

State of Alaska  
Department of Health & Social Services

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## Fiscal Year 2015 Performance and Budget Summary Book



**Governor Sean Parnell, State of Alaska**

**Commissioner William J. Streur, Department of Health & Social Services**



# Alaska Department of Health and Social Services Organization Chart



**Commissioner**  
*William J. Streur*

**Chief Medical Officer**  
*Ward B. Hurlburt, M.D.*

**PUBLIC HEALTH**  
*Director: Kerre Shelton*

- Public Health Nursing
- Epidemiology
- Chronic Disease Prevention & Health Promotion
- Emergency Programs
- Women's, Children's & Family Health
- Bureau of Vital Stat.
- State Laboratory
- State Medical Examiner's Office
- Health Planning & Systems Development

**Deputy Commissioner for Medicaid and Health Care Policy**  
*Craig J. Christenson*

- Medicaid Director
- Performance/Quality Assurance
- Medicaid Policy & Planning
- MMIS — DDI
- Rate Review
- Tribal Health

**HEALTH CARE SERVICES**  
*Director: Margaret Brodie*

- Medicaid Management
- Health Facility Survey
- Certification & Licensing

**ALASKA PIONEER HOMES**  
*Director: G. Ken Truitt*

**SENIOR & DISABILITIES SERVICES**  
*Director: Duane Mayes*

**BEHAVIORAL HEALTH**  
*Acting Director: Barbara Henjum*

- Boards & Commissions**
- \* Medical Care Advisory Committee
  - \* Pharmacy/Therapeutics Comm.
  - \* Alaska Pioneer Homes Advisory Board

**Deputy Commissioner for Family, Community & Integrated Services**  
*Ree Sailors*

**CHILDREN'S SERVICES**  
*Director: Christy Lawton*

**JUVENILE JUSTICE**  
*Acting Director: Karen Forrest*

- Boards & Commissions**
- \* Juvenile Justice Advisory Committee

**PUBLIC ASSISTANCE**  
*Director: Ron Kreher*

- Human Resources
- Regulations
- Health Information Technology

**Public Information Communications Manager**  
*Clay Butcher*

**Legislative Relations**  
*Jason Hooley*

**Health Care Policy**  
*Josh Applebee, Deputy Director*

**Special Assistant**  
*Tara Horton*

**Alaska Health Care Commission**  
*Deborah Erickson, Exec. Dir.*

- Boards & Commissions**
- (Behavioral Health)**
- \* Alaska Mental Health Board
  - \* Advisory Board on Alcoholism and Drug Abuse
  - \* Suicide Prevention Council
- (Senior & Disabilities Services)**
- \* Governor's Council on Disabilities and Special Education
  - \* Alaska Commission on Aging

**Assistant Commissioner for Finance and Management Services**  
*Sana P. Efirid*

- Facilities
- Administrative Services
- Budget
- Revenue
- Fiscal
- Grants & Contracts
- Information Technology
- Federal Allocation Management Unit

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

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## **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. AS 47.05.101

- Priority 1. Health & Wellness Across the Lifespan
- Priority 2. Health Care Access, Delivery & Value
- Priority 3. Safe & Responsible Individuals, Families & Communities

## **Core Services**

1. Protect and promote the health of Alaskans.
2. Provide quality of life in a safe living environment for Alaskans.
3. Manage health care coverage for Alaskans in need.
4. Facilitate access to affordable health care for Alaskans.
5. Strengthen Alaska families.
6. Protect vulnerable Alaskans.
7. Promote personal responsibility and accountable decisions by Alaskans.

## **Major Department Accomplishments in 2013**

- Executed department-wide results-based accountability and results-based budgeting exercise which resulted in clearly defined division alignment with the performance framework established in 2012-2013.
- Alaska recognized by federal government as leader in advancing the use of health information technology to enhance the safety and quality of health care across the state. Over 3,900 health care providers and their office staff are enabled for electronic care summary exchange as of 2013. This makes it easy and safe for doctors, nurses, pharmacists and others to communicate with each other on their patients' behalf.
- 10,480 children and 136 elementary schools across the state participated in the three-month Healthy Futures Physical Activity Challenge in the spring of 2013. The Challenge is run through a strong, ongoing partnership between Healthy Futures, the Alaska Division of Public Health's Play Every Day campaign and other organizations.
- Alaska was first in the nation in 2013 for neonatal and infant survival rates. Rate decreased to an all-time low of 1.92 deaths per 1,000 live births, the best in the nation for the second year in a row.
- The Division of Public Assistance attained the highest accuracy rate in the nation for the Food Stamp program and ranked second highest accuracy rate for case closures and

application denials.

- Department announced smoking among Alaska high school students has declined 40% between 2007 and 2013.
- Served 579 Alaska seniors and veterans in the Pioneer Home system.
- The department received five awards in the National Public Health Information Coalition's 2013 Awards for Excellence in Public Health Communications. The awards included: gold medals for the foster parent recruitment TV public service announcement, "One Child," and the web-based training "Alaska Medicaid 101: Medicaid Compliance and Ethics Training"; silver medals for the brochure "Bedtime for Baby: Safer Sleep for Nap and Nights," and the TB public service announcement "Play Every Day PSA: Athlete"; and a bronze medal for the poster "WIC for Farmers' Markets."
- The new Medicaid Management Information System launched October 1, 2013. The system processes approximately 190,000 claims per week. 9,000 Medicaid providers have been re-enrolled to date. The system is described 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.
- The Women Infants and Children, "SPIRIT" Management Information System began pilot operations October 2013 in two agencies. Pilot operations were flawless. Statewide roll-out took place in two phases: Phase I in November 2013 and Phase II in December 2013.
- The department's new Background Check Database launched December 2013.
- The Office of Children's Services exceeded national standards for placement stability and achieved the highest rate in the nation for timeliness of adoptions.
- Of all the children who were victims of substantiated maltreatment, 92.4% were not victims of another incident. For those children placed in foster care, 99.6% were free from maltreatment.
- The Division of Public Assistance fully implemented lean work processes, which improved customer service, efficiency and timeliness. Through this process, the division was able to service increased caseloads without increased staff.
- The Division of Juvenile Justice improved mental health services for juveniles in their care by initiating training and implementation of trauma-informed programming, developing strategies to strengthen internal capacity for training, and improving clinical supervision for mental health professionals within the division.
- The Senior Community Based Grant programs continued to provide essential, high quality services to seniors throughout the state despite the increasing needs in the senior population. Services included adult day services, primarily provided through a center for adults with impairments or Alzheimer's disease, in a protective group setting that is facility-based. The Aging and Disability Resource Centers expanded to four regions. They are part of an effort to help people more easily access the long-term services and supports available in their communities. Additionally, through Community Developmental Disabilities Grants, services were provided to developmental disabilities beneficiaries who are not receiving services through one of the Medicaid waiver programs. Services were delivered in more than 100 communities by 29 nonprofit grantee agencies.
- The Medicaid Program Integrity Office charged 29 individuals with Medicaid fraud and suspended payments to 56 providers based on credible allegations of fraud. In addition,

they recovered \$4,962,000 in Medicaid overpayments.

- Fifteen trainers were newly certified throughout Alaska to implement the National Alliance on Mental Illness (NAMI) suicide postvention training model. There are currently 30 postvention trainers that are implementing trainings throughout the state.
- Additional efforts by Health Care Services have resulted in a greater utilization of lower cost, clinically equivalent, generic medications. At the beginning of FY2013, only 75.5% of prescriptions for Medicaid recipients were for generic medications; the use of generic medications steadily increased to 78.9% by the end of FY2013.

### **Key Department Challenges in FY2015**

The Department of Health and Social Services continues to make progress towards 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 include:

- On-going training for all current and future Medicaid Management Information System users.
- Multiple system challenges with the self-service portal and the employee portal of the new Public Assistance Eligibility Information System, "ARIES." Original target for system launch was October 1, 2013, which was postponed to late November 2013.
- Management of the Medicaid component of the budget to ensure that services are provided in a quality manner using the resources available.
- Development and implementation of integrated services and programs when funding and program requirements are categorical and work against integration.
- Identification and resolution of issues relating to Alaska's health workforce.
- The Affordable Care Act presents opportunities and challenges to all Medicaid Service programs. If Alaska implements the optional Medicaid expansion component, regulations, state plan amendments, and benefit packages will need to be developed. Even without Medicaid expansion, it is likely that Alaska will experience increased enrollment by individuals currently eligible that have either never enrolled in Medicaid or were enrolled in the Medicaid program, but allowed their enrollment to expire. A Kaiser Foundation study estimates that even without expansion, the Affordable Care Act will lead to an increase in Medicaid enrollment in Alaska of 10,000 by year 2022.
- 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 (API) which is the only state-owned psychiatric hospital (with only 50 acute adult beds). In addition, there is a statewide shortage of residential supportive housing that can accommodate people with

behavioral health issues too severe to be managed in a standard assisted living home but who do not require hospitalization. Individuals exiting correctional facilities or involved with the Court System lack supportive housing to prevent repeated episodes of homelessness and institutionalization.

- Retention of staff is the number one challenge the Office of Children's Services faces. Without necessary positions filled in many offices statewide, the ability to meet state and federal requirements for family contact, worker visits with children, and worker visits with parents is compromised. Those three requirements directly correlate to the likelihood of a family being successful or a child being reunified or achieving permanency in a timely manner.
- The Division of Juvenile Justice continues to expand trauma-informed programming into all of its programs. The additional commitment to train all staff, not simply those directly working with juveniles, creates a strain on the division's training capacity, but is necessary to meet the needs of the juveniles and families within our care.
- 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. Some fraction of this population requires significant assistance from the state, and will grow proportionately to the overall senior population.

The DHSS Governor's request includes 3,650 positions. The details of their budgeted status and geographical location are shown in the chart below. Select types of employees (i.e. public health nurses, social workers) may be budgeted in one location, but provide continual itinerant services to numerous surrounding smaller rural communities.

***FY2015 Position Summary by Location***

<b>Location</b>	<b>Total Full Time</b>	<b>Total Part Time</b>	<b>Total Non Perm</b>	<b>Total Position Counts</b>
Anchorage	1,736	13	38	<b>1,787</b>
Aniak	3	0	0	<b>3</b>
Barrow	7	0	0	<b>7</b>
Bethel	105	0	3	<b>108</b>
Cordova	2	0	0	<b>2</b>
Craig	5	0	0	<b>5</b>
Delta Junction	6	0	0	<b>6</b>
Dillingham	9	1	0	<b>10</b>
Eagle River	1	0	0	<b>1</b>
Fairbanks	362	3	9	<b>374</b>
Fort Yukon	0	1	0	<b>1</b>
Gakona	2	0	0	<b>2</b>
Galena	2	1	0	<b>3</b>
Haines	2	0	0	<b>2</b>
Homer	15	0	0	<b>15</b>
Juneau	555	16	25	<b>596</b>
Kenai	90	1	2	<b>93</b>
Ketchikan	124	9	10	<b>143</b>
King Salmon	2	0	0	<b>2</b>
Kodiak	15	0	0	<b>15</b>
Kotzebue	10	0	0	<b>10</b>
McGrath	2	0	0	<b>2</b>
Nome	51	0	2	<b>53</b>
Palmer	121	13	6	<b>140</b>
Petersburg	3	0	0	<b>3</b>
Saint Mary's	3	0	0	<b>3</b>
Seward	4	0	0	<b>4</b>
Sitka	97	1	4	<b>102</b>
Tok	2	0	0	<b>2</b>
Valdez	5	1	0	<b>6</b>
Wasilla	134	0	1	<b>135</b>
Wrangell	2	0	0	<b>2</b>
<b>Totals</b>	<b>3,489</b>	<b>60</b>	<b>101</b>	<b>3,650</b>

## **FY2015 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 FY2015 Compared to FY2014**

	<b>FY2014 Management Plan</b>	<b>FY2015 Governor's Request</b>
Unrestricted General Funds	\$1,246.9 million	\$1,256.1 million
Designated General Funds	\$73.5 million	\$72.6 million
Federal Funds	\$1,250.3 million	\$1,250.50 million
Other Funds	\$95.3 million	\$90.3 million
<b>Total</b>	<b>\$2,665.9 million</b>	<b>\$2,669.5 million</b>
Increased Federal Revenue		\$0.2 million
Increased General Fund		\$8.4 million

#### **Increments:**

- \$250.0 PFD Hold Harmless Program Growth
- \$250.0 Inter-Agency Receipts Tribal Assistance
- \$26,258.2 UGF Medicaid Services Growth
- \$250.0 UGF Strengthening Families Initiative
- \$2,325.0 Federal Receipts for Title IV-E Foster Children

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

## **Expenditure Category Comparisons**

For purposes of historical comparisons, expenditures are broken 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***

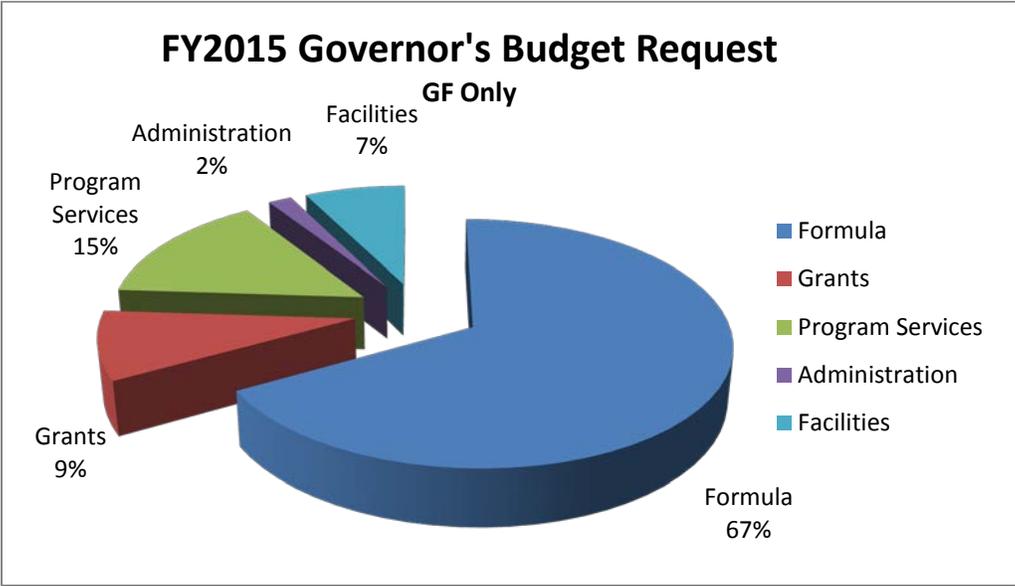
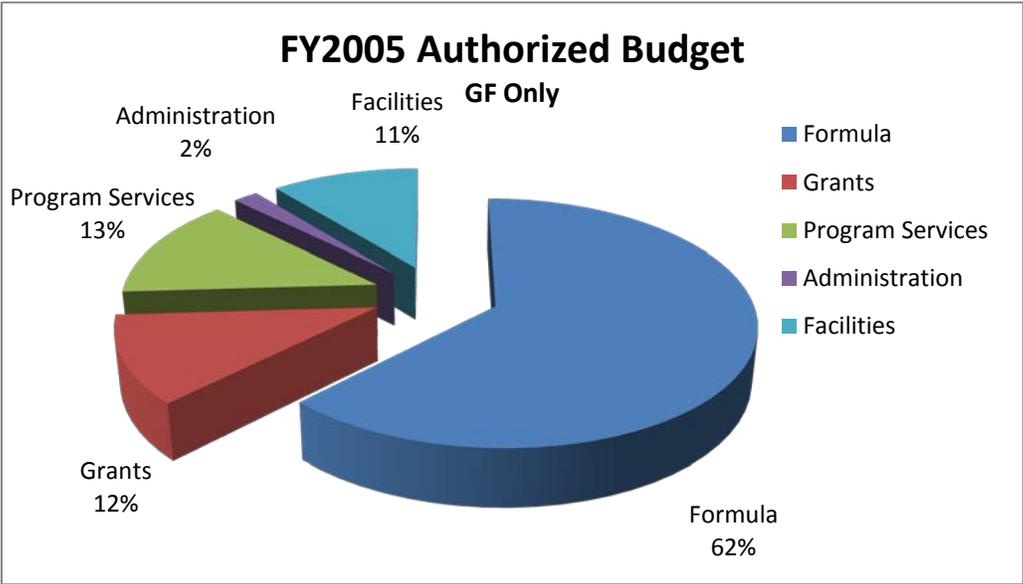
The department manages and operates 24-hour facilities and institutions. These include youth correctional facilities, the Alaska Psychiatric Institute, and Pioneer Homes.

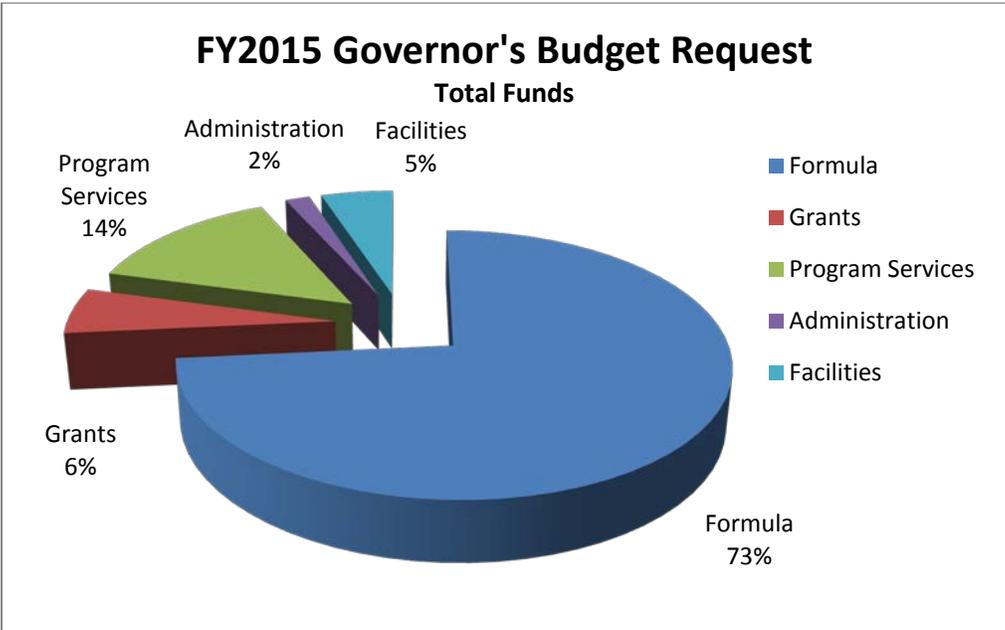
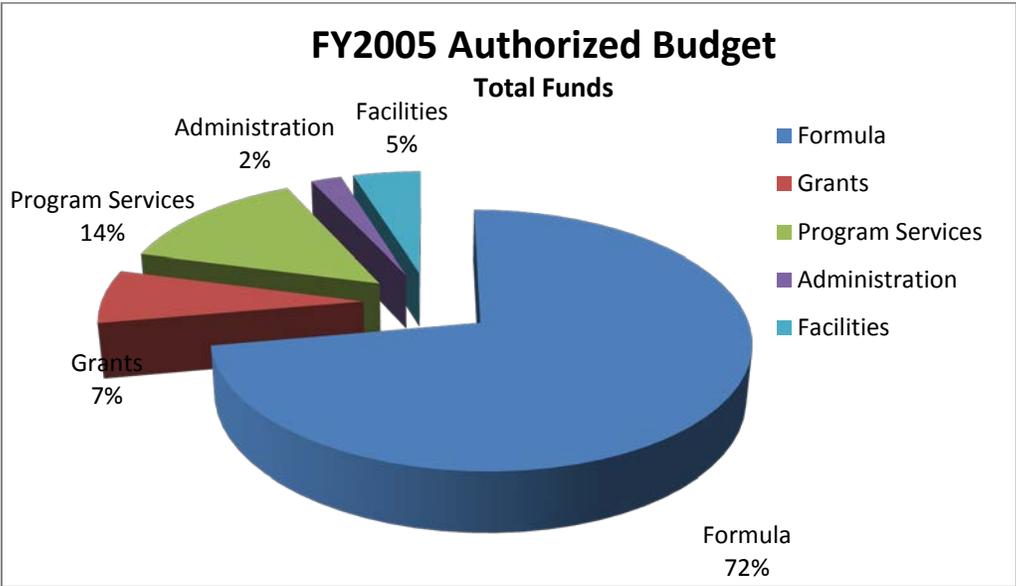
### ***Budget Charts and Graphs***

The table below shows the comparison of total funds for FY2005 and FY2015.

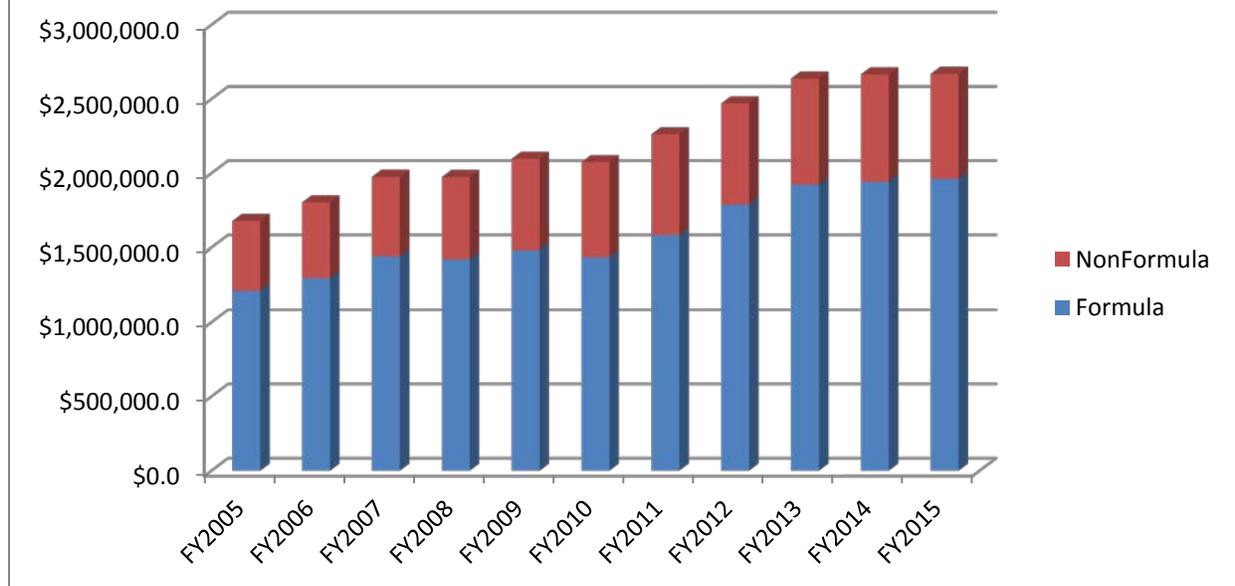
## **Department of Health and Social Services** **Expenditures by Category,** **FY2005-FY2015**

<b>Category</b>	<b>FY2005 Authorized</b>		<b>FY2015 Governor's</b>		<b>Change FY2005 to FY2015</b>
	<b>Total Funds</b>	<b>% of Total</b>	<b>Total Funds</b>	<b>% of Total</b>	
Formula	\$ 1,212,137.0	72%	\$ 1,961,873.1	73%	62%
Grants	\$ 115,752.4	7%	\$ 153,833.9	6%	33%
Program Services	\$ 232,751.2	14%	\$ 373,135.9	14%	60%
Administration	\$ 36,632.4	2%	\$ 45,960.6	2%	25%
Facilities	\$ 80,989.6	5%	\$ 134,739.1	5%	66%
<b>Total</b>	<b>\$ 1,678,262.6</b>	<b>100%</b>	<b>\$ 2,669,542.6</b>	<b>100%</b>	<b>59%</b>





## FY2005-FY2015 Comparison, Formula and Non-Formula



Medicaid is the largest formula program in the department, totaling about 85% of the total formula program category in the proposed FY2015 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
- Energy Assistance Program
- Catastrophic and Chronic Illness Assistance
- Alaska Temporary Assistance Program
- Adult Public Assistance
- Child Care Benefits
- General Relief Assistance
- Tribal Assistance Program
- Senior Benefits Payment Program
- Permanent Fund Dividend Hold Harmless
- Senior and Disabilities Medicaid Services



**MISSION** TO PROMOTE AND PROTECT THE HEALTH AND WELL-BEING OF ALASKANS

**VISION** ALASKA INDIVIDUALS, FAMILIES AND COMMUNITIES ARE SAFE AND HEALTHY

**SERVICE PHILOSOPHY**

WE AIM TO...



- INTEGRATE AND COORDINATE SERVICES
- STRATEGICALLY LEVERAGE TECHNOLOGY
- IMPLEMENT SOUND POLICY
- PRACTICE FISCAL RESPONSIBILITY
- MEASURE AND IMPROVE PERFORMANCE



**IN ORDER TO...**  
DELIVER THE **RIGHT CARE**  
TO THE **RIGHT PERSON**  
AT THE **RIGHT TIME**  
FOR THE **RIGHT PRICE**

**PRIORITY 1. HEALTH & WELLNESS ACROSS THE LIFE SPAN**

**CORE SERVICES**

PROTECT AND PROMOTE THE HEALTH OF ALASKANS



**OBJECTIVES**

- Improve the health status of Alaskans
- Decrease unintentional injuries
- Decrease substance abuse and dependency

PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS



- Improve the safety of children receiving department services
- Increase the number of older Alaskans who live safely in their communities
- Increase the number of Alaskans with disabilities who are living safely in the least restrictive environment
- Increase the number of Alaskans with behavioral health issues who report improvement in key life domains

**PRIORITY 2. HEALTH CARE ACCESS, DELIVERY & VALUE**

**CORE SERVICES**

MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED



**OBJECTIVES**

- Increase the number of Alaskans with a primary care provider
- Increase access for Alaskans with chronic or complex medical conditions to integrated care

FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS



- Improve access to health care
- Improve rural access to health care

**PRIORITY 3. SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES**

**CORE SERVICES**

STRENGTHEN ALASKA FAMILIES



**OBJECTIVES**

- Increase the number of Alaska families who are employed
- Increase the number of Alaska families with safe, affordable child care
- Increase the number of Alaska families with warm homes
- Increase the number of Alaska families with food security

PROTECT VULNERABLE ALASKANS



- Decrease the rate of maltreatment in children
- Decrease the rate of maltreatment in vulnerable populations
- Improve client safety within department and provider operated facilities

PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS



- Improve tobacco enforcement
- Increase the number of juveniles who remain crime-free
- Increase the number of Alaskans with health conditions who practice self-management
- Decrease interpersonal violence
- Increase disaster preparedness
- Reduce fraud, waste and abuse

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## PRIORITY 1. HEALTH & WELLNESS ACROSS THE LIFE SPAN

### CORE SERVICE 1.1 PROTECT AND PROMOTE THE HEALTH OF ALASKANS

<p>OBJECTIVE 1.1.1</p> <p><b>Improve the health status of Alaskans</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Percent of children 19 - 35 months of age who are fully immunized</p> <p><b>EFFICIENCY MEASURE:</b> Cost to fully immunize a child 19 - 35 months of age</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of clients served by the department who receive preventative health screenings per current recommendations</p> <p><b>EFFICIENCY MEASURE:</b> Cost per screening</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of communities that identify and address local health problems</p> <p><b>EFFICIENCY MEASURE:</b> Cost of community health improvement training and support per community</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of Alaskans reporting very good/good health</p> <p><b>EFFICIENCY MEASURE:</b> State wellness costs per capita</p>
<p>* POPULATION HEALTH INDICATORS</p>		
<p><b>HEALTHY ALASKANS 2020</b> (LHI 4): Percent of adults who are overweight and obese</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 5): Percent of adolescents and children who are overweight and obese</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 6): Percent of adults and adolescents who meet physical activity guidelines</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 1): Cancer mortality rate</p>		
<p>OBJECTIVE 1.1.2</p> <p><b>Decrease unintentional injuries</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Number of Alaskans experiencing unintentional injuries</p> <p><b>EFFICIENCY MEASURE:</b> Cost of injury prevention program per capita</p>
<p>POPULATION HEALTH INDICATORS</p>		
<p><b>HEALTHY ALASKANS 2020</b> (LHI16): Unintentional injury mortality rate</p>		
<p>OBJECTIVE 1.1.3</p> <p><b>Decrease substance abuse and dependency</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Percent of Alaskans discharged from substance abuse treatment services that successfully completed treatment</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of Alaskans who currently smoke cigarettes</p> <p><b>EFFICIENCY MEASURE:</b> Cost of tobacco prevention and control program per capita</p>
<p>POPULATION HEALTH INDICATORS</p>		
<p><b>HEALTHY ALASKANS 2020</b> (LHI 15): Percent of adults who binge drink</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 3): Percent of adults who currently do not smoke cigarettes</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 2): Percent of adolescents who have not smoked cigarettes or used smokeless tobacco in the past 30 days</p> <p><b>HEALTHY ALASKANS 2020</b> (LHI 14): Alcohol-related mortality rate</p>		

\* Population health indicators are population-based health and human service measures drawn from the "Healthy Alaskans 2020" list of 25 Leading Health Indicators (LHI) for Alaska.

## CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

<p>OBJECTIVE 1.2.1</p> <p><b>Improve the safety of children receiving department services</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Percent of screened-in reports of child abuse/neglect that are screened within one day</p> <p><b>EFFICIENCY MEASURE:</b> Cost per screening per intake worker</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of child abuse/neglect assessments (investigations) that are initiated within required time frames</p> <p><b>EFFICIENCY MEASURE:</b> Percent of assessments (investigations) completed timely</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of children in out-of-home care who receive a required monthly caseworker visit</p> <p><b>EFFICIENCY MEASURE:</b> Cost per caseworker visit</p> <p><b>EFFECTIVENESS MEASURE:</b> Percent of children on Medicaid who are prescribed psychotropic medication</p> <p><b>EFFICIENCY MEASURE:</b> Average cost of psychotropic medications for children on Medicaid</p>
<p>POPULATION HEALTH INDICATORS</p>		<p><b>HEALTHY ALASKANS 2020 (LHI 10):</b> Percent of adolescents with three or more adults besides their parents they're comfortable seeking help from</p>
<p>OBJECTIVE 1.2.2</p> <p><b>Increase the number of older Alaskans who live safely in their communities</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Number of months Long Term Services and Supports recipients are able to remain in their home before institutional placement</p> <p><b>EFFICIENCY MEASURE:</b> Average cost of Long Term Services and Supports per recipient</p>
<p>OBJECTIVE 1.2.3</p> <p><b>Increase the number of Alaskans with disabilities who are living safely in the least restrictive environment</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Percent of Alaskans who are receiving community-based Long Term Services and Supports</p> <p><b>EFFICIENCY MEASURE:</b> Average cost for waiver eligible Alaskans who are living in ICFMR or nursing home versus those who are living independently</p>
<p>OBJECTIVE 1.2.4</p> <p><b>Increase the number of Alaskans with behavioral health issues who report improvement in key life domains</b></p>	<p>PERFORMANCE MEASURES</p>	<p><b>EFFECTIVENESS MEASURE:</b> Percent of behavioral health recipients who report improvement in quality of life</p> <p><b>EFFICIENCY MEASURE:</b> Percent of behavioral health recipients who re-admit back into API within 30 days of discharge</p>
<p>POPULATION HEALTH INDICATORS</p>		<p><b>HEALTHY ALASKANS 2020 (LHI 8):</b> Percent of adolescents who report being sad/hopeless for more than two weeks</p> <p><b>HEALTHY ALASKANS 2020 (LHI 9):</b> Mean number of days adults are mentally unhealthy</p> <p><b>HEALTHY ALASKANS 2020 (LHI 7):</b> Suicide mortality rate</p>

## PRIORITY 2. HEALTH CARE ACCESS, DELIVERY & VALUE

### CORE SERVICE 2.1 MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED

<b>OBJECTIVE 2.1.1</b> <b>Increase the number of Alaskans with a primary care provider</b>	<b>PERFORMANCE MEASURES</b>
	<b>EFFECTIVENESS MEASURE:</b> Percent of individuals served by the department with access to a regular primary care provider <b>EFFICIENCY MEASURE:</b> Cost to provide health care services per client
	<b>POPULATION HEALTH INDICATORS</b>
	<b>HEALTHY ALASKANS 2020 (LHI 23):</b> Percent of adults reporting they could not afford to see a doctor in the last 12 months

<b>OBJECTIVE 2.1.2</b> <b>Increase access for Alaskans with chronic or complex medical conditions to integrated care</b>	<b>PERFORMANCE MEASURES</b>
	<b>EFFECTIVENESS MEASURE:</b> Number of Medicaid recipients enrolled in medical home <b>EFFICIENCY MEASURE:</b> Cost per recipient in medical home versus cost per recipient not enrolled in medical home
	<b>EFFECTIVENESS MEASURE:</b> Percent of providers connected to the Health Information Exchange (HIE) for Direct Exchange <b>EFFECTIVENESS MEASURE:</b> Percent of providers connected to the Health Information Exchange (HIE) for Query-Based Exchange
	<b>EFFICIENCY MEASURE:</b> Cost per provider connected to the Health Information Exchange

### CORE SERVICE 2.2 FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

<b>OBJECTIVE 2.2.1</b> <b>Improve access to health care</b>	<b>PERFORMANCE MEASURES</b>
	<b>EFFECTIVENESS MEASURE:</b> Percent of Medicaid eligibles who utilize Medicaid Services <b>EFFICIENCY MEASURE:</b> Cost per recipient
	<b>EFFECTIVENESS MEASURE:</b> Number of providers participating in the Medicaid Program <b>EFFICIENCY MEASURE:</b> Percent change in number of providers participating
	<b>EFFECTIVENESS MEASURE:</b> Number of residents who access the Medicaid Waiver <b>EFFICIENCY MEASURE:</b> Total Medicaid Waiver receipts
	<b>EFFECTIVENESS MEASURE:</b> Number of Alaskans with online access to health care records and health care education resources (Stage 2 MU) <b>EFFICIENCY MEASURE:</b> Percent of providers who attest to meeting Stage 2 MU requirements to provide online access to patients
	<b>EFFECTIVENESS MEASURE:</b> Percent of the estimated need for behavioral health services that are met through community-based services (*Separated into SUD, SMI & SED Met Need)
	<b>EFFICIENCY MEASURE:</b> Percent of clients whose wait time to access treatment is less than 7 days <b>EFFICIENCY MEASURE:</b> Percent of substance abuse residential treatment providers with a bed utilization rate of 85% or higher
	<b>EFFICIENCY MEASURE:</b> Percent of youth discharged from a Residential Psychiatric Treatment Center (RPTC) who did not re-admit in 12 months
	<b>POPULATION HEALTH INDICATORS</b>
	<b>HEALTHY ALASKANS 2020 (LHI 22):</b> Number of preventable hospitalizations based on Agency for Health Care Research and Quality <b>HEALTHY ALASKANS 2020 (LHI 21):</b> Percent of women who have not received prenatal care beginning in the first trimester of pregnancy

<p>OBJECTIVE 2.2.2</p> <p><b>Improve rural access to health care</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Number of paid tele-health claims in Medicaid programs
	<b>EFFICIENCY MEASURE:</b>	Travel costs saved where Medicaid tele-health visit replaced travel
	<b>EFFECTIVENESS MEASURE:</b>	Percent of providers participating in tele-health
	<b>EFFICIENCY MEASURE:</b>	Cost avoided from use of tele-health

### PRIORITY 3. SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

#### CORE SERVICE 3.1 STRENGTHEN ALASKA FAMILIES

<p>OBJECTIVE 3.1.1</p> <p><b>Increase the number of Alaska families who are employed</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Percent of individuals receiving employment-related services from the department who achieve employment
	<b>EFFICIENCY MEASURE:</b>	Cost of supported employment services per successful participant in Job Start or on-the-job training
	POPULATION HEALTH INDICATORS	
	<b>HEALTHY ALASKANS 2020 (LHI 24):</b> Percent of residents living above the federal poverty level as defined for Alaska	
	<b>HEALTHY ALASKANS 2020 (LHI 25):</b> Percent of 18-24 year olds with a high school diploma or equivalency	

<p>OBJECTIVE 3.1.2</p> <p><b>Increase the number of Alaska families with access to safe, affordable child care</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Percent of child care facilities participating in the Alaska Child Care Assistance Program that are licensed
	<b>EFFICIENCY MEASURE:</b>	Average time from receipt of application to license issuance
	<b>EFFECTIVENESS MEASURE:</b>	Percent of Alaska children participating in the Alaska Child Care Assistance Program that are cared for in licensed facilities
	<b>EFFICIENCY MEASURE:</b>	Family work dollars earned per state dollar amount spent on child care assistance

<p>OBJECTIVE 3.1.3</p> <p><b>Increase the number of Alaska families with warm homes</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Percent of low-income Alaskans who receive heating assistance
	<b>EFFICIENCY MEASURE:</b>	Average time from receipt of application to eligibility determination

<p>OBJECTIVE 3.1.4</p> <p><b>Increase the number of Alaska families with food security</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Percent of low-income Alaskans receiving supplemental benefits through the Food Stamp program
	<b>EFFICIENCY MEASURE:</b>	Accuracy rate for open Food Stamp cases
	<b>EFFICIENCY MEASURE:</b>	Average time from receipt of initial application to eligibility determination

## CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS

<p>OBJECTIVE 3.2.1</p> <p><b>Decrease the rate of maltreatment in children</b></p>	PERFORMANCE MEASURES	
	<p><b>EFFECTIVENESS MEASURE:</b></p> <p><b>EFFICIENCY MEASURE:</b></p> <p><b>EFFECTIVENESS MEASURE:</b></p> <p><b>EFFICIENCY MEASURE:</b></p>	<p>Percent of Alaska children with substantiated reports of abuse or neglect</p> <p>Cost per completed investigation</p> <p>Percent of children discharged from out-of-home care who are reunited with their parents</p> <p>Percent of children who re-enter out-of-home care within 12 months</p>
POPULATION HEALTH INDICATORS		
<p><b>HEALTHY ALASKANS 2020 (LHI 11):</b> Rate of unique substantiated child maltreatment victims</p>		

<p>OBJECTIVE 3.2.2</p> <p><b>Decrease the rate of maltreatment in vulnerable populations</b></p>	PERFORMANCE MEASURES	
	<p><b>EFFECTIVENESS MEASURE:</b></p> <p><b>EFFICIENCY MEASURE:</b></p> <p><b>EFFICIENCY MEASURE:</b></p> <p><b>EFFICIENCY MEASURE:</b></p>	<p>Percent of Alaska adults with substantiated reports of abuse or neglect</p> <p>Average time to initiate an investigation</p> <p>Percent of safety assessments concluded within required time frames</p> <p>Number of adults waiting in jail more than 7 days for in-patient competency evaluations at state hospitals</p>

<p>OBJECTIVE 3.2.3</p> <p><b>Improve client safety within department and provider operated facilities</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Percent of facilities licensed by the department that are free from substantiated reports of harm
	<b>EFFICIENCY MEASURE:</b>	Cost for licensure functions and oversight
	<b>EFFICIENCY MEASURE:</b>	Percent of time that enforcement action is issued within required time frame
	<b>EFFECTIVENESS MEASURE:</b>	Percent of background checks completed within established time frames
	<b>EFFICIENCY MEASURE:</b>	Cost of administering background check program
<b>EFFICIENCY MEASURE:</b>	Average time to complete final determination	
<b>EFFECTIVENESS MEASURE:</b>	Percent change in the number of fully licensed foster care homes	
<b>EFFICIENCY MEASURE:</b>	Rate of child abuse/neglect in out-of-home care	

## CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

<p>OBJECTIVE 3.3.1</p> <p><b>Improve tobacco enforcement</b></p>	PERFORMANCE MEASURES	
	<b>EFFECTIVENESS MEASURE:</b>	Prevalence of tobacco use
	<b>EFFICIENCY MEASURE:</b>	Cost of tobacco prevention and control program per capita
	<b>EFFECTIVENESS MEASURE:</b>	Vendor compliance rate with laws regulating the sale of tobacco products to youth
<b>EFFICIENCY MEASURE:</b>	Percent of youth-accessible tobacco vendors that receive an educational visit from tobacco enforcement staff	

OBJECTIVE 3.3.2	PERFORMANCE MEASURES
<b>Increase the number of juveniles who remain crime-free</b>	<b>EFFECTIVENESS MEASURE:</b> Rate of success for juveniles committed to probation
	<b>EFFICIENCY MEASURE:</b> Annual cost of services per occupied detention bed-day
	<b>EFFECTIVENESS MEASURE:</b> Rate of success for juveniles released from DJJ institutional treatment
	<b>EFFICIENCY MEASURE:</b> Annual cost of services per occupied treatment bed-day
	<b>EFFECTIVENESS MEASURE:</b> Rate of success for juveniles released from DJJ probation
	<b>EFFICIENCY MEASURE:</b> Annual cost of services per number of referrals

OBJECTIVE 3.3.3	PERFORMANCE MEASURES
<b>Increase the number of Alaskans with health conditions who practice self-management</b>	<b>EFFECTIVENESS MEASURE:</b> Percent of adults enrolled in chronic disease self-management programs
	<b>EFFICIENCY MEASURE:</b> Cost per client for chronic disease self-management services

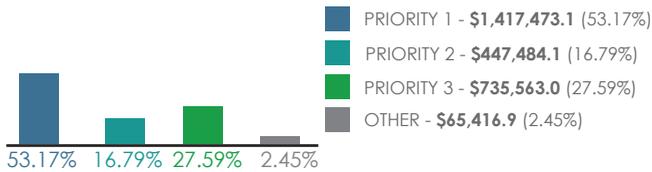
OBJECTIVE 3.3.4	PERFORMANCE MEASURES
<b>Decrease interpersonal violence</b>	<b>EFFECTIVENESS MEASURE:</b> Percent of clients provided domestic/interpersonal violence assessment and safety card
	<b>EFFICIENCY MEASURE:</b> Cost of implementing domestic/interpersonal violence assessment and safety card methodology
	<b>EFFECTIVENESS MEASURE:</b> Rate of adverse childhood experiences (ACE) among behavioral health treatment recipients
	<b>EFFICIENCY MEASURE:</b> Cost TBD
	POPULATION HEALTH INDICATORS
	<b>HEALTHY ALASKANS 2020 (LHI 13):</b> Percent of adolescents who have been hit, slapped or hurt by a partner in the past 12 months
	<b>HEALTHY ALASKANS 2020 (LHI 12):</b> Rate of rape

OBJECTIVE 3.3.5	PERFORMANCE MEASURES
<b>Increase disaster preparedness</b>	<b>EFFECTIVENESS MEASURE:</b> Percent of Alaska health care and support entities that participated in at least one disaster preparedness activity during the state fiscal year
	<b>EFFICIENCY MEASURE:</b> Cost for disaster preparedness activity per participant

OBJECTIVE 3.3.6	PERFORMANCE MEASURES
<b>Reduce fraud, waste and abuse</b>	<b>EFFECTIVENESS MEASURE:</b> Percent of investigations that result in fraud determinations
	<b>EFFICIENCY MEASURE:</b> Program savings per fraud investigator

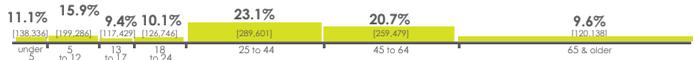
# DEPARTMENT SUMMARY | SPENDING BY PRIORITY (FY2014)

\$2,665,937.0  
TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

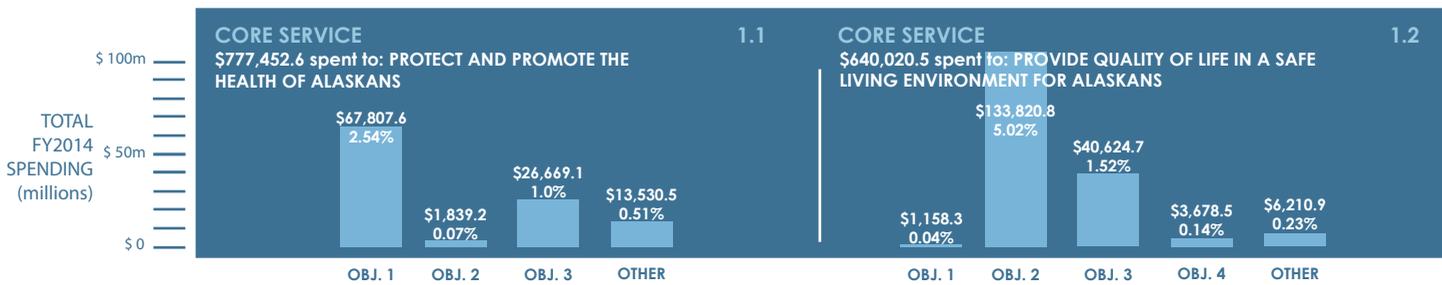
[Total service population 1,251,015 individuals.]



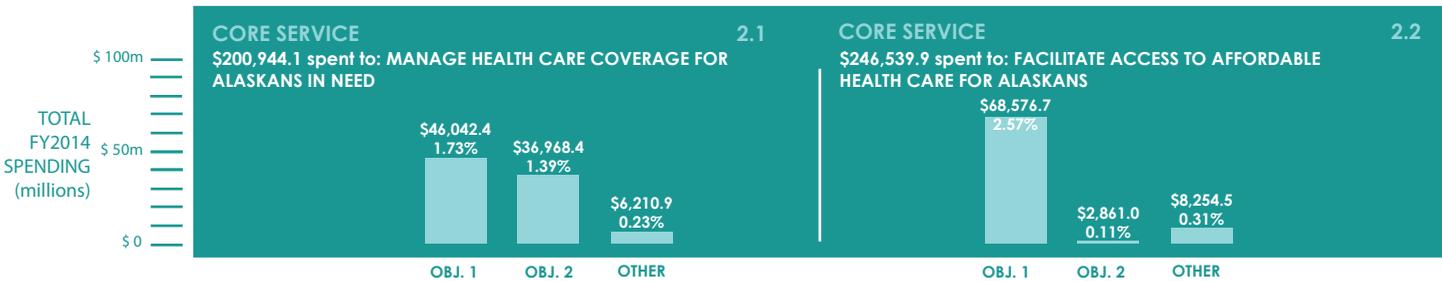
## SNAPSHOT OF ALASKANS SERVED

455,051 Children Served (36.4%)  
675,826 Adults Served (54.0%)  
120,138 Seniors Served (9.6%)

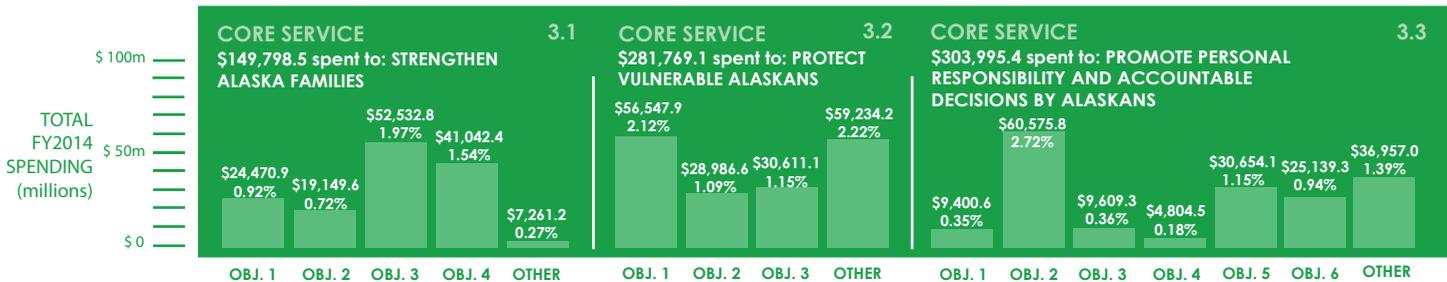
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



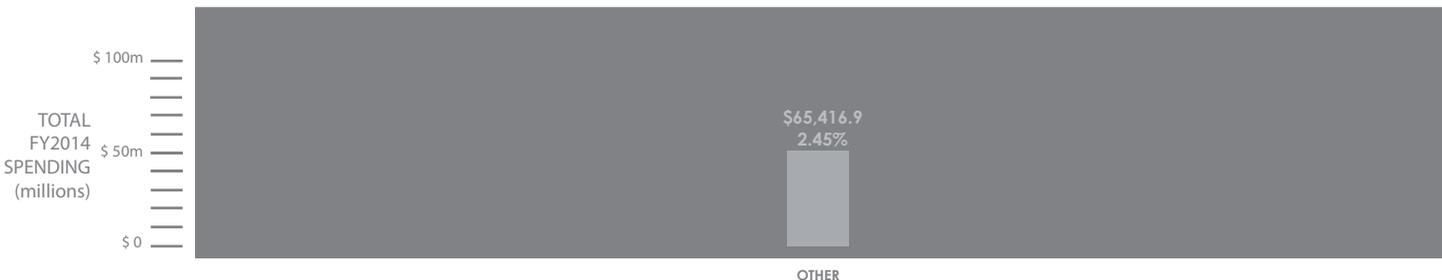
## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER

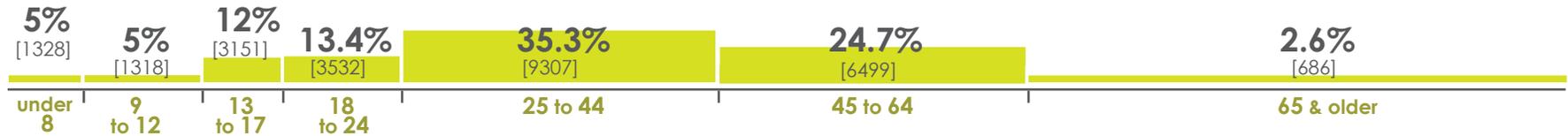


## PRIMARY SERVICE POPULATION AGE RANGE (by division)

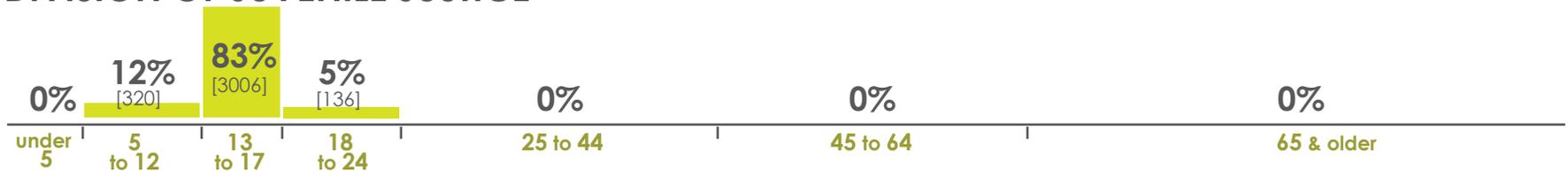
### ALASKA PIONEER HOMES [Total service population 463 individuals.]



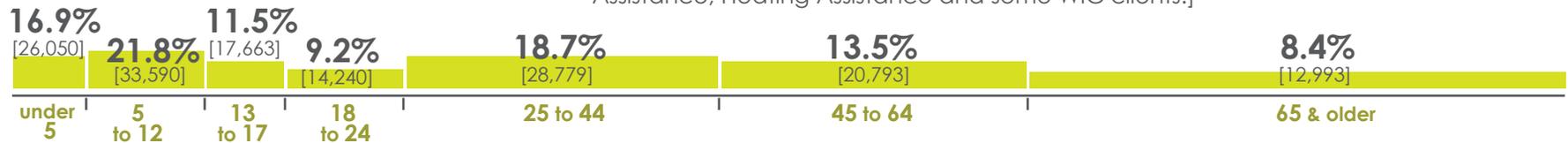
### DIVISION OF BEHAVIORAL HEALTH [Total service population 26,329 individuals. 2% of adults (508), age unknown.]



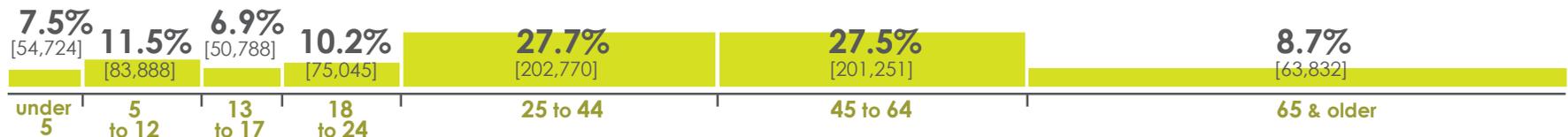
### DIVISION OF JUVENILE JUSTICE [Total service population 3462 individuals. Population age-range is 6 to 19 years old.]



### DIVISION OF PUBLIC ASSISTANCE [Total service population 154,108 individuals. Total does not include: General Assistance, Heating Assistance and some WIC clients.]

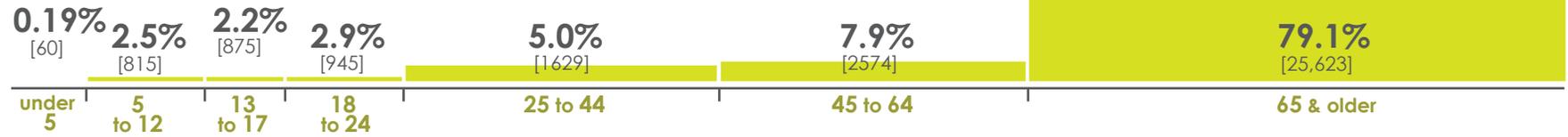


### DIVISION OF PUBLIC HEALTH [Total service population 732,298 individuals - also the total population of the state of Alaska.]

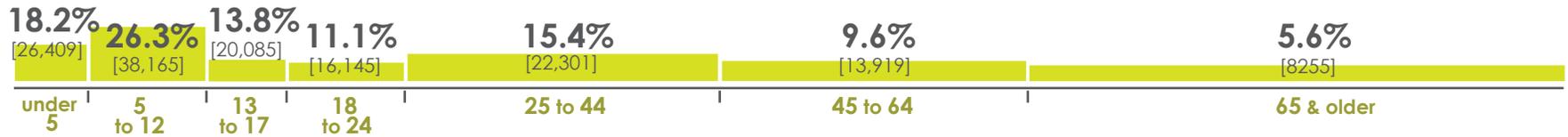


# PRIMARY SERVICE POPULATION AGE RANGE (by division)

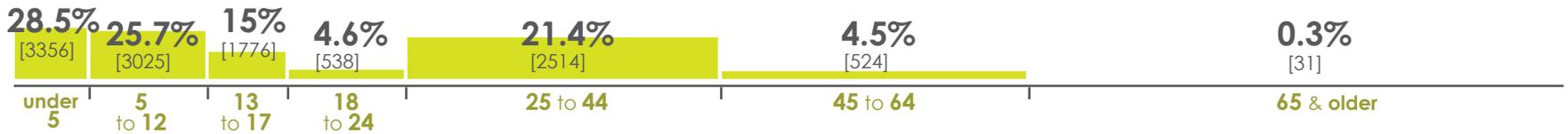
## ■ DIVISION OF SENIOR & DISABILITIES SERVICES [Total service population 32,521 individuals.]



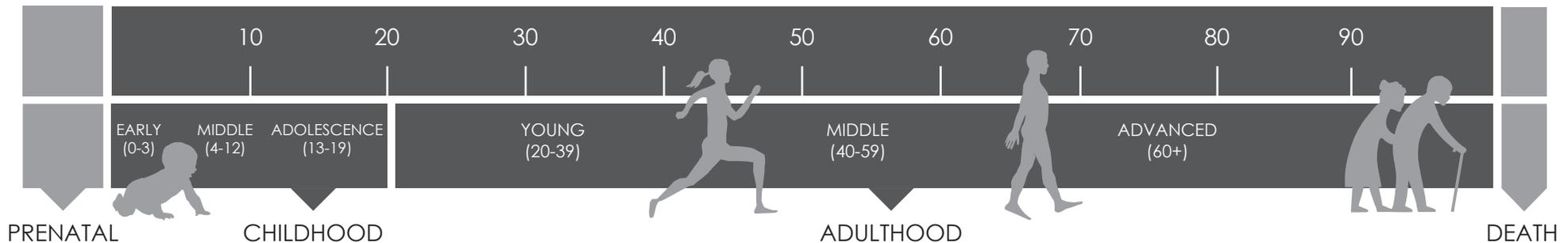
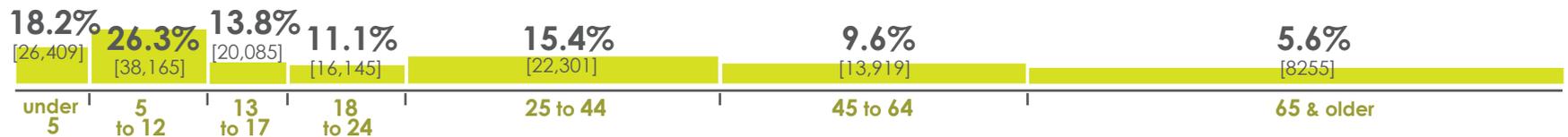
## ■ HEALTH CARE SERVICES [Total service population 145,279 individuals. This is the same total for Medicaid service population.]



## ■ OFFICE OF CHILDREN'S SERVICES [Total service population 11,764 individuals.]



## ■ MEDICAID [Total service population 145,279 individuals.]



## FY2015 Governor's Capital Budget

### *FY2015 Governor's Capital Budget Project Requests*

Capital		FY2014 Capital Funding Request			
		(In thousands)			
DHSS Division	Project Titles	GF	Fed	Other	Total
DHSS/Office of Children's Services	OCS Safety Enhancements to Offices, Facilities & Equipment	\$462.9	\$94.8		\$557.7
DHSS/Public Health	Emergency Medical Services Match for Code Blue	\$500.0			\$500.0
DHSS/FMS	MH Essential Program Equipment Capital Grant *	\$250.0		\$250.0	\$500.0
DHSS/FMS	MH Home Modification and Upgrades to Retain Housing *	\$750.0		\$300.0	\$1,050.0
DHSS/Public Health, Juvenile Justice, Behavioral Health	Deferred Maintenance, Renewal, Repair, and Equipment – Non-Pioneer Homes	\$3,000.0	\$18.9		\$3,018.9
DSS/Pioneer Homes	Deferred Maintenance, Renewal, Repair, and Equipment – Pioneer Homes	\$4,000.0			\$4,000.0
<b>Capital Budget Totals</b>		<b>8,962.9</b>	<b>113.7</b>	<b>550.0</b>	<b>9,626.6</b>

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

### ***Brief Description of Major Projects:***

#### **Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment - \$4,000,000 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 \$344 million.

#### **Non-Pioneer Home Deferred Maintenance, Renovation, Repair, and Equipment - \$3,018,946 (\$3,000,000 GF \$18,946 Fed)**

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 \$387 million.

**Office of Children's Services Safety Enhancements to Offices, Facilities and Equipment - \$557,700 (\$462,900 GF \$94,800 Fed)**

This request is for building safety enhancements as well as employee safety awareness training for the Office of Children's Services

**EMS – Match for Code Blue - \$500,000 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 Essential Program Equipment - \$500,000 (\$250,000 GF \$250,000 MHTAAR)**

This is a competitive capital grant program that addresses the need for equipment that is essential to core services and programs.

**MH Home Modification and Upgrades to Retain Housing - \$1,050,000 (\$750,000 GF/MH \$300,000 Other)**

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.

### ***Capital Project 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 capital project challenges as well as specific impacts on our operations.

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.



McLaughlin Youth Center Cottage Bathroom Upgrade

Upgrade to bathroom with new finishes that will withstand wear and tear.

# Medicaid Services

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## *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 appropriation. Only benefits, not administrative costs, are paid out of this 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 Medicaid 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

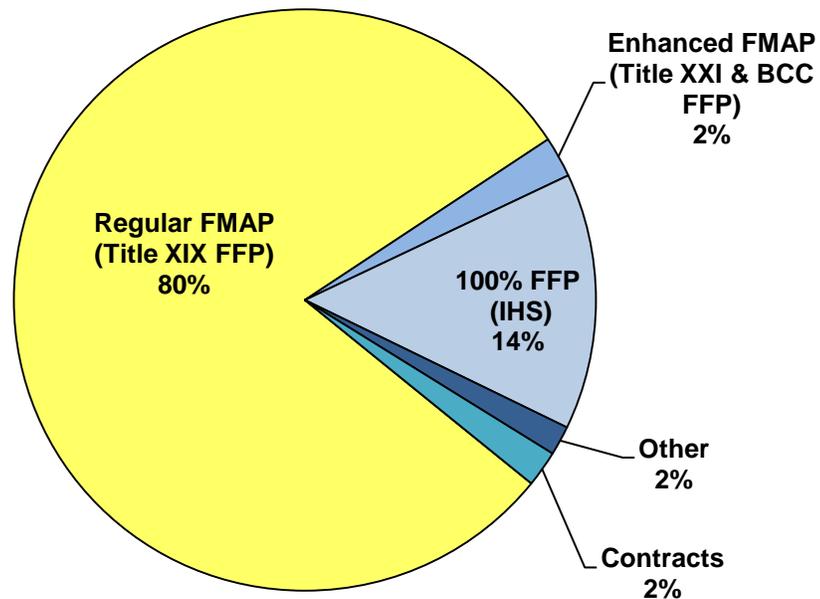
Program (CHIP or Title XXI) and women in the Breast and Cervical Cancer program (BCC) are reimbursed at an enhanced Federal Medical Assistance Percentage. Where possible, the state takes advantage of these higher reimbursement rates to contain the state's portion of the cost of providing Medicaid services.

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.

<b>Federal Medical Assistance Percentages for Claim Payments</b>				
<b>Year</b>	<b>Federal Fiscal Year Statutory Rate</b>		<b>State Fiscal Year Average Rate</b>	
	<b>Regular FMAP</b>	<b>Enhanced FMAP</b>	<b>Regular FMAP</b>	<b>Enhanced FMAP</b>
<b>Before 1998</b>	50.00	n/a	50.00	n/a
<b>1998</b>	59.80	71.86	57.35	71.86
<b>1999</b>	59.80	71.86	59.80	71.86
<b>2000</b>	59.80	71.86	59.80	71.86
<b>2001</b>	60.13	72.09	60.05	72.03
<b>2002</b>	57.38	70.17	58.07	70.65
<b>2003 Q1-Q2</b>	58.27	70.79	58.79	71.15
<b>2003 Q3-Q4</b>	61.22	72.85		
<b>2004 Q1-Q3</b>	61.34	72.94	61.31	72.92
<b>2004 Q4</b>	58.39	70.87		
<b>2005</b>	57.58	70.31	57.78	70.45
<b>2006</b>	57.58	70.31	57.58	70.31
<b>2007</b>	57.58	70.31	57.58	70.31
<b>2008</b>	52.48	66.74	53.76	67.63
<b>2009 Q1-Q2</b>	58.68	65.37	57.74	65.71
<b>2009 Q3-Q4</b>	61.12	65.37		
<b>2010 Q1</b>	61.12	66.00	61.79	65.84
<b>2010 Q2-Q4</b>	62.46	66.00		
<b>2011 Q1</b>	62.46	65.00	60.54	65.25
<b>2011 Q2</b>	59.58	65.00		
<b>2011 Q3</b>	57.67	65.00		
<b>2011 Q4</b>	50.00	65.00		
<b>2012 Q1-Q4</b>	50.00	65.00	50.00	65.00
<b>2013 Q1-Q4</b>	50.00	65.00	50.00	65.00
<b>2014 Q1-Q4</b>	50.00	65.00	50.00	65.00
<b>2015 Q1-Q4 (p)</b>	50.00	65.00	50.00	65.00

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

### FY2013 Medicaid Direct Services Expenditures by Federal Financial Participation

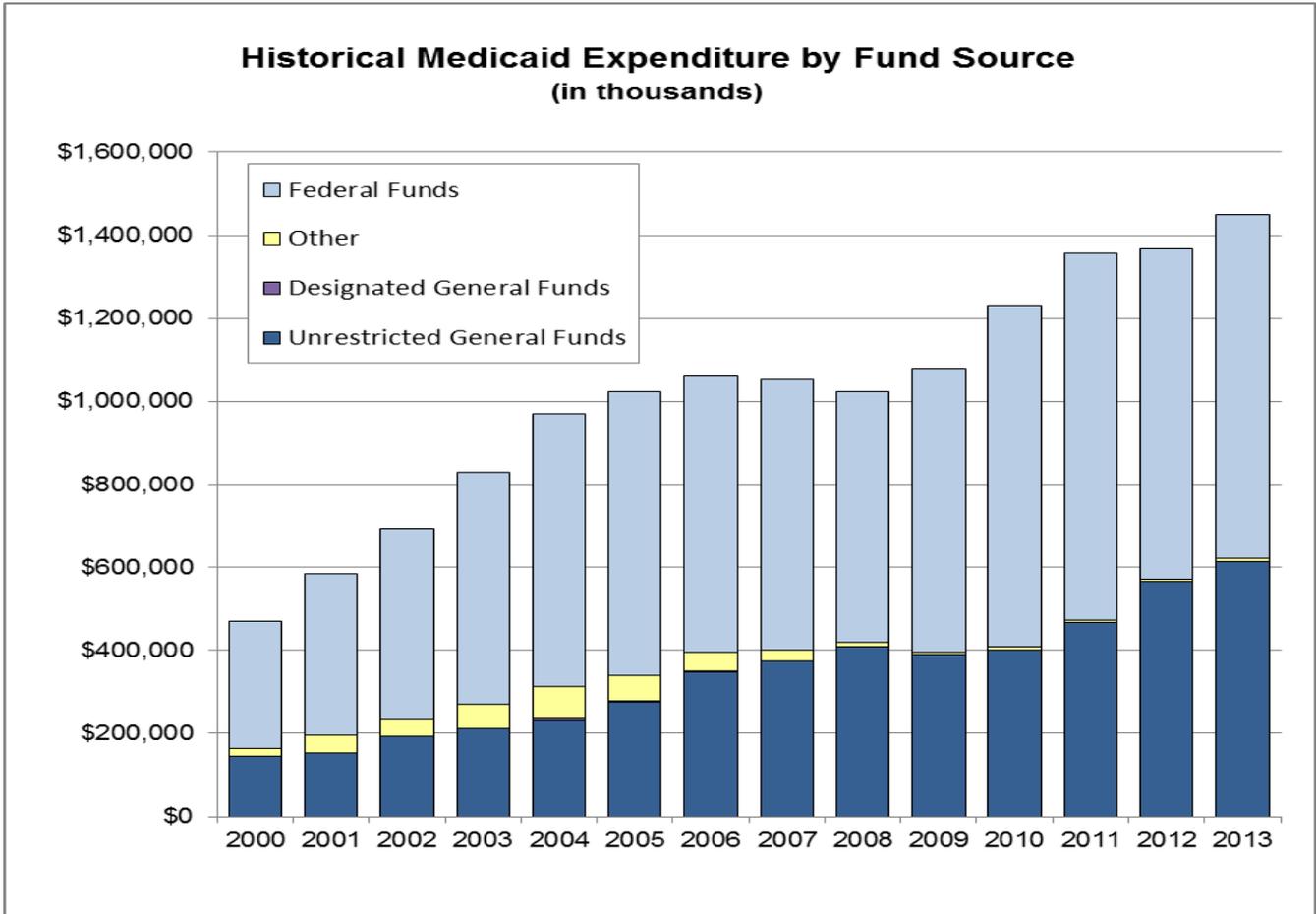


Source: AKSAS data, Medicaid direct services only.

Although total program costs have grown each year, cost containment has helped hold down increases in total Medicaid expenditures. The department's efforts to control costs have generally been successful in mitigating the impacts of increases in population and payment rates, as demonstrated by the slowing rate of growth in Alaska's Medicaid costs between 2007, 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.



Governor Parnell announced the creation of an Alaska Medicaid Reform Advisory Group to address Medicaid's structural issues and propose meaningful reforms to the State's Medicaid program. The group will address three key reform mandates:

- Stability and predictability in budgeting;
- Increase the efficiency of navigating the system by providers; and
- Providing whole care for the patient by uniting physical and behavioral health treatment.

The governor has also directed the commissioner of Health and Social Services to develop a report defining the current status of Alaska's safety net for those non-Medicaid-eligible Alaskans up to 100 percent of the FPL. Additionally, the commission is to report on the linkage between uncompensated care by providers, and higher health costs and premiums for Alaskans.

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	\$1,402	\$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	\$125,541		\$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	\$211,075	\$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	\$682,270	\$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	\$566,267	\$195	\$798,346	\$4,825	\$1,369,633
2013	\$613,951	\$455	\$827,695	\$6,692	\$1,448,793

Source: Medicaid Budget Group using Automated Budget System data.

## Annual Statistical Summary of Services Provided in FY2013

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.

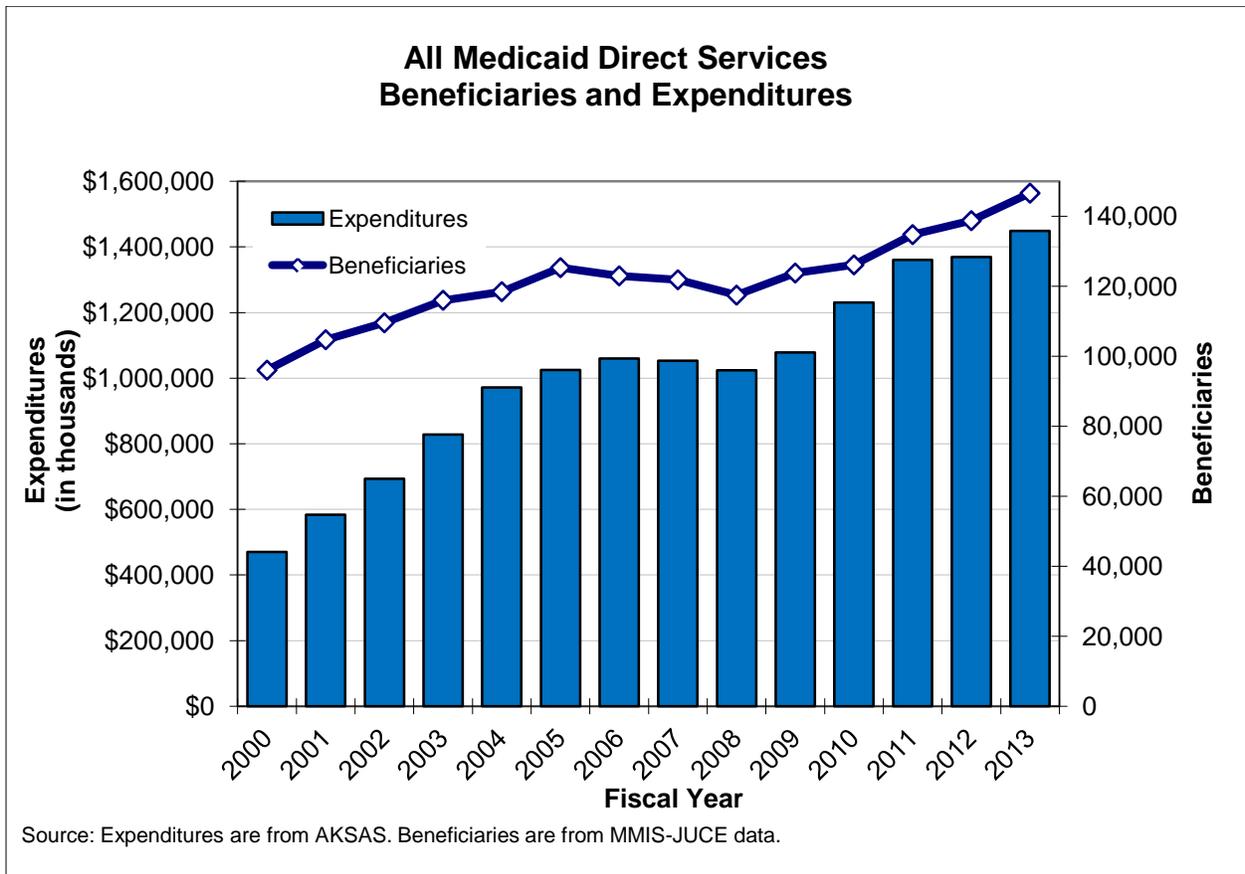
In FY2013, like most years in the past decade, close to one in five Alaskans was enrolled in the state's Medicaid program for at least one month during the year. An estimated 97% of Medicaid enrollees used at least one Medicaid service during the year. The ratio of enrollees to beneficiaries (those using services) is called the participation rate. Participation has ranged from 87% in FY2000 to 97% in FY2013, 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 only 0.5% in FY2013. The number of beneficiaries increased by 5.7%.

<b>Participation in Medicaid</b>					
<b>Fiscal Year</b>	<b>Alaska Population</b>	<b>Medicaid Enrollment</b>	<b>Medicaid Beneficiaries</b>	<b>Percent of Population Enrolled in Medicaid</b>	<b>Percent of Enrollees Receiving Benefits</b>
<b>2000</b>	626,931	110,219	96,033	18%	87%
<b>2001</b>	632,200	116,226	104,730	18%	90%
<b>2002</b>	640,643	121,582	109,571	19%	90%
<b>2003</b>	647,884	126,632	116,008	20%	92%
<b>2004</b>	657,483	129,528	118,466	20%	91%
<b>2005</b>	664,334	131,136	125,318	20%	96%
<b>2006</b>	671,202	131,996	122,978	20%	93%
<b>2007</b>	676,056	128,295	121,864	19%	95%
<b>2008</b>	681,977	125,138	117,472	18%	94%
<b>2009</b>	692,314	127,944	123,791	18%	97%
<b>2010</b>	710,231	135,086	126,127	19%	93%
<b>2011</b>	722,190	146,244	134,768	20%	92%
<b>2012</b>	732,183	150,998	138,755	21%	92%
<b>2013</b>	741,232	151,797	146,613	20%	97%

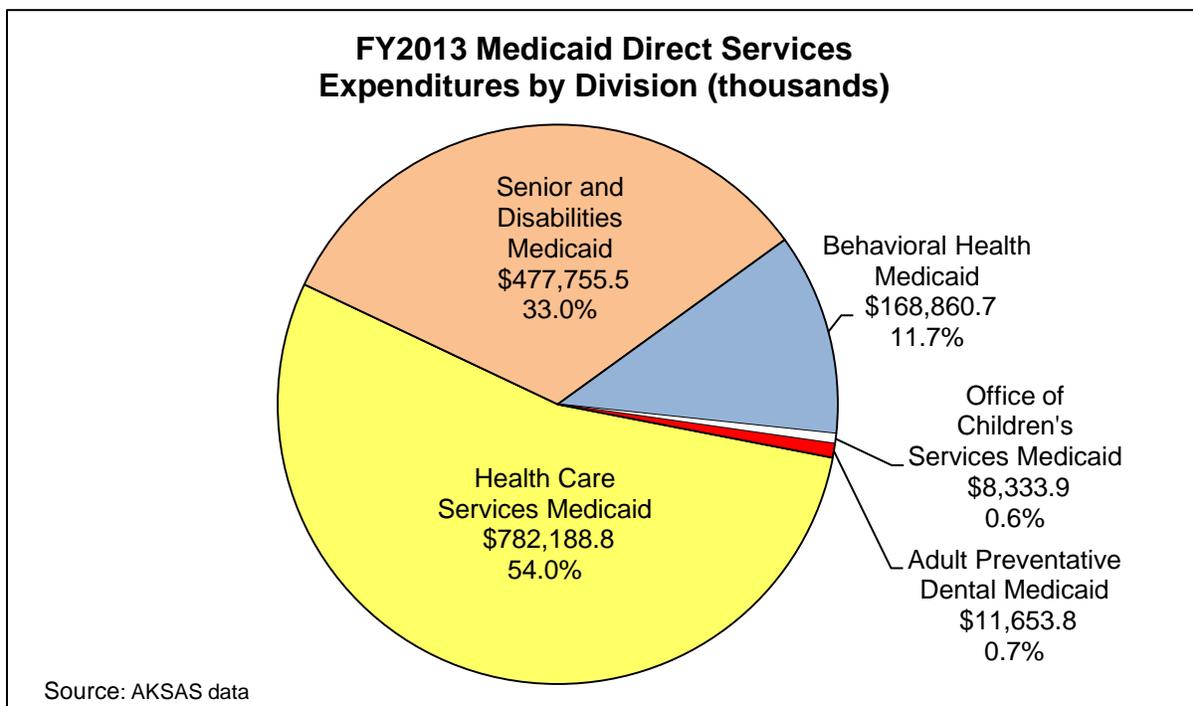
Source: Medicaid Budget Group (MMIS/JUCE) and AK Dept. of Labor and Workforce Development.  
Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

Total costs for direct services (claims paid in the fiscal year) increased by 5.8% between FY2012 and FY2013, a change in the trend indicated by the bar graph below. The cost per beneficiary showed an even smaller increase of 0.1%.



The majority of Medicaid expenditures for direct services in FY2013 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 Pro-share payments to the state's inpatient psychiatric facility, and other indirect Medicaid expenditures.

The Senior and Disabilities Medicaid Services component provided long-term and home-based care services that accounted for 33% of total Medicaid direct services costs in FY2013. The remaining 13% of expenditures were paid through the Behavioral Health Medicaid Services component (11.7%), Children's Medicaid Services component (0.6%) and the Adult Preventative Dental Care program (0.8%).



**Medicaid Direct Services Expenditures by Division, FY2013**  
(in thousands)

Total Medicaid Services	\$	1,448,792.85
Total Medicaid Indirect Services	\$	24,194.63
Total Medicaid Direct Services	\$	1,424,598.22
Health Care Services		
<i>Medicaid Services</i>	\$	<i>757,994.13</i>
Hospital Services	\$	301,829.80
Physician Services	\$	178,589.70
Pharmacy Services	\$	50,965.90
Dental Services	\$	55,543.89
Transportation	\$	68,084.29
Other Medicaid Direct Services	\$	59,182.23
Non-MMIS Services	\$	43,163.92
Medicaid Financing	\$	130.43
Medicaid (State-only)	\$	503.96
<i>Adult Preventative Dental Medicaid</i>	\$	<i>11,653.79</i>
Adult Preventative Dental	\$	11,653,788
Senior and Disabilities Services		
<i>Senior &amp; Disabilities Medicaid Services</i>	\$	<i>477,755.54</i>
Personal Care Services	\$	126,703.08
Nursing Homes	\$	99,422.78
Adults with Disabilities Waiver	\$	12,926.32
Children with Complex Medical Conditions	\$	11,149.89
Mental Retardation / Developmental Disabilities	\$	143,274.29
Older Alaskans Waiver	\$	83,991.16
Other Services	\$	288.03
Division of Behavioral Health		
<i>Behavioral Health Medicaid Services</i>	\$	<i>168,860,907.8</i>
Residential Psychiatric Treatment Centers	\$	33,959,260.31
Inpatient Psychiatric Hospitals	\$	20,459,850.88
General Mental Health Services	\$	111,446,360.09
PRTF Waiver	\$	1,312,887.54
Medical Necessity Review Contract (QUALIS)	\$	1,682,549.00
Office of Children's Services		
<i>Children's Medicaid Services</i>	\$	<i>8,333,851.3</i>
Behavioral Rehabilitation Services	\$	4,984,205.34
Behavioral Rehabilitation Services - BTKH	\$	3,349,646.00

Source: Medicaid Budget Group using AKSAS data.

Many beneficiaries receive services from more than one type of 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 FY2013, 98.9% of Medicaid beneficiaries used at least one Medicaid service that was funded through the Health Care Medicaid Services component. About 10.1% used Medicaid services funded through the Behavioral Health Medicaid Services component. Nearly 6.9% used Medicaid services funded through the Senior and Disabilities Medicaid Services component, and about 0.5% used Medicaid services funded through the Children's Medicaid Services component.

State FY 2013 DEPARTMENT LEVEL SUMMARY		MEDICAID CLAIMS AND ENROLLMENT							
		RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		PARTICIPATION (Recipients as Percent of Enrollment)
		Percent of Category	Year Count	Percent of Category	YEAR Total		Percent of Category	YEAR Count	
<b>Medicaid, Department Annual Totals</b>		<b>146,613</b>		<b>\$1,381,520,386</b>		<b>\$9,423</b>	<b>151,797</b>		<b>96.6%</b>
<b>Gender</b>									
	Female	56.2%	82,398	56.3%	\$ 777,467,616	\$9,436	54.3%	82,436	100.0%
	Male	43.8%	64,258	43.7%	\$ 604,052,770	\$9,400	45.7%	69,421	92.6%
	Unknown	0.0%	-	0.0%			0.0%	-	
<b>Race</b>									
	Alaska Native	38.6%	56,913	37.2%	\$ 514,251,534	\$9,036	37.7%	57,716	98.6%
	American Indian	1.6%	2,357	1.5%	\$ 20,305,397	\$8,615	1.6%	2,436	96.8%
	Asian	6.9%	10,122	6.4%	\$ 88,319,350	\$8,725	7.3%	11,193	90.4%
	Pacific Islander	3.8%	5,648	3.0%	\$ 40,855,412	\$7,234	4.0%	6,104	92.5%
	Black	5.9%	8,663	4.6%	\$ 64,115,012	\$7,401	5.8%	8,838	98.0%
	Hispanic	3.8%	5,574	2.7%	\$ 37,007,111	\$6,639	3.7%	5,639	98.8%
	White	37.1%	54,740	42.0%	\$ 579,758,207	\$10,591	37.4%	57,256	95.6%
	Unknown	2.4%	3,616	2.7%	\$ 36,908,363	\$10,207	2.6%	3,942	91.7%
	Native	40.3%	59,235	38.7%	\$ 534,556,931	\$9,024	39.5%	60,107	98.5%
	Non-Native	59.7%	87,769	61.3%	\$ 846,963,455	\$9,650	60.5%	92,172	95.2%
<b>Age</b>									
	under 1	8.9%	14,437	7.2%	\$ 99,803,556	\$6,913	7.2%	11,854	121.8%
	1 through 12	35.9%	58,393	15.8%	\$ 217,817,120	\$3,730	37.9%	62,063	94.1%
	13 through 18	15.3%	24,965	12.7%	\$ 174,979,372	\$7,009	16.0%	26,204	95.3%
	19 through 20	3.6%	5,824	2.4%	\$ 33,660,864	\$5,780	3.4%	5,529	105.3%
	21 through 30	11.2%	18,159	12.6%	\$ 174,177,071	\$9,592	10.4%	16,932	107.2%
	31 through 54	14.5%	23,651	21.4%	\$ 295,468,429	\$12,493	14.3%	23,352	101.3%
	55 through 64	4.4%	7,170	10.1%	\$ 139,510,474	\$19,458	4.3%	7,094	101.1%
	65 through 84	5.3%	8,634	13.2%	\$ 182,625,729	\$21,152	5.5%	9,058	95.3%
	85 or older	0.9%	1,519	4.6%	\$ 63,477,770	\$41,789	0.9%	1,458	104.2%
<b>Benefit Group</b>									
	Children	59.6%	89,340	31.5%	\$ 435,509,414	\$4,875	61.0%	93,897	95.1%
	Adults	20.6%	30,898	13.7%	\$ 189,573,542	\$6,135	19.3%	29,718	104.0%
	Disabled Children	2.0%	2,942	5.1%	\$ 70,695,824	\$24,030	1.8%	2,736	107.5%
	Disabled Adults	12.2%	18,270	34.3%	\$ 474,367,304	\$25,964	12.0%	18,517	98.7%
	Elderly	5.7%	8,559	15.3%	\$ 211,374,303	\$24,696	5.8%	8,957	95.6%
<b>Location (DHSS Region)</b>									
	Anchorage/Mat-Su	50.5%	76,921	52.5%	\$ 724,730,358	\$9,422	50.3%	78,445	98.1%
	SouthCentral	12.6%	19,145	15.2%	\$ 210,656,821	\$11,003	12.8%	19,975	95.8%
	Northern	11.8%	18,018	10.4%	\$ 143,467,214	\$7,962	12.5%	19,467	92.6%
	Western	14.5%	22,051	10.4%	\$ 143,581,885	\$6,511	14.5%	22,635	97.4%
	SouthEast	9.0%	13,730	11.0%	\$ 152,413,386	\$11,101	9.4%	14,599	94.0%
	Out of State or Unknown	1.6%	2,493	0.5%	\$ 6,670,722	\$2,676	0.5%	734	

Source: MMIS/JUCE.

Payment amounts are net of all claims paid during the calendar quarter. Amounts do not reflect payments for Medicaid services made outside of the Medicaid Management Information System (MMIS) such as lump sum payments, recoveries, or accounting adjustments and may therefore not equal expenditure totals in the state accounting or budget systems.

**Enrollment:** Number of persons eligible for Medicaid and enrolled for at least 1 month during SFY2013. 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 May birthdate would count in the under 1 age subgroup based on enrollment activity in April and May but would also be counted in the 1 through 12 age subgroup based on enrollment activity in June.

**Recipients:** Number of persons having Medicaid claims paid or adjusted during the SFY2013 (service may have been incurred in a prior quarter). 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 May birthdate obtained vision services in Jan or Feb, they would be included in the 1 through 12 age group fiscal year count if that claim was processed for payment anytime before Mar 31, 2013. If they later obtained dental services in Dec 2013, they would also be included in the 13 through 18 age subgroup count if the claim was paid anytime before Mar 31, 2013.

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

Department-wide recipient counts are unduplicated across divisions.

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

## List of Primary Programs and Statutory Responsibilities

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### 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

## FY2015 Operating Budget Requests

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### 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*

<b>Behavioral Health</b>	<b>FY2014 Mgt Plan</b>	<b>FY2015 Gov</b>	<b>14 to 15 Change</b>
Unrestricted General Funds	\$77,641.7	\$72,025.1	-\$5,616.6
Designated General funds	\$1,500.0	\$1,500.0	\$0.0
Federal Funds	\$119,076.8	\$119,076.8	\$0.0
Other Funds	\$717.5	\$717.5	\$0.0
<b>Total</b>	<b>\$198,936.0</b>	<b>\$193,319.4</b>	<b>-\$5,616.6</b>

#### Behavioral Health Medicaid Services Budget Request Table

<b>Behavioral Health Medicaid Services</b>	<b>Total</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>
<b>FY2014 Authorized Base</b>	\$ 198,936.0	\$ 1,500.0	\$ 77,641.7	\$ 119,076.8	\$ 717.5
Behavioral Health Grants Sec16 Ch14 SLA2013 Pg71 L10 (HB65)	\$ 6,000.0	\$ -	\$ 6,000.0	\$ -	\$ -
Align Authority for Reduction within Medicaid Services	\$ (2,376.7)	\$ -	\$ (2,376.7)	\$ -	\$ -
Reverse Behavioral Health Grants Sec16 Ch14 SLA2013 Pg71 L10 (HB65)	\$ (6,000.0)	\$ -	\$ (6,000.0)	\$ -	\$ -
Medicaid Services Growth Reduction	\$ (3,239.9)	\$ -	\$ (3,239.9)	\$ -	\$ -
<b>Total</b>	<b>\$ 193,319.4</b>	<b>\$ 1,500.0</b>	<b>\$ 72,025.1</b>	<b>\$ 119,076.8</b>	<b>\$ 717.5</b>

## Budget Requests

### **Growth Reduction, Behavioral Health Medicaid Services: (\$3,239.9) Total – (\$3,239.9) GF/MH Match**

The Behavioral Health Medicaid Services component supports 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.

Behavioral Health Medicaid component has seen a reduction in the rate of growth for the cost of services. Therefore a decrease of excess general fund match is needed to align authority with projected expenditures. Due to the reduction in the rate of growth for the Behavioral Health Medicaid component, the projected increase from FY2014 to FY2015 will only be 1.2%; this is based on the historical trends in population, utilization, and provider reimbursement. Although there was a 3% increase in beneficiaries from FY2012 to FY2013, the cost per beneficiary decreased by 0.8%. This trend has continued for a third year in a row, allowing this reduction of general fund match authority.

<b>Behavioral Health Medicaid Services</b>						
<b>State Fiscal Year</b>	<b>Historical Utilization</b>			<b>Annual Percent Change</b>		
	<b>Beneficiaries</b>	<b>Claim Payments (thousands)</b>	<b>Cost per Beneficiary</b>	<b>Beneficiaries</b>	<b>Claim Payments</b>	<b>Cost per Beneficiary</b>
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	\$154,100.0	\$12,041	5.9%	3.9%	-1.9%
2012	13,127	\$152,445.8	\$11,613	2.6%	-1.1%	-3.6%
2013	13,519	\$155,703.7	\$11,517	3.0%	2.1%	-0.8%

Source: MMIS/JUCE

**Budget Overview Table**  
*Children's Medicaid Services*

<b>Children's Medicaid Services</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>14 to 15 Change</b>
Unrestricted General Funds	\$6,308.1	\$4,410.7	-\$1,897.4
Federal Funds	\$7,629.3	\$7,629.3	\$0.0
Other Funds	\$0.0	\$0.0	\$0.0
<b>Total</b>	<b>\$13,937.4</b>	<b>\$12,040.0</b>	<b>\$1,897.4</b>

**Children's Services Medicaid Budget Request Table**

<b>Children's Medicaid Services</b>	<b>Total</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>
<b>FY2014 Authorized Base</b>	\$ 13,937.4	\$ 6,308.1	\$ -	\$ 7,629.3	\$ -
Align Authority for Reduction within Medicaid Services	\$ (1,648.7)	\$ (1,648.7)	\$ -	\$ -	\$ -
Medicaid Services Growth Reduction	\$ (248.7)	\$ (248.7)	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 12,040.0</b>	<b>\$ 4,410.7</b>	<b>\$ -</b>	<b>\$ 7,629.3</b>	<b>\$ -</b>

**Budget Requests**

**Growth Reduction, Behavioral Health Medicaid Services: (\$248.7) Total – (\$248.7)**  
**GF Match**

The Children's Medicaid Services component supports children, youth, and families by providing child protection and permanency through programs such as out-of-state Residential Psychiatric Treatment Centers for treatment of severely emotionally disturbed youth and the Bring the Kids Home program.

The Bring the Kids Home program brings children and youth who were previously sent into out-of-state care back to Alaska and ensures that the future use of out-of-state facilities for Residential Psychiatric Treatment Centers is kept to a minimum.

Children's Medicaid Services has seen a reduction in the rate of growth for the cost of services. Therefore a decrease of excess general fund match is needed to align authority with projected expenditures.

## Budget Overview Table

### *Adult Preventative Dental Medicaid Services*

<b>Adult Preventative Dental</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>14 to 15 Change</b>
Unrestricted General Funds	\$7,088.5	\$6,547.2	-541.3
Federal Funds	9,338.1	9,338.1	0.0
Other Funds	0.0	0.0	0.0
<b>Total</b>	<b>\$16,426.6</b>	<b>\$15,885.3</b>	<b>-\$541.3</b>

### Adult Preventative Dental Medicaid Budget Request Table

Adult Preventative Dental Medicaid Services	Total	UGF	DGF	Federal	Other
<b>FY2014 Authorized Base</b>	\$ 16,426.6	\$ 7,088.5	\$ -	\$ 9,338.1	\$ -
Align Authority for Reduction within Medicaid Services	\$ (711.4)	\$ (711.4)	\$ -	\$ -	\$ -
Medicaid Services Growth	\$ 170.1	\$ 170.1	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 15,885.3</b>	<b>\$ 6,547.2</b>	<b>\$ -</b>	<b>\$ 9,338.1</b>	<b>\$ -</b>

## Budget Requests

### **Medicaid Service Growth, Adult Preventative Dental Medicaid Services: \$170.1 Total -- \$170.1 GF/Match**

Growth within Adult Preventative Dental Medicaid Services is due to an increase in first time recipients within the program. As a cost-containment measure, there is a yearly cap of \$1,150 per recipient per year. New recipients drive up average spending per recipient as they typically spend up to this cap.

**Budget Overview Table**  
*Health Care Medicaid Services*

<b>Health Care Medicaid Services</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>14 to 15 Change</b>
Unrestricted General Funds	\$333,883.9	\$338,213.9	\$4,330.0
Designated General Funds	\$297.5	\$297.5	\$0.0
Federal Funds	\$564,462.0	\$564,462.0	\$0.0
Other Funds	\$6,256.7	\$6,256.7	-0.0
<b>Total</b>	<b>\$904,900.1</b>	<b>\$909,230.1</b>	<b>\$4,330.0</b>

**Health Care Medicaid Services Budget Request Table**

<b>Health Care Services Medicaid</b>	<b>Total</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>
<b>FY2014 Authorized Base</b>	\$ 904,900.1	\$ 333,883.9	\$ 297.5	\$ 564,462.0	\$ 6,256.7
Align Authority for Reduction within Medicaid Services	\$ (3,632.0)	\$ (3,632.0)	\$ -	\$ -	\$ -
Medicaid Services Growth	\$ 7,962.0	\$ 7,962.0	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 909,230.1</b>	<b>\$ 338,213.9</b>	<b>\$ 297.5</b>	<b>\$ 564,462.0</b>	<b>\$ 6,256.7</b>

**Budget Requests**

**Medicaid Service Growth, Health Care Medicaid Services: \$7,962.0 Total -- \$7,962.0 GF/Match**

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

Growth in the Health Care Medicaid Services component from FY2014 to FY2015 is projected to be 6.8%; this is based on the historical growth factors listed below:

- Enrollment growth from FY2012 to FY2013 was 5.5% for the Health Care Medicaid Services component.
- The utilization of Medicaid services by enrollees increased by 4.7 percentage points, from 91.9% in FY2012 to 96.6% in FY2013.
- Prices for medical services in Alaska, as measured by the United States Bureau of Labor Statistics' Consumer Price Index, increased by 2.7% in 2012.

Health Care Medicaid Services pays contractors like Xerox, Qualis, and other, smaller contractors. This increment will support annual cost increases for these contracts.

Continuing to provide these acute health care services through the Health Care Medicaid Services component supports the department's mission to manage health care for eligible Alaskans in need.

<b>Health Care Medicaid Services Direct Benefits</b>						
<b>State Fiscal Year</b>	<b>Historical Utilization</b>			<b>Annual Percent Change</b>		
	<b>Beneficiaries</b>	<b>Claim Payments (thousands)</b>	<b>Cost per Beneficiary</b>	<b>Beneficiaries</b>	<b>Claim Payments</b>	<b>Cost per Beneficiary</b>
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%
2013	145,279	\$739,611.9	\$5,091	5.5%	1.1%	-4.2%

Source: MMIS / JUCE. Paid claims for direct services to Medicaid clients only. Excludes CAMA, Senior Care Drug, and Public Assistance field services benefits. Excludes supplemental payments, premium payments, and other services processed outside of the MMIS claims system.

## Budget Overview Table

### *Senior and Disabilities Medicaid Services*

<b><u>Senior and Disabilities Medicaid Services</u></b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>14 to 15 Change</b>
Unrestricted General Funds	\$253,955.4	\$272,081.5	\$18,126.1
Federal Funds	\$265,815.0	\$265,815.0	\$0.0
Other Funds	\$1,068.4	\$1,068.4	\$0.0
<b><u>Total</u></b>	<b>\$520,838.8</b>	<b>\$538,964.9</b>	<b>\$18,126.1</b>

### Senior and Disabilities Medicaid Services Budget Request Table

Senior and Disabilities Medicaid Services	Total	UGF	DGF	Federal	Other
<b>FY2014 Authorized Base</b>	\$ 520,838.8	\$ 253,955.4	\$ -	\$ 265,815.0	\$ 1,068.4
Medicaid Services Growth	\$ 18,126.1	\$ 18,126.1	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 538,964.9</b>	<b>\$ 272,081.5</b>	<b>\$ -</b>	<b>\$ 265,815.0</b>	<b>\$ 1,068.4</b>

## Budget Requests

### **Medicaid Service Growth, Health Care Medicaid Services: \$18,126.1 Total -- \$18,126.1 GF/Match**

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 intellectual and developmental disabilities, adults with physical and developmental disabilities, and Alaskans living independently.

Growth in the Senior and Disabilities Medicaid Services component from FY2014 to FY2015 is projected to be 9.2%; this is based on the historical growth factors listed below:

- Enrollment growth from FY2012 to FY2013 was 2.2% for the Senior and Disabilities Medicaid Services component.
- The utilization of Medicaid services by enrollees increased by 4.7 percentage points, from 91.9% in FY2012 to 96.6% in FY2013.
- Prices for medical services in Alaska, as measured by the United States Bureau of Labor Statistics' Consumer Price Index, increased by 2.7% in 2012.

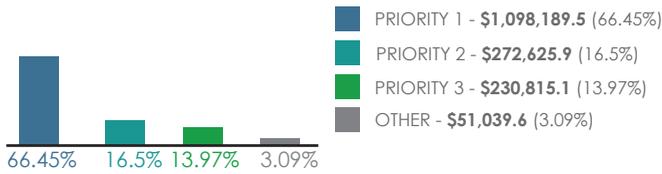
Providing long-term care through Medicaid improves the quality of life for seniors and persons with disabilities. This increment is necessary to maintain the current level of quality Medicaid services for eligible Alaskans.

<b>Senior and Disabilities Medicaid Services</b>						
<b>State Fiscal Year</b>	<b>Historical Utilization</b>			<b>Annual Percent Change</b>		
	<b>Beneficiaries</b>	<b>Claim Payments (thousands)</b>	<b>Cost per Beneficiary</b>	<b>Beneficiaries</b>	<b>Claim Payments</b>	<b>Cost per Beneficiary</b>
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%
2013	10,049	\$478,219.9	\$47,589	2.2%	\$8.5%	6.1%

Source: MMIS / JUCE

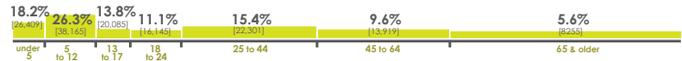
# MEDICAID | SPENDING BY PRIORITY (FY2014)

\$1,652,670.1 TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

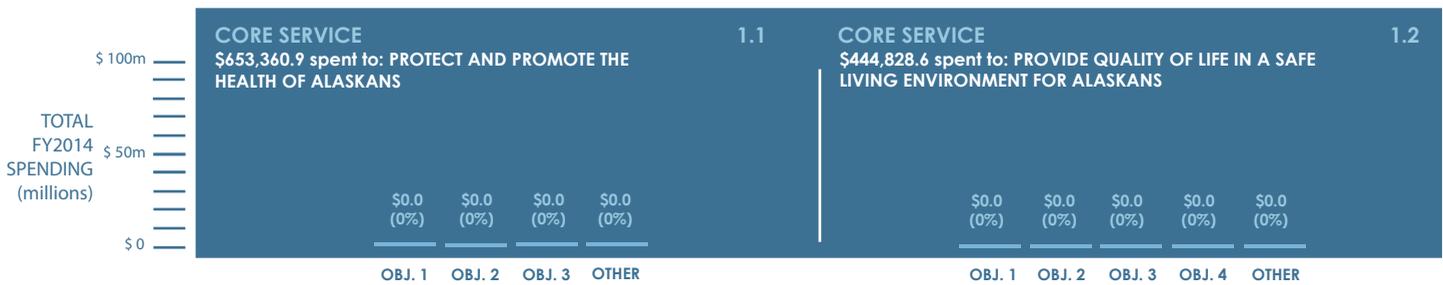
Total service population 145,279 individuals.



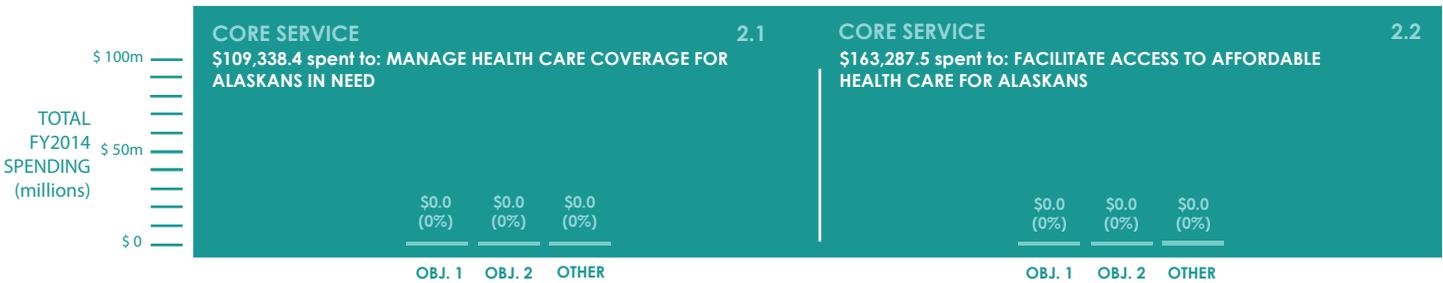
## SNAPSHOT OF ALASKANS SERVED

- 87,506 (60%) are children
- 2,759 (2%) are disabled children
- 8,197 (6%) are elderly
- 17,011 (12%) are disabled adults
- 29,806 (20%) are adults

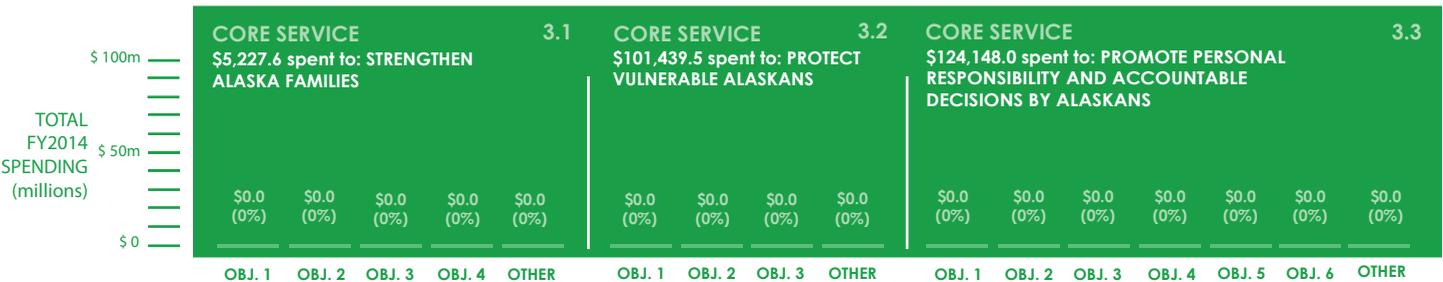
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



**DHSS FY2015 Governor's Request - Medicaid Services****General and Other Funds**

(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, CarryFwd, and Inter-RDU Trin and Trout Items Only)

<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Medicaid Services Growth (APD,HCS,SDS)	\$ 26,258.2	\$ -	\$ -	\$ -	\$ 26,258.2
Behavioral Health Grants Sec16 Ch14 SLA 2013 Pg71 L10 (BH)	\$ 6,000.0	\$ -	\$ -	\$ -	\$ 6,000.0
Reverse Behavioral Health Grants Sec16 Ch14 SLA 2013 Pg71 L10 (BH)	\$ (6,000.0)	\$ -	\$ -	\$ -	\$ (6,000.0)
Medicaid Services Growth Reduction (BH,OCS)	\$ (3,488.6)	\$ -	\$ -	\$ -	\$ (3,488.6)
<b>Medicaid Services Total</b>	<b>\$ 22,769.6</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 22,769.6</b>

# BUSINESS PLAN (2013-2015)



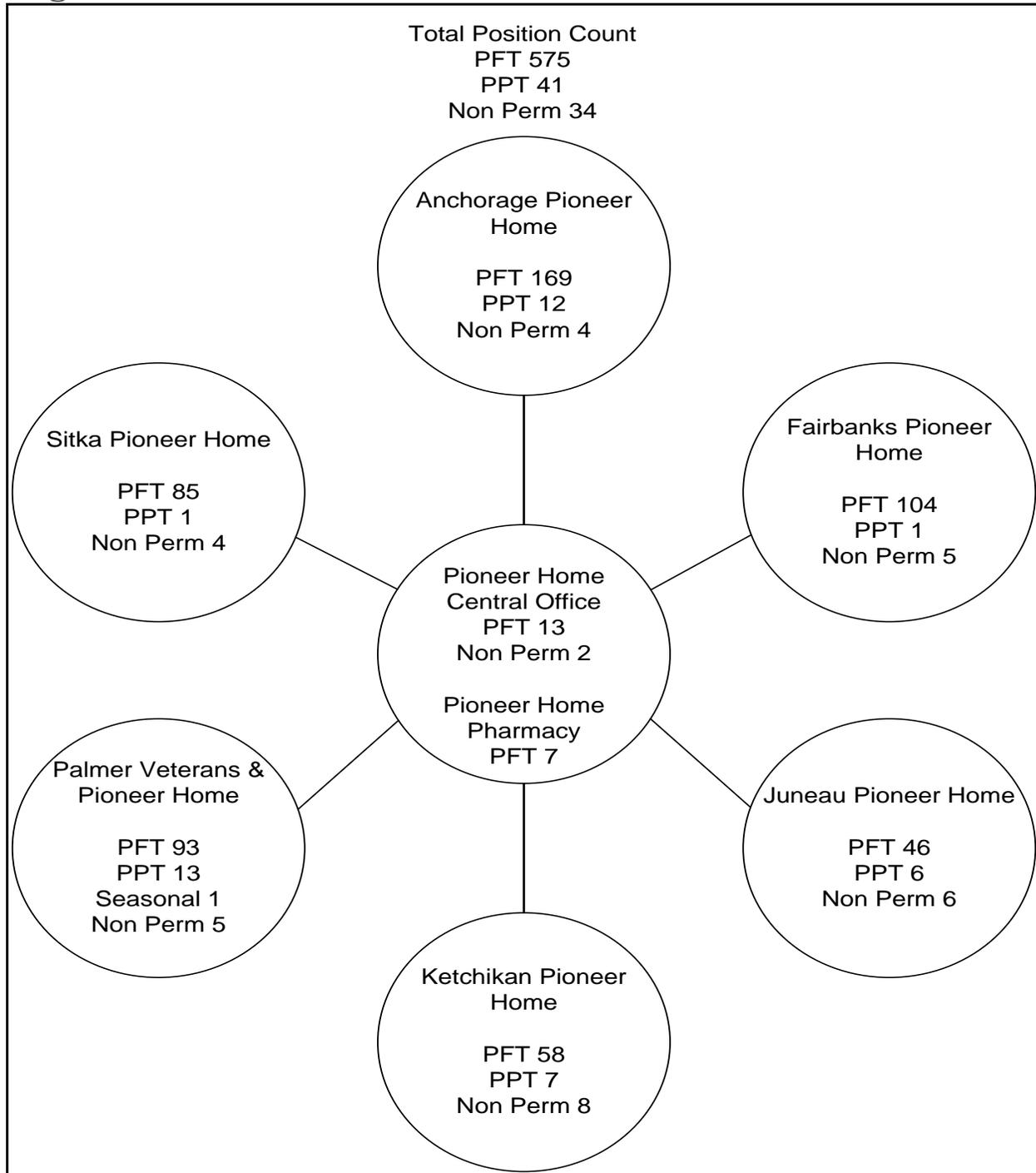
## DIVISION OF ALASKA PIONEER HOMES

**MISSION:** To provide the highest quality of life in a safe home environment for older Alaskans and Veterans.

# Contents

Organization Chart_____	1
Introduction_____	2
Priority 1 – Health & Wellness Across the Lifespan_____	5
Priority 2 – Health Care Access, Delivery and Value_____	12
Division Information_____	16
Division Performance Measure Contact_____	16

# Organization Chart—Alaska Pioneer Homes



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# Introduction

## PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

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## PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

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## PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

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### CORE SERVICES

The Division of Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer, and Juneau to qualified Alaskans age 65 and older. The three levels of services range from basic room and board (Level I) to 24 hour assistance with activities of daily living (Level III). Pioneer Home services are designed to maximize independence and quality of life by addressing the physical, emotional, and spiritual needs of residents. Since 2007, the Palmer Home has been certified as the Alaska Veterans and Pioneer Home.

### VISION FOR THE FUTURE

The Alaska Pioneer Homes system is a team of caring professionals who are committed to creating homes that enrich the lives of our residents and our staff, and reach out to Alaska's Alzheimer's Disease or Related Disorders (ADRD) community.

The Pioneer Home system continues to evolve in order to best care for the existing population of residents and to plan for future needs. This evolution is guided by the use of best practices, up to date information, and expertise in the field of geriatric care.

### CORE VALUES

**Positive Attitude:** "We enjoy what we do." | Optimism inspires open-mindedness and creativity.

**Love:** "We love who we serve." | Out of love and respect for our residents, we put their needs before staff convenience.

**Accountability:** "We do what we say." | We are accountable to our residents, to their families and to each other. Accepting responsibility is essential as we plan and deliver care.

**Trust:** "We say what we mean." | Open and honest communication is crucial to earning the trust of our residents, their families and our coworkers.

**Excellence:** "We provide excellent care, to every resident, every day, every time." | Our own excellence inspires excellence in others, including residents, families and our coworkers.

## SERVICES PROVIDED

The Pioneer Homes provide three service levels under The Eden Alternative™ care concept:

Level I	Provision of housing, meals, emergency assistance, and opportunities for recreation. The pioneer home pharmacy may supply prescribed medications.
Level II	Provision of housing, meals, emergency assistance, and staff assistance, including assistance with activities of daily living, medication administration, recreation, and health-related services. At this level, residents perform the activities of daily living with minor assistance provided by staff; the resident is independent during the night.
Level III	Same as Level II, but at this level, the staff provide the majority of assistance with the activities of daily living; the resident requires 24 hour assistance.

The Eden Alternative™ is an 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.

## RATES

Under Alaska Statute, the Department establishes the monthly rate to be charged for Pioneer Home services AS 47.55.030(b). The stated current policy is that the rate does not need to fully compensate the state for the provided services. *Id.* The current rates for services are provided in the table below.

Level I	\$2,350
Level II	\$4,260
Level III	\$6,170

A full history of the Pioneer Home rates was provided in the Department's FY 2014 Budget Overview Book. The Pioneer Home rates have not changed since that overview was published.

## ADMISSION REQUIREMENTS

To be eligible for admission into a Pioneer Home, a person must meet the following requirements:

- 65 Years of age
- An Alaskan resident one year immediately preceding initial application
- Maintain Alaska residency following initial application
- Participate in Medicare Parts A & B or the equivalent (or have applied for);
  - Be in need of aid or benefit of the Home;
  - Defined as: "inability to maintain a household without regular assistance in shopping, housekeeping, meal preparation, dressing, or personal hygiene because of physical or medical impairment, infirmity, or disability.
- Agree to pay monthly fee as established by the Department.

## ADMISSIONS PROCESS—“ACTIVE” AND “INACTIVE” WAITLISTS

Because of the high demand for Pioneer Home services, admission is generally not immediately available upon application. To manage this, the Division maintains two wait lists: the Active Wait List and the Inactive Wait List. When applying, applicants may choose either list.

**Active Wait List:** A choice for the active wait list requires that the applicant is prepared to enter the Home of choice within thirty (30) days after an admission invitation is received.

- Applicants choosing the active wait list will be required to submit, in addition to the application:
  - A recent medical history and physical provided by a qualified medical practitioner; and
  - A statement certifying the applicant's need for the services provided by a Pioneer Home.
    - The spouse of an eligible applicant who needs care is eligible without disability.
    - Applicants, who wish to have the same application date as that of their spouse, or of another person, should submit the applications together in the same envelope.
  - The applicant is admitted if the level of service the applicant requires matches the level of service of the available bed.

**Inactive Wait List:** An applicant choosing the inactive wait list is someone who does not wish to be considered for immediate entry into a Pioneer Home.

- An applicant may transfer to the active wait list at any time by requesting, in writing, his/her desire to move from one wait list to the other.
- The applicant's name will be merged into the list in the chronological order of the original application date.
- The applicant's original date of application will always be maintained.
  - For example, if your application was received on May 5, 1997, that date will always be the date of your application, without regard to which list you request or how many times you move from one list to the other.
- When an applicant transfers from the active to the inactive wait list, they must remain on the inactive list a minimum of 90 days before applying for a transfer back to the active wait list.

## PIONEER HOMES ADVISORY BOARD

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.

The Pioneer Homes Advisory Board is comprised of eight members. 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.

# Priority 1 – Health & Wellness Across the Lifespan

## CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

### Performance Measures

The Division has historically tracked and reported its occupancy and wait list data. As the Division continues to deepen its work on results based outcome measures, additional data points will be identified to track, measure, and report. The Division currently allocates 44.6% of its budget to this performance measure: The Pioneer Homes provide residents a high quality of life in a safe living environment.

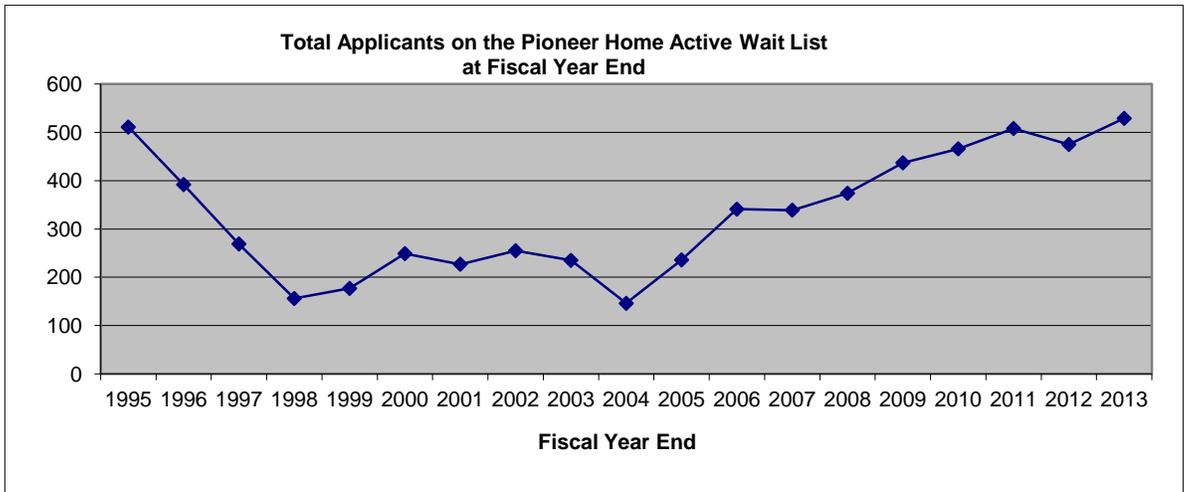
**Wait List Data:** Demand for the Pioneer Home services increased over the prior year:

As of September 30, 2013:

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	30	95	125	151	61	119	581
Inactive Branch	1,208	1,563	1,459	1,895	911	1,464	8,500
<b>Total</b>	<b>1,238</b>	<b>1,658</b>	<b>1,584</b>	<b>2,046</b>	<b>972</b>	<b>1,583</b>	<b>9,081</b>
Number of Applicants Choosing More than One Home (Duplicates)							4,589
Number of Actual Applicants on Active Wait List							389
Number of Actual Applicants on Inactive Wait List							4,103

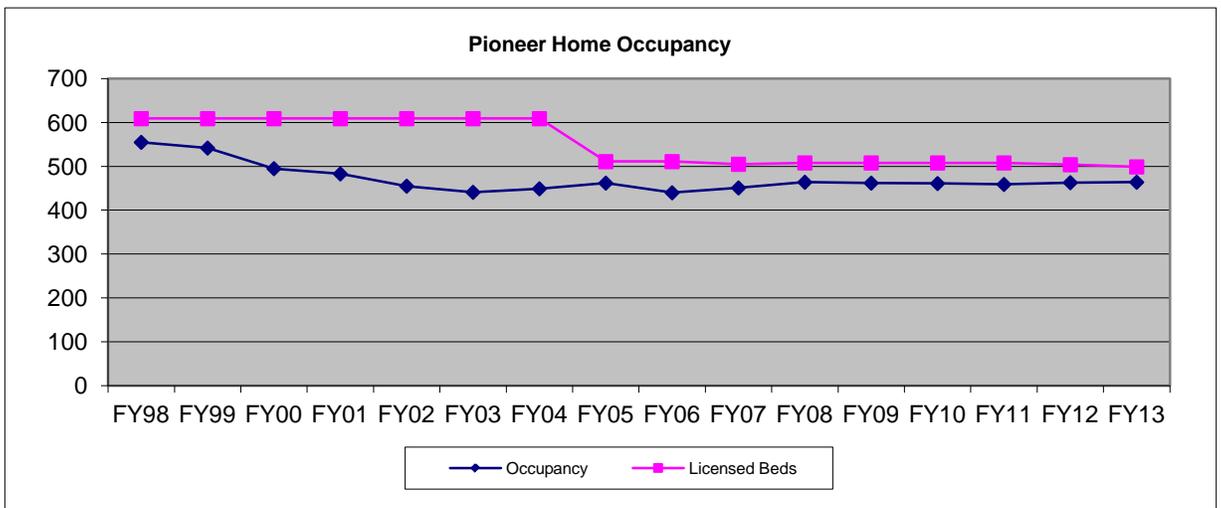
As of September 30, 2012:

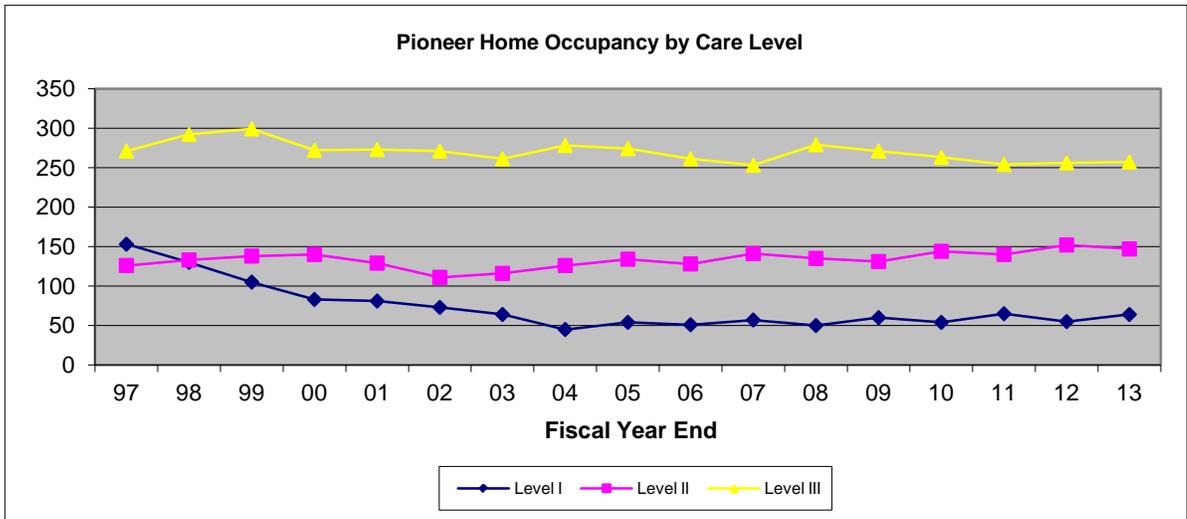
	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	31	94	98	135	42	100	500
Inactive Branch	1,067	1,433	1,337	1,697	804	1,326	7,664
<b>Total</b>	<b>1,098</b>	<b>1,527</b>	<b>1,435</b>	<b>1,832</b>	<b>846</b>	<b>1,426</b>	<b>8,164</b>
Number of Applicants Choosing More than One Home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



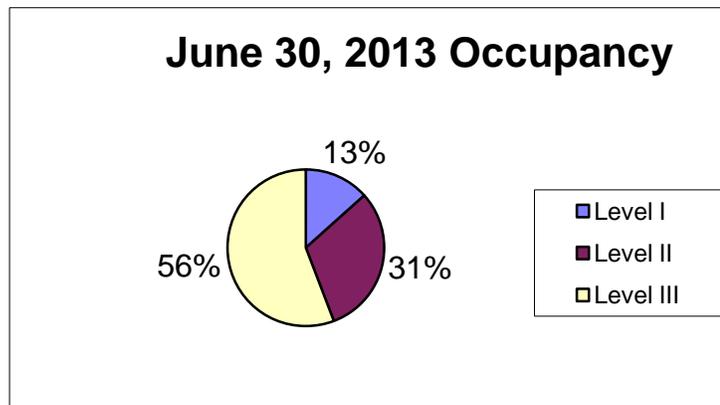
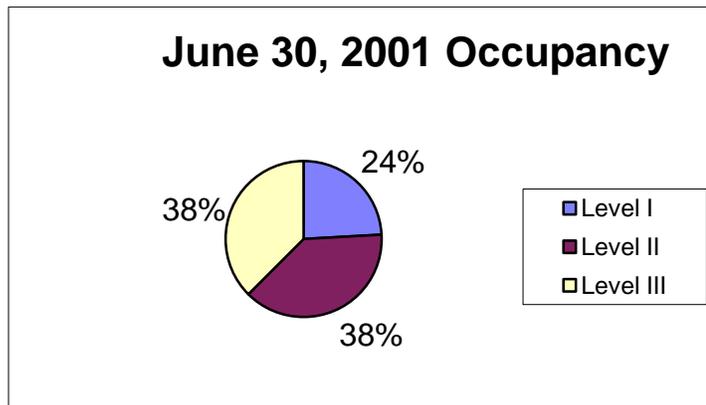
**Occupancy Data:** Currently, the Pioneer Homes are licensed for 499 residents. The Homes have been licensed for as many as 609 residents (1994). Different factors have contributed to this trend, the most significant being safe resident to staff ratios. Evolving standards relating to the facilities and patient safety have also contributed. Finding ways to increase resident occupancy to maximize the current Pioneer Home facilities is a strategy identified by the Pioneer Homes Advisory Board and Division leadership.

The following two graphs display: (1) actual occupancy to the total number of licensed Pioneer Home system beds and (2) occupancy by the three care levels.





The change in the level of service provided to Pioneer Home residents over the past decade is significant and is shown in the following two charts. Those residents requiring the highest level of service (i.e. staff help), Level III, have increased dramatically, while residents requiring Level I care (minimal staff help) decreased.

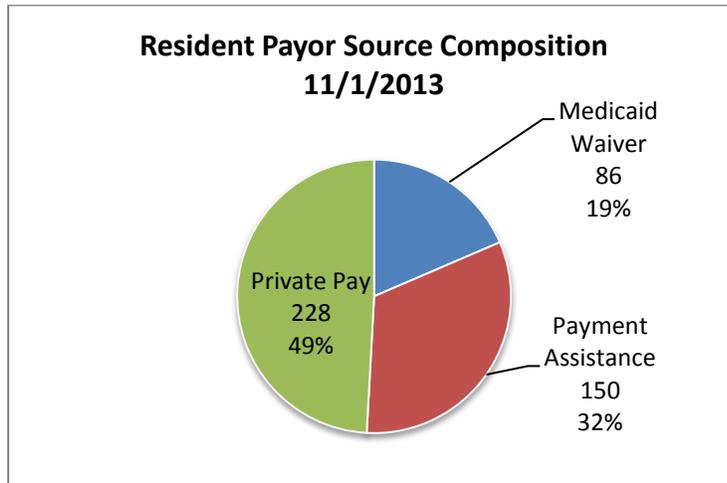


**Current Pioneer Homes Occupancy:** The table below shows the September 30, 2013 occupancy figures for each of the five Pioneer Homes and the Alaska Veterans and Pioneer Home located in Palmer by level of service.

Service Level	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Occupied/Assigned							
Level I	4	10	5	39	3	1	62
Level II	22	27	17	48	12	18	144
Level III	33	40	52	81	27	24	257
Total	59	77	74	168	42	43	463
Licensed Beds	65	93	79	168	46	48	499
Non-Occupied	6	16	5	0	2	5	36
Unavailable	0	0	0	0	2	0	2
% Available Beds Filled	90.8%	82.8%	93.7%	100.0%	95.5%	89.6%	93.2%

**Payment/Payor Mix:** Pioneer Home residents pay a monthly rate based on their assessed care needs; Level I, II or III. The Homes' resident payor mix includes:

- **Private Pay**
- **Medicaid Waiver:** Those approved for the Alaskans Living Independently Medicaid Waiver.
  - As part of the Medicaid program each wavier is a 50/50 split between federal dollars and state general funds.
  - The Medicaid Waiver does not pay room and board fees, but only level of care fees. Thus, a waiver recipient is responsible for the portion of the monthly rate that represents room and board.
  - If a waiver recipient is unable to meet the room and board portion of the rate, they may apply for the Pioneer Home Assistance Program.
- **Payment Assistance:** Those approved for the Pioneer Home Payment Assistance Program. 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. This is a pure general fund expense.



#### Strategies/Actions

The Pioneer Homes have been in a status quo management philosophy over the last several years. As the state budget undergoes downward and further cost containment pressure, the Division, like all executive branch agencies, finds itself unable to plan on continued status quo for the future.

This dynamic, coupled with the population the Homes serve, provides two distinct public policy pressures: 1) how to continue providing excellent services while depending less on the state general fund; and 2) how, or whether the Homes will be involved in the efforts, to meet the needs of the state's rapidly growing senior population.

The Commissioner has committed to providing a plan addressing these pressures. That plan is under development, and the following actions have occurred and are continuing:

- Upon the advice of the Pioneer Homes Advisory Board, Division leadership is analyzing needs to increase resident capacity to the full extent each facility's physical plant will allow. In each case, the current physical plant will not accommodate full occupancy. This is because of either, current standards for resident safety (the facility, or portions, were not designed for the current higher acuity resident mix) or municipal zoning restrictions prevent full occupancy.
- The Anchorage Pioneer Home has been clearing dormant resident rooms that were used for storage. Once the staffing needs to fill these rooms have been established, the Division can seek solutions to find resources or strategies to fill the positions to accommodate additional residents.
- The Division has been more aggressively managing procurement to use the purchase volume and quantity to its best advantage to drive down costs for supplies.

- The division is preparing to more fully implement Performance Based Metrics to find opportunities for more efficiency in the delivery of services.

#### Partners/Interdependencies

- **Alaska Commission on Aging:** The Alaska Commission on Aging (ACoA) advocates for state policy, public and private partnerships, state/federal projects and citizen involvement that assist Alaskans to age successfully in their homes, in their communities, or as near as possible to their communities and families. The Pioneer Homes benefit from the Commission’s 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 Commission’s Chair has a seat on the Pioneer Homes Advisory Board.
- **Division of Health Care Services - Medicaid; Certification & Licensing:** As a licensed service provider and biller of Medicaid—via the Medicaid Waiver—the Pioneer Homes are interdependent on the Division of Health Care Services which manages the State Medicaid Plan and issues the licenses under which the Pioneer Homes operate.
- **Division of Public Assistance:** The Division is responsible for determining the eligibility of individuals and families in need of Medicaid benefits. Generally, around 20% of Pioneer Home residents are Medicaid waiver recipients. Thus, the Pioneer Homes are interdependent with the Division of Public Assistance who determines residents’ eligibility for the waiver.
- **Division of Senior and Disabilities Services:** The Division manages the Medicaid Waiver program for older Alaskans who are eligible. As stated, roughly 20% of Pioneer Home residents qualify for this important source of assistance.
- **Alaska Veterans Advisory Council:** The Alaska Veterans Advisory Council’s mission is to address the needs and concerns of all of Alaska veterans, their dependants, and survivors and improve recognition of Alaska’s veterans. The Pioneer Home located in Palmer is certified as a Veterans home. The Alaska Veterans Advisory Council chair has a seat on the Pioneer Homes Advisory Board.

#### Analysis

**Resident Acuity and Costs are Rising.** The occupancy data shows that the Pioneer Homes are serving a greater proportion of high acuity residents. Since 2001, the Homes highest acuity level—Level III—has seen an increase from 38% to 56% of the resident population mix. Conversely, the lowest acuity level—Level I—has decreased from 24% to 13%.

This shift in acuity has several impacts for the Homes. First, Level III acuity residents require greater staff assistance and time. This requires the Homes to carry more staff and thus more expense. Second, Level I acuity residents require minimal staff assistance and offer the Homes the greatest opportunity to meet its expenses with the rates charged for services. Yet recent trends see residents at this acuity level remaining low.

**Current State Policy Regarding Pioneer Home Rates.** The current statutory policy regarding Pioneer Home rates is that the rates do not need to fully compensate the state for the care provided. Further, the statutory process for raising rates is different than for other administrative regulations. The process is more cumbersome and to the extent that the process helps to protect the resources of current residents, that is a laudable effect. However, the impact makes it a more challenging policy decision to adjust rates to stay current with expenses. The last Pioneer Home rate increase occurred in 2009. The Pioneer Homes Advisory Board and Division leadership have recognized the need to review current rates as well as the current statutory policy behind rates. Further recommendations on rates will be included in the plan under development.

#### Looking Ahead

The Division of Alaska Pioneer Homes and its staff remain committed to delivering compassionate, excellent, and resident centered care to all who live in a Pioneer Home. The oncoming surge in the population of residents over 65 and older will push the Pioneer Homes occupancy to the system's limits. The Division is committed to finding ways to accommodate this need while keeping expenses in check. As part of the Commissioner's plan for the Division, ideas related to Public-Private Partnerships will be explored as possible solutions for the need for expanded Pioneer Home services.

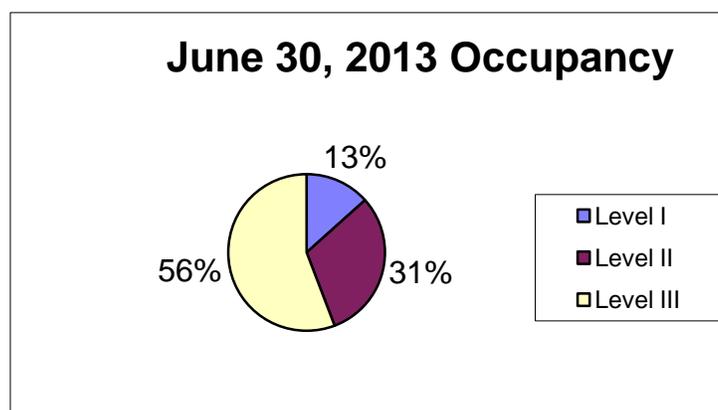
## Priority 2 – Health Care Access, Delivery and Value

### CORE SERVICE 2.1 MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED

**Objective 2- Increase access for Alaskans with chronic or complex medical conditions to integrated care.**

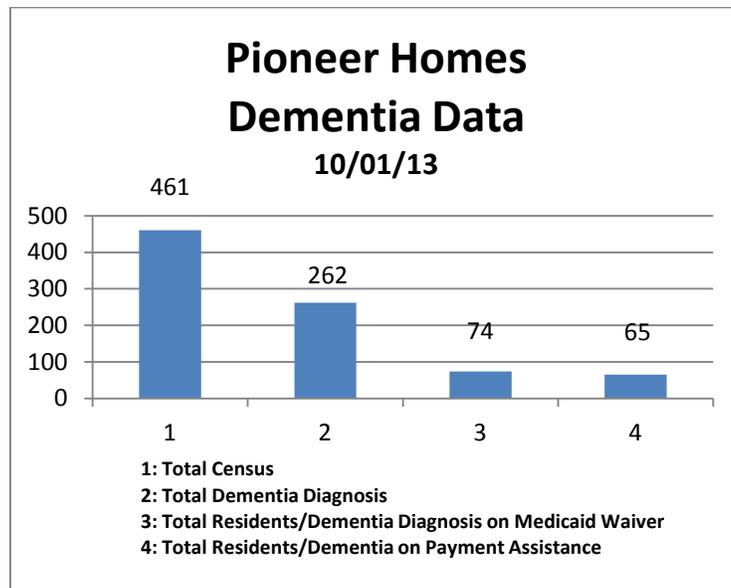
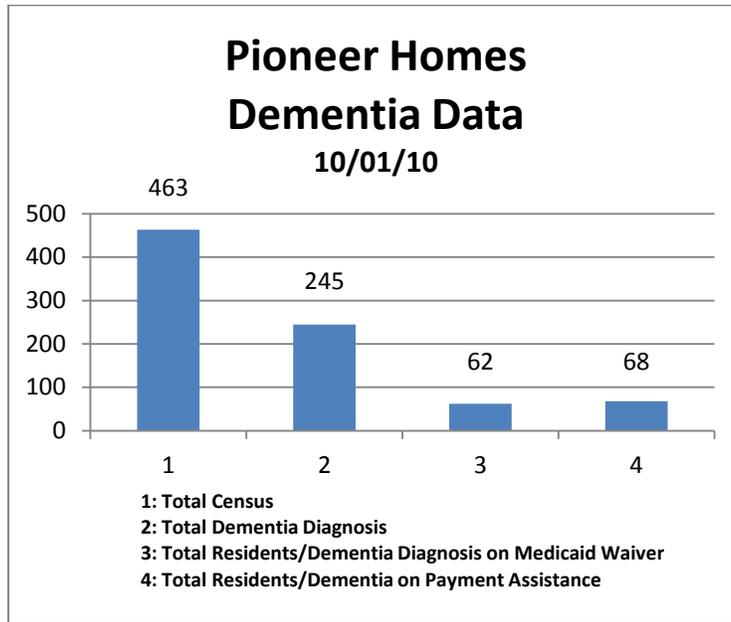
#### Performance Measures

The Division is in the process of developing its performance based measures at this time. Currently, 55.4% of the division's budget is allocated to this performance measure. The justification for this is reflected in the resident acuity mix: Currently over half of our residents occupy the highest level of acuity in the Pioneer Homes system.

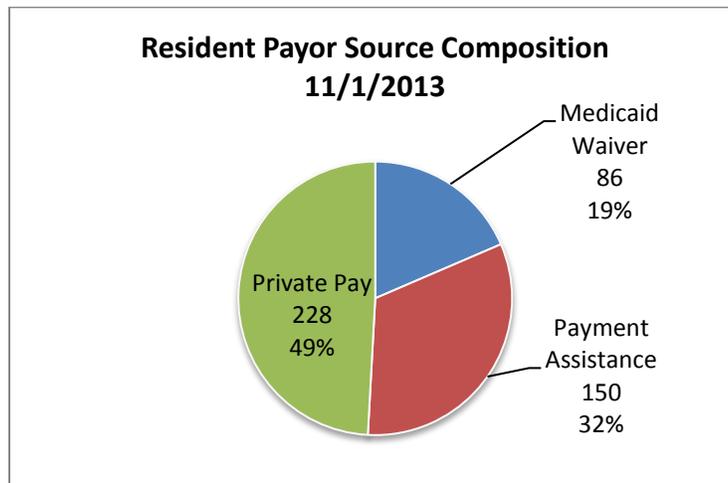


Many have chronic conditions, and many have multiple chronic conditions. The Centers for Disease Control and Prevention reports that two out of every three older Americans have multiple chronic medical conditions. (Centers for Disease Control and Prevention, *The State of Aging and Health in America 2013*, <http://www.cdc.gov/aging/publications/reports.htm>) The Pioneer Homes collects this data and as a part of the department's Performance Based Measures initiative will be reporting on this in the future.

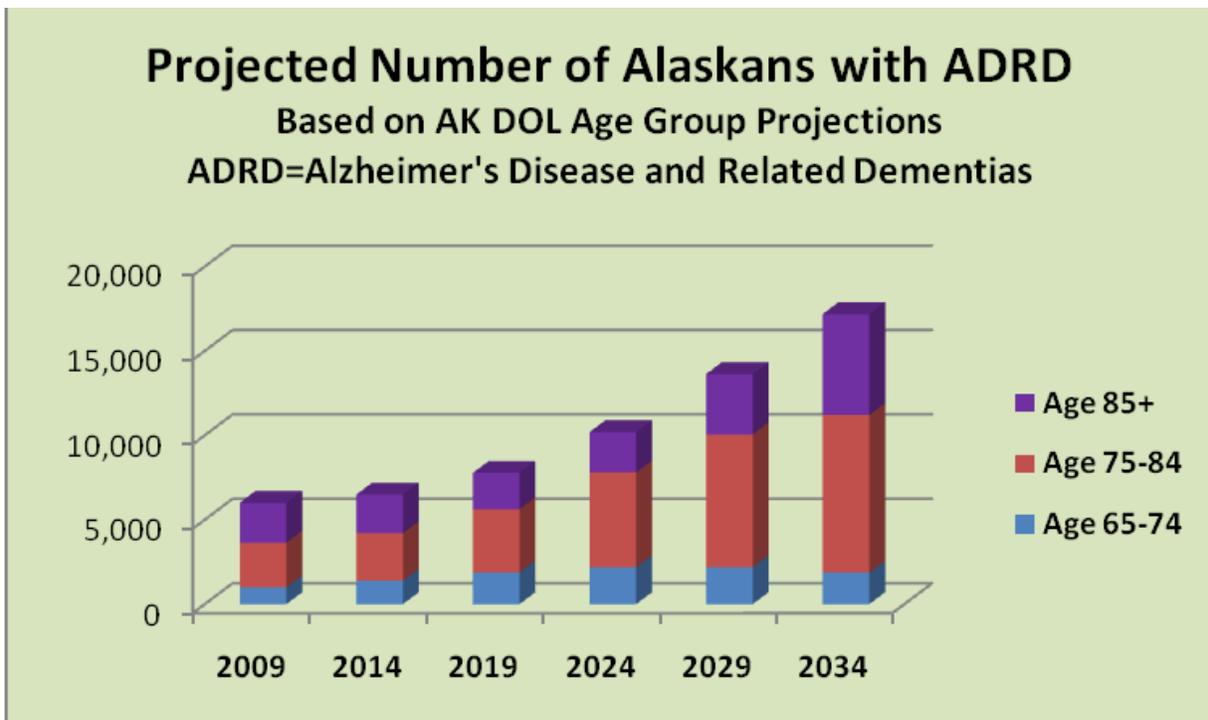
A specific condition that the Division has been reporting on is Alzheimer's disease and related dementia. Since 1995 the Pioneer Homes have focused on providing services to those suffering Alzheimer's disease and related dementia (ADRD). The charts that follow show two different data snapshots, the first from 2010 and the next current data. The data reflects that a high proportion of Pioneer Home residents are diagnosed with ADRD and a high proportion of those diagnosed rely on the Payment Assistance Program. Currently, under the Division's Payment Assistance program, if a resident or applicant is unable to pay the rates for services they may apply for assistance.



The Pioneer Homes are the provider of last resort for this population with this medical condition. No private service provider exists to care for these Alaskans. The following is the current breakdown of resident census by payor mix:



The Alaska Commission on Aging projects that the number of Alaskans diagnosed with ADRD will rise along with the growing proportion of older individuals in the population, attributable to greater longevity and the aging of the baby boomers. (Alaska Commission on Aging, *The Alaska State Plan For Senior Services FY 2012 – FY 2015*, Appendix C, p.18.)



#### Strategies/Actions

The Division currently measures and tracks its resident acuity and the specific services provided to residents with Alzheimer's disease and related dementia. The Division's general admission policy is to offer residency to those waiting admission if a current

vacancy can be matched to the prospective resident's needs that is next on the active waiting list. The Division has never set census targets for residents suffering from dementia, rather, the division seeks to accommodate and place all Alaskans on the Active Wait List.

#### Partners/Interdependencies

- **Alaska Commission on Aging:** The Alaska Commission on Aging (ACoA) advocates for state policies that would increase services for the ADRD community.
- **Division of Health Care Services (Medicaid):** The division plays a role in determining whether ADRD diagnosis alone should qualify for Medicaid waiver services.
- **Division of Senior and Disabilities Services:** The division manages the Medicaid Waiver program for older Alaskans who are eligible. As stated, roughly 20% of the Pioneer Home's residents qualify for this important source of assistance.

#### Analysis

The Division's data holds that at any point in time, 50% or more of the Pioneer Homes residents are diagnosed with ADRD. Of this cohort, consistently 24% (or 7% of the total resident population) rely on the Payment Assistance Program at the Pioneer Homes to provide their residential care and services. This represents a gap in the state's continuum of care. The Division works with residents to move them from payment assistance to the Medicaid waiver. This is not always possible with ADRD residents as currently, an ADRD diagnosis alone is not enough to qualify a resident for the Medicaid waiver. To qualify for the Medicaid waiver, an applicant's condition must require professional medical or nursing supervision, including supervision of occupational, physical, or speech-language therapy. Not all ADRD diagnosis rise to this level of severity.

As the Division seeks to find ways to reduce its dependence on general fund dollars, getting more residents qualified for the Medicaid waiver is one of the most obvious ways to accomplish this. However, because the Medicaid waiver requirements do not accept an ADRD diagnosis alone as a qualifying condition, the Pioneer Homes will likely always have residents relying on the Payment Assistance Program.

#### Looking Ahead

The Pioneer Homes will continue to provide care to its residents diagnosed with ADRD and other chronic conditions. The future of dementia care within the Homes is to continue with the care that we presently provide and to stay in the forefront of dementia care.

## Division Information



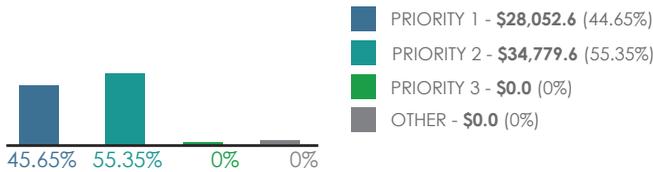
Division of Alaska Pioneer Homes  
333 Willoughby | 7<sup>th</sup> Floor | Juneau, Alaska 99801  
**Tel** 907.465.4416  
**Fax** 907.465.4108  
<http://dhss.alaska.gov/daph/Pages/default.aspx>

## Division Performance Measure Contact

G. Ken Truitt, Division Director  
333 Willoughby | 7<sup>th</sup> Floor | Juneau, Alaska 99801  
**Tel** 907.465.4416  
**Fax** 907.465.4108  
<http://dhss.alaska.gov/daph/Pages/default.aspx>

# ALASKA PIONEER HOMES | SPENDING BY PRIORITY (FY2014)

\$62,832.2 TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

[Total service population 463 individuals.]



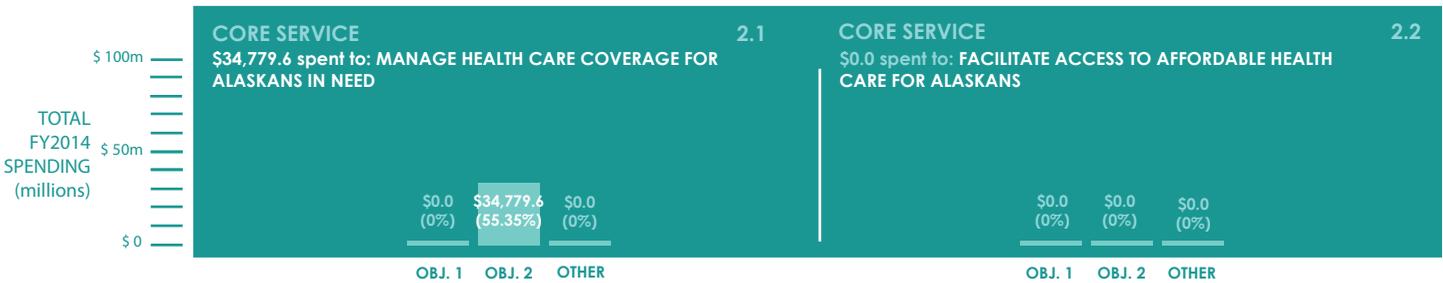
### SNAPSHOT OF ALASKANS SERVED

- 463 TOTAL RESIDENTS STATEWIDE (2960 on wait list)
- 62 (13.4%) Are relatively independent (LEVEL I)
- 144 (31.1%) Require some basic living skill support (LEVEL II)
- 257 (55.5%) Require high level of care (LEVEL III)
- 124 (26.8%) Are veterans

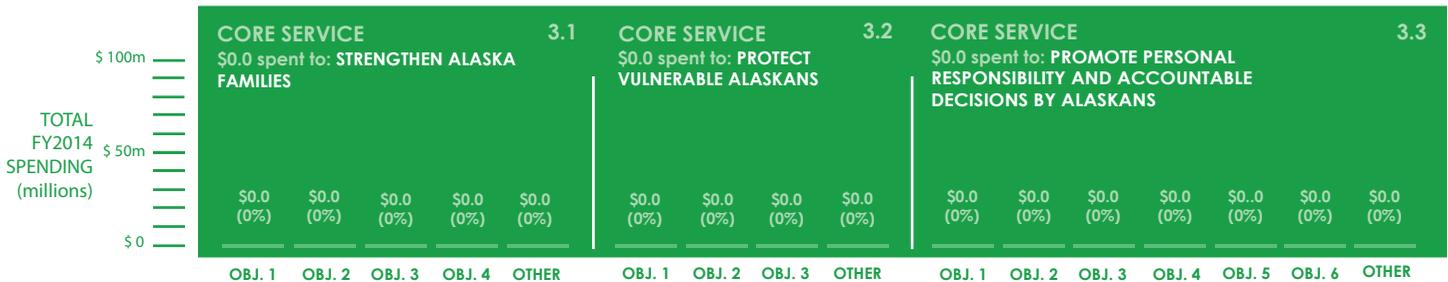
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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## Explanation of FY2015 Operating Budget Requests

### Alaska Pioneer Homes

#### Budget Overview Table

<b>Departmental Support Services</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>Difference</b>
Unrestricted General Funds	\$37,492.1	\$37,318.7	\$-173.4
Designated General Funds	\$15,501.5	\$15,479.9	\$-21.6
Federal Funds	\$593.2	\$693.0	\$99.8
Other Funds	\$9,245.4	\$8,831.5	\$-413.9
<b>Total</b>	<b>\$62,832.2</b>	<b>\$62,323.1</b>	<b>\$-509.1</b>

<b>DHSS FY2015 Governor's Request - Alaska Pioneer Homes</b>					
<b>General and Other Funds</b>					
<i>(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)</i>					
<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Reverse Alaska State Employees Association One-Time Payment (AKPH, AKPHM)	\$ (280.2)	\$ (66.6)	\$ (0.6)	\$ (44.4)	\$ (391.8)
FY2015 Health Insurance and Working Reserve Rate Reductions (AKPH, AKPHM)	\$ (89.3)	\$ (18.7)	\$ (0.1)	\$ (12.7)	\$ (120.8)
FY2015 Salary Increases (AKPH, AKPHM)	\$ 302.0	\$ 63.7	\$ 0.5	\$ 43.2	\$ 409.4
Increased Ratio of Veterans Serviced in the Palmer Home (AKPH)	\$ (100.0)	\$ -	\$ 100.0	\$ -	\$ -
Reduce Expenditure Level (AKPH)	\$ (5.9)	\$ -	\$ -	\$ -	\$ (5.9)
Reduce Uncollectible Statutory Designated Program Receipt Authority Associated with Dispensing Pharmaceuticals (AKPH)	\$ -	\$ -	\$ -	\$ (400.0)	\$ (400.0)
<b>Alaska Pioneer Homes Total</b>	<b>\$ (173.4)</b>	<b>\$ (21.6)</b>	<b>\$ 99.8</b>	<b>\$ (413.9)</b>	<b>\$ (509.1)</b>

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# BUSINESS PLAN (2013-2015)



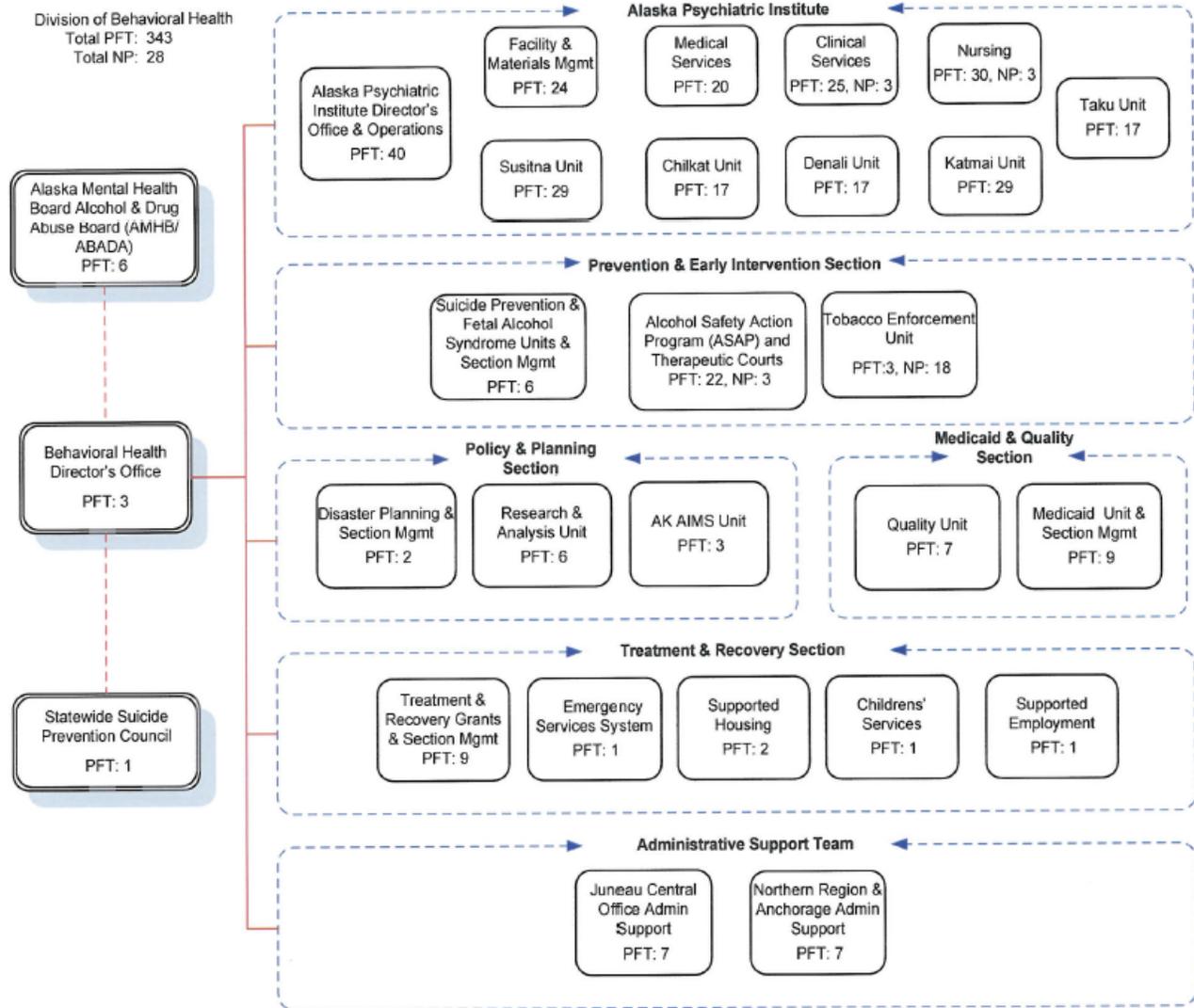
## DIVISION OF BEHAVIORAL HEALTH

**MISSION:** *To manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.*

# Contents

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Introduction	2
Priority 1 – Health & Wellness Across the Lifespan	4
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Priority 3 – Safe and Responsible Individuals, Families & Communities	21
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# Organization Chart



**PRIORITY 1  
HEALTH & WELLNESS  
ACROSS THE LIFESPAN**

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

**PRIORITY 2  
HEALTH CARE ACCESS,  
DELIVERY & VALUE**

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

**PRIORITY 3  
SAFE & RESPONSIBLE  
INDIVIDUALS, FAMILIES  
& COMMUNITIES**

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

# Introduction

Vision:

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

Mission:

To manage an integrated and comprehensive behavioral health system based on sound policy effective practices and open partnerships

Core Service

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.

The Behavioral Health Continuum of Care



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 and client outcomes.

Standard

- Quantity: How Much Did We Do?
- Quality: How Well Did We Do It?
- Outcome: Is Anyone Better Off?

Budget

Employee Count: PFT - 343 Non Perm - 28

Alaskans in Need

Behavioral health is the foundation of psychological wellbeing and social functioning. Behavioral health is fundamental for the well-being of individuals throughout the lifespan and for the well-being of the entire

community. It exerts a major effect on relationships, education, productivity and overall quality of life. Behavioral health problems are characterized by the extent to which they disrupt an individual's ability to function. In fact, the inability to learn, work, or participate fully in life is one of the hallmarks of having a mental illness or substance abuse addiction.

The impact of poor behavioral health is not always visually evident, and often difficult to understand. For example major depression is equivalent in burden to blindness or paraplegia. Active psychosis seen in schizophrenia is equal in disability burden to quadriplegia. Relapse of addiction is equal in course and impact to the disease relapse of cancer.

Treatment is very successful: depression (>80%), panic disorder (70-90%), Schizophrenia (60%). Again, as a point of comparison, heart disease has a treatment success rate of 45-50%.

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 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 DBH Business Plan reflects priority areas of Access, Engagement, Retention, Quality, and Outcomes, and aligns with the following Department core services:

- 1.1 PROTECT AND PROMOTE THE HEALTH OF ALASKANS
- 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS
- 2.2 FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS
- 3.2 PROTECT VULNERABLE ALASKANS
- 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

Behavioral Health is Essential to Health  
Prevention Works  
People Recover  
Treatment is Effective

# Priority 1 – Health & Wellness Across the Lifespan

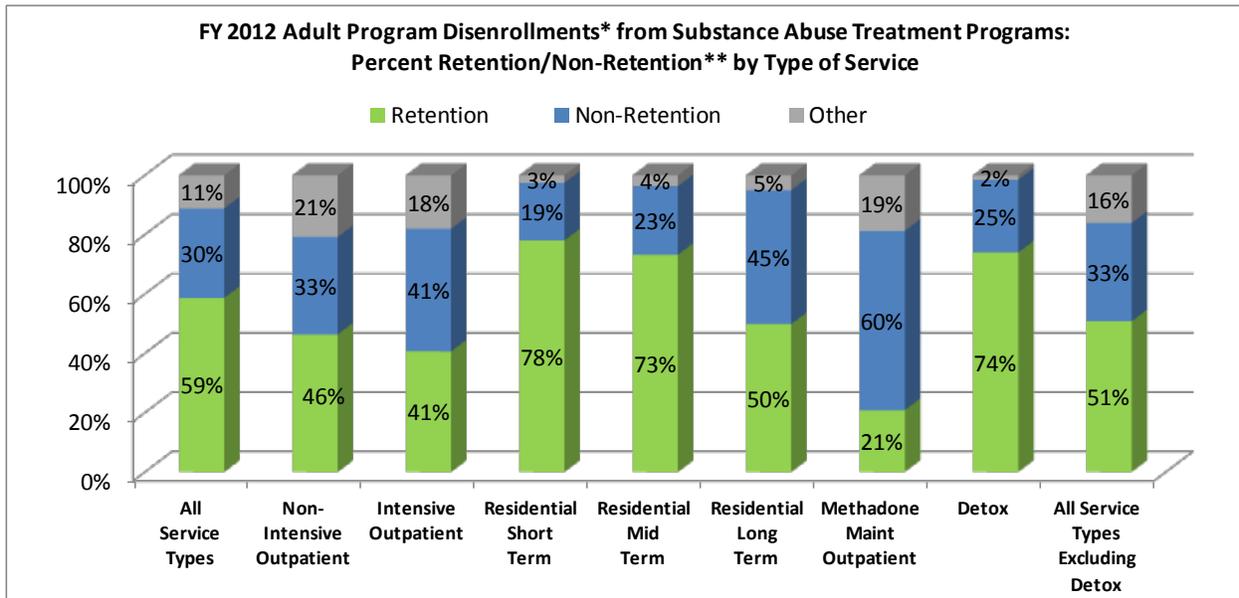
## CORE SERVICE 1.1 PROTECT AND PROMOTE THE HEALTH OF ALASKANS

### Objective 1.1.3- Decrease substance abuse and dependency

#### Performance Measure 1.1.3.1a Percent of Alaskans discharged from substance abuse treatment services that successfully complete treatment.

The Division maintains a focus on business and clinical practices that impact access to services and retention within the behavioral health service system. Research literature indicates a high correlation between successful retention and treatment completion with greater positive outcomes. One measure of retention within the service system is the percent of clients whose reason for disenrollment from a treatment program is ‘successfully completed treatment’ or ‘referred to another program or other service.’ A client’s treatment plan might include multiple program enrollments, where the client starts out at a high level of service intensity and is then “stepped-down” to a lower level of service intensity; at each step-down, the client is disenrolled from one program and enrolled into another. Measuring retention at the program level allows the Division to monitor retention for the various levels of service.

**Chart : FY2012 Percent of Adult Program Disenrollments from Substance Abuse Treatment Programs Indicating Retention in the Behavioral Health Service System**



\* **Program disenrollments** reflect duplicated client counts (i.e., a client may have been disenrolled from multiple programs and is counted for each disenrollment).

\*\* **Retention** in the behavioral health service system is indicated by a program disenrollment reason of ‘successfully completed treatment’ or ‘referred to another program or other service.’

**Non-retention** is indicated by a disenrollment reason of ‘left on own,’ ‘involuntary discharge/disenrollment due to nonparticipation or violation of rules,’ or ‘incarcerated while in treatment.’

**Other** includes a disenrollment reason of ‘transferred to another facility for health reasons,’ ‘deceased,’ or other.

**Data source:** Alaska Automated Information Management System (AKAIMS) Agency Disenrollment Reports.

## Strategies/Actions/Partners/Interdependencies

<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1 Utilize Grant Quarterly Reporting and Review to monitor levels of performance	1a. Develop performance measures of “retention” specific to each level of care for substance abuse services.	<ul style="list-style-type: none"> <li>• Behavioral Health Grantee Providers</li> <li>• Outcomes Identification &amp; Systems Performance Work Group.</li> </ul>
2 Utilize data to inform practice; mitigate client profiles at risk for lower completion rates	2a. Communicate with providers on the client profiles for higher/lower levels of treatment completion: ex. <ul style="list-style-type: none"> <li>• reported alcohol as their primary substance of abuse</li> <li>• referred to treatment by the criminal justice system</li> <li>• Employed at time of admission</li> <li>• Were non-Hispanic White</li> <li>• Used substances less than daily at admission</li> <li>• 12 or more years of education</li> <li>• Over age 40 at admission</li> <li>• male</li> </ul>	

### Analysis

The Division performed an analysis of FY2009 to FY2012 adult program disenrollment’s from substance abuse treatment programs to assess retention in the service system by type of service. Retention in the service system is indicated by a program disenrollment reason of ‘successfully completed treatment’ or ‘referred to another program or other service;’ non-retention is indicated by a disenrollment reason of ‘left on own,’ ‘involuntary discharge/disenrollment due to nonparticipation or violation of rules,’ or ‘incarcerated while in treatment.’ This analysis examined retention/non-retention in the service system for the following types of substance abuse treatment program services:

- Non-intensive outpatient
- Intensive outpatient
- Methadone maintenance outpatient
- Detoxification
- All treatment service types excluding detoxification
- Residential – short term (30 days or fewer)
- Residential – mid-term (31-90 days)
- Residential – long term (91 days or more)
- All treatment service types

Key trends in retention in the service system (based on reason for program disenrollment) from FY2009 to FY2012 are as follows

- For all treatment service types combined, approximately 60% of disenrollments indicated retention, ranging from 59% to 63%.
- For all treatment service types excluding detoxification, approximately 53% of disenrollments indicated retention, ranging from 51% to 54%.
- Disenrollments from short-term residential, mid-term residential, and detoxification programs indicated the highest percent retention:
  - For short-term residential services, approximately 74% of disenrollments indicated retention, ranging from 69% to 78%.
  - For mid-term residential services, approximately 73% of disenrollments indicated retention, ranging from 71% to 75%.
  - For detoxification services, approximately 72% of disenrollments indicated retention, ranging from 69% to 75%.
- Of the three levels of residential services, disenrollments from long-term residential programs indicated the lowest percent retention at approximately 52%, ranging from 44% to 60%.
- Disenrollments from outpatient programs indicated the lowest percent retention:
  - For non-intensive outpatient services, approximately 50% of disenrollments indicated retention, ranging from 46% to 52%.
  - For intensive outpatient services, approximately 43% of disenrollments indicated retention, ranging from 37% to 58%.
  - For methadone maintenance outpatient services, approximately 19% of disenrollments indicated retention, ranging from 8% to 35%.

## Looking Ahead

The Division of Behavioral Health plans to continue in monitoring the success of successful retention within the multiple levels of substance abuse treatment services. Research demonstrates a strong correlation between successful retention and treatment completion with greater positive outcomes. Ongoing refinement of the Divisions Performance Management System will enhance the identification of successful interventions to maximize the overall effectiveness of the treatment service array.

## CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

### Objective 1.2.4- Increase the number of Alaskans with behavioral health issues who report improvement in key life domains

#### Performance Measure 1.2.4.1a. Percent of behavioral health recipients who report improvement in quality of life

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 from treatment services. (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 "Health", "Safety", "Productive Activity", and "Living with Dignity". The structure, intent, and logic of the CSR are consistent with current and emerging national policy and planning on Quality of Life measurement. The Substance Abuse Mental Health Services Agency (SAMHSA) has included "quality of life" in the working definition of recovery for mental health and substance abuse populations and is fundamental to "strategic initiative" #7: Data, Outcomes, and Quality/

Quality of Life can be conceptualized as a multidimensional set of components consisting of a person's (1) satisfaction with his/her life as a whole, or *general wellbeing*; (2) observable social and material wellbeing, i.e. *objective quality of life*; (3) satisfaction with his/her social and material wellbeing, i.e. *subjective quality of life*; and (4) health and functional status, i.e. *health-related quality of life*.

Treatment Outcomes: FY 2013									
Child / Youth									
Client Improvement in Mental Health and Substance Abuse between first and second CSR (percent of clients showing improvement)									
		FY 2010	FY 2011	FY 2012	FY 2013	FY 2013 Q1	FY 2013 Q2	FY 2013 Q3	FY 2013 Q4
8c	SED (Mentally Unhealthy Days)	78.9%	67.3%	68.6%	67.8%	70.0%	62.8%	69.7%	68.0%
8e	COD CSR # 2,5,6	0.0%	78.1%	73.3%	73.7%	71.4%	63.6%	81.3%	75.0%
8f	MH CSR #2	88.0%	67.5%	72.7%	72.5%	78.3%	66.3%	67.7%	77.8%
8g	SUD CSR #5,6	0.0%	90%	89.8%	93.3%	100.0%	78.6%	95.1%	93.0%
Adults									
8a	SMI CSR #2	50.0%	73.1%	71.9%	76.2%	77.8%	77.6%	73.6%	75.4%
8c	SED CSR #2	0.0%	69.9%	71.6%	73.4%	76.2%	73.9%	61.5%	85.7%
8e	COD CSR #2 & 5 & 6	0.0%	75.0%	71.4%	78.8%	71.2%	80.3%	82.9%	87.5%
8f	MH CSR #2	0.0%	82.8%	76.5%	72.2%	71.1%	65.3%	76.5%	75.5%
8g	SUD CSR #5 & #6	0.0%	93.9%	93.2%	91.6%	90.2%	91.8%	91.3%	93.2%

## Strategies/Actions/ Partners/Interdependencies

The performance measure 1.2.4.1a “the percent of behavioral health recipients who report improvement in quality of life”, are directly aligned with the DHSS objective 1.2.4. Behavioral health is the foundation of psychological wellbeing and social functioning. Behavioral health problems are characterized by the extent to which they disrupt an individual’s ability to function. There is an expectation that treatment works and people recover.

The Division intends to implement the following strategies and action steps:

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Apply continuous quality improvement of the Division’s Performance Management System	<p>1a Utilize case risk adjustment (client type) to insure validity of performance measures</p> <p>1b. Utilize reporting by tenure and length in treatment.</p> <p>1c. Ensure appropriate services are being provided to the target populations, and to verify that desired outcomes are being achieved.</p>	<p>Community behavioral health providers</p> <p>The Alaska Mental Health Board, Alaska Board on Alcoholism and Drug Abuse, Alaska Behavioral Health Association</p>
2	Improve oversight using the quarterly reporting and review on quality of the ‘minimal data set’.	2a. Training in use of the Client Status Review and other minimal data set elements will be provided as needed through individual agency trainings or group venues such as the Change Agent Conferences.	Alaska Mental Health Trust Authority.
3	Increase monitoring of performance data.	3a. Insufficient provider performance or a drop in performance will trigger contact by assigned Program Managers to offer technical assistance in defining and correcting the problem.	

## Analysis

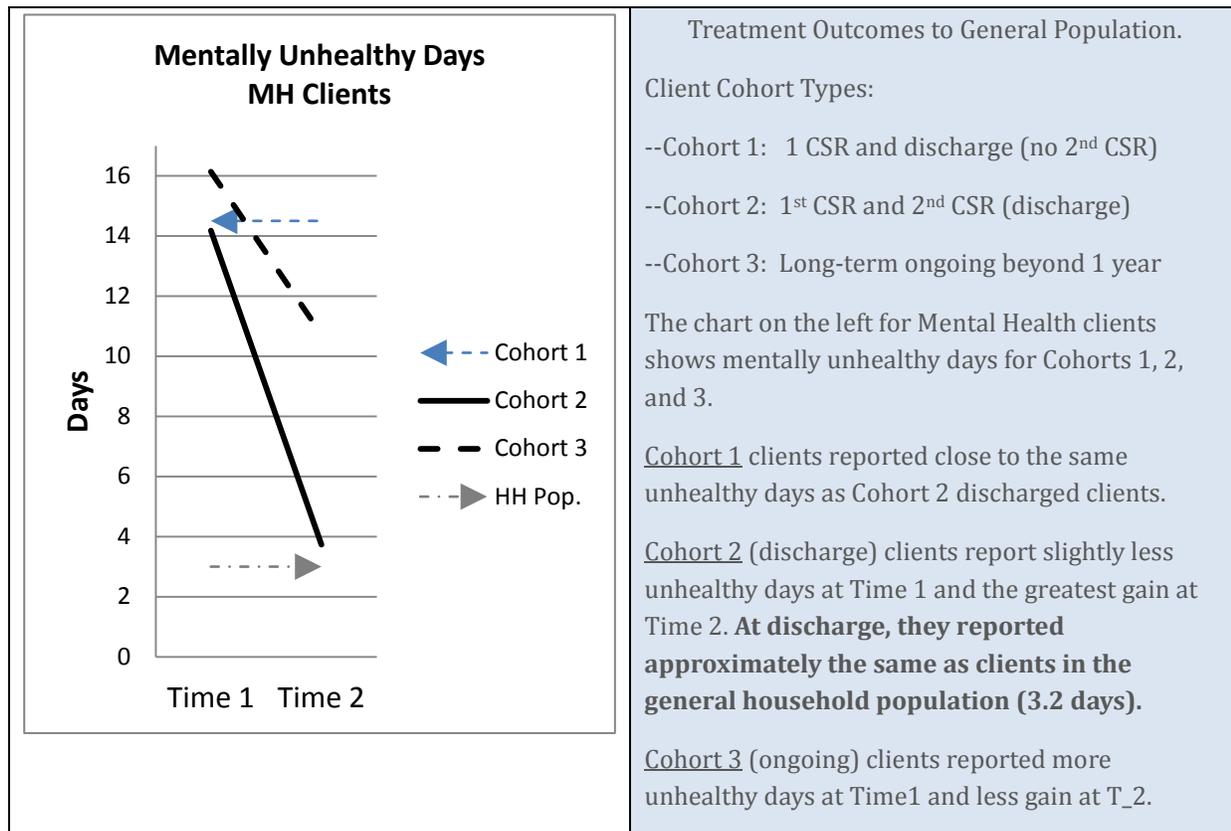
The quality of life questions to measure change over time for improved mental health and decreased substance abuse include:

- Mentally unhealthy days
- Alcohol and drug days ingested.

The table presents the change over time, and recognizes the outcomes are reported by:

- Age: Adult vs. youth
- Client “type”: severe mental illness, severe emotional disturbance, co-occurring, substance use disorder
- Time in treatment: From the initial CSR to the first follow-up (4-6 months in treatment).
- Over time: By fiscal year, and quarter of current fiscal year.

The questions for this measure include three questions widely used for health related quality of life and referred to as “Healthy Days”. These questions are also used by the CDC sponsored Behavioral Health Risk Factor Surveillance System (BRFSS) administered in each state to a random sample of households. The Alaska BRFSS survey includes these questions in an annual survey of approximately 2,500 persons. An additional comparison can be achieved by comparing these CSR questions to the Alaska BRFSS survey.



## Looking Ahead

The Division has refined the Performance Management System to effectively measure change over time that fulfills the threshold for clinical and statistical significance. Focus of future measurement will include client profiles that fall within “Cohort I” and Cohort “III”, effectively managing for “tenure in treatment” and by client types (i.e. Accounting for case mix/risk adjustment).

### Performance Measure 1.2.4.1b Percent of behavioral health recipients who re-admit back into API within 30 days of discharge.

The Alaska Psychiatric Institute is a critical element of the treatment system of care. This can, and often involves the coordination between two separate service components: 1) the community behavioral health providers; 2) Designated Evaluation & Stabilization and Designated Evaluation & Treatment (DES / DET) service providers. Challenges specific to each component has a corresponding and compounding impact on the others. The rate and frequency of client recidivism is an effective gauge of the effectiveness of the treatment system and is a critical issue in the function and operations of API.

Alaska Psychiatric Institute (API)								
	FY2010	FY2011	FY2013 Q1	FY2013 Q2	FY2013 Q3	FY2013 Q4	FY2013 FYTD	FY2012
Admissions	1375	1325	473	393	384	448	1698	1630
Average Daily Census	66.75	70.75	57.57	53.87	56.87	60.09	57.10	59.96
Inpatient Days	24,348	25,770	5,296	4,956	5,118	5,468	20,839	21,947
Readmission to Acute Care (30 days or <)	13.99%	12.53%	17.86%	15.28%	14.65%	15.39%	15.84%	14.26%

### Strategies/Actions/Partners/Interdependencies

API will set a 30 day re-admission rate goal of 10%, consistent with the national benchmark, for the purpose of quantitative performance measurement.

This goal cannot be achieved through the sole efforts of API, community stakeholders (emergency rooms, outpatient providers, ALFs, etc.) are a critical component to limit the need for re-hospitalization.

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Explore opportunities for improvement by API and community stakeholders (emergency rooms, outpatient providers, ALFs, etc.) to limit the need for re-hospitalization.	<p>1a. Identify common factors leading to readmission;</p> <p>1b. On a monthly basis, compile list of people readmitted &lt;39,</p> <p>1c. Review charts to identify key indicators of effective treatment and discharge planning</p>	Referring parties (emergency rooms); DBH T&R; DBH Emergency Services coordinator
2	Reduce readmit through effective d/c planning and improved communications with outpatient supporters	2a. Reinforce use of DSM	Outpatient providers; case managers; guardians
3	Implement change processes to improve the factors that are causing readmission	<p>3a. Support outpatient medication petition</p> <p>3b. Full time ACMHS staff person has office at API and is integrated in admissions and discharge planning</p> <p>3c. Link persons who refuse follow up services to peer support network</p> <p>3d. Obtain list from TTC of ALF's that have had BH training and use them as "preferred providers"</p> <p>3e. Improve match of ALF/patient</p> <p>3f. Better use of trial passes</p>	<p>ACMHS; SCF; Matsu BHS</p> <p>Peer Bridgers</p> <p>ALF (via Licensing); DBH grant program</p>
4	Reduce homeless shelter readmissions	4a. Point of contact with homeless/shelter team for direct referral	ACMHS homeless outreach team; BFS, Rescue mission

### **Analysis**

- Chart for populations (FY13 base set); all readmitted <30 days; # unique clients, actual individuals with frequent readmissions—chart review for common factors to support strategy/actions
- Pattern recognition common/co-occurring factors within unique readmits vs. frequent, rapid re-admits (via math model vs. human review and clinical discretion)

### **Looking Ahead**

- Expand 'transition care follow-up' (new CPT code) through TBH/iPad
- Link to peer support (homeless & unmotivated/unengaged consumers) via Consumer Family Specialist at API and Peer Bridger's
- ALF performance based funding and required training for de-escalation and efforts to *avoid* hospitalization—DBH to follow

## Priority 2 – Health Care Access, Delivery and Value

### CORE SERVICE 2.2 FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

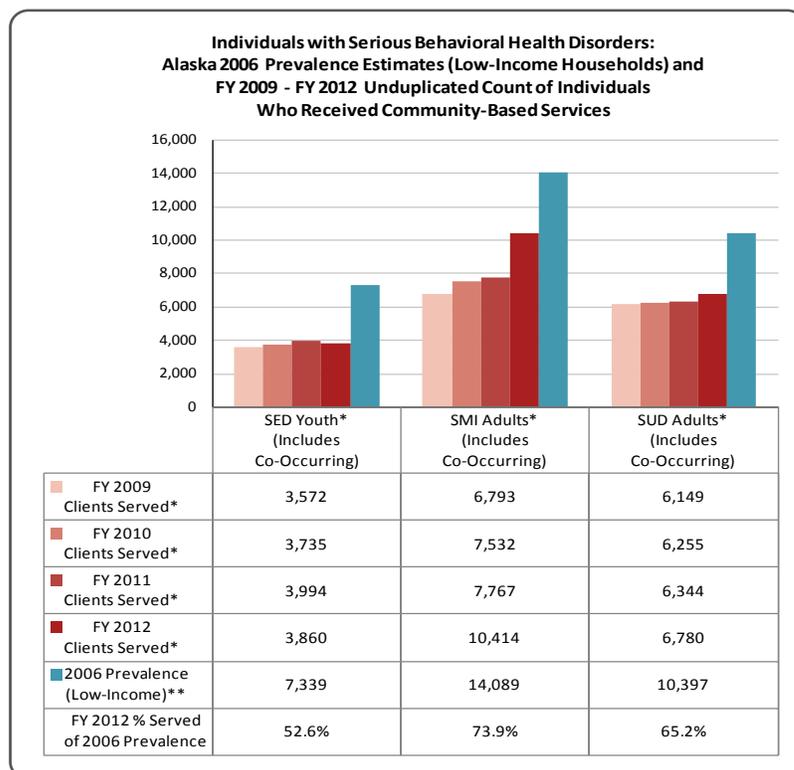
#### Objective 2.2.1- Improve urban access to health care

##### Performance Measures 2.2.1.5a Percent of the estimated need for behavioral health services met through community-based services (separated into SUD, SMI & SED Met Need)

Behavioral health is the foundation of psychological wellbeing and social functioning for individuals, families, and communities. It exerts a major effect on relationships, education, productivity and overall quality of life. Behavioral health problems are characterized by the extent to which they disrupt an individual’s ability to function. In fact, the inability to learn, work, or participate fully in life is one of the hallmarks of having a mental illness or substance abuse addiction. Timely access and capacity of the behavioral health treatment system to meet existing need is critical.

The selected measure targets the capacity of the community based behavioral health treatment system using “prevalence” and “penetration” rates. The Division uses Alaska prevalence estimates of serious behavioral health disorders, as a method to measure the need for behavioral health services. The estimated need of services (prevalence rate) is compared to those who accessed services, and results in an estimation of met need (penetration rate). The penetration rate of “met need” serves as a proxy for service capacity.

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



## Strategies/Actions /Partners/Interdependencies

The performance measure 2.2.1.5a “the estimated need for behavioral health services met through community based services”, are directly aligned with the DHSS objective 2.2.1 – Improve urban access to health care”. The measurement of determining the level at which the estimated need for BH services are being met, is a proxy for the ability of recipients of services to access treatment in a timely manner.

The Division intends to implement the following strategies and action steps:

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Refine Performance Measures to identify	1a. Develop, as a performance expectation, timely access of recipients into treatment services.	Behavioral Health Grantee Providers
2	Adopt the National Council “Same Day Access” Initiative strategies	2a. effective no show management, 2b. centralized scheduling, 2c. collaborative documentation, 2d. same day access, 2e. establishing guidelines for episodes of care, 2f. utilizing effective functional measures 2g. maintaining performance standards for staff.	National Council  ABHA  Behavioral Health Grantee Providers
3	Identify best practice models for increasing access to care	3a. Apply best practice models for increasing access to care 3b. The model of group therapy as a preferred best practice that improves quality of care, creates efficiency, and increases provider capacity 3c. Utilize individual clinic services to targeted diagnostic and symptomatic sequelae.	ABHA  Behavioral Health Grantee Providers
4	Increase capacity to measure system/ provider capacity to meet behavioral health needs.	4a. Develop mechanisms to define, measure, and report provider capacity	Consultants
5	Increase expectations of “timely access”	5a. Institutionalize expectations of “timely access” (i.e. Regulations vs. policy)	ABHA  Advisory Boards  Behavioral Health Grantee Providers

## Analysis

The Division uses Alaska prevalence estimates of serious behavioral health disorders, as a method to measure need for services. Prevalence estimates can be used as a benchmark to measure penetration rates of behavioral health services. These prevalence estimates provide a basis for identifying unmet needs in Alaska’s low-income household population. The Division’s FY12 penetration rate for community-based services was 52.6% for SED Youth, 73.9% for SMI Adults, and 64.2% for SUD Adults.

## Looking Ahead

The immediate landscape of behavioral health care is changing. The division will continue to pursue meaningful avenues, strategies to further expand capacity to meet the needs of Alaskans.

### Performance Measures 2.2.1.5b Percent of recipients whose wait time to access treatment is less than 7 days.

This measure tracks the amount of time it takes for clients to access follow-up community behavioral health treatment after discharge from the Alaska Psychiatric Institute (API). This follow up treatment refers to those services available at community mental health centers, physician’s clinics, primary care clinics, and private psychiatric and behavioral health practitioners. A key factor in effective discharge from API is connection to follow up community behavioral health care; API operates from an acute care model which expects continued care is necessary for further client stabilization and improvement. The optimal goal would be 100% of clients (who agree to a referral) receive follow-up care within 7 days of discharge from API.

### Strategies/Actions/ Partners/Interdependencies

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Provide follow up supports to reinforce access of continued care	1a. Consumer and Family Specialist/Peer Supporter telephone call to patient/guardian/ALF/responsible party/case manager, etc, to remind of appointments/follow-up.  1b. *Provide pocket size follow up appointment reminder card on discharge	DBH  Outpatient Providers
2	Use data to improve 30 day readmission rate & follow up.	2a. Review <30 day readmission database for patterns (provider/agency specific)  2b. Report results to provider to implement changes to improve results	Outpatient providers; DBH grantees/T&R

as indicated

### Analysis

- Create a discharge contact log
- Discharge appointment scheduling database/tracking via Meditech report; quarterly specific data to providers.

### Looking Ahead

- Create discharge database w/transitional care committee at API?
- Determine reimbursement potential for transitional care codes (CPT)

### Performance Measures 2.2.1.5c Percent of substance abuse residential treatment providers with a bed utilization rate of 85% or higher.

Alaska spends significant grant dollars in order to provide substance abuse treatment to its residents. As a state with some of the highest rates of substance abuse (alcohol and drugs use) in the nation, the Department – through the Division of Behavioral Health – has worked hard to make outpatient and inpatient (residential) treatment available. Despite these efforts, the need for substance abuse treatment far exceeds the availability of state funds to pay for the demand.

Residential treatment (where a person lives at a facility during the duration of their treatment) is designed for persons with a significant level of substance abuse addiction. It requires enrollment in a treatment program that can range from 30 to 90 days to as much as a year or a year and a half. Obviously, residential treatment is more expensive than outpatient substance abuse treatment, but it remains considerably less expensive than hospital level care for those who substance abuse has led to chronic medical problems and organ failure.

Both because of its expense and the lack of adequate numbers of residential treatment beds, the Department is anxious that the substance abuse residential provider programs that are supported by State grant dollars are managed efficiently and that the beds maintained by these treatment facilities are fully utilized. For these reasons, the Department has created a performance standard that measures the rate of utilization of substance abuse residential treatment beds.

### Strategies/Actions/Partners/Interdependencies

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Increase effectiveness of admissions screening and discharge procedures in order to ensure that a residential substance abuse treatment	1a. Using AKAIMS data, identify programs consistently below the target rate. 1b. Provide focused technical	Alaska Behavioral Health Association Individual Residential Treatment Substance Abuse Provider

<p>program achieves an average annual bed utilization rate of at least 85%.</p>	<p>assistance to the “below target” programs on effective admissions screening and discharge processes, to ensure that the recorded data is an accurate reflection of actual bed utilization.</p> <p>1c. Explore with all programs their current admission screening and discharge processes, in order to analyze those times when a vacant bed remains unfilled despite the common reliance on waitlists for enrollment in residential programs.</p>	<p>Agencies</p>
<p>2 Manage the wait lists of residential substance abuse treatment provider programs in order that the goal of 85% or higher bed annual average utilization is achieved</p>	<p>2a. Explore with all substance abuse residential treatment programs the variety of ways utilized by the programs to process their waitlists.</p> <p>2b. Share each waitlist approach with all other programs, indicating which programs / approaches have resulted in consistently maintaining bed utilization rates above the targeted 85%.</p> <p>2c. Provide technical assistance to those programs that have not maintained an active, successful waitlist, thus ensuring a steady flow of persons ready to step into a vacant residential treatment bed.</p>	
<p>3 Increase in the number of clients successfully completing the residential treatment program in which the client enrolled.</p>	<p>3a. Based on the results of the annual Behavioral Health Consumer Survey, analyze whether satisfaction with the treatment program equated to higher completion rates.</p>	

3b. Using survey data, determine whether programs with longer waitlists are likely to have lower satisfaction scores.

## Analysis

The data for this performance measure is collected by the Division's database, AKAIMS. Residential substance use treatment providers report monthly on their used bed days versus vacant (i.e., available) bed days, in order to determine the bed utilization rate for that treatment provider for the year.

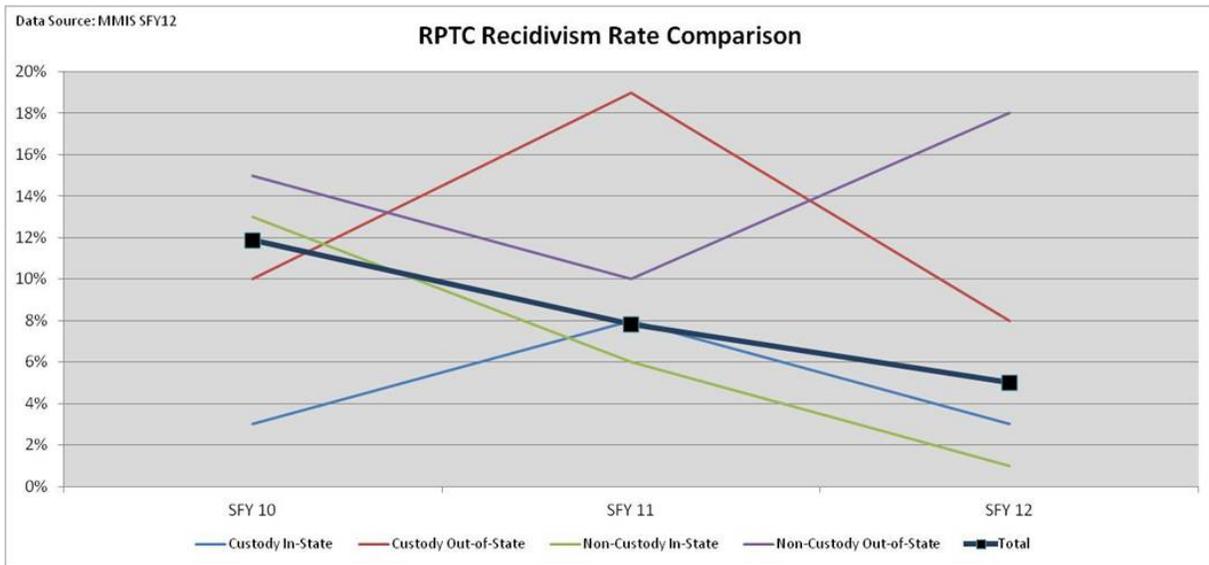
Presently, seven (7) of the current 20 substance abuse residential treatment programs are reporting utilization rates above the 85% goal, while another six (6) programs are within 5% of the target goal.

## Looking Ahead

We believe the activities listed above will greatly assist the programs that remain below the target rate to increase their utilization rates to the 85% level and above.

## Performance Measures 2.2.1.5d Percent of youth discharged from an RPTC who do not re-admit in 12 months.

As a result of the Bring the Kids Home (BTKH) initiative, capacity development, management and policy shifts, and the investment of new resources, BTKH has been successful at reforming Alaska's behavioral health system of care for children and adolescents. Many fewer children are now receiving Medicaid funded out-of-state mental health treatment. While lowering the admissions to institutional care remains a priority, in recent years the focus has changed to developing and maintaining new supports for children and their families in the community, lowering the lengths of stay, insuring successful discharges to community care and preventing readmissions to institutional care.



### Strategies/Actions/Partners/Interdependencies

The state has an overall 365-day readmission goal of 10%. The goal can be maintained by continuing efforts to support families in their communities and by isolating factors unique to the identified populations and customizing services to meet the specialized needs.

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Provide ongoing analysis to re-evaluate current residential programming and protocols	1a. Determine <i>who</i> is readmitted w/in 1 year and identify common factors leading to readmission; determine if RPTC was most valuable outcome for individual (i.e. appropriate)	Referring/treating providers ; DBH; OCS, DJJ, SDS
2	Provide ongoing strategic and targeted services to reduce readmission rates.	2a. Reduce readmit through effective d/c planning and improved care coordination with families and outpatient providers	Families, outpatient providers; case managers; care coordinators
3	Evaluate the current administrative processes for refinement	3a. Refinement of RPTC admission criteria and continued stay and discharge criteria.	Consultants

### Analysis

- 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.
  - The recidivism rate for children in state custody receiving services in Alaska was 3%.
  - The recidivism rate for children in state custody receiving services out of state was 8%
  - The recidivism rate for non-custody children receiving services in Alaska was 1%
  - The recidivism rate for non-custody children receiving services out of state was 18%
- For FY 12, of the 22 cases that experienced a readmission to a 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
- In FY2011 the rate was 8% (32 cases)
- In FY2010 the rate was 12% (35 cases)

### **Looking Ahead**

- Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska.
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate.
- Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

# Priority 3 – Safe and Responsible Individuals, Families & Communities

## CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS

### Objective 3.2.2- Decrease the rate of maltreatment in vulnerable populations

#### Performance Measures 3.2.2.1d Number of adults waiting in jail more than 24 hours for an inpatient psychiatric evaluation at API or a DET hospital.

A major concern of the Division of Behavioral Health, the Alaska Court System, the Attorney General’s Office, the Alaska Public Defender Agency, and Disability Law Center, is the length of time that a person is detained in a local jail cell because of allegations that the person expressed threats of harm to self or others or is so gravely disabled by their mental illness that they are incapable of meeting daily requirements of living. It is always the preference of the State and advocates for mental health consumers that persons experiencing a mental health crisis who are subject to court-ordered, mental health civil commitment processes, rather than being held in a jail cell, be held for evaluation in a hospital bed, a community crisis respite bed, or in the treatment room of a local primary care clinic with one on one observation. However, communities (with or without hospitals) often resort to holding the person in the safety and security of a jail cell, especially if the person at risk is highly agitated and suicidal or threatening harm to others.

It is the goal of the Division to ensure that every effort be made, when the care of a person in crisis defaults to a jail cell, that the individual who has been court-ordered to Alaska Psychiatric Institute (API) or a DET hospital (Fairbanks Memorial or Bartlett Regional Hospitals) be removed from the jail cell as soon as possible, with the goal being within 24 hours.

To that end, the State of Alaska has agreed to begin notifying the Alaska Court System whenever a person involuntarily committed for a psychiatric evaluation has not been transferred to API or a DET hospital within 24 hours of the time and date of the court commitment order. This requirement to keep the Court informed of any failure to move a person within the 24 hour time frame is a rolling requirement, meaning that the State must inform the Court every separate, passing 24-hour period until the person is finally delivered to the appropriate hospital for evaluation.

#### Strategies/Actions/Partners/Interdependencies

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Reduce the number of persons court-ordered for a 72-hour involuntary psychiatric evaluation who are held in a local jail awaiting transfer API or a DET hospital.	1a. Provide training to community agencies, including local BH agencies, around the intent of involuntary civil commitment procedures.  1b. Work with communities to find local alternative	Alaska Court System  Attorney General’s Office  Alaska Behavioral Health Association  Individual comprehensive BH centers.

	placements to the use of the local jail as a safe place to hold a person experiencing a mental health emergency.	Alaska State Troopers Local police departments Hospital Emergency Department doctors and ED RNs
	1c. Provide training to local behavioral health center clinicians and hospital emergency room doctors and staff regarding appropriate treatments for persons experiencing a range of psychiatric emergencies.	Local and regional social service agencies involved in the development of each community's plan for services and service delivery
2	Reduce the time required by a DBH-contracted secure escort company (or other emergency transport service) to transport to API or a DET hospital a person being held in jail on an involuntary 72-hour hold.	2a. Work closely with contracted companies to speed up response times.  2b. Explore alternatives to the need for hospitalization, including the use of tele-behavioral health capacities in order to conduct the required psychiatric evaluations closer to the person's home in the least restrictive setting.
		WEKA, LLC Securitas Security Services, USA Goldbelt Security Lifeflight Air Ambulance Guardian Flight Northwest Air Flight

## Analysis

In order for DBH to track its compliance with this performance measure, it will rely on data collected from API staff housed in the hospital's admission screening office (ASO). Any time a person is court-ordered to API or a DET hospital for psychiatric evaluation, a copy of the court order is faxed to the hospital. The court order always states the current known location of the person. If the person subject to the court order (the "respondent") is being held in jail pending their transfer to the evaluation facility, the court order will indicate that the respondent is awaiting transfer from jail and state the date and time of the order itself. API (and the two DET hospitals) will record this information on a form developed for this purpose and, once the respondent arrives at their hospital, the date and time of that arrival will also be noted on the form. In that way, DBH can track to the minute how long it took to remove a person being held in jail while experiencing a mental health crisis and transfer them to the more appropriate setting of a hospital for the evaluation as to need for treatment and/or continued involuntary commitment or a change to voluntary status or release.

## Looking Ahead

A major focus of this initiative will be the exploration of alternatives to jail for persons experiencing psychiatric crises. While communities with hospitals have, on its face, an obvious and preferred alternative to reliance on jail to keep the person and the community safe, even in these communities hospitals often prefer to transfer the difficult mental health patient to a jail cell rather than treat the person in the emergency department or in an acute care bed at the hospital. And, obviously, the situation is far more difficult in the majority of Alaska’s communities, where there is no hospital and the default option is to hold the person in jail until appropriate safe conduct to an evaluation hospital can be arranged and completed. It is clear that finding alternative solutions to jailing persons awaiting emergency mental health treatment depends on the level of local health and social resources available.

## CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

### Objective 3.3.1- Improve tobacco enforcement

#### Performance Measures 3.3.1.2a Vendor compliance rate with laws regulating the sale of tobacco products to youth

#### Performance Measures 3.3.1. 2b Percent of youth-accessible tobacco vendors that receive an educational visit from Tobacco Enforcement staff

The State’s Tobacco Enforcement program is committed to protecting children from the risk of smoking by reducing youth access to tobacco products. State Investigators work closely with businesses and community organizations to ensure compliance with local, state, and federal tobacco control laws. Tobacco Enforcement Investigators also ensure compliance and enforce the laws prohibiting the sale and distribution of tobacco products to minors. Activities to increase knowledge about youth access to tobacco, enforcement and compliance of retailers includes a multi-strategy approach. Materials are available for all Alaska retailers related to the state’s laws related to legal age for tobacco purchase/use, retailer responsibility to enforce youth access laws and suggestions to assist retailers in reducing violations of these laws

### Strategies/Actions/Partners/Interdependencies

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	Increase community and retailer awareness of current tobacco compliance requirements.	Provide retailer/clerk training and send materials to retailers regarding the sales of tobacco products, and health issues for youth. Using media messaging to highlight	Department of Health and Social Services / Public Health / Tobacco Prevention and Control Section, Department of Law / Commercial & Fair Business Section, Department of Commerce,

	compliance with the laws, and the annual retail violation rates of tobacco retailers throughout the state in an effort to educate and inform communities.	Community and Economic Development / Corporations, Business and Professional Licensing and The Alcoholic Beverage Control Board, Department of Revenue / Tax Division, Department of Public Safety / State Troopers, Local Police Departments, Alaska Court System, SAMHSA/Center for Substance Abuse Prevention / Division of State Programs, American Cancer Society, American Lung Association, Alaska Tobacco Control Alliance and local coalitions statewide.	
2	Increase community and tobacco vendors of the current tobacco access laws	Mail letters to all tobacco vendors annually as a reminder of the current tobacco access laws and to inform them that investigators may visit their premises to conduct undercover tobacco investigations.	Department of Health and Social Services / Public Health / Tobacco Prevention and Control Section, Department of Law / Commercial & Fair Business Section, Department of Commerce, Community and Economic Development / Corporations, Business and Professional Licensing.
3	Improve the timeliness and resolution of offenders.	Investigate and assist our partners to process suspensions for vendors convicted of selling tobacco to youths.	Department of Health and Social Services / Public Health / Tobacco Prevention and Control Section, Department of Law / Commercial & Fair Business Section, Department of Commerce, Community and Economic Development / Corporations, Business and Professional Licensing and, Department of Revenue / Tax Division, Department of Public Safety / State Troopers, Local Police Departments, Alaska Court System.

## Analysis

DBH staff conducts tobacco compliance investigation of tobacco retailers statewide throughout the year. Premise inspections/Educational visits are also conducted of statewide tobacco retailers year round. DBH staff educates local community coalitions statewide in regards to youth access to tobacco issues and help support their local issues. DBH staff help support DPH/TPC efforts.

## Looking Ahead

Work in closer partnership with DBH community grantees and Division of Public Health

Tobacco Prevention grantees to assist in educating the local community about the importance of retailer enforcement of tobacco access and sell laws. Work with Department of Law and Department of Commerce, Community and Economic Development to develop a standardized tobacco retailer seller's guide. Update vendor education materials and exploring positive rewards for vendors that do not sell tobacco to youths during investigations (example: publishing in local papers the names of vendors who do not sell tobacco to youths). Additional funds have been provided by the Alaska legislature to update and revise our current vendor education materials.

## Objective 3.3.4- Decrease inter-personal violence

### Performance Measures 3.3.4.1c Rate of Adverse Childhood Experiences among behavioral health treatment recipients

The Alaska Screening Tool (AST) is completed on all new and returning clients entering behavioral health treatment services. The AST is to inform the assessment, treatment planning, and service delivery. The AST screens for substance abuse, mental illness, co-occurring substance abuse and mental illness, traumatic brain injury (TBI), and Fetal Alcohol Spectrum Disorders (FASD). More recently, the AST was revised to include a new section on "adverse experiences" based on the findings of the Adverse Childhood Experiences (ACE) study.

The ACE's study, conducted by Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) established a strong correlation between ACE's and the likelihood of experiencing physical-medical, mental health and addiction issues later in life. Research demonstrates that traumatic (adverse) childhood experiences are risk factors for unhealthy behaviors and illnesses, such as

- Adolescent pregnancy
- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity

The AST upgrade to include ACE's recognizes the clinical value in identifying contributing experienced stressors that can functionally predict the risk and presenting needs to be addressed in treatment. For example,

- Treatment recipients could receive an inventory assessment of risk for past and current exposure to adverse experiences and interpersonal violence.
- Adult and children services could include family treatment, as is appropriate.

- Treatment is informed by “trauma-informed” models of intervention
- Issues of access to preventive and restorative health care are addressed.

**AST Adverse Experience by Population Types**  
7/1/2012 – 6/30/2013

# of Adverse Experiences	Substance Use Disorder		General Mental Health		Severe Mental Illness		Severe Emotional Disturbance		Co-Occurring Disorders		Other		Total Clients	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
0	1,578	27.03	679	29.12	507	16.69	299	21.94	105	21.00	388	27.34	3,556	24.54
1 to 2	1,615	27.67	660	28.30	735	24.20	356	26.12	140	28.00	447	31.50	3,953	27.28
3 to 4	1,214	20.80	515	22.08	702	23.11	346	25.39	109	21.80	298	21.00	3,184	21.98
5 to 6	840	14.39	324	13.89	703	23.15	239	17.53	99	19.80	185	13.04	2,390	16.50
7 to 8	590	10.11	154	6.60	390	12.84	123	9.02	47	9.40	101	7.12	1,405	9.70
	5,837		2,332		3,037		1,363		500		1,419		14,488	

**Strategies/Actions/ Partners/Interdependencies**

The performance measure 3.3.4.1c of ACE’s among behavioral health treatment recipients are directly aligned with the DHSS objective 3.3.4 – Decrease interpersonal violence. The Alaska Screening Tool measurement of adverse experiences includes the following related categories:

- I have lived with someone while they were physically mistreated or seriously threatened
- I have been physically mistreated or seriously threatened

The early identification provides important clinical value in identifying a principle threat that can undermine the safety, wellbeing and impacts on the outcomes of treatment for an individual. Applying the role and impacts of ACEs on an individual can be further applied within a “trauma informed” treatment setting. The Division intends to implement the following strategies and action steps:

	<u>Strategies</u>	<u>Actions</u>	<u>Partners</u>
1	increase awareness of ACEs and their impact on behavioral health and overall well-being	1a. Collect and report Alaska-specific data on the relationship between ACEs and health outcomes	DVSA Statewide Planning HCS: Medicaid Data
2	increase assessment of and application of ACEs into behavioral health treatment practice and settings,	2a. Increase the numbers of “preferred providers” trained in trauma informed care  2b. Expand family services to all SED children/youth, as is	BH Providers, Advisory Boards, Trust,  Alaska Behavioral Health Association

		appropriate.	
		2c. Target all adults in treatment services with ACES assessment of household landscape and risks and vulnerabilities.	
3	Enhance the capacity of communities to prevent and respond to ACEs	3a. Target DV/SA victim's providers to fast-track access to treatment services.	DV/SA Victim Providers

## Analysis

- For Fiscal Year 2013:
  - 14,488 clients were screened with the Alaska Screening Tool
  - Approximately 75% of all clients screened reported one or more ACE's.
  - Clients with a presentation of "general mental health" reported the lowest rates of ACE's (70.87%).
  - SMI adults proportionately experienced the highest rates of ACE's (83.3%)
- The specific adverse experiences of clients are also important. While the most reported adverse experience for any age group is "having lived with an addicted person" (44% children – 57% adults), a significant proportion have lived with someone who is physically abused, or been physically abused themselves. Rates are highest for clients in treatment for Mental Health or Co-occurring Disorders.
  - 38% of children have lived with an abused person, and 25% have been abused
  - 31% of youth have lived with an abused person, and 27% have been abused.
  - 35% of adults have lived with an abused person, and 46% have been abused.
- It is clear that the cycle of abuse is passed on, that treatment is important to interrupt the cycle and significant attention to prevention and early intervention is warranted.

## Looking Ahead

As the behavioral health prevention and treatment system continues its efforts to deepen the level of providers and policy makers trained in trauma informed treatment, the opportunities for individuals affected by this will begin to decrease. We know that unless we can impact the underlying trauma history of the clients – we cannot move them out of the self-destructive life patterns that led them to seek assistance. First statewide sponsored Trauma Conference was very well attended by providers, we are putting Trauma 101 on line for ease of access for rural providers, and we are just developing Trauma 201 curriculum.

## Division Information

Division of Behavioral Health

3601 C Street, Suite 878

Anchorage, Alaska 99503-5924

**Tel** Main: 907.269.3600

Toll Free: 800.770.3930

**Fax** 907.269.3623

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

## Division Performance Measure Contact

Melissa Stone, Director

3601 C Street, Suite 878

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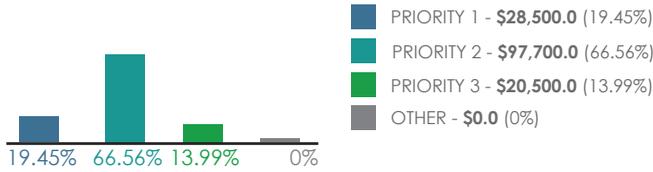
Toll Free: 800.770.3930

**Fax** 907.269.3623

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

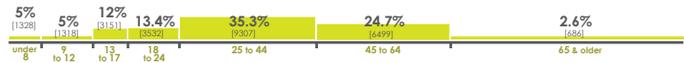
# DIVISION of BEHAVIORAL HEALTH | SPENDING BY PRIORITY (FY2014)

\$146,513.4 TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

[Total service population 26,329 individuals. 2% of adults (508), age unknown.]



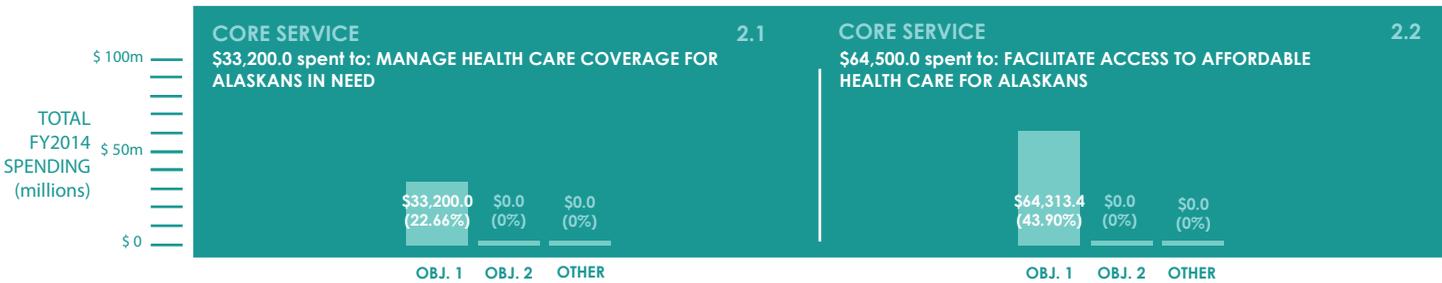
## SNAPSHOT OF ALASKANS SERVED

Alaskans who experience serious behavioral health disorders, including children and youth experiencing severe emotional disturbance, adults experiencing serious mental illness and youth and adults experiencing substance abuse disorders or co-occurring disorders. Service settings include community-based settings, Alaska Psychiatric Institute (API), and hospital psychiatric inpatient - designated evaluation and treatment/stabilization (DET/DES).

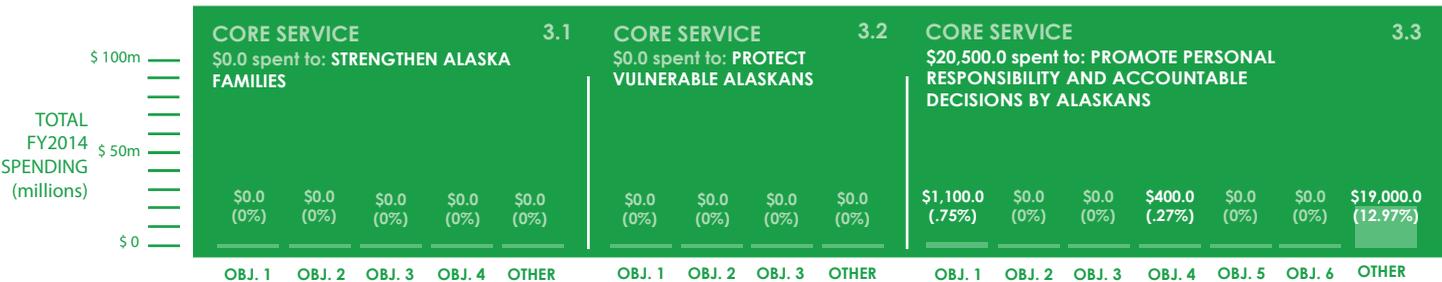
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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# Explanation of FY2015 Operating Budget Requests

## Division of Behavioral Health

### Budget Overview Table

Division of Behavioral Health	FY2014	FY2015 Gov	Difference
Unrestricted General Funds	\$81,252.9	\$76,792.7	\$-4,460.2
Designated General Funds	19,607.5	19,606.4	-1.1
Federal Funds	12,031.7	11,821.4	-210.3
Other Funds	33,621.3	32,321.0	-1,300.3
<b>Total</b>	<b>\$146,513.4</b>	<b>\$140,541.5</b>	<b>\$-5,971.9</b>

DHSS FY2015 Governor's Request - Behavioral Health General and Other Funds (Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)					
Item	UGF	DGF	Federal	Other	Total
Reverse Alaska State Employees Association One-Time Payment (ASAP, Admin, RCC, API, AKMHADAB, SPC)	\$ (92.8)	\$ (5.3)	\$ (11.3)	\$ (138.7)	\$ (248.1)
FY2015 Health Insurance and Working Reserve Rate Reductions (ASAP, Admin, RCC, API, AKMHADAB, SPC)	\$ (41.1)	\$ (1.7)	\$ (5.2)	\$ (53.5)	\$ (101.5)
FY2015 Salary Increases (ASAP, Admin, RCC, API, AKMHADAB, SPC)	\$ 123.7	\$ 5.9	\$ 15.4	\$ 179.0	\$ 324.0
Reverse Alcoholic Beverage Tax Revenue Sec23 Ch17 SLA2012 P178 L9 (BHG)	\$ (3,000.0)	\$ -	\$ -	\$ -	\$ (3,000.0)
Reverse Telehealth Strategic Capacity Expansion, Phase II	\$ (100.0)	\$ -	\$ (100.0)	\$ -	\$ (200.0)
Reverse FY2014 MH Trust Recommendation (BHG, BHA, SSM I, SSEDY, API, AKMHADAB)	\$ -	\$ -	\$ -	\$ (1,551.2)	\$ (1,551.2)
MH Trust: Housing - Grant 1377.07 Assisted Living Home Training and Targeted Capacity for Development (FY14-FY16) (BHG)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
MH Trust: Dis Justice - Grant 2819.05 Pre-Development for Sleep-Off Alternatives in Targeted Communities (FY15-FY17) (BHG)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
Reverse Three Year Federal Tobacco Enforcement Contract to Conduct Tobacco Vendors Compliance Investigations (FY14-FY16) (Admin)	\$ -	\$ -	\$ (650.0)	\$ -	\$ (650.0)
Reverse MH Trust: Housing - Grant 383.09 Office of Integrated Housing (FY14-FY16) (Admin)	\$ -	\$ -	\$ -	\$ (225.0)	\$ (225.0)
MH Trust: Housing - Grant 383.10 Maintain Office of Integrated Housing (FY14-FY16) (Admin)	\$ -	\$ -	\$ -	\$ 229.0	\$ 229.0
Replace Incoming Data Infrastructure Grant with a Contract (BHA)	\$ -	\$ -	\$ (133.0)	\$ 133.0	\$ -
Reduce Expenditure Level (Admin, SSEDY)	\$ (900.0)	\$ -	\$ (31.3)	\$ -	\$ (931.3)
Reverse Alaska Complex Behavior Collaborative Hub (SSM I)	\$ (450.0)	\$ -	\$ -	\$ -	\$ (450.0)
Reverse MH Trust: Housing - Grant 575.08 Bridge Home Program & Expansion (FY14-FY16) (SSM I)	\$ -	\$ -	\$ -	\$ (750.0)	\$ (750.0)
MH Trust: Housing - Grant 575.09 Bridge Home Program & Intensive Services for Community Integration (FY14-FY16) (SSM I)	\$ -	\$ -	\$ -	\$ 750.0	\$ 750.0
MH Trust: Housing - Grant 604.09 Department of Corrections Discharge Incentive Grants (SSM I)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
Replace Capital Improvement Project Receipt Authority to Support a Family Therapy and In-Home Grant (SSEDY)	\$ -	\$ -	\$ 705.1	\$ (705.1)	\$ -
MH Trust: Cont - Grant 2467.05 Impact Model of Treating Depression (API)	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
MH Trust: Cont - Grant 605.09 ABADA/AMHB Joint Staffing (FY15-FY17) (AKMHADAB)	\$ -	\$ -	\$ -	\$ 457.2	\$ 457.2
<b>Behavioral Health Total</b>	<b>\$ (4,460.2)</b>	<b>\$ (1.1)</b>	<b>\$ (210.3)</b>	<b>\$ (1,300.3)</b>	<b>\$ (5,971.9)</b>

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# BUSINESS PLAN (2013-2015)



## OFFICE OF CHILDREN'S SERVICES

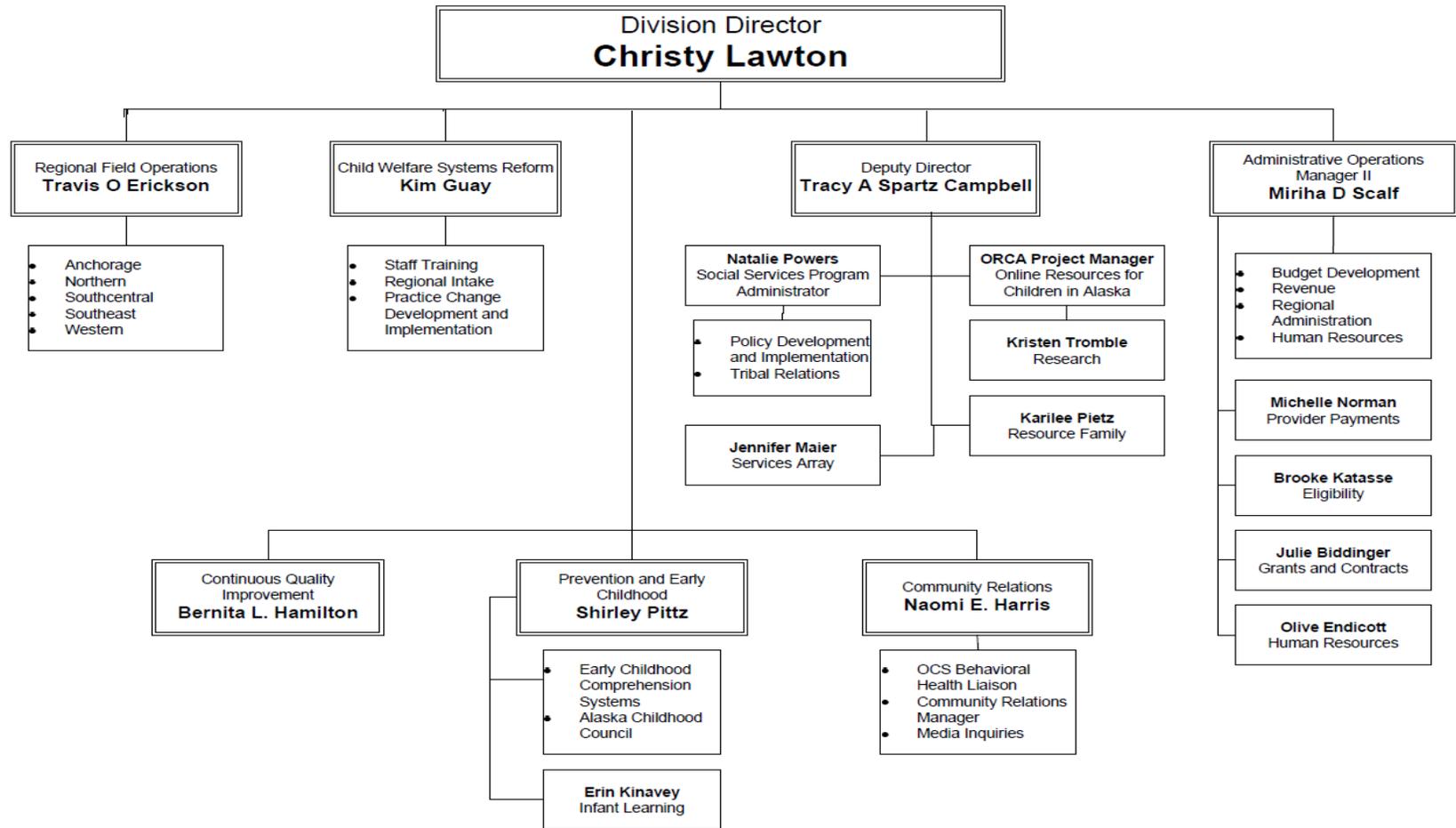
**MISSION:** To work in partnership with families and communities to support the well-being of Alaska's youth and children.

# Contents

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# Organization Chart

## Alaska Department of Health and Social Service Office of Children's Services



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# Introduction

## PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

### **The Mission of the Office of Children’s Services**

Work in partnership with families and communities to support the well-being of Alaska’s youth and children. Services will enhance families’ capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential.

### **The Vision of the Office of Children’s Services**

Safe Children, Strong Families

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## PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

### **The Values of the Office of Children’s Services**

***Keeping Children Safe:*** We are committed to responsive and timely assessment of child safety in Alaska.

***Strengthening Families:*** We effectively engage families in developing and insuring safety of children within their homes.

***Respect:*** Families and children will be treated with dignity and respect, with significant consideration to the family’s values and culture.

***Equity:*** We are committed to reducing the disproportionate and disparate number of children and families of Alaska Native heritage engaged in services with OCS.

***Community Partnerships:*** We are committed to building strong community partnerships that will support efforts to insure safety and well-being for children in Alaska.

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## PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

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## The Office of Children’s Services’ Core Service Areas

### PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

#### CORE SERVICE 1.1

Protect and promote the health of Alaskans

#### CORE SERVICE 1.2

Provide quality of life in a safe living environment for Alaskans

The Office of Children’s Services is mandated through Federal and State law to serve children and families, through the core service areas of safety, permanency and well-being. OCS utilizes these core service areas as the foundation of client services, programs and agency direction for front-line staff.

#### 1. *Safety*

Children have a right to be safe. The Office of Children’s Services engages with parents to keep children safe in their home, through initial and ongoing assessments of safety. Assessment is embedded in the primary prevention and early intervention services prior to custody, and continues at the point of intake when a report of maltreatment is received by OCS. Should an out of home removal be necessary, child safety continues to be monitored while the child resides in out-of-home care. First, and foremost, child safety is a paramount concern, throughout the life of a case.

#### 2. *Permanency*

Every child deserves a permanent home, preferably with their parents. The Office of Children’s Services is committed to reunification as the first permanency goal contemplated for every child. If a child is not able to remain safely in the parents’ home, the Office of Children’s Services will seek an alternate permanent home through adoption or guardianship with relatives or adult family friends as our first priority. If permanency with relatives is not possible, unrelated adult(s) who have demonstrated the desire and commitment to the child’s safety may be selected as a permanent home for children. In all permanency situations, efforts are made to help maintain the child’s important familial and cultural connections.

#### 3. *Well-being*

Every aspect of a child’s well-being must be considered to insure positive results for the child and family. The Office of Children’s Services assesses the well-being needs of children, including their developmental, physical, mental health, and educational needs. The impacts of trauma for the child and family are also assessed. When feasible and appropriate, decisions will be made in conjunction with the child’s parents. Additionally, the Office of Children’s Services insures the continuity of the child’s connections to siblings, family, community, and culture, while the child is in our care.

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### PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

#### CORE SERVICE 2.1

Manage health care coverage for Alaskans in need

#### CORE SERVICE 2.2

Facilitate access to affordable health care for Alaskans

---

### PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

#### CORE SERVICE 3.1

Strengthen Alaska families

#### CORE SERVICE 3.2

Protect vulnerable Alaskans

#### CORE SERVICE 3.2

Promote personal responsibility and accountable decisions by Alaskans

## Office of Children's Services Overview

The Department of Health and Social Services, Office of Children's Services serves families at various points in the service continuum. From primary prevention or early intervention services to children at risk of maltreatment, to children who have been determined at the intake (or investigation) stage to be unsafe, or at high risk of maltreatment, by their parent or caregiver. Fundamental to the provision of OCS services is that every family served will be treated with dignity and respect, and with consideration to their family and cultural values. Intervention and services to families will always be done in the least restrictive, least intrusive and most sustainable manner possible. In the case of Alaska Native or American Indian children, the diligent compliance with the Indian Child Welfare Act (ICWA) is critical and can only be done through full partnerships with Tribes and Tribal organizations associated with the child's family.

The Office of Children's Services utilizes the OCS Practice Model as a family intervention system with a focus on child safety. The Office of Children's Services' Practice Model focuses on those families where a formal intervention by the state is necessary. It seeks to bring clarity and purpose to child protective services and establishes clear parameters for the safety determinations as well as other key decision points, along with how families are to be treated within this framework. Child safety is the determinate at each key decision point throughout OCS' involvement with the family from intake to case closure. This model emphasizes a strengths-based, family-centered approach through the standardization of information gathering, enhanced assessment and critical thinking skills by the OCS staff. The OCS Practice Model seeks to operate in a less incident-driven manner, and instead looks at the overall functioning of the family. Decisions regarding needed interventions with families are based on thorough processes for initial and ongoing assessment of safety, risk, and protective capacities.

The Office of Children's Services' Practice Model is grounded in the following principles:

- A child's safety is paramount.
- A determination that safety threats are present within a family does not equate with removal of a child from their home. The assessment of safety threats directs staff to make informed decisions about safety planning that will control and manage the threats identified. Relevant services will be sought with respect for and understanding of the families' culture and specific needs.
- Partnership and collaboration with Alaska Native Tribes is fundamental to best practice.
- Families are treated respectfully, thoughtfully and as genuine partners.
- A person's right to self-determination is valued and supported.

- A safety intervention system is congruent with strengths-based and family-centered practice. Assessing for the safety of children is what we do; family-centered practice is how we do it.
- In collaboration with the family, interventions are identified using the family's perspective about what needs and strengths exist by engaging the family.
- By engaging in a collaborative problem-solving process with the family, case plans will be specific to the uniqueness of each family served.
- Enhancing parent/caregiver protective capacities are essential for the ability of families to protect their children.
- The Office of Children's Services needs partnerships within the community and stakeholders to achieve strong outcomes for children and families.

Additionally, the Office of Children's Services' Practice Model works in concert with the seven federal outcomes required of all 50 state child protection agencies.

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

The Office of Children's Services Practice Model outlines six core programmatic components within OCS.

- ***Prevention and Early Intervention:*** Prevention and early intervention works to engage families of young children prior to, or at the point of, the first Protective Services Report to OCS. Prevention and early intervention services are focused on developing and engaging families in services to prevent intake into the OCS child protection system.
- ***Intake:*** is the process of receiving and screening reports of allegations of child maltreatment, called a Protective Services Report (PSR), to determine whether a response is required by child protective services.
- ***Initial Assessment:*** An initial assessment requires OCS to go beyond whether the reported allegations are substantiated or not substantiated. The Initial Assessment requires the gathering of information to make an informed decision about whether the child is safe, unsafe, or at high risk by the parent/caregiver.

The initial assessment serves as the foundation for building the ongoing assessment of safety and the development of a case plan, and establishes parents as an equal partner in that process.

- **Family Services:** Family services works with families in need of on-going services and supports to insure child safety. The Family Services Assessment is utilized to assess safety, permanency and well-being for the child. At this stage, the family's progress with the case plan and child safety factors become critical in determining when and how the child will return to the parents' home. Familial, community and Tribal partners are key resources to families at this stage. If parents are unable to show progress with case planning and child safety at this juncture, OCS will then pursue alternative permanency planning through adoption or guardianship.
- **Resource families:** When out-of-home placement is needed to keep the child safe, OCS will make diligent efforts to identify, evaluate and consider relatives, family friends and those culturally tied to the family as the primary placement option. When relatives cannot be a placement option for the child, OCS will make efforts to actively recruit and support foster families within the child's home community and in as close proximity as possible to the child's parents, to assure that the child may continue to maintain important and lasting cultural, familial, educational and community-based connections.

The resource family component of OCS works to insure that critical child safety factors are assessed and evaluated within each relative, foster care, guardianship or adoptive home from placement through permanency. Key components are the foster care licensing and adoption or guardianship home study assessments of resource families.

- **Service Array:** is the component of community-based services that OCS provides through professional services contracts or grants. The services are aimed at meeting the needs of all children and families that come to the attention of the child protective services system, and to provide the necessary services and supports towards reunifying families.

The Office of Children's Services has an annual budget of \$140,518,000 to provide child protection services and resources across Alaska. The Office of Children's Services has five service regions with regional headquarters in Anchorage, Bethel, Fairbanks, Juneau and Wasilla, with a total of 497 employees.

# Priority 1 – Health & Wellness Across the Lifespan

## CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

### Objective 1.2.1- Improve the safety of children receiving department services

#### Performance Measures

Performance Measure 1.2.1.1a – Percent of screened-in reports of child abuse/neglect that are screened within one day

Performance Measure 1.2.1.1b –Cost per screening per intake worker.

Performance Measure 1.2.1.2a – Percent of child abuse/neglect assessments (investigations) that are initiated within required timeframes

Performance Measure 1.2.1.2b – Percent of assessments (investigations) completed timely

Performance Measure 1.2.1.3a – Percent of children in out of home care who receive a required monthly case worker visit

Performance Measure 1.2.1.3b – Cost per case worker visit

#### Strategies/Actions

The Office of Children’s Services has utilized many strategies and action steps to improve the safety of children receiving department services. Starting with prevention and early intervention, OCS has developed responsive and timely early intervention referrals and services for at-risk children 0-8 years. Additionally, through the embedding of the Strengthening Families protective factors, efforts for improving parental outcomes at a community-based level are pursued.

OCS has been transitioning intake and screening services within OCS to standardized regional intake services in each of the OCS service regions. By regionalizing the intake processes, there can be better consistency and effectiveness in responding to protective services reports statewide.

At Initial Assessment, the importance of quality supervisory monitoring and oversight with a focus on enhancing workers’ critical thinking skills is necessary to insure that sound, evidence-based decisions are being made in the initial assessment process. Providing safety assessments for children who remain in the parents’ care, with periodic review that the child continues to be safe in the home, are of importance of supervisory monitoring oversight.

National standards indicate a direct correlation between regular case worker visits with children and parents, with successful outcomes for the child and family in reunifying timely and permanently. OCS has identified as a priority,

assistance and monitoring of case workers with scheduling and maintaining monthly case worker visits to every child.

As a part of our continuous efforts to improve safety outcomes for children, OCS utilizes Field Office Performance Improvement Plans (FO-PIP) to target practice needs in an effort to sustain qualitative improvements to OCS practice. Likewise, child protection and licensing staff work at enhancing joint efforts in assessing safety of relative care and foster families at or before the point of placement of a child.

As a part of improving assessment of relative care and foster families, OCS will work towards implementing the Confirming Safe Environments curriculum to all OCS field and licensing staff. OCS is currently working in partnership with the Division of Public Assistance to analyze the use of TANF resources for relative foster families at the point of child placement.

### **Partners/Interdependencies**

The Office of Children's Services relies on close relationships with a wide range of partners and interdependencies to improve the outcomes for children and families of Alaskans. These partnerships are at various levels including inter-departmental, community-based and Tribal partnerships.

Child Protective Services workers partner with the Infant Learning Program for the early identification of very young children with developmental, cognitive and physical delays, for early intervention. Additionally, utilizing and coordinating with the Strengthening Families programs in Alaska, to improve community-based outcomes for families and children, rely heavily on strong community partnerships statewide.

The Tribal-State Collaboration Group (TSCG) which is made up of representatives of OCS, the Office of Public Advocacy, the Attorney General's Office, and many Tribal agencies that represent all regions of Alaska, is a long-standing partnership in which the positive outcomes for children and families are at the forefront. This group focuses on improving safety, permanency and well-being outcomes for children of Alaska Native heritage who are in the custody of the Office of Children's Services. A significant focus of this group is the reduction of disproportionality and disparity of Alaska Native children who are in the custody of OCS.

As a part of the Tribal partnership work, the Office of Children's Services has been actively working on the development of the federal Title IV-E pass-through agreements, with Alaska Village Council Presidents, Bristol Bay Native

Association, Tanana Chiefs Conference, and Central Council Tlingit and Haida Indian Tribes of Alaska.

The Court Improvement Project, a partnership of legal partners (e.g. Alaska Court System, Attorney General's Office, the Office of Public Advocacy, the Public Defender's Office, and the Office of Children's Services) focuses on improving the legal options, processes and outcomes for families with children in custody.

The Resource Family Advisory Board is a group of current and former foster, adoptive and guardianship families who are working in partnership with the Office of Children's Services on improved processes for the OCS resource family system, with a focus on improving outcomes for children in custody.

Multi-Disciplinary Teams (MDTs) are a community-based partnership in which representatives for the medical community, law enforcement, child protection, and the Tribal community work jointly on investigations of child physical and sexual abuse. Children are seen at the Child Advocacy Center, where forensic interviews and medical exams can occur within a child-friendly environment.

Internal to DHSS, partnerships include work on the Title IV-E waiver with the Divisions of Behavioral Health, Public Assistance, and OCS. Additionally, the DHSS Leadership and the Joint Management Team focus on intra-departmental partnerships across divisions on specific initiatives.

## **Analysis**

The Office of Children's Services is in the last year of a detailed five-year plan, called a Child and Family Services Plan (CFSP) which is mandated by federal law through the Administration for Children and Families. The Child and Family Services Plan outlines comprehensive systems improvements that are designed to improve safety, permanency and well-being outcomes for children and families alike. In SFY2014, the Office of Children's services will begin the development of another five-year plan to cover the period from 2015-2020.

During the previous five years, OCS had significantly enhanced its use of evidence-based, data-driven systems improvements through a Continuous Quality Improvement (CQI) process. Each of the 26 OCS offices is subject to case reviews that are selected through a random sample process. Review outcomes are then reflected in regional and field office performance improvement plans (FO-PIPS). Improvements have been shown in the areas of reduced placement changes for children, improved stability of placements for children, improved permanency outcomes for older youth, better partnerships on individual cases, and improved well-being for children in custody by

maintaining cultural, familial and social connections. As OCS continues to focus on data-driven practice, we anticipate seeing continued improvements in many areas of our practice.

In recent years, OCS has established regional intake staff and services in three of our five service regions. Regional intake has allowed for initial referrals to the agency, known as protective services reports (PSRs), to be screened utilizing standardized processes for screening, recording and tracking the PSRs.

### **Looking Ahead**

The Office of Children's Services will continue to build on strong relationships with partners and analyze the effectiveness of existing interventions and programs, as well as look for new projects and interventions which may improve child safety in Alaska. As we continue to strive towards improvements in child safety, permanency and well-being, OCS has identified the areas of high priority as: increased child safety for children in out of home care, reduced use of prescribed psychotropic medications for children in custody, and a stronger focus on trauma-informed care.

## Priority 2 – Health Care Access, Delivery and Value

### CORE SERVICE 2.1 MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED

#### Objective 2.1.1- Increase the number of Alaskans with a primary care provider

##### Performance Measures

Performance Measure 2.1.1.1b - Cost to provide health care services per client

##### Strategies/Actions

The Office of Children’s Services is federally mandated to monitor aspects of a child’s well-being while in care. The federal well-being outcomes outline a child’s education, mental and physical health, as well as the maintenance of a child’s familial, cultural and social connections as primary areas of emphasis. OCS field staff and supervisors must address ways by which each of these areas will be addressed for the child on the case plan. OCS is committed to insuring that a child’s well-being is assessed and evaluated with the same level of scrutiny and concern as the on-going assessments for safety.

The Office of Children’s Services contributes efforts to assure that young Alaskans have access to health care through timely screening and referrals. As part of the OCS implementation of trauma-informed services, children are screened by OCS workers for Adverse Childhood Experiences (ACEs) and signs of trauma. Additionally, within the first 30 days of entering care, children receive an Early Periodic Screening, Diagnosis and Treatment (EPSDT) well-child exam and follow-up exams as indicated by the EPSDT “periodicity schedule”. Children, birth to three, with substantiated reports of harm are automatically referred to local early intervention/Infant Learning Programs for screening and evaluation.

Referrals for health, mental health, and educational services are made for needed follow-up services. OCS provides coordination of Medicaid billing and services for children in need of residential services or psychiatric residential care. Prescribed use of psychotropic medication is tracked and monitored for children in custody. In partnership with the local school district, OCS ensures that children receive the necessary educational services and supports to be successful in the school setting.

Mental health and substance abuse referrals for parents are made as deemed necessary. OCS places significant emphasis on familial, cultural and social connections for children of Alaska Native heritage, as a part of our focus on well-being outcomes.

## **Partners/Interdependencies**

Improved access to primary services for children and families in the OCS system cannot occur without the effective involvement of the medical and mental health professionals in our communities, regions and within the department. OCS relies on the following partnerships to assist families and children with adequate access to primary care.

- Given that sixty percent of the children in OCS custody are of Alaska Native heritage, OCS relies heavily on the Indian Health Service clinics and hospitals, located throughout Alaska, as primary care resources for children and families.
- Infant Learning Programs collaborate with local child protection staff to identify very young children in need of developmental and medical screenings as soon as possible for children between 0-3 years of age.
- OCS, the Division of Behavioral Health and Health Care Services collaborate on medical-necessity determinations for children in need of residential or psychiatric residential care. Additionally these partners have developed a departmental response to track and monitor all children in custody who are on psychotropic medications.
- The Alaska Mental Health Trust and OCS support early childhood mental health grantees to provide mental health consultation and training for programs serving young children.
- OCS is partnering with the Division of Behavioral Health, as well as other state agencies in the pursuit of a Federal Title IV-E waiver, focusing on the most complex cases where parental mental health and substance abuse are impacting child safety.
- OCS facilitates a cross-divisional Developmental Screening and Brief Behavioral Services Project to increase standardized developmental screening and identification of “at-risk” children during well-child exams.
- The Office of Children’s Services is a partner in the statewide Child Injury and Fatality Team, along with the Division of Public Health, the State Medical Examiner’s Office, the Department of Public Safety, and others.

## **Analysis**

Well-being outcomes continue to be a significant area of focus of the Office of Children’s Services. However, the effectiveness of well-being outcomes is impacted by the inadequate number of primary health care and mental health

services available to meet the timely need of parents and children. This is particularly acute in the rural communities where services and resources generally are scarce, and/or can only be accessed at great, geographical distance. Additionally, there is a high turnover of service providers in many areas of the state.

### **Looking Ahead**

The Office of Children's Services commitment to improving the well-being of children in our custody is driving our efforts to provide trauma-informed care. Trauma-informed care will require that service providers statewide recognize, as a part of a family or child's treatment and services, the impacts of past trauma on the services and treatment received. The landmark ACES (Adverse Childhood Experiences Study) has identified that trauma at a young age affects outcomes later in life. The impacts cut across all divisions within the department, and therefore, require a departmental focus for change. OCS will continue the work with departmental and community-based partners in this focus on trauma-informed care.

# Priority 3 – Safe and Responsible Individuals, Families & Communities

## CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS

### Objective 3.2.1- Decrease the rate of maltreatment in children

#### Performance Measures

Performance Measure 3.2.1.1a – Percent of Alaskan children with substantiated reports of abuse or neglect

Performance Measure 3.2.1.1b – Cost per completed investigation

Performance Measure 3.2.1.2a – Percent of children discharged from out of home care who are reunified with their parents

Performance Measure 3.2.1.2b – Percent of children who re-enter out of home care within twelve months

#### Strategies/Actions

One of the most vulnerable populations that the department serves is children. Young children often cannot advocate or articulate what experiences they have had related to their own safety and are completely dependent upon adults to protect and nurture them toward healthy adulthood. When children are unsafe in their parents' care, the Office of Children's Services is contacted, and performs an assessment of the child's safety and family functioning. When necessary, protective actions are taken to ensure the child's safety and remedial services are provided to assist parents in creating and maintaining a safe home environment for their child.

To successfully fulfill the obligations of the organization, the Office of Children's Services is undertaking a number of service improvements including: 1) creating region-based intake processes to ensure timely, consistent and effective screening of all protective services reports; 2) emphasizing timely and accurate completion of initial assessments to determine if a child is unsafe or at risk of maltreatment; and 3) implementing timely and accurate Family Services strategies that are family-centered and behaviorally-based assessment and case planning.

In addition, with recognition that child protection is dangerous work and that the Office of Children's Services workforce needs to be assured safety within their work environment, OCS will continue to implement safety strategies for the workforce statewide.

Finally, the Office of Children's Services will implement the Title IV-E Performance Improvement Plan aimed toward increasing the number of licensed homes meeting the Title IV-E safety standards and improving the federal reimbursement funding levels.

### **Partners/Interdependencies**

The Office of Children's Services views each family as a partner in the care of their children and works diligently to use existing family strengths and supports to maintain a child safely in their parents' care. Additionally, OCS relies on community-based and Tribal agencies to assist with reporting and intervening with families in a culturally appropriate manner.

Alaska's mandated reporter law requires professions such as counselors, educators, mental health professionals, social service providers, and others, to report suspected child abuse or neglect to the Office of Children's Services. These reports are vital to the timely response for an unsafe child. Additionally, where available, the Office of Children's Services uses collaborative approaches such as Team Decision Making when selecting the best placement for a child, and coordinates investigation of protective services reports through Child Advocacy Centers where comprehensive, multi-disciplinary evaluations can be conducted simultaneously.

### **Analysis**

Protective Services Reports continue to be received at a steady rate and there is no indication this trend will change in the foreseeable future. Difficult social and economic factors have compounded the frequency and severity of the reports of abuse or neglect to the Office of Children's Services. The Office of Children's Services has elected to utilize multiple strategies to intervene with, and respond to, families as quickly and effectively as possible.

### **Looking Ahead**

The Office of Children's Services has adopted a Continuous Quality Improvement philosophy, and strives to continually improve the speed, accuracy, efficiency and quality of the services provided. The organization continually seeks proven strategies to better respond to reports of child abuse and neglect, help families develop the ability to safely care for their children, and ultimately and improve the safety, permanency and well-being of children.

### **Objective 3.2.3- Improve client safety within department and provider operated facilities**

#### **Performance Measures**

Performance Measure 3.2.3.3a – Percent change in the number of fully licensed foster care homes

Performance Measure 3.2.3.3b – Rate of child abuse/neglect in out of home care

#### **Strategies/Actions**

The OCS Resource Family Section is directly responsible for the licensing of all foster homes in Alaska. The foster care licensing standards are outlined in regulations that are shared with the Divisions of Public Assistance and Health Care Services who license facilities for vulnerable Alaskans. Timeframes for response for licensure, renewal and for enforcement actions are clearly outlined in statute and regulation.

OCS has developed and is utilizing tracking tools to track the timeliness to full licensure of a foster home; active investigations of currently licensed foster homes; current enforcement and criminal background safety checks of foster homes, inclusive of fingerprint-based checks. When safety concerns are identified or reported, the OCS licensing staff conducts joint foster home investigations with child protection staff, to insure that children remain safe in a foster home setting...

OCS is currently developing a standard assessment of resource families that outlines a continued assessment of child safety in the home of an unlicensed relative caregiver or a licensed foster care provider while the child resides in the home.

#### **Partners/Interdependencies**

The foster care licensing staff partners with the OCS child protection staff when investigating foster homes in which there are allegations of child abuse or neglect. Additionally, the foster care licensing staff works in partnership with other DHSS licensing divisions on joint investigations with other licensed facilities.

#### **Analysis**

Foster care licensing is a vital service of the Office of Children's Services in our work to insure child safety. Safety of children in foster homes is continually assessed through criminal background checks, child protection checks, and physical safety checks of the licensed home.

### **Looking Ahead**

OCS will continue to partner with the child protection staff on foster home licensing investigations in our efforts to keep children safe.

## CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

### Objective 3.3.4- Decrease inter-personal violence

#### Performance Measures

Performance Measure 3.3.4.1b - Cost of implementing domestic/interpersonal violence assessment and safety card methodology

#### Strategies/Actions

According to state statute, OCS workers are responsible for domestic violence screening and the distribution of safety information to victims of domestic violence. During the Initial Assessment phase of a case, OCS case workers are required to assess the family for domestic violence and if it is determined to be present, they are request to present the victim with written notice (Domestic Violence Safety Card) of rights, and services that are available.

OCS has incorporated the distribution of the safety cards, into our standard policies and procedures to promote consistency with this practice.

#### Partners/Interdependencies

The Office of Children's Services worked in partnership with the Council on Domestic Violence and Sexual Assault in the drafting of the safety cards. The Safety Cards contain community specific information about local victim services and information regarding how to obtain a protective order.

#### Looking Ahead

OCS will continue the practice of distributing the safety cards to victims of domestic violence.

## Division Information



Alaska Office of Children's Services  
130 Seward Street, Ste. 406  
Juneau, AK 99801

P.O. Box 110630  
Juneau, AK 99811-0630

Tel (907) 465-3191  
Fax (907) 465-3397  
<http://dhss.alaska.gov/ocs/Pages/default.aspx>

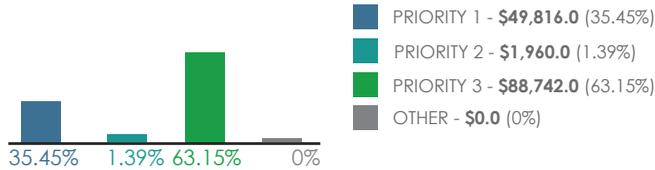
## Division Performance Measure Contact

Naomi Harris, Community Relations Manager  
P.O. Box 110630  
Juneau, AK 99811-0630  
Tel (907) 465-3548  
Fax (907) 465-3397

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# OFFICE of CHILDREN'S SERVICES | SPENDING BY PRIORITY (FY2014)

\$140,518.0 TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION



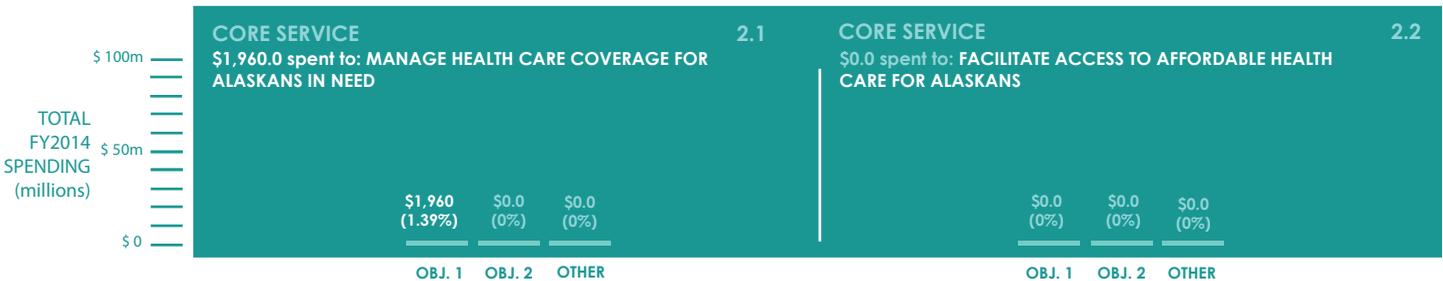
## SNAPSHOT OF ALASKANS SERVED

- In FY2013, served 11,764 Alaskans, 70% children ages 5 years through 17 years of age.
- In 2013, services were provided to 1,220 children who were enrolled in the Infant Learning Program. These children received screening and/or evaluation.
- In FY2013 a total of 15,721 Protective Services Reports were received and 6,858 Protective Services Reports were screened in for services.
- Subsidized Adoption and Guardianship 2013 budget of \$27,406.6 supported families of 2,775 Alaskan children in their "forever home".

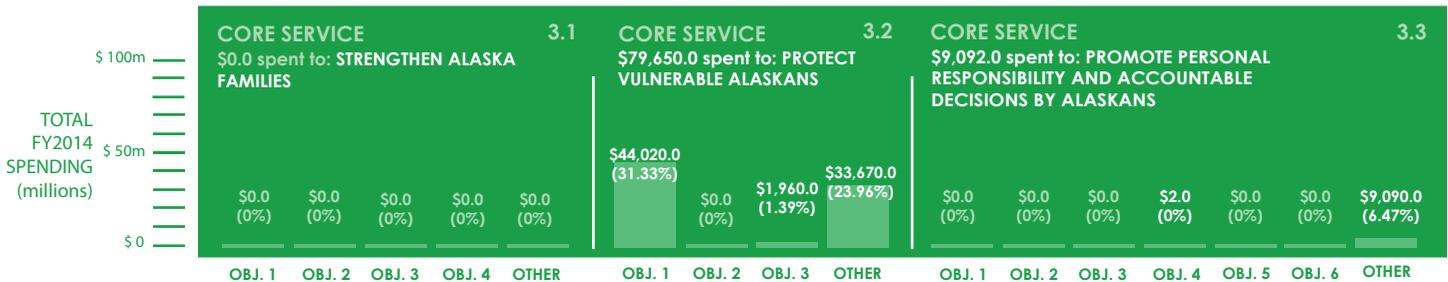
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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## Explanation of FY2015 Operating Budget Requests

### Office of Children's Services

#### Budget Overview Table

Office of Children's Services	FY2014	FY2015 Gov	Difference
Unrestricted General Funds	\$89,224.8	\$88,787.7	\$-437.1
Designated General Funds	3,000.0	3,000.0	0.0
Federal Funds	44,410.1	46,713.7	2,303.6
Other Funds	3,883.1	3,783.1	-100.0
<b>Total</b>	<b>\$140,518.0</b>	<b>\$142,284.5</b>	<b>\$1,766.5</b>

DHSS FY2015 Governor's Request - Children's Services					
General and Other Funds					
(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)					
Item	UGF	DGF	Federal	Other	Total
Reverse Alaska State Employees Association One-Time Payment (CSM, FLSW, ILP)	\$ (294.0)	\$ -	\$ (81.0)	\$ -	\$ (375.0)
Reduce Expenditure Level (CSM, CST)	\$ (607.3)	\$ -	\$ -	\$ -	\$ (607.3)
FY2015 Health Insurance and Working Reserve Rate Reductions (CSM, FLSW, ILP)	\$ (109.7)	\$ -	\$ (30.5)	\$ -	\$ (140.2)
FY2015 Salary Increases (CSM, FLSW)	\$ 323.9	\$ -	\$ 90.1	\$ -	\$ 414.0
Strengthening Families Alaska (FP)	\$ 250.0	\$ -	\$ -	\$ -	\$ 250.0
Maintain Title IV-E Foster Care Program Growth (SAG)	\$ -	\$ -	\$ 2,325.0	\$ -	\$ 2,325.0
Reverse FY2014 MH Trust Recommendation (ILP)	\$ -	\$ -	\$ -	\$ (280.0)	\$ (280.0)
MH Trust: Gov Cncl - 1207.07 Early Intervention/ Infant Learning Program Positive Parenting Training (ILP)	\$ -	\$ -	\$ -	\$ 80.0	\$ 80.0
MH Trust: BTKH - Grant 2550.04 Early Intervention for Young Children (ILP)	\$ -	\$ -	\$ -	\$ 100.0	\$ 100.0
<b>Children's Services Total</b>	<b>\$ (437.1)</b>	<b>\$ -</b>	<b>\$ 2,303.6</b>	<b>\$ (100.0)</b>	<b>\$ 1,766.5</b>

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# BUSINESS PLAN (2013-2015)



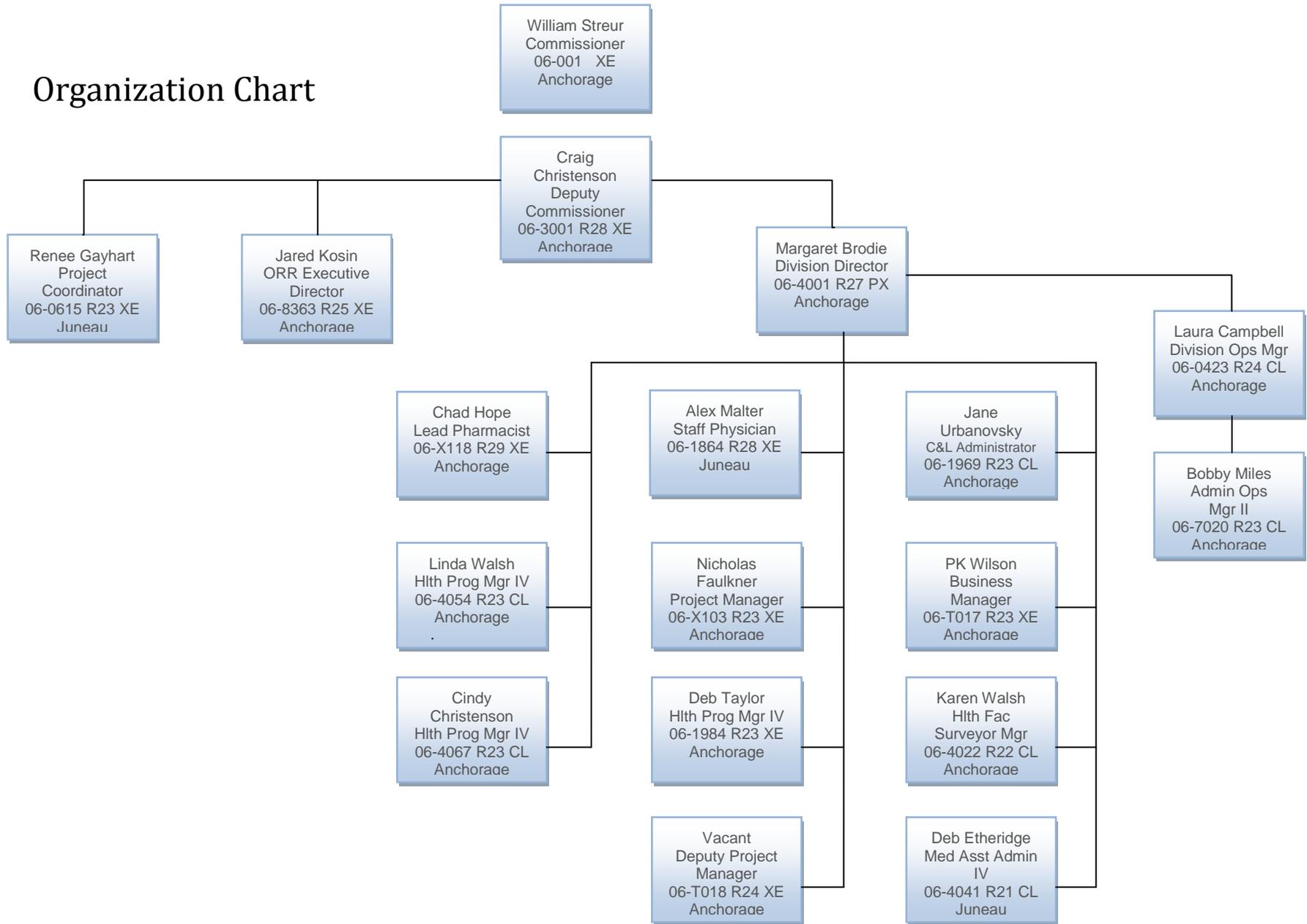
## DIVISION OF HEALTH CARE SERVICES

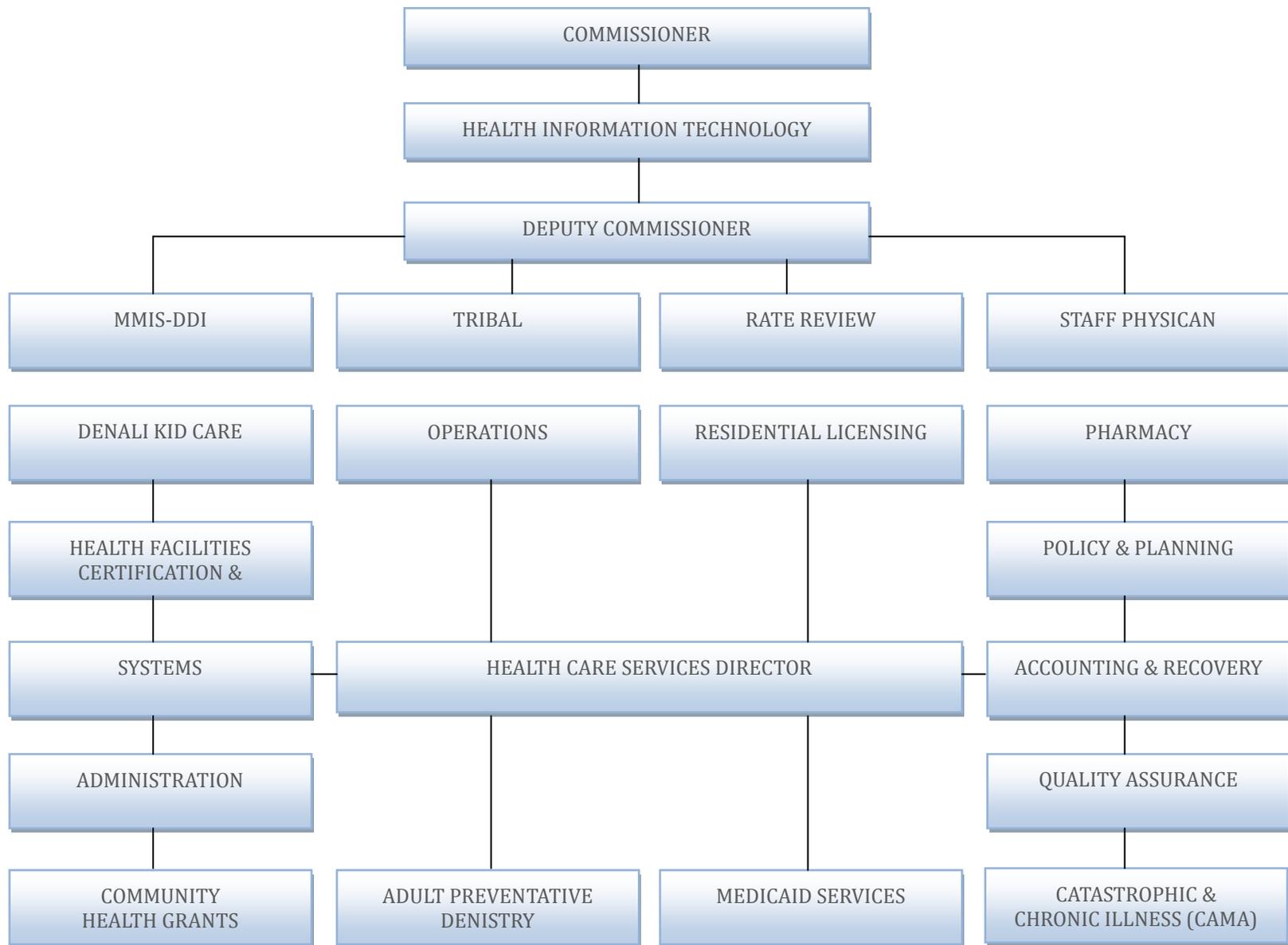
**MISSION:** *To provide health coverage to Alaskans in need.*

# Contents

Organization Chart	1
Division of Health Care Services	3
Priority 1 – Health & Wellness Across the Lifespan	5
Priority 2 – Health Care Access Delivery and Value	7
Priority 3 – Safe and Responsible Individuals, Families & Communities	12
Division Information	15
Division Performance Measure Contact	15

# Organization Chart





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**PRIORITY 1**  
**HEALTH & WELLNESS**  
**ACROSS THE LIFESPAN**

- CORE SERVICE 1.1**  
Protect and promote the health of Alaskans
- CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

---

**PRIORITY 2**  
**HEALTH CARE ACCESS,**  
**DELIVERY & VALUE**

- CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need
- CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

---

**PRIORITY 3**  
**SAFE & RESPONSIBLE**  
**INDIVIDUALS, FAMILIES**  
**& COMMUNITIES**

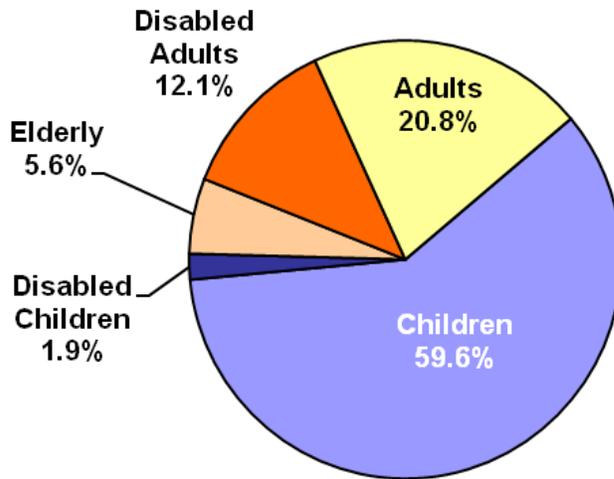
- CORE SERVICE 3.1**  
Strengthen Alaska families
- CORE SERVICE 3.2**  
Protect vulnerable Alaskans
- CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

## Division of Health Care Services

*Our Mission: To provide health coverage to Alaskans in need.*

The Health Care Services (HCS) Medicaid component provides funding for medically necessary covered services to enrolled children, adults, disabled individuals and the elderly. In FY13, 95.7% of enrolled individuals (151,797 recipients) received services paid by Alaska Medicaid. The FY13 overall medical services expenditure was \$739,611.9 which was an average of \$5,091 per recipient. FY13 expenditure breakdown by demographic:

**FY 2013 Health Care Services Medicaid Recipients by Benefit Group**



Source: MMIS JUCE

Direct Medicaid services funded and managed by HCS include but are not limited to: hospitals; physician services; pharmacy; dental; transportation; physical, occupational and speech therapy; laboratory services; radiology; durable and specialized medical equipment; hospice; home health care and a variety of other preventative and acute services.

In FY13, HCS' Medicaid component expenditures comprised 53.5% of the total expenditures for all Alaska Medicaid claims payments. Our FY13 expenditure breakdown by service area is as follows:

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**PRIORITY 1**  
HEALTH & WELLNESS  
ACROSS THE LIFESPAN

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

---

**PRIORITY 2**  
HEALTH CARE ACCESS,  
DELIVERY & VALUE

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

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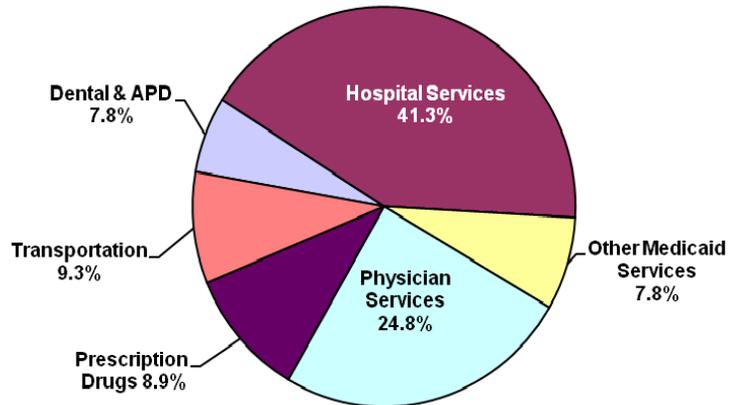
**PRIORITY 3**  
SAFE & RESPONSIBLE  
INDIVIDUALS, FAMILIES  
& COMMUNITIES

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

Health Care Services Medicaid  
FY 2013 Claim Payments by Service Category



Source: MMIS JUCE

HCS' operational structure includes 139 permanent full-time employees, 1 permanent part-time employee and 4 non-permanent positions. Juneau is home to a total of 7 staff while the remaining 137 are based in Anchorage. The major program areas within Medical Assistance Administration are: Operations; Systems and Analysis; Pharmacy; Accounting and Recovery; Quality Assurance; Tribal; Rate Review; Health Facilities Certification and Licensing; and Residential Licensing including the Background Check Program.

Providing for quality health care services through Medicaid is our top priority as we support the Department's goal of healthy Alaskans living in healthy communities.

Our staff is committed to outstanding management of these health care services in support of the Department's mission to manage health care for eligible Alaskans in need.

*Our Core Services:* The Division's major goal is to provide support services through management efficiencies and the capitalization of Medicaid financing and to assure that a full range of health care

services are available to our customers.

*Our Vision:* Medicaid must allocate resources as appropriately as possible. Our vision is to provide high quality services, at the right place, at the right time, for the right price, for the right people.

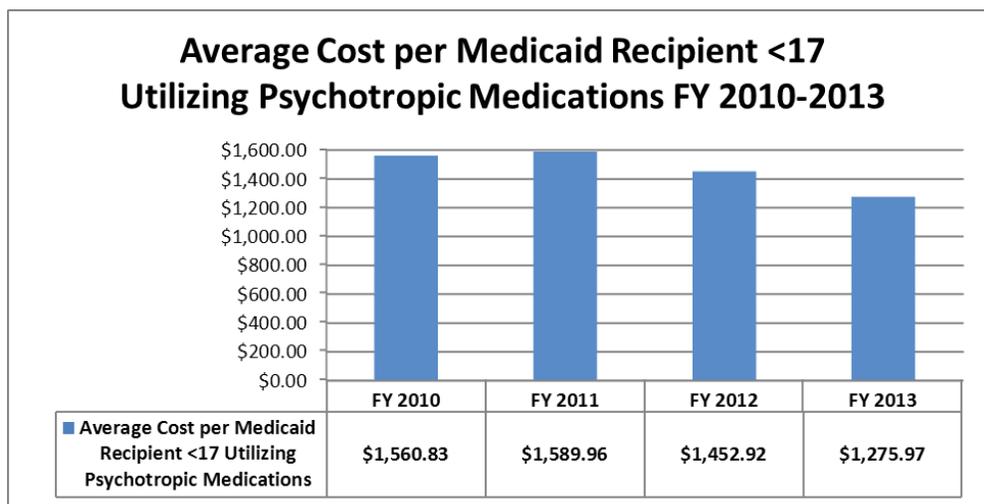
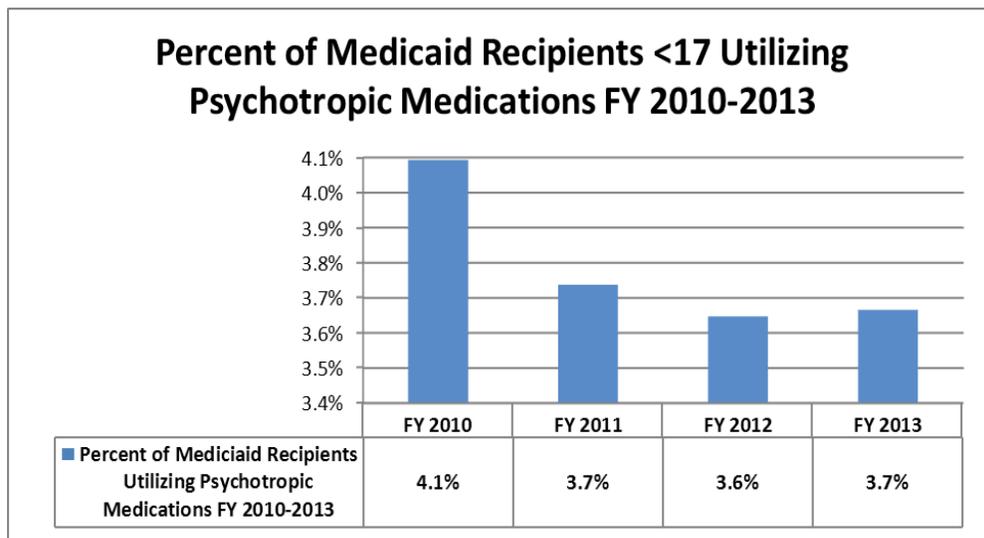
# Priority 1 – Health & Wellness Across the Lifespan

## CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

### Objective 1.2.1 - Improve the safety of children receiving Department services

#### Performance Measures

- Performance Measure 1.2.1.4a - Percent of children on Medicaid who are prescribed psychotropic medication
- Performance Measure 1.2.1.4b - Average cost of psychotropic medications for children on Medicaid



**Strategies/Actions**

Our goal is to strictly monitor the use of psychotropic medications for children in state custody under the age of 17 which will ensure appropriate use of these medications and will enhance continuity of overall medical care.

**Partners/Interdependencies**

- Division of Juvenile Justice
- Office of Children's Services

**Analysis**

- ⇒ 3.7% of Medicaid children (Under 17) received at least one psychotropic medication during FY13
- ⇒ The average cost per child for psychotropic medications in FY13 was \$1,276. This translates to an average of \$120.67 per prescription

**Looking Ahead**

We are developing of a utilization management contract for independent review of psychotropic medication prescriptions for children in foster care and in the custody of DJJ.

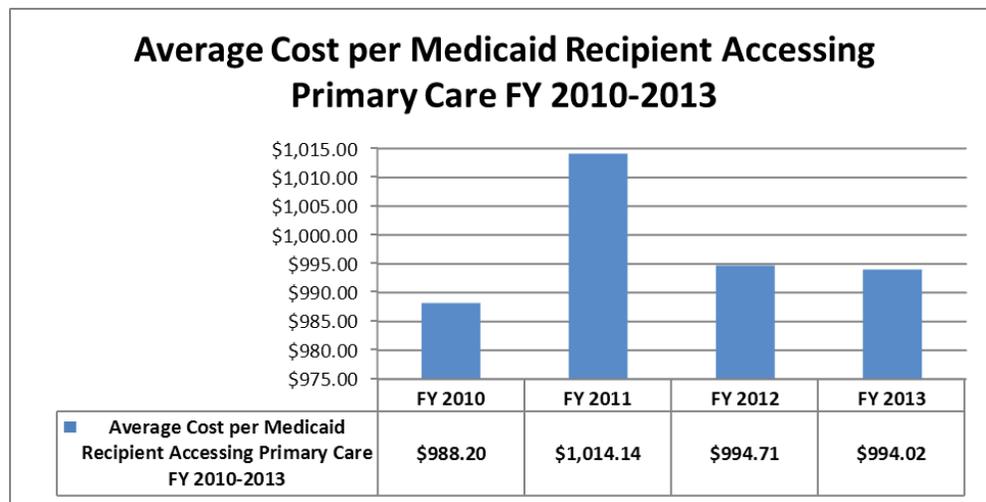
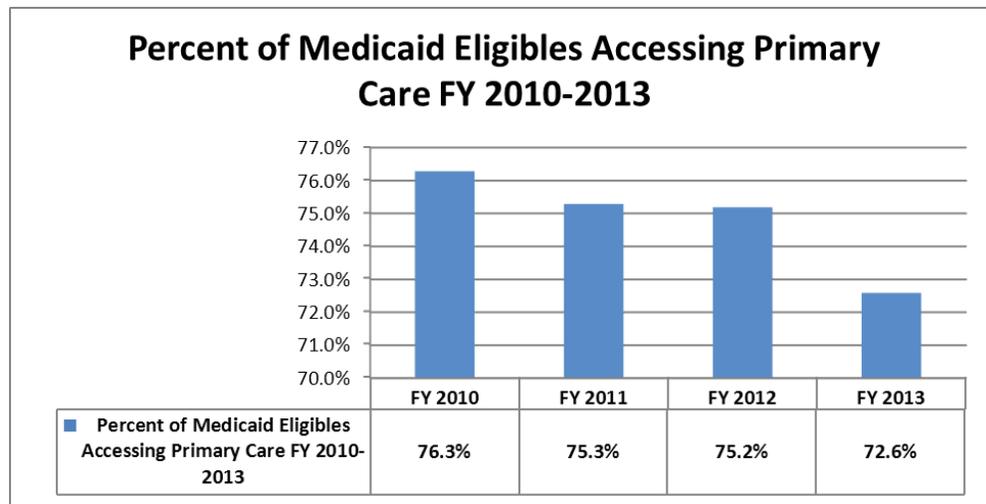
# Priority 2 – Health Care Access Delivery and Value

## CORE SERVICE 2.1 MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED

### Objective 2.1.1 - Increase the number of Alaskans with a primary care provider

#### Performance Measures

- Performance Measure 2.1.1.1a - Percent of individuals served by the department with access to a primary care provider
- Performance Measure 2.1.1.1b - Cost to provide health care services per client



### **Strategies/Actions**

Certain tribal providers have a virtual patient-centered medical home approach in which the needs of the patient as a whole and the needs of the patient's family are considered. We can learn from this while developing our own medical home perspective.

### **Partners/Interdependencies**

- Tribes
- Division of Public Health

### **Analysis**

Care Management: Xerox

Case Management: Qualis

### **Looking Ahead**

Patient Centered Medical Home

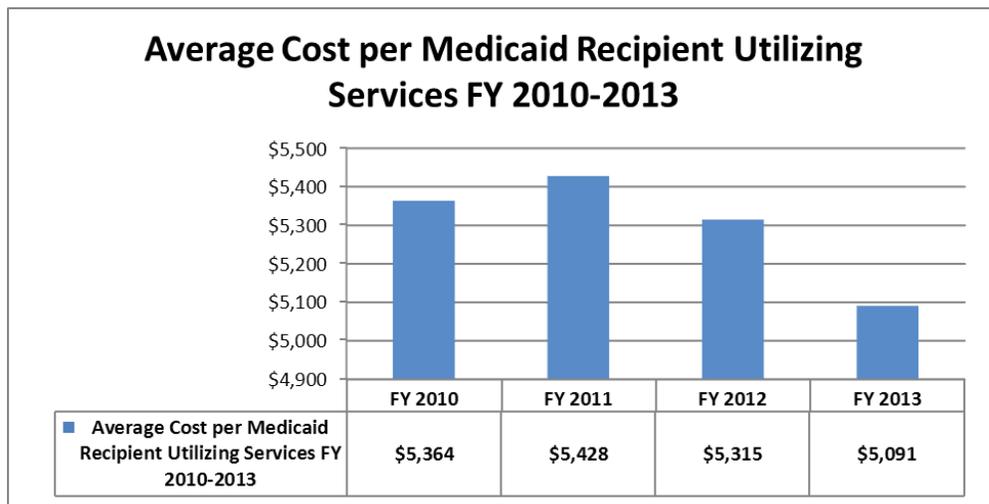
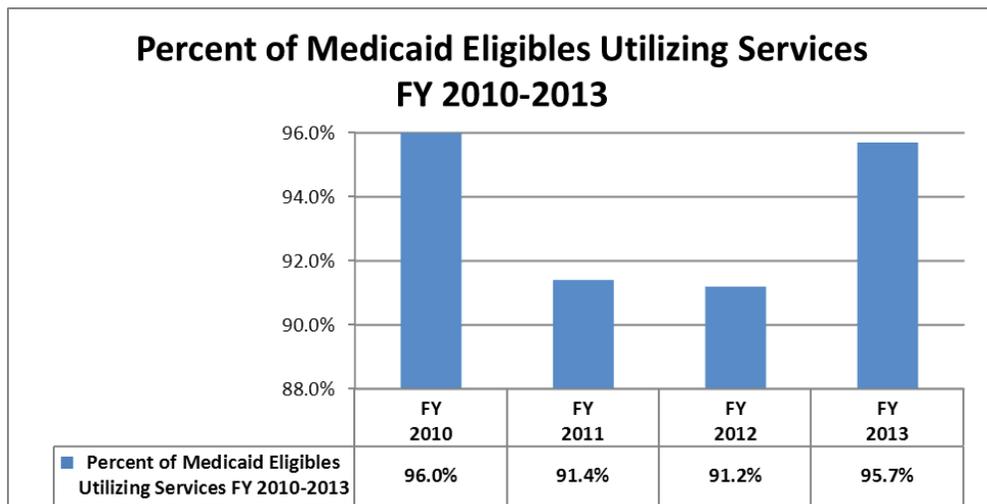
Super Utilizers

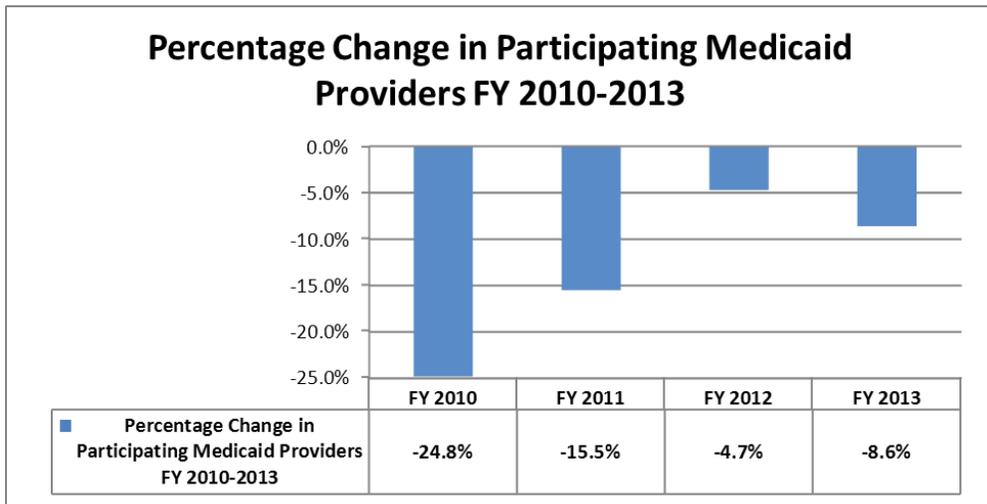
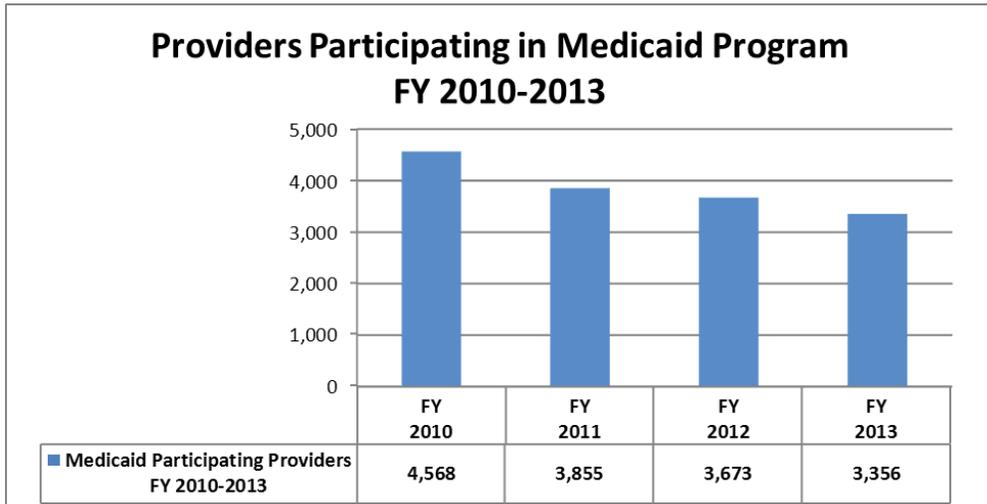
CORE SERVICE 2.2 FACILITATE ACCESS TO AFFORDABLE HEALTH CARE FOR ALASKANS

Objective 2.2.1 – Improve access to health care

Performance Measures

- Performance Measure 2.2.1.1a -Percent of Medicaid eligibles who utilize Medicaid services
- Performance Measure 2.2.1.1b -Cost per recipient
- Performance Measure 2.2.1.2a - Number of providers participating in the Medicaid program
- Performance Measure 2.2.1.2b - Percent change in number of participating providers





**Strategies/Actions**

DHCS completed a reenrollment of more than 9,000 Medicaid providers in anticipation of the new Medicaid Management Information System (MMIS) known as Enterprise.

**Partners/Interdependencies**

- Alaska Medicaid Fiscal Agent, Xerox
- Program Integrity
- Medicaid Fraud Control Unit
- Division of Senior and Disabilities Services
- Division of Behavioral Health

**Analysis**

There is considerable turnover with certain provider types. Some rendering providers move from agency to agency and others provide services for a short period of time. The quality of our programs depends upon monitoring the enrollment of these providers.

**Looking Ahead**

Alaska Medicaid provider enrollment regulations will be reviewed to look for areas that would allow for improved management of our providers. We are working with the federal Office of Inspector General (OIG) to ensure that all nationally excluded providers are disallowed from participating in Alaska Medicaid. Our Quality Assurance section will provide oversight to our fiscal agent's provider enrollment section to improve efficiencies.

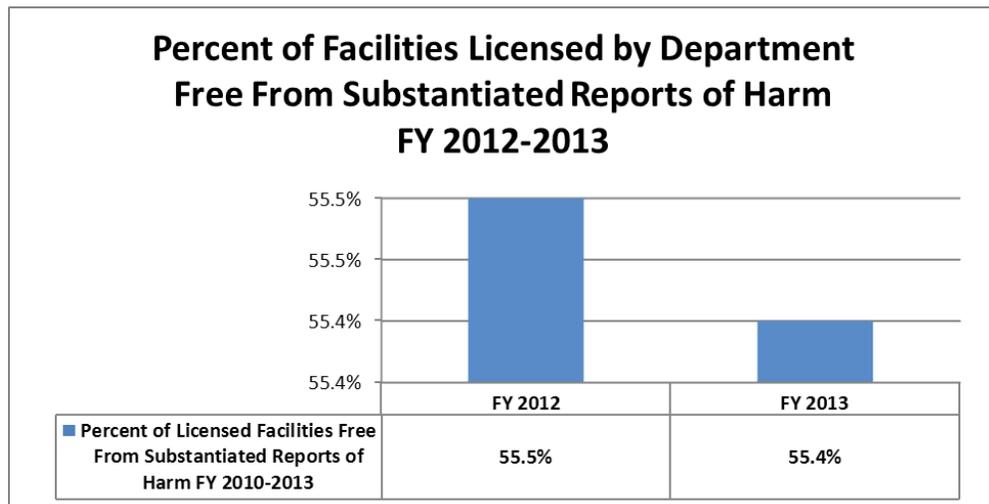
# Priority 3 – Safe and Responsible Individuals, Families & Communities

## CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS

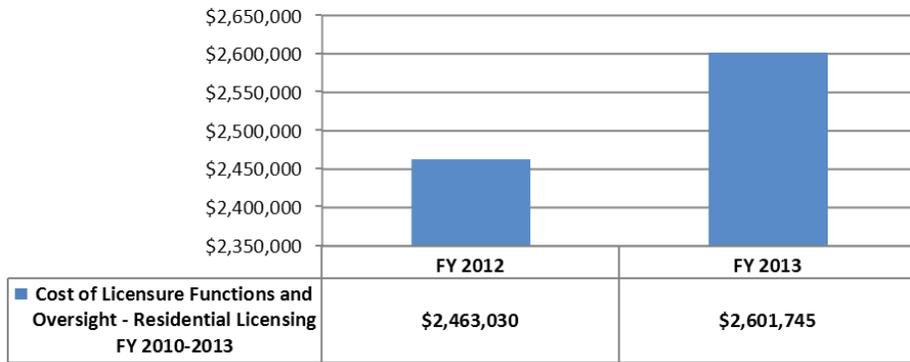
### Objective 3.2.3 - Improve client safety within Department and provider operated facilities

#### Performance Measures

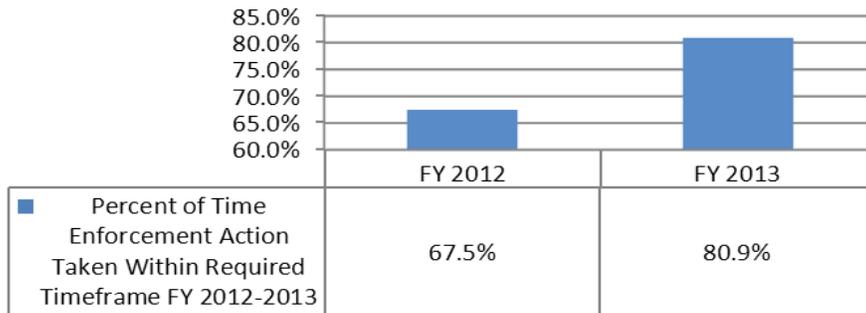
- Performance Measure 3.2.3.1a – Percent of facilities licensed by the Department that are free from substantiated reports of harm
- Performance Measure 3.2.3.1b – Cost for licensure functions and oversight
- Performance Measure 3.2.3.1c – Percent of time that enforcement action is issued within required timeframe
- Performance Measure 3.2.3.2a – Percent of background checks completed within established timeframes
- Performance Measure 3.2.3.2b – Cost of administering Background Check Program
- Performance Measure 3.2.3.2c – Average time to complete final determination



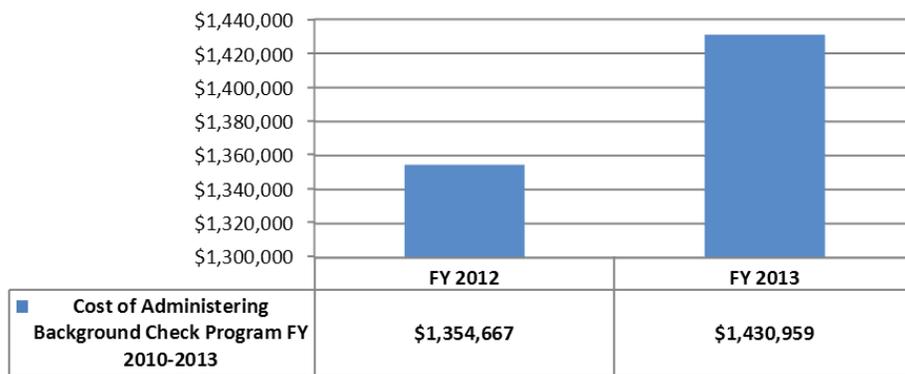
### Cost of Licensure Functions and Oversight - Residential Licensing FY 2012-2013

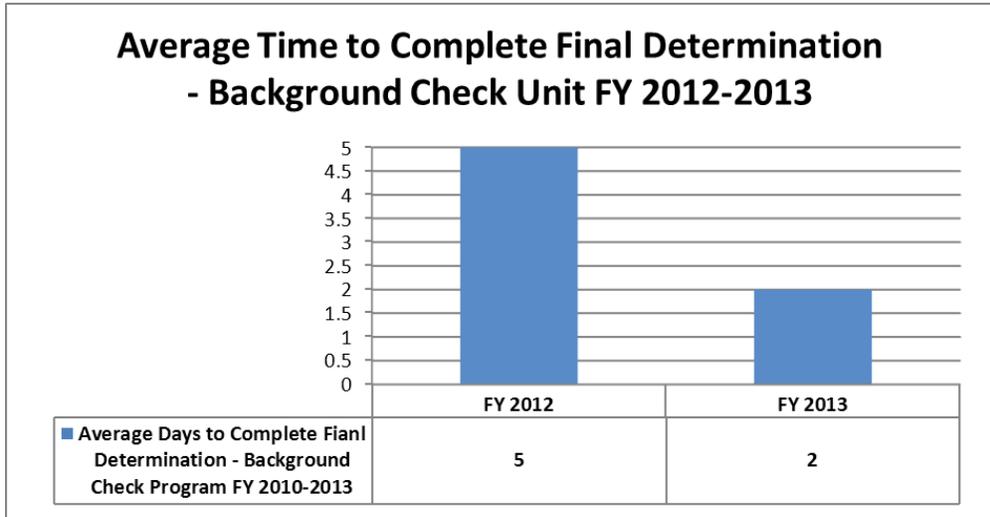


### Percent of Time Enforcement Action Taken Within Required Timeframe FY 2012-2013



### Cost of Administering Background Check Program FY 2012-2013





**Strategies/Actions**

We have streamlined processes to ensure that background checks are completed timely. In addition, we have identified individuals for whom finger prints have never been submitted and notified them that they must do so.

**Partners/Interdependencies**

- Division of Behavioral Health
- Office of Children’s Services
- Division of Senior and Disabilities Services
- Centers for Medicare and Medicaid Services (CMS)

**Analysis**

Implemented efficiencies have greatly improved processing time and have allowed people to become employee more timely than before.

**Looking Ahead**

Additional efficiencies created by the implementation of a new Background Check Database should further decrease processing timeframes.

## Division Information

Health Care Services

4501 Business Park Blvd, Ste 24, Anchorage, AK 99503

**Tel** 907.334.2400

**Fax** 907.561.1684

<http://dhss.alaska.gov/dhcs/Pages/default.aspx>

## Division Performance Measure Contact

Margaret Brodie

4501 Business Park Blvd, Ste 24, Anchorage, AK 99503

**Tel** 907.334.2520

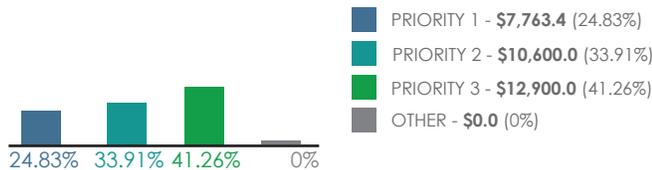
**Fax** 907.561.1684

<http://dhss.alaska.gov/dhcs/Pages/director.aspx>

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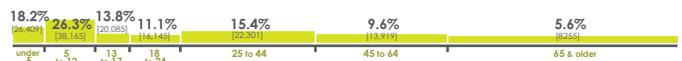
# HEALTH CARE SERVICES | SPENDING BY PRIORITY (FY2014)

**\$31,263.4** TOTAL BUDGET (FY2014)  
TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

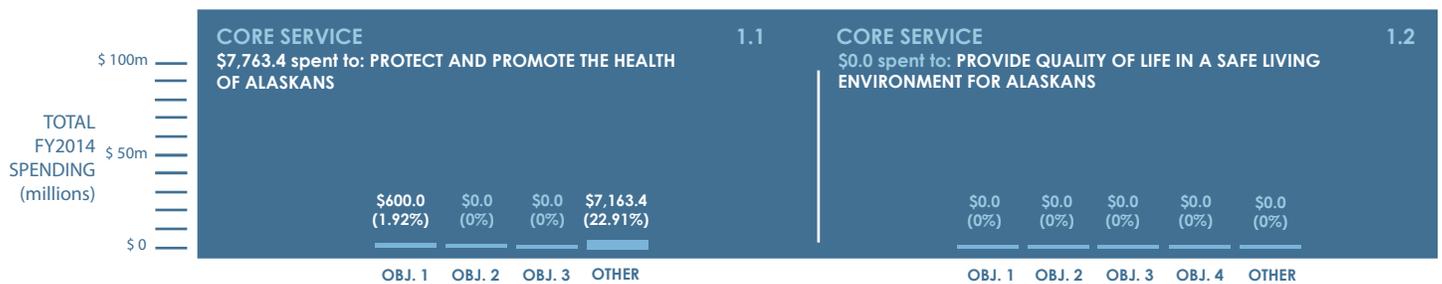
Total service population **145,279** individuals. This is the same total for Medicaid service population.



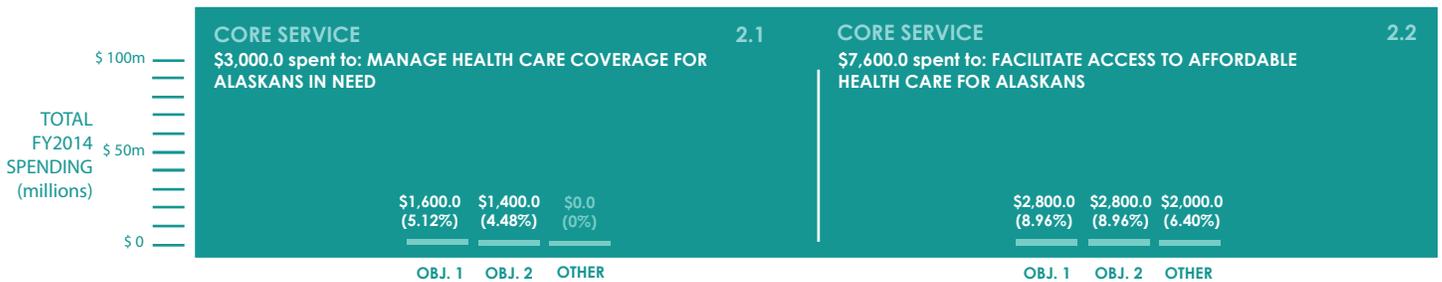
### SNAPSHOT OF ALASKANS SERVED

- 87,506 (60%) are children
- 2,759 (2%) are disabled children
- 8,197 (6%) are elderly
- 17,011 (12%) are disabled adults
- 29,806 (20%) are adults

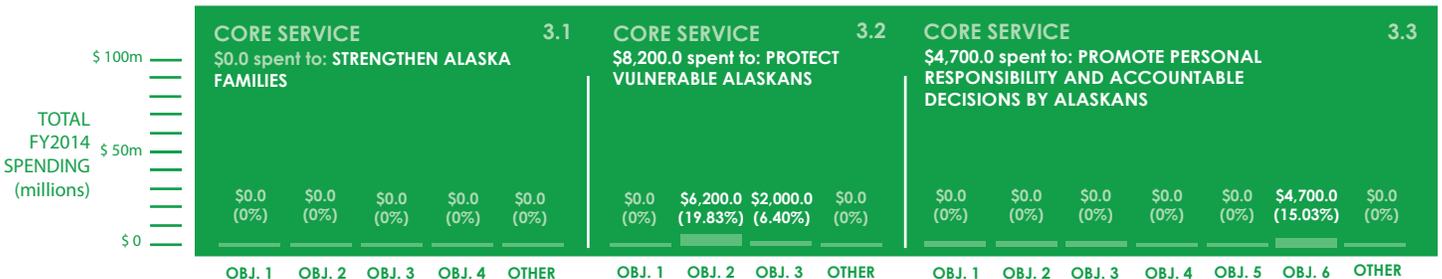
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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## Explanation of FY2015 Operating Budget Requests

### Division of Health Care Services

#### Budget Overview Table

<b>Health Care Services</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>Difference</b>
Unrestricted General Funds	\$12,364.6	\$9,903.6	\$-2,461.0
Designated General Funds	1,868.8	1,865.1	-3.7
Federal Funds	11,973.5	9,810.6	-2,162.9
Other Funds	5,056.5	2,780.0	-2,276.5
<b>Total</b>	<b>\$31,263.4</b>	<b>\$24,359.3</b>	<b>\$-6,904.1</b>

<b>DHSS FY2015 Governor's Request - Health Care Services</b>					
<b>General and Other Funds</b>					
(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)					
<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Reverse Alaska State Employees Association One-Time Payment (HFCL, RL, MAA, RR)	\$ (40.2)	\$ (8.8)	\$ (41.3)	\$ (3.1)	\$ (93.4)
Reduce Expenditure Level (HFCL, RL, MAA, RR)	\$ (246.3)	\$ -	\$ -	\$ -	\$ (246.3)
Delete Uncollectible Receipt Authority (HFCL)	\$ -	\$ -	\$ (100.0)	\$ -	\$ (100.0)
FY2015 Health Insurance and Working Reserve Rate Reductions (HFCL, RL, MAA, RR)	\$ (17.5)	\$ (2.4)	\$ (17.8)	\$ (7.9)	\$ (45.6)
FY2015 Salary Increases (HFCL, RL, MAA, RR)	\$ 51.9	\$ 7.5	\$ 51.2	\$ 16.8	\$ 127.4
Delete Authority No Longer Needed for the Federal Background Check Grant (RL)	\$ -	\$ -	\$ (1,000.0)	\$ -	\$ (1,000.0)
Transfer Project Analyst (06-T016) and Funding to Public Assistance Administration for Eligibility Info System Replacement (MAA)	\$ -	\$ -	\$ -	\$ (130.0)	\$ (130.0)
Transfer to Women Children and Family Health and Epidemiology to Support New Grant Programs (MAA)	\$ -	\$ -	\$ (1,000.0)	\$ -	\$ (1,000.0)
Delete Capital Improvement Project Receipt Authority No Longer Needed for Reimbursable Service Agreements (MAA)	\$ -	\$ -	\$ -	\$ (2,000.0)	\$ (2,000.0)
Delete Long Term Vacant Positions (06-T014, 06-T018) (MAA)	\$ (55.0)	\$ -	\$ (55.0)	\$ (152.3)	\$ (262.3)
Transfer Community Health Grants to Public Health (CHG)	\$ (2,153.9)	\$ -	\$ -	\$ -	\$ (2,153.9)
<b>Health Care Services Total</b>	<b>\$ (2,461.0)</b>	<b>\$ (3.7)</b>	<b>\$ (2,162.9)</b>	<b>\$ (2,276.5)</b>	<b>\$ (6,904.1)</b>

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# BUSINESS PLAN (2013-2015)



## DIVISION OF JUVENILE JUSTICE

**MISSION:** 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.

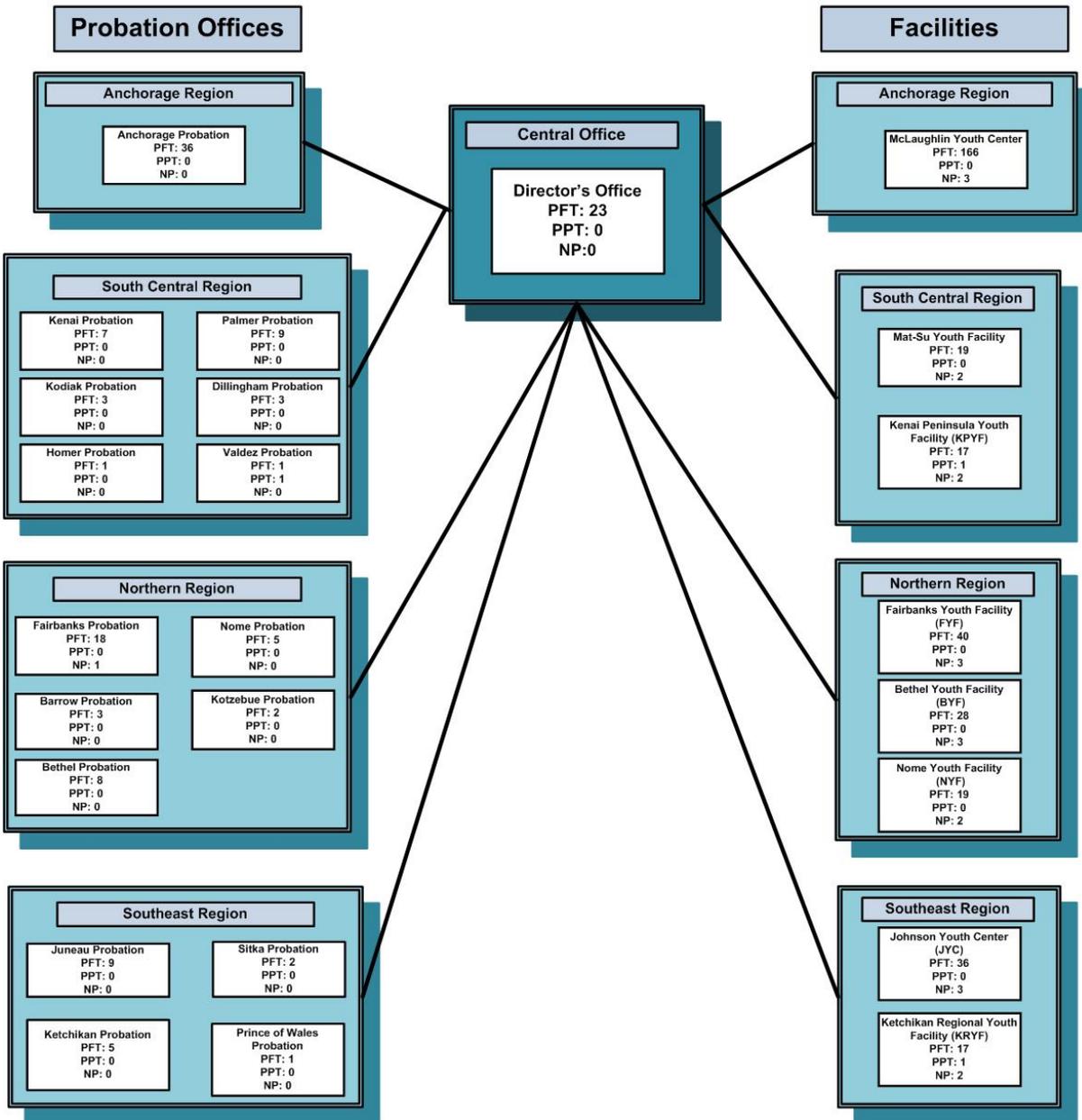
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# Organization Chart

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

Total Permanent Full Time: 478  
 Total Permanent Part Time: 3  
 Total Non-Perm: 21



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# Introduction

## PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

### CORE SERVICE 1.1

Protect and promote the health of Alaskans

### CORE SERVICE 1.2

Provide quality of life in a safe living environment for Alaskans

The Division of Juvenile Justice promotes the safety and security of Alaskans by responding to juvenile crime. When a young person breaks the law in Alaska, the Division's staff intervenes by holding the offender accountable, promoting the safety and restoration of the victim community, and assisting the juvenile in developing skills to prevent further delinquent behavior.

The Division performs this work through three core services: Juvenile Probation, Detention, and Treatment.

**Juvenile Probation** typically serves as a youth's initial point of contact with the juvenile justice system. After a law enforcement agency conducts an investigation and determines a juvenile was involved in an offense, it forwards the report to one of the 16 Juvenile Probation offices around the state. Juvenile Probation Officers receive approximately 4,000 reports (referrals) of delinquent activity a year. They are responsible for:

- conducting intake interviews;
- determining the appropriate course of action for the case;
- coordinating with the court system;
- providing case management and probation supervision;
- collaborating with the youth, family, and community to address the youth's risks and needs.

The **Detention** core service is provided through facilities providing secure holds for youth who may be a danger to themselves or others, or who need to be held to ensure a future court appearance. Approximately 900 juveniles are admitted to Alaska's eight juvenile Detention facilities each year, some of them more than once. Juveniles may be housed in these facilities from hours to months while they await a determination by a court or Juvenile Probation Officer on how their cases will be handled. Detention facilities offer services including:

- crisis stabilization;
- health assessments and services;
- mental health and suicide risk screenings;
- behavioral health intervention
- maintaining educational progress;
- life and social skills development;

The **Treatment** core service provides long-term, court-ordered secure custody for juveniles with chronic or particularly delinquent behavior. Alaska's four Treatment facilities assess the needs of these youth and provide

---

## PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

### CORE SERVICE 2.1

Manage health care coverage for Alaskans in need

### CORE SERVICE 2.2

Facilitate access to affordable health care for Alaskans

---

## PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

### CORE SERVICE 3.1

Strengthen Alaska families

### CORE SERVICE 3.2

Protect vulnerable Alaskans

### CORE SERVICE 3.2

Promote personal responsibility and accountable decisions by Alaskans

a range of services to help them overcome their delinquent behavior and make successful transitions back to their home communities. Approximately 100 youth are admitted to Treatment facilities per year. Services offered include:

- behavioral health services;
- educational and vocational training;
- medical care;
- substance abuse education and treatment;
- skill development opportunities;
- treatment services aimed at overcoming the factors resulting in persistent delinquent behavior.

The Division of Juvenile Justice is dedicated to managing these core services in the most effective and efficient manner possible, and is using the Department's Performance Measure framework as a means to monitor these efforts.

# Priority 3 – Safe and Responsible Individuals, Families & Communities

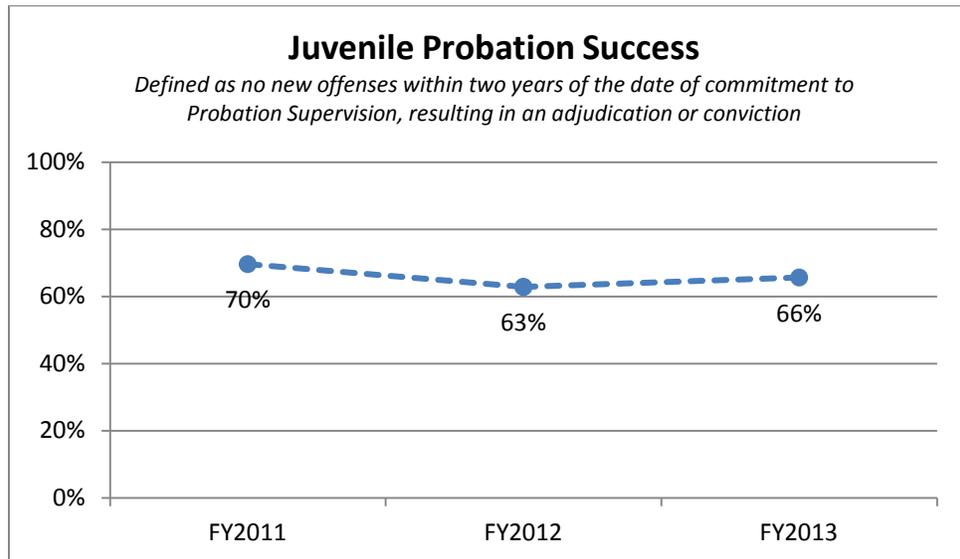
## CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

### Objective 3.3.2- Increase the number of juveniles who remain crime-free

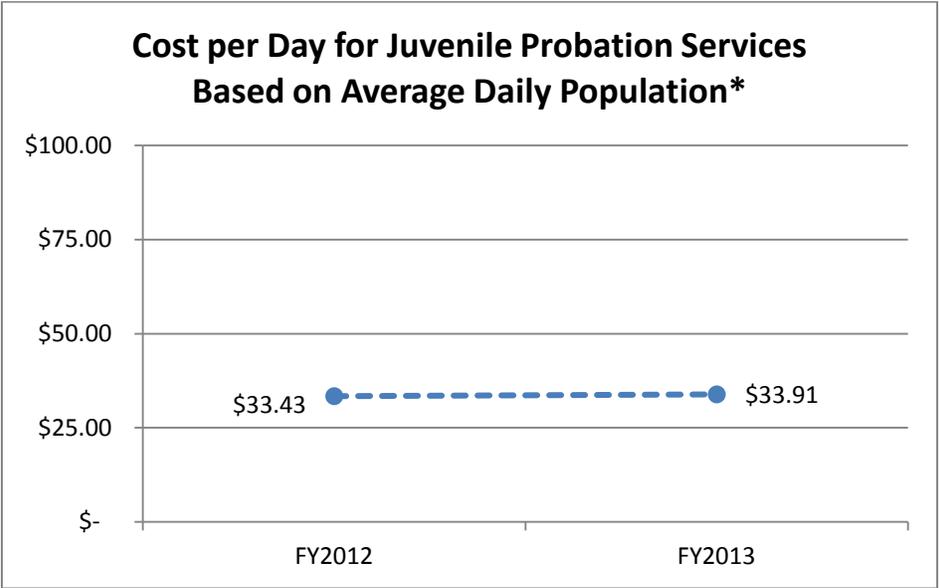
#### Performance Measures

The Division of Juvenile Justice’s six performance measures are housed under the objective of increasing the number of juveniles who remain crime-free:

#### Performance Measure 3.3.2.1a – Rate of success for juveniles committed to Juvenile Probation (Effectiveness)

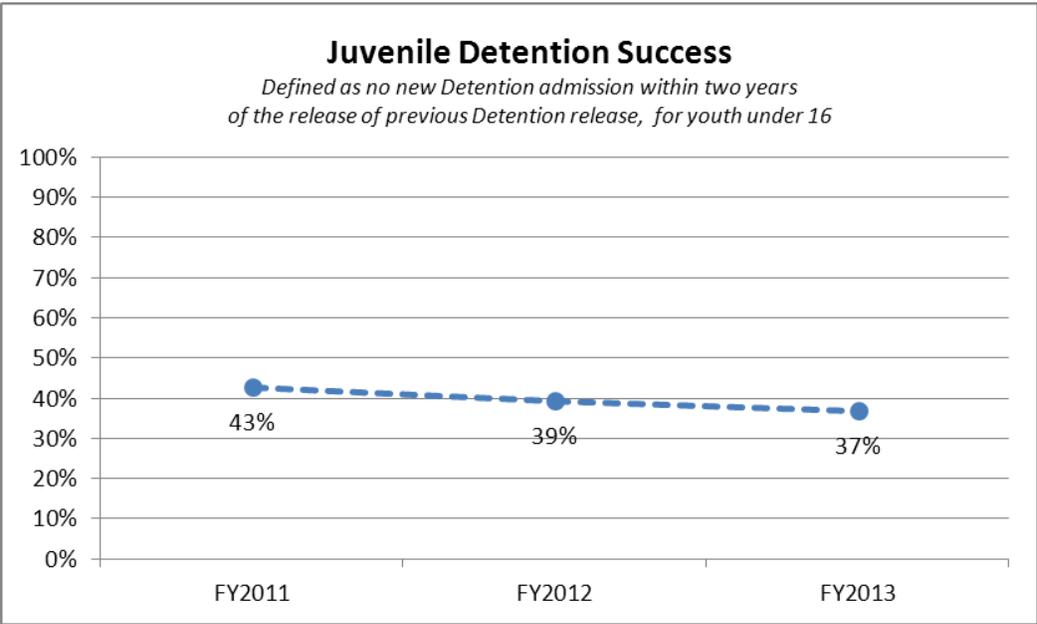


**Performance Measure 3.3.2.1b – Daily cost of Juvenile Probation services based on average daily probation population (Efficiency)**

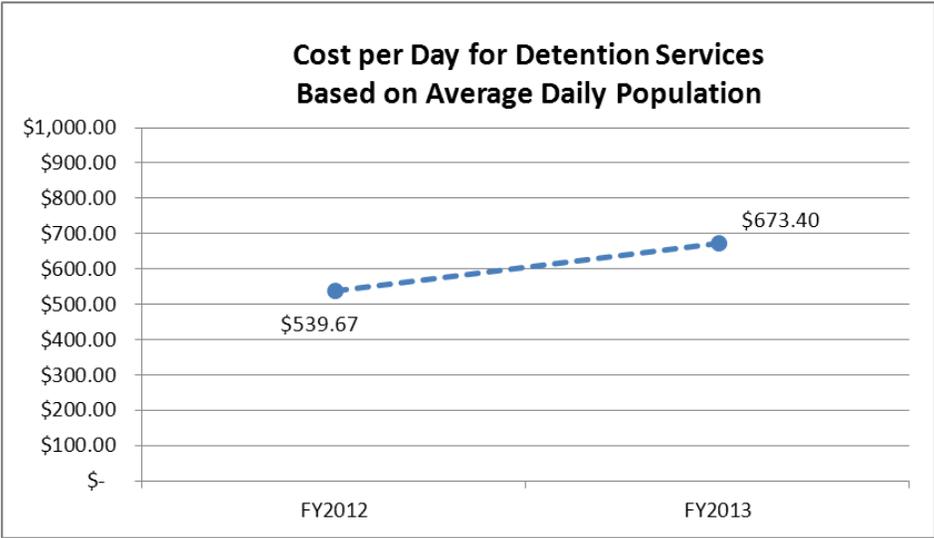


\*The average daily population for Juvenile Probation Services is based on the number of juveniles who had an open referral or supervision order at any time during the fiscal year.

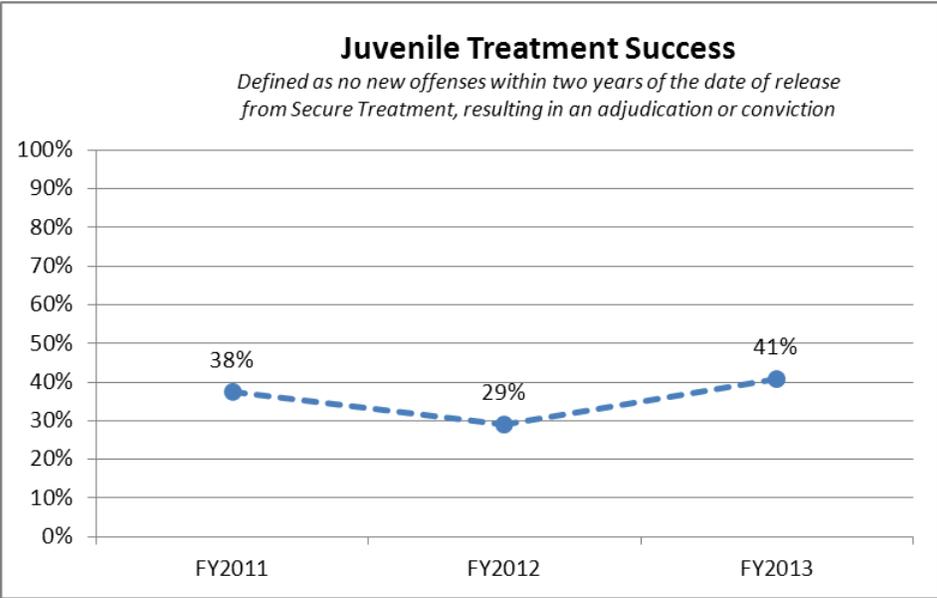
**Performance Measure 3.3.2.2a – Rate of success for juveniles released from DJJ Detention facilities (Effectiveness)**



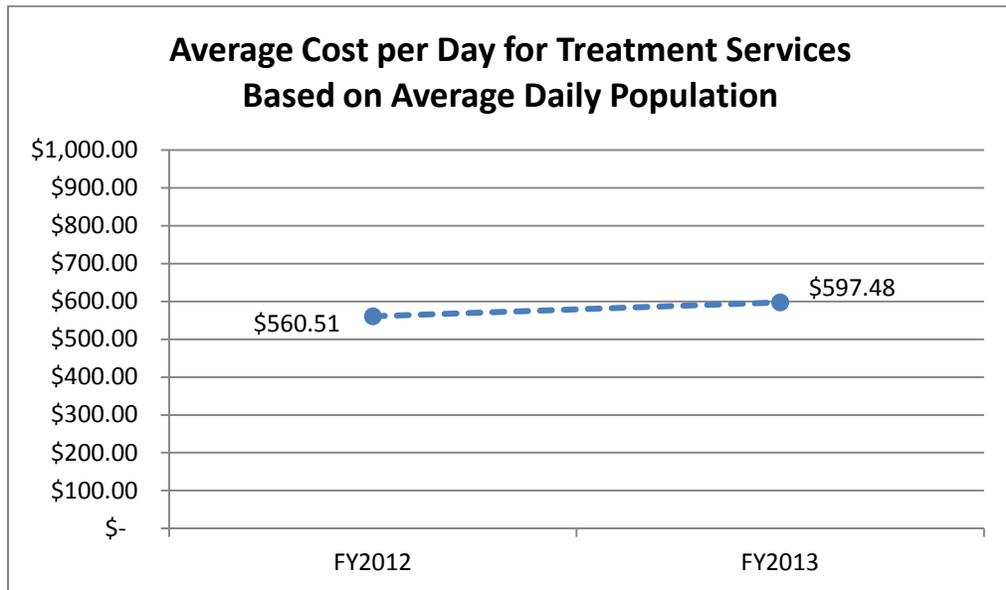
Performance Measure 3.3.2.2b – Daily cost of Detention services per bed-day (Efficiency)



Performance Measure 3.3.2.3a – Rate of success for juveniles released from DJJ Treatment facilities (Effectiveness)



Performance Measure 3.3.2.3b – Daily cost of Treatment services per bed-day (Efficiency)



Strategies/Actions

The Division of Juvenile Justice is strongly focused on improving the success of juveniles and improving efficiencies that will reduce the costs of juvenile crime to Alaskans. Juveniles may recidivate for a variety and combination of reasons and so the Division is looking closely at the characteristics of offenders and pursuing multiple strategies to improve outcomes, including research into subgroups of juvenile populations. For example, Alaska Native juveniles are found to have the highest Juvenile Probation and Treatment recidivism rates of any racial group, so the Division is developing strategies aimed at improving cultural competencies of staff and supports for youth in rural communities. The Division also is dissecting recidivism rates based on other factors such as whether youth have behavioral health issues, where in the state they live, and the types of services and programs they've received while on probation or in a facility.

Educational and employment status, substance use, and the presence of other behavioral issues also are known to be linked with recidivism, so Division leadership has charged itself with implementing proven or promising approaches, including those that:

- improve educational success;
- create more job-training and other skill-building opportunities;
- train staff in providing substance abuse prevention and intervention skills;
- enhance clinical capacity for youth in juvenile facilities and on probation.

Some of these strategies are intended to reduce recidivism in all three core service areas, while others specifically target youth being placed on Juvenile Probation supervision or

being released from a facility. Work plans are being developed at the statewide level to make systemic improvements; region and district Juvenile Probation managers and facility superintendents are also developing plans to address local needs and cultivate local resources. Some of these plans are for new efforts, while others are to expand efforts already known to be improving outcomes.

The Division also is pursuing multiple strategies to improve cost-effectiveness. For example:

- The Division has expanded alternatives to Detention programs such as “community detention,” which enable certain low-risk juveniles to remain in the community while still being held accountable by the Division.
- Detention facilities in Kenai, Ketchikan, Mat-Su, and Nome have begun working with youth “stepping down” from a period of long-term commitment in DJJ treatment facilities, to better enable juveniles to transition to life in their home communities.
- When the number of admissions to a Detention unit at McLaughlin Youth Center remained consistently low, the Division transformed this unit into a court room that reduced the need for costly transports of juveniles to downtown Anchorage for court house appointments.
- Consolidation of other units and new residential arrangements at McLaughlin Youth Center are expected to result in better outcomes for youth and more efficient use of staff resources. For example, for years the female residents were housed in one unit whether they were there for shorter-term detention stays or had been committed to long-term treatment. In FY2013 the Center moved these two populations into separate housing units, enabling staff to better focus on the distinctive needs of these girls.
- The Division is using federal funding to cost-effectively meet two important agency objectives. The federal funding is provided through the formula grant program of the U.S. Office of Juvenile Justice and Delinquency Prevention and is primarily intended for site audits of adult jails and lockup facilities around Alaska, to ensure that local law enforcement agencies understand and abide by federal rules surrounding the way juveniles can be held in these facilities. By having juvenile probation officers perform these audits, the officers are not only able to meet the federal requirements but also can use the time in the communities they visit to make contacts with juveniles on probation, parents, schools, and other community members. These visits, which can be highly effective in holding juveniles accountable and building relationships, would be prohibitively expensive for the Division to perform without the federal funding.

#### Partners/Interdependencies

The Division has myriad partners both within and outside government to assist with the strategies noted above. These partnerships enhance the Division’s efforts at building protective factors for juveniles in areas ranging from family circumstances to substance abuse, from behavioral management to peer relationships. For example, one determining factor in juveniles’ success is how well their education and employment needs are addressed. Among the Division’s partners in addressing these needs:

- The Department of Labor and Workforce Development, which is assisting juveniles in Juneau and Anchorage in gaining certifications to perform work as road constructions flaggers, food handlers, and other jobs.
- Labor's Division of Vocational Rehabilitation, which is working with DJJ to examine and enhance services for youth with special education needs.
- The Anchorage School District, which is working with the Division of Juvenile Justice has achieved success in improving educational outcomes for youth by working with the District to create the "Step Up" program, providing a highly structured academic, anger management, physical education, and community work services program for students who have been suspended or expelled from school for serious discipline problems. Juvenile facilities and offices in other parts of Alaska are exploring similar programs with their local school districts.

Local businesses, vocational training institutions and social service agencies also are working with the Division to provide educational and employment outcomes for juveniles. A variety of additional partnerships are helping the Division improve outcomes related to mental health and substance abuse; still others are aimed at improving the Division's ability to work effectively with Alaska Native juveniles and communities.

## Analysis

For the Juvenile Probation (3.3.2.1a) and Treatment (3.3.2.3a) measures presented in this report the Alaska Division of Juvenile Justice has aligned its definitions for success and recidivism with those of the national Council of Juvenile Correctional Administrators (CJCA). The CJCA has recently developed these national guidelines to better enable state-by-state comparisons of recidivism rates and, ultimately, lead to improved strategies to reduce reoffending by juveniles. A national definition on recidivism specifically for juveniles admitted to Detention is not yet under development by CJCA so the Division has developed this Detention measure (3.3.2.2a) internally as a means to analyze the effectiveness of this vital core service.

The results for the effectiveness measures show that:

- Juvenile Probation effectiveness has not significantly changed between FY2011 – FY2013, with success rates for juveniles on probation supervision holding steady between 63% - 70%.
- Detention success rates have held steady, between 37% - 43%, over the same time period.
- Overall Treatment success has varied between the years of analysis, from 38% to 29% to 41%. However, these changes are likely due to the relatively low numbers of juveniles are released from Treatment each year (just 66 juveniles for the FY2013 measure) compared with those placed on Juvenile Probation or those released from Detention. A few juveniles' success or failure can significantly change the measure's percentages but may not represent actual trends for the overall population.

A consistent finding over the years is that juveniles receiving Supervision have higher success rates compared with juveniles released from secure Treatment. One theory holds that, as the Division has improved its ability to distinguish among offenders of varying risks and needs, intensive (and expensive) Treatment services have appropriately housed increased proportions of higher-risk offenders, while Juvenile Probation supervision is reserved for lower-risk offenders with less intense needs and a higher likelihood of success.

In any event, the results for all three effectiveness measures demonstrate that a significant number of juveniles, whether placed on Juvenile Probation, in Detention, or Treatment, recidivate. The Division's first step in improving success rates lies in uncovering the reasons juveniles reoffend at all. In 2005, the Division adopted the nationally recognized Youth Level of Service/Case Management Inventory (YLS/CMI) to assess the likelihood of juveniles to reoffend. As the questions on the YLS/CMI demonstrate, delinquency may emerge from several sources— family dysfunction, substance use, peer influences, pro-criminal attitudes, and others. Other factors, while they may not be direct causes of delinquency (such as the presence of mental illness, a history of abuse, suicidal behavior, and other factors), can complicate the approaches that work best with a particular youth. The YLS/CMI is an effective assessment tool because it allows Division staff to develop case plans targeted to each youth's risks and needs. Quality assurance efforts are now underway to ensure Division staff is using this tool as intended and that our programs and interventions really do have an impact on juveniles' lives.

The Division's three efficiency measures provide an estimate of the costs to conduct the core services. The Division compiled two years (FY2012 and FY 2013) of financial and population data and found that:

- Juvenile Probation costs per day per were essentially the same between the two years (\$33.43 vs. \$33.91). This is expected given that this core service received no new allocations and no dramatic changes in referrals of juveniles to this service occurred.
- Detention costs rose from \$539.67 to \$673.40; the major contributor to this increase is believed to be a reduced number of Detention admissions. Also, low turnover and fewer vacancies in staffing resulted in the facilities employing longer-term employees who have higher salaries and benefits. This is believed to contribute to the rising cost of operating Detention facilities.
- Treatment costs rose from \$560.51 to \$597.48. The count of Treatment residents remained largely unchanged between FY2012 and FY2013, so the increase in cost in FY2013 compared with the previous year is believed due to the low turnover and few vacancies seen in Treatment facilities in the more recent years. Low turnover and few vacancies result in Treatment facilities employing longer-term employees with higher salaries and benefits than the facilities would employ if they had less experienced employees and more vacancies.

The results indicate the need for further analysis and refinement in the way costs and efficiencies for these core services are measured. The results also plainly illustrate how much less expensive it is to manage a youth through Juvenile Probation supervision compared with Detention and Treatment services. (Some youth receiving Juvenile Probation supervision are also in state's custody, and are housed in residential programs that incur costs to other state and community agencies.) Preventing juveniles from reoffending, enabling them to remain in their homes, and avoiding the need for more expensive treatment and detention services, remain ongoing, primary goals for the Division of Juvenile Justice.

### Looking Ahead

The Division of Juvenile Justice has undertaken a strategic planning process based on the "Results-based Accountability" model that has made measurable improvements in results for government agencies. Among the effective and promising practices that the Division is currently implementing statewide based on this planning process is Trauma-Informed Care. National research demonstrates that youth facing multiple exposures to violence or victimization, sometimes termed "Adverse Childhood Experiences," are at higher rates for delinquency as well as mental health problems, behavioral problems, and substance abuse. Trauma-Informed Care is an approach to working with youth that recognizes some of their challenging behaviors developed as a response to these experiences. Staff trained in Trauma-Informed Care demonstrates:

- increased awareness of how traumatic experiences may impact a juvenile's ability to benefit from treatment;
- improved understanding of the connection between trauma history, behaviors, and developmental impacts;
- an enhanced ability to increase youth emotional and behavioral regulations through coping skills and positive relationships.

The Division anticipates that staff will improve their effectiveness in working with juveniles once trained in Trauma-Informed Care approaches.

The Division's "looking ahead" strategies also are aimed at improving efficiencies, in the spirit of results-based budgeting. The Division's partnership with its sister Divisions of Health Care Services and Public Assistance is one of these strategies. Together these Divisions are exploring ways to reduce the costs of medical services for juveniles in detention and treatment facilities, using federal Medicaid support when possible and developing regulations that determine how much the Division will pay for medical services of juveniles committed to our care. The consolidations of units and re-directing the efforts of juvenile facility staff also are resulting in improved cost savings that nevertheless contribute toward our effectiveness in working with juveniles.

## Division Information



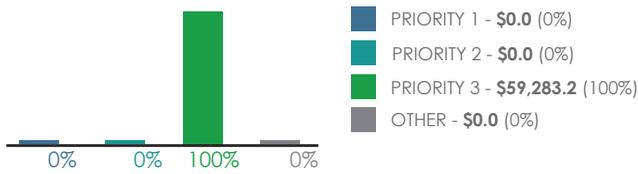
Division of Juvenile Justice  
240 Main Street, Suite 700  
Juneau, AK 99811  
**Tel** (907)465-2212  
**Fax** (907)465-2333  
<http://dhss.alaska.gov/djj>

## Division Performance Measure Contact

Karen Forrest, Deputy Director of Programs and Administration  
240 Main Street, Suite 700  
Juneau, AK 99811  
**Tel** (907)465-2339  
**Fax** (907)465-2333  
[karen.forrest@alaska.gov](mailto:karen.forrest@alaska.gov)

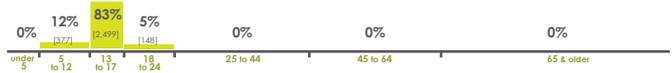
**\$59,283.2** DIVISION of JUVENILE JUSTICE | SPENDING BY PRIORITY (FY2014)  
 TOTAL BUDGET (FY2014)

**TOTAL BUDGET (FY2014)**



**PRIMARY SERVICE POPULATION**

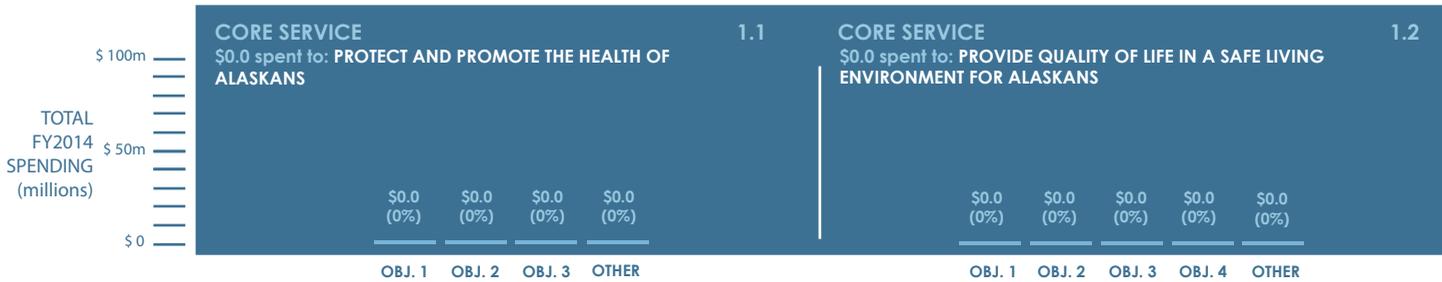
[Total service population 3462 individuals. Population age-range is 6 to 19 years old.]



**SNAPSHOT OF ALASKANS SERVED**

- 3,024 Probation Services (100%)
- 762 Secure Detention Services (25.2%)
- 135 Secure Treatment services (4.5%)
- 1,027 Alaska Native (34.0%)

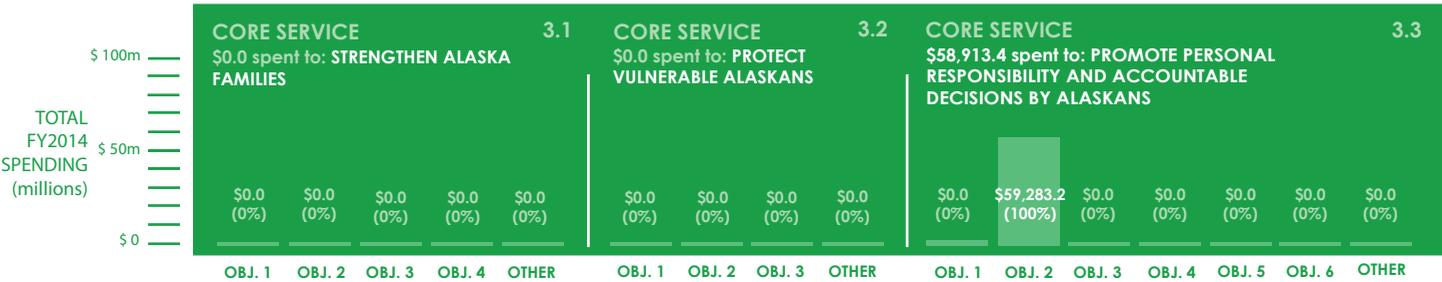
**PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN**



**PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE**



**PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES**



**OTHER**



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## Explanation of FY2015 Operating Budget Requests

### Division of Juvenile Justice

#### Budget Overview Table

Juvenile Justice	FY2014	FY2015 Gov	Difference
General Fund	\$56,037.2	\$55,951.9	\$-85.3
Federal Fund	1,817.9	1,518.4	-299.5
Other Funds	1,428.1	1,354.4	-73.7
<b>Total</b>	<b>\$59,283.2</b>	<b>\$58,824.7</b>	<b>\$-458.5</b>

DHSS FY2015 Governor's Request - Juvenile Justice					
General and Other Funds					
(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)					
Item	UGF	DGF	Federal	Other	Total
Reverse Alaska State Employees Association One-Time Payment (MYC, M at-Su, Kenai, Fairbanks, Bethel, Nome, JYC, Ketchikan, PS)	\$ (367.3)	\$ -	\$ (1.5)	\$ (1.0)	\$ (369.8)
Replace Child Nutrition Receipts for Anchorage School District's Rent for Step-Up Program (MYC)	\$ -	\$ -	\$ -	\$ -	\$ -
FY2015 Health Insurance and Working Reserve Rate Reductions (MYC, M at-Su, Kenai, Fairbanks, Bethel, Nome, JYC, Ketchikan, PS, YC)	\$ (131.1)	\$ -	\$ (1.1)	\$ (1.0)	\$ (133.2)
FY2015 Salary Increases (MYF, M at-Su, Kenai, Fairbanks, Bethel, Nome, JYC, Ketchikan, PS, YC)	\$ 418.3	\$ -	\$ 3.1	\$ 2.3	\$ 423.7
Reverse FY2014 MH Trust Recommendation (PS)	\$ -	\$ -	\$ -	\$ (341.5)	\$ (341.5)
Transfer to Epidemiology to Support New Grant Programs and Improved Indirect Claiming (PS)	\$ -	\$ -	\$ (300.0)	\$ -	\$ (300.0)
Reduce Expenditure Level (PS)	\$ (5.2)	\$ -	\$ -	\$ -	\$ (5.2)
MH Trust: Dis Justice - 4302.02 Mental Health Clinician Oversight in Youth Facilities (FY15-FY17) (PS)	\$ -	\$ -	\$ -	\$ 154.7	\$ 154.7
MH Trust: Dis Justice - Grant 3504.03 Div Juvenile Justice Rural Re-entry Specialist (FY15-FY17) (PS)	\$ -	\$ -	\$ -	\$ 112.8	\$ 112.8
Replace Uncollectible Interagency Receipt Authority for Interest Collected on Juvenile Accountability Block Grant (DP)	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Juvenile Justice Total</b>	<b>\$ (85.3)</b>	<b>\$ -</b>	<b>\$ (299.5)</b>	<b>\$ (73.7)</b>	<b>\$ (458.5)</b>

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# BUSINESS PLAN (2013-2015)



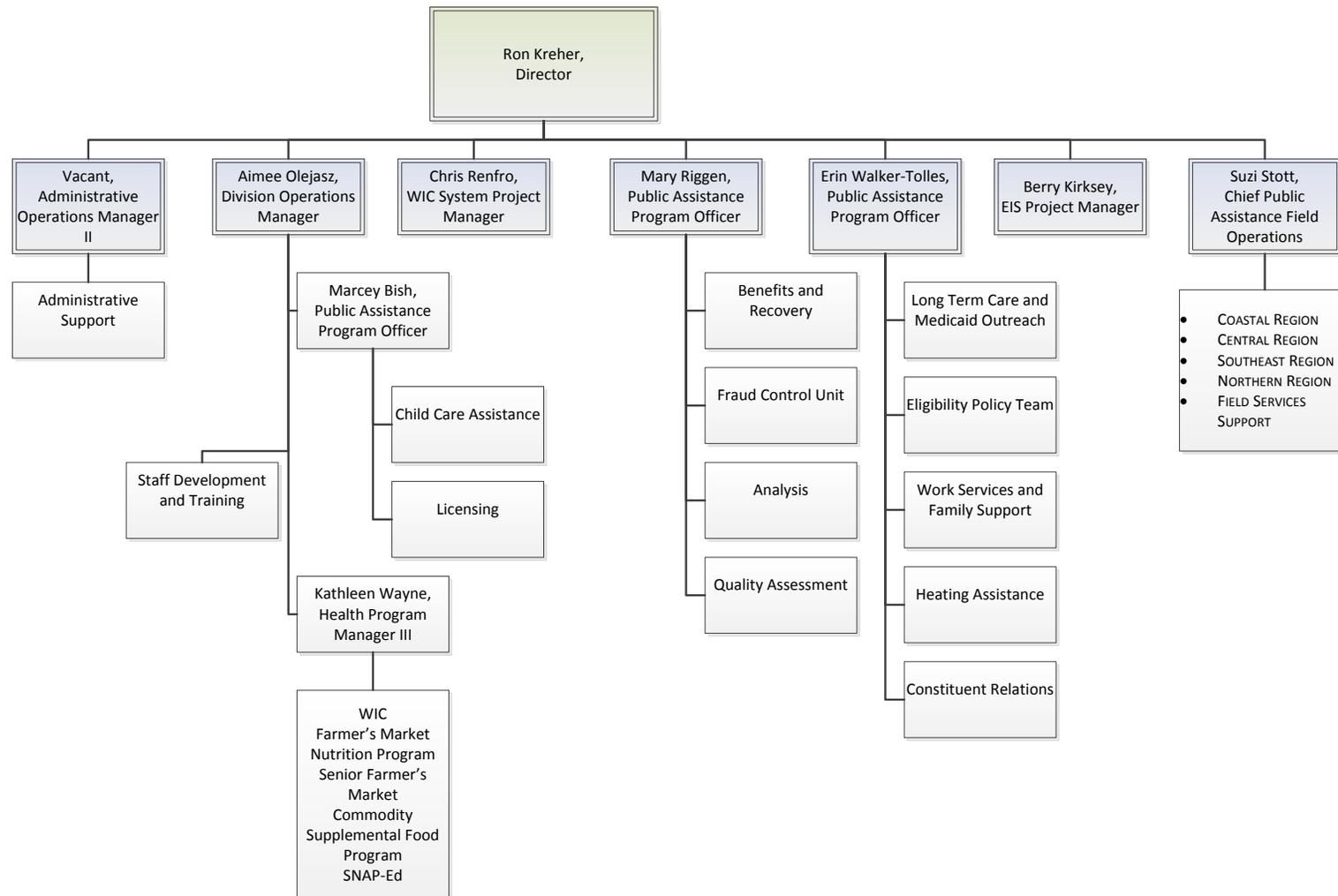
## DIVISION OF PUBLIC ASSISTANCE

**MISSION:** To promote self-sufficiency and provide for basic living expenses to Alaskans in need in order to support the health, safety and well being of all Alaskans.

# Contents

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# Organization Chart



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# Introduction

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## PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

### CORE SERVICE 1.1

Protect and promote the health of Alaskans

### CORE SERVICE 1.2

Provide quality of life in a safe living environment for Alaskans

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## PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

### CORE SERVICE 2.1

Manage health care coverage for Alaskans in need

### CORE SERVICE 2.2

Facilitate access to affordable health care for Alaskans

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## PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

### CORE SERVICE 3.1

Strengthen Alaska families

### CORE SERVICE 3.2

Protect vulnerable Alaskans

### CORE SERVICE 3.2

Promote personal responsibility and accountable decisions by Alaskans

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### ***Vision***

The Division of Public Assistance (DPA) is a national leader in best practices for the delivery of public assistance benefits and services. We continuously improve our business processes, effectively leverage technology, and enable our quality workforce to provide participant-centered services.

### ***Values***

The Division of Public Assistance:

Is *Customer Driven*.

Encourages and relies on *Community Partnerships*.

Promotes *Consistent, Efficient and Effective Management*

Promotes *Collaboration*.

Delivers *Effective, Outcome-Based Services*.

Develops and Supports a *Quality Work Force*.

Is a Responsible *Steward* of state resources and public funds.

Expects *Accountability and Responsibility*.

### ***About the Division of Public Assistance***

Every day thousands of Alaskans rely on the division to meet their most basic needs and to support their efforts to achieve economic independence. Our services are a significant element of the department's efforts to keep children safe and families healthy and strong. DPA's success as a partner in that effort depends upon over 550 employees located across the state, and our effective collaboration and coordination with other state departments and many community partners. The division and its partners are dedicated to supporting and improving the lives of children, adults and families in Alaska.

DPA provides statewide services through a range of programs such as Adult Public Assistance, Child Care, Medicaid, Denali KidCare Chronic and Acute Medical Assistance, Supplemental Nutrition Assistance Program (SNAP aka Food Stamps), Family Nutrition Programs, General Relief Assistance (includes burial assistance), Heating Assistance, Senior Benefits, Temporary Assistance, Work Services, and Native Family Assistance Programs.

Direct services are delivered at 19 state field offices for determining eligibility for Public Assistance, 3 Child Care Program Offices, 2 Family Nutrition Services Offices, and 13 support offices consisting of Fraud Control, Administrative Services, Policy Development, Quality Assurance,

Program Integrity, System Operations, and Training. In addition, the Women, Infants and Children (WIC) program, and some employment case management services and programs administered by the

Child Care Program Office, are provided through 59 grants and contracts with community agencies. In FY2013, the division provided cash, food and nutrition, medical, child care and heating assistance benefits and services to approximately 131,344 Alaskan households and over 195,340 individuals<sup>1</sup>.

### ***Core Services***

The division's core services are intended to help Alaskans remain safe and healthy, prevent long-term dependency, and support Alaskans as they work toward family stability and economic independence. Division staff provides accurate and timely eligibility determinations for program benefits and makes services available through a variety of programs that support the department's priorities. To qualify for assistance, individuals must meet financial and non-financial guidelines which vary by program.

DPA's core services focus on:

- 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, increase food security, and reduce obesity;
- Assistance with paying home heating costs;
- Child care assistance for families, including families caring for foster children and children with special needs, who need child care in order to work or participate in approved work or training activities as well as children in child protective services;
- Child care licensing services, monthly reimbursable grants to eligible child care providers and initiatives to promote access to high quality child care;
- Child care referrals to families, and training and technical assistance to early childhood care and education providers;
- 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.

The Division of Public Assistance serves a wide range of vulnerable and at-risk Alaskans every day. The division is always prepared to assist families or individuals that experience a personal crisis, disasters and local emergencies, or economic changes that impact self-reliance. The need for public assistance is very sensitive to economic conditions. When unemployment increases, even marginally, there is a greater demand for program services and more pressure on funding, staff, and additional resources.

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<sup>1</sup> Number of unduplicated recipients and households for the fiscal year.

The division's business plan supports the department's priorities and core services through its contribution to the following department objectives which are central to the division's mission:

- Alaskan families develop work skills
- Alaskan families have safe and affordable child care
- Alaskan families have warm homes
- Alaskan families have food security
- Health and social services facilities in which Alaskans are served are safe
- Reduce fraud, waste and abuse
- Alaskans are healthy

The division also contributes to the following department objectives for which metrics are currently in development:

- Alaskan have access to health care
- Older Alaskans live safely in their communities
- Alaskans with disabilities live safely in the least restrictive environment

DPA works constantly to improve its business practices and service delivery model to ensure the best outcome for program beneficiaries and the most efficient and effective program administration possible. This entails responsible stewardship of the programs and services we are entrusted to manage and wise use of public funds to accomplish program goals. The division's FY2014 operating budget of just over \$330 million is prudently managed to support the department's mission, with 78% of the budget going directly to eligible Alaskans or to local vendors providing direct services to program beneficiaries. The remaining 22% of the division's budget is divided between administrative costs including employee benefits and wages (14%) and all other costs (8%).

The division creates success by focusing on continuous improvement, accountability for our work, and objective measurement of performance. The division recognizes that our accomplishments are dependent on our partnerships with other departments, divisions and community organizations.

Strategies to ensure and improve efficient and effective program administration include:

- Business process improvements
- Integration and coordination of services
- Leveraging technology to support and enhance business processes
- Aligning policies to simplify and streamline program administration
- Staffing models that reflect needs of existing and projected workloads
- Improved and streamlined program training for staff
- Expanding support for fraud control
- Strategic planning
- Measuring and improving performance

# Priority 1 – Health & Wellness Across the Lifespan

## CORE SERVICE 1.1 PROTECT AND PROMOTE THE HEALTH OF ALASKANS

### Objective 1.1.1- Improve the Health Status of Alaskans

**Effectiveness measure 1.1.1a:** Percent of overweight and obese woman and children in Alaska

**Efficiency Measure 1.1.1b:** Decrease in the percent of woman and children identified as overweight or obese

**Effectiveness measure 1.1.1c:** Percent of women breastfeeding during the first month up to 12 months.

**Efficiency measure 1.1.1d:** Increase the breastfeeding rates at initiation, 6 month, and 12 months.

#### Strategies:

1. Reduce the proportion of Alaskans who are overweight and obese
2. Increase the proportion of Alaskans who are protected from vaccine-preventable diseases
3. Reduce the number of Alaskans experiencing domestic violence and sexual assault
4. Increase the proportion of Alaskans protected against dental diseases

#### Actions:

1. Focus program outreach messages on physical activity and making healthy food choices to increase consumption of healthy foods; provide routine nutrition counseling; encourage and support breastfeeding; issue targeted messages from both WIC and SNAP-Ed to impact the issues of overweight and obesity.
2. Enhance partnership with the Vaccinate Alaska Coalition; conduct checks of immunization records and refer WIC eligible children to obtain age-appropriate vaccinations.
3. Assess if WIC applicants are at risk of harm and refer applicants to shelters and provide additional resources to support the applicant.
4. Refer one year olds for dental care and fluoride supplementation and provide nutrition education geared towards the reduction in the consumption of sugary beverages.

#### Interdependencies- Our key business partners are:

- Alaska Food Bank
- Division of Public Assistance, Child Care Program Office
- Division of Public Health
- Families
- Federal partners
- Finance and Management Services/Information Technology
- Legislators and legislative staff

- Grantees
- University of Fairbanks

### **Analysis:**

- In FY14, WIC grantees were required to have a dedicated Registered Dietitian monitoring nutrition assessments, counseling, and food package assignments. WIC tracks the height and weight of all participants. Alaska WIC Overweight children rates have maintained at 21%. Reductions in WIC data on overweight and obesity for women and children cannot be solely attributed to services provided through WIC.
- The Alaska WIC Program partners with the DPH Immunization Program to ensure WIC agencies have information on current immunization standards. WIC clinics monitor child immunization records and make referrals. Increases in the number of infants and children up to 5 years of ages that receive vaccines cannot solely be attributed to WIC referrals.
- WIC is a mandatory reporting agency and WIC applications ask if clients have any concerns about themselves or their children being physically harmed or if the client is in a relationship with anyone who pushes, hits, or threatens the client. If WIC clients are concerned about physical harm, they are referred to their local family protective service providers; however, WIC does not track this in WIC computer system. Reductions in the number of Alaskans experiencing domestic violence and sexual assault cannot solely be attributed to WIC referrals.
- WIC tracks the number of infants that are given bottles containing sugary beverages. Between FY12 and 13, there was a 9% decrease in the number of times “Sugary Containing Fluids” was assigned as a nutrition risk code for children ages 1-5 participating in WIC. Any reduction in the proportion of Alaskans protected against dental diseases cannot solely be attributed to WIC counseling and referrals.

### **Looking Ahead:**

1. With each WIC agency having a dedicated Registered Dietitian on staff, the state now offers quarterly WIC Dietitian teleconferences to ensure the quality of our nutrition services meets federal requirements. The state also contracts with Western Michigan University to provide on-line nutrition education for WIC clients that are based on each client’s stage of behavioral change. WIC staff follow-up with clients that receive on-line nutrition information to answer questions or help set new nutrition goals.
2. WIC plans to facilitate local WIC agency access to the VacTrAK, Alaska’s immunization information system, to better monitor child immunization records.

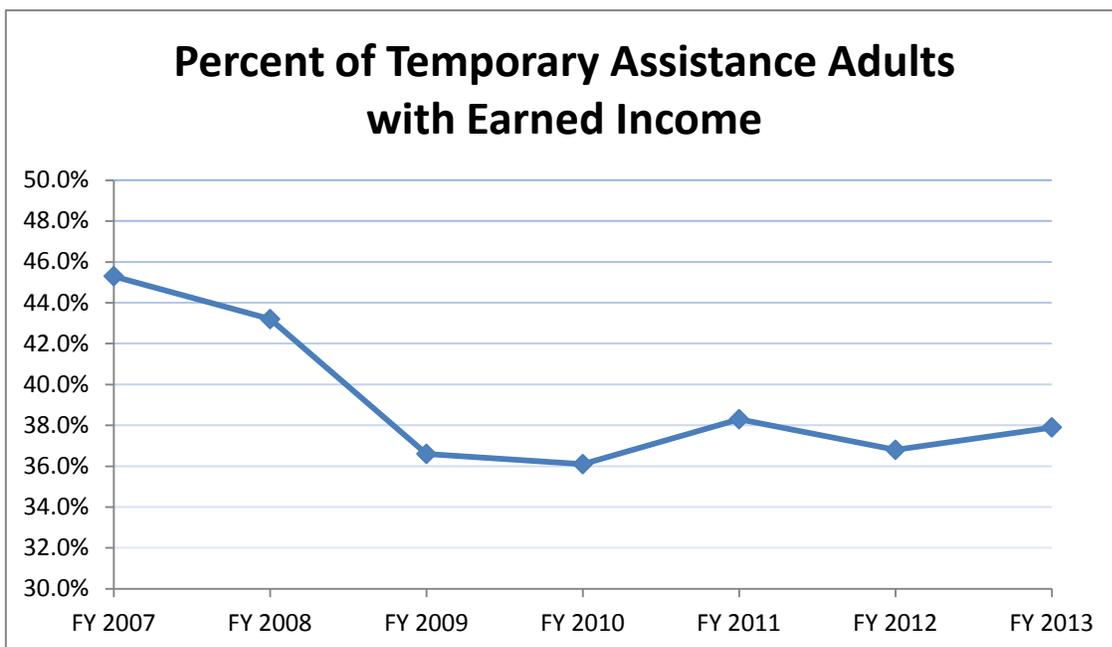
3. As part of the biennial WIC grantee monitoring visits, the state WIC staff monitors how often clinic staff receive training on domestic violence.
4. The WIC state office participates in the Alaska Alliance for Healthy Kids strategic plan which includes a subcommittee on the reduced consumption of surgery beverages. In addition, are members of the Healthy Alaskans 2020 Team.

# Priority 3 – Safe & Responsible Individuals, Families & Communities

## CORE SERVICE 3.1 STRENGTHEN ALASKA FAMILIES

### Objective 3.1.1- Increase the number of Alaska families who are employed

**Effectiveness Measure 3.1.1.1a** - Percent of individuals receiving employment related services from the department who achieve employment



**Efficiency Measure 3.1.1.1b** – Cost of supported employment services per successful participant in Job Start or on-the-job training.

#### Strategies

1. Develop and sustain integrated service delivery within the division, partner divisions and other agencies serving common clients
2. Leverage technology to better identify common clients served within the division and by partner divisions and to improve case management business processes
3. Develop individual and family-centered services and effective assessment tools to ensure services are appropriate and support movement toward self-sufficiency
4. Improve employment focused case management services for parents receiving temporary assistance
5. Ensure access to supports that promote getting and keeping a job
6. Help temporary assistance families to find and access high quality child care

## **Actions**

1. Coordinate and integrate department level initiatives that provide supports for at-risk families with dependent children (e.g. Division of Public Health Home visitation project and Division of Behavioral Health SHIELD initiative) into Work Services.
2. Incorporate Master Client Index into development of Alaska's Resource for Integrated Eligibility Services (ARIES)
3. Fully implement use of the Behavioral Health Screening Tool in Work Services delivery model.
4. Establish Work Services training specialist in the division's Staff Development and Training Unit and provide consistent, measurable, and appropriate adult learning techniques during training.
5. Provide trauma informed care training for all Division, grantees and contracted case management staff.
6. Allocate funding to ensure employment supports are available for parents receiving assistance including job development, job coaching, child care and other supports (such as bus passes, transportation, work tools and vocational training).
7. Ensure child care subsidy rates are current with the market price for child care, and income eligibility guidelines align with current state median income; facilitate coordination of Alaska's Child Care Resource and Referral Network and Work Services case management; train DPA staff and partners on the importance of high quality child care.

### **Interdependencies- Our key business partners are:**

- Advocacy Groups
- Alaska Child Care Resource and Referral Network
- Alaska Tribal Organizations
- Community-based organizations and service providers
- Department of Labor and Workforce Development
- Division of Behavioral Health
- Division of Juvenile Justice
- Division of Public Health
- Federal partners
- Finance and Management Services/Information Technology
- Legislators and legislative staff
- Office of Children Services

## **Analysis**

As more parents successfully enter the workforce and close their assistance case, a larger proportion of families remaining on assistance have multiple or profound challenges to obtaining and retaining employment.

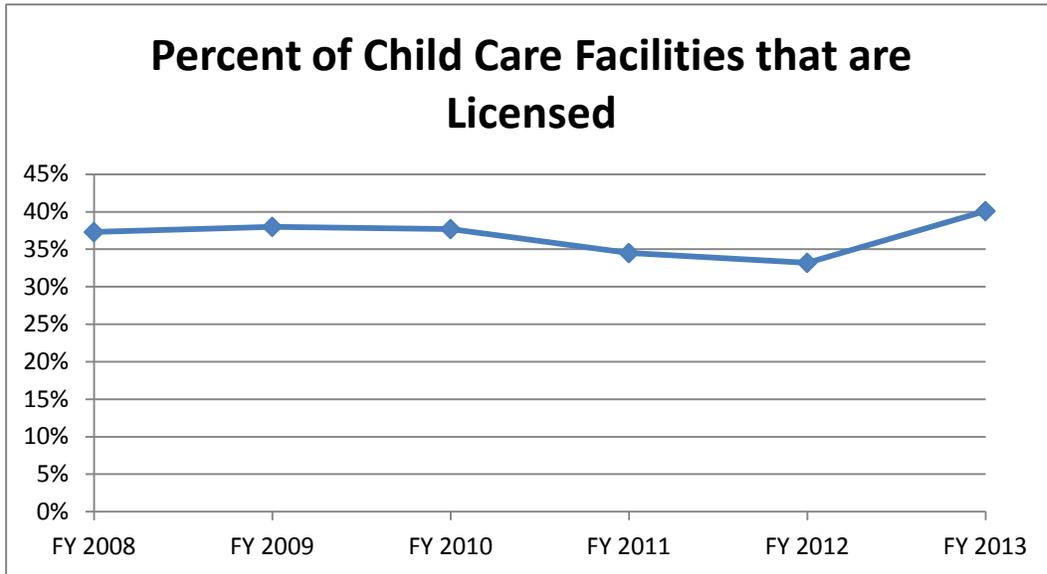
Regional and local economic conditions, and the availability of community-based resources that support employment and training opportunities, are significant constraints to meeting program objectives. Families with multiple and profound challenges are significantly impacted by these conditions and limited resources. Building and sustaining effective collaborations with key stakeholders are critical for improving outcomes for families.

## **Looking Ahead**

- The division has implemented the Families First Model of integrated, family-centric services to help families receiving Alaska Temporary Assistance Program (ATAP) benefits with complex and profound challenges leave temporary assistance;
- Families First ensures those parents unable to go to work full-time have the services and resources they need to go to work as soon as possible;
- Services include screening for hidden barriers and referrals to service agencies; leveraging agency resources and coordination with department and community partners to create integrated plans for all the services they receive to maximize effectiveness of services so families are safe, healthy and stable, and parents are able to go to work;
- Work First remains a critical part of ATAP services helping parents able to work full-time to get a job immediately;
- Increased placements in structured work experience and expanded range of work-focused rules and services for targeted job development, job coaching, and training in skills needed to retain and advance at work are being implemented for Families First and Work First parents to increase work opportunity and success;
- Continued support the expansion of Native Family Assistance Programs (NFAP) that, due to the special tribal/federal relationship, have greater flexibility in providing culturally relevant work activities and supports allow;
- Leveraging IT systems and resources to streamline administrative work for ATAP services and NFAP to maximize the impact each worker can make, and measure incremental progress parents make towards getting a job and working full-time;
- In-house (DPA staffed) ATAP services with a focus on employment and immediate Families First and Work First services in areas where past performance showed services administered by contractor or partner were not achieving outcomes as planned;
- Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program redesign to better leverage partner resources for cost sharing and meaningful services to help adults receiving SNAP go to work and no longer need SNAP benefits.

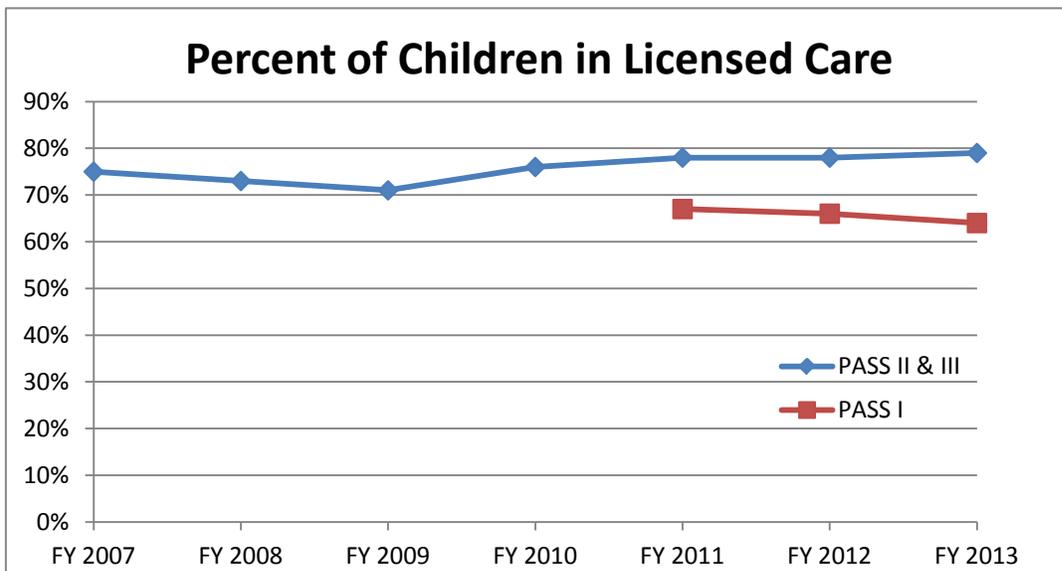
**Objective 3.1.2 Increase the number of Alaska families with access to safe, affordable, high quality child care**

**Effectiveness Measure 3.1.2.1a** - Percent of child care licensed facilities participating in the Alaska Child Care Assistance Program (CCAP)

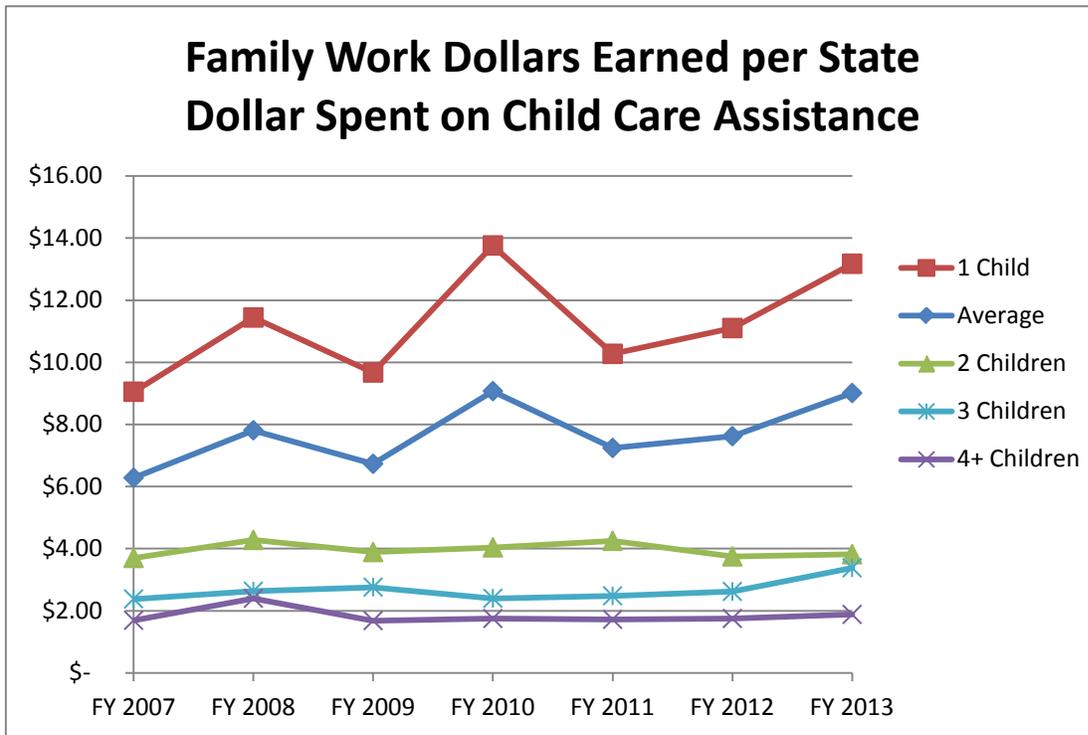


**Efficiency Measure 3.1.2.1b** – Average time from receipt of initial application to license issuance

**Effectiveness Measure 3.1.2.2a** – Percent of Alaskan children participating in the Alaska Child Care Assistance Program (CCAP) who are cared for in licensed child care facilities



**Efficiency Measure 3.1.2.2b** – Family work dollars earned per state dollar amount spent on child care assistance.



**Strategies**

1. Educate parents about high quality child care
2. Develop and implement a Quality Rating and Improvement System (QRIS)<sup>2</sup>
3. Increase access to high quality child care
4. Increase access to high quality child care for children with special needs
5. Review and revise policy to promote and support continuity of child care services for children and relief to families working toward long-term stability
6. Increase the number of licensed child care providers who offer services during non-traditional hours (evenings and weekends)

**Actions**

1. Targeted and widespread distribution of parent education materials pertaining to high quality child care to all DPA offices, grantees, contractors, providers, medical facilities, schools and partners.
2. Update the QRIS state plan, develop a timeline, and secure funding for implementation.
3. Improve timeliness and accuracy of child care authorization documents to families and providers.

<sup>2</sup> Alaska Early Childhood Coordinating Council Strategic Plan 2012

4. Coordinate department-wide efforts and partner with the Department of Education and Early Development to increase access to child care for children with special needs.
5. Revise child care regulations and policies to support ongoing eligibility for child care assistance benefits; for example, to account for changes in family circumstances such as a parent changing jobs, coverage when a child is sick or for limited days in which the family is on vacation.
6. Research reasons that providers are not currently offering services outside traditional hours.

**Interdependencies- Our key business partners are:**

Alaska Background Check Program

Advocacy groups

Alaska Child Care and Development Fund (CCDF) Tribal grantees

Alaska Child Care Resource and Referral Network

Alaska Early Childhood Coordinating Council (AECCC)

Alaska families

Child Care Providers

Department of Education and Early Development

Department of Public Safety

DPA Temporary Assistance Work Services providers

Federal Administration for Children & Families, Office of Child Care

Grantee organizations providing Child Care Assistance services

Legislators and legislative staff

Municipality of Anchorage (Child Care Licensing services within the municipality)

Office of Children's Services

System for Early Education Development (SEED) Committee

**Analysis**

The Division has seen an increase in the number of child care facilities that are licensed and children in licensed child care participating in the Child Care Assistance Program (CCAP) over the past state fiscal year. This means more children in families with low income are gaining access to higher quality child care. There are many factors that may be contributing to the increase: the economy; increased knowledge and awareness of the CCAP through distribution of brochures and consumer information; improved coordination and collaboration between the Child Care Program Office (CCPO), other Division programs, grantees and contractors; restructuring of the CCAP service delivery areas; increased CCPO and grantee efforts around recruitment and retention; and a decrease in the amount of time from receipt of an initial licensing application to license issuance.

An overall increase in family work dollars earned per state dollar amount spent on child care assistance has also been observed this past state fiscal year. However, it is important to note the huge disparity between work dollars earned per state dollar spent on child care assistance as the number of children in the family expands to more than one child. Please see graph for efficiency measure 3.1.2.2.

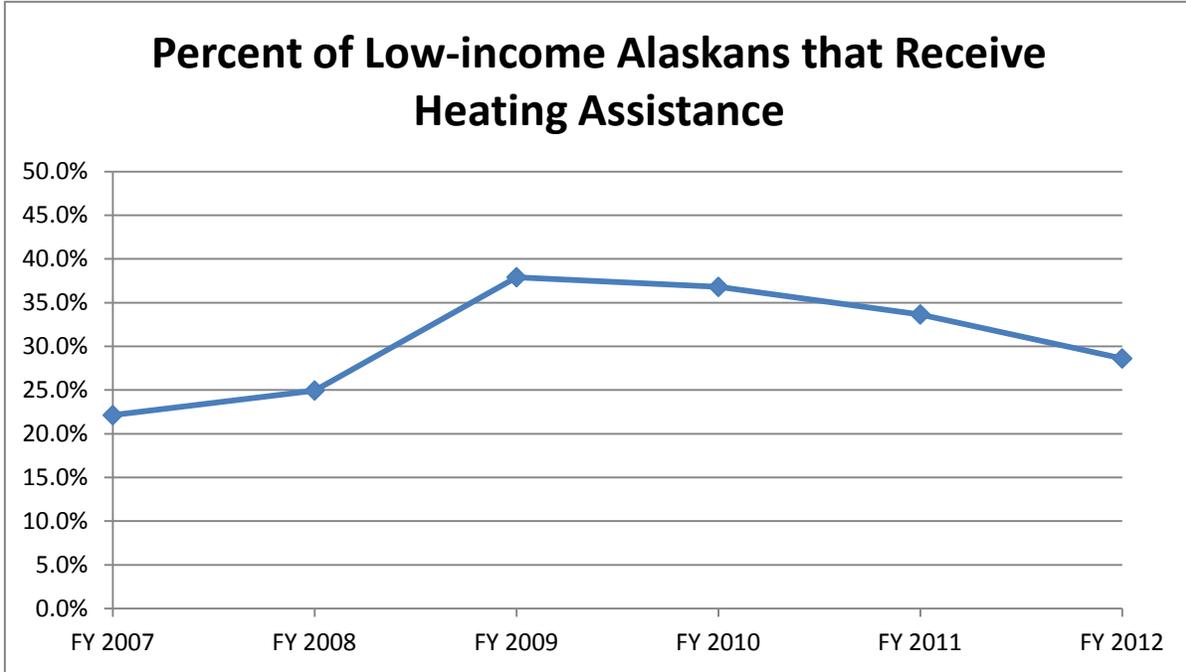
The high cost of child care, continuously increasing provider prices charged for child care, state subsidy rates that are not keeping pace with the growing cost of doing business, and outdated income qualifying standards contribute to significant out of pocket expenses for low income families needing child care especially when more than one child is needing care.

**Looking Ahead**

The division will continue to increase the number of Alaska families with access to safe, affordable, high quality child care. New parent education and resource materials on high quality child care rolling out early in calendar year 2014 will better inform parents on how to select appropriate care for their children. Sustaining renewed momentum for moving forward with a Quality Rating and Improvement System will support and promote quality care. Regular updates to child care subsidy rates and income eligibility guidelines are needed to close the gap between subsidy rates and child care costs. Targeted federal technical assistance around QRIS and recruitment and retention of the early care and education workforce will help providers build a quality workforce. Continued alignment, streamlining and integration of division programs and processes and continuous improvement of data collection, tracking, and analysis as it relates to child care will help ensure administrative efficiency and effective program integrity.

**Objective 3.1.3 Increase the number of low-income families with warm homes**

**Effectiveness Measure 3.1.3.1a- Percent of low –income families that receive heating assistance**



**Efficiency Measure 3.1.3.1b– Average time from receipt of application to eligibility determination**

**Strategies**

1. Simplify program rules to reduce administrative burden and ensure timely and equitable distribution of benefits for low-income households
2. Tribal organization increase and maintain capacity to administer LIHEAP and AKHAP programs
3. Increase outreach and access for heating assistance and weatherization programs
4. Achieve national program outcomes
5. Simplify and streamline business process
6. Development of consistent staff training program

**Actions**

1. Partner with legislators and stakeholders to revise statutes and regulations to replace community heating points funding system with a less complex and more easily maintained funding strategy.
2. Conduct grant monitoring and technical assistance to identify possible administrative supports.
3. Identify and pursue non-traditional outreach strategies.

4. Assess and address gaps in data collection needed to meet emerging federal program objectives.
5. Map businesses processed and implement identified efficiencies.
6. Task training unit to develop formal, measurable, and consistent training for staff. Provide documented policies and procedures, as well as updates timely for all staff.

**Interdependencies- Our key business partners are:**

Alaska Housing Finance Corporation (AHFC)

Department of Revenue

Federal partners

Heating and electrical vendors

Individuals who sell wood

Regulatory Commission of Alaska

Tribal organizations

Weatherization grantees

**Analysis**

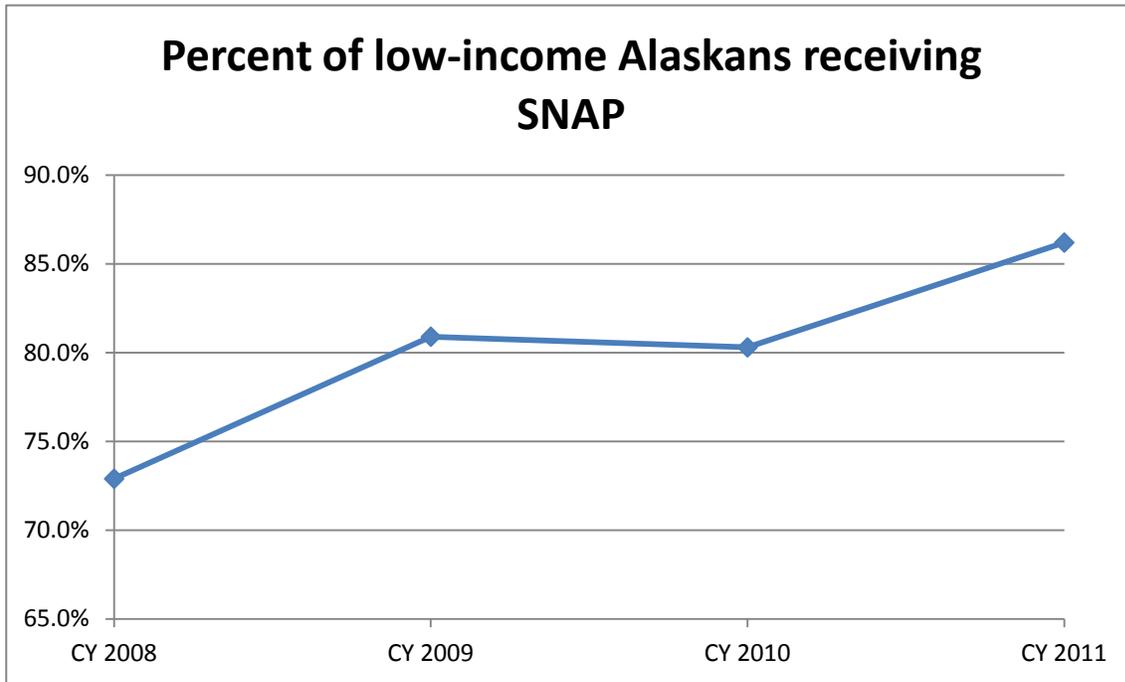
The percent of low income households receiving assistance is influenced by home heating costs and the severity of the weather. The current funding methodology can result in inconsistent and widely varied funding for this program. The community heating points system is complex and difficult to update and explain.

**Looking Ahead**

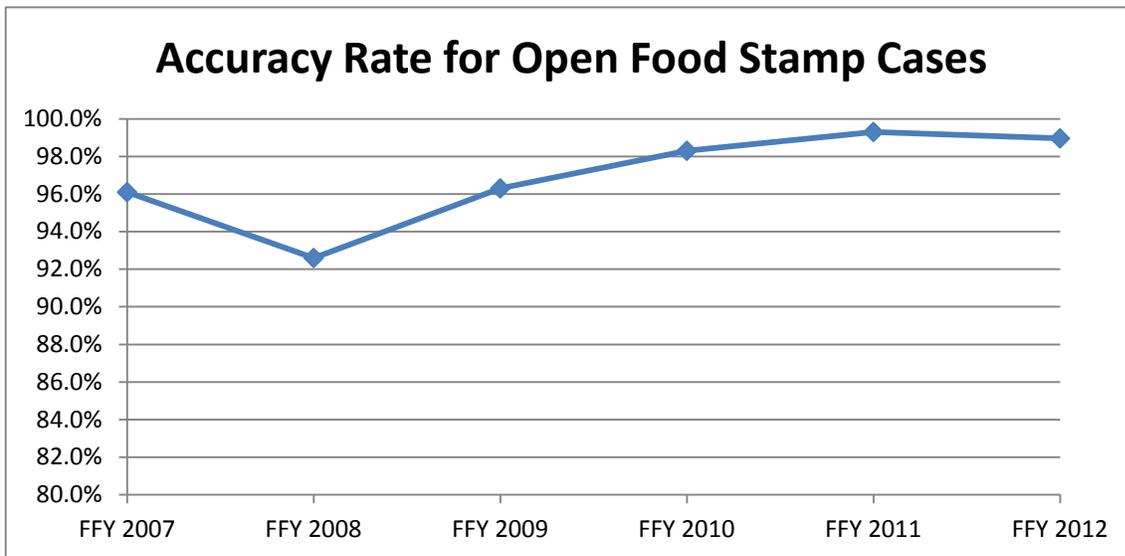
- Integration of heating assistance eligibility determination application for services into ARIES.
- Evaluate impact of change to a formula program.
- Evaluate the impact of weatherization and grants.

**Objective 3.1.4 Increase the number of Alaska families with food security**

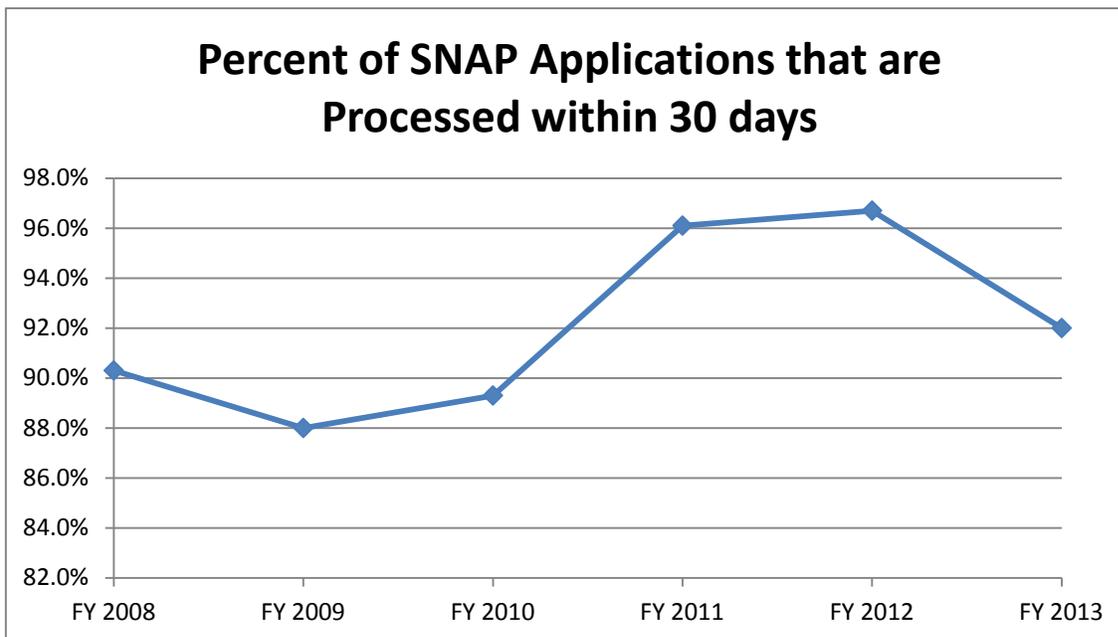
**Effectiveness Measure 3.1.4.1a**– Percent of low-income Alaskans receiving Supplemental Nutrition Assistance Program (SNAP) benefits through the Food Stamp program



**Efficiency Measure 3.1.4.1b**– Accuracy rate for open Food Stamp cases



**Efficiency Measure 3.1.4.1c – Percent of SNAP applications that are processed timely**



**Strategies**

1. Promote access to nutrition assistance programs
2. Continue direct certification of low income children for the school lunch program
3. Promote nutrition education and wise use of benefits and food resources
4. Ensure food availability to rural Alaskans
5. Ensure timely and accurate eligibility determinations

**Actions**

1. Increase the visibility of the locations providing applications for SNAP, WIC, and other nutrition assistance programs. Help low income Alaskans apply for benefits through outreach activities.
2. Provide a list of recipients to the Department of Education and Early Development and promote the summer lunch program for low-income children.
3. Increase access to farmers markets and nutrition education services to promote healthy choices.
4. Promote Electronic Benefit Transfers (EBT). Support local farmers markets and work with the Department of Natural Resources on a “fruit and vegetable Passport” to transport fruits and vegetables from urban areas to rural areas.

5. Design the new eligibility system to facilitate timely and accurate eligibility determinations; continued improvement of efficient business processes and equitable statewide caseload distribution.

**Interdependencies- Our key business partners are:**

Alaska Division of Agriculture  
Alaska Food Coalition and food banks  
Alaska Native Tribal Health Consortium  
Alaska schools  
Contractors, grantees and vendors  
Department Of Administration/Enterprise Technology  
Department of Education and Early Development  
Electronic Benefit Transfer (EBT) contractor  
Farmers  
Federal partners  
Finance and Management Services/Information Technology  
Food retailers and farmers markets  
Senior centers  
Tribal organizations  
United States Department of Agriculture (USDA) Alaska Task Force  
University of Alaska  
Western States EBT Alliance

**Analysis**

The economic downturn, coupled with the increase in food costs, has led to an increased proportion of low income Alaska households that apply for and receive food assistance. The division's ability to continue to provide accurately and timely benefits is impacted by the increased number of applications for assistance due to the economic downturn.

**Looking Ahead**

The Division will:

- Continue to increase the number of farmers markets that accept SNAP benefit cards.
- Complete the feasibility study for concrete data and move forward to complete the Nutrition needs assessment.
- Continue to work toward the implementation of WIC Electronic Benefit Transfer (EBT) system. The Implementation new eligibility and case management systems to promote access and increase efficiency for determining eligibility.
- Implement the WIC SPIRIT System (Successful Partners In Reaching Innovative Technologies).

## CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS

### **Objective 3.2.3 Improve client safety within department and provider operated facilities**

**Effectiveness Measure 3.2.3.1a** – Percent of facilities licensed by the department that are free from substantiated reports of harm

**Efficiency Measure 3.2.3.1b** – Cost of licensure functions and oversight

**Efficiency Measure 3.2.3.1c** – Percent of time that enforcement action is issued within required timeframe

#### **Strategies**

1. Conduct regularly announced and unannounced on-site inspections of licensed child care facilities
2. Improve timeliness of the issuance of enforcement actions
3. Review and revise regulations governing licensed child care facilities on a regular basis
4. Increase the number of early childhood caregivers with degrees in Early Childhood Education and related fields
5. Leverage technology to capture data necessary to effectively evaluate and contribute to business decisions.
6. Coordinate interdepartmentally to ensure consistent reporting on the cost of licensure functions and oversight related to enforcement actions,

#### **Actions**

1. Complete at least one announced and one unannounced on-site inspection per licensed child care facility annually.
2. Streamline report writing process to reduce the number of days between completion of an investigation and issuance of enforcement action.
3. Identify any licensing regulation needing revision, develop drafts, and engage stakeholders in public comment process.
4. Support the Retaining Our Outstanding Teachers (ROOT) initiative through Alaska's Child Care Resource and Referral Network (increased education improves the quality of care).

5. Provide resources for programming and testing of child care eligibility and case management system.
6. Organize and interdepartmental collaborative to develop and implement strategies to capture cost of licensure functions related to enforcement actions.

**Interdependencies- Our key business partners are:**

Administration for Children & Families, Office of Child Care  
Advocacy groups  
Alaska Child Care and Development Fund (CCDF) Tribal grantees  
Alaska Child Care Resource and Referral Network  
Alaska Early Childhood Coordinating Council (AECCC)  
Alaska families  
Child Care Providers  
Grantee organizations providing Child Care Assistance services  
Legislators and legislative staff  
Local and state law enforcement  
Municipality of Anchorage (Child Care Licensing services within the municipality)  
Office of Children's Services  
System for Early Education Development (SEED) Committee

**Analysis**

The Division has just started to track information related to these performance measures in FY 13. Data collection is manual at this time making evaluation of past years problematic due to a lack of resources to obtain the data. The information reported includes data collected from the State and Municipality of Anchorage Child Care Licensing Programs.

The Child Care Program Office has been working toward the national best practice standard of at least four on site inspections per year of licensed child care facilities by increasing the number of onsite inspections the past couple of years to at least one announced and one unannounced on site inspection annually per licensed child care facility. A higher number of onsite inspections with consistent evaluation and standards across the state have resulted in a low number of substantiated reports of harm.

While cost of licensure function oversight (total dollars spent on licensing and oversight) is not a true reflection of the actual cost of enforcement, it is the most readily available information the licensing entities of the department can consistently report on. More interdepartmental collaboration and coordination is necessary to identify an agreed upon method to capture cost of licensure functions specifically related to enforcement actions.

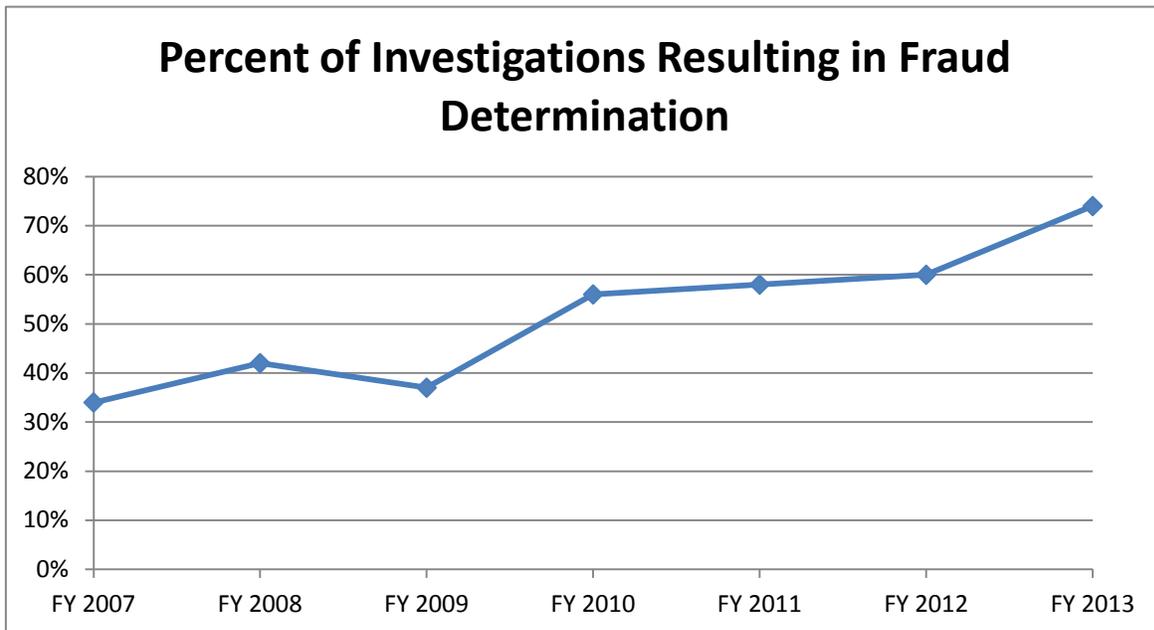
**Looking Ahead**

Through increased coordination and collaboration among state agencies with oversight of entities listed in AS 47.32 as well as state and local law enforcement, the Division will continue to reduce the number of substantiated reports of harm and better be able to capture the true cost of enforcement. More effective IT solutions and use of technical resources while on site at child care facilities will help to address Child Care management and data needs, eliminate duplication of work or the need for manual data collection, and increase the percent of time enforcement action is issued timely.

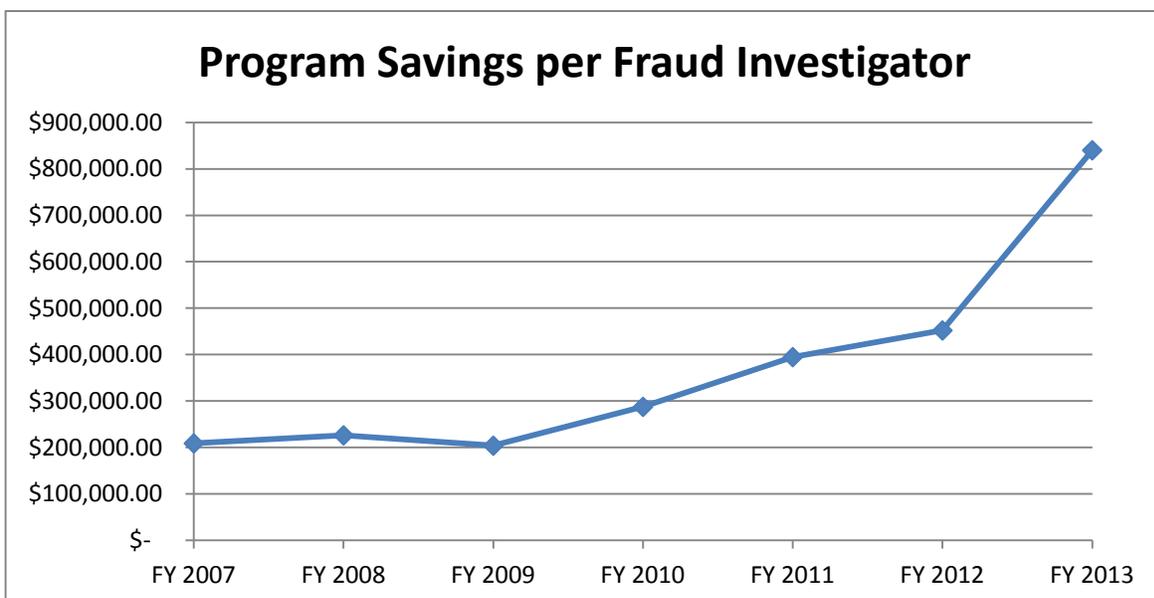
CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

Objective 3.3.6 Reduce fraud, waste and abuse

Effectiveness Measure 3.3.6.1a – Percentage of investigations that result in fraud determinations



Effectiveness Measure 3.3.6.1b – Program savings per fraud Investigator



## **Strategies**

1. Obtain necessary statutory and regulatory authority to investigate and prosecute fraud, and allow state evaluation of internal programs and procedures to ensure compliance with program rules and avoid federal findings and penalties.
2. Develop effective policy and procedures to support successful pursuit of fraud and trafficking
3. Leverage training and technology to better identify potential fraud and manage the investigatory and disqualification process
4. Increase use of analytics, data mining, and collaboration with stakeholders to generate fraud investigations
5. Add resources to increase fraud investigations that can be completed
6. Ensure timely and accurate audit processes to ensure compliance with financial and administrative rules

## **Actions**

1. Increase penalty for unsworn falsification from a class A misdemeanor to a class C felony, obtain authority to prosecute trafficking of non-cash benefits, and expand the programs for which fraud remedies can be pursued; obtain authority to initiate state audit and evaluation of programs to ensure compliance with federal rules and avoid federal penalties.
2. Coordination and collaboration between DPA program offices (Child Care Program Office, WIC, Medicaid, Heating Assistance Program, Senior Benefits, etc.) Fraud unit, Department of Law, and Department of Administration on identifying process and procedures for successfully pursuing potential fraud and trafficking.
3. Leverage IT, policy and training to reduce applicant misrepresentation of their circumstances; replace the fraud case management system.
4. Identify and use a variety of data, federal and state interfaces, and referrals from partner agencies, to target fraud investigations.
5. Secure funding and positions for investigators to increase prosecutions, plea bargains referrals, respond to partner agency referrals, and conduct trafficking investigations; identify funding resources to allow completion of a new fraud case management system.
6. Coordinate efforts to train staff and conduct audits of programs, grantees and contractors to verify inconsistencies and violations of federal and state rules.

## **Interdependencies- Our key business partners are:**

Advocacy groups

Data Sharing Partners (Public Safety, Elections, Corrections, Human Resources)

Department of Law

Department partners (Divisions)

Department of Revenue (Child Support Services Division, Permanent Fund Division)

EBT Contractors

ETS / IT

Federal partners

Grantee and contractors

Legislators and Staff

Local State Federal Law Enforcement

Office of Administrative Hearings

### **Analysis**

Increased fraud collections are due in part to hiring a full-time research analyst to support identification and pursuit of fraud activities via use of data mining and metrics to target most likely fraud circumstances.. Good fraud referrals lead to higher percentage of investigations resulting in fraud determinations. The increase of savings per fraud investigator is a result of a dedicated prosecutor for the Division programs and the investigators focusing on criminal prosecutions. Overall increase in program savings through fraud efforts includes the strategic use of data mining, preparation for criminal prosecution, increase in staff, and increased collaboration with partners such as Child Support services Division.

### **Looking Ahead**

Implementation of a Fraud case management system and integration with the new eligibility and child care systems will allow the division to continue to leverage and maximize programmatic saving through efforts to pursue fraud. Pursuit of fraud must include both federally required administrative hearings, and criminal proceedings. To continue to increase savings realized per investigator, additional Investigator IIIs with expertise in preparing cases for criminal prosecutions are needed. It is also critical to maintain the current number of Investigator IIs that complete administrative hearings and help conduct criminal investigations.

## Division Information

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Division Performance Measure Contact

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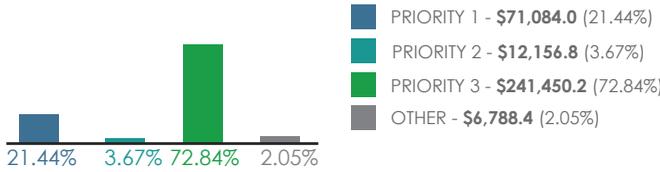
**Tel** 907.465.2680

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[dhss.alaska.gov/dpa](http://dhss.alaska.gov/dpa)

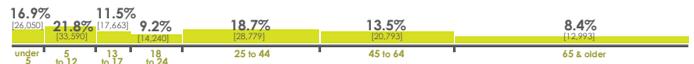
# DIVISION of PUBLIC ASSISTANCE | SPENDING BY PRIORITY (FY2014)

**\$331,479.4** TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

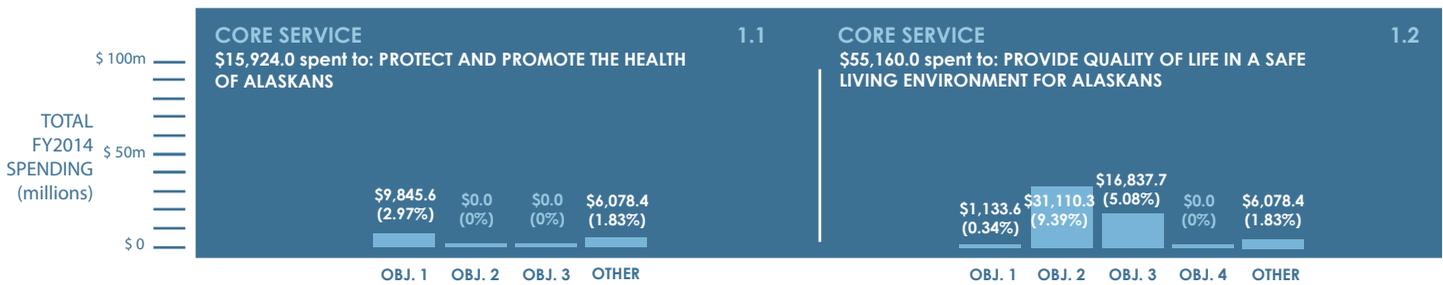
Total service population **154,108** individuals. Total does not include: General Assistance, Heating Assistance and some WIC clients.



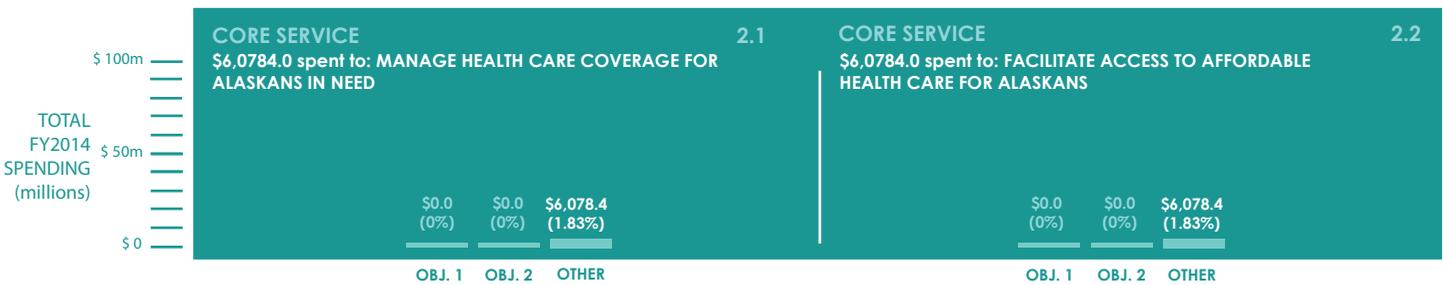
## SNAPSHOT OF ALASKANS SERVED

- Served 131,344 Alaskan households and over 195,340 individuals.
- Over 70% are children or elders (age 60 and older).
- Of the \$330 million budget, 78% of the budget goes directly to eligible Alaskans.
- Provided \$453 million dollars in public assistance benefits and supports to needy Alaskan's or vendors
- Licensed 551 child care facilities serving 4,203 children through the child care assistance program

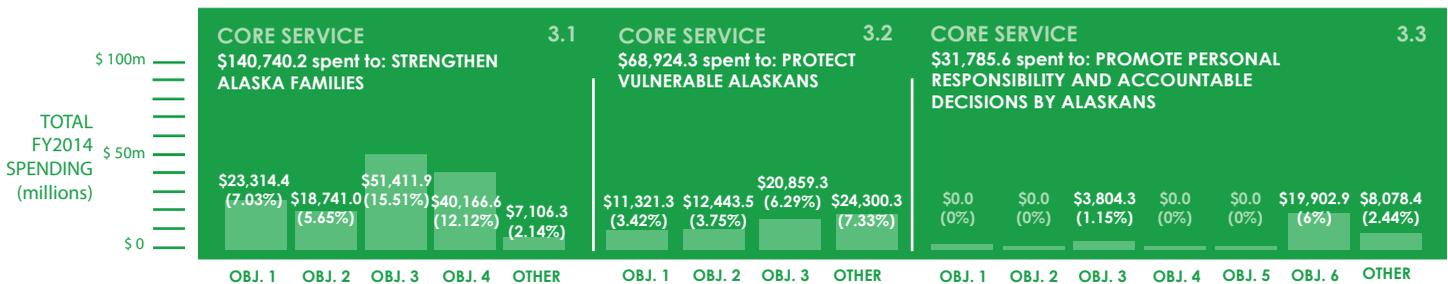
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



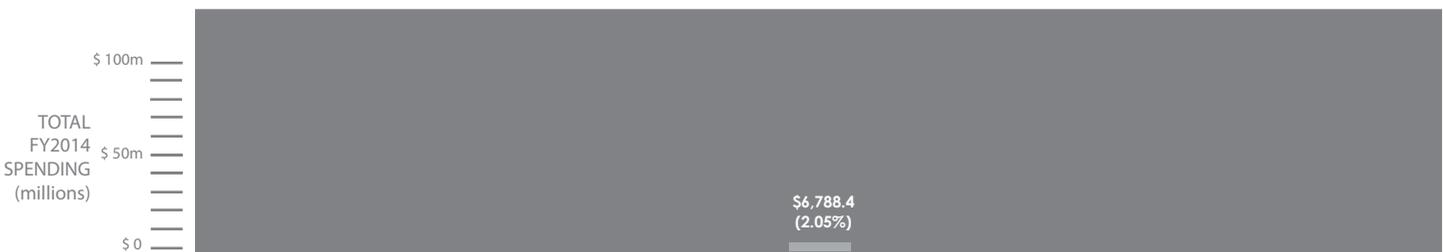
## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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## Explanation of FY2015 Operating Budget Requests

### Division of Public Assistance

#### Budget Overview Table

<b>Division of Public Assistance</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>Difference</b>
Unrestricted General Funds	\$165,967.8	\$165,841.0	\$-126.8
Designated General Funds	17,642.7	17,892.7	250.0
Federal Funds	133,904.5	133,046.0	-858.5
Other Funds	13,964.4	13,997.4	33.0
<b>Total</b>	<b>\$331,479.4</b>	<b>\$330,777.1</b>	<b>\$-702.3</b>

<b>DHSS FY2015 Governor's Request - Public Assistance</b>					
<b>General and Other Funds</b>					
<i>(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)</i>					
<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Reverse ARRA Funding (CCB, Admin, WIC)	\$ -	\$ -	\$ (935.3)	\$ -	\$ (935.3)
Reverse Alaska State Employees Association One-Time Payment (CCB, SBPP, EAP, Admin, PAFS, FI, QC, WS, WIC)	\$ (196.6)	\$ -	\$ (245.2)	\$ (6.0)	\$ (447.8)
FY2015 Health Insurance and Working Reserve Rate Reductions (CCB, SBPP, EAP, Admin, PAFS, FI, QC, WS, WIC)	\$ (55.9)	\$ -	\$ (79.4)	\$ (3.8)	\$ (139.1)
FY2015 Salary Increases (CCB, SBPP, EAP, Admin, PAFS, FI, QC, WS, WIC)	\$ 175.7	\$ -	\$ 244.6	\$ 9.3	\$ 429.6
Tribal Assistance Program Growth (TAP)	\$ -	\$ -	\$ -	\$ 250.0	\$ 250.0
Permanent Fund Dividend Hold Harmless Program Growth (PFD-HH)	\$ -	\$ 250.0	\$ -	\$ -	\$ 250.0
Transfer Project Analyst (06-T016) and Funding from Medical Assistance Admin for Eligibility Info System Replacement	\$ -	\$ -	\$ -	\$ 130.0	\$ 130.0
Reduce Expenditure Level (PAFS)	\$ (50.0)	\$ -	\$ (90.0)	\$ -	\$ (140.0)
Delete Long-Term Vacant Position (07-5733) (PAFS)	\$ -	\$ -	\$ (99.7)	\$ -	\$ (99.7)
Replace Uncollectible Capital Improvement Project Receipt Authority to Support Interagency Agreements (WIC)	\$ -	\$ -	\$ 346.5	\$ (346.5)	\$ -
<b>Public Assistance Total</b>	<b>\$ (126.8)</b>	<b>\$ 250.0</b>	<b>\$ (858.5)</b>	<b>\$ 33.0</b>	<b>\$ (702.3)</b>

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# BUSINESS PLAN (2013-2015)



## DIVISION OF PUBLIC HEALTH

**MISSION:** To Protect and Promote the Health of Alaskans

# Contents

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Priority 3 – Safe and Responsible Individuals, Families & Communities	21
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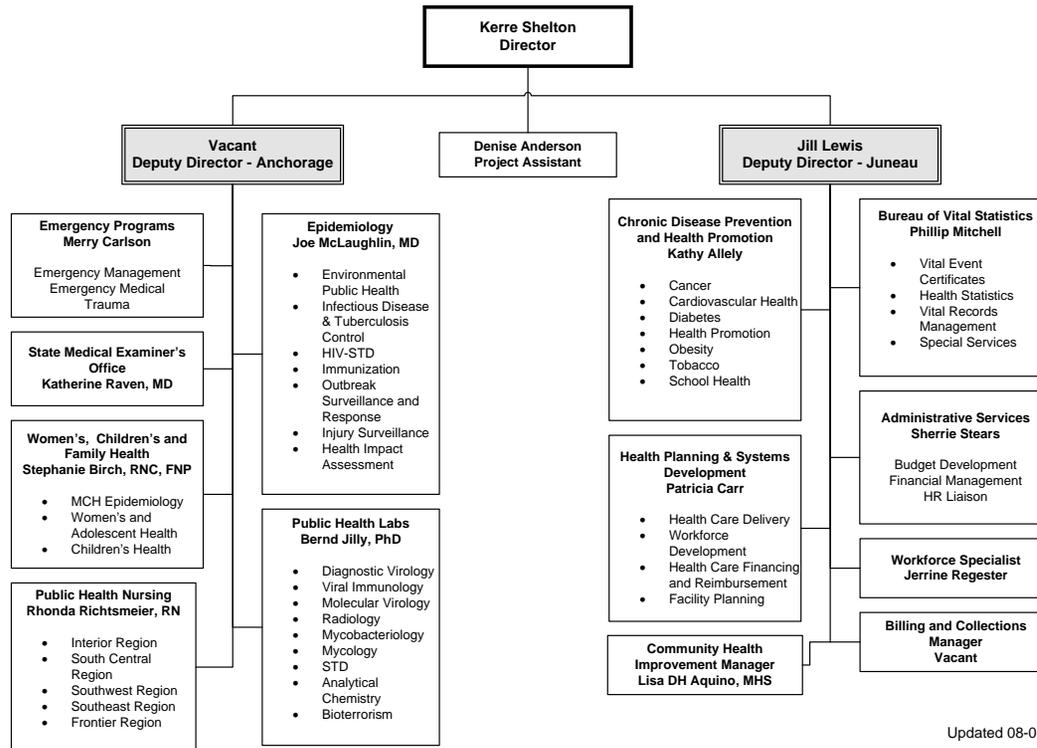
# Organization Chart



## Department of Health and Social Services - Division of Public Health Organization Chart



**Ward B. Hurlburt, MD, MPH  
Chief Medical Officer**



Updated 08-01-2013

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# Introduction

## PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

### The Mission of Public Health

To protect and promote the health of Alaskans.

### The Vision of Public Health

Alaskans enjoy optimum health and safety through achieving greater public, community and personal responsibility for healthy conditions and choices.

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## PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

### The Values of Public Health

**Accountability** – We are committed to responsible use of human, financial and environmental resources.

**Respect** – We provide services without discrimination or judgment.

**Human Potential** – We are committed to developing each Alaskan’s potential as a healthy individual, as well as fostering strong, healthy communities.

**Integrity** – We are honest and ethical in all we do.

**Scientific Excellence** – We are committed to adding to and contributing to the body of scientific knowledge and using the best available knowledge and data to set public health policy.

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## PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

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## Public Health 7 Essential Services

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### PRIORITY 1 HEALTH & WELLNESS ACROSS THE LIFESPAN

#### CORE SERVICE 1.1

Protect and promote the health of Alaskans

#### CORE SERVICE 1.2

Provide quality of life in a safe living environment for Alaskans

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.

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### PRIORITY 2 HEALTH CARE ACCESS, DELIVERY & VALUE

#### CORE SERVICE 2.1

Manage health care coverage for Alaskans in need

#### CORE SERVICE 2.2

Facilitate access to affordable health care for Alaskans

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.

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### PRIORITY 3 SAFE & RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES

#### CORE SERVICE 3.1

Strengthen Alaska families

#### CORE SERVICE 3.2

Protect vulnerable Alaskans

#### CORE SERVICE 3.2

Promote personal responsibility and accountable decisions by Alaskans

7. Monitor, research and evaluate health status, and service effectiveness, accessibility and quality to identify and solve community health problems.

## Public Health 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.

**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

**Those Sections Provide the Seven Essential Services as Described Below:**

*1. 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 disease, and coordinating responses with local 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 and Public Health Nursing follow-up on a variety of health and safety concerns including maternal/child health issues, epidemiological investigations, sexually transmitted diseases, and tuberculosis.
- 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 accurately determines the cause and manner of deaths that occur throughout the State. Cause and manner of death information can be used by partnering agencies to determine needs for prevention programs, identifying trends and to initiate efforts to decrease 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.

*2. 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.

### *3. 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.

### *4. 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.

*5. 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.

*6. 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.

*7. 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.

# Priority 1 – Health & Wellness Across the Lifespan

## CORE SERVICE 1.1 PROTECT AND PROMOTE THE HEALTH OF ALASKANS

### Objective 1.1.1- Improve the health status of Alaskans

#### Performance Measures

Performance Measure 1.1.1.1a - Percent of children 19 - 35 months of age who are fully immunized

Performance Measure 1.1.1.1b - Cost to fully immunize a child 19 -35 months of age

Performance Measure 1.1.1.2a – Percent of Alaskans who receive preventive health screenings per current recommendations

Performance Measure 1.1.1.2b – Cost per screening

Performance Measure 1.1.1.3a – Percent of communities that identify and address local health problems

Performance Measure 1.1.1.3b – Cost of (MAPP) community health improvement training and support per community

Performance Measure 1.1.1.4a – Percent of Alaskans reporting very good/good health

Performance Measure 1.1.1.4b - State wellness costs per capita

#### Strategies/Actions

Strategies and action steps that have been taken to improve the public’s health include the following:

- enrolling all providers into Alaska’s Immunization Information System to better promote, provide and track immunizations;
- working towards a universal vaccine financing solution which will ensure cost effective and easy access to immunizations for all providers and Alaskans;
- providing health care practices with periodic individualized assessments of their immunization coverage rates for their patients;
- assisting with reminder/recall efforts for children who are not up-to-date with their immunizations;
- promoting immunizations in both of the maternal child health home visiting programs, Healthy Start, and Nurse-Family Partnership;
- assessing immunization status during each of the WCFH-sponsored pediatric specialty clinics;

- generating a Healthy Alaskans 2020 document, which will assess leading health indicators and targets and assess evidence-based strategies;
- implementing a statewide Alaska Tobacco Quit Line outreach program, leading to significant reductions in smoking prevalence;
- launching the Play Every Day campaign to raise awareness about childhood obesity and promote physical activity;
- establishing a Clinical Screening Task Force as a part of the Chronic Disease Prevention and Health Promotion Collaborative in 2012 to review current recommendations, promote with providers and Alaskans, and track these key screenings and report the screening status on an annual basis;
- performing a gap analysis to review barriers in access to preventive screenings and key informant interviews of primary care providers is being completed by the Institute for Social and Economic Research at the University of Alaska Anchorage;
- implementing a pilot project to promote increased preventive screenings with the state employee workforce (to begin in January 2014);
- providing breast and cervical cancer screening services to uninsured, underinsured, and low-income women in Alaska; and
- providing preventative health care services to low-income women and men at two grantee sites in the state.

### **Partners/Interdependencies**

Public Health relies on close relationships with a wide range of partners and interdependencies to improve the health of Alaskans. Specific examples of such partnerships include working with the following:

- public and private immunization key stakeholders (e.g., Department of Education and Early Development, Child Care Licensing, Women Infants and Children, All Alaska Pediatric Partnership, Alaska Primary Care Association, Alaska Chapter of the American Academy of Pediatricians, Vaccinate Alaska Coalition, etc.) to ensure coordinated statewide immunization activities;
- providers to 'onboard' them into the Immunization Information System, which will assist with immunization administration and tracking; providers in developing a Vaccine Association in Alaska, to ensure access and affordability of vaccines to all;
- the Alaska Native Tribal Health Consortium and its members to better identify local health disparities and issues, and assist with targeting meaningful, cost-effective interventions;
- local hospitals and community groups to systematically assess the health status of their populations and to collaboratively identify and address issues that affect the health status of the community;

- Mobilizing for Action through Planning and Partnerships (MAPP) for strategic planning in working with agencies and communities for improving health;
- providers, hospitals, clinics private businesses to assist with health care delivery and access to preventive medicine services;
- federal partners such as the Indian Health Service, Centers for Disease Control and Prevention, Environmental Protection Agency, and Food and Drug Administration to support our goals;
- the Alaska Native Tribal Health Consortium on maintaining a robust tumor registry;
- ANTHC, Providence Family Practice, Providence Employee Health, private practice providers, and community agencies (e.g., the American Heart Association, American Cancer Society, American Diabetes Association) on the Chronic Disease Prevention and Health Promotion Collaborative and the Clinical Screening Task Force;
- health care providers across the state to enroll them as providers of cancer screening services for women.

## **Analysis**

Due in part to Public Health’s sustained effort to improve immunization coverage rates, the proportion of 19-35 month old children who are fully immunized has increased steadily in recent years. Alaska’s coverage rates are currently based on National Immunization Survey data. With the current increased use of providers entering administration data into VacTrAK this will allow us to measure coverage rates on a real-time basis and provide us with a more timely measurement of our success in implementing strategies. This enhanced VacTrAK database will also serve to provide a more robust reminder/recall functionality for providers. The use of state immunization information systems in this manner is considered a best practice for increasing immunization coverage rates.

While screening services that include advice and referrals are a critical component in the clinical preventive services and have been shown to reduce the burden of illness, death and disability key Alaskan preventive screening data trends show little improvement over the past 10 years. Promotion of best practice clinical services and interventions that have a proven track record are needed to see improvement in these key screening behaviors. In collaboration with our Clinical Screening partners and utilizing information from key informant interviews, a communication outreach plan will be implemented.

In the two communities where Public Health provides Title X Family Planning preventative health services, it is noted that these communities experience lower rates of unintended births when compared to the statewide rate as a whole.

## **Looking Ahead**

Public Health plans to continue to build on strong relationships with partners, and to continue to analyze the effectiveness of interventions and programs that are in place, as well as to continue to look for new projects and interventions which may improve the health status of Alaskans.

Identifying high-priority areas, such as increasing immunization rates, reducing obesity rates and reducing tobacco abuse, and searching for cost-effective ways to provide meaningful improvement in the lives of Alaskans, will remain our focus. Furthermore, in collaboration with our Clinical Screening partners and utilizing information from the ISER analysis and key informant interviews, a communication outreach plan will be implemented in 2014. A pilot project in partnership with Alaska Cares and the State Employee Health Trust will begin in January 2014 and will be used to test the success of our evidence based approaches and communications. These will then be expanded to include all Alaskans in 2015 and beyond.

## **Objective 1.1.2- Decrease unintentional injuries**

### **Performance Measures**

Performance Measure 1.1.2.1a – Number of Alaskans experiencing unintentional injuries

Performance Measure 1.1.2.1b - Cost of injury prevention program per capita

### **Strategies/Actions**

The Injury Prevention program is focused on factors that influence the safety of our citizens over their life span. The current approach emphasizes the three E's that include education/behavior, engineering/technology, and enforcement/legislation. After examining available data from multiple sources, programs and actions are developed with the active collaboration of statewide and local agencies and groups.

The Injury Prevention program currently has five actively funded programs including water safety with the 1) Kids Don't Float program which places loaner life jackets at lakes and other bodies of water, 2) Poisoning Prevention through a poison help hotline, 3) Older Adult Fall Prevention education campaign, 4) Older Adult Driver Safety education campaign and 5) the AK Be Safe Be Seen project which provides training and education for communities on pedestrian and bicycle safety. In addition, materials and guidance are provided across a wider spectrum of injury prevention, e.g., fire safety, child passenger safety and helmet use.

### **Partners/Interdependencies**

The Injury Prevention program currently works with several Division Sections (Emergency Programs, Epidemiology, and Vital Statistics) for data resources, and consults with the Sections of Public Health Labs and Public Health Nursing for enhanced technical safety information. The Division of Senior and Disability Services has been a valuable partner, as well as the Boating Safety program in the Department of Natural Resources and the Division of Motor Vehicles.

Outside of the state system, the Alaska Native Tribal Health Consortium and SouthEast Alaska Regional Health Consortium are vital partners on many injury prevention projects on a regular basis.

At the community level, the Injury Prevention program interacts with local agencies and advocacy groups on a variety of issues. A sample of these agencies would include senior centers, native corporation health agencies, United Way, health clinics, and citizen groups involved in the Kids Don't Float program, which relies heavily on volunteers.

Nationally, the program is directly aided through the efforts of the Centers for Disease Control and Prevention, the Poison Control Center, Safe States and the Consumer Product Safety Commission.

### **Analysis**

Most wellness behavior change programs take consistent work over many years to yield population based results. Two of the longest standing programs (Kids Don't Float and the Child Passenger Safety programs) have been shown to be effective and sustained over many years. There has been consistency in personnel, time, funding and interest, which has undoubtedly contributed to their success. The collaboration between our tribal agencies and health clinics with the Injury Prevention office has been helpful in developing materials and educational programs across the state.

### **Looking Ahead**

The Injury Prevention program is gradually becoming more generalist in its approach, with the ability to provide support and technical assistance on a wider range of prevention efforts. Rather than spending the bulk of resources on one or two specific projects, the program is able to respond to a wider variety of issues, with more focus on local participation in the actual delivery of the interventions.

The inclusion of the Hospital Discharge database, Emergency Department database and the emergency medical services database in the online version of Informed Alaskans/Instant Atlas will greatly enhance the programs efforts at providing current and comprehensive data for the Injury Prevention program and the citizens of our state.

The program will continue to seek additional funding sources to support the work and materials proven effective in preventing unintentional injuries.

## **Objective 1.1.3- Decrease substance abuse and dependency**

### **Performance Measures**

Performance Measure 1.1.3.2a - Percent of Alaskans who currently smoke or use smokeless tobacco

Performance Measure 1.1.3.2b - Cost of Tobacco Prevention and Control program per capita

## **Strategies/Actions**

Implementing a sustained, comprehensive tobacco prevention and control program (TPC ) has led to significant decreases in adult smoking and youth tobacco use. The program includes funding to over 38 communities to work on strategies such as eliminating exposure to secondhand smoke, promoting implementation of tobacco-free school campuses, increasing the price of tobacco, and supporting tobacco users in tobacco cessation. The program also provides locally based and statewide health education campaigns to inform Alaskans of the harms of tobacco use and promotes resources for them to quit, such as Alaska's Tobacco Quit Line. For FY14, the program has increased funding to communities and aligned grantee organizations in a regional model to build capacity and identify common goals across a region. Program technical assistance and training will support regions to develop strategies to accomplish their goals. The program has developed an outcome based reporting system to track where grantees are working, which populations they are focused on, and demonstrate success towards strategies and goals. The cost per capita of the Tobacco Prevention and Control Program aligns with the Centers for Disease Control and Prevention's Best Practices and is approximately, \$15.81 per capita in FY14.

## **Partners/Interdependencies**

The TPC relies on an alliance model to ensure that State dollars are used as effectively as possible. For FY14, there are 15 grantee agencies across the state, two in each of the six public health regions and three grantees providing services statewide. Each grantee has subcontracts with additional agencies and a wide array of partnerships, including engagement in local coalitions. To assist communities with grant goals, the TPC contracts for professional services in Training & Orientation with Alaska Native Tribal Health Consortium, a Mission 100 technical assistance contract, and support for health education goals through a communications contract. Community work is supported by Alaska's Tobacco Quit Line contract, support to the Alaska Tobacco Control Alliance, and evaluation and surveillance consultation and services.

## **Analysis**

By implementing a comprehensive tobacco prevention and control program we have seen declines in tobacco use across Alaska and thousands of lives have been saved, but there remains much work to be done. Tobacco use remains the leading cause of preventable death in Alaska. There are several groups still experiencing disparate health outcomes, including Alaska Natives, individuals of low socio-economic status, and young adults. Program evaluation has demonstrated we are making progress by implementing a sustained, comprehensive program. More smokers want to quit and a significant majority of Alaskans believe that everyone has the right to breathe smoke-free air.

## **Looking Ahead**

Ongoing community input has shaped the regional grant model to build alliances and support local goals based on need. The program is increasingly focusing on health equity in order to see a decline

in tobacco use across all populations. For FY14, the program has increased funding to communities and aligned grantee organizations in a regional model to build capacity and identify common goals across a region. Each region will develop a regional plan to align individual grant goals, the tobacco use prevalence in the region, and determine the best approach for accomplishing strategies in partnership. Program technical assistance and training will support regionally-based grantees to develop strategies, provide resources and tools to accomplish their goals, and evaluate program outcomes. The program has developed an outcome based reporting system to track where grantees are working, which populations they are focused on, and demonstrate success toward strategies and goals. The program continuously evaluates its impact and identifies changes to meet community needs.

# Priority 2 – Health Care Access, Delivery and Value

## CORE SERVICE 2.1 MANAGE HEALTH CARE COVERAGE FOR ALASKANS IN NEED

### Objective 2.1.1- Increase the number of Alaskans with a primary care provider

#### Performance Measures

Performance Measure 2.1.1.1a - Percent of individuals served by the department with access to a regular primary care provider

Performance Measure 2.1.1.1b - Cost to provide health care services per client

#### Strategies/Actions

The Division of Public Health contributes to efforts to assure that Alaskans have access to health care through several strategies:

(1) Direct service and grant funding for services to selected needy populations (e.g., public health nurses provide care and preventive services in some communities, in instances where the patient cannot access another public or private provider; the Section of Women’s Children’s Family Health covers the cost of two pediatric care coordinators as part of a medical home demonstration project, and provides access to health care to children with special health care needs through pediatric specialty and outreach clinics throughout the state. Some specific services are paid for directly by the Division while others are provided through contracts and grants to health care providers.

(2) Advocacy and technical assistance to health care services such as critical access hospitals, community health centers, and other health care facilities. Technical assistance includes providing data needed for grant applications; providing trainings and consultations on financial management, practice management, performance and quality measurement, and improvement techniques; telehealth resources; community planning and needs assessments; and health status and need measures.

(3) Monitoring of health insurance coverage of Alaskans, health care expenditures, affordability and costs of care, morbidity and mortality rates, other health status measures and needs, and risk and protective factors, and conveying actionable information to policy makers.

(4) Monitoring of workforce and facility capacity, including managing health care workforce loan repayment and other support-for-service programs, and providing updates and recommendations to leadership as appropriate.

#### Partners/Interdependencies

Both improved access to primary care services and more effective public health measures are critical to ensuring that individuals have access to high-quality services at the place and time that best meets their needs. It is important that individuals be informed of existing community services

that support health promotion and if diagnosed with diseases or adverse health conditions, they can be linked to these same community services whether they are provided through the division, or are partners to enable them to take a holistic approach to improving their health.

Within the Division of Public Health (internal partners):

- Section of Chronic Disease Prevention and Health Promotion – health promotion and prevention programs include educating providers on how to fight obesity, tobacco control, encouraging prevention and treatment of diabetes, injury, etc.
- Section of Epidemiology - immunizations; “health protection” through environmental health programs; health alert network (in conjunction with Preparedness and EMS) related to infectious diseases and bioterrorism; tuberculosis treatment.
- Section of Public Health Nursing – community based planning and needs assessments, prevention work, family planning, health education.
- Section of Women’s, Children’s and Family Health – provides pediatric specialty clinics for children with special health care needs, administers newborn metabolic and hearing screening programs, administers two maternal child health home visiting programs, and promotes well child visits and developmental screening among other programs. The Breast and Cervical Health Check program also provides access to cancer screening for low-income and underinsured or uninsured women.
- Section of Health Planning and Systems Development – manages State Office of Rural Health, Alaska Primary Care Office, Rural Hospital Flexibility Project and Small Hospital Improvement Program, Tri-State Children’s Health Improvement Consortium project, loan repayment program, hospital discharge data program, community needs assessments, planning and data development projects.
- Section of Laboratories – screening and diagnostic services for sexually transmitted and communicable diseases.

Other Divisions - Other divisions are partners which work with the Division of Public Health to put strategies in place ensuring primary health care workers are able to apply key psychosocial and behavioral science skills (for example interviewing and counseling); promote health, well- being and safety for individuals; and enroll and provide health coverage for those in need. Other division partners include: Division of Behavioral Health, Senior and Disability Services, Health Care Services (Medicaid, Office of Rate Review, Certificate of Need program), and Division of Public Assistance.

Outside stakeholders work with the Division of Public Health to provide infrastructure and economic support; build capacity; act as a catalyst for change; provide statewide leadership to address health care delivery challenges; encourage all Alaskans to make healthy choices that keep families and communities strong; workforce expansion including recruitment and retention; outreach and enrollment efforts for health care programs; collect and track data. Outside stakeholders include: Alaska Native Tribal Health Consortium, Alaska Primary Care Association, Alaska State Hospital and Nursing Home Association, Alaska Public Health Association, University of Alaska Area Health Education Center and other universities, Alaska Mental Health Trust Authority, Alaska Mental Health Board, Indian Health Service, Community Health Centers, Alaska State Medical Association, HealthCare Commission, Denali Commission, All Alaska Pediatric Partnership, Alaska

Children’s Trust, and the Alaska Chapter of the American Academy of Pediatrics, March of Dimes, United Way, Stone Soup Group, providers across the state, and Federal Partners (Health Resources Services Administration, etc). Other departments of state government with which the Division of Public Health works regarding coverage, insurance benefit offerings, workforce and community resources are the Alaska Departments of Labor, Education and Early Development, Commerce and Economic Development (Occupational Licensing and Community and Regional Affairs), and on specific issues Environmental Conservation, Public Safety and Department of Law.

## **Analysis**

Trends and comparative analyses show that there are a number of barriers for Alaskans related to access to a primary care provider – our data systems help track the need in terms of population trends, morbidity and mortality trends, facility and workforce capacity, and resource changes such as health coverage changes, program funding, and income levels. Selected issues affecting adequacy of access to care include:

- The low number of primary health care providers to the number of patients, with high concentration of providers in urban areas compared to the rural areas of the state;
- High turnover of providers;
- High cost of care such that many Alaskans defer going to a primary care provider until a situation becomes more severe and harder to treat;
- Cultural and language barriers;
- Over 70% of Alaska is not accessible by road, and airfare cost to receive routine care is very expensive; even travel on the road system requires a great deal of travel time and can be difficult;
- Severe weather and seasonal variations make travel difficult to healthcare sites;
- Limited scope of services in rural areas results in limited or delayed access to specialists;
- Inadequate coverage or lack of insurance limits access for many Alaskans;

## **Looking Ahead**

The division will continue to promote initiatives/activities that increase the number of Alaskans with a primary care provider. To improve access to primary care, we must support and continue to move toward community based organized systems for rural as well as urban areas, built on foundations of: affordability, accessibility, community focus, high quality and patient centered.

To that end, the division will continue to work with all of the partners listed above to continue to collaborate on surveys and planning processes for assessing trends and cost coverage as well as utilization, adequacy of facilities, etc; work to provide a robust telehealth program; track insurance coverage and various measures of access to primary care including behavioral health and oral

health services (primary care and preventive); workforce planning and development including ways to promote working at the highest level of practice, and expanding scope of practice (such as paramedicine for EMS in targeted areas and the dental health aide therapists; continue to work with the Federal government to assist in allocating resources to the neediest areas; work with communities, hospitals and clinics on their community health assessments; monitor improvements and identify and target emerging needs with adequacy of care in rural/frontier Alaska communities and access for special populations; develop and implement plans for improvement; suggest initiatives/policies to transform practices to patient centered medical home; and monitor and improve effectiveness of health care system.

# Priority 3 – Safe and Responsible Individuals, Families & Communities

## CORE SERVICE 3.3 PROMOTE PERSONAL RESPONSIBILITY AND ACCOUNTABLE DECISIONS BY ALASKANS

### Objective 3.3.1- Improve tobacco enforcement

#### Performance Measures

Performance Measure 3.3.1.1a – Prevalence of youth tobacco use

Performance Measure 3.3.1.1b – Cost of Tobacco Prevention and Control program per capita

#### Strategies/Actions

Implementing a sustained, comprehensive tobacco prevention and control program (TPC) has led to significant decreases in adult smoking and youth tobacco use. The program includes funding to over 38 communities to work on strategies such as eliminating exposure to secondhand smoke, promoting implementation of tobacco-free school campuses, increasing the price of tobacco, and supporting tobacco users in tobacco cessation. Each of these components work together to reduce tobacco use in communities and show youth tobacco use is not the norm. Primary youth prevention strategies include increasing the price of tobacco, restricting youth access to tobacco, and promoting tobacco-free environments such as K-12 school district campuses. Alaska has a statewide tax of \$2.00 per pack of cigarettes and 75% wholesale price on other tobacco products, and several communities have increased their local taxes of up to an additional \$2.21 per pack or 45% wholesale price on other tobacco products help to deter young people from starting to use tobacco. The cost per capita of the Tobacco Prevention and Control Program aligns with the Centers for Disease Control and Prevention’s Best Practices and is approximately, \$15.81 per capita in FY14.

#### Partners/Interdependencies

The TPC relies on an alliance model to ensure that State dollars are used as effectively as possible. For FY14, there are 15 grantee agencies across the state, two in each of the six public health regions and three grantees providing services statewide. Each grantee has subcontracts with additional agencies and a wide array of partnerships, including engagement in local coalitions. TPC has developed relationships with the Alaska Association of School Boards to adopt and promote a Gold Standard Tobacco-Free K-12 School District Model Policy. Each school district is supported with technical assistance in adopting tobacco-free campuses, signs to communicate the tobacco-free school zone, and helping with any implementation challenges. To assist communities with grant goals, the TPC contracts for professional services in Training & Orientation with Alaska Native Tribal Health Consortium, a Mission 100 technical assistance contract, and support for health education goals through a communications contract. The TPC also partners with the Rural Alaska Community Action Program and the Alaska School Activities Association to facilitate the Alaska

Tobacco Control Alliance Youth Leaders, a coalition of youth leaders from youth-led coalitions across the state.

In addition, the Section partners with the Division of Behavioral Health on tobacco enforcement as well as to promote integration of tobacco cessation and prevention in behavioral health settings.

### **Analysis**

The significant and sustained reduction in youth tobacco use since 1995 has been accomplished by implementing a comprehensive tobacco prevention and control program. We have seen declines in tobacco use across Alaska and thousands of lives have been saved, but there remains much work to be done. Tobacco use remains the leading cause of preventable disease in Alaska. Nationally, almost 90% of smokers today started before the age of 18. Tobacco companies still market to their youngest customers, spending over \$1 million an hour to market their products. In much of Alaska, schools are the community gathering places; by implementing tobacco-free campus policies we can help protect our youth by establishing tobacco-free norms. Additionally, tobacco taxes are one of the most effective ways to reduce tobacco use, especially among youth.

### **Looking Ahead**

Ongoing community input has shaped the regional grant model to build alliances and support local goals based on need. The program is increasingly focusing on health equity in order to achieve a decline in tobacco use across *all* populations. For FY14, the program has increased funding to communities and aligned grantee organizations in a regional model to build capacity and identify common goals across a region. The program also is funding the Alaska School Activities Association as a statewide grantee who will partner with RurAL CAP, American Lung Association of Alaska, ATCA Youth Leaders, and the Alaska Association of School Boards to promote tobacco-free K-12 school district policies. Regional grantees will work with statewide partners to continue promoting tobacco-free school districts, and provide resources and information for communities looking to increase the price of tobacco. Program technical assistance and training will support regions to develop strategies, provide resources and tools to accomplish their goals, and evaluate program outcomes. The program has developed an outcome based reporting system to track where grantees are working, which populations they are focused on, and demonstrate success towards strategies and goals. The program continuously evaluates its impact and identifies changes to meet community needs.

## **Objective 3.3.3- Increase the number of Alaskans with health conditions who practice self-management**

### **Performance Measures**

Performance Measure 3.3.3.1a – Percent adults enrolled in chronic disease self-management programs

Performance Measure 3.3.3.1b – Cost per client for self-management services

## **Strategies/Actions**

The Section of Chronic Disease Prevention and Health Promotion established a statewide chronic disease self-management program (CDSMP) in 2006. The CDSMP model was the Stanford University CDSMP model because it was evidence-based and backed by over 20 years of clinical trials.

Patients with chronic conditions make daily decisions that require skills and information to manage their illnesses. Traditional patient education provides patients the necessary information to understand and manage their condition and self-management education teaches problem-solving skills. Self-management programs have been shown to: a) enhance problem-solving skills; b) lead to improved clinical outcomes (compared to information-only programs); and c) yield cost savings (compared to usual care).

The Stanford University Patient Education Research Center has tested and evaluated self-management programs for people with chronic health conditions for the past 20 years. Initially developed to address arthritis, Stanford's CDSMP was expanded to a wide range of chronic conditions. Each variant of CDSMP has been designed to help people gain self-confidence in their ability to manage their symptoms and develop skills sets to manage their conditions.

With our partners, we are training individuals to become workshop leaders and we are providing continuing education to existing leaders to upgrade their skills and competencies. We are providing 1:1 skill assessments (fidelity evaluations) of leaders as they facilitate workshops to provide feedback and to ensure fidelity to the program. We are providing outreach to healthcare systems and clinics to encourage their patient referrals to local CDSMP workshops. . Because we have marketed this program primarily to seniors and low-income persons with chronic conditions, there is no charge for the courses. By encouraging Alaskans with chronic conditions to take CDSMP workshops, we are contributing to the health of our state, thereby addressing the division goal of improved health status for Alaskans.

## **Partners/Interdependencies**

We have partnered with the University of Alaska Fairbanks, Cooperative Extension Service (CES) and the Parish Nurse Resource Center to provide leader training and assist with quality improvement monitoring of trained leaders to assure program fidelity. We have also partnered with the Veterans Administration, multiple senior centers and tribal clinics, and the community health centers by training leaders at these facilities so they can provide this education to disparate populations.

## **Analysis**

Chronic conditions have replaced infectious diseases as the leading causes of death and disability in the US. Chronic diseases currently account for 70% of all deaths and 75% of our health care expenditures.

The Chronic Disease Self Management Program was first evaluated in a 5-year randomized study involving more than 1,000 subjects. This study found that people who participated in the program, when compared to people who did not, improved healthy behaviors (exercise, cognitive symptom

management, coping and communications with physicians), improved their health status (self-reported health, fatigue, disability, social/role activities, and health distress), and decreased their days in the hospital, which was associated with a cost savings. In one randomized trial, use of subsequent health service did not differ between the control and treatment groups; however, the treatment group (i.e., CDSMP attendees) did report greater health-related quality of life.

### **Looking Ahead**

We will continue to partner with the Cooperative Extension Service to offer trainings for leaders and work on quality improvement. We will continue to look for grants and external funding to expand this program.

## **Objective 3.3.4- Decrease inter-personal violence**

### **Performance Measures**

Performance Measure 3.3.4.1a – Rate of Domestic Violence/Interpersonal Violence referrals to community services

Performance Measure 3.3.4.1b – Number of clients screened for Domestic Violence/Interpersonal Violence

### **Strategies/Actions**

The Division of Public Health implements a continuum of strategies and actions aimed at impacting the rate of domestic/interpersonal violence in Alaska. Primary prevention strategies focus on reducing the incidence of interpersonal violence before it occurs. This is addressed by raising awareness about family and interpersonal violence as a public health issue and by providing education on the harm caused by domestic violence. Secondary prevention activities focus on decreasing the prevalence and impact after early signs of the problem are identified. This is addressed by asking about personal safety, assisting clients to self-assess their situations, providing personal safety education and awareness, and by communicating the availability of supportive services. Tertiary prevention activities or intervention once the problem is clearly evident and causing harm include informing the proper authorities if the violence is possibly affecting the health or safety of a minor. Public health gives presentations and workshops on intimate partner/domestic violence and the impact of exposure to domestic violence on children, and participates in efforts to increase local community resources for victims. Individual health services provided by the division routinely include screening for domestic/family or interpersonal violence, personal safety awareness education, and referral to supportive or public safety resources as appropriate. A new evidence-based method of domestic/interpersonal violence and sexual coercion assessment and universal education known as the Safety Card Approach is being adopted as the next step to improve domestic/interpersonal violence screening and awareness and to connect victims with available services.

### **Partners/Interdependencies**

Partnership with other divisions, departments, stakeholders and care providers is essential to impacting interpersonal/domestic violence rates. The Alaska Family Violence Prevention Project (AFVPP) has played a crucial role in supporting the division as well as other Alaskan health care and other service providers in their intentional injury prevention and intervention efforts, including the initiation of an “Alaskanized Safety Card.” In addition, the division partners with the Alaska Council on Domestic Violence and Sexual Assault, the Alaska Network on Domestic Violence and Sexual Assault (together with its network of statewide programs/crisis centers), education and early development, public safety, village and regional Native health corporations, and local community groups to improve awareness and decrease incidence of domestic and family violence.

### **Analysis**

Intimate partner violence (physical violence, sexual violence, threats of physical or sexual violence and psychological abuse by a current or former partner) is a critical public health problem across the nation. One in four women and one in seven men in the U.S. have experienced severe physical violence by an intimate partner at some point in their lifetime and approximately ten percent of high school students report physical dating violence. Intimate partner violence can't be addressed by single programs or in isolation. Collaboration across all sectors and leadership across all sectors are crucial to addressing domestic/intimate partner violence and building a prevention infrastructure that supports the planning, implementation and evaluation of evidence-informed statewide and local prevention efforts. Public health is taking an active role in breaking the silence about intimate partner violence.

### **Looking Ahead**

The division plans to continue to build on strong relationships with community and statewide partners to decrease the incidence of interpersonal violence and to encourage healthy relationships by linking science, practice, policy and advocacy. The emphasis will be on working together to increase public acknowledgement and understanding of the impact interpersonal violence has on individuals and on society, and on application of evidence-informed prevention best practices. Preventing domestic/interpersonal violence will involve engaging communities in supporting, developing, and implementing prevention strategies that target change in individuals, in the community and in society.

## **Objective 3.3.5 – Increase disaster preparedness**

### **Performance Measures**

Performance Measure 3.3.5.1a – Percent of Alaskan healthcare and support entities that participated in at least one disaster preparedness activity during the state fiscal year

### Strategies/Actions

Disaster preparedness for healthcare enables facilities enables them to prevent, respond to, recover from, and mitigate against natural and man-made disasters. Preparedness strategies include a robust cycle of preparedness in which entities plan, organize, equip, train, exercise, evaluate, and improve healthcare preparedness. State-led preparedness activities rely completely on federal grant funding for building health and medical preparedness at the facility, jurisdiction, and state levels. Short- and long-term strategies focus on building capabilities across 14 Target Capabilities. A 5-year forecast elucidates general strategies, while annual workplans identify specific activities to accomplish current goals and objectives that further disaster preparedness.

Preparedness outreach, training, and exercise opportunities and requirements across Alaska's healthcare and medical system are found in the *Public Health and Healthcare Training and Exercise Plan (TEP)*, which is updated annually. The current TEP outlines how Alaska will address the health-specific emergency preparedness and response training and exercise objectives for 2012-2015. It integrates, supports and enhances public health preparedness and response activities with federal, state, local, and tribal governments, the private sector, and non-governmental organizations. The plan identifies core emergency preparedness training and exercise requirements and personal and organizational strategies to prepare Alaska, and every Alaskan, in the event of a public health or all hazards threat or emergency. Critical eligible entities receive grant funding for essential preparedness activities that align with strategic, training and exercise plans.

The Section of Emergency Programs utilizes each unit within the section – Emergency Medical Systems, Trauma, and Preparedness – to build Alaska's disaster response and recovery capabilities. Preparedness and Trauma are featured as multi-day tracks in the Statewide EMS Symposium, offering hands-on clinical training on catastrophic disaster response for Emergency Medical Technicians and their medical directors; Trauma training is featured at the first annual Public Health and Medical Preparedness Conference in Fall 2013. Strategies to increase participation in preparedness include newly established requirements for Regional EMS Offices, funded by state grants, and healthcare facilities, funded through the Hospital Preparedness Program, to participate in the Public Health and Medical exercise, Hale Borealis, that is part of the statewide full-scale Alaska Shield 2014 exercise that will coincide with the 50<sup>th</sup> anniversary of the 1964 earthquake.

Illuminating the cost of disaster preparedness activity per participant is currently limited to grant-funded work within the division and across providers. Strategies to strengthen our understanding of cost include requiring entities to delineate activities and include information on numbers of participants.

### Partners/Interdependencies

The Section of Emergency Programs provides Preparedness training across the Department. The Preparedness Program recently published a Continuity of Operations Planning (COOP) toolkit to facilitate COOP efforts that ensure essential functions continue following disasters or other emergencies. Preparedness funding across the Division of Public Health sustains and builds

response capabilities across targeted areas. Key external partners in public health emergency preparedness and response include: Hospitals and acute care centers represented by the Alaska State Hospital and Nursing Home Association (ASHNHA), primary and urgent care facilities represented by Alaska Native Tribal Health Consortium for Tribal organizations, primary care clinics and providers, Municipality of Anchorage, Department of Health and Human Services, and the Emergency Medical Services responders across the state. Entities that are not eligible for grant funding are included in preparedness activities through: outreach events to provider groups and to the general public; Alaska-specific publications and resources focusing on both responders and target populations, including children and individuals with special medical needs; online and direct instruction offered to communities, agencies and groups statewide; and technical assistance and Department Emergency Operations Center participation in facility, local, state, and federal exercises. These strategies enable us to reach the full spectrum of healthcare providers: clinics, social service agencies; licensed healthcare providers; pharmacies; and other essential entities.

## **Analysis**

Healthcare entities vary in their understanding of, and commitment to, preparedness activities. Grant funding enhances participation in preparedness, but more importantly, builds critical capabilities in sustainability and ability to respond to events such as a mass casualty incident. State support for the Trauma Care Fund has also enhanced preparedness and the associated staffing, training and equipment is credited with lives saved. While equipment and staffing require a financial commitment, much planning, training, and exercise can be accomplished with existing resources and a commitment to be prepared. The percentage of participation will increase as entities understand the value that disaster preparedness has to their employees and their organization.

## **Looking Ahead**

Current outreach, training, and exercise outcomes will shape future strategies in the ongoing cycle of preparedness. The Alaska Shield 2014 full-scale exercise has focused current work on building catastrophic preparedness and the lessons learned from this seminal event will shape the work ahead. As grantees gain experience in preparedness, staff time will be increasingly available to support the entire health and medical community activities. Increased emphasis on preparedness, and alignment across funding streams, will build capacity. Newly established healthcare coalitions will develop regional plans that will enhance support across healthcare entities within each region and that will ultimately expand to include additional healthcare partners within those regions. Program technical assistance and training will support both grant-funded and non-grant funded entities. Grant-funded programs are required to perform and report on specific deliverables providing robust data for participation and related costs. However, many non-funded entities complete preparedness activities at the facility or local jurisdiction level – a desired outcome, but one that provides less visibility. The program will continue to develop robust relationships to further preparedness as well as our understanding of participation, and more importantly, of the gaps in our ability to prepare for, respond to, and recover from disasters.

## Division Information



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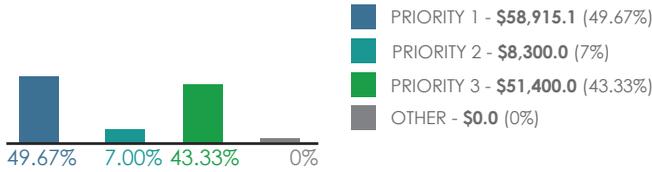
## Division Performance Measure Contact

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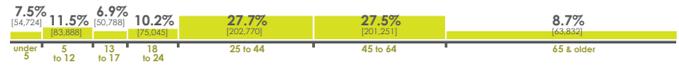
# DIVISION of PUBLIC HEALTH | SPENDING BY PRIORITY (FY2014)

**\$118,615.1** TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION

Total service population **732,298** individuals - also the total population of the state of Alaska.



## SNAPSHOT OF ALASKANS SERVED

- 65% of adults and 26% of high school students are overweight or obese.
- 11% of high school students smoked cigarettes on at least one of the past 30 days.
- 31% of children ages 19-36 months, are not fully immunized.
- 45% of Alaskans with community water systems do not have optimally fluoridated water.
- 10% of Alaskan deaths are from accidental injuries.

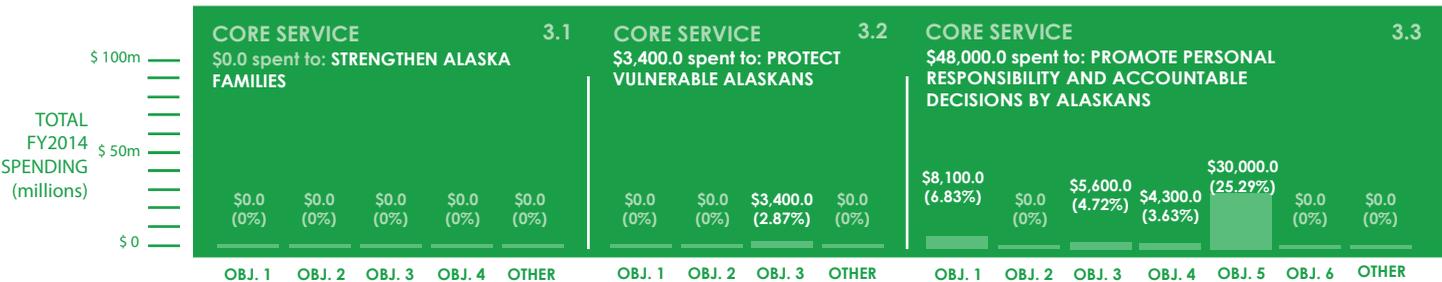
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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# Explanation of FY2015 Operating Budget Requests

## Division of Public Health

### Budget Overview Table

<b>Division of Public Health</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>Difference</b>
Unrestricted General Funds	\$57,800.6	\$58,986.5	\$1,185.9
Designated General Funds	14,056.0	12,947.9	-1,108.1
Federal Funds	39,138.1	40,742.7	1,604.6
Other Funds	7,620.4	6,562.5	-1,057.9
<b>Total</b>	<b>\$118,615.1</b>	<b>\$119,239.6</b>	<b>\$624.5</b>

<b>DHSS FY2015 Governor's Request - Public Health</b>					
<b>General and Other Funds</b>					
<i>(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)</i>					
<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Reverse Alaska State Employees Association One-Time Payment (HPSD, Nurs, WCFH, PHAS, EP, CDPHP, Epi, BVS, SME, Lab)	\$ (245.2)	\$ (26.7)	\$ (79.0)	\$ (4.1)	\$ (355.0)
Reverse MH Trust Workforce Dev - Grant 1383.06 Loan Repayment (HPSD)	\$ -	\$ -	\$ -	\$ (200.0)	\$ (200.0)
MH Trust: Cont - Scorecard Update (FY15-FY17) (HPSD)	\$ -	\$ -	\$ -	\$ 40.0	\$ 40.0
MH Trust: Workforce Dev - Grant 1383.07 Loan Repayment (FY14-FY15) (HPSD)	\$ -	\$ -	\$ -	\$ 200.0	\$ 200.0
Replace Uncollectible Program Receipts to Support Existing Health Programs (HPSD)	\$ -	\$ -	\$ 400.0	\$ (400.0)	\$ -
Reduce Expenditure Level (HPSD, Nurs, WCFH, CDPHP, Epi, BVS)	\$ (498.2)	\$ -	\$ -	\$ -	\$ (498.2)
Delete Long-Term Vacant Positions (HPSD, PHAS, EP, Lab)	\$ (401.4)	\$ -	\$ (289.8)	\$ -	\$ (691.2)
FY2015 Health Insurance and Working Reserve Rate Reductions (HPSD, Nurs, WCFH, PHAS, EP, CDPHP, Epi, BVS, SME, Lab)	\$ (104.3)	\$ (10.0)	\$ (39.2)	\$ (3.2)	\$ (156.7)
FY2015 Salary Increases (HPSD, Nurs, WCFH, PHAS, EP, CDPHP, Epi, BVS, SME, Lab)	\$ 301.2	\$ 28.6	\$ 112.6	\$ 9.4	\$ 451.8
Reverse FY2014 MH Trust Recommendation (WCFH)	\$ -	\$ -	\$ -	\$ (75.0)	\$ (75.0)
MH Trust: Gov Cncl - Grant 3505.02 Autism Workforce Development Capacity Building (WCFH)	\$ -	\$ -	\$ -	\$ 75.0	\$ 75.0
Transfer from Medical Assistance Administration to Support New Grant Programs and Improved Indirect Claiming (WCFH, Epi)	\$ -	\$ -	\$ 1,000.0	\$ -	\$ 1,000.0
Reduce Authority in Order to Sustain Tobacco Prevention and Control Efforts (CDPHP)	\$ -	\$ (1,600.0)	\$ -	\$ -	\$ (1,600.0)
Replace Uncollectible Program Receipts to Support Behavioral Risk Factor Surveillance System Grant (CDPHP)	\$ -	\$ -	\$ 200.0	\$ (200.0)	\$ -
Reduce Naturally Occurring Asbestos (Epi)	\$ (20.1)	\$ -	\$ -	\$ -	\$ (20.1)
Reverse Chlamydia Media Campaign, Testing, and Therapy (FY13-FY15) (Epi)	\$ (360.0)	\$ -	\$ -	\$ -	\$ (360.0)
Restore Chlamydia Media Campaign, Testing, and Therapy (FY13-FY15) (Epi)	\$ 360.0	\$ -	\$ -	\$ -	\$ 360.0
Replace Uncollectible Program Receipts to Accommodate Additional Fee Receipts from Disease Treatment (Epi)	\$ -	\$ 500.0	\$ -	\$ (500.0)	\$ -
Transfer from Probation Services to Support New Grant Programs and Improved Indirect Claiming (Epi)	\$ -	\$ -	\$ 300.0	\$ -	\$ 300.0
Transfer Community Health Grants from Health Care Services (CHG)	\$ 2,153.9	\$ -	\$ -	\$ -	\$ 2,153.9
<b>Public Health Total</b>	<b>\$ 1,185.9</b>	<b>\$ (1,108.1)</b>	<b>\$ 1,604.6</b>	<b>\$ (1,057.9)</b>	<b>\$ 624.5</b>

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# BUSINESS PLAN (2013-2015)



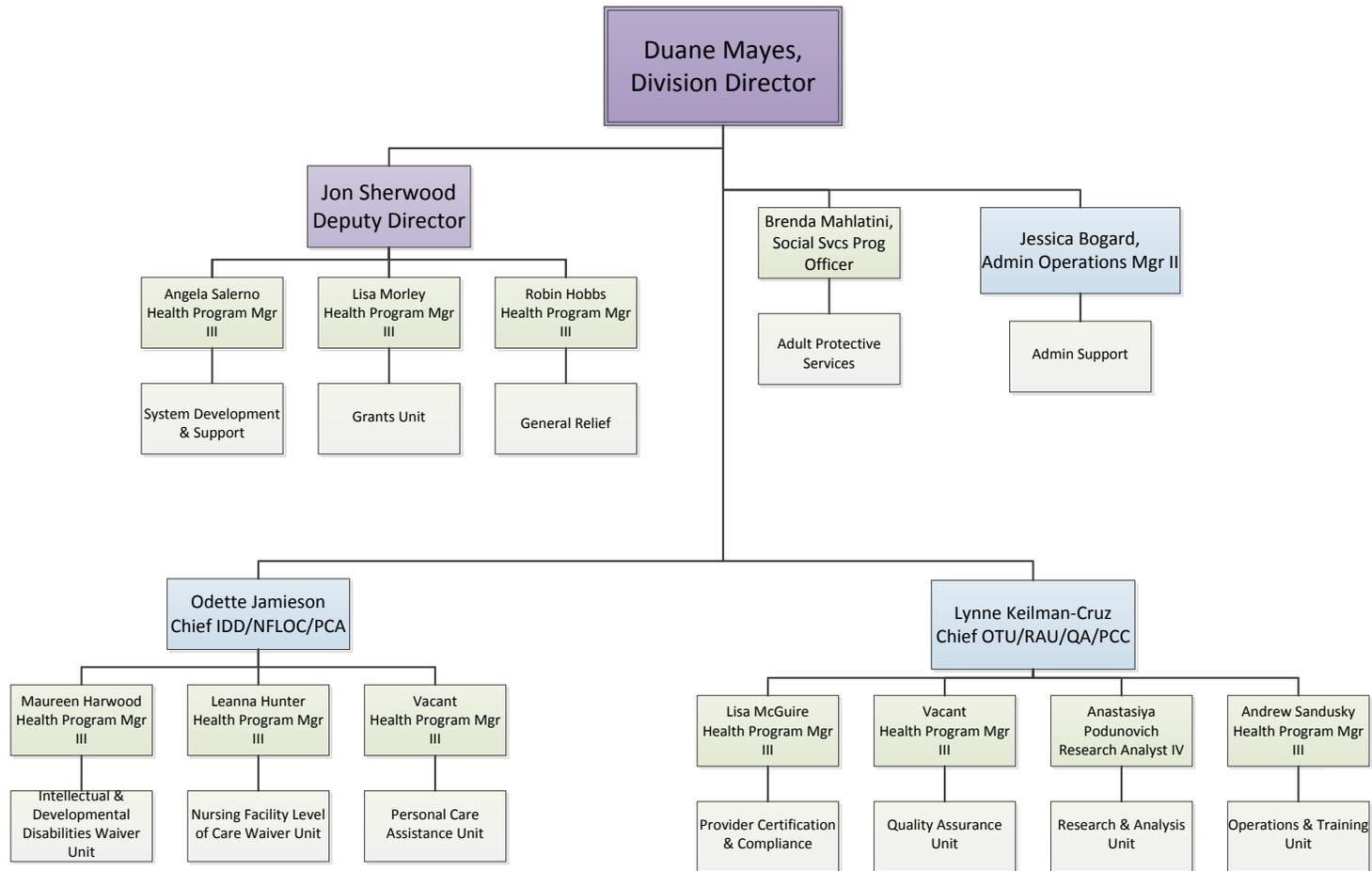
## DIVISION OF SENIOR & DISABILITIES SERVICES

**MISSION:** *Senior & 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.*

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# Organization Chart



Updated on 11/14/2013

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**PRIORITY 1**  
**HEALTH & WELLNESS**  
**ACROSS THE LIFESPAN**

**CORE SERVICE 1.1**  
Protect and promote the health of Alaskans

**CORE SERVICE 1.2**  
Provide quality of life in a safe living environment for Alaskans

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**PRIORITY 2**  
**HEALTH CARE ACCESS,**  
**DELIVERY & VALUE**

**CORE SERVICE 2.1**  
Manage health care coverage for Alaskans in need

**CORE SERVICE 2.2**  
Facilitate access to affordable health care for Alaskans

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**PRIORITY 3**  
**SAFE & RESPONSIBLE**  
**INDIVIDUALS, FAMILIES**  
**& COMMUNITIES**

**CORE SERVICE 3.1**  
Strengthen Alaska families

**CORE SERVICE 3.2**  
Protect vulnerable Alaskans

**CORE SERVICE 3.2**  
Promote personal responsibility and accountable decisions by Alaskans

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## Introduction

### *Mission*

Senior & 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.

### *Vision*

Choice, safety, independence and dignity in home and community-based living.

### *Core Service Principles*

- Individuals have a right to choice and self-determination and are treated with respect, dignity and compassion.
- Individuals have knowledge of and access to community services.
- Individuals are safe and served in the least restrictive manner.
- We and our partners are responsible and accountable for the efficient and effective management of services.
- We and our partners foster an environment of fairness, equality, integrity and honesty.
- Quality services are delivered through collaboration and community partnerships.
- Quality services are designed and delivered to build communities where all members are included, respected and valued.
- Quality services promote independent and incorporate each individual's culture and value system.
- Quality services provided by competent, trained caregivers who are chosen by individuals and their families.

## Priority 1 – Health & Wellness Across the Lifespan

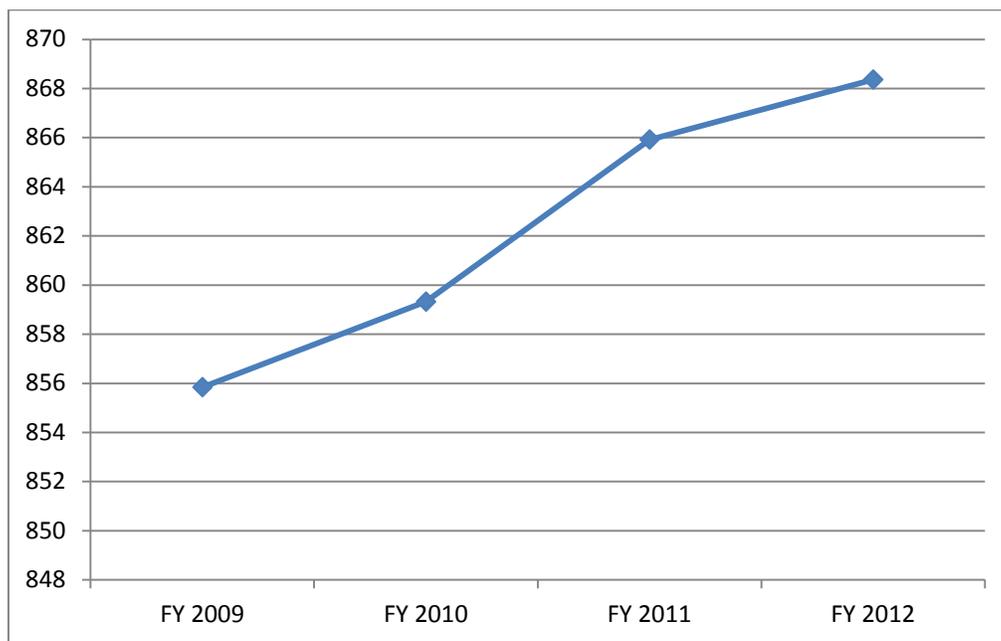
CORE SERVICE 1.2 PROVIDE QUALITY OF LIFE IN A SAFE LIVING ENVIRONMENT FOR ALASKANS

**Objective 1.2.2- Increase the number of older Alaskans who live safely in their communities.**

Performance Measures

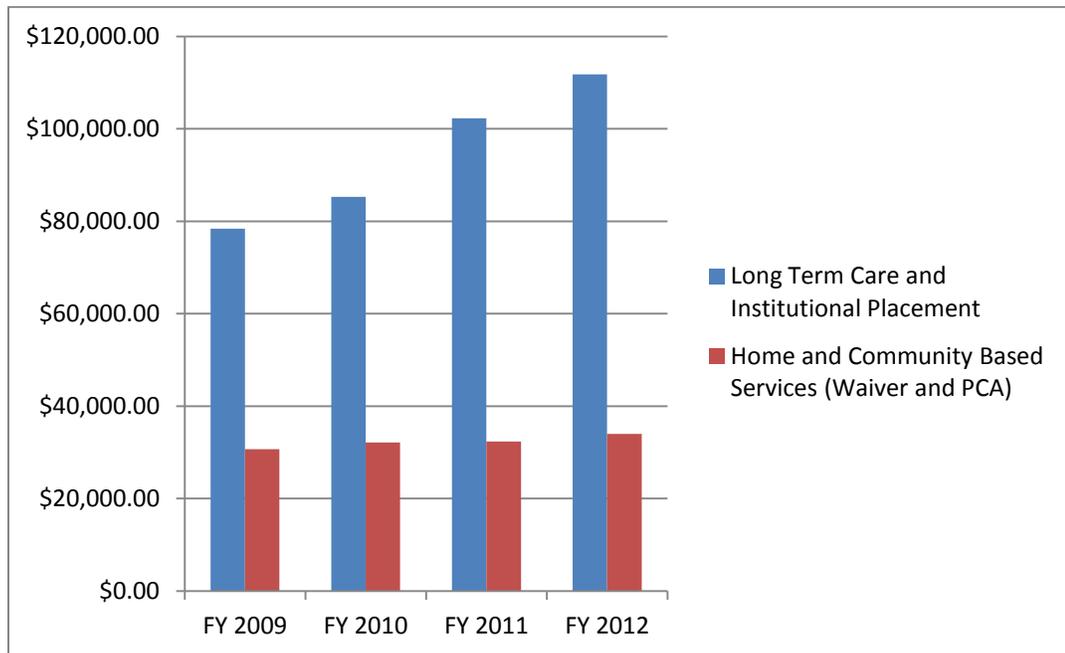
**Performance Measure 1.2.2.1a- Number of months Long Term Services & Supports recipients are able to remain in their home before institutional placement.**

The average number of months that Alaskans are staying out of institutional placement has increased over the last four years.



**Performance Measure 1.2.2.1b- Average cost of Long Term Services & Supports per recipient.**

The average cost of Long Term Care/Institutional Placement has increased over the last four years while the average cost of Home and Community Based Services has remained relatively steady during the same time frame.



**Strategies/Actions**

Assisting Alaskans to remain in their homes and communities as long as possible is a key tenet of Senior and Disabilities Services. Senior and Disabilities Services utilizes a continuum of care ranging from grants services, personal care assistance, waiver services and long term care services, in order to provide the least restrictive level of appropriate care to each recipient. The continuum of care allows Senior and Disabilities Services the ability to promote health and wellness across the lifespan for Alaskans on a daily basis.

**Partners/Interdependencies**

Senior and Disabilities Services has interdependent relationships with the U.S. Centers for Medicare and Medicaid Services, the Alaskan Division of Public Assistance, Alaska Commission on Aging, along with the Alaskan Governor’s Council on Disabilities and Special Education. In addition to these entities, Senior

and Disabilities Services works closely with community partners ranging from service providers to recipient families.

### Analysis

The increase in time at home before institutional placement highlights the usage of other care services prior to placement in institutional style care (e.g., family members, grants services, waiver services). The growing cost of institutional placement can be explained by the longer time out of institutional placement, in that only the recipients requiring the most in depth care are going into institutional placement which contributes to increasing average costs.

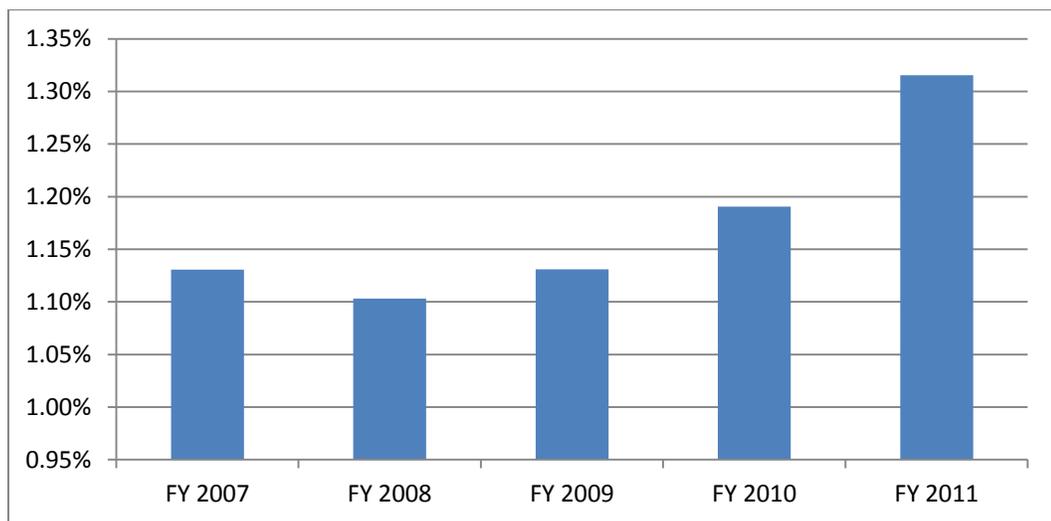
### Looking Ahead

In the future Senior and Disabilities Services will have to plan for the steadily increasing population requiring HCBS waiver services, PCA services or institutional placements. Planning ahead will include leveraging current technologies, staff and processes to manage the influx while giving consideration to new processes that may benefit the organization.

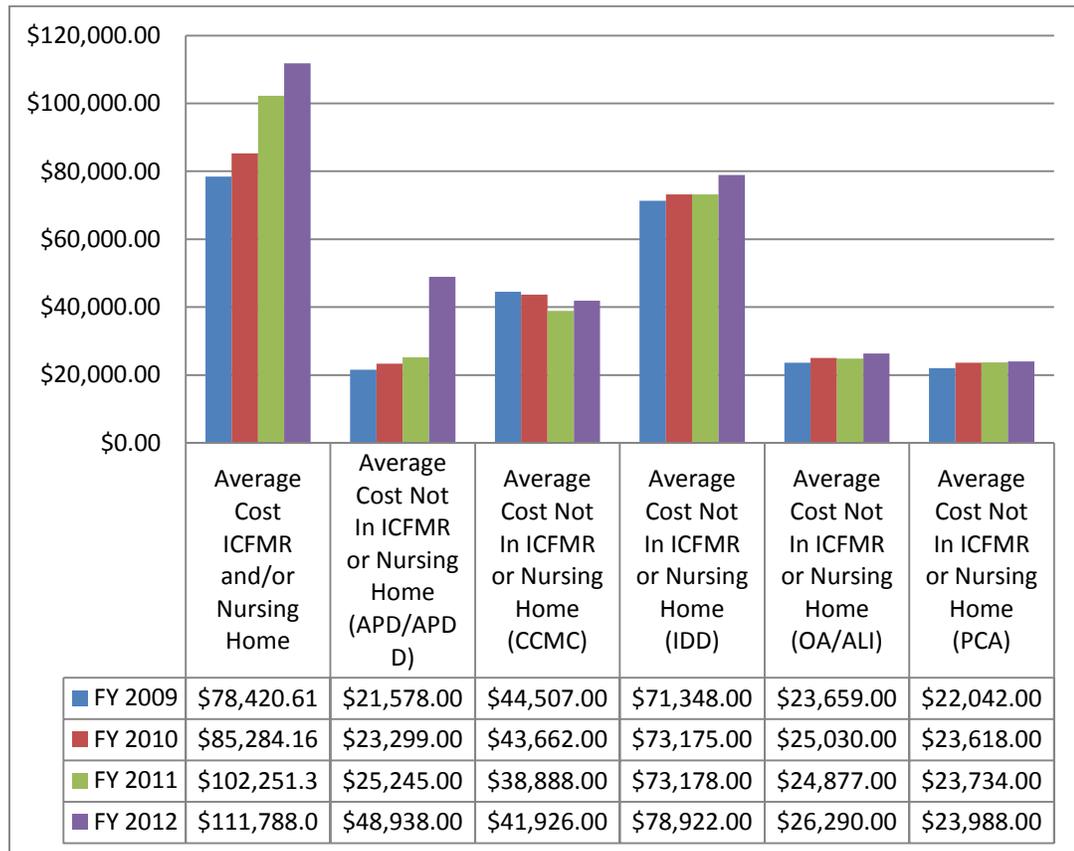
## **Objective 1.2.3-Increase the number of Alaskans with disabilities who are living safely in the least restrictive environment.**

### Performance Measures

#### **Performance Measure 1.2.3.1a- Percent of Alaskans who are receiving community-based Long Term Services & Supports.**



**Performance Measure 1.2.3.1b- Average cost for waiver eligible Alaskans who are living in ICFMR or Nursing Home vs. those who are living independently.**



**Strategies/Actions**

Assisting Alaskans to remain in their homes and communities as long as possible is a key tenet of Senior and Disabilities Services. Senior and Disabilities Services utilizes a continuum of care ranging from grants services, personal care assistance, waiver services and long term care services, in order to provide the least restrictive level of appropriate care to each recipient. The continuum of care allows Senior and Disabilities Services the ability to promote health and wellness across the lifespan for Alaskans on a daily basis.

**Partners/Interdependencies**

Senior and Disabilities Services has interdependent relationships with the U.S. Centers for Medicare and Medicaid Services, the Alaskan Division of Public Assistance, Alaska Commission on Aging, along with the Alaskan Governor's Council on Disabilities and Special Education. In addition to these entities, Senior and Disabilities Services works closely with community partners ranging from service providers to recipient families.

#### Analysis

Waiver and PCA services are still more cost effective than institutional placement. Waiver and PCA services also offer the advantage of keeping recipients within their homes and communities. The growing demand for services within the Alaskan population will require close study to help manage growing costs.

#### Looking Ahead

In the future Senior and Disabilities Services will have to plan for the steadily increasing population requiring HCBS waiver services, PCA services or institutional placements. Planning ahead will include leveraging current technologies, staff and processes to manage the influx while giving consideration to new processes that may benefit the organization.

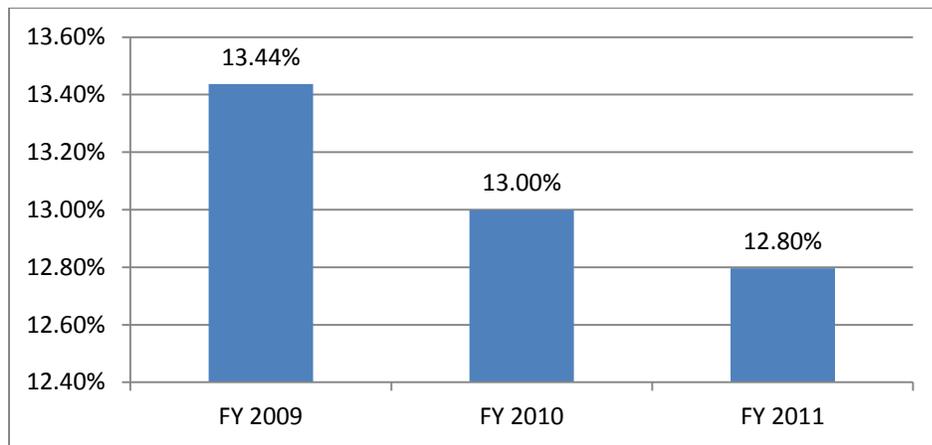
# Priority 3 – Safe and Responsible Individuals, Families & Communities

## CORE SERVICE 3.1 STRENGTHEN ALASKA FAMILIES

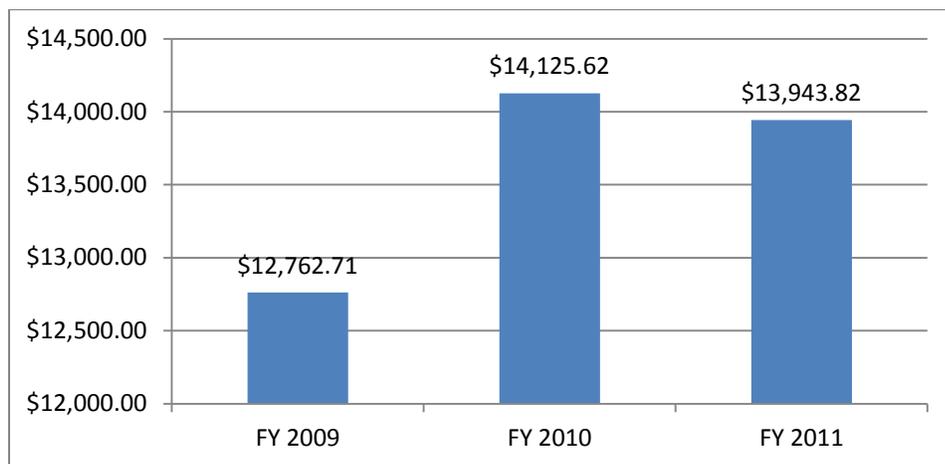
### Objective 3.1.1- Increase the number of Alaska families who are employed.

#### Performance Measures

#### Performance Measure 3.1.1.1a- Percent of individuals receiving employment related services from the department who achieve employment.



#### Performance Measure 3.1.1.1b- Costs of supported employment services per successful participant.



## Strategies/Actions

Assisting Alaskans to remain in their homes and communities as long as possible is a key tenet of Senior and Disabilities Services. Senior and Disabilities Services utilizes a continuum of care ranging from grants services, personal care assistance, waiver services and long term care services, in order to provide the least restrictive level of appropriate care to each recipient. The continuum of care allows Senior and Disabilities Services the ability to promote health and wellness across the lifespan for Alaskans on a daily basis.

## Partners/Interdependencies

Senior and Disabilities Services has interdependent relationships with the U.S. Centers for Medicare and Medicaid Services, the Alaskan Division of Public Assistance, Alaska Commission on Aging, along with the Alaskan Governor's Council on Disabilities and Special Education. In addition to these entities, Senior and Disabilities Services works closely with community partners ranging from service providers to recipient families.

## Analysis

Assisting recipients to maintain independence by having gainful employment is a way to assist recipients in staying within their homes and communities.

## Looking Ahead

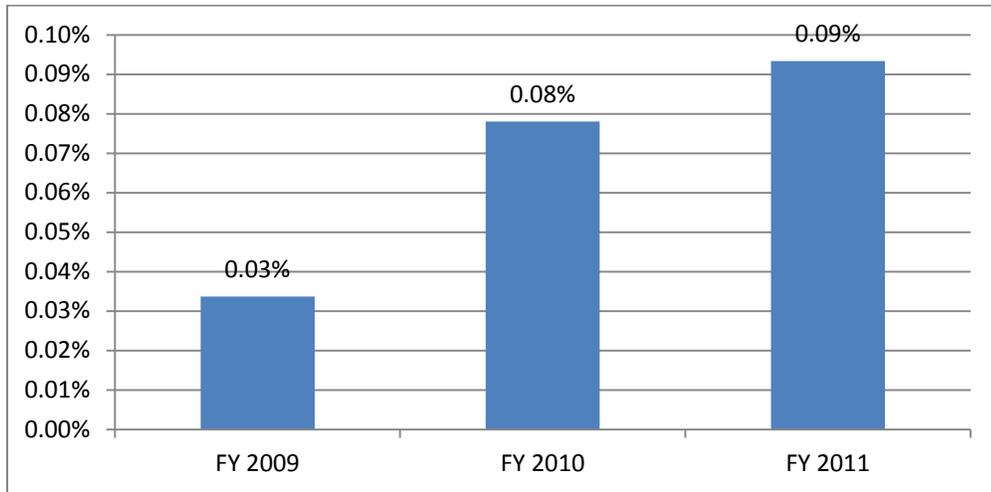
In the future Senior and Disabilities Services will have to plan for the steadily increasing population requiring HCBS waiver services, PCA services or institutional placements. Planning ahead will include advocating that employers consider hiring recipients and paying them a competitive wage.

CORE SERVICE 3.2 PROTECT VULNERABLE ALASKANS.

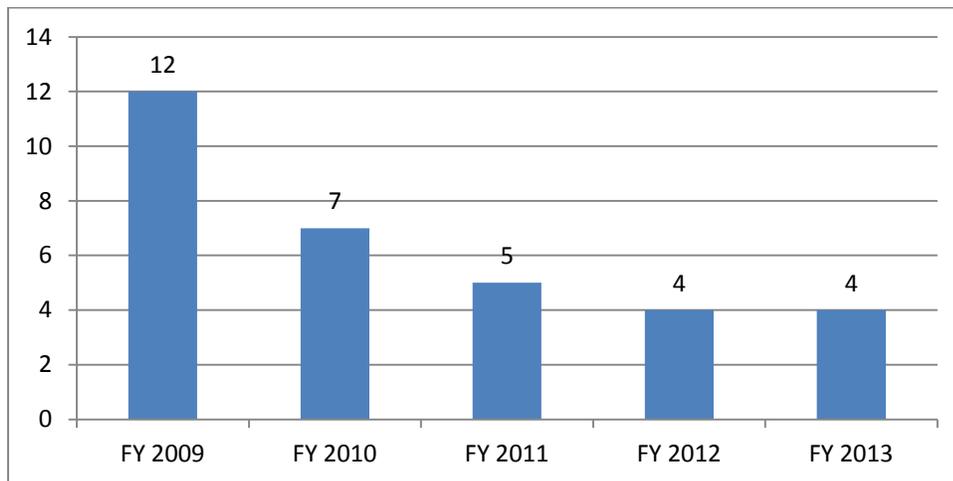
**Objective 3.2.2- Decrease the rate of maltreatment in vulnerable populations.**

Performance Measures

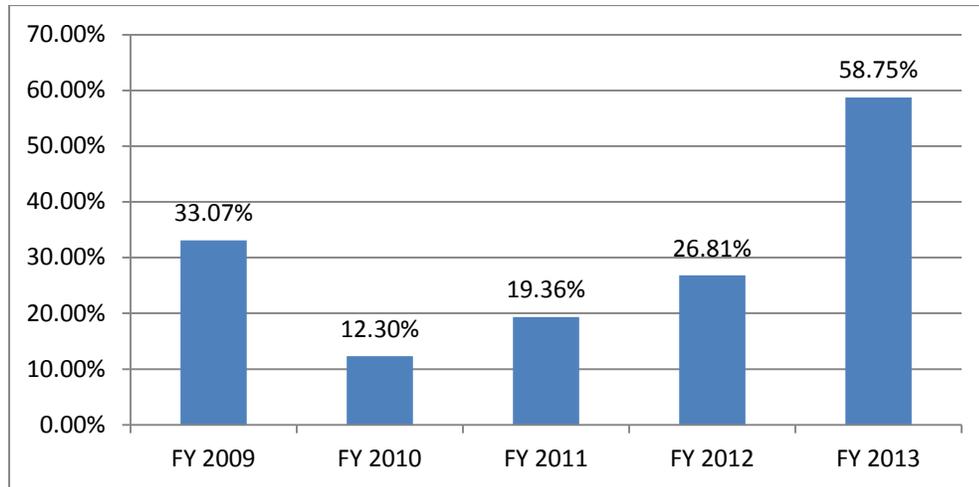
**Performance Measure 3.2.2.1a- Percent of Alaskan adults with substantiated reports of abuse or neglect.**



**Performance Measure 3.2.2.1b- Average time (in days) to initiate an investigation.**



**Performance Measure 3.2.2.1c- Percent of safety assessments concluded within required timeframes.**



**Strategies/Actions**

The protection of vulnerable adults by Adult Protective Services includes public outreach, investigation and case management. Investigations regarding abuse, neglect and exploitation are undertaken by Adult Protective Services.

**Partners/Interdependencies**

Senior and Disabilities Services has interdependent relationships with the U.S. Centers for Medicare and Medicaid Services, the Alaskan Division of Public Assistance, Alaska Commission on Aging, along with the Alaskan Governor’s Council on Disabilities and Special Education. In addition to these entities, Senior and Disabilities Services works closely with community partners ranging from service providers to recipient families.

**Analysis**

Increased demands on Adult Protective Services required addressing via additional employees for this program. The additional employees for Adult Protective Services reduced the case load for the protective services workers thus improving the protection offered to vulnerable Alaskans.

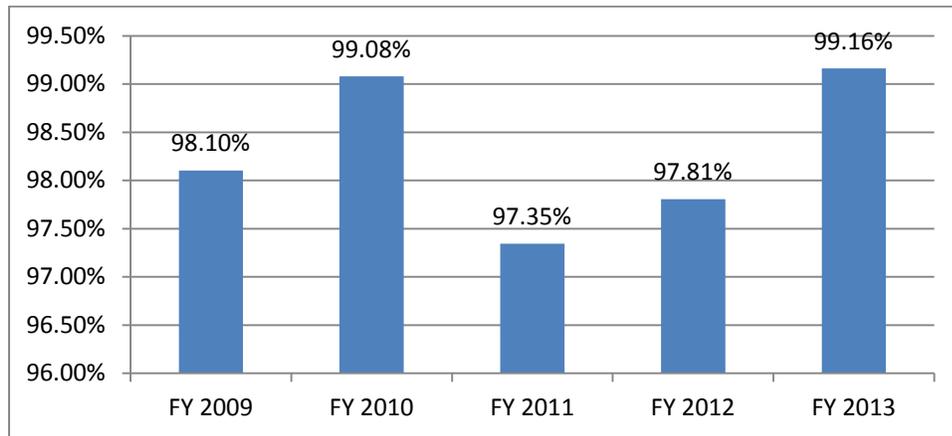
**Looking Ahead**

In the future Senior and Disabilities Services will have to plan for the steadily increasing population requiring Adult Protective Services. The range of assistance offered by Adult Protective Services will have to be reviewed in order to respond to the shifting needs of vulnerable Alaskans.

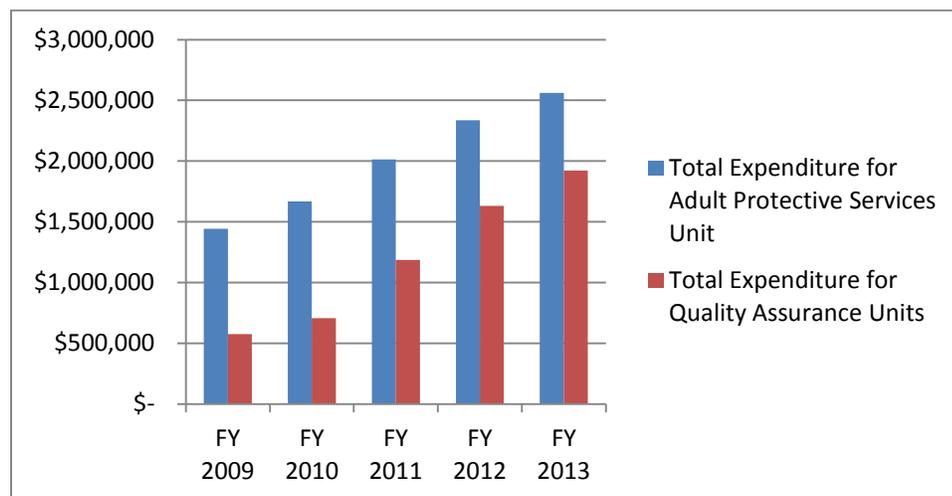
**Objective 3.2.3-Improve client safety within department and provider operated facilities.**

Performance Measures

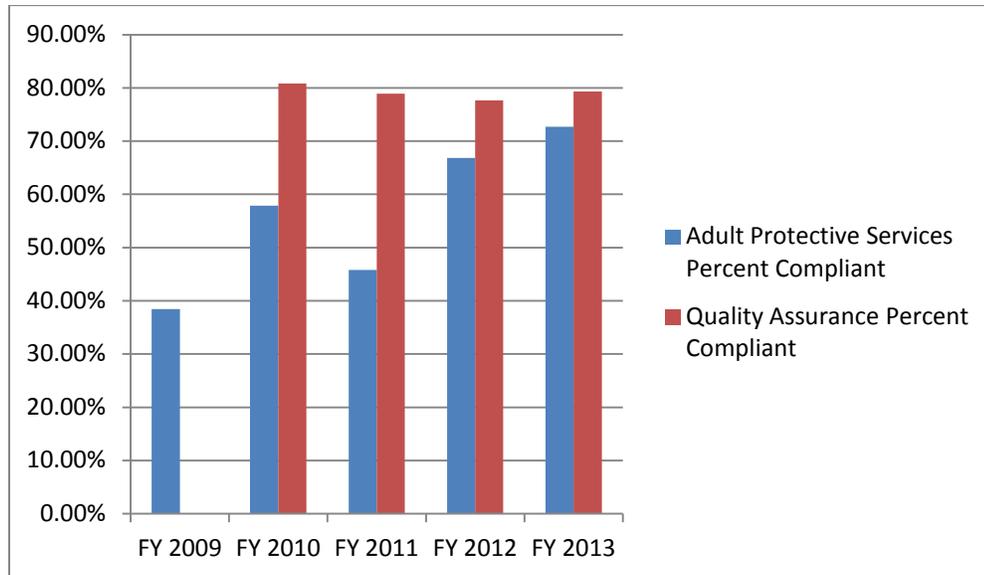
**Performance Measure 3.2.3.1a- Percent of facilities licensed by the department that are free from reports of harm.**



**Performance Measure 3.2.3.1b- Cost for licensure functions and oversight.**



**Performance Measure 3.2.3.1c- Percent of time that enforcement action is taken within required timeframes.**



**Strategies/Actions**

Client safety is paramount to Senior & Disabilities Services. Oversight and concerns regarding client safety are addressed through Adult Protective Services & Quality Assurance efforts.

**Partners/Interdependencies**

Senior and Disabilities Services has interdependent relationships with the U.S. Centers for Medicare and Medicaid Services, the Alaskan Division of Public Assistance, Alaska Commission on Aging, along with the Alaskan Governor’s Council on Disabilities and Special Education. In addition to these entities, Senior and Disabilities Services works closely with community partners ranging from service providers to recipient families.

**Analysis**

Increased demands on Adult Protective Services and Quality Assurance required addressing via additional employees for these programs. The additional employees for Adult Protective Services and Quality Assurance reduced the case load for the protective services workers and quality assurance unit employees thus improving safety for recipients due to faster response times.

## Looking Ahead

In the future Senior and Disabilities Services will have to plan for the steadily increasing population requiring Adult Protective Services and Quality Assurance responses. The range of assistance offered by Adult Protective Services and Quality Assurance will have to be reviewed in order to respond to the shifting needs of vulnerable Alaskans and recipients of home and community-based waiver services.

## Division Information

Division of Senior and Disabilities Services

550W 8<sup>th</sup> Ave

Anchorage, AK 99501

**Tel** 907-269-3666

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## Division Performance Measure Contact

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240 Main Street

Juneau, AK

**Tel** 907-465-4917

<http://dhss.alaska.gov/dsds/>

# Alaska Commission on Aging

## Introduction

### *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 that all older Alaskans should have the opportunity to meaningfully participate in their communities and have access to services where they reside to maintain their health, independence, and ability to live safely in their homes and communities.

### *Overview*

Since 1982, the Alaska Commission on Aging (ACoA), an agency within the Department of Health and Social Services has served to ensure the dignity and independence of all older Alaskans by addressing their needs through planning, advocacy, education and interagency coordination. 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 (SDS) with the Alaska Commission on Aging.

The ACoA consists of eleven members, seven of whom are public members (with six members being 60 years and older) appointed by the Governor to serve four-year terms. Two seats are filled by the Commissioners of the Departments of Health and Social Services (DHSS) and Commerce, Community and Economic Development, or their designees. The remaining seats are reserved for the Chair of the Alaska Pioneer Homes Advisory Board and a senior services provider, regardless of age. The Commission is supported by an office staff of four that includes the Executive Director, two Planners, and an Administrative Assistant.

### *Core Service Principles*

- 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 about current and projected needs of Alaska seniors and the programs and services benefiting them 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 (AMHTA) 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 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 their caregivers 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 policymakers and the public on senior issues related to health and wellness, financial security, elder safety and housing.

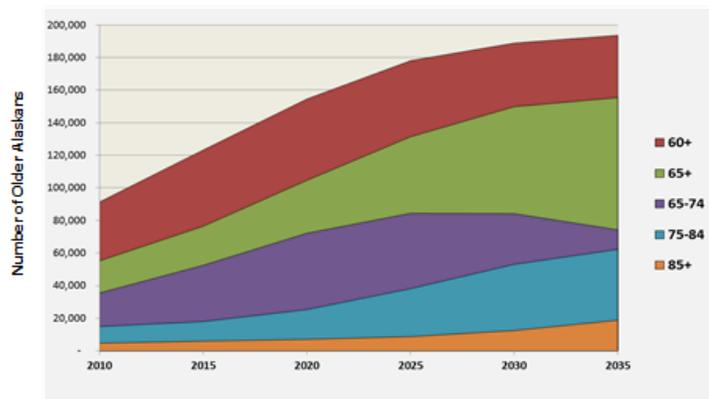
### *Services Provided*

- Planning
- Advocacy
- Inter-Agency Coordination
- Public Awareness/Community Education

### *Populations of Interest*

Seniors

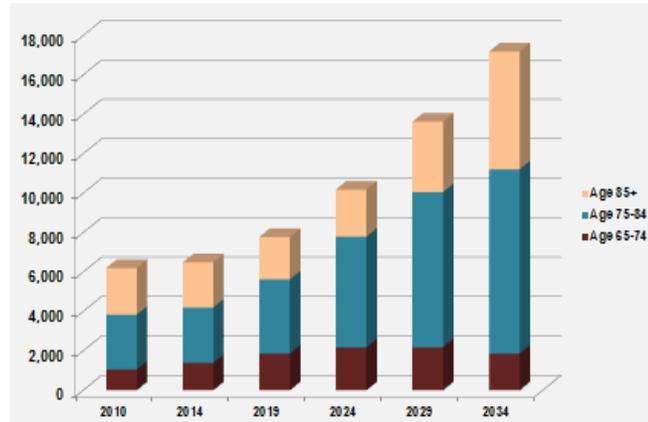
***"Silver Tsunami Wave"***  
**Projected Alaska Senior Population by Age Group**  
**2010-2035**



Alaska Department of Labor  
 Research & Analysis Section, 2012 Projection Estimates

## Individuals with Alzheimer’s Disease and Related Disorders

**Projected Number of Alaskans with Alzheimer’s Disease and Related Dementia (ADRD)**  
(AK Department of Labor Research & Analysis Age Group Projections & ADRD Prevalence Estimates)



### Looking Ahead

The Silver Tsunami Wave has arrived to Alaska. The number of older Alaskans (age 60+) is increasing an average of 6,400 persons each year. Because of the size of the baby boomer population, as well as historical trends in migration and longevity, the growth of Alaska’s senior population is predicted to be strong for the next 20 years. After 2030, the growth of this age segment will begin to slow, but that is when the oldest boomers will begin to reach age 85, a time when their need for services is likely to become more acute.

Access to an appropriate array of long-term services and supports will become increasingly important to Alaskans as they age into their golden years. Most seniors, stakeholders and experts agree that helping older people to maintain and regain their optimal health to allow them to live as independently as possible is the goal for long-term services. Developing a continuum of services and supports from low- to highly-intensive that is flexible, coordinated, and offers a variety of levels of care is required to meet an individual’s specific needs. Family caregivers, who provide the foundation of long-term care, reduce the need for early placement of their loved ones in assisted living and nursing homes, which helps to hold down the rising costs of care. Many family caregivers are also aging themselves with seniors taking care of other seniors, elderly parents caring for their adult children with disabilities, and a growing number of grandparents raising their grandchildren. Family caregivers require training and supports to equip them with the tools they need to be successful in their caregiving role.

With the increase in the number of older Alaskans, there is an increasing percentage of Alaska’s elderly with Alzheimer’s disease which presents challenges for serving this vulnerable population. Based on national prevalence rates, almost 40% of people age 85 and older have some form of dementia. Older Alaskans with dementia rely heavily on their family caregivers for supports. Because of the current eligibility requirements for the Medicaid waiver, some people with dementia do not meet the level of care requirements to be served by the waiver. They can technically perform activities of daily living but need

cueing and supervision, which are types of long-term supports, in order to live safely at home. Even devoted family caregivers can become exhausted and burned-out because they lack the training and supports to cope with the demands of dementia care. Adult day programs need to be expanded in order to provide more support for family caregivers so that they can maintain their elderly loved ones at home longer. Many adult day programs provide uniform care that is not tailored to meet the lower needs of persons with early stage dementia and higher needs of persons with advanced dementia. Adding medical services and physical therapy could also improve the quality of adult day care and postpone high cost institutional placement. Many assisted living homes are not equipped and lack trained staff to care for residents with dementia. ACoA is collaborating with DHSS, Alaska Mental Health Trust Authority and other partner agencies in the development of an Alaska State Plan for Persons with Alzheimer's Disease and Related Dementia to promote greater public awareness about Alzheimer's disease and strengthen services for persons with ADRD 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. 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 are instrumental to keeping seniors healthy, independent and able to live in their own homes. Building Alaska's senior housing continuum will require innovative funding strategies including the use of grant funds, loan financing, tax credits, and public-private partnership investments. Providing appropriate and affordable senior housing is an important strategy for sustaining a healthy community and allowing older Alaskans to maintain a high quality of life in communities of their choice.

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 seniors to seek 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, ACoA 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 in the primary care setting.

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.

ACoA believes it is imperative to provide services and programs to help older Alaskans live and thrive in our state. Seniors are important to their families, their communities and to Alaska. By investing in services for seniors, we keep our heritage, culture, and knowledge alive and strong.

## Alaska Commission on Aging Information

Alaska Commission on Aging  
PO Box 110693  
Juneau, AK 99811  
**Tel** 907-465-3250  
**Fax** 907-465-1398  
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## Alaska Commission on Aging Contact

Denise Daniello, Executive Director  
150 Third Street  
Juneau, AK 99811  
**Tel** 907-465-4879  
<http://dhss.alaska.gov/acoa/>

# Governor's Council on Disabilities and Special Education

## Introduction

### *Mission*

To work towards systems changes for individuals with disabilities in the following areas: advocacy and leadership, housing, employment, transportation, early intervention, special education, health, independent living and inclusion in the community.

### *Overview*

Alaska's unique geographical area with a relatively small population requires a management system tailored to meet the needs of Alaskans. The Governor's Council on Disabilities & Special Education was created to meet Alaska's diverse needs.

The Council provides a constructive process that connects the public with policymakers, to ensure the thoughtful development of an efficient and seamless service delivery system that meets the needs of individuals with disabilities across the life span.

The Council is composed of 28 members appointed by the Governor. Council members' appointments are made on a revolving basis by an application process.

### *Services Provided*

The Council serves a variety of federal and state roles, combining the expertise and experience of many stakeholders throughout the state into one unique Council. All states are required by federal law to have a State Council on Developmental Disabilities, an Interagency Coordinating Council (ICC) for Infants and Toddlers with Disabilities, and a Special Education Advisory Panel. Alaska decided to create one Council to fulfill all of the responsibilities required under federal law for these Councils in order to be effective and efficient. The Council also fulfills two responsibilities under state law including serving as a beneficiary board for the Alaska Mental Health Trust Authority as well as the Governing body of the Special Education Service Agency.

The following list includes the many groups that the Council works with to coordinate their efforts towards making systems changes.

- Center for Human Development (a partner required by federal law)
- Disability Law Center of Alaska (a partner required by federal law)
- State Infant Learning Program office (a partner required by federal law)
- Department of Education and Early Development (a partner required by federal law)

- the Special Education Service Agency (a partner required by state law)
- The Alaska Mental Health Trust Authority (a partner required by state law)
- Stone Soup Group
- State Independent Living Councils
- Alaska Association on Developmental Disabilities
- Alaska Infant Learning Program Association
- Alaska Mobility Coalition
- Alaska Association of School Boards
- Department of Labor and Workforce Development
- And many others too numerous to list

#### Looking Ahead

The Council defined their five year goals in the “Governor’s Council on Disabilities and Special Education 2011-2016 State Plan”. When looking ahead, the Council intends to continue efforts towards reaching these goals and advocating for change.

#### Advocacy and Leadership

- Goal 1.1 The Council, in collaboration with the Center for Human Development and the Disability Law Center of Alaska, will assist in re-establishing and supporting a statewide self-advocacy organization led by individuals with intellectual and developmental disabilities (IDD).
- Goal 1.2 Increase the knowledge of the policymaking process and advocacy skills of at least 300 Alaskans with intellectual and developmental disabilities, family members, and/or other stakeholders each year.

#### Community Choice and Supports

- Goal 2.1 Advocate for a minimum of five new or amended state or public programs, policies or practices per year that promote consumer choice, flexibility and control of services.
- Goal 2.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that promote consumer choice, flexibility and control of services for at least 1,000 individuals per year.
- Goal 2.3 Conduct statutorily mandated responsibilities as a beneficiary board to the Alaska Mental Health Trust Authority (The Trust).

## Housing

- Goal 3.1 Advocate for a minimum of three new or amended state or public programs, policies or practices that increase accessible, affordable housing per year.
- Goal 3.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that increase accessible, affordable housing for at least 100 individuals per year.

## Transportation

- Goal 4.1 Advocate for a minimum of five new or amended state or public programs, policies or practices per year that increase accessible public transportation options.
- Goal 4.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that increase accessible public transportation options for at least 60 individuals per year.

## Employment

- Goal 5.1 Advocate for a minimum of five new or amended state or public programs, policies or practices per year that improve employment opportunities.
- Goal 5.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that improve opportunities for individuals with disabilities to become employed for at least 800 individuals per year.

## Early Intervention

- Goal 6.1 Advocate for a minimum of 10 new or amended state or public programs, policies or practices per year that improve quality early intervention services.
- Goal 6.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that improve the quality of early intervention services for at least 100 individuals per year.

## Education

- Goal 7.1 Advocate for a minimum of 20 new or amended state or public programs, policies or practices per year that improve the quality of education for students with disabilities.
- Goal 7.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that improve the quality of education for students with disabilities for at least 1,000 individuals per year.

## Health

- Goal 8.1 Advocate for a minimum of eight new or amended state or public programs, policies or practices each year that improve health and well-being.

- Goal 8.2 Support capacity building activities (i.e., training, technical assistance, collaboration, consultation) that improve health and well-being for at least 1,000 individuals per year.

## Governor's Council on Disabilities and Special Education Information

Governor's Council on Disabilities and Special Education  
3601 "C" Street, Suite 740  
Anchorage, AK 99503  
**Tel** 1-888-269-8990  
**Fax** 907-269-8995  
<http://dhss.alaska.gov/gcdse/>

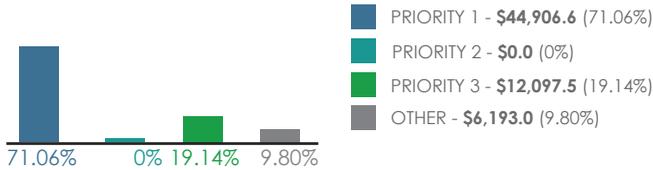
## Governor's Council on Disabilities and Special Education Contact

Teresa Holt, Executive Director  
3601 "C" Street, Suite 740  
Anchorage, AK 99503  
**Tel** 907-269-8994  
<http://dhss.alaska.gov/gcdse/>

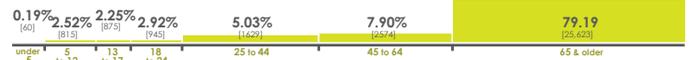
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# DIVISION of SENIOR & DISABILITIES SERVICES | SPENDING BY PRIORITY (FY2014)

\$63,197.1 TOTAL BUDGET (FY2014)



## PRIMARY SERVICE POPULATION



## SNAPSHOT OF ALASKANS SERVED

- Live in urbanized area: 81.72%
- Live outside of urbanized area: 18.28%
- Female: 58.17%
- Male: 41.83%

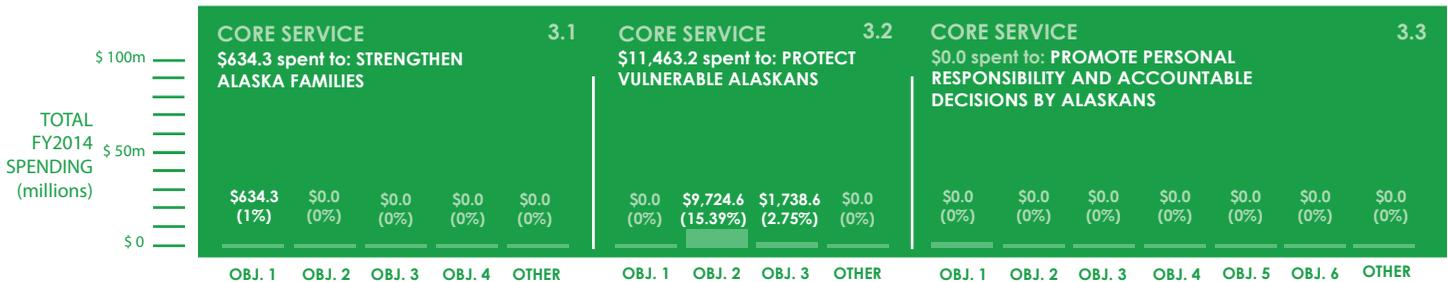
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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## Explanation of FY2015 Operating Budget Requests

### Division of Senior & Disabilities Services

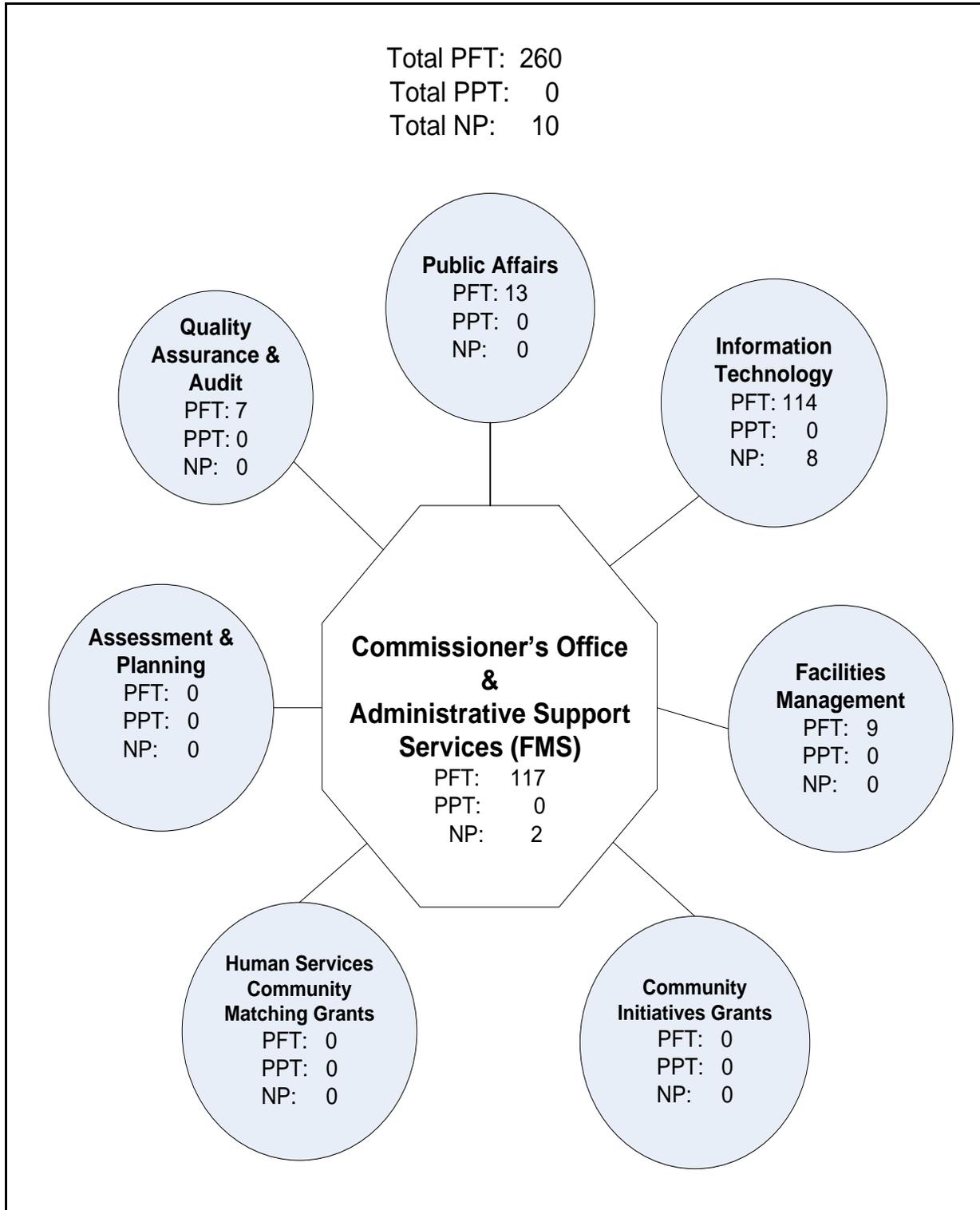
#### Budget Overview Table

<b>Departmental Support Services</b>	<b>FY2014</b>	<b>FY2015 Gov</b>	<b>Difference</b>
Unrestricted General Funds	\$42,259.1	\$41,951.5	\$-307.6
Designated General Funds	\$0.0	\$0.0	0.0
Federal Funds	\$18,118.2	\$18,077.2	\$-41.0
Other Funds	\$2,819.8	\$2,871.3	\$51.5
<b>Total</b>	<b>\$63,197.1</b>	<b>\$62,900.0</b>	<b>\$-297.1</b>

<b>DHSS FY2015 Governor's Request - Senior and Disabilities Services</b>					
<b>General and Other Funds</b>					
<i>(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)</i>					
<b>Item</b>	<b>UGF</b>	<b>DGF</b>	<b>Federal</b>	<b>Other</b>	<b>Total</b>
Reverse Alaska State Employees Association One-Time Payment (Admin, COA, GCD)	\$ (57.3)	\$ -	\$ (60.2)	\$ (7.3)	\$ (124.8)
Reverse MH Trust: Grant 68.10 Rural Long Term Care Development (Admin)	\$ -	\$ -	\$ -	\$ (140.0)	\$ (140.0)
Reverse FY2014 MH Trust Recommendation (Admin, SCBG, CDDG, COA, GCD)	\$ -	\$ -	\$ -	\$ (1,023.7)	\$ (1,023.7)
MH Trust: Housing - Grant 68.11 Maintain Rural Long Term Care Development (FY14-FY16) (Admin)	\$ -	\$ -	\$ -	\$ 141.8	\$ 141.8
MH Trust: Brain Injury - Grant 3178.04 Traumatic / Acquired Brain Injury Program Research Analyst and Registry Support (Admin)	\$ -	\$ -	\$ -	\$ 136.5	\$ 136.5
Reduce Expenditure Level (Admin, COA)	\$ (292.6)	\$ -	\$ -	\$ -	\$ (292.6)
FY2015 Health Insurance and Working Reserve Rate Reductions (Admin, COA, GCD)	\$ (22.7)	\$ -	\$ (25.2)	\$ (2.6)	\$ (50.5)
FY2015 Salary Increases (Admin, COA, GCD)	\$ 65.0	\$ -	\$ 72.3	\$ 8.2	\$ 145.5
MH Trust: ACoA - Grant 1927.06 Aging and Disability Resource Centers (FY15-FY17) (SCBG)	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
MH Trust: Cont - Grant 124.10 Mini Grants for Beneficiaries with Disabilities (FY15-FY17) (CDDG)	\$ -	\$ -	\$ -	\$ 250.3	\$ 250.3
Reverse MH Trust: Dis Justice - Grant 4303.01 AK Safety Planning and Empowerment Network (ASPEN) (GCD)	\$ -	\$ -	\$ -	\$ (150.0)	\$ (150.0)
MH Trust: Cont - Grant 151.10 AK Commission on Aging Planner (06-1513) (FY15-FY17) (COA)	\$ -	\$ -	\$ -	\$ 116.2	\$ 116.2
MH Trust: Benef Employment - Disability Employment Initiative (GCD)	\$ -	\$ -	\$ -	\$ 150.0	\$ 150.0
MH Trust: Benef Employment - Disability Employment Initiative (GCD)	\$ -	\$ -	\$ -	\$ 50.0	\$ 50.0
MH Trust: Cont - Grant 105.10 Research Analyst III (06-0534) (FY15-FY17) (GCD)	\$ -	\$ -	\$ -	\$ 122.1	\$ 122.1
MH Trust: Dis Justice - Grant 4303.02 AK Safety Planning & Empowerment Network (ASPEN) (FY15-FY17) (GCD)	\$ -	\$ -	\$ -	\$ 150.0	\$ 150.0
MH Trust: Benef Employment - Grant 200.11 Microenterprise Capital (FY15-FY17) (GCD)	\$ -	\$ -	\$ -	\$ 125.0	\$ 125.0
Delete Long-Term Vacant Position (GCD)	\$ -	\$ -	\$ (27.9)	\$ -	\$ (27.9)
<b>Senior and Disabilities Services Total</b>	<b>\$ (307.6)</b>	<b>\$ -</b>	<b>\$ (41.0)</b>	<b>\$ 51.5</b>	<b>\$ (297.1)</b>

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# Departmental Support Services



<b>Mission</b>	<b>3</b>
<b>Introduction</b>	<b>3</b>
<b>Core Services</b>	<b>3</b>
<b>Services Provided</b>	<b>4</b>
<b>FY2015 Governor's Operating Budget</b>	<b>14</b>

## **Introduction to Departmental Support Services**

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### ***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, Medicaid Quality Assurance and Audit, and Finance and Management Services. Departmental Support Services provides a varied range of services to support program efforts across the department, and includes the following budgetary 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 for two small, stand-alone grant program components:

- Community Initiative Matching Grants
- Human Services Community Matching Grants

## Services Provided

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### *Commissioner's Office*

The Commissioner's Office offers support and policy direction to the divisions and offices within the department to ensure the promotion and protection of the health and well-being of Alaskans.

The Commissioner's Office:

- Provides leadership and strategic direction for the department.
- Provides management oversight to all divisions within the department.
- Ensures the department achieves its goals within budgetary, statutory, and regulatory parameters.
- Coordinates all legislative activities for the department, including legislative inquiries, preparation of department fiscal notes, and coordinating testimony for committee hearings.
- Interacts with constituents, public and private stakeholders, and the legislature in order to uphold department values and achieve its mission to promote and protect the health and well-being of Alaskans.

### *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)

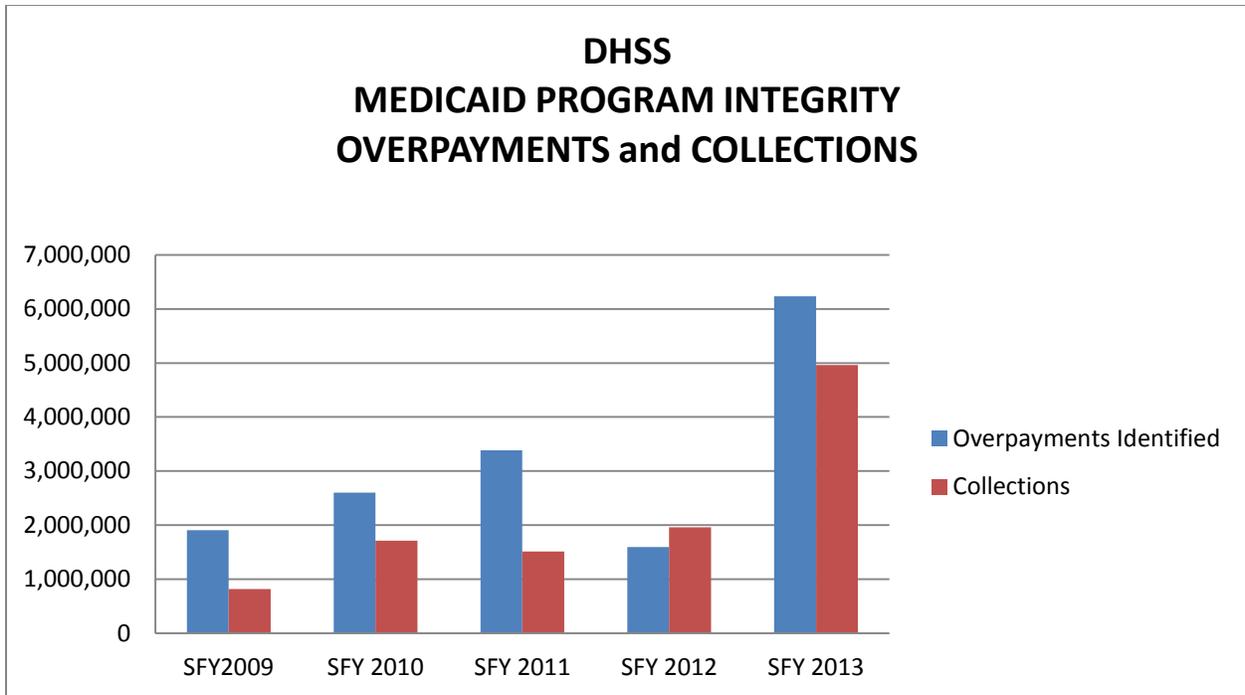
#### **Public Affairs Work Products**

<b>Website Maintenance</b>	<b>15,000 web pages updated</b>
<b>Video Production</b>	32 television/radio/film productions
<b>Publication Design</b>	260 publications produced
<b>Media Relations</b>	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 has also implemented a Recovery Audit contract and is managing 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***

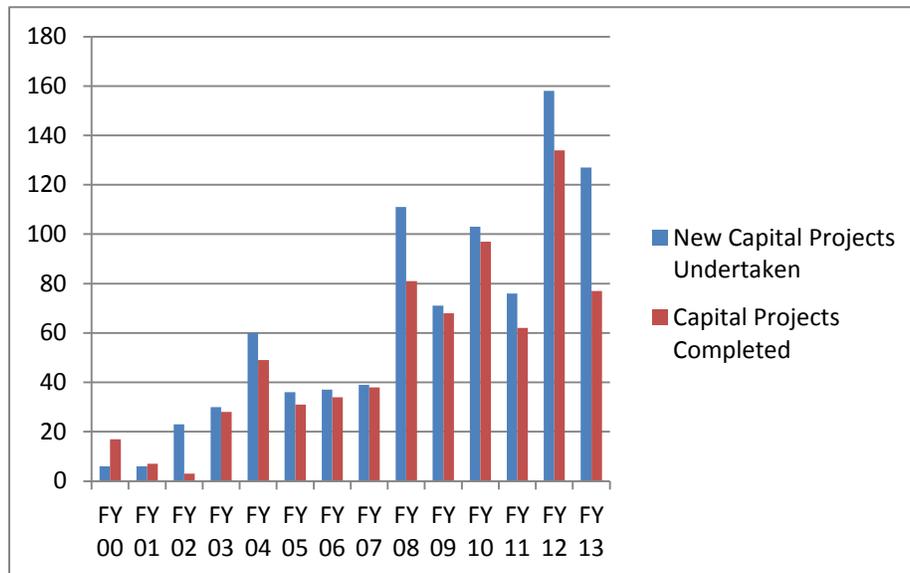
Assessment and Planning provides planning, assessments and forecasting activities for the Medicaid Program. Medicaid is an entitlement program providing for more than \$1.4 billion in services to eligible Alaskans. Accurate data and forecasting of expenditures and revenues is critical to the management 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 approximately one million 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 FY2013. These figures include construction and design, information technology and capital grant undertaken.



### ***Information Technology Services***

Information Technology Services delivers IT services and supports the three Department priorities, Health & Wellness Across the Life Span, Health Care Access, Delivery & Value and Safe & Responsible Individuals, Families & Communities through the following core services:

- Core Service 1 - Security**  
*Secure Stewardship & Access to Information, to ensure Alaskans’ right to Privacy through HIPAA Compliance and Managing Risk.*
- Core Service 2 - Systems Maintenance**  
*Ongoing Business Enablement – Maintain Existing Data Systems, Infrastructure, Desktops/Laptop Computers and Applications.*
- Core Service 3 - New Business & Process Functionality**  
*Expand or Add systems capabilities through IT Development.*

The Information Technology Services organization is structured into four organizational units to provide the following services:

- **Project Management and Planning**
  - 200 IT Projects
- **Business Management – Health related vertical market applications, systems development, and support.**
  - Development and support for 109 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 & Disaster Recovery, HelpDesk, Call Center
- **Technology Standards, Training, Licensing, Privacy, Security Services to protect public, internal, confidential and restricted data**
  - Security framework, logging/auditing/monitoring, risk mitigation, investigations, Privacy, HB-65 Alaska Personal Information Protection Act (APIPA), (the security policy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Payment Card Interface (PCI), IRS 1075, Federal Information Security Management Act (FISMA).

<b>DHSS Computing Environment Statewide Totals:</b>	
<b>Desktops:</b>	<b>3,665</b>
<b>Servers (physical):</b>	<b>160</b>
<b>Servers (virtual):</b>	<b>265</b>
<b>Networks Statewide:</b>	<b>201</b>
<b>Housed Facilities Networks:</b>	<b>113</b>
<b>FY11 Help Calls</b>	<b>22,596</b>
<b>FY12 Help Calls</b>	<b>22,240</b>
<b>FY13 Help Calls</b>	<b>24,989</b>
<b>FY11 Average Calls per Day</b>	<b>91</b>
<b>FY12 Average Calls per Day</b>	<b>85</b>
<b>FY13 Average Calls per Day</b>	<b>101</b>
<b>Communities with IT Infrastructure</b>	<b>35</b>
<b>Number of Business Applications</b>	<b>98</b>

### *Administrative Support Services*

The Administrative Support Services component is responsible for finance, budget, grant and contract administration, procurement, and human resources. 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. In FY2013, for over 250 federal programs, the Department had revenue collections totaling \$1,113,399,771 (billion).

The Revenue Section also has overall responsibility for the state fiscal year-end close out activities. The revenue section ensures budgetary and financial compliance for all divisions.

The Revenue Section is DHSS's lead unit on implementing the new State of Alaska Integrated Resource Information System (IRIS). At this time, we have completed the required chart of account elements. Our current focus is on implementing the federal grants management section of IRIS, as well as developing interfaces between IRIS and standalone systems unique to the Department.

### ***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 helps facilitate 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 \$2.7 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 included guiding divisions through the various steps of developing the FY2014 and FY2015 budget, processing over 1,100 FY2013 reimbursable service agreements and revised program documents, and tracking division revenue and expenditure projections on a quarterly basis.

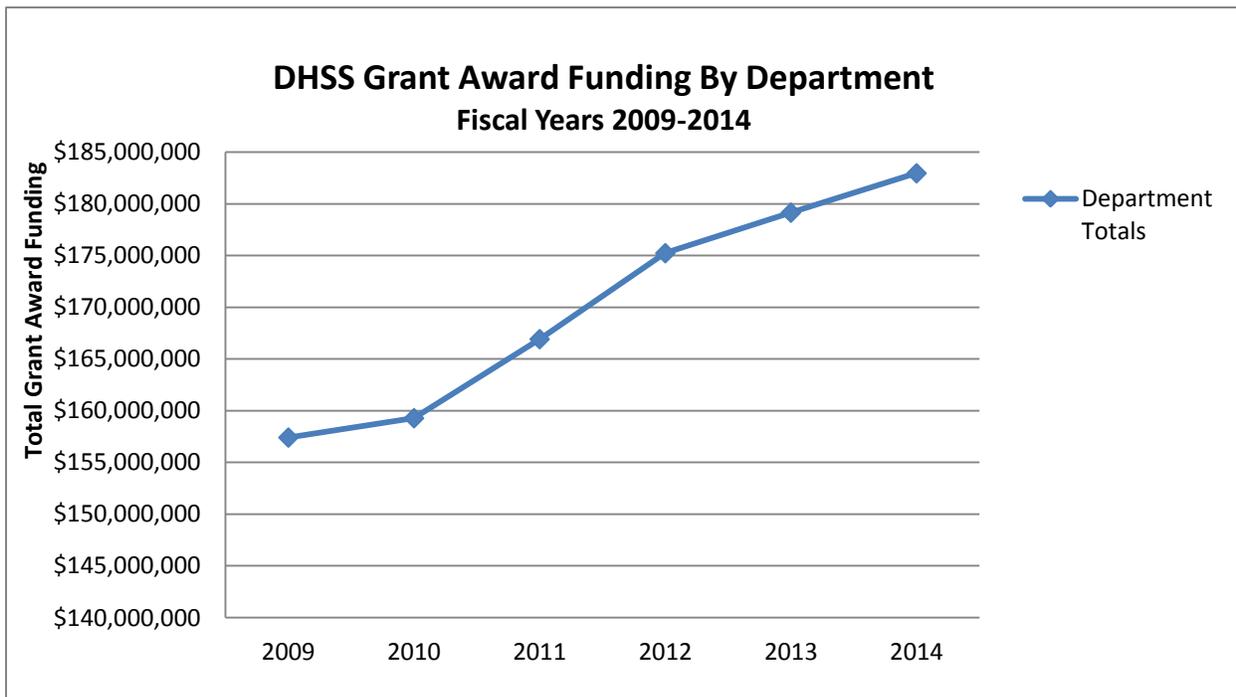
Two significant accomplishments included editing, compiling, and publishing the FY2015 Budget Detail Book and the FY2014 Budget Overview Book. Once budget staff members received the division-authored narrative of both publications, they then collaborated with the divisions to ensure budget descriptions and justifications were accurate, logical, and clear. At over 1,800 pages, the Budget Detail Book served as an important reference for individuals

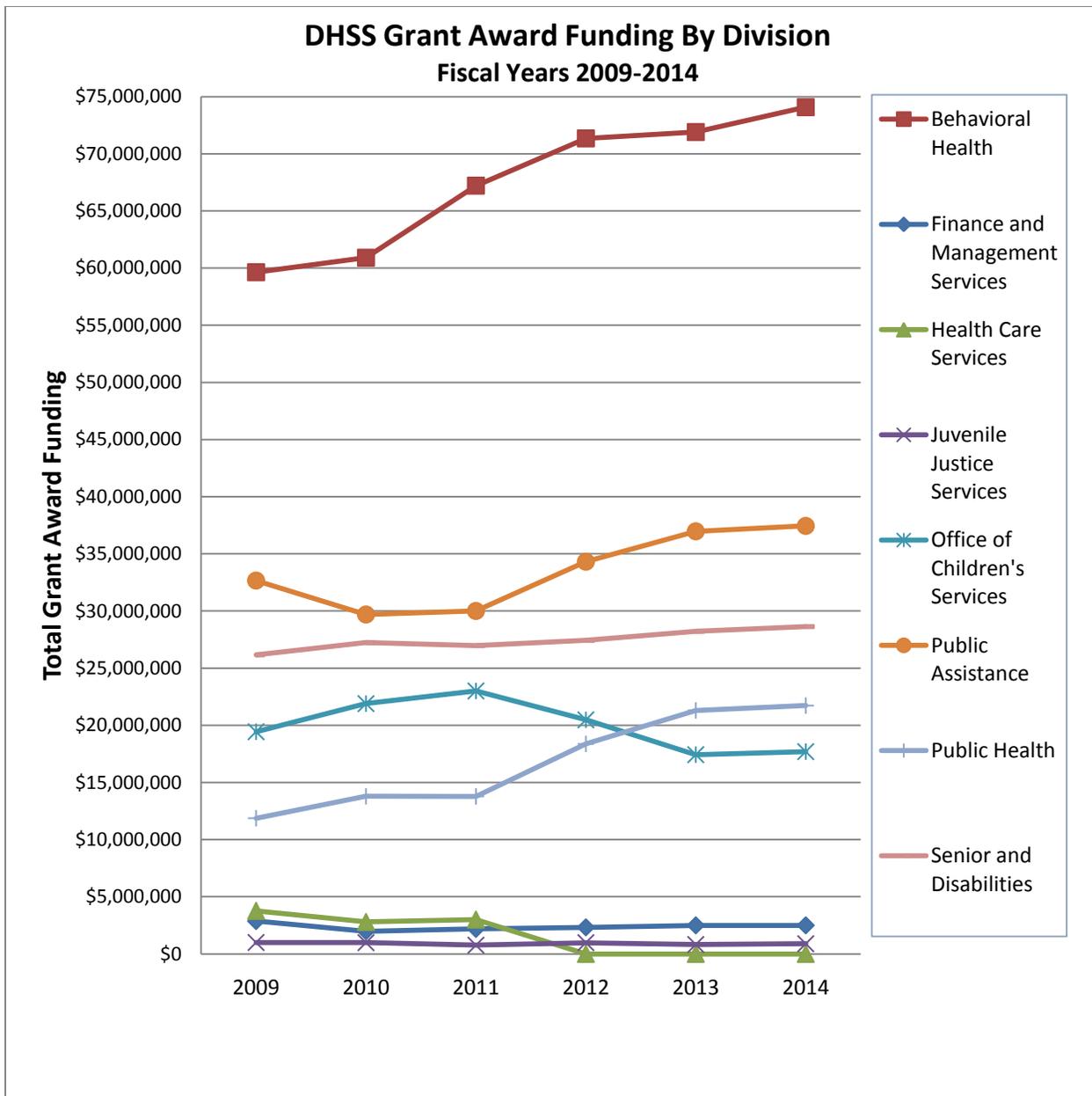
throughout the state. At almost 430 pages, the Budget Overview Book provided key budget, programmatic, and performance measure information to stakeholders in the executive and legislative branches not only during the legislative session, but throughout the year.

The Medicaid Budget Unit provided departmental leadership with key internal updates of Medicaid projections and estimates, including an update of the twenty-year, long-term forecast of Medicaid enrollment and spending in Alaska (MESA), and monthly adjustments to the Short Term Alaska Medicaid Projections (STAMP) report. Additionally, the unit provided 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 \$1,805 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 for smoking cessation to contracts with vendors to provide food service in our Pioneer Homes.





### ***Human Resources***

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. In July 2013, the section took on the responsibility of coordinating department training.

### ***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

physical hardship or death. Services focus on the most basic of essential human services. Related services include: homeless shelters, food banks, day shelters, homeless find programs, cold weather distribution centers for the homeless, legal support services for the needy, sexual assault and domestic violence shelters, home medical and safety equipment distribution, hospice services to the homeless, 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 associated with the Municipalities current needs assessment. (AS 29.60.600 Human Services Community Matching Grants.)

## List of Primary Programs and Statutory Responsibilities

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### 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 23.40	Public Employment Relations Act
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 39.25	Personnel Act
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

### 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
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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

# FY2015 Governor's Operating Budget

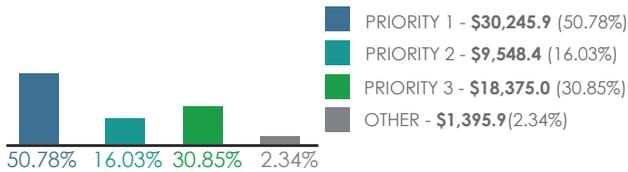
## FY2014 and FY2015 Fund Change Comparison

Departmental Support Services	FY2014	FY2015 Gov	Difference
Unrestricted General Funds	\$25,299.3	\$24,666.0	-\$633.3
Designated General Funds	2.8	0.0	-2.8
Federal Funds	22,010.0	21,727.3	-\$282.7
Other Funds	9,573.4	9,780.5	\$207.1
<b>Total</b>	<b>\$56,885.5</b>	<b>\$56,173.8</b>	<b>-\$711.7</b>

DHSS FY2015 Governor's Request - Department Support Services					
General and Other Funds					
(Includes Inc, IncM, IncT, Dec, OTI, SalAdj, FndChg, and Inter-RDU Trin and Trout Items Only)					
Item	UGF	DGF	Federal	Other	Total
Reverse Alaska State Employees Association One-Time Payment (PA, QAA, CO, Admin, FM, IT)	\$ (104.2)	\$ -	\$ (52.4)	\$ (13.3)	\$ (169.9)
Replace Uncollectible Receipts to Support Operating and Capital Reimbursable Service Agreements (PA)	\$ -	\$ -	\$ (200.0)	\$ 200.0	\$ -
FY2015 Health Insurance and Working Reserve Rate Reductions (PA, QAA, CO, Admin, FM, IT)	\$ (52.0)	\$ -	\$ (26.6)	\$ (12.2)	\$ (90.8)
FY2015 Salary Increases (PA, QAA, CO, Admin, FM, IT)	\$ 152.4	\$ -	\$ 78.0	\$ 29.8	\$ 260.2
Reduce Expenditure Level (Admin, IT)	\$ (438.8)	\$ -	\$ -	\$ -	\$ (438.8)
Delete Long-Term Vacant Position (Admin, IT)	\$ (190.7)	\$ -	\$ (81.7)	\$ -	\$ (272.4)
Replace Uncollectible Interagency Receipts to Support Capital Reimbursable Services Agreements (FM)	\$ -	\$ -	\$ -	\$ -	\$ -
Replace Uncollectible Program Receipts to Support Special Project Capital Reimbursable Service Agreements (IT)	\$ -	\$ (2.8)	\$ -	\$ 2.8	\$ -
<b>Department Support Services Total</b>	<b>\$ (633.3)</b>	<b>\$ (2.8)</b>	<b>\$ (282.7)</b>	<b>\$ 207.1</b>	<b>\$ (711.7)</b>

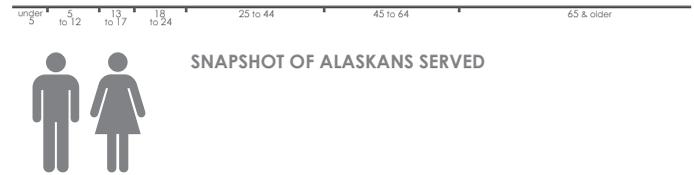
# SUPPORT SERVICES | SPENDING BY PRIORITY (FY2014)

\$59,565.1 TOTAL BUDGET (FY2014)  
TOTAL BUDGET (FY2014)

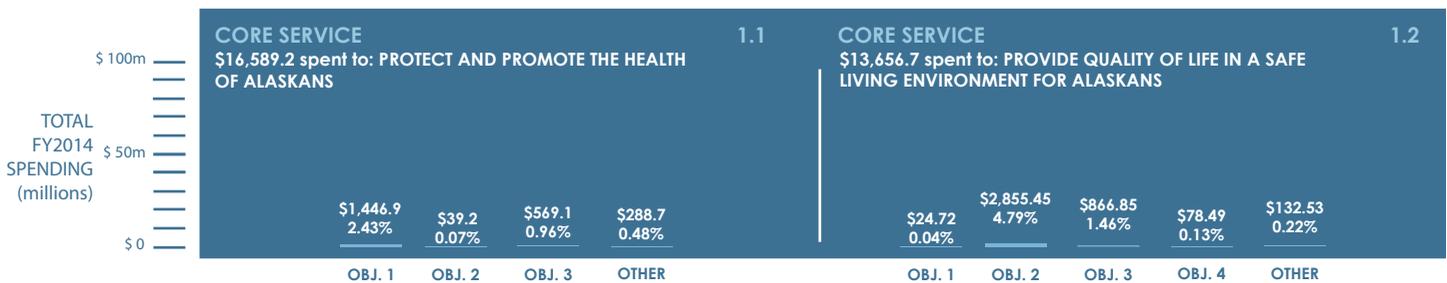


## PRIMARY SERVICE POPULATION

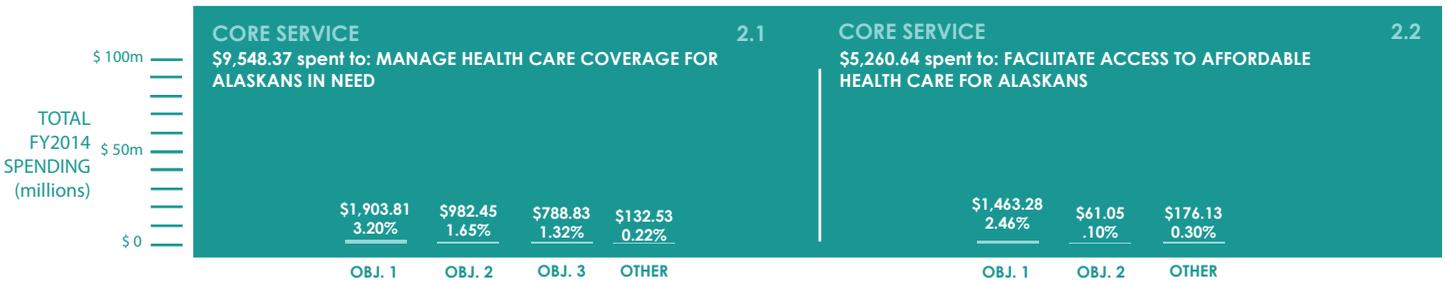
[Total service population \_\_\_ individuals.]



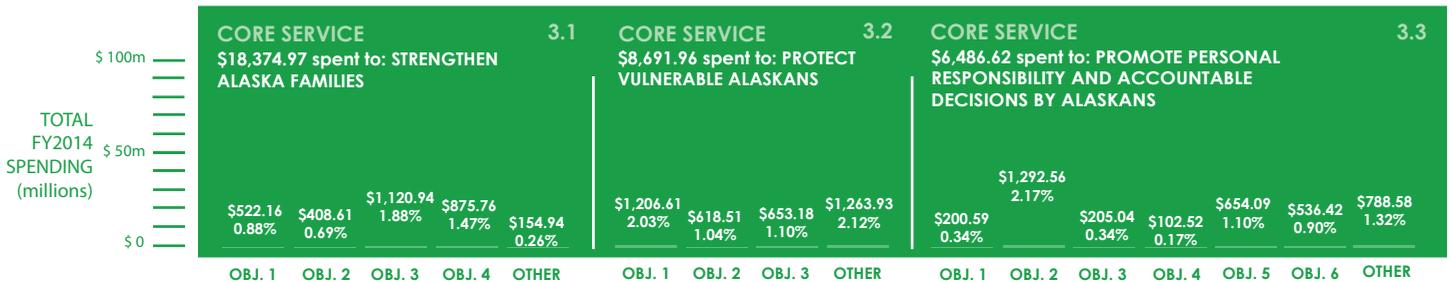
## PRIORITY 1: HEALTH & WELLNESS ACROSS THE LIFESPAN



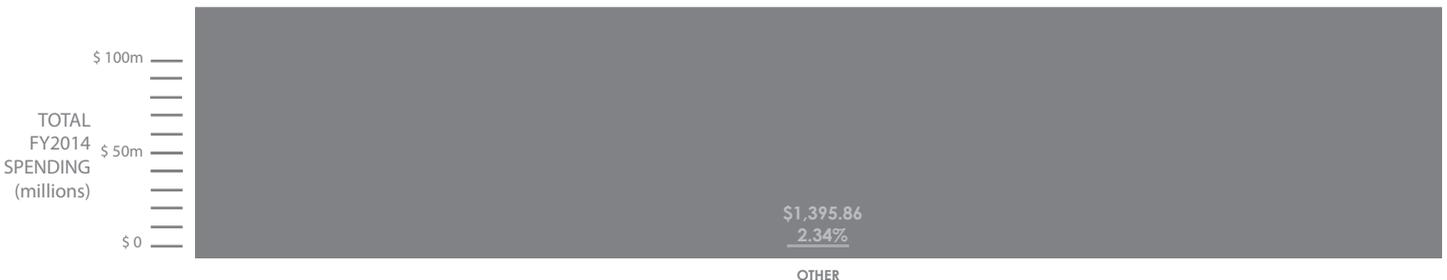
## PRIORITY 2: HEALTH CARE ACCESS DELIVERY & VALUE



## PRIORITY 3: SAFE AND RESPONSIBLE INDIVIDUALS, FAMILIES & COMMUNITIES



## OTHER



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# Appendices

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## RDU/Component Listing FY2015

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Alaska Pioneer Homes  
Alaska Pioneer Homes

Alaska Pioneer Homes Management  
Pioneer Homes

Behavioral Health  
Behavioral Health  
Behavioral Health  
Behavioral Health  
Behavioral Health

AK Fetal Alcohol Syndrome Program  
Alcohol Safety Action Program (ASAP)  
Behavioral Health Grants  
Behavioral Health Administration  
Community Action Prevention & Intervention  
Grants

Behavioral Health  
Behavioral Health  
Behavioral Health  
Behavioral Health  
Behavioral Health  
Behavioral Health

Rural Services and Suicide Prevention  
Psychiatric Emergency Services  
Residential Child Care  
Services to the Seriously Mentally Ill  
Designated Evaluation and Treatment  
Services for Severely Emotionally Disturbed  
Youth

Behavioral Health  
Behavioral Health  
Behavioral Health

Alaska Psychiatric Institute  
Alaska Psychiatric Institute Advisory Board  
AK Mental Health Board & Advisory Board on  
Alcohol & Drug Abuse  
Suicide Prevention Council

Behavioral Health

Children's Services  
Children's Services

Children's Services Management  
Children's Services Training  
Front Line Social Workers  
Family Preservation  
Foster Care Base Rate  
Foster Care Augmented Rate  
Foster Care Special Need  
Subsidized Adoptions & Guardianship  
Infant Learning Program Grants

Health Care Services  
Health Care Services

Catastrophic and Chronic Illness Assistance  
Health Facilities Licensing and Certification  
Medical Assistance Administration  
Rate Review  
Residential Licensing  
Community Health Grants

Juvenile Justice  
Juvenile Justice

McLaughlin Youth Center  
Mat-Su Youth Facility  
Kenai Peninsula Youth Facility  
Fairbanks Youth Facility  
Bethel Youth Facility  
Nome Youth Facility  
Johnson Youth Center  
Ketchikan Regional Youth Facility  
Probation Services  
Delinquency Prevention  
Youth Courts

Public Assistance  
Public Assistance

Alaska Temporary Assistance Program  
Adult Public Assistance  
Child Care Benefits  
General Relief Assistance  
Tribal Assistance Programs  
Senior Benefits Payment Program  
Permanent Fund Dividend Hold Harmless  
Energy Assistance Program  
Public Assistance Administration  
Public Assistance Field Services  
Fraud Investigation  
Quality Control  
Work Services  
Women, Infants and Children

Public Health  
Public Health  
Public Health  
Public Health  
Public Health  
Public Health  
Public Health

Health Planning and Systems Development  
Nursing  
Women, Children and Family Health  
Public Health Administrative Services  
Emergency Programs  
Certification and Licensing  
Chronic Disease Prevention and  
Health Promotion

Public Health  
Public Health  
Public Health  
Public Health  
Public Health  
Public Health

Epidemiology  
Bureau of Vital Statistics  
Emergency Medical Services Grants  
State Medical Examiner  
Public Health Laboratories  
Tobacco Prevention and Control

Senior and Disabilities Services  
Senior and Disabilities Services

General Relief/Temporary Assisted Living  
Senior and Disabilities Services Administration  
Senior Community Based Grants  
Senior Residential Services  
Community Developmental Disabilities Grants  
Commission on Aging  
Governor's Council on Disabilities and Special  
Education

Departmental Support Services  
Human Services Community Matching Grant  
Community Initiative Matching Grants (non-  
statutory)

Medicaid Services  
Medicaid Services  
Medicaid Services  
Medicaid Services  
Medicaid Services

Public Affairs  
Quality Assurance and Audit  
Commissioner's Office  
Assessment and Planning  
Administrative Support Services  
Facilities Management  
Information Technology Services  
Facilities Maintenance  
Pioneers' Homes Facilities Maintenance  
HSS State Facilities Rent  
Performance Bonuses  
Human Services Community Matching Grant  
Community Initiative Matching Grants (non-  
statutory)

Behavioral Health Medicaid Services  
Children's Services Medicaid Services  
Adult Preventative Dental Medicaid Services  
Health Care Services Medicaid Services  
Senior and Disabilities Services Medicaid  
Services

## Glossary of Acronyms

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AAC	Alaska Administrative Code
ABADA	Advisory Board on Alcoholism and Drug Abuse
ABDR	Alaska Birth Defects Registry
ABS	Alaska Budget System
ACA	Affordable Care ACT (aka PPACA - Patient Protection Affordable Care Act)
ACOA	Alaska Commission on Aging
ACS	Affiliated Computer Services
ACT	Alaska Children's Trust
ADRC	Aging and Disability Resource Center
ADRD	Alzheimer's Disease and Related Dementias
ADTPF	Alcohol and other Drug Treatment and Prevention Fund
AERT	Alaska Emergency Response Team
AFHCAN	Alaska Federal Health Care Access Network
AG	Attorney General
AI/AN	American Indian/Alaska Native
AJJAC	Alaska Juvenile Justice Advisory Committee
AKAIMS	Alaska Automated Information Management System
AKHAP	Alaska Heating Assistance Program
AKPH	Alaska Pioneer Homes
AK-PIC	Alaska Psychology Internship Consortium
AKPUD	Alaska Interagency Committee to Prevent Underage Drinking
AKSAP	Alaska Senior Assistance Program
AKSAS	Alaska State Accounting System
ALH	Assisted Living Home
AMHB	Alaska Mental Health Board
AMHTA	Alaska Mental Health Trust Authority
ANHB	Alaska Native Health Board
ANMC	Alaska Native Medical Center
ANTHC	Alaska Native Tribal Health Consortium
AoA	United States Administration on Aging
AORH	Alaska Office of Rural Health
APA	Adult Public Assistance
APCA	Alaska Primary Care Association
APCO	Alaska Primary Care Office
APD	Advanced Planning Document
APD	Adults with Physical Disabilities (Waivers)
APHIP	Alaska Public Health Improvement Process

APHL .....Alaska Public Health Laboratories  
API .....Alaska Psychiatric Institute  
APPIC.....Association of Psychology Postdoctoral and Internship Centers  
APS.....Adult Protective Services  
APSN.....Alaska Public Safety Information Network  
ARBD .....Alcohol Related Birth Defects  
ARND .....Alcohol and Related Neurodevelopmental Disorder  
ARRA.....American Recovery and Reinvestment Act of 2009  
AS .....Alaska Statute  
ASAP .....Alcohol Safety Action Program  
ASPEN.....Automated Survey Processing Environment  
AST.....Alaska Screening Tool  
ASTHO .....Association of State & Territorial Health Officials  
ATAP .....Alaska Temporary Assistance Program  
ATCA.....Alaska Tobacco Control Alliance  
ATCO.....Alaskans Taking on Childhood Obesity  
ATSDR .....Agency for Toxic Substances and Disease Registry  
AVCP.....Association of Village Council Presidents  
BBNA .....Bristol Bay Native Association  
BBAHC.....Bristol Bay Area Health Corporation  
BCC.....Breast and Cervical Cancer  
BCP.....Background Check Program  
BH.....Behavioral Health  
BHCS.....Behavioral Health Consumer Survey  
BHIP .....Behavioral Health Integration Project  
BRFSS.....Behavioral Risk Factor Surveillance System  
BRS .....Behavioral Rehabilitation Services  
BTKH.....Bring the Kids Home  
BVS.....Bureau of Vital Statistics  
BYF.....Bethel Youth Facility  
CAC.....Child Advocacy Center  
CADCA.....Community Anti-Drug Coalitions of America  
CAHPS.....Consumer Assessment of Health Plans Survey  
CAMA.....Chronic and Acute Medical Assistance  
CAPI .....Community Action, Prevention and Intervention  
CCDF .....Child Care Development Fund  
CCISC.....Comprehensive, Continuous, Integrated System of Care  
CCMC.....Children with Complex Medical Conditions (Waiver)  
CCTHITA .....Central Council of Tlingit and Haida Indian Tribes of Alaska  
CD, CDP/HP).....Chronic Disease Prevention and Health Promotion component

CDC .....Centers for Disease Control and Prevention  
CDDG .....Community Developmental Disabilities Grants  
CFDA .....Catalogue of Federal Domestic Assistance  
CDVSA .....Council on Domestic Violence and Sexual Assault  
CFR .....Code of Federal Regulations  
CFSR .....Federal Child and Family Services Review  
CHATS .....Community Health Aide Training and Supervision  
CHC .....Community Health Center  
CHEMS .....Community Health & Emergency Medical Services  
CHG .....Community Health Grants  
CHIP(RA) .....Children’s Health Insurance Program (Reauthorization Act)  
CIG .....Community Initiative Grants  
CIP .....Capital Improvement Project  
COMP Plan .....Comprehensive Integrated Mental Health Plan  
C&L .....Certification & Licensing  
CITC .....Cook Inlet Tribal Corporation  
CLIA .....Clinical Laboratory Improvement Amendments  
CMHC .....Community Mental Health Center  
CMHS .....Community Mental Health Services Block Grant  
CMI .....Chronically Mentally Ill  
CMS .....Centers for Medicare & Medicaid Services  
CNA .....Certified Nurse Aide  
COFIT .....Outcome Fidelity and Implementation Tool  
COMPASS .....Community Partnership for Access Solutions and Success  
CON .....Certificate of Need  
COPD .....Chronic Obstructive Pulmonary Disease  
COSIG .....Co-Occurring State Inventive Grants  
CPS .....Child Protective Services (Office of Children’s Services)  
CQI .....Continuous Quality Improvement  
CSAT .....Center for Substance Abuse Treatment  
CSM .....Children’s Services Management  
CSN .....Children with Special Needs  
CSR .....Client Status Review  
CSU .....Crisis Stabilization Unit  
CTC .....Crisis Treatment Center  
CTU .....Closed Treatment Center  
DAI .....Detention Assessment Instrument  
DBH .....Division of Behavioral Health  
DD .....Developmentally Disabled  
DDI .....Design, Development & Implementation

DEC.....Department of Environmental Conservation  
DEED.....Department of Education & Early Development  
DET.....Designated Evaluation & Treatment  
DES.....Designated Evaluation & Stabilization  
DHSS.....Department of Health and Social Services  
DJJ.....Division of Juvenile Justice  
DKC.....Denali KidCare (State Children’s Health Insurance Program)  
DOC.....Department of Corrections  
DOL/WD.....Department of Labor and Workforce Development  
DOL.....Department of Law  
DOT.....Direct Observed Therapy  
DOT.....Department of Transportation  
DOT-PF.....Department of Transportation and Public Facilities  
DPA.....Division of Public Assistance  
DPH.....Division of Public Health  
DPS.....Department of Public Safety  
DSDS.....Division of Senior and Disabilities Services  
DSH.....Disproportionate Share Hospital  
DSS.....Department Support Services (aka Finance and Management Services)  
DUR.....Drug Utilization Review  
DWI.....Driving While Intoxicated  
EAP.....Energy Assistance Program  
EBT.....Electronic Benefit Transfer  
ECCS.....Early Childhood Comprehensive Systems Initiative  
EI.....Early Intervention  
EIEIO.....Early Intervention, Enhancement and Improvement Opportunity  
EI/ILP.....Early Intervention/Infant Learning Program  
EIS.....Eligibility Information System  
EMR.....Electronic Medical Record  
EMS.....Emergency Medical Services  
EPI.....Epidemiology  
EPSDT.....Early & Periodic Screening, Diagnosis and Treatment  
ER.....Emergency Room  
FAE.....Fetal Alcohol Effects  
FARS.....Fatal Accident Reporting System  
FAS.....Fetal Alcohol Syndrome  
FASD.....Fetal Alcohol Spectrum Disorder  
FFP.....Federal Financial Participation  
FFY.....Federal Fiscal Year  
FY.....Fiscal Year

FYF.....Fairbanks Youth Facility  
FLEX.....Rural Hospital Flexibility Program  
FLSW.....Front Line Social Worker  
FMAP.....Federal Medical Assistance Program  
FMS.....Finance and Management Services  
FPG.....Federal Poverty Guidelines  
FQHC.....Federally Qualified Health Centers  
FS.....Food Stamps  
FTE.....Full Time Equivalent  
GCDSE.....Governor’s Council on Disabilities and Special Education  
GF.....General Fund  
GPRA.....Government Performance and Results Act  
GRA.....General Relief Assistance  
HAIL.....Healthy Alaskans Information Line  
HAN.....Health Alert Network  
HAP.....Heating Assistance Program  
HB.....House Bill  
HCBC.....Home and Community Based Care  
HCBW.....Home and Community Based Waivers  
HCP.....Health Care Program  
HCS.....Health Care Services  
HDDS.....Hospital Discharge Data System  
HDM.....Hospital Discharge Model  
HF.....Healthy Families  
HIT.....Healthy Information Technology  
HIFA.....Health Insurance Flexibility and Accountability  
HIPA.....Health Insurance Premium Payment (Medicaid)  
HIPAA.....Health Insurance Portability and Accountability Act  
HIV.....Human Immunodeficiency Virus  
HPG.....Health Purchasing Group  
HPI.....Health Planning and Infrastructure  
HRSA.....Health Resource Services Administration  
HSCMG.....Human Services Community Matching Grants  
IA.....Interim Assistance  
I/A.....Interagency Receipts  
ICCIS.....Integrated Child Care Information System  
ICD-10.....International Classification of Disease – version 10  
IDEA.....Individuals with Disabilities Education Act  
IDP.....Institutional Discharge Planning  
IECCC.....Interdepartmental Childhood Coordinating Council

IEP.....Individualized Education Plan  
 IFSP.....Individual Family Service Plan  
 IHS .....Indian Health Services  
 ILLECP .....Local Law Enforcement & Community  
 ILP.....Infant Learning Program  
 IMD.....Institution for Mental Disease  
 IOP .....Intensive Outpatient Program  
 ISA .....Individualized Service Agreements  
 ISP.....Individual Service Provider  
 IT.....Information Technology  
 ITG.....Information Technology Group  
 JJDP .....Office of Juvenile Justice and Delinquency Prevention  
 JOMIS .....Juvenile Offender Management Information System  
 JPO.....Juvenile Probation Officer  
 JTPA .....Job Training Partnership Act  
 JUCE.....Juneau Claims and Eligibility  
 JYC.....Johnson Youth Center  
 KPYF.....Kenai Peninsula Youth Facility  
 KRYF.....Ketchikan Regional Youth Facility  
 LCSW .....Licensed Certified Social Worker  
 LIHEAP .....Low Income Home Energy Assistance Program  
 LTC.....Long Term Care  
 MBU .....Medicaid Budget Unit  
 MCAC.....Medicaid Care and Advisory Committee  
 MCFH .....Maternal, Child & Family Health  
 MCH .....Maternal, Child Health (Block Grant)  
 MDS .....Minimum Data Set  
 MH .....Mental Health  
 MHDD .....Mental Health and Developmental Disabilities  
 MHSIP .....Mental Health Statistics Improvement Project  
 MHTAAR .....Mental Health Trust Authority Authorized Receipts  
 MI.....Motivational Interviewing  
 MIS .....Management Information System  
 MMIS .....Medicaid Management Information System  
 MMIS-JUCE.....MMIS – Juneau Claims and Eligibility System  
 MOA .....Municipality of Anchorage or Memorandum of Agreement  
 MOE.....Maintenance of Effort  
 MRDD.....Mental Retardation/Developmental Disability (Waiver)  
 MSYF.....Mat-Su Youth Facility  
 MYC .....McLaughlin Youth Center

NEMT.....Non-Emergency Transportation  
NCC.....Nome Community Center  
NHSC.....National Health Service Corps  
NIH .....National Institutes of Health  
NOMs.....National Outcome Measurements  
NPS .....National Pharmaceutical Stockpile  
NSH.....North Star Hospital  
NSHC.....Norton Sound Health Corporation  
NSIP .....Nutrition Services Incentive Program  
NSOR.....National Sex Offender Registry  
NTSS.....Nutrition, Transportation and Support Services  
NYF.....Nome Youth Facility  
OA.....Older Alaskans (Waiver)  
OAA .....Older Alaskan's Act  
OASIS .....Outcome & Assessment Information Set  
OCS.....Office of Children's Services  
OEP.....Office of Emergency Preparedness  
OIG.....Office of Inspector General (Federal)  
OLTCO..... Office of Long Term Care Ombudsman  
OOS.....Out of State  
ORCA .....Online Resource for the Children of Alaska  
ORR .....Office of Rate Review  
OSEP.....Office of Special Education Programs  
OSHA.....Occupational Safety and Health Association  
P&T.....Pharmacy & Therapeutics  
PA .....Public Assistance  
PASS .....Parents Achieving Self-Sufficiency  
PASS Grant.....Personal Assistance, Supports and Services  
PbS.....Performance-based Standards  
PC.....Personal Computer  
PCA.....Personal Care Assistant  
PCBs .....Polychlorinated Biphenyls  
PCCM .....Primary Care Case Management  
PCMH.....Patient Centered Medical Home  
PCN.....Position Control Number  
PCO.....Primary Care Office  
PCSA.....Protection, Community Services, and Administration  
PCW.....Personal Care Worker  
PDL.....Preferred Drug List  
PDPs.....Prescription Drug Plans

PEC .....Proposal Evaluation Committee  
PERM.....Payment Error Rate Measure  
PES.....Psychiatric Emergency Services  
PFDHH .....Permanent Fund Dividend Hold Harmless  
PFT.....Permanent Full Time  
PHAB .....Pioneers’ Homes Advisory Board  
PHN.....Public Health Nursing  
PIC .....Private Industry Council  
PIP.....Performance (or Program) Improvement Plan  
PL.....Public Law  
POP.....Persistent Organic Pollutants  
PPC .....Prevention Policy Committee  
PPT.....Permanent Part-Time  
PSR .....Protective Service Reports  
RCCF .....Residential Child Care Facilities  
RCSC.....Real Choice System for Change  
RDT.....Residential Diagnostic Treatment  
RBRVS .....Resource-Based Relative Value Scale  
RDU .....Results Delivery Unit  
RFP .....Request for Proposal  
RFR.....Request for Recommendations  
RHSS.....Rural Health Services System  
RHSSP.....Rural Human Services Systems Project  
RPMS.....Resources and Patient Management System  
RPTC.....Residential Psychiatric Treatment Center  
RSA.....Reimbursable Services Agreement  
RSS .....Receipt Supported Services  
RSSP .....Rural Services and Suicide Prevention  
SA.....Substance Abuse  
SAG.....Subsidized Adoption and Guardianship  
SAMHSA.....Substance Abuse and Mental Health Services Administration  
SAPT.....Substance Abuse Prevention and Treatment Block Grant  
SCHIP .....State Children’s Health Insurance Program  
SDPR.....Statutory Designated Program Receipts  
SDS .....Senior and Disabilities Services  
SECC.....State Emergency Coordination Center  
SEARHC.....Southeast Alaska Regional Health Consortium  
SEARCH.....Student Experiences & Rotations in Community Health  
SED .....Seriously Emotionally Disturbed  
SEDY.....Seriously Emotionally Disturbed Youth

SFY.....State Fiscal Year  
 SHIP.....State Health Insurance Assistance Program  
 SIG/ACT.....State Incentive Grant/Alaskans Collaborating for Teens  
 SME .....State Medical Examiner  
 SMI.....Seriously Mentally Ill (aka CMI Chronically Mentally Ill)  
 SMI .....Supplementary Medical Insurance  
 SMP.....Senior Medicare Error Patrol  
 SPF.....Strategic Prevention Framework  
 SPFSIG.....Strategic Prevention Framework State Incentive Grant  
 SPMP .....Skilled Professional Medical Personnel  
 SSBG.....Social Services Block Grant  
 SSI.....Supplemental Security Income  
 SSPC.....Statewide Suicide Prevention Council  
 STARS .....Service Tracking Analysis Reporting System (based on MMIS)  
 STAR Grants.....Short Term Assistance and Referral  
 STD.....Sexually Transmitted Disease  
 SUD.....Substance Use Dependent, Substance Use Disorder  
 SVCS/SMI .....Services to the Seriously Mentally Ill  
 TANF .....Temporary Assistance to Needy Families  
 TB .....Tuberculosis  
 TBI.....Traumatic Brain Injury  
 TCC.....Tanana Chiefs Conference  
 TCM.....Targeted Case Management  
 TDM.....Team Decision Making  
 TEDS.....Treatment Episode Data Sets  
 TEFRA.....Tax Equity and Fiscal Responsibility Act of 1982  
 TFAP.....Tribal Family Assistance Programs  
 Title IV E  
 Title V .....Maternal, Child Health Block Grant  
 Title X .....Family Planning (Federal)  
 Title XIX.....Medicaid  
 Title XXI.....SCHIP/Denali KidCare  
 T&H .....Central Council of Tlingit and Haida Indian Tribes  
 TPL .....Third Party Liability  
 TSU.....Transitional Services Unit  
 TYP.....Tribal Youth Program  
 UAA.....University of Alaska, Anchorage  
 UAF.....University of Alaska, Fairbanks  
 USDA.....U. S. Department of Agriculture  
 USDHHS.....U. S. Department of Health and Human Services

WAS.....Women and Adolescent Services  
WIA.....Workforce Investment Act  
WIC.....Women, Infants and Children  
WISH.....Women in Safe Homes  
YF .....Youth Facility  
YKHC .....Yukon-Kuskokwim Regional Health Corporation  
YRBS .....Youth Risk Behavior Survey

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