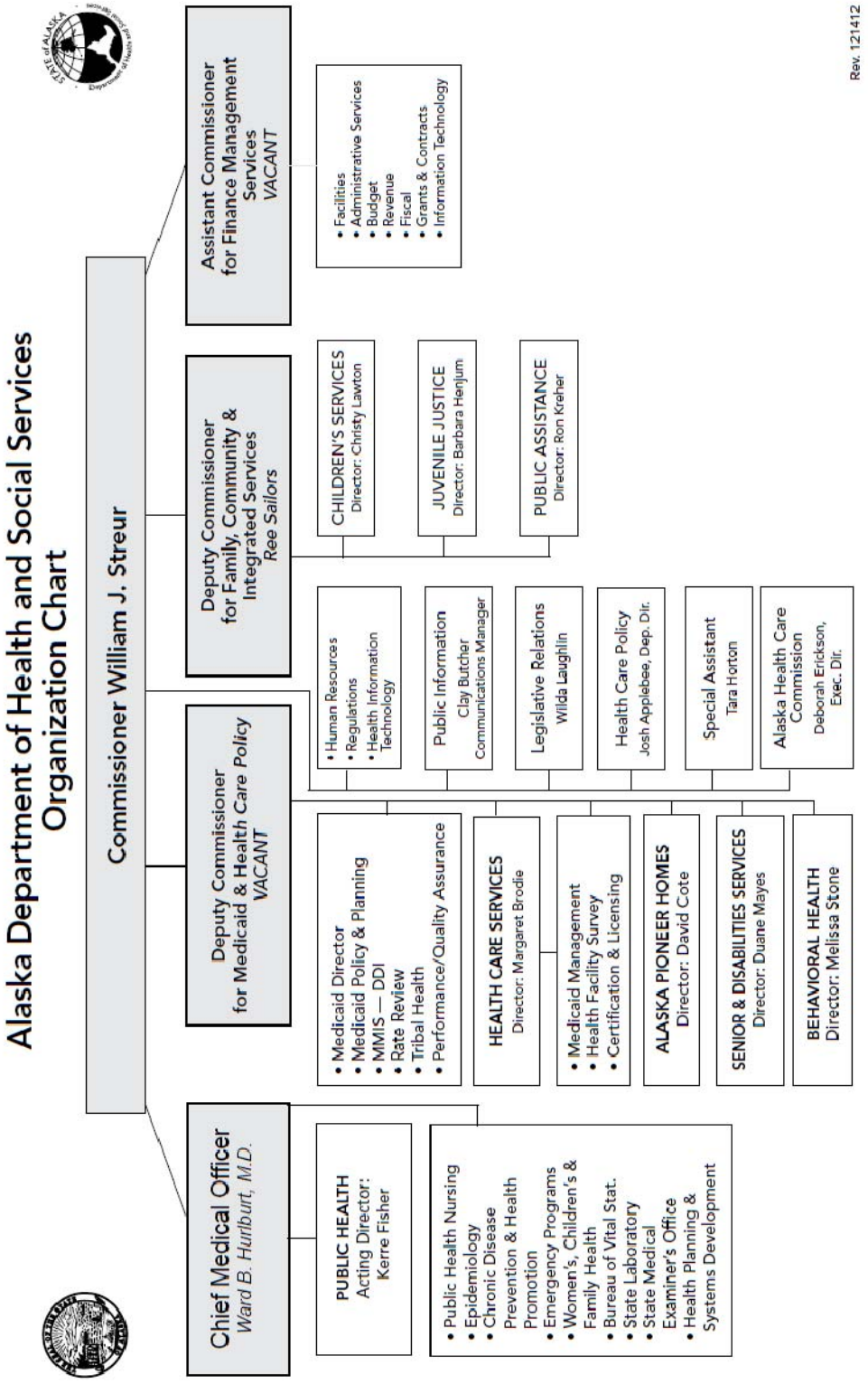
State of Alaska
Department of Health & Social Services

Fiscal Year 2014 Budget Overview

Governor Sean Parnell, State of Alaska

Commissioner Bill Streur, Department of Health & Social Services

Department of Health and Social Services



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.

Vision

Alaskan individuals, families and communities are safe and healthy.

Service Philosophy

Deliver the right care to the right person at the right time for the right price.

Department-Level Objectives

- Integrate and coordinate services.
- Strategically leverage technology.
- Implement sound policy.
- Practice fiscal responsibility.
- Measure and improve performance.

Core Services

- Protect and promote the health of Alaskans.
- Provide quality of life in a safe living environment for Alaskans.
- Manage health care coverage for Alaskans in need.
- Facilitate access to affordable health care for Alaskans.
- Strengthen Alaskan families.
- Protect vulnerable Alaskans.
- Promote personal responsibility and accountable decisions by Alaskans.

Department Priorities

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how DHSS measures the impact on the health and well-being of Alaskan individuals, families and communities. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to

cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

The new department priorities for FY2013 are:

- Health and Wellness Across the Lifespan
- Health Care Access, Delivery and Value
- Safe and Responsible Individuals, Families and Communities

Major Accomplishments in FY2012

HEALTH AND WELLNESS ACROSS THE LIFESPAN

- The Obesity Prevention and Control Program launched a social marketing campaign - "Play Every Day." Nearly 7,000 students in 110 schools completed a physical activity challenge that was launched in partnership with Healthy Futures.
- US Administration on Aging awarded Alaska a three-year grant for $1 million to develop and operate a Elder Services Case Management section focused on evidence based case management model. This was one of only eight awards in the U.S.
- Served 578 Alaska seniors and veterans in the Pioneer Home system.
- The Division of Juvenile Justice has developed a partnership with the Division of Behavioral Health and the Mental Health Trust Authority as well as other organizations to work on the Comprehensive Mental Health Integrated Plan for the department. This work continues.
- Provided radiation health support during the Fukushima Daiichi nuclear disaster. The Laboratory Radiation Specialist and laboratory response staff provided factual, scientific information for public reporting and real-time monitoring of radiation data.

HEALTH CARE ACCESS, DELIVERY, AND VALUE

- Alaska's public health nurses provided approximately 75,000 health care visits in FY2012; more than 45,000 of these were to children and youth ages birth to 19 years.
- The Aging and Disability Resource Centers have expanded to four regions and served 10,367 individuals in FY2012. The Aging and Disability Resource Centers are part of the division's effort to help people more easily access the long-term services and supports available in their communities. The Aging and Disability Resource Centers specialists counsel callers and visitors on long-term supports that fit their circumstances. These supports include transportation, assistive technology, or in-home care.
- The Division of Behavioral Health implemented the Integrated Behavioral Health Services Regulations on October 1, 2011. A full systems implementation occurred on December 1, 2011. This created a single set of Behavioral Health reimbursement rates for Medicaid Services and a single set of service guidelines for mental health, substance abuse, and co-occurring disorders.
- Thirty new community-based mental health programs have been developed statewide to provide home-based family services, community and school-based treatment services and develop rural treatment resource homes.

- Served more than 6,700 Medicare beneficiaries in Alaska with complex one-on-one counseling. In addition to personalized counseling, provided education and outreach to Medicare beneficiaries and their families as well as educated beneficiaries and others on how to spot and report potential Medicare errors, fraud, waste, and abuse. For 93% of the contacts, it was their first contact with the program. 42% of the contacts involved Medicare Prescription Drug benefits questions and 25.8% of the contacts raised questions that involved plan comparisons.

- The U.S. Department of Agriculture awarded Alaska a performance bonus award for best in the nation for State Nutrition Action Plan payment accuracy and second overall for accurate case closures and application denials in FFY2011. The two bonuses totaled $562,113,000.

- Health Care Services implemented a state maximum allowable cost pricing type for pharmaceuticals that yielded nearly $5 million in savings. Additional efforts by Health Care Services have resulted in a greater utilization of lower cost, clinically equivalent, generic medications. At the beginning of FY2012 only 70.5% of prescriptions for Medicaid recipients were for generic medications; the use of generic medications steadily increased to 75.5% at the end of FY2012.

- As mandated by the federal Patient Protection and Affordable Care Act, and amended by the Health Care and Education Reconciliation Act of 2010, Health Care Services completed enrollment of rendering providers employed by Federally Qualified Health Centers, Rural Health Clinics, and tribal health clinics. In accordance with state regulations, Health Care Services also concluded efforts enrolling individuals employed as Personal Care Assistants as rendering providers. This will allow Health Care Services to identify the individual providing personal care service and ensure that he/she has been properly credentialed. It will also assist in identifying patterns of fraud, waste, or abuse.

- Implemented a new training model for the Division of Public Assistance that will provide the line staff with training in all programs in 12 weeks; the former training program took almost two years for learners to complete. The new model has line staff completing training in all major public assistance programs faster and allows them to take on an equitable workload soon after completion of training.

- Successfully utilized the Alaska Respond program for electronic registration of volunteer health professionals for disaster assignments in Alaska Shield 2012. A total of 26 trainings were conducted and over 75% of healthcare facilities participated in the Alaska Respond Conference.

- IT support for our rural offices has been inadequate and emergency based. Through the support of the Department, the Governor's Office, and the Legislature, additional operating budget funding was secured to improve the IT environment at each of our offices.

SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

- Domestic Violence and Sexual Assault Rural Pilot Project grants were awarded in February 2011. Four communities received these grants as part of the Governor's Domestic Violence and Sexual Assault Initiative. Communities receiving grants are Dillingham, Bethel, Kodiak, and Sitka. The grant programs continued into FY2012 with one implementation grant awarded at $800,000 (Dillingham) and three building capacity grants awarded at $200,000 each for Bethel, Kodiak, and Sitka. Key accomplishments in FY2012 include the completion of three additional regional service area Alaska Victimization Surveys in Sitka, Bethel, and Kodiak. Additionally, a statewide initiative to implement the Green Dot By-Stander participation program; the continuation of Undoing Racism training in Bethel; and a number of youth leadership programs in Bethel, Kodiak, Dillingham and Sitka occurred. The four programs also met to begin mapping three shared measurements: (1) increased youth participation in activities to reduce domestic violence and sexual assault; (2) enhanced local victim and family services; and (3) changed public norms and acceptance of domestic violence and sexual assault.

- The Statewide Suicide Prevention Council launched a three-year pilot program offering evidence-based suicide prevention training to high school teachers, administrators, and staff in September 2012. This training, Kognito At-Risk, is a nationally recognized training and is made available at no charge to teachers and school districts, due to state support of the pilot.

- The Quality Assurance Unit of the Division of Juvenile Justice has grown into a vital and energetic entity with the division's State Office section. It is providing the division with a capability for continual self-assessment and timely address of service gaps.

Key Department Challenges

The Department of Health and Social Services continues to focus on the following overall objectives:

- Integrate and coordinate services.
- Strategically leverage technology.
- Implement sound policy.
- Practice fiscal responsibility.
- Measure and improve performance.

Some of the Department's challenges, categorized under the new FY2013 priorities, are listed below.

HEALTH AND WELLNESS ACROSS THE LIFESPAN

- Managing quality assisted living services for a rapidly expanding aging population with increasingly complicated and difficult health care needs and behaviors, and doing so within limited resources.

- As the Division of Public Health (DPH) 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. The fight against chronic diseases is critical: three of every five deaths in Alaska are linked to chronic diseases. The primary risk factors for such diseases are obesity, poor diet, lack of exercise, and tobacco use. As federal funding shrinks for disease prevention and health promotion programs, a major challenge for the division is to continue its work to prevent chronic diseases and promote good health through better education efforts, especially the important fight to reverse or at least slow Alaska's growing and alarming rates of overweight and obesity. This makes sense financially because investments in a healthier Alaska now will save healthcare dollars in the years to come. Another major challenge is the fight against infectious disease, with new diseases discovered all the time and old scourges still lingering. In addition, there is an urgent and ever-present need in the division to assure an adequate public health nursing workforce around the state. These nurses are the "foot soldiers" of Alaska's public health system and deliver critical services in every corner of Alaska.

HEALTH CARE ACCESS, DELIVERY, AND VALUE

- A significant challenge continues to be the effective control of the Medicaid Management Information System project to ensure the strict adherence to development and implementation timeline. The Medicaid Management Information System is the engine that processes claims for the Medicaid program. Health Care Services processes 189,759 claims per week in our existing Common Business Oriented Language based legacy Medicaid Management Information System that is now 24 years old.

- In 2007, the department awarded a contract to Affiliated Computer Services, now Xerox, for a new Medicaid Management Information System, including design, development,

and implementation. The new Medicaid Management Information System, known as Alaska Medicaid Health Enterprise, was scheduled for an October 2012 implementation. Ongoing testing delays coupled with newly-found defects in Enterprise source code have caused the Alaska Medicaid Health Enterprise implementation to be delayed. Current estimates are for a FY2014 implementation. Xerox describes Alaska Medicaid Health Enterprise as a sophisticated, web-enabled solution for administering all Medicaid programs that will be available to providers and recipients who participate in the medical assistance programs. It will have features allowing users to access the system through a user-friendly web portal. This progressive Medicaid Management Information System will incorporate innovative features and advancements that will grow as health care services grow.

- 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%. Some fraction of this population requires significant assistance from the state, and will grow proportionately to the overall senior population. The current service provider capacity is insufficient to meet their care needs.

- Resolve outstanding audit findings, reduce exceptions and improve responsiveness to federal program and legislative auditors.

- The Affordable Care Act continues to present opportunities and challenges to all Medicaid Service programs, resulting from the limited amount of information being provided by the Federal government at this time. If Alaska implements the optional Medicaid expansion component, regulations, state plan amendments and benefit packages will need to be developed and claims, service authorizations, and other claims-related activities will need to be reviewed for capacity to accommodate the additional adults who would qualify.

SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

- 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 ist 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

- The Division of Juvenile Justice's aging youth facilities are becoming increasingly difficult to maintain as these buildings sustain hard use 24/7 in challenging climates, ranging from the cold arctic climate at the Bethel Facility to the damp Southeast climate at Juneau’s Johnson Youth Center. Severe overcrowding for probation staff remains a serious concern in most probation offices but especially in those offices co-located with a

Division of Juvenile Justice 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. The Fairbanks Youth Facility is plagued with structural and utilization problems that need to be addressed if this facility is to offer secure, safe services. The Johnson Youth Center was also plagued with structural and utilization problems, but with the current renovation near completion, these issues should be resolved.

- The goal to promote self-sufficiency by assisting individuals and families to move off public assistance and leave poverty through employment is difficult to achieve. Over 30% of Temporary Assistance families face significant challenges to self-reliance. These families require more intensive services.

- The Office of Children's Services struggles to:
  - Attract and retain qualified staff, particularly in rural office locations, that can meet the emotional and complex demands that are placed on them regardless of their workload.
  - Direct available funds to invest in prevention and in-home services to keep families intact and prevent them from entering the system.
  - Provide culturally relevant services in rural areas.
  - Adequately equip staff to work effectively, collaboratively, and sensitively with the 200+ Alaska Native Tribes where the culture is foreign and not well understood by staff.

Position Information

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

Direct Field Workers

118	Public Health Nurses
315	Protective Services Specialists
304	Eligibility Determination Staff
290	Youth Detention/Treatment Workers
90	Juvenile Probation Officers
254	API Staff
635	Pioneer Homes Staff
2,006	**TOTAL**

Program Support Services

117	Behavioral Health Programs
171	Senior and Disability Programs
384	Public Health Programs
184	Children's Services
126	Juvenile Programs
9	Facilities Management
373	Benefit Payments/Systems
1,364	**TOTAL**

Administrative/Management Support

122	Information Technology
155	All Other Centralized Admin/Mgmt
277	**TOTAL**

3,647 FY2014 GRAND TOTAL

The DHSS FY2014 Governor's request includes 3,647 positions. The details of positions' budgeted status and geographical location are shown in the chart below. Select types of employees (i.e. public health nurses, protective service specialists) may be budgeted in one location, but provide continual itinerant services to numerous surrounding smaller rural communities.

FY2014 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1,746	14	45	**1,805**
Aniak	2	0	0	**2**
Barrow	8	0	0	**8**
Bethel	100	0	3	**103**
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	12	**374**
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	561	17	26	**604**
Kenai	82	1	2	**85**
Ketchikan	119	9	10	**138**
King Salmon	2	0	0	**2**
Kodiak	15	0	0	**15**
Kotzebue	10	0	0	**10**
McGrath	2	0	0	**2**
Nome	45	0	2	**47**
Palmer	121	14	7	**142**
Petersburg	3	0	0	**3**
Saint Mary's	5	0	0	**5**
Seward	3	0	0	**3**
Sitka	99	1	4	**104**
Tok	2	0	0	**2**
Valdez	5	1	0	**6**
Wasilla	136	0	2	**138**
Wrangell	2	0	0	**2**
Totals	**3,470**	**64**	**113**	**3,647**

Explanation of FY2014 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 FY2014 Compared to FY2013

	FY2013 Management Plan	FY2014 Governor's Request
Unrestricted General Funds	$1,231.2 million	$1,244.2 million
Designated General Funds	74.1 million	74.8 million
Federal Funds	1,230.6 million	1,244.0 million
Other Funds	101.9 million	94.2 million
Total	**$2,637.8 million**	**$2,657.2 million**
Increased Federal Revenue		$13.4 million
Increased General Fund		$13.0 million *

** It should be noted that a one-time, multi-year appropriation of $9 million in general funds was appropriated for Behavioral Health Grants for FY2013 through FY2015. All one-time funding is removed from the base budget; therefore, this $9 million appears in the FY2013 Management Plan but not in the FY2014 Governor's Budget.*

The proposed budget for FY2014 increases general funds (GF) by $12,960.5. Some of the requested general fund increments include:

- Medicaid program growth ($11,001.4);
- Implementation of the social worker class study ($1,185.0);
- Child Abuse Prevention and Treatment Act integration ($1,500.0);
- Adult Public Assistance program growth ($2,244.0);
- General Relief Program growth ($1,140.0);
- Health Information Security/Privacy Compliance and Remediation ($595.0).

Each of the requested increments support the department's mission of promoting and protecting the health and well-being of Alaskans.

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. The eligibility standards and benefits must be based in statute.

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.

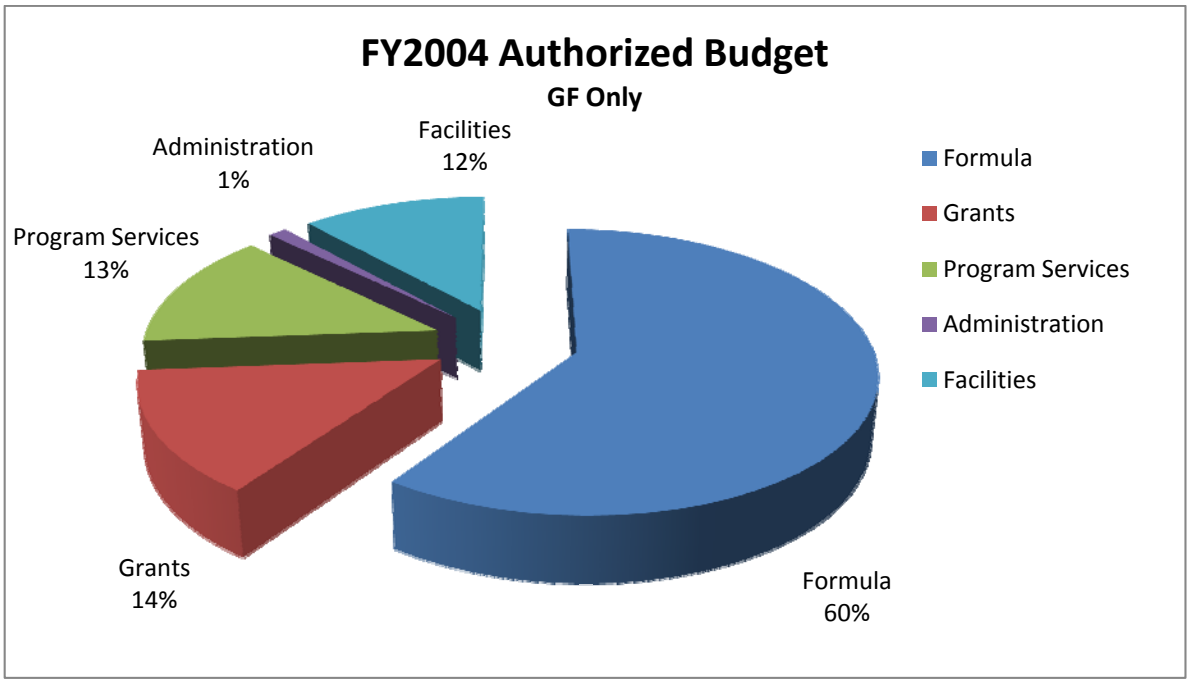
Budget Charts and Graphs

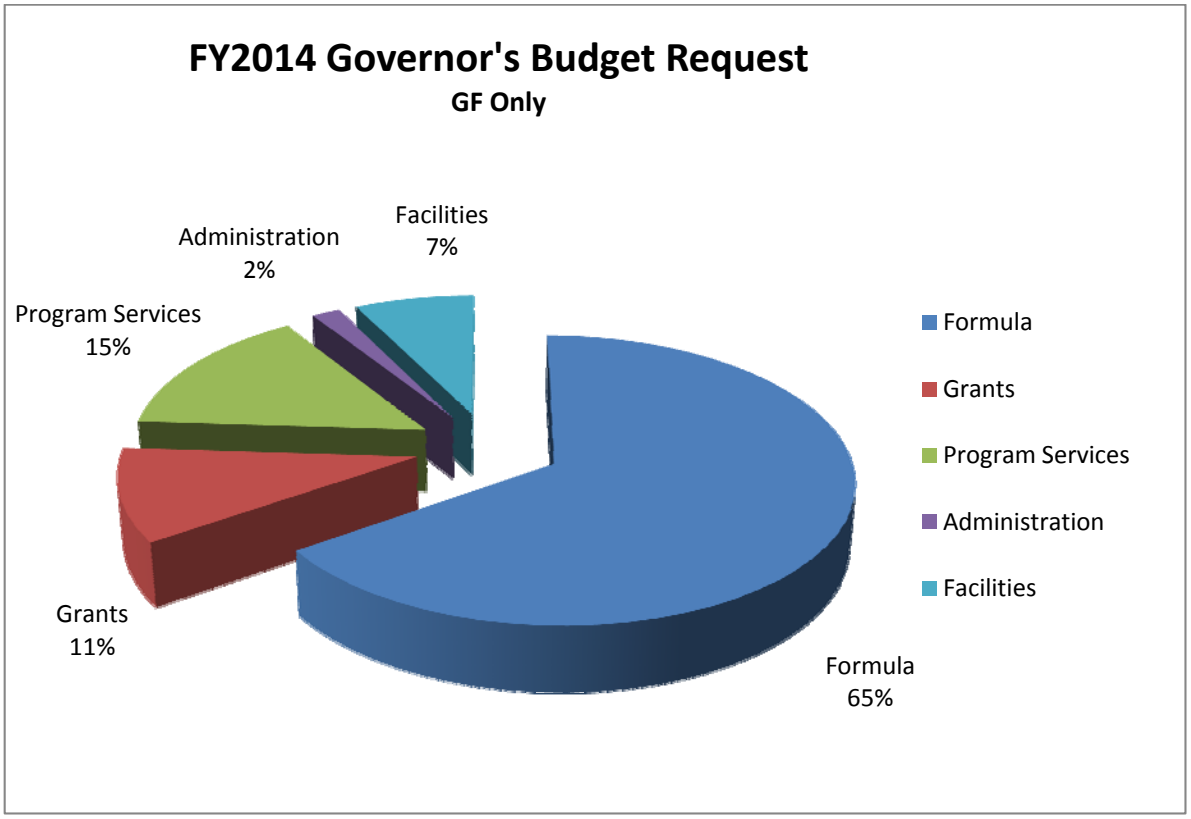
The table below shows the comparison of total funds for FY2004 and FY2014.

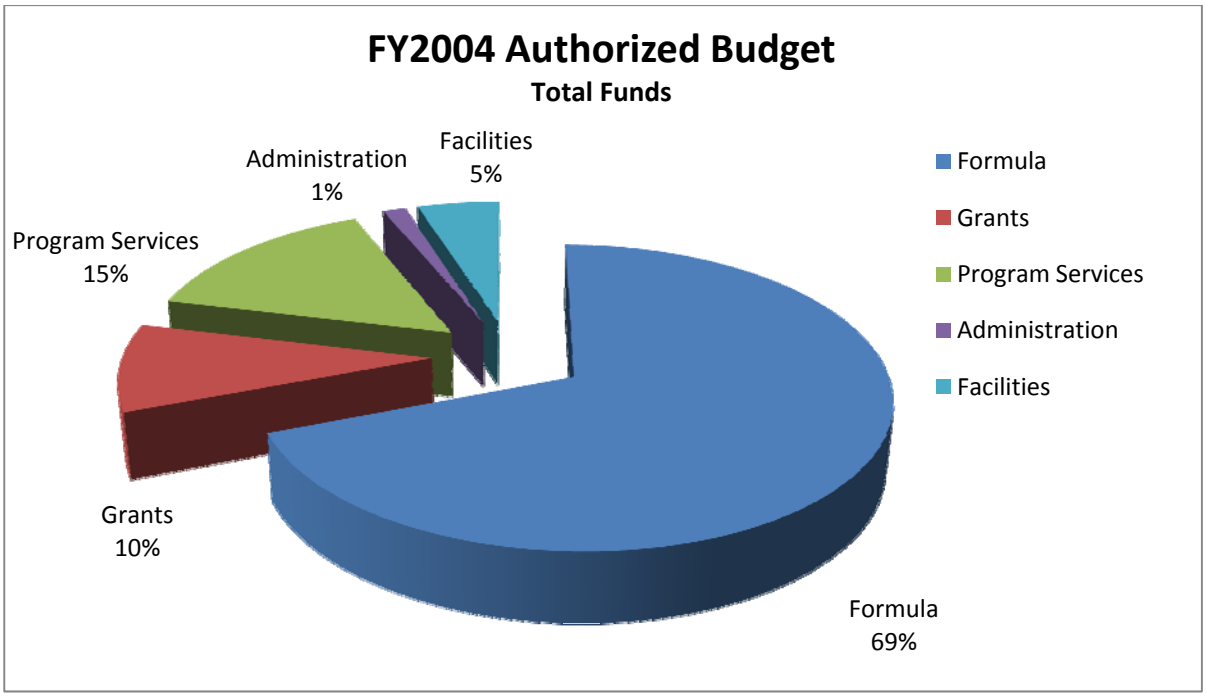
Department of Health and Social Services

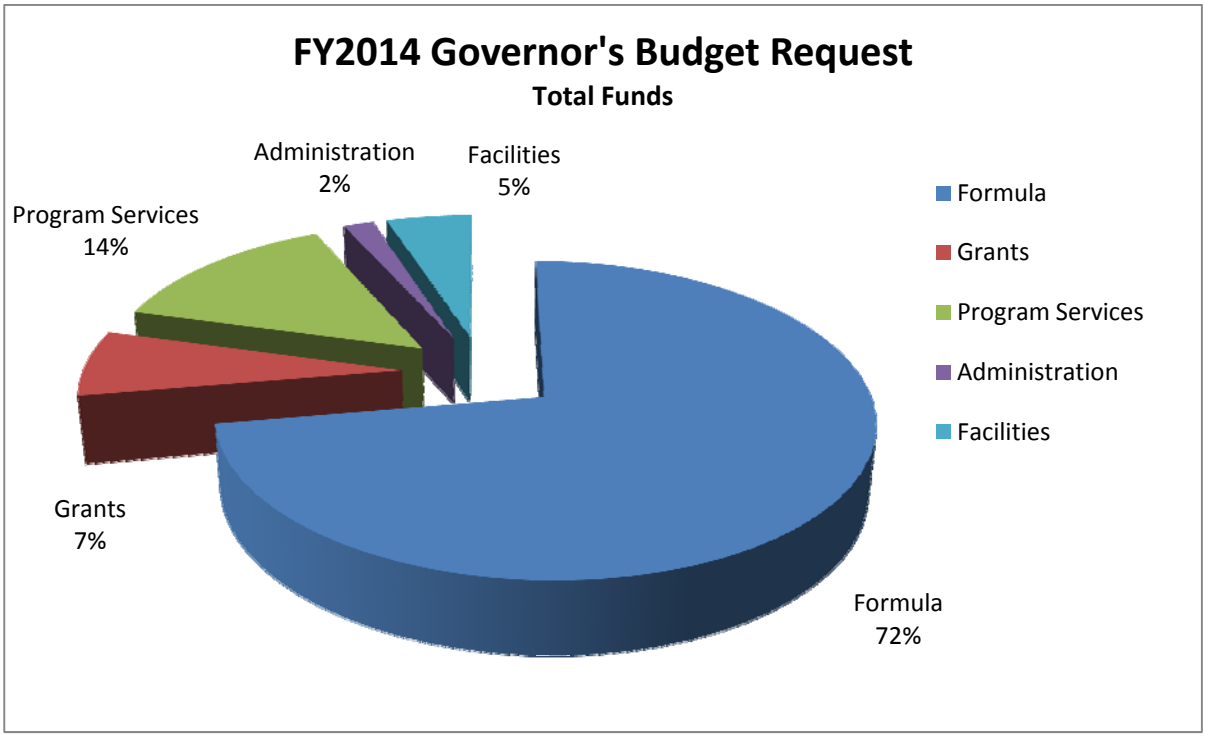
Expenditures by Category, FY2004-FY2014

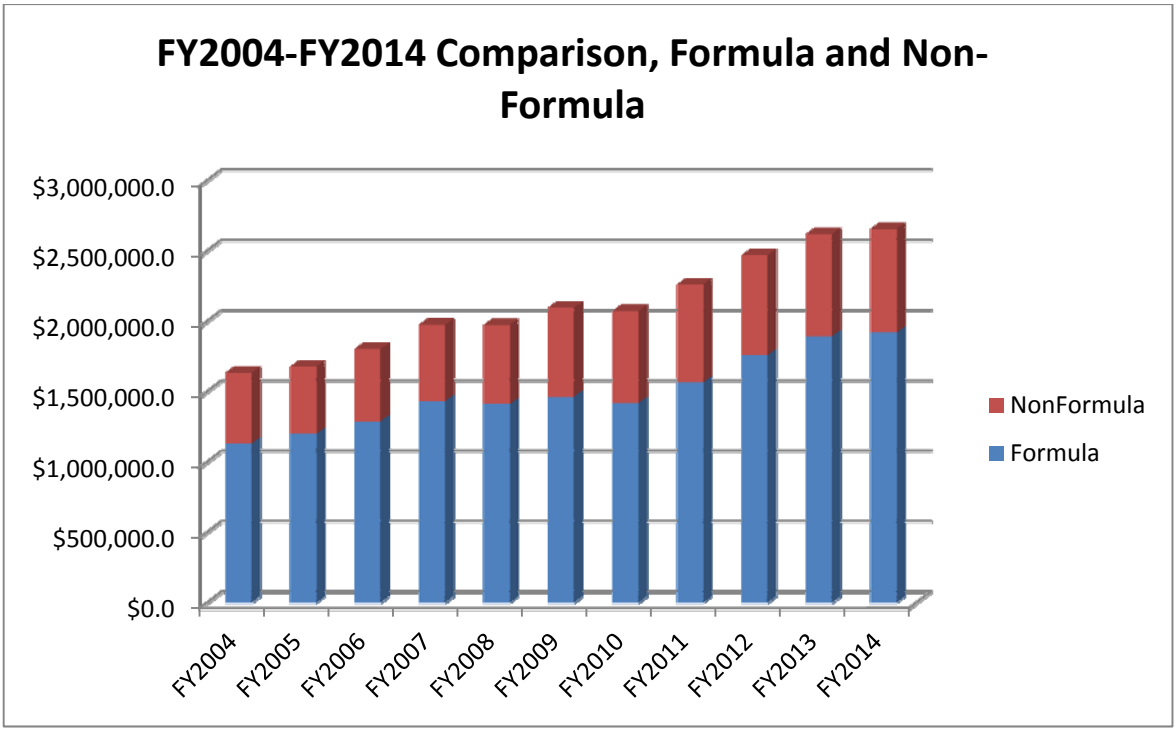
	FY2004 Authorized		FY2014 Governor's		
Category	**Total Funds**	**% of Total**	**Total Funds**	**% of Total**	**Change: FY04 to FY14**
Formula	$1,132,194.1	69%	$1,921,965.6	72%	170%
Grants	$156,842.7	10%	185,476.0	7%	118%
Program Services	244,214.8	15%	370,215.9	14%	152%
Administration	22,086.5	1%	46,565.2	2%	211%
Facilities	80,764.5	5%	133,033.1	5%	165%
Total	**$1,636,102.6**	100%	**$2,657,255.8**	100%	**162%**


FY2004 Authorized Budget
GF Only
Administration 1%
Facilities 12%
Program Services 13%
Grants 14%
Formula 60%
Formula
Grants
Program Services
Administration
Facilities


FY2014 Governor's Budget Request
GF Only
Administration 2%
Facilities 7%
Program Services 15%
Grants 11%
Formula 65%
Formula
Grants
Program Services
Administration
Facilities


FY2004 Authorized Budget
Total Funds
Administration 1%
Facilities 5%
Program Services 15%
Grants 10%
Formula 69%
Formula
Grants
Program Services
Administration
Facilities


FY2014 Governor's Budget Request
Total Funds
Administration 2%
Facilities 5%
Program Services 14%
Grants 7%
Formula 72%
Formula
Grants
Program Services
Administration
Facilities



Medicaid is the largest formula program in the department, totaling about 87% of the total formula program category in the proposed FY2014 budget.

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

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

Department Level Performance Measures

Priority Programs - Key Performance Indicators

PRIORITY I: HEALTH & WELLNESS ACROSS THE LIFESPAN		
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.		
OUTCOME 1. Alaskans are healthy.		
EFFECTIVENESS MEASURE:	Percent of Alaskans who demonstrate improved health status.*	DEPARTMENT (*Division Aggregate)
EFFICIENCY MEASURE:	Cost per percentage of improved health.*	
EFFECTIVENESS MEASURE:	Percent of Alaskans reporting very good/good health.	DEPARTMENT (DPH)
EFFICIENCY MEASURE:	Treatment costs per capita.	
OUTCOME 2. Alaskans are free from unintentional injury.		
EFFECTIVENESS MEASURE:	Number of Alaskans experiencing unintentional injuries.	DEPARTMENT (DPH)
EFFICIENCY MEASURE:	Cost of injury prevention program per capita.	
OUTCOME 3. Alaskans are free from substance abuse and dependency.		
EFFECTIVENESS MEASURE:	Percent of Alaskans discharged from substance abuse treatment services who successfully completed treatment.	DEPARTMENT (DBH)
EFFICIENCY MEASURE:	Cost of treatment per completion.	
EFFECTIVENESS MEASURE:	Rate of tobacco use by age group.	DEPARTMENT (DPH)
EFFICIENCY MEASURE:	Cost per capita of Tobacco Prevention & Control program.	
CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.		
OUTCOME 1. Alaskan children receiving department services live in a supportive setting.		
EFFECTIVENESS MEASURE:	Percent of children receiving department services who are safe and supported.*	DEPARTMENT (*Division Aggregate)
EFFICIENCY MEASURE:	Cost of services per child.*	
OUTCOME 2. Older Alaskans live safely in their communities		
EFFECTIVENESS MEASURE:	Number of months Long Term Services and Supports recipients are able to remain in their home before institutional placement.	DEPARTMENT (SDS)
EFFICIENCY MEASURE:	Average cost of Long Term Services and Supports per recipient.	
OUTCOME 3. Alaskans with disabilities live safely in the least restrictive environment.		
EFFECTIVENESS MEASURE:	Percent of Alaskans who are receiving community-based Long Term Services and Supports.	DEPARTMENT (SDS)
EFFICIENCY MEASURE:	Average cost for waiver eligible Alaskans who are living in ICFMR or Nursing Home vs. those who are living independently with Long Term Services & Supports.	
OUTCOME 4. Alaskans with behavioral issues report improvement in key life domains.		
EFFECTIVENESS MEASURE:	Percent of Behavioral Health clients who report improvement in quality of life between their initial Client Status Review and first subsequent review.	DEPARTMENT (DBH)
EFFICIENCY MEASURE:	Average cost of care for those who report improved quality of life vs. those who do not report improved quality of life.	
PRIORITY II: HEALTH CARE ACCESS, DELIVERY & VALUE		
CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.		
OUTCOME 1. Each Alaskan has a primary care provider.		
EFFECTIVENESS MEASURE:	Percent of individuals served by the department who have a primary care provider.*	DEPARTMENT (*Division Aggregate)

EFFICIENCY MEASURE:	Cost per recipient served by the department who has a primary care provider.*	
OUTCOME 2. Alaskans with chronic or complex medical conditions receive integrated care.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Number of Medicaid recipients empaneled in medical home. Cost per recipient in medical home vs. cost per recipient not enrolled in medical home.	DEPARTMENT (HCS)
EFFECTIVENESS MEASURE: EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of providers connected to the Health Information Exchange (HIE) for Directed Exchange. Percent of providers connected to the Health Information Exchange (HIE) for Query-Based Exchange. Cost per provider connected to the Health Information Exchange.	DEPARTMENT (HIT)
CORE SERVICE B. FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS.		
OUTCOME 1. Alaskans have access to health care.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of Alaskans in urban communities that can access care.* Department cost per percent of Alaskans with access to care.	DEPARTMENT (*Division Aggregate)
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of Alaskans in rural communities that can access care.* Department cost per percent of Alaskans with access to care.	DEPARTMENT (*Division Aggregate)

PRIORITY III: SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES		
CORE SERVICE A. STRENGTHEN ALASKAN FAMILIES.		
OUTCOME 1. Alaskan families develop work skills.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of individuals receiving employment related services from department who achieve employment. Cost of supported employment services per successful participant.	DEPARTMENT (*Division Aggregate)
OUTCOME 2. Alaskan families have safe and affordable child care.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of licensed child care facilities in Alaska. Average time to process a license application.	DEPARTMENT (DPA)
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of children in licensed facilities. Average cost of child care per hour per child provided in a licensed facility.	DEPARTMENT (DPA)
OUTCOME 3. Alaskan families have warm homes.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of low-income households that receive heating assistance. Average application cycle time.	DEPARTMENT (DPA)
OUTCOME 4. Alaskan families have food security.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE: EFFICIENCY MEASURE:	Percent of low-income Alaskans receiving supplemental nutrition benefits. Accuracy rate for initial eligibility determinations. Initial application cycle time.	DEPARTMENT (DPA)
CORE SERVICE B. PROTECT VULNERABLE ALASKANS.		
OUTCOME 1. Alaskan children at risk of maltreatment are protected from abuse and neglect.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE: EFFICIENCY MEASURE:	Percent of Alaskan children with substantiated reports of abuse or neglect. Average time to initiate an investigation. Percent of safety assessments concluded within required timeframes.	DEPARTMENT (OCS)

EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Number of children in foster care who achieve or maintain permanency within required timeframes. Percent of children who re-enter care within six months.	DEPARTMENT (OCS)
OUTCOME 2. Alaskan adults at risk of maltreatment are protected from abuse, neglect and exploitation.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE: EFFICIENCY MEASURE:	Percent of Alaskan adults with substantiated reports of abuse or neglect. Average time to initiate an investigation. Percent of safety assessments concluded within required timeframes.	DEPARTMENT (SDS)
OUTCOME 3. Health and social service facilities in which Alaskans are served are safe.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE: EFFICIENCY MEASURE:	Percent of licensed facilities that are free from reports of harm.* Cost for licensure functions and oversight.* Percent of time that enforcement action is taken within required timeframe. *	DEPARTMENT (*Division Aggregate)
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE: EFFICIENCY MEASURE:	Percent of background checks completed within established timeframes. Cost of administering background check program. Average time to complete final determination.	DEPARTMENT (HCS)
CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.		
OUTCOME 1. Alaskan communities support tobacco enforcement.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Incidence of under-age smoking. Cost of Tobacco Prevention and Control program per capita.	DEPARTMENT (DPH)
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Vendor compliance rate with laws regulating the sale of tobacco products to youth (i.e., based on Syntar retailer violation rate). Percent of youth-accessible tobacco vendors that receive an educational visit from Tobacco Enforcement staff.	DEPARTMENT (DBH)
OUTCOME 2. Juveniles develop and demonstrate skills in positive decision making.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Rate of recidivism for juveniles receiving services from the department. Cost of services per number of juveniles served.	DEPARTMENT (DJJ)
OUTCOME 3. Alaskans with health conditions practice self-management.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of clients with chronic disease enrolled in self-management programs. Cost per client for self-management services.	DEPARTMENT (DPH/DBH)
OUTCOME 4. Alaskans choose respect.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Rate of Domestic Violence/Interpersonal Violence referrals to community services.* Number of clients screened for Domestic Violence/Interpersonal Violence.*	DEPARTMENT (*Division Aggregate)
OUTCOME 5. Communities prepare for disaster.		
EFFECTIVENESS MEASURE: EFFICIENCY MEASURE:	Percent of Alaskan communities that participated in at least one disaster preparedness activity during state fiscal year. Cost for disaster preparedness training per participant.	DEPARTMENT (DPH)

FY2014 Capital Project Requests

Capital		FY2014 Capital Funding Request (In thousands)			
DHSS Division	***Project Titles***	***GF***	***Fed***	***Other***	***Total***
DSS/Juvenile Justice	Bethel Youth Facility Expansion, Phase 2	10,600.0			10,600.0
DSS/Health Care Services	Master Client Index, State Interface Improvements to the Health Information and Direct Secure Messaging Gateway	2,411.0	3,338.7		5,749.7
DSS/Health Care Services	Transition of Care Pilot Project	104.0	936.0		1,040.0
DSS/Health Care Services	Personal Care Assistant Pilot Project	104.0	936.0		1,040.0
DSS/Public Health	Electronic Vital Record Registration System Phase 2 of 2	1,785.0			1,785.0
DSS/Pioneer Homes	Alaska Veterans and Pioneer Home Resident Lifts	212.0			212.0
DSS/Juvenile Justice	Equipment Needs for Front Line Probation Officers, Juvenile Justice Officers, and Facilities and Probation Offices	267.5			267.5
DSS/ Children's Services	LiveScan Fingerprinting	135.2			135.2
DSS/Pioneer Homes	Juneau Pioneer Home Security Cameras	106.0			106.0
DSS/IT	Department-Wide Disaster Recovery	805.8			805.8
DSS/Health Care Services	Electronic Health Record Incentive Payments		30,187.5		30,187.5
DSS/Public Health	Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue	450.0			450.0
DSS/Public Health, Juvenile Justice, Behavioral Health	Deferred Maintenance, Renewal, Repair, and Equipment – Non-Pioneer Homes	2,902.8			2,902.8
DSS/Pioneer Homes	Deferred Maintenance, Renewal, Repair, and Equipment – Pioneer	3,871.2			3,871.2

	Homes				
DSS	MH – Medical Appliances for Beneficiaries Experiencing Sensory Impairments*	500.0			500.0
DSS	MH – Implementation of Replacement Grant System *	700.0			700.0
DSS	MH – Deferred Maintenance and Accessibility Improvements*	1,000.0			1,000.0
DSS	MH – Home Modification and Upgrades to Retain Housing*	750.0		300.0	1,050.0
Capital Budget Totals		**26,704.5**	**35,398.2**	**300.0**	***62,402.7***

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

Major Capital Projects

Brief Description of Major Projects:

Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $3,871.2 Total -- $3,871.2 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 $334 million.

Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $2,902.8 Total -- $2,902.8 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 $368 million.

Bethel Youth Facility Renovation Phase 2 of 2: $10,600.0 Total -- $10,600.0 GF

Bethel Youth Facility requires extensive renovation and construction. This capital request will provide funding for the completion of the project. The construction work will consist of building four new detention beds for a total of twelve detention beds, upgrading the existing treatment beds, providing additional probation space and expanded medical space, constructing a vehicle sally port, a small gymnasium, and a secure outdoor recreation area.

EMS – Match for Code Blue: $450.0 Total -- $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.

MH Home Modification and Upgrades to Retain Housing: $1,050.0 Total -- $750.0 GF/MH, $300.0 MHTAAR

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 Deferred Maintenance and Accessibility Improvements: $1,000.0 Total -- $1,000.0 GF/MH

Capital grant funds offered competitively to providers serving Alaska Mental Health Trust beneficiaries will be awarded statewide to agencies on a competitive basis for deferred maintenance, including facility renovation and repair, energy efficiency upgrades, and accessibility improvements. This project contributes to the department's mission "To promote and protect the health and well-being of Alaskans". The funds are needed to keep program facilities operational and accessible.

Master Client Index, State Interface Improvements to the Health Information and Direct Secure Messaging Gateway: $5,749.7 Total -- $3,338.7 Fed, $2,411.0 GF

This project covers the post implementation services required to operate the Health Information Gateway or Exchange. This includes general hosting requirements in operating software as a service; proactive service monitoring and management infrastructure; provision of back-up systems and development of corrective action plans in event of service outages or failures. This project will also encompass the prioritization, updating, and modifications needed to a state system, such as the Master Client Index to successfully integrate data to the Health Information Gateway to meet Centers for Medicare and Medicaid Services' and Office of the National Coordinator's meaningful use and security requirements.

Electronic Vital Record Registration System Phase 2 of 2: $1,785.0 Total -- $1,785.0 GF

The information system currently supporting registration of births, deaths, marriages, and divorces in Alaska is more than 20 years old. The system is based on computer technologies no longer supported by modern operating systems. This is Phase 2 of 2.

Alaska Pioneer Homes Summary

The Alaska Pioneer Homes provides residential assisted living and pharmaceutical services to Alaskan seniors sixty-five or older who are residing in the six statewide Pioneer Homes, including the Alaska Veterans and Pioneer Home. The services are designed to maximize independence and quality of life by addressing the physical, emotional, and spiritual needs of residents, many who have acute medical needs or dementia.

Applicants for a Pioneer Home are frequently not seeking the services of a Pioneer Home until they are much older and their needs are more acute. As a result, the majority of applicants are found to need Level III service.

The Pioneer Homes have been experiencing an increase in the number of residents who exhibit out of control or assaultive behavior. These residents require additional staff to keep the other residents safe.

Recruiting and retaining qualified health care personnel has been an ongoing challenge in some Pioneer Home locations.

Documentation requirements for Medicaid and the Medicaid Waiver, the Veterans Administration, Occupational Safety and Health Administration, and licensing continue to be a challenge and keep staff from providing direct care to residents.

We continue to move toward meeting the Veterans Administration and Pioneer Home goal of 75% or 59 beds occupied by veterans in the Alaska Veterans and Pioneer Home in Palmer. There were 41 veterans in the Home as of 10/31/2012.

The Alaska Pioneer Homes provide compassionate direct care for vulnerable seniors. We support the core services of protecting and promoting the health of Alaskans and managing health care coverage for Alaskans in need to keep Alaskan Pioneer Home residents healthy.

Division of Behavioral Health Summary

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 behavioral health (mental health and substance use disorder) services. The array of behavioral health services crosses the lifespan of individuals in Alaska, and range from prevention and early intervention through treatment, including inpatient psychiatric hospitalization. Settings include clinic or community-based outpatient services, school-based programs, residential programs and hospital services. Services are provided in bush villages, rural and urban communities, and regional centers throughout the state.

There is a deepening crisis in Anchorage and statewide due to the freeze in subsidized housing vouchers through Alaska Housing Finance Corporation. The Division has four increments that address this challenge. They include: $100.0 GF and $100.0 one-time only MHTAAR for training of caregivers in Assisted Living Homes; $225.0 one-time only MHTAAR for two existing staff positions whose efforts are dedicated to housing issues; $200.0 GF and $750.0 one-time only MHTAAR for the Bridge Home program which is a "housing first" model of intervention and care with persons having extensive histories of inpatient psychiatric care and the jail system; and $200.0 GF and $100.0 one-time only MHTAAR for a program run in conjunction with the Department of Corrections to provide housing incentives for persons recently released from the correctional system.

The Bring the Kids Home Initiative is transitioning from the "active-execution" to "benefits gained" phase. The goal is to sustain the forward progress achieved by this successful endeavor and integrate the BTKH initiative with the regular business and clinical practices of the children's treatment system to support in-state expansion and a focus on treatment of the whole family together. The FY2014 budget includes two increments to address continuing mental health and substance use disorder treatment needs for children and their families: a one-time only $200.0 MHTAAR increment for transitional age projects to help young adolescents with normal life-cycle tasks and a $270.0 GF/MH and $400.0 one-time only MHTAAR increment to expand on family-based treatment services. At any given time, children/youth comprise approximately 25% of all clients receiving clinic and rehabilitation services. However, the majority of services delivered target the child/youth separately from their families. Family systems theory recognizes and values the role and impact families have on children/youth with mental health and substance use disorders. The increment will address this gap and build on the potential for good treatment outcomes for children and their families.

Insuring access to appropriate services is a complex challenge. To help meet this challenge, the Division recognizes the value of providing resources to Alaskans in rural communities to assist with access to care. Two related increments are included in the budget: $100.0 GF and $100.0 federal for expansion of telehealth resources and $50.0 GF for Alaska 2-1-1 which is an information and referral system for health and human services resources throughout Alaska. The Division continues to refine a performance management system to insure an efficient, equitable, and effective system of behavioral health care for Alaskans. These refinements include the continuation of a pilot behavioral health survey of clients measuring their levels of recovery at four month intervals up to one year after treatment. A one-time $119.2 MHTAAR increment is included in the budget for this project.

The landscape of behavioral health service delivery is becoming more integrated and coordinated. The Division has an opportunity to enter into a contract with the U.S. Food and Drug Administration to conduct compliance investigations to ensure that the tobacco vendors are not selling tobacco products to persons under 19 years of age. A $650.0 federal increment is included in the budget for this project.

The Telehealth Expansion and Alaska 2-1-1 increments support the DHSS Core Service Priority II: Health care access, delivery and value.

The Tobacco Enforcement increment ties directly to the DHSS Core Service Priority III: Safe and Responsible Individuals, families and communities / Core Service D: Hold Alaskans accountable for responsible behavior.

The Housing increments relate to DHSS Priority I: Health and wellness across the lifespan / Core Service B: Provide quality of life in a safe living environment for Alaskans.
The Behavioral Health Survey of clients measuring their level of recovery provides a measure for Outcome 3: Alaskans are free from substance abuse dependency under Priority I, Core Service A: Protect and promote the health of Alaskans.

Office of Children's Services Summary

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 through a variety of ways: Office of Children's Services works to prevent and remedy child abuse and neglect through early intervention and treatment services, standardized screening of alleged maltreatment, thorough assessments of family functioning to identify present or impending danger, delivery of services to children and families as appropriate, development of permanency plans for children in out-of-home placements that promotes reunification wherever possible, and the recruitment and retention of resource families who are equipped to provide short and long-term care for children in need of an out-of-home placement.

The most significant operational challenge the Office of Children's Services faces is the recruitment and retention of front line caseworker staff. Child Protective Services (CPS) is the toughest, most complex, and emotionally-demanding vocation within the social services arena. The job demands workers serve as; pseudo police officers, therapists, coaches, parent skill trainers, legal aides, substance abuse experts, domestic violence advocates, job counselors, play therapists, and be absolutely skilled in computer technology and interpersonal communications with *all people and all times*. The Office of Children's Services sends lone Child Protective Services workers to areas or homes where law enforcement would never travel, without weapons in hand, or back up close by within both urban and remote locations. In rural locations, workers face challenges of inadequate housing availability, extreme temperatures, and extremely challenging travel by boat, snow machine, and small aircrafts to do their job. Across the state, fatigue and vicarious trauma lead to high turnover and vacancy rates among front-line caseworkers. Rather than being among the most highly lauded, and recognized professional groups; the reality is the workers work in an agency that is either vilified for removing a child or characterized as inept or "broken". Our social worker class study implementation increment addresses part of this need by resolving some pay issues around like pay for like work that increases the equality of pay. The results of this class study were implemented by human resources beginning July 1, 2012. Our social worker class study implementation increment crosses most, if not all, of our performance measures as better staff recruitment and retention will assist with everything we do.

In the coming fiscal year the Office of Children's Services will be facing added challenges and opportunities for growth through the settlement of several lawsuits as well as through mandates provided by the federal government. By and large, all of these new and upcoming changes are positive and are what families deserve. However, due to the ever-increasing workload of staff at all levels; the ability to ensure effective and timely services becomes increasingly difficult to do consistently and with a high degree of quality. Our Child Abuse Prevention and Treatment Act increment stems from a mandate from federal legislation by the same name requiring all children under the age of three with substantiated reports of harm must be referred to the infant learning program for evaluation and therapeutic and/or educational services.

The class study implementation, Strengthening Families, and Child Abuse Prevention Treatment Act Infant Learning Program increments all tie directly back to core services primarily within DHSS Priority III: Safe & Responsible individuals, Families, and Communities. Core Service A-C: Strengthening families, protecting vulnerable Alaskans and promoting personal

responsibility are at the heart of what the Office of Children's Services is mandated to provide. These increments most notably tie to our ability to retain and support quality staff that without whom, we are unable to consistently and effectively meet the needs of the families we are mandated to serve.

As our ability to recruit, retain, and support our staff along the entire child welfare continuum improves, as will out outcomes related to safety, permanency and wellbeing for children and families.

Division of Health Care Services Summary

The Division of Health Care Services provides access and oversight to the full range of appropriate Medicaid health care services to all eligible Alaskans in need. These services include but are not limited to hospitals, physicians, pharmacy, dental, vision, durable medical equipment, and transportation. The division also has the responsibility for protecting Alaska's most vulnerable populations, through its certification and licensing sections.

The Division of Health Care Services has focused its efforts in addressing the following major challenges:

- Adult Preventative Dental Medicaid Services – maintaining adequate provider capacity through private dental participation in the Medicaid program and tribal dental access
- Medicaid Services – ensuring sufficient numbers of all types of enrolled providers, particularly in rural areas
- Medicaid Pharmacy – ensuring pharmacy providers are adequately and accurately reimbursed
- Tribal Medicaid – conducting sufficient Tribal consultations to ensure Tribal Health Organizations are aware of changes to Medicaid State Plan Amendments
- Catastrophic and Chronic Illness (CAMA) – providing specified health care services to eligible Alaskans with a very limited general fund budget
- Health Facilities Licensing and Certification – Staff training and retention to ensure capacity to complete Centers for Medicare and Medicaid survey-related mandates
- Medical Assistance Administration – completion of the new web-enabled Medicaid Management Information System; Health Information Technology, moving the Health Information Exchange from pilot status to production status; incorporating rendering providers into more claim types
- Rate Review – implementation of acuity-based rate setting systems for Behavioral Health and Senior Services; incorporation of tribal health and dental encounter payment processes into the new Medicaid Management Information System
- Certification and Licensing – updating the Assisted Living Program database and implementing a new database for the Background Check Program

The division has requested a $457.0 increment for the Health Facilities Licensing and Certification component. This requested increment supports staff retention to complete the Centers for Medicare and Medicaid survey-related mandates. Training staff that are required to be certified for each type of facility (certification in each area takes approximately 6 months). The funds will be used to continue to license and/or certify hospitals, nursing homes, ambulatory surgery centers, hospices (paid and volunteer), outpatient physical therapy providers, rural health clinics, freestanding birth centers, home health care providers, Frontier Extended Stay Clinics, and end stage renal disease facilities. Certification takes part through an agreement with the Centers for Medicare and Medicaid Services for those facilities that take part in the federal Medicare and state Medicaid programs. The Centers for Medicare and Medicaid Services mandate strict timeframes of when inspections are to be completed.

The challenge/increment request fits into Priority I, Health and Wellness Across the Lifespan; Core Service A, Protect and Promote the Health of Alaskans; Outcome 2, Alaskans are free from unintentional injury. It also fits into Priority III, Safe and Responsible Individuals, Families, and Communities; Core Service B, Protect Vulnerable Alaskans; Outcome 3, Health and Social Services facilities in which Alaskans are served are safe.

The complaint investigations, and the certification and licensing on-site visits to facilities, ensure quality of care and the safety of vulnerable Alaskans.

Division of Juvenile Justice Summary

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.

The Division of Juvenile Justice continues to review, evaluate and refine its services for juveniles, many of whom have mental health problems, substance abuse and/or exposure to trauma. Interventions for these youth must address these factors in order to ensure their greatest opportunity for success. The division has three increments that address these issues. They include: $75.0 of MHTAAR funding to provide trauma-informed care on a statewide basis; $75.0 of General Funds to provide trauma-informed care on a statewide basis; and $152.9 MHTAAR funding to provide mental health clinician oversight in juvenile facilities.
The division has a fourth increment, $400.0 in General Funds, to address the rising cost of providing health care services in juvenile justice facilities (this increment covers increased costs for dental, medical and psychiatric services).

In addition, division staff are working to reduce juvenile recidivism, especially Alaska Native youth recidivism. To assist in this effort, we have an increment request of $110.9 MHTAAR funding for the rural specialist position to assist the division in its effort to improve cultural programming for youth. This staff person works with both division staff and Alaska Native communities to increase contact and cultural competency.

The Bethel Youth Facility is plagued with structural and utilization problems that need to be addressed, including overcrowded offices. In FY2013, the division received funding for the first phase of the renovation project at the Bethel Youth Facility. Initial design has been completed, a contractor has been selected and construction will begin in the spring. The division has a $10,600.0 General Fund increment in the FY2014 capital budget for the final phase of this project.

Division increment requests fit well into department priorities. Renovation of the Bethel Youth Facility will help ensure that the division *Provides Quality of Life in a Safe Living Environment* (Priority I, Core Service B) supporting Outcome 1, Alaskan children receiving department services live in a supportive setting). In addition, an adequate facility will assist with *Protecting Vulnerable Alaskans* (Priority III, Core Service B) supporting Outcome 3, Health and Social service facilities in which Alaskans are served are safe).

Adequately-funded Juvenile Justice facility medical services will continue to ensure that the Division *Protects and Promotes the Health of Alaskans* (Priority I, Core Service A) supporting Outcomes 1 & 2, Alaskans are healthy and Alaskans are free from unintentional injury.

Addressing exposure to trauma and the behavioral health needs of juveniles through the Trauma-Informed Care initiative and statewide mental health clinician oversight will reduce recidivism and episodes of domestic violence (Priority III, Core Service C *Hold Alaskans Accountable for*

Responsible Behavior) supporting Outcomes 2 & 4, Juveniles develop and demonstrate skills in positive decision making, Alaskans choose respect. In addition, these improvements will Strengthen Alaskan Families (Priority III, Core Service A) supporting Outcome 1, Alaskan families develop work skills. The Rural Specialist position will assist with improving these outcomes for Alaska Native youth especially.

Division of Public Assistance Summary

The Division of Public Assistance provides essential services to meet many of the basic and urgent needs of Alaska's most vulnerable families and individuals. The division provides temporary economic support to needy families with dependent children; financial assistance to elderly, blind, and disabled individuals; food support and nutrition education; medical benefits, home heating assistance, child care assistance, and work supports that encourage Alaskans to pursue economic independence and self-sufficiency.

As the Division of Public Assistance continues to make progress on its overall mission to promote self-sufficiency and provide for basic living expenses to Alaskans in need, several new and ongoing challenges may affect the division's ability to meet performance objectives for FY2014. These challenges include Alaskan's increasing need for assistance, workload challenges, and sustaining efforts to ensure continuous improvement of business processes and services.

The increments that address the increasing need for assistance are:

- Alaska Temporary Assistance Program funding of $3,850.0 in federal funding authority needed 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 funded by the federal Temporary Assistance for Needy Families (TANF) block grant.
- Adult Public Assistance (APA) formula program funding of $2,244.0 in general fund and $40.0 in federal authority due to increased caseload growth so eligible needy, elderly, blind, and disabled persons will still receive benefits.
- General Relief Program funding for $1,140.0 general fund to address the need for indigent burials and their increased burial costs and other emergency services incurred by individuals who meet the eligibility requirements for the program. The additional funding will ensure the division can provide a safety net for very low-income individuals who lack needed resources and are not eligible for other state or federal assistance.
- Permanent Fund Hold Harmless program funding of $650.0 due to the increase caseload growth. 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 Divided Hold Harmless payments. As public assistance caseloads increase, there is increased need for hold harmless payments.

Department-Level Objective: Integrate and coordinate services

Core Service: Strengthen Alaskan Families

Outcome: Alaskan families develop work skills

In order to reduce the number families receiving Temporary Assistance for Needy Families (TANF), the department supports implementation of a new model for delivering work services.

In FY2013 the new Work Services model will use two tracks to serve families. Work First employment focused services will continue to help job-ready parents become employed and close their family's TANF case. Families First services targets families who are not yet job-ready due to profound and multiple challenges to self-sufficiency. Families First services include collaborative service plans with partner agencies, early screening and assessment, supports to access services to remediate challenges to participation and successful application for non-time limited benefits such as Supplemental Security Income.

Budget Increment: Alaska Temporary Assistance Program Funding: $3,850.0 federal.

The Families First initiative requires additional services which results in the need for additional federal receipt authority. As families targeted with Families First service leave Alaska Temporary Assistance Program more quickly than in previous years, the cost of total benefits statewide will decrease.

Division of Public Health Summary

The Division of Public Health serves the community of Alaska. All Alaskan's are touched by Public Health at some point in their lives; either through Public Health Nursing, infectious disease control, laboratory testing, emergency medical services, death investigations and, birth or death registrations, to name a few. Public Health work is best described by the "3Ps" – Prevention, Promotion, and Protection. Public Health works behind the scenes with multiple stakeholders to serve all Alaskans. Our success is that you don't know that we are there.

The only new increment for the Division of Public Health is a $75.0 GF for Bureau of Vital Statistics as a replacement of the lost general fund program receipts. This increment is needed due to the inadvertent omission of the HB 129 Deceased Veterans Death Certificates fiscal note from the FY2013 appropriations bill.

The Public Health mission aligns with the Department of Health and Social Services framework to promote health and wellness across the lifespan; protect the quality of life in a safe living environment; and, promote health care access, delivery and value. Public Health works to prevent infectious disease, intentional/unintentional injury and, tobacco use through immunization, lab testing, monitoring and education.

Public Health promotes care access through 26 public health clinics across Alaska, plus itinerant services to other communities; specialty health clinics; tele-health; and incentives for health care professionals to practice in rural areas.

Public Health protects Alaskans with the Alaska Family Violence Prevention Program; by performing health impact assessments; and by conducting medico/legal investigations related to unanticipated, sudden or violent deaths.

Division of Senior and Disabilities Services Summary

The Division of Senior and Disabilities Services provides community grants, and home- and community-based services for older Alaskans and persons with disabilities as well as protection of vulnerable adults from abandonment, abuse, exploitation, neglect or self-neglect. The division administers four Medicaid waiver programs, the Personal Care Assistance program, Traumatic Brain Injury services, Senior Services and Community Developmental Disabilities grants programs.

The Division of Senior and Disabilities Services must annually conduct face-to-face assessments, level of care determinations, and plan of care reviews in order to meet requirements outlined in the waiver plans approved by the Centers for Medicaid and Medicare Services for Alaska's four Medicaid Home and Community Based Waiver programs. With the projections of an increasing senior population in Alaska, the challenge to the division is to manage the waivers in a way that controls the growth of spending and contains costs as much as possible, while ensuring that quality services get to the individuals that really need them. Growth within the Personal Care Assistance program will also need to be addressed.

Medicaid Home and Community Based Waiver services rate setting regulations were reviewed and revised in 2011 by the Office of Rate Review within the Division of Health Care Services. New waiver services payment rate schedules continue to impact costs in the Division of Senior and Disabilities Services Medicaid Services component.

The Division has identified four major challenges that it needs to focus on in order to provide a balanced and cost effective system of care to meet the needs of its service population into the future. Those are:

- Ensuring that waiver participants receive home and community based services as close to home as possible and at the lowest level of care appropriate to meet their needs.
- Ensuring that vulnerable adults are safe and protected from abuse, neglect and exploitation.
- Ensuring that service participants receive quality services in a timely manner.
- Maximizing operational efficiency and ensuring effective administration and management of the Division of Senior and Disabilities Services.

The Division of Senior and Disabilities Services promotes 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. The programs administered through the Division support the department's core services of protecting and promoting the health and well-being of Alaskans, providing quality of life in a safe living environment, managing health care coverage for Alaskans in need, and protecting vulnerable Alaskans.

Departmental Support Services Summary

Departmental Support Services provides support to the department's eight programmatic divisions across an array of business functional areas. Sections include Fiscal, Revenue, Federal Allocations, Budget, Facilities, Human Resources, Information Technology, Grants and Contracts, Audit, and internal administration.

The Department of Health and Social Services along with other healthcare partner agencies nationwide now face aggressive regulatory oversight and enforcement by the Office of Civil Rights. The Department is required to safeguard Private Health Information. The state is also required to migrate all of its manual paper-based health information to electronic-based systems. Technology advances have made it possible to share Private Health Information across Alaska to improve health care, but also put the Department at severe risk of disclosing protected information. With the mandated growth in electronic transmission of confidential data comes the additional regulatory responsibility to protect that data. Each month DHSS investigates reports of possible data breeches, is required to report to the Office of Civil Rights its findings, should an actual breech occur, and face the consequences of each incident.

Currently DHSS does not have an annually funded security program in place to meet requirements under the Health Insurance Portability and Accountability Act (HIPAA) and the more recent stricter Health Information Technology for Economic and Clinical Health Act. On April 26, 2012, the Office of Civil Rights notified DHSS that it had completed an investigation of the Department and determined that DHSS has not met five requirements under the Health Insurance Portability and Accountability Act (HIPAA) rules and is required under Corrective Action Plans to remediate each of the issues. In addition, it is required to perform an in-depth security analysis of all of its systems that contain Private Health Information. From this analysis, a comprehensive remediation plan is being developed to correct all Health Insurance Portability and Accountability Act deficiencies, with a priority level, timeline and costs for each item.

The DHSS Information Technology section has requested $850.0 ($595.0 GF, $255.0 Fed) to implement a 7x24x365 security program to secure its Protected Health Information that resides in nearly 200 applications, and is shared with partners, providers, patients and agencies.

This request supports DHSS Core Service Priority II, *"Health care access, delivery and value."* The challenge is to appropriately share medical information and improve healthcare, while carefully safeguarding the confidentiality of protected data. This budget request is for the health information security, privacy compliance and remediation to support the Department's mission to "*protect and promote the health and well-being of Alaskans*."

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 one appropriation, Medicaid Services. Staff of the four involved divisions: Behavioral Health, Children's Services, Health Care Services and Senior and Disabilities Services all manage the benefits within this new appropriation. Only benefits, not administrative costs are paid out of this new appropriation.

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), individuals with intellectual and developmental disabilities (IDD), Alaskans living independently (ALI), and adults with physical and developmental disabilities (APDD).

Funding Overview

Medicaid is a joint federal-state program; the federal government shares the cost of Medicaid with the state. The portion of the cost of Medicaid benefits (direct services) paid by the federal government for most Medicaid eligibility groups and service categories is called the Federal Medical Assistance Percentage. Each state has its own Federal Medical Assistance Percentage. 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 of a state's ranking, its regular Federal Medical Assistance Percentage for Title XIX services can be set no lower than 50%.

Most benefits costs are reimbursed at this regular Federal Medical Assistance Percentage 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

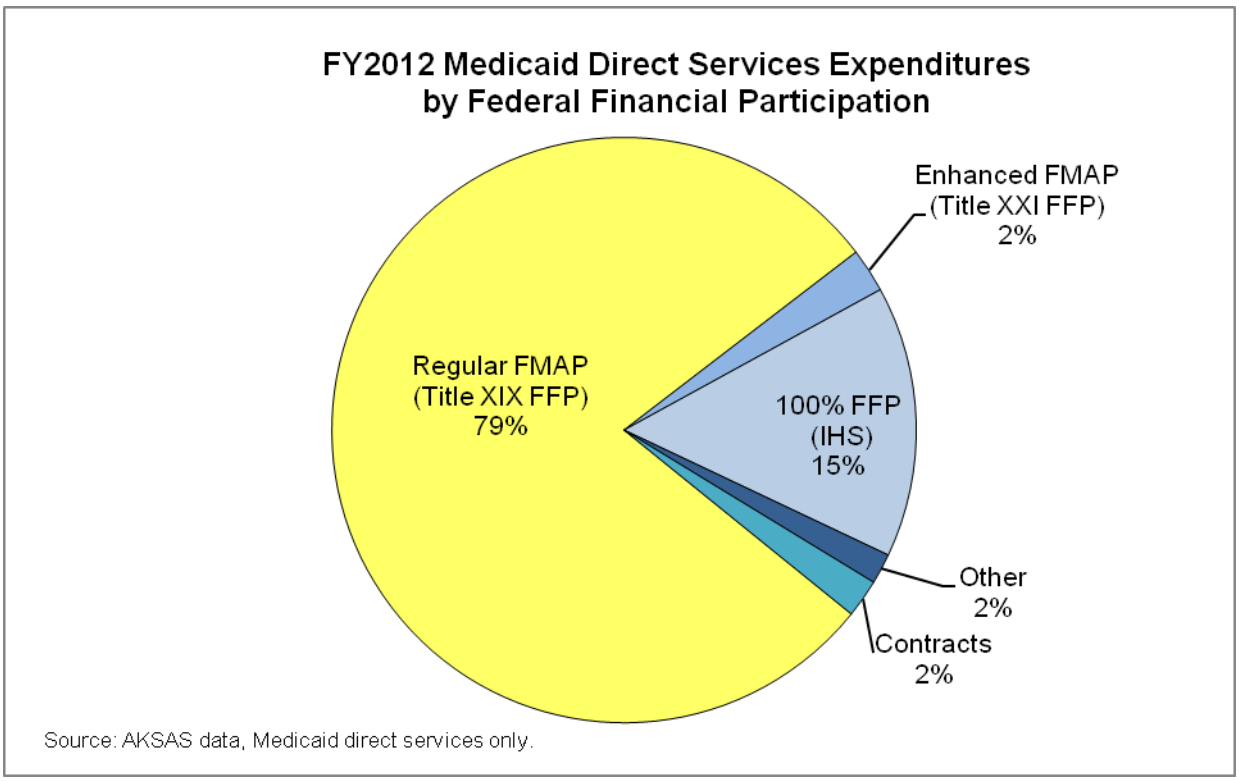
Program (CHIP or Title XXI) and women in the Breast and Cervical Cancer program (BCC) are reimbursed at an enhanced Federal Medical Assistance Percentage. Where possible, the state takes advantage of these higher reimbursement rates to contain the state's portion of the cost of providing Medicaid services.

The indirect costs of administering the Title XIX Medicaid and Title XXI Children's Health Insurance programs are shared with the federal government as well, generally at 50% Federal Medical Assistance Percentage, though there are some exceptions. For example, Children's Health Insurance Program administrative costs and the costs of information technology infrastructure development have higher federal financial participation rates.

Federal Medical Assistance Percentages for Claim Payments

	Federal Fiscal Year Statutory Rate		State Fiscal Year Average Rate	
Year	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
Before 1998	50.00	n/a	50.00	n/a
1998	59.80	71.86	57.35	71.86
1999	59.80	71.86	59.80	71.86
2000	59.80	71.86	59.80	71.86
2001	60.13	72.09	60.05	72.03
2002	57.38	70.17	58.07	70.65
2003 Q1-Q2	58.27	70.79	58.79	71.15
2003 Q3-Q4	61.22	72.85		
2004 Q1-Q3	61.34	72.94	61.31	72.92
2004 Q4	58.39	70.87		
2005	57.58	70.31	57.78	70.45
2006	57.58	70.31	57.58	70.31
2007	57.58	70.31	57.58	70.31
2008	52.48	66.74	53.76	67.63
2009 Q1-Q2	58.68	65.37	57.74	65.71
2009 Q3-Q4	61.12	65.37		
2010 Q1	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
2014 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 w as 50%. The enhanced FMAP started in 1998.

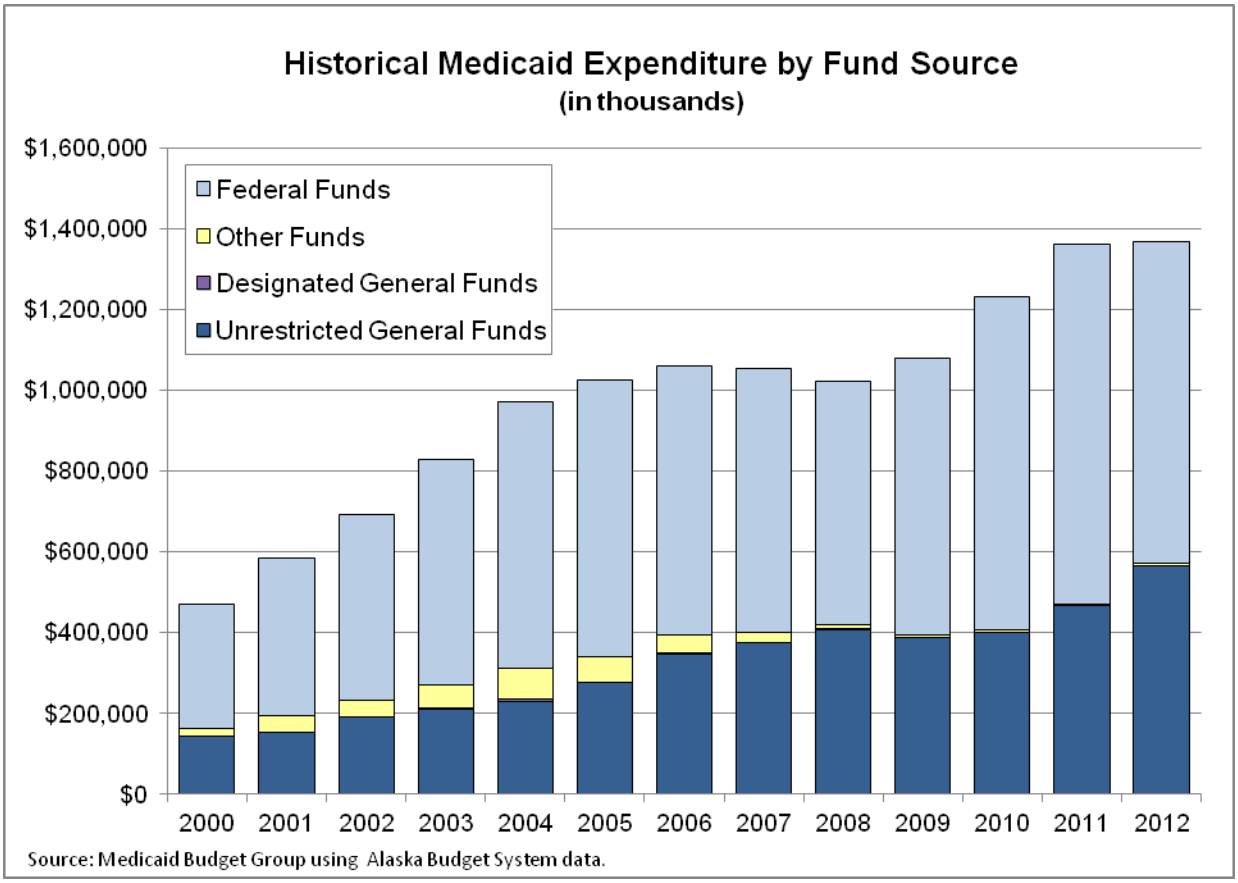


Although total program costs have grown each year, cost containment has helped hold down increases in total Medicaid expenditures. The department's efforts to control costs have generally been successful in mitigating the impacts of increases in population and payment rates, as demonstrated by the slowing rate of growth in Alaska's Medicaid costs between 2007, 2009, and 2012. Holding Medicaid spending to small increases from FY2011 to FY2012 was accomplished through implementing several cost containment recommendations made by the Medicaid Task Force. This included, but was not limited to, savings generated by switching from 'name brand' to generic medication and increasing utilization of generics, utilizing Option B care management, managing shifts in the cost due to some recipients having dual eligibility (i.e. Medicaid and Medicare), and changing eligibility requirements for Working Disabled through buy-in collections.

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 American Recovery and Reinvestment Act (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, to 33% in FY2010, then to 34% in FY2011, going up to 41% in FY2012. State funding is projected to be about 41% and 42% of the total program costs in FY2013 and FY2014 respectively.

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. For every dollar shifted to the tribal system from regular Federal Medical Assistance Percentage, 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.



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	$131,328	$195	$261,316	$2,851	$395,690
2000	$145,250	$265	$307,508	$17,686	$470,709
2001	$152,427	$364	$387,432	$43,671	$583,894
2002	$192,558	$364	$461,847	$38,911	$693,680
2003	$211,076	$1,427	$558,581	$57,034	$828,117
2004	$230,119	$4,512	$658,741	$78,119	$971,491
2005	$276,089	$1,533	$685,474	$61,822	$1,024,918
2006	$348,648	$1,500	$664,722	$45,007	$1,059,877
2007	$374,492	$52	$651,908	$26,924	$1,053,376
2008	$408,250	$1,558	$604,348	$9,632	$1,023,788
2009	$389,170	$74	$682,271	$6,774	$1,078,288
2010	$400,284	$87	$822,907	$6,982	$1,230,260
2011	$466,585	$192	$888,944	$4,527	$1,360,248
2012	$566,268	$195	$798,346	$4,825	$1,369,633

Source: Medicaid Budget Group using Alaska Budget System data.

Annual Statistical Summary of Services Provided in FY2012

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 FY2012, 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 FY2009, with a ten year average of 94%.

After slowing between FY2004 and FY2008, the number of persons enrolled annually increased by 5.6% in FY2010 and 8.3% in FY2011. Annual enrollment growth slowed down to 3.3% in FY2012. The number of beneficiaries increased by 3%.

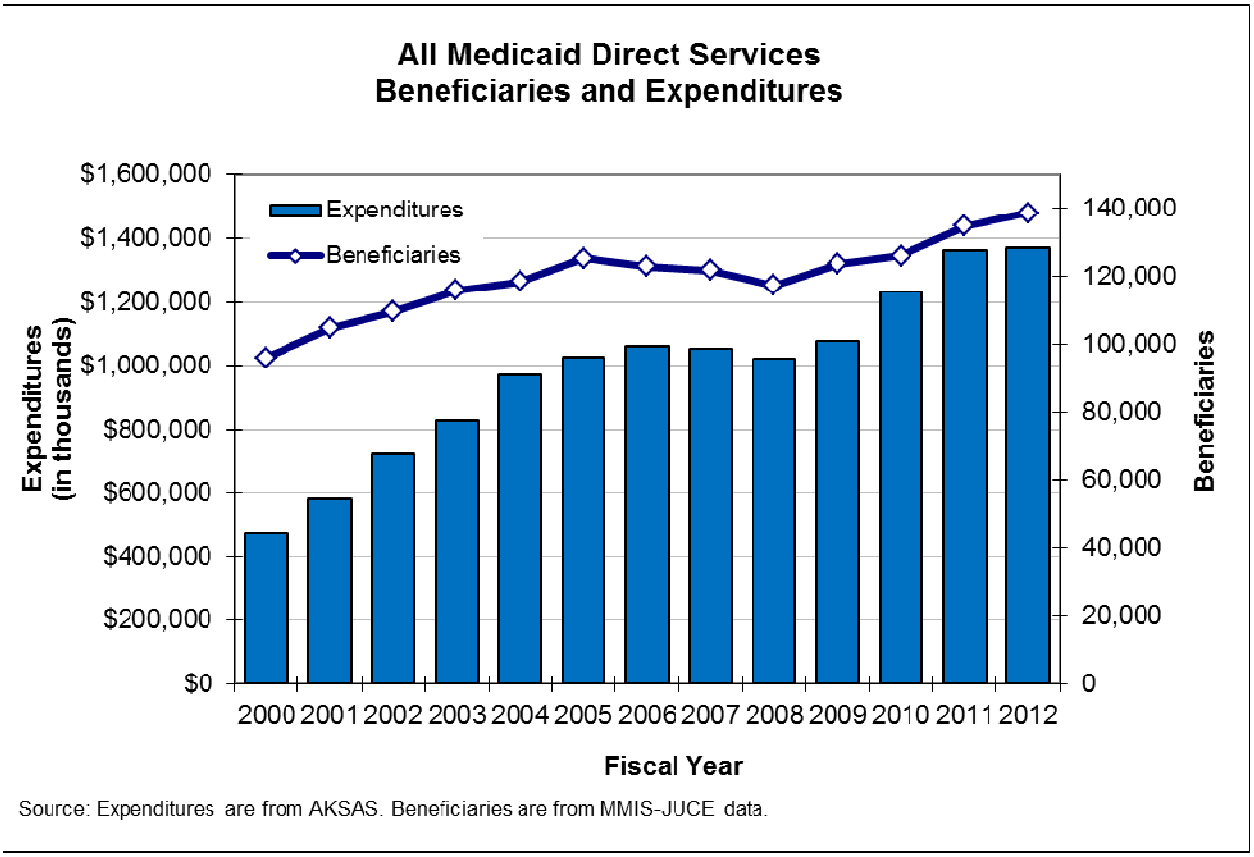
Participation in Medicaid

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	722,190	146,244	134,768	20%	92%
2012*	732,183	150,998	138,755	21%	92%

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

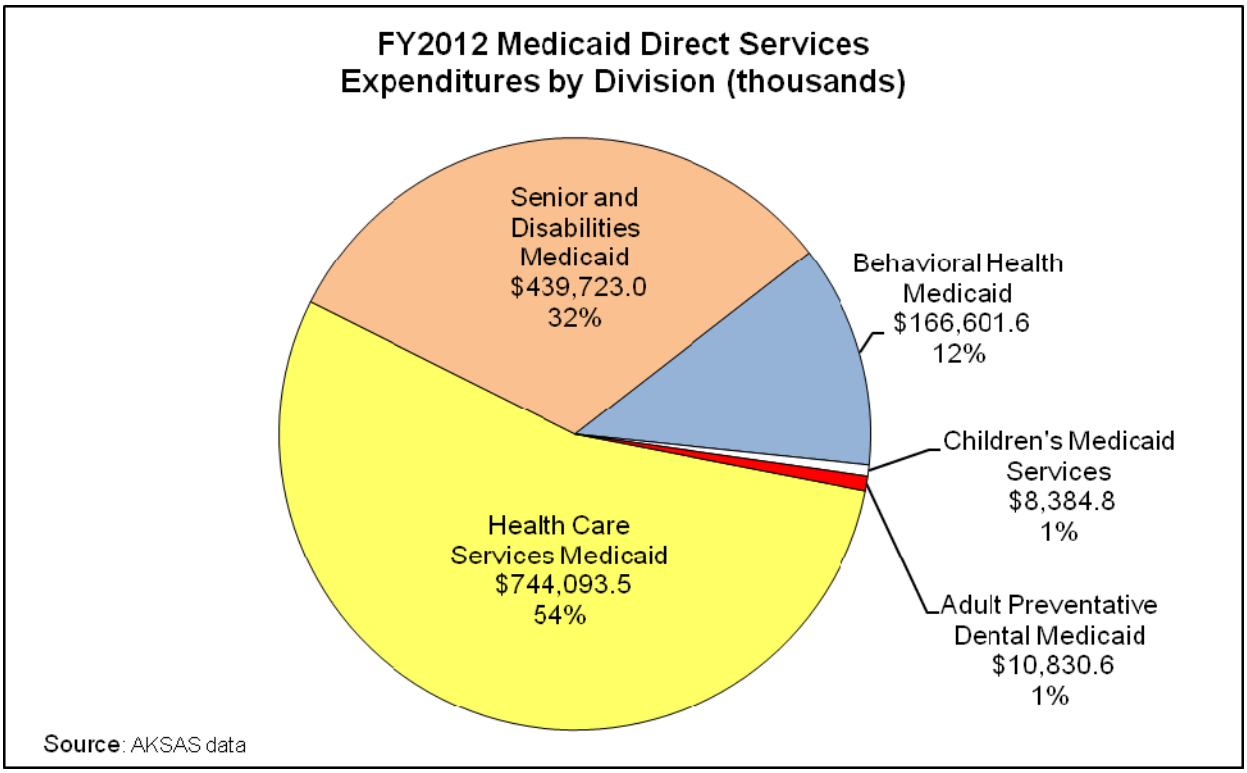
Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

Total costs for direct services (claims paid in the fiscal year) increased by only 3.4% between FY2011 and FY2012, a significant change in the trend line indicated by the bar graph below. The cost per beneficiary showed an even smaller increase of 0.4%. This cost savings success is attributable to numerous Medicaid cost containment measures implemented in FY2012.



The majority of Medicaid expenditures for direct services in FY2012 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 97% of that expenditure was for services provided directly to enrolled individuals. The remainder (less than 3%) 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 32% of total Medicaid direct services costs in FY2012. The remaining 14% of expenditures were paid through the Behavioral Health Medicaid Services component (12%), Children's Medicaid Services component (1%) and the Adult Preventative Dental Care program (1%).



Medicaid Direct Services Expenditures by Division, FY2012
(in thousands)

Total Medicaid Direct Services	$	1,369,633.4
Health Care Services		
Medicaid Services	*$*	*744,093.5*
Hospital Services	$	298,932.0
Physician Services	$	178,473.0
Pharmacy Services	$	33,513.6
Dental Services	$	52,169.5
Transportation	$	64,443.8
Other Medicaid Direct Services	$	54,184.9
Non-MMIS Services	$	43,636.5
Medicaid Financing	$	260.5
Medicaid (State-only)	$	590.7
Contracts (ACS, Qualis, etc.)	$	17,888.9
Adult Preventative Dental Medicaid	*$*	*10,830.6*
Adult Preventative Dental	$	10,830.6
Senior and Disablilities Services		
Senior & Disabilities Medicaid Services	*$*	*439,723.0*
Personal Care Services	$	117,672.7
Nursing Homes	$	93,644.1
Adults with Physical Disabilities Waiver	$	30,672.9
Children with Complex Medical Conditions	$	12,386.9
Intellectual and Developmental Disability Waiver	$	127,209.6
Older Alaskan Waiver	$	57,836.3
Other Services	$	300.5
Division of Behavioral Health		
Behavioral Health Medicaid Services	*$*	*166,601.6*
Residential Psychiatric Treatment Centers	$	36,330.8
Inpatient Psychiatric Hospitals	$	19,495.5
General Mental Health Services	$	106,748.0
PRTF Waiver	$	2,475.4
Medical Necessity Review Contract (QUALIS)	$	1,551.9
Office of Children's Services		
Children's Medicaid Services	*$*	*8,384.8*
Behavioral Rehabilitation Services	$	5,184.4
Behavioral Rehabilitation Services - BTKH	$	3,200.4

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 the Health Care Medicaid Services budget, behavioral rehabilitation services provided through Children's Medicaid Services and drug abuse counseling funded through the Behavioral Health Medicaid services budget. An elderly beneficiary using waiver services under the Older Alaskans waiver program might receive prescription drugs funded through Health Care Medicaid Services.

Based on claims processed for payment during FY2012, 99% of Medicaid beneficiaries used at least one Medicaid service that was funded through the Health Care Medicaid Services component. About 9% used Medicaid services funded through the Behavioral Health Medicaid Services component. Nearly 7% used Medicaid services funded through the Senior and Disabilities Medicaid Services component, and less than 1% used Medicaid services funded through the Children's Medicaid Services component.

FY2012 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		**138,755**		**$1,333,147,618**	**$9,608**		**150,998**	**91.9%**
Gender								
Female	56.0%	77,764	56.1%	$747,507,771	$9,613	54.4%	82,181	94.6%
Male	44.0%	61,053	43.9%	$585,639,564	$9,592	45.6%	68,892	88.6%
Unknown	0.0%	1	0.0%	$283	$283	0.0%	2	50.0%
Race								
Alaska Native	39.1%	54,813	36.3%	$483,780,477	$8,826	37.1%	56,627	96.8%
American Indian	1.6%	2,251	1.5%	$20,455,060	$9,087	1.6%	2,431	92.6%
Asian	6.5%	9,145	6.5%	$87,149,860	$9,530	7.1%	10,827	84.5%
Pacific Islander	3.5%	4,934	2.8%	$37,633,925	$7,627	3.8%	5,800	85.1%
Black	5.5%	7,668	4.6%	$61,561,610	$8,028	5.7%	8,746	87.7%
Hispanic	3.7%	5,135	2.5%	$33,600,748	$6,543	3.7%	5,705	90.0%
White	37.6%	52,614	42.9%	$572,481,854	$10,881	38.3%	58,506	89.9%
Unknown	2.5%	3,458	2.7%	$36,484,084	$10,551	2.6%	4,008	86.3%
Native	40.9%	57,038	37.8%	$504,235,537	$8,840	38.9%	59,024	96.6%
Non-Native	59.1%	82,457	62.2%	$828,912,081	$10,053	61.1%	92,861	88.8%
Age								
under 1	8.3%	12,474	7.5%	$100,475,647	$8,055	7.5%	12,156	102.6%
1 through 12	37.0%	55,873	15.6%	$207,509,653	$3,714	38.2%	62,240	89.8%
13 through 18	15.2%	22,938	13.4%	$178,257,339	$7,771	16.1%	26,198	87.6%
19 through 20	3.6%	5,392	2.6%	$35,067,422	$6,504	3.5%	5,629	95.8%
21 through 30	10.8%	16,271	12.5%	$166,800,447	$10,251	10.3%	16,798	96.9%
31 through 54	14.4%	21,721	21.2%	$283,225,328	$13,039	14.1%	22,954	94.6%
55 through 64	4.4%	6,588	10.0%	$133,315,310	$20,236	4.2%	6,765	97.4%
65 through 84	5.5%	8,236	12.7%	$168,725,163	$20,486	5.3%	8,622	95.5%
85 or older	1.0%	1,489	4.5%	$59,771,310	$40,142	0.9%	1,445	103.0%
Benefit Group								
Children	60.4%	85,273	31.9%	$424,929,426	$4,983	61.8%	94,457	90.3%
Adults	19.5%	27,571	13.3%	$177,018,470	$6,420	18.9%	28,946	95.2%
Disabled Children	1.9%	2,691	5.7%	$75,389,996	$28,016	1.7%	2,671	100.7%
Disabled Adults	12.4%	17,547	34.2%	$455,913,113	$25,982	12.0%	18,298	95.9%
Elderly	5.8%	8,174	15.0%	$199,896,612	$24,455	5.6%	8,523	95.9%
Location (DHSS Region)								
Anchorage/Mat-Su	49.2%	70,462	52.0%	$693,872,273	$9,847	50.2%	77,902	90.4%
SouthCentral	13.0%	18,640	15.4%	$205,148,217	$11,006	13.0%	20,211	92.2%
Northern	12.3%	17,634	10.6%	$141,391,854	$8,018	12.6%	19,508	90.4%
Western	14.9%	21,309	10.6%	$141,456,928	$6,638	14.2%	22,075	96.5%
SouthEast	9.4%	13,380	10.9%	$145,933,986	$10,907	9.4%	14,617	91.5%
Out of State or Unknown	1.2%	1,647	0.4%	$5,344,359	$3,245	0.5%	719	

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 recipent or enrollee, not the location where service was provided.

Enrollment: Number of persons eligibile for Medicaid and enrolled for at least 1 month during state FY2012. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,and benefit group, and region categories). Some duplications may occur between subgroup counts. For example, an infant with a September birthdate would count in the under 1 age subgroup based on enrollment activity between July and September but would also be counted in the 1 through 12 age subgroup based on enrollment activity between October and June.

Recipients: Number of persons having Medicaid claims paid or adjusted during state FY2012 (service may have been incurred in a prior year). Grouping is based on status on the date when service was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories) but some duplication may occur between subgroup counts. For example, if a 12 year old child with a September birthdate obtained vision services in August, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before June 30, 2012. 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 anytime before June 30, 2012.

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

Statutes

AS 08.64.010 - 380	State Medical Board
AS 08.68.010 - 410	Nursing
AS 08.84.010 - 190	Physical Therapists and Occupational Therapists
AS 08.86.010 - 230	Psychologists and Psychological Associates
AS 08.95.010 - 990	Clinical Social Workers
AS 12.47.010 - 130	Insanity and Competency to Stand Trial
AS 18.20	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 (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

Regulations

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

Federal Statutes

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
PL 102-321	Community Mental Health Services
Social Security Act:	Title XVIII Medicare
	Title XIX Medicaid
	Title XXI Children's Health Insurance Program

Federal Regulations

42 CFR Part 400 to End

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 smoother and more gradual than the annual fluctuations experienced in the short term.

Budget Overview Table

Behavioral Health Medicaid Services

Behavioral Health	**FY2013**	**FY2014 Gov**	**13 to 14 Change**
Unrestricted General Funds	$83,641.7	$83,641.7	$0.0
Designated General funds	$1,500.0	1,500	$0.0
Federal Funds	$119,076.8	119,076.8	$0.0
Other Funds	$717.5	717.5	$0.0
Total	**$204,936.0**	**$204,936.0**	**$0.0**

Behavioral Health Medicaid Services Funding Needs Table

Behavioral Health Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2013 Authorized Base	**204,984.1**	**83,641.7**	**1,500.0**	**119,124.9**	**717.5**
No changes for FY2014	0.0	0.0	0.0	0.0	0.0
Total	**204,984.1**	**83,641.7**	**1,500.0**	**119,124.9**	**717.5**

Budget Requests

No additional funding has been included in FY2014 for Behavioral Health Medicaid Services

Although there is a 2.6% increase in beneficiaries from FY2011 to FY2012, the cost per beneficiary has been going down, which resulted in a 1.1% decrease in FY2012 in total spending for Behavioral Health Medicaid Services.

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.

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%
2012	13,127	$152,445.8	$11,613	2.6%	-1.1%	-3.6%

Source: MMIS/JUCE

Budget Overview Table

Children's Medicaid Services

Children's Medicaid Services	FY2013	FY2014 Gov	13 to 14 Change
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
FY2013 Authorized Base	**13,937.4**	**6,308.1**	**0.0**	**7,629.3**	**0.0**
No changes for FY2014	0.0	0.0	0.0	0.0	0.0
Total	**13,937.4**	**6,308.1**	**0.0**	**7,629.3**	**0.0**

Budget Requests

No additional funding has been included in FY2014 for Children's Medicaid Services

Budget Overview Table

Adult Preventative Dental Medicaid Services

Adult Preventative Dental	FY2013	FY2014 Gov	13 to 14 Change
Unrestricted General Funds	$5,390.2	$7,088.5	$1,698.3
Federal Funds	7,146.5	9,338.1	2,191.6
Other Funds	0.0	0.0	0.0
Total	**$12,536.7**	**$16,426.6**	**$3,889.9**

Adult Preventative Dental Medicaid Funding Needs Table

Adult Preventive Dental	Total	Unrestricted GF	Designated GF	Federal	Other
FY2013 Authorized Base	**12,536.7**	**5,390.2**	**0.0**	**7,146.5**	**0.0**
Growth from Increased Utilization	3,889.9	1,698.3	0.0	2,191.6	0.0
Total	**16,426.6**	**7,088.5**	**0.0**	**9,338.1**	**0.0**

Budget Requests

Increased Utilization, Adult Preventative Dental Medicaid Services: $3,889.9 Total -- $1,698.3 GF/Match, $2,191.6 Fed

Spending for Adult Preventive Dental grew by 13.4% from FY2009 to FY2010, but by 37.5% from FY2010 to FY2011, and by 17.1% from FY2011 to FY2012.

This request will support projected growth in utilization of Adult Preventative Dental Medicaid Services. The estimate of cost increases is based on analysis of five methods of cost projections for FY2014, looking back across programmatic cost changes by service type within the component since the program's inception.

Budget Overview Table

Health Care Medicaid Services

Health Care Medicaid Services	FY2013	FY2014 Gov	13 to 14 Change
Unrestricted General Funds	$332,665.8	$335,484.0	$2,818.2
Designated General Funds	847.5	297.5	-550.0
Federal Funds	559,894.9	564,462.0	4,567.1
Other Funds	9,796.7	6,256.7	-3,540.0
Total	**$903,204.9**	**$906,500.2**	**$3,295.3**

Health Care Medicaid Services Funding Needs Table

Health Care Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2013 Authorized Base	**903,204.9**	**332,665.8**	**847.5**	**559,894.9**	**9,796.7**
Anticipated 'Woodwork' Effect as of January 2014	7,385.3	2,818.2		4,567.1	
Reduce General Fund / Program Receipt Authority	-550.0		-550.0		
Reduce Interagency Receipt Authority	-4,190.0				-4,190.0
Transfer SDPR Authority from SDS Medicaid	650.0				650.0
Total	**906,500.2**	**335,484.0**	**297.5**	**564,462.0**	**6,256.7**

Budget Requests

Anticipated 'Woodwork' Effect as of January 2014 Affordable Care Act Implementation: $7,385.3 Total -- $2,818.2 GF Match, $4,567.1 Fed

The Health Care Medicaid Services component supports a wide variety of medical and health care services for eligible individuals - inpatient and outpatient hospital services; physician, pharmacy, transportation, dental, vision laboratory and x-ray services; physical/occupational/speech therapy; chiropractic services, etc.

This request will support projected growth in utilization of Medicaid services across all components, based on the anticipated 'woodwork' effect as elements of the Affordable Care Act are implemented effective January 2014. As of that date, individuals will be required to have secured health insurance coverage, and individuals currently eligible for Medicaid under existing rules, but not yet enrolled, are anticipated to enroll. Current projections are for a resulting additional 1,500 Alaska enrollees.

Cost projections are based on the FY2012 per recipient average cost of Medicaid services provision across all components, for 1,500 new participants for one half fiscal year.

In recent years the department has implemented reforms aimed at improving Medicaid sustainability. Cost containment efforts begun in FY2004 have successfully reduced the rate of growth in recent years for direct benefits from a high of 21.5% for FY2003. Cost containment has been especially effective in pharmacy services; costs for this category have fallen 37% since

the high of $95.7 million in FY2005, continued to decline to $60.4 million in FY2011. Spending in Pharmacy Services decreased again in FY2012, falling to $33.5 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.

Reduce General Fund/ Program Receipt Authority: -$550.0 Total -- -$550.0 GF Prgm

Based on a comparison of FY2012's final authority to actuals by line item, fund source, and component, the Medicaid program is requesting a reduction in GF/Program Receipt authority in grants for the Health Care Medicaid Services component.

Reduce Interagency Receipt Authority: -$4,190.0 Total -- -$4,190.0 I/A Rcpts

Based on a comparison of FY2012's final authority to actuals by line item, fund source, and component, the Medicaid program is requesting a reduction in interagency receipt (I/A) authority in services for the Health Care Medicaid Services component.

Transfer Statutory Designated Program Receipt Authority from Senior and Disabilities Medicaid Services: $650.0 Total -- $650.0 Stat Desig

Based on a comparison of FY2012's final authority to actuals by line item, fund source, and component, the Medicaid program is requesting a transfer of statutory designated program receipt (SDPR) authority in grants from the Senior and Disabilities Medicaid Service component to the Health Care Medicaid Services component.

These funds are collected from overpayment recoveries. During FY2012, statutory designated program receipt collections for Health Care Medicaid services exceeded the initial authorization of $906.3. Additional authorization was transferred to Health Care Medicaid Services from Senior and Disabilities Medicaid through the revised program (RP) process. Senior and Disabilities Medicaid only collected $102.6 of its initial statutory designated program receipt authorization of $1,200.0.

This transfer will give Health Care Medicaid Services the additional authorization it needs to collect additional statutory designated program receipts.

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%
2012	137,678	$731,696.9	$5,315	2.9%	0.8%	-2.1%

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	FY2013	FY2014 Gov	13 to 14 Change
Unrestricted General Funds	$247,470.5	$253,955.4	$6,484.9
Federal Funds	259,130.0	265,815.0	6,685.0
Other Funds	3,752.2	1,068.4	-2,683.8
Total	**$510,352.7**	**$520,838.8**	**$10,486.1**

Senior and Disabilities Medicaid Services Funding Needs Table

Senior and Disabilities Medicaid Services	Total	Unrestricted GF	Designated GF	Federal	Other
FY2013 Authorized Base	**510,352.7**	**247,470.5**	**0.0**	**259,130.0**	**3,752.2**
Growth from Waiver and Personal Care Assistance	13,169.9	6,484.9	0.0	6,685.0	
Transfer SDPR Authority to HCS Medicaid	-650.0				-650.0
Reduce Interagency Receipt Authority	-2,033.8				-2,033.8
Total	**520,838.8**	**253,955.4**	**0.0**	**265,815.0**	**1,068.4**

Budget Requests

Waiver and Personal Care Assistance Program Growth: $13,169.9 Total -- $6,484.9 G/F Match, $6,685.0 Fed Rcpts

The Senior and Disabilities Medicaid Services component supports nursing home and personal care services, as well as a variety of home- and community-based waiver programs for children with complex medical conditions, individuals with mental retardation or developmental disabilities, adults with disabilities, and older Alaskans.

This request will support projected growth in utilization of both the Individuals with Intellectual and Developmental Disabilities waivered community-based services and the Personal Care Assistance Program. The estimate of cost increases is based on analysis of five methods of cost projections, looking back across programmatic cost changes by service type within the component for FY2004-2012.

Transfer Statutory Designated Program Receipt Authority to Health Care Medicaid Services: -$650.0 Total -- -$650.0 Stat Desig

Based on a comparison of FY2012's final authority to actuals by line item, fund source, and component, the Medicaid program is requesting a transfer of statutory designated program receipt (SDPR) authority in grants from the Senior and Disabilities Medicaid Service component to the Health Care Medicaid Services component.

These funds are collected from overpayment recoveries. During FY2012, statutory designated program receipt collections for Health Care Medicaid services exceeded the initial authorization of $906.3. Additional authorization was transferred to Health Care Medicaid Services from Senior and Disabilities Medicaid through the revised program (RP) process. Senior and Disabilities Medicaid only collected $102.6 of its initial statutory designated program receipt authorization of $1,200.0.

This transfer will give Health Care Medicaid Services the additional authorization it needs to collect additional statutory designated program receipts.

Reduce Interagency Receipt Authority: -$2,033.8 Total -- -$2,033.8 I/A Rcpts

Based on a comparison of FY2012's final authority to actuals by line item, fund source, and component, the Medicaid program is requesting a reduction in interagency receipt (I/A) authority in services for the Senior and Disabilities Medicaid Services component.

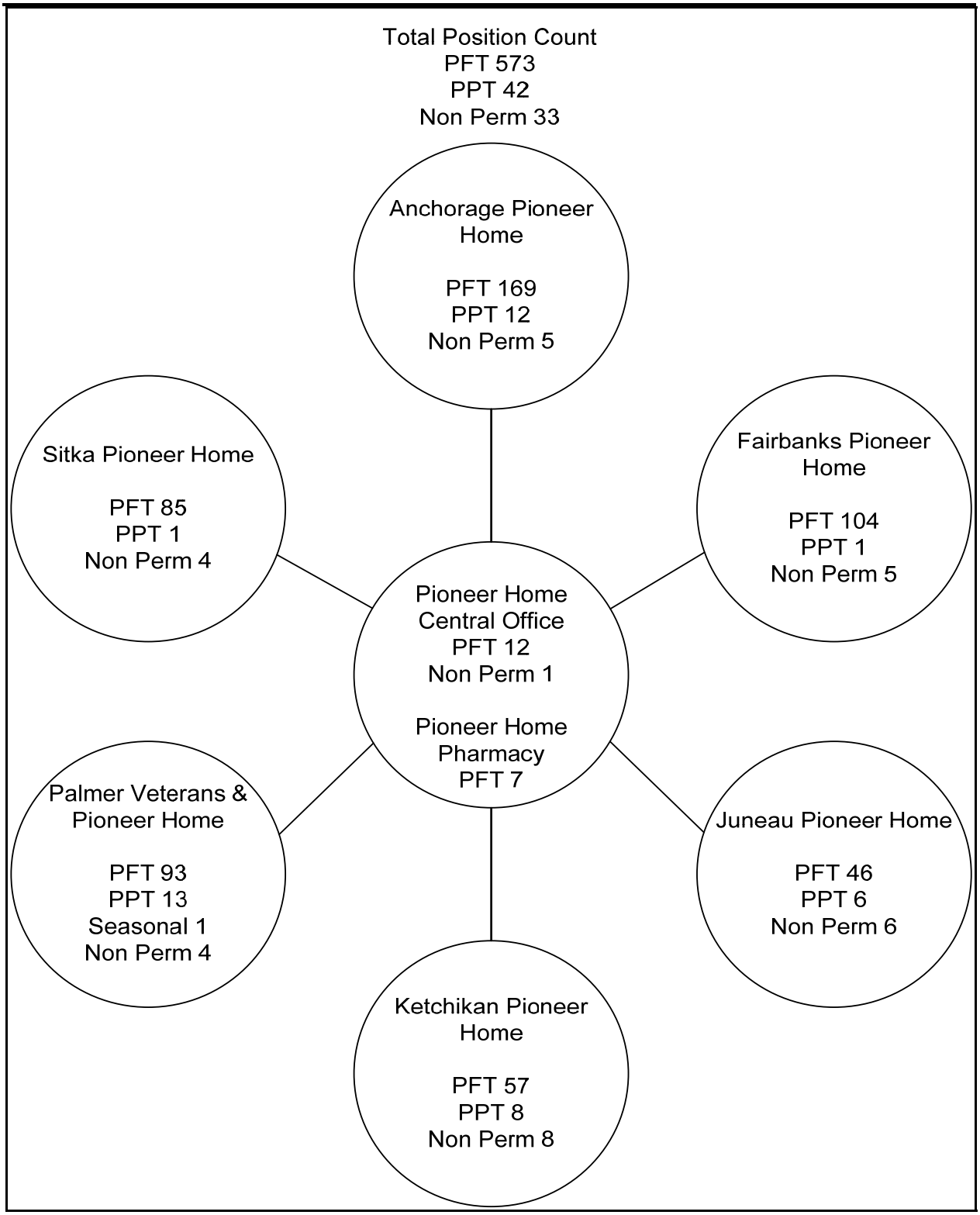
Senior and Disabilities Medicaid Services						
State Fiscal Year	Historical Utilization			Annual Percent Change		
	Beneficiaries	Claim Payments (thousands)	Cost per Beneficiary	Beneficiaries	Claim Payments	Cost per Beneficiary
1999	2,688	$79,351.7	$29,521			
2000	2,914	$90,587.8	$31,087	8.4%	14.2%	5.3%
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%
2012	9,828	$440,724.9	$44,844	7.2%	10.1%	2.7%

Source: MMIS / JUCE

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Medicaid Services General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
Increased Utilization, Adult Preventative Dental Medicaid Services (APD)	$ 1,698.3	$ -	$ 2,191.6	$ -	$ 3,889.9
Anticipated 'Woodwork' Effect as of January 2014 Affordable Care Act Implementation (HCS)	$ 2,818.2	$ -	$ 4,567.1	$ -	$ 7,385.3
Reduce General Fund/Program Receipt Authority (HCS)	$ -	$ (550.0)	$ -	$ -	$ (550.0)
Reduce Interagency Receipt Authority (HCS)	$ -	$ -	$ -	$ (4,190.0)	$ (4,190.0)
Reduce Interagency Receipt Authority (SDS)	$ -	$ -	$ -	$ (2,033.8)	$ (2,033.8)
Waiver and Personal Care Assistance Program Growth (SDS)	$ 6,484.9	$ -	$ 6,685.0	$ -	$ 13,169.9
Medicaid Servics Total	***$ 11,001.4***	***$ (550.0)***	***$ 13,443.7***	***$ (6,223.8)***	***$ 17,671.3***

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 578 Alaska seniors during FY2012. As of September 30, 2012, 356 Alaska seniors were on the active wait list and 3,706 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 of Alaska 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 that 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 $5.63 million in Medicaid Waiver receipts in FY2012 and are budgeted to collect $5.55 million in FY2013.

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 have three categories of residents

for payment purposes: private pay, those on the Alaskans Living Independently Medicaid Waiver and those on the Pioneer Home Payment Assistance Program. The portion of the monthly rent not paid by the resident and/or the Medicaid Waiver is the state assistance provided.

Pioneer Homes 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. The Governor appoints all board members.

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

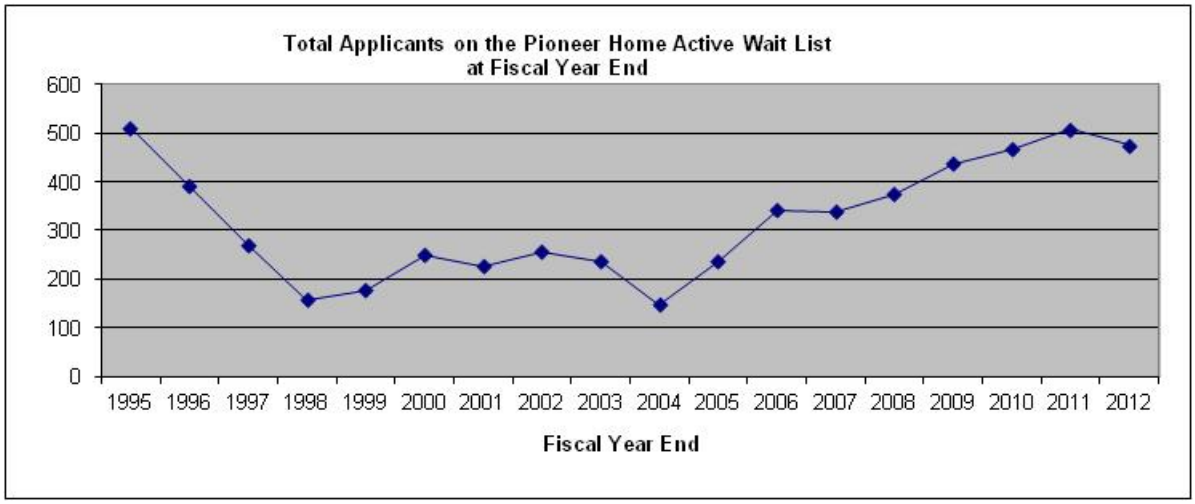
Pioneer Homes Wait List

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

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

Pioneer Home Applicants on the Active Wait List							
Fiscal Year End	**Sitka**	**Fairbanks**	**Palmer**	**Anchorage**	**Ketchikan**	**Juneau**	**Total**
1994	37	67	103	190	39	52	488
1995	50	84	111	153	55	58	511
1996	39	75	79	111	30	58	392
1997	34	39	55	58	24	59	269
1998	16	24	27	15	25	49	156
1999	14	24	26	44	18	51	177
2000	11	44	52	64	28	50	249
2001	6	44	44	46	34	53	227
2002	8	90	31	68	29	29	255
2003	15	89	12	56	27	36	235
2004	4	78	16	21	7	20	146
2005	15	84	24	76	16	21	236
2006	13	93	67	100	24	44	341
2007	9	87	74	91	33	45	339
2008	6	90	92	116	23	47	374
2009	4	86	122	129	34	62	437
2010	10	87	112	129	53	75	466
2011	16	77	113	153	56	93	508
2012	31	87	87	130	40	100	475

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 September 30, 2012. Since September 30, 2011, the number of actual applicants on the active wait list increased by 16 and the number of actual applicants on the inactive wait list increased by 427. During this same time period, the Pioneer Homes admitted 123 new residents.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	31	94	98	135	42	100	500
Inactive Branch	1,067	1,433	1,337	1,697	804	1,326	7,664
Total	**1,098**	**1,527**	**1,435**	**1,832**	**846**	**1,426**	**8,164**
Number of Applicants Choosing More than One Home (Duplicates)							4,102
Number of Actual Applicants on Active Wait List							356
Number of Actual Applicants on Inactive Wait List							3,706

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

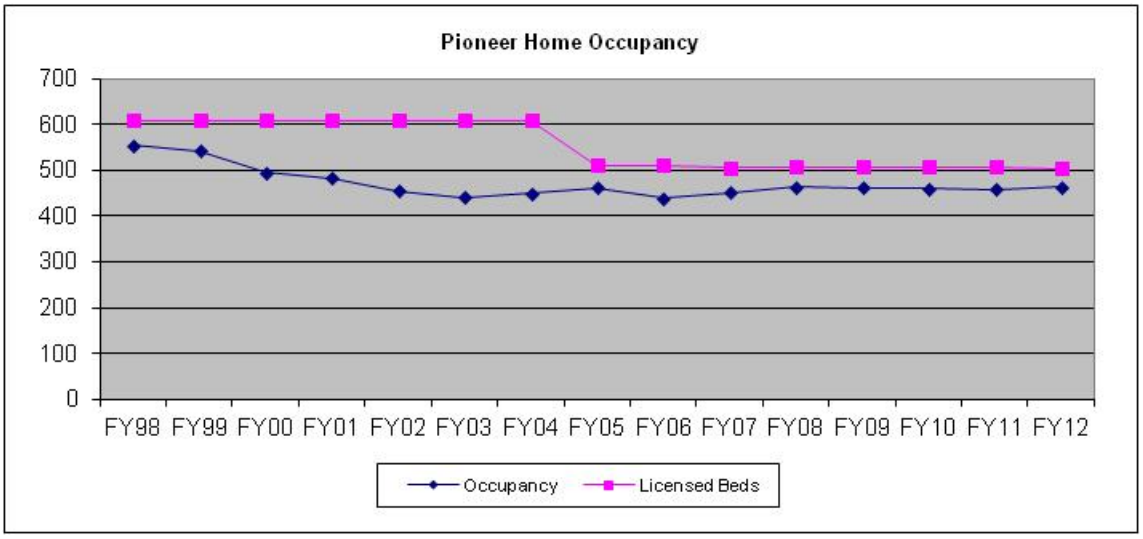
Effective Date	Level #1	Level #2	Level #3
July 2004	$2,240	$4,060	$5,880
July 2005	$2,240	$4,060	$5,880
July 2006	$2,240	$4,060	$5,880
July 2007	$2,240	$4,060	$5,880
July 2008	$2,240	$4,060	$5,880
July 2009	$2,350	$4,260	$6,170
July 2010	$2,350	$4,260	$6,170
July 2011	$2,350	$4,260	$6,170
July 2012	$2,350	$4,260	$6,170

Assistance from the Alaskans Living Independently 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

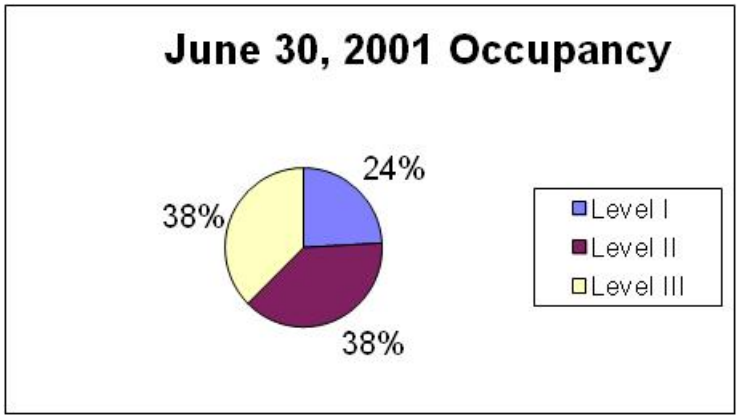
In FY2005, the division reduced the number of its licensed beds by 91 to more accurately reflect the number of beds that met current licensure requirements and were available for occupancy. In FY2006 the licensed beds in the Fairbanks and Juneau Homes decreased by three to reflect a safer resident-to-staff 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 September 30, 2012, there were seven Level I vacancies, ten Level II vacancies and seven 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.

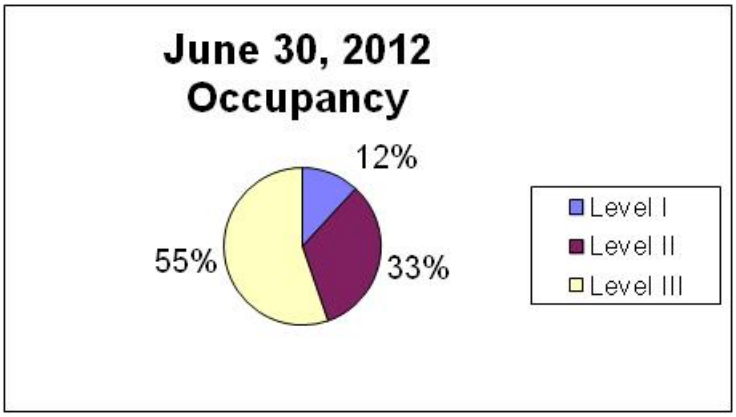
The following two graphs display: (1) actual occupancy to the total number of licensed Pioneer Home system beds and (2) the residents and the percentage of residents in each of the three care levels in FY1996 and FY2011. As mentioned above, the gap between licensed and occupied beds decreased significantly 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 eleven 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 24 to 12 percent.

Alaska Pioneer Homes Level of Service Breakdowns: 2001 and 2012



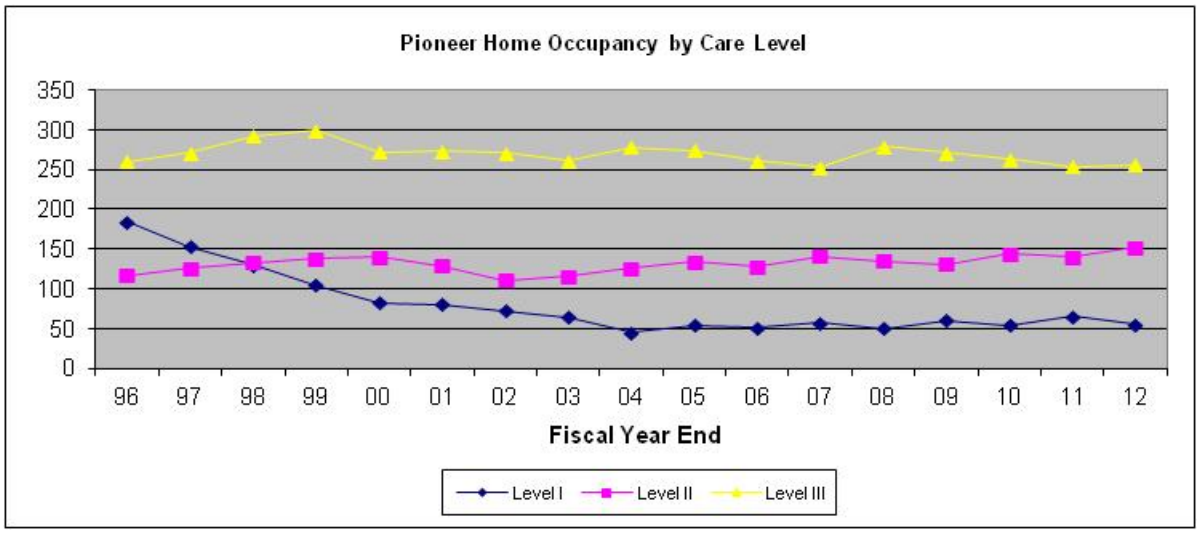


Current Pioneer Homes Occupancy

The table below shows the September 30, 2012 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home located in Palmer by level of service.

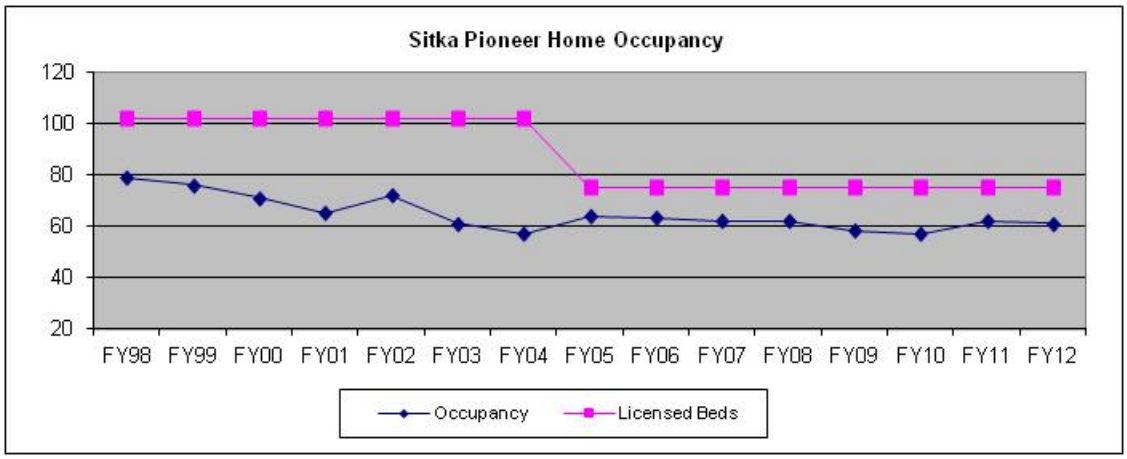
Service Level	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Occupied/Assigned							
Level I	6	8	3	37	3	1	58
Level II	22	27	18	49	12	26	154
Level III	33	50	54	81	26	18	262
Total	61	85	75	167	41	45	474
Licensed Beds	75	93	79	168	48	45	508
Non-Occupied	14	8	4	1	7	0	34
Unavailable	3	4	0	0	3	0	10
% Available Beds Filled	84.7%	95.5%	94.9%	99.4%	91.1%	100.0%	95.2%

The following graph shows the Pioneer Home occupancy by level of care from FY1996 through FY2012. As you can see, the care levels of the residents served over the past few years has remained relatively stable.



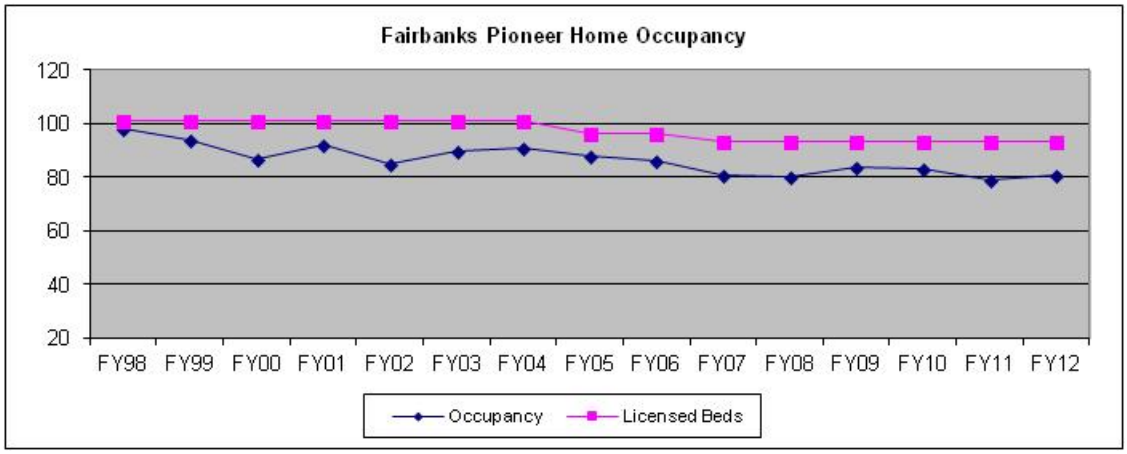
Sitka Pioneer Home

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, 61 were occupied as of September 30. 2012.



Fairbanks Pioneer Home

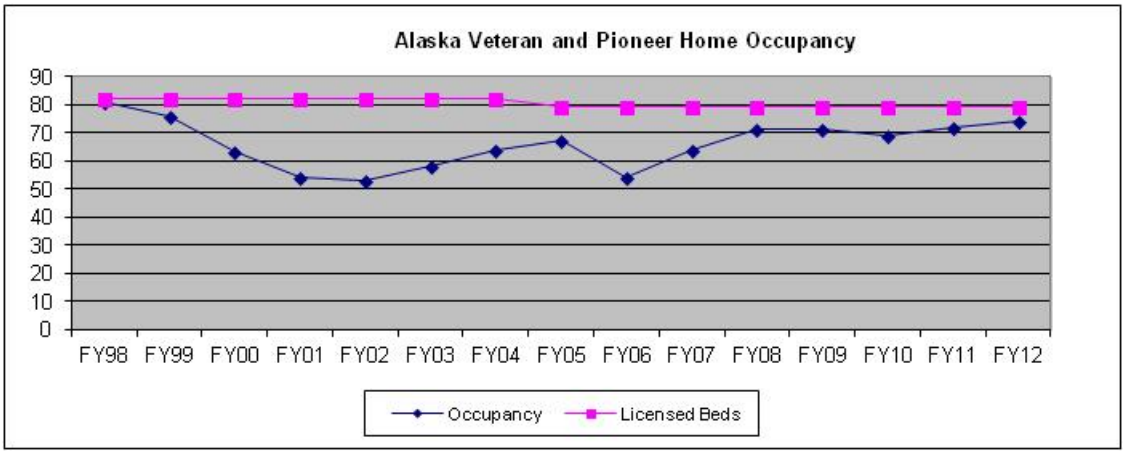
The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93. As of September 30, 2012, 85 of the 93 licensed 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 September 30, 2012 75 of the 79 licensed beds were occupied.

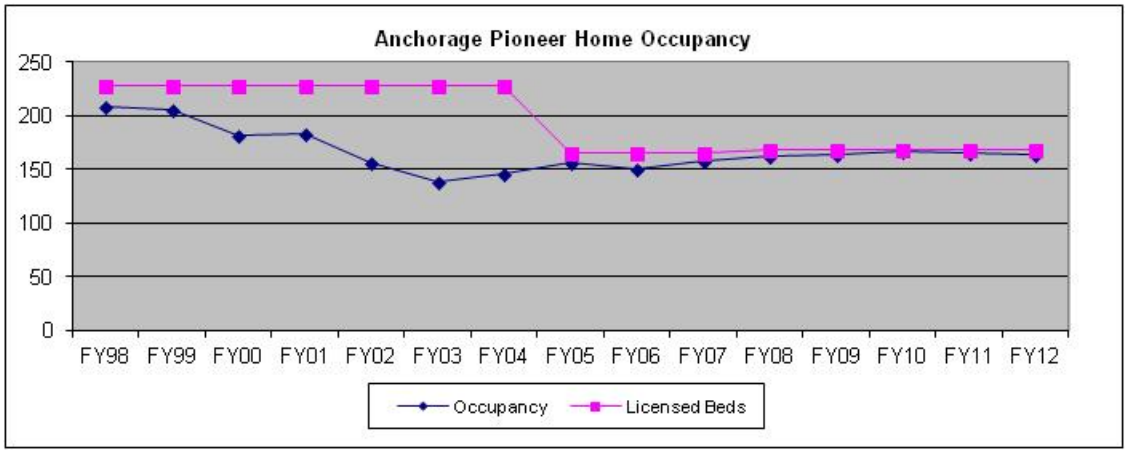
Effective February 2007, the Palmer Home was certified by the US Department of Veterans Affairs to become Alaska's first state Veterans Home. Veterans residing in this home are eligible to receive the federal domiciliary care per diem payment, which is currently $41.90 per day. The Home is transitioning to fill 59 of its 79 licensed beds with veterans. As of September 2012, 42 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

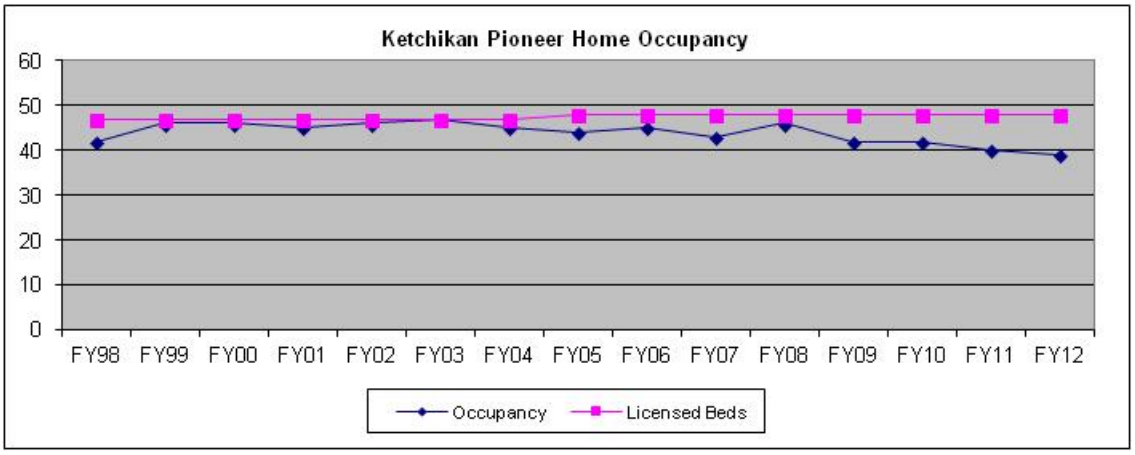
The Anchorage Home is the largest Pioneer Home with 168 licensed beds. The Home was built in two stages. The five-story south side was built in 1977 and the two-story north wing opened in 1982. As of September 2012, 167 of the 168 beds were occupied. Early in FY2008 the

Anchorage Home increased its licensed beds by three to accommodate Level I residents on the active wait list.



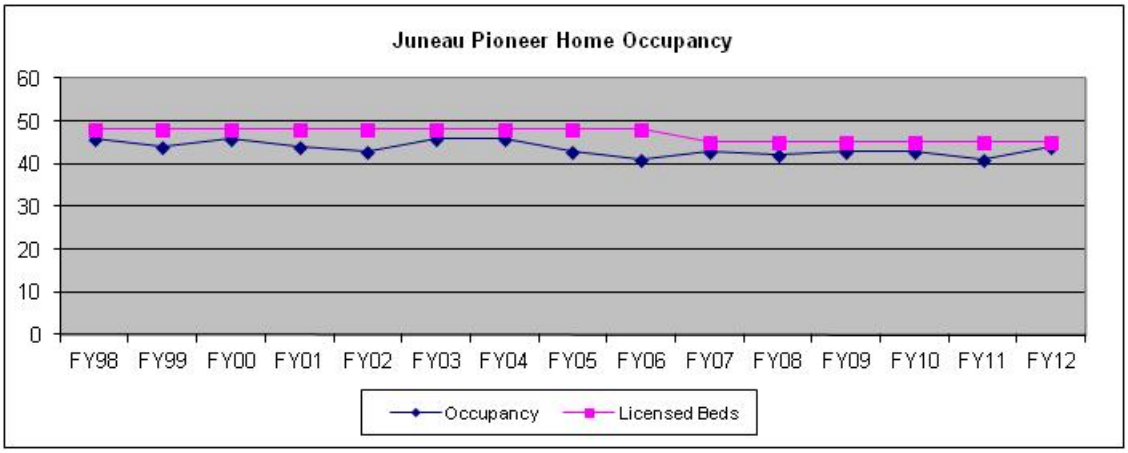
Ketchikan Pioneer Home

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 September 2012, 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 45 Alaska seniors as an Assisted Living Home and is licensed for 45 beds.



List of Primary Programs and Statutory Responsibilities

Statutes

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

Regulations

7AAC 74	Pioneers' Home – Revised August 2004

Alaska Pioneer Homes

Budget Overview Table

Alaska Pioneer Homes	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	**$35,504.8**	**$35,701.4**	**$196.6**
Designated General Funds	**16,328.3**	**16,103.3**	**-225.0**
Federal Funds	**342.0**	**567.0**	**225.0**
Other Funds	**9,193.5**	**9,193.5**	**0.0**
Total	**$61,368.6**	**$61,565.2**	**$196.6**

Budget Requests

Pioneer Homes Component

Align Fund Authorization with Actual Collections: $0.0 Total -- $225.0 Fed, -$225.0 GF/Prgm

In the FY2012 the Pioneer Home component collected $244.1 more than the federal receipt authorization. The federal receipts are federal per-diem payments to qualifying Veterans living in the Veterans and Pioneer Home in Palmer. During this same period, the division under collected its general fund program receipt authority by $325.9. The general fund program receipts are the resident payments towards their room, board, and monthly care.

While this fund change does not completely cover the under collection of program receipts, it moves the division closer to the actual collections realized in FY2012.

Alaska Pioneer Homes

Pioneer Homes Deferred Maintenance, Renovation, Repair, and Equipment: $3,871.2 Total -- $3,871.2 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 88% in June 2012. 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, 2012 the average age of a Pioneer Home resident was 86.5. 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 356 applicants as of September 30, 2012. This is double the 178 applicants on the wait list September 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.

Billing Medicaid for the Alaskans Living Independently Waiver

Due to a federal correct coding mandate, effective November 1, 2012 residential supported living claims must be submitted and billed with a single date of service. These claims were previously billed using a single line of coding for a full month or partial month of service. This increases the time spent on data entry from 100 lines of coding to 3,100 lines of coding for a 31 day month.

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 September 30, 2012 there were 42 veterans residing in the Alaska Veterans and Pioneer Home. This is an increase of seven 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

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN	
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.	
OUTCOME 1. Alaskans are healthy	
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who are immunized.
EFFICIENCY MEASURE	Cost per immunization.
EFFECTIVENESS MEASURE	Percent of Alaskans who are overweight/obese.
EFFICIENCY MEASURE	Cost per child of physical education campaign.
EFFICIENCY MEASURE	Total Women, Infant and Children grant cost per direct service FTE.
OUTCOME 2. Alaskans are free from unintentional injury	
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS	Percent of non-fatal injuries requiring hospitalization.

	MEASURE	
	EFFICIENCY MEASURE	Cost of emergency medical services per capita.
	EFFICIENCY MEASURE	Cost of injury prevention program per unintended injuries/deaths.
	EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of the department.
	EFFICIENCY MEASURE	Number of hospitalizations due to medication errors.
	EFFICIENCY MEASURE	Cost of medical services in facilities.
	EFFECTIVENESS MEASURE	Number of resident falls per 1000 resident bed days of care.
	EFFICIENCY MEASURE	Number of sentinel events due to falls.

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**
EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

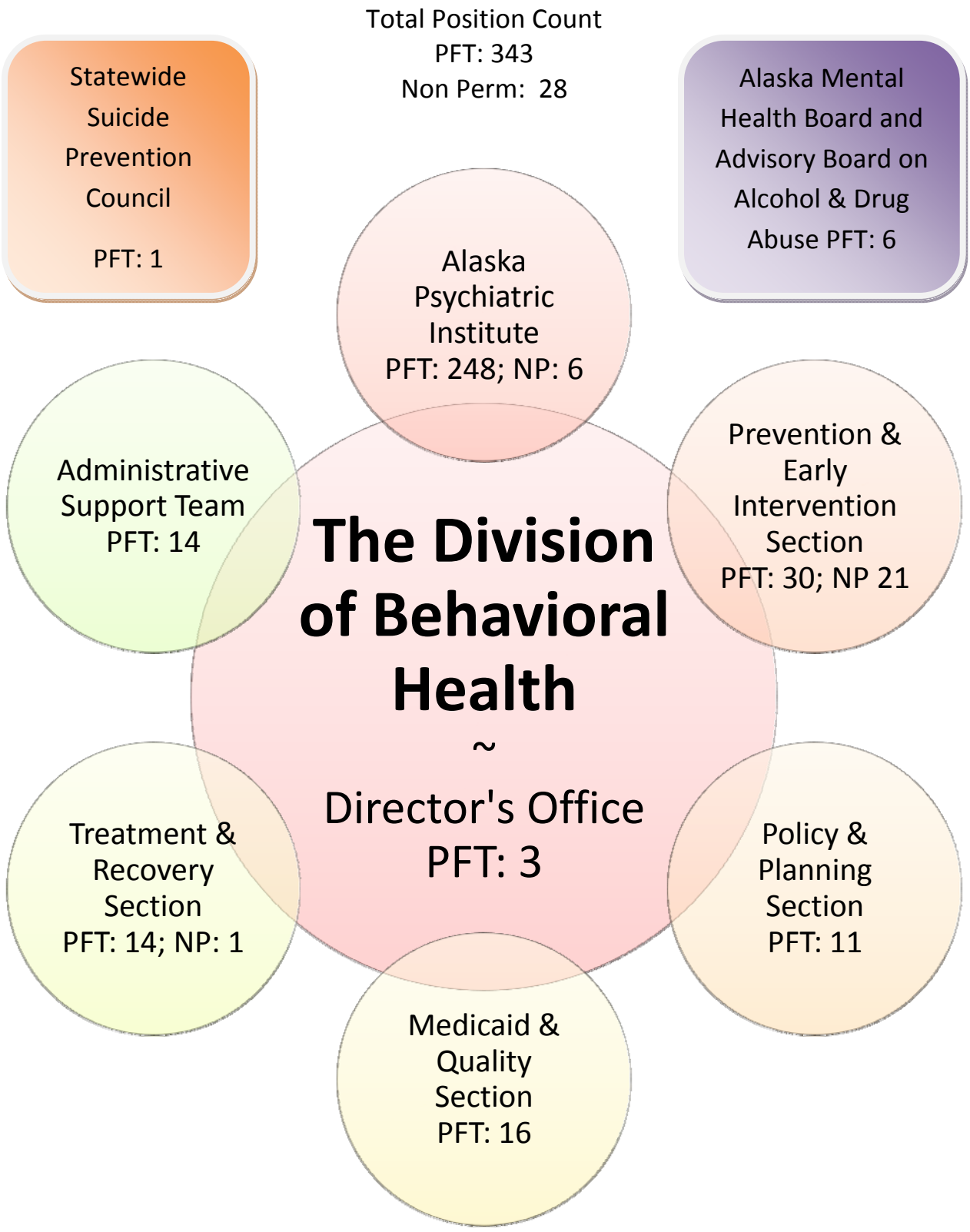
CORE SERVICE B. FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

OUTCOME 1. Alaskans have access to health care.		
EFFECTIVENESS MEASURE	**Percent of Alaskans in urban communities that can access care.***	
EFFICIENCY MEASURE	**Department cost per percent of Alaskans with access to care.***	
	*** AGGREGATE DIVISION MEASURES - (Percent of Alaskans in urban communities that can access care).**	
	EFFECTIVENESS MEASURE	Number of residents who access the Medicaid Waiver.
	EFFICIENCY MEASURE	Total Medicaid Waiver receipts.

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Alaska Pioneer Homes General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
FY2014 Salary and Health Insurance Increases (AKPHM)	$ 0.7	$ -	$ -	$ -	$ 0.7
Align Fund Authorization With Actual Collections (AKPH)	$ -	$ (225.0)	$ 225.0	$ -	$ -
FY2014 Salary and Health Insurance Increases (AKPH)	$ 138.7	$ 34.4	$ -	$ 22.8	$ 195.9
Replace Uncollectible Fund Sources for Personal Services Increases (AKPH)	$ 57.2	$ (34.4)	$ -	$ (22.8)	$ -
Alaska Pioneer Homes Total	***$ 196.6***	***$ (225.0)***	***$ 225.0***	***$ -***	***$ 196.6***

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.

Introduction

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 behavioral health (mental health and substance use disorder) services (see chart below). The array of behavioral health services crosses the lifespan of individuals and range from prevention and early intervention through treatment, including inpatient psychiatric hospitalization. Settings include clinic or community-based outpatient services, school-based programs, residential programs and hospital services. Services are provided in bush villages, rural and urban communities, and regional centers throughout the state.

Through a combination of funding streams that includes Medicaid, Federal Block Grants, and State funded grants, the Division funds programs and services to provide prevention and treatment services. The Division develops regulations and policies that govern the planning and implementation of services, and promotes program standards, utilization management measures, and quality requirements for provider performance and client outcomes. The division is committed to the Recovery-Oriented System of Care (ROSC) framework in the ongoing planning and implementation of services. The Recovery-Oriented System of Care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of behavioral health issues.

Behavioral health needs arise in various settings and circumstances. To maximize the treatment opportunities and access to care, the Division of Behavioral Health coordinates treatment services with various community, provider, and agency partners. 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, 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.

The Division 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 behavioral health (mental health and substance use disorder) services ranging from prevention, screening, and brief

intervention to acute psychiatric care. Included are services for the general population (prevention and brief intervention), individuals experiencing emotional disturbance and emergency/crisis, seriously mentally ill adults, seriously emotionally disturbed youth, and substance use disorder services for youth and adults.

The Division of Behavioral Health has a commitment to improve the quality life of Alaskans through the right service to the right person at the right time. **The Behavioral Health Continuum of Care** represents the range of services available to citizens of Alaska, according to their respective presenting need. Each individual component fulfills an essential role and contributes to the overall effectiveness of the continuum of care. The continuum of care represents a commitment to mitigating risk of behavioral health with prevention and early intervention, insuring Alaskans are served effectively at the lowest level of care possible, while recognizing that the most acute and chronic conditions require a corresponding increased level of services, supports and resources.

The Behavioral Health Continuum of Care

Population Served									
Adults									
General Population	✦	✦							
Emergency /Crisis	✦	✦	✦						
Emotional Disturbance	✦	✦	✦						
Substance Use Disorder	✦	✦	✦		✦	✦			
Severe Mental Illness		✦	✦					✦	✦
Co-occurring Disorders		✦	✦		✦	✦		✦	✦
Child/Youth									
General Population	✦	✦							
Emergency /Crisis	✦	✦	✦	✦					
Emotional Disturbance	✦	✦	✦	✦					
Substance Use Disorder	✦	✦	✦	✦	✦	✦			
Severe Emotional Disturbance		✦	✦	✦			✦		✦
Co-occurring Disorders		✦	✦	✦	✦	✦	✦		✦

Key to Acronyms
Residential BRS = Residential Behavioral Rehabilitation Services
DES/DET = Designated Evaluation & Stabilization / Designated Evaluation & Treatment

Services Provided

This section of the Budget Overview is organized to include a visual reference to each component of the continuum of care.

Prevention and Early Intervention Services

Within the Division of Behavioral Health (DBH), the section of Prevention and Early Intervention Services provides an array of behavioral health promotion, prevention and intervention programming. The core components of prevention and early intervention services, based on a theme of *partners promoting healthy communities*, include: community-based strategies to prevent and reduce adult and youth substance use and abuse; fetal alcohol spectrum disorders services; suicide prevention; youth development, resiliency and connectedness; tobacco enforcement and education; rural behavioral health workforce development through partnering with the University of Alaska Fairbanks (Rural Human Services and Social Work); and Alcohol Safety Action Program (ASAP) and therapeutic court programming.

The Division is committed to broadening the vision of Prevention and Early Interventions services.

- 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; traditional prevention strategies; and recognizing the need to act earlier and to incorporate all aspects of health into our state and community health planning.

- 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.

Seven prevention grant programs provide statewide community-level funding to align with the stated core components:

- Comprehensive Behavioral Health Prevention and Early Intervention Services
- Alcohol Safety Action Program
- Rural Human Services System Project
- Suicide Prevention
- Fetal Alcohol Spectrum Disorders Diagnostic Teams and Case Management
- Alaska's Strategic Prevention Framework State Incentive Grant
- Rural Domestic Violence & Sexual Assault Prevention Programs

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, i.e. Substance abuse, mental health, suicide, fetal alcohol spectrum disorders, underage alcohol use, family violence, juvenile delinquency, and other issues are interrelated.
- Each community applying for these funds is 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.

Alcohol Safety Action Program

- The Alcohol Safety Action Program is an integral part of the criminal justice and behavioral health care service systems, providing monitoring and tracking of clients referred by the criminal justice system to substance abuse services throughout the state.
- By entering the program, clients receive intensive case management, such as daily contact, alcohol and other drug testing, random home and work visits, group sessions and weekly court sessions.
- 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.
- Alcohol Safety Action Programs operate in Anchorage, Fairbanks, Juneau, Kenai/Homer, Kotzebue, Wasilla/Palmer, Dillingham, Glenallen, Ketchikan, Kodiak, Seward, Nome and Bethel.
- 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.
- 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 the Alcohol Drug Information School believe that the course was either helpful or very helpful, and 85% report that the program helped them make changes in the behaviors that caused their problems in the first place.

	FY2011	FY2012
***ASAP New Case Statistics**		
Adult ASAP	7829	6809
Juvenile ASAP	2038	1518
Total ASAP	9867	8633
Adult Cases Completed & Closed	*4122	*3116
Juvenile Cases Completed & Closed	975	774
****Therapeutic Court Statistics**		
Point in Time Caseload (# participants at end of quarter)	398	238
New Admissions	172	184
Therapeutic Court Graduates	103	145

Data Notes:
*Alcohol Safety Action Program Misdemeanor Court: When a 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.
**Anchorage Wellness Court Exit Data October 1, 2006-September 30, 2011:
Two hundred seventy one (271) participants exited the Anchorage Wellness Court between October 1, 2006 and September 30, 2011. Of those who exited the Anchorage Wellness Court, 243 or 89% have had no further substance related vehicular sentencing.

Fetal Alcohol Spectrum Disorders Diagnostic Team & Case Management Provider Agreements

- The Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Team Network provides a system for trained and approved community-based Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Teams, who receive a Provider Agreement payment following the completion of a Fetal Alcohol Spectrum Disorders diagnosis.
- Currently, five community-based Fetal Alcohol Spectrum Disorders Diagnostic Teams are registered as State "approved" providers of Fetal Alcohol Spectrum Disorders diagnostic services. Teams are located in Bethel, Kenai, Fairbanks, Anchorage, and Sitka. At this time the Juneau team, is searching for an appropriate administrative home. There is interest in developing diagnostic teams in Dillingham, Nome, and Barrow.
- During FY2012 a total of 194 diagnoses were completed, an increase from the 179 diagnoses completed in FY2011. This diagnostic rate is notably high and speaks to the enhanced diagnostic capacity of the current five Fetal Alcohol Spectrum Disorders diagnostic teams.

- By converting Fetal Alcohol Spectrum Disorders data entry to Alaska Automated Information and Management System, Prevention and Early Intervention will be better able to access and analyze outcome data.
- In FY2012, the state implemented a new initiative to provide case management services to individuals who have been diagnosed with a Fetal Alcohol Spectrum Disorders by one of the diagnostic teams located in Kenai, Bethel, Juneau, or Sitka. This new effort will provide services needed to link people with Fetal Alcohol Spectrum Disorders to necessary community resources.
- The most current Alaska Fetal Alcohol Syndrome prevalence rates show an overall 32% decrease in Fetal Alcohol Syndrome 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

- The Rural Human Services System Project 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 internships at local agencies for students taking Rural Human Service 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 Rural Human Services (RHS) certification program while living and working in their home community. Following Rural Human Services (RHS) certification, students can continue in the Human Services Associate degree program and continue into the Intensive Rural Bachelor of Social Work program.
- Currently Rural Human Services Systems Project grants fund students through twelve regional hub agencies in rural Alaska from Kotzebue to the Eastern Aleutian Islands.
- The Rural Human Services System Project 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.

Suicide Prevention

Suicide is a critical issue for the State of Alaska. As such, the 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 Alaska's Veterans organizations.

Specialized strategies include:

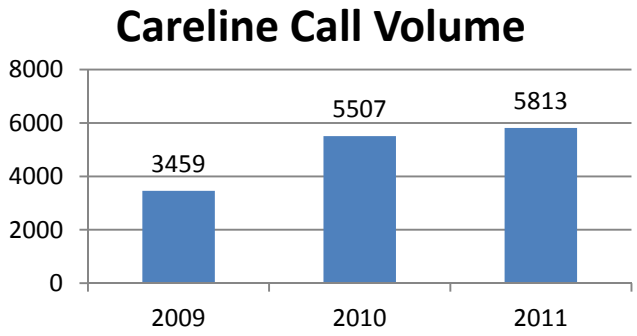
- The Postvention project will consist of 1) training of trainer's model utilizing a postvention best-practice *Connect Postvention Training*, 2) enhanced postvention resource guide and survivor of suicide loss materials. Behavioral Health plans to solicit a

statewide contract for training and technical assistance to help support communities in developing these resources locally.

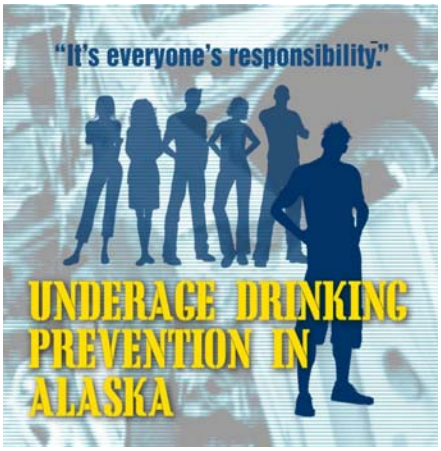
- Alaska's suicide prevention initiative includes the strategy to integrate and align suicide prevention programs with other behavioral health prevention strategies. This approach allows the Division of Behavioral Health and its partners to place emphasis on the multiple risk and protective factors that are strongly associated with suicide.
- The Division is working to improve monitoring of 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 statewide suicide prevention web-portal www.stopsuicidealaska.org will continue development and will be used as an on-going resource to strengthen statewide coordination.

Targeted suicide prevention programming that contributes to the continuum of care includes:

- A 3-year contract with the Alaska Careline, the state's only crisis call center. Recently, the Careline released a new texting option to increase outreach efforts to vulnerable teens. This strategy has been found (in Nevada) to dramatically increase call volume for this hard-to-reach population. Careline will also begin to utilize the Alaska Automated Information Management System for data entry which will allow us to measure call volume and effectiveness of services.
- Careline Data Notes:
    - Careline has seen an **8% increase in new callers**, from 27% of the total call volume in FY2011 to 35% in FY2012. However, new caller volume has slowed even showing a slight decrease indicating a "leveling out" that requires a review of call procedures and strategies.
    - More recent data (January-June, 2012) shows callers are experiencing a reduction in suicidality and an increase in accepted follow-back calls and referrals for services.
    - Of 1,148 calls **75% indicated a reduction in risk** by the end of the call. This is a slight decrease of 3% from last period.
    - Increase of **6% follow-up calls,** out of total Careline call volume.



Alaska's Strategic Prevention Framework State Incentive Grant: Building Community Coalitions and Regional Infrastructure



- 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)
  - and Adult heavy and binge drinking (ages 21-44)
- Six grantees across the state have received Strategic Prevention Framework State Incentive grant funds to address these priority areas. In addition to addressing alcohol abuse each grantee has identified a community-level consequence resulting from adult heavy and binge drinking.

Rural Domestic Violence and Sexual Assault Prevention Programs

- 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. Behavioral Health took the lead in three primary Domestic Violence and Sexual Assault prevention projects:
  - Rural Domestic Violence and Sexual Assault Prevention Pilot Projects;
  - Trauma Informed Care Training for Service Providers; and
  - Expansion of the Family Wellness Warriors Initiative.

Prevention Programs and Initiatives

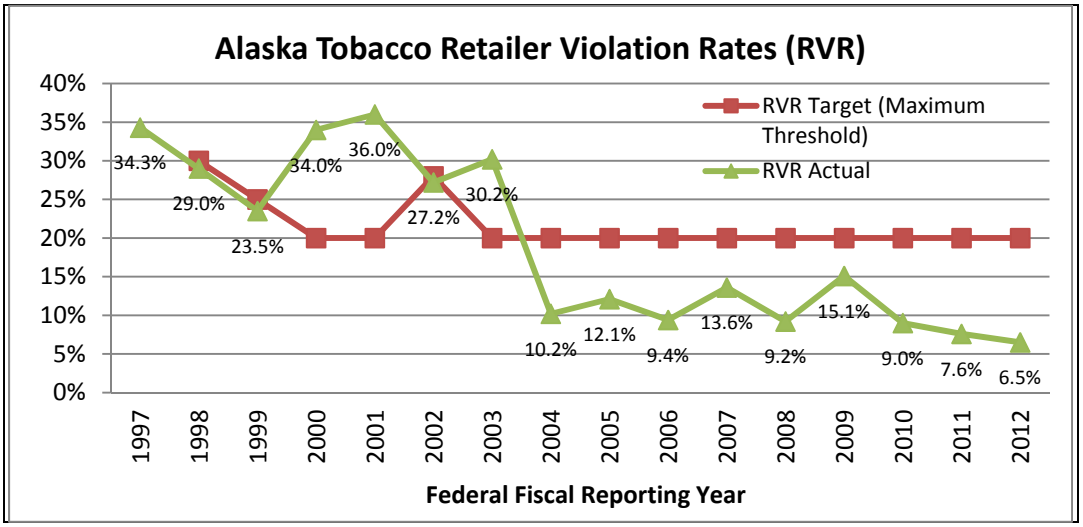
In addition to grant funded services the Division has a number of other programs and initiatives that complement our grant programs. The prevention programs and initiatives are described below and include:

Alaska's Plan to Reduce and Prevent Underage Drinking

- In October 2009, the Division of Behavioral Health, in partnership with the Alaska Interagency Committee to Prevent Underage Drinking, 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 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 DBH developed a video related to underage drinking in Alaska. 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

Tobacco Enforcement and Education

- The Tobacco Enforcement and Education program 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 6.5% in 2012. 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.



Treatment and Recovery Services

Substance Use Disorder Treatment Services

For Substance Use Disorder (SUD) treatment, the Division offers competitive grant funding to community behavioral health agencies to provide a range of services for adult and youth populations: outpatient (clinic and rehabilitation), residential treatment, and detoxification. Supportive services include housing, employment, peer support, education, advocacy, and case

management. The Substance Use Disorder service array may include crisis intervention; brief therapeutic interventions for stabilization; and individual, group, family, and psychiatric supports. The Division funds these services from the Behavioral Health Grant component. Higher levels of acuity and severity may require referral to higher levels of care within the treatment continuum including Alaska Psychiatric Institute (API) or a hospital (i.e. Designated Evaluation and Stabilization / Designated Evaluation & Treatment facility).

The Division utilizes the American Society of Addiction Medicine (ASAM) to inform the continuum of care for Substance Use Disorder treatment based on clients presenting symptoms and needs. Division grantees providing Substance Use Disorder treatment services provide one or more levels of care to the community or region they serve. All services are informed by industry principles of effective treatment:

- Addiction is a complex but treatable disease that affects brain function and behavior
- Remaining in treatment for an adequate period of time is critical.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- Many individuals with substance abuse also have co-occurring mental health disorders.
- Treatment programs should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

Services for Substance Use Disorder (SUD) Adults and Youth include:

<u>Outpatient Treatment</u>

- Outpatient services include two levels of care (1) basic outpatient and (2) intensive outpatient. Intensive outpatient is a higher level of care, requiring nine hours of treatment a week. Outpatient care is offered at over forty sites statewide.
- Outpatient services are also available for Opioid abusers who may require medication assisted treatment.
- Utilization of outpatient services: The number of individuals who received outpatient services has continued to decrease, with a 3.7% decrease from FY2009 to FY2010, a 5.0% decrease from FY2010 to FY2011, and a 1.1% decrease from FY2011 to FY2012. Across the four year period, the number decreased by 9.5% (from 4,499 in FY2009 to 4,073 in FY2012).
- Utilization of Opioid services: The number of individuals who received opioid services has continued to increase, with a 2.0% increase from FY2009 to FY2010, a 24.0% increase from FY2010 to FY2011, and a 2.7% increase from FY2011 to FY2012. Across the four year period, the number increased by 29.9% (from 147 in FY2009 to 191 in FY2012).
- Utilization of other Substance Use Disorder services (non-treatment services): The number of individuals who received non-treatment Substance Use Disorder services has continued to increase, with a 4.8% increase from FY2009 to FY2010, a 20.2% increase from FY2010 to FY2011, and a 58.8% increase from FY2011 to FY2012. Across the four year period, the number increased by 100% (from 547 in FY2009 to 1,094 in

FY2012). These services include substance abuse case management, assessment only, and other non-treatment Substance Use Disorder services.

Residential Substance Use Disorders Treatment

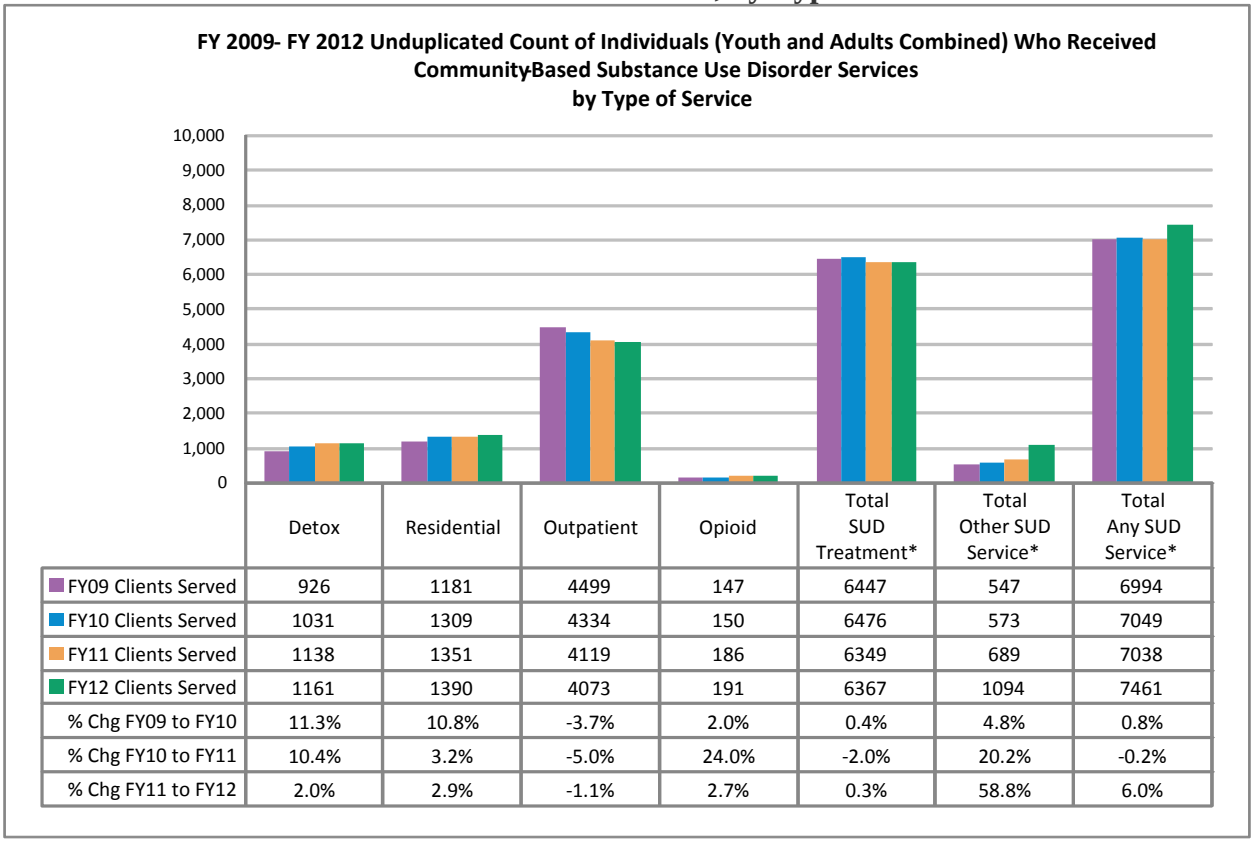
- Residential treatment is provided in fifteen sites across the state, including: Anchorage, Fairbanks, Juneau, Sitka, Ketchikan, Dillingham, Eagle River, Old Minto and Wasilla.
- Specialized residential treatment for youth, pregnant women, and women with children is also available.
- Utilization of Residential services: The number of individuals who received residential services has continued to increase, with a 10.8% increase from FY2009 to FY2010, a 3.2% increase from FY2010 to FY2011, and a 2.9% increase from FY2011 to FY2012. Across the four year period, the number increased by 17.7% (from 1,181 in FY2009 to 1,390 in FY2012).

Detoxification Services

- One of the goals of detoxification in addition to stabilization of the clients' medical condition is to motivate the client to enter and complete treatment.
- Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.
- Detoxification patients have the most acute medical symptoms. Detoxification takes from three to five days depending upon the condition of the patient.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
- Detoxification services are currently provided in Anchorage, Fairbanks, and Juneau.
- Utilization of Detoxification services: The number of individuals who received detoxification services has continued to increase, with an 11.3% increase from FY2009 to FY2010, a 10.4% increase from FY2010 to FY2011, and a 2.0% increase from FY2011 to FY2012. Across the four year period, the number increased by 25.4% (from 926 in FY2009 to 1,161 in FY2012).

A summary of the FY2009 to FY2012 unduplicated count of individuals (youth and adults combined) who received Substance Use Disorder services, by type of service, is presented in the Chart below:

Chart 1: FY2009-FY2012 Number of Individuals who Received Substance Use Disorder Services, by Type of Service



	Detox	Residential	Outpatient	Opioid	Total SUD Treatment*	Total Other SUD Service*	Total Any SUD Service*
FY09 Clients Served	926	1181	4499	147	6447	547	6994
FY10 Clients Served	1031	1309	4334	150	6476	573	7049
FY11 Clients Served	1138	1351	4119	186	6349	689	7038
FY12 Clients Served	1161	1390	4073	191	6367	1094	7461
% Chg FY09 to FY10	11.3%	10.8%	-3.7%	2.0%	0.4%	4.8%	0.8%
% Chg FY10 to FY11	10.4%	3.2%	-5.0%	24.0%	-2.0%	20.2%	-0.2%
% Chg FY11 to FY12	2.0%	2.9%	-1.1%	2.7%	0.3%	58.8%	6.0%

*** Key:**

Total SUD Treatment: Total unduplicated count of youth and adults who received treatment for a substance use disorder. Treatment includes the following types of services: detoxification, residential, outpatient, and opioid.

Total Other SUD Service: Total unduplicated count of youth and adults who did not receive a Substance Use Disorder *treatment* service, but did receive a Substance Use Disorder *non-treatment* service (e.g., assessment only, case management, etc.)

Total Any SUD Service: Total unduplicated count of youth and adults who received any Substance Use Disorder service (includes *treatment* and *non-treatment* services).

Data Source: *Alaska Automated Information Management System (AKAIMS) Treatment Utilization Matrix and DBH Uniform Reporting (UR) Client Profile Tables.*

Psychiatric Emergency Services (PES)

The Division funds community behavioral health agencies for Psychiatric Emergency Services (PES) services intended to aid people experiencing a behavioral health crisis. Psychiatric Emergency Services may include: crisis intervention; brief therapeutic interventions for stabilization; and family, consumer, and community wrap-around supports. Higher levels of acuity and severity may require referral to higher levels of care within the treatment continuum including Alaska Psychiatric Institute (API) or a hospital (i.e. Designated Evaluation & Stabilization / Designated Evaluation & Treatment facility).

The following guiding principles / objectives inform quality of care:

- Acknowledging that many people in psychiatric crisis are also under the influence of alcohol or other drugs, Alaska's behavioral health Psychiatric Emergency Services system works to incorporate, to the extent feasible, local access to treatment services, with the goal of appropriately treating the psychiatric and substance use symptoms identified.
- Maintaining functioning partnerships between local hospitals and community behavioral health providers and other key social service agencies in order to facilitate efficient and effective shared responses to local behavioral health emergencies.
- The development of quality local Psychiatric Emergency Services throughout the State, as well as the development of alternatives to hospitalization (such as crisis respite beds), to minimize admissions to Alaska Psychiatric Institute.

Specialized and targeted initiatives include:

- The Division continues implementation of the Psychiatric Emergency Services system changes including a focus on patient secure transportation, behavioral health clinic and hospital relationships, and the role of the courts in mental health emergencies.
- The Division, in collaboration with the Alaska State Hospital & Nursing Home Association, has a priority focus on the negative impacts on hospital emergency departments specific to the process of patient transfers to the Alaska Psychiatric Institute or a Designated Evaluation & Stabilization / Designated Evaluation & Treatment hospitals.

Services for Seriously Mentally Ill (SMI) Adults

The Division utilizes competitive grant funding for community behavioral health agencies to provide an array of treatment services for adults with severe mental illness. Community-based services are intended to enable people with serious mental illness to live in their home communities as independently as possible and in the least restrictive environment. Core services include assessment, psychiatry, medication management, clinical therapies, and rehabilitative services. Specialized services include supported living, supported employment and intensive services necessary to maintain community placements. Effective services at the community level help to manage the access of higher levels of care, including referrals to Designated Evaluation & Stabilization / Designated Evaluation & Treatment and the Alaska Psychiatric Institute (API).

Additionally, guiding principles inform quality of care:

- The Division continues to develop a "Recovery Oriented System of Care" that provides coordinated community-based services and supports. These supports are person-centered and promote strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with behavioral health issues.

- Respect individual, family and community values (culturally competent, individualized care, community-specific solutions).
- Consumers are satisfied and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability).

Specially funded components of this component of the continuum of care include:

- **Alaska Complex Behavior Collaborative**
  Increasing numbers of individuals with mental illness have co-occurring cognitive disabilities and such complex, challenging behaviors that they are at risk for psychiatric hospitalization, incarceration, or costly out-of-state placement in Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The Complex Behavior Collaborative (CBC) was initiated to develop competency and capacity within the Alaska workforce to effectively deal with the challenging behaviors. The Complex Behavior Collaborative consultation and training component provides services to community agencies that are working with the most difficult individuals who present complex behavior management needs, helping to keep them in the community, reduce lengths of stays in inpatient settings, and divert admissions from the Alaska Psychiatric Institute and out-of-State placement. Assistance is also provided to the Pioneer Homes and long-term care providers to work successfully with their most difficult residents.

- **Bridge Home**
  Bridge Home is a Mental Health Trust funded pilot program operating in Anchorage. This program is based on a "Housing First" model where a person is housed first to get him/her safely off the streets after which needed services are provided. The program is outcome driven and has shown repeatedly in past years to be able to reduce use of inpatient psychiatric services at Alaska Psychiatric Institute and to reduce use of Department of Corrections resources by clients that have a documented history of high utilization of these resources. The Bridge Home project provides transitional housing and services for clients who have failed in other placements and would otherwise likely be incarcerated or hospitalized due to their difficult and challenging behaviors. A similar smaller program is funded and operated in Juneau. It has shown much success in housing and supporting hard to serve SMI adults who have failed in most other local housing. FY2013 funding is also being utilized to begin to develop an assertive community treatment (ACT) program to better engage and serve the high needs, complex, seriously mentally ill population in Anchorage.

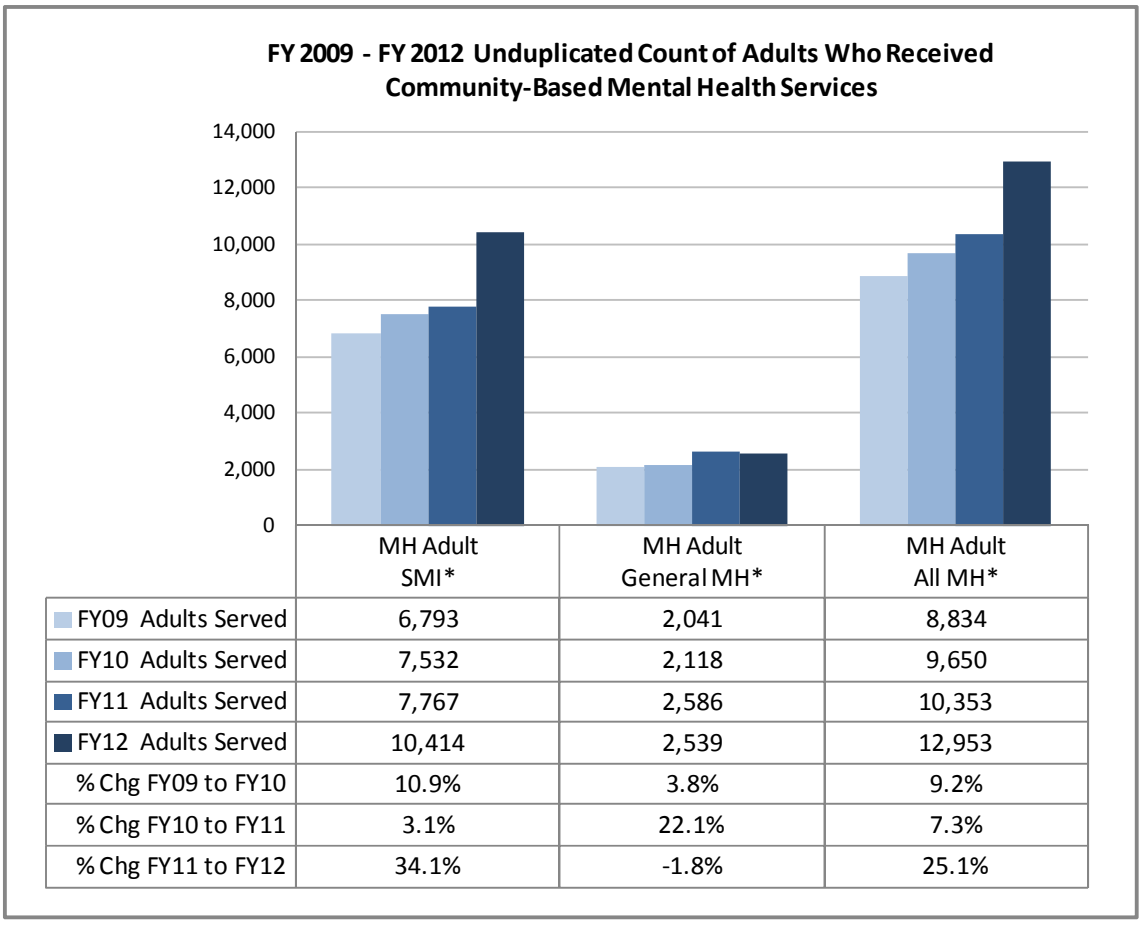
- **DOC Grants**
  The Department of Corrections (DOC) Discharge Incentive Grant funds the community based post-release program. The purpose of this grant is to provide for the immediate needs (primarily supportive housing) of a person who has a serious mental illness who is exiting Department of Corrections incarceration. This is a transitional program that provides supports until the person can be integrated into the standard community service delivery system and is especially important for individuals who have felony crimes that present barriers to housing. This is collaboration between the Division of Behavioral Health, the Mental Health Trust Authority and Department of Corrections.

- **Individualized Services Agreements (ISA)**
  The Individualized Services Agreements for Adults with Serious Mental Illness offer flexible funding to individuals at risk of de-compensation and potential hospitalization. Currently Individualized Services Agreements are available to agencies in the Anchorage and South Central regions where Alaska Psychiatric Institute admissions are highest, the program provides funding for a variety of both traditional and flexible behavioral health services including support for the cost of psychiatric medication and transportation to access services.

A summary of the FY2009 to FY2012 unduplicated counts of adults who received services are presented in Chart 2 below. General trends across the four year period are as follows:

- Adults with serious mental illness (SMI): Across the four year period, the number served increased by 17.7% (from 6,793 in FY2009 to 7,994 in FY2012).
- Adults receiving general mental health services (Non-SMI adults): Across the four year period, the number served increased by 24.4% (from 2,041 in FY2009 to 2,539 in FY2012).

Chart 2: FY2009-FY2012 Number of Adults who Received Community-Based Mental Health Services



	MH Adult SMI*	MH Adult General MH*	MH Adult All MH*
FY09 Adults Served	6,793	2,041	8,834
FY10 Adults Served	7,532	2,118	9,650
FY11 Adults Served	7,767	2,586	10,353
FY12 Adults Served	10,414	2,539	12,953
% Chg FY09 to FY10	10.9%	3.8%	9.2%
% Chg FY10 to FY11	3.1%	22.1%	7.3%
% Chg FY11 to FY12	34.1%	-1.8%	25.1%

Chart Key:

MH Adult - SMI: Adults with Serious Mental Illness (SMI) who received Mental Health (MH) services; includes individuals with Co-Occurring disorders. **FY2012 is the first year that the count of adults with SMI includes individuals who received illness self management services (n=2420).**

MH Adult - General MH: Non-SMI Adults who received General Mental Health services; includes individuals with Co-Occurring disorders.

MH Adult - All MH: All Adults (SMI and Non-SMI) who received Mental Health services; includes individuals with Co-Occurring disorders.

Data Source: *Alaska Automated Information Management System (AKAIMS), DBH Uniform Reporting (UR) Client Profile Tables. Starting in FY2012, the number of adults who received illness self management (ISM) services was added to the AKAIMS count for the total number adults with SMI who received services. Due to this change in methodology, caution should be exercised when making comparisons with prior year data.* ***In FY2012, the AKAIMS count of adults with SMI was 7,994; the total number of adults with SMI who received community-based mental health services was 10,414, which includes 2,420 adults who received ISM services.***

Services for Seriously Emotionally Disturbed Youth (SEDY)

For Seriously Emotionally Disturbed Youth (SEDY) the Division offers competitive grant funding to community behavioral health agencies to provide a range of services: community based outpatient (clinic and rehabilitation) services and residential treatment services. Seriously Emotionally Disturbed Youth 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. Additionally, the following guiding principles inform quality of care:

- 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)
- Consumers are satisfied, and collaborative meaningful outcomes are achieved (emphasis on research, evidence, quality improvement, accountability)

Additional grants are targeted to support development of appropriate community services, reduce out-of-state treatment, transition youth to independent living, reduction of length of stay, etc. Grant outcomes are designed to:

- Improve local community-based services for individuals with co-occurring developmental and behavioral health challenges including cross system communication, data development and tracking, and use of best practices.
- Focus on children in the context of their families and to intervene with children and families earlier and before problems become severe.
- Expand transition-aged youth interventions to address young people with behavioral health challenges and experience high rates of homelessness, unemployment, poverty and reliance on emergency health and mental health services as they move into adulthood.

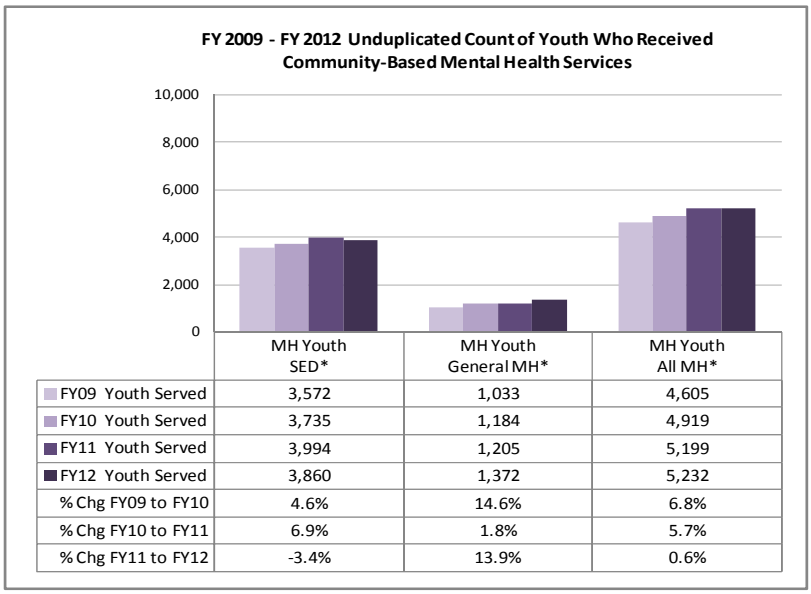
Specialized and targeted initiatives include:

- The evidence-based practice "Parenting with Love and Limits" (PLL) contract provides bi-weekly telephonic supervision to clinicians who have been trained in seven sites in Kenai Peninsula, Anchorage, Fairbanks, Kodiak, Mat-Su, and Ketchikan. A total of 141 youth and families were served in FY2012 including youth returned to the home from in-state and out-of-state residential treatment and in-state Division of Juvenile Justice facilities.
- A Transitional Aged Youth contract using the Transition to Independence Process (TIP) model included site visits to Anchorage, Sitka, Juneau, Fairbanks, and Mat-Su in which community wide stakeholder trainings occurred in addition to grantee focused Transitional Aged Youth training specifically with program managers and peer facilitators.
- Parent and Youth Navigation services: 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.

A summary of the FY2009 to FY2012 unduplicated counts of youth who received mental health services are presented in Chart 3 below. General trends across the four-year period are as follows:

- Youth with severe emotional disturbance (SED): Across the four-year period, the number served increased by 8.1% (from 3,572 in FY2009 to 3,860 in FY2012.
- Youth receiving general mental health services (Non-SED youth): Across the four-year period, the number served increased by 32.8% (from 1,033 in FY2009 to 1,372 in FY2012).

Chart 3: FY2009-FY2012 Number of Youth who Received Mental Health Services



	MH Youth SED*	MH Youth General MH*	MH Youth All MH*
FY09 Youth Served	3,572	1,033	4,605
FY10 Youth Served	3,735	1,184	4,919
FY11 Youth Served	3,994	1,205	5,199
FY12 Youth Served	3,860	1,372	5,232
% Chg FY09 to FY10	4.6%	14.6%	6.8%
% Chg FY10 to FY11	6.9%	1.8%	5.7%
% Chg FY11 to FY12	-3.4%	13.9%	0.6%

Chart 1Key:

MH Youth - SED: Youth with Serious Emotional Disturbances (SED) who received Mental Health (MH) services; includes individuals with Co-Occurring disorders.

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

MH Youth - All MH: All Youth (SED and Non-SED) who received Mental Health services; includes individuals with Co-Occurring disorders.

Data Source: *Alaska Automated Information Management System (AKAIMS), DBH Uniform Reporting (UR) Client Profile Tables.*

Designated Evaluation and Stabilization (DES) Services and Designated Evaluation and Treatment (DET) Services

The Division makes public funds available for hospitals treating patients who are court-ordered for involuntary, inpatient psychiatric evaluation and stabilization and/or treatment. The Designated Evaluation and Stabilization (DES) and Designated Evaluation and Treatment (DET) hospitals provide the level of intervention required to appropriately treat Alaska residents experiencing acute behavioral health crises and either return them to their home community after stabilization (the Designated Evaluation and Stabilization level of care) or refer them to the next higher level of care.

The Designated Evaluation and Stabilization and Designated Evaluation and Treatment service array includes inpatient psychiatric evaluation (up to 72 hours), crisis stabilization (up to 7 days), or inpatient psychiatric treatment services (up to 40 days) as close to the consumer's home as

possible, in order to take advantage of family and other local support systems. Component funding also supports consumer and escort travel between the designated hospitals and their home community.

The Designated Evaluation and Stabilization level care is offered at Peace Health Ketchikan Medical Center and Yukon-Kuskokwim Delta Regional Hospital in Bethel. Longer term, more intensive Designated Evaluation and Treatment level care is offered at Bartlett Regional Hospital in Juneau for Southeast Alaskans and at Fairbanks Memorial Hospital for Interior and Northern Alaskans.

Program principals include:

- The state is mandated to pay for these hospital-based services when a person experiencing a behavioral health crisis: 1) becomes the subject of a court-ordered involuntary evaluation or treatment commitment, and 2) meets certain statutorily-defined criteria (e.g., low income, lack of or inadequate insurance coverage).
- A resident has the option even if (s)he has been court-ordered to receive appropriate evaluation and / or treatment services, or would otherwise meet commitment criteria, to accept inpatient services voluntarily, in lieu of any formal commitment procedures.
- These hospital-based treatments, Designated Evaluation and Stabilization and Designated Evaluation and Treatment, assist the Division in controlling admissions to the Alaska Psychiatric Institute, Alaska's only public psychiatric hospital, which has very limited capacity.

Alaska Psychiatric Institute

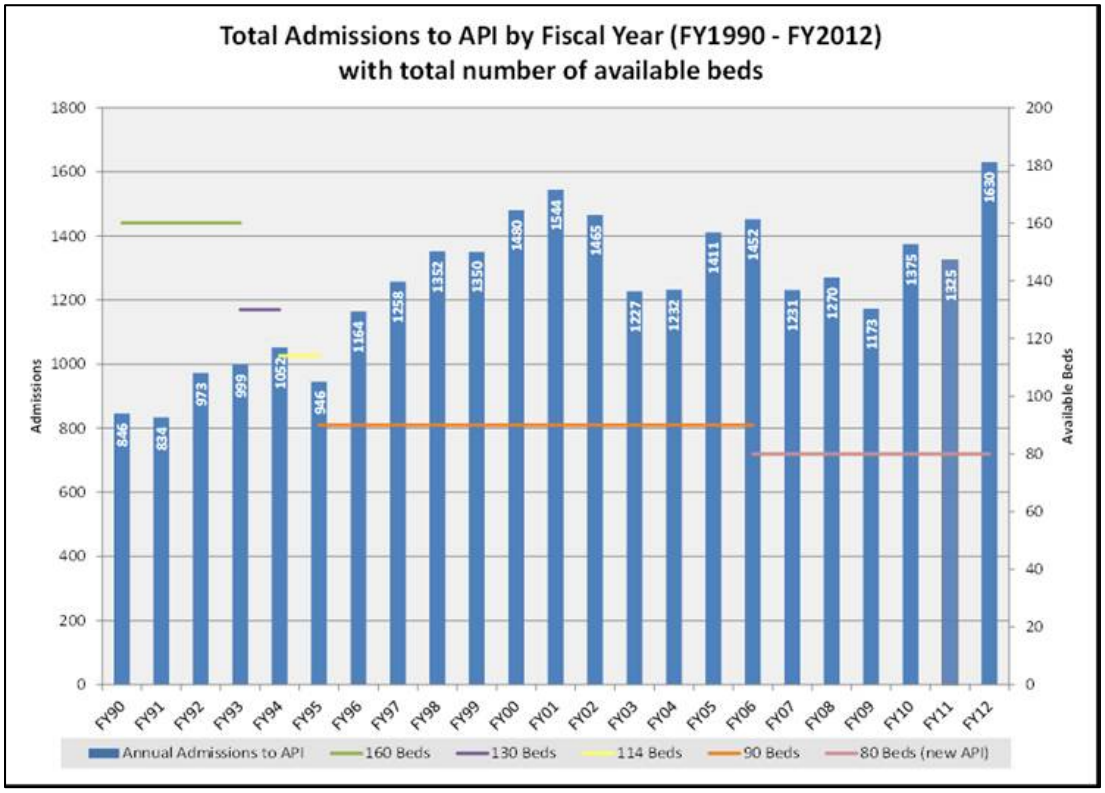
The Alaska Psychiatric Institute treats the most acute phase of a psychiatric illness when hospitalization is medically necessary. The treatment focus is on the resolution of acute symptoms which interfere with daily functioning and the precipitating psychosocial stressors that preceded the need for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

Principles and objectives to guide quality of care:

- Alaska Psychiatric Institute's treatment philosophy:
    - Provide for the safety and health of persons served and staff;
    - Accept and respect individuals' uniqueness and affirms and nurtures their worth and hope;
    - Apply the best scientific knowledge available to inform and engage persons being served with choices and responsibility for managing their recovery;
    - Provide services in a trusting partnership with persons being served, their families, and support systems.

- Alaska Psychiatric Institute utilizes an acute care model of inpatient psychiatric treatment services.
- 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.

During FY2012, the Alaska Psychiatric Institute – Alaska Recovery Center completed the transition to an acute care model of inpatient psychiatric treatment services. Also of consequence in FY2012 was a marked increase in admissions (total annual admissions: 1,630).



Specialized and targeted initiatives for FY2013 include:

- Establishing a permanent Admissions Screening Office to review each incoming request for admission;
- Establishing a Utilization Review/Utilization Management (UR/UM) process for medical necessity, continued stay, and discharge criteria consistent with acute care;
- Establishing a retrospective review process with providers to reduce the number of admissions that may have been treated in the community;
- Realigning internal resources to maximize hospital operations and promote a staffing effectiveness model in all departments;
- Realigning the Telebehavioral Health Program to promote and sustain evidence-based practice integrating Behavioral Health and Primary Care;

- Working collaboratively with statewide Psychiatric Emergency Services to make sure Alaskans have choices and access to local treatment services;
- Targeting efforts to recruitment and retention of the appropriate licensed professionals to serve Alaskans with psychiatric issues.

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, supports and behavioral health treatment. The Division 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 its business practices and management philosophy in relation to the **three core functions**:

1. Monitoring and managing the use of public funds to provide accessible, efficient and effective behavioral health prevention and treatment services for Alaskans.
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.

As the Division engages in the business and management practices of these core functions, it is recognized that the evolving landscape of behavioral health service delivery is changing, and requiring creative partnerships and coordination with other non-traditional providers. The landscape of behavioral health service delivery is becoming more integrated and coordinated, and challenges the historical silos of designated treatment settings. These efforts at "cross coordination" with behavioral health include: primary care, medical home models, corrections, therapeutic courts, and domestic violence/sexual assault providers. This cross coordination will provide opportunities for changes in business and clinical practices with new skills, including: business modeling that balances fiscal, revenue and clinical management, resulting in maximum service capacity, and delivery of quality care with meaningful outcomes.

The Division's "management and administrative services" continues to implement business practices that include the development and refinement of a Performance Management System, which guides policy and decision-making for improving the behavioral health of Alaskans. The Division's Performance Management System seeks to improve the quality of life of Alaskans

through the right service to the right person at the right time, using the Results Based Accountability framework of (1) Quantity: How much did we do? (2) Quality: How well did we do it? and (3) Outcome: Is anybody better off? The Division is developing formal feedback loops via processes and policies on the application of data to monitor the treatment system, in collaboration with grantee providers. This includes the development of a performance "scorecard", with targeted performance measures in the following areas: acute care volume; access to treatment; volume of emergency medical services; engagement & retention; treatment quality and outcomes. The reporting capability will include quarterly individual provider agency, regional and statewide reporting, across multiple years. This will include measures for adults, youth, and children accessing behavioral health services. The developing template for the Division of Behavioral Health Performance Scorecard is listed below:

Results Based Accountability Dashboard

	FY 12 ADULTS, CHILD & YOUTH	Status	FY 09	FY 10	FY12 Q1	FY12 Q2	FY12 Q3	FY12 Q4	FY12 YTD	Last FY Total (FY11)	% of ↑ or ↓ over Last FY
	I. Acute Care Volume										
1	API Census										
2	Readmission to Acute Care										
	II. Access to Treatment										
3	Response Time (screening to first treatment service)										
4	Substance Abuse Service Access (SUD residential bed utilization)										
	III. Emergency Medical Services Volume										
5	Emergency Medical Services (avg use in last 30 days - from CSR)										
	IV. Engagement & Retention										
6	Treatment Engagement (API discharge to 1st community-based service)										
7a	Treatment Retention (services within 30 days)										
7b	Treatment Retention (Not served within 135 days)										
	V. Treatment Outcomes										
8	Client Improvement in Life Domains (percent of clients showing improvement)										
9.	Clients Improvement in Quality of Life Domains (percent of clients showing improvement)										
10.	Client perceptions of their treatment (percentage of clients showing improvement)										

The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the Division's *Performance Management System*. The Alaska Automated Information Management System is a web-based application and database that serves the dual purpose of a management information system and an electronic medical record. As a management information system 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, Government Performance and Results Act, both Mental Health and Substance Abuse Block Grants and National Outcome Measurements.

The Alaska Automated Information Management System provides an agency the ability to create an electronic medical record 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.

The Alaska Automated Information Management System 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. The Alaska Automated Information Management System serves community-based outpatient behavioral health programs, residential, detox, and Opioid treatment facilities. The scope of The Alaska Automated Information Management System users has expanded to include:

- The Office of Children Services using The Alaska Automated Information Management System as the electronic health record for the 35 Behavioral Rehabilitation Services residential programs;
- Therapeutic Courts expanding the "e-courts" module state-wide, that will use The Alaska Automated Information Management System as a platform to manage court-referred clients to the treatment system;
- The Alcohol Safety Action Program migrating its data collection system to The Alaska Automated Information Management System;
- Department of Corrections, Substance Abuse Services using The Alaska Automated Information Management System as the electronic health record (mental health services are under consideration);
- Statewide Division Fetal Alcohol Spectrum Disorder Diagnostic Teams recording their data in The Alaska Automated Information Management System.

Future development and enhancements of The Alaska Automated Information Management System include:

- The implementation of a Prevention/Early Intervention Module to collect related data from grantee providers;
- The Alaska Automated Information Management System has successfully completed Stage One Meaningful Use certification at the end of calendar year 2011. As national specifications are complete, Stage Two Meaningful Use will be scheduled for completion.

The division successfully implemented The Alaska Automated Information Management System "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

Behavioral health services may be accessed by eligible individuals across the array of covered Medicaid services from physician offices and other primary care settings to acute care hospitals. However, the Medicaid behavioral health services targeting individuals experiencing an emotional disturbance and/or substance abuse disorders are managed by the Division of Behavioral Health. This consolidation with behavioral health grant services maximizes financial support for the programs and has the advantage of Division expertise. 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.

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

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

Core Services

The Alaska Mental Health Board is the state planning and coordinating agency for purposes of federal and state laws relating to the mental health program. The Mental Health Board is responsible for participating in the evaluation of the mental health program. The Mental Health Board 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 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 the Mental Health Board, the Advisory Board provides an opportunity for public participation in the planning and evaluation of the behavioral health system.

Services Provided

The services provided by the Advisory Board and Mental Health Board fall within the statutory duties: advise, plan and coordinate, educate, evaluate, and advocate.

Advise
The Advisory Board and Mental Health Board 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 and Coordinate

The Advisory Board and Mental Health Board staff and board members participate in the creation, implementation, and update of several health plans related to behavioral health. These include the state plans for the Mental Health and Substance Abuse Prevention and Treatment Block Grants, the state Senior Plan, the Plan to Reduce and Prevent Underage Drinking, and the Statewide Suicide Prevention Plan, among 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 together more effectively. We collaborate with community and consumer organizations, like the Alaska Behavioral Health Association, Alaska Addiction Professionals Association, National Alliance on Mental Illness, Alaska Coalition on Housing and Homelessness, and regional wellness coalitions throughout the state. The Mental Health Board and Advisory Board continued to provide support to the Alaska Fetal Alcohol Syndrome Disorder Partnership, a volunteer coalition of individuals experiencing Fetal Alcohol Syndrome Disorder and their families, providers and community members. The Mental Health Board and Advisory Board host a page for the Alaska Fetal Alcohol Syndrome Disorder Partnership on their website. This close partnership with the statewide Fetal Alcohol Syndrome Disorder coalition ensures better coordination of policymaking and planning related to improving Fetal Alcohol Syndrome Disorder prevention, treatment and support services.

Educate

The Advisory Board and the Mental Health Board 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 with the Alaska Mental Health Trust Authority. Our "We Are All Alaskans!" anti-stigma campaign is in its third year, and has evolved to include a broader community inclusion focus. The Mental Health Board and Advisory Board education efforts focus on the fact that "Treatment Works – Recovery Happens!" The Advisory Board partners with Alaska Cabaret, Hotel, Restaurant and Retailers Association, the restaurant and hospitality industry organization, and local community groups in an annual Fetal Alcohol Syndrome Disorder prevention campaign every September. During October and November, when Permanent Fund Dividends are distributed, the Advisory Board runs a television public service campaign encouraging Alaskans to spend their annual dividend wisely – and not on alcohol. 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 policies and programs.

Advocate

Board members and staff are committed to making the voices of consumers and their families heard, 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 the Advisory Board and Mental Health Board require close working relationships with the other statutory advisory 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 Statewide Suicide Prevention Council 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 Council 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 Council 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 Council 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 Council'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. The Council coordinates implementation of the state plan through regional suicide prevention teams and in partnership with Alaska Native Tribal Health Consortium, Department of Health and Social Services and other partners. The 2012 annual *Casting the Net Upstream* implementation report will be/was published January 2013 and is/will be available at www.StopSuicideAlaska.org.

The Council engages in large and small public education/awareness campaigns. The Alaska Mental Health Trust Authority funds a limited statewide education campaign for the Council through its coordinated communications efforts. 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 Alaska

Federation of Natives, Alaska Psychiatric Association, Alaska Counseling Association, and Bureau of Indian Affairs Tribal Providers Conference.

The Council 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 Council 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 Council'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 Council 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. It is being updated in 2013 to achieve the goal of StopSuicideAlaska.org being more than a website – becoming 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 is the keystone of the Council's outreach and continues to evolve as an important tool for the Council as well as community suicide prevention providers.

Behavioral Health Treatment Services Statistics

The Division utilizes a *Performance Management System*, which guides policy and decision-making for improving the behavioral health of Alaskans through "the right service to the right person at the right time." To be able to measure performance of the continuum of care, the Division has adopted the Results Based Accountability (RBA) framework of (A) Quantity: How much did we do? (B) Quality: How well did we do it? and (C) Outcome: Is anybody better off? An example of the developing template for the Results Based Accountability Dashboard is presented in the Division's "management and administrative" section. Related questions to be answered by a performance management system include:

- Are Alaskans who need services getting the services they need 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 Division uses certain information and instruments to answer these critical questions.

4. Access to behavioral health services
5. The Alaska Screening Tool (AST)
6. The Client Status Review of Life Domains (CSR)
7. The Behavioral Health Consumer Survey (BHCS)

1. Access to Behavioral Health Services

In order to improve and enhance the quality of life of Alaskans who experience a behavioral health disorder, access to a comprehensive, integrated continuum of care is critical. A measure of the number of individuals receiving services reflects accessibility and capacity of the behavioral health service system.

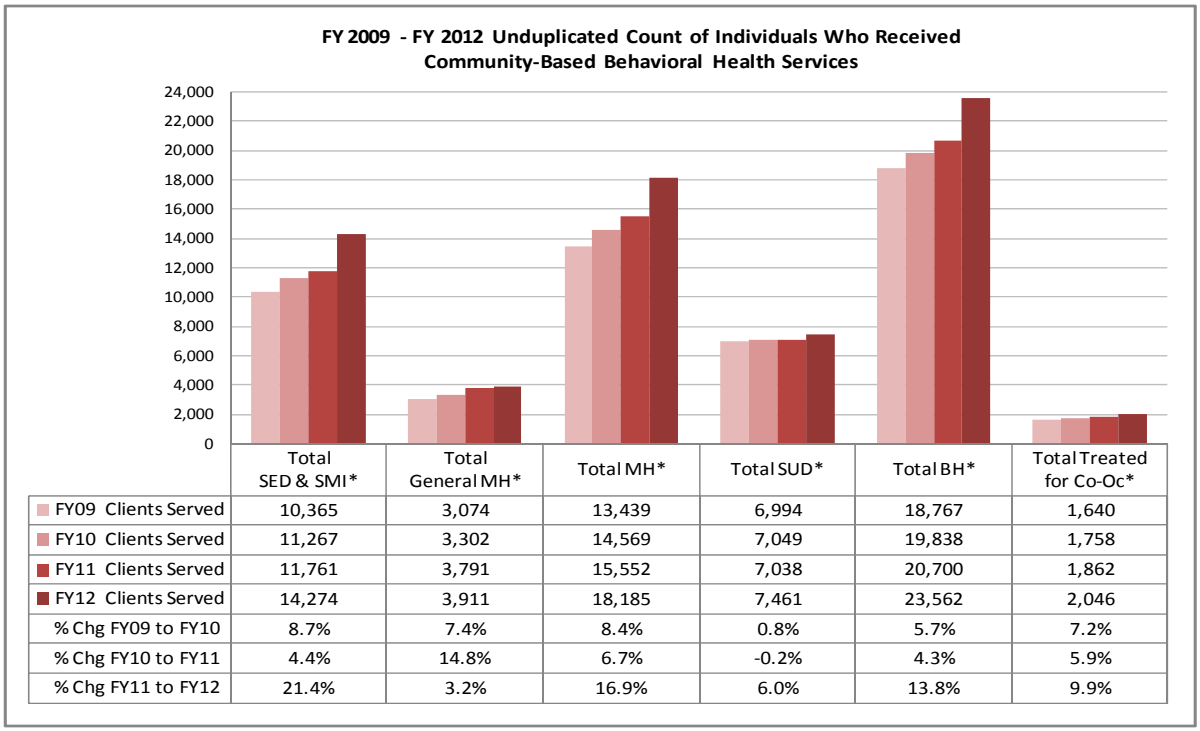
From FY2009 to FY2012, the number of individuals who received community-based behavioral health services has continued to increase. A summary of the FY2009 to FY2012 unduplicated counts of individuals who received services, by service population for adults and youth combined, is presented in the chart below.

Data Note: Starting in FY2012, the number of adults who received "illness self-management" (ISM) services was added to the Alaska Automated Information Management System (AKAIMS) counts for the total number adults with serious mental illness who received services. Due to this change in methodology, caution should be exercised when making comparisons with prior year data. In FY2012, the Alaska Automated Information Management System count of adults with serious mental illness (SMI) was 7,994; the total number of adults with serious mental illness who received community-based mental health services was 10,414, which includes 2,420 adults who received illness, self-management services.

General trends across the four-year period, excluding the 2,420 adults who received illness, self-management services in FY2012, are as follows:

- The number of individuals who received behavioral health services has continued to increase. Across the four-year period, the number served increased by 12.7% (from 18,767 in FY2009 to 21,142 in FY2012).
- The number of individuals who received mental health services has continued to increase; across the four-year period, the number served increased by 17.3% (from 13,439 in FY2009 to 15,765 in FY2012).
    - **Data Note**: Youth with severe emotional disturbance (SED): The number of youth with serious emotional disturbance who received mental health services continued to increase from FY2009 through FY2011. However, from FY2011 to FY2012, the number decreased by 134 (3.4%), from 3,994 to 3,860. Across the four-year period, the number served increased by 8.1% (from 3,572 in FY2009 to 3,860 in FY2012.
- The number of individuals who received substance use disorder services has continued to increase, with the percent increase going up considerably for FY 2012. Across the four-year period, the number served increased by 6.7% (from 6,994 in FY2009 to 7,461 in FY2012).
    - **Data Note:** Youth receiving substance use disorder (SUD) services: The number of youth who received services for a substance use disorder has continued to decrease, with a 6.0% decrease from FY2009 to FY2010, a 12.6% decrease from FY2010 to FY2011, and a 1.9% decrease from FY2011 to FY2012. Across the four-year period, the number decreased by 19.4% (from 845 in FY2009 to 681 in FY2012).
- The number of individuals who received behavioral health services for a co-occurring disorder has continued to increase: Across the four-year period, the number served increased by 24.8% (from 1,640 in FY2009 to 2,046 in FY2012).

FY2009-FY2012 Number of Individuals who Received Behavioral Health Services



	Total SED & SMI*	Total General MH*	Total MH*	Total SUD*	Total BH*	Total Treated for Co-Oc*
FY09 Clients Served	10,365	3,074	13,439	6,994	18,767	1,640
FY10 Clients Served	11,267	3,302	14,569	7,049	19,838	1,758
FY11 Clients Served	11,761	3,791	15,552	7,038	20,700	1,862
FY12 Clients Served	14,274	3,911	18,185	7,461	23,562	2,046
% Chg FY09 to FY10	8.7%	7.4%	8.4%	0.8%	5.7%	7.2%
% Chg FY10 to FY11	4.4%	14.8%	6.7%	-0.2%	4.3%	5.9%
% Chg FY11 to FY12	21.4%	3.2%	16.9%	6.0%	13.8%	9.9%

*** 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. **FY2012 is the first year that the count of adults with SMI includes individuals who received illness self management services (n=2420).**

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. Starting in FY2012, the number of adults who received illness self management (ISM) services was added to the AKAIMS count for the total number adults with SMI who received services. Due to this change in methodology, caution should be exercised when making comparisons with prior year data. In* ***FY2012, the AKAIMS count of adults with SMI was 7,994; the total number of adults with SMI who received community-based mental health services was 10,414, which includes 2,420 adults who received ISM 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 substance use disorder (SUD) services requires analysis and strategic development. The Division intends to address these service capacity issues in the following manner:

- Establishment of a methodology to determine the capacity of the behavioral health system. (The Division is collaborating with The Trust in a Behavioral Health System Review on access and capacity.)

- Identification of system gaps and recommendations for improvement including a review of payment systems to insure a reasonable reimbursement for quality services. (The Division is collaborating with the Department of Health and Social Services, Office of Rate Review in a study that examines reimbursement and alignment with differing levels of acuity and severity.)

- 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. (The Division has implemented a Results Based Accountability scorecard measuring the performance of the system of care).

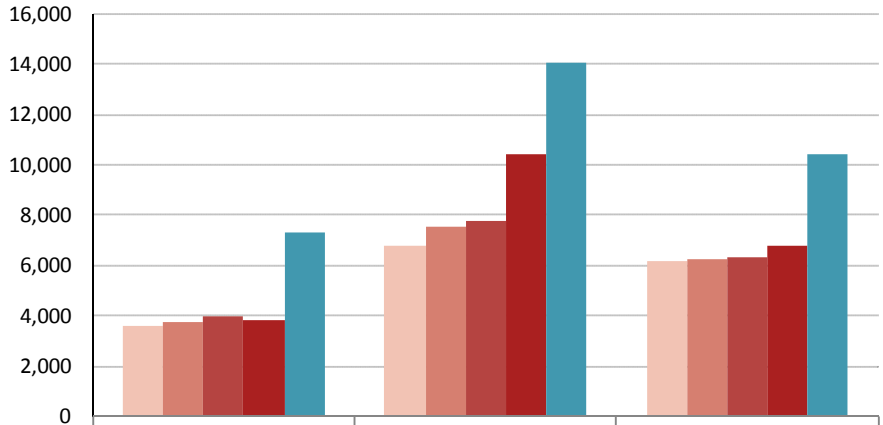
Serious Behavioral Health Disorders: Prevalence and Met/Unmet Need

The Division completed an Alaska prevalence estimation of serious behavioral health disorders. Prevalence estimates can be used as a benchmark to measure penetration rates of behavioral health services. The following chart below compares the prevalence estimates (for low-income households) with the FY2009 - FY2012 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 met and unmet needs in Alaska's low-income household population.

The FY2012 percentages "met need" for behavioral health services of the prevalence estimates for low-income households are as follows:

- 52.6% for Severely Emotionally Disturbed (SED) Youth
- 73.9% for Seriously Mentally Ill (SMI) Adults
- 65.2% for Substance Use Disorder (SUD) Adults

Alaska 2006 Prevalence Estimates (Low-Income Households) and FY2009-FY2012 Number of Individuals who Received Behavioral Health Services



	SED Youth* (Includes Co-Occurring)	SMI Adults* (Includes Co-Occurring)	SUD Adults* (Includes Co-Occurring)
FY 2009 Clients Served*	3,572	6,793	6,149
FY 2010 Clients Served*	3,735	7,532	6,255
FY 2011 Clients Served*	3,994	7,767	6,344
FY 2012 Clients Served*	3,860	10,414	6,780
2006 Prevalence (Low-Income)**	7,339	14,089	10,397
FY 2012 % Served of 2006 Prevalence	52.6%	73.9%	65.2%

*Key: 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.*

** 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 Alaska Screening Tool (AST) functions as a standardized state-wide instrument that is designed to screen for substance abuse, mental illness, dual diagnosis, Fetal Alcohol Spectrum Disorder, and traumatic brain injury (TBI). The Alaska Screening Tool is required for all clients entering treatment services. The Alaska Screen Tool can produce multiple recommendations, which in turn can result in more than one referral for consumers to indicated services. Screening tool data assists the Division 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 FY2012, 14,069 Alaska Screen Tool screenings were conducted with the results displayed in the following chart. In order to maximize the clinical utility of the Alaska Screen Tool, the Division developed the Alaska Screen Tool Clinical Guidance Document. This guidance document provides the most recent research literature that assists clinicians in the identification of individual and combined the Alaska Screen Tool indictors that further inform assessments to meet the individual needs of clients seeking services.

Alaska Screening Tool (AST) FY2012

Agency	ASTs	Screening Outcomes										
		Substance Abuse	Mental Health				Dual Diagnosis	TBI	FASD	Adverse Experience	Major Life Change	Intimate Partner Violence
			Depression	Anxiety Sx.	Risk Self/ Others	Trauma Sx.						
Total Counts	14,069	9,016	8,205	9,156	4,535	9,727	8,196	5,056	1,038	10,639	9,003	2,799
Total Percent		64 %	58 %	65 %	32 %	69 %	58 %	36 %	7 %	76 %	64 %	20 %

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 Alaska Screening Tool (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 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 Client Status Review is used in multiple ways: 1) the initial Client Status Review 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 Client Status Review functions as a baseline measure of a persons' quality of life prior to an assessment and entry into services. This initial Client Status Review can be compared with subsequent Client Status Reviews to monitor change over time and outcomes. (3) The Client Status Review is used to revise a client's behavioral health treatment plan, and measure change at discharge from services.

The Client Status Review 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 Client Status Review results are entered into the Alaska Automated Information Management System (AKAIMS) or through an agency's Electronic Data Interface (EDI). The Client Status Review instrument can be located at: https://akaims-support.dhss.alaska.gov/forms.htm

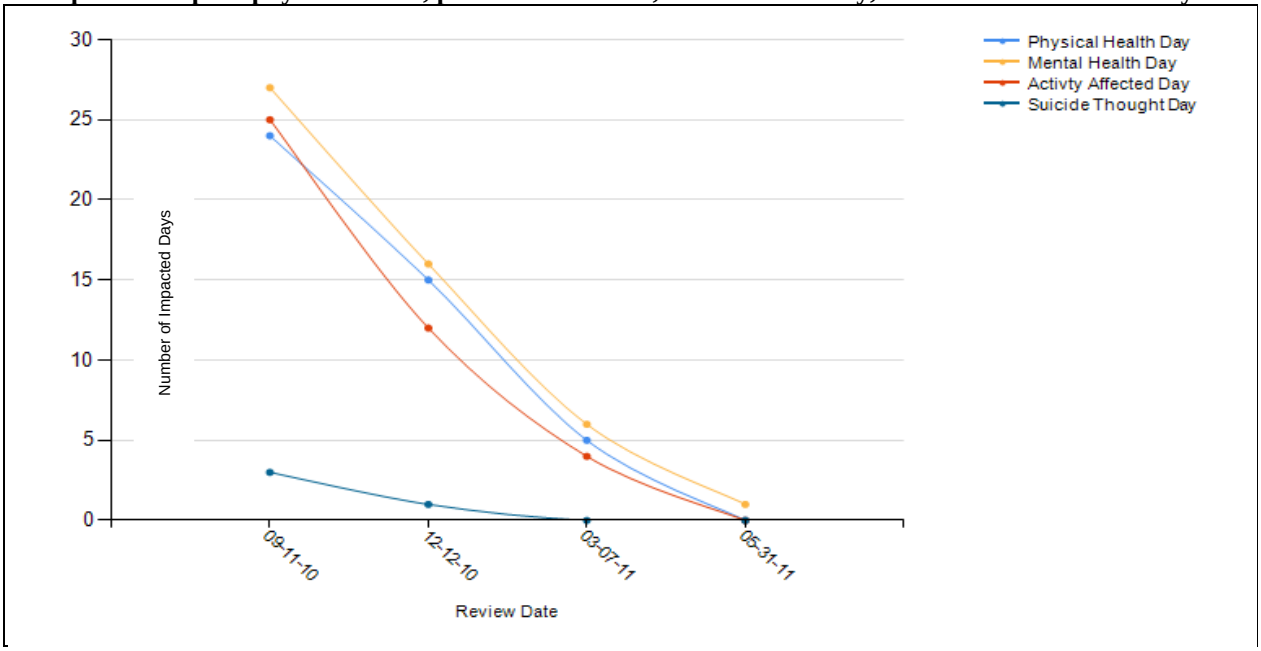
The Division initiated an upgrade of the Client Status Review during FY2010 to improve the ability to assess change over time. The revised Client Status Review instrument was implemented in the Alaska Automated Information Management System in October, 2010. Specific focus was placed on the scoring methodology, 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 Client Status Review 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, and individuals with Co-occurring disorders

The following chart 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 Client Status Review 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 Client Status Review to review the impact of treatment and make adjustments to improve outcomes.

Client Status Review (CSR) Change over Time
CSR questions: poor physical health, poor mental health, decreased activity, and number of suicidal days.



Data Source: AKAIMS Report Manager

4. The Behavioral Health Consumer Survey for Treatment Services

The annual Behavioral Health Consumer Survey (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
- Participation in Treatment Planning
- Positive Outcomes
- Social Connectedness
- Quality and Appropriateness
- Cultural Sensitivity

The Behavioral Health Consumer Survey domain questions were developed nationally through the Mental Health Statistics Improvement Program (MHSIP). The Division implemented the Behavioral Health Consumer Survey for mental health providers in FY2003. In FY2006, the Division expanded the Behavioral Health Consumer Survey process to include substance abuse providers. In FY2008, additional questions were incorporated in the survey (i.e., through the MHSIP process) and a new baseline year was established.

There are three Behavioral Health Consumer Survey instruments:

- Adult (for clients ages 18 and older)
- Parent/Caregiver of Youth (for parents/caregivers of youth all ages younger than 18)
- Adolescent (self report for youth ages 13-17; this survey contains the same questions and domains as the Parent/Caregiver of Youth survey)

For each of the three Behavioral Health Consumer Survey instruments, an analysis of client evaluation of services was performed for each of the following respondent groups:

- Mental Health Outpatient clients
- Substance Abuse Outpatient clients

The primary focus of this analysis is to show patterns and trends across all four years relative to respondents' evaluation of services for the different domains. Although there were changes from year to year, these changes are not considered to be significantly different based on overlapping confidence intervals. The small sample sizes contribute toward relatively wide confidence intervals, which further emphasize the need to exercise caution when interpreting findings.

General conclusions based on survey results across all four years are as follows:

- Mental Health Outpatient Respondent Groups (includes Co-Occurring)
  - Adults:
    - A relatively high percent of respondents reported positively about General Satisfaction and Quality & Appropriateness.
    - A relatively low percent of respondents reported positively about Improved Functioning and Positive Outcomes.
  - Parents/Caregivers of Youth:
    - 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 Improved Functioning and Positive Outcomes.
  - Adolescents:
    - 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.

- Substance Abuse Outpatient Respondent Groups (includes Co-Occurring)
  - Adults:
    - 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.
  - Parents/Caregivers of Youth:
    - A relatively high percent of respondents reported positively about Cultural Sensitivity and Social Connectedness.
    - A relatively low percent of respondents reported positively about Improved Functioning and Positive Outcomes.
  - Adolescents:
    - A relatively high percent of respondents reported positively about Social Connectedness.
    - A relatively low percent of respondents reported positively about Access to Services.

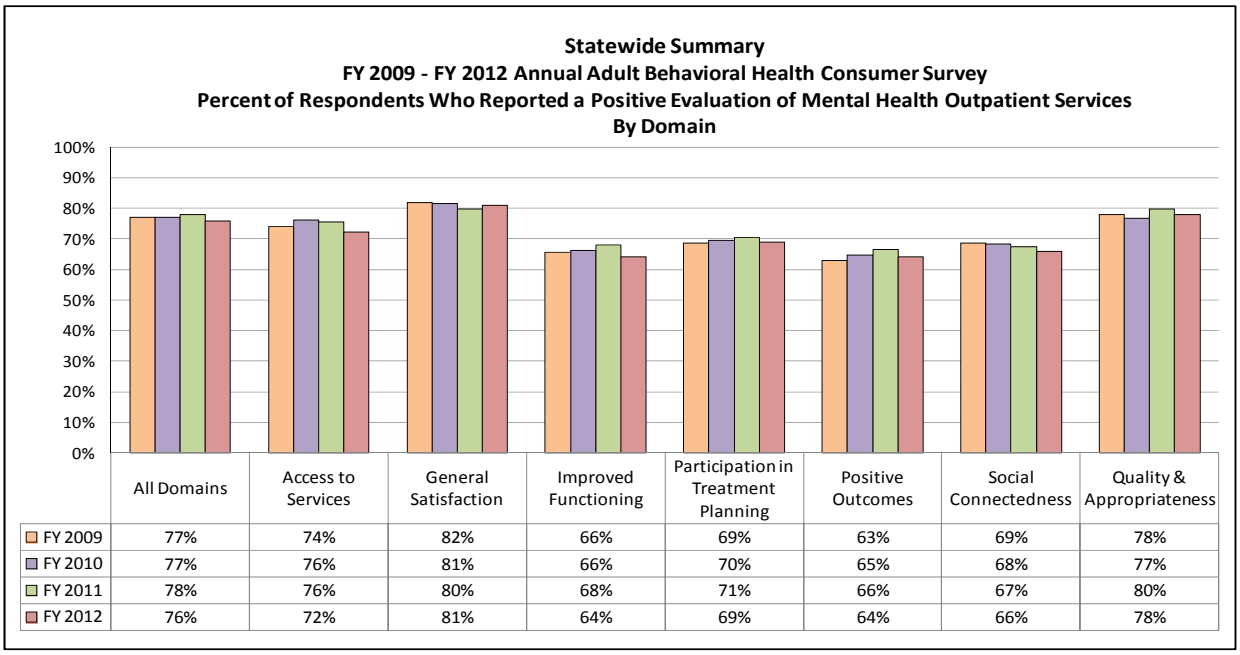
The Division works with grantees to develop quality assurance mechanisms by which program adjustments can be made based on the Behavioral Health Consumer Survey results. The Division's efforts to improve service delivery include enhanced technical assistance that is made available to grantees experiencing programmatic or administrative difficulties. The following are specific areas of focus for the Division:

- **Access to services**: The Division intends to address access and service capacity issues in the following manner:
  - Establish a methodology to determine the capacity of the behavioral health system.
  - Identify system gaps and recommendations for improvement, including a review of payment systems to insure a reasonable reimbursement for quality services.
  - 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 and Positive Outcomes**: The Division has adopted a primary focus on tracking and measuring treatment outcomes to help guide service delivery improvements. In particular, the Division has invested resources into the following structures that will support a primary focus on treatment outcomes:
  - As described in the "Client Status Review" section of this document, the Client Status Review has been updated to more accurately measure change over time.
  - The Client Status Review 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 Client Status Review to inform assessments, and measuring for positive treatment outcomes has been mandated to all providers.
  - The Division's implementation of Performance-Based Funding has specific measures that focus on client outcomes.
  - Adoption of the Results Based Accountability (RBA) framework and performance scorecard will enable enhanced outcomes reporting be used to inform Division technical assistance.

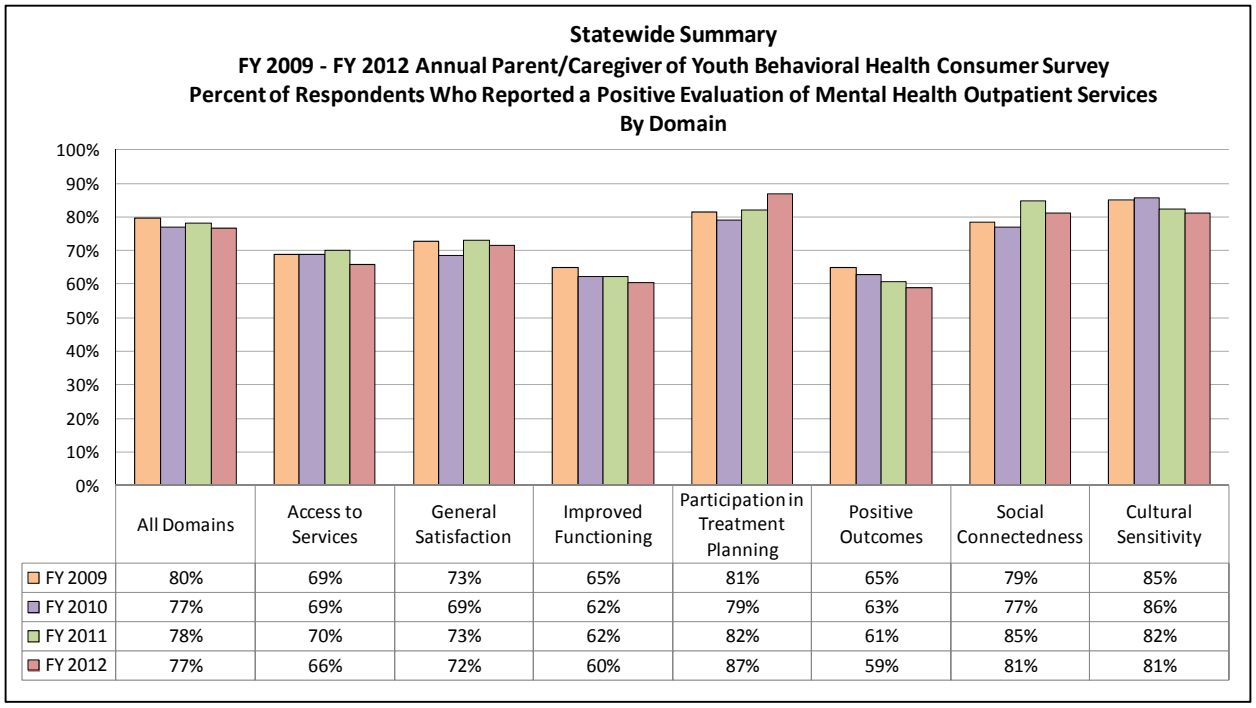
The statewide Behavioral Health Consumer Survey results for the Mental Health Outpatient respondent groups are submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) as National Outcome Measures (NOMS). Substance Abuse and Mental Health Services Administration summarizes mental health National Outcome Measures data submitted by the states and prepares Uniform Reporting System (URS) Output Tables for each state. Each state's Uniform Reporting System Output Tables include a comparison of the state and US results; the Uniform Reporting System Output Tables can be found at: http://www.samhsa.gov/dataoutcomes/urs/.

FY2009 - FY2012 Annual Adult Behavioral Health Consumer Survey Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services



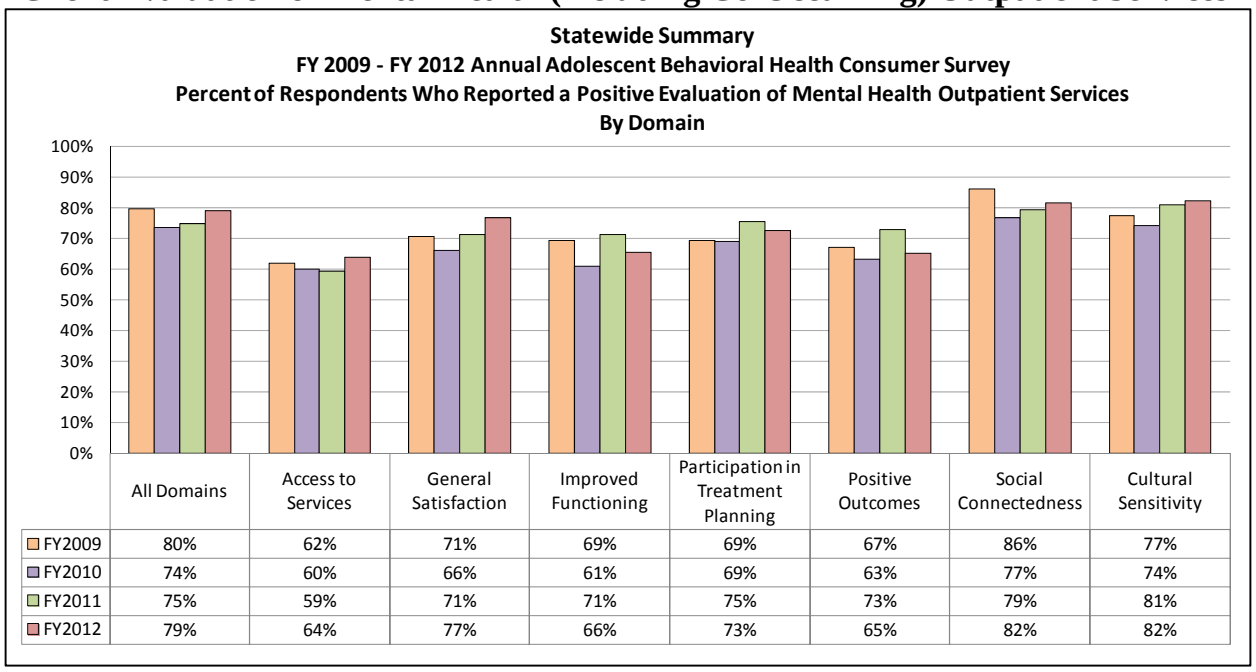
	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Quality & Appropriateness
FY 2009	77%	74%	82%	66%	69%	63%	69%	78%
FY 2010	77%	76%	81%	66%	70%	65%	68%	77%
FY 2011	78%	76%	80%	68%	71%	66%	67%	80%
FY 2012	76%	72%	81%	64%	69%	64%	66%	78%

FY2009-FY2012 Annual Parent/Caregiver of Youth Behavioral Health Consumer Survey Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services



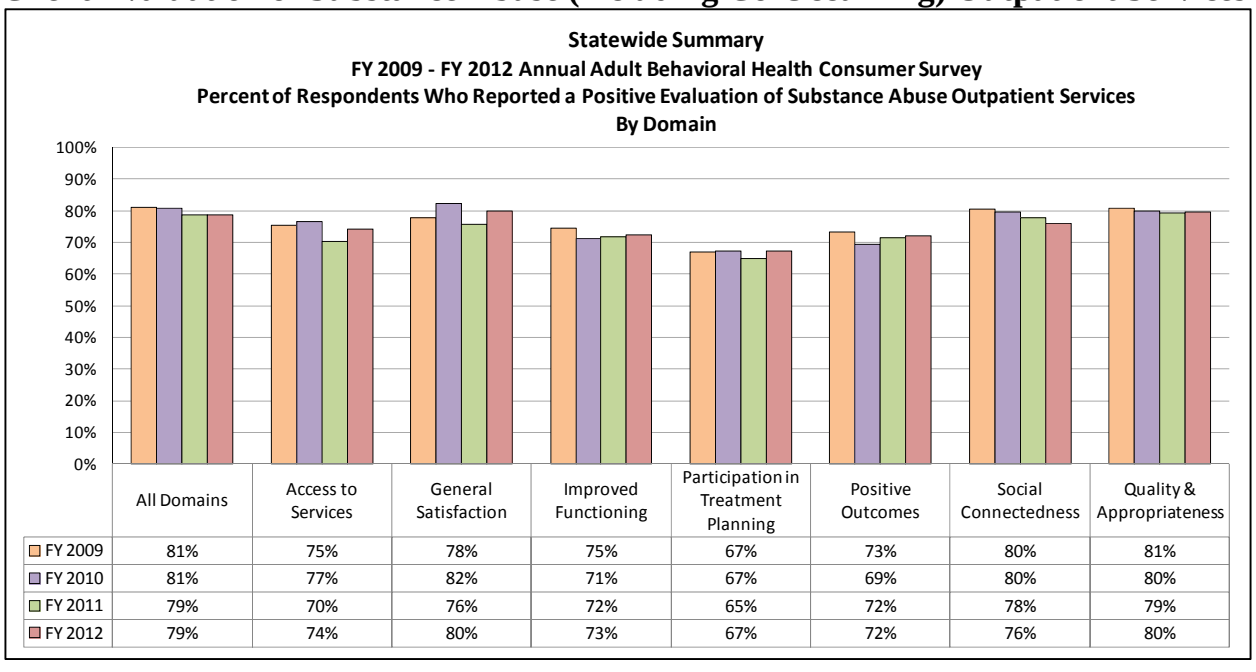
	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY 2009	80%	69%	73%	65%	81%	65%	79%	85%
FY 2010	77%	69%	69%	62%	79%	63%	77%	86%
FY 2011	78%	70%	73%	62%	82%	61%	85%	82%
FY 2012	77%	66%	72%	60%	87%	59%	81%	81%

FY2009 - FY2012 Annual Adolescent Behavioral Health Consumer Survey
Client Evaluation of Mental Health (including Co-Occurring) Outpatient Services



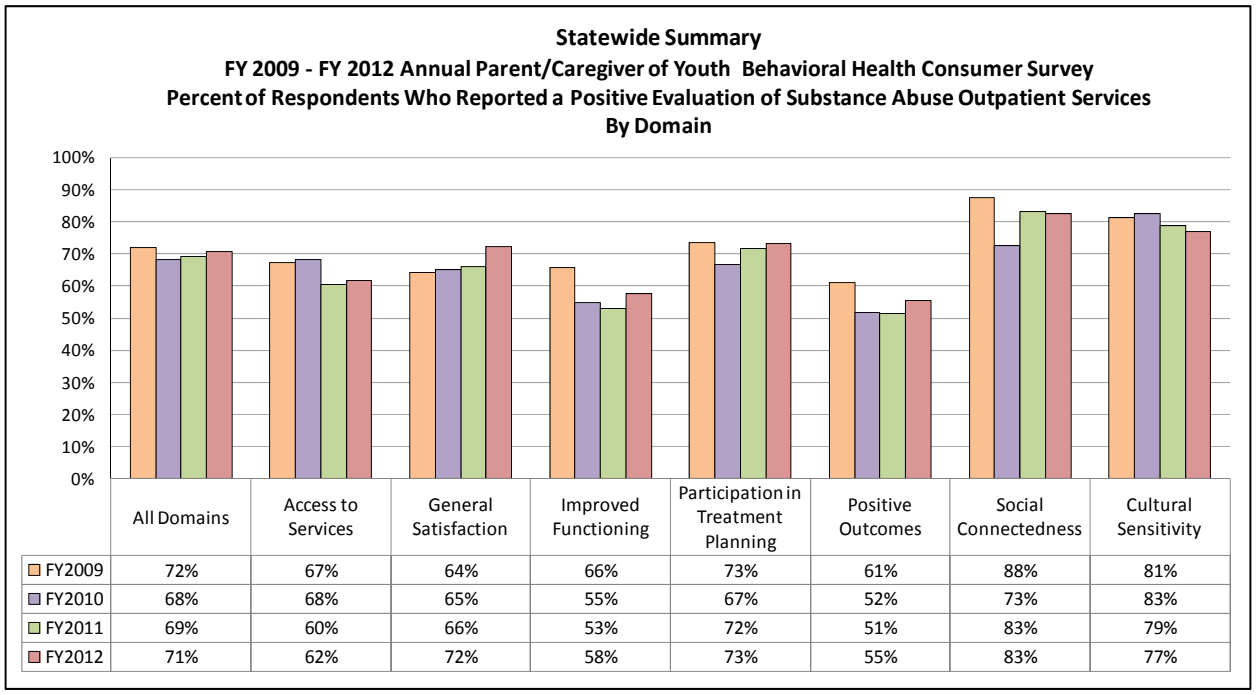
	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY2009	80%	62%	71%	69%	69%	67%	86%	77%
FY2010	74%	60%	66%	61%	69%	63%	77%	74%
FY2011	75%	59%	71%	71%	75%	73%	79%	81%
FY2012	79%	64%	77%	66%	73%	65%	82%	82%

FY2009 - FY2012 Annual Adult Behavioral Health Consumer Survey
Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services



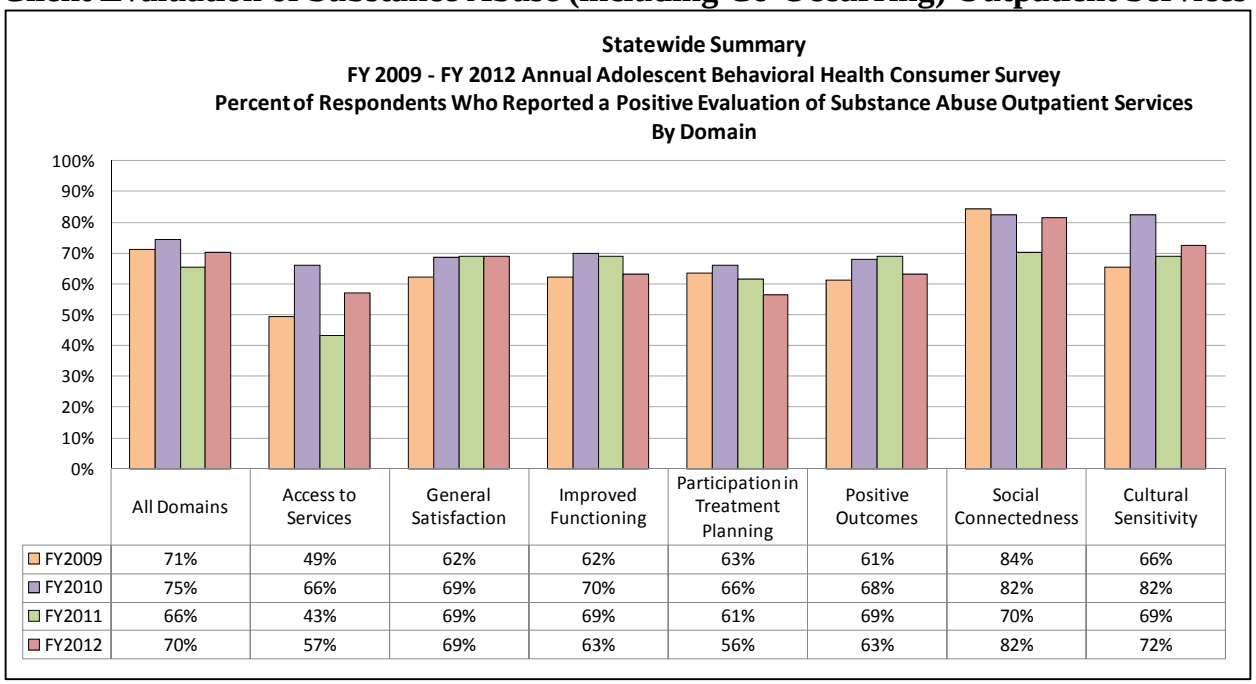
	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Quality & Appropriateness
FY 2009	81%	75%	78%	75%	67%	73%	80%	81%
FY 2010	81%	77%	82%	71%	67%	69%	80%	80%
FY 2011	79%	70%	76%	72%	65%	72%	78%	79%
FY 2012	79%	74%	80%	73%	67%	72%	76%	80%

FY2009 - FY2012 Annual Parent/Caregiver of Youth Behavioral Health Consumer Survey Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services



	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY2009	72%	67%	64%	66%	73%	61%	88%	81%
FY2010	68%	68%	65%	55%	67%	52%	73%	83%
FY2011	69%	60%	66%	53%	72%	51%	83%	79%
FY2012	71%	62%	72%	58%	73%	55%	83%	77%

FY2009 - FY2012 Annual Adolescent Behavioral Health Consumer Survey Client Evaluation of Substance Abuse (including Co-Occurring) Outpatient Services



	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY2009	71%	49%	62%	62%	63%	61%	84%	66%
FY2010	75%	66%	69%	70%	66%	68%	82%	82%
FY2011	66%	43%	69%	69%	61%	69%	70%	69%
FY2012	70%	57%	69%	63%	56%	63%	82%	72%

Bring the Kids Home Initiative: Indicators for FY2012

The Department of Health and Social Services initiated the "Bring the Kids Home" (BTKH) Project to return children being served in out-of-state facilities back to in-state residential or community-based care. The following are select project findings specific to FY2012.

Admissions

- There is approximately a 2 to 1 ratio of youth admitting to in-state vs. out-of-state residential psychiatric treatment centers (256 to 143).
- The distinct number of total residential psychiatric treatment center admissions for FY2012 **increased** by 3% (from 386 to 399).
- As the 'eligible' Medicaid population has grown over time, the distinct count of Residential Psychiatric Treatment Center admissions and recipients served (per 1, 000) has declined, with a corresponding increase of clients served through community based services.

Served

- Total residential psychiatric treatment center recipients served during FY2012 **decreased** by 3% (from 623 to 603).

Medicaid Claims

- There was an overall **increase** (5%) of Medicaid paid claims to in-state and out-of-state residential psychiatric treatment center recipients during FY2012 from the previous year.

Length of Stay

- The overall length of stay for out-of-state residential psychiatric treatment center recipients has **decreased** during FY2012 from the previous years.
- The overall length of stay for in-state residential psychiatric treatment center recipients has **increased** during FY2012 from the previous years.

Recidivism

- The FY2012 over-all recidivism rate of 5% (22 cases) is **decreased** from the FY2011 rate of 8% (32 cases).

Medicaid Eligibility in relation to Clients Served

- While the count of youth admitted to residential psychiatric treatment center's appear to be on the rise for the past two fiscal years, this is mitigated when the overall admission/served rate is compared to total Medicaid-eligible youth; the finding would indicate an overall decline of clients per 1,000 rate.
    - FY2012, 5.9 per 1,000 youth admitted to residential psychiatric treatment centers in-state and out-of-state is compared to FY2011 (6.1 per 1,000 youth).
    - FY2012 distinct count of youth served in Residential Psychiatric Treatment Centers was 9.0 per 1,000 youth is compared to FY2011 (9.9 per 1,000 youth).
    - As the 'eligible' Medicaid population has grown over time, the distinct count of Residential Psychiatric Treatment Center admissions and recipients served (per

1,000) has declined, with a corresponding increase of clients served through community based services (through FY2011).

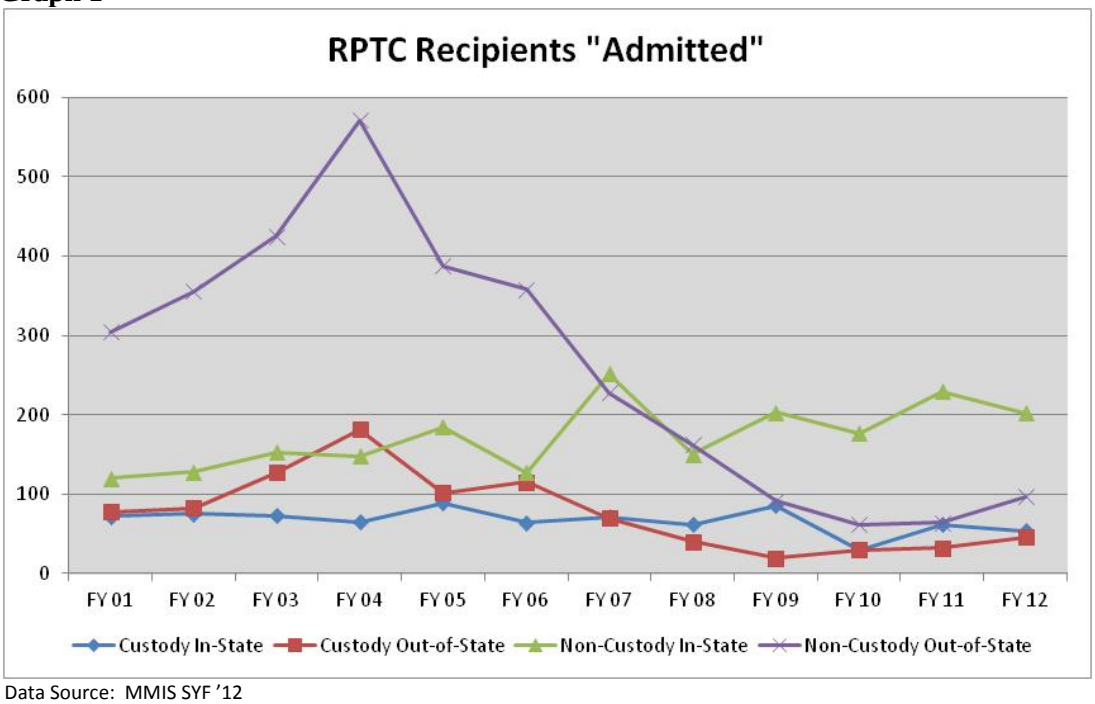
Indicator 1: **Client Shift – A reduction in the total number of severe emotionally disturbed children / youth admitted to out-of-state Residential Psychiatric Treatment Center care by 90 percent by FY2012**

Findings:

The Residential Psychiatric Treatment Center admissions, as a whole, steadily increased from FY1998-2004. From FY2005 to the present, there has been a decrease every year. For FY2012 there is a slight increase for total admissions.

- The distinct number of In-State Custody Residential Psychiatric Treatment Center recipients "admitted" during FY2012 **decreased** by 12% (from 61 to 54).
- The distinct number of out-of-state Custody Residential Psychiatric Treatment Center recipients "admitted" during FY2012 **increased** by 30% (from 32 to 46).
- The distinct number of In-State Non-Custody Residential Psychiatric Treatment Center recipients "admitted" during FY2012, **decreased** by 12% (from 229 to 202).
- The distinct number of out-of-state Non-Custody Residential Psychiatric Treatment Center recipients "admitted" during FY2012, **increased** by 30% (from 64 to 97).
- The distinct number of total Residential Psychiatric Treatment Center admissions for FY2012 **increased** by 3% (from 386 to 399).

Graph 1



Data Source: MMIS SYF '12

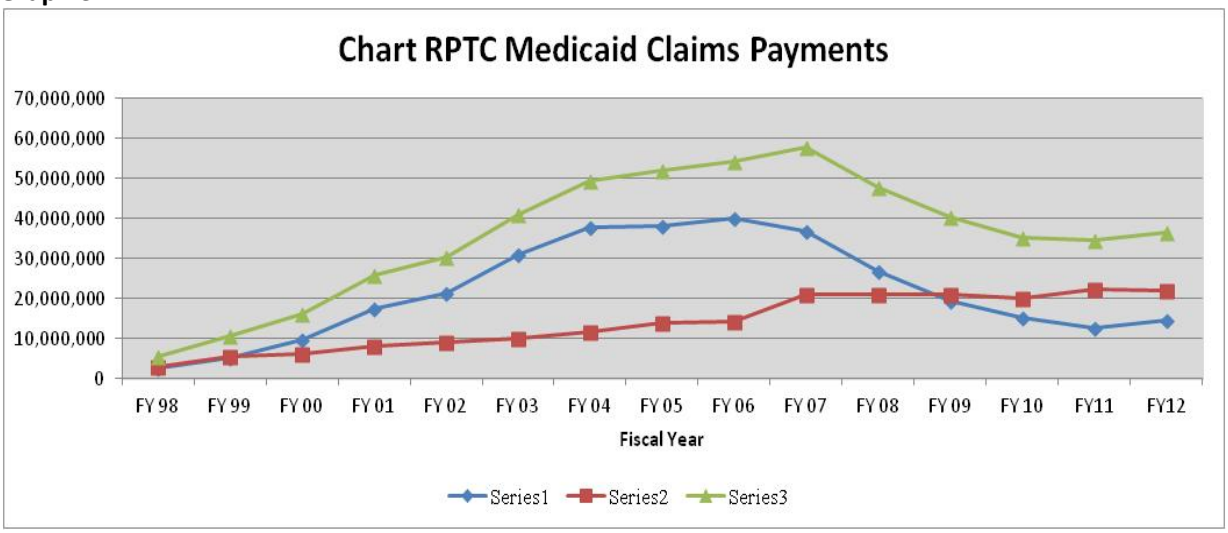
***Indicator 2*: Funding Shift- Ninety percent reduction in Medicaid / General Fund match dollars from out-of-state services to severely emotionally disturbed children / youth with a corresponding increase in Medicaid / General Fund match dollars for in-state services by FY2012. (15 percent per year)**

Findings:
Between FY 1998 and 2004 out-of-state Residential Psychiatric Treatment Center Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. During the same time period in-state Residential Psychiatric Treatment Center Medicaid expenditures increase a little more than 300% and realized smaller average annual increases of 29.6%.

For FY 2012, in comparison to FY2011:

- Out-of-State Residential Psychiatric Treatment Center Medicaid expenditures **increased** by 14%
- In-State Residential Psychiatric Treatment Center Medicaid expenditures **decreased** by 0.7%
- Total Residential Psychiatric Treatment Center Medicaid expenditures **increased** by 5%.

Graph 3

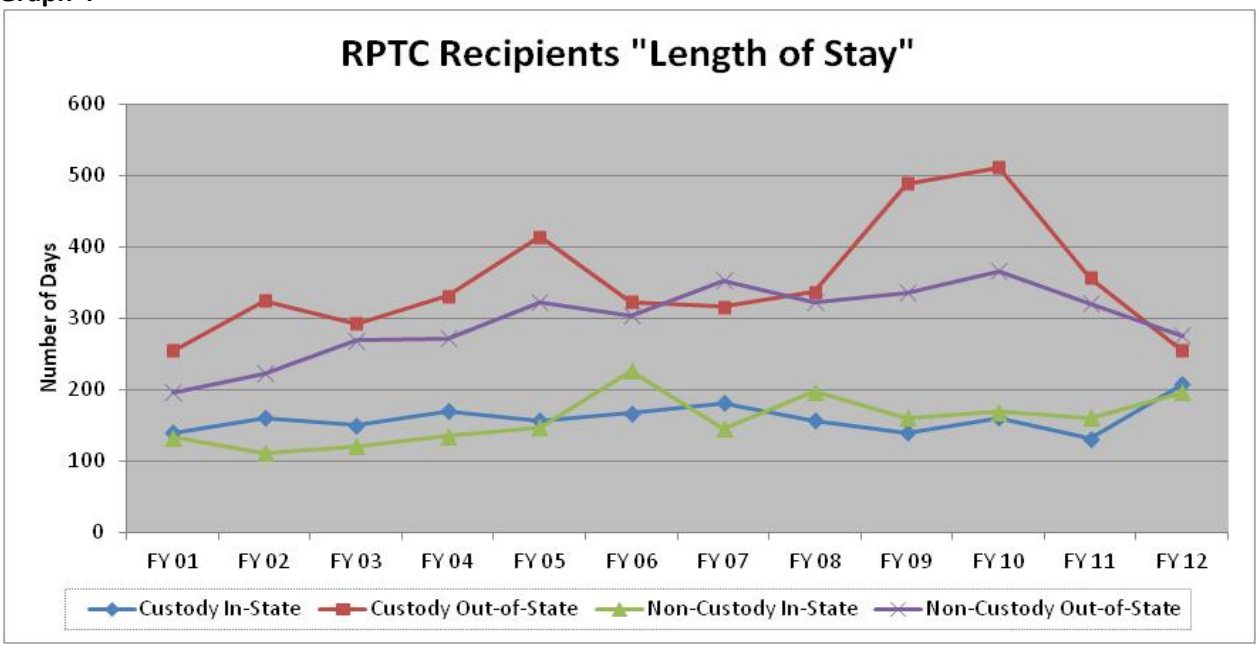


Indicator 3: *Length of Stay ( ) - Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by FY 2012.*

Findings:
For FY 2012, the Average Length of Stay for Residential Psychiatric Treatment Center:

- Custody In-State: 207 days. **Increase** of 76 days (37%) from FY2011.
- Custody Out-of State: 254 days. **Decrease** of 103 days (29%) from FY2011.
- Non-Custody In-State: 196 days. **Increase** of 35 days (18%) from FY2011.
- Non-Custody Out-of-State: 276 days. **Decrease** of 44 days (14%) from FY2011.

Graph 4



Indicator 5: **Recidivism: Decrease in the number of children/youth returning to residential psychiatric treatment center and acute hospitalization care by 75% by FY2012. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)**[1]

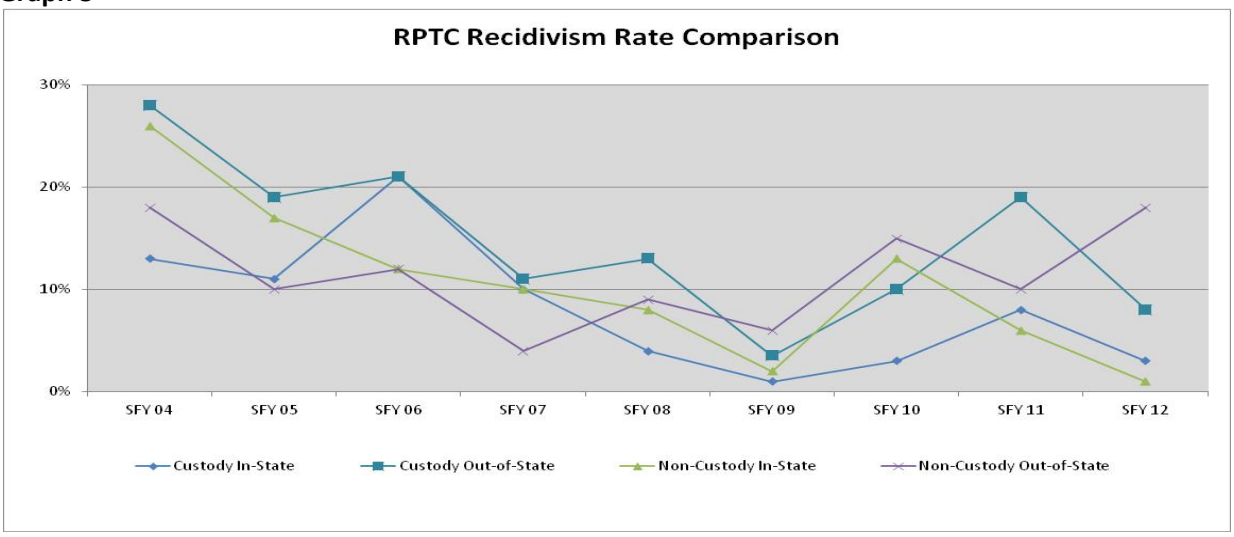
Findings:
For FY2012,

- Custody In-State recidivism rate was 3%.
- Custody Out-of-State recidivism rate was 8%
- Non-Custody In-State recidivism rate was 1%.
- Non-Custody Out-of-State recidivism rate was 18%.
- For FY2012, the over-all recidivism rate was 5% (22 cases) for readmission to a residential psychiatric treatment center within 365 days of the discharge date.
- Of the 22 cases that experienced a readmission to an residential psychiatric treatment center within 365 days of discharge,
    - Five cases were readmitted in 1-30 days of discharge
    - Eight cases were readmitted in 31-180 days of discharge
    - Nine cases were readmitted in 181-365 days of discharge
- The FY2012 over-all recidivism rate of 5% (22 cases) is compared to:
    - an FY2011 rate of 8% (32 cases)
    - an FY2010 rate of 12% (35 cases)
    - an FY2009 rate of 3% (16 cases)

[1] 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 SFY2012. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)*

- an FY2008 rate of 8% (41 cases)
- an FY2007 rate of 8% (42 cases)
- an FY2006 rate of 14% (61 cases)
- an FY2005 rate of 13% (56 cases)
- an FY2004 rate of 20% (93 cases)

Graph 5



BTKH: Rate of Residential Psychiatric Treatment Center admissions in relation to the increasing Medicaid eligible population of children/youth

Findings: (Reference Table 1a & 1b)

- Medicaid eligible recipients for children/youth increased over 13% from FY2000 to FY2012
- While the count of youth admitted to residential psychiatric treatment center's appear to be on the rise for the past two fiscal years, this is mitigated when the overall admission/served rate is compared to total Medicaid-eligible youth; the findings would indicate an overall decline of clients per 1,000 rate.

Table 1a (FY2007 through FY2012)

Unduplicated Count of Medicaid RPTC Recipients "Admitted" to Total Medicaid Eligible Recipient						
	FY2007	**FY2008**	**FY2009**	**FY2010**	**FY2011**	**FY2012**
Total Admitted RPTC Recipients	620	413	399	295	386	399
Total Medicaid Eligible Recipients	64,353	63,481	63,393	58,411	63,231	67,274
Rate per 1000	9.6	6.5	6.3	5.1	6.1	5.9

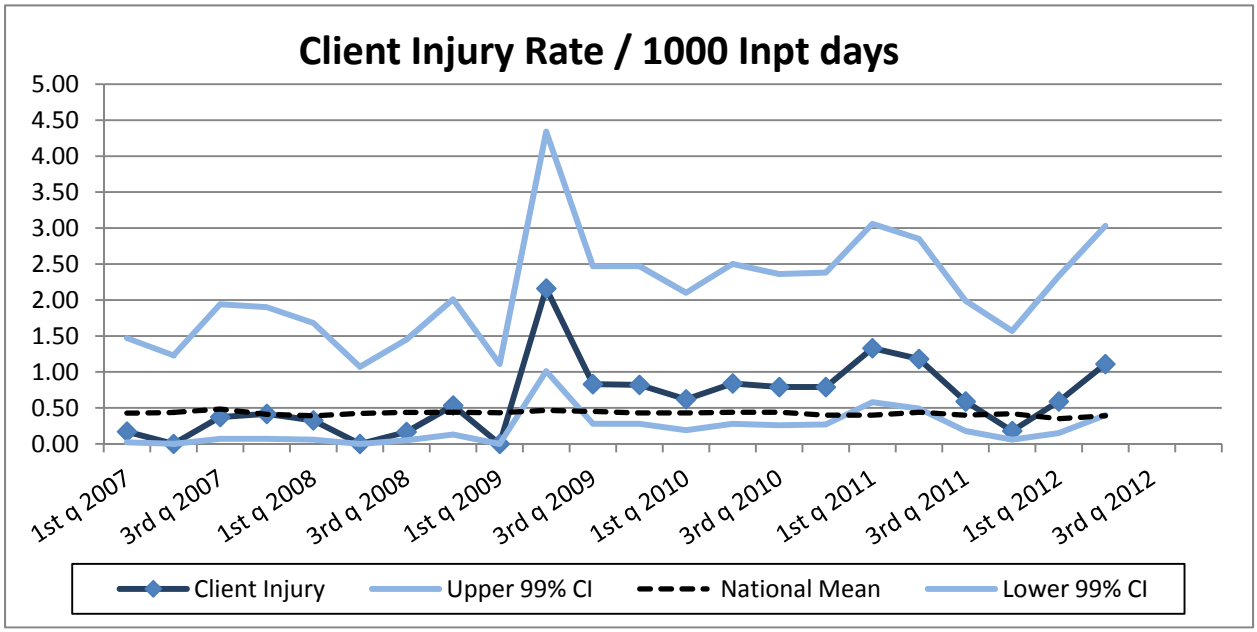
Data Source: MMIS SYF '12

Table 1b (FY2001 through FY2006)

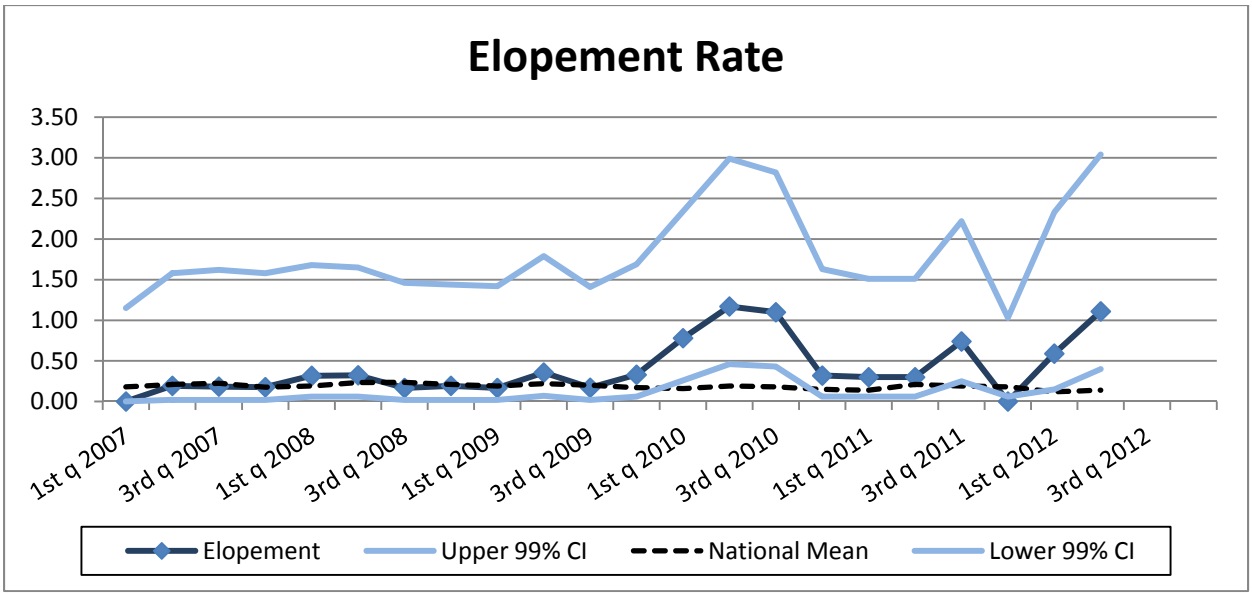
Unduplicated Count of Medicaid RPTC Recipients "Admitted" to Total Medicaid Eligible Recipient						
	FY2001	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**FY2006**
Total Admitted RPTC Recipients	573	640	778	965	763	664
Total Medicaid Eligible Recipients	59,149	60,173	61,661	62,323	64,904	67,629
Rate per 1000	9.7	10.6	12.6	15.5	11.8	9.8

Alaska Psychiatric Institute "Dashboard" of Key Performance Measures

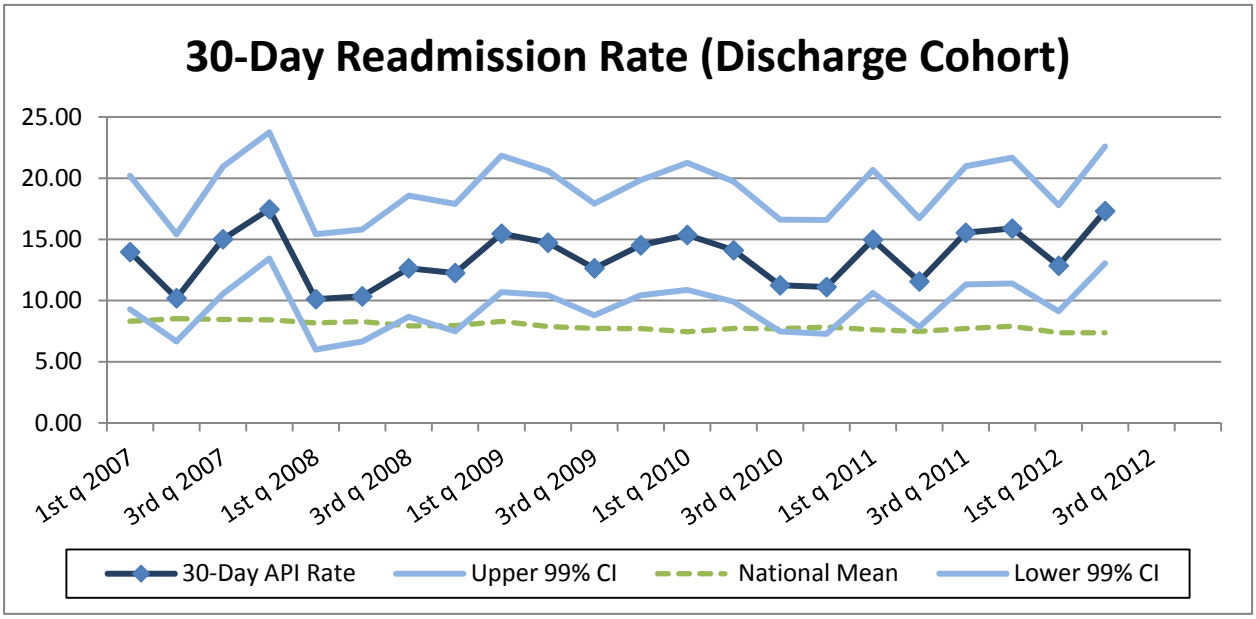
API has changed the format of the dashboard. The following graphs provide a review of our data over time. This allows us to look back at the road traveled, evaluate the course we have taken, anticipate the future, and evaluate how well our effects are meeting the challenges we face. Thank you for taking 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 third quarter 2011 is significant and could point to a trend change. Alaska Psychiatric Institute has initiated efforts to evaluate our care environment, utilization of program and staff training to identify effective ways to mitigate the trend. After a prolonged stretch above the national mean the measure moved below the mean in the 4th quarter 2011.

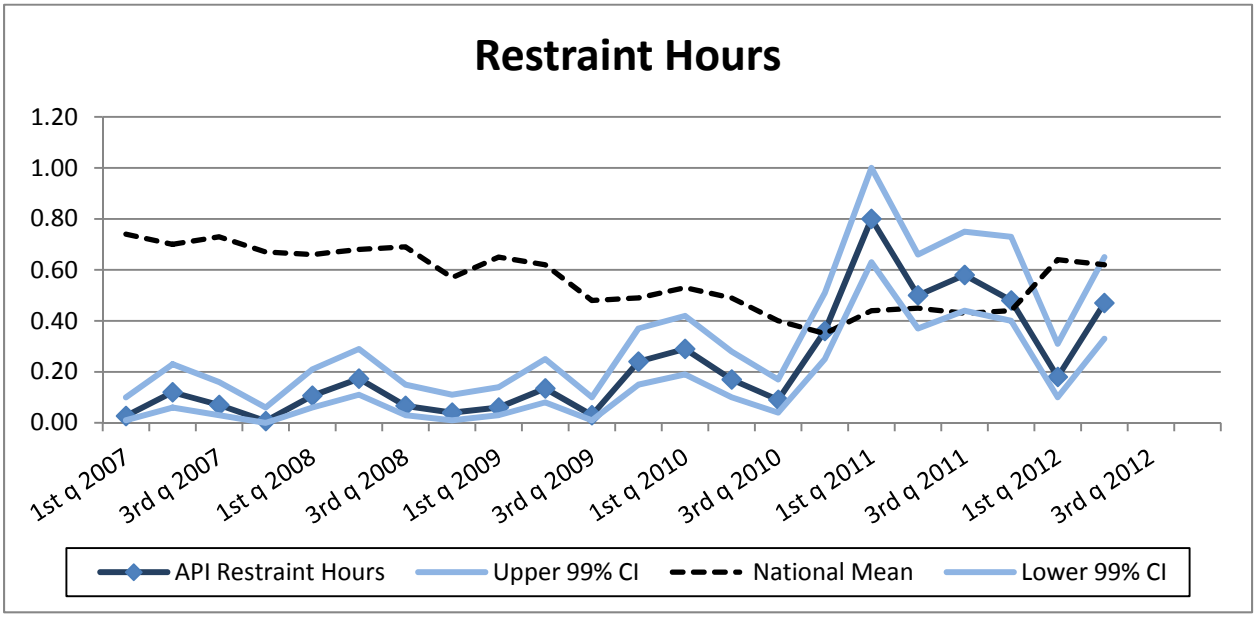


Increasing emphasis is being placed on recovery and patient centered treatment which necessitates allowing patients more independence. Given this shift in treatment paradigm, the recent increase in elopements is not a surprising development. During the first and second quarters of 2012, the rate of patients eloping while on pass to an assisted living facility increased markedly due to two patients unwilling to follow treatment plans. Alaska Psychiatric Institute is currently working to improve the discharge planning process and community provider engagement to improve client outcomes at the point in their care when we are most likely to see elopement.

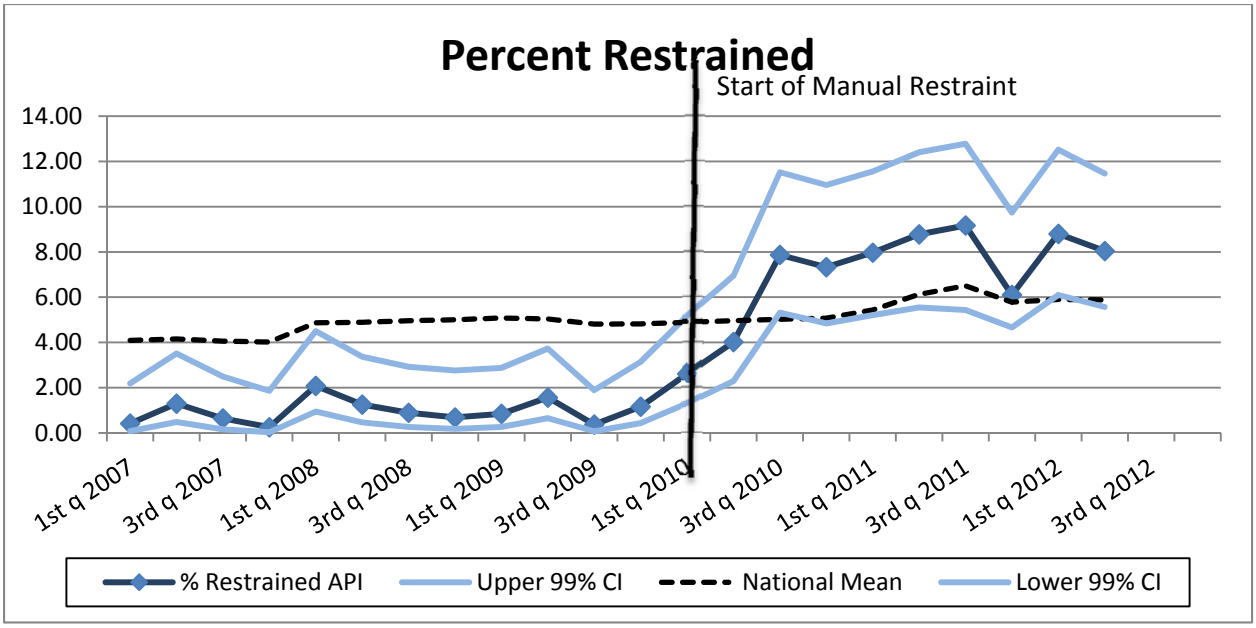


The 30-Day re-admission rate at Alaska Psychiatric Institute has been consistently above the National Mean over the last 5 years. The difference between the 30-day re-admission rate at Alaska Psychiatric Institute and the National mean is statistically significant at each point

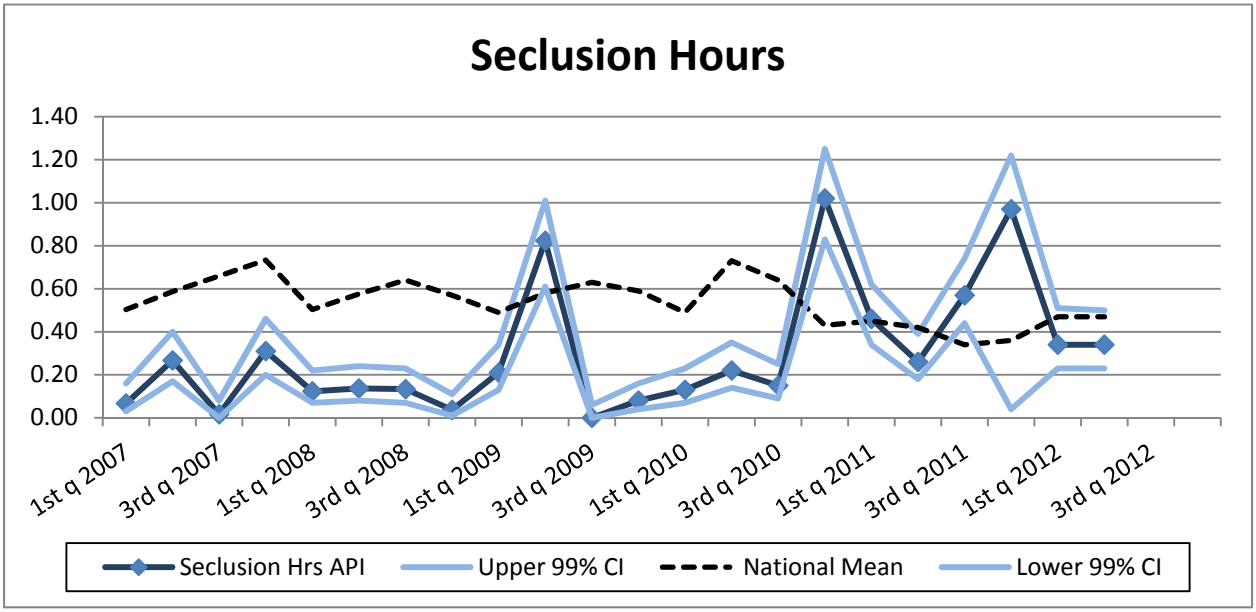
where the lower 99% confidence interval is above the (black dashed) National Mean line. Alaska Psychiatric Institute is working to improve outcomes through evaluation of its discharge process, collaboration with the Division and community providers in the goal of improving client outcomes post discharge.



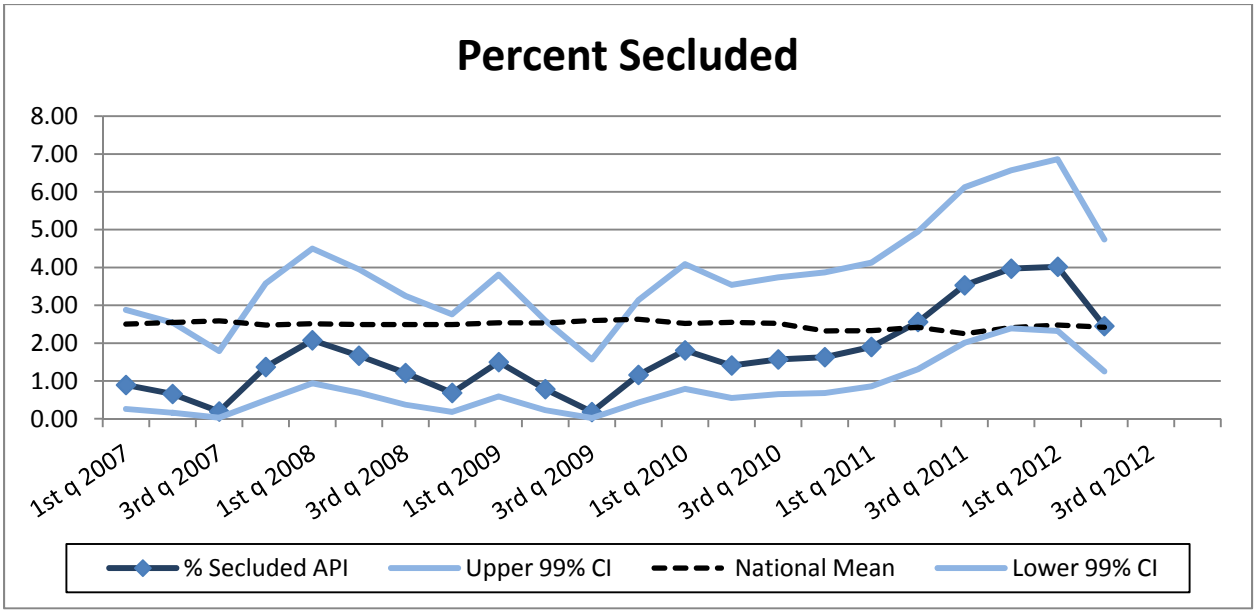
Alaska Psychiatric Institute has traditionally maintained restraint hours per 1000 inpatient hours well below the national mean for this measure. Over the last five quarters Alaska Psychiatric Institute has seen a marked increase in restraint hours. Alaska Psychiatric Institute continues to monitor this important indicator as part of its commitment to providing the best possible care for our clients. Alaska Psychiatric Institute 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.



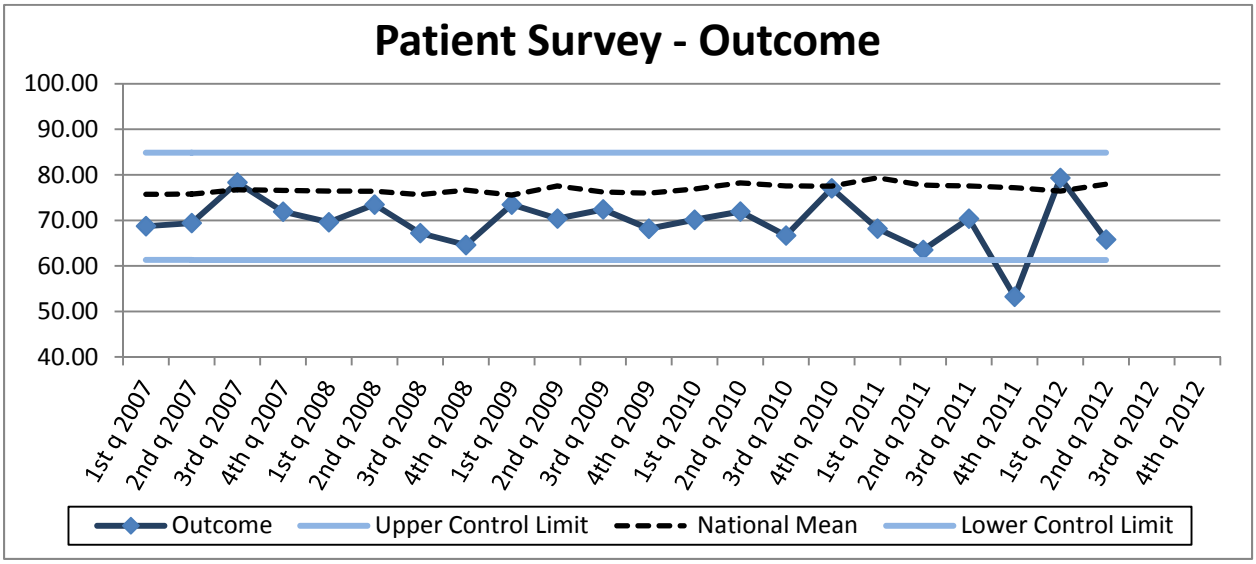
The percentage of patients restrained at Alaska Psychiatric Institute remained consistently well below the national mean between the first quarter of 2004 and the fourth quarter of 2009. Beginning with the first quarter of 2010, the measure also includes the patients that are manually restrained for five minutes or less. The percent of patients restrained will reflect this change in how the measure is calculated.



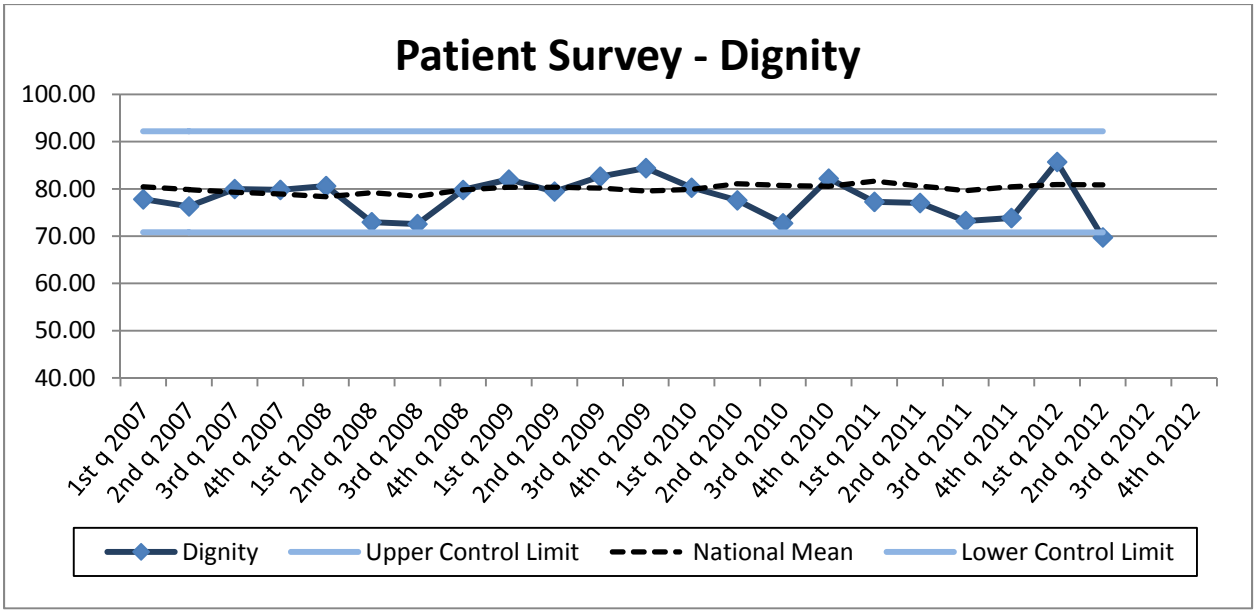
The total number of seclusion hours per 1000 inpatient hours at Alaska Psychiatric Institute has moved from consistently below the national mean with occasional outliers to a less stable pattern over the last eight quarters. Alaska Psychiatric Institute has adopted this as a quality measure and has identified initiatives designed to decrease the volatility of the measure and decrease use of seclusion by 20% in the current fiscal year.



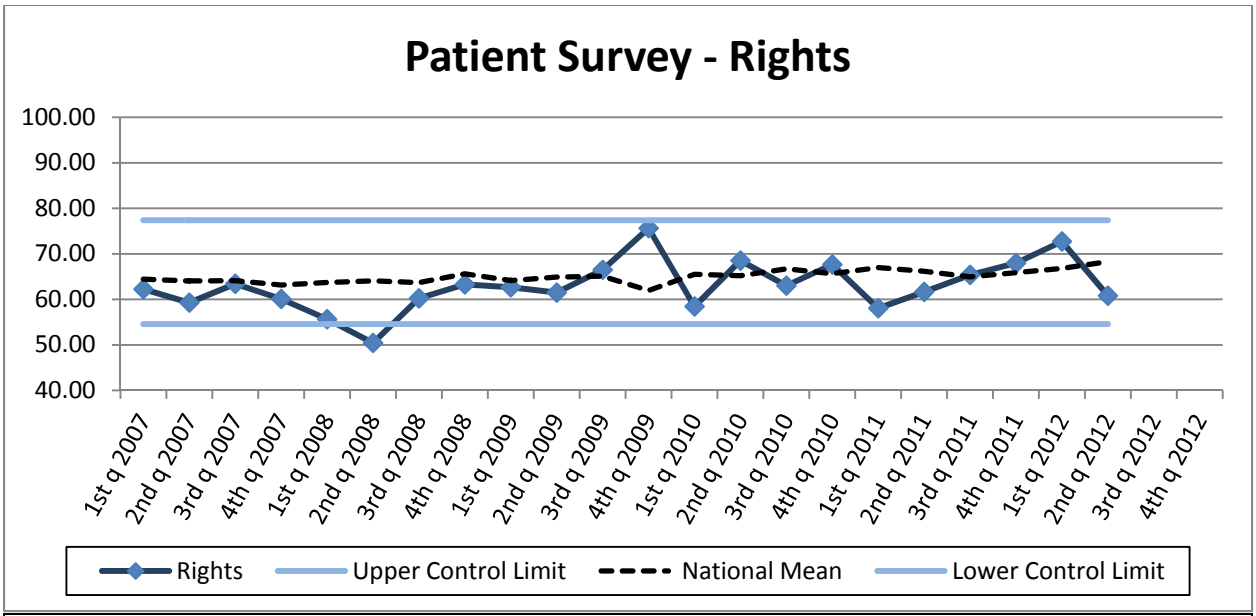
As identified in the percent secluded measure, Alaska Psychiatric Institute has identified objectives to improve treatment programming, client engagement, and other best practice measures to work toward a reduction in restraint and seclusion use in the hospital.



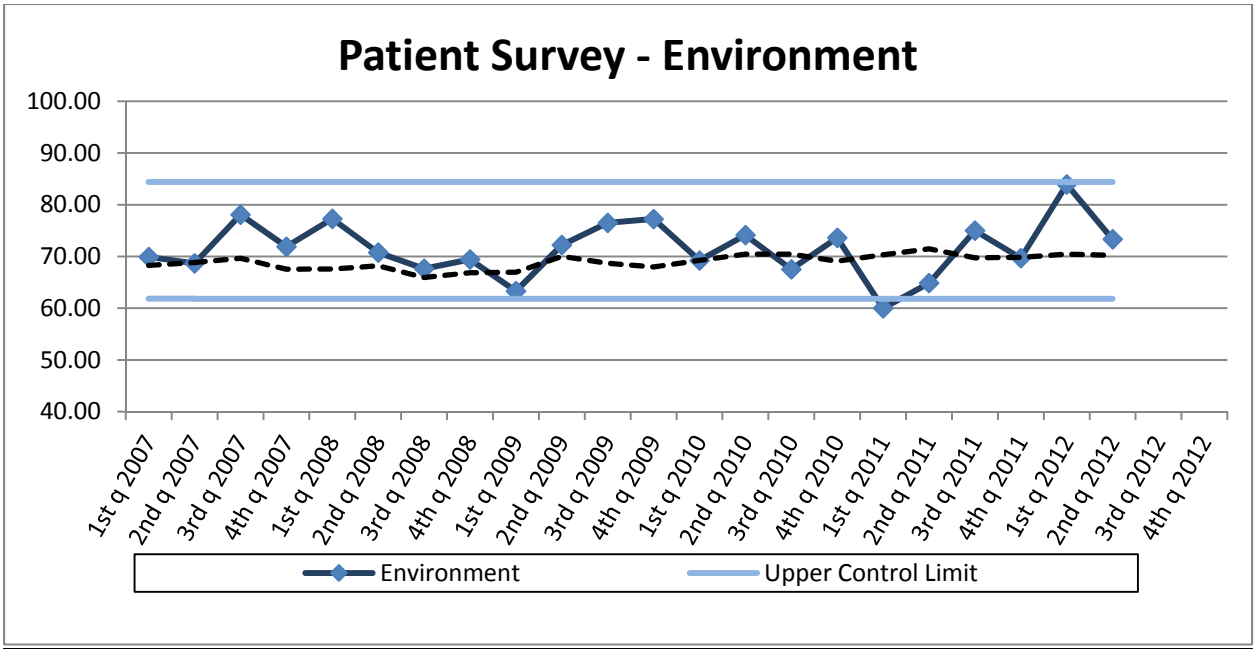
Although the majority of data points for Alaska Psychiatric Institute are below the national mean, Alaska Psychiatric Institute's scores for the Outcome Measure have remained consistently within the upper and lower control limits since the first quarter of 2005. Each of Alaska Psychiatric Institute's data points which fall within the upper and lower control limits is not statistically significantly different from the National Mean. 4th quarter 2011 results fell below the lower control limit, which may be due to a very low number of patient surveys collected in November of 2011 which allows a negative response to have a strong influence on outcome. Alaska Psychiatric Institute will work to improve collection of discharge surveys to improve assurance of survey results.



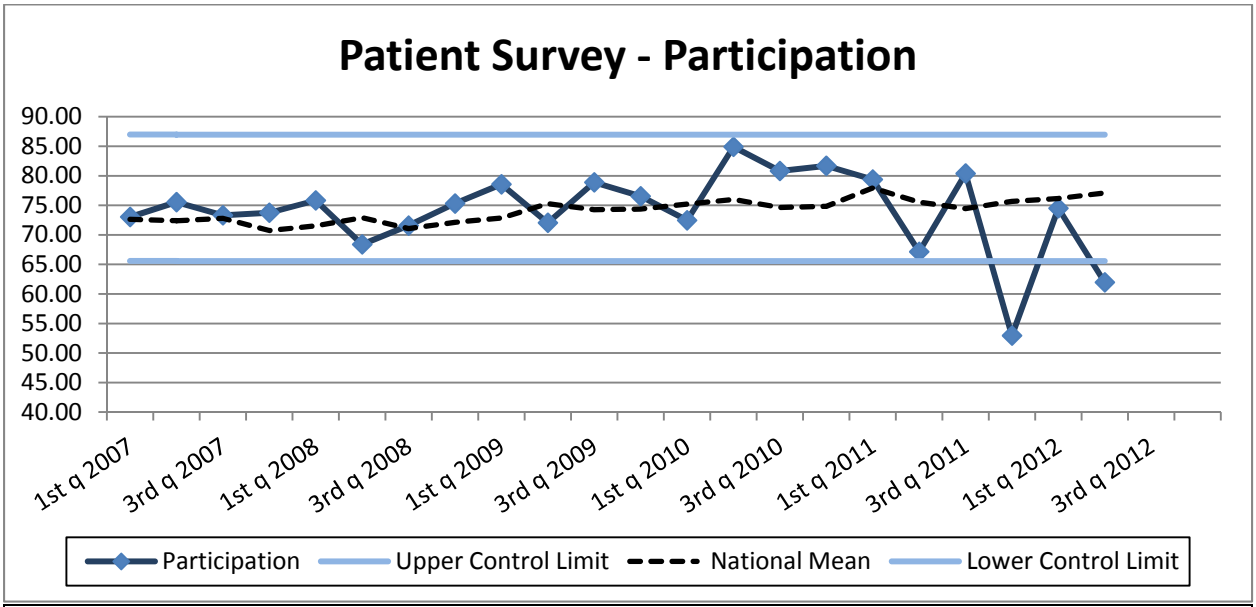
This measure reflects the percentage of patients interviewed upon discharge that agree or strongly agree with four statements regarding the dignity and respect with which they were treated during their stay at Alaska Psychiatric Institute. Of the five areas included in the survey, dignity is the domain with the highest scores. This measure is tracked in comparison with the weighted national mean. However, the goal in this area is to consistently maintain high scores. Hospital leadership will continue to monitor this measure for trend changes below national mean results.



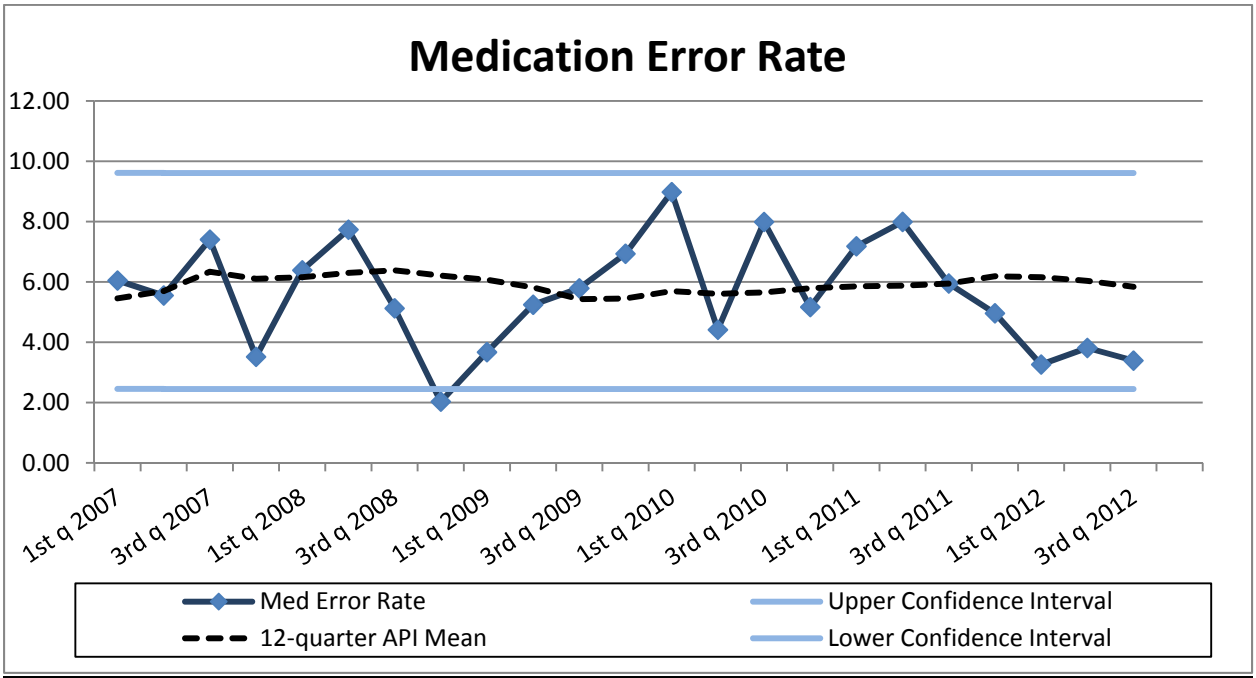
The 'Rights' domain of the impatient survey results shows a higher monthly and quarterly variability than the other four areas. Contributing factors to this increased variation are the high percentage of missing or illegible responses in this category and fewer questions within the overall domain.



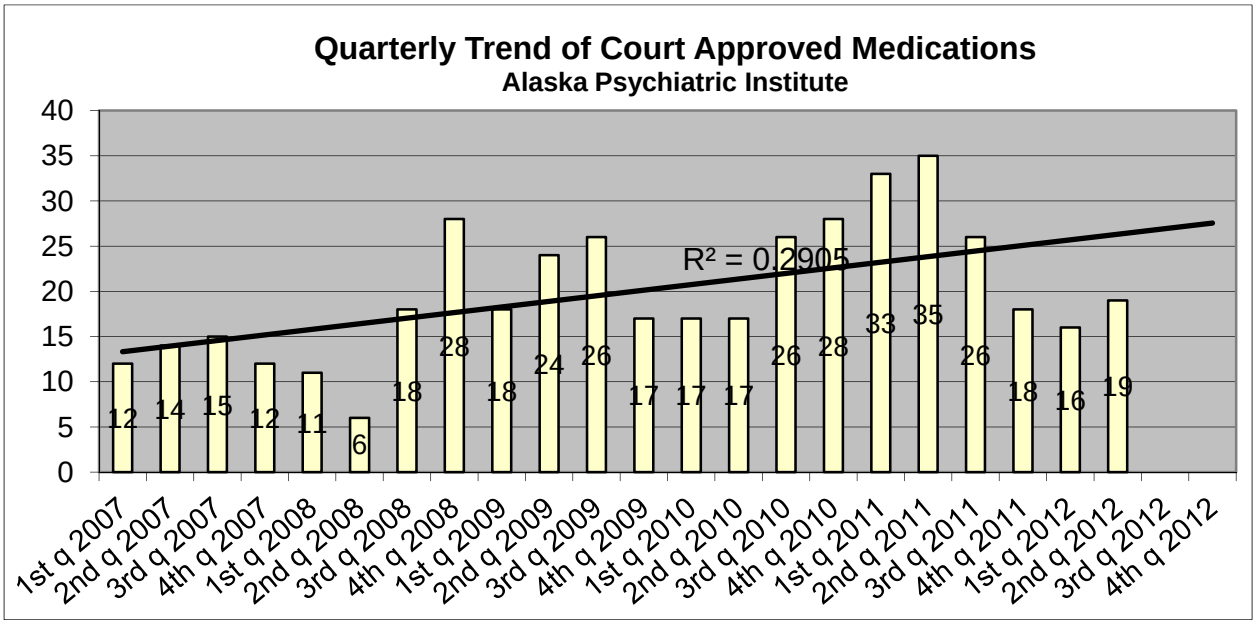
Of the five domains on the Mental Health Statistics Improvement Program (MHSIP), Environment is the one that Alaska Psychiatric Institute consistently scores higher than the National mean. The degrees to which the scores are above the national mean do not make them statistically significantly different from the mean. However, Alaska Psychiatric Institute's goal in this area is to consistently maintain high scores.



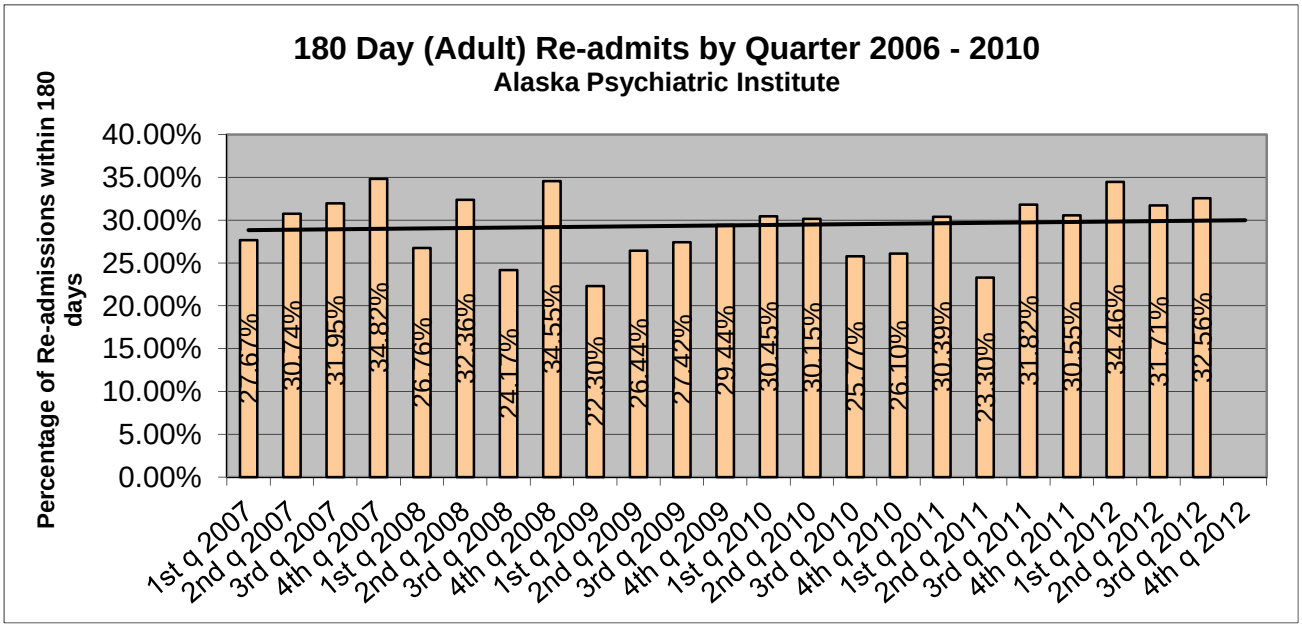
This measure reflects the percentage of patients interviewed upon discharge that agree or strongly agree with three statements about participation in treatment during the hospital stay as well as discharge planning. The quarterly scores in the participation domain of the consumer survey for Alaska Psychiatric Institute show variation within an expected range. 4th quarter 2011, and 2nd quarter 2012 results have fallen below the lower control limit. Hospital leadership will be considering what variables may be affecting this measure and what initiatives may provide improvement.



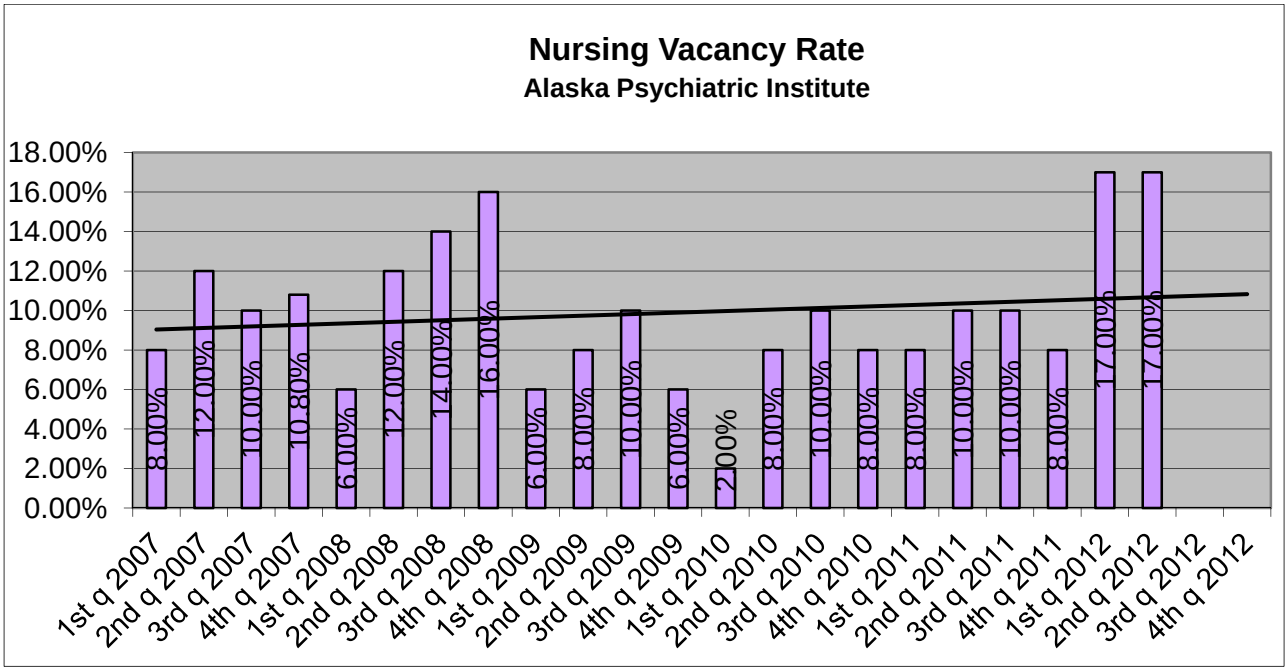
Alaska Psychiatric Institute has not experienced any special cause variation since the 4th quarter 2008 and is experiencing a period of common variation that represents a stable system.



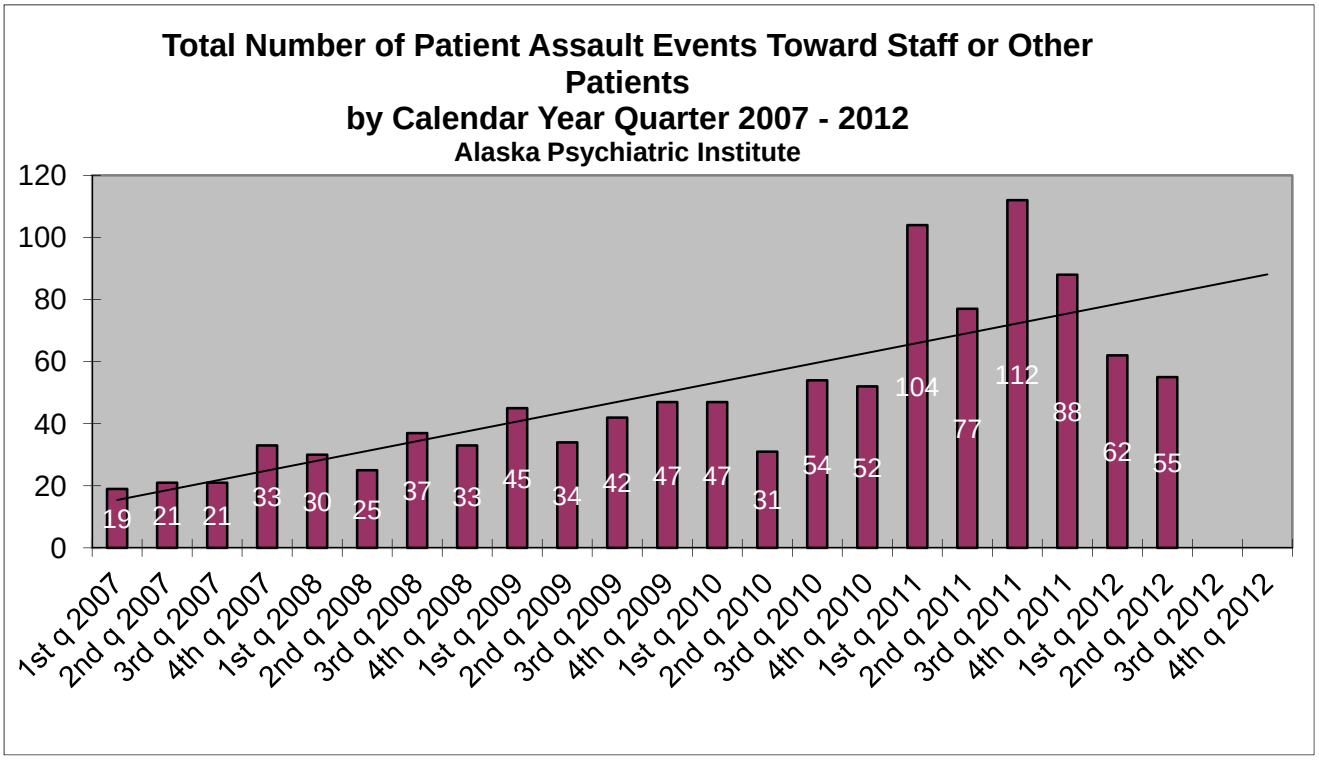
The trend line is not particularly robust in this chart as the variation in the regression to the mean for each quarter is highly variable. This means that there is neither a significant increasing nor decreasing trend in the number of Court Approved Medications over the last 22 quarters. Many factors affect 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.



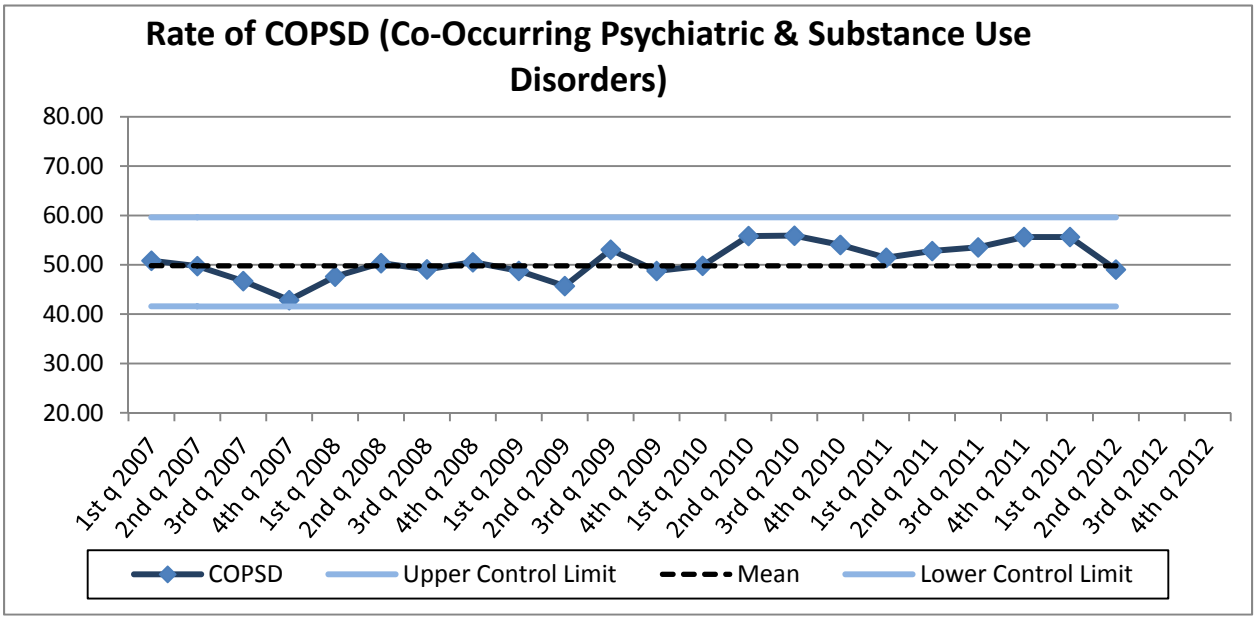
The rate of 180 Day readmissions over the past five years, as depicted in this graph, shows that Alaska Psychiatric Institute is very consistently re-admitting about one third of all discharges within six months. Alaska Psychiatric Institute is working to improve admission processes which include improved evaluation of what is not working for patients that return within 180 days. The hospital will work to use identified problems to further improve the system of care.



The nursing vacancy rate is cyclical by nature. Among the factors that add to the variability for this measure is attrition, retirement, and extended leave of absences. The extent of a long-term cycle remains to be seen.



Alaska Psychiatric Institute's efforts to improve this measure include improvements to treatment programming, patient engagement, and adoption of other mental health care best practices that show evidence of effectiveness in the acute care setting. There appears to have been some improvement in this measure over the last two quarters, and it will continue to be monitored.



The Co-Occurring Psychiatric and Substance Use Disorders rate is the percentage of patients admitted to Alaska Psychiatric Institute with a substance use diagnosis in addition to a

psychiatric diagnosis. The national mean is not part of this chart as it is no longer available as a benchmark. The mean here is the average of the percentage of patients with Co-Occurring Psychiatric and Substance Use Disorders each month from January 2005 through June 2012. The patient population remains fairly consistent, and thus there is low variability around the mean. While there is no expectation for this rate to change in the future, Alaska Psychiatric Institute continues to use this measure as a reminder that a significant proportion of patients here have co-occurring disorders.

List of Primary Programs and Statutory Responsibilities

Statutes

AS 08.86.010 - 230	Psychologists and Psychological Associates
AS 08.68.010 - 410	Nursing
AS 08.64.010 - 380	State Medical Board
AS 08.84.010 - 190	Physical Therapists and Occupational Therapists
AS 08.95.010 - 990	Clinical Social Workers
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 (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

Regulations

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

Federal Statutes

Social Security Act:	
Title XIX	Medicaid
Title XVII	Medicare
Title XXI	Children's Health Insurance Program
PL 102-321	Community Mental Health Services

Federal Regulations

Code of Federal Regulations	42 CFR Part 400 to End

Division of Behavioral Health

Budget Overview Table

Division of Behavioral Health	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$83,726.1	$75,197.1	-$8,529.0
Designated General Funds	19,593.6	19,593.6	0.0
Federal Funds	10,985.8	11,736.0	750.2
Other Funds	34,068.2	32,932.4	-1,135.8
Total	**$148,373.7**	**$139,459.1**	**-$8,914.6**

Budget Requests

Behavioral Health Grants

MH Trust: Housing - Grant 1377.06 Assisted Living Home Training and Targeted Capacity for Development: $200.0 Total -- $100.0 GF/MH, $100.0 MHTAAR

The Assisted Living Home training project, managed by Division of Behavioral Health, improves the quality of training available for assisted living home providers and selected supported housing providers serving individuals with serious mental illness and other conditions such as chronic addictions, traumatic brain injury and developmental disabilities. The Department of Health and Social Services Behavioral Health General Relief Adult Residential Care (ARC) program funds assisted living costs for approximately 142 indigent individuals with severe mental health disabilities statewide. The assisted living home program and the supported housing programs are intended to prevent homelessness and to improve daily functioning for very impaired beneficiaries. This project supports these goals by providing training to assisted living home and supported housing caregivers, which increases the capacity of these providers to house individuals with intensive behavioral health needs. The project is granted to the Trust Training Cooperative to perform the training in collaboration with the Division.

MH Trust: Dis Justice - Grant 2819.04 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome): $100.0 Total -- $100.0 MHTAAR

FY2014 funds will be used to support the Division of Behavioral Health staff in pre-development and planning activities for a Wellness Center for the Norton Sound region. The Wellness Center serves as an alternative to incarcerating persons requiring protective custody under AS 47.37.170 in Nome, AK.

Activities may include but are not limited to 1) maintaining a staff person to plan, develop, and manage the implementation of the identified Wellness Center, 2) assessing the service capacity of existing programs & facilities within the region, 3) developing a regional implementation plan for the needed identified treatment services, and 4) securing support (fiscal & otherwise)

for the identified treatment services & any physical facilities needed for the provision of the treatment services at the Wellness Center.

MH Trust: Cont - Grant 3736.02 Behavioral Health Follow-up Survey: $119.2 Total -- $119.2 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. The Division of Behavioral Health 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.

This project was started with MHTAAR funding in FY2010. This FY2014 MHTAAR increment maintains the FY2013 funding level and momentum of effort.

Domestic Violence and Sexual Assault Initiative: Telehealth Strategic Capacity Expansion Phase II: $200.0 Total -- $100.0 Fed, $100.0 GF/MH

Workforce shortages present significant barriers to providing effective responses to behavioral health emergencies, especially in rural areas. Expansion of telehealth capacity, including a PC–based application of telehealth to a home-based or behavioral health clinic-based model that is less expensive and has more comprehensive application, shows great promise in helping to connect and coordinate behavioral health aides, supervisors, clinicians, psychologists, psychiatrists, and consumers in a supportive practice model.

During Phase II of this project the Division proposes to:

- add primary care pilot providers, behavioral health providers, Department of Health and Social Services partners, and health care partners
- provide funding for one vacant internet technology position
- expand equipment
- continue training, system support and expansion

If not funded, consequences can include higher personnel and transportation costs, poor access, poor integration, and a deepening workforce shortage.

Behavioral Health Administration

MH Trust: Housing - Grant 383.09 Office of Integrated Housing: $225.0 Total -- $225.0 MHTAAR

This is an ongoing project through the Division of 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 general fund/mental health funds dating back to FY2001.

MH Trust Continuing – Sustaining Alaska 2-1-1: $50.0 Total -- $50.0 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.

Federal Tobacco Enforcement Contract: $650.0 Total -- $650.0 Fed

The Department of Health and Social Services, Division of Behavioral Health requests additional federal receipt authority for a three-year contract with the U.S. Food and Drug Administration to conduct compliance investigations to ensure that the tobacco vendors comply with the Federal Food, Drug and Cosmetic Act as amended by the Tobacco Control Act. This will, in conjunction with enforcement of Alaska State Law, strive to prevent the sale of tobacco products to persons under 19 years of age, assure that tobacco advertising in the retail environment does not lead to the initiation of youth smoking, labeling of tobacco complies with restrictions on the use of deceptive modifiers, and that flavored cigarettes have been removed from the market. The contract is reimbursement based.

The proposed budget includes funding in the personal services, supplies, contractual and travel expenditure lines. Through this contract, it is estimated that approximately 230 additional investigations will be conducted annually, above and beyond the current Synar investigations. The investigation team for youth access inspections will consist of a minimum of two adults and two student interns. The three existing investigators will not be able to extend their work to conduct the required investigations. A reimbursable service agreement will be pursued if a new position is unavailable. The terms of the contract require that anyone working on the contract be paid from the contract, so personal services for ancillary staff are also included in the increment.

Through this project, State tobacco enforcement efforts will be enhanced and will guarantee the State is in compliance with federal laws.

Without this increment, the Division will have insufficient federal authority to carry out the requirements as stated in the Federal Food, Drug and Cosmetic Act as amended by the Tobacco Control Act.

Services to the Seriously Mentally Ill

MH Trust: Housing - Grant 575.08 Bridge Home Program & Expansion: $950.0 Total -- $750.0 MHTAAR, $200.0 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 U.S. Department of Housing and Urban Development 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 604.08 Department of Corrections Discharge Incentive Grants: $300.0 Total -- $100.0 MHTAAR, $200.0 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 2463.03 Evidence Based Family Therapy Models: $670.0 Total -- $400.0 MHTAAR, $270.0 GF/MH

This increment will provide $400.0 MHTAAR and $270.0 GF to sustain the evidence based family therapy projects and support the system investment that has been developed for their training and ongoing supervision, deploying it strategically to the cases for which it is most beneficial, and to develop an in-state owned and directed family clinic component for statewide application. During FY2014, Health & Social Services will be turning to more cost effective means to expand family services statewide.

MH Trust: BTKH - Grant 2466.04 Transitional Aged Youth: $200.0 Total -- $200.0 MHTAAR

This increment will provide $200.0 MHTAAR for FY2014 for the Transition to Independence Process (TIP). This will maintain stable funding between FY2014 and FY2013 and allow expansion to additional sites as the funding for earlier sites decreases and they shift towards sustaining Transition to Independence Process through Medicaid, insurance and other resources to the extent possible. In addition, during FY2013 and FY2014, we will continue to invest in developing in-state trainers and train-the-trainer capacity to improve the sustainability of Transition to Independence Process services.

Alaska Psychiatric Institute (API)

MH Trust Cont - Grant 2467.04 IMPACT Model of Treating Depression: $75.0 Total -- $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 telehealth equipment and other technology for a psychiatrist from Alaska Psychiatric Institute to provide weekly consultation to participating clinics providing integrated care and using the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) model in the treatment of depression.

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

MH Trust: Cont - Grant 605.08 ABADA/AMHB Joint Staffing: $448.6 Total -- $448.6 MHTAAR

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

Challenges

Key RDU Challenges

Legislative and Policy Development
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 might 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 may 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 potentially 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 possible expansion of coverage and the anticipated increased demand in access to services would challenge and strain the current behavioral health treatment system.

- **Health Information Technology for Economic and Clinical Health Act (HITECH Act)** is rapidly reshaping the arena of electronic health records requiring an interoperable health Information Technology network. At the core of interoperability is the requirement for electronic health record 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. Through the Alaska Automated Information Management System, the Division functions as a vendor of an electronic health record application 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 electronic health record applications.

- **Federally Mandated Change in Disease Classification and Electronic Data Transmission Format (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 International Classification of Diseases 9 system to an expanded International Classification of Diseases 10 version to be implemented by October 1, 2013. In addition, the government has also mandated an upgrade of the nine Health Insurance Portability and Accountability Act transaction formats for electronic data transmission from the initial 4010 version to version 5010. Developing 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.

Partnerships - Coordination of Behavioral Health with Other Non-Traditional Provider Settings

The landscape of behavioral health service delivery is becoming more integrated and coordinated, and challenges the historical silos of designated treatment settings. These efforts at "cross coordination" with behavioral health include primary care, medical home models, corrections, therapeutic courts, and domestic violence/sexual assault providers. This cross coordination will require changes in business and clinical practice, with new resources and skills, including business modeling that balance fiscal, revenue and clinical management and results in maximum service capacity, delivery of quality care, with meaningful outcomes.

Resource Eligibility, Service Capacity, and Access

Insuring access to appropriate services and determining sufficient treatment capacity is a complex challenge. 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 the development of 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.
- Measurement and monitoring capacity to insure resource eligibility results in access of care and targets disparity of care (ex. the historical lack of Medicaid coverage for substance use disorder services and the lack of coverage as the number one cause of not accessing substance use disorder treatment.).

Performance Management System - Use of Data

The Division of Behavioral Health continues to refine a performance management system to insure an efficient, equitable, and effective system of behavioral health care for Alaskans. The Division is applying the Results Based Accountability framework to inform this performance management system. This includes the development of a scorecard, with targeted performance measures in the following areas: acute care volume, access to treatment, emergency medical services volume, engagement and retention, treatment quality, and outcomes. Behavioral Health is developing formal feedback loops via processes and policies on the application of data to monitor the treatment system. Related challenges involve budgeting for appropriately skilled research staff in order to maximize the necessary data collection, analysis, reporting, and application to business and service delivery practices. This system realignment absorbs a significant amount of leadership time and energy that limits our resources for timely analysis of emerging issues.

Statewide Behavioral Health Psychiatric Emergency Services System

Psychiatric Emergency Services is a critical element of the prevention and treatment system of care. This can, and often involves the coordination between three separate service components: 1) the community behavioral health providers; 2) Designated Evaluation & Stabilization and Designated Evaluation & Treatment service providers, and 3) the Alaska Psychiatric Institute. Challenges specific to each component has a corresponding and compounding impact on the others:

1) Community Behavioral Health Providers:
   - Communities statewide, but especially in more isolated rural areas, face significant workforce issues; local behavioral health programs in particular have great difficulty recruiting and retaining psychiatrists, advanced nurse practitioners or registered nurses with psychiatric specialties, licensed clinical psychologists, and licensed social workers. Rural social service programs routinely experience workforce shortages and high turnover in other behavioral health professions and positions.
   - Maintaining functioning partnerships between local hospitals and community behavioral health providers and other key social service agencies, in order to facilitate efficient and effective shared responses to local behavioral health emergencies, is a significant, continuing challenge.
   - The development of quality local Psychiatric Emergency Services throughout the State, as well as the development of alternatives to hospitalization (such as crisis respite beds), is needed to minimize admissions to Alaska Psychiatric Institute - the State psychiatric hospital - which has very limited capacity (80 total beds, with only 50 acute adult beds) and has experienced a significant census increase in recent years.

2) Designated Evaluation and Stabilization / Treatment
   - Clear expectations need to be established and supported through ongoing orientation, training, technical assistance, and continuing quality improvement processes, in order to develop and sustain stabilization services in those communities fortunate enough to have both a small, critical access hospital and a comprehensive behavioral health center program.
   - It is anticipated that Designated Evaluation & Stabilization and Designated Evaluation & Treatment facilities and local community behavioral health centers will continue to struggle with workforce issues, including shortages and turnover in psychiatrist, advanced nurse practitioner, psych nurse, and other behavioral health clinician positions. Fluctuations in staffing at any of the partners involved in the provision of behavioral health emergency services (including transportation) can render the Designated Evaluation, Stabilization and Treatment delivery system ineffective.
   - The inability to successfully recruit and fund new hospitals to provide Designated Evaluation & Stabilization and Designated Evaluation & Treatment services in the Mat-Su Valley and Anchorage bowl (areas that are the source of over 80% of the Alaska Psychiatric Institute's annual admissions) increases the need for the Division to develop communications and placement strategies in order to respond when the census pressure on Alaska Psychiatric Institute creates a backlog of committed

patients awaiting transfer to Alaska Psychiatric Institute from hospital emergency rooms statewide.

3) Alaska Psychiatric Institute
   - 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 Alaska Psychiatric Institute 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.
   - Alaska Psychiatric Institute, as the only hospital with psychiatric acute care inpatient capacity serving a metropolitan area greater than 425,000 people, creates a demand for bed utilization that sometimes exceeds capacity. The system is challenged to create additional capacity in the private sector.
   - 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.
   - With the adoption of revised Alaska Court System forms related to the processes involved in the emergency detention and involuntary commitment of persons experiencing a behavioral health crisis, the Division of Behavioral Health now faces significant pressure (both monetary and legal) to arrange transport of those persons subject to court-ordered involuntary 72-hour evaluation holds **within 24 hours** of the time and date of the court order.

Family Based Treatment

At any given time, children/youth comprise approximately 25% of all clients served (publicly funded) and receive clinic and rehabilitation services. However, the majority of services delivered target the child/youth and not the child/youth and their families. An analysis of Medicaid data indicated that 62% of all youth served did not receive any family services. Of those 38% who did, it only resulted in an average of 5.8 hours per year. Family systems theory recognizes and values the role and impact families have on children/youth with mental health and substance use disorders. This approach regards the family, as a whole, as a unit of treatment. The Division has growing concerns that the level of family based treatment is minimal at best, and reflects a lack of adequately trained behavioral health professionals to provide this skilled service. By default this results in unintended consequence of institutional parenting of children and reinforces a dependency on treatment providers, and undermines the potential for good treatment outcomes for children and their families.

Bring the Kids Home (BTKH) – The Next Phase

The Bring the Kids Home Initiative is transitioning from the "active-execution" phase to "benefits gained" and aligning efforts with the regular business and clinical practices of the children's treatment system (children and adolescents who are seriously emotionally disturbed and/or have a substance use disorder). The Division of Behavioral Health has implemented a

more effective on-going review of all children and youth in Residential Psychiatric Treatment Center (RPTC) care to shorten their length of stay and reintegrate them into their family and community earlier with more success. This will require that we realign funding within the initiative to support in-state service expansion and a renewed focus on treating the whole family together. The goal is to sustain the forward progress achieved by this very successful endeavor and implement strategies that will inform the entire children's system with the values of the initiative:

- 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).

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.

Affordable Housing

There is a deepening crisis in Anchorage and statewide due to the freeze in subsidized housing vouchers through Alaska Housing Finance Corporation. 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 the Division of Behavioral Health currently has multiple grant programs to distribute public funds for behavioral health treatment services (seriously mentally ill adults, severely emotionally disturbed children and substance use disorder adults and adolescents). As new funding has become available for expansion of service capacity or to promote systems change, additional grant programs were created to manage and monitor expected program outcomes. Over time the volume of individual grant programs has increased, resulting in greater administrative burden for the Division, as well as provider grantees.

We will be developing a new model to align all adult services and all children/youth services into programs that will encompass all behavioral health (integrated mental health and substance abuse) 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 behavioral health treatment providers and their primary care providers to partner in development of medical home models for our behavioral health clientele.

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN	
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.	
OUTCOME 1. Alaskans are healthy	
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who are immunized.
EFFICIENCY MEASURE	Cost per immunization.
OUTCOME 2. Alaskans are free from unintentional injury	
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of HSS.
EFFICIENCY MEASURE	Number of hospitalizations due to medication errors. (HCS)
EFFICIENCY MEASURE	Cost of medical services in facilities. (DJJ)
EFFECTIVENESS MEASURE	Percent of facilities with deficiencies.
EFFICIENCY MEASURE	Percent of decrease in facilities with deficiencies.
EFFICIENCY MEASURE	Percent of complaints investigated within established timeframes.
OUTCOME 3. Alaskans are free from substance abuse and dependency	
EFFECTIVENESS MEASURE	**Percent of Alaskans discharged from substance abuse treatment services who successfully completed treatment.**
EFFICIENCY MEASURE	**Cost of treatment per completion.**
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percent of disenrollments from substance abuse treatment programs indicating that the client successfully completed the program.

	EFFICIENCY MEASURE	Percent of adults receiving substance abuse outpatient service who report a positive evaluation of treatment outcomes.

CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.

OUTCOME 4. Alaskans with behavioral issues report improvement in key life domains.

EFFECTIVENESS MEASURE	**Percent of Behavioral Health clients who report improvement in quality of life between their initial Client Status Review and first subsequent review.**
EFFICIENCY MEASURE	**Average cost of care for those who report improved quality of life vs. those who do not report improved quality of life.**

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***	
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***	
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**	
	EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
	EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
	EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

CORE SERVICE B. FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

OUTCOME 1. Alaskans have access to health care.

EFFECTIVENESS MEASURE	**Percent of Alaskans in urban communities that can access care.***	
EFFICIENCY MEASURE	**Department cost per percent of Alaskans with access to care.***	
	***** AGGREGATE DIVISION MEASURES - (Percent of Alaskans in urban communities that can access care).**	
	EFFECTIVENESS MEASURE	The percentage of the estimated need for behavioral health services are met through community-based services.
	EFFICIENCY MEASURE	Percent of clients whose wait time to access treatment is less than 7 days.
	EFFICIENCY MEASURE	Percent of substance abuse residential treatment providers with a bed utilization rate of 85% or higher.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 2. Alaskan adults at risk of maltreatment are protected from abuse, neglect and exploitation.

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Number of transports for psychiatric emergency commitments (i.e., Title 47 Transports)
	EFFICIENCY MEASURE	Cost per transport for psychiatric emergency commitments (i.e., Title 47 Transport)

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

OUTCOME 1. Alaskan communities support tobacco enforcement.

EFFECTIVENESS MEASURE	Vendor compliance rate with laws regulating the sale of tobacco products to youth (i.e., based on Syntar retailer violation rate).
EFFICIENCY MEASURE	Percent of youth-accessible tobacco vendors that receive an educational visit from Tobacco Enforcement staff.

OUTCOME 3. Alaskans with health conditions practice self-management.

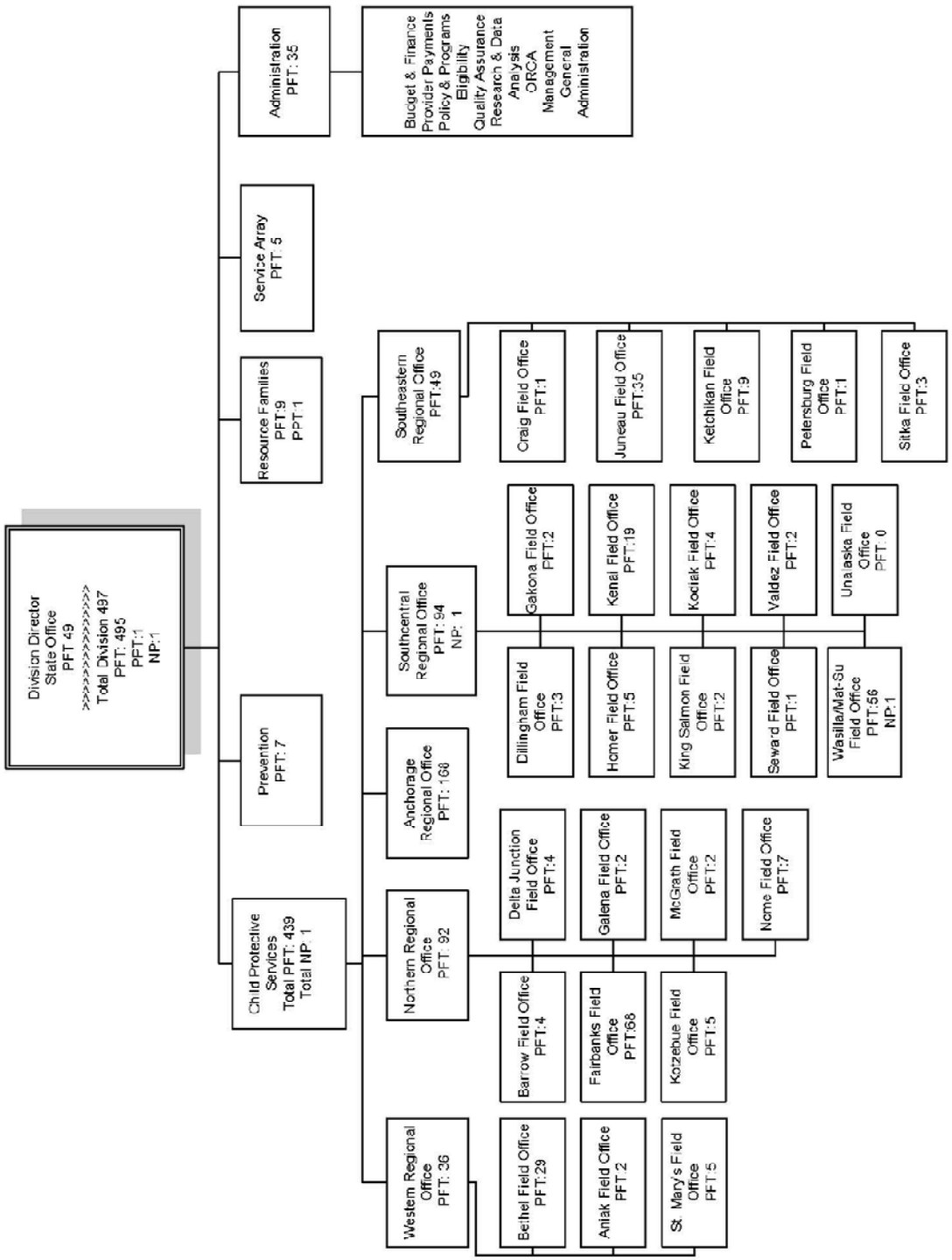
EFFECTIVENESS MEASURE	Percent of clients with chronic disease enrolled in self-management programs.
EFFICIENCY MEASURE	Cost per client for self-management services.

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Behavioral Health General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
Change Capital Improvement Project Receipt Authority to Interagency Receipt Authority for Probation Officer Position (ASAP)	$ -	$ -	$ -	$ -	$ -
MH Trust: Cont - Grant 3736.02 Behavioral Health Follow-up Survey (BHG)	$ -	$ -	$ -	$ 119.2	$ 119.2
MH Trust: Dis Justice - Grant 2819.04 Pre-Development for Sleep Off Alternatives in Targeted Communities (Nome) (BHG)	$ -	$ -	$ -	$ 100.0	$ 100.0
MH Trust: Housing - Grant 1377.06 Assisted Living Home Training and Targeted Capacity for Development (BHG)	$ 100.0	$ -	$ -	$ 100.0	$ 200.0
Reverse FY2013 MH Trust Recommendation (BHG)	$ -	$ -	$ -	$ (275.0)	$ (275.0)
Telehealth Strategic Capacity Expansion, Phase II (BHG)	$ 100.0	$ -	$ 100.0	$ -	$ 200.0
Transfer from Family Preservation for Substance Abuse Treatment and Recovery Services for Parents (BHG)	$ 225.0	$ -	$ -	$ -	$ 225.0
Federal Tobacco Enforcement Contract (BHA)	$ -	$ -	$ 650.0	$ -	$ 650.0
FY2014 Salary and Health Insurance Increases (BHA)	$ 1.9	$ -	$ 0.2	$ -	$ 2.1
MH Trust Continuing - Sustaining Alaska 2-1-1 (BHA)	$ 50.0	$ -	$ -	$ -	$ 50.0
MH Trust: Housing - Grant 383.09 Office of Integrated Housing (BHA)	$ -	$ -	$ -	$ 225.0	$ 225.0
Reverse FY2013 MH Trust Recommendation (BHA)	$ -	$ -	$ -	$ (331.0)	$ (331.0)
MH Trust: Housing - Grant 575.08 Bridge Home Program & Expansion (SSMI)	$ 200.0	$ -	$ -	$ 750.0	$ 950.0
MH Trust: Housing - Grant 604.08 Department of Corrections Discharge Incentive Grants (SSMI)	$ 200.0	$ -	$ -	$ 100.0	$ 300.0
Reverse FY2013 MH Trust Recommendation (SSMI)	$ (325.0)	$ -	$ -	$ (1,275.0)	$ (1,600.0)
MH Trust: BTKH - Grant 2463.03 Evidence Based Family Therapy Models (SSEDY)	$ 270.0	$ -	$ -	$ 400.0	$ 670.0
MH Trust: BTKH - Grant 2466.04 Transitional Aged Youth (SSEDY)	$ -	$ -	$ -	$ 200.0	$ 200.0
Reverse FY2013 MH Trust Recommendation (SSEDY)	$ -	$ -	$ -	$ (1,275.0)	$ (1,275.0)
Transfer to Infant Learning Program Grants for Early Childhood Screening (SSEDY)	$ (360.0)	$ -	$ -	$ -	$ (360.0)
FY2014 Salary and Health Insurance Increases (API)	$ 8.7	$ -	$ -	$ 25.6	$ 34.3
MH Trust Cont - Grant 2467.04 Impact Model of Treating Depression (API)	$ -	$ -	$ -	$ 75.0	$ 75.0
Reverse FY2013 MH Trust Recommendation (API)	$ -	$ -	$ -	$ (75.0)	$ (75.0)
FY2014 Salary and Health Insurance Increases (AKMHADAB)	$ 0.4	$ -	$ -	$ 0.4	$ 0.8
MH Trust: Cont - Grant 605.08 ABADA/AMHB Joint Staffing (AKMHADAB)	$ -	$ -	$ -	$ 448.6	$ 448.6
Reverse FY2013 MH Trust Recommendation (AKMHADAB)	$ -	$ -	$ -	$ (448.6)	$ (448.6)
Suicide Prevention Council Members Ch33 SLA2012 (HB21) (Ch16 SLA2012 P9 L10-15) (HB285) (SPC)	$ 4.0	$ -	$ -	$ -	$ 4.0
Behavioral Health Total	***$ 475.0***	***$ -***	***$ 750.2***	***$ (1,135.8)***	***$ 89.4***

It should be noted that a one-time, multi-year appropriation of $9 million in general funds was appropriated for Behavioral Health Grants for FY2013 through FY2015. All one-time funding is removed from the base budget. The $9 million decrement for the Governor's request is not included in the table above.

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:

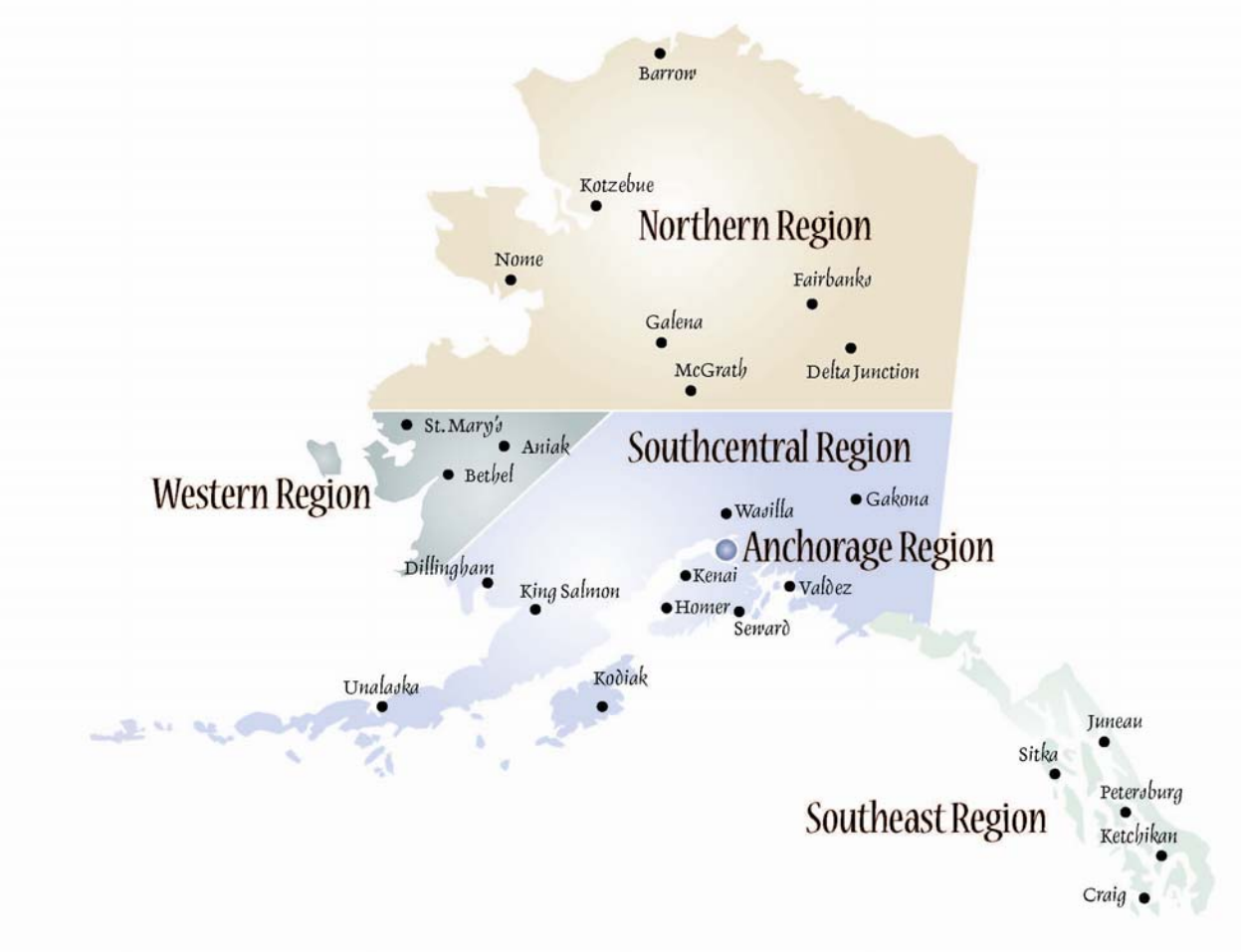
- Prevent and remedy child abuse and neglect through the provision and facilitation of early intervention and treatment services;
- Timely and interactive intake functions that serve as resource referral and screening of alleged maltreatment reports;
- Provide initial safety assessments of protective service reports that are timely and identify the presence of present or impending danger;
- Ensure delivery of quality and effective ongoing services to children and their families when necessary;
- Develop permanency plans for children in out-of-home care that promotes reunification whenever possible and reduces length of stays in care; and
- Recruit and retain resource families to provide short and long term care for children requiring out-of-home placement.

The Office of Children's Services has five regional offices; these regional offices support 26 local offices across Alaska that deliver child welfare services through the field offices.

- Northern Regional Office (NRO) in Fairbanks:
  - Nome, Kotzebue, Barrow, Galena, McGrath and Delta Junction.
- Southcentral Regional Office (SCRO) in Wasilla:
  - Kenai, Valdez, Kodiak, Dillingham, Unalaska, Homer, Seward, Gakona, and King Salmon.
- Anchorage Regional Office (ARO) is responsible for Anchorage municipality and surrounding areas;
- 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 FY2013

Quality Assurance and Outcomes

In 2008, the Office of Children's Services underwent the second Federal Child and Family Services Review (CFSR) which resulted in the need for a Program Improvement Plan (PIP) to address areas not meeting required benchmarks in safety, permanency and well-being outcomes for children and families. The Program Improvement Plan was a substantial and successful undertaking that resulted in many policy and practice improvements. The goal following the completion of the Program Improvement Plan and the end of quarterly data submissions on outcomes to the Administration of Children and Families (ACF) federal Region 10 was to not only sustain those improvements, but to build upon them. The date for the third round of reviews has not yet been provided, but is anticipated to be in FY2013-FY2014.

- Since FY2008, the Office of Children's Services has been monitoring the outcomes on systemic factors for safety, permanency, and well being. The data reflects that OCS continues to make steady progress in a positive direction in almost every area reviewed.
- The Office of Children's Services continues to monitor the data closely for outliers or areas where the trends are moving in a negative direction to ensure we continue to make gradual and sustainable gains towards achieving federal benchmarks. Through a variety of new and continuous quality improvement measures, the Office of Children's Services continues to evaluate the efforts, make adjustments when necessary, and enhance training and support for staff as needed.
- Quality assurance reviews are critical to the Office of Children's Services' continued success. This is an area that the Office of Children's Services is working to not only enhance, but to increase our efforts to a higher level of reliability and sophistication.

Tribal Partnerships and Community Connections

The relationships and partnerships the Office of Children's Services has statewide with Tribes, Tribal non-profits, and their respective leaders and staff are some of the most critical. The disproportionality of Alaska Native children being served in the system is grossly overrepresented when you look at the ethnic composition of the population of children statewide. Once in care, Alaska Native children often experience poor outcomes at all critical points. While it is difficult to control and manage who is reported to the Office of Children's Services, we do have the ability, along with our Tribal partners, to impact their outcomes to ensure they are in alignment with their peers of other ethnicities.

- Through the collaborative work with statewide Tribal partners, the Office of Children's Services is working towards solutions and strategies that can make the system better. The Office of Children's Services continues to meet regularly (three times annually) face-to-face with the Tribal leadership to strategize on solutions and identify new initiatives that will get the results that are mutually sought.

- Additionally, in many of the 26 field offices, there are significantly fewer formal resources, but there is a richness of resources available within the local Tribal organizations and the local people themselves. It is through these Tribal partnerships that the Office of Children's Services is able to better understand how to utilize and access traditional tribal resources; Tribal partners are often pivotal in helping ensure the safety of their children.

- During the last fiscal year, the Office of Children's Services enhanced those partnerships through increased joint decision-making on policies and practices that impact native families, as well as partnering on efforts to increase individual Tribal capacity to provide in-home services to families.

The Resource Family Advisory Board (RFAB) was created in FY2013. The board is made up of licensed and unlicensed caregivers who provide guidance and consultation to the Office of Children's Services leadership. Licensed foster parents, relative caregivers, and adoptive and guardianship families are fundamentally essential to our ability to ensure child safety when we are not able to do so within their own home. Whether licensed, or unlicensed, these families are the backbone of this agency and their commitment is commendable.

- Over the past year, with support from Casey Family Programs, the Office of Children's Services has been working on developing the leadership and infrastructure of this board. Recruiting and retaining families who are better equipped to care for children in care is a challenge. However, the Office of Children's Services does not want one of those challenges to be that it is too difficult to work with the agency and staff. Therefore, the Office of Children's Services must partner and provide the support, resources, and communication that every resource family requires in order to perform what we ask of them. As the Resource Family Advisory Board develops and evolves, the Office of Children's Services hopes to minimize challenges and increase our ability to successfully retain quality families.

Through the new external newsletter, ***The Pipeline***, we strive to increase transparency, and increase understanding about whom and what the Office of Children's Services represents. The veil of perceived mystery, from the public's perspective, that seems to surround the Office of Children's Services is not new, but it is one we are slowly endeavoring to change.

- ***The Pipeline***, issued quarterly, now has over 500 subscribers. The content of each issue is designed to address issues that the Office of Children's Services most often receives questions or complaints about, items of national or local media attention, and also always includes a piece focused on specific employees: who they are and what they do to personalize the business of child welfare services.

- In addition to the newsletter, the agency has taken a more assertive and proactive approach to working with the media. The Office of Children's Services is always looking for opportunities to use a story to educate the public and/or highlight the work that is done to keep the kids of Alaska safe. Although bound by the same confidentiality constraints as always, the Office of Children's Services works to find ways to engage in dialogue that can enhance a story, thereby increasing public awareness.

Worker Retention and Regional Improvements

The ability to retain quality and skilled professionals requires that the Office of Children's Services invest in training and nurturing its workforce. The inability to retain staff is the most significant challenge we are facing. This inability directly correlates to our ability to meet the needs of the families we are legally obligated to serve. Over the past year, numerous strategies and processes have been put in place to improve retention, primarily in the front-line, case carrying workforce.

- In August, the Office of Children's Services implemented (for the first time) standardized statewide requirements for how new employees should be oriented. The new on-the-job protocol was created using feedback from staff, supervisors, and employees. It is intended to ensure workers aren't learning by "trial and error," but rather, by increasing the workers' comfort level. Thus, workers are less anxious when they begin working with families and the many stakeholders they will encounter. It seeks to orientate new workers to the size and complexities of the organization, the mission, and to help workers connect to those they will most frequently be calling upon later.

- In February 2011, the first meeting of the newly created Staff Advisory Board (SAB) was held. The Staff Advisory Board is comprised of three staff representatives from each of the five Office of Children's Services regions along with two representatives from staff in our state office. The board members, along with the director and seven other senior level leaders, meet monthly with the primary purpose of increasing communication, identifying solutions, and finding ways to bridge the gap that sometimes occurs between field staff and leadership. This forum provides the opportunity for staff at all levels to speak directly with the Director and the leadership team through their local representatives. This ensures that their voice is not only heard, but that it matters.

New worker training delivered through the University of Alaska Anchorage, Child Welfare Academy, was significantly revised in FY2012. The first class of new employees went through the redesigned training model in August, 2011.

- This redesigned and expedited training delivery model will keep quality high, and allow the Office of Children's Services to get "boots on the ground" faster. The training will enable new workers to more rapidly take over case supervision from remaining staff that are often overburdened during times of vacancy. The training will be delivered via standard classroom settings, webinars, as well as on-site training that will support more hands-on coaching and mentoring .

- Additional new trainings of note, is the course *Critical Thinking* training for supervisors. This is an expansion to the existing supervisory training and provides opportunity for interactive peer-to-peer case review to enhance decision making skills regarding the Office of Children's Services safety intervention model.

- New and improved case plan development training has been created that is more interactive and parent-driven. This new design aims to increase parental ownership and invest in the plan geared towards making their family safe once again.

- With increasing opportunities to effectively use technology, the Office of Children's Services added to the array of training already being offered with the addition of interactive webinars. These topic specific webinars are for both new and advanced workers, and allows them to participate right from their own computer. So far, these sessions have been well received and utilized.

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 are focused on providing for a safe and stable permanent home for a child, as quickly as possible.

Client Services

Prevention and Early Intervention Services

Prevention and early intervention programs administered by the Office of Children's Services are provided to children served through child protection services, as well as to all young children in Alaska with significant developmental delays or disabilities.

Infant Learning

The Infant Learning Program (ILP) provides early intervention services through special education to children with developmental delays and their families. Additionally, Infant Learning Program administers services to providers through 16 regional 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 to families to best support the child's development;
- Physical, Occupational, and Speech therapy, as well as mental health and special education services;
- Specialized equipment;
- Targeted case management for complex cases.

In FY2012, approximately 3,000 children, from birth to three years of age, received a referral for screening and evaluation of their needs for early intervention services through Infant Learning Programs in Alaska. Of these referred children, over 1,900 were eligible for early intervention services funded with state general funds and under Part C of the Individuals with Disabilities Education Act.

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

The Early Childhood Comprehensive Systems Initiative

The Early Childhood Comprehensive Systems (ECCS) Initiative is a project that promotes 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. The *Alaska Early Childhood Comprehensive System Plan* was developed by multiple stakeholders across the state. The Early Childhood Comprehensive Systems Plan is providing guidance on how to improve services for young children and their families.

During FY2012, Early Childhood Comprehensive Systems provided staff support to the Alaska Early Childhood Coordinating Council (AECCC), a public/private partnership made up of 23 members. The purpose of the Alaska Early Childhood Coordinating Council is: to facilitate the integration and alignment of services, planning efforts, resources, policy development and funding; and establish connections between health, mental health, education, family support systems, and public and private partners. The Alaska Early Childhood Coordinating Council work in FY2012 focused on the development of a *Strategic Report to the Governor.*

Additionally, Early Childhood Comprehensive Systems completed the *Indicators and Monitoring Report,* which tracks approximately 60 indicators on the status of Alaska's young children, and has continued management of the grant providing *Early Childhood Mental Health Consultation* and the *Early Childhood Mental Health Learning Network.*

Early Childhood Comprehensive Systems co-facilitated the Office of Children's Services Health Oversight Committee, the Early Childhood Protective Services Collaborative, and facilitated the EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) Developmental Screening Committee, and the Strengthening Families Leadership Team.

Strengthening Families Program

In FY2012, nine new early care and learning programs, two Early Childhood Community Partnerships, and two Child Care Resource and Referral agencies were recruited to embed the Strengthening Families protective factors in their programs. Support was given to Best Beginnings to develop a marketing campaign around the Strengthening Families Protective Factors. The Child Welfare Academy provided two days of Strengthening Families training to Office of Children's Services staff and community partners in eleven hub communities. Additionally, a *Community Café Toolkit* was developed in collaboration with the Governor's CHOOSE Respect campaign.

Intervention Services

Child Protective Services

Child Protection Services (CPS) is comprised of three core program services: Intake, Initial Assessment, and Family Services.

Intake

The critical task of assessing child safety begins at Intake. Intake is the process of receiving reports of allegations of child maltreatment, called a Protective Service Report (PSR). To determine whether a response is required by the Office of Children's Services, intake workers collect the necessary information known to the reporter, including the extent of the alleged maltreatment, circumstances surrounding the alleged maltreatment, family and adult functioning, child functioning, parenting practices of the parent or caregiver, and the disciplinary practices of the parent or caregiver.

The Office of Children's Services began the regionalized Intake process three years ago, one region at a time, as capacity and resources were aligned to support the undertaking. Prior to regionalizing, the intake function was delegated down to each individual field office. The decision to become regionalized allowed the standardization and enhancement of this critical function across all regions and field offices. By regionalizing the process, dedicated and uniquely trained workers are equipped to respond to calls in a timely manner and ensure that all reports of child maltreatment are entered into the Online Resource for the Children of Alaska (ORCA- the 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 to corroborate available information, and if the protective services report is 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 or caregiver, the report will be screened in for an initial assessment and assigned to the local field office for a full safety assessment (or Initial Assessment). If the report is not screened in, the reporter will be referred, if appropriate, to community-based services. As per state law, all mandated reporters are notified of the screening decision. During FY2012, the Office of Children's Services received and documented 16,254 Protective Service Reports. This number represents a .5% increase from FY2011. Of these Protective Service Reports, 6,156 were screened in and referred for initial assessment.

Initial Assessment of Safety

Formerly called an investigation, the initial assessment of child safety stemming from a report of alleged maltreatment encompasses the decision-making process once a Protective Service Report is screened in for the Office of Children's Services intervention. Using a standardized protocol for information gathering and specialized safety tools, initial assessment workers assess 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. With rigorous and diligent efforts to know as much about how a family is functioning overall, as opposed to just focusing on a domestic violence event that has occurred, the Office of Children's Services has an increased likelihood of predicting whether another incident of maltreatment may occur sooner, rather than later. This kind of assessment, if applied with fidelity, is the key to reducing the number of children with no assistance, to find assistance. If it is determined that a child is unsafe or at high risk, the Office of Children's Services will open a case for family services, and work with the family to implement the least intrusive approach to keep that child safe. The first consideration of use is an in-home safety plan only if the children can be safely maintained in

their own homes with support. If children cannot be safely maintained in-home, then an out of home placement is used. During FY2012, statewide initial assessment staff completed 6,554 assessments. This is an increase of 15% from FY2011.

Family Services

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

Family services workers are responsible for ensuring the care and well-being of children when state intervention has occurred. In addition to monitoring and addressing the educational, physical, and mental health needs of the child, family services workers must make every effort to maintain a child's family and cultural connections. In collaboration with the family, tribe, and Guardian ad Litem, workers develop and implement family contact (visitation) plans.

Regular face to face case worker visits are central to the Office of Children's Services' ability to provide ongoing assessments of safety, and to stay current on the family's needs to achieve case plan goals. Family services workers are required to visit every child, birth parent, and alternative caregiver (resource parent or relative care provider) at least once every month, and more frequently as family needs indicate.

In FY2012, the Office of Children's Services reunited 449 children with their biological parents, facilitated adoption for 316 children, and arranged guardianship for 24 children. An additional 48 youth reached adulthood, and were released from care.

Child Advocacy Centers

Child Advocacy Centers (CAC) provide child victims of alleged sexual abuse and/or 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 aims to not re-traumatize the child nor 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 for determining what services the child victim and non-offending caretakers need for immediate support, 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 that 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.

There are a total of ten operating Child Advocacy Centers statewide, in both rural and urban centers. The fully operating centers include: Nome, Bethel, Dillingham, Fairbanks, the Mat-Su Valley, Copper River Basin, Anchorage, Kenai, Juneau, and Kodiak. In FY2013, The communities of Barrow and Kotzebue are expanding their efforts to establish local child protection teams, and are moving towards establishing a Child Advocacy Center in their community. Currently, children and families are referred to the Fairbanks, Nome or Anchorage Child Advocacy Centers for services. Support is being provided by the Alaska Children's Alliance (ACA), other established Child Advocacy Centers, and the Office of Children's Services in the Northern Region.

Family Preservation

Family Preservation services are provided through grant programs with agencies in communities throughout the state. These programs provide a broad array of services to families and children, from primary and secondary prevention services, to families not yet involved with the Office of Children's Services, to families involved with the Office of Children's Services needing support to prevent removal or return home. Funded grant programs include:

1. Family Support Services;
2. Family Preservation Services;
3. Intensive Family Preservation Services for Children at Risk or Experiencing Severe Emotional Disturbance;
4. Time-Limited Family Reunification Services.

The primary focus of services occurs 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 the federal Social Services Block Grant, Title IV-B Child Welfare Services, Community-Based Child Abuse Prevention Program grants, and state general funds.

1) Family Support Services

Family Support Services are provided statewide and are designed to support young parents, first-time parents, and families with young children from birth to 12 years of age. The focus is on primary and secondary prevention and concrete support for families. 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 referred for these services do not have an Office of Children's Services case. Referrals can be made by schools, early education programs, medical services, social services programs, or clients may self-refer.

Currently, there are eight family support grantees located in Palmer, Juneau, Prince of Wales, Anchorage, Fairbanks, Kenai, Nome, and Bethel. Grantees saw an increase of self-referrals in FY2012 and expect a continued increase in self-referrals for FY2013 as more families struggle to meet their basic needs due to economic challenges, as well as the continued rise in substance abuse, domestic violence, and suicide.

2) Family Preservation Services

Family preservation services helps to prevent the out-of-home placement of children who are at high risk or unsafe. The Office of Children's Services and grantee staff partner as a team to provide services to referred families. Services include:

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

Referrals will come exclusively from the Office of Children's Services. Referred families will have an open family services case and a safety plan in place to ensure continued efforts to ensure safety for the children. Each member of the family is considered when coordinating services.

Currently, there are ten family preservation grantees located in Palmer, Juneau, Ketchikan, Anchorage, Fairbanks, Kenai, Nome, and Bethel. In FY2012, grantees saw a decrease in referrals from the Office of Children's Services, which had an impact on their ability to meet the performance outcomes associated with the program. The Office of Children's Services program staff will continue to educate staff about family preservation services, and encourage increased utilization of the grant programs.

3) Intensive Family Preservation Services for Children at Risk of, or Experiencing, Severe Emotional Disturbance

Intensive family preservation services provide crisis intervention and support services to families with young children at risk of, or experiencing, a severe emotional disturbance. Families are referred for services when risk factors have been identified that could lead to the transition of

children to out-of-home care, or when aftercare services are needed to ensure safety and stability of children returning home. Services include:

- Ongoing family assessments;
- Service Coordination (Preventative and/or Aftercare Services);
- Developing family support teams;
- Parent education and support;
- Transportation services.

Family preservation services provide increased parental capacity and build strong parent-child bonds, promoting a safe environment for the child. Family group conferencing is used to guide the development of family support teams. Services are voluntary, and referrals can come from the Office of Children's Services, the Division of Juvenile Justice, the community, or families may self-refer.

There is one intensive family preservation services grant program located in Juneau. The program was launched in the second quarter of FY2011 and focuses on staff development and outreach. In FY2012, the program increased outreach to providers in the community and tripled the number of families served in the first year.

4) Time-Limited Family Reunification/Family Contact Services Center

Time-limited family reunification/family contact services center is provided to families when a child enters the foster care system. They are designed to expedite the reunification process of children with their parents through parenting education and support during family contact. Services include:

- Supervised family contact,
- Transportation services.

Referrals are made by the Office of Children's Services, who provides an initial plan outlining the level of supervision, and goals in working toward reunification. The family contact services center is more geared toward providing moderate to high levels of supervision for families needing a more structured environment during family contact.

Currently, only one family contact services center is being funded in Anchorage. There are seven time-limited family reunification grant programs located in Palmer, Juneau, Anchorage, Fairbanks, Kenai, Nome, and Ketchikan. These programs are the most utilized of the grant programs within the family preservation component. In FY2014, funding will be increased in this service category to respond to the demand.

Intensive Rural Case Management Services Program (formerly Rural Social Services Program)

The intensive rural case management services program (formerly, the rural social services program), funded through state grants, is designed to provide services to 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. These services include, but are not limited to, service coordination, transportation, safety plan development and monitoring, family meetings, home visits to monitor safety, individualized parenting education, relative searches, foster parent recruitment, foster parent support, and family contract coordination and supervision that seek to increase the frequency and quality of visits between parents and children.

Federal and state mandates require that the Office of Children's Services make efforts to maintain cultural and family continuity while serving children and families involved in the child welfare system. Additionally, the Indian Child Welfare Act (ICWA) requires additional mandates for Alaskan Native children. Alaska has a disproportionate number of Alaskan Native children in the foster care system. While many children reside in urban hubs of Alaska, a significant percentage reside in their rural communities of origin. These cases require more intensive oversight and case management support that is more complex and more challenging by design. In many of these areas, the Office of Children's Services must serve clients remotely and/or does not have a stable workforce to provide the close monitoring and support necessary to adequately meet the legal mandates needed to serve Alaskan Native families.

Because of the disproportionate number of Alaska Native/American Indian children involved in the Office of Children's Services system, there is a critical need for the Office of Children's Services to purchase culturally relevant services that are able to meet the needs of families in remote and difficult/expensive to serve areas. This program funds service providers with a demonstrated understanding of the Indian Child Welfare Act, and an existing infrastructure in remote/local settings to provide culturally relevant intensive case management services.

Independent Living Services

Independent living services provides opportunities for youth to learn valuable skills necessary to make a successful transition from state and Tribal custody, to self-sufficiency. Currently, the independent living program provides services to foster youth 16 to 21, former foster youth (ages 18-21), and to youth who left foster care for kinship guardianship or adoption on or after their 16th birthday. Independent living services are available to the approximately 511 foster youth ages 16 and older, both in and out of the Office of Children's Services 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, mentorships, health education and risk prevention training, life skills assessments, transition planning, 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. Twenty-five youth from throughout Alaska attended the October 2012 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. Education Training Vouchers offer financial assistance to attend colleges, universities, and vocational or technical programs. Tuition waivers, and up to $5,000 in Education Training Voucher funds, are available to eligible students. Education Training Voucher awards are unique to each student and are based on the cost-of-attendance formula established by their college of choice, and by any unmet need they may have in their financial aid award.

Tribal Title IV-E

The Office of Children's Services administers the Tribal Title IV-E reimbursement program through agreements with Alaskan tribes and tribal organizations. This program was developed to:

- Facilitate cooperation between the Office of Children's Services and Tribes/Tribal Entities;
- Increase opportunities for Tribes/Tribal entities to provide services to Tribal citizens;
- Increase and support Tribal child welfare infrastructures;
- Provide for the best interests of Alaska Native children;
- Meet the policy goals of the Indian Child Welfare Act of 1978;
- Assure compliance with the Adoption and Safe Families Act and the Fostering Connections Act;
- Provide Tribes/Tribal entities access to federal funding under the Title IV-E administration and training regulations.

The Tribal Title IV-E reimbursement 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 the Office of Children's Services to provide the federal government with the required, substantial documentation for Title IV-E claiming.

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

Foster Care

Foster care enables the State to find temporary homes for children who have been maltreated and cannot remain in their homes. Placement into foster care is based on a placement preference priority, in which safe and appropriate relative care providers are the first choice for a child's placement. 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 or tribal member is not identified for the child, then placement consideration is given to non-relative foster care placements.

All non-relative foster homes must be licensed by the State of Alaska. Relative caregivers have the option to care for a child as an unlicensed relative care provider, or become licensed through the State of Alaska. Currently there are 1,233 licensed foster care providers in Alaska. Currently,

594 children are placed with relatives (both licensed and unlicensed), 3 children are placed with licensed providers identified as fictive kin, and 1,000 children reside in licensed non-relative foster care.

In November 2010, the Resource Family Advisory Board was organized. This group continues to develop themselves and make strides in their work to become a cohesive advocacy group for the resource families in Alaska. The Resource Family Advisory Board has identified communication with other resource families as a top goal for the coming year. They hope to gather information from families across Alaska to identify key areas for improvement.

Foster Care Rate

The Foster Care Base Rate program provides a stipend to foster care providers for the ongoing basic costs of providing care to a child, and is provided for the days a child is placed in the home.

The Augmented Foster Care Rate program may provide an additional support to cover the extraordinary costs and higher level of supervision for children with special needs related to a physical or cognitive disability, not otherwise covered by the 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 provides funds for: childcare for working foster parents, respite care for parents of children at risk, clothing and food in emergency travel situations' related to the safety and well being of the child, 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. 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 family that should not be severed.

Many times, children who have been removed from their homes as a result of maltreatment, and who cannot be returned to their homes safely, have long-lasting disabilities, disturbances, or other special needs that make it difficult to find permanent adoptive or legal guardianship homes without a subsidy. At the end of FY2007, there were 2,241 children living in permanent adoptive or guardianship homes, assisted through the Subsidized Adoption and Guardianship program. At the end of FY2012, there were 2,845 children living in permanent adoptive or guardianship homes assisted through the Subsidized Adoption and Guardianship program.

Early Intervention/Infant Learning Program

In FY2012, an infant learning program family outcomes survey was conducted and the results provide important outcome information about family experiences.

- 85% of families respond that they are sure they know how to help their children develop and learn most or all of the time.
- 91% of families reported that they were involved in developing their child's education plan most or all of the time.
- 82% of families responded that Early Intervention had done an excellent job helping them help their children develop and learn all or most of the time.
- 42% of families indicated that they did not have access to quality child care for their child with special needs.

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 exited the program.

Summary Statement 1	**FY2010**	**FY2011**	**FY2012**
Child Outcome Area	***Percent Substantially Increase Rate of Growth***	***Percent Substantially Increase Rate of Growth***	***Percent Substantially Increase Rate of Growth***
Emotional: Positive social relationships	**66%** (154 of 234)	**69%** (205 of 296)	**64%** (209 of 326)
Knowledge: Acquisition of knowledge and skills	**71%** (191 of 271)	**70%** (240 of 342)	**71%** (269 of 380)
Action: Taking appropriate actions to get needs met	**72%** (185 of 258)	**73%** (248 of 338)	**73%** (269 of 368)

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

Summary Statement 2	**FY2010**	**FY2011**	**FY2012**
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)	**55%** (213 of 391)	**50%** (218 of 434)
Knowledge: Acquisition of knowledge and skills	**57%** (139 of 244)	**45%** (177 of 391)	**46%** (201 of 438)
Action: Taking appropriate actions to get needs met	**55%** (134 of 244)	**48%** (187 of 391)	**50%** (217 of 433)

Early Childhood Comprehensive Systems

While the Early Childhood Comprehensive Systems 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: 45 individual child and 12 environmental consultations impacting 912 children, "intensive" consultation to two programs impacting 62 children, and *"What's Beneath the Behavior?"* training to 209 early childhood professionals. The Early Childhood Mental Health Learning Network provided early childhood mental health training to 732 educators, physical therapists, occupational therapists, speech and language pathologists, psychologists, clinical social workers, etc… impacting approximately 2,562 children.

Approximately 175 participants attended the Early Childhood Mental Health Institute.

97%	I have gained a better understanding of how my child care program can support my family and skills as a parent.
95%	I feel comfortable going to staff when I need to seek resources in the community.
95%	I feel comfortable going to staff when I am worried about my child's development and/or behavior.
94%	I now have more ways to respond to my child's skills, needs and behaviors.
83%	I now know more parents I can connect with.
96%	I feel confident in knowing how to connect to community resources when I need them.
95%	I understand the importance of my child knowing they are loved, feel they belong, and being able to get along with others.

Strengthening Families Program

Parents in the Strengthening Families early childhood programs reported improved protective factors as follows:

The Child Welfare Academy provided training in 11 hub communities for 104 Office of Children's Services staff and 114 community partners in the Strengthening Families Protective Factors Framework, Child Abuse Prevention and Treatment Act (CAPTA) requirements, and best practices for young children in child protective services. The results of the training:

- Office of Children's Services staff reporting their knowledge of the protective factors as High/Very High, increased from 45% to 85%.
- Office of Children's Services staff reporting their knowledge of Strengthening Families as High/Very High, increased from 38% to 84%.
- Office of Children's Services staff reporting their understanding of their role in supporting families using the Strengthening Families and Protective Factors concepts as High/Very High, increased from 47% to 83%.

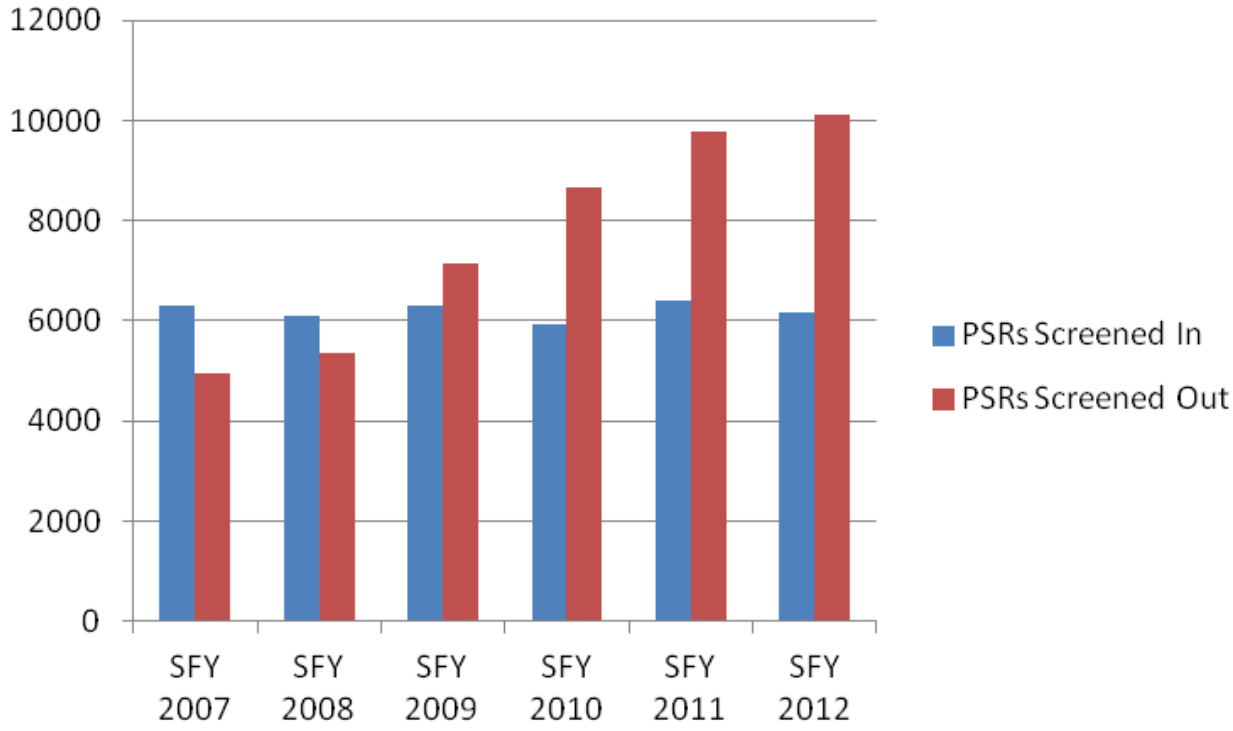
Protective Services Reports

Intake Reports

All front line workers deliver services that carry out Alaska's legal mandates to address and remedy the abuse, neglect, and exploitation of children, as reported to the Office of Children's Services. This significant responsibility starts at Intake with the receipt and assignment of Protective Services Reports.

The chart below indicates the total reports received for FY2007 – FY2012. Intake is required to either screen the Protective Services Reports in for initial assessment, or to screen out the Protective Services Reports. The increase of screen outs starting in FY2009 reflects an agency decision to make clearly documented Protective Services Reports.

Protective Services Report Screenings by Decisions and Fiscal Year

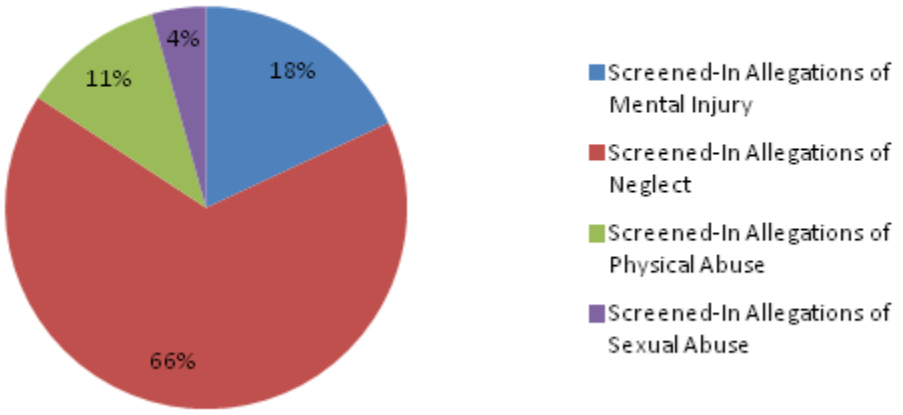


There are four categories of abuse that are screened for at the Intake level: neglect, physical abuse, mental injury, and sexual abuse.

The chart below shows the screening results for abuse types in FY2012.

Protective Services Reports Screened In by Type and Percent

SFY 2012



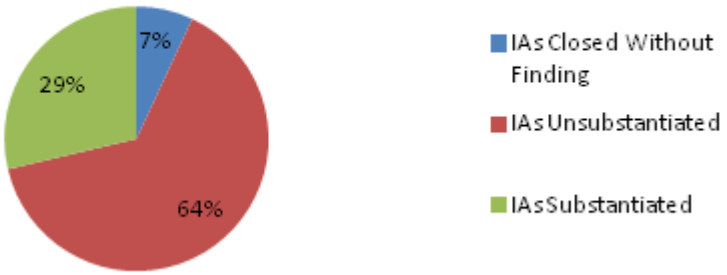
Initial Assessment Reports

The initial assessment worker continues the work forward after a Protective Service Report is received and screened in. The worker is mandated to respond and assess for safety, determine if the child was maltreated, and determine if the child is unsafe or at high risk, and warrants on-going services.

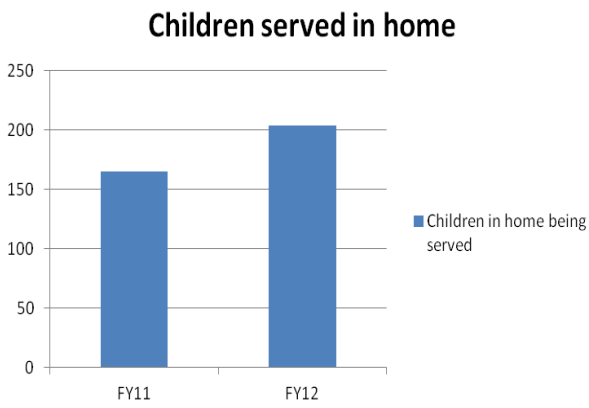
The chart below presents the findings of initial assessments for FY2012. Findings are either substantiated or not substantiated. The findings are substantiated when a child is believed to have been maltreated. A finding is not unsubstantiated occurs when a child is not believed to have been maltreated or when a determination of maltreatment could not be made. There are some cases where the initial assessments were closed without a finding due to the Office of Children's Services being unable to locate a family or the family has relocated to another state.

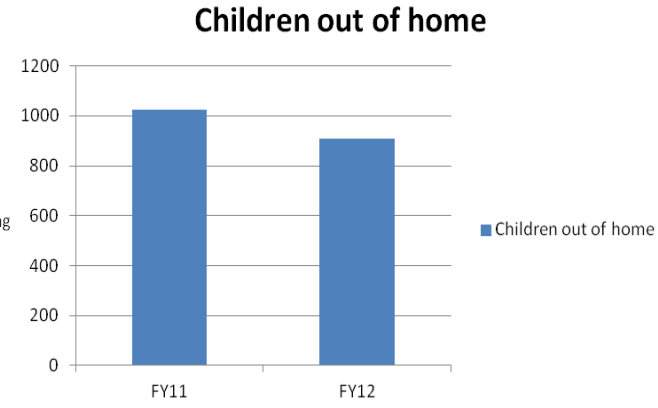
Initial Assessment Findings by Type and Percent

SFY12



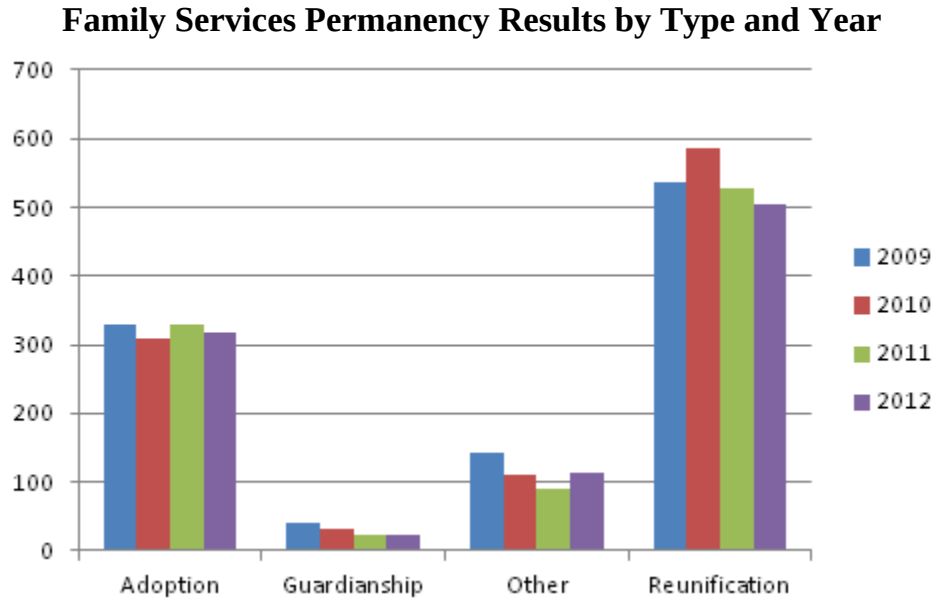
Initial assesment makes the determination if the family needs intervention to keep children safe. Intervention can include a family that is being served with the children safely in their own home, to families where removal of children is necessary for safety reasons. The Office of Children's Services has made a concerted effort during FY2012 to serve more children in their own home. The charts below indicate that in FY2012, the Office of Children's Services reduced the number of children in out-of-home placement by increasing services to children in their own homes.





Family Services

Family Services is charged with assisting families with achieving reunification; when reunification is not possible, the worker must work towards achieving other permanent options such as adoption or guardianship. The chart below shows how children exit the Office of Children's Services care.



List of Primary Programs and Statutory Responsibilities

Statutes

AS 25.23.005-240	Adoption
AS 37.14.200-270	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 47.10.005-990	Children in Need of Aid
AS 47.14.100	Powers and Duties of Department over Care of Child
AS 47.14.980	Grants-in-aid
AS 47.17.010-290	Child Protection
AS 47.20.070-075	Services for Developmentally Delayed or Disabled Children
AS 47.32.010-900	Centralized Licensing Related to Administrative Procedures
AS 47.70.010-080	Interstate Compact on the Placement of Children

Regulations

7 AAC 23 Article 1	Infant Learning Program
7 AAC 50	Community Care Licensing
7 AAC 53	Social Services
	Article 1 Child Care Foster Care Payments
	Article 2 Subsidized Adoption and Subsidized Guardianship Payments
	Article 3 Children in Custody or Under Supervision: Needs and
	Article 4 Resumption of State Custody
7 AAC 54	Administration
	Article 1 Privacy of Client Records: Child Protection Services
	Article 2 Grievance Procedure
	Article 4 Review and Evidentiary Hearing Regarding Foster Care, Adoption Subsidy, or Guardianship Subsidy Payment
7 AAC 56	Child Placement Agencies
7 AAC 78	Grant Programs
7 AAC 80.010-925	Fees for Department Services

Federal Statutes

20 U.S.C. 1431-1444	Infants and Toddlers with Disabilities
25 U.S.C. 1901-1923	Indian Child Welfare Act
42 U.S.C. 5106	Child Abuse Prevention and Treatment Act (CAPTA)
42 U.S.C. 5107	Children's Justice Act
42 U.S.C. 620-629	Social Security Act, Title IV-B
42 U.S.C. 670-679	Social Security Act, Title IV-E

Office of Children's Services

Budget Overview Table

Office of Children's Services	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$83,560.8	$87,431.9	$3,871.1
Designated General Funds	2,100.0	3,000.0	900.0
Federal Funds	46,278.9	46,593.4	314.5
Other Funds	3,696.1	3,883.1	187.0
Total	**$135,635.8**	**$140,908.4**	**$5,272.6**

Budget Requests

Front Line Social Workers

Social Worker Class Study Implementation: $1,500.0 Total -- $1,185.0 GF, $315.0 Fed

At the request of the Alaska State Employees Association (ASEA) union, the Department of Administration, Division of Personnel and Labor Relations conducted a job classification study of the social worker and children's services specialist job classes. The study affected 288 caseworkers within the Office of Children's Services. The focus of the study was to identify and correct inequity in like-pay for like-work, which is the basis of the state's classification system.

The case workers were in a dual job class structure including: children's services specialist and social workers. Because of the requirement to have and maintain a social workers license, the social workers were paid at higher ranges than the children's services specialists. As the study progressed, the children's services Manager and staff manager job class series were added to the study to ensure the entire scope of work was identified, and appropriately classified.

The study determined that licensure was not a requirement to perform case work, and a single protective services specialist job class series was developed. Ranges were assigned to the new series based on classification principles.

Effective July 1, 2012, the new job class series was implemented. Each position was individually allocated, which resulted in a substantial number of positions being assigned a one or two range increase. Costs were projected based upon these range increases in FY2013 Management Plan. The Office of Children's Services will be requesting a supplemental in FY2013 to pay for this increase. Actual annual projected increase is $1,490.6.

Family Preservation

Child Advocacy Centers (DVSA): $400.0 Total -- $400.0 GF

The Office of Children's Services base budget for support of the ten existing child advocacy centers is $2,538.4. Support levels have not changed since program inception. Grantees are struggling to provide the needed level of service as referrals to child advocacy centers are growing up to 70% in some communities. This makes it difficult for the child advocacy centers to adequately respond to the complex and growing needs of those served.

Increased authority would support the existing level of service at ten centers, allow them to expand to meet the increasing demands for services in the communities served, and ensure the needed resources are available locally for families served.

Strengthening Families through Early Care and Education (DVSA): $250.0 Total -- $250.0 GF

Strengthening families is a proven, cost-effective, research-based strategy to prevent child abuse and neglect, reduce adverse childhood experiences, strengthen families, and support optimal child development.

The FY2014 funding will support the following activities for strengthening families:

- Recruit and support ten new programs to embed the strengthening families protective factors framework in their work.
- Provide community-wide training and stakeholder meetings in four to eight communities to enhance collaboration focused on reducing adverse childhood experiences and implementing Strengthening Families Alaska.
- Provide a "Learning Network" for strengthening families programs across the state.
- Facilitate a systematic and coordinated approach to implementing Strengthening Families Alaska by working with key partners such as: the CHOOSE RESPECT campaign, the Alaska Children's Trust, The Alaska Mental Health Trust, The Alaska Mental Health Board, the University of Alaska, key programs in the Department of Health & Social Services and the Department of Education and Early Development, United Way of Anchorage, parents, and community members.
- Support continued data collection, monitoring and reporting.

Foster Care Base Rate

Additional Social Security Income and Child Support Receipts for Children in State Custody: $900.0 Total -- $900.0 GF/Prog

This is social security income and child support receipts for children in the Office of Children's Services protective custody. The Division will apply for and collect these Social Security Income receipts for eligible children in custody and use this revenue to offset cost-of-care. Child support receipts come to the Office of Children's Services via Child Support Services Division for children in State custody. This income supplants Title IV-E and state general funds. Currently, collections exceed available authority. The component's general fund program receipt authority is currently $2,100.0. In FY2012, collections totaled $2,759.7 and in FY2011,

$2,658.4. Without this increment, the Division is unable to fully utilize social security income and child support collections to offset the cost of care for children in protective custody.

Foster Care Special Need

Foster Care Special Needs Interagency Receipt Authority for Child Care Reimbursable Service Agreements: $300.0 Total -- $300.0 I/A

Additional interagency receipt authority is needed to increase a child care reimbursable services agreement with the Division of Public Assistance. The reimbursable services agreement is intended to cover child care costs for foster parents and unlicensed relatives caregivers who are working or actively seeking work, and may otherwise be ineligible for child care assistance.

This request would provide the Office of Children's Services with enough authority to accommodate the increasing cost of the reimbursable services agreement.

Infant Learning Program Grants

Child Abuse Prevention and Treatment Act (CAPTA): $1,500.0 Total -- $1,500.0 GF/MH

The Child Abuse Prevention and Treatment Act is federal legislation that requires that all children under the age of three with substantiated reports of harm be referred to the infant learning program (part C of the Individuals with Disabilities Act) for evaluation and therapeutic and/or educational services.

This request will cover the cost of 312 evaluations of children between ages birth to three, where an incident of substantiated maltreatment has occurred. The funding will also cover the cost of therapeutic and educational services for 250 children who meet our eligibility criteria, (120 currently being served plus an anticipated additional 130 in FY2014), identified through multi-disciplinary evaluations,.

Cost Breakdown per Child
312 evaluations @ $600 per =$187,200
250 children receiving services (120 currently served + 130 additional Part C eligible children) @ Cost per child of $5,500 = $1,375,000

Challenges

Federal Title IV-E Audit

Recently, the Office of Children's Services underwent a primary federal Title IV-E foster care eligibility review, which occurs every three years. This ensures children for whom Title IV-E foster care maintenance payments are being made meet federal eligibility requirements. The last review occurred in FY2009. The on-site review intensively reviewed 80 cases from around the state and allowed for a margin of error in which Office of Children's Services could fail no more than four cases in total. Unfortunately, the Office of Children's Services failed seven cases. While Office of Children's Services has challenged some of these findings, it is almost certain that the Office of Children's Services will, in fact, have to create and implement a program improvement plan in partnership with our federal Administration for Children & Families Region X partners. The Office of Children's Services will have one year to successfully complete all elements of the plan as evidenced by ongoing data collection and monitoring. An exception to the one year completion will be made if the plan requires state legislation.

Following a review in which a state has been found to not be in substantial compliance, the next review will be considered a secondary review, involving a significantly larger number of cases to be reviewed. These reviews ultimately enhance the agency's ability to improve practice, court documentation, and ensure that our Title IV-E claiming is precise. The reviews may also lead to increased reimbursements to Alaska to support our foster care program. The performance improvement plan would also create additional pressure on limited and stretched existing staff resources. However, failure is not an option and the Office of Children's Services expects to rise to the occasion and succeed with flying colors. To not do so could place Alaska at risk of financial penalties.

Implementation and Compliance of Unfunded Federal Mandates and Lawsuits

In FY2014, the Office of Children's Services will be facing challenges and opportunities for growth with the settlement of several lawsuits, as well as through the directives provided by the federal Children's Bureau.

By and large, all of these new and upcoming changes are positive and are what families deserve. However, due to the ever increasing workload of the Office of Children's Services staff at all levels, the ability to ensure effective and timely services may suffer.

Ensuring due process and timely notification of legal proceedings, (including decisions regarding placement changes for children in foster care) is essential to all legal parties in child custody cases, and is important to the agency. Similarly, ensuring that foster or resource families are kept abreast of any changes in their monthly foster care payment rate and are receiving financial support commensurate to the cost of caring for a child in Alaska is also crucial. Without them, the Office of Children's Services would not be able to safely provide care to children. Compliance, with these complex due process and legal obligations, requires extensive time and resources at all levels within the agency. These efforts continue to divert time away from the many other endeavors needing staff attention.

Additionally, it is well documented across the country that children in foster care, including Alaska are, at times over medicated by toxic and unneeded psychotropic medications. The Office of Children's Services applauds the efforts at the federal level for improving and enhancing the oversight and monitoring of psychotropic medications prescribed to children in foster care. The agency looks forward to making improvements on behalf of Alaska's children. However, it is just another example of a complex problem that will come with multi-tiered solutions and strategies, and whereby implementation will involve folks at every level of the Office of Children's Services, as well as within other divisions of the Department.

These are but a few examples to illustrate the challenges the Office of Children's Services has, related to improving the system in Alaska. The Office of Children's Services staff spends the majority of their time on required or mandated activities, leaving little room for innovative ideas and new strategies that could help resolve many of our areas needing improvement.

Frontline Staff Recruitment and Retention

Child protective services is the toughest, most complex, and emotionally-demanding vocation within the social services arena. The job demands workers serve as: pseudo police officers, therapists, coaches, parent skill trainers, legal aides, substance abuse experts, domestic violence advocates, job counselors, play therapists, and be absolutely skilled in computer technology and interpersonal communications with *all people at all times*. Office of Children's Services sends Child Protective Services workers to areas or homes where law enforcement does not travel, without weapons in hand, or back-up close by. The Office of Children's Services provides no housing for these workers, unlike the local teachers, Tribal workers, or law enforcement, (which Child Protective Services workers encounter and work with every day), who are provided with this amenity. Across the nation, fatigue and vicarious trauma lead to high turnover rates and high vacancy rates among front-line caseworkers. Rather than being among the most highly lauded and recognized professional groups, the reality is that Child Protective Services staff work in an agency that is either vilified for removing a child, or characterized as inept or "broken."

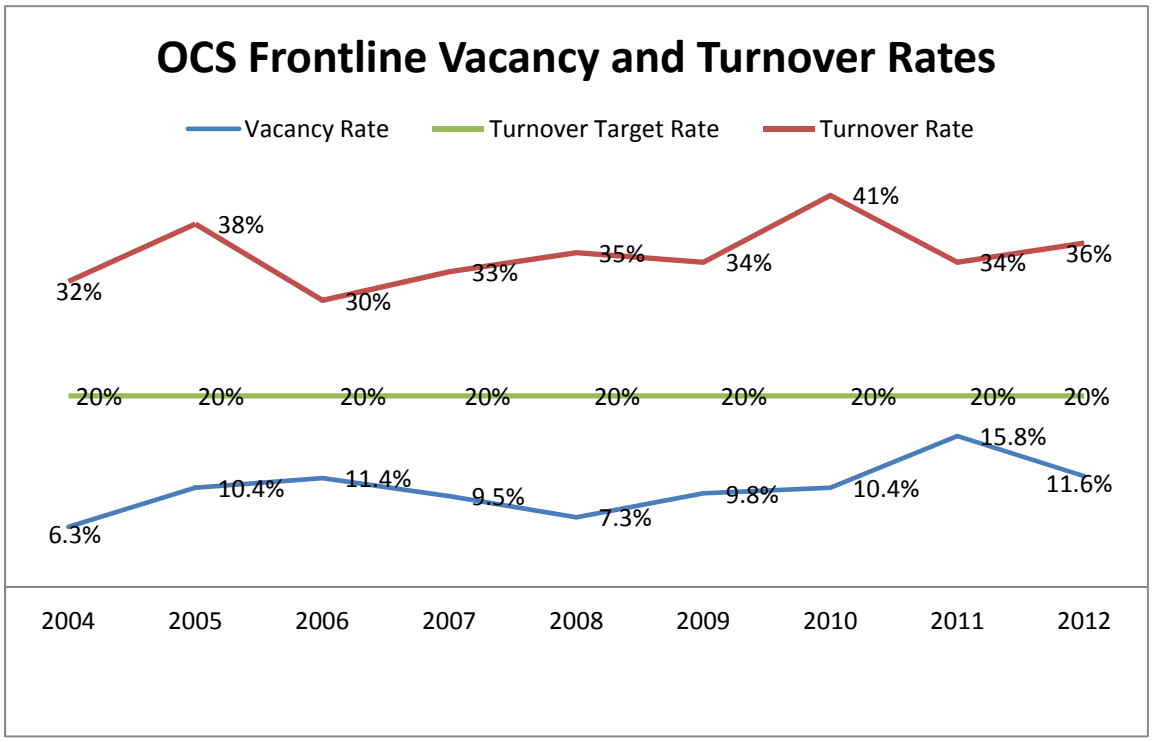
The Office of Children's Services has been diligently and relentlessly employing strategies big and small to try and positively impact worker retention. In order to retain workers, the Office of Children's Services has invested time and money into training as the most critical part of the equation. The Office of Children's Services goes to great lengths to help strengthen and support staff that are struggling either because of the nature of the job, or because in some cases they are ill-equipped to manage the duties expected. This issue only becomes more intense when staff is working in rural locations all over the state in one-person offices, and are lacking the benefit of an on-site supervisor. In some cases these workers have recently moved from outside of Alaska and are dealing with significant culture shock.

The inability to retain staff can be directly measured by the outcomes the Office of Children's Services experiences in federally measured items of safety, permanency, and well-being. Federal data indicates that without a trained and stable caseworker, a family's ability to be successful in achieving reunification drastically declines. While working with the agency, it is not uncommon for families to experience five to eight new workers within a two-year period. While not all turnover is bad, (some is attributable to promotions or lateral moves to other

communities), the bulk of it is a direct result of their inability to continue doing a job that they feel is "undoable". People come to the Office of Children's Services to "help people" and keep children safe; when they feel they can do neither, they leave.

Recruitment of qualified, new, and mission-driven staff is equally challenging, but for different reasons. Alaska has benefitted from the lay-off and downsizing that other child welfare agencies nationwide have experienced. More and more of the new Office of Children's Services employees are coming from outside Alaska, primarily drawn to remote office locations that not only offer the true Alaska adventure, but also the high cost of living salary that - on paper - seems like a dream. While the Office of Children's Services has benefitted from many wonderful, bright, committed, and eager transplants that do ultimately make their home long-term in Alaska, we also see many leave as quickly as they came.

Despite specific efforts to combat high vacancy rates and turnover rates at the Office of Children's Services, both remain high. Through the Supervisory Council, and recently the staff advisory board, the Office of Children's Services is seeking to get as much insight and recommendations as possible from those that live and breathe the experience every day. Both groups are growing and developing their voice and focus. However, the solution to slowing the revolving door is a multi-faceted one that can't be solved with one or two strategies alone.



The Office of Children's Services continues to work internally to focus on retention and recruitment through our recruitment and retention workgroup, and recently began a partnership with the Alaska Mental Health Trust Authority and their contractor, Agnew Beck. Through the Alaska Mental Health Trust Authority's own independent research of what is cutting-edge in the area of value-based recruitment and innovative retention strategies demonstrated to work from other states, we are optimistic about the opportunities that will result.

The agency's internal work group has maintained (along with support from the Department's Public Information Team) a web site 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 most recent video can be viewed at the *Vimeo* link below. The link to job openings and other videos is listed below as well.

http://vimeo.com/44692712

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

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities, and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN

CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.

OUTCOME 1. Alaskans are healthy

EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who receive preventative health screenings.
EFFICIENCY MEASURE	Percent increase of screenings completed within mandatory 30 days from date of entry.

CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.

OUTCOME 1. Alaskan children receiving department services live in a supportive setting.

EFFECTIVENESS MEASURE	**Percent of children receiving department services who are safe and supported.***
EFFICIENCY MEASURE	**Cost of services per child.***
	***AGGREGATE DIVISION MEASURES - (Percent of children receiving department services who are safe and supported).**
EFFECTIVENESS MEASURE	Percent of children who experience 2 or less placements per placement episode.
EFFICIENCY MEASURE	Percent decrease of placements per child, by region.
EFFECTIVENESS MEASURE	Rate of positive child well-being outcomes.
EFFICIENCY MEASURE	Percent increase in monthly caseworker visits.

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**
EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
EFFICIENCY MEASURE	Average cost per recipient.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 1. Alaskan children at risk of maltreatment are protected from abuse and neglect.

EFFECTIVENESS MEASURE	**Percent of Alaskan children with substantiated reports of abuse or neglect.**
EFFICIENCY MEASURE	**Average time to initiate an investigation.**
EFFICIENCY MEASURE	**Percent of safety assessments concluded within required timeframes.**
EFFECTIVENESS MEASURE	**Number of children in foster care who achieve or maintain permanency within required timeframes.**
EFFICIENCY MEASURE	**Percent of children who re-enter care within six months.**

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

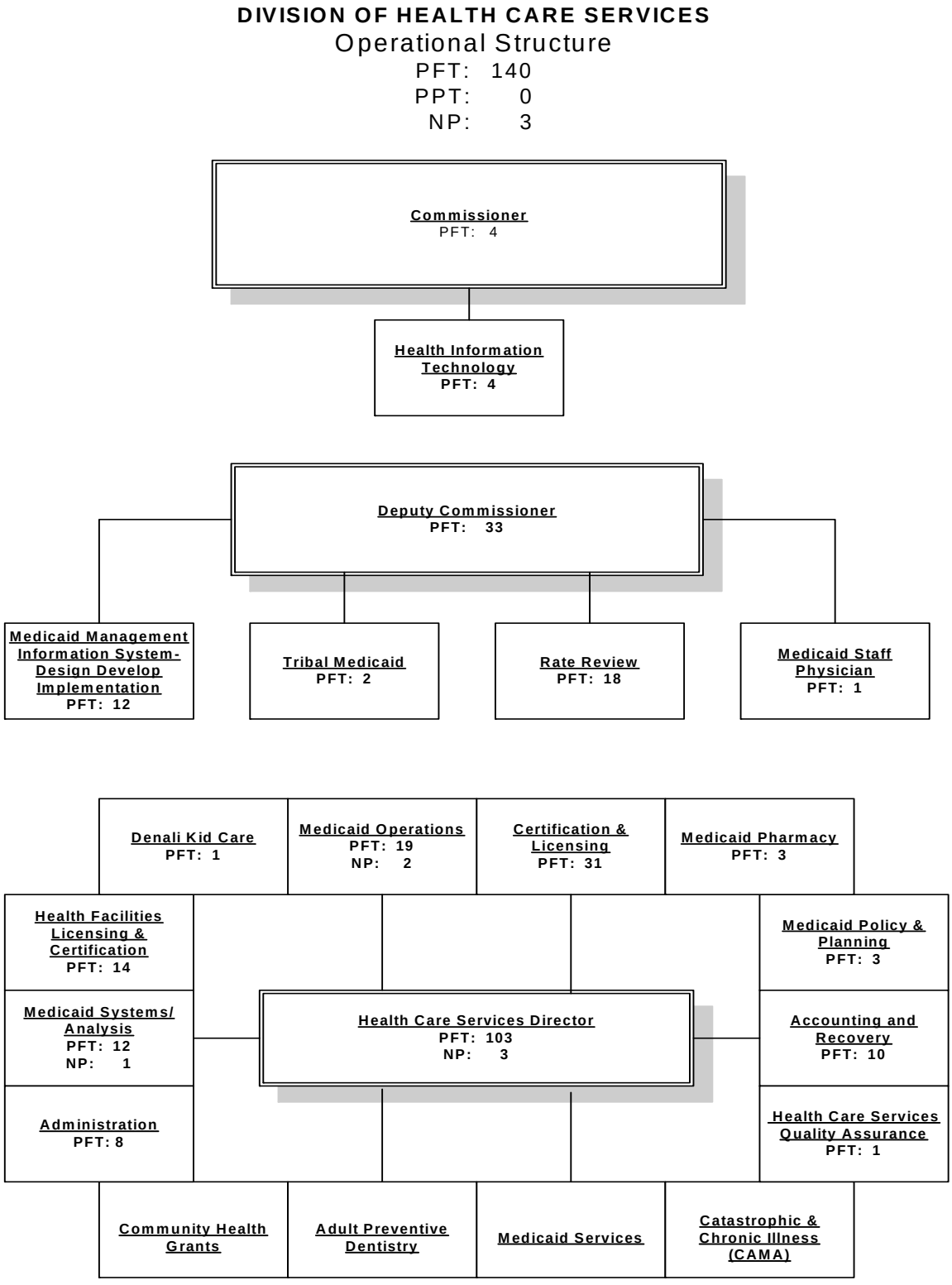
OUTCOME 4. Alaskans choose respect.

EFFECTIVENESS MEASURE	**Rate of Domestic Violence/Interpersonal Violence referrals to community services.***
EFFICIENCY MEASURE	**Number of clients screened for Domestic Violence/Interpersonal Violence.***
	*** DIVISION AGGREGATE - (Rate of Domestic Violence/Interpersonal Violence referrals to community services).**
EFFECTIVENESS MEASURE	Rate of Domestic Violence/Interpersonal Violence referrals to community services.*
EFFICIENCY MEASURE	Number of clients screened for Domestic Violence/Interpersonal Violence.*

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Children's Services General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
FY2014 Salary and Health Insurance Increases (CSM)	$ 1.1	$ -	$ 0.3	$ -	$ 1.4
Social Worker Class Study Implementation (FLSW)	$ 1,185.0	$ -	$ 315.0	$ -	$ 1,500.0
Child Advocacy Centers (FP)	$ 400.0	$ -	$ -	$ -	$ 400.0
Reverse FY2013 MH Trust Recommendation (FP)	$ -	$ -	$ -	$ (138.0)	$ (138.0)
Strengthening Families Through Early Care and Education (FP)	$ 250.0	$ -	$ -	$ -	$ 250.0
Transfer to Behavioral Health Grants for Substance Abuse Treatment and Recovery Services for Parents (FP)	$ (225.0)	$ -	$ -	$ -	$ (225.0)
Social Security Income for Children in State Custody (FCBR)	$ -	$ 900.0	$ -	$ -	$ 900.0
Foster Care Special Needs Interagency Receipt Authority for Child Care Reimbursable Service Agreements (FCSN)	$ -	$ -	$ -	$ 300.0	$ 300.0
ARRA Funding Sec30(b) Ch15 SLA2012 P93 L16-20 (HB284) Lapses 6/30/2013 (ILPG)	$ -	$ -	$ 0.8	$ -	$ 0.8
Child Abuse Prevention and Treatment Act Integration (ILPG)	$ 1,500.0	$ -	$ -	$ -	$ 1,500.0
MH Trust: BTKH - Grant 2550.04 Early Intervention for Young Children (ILPG)	$ 400.0	$ -	$ -	$ 200.0	$ 600.0
MH Trust: Gov Cncl - 1207.06 Early Intervention/Infant Learning Pgm Positive Parenting Training (ILPG)	$ -	$ -	$ -	$ 80.0	$ 80.0
Reverse FY2013 Mental Health Trust Recommendation (ILPG)	$ -	$ -	$ -	$ (255.0)	$ (255.0)
Reverse-ARRA Funding Sec30(b) Ch15 SLA 2012 P93 L16-20 (HB284) Lapses 6/30/2013 (ILPG)	$ -	$ -	$ (0.8)	$ -	$ (0.8)
Transfer from Services for Emotionally Disturbed Youth for Early Childhood Screening (ILPG)	$ 360.0	$ -	$ -	$ -	$ 360.0
Children's Services Total	***$ 3,871.1***	***$ 900.0***	***$ 315.3***	***$ 187.0***	***$ 5,273.4***

Division of Health Care Services



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. However, an individual may '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, often before recent policies have been fully implemented and reflected in the baseline spending data, it is premature to predict whether 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 coverage of 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 providers using 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 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.

In FY2012 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. Additional revisions to the reimbursement methodology are anticipated in FY2013 as a new cost of dispensing survey was completed and is in process of being incorporated into the Medicaid payment regulations. The Pharmacy and Ancillary Services unit has several ongoing initiatives, enumerated below. These initiatives provide excellent pharmaceutical care through the following:

Preferred Drug List:
The Preferred Drug List is a list of medications that contains classes representing Medicaid's first choice when prescribing for Medicaid recipients. This list aligns the patient's needs, the physicians' knowledge, and the state's purchasing power. The Preferred Drug List supports cost efficiency when preferred drugs are prescribed and dispensed.

Drug Utilization Review Committee:
The Drug Utilization Review 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. Drug Utilization Review activities are overseen by a committee of licensed Alaskan health care professionals.

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 other medical providers including physician services, dental services, physical, occupational, and speech therapies, laboratory, radiology, durable medical equipment, vision services, hospice, and home health care. The unit also manages transportation and accommodation services. 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, 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 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

Chronic and Acute Medical Assistance is a state general fund only program that provides health services to low-income individuals with covered medical conditions who do not qualify for the Medicaid program. Select outpatient and prescription services are available to Chronic and Acute Medical Assistance 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 to the whole age range from birth to death of American Indian and Alaska Native recipients at or through tribal health care facilities statewide. This includes oversight and liaison work across divisions within the Department that focuses on tribal Medicaid service delivery. 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. The Tribal Unit provides program management and oversees policy for core Medicaid services at or through Tribal facilities, including those delivered at inpatient and outpatient facilities and by physicians and other paraprofessional groups.

The Tribal Unit works closely with the Operations Unit and focuses on similar tasks specific to tribal providers parallel to the non-tribal providers. These two units work together to assure compliance with federal and state Medicaid regulations and related program policies covered under the Medicaid State Plan. The Tribal Unit ensures positive and productive relationships are maintained with American Indian and Alaska Native recipients and tribal health organizations. It works directly with various tribal workgroups, professional health organizations and solicits input into policy and program development through tribal consultation. The Tribal Unit is responsible for contract management of the Enhanced Provider Services and training specific to tribal providers at the Medicaid fiscal agent, and is responsible for oversight and monitoring of the training and claims submission, tribal provider enrollment, education, and outreach efforts.

Medicaid Systems and Analysis Unit

This unit bears technical responsibility for the Medicaid Management Information System and related systems. Their purpose is to ensure the integrity of the claims payment system, and to translate Medicaid program business needs into the Medicaid Management Information System 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, and all interfaces to and from the Medicaid Management Information System and decision support system.

Additionally, the unit has responsibility for preparing planning documents to secure federal funding related to the Medicaid Management Information System and fiscal agent services. This includes standard weekly Medicaid Management Information System 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 Medicaid Management Information System 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 program. The Certificate of Need 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

The Children's Health Insurance Program is an expansion of the Medicaid program in Alaska. Coverage, benefits, including the Early Periodic Screening Diagnosis Treatment service provision and program management, are the same as under Medicaid except the Children's Health Insurance Program has additional program requirements under Title XXI of the Social Security Act. The program covers children and teens through age 18, and eligibility is determined in a stand-alone office in Anchorage (operated by the Division of Public Assistance), which also determines eligibility for poverty-level Medicaid children and pregnant women who apply on a Denali KidCare application.

The program was reauthorized through the Children's Health Insurance Program Reauthorization Act until 2013 and the authorization period was extended by the Affordable Care Act through 2019 with funding through 2015. Under the Children's Health Insurance Program Reauthorization Act, 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 and care coordination models across 21 practices integrating health information technology. The Department in FY2012 was one of seven states to receive national recognition by the National Governors' Association for reporting to the Centers for Medicare and Medicaid Services on more than half of the 24 Children's Health Insurance Program Reauthorization Act core children's quality measures. Last year, Alaska received a $5.7 million performance bonus payment for streamlining eligibility and meeting enrollment targets, bringing the cumulative total to $11.3 million over three years.

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 692 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 complement 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 120,000 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 and State licensure 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 Medicare 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.

Health Information Technology Project

State law requires Alaska to implement a Health Information Exchange. The State Health Information Technology Coordinator leads the Health Information Technology office. This position is responsible for managing the contract with the non-profit board and vendor, Alaska

eHealth Network. The Alaska eHealth Network procured and is managing the HIE for the State of Alaska.

The Health Information Technology office is responsible for development of the Statewide Health Information Technology and State Medicaid Health Information Technology plans and facilitating the Health Information Technology Governance committee including: management of prioritizing Information Technology initiatives and projects across the DHSS enterprise to include ensuring initiatives are aligned with Department goals and priorities and projects are Medicaid Information Technology Architecture and National Human Services Interoperability Architecture compliant.

The Health Information Technology office will interact with federal partners for funding requests and reporting, and works closely with the Health Information Technology Governance and other divisions regarding initiatives and projects occurring within DHSS.

Medicaid Management Information System –Design, Develop, Implementation

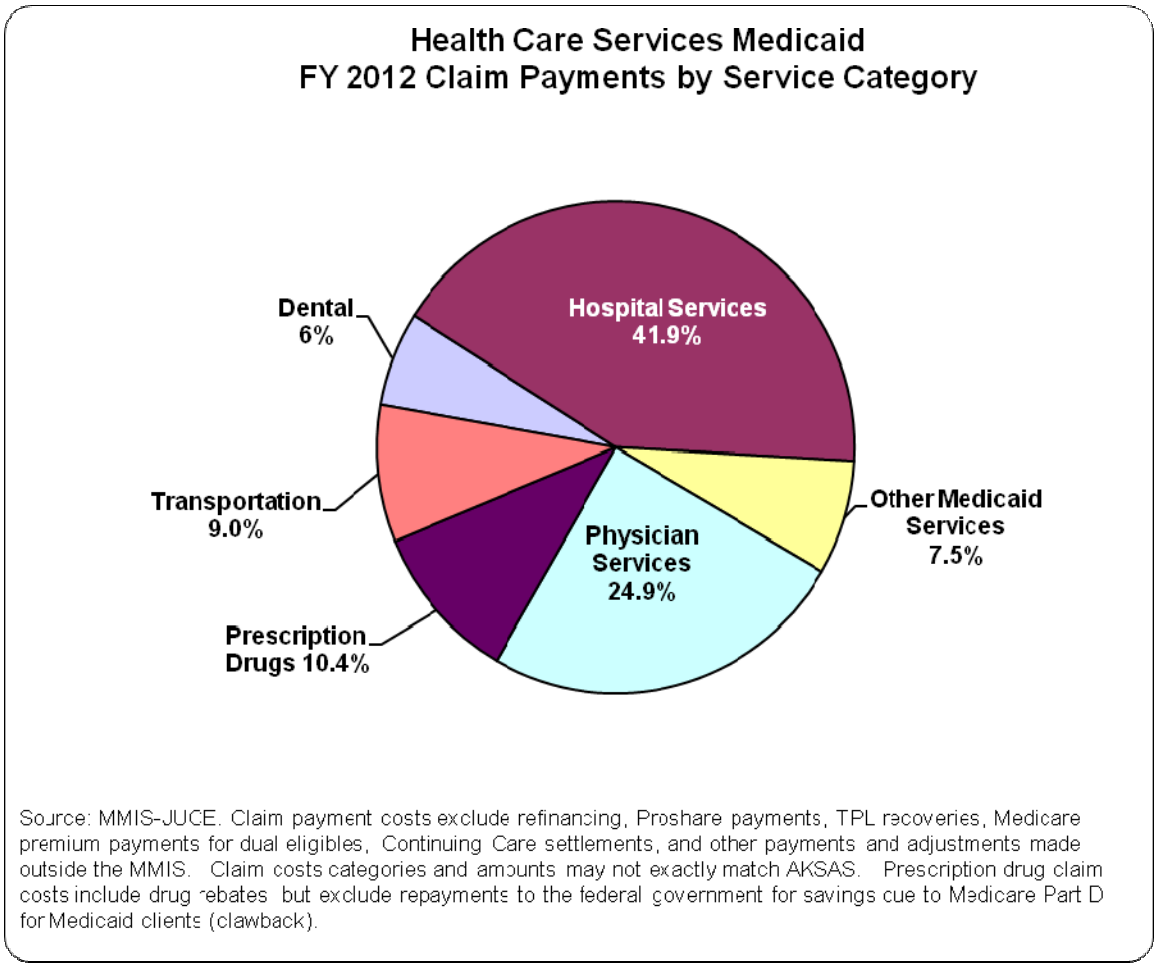
Federal law requires all states participating in the Medicaid program to operate an automated claims processing system that must be certified by the federal government. In FY2007, the State successfully bid and awarded a contract to Affiliated Computer Services, now Xerox, for this work. The contract includes: design, development and implementation of a new claims payment system; a claims data warehouse system; and the operation of the new Medicaid Management Information System. The new Medicaid Management Information System, known as Alaska Medicaid Health Enterprise, is a web-enabled solution for administering Alaska's Medicaid programs.

The Department is fully prepared to receive and send Health Insurance Portability and Accountability Act X12N 5010 transactions and code sets. The Department met the mandated effective date of January 1, 2012 with the current legacy Medicaid Management Information System. Alaska Medicaid Health Enterprise will be fully compliant with the 5010 transaction set at system go live.

Health Care Medicaid Services

The Health Care Services, 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 FY2012, approximately 96.9% of the Health Care Services 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 FY2012, Health Care Services Medicaid expenditures comprised 54.9% of the total expenditures for all Alaska Medicaid claim payments. Hospital services accounted for the largest share of HCS Medicaid expenditures (41.9%), followed by physician services (24.9%), prescription drugs (10.4%), transportation services (9.0%), other Medicaid services (7.5%), and dental services (6.0%).



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

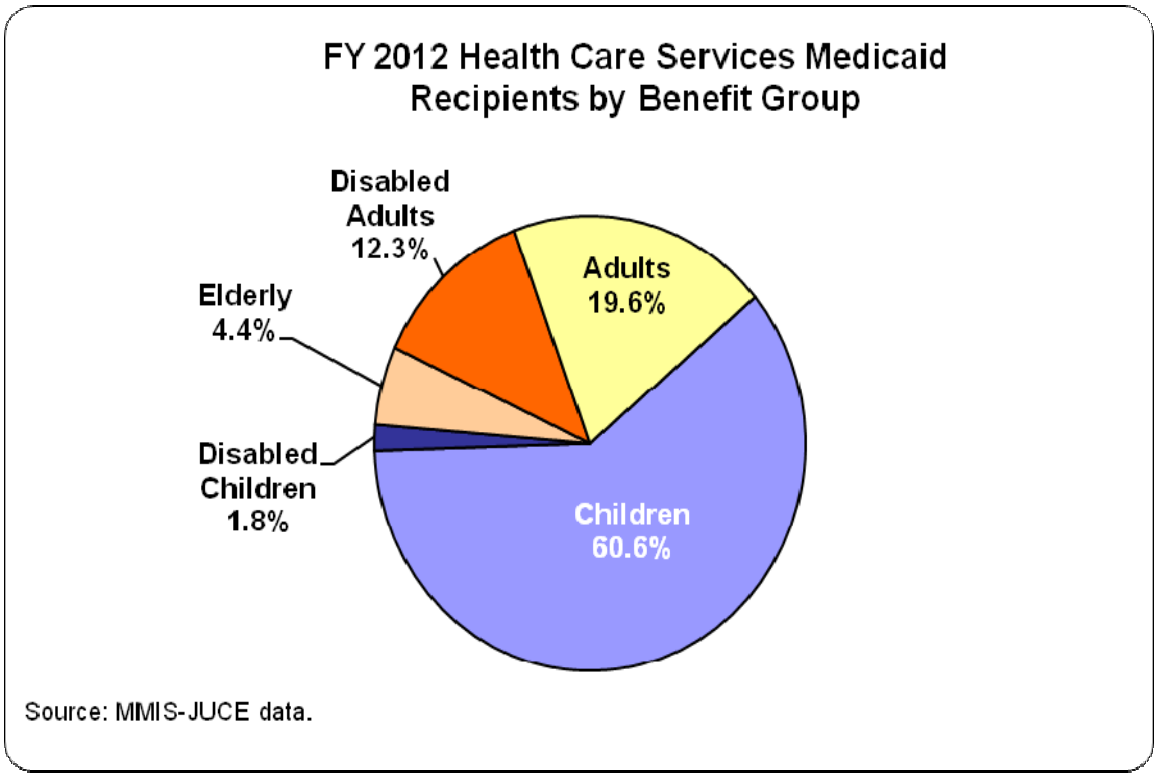
In FY2012, the Alaska Health Care Medicaid Services component supplied medical and related services to 137,678 Alaskans, or 99.2% of all individuals eligible for the Alaska Medicaid program. The total cost of direct medical benefits provided to Medicaid enrollees through Health Care Services totaled $731,696.8 dollars during FY2012. 62.4% of FY2012 Health Care Services claim payments provided medical services to children, 31.9% of Medicaid expenditures provided medical services for adults, and 5.6% of payments provided medical care for elderly individuals. 68.0% of Health Care Services Medicaid medical service expenditures made during FY2012 supported medical care for children and the elderly.

Benefit Group	Percent of Recipients	Number of Recipients	Percent of Payments	Payments (thousands)	Cost per Recipient per Year (CPRPY)
Children	60.6%	84,857	41.8%	$305,981.7	$3,606
Disabled Children	1.8%	2,570	5.5%	$39,968.1	$15,552
Elderly	5.6%	7,849	4.4%	$32,291.8	$4,114
Disabled Adults	12.3%	17,276	24.8%	$181,565.2	$10,510
Adults	19.6%	27,485	23.5%	$171,890.1	$6,254
Unduplicated Clients		**137,678**			
Total Div Mdcd Payments (dollars)				**$731,696.8**	
Div. Mdcd. CPRPY					**$5,315**

Source: MMIS/JUCE claims paid during FY2012. The benefit category "disabled adults includes disabled persons between 19 and 20 years of age as well as adults over 21.

Number of Recipients: Individuals having Medicaid claims paid during State fiscal year 2012 (service may have been incurred in a prior year). Grouping is based on recipient status the date the service was provided. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age, and benefit group categories), although 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 any time before June 30, 2012. If they later obtained dental services in December 2011, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2012.



Total medical claim expenditures for Health Care Services Medicaid increased by 0.8% between FY2011 and FY2012, with minimal increases in reimbursements for medical services across the spectrum of Medicaid services. This minimal growth in expenditures can be attributed to smaller increases in the reimbursement rates for Medicaid services, clean-up and monitoring of recipient eligibility, and increased oversight of both payment procedures and utilization of Medicaid services. The number of recipients utilizing HCS Medicaid medical services in FY2012 was subject to an increase of 2.9% from FY2011. During this same period, the annual cost per recipient decreased by 2.1%, from an average cost of $5,428 per participating recipient in FY2011 to $5,315 in FY2012. As noted above, decreases in the average recipient expenditures can be attributed to a number of measures, with review and monitoring of Medicaid programs and their utilization contributing greatly to controlling Medicaid costs.

Health Care Services Medicaid Spending for Select Service Categories

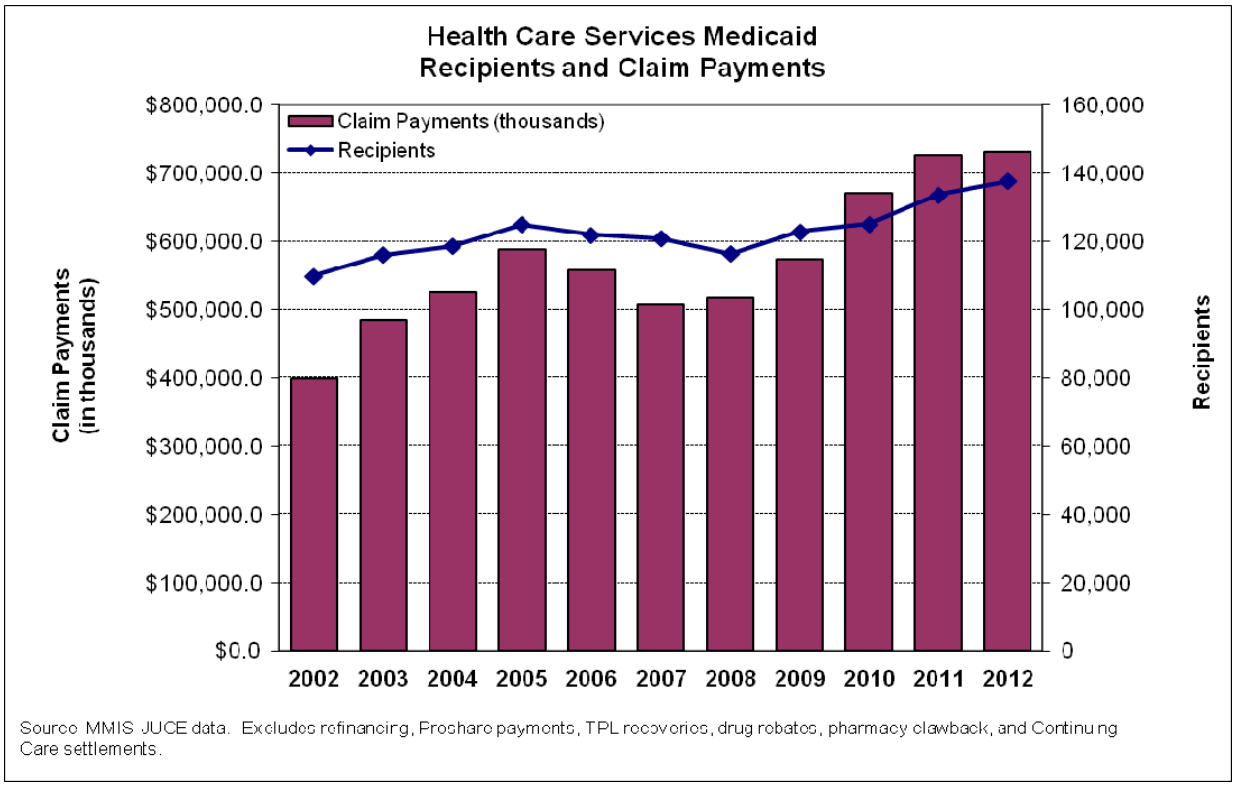
All Medicaid Services*	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	63.1%	87,455	48.0%	$351,081.9	$4,014
21 or Older	36.9%	51,227	52.0%	$380,615.0	$7,430
Unduplicated Annual Clients		**137,678**			
Total Medicaid Claim Payments (thousands)				**$731,696.9**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$5,315**
State Only	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	26.3%	252	27.6%	$163.1	$647
21 or Older	73.7%	705	72.4%	$428.5	$608
Unduplicated Annual Clients		**955**			
Total Medicaid Claim Payments (thousands)				**$591.6**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$619**

Hospital Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	55.2%	43,111	47.9%	$144,454.4	$3,351
21 or Older	44.8%	35,013	52.1%	$157,384.6	$4,495
Unduplicated Annual Clients		**77,730**			
Total Medicaid Claim Payments (thousands)				**$301,839.0**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$3,883**
Physician Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	62.0%	73,450	49.0%	$87,853.2	$1,196
21 or Older	38.0%	44,935	51.0%	$91,579.8	$2,038
Unduplicated Annual Clients		**117,718**			
Total Medicaid Claim Payments (thousands)				**$179,433.0**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$1,524**
Pharmacy	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	60.3%	47,319	30.5%	$22,957.8	$485
21 or Older	39.7%	31,114	69.5%	$52,272.9	$1,680
Unduplicated Annual Clients		**78,069**			
Total Medicaid Claim Payments (thousands)				**$75,230.7**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$964**
Transportation	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	51.8%	15,015	52.7%	$34,155.5	$2,275
21 or Older	48.2%	13,986	47.3%	$30,666.3	$2,193
Unduplicated Annual Clients		**28,886**			
Total Medicaid Claim Payments (thousands)				**$64,821.8**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$2,244**
Other Medicaid Services	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	48.8%	28,816	48.7%	$26,408.4	$916
21 or Older	51.2%	30,227	51.3%	$27,861.1	$922
Unduplicated Annual Clients		**58,808**			
Total Medicaid Claim Payments (thousands)				**$54,269.5**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$923**
Dental	PCT of Recips	Recips	PCT of Payments	Payments (thousands)	CPRPY
Under 21	75.7%	42,390	78.6%	$35,089.4	$828
21 or Older	24.3%	13,606	21.4%	$9,563.6	$703
Unduplicated Annual Clients		**55,942**			
Total Medicaid Claim Payments (thousands)				**$44,653.0**	
Average Annual Medicaid Cost per Beneficiary (CPRPY)					**$798**

Source: MMIS-JUCE

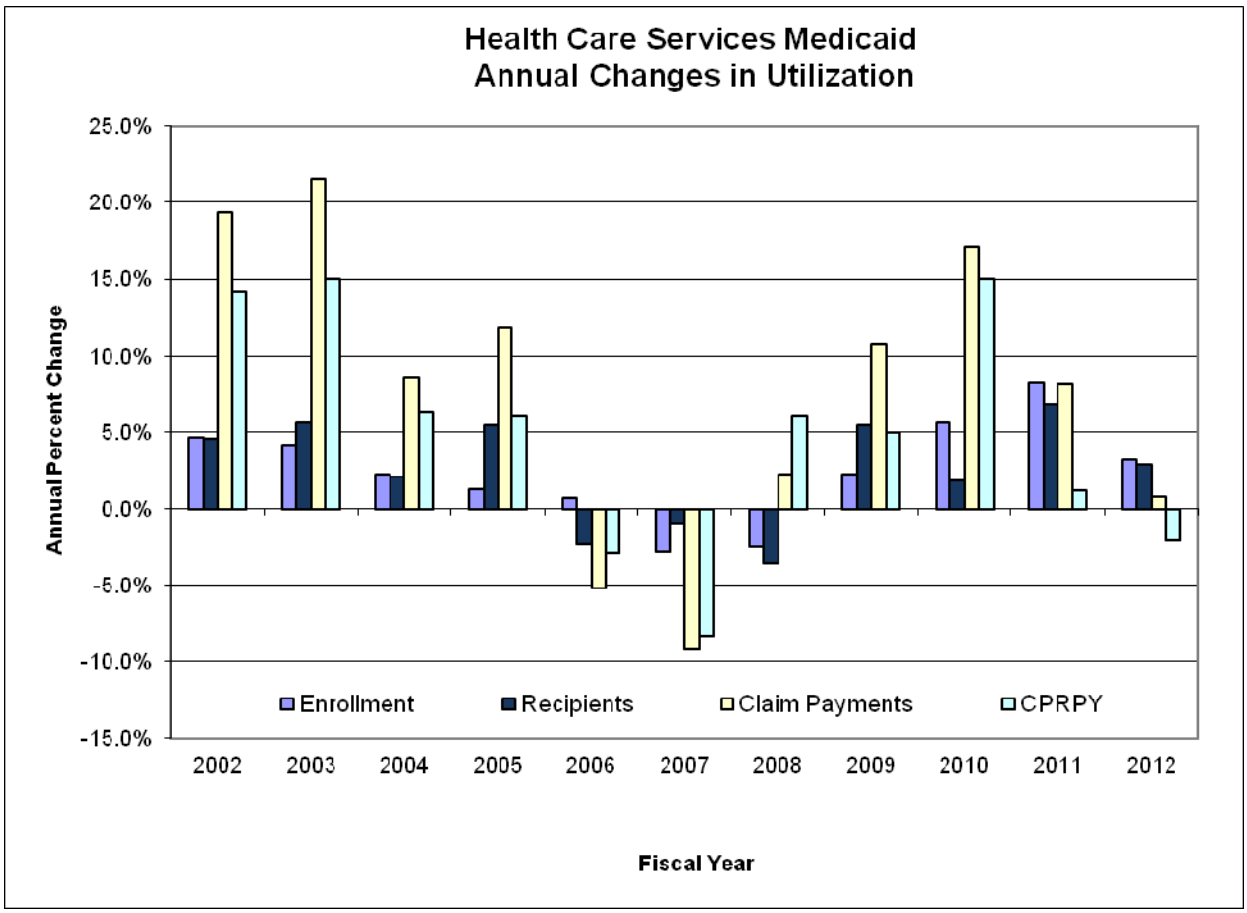
*****The recipient counts and payments for All Medicaid Services include all services provided by Health Care Services. This table provides details for some, but not all, of the service categories.

***Note: In some instances recipient counts will not add to total due to change in age over course of fiscal year.**



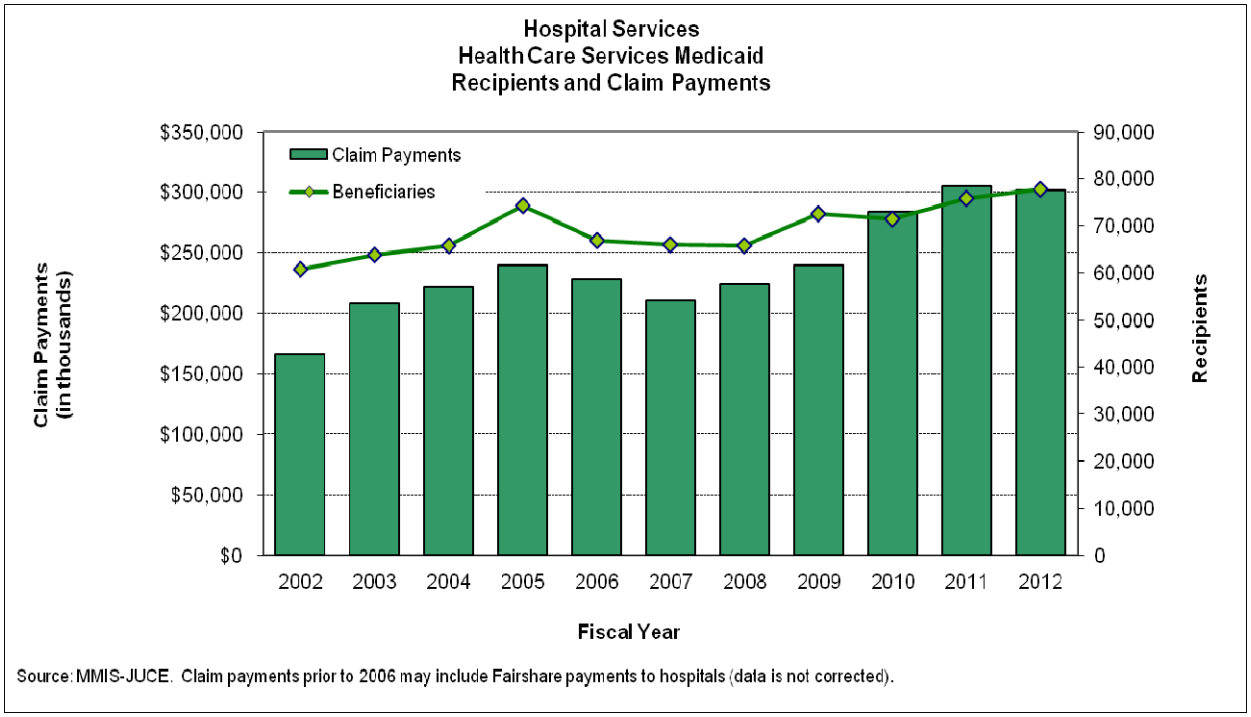
Health Care Medicaid Services Historical Utilization				
SFY	Annual Percent Change			
	Enrollment	Recipients	Claim Payments	Cost per Recipient per Year
2002	4.6%	4.5%	19.3%	14.2%
2003	4.2%	5.6%	21.5%	15.0%
2004	2.3%	2.1%	8.6%	6.3%
2005	1.2%	5.4%	11.8%	6.1%
2006	0.7%	-2.4%	-5.2%	-2.9%
2007	-2.8%	-0.9%	-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%
2012	3.3%	2.9%	0.8%	-2.1%

Source: MMIS-JUCE



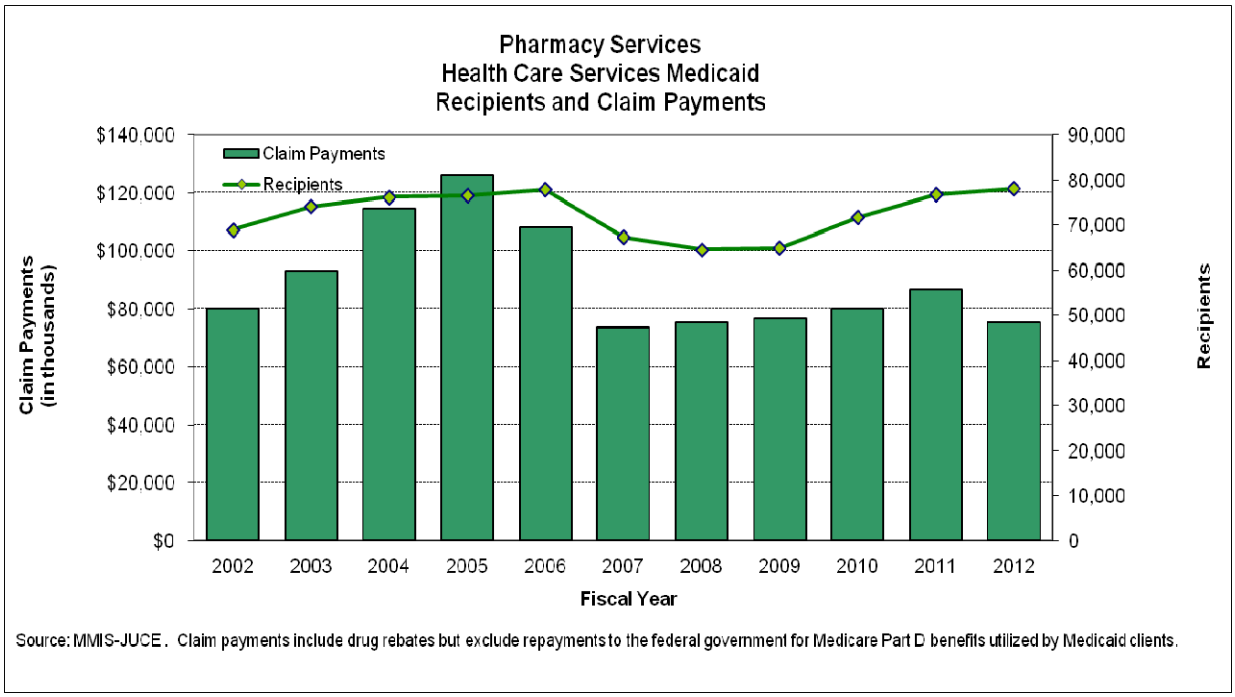
Source: MMIS JUCE

Overall claims expenditures for Medicaid hospital services decreased by 1.0% between FY2011 and FY2012. This decrease can be attributed to a number of factors mentioned in previous sections, with oversight and limited compensation increases at the forefront of cost control. The effects of this oversight can most easily be noticed in the 3.6% decrease in average expenditure per recipient. Also noticeable was that while the overall claims expenditures fell, the number of Medicaid recipients utilizing Medicaid hospital services increased by 2.7%, from 75,717 recipients in FY2011 to 77,730 in FY2012.



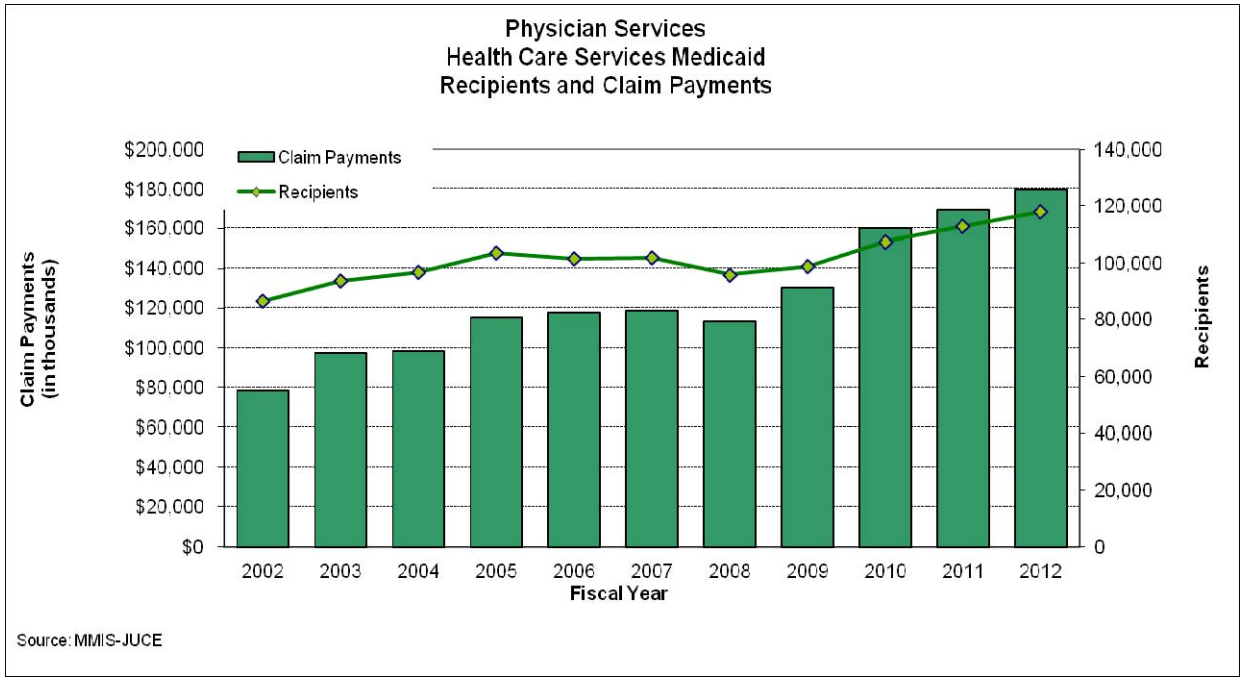
Source: MMIS-JUCE. Claim payments prior to 2006 may include Fairshare payments to hospitals (data is not corrected).

Pharmacy claim payments decreased by approximately 13.2% from FY2011 to FY2012. While pharmacy expenditures fell substantially between FY2006 and FY2007 (due to the addition of Medicare Part D prescription drug coverage) there have been consecutive yearly increases in expenditures until the most recent year, FY2012. One driving factor of this decrease in pharmacy expenditures is an increase in drug rebates, although there are several factors, such as program monitoring, which are contributing to this decrease as well. The number of Medicaid recipients receiving prescription drugs increased by 1.8% between FY2011 and FY2012, while the annual average cost per recipient decreased by 14.7% during this same period.

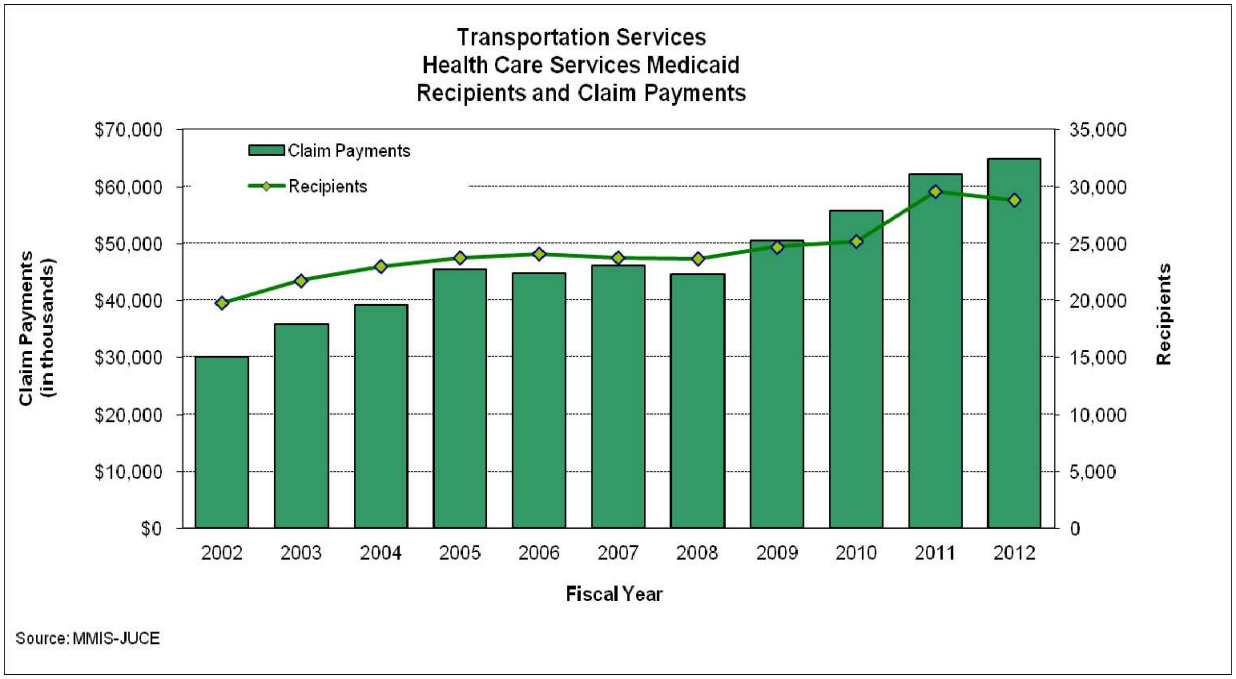


Source: MMIS-JUCE. Claim payments include drug rebates but exclude repayments to the federal government for Medicare Part D benefits utilized by Medicaid clients.

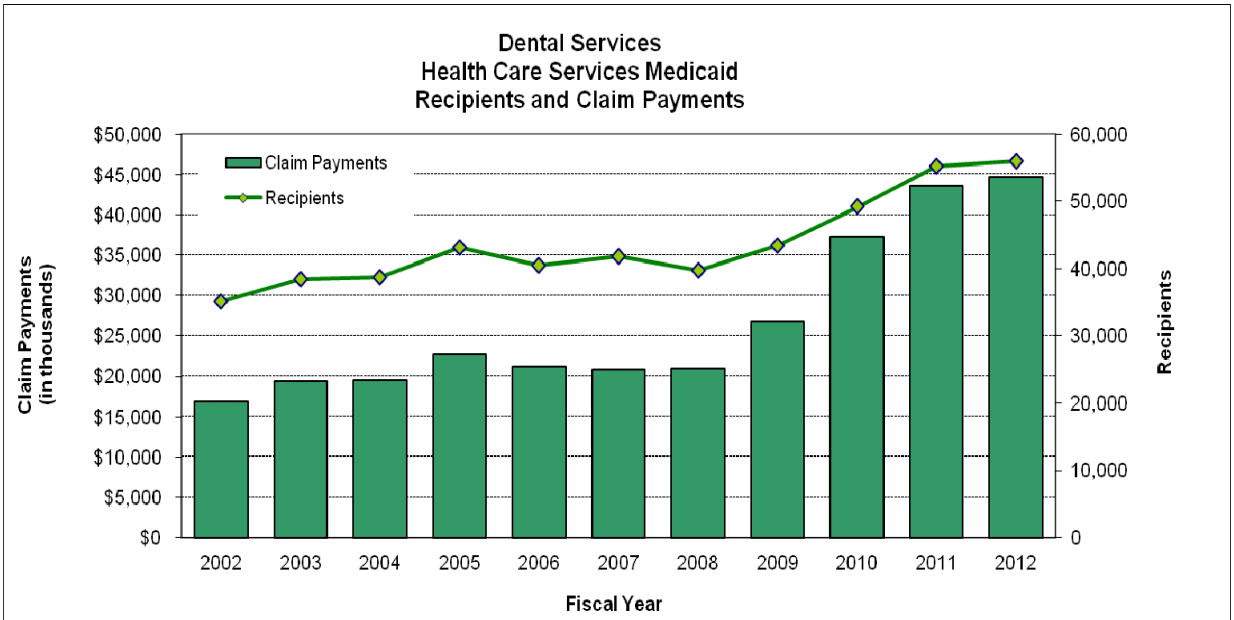
Claims payments for Medicaid physician services saw an increase of 5.9% between FY2011 and FY2012. The number of Medicaid recipients utilizing physician services during this same period increased by 4.3%. The average expenditure per recipient for physician services increased by $22.00, or 1.5%.



Expenditures for Medicaid transportation services grew by 4.4% between FY2011 and FY2012. This represents a slowdown in expenditures for travel from FY2011, due in large part to a wider array of services being offered in rural communities/areas, with less travel for more routine procedures. The number of Medicaid recipients utilizing Medicaid transportation services decreased by 2.4%, while the average cost per recipient increased by 7.1%, from $2,096 average per recipient in FY2011 to $2,244 in FY2012.

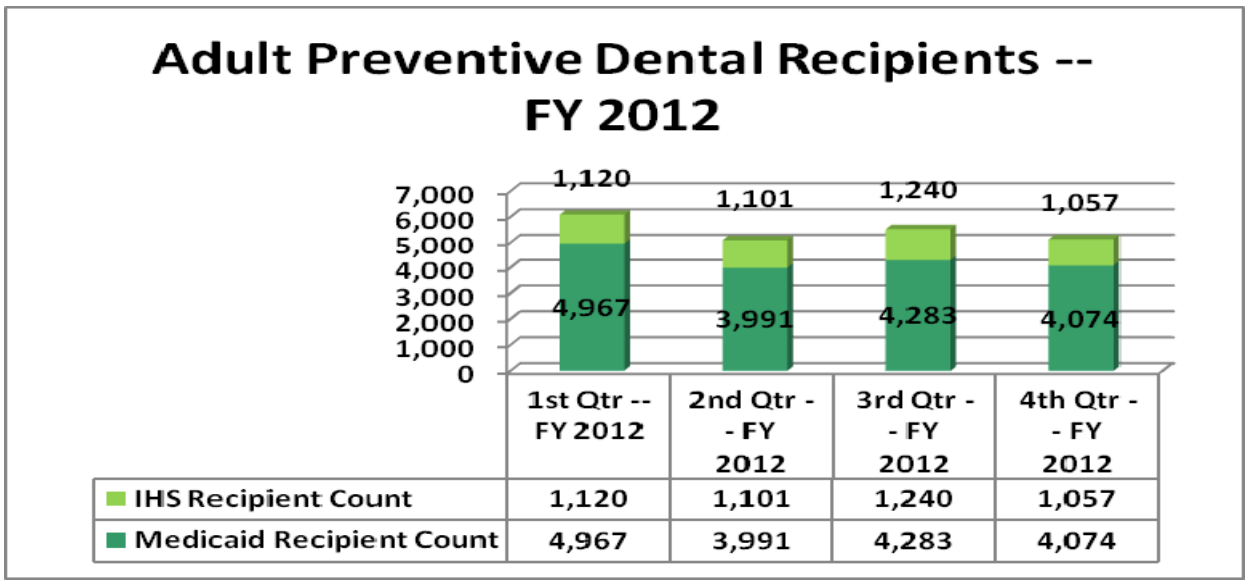


Total Medicaid expenditures for dental services increased by 2.6% between FY2011 and FY2012, while the number of Medicaid recipients utilizing dental services increased by 1.3%. The average cost per recipient increased by $9.00, or 1.2%, between FY2011 and FY2012. (Note: Dental services discussed here do not include Medicaid adult preventive dental services.)

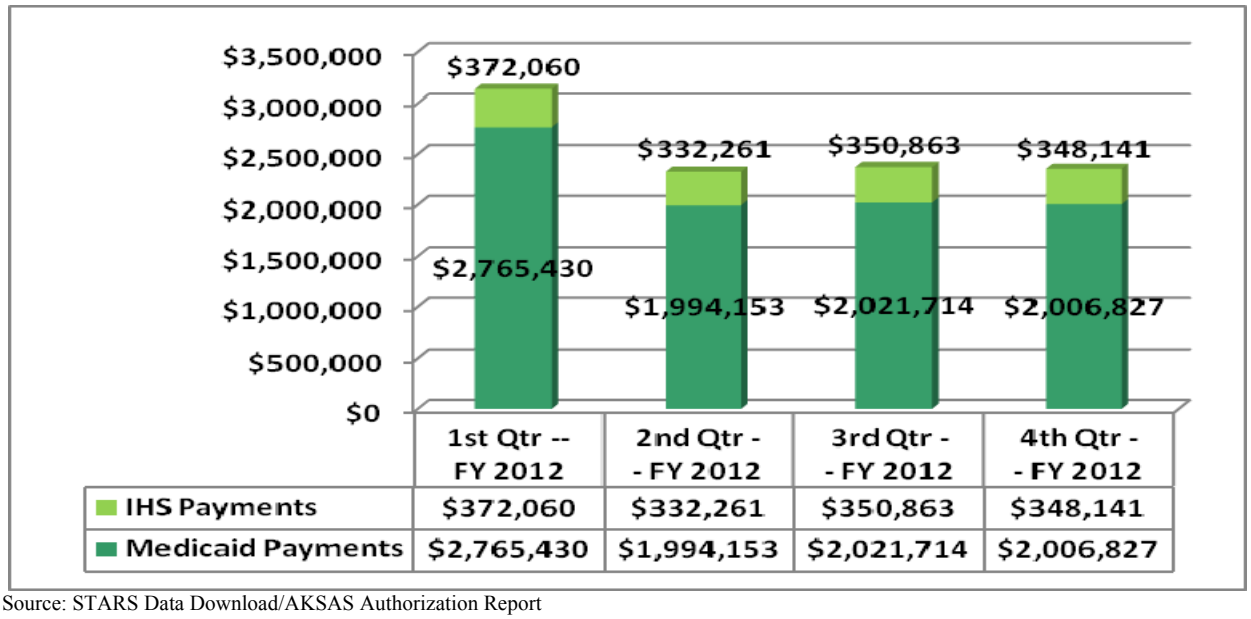


The Adult Preventative Medicaid Dental program was established with the passage of House Bill 105 in FY2006. Its implementation in April 2007 began a three-year trial period for the program. House Bill 26 (passed into law during the 2009 session) repealed the sunset clause in the original bill, and reauthorized 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.

*Note: A bill signed into law, which took affect October 2010, allows individuals to combine two years of benefits in order to receive a full set of dentures, which exceeded the yearly limit of $1,150 dollars prior to the implementation of this regulation change. The use of two years dental benefits for dentures then leaves only emergency dental benefits for that recipient the following fiscal year.

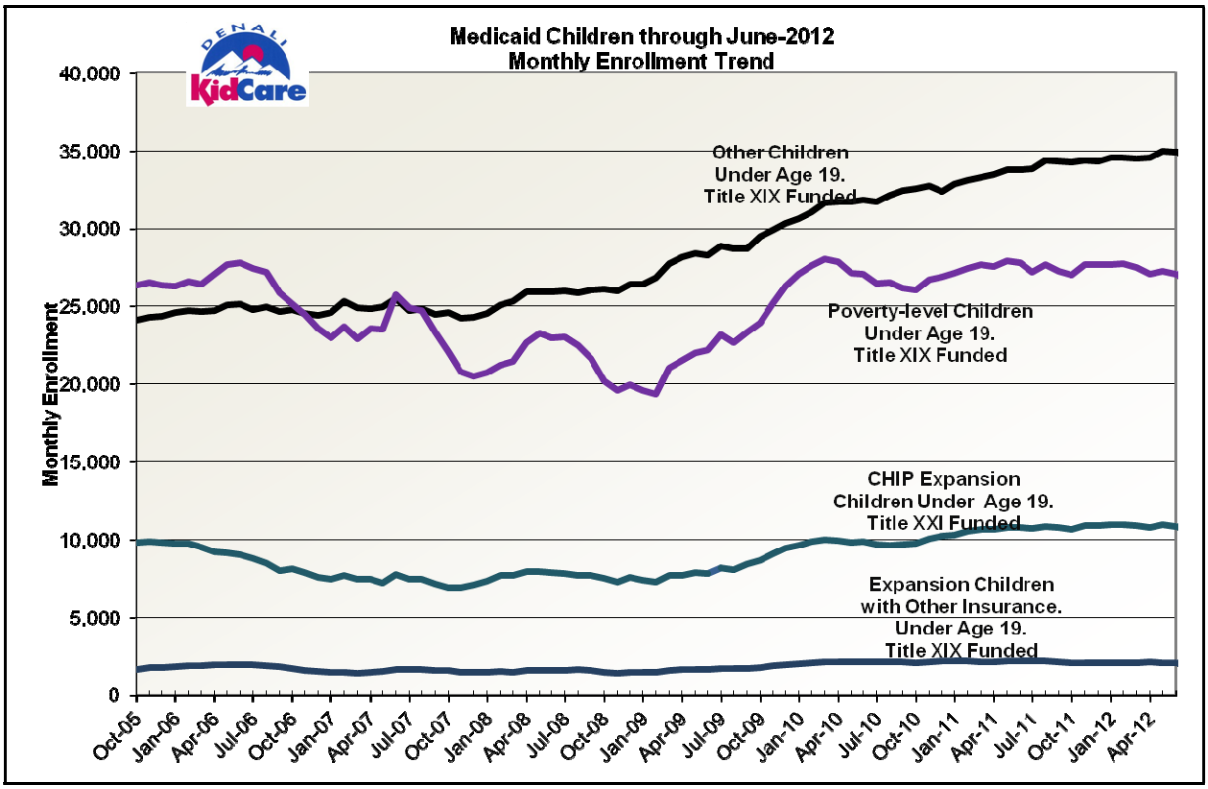


Source: STARS Data Download/AKSAS Authorization Report



Source: STARS Data Download/AKSAS Authorization Report

Child enrollment in Medicaid/Children's Health Insurance Program represents more than 2/3 of total Medicaid enrollment.


Medicaid Children through June-2012
Monthly Enrollment Trend
DENALI KidCare
Monthly Enrollment
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Other Children Under Age 19. Title XIX Funded
Poverty-level Children Under Age 19. Title XIX Funded
CHIP Expansion Children Under Age 19. Title XXI Funded
Expansion Children with Other Insurance. Under Age 19. Title XIX Funded
Oct-05
Jan-06
Apr-06
Jul-06
Oct-06
Jan-07
Apr-07
Jul-07
Oct-07
Jan-08
Apr-08
Jul-08
Oct-08
Jan-09
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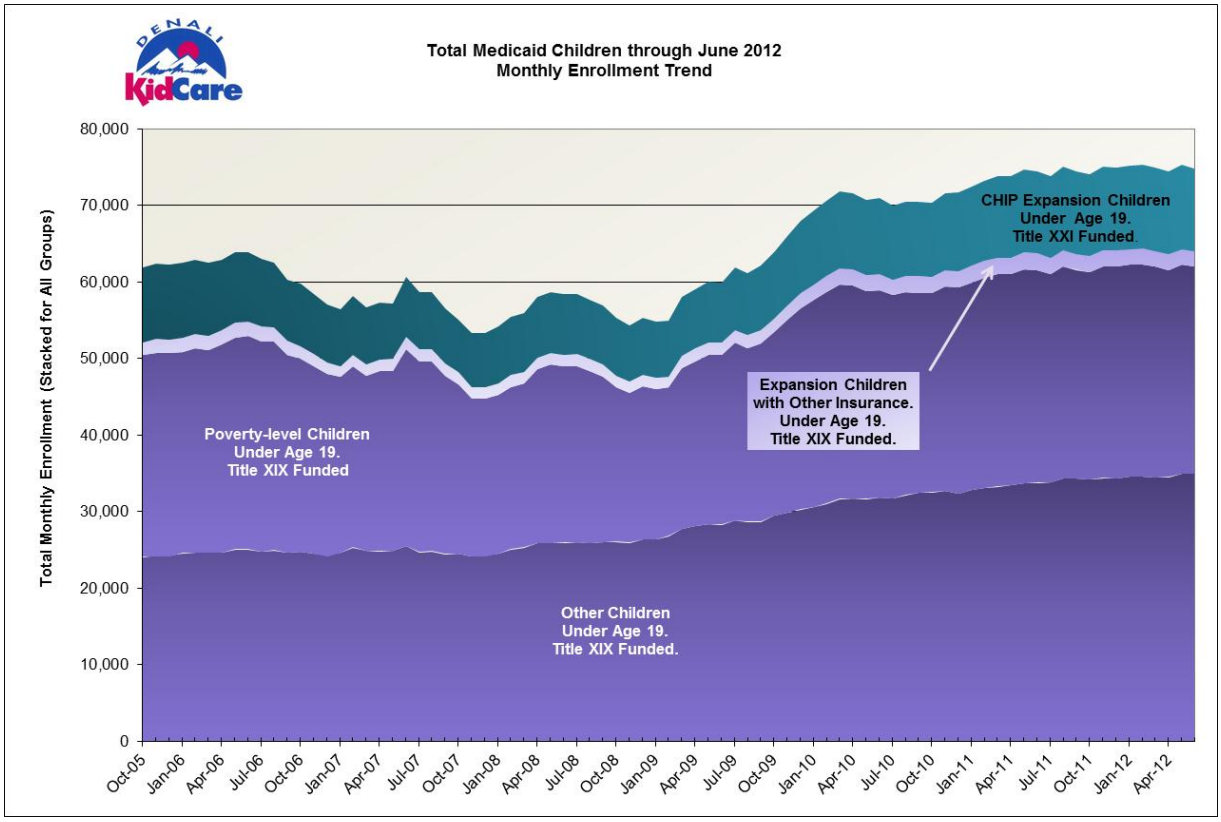
Jul-09
Oct-09
Jan-10
Apr-10
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12

The teal green bar below reflects the number of children funded under the Children's Health Insurance Program with Title XXI enhanced funding. As of June, 2012, there were more than 70,000 children enrolled in Medicaid and the Children's Health Insurance Program expansion.



FY2012 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		**137,678**		**$731,696,884**	**$5,315**
Gender					
Female	56.1%	77,288	59.4%	$434,454,785	$5,621
Male	43.9%	60,452	40.6%	$297,241,816	$4,917
Unknown	0.0%	1	0.0%	$283	$283
Race					
Alaska Native	39.3%	54,594	43.6%	$319,122,476	$5,845
American Indian	1.6%	2,230	1.5%	$11,277,105	$5,057
Asian	6.6%	9,107	5.3%	$38,797,365	$4,260
Pacific Islander	3.5%	4,896	2.9%	$21,503,477	$4,392
Black	5.5%	7,603	4.8%	$34,836,848	$4,582
Hispanic	3.7%	5,115	2.8%	$20,185,027	$3,946
White	37.4%	52,012	36.9%	$270,123,827	$5,193
Unknown	2.4%	3,365	2.2%	$15,850,759	$4,710
Native	41.0%	56,799	45.2%	$330,399,581	$5,817
Non-Native	59.0%	81,610	54.8%	$401,297,303	$4,917
Age					
under 1	8.3%	12,470	13.7%	$100,315,240	$8,045
1 through 12	37.2%	55,603	20.4%	$149,615,570	$2,691
13 through 18	15.1%	22,605	10.8%	$78,867,443	$3,489
19 through 20	3.5%	5,301	3.0%	$22,283,655	$4,204
21 through 30	10.8%	16,135	14.0%	$102,799,518	$6,371
31 through 54	14.4%	21,552	22.9%	$167,651,872	$7,779
55 through 64	4.3%	6,490	9.8%	$71,978,037	$11,091
65 through 84	5.3%	7,977	4.7%	$34,271,310	$4,296
85 or older	0.9%	1,367	0.5%	$3,914,238	$2,863
Benefit Group					
Children	60.6%	84,857	41.8%	$305,981,699	$3,606
Adults	19.6%	27,485	23.5%	$171,890,083	$6,254
Disabled Children	1.8%	2,570	5.5%	$39,968,136	$15,552
Disabled Adults	12.3%	17,276	24.8%	$181,565,166	$10,510
Elderly	5.6%	7,849	4.4%	$32,291,800	$4,114
Location (DHSS Region)					
Anchorage/Mat-Su	49.2%	69817	62.1%	$344,526,019	$4,935
SouthCentral	13.0%	18470	17.8%	$98,702,132	$5,344
Northern	12.4%	17518	15.4%	$85,412,472	$4,876
Western	15.0%	21269	22.7%	$125,882,432	$5,919
SouthEast	9.3%	13162	13.2%	$73,068,392	$5,551
Out of State or Unknown	1.1%	1560	0.7%	$4,105,437	$2,632

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, 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 2012 (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, 2012. If they obtained dental services again in December 2011, they would also be included in the 13 through 18 age subgroup count if the claim was paid any time before June 30, 2012.

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

Statutes

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

Regulations

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

Federal Regulations

Title 42	CFR Part 400 to End
Title XVIII	Medicare
Title XIX	Medicaid
Title XXI	Children's Health Insurance Program

Division of Health Care Services

Budget Overview Table

Health Care Services	FY2013	FY2014 Gov	13 to 14 Change
Unrestricted General Funds	$12,113.3	$12,252.1	$138.8
Designated General Funds	1,909.6	1,849.6	-60.0
Federal Funds	13,302.2	11,859.1	-1,443.1
Other Funds	6,054.7	5,036.5	-1,018.2
Total	**$33,379.8**	**$30,997.3**	**-$2,382.5**

Budget Requests/Adjustments

Health Facilities Licensing and Certification

Sustain Mandatory Facility Inspections: $457.0 Total -- $457.0 GF Match

Health Facilities Licensing and Certification needs $457.0 of additional general fund revenue to continue to license and/or certify hospitals, nursing homes, ambulatory surgery centers, hospices (paid and volunteer), outpatient physical therapy providers, rural health clinics, freestanding birth centers, home health care providers, Frontier Extended Stay Clinics, and end stage renal disease facilities. Certification takes part through an agreement with the Centers for Medicare and Medicaid Services for those facilities that take part in the federal Medicare and state Medicaid programs. The Centers for Medicare and Medicaid Services mandate strict timeframes of when inspections are to be completed.

Certification and Licensing

Delete Federal Receipts Authorization Transferred From Public Health in FY2012: -$500.0 Total -- -$500.0 Federal

Health Care Services requests a decrement of $500.0 excess federal authorization from the Certification and Licensing component. This component was transferred from the Division of Public Health with excess federal receipts authorization in the FY2012 budget cycle. There is no realistic expectation of collecting these receipts. Therefore, the Division of Health Care Services requests this decrement to place the FY2014 federal receipts budget at a more realistic level.

Medical Assistance Administration

Delete One-Time Increment from Alaska Mental Health Trust -$500.0 Total -- -$500.0 MHTAAR

This decrement deletes one-time funding from the Alaska Mental Health Trust for the Patient-Centered Medical Homes with Integrated Services (Medical Home Model) Project.

Rate Review

Delete One-Time Increment for Rate Settings and Acuity Measurement Systems: -$640.0 Total -- -$320 Federal, -$320.0 GF Match

This decrement deletes one-time funding for Rate Settings and Acuity Measurement Systems for the following:

- Behavioral Health Outpatient Rate Setting and Acuity Measurement System: -$100.0 Total -- -$50.0 Fed, -$50.0 GF Match
- Behavioral Health Outpatient Rate Setting and Acuity Measurement System: -$100.0 Total -- -$50.0 Fed, -$50.0 GF Match
- Home and Community Based Services Acuity Measurement System: -$300.0 Total -- -$150.0 Fed, -$150.0 GF Match
- Tribal Dental and Behavioral Health Encounter Rate Settlement Calculations: -$140.0 Total -- -$70.0 Fed, -$70.0 GF Match

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, 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 four of the five 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 continues to seek new ways to provide affordable access to quality health care services to eligible Alaskans. Ensuring that 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 payment methodology had been problematic, as existing regulations did not provide an objective means by which to make fee schedule adjustments. Health Care Services resolved this problem by proposing regulations that adjusted the Resource Based Relative Value Scale fee schedules in accordance with the U.S. Department of Labor's Consumer Price Index. The regulations were adopted and have now been fully implemented, with all future adjustments effective July 1 of each year. In addition to providing objectivity to rate setting, rate adjustments now correspond with the state fiscal year for budgeting purposes. This change also allows adequate time for staff to review Resource Based Relative Value Scale changes published by Centers for Medicare and Medicaid Services, effective January 1 of each year.

Health Care Services is exploring options for developing a sound payment methodology for taxi and other ground transportation providers.

Medicaid Pharmacy

The Department is in the process of incorporating the results of the 2012 dispensing fee survey and other federal mandates into the pharmacy payment methodology. The Department is constantly striving to ensure providers are adequately and accurately reimbursed in a manner that

is compliant with federal requirements and ensures access to pharmacy services for Medicaid recipients.

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 that affect American Indian/Alaska Native beneficiaries. The challenge in maintaining this process is to meet the requirements the Centers for Medicare and Medicaid Services 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 State Plan Amendments that affect the whole Medicaid beneficiary base, which includes the American Indian/Alaska Native base. This includes at least 12 consultation events per year.

The other change that continues to be considered is cost-based reimbursement for Community Health Aide Practitioners and the inclusion of behavioral health aides in the Community Health Aide Practitioners service delivery model. This effort follows the reimbursement request process through Centers for Medicare and Medicaid Services, as was done for tribal dental and behavioral health services. The cost-based reimbursement of Community Health Aide Practitioners and inclusion of behavioral health aides in the Community Health Aide Practitioners model would provide improved financial stability allowing tribes to expand infrastructure and scope of Community Health Aide Practitioners/Behavioral Health Aides services.

Chronic and Acute Medical Assistance

Health Care Services strives to stay within the Chronic and Acute Medical Assistance limited budget while providing prescription drugs and outpatient care for approximately 500 recipients each month. Chronic and Acute Medical Assistance funding is 100 percent general fund.

Health Facilities Licensing and Certification

The ability to meet Centers for Medicare and Medicaid Services 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 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 Centers for Medicare and Medicaid Services mandates, and avoid serious delays in licensing and/or certifying new providers.

Medical Assistance Administration

Medicaid Management Information System Development Project

As mentioned previously, the new Medicaid Management Information System, known as Alaska Medicaid Health Enterprise, is a web-enabled solution for administering Alaska's Medicaid programs. In FY2011, Xerox 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 Medicaid Management Information System –Design, Develop, Implementation project team received the Enterprise source code and continues to build out the Alaska-specific requirements. Ongoing testing of the code, as well as of Alaska-specific requirements, has shown that Enterprise source code contains higher than anticipated levels of defects that must be addressed first in order to properly pay claims. Therefore, Alaska Medicaid Health Enterprise now is expected to be available to state staff, providers, and members in 2013. The Medicaid Management Information System –Design, Develop, Implementation project team successfully deployed the claims data warehouse that became operational in FY2013 for select Health Care Services staff, before Alaska Medicaid Health Enterprise is fully operational. Health Care Services and the project team have a robust provider outreach and education program in progress for reenrollment purposes leading up to the Medicaid Management Information System implementation. The project team has also made active headway developing business transformation processes, operational readiness, and fiscal agent readiness work.

Health Information Technology Project

The Health Information Exchange is jointly funded by the state and the federal government. The federal funds come from a Cooperative Agreement with the Office of the National Coordinator for Health Information Technology, which was funded under the American Recovery and Reinvestment Act of 2009. There have been significant challenges due to changing landscapes and expectations by the Office of the National Coordinator for Health Information Technology Cooperative Agreement. There has been a shift in focus by the Office of the National Coordinator towards Direct protocol (secure email) and states providing direct services under their Health Information Exchange Cooperative Agreements rather than a more robust Health Information Exchange. The Health Information Technology office continues to focus on moving the Health Information Exchange from pilot status to a production status in addition to supporting the Office of the National Coordinator's more immediate goals. The more robust Health Information Exchange should be moving from its current pilot status to a production status during calendar year 2013.

In addition to the Health Information Exchange, the Health Information Technology office is also responsible for managing and administering the Medicaid Electronic Health Records Incentive Payment Program which provides federal incentives funds to eligible professionals and eligible hospitals who adopt, implement, or upgrade and meaningfully use a certified electronic health record system. The Medicaid Electronic Health Records Incentive program has seen a slow increase in the number of eligible professional's attestations due to varying reasons such as the professionals being unaware of the program; the professional's organization hasn't adopted,

implemented or upgraded to a certified Electronic Health Records; or professionals didn't understand how to calculate their Medicaid patient volumes. The Medicaid Electronic Health Records Incentive Program has also seen a change in landscape due to regulation and procedure changes by the Centers for Medicare and Medicaid Services.

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 Health Care Services 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. This item poses a challenge to Health Care Services, 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 Medicaid Management Information System, 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 updating the ACCESS-based database in order to streamline all functions. The licensing staff has 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.

The Background Check Program continues work toward implementing a new database in an effort to streamline processes. With an antiquated database, unintentional delays occurred, impacting the ability for applicants to go to work. With funding from a competitive grant from the Centers for Medicare and Medicaid Services, emphasis was placed on replacing the current database with a new and improved program. In addition, continued work to expand the use of live scan machines is ongoing statewide, in order to capture fingerprints electronically that can be transmitted straight to the Department of Public Safety; thus, eliminating the need for paper copies that may need to be mailed to the Department of Public Safety 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 FY2014, 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 mandates. The International Classification of Diseases version 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 federal implementation date for this mandate has shifted to October 1, 2014. Project work efforts commenced in FY2011 and are ongoing in FY2014.

In FY2014, Health Care Services will continue departmental compliance efforts relating to changes mandated by the Affordable Care Act. This compliance effort began in FY2011 with efforts to enroll rendering providers and identify them on claims and efforts to identify health care acquired conditions. It has continued in FY2012 and FY2013 with compliance efforts relating to additional rendering, prescribing, ordering/referring providers and preventive services for women. This project is ongoing in FY2014 with continued rendering, ordering/referring provider compliance efforts.

In FY2014, Health Care Services will continue departmental compliance efforts relating to Health Information Portability and Accountability Act Operating Rules. The first set of Operating Rules for electronic health care transactions became effective January 1, 2013 and relates directly to member eligibility and claim status. The second set of Operating Rules will become effective January 1, 2014 and relate to claims and claim payment transactions.

Also in FY2014, 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 Health Information Portability and Accountability Act 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 is managing the project to re-enroll all Medicaid providers. This project began in FY2012 and continues in FY2013 with project finalization and close out in FY2014. This project is a prerequisite to the implementation of the replacement of Medicaid Management Information System.

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN		
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.		
OUTCOME 2. Alaskans are free from unintentional injury		
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of HSS.
	EFFICIENCY MEASURE	Number of hospitalizations due to medication errors. (HCS)
	EFFICIENCY MEASURE	Cost of medical services in facilities. (DJJ)
	EFFECTIVENESS MEASURE	Percent of facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of decrease in facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of complaints investigated within established timeframes.
CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.		
OUTCOME 1. Alaskan children receiving department services live in a supportive setting.		
EFFECTIVENESS MEASURE	**Percent of children receiving department services who are safe and supported.***	
EFFICIENCY MEASURE	**Cost of services per child.***	
	***AGGREGATE DIVISION MEASURES - (Percent of children receiving department services who are safe and supported).**	
	EFFECTIVENESS MEASURE	Percent of children on Medicaid who are prescribed psychotropic medication.

	EFFICIENCY MEASURE	Average cost of psychotropic medications for children on Medicaid.

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**
EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

OUTCOME 2. Alaskans with chronic or complex medical conditions receive integrated care.

EFFECTIVENESS MEASURE	**Number of Medicaid recipients empanelled in medical home.**
EFFICIENCY MEASURE	**Cost per recipient in medical home vs. cost per recipient not enrolled in medical home.**
EFFECTIVENESS MEASURE	**Percent of providers connected to the Health Information Exchange (HIE) for Directed Exchange.**
EFFECTIVENESS MEASURE	**Percent of providers connected to the Health Information Exchange (HIE) for Query-Based Exchange.**
EFFICIENCY MEASURE	**Cost per provider connected to the Health Information Exchange.**
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percent of primary care providers that provide integrated services.
EFFICIENCY MEASURE	Cost of integrated primary care per recipient.
EFFECTIVENESS MEASURE	Percent of patients receiving case management services.
EFFICIENCY MEASURE	Average cost per recipient in case management.
EFFECTIVENESS MEASURE	Percent of cases under utilization review.
EFFICIENCY MEASURE	Savings from utilization review compared to cost of service.

CORE SERVICE B. FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

OUTCOME 1. Alaskans have access to health care.

EFFECTIVENESS MEASURE	**Percent of Alaskans in urban communities that can access care.***
EFFICIENCY MEASURE	**Department cost per percent of Alaskans with access to care.***
	*** AGGREGATE DIVISION MEASURES - (Percent of Alaskans in urban communities that can access care).**

	EFFECTIVENESS MEASURE	Percent of Medicaid eligibles who utilize Medicaid Services.
	EFFICIENCY MEASURE	Cost per recipient.
	EFFECTIVENESS MEASURE	Number of providers participating in the Medicaid Program.
	EFFICIENCY MEASURE	Percent change in number of providers participating.
	EFFECTIVENESS MEASURE	Number of Alaskans with online access to health care records and health care education resources (Stage 2 MU).
	EFFICIENCY MEASURE	Percentage of providers who attest to meeting Stage 2 MU requirements to provide online access to patients.
EFFECTIVENESS MEASURE	**Percent of Alaskans in rural communities that can access care.***	
EFFICIENCY MEASURE	**Department cost per percent of Alaskans with access to care.***	
	*** AGGREGATE DIVISION MEASURES - (Percent of Alaskans in rural communities that can access care).**	
	EFFECTIVENESS MEASURE	Number of paid telehealth claims in Medicaid programs.
	EFFICIENCY MEASURE	Travel cost saved where Medicaid telehealth visit replaced travel.
	EFFECTIVENESS MEASURE	Percent of providers participating in telehealth.
	EFFICIENCY MEASURE	Costs avoided from use of telehealth.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE A. STRENGTHEN ALASKAN FAMILIES.

OUTCOME 1. Alaskan families develop work skills.

EFFECTIVENESS MEASURE	**Percent of individuals receiving employment related services from department who achieve employment.**	
EFFICIENCY MEASURE	**Cost of supported employment services per successful participant.**	
	*** AGGREGATE DIVISION MEASURES - (Percent of individuals receiving employment related services from department …)**	
	EFFECTIVENESS MEASURE	Percent of Medicaid recipients who receive subsidized health insurance (HIPP); Percent of Medicaid recipients that participate in the Working Disable Program
	EFFICIENCY MEASURE	Savings realized from paying health insurance premiums; Amount collected for the Working Disable Program

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 3. Health and social service facilities in which Alaskans are served are safe.

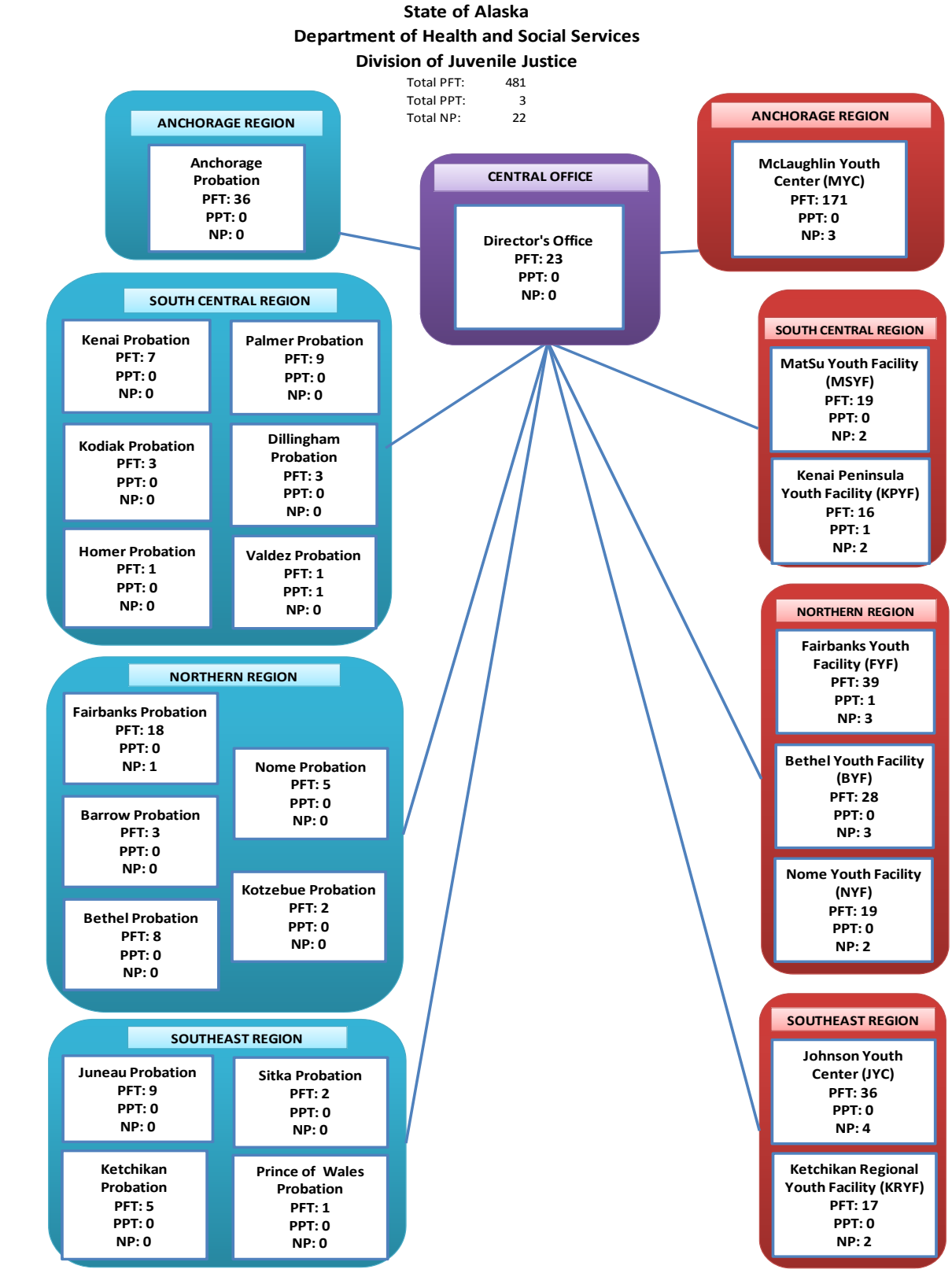
EFFECTIVENESS MEASURE	**Percent of licensed facilities that are free from reports of harm.***	
EFFICIENCY MEASURE	**Cost for licensure functions and oversight.***	
EFFICIENCY MEASURE	**Percent of time that enforcement action is taken within required timeframe. ***	
	*** AGGREGATE DIVISION MEASURES - (Percent of licensed facilities that are free from reports of harm).**	
	EFFECTIVENESS MEASURE	Percent of licensed facilities that are free from reports of harm.

	EFFICIENCY MEASURE	Cost for licensure functions/oversight.
	EFFICIENCY MEASURE	Percent of time that enforcement action is taken within required timeframe.
EFFECTIVENESS MEASURE	**Percent of background checks completed within established timeframes.**	
EFFICIENCY MEASURE	**Cost of administering background check program.**	
EFFICIENCY MEASURE	**Average time to complete final determination.**	

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Health Care Services General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
Health Facilities Licensing and Certification (HFLC)	$ 457.0	$ -	$ -	$ -	$ 457.0
Maintain Civil Penalties Receipts (HFLC)	$ -	$ (60.0)	$ -	$ 60.0	$ -
Reduce Authority Interagency Receipt Authority (HFLC)	$ -	$ -	$ -	$ (80.7)	$ (80.7)
Delete Federal Receipt Authorization Transferred from Public Health in FY2012 (CL)	$ -	$ -	$ (500.0)	$ -	$ (500.0)
ARRA Funding Sec30(b) Ch15 SLA2012 P93 L16-20 (HB284) Lapses 6/30/2013 (MAA)	$ -	$ -	$ 625.4	$ -	$ 625.4
FY2014 Salary and Health Insurance Increases (MAA)	$ 1.4	$ -	$ 2.1	$ 9.2	$ 12.7
Reverse FY2013 MH Trust Recommendation (MAA)	$ -	$ -	$ -	$ (500.0)	$ (500.0)
Reverse-ARRA Funding Sec. 30(b) Ch 15 SLA 2012 P93 L16-20 (HB284) Lapses 06/30/2013 (MAA)	$ -	$ -	$ (625.4)	$ -	$ (625.4)
Transfer to Departmental Support Services for (06-T026) Data Processing Manager IV (MAA)	$ -	$ -	$ -	$ (151.0)	$ (151.0)
Transfer to Public Assistance for Eligibility Information System Replacement Project Positions (MAA)	$ -	$ -	$ -	$ (355.7)	$ (355.7)
FY2014 Salary and Health Insurance Increases (RR)	$ 0.4	$ -	$ 0.2	$ -	$ 0.6
Reverse Rate Settings and Acuity Measurement Systems (RR)	$ (320.0)	$ -	$ (320.0)	$ -	$ (640.0)
Health Care Services Total	***$ 138.8***	***$ (60.0)***	***$ (817.7)***	***$ (1,018.2)***	***$ (1,757.1)***

Division of Juvenile Justice



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

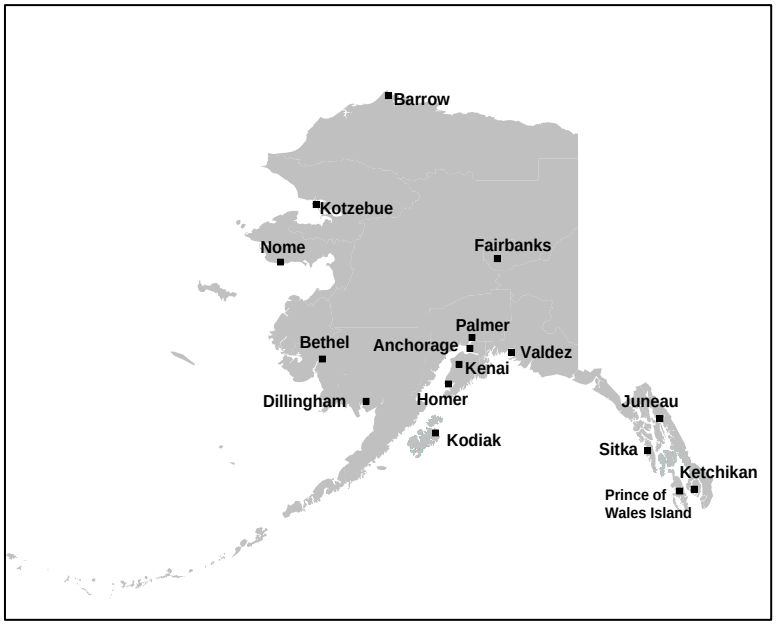
The Division of Juvenile Justice provides supervision and services to juveniles who commit delinquent offenses. The division responds to the needs of juvenile offenders in a manner that supports community safety, prevents repeated criminal behavior, restores the community and victims, and helps youth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

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

Services Provided

Services provided by the Division of Juvenile Justice can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions. Probation Services and Detention and Treatment facilities are located in four regions: Northern, Southcentral, 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 and provide services and supervision to juveniles both on and off the road system.

Probation officers have a number of responsibilities and perform a variety of duties, beginning at the point a juvenile is arrested or identified by law enforcement as the perpetrator of a delinquent offense (an offense that would be a crime if committed by an adult). When police refer a juvenile for having committed a delinquent offense, probation officers review the investigative report to determine if the charges are legally sufficient to support the allegation and provide the legal basis for further action against the juvenile. Once sufficiency and jurisdiction have 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. In some cases, 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 in the community but outside of the home. Approximately 48% 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 both rural and urban community-based services for juveniles 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 the division. The division needs additional foster homes and therapeutic placement options for juveniles. The division is working to develop 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 offender database 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 $550,000 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. The Data and Research Unit ensures the smooth functioning of the Juvenile Offender Management Information System and develops Juvenile Offender Management Information System to address current data collection and extraction needs of the division and the department. This unit partners with department entities and other justice agencies to collectively improve information-sharing mechanisms.

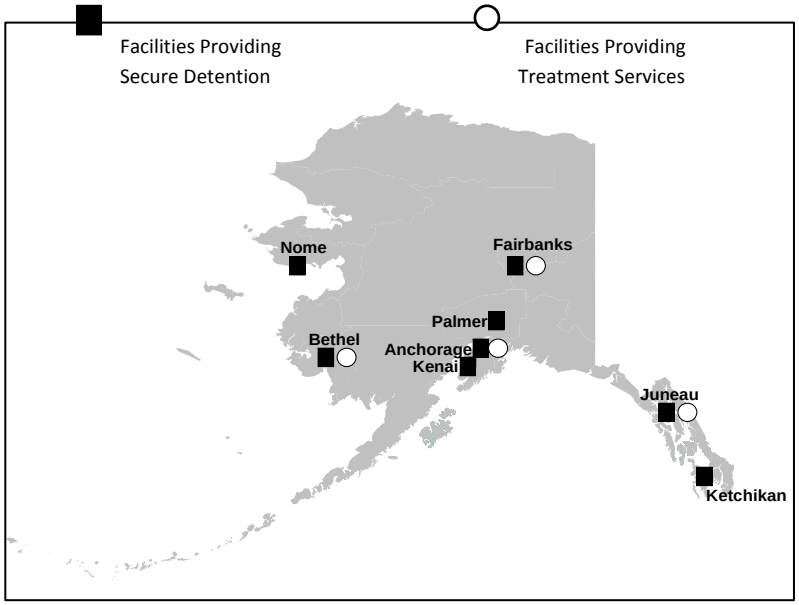
- *Quality Assurance and Training:* The division's Quality Assurance and Training Unit directs resources towards key areas such as facility safety and programming, residential service review and risk/need assessment, and case planning. The division's statewide training specialist works with staff to 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 priority.

- *Policy and Planning:* The Director's Office Policy and Planning Unit 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 serve 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 by this unit. 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 and 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 or placement following charge resolution; and (2) treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. The division operates four detention only facilities, and four facilities with both detention and treatment components.



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

The northern region of the division's probation services is geographically the largest and most remote in Alaska, comprising approximately 66% of the state's total landmass (or roughly twice

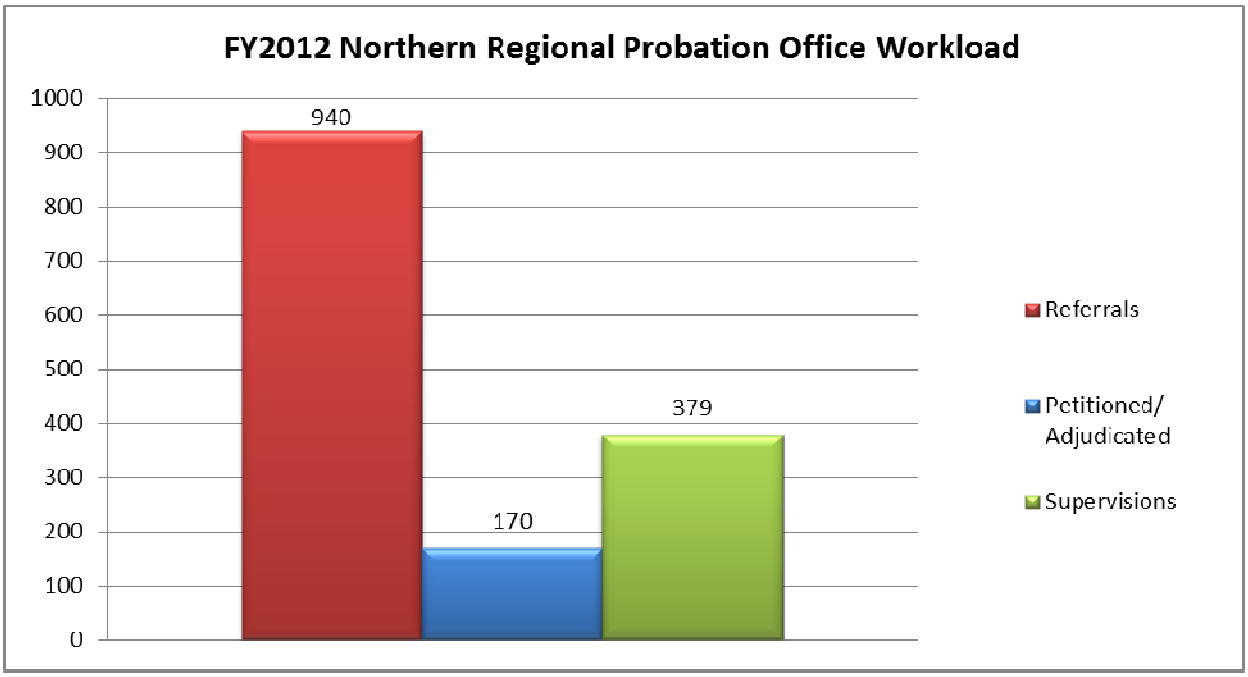
the size of the State of Texas). Much of the region is inaccessible by road and must be visited by small aircraft, boat, or snow machine. Probation services are centered in five district offices located in Fairbanks, Barrow, Bethel, Kotzebue, and Nome. During FY2012 the northern region probation offices received nearly 1,000 delinquency referrals from law enforcement, accounting for over 1,700 separate charges.

The Fairbanks District is the home of the division's second largest probation office. The district 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 with a population of 8,004 (2010 census). 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 the Barrow and Kotzebue districts 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 Diomede. 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, in this case, the northern region 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 of the juvenile probation offices in the northern region, an extensive range of preventive, remediation, assessment and restorative services are provided to division 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

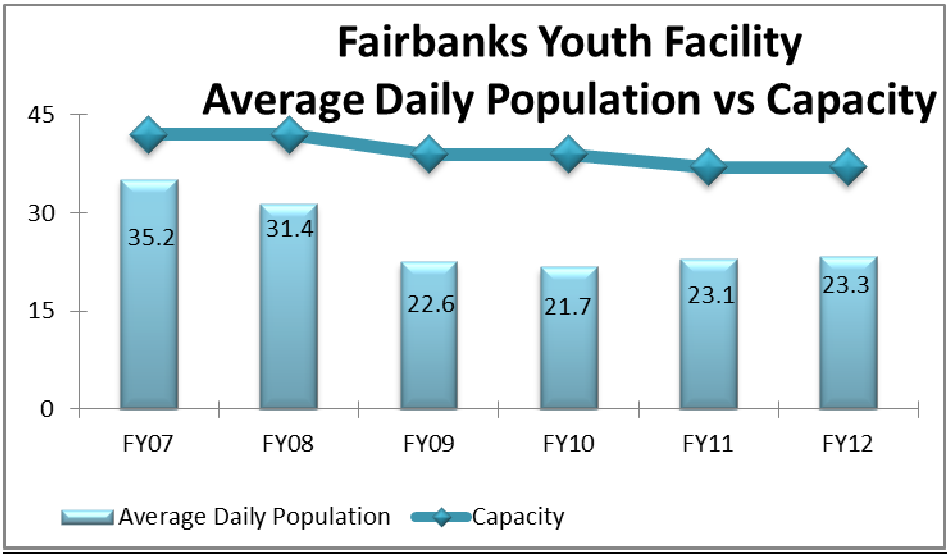
The Fairbanks Youth Facility consists of a 20-bed detention unit and a 17-bed treatment unit. The detention unit provides temporary placement to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court or an appropriate non-detention placement option; in FY2012 the detention unit admitted 201 juveniles. The treatment unit houses and provides rehabilitative services to adjudicated offenders who have been committed to the division by the Court for long-term treatment; in FY2012, 13 juveniles received treatment. Fairbanks Youth Facility is the second largest of Alaska's juvenile correctional facilities. This facility is located in our northern region, which is geographically the largest of the division'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, is an outcome-focused process that encourages consistent system improvement.

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 Fairbanks Youth Facility Program Unit provides care and individual, group, and family treatment for male juveniles who have been committed to the custody of the Department for up to two years or until their 19th birthday, whichever comes first. The increase in the percentage of residents with intensive mental health, Fetal Alcohol Spectrum Disorder, 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 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 the Fairbanks Youth Facility and the capacity went to 37.

Bethel Youth Facility

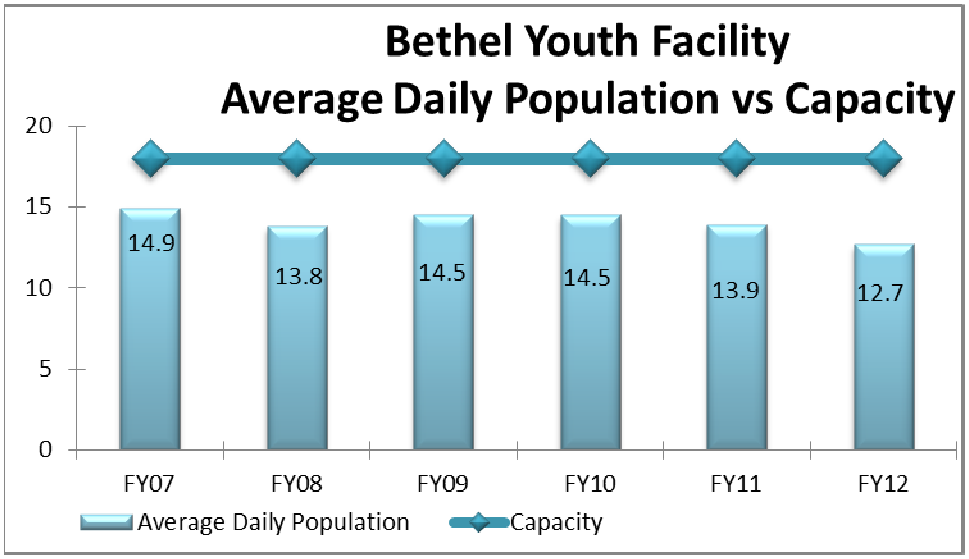
Bethel Youth Facility is the only youth facility in the Yukon-Kuskokwim Delta, an area the size of the State of Oregon that is home to approximately 30,000 people spread between more than 56 villages. The facility consists of an eight-bed co-ed detention unit and an 11-bed treatment unit for male juveniles.

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. The facility makes a clear and consistent effort to ensure the youth in its programs remain in close contact with families and their culture. The use of Alaska Native foods and activities associated with subsistence and traditional crafts help to maintain this connection as does the invaluable involvement with Yupik elders. Each year the facility holds a "culture week" when all staff and residents take part in a celebration that involves community partners.

Core Services

Bethel Youth Facility's detention services provides for the care and secure placement of juveniles involved with a court process or awaiting placement. This detention unit maintains the lowest vacancy level of any division 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 Fetal Alcohol Spectrum Disorder 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.



Nome Youth Facility

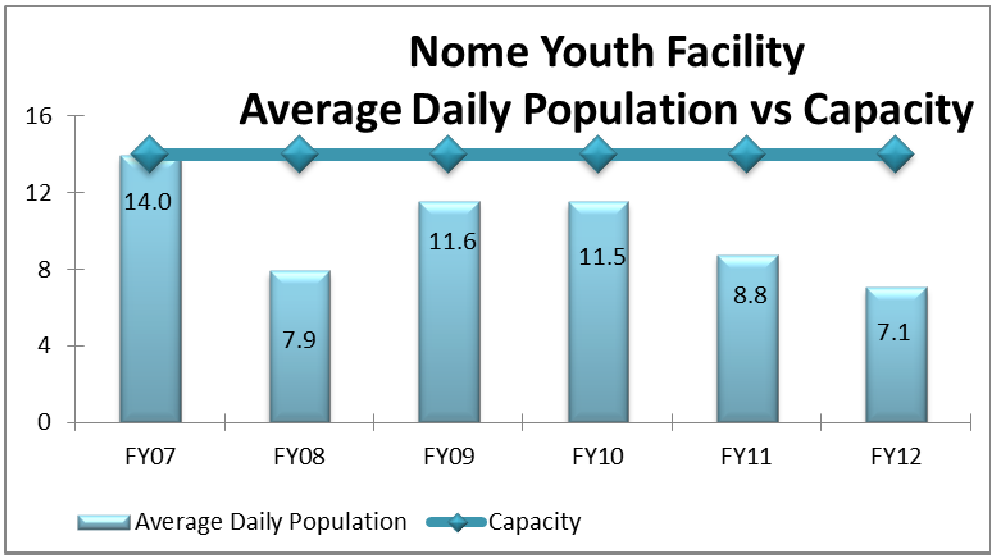
The Nome Youth Facility is a 14-bed therapeutic co-ed detention facility providing supervision, custody, care, and rehabilitative services for accused and adjudicated youth from the communities of Nome, Kotzebue and the 28 surrounding villages. During FY2012, the facility provided these services for 68 youth.

The resident population is primarily male and Alaska Native; most come from outlying villages rather than the population centers. Maintaining a cultural connection for residents is an integral part of the facility's therapeutic approach. A summer "culture camp" and use of a "fish camp" donated by the local native corporation help maintain this cultural relationship. 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 offenses. Many of the youth have a history of substance abuse and/or inhalant abuse.

The Nome Youth Facility continues its successful relationship with the national quality assurance process of Performance-based Standards. The facility is currently working on Level II certification within that process.

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 the facility appears to be less confining than other division detention facilities, the apparent lower security aspects are mitigated by 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 a Nome Youth Facility 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, 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 facility programming. Besides the restorative aspect of this service, the work places an emphasis on helping those in need.



Southcentral Region

Southcentral Probation Services

Southcentral Region Probation Services cover 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. During FY2012, together they received 765 referrals from law enforcement containing 1,609 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.

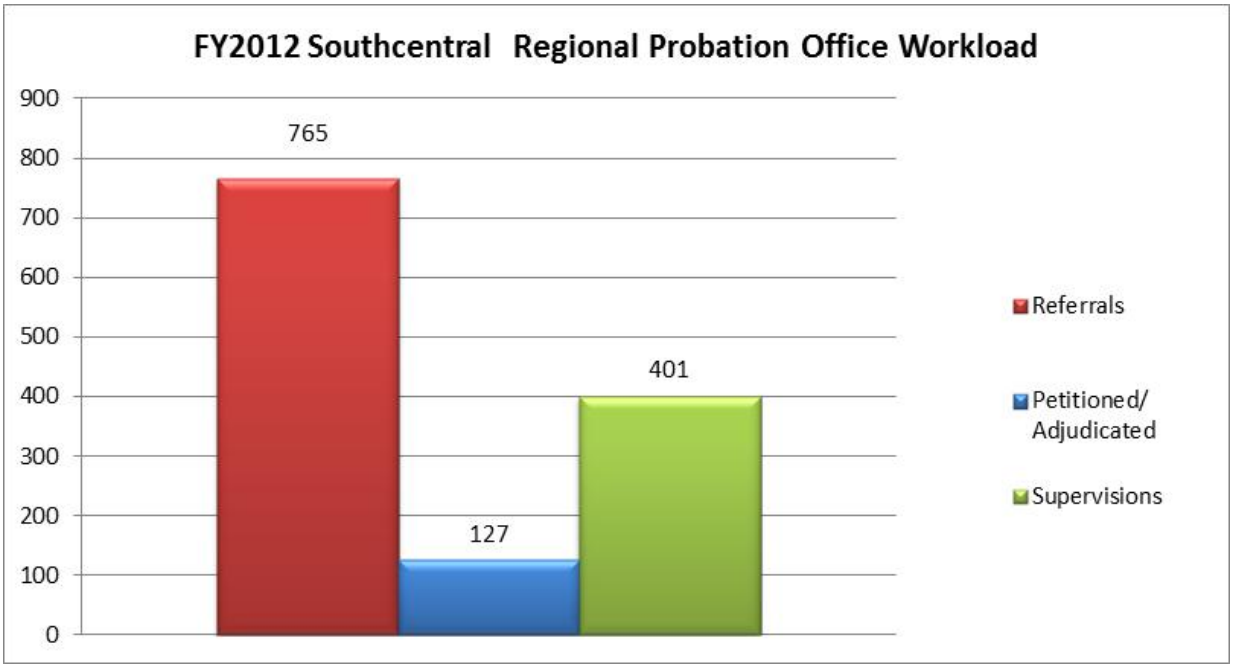
The Mat-Su district serves the Matanuska-Susitna Borough and contains approximately 24,682 square miles and a population of almost 90,000. The population of this district has doubled since 2000 and is the fastest growing area in Alaska.

The south coastal district stretches along the southcentral Alaska coast from Valdez and Cordova though Kodiak southwest through the Aleutian Islands.

Southcentral Probation Core Services

The Southcentral Region provides 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 division correctional facility. In each case the juvenile remains under the supervision of their assigned probation officer. Juveniles leaving correctional treatment are provided additional re-entry and transition services through specialized case management.



Mat-Su Youth Facility

The Mat-Su Youth Facility 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 FY2012 the facility accepted 115 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.

Core Services

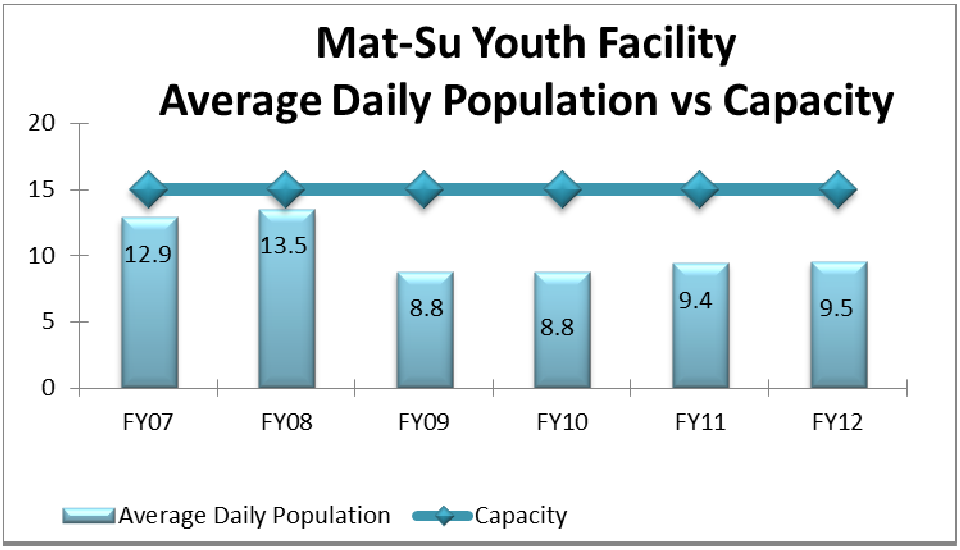
Services provided to residents of Mat-Su Youth Facility focus on education, physical and mental health, substance abuse prevention, victim empathy, and a variety of related activities and groups geared toward competency development and victim restoration. The facility offers educational opportunities and basic group counseling year round. These groups include life skills, healthy relationships, and decision making. In addition to groups led by staff, the facility 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.

The Mat-Su Youth Facility operates a Community Detention Program for youth who do not need the structure of a 24-hour detention setting but still require 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.

Mat-Su Youth Facility has been successful in implementing the national quality assurance process of the Performance-based Standards program. The facility is currently working on Level II certification within that program.



Kenai Peninsula Youth Facility

The Kenai Peninsula Youth Facility 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 are awaiting court action or placement in a foster home, residential treatment, or correctional program. In FY2012, 68 juveniles received services at the facility. The current population in this area is approximately 56,300. The Kenai District Juvenile Probation offices are co-located with the facility.

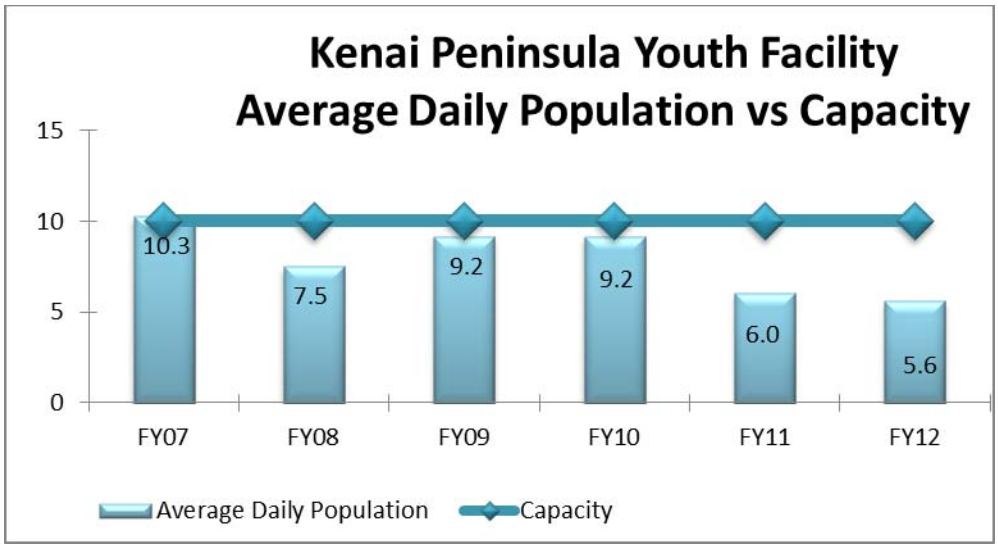
Core Services

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.

Kenai Peninsula Youth Facility has been successful in implementing the national quality assurance process of the Performance-based Standards program. The facility has earned a Level III certification within the four-level system.



Southeast Region

Southeast Region Probation Services

The Southeast Region Probation Services 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 FY2012, the region provided probation services in relation to 545 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.

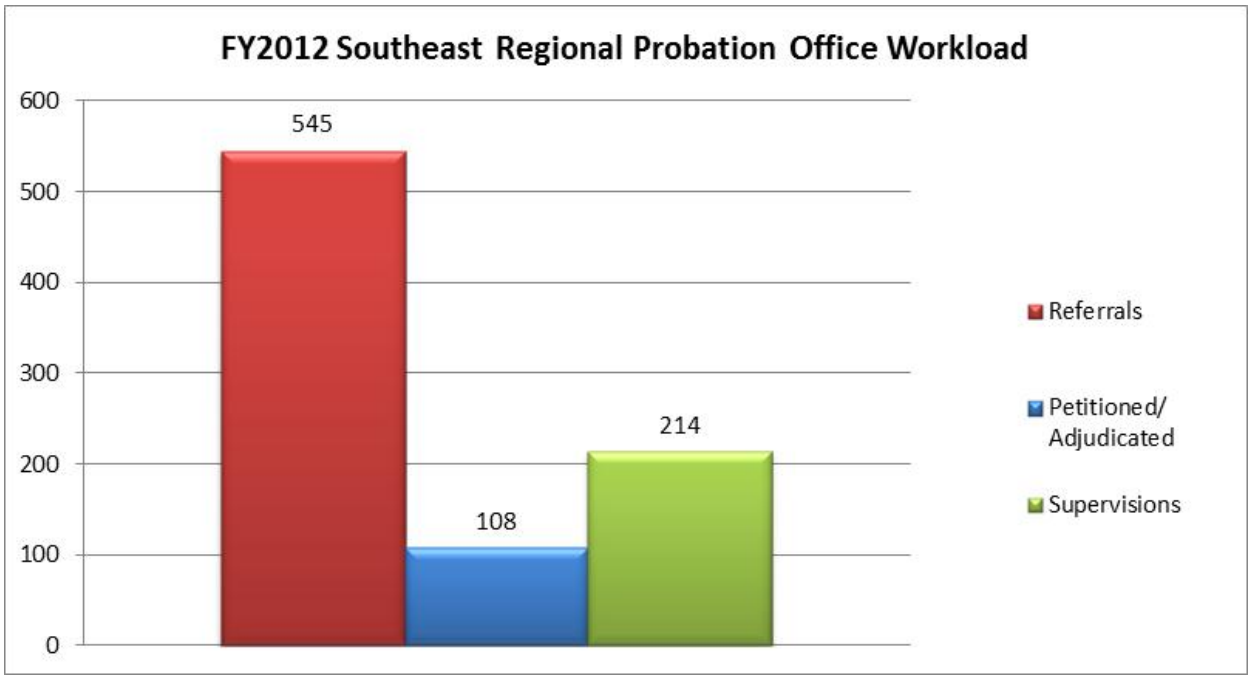
The Sitka district office consists of one juvenile probation officer and one social services associate. It serves the Sitka area as well as Pelican, Elfin Cove, Angoon, Port Alexander, and several outlying fishing and logging camps.

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 in Craig on Prince of Wales Island and serves the surrounding communities.

Core Services

The mission of Southeast Probation Services 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. The region's 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

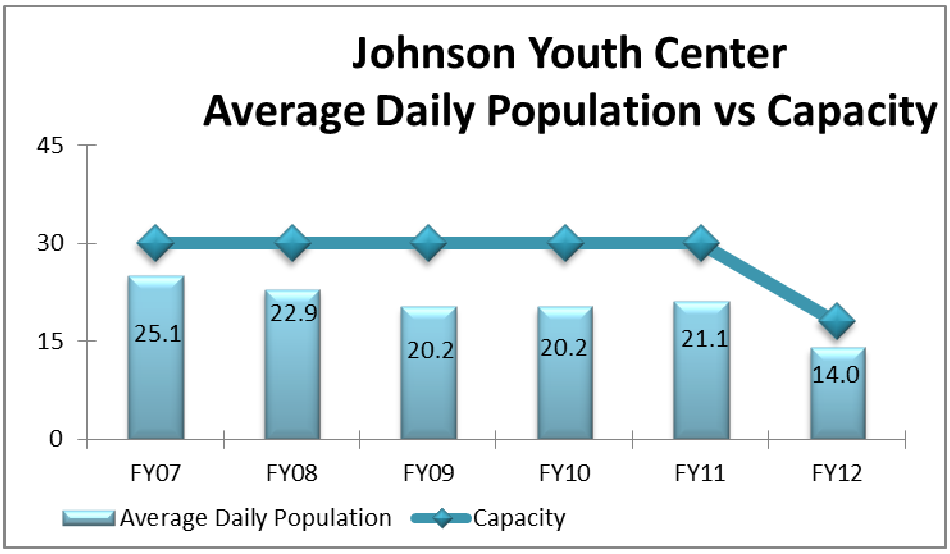
The Johnson Youth Center in Juneau is a facility with a design capacity of 30-beds (8-detention and 22-treatment) that provides short-term, pre-trial detention, control and intervention for juveniles who have been ordered into confinement by the Superior Court due to the danger they present to the public 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 Southeast Probation Services. Capacity of the facility has been reduced for the past year due to renovation of the detention unit, offices of the Juneau District of Probation Services, and regional administration. The renovation required the co-location of detention and treatment units. Renovation is expected to be complete by early 2013 when treatment bed capacity will return to 22 and previously co-located services return to the Johnson Youth Center campus.

Core Services

With two distinct and different programs within the Johnson Youth Center (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 and substance abuse prevention and education.

The 22-bed (designed capacity) 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 and Youth Level of Services/Case Management Inventory instruments are utilized to identify specific individual strengths, needs, and risks of each resident.

Johnson Youth Center has been successful in implementing the national quality assurance process of the Performance-based Standards program. The facility has earned Level III certification within the program.



In FY2012, the Johnson Youth Center renovation began reducing the bed capacity to 18. The bed capacity will return to 28 midway through FY2013.

Ketchikan Regional Youth Facility

The Ketchikan Regional Youth Facility 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 in one location is an innovative feature for a youth facility, both in Alaska and in the United States.

Core Services

The facility's Detention Unit provided secure care and temporary placement to 89 juveniles in FY2012 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.

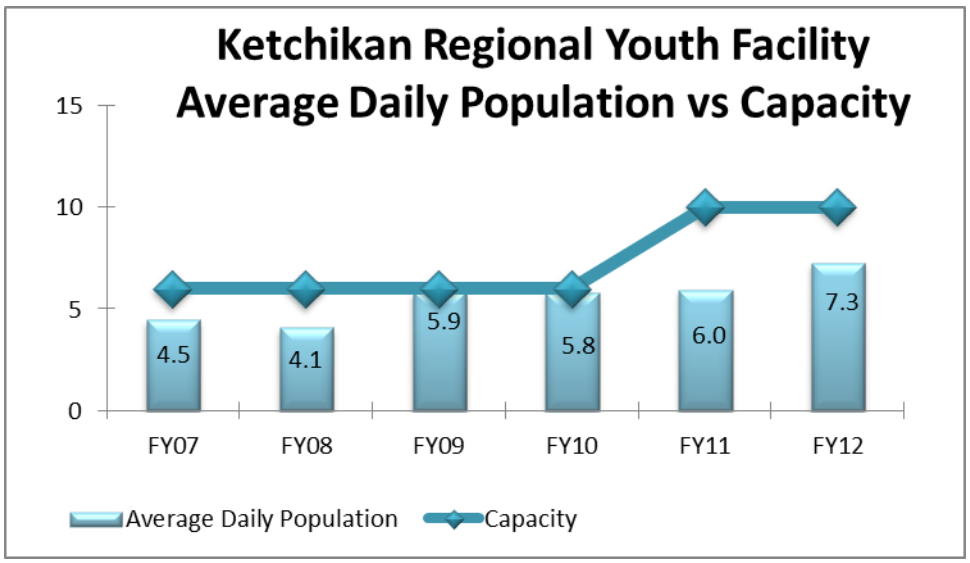
The Crisis Stabilization Unit provides a safe environment for up to four youth in crisis and in need of assessment or evaluation to assist in treatment planning. Services provided are short-term, with a maximum stay of up to 30 days. These services allow youth the opportunity to remain in their community during sub-acute episodes, while still receiving the structure and support necessary for them to promote safety and stability. Resources for the Crisis Stabilization Unit include 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. Eighteen youth were placed in the Crisis Stabilization Unit during the past fiscal year. Use of this unit to provide transitional "step-down" placement for juveniles returning to the community from long-term treatment has begun this year.

Electronic monitoring is 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. Ketchikan Regional Youth Facility 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 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 the facility.

Ketchikan Regional Youth Facility's partnership with the Ketchikan agency Women in Safe Homes has resulted in a series of groups provided by that agency for facility residents. WISH staff and volunteers provide weekly groups on topics such as healthy relationships, domestic violence, bullying, and empathy.

Additionally, the community partner remains a resource for these youth after their release from custody.



Beginning in FY11, the chart includes the 4 Crisis Stabilization Unit beds.

Anchorage Region

Anchorage Probation Services

The Anchorage Regional Probation Office 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 42% of Alaska's delinquency referrals. In FY2012, Anchorage Probation received over 1,600 referrals from law enforcement containing 2,441 individual offenses. Given the size and diversity of Anchorage, Probation Services are 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. Anchorage Probation is the only division probation office staffed seven days a week.

Core Services

The Anchorage Probation Services Intake Unit is the first responder to the majority of delinquency referrals from law enforcement. This unit makes the decisions regarding which 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.

Anchorage Probation Services 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.

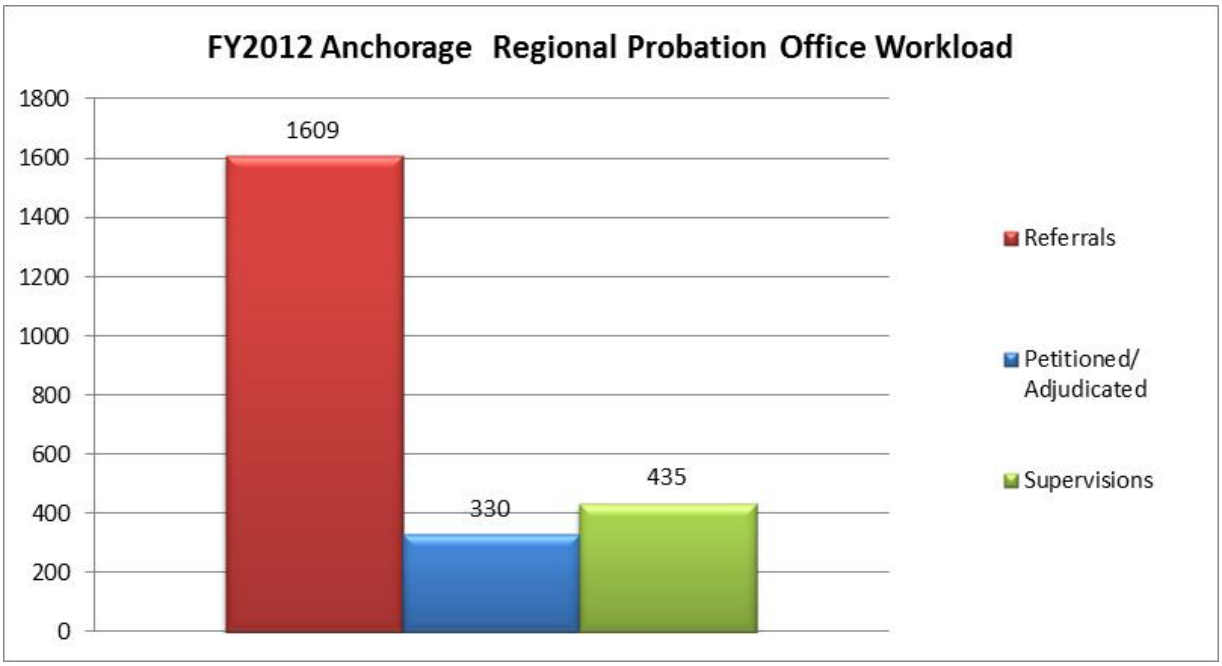
The probation officers in these units are considered to be "school-focused" and work closely with school resource officers from the Anchorage Police Department. The presence of juvenile probation officers in the schools encourages better attendance and better academic and behavioral performance from division 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 is assigned to work with juveniles at all levels of the juvenile justice system that have or are experiencing behavioral health issues. In addition to standard probation services, the unit 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 is located in Anchorage and is the oldest and largest of the division's eight facilities. In FY2012, the facility had 165 beds (60 detention beds and 105 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. In FY2012, the detention program admitted 574 juveniles.

The division'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. McLaughlin Youth Center houses the division's only treatment unit for females and for youth adjudicated on sexual offenses. This system results in McLaughlin receiving long-term placements from all regions of Alaska.

Core Services

Primary among the services provided by McLaughlin Youth Center 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, it 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, the facility 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.

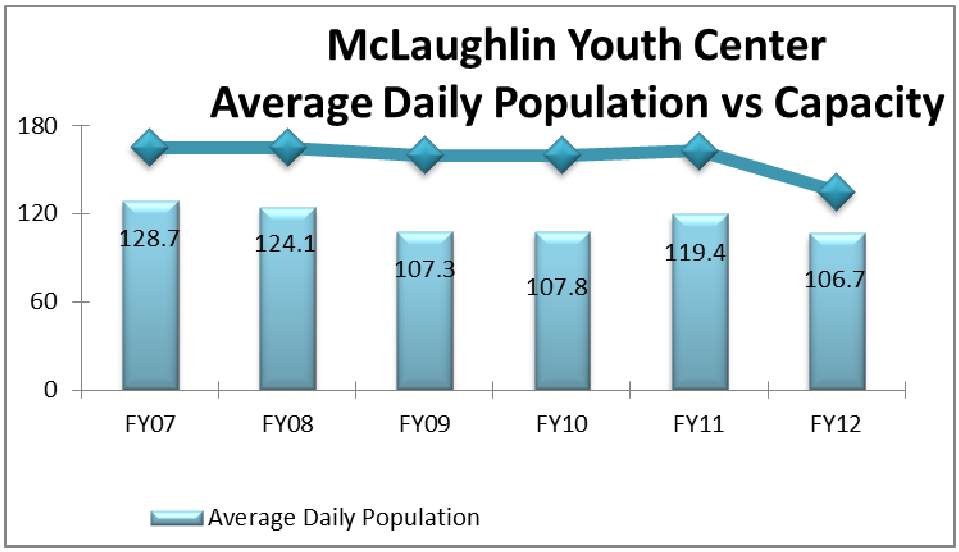
McLaughlin Youth Center's Community Detention program is an "alternative to detention" resource for juveniles who may be released from the detention unit, juveniles being supervised on probation in the community, or those juveniles being informally supervised by the division but who are suspended from school. The program offers academic instruction through the Anchorage School District, therapeutic groups, and opportunities to give back to the community in the form of community work service.

McLaughlin Youth Center's Transitional Services Unit 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. Transitional services 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.

Among the many community partnerships for McLaughlin Youth Center is the collaborative relationship with the Anchorage School District to provide services to suspended and expelled students. This program completed another successful school year in 2011-2012. The initial year of bumps and obstacles led to a solid and effective program that has now expanded. Much of this success can be attributed to the leadership and effort of the facility's juvenile justice staff.

McLaughlin Youth Center has been successful in implementing the national quality assurance process of the Performance-based Standards program. The facility has earned Level II certification in that program.

The chart below indicates the average daily population and capacity during several fiscal years. Beginning in FY2009, the number is reduced to 160 as McLaughlin Youth Center re-evaluated the way they count their beds. In FY2010, the number of beds was reduced by four - two due to the construction project that is currently taking place at the facility, and two that are strictly used as observation rooms. In FY2011, the facility again re-evaluated how beds are counted and the facility had 163 beds. Late in FY2012, the bed count dropped to 135 due to a reorganization effort at McLaughlin, turning one of the detention units into the Court Unit.



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 an agreement with the Alaska Psychiatric Institute that outlines a protocol for juvenile admissions to Alaska Psychiatric Institute and transfers to the Division of Juvenile Justice 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 with the Department of Education and Early Development to ensure youth within Division of Juvenile Justice 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 Michael Geraghty. 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 Division of Juvenile Justice 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. This program expanded to include middle-school age youth this year.

- The division has two Memorandums of Agreement with the Office of Children's Services: one outlines programmatic responsibility for shared resource areas, such as foster care and residential services; the second agreement 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 the Division of Juvenile Justice. This team works to ensure the success of the Bring the Kids Home project.

- The division has developed a partnership with the Division of Behavioral Health, the Mental Health Trust Authority, and other organizations to work on the Comprehensive Integrated Mental Health Plan for the department.

- For the past several years, the division 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.

- The Division of Juvenile Justice 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 division's 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, the division is collaborating with the federal Tribal Youth Program staff responsible for coordinating Tribal Youth Program services in Alaska and assisting community groups in Fairbanks and Anchorage to directly address Disproportionate Minority Contact in their communities.

- The division has a Memorandum of Agreement 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.

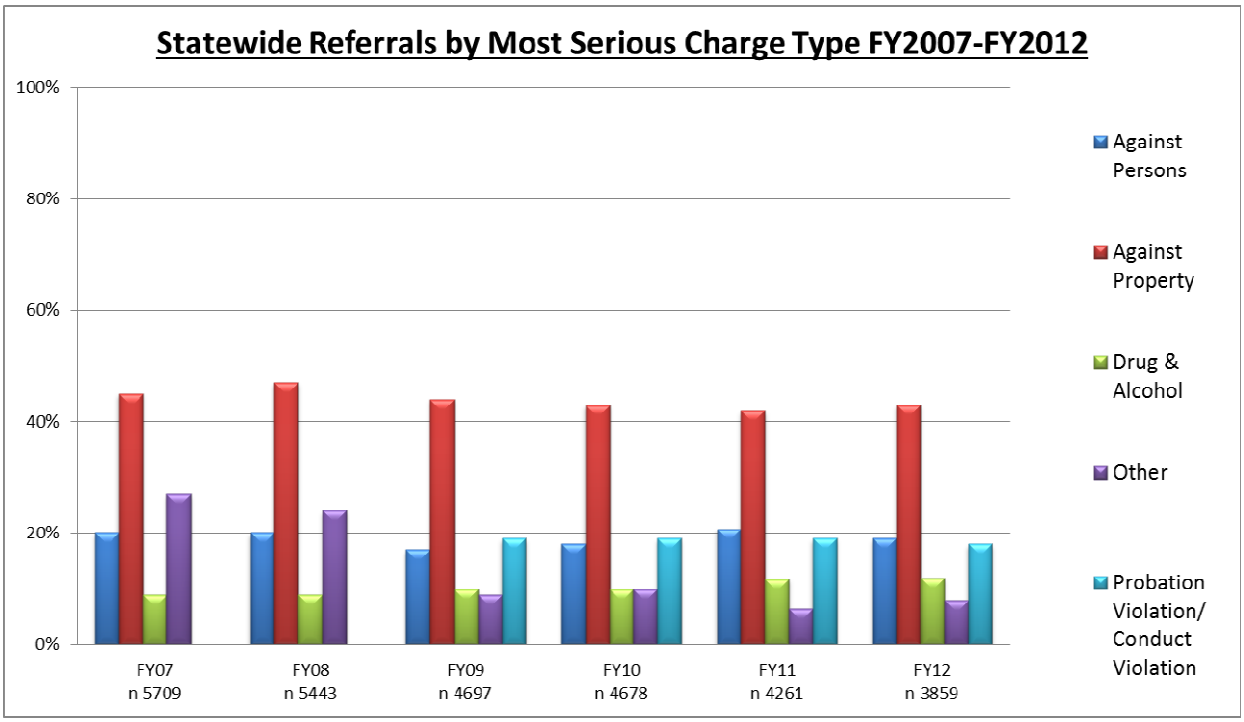
The division continues to incorporate the goals of its FY2003 "system improvement initiative" into its routine practice. This initiative was launched to help guarantee that the Alaska juvenile justice system is using its resources effectively and efficiently, that decisions are based on objective criteria, and that the agency is continually using data to improve the quality of services offered. These initiatives include:

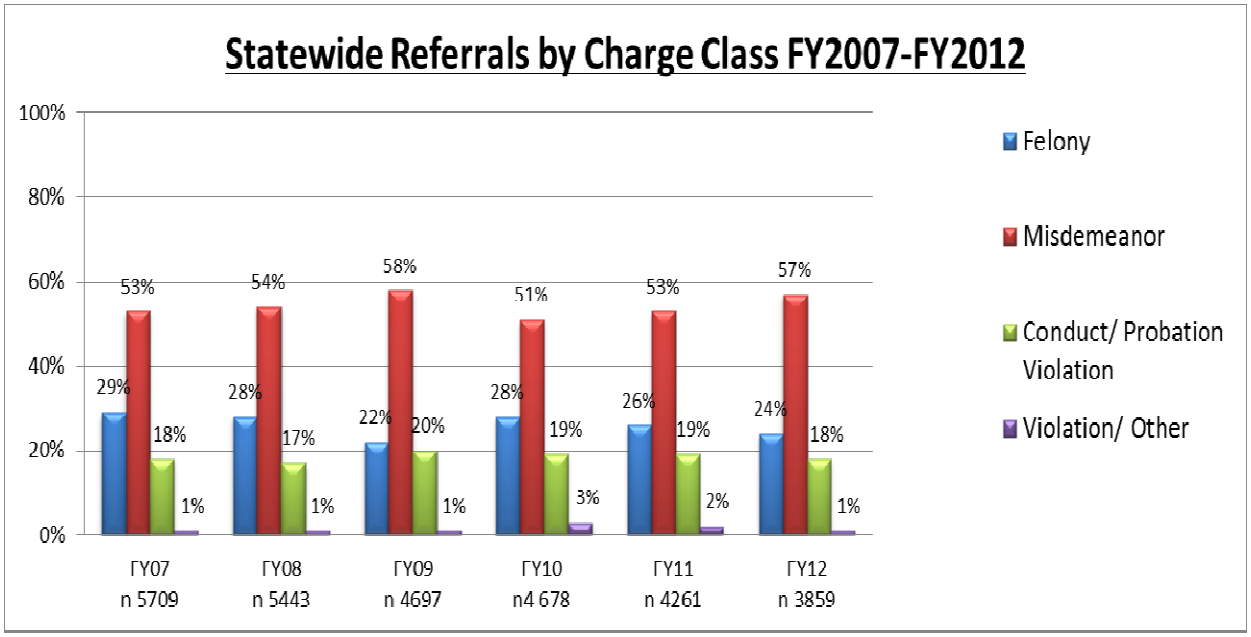
- The use of assessment instruments to assist staff in accurately determining a youth's risk of re-offense and need for secure detention including the Youth Level of Services/Case Management Inventory, Detention Assessment Instrument, and the Massachusetts Youth Screening Instrument-2.
- A quality assurance 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 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.

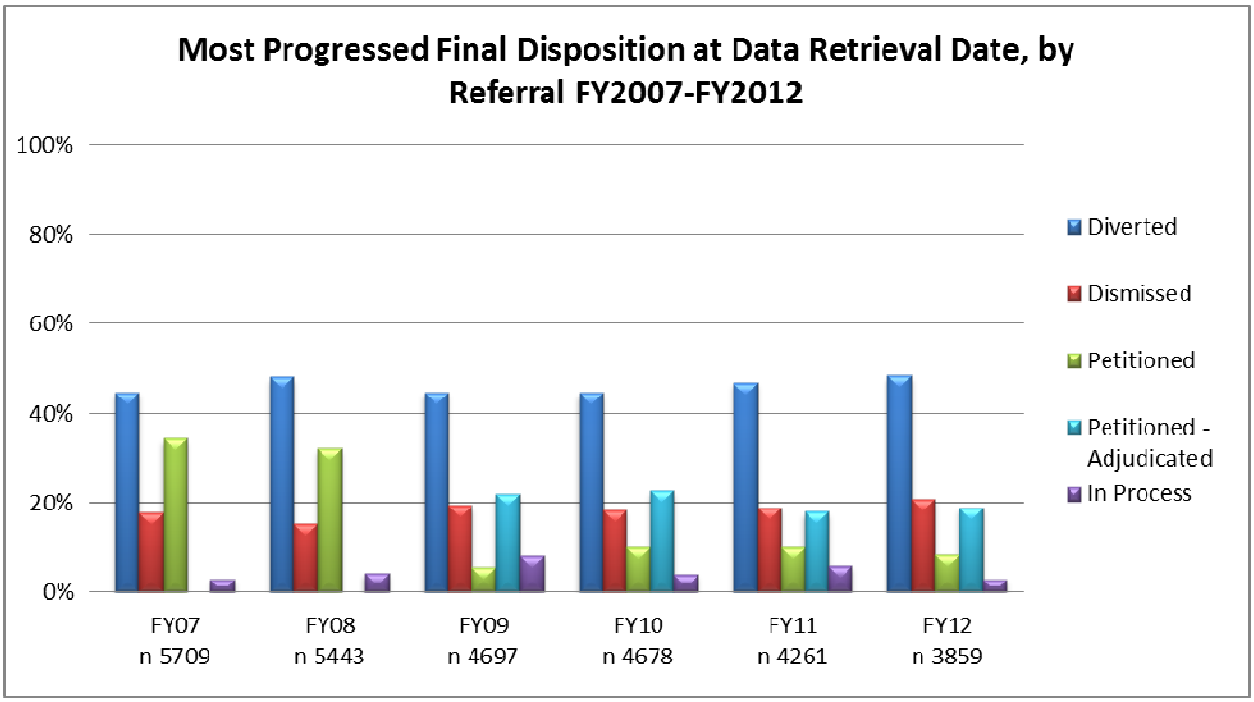
In FY2014, the division's leadership will continue to incorporate these system improvement projects into the strategic plan and vision for juvenile justice in Alaska. The system improvement projects will improve public safety, ensure that victim needs are met, and ensure offenders are being held accountable.

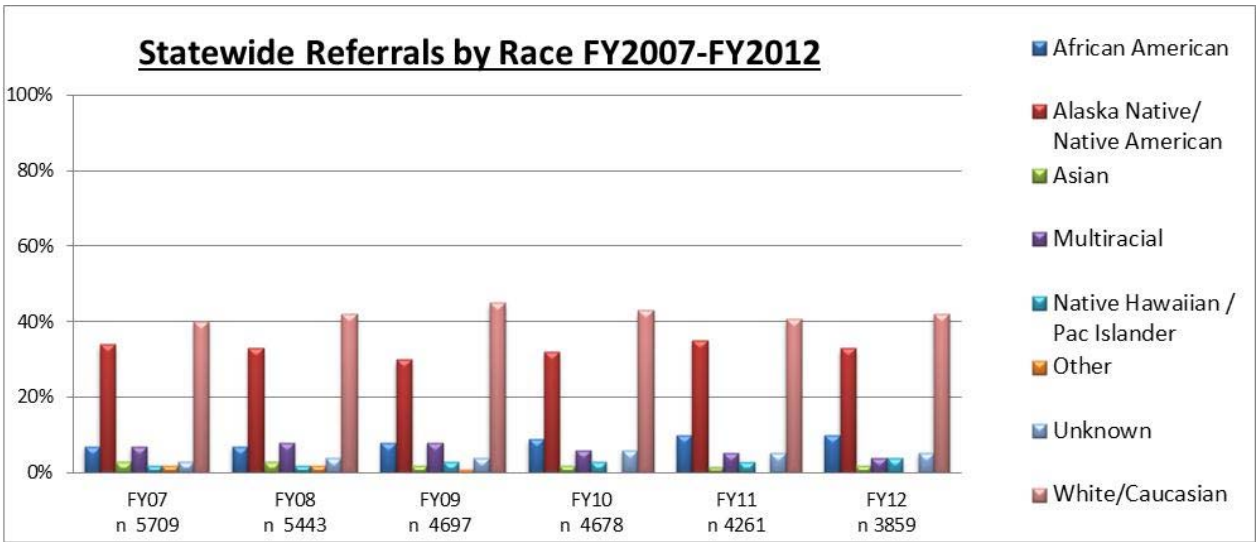
FY2012 Delinquency Referral Summaries

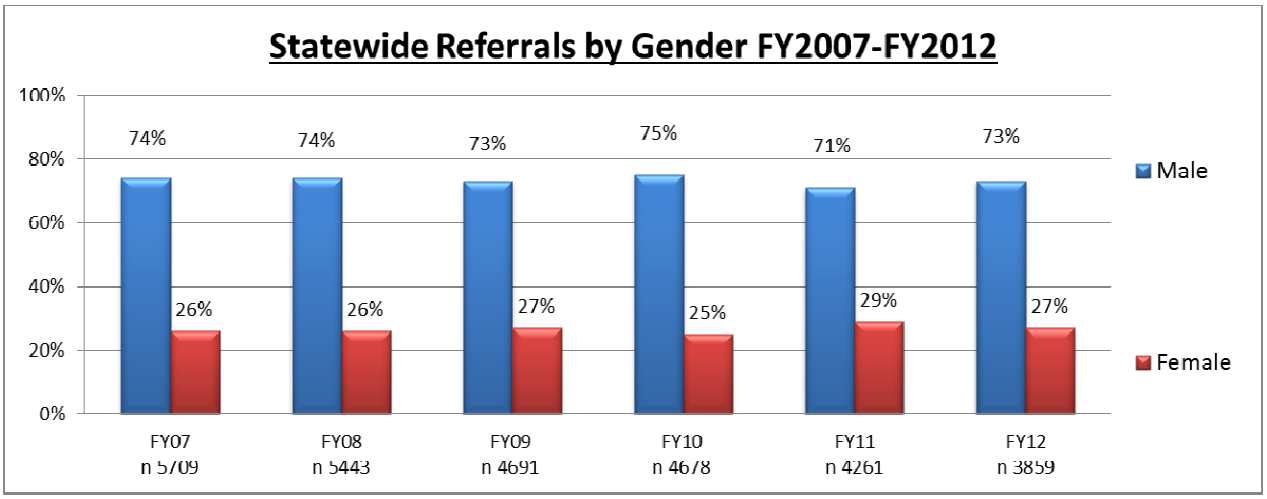
The following charts provide a summary of referrals for FY2007 through FY2012.






Most Progressed Final Disposition at Data Retrieval Date, by Referral FY2007-FY2012
100%
80%
60%
40%
20%
0%
FY07 n 5709
FY08 n 5443
FY09 n 4697
FY10 n 4678
FY11 n 4261
FY12 n 3859
Diverted
Dismissed
Petitioned
Petitioned - Adjudicated
In Process


Statewide Referrals by Race FY2007-FY2012
100%
80%
60%
40%
20%
0%
FY07 n 5709
FY08 n 5443
FY09 n 4697
FY10 n 4678
FY11 n 4261
FY12 n 3859
African American
Alaska Native/ Native American
Asian
Multiracial
Native Hawaiian / Pac Islander
Other
Unknown
White/Caucasian



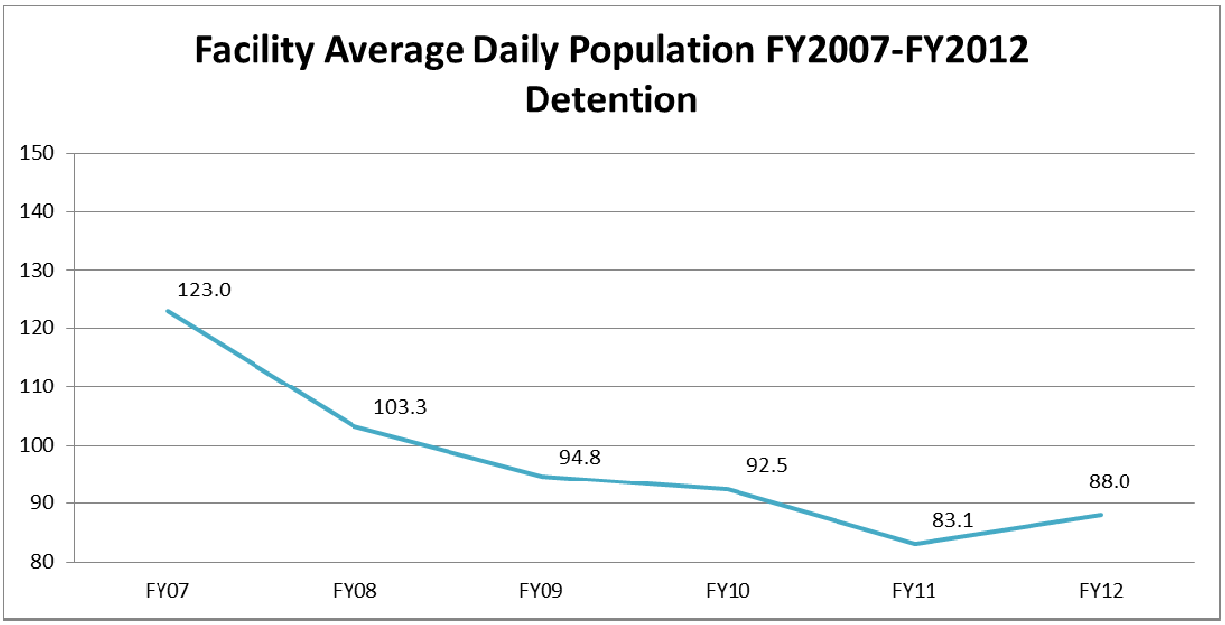
The table below shows the bed capacity at each of the division's secure juvenile facilities at the end of FY2012.

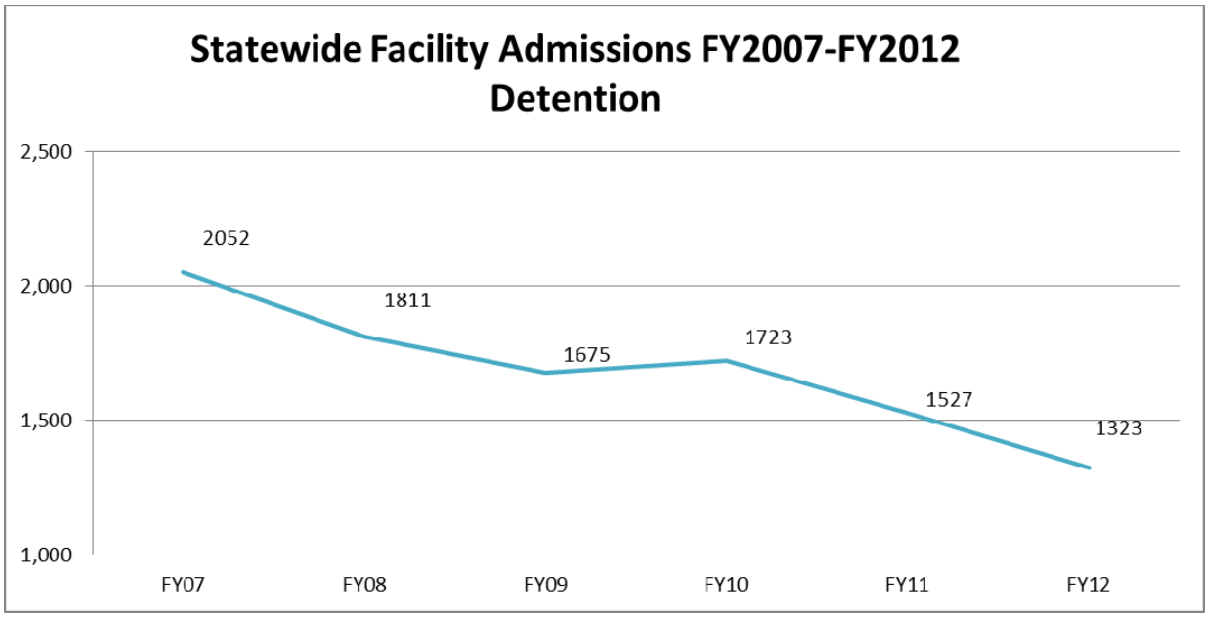
Youth Facility Existing Hard Bed Capacity FY2012			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	163	-28	135
Mat-Su Youth Facility	15		15
Kenai Peninsula Youth Facility	10		10
Fairbanks Youth Facility	37		37
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Johnson Youth Center	30	-12	18
Ketchikan Youth Facility	10		10
Total	297	-40	257

Facility Data

Detention Units

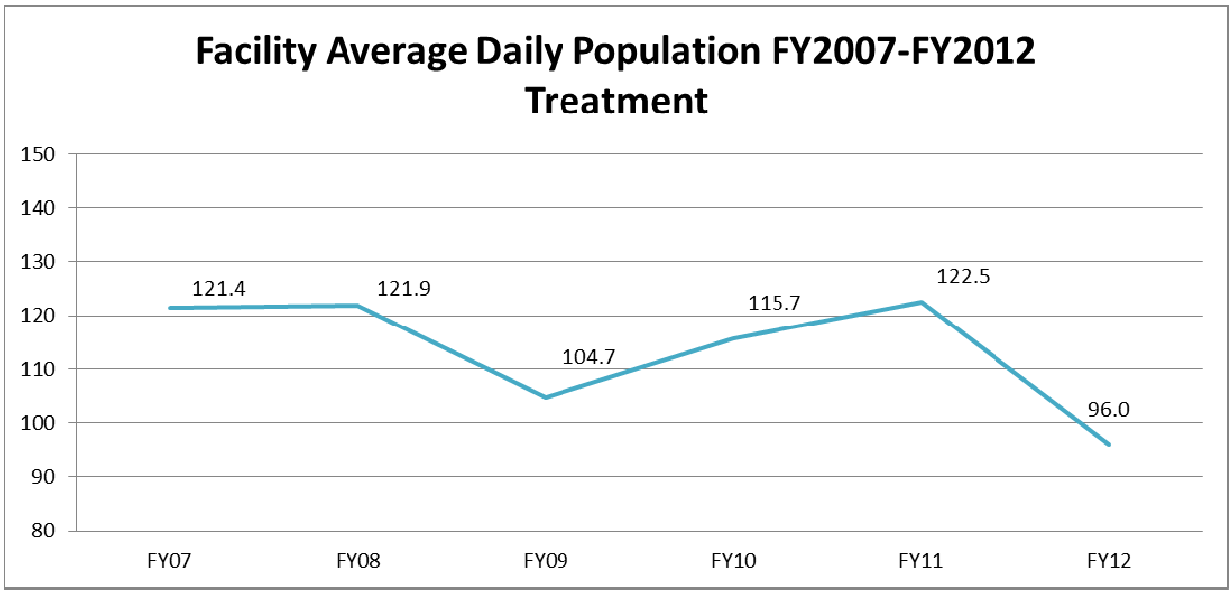
The charts below show juvenile detention average daily population and admissions from FY2007 through FY2012. Detention units are designed as short-term secure units for youth who are awaiting court hearings and other determinations of outcome on their offenses. Statewide detention capacity in FY2012 was 117 beds.

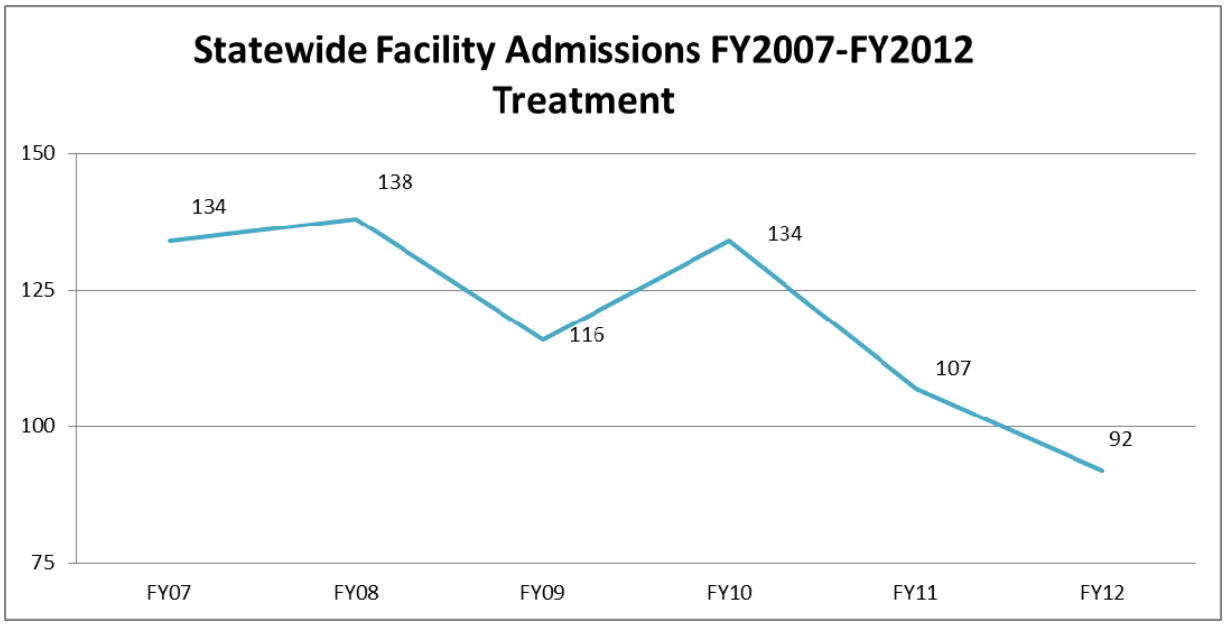




Treatment Units

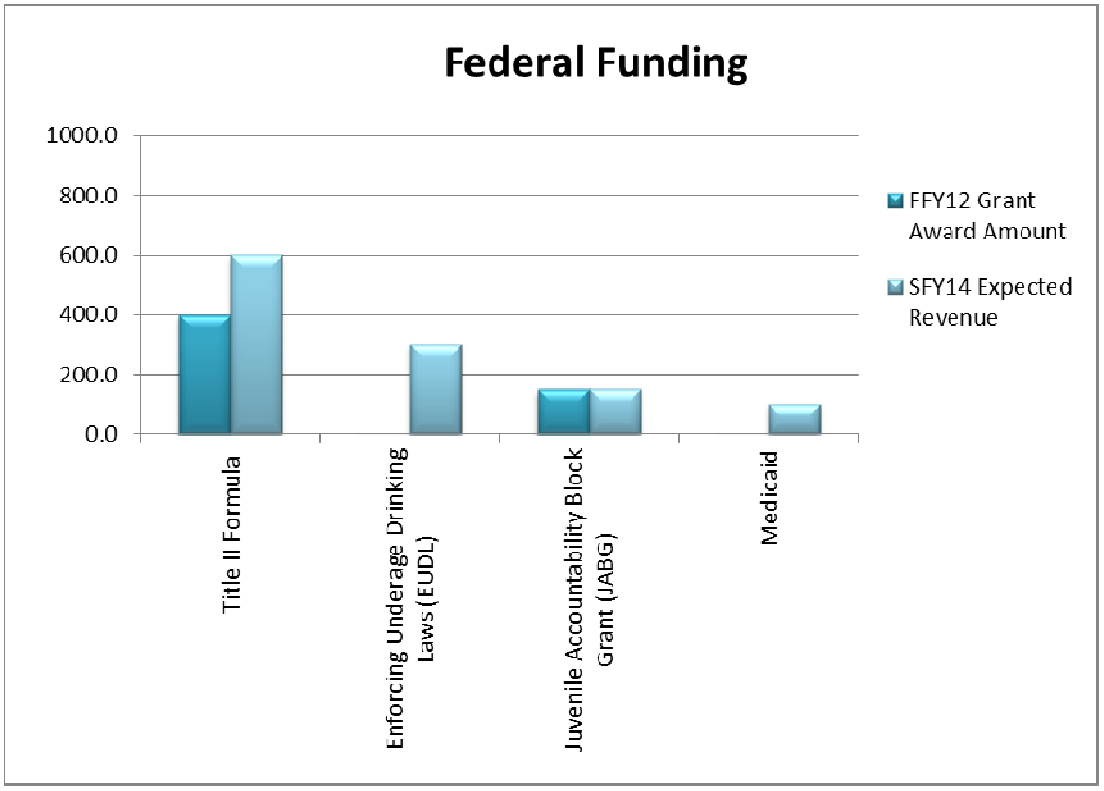
Below are charts showing juvenile program average daily population and admissions from FY2007 through FY2012. Treatment units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY2012 was 140, including the 4 unlocked crisis stabilization beds located at the Ketchikan Regional Youth Facility.


Facility Average Daily Population FY2007-FY2012
Treatment
150
140
130
120
110
100
90
80
121.4
121.9
104.7
115.7
122.5
96.0
FY07
FY08
FY09
FY10
FY11
FY12


Statewide Facility Admissions FY2007-FY2012
Treatment
150
125
100
75
134
138
116
134
107
92
FY07
FY08
FY09
FY10
FY11
FY12

Federal Funding

The Alaska Juvenile Justice Advisory Committee is the federally mandated state advisory group to the division. The committee collaborates with the Division of Juvenile Justice by advising on priorities for spending federal funds and juvenile justice programming with particular emphasis on juvenile justice system improvements. The committee 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 FFY2012 grant programs and budgeted revenues for SFY2014. 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

Statutes

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 of 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

Regulations

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

Division of Juvenile Justice

Budget Overview Table

Juvenile Justice	FY2013	FY2014 Gov	Difference
General Fund	$55,060.5	$55,566.8	$506.3
Federal Fund	1,812.3	1,812.3	0.0
Other Funds	1,351.6	1,424.1	72.5
Total	**$58,224.4**	**$58,803.2**	**$578.8**

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

FY2014 Budget Requests

McLaughlin Youth Center

FY2014 Salary and Health Insurance Increases: $18.3 Total -- $18.3 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Federal Authority to Delinquency Prevention Component: $-1.0 Total -- -$1.0 Fed

This change record moves $1.0 of federal authority from the McLaughlin Youth Center component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Health Services for Youth in Juvenile Justice Facilities: $400.0 Total -- $400.0 GF

For the last several years, the Division of Juvenile Justice has required supplemental funding to cover the cost of health (medical, psychiatric, dental, etc.) services that youth in our secure, locked facilities require. The division has looked at the average cost for the last three years for each facility and what is currently in the budget to cover these costs. Below is the anticipated amount needed for the McLaughlin Youth Center component to cover health service costs, based on a three-year average:

	Contracted Medical Expenses	Direct Client Services
Three Year Average	$320.5	$555.0
Budgeted	$134.5	$130.0
Difference	**$186.0**	**$425.0**

Transfer Authority to Probation Services and Bethel Youth Facility Components to Align with Vacancy Factor Guidelines: -$287.8 Total -- -$287.8 GF

Transfer personal service authority from the McLaughlin Youth Center component to the Probation Services and Bethel Youth Facility components to cover anticipated FY2014 expenditures. McLaughlin has had some vacancies that when filled will be filled at a lower step than the incumbents that vacated the position.

This transfer of authority will assure that the Probation Services component will not be forced to budget with an 8.4% vacancy factor, and that the Bethel Youth Facility will not be budgeted with a 5.9% vacancy factor. Both of these are more than what is allowed for components their size.

Transfer Juvenile Justice Officer PCN 06-4823 to Administrative Support Services Component (One Full-Time PCN Agency Transfer Out)

The Division of Juvenile Justice is transferring PCN 06-4823 to the Departmental Support Services division, Administrative Support Services component. This position will coordinate departmental training and make recommendations for an online learning management system. This position is available due to some reorganization at the McLaughlin Youth Center.

Issue: Training within the department is conducted inconsistently; some divisions/sections have comprehensive, modern tools and approaches to training, while others have a minimally coordinated effort that depends on person-to-person exchanges of information. The department's online training also consists of mainly uncoordinated efforts, which is costly in training deployment, administrative overhead, and redundant funding of multiple systems.

Solution: This position will deliver core training and oversee efforts to achieve more coordination, and effective use of department-wide training resources for the maximum benefit of department staff. This position will perform an assessment of department training, and convene a committee of division subject matter experts to make recommendations to the department's leadership group.

Mat-Su Youth Facility

FY2014 Salary and Health Insurance Increases: $1.5 Total -- $1.5 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Uncollectible Authority to Delinquency Prevention: -$0.5 Total -- -$0.5 Fed

Transfer $0.5 of federal authority from the Mat-Su Youth Facility component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid

Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Align Authority for Food Services Provided (Line Item Transfer)

The Mat-Su Youth Facility will no longer enter into an agreement with the Alaska Pioneer's Home for the use of their kitchen for meal preparation. The Division has entered into an agreement with a new vendor that will provide and prepare the meals for the facility.

Kenai Peninsula Youth Facility

FY2014 Salary and Health Insurance Increases: $1.5 Total -- $1.5 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Uncollectible Authority to Delinquency Prevention: -$1.0 Total -- -$1.0 Fed

Transfer $1.0 of federal authority from the Kenai Peninsula Youth Facility component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Fairbanks Youth Facility

FY2014 Salary and Health Insurance Increases: $3.1 Total -- $3.1 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Uncollectible Authority to Delinquency Prevention: -$4.5 Total -- -$4.5 Fed

Transfer $4.5 of federal authority from the Fairbanks Youth Facility component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Align Authority for Food Services Provided by the Department of Corrections (Line Item Transfer)

The Fairbanks Youth Facility will no longer enter into an agreement with the Alaska Pioneer's Home for the use of their kitchen for meal preparation. The Division has entered into an agreement with the Department of Corrections to prepare the meals for the facility. The cost for this service will be recorded under the commodities line for food.

Bethel Youth Facility

FY2014 Salary and Health Insurance Increases: $1.6 Total -- $1.6 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Uncollectible Authority to Delinquency Prevention: -$3.0 Total -- -$3.0 Fed

Transfer $3.0 of federal authority from the Bethel Youth Facility component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Transfer from McLaughlin Youth Center to Comply with Vacancy Factor Guidelines: $76.3 Total -- $76.3 GF

Transfer personal service authority from the McLaughlin Youth Center component to the Bethel Youth Facility component to cover anticipated FY2014 expenditures. McLaughlin has had some vacancies that when filled will be filled at a lower step than the incumbents that vacated the position.

This transfer keeps this component within the recommended vacancy guidelines provided by the Office of Management and Budget.

Nome Youth Facility

FY2014 Salary and Health Insurance Increases: $1.4 Total -- $1.4 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Uncollectible Authority to Delinquency Prevention Component: -$2.0 Total -- -$2.0 Fed

Transfer $2.0 of federal authority from the Nome Youth Facility component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Johnson Youth Center

FY2014 Salary and Health Insurance Increases: $1.8 Total -- $1.8 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Transfer Federal Authority to Delinquency Prevention Component: -$2.2 Total -- -$2.2 Fed

Transfer $2.2 of federal authority from the Johnson Youth Center component to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in this component. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Align Authority for Food Services Provided by the Department of Corrections (Line Item Transfer)

The Johnson Youth Center will no longer enter into an agreement with the Alaska Pioneer's Home for the use of their kitchen for meal preparation. The Division of Juvenile Justice has

entered into an agreement with the Department of Corrections to prepare the meals for the facility. The cost for this service will be recorded under the commodities line for food.

Ketchikan Regional Youth Facility

FY2014 Salary and Health Insurance Increases: $1.4 Total -- $1.4 GF

This increase covers negotiated employer coverage for health insurance and salary for Labor, Trades and Crafts employees within this component.

Align Authority for Food Services Provided (Line Item Transfer)

The Ketchikan Regional Youth Facility will no longer enter into an agreement with the Alaska Pioneer's Home for the use of their kitchen for meal preparation. The Division has entered into a contract with a local vendor that provides complete meal service for the facility. The cost for these meals will be recorded on the commodities line item under food.

Probation Services

MH Trust: Grant 4688 Division of Juvenile Justice Trauma Informed Care: $150.0 Total - $75.0 GF/MH, $75.0 MHTAAR

This project is a partnership between The Trust and the Department of Health and Social Services, Division of Juvenile Justice. It will support the division's efforts to implement Trauma Informed Care approach and principles statewide in its youth facilities and community supervision programs. In 2009, 70% of youth surveyed at the McLaughlin detention unit reported some history of traumatic abuse/neglect. Assisting the Division of Juvenile Justice implement this approach statewide will increase the staff recognition regarding the pervasiveness of trauma experienced by youth, their understanding of the connection between a history of trauma and a youth's challenging behaviors, an emphasis on increasing youth emotional and behavioral regulations through coping skills and how to foster positive relationships with the youth. This will result in a decrease in youth requiring a restraint and/or room confinement, an overall increase in safety for staff and youth and overall more positive outcomes for youth involved with the division.

MH Trust: Grant 4302.01 Mental Health Clinician Oversight in Youth Facilities: $152.9 Total -- $152.9 MHTAAR

The MH Trust: Disability Justice - Mental Health Clinician Oversight in the Division of Juvenile Justice Youth Facilities is a position to provide supervisory oversight to mental health clinicians 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 the division's 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. Currently, Division of Juvenile Justice mental health clinical staff are located in six locations and provide services in eight juvenile facilities and two probation offices statewide. The division 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 3504.02 Division of Juvenile Justice Rural Re-entry Specialist: $110.9 Total -- $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.

Reverse FY2013 Mental Health Trust Recommendation: -$266.3 Total -- -$266.3 MHTAAR

This zero-based adjustment record includes all MHTAAR and/or Mental Health Trust Admin funding for FY2013 for this component.

FY2014 Salary and Health Insurance Increases: $0.7 Total -- $0.7 GF

This increase covers negotiated employer coverage for health insurance and salary for non-covered employees within this component.

Transfer Personal Service from the McLaughlin Youth Center to Comply with Vacancy Factor Guidelines: $211.5 Total -- $211.5 GF

Transfer personal service authority from the McLaughlin Youth Center component to the Probation Services component to cover anticipated FY2014 expenditures. McLaughlin has had some vacancies that when filled will be filled at a lower step than the incumbents that vacated the position.

This transfer of authority will keep the Probation Services component within the recommended vacancy guidelines provided by the Office of Management and Budget.

Delinquency Prevention

Transfer Excess Federal Authority from Various Components within Juvenile Justice: $14.2 Total -- $14.2 Fed

Transfer $14.2 of federal authority from various facility components (McLaughlin Youth Center, Mat-Su Youth Facility, Kenai Peninsula Youth Facility, Fairbanks Youth Facility, Bethel Youth Facility, Nome Youth Facility, and the Johnson Youth Center) to the Delinquency Prevention component. There have been very few opportunities to collect federal Medicaid Admin in these components. Rather than continue to carry federal authority that won't be collected or spent, the division will move the authority to the Delinquency Prevention component.

Youth Courts

Align Authority to Cover Cost of Program Coordinator I (PCN 06-4946) (Line Item Transfer)

Align authority to fund a portion of a position that administers the youth court grants. This position (PCN 06-4946) has been split between this component and the Probation Services

component. By having the position split, the Division of Juvenile Justice will avoid requesting revised programs through the Office of Management and Budget to move authority from this line item to the personal services line item to cover these expenditures.

Explanation of FY2014 Capital Budget Requests

Bethel Youth Facility Renovation, Phase II: $10,600.0 Total -- $10,600.0 GF

This capital request will completely fund all the remaining design and construction costs that will incorporate 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.

During initial planning utilizing the FY2013 funding, it was determined that the State may save dollars if the population of the existing facility could be temporarily housed elsewhere. If the building was unoccupied, the amount of construction time could be conceivably reduced by one year. A service relocation cost and benefit analysis will be performed that will determine if relocating the detention and probation services off site is possible, the cost of such a move, and whether this cost is justified through time and money saved by allowing the contractor complete and unfettered access to the facility.

Equipment Needs for Front-Line Probation Officers, Juvenile Justice Officers and Facilities: $267.5 Total -- $267.5 GF

This request will go toward purchasing the following for our staff and offices:

- Soft Body Armor/Ballistic Vests: The lifespan of a ballistic vest is five years before they must be replaced; as new staff come on board, they need to be fitted with a vest so that it is effective if the need should arise. In addition as more and more of our juvenile justice officers work with youth within the community, it is important that they be protected with these vests. Each vest costs approximately $.6 each and we can purchase up to 25 per year for a total annual cost of $15.0.
- Jackets/Officer ID: It is critical that Division Juvenile Probation Officers, Juvenile Justice Officers, and Social Service Associates wear gear that identifies them as division staff when they are in the public for safety and security reasons. These jackets run approximately $300 each and we may purchase up to 25 per year for a total cost of $7.5 per year.
- Training supplies such as cardiopulminary resusitation mannequins for staff. Annual trainings are required for staff. When supplies wear out they need to be replaced. $10.0.
- Replacement of recreational equipment for facilities around the state. This may include skis, snowshoes, basketballs, and other recreational equipment. Approximate cost is $10.0.
- Recreational workout stations for outdoor use at the Kenai and Mat-Su youth facilities. $40.0

- Furniture that needs to be replaced at the division's youth facilities. This may be beds that the youth sleep in, furniture in the common areas, etc. As furniture wears out, it needs to be replaced. If not, it can become a safety and security issue. $50.0
- Electronic equipment such as fingerprint machines, security cameras, touchscreen monitors, etc., in need of replacement at facilities. $75.0
- Replace, vacuum cleaners, dishwashers, washers and dryers, etc. at various facilities as they become worn out and need to be replaced. $40.0
- Replace hand held metal detectors, restraints, handcuffs, etc., as they become worn out and need to be replaced. $20.0

Challenges

Improved Services:

The division is taking advantage of the opportunity and challenge presented by a decrease in delinquency referrals. Though it is impossible to predict the length of this trend, it provides the division with a chance to realign internal resources to better address the ever-changing characteristic of Alaska's delinquent demographic.

Juveniles with identified mental health issues are increasingly more common in division facilities and on probation caseloads. The treatment and supervision needs of these juveniles are not only different but more intense. Working effectively with this population requires programming changes and staff training. The division is embarking on the statewide expansion of a pilot project implementing a "trauma-informed care" approach that recognizes the effect of past childhood trauma on current behavior while working to minimize additional trauma related to involvement with the juvenile justice system.

The availability of video-conferencing equipment in division facilities is allowing for better contact between incarcerated juveniles placed sometimes hundreds of miles from their families and culture. It is increasingly being used for visitation and therapeutic clinical contact but the use is still minimal as access to the equipment in many rural sites is inconsistent. It is also not readily available to probation services not co-located with division facilities. It is, however, a resource with obvious benefit and one in which the division will work to expand capability.

Alaska Native Outreach:

The division determined several years ago that recidivism of its Alaska Native clients was higher than that of other demographic groups. The challenge is to understand the factors present and driving these numbers. The division has initiated a program of "conversations" (or mini conferences) held in rural hub communities and intended to open communication and understanding while building a positive relationship between division employees and village representatives. Three "conversations" have been held to date, in Bethel, Dillingham, and Kotzebue and plans are to continue this program to other regions of the state.

The division has hired a Rural Justice Specialist to assist the outreach effort and is encouraging probation and facility staff to continue this work but to also increase their Alaska Native and rural Alaskan contact and cultural competency.

Facilities/Offices Safety and Security:

The division's aging youth facilities are becoming increasingly difficult to maintain as these buildings sustain hard use 24 hours a day, 365 days a year in challenging climates, ranging from the windblown sub-arctic at the Nome Youth 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 Division of Juvenile Justice facility. In Bethel and Anchorage, 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 outcomes. Probation offices not co-located with facilities are often extremely small and less than conducive to interviews, supervision, and meetings with clients. Most have only the most rudimentary security; this presents significant confidentiality and safety concerns.

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 second of four phases for the McLaughlin Youth Center renovation was funded and is underway. The division was able to obtain funding for the renovation of the Johnson Youth Center's detention and administration building. This work will be completed in FY2013. The current challenge is to complete planning and initiate construction of the funded renovation of the Bethel Youth Facility, and to assess current renovation needs at the Fairbanks Youth Facility.

Prison Rape Elimination Act:

The federal Prison Rape Elimination Act was signed in 2003 but the guiding standards were not finalized until August 2012. The intent of the act is to address and eliminate sexual assault, sexual abuse, and sexual harassment of the inmates or residents in adult and juvenile correctional facilities. For Alaska's Division of Juvenile Justice this means significant policy and procedure changes must be in place before federal auditing starts in late 2013.

Many changes can be satisfied by adding specific language to policies that are currently too general to be considered in compliance. Other changes require the division to assess the possibility and advisability of increasing internal surveillance capabilities, increase the level of background checks on employees and potential employees, and develop a structured response to allegations or reports of sexual misconduct within juvenile facilities.

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. Low staff turnover means that fewer resources and energy needs 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 the division to make up for its shortfall by no longer budgeting at a zero vacancy rate for its facility components.

The division also continues to experience problems recruiting staff in the rural areas. The remoteness of some offices and facilities is a significant factor but so is the lack of housing resources in rural Alaska, especially for potential applicants with families.

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 division services in Kenai, 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 division 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. Each of the division's detention facilities has developed programming that is either a direct alternative to detention (community detention programs) or is designed to provide a service intended to help juveniles stay out of trouble (school programs for suspended or expelled students). These services are available in the eight locations where facilities are located, however it is challenge and a goal to develop alternative to detention programs in rural areas. The division's emphasis on a collaborative and community-focused strategy shows promise as we attempt to address this issue.

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 for substance abuse issues with youth referred to the division and to also provide improved services for identified youth. In addition, the division continues to collect data that will help us understand and work with not only substance abuse concerns but also the common co-occurrence of mental health and substance abuse. The division believes improved screening and referral, improved access to community-based services, increased training for division staff, and stronger substance abuse treatment services in our facilities will all work to improve our outcomes with youth with substance abuse issues.

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN	
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.	
OUTCOME 1. Alaskans are healthy	
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who receive preventative health screenings.
EFFICIENCY MEASURE	Cost for medical services per resident. (DJJ)
OUTCOME 2. Alaskans are free from unintentional injury	
	ALIGNING DIVISION LEVEL MEASURES
EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of HSS.
EFFICIENCY MEASURE	Cost of medical services in facilities. (DJJ)
CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.	

OUTCOME 1. Alaskan children receiving department services live in a supportive setting.	
EFFECTIVENESS MEASURE	**Percent of children receiving department services who are safe and supported.***
EFFICIENCY MEASURE	**Cost of services per child.***
	***AGGREGATE DIVISION MEASURES - (Percent of children receiving department services who are safe and supported).**
EFFECTIVENESS MEASURE	Rate of positive responses by juveniles on facility climate surveys.
EFFICIENCY MEASURE	Cost to operate juvenile facilities per day.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE A. STRENGTHEN ALASKAN FAMILIES.

OUTCOME 1. Alaskan families develop work skills.	
EFFECTIVENESS MEASURE	**Percent of individuals receiving employment related services from department who achieve employment.**
EFFICIENCY MEASURE	**Cost of supported employment services per successful participant.**
	*** AGGREGATE DIVISION MEASURES - (Percent of individuals receiving employment related services from department …)**
EFFECTIVENESS MEASURE	Percent of juveniles whose math and reading scores increased during their institutional treatment stay.
EFFICIENCY MEASURE	Cost to provide educational services in DJJ facilities.

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

OUTCOME 2. Juveniles develop and demonstrate skills in positive decision making.	
EFFECTIVENESS MEASURE	**Rate of recidivism for juveniles receiving services from the department.**
EFFICIENCY MEASURE	**Cost of services per number of juveniles served.**
	*** DIVISION AGGREGATE - (Rate of recidivism for juveniles receiving services from the department).**
EFFECTIVENESS MEASURE	Rate of recidivism for juveniles completing institutional treatment.

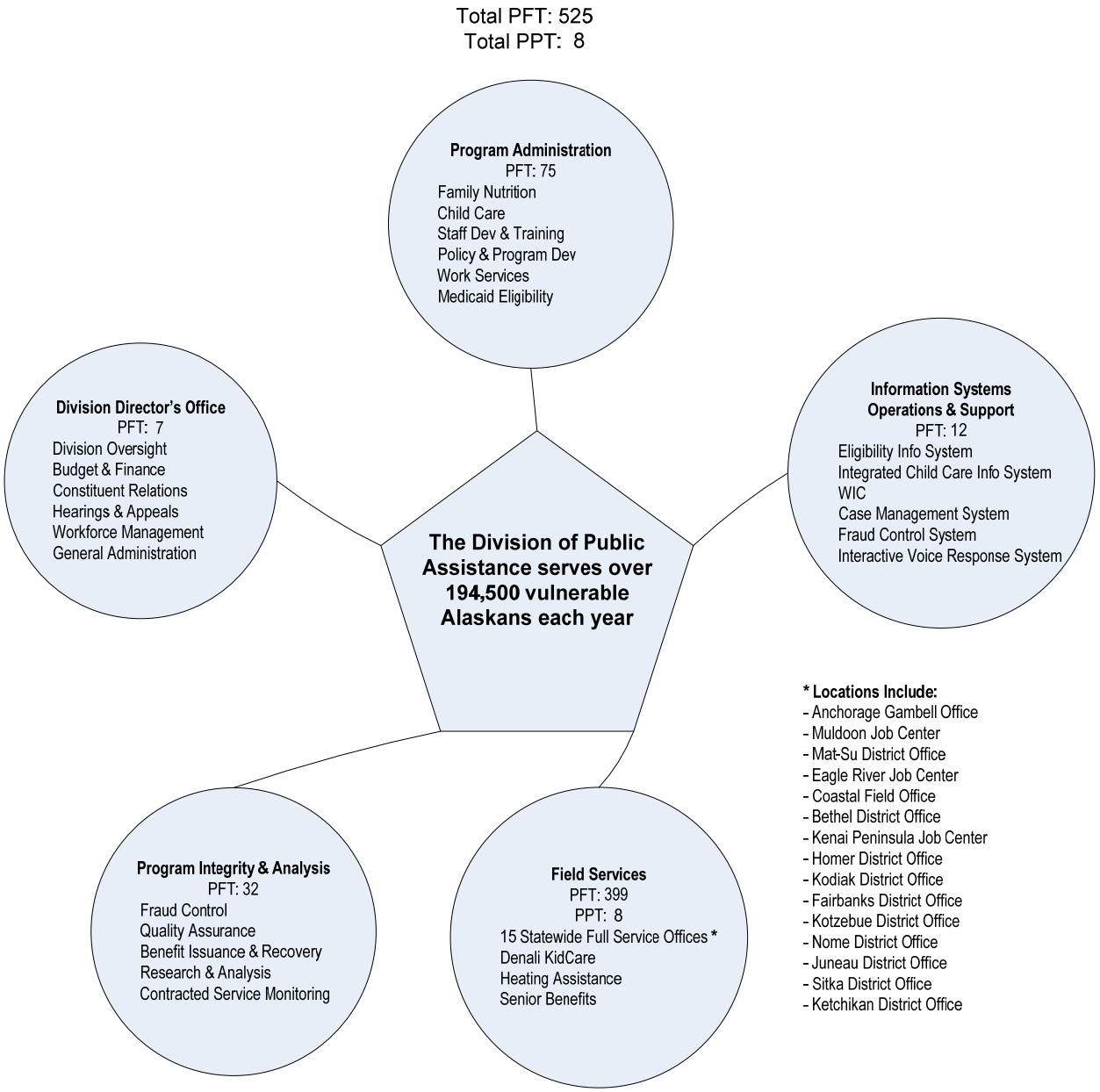
	EFFICIENCY MEASURE	Cost of facility services per resident.
	EFFECTIVENESS MEASURE	Rate of recidivism for juveniles completing probation supervision.
	EFFICIENCY MEASURE	Cost of probation services per referral.
	EFFECTIVENESS MEASURE	Rate of recidivism for juveniles completing youth court.
	EFFICIENCY MEASURE	Cost of youth court per referral.
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percent of adjudicated youth assessed for family risk factors for delinquency.
	EFFICIENCY MEASURE	Cost to provide family services per resident.

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Juvenile Justice
General and Other Funds
(Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)

Item	UGF	DGF	Federal	Other	Total
FY2014 Salary and Health Insurance Increases (McLaughlin)	$ 18.3	$ -	$ -	$ -	$ 18.3
Health Services for Youth in Juvenile Justice Facilities (McLaughlin)	$ 400.0	$ -	$ -	$ -	$ 400.0
FY2014 Salary and Health Insurance Increases (Mat-Su)	$ 1.5	$ -	$ -	$ -	$ 1.5
FY2014 Salary and Health Insurance Increases (Kenai)	$ 1.5	$ -	$ -	$ -	$ 1.5
FY2014 Salary and Health Insurance Increases (Fairbanks)	$ 3.1	$ -	$ -	$ -	$ 3.1
FY2014 Salary and Health Insurance Increases (Bethel)	$ 1.6	$ -	$ -	$ -	$ 1.6
FY2014 Salary and Health Insurance Increases (Nome)	$ 1.4	$ -	$ -	$ -	$ 1.4
FY2014 Salary and Health Insurance Increases (Johnson)	$ 1.8	$ -	$ -	$ -	$ 1.8
FY2014 Salary and Health Insurance Increases (Ketchikan)	$ 1.4	$ -	$ -	$ -	$ 1.4
FY2014 Salary and Health Insurance Increases (PS)	$ 0.7	$ -	$ -	$ -	$ 0.7
MH Trust: Dis Justice - 4302.01 Mental Health Clinician Oversight In Youth Facilities (PS)	$ -	$ -	$ -	$ 152.9	$ 152.9
MH Trust: Dis Justice - Grant 3504.02 Div Juvenile Justice Rural Re-entry Specialist (PS)	$ -	$ -	$ -	$ 110.9	$ 110.9
MH Trust: Dis Justice - Grant 4688 Div Juvenile Justice Trauma Informed Care (PS)	$ 75.0	$ -	$ -	$ 75.0	$ 150.0
Reverse FY2013 MH Trust Recommendation (PS)	$ -	$ -	$ -	$ (266.3)	$ (266.3)
Juvenile Justice Total	***$ 506.3***	***$ -***	***$ -***	***$ 72.5***	***$ 578.8***

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 provides essential services to meet many of the basic and urgent needs of Alaska's most vulnerable families and individuals. The Division of Public Assistance provides temporary economic support to needy families; financial assistance to elderly, blind, and disabled individuals; food support and nutrition education; medical benefits, home heating assistance, child care assistance, and work supports that 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 paying for home heating costs;
- Child care subsidies to families who need child care in order to work or participate in approved work or training activities;
- Child care licensing services to promote the safety and quality of child care in Alaska;
- Access to health care by determining eligibility for Medicaid, Denali KidCare, and Chronic and Acute Medical Assistance; and
- Administrative accountability and prevention of fraud and program abuse.

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

Every day thousands of Alaskans rely on the Division of Public Assistance to meet their most basic needs and to support their efforts to achieve economic independence. The Division of Public Assistance services are a significant element of the Department's larger effort to keep children safe and families strong. The Division of Public Assistance's success as a partner in that effort depends upon over 500 employees located across the state, as well as many community

partners, all of whom are dedicated to supporting and improving the lives of children, adults and families in Alaska.

The Division of Public Assistance provides direct services in 18 customer service offices statewide. In addition, the Women, Infants and Children program, Child Care Assistance, and employment case management services are provided through grants and pay-for-performance contracts with community agencies. In FY2012, the division provided cash, food, and medical benefits and services to over 130,000 Alaskan households and over 194,500 individuals.

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

The remaining fifth of the Division of Public Assistance budget is divided between staff costs – direct service and administrative (14%) and all other costs (8%).

Services Provided

Alaska Temporary Assistance Program

The Alaska Temporary Assistance Program provides temporary financial assistance to needy families with children while adults work to become self-sufficient. The Alaska Temporary Assistance Program was created by the state and federal welfare reform laws passed in 1996 and replaced the Aid to Families with Dependent Children program. The program is funded by the federal Temporary Assistance for Needy Families block grant and requires state maintenance-of-effort funding based on the amount spent in federal fiscal year 1994 for the Aid to Families with Dependent Children program in Alaska.

The program provides assistance to about 3,800 families throughout the state every month. 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. The Alaska Temporary Assistance Program 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 "Families First" services aimed at allowing them to address their challenges and increase their family's income. These Work First and Families First services are referred to as Work Services.

The division continues to invest Temporary Assistance for Needy Families block grant savings, (that accrued as a result of welfare reform), to sustain budgets for work services and supports for low income working families, such as child care assistance. The division also transfers funds to the Social Services Block Grant for child protection services. The remaining Temporary Assistance for Needy Families block grant balance is reserved to respond to increases in the Alaska Temporary Assistance Program 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 such as replacement of the division's aging Eligibility Information System.

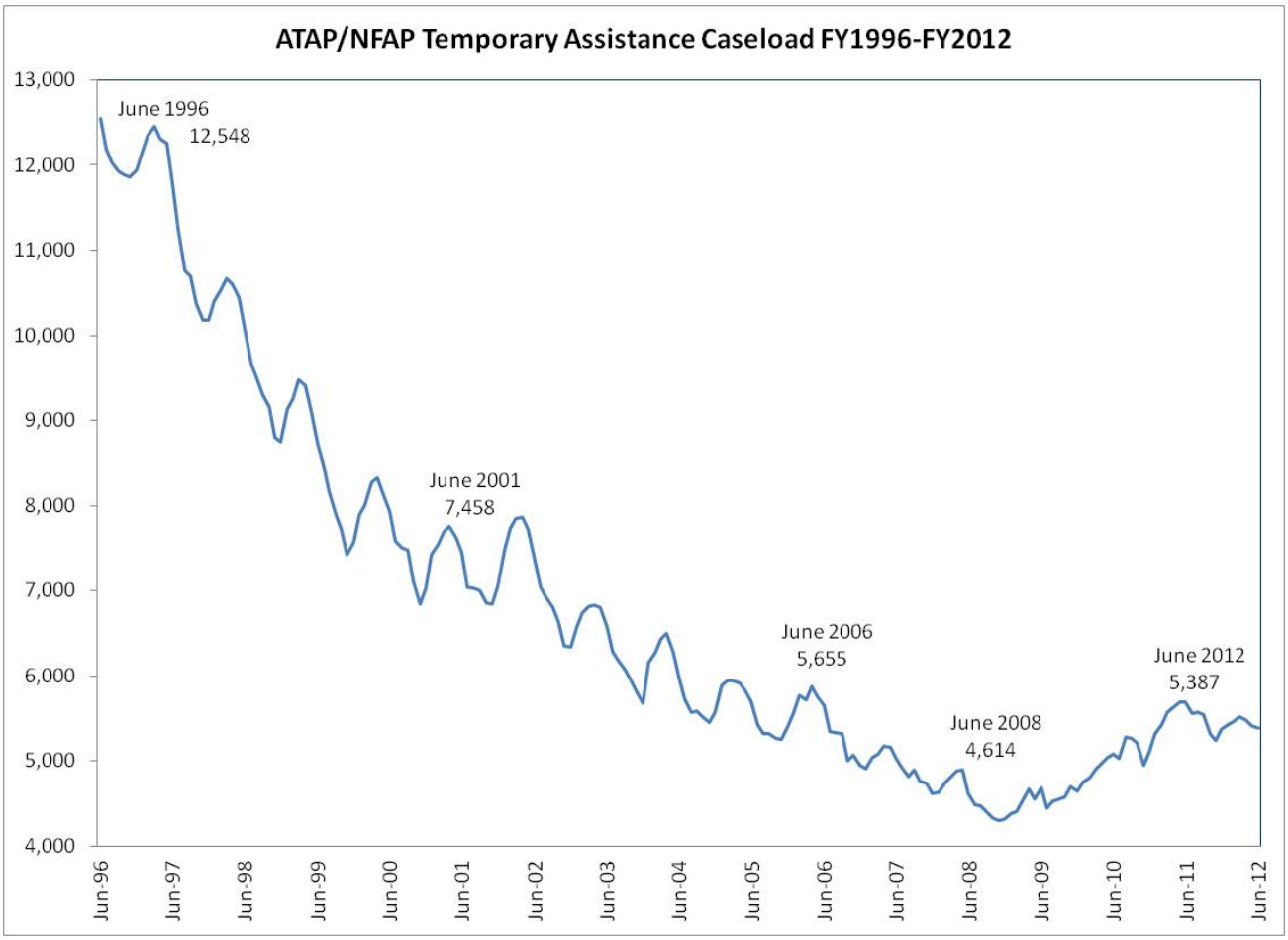
Native Assistance Programs

Federal law allows tribes and Alaska Native regional nonprofit organizations to operate tribal Temporary Assistance for Needy Families programs and to receive direct federal funding from the federal Temporary Assistance for Needy Families block grant. These programs are known as Native Family Assistance Programs. Federal funding for these programs is supplemented with state funds that would otherwise be spent to serve Native families through the Alaska Temporary Assistance Program.

While Native Family Assistance Programs must be comparable to the state's program, the Native Family Assistance Programs have the flexibility to be culturally relevant and regionally focused.

The program may serve both Natives and non-Natives in a region, or serve only Native families in a specific service area.

Approximately 1,640 Alaskan families receive Temporary Assistance for Needy Families services and benefits from Native Family Assistance Programs every month. These programs are operated and administered by the Association of Village Council Presidents, Inc., Bristol Bay Native Association, Central Council of Tlingit & Haida Indian Tribes, Cook Inlet Tribal Council, Kodiak Area Native Association , Maniilaq Association, and Tanana Chiefs Conference.



The sustained efforts of the division since the implementation of Alaska Temporary Assistance Program, 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.

Child Care Benefits

The Child Care Assistance Program helps low-income families pay for a portion of their child care costs while they are working, or participating in an education or training program. Child care benefits pay for part of the child care costs, and parents also pay for a portion of the child care costs (called "co-pay"). The parent's share is based on the size of the family and the amount of their income.

Providing access to affordable, safe, and quality child care 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 child care is essential to ensure that families can work and move toward economic self-sufficiency confident their children are in safe and healthy child care and have the opportunity to grow and learn in nurturing environments. In addition to child care assistance, the Child Care Assistance Program provides:

- Licensing, oversight and approval of child care facilities across the state to promote the health and safety of children in child care; and
- Activities to promote quality care, such as parent education and support provided by Child Care Resource and Referral agencies, professional development for child care providers, and other special initiatives.

During FY2012, the Division of Public Assistance, either directly or through its partners, supported child care services for over 3,000 low-income eligible families per month, served over 5,000 children per month in the Child Care Assistance Program, and licensed and monitored 2,322 child care facilities.

Work Services

The Alaska Temporary Assistance Program's time-limited benefits and focus on moving recipients into the workforce requires services that assist program participants to gain paid employment quickly. Work First services help and promote the efforts of Alaska Temporary Assistance Program recipients to attain economic self-sufficiency through employment. Those families with multiple and profound challenges to getting and keeping a job are helped with Families First 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, 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 to assist recipients in their communities to move from welfare to work.

Based on new research on families on Temporary Assistance to Needy Families in Alaska and ongoing data collection, the division determined that a more comprehensive scope of services for these families is needed to make progress in reducing the number of families who have a long-term dependence on Temporary Assistance to Needy Families support. Families First strategies are designed to address these challenges and to reduce the amount of time these families receive Temporary Assistance benefits before they are able to achieve self-sufficiency.

Families First services help families to 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. Families

First providers screen and assess families for challenges to employment. 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.

Families First services 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 are also provided to support customized employment for parents able to work with accommodation.

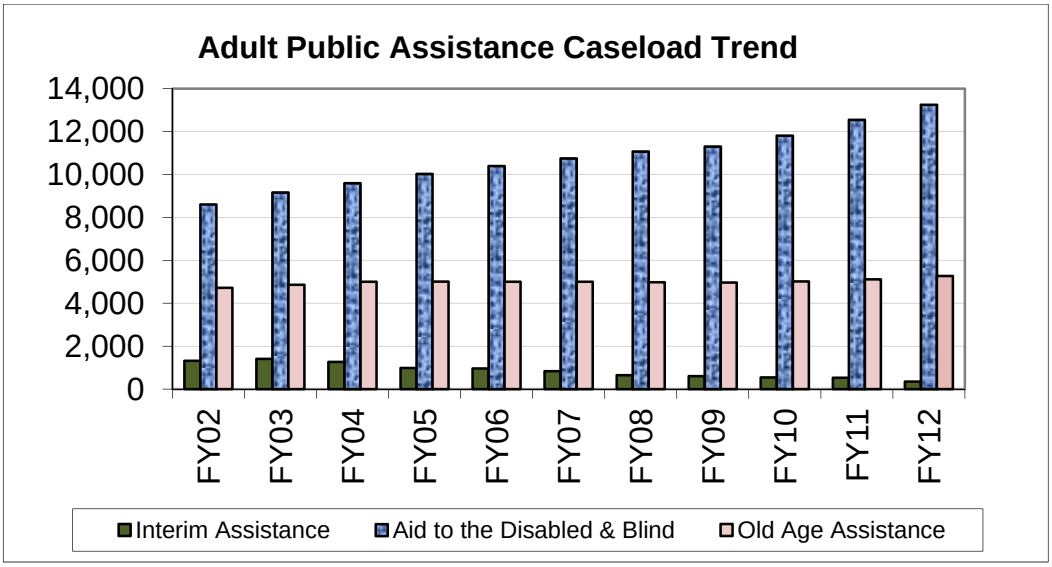
Adult Public Assistance

The Adult Public Assistance program provides financial assistance and access to medical care for nearly 5,300 elderly and over 13,500 blind and disabled Alaskans every month. The program was created to provide income support to very needy elderly, blind, and disabled persons. The Adult Public Assistance benefits serve to augment the federal Supplemental Security Income 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 Supplemental Security Income. To qualify for Supplemental Security Income, 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.

In FY2012, an average of 350 individuals received Interim Assistance each month while they waited for their SSI decision. In FY2004, the Division of Public Assistance implemented a rigorous medical review process to determine if a person would likely meet the Supplemental Security Income disability criteria. This change has slowed the rate of growth in Interim Assistance and has decreased the caseload by approximately 80% from an all-time high reached at the end of FY2003.

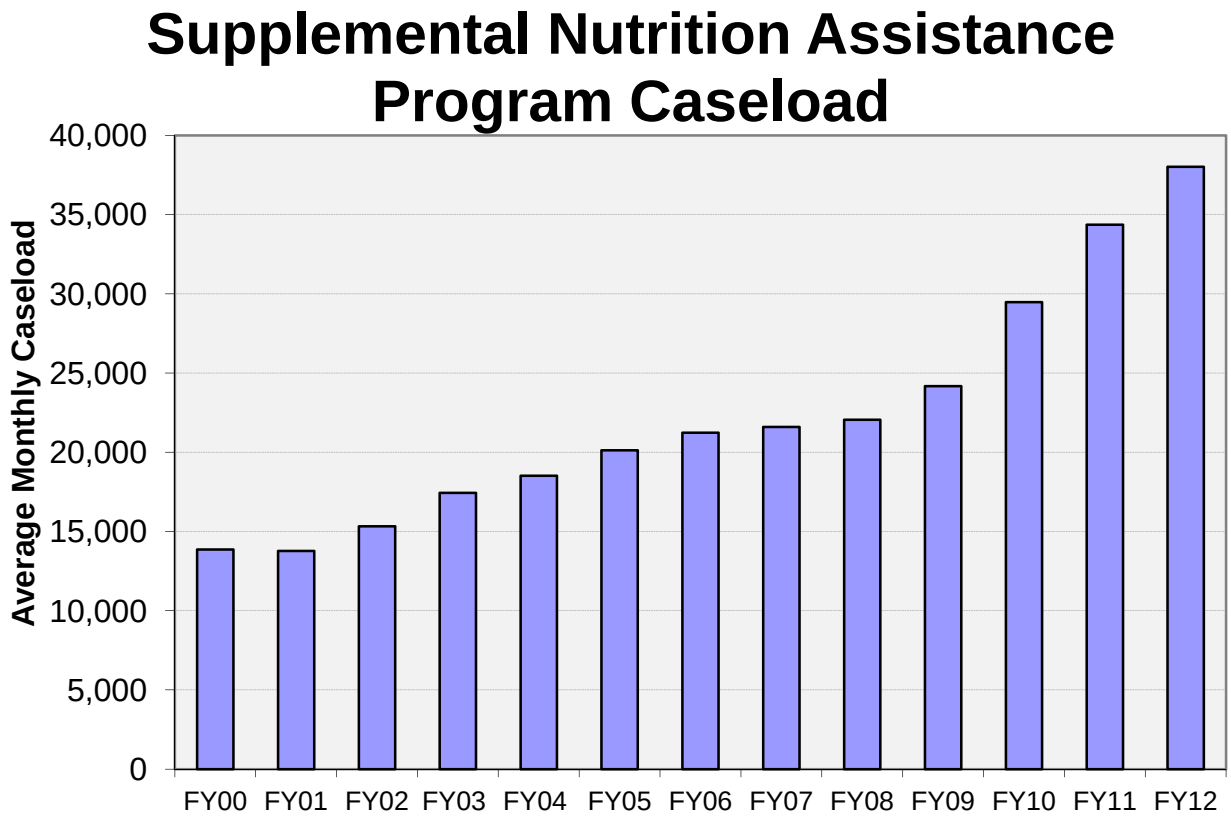
Adult Public Assistance serves the community by promoting the stability and independence of needy individuals. Adult Public Assistance benefits help many Alaskans achieve well-being through providing opportunities for community living, promoting independence, and averting problems such as homelessness, and avoiding higher-cost settings such as hospitals, nursing homes, or incarceration.



Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program, also known as the Food Stamp Program, helps low-income households maintain adequate nutritional needs. Eligible participants receive monthly Supplemental Nutrition Assistance Program benefits on the Alaska Quest card and use the card to purchase food products from 800 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. Supplemental Nutrition Assistance Program benefits are 100% federally funded by the U.S. Department of Agriculture, Food and Nutrition Service. Costs for the administration of the program are shared equally by the state and federal government. The United States Department of Agriculture estimates that for every $5.00 in Supplemental Nutrition Assistance Program 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 conferring financial eligibility for the Women, Infants and Children's Program. Employment and Training supports are available to Supplemental Nutrition Assistance Program recipients in urban areas with employment opportunities.

Alaska's Supplemental Nutrition Assistance Program caseload continues to climb, with a significant increase in participation over the last four years with more households applying for help as they struggle to meet their basic needs. In FY2012 the program served an average of 38,016 eligible households, a 72.4% increase compared to the number of households served in FY2008. As of August 2012, 38,707 Alaska households were receiving Supplemental Nutrition Assistance Program benefits. Monthly benefit issuances climbed from almost 8 million dollars a month in FY2008 to almost $16 million per month in FY2012.



For FFY 2011, Alaska received $562,113 in bonus funds from the U.S. Department of Agriculture for high accuracy of both issuing benefit payments and performing denials and terminations. Alaska ranked first among states with a payment accuracy of 99.24%, and ranked second in applications denials and case closure accuracy with 98.93% correct. With half of FFY 2012 reported, Alaska is again positioned for a bonus payment, ranking second in payment accuracy and third in accuracy for application denials and case closures.

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 Supplemental Nutrition Assistance Program, Medicaid, and Child Care Assistance Programs. The division also conducts payment accuracy reviews for the Alaska Temporary Assistance Program, Senior Benefits, and Adult Public Assistance programs when Quality Control staff resources are available.

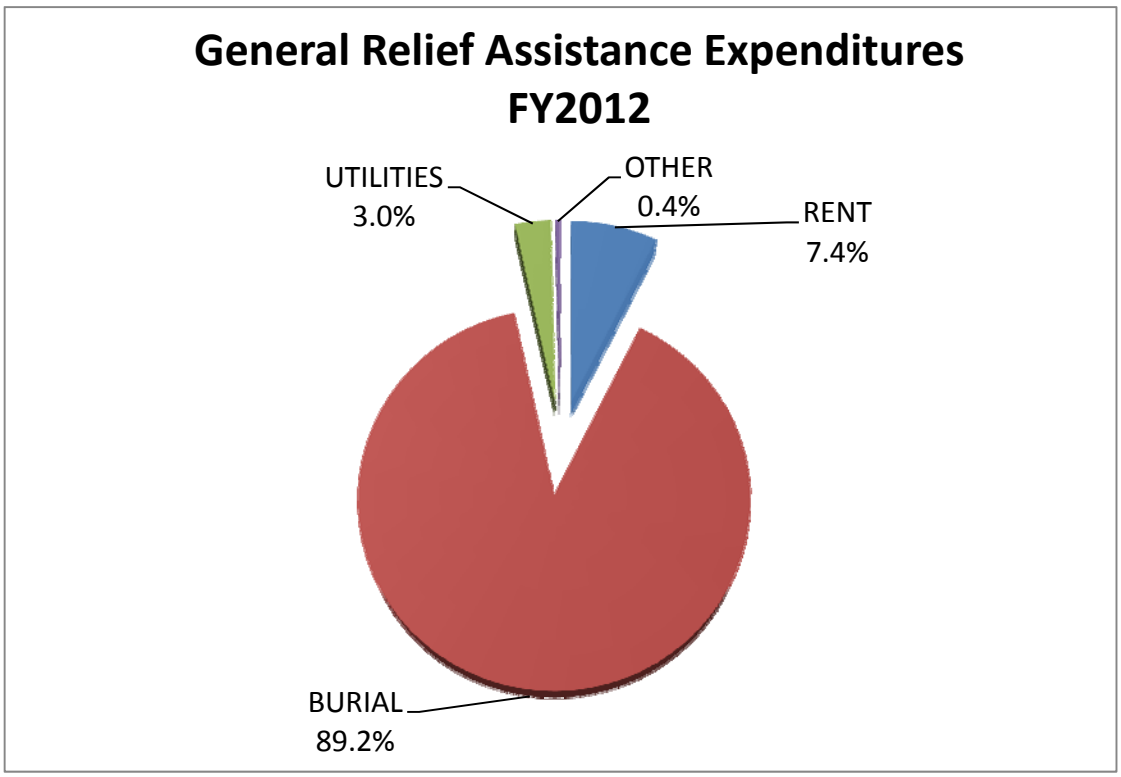
Fraud Control

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 program is the safety net 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 with no other resources available. Approximately 89% of General Relief Assistance program expenditures are used to pay for funeral and burial expenses. The remainder is used to meet emergency shelter, food, and clothing needs.



In FY2012 the program covered burial expenses for 814 deceased individuals, and each month met emergency shelter or utility needs, preventing eviction and homelessness for approximately 110 households.

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 is responsible for managing payments to health care providers. The Division of Public Assistance 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 121,000 Alaskans each month. Medicaid recipients often participate in other public assistance programs.

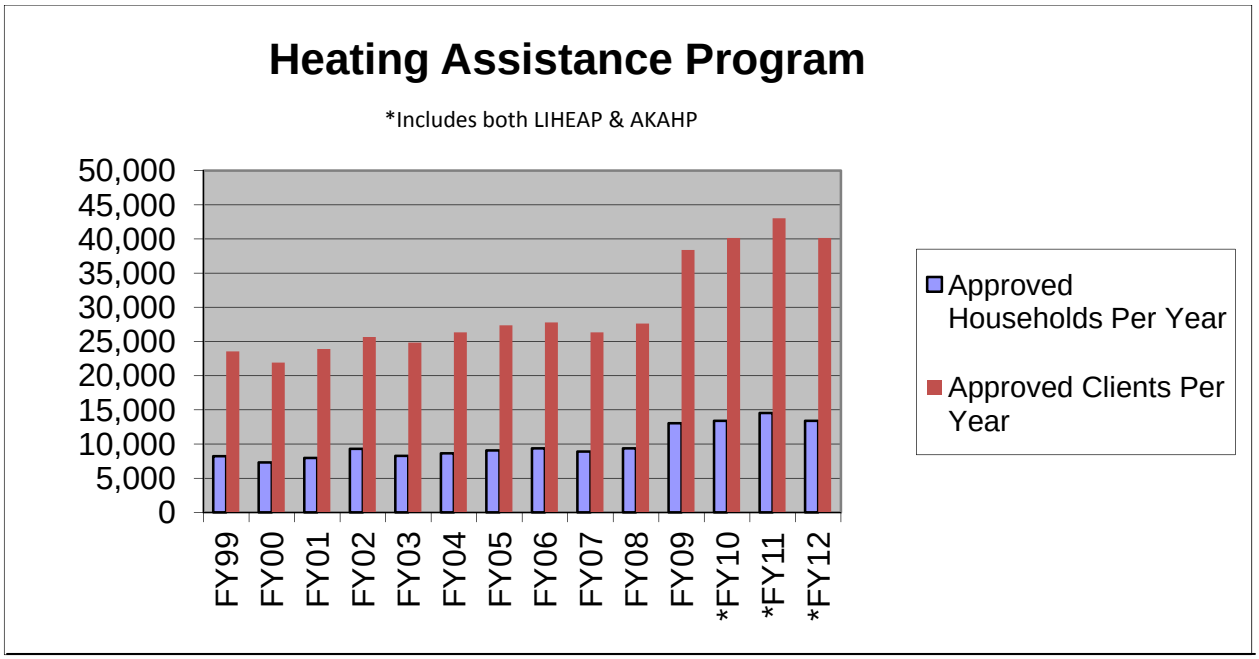
Chronic and Acute Medical Assistance

The Chronic and Acute Medical Assistance 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. The Division of Public Assistance develops and administers policies for the program, ensures access, and determines eligibility of individuals. The Division of Health Care Services is responsible for authorizing care and generating payments to health care providers.

Energy Assistance Program

The Energy Assistance Program component includes the Heating Assistance Program and funding to support weatherization projects. The Heating Assistance Program 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 block grant. In October 2008, the Division of Public Assistance began operating the state-funded Alaska Heating Assistance Program. In October 2010, the Alaska Heating Assistance Program transitioned to the new Alaska Affordable Heating Program.

While federal Low Income Home Energy Assistance Program funds can only be used to serve households with income below 150% of the federal poverty limit in Alaska, the Alaska Affordable Heating Program connects the income eligibility standards and the annual benefit levels to the average price per barrel of North Slope crude oil. The Alaska Affordable Heating Program is available for households with income between 151% and 225%, and increases to 250% of the federal poverty limit if the average price per barrel of oil reaches $150 a barrel.

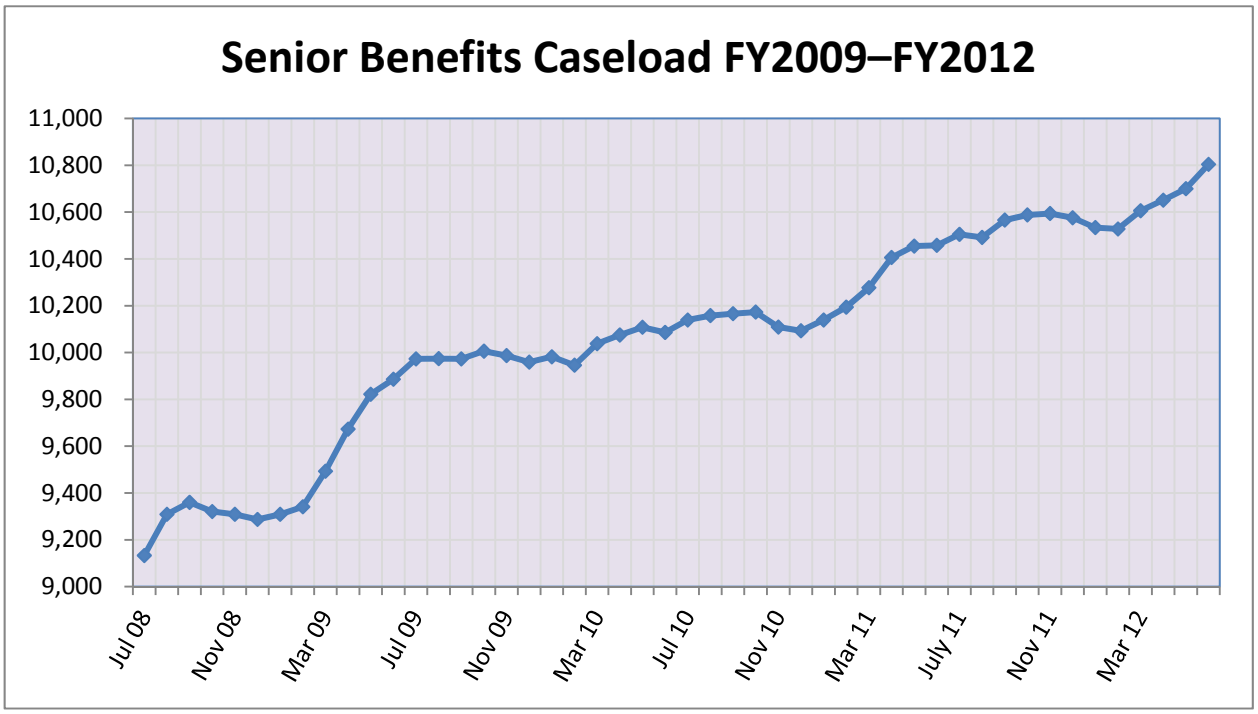


During the 2011 - 2012 heating season, 13,385 households (11,124 Low Income Home Energy Assistance Program and 2,261 Alaska Affordable Heating Program) received help from the State administered heating assistance programs.

The Energy Assistance Program also contributes funds to the Alaska Housing Finance Corporation's 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 FY2012 the number of seniors enrolled in Senior Benefit reached over 10,800, 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 11,100 cases by the end of FY2013.

Women, Infants and Children

The Women, Infants and Children's Program 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 Women, Infants and Children's 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 Women, Infants and Children program recently increased the amount of food provided to mothers who breast-feed their baby full time to better promote and support breast-feeding.

Beginning in FY2012 the Women, Infants and Children program assumed responsibility for administering the Division's Supplemental Nutrition Assistance Program Education and Obesity Prevention program. The program delivered nutrition and obesity prevention services to 93,123 children, adults, and seniors eligible for Supplemental Nutrition Assistance Program benefits. Program services include direct nutrition education, food preparation and storage, and food cost

management resource tools. Instruction is provided at schools, state agencies, churches, food banks, and clients' homes

The Women, Infants and Children, Farmers' Markets, and Commodity Supplemental Food Programs are primarily federally funded. In FY2012, approximately 26,000 Alaskan women, infants and children participated in the Women, Infants and Children program each month, and approximately 2,174 seniors received food from the Commodity Supplemental Food Program. Over 15,200 Women, Infants and Children's participants were issued $25 worth of vouchers for the Farmers' Market Nutrition Program that ran from June 2012 through October 2012 harvest season. The value of redeemed Farmers' Market Nutrition Program vouchers for the 2012 season is expected to be $169,000. The Senior Farmers' Market Nutrition Program provided more than 3,300 coupon books valued at $82,930 and were distributed at 32 senior service agencies.

Comparison of Public Assistance Programs

	Energy Assistance Programs:[2] LIHEAP (Federal)	AKAHP (State)	Child Care (PASS I, II, III)	Senior Benefits	Woman, Infants, & Children (WIC)
Average # of Cases/Month[1]	11,124	2,261	3,181	10,595	17,211
Average # of Clients/Month[1]	33,372	6,783	5,280	10,595	27,853
Demographics of Recipients	**Percent**	**Percent**	**Percent**	**Percent**	**Percent**
Race					
Alaska Native[3]	22%	17%	6%		28%
American Indian	n/a	n/a	0%		n/a
Asian[4]	7%	5%	5%	Not Available	6%
Black	3%	3%	11%		4%
Pacific Islander	n/a	n/a	6%		3%
White	63%	70%	45%		38%
Not Reported	6%	4%	5%		0%
Two or More Races	n/a	n/a	21%		21%
DPA Region of Residence					
Central	42%	37%	67%	49%	47%
Northern	26%	24%	11%	16%	25%
Coastal	26%	32%	12%	22%	20%
Southeast	6%	7%	10%	13%	8%
Category of Services	**Percent**	**Percent**	**Percent (Expenditures)**	**Percent (Receiving Benefits)**	**Percent (Receiving Benefits)**
Employed, retired, temp. unemployed:	68%	92%	PASS I: 22%	SNAP: 31%	SNAP: 43%
Receiving ATAP:	7%	1%	PASS II: 8%	APA: 55%	Medicaid: 66%
Receiving APA:	24%	6%	PASS III: 69%	Medicaid: 66%	

Notes:

1. Caseload and client numbers for Heating Assistance are annual totals; all other programs are monthly averages
2. The Energy Assistance program data does not include Alaskans receiving Heating Assistance through tribal organizations funded directly by the federal government.
3. Race distribution for the Heating Assistance and WIC programs combine Alaska Native and American Indian.
4. Race distribution for the Heating Assistance programs combine Asian and Pacific Islander.

Comparison of Public Assistance Programs (continued)

	ATAP/NFAP[1]	Adult Public Assistance (APA)	General Relief	SNAP
Average # of Cases/Month	3,804	18,865	187	38,016
Average # of Clients/Month	10,331	18,865	327	93,123
Demographics of Recipients	**Percent**	**Percent**	**Percent**	**Percent**
Race				
Alaska Native	12%	26%		39%
American Indian	0%	1%		1%
Asian	8%	9%		6%
Black	11%	5%	Not Available	5%
Pacific Islander	7%	3%		4%
White	45%	50%		35%
Not Reported	5%	4%		3%
Two or More Races	10%	2%		7%
DPA Region of Residence				
Central	70%	57%	60%	49%
Northern	13%	15%	12%	19%
Coastal	9%	17%	19%	22%
Southeast	8%	12%	10%	11%
Age Group (Avg. Cases/Month)				
Children 0-18 years	7,018	91	Not Available	41,857
Adults 19-59 years	3,298	11,090		45,769
Adults 60+ years	15	7,684		5,497
Category of Services[2]	**Percent (Expenditures)**	**Percent (Expenditures)**	**Percent (Expenditures)**	**Percent (Expenditures)**
Single Parent:	65%	Disabled: 72%	Burial Services: 89%	SNAP and ATAP: 12%
Two Parent:	10%	Aged: 28%	Rent Assistance: 7%	SNAP Only: 22%
Child Only:	25%	Blind: <1%	Other: 4%	SNAP and APA: 11%
				SNAP and Medicaid: 77%

Notes:

1. Percentages do not necessarily add to 100% - some cases overlap multiple categories

List of Primary Programs and Statutory Responsibilities

Statutes

AS 18.05.010-070	Administration of Public Health and Related Laws
AS 43.23.075	Eligibility for Public Assistance
AS 43.23.085	Eligibility for State Programs
AS 44.29.020	Department of Health & Social Services
AS 47.05.010-080	Public Assistance
AS 47.05.300-.390	Criminal History; Registry
AS 47.07.010-900	Medicaid
AS 47.25.001-.095	Day Care Assistance and Child care Grants
AS 47.25.120-300	General Relief Assistance
AS 47.25.430-615	Adult Public Assistance
AS 47.25.621-626	Alaska Affordable Heating Program
AS 47.25.975-990	Food Stamps
AS 47.27.005-.990	Alaska Temporary Assistance Program
AS 47.32.010-.900	Centralized Licensing and Related Administrative Procedures
AS 47.45.301-.309	Senior Benefits Payment Program

Regulations

7AAC 10	Licensing, Certification, and Approvals
7 AAC 38	Permanent Fund Dividend Distributions
7 AAC 39	Child Care Grant Program
7 AAC 40	Adult Public Assistance
7 AAC 41	Child Care Assistance Program
7 AAC 44	Heating Assistance Program
7 AAC 45	Alaska Temporary Assistance Program
7 AAC 47.020-290	General Relief Assistance
7 AAC 47.545-599	Senior Benefits Payment Program
7 AAC 57	Child Care Facilities Licensing
7 AAC 78.010-320	Grant Programs
7 AAC 100	Medicaid Assistance Eligibility

Federal Statutes

PL97-35	L.I.H.E.A.P. Act of 1981

Federal Regulations

7 CFR 273.16	Food Stamp Program
7 CFR 275.10	Food Stamp Quality Control
42 CFR 431	Medicaid Program
42 CFR 457	State Children's Health Insurance (SCHIP) Payment Error Rate Measurement (PERM)
45 CFR 98	Child Care and Development Fund
45 CFR 235.110	Welfare Fraud
45 CFR 431.800	Medicaid Quality Control

Division of Public Assistance

Budget Overview Table

Division of Public Assistance	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$162,297.4	$165,924.9	$3,627.5
Designated General Funds	16,992.7	17,642.7	650.0
Federal Funds	132,388.5	132,400.7	12.2
Other Funds	13,542.1	13,941.2	399.1
Total	**$325,220.7**	**$329,909.5**	**$4,688.8**

Budget Requests

The proposed FY2014 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 - low income seniors, people with disabilities, emergency services to destitute individuals, and burial assistance on behalf of deceased, indigent persons.

Alaska Temporary Assistance Program

Alaska Temporary Assistance Program Growth: $3,850.0 Total -- $3,850.0 Fed

Increased funding authority of $3,850.0 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 block grant.

Without additional authority, the Alaska Temporary Assistance Program will not be able to provide temporary financial assistance and self-sufficiency services at a level to assist the increasing population meeting the eligibility requirements for the program.

Adult Public Assistance

Formula Program Funding Increase Due to Caseload Growth: $2,284.0 Total -- $2,244.0 GF, $40.0 I/A Rcpts

Increase general funds by $2,244.0 and interagency receipt authority by $40.0 to meet the $2,284.0 in total projected general fund expenditures. 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 program in Alaska. Recipients, who are disabled or blind, for both the Adult Public Assistance and Supplemental Security Income programs have seen a 5.7% increase. 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% a 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.

General Relief Assistance

Program Funding Due to Caseload Growth: $1,140 Total -- $1,140.0 GF

An additional $1,140.0 is needed to cover the projected shortfall caused by increased growth. The cost of the General Relief Assistance Program has grown due to a significant increase in the number of burials paid for by the program. There has also been more demand for assistance to individuals and families who need emergency services. The actual number of burial expenses for indigent people increased over 15% in FY2012. Currently, 89.1% of program expenditures are used to pay for burial expenses. Current funding levels are inadequate to meet projected expenditures.

If this increment is not funded, the General Relief Assistance Program will not be able to pay providers for burial costs and other emergency services incurred by individuals who meet the eligibility requirements for the program. In addition, the program will not be able to provide a safety net for very low-income individuals who lack needed resources and are not eligible for other state or federal assistance.

Permanent Fund Dividend Hold Harmless

Program Funding Increase Due to Caseload Growth: $650.0 Total -- $650.0 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 Permanent Fund Dividend Hold Harmless payments. Current Permanent Fund Dividend Hold Harmless funding is not sufficient to cover the amount of hold-harmless payments needed due to the growth of the Supplemental Security Income, Food Stamp, and the Adult Public Assistance programs.

If funding is not increased, there will not be sufficient funds for the Permanent Fund Dividend Hold Harmless program and general funds will need to be used to meet the state requirement. Failure to fund the FY2014 increment request would mean general funds would be used instead of Permanent Fund Dividend Hold Harmless funds.

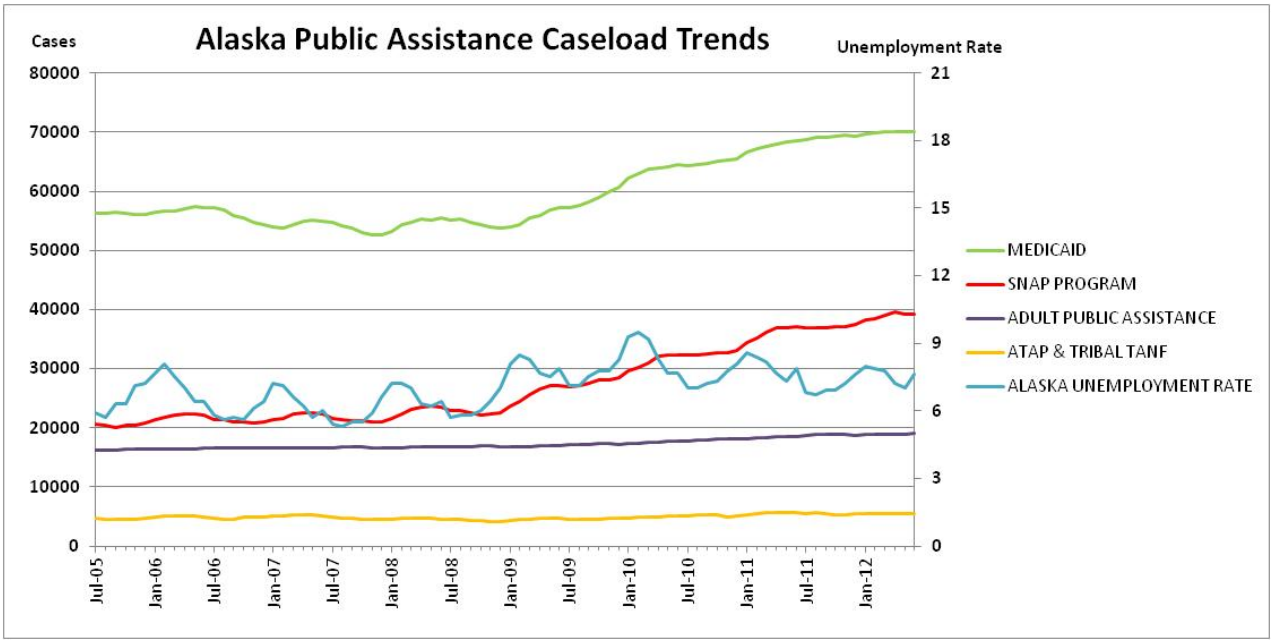
Challenges

As the Division of Public Assistance 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 FY2014.

Increasing Need, Workload Challenges, and Continuous Improvement

Many individuals and families in Alaska still struggle to find jobs with hours and wages sufficient to meet their basic needs. Costs for food, housing, heating fuel and transportation put immense stress on low-income households throughout the State. As a result, requests for help from programs designed to meet the most basic needs of economically challenged individuals and families have increased dramatically.

The number of families receiving Alaska Temporary Assistance Program benefits grew by 5.1% between FY2011 and FY2012. The number of households receiving Supplemental Nutrition Assistance Program benefits grew by another 10.6% in FY2012, which is the slowest rate of growth in the last four fiscal years. Between FY2009 and FY2012, the number of households receiving Supplemental Nutrition Assistance Program benefits increased by 57%.



Work and Personal Responsibility

Research conducted by the University of Alaska, Institute of Circumpolar Health Studies, revealed that families on Temporary Assistance for Needy Families unable to go to work and participate full-time and those families who have used more than 40 months of the 60 month life-time limit, have significantly different characteristics and challenges than those able to work and quickly exit the Temporary Assistance for Needy Families program through employment. To assist families facing significant challenges to self-sufficiency while continuing to support those

ready to enter the workforce, the Division must implement a new model for delivering Work Services.

Based on the recent research, the FY2013 Work Services model will rely on two tracks to serve families. Work First employment focused services will continue to help job-ready parents become employed and close their family's Temporary Assistance for Needy Families case. Families First services target families who are not yet job-ready due to profound and multiple challenges to self-sufficiency. Families First services include collaborative service plans with partner agencies, early screening and assessment, supports to access services to remediate challenges to participation and successful application for non-time limited benefits such as Supplemental Security Income.

Child Care Assistance - Parents Achieving Self-Sufficiency

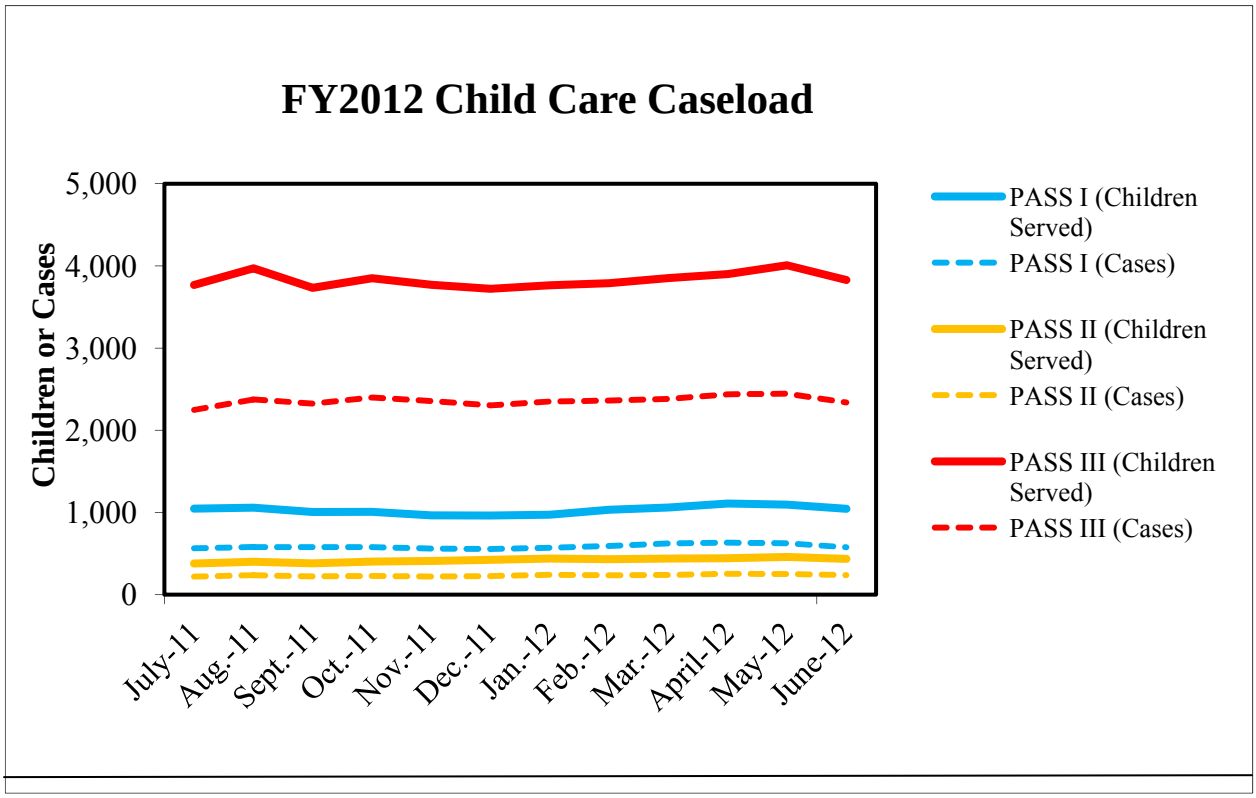
Children who grow up safe, healthy, and filled with a love of learning are better prepared to succeed in school and in life. The Child Care Assistance Program and its initiatives are intended to ensure children in low income eligible families have access to affordable, safe, quality child care. Child care assistance often provides the support that parents need in order to stay working or to stay participating in education or training programs.

The division continues to work on strategies to increase the effectiveness of its Child Care Assistance Program to enable low-income eligible parents to find and afford safe, stable quality child care. Strategies include increasing access, and raising child care subsidy rates closer to actual market levels. Because child care subsidy rates had not increased since 2001, rate adjustments were implemented in September of 2008 and again in March 2010 based on the findings of the 2009 market rate survey (market price study). 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 had not been adjusted since 2002. Federal guidelines allow states to serve families with incomes up to 85% of the state median income. The new standards set Alaska's child care assistance income limits at 75% of Alaska's state median income.

The federal government requires states to survey their child care 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 child care for families. The Child Care Market Price Survey completed in 2011 showed that child care 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 child care providers is responsible for a decline in the number of working families participating in the Child Care Benefits program. Additional funding is needed to stabilize Alaska's child care rates. Regular increases to the child care subsidy rates that keep pace with the growing costs experienced by child care providers are essential to promote and support access to quality child care for low income families.

Early childhood development is a key priority for the division in achieving its dual goals of supporting employment for low-income families and improving quality in early childhood care and learning programs. Establishing a Quality Rating and Improvement System, that provides an

affordable and efficient systematic framework for evaluating, improving, and communicating the quality of care in early childhood programs, is essential to this priority.



Building and Retaining a Quality Workforce

The division is expected to deliver timely and accurate benefits and the staff takes great pride in ensuring families and individuals receive the best possible service. Maintaining a quality workforce is essential to the success of the division. However, the 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 needs to recruit and retain staff with the right aptitudes and attitudes. 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. Despite staff turnover and growing caseloads, changes to core business practices have been implemented that have helped improve employee morale and overall performance outcomes.

Sustaining Business Process Improvements

Despite the implementation of new business processes to provide better customer service and increase efficiency and streamline service delivery, the Division remains challenged by the volume of people seeking assistance. 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 are achieved. Given this increase in demand, the division will work to continually improve and standardize work processes and to leverage new technologies in order to increase its service capacity.

Replacing Aging Automated Systems

The division has three major information and management systems under various stages of replacement.

Alaska Women Infant and Children system: This computer system, which supports the Women, Infants and Children program, 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 Women, Infants and Children system. In FY2012 the division began the transfer of SPIRIT, a federally approved Women, Infants and Children information system. Despite the termination of the contractor in November 2012, the division still anticipates full implementation in FY2013. DPA expects transition to the new system will provide uninterrupted services to the Women, Infants and Children 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 deployed to ensure continued progress on a new Fraud Case Management System.

Eligibility Information System Replacement: In FY2012 the division received a general fund appropriation and the authority to expend federal funds at an enhanced match rate in order to begin the design, development and implementation of a modern eligibility system. Meeting federal deadlines will be a challenge. By October 2013 the Division must be able to roll out the Medicaid module of the new eligibility system. By January 2014 the system must be able to interface with a health insurance exchange and to enroll eligible people in Medicaid. Failure to meet federal deadlines and milestones can result in the loss of the enhanced federal match rate.

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 mandatory provisions of Health Care Reform legislation is the 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 any and all other options that the state may select, will require research and policy development as well as computer information system changes to implement. As necessary, division resources will be re-directed from other projects and programs to support this planning effort.

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities, and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN

CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.

OUTCOME 1. Alaskans are healthy		
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***	
EFFICIENCY MEASURE	**Cost per percentage of improved health.***	
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**	
	EFFECTIVENESS MEASURE	Percent of Alaskans who are overweight/obese.
	EFFICIENCY MEASURE	Cost per child of physical education campaign.
	EFFICIENCY MEASURE	Total Women, Infant and Children grant cost per direct service FTE.
	EFFECTIVENESS MEASURE	Rate of high-risk maternal (pre-natal) behaviors.
	EFFICIENCY MEASURE	Number of clients served by mini-grants.

OUTCOME 2. Alaskans are free from unintentional injury		
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percent of facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of decrease in facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of complaints investigated within established timeframes.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE A. STRENGTHEN ALASKAN FAMILIES.

OUTCOME 2. Alaskan families have safe and affordable child care.

EFFECTIVENESS MEASURE	**Percent of licensed child care facilities in Alaska.**
EFFICIENCY MEASURE	**Average time to process a license application.**
EFFECTIVENESS MEASURE	**Percent of children in licensed facilities.**
EFFICIENCY MEASURE	**Average cost of child care per hour per child provided in a licensed facility.**

ALIGNING DIVISION LEVEL MEASURES

EFFECTIVENESS MEASURE	Percent of children in child care assistance program who are in licensed child care.
EFFICIENCY MEASURE	Number of non-compliance investigations per child care program office site inspection.

OUTCOME 3. Alaskan families have warm homes.

EFFECTIVENESS MEASURE	**Percent of low-income households that receive heating assistance.**
EFFICIENCY MEASURE	**Average application cycle time.**

OUTCOME 4. Alaskan families have food security.

EFFECTIVENESS MEASURE	**Percent of low-income Alaskans receiving supplemental nutrition benefits.**
EFFICIENCY MEASURE	**Accuracy rate for initial eligibility determinations.**
EFFICIENCY MEASURE	**Initial application cycle time.**

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 3. Health and social service facilities in which Alaskans are served are safe.

EFFECTIVENESS MEASURE	**Percent of licensed facilities that are free from reports of harm.***
EFFICIENCY MEASURE	**Cost for licensure functions and oversight.***
EFFICIENCY MEASURE	**Percent of time that enforcement action is taken within required timeframe. ***

*** AGGREGATE DIVISION MEASURES - (Percent of licensed facilities that are free from reports of harm).**

EFFECTIVENESS MEASURE	Percent of licensed facilities that are free from reports of harm.
EFFICIENCY MEASURE	Cost for licensure functions/oversight.
EFFICIENCY MEASURE	Percent of time that enforcement action is taken within required timeframe.

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

OUTCOME 4. Alaskans choose respect.

EFFECTIVENESS MEASURE	**Rate of Domestic Violence/Interpersonal Violence referrals to community services.***
EFFICIENCY MEASURE	**Number of clients screened for Domestic Violence/Interpersonal Violence.***

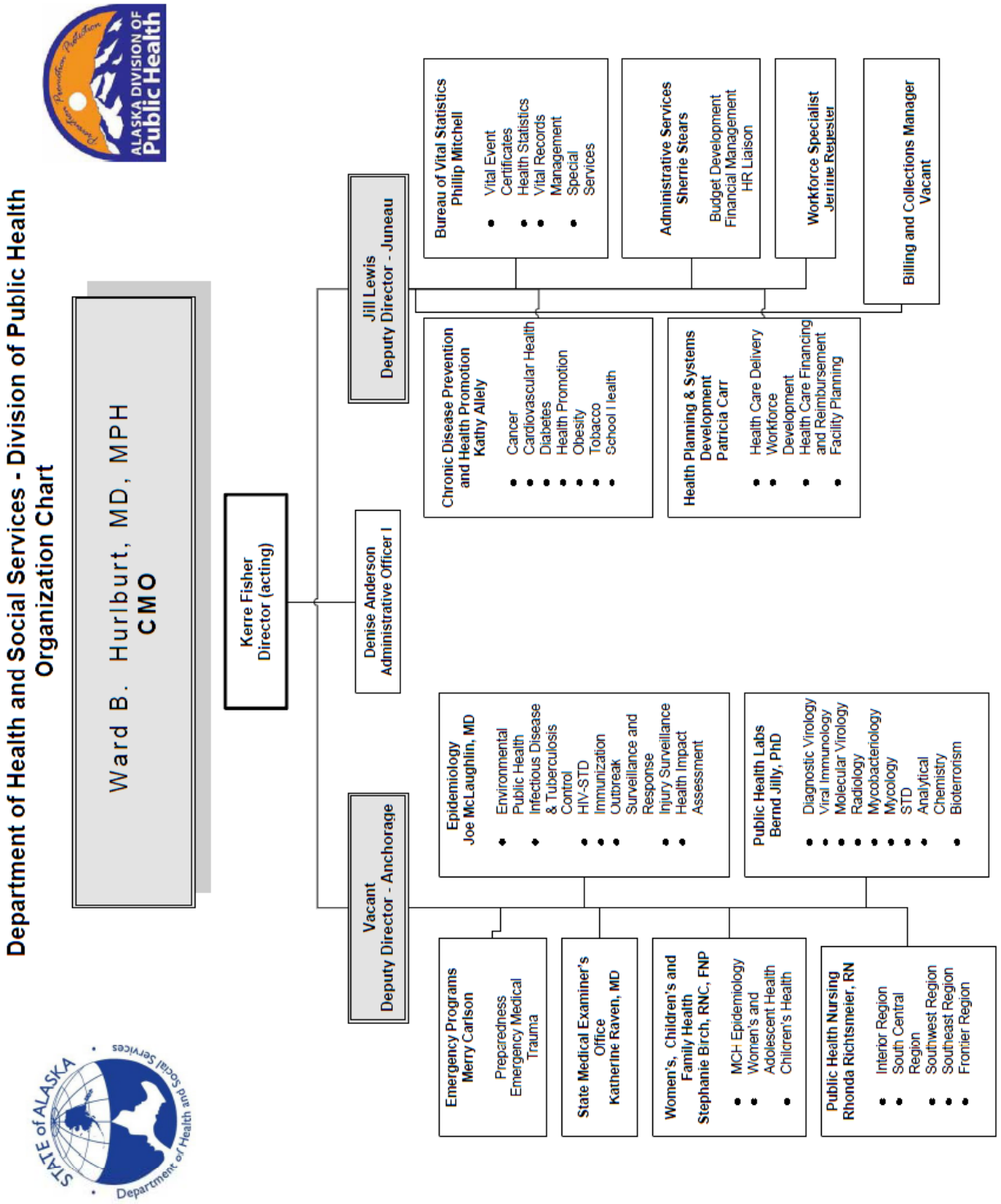
*** DIVISION AGGREGATE - (Rate of Domestic Violence/Interpersonal Violence referrals to community services).**

EFFECTIVENESS MEASURE	Rate of Domestic Violence/Interpersonal Violence referrals to community services.*
EFFICIENCY MEASURE	Number of clients screened for Domestic Violence/Interpersonal Violence.*

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Public Assistance General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
Alaska Temporary Assistance Program Growth (ATAP)	$ -	$ -	$ 3,850.0	$ -	$ 3,850.0
Adult Public Assistance Program Growth (APA)	$ 2,244.0	$ -	$ -	$ 40.0	$ 2,284.0
ARRA Funding Sec30(b) Ch15 SLA2012 P93 L16-20 (HB284) Lapses 6/30/2013 (CCB)	$ -	$ -	$ 0.8	$ -	$ 0.8
Reverse ARRA Funding Sec30(b) Ch15 SLA 2012 P93 L16-20 (HB284) Lapses 06/30/2013 (CCB)	$ -	$ -	$ (0.8)	$ -	$ (0.8)
General Relief Growth (GRA)	$ 1,140.0	$ -	$ -	$ -	$ 1,140.0
Permanent Fund Dividend Hold Harmless Program Growth (PFD-HH)	$ -	$ 650.0	$ -	$ -	$ 650.0
Energy Assistance Funding Sec15(a) Ch15 SLA2012 P76 L17-23 (HB284) (EAP)	$ 3,385.8	$ -	$ -	$ -	$ 3,385.8
Add Energy Assistance in Numbers Section to Replace Sec15(a) Language (EAP)	$ 3,629.0	$ -	$ -	$ -	$ 3,629.0
Add Energy Assistance in Numbers Section to Replace Sec15(b) Language (EAP)	$ 5,000.0	$ -	$ -	$ -	$ 5,000.0
FY2014 Energy Assistance Contingency Language (EAP)	$ -	$ -	$ -	$ -	$ -
Reduce Authority No Longer Available for Energy Assistance Funding (EAP)	$ -	$ -	$ (3,000.0)	$ -	$ (3,000.0)
Reverse Energy Assistance Funding Sec15(a) Ch15 SLA2012 P76 L17-23 (HB284) (EAP)	$ (3,385.8)	$ -	$ -	$ -	$ (3,385.8)
Reverse Energy Assistance Funding Sec15(b) Ch15 SLA2012 P76 L17-23 (HB284) (EAP)	$ (5,000.0)	$ -	$ -	$ -	$ (5,000.0)
ARRA Funding Sec30(b) Ch15 SLA2012 P93 L16-20 (HB284) Lapses 6/30/2013 (PAA)	$ -	$ -	$ 0.7	$ -	$ 0.7
FY2014 Salary and Health Insurance Increases (PAA)	$ 0.3	$ -	$ 0.4	$ 2.7	$ 3.4
Reverse-ARRA Funding Sec. 30(b) Ch 15 SLA 2012 P93 L16-20 (HB284) Lapses 06/30/2013 (PAA)	$ -	$ -	$ (0.7)	$ -	$ (0.7)
Transfer from Medical Assistance Administration for Eligibility Information System Replacement Project Staff (PAA)	$ -	$ -	$ -	$ 355.7	$ 355.7
ARRA Funding Sec30(b) Ch15 SLA2012 P93 L16-20 (HB284) Lapses 6/30/2013 (WIC)	$ -	$ -	$ 837.4	$ -	$ 837.4
FY2014 Salary and Health Insurance Increases (WIC)	$ -	$ -	$ 0.7	$ 0.7	$ 1.4
Reverse-ARRA Funding Sec. 30(b) Ch 15 SLA 2012 P93 L16-20 (HB284) Lapses 06/30/2013 (WIC)	$ -	$ -	$ (837.4)	$ -	$ (837.4)
Public Assistance Total	***$ 7,013.3***	***$ 650.0***	***$ 851.1***	***$ 399.1***	***$ 8,913.5***

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, the 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:

1. Diagnose and investigate health problems and health hazards in the community.
2. Inform, educate and empower people about health issues.
3. Mobilize community partnerships and action to identify and solve health problems.
4. Develop policies and plans that support individual and community health efforts.
5. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
6. Assure adequate and competent public health infrastructure and enforcement of health and safety laws/regulations.
7. Monitor, research, and evaluate health status, and service effectiveness, accessibility and quality to identify and solve community health problems.

Public Health is organized into 10 sections:

- Administrative Services
- Bureau of Vital Statistics
- Chronic Disease Prevention and Health Promotion
- Emergency Programs
- Epidemiology
- Health Planning and Systems Development
- Public Health Laboratories
- Public Health Nursing
- State Medical Examiner's Office
- Women's, Children's and Family Health

Services Provided

Diagnose and Investigate Health Problems and Health Hazards in the Community

- Public health nurses identify the presence of disease, and prevent the spread of infectious diseases such as tuberculosis and sexually transmitted infections by educating on prevention measures, screening for disease, treating disease, identifying and notifying persons who have had contact with the person infected with the disease, and coordinating responses with local health care providers.

- Public health nurses prepare for and respond to public health emergencies and disasters, and coordinate local community preparedness planning and training. They also focus on public health's response to health hazards associated with natural and man-made disasters, as well as new and emerging infectious disease threats.

- Epidemiology requested Public Health Nursing to follow-up on a variety of health and safety concerns including maternal/child health issues, epidemiological investigations, sexually transmitted diseases, and tuberculosis.

- The contribution of the Section of Epidemiology is to characterize, control, and prevent infectious diseases, environmental toxin exposures, injury, and adverse health impacts from large-scale natural resource development projects.

- The State Medical Examiner, through proper death investigations, can accurately determine the cause and manner of deaths that occur throughout the State of Alaska. Cause and manner of death information can be used by partnering sections, divisions, and agencies to determine needs for prevention programs, identifying trends and to initiate efforts to decrease the number of preventable deaths.

- The Alaska State Public Health Laboratories provides timely, accurate, science-based, and validated analysis of human, environmental, and forensic samples. These analytical results are used to: treat and control communicable diseases; monitor human exposure to toxic substances; assess the safety and efficacy of ionizing radiation-producing equipment and procedures; assist in the determination of cause of death or morbidity; and identify intentional and accidental release of biological, nuclear, incendiary, chemical, and explosive hazards.

Inform, educate and empower people about health issues.

- Alaska's public health nurses serve as the frontline public health workforce in communities and villages across the state, delivering essential public health services from

public health centers in 23 towns and cities and through itinerant visits to 280 communities and villages statewide. They work in schools, homes, clinics, shelters, and out of small planes, boats, 4-wheelers, and snowmobiles.

- Public health nurses inform, educate, and collaborate with individuals and community groups to tackle significant public health issues such as obesity and domestic/interpersonal violence.
- Public health nurses help prevent injury and chronic disease by educating on risk factors and actively promoting healthy behaviors in communities conducive to improving health.
- Women, Children, and Family Health works to improve on women and maternal child health outcomes and reduce health inequities through data surveillance and reporting. It offers technical assistance on evidenced-based best practices, by developing educational forums for training and skill development and recruiting specialty health services to meet the needs of women, children and families across the state.
- Chronic Disease Prevention Health Promotion promotes healthy behaviors by producing informational documents and publications on chronic diseases, injuries and risk factors, conducts social marketing campaigns, sponsors educational events, chronic disease self-management workshops, toll-free poison hotline and tobacco cessation counseling, coordinates the provision of life jackets for children at parks, and offers workshops for multiple audiences on the impact of violence on early childhood and adolescent brain development.

Mobilize community partnerships and action to identify and solve health problems.

- Health Planning Systems Development supports and strengthens Alaska's health care infrastructure by developing reimbursement strategies and planning service configuration to assist health care providers qualify for federal programs that strengthen services and improve access to rural and remote communities.

- Public health nurses partner with policymakers, faith-based organizations, firefighters, law enforcement agencies, hospitals, community clinics, tribal health groups, schools, and numerous social service organizations.
- Public health nurses coordinate community-based environmental hazard identification and response.
- Emergency Programs gathers critical data on Preparedness, Emergency Medical Services, and Trauma systems to identify critical gaps, to initiate subsequent planning, training, exercising, and to mitigate for more efficient and timely emergency response and recovery.
- Chronic Disease Prevention Health Promotion supports multiple coalitions by providing training, best practices, technical assistance, meeting coordination and facilitation, data, evaluation, and financial support. These coalitions work at the state and community levels to promote healthy behaviors, eliminate tobacco use and exposure to secondhand

smoke, increase access to healthy foods and physical activity, encourage preventive health screenings, prevent injuries and domestic violence, and promote health among Alaska's students.

Develop policies and plans that support individual and community health efforts.

- Public health nurses engage communities to ensure that programs and policies are designed with input from- and are acceptable to- the intended community.
- Women, Children, Family Health develops policies and plans that support individual and community health efforts by working with tribal and private health care providers.
- Preparedness, Emergency Medical Services, and Trauma work collaboratively with appropriate local, regional, and federal partners to develop emergency response policies and plans that support integrated community health efforts.
- Chronic Disease Prevention and Health Promotion assists community coalitions in identifying and assessing evidence-based policies that support individual and community health efforts. Chronic Disease Prevention and Health Promotion facilitates planning processes in communities, such as through Mobilizing for Action through Planning and Partnerships, and convenes groups to develop plans.

Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

- Public health nurses link individuals to needed healthcare and social services, a primary healthcare home, and provide clinical services such as immunizations, well child exams, developmental screening, HIV testing and prevention counseling, family planning services, pregnancy testing, and postpartum-newborn home visits that would otherwise not be available to individuals due to access-to-care difficulties.
- Emergency Programs link communities with critical resources during shortages, emergencies, and disasters to ensure continuity of care.
- Women, Children, and Family Health works collaboratively with partners to inform the public about activities they can participate in to improve their health outcomes, and links to other services.

Assure adequate and competent public health infrastructure and enforcement of health and safety laws/regulations.

- Health Planning Systems Development helps Alaskan communities improve access to health care by supporting the development of direct service provision through multiple programs, including addressing workforce disparities through recruitment and retention of a competent workforce.
- Emergency Programs outreach, training, and technical assistance to pre-hospital, hospital, and volunteer providers build integrated Preparedness, Emergency Medical Services and Trauma systems of care, and supports regulatory compliance.
- Public Health Laboratories enforces radiation safety regulations and federal clinical laboratory quality regulations.

Monitor, research, and evaluate health status, service effectiveness, accessibility, and quality to identify and solve community health problems.

- Health Planning Systems Development improves health care in Alaska through data collection, analysis, planning for health care programs and facilities, as well as developing quality improvement systems in small rural hospitals
- Public health nurses know the communities they serve and capitalize on their nursing knowledge and their unique relationships to those that they serve, to design and implement programs and services that truly meet the needs of populations.
- Emergency Programs data ensures evidence-based approaches to enhance community preparedness and emergency capabilities.
- Chronic Disease Prevention and Health Promotion is responsible for reporting cancer incidents to the Center for Disease Control, conducts the Youth Risk Behavior Survey, and the Behavioral Risk Factor Surveillance System survey. Chronic Disease Prevention and Health Promotion analyzes and publishes data on health behaviors, and makes it available via the web for researchers, community groups, and public and private organizations working to solve community health problems.
- The major outputs include disease surveillance, outbreak detection and response, vaccine procurement and distribution, epidemiologic and toxicological studies, and health impact assessments.
- The Bureau of Vital Statistics is responsible for registering all vital events in Alaska. The information from birth and death records provide the most complete and continuous data available to public health officials at the local, state, and national levels, and in the private sector. Timely vital statistics data is a critical component of the state's health information system, allowing health care professionals to monitor progress toward achieving important health goals. Examples of vital records data include: teen births and birth rates; prenatal care and birth weight; risk factors for adverse pregnancy outcomes; infant mortality rates; leading causes of death; chronic disease rates, and life expectancy.

Annual Statistical Summary of Services Provided in FY2012

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. These efforts support the division's mission to protect, promote, and improve the health of hundreds of thousands of Alaskans every day. Some of the results of these services from FY2012 are provided below.

Diagnose and investigate health problems and health hazards in the community.

- Public health nurses screened 18,000 individuals for Tuberculosis and started 199 patients on medication to treat Tuberculosis. Nursing visits to Tuberculosis (TB) clients increased by 11% from FY2011 to FY2012 (from 4,642 to 5,131).
- Public health nurses screened 5,802 men and women for Chlamydia with 645 individuals testing positive, and 5,772 men and women for Gonorrhea with 70 of those testing positive.
- Public health nurses made 127 referrals to the Office of Children's Services for suspected incidents of child abuse, child neglect, or sexual offense against a minor.
- Public health nurses received and responded to almost 4,000 referrals from local hospitals, outpatient care providers, schools, correctional facilities, and from our own DHSS Offices of Children's Services.
- Eighty-eight percent of the individuals identified by a public health nurse as positive for Chlamydia were treated within 14 days and 96% of those identified by a public health nurse as positive for Gonorrhea were treated within 14 days.
- 89 children were screened at outreach clinics for Autism and other neuro-developmental conditions in nine communities. The number of children referred, that are over age 3 is beginning to significantly decline.
- Injury Surveillance reviewed coding on 92,579 cases entered in the Alaska Trauma Registry to provide users with additional information on patients' industry and occupation.
- 26 infectious disease outbreaks were investigated in FY2012.
- 2,634 persons received Sexually Transmitted Disease (STD) partner services in FY2012.
- 6 environmental health hazard risk assessments were performed in FY2012.
- Completed new and updated radiological health regulations to better reflect new technological advances and cost recovery.

Major Accomplishments

- Free standing birthing center staff received training in newborn hearing screening and improved their screening rates of newborns by 50% in the last quarter of FY2012.
- 99.9 % of all newborns were screened for over 30 metabolic conditions, and 97.6 % of all newborns (born in hospitals) were screened for hearing loss.
- 75% of the audiologists successfully reported their diagnostic data on newborn hearing loss within one month of diagnosis.
- 72% of women age 50-64 received mammograms.
- Completed new and updated radiological health regulations to better reflect new technological advances and cost recovery.
- Initiated bi-directional laboratory test requesting and reporting between the Fairbanks and Anchorage laboratories; thus, reducing transcription errors and turn-around-times.
- Began direct nucleic acid amplification testing on suspected TB cases, thus resulting in same-day confirmation of: patients leading to improved patient outcomes, earlier treatment intervention, increased opportunities to interrupt transmission, and more effective public health interventions.
- The Biothreat response team responded to 15 biothreat letters, while the toxicology team responded to over 50 acute toxic chemical events.

Inform, educate and empower people about health issues.

- Screening for interpersonal/domestic violence during public health nurse client visits identified 443 clients with positive screening results and an additional 138 with suspect screening results. Clients at- risk-of harm were offered appropriate counseling and resource information to help them protect themselves
- The “Get Out and Play. Every Day.” campaign was launched in January, 2012 to encourage elementary-aged students to enroll in a physical activity challenge. Through a partnership with Healthy Futures, 110 schools participated and 6973 children completed at least one challenge.
- 3,371 people received tobacco cessation counseling and/or nicotine replacement therapy through the Alaska Quit Line.

- 4 media campaigns were produced and aired on statewide TV, radio, web, and in print. These include "Good for Health, Great for Business", "Dear Me", "Tips" and "The Real Cost" addressing smoke-free workplace policy, cessation and return on investment.
- 256 individuals participated in Chronic Disease Self Management workshops. On average, participants rated their ability to manage their chronic condition at 8.6/10 after taking the workshops.
- 8,442 calls were placed to the Poison Control Hotline.
- 14 webinars covering tobacco prevention and control topics were facilitated for partners and grantees.
- A public service announcement, featuring the Chief Medical Officer, Dr. Ward Hurlburt, aimed at preventing falls among older adults was developed and aired statewide.
- 140 individuals participated in the School Health and Wellness Institute held in October, 2011.
- 53 teachers from 20 school districts participated in training for delivering high quality physical education to elementary school students.
- 22 trainings were held for exposure to violence and its impact on brain development. Attendance included public health nurses, teachers, students, parents, tribal judges and tribal organizations, volunteer attorneys, early childhood educators, and staff from Department of Corrections.
- A train-the-trainers workshop for Adolescent Brain and Risks Associated with Substance Abuse and Dating Violence was held.
- A new, train-the-trainers curricula and workshop was developed for the Department of Corrections for childhood exposure to violence and adverse childhood experiences.
- The Cancer Program sponsored 18 cancer education, awareness, and survivorship events.
- The Section of Epidemiology performed over 90 media interviews in FY2012.
- Section of Epidemiology published 34 Epidemiology Bulletins/Recommendations & Reports during FY2012.

Major Accomplishments

- Public health nurses have continued to indicate assessment for domestic/interpersonal violence screening on more than 90% of individual client encounters in FY2012, and visits for which a domestic/interpersonal violence screening was able to be completed increased from 73% in FY2011 to 75% in FY2012.
- Among Alaska high school students, the prevalence of abstinence from sexual intercourse increased from 56.5% in 2009 to 61.7% in 2011.
- The prevalence of pregnant women who reported using tobacco in the last three months increased from 15.3% to 16.8% in 2010 Pregnancy Risk Assessment Monitoring System (PRAMS).
- The rate of pregnancy among 15-17 year olds dropped to16.3 births/1000 in 2010. An average of 3.1 newborns per 1000 live births died prior to their first birthday between 2009 and2011. Nearly half of these deaths were sleep related (SUID/asphyxia**).**

- The division adopted a policy statement on Infant Safe Sleep that reflects the statement written by the American Academy of Pediatrics. Women Children Family Health is partnering with the larger birthing hospitals to develop a nurse training module that will be completed by all maternity nursing personnel. A social marketing evaluation was completed and is informing the approach and information that will be used in a public campaign.
- Supported the Stand Up, Speak Up multi-media youth campaign aimed at ending dating sexual violence.
- The Tobacco Program's media productions won six Telly awards that honor the very best film and video productions for television commercials and programs.
- The "Get out and Play. Every Day." advertisement campaign won four gold awards, one silver award, and one bronze award from the National Public Health Information Coalition.
- The Healthy Futures Challenge saw a three-fold increase in school participation and a five-fold increase in student participation from the previous year.
- Media interest in the obesity problem in Alaska, the *Get out and Play Every Day* and *Healthy Futures Challenge* efforts received 30 publications/stories.
- Co-sponsored a statewide provider education conference, where immunization experts presented strategies to increase statewide immunization coverage rates and information on how to effectively communicate vaccine safety information to hesitant parents.

Mobilize community partnerships and action to identify and solve health problems.

- Fourteen communities received training and technical assistance related to Mobilizing for Action through Planning and Partnerships (MAPP)
- The Kids Don't Float Loaner Board program had 605 active sites throughout the state.
- The Obesity program mobilized the Kenai Peninsula Borough School District's participation in a body mass index study of their student population.
- In partnership with Southeast Alaska Regional Health Consortium, the division conducted policy and community mobilization training for 38 people throughout southeast Alaska.
- Provided financial support for approximately 135 youth and adult chaperones to attend the annual Lead On youth leadership event.
- Eleven interagency emergency preparedness workshops and exercises, including the statewide Alaska Shield 2012 full-scale exercise developed leadership and infrastructure across trauma centers, Emergency Medical Services providers, acute care hospitals, and emergency preparedness. Joint efforts developed and practiced protocols among medical facilities for inter-facility transfers, forward patient movement, and medical surge capabilities.
- Emergency Medical Services and Trauma supported continued education that sustained and advanced pre-hospital and hospital care through training and certification efforts for over 5,000 healthcare providers. This effort included grant support to seven Emergency Medical Services Regions for rural Emergency Medical Services training, which provided over 2,000 additional basic and advanced courses to another 11,000 students.

- Partnerships among the municipality of Anchorage, the Matanuska-Susitna Borough, and state and federal agencies increased objective scores relating to capabilities associated with the Strategic National Stockpile and medical countermeasures.
- A total of $4,093,198 in grants was awarded to 38 community, school, and health care organizations to conduct tobacco prevention and control activities.
- 50 coalitions supported by the Section of Chronic Disease Prevention and Health Promotion were actively working on solving health problems in their communities, or at the state level.

Major Accomplishments

  - Population and community-focused activities by public health nurses in the communities they serve resulted in more local health care providers agreeing to provide immunizations in their practices, and an increase in local partnerships focused on working to improve overall immunization status in their communities.
  - 44.6% of Alaskans served by community water systems are fluoridated optimally.
  - The Dental Health Official has actively worked with communities in the last year to provide evidenced-based information on the health benefits of water fluoridation.
  - One (documented) life was saved when a child was pulled from the water wearing a Kids Don't Float life jacket. This brings the total number of lives known to be saved through the Kids Don't Float program to 23.
  - There was a slight, but statistically significant decline of obesity rates in the Anchorage School District.
  - Adult smoking in Alaska has decreased 25% since 1996 to 20.6% in 2010. This translates into 31,000 fewer tobacco-related deaths and $290 million in savings of future health care costs.
  - Smoking among high school students reached a low 14%. This represents a decrease of more than 60% since 1995.
  - Five additional Farmer's Markets adopted the Quest card as a form of payment, making fresh fruits and vegetables more available to residents with lower incomes.
  - Based on Homer's Mobilizing for Action through Planning and Partnerships (MAPP) plan, the coalition received $750,000 through three grant awards to continue their work.
  - Emergency Medical Services (EMS) and Trauma trainings and technical assistance programs for acute care facilities, emergency medical services, and public health agencies, enhanced trauma program development, implementation and data utilization, and education on pediatric medical care, trauma damage control surgery, disaster management, tactical combat casualty care, pre-hospital and advanced trauma life support, and rural trauma.
  - Increased awareness among trauma centers, emergency medical services, and public health agencies that trauma is a major preventable health problem. It also promoted strategies for prevention and education through participation in collaborative community programs.

- Linkages to collect and share trauma data among public health agencies, emergency medical services, hospitals, and public safety, contributed to evidenced-based practices.
- Enhanced the ability of the Alaska Immunization Tracking and Information System to meet national requirements for Health Level 7 (HL7) data exchange standards and thereby, facilitate interoperability with meaningful use of initiatives, such as: Health information Exchange (HIE) and Electronic Health Records (EHRs)

Develop policies and plans that support individual and community health efforts.

- Women Children Family Health, Maternal Child Health emergency preparedness staff conducted ten community site visits to assess readiness of emergency plans to address vulnerable populations with an emphasis on pregnant and parenting women and children with special health and chronic care needs.
- Conducted study of the prevalence of overweight and obesity for the Anchorage School District comparing data from 1998-1999 through 2010-2011.
- Health care organizations are documenting tobacco use among patients and instituting a protocol for advising and referring patients to cessation services.
- Nineteen tribal, community, school, and health care organizations have passed a tobacco free resolution or policy.
- Facilitated the development of a strategic plan for the Food Policy Council
- Worked with school districts to implement salad bar in the schools
- Thirty-four healthcare organizations (non-funded partners and stakeholders) received technical assistance and support in implementing system-wide tobacco prevention and control policies including screening.
- Initial trauma designation for seven Alaska hospitals was supported by drafting the Trauma System Plan, developing and providing training and technical assistance, and administering the Trauma Care Fund.
- Protocols from newly drafted Alaska Respond policies and plans were implemented during the Alaska Shield full-scale exercise, following 26 associated trainings and electronic registration of licensed healthcare providers to volunteer as disaster responders. In addition, over 75% of healthcare facilities participated in the Alaska Respond Conference.

Major Accomplishments

- Over 5,000 pieces of materials to plan for emergencies were designed and distributed to families with children with special health care needs. Sessions on preparedness have been offered to disability care coordinators, pediatricians and nurses across the state.
- Women Children Family Health was awarded a three-year federal grant award from Center for Disease Control to work on health promotion and screening activities for vulnerable populations, including those with physical and intellectual limiting conditions

- 100% of Local Emergency Preparedness Coalitions (LEPCs) continue to have active public health nurse participation.
- 53% of Alaskans are protected by comprehensive, smoke-free workplace policies.
- The Alaska Federation of Natives passed a resolution calling for smoke-free workplaces, which solidified tribal leader support.
- The village of Kiana implemented a salad bar in their school and submitted a video in response to a contest sponsored by the Department of Education, the Farm to School program, and the Obesity program. The video was featured on the "Let's Move!" blog sponsored by the White House.
- The City of Nome passed a 100% comprehensive smoke-free policy.
- Supported Continuity of Operations Plans development within the Division of Public Health.

Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

- Alaska's public health nurses provided approximately 75,000 health care visits in FY2012; more than 45,000 of these were to children and youth ages birth to 19 years.
- 721 itinerant public health nurse visits were made to villages and small communities that would otherwise not have received routine public health services.
- Public health nurses administered more than 44,000 doses of vaccine to protect against infectious diseases.
- Public Health Nurses initiated more than 4,000 immunizations outreach and reminder contacts via letters, postcards, telephone calls, etc for clients 0-18 years of age.
- Public health nurses made more than 1,650 postpartum home visits to new moms and babies requiring nurse follow-up.
- All immunizations given by public health nurses are now being sent to VacTrAK – a web-based Immunization Registry

Major Accomplishments

- Immunization rate for 10-35 month-old children served by State public health nurses rose from 65% in FY2011 to 69% in FY2012.
- Initiated public health nurse outreach and case management services for families in order to facilitate prompt immunization of children within a parents-preferred immunization scheduling structure.
- Population- and community-focused activities by public health nurses in the communities they serve resulted in more local health care providers agreeing to provide immunizations in their practices and an increase in local partnerships focused on working to improve overall immunization status in their communities.
- Over 35 schools have implemented the 4th R curriculum to high school students, with more than 500 students participating last year. This curriculum teaches healthy relationship skills with a focus on what respectful relationships should be like.

- There was a decrease in the percentage of high school students, who reported getting hit, slapped or physically hurt on purpose, by their boyfriend or girlfriend during the previous 12 monthsfrom13.3% in 2011, to 12.0% in 2012.
- Women Children Family Health awarded a contract to initiate the Nurse Family Partnership Home Visiting Program for high-risk pregnant women. Early screening and identification of women at risk for intimate partner violence will be stressed during these visits.
- Over 400 children were served by specialty pediatric clinics in the areas of genetics, metabolic, cleft lip/palate conditions, or those with Autism/Neurodevelopmental Disorders

Assure adequate and competent public health infrastructure and enforcement of health and safety laws/regulations.

- The Section of Nursing assumed responsibility for public health nursing services to Nome and the Norton Sound area from Norton Sound Health Corporation at their request.

- Seven Alaska hospitals were designated as Level IV Trauma Centers, bringing the total to eleven in FY2012. Trauma staff provided six trauma designation consultation visits to non-designated hospitals in the ongoing designation process.

- State funding of $509,000 for the Code Blue Program leveraged an additional $365,000 in federal and local funding, for a total of over $1.1 million. From 2001 to 2011, state funding of $4.6 million produced a return on investment of over 3:1 in additional funding to meet over $19.7 million of essential EMS capital equipment needs.

- Over 500 courses for pre-hospital and hospital medical personnel statewide were approved, recertified, developed, and delivered. The number of ground and air ambulance services that were certified grew to 128, while nearly doubled the number of EMS services providing data in the Aurora system to 50%.

- The Bureau of Vital Statistics is responsible for registering all vital events in Alaska. Examples of vital records data include: teen births and birth rates; prenatal care and birth weight; risk factors for adverse pregnancy outcomes; infant mortality rates; leading causes of death; chronic disease rates, and life expectancy.

- The State Medical Examiner's Office is another program that supports all core public health services. Activities include providing an accurate, legally-defensible determination of the cause and manner of death, and conducting a comprehensive medico-legal death investigation.

- Information determined, collected, and gathered by the State Medical Examiner's Office is used by other sections, division and agencies, both state and federal, to identify trends and initiate efforts to decrease the number of preventable deaths that occur throughout the State of Alaska.

Major Accomplishments

- Transition of public health nursing services from Norton Sound Health Corporation to State Public Health Nursing was managed so that the change was smooth and did not disrupt client services; clients saw very little change from their perspective. During the transition period, public health nurses were able to successfully manage TB outbreaks in Nome, Savoonga, and Elim.
- All public health centers have been upgraded from outdated 56K modem speed connection to the optimal State connection available in the area; this resulted in a significant positive impact on workplace efficiency
- All State public health centers can now accept electronic payments (credit/debit) from clients for services provided. A new fee-for-service policy instituted collection of sliding-scale-fees for many services previously delivered without charge (i.e. services to children and some infectious disease services). Training on the new policy was completed and it went into effect starting July 1, 2012. Comparison of charges collected for public health nursing services in July 2011 (FY2012) and July 2012 (FY2013) revealed a 54% increase in revenue – from $12,078 to $18,580
- The vacancy and turnover rate for Section of Nursing was reduced from 17.5% at the end of FY2011 to 15.8% at the end of FY2012 and is currently at 11.63%.
- The EMS Unit drafted new EMS Regulations and conducted four public workshops, while beginning the process of aligning training, testing, and other practices to those draft regulations in preparation for potential implementation.
- The Alaska Trauma Registry is current through 2012 with completion of web-based training for all 24 hospitals and a go-live date of January 1, 2013.
- 82% of the cases reported in FY2012 were transported to the State Medical Examiner's Office for further examination, compared to 77% in FY2011.
- Conducted training for Medical Examiner staff as well as local, state and federal law enforcement in proper recovery methods for buried bodies and surface scattered human remains.

Monitor research and evaluate health status, and service effectiveness, accessibility and quality to identify and solve community health problems.

- Provided 1,073 technical assistance encounters on health care services and funding to over 103 different community-based organizations and health care organizations (SORH and Data Team)
- Increased the health care workforce through direct loan repayment awards for 16 health care professionals in FY2012 for a total of 40 professionals' to-date.
- Supported another 67 health professionals receiving National Health Service Corps federal loan repayment and 15 federally-funded scholars
- Awarded $401,000 in grants to 12 community health centers for improving access to primary care for those 65 years of age and older.

Major Accomplishments

- 20 years of Behavioral Risk Factor Surveillance System data are available on line through Instant Atlas. This data can be viewed graphically and for the first time is widely available and accessible to researchers, partners, private and public organizations, and interested members of the public. This includes 226,000 data points.
- The Cancer Registry achieved Gold Status for quality, completeness and timeliness from the National Association of Central Cancer Registrars.
- Investigated whether there was an association between sulfolane and cancer incidence in a North Pole census track where ground water had been contaminated. No association was found.
- Analyzed data and published obesity facts, tobacco facts, a brief summary of chronic disease data, an evaluation of a distance delivery project for chronic disease self management, and a study of the prevalence of overweight and obesity among students in the Anchorage School District.
- Collected and reported cancer incidence data to the Centers for Disease Control and Prevention
- Collected, analyzed, and published Behavioral Risk Factor Surveillance System data on adult behaviors that are risk factors for multiple health problems
- Analyzed and reported Youth Risk Behavior Survey results from the 2010 survey
- Analyzed data and published an extensive report on tobacco use in Alaska – "Tobacco in the Great Land"

Other Division of Public Health Statistical Information

Information determined, collected and gathered by the State Medical Examiner's Office is used by other sections, divisions, and agencies, both state and federal, to identify trends and initiate efforts to decrease the number of preventable deaths that occur throughout the State of Alaska. Statistical data collected by the State Medical Examiner's Office is used to demonstrate the need for prevention programs. Child Fatality Review Team (CFRT) is comprised of local and state law enforcement, Department of Law, Medical Examiner staff, Office of Children Services, local pediatrician, and other Division of Public Health staff who meet monthly to review all child fatalities reported to the State Medical Examiner's Office.

- 82% of the cases reported in FY2012 were transported to the State Medical Examiner's Office for further examination, compared to 77% in FY2011.
  - Total cases investigated: 1,625
  - Cases where jurisdiction was assumed: 893
  - Cases where jurisdiction was not assumed: 732
  - Cases autopsied: 502
  - Cases with Inspections: 232

- Cases with consultations: 159
- Cases transported to Anchorage office: 734

- In FY2012, the Bureau of Vital Statistics recorded:
  - Births: 11,051
  - Deaths: 3,839
  - Fetal Deaths: 57
  - Intentional Termination of Pregnancy: 1,606
  - Marriage licenses issued: 5,394
  - Divorces: 3,324
  - Adoptions of Alaska-born children: 764
  - Establishments of paternity of Alaska-born children: 3.764
  - Applications for the Medical Marijuana Registry: 946
  - Funds collected for the Alaska Children's Trust from marriage heirloom birth and marriage certificates: $22.7

- 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
  - Unique healthcare providers served 275
  - Unique patients tested 38,976
  - Patient samples 82,142
  - Commercial value of tests performed $ 23,771.0

List of Primary Programs and Statutory Responsibilities

Statutes

AS 08.36.271	Dentist Permits for Isolated Areas
AS 08.64.326	Grounds for Imposition of Disciplinary Sanctions
AS 08.64.369	Medicine
AS 08.65	Direct-Entry Midwives
AS 08.68	Board of Nursing
AS 09.55.060	Special Actions & Proceedings
AS 09.55.556	Informed Consent
AS 09.65.161	Immunity for Disclosure of Required Health Care Data
AS 11.41.360	Human Trafficking - criminal definitions
AS 11.41.432	Defenses - exclusion of marriage as defense for sexual abuse
AS 11.41.434-440	Sexual Abuse of a Minor
AS 11.66.110-150	Sex Trafficking/Promoting Prostitution (<18yo in adult entertainment or prostitution by definition forced/trafficked)
AS 11.81.430	Use of Force, Special Relationships
AS 12.55.155	Sentencing & Probation
AS 12.65	Death Investigations & Medical Examinations
AS 13.52.060	Health Care Decisions Act
AS 14.07.020	Duties of the Department of Education and Early Development
AS 14.30.065 - 125, 127, 191, 231	Physical Examinations and Screening Examinations (includes immunization, vision and hearing screening, physicals)
AS 14.30.065-127	Physical Examinations and Screening Examinations
AS 14.30.125	Immunization
AS 14.30.231	Gov's Council on Disabilities assures appropriate programs & services for children with disabilities
AS 17.37.030	Medical Use of Marijuana
AS 18.05.010-.070	Administrations of Public Health and Related Laws
AS 18.05.042	Access to Healthcare Records
AS 18.08.010-200	Emergency Medical Services
AS 18.08.085	Trauma Care Fund
AS 18.15	Disease Control and Threats to Public Health / Public Health Authority and Powers
AS 18.15.010-900	Disease Control & Threats to Public Health
AS 18.15.200	Screening for Metabolic Disorders
AS 18.15.250	Vaccination Program for Volunteer Emergency Personnel
AS 18.15.395	Definitions
AS 18.16.010	Regulation of Abortions
AS 18.20.200	Acceptance of Grants
AS 18.23.005	Patient Records - patient right of access

AS 18.23.010-070	Health Care Services Information and Review Organizations
AS 18.23.100, 300-325	Form of Medical records (they maybe electronic) and electronic information exchange security
AS 18.28.010-100	State Assistance for Community Health Aide Programs
AS 18.29	Health Care Professions' Loan Repayment and Incentive Program
AS 18.50.010-990	Vital Statistics Act
AS 18.50.020	Department to adopt regulations
AS 18.50.310	Disclosure of records
AS 18.50.320	Copies of data from vital records
AS 18.50.350	Duty to Furnish Information to Vital Stats
AS 18.60.010-075	Prevention of Accident and Health Hazards - general employer responsibilities
AS 18.60.475-545	Radiation Protection
AS 18.60.880-890	Needle stick and sharps injury protections for health care workers
AS 25.05.071-391	Alaska Marriage Code
AS 25.20.010	Age of majority
AS 25.20.025	Examination and Treatment of Minors
AS 25.20.050(b), 055	
AS 25.20.20	Arrival at majority upon marriage
AS 25.23.130, 160	Effect of adoption decree, foreign adoption same effect
AS 25.23.160-170	Adoption
AS 25.24.150	Child Custody during/after divorce
AS 26.23	Disasters (Alaska Disaster Act)
AS 37.05.580	Tobacco Use Education & Cessation Fund
AS 40.25.110, 115	Public Records: copying, fees, applicable to electronic records
AS 40.25.120	Public Records: exceptions; certified copies
AS 40.25.125	Public Record Disclosures
AS 44.29.020	Department of Health & Social Services
AS 44.29.022, 024	Fees for services of department and grantees
AS 44.62.245	Material Incorporated by Reference
AS 47.05.010-050	Duties of Department - administrative, incorporation of federal classifications for disease and federal rates, ability to set policy for records, cooperate with feds
AS 47.05.012	Material Incorporated by Reference
AS 47.05.060-065	Purpose and Policy Relating to Children
AS 47.07.010-030	Medical Assistance for Needy Person
AS 47.17.010-290	Child Protection
AS 47.17.020	Child Protection - Persons Required to Report
AS 47.18.010-200	Comprehensive Planning (adolescent pregnancy prevention, provision of services to adolescent parents and their children, and peer counseling)

AS 47.20	Services for Developmentally Delayed or Disabled Children
AS 47.20.300-390	Newborn and Infant Hearing Screening, Tracking and Intervention Program
AS 47.24.900	Protection for Vulnerable Adults

Regulations

04 AAC 06.055	Immunizations
07 AAC 05.110-990	Vital Records
07 AAC 05.931	Disclosure to immunization registries (cites AS 18.50.020, AS 18.50.310, and AS 18.50.320)
07 AAC 12.009	Free Standing Birth Centers
07 AAC 12.450 - 7 AAC 12.920	Determination of a Frontier Extended Stay Clinic
07 AAC 12.650	Employee Health Program - TB Testing; Rubella & Hepatitis B Immunity
07 AAC 12.810	Laboratory Safety, REPEALED 2006
07 AAC 12.830	Mailing of Lab Specimens
07 AAC 16.010-090	Do Not Resuscitate Protocol & Identification
07 AAC 18	Radioactive Materials; Radiation Sources & Radiation Protection
07 AAC 23.010-.900	Programs for Children with Disabilities
07 AAC 26.010-999	Emergency Medical Services
07 AAC 26.710-745	Trauma Centers, Trauma Registry, & Trauma Care Fund
07 AAC 27	Preventative Medical Services
07 AAC 27.005-900	Preventative Medical Services (Includes Birth Defects Registry)
07 AAC 27.011	Reporting of Cancer and Brain Tumors
07 AAC 27.011	Confidentiality of Required Reports and Medical Records
07 AAC 27.510-590	Screening of Newborn Children for Metabolic Disorders
07 AAC 27.600-650	Newborn Hearing Screening
07 AAC 27.892	Maintaining List and Registries of Immunizations
07 AAC 35	Embalming & Other Post-Mortem Services
07 AAC 50.455	Health in Child Care Facilities & Full Time Care Facilities
07 AAC 57.545	Reducing the spread of disease
07 AAC 57.550	Child Care Regulations - Health (includes immunizations)
07 AAC 75.220	Assisted Living Homes
07 AAC 78.010-320	Grant Programs
07 AAC 80	Fees for Department Services
12 AAC 02.280-282	Board of Nursing - licensing fees
12 AAC 40.967	Unprofessional Conduct
12 AAC 44	Board of Nursing, including Advanced Nurse Practitioner

14 AAC 12 & 14	Renewal & Continuing Competency Requirements for Certified Direct-Entry Midwives
18 AAC 80	Drinking Water

Federal Authority

10 CFR	Nuclear Regulatory Commission - Authority to Regulate
21 CFR 900	Mammography Quality Standards - Authority to Inspect
42 CFR 72 & 73	Possession, Use, & Transfer of Select Agents & Toxins (Select Agents Rule)
9 CFR 2.31	Institutional Animal Care & Use Committee
PL 106-386 (TVPA 2000)	Trafficking Victims Protection Act
Public Law 104-191	Health Insurance Portability and Accountability Act (HIPAA) of 1996
Public Law 107-56	Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept & Obstruct Terrorism (USA PATRIOT ACT) Act of 2001
Public Law 107-188	Public Health Security & Bioterrorism Act of 2002
Title X	Family Planning Program
Title XIX	Medicaid
Title XVIII	Medicare
Title XXI	Children's Health Insurance Program

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 obesity[2] 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.

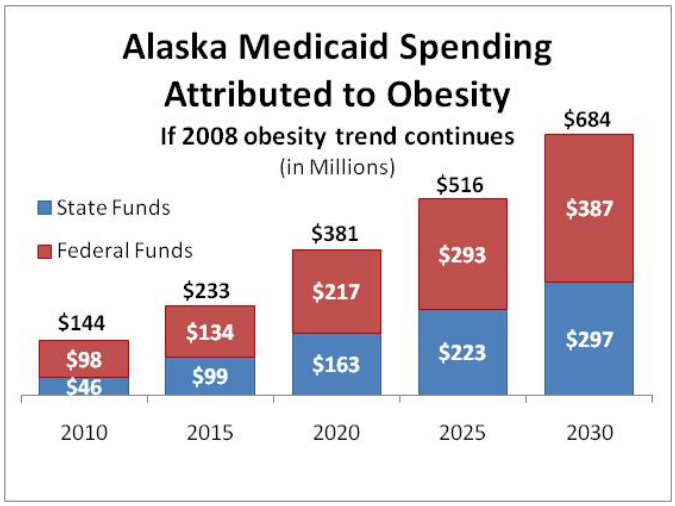
The Magnitude of the Problem

- 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.

[2] 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 consume excess calories, while making it harder to be physically active enough to burn those excess 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 funds.

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 Physical Education (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 for 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, causing 600 deaths 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 users by implementing a sustained, comprehensive tobacco prevention and control program that includes a tobacco quit line, media, community programs, and grants to schools and healthcare organizations. Since the inception of the program, adult smoking rates have declined significantly and youth smoking rates have been cut in half.

Despite the progress, 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 Native 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 %) was below the national average (21 %). The overall youth smoking rate has dropped by over 50 % between 1995 (37 %) and 2009 (16 %), below the national rate of 20%. 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 % of Alaskans
- Tobacco product price increases, - tobacco taxes - at the state and local level help dissuade kids from starting
- Enforcement of laws 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

- Secured state funding to support vaccine procurement and distribution of select recommended vaccines for underinsured children and under/uninsured adults.
- Implemented a perinatal hepatitis B case management program designed to prevent hepatitis B transmission from mother to infant during the delivery process.
- Enhanced VacTrAK's (Alaska Immunization Tracking and Information System) ability to meet national requirements for HL7 data exchange standards, and thereby facilitate interoperability with meaningful use initiatives, such as, Health information Exchange and Electronic Health Records.
- Co-sponsored a statewide provider education conference, where immunization experts presented strategies to increase statewide immunization coverage rates and information

on how to effectively communicate vaccine safety information to hesitant parents.

- Recommended vaccine series coverage rates have increased among 19-35 month-olds from 66.1% in 2010 to 69.0% in 2011, which raised Alaska from 42nd to 39th in the national ranking.
- The state's immunization information system , VacTrAK (Alaska Immunization Tracking and Information System), has two or more vaccines recorded for 56% of children in the IIS and is actively receiving data from 65% of enrolled VFC (Vaccine for Children) providers
- Enhanced collaboration with the Division of Global Migration and Quarantine to better detect and respond to illness aboard cruise ships in Alaska.
- Worked with industries employing large numbers of seasonal employees from abroad to better screen their employees for vaccination status and tuberculosis status, to prevent outbreaks of disease.

Community Water Fluoridation

Alaska is losing ground with 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's 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. Between 2004 and 2007, the Alaska Native unintentional injury death rate was twice as high compared to 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

- Injury Surveillance (Section of Epidemiology) in collaboration with the Division of Behavioral Health, Early Development Program, continue its work to assess data gaps associated with substance use and abuse.
- Injury Surveillance initiated the Public Health Data Workgroup to maintain communication among personnel utilizing Division of Public Health data and to identify collaborative statewide projects in order to eliminate redundancy of efforts and promote promising practices for data use.
- Provide education and programming strategies to decrease the rate of older adult fall-related injuries and deaths.
- Alaska's drowning fatality rate holds steady at 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 (highway motor vehicle crash injuries, falls, assaults, all-terrain vehicle, and snow machine crash injuries) of hospitalization. Increasing the public's knowledge through education on age-appropriate and properly fitted restraints, and safe riding and helmet use may reduce the number of hospitalizations.

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 continuing its work to protect and promote the health of Alaskans with existing resources. Investing in Public Health 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:
    - 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 and service effectiveness, and accessibility and quality to identify and solve community health problems.
- 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 such 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 cooperation 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 to make reforms within the State Medical Examiner's Office to better serve statewide needs.

Division of Public Health

Budget Overview Table

Division of Public Health	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$56,531.0	$56,607.4	$76.4
Designated General Funds	14,811.5	14,811.5	0.0
Federal Funds	37,917.0	38,918.9	1.9
Other Funds	7,731.9	7,606.6	-125.3
Total	**$117,991.4**	**$117,944.4**	**-$47.0**

The increase of unrestricted general funds in FY2014, is due to the replacement of the anticipated loss of the general fund program receipts revenue by the Bureau of Vital Statistics. This anticipated loss is due the inadvertent omission of the HB 129 Deceased Veterans Death Certificates fiscal note from the FY2013 appropriations bill.

HB 129 provides for Bureau of Vital Statistics to issue up to four death certificates to family members or representatives of deceased Veterans without cost. This bill was passed with a fiscal note replacing the lost fee revenue (GF/PR) with general funds. The fee for a Death Certificate is $25.00; lost revenue to Bureau of Vital Statistics is estimated to be $75.0 in the first year.

Restricted revenues make up 97% of the annual budget for Bureau of Vital Statistics; 77% of this revenue is General Fund Program Receipts or fees, of which death certificates are a portion. Without replacement of this revenue, the public would suffer longer processing time as staffing levels are reduced. This request addresses that issue.

A decrement of $75.0 in Mental Health Trust funds were for the Autism Workforce Development Capacity Building project. The three year funding for this project ended in FY2013.

The remaining difference is due to various salary adjustments.

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.

To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN	
CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.	
OUTCOME 1. Alaskans are healthy	
EFFECTIVENESS MEASURE	**Percent of Alaskans who demonstrate improved health status.***
EFFICIENCY MEASURE	**Cost per percentage of improved health.***
	***AGGREGATE DIVISION MEASURES - (Percent of Alaskans who demonstrate improved health status).**
EFFECTIVENESS MEASURE	Percent of Alaskans who are immunized.
EFFICIENCY MEASURE	Cost per immunization.
EFFECTIVENESS MEASURE	Percent of Alaskans who are overweight/obese.
EFFICIENCY MEASURE	Cost per child of physical education campaign.
EFFICIENCY MEASURE	Total Women, Infant and Children grant cost per direct service FTE.
EFFECTIVENESS MEASURE	Percent of Alaskans who receive preventative health screenings.
EFFICIENCY MEASURE	Savings realized due to early detection and treatment of childhood disease, disability and conditions. (DPH)

	EFFICIENCY MEASURE	Cost per client for screening. (DPH)
	EFFICIENCY MEASURE	Cost per screening. (DBH)
	EFFICIENCY MEASURE	Cost for medical services per resident. (DJJ)
	EFFICIENCY MEASURE	Percent increase of screenings completed within mandatory 30 days from date of entry. (OCS)
	EFFECTIVENESS MEASURE	Rate of high-risk maternal (pre-natal) behaviors.
	EFFICIENCY MEASURE	Cost per client served. (DPH)
	EFFICIENCY MEASURE	Number of clients served by mini-grants. (DPA)
	EFFECTIVENESS MEASURE	Percent of communities that identify and address local health problems.
	EFFICIENCY MEASURE	Cost of MAPP training and support per community.
EFFECTIVENESS MEASURE	**Percent of Alaskans reporting very good/good health.**	
EFFICIENCY MEASURE	**Treatment costs per capita.**	

OUTCOME 2. Alaskans are free from unintentional injury

EFFECTIVENESS MEASURE	**Number of Alaskans experiencing unintentional injuries.**	
EFFICIENCY MEASURE	**Cost of injury prevention program per capita.**	
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percent of non-fatal injuries requiring hospitalization.
	EFFICIENCY MEASURE	Cost of emergency medical services per capita.
	EFFICIENCY MEASURE	Cost of injury prevention program per unintended injuries/deaths.

OUTCOME 3. Alaskans are free from substance abuse and dependency

EFFECTIVENESS MEASURE	**Rate of tobacco use by age group.**
EFFICIENCY MEASURE	**Cost per capita of Tobacco Prevention & Control program.**

CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.

OUTCOME 2. Older Alaskans live safely in their communities.

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Number of falls requiring hospitalization among adults 65 and over.
	EFFICIENCY MEASURE	Cost per capita of senior falls campaign.

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***

	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**	
	EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
	EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
	EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

OUTCOME 2. Alaskans with chronic or complex medical conditions receive integrated care.

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Number of clinics providing telehealth services to veterans.
	EFFICIENCY MEASURE	Cost per capita of the veterans telehealth program.
	EFFECTIVENESS MEASURE	Number of women receiving services through the Maternal, Infant and Early Childhood Home Visiting and Healthy Starts programs.

	EFFICIENCY MEASURE	Cost per service recipient of the Maternal, Infant and Early Childhood Home Visiting and Healthy Starts programs.

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

OUTCOME 3. Health and social service facilities in which Alaskans are served are safe.

EFFECTIVENESS MEASURE	**Percent of licensed facilities that are free from reports of harm.***
EFFICIENCY MEASURE	**Cost for licensure functions and oversight.***
EFFICIENCY MEASURE	**Percent of time that enforcement action is taken within required timeframe. ***

	*** AGGREGATE DIVISION MEASURES - (Percent of licensed facilities that are free from reports of harm).**	
	EFFECTIVENESS MEASURE	Percent of licensed facilities that are free from reports of harm.
	EFFICIENCY MEASURE	Cost for licensure functions/oversight.
	EFFICIENCY MEASURE	Percent of time that enforcement action is taken within required timeframe.

CORE SERVICE C. PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS.

OUTCOME 1. Alaskan communities support tobacco enforcement.

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Number of tobacco free policies adopted.
	EFFICIENCY MEASURE	Cost per capita of Tobacco Prevention & Control program.

OUTCOME 2. Juveniles develop and demonstrate skills in positive decision making.

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Rate of teen births to women 15-17 years old.
	EFFICIENCY MEASURE	Cost per capital of Title X program.

	EFFECTIVENESS MEASURE	Percent of Alaskan children who are overweight/obese.
	EFFICIENCY MEASURE	Cost per child of physical education campaign.

OUTCOME 3. Alaskans with health conditions practice self-management.		
EFFECTIVENESS MEASURE	**Percent of clients with chronic disease enrolled in self-management programs.**	
EFFICIENCY MEASURE	**Cost per client for self-management services.**	
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Rate of tobacco use by age group.
	EFFICIENCY MEASURE	Cost per capita of Tobacco Prevention and Control program.

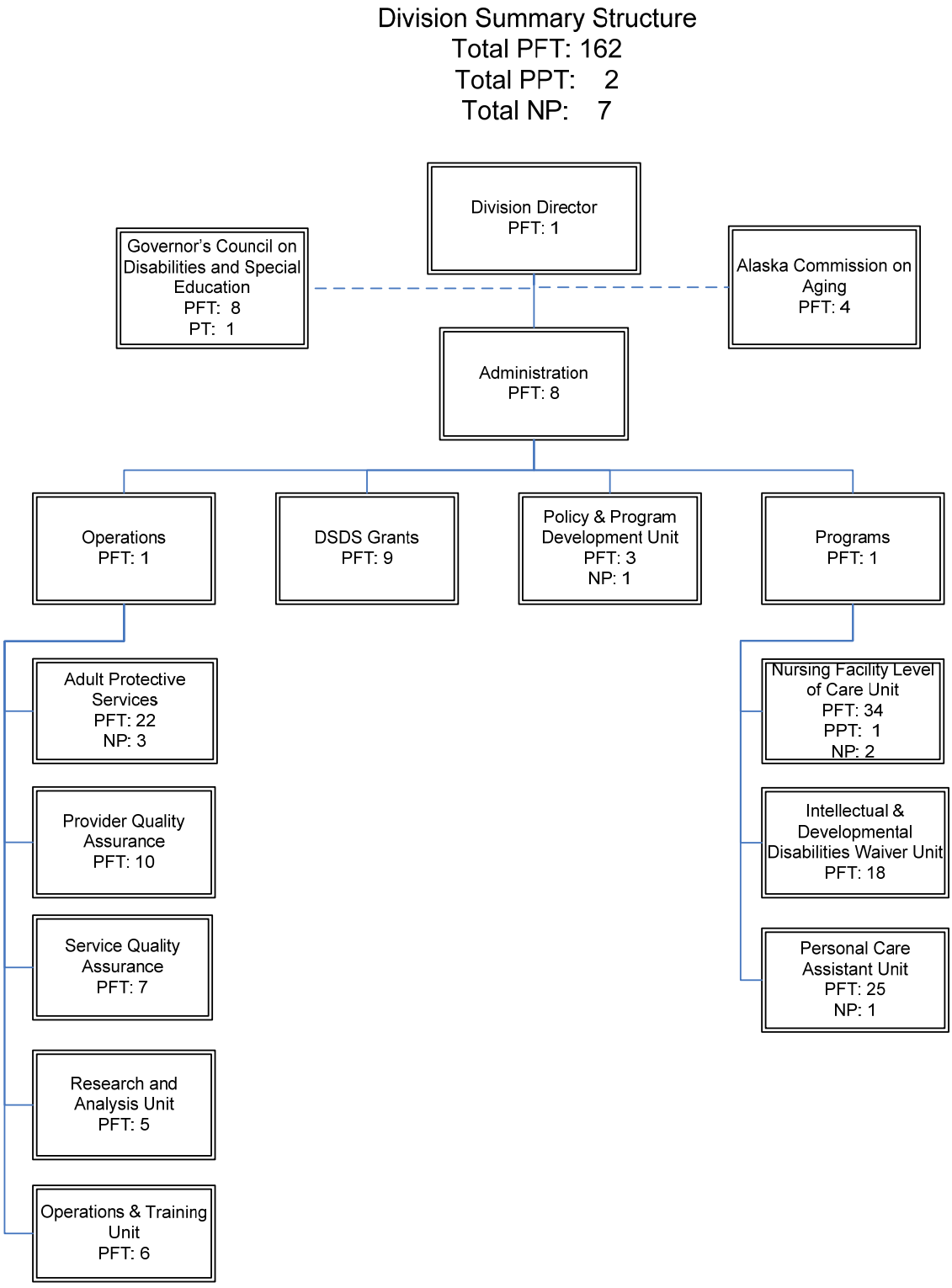
OUTCOME 4. Alaskans choose respect.		
EFFECTIVENESS MEASURE	**Rate of Domestic Violence/Interpersonal Violence referrals to community services.***	
EFFICIENCY MEASURE	**Number of clients screened for Domestic Violence/Interpersonal Violence.***	
	*** DIVISION AGGREGATE - (Rate of Domestic Violence/Interpersonal Violence referrals to community services).**	
	EFFECTIVENESS MEASURE	Rate of Domestic Violence/Interpersonal Violence referrals to community services.*
	EFFICIENCY MEASURE	Number of clients screened for Domestic Violence/Interpersonal Violence.*

OUTCOME 5. Alaskans prepare for disaster.		
EFFECTIVENESS MEASURE	**Percent of Alaskan communities that participated in at least one disaster preparedness activity during state fiscal year.**	
EFFICIENCY MEASURE	**Cost for disaster preparedness training per participant.**	

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Public Health General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
Incentives for Certain Medical Providers Ch25 SLA2012 (HB78) (Ch15 SLA2012 P43 L10-16) (HB284) (HPSD)	$ 2,164.2	$ 678.7	$ -	$ -	$ 2,842.9
FY2014 Salary and Health Insurance Increases (HPSD)	$ 1.4	$ -	$ -	$ -	$ 1.4
MH Trust Workforce Dev - Grant 1383.06 Loan Repayment (HPSD)	$ -	$ -	$ -	$ 200.0	$ 200.0
Reverse FY2013 MH Trust Recommendation (HPSD)	$ -	$ -	$ -	$ (325.9)	$ (325.9)
Reverse-Year 2 FN Incentives for Certain Medical Providers CH25 SLA 2012 (HB78) (CH15 SLA2012 P43 L10-16) (HB284) (HPSD)	$ (7.6)	$ -	$ -	$ -	$ (7.6)
FY2014 Salary and Health Insurance Increases (Nursing)	$ 0.7	$ -	$ -	$ -	$ 0.7
FY2014 Salary and Health Insurance Increases (WCFH)	$ 0.2	$ -	$ 0.5	$ -	$ 0.7
MH Trust: Gov Cncl - Grant 3505.02 Autism Workforce Development Capacity Building (WCFH)	$ -	$ -	$ -	$ 75.0	$ 75.0
Reverse FY2013 MH Trust Recommendation (WCFH)	$ -	$ -	$ -	$ (75.0)	$ (75.0)
FY2014 Salary and Health Insurance Increases (PHAS)	$ 0.9	$ -	$ 0.3	$ 0.2	$ 1.4
Naturally Occurring Asbestos Ch13 SLA2012 (HB258) (Ch15 SLA2012 P45 L26-29) (HB284) (Epi)	$ 21.3	$ -	$ -	$ -	$ 21.3
State Immunization Program Ch24 SLA2012 (HB310) (Ch15 SLA2012 P46 L25-30) (HB284) (Epi)	$ 4,496.0	$ -	$ -	$ -	$ 4,496.0
FY2014 Salary and Health Insurance Increases (Epi)	$ 1.9	$ -	$ 1.1	$ 0.4	$ 3.4
Restore Chlamydia media campaign, testing, and therapy (FY13-FY15) (Epi)	$ 360.0	$ -	$ -	$ -	$ 360.0
Reverse Chlamydia Media Campaign, Testing, and Therapy (FY13-FY15) (Epi)	$ (360.0)	$ -	$ -	$ -	$ (360.0)
Reverse-Year 2 FN Naturally Occurring Asbestos CH13 SLA2012 (HB 258) (CH15 SLA2012 P45 L26-29) (HB284) (Epi)	$ (1.2)	$ -	$ -	$ -	$ (1.2)
HB129 Deceased Veterans Death Certificates (BVS)	$ 75.0	$ -	$ -	$ -	$ 75.0
FY2014 Salary and Health Insurance Increases (SME)	$ 2.1	$ -	$ -	$ -	$ 2.1
FY2014 Salary and Health Insurance Increases (PHE)	$ 3.0	$ -	$ -	$ -	$ 3.0
Public Health Total	***$ 6,757.9***	***$ 678.7***	***$ 1.9***	***$ (125.3)***	***$ 7,313.2***

Division of Senior and Disabilities Services



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 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, the Personal Care Assistance program, Traumatic Brain Injury services, Senior Services, and Community Developmental Disabilities grants programs.

Core Services

- Protection of vulnerable adults from abuse, neglect, and exploitation through investigation and the provision of protective services
- Authorization of nursing home placements and facilitation of transitions out of nursing homes to community placements
- Administration of Medicaid State Plan Personal Care Assistance 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.
- Administration of four Medicaid Home and Community Based Waivers
- Prior Authorization of Medicaid waiver services to 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
- Provision of temporary assisted living for vulnerable adults over the age of 18, as referred by Adult Protective Services investigators or community health professionals
- Administration of community-based grant programs for individuals with developmental disabilities, seniors, and their caretakers
- Administration of 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 Home and Community-Based services and providers through a continuous quality improvement process
- Investigation of critical incidents and complaints related to the delivery of Home and Community-Based services.

Services Provided

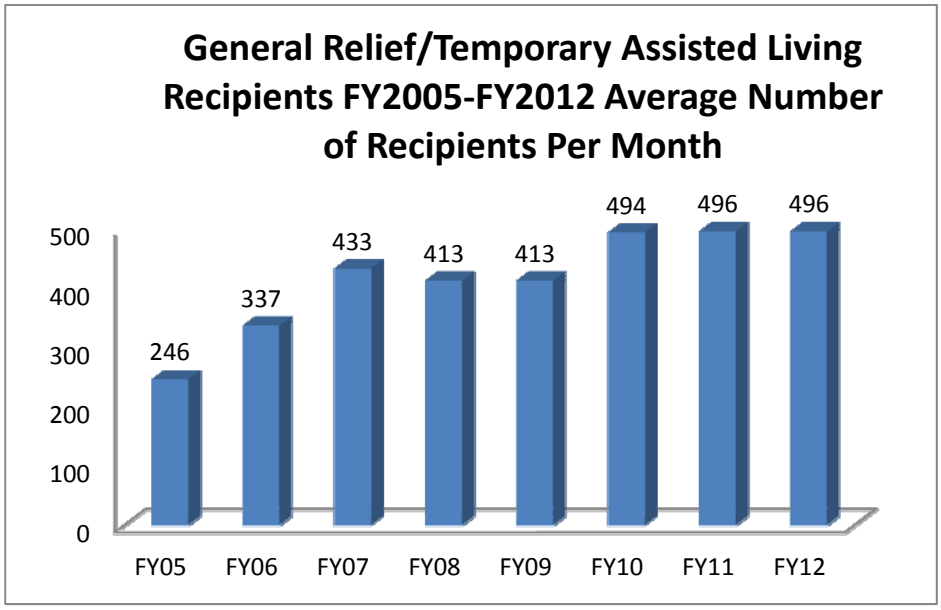
Adult Protective Services

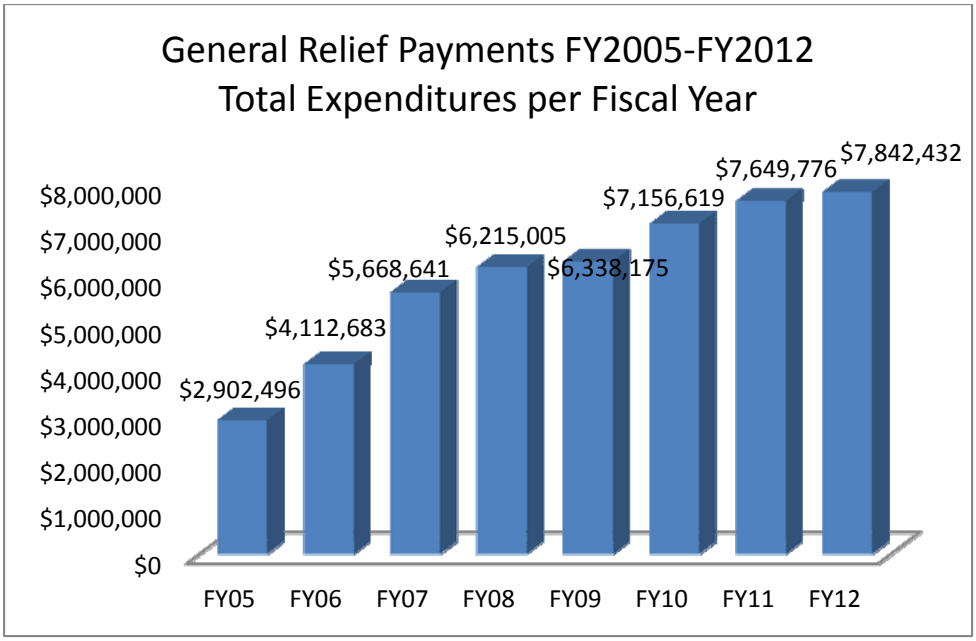
The Adult Protective Services Unit protects vulnerable adults over the age of 18 from abuse, neglect, and exploitation. Staff investigate incidents in which a vulnerable adult suffers harm from abandonment, abuse, exploitation, neglect or self-neglect. Upon investigation of reports of harm, staff take appropriate action (up to and including removal from the client's home) to ensure that vulnerable adults are safe. The Adult Protective Services Unit responded to 1,508 investigations of vulnerable adults in FY2012.

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 FY2012, the Division of Senior and Disabilities Services served an average of 496 individuals monthly through the General Relief / Temporary Assisted Living Program. The net expenditure, after recoupment efforts, was $7,842,432.





Total expenditures for the General Relief Program increased 6.9% between FY2010 and FY2011 with additional 2.5% increase between FY2011 and FY2012.

Senior Community-Based Grants

Senior Community-Based Grants provide a safety net for seniors age 60 or older and their caregivers who wish to remain in their homes and would not otherwise qualify for services under the Medicaid Waiver program. These grant programs follow the guidelines of the approved Alaska State Plan on Aging and target senior 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. Senior Community-Based Grants are co-financed through state and federal funds.

Senior Community-Based Grant programs include: Nutrition, Transportation and Support Services, Senior In-Home, Adult Day Services, Aging and Disability Resource Centers, National Family Caregiver Support Program, and the Alzheimer's Disease and Related Dementia Education and Support program.

Nutrition, Transportation and Support grant services 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.

Health Promotion and Disease Prevention programs for seniors improve health outcomes for seniors with chronic health conditions by increasing physical activity, fall prevention, and nutrition counseling.

Other important Senior Community-Based Grant programs include Adult Day Services. These services are furnished at a center for adults with impairments, primarily Alzheimer's disease or related disorders, and are 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.

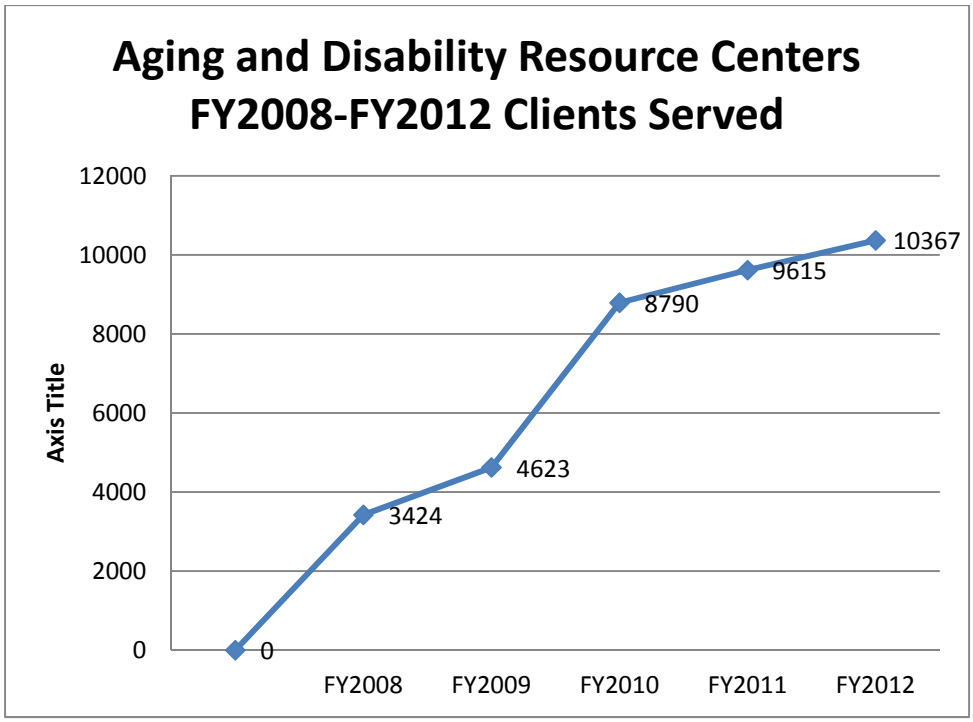
Senior In-Home Services include care coordination, chore, respite, extended respite, and supplemental services.

The Alzheimer Disease and Related Disorders Education and Support Program provides outreach, information and referral, education, consultation, and support to individuals with Alzheimer disease and related disorders, their family caregivers, professionals in the field, and the general public about Alzheimer disease and related disorders.

The Senior Community-Based Grants programs have seen a steady increase in the number of clients served over the past three years while the average funds available per client for the same time period has decreased. The number of seniors served has increased from 21,261 in FY2010 to an estimated 31,000 for FY2012 with a comparative per client annual cost decreasing from $546 per senior to $436 per senior.

The Aging and Disability Resource Center program is designed to streamline access to long-term care. This program provides the state with an opportunity to effectively integrate the full range of long-term supports and services into a single, coordinated system.

Four Alaska Aging and Disability Resource Centers 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 number of individuals served has increased more than 200% in the past five years. The growth in the number of clients served is attributed to a number of factors that include increased outreach and networking to providers and community members and coordination with other community-based services. In FY2012, the Aging and Disability Resource Centers served a total of 10,367 clients at a total cost of $810,221.



A Real Choice Systems Change grant was awarded to the Division of Senior and Disabilities Services 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 to clients once they are released from the hospital. This program bridges the gap between hospitalization and community-based services. 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, is being used in this program.

In FY2013, the Division of Senior and Disabilities Services received funding to implement a pilot project through the Aging and Disability Resource Centers to reduce the number of denied applications for individuals seeking services through the Medicaid Waiver program. The division anticipates this would result in a cost saving to the state, as well as reduce the amount of time and confusion for participants who are in need of in home services, but may not meet nursing home level of care. In addition, the Aging and Disability Resource Center pilot project will incorporate a behavioral health screening to provide more comprehensive care.

The Mat-Su Health Foundation in collaboration with local senior and disability services providers is seeking to develop an Aging and Disability Resource Center to serve the Matsu Region in FY2014. The Division of Senior and Disabilities Services is working with the coalition of local providers to assist with planning and development of a Matsu Aging and Disability Resource Center.

Senior Residential Services

Through designated funding from the Alaska State Legislature, the division oversees grants to rural-remote providers in Dillingham, Galena, and Tanana (Tanana Tribal Association). These Senior Residential Grants provide 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 68 individuals in FY2012. By definition, assisted living facilities provide meals and assistance with daily activities to enable seniors to remain in or near their community of choice.

In FY2013, Senior Residential Services grant funds will provide support to three rural senior residential assisted living facilities. In addition, funds were made available through provider agreements to pay for travel expenses for individuals residing in these homes who are eligible to receive residential supported living through the Medicaid Waiver programs. This mechanism will sustainability increase the Senior Residential Services homes in rural areas and provide additional support to seniors in rural areas. The Senior Residential Services funds planning grants will be awarded in FY2014 for the planning and development of Supportive Housing or Assisted Living Facilities to meet the needs of seniors living in rural Alaska.

State Health Insurance Assistance Program

The State Health Insurance Assistance Program 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 State Health Insurance Assistance 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 6,721 contacts with individuals during FY2012.

Senior Medicare Error Patrol

The federally funded Senior Medicare Error Patrol program supports a variety of outreach strategies to educate and empower Alaskans to identify, prevent, and report health care fraud. The Senior Medicare Error Patrol program empowers seniors through increasing 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. The activities of the Senior Medicare Error Patrol 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 FY2012.

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 FY2012, 30 individuals transitioned from a nursing facility back to the community, at an average cost of $1,469 per person.

Community Developmental Disabilities Grants

The Community Developmental Disabilities Grant 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 FY2012, developmental disabilities grants provided services to 1, 285 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 included 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 also 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 Program. In FY2012, 12 organizations were awarded funds to operate a Short-Term Assistance and Referral 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 FY2012, 842 individuals accessed services provided by the Short-Term Assistance and Referral 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 FY2012, 186 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.

FY2012 SDS Non-Medicaid

Grant Services

Grant	Clients Served	Total Expenditure
Community Develop Disability Grants	1,285	13,734,518
General Relief/Temporary Assisted Living	5,958	7,842,432
Nursing Facilities Transition Grant	31	83,105
Senior Community-Based Grants	31,000	13,504,376
Senior Residential Grants	68	806,870
State Health Insurance Assistance Program	6,721	44,979
Total	45,063	36,016,280

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 certifies and monitors providers of Home and Community-Based Waiver and Personal Care Assistance 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 and restrictions on Medicaid payments, up to and including termination or suspension from the Medicaid program.

The unit monitors 1,123 active service types that are provided by 912 provider agencies throughout the State of Alaska. Providers are required to reapply every two years to continue to be certified.

The oversight responsibilities continue to grow for the unit. In FY2012, over 162 new certifications were issued. Initial certification application packets contain provider policy and procedures, certificates of insurance, organizational charts, and other business documents that are examined thoroughly. This process is necessary in order to determine whether or not the provider will be able to provide quality services, maintain compliance with regulations, and have the capacity to ensure the health and safety of all participants. The proposed regulatory changes that are currently in consideration will require significant process changes and additional workload for the certification staff.

Provider reviews were implemented in April 2011 and initially all service types were to be randomly selected for desk or onsite reviews. Due to staffing constraints, currently only residential supported living services and adult day care services are subject to provider review. The recent addition of a Long Term Non-Permanent full-time employee will allow Senior and Disabilities Services to expand the scope to include desk reviews on all service types and on-site reviews on one additional service type. There are nine remaining service types that do not get routine on-site reviews but may be reviewed as a result of a complaint investigation.

Service Quality Assurance

The Service Quality Assurance Team is responsible for conducting case record review, mortality review, incident report management, complaint intake, and quality monitoring reporting for the division. Team members are cross trained to perform work duties in multiple domains in order to cover temporary absences, vacation, and to assist other team members with heavy workloads or shifting priorities.

The data from each domain is compiled into monthly reports and shared with task committees and the Senior and Disabilities Services Quality Improvement Workgroup. The information is used to track and trend performance, demonstrate compliance with assurances in the Home and Community Based Waivers, and to improve services to individuals served.

Critical Incident Reporting is a requirement for all providers of Home and Community Based Services and is a key element in monitoring the health and welfare of the individuals receiving

services in our programs. Providers are required to report certain types of incidents, based on established criteria. Adult Protective Services screens all incidents for Abuse, Neglect, Exploitation, Self-Neglect, and Abandonment. If none of those elements are present, Adult Protective Services releases the incident report to the Service Quality Assurance Team for review to determine if further action is needed or whether the service providers acted in compliance with rules and regulations. Incidents are tracked and trended by type.

Monthly averages for critical incident reports received in FY2011 were 413. In FY2012, the monthly average of reports received rose to 635. At this rate of increase, the number of total reports for FY2013 is projected to be over 10,200. Many of the incidents are considered "general" events, or are expected given the age, diagnoses and health of the participants in the program. The incidents that are unexpected appear to be part of a pattern, or that clearly indicate a violation of program rules are carefully reviewed or referred to the appropriate entity for follow-up or investigation. The reviews are conducted mainly by one full-time employee in Service Quality Assurance. Though all incidents are screened by Adult Protective Services for abuse, neglect, and exploitation, the Service Quality Assurance Team is responsible for recognizing the need for administrative action, trending data for systemic process needs, and reporting results for quality improvement.

The Mortality Review Committee is comprised of multiple state agencies and reviews all active participants' deaths. Deaths are reported to Senior and Disabilities Services via critical incident reports, and cross matched with vital statistics reports on a quarterly basis. In FY2012, 719 deaths were reviewed by the Service Quality Assurance Team. Alaska is one of the few states that has a committee to review deaths across multiple waivers and personal care programs and has provided technical assistance to other states via a national webinar focused on quality and hosted by Centers for Medicaid and Medicare Services.

In FY2012, 1,135 Case Record Reviews were conducted. Reviews entail analyses of levels of care, service plans, claims data, and other records to determine compliance with performance measures. Findings of non-compliance are sent to appropriate entities for remediation, and reported on a monthly basis to task committees.

The number of complaint intakes for FY2012 was 1,224. The intake process involves analysis, screening, and possible assignment to a complaint investigator.

Summary

The number of participants and service providers continues to grow each fiscal year. Oversight responsibilities are becoming more stringent and the Centers for Medicaid and Medicare Services have clearly indicated the need for on-going monitoring and active collaboration between state agencies to eliminate fraud, waste, and abuse of Medicaid funds.

Both Quality Assurance units partner with multiple state agencies such as the Division of Health Care Services, the Office of Long Term Care Ombudsman, the Office of Children's Services, Program Integrity, the Office of Rate Review, 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.

The challenge for both Provider Quality Assurance and Service Quality Assurance is to continue to monitor the health and welfare of recipients, streamline and automate systems in order to track and trend data, improve quality and compliance of service providers, and eliminate waste and abuse of Medicaid funds within an environment of limited human resources.

The Quality Assurance units have made great strides in defining discovery methods, building relationships with other State partners, and developing performance measures to ensure compliance. The inability to use automated systems for tracking requires a great amount of staff time to monitor compliance. The goal of the Quality Assurance team is to streamline internal systems in order to devote more staff time to hands-on community based technical assistance and monitoring.

Medicaid Waiver Services

Home and Community-Based Waiver Programs

In response to the high costs of institutional care, Medicaid Home and Community-Based Waivers allow 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 Waiver

The Children with Complex Medical Conditions 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 Waiver

The Intellectual and Developmental Disability 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 Waiver

The current Older Alaskan 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 Waiver

The Adults with Physical Disabilities 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,".

In addition to the four Medicaid waivers above, the division offers Personal Care Assistance and Nursing Home Authorization Medicaid programs.

Personal Care Assistance

Personal Care Assistance services are provided statewide in Alaska. The level of need for services is determined by an 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 Personal Care Assistance providers.

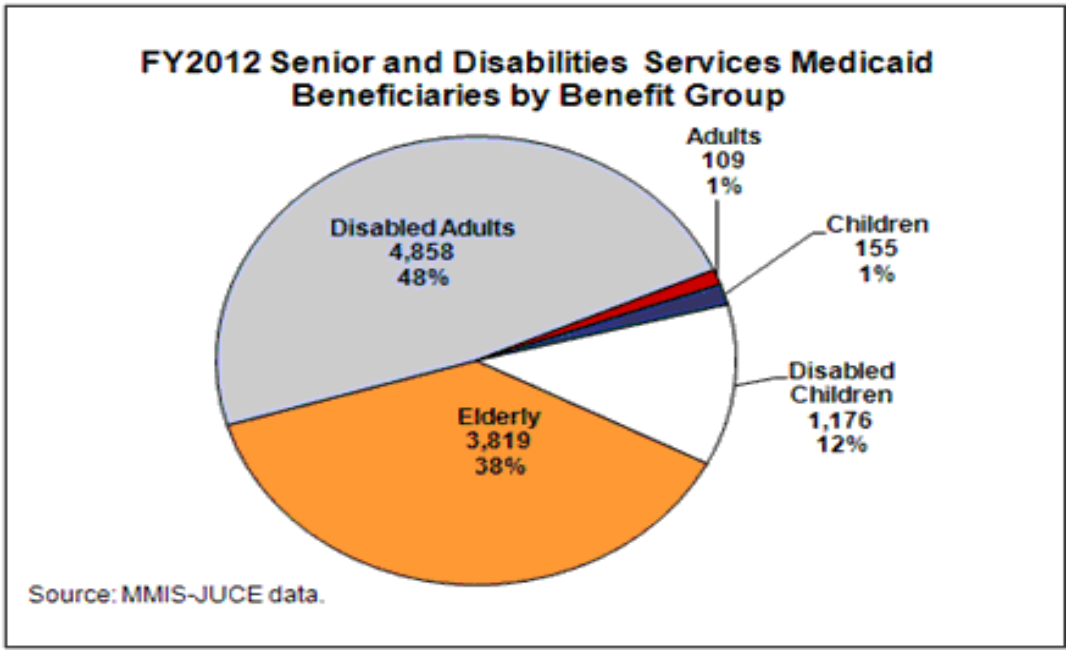
Personal Care Assistance services are typically provided in a participant's home by health care paraprofessionals called personal care attendants. These services enable functionally disabled Alaskans of all ages, and frail elderly Alaskans, to live in their own homes, instead of being placed in a more costly and restrictive long-term care setting. Recipients have a choice between two different options of Personal Care Assistance services. The Agency-Based Personal Care Assistance model allows participants to use one of the qualified agencies that oversee, manage, and supervise their care; or, participants may choose the Consumer Directed Personal Care Assistance model that allows them to select, train, supervise, and discharge their personal care attendants.

Senior and Disabilities Medicaid and Waiver Services

The Senior and Disabilities Services Medicaid program funded benefits for 9,828 Medicaid beneficiaries during FY2012 with total expenditures of $440,725,000. This equates to an average annual claim cost of approximately $44,844 per recipient. About 48% of beneficiaries were disabled adults, 38% were elderly, and 12% were disabled children.

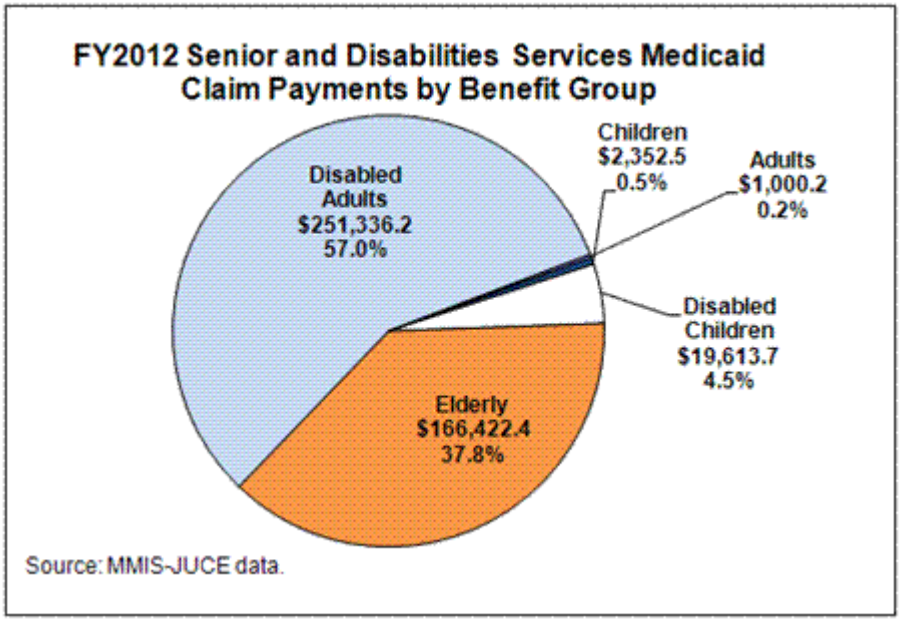
Benefit Group	Percent of Beneficiaries	Number of Beneficiaries	Percent of Payments	Claim Payments (thousands)	Cost Per Beneficiary
Children	1.5%	155	0.5%	2,352.5	$15,178
Disabled Children	11.6%	1176	4.5%	19,613.7	$16,678
Elderly	37.7%	3,819	37.8%	166,422.4	$43,577
Disabled Adults	48.0%	4,858	57.0%	251,336.2	$51,737
Adults	1.1%	109	0.2%	1,000.2	$9,176
Unduplicated Annual Clients		**9,828**			
Total Medicaid Claim Payments				**$440,724,942**	
Average Annual Medicaid Cost per Beneficiary					**$44,844**

Source: MMIS/JUCE claims paid during FY2012. The benefit category "disabled adults" includes disabled persons between 19 and 20 years of age as well as adults.



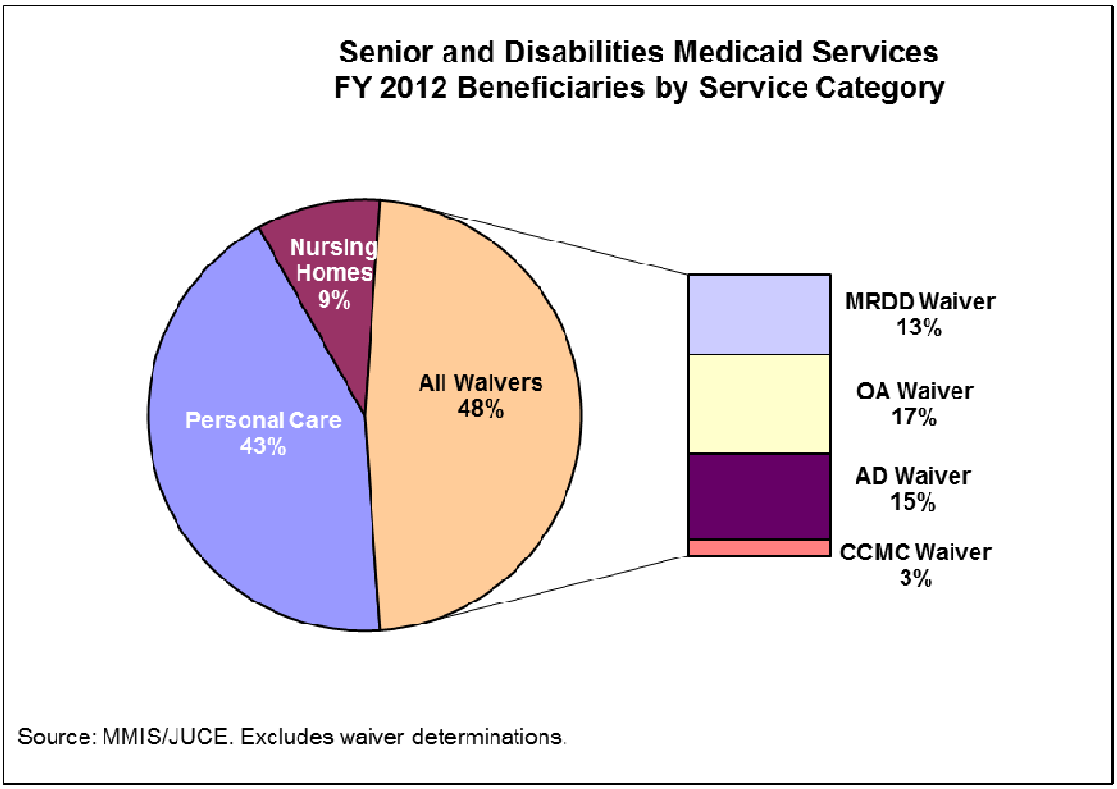
The Senior and Disabilities Medicaid program serves Alaskans of all ages. For all programs, in FY2012, 8,396 or 92.2% of all beneficiaries were 21 years of age or older, and they were served at a total cost of $406,175,700 or $48,377 per beneficiary. In FY2012, 1,551 or 7.8% of all

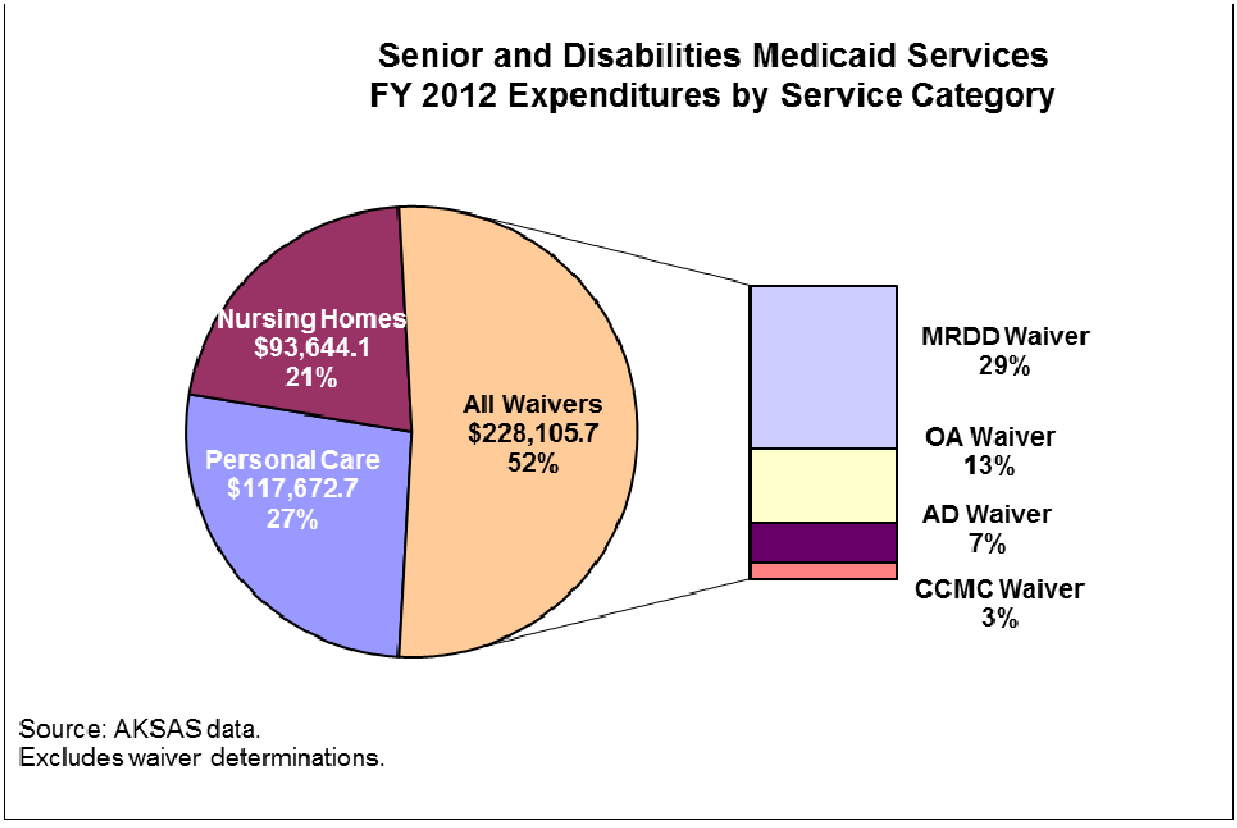
beneficiaries were under 21 years of age. These clients were served at a total cost of $34,549,200 for a per-beneficiary cost of $22,865.



The Division of Senior and Disabilities Services served 1,618 recipients, 15% of waiver beneficiaries, through the Adult with Physical Disabilities Waiver program at a cost of $20,508 per recipient. Over 280 children, approximately 3% of beneficiaries, were served though the Children with Complex Medical Conditions Waiver program at a cost of $42,891 per participant. Through the Intellectual and Developmental Disabilities Waiver program, close to 1,590 recipients, or 13%, were served at a cost of $79,000 per recipient. The Division of Senior and Disabilities Services also served 3,072 seniors, roughly 17% of waiver recipients, through the Older Alaskans Waiver program at a cost of $18,900 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 $107,048 per beneficiary. This increase is approximately 15% over

FY2011, when the average nursing home care cost was $93,104 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 $23,339 in FY2011 to an average of $22,676 in FY2012. The division did see an increase in the per-beneficiary cost of Home and Community-Based Waiver Services. In FY2011 these services averaged $38,700 per beneficiary. In FY2012 the services reached $43,500 per beneficiary, an increase of 12.4%.

Home and Community Based Waiver	Cost per Beneficiary per Year	Percent of Waiver Beneficiaries
Adults with Disabilities	$20,500	24.7%
Children with Complex Medical Conditions	$42,900	4.3%
Mental Retardation/Developmental Disabilities	$79,000	24.2%
Older Alaskans	$18,900	46.8%
All Home and Community Based Waivers	$43,500	100.0%

Source: MMIS/JUCE for claims paid during fiscal year 2012.

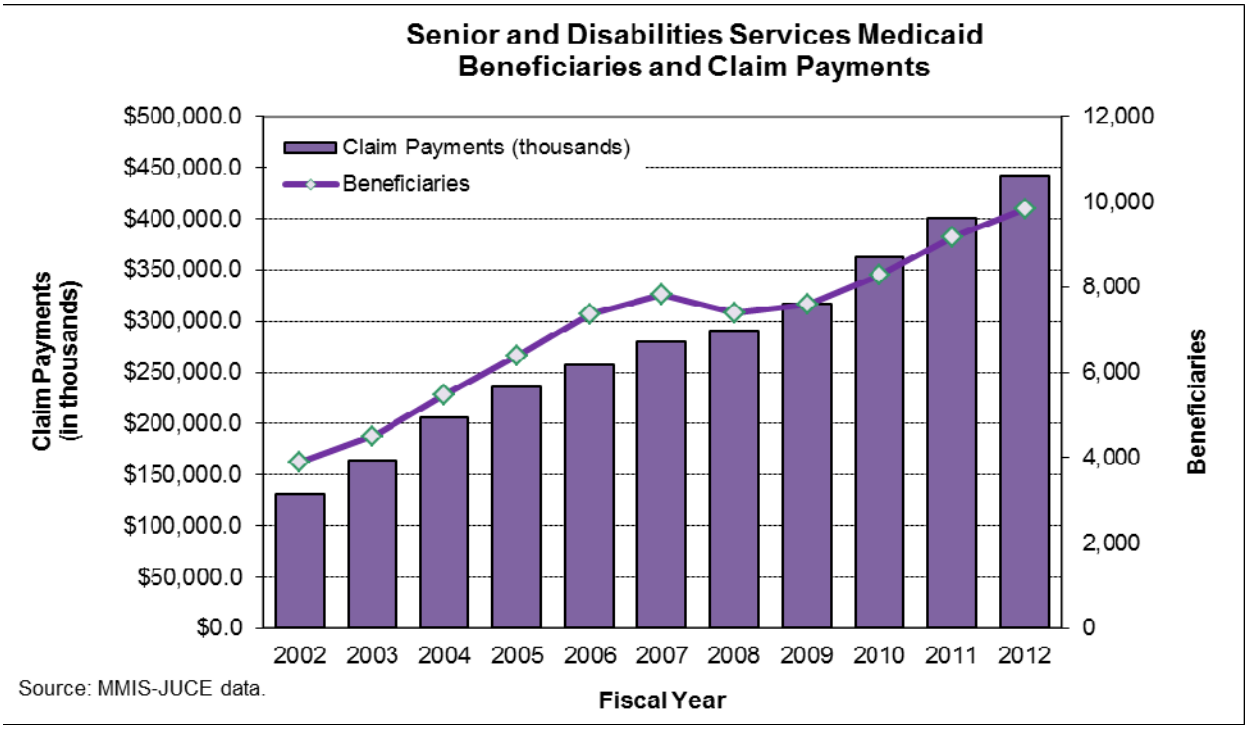
Within all waiver programs, in FY2012 the Older Alaskans waiver served the greatest percentage of waiver beneficiaries, 46.8%, followed by Adults with Physical Disabilities, 24.7% and Intellectual and Developmental Disabilities, 24.2%. The Children with Complex Medical Conditions waiver had the lowest number of participants with only 4.3% of waiver beneficiaries.

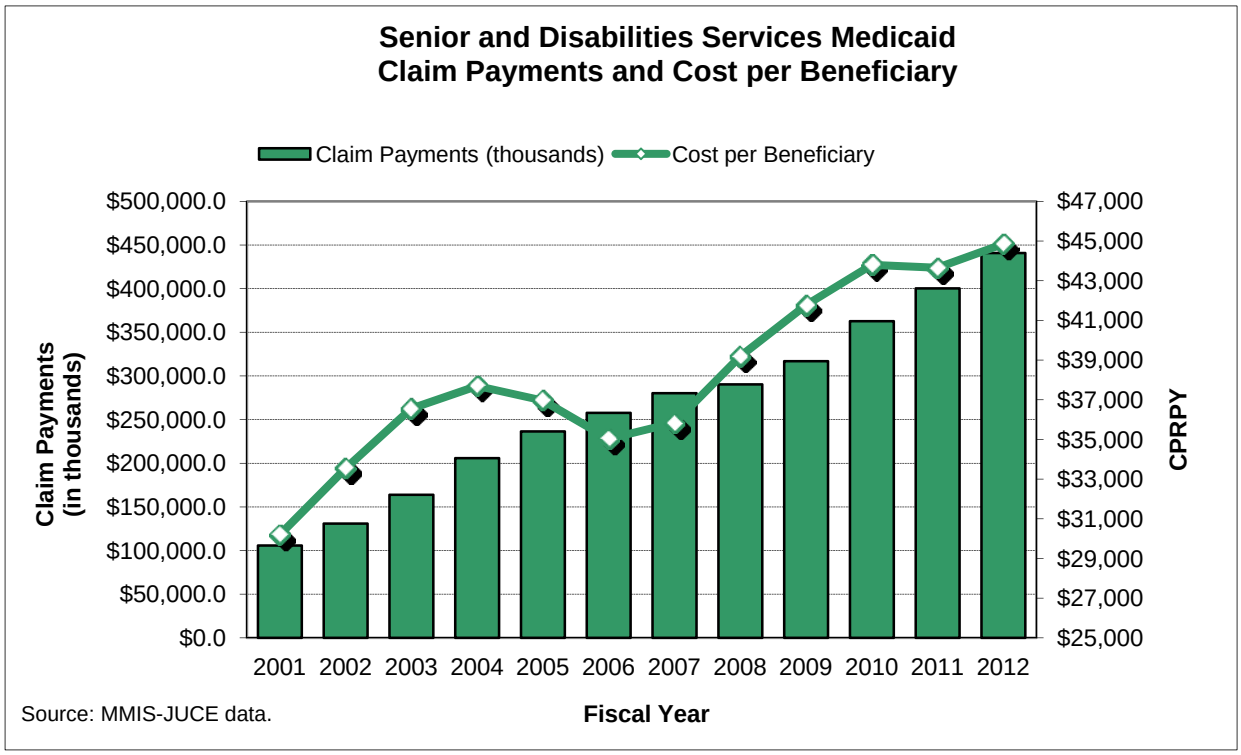
The Home and Community-Based Waiver program costs per beneficiary ranged from $18,900 for Older Alaskan Waiver services to $79,000 for Intellectual and Developmental Disabilities Waiver services.

Total claim payments for Senior and Disabilities Medicaid services in FY2012 increased by 10.0% from FY2011. The number of beneficiaries using any Senior and Disabilities Medicaid service increased in excess of 10.3% while the annual cost per beneficiary decreased just over $44,800.

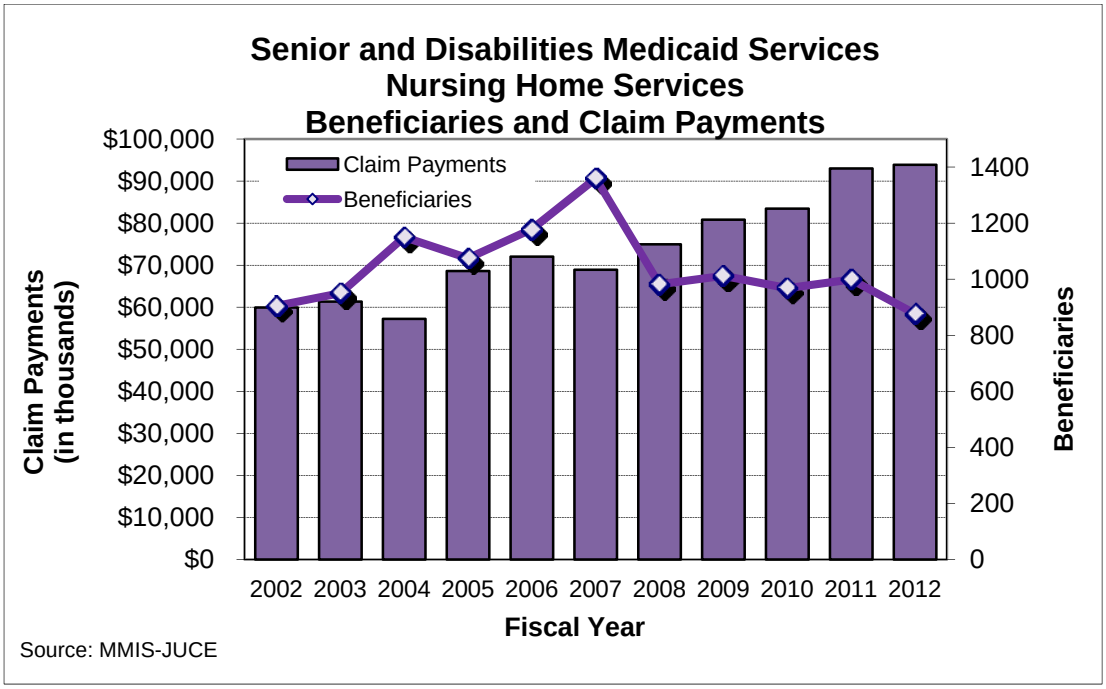
Service Category	Cost per Beneficiary per Year	Percent of Beneficiaries
Nursing Home Services	$107,000	8.9%
Personal Care Attendant Services	$22,700	52.9%
Home and Community Based Waiver Services	$43,500	56.0%
All Senior and Disabilities Medicaid, cost per beneficiary per year	$44,800	
All Senior and Disabilities Medicaid, unduplicated annual beneficiaries		9,828

Source: MMIS/JUCE for claims paid during fiscal year 2012. Percent of beneficiaries includes individuals receiving services in multiple categories and may not sum to 100%.

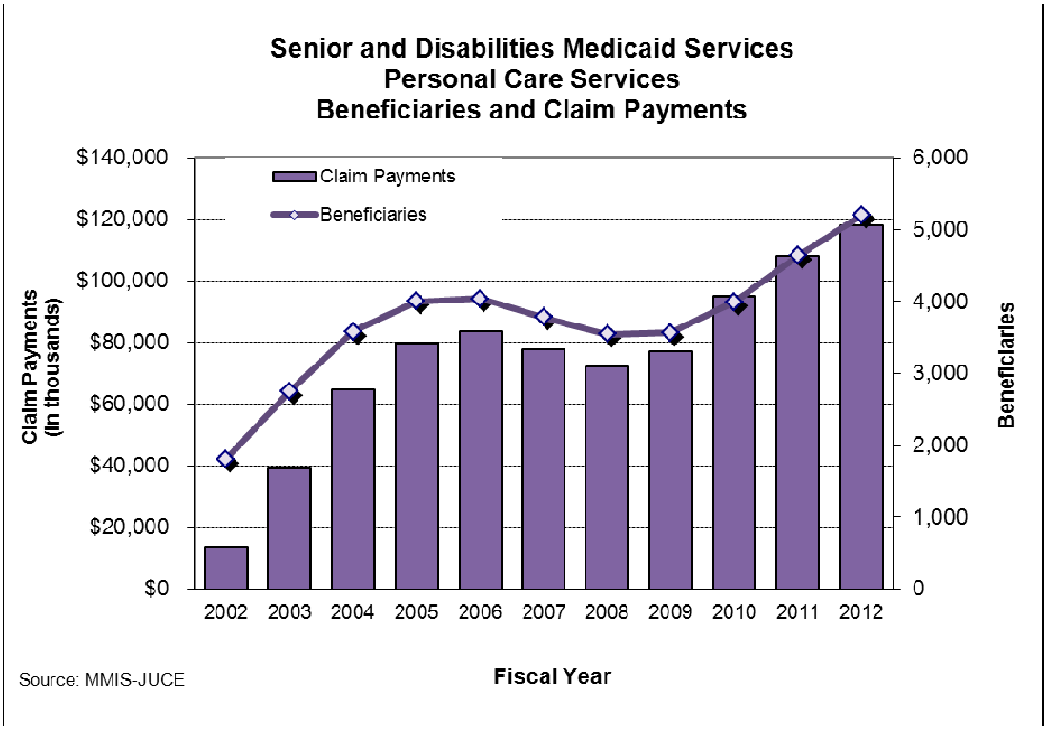


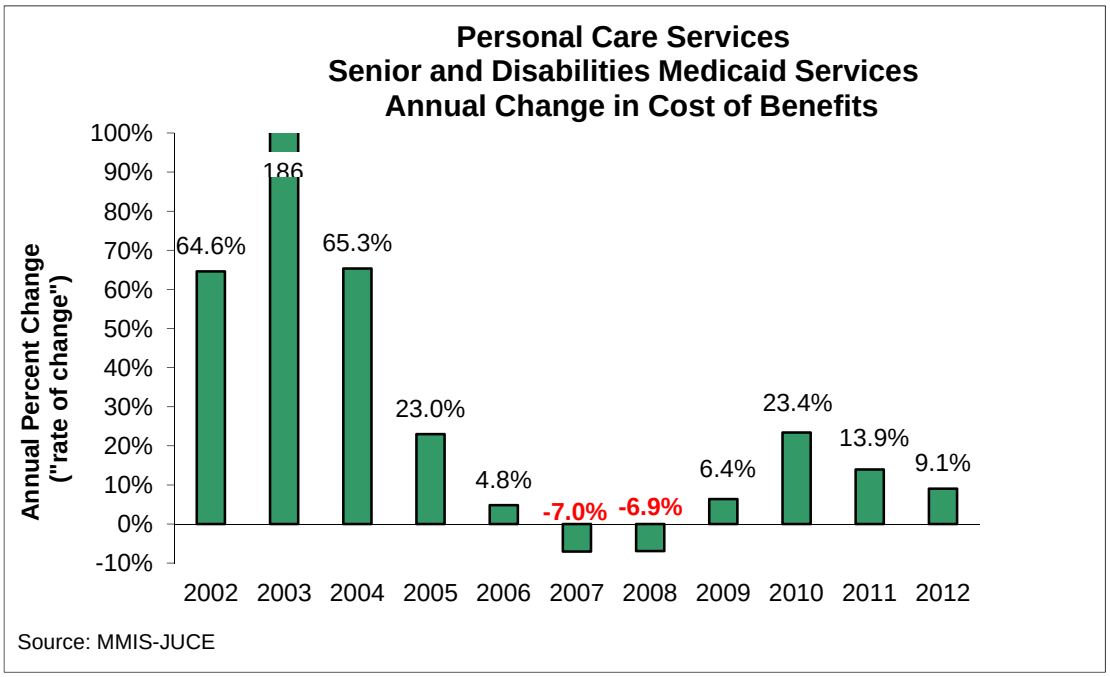


Total nursing home costs increased .9% in FY2012 to $93,644,083. The number of Medicaid beneficiaries using nursing home services increased 2% and the annual nursing home Medicaid cost increased by 15% per beneficiary.

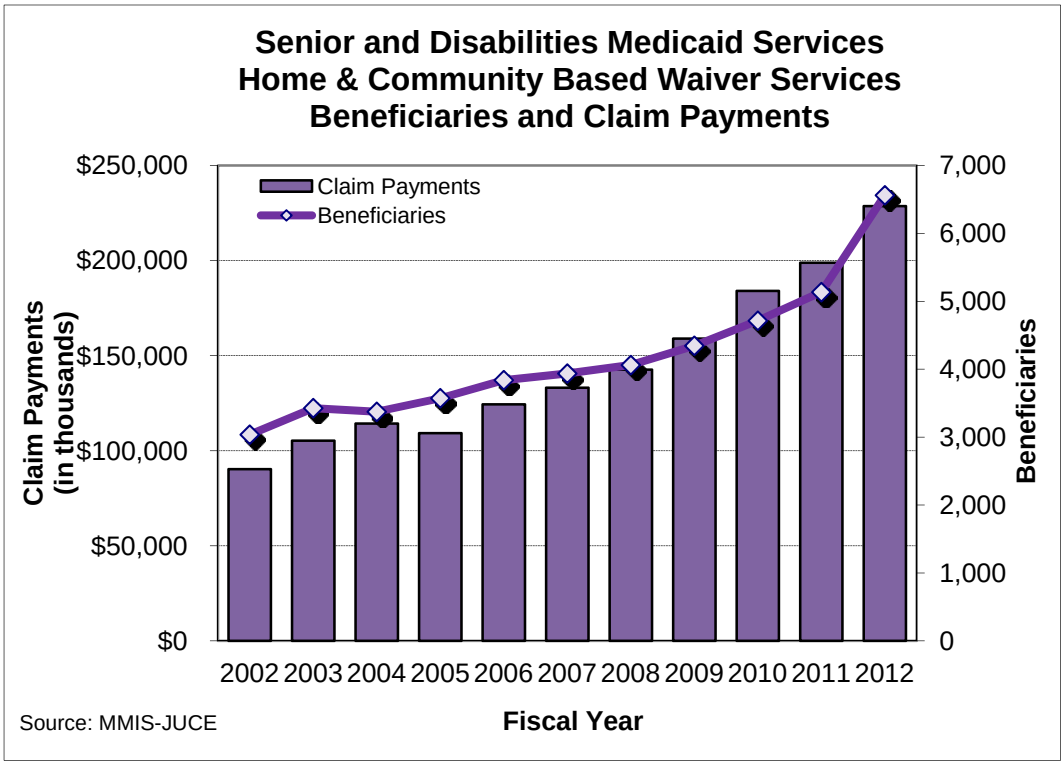


Between FY2011 and FY2012 the number of Personal Care Assistance program recipients increased by 12.2%. The average cost per recipient in FY2012 decreased by 2.8% over FY2011. The increased number of recipients had the net effect of a 9.1% increase in paid claims. The Division of Senior and Disabilities Services, in collaboration with the Division of Health Care Services, has instituted Personal Care Assistance renderer enrollment. Enrollment of individual personal care assistants will allow improved oversight by the two divisions in the areas of qualified providers and utilization of services.





Combined claim costs for all home- and community-based waiver services increased by 15% between FY2009 and FY2010 and 8% between FY2010 and FY2011. These services increased again 15% from FY2011 and FY2012. The number of beneficiaries using any waiver service at some time during the fiscal year increased by about 27.8%.



Challenges

The Division of Senior and Disabilities Services must annually conduct face-to-face assessments, level of care determinations, and plan of care reviews in order to meet requirements outlined in the waiver plans approved by the Centers for Medicaid and Medicare Services for Alaska's four Medicaid Home and Community Based Waiver programs.

With the projections of an increasing senior population in Alaska, the challenge to the division is to manage the waivers in a way that controls the growth of spending and contains costs as much as possible, while ensuring that quality services get to the individuals that really need them. Growth within the Personal Care Assistance program will also need to be addressed.

Medicaid Home and Community Based Waiver services rate setting regulations were reviewed and revised in 2011 by the Office of Rate Review within the Division of Health Care Services. New waiver services payment rate schedules continue to impact costs in the Division of Senior and Disabilities Services Medicaid Services component.

The Division identifies four major challenges that it needs to focus on in order to provide a balanced and cost effective system of care to meet the needs of its service population into the future. Those are:

- Ensuring that waiver participants receive home and community based services as close to home as possible and at the lowest level of care appropriate to meet their needs.
- Ensuring that vulnerable adults are safe and protected from abuse, neglect and exploitation.
- Ensuring that service participants receive quality services in a timely manner.
- Maximizing operational efficiency and ensuring effective administration and management of the Division of Senior and Disabilities Services.

Senior Community Based Grants

Mental Health Trust: Brain Injury-Traumatic/Acquired Brain Injury Program: $300.0 Total -- $300.0 GF/MH

The division's Senior Community Based Grants component includes a $300,000 increment supported by the Alaska Mental Health Trust to expand Traumatic/Acquired Brain Injury multiple-year grants to nonprofit organizations and agencies in the Northwest Alaska region to provide person-centered, goal-oriented case management services with innovative programs/training to improve independence and vocational outcomes for people with acquired and/or traumatic brain injury.

Mental Health Trust: Alzheimer's Disease and Related Dementia Education and Support Program: $230.0 Total -- $230.0 GF/MH

These funds would build capacity in Alzheimer's Disease & Related Dementia education, training, and supports for Alzheimer's Disease & Related Dementia persons, family caregivers, and professional caregivers. Current service levels would increase annually and new services would be added. This would lead to an increase in public awareness and help to reduce the stigma associated with Alzheimer's disease.

Mental Health Trust: Health Promotion, Disease Prevention for Older Alaskans (HPDP) "Senior Fall Prevention": $150.0 Total -- $150.0 GF/MH

This project aims to reduce the fear of falling and the senior fall rate by providing Health Promotion, Disease Prevention grants to providers who serve seniors.

Mental Health Trust: Grant 1927.05 Aging and Disability Resource Centers: $125.0 Total -- $125.0 MHTAAR

These funds support the current Aging and Disability Resource Centers, which 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. 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 Aging and Disability Resource Centers are minimally funded and staffed.

Community Developmental Disabilities Grants

Mental Health Trust: Benefits Projects - Grant 124.09 Mini Grants for Beneficiaries with Disabilities: $250.3 Total -- $250.3 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.

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. The Alaska Commission on Aging believes all older Alaskans should have the opportunity to meaningfully participate in communities that value their contributions and to have access to services which maintain their health and independence so that they may enjoy a high quality of life and live safely in their homes and communities.

Introduction

The Alaska Commission on Aging was established in 1982 and 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 with the Alaska Commission on Aging. The Commission is an agency of Department of Health and Social Services under the Commissioner's Office.

The Alaska Commission on Aging 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 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

- Advocates for the needs and concerns of older Alaskans to the Governor, the Legislature, the Administration, Alaska's Congressional delegation, and the public.
- Advises the Governor, the Legislature, the Administration, the Congressional delegation and the public on current and potential programs and services for older Alaskans and their caregivers.
- Prepares a comprehensive four-year state plan for senior services in accordance with the Older Americans Act and implements the Plan in collaboration with agency partners to improve services for older Alaskans and reduce duplication of effort.
- Provides recommendations to the Alaska Mental Health Trust Authority for the integrated comprehensive mental health plan and identifies issues, proposes projects, and submits budget recommendations that use funding from the mental health trust settlement account for services provided to older Alaskans with Alzheimer's disease and related dementias and other behavioral health conditions.
- Gathers, analyzes and reports data about programs and services impacting the health, safety and quality of life for older Alaskans.

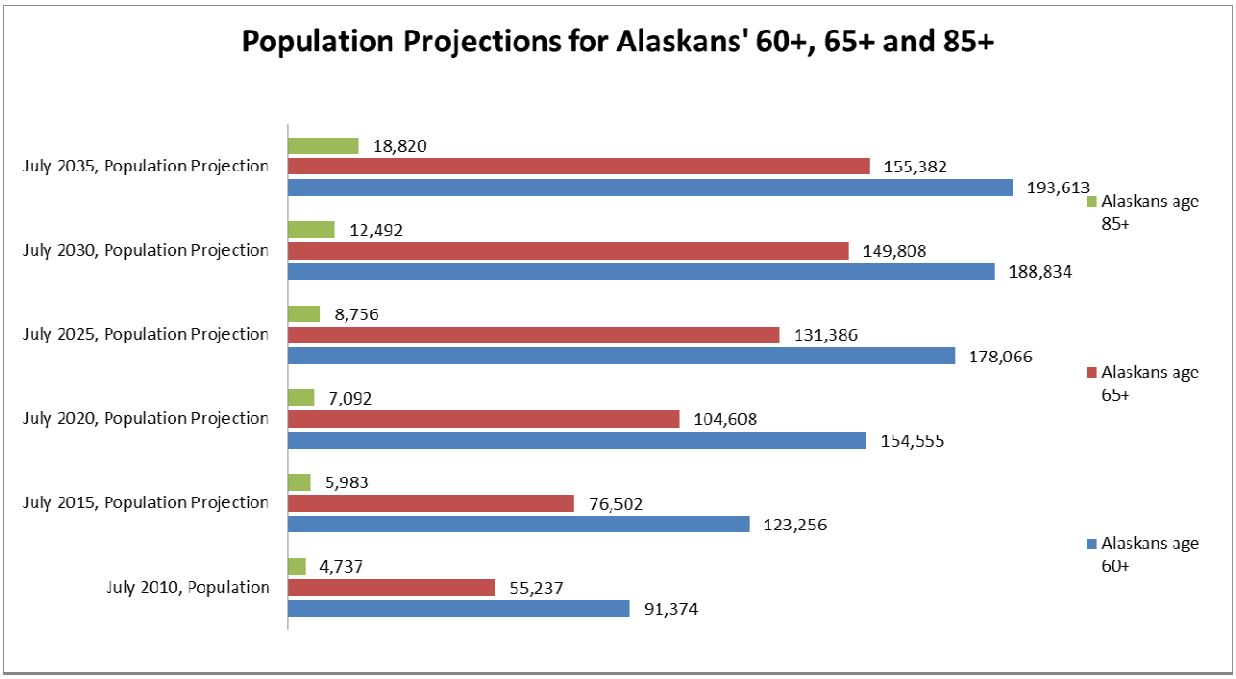
- Surveys Alaska seniors and analyzes their responses to identify priority issues, needs and concerns.
- Reviews and provides comment on proposed regulations relating to programs and services affecting older Alaskans.
- Promotes public awareness of aging issues and trends and provides information to the public and policy makers on senior issues including health, financial security, and housing.

Services Provided

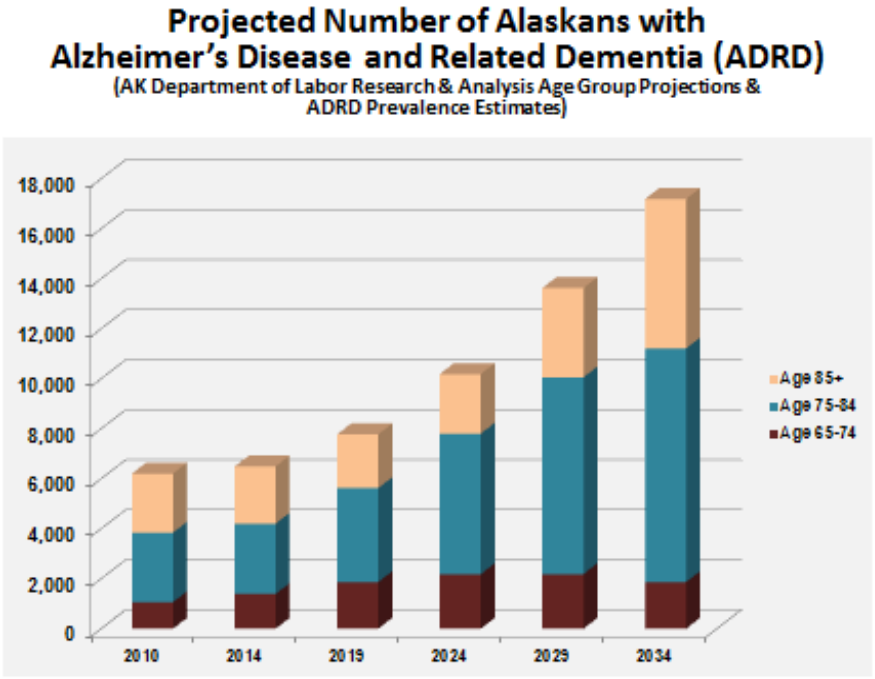
The Alaska Commission on Aging services are organized under its mission areas of planning, advocacy, public awareness/community education, and inter-agency collaboration.

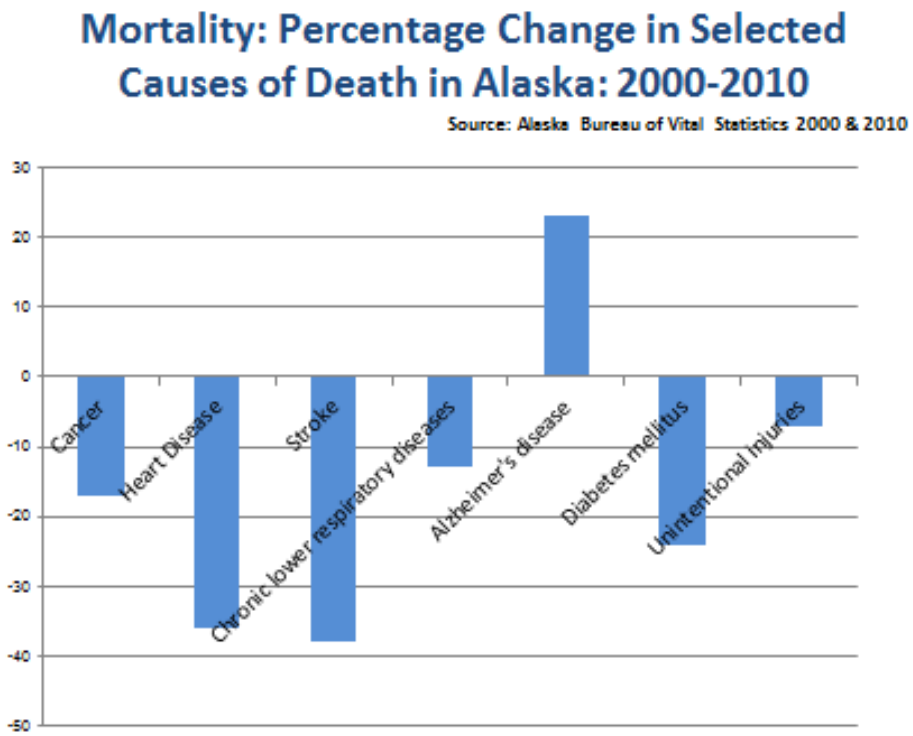
Planning

Not only is Alaska the state with the fastest-growing population of people age 65 years and older, Alaska seniors are by far the fastest-growing age sector in our State. Looking forward, from 2010 to 2020, Alaskans age 60 years and older (91,374 in 2010) is projected to grow at a rate of 69% over the next 10 years to number 154,555 persons. At this same time, seniors age 85 and older are projected to increase by 50% to number 7,092 persons by 2020. Senior growth rates are estimated to be higher than those for younger populations projected for 2020 including youth up to age 17 (13%), young adults from age 18 to 34 years (2.3%), middle-aged adults from 35 to 59 years (-1.3%), and the State's total population (12.4%). By 2020, the number of seniors age 65+ will almost double to comprise 13% of the Alaska population with those of age 60+, making up 19% of the total population. The oldest group of seniors, those age 85 and older, is expected to almost triple during the next 20 years, significantly increasing the number of Alaskans with Alzheimer's disease and related dementias.



Alzheimer's disease, an under-recognized public health problem, is accelerating as the result of Alaska's aging population. While deaths from heart disease, cancer, diabetes, and other diseases are declining, the number of deaths related to Alzheimer's disease is on the rise. Mortality rates related to Alzheimer's disease increased 23% from 2000 to 2010. Associated health care costs continue to climb.





Almost half of all states have a dedicated Alzheimer's Disease and Related Dementia state plan based on the National Plan for Alzheimer's Disease. The Alaska Commission on Aging and other stakeholders believe that an Alaska State Plan for Persons with Alzheimer's Disease and Related Dementia will provide a roadmap to promote greater public awareness and strengthen

services for people with Alzheimer's Disease and Related Dementia and their caregivers. To ensure public participation in the planning process of an Alaska Alzheimer's Disease and Related Dementia State Plan, the Commission conducted a series of community forums held statewide to gather input from more than 140 family caregivers, providers and public members to learn about the needs of persons with Alzheimer's Disease and Related Dementia and their caregivers.

Based on the public input received, five major challenges emerged: (1) A lack of public awareness which includes insufficient knowledge and misunderstanding about Alzheimer's disease and the scope of the disease that can lead to fear and denial, negative experiences that affect personal and professional relationships, stigma, and delay in connecting with services; (2) Poor dementia care that results from workforce issues, insufficient training opportunities for professional and family caregivers, fragmented services that do not result in a personalized plan of care, and inadequate access to appropriate home- and community-based services, especially for persons living in rural and remote locations; (3) Stressed and unprepared caregivers needing respite, counseling, peer support and training who are not able to access these critical supports to be successful in their caregiving role; (4) Acute need for safe and appropriate housing for seniors with Alzheimer's Disease and Related Dementia and those with challenging behaviors; and (5) Need to improve safety for persons with Alzheimer's Disease and Related Dementia by increasing residential home modifications to prevent senior falls and implementing a coordinated community response system for persons with Alzheimer's Disease and Related Dementia who wander to prevent life-threatening consequences.
The Commission is committed to representing the interests of and promoting for the well-being of all older Alaskans age 60 and older. Commission members testify at legislative hearings, prepare letters of support, and correspond with legislators, members of the executive branch, as well as with Alaska's Congressional delegation to convey the perspectives of older Alaskans and their caregivers throughout the year. Through Alaska Commission on Aging'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 the needs of seniors to their elected officials.

Inter-Agency Coordination

The Alaska Commission on Aging partners with the Department of Health and Social Services, the Alaska Mental Health Trust Authority and other advisory bodies in preparing and implementing the Alaska State Plan for Senior Services. These agencies work together in 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 Alaska Commission on Aging 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 impact older Alaskans have on the State. In 2012, Alaska seniors contributed an estimated $1.9 billion to the State's economy and volunteered countless hours in service to their communities and families.


How important are these to you?
Independence
Choice
Confidence
September 18-24: Fall Prevention Week
Your choices can make all the difference.
I want to stay in my own home as long as I can, so I got one of those home safety checklists and went through every room. I'm making some changes and I know they will pay off.
I got my eyes checked because I know vision problems can cause a slip, trip or fall.
I decided to take up activities that build strength, balance and flexibility.
I asked my pharmacist to look at all my medicines. I know there are medicines that can make me light-headed or fuzzy — more likely to slip or trip.
It's never to early or too late to start — what's right for you?
If you'd like to know more, contact the Senior Falls Coalition or ANTHC today:
nancy.jamieson@alaska.gov
(907) 465-1605
www. AlaskaAging.org/falls/
hdstrayer@anthc.org
(907) 729-1900
www.anthc.org/chs/wp/injprev/elder-fall.cfm


You are not alone.
Support and resources are available.
Concerned that someone you know may have Alzheimer's disease and related dementia? Early evaluation is important. Learn the signs and what services are available for people with Alzheimer's disease and their caregivers.
Information:
• Alzheimer's Disease Resource Agency of Alaska (800) 478-1080
• The Aging & Disability Resource Center (877) 625-2372
• Do you care for a person with ADRD? Please help us learn about your needs by completing a survey at www.alaskaaging.org.
This message brought to you by:
The Alaska Commission on Aging
www.alaskaaging.org
and
The TRUST
The Alaska Mental Health Trust Authority
www.mhtrust.org
Geneva Tryck Mortimer, age 95, and daughter Sabra Tryck (seated) with Helene Wood who helps care for Geneva. Helene is a Certified Nursing Assistant and volunteer for the Office of the Long Term Care Ombudsman.

Challenges

An emerging challenge is the growing number of Alaskans with Alzheimer's Disease and Related Dementias and the public health impact it will pose on thousands of older Alaskans and their families. Due largely to the aging of the State's population, there are an estimated 6,979 Alaskans age 65+ who may have Alzheimer's Disease and Related Dementias, a count that is projected to nearly triple by 2030. In FY2014, the Commission will offer leadership to a steering committee comprised of state agencies and stakeholders to develop an Alaska State Plan for Persons with Alzheimer's Disease and Related Dementias that will provide a roadmap to promote greater public awareness and help to strengthen services for persons with Alzheimer's Disease and Related dementias and their caregivers.

A continuing challenge in Alaska is the availability of appropriate and affordable housing that addresses the continuum of care for Alaska seniors. How will Alaska provide independent housing for seniors, housing with supportive services to help seniors maintain their quality of life within their community, and for transitions to assisted living and long-term care housing? According to the findings from the Commission's 2010 Senior Survey, 95% of seniors surveyed age 60 years and older indicated their preference to remain in their current home. Providing accessible housing based on universal-designed principles and a host of supportive services including home- and community-based services, tele-health care and assistive technology can be instrumental to keeping seniors healthy, independent and living in their own homes.

The negative impact of behavioral health issues on the well-being of older adults is becoming a more troubling issue. Such conditions as depression, alcohol and substance misuse are not a normal part of aging, yet these conditions greatly impact the lives of many older Alaskans. Many barriers to behavioral health treatment exist such as under-diagnosis, social stigma that discourages seeking help, and the presence of other health conditions. Behavioral health conditions are common, costly and detrimental to the overall health of seniors. To address senior behavioral health needs, the Alaska Commission on Aging recommends use of behavioral health services designed to meet the needs of the older adult and greater implementation of the Patient Centered Medical Home Model which provides whole person-centered medical and behavioral health care coordinated by a care management team.

Alaska continues to be the state with the fastest-growing senior population. As Alaska's population continues to age, economic challenges and new technologies will shape our programs and services. The Commission supports evidence-based prevention strategies across the lifespan, as described in the Healthy Alaskans 2020 Initiative, and those specifically tailored for older adults to reduce preventable chronic diseases and disabilities, lower associated health care costs, and improve quality of life. Investing in home- and community-based services to provide person-centered care in addition to senior transportation, appropriate senior housing and other supportive services are crucial to supporting seniors which are our most treasured resource.

Mental Health Trust: Cont - Grant 151.09 Alaska Commission on Aging Planner (06-1513): $114.1 Total -- $114.1 MHTAAR

This project funds one of the two Alaska Commission on Aging planner positions. The planner is responsible for supporting the Executive Director in coordination between the Commission and the Alaska Mental Health Trust, including gathering data for reporting and coordination of advocacy and planning. 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.

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 conducts capacity building, systems change, and advocacy activities that help Alaskans with developmental and other severe disabilities, students receiving special education services, and infants and toddlers with disabilities live safe, healthy, and productive lives in their local communities. The Council is comprised of 28 members appointed by the Governor; of the 28, a minimum of 60% (17) 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 for 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 FY2012 include establishing an ad hoc committee on health for people with disabilities which led to the Division of Public Health, Section on Women, Children & Family Health securing a health promotion grant from the Center for Disease Control. The Council also helped plan and/or co-sponsor the Alaska State Special Education Conference, the Early Childhood Networking Forum, the Healthcare & Human Services Career Fair, the Full Lives Conference, and Career X – A Career Exploration Day.

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 FY2012 include working with the 1-stop job centers to phase in acceptance of Tickets-to-Work from Social Security beneficiaries of working age, thereby increasing employment options for Alaskans with disabilities. The Council also worked to establish the Southeast Financial Network to increase asset building opportunities for low-income individuals, including people with disabilities.

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.

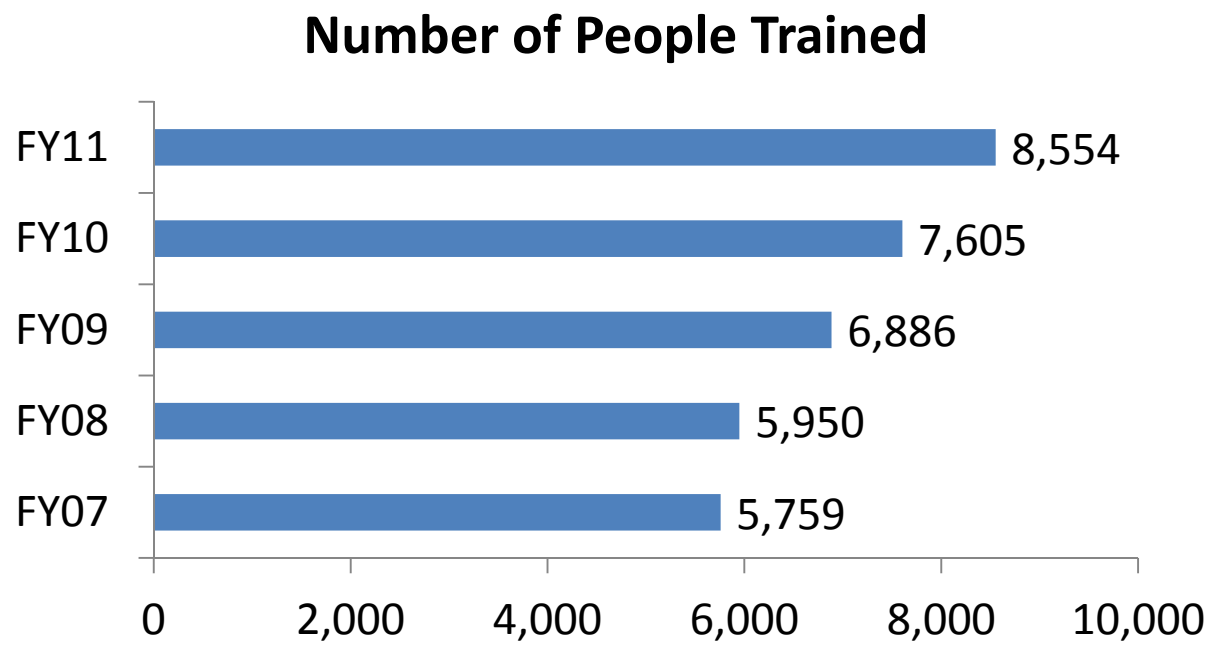
Major accomplishments in FY2012 include Council members met with every legislator and/or staff during the January Council meeting. The Council worked toward the passage of the autism insurance reform bill (Senate Bill 74), secured a $135,000 increment for services for the deaf, and a $100,000 increment for Project Search;

Annual Statistical Summary of Services Provided in FY2012

The Governor's Council on Disabilities and Special Education collects and reports data on a federal fiscal year (October 1 – September 30) for the federal Administration on Developmental Disabilities; an annual Performance Program Report is submitted by January 1 of each year.

Capacity Building

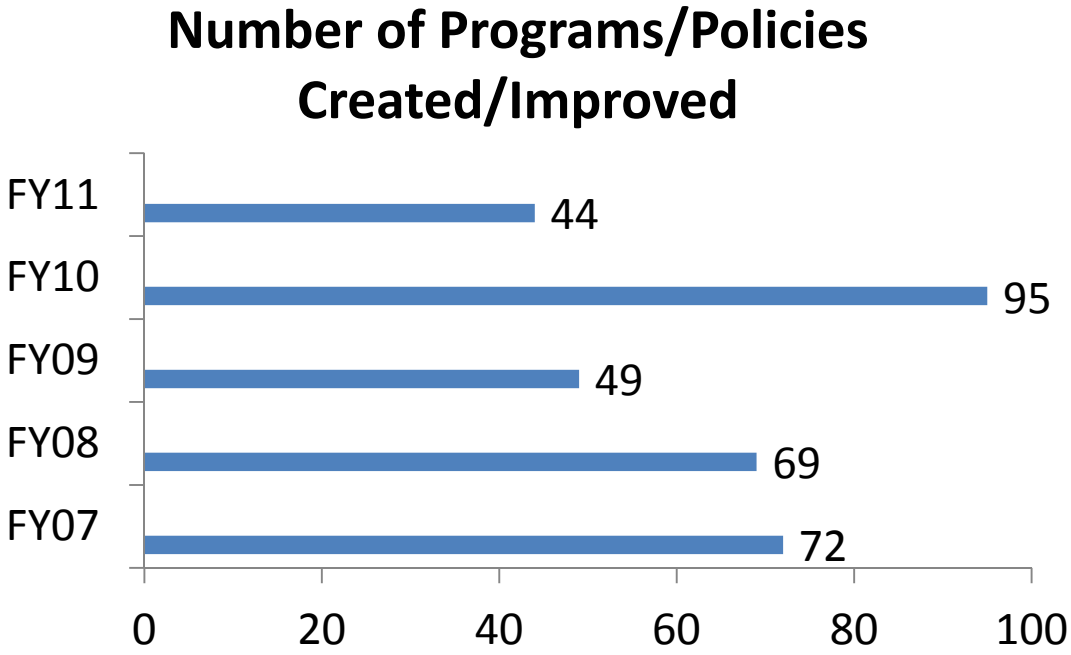
The following graph reports the number of people who received training as a result of Council activities. The Council works with a variety of different entities and organizations to plan, sponsor or co-sponsor, and/or provide training across a number of life domain areas, including: employment, housing, 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 considerably over the past five years. This most likely occurred because of new partnerships the Council has entered into, to increase the number of people with disabilities who are employed or 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, and increase access to assistive devices and services that will enable people with disabilities and seniors live more independently at less cost in the community.

Systems Change and Advocacy

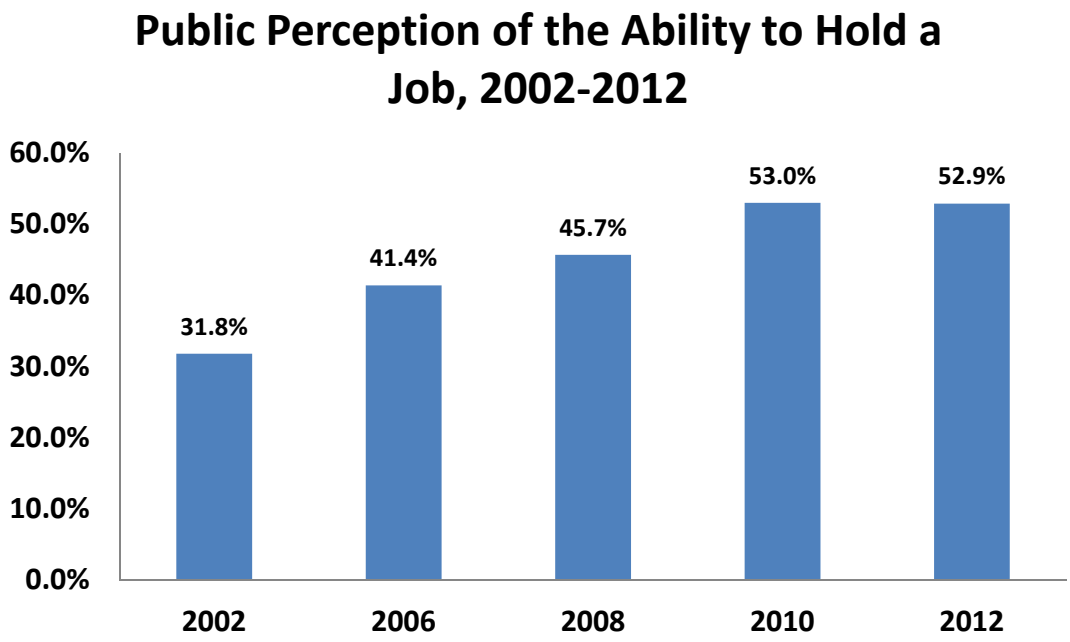
The next graph reports the number of programs and/or policies created or improved as a result of Council's systems change and advocacy activities. The Council works with a variety of stakeholders to improve service delivery systems for people with disabilities, including systems designed specifically for people with disabilities as well as those available to all Alaskans, including but not limited to employment, housing, health care, early intervention, education, health, community participation, and transportation.



As can be seen, the number of programs and policies created or improved in FY2011 decreased considerably from FY2010, which in turn reflected a considerable increase from FY2009. This may relfect the cyclical nature of systems and the signifciant amount of time and advanced preparation it takes to make systems change. Advocacy alone is not enough to make sytems 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 2013 and 2014. 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 related 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 and stabilized around 53% in 2010 and 2012; however, a closer look at the data shows that the percent of respondents who moved up from "some of the time" to "most of the time" or "all of the time" changed considerably starting in 2010 and continuing in 2012. 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.

Division of Senior and Disabilities Services

Budget Overview Table

Senior and Disabilities Services	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$40,698.5	$41,403.9	$705.4
Designated General Funds	0.0	0.0	0.0
Federal Funds	17,962.7	17,963.7	1.0
Other Funds	2,650.1	2,648.1	- 2.0
Total	**$61,311.3**	**$62,015.7**	**$704.4**

Budget Requests

Governor's Council on Disabilities and Special Education

Mental Health Trust: Dis Justice - Grant 4303.01AK Safety Planning & Empowerment Network: $150.0 Total -- $150,000 MHTAAR

This project is a collaborative effort between the Alaska Network on Domestic Violence and Sexual Assault, the Governor's Council on Disabilities and Special Education, the Alaska Native Justice Center, and the University of Alaska Center for Human Development. The effort seeks to build capacity of the service delivery system in targeted communities by: resolving barriers to safety, empowerment, access to non-judgmental services provided by disability and Domestic Violence and Sexual Assault service providers; fostering local collaborations to link survivors with services and resources; providing cross-training and technical assistance; and developing policies and procedures designed to prioritize safety, empowerment, and access.

Mental Health Trust: Cont - Grant 105.09 Research Analyst III (06-0534): $120.0 Total -- $120.0 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.

Mental Health Trust: Beneficiaries Projects - Grant 200.10 Microenterprise Capital: $150.0 Total -- $125.0 MHTAAR, $25.0 GF/MH

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.

Challenges

In FY2014, the Council will continue to implement its five-year plan. 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 a recent survey conducted by the 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

Statutes

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

Regulations

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

Federal Statutes

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

Federal Regulations

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

Performance Measure Detail

In FY2013, the department implemented a results-based management framework which led to:

- a refinement of overarching priorities
- the development of core service areas and agency performance measures
- the alignment of division-level performance measures

This process set in motion an agency-wide shift in how we measure our impact on the health and well-being of Alaskan individuals, families and communities and how we align our budget. With this shift, it is the intent of the department to deliver quality service (effectiveness) while making the best use of public resources (efficiency). At an agency glance, this framework allows department level measures to cascade to divisions and division measures to more strategically align upward towards meaningful outcomes.
To that end, the following measures reflect this division's contribution to the department performance measure structure for FY2014.

PRIORITY I. HEALTH & WELLNESS ACROSS THE LIFESPAN

CORE SERVICE A. PROTECT AND PROMOTE THE HEALTH OF ALASKANS.

OUTCOME 2. Alaskans are free from unintentional injury

	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percent of non-fatal injuries requiring hospitalization.
	EFFICIENCY MEASURE	Cost of emergency medical services per capita.
	EFFICIENCY MEASURE	Cost of injury prevention program per unintended injuries/deaths.
	EFFECTIVENESS MEASURE	Percentage of medication errors for Alaskans in the care/custody of HSS.
	EFFICIENCY MEASURE	Number of hospitalizations due to medication errors. (HCS)
	EFFICIENCY MEASURE	Cost of medical services in facilities. (DJJ)
	EFFECTIVENESS MEASURE	Percent of facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of decrease in facilities with deficiencies.
	EFFICIENCY MEASURE	Percent of complaints investigated within established timeframes.

CORE SERVICE B. PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS.

OUTCOME 2. Older Alaskans live safely in their communities.

EFFECTIVENESS MEASURE	**Number of months Long Term Services and Supports recipients are able to remain in their home before institutional placement.**
EFFICIENCY MEASURE	**Average cost of Long Term Services and Supports per recipient.**

OUTCOME 3. Alaskans with disabilities live safely in the least restrictive environment.

EFFECTIVENESS MEASURE	**Percent of Alaskans who are receiving community-based Long Term Services and Supports.**
EFFICIENCY MEASURE	**Average cost for waiver eligible Alaskans who are living in ICFMR or Nursing Home vs. those who are living independently with Long Term Services & Supports.**

PRIORITY II. HEALTH CARE ACCESS, DELIVERY AND VALUE

CORE SERVICE A. MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED.

OUTCOME 1. Each Alaskan has a primary care provider.

EFFECTIVENESS MEASURE	**Percent of individuals served by the department who have a primary care provider.***	
EFFICIENCY MEASURE	**Cost per recipient served by the department who has a primary care provider.***	
	***AGGREGATE DIVISION MEASURES - (Percent of individuals served by the department who have a primary care provider).**	
	EFFECTIVENESS MEASURE	Percent of clients with access to a regular primary care provider.
	EFFICIENCY MEASURE	Cost to provide health care services per client.
	ALIGNING DIVISION LEVEL MEASURES	
	EFFECTIVENESS MEASURE	Percentage of Medicaid recipients served.
	EFFICIENCY MEASURE	Average cost per recipient. (APH, DBH, DPH, OCS, SDS)

PRIORITY III. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES AND COMMUNITIES

CORE SERVICE B. PROTECT VULNERABLE ALASKANS.

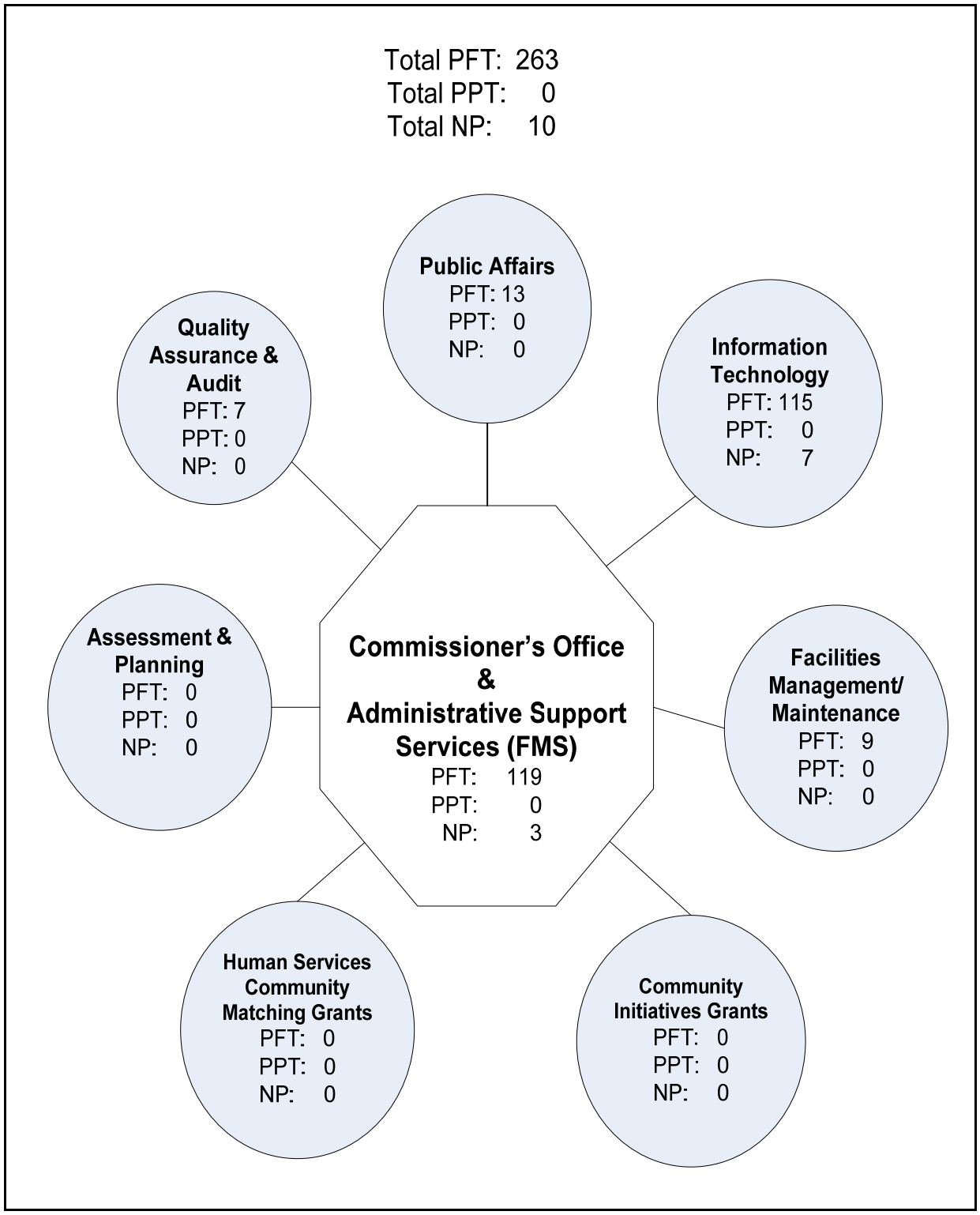
OUTCOME 2. Alaskan adults at risk of maltreatment are protected from abuse, neglect and exploitation.	
EFFECTIVENESS MEASURE	**Percent of Alaskan adults with substantiated reports of abuse or neglect.**
EFFICIENCY MEASURE	**Average time to initiate an investigation.**
EFFICIENCY MEASURE	**Percent of safety assessments concluded within required timeframes.**

OUTCOME 3. Health and social service facilities in which Alaskans are served are safe.		
EFFECTIVENESS MEASURE	**Percent of licensed facilities that are free from reports of harm.***	
EFFICIENCY MEASURE	**Cost for licensure functions and oversight.***	
EFFICIENCY MEASURE	**Percent of time that enforcement action is taken within required timeframe. ***	
	*** AGGREGATE DIVISION MEASURES - (Percent of licensed facilities that are free from reports of harm).**	
	EFFECTIVENESS MEASURE	Percent of licensed facilities that are free from reports of harm.
	EFFICIENCY MEASURE	Cost for licensure functions/oversight.
	EFFICIENCY MEASURE	Percent of time that enforcement action is taken within required timeframe.

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Senior and Disabilities Services General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
FY2014 Salary and Health Insurance Increases (Admin)	$ 0.4	$ -	$ 0.3	$ -	$ 0.7
MH Trust: Brain Injury - Grant 3178.03 Acquired & Traumatic Brain Injury Pgm Research Analyst & Registry Support (Admin)	$ -	$ -	$ -	$ 136.0	$ 136.0
MH Trust: Housing - Grant 68.10 Rural Long Term Care Development (Admin)	$ -	$ -	$ -	$ 140.0	$ 140.0
Reverse FY2013 MH Trust Recommendation (Admin)	$ -	$ -	$ -	$ (278.7)	$ (278.7)
MH Trust: ACoA - Alzheimer's Disease & Related Dementia Education & Support Program (ADRD-ESP) (Grants)	$ 230.0	$ -	$ -	$ -	$ 230.0
MH Trust: ACoA - Grant 1927.05 Aging and Disability Resource Centers (Grants)	$ -	$ -	$ -	$ 125.0	$ 125.0
MH Trust: ACoA - Health Promotion, Disease Prevention for Older Alaskans (HPDP): "Senior Fall Prevention" (Grants)	$ 150.0	$ -	$ -	$ -	$ 150.0
MH Trust: Brain Injury-Traumatic/Acquired Brain Injury Program	$ 300.0	$ -	$ -	$ -	$ 300.0
Reverse FY2013 MH Trust Recommendation (Grants)	$ -	$ -	$ -	$ (125.0)	$ (125.0)
MH Trust: Benef Projects - Grant 124.09 Mini Grants for Beneficiaries with Disabilities (CDDG)	$ -	$ -	$ -	$ 250.3	$ 250.3
Reverse FY2013 MH Trust Recommendation (CDDG)	$ -	$ -	$ -	$ (252.5)	$ (252.5)
FY2014 Salary and Health Insurance Increases (CA)	$ -	$ -	$ -	$ 0.7	$ 0.7
MH Trust: Cont - Grant 151.09 ACOA Planner (06-1513) (CA)	$ -	$ -	$ -	$ 114.1	$ 114.1
Reverse FY2013 MH Trust Recommendation (CA)	$ -	$ -	$ -	$ (114.1)	$ (114.1)
FY2014 Salary and Health Insurance Increases (GCD)	$ -	$ -	$ 0.7	$ -	$ 0.7
MH Trust: Benef Projects - Grant 200.10 Microenterprise	$ 25.0	$ -	$ -	$ 125.0	$ 150.0
MH Trust: Cont - Grant 105.09 Research Analyst III (06-0534) (GCD)	$ -	$ -	$ -	$ 120.0	$ 120.0
MH Trust: Dis Justice - Grant 4303.01AK Safety Planning & Empowerment Network (ASPEN) (GCD)	$ -	$ -	$ -	$ 150.0	$ 150.0
Reverse FY2013 MH Trust Recommendation (GCD)	$ -	$ -	$ -	$ (392.8)	$ (392.8)
Senior and Disabilities Services Total	***$ 705.4***	***$ -***	***$ 1.0***	***$ (2.0)***	***$ 704.4***

Departmental Support Services



Introduction to Departmental Support Services

Mission

Provide quality administrative services in support of the department's mission.

Introduction

Departmental 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.

Core Services

The Departmental Support Services (DSS) results delivery unit includes the Commissioner's Office, Public Affairs, and Finance and Management Services. Departmental Support Services provides a varied range of services to support program efforts across the department which consists of the following components:

- Commissioner's Office
- Public Affairs
- Quality Assurance and Audit
- Assessment and Planning
- Facilities Management
- Facilities Maintenance
- Pioneers' Homes Facilities Maintenance
- HSS State Facilities Rent
- Information Technology Services
- Administrative Support Services

Additionally, Departmental Support Services provides oversight over two small, stand-alone grant program components:

- Community Initiative Matching Grants
- Human Services Community Matching Grants

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

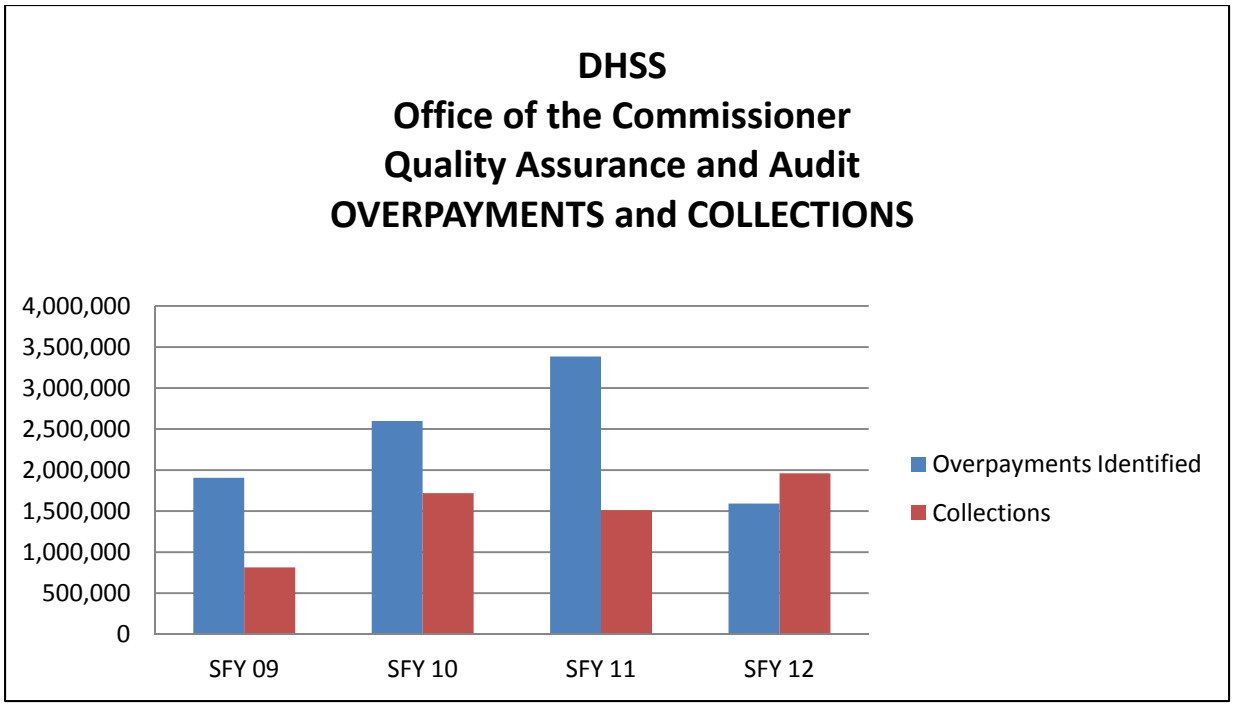
Public Affairs is tasked with ensuring consistency and continuity in department communication with stakeholders and ensures responsiveness to media, legislative, and constituent inquiries. The Public Affairs component includes the functions of public information management, publications design, video production, and web site design, maintenance, and communication. (AS 18: Health, Safety and Housing; AS 44.29 Department of Health and Social Services)

Public Affairs Work Products

Website Maintenance	**15,000 web pages updated**
Video Production	32 television/radio/film productions
Publication Design	260 publications produced
Media Relations	800+ media inquiries coordinated

Quality Assurance and 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 required by the patient protection and affordable act, the unit is also implementing a Recovery Audit contract and will manage an Electronic Health Record incentive payment audit contract. 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

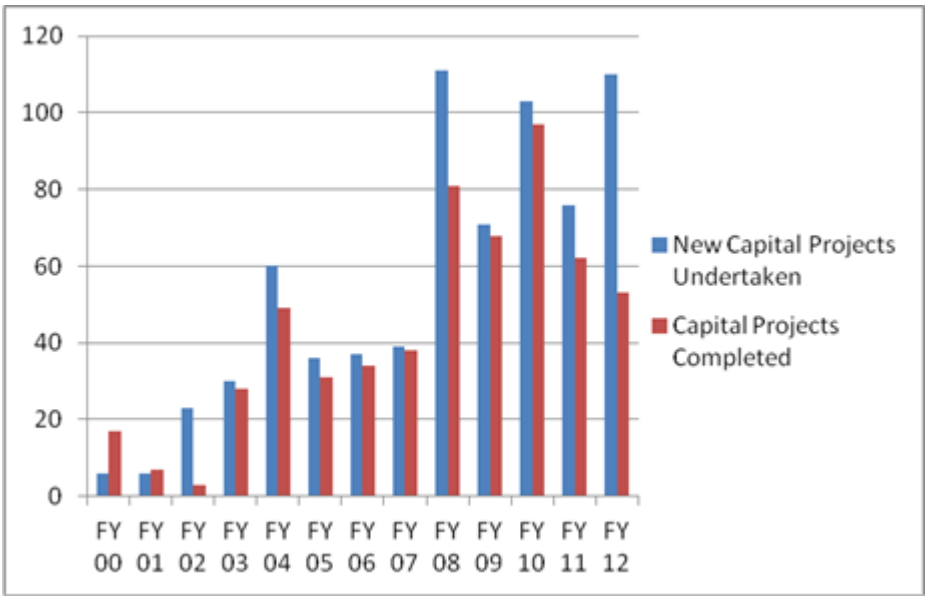
Assessment and Planning provides planning, assessments and forecasting activities for the Medicaid Program. Medicaid is an entitlement program providing for more than $1.3 billion in services to eligible Alaskans. Accurate data and forecasting of expenditures and revenues is critical to the management of this large program and to the state. (AS 37.07, 47.07, 7AAC 43, 7AAC 100.)

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 $702 million.

The following chart shows the level of activity within Facilities Management for FY2000 through FY2012.



In addition, Facilities Management administers all capital grants including pass through federal funds from the Denali Commission. In FY2012, Facilities managed eight Denali Commission grants with a value of $4.3 million and an additional 38 state capital grants with a value of $5.1 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. These facilities also 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.

- **Project Management Office**
  - Currently 89 managed IT projects
- **Business Management – Health related vertical market applications, systems development, and support.**
  - Development and support for 135 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 two data centers, 3784 desktops, 139 networks
- **Security services to protect public, internal, confidential and restricted data**

- Security framework, logging/auditing/monitoring, risk mitigation, investigations HB-65 Alaska Personal Information Protection Act (APIPA), (the security policy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- **Technology Standards, Communications, Privacy, Compliance and Training**
  - Managing State and department IT standards, approve technologies, IT communications/training infrastructure and privacy office.

DHSS Computing Environment Statewide Totals:	
Desktops:	**3,784**
Servers (physical):	**187**
Servers (virtual):	**219**
Networks Statewide:	**139**
Housed Facilities Networks:	**113**
FY10 Help Calls	**20,596**
FY11 Help Calls	**22,596**
FY12 Help Calls	**22,240**
FY10 Average Calls per Day	**74**
FY11 Average Calls per Day	**91**
FY12 Average Calls per Day	**85**
Communities with IT Infrastructure	**82**
Number of Business Applications	**135**

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 Section is responsible for reporting of expenditures and federal revenue collections for the department. Core services include daily, weekly, and quarterly drawdown of cash from

the federal treasury in compliance with the Cash Management Improvement Act, quarterly cost allocation processing in accordance with the Department's federally approved Public Assistance Cost Allocation Plan and filing of multiple federal financial reports for departmental programs, grants, and contracts. Total collection of revenues exceeded $1,022,402,157 (billion) in FY2012 for 250 federal programs.

The Revenue Section also has overall responsibility for the state fiscal year-end close out activities. The revenue section also ensures budgetary and financial compliance for all divisions.

Federal Allocation Management Unit

The Federal Allocation Management Unit is responsible for the quarterly federal reporting of the department's open-entitlement programs of Titles XIX, XXI, and IV-E; management of the Public Assistance Cost Allocation Plan; administration of cost allocation system; and facilitation of responses to federal and state compliance audits, responses, or inquiries.

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 $2.6 billion operating budget, including processing budget amendments, revised programs, supplemental budget requests, fiscal notes, and legislative requests for information for each of the nine divisions.

Major efforts include guiding departments through the various steps of developing the FY2013 and FY2014 budget, processing over 1,000 FY2012 reimbursable service agreements and revised program documents, and tracking division revenue and expenditure projections on a quarterly basis.

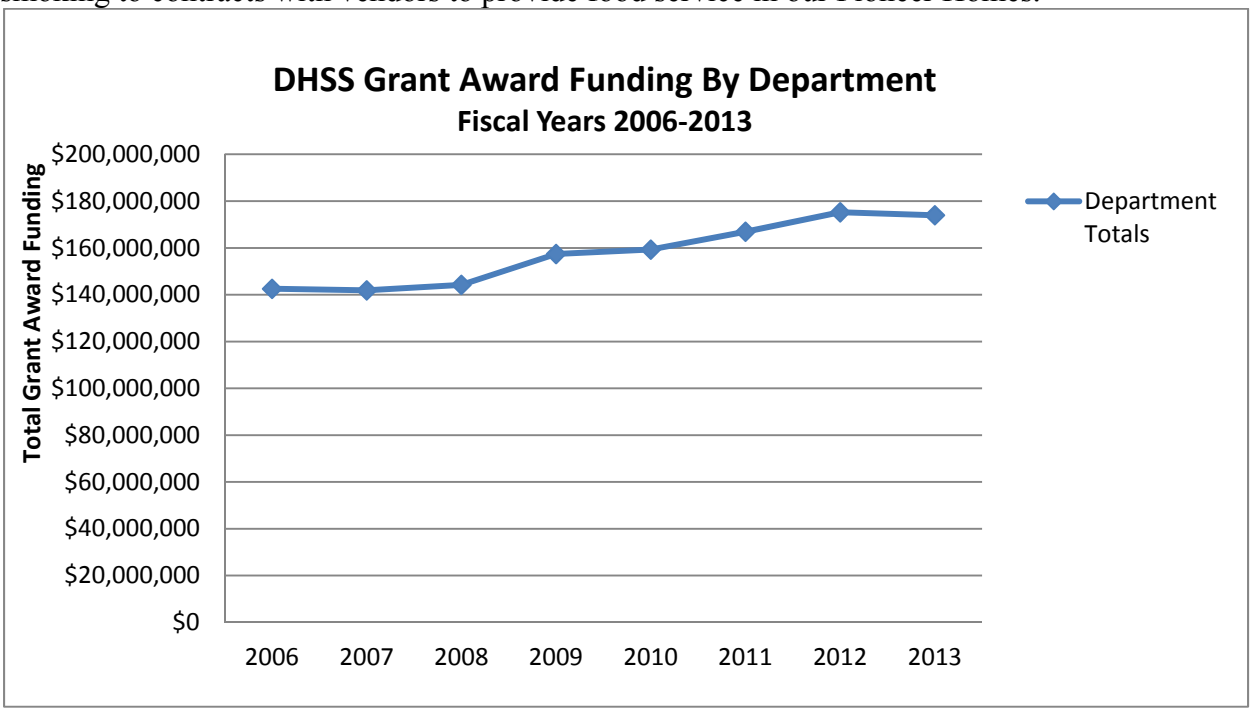
Two significant accomplishments include editing, compiling, and publishing the FY2013 Budget Detail Book and the FY2013 Budget Overview Book. Once budget staff members receive the division-authored narrative of both publications, they then collaborate with the divisions to ensure budget descriptions 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 almost 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.

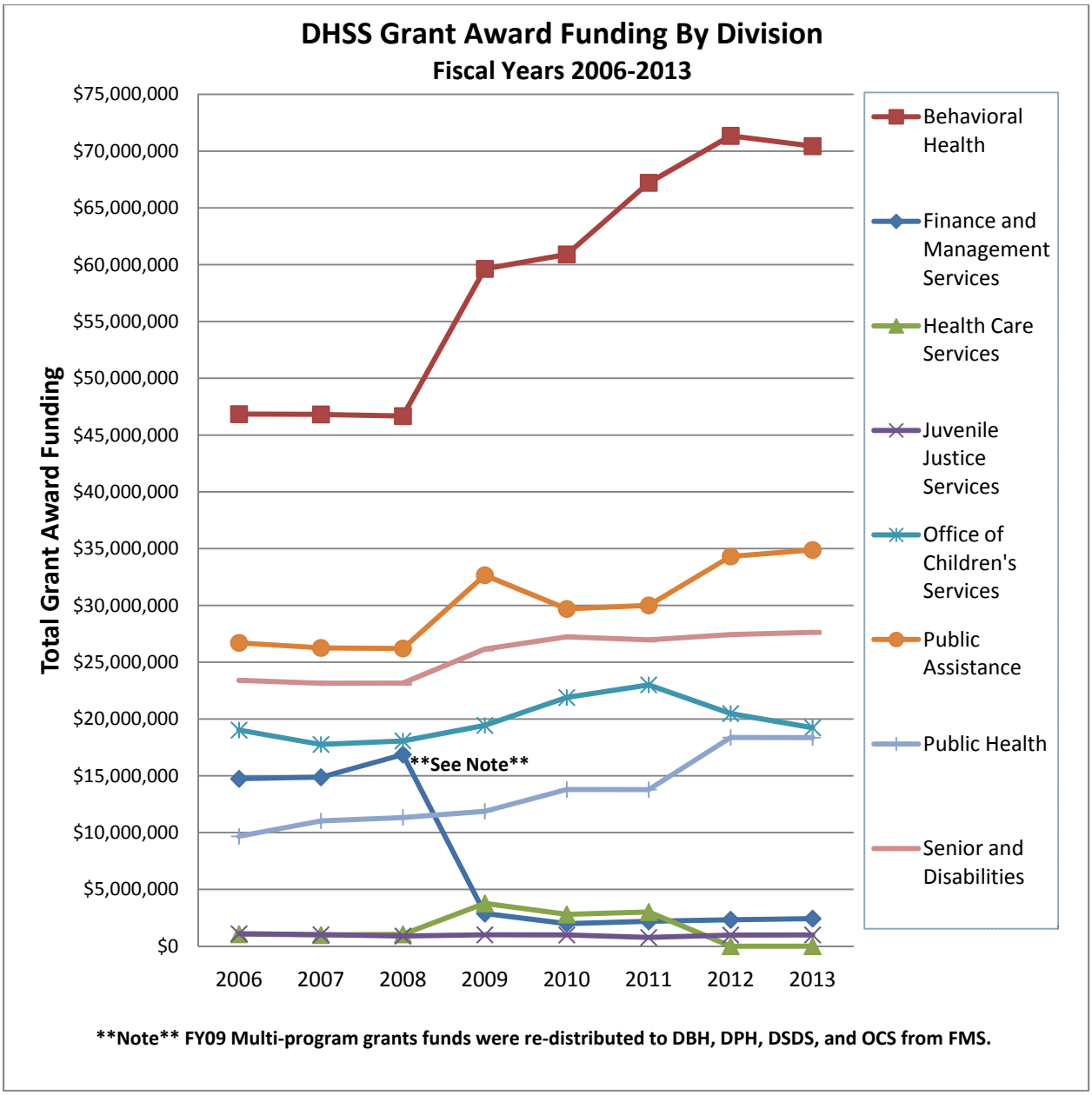
The Medicaid Budget Unit provides departmental leadership with key internal updates of Medicaid projections and estimates, including an update of the twenty-year long-term forecast of Medicaid enrollment and spending in Alaska (MESA) and monthly adjustments to the Short

Term Alaska Medicaid Projections (STAMP) report. Additionally, the unit provides detailed programmatic and fiscal data in response to information requests and fiscal notes.

Grants and Contracts Support Team

The Grants and Contracts Section of Finance and Management Services is responsible for the procurement and administration of all operating grants issued on behalf of DHSS. The Department awards approximately 650 operating grants annually which last year exceeded 175 million dollars. The grants cross the spectrum of services from nutrition, transportation, and support services for seniors in our Senior and Disabilities Services Division to family preservation grants within Office of Children's Services to public health nursing.
Grants and Contracts is also responsible for the procurement and administration of all professional services contracts which include everything from advertising campaigns to help stop smoking to contracts with vendors to provide food service in our Pioneer Homes.





Human Resources

On July 1, 2012, the Human Resources Section completed the transition from Department of Administration to Department of Health and Social Services. With this transition, payroll services remained in the Department of Administration, but recruitment services and management services/employee relations transferred to the Department of Health and Social Services. The Human Resources Section provides professional and labor relations human resource services to managers and supervisors in the areas of management consulting. Additionally, the Section provides assistance to hiring managers in recruiting and selecting qualified individuals by approving recruitment announcements and requests to hire.

Community Initiative Grants

The Community Initiative Matching Grant program was created by the legislature to fund grants to areas ineligible for the Human Services Community Matching Grant. The funds are used to provide essential human services whose unavailability would subject persons in need to serious mental or physical hardship. Upcoming services will focus on the most basic of essential human services. Related services include: homeless shelters, food banks, runaway shelters, homeless find programs, distribution centers for the homeless, support services for the needy, sexual assault and domestic violence shelters, and transportation services for medical and support 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.)

List of Primary Programs and Statutory Responsibilities

Statutes

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

Regulations

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

Administrative Order

Administrative Order #221	Governor's Advisory Council on Faith Based & Community Initiatives

Federal Statutes

Social Security Act	Title IV Grants to States for Aid and Services to Needy Families with Children and for Child Welfare Services

Title XVIII Health Insurance for the Aged and Disabled
Title XIX Grants to States for Medical Assistance Programs
Title XX Block Grants for Social Services
Title XXI State Children's Health Insurance Program

Federal Regulations

Title 7	CFR Part 273.15-16
Title 42	CFR Part 400 to End
Title 45	CFR Part 200 to End

Departmental Support Services

Budget Overview Table

Departmental Support Services	FY2013	FY2014 Gov	Difference
Unrestricted General Funds	$23,603.0	$24,969.0	$1,366.0
Designated General Funds	2.8	2.8	0.0
Federal Funds	15,712.3	15,845.5	133.2
Other Funds	9,355.5	9,517.1	161.6
Total	**$48,673.6**	**$50,334.4**	**$1,660.8**

Budget Requests

Information Technology Services

Health Information Security/Privacy Compliance and Remediation: $850.0 Total -- $255.0 Fed, $595.0 GF

Problem Statement: DHSS and other health entities nationwide are facing an increasingly aggressive regulatory oversight environment. This became evident when the Office of Civil Rights (OCR) sanctioned DHSS for insufficient compliance with the safeguarding of Protected Health Information. The Office of Civil Rights imposed a $1.7 million penalty and placed the department on a Correction Action Plan that mandates a Risk Assessment and Remediation Plan to be completed by January 2013. It is anticipated that the Office of Civil Rights will require DHSS to begin security remediation immediately following the assessment which will result in a supplemental request in FY2013 to begin the work prior to any FY2014 funding being available.

Proposal: This request addresses the resources needed to comply with regulatory requirements not currently being fully addressed. The complexity of the department's information systems continues to grow with over three hundred servers, a hundred applications, sixty terabytes of data and dozens of critical information systems required for the everyday work within the department. To ensure compliance with a multitude and growing number of federal and state legal requirements contractual services, task orders, tools, training, travel, and legal advice, such as the below, are required to reasonably and appropriately safeguard the department's information, while meeting regulatory requirements and reducing the likelihood and cost of public breach notification.

- Manage effective security measurements
- Security awareness and education
- Maintain and implement security policies, procedures, and guidelines
- Schedule and provide system and application assessments
- Remediate ongoing identified security risks to DHSS systems

- Manage and remediate security incidents
- Test and certify systems and applications
- Audit and direct security and compliance controls
- Provide timely reporting of corrective action progress
- Provide preventative and proactive accountability to executive management
- Assessment, auditing, and reporting tools
- Legal services from Department of Law
- Security software/hardware
- Encryption
- Firewall management
- Mobile and device management
- Technical security training for 100 IT staff
- Contractual security services and tasks orders

Consequences of no funding: DHSS will remain in non-compliance with the Federal Office of Civil Rights (OCR). The department will risk formal enforcement, including civil monetary penalties, enhanced scrutiny, investigations, and regulatory oversight by the Office of Civil Rights. DHSS will continue to be sanctioned. Mandated compliance directives from the Office of Civil Rights have cost various entities, such as Providence Hospital, millions of dollars annually.

Without the accountability and preventative focus provided by a security team, the number of public breach notifications mandated by the Health Insurance Portability and Accountability Act (HIPAA)/Health Information Technology for Economic and Clinical Health (HITECH) and Alaska Personal Information Protection Act (APIPA) may continue to grow. These breach notifications could impact the confidence providers have in participating in a health information exchange.

Explanation of FY2014 Capital Budget Requests

Departmental Support Services is requesting the following capital funding:

- Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $3,871.2 Total -- $3,871.2 GF
- Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $2,902.8 Total -- $2,902.8 GF
- Bethel Youth Facility Renovation Phase 2 of 2: $10,600.0 Total -- $10,600.0 GF
- Master Client Index, State Interface Improvements to the Health Information and Direct Secure Messaging Gateway: $5,749.7 Total -- $2,411.0 GF, $3,338.7 Fed
- Emergency Medical Services Ambulances and Equipment Statewide – Match for Code Blue Project: $450.0 Total -- $450.0 GF
- MH Deferred Maintenance and Accessibility Improvements: $1,000.0 Total -- $1,000.0 GF
- MH Home Modification and Upgrades to Retain Housing: $1,050.0 Total -- $750.0 GF/MH, $300.0 MHTAAR
- MH Implementation of Replacement Grant System: $700.0 Total -- $700.0 GF/MH
- MH Medical Appliances for Beneficiaries Experiencing Sensory Impairments: $500.0 Total -- $500.0 GF/MH
- Transition of Care Pilot Project: $1,040.0 Total -- $936.0 Fed, $104.0 GF
- Personal Care Assistant Pilot Project: $1,040.0 Total -- $936.0 Fed, $104.0 GF
- Electronic Vital Record Registration System Phase 2 of 2: $1,785.0 Total -- $1,785.0 GF
- Alaskans Veterans and Pioneers Home Resident Lifts: $212.0 Total -- $212.0 GF
- Equipment needs for Front-Line Probation Officers, Juvenile Justice Officers and Facilities and Probations Offices: $267.5 Total -- $267.5 GF
- Livescan Fingerprinting for Offices of Children's Services: $135.2 Total -- $135.2 GF
- Juneau Pioneer Home Security Cameras: $106.0 Total -- $106.0 GF
- Department-wide Disaster Recovery: $805.8 Total -- $805.8 GF
- Electronic Health Records Incentive Payments – Expanded Authorization: $30,187.5 Total -- $30,187.5 Fed

Brief Description of Major Projects:

Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $3,871.2 Total -- $3,871.2 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 $334 million.

Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment: $2,902.8 Total -- $2,902.8 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 $368 million.

Bethel Youth Facility Renovation Phase 2 of 2: $10,600.0 Total -- $10,600.0 GF

Bethel Youth Facility requires extensive renovation and construction. This capital request will provide funding for the completion of the project. The construction work will consist of building four new detention beds for a total of twelve detention beds, upgrading the existing treatment beds, providing additional probation space and expanded medical space, constructing a vehicle sally port, a small gymnasium, and a secure outdoor recreation area.

Emergency Medical Services Match for Code Blue: $450.0 Total -- $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.

MH Home Modification and Upgrades to Retain Housing: $1,050.0 Total -- $750.0 GF/MH, $300.0 MHTAAR

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 Deferred Maintenance and Accessibility Improvements: $1,000.0 Total -- $1,000.0 GF/MH

Capital grant funds offered competitively to providers serving Alaska Mental Health Trust beneficiaries will be awarded statewide to agencies on a competitive basis for deferred maintenance, including facility renovation and repair, energy efficiency upgrades, and accessibility improvements. This project contributes to the department's mission "To promote and protect the health and well-being of Alaskans". The funds are needed to keep program facilities operational and accessible.

Master Client Index, State Interface Improvements to the Health Information and Direct Secure Messaging Gateway: $5,749.7 Total -- $2,411.0 GF, $3,338.7 Fed

This project covers the post implementation services required to operate the Health Information Gateway or Exchange. This includes general hosting requirements in operating software as a service; proactive service monitoring and management infrastructure; provision of back-up systems and development of corrective action plans in event of service outages or failures. This project will also encompass the prioritization, updating, and modifications needed to a state system, such as the Master Client Index to successfully integrate data to the Health Information Gateway to meet Centers for Medicare and Medicaid Services' and Office of the National Coordinator's meaningful use and security requirements.

Electronic Vital Record Registration System Phase 2 of 2: $1,785.0 Total -- $1,785.0 GF

The information system currently supporting registration of births, deaths, marriages, and divorces in Alaska is more than 20 years old. The system is based on computer technologies no longer supported by modern operating systems. This is Phase 2 of 2.

Challenges

As the administration and management of the Department, Financial Management Services 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.

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, requires 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.

Deferred Maintenance: DHSS has responsibility for an aging infrastructure to support our public health centers, public health labs, and 24-hour facilities, including youth facilities, pioneer homes, and Alaska Psychiatric Institute. It is crucial that deferred maintenance requirements and funding is provided so that these critical facilities can continue to have a useful life.

Sample Deferred Maintenance Project

Johnson Youth Facility Fuel Tank Replacement

This aging underground storage fuel tank could become a hazard if not abated and replaced prior to possible leakage.

FY2014 Governor's Request Increment and Decrement Fund Breakout

DHSS FY2014 Governor's Request - Department Support Services General and Other Funds (Includes Inc, IncM, Dec, OTI, SalAdj, FndChg, CntNgt, CarryFwd, and Inter-RDU Trin and Trout Items Only)					
Item	**UGF**	**DGF**	**Federal**	**Other**	**Total**
FY2014 Salary and Health Insurance Increases (PA)	$ 0.3	$ -	$ 0.2	$ 0.1	$ 0.6
FY2014 Salary and Health Insurance Increases (CO)	$ 4.3	$ -	$ 2.0	$ 0.7	$ 7.0
Reverse FY2013 MH Trust Recommendation (CO)	$ -	$ -	$ -	$ (115.0)	$ (115.0)
Transfer from Medical Assistance Administration for (06-T026) Data Processing Manager IV (CO)	$ -	$ -	$ -	$ 151.0	$ 151.0
Department of Administration Core Services Rates (Admin)	$ 764.6	$ -	$ -	$ -	$ 764.6
FY2014 Salary and Health Insurance Increases (Admin)	$ 1.8	$ -	$ 0.8	$ -	$ 2.6
Replace Uncollectible Federal Receipts with CIP Receipts (FM)	$ -	$ -	$ (124.8)	$ 124.8	$ -
Health Information Security/Privacy Compliance and Remediation (ITS)	$ 595.0	$ -	$ 255.0	$ -	$ 850.0
Department Support Services Total	***$ 1,366.0***	***$ -***	***$ 133.2***	***$ 161.6***	***$ 1,660.8***

Appendices

RDU/Component Listing FY2014

Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Behavioral Health	AK Fetal Alcohol Syndrome Program
Behavioral Health	Alcohol Safety Action Program (ASAP)
Behavioral Health	Behavioral Health 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	Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse
Behavioral Health	Suicide Prevention Council
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	Catastrophic and Chronic Illness Assistance
Health Care Services	Health Facilities Licensing and Certification
Health Care Services	Certification and Licensing
Health Care Services	Medical Assistance Administration
Health Care Services	Rate Review
Health Care Services	Community Health Grants
Juvenile Justice	McLaughlin Youth Center
Juvenile Justice	Mat-Su Youth Facility
Juvenile Justice	Kenai Peninsula Youth Facility
Juvenile Justice	Fairbanks Youth Facility

Juvenile Justice	Bethel Youth Facility
Juvenile Justice	Nome Youth Facility
Juvenile Justice	Johnson Youth Center
Juvenile Justice	Ketchikan Regional Youth Facility
Juvenile Justice	Probation Services
Juvenile Justice	Delinquency Prevention
Juvenile Justice	Youth Courts
Public Assistance	Alaska Temporary Assistance Program
Public Assistance	Adult Public Assistance
Public Assistance	Child Care Benefits
Public Assistance	General Relief Assistance
Public Assistance	Tribal Assistance Programs
Public Assistance	Senior Benefits Payment Program
Public Assistance	Permanent Fund Dividend Hold Harmless
Public Assistance	Energy Assistance Program
Public Assistance	Public Assistance Administration
Public Assistance	Public Assistance Field Services
Public Assistance	Fraud Investigation
Public Assistance	Quality Control
Public Assistance	Work Services
Public Assistance	Women, Infants and Children
Public Health	Health Planning and Systems Development
Public Health	Nursing
Public Health	Women, Children and Family Health
Public Health	Public Health Administration Services
Public Health	Emergency Programs
Public Health	Chronic Disease Prevention and Health Promotion
Public Health	Epidemiology
Public Health	Bureau of Vital Statistics
Public Health	Emergency Medical Services Grants
Public Health	State Medical Examiner
Public Health	Public Health Laboratories
Public Health	Tobacco Prevention and Control
Senior and Disabilities Services	Senior and Disabilities Services Administration
Senior and Disabilities Services	General Relief / Temporary Assisted Living
Senior and Disabilities Services	Senior Community Based Grants
Senior and Disabilities Services	Community Developmental Disabilities Grants
Senior and Disabilities Services	Senior Residential Services
Senior and Disabilities Services	Commission on Aging
Senior and Disabilities Services	Governor's Council on Disabilities and Special Education
Departmental Support Services	Public Affairs

Departmental Support Services	Quality Assurance and Audit
Departmental Support Services	Commissioner's Office
Departmental Support Services	Assessment and Planning
Departmental Support Services	Administrative Support Services
Departmental Support Services	Hearings and Appeals
Departmental Support Services	Facilities Management
Departmental Support Services	Information Technology Services
Departmental Support Services	Facilities Maintenance
Departmental Support Services	Pioneers' Homes Facilities Maintenance
Departmental Support Services	HSS State Facilities Rent
Human Services Community Matching Grant	Human Services Community Matching Grant
Community Initiative Matching Grants (non-statutory)	Community Initiative Matching Grants (non-statutory grants)
Medicaid Services	Behavioral Health Medicaid Services
Medicaid Services	Children's Medicaid Services
Medicaid Services	Adult Preventative Dental Medicaid Svcs
Medicaid Services	Health Care Medicaid Services
Medicaid Services	Senior and Disabilities Medicaid Services

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 (now known as Xerox)
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
AeHN .....Alaska eHealth Network
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
ANP.....Advanced Nurse Practitioner
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)
APH.....Alaska Pioneers Home
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
ASHNHA.....Alaska State Hospital and Nursing Home Association
ASPEN.....Automated Survey Processing Environment
AST…….Alaska Screening Tool
ASTHO.....Association of State and 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
BHAs.....Behavioral Health Aides
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
CAP.....Corrective Action Plan
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
CHAP's.....Community Health Aide Practitioners
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 and Licensing
CITC .....Cook Inlet Tribal Corporation
CLIA .....Clinical Laboratory Improvement Amendments
CM .....Case Management
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 Incentive Grants
CPS .....Child Protective Services (Office of Children's Services)

CPT .....Current Procedural Terminology
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 and 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 (Children's Health Insurance Program)
DME.....Durable Medical Equipment
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
DSM.....Direct Secure Messaging
DSS .....Decision Support System
DSS .....Departmental 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
EHR…….. Electronic Health Record
EMR……. Electronic Medical Record
EMS .....Emergency Medical Services
EPI.....Epidemiology
EPS.....Enhanced Provider Services
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
FESC.....Frontier Extended Stay Clinic
FFP.....Federal Financial Participation
FFY .....Federal Fiscal Year
FPG .....Federal Poverty Guidelines
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
HCPCS.....Healthcare Common Procedural Coding System
HCS.....Health Care Services
HDDS…….Hospital Discharge Data System
HDM……. .Hospital Discharge Model
HF .....Healthy Families
HIE.....Health Information Exchange
HIT.....Healthy Information Technology
HIFA .....Health Insurance Flexibility and Accountability
HIPP.....Health Insurance Premium Payment (Medicaid)
HIPAA .....Health Insurance Portability and Accountability Act
HIV .....Human Immunodeficiency Virus
HPG.....Health Purchasing Group
HPI…….Health Planning and Infrastructure
HRSA.....Health Resource Services Administration
HSCMG .....Human Services Community Matching Grants
IA .....Interim Assistance
I/A .....Interagency Receipts
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 and 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 Clinical Social Worker
LIHEAP .....Low Income Home Energy Assistance Program
LTC.....Long Term Care
MAGI.....Modified Adjusted Gross Income
MBU .....Medicaid Budget Unit
MCAC.....Medical Care and Advisory Committee
MITA .....Medicaid Information Technology Architecture
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
MTF……..….Medicaid Task Force
MTO……..….Medicaid Travel Office
MYC .....McLaughlin Youth Center
NEMT…… Non-Emergency Medical Transportation
NCC……Nome Community Center
NHSC.....National Health Service Corps
NHSIA .....National Human Services Interoperability Architecture
NIH .....National Institutes of Health
NOMs…….National Outcome Measurements

NPI…….National Provider Identifier
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
NUBC .....National Uniform Billing Committee
NUCC .....National Uniform Claim Committee
OA.....Older Alaskans (Waiver)
OAA.....Older Alaskan's Act
OASIS.....Outcome and 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
ONC .....Office of the National Coordinator
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
(PFD)HH.....(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
QA.....Quality Assurance
QI .....Quality Improvement
QIO .....Quality Improvement Organization
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
RFP .....Request for Proposal
RHC .....Rural Health Clinic
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
SPA .....State Plan Amendments
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……Foster Care and Adoption Assistance
Title V .....Maternal, Child Health Block Grant
Title X .....Family Planning (Federal)

Title XIX.....Medicaid
Title XXI.....CHIP/Denali KidCare
T&H .....Central Council of Tlingit and Haida Indian Tribes
THO .....Tribal Health Organizations
TPL .....Third Party Liability
TSU…….Transitional Services Unit
TTD.....Therapeutic Transition Days
TYP…….Tribal Youth Program
UAA……...University of Alaska, Anchorage
UAF……University of Alaska, Fairbanks
UM.……Utilization Management
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