50.0	\$ -	\$ -	\$ -	\$ 50.0
Adult Probation Officer II (06-?005) for Anchorage Municipal Wellness Court	\$ -	\$ -	\$ -	\$ -	\$ -
Authority for Anchorage Municipal Wellness Court Case Management Reimbursable Services Agreement	\$ -	\$ -	\$ -	\$ 85.0	\$ 85.0
Domestic Violence and Sexual Assault: Family Wellness Warriors Initiative - Year Three - RSA from Governor's Office	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
Domestic Violence and Sexual Assault: Trauma Informed Training - Year Three - RSA from Governor's Office	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
MH Trust Cont - Grant 2467.03 IMPACT Model of Treating Depression	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
MH Trust: BTKH - Grant 1390.05 Expansion of School-Based Services Capacity via Grants	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
MH Trust: BTKH - Grant 2463.03 Evidence Based Family Therapy Models	\$ 300.0	\$ -	\$ -	\$ 200.0	\$ 500.0
MH Trust: BTKH - Grant 2465.03 Tribal/Rural System Development	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: BTKH - Grant 2466.03 Transitional Aged Youth	\$ 250.0	\$ -	\$ -	\$ 200.0	\$ 450.0
MH Trust: BTKH - Grant 3051.02 Peer Navigator Program	\$ 100.0	\$ -	\$ -	\$ 100.0	\$ 200.0
MH Trust: BTKH - Grant 1392.05 Community Behavioral Health Centers Outpatient & Emergency Residential Services & Training	\$ -	\$ -	\$ -	\$ 450.0	\$ 450.0
MH Trust: Cont - Grant 3736.01 Behavioral Health Follow-up Survey	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
MH Trust: Cont - Grant 605.07 ABADA/AMHB Joint Staffing	\$ -	\$ -	\$ -	\$ 435.0	\$ 435.0
MH Trust: Dis Justice - Grant 2819.03 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: Housing - Grant 1337.05 Assisted Living Home Training and Targeted Capacity for Development	\$ 100.0	\$ -	\$ -	\$ 100.0	\$ 200.0
MH Trust: Housing - Grant 383.08 Office of Integrated Housing	\$ -	\$ -	\$ -	\$ 225.0	\$ 225.0
MH Trust: Housing - Grant 575.07 Bridge Home Program & Expansion	\$ 300.0	\$ -	\$ -	\$ 750.0	\$ 1,050.0
MH Trust: Housing - Grant 604.07 Department of Corrections Discharge Incentive Grants	\$ 50.0	\$ -	\$ -	\$ 200.0	\$ 250.0
Multidisciplinary Rural Community Pilot Project - Year Three - Reimbursable Services Agreement from Governor's Office	\$ -	\$ -	\$ -	\$ 1,400.0	\$ 1,400.0
Reverse Alaska Complex Behavior Collaborative Half-Year Funding	\$ (325.0)	\$ -	\$ -	\$ -	\$ (325.0)
Reverse August FY2012 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (23.5)	\$ -	\$ -	\$ -	\$ (23.5)
Reverse Family Wellness Warriors Initiative - Year Two - Reimbursable Services Agreement from Governor's Office	\$ -	\$ -	\$ -	\$ (200.0)	\$ (200.0)
Reverse Funding for a Probation Officer for Case Management at the Anchorage Municipal Wellness Court	\$ -	\$ -	\$ -	\$ (79.9)	\$ (79.9)
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ (3,511.6)	\$ (3,511.6)
Reverse Multidisciplinary Rural Community Pilot Project - Year Two - Reimbursable Services Agreement from Gov's Office	\$ -	\$ -	\$ -	\$ (1,400.0)	\$ (1,400.0)
Reverse Trauma Informed Training - Year Two - Reimbursable Services Agreement from Governor's Office	\$ -	\$ -	\$ -	\$ (200.0)	\$ (200.0)
Behavioral Health Total	\$ 2,676.5	\$ -	\$ -	\$ (256.5)	\$ 2,420.0

Office of Children's Services



Introduction to the Office of Children's Services



Vision

Safe children and strong families

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

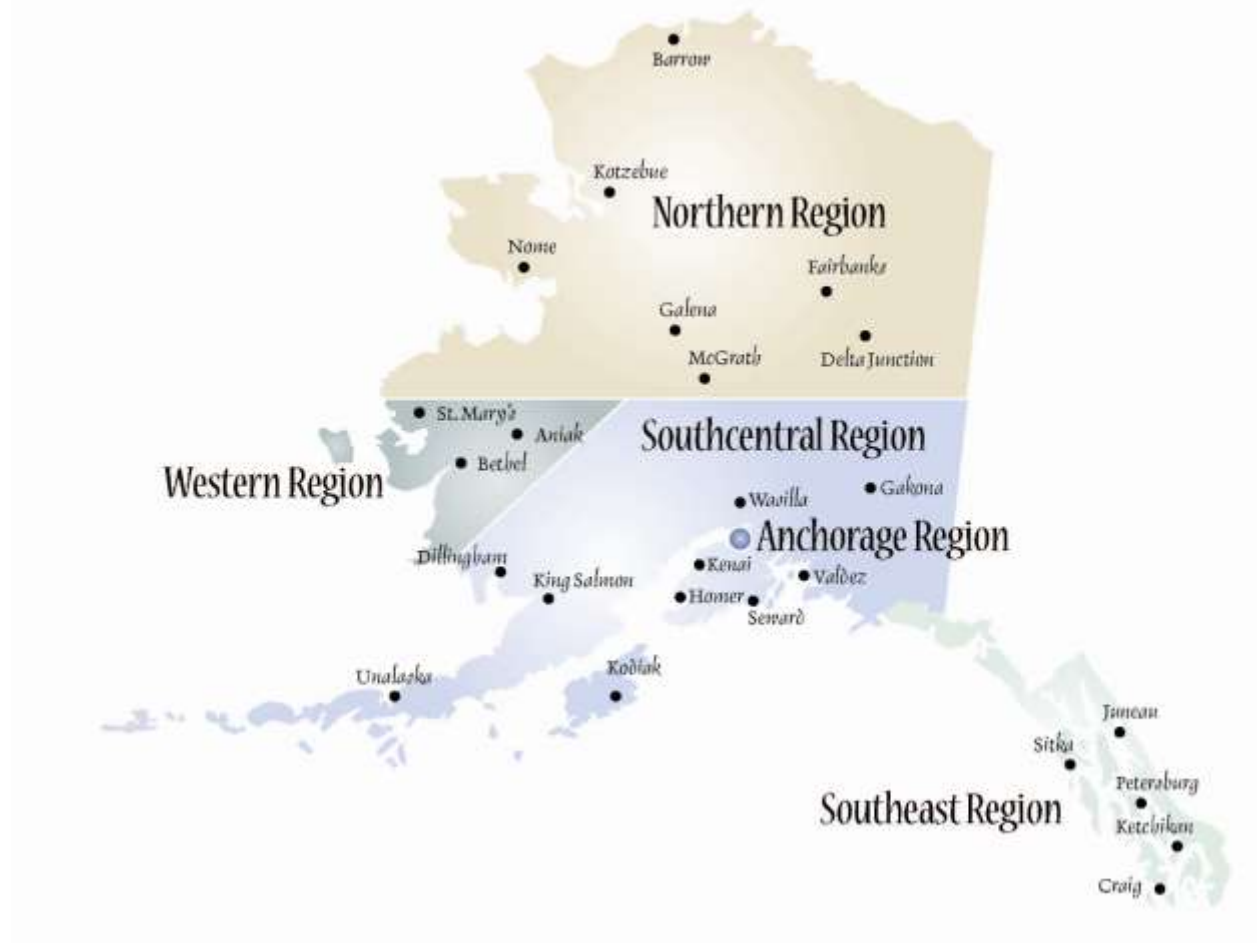
Ensure that children are safe and families remain intact whenever possible:

- Prevent and remedy child abuse and neglect.
- Facilitate early intervention and treatment services.
- Interactive intake functions that serve as resource referral and screening of alleged maltreatment reports.
- 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, Galena, McGrath and Delta Junction.
- Central Regional Office (SCRO) in Wasilla: Kenai, Valdez, Kodiak, Dillingham, Unalaska, Homer, Seward, Gakona, and King Salmon.
- Anchorage Regional Office (ARO) is responsible for Anchorage.
- Southeastern Regional Office (SERO) in Juneau: Sitka, Petersburg, Ketchikan, Craig.
- Western Regional Office (WRO) in Bethel: Aniak, and Saint Mary's.

*ALASKA CHILDREN'S SERVICES
REGIONAL AND OFFICE COVERAGE*



Major Accomplishment in FY2011

In 2005, the Office of Children's Services (OCS) recognized that that in order to meet desired outcomes, child protection work in Alaska needed to be restructured. At that time, the OCS began the long process of restructuring its child welfare program through the implementation of a comprehensive state of the art safety practice model. This model emphasizes a strengths-based, family-centered approach through the standardization of information gathering, enhanced assessment and critical thinking skills.

Throughout FY 2010 and FY2011, much of the work related to implementation of the new practice model was incorporated into a Program Improvement Plan (PIP). The PIP, a Federal requirement, was comprised of nine major goal areas with numerous strategies and action steps, all formulated to address areas needing improvement in the child welfare system identified during the State's 2008 Child and Family Services Review (CFSR).

November 30, 2011 will mark the commendable close out of the OCS' two-year Program Improvement Plan (PIP). The work accomplished as outlined in the PIP represents extraordinary efforts by stakeholders and staff at all levels of the agency to make significant and lasting practice improvements through the successful completion of numerous action steps. The OCS has substantially met required goals for safety and permanency standards in eight out of the nine goal areas. The uncompleted goal relates to improving services to youth who are aging out of foster care. OCS has an additional year to complete this goal. The OCS has implemented an aggressive plan, building on a variety of already developed strategies to execute this goal.

Some specific target areas and PIP strategies that we have successfully addressed include:

- Increased timeliness and enhanced quality of investigations (initial assessments).
- Increased frequency and quality of caseworker visits with child.
- Continued implementation efforts around the practice model.
- The development of a variety of quality assurance tools and systems for monitoring outcomes.
- The development of the strategic plan.
- The development of a Resource Family Advisory board.
- The development of a Resource Family Recruitment Plan.
- Working with Tribes to reduce the disproportionate number of Alaska Native children in care.
- The development of an innovative in-home service model with the tribes.

Much of the work that was initiated during the PIP will need to be sustained and monitored. To support these efforts, key strategies have been incorporated into the OCS 2010-2014 Child and Family Services Plan (CFSP). The CFSP is a five-year strategic plan that sets forth the vision and goals for the agency. The OCS Leadership team has identified the completion of the CFSP and the sustained progress and successes achieved through the PIP as a key priority.

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 safe and 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:

- Family counseling on child development.
- 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.
- Targeted case management.

In FY2011, approximately 2,668 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 2,668 children, over 1,873 were eligible for early intervention services funded under Part C of the Individuals with Disabilities Education Act.

The Infant Learning Program is actively working toward universal access to developmental screening through regional agencies and medical homes.

FY2011 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	FY2011
Child Outcome Area	Percent Substantially Increased Rate of Growth	Percent Substantially Increased Rate of Growth	Percent Substantially Increased Rate of Growth
Emotional: Positive social relationships	67% (104 of 155)	66% (154 of 234)	69% (205 of 296)
Knowledge: Acquisition of knowledge and skills	78% (146 of 188)	71% (191 of 271)	70% (240 of 342)
Action: Taking appropriate actions to meet own needs	73% (143 of 195)	72% (185 of 258)	73% (248 of 338)

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	FY2011
Child Outcome Area	Percent within Age Expectations at Exit	Percent within Age Expectations at Exit	Percent within Age Expectations at Exit
Emotional: Positive social relationships	58% (142 of 244)	58% (142 of 244)	55% (213 of 391)
Knowledge: Acquisition of knowledge and skills	57% (139 of 244)	57% (139 of 244)	45% (177 of 391)
Action: Taking appropriate actions to meet own needs	55% (134 of 244)	55% (134 of 244)	48% (187 of 391)

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.

ECCS work over the last year has included:

- Support for the Alaska Early Childhood Coordinating Council (AECCC) which is jointly facilitated by the Departments of Health and Social Services and Education and Early Development. This public-private partnership is made up of 23 members and serves in an advisory capacity to the Governor. The purpose of the AECCC is to facilitate the integration and alignment of services, planning efforts, resources, policy development and funding, as well as establish connections between health, mental health, education, and family support systems and public and private partners.
- Facilitation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Developmental Screening Workgroup which is focused on increasing the use of standardized developmental screening tools during well-child exams by primary care providers. Policy changes as well as provider education recommendations are being developed.
- Continuing work with child protection services to revise policies and procedures regarding Early Periodic Screening, Diagnosis, and Treatment well-child exams for children in custody.

- Initiation of an Early Childhood Protective Services Collaboration for providers in the Anchorage area serving children birth to five years of age, in the child protection system.
- Participation in the Quality Rating and Improvement System Advisory Committee and Professional Development Committee for early care and learning programs.
- Providing support for several early childhood mental health programs/projects such as the annual Early Childhood Mental Health Institute, the “Early Childhood Mental Health Learning Network”, and an Early Childhood Mental Health Consultation Project in the Anchorage area.
- Facilitating the expansion of the “Strengthening Families” approach for supporting families by strengthening and supporting “protective factors”. Training and technical support was provided to existing early childhood and family support programs interested in implementing this approach in their work with young children and families.

Strengthening Families Program

The Strengthening Families Initiative is an evidence-based, 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 include:

- Partnering with the United Way of Anchorage and “*thread* connecting early child care & education to Alaska”, to train and support 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 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.

Intervention Services

Child Protective Services

Child Protection Services (CPS) is comprised of three core components: Intake, Initial Assessments and Family Services.

Intake

The critical task of assessing child safety begins in Intake. Intake is the process of receiving reports of allegations of child maltreatment, called a Protective Service Report (PSR). By engaging reporters in an interactive process, OCS Intake workers capture all the necessary information known to the reporter including the extent of the alleged maltreatment, circumstances surrounding the alleged maltreatment, family/adult functioning, child functioning, parenting practices of the parent/caregiver and disciplinary practices of parent/caregiver, to determine whether a response is required by child protective services.

During the last two years OCS has incrementally phased in Regional Intake Units. This move was prompted by the realization that OCS needed to standardize and enhance this critical business function across all regions and field offices. By regionalizing the process, dedicated, trained workers are equipped to answer or respond to every call in a timely manner and ensure that all reports of child maltreatment are entered into ORCA, our automated case management system of record. Intake workers not only gather information from the reporter, but they are also responsible for gathering other related information that could help determine the appropriate agency response. This may include contacting collateral sources if necessary to corroborate available information and if screened in for intervention to help inform the initial assessment of safety. If the available information indicates that the child is either unsafe or at high risk of maltreatment by their parent/caregiver, the report will be screened in for initial assessment and assigned to the local field office for a full safety assessment (or Initial Assessment) or if not, the reporter will be referred, if appropriate to community services. As per state law, all mandated reporters are notified of the screening decision. During FY2011, OCS received and documented 16,178 PSRs. This number represents an 11% (increase) from FY2010. Of these PSRs, 6,412 were screened in and referred for initial assessment.

Initial Assessment

Formerly called an investigation, the initial assessment encompasses the decision making process once a PSR is screened in for OCS intervention. Using a standardized protocol for information gathering, and specialized safety tools, Initial Assessment workers assess beyond whether the incident in the reported allegation is substantiated or not substantiated; they must determine whether there are conditions present in the family which pose immediate or impending danger such that some kind of intervention is necessary to keep a vulnerable child safe. If it is determined that a child is unsafe or at high risk, OCS will open a case for Family Services and work with the family to implement the least intrusive approach to keep children safe, first with consideration of an in-home safety plan and last , an out-of-home placement. During FY2011, statewide Initial Assessment staff completed 5,701 assessments. The table below details these assessments by allegation type and substantiation.

Allegations Initially Assessed and Substantiated during FY2011 (7/1/10-6/30/11)

Maltreatment Type	Total Allegations	Substantiated Allegations	Children with Substantiated Allegations	Perpetrators of Substantiated Allegations
Mental Injury	3,000	688	512	356
Neglect	10,690	3,815	2,534	1,871
Physical Abuse	2,069	415	378	356
Sexual Abuse	674	143	135	117
Total	16,433	5,061	3,043	2,340

Family Services

Family Services covers the entire scope of work required by CPS staff to manage the open cases for families whose children have been identified as unsafe or at high risk and state intervention is warranted. Always in collaboration with the family's tribe when appropriate, this entails case plan development and case management with birth parents/caregivers to rehabilitate diminished parenting abilities (or protective capacities) so the parent/caregiver may resume the total care and responsibility for their children. If reunification is not possible Family Service workers must work towards other permanent living solutions (adoption, guardianship, independent living) in an effort to meet the child's best interest.

Family services workers are responsible for ensuring the care and well-being of children in out of home care. In addition to monitoring and addressing all educational, physical and mental health needs; family services workers must make every effort to maintain a child's family and cultural connections. In collaboration with the family, tribe, and GAL, workers develop and implement family contact (visitation) plans.

Central to the ability to provide ongoing assessment of safety and to stay current on what the family needs to achieve case plan goals, is monthly face to face case worker visits. Family Services workers are required to visit every child, birth parent and alternative caregiver (resource parent or relative care provider) every month.

In FY2011, OCS reunified 523 children with their parents, exited 329 children to adoption, and 31 to guardianship, while 44 children aged out of care.

Child Advocacy Centers

Child Advocacy Centers (CAC) 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 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 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 the 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, through a co-located services model, provides the best forum for an investigation to occur that can assure victims are not re-traumatized by repeated interviews and examinations.

During FY2011, Kodiak formed its Multidisciplinary Team, ratified their protocols and are serving families. They are currently in the process of moving into their permanent home. Pre-planning activities are forming in at least three rural communities as well. It is expected that at least one of these communities may apply for start-up funding for planning activities when the 2013 grant year arrives.

There are a total of ten operating CACs statewide, situated in both rural and urban centers. The fully operating CACs include locations in Nome, Bethel, Dillingham, Fairbanks, the Mat-Su Valley, Copper River Basin, Anchorage, Kenai, Juneau, and Kodiak. Fairbanks and Homer are preparing for their site visits to attain initial accreditation while Juneau is planning a re-accreditation site review for FY2013. With Anchorage and Mat-Su CACs having attained full re-accreditation through the National Children's Alliance in FY2011, Alaska will soon have half of its Centers nationally accredited. With the remaining Centers focused on attaining accreditation in the near future, Alaska's Child Advocacy Centers will represent a fully standardized approach to child abuse investigations utilizing best practices statewide.

Family Preservation

Family preservation services include 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.
- Family Contact Services Center.

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

Family Preservation is supported through blended funding from federal Title IV-B Child Welfare Services and Community-Based Child Abuse Prevention Program grants and state general funds.

Family Support Services

Family Support Services are provided statewide and are designed to support young, first-time parents and parents with young children from birth to 12 years of age. 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.
- Transportation services.

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

Family Preservation Services

Family Preservation 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 unit, 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.
- 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/ 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.

Referrals to Time-Limited Family Reunification Services are made by the Office of Children's Services (OCS) when it is determined, through an initial assessment, that a child is unsafe and removal from the home is necessary.

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

The data collected from the grantees will be analyzed to show progress toward desired outcomes. The outcomes are dependent on capturing client data related to family/child functioning and entry or re-entry into the OCS system; linking client outcomes to services related to employment or treatment services; and tracking data related to each grantee's ability to maintain compliance with grant requirements. Evaluation is ongoing and long-term.

Minimal recent baseline data is available at this time. Of the data available, the OCS was able to generate these findings:

- Of the families served by the Time-Limited Family Reunification and Family Contact Services Center Programs funded by the OCS whose children were reunified in FY2010 and/or FY2011, all of those children (100%) remained in the home following their reunification as of July 27, 2011. This means that services to support reunification were effective in preventing re-entry into an out-of-home setting 100% of the time.

The OCS will be continuing with the analysis and should have a baseline report generated in its entirety in FY2013.

Independent Living Services

The Independent Living Program provides services designed to help youth make the transition from foster care to become positive, productive adults. This program provides services to foster youth 16 to 21, and former foster youth (ages 18-21) and, as a result of the Fostering Connections to Success and Improving Adoptions Act, to youth who left foster care for kinship guardianship or adoption on or after their 16th birthday.

FY2011 Independent Living Youth Participants by Region			
Region	In Custody	Out of Custody	Total Youth
Anchorage	50	90	140
Northern	26	56	82
Southcentral	47	95	142
Southeast	21	47	68
Western	30	33	63
Total	174	321	495

Independent Living services are available to the approximately 495 foster youth ages+ 16 and older, both in and out of OCS custody throughout Alaska.

To assist foster youth achieve self-sufficiency, Independent Living Services are offered to all eligible youth. Services 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.

The Independent Living Program also supports a youth advisory group of youth in state custody and alumni of the foster care system. This group meets on a quarterly basis and has approximately 20-30 current and former foster youth participants from throughout the state. The Independent Living Program also hosts an annual Education conference. Thirty youth from throughout Alaska attended the August 2011 conference at the University of Alaska, Anchorage campus.

As part of the Independent Living Program, an Education Training Voucher (ETV) is awarded to current and former foster youth wishing to further their education. ETVs offer financial help to attend colleges, universities, and vocational or technical programs. Up to \$5,000 in funds are available to eligible students. ETV awards are unique to each student and are based on the cost-of-attendance formula established by their college of choice, and by any un-met need they may have in their financial aid award.

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 Services Program provides child abuse prevention and support services to families' members at risk of entering into OCS custody, and coordinated case management services to families and children who are already involved in the OCS system.

The priority for services 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 is given to 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 (OCS) 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, or 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 Title IV-E eligibility determinations.

OCS chose not to implement the option of extending eligibility for Title IV-E foster care, adoption assistance, and kinship guardianship payments to age 21, for the following reasons:

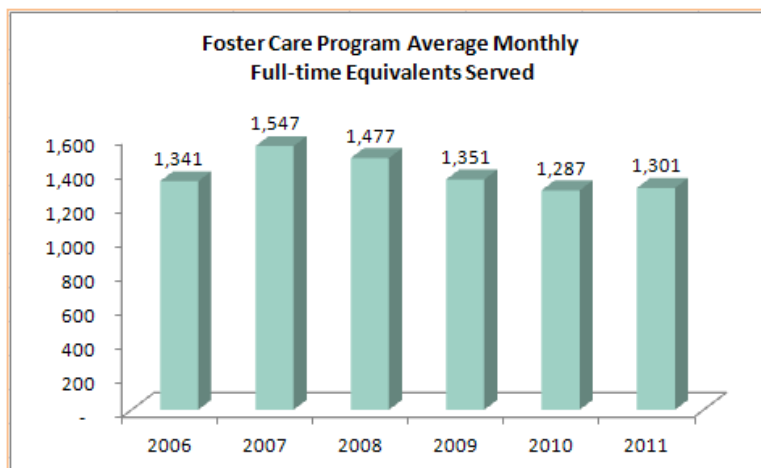
1. OCS would have been required to apply this new law to all three programs, which would require a statute change because the current statute allows adoption and guardianship subsidy payments only until the child turns 18 years of age.
2. Extending adoption and guardianship payments to age 21 would have a major fiscal impact based upon the large number of children receiving subsidies.

OCS did implement a kinship guardianship assistance program and made the change of de-linking adoption assistance from Aid to Families with Dependent Children (AFDC). This required amendments of the payment regulations and the Title IV-E state plan. The regulation amendments became effective April, 13, 2011. The policy revisions were effective May 1, 2011, and the amended IV-E state plan was submitted in May 2011. As a result, we were able to start Title IV-E claiming for the IV-E kinship guardianship program right away.

Foster Care, Foster Care Base Rate, Foster care Augmented Rate and Special Needs

Foster Care

Foster Care enables the state to find temporary homes for children who have been maltreated and cannot remain in their own families' homes. Children who are placed into foster care are placed based on a placement preference priority, in which relative-care placements are the first choice for the child. For children of Alaska Native heritage, additional placement preferences are in place so that relatives and other Tribal members may be considered as placement options for a child in care. If a relative and/or Tribal member cannot be identified to care for the child, then placement consideration is given to non-relative foster care placements.



Relatives have the option to care for the child as an unlicensed relative-care provider or as a licensed foster home. All non-related foster homes must be licensed foster homes. Currently, there are 1302 licensed home foster care providers in Alaska. Currently, 727 children in care are residing in the home of a relative (licensed and unlicensed) and 751 children are residing in non-relative foster care.

Foster care support services and funding can also provide support to those children who are at risk of being removed from their homes and from their families.

Foster Care Base Rate

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 a 15% increase in out-of-home placements between FY2006 and FY2007 based on full-time equivalents. Since then, foster care numbers have shown a steady decrease in subsequent years, with an 8.5% drop between FY2008 and FY2009 and another 5% drop between FY2009 and FY2010.

Although FY2011 reflects a slight increase of 1%, 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 had been finalized during that time period.

Movement of children into and out of the program is a common occurrence. Therefore, the Office of Children's Services calculations are based on full-time equivalents rather than on the number of children in custody. This assures that if two children each come into the program for two weeks out of a month, they are counted as one full-time equivalent. Full-time equivalents are tied to dates of service and are adjusted throughout the fiscal year.

The Augmented Foster Care Rate benefit covers extra-ordinary costs and higher levels of supervision for children with special needs related to, for example, a physical or cognitive disability, and care not otherwise covered by base rate benefits.

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

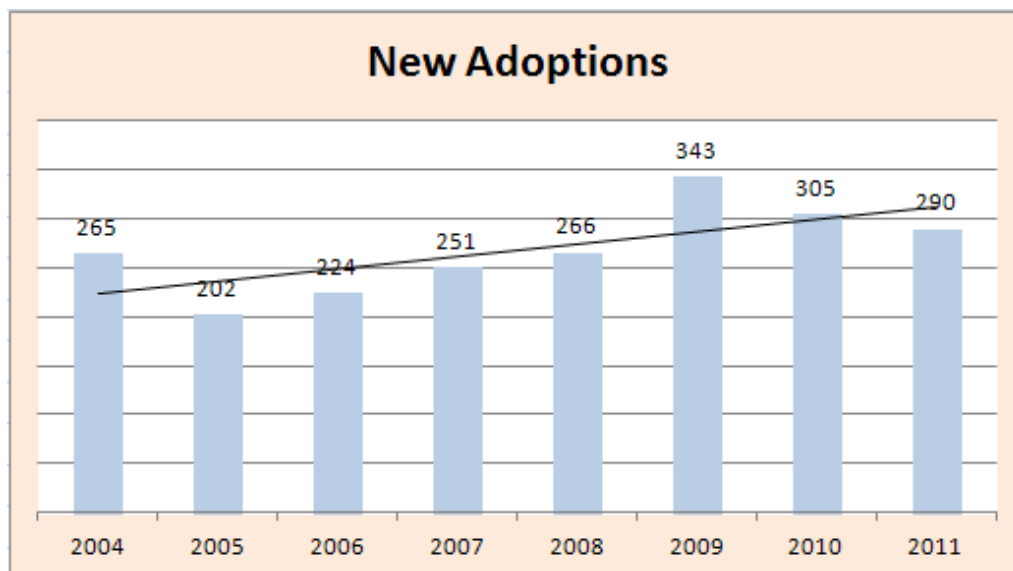
Subsidized Adoption and Guardianship

The Subsidized Adoption and Guardianship program facilitates permanent placements in adoptive and guardianship homes for children in state custody whose special needs make them harder 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 released for adoption, but for whom a reasonably permanent home can be provided through guardianship. This is often the best choice for children who are not able to live with their parents, but have an important emotional tie to their families that should not be severed.

Many times, children who have been removed from their homes as a result of maltreatment and cannot be returned to their homes safely, have long-lasting disabilities and/or 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 five years, the Office of Children's Services has experienced overall increases in the numbers of finalized adoptions. It is expected that those numbers will continue to increase through FY2012 with 97 new adoptions and guardianships completed just in the first quarter.



Residential Child Care

Residential Child Care facilities deliver 24-hour high-quality, time-limited residential treatment services and care for abused, neglected, and delinquent children who are unable to remain in their own homes, or who need structured treatment. These children may be in custody of the Office of Children's Services or 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. Beginning in FY2013, these services will be administered through the Division of Behavioral Health.



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 a funding source of last resort to meet specialized needs. OCS also provides training and technical support specific to residential care for 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 of Alaska's three urban hubs, and three of those rural facilities provide flexible levels of service to ensure children receive the services needed as close to their home communities as possible.

Residential bed capacity and utilization of beds has remained fairly stable at around 70%. 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. Several rural shelters were made eligible to provide longer term services when appropriate for youth. This has allowed youth to stay in their home community when possible and may aid rural shelters to remain financially viable.

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



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

Annual Statistical Summary of Services Provided in FY2011

Early Intervention/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 FY2011, 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 are satisfied with the services they have received.
- Families have support systems.
- Families access desired services, programs and activities in their community.
- Over 91% of families reported that ILP did an excellent job helping them know their rights.
- Over 91% of families reported that ILP did an excellent job helping them effectively communicate their child's needs.
- Over 93% 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 37 classrooms with over 400 children in FY2011. Of the children receiving individual consultation, all but two remained in their child care program.

The Early Childhood Mental Health Learning Network provided training to 378 practitioners in FY2011, up from 104 in FY2010.

Strengthening Families Program

Strengthening Families builds protective factors around children by supporting family strengths and resiliency through early childhood and family support programs. These programs provided 122 hours of training to 712 participants in FY2011.

Protective Services Reports

Front Line Social 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, the assessment of allegations of child abuse and neglect to determine whether or not they are substantiated, and determine whether or not 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—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 into 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 is in the works between the OCS and tribal child welfare leaders to decrease this disproportionate and disparate statistic. This is being done through strategic planning with the Tribal State Collaboration Group and local plans between tribal and state partners.

It should be noted that the number for “Unique Count of Children in OOH Care...” includes trial home visits.

Protective Services Reports Screened In by State Fiscal Year							
	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Screened in for OCS Assessment	5,936	6,219	6,313	6,101	6,294	5,918	6,412
Protective Services Reports Screened Out by State Fiscal Year							
Screen Out Reason	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Differential Response	414	534	324	297	183	0	0
Does not Meet IA Criteria	1,478	1,787	2,289	2,386	3,548	4,630	7,487
Insuf. Info. To Locate	170	214	582	889	1,078	1,740	98
Law Enforcement Juris. Only	794	740	872	902	1,165	1,157	1,130
Mult. Ref. on Same Incident	121	238	488	571	798	881	955
Referred to Another State	17	40	45	35	51	64	58
Referred to Military or Tribe	201	254	346	273	324	185	38
Total	3,195	3,807	4,946	5,353	7,147	8,657	9,766
Total Protective Services Reports Screened by State Fiscal Year							
	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total PS Reports Received	9,131	10,026	11,259	11,454	13,441	14,575	16,178

Unique Count of Alleged Victims by State Fiscal Year							
	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Alleged Victims in Screened In Reports	7,957	8,652	8,468	8,475	9,011	8,315	8,815
Alleged Victims in Screened Out Reports	3,861	4,798	6,006	6,275	8,005	9,447	10,696
Total*	10,929	12,318	12,794	12,980	14,634	15,194	16,339

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

Unique Count of Children in OOH Care for Entire State Fiscal Year							
	FY06	FY07	FY08	FY09	FY10	FY11	
Native	1,620	1,754	1,883	1,926	1,834	1,778	
White	752	852	861	852	789	825	
Other	273	333	300	265	238	232	
Undetermined	27	33	23	27	30	78	
Number of Children	2,672	2,972	3,067	3,027	2,891	2,913	

Native - Alaska Native or American Indian only or in combination with other races
White - White only
Other - any single race other than White and any combination of non-Native races
The figures above include trial home visits

Absence of Recurrence by Region							
	FY06	FY07	FY08	FY09	FY10	FY11	
Anchorage	94.9%	95.0%	92.4%	92.5%	94.4%	94.7%	
Northern	90.5%	88.8%	92.6%	93.1%	90.1%	91.0%	
Southcentral	89.1%	89.2%	92.8%	92.4%	90.5%	93.1%	
Southeast	94.8%	87.7%	83.1%	90.2%	83.1%	84.6%	
Western*	-	-	-	-	-	91.8%	
Total Alaska	91.6%	91.1%	91.7%	92.4%	91.7%	92.4%	

*Western region was formed out of Southcentral at the beginning of SFY 2011
** National standard for absense of maltreatment recurrence is 94.6%

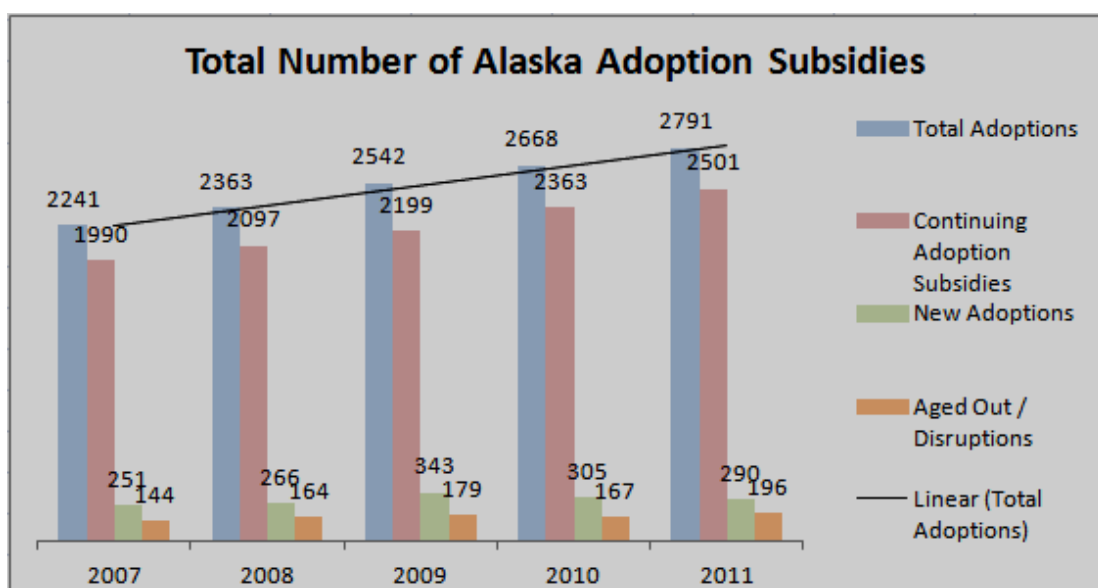
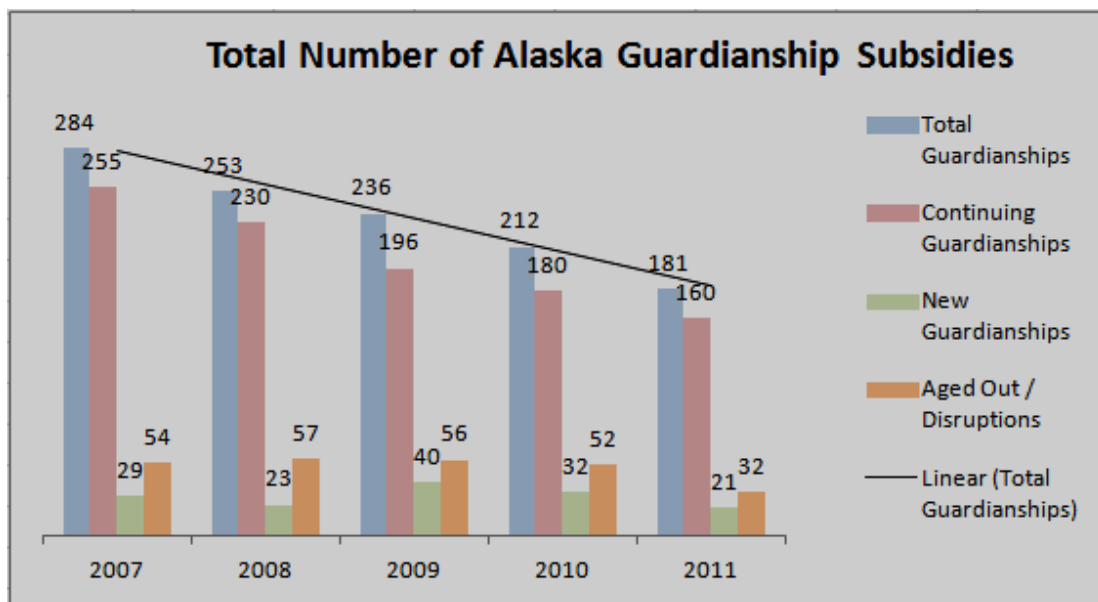
Data Source: allalleg; CPS_REPORT; spell_iu; and Absence of Recurrence report
Program used to tabulate statistics: SR11275.sas
Date of data: October 25, 2011

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 FY2011, that number was 2,746. The total number of Alaska subsidies for adoptions and guardianships has steadily increased over the past five years, and early FY2012 numbers indicate that trend will continue.

The following charts outline the continued growth of Subsidized Adoption and Guardianships since FY2007. These charts show the increase 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 FY2007 through FY2011 that provides detail on the numbers of subsidies and the funding sources. Please note that beginning April 13, 2011, State regulation became effective allowing for federal Title IV-E funding to be used for qualifying guardianship subsidies. Until this time, all guardianship subsidies were funded by state general funds.

Adoptions and Guardianship Subsidies by State Fiscal Year					
Totals by Subsidy Type	Fiscal year				
Adoptions Funded through Title IV-E Funds	2007	2008	2009	2010	2011
IV-E Continuing Adoptions	1658	1721	1764	1875	1963
IV-E New Adoptions	188	183	262	221	212
IV-E Aged Out	102	130	127	124	150
IV-E Disrupted	25	10	24	9	10
Current=Continuing + New - Aged Out - Disruptions	1719	1764	1875	1963	2015
Adoptions Funded by the State of Alaska					
State Continuing Adoptions	332	376	435	488	538
State New Adoptions	63	83	81	84	78
State Aged Out	11	21	25	30	36
State Disrupted	6	3	3	4	0
Current=Continuing + New - Aged Out - Disruptions	378	435	488	538	580
Guardianship funded through Title IV-E Funds					
Guardianships Continuing	n/a	n/a	n/a	n/a	0
Guardianships New	n/a	n/a	n/a	n/a	2
Guardianships Aged Out	n/a	n/a	n/a	n/a	0
Guardianship Disrupted	n/a	n/a	n/a	n/a	0
Current=Continuing + New - Aged Out - Disruptions					2
Guardianship funded by the State of Alaska					
Guardianships Continuing	255	230	196	180	160
Guardianships New	29	23	40	32	21
Guardianships Aged Out	42	48	43	42	23
Guardianship Disrupted	12	9	13	10	9
Current=Continuing + New - Aged Out - Disruptions	230	196	180	160	149
TOTALS					
(TTL) YTD New Adoption/Guardianship	280	289	383	337	313
plus TTL continuing Adoption/Guardianship	2245	2327	2395	2543	2661
less TTL YTD Aged Out	155	199	195	196	209
less TTL Disruptions	43	22	40	23	19
Total Children in Active Subsidies at the end of the FY	2327	2395	2543	2661	2746

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 FY2013 Operating Budget Requests

Office of Children's Services

Budget Overview Table

Office of Children's Services	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$81,741.4	\$83,395.8	\$1,654.4
Designated General Funds	2,250.0	2,100.0	-150.0
Federal Funds	45,781.8	46,278.1	496.3
Other Funds	3,621.1	3,696.1	75.0
Total	\$133,394.3	\$135,470	\$2,075.7

Budget Requests

Early Intervention for Young Children: \$525.0 (\$350.0 GF/MH, \$175.0 MHTAAR)

This increment will be used to continue and expand implementation of two projects recommended by the Alaska Early Childhood Comprehensive Systems Plan in order to improve services for young children (birth to five) with behavioral health challenges: early childhood consultation and the early childhood mental health learning network. The early childhood consultation project targets improving early care and learning environments and reducing expulsions from early care and learning programs. It does this by addressing challenging behavioral issues and preventing serious social and emotional issues from developing. Both child-specific and program consultation is provided. The early childhood mental health learning network provides training, consultation, technical assistance, and support to mental health clinicians, family support workers, early interventionists, and others working with young children and their families. Delaying age-appropriate interventions with young children and their families can allow problems to become more significant, requiring more costly interventions at a later date.

Foster Parent & Parent Recruitment Training & Support: \$276.0 (\$138.0 GF/MH, \$138.0 MHTAAR)

This increment will be utilized to recruit and screen potential resource families and provide training and technical assistance for parents and resource families of youth experiencing serious emotional disturbances. The OCS will manage the funds and contract to recruit and screen resource families, as well as provide technical assistance to retain these parents. The services are intended to improve the ability of parents and foster parents to effectively parent children with severe emotional disturbances and to reduce the need for out-of-home care and for residential placements. If not funded, training will not occur and advancement toward appropriate foster homes for individual children in custody will continue to be in shortfall.

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

The State Early Intervention/Infant Learning Program Office (EI/ILP) office is supporting three early childhood demonstrations sites to fully implement the “Teaching Pyramid” to support social competence and prevent challenging behaviors in young children. The Positive Parenting Training 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. 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. Training will be provided to foster and biological families on the following six (3-hour) modules:

- 1) “Making a Connection: Building Positive Relationships with Children”
- 2) “Making It Happen: The Power of Encouragement”
- 3) “Why Children Do What They Do: Determining the Meaning of Behavior”
- 4) “Teach Me What to Do: Making Expectations Clear and Consistent”
- 5) “Facing the Challenge – Part 1: Strategies to Promote Positive Child Behavior in Home & Community Settings”
- 6) “Facing the Challenge – Part 2: Developing and Using an Individualized Positive Behavioral Support Plan”

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 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 two years with completion in November 2011. Implementation efforts required concentrated resources, leaving the division struggling to develop, train, and maintain specific portions of the plan while continuing to provide services to children and families.

The Office of Children's Services must continue to focus on increasing the timeliness of investigations, enhancing the initial assessment practice through statewide implementation of the Protective Capacity Assessment (PCA), implementing family contact, developing and supporting supervisors, increasing quality case worker visits, working with tribes to reduce disproportionality, and working across divisions to increase the availability and accessibility of service delivery to children and families.

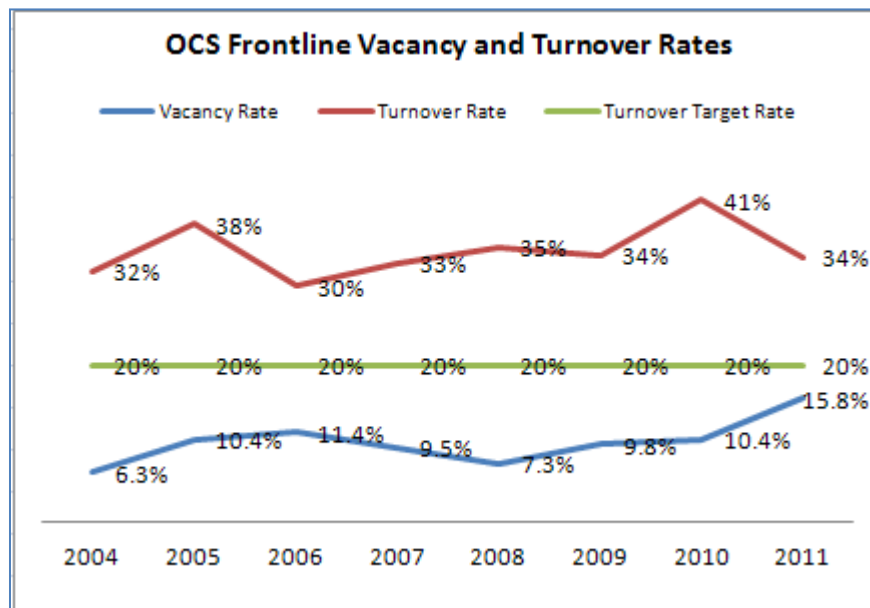
The Office of Children's Services will complete statewide training and implementation of the PCA. The PCA is a structured interactive process intended to build partnerships with caregivers in order to identify and seek agreement regarding what needs to change in relation to child safety, and to develop case plans that will effectively address caregiver protective capacities, child needs, and permanency. The PCA has been piloted in Anchorage and Fairbanks in order to help develop policy, documentation, curriculum and practice.

Frontline Staff Recruitment and Retention

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

The 2011 staff survey continues to indicate that most front-line caseworkers have been employed with the Office of Children's Services less than two years. Relatively new workers at the front line are reflective of the trend of high turnover rates in this job class.

Despite specific efforts to combat high vacancy and turnover at the OCS, both rates remain high.



In an effort to improve OCS' 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 Child Welfare Academy, the Division of Personnel, and several members of OCS staff.

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 from current employees to frequently asked questions that focus on both the positive and the negative aspects of employment as a front-line caseworker 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 though progress is extremely slow.

Implementation of Public Law 110-351

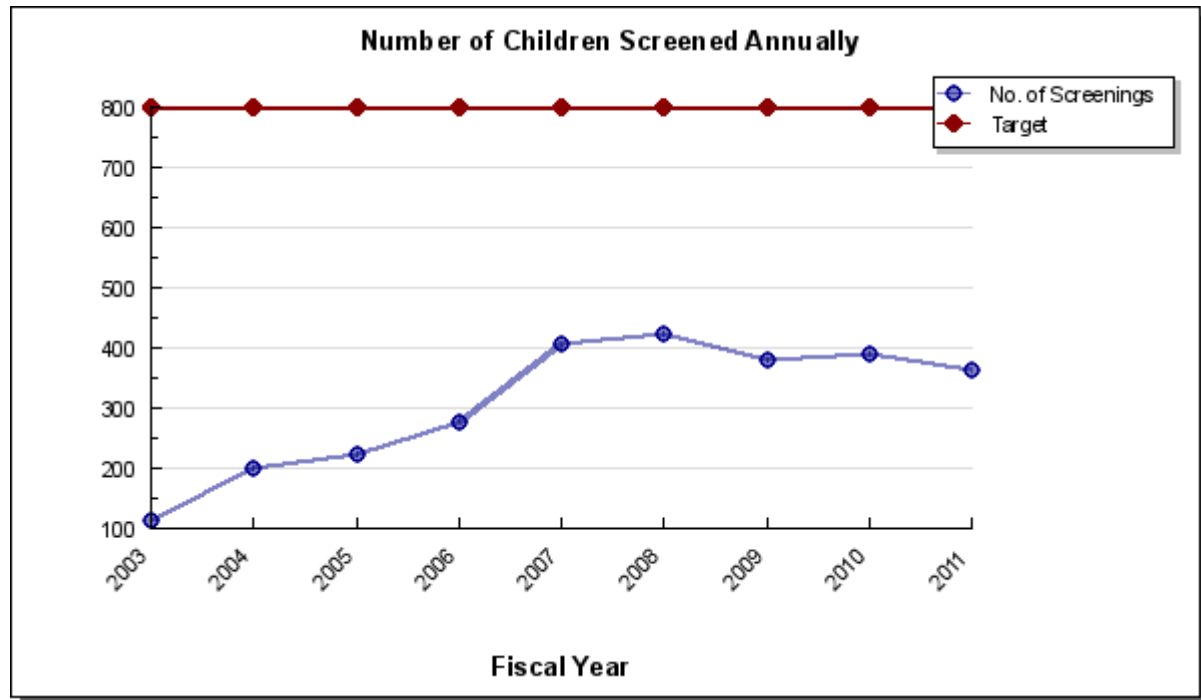
The President signed the Fostering Connections to Success and Increasing Adoptions Act into law October 7, 2008. Generally, the law amends the Social Security Act to extend and expand adoption incentives through 2013; creates an option to provide kinship guardianship assistance payments; creates an option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

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 referred from Child Protective Services.

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 eight years. In FY2003, 113 children were screened. In FY2011, 365 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 2011	365	800
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.

In 2003, Congress passed the Child Abuse Prevention and Treatment Act 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 years of age 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 to 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, instances of abuse or neglect have already occurred, but by providing screening and subsequent services, the likelihood of repeat maltreatment is reduced.

As the number of screenings increase, the program aims to improve 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, eligibility for EI/ILP services was based on education-based domains of development, but strategies must be developed to assure referrals of children who are not yet of school age.

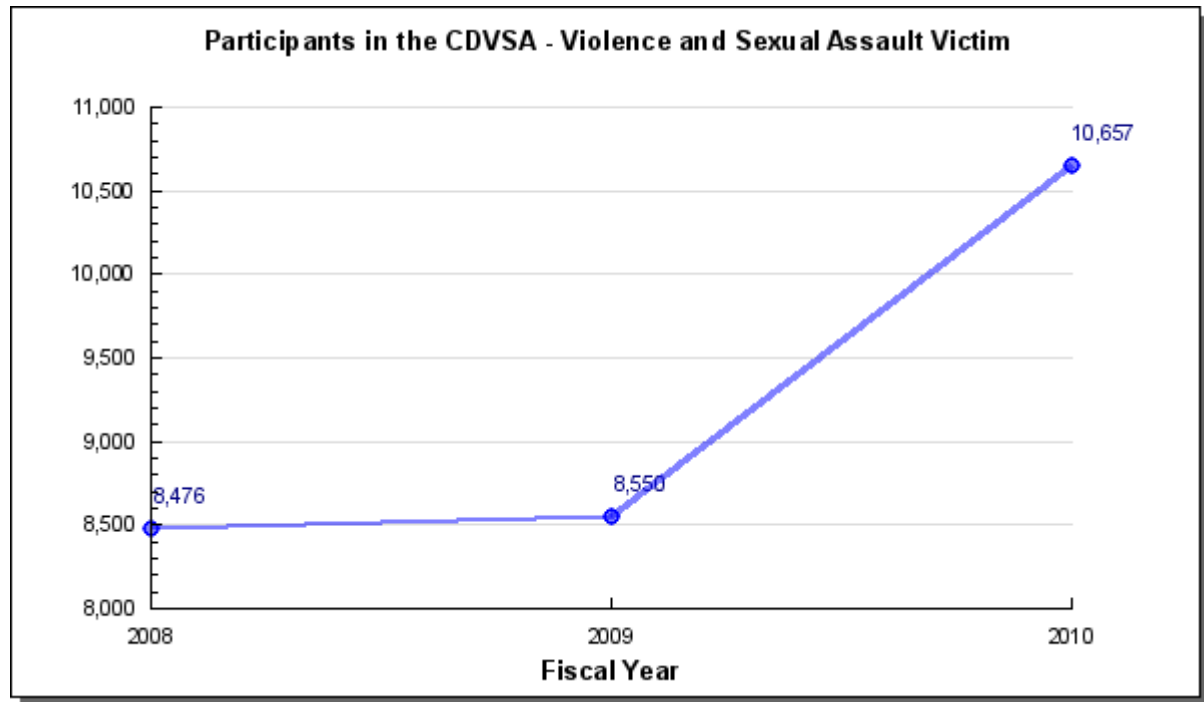
In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%, while 182 children (10%) had social and emotional delays greater than 50%. Current programs do not have the capacity to provide adequate training and 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 increase as child protection services and EI/ILP continues to improve communication and understanding of how best to provide supports to these children and families.

EI/ILP continues to identify an increase in the number of 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 this issue. EI/ILP currently has a cohort of six providers receiving training in the treatment of social and emotional delays.

Target #2: Reduce incidents of domestic violence and sexual assault.

Status #2: The target to reduce incidents of domestic violence and sexual assault was not met.

In FY2010, Alaskans reported 10,657 incidents, a 25% increase from the 8,550 incidents reported in FY2009, and a 26% increase from the 8,476 incidents reported in FY2008. (Source: AK Council on Domestic Violence and Sexual Assault Annual Report to Governor Parnell, 2010, page 10.)



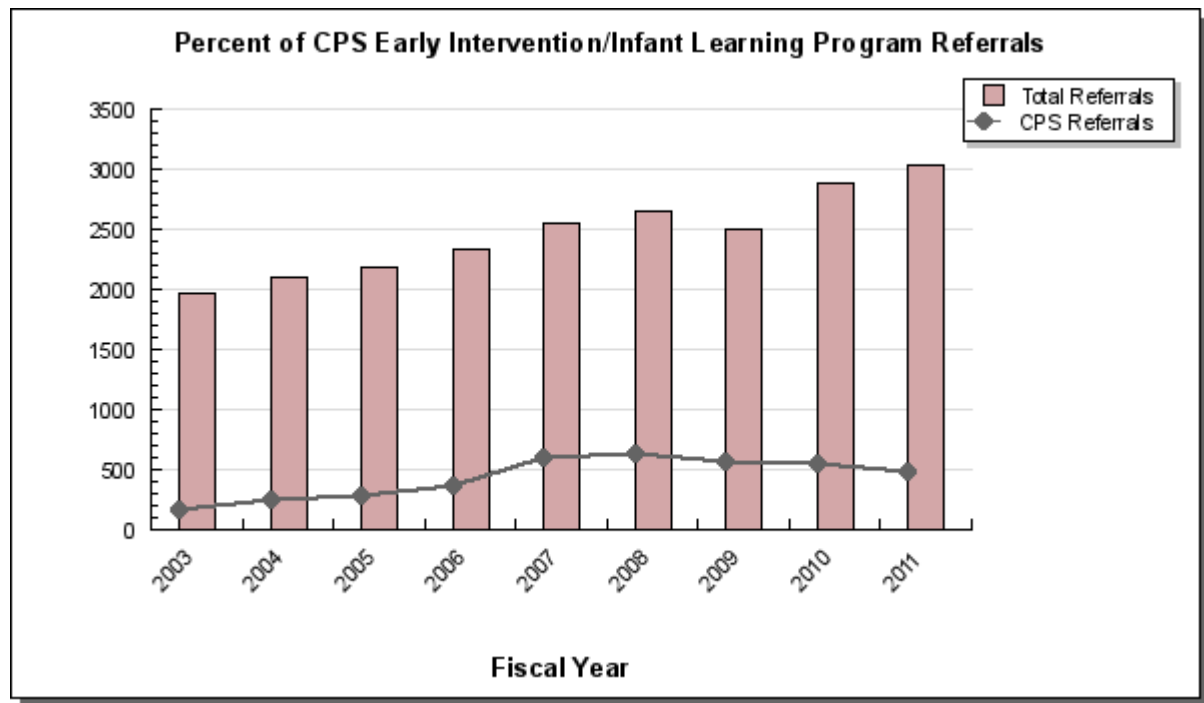
Participants in the CDVSA - Violence and Sexual Assault Victim

Fiscal Year	YTD Total
FY 2010	10,657 +24.64%
FY 2009	8,550 +0.87%
FY 2008	8,476

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 Early Intervention/Infant Learning Program (EI/ILP) referrals of children ages 0-3 year olds that are from Child Protective Services.

Status #1: The percentage of Early Intervention/Infant Learning Program referrals from Child Protection Services increased 55% from FY2003 to FY2008. The numbers decreased by 1% in FY2009, 2% in FY2010 and 3% in FY2011.



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

Percent of CPS Early Intervention/Infant Learning Program Referrals

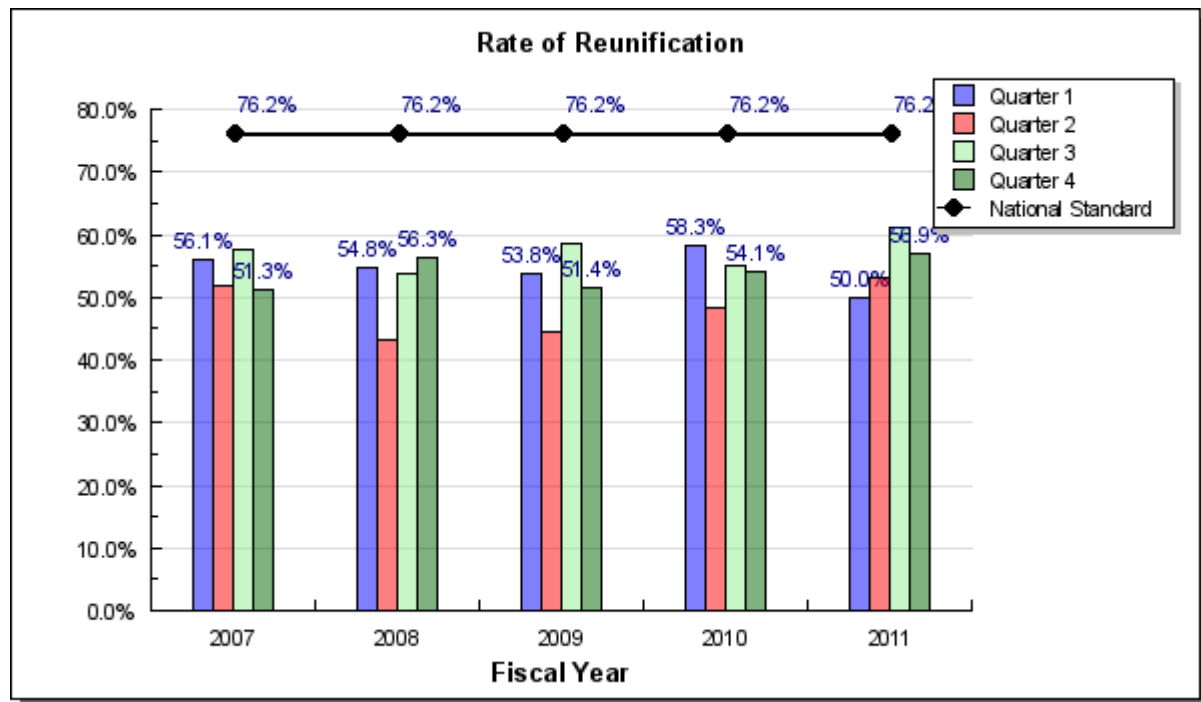
Fiscal Year	Total Referrals	CPS Referrals	Percent
FY 2011	3030	482	16%
FY 2010	2890	544	19%
FY 2009	2503	574	21%
FY 2008	2657	630	22%
FY 2007	2557	602	21%
FY 2006	2331	363	15%
FY 2005	2182	280	13%
FY 2004	2107	248	12%
FY 2003	1964	169	9%

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 through FY2011 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 1.5% in FY2011.



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	50.0%	53.2%	61.2%	56.9%	76.2%
FY 2010	58.3%	48.4%	55.2%	54.1%	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 reunification rate increased by 1.7% between FY2009 and FY2010, and by an additional 1.5% in FY2011. 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.

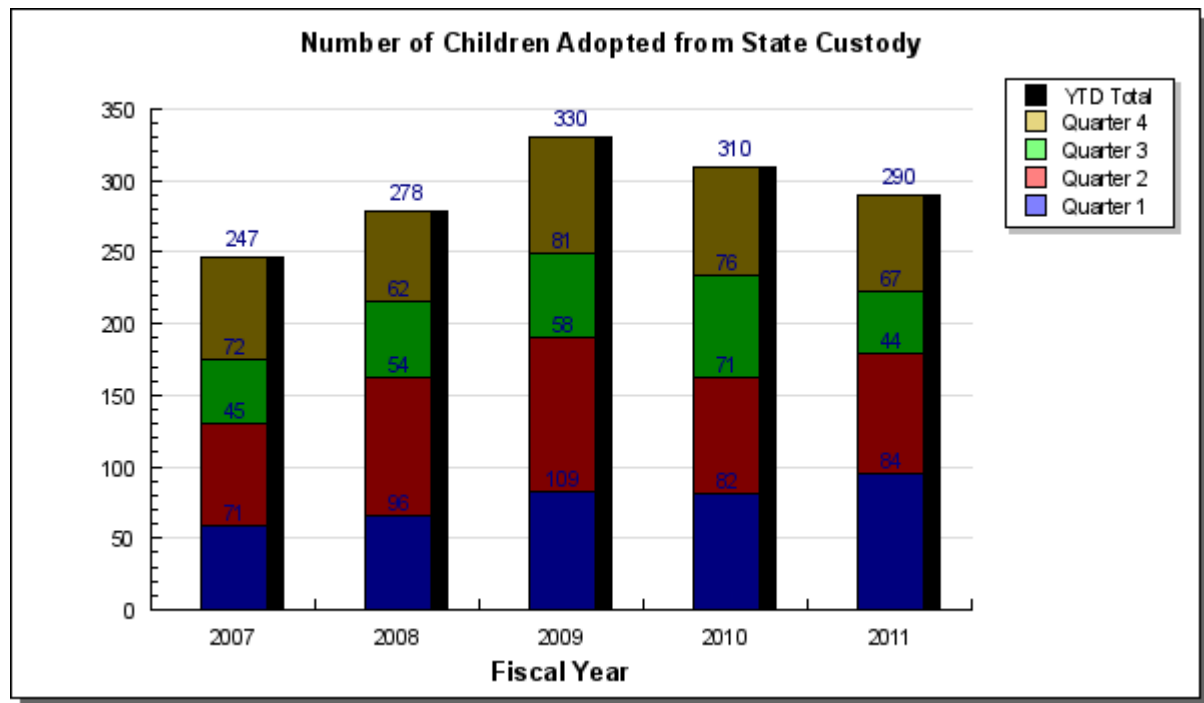
By successfully completing the implementation of the new practice model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new model encourages 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 FY2007 to FY2008, by 52 in FY2009. In FY2010, 20 fewer adoptions were completed. FY2011 realized another drop of 20 completed adoptions. This leveling of the numbers of completed adoptions is anticipated as the number of children in out-of-home care decreases.



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	84	44	67	290
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 chart above shows the number of finalized adoptions as reported by State Fiscal Year. As anticipated, FY2010 and FY2011 realized slight drops in the number of children who reached permanency through adoption due to the reduction of children

in out-of-home care. As of June 30, 2011, however, the total number of children in the subsidized adoption program has grown to 2,673. OCS continues to place emphasis on meeting the 15 out of 22 month timeframes outlined in the Adoption and Safe Families Act.

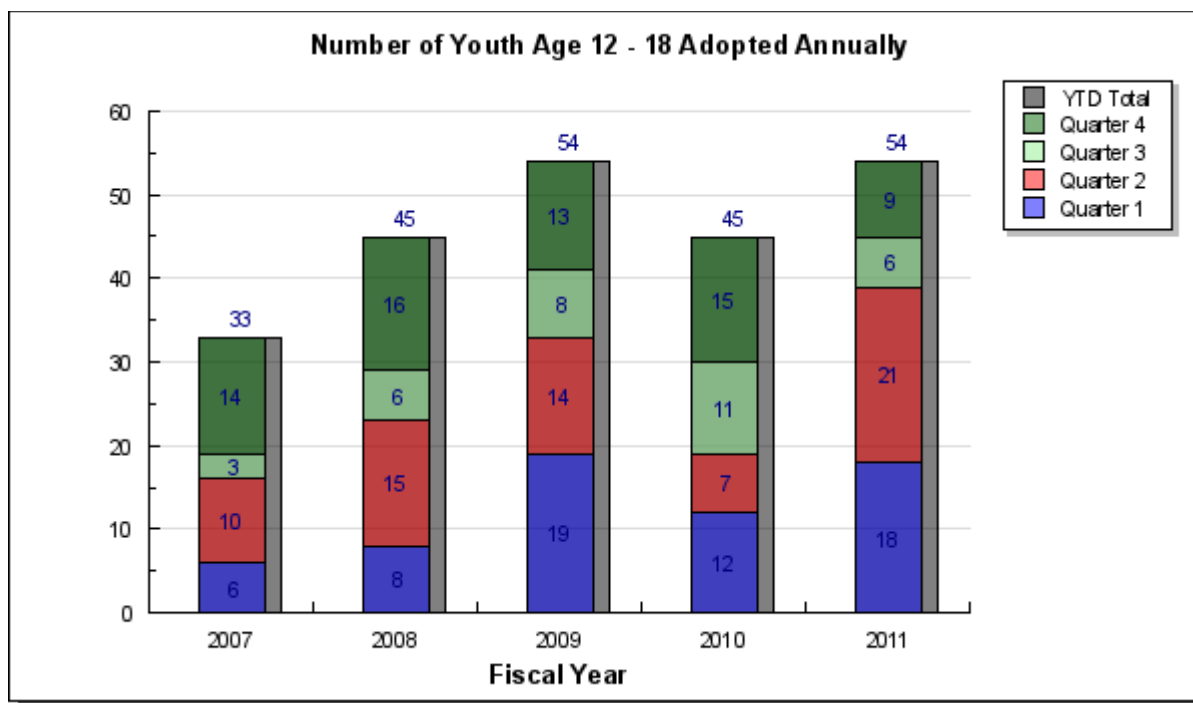
Target #2: Decrease the rate of child abuse and neglect per 1,000 children ages 0-17.

Status #2: The target to decrease the rate of child abuse and neglect was met. In FY2010 that rate equaled 17.4 victims per 1,000 children. In FY2011 that rate dropped slightly to 17.1. (Source: DHSS ORCA)

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 FY2007 to FY2008 and another 20% in FY2009. In FY2010, the number decreased by 17%, but increased by 17% in FY2011.



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

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

Number of Youth Age 12 - 18 Adopted Annually

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2011	18	21	6	9	54
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 FY2010. In FY2011, 98.3% received service coordination.

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

Status #3: In FY2010, DHSS Children's Services had a 28% turnover rate with a 9% vacancy rate in the social services workforce. In FY2011, the overall turnover rate was 28.7% with an 18.7% vacancy rate in the social services workforce.

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

Status #4: In FY2010, 23.4% of child protection assessments were completed within 45 days. In FY2011 that percentage dropped to 22.1%.

Target #5: Increase the percentage of 0-3 year olds with a substantiated report of harm from Child Protective Services to the Early Intervention/Infant Learning Program.

Status #5: In FY2010, 42% of 0-3 year old children with a substantiated report of harm were referred to the Early Intervention/Infant Learning Program from Child Protective Services. The percentage of children referred in FY2011 fell to 30%.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Children's Services</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Eliminate Administrative Funds - Children's Trust No Longer Held by State	\$ -	\$ (150.0)	\$ -	\$ -	\$ (150.0)
MH Trust: BTKH - Grant 1926.04 Foster Parent & Parent Recruitment training & support	\$ 138.0	\$ -	\$ -	\$ 138.0	\$ 276.0
MH Trust: BTKH - Grant 2550.03 Early Intervention for Young Children	\$ 350.0	\$ -	\$ -	\$ 175.0	\$ 525.0
MH Trust: Gov Cncl - 1207.05 Early Intervention/Infant Learning Pgm Positive Parenting Training	\$ -	\$ -	\$ -	\$ 80.0	\$ 80.0
Reverse American Recovery and Reinvestment Act (ARRA) Funding Sec 33(d) CH3 FSSLA2011 P92 L8-12 (HB108)	\$ -	\$ -	\$ (3.6)	\$ -	\$ (3.6)
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ 318.0	\$ 318.0
<i>Children's Services Total</i>	\$ 488.0	\$ (150.0)	\$ (3.6)	\$ 711.0	\$ 1,045.4

Division of Health Care Services

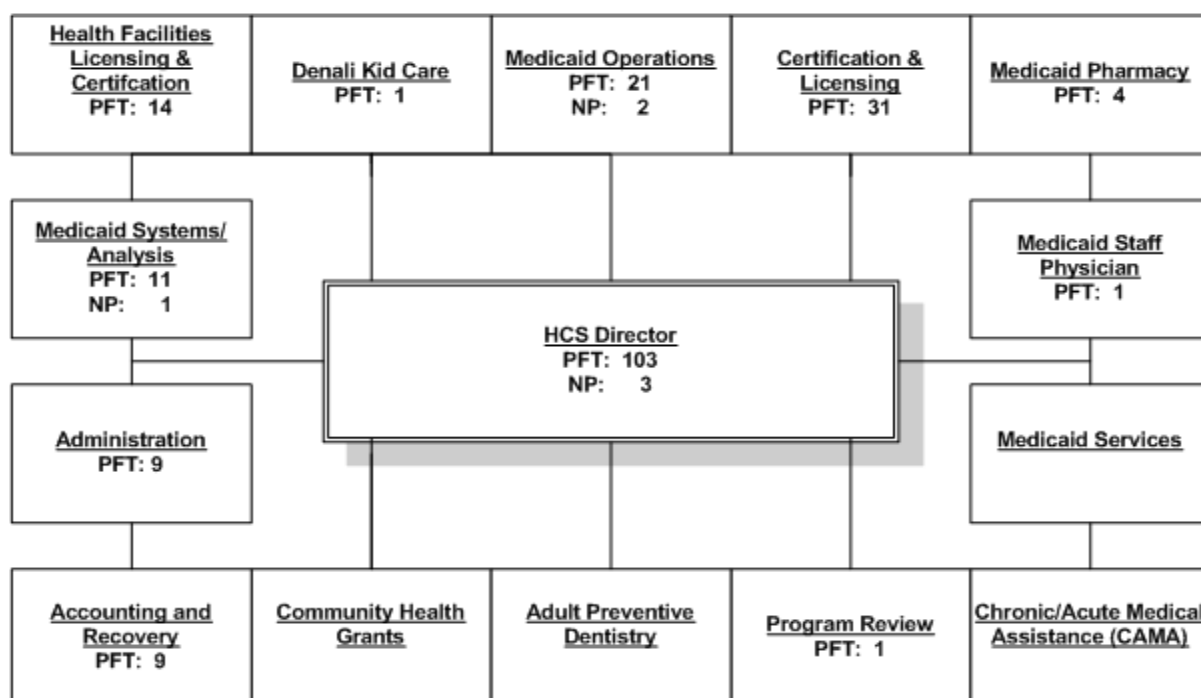
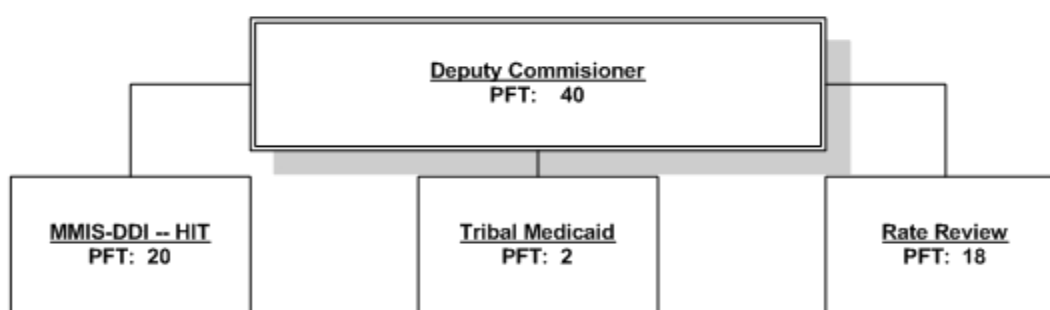
Health Care Services

Operational Structure

PFT: 143

PPT: 0

NP: 3



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

Since 2007, the Adult Preventative Medicaid Dental program has provided restorative and preventive dental services that were previously not available to adults. Fiscal limits set by the legislature limit total Adult Preventative Dental program costs, ensuring that 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 offers 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.

Adult Preventive Dental covered services are limited to \$1,150 per person per year. Recently-adopted regulations, however, allow an individual to 'borrow' the upcoming year's limit so that he or she may receive both upper and lower dentures at the same time, as a single year's limit will not cover both.

The program supports the Department's mission to manage health care for eligible Alaskans in need. Providing adult preventive 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 more smooth and 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 care services through Medicaid improves the Department's goal of healthy Alaskans living 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 providers through policy and regulation development, implementation, and oversight. The unit completes research, analysis, planning, and program implementation for the preceding provider types. The unit ensures services to vulnerable Alaskans are high quality and cost effective. 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 implemented a new payment methodology to appropriately reimburse pharmacy providers for dispensing medications and establish a new pricing tool to accurately reimburse providers for medications. The former tool was retired due to federal litigation. The Pharmacy and Ancillary Services unit has several initiatives, enumerated below. These initiatives provide excellent pharmaceutical care through the following:

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's needs, the physicians' knowledge, and the state's purchasing power. The PDL supports cost efficiency when preferred drugs are prescribed and dispensed. Alaska Medicaid participates in the National Medicaid Pooling Initiative to obtain the best rebates.

Pharmacy and Therapeutics Committee (P&T):

The P&T Committee is 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, physician assistants, and nurse practitioners. The P&T Committee is responsible for determining which drugs are effective and whether these should/should not be on the PDL.

Drug Utilization Review Committee (DUR): The DUR Committee is responsible for maintaining appropriate use of medications and to prevent inappropriate use and adverse reactions. This program ensures that medications are used safely and appropriately by our Medicaid recipient population. DUR activities are overseen by a committee of licensed Alaskan health care professionals.

Prospective drug utilization review (ProDUR) is performed by all Alaska Medicaid enrolled pharmacists before filling any prescription for a Medicaid recipient. Proprietary software is used to check for potential problems with a Medicaid patient's medication therapy. This immediate review of prescriptions at the time of filling assists pharmacists in determining if the medication is appropriate and will bring to the attention of the pharmacist concerns such as drug-interactions, therapeutic duplications, early refills, pregnancy cautions, and other potential problems.

Medicaid Operations Unit

The Operations Unit performs program management and oversees policy for core Medicaid services, including those delivered at inpatient and outpatient facilities and by physicians and other practitioners. The Operations Unit is also responsible for program management of recipient services, including operation and oversight of a toll-free help line, transportation coordination and prior approval, provider/recipient liaison, provision of case management services, and facilitation of fair hearings.

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

The unit is responsible for contract management of all fiscal agent activities, and 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 to resolve recipient and provider disputes regarding eligibility and claims processing.

Accounting and Recovery Unit

The Accounting and Recovery Unit provides financial and collection services to support the Department's Medicaid divisions. The primary responsibilities of the accounting staff 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.

This unit is also responsible for pended claims related to Third Party Liability (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. Additionally, this

unit administers the Working Disabled Program, the Health Insurance Premium Payment (HIPP) program, the Estate Recovery Program, and works in tandem with the Department of Law on subrogation and trust cases. The cost recovery activities apply to all Departmental Medicaid services.

Chronic and Acute Medical Assistance (CAMA)

The CAMA program provides a limited package of state general fund and only provides health services to those individuals with covered medical conditions who do not qualify for the Medicaid program. Select outpatient and prescription services are available to CAMA recipients with 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 for the whole age range from birth to death at or through tribal health care facilities statewide. This includes oversight and liaison work across divisions within the Department. Tribal healthcare delivery is considered a state-wide three-tiered system that is managed through 16 regional health organizations and 17 local health organizations from hospitals to sub regional clinics to village clinic sites.

This unit serves both as a liaison and as a technical assistance resource to each of the Medicaid divisions within the Department to develop, maintain and enhance existing tribal functions (waivers, Behavioral Health, Division of Public Assistance Eligibility Information System (EIS) access, hospital and clinic based services, administrative claiming efforts, settlements, Senior and Disability Services (SDS) and new Long Term Care (LTC) facilities, etc); assists with expansion of tribal refinance efforts through data analysis to promote capacity building in the tribal health care system; maintains 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 oversee 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.

Additionally, the unit 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 the Department's Grants and Contracts staff.

The unit also provides research and analysis with regard to MMIS processing outcomes, as well as decision support system training and support to the Department's 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.

The unit also has responsibility for the State's Certificate of Need (CON) program. The CON program administers State statutes requiring preliminary reviews of large health care projects to ensure the projects are needed and practical additions to the State's health care infrastructure, and to provide a public process for proposed large health care projects.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is an expansion of the Medicaid program in Alaska. It is managed through the same rules and processes as Medicaid in general. The program, implemented in Alaska in 1999 covers children and teens through age 18; and, is a part of the Denali KidCare program. Services include comprehensive Early Periodic Screening Diagnostic Treatment (EPSDT) services, a children's Medicaid service provision. The program has Federal authorization through 2019, most recently being extended by the Affordable Care Act (ACA) of 2010 that extended CHIP authorization through 2019 and funding through 2015. Under CHIPRA, in 2010, Alaska, Oregon, and West Virginia, were awarded \$15,000,000 for a children's quality of care five-year demonstration that encompasses evaluation of 24 children's quality measures and patient-centered medical homes (PCMH), and care coordination models integrating health information technology (HIT).

Child enrollment in Medicaid and CHIP is illustrated in the charts below. The blue line below reflects the number of children funded under CHIP, with Title XXI enhanced federal financial participation (FFP). For example, for every dollar spent on children financed under the CHIP, the federal government contributes \$.65 and the state general fund (GF) match is \$.35. Children and others enrolled in Medicaid are funded with a lower FFP in that the federal government contributes \$.50 and the state GF match is \$.50.

Certification and Licensing

The Section of Certification and Licensing's overall responsibility is to protect and reduce the risk to the health, safety, and exploitation of Alaska's most vulnerable citizens being served, and to ensure that there is public confidence in the health care and community service delivery

systems through regulatory, enforcement, and educational activities. This is accomplished by: 1) inspecting adult and children's residential facilities to ensure compliance with state licensing requirements; 2) providing essential technical assistance to residential providers, as needed; 3) receiving and investigating complaints involving resident physical, mental, and sexual abuse, financial exploitation, and safety/sanitation concerns; 4) providing facilities with a notice of violation, when necessary, and taking appropriate action when facilities fail to come into compliance with state or federal law; and 5) ensuring a process wherein all service providers with direct client access must have a background check.

The Adult and Children's Residential Licensing Program is responsible for the inspection, licensure, and investigations of approximately 670 facilities statewide that are required to meet state and federal licensing mandates. Other responsibilities of the program include, providing consultation to licensees, working with other government agencies to compliment licensing functions, and working with individuals, groups, and communities to encourage and support the development of safe and effective residential care homes.

The Background Check Program is responsible for improving the overall safety and security of vulnerable individuals in state licensed and /or certified programs, by providing safeguards against abuse and neglect of individuals receiving direct care services. These functions are accomplished through the implementation of a fingerprint-based criminal history investigation and fitness determination program administered to all staff serving vulnerable populations. Since April 2006, the program has processed over 100,000 applications.

Health Facilities Licensing and Certification

The State Survey Agency is responsible for performing certification functions created by section 1864 of the Social Security Act. Health Facilities Licensing and Certification conducts initial surveys (inspections), periodic resurveys, and complaint surveys for 17 different categories of health providers in the State of Alaska. Surveys are conducted to determine 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 State Agency conducts validation surveys of accredited and deemed facilities in order to furnish the U.S. Department of Health and Human Services (DHHS) a monitoring of the validity of surveys conducted by accrediting bodies.

The Health Facilities Licensing and Certification unit 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 unit's regulatory oversight of health care facilities includes renewing, and if warranted, denying, suspending, or revoking licenses when there is substantial failure to comply with regulatory requirements.

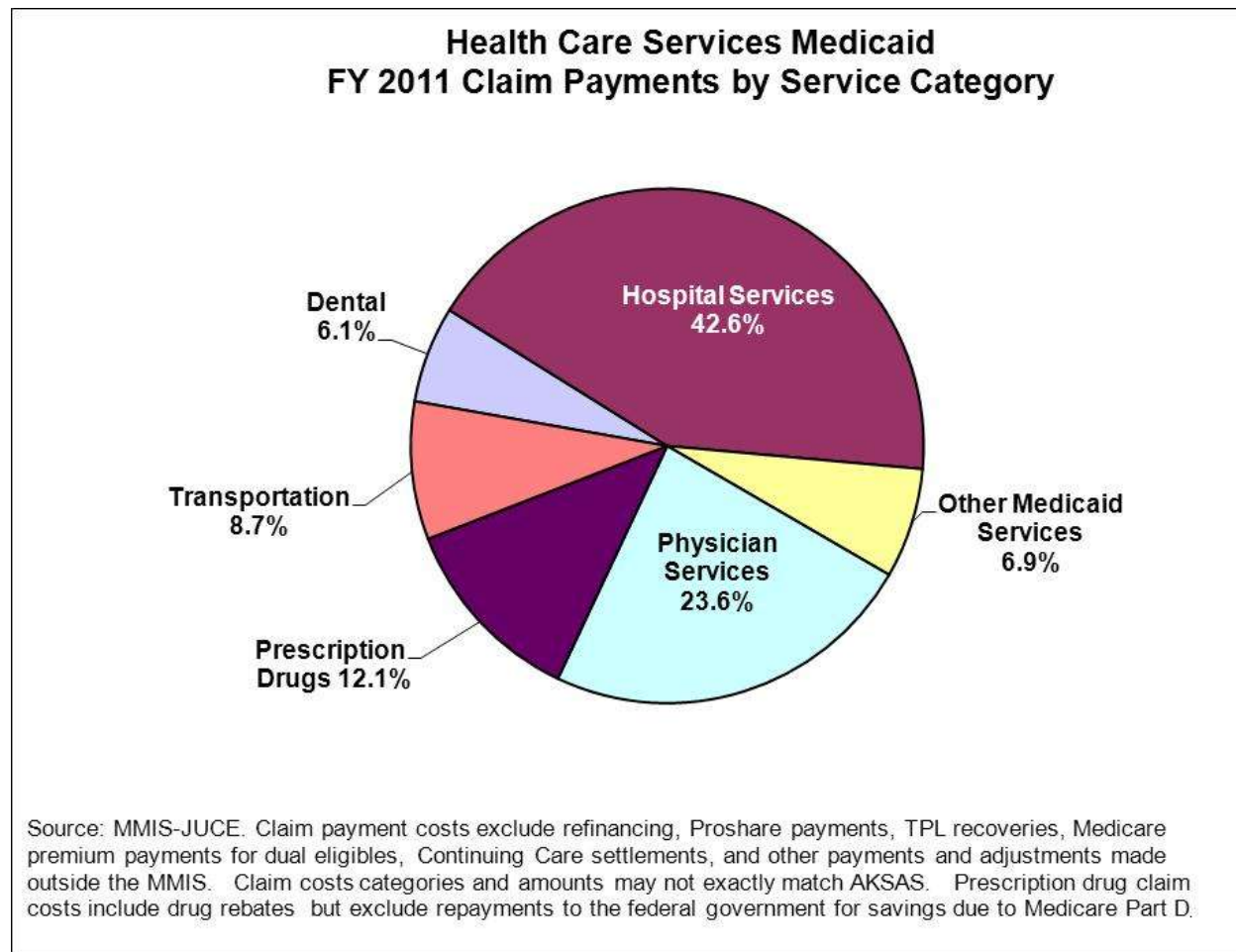
Health Facilities Licensing and Certification, in conjunction with the Centers for Medicare and Medicaid Services and the State's Medicaid Program, promotes efficiency and quality within the health care delivery system.

Annual Statistical Summary of Medicaid Services Provided in FY2011

Health Care Medicaid Services

The Health Care Services (HCS), Medicaid Services component, provides funding for medical assistance services provided for Medicaid enrollees and non-claim payments issued to cover Alaska Medicaid program service costs. In FY2011, approximately 94.4% of the HCS component's expenditures were utilized for direct Medicaid medical services payments. Direct medical assistance services include, but are not limited to, claims for medical services from hospitals, physicians, pharmacies (prescription drugs), dental services, transportation, and a wide range of other preventive and acute care services. Non-claim payments include supplemental payment programs (e.g., Disproportionate Share Hospital, Upper Payment Limit), as well as Medicare premium payments and judgment restitutions.

In FY2011, Health Care Services Medicaid expenditures comprised 54.5% of the total expenditures for all Alaska Medicaid claim payments. Hospital services accounted for the largest share of HCS Medicaid expenditures (42.6%), followed by physician services (23.6%), prescription drugs (12.1%), transportation services (8.7%), other services (6.9%), and dental services (6.1%).



In FY2011, the Alaska Health Care Medicaid Services component supplied medical and related services to 133,773 Alaskans, or 91.9% of all individuals eligible for the Alaska Medicaid program. The total cost of direct medical benefits provided to Medicaid enrollees through Health Care Services (HCS) totaled \$726,131.7 million dollars during FY2011. 62.8% of 2011 HCS claim payments provided medical services to children; 31.7% of expenditures provided services for adults; and 5.6% of payments provided medical care for elderly individuals. Approximately 2/3 of Medicaid Medical service expenditures made during FY2011 supported medical care for children and the elderly.

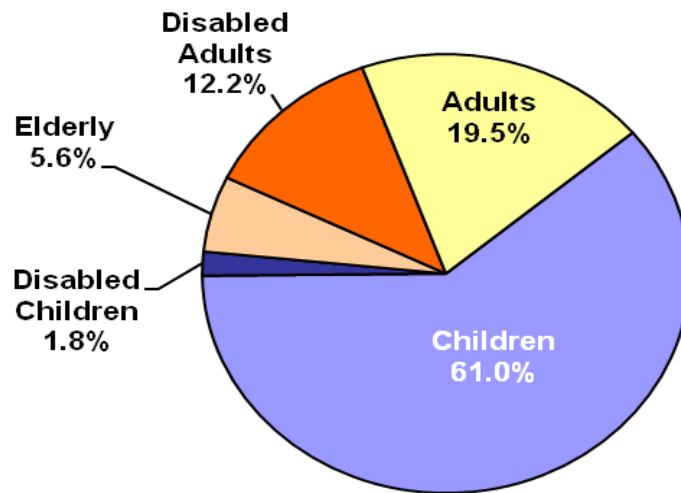
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Payments (thousands)	CPRPY
Children	61.0%	82,989	41.3%	\$299,707.5	\$3,611
Disabled Children	1.8%	2,399	4.9%	\$35,317.4	\$14,722
Elderly	5.6%	7,621	4.0%	\$28,959.6	\$3,800
Disabled Adults	12.2%	16,618	26.4%	\$191,370.0	\$11,516
Adults	19.5%	26,508	23.5%	\$170,777.2	\$6,442
Unduplicated Annual Clients		133,773			
Total Medicaid Claim Payments (dollars)				\$726,131,688	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					\$5,428

Source: MMIS/JUCE claims paid during FY11. CPRPY is annual cost per beneficiary. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

The benefit category "disabled Adults" includes disabled persons between 19 and 20 years of age, as well as adults over age 21.

Number of Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2011 (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 any time before June 30, 2011. If they later obtained dental services in December 2010, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2011.

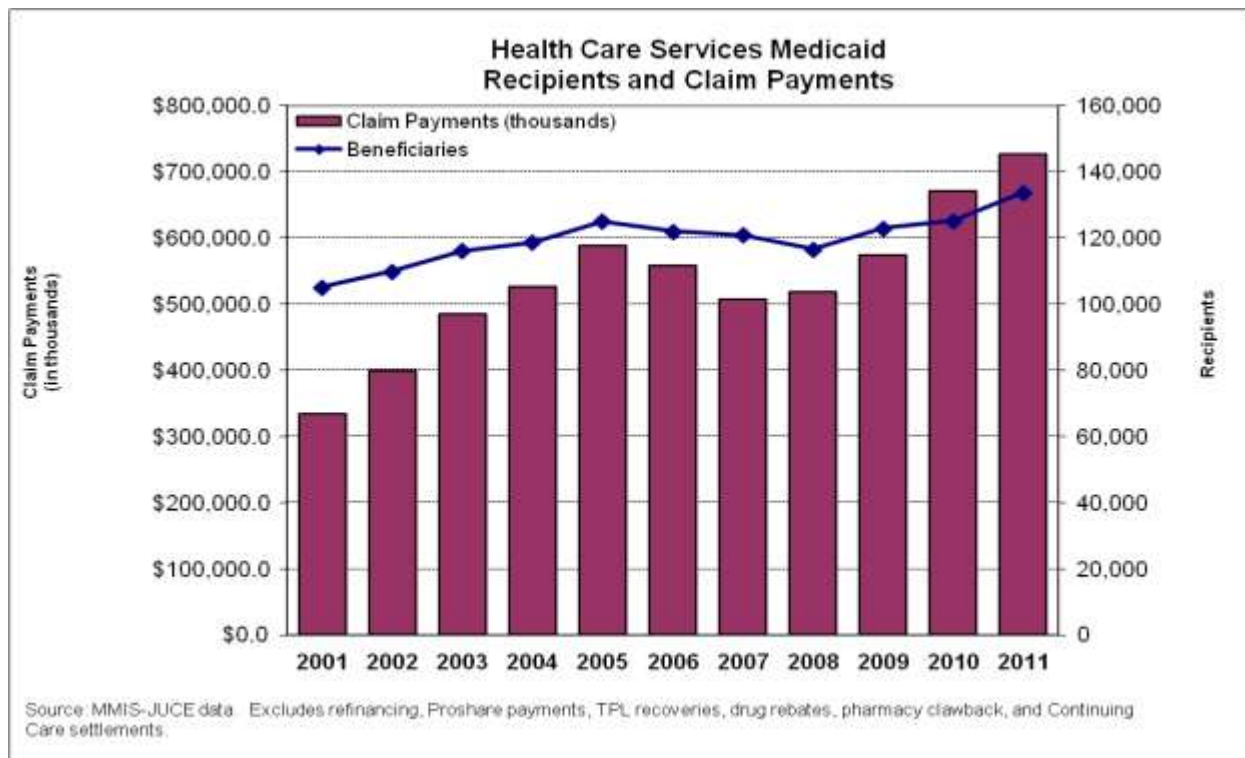
FY 2011 Health Care Services Medicaid Recipients by Benefit Group



Source: MMIS-JUCE data.

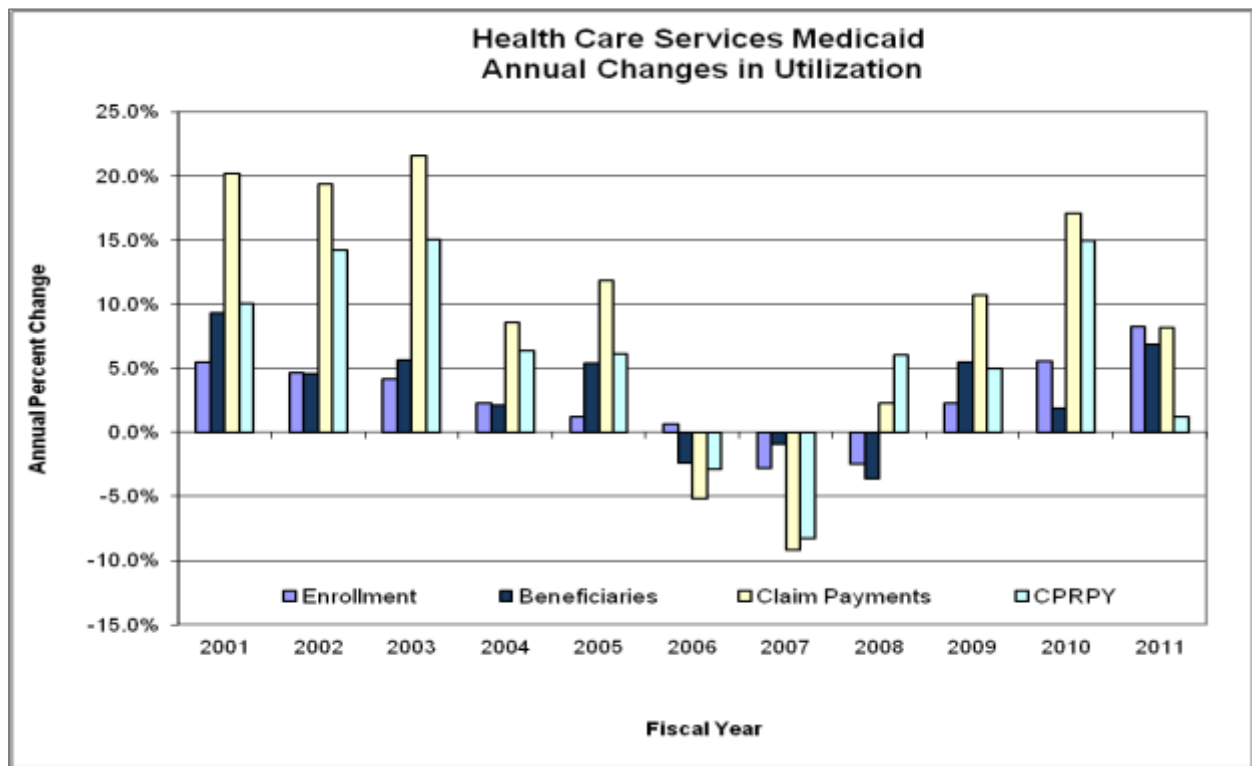
Total medical claim expenditures for Health Care Services Medicaid increased by 7.5% between FY2010 and FY2011, with increased reimbursements for medical services noticeable across several categories of service. This growth in expenditures can be attributed to a combination of increased recipient Medicaid service utilization, as well as, augmented service costs. The number of recipients utilizing HCS Medicaid services in FY2011 increased by 6.8% from FY2010. During this same period, the annual cost per recipient increased 1.2%, from an average cost of \$5,366 per participating recipient in FY2010 to \$5,430 in FY2011. As noted, increases in medical service costs can in most instances be directly linked to medical service rate changes issued by the Federal Centers for Medicare and Medicaid Services and increased utilization of Medicaid services.

All Medicaid Services*	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	63.4%	85,457	47.0%	\$341,098.4	\$3,991
21 or Older	36.6%	49,334	53.0%	\$385,075.7	\$7,805
Unduplicated Annual Clients			133,733		
Total Medicaid Claim Payments (thousands)				\$726,174.1	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$5,428	
Hospital Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	55.5%	42,228	46.2%	\$140,766.8	\$3,333
21 or Older	45.5%	33,875	53.8%	\$164,223.4	\$4,848
Unduplicated Annual Clients			75,717		
Total Medicaid Claim Payments (thousands)				\$304,990.2	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$4,028	
Physician Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	62.4%	70,782	48.9%	\$82,815.3	\$1,170
21 or Older	37.6%	42,701	51.1%	\$86,650.9	\$2,029
Unduplicated Annual Clients			112,855		
Total Medicaid Claim Payments (thousands)				\$169,466.1	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$1,502	
Pharmacy	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	60.5%	46,657	30.0%	\$25,998.1	\$557
21 or Older	39.5%	30,472	70.0%	\$60,711.1	\$1,992
Unduplicated Annual Clients			76,718		
Total Medicaid Claim Payments (thousands)				\$86,709.1	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$1,130	
Transportation	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	53.7%	15,952	52.3%	\$32,486.9	\$2,037
21 or Older	46.3%	13,765	47.7%	\$29,573.8	\$2,148
Unduplicated Annual Clients			29,609		
Total Medicaid Claim Payments (thousands)				\$62,060.8	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$2,096	
Other Medicaid Services	PCT of Recipients	Recipients	PCT of Payments	Payments (thousands)	CPRPY
Under 21	49.3%	28,070	48.8%	\$24,176.7	\$861
21 or Older	50.7%	28,818	51.2%	\$25,395.3	\$881
Unduplicated Annual Clients			56,642		
Total Medicaid Claim Payments (thousands)				\$49,572.0	
Average Annual Medicaid Cost per Recipient (CPRPY)				\$875	
Source: MMIS-JUCE:					
*The recipient counts and payments for All Medicaid Services include all services provided by Health Care Services. The table provides details for some, but not all, of the service categories.					



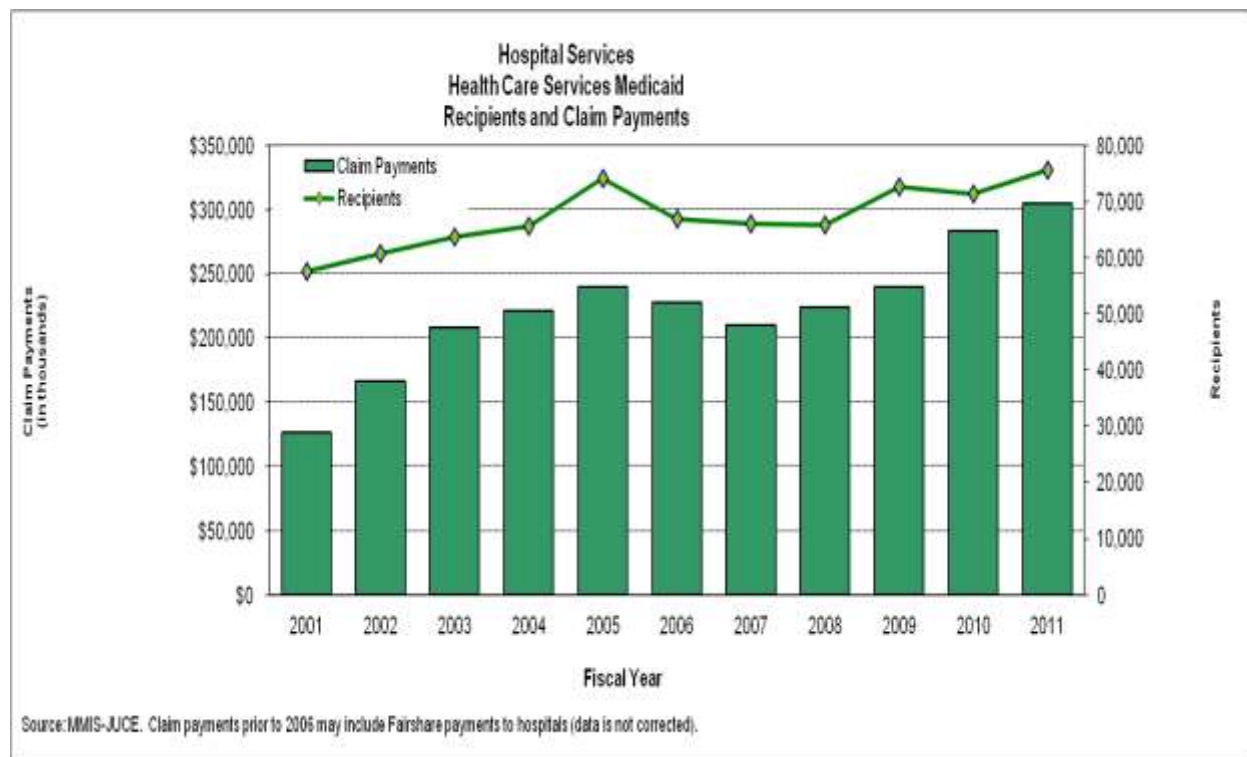
Health Care Medicaid Services Historical Utilization				
SFY	Annual Percent Change			
	Enrollment	Recipients	Claim Payments	Cost per Recipient per Year
2000	15.0%	20.2%	18.1%	-1.7%
2001	5.5%	9.3%	20.2%	10.0%
2002	4.6%	4.5%	19.3%	14.2%
2003	4.2%	5.6%	21.5%	15.0%
2004	2.3%	2.1%	8.6%	6.3%
2005	1.2%	5.4%	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%
2011	8.3%	6.9%	8.1%	1.2%

Source: MMIS-JUCE

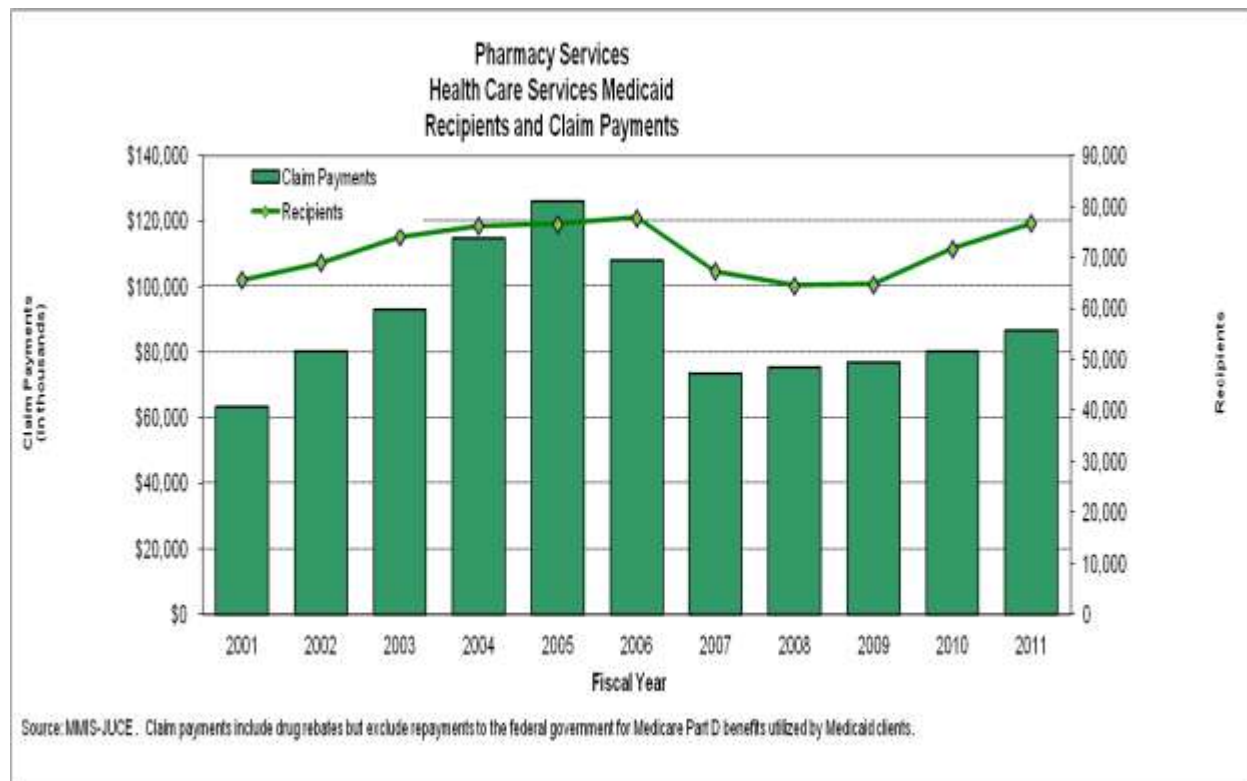


Source: MMIS JUCE

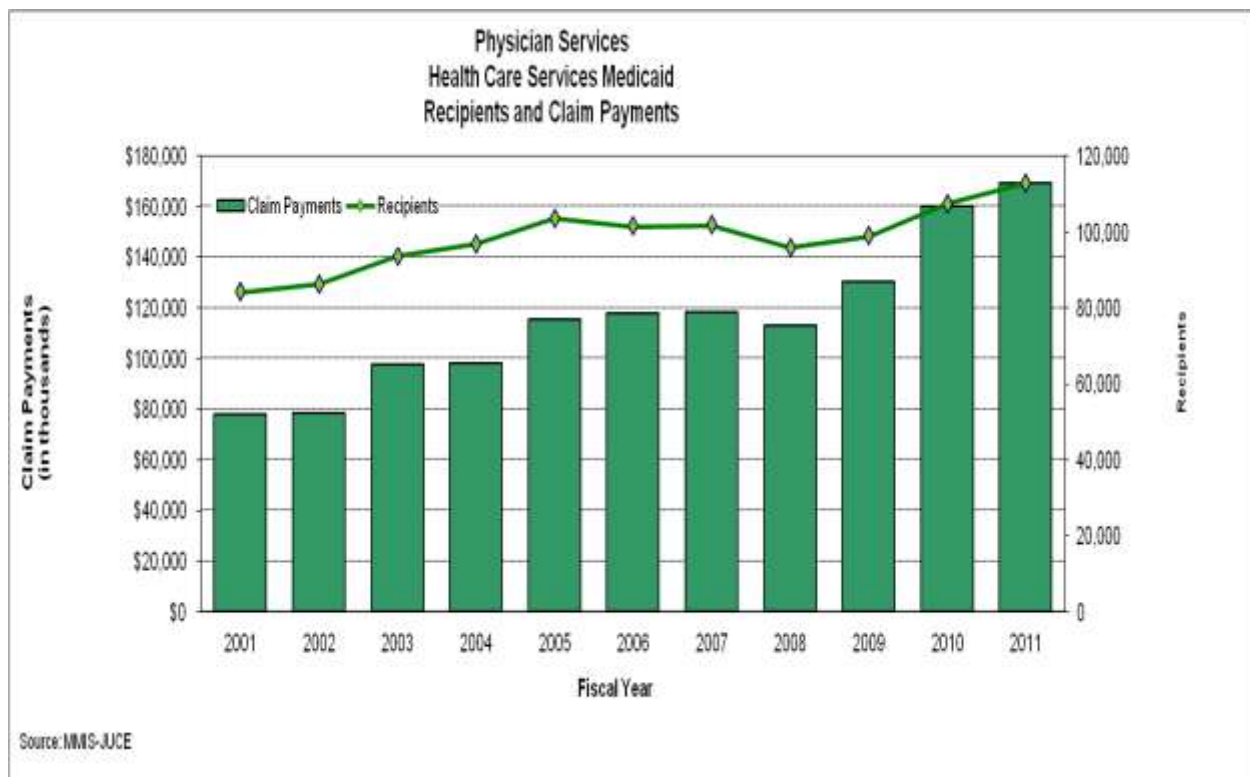
Overall claims expenditures for Medicaid hospital services increased by 7.5% between FY2010 and FY2011. This increase can be attributed to a number of factors, which includes, but is not limited to, increases in recipient enrollment leading to higher levels of service utilization by recipients and increases in service rates. The number of Medicaid recipients utilizing Medicaid hospital services increased by 6.0% between FY2010 and FY2011.



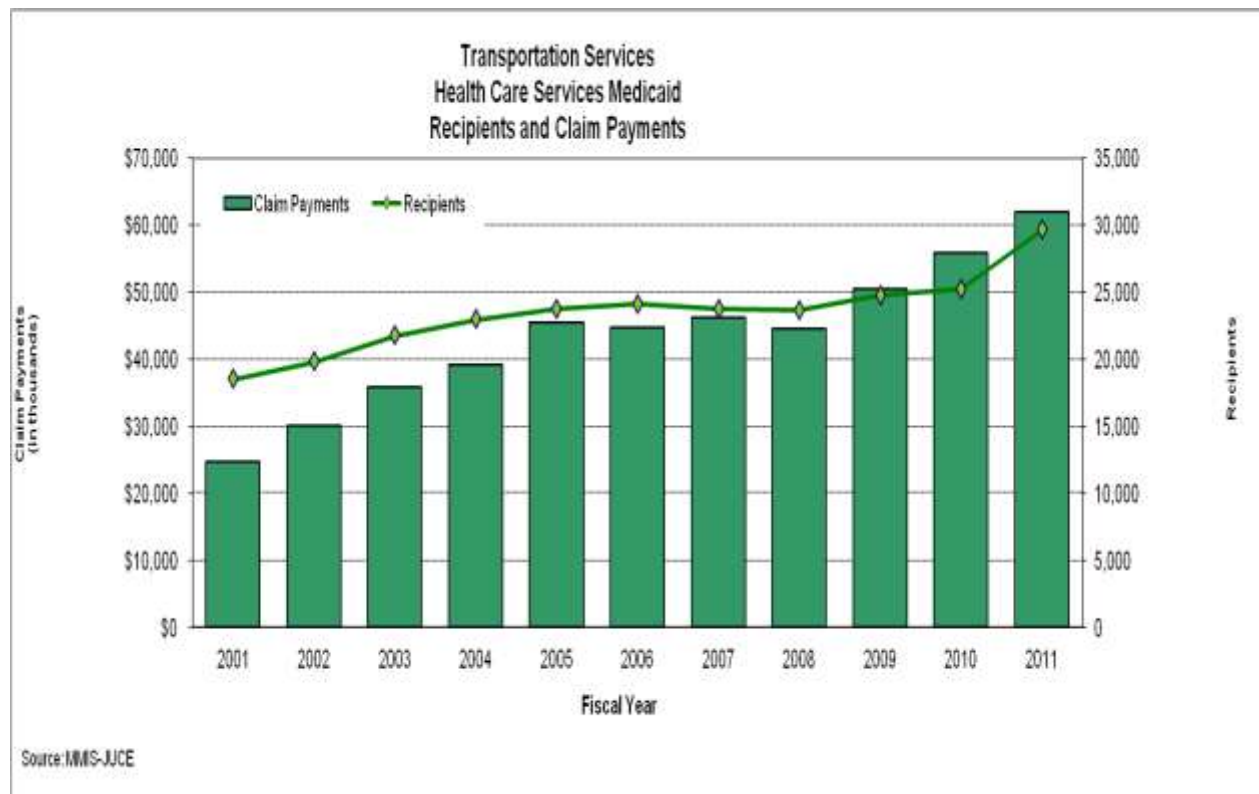
Pharmacy claim payments increased by 8.2% from FY2010 to FY2011. While pharmacy expenditures fell substantially during FY2006 and FY2007, due to the addition of Medicare Part D prescription drug coverage, there has been an increase in expenditures from that period forward. The number of Medicaid recipients receiving prescription drugs increased by 6.9% between FY2010 and FY2011, while the annual average cost per recipient rose by .6% during this period.



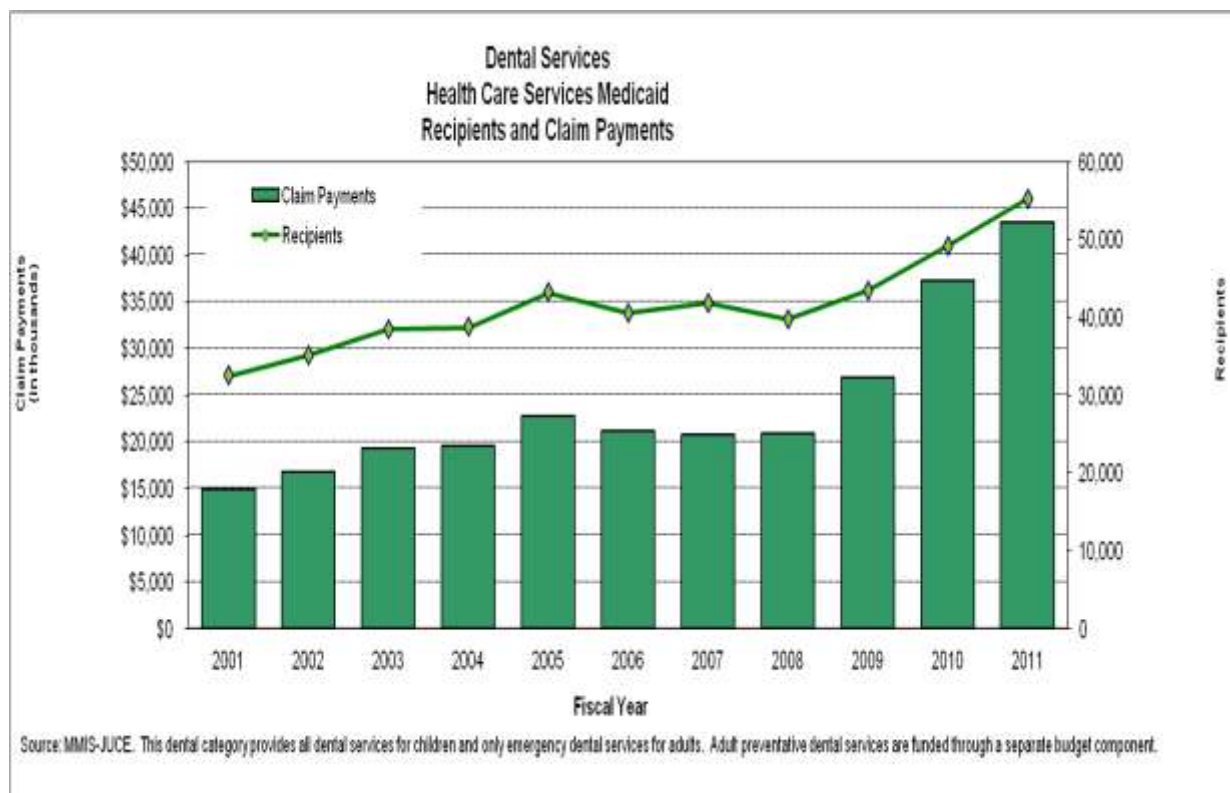
Claims payments for Medicaid physician services saw an increase of 5.8% between FY2010 and FY2011. The number of Medicaid recipients utilizing physician services during this period increased by 5.1%, while the average expenditure per recipient increased by \$11.00, or .7%.



Expenditures for Medicaid transportation services grew by 11.2% between FY2010 and FY2011, due in large part to increased reimbursement rates and increased service utilization. The number of Medicaid recipients utilizing Medicaid transportation services increased by 17.5%, while the average cost per recipient decreased by 5.3%, from \$2,214 in FY2010 to \$2,096 in FY2011.

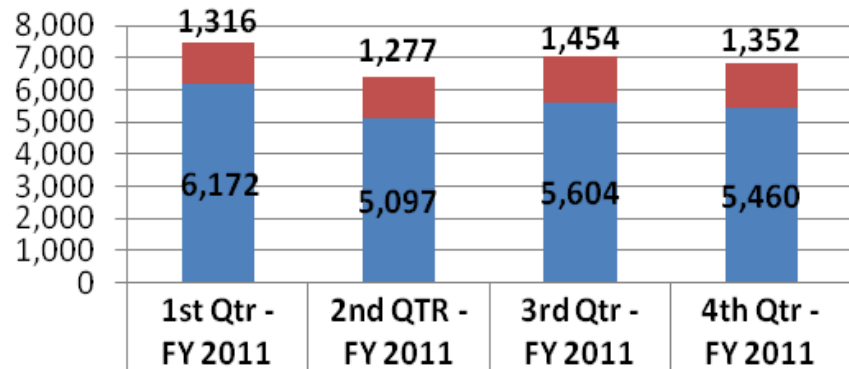


Total Medicaid expenditures for dental services increased by 16.8% between FY2010 and FY2011, while the number of Medicaid recipients utilizing dental services increased by 12.3%. The average cost per recipient increased by \$34, or 4.1%, between FY2010 and FY2011. (Note: Dental services discussed here do not include Medicaid adult preventative dental services.)



The Adult Preventative Medicaid Dental program was established with the passage of House Bill 105 in FY2006. 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.)

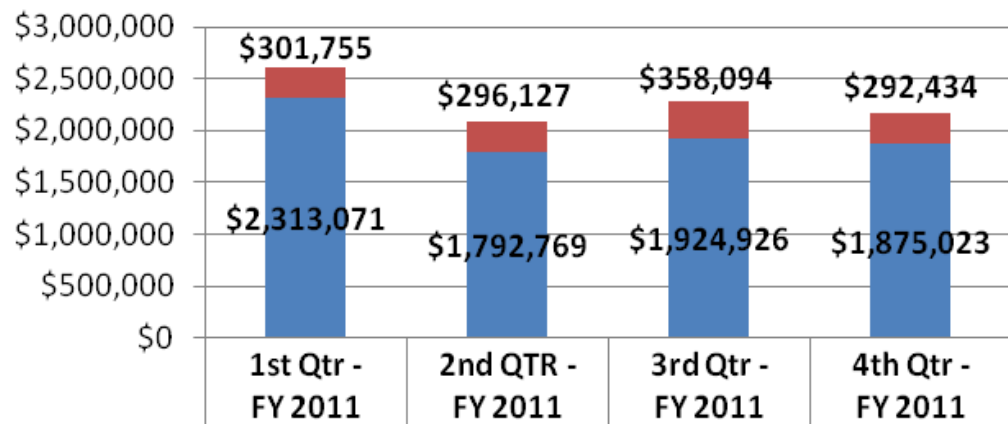
Adult Preventive Dental Recipients FY 2011



IHS Recipient Count	1,316	1,277	1,454	1,352
Medicaid Recipient Count	6,172	5,097	5,604	5,460

Source: STARS Data Download/AKSAS Authorization Report

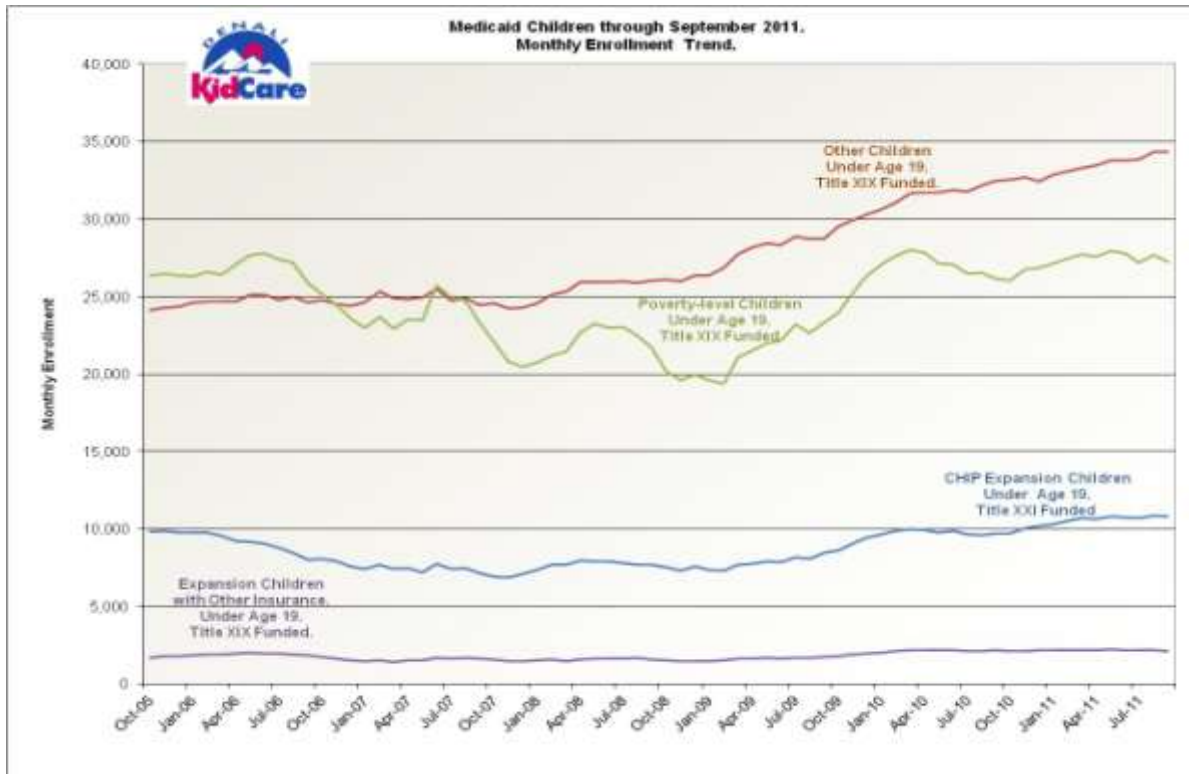
Adult Preventive Dental Payments FY 2011



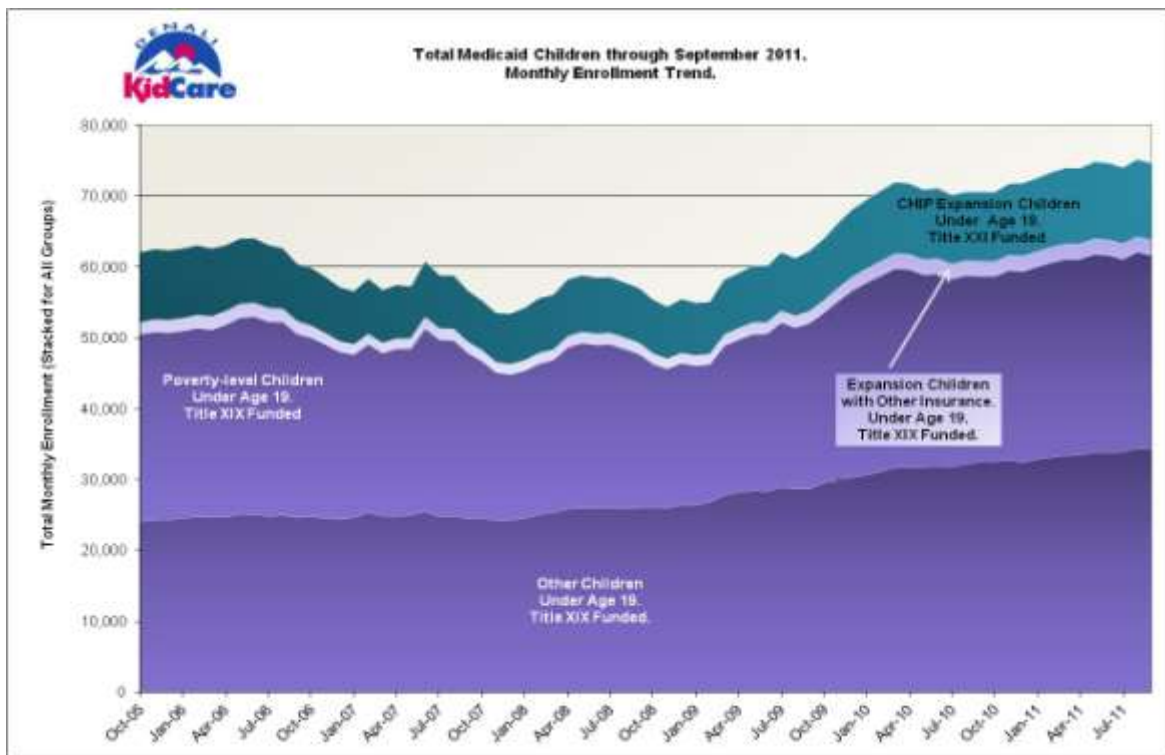
IHS Payments	\$301,755	\$296,127	\$358,094	\$292,434
Medicaid Payments	\$2,313,071	\$1,792,769	\$1,924,926	\$1,875,023

Source: STARS Data Download/AKSAS Authorization Report

Child enrollment in Medicaid/CHIP represents more than 2/3 of total Medicaid enrollment.



The teal green bar below reflects the number of children funded under CHIP with Title XXI enhanced funding. As of September 30, 2011, there were more than 70,000 children enrolled in Medicaid and the CHIP expansion.



FY 2011 DIVISION LEVEL SUMMARY: Health Care Services Medicaid	HEALTH CARE SERVICES MEDICAID CLAIMS (DIRECT SERVICES ONLY)				
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR
	Percent of Category	Annual Count	Percent of Category	Annual Total	
Medicaid, Division Annual Totals		133,773		\$726,131,688	\$5,428
Gender					
Female	56.3%	75,283	58.9%	\$427,678,628	\$5,681
Male	43.7%	58,523	41.1%	\$298,453,060	\$5,100
Unknown	0.0%	0	0.0%	\$0	\$0
Race					
Alaska Native	38.4%	51,695	42.4%	\$307,582,851	\$5,950
American Indian	1.6%	2,126	1.6%	\$11,623,191	\$5,467
Asian	6.4%	8,675	5.3%	\$38,522,751	\$4,441
Pacific Islander	3.3%	4,496	2.7%	\$19,862,476	\$4,418
Black	5.5%	7,434	4.7%	\$34,218,449	\$4,603
Hispanic	3.6%	4,828	2.7%	\$19,346,476	\$4,007
White	38.6%	51,977	38.3%	\$278,398,651	\$5,356
Unknown	2.6%	3,445	2.3%	\$16,576,843	\$4,812
Native	40.1%	53,801	44.0%	\$319,206,043	\$5,933
Non-Native	59.9%	80,374	56.0%	\$406,925,645	\$5,063
Age					
under 1	8.6%	12,504	13.2%	\$96,116,714	\$7,687
1 through 12	36.8%	53,630	19.4%	\$140,847,150	\$2,626
13 through 18	15.4%	22,483	10.8%	\$78,398,041	\$3,487
19 through 20	3.7%	5,354	3.5%	\$25,736,540	\$4,807
21 through 30	10.9%	15,877	14.8%	\$107,728,335	\$6,785
31 through 54	14.2%	20,641	23.9%	\$173,192,984	\$8,391
55 through 64	4.1%	6,032	9.6%	\$69,387,243	\$11,503
65 through 84	5.3%	7,697	4.3%	\$31,288,721	\$4,065
85 or older	0.9%	1,338	0.5%	\$3,435,960	\$2,568
Benefit Group					
Children	61.0%	82,989	41.3%	\$299,707,538	\$3,611
Adults	19.5%	26,508	23.5%	\$170,777,159	\$6,442
Disabled Children	1.8%	2,399	4.9%	\$35,317,438	\$14,722
Disabled Adults	12.2%	16,618	26.4%	\$191,369,991	\$11,516
Elderly	5.6%	7,621	4.0%	\$28,959,562	\$3,800
Location (DHSS Region)					
Anchorage/Mat-Su	48.8%	67295	62.2%	\$345,047,432	\$5,127
SouthCentral	13.3%	18285	17.5%	\$97,040,220	\$5,307
Northern	12.3%	16974	14.8%	\$81,976,157	\$4,830
Western	15.2%	20927	21.9%	\$121,625,588	\$5,812
SouthEast	9.2%	12673	13.2%	\$73,309,324	\$5,785
Out of State or Unknown	1.3%	1759	1.3%	\$7,132,968	\$4,055

Notes to HCS Medicaid Claims Table:

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 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, 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 any time before June 30, 2010.

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

Division, Percent of Department Medicaid for all 4 divisions may exceed 100%.

Source: MMIS/JUCE.

List of Primary Programs and Statutory Responsibilities

AS 47.07	Medical Assistance for Needy Persons
AS 47.08	Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25	Public Assistance
AS 47.30	Mental Health
Title 42	CFR Part 400 to End
Title XVIII	Medicare
Title XIX	Medicaid
Title XXI	Children's Health Insurance Program
7 AAC 43	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 FY2013 Operating Budget Requests

Division of Health Care Services

Budget Overview Table

Health Care Services	FY2012	FY2013 Gov	12 to 13 Change
Unrestricted General Funds	\$11,710.8	\$12,113.3	\$402.5
Designated General Funds	1,836.7	1,909.6	72.9
Federal Funds	14,887.4	12,676.8	-2,210.6
Other Funds	5,751.1	5,554.7	-196.4
Total	\$34,186.0	\$32,254.4	(\$1,931.6)

Budget Requests/Adjustments

Medical Assistance Administration

Interagency Receipt Authorization Reduction: (\$250.0) Total – (\$250.0) I/A

Health Care Services requests a reduction of \$250.0 in its interagency (I/A) receipts authorization. The division has determined that I/A funding requested in the FY2012 budget is not required in the FY2013 budget.

Federal Receipt Authorization Reduction: (\$2,000.0) Total – (\$2,000.0) Federal

Health Care Services (HCS) requests the decrement of \$2,000.0 of excess federal authorization from the Medical Assistance Administration component. This excess federal authorization has been in the HCS budget for a number of years without any expectation of actual federal receipts collection. The authorization was originally placed in the budget to meet improvements to the legacy Medicaid Management Information System (MMIS) mandates issued by the Centers for Medicare and Medicaid Services (CMS). The amount listed above is no longer needed because the legacy MMIS mandates are less than originally anticipated.

Rate Review

Rate Settings and Acuity Measurement Systems: \$640.0 Total - \$320.0 Federal/\$320.0 GF

Behavioral Health Outpatient Rate Setting and Acuity Measurement System
\$100.0 (\$50.0 Federal/\$50.0 GF)

The Department believes it is necessary to update rate setting methodologies for outpatient behavioral health services. Work in other areas of the Department has shown that well-documented rate setting methodologies consistent with state and federal laws and regulations are invaluable in avoiding federal findings, and ensuring access to quality care for Medicaid recipients. After many meetings with providers and much review of formal public comments, the need for a robust acuity measurement system is obvious for rate setting and claims payment purposes as well as for Behavioral Health program administration.

Home Health Rate Setting and Acuity Measurement System
\$100.0 (\$50.0 Federal/\$50.0 GF)

The Department has recently been informed that federal state plan reviewers find the current state plan requirements for home health services, in particular the rate setting methodology, unacceptable.

The Department proposes to hire experienced consultants as necessary to design and implement a rate setting system for Medicaid home health services in Alaska. The design would include a relationship to costs and related adjustments to Medicaid payment rates for various acuity levels.

Home and Community Based Services Acuity Measurement System
\$300.0 (\$150.0 Federal/\$150.0 GF)

The Department over the last 2-3 years has worked to establish a new rate setting system for home and community based services. After many meetings with providers and much review of formal public comments, the need for a robust acuity measurement system is obvious for rate setting and claims payment purposes, as well as for the Division of Senior and Disability Services (DSDS) program administration. Without an accurate measurement of acuity, long term cost containment in rate setting would be compromised, access to services could eventually deteriorate for Medicaid clients, accurate trends in the condition of Medicaid clients and related impacts of policy decisions could not be measured, and provider concerns about the fairness of payment rates cannot be addressed completely.

Tribal Dental and Behavioral Health Encounter Rate Settlement Calculations
\$140.0 (\$70.0 Federal/\$70.0 GF)

The Department has adopted encounter rate based payment methodologies for tribal behavioral health and dental payments. Since these new payment methodologies have not been incorporated into the Medicaid Management Information System (MMIS), the Department's Information Technology section is designing and operating systems necessary to reprocess fee for service claims into the appropriate encounter format.

Challenges

Adult Preventative Dental Medicaid Services

The Adult Preventive Medicaid Dental program was reauthorized in FY2009 when the three-year sunset provision was repealed.

The key to the continued success of the adult preventive Medicaid dental program is adequate provider capacity, both private dental participation in the Medicaid program and dental access through tribal and community health center dental programs. DHSS continues to work with the Alaska Dental Society to encourage more participation of private dentists in the Medicaid program. Other measures taken to increase provider participation include significant fee schedule increases in three of the four previous years, as well as new regulations to implement a mechanism for annually reviewing and adjusting dental reimbursement rates based on changes in the U.S. Department of Labor, Consumer Price Index.

.Medicaid Services

Health Care Services (HCS) continues to seek new ways to provide affordable access to quality health care services to eligible Alaskans. Ensuring there are sufficient numbers of enrolled providers, particularly in rural areas, continues to be a challenge.

The primary strategy to maintain adequate provider enrollment is to offer reimbursement rates that maintain pace with the rising cost of providing health care. During the past two years, rates paid to dentists, hospitals, nursing homes, ambulatory surgery centers, and other providers have been increased.

Adjustment of rates for physician, advanced nurse practitioner, chiropractic, direct-entry midwife, and other professional services that are subject to Resource Based Relative Value Scale (RBRVS) payment methodology has been problematic, as current regulations do not provide an objective means by which to make fee schedule adjustments. HCS is working to resolve this problem by proposing new regulations that will adjust RBRVS fee schedules in accordance with the U.S. Department of Labor's Consumer Price Index. The new regulations will propose to make all future adjustments effective July 1 of each year. In addition to providing objectivity to rate setting, rate adjustments will correspond with the state fiscal year for budgeting purposes. This change will allow adequate time for staff to review RBRVS changes published by CMS and effective January 1 of each year.

HCS is also exploring brokerage services and other means to expand ground transportation services, while simultaneously developing a sound payment methodology for taxi and other ground transportation providers.

HCS will need to adopt regulations and develop benefit packages for the projected 25,000 – 30,000 additional adults who will qualify for Medicaid in 2014 as a result of the Patient Protection and Affordable Care Act. It is speculated that many of the new enrollees may have chronic medical and/or behavioral health challenges. In addition, HCS will need to accommodate the resulting increase in claims, prior authorizations, and other claims-related activities.

Medicaid Pharmacy

The Department will begin work on a new dispensing fee survey in FY2012 to examine the current pharmacy payment methodology and evaluate whether future changes are needed to adequately and accurately reimburse pharmacy providers and ensure access to pharmacy services for Medicaid recipients. The pharmacy program will also implement the new pharmacy point-of-sale claims transaction standard mandated by HIPAA 5010 during FY2012. Implementation will present challenges for pharmacy providers, as they will have to update their claims processing software to submit claims compliant with the new transaction standard by January 1, 2012. Alaska Medicaid is prohibited from paying any pharmacy claims that do not comply with the new standard after December 31.

Tribal Medicaid

The Tribal unit of the Division of Health Care Services is required to draft, submit and gain approval on a Tribal consultation process that details the steps taken to inform Tribal Health organizations of changes to Medicaid State Plan Amendments (SPA) that affect American Indian/Alaska Native (AI/AN) beneficiaries.

The challenge in crafting this document is to meet the requirements CMS specifies for consultation without necessarily gaining consensus of all Tribal Health organizations. The goal is to ensure both parties are successful in defining and achieving consultation and gaining approval of SPAs that affect the whole Medicaid beneficiary base, which includes the AI/AN population. The other change that continues to be considered is cost-based reimbursement for Community Health Aide Practitioners (CHAP's) and the inclusion of behavioral health aides (BHAs) in the CHAP service delivery model. 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, and inclusion of BHAs in the CHAP model, would provide improved financial stability allowing tribes to expand infrastructure and scope of CHAP/BHA services.

The more Medicaid services CHAP/BHA'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 this model creates is 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 strives to stay within CAMA's limited budget while providing prescription drugs and outpatient care for approximately 600 recipients each month. CAMA funding is 100 percent GF.

Health Facilities Licensing and Certification

The ability to meet CMS survey-related mandates is dependent upon having qualified registered nurse surveyors. Due to a rigorous training and travel schedule, retention of staff is challenging. There is a 1-2 year orientation period and additional training is required for each facility type. Surveyors spend approximately 6 months of the year conducting surveys, with the majority being out-of-town.

The unit is conducting additional training surveys in an effort to meet the training needs of new surveyors. In addition, the unit implemented an internal quality assurance process to identify specific training needs. The State Agency is also exploring the implementation of a consultative, collaborative technical assistance program to promote regulatory compliance and improve nursing home care practices. Meeting these challenges can enhance safe and adequate quality of care, meet CMS mandates, and avoid 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 FY2008 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 described by ACS as a sophisticated, web-enabled solution for administering all Medicaid programs. It was scheduled to be available to providers and recipients who participate in the Medicaid programs in FY2011. ACS has informed the Department that delivery of the source code for the Enterprise product will be delayed; therefore, Alaska Medicaid Health Enterprise will be delayed.

The MMIS DDI project team has received a complete, stable version of the Enterprise source code, and continues to build out the Alaska specific requirements. Alaska Medicaid Health Enterprise is expected to be available to state staff, providers, and members in 2012. The MMIS DDI project team continues to analyze and develop services that can be implemented before Alaska Medicaid Health Enterprise is fully operational, such as ePrescribe, Smart Non-Emergency Transportation (NEMT), and the early deployment of the data warehouse.

DHSS will be prepared to receive and send Health Insurance Portability and Accountability Act (HIPAA) X12N 5010 transactions and code sets by the mandated effective date of January 1, 2012 with the current legacy MMIS system. Alaska Medicaid Health Enterprise will be fully compliant with the 5010 transaction set at system go live.

Rate Review

Rate Review will complete implementation of acuity-based rate setting systems for behavioral health and senior services that will make rate adjustments based on the characteristics of individual clients and their needs. This item poses a challenge to HCS because once the acuity rate systems are designed for Medicaid Waiver and Behavioral Health services, full implementation, which will involve significant problem solving and working with providers on details of implementation, will proceed during this year.

The unit will also work to incorporate tribal behavioral health and dental encounter payment processes into the Department's Medicaid Management Information System (MMIS). This item poses a challenge to HCS because after years of processing tribal dental and behavioral health payments for services through specially designed data processing applications, the Department will shift this complex logic to an updated MMIS, with prior year adjustments, that can process those payments as part of claims processing.

Certification and Licensing

Advanced technology is critical in order to better utilize staff time and enhance data production for both the Background Check and Licensing programs. The Assisted Living Program is currently working on a request for proposal for case management software. Licensing staff have never had a program database, which has reduced their ability to obtain basic licensing identification information, requiring staff to utilize valuable time pulling hard copy information. A database will also serve as a tracking mechanism for licensing inspections, violations, investigations and other essential information needed to ensure the health, safety and welfare of those that reside in assisted living homes.

This coupled with a dramatic increase in the number of licensing complaints and complaints that involve health-related concerns, has also been a challenge. The future plan for the program is to reassess licensing positions, as they are vacated, with the anticipation of having the medical and/or geriatric expertise to sufficiently work with providers in adapting to a higher level of need resident population.

The Background Check Program will also work toward enhancing their database in an effort to streamline processes. With an antiquated database, the program has unintentionally caused delays in providing timely background checks, impacting the ability for applicants to go to work. With funding from a competitive grant from the Centers for Medicare and Medicaid Services, emphasis is being placed on replacing the current database with a new and improved program. In addition, plans are in place to expand the use of live scan machines, statewide, in order to capture fingerprints electronically that can be transmitted straight to the Department of Public Safety (DPS); thus, elevating the need for paper copies that may need to be mailed to the DPS which in turn causes further delay. The goal is to provide background checks in a seamless, expeditious way to encourage the marketability of jobs in the health care service provider industry.

Other Challenges

In FY2013, Health Care Services will be leading departmental efforts to keep the Medicaid program fully compliant with the federal mandate to implement a new version of the code sets used for reporting diagnoses and inpatient hospital surgical procedures. This is the International Classification of Diseases version 10 (ICD-10) mandate. The ICD-10 project requires significant work efforts to analyze and convert to a new code set for all current program rules that use diagnosis criteria. The implementation date for this mandate is October 1, 2013. Project work efforts commenced in FY2011 and are ongoing in FY2012.

Also in FY2013, Health Care Services will be developing solutions to respond to a federal mandate relating to insurance plan IDs. This is the National Plan ID mandate. This mandate is an outgrowth of the 1996 federal HIPAA legislation; it establishes national identification numbers for health plans. Federal Medicaid rules require that services for clients with both private insurance and Medicaid coverage be first processed by the private insurance payer before consideration for payment by Medicaid. The electronic exchange of this payment information will need to incorporate the National Plan IDs.

In addition to these items, Health Care Services will be managing the project to re-enroll all Medicaid providers. This project will begin in FY2012 and continue in FY2013 leading up to the implementation of the replacement of MMIS.

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 IHS billings, the target strategy of increasing IHS billings by 5% was realized, with an increase of approximately 7% from FY2010 to FY2011.

In addition, the division far exceeded the target of a 2% increase in GF recovery. Recovered GF increased by approximately 28.7% in FY2011 when compared to FY2010.

*Note: The large increase in recovered GF during FY2011 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.

Source: FY2011 AKSAS Authorization Report/ FY2011 TPL/Recovery Quarterly Payment Reports

Health Care Services Actuals - Other Funds (by percentage)

Fiscal Year	% Federal	% General	% Other
FY 2011	51.1%	40.1%	8.8%
FY 2010	69.2%	30.0%	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%	0.8%

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 FY2010 to FY2011. Total IHS expenditures were \$206.0 million in FY2011, compared to \$192.7 million in FY2010, an increase of approximately 7% in FY2011. The increase in IHS participation is attributable to a number of factors, but the two projects which contributed the most to the increase were the updating of race codes in EIS to insure a higher percentage of IHS eligible claims were billed accordingly, and the addition of three new IHS facilities during FY2011.

(Source: 2011 AKSAS Authorization Report, Tribal Health Team)

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2011	\$726.1	\$206.0	28%	7%
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 Services (IHS) expenditures increased from FY2010 to FY2011 by \$13.3 million. The increase can be attributed to a higher percentage of IHS claim filings, increased utilization of IHS facilities, the addition of three new IHS medical

facilities, and the updating of EIS eligibility records to insure correct race codes have been applied to recipients to correct billing irregularities.

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) recipients going to non-tribal facilities. Certain tribal entities with 638 statuses receive 100% FMAP for service delivery to AI/recipients, thus assisting the state with maximizing federal reimbursement through Centers for Medicare and Medicaid Services.

In addition, the Department completes periodic data matches between IHS and the MMIS to ensure that AI/AN recipients are appropriately coded in the Eligibility Information System (EIS) as noted in Status #1.

This allows DHSS to capture 100% FMAP vs. the standard match for non-native recipients. Once AI/AN recipients are connected to a tribal healthcare delivery system that is eligible to bill Medicaid, recipients can access additional service areas as required. Depending on the door recipients enter, (for example: behavioral health, rural health clinic, or dental services facility), 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 services the long-term system can provide.

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 FY2011. The division experienced an increase in recovered funds of approximately 29.7% in comparison to FY2010.

*Note: Increases in recovered GF during FY2011 can be directly attributed to an expanded focus by the Third Party Liability (TPL) Unit on subrogation, AG restitution/subrogation, drug rebates, Miller Trust recoveries, and increased oversight of health services utilization.

The large increases in recovered GF may not be attainable in future funding cycles.

Source: TPL/Recovery Quarterly Recoupment Reports

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

Year	Drug Rebates	TPL	Total	% Change
2011	37.8	54.2	92.0	30%
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 by 29.7% between FY2010 and FY2011. The increase in recoveries experienced during FY2011 can be attributed to a number of factors, the majority of which are listed above in Status #1.

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: The definition of enrolled provider has changed in FY2011 as the Department makes a concerted push towards group enrollment, statutory requirements for enrollment of PCAs as rendering providers, and similar changes in enrollment requirement statutes. This being said, there were 11,642 eligible Medicaid providers enrolled during FY2010. This number has increased (due to the reasons mentioned above) to 16,441 eligible Medicaid providers in FY2011. This represents an increase of 41.2% in eligible providers.

Note: The comparison between FY2010 and FY2011 is for informational purposes only. A more accurate comparison of providers will be shown between FY2011 and FY2012 due to re-enrollment under the new statute parameters listed above.

(Source: MARS MR-O-02-M Medical Assistance Program Status)

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2011	3,600 +30.43%	185 +6.94%	2,942 +6.59	1,213 -20.46%	16,441 +41.22%
2010	2,760 +11.74%	173 +35.16%	2,760 +12.75%	1,525 +53.73%	11,642 +13.53%
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 FY2011.

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 Medicaid 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 contributing factor to provider participation and enrollment figures 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 targeted at increasing provider enrollment or participation.

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 3 days in adjudication time from receipt of a claim to final adjudication, decreasing from 11 days in FY2010 to 8 days in FY2011. This represents a decrease in adjudication time of approximately 27%. The time required for claim processing depends largely on the method of claim submission, the type of claim submitted, and the day of the week the submission occurred. For example, a point-of-sale pharmacy claim submitted on Monday may only take one day to process, whereas an inpatient hospital claim may take several days for processing due to a pending claim resolution, requests for additional documentation, etc. At this time, it can be safely assumed that an average processing time of 6 days from entry to adjudication for all claims would be the maximum efficiency attainable with the necessary constraints noted above.

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

Fiscal Year	Medicaid Claims	Average Days	Days Changed
FY 2011	8,961,689	8	-3
FY 2010	8,215,221	11	-4
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 FY2010 and FY2011 decreased from 11 days to 8 days.

There may be several reasons for the continuing decrease in claims processing times, though the most prominent of these would be the continuing Medicaid claims processing familiarization occurring with ACS staff members. As the contractor employees acquire experience, the ability to supply accurate provider helpdesk information, and provide the necessary provider outreach and training, a decrease in processing times would be the expected result, and is noticeable in the above comparison. There are other behind-the-scenes factors which may also contribute to the decrease, such as electronic claim submissions, clear and concise medical coding instructions, etc. It is the coordination of all these factors that are having a positive impact on claims processing times outlined in the above table.

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 remained at 75% between FY2010 to FY2011.

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

Year	Medicaid Claims Paid	% No Errors	% Change
2011	7,284,060	75%	0
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 ensure timely claims payments. ACS, 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.

At this time, it is not possible to predict the effect changes in claims billing procedures implemented with the change to ICD-10, in tandem with implemented billing processes necessary to support the Affordable Care Act will have on the provider claims billing, and payment of claims without errors. Large amounts of provider outreach and clarification of coding questions have been underway by both the fiscal agent and the Department in an attempt to raise the percentage of claims adjudicated without error. However, it can be stated with a fair amount of certainty that a percentage of 80% of claims adjudicated without error would be the highest threshold attainable.

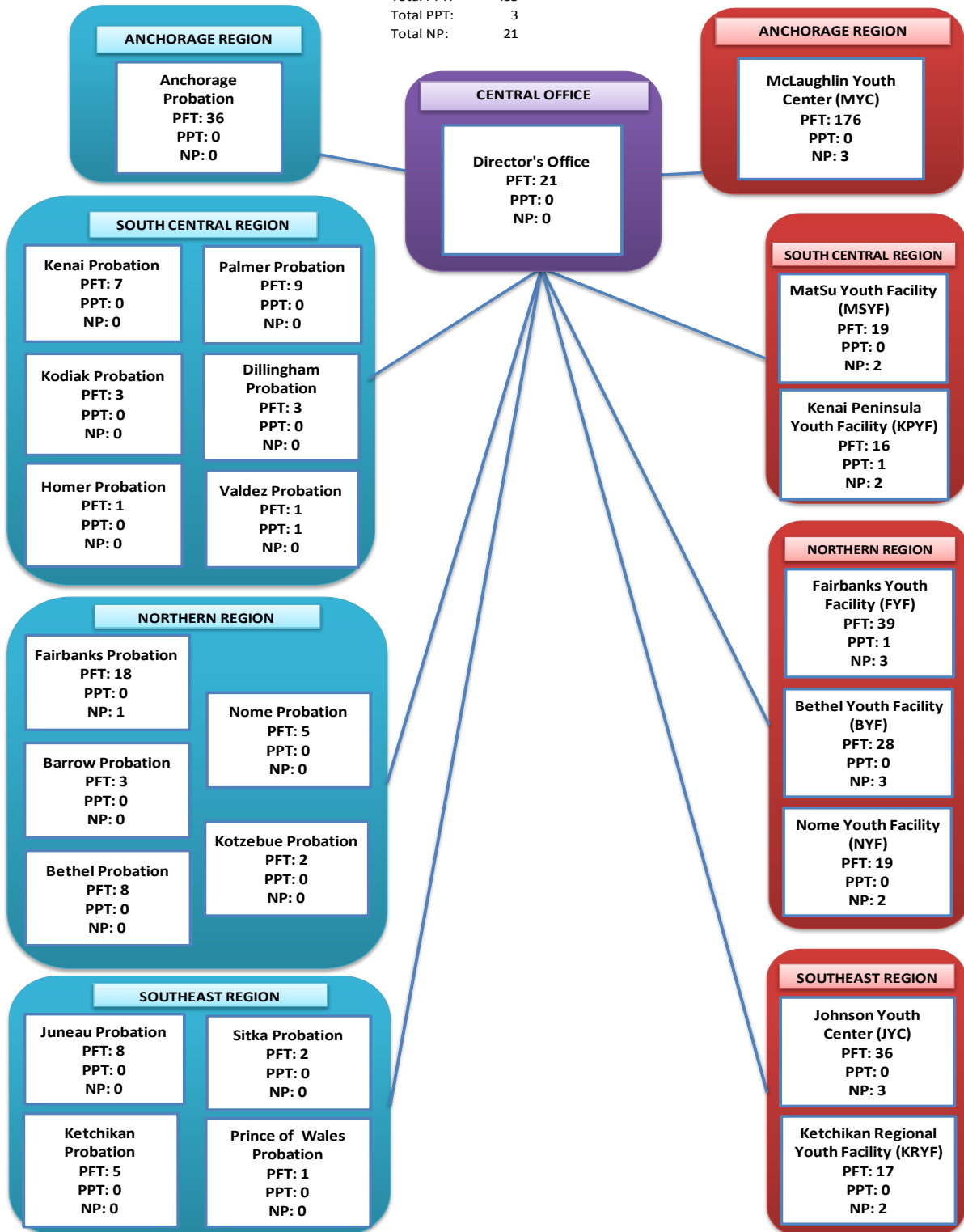
FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Health Care Services</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Delete Unrealizable Authorization	\$ -	\$ -	\$ (2,000.0)	\$ -	\$ (2,000.0)
Unrealized Authority	\$ -	\$ -	\$ -	\$ (250.0)	\$ (250.0)
Authority for Collection of Civil Money Penalties for Protection of Nursing Home Residents	\$ -	\$ 60.0	\$ -	\$ -	\$ 60.0
Rate Settings and Acuity Measurement Systems	\$ 320.0	\$ -	\$ 320.0	\$ -	\$ 640.0
Reverse American Recovery and Reinvestment Act (ARRA) Funding Sec 33(d) CH3 FSSLA2011 P92 L8-12 (HB108)	\$ -	\$ -	\$ (625.4)	\$ -	\$ (625.4)
Health Care Services Total	\$ 320.0	\$ 60.0	\$ (2,305.4)	\$ (250.0)	\$ (2,175.4)

Division of Juvenile Justice

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

Total PFT: 483
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 assist offenders and their families in developing skills to prevent crime.

Introduction

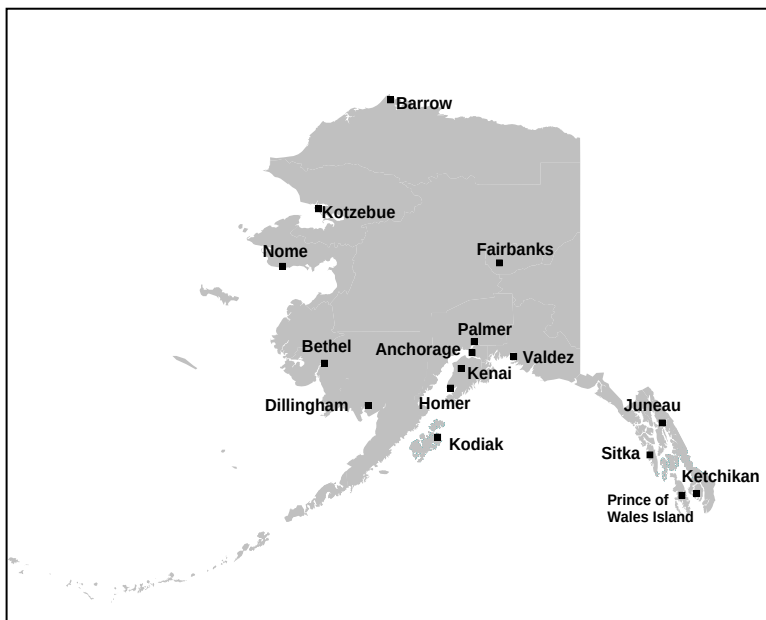
The Division of Juvenile Justice provides supervision and services to juveniles who commit delinquent offenses. The division responds to the needs of juvenile offenders in a manner that supports community safety, prevents repeated criminal behavior, restores the community and victims, and helps youth 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 provided by the Division of Juvenile Justice (DJJ) can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions. Probation Services and Detention and Treatment facilities are located in four regions: Northern, South Central, Southeast, and Anchorage.



Probation Services

Juvenile probation officers provide preventive and rehabilitative services by conducting intake investigations of youth who are alleged to have committed delinquent acts, including determining legal sufficiency to take further action; completing detention screening; implementing diversion plans; initiating formal court action against juvenile offenders; contacting victims; providing formal community probation supervision services for

adjudicated youth; and, assisting in re-entry into the community following release from secure juvenile institutional care. Alaska's juvenile probation officers work out of offices based in 16 communities around Alaska.

Probation officers perform a number of functions and responsibilities, beginning from the point a juvenile is arrested or identified by law enforcement as the perpetrator of a delinquent offense. Probation officers evaluate a police officer's request to detain a juvenile following an arrest, and make a decision about whether the juvenile should remain at home, be held in a secure facility, or be placed outside of the home. When police refer a juvenile for having committed a delinquent offense, probation officers review the reports to determine if the charges are legally sufficient to take further action against the juvenile. Once jurisdiction has been established, the probation officer meets with the juvenile, their family, and the victim(s) involved in the case, to decide if the matter can be handled informally (through a community diversion plan), or if it requires formal court intervention. Approximately 65% of Alaska's arrested juveniles are diverted from the juvenile justice system through the use of community resources such as counseling and youth court and using accountability measures such as community work service and restitution. The majority of these juveniles do not commit a second offense.

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 DJJ. 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.

Director's Office

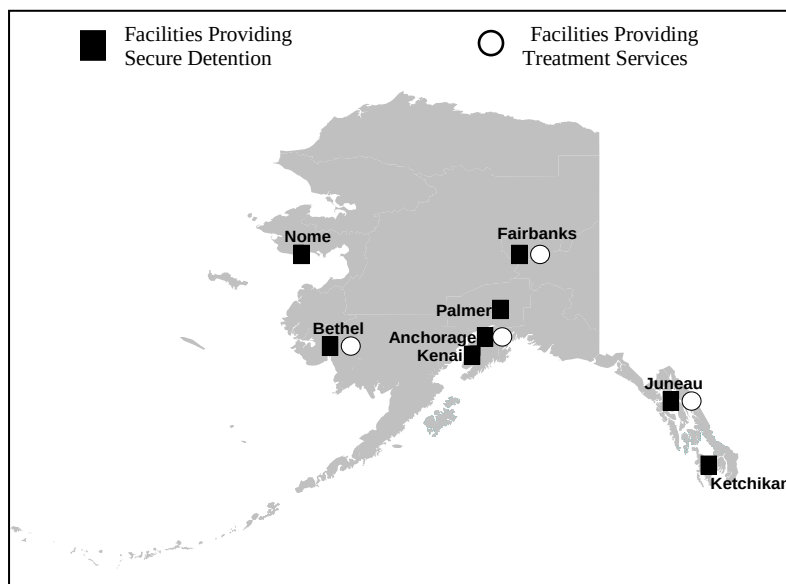
The division director's office in Juneau oversees a number of functions that support the public, the Legislature, other executive branch agencies, and field staff around the state. The office is responsible for: statewide policy development and implementation; coordinated service delivery between field probation and the youth facilities; statewide staff training; quality assurance for both field probation and juvenile institutions; research and statistical analysis of juvenile justice data; and development and administration of federal grant programs. This office ensures ongoing operation and quality assurance for the division's automated offender database JOMIS (Juvenile Offender Management Information System), as well as focusing on continued refinements to the system, including integration with all facets of the juvenile justice service and delivery process.

The Director's Office functions include:

- *Statewide Programs:* Alaska, a participating state in the federal Juvenile Justice and Delinquency Prevention Act, receives approximately \$1.2 million in federal 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 funds are also used to improve juvenile programming and build community partnerships throughout the state.
- *Data and Research:* 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 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. Adequate quality assurance that will ensure the success of the division's system improvement efforts remains a key need.
- *Quality Assurance and Training:* The division is directing limited quality assurance resources towards 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 training 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 and Planning:* The Director's Office policy staff develops and monitors legislative proposals, facilitates regulation revision, coordinates development and review of policies and procedures that enhance operation of probation, facility and state office services, and assists 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 members write 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.

Juvenile Detention and Treatment Facilities

Youth facilities in Alaska perform two primary functions: 1) detention units are designed as short-term secure units for youth awaiting a determination on an outcome for their offense; and 2) treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. There are eight detention units and four treatment units around the state.



The division is continuing the process of having stand-alone detention facilities develop a continuum of detention services that will include some facility staff providing non-secure detention and transitional/re-integration services in the community.

Northern Region

Northern Region Probation Services (NRO)

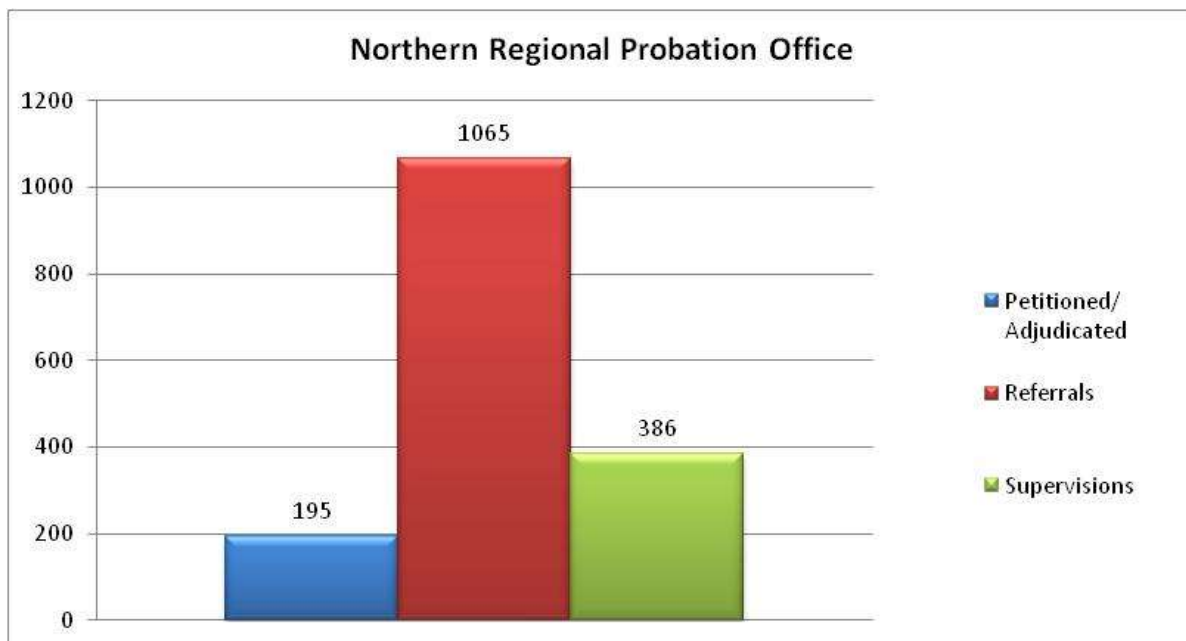
The northern region of DJJ's probation services is geographically the largest and most remote in Alaska, comprising approximately 66% of the state's total landmass. Much of the region is inaccessible by road and must be visited by small aircraft, boat, or snow machine. Probation services are centered in five district offices located in Fairbanks, Barrow, Bethel, Kotzebue, and Nome. During FY2011 the northern region probation offices received over 1,000 delinquency referrals from law enforcement, accounting for over 2,000 separate charges.

The Fairbanks District is the home of the division's second largest probation office and covers an area that includes Fairbanks and the North Star Borough, as well as a multitude of interior Alaska villages as far reaching as Arctic Village, Northway, and Cantwell. The Bethel district office serves the Yukon-Kuskokwim Delta, which includes the hub of Bethel and 56 surrounding villages. The population of this district is approximately 30,000 and is primarily of Yupik Eskimo ethnicity. The Barrow district provides services to Barrow and six outlying villages in the North Slope Borough, an area of approximately 95,000 square miles. Its population of 9,430 is primarily Inupiaq Eskimo. The Kotzebue district covers the city of Kotzebue and 11 surrounding villages in the Northwest Arctic Borough and the far western portion of the North Slope Borough. The population of this district is primarily Inupiaq Eskimo. And, finally, the Nome district office serves the Norton Sound/Seward Peninsula area, including the city of Nome and 15 surrounding villages, which includes Saint Lawrence Island and Little Diomed. The ethnicity of the district is primarily Inupiaq Eskimo in the north, Yupik Eskimo in the south, and Siberian Eskimo on Saint Lawrence Island.

Northern Region Probation Core Services

The primary focus of the division, in general, and the northern region, specifically, is the provision of core intake and probation services for juveniles charged and/or adjudicated for delinquent behavior. In addition to the standard intake, adjudication, disposition and probation services offered by all the juvenile probation offices in the northern region, an extensive range of preventive, remediation, assessment and restorative services are provided to DJJ clients, parents, and communities. Among these are risk/needs assessment, community work service, foster care, alternative to detention programs, and the state's only juvenile mental health court (Fairbanks). Services do not always wait for a juvenile to get into legal trouble as northern region probation officers regularly meet with pre-delinquent youth in support of parents and schools.

Northern region probation officers are regularly involved with community partners as part of their efforts to provide for prevention and intervention services. This involvement may include educational presentations on juvenile justice issues, community and law enforcement trainings, and efforts to develop resources and positive relationships in rural villages.



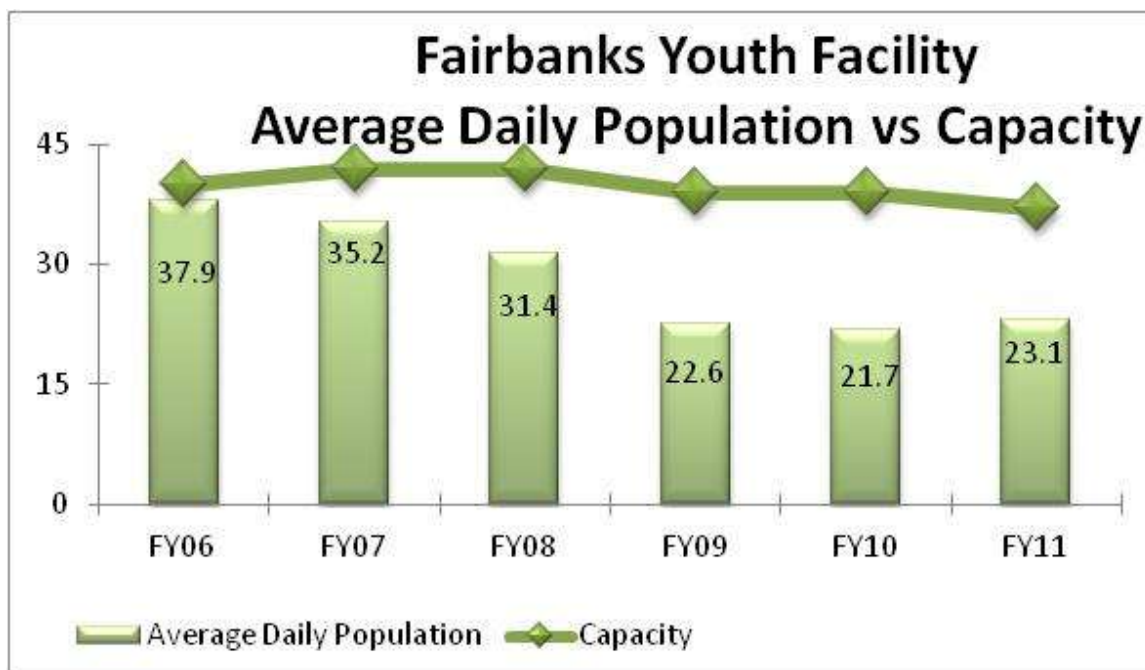
Fairbanks Youth Facility

The Fairbanks Youth Facility (FYF) consists of a 20-bed detention unit and a 17-bed treatment unit. The detention unit provides temporary placement to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court; in FY2011 the detention unit admitted 199 juveniles. The program unit houses and makes rehabilitative services available to adjudicated offenders who have been committed to the division by the Court for long-term treatment; 17 juveniles received treatment in the past year. FYF is the second largest of Alaska's juvenile correctional facilities. This facility is located in our northern region, which is the largest geographically of DJJ's four regions. The facility has been accredited since 1986, initially by the American Correctional Association and currently by the Council of Juvenile Correctional Administrators. The current accreditation process, Performance-based Standards (PbS), is an outcome-focused process that encourages consistent system improvement.

FYF Core Services

The co-ed detention unit provides secure housing and services to alleged and adjudicated juveniles who are either involved in a court process or awaiting other placement. While detained, residents have access to educational, medical, and mental health services through the facility. They are also provided specific information related to criminogenic issues such as substance abuse and anger management.

The FYF Program Unit provides care and individual, group, and family treatment for male juveniles who have been committed to the custody of DJJ for up to two years or their 19th birthday, whichever comes first. The increase in the percentage of residents with intensive mental health, FASD, or substance abuse-related disorders continue to challenge the facility's ability to provide appropriate therapeutic services while maintaining the safety and security of residents and staff. Increasingly, these special needs offenders demonstrate clinical needs that require one-on-one supervision and care, which significantly impacts the staff resources available.



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. In FY2011, the division re-evaluated the way beds were counted at FYF and the capacity went to 37.

Bethel Youth Facility

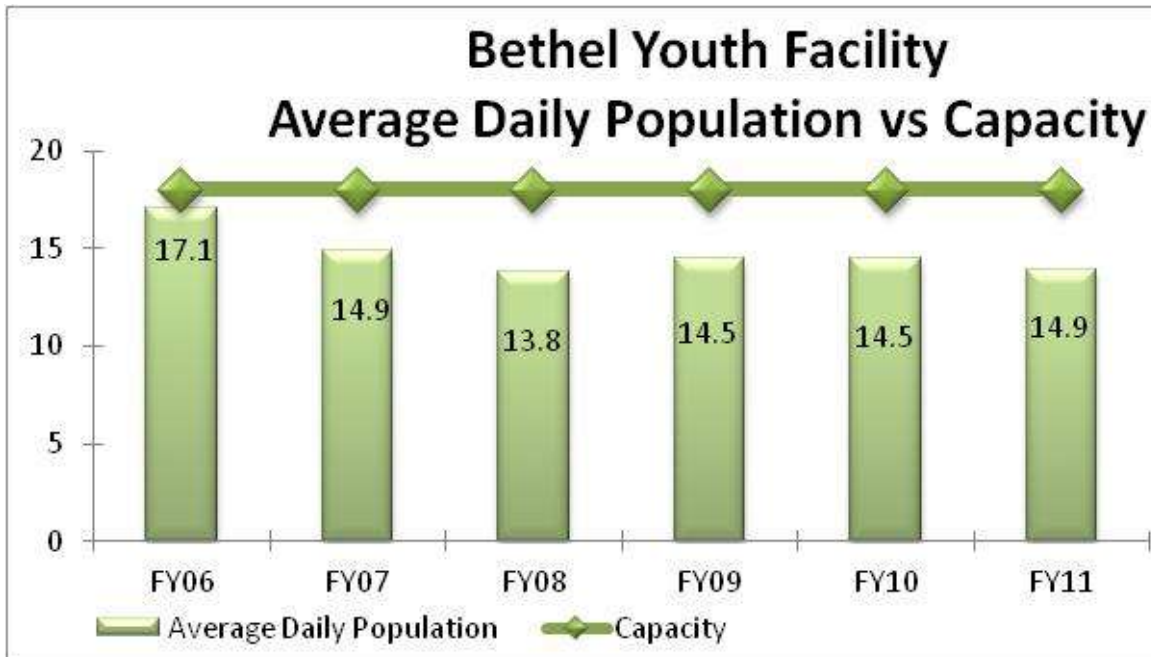
Bethel Youth Facility (BYF) is the only youth facility in the Yukon-Kuskokwim Delta, an area the size of the State of Oregon that is home to approximately 30,000 people spread between more than 56 villages. The facility consists of an eight-bed co-ed detention unit and an 11-bed treatment unit for male juveniles.

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 committed to the division by the Court. The facility's population is largely Alaska Native, particularly Yupik Eskimo.

BYF Core Services

BYF's detention services provides for the care and secure placement of juveniles involved with a court process or awaiting placement. This detention unit is as commonly over capacity as it is under capacity as it maintains the lowest vacancy level of any DJJ detention unit.

The facility's treatment programming is based upon a strength-based cognitive behavior approach that combines a supportive and pro-social milieu with individual, group, and family counseling. Youth in the program complete general treatment components in addition to their individual treatment work. These components include victim impact, thinking errors, and substance abuse, as well as a variety of skill building exercises and cultural activities. A significant number of residents have FASD and other mental health needs. Through training and experience, staff members at the facility have developed a high level of expertise in working with this challenging group of juveniles.



In FY2006, a treatment room was converted to an office for the Mental Health Clinician, reducing the capacity by one.

Nome Youth Facility (NYF)

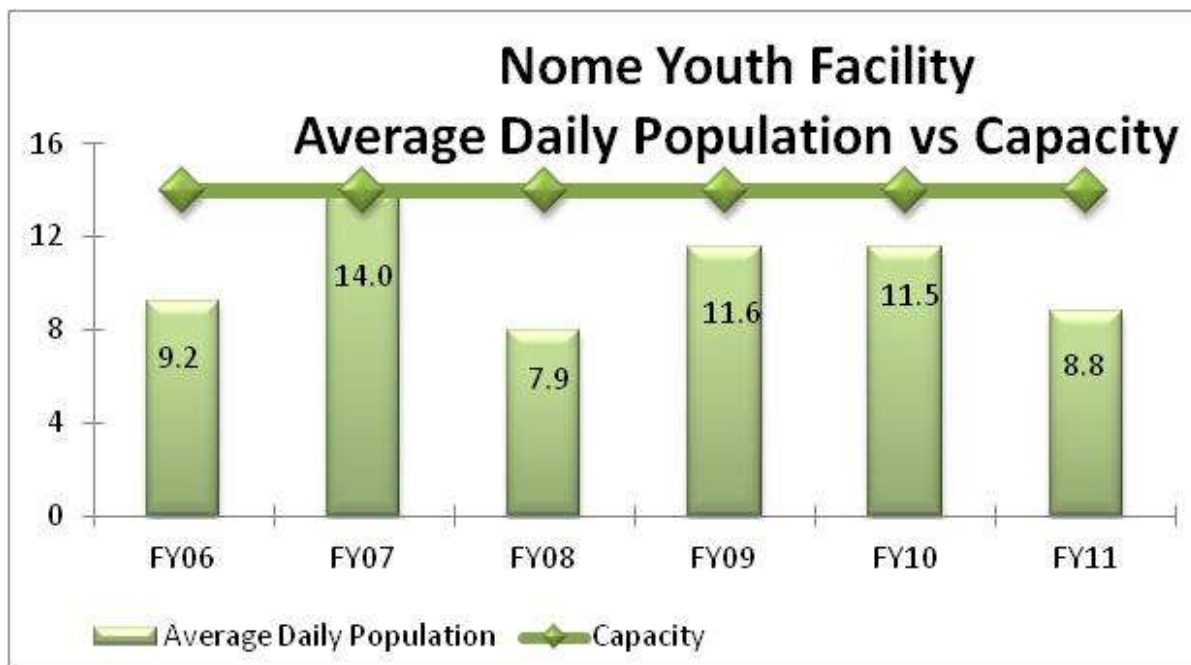
The Nome Youth Facility is a 14-bed therapeutic co-ed detention facility providing supervision, custody, care and rehabilitative services for accused and adjudicated youth from the communities of Nome, Kotzebue and the 28 surrounding villages. During this FY2011, the facility provided these services for 77 youth.

The resident population is primarily male and Alaska Native; most come from outlying villages rather than the population centers. 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.

NYF continues its successful relationship with the national quality assurance process of PbS. The facility is currently working on Level IV data certification.

NYF Core Services

Nome Youth Facility is a unique detention facility with security aspects considerably less constraining than the traditional detention facility. Residents regularly partake in supervised social/recreational activities, therapeutic groups and community service projects outside the physical structure of the program. Although NYF appears to be less confining than other DJJ detention facilities, the apparent lower security aspects are mitigated with staff training and the geographical isolation of Nome. In several ways the facility's programming could be considered a combination of detention and short-term therapeutic intervention. Educational therapeutic groups and competency development make up much of an NYF resident's detention time. The number of substance abuse prevention/education groups has tripled in the past year and other groups have been redesigned to carry a similar message regarding the negative effects of alcohol and drug use. These other groups include smoking cessation, violence prevention, Aggression Replacement Therapy (ART), positive life skills, and jobs skills training. Residents also participate in the Live Strong program that emphasizes personal wellness and positive acts. Community work service is a primary component of the division's restorative justice mission and an integral part of NYF programming. Besides the restorative aspect of this service, the work places an emphasis on helping those in need.



South Central Region

South Central Probation Services

The South Central Region Probation Office (SCRO) covers an area of some 1,300 miles from the tip of the Aleutian Islands in the east to the Canadian border in the west, roughly equivalent to the distance between New York City and New Orleans. Its geographical area of 138,620 square miles is larger than 46 of the other 49 states. Between 2000 and 2010, the population of the region increased by approximately 23%. The population of 183,800 people is predominately white (83%) and Alaska Native (11%).

The region is comprised of four district offices located in Dillingham, Kenai, Mat-Su, and South Coastal. Together they received 777 referrals from law enforcement containing 1,533 offenses. The Dillingham District Office covers an area approximately the size of Alabama and includes Dillingham, as well as the Pribiloff Islands, Bristol Bay, Lake, and Peninsula Boroughs. The population of this district is 73% Alaska Native.

The Kenai district is headquartered in Kenai with a second office in Homer. It serves an area of approximately 26,600 square miles and includes about 26 communities both on and off the road system.

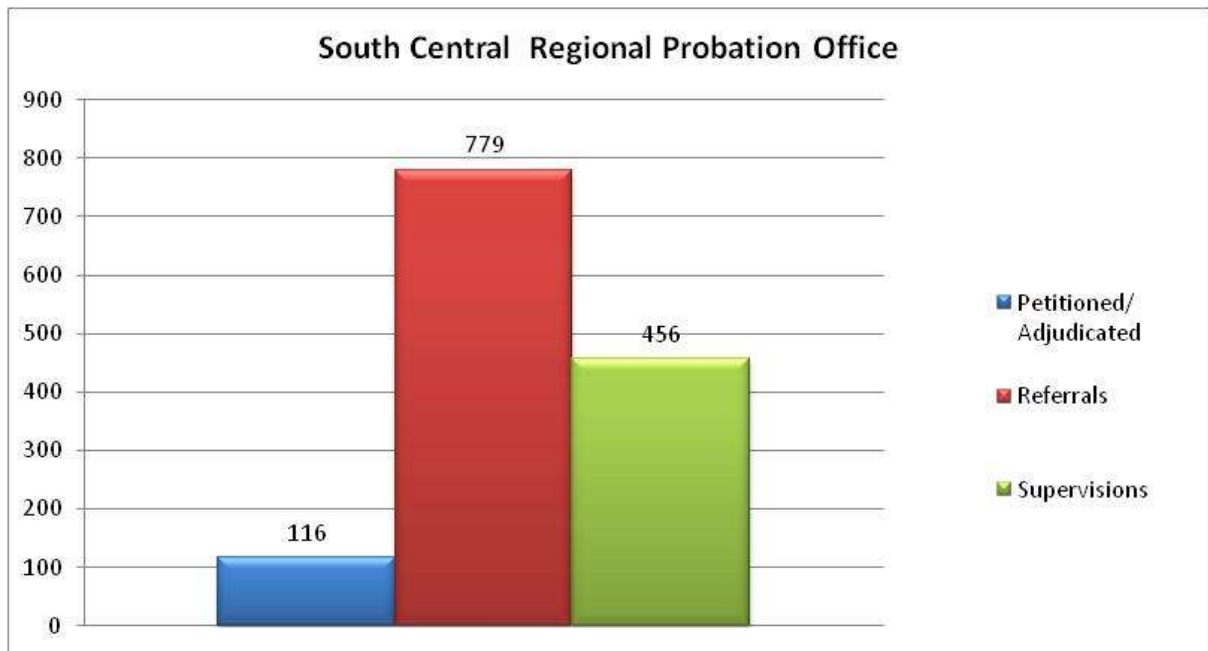
The Mat-Su district serves the Matanuska-Susitna Borough and contains approximately 24,682 square miles and a population of almost 90,000. The population of this district has doubled since 2000 and is the fastest growing area in Alaska.

The south coastal district stretches along the south central Alaska coast from Valdez and Cordova though Kodiak southwest through the Aleutian Islands.

South Central Probation Core Services

SCRO provides a probation services that run through the entire life cycle of a case, from initial case assessment, to diversion or formal court processes, and then through the expiration of a court's custody or supervision order. These services include, but are not limited to prevention, case assessment, counseling, community supervision, case management, probation enforcement, community outreach, and education. Most juveniles who come into contact with the juvenile justice system do not require formal court intervention and can be dealt with in an informal manner using various forms of services designed to ensure accountability while allowing the juvenile to avoid a formal juvenile record.

Youth whose behavior requires more formal court intervention either remain with their families, stay in a foster home or residential treatment setting, or are committed to a DJJ correctional facility. In each case the juvenile remains under the supervision of their assigned probation officer. Juveniles leaving DJJ correctional treatment are provided additional re-entry and transition services through specialized case management.



Mat-Su Youth Facility

The Mat-Su Youth Facility (MSYF) is a 15-bed co-ed detention center located in the Matanuska-Susitna Valley serving the Palmer/Wasilla area as well as Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. During FY2011 the facility accepted 127 admissions. Juveniles are housed at the secure facility while awaiting trial, adjudication, disposition, placement or diagnostic evaluation to help determine a longer term plan of intervention, habilitation or treatment that is appropriate to their needs. The Mat-Su juvenile probation offices are co-located with the facility.

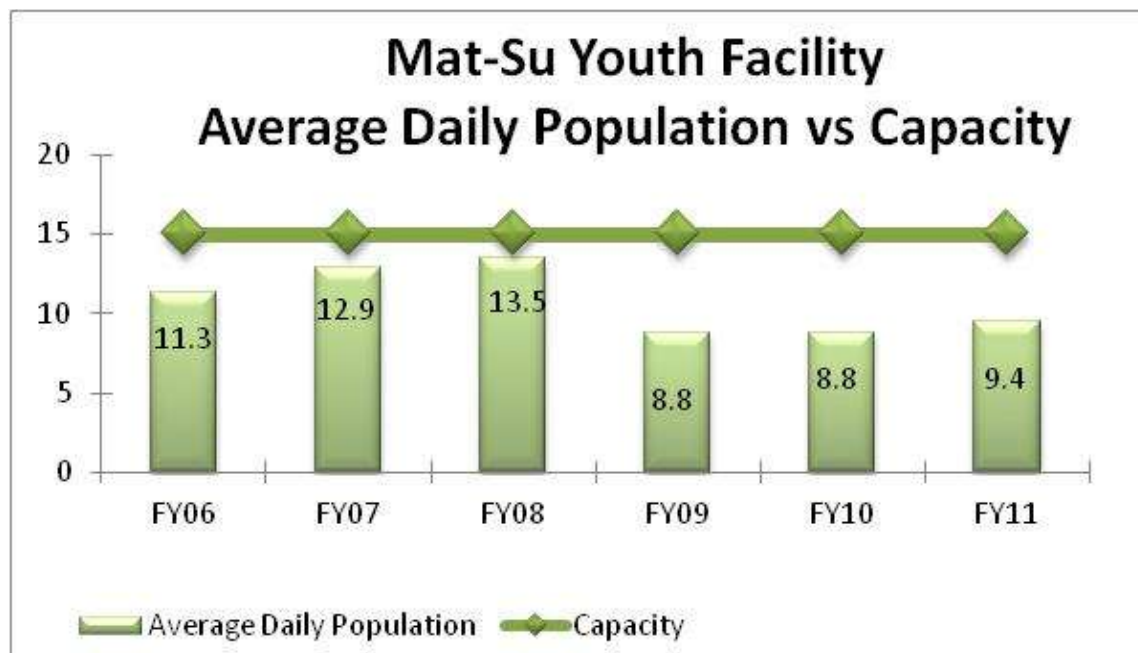
MSYF Core Services

Services provided to residents of MSYF focus on education, physical and mental health, substance abuse prevention, victim empathy, and a variety of related activities and groups geared toward competency development and victim restoration. The facility offers educational opportunities and basic group counseling year round. These groups include life skills, healthy relationships, and decision making. In addition to groups led by facility staff, MSYF has community volunteers who facilitate substance abuse education and religious services. The facility behavior modification program is centered on a strength-based model.

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.

Near the end of the FY2011 MSYF began operating a Community Detention Program for youth who didn't need the structure of a 24-hour detention setting but still required additional supervision. Educational groups involving substance abuse prevention and social skills are provided to participants as well as an opportunity to give back to their communities through community work service.

MSYF has been successful in implementing the national quality assurance process of the PbS program. The facility is currently working on Level III data certification.



Kenai Peninsula Youth Facility

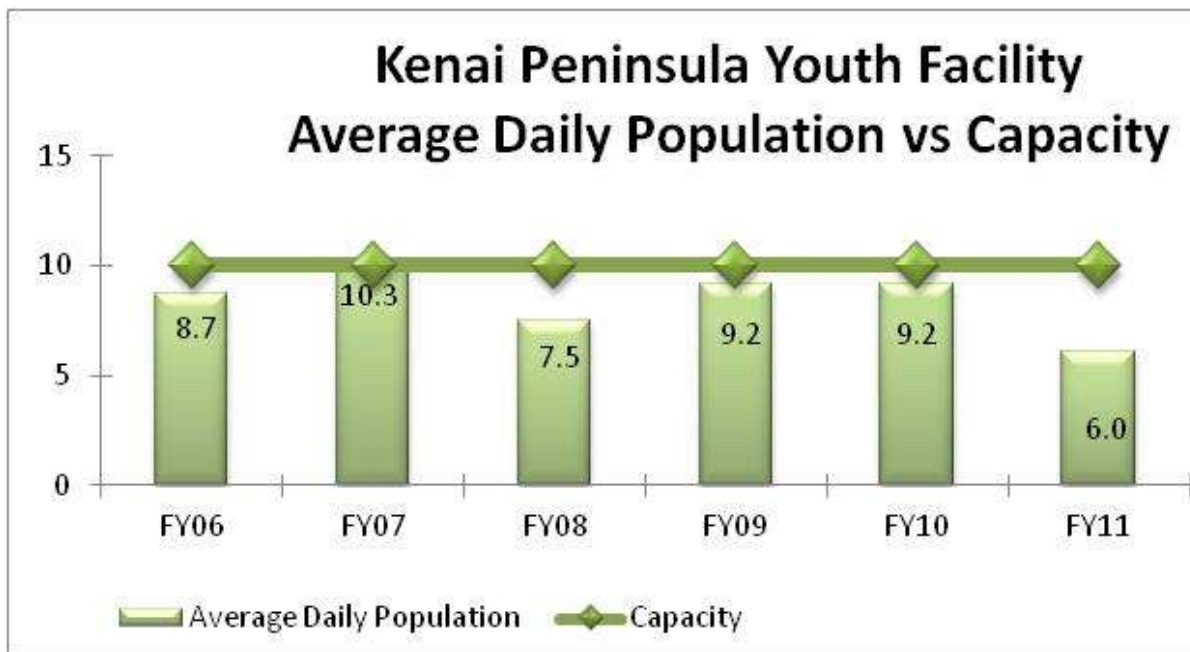
The Kenai Peninsula Youth Facility (KPYF) is a 10-bed facility built in 2003 and located in the city of Kenai. It provides secure detention for youth from the Kenai Peninsula who await court action or placement in a foster home, residential treatment, or correctional program. In FY2011, 82 juveniles received services at the facility. Since the year 2000, the population of the Kenai Peninsula Borough has increased by 11.5%. The Kenai District Juvenile Probation offices are co-located with the facility.

KPYF Core Services

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 the restoration of communities and victims.

The facility provides core services that focus on promoting social and moral growth and the acceptance of personal responsibility for behavior, while meeting the youth's basic physical needs for food, shelter, and clothing in a safe and secure environment. The facility provides educational services, daily activities, and recreational programming that focus on promoting psychological and behavioral growth, including life skills education, victim empathy, substance abuse education, increased self-awareness, healthy lifestyle choices, and improved decision making. When youth are returned to the community, probation and facility staff work with local service providers to appropriately place youth leaving the facility, and to provide community outreach services to encourage victim and community restoration.

KPYF has been successful in implementing the national quality assurance process of the PbS program. The facility is currently working on Level III data certification.



Southeast Region

Southeast Region Probation Services

The Southeast Region of Probation Services (SERO) covers the greater Alaskan Panhandle from the communities of Yakutat, Haines, and Skagway on up north to Hyder on its southern edge. The total population of the region is approximately 74,500 people. The region includes approximately 40 established communities plus numerous semi-permanent logging camps. In FY2011 SERO provided probation services in relation to 557 referrals from local and state law enforcement.

The region is divided into three districts: Juneau, Sitka, and Ketchikan. The Juneau district office, co-located with Johnson Youth Center, provides intake and supervision in seven communities: Juneau, Haines, Skagway, Hoonah, Gustavus, Tenakee, and Yakutat.

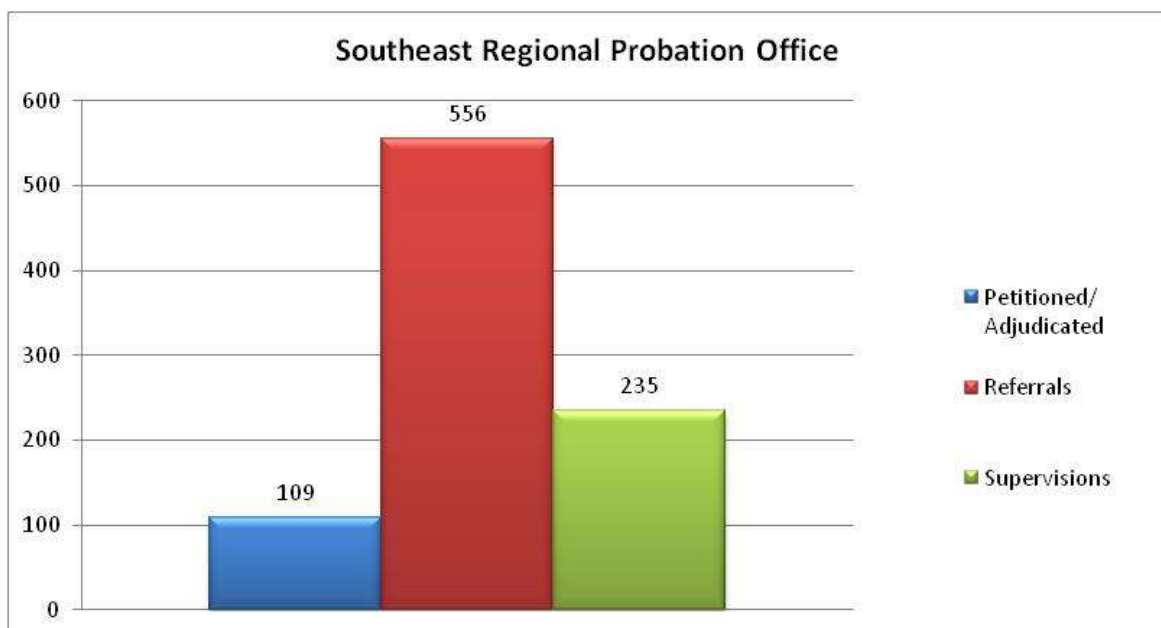
The Sitka district office consists of one juvenile probation officer and one social services associate. It serves the Sitka area as well as Pelican, Elfin Cove, Angoon, Port Alexander, and several outlying fishing and logging camps.

The Ketchikan district office provides services for southern southeast Alaska and encompasses the area from Hyder north to Petersburg. Other communities within this district include Metlakatla, Saxman, and Wrangell. A secondary office is located on Prince of Wales Island and serves the surrounding communities.

Southeast Region Core Services

The mission of SERO continues to be that of restorative justice. Each district office provides a range of services from preventative community education and action to early intervention and assessment to formal intervention through court action and subsequent supervision.

A key component of probation services is transition of a juvenile into the community after incarceration or residential care. SERO probation officers work with correctional facility staff and juveniles to plan and structure discharge in a manner that will allow juveniles to maintain the behavioral change successes they experienced in treatment.



Johnson Youth Center

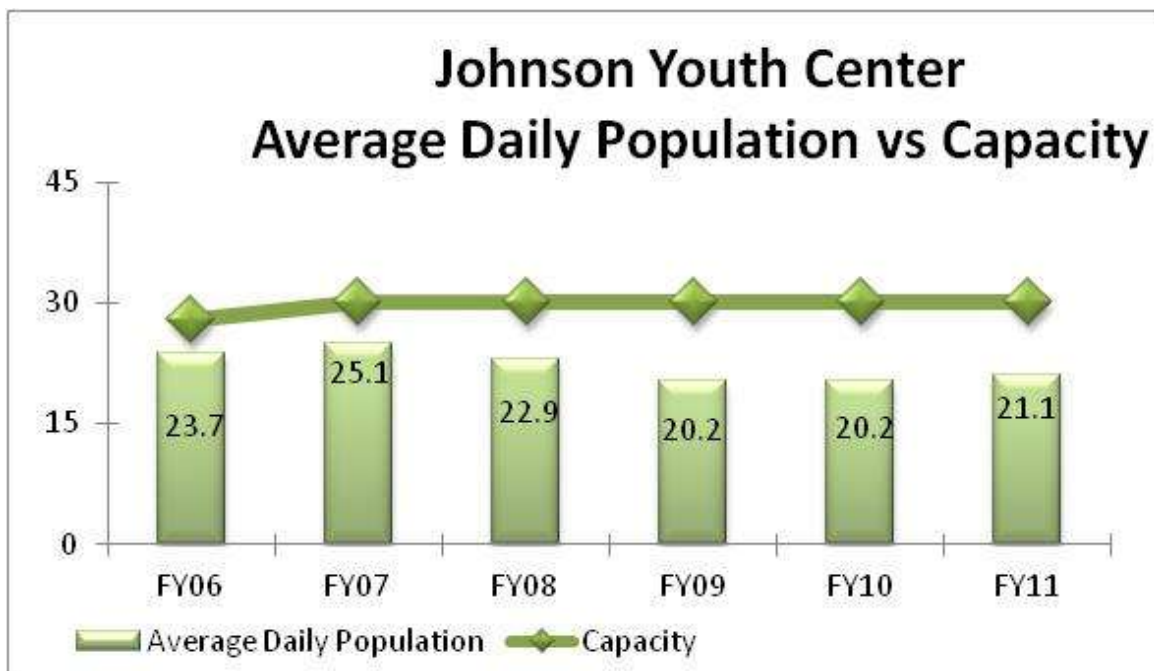
The Johnson Youth Center (JYC) is a 30-bed facility (8-detention and 22-treatment) that provides short-term, pre-trial detention, control and intervention for juveniles who have been ordered into confinement by the Superior Court due to the danger they present to the public and/or to themselves and long-term residential and treatment services to youth committed to longer-term secure treatment. Facility employees also provide support services for the Ketchikan Regional Youth Facility in Ketchikan and administrative support for SERO.

Johnson Youth Center Core Services

With two distinct and different programs within JYC (short-term detention and long-term treatment), the implementation and facilitation of core service programming requires facility staff to be knowledgeable and flexible. Detention unit programming must take the reality of short-term placement and legal issues into account when working with juveniles. Detention staff's ability to engage and interact with detained juveniles supports relationship building and positive rapport with most admits. Due to the short duration of a detention placement, a full course of treatment interventions is not possible, though staff initiate introductory groups of Aggression Replacement Training (ART) and substance abuse prevention and education.

A 22-bed Cognitive Behavioral Treatment Program focuses on skill streaming, appropriate anger management, moral reasoning, intensive substance abuse assessment and 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 risks of each resident.

JYC has been successful in implementing the national quality assurance process of the 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

The Ketchikan Regional Youth Facility (KRYF) serves an area of Southeast Alaska that includes the southernmost portion of the Alaska Panhandle. It is a 10-bed facility (six-bed detention and four-bed crisis stabilization) that provides secure detention of youth who are awaiting a court hearing or other placement, and short-term-crisis respite and stabilization services in an unlocked wing of the facility for youth experiencing problems related to 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.

KRYF Core Services

KRYF's Detention Unit provided secure care and temporary placement to 58 juveniles in FY2011 who were awaiting court process on charges of delinquency, probation violation, or pending transfer to another placement. Detained youth benefit from the facility's strength-based programming where staff members work to identify each juvenile's individual strengths. Team meetings then focus on incorporating positive attributes into the juvenile's behavior management program while in the facility and into their assessments for court review.

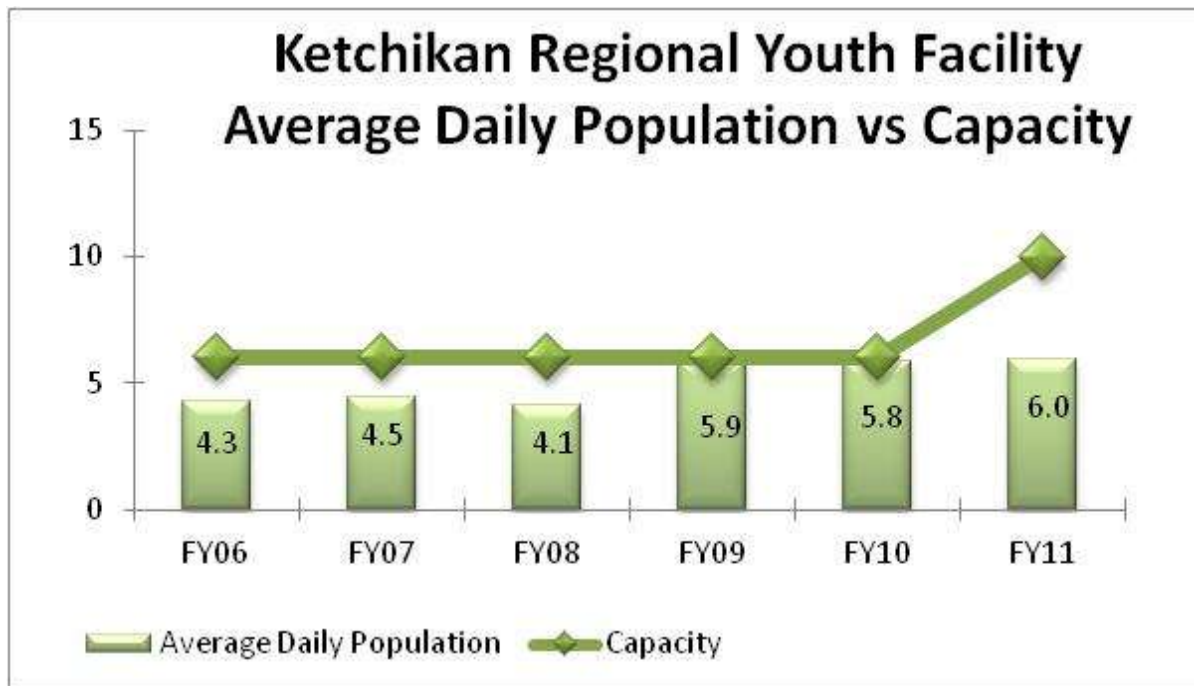
The Crisis Stabilization Unit (CSU) provides a safe environment for up to four youth in crisis and in need of assessment or evaluation to assist in treatment planning. Services provided are short-term, with a maximum stay of up to 30 days. These services allow youth the opportunity to remain in their community during sub-acute episodes, while still receiving the structure and support necessary for them to promote safety and stability. Resources for the CSU includes support from the facility's 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. Thirty youth were placed in the CSU during the past fiscal year.

Electronic monitoring has always been a program favored by the Ketchikan courts as an alternative to detention. Youth on electronic monitoring check in with facility staff. Parents are also offered instruction on appropriate discipline and supervision techniques by staff. Facility staff members respond to any alarms from the electronic monitoring equipment. This program is aligned with the division's system reinvestment plan to develop a balanced juvenile justice service continuum that uses resources effectively and efficiently. The electronic monitoring program in Ketchikan has been modified and adapted for use by other detention facilities across Alaska, including Fairbanks, Mat-Su, Nome, Kenai, and Juneau.

The facility continues its strong working relationships with parents, juvenile probation, the local school district and school board, and local service agencies including Community Connections, Gateway Human Services Center, Metlakatla Social Services, and the Ketchikan Indian Corporation. KRYF has a strong partnership with the Ketchikan Gateway Borough School District. A school district grant under the Safe Schools and Healthy Students initiative provides valuable services for KRYF residents. As part of that grant program, a school district transition liaison position works with students as they transition into and out of the education program at KRYF.

KRYF's partnership with the Ketchikan agency Women in Safe Homes (WISH) has resulted in a series of groups provided by that agency for KRYF residents. WISH staff and volunteers 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.



Beginning in FY11, the chart includes the 4 Crisis Stabilization Unit beds.

Anchorage Region

Anchorage Probation Services

The Anchorage Regional Probation Office (ARPO) covers the greater Anchorage area north to the Eklutna Flats and south to Portage, Whittier, and Hope. This region's population of over 300,000 people equates to the Anchorage office receiving approximately 40% of Alaska's delinquency referrals. In FY2011, Anchorage Probation received 1,862 referrals from law enforcement containing 2,815 individual offenses. Given the size and diversity of Anchorage, ARPO is divided into four units covering intake functions, two units providing standard field supervision, and a Behavioral Health Unit. Several smaller "sub-units" (Aftercare, the Female Intervention Unit, and Foster Care) exist to address specific supervision and treatment needs. ARPO is the only DJJ probation office staffed seven days a week.

Anchorage Regional Probation Core Services

The ARPO Intake Unit is the first responder to the majority of law enforcement referrals. This unit makes the decisions regarding what youth are admitted to the McLaughlin Youth Center Detention Unit, which juveniles are diverted from penetrating deeper into the juvenile justice system, and which juveniles proceed to formal court intervention. This unit works closely with community diversion resources, the Office of the District Attorney, the local defense bar, and the Anchorage Police Department.

ARPO field supervision is made up of units that cover the north/east and south/west portions of the municipality. These units are assigned cases following formal adjudication and must assess the needs of the juvenile in terms of treatment and the structure necessary for the juvenile to make the positive adjustment necessary to be successful under probation supervision. These units also provide immediate supervision for youth placed in Anchorage from other regions of the state in order to access treatment resources.

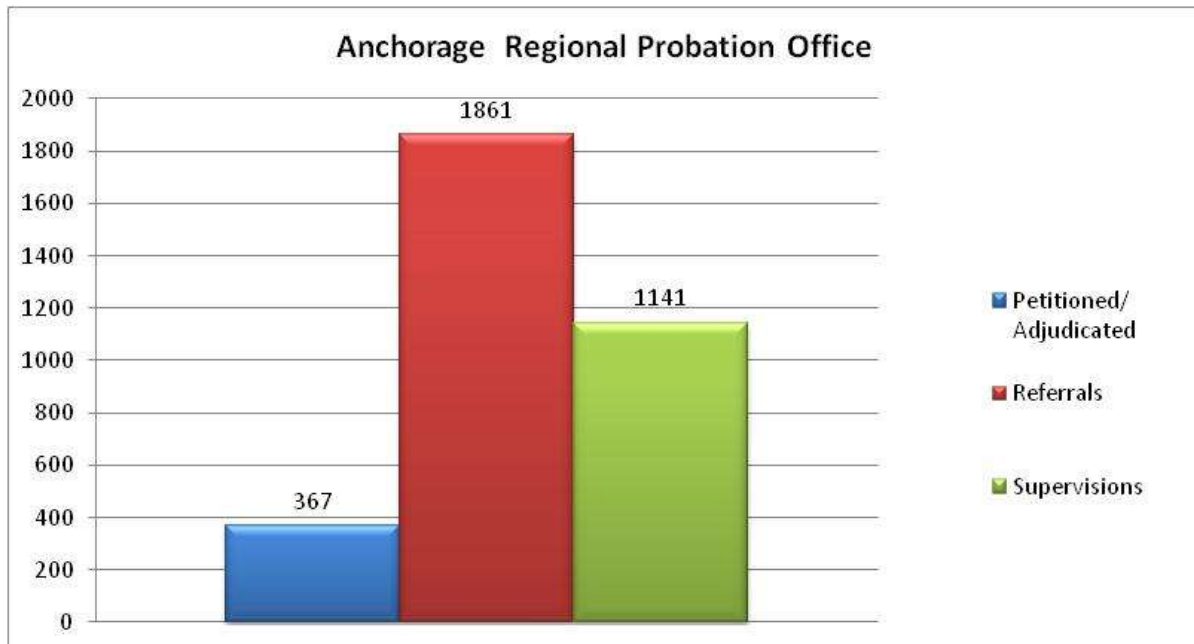
The probation officers in these units are considered to be "school-focused" and work closely with school resource officers from the Anchorage Police Department. The presence of juvenile probation officers in the schools encourages better attendance and better academic and behavioral performance from DJJ clients. At the request of the Anchorage School District, Anchorage juvenile probation officers maintain a highly visible presence at school functions, such as registration and the final day of school. At other times these officers have also answered requests from schools and law enforcement to be present on campuses as a proactive measure to head off anticipated problems.

The North Field Supervision Unit is also home to the McLaughlin Youth Center-based component that works with facility staff to plan transitional services for juveniles leaving the secure correctional setting as well as to provide supervision when the juvenile re-enters the community.

The Female Intervention Team is located within the South Field Supervision Unit and provides gender-specific programming for adjudicated female juveniles. The two probation officers in this unit have been operating a "girl's circle" for clients. This national model provides structured support groups for females that are designed to foster self-esteem, help participants to establish and maintain positive relationships with peers and adult women in the community, counter

tendencies toward self-doubt, and allow for genuine self-expression through verbal and creative sharing.

Anchorage Behavioral Health Unit (BHU) is assigned to work with juveniles at all levels of the juvenile justice system who have or are experiencing behavioral health issues. In addition to standard probation services, the BHU provides case staffing and consultation on mental health cases, obtains records from previous mental health providers to assist in treatment planning, researches mental health treatment options, refers to social service and mental health agencies, and applies for supportive funding for individual services. A primary goal of this unit is to work to keep this group of juveniles from penetrating deeper into the formal delinquency system.



McLaughlin Youth Center

The McLaughlin Youth Center (MYC) is located in Anchorage and is the oldest and largest of DJJ's eight facilities. The facility currently has 163 beds (60 detention beds and 103 longer-term correctional treatment beds). The detention units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Cordova, Valdez, Kodiak, Dillingham, and Aleutian/Pribilof Islands. The detention program admitted 703 juveniles in the past fiscal year. DJJ's system of statewide classification is intended to assure that institutionalized juveniles are placed in the correctional treatment facility that will best meet their individual treatment needs. This system results in MYC receiving long-term placements from all parts of Alaska.

McLaughlin Youth Center Core Services

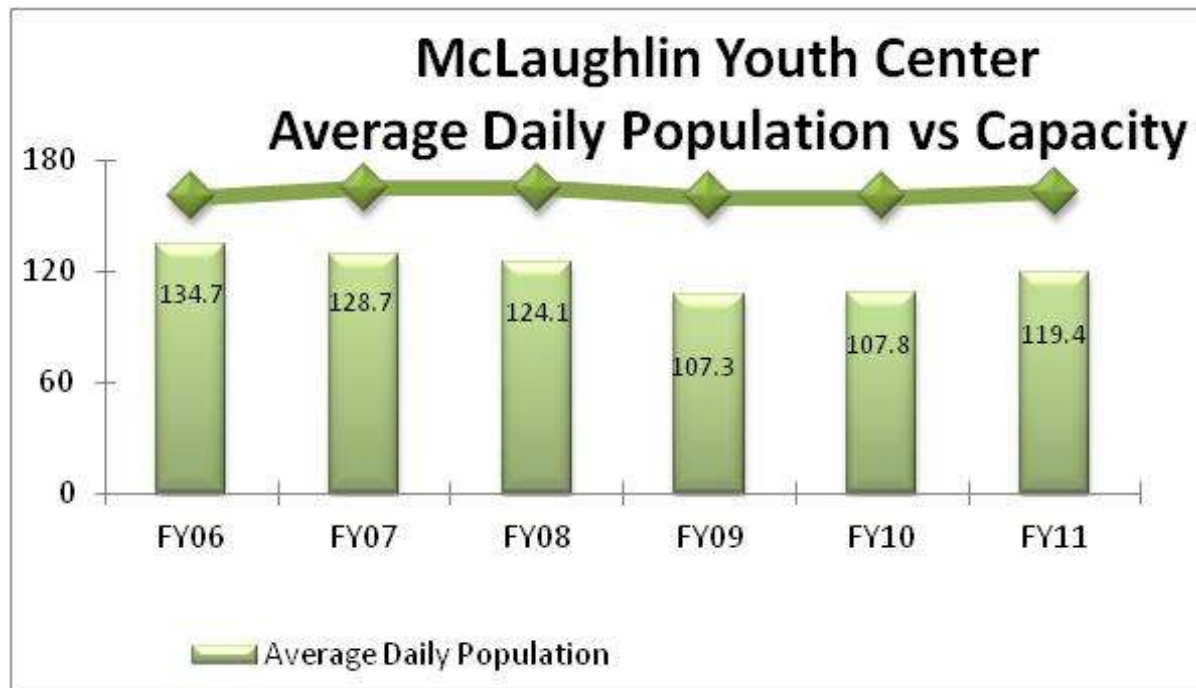
Primary among the services provided by MYC is the mission to provide safe and secure housing and care for detention and treatment program residents. In addition to the fundamental tasks of housing, feeding, and providing safe and secure environments for youth, the facility provides extensive educational and treatment services for both short-term detention and long-term program youth. The girl's detention unit, for example, offers therapeutic groups dealing with substance abuse education and prevention, life skills, thinking errors, and parenting. Because of its size and history as the state's first facility, MYC has been able to develop a range of program options that do not exist in most of the smaller facilities. In addition to secure detention and long-term treatment, MYC also provides community detention, sex offender treatment, a separated female detention and treatment unit, an intensive treatment unit (ITU) for juveniles whose behavior or history require a high level of security and treatment, and transitional services for youth leaving long-term institutional treatment.

The MYC's Transitional Services Unit (TSU) was created in FY2004 and was designed to prepare each institutionalized youth for a gradual and successful re-entry into the community from the time he/she is institutionalized. TSU staff work with the juvenile's assigned probation officer to provide monitoring, supervision, and support to youth in the community prior to and after release. Smaller versions of this program have been implemented in other facilities around the state.

Among the many community partnerships for MYC is the collaborative relationship with the Anchorage School District to provide services to suspended and expelled students. This program completed its second year during FY2011. The initial year of bumps and obstacles has led to a solid and effective program that is now looking towards expansion. Much of this success can be attributed to the leadership and effort of MYC staff.

McLaughlin Youth Center has been successful in implementing the national quality assurance process of the PbS program. McLaughlin is currently working on Level III data certification.

The chart below indicates the average daily population and capacity during several fiscal years. In 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 count their beds. For FY2010, the number of beds was been reduced by four. Two due to the construction project that is currently taking place at the facility and two rooms that are strictly used as observation rooms. In FY2011, MYC again re-evaluated how beds are counted and the facility had 163 beds.



Collaborations

The division is committed to developing partnerships with sister agencies and community partners to ensure that the needs of our youth are met and that state resources are fully utilized. These partnerships are vital to the success of the division’s mission and to the present and future success of youth and their families. Some examples of collaboration efforts are as follows:

- The division has partnered with the department’s other divisions in an effort entitled Families First. This key project requires the collaboration of division partners providing support services for Alaska’s families. Through inter-divisional communication, cooperation, and planning, the supportive entities can offer a more effective and efficient response to family needs.
- The division has an agreement with the Alaska Psychiatric Institute (API) that outlines a protocol for juvenile admissions to API and transfers to DJJ facilities to ensure that youth who are in a crisis situation receive the mental health services that may be needed.
- The division has signed a Memorandum of Agreement (MOA) with the Department of Education and Early Development to ensure youth within DJJ 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.

- 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 the State Attorney General. 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, the Department of Public Safety, and other member agencies to develop research questions and generate statistics on juvenile crime, offenders, and recidivism.
- The division has partnered with the Mental Health Trust Authority to increase and improve mental health services provided by the division. And, as part of the Disability Justice Focus Area, the Trust provided funding to support a rural specialist position that will work with rural communities to assist youth returning to their homes after leaving the DJJ system.
- The division worked with the Anchorage School District and Nine Star Education and Employment Services to create the Step-Up Program, an educational program tailored to the needs of youth who have been previously expelled from school.
- The division has two MOAs with the Office of Children's Services: one outlines programmatic responsibility for shared resource areas, such as foster care and residential services; the second MOA describes guidelines for the management of shared cases. In addition, the division is working with the Office of Children's Services to develop a specific policy and 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 Department's Joint Management team includes the Division of Behavioral Health, Office of Children's Services, Division of Public Assistance, and DJJ. This team works to ensure the success of the Bring the Kids Home project.
- The division has developed a partnership with the Division of Behavioral Health and the Mental Health Trust Authority and other organizations to work on the Comprehensive Integrated Mental Health Plan for the department.
- For the past several years, DJJ has received funding from the Division of Behavioral Health to provide services related to the Bring the Kids Home project. This has allowed for more family counseling sessions with families and follow-up with youth once they have been released.
- The Reclaiming Futures Project in Anchorage has been a successful collaboration with the court system and Volunteers of America to address special needs of youth with substance abuse issues who enter the juvenile justice system.
- DJJ has increased efforts to turn the curve on the high rate of recidivism of Alaska Native youth 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, First Alaskans Institute, the Alaska Native Justice Center, and other organizations representing Alaska's indigenous population. Additionally, DJJ is 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 has an MOA with the Department of Public Safety to increase opportunities for transportation of departmental staff to Alaska's rural communities, by meeting regularly to determine availability of flights and schedule travel.

The division 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 data to improve the quality of services offered. These initiatives include:

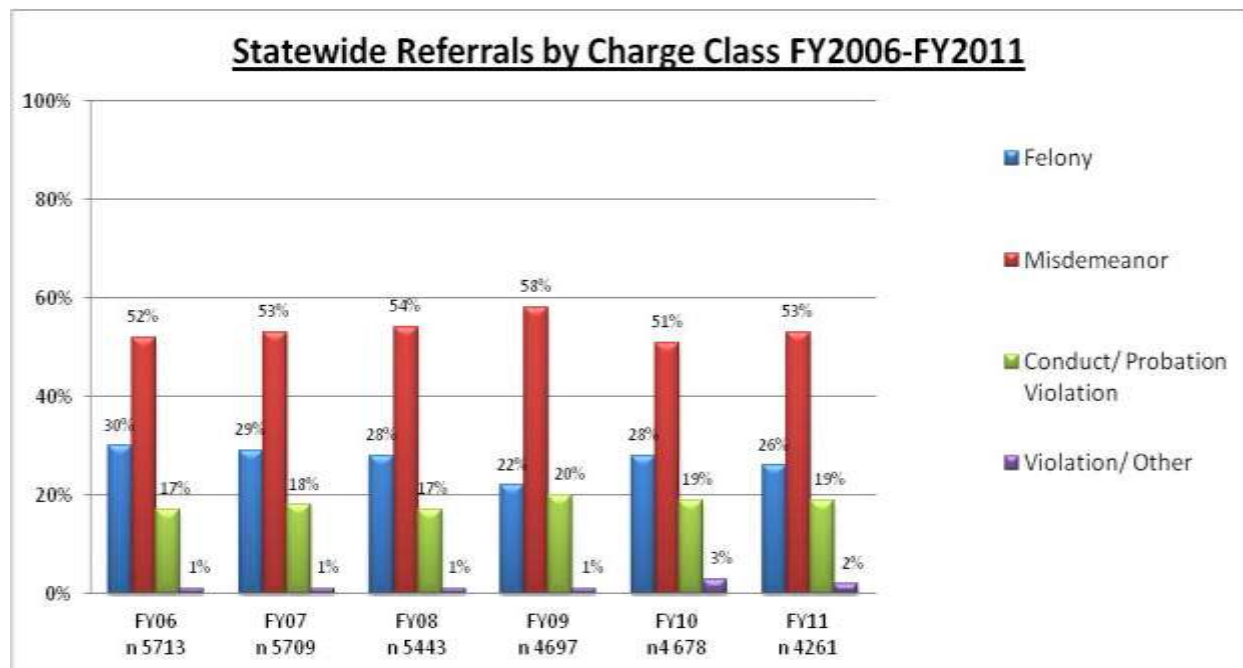
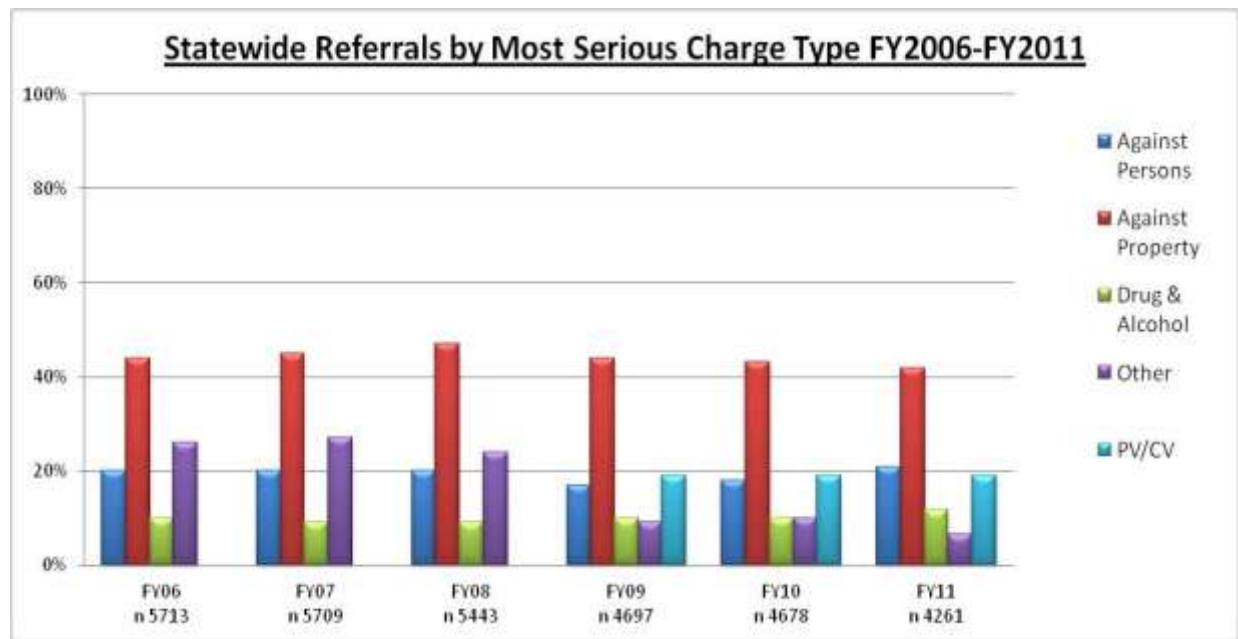
- The use of assessment instruments to assist staff in accurately determining a youth's risk of re-offense and need for secure detention including the Youth Level of Services/Case Management Inventory (YLS/CMI), Detention Assessment Instrument (DAI), and the Massachusetts Youth Screening Instrument-2 (MAYSI-2);
- A quality assurance process (Performance-based Standards) 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 (ART) 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 FY2013, the division's leadership will continue to incorporate these system improvement projects into the strategic plan and vision for juvenile justice in Alaska. The system improvement projects will improve public safety, and ensure that victim needs are met and offenders are being held accountable.

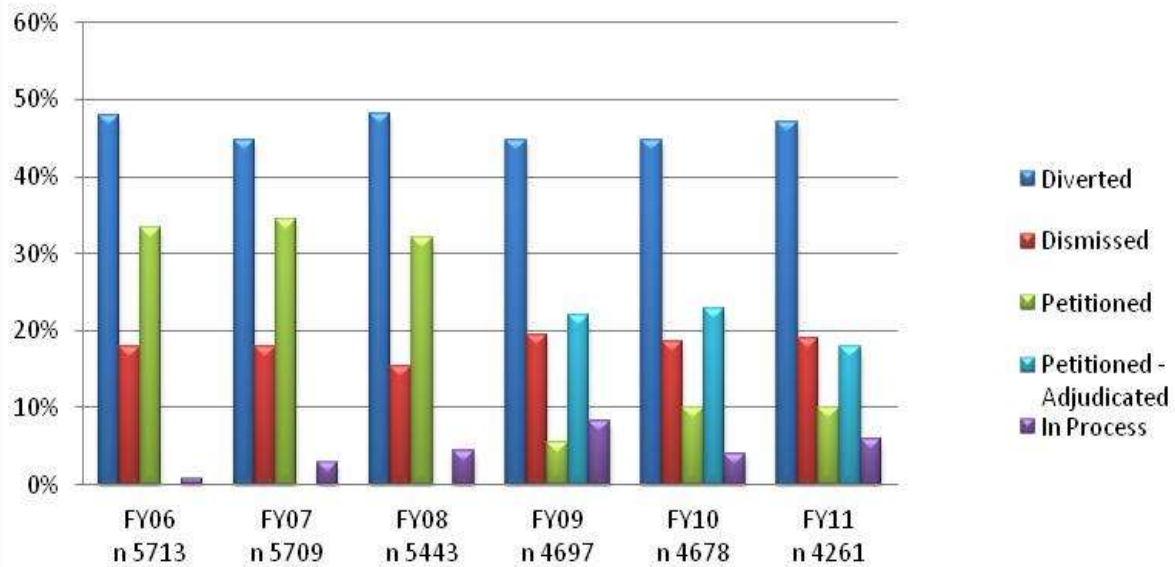
Annual Statistical Summary of Services Provided in FY2011

FY2011 Delinquency Referral Summaries

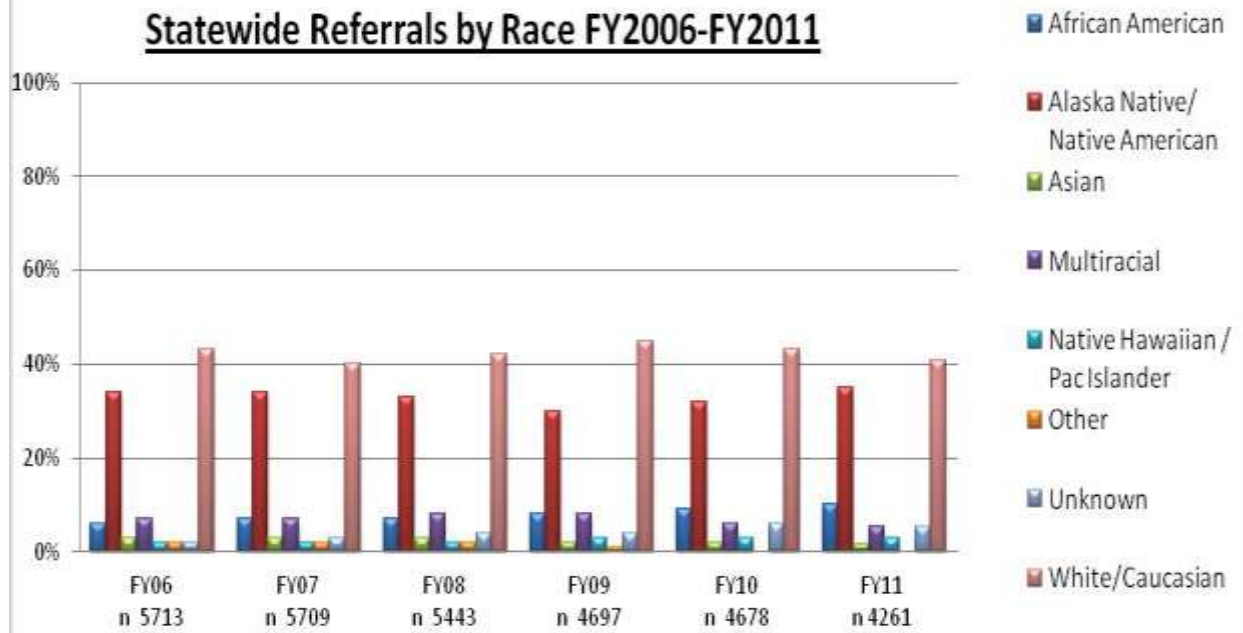
The following charts provide a summary of referrals for FY2006 through FY2011.

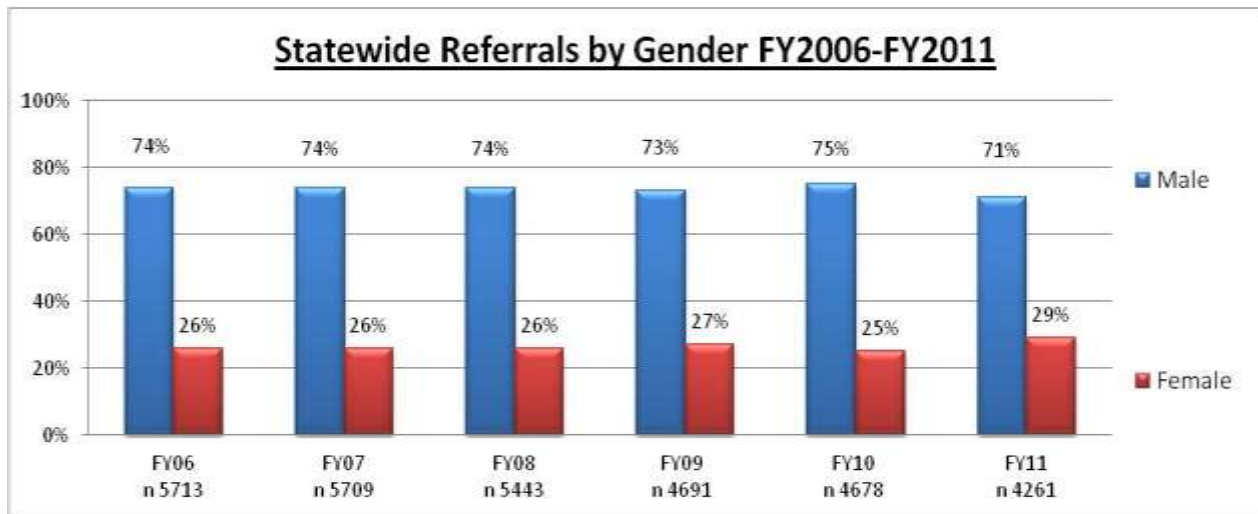


**Most Progressed Final Disposition at Data Retrieval Date, by
Referral FY2006-FY2011**



Statewide Referrals by Race FY2006-FY2011





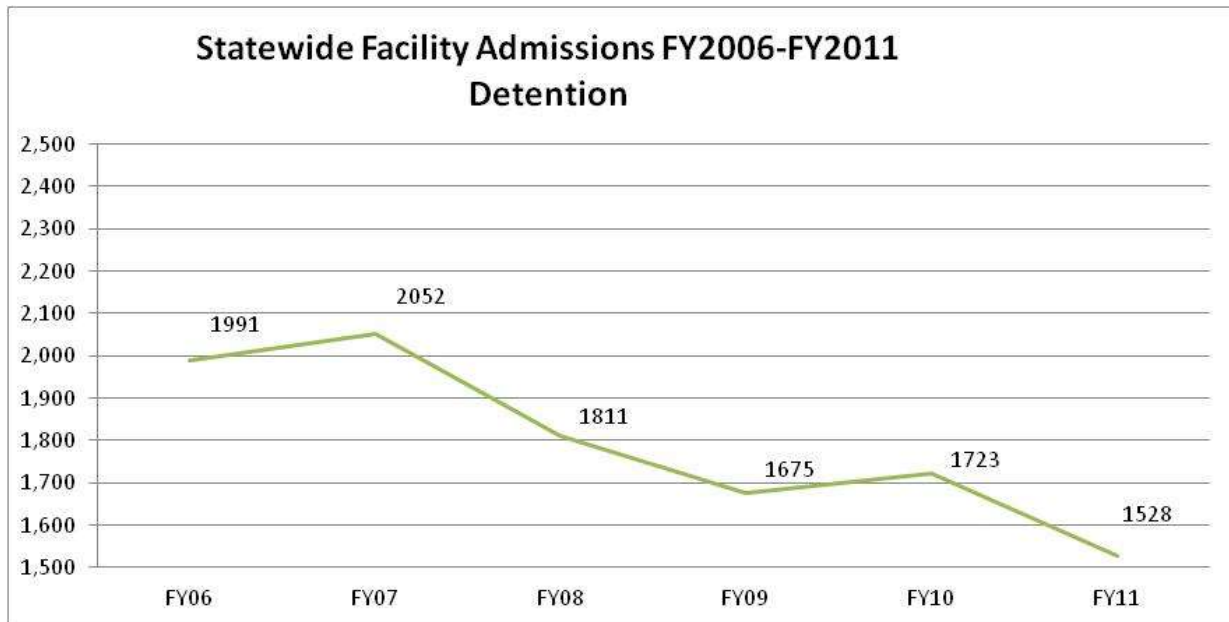
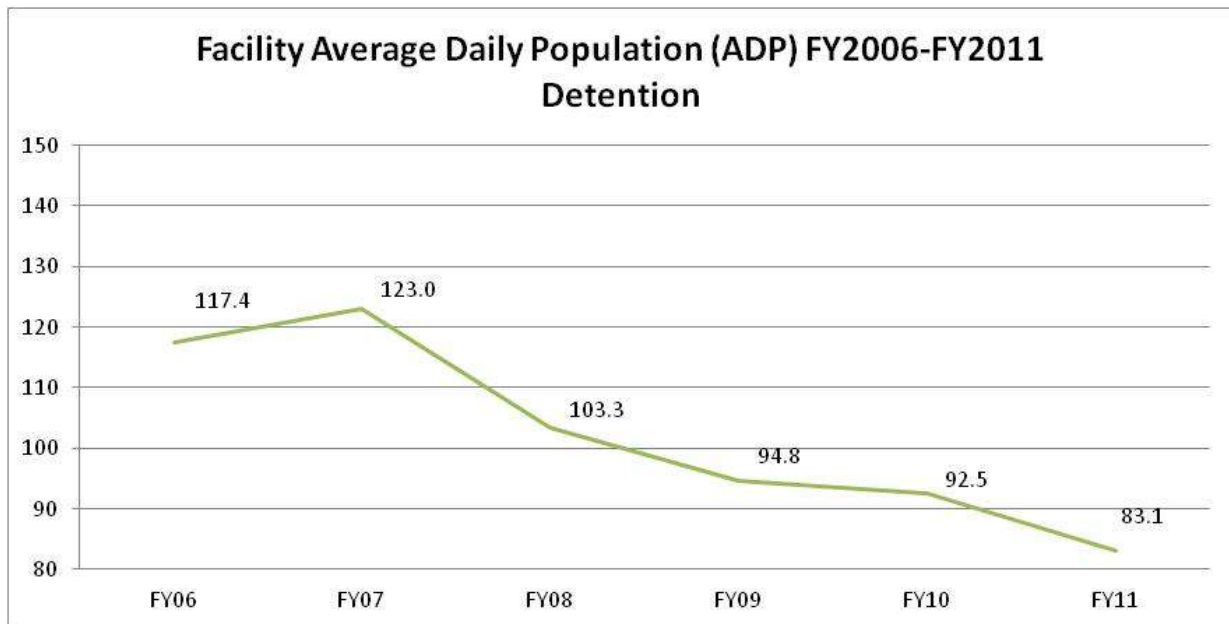
The table below shows the bed capacity at each of the division's secure juvenile facilities during FY2011.

Youth Facility Existing Hard Bed Capacity FY2011			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	160	3	163
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		297

Facility Data

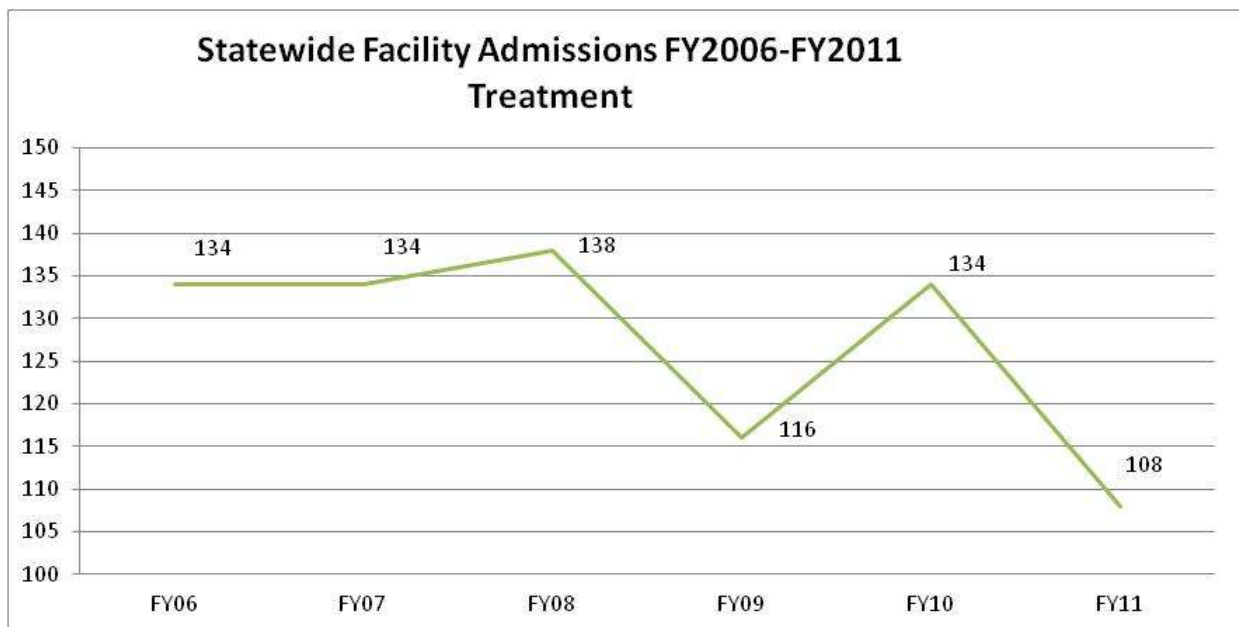
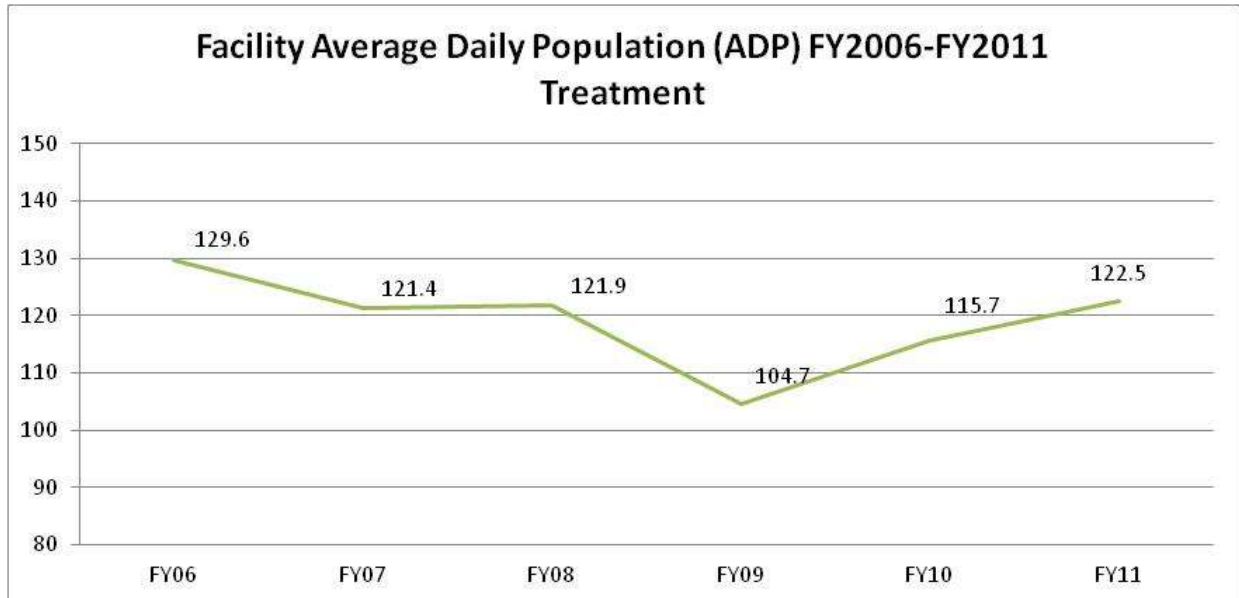
Detention Units

The charts below show juvenile detention average daily population and admissions from FY2006 through FY2011. 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 FY2011 was 141 beds.



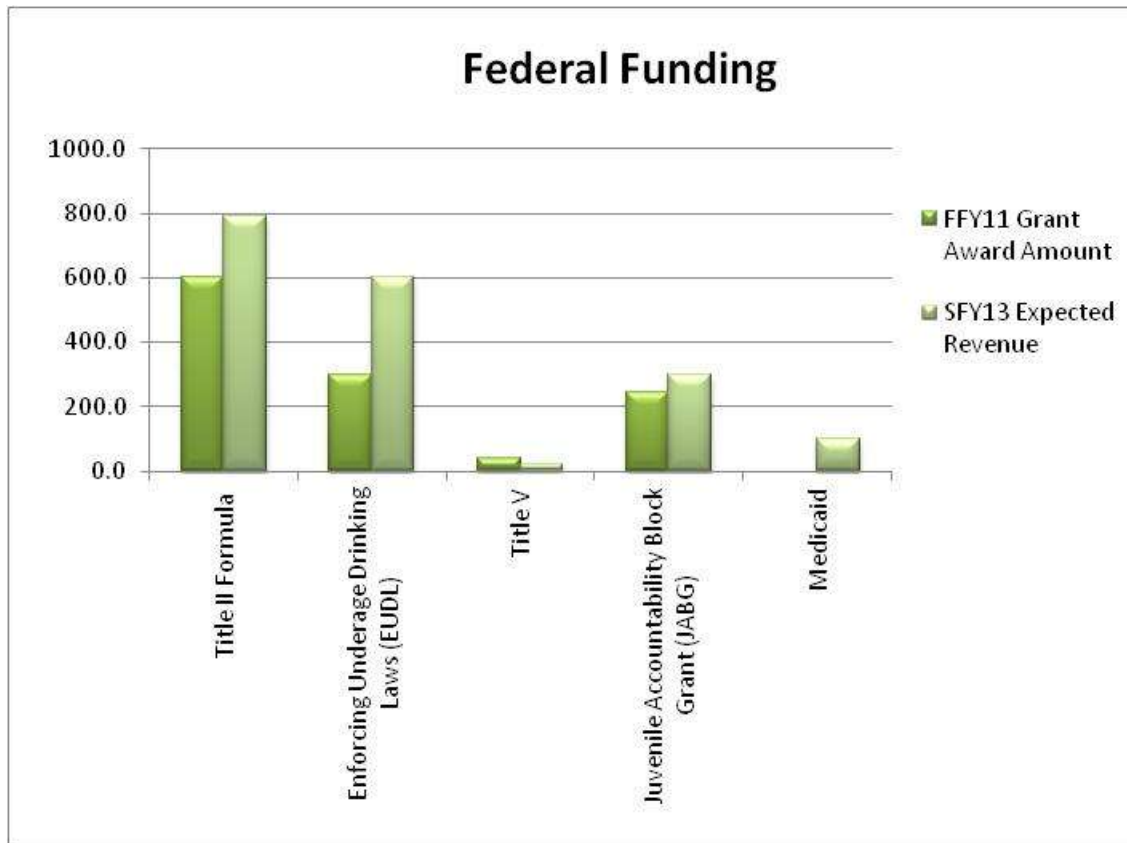
Treatment Units

Below are charts showing juvenile program average daily population and admissions from FY2006 through FY2011. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY2011 was 152, including the 4 unlocked crisis stabilization beds located at the Ketchikan Regional Youth Facility.



Federal Funding

The Alaska Juvenile Justice Advisory Committee (AJJAC) is the congressionally mandated state advisory group to the division. The committee collaborates with DJJ by advising the division on priorities for spending 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 FFY2011 grant programs and budgeted revenues for FY2013. 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 FY2013 Operating Budget Requests

Division of Juvenile Justice

Budget Overview Table

Juvenile Justice	FY2012	FY2013 Gov	Difference
General Fund	\$53,202.0	\$55,011.3	\$1,809.3
Federal Fund	1,796.1	1,812.3	16.2
Other Funds	1,028.4	1,351.6	323.2
Total	\$56,026.5	\$58,175.2	\$2,148.7

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

Reverse FY2012 MH Trust Recommendation: (\$7.2) MHTAAR

This is a zero-based adjustment record that includes all MHTAAR funding for FY2012 for this component. This was part of a salary adjustment that should not have been put into the budget.

Grave Shift Coverage at the McLaughlin Youth Center: Increment \$300.0 General Funds

The division is requesting three Juvenile Justice Officer I/II positions for the McLaughlin Youth Center (MYC) for two units that currently do not have appropriate coverage for the graveyard shifts. Both of these units serve volatile, serious juvenile offenders. Acquiring the three additional Juvenile Justice Officer I/II positions would bring the staffing pattern of two staff on every grave shift for both the Intensive Treatment Unit (ITU) and Specialized Treatment Unit (STX).

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Mat-Su Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Kenai Peninsula Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Fairbanks Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Bethel Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 4.0% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Nome Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Delete Long-Term Vacant Positions: Position Adjustment 1

OMB has requested that positions that are vacant for more than one year be deleted. The division has requested that PCN 06-3649 within the Probation Services component be deleted instead. This transaction restores PCN 06-4561.

Johnson Youth Center

Grave Shift Coverage for the Johnson Youth Center: Increment \$200.0 General Funds

The division is requesting two positions to provide adequate coverage during the grave shifts (two staff on duty during each of these shifts) at the Johnson Youth Center for both the Detention and Treatment units. The current lack of staffing in our 24 hour facility that operates 365 days per year, creates the need to constantly adjust established work schedules to cover the grave shifts. Consequently, these adjustments cause safety concern on the other waking shifts (day and swing) and pose an additional hardship for staff working at those times.

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 2.5% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Ketchikan Regional Youth Facility

Realign Funding to Cover Personal Services Expenditures for FY2013: Line Item Transfer

This line item transfer is necessary to cover the cost of personal services within this component, still forcing the division to budget a 4.0% vacancy. For several years, the division was requested to fund premium pay as a lump sum. Unfortunately, cost of living allowance increments were not applied to the lump sum premium pay amounts; this has forced the division to request two increments in recent years to get closer to a zero vacancy rate. These increments have not been enough to allow the division to stay at a low vacancy rate. Requesting the increments and supplemental requests have been necessary to ensure our facilities are appropriately staffed and the division is not forced to hold positions vacant to stay within the appropriated budget.

Transfer from Probation Services to Fund Personal Services: Transfer In \$50.0 General Funds
This transfer of funds is necessary to cover the cost of personal services within this component, still forcing the division to budget a 4.0% vacancy.

Probation Services

MH Trust: Mental Health Clinician Oversight in Youth Facilities \$152.9 MHTAAR Increment
The MH Trust: Disability Justice - Mental Health Clinician Oversight in DJJ Youth Facilities is a position to provide supervisory oversight to mental health clinicians (MHCs) in areas such as clinical service delivery, case consultation, development of training plans, and expertise related to confidentiality and ethical issues. In addition, this position will work with DJJ senior management to further the integration and development of statewide behavioral health services within the 24/7 secure facilities as well as the probation services of DJJ. Currently, DJJ mental health clinical staff are located in six locations and provide services in eight juvenile facilities and two probation offices statewide. DJJ does not have the capacity to provide adequate support and supervision of the clinical services provided by these key staff.

MH Trust: Disability Justice—Grant 3504.01 Division of Juvenile Justice Rural Re-entry 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 project 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.

Increase I/A Authority to Account for RSA with Division of Behavioral Health for Bring the Kids Home, Individualized Services \$100.0 Increment I/A Add \$100.0 I/A authority for RSA between the DJJ and the Division of Behavioral Health. This is for Bring the Kids Home funds that are transferred to us through the Individualized Services. The divisions have had an unbudgeted RSA for the past several years. This will allow the RSA to be budgeted on DJJ's side.

Transfer Funding to Ketchikan Regional Youth Facility for Personal Services: (\$50.0)
General Fund Transfer Out This transfer of funds is necessary to cover the cost of personal services within the Ketchikan Regional Youth Facility component.

Delete Long-Term Vacant Positions: Position Adjustment -1
OMB has requested that positions that have been vacant for more than one year be deleted from the budget. The division has requested that PCN 06-3649 within the Probation Services component be deleted.

Delinquency Prevention

Increase I/A Authority for the Workers' Investment Act Funds Received from the Department of Labor and Workforce Development: \$75.0 I/A Increment

The RSA with the Department of Labor and Workforce Development has increased and additional I/A authority is needed to cover the amount of funds that are transferred to DJJ for this grant.

Explanation of FY2011 Capital Budget Requests

Bethel Youth Facility: \$10,000.0 General Funds

The Bethel Youth Facility (BYF) is in need of extensive renovation and construction. This capital request will provide for the pre-construction work of four new Detention beds for a total of 12, upgraded Treatment beds, additional Probation space, expanded medical space, a vehicle sally port, a small gymnasium and a secure outdoor recreation area. The first phase will complete the design, address site issues and will assist in the removal of the Yukon Kuskokwim Health Corporation's (YKHC) Keyes Building that is in too close proximity to the Bethel Youth Facility.

BYF was part of an assessment study performed on the division's four oldest facilities in 2007 to identify safety and security concerns in these facilities. The study identified BYF as a poorly designed facility with serious safety and security deficiencies. Recently, the study has been re-evaluated for Bethel and the scope has been trimmed down to address the current deficiencies in a two-phased project. First phase of \$10,000.0 will address pre-construction (design) and site development work. The balance of the funds remaining will be added to a FY2014 request to complete the construction phase. Total cost for the project in FY2013 dollars is \$19,024.4

This request will completely fund the design work. The design will encompass the pre-concept planning document that incorporates a central spine that connects the new gym, outdoor recreation, sally port, and medical space with the existing building. The existing housing areas are to be extensively renovated with significant restructuring, thus addressing significant infrastructure issues. These include septic system failure, water pipe problems, electrical issues and structural problems with four cells on the Detention Unit. The central spine will separate the 11-bed Treatment area from the 12-bed Detention space. The intake area will be immediately adjacent to the vehicle sally port.

Funding for this first phase will also address the security and adjacency issues with the YKHC Keyes Building, a former children's receiving home once owned and operated by the department and transferred to YKHC. This site is less than 30 feet away from the Treatment Unit and shares the north property line. There is no fence defining the property boundary and casual trespassing onto the BYF grounds is common. Visual access onto the site is unimpeded and conformance to child protection and confidentiality requirements are difficult to provide since the only outdoor recreation area is in full view of this neighboring facility. The department will partner with YKHC to remove the building to another site and the land will revert back to the department for use by BYF.

Pre-construction funding will also address demolition of unused building(s) on the site in preparation for construction. Any remaining funds from this appropriation will be combined with the Phase 2 request to complete the project.

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 sub-arctic at the Bethel Facility to the damp southeast climate at the Ketchikan Regional Youth Facility. The Bethel Youth Facility and the Fairbanks Youth Facility are plagued with structural and utilization problems that need to be addressed if these facilities are to continue to offer secure, safe services.

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.

In the summer of 2007, a study was commissioned to identify significant safety and security breaches within the four oldest facilities. The study recommended renovation in each of the four facilities. The first of four phases for the MYC renovation was funded and is underway. The division was able to obtain funding for the renovation of the Johnson Youth Center in FY2011 and this work began in the fall of FY2012. The current challenge is to receive funding for the two remaining facilities: The Bethel Youth Facility and the Fairbanks Youth Facility. Funding for the Bethel Youth Facility renovation is presently the top capital priority for the division.

Appropriate Staffing:

The McLaughlin Youth Center and the Johnson Youth Center lack the appropriate number of staff to meet the standards of the prison Rape Elimination Act. Several units are not adequately covered with at least two staff for grave shifts. This means that the division may not be providing the safety and security to staff and youth that is necessary. Without incurring overtime costs or hiring non-perms to do this work, the division can be held liable for the safety of the youth.

Safety and Security:

DJJ is working with other Federal, State, and local emergency services as part of the development of the 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 the division needs funding to provide Anchorage with the necessary radios.

Quality Assurance:

Although the division has reallocated positions to help provide a measure of quality assurance, there are considerable shortcomings in our ability to provide the scrutiny and oversight necessary to ensure that DJJ facilities and probation services are contributing to public safety and positive outcomes for the youth in our care. Correct implementation of evidence-based practices can lead to reduced recidivism; improper implementation has been demonstrated to lead to more delinquent behaviors among juveniles.

Recruitment and Retention:

The past several years have been marked by particularly low turnover among division line staff. Low staff turnover has both costs and benefits for the division. While low staff turnover means that fewer resources and energy need to be devoted to recruiting, training, and closely supervising new staff, low staff turnover also has the effect of costing the division *more* money because long-time staff are not being replaced by lower-paid, new staff. Fewer vacancies mean that there are fewer periods where positions are held open and salaries are not being paid. Increases in pay for longevity, plus increased pay rates for non-permanent employees and those earning premium pay, are forcing our division to make up for its shortfall by no longer budgeting at a zero vacancy rate for its facility components.

While turnover in line staff has been low, the retirement of longtime, upper-management staff continues and poses its own set of challenges as institutional knowledge and experience are lost. The division's director and the deputy director of operations, as well as key administrative and maintenance staff in Anchorage, retired at the end of FY2010. This initiated the predictable domino effect throughout FY2011 of promotions within division ranks followed by the ultimate need to hire new employees. The division also continues to experience problems recruiting staff in the rural areas. For example, the superintendent position at the Ketchikan Regional Youth Facility remained vacant for over two years until an applicant from outside of Alaska was hired in FY2011.

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

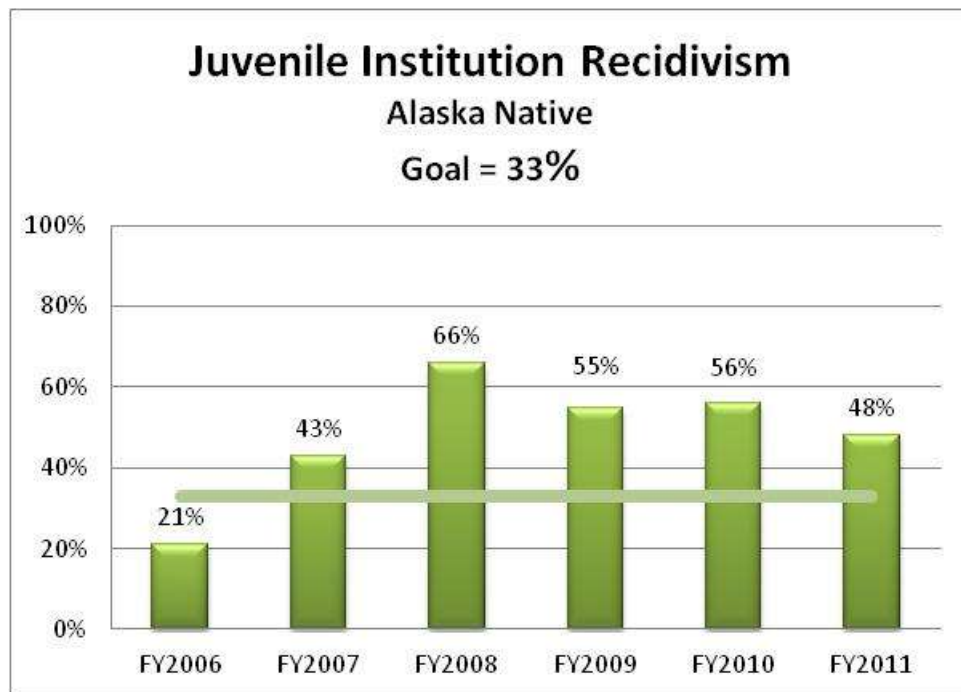
The division is also determined to enhance interest in juvenile justice careers. Employee recruitment videos have been completed for DJJ services in Kenai, Ketchikan, Juneau, Nome, and Bethel. It is expected that similar videos will be created for other areas of the state. These videos are accessible on the DJJ website and are being used in community presentations and career fairs.

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. These services are more available in population centers but also can be developed in rural areas through a collaborative and community-focused strategy. The division's commitment to the use of "graduated responses" to delinquency will encourage this process.

Substance Abuse Services: There is a strong correlation between juvenile delinquency and substance abuse and for the past several years the division has been working to improve the screening of substance abuse issues for youth referred to DJJ and to also provide improved services for identified youth. In addition, the division continues to collect data that will help us understand not only substance abuse concerns but also the co-occurrence of mental health and substance abuse. The division believes improved screening and referral, improved access to

community-based services, increased training from DJJ staff, and stronger substance abuse treatment services our DJJ facilities will all work to improve our outcomes with youth with substance abuse issues.

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

priority need and deserve more effective resources, and will work with its partners in both the nonprofit social services sector, as well as within the Department of Health of Social Services to meet this need. Ultimately, the division thinks that the instrument will guide development of resources such that each community will have ways to address and prevent the factors that result in juvenile delinquency and victimization.

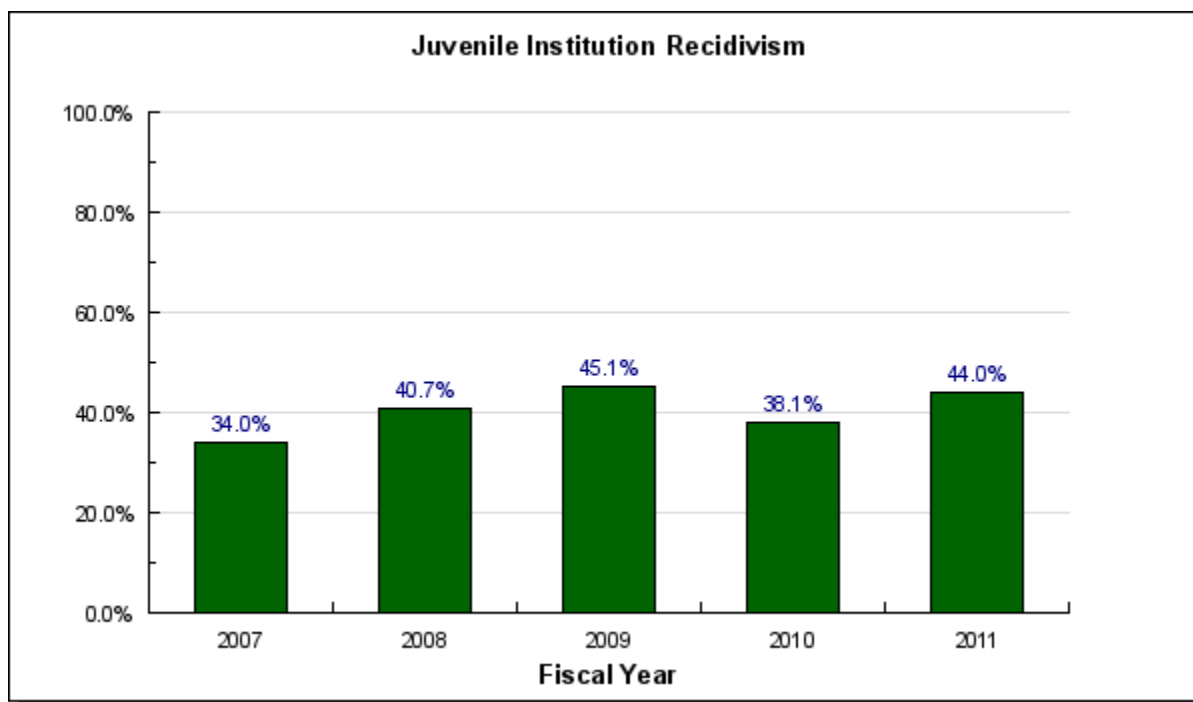
During FY2012, the division will work to meet the newly established national standards for tracking juvenile recidivism. The Council of Juvenile Correctional Administrators (CJCA) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) have supported this effort and the division is participating on the national implementation committee that is moving this effort forward. The division hopes to be in full compliance with the new national juvenile recidivism standards by FY2014.

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 recidivism rate for juveniles released from secure treatment in FY2009 and followed up in FY2011 was 44%, an increase over last year. The division did not meet its target of having a recidivism rate of less than 33% for this population.



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 particularly violent behavior or have failed to meet requirements of probation supervision or less-restrictive placements.

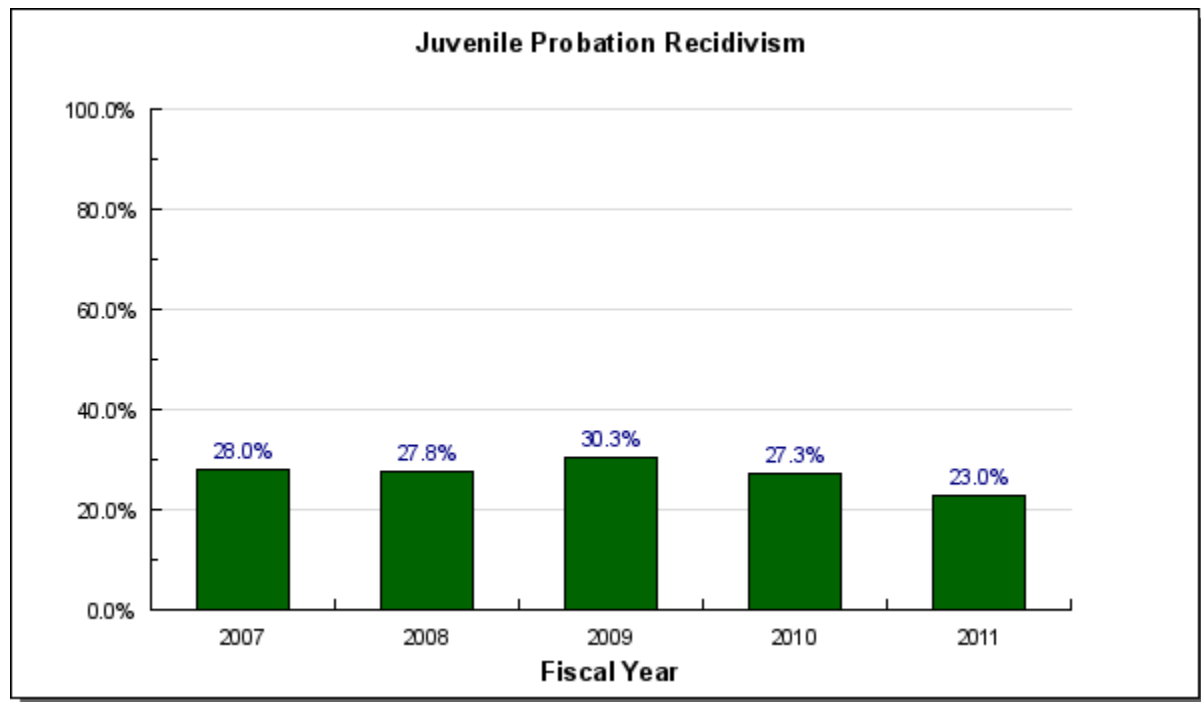
This year's identified recidivism rate for these juveniles was increased over the year before but less than the rate two years prior. Marked changes in recidivism rates from year to year are not unexpected given that these rates actually represent small numbers of youth. (In FY2009, a total of 77 juveniles were released from secure treatment institutions and met the criteria for inclusion in this report.) Nevertheless, the division takes each juvenile's recidivism seriously and has launched several initiatives to determine contributing factors. Two factors known to be associated with increased recidivism, substance abuse and educational failure, are receiving particular scrutiny; managers around the state have launched efforts to improve results in these domains with the expectation that recidivism will decrease as a result. The division also has recognized that the recidivism rate for Alaska Native juveniles remains high, and is exploring culturally relevant solutions to try and improve results for these youth.

Differences in the way juvenile delinquency is managed across the country 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 expects to change 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.

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 FY2011 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 September 7, 2011. 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 (28%).

Status #2: The division met its goal of having a recidivism rate for its juvenile probation population that was less than the average rate for the previous three years. The recidivism rate for the population released in FY2009 and followed up by FY2011 was 23%. The three-year average rate for FY2008-2010 was 28%.



Analysis of results and challenges: This measure examines reoffense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized. Recidivism rates for institutionalized youth are analyzed in a separate performance measure (above). The two groups are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

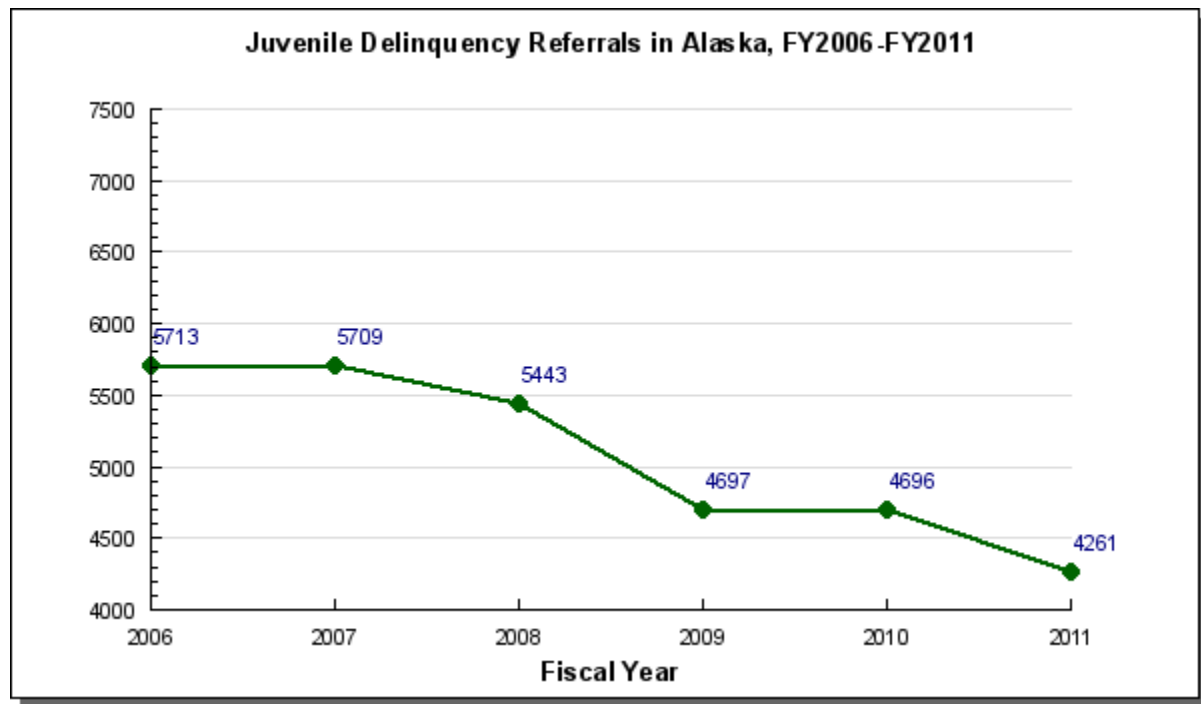
The FY2011 results show a marked decline in the recidivism rate for juveniles released from formal supervision. Prior to this year the recidivism rate has consistently been in the 27-30% range each year since 2006, when the division adopted its current procedures for tracking re-offenses for this population. We do not know at this time whether the marked decrease this year is the beginning of a trend or represents a single occurrence, but we are hopeful that division efforts at service and system improvements are contributing to this decrease. The division has recently initiated an effort to address some of the root causes of recidivism (substance abuse and education failure in particular) and also is working to identify culturally relevant approaches that can reduce the high rate of recidivism noted among Alaska Native youth. We are hopeful these initiatives will contribute to declines in recidivism in the future.

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 will continue to participate in the effort led by the Council of Juvenile Correctional Administrators to develop consistent national guidelines in measuring recidivism. The division expects to revise its definition and reporting procedures for recidivism in the coming year to be in closer alignment with the way other states report this information.

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 FY2011 study is represented in the graph above by youth who were released from formal probation in FY2009 and who re-offended within FY2010. For this FY2011 report, adjudication and conviction information on offenses that occurred within 12 months of release must have been entered in APSIN or JOMIS by September 7, 2011.) 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: Reports of juvenile activity from law enforcement resumed their decline in FY2011, with referrals to the Division of Juvenile Justice declining by 4.2% compared with FY2009 and by 4.7% compared with FY2010.



Juvenile Delinquency Referrals in Alaska, FY2006-FY2011

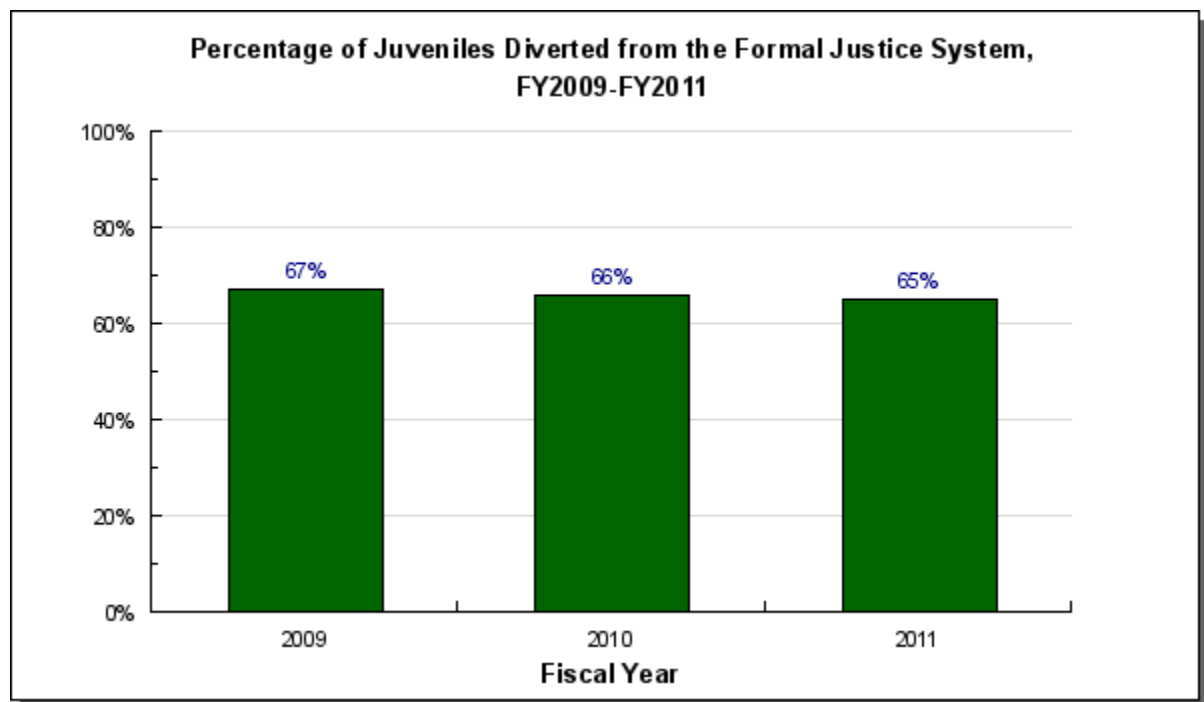
Fiscal Year	YTD Total	% Change Over Previous Year
FY 2011	4261	-9.26%
FY 2010	4696	-.02%
FY 2009	4697	-13.71%
FY 2008	5443	-4.66%
FY 2007	5709	-.07%
FY 2006	5713	

Analysis of results and challenges: The number of reports of juvenile activity made to the Division of Juvenile Justice by law enforcement fell from 4,696 in FY2010 to 4,261 in FY2011—a decline of 435 referrals, whereas the difference in the number of referrals from FY2009 to FY2010 was just a single referral. The declines in juvenile delinquency activity that Alaskans have witnessed over the past several years are similar to trends witnessed nationally. (See Alaska Kids Count, published by the Alaska Institute for Social and Economic Research <http://kidscount.alaska.edu/2010/2010index.html>.) 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 combinations of some or all of these.

Note: Population estimates for the years 2008 – 2010 are provided by the report Alaska Population Projections 2007-2030, published by the Alaska Department of Labor and Workforce Development. Population estimates for 2011 are based on 2010 U.S. Census figures, also available through the Alaska Department of Labor and Workforce Development. Information on juvenile referrals is extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database on August 16, 2011 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 percentage of juveniles diverted from formal court processes was 65%, a percentage similar to that for previous years.



Analysis of results and challenges: “Diversion” refers to the process of managing juvenile 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 the management of 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.

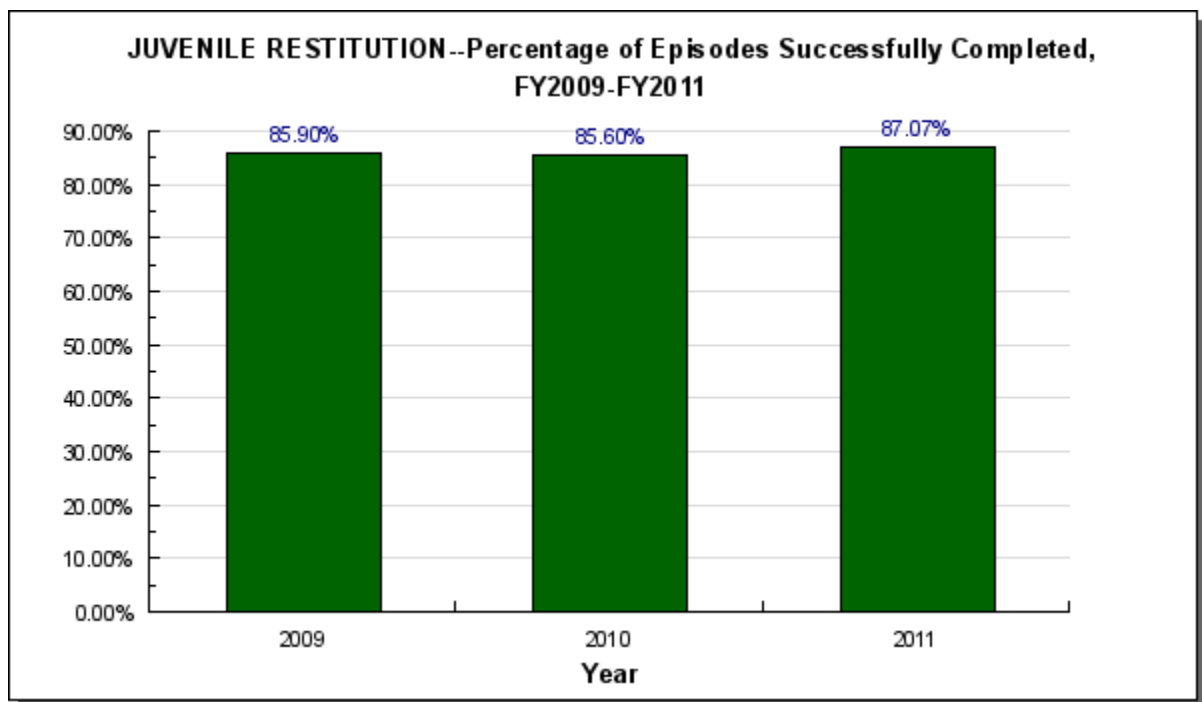
In FY2011, 1,881 (65%) of 2,906 juveniles referred to the division had all the offenses in their referrals (reports from law enforcement officers) for that year managed through non-formal-court

processes. This percentage is similar to the number of youth diverted in FY2010 and FY2009. As proposed last year, the division refined this measure so that juveniles are counted as “diverted” when they have had all offenses in their referrals managed through non-court processes. In previous years, juveniles were considered diverted for this measure when any offense in a referral was managed through non-court processes, even if another offense in the same police report was managed formally. The new approach results in a more accurate depiction of the percentage of juveniles who are truly diverted from the formal court process, and better illustrates the significant amount of work performed by the division to keep juveniles from entering the formal court system when this is appropriate given their risks and needs.

Note: For this measure, juveniles are considered to have been diverted away from the formal court system if the intake decision for their delinquency referrals resulted in all offenses in all referrals received in the fiscal year being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Referrals that were 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 this analysis. Diversion information was retrieved from the Juvenile Offender Management Information System on August 3, 2011. This data is continually refined and corrected and percentages in future reports may change slightly.

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 FY2011 was 87.07%, a percentage similar to that for previous years. A total of 147 orders or requests for restitution were closed in FY2011 and of these 128 were completed successfully. This represents \$69,991.12 in total restitution ordered and requested, of which \$57,894.62 was paid.



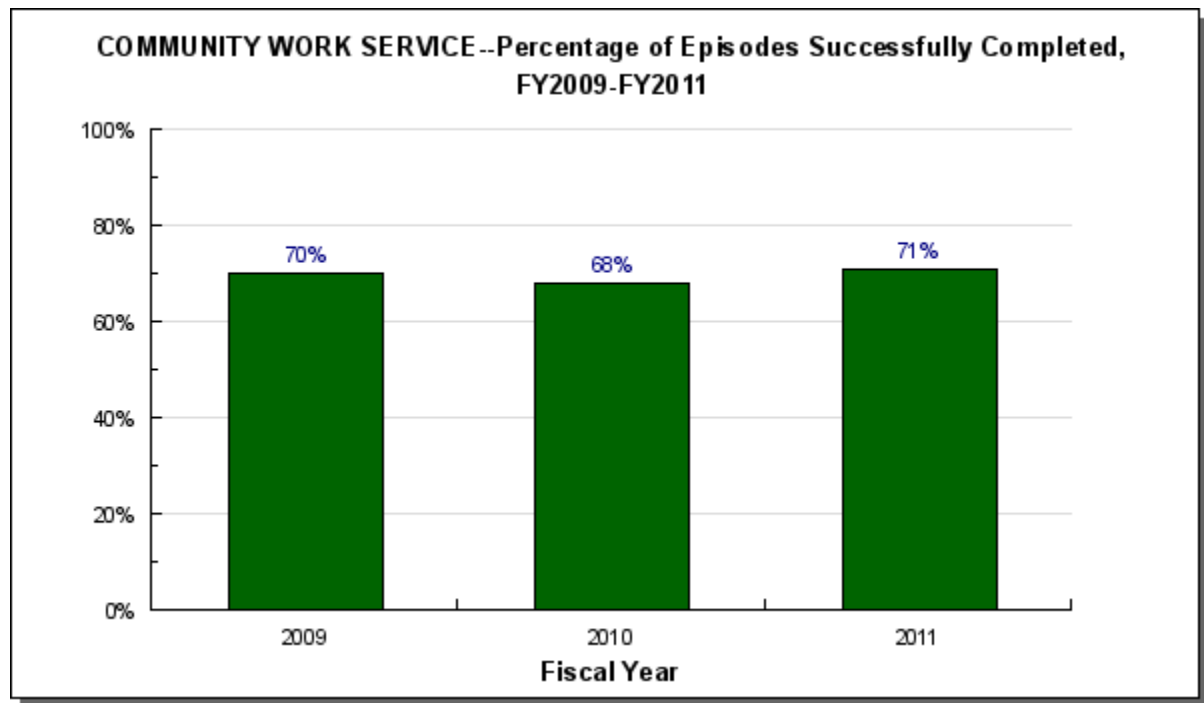
Analysis of results and challenges: Restitution provides a means for juvenile offenders to make reparations to their victims and as such is a critical measure of a restorative justice agency's effectiveness. Restitution is typically requested or ordered following property loss or destruction, and provides a clear consequence for 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 juveniles in their efforts to make reparations to those impacted by their delinquent behavior, as juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system.

Juveniles may not succeed in completing their restitution expectations for a variety of reasons. They may have aged out of the juvenile system, have had their case transferred to a formal court process, or have moved from Alaska and are difficult to locate. While the division can exercise only limited control over some of these factors, the 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 so that we may better clarify expectations of their supervision and improve their outcomes.

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 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 2, 2011.

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 FY2011 was 71%, a percentage similar to that for previous years. A total of 577 episodes of community work service episodes were closed in FY2011 and of these 411 were completed successfully. This represents a total of 18,483 hours of community work service requested or ordered, of which 14,515 hours were completed.



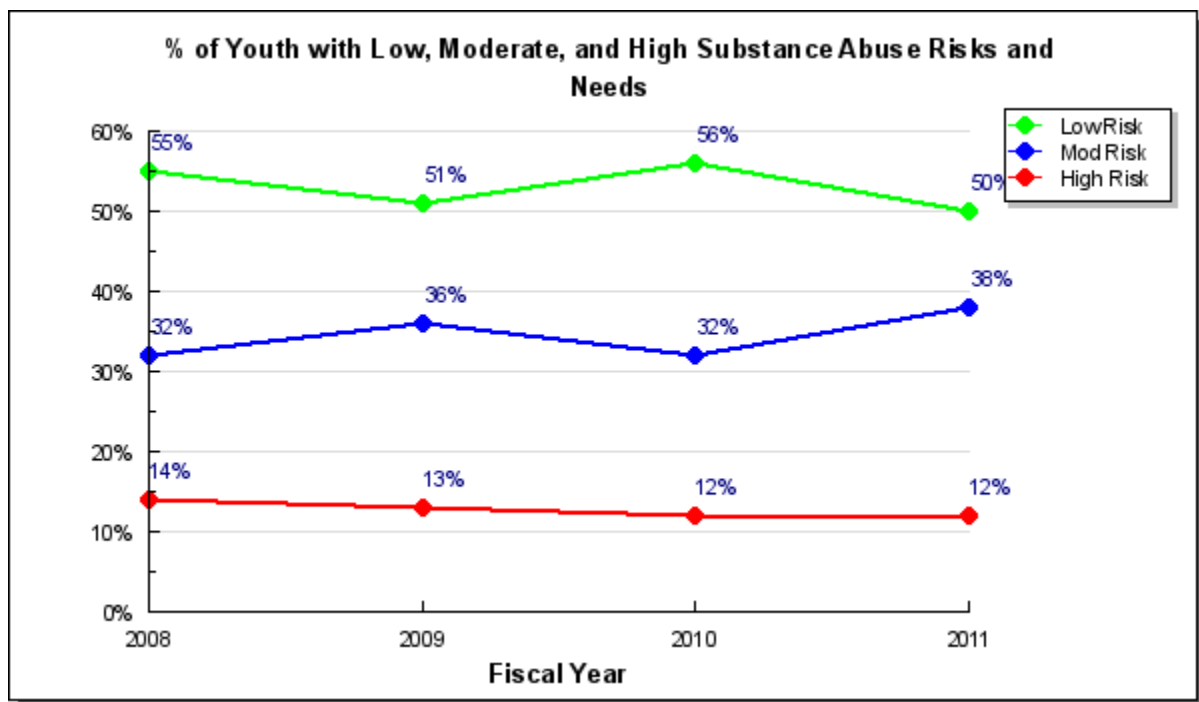
Analysis of results and challenges: Community work service (CWS) is an inherent part of a balanced and restorative justice system, providing juveniles with opportunities to: be accountable for delinquent conduct; develop a meaningful sense of self and community; and demonstrate responsibility through 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.

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. While the division can exercise only limited control over some of the reasons youth do not complete all their CWS requirements, the high percentage of episodes completed attests to the solid job probation officers are doing in assisting juveniles in meeting this obligation.

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 2, 2011.

Target #7: Reduce substance abuse risk among juveniles as measured by the division's assessment instrument.

Status #7: The target to reduce substance abuse risk among juveniles as a percentage of those assessed as low risk for substance abuse upon the completion of Division of Juvenile Justice services was not met. The percentage of juveniles assessed as low risk decreased from 56% in FY2010 to 50% in FY2011. The number assessed as moderate risk increased from 32% to 38%, and the percentage of youth assessed as high risk remained unchanged at 12% between FY2010 and FY2011.



Analysis of results and challenges: This measure provides an indication of the division's success in addressing substance abuse among juveniles. Substance abuse is a primary factor influencing a youth's risk to reoffend. The better the division can address substance abuse needs, the more successful juveniles will be in reducing their delinquent behavior.

In FY2011, the division embarked on a strategic effort to identify the ways it has been effective in addressing substance abuse and areas of need. In FY2012 we are implementing strategies for improvement. These strategies include enhancements to the quality assurance surrounding use of screening and assessment tools for substance abuse; a graduated response policy to ensure consistent, effective responses when juveniles abuse substances; plans to address resource needs

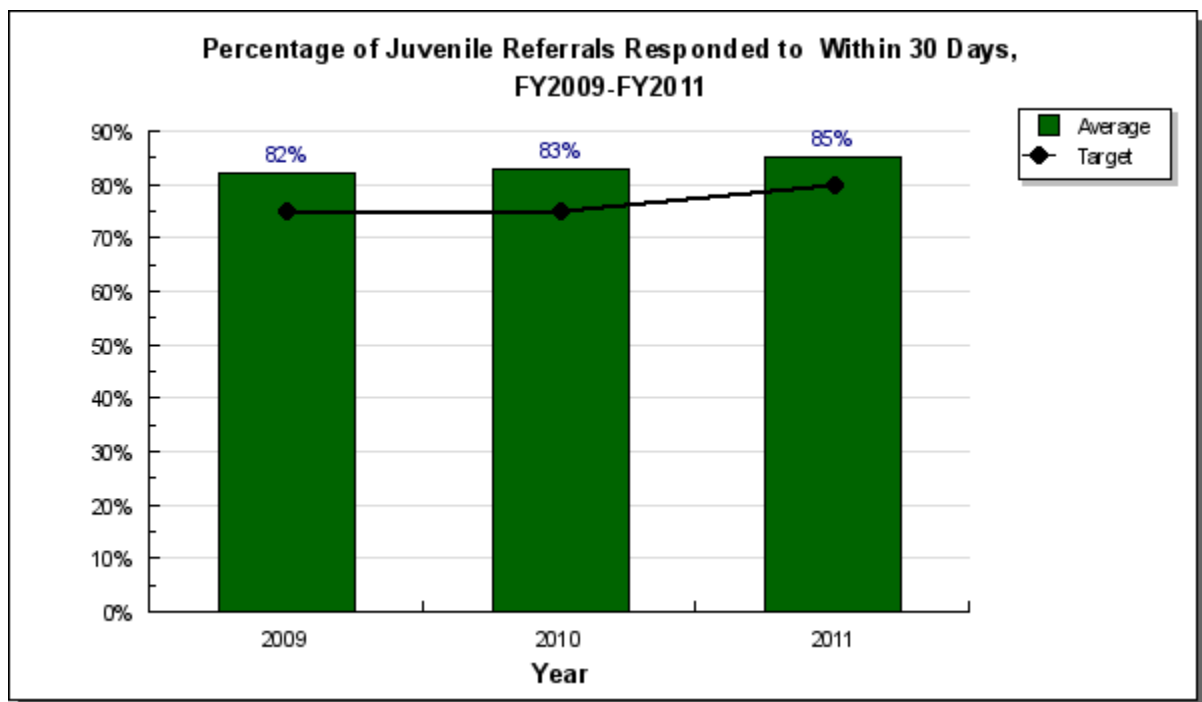
at both local and statewide levels; and improved staff training in understanding and intervening in adolescent substance abuse.

Note: The division assesses juveniles for delinquency risk with the Youth Level of Service/Case Management Inventory (YLS/CMI), a structured instrument that assesses for risks and needs across eight life domains, including substance abuse. The YLS/CMI is administered by probation officers following a juvenile's adjudication in court and is repeated at regular intervals while the juvenile remains under division supervision. For this measure, juveniles who complete division services in the fiscal year are determined to be either low, moderate, or high risk for substance abuse depending on their outcomes in this domain. The substance abuse risk scale is 0 – low risk, 1-2 – medium risk, 3-5 – high risk.

A1: Strategy - Improve the timeliness of response to juvenile offenses.

Target #1: Eighty 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 goal for responding to referrals (reports from law enforcement of juvenile activity) was met, with 85% of reports responded to within 30 days. The average response time for juvenile probation staff to respond to referrals was 17.8 days, a response time consistent with that for previous years.



Analysis of results and challenges: Research indicates that responses to juvenile offenses must be timely and appropriate 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). In years past the division’s goal was for an average of 75% of referrals to receive a response within 30 days. Because the statewide average percentage of referrals that received a response within this time frame consistently exceeded 75%, this year the goal was

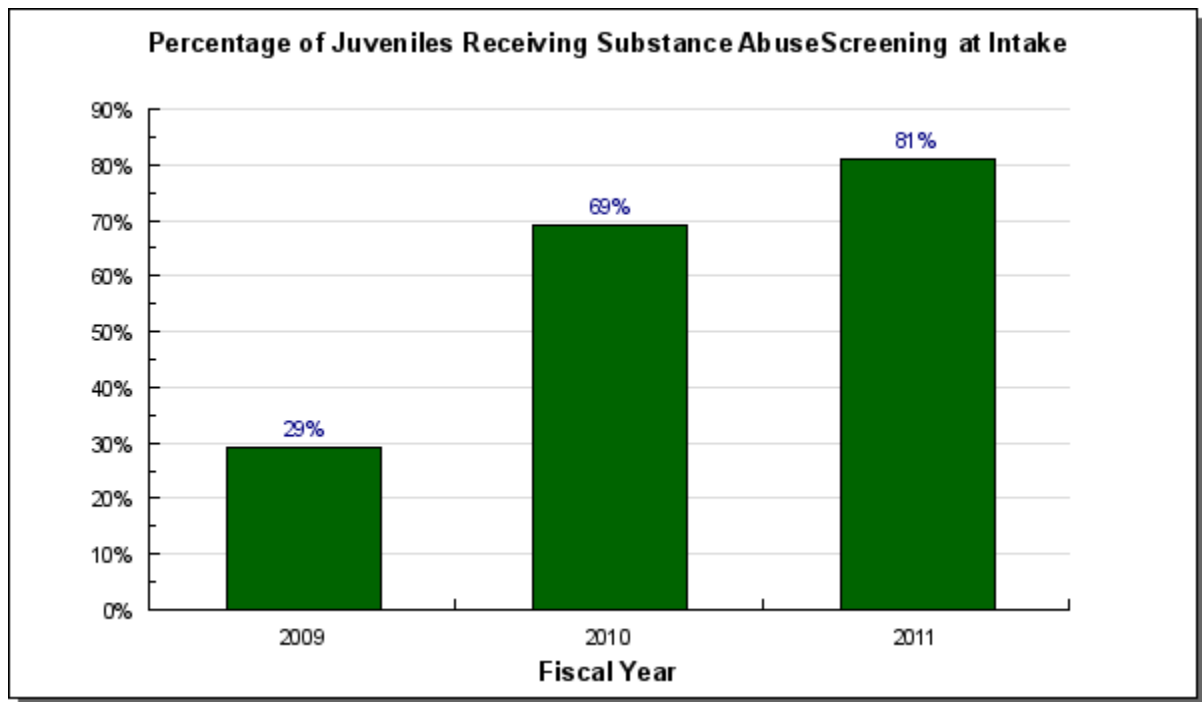
increased to 80%. The division exceeded this higher standard and if this continues to occur we will explore whether to again raise our target for this measure.

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 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: Increase the percentage of juveniles assessed for substance abuse risk to 100%.

Status #1: In FY2011, 82% of juveniles referred to the division from law enforcement agencies were screened for substance abuse according to policy guidelines, reflecting a gradual improvement in implementation of this policy since its implementation in mid-FY2009.



Analysis of results and challenges: If the division is to be successful in decreasing substance abuse risk among juveniles, we must begin by identifying those with substance abuse needs. In FY2009 the division adopted the CRAFFT substance abuse screening tool, a simple seven-question instrument completed by juveniles when they are initially referred from law enforcement. Results from the CRAFFT provide probation officers with an understanding of the impact substance abuse may have in the life of a juvenile and helps them determine when further assessment may be warranted. Routine use of the CRAFFT has been improving since its adoption. The division intends to conduct training and make improvements to the CRAFFT

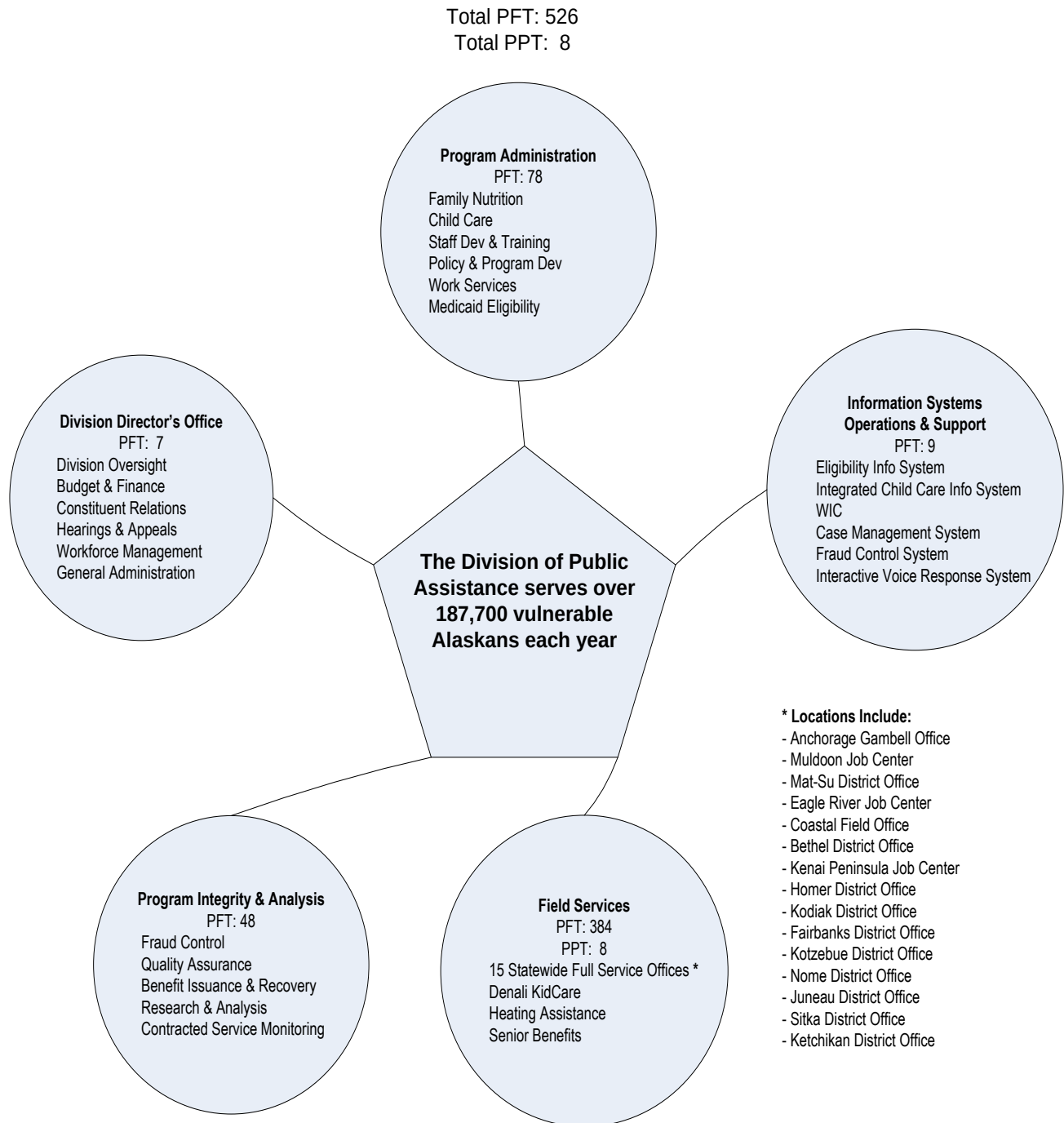
policy and procedures in FY 2012, which are expected to result in improved results for this measure.

Note: The CRAFFT substance abuse screen is copyrighted by Children's Hospital, Boston, and has been evaluated for efficacy through national research. division policy requires that juveniles ages 13 or older who have been referred to the division on new criminal offenses complete the CRAFFT at the time of their intake interview. A CRAFFT need not be completed by those juveniles who have already completed one within the previous 6 months. In FY2012, 1,453 juveniles met these criteria; of these, 1,198 (82%) had a CRAFFT performed within the timelines prescribed in the policy.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Juvenile Justice</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Authority for RSA with Division of Behavioral Health for Bring the Kids Home Individualized Services	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
Authority for the Workers' Investment Act Funds Received from Department of Labor and Workforce Development	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
Grave Shift Coverage at McLaughlin Youth Center	\$ 300.0	\$ -	\$ -	\$ -	\$ 300.0
Grave Shift Coverage for the Johnson Youth Center	\$ 200.0	\$ -	\$ -	\$ -	\$ 200.0
MH Trust: Dis Justice - Mental Health Clinician Oversight In Youth Facilities	\$ -	\$ -	\$ -	\$ 152.9	\$ 152.9
MH Trust: Dis Justice - Grant 3504.01 Div Juvenile Justice Rural Re-entry Specialist	\$ -	\$ -	\$ -	\$ 110.9	\$ 110.9
Reverse August FY2012 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (159.3)	\$ -	\$ -	\$ -	\$ (159.3)
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ 118.1	\$ 118.1
Juvenile Justice Total	\$ 340.7	\$ -	\$ -	\$ 556.9	\$ 897.6

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

The Division of Public Assistance (DPA) provides essential services to meet many of the basic and urgent needs of Alaska's most vulnerable families and individuals. 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, childcare assistance; and work supports that 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:

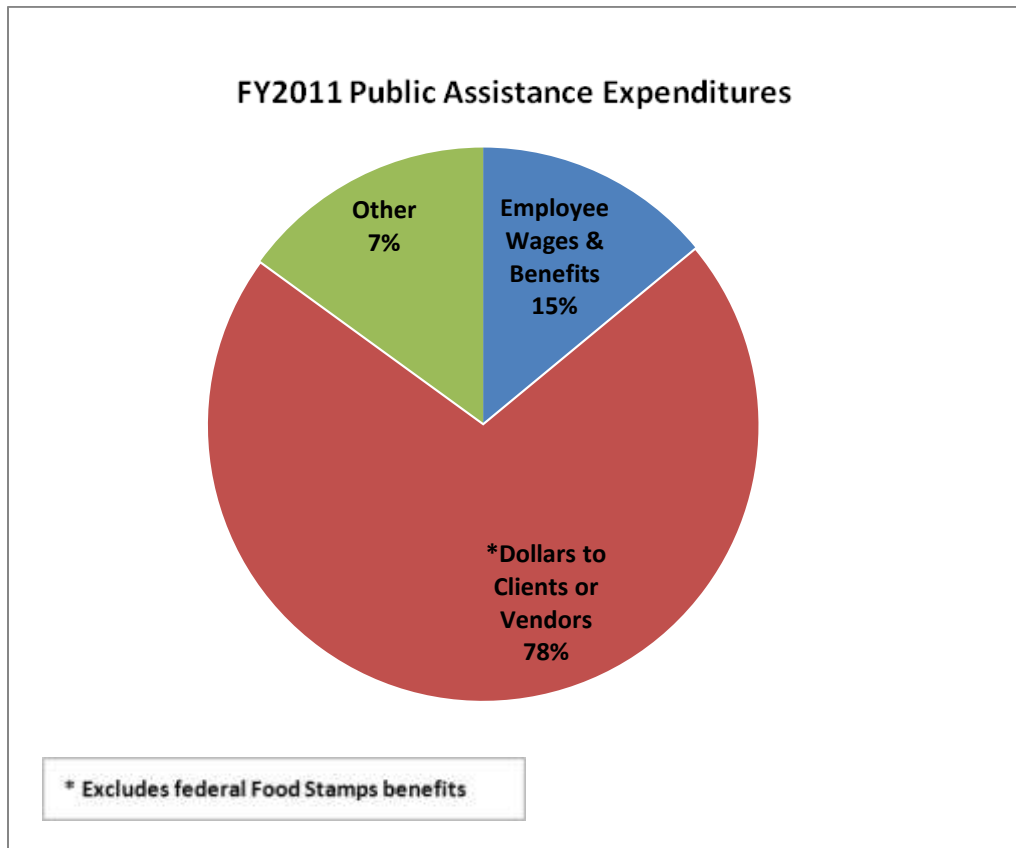
- Temporary financial assistance to help low-income Alaskan families with children meet basic needs, and to encourage family self-sufficiency and stability by planning for self-support through employment.
- Employment assistance to help individuals find and keep jobs and advance to better employment.
- Financial and medical assistance to elderly, blind, or disabled Alaskans incapable of self-sufficiency to help them 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.
- Childcare subsidies to families who need childcare in order to work or participate in approved work or training activities.
- Childcare licensing services to promote the safety and quality of childcare in Alaska;
- Access to health care by determining eligibility for Medicaid, Denali KidCare, and Chronic and Acute Medical Assistance.
- 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, 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 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.

DPA provides direct services in 18 customer service offices statewide. In addition, Women, Infants and Children (WIC), Childcare Assistance, and employment case management services are provided through grants and pay-for-performance contracts with community agencies. In FY2011, the division provided cash, food, and medical benefits and services to nearly 125,000 Alaskan households and 187,700 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 childcare 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 Childcare subsidies, Childcare 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 non-profit organizations that operate Native Temporary Assistance for Needy Families programs and tribal organizations that operate regional Alaska Affordable Heating Programs.

The remaining one-fifth of the DPA budget is divided between staff costs – direct service and administrative (15%) and all other costs (7%).

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 3,620 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 ultimately leave the program. They receive support to help them seek, secure, and retain employment.

Case management and employment-related “Work First” services are provided to emphasize quick entry into the work force. Those families who have multiple or profound challenges to getting and keeping a job are provided with “Work Support” services aimed at allowing them to address their challenges and increase their family’s income. These Work First and Work Supports services are referred to as Work Services.

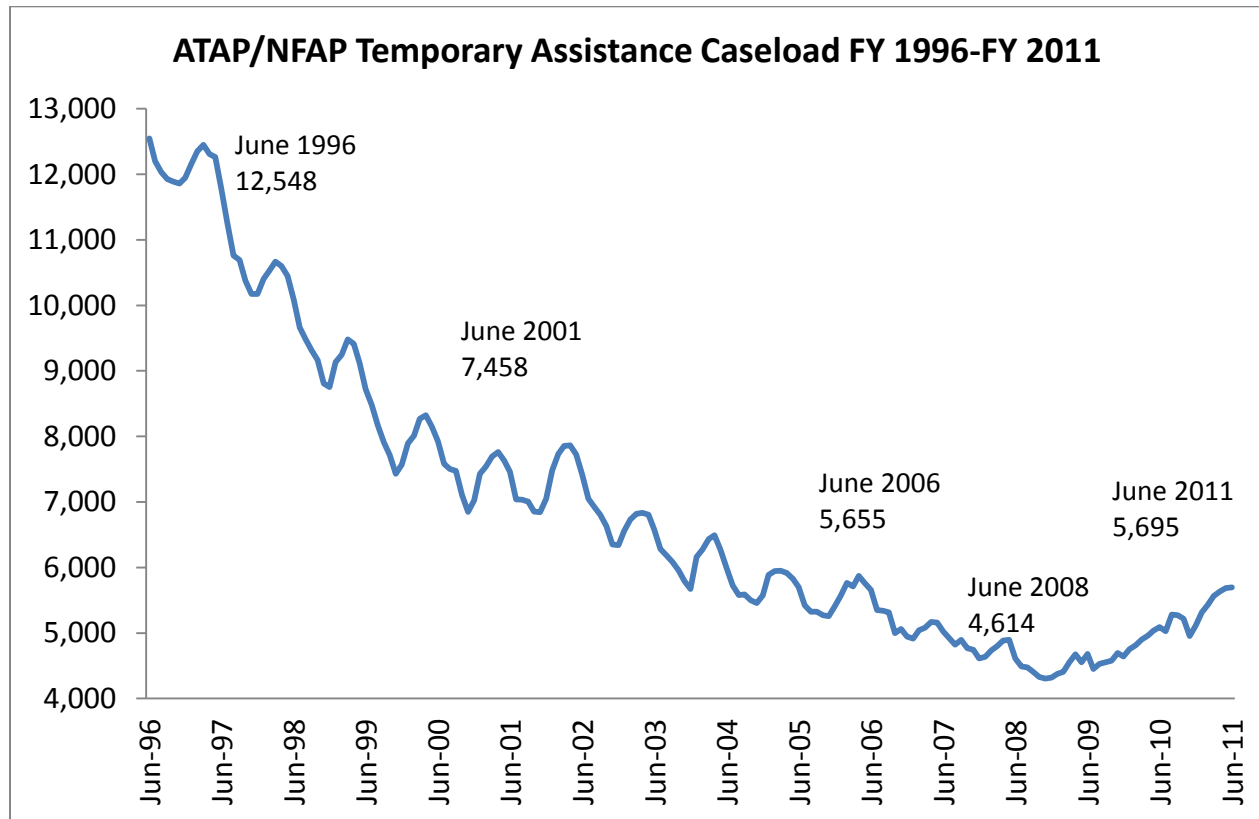
The division continues to invest TANF block grant savings (accrued as a result of welfare reform) to sustain budgets for work services and supports for low income working families, such as childcare assistance. The division also transfers funds to the Social Services Block Grant for child protection 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 FY2010 as more families struggled to make ends meet, and to ensure funds are available to support core business needs in future years such as replacement of the division's aging Eligibility Information System (EIS).

Native Assistance Programs

Federal law allows for tribes and Alaska Native regional nonprofit organizations to operate tribal TANF programs, known as Native Family Assistance Programs (NFAPs), and to receive direct federal funding through the TANF block grant. The State also supplements these programs using funds that would otherwise be spent to serve Native families through the Alaska Temporary Assistance Program.

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 1,730 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 FY2010.

Overall, the annual monthly average of families receiving temporary assistance from the State and Native Family Assistance programs has decreased significantly since 1996 and has generated millions of dollars in savings. The decline in the caseloads and in the amount of temporary assistance benefits paid to families is a result of the program's continued emphasis on employment.

Childcare Benefits

The Childcare Assistance Program helps low-income working families pay for a portion of their childcare costs while they are working, looking for work, or attending school or training. Childcare benefits pay for part of the childcare costs, and parents also provide a co-pay. The parent's share is based on the size of the family and the family's income.

Providing access to affordable, safe, and quality childcare is a key component in the state's efforts to help families succeed in the work place and to attain self-sufficiency. Continued commitment to improving the quality, availability, and affordability of childcare is essential to ensure that families can work and move toward economic self-sufficiency while their children are in safe and healthy childcare and afforded the opportunity to grow and learn in nurturing environments. In addition to childcare assistance, the Childcare Assistance Program provides:

- Oversight and approval of or licensing of childcare facilities across the state to promote the health and safety of children in childcare.
- Activities to promote quality care, such as parent education and support provided by Childcare Resource and Referral agencies, professional development for childcare providers, and other special initiatives.

During FY2011, DPA either directly or through its partners supported childcare services for nearly 3,000 low-income working families, serving over 4,900 children in the Childcare Assistance Program, and licensed and monitored 1,771 childcare facilities.

Childcare 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 childcare assistance and services comes from the federal Childcare 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 in gaining paid employment quickly. Work First services help and promote the efforts of ATAP recipients in attaining economic self-sufficiency through employment. Families with multiple and profound challenges to getting and keeping a job are helped with Work Support services to increase their job readiness or, if they are disabled, to apply for benefits that are not time limited.

Work First services include activities and support systems that prepare clients to enter the workforce, help them to retain jobs, advance professionally, and succeed. Work Services may also provide wage subsidies to employers who create new jobs and hire recipients to fill them. The majority of Work First services are 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 that assist recipients in their communities in moving from welfare to work.

Work Support services help families identify their most likely route to increased self-sufficiency either through employment, or through pursuit of other benefits that are not time-limited, and help them into activities that allow them to progress towards their goals. Work Support Providers screen and assess families for challenges to becoming employed. They help the family to coordinate multiple agency plans and activities, access health, behavioral health, and domestic violence services, and partner with state and community agencies to ensure the family is making

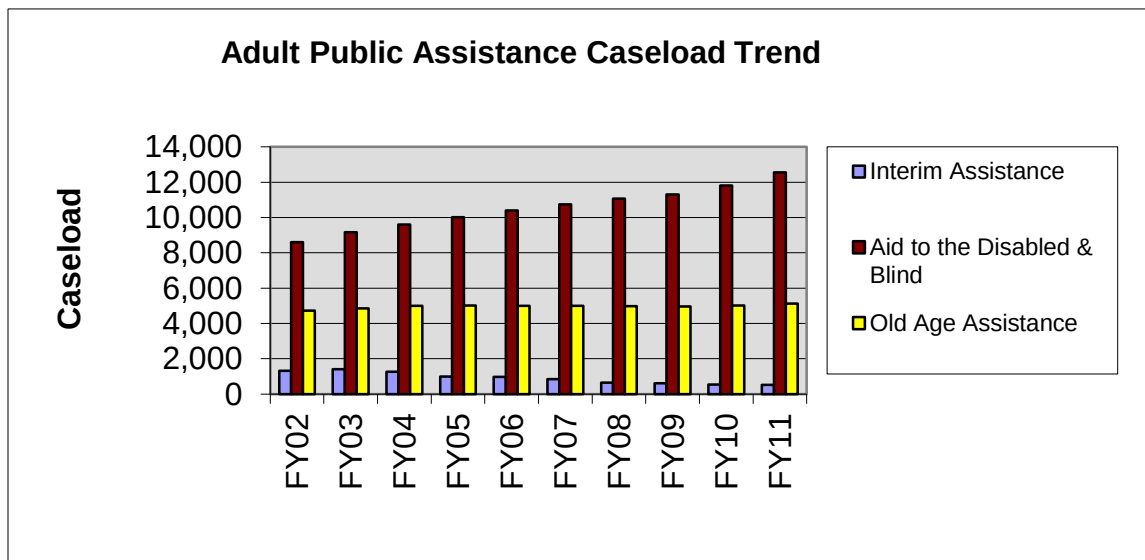
progress. Work Supports are delivered through grants and contracts with community-based organizations that use case managers and vendors to deliver services and support development of coordinated services plans across multiple DHSS agencies and community partners. Assistance in applying for and generating back-up documentation to support application for Social Security Disability Insurance and Supplemental Security Income is provided to those who are disabled. Discovery, Portfolios, and other tools to support customized employment for parents able to work with accommodation are also provided. Grants and contracts are issued to non-profit and for-profit organizations, and private sector businesses to help recipients in their communities move from welfare to self-sufficiency.

Adult Public Assistance

The Adult Public Assistance (APA) program provides financial assistance and access to medical care for over 5,000 elderly and nearly 12,500 blind and disabled Alaskans annually. The program was created to provide income support to very needy elderly, blind, and disabled persons. APA benefits serve as a supplement to the federal Supplemental Security Income (SSI) program and provide individuals with income sufficient to meet basic needs and to remain as independent as possible in the community. To qualify, an individual must be over age 64, or at least 18 years of age and blind, or diagnosed by a physician as permanently disabled or terminally ill. Certain income and asset eligibility standards also apply.

The Adult Public Assistance program includes an Interim Assistance benefit of \$280 per 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 that person temporarily or permanently incapable of self-support through gainful employment. Over 500 individuals receive Interim Assistance each month while they wait for their SSI decision. In FY2004, DPA implemented a rigorous medical review process to determine if a person will likely meet the SSI disability criteria. This change has slowed the rate of growth in Interim Assistance and has decreased the caseload by approximately 63% since it reached an all-time high at the end of FY2003.

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 avoiding homelessness, incarceration, and higher-cost settings such as hospitals and nursing homes.

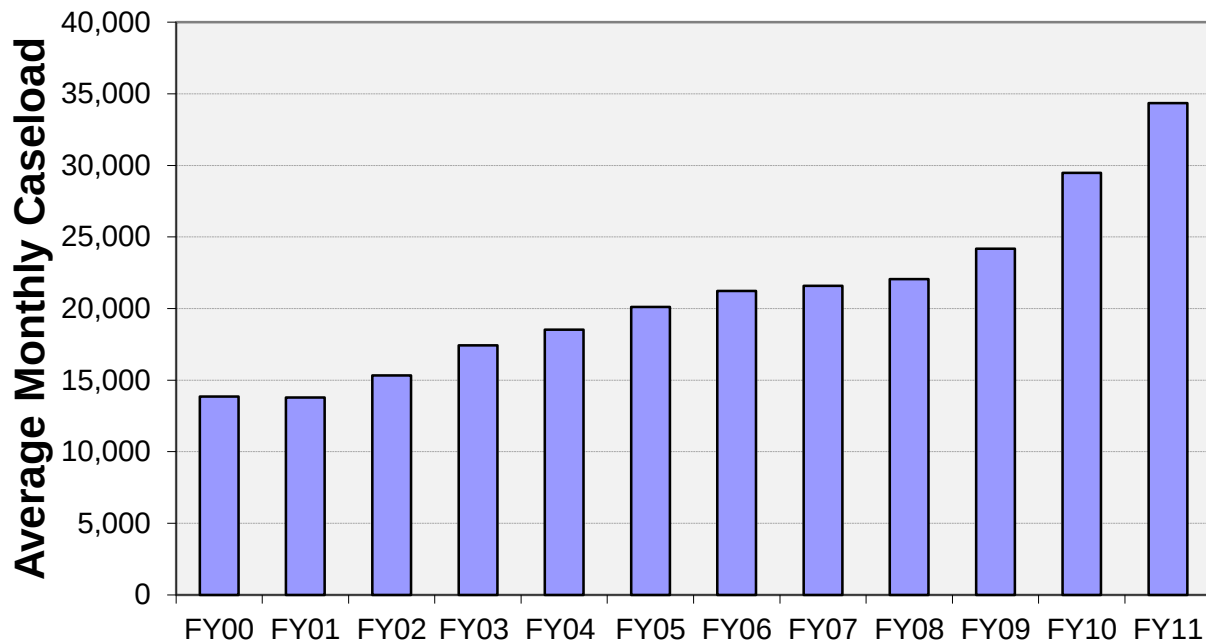


Food Stamp Program

The Food Stamp Program, also known as the Supplemental Nutrition Assistance Program (SNAP), helps low-income households maintain adequate nutritional needs. Eligible participants receive monthly food stamp benefits on the Alaska Quest debit card and 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, \$9.00 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). Employment and Training supports are available to Food Stamp Program recipients in urban areas with employment opportunities.

Alaska's Food Stamp caseload continues to climb, with a significant increase in participation over the last two years with more households applying for help as they struggle to meet their basic needs. In FY2011 the program served an average of 34,360 eligible households, a 16.6% increase compared to the number of households served in FY2010. In August 2011, nearly 37,000 Alaska households were receiving food stamp benefits. Monthly benefit issuances climbed from over \$14.0 million dollars a month in FY2010 to close to \$16 million per month in FY2011.

Food Stamp Caseload



Alaska received \$232,898 in bonus funds from the USDA for being one of the 10 states in the nation with the best Food Stamps Program payment accuracy in FFY2010. Currently, Alaska is ranked first in the nation in Food Stamp payment accuracy.

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 Childcare Assistance programs. The division also conducts payment accuracy reviews for the Alaska Temporary Assistance Program, Senior Benefits, and Adult Public Assistance programs when Quality Control staff resources are available.

As of October 4, 2011, Alaska is ranked first in the nation for achieving a Food stamp payment accuracy rate of 99.14% in FFY2011. This is the highest payment accuracy rate in the nation and is well above the cumulative national rate of 96.36%. It is anticipated that Alaska will receive a bonus award for payment accuracy for FFY2011.

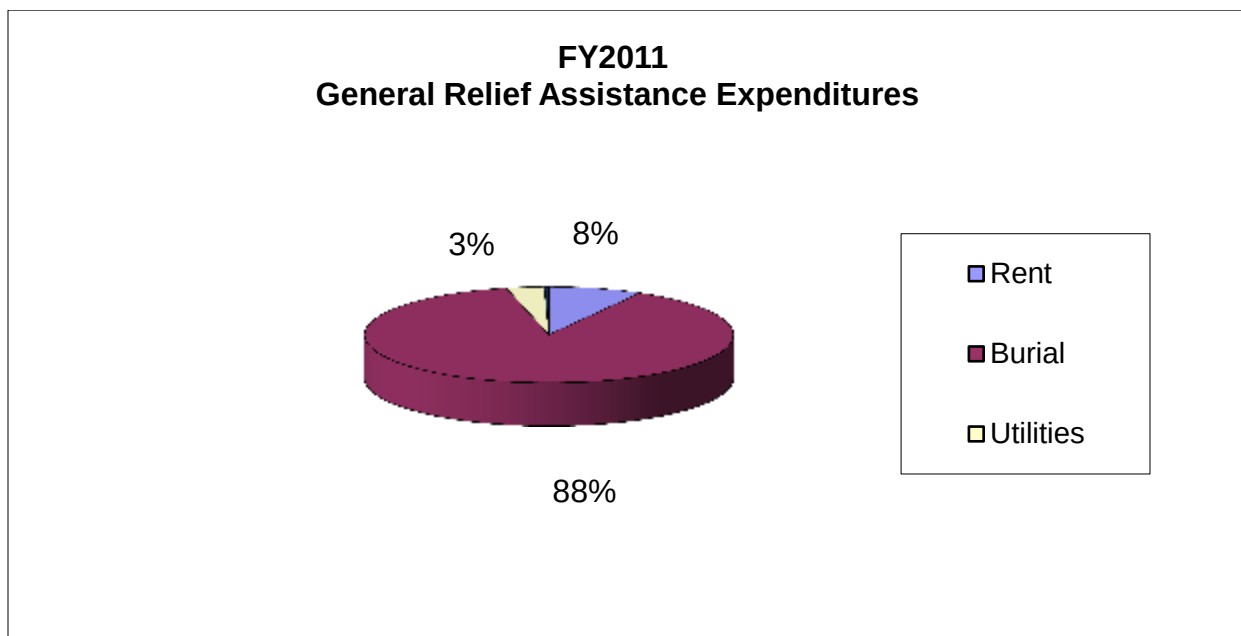
Fraud Control

The division maintains an active statewide welfare fraud control effort. The Fraud Control Unit investigates allegations of applicant and recipient fraud initiated by staff or the public. The investigations involve most of the division's major programs. The unit's investigative staff is

stationed at offices in Anchorage, Fairbanks, Wasilla, and Kenai. Individuals found to have intentionally violated program rules are disqualified from program participation and required to re-pay the amounts they were paid. The most serious cases are referred to the Department of Law for possible criminal prosecution. 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. Approximately 89% of GRA program expenditures are used to pay for funeral and burial expenses. The remainder is used to meet emergency shelter, food, and clothing needs.



In FY2011 the program covered burial expenses for 742 deceased individuals and met emergency shelter needs to prevent eviction and homelessness for an average of about 106 households per 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 Medicaid eligibility for over 111,000 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, few personal resources, and 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.

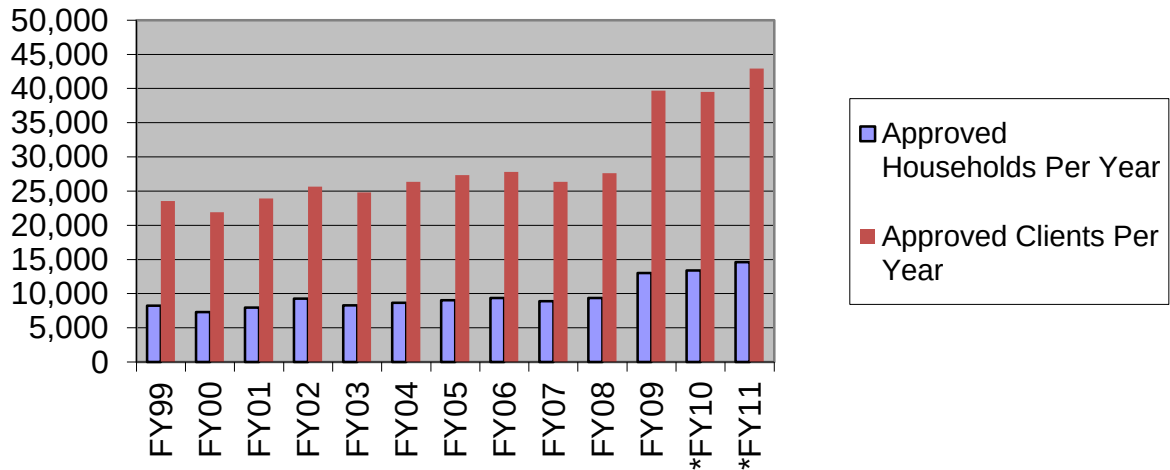
Energy Assistance Program

The Energy Assistance Program component includes the Heating Assistance Programs (HAP) and funding to support weatherization projects. HAP provides seasonal assistance with home heating expenses. Benefits are based on family income, home heating costs, housing type and geographical region. Households apply for 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 FY2009, 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 (AKAHP).

While federal LIHEAP funds can only be used to serve households with income below 150% of the federal poverty limit in Alaska, AKAHP connects the income eligibility standards and the annual benefit levels to the average price per barrel of North Slope crude oil. The AKAHP 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.

Heating Assistance Program

*Includes both LIHEAP & AKHAP

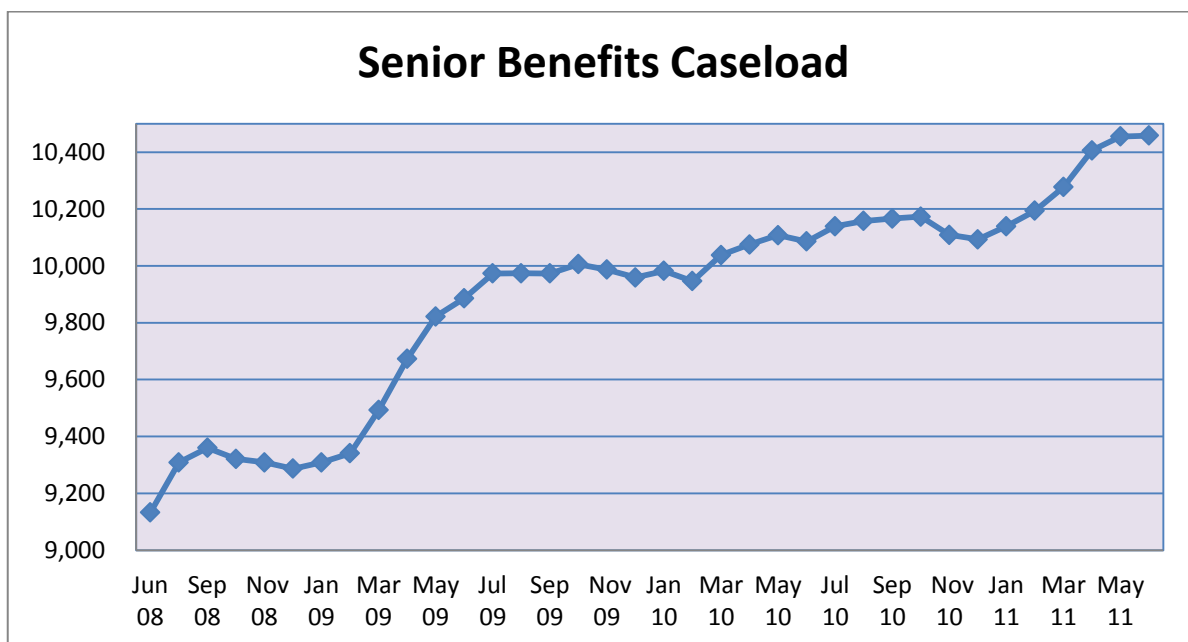


During the 2010 - 2011 heating season, over 14,623 households (12,114 LIHEAP and 2,509 AKHAP) received help from the State administered heating assistance programs. Not included in the chart above, an additional 6,749 households (6,251 LIHEAP and 498 AKHAP) received help from Alaska Native organizations 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 on June 30, 2007 of the Senior Care program.



During FY2011 the number of seniors enrolled in Senior Benefit reached over 10,458, compared to approximately 7,000 served under the former Senior Care program. The Senior Benefits Payment Program was re-authorized during the 2011 Legislative Session and has a sunset date of June 30, 2015. The division projects continued growth through the year with an estimated enrollment of 10,900 cases by the end of FY2012.

Women, Infants, and Children (WIC)

The Women, Infants and Children (WIC) component includes family nutritional 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. The program provides participants opportunities to include a variety of healthy food choices for infants, including fresh fruits and vegetables, low-fat milk and a variety of whole grain foods. The WIC program also increases the amount of food provided to mothers who breast-feed their babies full time to better promote and support breast-feeding. In FY2011, the division ranked fourth in the nation for breastfeeding initiation rates.

The WIC, Farmer's Markets, and Commodity Supplemental Food Programs are primarily federally funded. In FY2011, over 26,000 Alaskan women, infants and children participated in WIC each month, and approximately 2,190 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 ran from June 2011 through October 2011 harvest season. The value of redeemed FMNP vouchers for the 2011 season is expected to be \$160,000; the Senior Farmer's Market Nutrition Program (SFMNP) provided more than 3,400 coupon books valued at \$84,180 and were distributed at 32 senior service agencies.

Annual Statistical Summary of Services Provided in FY2011

Comparison of Public Assistance Programs

	Energy Assistance Programs ²		Child Care (PASS I, II, III)	Senior Benefits	Women, Infants & Children (WIC)
	LIHEAP (Federal)	AKHAP (State)			
FY11 Cases avg/month ¹	12,114	2,509	2,982	10,458	26,490
# of clients avg/month ¹			4,968	10,458	26,490
Race Distribution					
White	58%	68%	46%	Not Available	39%
Alaska Native/American Indian	26%	19%	7%		36%
Asian/Pacific Islander	6%	5%	11%		10%
Black	3%	3%	11%		6%
Two or more races	n/a	n/a	20%		n/a
Not reported/Other	7%	5%	5%		9%
Recipients by DPA Region					
Central	46%	35%	Not Available	49%	47%
Northern	24%	30%		15%	25%
Coastal	24%	23%		25%	20%
Southeast	6%	12%		12%	8%
% by Category of Service			% expenditures	% receiving benefits	% receiving benefits
Employed, retired or temp unemployed	70%	93%	Pass I 21%	Food Stamp 27%	Food Stamp 21%
Receiving ATAP	7%	1%	Pass II 7%	APA 53%	Medicaid 61%
Receiving APA	23%	7%	Pass III 72%	Medicaid 65%	
Total Expenditures	\$13,910,237	\$1,424,261	Pass I \$6,142,217 Pass II/III \$23,040,073	\$20,609,507	\$27,657,085
Federal	\$11,813,208	\$0	\$21,755,733	0	\$26,467,592
GF	\$2,097,029	\$1,424,261	\$7,426,557	\$20,609,507	\$364,286
Other	\$0	\$0	\$1,631,888	0	\$825,207

Notes:

1. Caseload and client numbers for Heating Assisting are annual totals; all other programs are monthly averages
2. Energy Assistance program data does not include Alaskans receiving Heating Assistance through tribal organizations funded directly by the federal government

	ATAP/NFAP ¹	Adult Public Assistance	General Relief	Food Stamps				
FY11 Cases avg/month	3,619	18,146	168	34,360				
# of clients avg/month	9,875	18,146	282	85,749				
Race Distribution								
White	46%	49%	Not Available	35%				
Alaska Native/American Indian	13%	28%		41%				
Asian/Pacific Islander	16%	12%		9%				
Black	11%	5%		5%				
Two or more races	9%	1%		7%				
Not reported	5%	4%		3%				
Recipients by DPA Region of Residence								
Central	70%	56%	59%	49%				
Northern	9%	12%	9%	12%				
Coastal	14%	21%	21%	29%				
Southeast	7%	11%	11%	10%				
Recipients by Age Group (avg cases per month)								
Children 0-18 years	6,791	83	Not Available	39,404				
Adults 19-59 years	3,071	10,356		41,596				
Adults 60+	13	7,707		4,749				
% Expenditure By Category of Service ²								
Single parent	65%	Disabled	74%	Burial service	88%	FS and ATAP	13%	
Two parent	13%	Aged	25%	Rent assistance	8%	FS only	22%	
Child Only	21%	Blind	<1%	other	4%	FS and APA	11%	
						FS and Medicaid	80%	
Total Expenditures					\$27,799,199	\$59,494,405	\$1,955,877	\$175,306,900
Federal	\$11,787,925	\$1,417,728	\$0	\$175,306,900				
GF	\$12,457,204	\$53,818,427	\$1,955,877	\$0				
Other	\$3,554,070	\$4,258,250	\$0	\$0				

Notes:

1. ATAP/NFAP caseload includes the Alaska Temporary Assistance Program only. Expenditures include the Alaska Temporary Assistance Program and the Native Family Assistance Program.
2. Percentages do not necessarily add to 100% - some cases overlap multiple categories

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 Childcare 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 Distributions
7 AAC 39	Childcare Grant Program
7 AAC 40	Adult Public Assistance
7 AAC 41	Childcare 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	Childcare 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	Childcare 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 FY2013 Operating Budget Requests

Division of Public Assistance

Budget Overview Table

Division of Public Assistance	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$154,987.8	\$161,911.6	\$6,923.8
Designated General Funds	16,452.7	16,992.7	540.0
Federal Funds	130,232.7	131,549.6	1,316.9
Other Funds	13,100.1	13,542.1	442.0
Total	\$314,773.3	\$323,996.0	\$9,222.7

Budget Requests

The proposed FY2013 budget requests reflect funding required to cover an increase in the number of cases for programs that provide basic safety net support to Alaska's most needy and vulnerable citizens, including support for low income seniors and people with disabilities, emergency services for destitute individuals, and burial assistance on behalf of deceased indigent persons.

Alaska Temporary Assistance Program (ATAP)

Alaska Temporary Assistance Program Funding: \$3,500.0 Fed

Increased funding authority of \$3,500.0 is requested to provide cash assistance and work services to low-income families with children to help them with basic needs while they work toward becoming self-sufficient. This program is provided for under the federal Temporary Assistance for Needy Families (TANF) block grant.

Without additional authority, ATAP will not be able to provide temporary financial assistance and self-sufficiency services at the current level to the increasing population meeting the eligibility requirements for the program.

Adult Public Assistance (APA)

Formula Program Funding Increase Due to Caseload Growth: \$409.5 Fed/\$5,665.5 GF

Enrollment in the Adult Public Assistance Program is increasing, particularly in the Aid to the Disabled & Blind category. This growth is similar to that experienced by the Supplemental Security Income (SSI) program in Alaska. Both the APA and SSI programs have seen a 4% increase in the number of recipients who are disabled or blind. Based on demographic trends for Alaska, it is anticipated that the old age population will also increase in coming years. As a result, expenditures for the program are expected to increase. Overall, the number of individuals served by the program is expected to continue to increase by over 5% per year. Current funding levels are inadequate to meet projected expenditures.

If this increment is not funded, the Adult Public Assistance Program will not be able to provide benefits to the full population meeting the eligibility requirements for the program. Without increased funds some needy, elderly, blind, and disabled persons will not receive benefits.

Permanent Fund Hold Harmless (PFD-HH)

Program Funding Increase Due to Caseload Growth: \$540.0 PFD-HH

Alaska law stipulates that recipients of public assistance programs not lose their 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 4% in recent years, and this trend is expected to continue. The Food Stamp program caseload grew over 16% between FY2010 and FY2011 and we expect the program to continue to grow at a rate of 16% into FY2013.

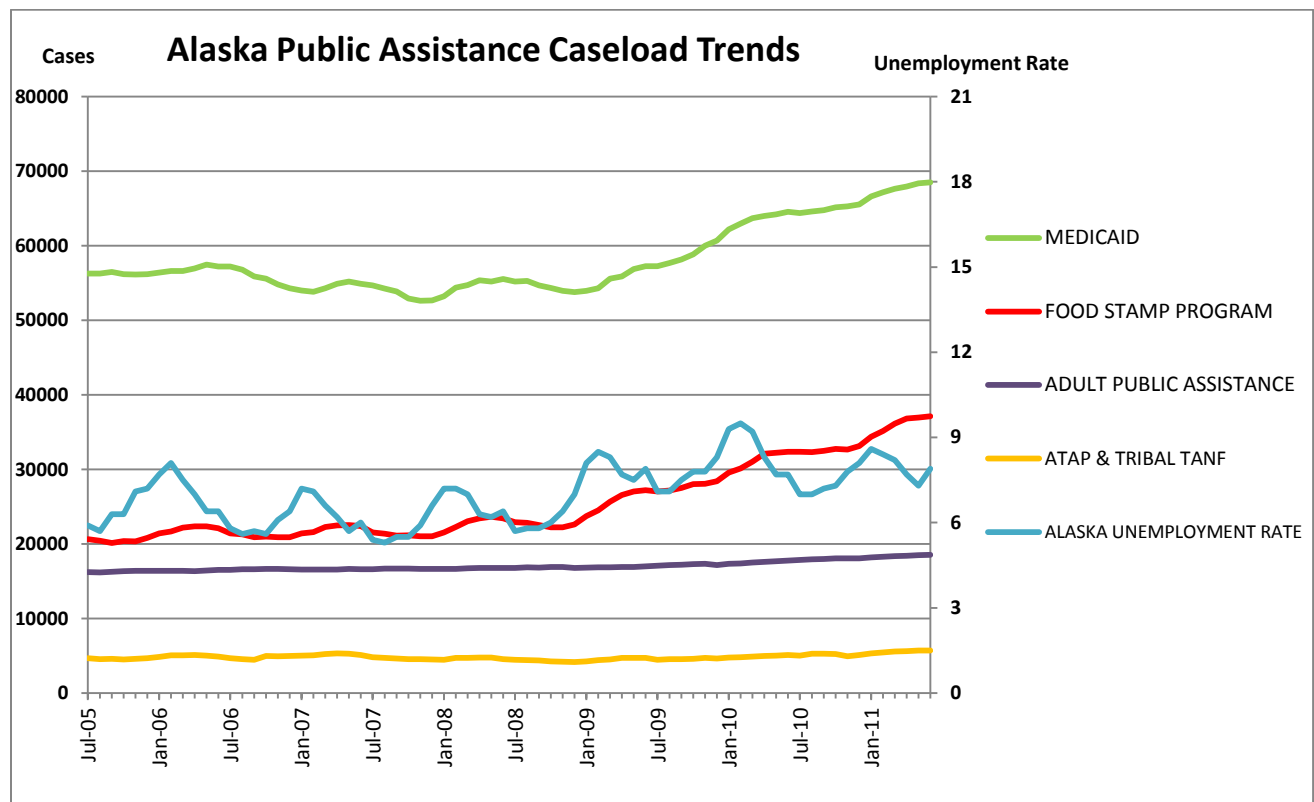
Challenges

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 for FY2013.

Increasing Need, Workload Challenges, and Continuous Improvement

The rise and fall of Alaska's unemployment rates over the past two years, in addition to the costs for food, housing, heating fuel, transportation, and other vital needs, has put immense stress on low-income households, amplifying 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 12.6% between FY2010 and FY2011. The number of households receiving food stamp benefits grew by another 16.6% in FY2011, with an overall increase of 42.1% over the past two fiscal years.



Work First Accountability

In April 2011, the Administration for Children and Families (ACF) published the FFY2009 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 21.4% by achieving an overall participation rate of 37.2%. Alaska, however, did not meet the two-parent work participation rate. Alaska's two-parent rate was set at 51.0%, and the state achieved a two-parent rate of 40.5%. In 2009 and 2010, ACF informed the state of penalties for failure to achieve the two-parent rate in FFY2007 and FFY2008.

Despite the challenges, Alaska achieved the 11th highest two-parent participation rate in the nation in FFY2009. This reflects DPA's commitment to achieve results despite great adversity. DPA submitted a reasonable cause claim to ACF in June 2011 and has implemented corrective compliance actions that will enable Alaska 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 mandated targets and new verification requirements in the Deficit Reduction Act (DRA) of 2005. In FFY2005 the two-parent participation rate target was 31.1%. Due to DRA rules, the FFY2009 two-parent participation rate target was 20% higher than the FFY2005 target. ACF 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.

The state relied on program enhancements, new service strategies, and practices employed by other states to help Alaska reach the two-parent participation target. For instance, innovative ways to increase work participation levels have been implemented through new partnerships. In October 2010 DPA provided a Native Employment Work Services (NEWS) grant to Kawerak, Inc. for development of work and work experience activities in Nome and surrounding villages. As a result, the number of families working or in work experience placements has increased dramatically. In September 2010, the month before Kawerak began NEWS services, 37.9% of ATAP families in Nome and surrounding villages were participating in work activities. Twelve months later, in September 2011, 54.7% of ATAP families were in work activities—an increase of 16.3%. The state is currently working with Aleutian Pribilof Islands Association (APIA) to explore a similar grant partnership to provide NEWS to families in the APIA services area. As a result of these efforts, Alaska has reported to ACF that it has met both participation rates for FFY2011 and anticipates that ACF will respond, as per regulation, to dismiss all pending penalties against the TANF block grant.

Steps 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, have been effective. For the first time since the DRA, legislative audit of ATAP had no findings of work verification errors.

DPA continues to keep a focus on a rapid attachment to the workforce. The state is re-procuring for Work First services using pay-for-performance contracts. Work First will continue to ensure that families with adults able to go to work become employed as quickly as possible.

Work Support services will be procured through grants and contracts that focus on directly

addressing significant challenges that prevent any families from success in getting a job and becoming self-sufficient. For families with disabled members that receive ATAP benefits, Work Supports will also reduce the number of months before they are determined eligible for Social Security Disability Insurance or Supplemental Security Income benefits.

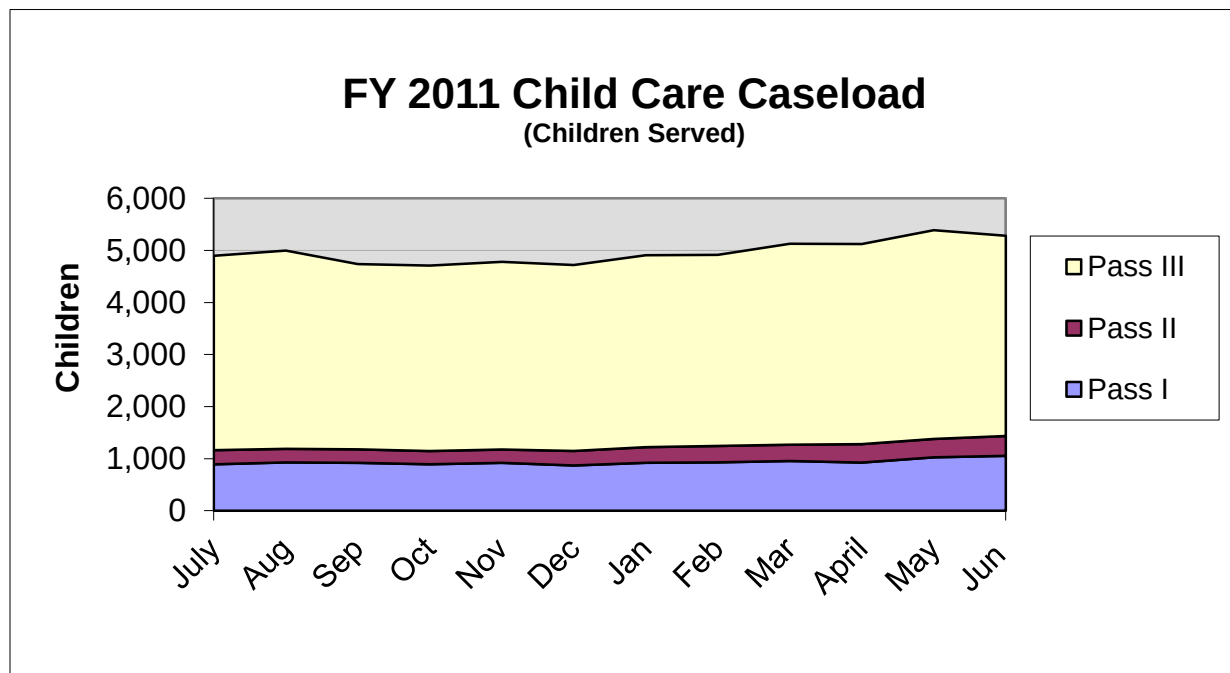
The division's Families First! Initiative will be integrated into the Work Supports services that will begin on July 1, 2012. All ATAP families with multiple DHSS involvement will be participating in service teams that aim to create "informed plans." Partnerships with other DHSS division and community social service providers across the state will be an expectation for all Work Support case managers and will allow for better service coordination and employment planning for families with profound challenges to move to work and self-sufficiency.

Childcare 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 Childcare Assistance Program and its initiatives are intended to ensure children in low income working families have access to affordable, safe, quality childcare. Childcare assistance often provides the support that parents need in order to stay working.

The division continues to work on strategies to increase the effectiveness of its Childcare Assistance Program to enable low-income working parents to find and afford safe, stable, and quality childcare. Strategies include increasing access and raising childcare subsidy rates closer to actual market levels. Because childcare 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). The division also 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 childcare assistance income limits at 75% of Alaska's state median income.

The federal government requires states to survey their childcare markets at least every two years and recommends that rates are set for all age categories at the 75th percentile of the market rate to ensure equal access to childcare for families. The Childcare Market Price Survey completed in 2011 showed that childcare subsidy rates range from 10% to as much as 40% below market rates. It is believed that this disparity between the state subsidy rate and the rate charged by childcare providers is responsible for a decline in the number of working families participating in the Childcare Benefits program. Additional funding is needed to stabilize Alaska childcare rates. Regular increases to the childcare subsidy rates that keep pace with the growing costs experienced by childcare providers are essential to promote and support access to quality childcare for low income families.



Quality Workforce

While improved, retention of 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 has enhanced its recruitment strategies to select the best possible candidates and is working with the DHSS Public Information Office to develop recruitment videos to target job classes and communities that face chronic recruitment challenges. Changes to core business practices have been implemented that have helped improve employee morale.

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, 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 FY2011, the division completed the initial delivery and implementation of LEAN work process improvements in all of the agency's 15 field offices and the Childcare Program Office. Staff in the Administrative Support Unit, System Operations and the WIC Program initiated process improvements to promote administrative efficiency and program effectiveness.

Even with these improvements in work processes, the division's workforce is challenged by the growth in public assistance cases. The increased demand for services necessitates the use of overtime and non-permanent positions to ensure accurate, timely, and quality services for public assistance applicants and recipients. However, the division will work to continually improve and standardize work processes and to leverage new technologies in order to increase its service capacity.

Automated System Replacements

The division has three major 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 FY2011; however, implementation was delayed due to unforeseen complications in securing a vendor for the transfer of a federally certified WIC system. The division has been 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. In FY2012 the division was able to procure an implementation contract to transfer SPIRIT, a federally approved WIC information system. The division anticipates full implementation in FY2013. DPA expects transition to the new system will provide uninterrupted services to WIC program participants, vendors, and grantees.

Fraud Case Management System: The contractor for the replacement of this system was unable to meet project deadlines and deliverables and the contract was terminated. A new strategy is being displayed to ensure continued progress on a new Fraud Case Management System.

Upgrading or replacing the Eligibility Information System (EIS): The division completed a comprehensive business needs assessment and feasibility study that evaluated options and the costs for replacing the EIS. The contractor responsible for the feasibility study prepared draft Technical Services and Quality Assurance RFPs. The feasibility study also provides the basis for the Department's FY2013 capital request for the funds needed for the design, development, and implementation of the replacement system.

Originally implemented in 1984, EIS is the backbone of Public Assistance operations. EIS is a complex system that supports Alaska's public assistance programs including: Food Stamps, Medicaid, Temporary Assistance, Denali KidCare, Childcare 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. EIS interfaces with systems in multiple agencies to support the administration of their programs and services.

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 using more advanced applications. Many significant changes in public assistance programs, program requirements, and associated business practices have occurred since EIS was developed. The division needs a more user-friendly and adaptable system to gain efficiencies and keep up with increased service demands, reduce system maintenance costs, and support better customer service, timeliness, and accuracy of eligibility decisions.

Health Care Reform

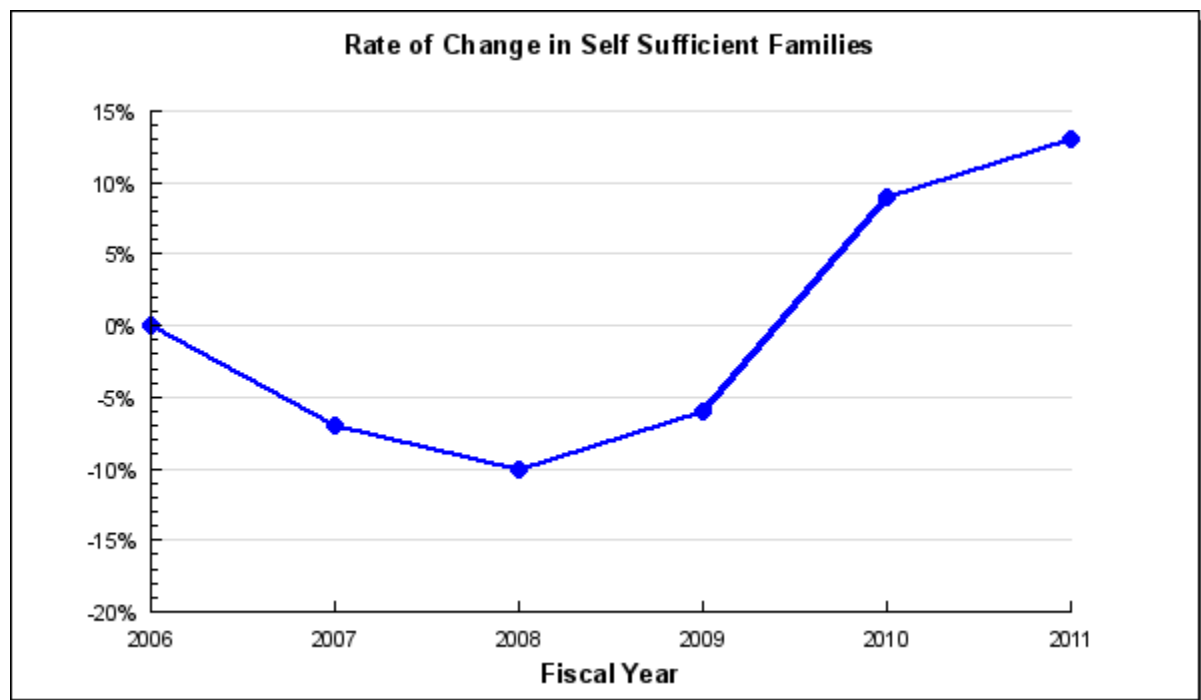
The federal Affordable Care Act, also referred to as Health Care Reform, includes a number of requirements related to Medicaid eligibility that are mandatory for state programs, as well as offering optional provisions that the state may implement. One of the most significant provisions of the health 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 FY2011, the Alaska Temporary Assistance Program (including the Native Temporary Assistance for Needy Families Program) showed a 13% 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 2011	5,400	13%
FY 2010	4,800	9%
FY 2009	4,400	-6%
FY 2008	4,700	-10%
FY 2007	5,200	-7%
FY 2006	5,600	0

Analysis of results and challenges: As shown in the YTD Total column, FY 2011 had a 13% increase in the number of families receiving Alaska Temporary Assistance Program benefits compared to FY 2010. 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 2009, the percentage of food stamp families with incomes below the poverty threshold was reduced by 25% after receiving food supports, compared to 18% in 2008.

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 FY2011 percentage of Alaska Temporary Assistance families who left the program with earnings and did not return for six months was 86%, which is 1% higher than in FY2010.

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
2011	88%	86%	84%	86%
2010	82%	85%	85%	85%
2009	88%	87%	85%	85%
2008	86%	86%	87%	86%
2007	88%	88%	88%	87%
2006	87%	87%	80%	84%
2005	88%	85%	80%	82%
2004	90%	85%	79%	80%
2003	85%	87%	82%	82%
2002	83%	83%	76%	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 FY2011 increased to 30% from 29% in FY2010.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2011	32%	30%	29%	30%	30%
2010	31%	29%	28%	29%	29%
2009	34%	33%	31%	31%	31%
2008	35%	33%	32%	33%	33%
2007	36%	34%	33%	34%	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 jobs that pays well enough for the families 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 FY2011, 37% of all Alaska Temporary Assistance families met the federal participation requirements, exceeding the federal target of 33%.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2011	36%	36%	36%	37%	37%
2010	36%	34%	33%	33%	33%
2009	41%	40%	38%	38%	38%
2008	46%	42%	41%	42%	42%
2007	47%	47%	46%	47%	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 the timeliness of benefit delivery.

Target #1: 95% of food stamp expedited service applications are processed within 5 days.

Status #1: In FY2011, 95% of emergency food stamp applications were processed within 5 days which is an increase from 90% in FY2010.

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 2011	94.2%	94.2%	95.1%	95.4%	95.4%
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 FY2011, 96% of new food stamp applications were processed within 30 days with an overall average processing time of 18 days, compared to 89% in FY2010.

Percentage of new food stamp applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2011	84.2%	95.3%	95.2%	96.1%	96.1%
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 FY2011, 91% of food stamp recertification applications were processed within 30 days, compared to 87% in FY2010.

Percentage of food stamp recertification applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2011	88.1%	88.8%	89.5%	91.2%	91.2%
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 FY2011, 90% of Alaska Temporary Assistance applications were processed within 30 days with an overall average processing time of 23 days. This is an increase from 75% in FY2010 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 2011	86.7%	85.6%	88.3%	90.1%	90.1%
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 FY2011, 91% of Medicaid applications were processed within 30 days, an 11% increase from FY2010.

Percentage of Medicaid applications that meet federal time requirements

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2011	89.4%	88.8%	89.7%	90.8%	90.8%
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 FY2008 processing times far exceeded the 30-day standard. As a result, children did not receive timely medical care, and payments to vendors and medical care providers were 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 the accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.

Status #1: In FFY2010, 98% of food stamp benefits were accurate, compared to 96% in FFY2009.

Percentage of accurate food stamp benefits

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2011	99.2%	99.0%	0	0	99.0%
FFY 2010	99.7%	98.3%	98.6%	98.3%	98.3%
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 FFY2010 Alaska Temporary Assistance benefit accuracy was 97%, compared to 98% in FFY2009.

Percentage of accurate temporary assistance benefits.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FFY 2011	95.6%	95.7%	0	0	95.7%
FFY 2010	98.2%	97.7%	97.7%	97.4%	97.4%
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 FY2008 were temporarily suspended due to the additional efforts needed to perform both the federally mandated Medicaid payment accuracy rate and Childcare accuracy measurements.

Target #3: 93% of Medicaid eligibility determinations are accurate.

Status #3: In FFY2011, 99% of the Medicaid eligibility determinations were accurate compared to 94% in FFY2010.

Percentage of accurate Medicaid eligibility determinations

Fiscal Year	YTD Total
FFY 2011	99%
FFY 2010	94%
FFY 2009	90%
FFY 2008	98%
FFY 2007	90%
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 FFY2010, 98% of Food Stamp Program benefits, 97% of Temporary Assistance benefits, and 94% 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 FY2011, 76% of children receiving childcare assistance were in licensed care, equal to 76% in FY2010.

Percentage of subsidy children in licensed care

Fiscal Year	September	December	March	June	YTD Total
FY 2011	76%	76%	76%	76%	76%
FY 2010	73%	75%	75%	76%	76%
FY 2009	70%	70%	71%	71%	71%
FY 2008	73%	73%	73%	73%	73%
FY 2007	74%	74%	75%	75%	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.

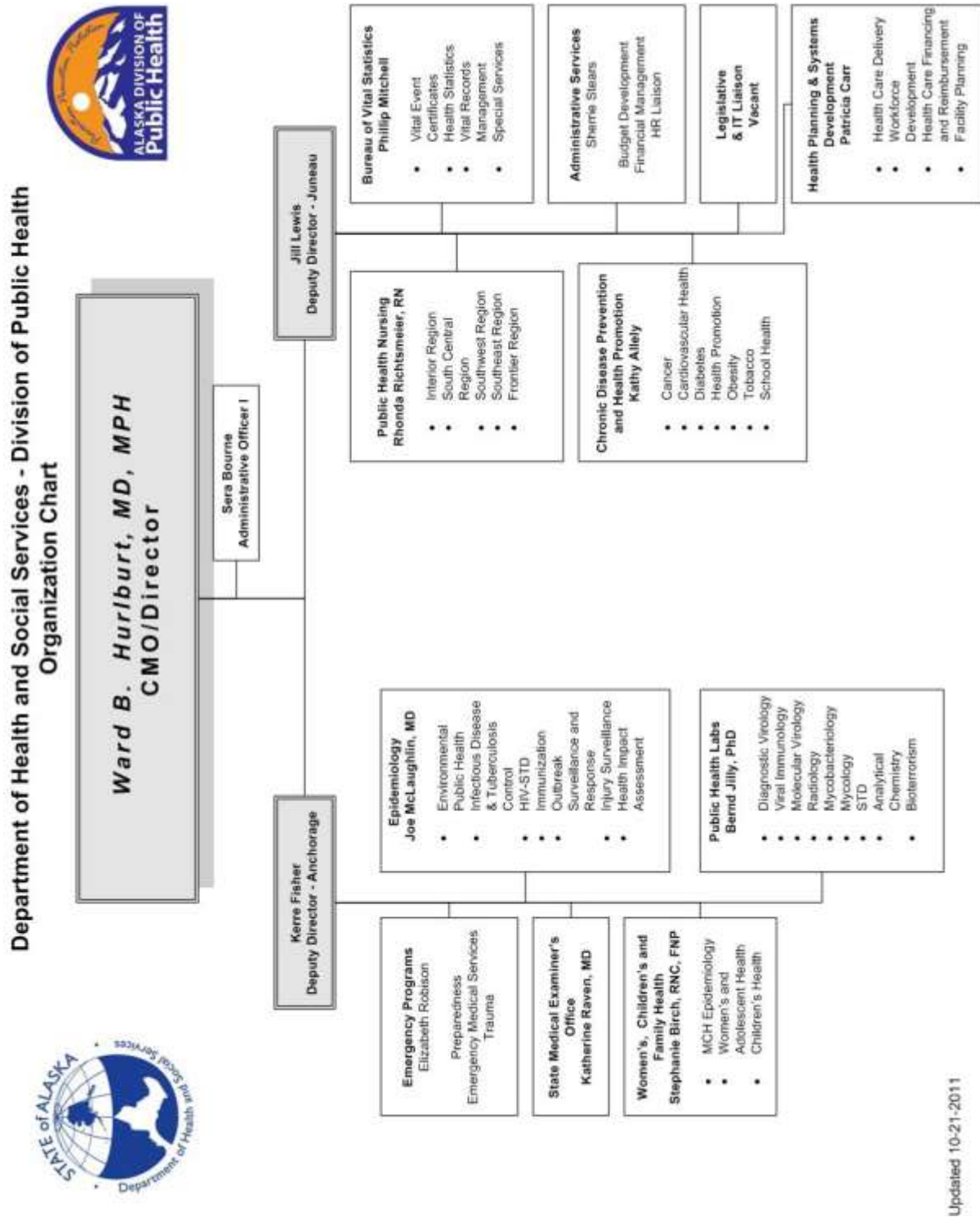
The number of working families participating in the Childcare Assistance Program has decreased over the past year. The decrease is partially attributed to State rates for childcare not keeping up with the rates that childcare providers charge. As state rates decline in relation to the market rate, low income families on childcare assistance are faced with an increased financial burden to pay the difference between the state rate and the childcare provider's rate (in addition to their required co-payment) or to choose lower priced and usually lower-quality childcare. The decline in state rates in relation to the market rate has resulted in fewer families being assisted by the Childcare Assistance Program and childcare providers being less able to provide care at state payment levels. State rates for licensed childcare providers who accept children on childcare assistance were increased effective September 2008 as an initial step to bridge that gap.

The YTD total is the average for the year.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Public Assistance</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Additional Temporary Assistance for Needy Families (TANF) Federal Authority	\$ -	\$ -	\$ 3,150.0	\$ -	\$ 3,150.0
Adult Public Assistance Program - Formula Funding Increase Due to Caseload Growth	\$ 5,665.5	\$ -	\$ -	\$ 409.5	\$ 6,075.0
Hold Harmless Program Authority Increase Due to Public Assistance Caseload Growth	\$ -	\$ 540.0	\$ -	\$ -	\$ 540.0
Extend Senior Benefits Payment Pgm CH6 SLA2011 (HB16) FN year 2	\$ 604.8	\$ -	\$ -	\$ -	\$ 604.8
Federal Low Income Home Energy Assistance Program (LIHEAP) Funding for Tribes	\$ 3,373.0	\$ -	\$ -	\$ -	\$ 3,373.0
Federal Low Income Home Energy Assistance Program (LIHEAP) Funding to the State	\$ 4,627.0	\$ -	\$ -	\$ -	\$ 4,627.0
Reverse American Recovery and Reinvestment Act (ARRA) Funding Sec33(d) CH3 FSSLA2011 P92 L8-12 (HB108)	\$ -	\$ -	\$ 2,666.1	\$ -	\$ 2,666.1
Reverse Energy Assistance Program Contingency Language Sec28(c) CH5 FSSLA2011 P163 L12-19 (SB 46)	\$ (4,627.0)	\$ -	\$ -	\$ -	\$ (4,627.0)
Reverse LIHEAP Tribes Contingency Language Sec28(b) CH5 FSSLA2011 P163 L5-11 (SB 46)	\$ (3,373.0)	\$ -	\$ -	\$ -	\$ (3,373.0)
Public Assistance Total	\$ 6,270.3	\$ 540.0	\$ 5,816.1	\$ 409.5	\$ 13,035.9

Division of Public Health



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.

Professional staff monitors and assesses health status through the collection and analysis of: vital statistics; behavioral risk factors, 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 seven key public health activities are:

- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure adequate and competent public health infrastructure and enforcement of health and safety laws/regulations.
- Monitor, research, and evaluate health status, service effectiveness, accessibility, and quality to identify and solve community health problems.

Public Health is organized into 10 sections:

○ Administrative Services	○ Health Planning and Systems
○ Bureau of Vital Statistics	Development
○ Chronic Disease Prevention and Health	○ Public Health Laboratories
Promotion	○ Public Health Nursing
○ Emergency Programs	○ State Medical Examiner's Office
○ Epidemiology	○ Women's, Children's and Family Health

In FY2011, the Section of Certification and Licensing was transferred from Public Health to Health Care Services, and Health Planning and Systems Development was transferred from Health Care Services to Public Health. This was an organizational shift to better align programs with the department's strategic plan. The core services that these sections provide did not change.

Services Provided

Unlike other areas of health care that deal with patients individually, in Public Health the entire community is our patient. Public Health touches the lives of Alaskans from “cradle to grave” and there are no better examples of that than the services of the Bureau of Vital Statistics and State Medical Examiner’s Office.

The Bureau of Vital Statistics 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 deaths. 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 provided free vaccines to health care providers; however, recent reductions in federal funding have meant that Public Health has had to make fewer free vaccines available. 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, 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 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, providing trauma training to rural communities, and administering state and federal grants that provide operational and capital equipment support for EMS systems across the 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.

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 to plan, implement and based strategies and interventions; evaluate evidence-based strategies and interventions; prevention and control of chronic diseases; and promotes healthy lifestyles. The Tobacco Prevention and Control unit funds an extensive 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 collaborates with local, state, federal, tribal and private industry partners as well as Alaska’s healthcare facilities, emergency medical and trauma systems to ensure everyone is 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 Health Planning and Systems Development section works with communities and organizations to assure access to quality primary and acute health care services in Alaska. The section assures quality care is provided through state and federally funded programs that strengthen health care access with a focus on rural areas and underserved populations. Statewide health planning helps sustain organized and efficient health care delivery in Alaska. The section provides technical assistance and other resources to hospitals, primary care delivery sites, and other community organizations regarding health care delivery, workforce, financing and reimbursement, and facilities.

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. The Section of Emergency Programs provides education and training throughout the state on all hazards response for pre-hospital and acute care facilities and works with many federal, state, and local partners to develop a comprehensive approach to hazard response.

Annual Statistical Summary of Services Provided in FY2011

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 FY2010 are provided below.

Infectious Disease and Epidemic Prevention and Control

- Distributed 375,300 doses of vaccine; of those, 130,000 were distributed by public health nurses.
- Shipped 10,275 vials containing 102,750 doses of PPD to test for tuberculosis.
- The laboratory received and processed 175,554 total tests:
 - STD tests: 94,450
 - Hepatitis tests: 30,601
 - Tuberculosis tests: 10,825
 - Toxicology tests: 767
 - Viral tests: 28,386
 - Other various tests: 10,525
- Published 33 Epidemiology Bulletins informing health care providers and the public of important investigations, concerns, and alerts regarding health issues.
- Approximately 2,500 referrals were received from local hospitals, outpatient care providers, schools, correctional facilities, and from DHSS Offices of Children's Services and Section of Epidemiology requesting public health nursing follow-up on a variety of health and safety concerns, including maternal/child health issues, epidemiological investigations, sexually transmitted diseases, and tuberculosis.
- Public health nurses started 197 patients on medication to treat Tuberculosis and provided the care coordination needed to both treat the disease and protect the health of the patient.
- Public health nurses administered more than 55,000 immunizations.



Major Accomplishments

- Immunization coverage rates in 19 to 35 month olds went from 49th to 42nd in state ranking (2009 to 2010).
- Sponsored statewide provider education conference where national and local experts presented innovative and practical ideas to effectively communicate: evidence-based vaccine safety information to hesitant parents; how to reduce or eliminate costly loss

of vaccine; and strategies to increase immunization coverage and to protect all Alaskans against vaccine-preventable disease.

- Investigated and helped control an outbreak of *Campylobacter* infection associated with consumption of raw milk.
- Decreased the number of gonorrhea cases reported by 23% in the first three quarters of 2011. Investigated and controlled an ongoing, large-scale outbreak of gonorrhea infection that affected more than 200 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.
- The state's immunization registry, VacTrAK, has 131 providers participating; 56% of Alaska residents had at least one vaccine recorded in VacTrAK, up from 45% in 2010.

Injury Prevention Control and Emergency Medical Services

- The Poison Prevention and Control Program reported 8,945 calls to the Alaska Poison Control System and distributed 12,752 poison prevention and information resources statewide.
- Kids Don't Float drowning prevention program added 15 sites, totaling 595 active sites and education centers in 257 communities statewide.



- Certified 2,790 emergency medical personnel, 284 instructors, and 50 ambulance services.
- 47 communities received essential EMS equipment and vehicles under the Alaska Code Blue project.
- Four Alaska hospitals were re-designated as Level IV Trauma Centers – Yukon-Kuskokwim Health Corporation, Norton Sound Regional Hospital, Sitka Community Hospital, and Mt. Edgecumbe Hospital. Alaska Native Medical Center continues to maintain its Level II Trauma designation. Eight additional hospitals received trauma designation consultation visits.
- Screening for interpersonal/domestic violence identified 464 clients with positive screening results and an additional 144 with suspect screening results. These individuals were provided appropriate referral, education, and counseling regarding protection of themselves and any children in the household. In addition, 86 referrals were made to the Office of Children's Services for suspected child abuse, child neglect, or sexual offense against a minor.
- The Injury Surveillance Programs continues to work with DHSS data managers and analysts across multiple professional disciplines to maintain an epidemiologic profile that identifies and reviews state-level data pertaining to alcohol, illicit drug, tobacco use, and outcomes highly associated with substance use and abuse. The profile ensures the continued availability of data on consumption, consequence, and contributory factors and

evaluates longevity of the measures as useful indicators of substance abuse and prevention activities and trends.

Major Accomplishments

- Nineteen lives have been saved to date by direct use of personal floatation devices from Kids Don't Float.
- In close collaboration with the Alaska Native Tribal Health Consortium Injury Prevention, established an injury and violence prevention 'supercoalition' of 60 statewide coalitions and programs. The Alaska Violence and Injury Prevention group will assess existing injury and violence prevention efforts across Alaska to better align resources for greater impact, as well as address gaps in services across Alaska.

Chronic Disease Prevention and Control

- The Obesity Prevention and Control Program partnered with the Matanuska-Susitna Borough School District to identify the obesity prevention strategies implemented by the district and to determine the impact of those strategies. The prevalence of overweight and obesity of the student population significantly declined during the last seven years. This is the first documented decline in overweight and obesity prevalence in any school district in Alaska.
- Training was provided to 50 health professionals and community members to become chronic disease self-management leaders. Training was provided to 50 existing course leaders to become re-certified as course leaders.
- The Alaska Family Violence Prevention Project provided training and technical assistance to more than 700 service providers on the health effects of domestic violence on women and children and best practices for assessment, intervention, and prevention.
- One new community was added to the cessation interventions program.

Major Accomplishments

- The Alaska Cancer Registry met the 12 month standard established by the CDC's/National Program of Central Cancer Registries for data completeness, for the first time since its inception in 1996. This was achieved by only 44% of the funded states.



- The Alaska Family Violence Prevention Project developed and launched a new training module on sexual assault and reproductive coercion for health care providers in 2011 that includes scripted screening tools, harm reduction practices, and safety cards.
- Overall youth tobacco use prevalence is at an all time low of 16%, which is statistically significant and lower than the US average.
- A School Nursing Advisory Committee completed guidelines for conducting health assessments in schools including weight and body mass index calculations. Guidelines for infection control management and vision screening were initiated. The School Nursing Consultant continues to contribute significantly to the Department of Education and Early Development's work with school nurses statewide on obesity reduction efforts for school-aged children.

Public Health Emergency Preparedness and Response

- Conducted 11 interagency emergency preparedness exercises and three community-wide preparedness outreach workshops focusing on mass casualty and mass fatality planning.
- The Laboratory tested 57 samples suspected of containing biological threat agents and 85 samples from botulism outbreaks. Alaska consistently has the highest rate of food-borne botulism in the country.

Major Accomplishments

- Successfully launched the AK Respond program for electronic registration of all types of volunteer health professionals for disaster assignments. AK Responder is built on the Alaska Nurse Alert System, which has registered and deployed volunteer nurses to assist in response to public health emergencies since 2005. Currently, AK Respond has 570 responders registered in the registry.
- Increased capacity to respond to local community needs with a Statewide Medical Reserve Corps (MRC) Coordinator and 4 local MRCs in Anchorage, Ketchikan, and the Kenai Peninsula Borough.
- Collaborated with statewide law enforcement in a full scale security/medical distribution exercise around a Strategic National Stockpile deployment to Alaska.



- Point of Dispensing planning processes in local communities increased the ability to vaccinate every Alaskan so that medical countermeasures can be distributed to all Alaskans in a timely manner.

Access to Early Preventive Services and Quality Health Care

- Alaska's public health nurses provided more than 83,300 health care visits in FY2011; 47,512 of these were to children and youth ages birth to 19 years.
- Nursing made more than 1,700 postpartum home visits to new mothers and babies needing follow-up.
- 99.9 percent of all newborn children were screened for over 30 metabolic conditions, and 92 percent of all babies were screened for newborn hearing loss.
- 49 children were seen for screening and diagnosis of autism spectrum disorder in ten communities. Fourteen children ages 0 to 5 received a diagnosis of autism or other neurodevelopmental disorders and were referred to specialists.



Major Accomplishments

- Provided 878 technical assistance encounters on health care services and funding to over 98 different community-based organizations and health care organizations.
- Increased the health care workforce through direct loan repayment awards for 14 health care professionals in FY2010 and 12 more health care professionals in FY2011. Supported another 77 health professionals receiving National Health Service Corps federal loan repayment and

three federally funded scholars.

- Over \$400.0 in grants to 12 community health centers for improving access to primary care for those 65 years of age and over.
- Provided technical assistance to 28 individuals and organizations regarding federal funding to expand health centers in Alaska.

Protecting Human Health from Environmental Hazards

- Conducted follow-up investigations on 3 cases of childhood and 10 cases of adult elevated blood lead levels. Investigated and helped control an occupational lead exposure problem at a geochemical laboratory.
- Investigated and helped control one of the largest recognized outbreaks of paralytic shellfish poisoning in Alaska.

Major Accomplishments

- Published the Health Impact Assessment Toolkit, which provides detailed technical guidance for HIA in Alaska.
- Completed a health impact assessment on the Point Thompson project, and approached completion of an HIA for the Wishbone Hill Coal Mine.
- Performed baseline health assessments on the Chuitna Coal Mine and the Donlin Creek Gold Mine.
- Assisted with the DHSS response to the 2011 earthquake and tsunami in Japan by providing information to the public about radiation exposure risks from the failed Fukushima Daiichi nuclear power plant. The Laboratory Radiation Health Specialist and laboratory response staff provided factual, scientific information for public reporting and real-time monitoring of radiation data.
- 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

- 77% of cases were transported to the State Medical Examiner's Office for further examination. The Office performed 511 autopsies and 264 inspections.
- In FY2011, the Bureau of Vital Statistics processed:
 - Births: 11,697
 - Deaths: 3,888
 - Registered Marriages: 5,631
 - Marriage licenses issued: 4,357
 - Divorces: 3,393
 - Adoptions of Alaska-born children processed: 740
 - Establishments of paternity of Alaska-born children processed: 3,381
 - Applications for the Medical Marijuana Registry processed: 354
 - Funds for the Alaska Children's Trust from heirloom birth and marriage certificates: \$25,000.

- A focus on improving public health clinic flow and efficiency over the past two years is beginning to show positive results. Improvements in clinic management and efficiency noted in several of the public health centers include:
 - Replacing open “walk-in” time for patients in clinic schedules with scheduled appointments. This has resulted in availability of “same day” appointments for those who need them, appointment slots for clients to be seen over the lunch hour, and extended clinic hours in some public health centers.
 - Adjustment of the types of appointments available, for example increasing appointments for immunizations, STD and family planning, thus increasing access to better meet the needs of our at risk population.
 - Improved check-in and check-out paper processes resulting in decreased congestion at the client registration desk and increased privacy for clients.
 - Decreased client wait time; May 2011 Customer Satisfaction Survey results showed that 86% of clients waited less than 15 minutes to see a public health nurse and 99% reported that they could obtain an appointment at the time they wanted.

Major Accomplishments

- Awarded the Paul Coverdell Forensic Science Improvement Grant, which funded forensic training for pathologists and investigative staff, DEXIS portable dental x-ray equipment, digital photography equipment, new computers and software for the office, new server and autopsy equipment and supplies.
- 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 rural Alaska.
- Improved financial controls that resulted in better fiscal accountability such as annual spending plans, more frequent projections, quarterly reviews of cost allocations, and increased training and coaching of program staff and managers in budgeting and finance.



List of Primary Programs and Statutory Responsibilities

Statutes

AS 08.36	Business and Professions -- Dentistry
AS 08.64	Business and Professions -- Medicine
AS 08.65	Business and Professions -- Direct-entry Midwives
AS 08.68	Business and Professions -- Nursing
AS 08.80	Business and Professions -- Pharmacists and Pharmacies
AS 09.55.060	Special Actions and Proceedings
AS 09.65.090, 095, 100	Actions, Immunities, Defenses and 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 and Probation
AS 12.65	Death Investigations and Medical Examinations
AS 13.52.010-.395	Health Care Decisions Act
AS 14.07.020	Duties of the Department of Education and Early Development
AS 14.30.065-.127, 191, 231	Physical Examinations and Screening Examinations
AS 17.37.030	Medical Use of Marijuana
AS 18.05.010-.070	Administration of Public Health and Related Laws
AS 18.07	Health, Safety and Housing, Certificate of Need Program
AS 18.08.010-.200, .900	Emergency Medical Services
AS 18.15.120-.138	Public Health Authority and Powers
AS 18.16.010	Regulation of Abortions
AS 18.23	Patient Records
AS 18.25	Assistance to Hospitals and Health Facilities
AS 18.28	State Assistance for Community Health Aide Programs
AS 18.50	Vital Statistics Act
AS 18.60.475-545	Radiation Protection
AS 18.60.880-.890	Health Care Protections
AS 25.05.071-.391	Alaska Marriage Code
AS 25.20.025	Parent and Child
AS 25.23.160 - 170	Adoption
AS 26.23	Alaska Disaster Act
AS 37.05.146	Receipts for Fees for Business Licenses for Tobacco Products
AS 37.05.580	Tobacco Use Education and Cessation Fund
AS 40.25.120, .125	Public Records: Exceptions and Disclosures
AS 44.29	Department of Health and Social Services
AS 44.62	Administrative Procedure Act
AS 47.07	Medical Assistance for Needy Persons
AS 47.17.020	Child Protection-Persons Required to Report
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 47.30.660	Comprehensive Integrated Mental Health Plan

Regulations

4 AAC 06.055	Immunizations
4 AAC 60.100	Pre-elementary Schools – Immunizations Required
7 AAC 05.110 - 990	Vital Records
7 AAC 07.010	Health and Social Services Certificate of Need
7 AAC 12.009	Free Standing Birthing Centers
7 AAC 12.450	Frontier Extended Stay Clinic
7 AAC 12.650	Employee Health Program
7 AAC 12.810	Laboratory Safety
7 AAC 16.010 – 090	Do Not Resuscitate Protocol and Identification
7 AAC 18	Radioactive Materials
7 AAC 26.280, 390, 710	Emergency Medical Services
7 AAC 27	Preventative Medical Services
7 AAC 35	Embalming and Other Post-Mortem Services
7 AAC 43	Medical Assistance
7 AAC 50.450, .455	Health in Child Care Facilities and Full Time Care Facilities
7 AAC 57.550	Health
7 AAC 75.220	Assisted Living Homes
7 AAC 78.010 - 320	Grant Programs
7 AAC 80	Fees for Department Services
7 AAC 105-160	Medicaid Coverage and Payment
12 AAC 40	State Medical Board
12 AAC 44	Board of Nursing
12 AAC 52	Board of Pharmacy
13 AAC 08.025	Medical Standards – School Bus Drivers’ Health Screening
14 AAC .012-.014	Certified Direct-entry Mid-wives
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 (CHIP)
P.L. 104-191	Health Insurance Portability and Accountability Act of 1996 (HIPAA)
P.L. 107-56	Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (USA PATRIOT Act)
P.L. 107-188	Public Health Security and Bioterrorism Act of 2002
P.L. 111-5	American Recovery and Reinvestment Act of 2009 (ARRA), including Health Information Technology for Economic and Clinical Health (HITECH) Act
9 CFR 2.31	Institutional Animal Care and Use Committee
10 CFR	Nuclear Regulatory Commission – Authority to Regulate
21 CFR 900	Mammography Quality Standards – Authority to Inspect
42 CFR 72-73	Possession, Use and Transfer of Select Agents and Toxins
42 CFR 493	Public Health Laboratory Requirements

Explanation of FY2013 Operating Budget Requests

Division of Public Health

Budget Overview Table

Division of Public Health	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$46,878.8	\$49,504.0	\$2,625.2
Designated General Funds	13,682.2	13,782.8	100.6
Federal Funds	38,796.9	38,917.0	120.1
Other Funds	7,186.1	7,731.9	545.8
Total	\$106,544	\$109,935.7	\$3,391.7

Budget Requests

Stabilize Funding to Public Health Nursing Grantees-Phase III: \$1,100.0 (\$990.0 GF/ \$110.0 Federal)

This \$1,100.0 is Phase III of a series of requests to stabilize funding to public health nursing grantees. Phase III provides the three public health nursing grant program recipients with the state grant funding needed to maintain services at their current level without local subsidies. It assures that the three grantees continue to provide 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 public health disasters; preventing injury and chronic disease; and assuring access to care for children and vulnerable adults.

The Division of Public Health currently 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.

Current grants are inadequate. Until the Division of Public Health began efforts to stabilize grantee funding beginning with the FY2011 budget, the grantees had gone decades with little or no increased funding for public health nursing services. Meanwhile costs for travel, facility operations, and supplies rose significantly, increasing the financial burden on the grantees. Grantee public health nurse salaries have not kept pace with State salaries and the rural areas suffer from chronic public health nurse shortages. Even with increments of \$1 million for FY2011 (Phase I) and \$1.75 million for FY2012 (Phase II), grantees still must subsidize operations with \$1,300.0 of local funding. The remainder of the state receives public health nursing services without the requirement of locally subsidized funding.

Basic public health services have dwindled. 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. 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 their low salaries and as a result has struggled to provide adequate basic public health nursing services to the people in that area. The public health nursing service level of Anchorage is much less than the level supported for the rest of the state either through grants or operated directly. With Phase I and II funds, North Slope was able to increase salaries for their public health nurses, making salaries more competitive. Maniilaq Association also gave a raise to their nurses. The Municipality of Anchorage used some of the funds for interpreter services, tuberculosis-related lab tests and x-rays.



The grantees' inability to meet basic public health needs affects the health of all Alaskans. If not funded we expect to see a continued decline in public health service delivery in these regions, accompanied by an increased rise in public health problems. In addition, supporting the grantees by keeping their public health nursing programs local keeps these jobs in the communities, helps to support other local jobs that support these staff positions, and keeps the income related to these jobs in the local economy as well.

The Municipality of Anchorage has expressed an interest in discontinuing these services as they cannot afford to continue to support their public health program. This would mean the state would be required to assume direct provision of these services at a significant increase in cost to the state. This is not unprecedented as Norton Sound Health Corporation was a grantee until July 2012 when they returned responsibility for provision of public health nursing services to the State as a result of chronic underfunding.

NATIONAL STANDARD	1 : 5,000
ALASKA DIVISION OF PUBLIC HEALTH	
Interior Region	1 : 4,319
South Central Region	1 : 6,174
Southwest Region	1 : 3,023
Southeast Region	1 : 3,103
GRANTEES	
Municipality of Anchorage	1 : 20,041
Maniilaq Association	1 : 2,693
North Slope Borough	1 : 1,475

If the Municipality of Anchorage returned public health nursing responsibilities back to the state it would have catastrophic consequences for all Alaskans. Assuming responsibility for Municipality's population of nearly 300,000 or 42% of the state population would double the workload of the Section of Public Health Nursing, significantly impact the workload of the rest of the Division of Public Health, and more than double the cost of providing public health services to this population at even the current level. It would cost the State more than it currently costs the Municipality for the same services because of the higher state salaries and higher administrative costs within the state system.

These consequences would bring a significant impact upon the State's ability to protect our citizens from public health threats such as infectious disease outbreak, reduce

the promotion of health and well-being through services such as domestic violence screening, and bring devastating fiscal consequences to the State budget.

Immunizations for Children and Seniors \$700.0 (\$630.0 GF/\$70.0 Federal)

This \$700.0 proposal is to purchase sufficient vaccine to maintain distribution levels for the highest priority populations.

1. Pediatric vaccine (\$325.0): Continue universal coverage for children age 19-35 months.
2. Adult vaccine (\$375.0): Restore influenza and pneumococcal vaccine for adults age 65 and up who do not have other resources.

In 2009, Alaska ranked 49th in the nation in the National Immunization Survey for overall vaccine coverage rates for children aged 19-35 months. A strong immunization program is essential to prevent and control vaccine-preventable diseases. For over 30 years the Division of Public Health has supported a "universal" vaccine program, distributing at no cost all recommended pediatric and selected adult vaccines to public and private providers in Alaska using federal funds.

Federal vaccine funds decreased. A universal vaccine policy has become increasingly difficult to sustain with a steadily increasing number of new vaccine recommendations, rapidly rising vaccine costs, and reduced federal funding. Costs have risen almost seven-fold in the last 10 years. The CDC will be reducing the state's pediatric vaccine funds by almost \$4 million by 2013.



Adult vaccines eliminated; pediatric vaccines threatened. The Division decided to continue pediatric/adolescent vaccine distribution to the extent possible with decreasing funds. Pediatric vaccines will be prioritized to assure full access to those vaccines required for school and child care attendance (DTaP, Tdap, polio, hepatitis A, hepatitis B, Hib, MMR) as remaining funds allow. Adults are believed to be more likely to have alternate venues in which to obtain vaccines, as well as greater opportunities for coverage through private insurance or Medicare. As of January 2011, adult vaccines that historically have been provided by the state (i.e., influenza, pneumococcal, tetanus/diphtheria) were discontinued to public and private sector providers.

Appropriate and timely use of vaccines saves lives and health care dollars. Without funding for immunizations, children and seniors may not get the vaccinations they need to protect them from potentially life-threatening diseases.

MH Trust Workforce Dev - Grant 1383.05 Loan Repayment: \$400.0 (\$200.0 GF-MH/\$200.0 MHTAAR)

This request is a continuation of the SHARP program. For FY2012, this proposed increment will field an estimated 16 to 22 health care practitioners. The entire amount is for practitioner loan repayments, with none requested for administration.

Alaska's "Supporting Health Care Access [through loan] Re-Payment" (SHARP) program is a loan repayment program designed to help recruit and retain healthcare clinicians in Alaska, especially in those areas having the most critical practitioner shortages. The program provides assistance in education loan repayment for those clinicians who provide healthcare to disadvantaged populations. Considerable evidence nationwide indicates that healthcare practitioners are finishing their training programs with substantial educational debt. Further, many of these providers are quite willing to work in high-need areas with high-need populations if agencies can help relieve this debt in return. Nationally, this workforce "support-for-service" strategy has been shown repeatedly to increase both recruitment and retention.

MH Trust: Cont - Grant 120.08 Comprehensive Integrated Mental Health Plan: \$120.0 MHTAAR

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 beneficiary 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 beneficiary-related indicators and guide program evolution and service delivery; it contributes significantly to the establishment of funding priorities. The Comprehensive Plan is developed within a results-based framework that will assist policymakers in identifying beneficiary needs and determining service effectiveness.

MH Trust: Workforce Development-1452.02 Autism Capacity Building: \$75.0 MHTAAR

This \$100.0 proposal is a continuation of the Capacity Building for Autism Intervention project supported by the Alaska Mental Health Trust. Funds will be used to continue a Reimbursable Services Agreement with University of Alaska Center for Human Development to train individuals on effective early autism intervention services. UAA has successfully developed relationships with a major university outside the state to offer master's level education in the area of applied behavioral analysis and other evidence-based interventions.

Currently there is not enough capacity within the workforce to offer evidence-based intensive services for children diagnosed with autism spectrum disorder. On average more than 160 children are diagnosed annually. There are not adequate services available to refer families for assistance in behavior management, social/emotional regulation, or language development.



Children diagnosed with autism spectrum disorders have few resources available in the state for intensive intervention that helps them acquire communication and language skills, learn to regulate their behaviors, develop social skills, and in the long run be successful in school and the employment world. By providing training, a cadre of professionals and paraprofessionals will be available to deliver intensive autism intervention soon after a child is diagnosed and early in a child's life when research shows intervention has the greatest impact. Children without interventions require significantly more special education supports when they enter school and are not able to reach their full potential.

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.

Obesity Prevention and Control

Overweight and obesity⁴ is our dominant public health problem. This largely avoidable disease affects Alaskans of all ages, from all areas of the state, across all levels of education and income, and of all racial and ethnic backgrounds. The dramatic increase in overweight and obesity prevalence that occurred over the past 18 years will have lasting financial and health impacts on Alaskan families, communities, businesses, and the healthcare system for decades to come.



The Magnitude of the Problem

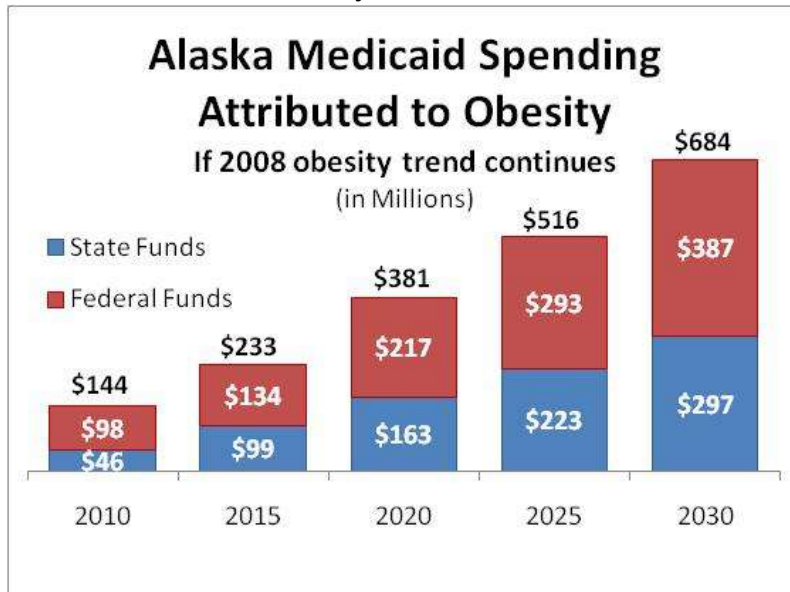
- Americans are blind to the obesity epidemic.
 - 30% of overweight Americans believe they are of “normal” size.
 - 70% of obese Americans believe they are simply overweight.
 - 60% of morbidly obese Americans believe they are merely overweight.
 - The average American consumes 50 gallons each year of sugar sweetened beverages.
- Obesity and overweight rates remain alarmingly high among Alaska young people and adults.
 - 65% of Alaska adults are overweight or obese.
 - As many as 40% of Alaska's children are overweight or obese.
- Medical complications of obesity are predicted to overtake tobacco as the leading cause of premature death. It has already eclipsed tobacco in terms of medical costs.
- Adult obesity prevalence has doubled from 13% in 1991 to 26% in 2009.
- Rates of U. S. childhood overweight and obesity have tripled over the past four decades.
- One-third of all American children born in 2000 are expected to develop diabetes during their lifetime (primarily related to overweight/obesity).
- More than one quarter of all Americans ages 17 – 24 are unqualified for military service because they are too heavy.
- Obesity and inactivity cause 365,000 premature deaths a year in the U.S.
- Obesity is predicted to shorten life expectancy in the U.S. by two to five years by 2050.

⁴ Overweight and obesity are determined by calculating BMI from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and it is used to screen for weight categories that may lead to health problems. A five foot five inch woman weighing more than 180 pounds would be considered obese. A five foot ten inch man weighing more than 209 pounds would be considered obese.

The Economic Cost is Immense

The total economic cost of overweight and obesity is staggering and is a key driver of unsustainable health care costs.

- In the U.S. and Canada the combined cost for medical costs, lost productivity, and disability is \$300 billion annually. The total economic cost for Alaska is estimated to be \$947 million annually.
- Direct medical spending in the U.S. on obesity alone is \$147 billion. For Alaska it is \$477 million.
- Direct medical spending on obesity of \$477 million exceeds Alaska's tobacco-related medical costs of \$380 million.
- Alaska's Medicaid obesity-related costs could reach \$684 million by 2030 if obesity prevalence increases as predicted by the Trust for America's Health.



- In 2008, 12% of Medicaid spending goes toward obesity-related costs. That number will grow to 16% by 2018.

- If the obesity rate could be held to the 2008 level (26%) projected costs would be \$508 million, saving \$176 million dollars by 2030. The State of Alaska experiences about \$10.3 million annually in total economic costs related to obesity and overweight among its employees.

- Obese people spent

\$1,429 per person more on medical costs compared to normal weight people in 2006.

- Americans purchased an additional \$2.8 billion in automobile gasoline in 2005 due to extra body weight in vehicles compared with 1960.

Alaska's Response: A decades-long process we must embark on now

Sixty-two percent of Alaskans believe that the government has some and/or a lot of responsibility for addressing obesity. Investing in obesity prevention and control makes sense financially because investments in a healthier Alaska now will save healthcare dollars in the years to come.

- The biggest challenge to reversing this trend will be addressing the physical, social, and economic environment that makes it easy to take in excess calories while making it harder to be physically active enough to burn those extra calories. To be successful in reducing obesity and obesity-related disparities, government, communities, and individuals need to work together to create population-wide and targeted policy and environmental changes. The Department of Health and Social Services, Division of Public Health is already engaged in several limited initiatives mostly financed with one-time sources.

Strategies

- The Department of Health and Social Services directed \$500.0 in one-time funds to the obesity prevention program for a statewide media campaign that will mobilize the actions of families and community members to ensure kids have opportunities to be physically active, and are active every day. The media campaign will deliver strategic, culturally appropriate, and high-impact messages integrated into the overall state obesity prevention program effort. The campaign includes: paid television, radio, print, website, and web-based advertising at the state and local levels; media advocacy through public relations efforts; and the sponsorship of local events to promote physical activity.
- Capital funding of \$430.0 allocated in FY2012 is being used to increase the amount of quality PE taught statewide through the provision of technical assistance, resources, professional development to school districts, support of the Alaska Food Policy Council, and professional development for more school nurses, PE, health and other teachers on health, PE, and evidence-based curricula.
- A grant program to school districts to hire staff to implement high quality recess, sports programs, after-school physical activity clubs, walk to school campaigns is planned when sustainable funding is identified.

Tobacco Prevention and Control

Tobacco remains a significant public health problem in Alaska, killing nearly 600 people annually and generating almost \$500 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 quitline, 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.

Despite the progress made, tobacco use remains a critical health issue in Alaska and disproportionately affects Alaska Natives, individuals of low socioeconomic status, and rural residents. Forty-one percent of Alaska Natives adults smoke, compared to the state average of 22%. Alaska Native youth are also more likely to smoke than their non-Native peers (32% vs. 13%). Smoking prevalence among adults of lower socioeconomic status is 38%, and 36% of adults living in rural areas report being current smokers. Smokeless tobacco use rates are also of great concern. Alaskan adults use smokeless tobacco at a higher rate (5%), than the rest of the country (3%), and Alaska's youth smokeless tobacco rate of 10% is higher than the national average of 8%. Smokeless tobacco use rates are especially high within the Alaska Native population, where 15% of men, 8% of women, and 17% of high school students use smokeless tobacco. Extreme regional disparities in smokeless tobacco use rates exist as well, with 23% of adults in Southwest Alaska reporting smokeless tobacco use.



Over the past 10 years, Alaska has engaged in successful strategies to reduce the disease and premature death caused by tobacco use and secondhand smoke. Alaska's 2009 overall adult smoking rate (19 percent) was below the national average (21 percent). The overall youth

smoking rate has dropped by over 50 percent between 1995 (37 percent) and 2009 (16 percent), below the national rate of 20 percent. Today in Alaska more tobacco users want to quit, more smokers and non-smokers agree that everyone has the right to breathe smoke-free air, and more Alaska communities have adopted laws to protect workers from the toxins in secondhand smoke.

Strategies

- Comprehensive local smoke-free workplace policies now protect 53 percent of Alaskans.
- Tobacco product price increases, - tobacco taxes - at the state and local level help dissuade kids from starting.
- Enforcement of laws that reduce illegal sales of tobacco to children.
- Statewide cessation support systems help tobacco users quit.
- Sustained statewide multi-media counter-marketing campaigns inform and motivate Alaskans.
- Community and school efforts create tobacco-free environments.

Infectious Disease

Another major challenge is the fight against infectious disease, with new diseases discovered regularly 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.
- The section of Public Health Nursing purchased 10,000 doses of adult influenza vaccine, primarily for the elderly and those at high risk for complications from the flu who visit the public health clinics.
- A national flu vaccine manufacturer is giving 20,000 doses of adult flu vaccine to the state Division of Public Health. The division is in turn making the vaccine available free of charge to organization or providers to administer to adults who have not yet been vaccinated against influenza.

Community Water Fluoridation

Alaska is losing ground on the population served by public water systems with optimally fluoridated water. In 2006, the percentage of Alaskans on public water systems with fluoridated water was slightly above 67%. Since that time the percentage has been decreasing. With Fairbanks and Palmer discontinuing fluoridation in 2011 that percentage will be about 55%.



Community water fluoridation is recognized by the U.S. Centers for Disease Control and Prevention as one of the top ten public health accomplishments of the 20th century for its role in reducing tooth decay in the second half of the century. Although other fluoride-containing products are available, including fluoridated toothpaste, adjusting naturally occurring levels of fluoride in drinking water to an optimal level remains the most equitable and cost-effective method of reducing dental decay within a

community. A 2008 study of dental decay in rural Alaska Native children found:

- Four-to-five year old Alaska Native children living in non-fluoridated villages had an average of 2.6 times more decayed or filled baby (primary) teeth than those living in fluoridated villages.
- Alaska Native children aged 12-15 years living in non-fluoridated villages had 2.1 times more decayed, missing or filled adult (permanent teeth) than those living in fluoridated villages.

Despite the cost-effectiveness of water fluoridation in reducing dental decay, the local government role in this public health intervention has come under question in a number of Alaska communities over the past five years. While some communities have voted to retain or implement water fluoridation, larger communities that have decided against continued fluoridation include Juneau, Fairbanks, and most recently Palmer. Evidence from the literature is that these local decisions will result in increased dental decay experienced by Alaskans, contribute to rising dental expenditures in Medicaid, and disproportionately affect those with the least resources to access dental care.

Strategies

- Continue to support communities which have the infrastructure to implement water fluoridation.
- Continue to provide information in response to health and safety concerns put forth by water fluoridation opponents.
- The division will analyze Medicaid dental claims to assess and report on variation in dental procedures for optimally fluoridated and non-fluoridated Alaska communities.
- Other states have enacted legislation mandating water fluoridation in communities of a certain size.

Injury Prevention

Unintentional injuries are the leading cause of death for ages one to 44 years and the third leading cause of death overall. Falls are the leading cause of non-fatal hospitalized injuries for all ages and fatal injuries for those over 75 years of age. During 2004 to 2007, the Alaska Native unintentional injury death rate was twice as high as for Alaska non-Natives. Local, tribal, and statewide infrastructure is insufficient to address the various types of preventable injuries. Fatal injuries are not an inevitable consequence of life. They are a public health problem that is largely preventable through consistent support and expertise from prevention specialists.



Strategies

- Co-convened by the Division of Public Health and the Alaska Native Tribal Health Consortium, the Violence and Injury Prevention Program (AKVIP) is a statewide group of injury prevention coalition members created to assess and build the capacity to prevent and control injuries and injury-related deaths. AKVIP plans to develop a comprehensive injury and violence prevention and control plan for Alaska.
- Provide education and programming strategies to decrease the rate of older adult fall-related injuries and deaths.
- Alaska's drowning fatality rate holds 4 -5 times the national average. Over 90% of the victims were not wearing a life jacket. Creating accessibility to life jackets and water safety education increases the awareness of the impacts of drowning.
- Brain injury is the result of the five leading causes of hospitalization (highway motor vehicle crash injuries, falls, assaults, all-terrain vehicle, and snow machine crash injuries). Increase the public's knowledge through education on age-appropriate and properly fitted restraints, and safe riding and helmet use.

10 Leading Causes of Non-Fatal Hospitalized Injuries, All injuries, by Age Group, 2005-2009

Rank	Age Group										
	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74
1	Falls 93	Falls 154	Falls 224	Falls 213	Suicide 661	Suicide 606	Suicide 713	Falls 816	Falls 1259	Falls 1253	Falls 998
2	Assault 27	Poisoning 139	Fall from playground 75	ATV 111	MV Traffic 267	Assault 347	Falls 555	Suicide 610	Suicide 444	MV Traffic 200	MV Traffic 90
3	Burn 18	Burn 53	Bicycle 60	Suicide 95	Falls 246	MV Traffic 305	Assault 419	Assault 338	MV Traffic 296	Suicide 132	Acc. Struck 25
4	Swallow Object 13	Acc. Struck 43	ATV 33	Bicycle 90	Assault 170	Falls 272	MV Traffic 308	MV Traffic 247	Assault 256	Assault 92	Suicide 24
5	Suffocation 12	Swallow Object 30	Acc. Struck 31	Sports 85	ATV 148	ATV 111	Snow machine 126	ATV 127	ATV 95	Acc. Struck 50	Cut 22
6	MV Traffic 7	Pedestrian 26	Pedestrian 29	MV Traffic 65	Poisoning 141	Snow machine 92	Cut 118	Snow machine 115	Acc. Struck 88	Machinery 44	Hypothermia/Frostbite 11
7	Acc. Struck 5	Dog Bite 24	Dog Bite 21	Poisoning 44	Sports 130	Cut 79	ATV 107	Cut 95	Snow machine 84	Cut 42	ATV 18
8		Suffocation 24	Suffocation 24	Snow machine 39	Snow machine 117	Sports 56	Sports 84	Acc. Struck 74	Bicycle 79	ATV 34	Assault 10
9		Fall from playground 22	Sliding 16	Acc. Struck 32	Bicycle 74	Acc. Struck 44	Acc. Struck 65	Sports 54	Pedestrian 57	Bicycle 34	Ped. 6
10		Assault 19	Sports 15	Fall from playground 31	Acc. Struck 33	Acc. Struck 31	Bicycle 44	Bicycle 53	Fire Flame 52	Pedestrian 33	Sports 15
		MV Traffic 18	Poisoning 13								

Source: Division of Public Health, Dept. of Health & Social Services, Alaska Trauma Registry: Admitted to the hospital for 24 hours or greater. Occurrences less than 5 not listed. Created January 4, 2011

10 Leading Causes of Fatal Injuries in Alaska by Age Group, 2005-2009

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	Suffocation 41	MV Traffic 6	Drowning 8	MV Traffic 12	Suicide 179	Suicide 130	Suicide 132	Poisoning 156	Suicide 82	Suicide 26	Falls 31	Falls 15
2	Assault 6	Fire 8	Fire 7	Suicide 7	MV Traffic 87	Poisoning 93	Poisoning 118	Suicide 136	MV Traffic 39 Poisoning 39	MV Traffic 25	Suicide 13	Suicide 10
3			MV Traffic 6	Poisoning 5	Poisoning 59	MV Traffic 57	MV Traffic 51	MV Traffic 56	Drowning 13	Falls 15	Suffocation 8	Suffocation 6
4					Assault 47	Assault 36	Assault 41	Assault 29	Assault 12	Poisoning 12	MV Traffic 7	
5					Drowning 27	Drowning 28	Drowning 39	Drowning 27	Aircraft 11	Fire 5	Hypothermia/ Frostbite 5	
6					Snow machine 19	Snow machine 17	Snow machine 14	Hypothermia/ Frostbite 22	Falls 11 Pedestrian 8		Poisoning 5	
7					ATV 16	Falls 10 Fire 10 Hypothermia/ Frostbite 10	ATV 13	Falls 15	Hypothermia/ Frostbite 7 Suffocation 7			
8					Hypothermia/Frostbite 12	Avalanche/ Landslides 7	Hypothermia/ Frostbite 11	Fire 13	Fire 6			
9					Fire 7	Aircraft 6	Pedestrian 10	Pedestrian 12				
10					Aircraft 6		Aircraft 9	Aircraft 8 Snow machine 8				

Source: Division of Public Health, Dept. of Health & Social Services, Alaska Bureau of Vital Statistics, occurrences less than 5 not listed. * ATV and snow machine deaths may be included in drowning death counts, pedestrian, bicycle, ATV, and snow machine deaths may be included in MV Traffic death counts. Poisonings include accidental poisoning by exposure to alcohol. Created January 4, 2011

Public Health Infrastructure

As federal funding shrinks – and with little commitment of state general funds 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 support 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 integrated emergency medical services personnel and service certifications). 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 in the state.
- Expand the number of Alaska hospitals that undergo trauma system certification and designation.
- Continue with the State Medical Examiner’s Office reforms to better serve statewide needs.

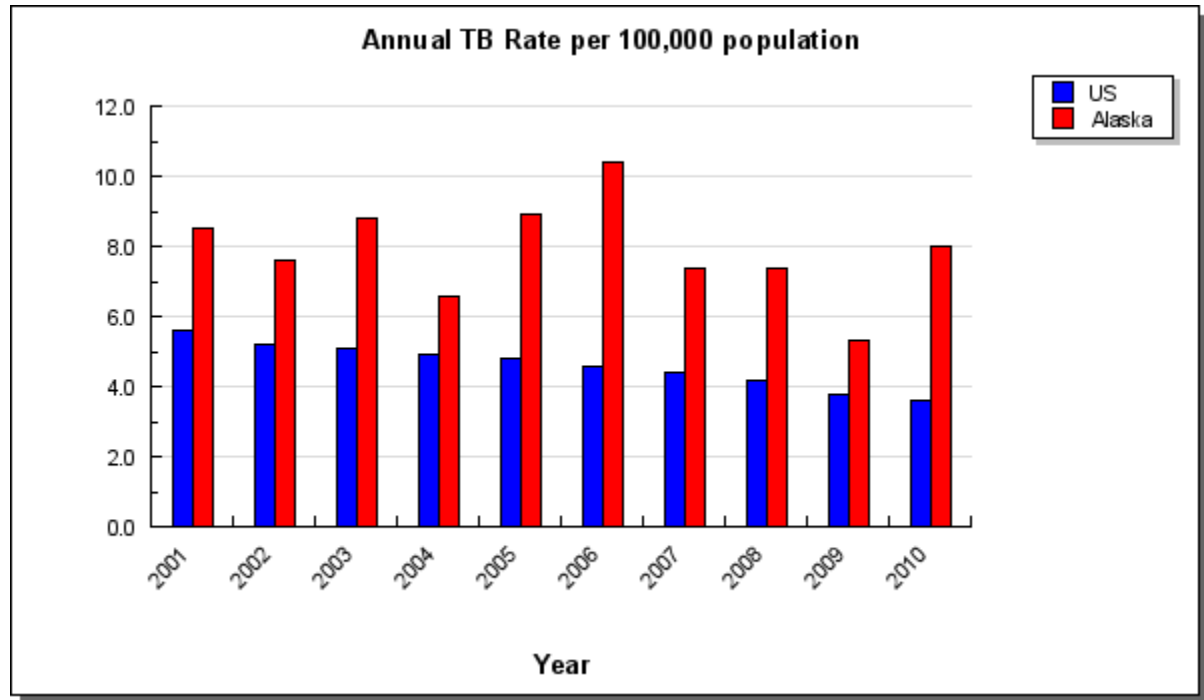


Performance Measure Detail

A: Result - Healthy people in healthy communities.

Target #1: Reduce Alaska's tuberculosis (TB) rate.

Status #1: The target to reduce Alaska's tuberculosis (TB) rate was not met. The 2010 rate of tuberculosis was 8.0 cases/100,000 population, a 51% increase from 2009.



Methodology: U.S. TB rates come from the Centers for Disease Control and Prevention(CDC). Alaska TB rates are tracked by the Alaska TB program in the Section of Epidemiology, Division of Public Health. Data is kept in the AK Stars and Infectious Disease Electronic Data System. This data was reported in the Annual TB report. (See Website below)

Annual TB Rate per 100,000 population

Year	US	Alaska
2010	03.6 -5.26%	08.0 +50.94%
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. In subsequent years, Alaska continued to have one of the highest TB rates in the nation; for 2010, Alaska had the second highest rate. Periodic outbreaks that occur primarily in small remote villages inhabited by Alaska Natives often contribute to large fluctuations in annual TB case rates. 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, 10 people who were exposed and must also be found, evaluated, and often treated as well. The Sections of Epidemiology, Nursing and Laboratories are essential partners in preventing and controlling tuberculosis in Alaska.

Alaska's population is small, so even a small change in the 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 2009 death rate caused by unintentional injuries was 54.0 per 100,000 population, slightly lower than the 2008 rate of 54.7; however it did not meet the Healthy Alaskans 2010 target of 31.0 per 100,000 population.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
2009	53.9 -1.46%	N/A
2008	54.7 -4.54%	N/A
2007	57.3 +9.98%	N/A
2006	52.1 +2.96%	40.6 +2.27%
2005	50.6 -8.00%	39.7 +4.2%
2004	55.0 -0.54%	38.1 +1.33%
2003	55.3 -6.59%	37.6 +1.62%
2002	59.2 -3.11%	37.0 +3.64%
2001	61.1 -4.38%	35.7 +2.59%
2000	63.9 +11.13%	34.8 -0.85%
1999	57.5	35.1

Methodology: Age-Adjusted Rate.

Source: Alaska Bureau of Vital Statistics (Alaska); U.S. Center for Disease Control and Prevention, National Center for Health Statistics, Web-Based Injury Statistics Query and Reporting System (US).

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: Reduce prevalence of overweight and obesity.

Status #3: The overall target to reduce prevalence of overweight and obesity was not met. The rate of overweight/obese high school students in 2009 was 26.2%, down from 27.3% in 2007; however, the Department's Healthy Alaskans 2010 target of 17% for high school students was not met. The rate of overweight/obese adults in 2010 was 66.7%, up from 65.02% in 2009. The Department's Healthy Alaskans 2010 target of 48% for adults was not met.

Prevalence of Overweight and Obesity

Year	High School Students-AK	High School Students-US	Adults-AK	Adults-US
2009	26.2%	27.8%	65.0%	64.1%
2007	27.3%	28.8%	66.0%	63.0%
2005	N/A	28.8%	63.4%	61.5%
2003	25.4%	26.9%	60.8%	60.0%
2001	N/A	24.1%	63.3%	59.1%

Methodology: The source for High School Students is Alaska and US Youth Risk Behavior Survey (YRBS) data. YRBS data are collected every other year. Alaska data not released in years when a statistically valid sample is not available. The source for Adults is Alaska and US Behavioral Risk Factor Surveillance System (BRFSS) data. Section of Chronic Disease Prevention and Health Promotion, Division of Public Health.

Analysis of results and challenges: Obesity has become a major health problem for Alaskans and Americans. About a third of the adult population is now obese and an additional one-third is overweight.[1] Obesity is expensive. It is estimated medical complications of obesity cost Alaska's economy \$477 million a year in direct medical expenditures (E.A. Finkelstein, personal communication, July 2009). The spread of the obesity epidemic has been equally, if not more, severe among children and adolescents. Since 1980, the national overweight and obesity rates have tripled for youth, with 34% of two to 19 year olds above a normal weight (above the 85th percentile).[2] The impact of the obesity epidemic is reflected in the nation's concurrent epidemics of diabetes, heart disease, and other chronic diseases, and has even lead to the projection that, due to obesity, today's children may be the first generation to have a shorter life expectancy than their parents' generation.[3]

Neither the youth nor the adult Healthy Alaskans 2010 target for overweight and obesity will be met. Limitations with these data are that: (a) both youth and adult measures are self-reported and as such underestimate true overweight and obesity prevalence; (b) YRBS data are only available for 3 years in the last decade, making trend assessment challenging; and (c) BRFSS data on prevalence of overweight and obesity combined mask trends in prevalence of obesity; Alaska adult obesity rates have increased 23% from 2001 to 2010.

[1] Flegal KM, Carroll MD, Ogden CL, Curtin LR. Prevalence and trends in obesity among US adults, 1999-2008. JAMA. 2010 Jan 20;303(3):235-41.

[2] Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of high body mass index in US children and adolescents, 2007-2008. JAMA. 2010 Jan 20;303(3):242-9.

[3] Olshansky SJ, Passaro DJ, Hershow RC et al. A potential decline in life expectancy in the United States in the 21st century. NEJM 2005;352(11):1138-45.

Target #4: Increase the prevalence of pregnant women who receive adequate prenatal care to at least 75%.

Status #4: The 75% target was last met in 2003. Since then, the percentage of women receiving adequate prenatal care, as measured by the Kotelchuck Index, has decreased steadily. In 2009, 67% of women with a live birth met the criteria of receiving adequate prenatal care.

Analysis of results and challenges: There is a disparity in access to prenatal care. In 2008, 39% of mothers on Medicaid reported having no prenatal care or having started care after the first trimester, compared to 15% of non-Medicaid mothers. Adequacy of prenatal care can be measured by the Adequacy of Prenatal Care Utilization Index (APNCU). This index combines information about the month prenatal care began and the number of prenatal care visits made compared to the number recommended by the American College of Obstetricians and Gynecologists. "Adequate Plus" rating means prenatal care began by the 4th month and 110% or more of the recommended visits were made. "Adequate" rating means care began by the 4th month and 80% - 109% of the recommended visits were made. Prenatal health care services must be available, accessible, affordable, and of high quality, including use of evidence-based interventions. The type of health care provider seen, insurance status, early recognition of pregnancy and ability to find prenatal care locally may affect the level of prenatal care coverage in a population. Prenatal care providers should offer education and counseling that has been demonstrated to alter behaviors affecting maternal and infant health, as well providing evidence-based strategies for reducing risks and insuring a safe pregnancy and delivery.

Target #5: Reduce cases of vaccine-preventable disease in Alaska.

Status #5: The number of reportable conditions that are vaccine-preventable in 2010 was 99, a decrease from 128 in 2009. However, it did not meet the Healthy Alaskans 2010 target of zero cases.

Analysis of results and challenges: Despite substantial progress due to the implementation of vaccines, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the US currently target 17 vaccine-preventable diseases across the lifespan. Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Although childhood immunization programs clearly provide a very high return on investment we are faced with new challenges. Understandably, vaccine safety gets more public attention than vaccination effectiveness and these misguided safety concerns have led to a fall in vaccination coverage, causing the re-emergence of pertussis and measles. Alaska communities with pockets of unvaccinated and under vaccinated populations are at increased risk for outbreaks of vaccine-preventable diseases. In addition, due to an increased opportunity for global travel many cases of vaccine-preventable diseases are imported from countries with lower immunization rates and this decrease in immunization coverage rates has led to an ongoing potential for outbreaks of vaccine-preventable disease. The number of cases cited for 2010 and 2009 are reported from the Annual Infectious Disease Report released in Epidemiology Bulletins. The conditions included in these reported cases are: chickenpox, hepatitis A and B, measles, mumps, pertussis, and rubella (haemophilus influenzae, meningococcal and pneumococcal invasive diseases were not included since not all serotypes are vaccine-preventable).

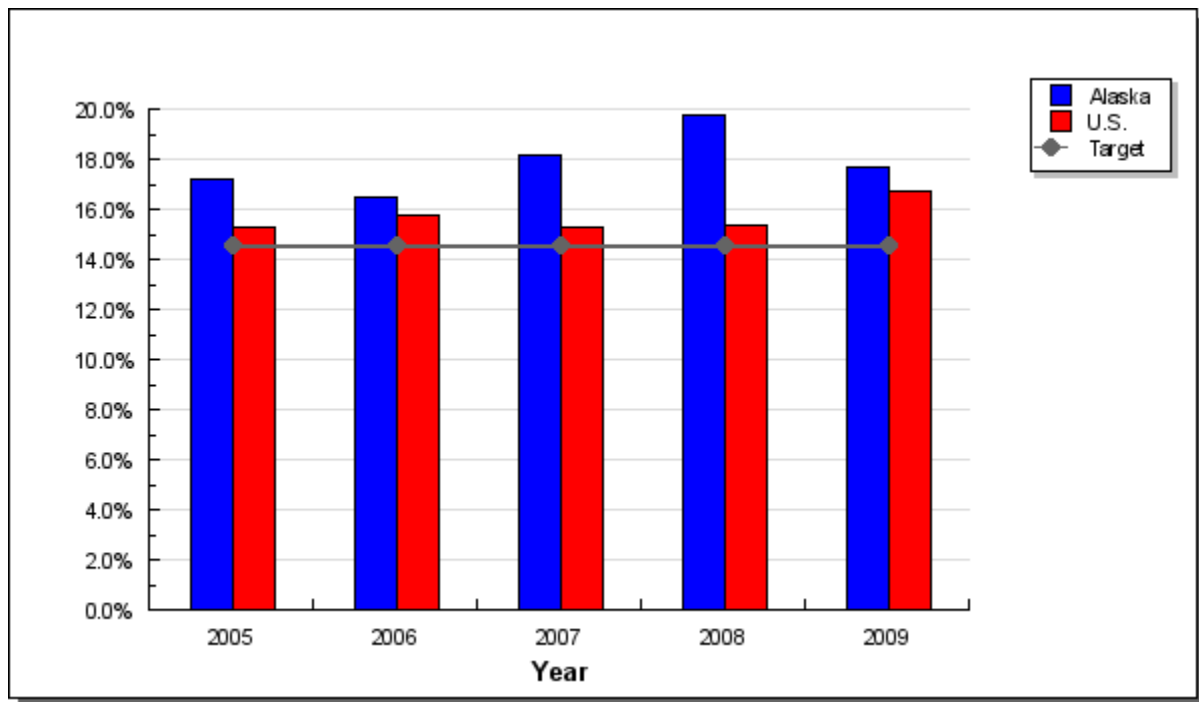
Target #6: Increase number of adults who visited a dentist in the last year.

Status #6: The number of adults who visited a dentist in 2008 was 65.3% of the Alaska adult population. During 2010 the percentage of Alaskan adults that visited a dentist increased slightly to 68.3%. However, this percentage is still far below the target of 80% set for 2010.

Analysis of results and challenges: The 80% target for adults receiving a dental service in the past year is an aggressive goal. Routine dental care offers the opportunity for provision of preventive dental services and to address treatment needs before they progress to more severe and costly treatment. Common cited reasons for failure to access dental care include: lack of dental coverage, cost of dental care, fear of dental procedures and misperceptions related to utilization of dental services on a problem-focused basis. Private dental participation in Medicaid is an oft-cited reason for lack of access to individuals enrolled in Medicaid.

Target #7: Reduce the rate of uninsured Alaskans to less than 14.6%.

Status #7: The target to reduce the rate of uninsured Alaskans to less than 14.6% was not met but is improving. In 2009, the rate of uninsured Alaskans was 17.7%, down from 19.8% in 2008. (Source: U.S. Census Bureau, Current Population Survey for Alaska)



Methodology: U.S. Census, Current Population Survey, Annual Social and Economic Supplement.

Year	Alaska	U.S.	Target
2009	17.7%	16.7%	14.6%
2008	19.8%	15.4%	14.6%
2007	18.2%	15.3%	14.6%
2006	16.5%	15.8%	14.6%
2005	17.2%	15.3%	14.6%

Target #8: Increase the number of active, licensed health care providers in Alaska in proportion to population growth.

Status #8: The target to increase the ratio of active licensed healthcare providers in Alaska in proportion to the population growth has not been met. The ratio of active physicians to Alaska residents decreased slightly, with 1 physician per 424 residents as of July 1, 2011, as compared to 1 per 405 residents during 2010.

Ratio of Active Licensed Healthcare Providers

Year	Alaska
2011	1:424
2010	1:405

Methodology: Alaska Occupational Licensing (downloaded 8/3/11).

Analysis of results and challenges: The number of physicians increased by eight, but with the 2010 census the Alaska population was adjusted to a higher number than predicted, thus the ratio of physicians to population was lower.

Target #9: Reduce the percentage of high school students in Alaska who use any tobacco products.

Status #9: The target to reduce the percentage of high school students in Alaska who use any tobacco products was not met. Also, 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.

Prevalence of Tobacco Use in Alaska Youth in Past 30 Days (Per YRBS Survey)

Year	Alaska	US	Healthy AK 2010 Target
2009	25.2%	26.0%	20%
2007	24.1%	25.7%	20%
2005	N/A	28.4%	20%
2003	24.8%	27.5%	20%
2001	N/A	33.9%	20%
1999	N/A	40.2%	20%

Methodology: Alaska and US Youth Risk Behavior Survey (YRBS) data. YRBS data are collected every other year. Alaska data not released in years when a statistically valid sample is not available.

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.

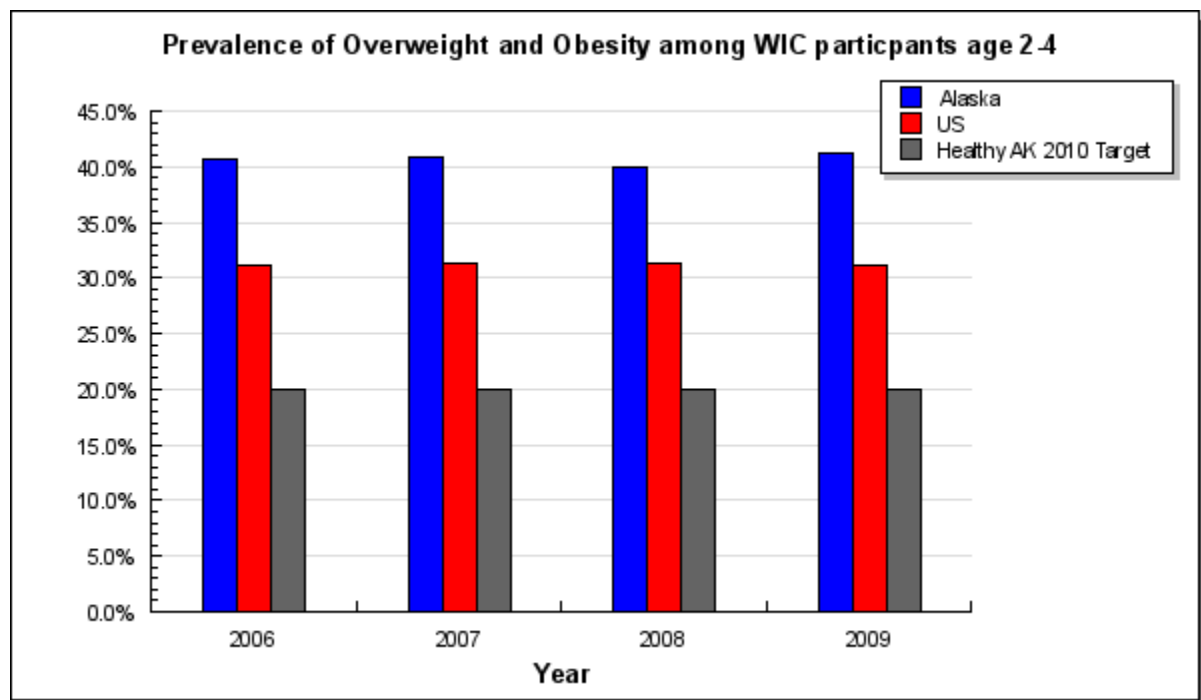
Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, 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.

A1: Strategy - Prevention and Health Promotion

Target #1: Less than 20% of children aged 2 to 5 served by WIC are overweight or obese.

Status #1: In 2009, 41% of children aged 2 to 4 served by WIC were overweight or obese. This does not meet the Healthy Alaskans 2010 target of less than 20% overweight or obese WIC children.



Methodology: Alaska Department of Health and Social Services, Division of Public Assistance, Family Nutrition Programs, WIC program data (Alaska) and Pediatric Nutrition Surveillance System (PedNSS) Reports (US). PedNSS is a child-based public health surveillance system that describes the nutritional status of low-income U.S. children who attend federally-funded maternal and child health and nutrition programs. The Alaska WIC Program does not contribute data to the PedNSS database.

Prevalence of Overweight and Obesity among WIC participants age 2-4

Year	Alaska	US	Healthy AK 2010 Target
2009	41.2%	31.1%	20%
2008	40.0%	31.3%	20%
2007	40.8%	31.3%	20%
2006	40.6%	31.2%	20%

Analysis of results and challenges: An increasing number of children and adolescents will enter adulthood overweight or obese and with serious health risks. Since 1980, the national overweight and obesity rates have tripled for youth, with 34% of two to 19 year olds above a normal weight (above the 85th percentile).[1] In 2009, 41% of children aged 2 to 4 served by the Women, Infants and Children Program (WIC) were overweight or obese. This is over twice the Healthy Alaskans 2010 target of less than 20% overweight or obese WIC children. Statewide representative data for children younger than high school age are not available. The WIC Program collects height and weight records for low income children age 2 to 4 served by their program. These data are not representative of all Alaskan children in these age groups, but provide the best estimate of childhood overweight and obesity in Alaska.

In an effort to improve the nutrition and nutrition-related outcomes—such as obesity—among WIC participants, the Alaska WIC Program implemented the New Food Packages (NFP) and Value Enhanced Nutrition Assessment (VENA) on October 1, 2009 and Participant Centered Services (PCS) on October 1, 2010. Updated WIC food packages include fruits and vegetables, fresh, frozen or canned; soy milk and tofu as milk alternatives; whole grains such as cereals and breads. The NFP provide less milk, eggs, and juice. VENA and PCS are promising client centered approaches to help WIC participants make positive nutrition and health related behaviors changes. WIC continues to implement and use Alaska WIC Nutrition Reports for quality assurance and program planning.

[1]Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of high body mass index in US children and adolescents, 2007-2008. JAMA. 2010 Jan 20;303(3):242-9.

A2: 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 2009, 88% of persons with tuberculosis (TB) completed adequate treatment within one year; this was a slight increase from the previous year but still below the target rate of 95%, primarily due to some difficult cases.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2009	88%
2008	87%
2007	90%
2006	90%
2005	92%
2004	86%
2003	93%
2002	93%

*Methodology: Alaska Tuberculosis Control Program, Section of Epidemiology, Division of Public Health. *Analysis excludes cases who died before or during treatment or for whom less than 12 months of treatment is recommended.*

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: Young children between 19 and 35 months of age receive all vaccines recommended by the Centers for Disease Control and Prevention (CDC).

Status #2: The target for young children to receive all vaccines was not met, as 56.6% of these children received vaccines in 2009, down from 69.2% in 2008.

Vaccination Rates for Children Age 2-5

Year	Rate
2009	56.6%
2008	69.2%

Methodology: VacTrAK immunization information system, Section of Epidemiology, Division of Public Health.

Analysis of results and challenges: The National Immunization Survey began gathering information about the immunization status of 2-year-old children during the second half of 1994. Over the years, both Alaska and the nation as a whole have significantly increased immunization rates among young children. From 1995 – 2009, Alaska has ranked as low as 49th and as high as 27th among the 50 states. Examination of NIS coverage data over the years is made more complex because the standard being assessed is revised periodically. However, in 2009, the national average for completion of the 4/3/1/0/3/1/4 (“0” = Hib series), which was excluded from the 2009 analysis due to a national shortage of this vaccine that year) standard series was 70.5%, while Alaska’s coverage rate was 56.6%. With this coverage rate, Alaska ranked 49th among all states.

Alaska ranked below the U.S. average for all standard series vaccines included in the 2009 ranking. Of particular concern, Alaska ranked 48th in the country for 1+ MMR (85.2%) and 50th for 1+ varicella (76.0%). Alaska also ranked in the bottom 10% of states for completion of 4+ DTaP and 3+ rotavirus vaccines.

Although coverage rates in Alaska are well below the target indicators we have seen improvements in some areas. Alaska did relatively well in provision of vaccines against hepatitis A and B, as well as pneumococcal and haemophilus influenza B invasive disease. In addition, Alaska is well above the national average for birth dose of hepatitis B. There are numerous challenges to increasing immunization rates, including the increasingly complex schedule and vaccine safety concerns.

A4: Strategy - Reduce suffering, death, and disability due to injuries.

Target #1: Reduce the number of Alaskans who die from drowning each year.

Status #1: The 2009 death rate due to unintentional drowning was 2.6 per 100,000 population, lower than 2008 rate of 4.2. Alaska’s drowning rates are consistently 3 to 4 times higher than comparable US rates.

Unintentional Drownings per 100,000 persons

Year	Alaska	US
2009	2.6 -38.1%	N/A
2008	4.2 +7.69%	N/A
2007	3.9 +25.81%	1.1 -8.33%
2006	3.1 -20.51%	1.2 0%
2005	3.9 -18.75%	1.2 +9.09%
2004	4.8 +50%	1.1 0%
2003	3.2	1.1

Methodology: Age-adjusted mortality rates from Alaska Bureau of Vital Statistics (Alaska) and CDC's Web-based Injury Statistics Query and Reporting System (US).

Analysis of results and challenges: During 2001-2009, 221 unintentional drowning deaths occurred in Alaska, of which 80% were non-occupational; the average annual fatality rate was 3.7 deaths per 100,000 Alaskans. In a study of documented unintentional drowning victims for incidents that occurred in Alaska from 2000 to 2006, the majority of drowning victims were male (86%), 45% Alaska Native, and 40% occurred in the Southwest region of Alaska.[1] The majority of child drowning deaths in this study (55 of 71) occurred in open bodies of water (lakes, rivers, oceans), comparable to other states. Alaska children share many risk factors with children in other states, including not using PFDs, being subject to the risky behavior of supervising adults, and caregiver's over-confidence about children's safety awareness and abilities. Alcohol involvement has also been a factor in numerous fatal incidents involving child victims. For those cases with documentation on alcohol use, 33% of non-occupational drowning deaths, including 78% of those involved with all-terrain vehicle crashes, were associated with alcohol consumption. Only 17% of non-occupational drowning victims who were boating wore a Personal Flotation Device (PFD).

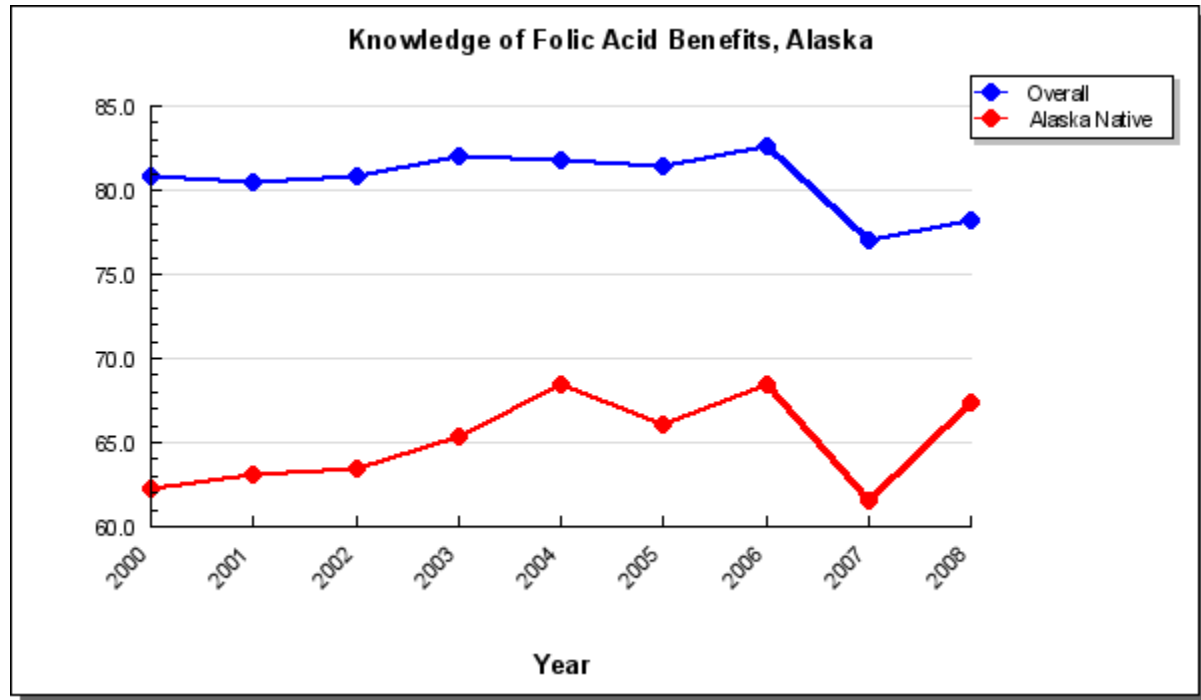
Calculating a 5-year moving averages (used to evaluate small annual numbers), rates overall have remained relative constant. However, the incidence and prevalence for drowning deaths in 2009 was at its lowest in a ten-year period. Boating in Alaska can be a normal form of daily transportation between home and community, as well as a common recreational activity. Increased law enforcement of Boating Under the Influence (BUI), public service communications on adult PFD use, and grassroots drowning prevention projects such as the Kids Don't Float supporting community-sponsored life jacket loan stations may be plausible reasons for the dramatic reduction.

[1] Strayer HD, Lucas DL, Hull-Jilly DC, Lincoln JM. Drowning in Alaska: progress and persistent problems. *Int J Circumpolar Health*. 2010 Jun;69(3):253-64.

A5: Strategy - Assure access to early preventative services and quality health care.

Target #1: At least 95% of three-year olds receive an annual well-child checkup or physical exam.

Status #1: In 2009, 87.5% of mothers of three-year old toddlers reported that their child had seen a health care provider for routine medical care.



Methodology: Alaska Childhood Understanding Behaviors Survey (CUBS), Section of Women's, Children's and Family Health.

Well-Child Visits

Year	Alaska	Target
2009	87.5%	95%

Analysis of results and challenges: While most children have received check-ups, there are gaps in particular types of services. According to Alaska Childhood Understanding Behaviors Survey (CUBS), 51% of three year olds have never been to see a dentist or dental care provider. The current recommendation by the American Academy of Pediatric Dentistry and other professional medical organizations is a dental exam by age one. Among EPSDT (early, periodic, screening, diagnosis and treatment) eligible children ages 6-9 enrolled in Medicaid, only 58% received any dental services during the year. Diagnosis and treatment of mental health among children under 5 years is a growing concern and additional workforce capacity is needed. Another serious gap is subspecialty services for children and youth with special health care needs. The Maternal Child Health Title V Block Grant funding is used to provide outreach clinics for genetics counseling, metabolic disorders treatment, neurodevelopmental screening and cleft lip and palate.

Target #2: At least 95% of children 0-18 years of age have continuous health insurance coverage during the year.

Status #2: The target of at least 95% of children 0-18 years of age have continuous health insurance coverage during the year was not met. In 2009, 88% of children 0-18 years of age had continuous health insurance coverage. At least 17% of three-year old toddlers had experienced a gap in health insurance coverage since they were born.

Continuous Health Insurance Coverage, Age 0-18

Year	Alaska	Target
2009	88%	95%

Methodology: Alaska Childhood Understanding Behaviors Survey (CUBS), Section of Women's, Children and Family Health.

Analysis of results and challenges: The proportion of children 0-18 years of age lacking health insurance has increased over 30% from 2005-2009. The challenge is to find ways to increase coverage in a fiscally responsible manner. In 2010 Alaska was one of only nine states to receive a federal bonus payment for increasing enrollment of eligible low income children to Medicaid. Denali KidCare is a State of Alaska program designed to ensure that children and teens of both working and non-working families can have the health insurance they need. Denali KidCare provides excellent health insurance coverage for children and teens through age 18, and for pregnant women who meet income guidelines. Access to quality care is important as well. Alaska is collaborating with Oregon and West Virginia in a tri-state child health improvement consortium (T-CHIC) demonstration project to improve quality of care by implementing a patient-centered care delivery model and developing health information technology. Source: Henry Kaiser Family Foundation and Alaska Childhood Understanding Behaviors Survey (CUBS).

A6: Strategy - Emergency response planning and preparedness

Target #1: At least 25 percent of Alaska's hospitals will be certified as trauma centers at the recommended level.

Status #1: In 2010, 21%, or 5 of the 24 acute care facilities in Alaska achieved designation as trauma centers. This rate was unchanged from 2008. This percentage did not meet the Healthy Alaskans 2010 target of 100% trauma designation of all acute care facilities

Designated Trauma Centers as of January 2010

Year	Designated	Target
2010	21%	25%

Methodology: Alaska Trauma Services System, Section of Emergency Programs. There are 24 hospitals in Alaska.

Analysis of results and challenges: There is currently one Level II and four Level IV trauma centers in Alaska. With the passage of HB 168 in June 2010, there has been a robust 90% participation in the trauma designation process. Currently 17 of 19 acute care facilities have requested trauma designation packets to evaluate or initiate trauma designation.

An inclusive trauma system is a network of definitive care facilities providing a spectrum of care for injured patients. All levels of trauma centers (Level I-IV) cooperate in care of injured patients to improve patient care and outcomes, effectively utilize limited resources, and minimize variations in care provided in all locations. Extensive data through the National Trauma Data

Bank demonstrates nationally there is a 25% increase in survival rates of seriously injured patients that are treated at a designated trauma center versus a nondesignated trauma center. Incentives, such as the Alaska Trauma Care Fund, are provided to acute care facilities to seek state or nationally recognized accreditation in areas that contribute to overall improvement to the Alaska Trauma System. The Alaska Trauma Registry collects data from all 24 acute care facilities to assess system performance and to improve quality of care through performance improvement and quality assurance. The voluntary contribution of the non-designated facilities to the Alaska Trauma Registry provides comprehensive data to our state and national stakeholders to measure patient outcomes. The revision of the State Trauma System Plan brings the organized, systematic approach to trauma care with clear descriptions of the system design components necessary to have an integrated and inclusive trauma system and is used to guide system implementation and management. The lead agency has developed and implemented a statewide multidisciplinary trauma system committee to provide overall guidance to trauma system planning and implementation strategies. The committee meets regularly and is instrumental in providing guidance to the lead agency. Trauma System Leadership implements and regularly reviews the Alaska Trauma System, system performance, and determines the need for system modifications and development. One of the greatest challenges to the Alaska Trauma System is the lack of public information and education programs that heighten public awareness of trauma as a disease and the need for a trauma care system. Another challenge for Alaska's trauma system is the lack of motivation from physicians to support hospital-based efforts to build an integrated trauma system. A 2004 Harris poll found that 94% of Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury. Nearly nine in ten Americans (87%) think it is extremely or very important for an ambulance to take them to a trauma center in the event of a life threatening injury, even if it is not the closest hospital. Nine in ten Americans (90%) indicate it is extremely or very important for their state to have a trauma system. This lack of awareness, paired with underserved regions with too few trauma centers, impedes the development of trauma care in Alaska.

Target #2: Increase the number of certified air medical services statewide to at least 20.

Status #2: In FY 2011 there are 19 Certified Air Medical Services operating in the State of Alaska. This represents an increase of two services from FY 2010 but remains below the target of 20.

Certified Air Medical Services

Fiscal Year	Alaska	Target
FY 2011	19 +11.76%	20 0%
FY 2010	17	20

Methodology: EMS Certification Unit, Section of Emergency Programs.

Analysis of results and challenges: The target of 20 certified Air Medical Services in the State of Alaska appears to be close to being met. That being said, as 50% of Certified Ambulance Services (including air and ground medical services) expire on any given year, the number is subject to constant fluctuation and change based on applications for recertification received. In addition, the increase of two services appears to be a result a market forces as opposed to any specific activity engaged in by the EMS Unit to promote or increase the number of Air Medical Services to 20 in the State of Alaska.

A7: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: Increase the number of health impact assessments (HIAs) performed on new large-scale development projects in Alaska.

Status #1: During 2010, the Alaska HIA Program worked on seven HIAs for several large-scale natural resource development projects. The Alaska Department of Health and Social Services established an HIA Program in July 2010.

Health Impact Assessments

Year	Alaska
2010	7

Methodology: Alaska Health Impact Assessment Program, Section of Epidemiology.

Analysis of results and challenges: HIA work began in Alaska during 2004 when the North Slope Borough conducted two HIAs for resource development projects on the North Slope. In 2008, a conference on HIA was held in Anchorage and included experts from federal agencies, including CDC, state and local governments, regional health corporations, the Alaska Native Tribal Health Consortium, and expert HIA practitioners from the international arena. Conference attendees established a working group that developed a toolkit to provide technical guidance for Alaska-specific HIA practice. Working group participants also identified a clear need for one agency to maintain and update the HIA toolkit, respond to public feedback, and to lead ongoing efforts to develop Alaska's capacity for HIA. In response to this need and with support from partners, the Alaska Department of Health and Social Services established an HIA Program in July 2010. During 2010, The Alaska HIA Program worked on seven HIAs for several large-scale natural resource development projects. HIAs are not legally required in Alaska; rather, they are seen as one aspect of a "best practices" approach to responsible development.

The HIA Program will continue work on current projects listed above, identify new needs for HIAs, and initiate new HIA projects as funds become available. The HIA Program will continue to develop policies for data collection, data reporting, and communication that will make the program more effective and efficient over time. The HIA Program will also continue oversight and editing of the HIA Toolkit. Health Impact Assessment involves a web of partnerships and stakeholder interests and the HIA program will intentionally cultivate these vital connections on a local, statewide, and national level. HIA is a rapidly developing field and the HIA program will continually seek cutting edge strategies for data gathering, data presentation, and community involvement.

The HIA process exists in a complex socio-cultural and political environment and so one key challenge is to maintain the neutrality and objectivity of the HIA process. In addition, HIA occurs in the presence of significant data gaps and so another key challenge is to find improved scientific evidence for analysis and decision making. Current HIA funding in Alaska focuses on large scale development projects, so the HIA program will continue to seek opportunities to identify funding streams for HIAs involving urban planning, urban policies, and public programs.

A8: Strategy - Health care workforce

Target #1: Decrease by 10 percent the number of communities with severe health care shortages as defined by low provider to population ratios (determined by federal Health Professional Shortage Area designations).

Status #1: The target was not met. Alaska regained one geographical primary care HPSA due to physician departure.

Analysis of results and challenges: There was an increase in the number of physicians working in Health Professional Shortage Areas (HPSAs) through loan repayment programs. However they are not “counted” for HPSA provider count until they complete their loan repayment placements and remain permanently.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Public Health</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Unrealized Authority	\$ -	\$ -	\$ (300.0)	\$ -	\$ (300.0)
Immunization for Children and Seniors	\$ 630.0	\$ -	\$ 70.0	\$ -	\$ 700.0
MH Trust: Gov Cncl - Grant 3505.01 Autism Workforce Development Capacity Building	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
Stabilize Funding for Public Health Nursing Grantees Phase 3	\$ 990.0	\$ -	\$ 110.0	\$ -	\$ 1,100.0
MH Trust Workforce Dev - Grant 1383.05 Loan Repayment	\$ 200.0	\$ -	\$ -	\$ 200.0	\$ 400.0
MH Trust: Cont - Grant 120.08 Comprehensive Integrated Mental Health Plan	\$ -	\$ -	\$ -	\$ 120.0	\$ 120.0
Public Health Data System Project	\$ -	\$ -	\$ -	\$ 300.0	\$ 300.0
Reverse American Recovery and Reinvestment Act (ARRA) Funding for Prevention and Wellness	\$ -	\$ -	\$ (141.3)	\$ -	\$ (141.3)
Reverse August FY2012 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (35.4)	\$ -	\$ -	\$ -	\$ (35.4)
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ 400.8	\$ 400.8
Reverse Transfer Public Health Nursing Services from Norton Sound Health Corporation to the Division of Public Health	\$ (30.0)	\$ -	\$ -	\$ -	\$ (30.0)
Public Health Total	\$ 1,754.6	\$ -	\$ (261.3)	\$ 1,095.8	\$ 2,589.1

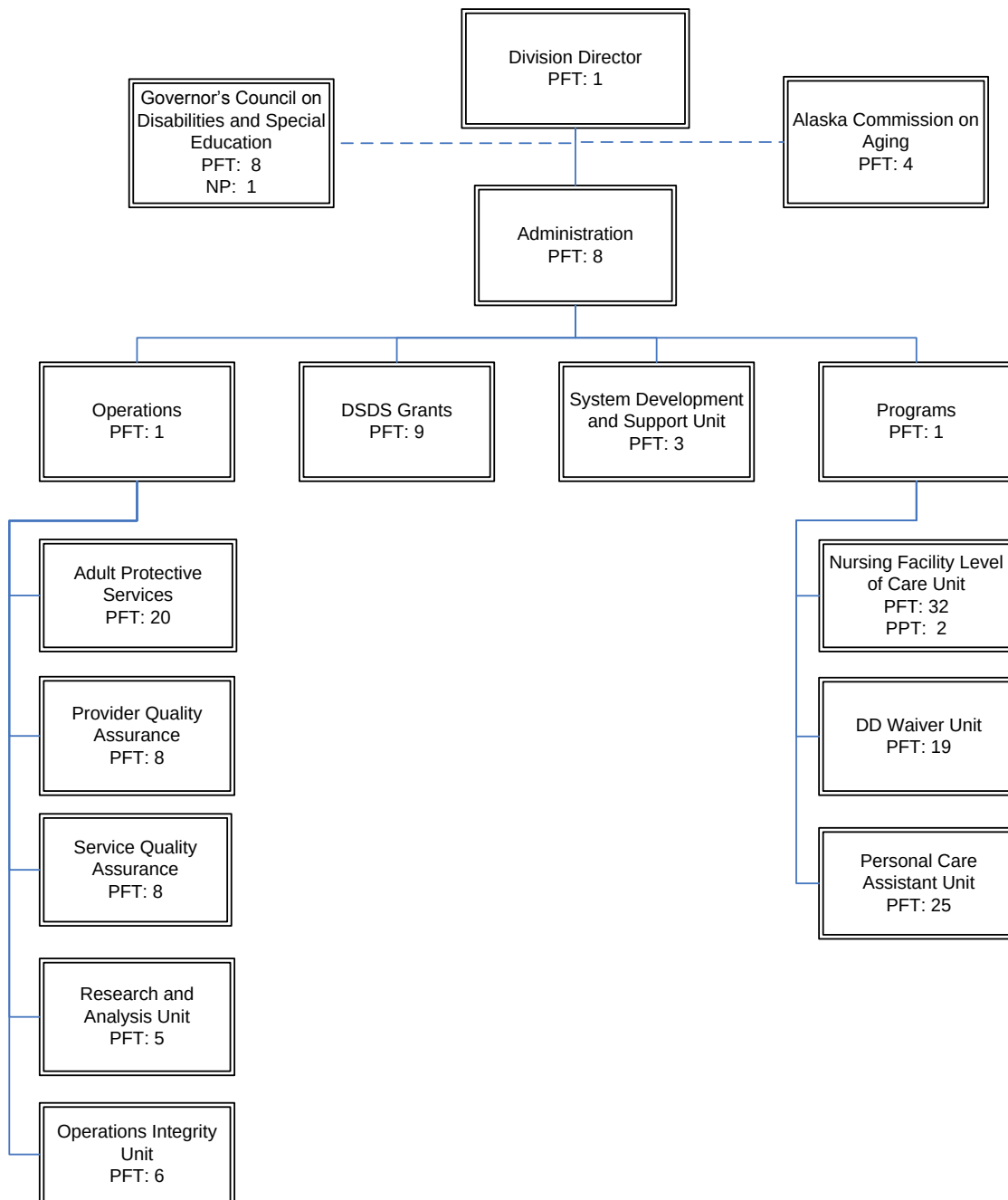
Division of Senior and Disabilities Services

Division Summary Structure

Total PFT: 158

Total PPT: 2

Total NP: 1



Introduction to the Division of Senior and Disabilities Services

Mission

To promote health, well-being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity.

Overview

The Division of Senior and Disabilities Services (SDS) 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

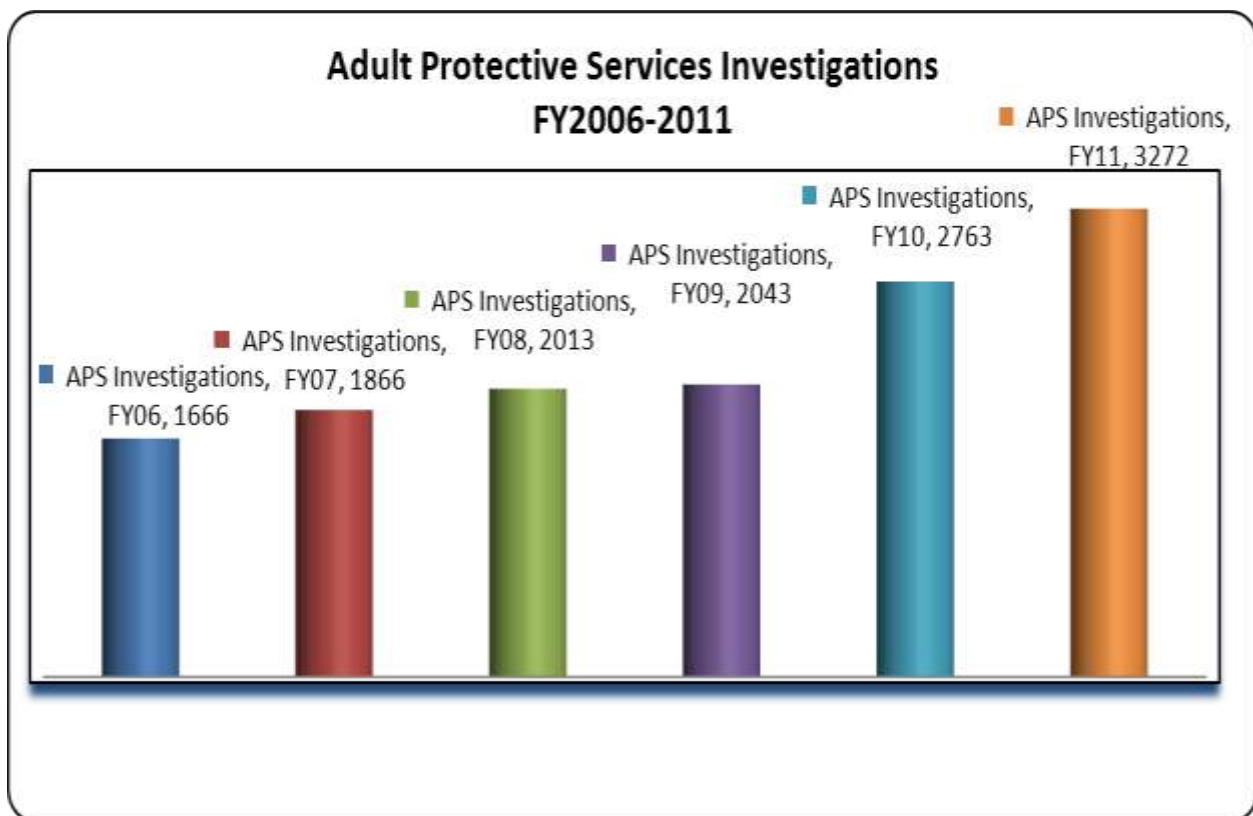
- Provide protection of vulnerable adults.
- Provide Nursing Facility Services that include placement in a nursing institution which provides either an intermediate or skilled level of nursing care.
- Provide Personal Care Services that support non-technical, hands-on assistance with activities of daily 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 Intellectual and Developmental Disability Waiver services to Medicaid eligible persons with an intellectual disability, autism, cerebral palsy, seizure disorder, or a condition that means the person functions as if having an intellectual disability.
- 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)

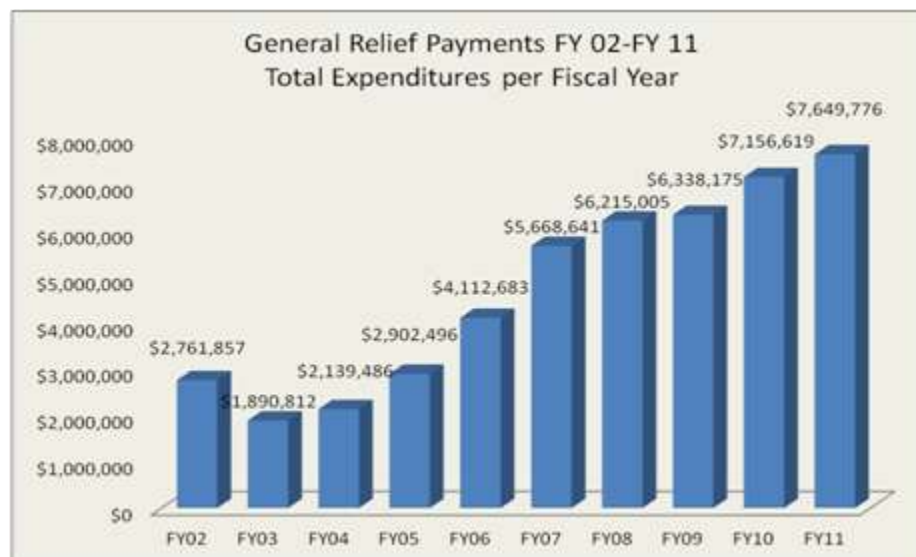
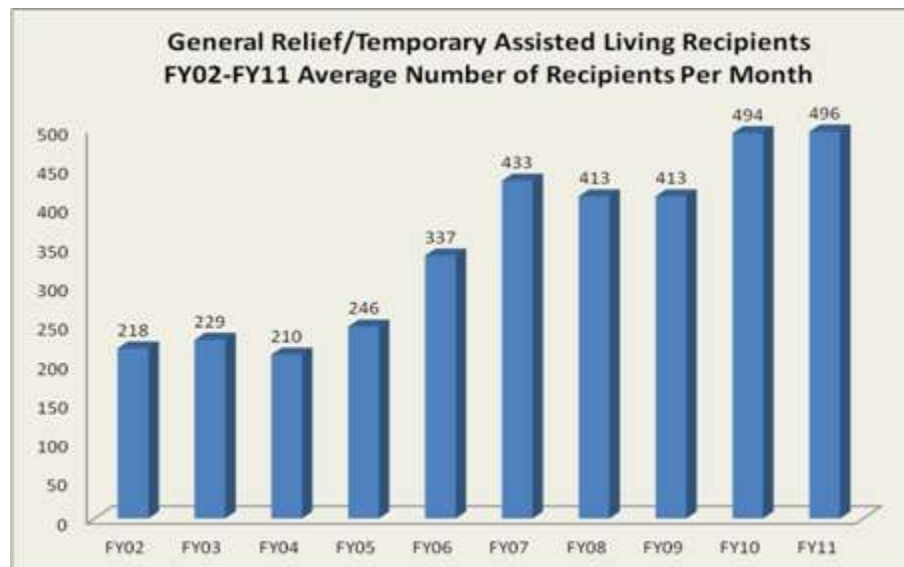
The Adult Protective Services Unit protects vulnerable adults over the age of 18 from abuse, neglect, and exploitation. APS staff investigate incidents in which a vulnerable adult suffers harm from abandonment, abuse, exploitation, neglect or self-neglect. Upon investigation of reports of harm, APS staff 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 FY2006 to FY2007 and an additional 8% to FY2008. The number of investigations increased another 1% in FY2009, 35% in FY2010 and 18.4% in FY2011. The increase in FY2010 and FY2011 is attributed to SDS policies requiring reporting by Home and Community-Based waiver providers and enhanced education to mandatory reporters.



General Relief Temporary Assisted Living Program

The Adult Protective Services 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 FY2011, SDS served an average of 496 individuals monthly through the General Relief / Temporary Assisted Living Program. The net expenditure, after recoupment efforts, was \$7,649,776.



Total expenditures for the General Relief Program increased 12.9% between FY2009 and FY2010 with an additional 6.9% increase between FY2010 and FY2011.

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

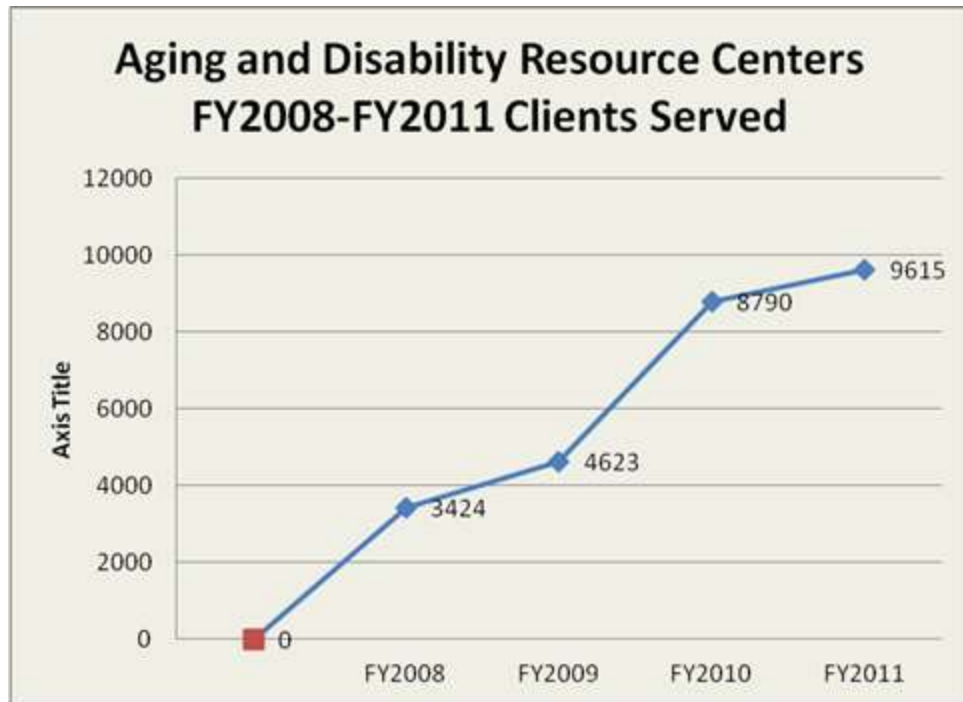
seniors who live in rural areas, are members of minority groups, or are physically frail. Grants are awarded to local provider organizations through a variety of grant programs administered by the Division of Senior and Disability Services. Senior Community-Based Grant programs include: Nutrition, Transportation and Support Services, Senior In-Home, Senior Adult Day, Aging and Disability Resource Centers (ADRC's), National Family Caregiver Support Program, and the Alzheimer's Disease and Related Dementia (ADRD) Education and Support program.

Senior Community-Based Grants 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, Administration on Aging Title III federal funds, and ADRC grant funds.

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 FY2009, the estimated number of individuals served was 15,590. The number of clients served through the Senior and Community-Based Grants program rose from FY2009 to FY2010 to 21,261 clients served, at a total cost of \$11,603,300, for a per client funding level of \$546. In FY2011, the estimated number of unduplicated clients served through the Senior Community-Based grants programs grew to 25,000 with additional funding coming from the Aging and Disability Resource Centers included in the expenditures (not included in previous years), for a total amount of funding in FY2011 of \$12,264,006, for a cost of \$491 per senior.

The Aging and Disability Resource Center is 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 fourth year of development in FY2012.

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 consumers. The number of individuals ADRCs has provided information and assistance regarding long term care services increased to 181% between FY2008 and FY2011. The 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 FY2012 to increase but at a less significant rate.



The Real Choice Systems Change (RCSC) Grant was awarded to SDS in FY2008 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 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.

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.

Other important Senior Community-Based grant programs include 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 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 23 individuals in FY2011. By definition, assisted living facilities provide meals and assistance with daily activities to enable seniors to remain in or near their community of choice.

Maniilaq Association closed their Assisted Living Home in October 2011 to begin operation of their new Skilled Nursing Facility. In FY2013, Senior Residential Services Grant funds will provide support to up to four rural senior residential assisted living facilities. In addition, Senior Residential Services funds will be made available through provider agreements to pay for travel expenses for individuals residing in Senior Residential Services homes who are eligible to receive residential supported living through the Medicaid Waiver. This mechanism will increase sustainability of the Senior Residential Services homes in rural areas and provide additional support to seniors in rural areas.

State Health Insurance Assistance Program

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 these services via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. The program maximizes partnerships with dozens of community-based and tribal organizations to build capacity in the state to help people with Medicare. Public outreach and education about Medicare services are provided through two Senior and Disabilities staff and a network of Certified Medicare Counselors working in the aging and disabilities network. There were 7,022 encounters with individuals during FY2011.

Senior Medicare Error Patrol

The Senior Medicare Error Patrol (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 how to track and review billing statements for medical encounters. 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 assisted over 5,000 beneficiaries in FY2011.

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 FY2011, 51 individuals transitioned from a nursing facility back to the community, at an average cost of \$1,750 per person. This is an increase of 19% in the number of transitions and an increase of 29.6% in the average cost per individual. The division believes the increased focus on nursing facilities transitions across the state, due to remediation efforts and monitoring of clients, plays a key role in the increase in transitioned individuals and costs.

Community Developmental Disabilities Grants

The Community Developmental Disabilities Grant (CDDG) program minimizes institutionalization and provides care for people with developmental disabilities. These 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.

In FY2011, developmental disabilities grants provided services to 1,036 recipients with conditions such as an intellectual disability, autism, or cerebral palsy. Services funded by these grants result in the acquisition or maintenance of skills to live with independence and improved capacity and reduce the need for long-term residential care.

Services include 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

with a developmental disability qualifies for Medicaid or meets the threshold for long-term supports that the Intellectual and Developmental Disability Waiver is designed to provide.

Other grant programs under the Community Developmental Disabilities Grant umbrella include the Short-Term Assistance and Referral Programs (STAR). In FY2011, 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. In FY2011, 826 individuals accessed services provided by the STAR programs.

Mental Health Trust Authority funds support mini grants that provide one-time awards to beneficiaries with developmental disabilities. 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 FY2011, 192 mini-grants were awarded to assist individuals with developmental disabilities.

In the Community Developmental Disabilities Grant component, Behavioral Risk Management Services addresses difficult behaviors through technical assistance and training. These services are designed for personnel working in community developmental disability programs or family members and guardians. Additionally, funds are used for personal safety training for women with a developmental disability.

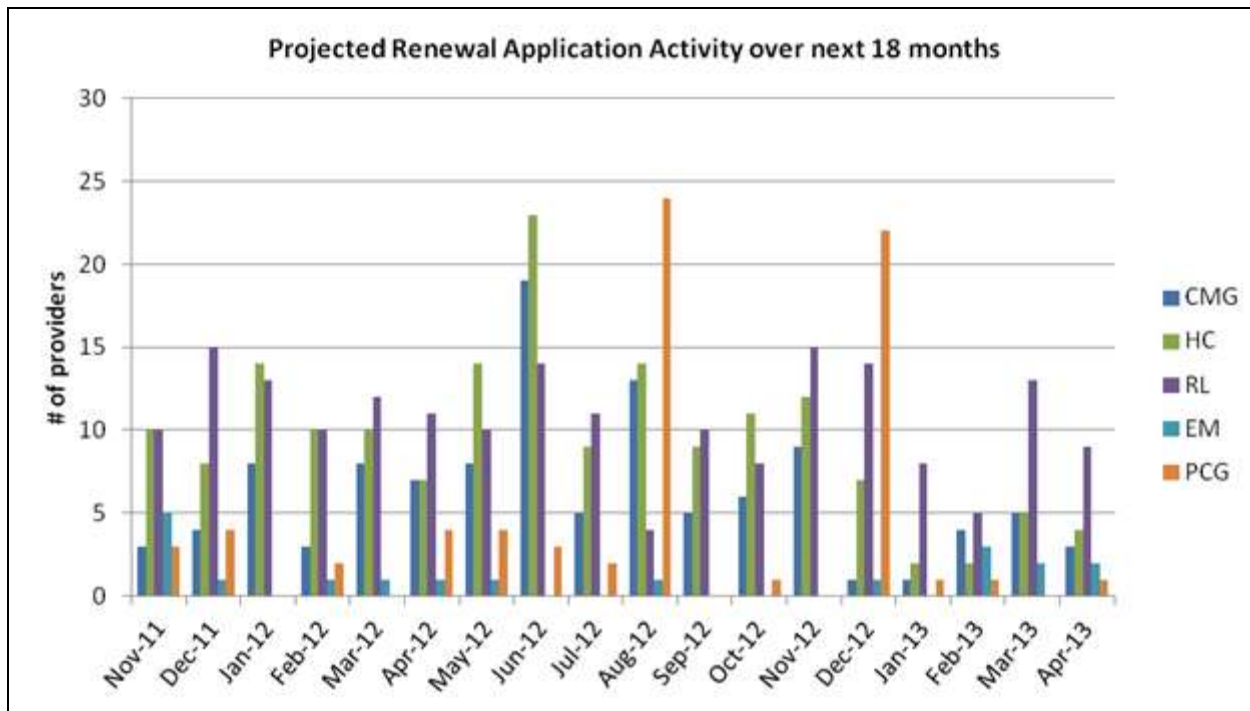
FY2011 SDS Non-Medicaid Grant Services		
Grant	Clients Served	Total Expenditure
Community Develop Disability Grants	1,036	11,446,119
General Relief/Temporary Assisted Living	5,952	7,649,776
Nursing Facilities Transition Grant	51	120,000
Senior Community-Based Grants	25,000	12,264,006
Senior Residential Grants	23	815,000
State Health Insurance Assistance Prog	7,022	26,250
Total	39,084	32,321,151

Provider Quality Assurance

In the Division of Senior and Disabilities Services, the Provider Quality Assurance Unit ensures safe and quality services are provided to Alaskan seniors, disabled individuals, and vulnerable adults. This unit monitors providers of Home and Community-Based Waiver and Personal Care Attendant services through application evaluations, provider desk and site reviews, and critical incident or complaint investigations. The unit may issue sanctions to achieve provider compliance with requirements. Some common sanctions are mandatory provider education, restrictions on Medicaid payments, and up to and suspension and including termination from the Medicaid program.

The unit monitors 848 active service types that are provided by 562 provider agencies located across the state of Alaska. Provider agencies may be certified for multiple service types.

Providers are required to reapply every two years to continue to be certified. The chart below illustrates the number of renewal application evaluations that are expected to be evaluated and processed by the unit over the next 18 months.



The oversight responsibilities continue to grow for the unit. In FY2011, over 150 new certifications were issued which included 90 new certifications for individual care coordinators.

Provider reviews were implemented in April 2011 and initially all service types were to be randomly selected for desk or onsite reviews. Due to lack of evidence of compliance in provider files; requiring more time to remediation each provider review and due to staffing constraints; only residential supported living service and adult day care services are subject to provider review at this time.

The unit also partners with multiple state agencies such Health Care Services, Office of Long Term Care Ombudsman, Program Integrity, and the Medicaid Fraud Control Unit as part of the larger state efforts to protect the health and welfare of participants and the integrity of state and federal funding.

Medicaid Waiver Services

Home and Community-Based Waiver Programs

In response to the high costs of institutional care, Medicaid Home and Community-Based Waivers 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:

1. 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.

2. Intellectual and Developmental Disability (IDD) Waiver

The IDD waiver is specifically for individuals with an intellectual disability, 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.

3. Older Alaskan (OA) Waiver

The current 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. A federal review has resulted in the redesign of this waiver. As soon as new regulations are in place, the minimum age limit for this waiver will be changed from 65 to 21 years of age and rename the waiver "Alaskans Living Independently (ALI)."

4. 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 program serves participants between the ages of 21 and 64 years of age. A federal review has resulted in the redesign of this waiver. As soon as new regulations are in place the targeting criteria for this waiver will be changed to include adults who have either intellectual or developmental disabilities, as well as physical disabilities that qualify the individual for a nursing home level of care, and will rename the waiver "Adults with Physical and Developmental Disabilities (APDD)."

In addition to the four Medicaid waivers above, the division offers Personal Care Assistance and Nursing Home Authorization Medicaid programs.

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.

Annual Statistical Summary of Services Provided in FY2011

Senior and Disabilities Medicaid and Waiver Services

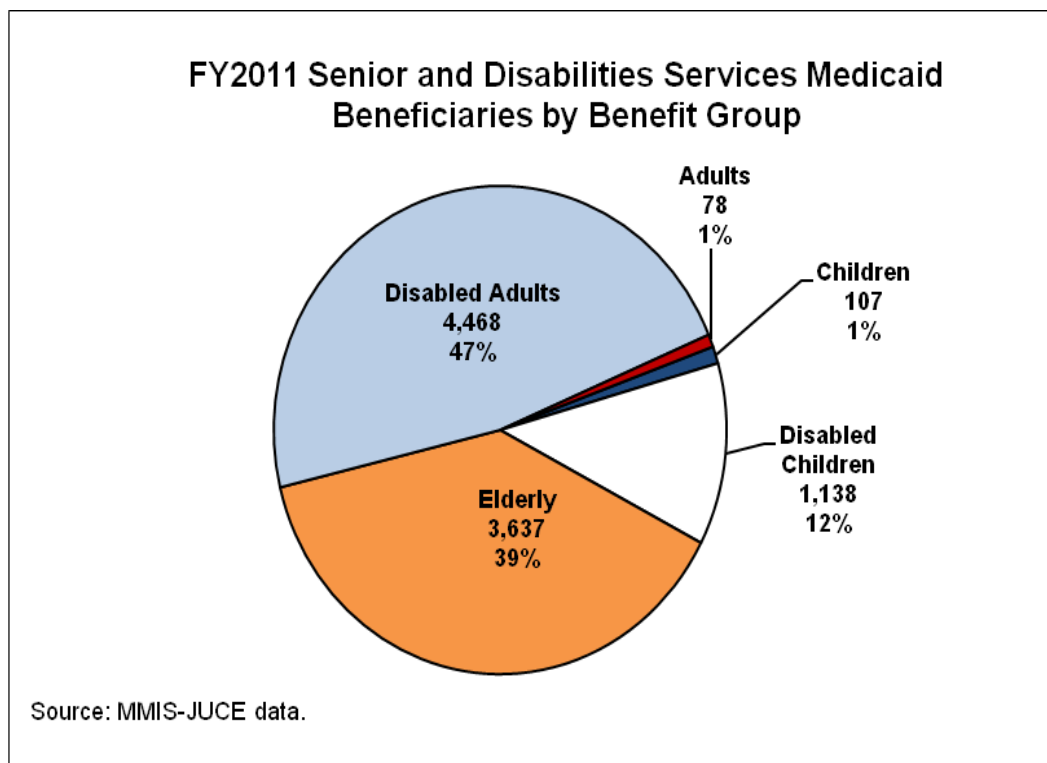
The Senior and Disabilities Services Medicaid program funded benefits for 9,169 Medicaid beneficiaries during FY2011, with total expenditures of \$400,248.7. This equates to an average annual claim cost of approximately \$44,000 per recipient during FY2011.

FY2011 SDS Medicaid Services by Benefit Group

Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost Per Beneficiary
Children Disabled	1.1%	107	0.4%	1,498.6	\$14,006
Children	12.1%	1,138	4.5%	17,920.5	\$15,747
Elderly	38.6%	3,637	38.9%	155,833.4	\$42,847
Disabled Adults	47.4%	4,468	56.0%	224,332.4	\$50,209
Adults	0.8%	78	0.2%	663.7	\$8,509
Unduplicated Annual Clients		9,169			
Total Medicaid Claim Payments (thousands)				\$400,248,680	
Average Annual Medicaid Cost per Beneficiary					\$43,652

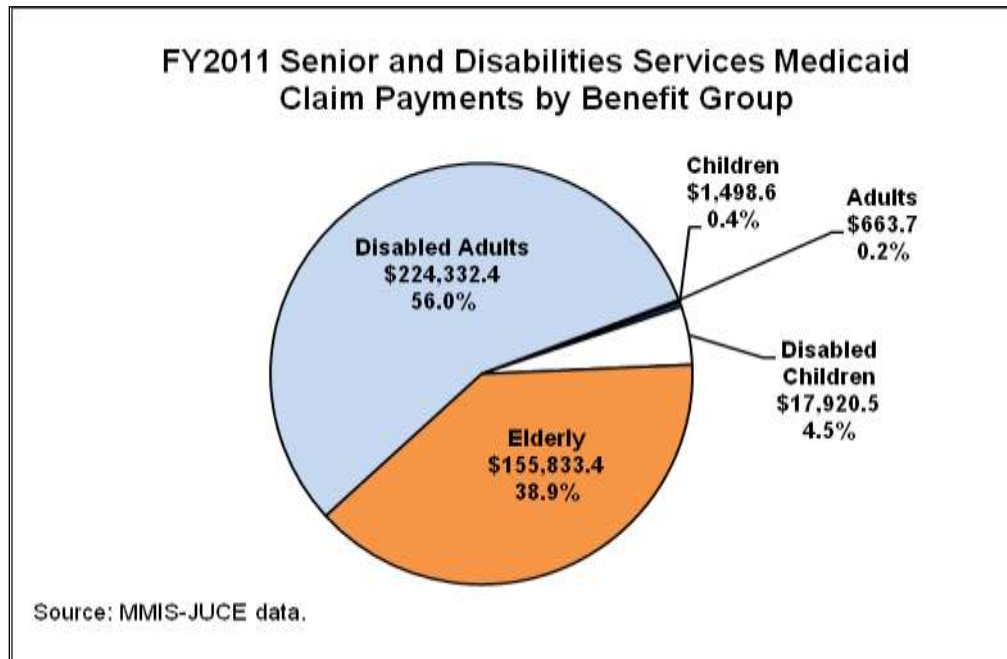
Source: MMIS/JUCE . The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.

In FY2011 in excess of 87% of Medicaid services were provided to adults, with 47% of those beneficiaries disabled and 39% elderly. The division provided 13% of Medicaid services in FY2011 to children. 12% of those children were disabled.

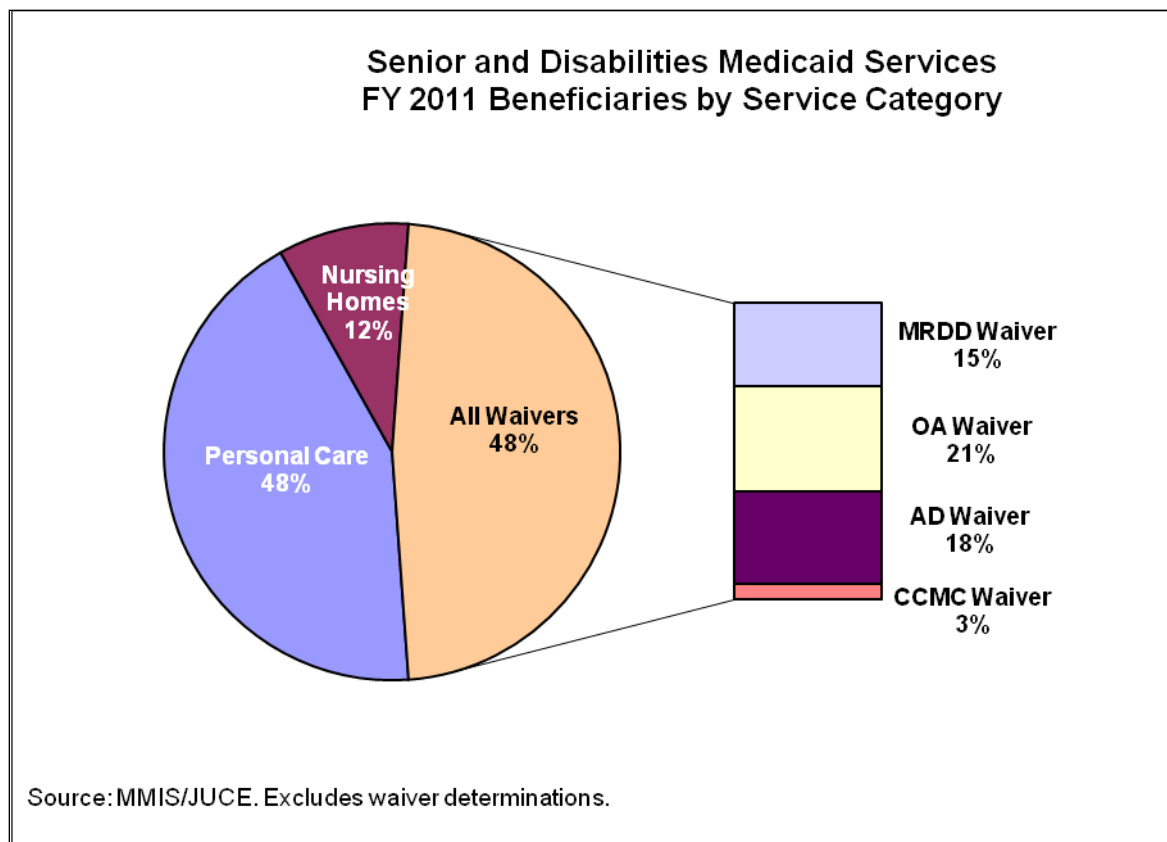


Senior and Disabilities Medicaid serves Alaskans of all ages. For all programs, in FY2011, 84.5% of all beneficiaries were 21 years of age or older, and they were served at a total cost of \$362,733.3 or \$44,783 per beneficiary. In FY2011, 15.5% of all beneficiaries were under 21 years of age. These clients were served at a total cost of \$30,524.6 for a per-beneficiary cost of \$20,016.

Benefits provided to children comprised 4.9% of claim payments, while benefits provided to adults comprised 56.2%. Services provided to the elderly were 38.9% of the Senior and Disabilities Services Medicaid claim payments.



The Division of Senior and Disabilities Services served 1,587 recipients through the Adult with Physical Disabilities Waiver program at a cost of \$23,800 per recipient. Approximately 280 participants were served through the Children with Complex Medical Conditions Waiver program at a cost of \$37,885 per participant. Through the Intellectual and Developmental Disabilities Waiver program, 1,445 recipients were served at a cost of \$73,650 per recipient. SDS also served 1,820 seniors through the Older Alaskans Waiver program at a cost of \$24,104 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.



Nursing home care is by far the most expensive long-term care service per person at an annual average Medicaid cost of \$93,100 per beneficiary. This increase is approximately 8% over FY2010, when the average Medicaid cost was \$86,200 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 **decreased** slightly from an average of \$23,750 in FY2010 to an average of \$23,300 in FY2011. The division also saw a **decrease** in the per-beneficiary cost of Home and Community-Based Waiver Services. In FY2010 these services averaged \$41,800 per beneficiary. In FY2011 the services reached \$38,700 per beneficiary, a decrease of 7.4%. The average cost of all Senior and Disabilities Medicaid services per beneficiary also decreased slightly from FY2010 to FY2011. In FY2010 average cost per beneficiary of \$43,800 decreased to \$43,700 in FY2011, or approximately .23%.

Home and Community-Based Waiver	Cost per Beneficiary per Year	Percent of Waiver Beneficiaries
Adults with Disabilities	\$23,800	30.9%
Children with Complex Medical Conditions	\$37,900	5.5%
Intellectual and Developmental Disabilities	\$73,700	28.1%
Older Alaskans	\$24,100	35.4%
All Home and Community-Based Waivers	\$38,700	100.0%

Source: MMIS/JUCE for claims paid during fiscal year 2011.

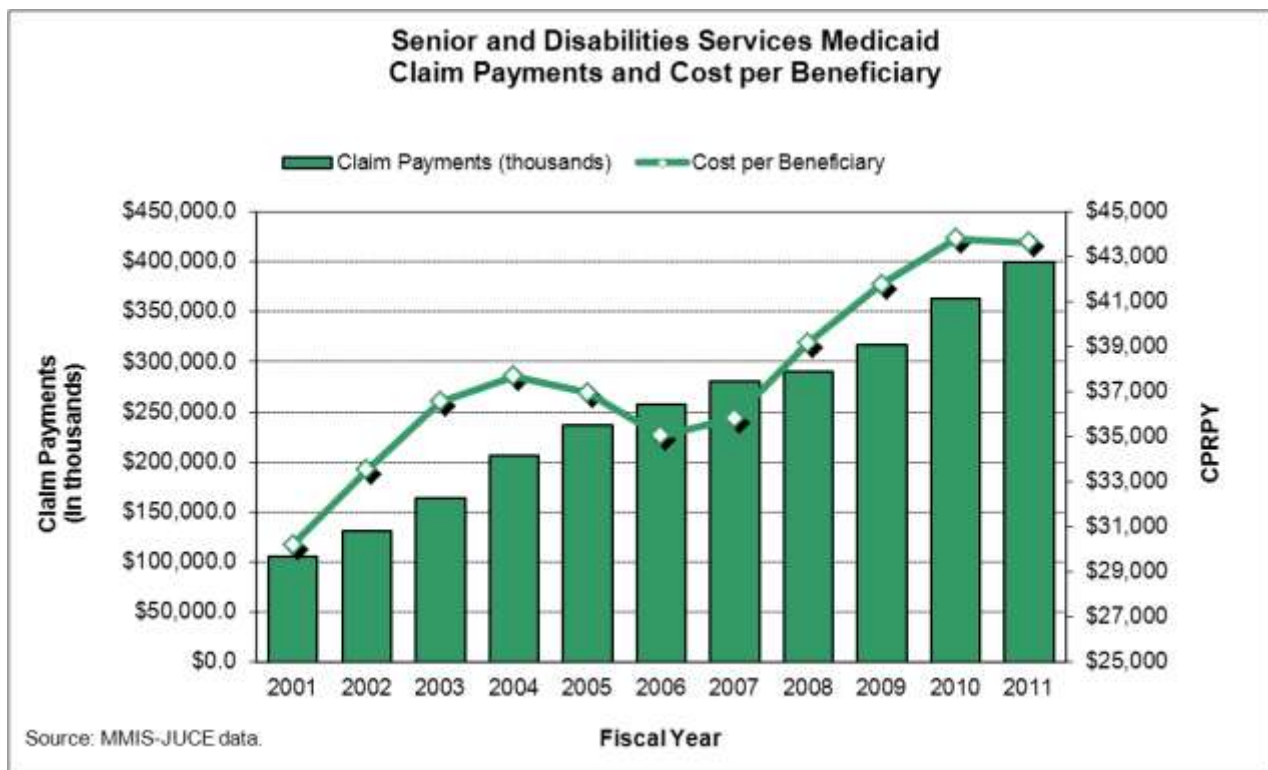
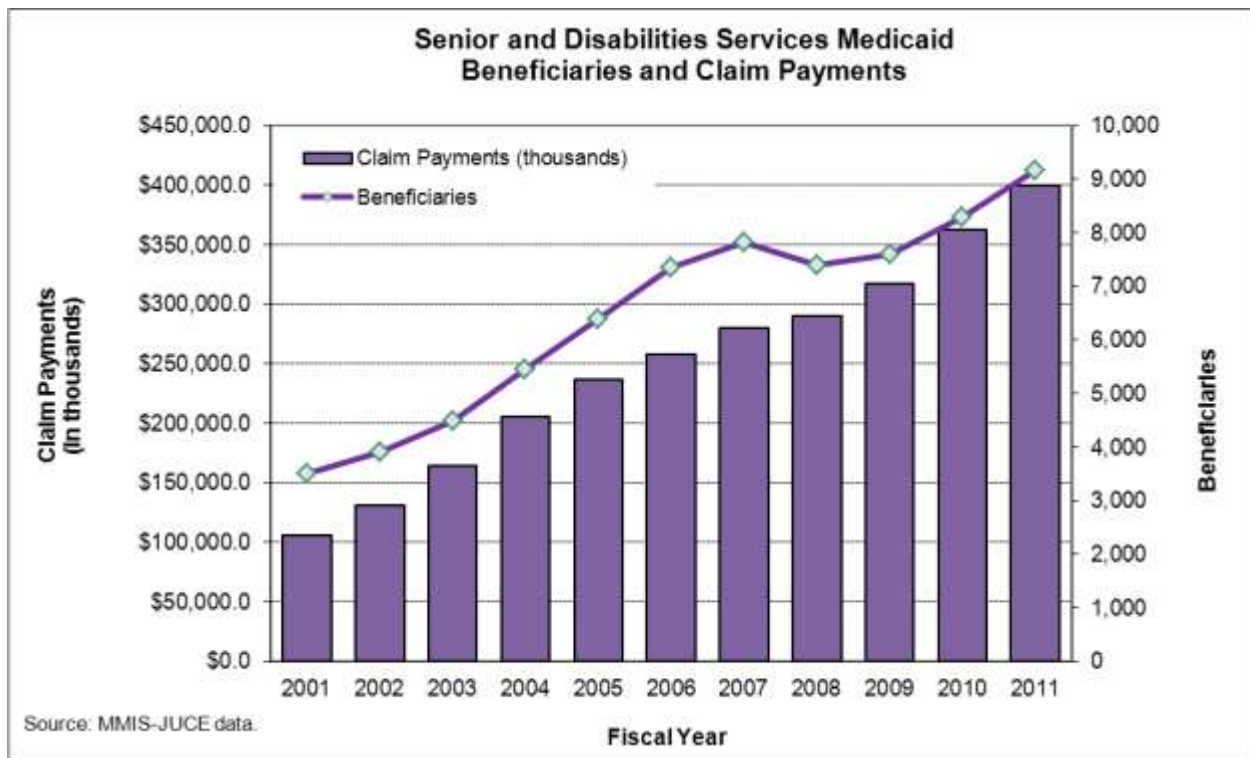
Within all waiver programs, the Older Alaskans waiver served the greatest percentage of waiver beneficiaries, 35.4%, in FY2011, followed closely by Adults with Physical Disabilities, 30.9% and Intellectual and Developmental Disabilities, 28.1%. The Children with Complex Medical Conditions waiver had the lowest number of participants with only 5.5% of waiver beneficiaries.

The Home and Community-Based Waiver program costs per beneficiary ranged from \$23,800 for Adults with Physical Disabilities Waiver services to \$73,700 for Intellectual and Developmental Disabilities Waiver services.

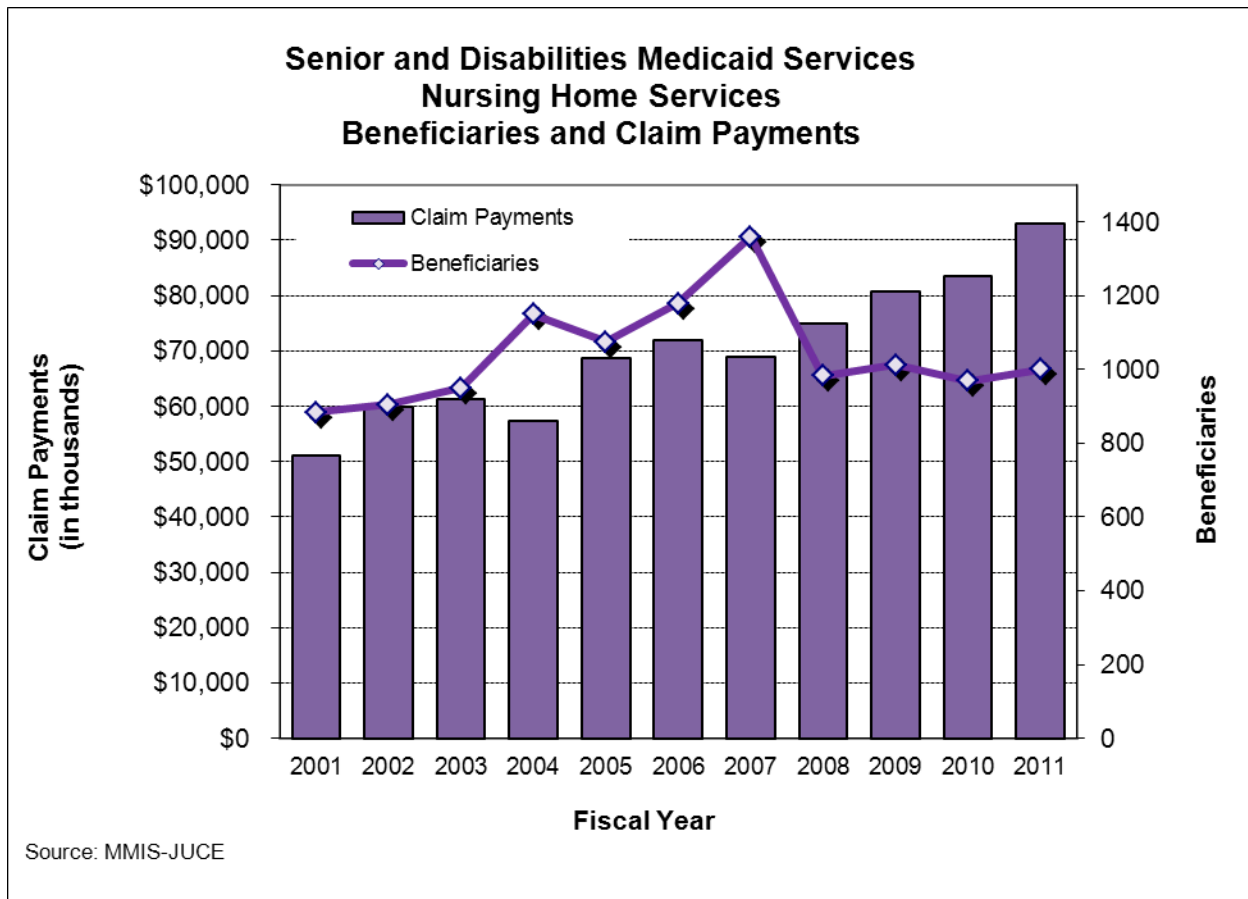
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Source: MMIS/JUCE for claims paid during fiscal year 2011.

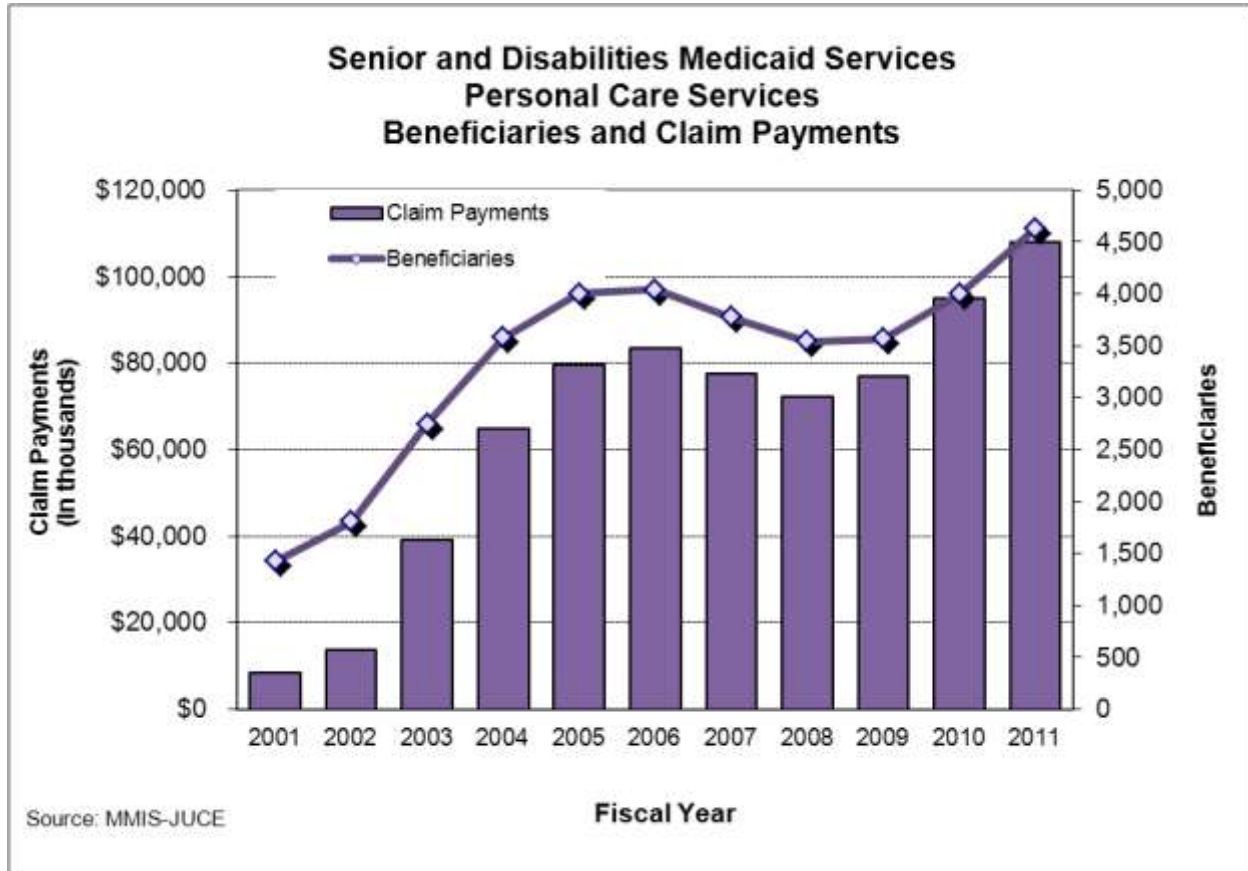
Total claim payments for Senior and Disabilities Medicaid services in FY2011 increased by 10.3% from FY2010. The number of beneficiaries using any Senior and Disabilities Medicaid service increased in excess of 10% while the annual cost per beneficiary **decreased** by 0.3% to \$43,652.



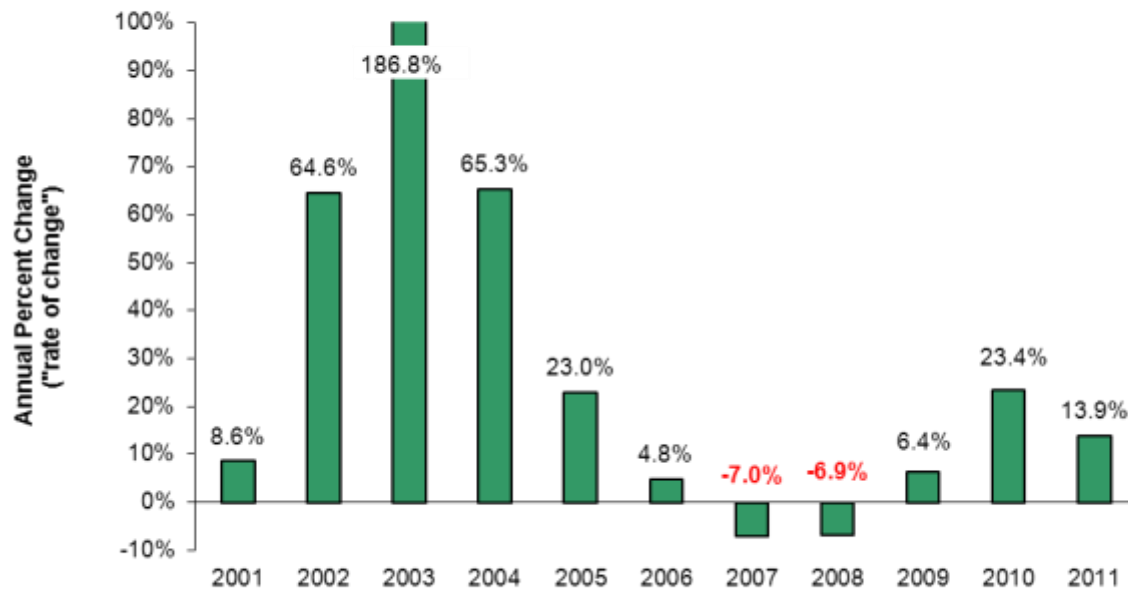
Total nursing home costs increased 11.9% in FY2011 to \$92,511.4. The number of Medicaid beneficiaries using nursing home services increased by 3.2% and the annual nursing home Medicaid cost increased by 8% per beneficiary.



Between FY2010 and FY2011 the number of PCA recipients increased by 15.9%. The average utilization per recipient in FY2011 **decreased** by 1.7% over FY2010. SDS, in collaboration with Health Care Services (HCS), has instituted 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 increased number of recipients had the net effect of a 14% increase in paid claims.

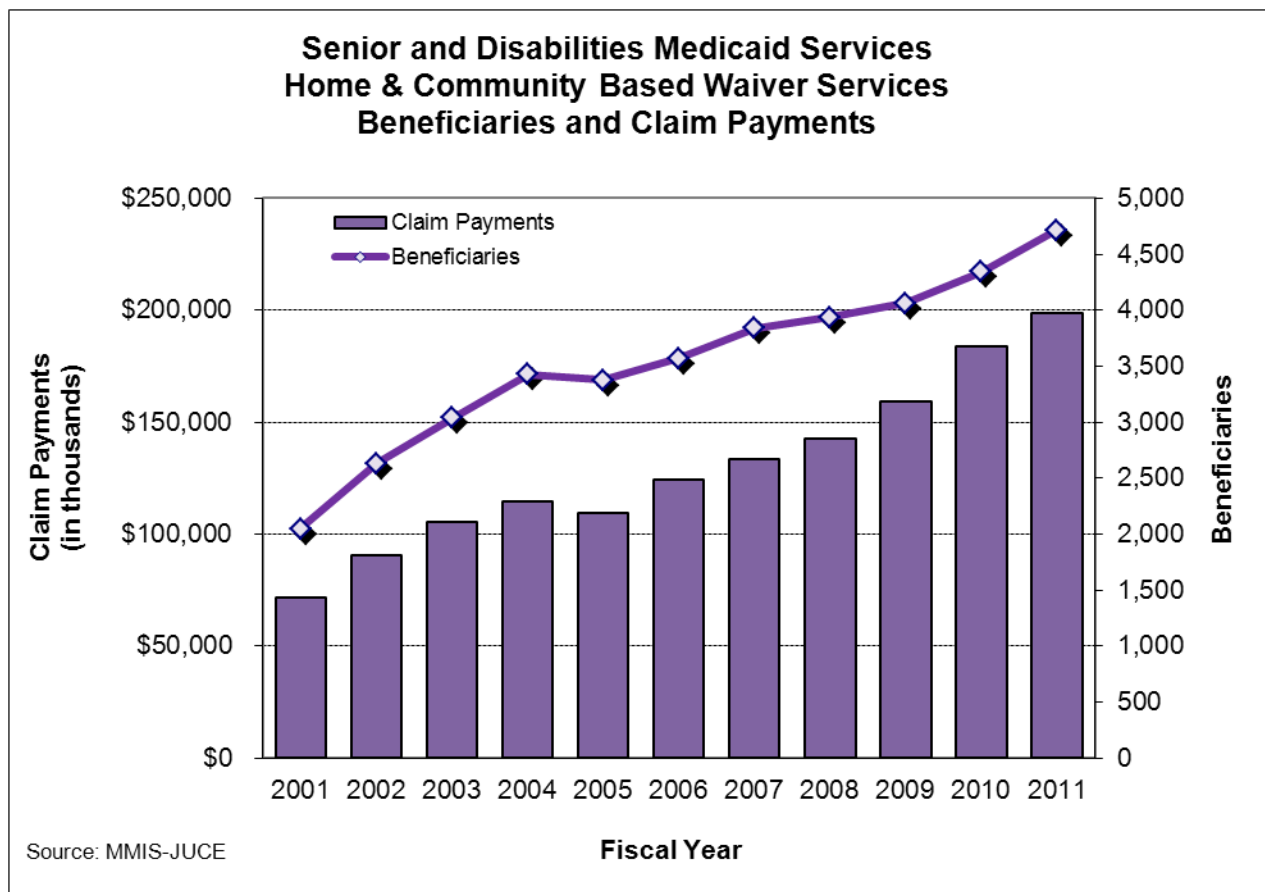


**Personal Care Services
Senior and Disabilities Medicaid Services
Annual Change in Cost of Benefits**



Source: MMIS-JUCE

Combined claim costs for all home- and community-based waiver services increased by 15% between FY2009 and FY2010. These waiver services increased 8% between FY2010 and FY2011. The number of beneficiaries using any waiver service at some time during the fiscal year increased by about 6%.



Introduction to the Alaska Commission on Aging

Mission

To ensure the dignity and independence of all older Alaskans, and to assist them to lead useful and meaningful lives through planning, advocacy, education, and interagency cooperation. 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.

Introduction

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 all 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 Commission is an agency of DHSS under the Commissioner's Office.

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 that includes the Executive Director, two Planners, and an Administrative Assistant.

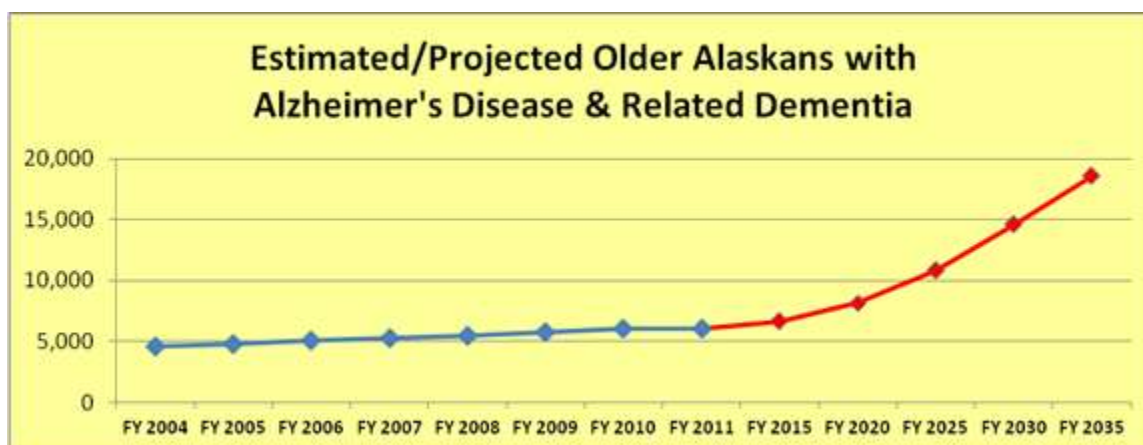
Core Services

- 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. Alaska's senior population continues to grow at accelerated rates. Not only is Alaska the state with the fastest-growing population of people age 65 years and older (currently number 54,938), Alaska seniors are by far the fastest-growing age sector in our state. From 2000 to 2010, Alaskans age 60 years and older (with a current population of 90,876) grew by 71.4%, while seniors age 85 and older increased by almost 79%. Senior growth rates are substantially higher than those for younger populations including youth up to age 17 (-1.8%), young adults from age 18 to 34 years (+21.3%), middle-age adults from 35 to 59 years (+7.4%), and the state's total population (13.3%). 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.



Alaska State Plan for Senior Services. The ACoA's most important planning accomplishment this year was completion of the new Alaska State Plan for Senior Services, FY 2012-2015, which was approved by the U.S. Administration on Aging and developed with input from an interagency Steering Committee comprised of partners representing state agencies, service providers, and senior consumers. The state plan satisfies a federal requirement for all states to allow the DHSS to draw down federal funding through the Older Americans Act to support home- and community-based grant-funded senior services, elder protection, vocational training for modest-income seniors, legal assistance, and other important programs serving older Alaskans. The ACoA conducted surveys of seniors and service providers and hosted six elder-senior community forums to identify needs and gaps in service that were used to develop the plan's needs assessment. More than 2,800 Alaskans age 60 years and over responded to the senior survey. The new plan seeks to address the emerging needs of the growing numbers of older Alaskans statewide and their caregivers, taking into account that the baby boomers are aging into their senior years and that our state is home to an increasing number of older people of advanced age. The duration of the new plan is July 1, 2011 through June 30, 2015. Implementation of the new plan has begun in FY2012.



The ACoA also advises the Alaska Mental Health Trust Authority on policy and funding for programs that serve individuals with Alzheimer's disease and related dementia (ADRD), seniors with behavioral health needs, and older adults with mental illness.



Advocacy. ACoA advocates on behalf of older Alaskans and their caregivers to ensure they have access to services when and where they need them, allowing them to 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 senior advisory commissions and stakeholder groups to ensure that the voices of older Alaskans and their caregivers are heard.

In FY2011, the ACoA and other partners advocated successfully for passage of the four-year extension for the Senior Benefits program, which assists more than 10,000 modest-income seniors by providing a cash supplement to pay for life necessities; an increment for the senior meal program that provides home-delivered and congregate meals to more than 11,000 older Alaskans; funding for community transportation; funding to establish the Alaska Complex Behavior Collaborative Hub pilot project to improve care for persons with cognitive impairments (such as Alzheimer’s disease and related dementia) who are at risk for institutional or out-of-state placement due to aggressive behavior and other complex behavior management needs; funding for AHFC’s Senior Citizen Housing Development Fund to develop new and improve existing senior housing stock; and supported passage of *Promoting the Safety and Protection of Older Alaskans* (HCR 3).

The Commission is committed to representing the interests of and promoting the well-being for all older Alaskans age 60 and older. 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 with 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 Alaska Mental Health Trust Authority (AMHTA), DHSS 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. Promoting efforts to prevent elder abuse and reduce risks for senior falls 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

Although the majority of older Alaskans use no senior services, as seniors age they are more likely to need in-home supports (such as home-delivered meals, assistance with activities of daily living, and respite for family caregivers) and home- and community-based services (like congregate meals, care coordination, assisted transportation, and adult day) to help forestall the need for more intensive care in assisted living and skilled nursing facilities. Preparing for the future will require: more intensive planning to design quality and cost-effective long-term support services; implementation of a patient-centered medical home model that utilizes innovative tele-medicine technologies to address seniors' medical and behavior health needs; greater investment in home- and community-based services that encourage health, wellness and choice; support for family caregivers, who provide the majority of long-term care for older Alaskans; and greater social awareness of the importance of healthy aging. These evolving opportunities will help to assist older Alaskans to age successfully in their chosen communities with the support of family, friends, and community.

The growth of the senior population is an important asset for Alaska as retired Alaskans constitute one of the largest and healthiest sectors of Alaska's economy. Senior retirees contribute an estimated \$1.7 billion of revenue annually to the state's economy from their pensions, Social Security, investments, and health care payments – which is almost ten times the total cost of State programs targeting seniors. The retirement industry is an economic engine that creates jobs, particularly in public and private health care services, long-term care, and housing and helps to foster new business opportunities. Moreover, seniors play a huge role in providing knowledge and transmitting cultural values to following generations through mentoring, teaching, and professional expertise.

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 27 members appointed by the Governor; of these 27, 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, in collaboration with many stakeholders, 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 FY2011 include helping plan and/or co-sponsor the Alaska State Special Education Conference, the Stone Soup Group Parent 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); training for the one-stop job center staff; piloting two Project SEARCH sites in Anchorage and Mat-Su; and helping coordinate the Real Economic Impact Tour (of the 559 individuals who received free tax assistance, 119 or 21.3% identified themselves as having a disability and 13.8% of the 80 people who participated in Super Saturday had a disability; both of these figures are well above the national average. Earned Income Tax Credits for all participants exceeded \$1 million).

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 FY2011 assisting Dillingham and Ketchikan to develop strategic plans for better meeting the needs of women with disabilities who are victims of sexual or physical assault or stalking; transitioning responsibilities for recruitment of direct service staff serving beneficiaries of the Alaska Mental Health Trust Authority to the Department of Labor & Workforce Development; the United Way Financial Stability Workgroup has agreed to take the lead on asset building activities; and a rapid rural response system to better meet the needs of young children with autism is now in place (previously, children residing in rural and remote areas of the state were diagnosed one-three years later than children living in urban areas).

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 FY2011 include providing public comment to the Medicaid Task Force on proposed cost savings recommendations; testifying before the State Board of Education & Early Development on restraint and seclusion; Council members met with every legislator and/or staff during the January Council meeting; for the first time ever, \$1 million allocated for Public Transit Programs State Match, which was distributed to partially fund federal match requirements; and a \$325.0 OTI increment (half-year funding) was secured for the Complex Behaviors Collaborative Hub to establish a high-level consultation group that provides intensive support & intervention services to people with complex behaviors who are at risk of being institutionalized.

Annual Statistical Summary of Services Provided in FY2011

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.

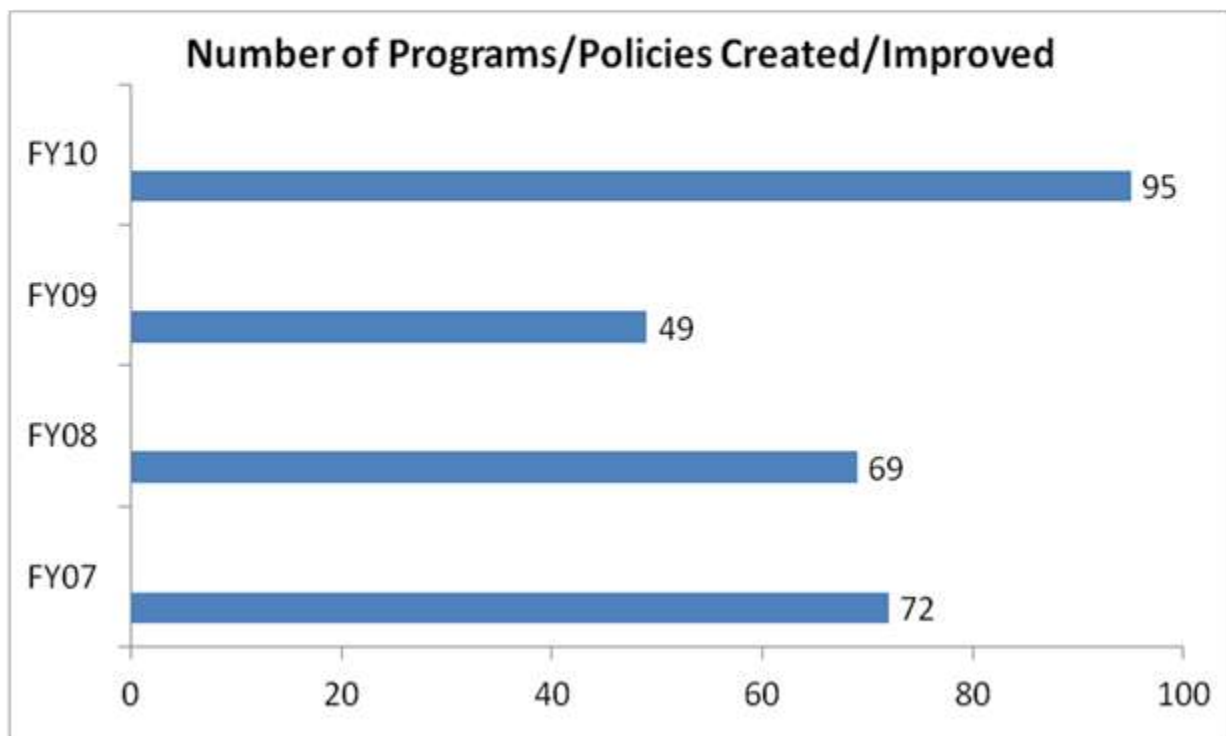


As can be seen, the number of people trained increased significantly over the past four years. This has most likely occurred because of new partnerships the Council has entered into to increase the number of people with disabilities who are self-employed, increase the number of people with disabilities who use the one-stop job centers to secure employment, 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 assault, 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.

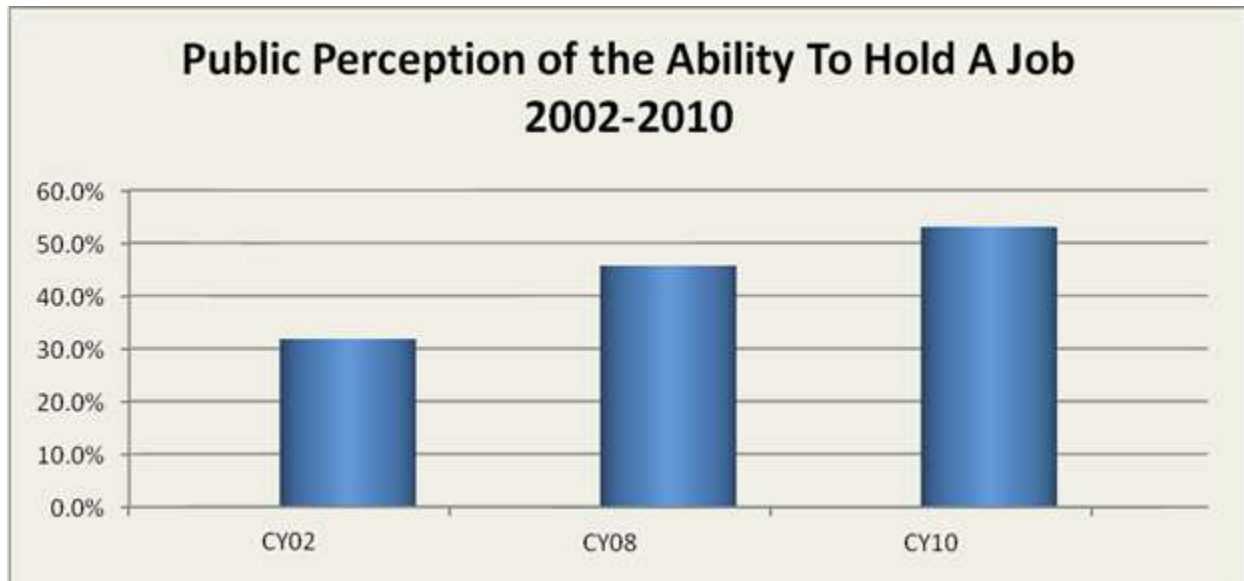
SYSTEMS CHANGE



As can be seen, the number of programs and policies created or improved increased considerably over the past four years, after a dip in FY2009. 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 2012 and 2013. Several initiatives and projects the 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 have shifted or 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 random telephone studies 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.



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 FY2013 Operating Budget Requests

The Council has received funding from the Centers for Medicare and Medicaid Services to increase the employment rate of Alaskans with disabilities for the past 10 years; as a result, there was a 59.3% increase in the number of people on SSDI whose benefits were withheld due to earnings and a 13.2% increase in the number of people on SSI who worked from 2005 to 2010. These dedicated funds end December 31, 2012, which will severely impact the ability of the Council to maintain momentum around its employment-related capacity building, systems change and advocacy agenda. 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.

The Council will receive \$150.0 from the Alaska Mental Health Trust Authority to work with one-two communities to replicate its process for better meeting the needs of women with disabilities who are the victims of sexual or physical assault or stalking.

Challenges

In FY2013, 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 are 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.” This will most likely require the Council to develop new partnerships with non-traditional organizations and groups that are not part of the disability community.

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 and 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 FY2013 Operating Budget Requests

Division of Senior and Disabilities Services

Budget Requests

Senior and Disabilities Services	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$39,450.2	\$40,561.0	\$1,110.8
Designated General Funds	0.0	0.0	0.0
Federal Funds	17,452.3	17,962.7	510.4
Other Funds	2,439.5	2,650.1	210.6
Total	\$59,342.0	\$61,173.8	\$1,831.8

Senior and Disabilities Services Administration

Adult Protective Services and Provider Quality Assurance: \$550.0 Total - \$275.0 GF Match, \$275.0 Federal Receipts

The Division of Senior and Disabilities Services (SDS) requests \$550.0 to ensure compliance with the Centers for Medicare and Medicaid Services (CMS) requirements to protect the health and welfare of persons receiving waiver services and to deliver improved and measurable services to vulnerable adults.

The Adult Protective Services Program provides services designed for the protection of vulnerable adults suffering from exploitation, abuse, neglect or self-neglect and abandonment. This unit also functions as statewide Central Intake for all Reports of Harm as well as all Critical Incident Reports for Senior and Disabilities Services. In FY2011, including Assisted Living Home reports, APS received 4,425 Reports of Harm and investigated 3,272 of these reports for abuse and/or risk of abuse. With only nine investigators statewide, it is becoming increasingly difficult to meet statutory requirements for protection of vulnerable adults across the state, especially in the rural areas.

Caseloads per worker are approximately triple (75) the recommended average (25). The number of Reports of Harm has increased 183% over the last five years and is expected to continue to climb as the Baby Boomers continue to age. The lack of adequate staffing levels, as well as extremely high caseloads, have resulted in slower response times, worker burnout, inability to follow-up on interventions to ensure that safety provisions are adequate and the inability to close cases. APS is no longer able to provide information and referral services to vulnerable adults due to the lack of resources.

The division has and will need to continue to rely on long term non-permanent Social Services Specialists positions to allow for smaller case loads and enable the permanent investigators to conduct full and comprehensive investigations to ensure safety and well-being for vulnerable

adults. Long term non permanent staff would also allow APS to promote public policies to effectively and efficiently recognize, report, and respond to the needs of the increasing number of older persons and adults with disabilities who are abused, neglected, and exploited, and to prevent such abuse whenever possible; and to increase public awareness of abuse of elders and adults with disabilities.

As part of its administration of four Home and Community-Based Services (HCBS) waivers approved by the Centers for Medicare and Medicaid Services (CMS), SDS is required to assure the federal government that necessary safeguards have been taken to protect the health and welfare of persons receiving services under the waivers. These safeguards include adequate operating standards for all provider types as well as licensing and certification standards. Monitoring of provider compliance with these standards requires the capability to conduct on-site reviews of provider agencies.

Provider oversight activity is essential to: 1) meet CMS and regulatory requirements; 2) provide technical assistance; 3) reach consistent outcomes with non-compliant providers; 4) and protect the health and welfare of participants and fiscal integrity of the programs. In addition, the number of new provider applications is expected to continue to climb approximately 10% per year, adding approximately 100 new applications annually. Quality Assurance standards for the Personal Care Attendant (PCA) program also need to be developed and monitored.

Current staffing levels are inadequate to meet this federal requirement. Contractual agreements for services are needed to provide the oversight activity that is required to monitor provider compliance with quality standards. The division needs “boots on the ground” to be out in the community conducting on-site reviews of HCBS providers. These additional services will provide better quality evaluation of new providers, onsite reviews at provider locations, technical assistance and training, timely completion of complaint investigations, reports of findings and sanctions when applicable.

Failure to fund this increment will severely impact the health and welfare of vulnerable adults. Inadequate and untimely response by APS carries insurmountable consequences for those that are most in need of help and intervention. In addition, the health and safety of recipients/ participants will be compromised, as well as the integrity of the overall HCBS and PCA programs without this funding. The waiver assurances to CMS will not continue to be met. There will be significant delays in the processing of provider applications and renewals as well as responding to general provider issues.

MH Trust: Housing - Rural Long Term Care Development: \$140.0 MHTAAR

This project has been a technical assistance resource through DHSS 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. The Division 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, 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 - Acquired & Traumatic Brain Injury Program Research Analyst & Registry Support: \$136.0 MHTAAR

Managed by DHSS/Senior and Disabilities Services, this increment will continue to fund a Research Analyst III as lead staff for all data development, collection, analysis and reporting activities associated with the planning and implementation of the Alaska Acquired and Traumatic Brain Injury (ATBI) program. The increment will be maintained at \$136.0 MHTAAR. The passage of SB 219 in 2010 established an Acquired/ Traumatic Brain Injury program and registry within the Department. This 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.

MH Trust: ACoA -Adult Day Services: \$225.0 GF/MH

Administered by the Division of Senior and Disabilities Services, this funding will increase multiple year grants to Adult Day Service (ADS) Providers to serve additional older Alaskans with Alzheimer's Disease and Related Dementia, those with physically disabling conditions, and older persons with other cognitive impairments who are not safe staying alone unsupervised; provide critical respite for unpaid family caregivers; and provide start-up funds for one new program in an underserved area. Twelve grant-funded ADS programs served 472 seniors in FY2010, of whom 56% have dementia. ADS activities include age-appropriate structured activities including exercises, games, art projects, outings, assistance with personal care, and lunch/snacks.

MH Trust: ACoA -Senior In-Home Services (SIH Services): \$250.0 GF/MH

Administered by the Division of Senior and Disabilities Services, this funding will increase multiple year grants to Senior Home and Community-Based Service Providers to provide care coordination, chore, and respite services for seniors and unpaid family caregivers to address growing waitlists for SIH services (142 seniors who qualify for services but receive none and 108 seniors who receive partial services), to reduce the need for nursing home placement by providing appropriate supports that allow elderly persons to maintain their health and independence in their homes, and to provide start-up funds for one new program in an

underserved area. This project targets adults with Alzheimer's disease and related dementia and Alaskans age 60 years and older with physical disabilities or mental health conditions who are at risk for institutionalization; older persons having greatest social and economic need; Alaska Native elders; and older Alaskans living in rural areas. In FY2010, this program served 1,308 older Alaskans.

Community Developmental Disabilities Grants

MH Trust: Gov Cncl- Services for the Deaf: \$150.0 GF/MH

Administered by the Division of Senior & Disabilities, these funds will be used for the provision of services to improve employment and housing outcomes for Alaskans who are deaf or hard of hearing and reduce the number of placements in correctional institutions or the Alaska Psychiatric Institute. Services designed specifically for the deaf community have gradually disappeared over the past six years due to funding limitations and a lack of understanding regarding service provision. With the elimination of the Anchorage deaf and hard of hearing center, deaf individuals with multiple disabilities are attempting to access generic disability services with minimal success; communication is a constant barrier and many individuals report that services are fragmented. This increment will add \$150.0 to the \$14,498.8 base for developmental disabilities community grants.

MH Trust: Benef Projects - Mini Grants for Beneficiaries with Disabilities: \$227.5 and \$25.0 MHTAAR

The Mini-grants for Beneficiaries with Disabilities program has been funded by the Trust since FY1999 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 FY2013 MHTAAR increment maintains the momentum of effort.

Commission on Aging

MH Trust: Cont - ACOA Planner: \$91.0 and \$18.1 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 ongoing 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, including participating in the development of state plans, working on collaborative projects, and other duties. Outcomes and reporting requirements are negotiated with the Trust annually.

Governor's Council on Disabilities and Special Education

MH Trust: Dis Justice - AK Safety Planning & Empowerment Network (ASPEN): \$150.0

MHTAAR

This project is a collaborative effort between the Alaska Network on Domestic Violence, the Governor's Council on Disabilities and Special Education, the Alaska Native Justice Center and the UAA Center for Human Development. The effort seeks to build capacity of the service delivery system in targeted communities by: 1) resolving barriers to safety, empowerment, access to non-judgmental services provided by disability & DVSA service providers; 2) fostering local collaborations to link survivors with services and resources; 3) providing cross-training and technical assistance; and 4) developing policies and procedures designed to prioritize safety, empowerment, and access.

The FY2013 MHTARR increment for this project builds upon the Governor's Domestic Violence and Sexual Assault Initiative.

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, FY2012 funding recommendation is increasing to allow for more beneficiary small business start-up grants.

MH Trust: Cont - Research Analyst III: \$110.0 and \$5.0 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 FY2012 MHTAAR increment (\$110.0) maintains the FY2011 funding level and momentum of effort.

Challenges

The Division of Senior and Disabilities Services faces many on-going and new challenges in FY2013. Ongoing challenges include eliminating the Developmental Disabilities waitlist registry and implementing timely eligibility assessments for Medicaid applicants.

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. In FY2012 SDS hired a contractor to take the lead in the design and development of a new Community First Choice Option program that will successfully meet fiscal and service delivery goals. This redesign of the existing Personal Care Assistance program will serve to keep individuals out of the higher cost institutional care settings, address the need to implement quality assurance strategies, address gaps in the current delivery system and promote a service array that meets the needs of vulnerable Alaskans.

Maintaining compliance with federal and state requirements to manage the Older Alaskans and Adults with Physical Disabilities waiver programs and meet documentation and timeline requirements is an additional challenge. 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 Detail

A: Result - The quality of life for seniors and persons with disabilities is enhanced through cost-effective delivery of services.

Target #1: The use rate of nursing home bed days per year for seniors 65 years and older in skilled nursing facilities will not increase.

Status #1: 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 - Long-term care service array

Target #1: Percentage of participants who have adequate and appropriate service plans based on needs identified in the waiver assessment process.

Status #1: In July, 2011, 93.5% of Medicaid waiver participants had adequate and appropriate service plans based on the needs identified in the waiver assessment process.

A2: Strategy - Quality

Target #1: Percentage of participants who received services in the amount, duration and frequency prescribed in their plan of care (POC).

Status #1: In July 2011, 100% of Medicaid waiver participants received services in the amount, duration and frequency prescribed in the service plan.

A3: Strategy - Access

Target #1: Percentage of applicants who receive a level of care (LOC) determination within 30 days of submission of a complete application.

Status #1: In July, 2011, 90.3% of applicants for Medicaid waiver services received a level of care determination that verified their eligibility within 30 days of submission of a complete application.

Target #2: Increase by 10% the number of disabled and elderly Alaskans utilizing Aging and Disability Resource Centers (ADRC).

Status #2: In FY2010, 8,790 individuals used ADRCs to access information and to apply for long-term services and supports. In FY2011 that number rose to 9,615, an increase of 9.14%.

A4: Strategy - LTC Facility and Program Safety

Target #1: Percentage of participants with plans of care (POC) that address health and safety factors.

Status #1: In July 2011, 98.9% of Medicaid waiver participants had service plans that address health and safety factors.

A5: Strategy - LTC Workforce

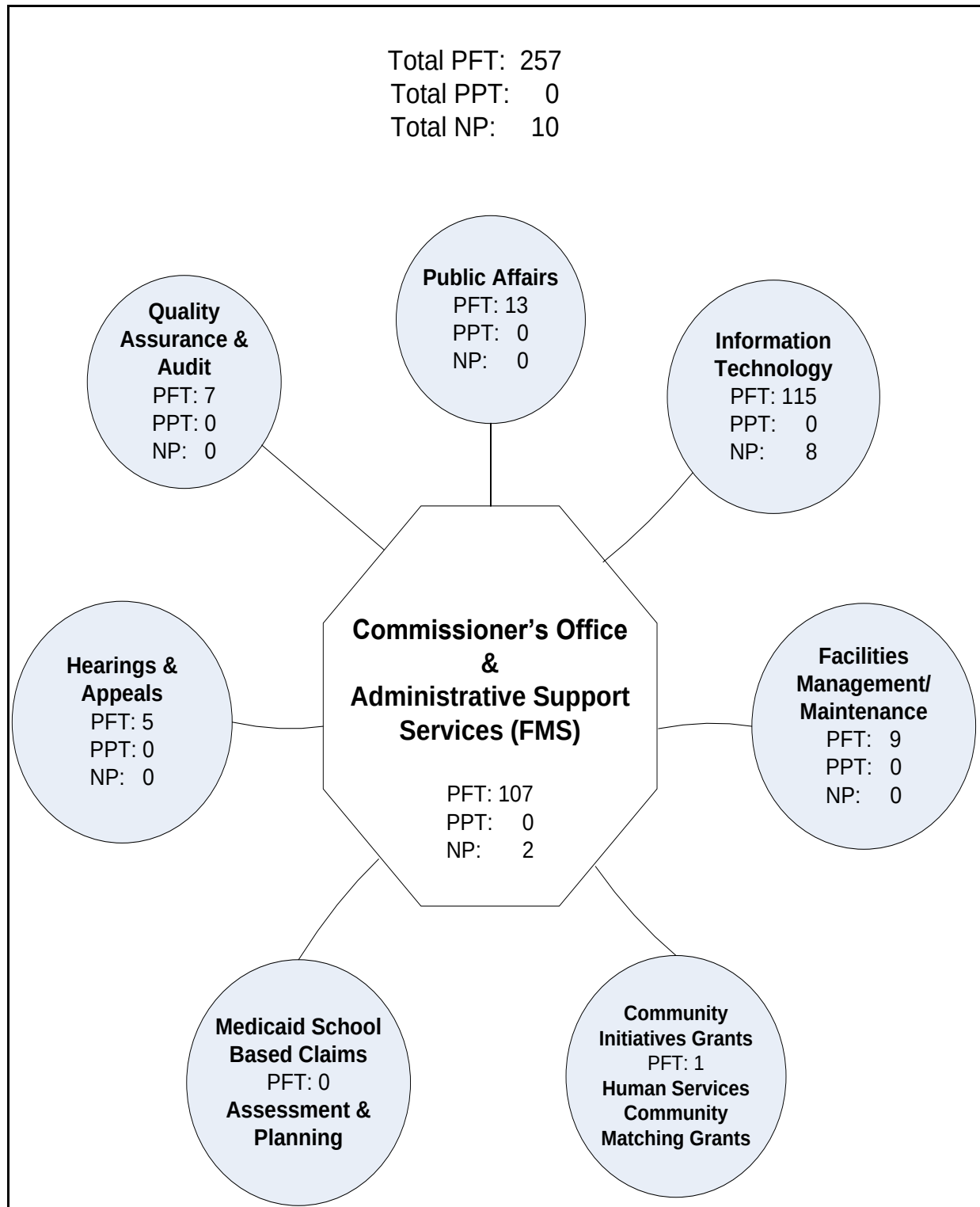
Target #1: Percentage of home and community-based services providers who are compliant with provider certification standards.

Status #1: In July 2011, 98% of Medicaid waiver home and community-based service providers were compliant with provider certification standards.

FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Senior and Disabilities Services</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Adult Protective Services and Provider Quality Assurance	\$ 275.0	\$ -	\$ 275.0	\$ -	\$ 550.0
MH Trust: ACoA - Adult Day Services	\$ 225.0	\$ -	\$ -	\$ -	\$ 225.0
MH Trust: ACoA - Senior In-Home Services (SIH Services)	\$ 250.0	\$ -	\$ -	\$ -	\$ 250.0
MH Trust: Dis Justice - AK Safety Planning & Empowerment Network (ASPEN)	\$ -	\$ -	\$ -	\$ 150.0	\$ 150.0
MH Trust: Gov Cncl - Services for the Deaf	\$ 150.0	\$ -	\$ -	\$ -	\$ 150.0
MH Trust: ACoA - Grant 1927.04 Aging and Disability Resource Centers	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
MH Trust: Benef Projects - Grant 124.08 Mini Grants for Beneficiaries with Disabilities	\$ -	\$ -	\$ -	\$ 252.5	\$ 252.5
MH Trust: Benef Projects - Grant 200.09 Microenterprise Capital	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
MH Trust: Brain Injury - Grant 3178.02 Acquired & Traumatic Brain Injury Pgm Research Analyst & Registry Support	\$ -	\$ -	\$ -	\$ 136.0	\$ 136.0
MH Trust: Cont - Grant 105.08 Research Analyst III (06-0534)	\$ -	\$ -	\$ -	\$ 115.0	\$ 115.0
MH Trust: Cont - Grant 151.08 ACOA Planner (06-1513)	\$ -	\$ -	\$ -	\$ 109.1	\$ 109.1
MH Trust: Housing - Grant 68.09 Rural Long Term Care Development	\$ -	\$ -	\$ -	\$ 140.0	\$ 140.0
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ 969.8	\$ 969.8
Senior and Disabilities Services Total	\$ 900.0	\$ -	\$ 275.0	\$ 2,122.4	\$ 3,297.4

Department Support Services



Introduction to Department Support Services

Mission

Provide quality administrative services in support of the department's mission.

Overview

The Division of Department Support Services assists Department of Health and Social Services divisions in meeting their administrative and financial responsibilities. The division serves both external and internal customers providing centralized administrative services including accounting, revenue collections, cost allocation, human resources, payroll, budgeting, procurement, grants administration, information systems support, and facilities management and maintenance.

Core Services

Departmental Support Services (DSS) includes the Commissioner's Office, Public Affairs and Finance and Management Services. DSS provides a varied range of centralized administrative services to support program efforts across the department. DSS consists of the following components:

- Commissioner's Office
- Public Affairs
- Hearings and Appeals
- Medicaid and School Based Services
- Quality Assurance & Audit
- Assessment & Planning
- Community Initiative Matching Grants
- Human Services Community Matching Grants
- Facilities Management
- Facilities Maintenance
- Information Technology Services
- Administrative Support Services

Services Provided

Commissioner's Office

The Commissioner's Office component funds leadership, strategic direction and policy development for the Department of Health and Social Services. (AS 18.05: Health, Safety and Housing)

Public Affairs

Public Affairs 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)

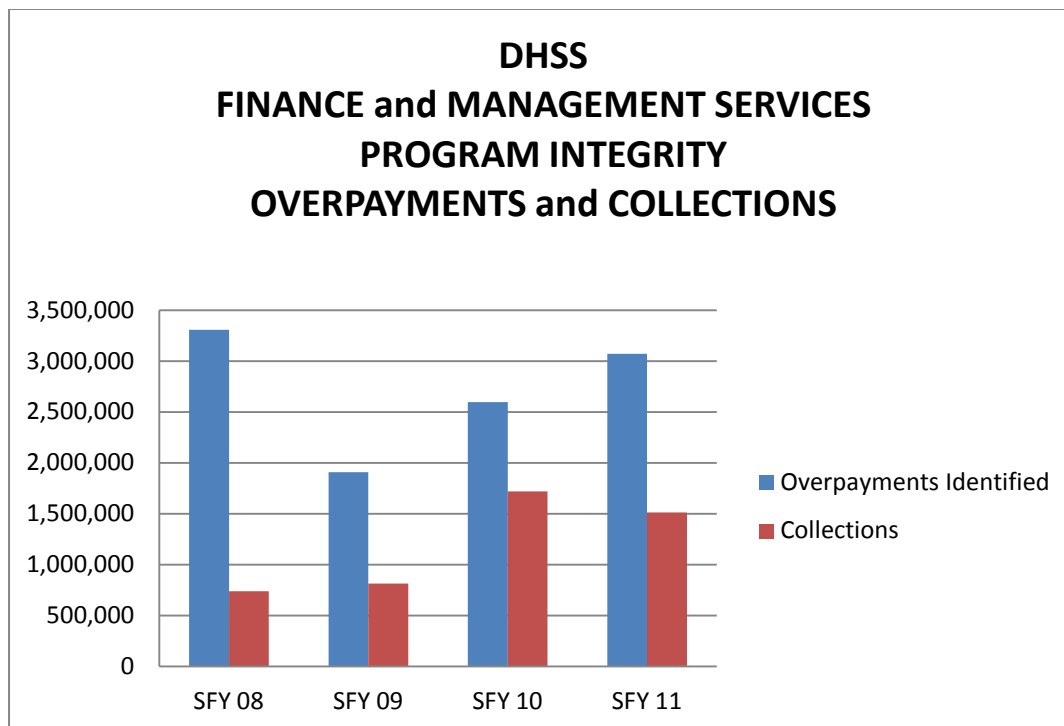
Hearings and Appeals

Hearings and Appeals is responsible for adjudicating claims or disputes between clients/grantees/providers and the offices/divisions of the department. This office conducts hearings and issues impartial decisions that comply with due process requirements. A mediation process is also provided for the resolution of claims or disputes. Ultimately, all issued decisions can be appealed to the State Superior Court.

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)

Quality Assurance & Audit

Quality Assurance and Audit 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.)



Assessment and Planning

Assessment and Planning provides planning, assessments and forecasting activities for the Medicaid Program. Medicaid is an entitlement program providing for more than \$1 billion in services to eligible Alaskans. Accurate data and forecasting of expenditures and revenues is critical to the management of this large program and to the state. (AS 37.07, 47.07, 7AAC 43, 7AAC 100.)

Medicaid School Based Claims

The Medicaid School Based Claims program provided federal reimbursement to participating school districts for performing medical activities within the schools. This program was discontinued effective November, 2011. (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

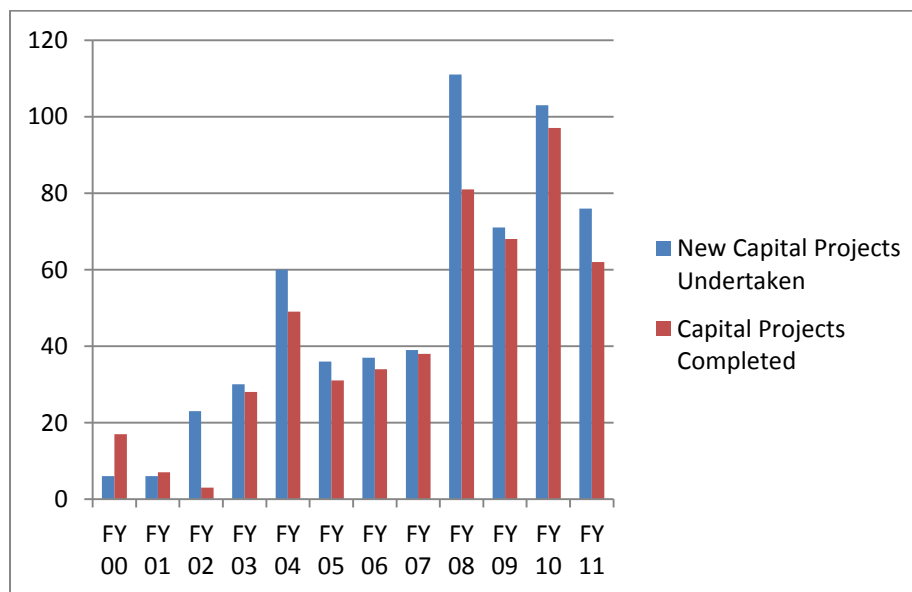
The Human Services Community Matching Grants component funds grants to qualified municipalities. These grants provide for substance abuse treatment, mental health services, food and shelter, sexual assault shelters, and other related needs. (AS 29.60.600 Human Services Community Matching Grants.)

Facilities Management

Facilities Management 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.)

Facilities Management 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 FY2000 through FY2011.



In addition, Facilities Management administers all capital grants including pass through federal funds from the Denali Commission. In FY2011, Facilities managed four Denali Commission grants with a value of \$4.7 million and an additional 65 state capital grants with a value of \$8.3 million.

Facilities Maintenance

The Facilities Maintenance, Pioneer Homes Facilities Maintenance, and DHSS State Facilities Rent components 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

Information Technology is designed to be a customer focused, strategically aligned, operationally sound technology business enabler for the Department's health programs.

The Information Technology Organization is structured to provide the following five core services.

- **Strategic Planning/Project Management & Health Information Technology Interface**
 - *Currently 70 Managed IT projects*
- **Business Management – Health related vertical market applications, systems development & support.**
 - *Development and support for 85 IT systems*
- **Operations – Support for day-to-day Information Technology services required to support office productivity tools, Data Centers, desktops, networks, infrastructure and computing resources.**
 - *Support for 2 Data Centers, 3269 Desktops, 139 Networks*
- **Security Services to protect Public, Internal, Confidential & Restricted data**
 - *Security Framework, logging/auditing/monitoring, risk mitigation, investigations HB-65 (APIPA), HIPAA*
- **Technology Standards, Communications, Privacy, Compliance & Training**
 - *Managing State & department IT standards, approve technologies, IT Communications/training infrastructure & Privacy Office.*

DHSS Computing Environment (Statewide Totals)	
Desktops	3,269
Servers (physical)	186
Servers (virtual)	109
Networks	139
Housed Facilities Networks	113
FY2009 Help Calls	19,941
FY2010 Help Calls	20,596
FY2011 Help Calls	22,596
FY2009 Average Calls per Day	72
FY2010 Average Calls per Day	74
FY2011 Average Calls per Day	91
Communities with IT Infrastructure	82
Number of Business Applications	85

Administrative Support Services

The Administrative Support Services component is responsible for finance, 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. (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 \$1,129,682,562 (Billion) in FY2011 for 150 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.

Budget Section

The Budget Section is responsible for analyzing, monitoring, and controlling the Department's annual \$2.4 billion operating budget, including processing budget amendments, revised programs, supplemental budget requests, fiscal notes, and legislative requests for information for each of our nine divisions.

Major efforts included guiding departments through the various steps of developing the FY2012 and FY2013 budget, processing over 1,000 FY2011 reimbursable service agreements and revised program documents, and tracking division revenue and expenditure projections on a quarterly basis.

Two significant accomplishments include editing, compiling, and publishing the FY2012 Budget Detail Book and the FY2012 Budget Overview Book. Once budget staff members receive the division-authored narrative of both publications, they then collaborate with the divisions to ensure budget descriptions and justifications are accurate, logical, and clear. At over 1,900 pages, the Budget Detail serves as an important reference for individuals throughout the state. At over 430 pages, the Budget Overview provides key budget, programmatic, and performance measure information to stakeholders in the executive and legislative branches not only during the legislative session, but throughout each year.

The Medicaid Budget Unit provided departmental leadership with key internal updates of Medicaid projections and estimates, including an update of the twenty-year long-term forecast of Medicaid enrollment and spending in Alaska (MESA) and monthly adjustments to the STAMP report. Additionally, the unit provided detailed programmatic and fiscal data in response to information requests and fiscal notes.

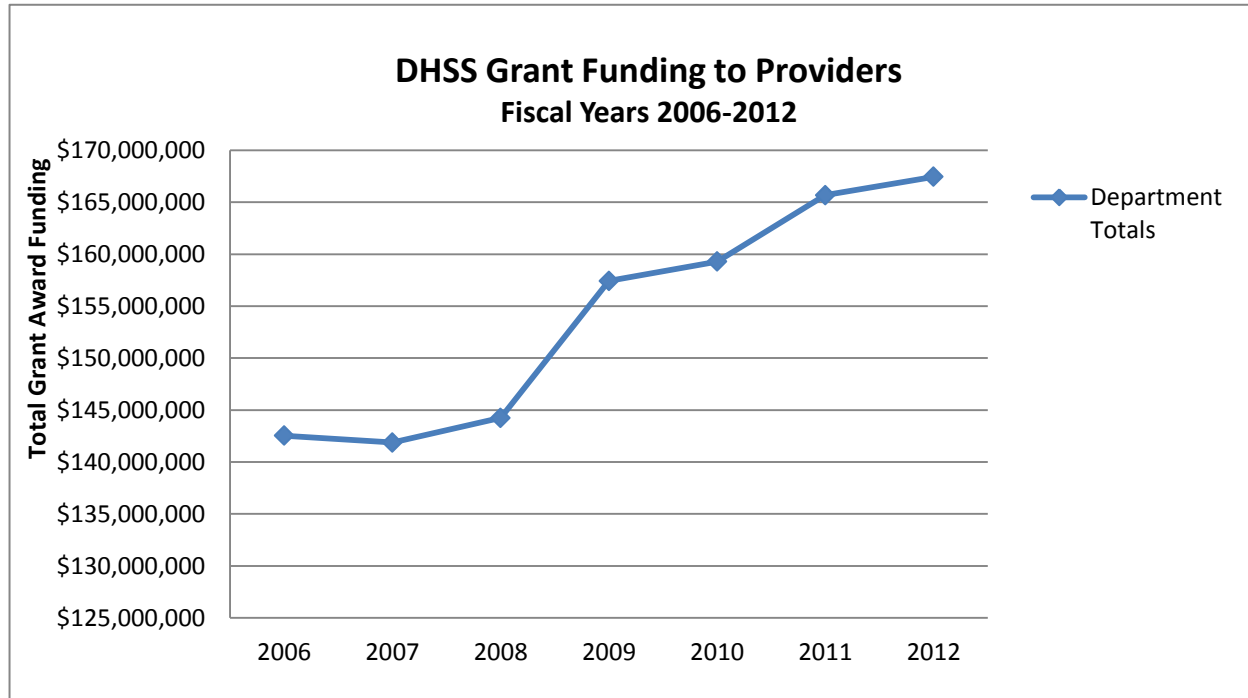
Grant and Contracts Support Team

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 and professional services solicitations and award administration.

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.

Overall, this change has been extremely successful and embraced by many both inside and outside of the Department, especially our partners in the non-profit community.



During the past several years, the number of operating grants has remained fairly consistent with approximately 650 awards issued annually. However, the chart above reflects an increase of nearly 25 million dollars in the total dollars awarded from 142,532,843 in FY2006 to 167,441,687 in FY2012.

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 FY2013 Operating Budget Requests

Department Support Services

Budget Overview Table

Department Support Services	FY2012	FY2013 Gov	Difference
Unrestricted General Funds	\$22,275.1	\$23,718.0	\$1,442.9
Designated General Funds	2.8	2.8	0.0
Federal Funds	20,664.8	15,712.3	-4,952.5
Other Funds	9,499.9	9,355.5	-144.4
Total	\$52,442.6	\$48,788.6	-\$3,654.0

Budget Requests

Information Technology Services

Rural Support Program:

\$610.5 (\$183.0 Federal/\$427.5 GF)

0 PFT, will fund vacant

Problem Statement: Currently, information technology support in rural Alaska is sporadic at best. Information Technology Services acts in a reactionary mode in areas of desktop replacement and infrastructure upgrades. Typically it takes the failure of a desktop computer, server, switch or router before ITS performs a replacement or upgrade. Often these failures leave customers without service until ITS can react to the failure, greatly affecting the service offered in the community.

Proposal: Establish an information technology rural support program to proactively address the unique needs of our rural customers. Desktops and network infrastructure should be replaced every three years in a staggered approach so that one third of these devices are replaced each year. Hardware will be the primary cost of this program. It is estimated that ITS supports approximately 700 desktops in rural areas, making the yearly desktop refresh number at 235. Yearly network infrastructure upgrades are estimated at \$10k per site for 28 sites. Current customer services staff can support this effort, but additional travel costs will be necessary to visit our numerous rural sites three times each year.

- \$72.0 Travel (3 visits)
- \$280.0 Infrastructure (\$10.0 per site)
- \$258.5 Desktop computers (\$1.1 per desktop)

Consequences of no funding: Underfunding or not funding information technology rural support will reduce the department's ability to deliver critical services that impact all Alaskans, especially those in rural areas. This was recently demonstrated when the Ketchikan Public Assistance office went offline for two days. The inability to stay current with desktop and server-based hardware jeopardizes the effective operation of the myriad of computer-based case management systems upon which the department relies, leaving the organization at the mercy of hardware failures.

Explanation of FY2013 Capital Budget Requests

Department Support Services is requesting the following capital funding:

- Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment - \$4,000.0 GF
- Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment - \$3,015,740 (\$3,000.0 GF)
- Bethel Youth Facility Renovation Phase 1 - \$10,000.0 GF
- International Classification of Disease–10 Phase 2 - \$4,676,400 (\$901.6 GF)
- Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue Project - \$450.0 GF
- MH Essential Program Equipment - \$475.0 GF/MH
- MH Aging and Disability Resource Centers Pilot to Improve - \$425.0 GF/MH
- MH Home Modification and Upgrades to Retain Housing - \$1,050.0 (\$750.0 GF/MH)
- MH Assistive Technology - \$125.0 GF/MH
- Copper River Health Clinic – \$8,000.0 GF
- Kenaitze Health Clinic - \$10,000.0 GF

Brief Description of Major 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 (6) Pioneer Homes. The homes are located in Ketchikan, Sitka, Juneau, Anchorage, Palmer, and Fairbanks, and have a combined replacement value of approximately \$310 million.

Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment - \$3,015,740 (\$3,000.0 GF)

This request is for deferred maintenance and renovation projects for the Department's thirty-five (35) facilities statewide – which include youth facilities, public health centers, laboratories, and behavioral health buildings. The combined replacement value of these facilities is approximately \$343 million.

Bethel Youth Facility Renovation - \$10,000.0 GF

This capital request will provide for the pre-construction work of four new Detention beds for a total of twelve, upgraded Treatment beds, additional Probation space, expanded medical space, a vehicle sally port, a small gymnasium and a secure outdoor recreation area. This first phase will complete the design, address site issues and will assist in the removal of the Yukon Kuskokwim Health Corporation's Keyes Building that is in too close in proximity to the Bethel Youth Facility.

International Classification of Disease – 10 Phase 2 - \$4,676,400 (\$871.0 GF)

This request will fund phase 2 of the project to initialize standardized formats for exchange of data between computer systems. By using this updated standard Alaska Medicaid eliminates the risk of federal penalties for failure to comply with the law. The International Classification of Diseases-10 (ICD-10) code sets provide a standard coding convention that is flexible, providing unique codes for all substantially different health conditions.

EMS – Match for Code Blue - \$450.0 GF

This request will fund the purchase of critical Emergency Medical Services (EMS) equipment and ambulances for EMS agencies around the state, particularly in rural locations.

Copper River Health Clinic - \$8,000.0 GF

This request will fund a named recipient grant to the Copper River Native Association to leverage existing funding to complete the construction of a new health clinic.

Kenaitze Health Clinic - \$10,000.0 GF

This request will fund a named recipient grant to Kenaitze Indian Tribe to leverage existing funding to complete construction of a new health clinic.

MH Home Modification and upgrades to Retain Housing - \$1,050.0 (\$750.0 GF/MH)

This is a competitive capital grant program that provides housing modifications for persons with special needs. People are able to remain in their homes, thus, reducing costs of providing supported housing or moving to institutional housing.

MH Essential Program Equipment - \$475.0 GF/MH

The request will provide capital equipment grants through the competitive process for agencies providing services, activities and programs for Mental Health Trust beneficiaries.

MH Aging and Disability Resource Centers Pilot to Improve - \$425.0 GF/MH

This request will fund a three-year pilot to use Aging and Disability Resource Centers (ADRCs) to better guide individuals to the most appropriate care setting, increase independence in a community-based setting, improve health outcomes for seniors and individuals with developmental disabilities to reduce inappropriate or nursing home placements, decrease cost to the state for unnecessary level of care assessments, and provide a formalized process for assessment and referral for behavioral health services.

MH Assistive Technology - \$125.0 GF/MH

This capital program will provide funding for high-technology and low-technology assistive devices for Alaskans experiencing disabilities.

Challenges

As the administration and management of the department, FMS and the Commissioner's Office are in a unique position to understand overall department challenges as well as specific impacts on our operations.

Audit requirements and department-wide Quality Assurance program: Medicaid program integrity continues to be of high interest from funding agencies, including the federal government and the Department. Review and audit of federal and state programs is anticipated to increase. Efforts are underway to evaluate resources, workflow alignment, and management structure to produce a comprehensive Program Integrity operation that is efficient and effective.

Deferred Maintenance: DHSS has responsibility for an aging infrastructure to support our public health centers and 24-hour facilities, including Youth Facilities and Pioneer Homes. It is critical that deferred maintenance requirements and funding is provided so that these critical facilities can continue to have a useful life.

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 three residents. This coupled with the fact that the active and inactive waitlists continue to grow cause the need for renovations and expansions at pioneer homes to address the growth and change in Alaska's aging population. 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.

Ketchikan Pioneer Home Grease Trap Replacement:

This is a sample of how plumbing has deteriorated in some of the older facilities. The pioneer homes operate 24 hours a day. Replacing plumbing requires tremendous coordination in order not to interrupt services for the residents.



FY2013 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2013 Governor's Request for <u>Departmental Support Services</u> General and Other Funds (Increase, Decrease and OTI Items Only)					
Item	UGF	DGF	Federal	Other	Total
Establish Rural Information Technology Support Program	\$ 427.5	\$ -	\$ 183.0	\$ -	\$ 610.5
MH Trust: Workforce Dev - Grant 2347.04 Workforce Development Coordinator	\$ -	\$ -	\$ -	\$ 115.0	\$ 115.0
Reverse August FY2012 Fuel/Utility Cost Increase Funding Distribution from the Office of the Governor	\$ (109.0)	\$ -	\$ -	\$ -	\$ (109.0)
Reverse FY2012 Mental Health Trust Recommendation	\$ -	\$ -	\$ -	\$ (115.0)	\$ (115.0)
Reverse Medicaid School Based Administrative Claims Program Operating Costs Sec 15(c)(1) CH3 FSSLA2011 P74 L1 (HB108)	\$ -	\$ -	\$ (215.0)	\$ -	\$ (215.0)
Reverse Medicaid School Based Administrative Claims Program Sec 15(c)(2) CH3 FSSLA2011 P74 L3 (HB108)	\$ -	\$ -	\$ (5,328.8)	\$ -	\$ (5,328.8)
Departmental Support Services Total	\$ 318.5	\$ -	\$ (5,360.8)	\$ -	\$ (5,042.3)

Appendices

RDU/Component Listing FY2013

Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Alaska Pioneer Homes	Pioneers Homes Advisory Board
Behavioral Health	AK Fetal Alcohol Syndrome Program
Behavioral Health	Alcohol Safety Action Program (ASAP)
Behavioral Health	Behavioral Health Medicaid Services
Behavioral Health	Behavioral Health Grants
Behavioral Health	Behavioral Health Administration
Behavioral Health	Community Action Prevention & Intervention Grants
Behavioral Health	Rural Services and Suicide Prevention
Behavioral Health	Psychiatric Emergency Services
Behavioral Health	Services to the Seriously Mentally Ill
Behavioral Health	Designated Evaluation and Treatment
Behavioral Health	Services for Severely Emotionally Disturbed Youth
Behavioral Health	Alaska Psychiatric Institute
Behavioral Health	Alaska Psychiatric Institute Advisory Board
Behavioral Health	AK Mental Health Board & Advisory Board on Alcohol & Drug Abuse
Behavioral Health	Suicide Prevention Council
Children's Services	Children's Medicaid Services
Children's Services	Children's Services Management
Children's Services	Children's Services Training
Children's Services	Front Line Social Workers
Children's Services	Family Preservation
Children's Services	Foster Care Base Rate
Children's Services	Foster Care Augmented Rate
Children's Services	Foster Care Special Need
Children's Services	Subsidized Adoptions & Guardianship
Children's Services	Residential Child Care
Children's Services	Infant Learning Program Grants
Children's Services	Children's Trust Programs
Health Care Services	Adult Preventative Dental Medicaid Svcs
Health Care Services	Medicaid Services
Health Care Services	Catastrophic and Chronic Illness Assistance
Health Care Services	Health Facilities Survey
Health Care Services	Medical Assistance Administration
Health Care Services	Rate Review
Health Care Services	Health Planning and Infrastructure

Health Care Services

Juvenile Justice

Juvenile Justice

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Senior and Disabilities Services

Departmental Support Services

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

Governor's Council on Disabilities and Special
Education

Public Affairs

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)

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
ACA	Affordable Care ACT (aka PPACA - Patient Protection Affordable Care Act)
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
AG	Attorney General
AI/AN	American Indian/Alaska Native
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
ALH	Assisted Living Home
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
 APSIN.....Alaska Public Safety Information Network
 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
 BCP.....Background Check Program
 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 Centers for Disease Control and Prevention
 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 Centers for Medicare & Medicaid Services
 CNA.....Certified Nurse Aide
 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

DEC.....Department of Environmental Conservation
 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
 HIT.....Healthy Information Technology
 HIFA.....Health Insurance Flexibility and Accountability
 HIPPP.....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
 ICCIS.....Integrated Child Care Information System
 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
ISP.....	Individual Service Provider
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
KPYF.....	Kenai Peninsula Youth Facility
KRYF.....	Ketchikan Regional Youth Facility
LCSW	Licensed Certified Social Worker
LIHEAP	Low Income Home Energy Assistance Program
LTC	Long Term Care
MBU	Medicaid Budget Unit
MCAC.....	Medicaid Care and Advisory Committee
MCFH	Maternal, Child & Family Health
MCH	Maternal, Child Health (Block Grant)
MDS.....	Minimum Data Set
MH	Mental Health
MHDD	Mental Health and Developmental Disabilities
MHSIP	Mental Health Statistics Improvement Project
MHTAAR	Mental Health Trust Authority Authorized Receipts
MI.....	Motivational Interviewing
MIS	Management Information System
MMIS.....	Medicaid Management Information System
MMIS-JUCE.....	MMIS – Juneau Claims and Eligibility System
MOA	Municipality of Anchorage or Memorandum of Agreement
MOE.....	Maintenance of Effort
MRDD.....	Mental Retardation/Developmental Disability (Waiver)
MSYF.....	Mat-Su Youth Facility
MYC	McLaughlin Youth Center

NEMT.....Non-Emergency Transportation
 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
 NSOR.....National Sex Offender Registry
 NTSS.....Nutrition, Transportation and Support Services
 NYF.....Nome Youth Facility
 OA.....Older Alaskans (Waiver)
 OAA.....Older Alaskan’s Act
 OASIS Outcome & Assessment Information Set
 OCS.....Office of Children’s Services
 OEP Office of Emergency Preparedness
 OIG.....Office of Inspector General (Federal)
 OLTCO..... Office of Long Term Care Ombudsman
 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
 PCMH Patient Centered Medical Home
 PCN.....Position Control Number
 PCO.....Primary Care Office
 PCSA.....Protection, Community Services, and Administration
 PCW.....Personal Care Worker
 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
RCCF	Residential Child Care Facilities
RCSC.....	Real Choice System for Change
RDT.....	Residential Diagnostic Treatment
RBRVS	Resource-Based Relative Value Scale
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