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ALASKA HEALTH CARE COMMISSION

FRIDAY, MARCH 9, 2012

8:10 A.M.

UAA STUDENT HOUSING

GORSUCH COMMONS, ROOM 107

3700 SHARON GAGNON LANE

ANCHORAGE, ALASKA

VOLUME 2 OF 2

PAGES 209 THROUGH 335

1 and is going to start with the initial overview. And maybe
2 Deb said it to you, but if you could try to keep your speaking
3 closer to the microphone than you feel comfortable with,
4 yesterday, we had a real problem with the folks that were on
5 the phone hearing what was said, and it seemed to help if you
6 could speak very directly right into the microphone. So
7 Melissa, please?

8 MS. STONE: Now it's working. Oh, that's very loud.
9 That should work for people. Good morning. Thank you for
10 inviting us here today. We'll introduce the panel when they
11 come forward, but I just want to say I think the panelists --
12 there is a lot of knowledge in this group and a lot of
13 collegueship in the group of people who are here to
14 supplement this story. So hopefully, we have the right
15 information that will help you in your task.

16 For the record, my name is Melissa Stone. I'm the
17 Director of Behavioral Health in Department of Health and
18 Social Services. And you're going to do my slides for me, I
19 take it, since I have no button.

20 So to start with, as an overview, the core services in
21 this state are organized in this way from prevention to early
22 intervention, mental health treatment, substance use disorder
23 treatment, and the Alaska Psychiatric Institute being part of
24 our system.

25 Some years ago in about 2002, the State integrated what

1 had previously been the mental health and developmental
2 disabilities, separating out mental health and integrating it
3 with substance abuse so that we now have an integrated
4 division in the state of Alaska, and we call that Behavioral
5 Health.

6 In my experience in this position, when I go and meet
7 with my colleagues from other states -- they call us single
8 state authorities -- states are organized very differently, as
9 Ward said, and we're fortunate to have a structure where
10 mental health and substance abuse are together, where adult
11 and youth services are together because that doesn't even
12 happen in all states, and where Medicaid planning is also
13 coordinated. So our structure brings us some opportunities
14 that, in other states, present real barriers and people don't
15 even know one another, let alone have good working
16 relationships.

17 In relation to those core services, if you look ahead at
18 your slides, you'll see on slide number ten, your Health
19 Commission Continuum of Care, and the way we think about
20 services in Behavioral Health is very much along that same
21 continuum of care from prevention through early intervention,
22 treatment, and recovery up to inpatient psychiatric care being
23 the most intensive at the far end of the continuum.

24 Back to the second slide, some of the issues that are
25 particular to us -- sorry. I mean slide number three. Some

1 of the issues that are particular to us in the state of Alaska
2 are these that I have listed. My colleagues, when they come
3 forward, might have some additional issues that they see as
4 being particularly relevant for us in the state.

5 I think you all know that the State of Alaska has the
6 highest rate per capita of suicide in the country. In 2007,
7 the U.S. had 11.5 suicides per 100,000; Alaska had 21.8, and
8 Alaska Natives had 35.1. Alaska Native men 15 through 24 age
9 have the highest rate in the country. This is a real problem.
10 It's a problem that goes far beyond what we do in behavioral
11 health. It has to do with many psychosocial factors and
12 health factors and community factors.

13 Domestic violence and sexual assault, we're fortunate
14 that the Governor has brought attention to this problem that's
15 a huge one for our state. If you haven't done it already, you
16 might go to the Department of Public Safety, DVSA website, and
17 you can see there they now have a DVSA dashboard that is able
18 to -- has identified some of the measures that they're looking
19 at through that initiative in order to see how we can move
20 this curve and change this curve for domestic violence.

21 Alcohol is a huge problem in the state, and of course,
22 influences so many other problems that we're dealing with. In
23 behavioral health services, we served 7,038 people in FY11,
24 providing substance abuse services. We have a way that we
25 measure prevalence in the Division, and our estimate is that

1 we're serving about 61% of the people who have substance use
2 disorders in the state.

3 We have a grant from the Feds, a SAMHSA grant, called a
4 Strategic Prevention Framework State Incentive Grant, and the
5 Feds, through the process of putting these grants together,
6 require us to do a pretty extensive data collection process
7 before we can put our plan back out to the Feds for approval,
8 and in that process of looking at the problem of alcohol
9 around the state, the grant has determined to focus on youth
10 abuse, ages 17 and 20, that being a huge problem in our state,
11 adult heavy and binge drinking, ages 21 to 44, and then six
12 related consequences that are particular to our state
13 (indiscernible - voice lowered) deaths, alcohol-related
14 deaths, alcohol-related crashes, driving under the influence,
15 minor consuming, alcohol-related suicides, and alcohol-related
16 interpersonal violence. So that's where we see, in a major
17 way, the consequences of alcohol, the costs of alcohol in our
18 state.

19 Another issue for us -- is this reverberating too much,
20 am I too close? Another issue for us that is significant is
21 co-occurring disorders. Co-occurring disorders mean different
22 things to different people depending on who you are and what
23 your disorder is. Certainly, we are very much impacted by
24 people who have a mental health issue and a cognitive
25 disability. We also have challenges when we're working with

1 people who have co-occurring mental health and substance abuse
2 disorders. We have a screening tool that I think I've
3 described to you previously called the Alaska Screening Tool,
4 and it tells us that 57% of the people that we serve in our
5 behavioral health system have co-occurring disorders. Of
6 course, co-occurring disorders present higher costs, a higher
7 challenge, require more specialized skills, and are problems
8 that we're putting significant energy into.

9 Housing. It's hard for people to recover if they don't
10 have a place to live, and housing is a huge challenge for us.
11 We know that 64% of homeless people have a substance use
12 disorder, and having a continuum of supported housing that
13 leads to independence is ultimately the goal, in order to help
14 people not get stuck in supported housing but actually help
15 them move with recovery to as great of independence as they
16 can.

17 Employment is a big problem. Across the nation, 21% of
18 people served by the state mental health authorities are
19 employed. Of that, only 2.1% get employment services. It's
20 hugely under-serviced. This is a big problem. I went to a
21 workshop done by the Social Security Administration talking
22 about Ticket to Work, and it was really appalling to think
23 that one of the gentlemen who is now a presenter and employed
24 in this activity said that he spent 20-some years in the
25 mental health system and no one ever asked him whether he

1 wanted to work. No one ever even brought it up. He was
2 simply a dependent person on services.

3 We know that supported employment reduces need for
4 services, and we know that our people with serious mental
5 illness and substance use disorders are highly impoverished.

6 When I spoke to you before, we spoke quite a bit about
7 adverse childhood experiences and the significance of those.
8 Again looking at our Alaska Screening Tool, we know that 69%
9 of the people that we serve tell us that they have adverse --
10 have experienced adverse incidents in their lives. These
11 folks are more likely to suffer from diabetes, obesity, heart
12 disease, and engage in substance abuse.

13 And behavioral health emergencies are a huge problem for
14 us. We need to be able to deal with that systemwide at all
15 levels all throughout the state, and some of our challenges,
16 in terms of geography, certainly present difficulties with
17 being able to do that well.

18 On the next slide, this is kind of obvious, but I think
19 not really obvious, when I was talking with Deb. When I'm
20 speaking with you about behavioral health, I'm talking about
21 the public behavioral health system. I'm not talking about
22 behavioral health through private practitioners that people
23 buy with their insurance.

24 Our system is made up of, basically, two components,
25 grantees and Medicaid providers. And in the following slides,

1 we'll be kind of thinking about this as a continuum.

2 The entree to our system for community behavioral health
3 is through a grant, a grant from the state, and the intent of
4 that grant is to be for the provider to be able to provide
5 care to people who have no other source of pay, and you'll
6 see, in the slides, that we know what percentage of people
7 coming into our system have Medicaid or are non-resourced, and
8 these grants are intended to help our provider agencies pay
9 for services for people who have no source of pay.

10 So our grantees -- some of our grantees are Medicaid
11 providers. There are grantees who are not Medicaid providers,
12 and there are many Medicaid providers who are not grantees,
13 and I'll make further explanation of that.

14 So in terms of grantee providers, we basically think of
15 our world in two groupings, prevention and early intervention
16 grantees and then those provider agencies, non-profit
17 providers who are providing behavioral health treatment and
18 recovery.

19 We have 50 agencies or 50 grantees, if you will, that
20 receive 68 funded grants under prevention and early
21 intervention. I mention the numbers because a huge business
22 for the Division is managing these grants, managing the
23 grantees and doing the administrative processes that the
24 grants require, which amounts to putting together Requests for
25 Proposals, going through this competition solicitation

1 process, and then monitoring grant services to see that
2 they're compliant with the requirements in the grant award.

3 In terms of prevention and early intervention, we funded
4 -- in FY12 when we were in a solicitation year, we received 46
5 proposals that amounted to \$11 million. We ended up
6 distributing, within our budget, \$4.1 million to 25 grantees.
7 Seven of those grants were for capacity building, which is
8 important to our system in terms of developing community
9 readiness. Treatment recovery grantees, we have 81 non-profit
10 agency grantees receiving 120 funded grants.

11 All of these services, really, we consider to be
12 gatekeepers to that end point on our continuum of care. The
13 Alaska Psychiatric Institute. It's an important assumption on
14 our system that success at lower levels of care prevent more
15 costly inpatient, involuntary psychiatric care. So having
16 adequate resources at the lower ends of the continuum and
17 access is very important to managing that far end.

18 On the next slide -- I have a couple slides talking about
19 API Census. Just to give a picture of this, at last year's
20 legislative session, we were going through a period of census
21 crisis at Alaska Psychiatric Institute. We had people waiting
22 in emergency rooms around the state. We had forensics
23 referrals backed up in DOC, and it was pretty hairy. Ugly.
24 It was ugly.

25 Recently, folks at API did kind of a look back. We did a

1 lot of work over the last year, and things have changed. So
2 we did a look back to just see what that change looked like.
3 So this is just a snapshot for you and gives you an idea of
4 kind of the management and the problems with -- at the far end
5 of our continuum at Alaska Psychiatric Institute.

6 So a year ago, we were at 91% capacity at API. The total
7 beds there is 80. We were averaging 73. This was, again, a
8 January-to-January comparison. Compared to January of this
9 year, you see, we were at 49 in the average census, 62%.
10 Average length of stay a year ago was 16 days. Average length
11 of stay, more recently, ten. Total admissions a year ago,
12 128. January of this year, 132. Involuntary admissions
13 pretty much the same. Legal holds after admission -- people
14 come into the hospital on an involuntary status. That's the
15 definition of the hospital, but the significance of that last
16 item has to do with communicating with patients once they're
17 in the hospital and helping them to realize the value of being
18 in the hospital and getting their agreement to voluntarily
19 stay in the hospital. That ultimately saves time and money
20 because then we're not going through court hearings. So you
21 can see that the legal holds after admission went from 63% to
22 12%.

23 Some of the problems that were causing these issues
24 briefly that, again, I mentioned previously, co-occurring
25 disorders, utilization management, issues in the hospital in

1 terms of who was coming in, how long they were staying, the
2 treatment they were getting at the time, the discharge process
3 at the end, heavy admits from Anchorage/MatSu; 62% of the
4 admissions to API are from Anchorage/MatSu. This compares to
5 4% coming in from Fairbanks where we have the Fairbanks
6 Memorial functioning as a designated evaluation and treatment
7 hospital helping us with these involuntary commitments, and
8 compares, for example, to the admissions from the Southeast of
9 only 2%, where also Bartlett provides that function for us.

10 Forensics were an issue in terms of hearings and people
11 staying longer than they need to in the referral process from
12 DOC.

13 Locum tenens psychiatrists. We, at one point, had all
14 locum tenens. They cost twice as much money. They, of
15 course, are not, you know, engaged in the treatment process to
16 the same extent as someone who is local and committed.

17 Staffing. How staff were employed. How teens were
18 working cases was an issue. The fact that API is seen as a
19 safety net throughout the state -- seems like it almost
20 doesn't matter what a person's problem is, if they can get
21 into API through the court process, people perceive them as
22 being safe, and indeed, they are safe once there. So that's a
23 problem. People get into the hospital for whom that's not
24 necessarily the best place. And community resources are an
25 issue.

1 Slide eight shows some of the things that were done over
2 the year period with a lot of effort from a lot of people
3 working toward an acute care model, reducing, as I mentioned
4 previously, the involuntary holds, getting better processes,
5 working with co-occurring disorders, managing the treatment
6 team differently, working -- using peers in the process,
7 leadership all throughout the organization from the CEO to the
8 Director of Nursing through medical leadership, enhanced
9 discharge planning, engaged partners, including our community
10 partners, our people in DVH who assisted with discharge
11 planning all throughout the system.

12 So the providers on slide nine include our grantee
13 providers right there in the middle. The community behavioral
14 health, mental health and substance abuse are grantee
15 providers. All of those other folks that you see on there are
16 Medicaid providers. So our world is a lot bigger in
17 behavioral health than what we characteristically talk about
18 and present when we talk about community behavioral health.
19 We're usually talking about, going back to that previous
20 slide, our grantee services, but where people get behavioral
21 health is much bigger than just community behavioral health.

22 And again these services, going along to slide ten,
23 whether we're talking about Medicaid or grant, also fall along
24 that continuum.

25 So on slide 11, we see some information that we were

1 recently able to pull together, which is for Medicaid and non-
2 resourced. Where in that service continuum are people getting
3 their services? These percentages don't add up to 100 because
4 people can be getting services in more than one place. For
5 example, you could be getting services in community health and
6 have gone to a hospital emergency room. You could be getting
7 services in community health and be going to a physician's
8 clinic and getting your prescription through a physician's
9 clinic. So there is duplication across these.

10 So for adults, the highest provider of service, if you
11 will, is in that community behavioral health grantee system.
12 It's, I think, very interesting to see -- first of all, it's,
13 again, the highest intensity being the highest cost, 6% at the
14 highest level of cost in intensity, and this information is
15 very meaningful to us, particularly in relation to those
16 bottom two categories, the community clinics, physician
17 clinics, independent psychologists, Indian Health Service,
18 rural health, and then the other, the numbers of people
19 getting behavioral health services through physicians, nurse
20 practitioners, and school-based services is pretty high.

21 Then you look at the next slide, which is for youth, and
22 if you can look at the two of those on your printout, they're
23 pretty different, and there is reason for those to be
24 different, as you'll see when we go to slide 13, and I think
25 it has to do with payment source. If you have payment, if you

1 have Medicaid, you're more able to go to the clinic or the
2 other practitioners and be able to get service as opposed to
3 coming to the community behavioral health center where we use
4 our General Funds in order to pay for uncompensated care.

5 So slide 13 tells us that, for adults within the
6 community behavioral health system, 37% -- only 37% of adults
7 receiving behavioral health services had Medicaid. That's
8 surprising to us -- or surprising to me. And specifically for
9 mental health, 45% of the people had Medicaid, and for
10 substance abuse, only 23%.

11 For youth, again, the numbers are quite different because
12 youth qualify for Medicaid differently through Denali Kid Care
13 and as dependents. And for youth, 78% of the people were
14 Medicaid recipients. For mental health, that represented 79%.
15 For substance abuse, 57%.

16 Slide 14 is an overview of our budget, just looking at
17 our non-Medicaid and Medicaid sources of funds that, again,
18 we've been talking -- and differentiating in our system, our
19 General Funds for non-resourced people and Medicaid.

20 Slide 15 shows where behavioral health kind of stands
21 within the Medicaid system. We represent 15% of the Medicaid
22 expenditures in the state of Alaska.

23 Some of the strengths and challenges of our system. I
24 think a big strength is the partnerships that we have,
25 partnerships with our tribal team, with folks in public safety

1 working on domestic violence and sexual assault, folks at the
2 Trust, the boards, and I think, in spite of times when we have
3 some tenseness between our providers, I think we have a very
4 positive partnership with our provider agencies.

5 Advocacy is an important part of our system. We, again,
6 have advocates, particularly in the boards, who are here and
7 will be talking to you through Kate Burkhart, and the work of
8 the Trust is hugely relevant to helping us identify our
9 challenges, helping us to strategize to minimize those
10 challenges.

11 We have a lot of support in this state for peer services.
12 The Trust focused on the use of peers in our system some years
13 ago, so that there has been a developed capacity amongst our
14 peers, and we took that a step further with our recent
15 integrated Medicaid regulations, including peers as a billable
16 service.

17 Accountability is important in our system, and again, is
18 something we've been working on for quite some time. Being
19 able, consistently, to measure how much we do, how well we do
20 it, and is anyone better off is very important in our daily
21 business.

22 We have accomplished a lot relative to having data to be
23 able to drive our management system, our understanding of the
24 system. We have data through AK AIMS. We have data through
25 the state management information system, and those are very

1 important to us.

2 COMMISSIONER ERICKSON: Excuse me, Melissa. Could you
3 just describe briefly what AK AIMS is for the Commission
4 members?

5 MS. STONE: Yes. AK AIMS is both a management
6 information system and an Electronic Health Record. Agencies
7 submit a minimal amount of data to that system. We are kind
8 of the repository and are able to then use that data to
9 present reports to extract data. Agencies can extract data.
10 We're able to meet our federal reporting requirements. What
11 else to say about it? I think that's it.

12 I'd say funding is a strength in the state, particularly
13 when you compare the state of Alaska to other states where
14 there are a lot of states in a lot of trouble who have had,
15 consequently, experienced severe behavioral health decreases
16 in services as a result of state budget challenges.

17 Some of these challenges on the other side of this grid,
18 I think, you're very familiar with. Geography is a huge
19 challenge for behavioral health services as it is for fiscal
20 health care. I mentioned previously the huge amount of
21 numbers of grants that we manage. That's absorbed time and
22 resources. It's a huge problem that we're a fee-for-service
23 system. We have no managed care. Our relationship to each
24 one of our providers is a single relationship. We don't have
25 any regionalized authorities. So it's time-consuming and not

1 summarized or coordinated in a more economical way.

2 Workforce is an issue at whatever level we're talking in
3 behavioral health. Acuity and our inability to, at this
4 point, differentiate acuity presents a problem to us. It's a
5 problem in terms of reimbursement. According to acuity, it's
6 a problem in terms of that last element that I put up there,
7 shared risk and shared responsibility. And going back to that
8 idea of fee-for-service, we don't have a service system as in
9 some states where a region is responsible for that whole
10 continuum of care that we talked about. In our system,
11 individual providers are responsible for different pieces and
12 not the entire continuum. That makes for a lack of shared
13 risk across the whole continuum and an ability for providers
14 to pick and choose the kinds of services.

15 The next several slides are related, and there is a lot
16 to be talked about in the next three slides. They are kind of
17 the development of our potential, recognizing that we have a
18 huge number of people who are being seen through physicians'
19 clinics and private providers. The question is, to what
20 extent are those services integrated and collaborative?

21 We know that as many as 70% of primary care visits stem
22 from psychosocial issues. We also know that people
23 frequently, in primary care, present with a physical health
24 complaint that, actually, underlying it is a mental health or
25 substance abuse issue that's triggering that.

1 The solution to that is within the ideas of integration
2 and collaboration. Integration meaning improving screening
3 and treatment of mental health and substance use disorders in
4 primary care. So the primary care end of that continuum that
5 we looked at before -- the primary care end has integrated
6 services, and at the other end, through collaboration,
7 improving medical care for individuals with serious mental
8 illness and substance disorders in behavioral settings. So
9 you can -- there is a difference between integration and
10 collaboration.

11 Again if you can look on your written sheets, as I'm
12 going to talk for the next couple of minutes, these three
13 slides, 17, 18, and 19, are all interrelated and kind of
14 different representations of the same story.

15 The idea of medical homes, which I think you have been
16 considering and talking about, has to do with improved patient
17 tracking and registry, using non-physicians for case
18 management, using evidence-based guidelines, referral
19 tracking, self care management, use of screening and so on.
20 And an assumption in medical homes to enhance care is that
21 there be some aspect of behavioral health care.

22 So the four quadrants talk about kind of a beginning
23 model for a combination of thinking whether a person has low
24 or high physical health needs on the vertical axis in
25 juxtaposition with low to high behavioral health needs on the

1 up and down and then where it makes sense for people with
2 behavioral health to be receiving their services.

3 I'm going to speak from the next slide and give a
4 description of the eight models of integration, and these
5 eight -- as I talk about these eight models of integration,
6 I'm going to be referencing the degree of integration slides,
7 slide 19 and going back to slide 17.

8 So the models of integration, in terms of improved
9 collaboration, are relevant to quadrants one and three in
10 terms of the quadrants. So we're talking about people with
11 low behavioral health needs. Improved collaboration basically
12 is separate facilities, separate systems with occasional
13 communication between behavioral health and primary care.

14 The second model, medical provided behavioral care, is
15 basic collaboration at a distance, and I'm referencing the
16 degree of integration slide, this other slide. So medical
17 provided behavioral health care is basically about medical
18 providers delivering behavioral health care with collaboration
19 from behavioral health specialists. So they might call a
20 psychiatric now and then. They might call the behavioral
21 health agency now and then. They might call a substance abuse
22 agency. The idea of consultation liaison is significant in
23 this model. The medical entities probably use behavioral
24 health screening tools, brief intervention models, like SPIRT
25 (ph), fall into the medical provided behavioral health care.

1 Co-location takes things a step further, is most relevant
2 to people falling into quadrants one, two, and three. In co-
3 location, there is basic collaboration onsite, medical care
4 and behavioral health care in the same location. There is a
5 referral process back and forth from the medical providers to
6 the behavioral health providers. There is increased and
7 formal communication between those two provider systems.
8 There is consultation between the two providers. There is
9 increasing quality in the behavioral health services. In
10 general, they're shared space, but separate services. There
11 is not really a guarantee of integration, but people are
12 talking back and forth to each other.

13 A step further, disease management is, in terms of the
14 degree of integration, close collaboration in a partly
15 integrated system. It's from a specific point of view of a
16 chronic care model, looking at specific diagnoses and looking
17 at the behavioral health needs in relation to those diagnoses,
18 usually looking at depression, diabetes, obesity, asthma. A
19 care manager monitors the patients. There is brief
20 psychotherapy.

21 Reverse co-location. Quadrants two and four are most
22 relevant for -- reverse co-location is the idea that primary
23 care is provided and is available through the behavioral
24 health agency. The behavioral health agency can continue to
25 be the specialty behavioral health care.

1 Where these models exist, there is certainly an increased
2 compliance when the medical and the behavioral health happens
3 on the same day. This is most relevant to people with high
4 behavioral health needs to have the medical care come to where
5 they're getting intensive behavioral health. So that's
6 quadrants two and four.

7 Unified primary care and behavioral health is relevant
8 for all quadrants. It's a model of close collaboration in a
9 fully integrated system. There are integrated medical
10 records. There's a single treatment plan. The providers are
11 in the same setting, and they're making referrals back and
12 forth.

13 Primary care takes this a step further. Behavioral
14 health is actually part of the primary care team. A person
15 coming into the setting might actually be coming in for
16 behavioral health as much as for primary care. Their brief
17 focused intervention is available to all. It's not specific
18 to any disease, specific disease entity.

19 And the collaborative system of care is the same thing,
20 but it's kind of more of a wraparound system. Community teams
21 might function in a collaborative system of care where you're
22 really wrapping a whole team of care around a person in the
23 primary care setting.

24 So some of the trends and impacts that are influencing
25 our system on screen 20. SAMHSA, Substance Abuse and Mental

1 Health Services Administration identified these strategic
2 initiatives that you see. These provide some focus to us and
3 really, for our purposes in behavioral health and for your
4 purposes as well, kind of lay out what some of the big focused
5 areas are for behavioral health.

6 Affordable Care Act is going to have a huge impact on our
7 system, particularly related to Medicaid eligibility. When
8 people at 133% of poverty are eligible for Medicaid by virtue
9 of their finances as opposed to by virtue of their disability
10 status, that means more people will be able to access services
11 and that means, of course, greater demand and increased need
12 for capacity in our system, which is already maxed out.
13 Medical homes are a part of that model at the federal level,
14 and again, I know something that you're all concerned about.

15 So some of the change that's coming our way, the
16 integrated regulations have been a huge process for us in the
17 Division and the inter-provider system. The integrated
18 regulations, basically, took two sets of regulations because
19 we have two systems, mental health and substance abuse, put
20 them together with the same rules, integrated our Medicaid
21 billing so that providers were able to bill under the same set
22 of rules. It really, in effect, created parity in our system
23 for mental health and substance abuse. In part of those
24 rules, we included accreditation. All of our provider
25 agencies will be required to be accredited by 2015, and

1 another piece that I mentioned is important in our Medicaid
2 rules was the integration of peers as reimburseable services.

3 I mentioned earlier, as the challenge that a lack of an
4 ability to identify acuties in our youth and in our adults is
5 a problem. We have a consultation underway working with
6 health care services and senior and disability services in
7 order to get some assistance for a mechanism to measure acuity
8 and apply rates to that. That should greatly enhance our
9 providers and our ability to adequately serve all levels of
10 care, including the highest levels of care.

11 We have another consultation that I didn't put on here --
12 I don't know if Jeff intends to mention it or not -- in
13 support with the Mental Health Trust Authority to get
14 consultation on our system as a whole. So between the
15 consultation on the reimbursement side with acuity and rate
16 and someone helping us look at how we organize our system
17 relative to grants and our rate structure, we should have a
18 better positioned system to take us into the future concerning
19 what's happening with health care reform and more people
20 having the ability to purchase behavioral health services.

21 As a last item, I put this encrypted closed-end PC
22 delivery. In our increments with the Legislature, a part of
23 the Governor's budget is a Request for Consultation on this
24 model, which is used throughout the country, but extensively
25 in Oklahoma, which takes telehealth a step further into

1 people's homes by a provider being able to use a personal
2 computer in the home, for example, with a behavioral health
3 aide connected on the other end through an encrypted system to
4 the clinician at the -- wherever that clinician might be.

5 As the final slide, this slide I put in, we had, I think,
6 a very valuable conversation with the Health Finance
7 Subcommittee around these questions of mission, and I lay it
8 out here because I think it's -- it kind of talks about where
9 we are in time and how we see our system as being -- as
10 changing and being different.

11 The DBH mission, "improved quality of life through the
12 right service to the right person at the right time" is really
13 very much what we've been talking about all along, you know,
14 where are people in our continuum of care receiving services,
15 is it the right place for them to receive those services, i.e.
16 through a physician, through a primary care clinic, through a
17 tribal health clinic, wherever, and are they getting the right
18 services at the right place, the right service, and then the
19 question of the right -- you know, the right cost, so the
20 acuity and the rate question coming into question there.

21 Our previous -- the discussion, I'll tell you, in the
22 House hearing was about whether this mission, while it might
23 be true, was too far-reaching because this is a mission that
24 goes beyond just behavioral health. This is a mission of the
25 entire department, which I think is a good point. It's,

1 nevertheless, not our mission, but it's certainly a mission
2 greater than just the Division of Behavioral Health.

3 The previous mission to manage an integrated and
4 comprehensive behavioral system based on sound policy, effect
5 practices and open partnerships is really about what we do in
6 the Division. It's about service management. It's not about
7 the outcome to the client or what the client gets. It's
8 really about what we do. So however we -- whatever we land on
9 for our mission, I think these two are kind of interesting
10 juxtaposition in terms of what we do to manage a system versus
11 what we get out of the system. Ultimately, our vision is
12 partners promoting healthy communities.

13 CHAIR HURLBURT: Thank you very much, Melissa. I think
14 we'll have some time for questions and maybe I'll start out
15 asking some, maybe, historical context of changes.

16 Going back in my earlier days in Alaska with the Indian
17 Health Service system, we had no inpatient behavioral health
18 capabilities, partly because budget was much more limited in
19 those days, but partly because the understanding was that the
20 inpatient behavioral health services were a state
21 responsibility for all citizens of the state. And the average
22 length of stay was much longer than the ten days that we're
23 reporting now for this year. So API was pretty much full all
24 the time, ever since I've been around, and it was an issue.

25 Finally, because of the difficulty in getting patients

1 into API who may be a danger to themselves or to others -- I
2 remember, probably back in the '70s when the first couple of
3 locked rooms were opened up at the old ANMC, because we
4 couldn't move the patients, there was no ability for the
5 Indian Health Service to receive funding from Medicaid or the
6 State or anything in those days. The same thing happened in
7 the private sector a little bit, but in a different way.
8 Because API was so full, the State tried to entice private
9 hospitals to have some inpatient behavioral health beds as a
10 new source of a revenue stream for them to be paid by the
11 State.

12 Now as I describe that, that's a little different than
13 your slide number four where what you were talking about was
14 the public behavioral health system as distinct from the
15 private system. In those days a few decades ago, the
16 perception was that the inpatient behavioral health system
17 kind of uniquely in Alaska was a state responsibility.
18 Obviously, it's gone beyond that for Alaska Native people. In
19 those days, relatively few had good jobs and insurance. Many,
20 many more folks now have gotten education, gotten into
21 professions and have that, but it is a change from what I saw
22 then.

23 The other thing that impacted on it is there was much
24 more of the warehousing probably in API than there is with a
25 pretty short average length of stay now. So how do we deal

1 with those smaller numbers of people with better medications
2 and so on, but who do need long-term institutional care?

3 MS. STONE: Well, you have a lot of different subjects in
4 that, in your comments, and I hope that -- I would think that
5 Jeff and Ron, when they come forward, can speak to this as
6 well, Jeff maybe particularly well, I would think, from the
7 point of view of the history of the Mental Health Trust and
8 the history of mental health services in the state.

9 I think that that question of the responsibility in our
10 system for uncompensated acute behavioral health care
11 continues to be a question, and it's a problem, obviously. In
12 health care, hospitals absorb unresourced care individually.
13 People with unresourced fiscal care don't go to someplace in
14 the state for congregate care. In other states, people don't
15 come to one place for uncompensated care, and it's spread out
16 regionally. And again, this is a weakness of our system.
17 It's spread out regionally with the health -- not always.

18 In systems that absorb this better, that uncompensated
19 care is spread out regionally for the whole continuum, whether
20 it's prevention, early intervention, or the more intensive
21 care. And when a regional entity has responsibility for that
22 whole continuum, they have more incentive and motivation to
23 provide the care at the earliest part because they're
24 responsible financially and in terms of service of the person
25 goes for inpatient care. So you know, I can't tell you why we

1 have evolved in the way we have over time, but it has
2 certainly caused us the problem that we're in.

3 COMMISSIONER STINSON: I'm going to go over just a few of
4 the things that I think are frustrations for practicing
5 physicians. I've taken care of patients in all four quadrants
6 of the care that you described, and in pain management,
7 behavioral health issues and pain management go hand-in-hand.
8 Sometimes people are fortunate enough to be high-functioning
9 and they have insurance and then we can get additional
10 psychologic or psychiatric or other care for them, but often
11 not.

12 At different times, we've had pain psychologists that we
13 employed, and Medicaid didn't reimburse pain psychologists.
14 So we absorbed the cost of that for as long as we could, and
15 as usual, often the people that need it the most are the ones
16 that get it the least. And then eventually, the psychologists
17 move on, and we had psychiatric nurse practitioners, and
18 eventually, they move, too -- usually issues of
19 reimbursement.

20 Other issues that come up, when you try to access
21 community mental health, two separate issues, one, it's weeks
22 long usually before people can access that system, and then if
23 they do, you never hear anything back from them. When some of
24 my patients have wound up in API, we now have a standard
25 question when we have some of our patients come back; have you

1 been admitted or received mental health treatment at other
2 places since we last saw you? Because the only time I've ever
3 been notified by API that one of the patients that I co-treat
4 with was there was when her medications were stolen by an
5 attendant at API, which it surprised me that she was even API.
6 We had no knowledge of that, and they just wanted to make sure
7 that I would rewrite her medications when she came out.

8 So now, we standardly (ph) ask our patients because we
9 get nothing from API. We get nothing from community mental
10 health. We don't know what their plans are and what care has
11 been given or what medications they were discharged with.
12 That makes it very difficult to coordinate care. We send
13 notes to everybody. You give me the name of a practitioner or
14 who they're seeing, they get a copy of everything we do, and
15 we make sure that we do that. It's not vice versa and that's
16 difficult. Those are some of the issues off the top of my
17 head.

18 MS. STONE: Absolutely. I mean, these are problems
19 across the country. Behavioral health and physical health
20 have been two separate systems in most systems, and that's
21 what this integration is all about, and that's what those
22 descriptions of those models is about in terms of how,
23 incrementally, that could look differently, but we're going to
24 have do something to make that happen.

25 Our system, our behavioral health system has, again, not

1 unlike in other states, historically operated in its own silo.
2 Yeah (affirmative), in its own silo. In its own silo. Its
3 own silo of reimbursement. Generally, our agencies aren't --
4 I think one of the problems is, generally, our agencies aren't
5 in a health model because, generally, they're not accepting --
6 it's changing, but -- and I don't know what percentage, but
7 many of our agencies aren't focused on private insurance. So
8 they don't see themselves as that component of care. Our
9 agencies have grown out of a community behavioral health
10 treatment model, not a medical model, and that's what we need
11 to fix. Those things that you're mentioning are things we
12 need to fix as we're looking at these different consultations,
13 as we're looking at your assistance, as we look at our
14 regulations and how to change the regulations to be able to
15 remove some of the barriers for the things that you're talking
16 about. Absolutely. Those are huge problems.

17 COMMISSIONER ERICKSON: Melissa, could I just ask a real
18 quick follow-up question to that? Are some of the challenges
19 with providing information to other clinicians related in any
20 way to state or other laws that impact the privacy of
21 behavioral health records any differently? I see Jeff shaking
22 his head no.

23 MS. STONE: Well, it might be true for substance abuse
24 services, and I think Anna can probably talk to that when she
25 comes up. But with release of information, there is no reason

1 for information not to be shared, and there's no reason for
2 integration not to occur between treatment plans. So there
3 are barriers that are perceived that aren't necessarily real.

4 CHAIR HURLBURT: Larry, a follow-up and then Keith?

5 COMMISSIONER STINSON: We often have to have our patients
6 sign the release of information waivers, after every time we
7 see them, to try to get whatever has been going on in
8 community mental health, and we send that in, and even with
9 that, it's rare that we get anything back, and the problem is,
10 particularly with some of the psychotropic medications, they
11 have a lot of interactions, and I really need to know what
12 these people are on, and if we're lucky, they bring their
13 medications in with them, and we ask them to do that, but as
14 you know in this particular population, they often don't. And
15 so we're trying to guess how to help them maximize function,
16 reduce (indiscernible - voice lowered), and guessing what
17 other treatment they're on, that's difficult.

18 MS. STONE: Well, I absolutely agree, and part of the
19 problem, of course, is that the behavioral health provider
20 doesn't even necessarily know the patient has gone over there.
21 They aren't asking, and if they don't ask, the patient is
22 probably not going to tell them, and even if they do ask,
23 there is no guarantee that there is going to be coordination
24 or the thought of the need for that coordination. So yeah
25 (affirmative); we have a long way to go with that.

1 COMMISSIONER CAMPBELL: Two questions, Melissa. The
2 waive of electronic medical records seems to be close to
3 cresting here, at least with some of our systems in the state.
4 Have your clientele been working towards an integration? For
5 instance, in my community, I don't know whether the behavioral
6 health is there, but our electronic medical record is up and
7 going really well. And it strikes me, even though one of, I
8 think, the physicians sits on the local board, I'm not sure if
9 there is any attempt at integration, which would help -- you
10 know, with electronic prescribing and things like that and
11 that would overcome some of Larry's angst. But I just
12 wondered if there is any sort of integrated planning with e-
13 Health or telehealth or whatever you want to call it from your
14 Division to help draw this circle closed? And it's a major
15 problem, for sure. Always has been in my tenure.

16 MS. STONE: The AK AIMS, Alaska Automated Information
17 Management System, as I mentioned previously, functions both
18 as an electronic health record and as a management information
19 system. So agencies can choose to adopt it as an EHR if they
20 desire. SeaView uses AK AIMS as an electronic health record.

21 In terms of your question about the greater interface,
22 it's a good question. I was just talking yesterday with Jeff
23 Jessee and Katie Baldwin-Johnson who are going to help us
24 facilitate a steering group in the Division with providers'
25 division and department IT to talk not just about AK AIMS and

1 its functionality and effectiveness in the system, but the
2 bigger issues of our behavioral health systems integration
3 throughout the statewide network.

4 COMMISSIONER CAMPBELL: Second question. The question
5 was asked -- I think warehousing the long-term patient. Is
6 this generally being done now in our nursing home situations?
7 Or I don't see it happening, of course, at API as an acute
8 facility, but where are these people ending up?

9 MS. STONE: Right now in the state of Alaska, we're
10 really fortunate compared to some other states that have
11 multiple state hospital facilities, some of which, you know, a
12 whole hospital might be devoted just to long-term care. The
13 Olmstead rule was a ruling that was trying to prevent
14 warehousing of people. (Indiscernible - voice lowered), as a
15 federal ruling, also looked at how -- required states to look
16 at whether a person has a mental illness or a developmental
17 disability who were going into long-term care. So in our
18 state, we have a minimal problem compared to other states, but
19 there are people with co-occurring disorders in long-term
20 care, appropriately so if they have appropriate treatment. We
21 have more people now -- I believe there are now 20 adults with
22 co-occurring disabilities, cognitive disabilities and mental
23 health disabilities out of state.

24 We moved -- years ago when we deinstitutionalized people
25 from Harborview to a community-based disability system. So

1 again unlike other states that are still working to
2 deinstitutionalize people with developmental disabilities, we
3 are, I would say, a leader in the country in that regard. As
4 people age and as people with mental health disabilities age,
5 the problems are becoming, you know, more intense relative to
6 the need for those people to have care for both physical and
7 behavioral health needs. There are a number of people right
8 now with chronic mental illness in assisted living homes in
9 our state. I think, in some circumstances, those folks are
10 warehoused. In many circumstances -- and Jerry Jenkins can
11 probably speak to this aspect -- particularly in, of course,
12 our high urban area, there is good coordination between the
13 behavioral health agency and the people in assisted livings,
14 but there is a lot of variety in the quality of service to a
15 person who is an assisted living home.

16 CHAIR HURLBURT: Maybe we'll have one more question or
17 comment from Emily. And then Jeff Jessee, if we could plan to
18 go ahead for your presentation? Then we'll take the break
19 after that. Emily?

20 COMMISSIONER ENNIS: Thank you, Ward. I have a question
21 related to your comment about the medical model, and I wasn't
22 quite sure exactly what you said, Melissa, but the need -- and
23 it may be necessary, I guess, to promote or use the medical
24 model to support integrated care, and it made me think about
25 what's happening to services for people with developmental

1 disabilities and our seniors with disabling conditions,
2 particularly Alzheimer's and dementia.

3 You mentioned that our agencies are now community-based.
4 You know, we've really moved from institutional care to
5 community services, and in doing so, we really wanted to shy
6 away, 20 to 30 years ago, from the medical model. We just
7 wanted services to look like everyday living in communities
8 and that works well to a degree, but we have particularly
9 noticed the consequences for people with developmental
10 disabilities, and more recently, for seniors.

11 If you use the word silo or we're using the word
12 segregated, they don't have access to be integrated both
13 physical care, medical care, or the behavioral health. They
14 are sort of sitting aside. And you know, particularly with
15 people with developmental disabilities, their opportunity or
16 chance for having a mental health issue is greater than even
17 the percentage in our regular population and that has become a
18 greater and greater issue for us. And also for our seniors in
19 assisted living homes when, you know, primarily they went to
20 nursing homes, they had the physical and medical care readily
21 available and perhaps behavioral, but it's making me think
22 that this whole idea of community-based services that are
23 separated from behavioral health and physical care needs to be
24 looked at. So I just wondered if you could take a moment to
25 address your concept of this medical model being applied in a

1 greater way.

2 MS. STONE: Well, I think, again, that question, Emily,
3 goes right back to the integrated circle. What slide is that,
4 17? Sorry. I got myself all mixed up; 18, I think. There
5 are different models for doing that that I think we need to be
6 conscious about as we move this system.

7 In a collaborative integrated -- what are the words --
8 fully -- close collaboration in a fully integrated system, the
9 behavioral health specialist still functions within that
10 primary care setting, still bringing issues of housing and
11 employment into the conversation. So part of the problem, I
12 think, here is, if you go back and look at some of our
13 problems, for example, being housing and employment, what does
14 that have do with health? I mean, how is a primary care
15 physician going to work on housing and employment?

16 So somehow, there needs to continue to be, you know, the
17 integration of those aspects of behavioral health care, even
18 as we, you know, break down the silos between our systems.
19 And again, they're very -- there are a variety of ways of
20 doing that, bringing the behavioral health specialists in or
21 out of that system, the degree to which, you know, the
22 psychologist you mentioned, the kind that was turning over and
23 coming and going, the degree to which you actually have that
24 person integrated in practice, the degree to which that person
25 is actually working with the physician as opposed to the

1 physician referring to and not really coordinating the care,
2 the degree to which the person with a serious mental illness
3 still continues to receive that service in the specialty
4 mental health clinic, not in the primary care clinic, but one
5 of those four quadrants is, you know, for people to continue
6 to receive their care in the specialty mental health, but then
7 how do you integrate it within this capacity?

8 So you know, I'm a Social Worker. So I'm all about -- I
9 guess not so, but I am all about context. I believe in
10 context. I believe in the context of environment, family,
11 community impacting our behavioral health issues. I very much
12 believe in that. I don't believe that all of our behavioral
13 health issues are a result of chemical in the same way a
14 medical system does. So how do you integrate that idea of
15 context with a medical model? I think carefully, with a lot
16 of thought, and learning what there is to be learned. And I
17 think the positive thing is there is a lot of practice out
18 there to learn from in terms of the models to bring to bear on
19 this.

20 CHAIR HURLBURT: I think Val had one, too. And then
21 we'll go on to Jeff.

22 COMMISSIONER DAVIDSON: Thanks. So first of all, this is
23 an excellent presentation. I mean really -- very well
24 organized, really great at distinguishing between the kinds of
25 levels of care. I mean, it was really excellent, probably the

1 best presentation we've heard.

2 Now let's pretend it's Christmastime and you're writing a
3 letter to Santa. If you had one wish that you think would
4 make the biggest impact in Alaska, what would that be? Or a
5 Fairy Godmother? Either one.

6 MS. STONE: I think that it would be -- I think it would
7 be having a system where a person's needs are able to be
8 assessed, recognized, and managed is a bad word -- by someone
9 who is identified to do that whole thing because one of the
10 problems now is people go to all different places. They have
11 to figure out where all those different places are and then
12 some of those places don't want them because they don't have
13 money or because they look scary, and you know -- so that -- I
14 mean, that -- I'm not sure that that answers your question
15 because it's a pretty broad.....

16 COMMISSIONER DAVIDSON: I think it does, and I think
17 you're right, that we need to stop asking individuals to be
18 medical athletes where they have to run from one place to
19 another to get what they need and one payer to another to get
20 what they need. Thank you.

21 CHAIR HURLBURT: Thank you very much, Melissa. Jeff
22 Jessee is the CEO of the Alaska Mental Health Trust Authority,
23 and I think will have some very interesting stories to tell us
24 about some things that go back even prior to statehood here in
25 Alaska. So Jeff, thank you for coming. Look forward to

1 hearing it.

2 MR. JESSEE: Thank you, Dr. Hurlburt, members of
3 Commission. It's really tempting to jump right in to all
4 these sexy issues you guys have brought up, but I've been
5 asked to provide a little background on the Mental Health
6 Trust because it is a pretty unique entity around the country.

7 Back in territorial days, we had what really can only be
8 described as a barbaric mental health system. If you had any
9 mental disability, a developmental disability, chronic
10 alcoholism, Alzheimer's, mental health, traumatic brain
11 injury, and you came to the attention of the federal officials
12 because you weren't making it with what supports we had -- and
13 remember in territorial days, we didn't have much. Maybe some
14 churches. A lot of people didn't even have family. If you
15 came to the attention of the territorial officials, they
16 convicted you of a territorial crime of being an insane person
17 at-large. You didn't have to have done anything wrong, just
18 have had a mental disability and come to the attention of the
19 federal officials. And a federal marshal would fly you down
20 to Morningside Hospital in Oregon where you would serve a
21 sentence, and many hundreds of Alaskans were sent to
22 Morningside. Some returned; some didn't. Many from rural
23 Alaska ended up in Morningside.

24 Well, when statehood was starting to be discussed in the
25 '50s, this mental health issue became a real hang up, and the

1 primary reason was that the territorial officials were
2 federally-funded and the Feds were paying for Morningside.
3 When we became a state, we would have to, at least, pay for
4 Morningside, and of course, we weren't that crazy about this
5 so-called mental health system to start with. And so it
6 actually hung up statehood while they grappled with this
7 mental health issue.

8 Eventually, they passed the Mental Health Enabling Act,
9 and it had three parts. One was some cash, which was to build
10 our own psychiatric hospital, which was the first wing of API,
11 and it also bought a motel in Valdez for people with
12 developmental disabilities. Now why would you buy a motel in
13 Valdez for people with developmental disabilities? Well,
14 Governor Egan was from Valdez, and Harborview was the first
15 pork barrel project in the new state of Alaska.

16 The second part of the three-legged stool was some
17 operating money that would go down a little bit every year
18 over eight years to pay for the hospitals and to wean us off
19 of the federal gold.

20 And the third part was to take a page out of the School
21 Lands Trust and University Land Trust and create a Mental
22 Health Lands Trust. So the State could select land, generate
23 income from it to pay for this mental health system over the
24 long-term.

25 A couple of the interesting little side stories.

1 Originally, it was to be a 500,000 acre trust, and in a
2 committee in the House of Representatives, a representative
3 from Nebraska took great umbrage that the federal government
4 was going to give away a half-a-million acres of federal land
5 to the new state of Alaska for mental health, and he said,
6 well, hell, if you're going to do that, make it a million, and
7 they did. And he thought it would kill the bill. Well, it
8 didn't kill the bill.

9 Another interesting little story is, remember, this is
10 the late '50s, and right when the act was on the verge of
11 being voted on in Congress, the interesting group of
12 Scientology got a hold of this in San Diego and convinced the
13 San Diego paper to run an article about this Enabling Act with
14 a banner headline that said "Siberia USA," and the tagline was
15 that the federal government was about to build a gulag in the
16 frozen north of Alaska to send the Communists and other
17 dissidents in America and that held up the Act for another
18 session. But eventually, the Act did pass.

19 We became a state, and the Mental Health Trust Lands were
20 actually the first lands selected by the State from the
21 federal government, and they did a heck of a job, Homer Spit,
22 Kenai river frontage, Beluga coalfields, big trees around
23 Haines. In southeast Alaska, the Mental Health Lands looked
24 like little donuts, and the idea was, as Alaska grew, these
25 lands would be more valuable. They would make more money to

1 fund the growing mental health program. Now we didn't know
2 about Prudhoe Bay or we'd have a heck of a mental health
3 program, but we did get about the most valuable million acres
4 that the state selectors could find at the time.

5 Well, statehood passed and the State got 100 million
6 acres of general state land, and they just rolled it all
7 together. And over the next 25 years, about half of that
8 million acres was taken out of the Trust. We gave the big
9 trees to the bald eagles and created the Chilkat Bald Eagle
10 Preserve. We gave thousands of parcels to individual Alaskans
11 through land lotteries, homesteading, agricultural projects.
12 We gave Usibelli less than market value coal leases in order
13 to stimulate economic activity. Tons of land went out of
14 state hands.

15 Now this whole thing started to fall apart in the '70s
16 when the local governments were able to select state lands for
17 local uses, just like the State had selected federal lands.

18 Now even though Mental Health Lands were only 1% of the
19 total land portfolio, it was 27% of the land selected by local
20 governments. Location, location, location. And when their
21 lawyers went to record their record of title, lo and behold,
22 this was Trust land for which their clients were paying
23 nothing and so they had a cloud on their title, and there's
24 nothing worse than having a cloud on your title.

25 So what do you? Well, you go to the Legislature in 1979,

1 and you say hey, we want to get clear title to this million
2 acres. Fix this, and the Legislature said sure. That's what
3 we do; we fix things. They passed a law that said all the
4 Mental Health Trust Lands were now general state lands. Now
5 of course, they had lawyers, and their lawyers told them that
6 you can't just do that. You're the trustees. You have to pay
7 for this land. And so they set up the Mental Health Trust
8 Income Account, and they promised that they would put 1.5% of
9 the income from all state lands into this account to pay for
10 mental health services. Well, they forgot to make any
11 deposits, and it only took three years for the advocates to
12 realize there was something wrong with this. And they went to
13 Fairbanks, and they found a lawyer wearing a cowboy hat and
14 cowboy boots. He wanted to make a name for himself, and Steve
15 Cooper filed the original Mental Health Lands Trust suit.

16 Now Steve has the best history of anyone with the Trust.
17 In 1979, he voted to steal the land. In 1982, he filed the
18 lawsuit to get it back. And then later as governor, he would
19 preside over two failed settlement attempts. It doesn't get
20 any better than that.

21 So here we are, off on this litigation, which took over
22 another decade, and eventually, it got resolved, and the way
23 it got resolved was well, first, what are going to do with the
24 land? We've got to get back to a million acres. And so we
25 pulled all the stakeholders, the miners, the timber guys, the

1 environmentalists, the local governments, and we got them all
2 in the room and we say, we have to agree on a half-a-million
3 acres of replacement land to make up for this land that's been
4 taken out. And it worked. The environmentalists said things
5 like, oh my God, if you're going to get timber, don't get
6 timber in pristine forests. We want to protect those. Get
7 timber where there is already logging. And so we got timber
8 in Thorne Bay, Icy Cape. Good for us; they have log transfer
9 facilities. They have roads. They have infrastructure.

10 So we got our million acres back. Well, of course, what
11 we got as replacement land wasn't worth what the original
12 million acres was worth. So we got a \$200 million cash
13 endowment.

14 Now the biggest thing we got out of the settlement was --
15 generally, it's probably not a good idea to have your
16 Legislature as your trustee for a select set of resources
17 dedicated to a special group of beneficiaries. I mean, they
18 have to keep their focus on the big public interest.

19 And so we pushed for an independent Board of Trustees
20 that could make sure these assets were managed properly and --
21 this was the key thing -- spend the money without a
22 legislative appropriation.

23 Now the Permanent Fund Corporation manages the cash. We
24 get our share of their profit or loss. We pay our share of
25 their expenses. The land is managed by a separate unit within

1 the Department of Natural Resources called the Trust Land
2 Office. We pay their costs, and they have a set of
3 regulations that focus, of course, on generating income from
4 the land, and they manage the land. The trustees then take a
5 pay out, like a private foundation, from the principle at the
6 Permanent Fund. Currently, it's 4.25%. They add the income
7 from the land and that's what they have to spend every year to
8 advance the mental health system of the state of Alaska.

9 Well, so how do you do that? If you have, say, \$25
10 million a year and you're trying to push around a mental
11 health program that's about \$160 million in General Funds --
12 and if you add Medicaid, it's going way over \$300 million --
13 well, you can't just meet unmet need because you'd be a drop
14 in the bucket, first of all, and second of all, maybe the
15 Legislature would just reduce their contribution in proportion
16 to how much you put in. And so the trustees, early on,
17 decided that we had to become the venture capital for the
18 State's mental health program. We had to leverage our
19 resources into improving the State's mental health program.

20 So let me give you just a couple of examples of how
21 that's done. We mentioned Harborview. Well, by the time the
22 Trust came along, Harborview had been whittled down to about
23 80-some residents and there was a moratorium on admissions.
24 The problem for the State was everyone knew we needed to close
25 it, but to close an institution, you have to double fund. If

1 you want to do it right, you have to continue to fund the
2 institution while you develop the community alternatives, and
3 the Legislature was unwilling to double fund for two or three
4 years in order to get this accomplished. So the Trust agreed
5 that we would hold the State financially harmless.

6 Now everyone thought we would pay for the cool community
7 programs, group homes, family supports, foster homes. Well,
8 no. If we did that, then chances are, when the State closed
9 the institution, they would keep the savings, and we would end
10 up long-term funding a poor operating budget. And so the
11 Trust agreed to spend over \$3 million a year to run Harborview
12 on the condition that the Legislature would reinvest those
13 dollars into community-based services. Now remember, if the
14 State reneged, my trustees have the ability to cut off the
15 funding, and it worked.

16 In three years, we closed Harborview, and at the time,
17 became the second state without an institution for the
18 developmentally disabled, and we did it the right way by
19 building community services.

20 I'll give you one other quick example. Corrections. You
21 talked about where warehousing is going on. Well, a lot of
22 warehousing for the mentally ill is going on in the Department
23 of Corrections where 42% of all inmates are Trust
24 beneficiaries. But when we first started looking at this, we
25 found that women in Corrections with chronic mental illnesses

1 were in deplorable conditions. They were in 23-hour
2 segregation cells. Many of them were water intoxicators, if
3 you're familiar with that. If you drink too much water, you
4 flush out your electrolytes. First, you get high and then you
5 can die. Well, the Corrections' solution to that, at the
6 time, was just to turn off the water in their cells.

7 So we worked on this for about a year-and-a-half, and
8 finally, we were ready and we went to the Co-Chair of House
9 Finance at the time, Eldon Mulder, and we had Eldon go and
10 look at what was happening with these people and met with him,
11 and we said, what did you think, Eldon? And Eldon said, oh
12 gosh, this is terrible. I mean, I had no idea we had this
13 going on, but you know, I'm the Co-Chair of House Finance, and
14 we're trying to cut \$250 million out of the budget. And the
15 Governor is Tony Knowles, a notorious liberal spendthrift, and
16 we can't just be giving him money to try to throw it at a
17 problem. We don't even know how big this problem is.

18 Well, the first thing my Chair did was reach in his
19 briefcase, and he said, well, the first thing we did is we
20 funded a study of how many of these women there were and what
21 their conditions are and what their needs are. Handed it to
22 the Representative. He looked through it. He said, well,
23 this is really good, but it's Tony Knowles. We don't even
24 have a plan. And then Nelson reached in his briefcase, and he
25 said, well, the next thing we did is we funded a planner,

1 (indiscernible - voice lowered) Rabinowitz, and she worked
2 with the Department for a year to come up with a plan to serve
3 these people, handed it to the Representative. Eldon looks
4 through it. He gets to the end. He goes, oh my God, \$600,000
5 a year, \$600,000. You don't understand; I have a cap on my
6 budget, and I'm the Co-Chair of Finance. If I break my cap,
7 everyone breaks their cap, and the world, as we know it, comes
8 to an end. Well, he didn't quite say that, but -- and so my
9 Chair looked at him, and he said, here's the deal. We will
10 pay the entire cost the first year. We'll pay two-thirds of
11 the costs the next year and one-third of the costs the next
12 year. It's what I call the "no money down, three easy
13 payments;" order before midnight tonight. And Eldon had a
14 napkin on his desk, and he wrote that. He said, wait a
15 minute. Over three years, that's \$1.8 million, and the Trust
16 is going to pay 1.2 and I don't have to put any money in this
17 year, and Nelson looked at him and said, well, that's why you
18 have the Mental Health Trust, and Eldon said, sold; I had no
19 idea this would work.

20 Now as we walked out, what we realized was, well, we had
21 now helped develop a whole system of care in Corrections that
22 would live far beyond this transition period.

23 So as you go through your deliberations around behavioral
24 health, you have an asset in the Trust that almost -- well, no
25 other state has. As you develop your strategies, we're able

1 to pick those up and bring the leverage of our funding to bear
2 to help implement those types of strategies. So I hope that,
3 as you look at this -- you know, we really want to be partners
4 in this, and it's not always easy going to the Legislature.

5 A couple years ago, I was called to the Speaker's office
6 and Speaker Chenault sat me down and said, you know, we've got
7 a problem with the Mental Health Trust, and I go, what is it?
8 Well, you guys get all these programs started with your
9 funding and they work and then you come and expect us to pick
10 up the funding for them. You know, you're developing too many
11 good programs for us to fund. Stop that. You need to put
12 more money into the core operating budget and take the
13 pressure off of us to fund these new programs.

14 Well, that's a problem for us because the only way you
15 get progress in a system is to try some things, and we're very
16 data-driven, very outcome-driven, and we're one of the few
17 agencies that's actually gone to the Legislature and said stop
18 funding this; it doesn't work. And so that's always a
19 challenge in working with the Legislature.

20 I'll give you one more quick example and then I'll stop.
21 When we originally got into the therapeutic court arena, there
22 was a judge in Anchorage that had started, on a shoestring, a
23 mental health program. And then we started helping to provide
24 funding for that to get it up-to-speed and to evaluate its
25 outcomes, and it was very effective, dramatic decreases in re-

1 arrests and in API stays. And Lyda Green, a Senator from the
2 Valley, went to that mental health court and went, wow, this
3 is awesome; I need one of these in my district. How much do I
4 have to put in the budget in order to develop this in Palmer?
5 And I said, well, you don't want to do that, Senator. You
6 don't want to do that because developing a mental health court
7 is really difficult. You need to get a judge, a prosecutor, a
8 defense attorney, the probation parole, and the community
9 providers all have to be working together for a mental health
10 court to be successful. Somebody has to hold the money and
11 bribe and convince and mediate and negotiate to get all these
12 players on the same page.

13 So here's what we'll do. If you put \$250,000 into the
14 Anchorage Mental Health Court so that we can free up our
15 dollars, we will take \$350,000. I will send my Program
16 Officer out to the Valley, and we will develop a mental health
17 court for you in the Valley. And Senator Green leaned back
18 and said, Jeff, I know you; you're going to be back here in
19 three years expecting me to put General Funds into this
20 program, and I said, you're right, Senator, but here's the
21 difference. If you put money in that court today, you are
22 betting on the (indiscernible - voice lowered) that it will
23 work. If we go out and start this court, when I come back
24 here and ask you to put General Funds in, you will have the
25 outcome data in front of you and then you get to decide if you

1 think that's worth the investment. If it's not, don't fund
2 it.

3 And so as we look at working with the Department, whether
4 it's the \$500,000 we gave them to do a pilot on medical home
5 or the \$100,000 we're supplying to do a review of the
6 behavioral health system, our goal is to be that flexible
7 venture capital to improve our behavioral health, and we
8 believe, our health care system and improve the lives of our
9 beneficiaries.

10 CHAIR HURLBURT: Thank you very much, Jeff. Are there
11 any questions or comments before we take our break? I found
12 that fascinating. I don't think I've heard of Lyda Green and
13 Steve Cooper woven into the same narrative before; that was
14 good. Thank you, Jeff.

15 9:39:27

16 (Off record)

17 (On record)

18 9:57:04

19 CHAIR HURLBURT: I wonder if we could get back together
20 again, please? We still have five more folks we want to hear
21 from and have some time for discussion. Kate, why don't you
22 come up to the table there? So we'll have each of the next
23 presenters just come up to the table, as your turns comes, and
24 just be a little bit uncomfortably close to the mic.
25 Yesterday, we had some significant challenges with folks on

1 the phone hearing and that seems to help, if you can be close
2 to the mic, and we may be having some problems today from what
3 the operator just said a little bit ago.

4 The next presentation that we have is by Kate Burkhardt,
5 who is the Executive Director of the Alaska Mental Health
6 Board and Advisory Board on Alcoholism and Drug Abuse and the
7 Statewide Suicide Prevention Program. So we'll be hearing
8 from Kate, particularly on some of those aspects of the
9 overall behavioral health problem. Thank you for coming,
10 Kate.

11 MS. BURKHART: Thank you, Dr. Hurlburt, members of the
12 Commission. I appreciate the opportunity to speak with you
13 this morning. The Alaska Mental Health Board and the Advisory
14 Board on Alcoholism and Drug Abuse have watched the Commission
15 grapple with a lot of tough issues, and we're grateful for the
16 work that you're doing. If you're not familiar with my
17 organizations, I'd like to give you just a quick refresher.

18 I'd also like to recognize that I have board members in
19 the room. Anna Sappah from the Association of Addiction
20 Professionals is a member of the Advisory Board on Alcoholism
21 and Drug Abuse. She sits on one of our consumer seats. And
22 Brenda Moore is a member of the Alaska Mental Health Board and
23 is with Christian Health here in Anchorage. And both Anna and
24 Brenda serve on the Statewide Suicide Prevention Council.
25 Melissa Stone is an ex officio member, and while she is now

1 gone, Kimberly Poppe-Smart, the Deputy Commissioner of the
2 Department of Health and Social Services, is an ex officio
3 member as well. And so that's an example of how our boards,
4 just by virtue of their membership, provide the contacts for
5 increased collaboration and coordination of services.

6 Our boards were created at different times by statute,
7 and they are considered planning councils, entities devoted to
8 developing and monitoring the implementation of statewide
9 systems of care related to mental health and substance abuse
10 as well as Advisory Boards, sources of advice and counsel,
11 like we've provided in written comment and like I'll provide
12 today, an advocacy as well.

13 Before I continue with my prepared comments, I did want
14 to address a couple of things that came up during Melissa's
15 presentation. She provided a great overview of the issues
16 that face the behavioral health system and how it's much
17 broader than purely treatment, that it includes things like
18 housing and employment. I would add, in addition to the issue
19 of co-occurring, which typically refer to co-occurring mental
20 health and substance use disorders or cognitive impairments,
21 co-morbid conditions and the high incidence of physical
22 conditions, like diabetes, obesity, heart disease, asthma, and
23 other conditions, because that is an issue that Commissioner
24 Stinson brought up that need to better coordinate in those
25 areas.

1 I would also add that, in addition to trauma as we
2 understand it relates to average childhood experiences and
3 domestic violence, from our perspective, trauma must also
4 include historic, learned, and secondary trauma, and there
5 have been efforts within the behavioral health system to
6 ensure that, when we're screening for trauma and addressing
7 trauma, we take into account that many Alaskans may experience
8 historic or secondary trauma.

9 In reference to Commissioner Stinson's comments about
10 your experience in your community, I'd like to provide what's
11 possible. In Fairbanks as part of the community's efforts to
12 improve how behavioral health services are delivered there, we
13 are seeing the coordination of care between the community
14 health center -- you heard from their Director yesterday
15 during public comment, Cheryl Kilgore -- and the community
16 mental health -- behavioral health center, Fairbanks Community
17 Behavioral Health as well as Fairbanks Memorial. They have
18 even pursued the idea of universal intake applications and
19 ways to capitalize on Interior Community Health's
20 participation in the Alaska e-Health Network, so that they can
21 better share information and coordinate care for their common
22 clients. And so while we recognize that many communities
23 don't have that experience and they have Commissioner
24 Stinson's experience, we can show, in Alaska, that it is
25 possible for behavioral health provider, primary care

1 providers, and hospitals to collaborate in a way that improves
2 health outcomes for their common clients.

3 And in reference to Commissioner Campbell's comments
4 about drawing the electronic health records' circle closed,
5 Fairbanks is an example. I just mentioned that. The boards
6 have members on staff involved with the Alaska e-Health
7 Network through their workgroups to ensure that behavioral
8 health is part of their conversations. I sit on the Legal
9 Committee addressing legal issues and the implication of the
10 enhanced protections for substance abuse treatment and how
11 that works with an e-Health Network and sharing information.

12 So there are efforts to improve the way that both the
13 states and individual providers' EHRs work together to serve
14 these folks and so I just kind of wanted to follow-up on those
15 things before I launched into my spiel, and I'm going to try
16 to keep us right on time.

17 So you'll hear from the panelists about different
18 examples of how there are projects and practices underway in
19 Alaska that are addressing those specific areas that you, as a
20 Commission, identified for improvement in your previous annual
21 reports. Those include integration of health care -- Melissa
22 spoke at length about that -- coordination of primary and
23 specialty care and screening for behavioral health conditions.

24 What I'd like to focus on is an aspect of the behavioral
25 health system that is specifically addressing all of those

1 issues that Melissa enumerated that are facing the behavioral
2 health system, access to treatment, employment, housing, co-
3 occurring disorders, my addition of co-morbidity, domestic
4 violence, adverse childhood experiences, and other forms of
5 trauma, and that is the provision of peer support services.

6 So peer support services are exactly what they sound
7 like. They are support services designed and delivered by
8 people who have achieved recovery from a mental health or
9 substance use disorder and who have been able to maintain that
10 recovery. Peer support services provide a very powerful
11 message and example of how treatment does work when you have
12 access to it and how recovery is possible. It also provides
13 people the opportunity to see the different facets of recovery
14 because recovery doesn't look the same for everybody, and so
15 by having these peer-designed and peer-delivered services, we
16 give our constituency the opportunity to see how they can
17 achieve wellness.

18 The peer support services extend the reach of treatment
19 beyond the clinical setting into the everyday environment, and
20 Commissioner Ennis, you talked about moving services to that
21 everyday living and that's one of the benefits of peer support
22 services is they can be offered in concert with clinical
23 services or as a standalone. They're more effective when they
24 are coordinated, but they don't have to be.

25 It also helps people with serious behavioral health

1 disorders not only achieve wellness but then maintain it. You
2 may be familiar with the fact that many people with serious
3 mental illness or a serious substance use disorder get better
4 and then they get worse, and then they get better and then
5 they get worse. And so peer support services actually help
6 maintain that better, longer.

7 There is research that shows that recovery is facilitated
8 by social supports, like peer support services. For those of
9 you that are interested in learning more about the research-
10 base and the evidence-base for peer support services, I have a
11 bibliography I can share with you. There are some great
12 articles in journals, like the *Addiction Journal* and
13 *Psychological Rehabilitation* journals and the journal of the
14 American Medical Association. So if you want to delve into
15 that, please let me know, and I can give you that
16 bibliography.

17 You had the opportunity to hear from two of Alaska's peer
18 support providers yesterday, Barry Creighton from Ionia in
19 Kasilof and Polaris House; Dorothy Green called from Juneau.
20 And I'm hoping, from their comment, you realized just how
21 different the two organizations and what they are and how, as
22 unique and different as they are, each helps their members and
23 participants achieve wellness and that wellness is tailored to
24 the strengths and the needs of their particular service
25 population.

1 One of the things I'd like to really emphasize is that
2 peer support is a service. It's not merely let's all get
3 together and we'll talk for an hour and we'll have cookies and
4 then we're done. This is a service provided by trained people
5 who have achieved recovery and have gone and secured peer
6 support specialist training. So they are part of our
7 behavioral health workforce and that's something that, when
8 you're first learning about peer support, you don't always
9 recognize that these are trained para-professionals, and they
10 are part of our workforce, and they help address some of our
11 workforce shortages by extending the reach of our clinical
12 services by supporting people with serious behavioral health
13 disorders in the community.

14 We talk about peer support today, and I've been in this
15 position just a little over four years. And so in my mind,
16 peer support is just part of my world. It's something we do.
17 But ten years ago, that was not true. In fact, even just five
18 years ago, peer support services were funded mostly by the
19 Beneficiary Projects Initiative at the Alaska Mental Health
20 Trust Authority and the small pot of money that the State
21 receives from the federal mental health block grant, which is
22 about \$750,000, and in the grand scheme of things, that sounds
23 like a lot, but in the grand scheme of things, it's a small
24 pot.

25 Over the last five years, through the work we have done

1 with our self-advocates, our consumer groups, the Alaska
2 Mental Health Trust Authority, the Division of Behavioral
3 Health, the Legislature, and others, we have been able to
4 start a system transformation around peer support to get to
5 the point where we are today.

6 The integrated regulations that Melissa spoke about in
7 her presentation expressly include peer support, and the peer
8 support community commented in every iteration of those
9 regulations to ensure that the regulations, as they applied to
10 them, made sense and that they were not the red-headed
11 stepchild of behavioral health, but an integrated part of how
12 we provide services. And having access to that Medicaid
13 reimbursement means that community behavioral health providers
14 now have an incentive to bring that in as part of their cohort
15 of services because people want to get paid for the services
16 they do. And so it will expand access that way.

17 There has also been an increase in General Fund support
18 for peer support services through the Legislature. We have
19 seen, incrementally over the last five years, continued
20 support as we have been able to prove that these services
21 work, and at this point, there are a variety of peer support
22 services available in our urban centers, the Anchorage, MatSu
23 area, Fairbanks, and Juneau, as well as a few of our rural
24 communities.

25 In FY12, the Legislature appropriated additional funding

1 specific to expanding peer support to rural communities and
2 that is being done in coordination with the Alaska Peer
3 Support Consortium, which is the umbrella organization for all
4 of our peer support providers, and they are the organization
5 that has helped ensure that we have standard competencies for
6 our peer support specialists, so we have a standard of care
7 across the state for people who receive peer support services.

8 And so that's an example of how working all of us
9 together -- everybody that you will hear from in the next
10 little bit, we all, I feel like, do everything in each other's
11 pockets sometimes, but it's all a collaborative effort, and it
12 wouldn't have been possible if we all hadn't agreed this is
13 important.

14 And so going back to the transformative power of starting
15 small and proving it works -- Jeff talked at-length about that
16 -- and then moving it forward on a systems level, I want to
17 emphasize that the Boards' role in that has, by and large,
18 been ensuring the consumer role in all of those conversations.
19 That's a value that the Commission has, improving the
20 consumers' role in their health care and that's something that
21 we bring not just to the peer support conversation, but to
22 every conversation. My Boards' membership is over 50%
23 consumers, and they have had the commitment, both as boards,
24 but also in their statute, to ensure that they always
25 represent the voice of consumers and their constituencies.

1 And so Jeff talked about the opportunities to partner
2 with the Alaska Mental Health Trust Authority and how they use
3 their funding to promote change, and I would encourage you to
4 partner with my organizations because we have the ability to
5 bring that consumer voice forward in a way that is
6 constructive and collaborative and really does have the
7 ability to transform systems. And so I see my time is just
8 about up. So with that, I might jump up. Was there
9 questions?

10 CHAIR HURLBURT: Any questions? Yes, Larry?

11 COMMISSIONER STINSON: How do practitioners either
12 initiate or access these peer support services in Anchorage?

13 MS. BURKHART: In Anchorage? So if you were a primary
14 care doctor in Anchorage and you wanted to figure out how to
15 integrate this, my recommendation would be that you call Jerry
16 Jenkins at Anchorage Community Mental Health Services, and he
17 will connect you with their program, the Wellness Innovations
18 Center, and Andrea Schmook is the Director there until August.
19 Is that right? And she's also a board member and a person in
20 recovery and that would be a great way to connect through one
21 of the community behavioral health centers that has integrated
22 peer support into their practice.

23 There is also. in Anchorage, the Alaska Mental Health
24 Consumer Web, which is a drop in center with many, many
25 supports. They have employment programs. They have sobriety

1 support groups. They have all kinds of wonderful things, and
2 Tracy Barbee is the person to speak with there. So those are
3 just two examples of what's available in Anchorage.

4 CHAIR HURLBURT: Larry, follow-up?

5 COMMISSIONER STINSON: So in each community, there is
6 going to be -- so there is not one integrated place to call,
7 if you're in Wasilla, if you're in Kenai, you have to access
8 different local groups?

9 MS. BURKHART: Each community has different resources for
10 peer support. If you're looking for a more broad approach, I
11 would say that the Alaska Peer Support Consortium, which is
12 the umbrella organization, would be a great place to start.
13 Their Executive Director's name is Robyn Priest, and she would
14 be able to tell you what's available in your community, and if
15 you were interested in starting a program, they offer the peer
16 support specialist training, and there is actually a training
17 coming up in April and May. So I mean, there are
18 opportunities right now to partner with the Consortium, if
19 that's something you're interested in.

20 CHAIR HURLBURT: Allen then Emily?

21 COMMISSIONER HIPPLER: Thank you, Ms. Burkhardt. You
22 mentioned historic, learned, and secondary trauma. Can you
23 tell me what those are?

24 MS. BURKHART: I can try, and I'm hoping that maybe
25 Valerie will jump in, if I get it wrong.

1 The concept of historic trauma is the idea that I could
2 present with the symptoms of having experienced a traumatic
3 incident, but it turns out that what I am -- the symptoms I'm
4 presenting are due to a social or disaster-related trauma in
5 the past and so what we see, especially among our indigenous
6 population, is that traumatic events in the past, the flu
7 epidemic, boarding school, having grandparents and parents
8 into boarding school, loss of culture, that those kinds of
9 events can actually present to where, when I walk in to see a
10 mental health professional, at first blush, it looks like I'm
11 the one that has been directly traumatized, but instead, it's
12 something that's been passed down through my family or through
13 my community.

14 Secondary trauma can also be what a child experiences
15 where they, themselves, are not abused and they may not
16 necessarily always witness the abuse of another parent, but
17 it's happening in the household and so they're being exposed
18 to it.

19 CHAIR HURLBURT: Would an analogy be secondhand smoke, to
20 some extent?

21 MS. BURKHART: Perhaps, but especially the example I gave
22 with the child, it could be that the person would be smoking
23 out there and so I'm not actually breathing it, but I know
24 it's happened. And with historic trauma, I don't think that
25 that's a good analogy at all. Thank you.

1 COMMISSIONER ENNIS: The peer support model is certainly
2 exciting. I can see it having a lot of benefits. Has there
3 been discussion of that extending to other beneficiary groups?

4 MS. BURKHART: Yes, ma'am. So in Sitka -- this is one of
5 my favorite peer support organizations, and it's a not a
6 mental health organization. In Sitka, there is a program
7 called Brave Heart, and it is one of the few peer support
8 organizations that started with funding from the Alaska Mental
9 Health Trust Authority and has managed to become self-
10 sufficient. It is supports for families in which there is a
11 person with Alzheimer's or related dementia. And so the peer
12 support is actually mostly for the caregivers, although they
13 do have programs for the person experiencing Alzheimer's
14 disease as well.

15 I think some of the programs, like Will's Farm, where
16 there is an employment aspect to it and there is a lot of buy
17 in from the person with developmental disabilities, that
18 that's another possibility. I see no reason that peer support
19 doesn't work. I mean, I have my own peer support network, and
20 you know, so I think it will work for any population. I think
21 the issue is ensuring the quality of the service through those
22 competencies and that standard of care and ensuring that it's
23 designed and implemented by the peer group. Some peer groups
24 might need mentoring and coaching from maybe non-peers, but I
25 think it's possible, regardless of whether it's a Mental

1 Health Trust beneficiary group or just a wellness cohort. I
2 mean, I have a person I call at my state insurance that yells
3 at me to go the gym. You know, we have that.

4 COMMISSIONER ENNIS: I would interested in then knowing
5 whether or not that idea could be developed into both, I
6 guess, a permanent part of the array of services and also that
7 there could be funding provided to, you know, keep it going
8 and growing, and we can talk about that later, but I just
9 wanted to know if there were plans to make it a little more
10 formal and as a part of an array of services.

11 MS. BURKHART: And that would be something that we would
12 want to have a conversation with the Division of Senior and
13 Disability Services because they fund the array of services
14 for developmental disabilities. As Melissa spoke about, it's
15 funded through the integrated behavioral health regulations on
16 our side. So I mean, we can show how we did it. It might
17 work a little different for waiver recipients and things like
18 that, but it's a conversation that I'd be comfortable having
19 with Director Mayes, absolutely.

20 CHAIR HURLBURT: Thank you, Kate, very much. I'd like to
21 have, at least, 15 minutes for each of the other four
22 presenters there, and we do want to have some discussion time
23 as a group. So we're running a little bit behind on that, so
24 just kind of keep that in mind.

25 The next presenter is Ron Adler, who is the Director of

1 API. And Ron, there were a number of questions, when Melissa
2 was up here, that related to your institution. So if you have
3 the opportunity, maybe you could comment on some of those as
4 well. Thank you, Ron.

5 MR. ADLER: I'll be glad to do that, and I'm going to
6 weave that into a little story. My presentation to you is a
7 little bit different. Rather than telling you what API is,
8 because I think you all have your individual idea of what API
9 is and I think Division Director Stone covered eloquently in
10 her slides the challenges we face, I want to peer into the
11 year 2014 from the perspective of cost, quality of care, and
12 access to treatment, access to services because I think those
13 are the three pillars of health care reform, and my
14 understanding is that your Commission is dealing with those
15 issues as it relates to Alaska.

16 Valerie, I like your question about what kind of a
17 Christmas gift somebody wants, and putting that into my own
18 ethnicity, for Hanukkah next year, I would like Jeff Jessee to
19 deliver a plan and a roadmap of how we're going to get to the
20 year 2014, and I say that because, you see, much the way
21 SAMHSA provides the direction and line of sight for the United
22 States in terms of how substance abuse and mental health
23 services progress through the United States, the Mental Health
24 Trust Authority has a tremendous amount of influence and
25 rightly so, because they do the right thing on the direction

1 and the trajectory we take in the state of Alaska. And I
2 think that we have to start dealing with the year 2014 because
3 it's coming up. Other state systems have been dealing with
4 this now for two years out of necessity because they're
5 Medicaid budgets went into the proverbial tank.

6 So I'd like to begin driving by the Mental Health Trust
7 Authority office and see a flashing neon sign that says, let's
8 start planning now in concert with the Health Care Commission,
9 so that we have a roadmap that helps us deal with the changes
10 that have to happen in the year 2014.

11 And Ward, we live -- we have a very dynamic tension that
12 exists in this state, the dynamic tension between our ideal of
13 being a home and community-based waiver state where we really
14 promulgate those services and the reality of the need for some
15 kind of quasi-institutional facility that deals with folks,
16 not that they can't make it in the community, but are
17 potentially dangerous because, other than people who are
18 potentially dangerous -- Keith, I think there is a miracle
19 happening in our field, and that miracle that's happening is
20 when individuals with serious and persistent mental illness
21 co-author and participate in their treatment team, it
22 ultimately leads to -- and part of that is evidence-based
23 medicine. Part of that leads to something that consumers
24 conceptualize as recovery from mental illness, and we have a
25 variety of ways to do that, which gets back at the warehousing

1 issue, and I'm going to come back to that, Keith and Ward.

2 I think the integration with primary care is critical,
3 and I want to talk about the concept of access. By a show of
4 hands, I want to know how many of you have ever walked into
5 Anchorage Neighborhood Health Clinic at 9:15 a.m.

6 Did you see the waiting lines, waiting for service?

7 Okay. That's called access. You could find the same thing in
8 the primary care clinic at Maniilaq in Kotzebue. People know
9 how to access primary care. That's fundamental to the service
10 delivery system of the year 2014.

11 There are two places that I can call your attention to
12 that that happens in the greater Anchorage area. There is a
13 building on the corner of Folker and Tudor that's operated by
14 Anchorage Community Mental Health Services, and you should
15 stay out there one day with the clicker in your hand, you
16 know, the ones that the traffic folks use and count the number
17 of people with chronic and serious and persistent mental
18 illness who go in there. There are programs inside that
19 building that attract people to come in, and not all of them
20 have an appointment. That's critical. They walk in. They
21 get something, and they're satisfied.

22 The same thing happens on Gamble Street next to Carr's,
23 which Kate illustrated, the Alaska Consumer's Web. That unit
24 there gets so busy that, in the middle of the winter at times
25 this year, they've had to close the doors and bring hand

1 warmers out to people. And I have to tell you that that's
2 part of the safety net that's replacing API as the safety net.
3 That combination of services from a very active drop in
4 center, Brother Francis Shelter, and case managers that reach
5 into the shelter from Anchorage Community Mental Service to
6 get the right person and the right treatment at the right time
7 is part of the new safety net in this community that is being
8 funded and financed by our public sector system.

9 We have one program happening in the state. It's called
10 Impact, and it was developed by the University of Washington,
11 Department of Psychiatry, and it's an evidence-based model of
12 treating depression in primary care.

13 Let's talk about cost for a minute. We have roughly
14 20,000 members enrolled in the AK AIMS public health system.
15 I think that data is accurate as of three months ago. Of
16 those adults being served -- and I'm sorry I don't have the
17 number on the adults -- let's make believe, for a minute, that
18 we waive a magic wand, and through Jeff Jessee's planning
19 process, we hypothesize in building a system of care for 2014
20 that everybody with major depression recurrence is going to
21 migrate into some kind of a medical home model, and primary
22 care is going to be that place.

23 Let's further that, in the substance abuse silo, everyone
24 with a substance abuse treatment of moderate scale, not
25 severe, but moderate -- and I'm not talking about substance

1 dependence; I'm talking substance abuse, according to the DSM4
2 -- also migrates into primary. The question that we need to
3 ask, Ward, is, is primary care ready for this? What other
4 services need to be developed in the medical home model and
5 also available to Sunshine Community Health Center, Homer
6 Community Health Center, and all the other primary care
7 clinics that are not necessarily integrated with tribal health
8 corporations or FQHCs that have a behavioral health component,
9 how do we do that?

10 And as we back that percentage of people out of the
11 20,000, what's left for behavioral health to manage within the
12 grant system, and how effective is the grant system? Health
13 and Social Services, and in particular, Behavioral Health
14 spends a lot of time, effort, and money in being grant
15 managers.

16 Question, Ward, for you to ask Jeff, will the grant
17 system be a dinosaur in 2014? If -- stop agreeing with me;
18 that's dangerous. Then they'll be two of us.

19 We do have to look at these things. If that's the case,
20 we need to begin moving in a direction that other states are
21 moving. For example, we have very competent staff in the
22 Division of Behavioral Health who can then become care
23 managers. Twenty percent of our population takes 80% of the
24 costs. So when Larry gets somebody at his pain clinic that he
25 knows is enrolled in the behavioral health system and is in

1 that upper 20% packet, can Larry, through an encrypted email,
2 ask for personal health information directly to the care
3 coordinator or care manager, and can he get a response by the
4 close of business that day? That's the way other systems
5 work.

6 And Larry, I think we have the components in place to be
7 able to do that. I think somebody needs to light a fire under
8 us and that goes back to that neon sign that's blinking
9 outside of the Mental Health Trust Authority; let's do this
10 now. We have a very good encounter system through AK AIMS,
11 and they're building out more components into this platform
12 that will give us the information you need to be able to get
13 same-day service from a care coordinator in the Division of
14 Behavioral Health.

15 Quality of care. On the UW Impact website, Ward, they
16 have deployed this in four to five states now, the Impact
17 model of treating depression. Whether you are talking about
18 major depression/single-episode, major depression/recurrent,
19 or major depression with co-morbidities, the average episode
20 of care is \$580.

21 So again I ask, how can we use the technology that we
22 have and the pilot project that the Trust Authority is
23 demonstrating at this point in time to begin to move to a more
24 cost-effective system in 2014? And a system that begins to
25 get at one of the bad news stories about our trade over the

1 years, which is that folks with serious and persistent mental
2 illness and chronic substance abuse are dying 25 years ahead
3 of their aging cohort. By keeping folks in a silo, the
4 medical costs we're incurring in later years is significant,
5 and we have to find a way to make that integration.

6 When I have a person that is languishing at API, we now
7 use something called court-ordered treatment to get them out
8 of the hospital, court-ordered outpatient treatment. We do
9 this selectively with Anchorage Community Mental Health
10 Services. We make sure, through funding that Melissa Stone
11 makes available, that funding is in place, so this person has
12 an apartment, this person has a case manager from ACMHS, this
13 person, while they're still at API, has the ability to shop on
14 day passes to set that apartment up, and then we develop
15 conjointly an outpatient treatment plan with the treatment
16 team at ACMHS.

17 We just deinstitutionalized somebody three months ago
18 with this enhanced funding. The person didn't meet the terms
19 of her outpatient treatment plan. She was brought to API
20 through the Admissions area. We didn't know what to do
21 because this was one of the few people that we have out on
22 court-ordered outpatient treatment. She had to wait 20-25
23 minutes in the car, and she said, oh, forget it. Take me --
24 just take me over to ACMHS, and I'll get my intramuscular
25 injection, and let me go back to my apartment. That place is

1 much nicer than API anyway. That's why warehousing doesn't
2 exist. And what I want to tell you is that we could do this
3 with people with primary diagnoses of severe and persistent
4 mental illness. They don't need warehouses, and we believe
5 passionately in that concept of community-based care for those
6 individuals. I'll stop now and be glad to take some
7 questions.

8 CHAIR HURLBURT: Thank you. Any questions?

9 COMMISSIONER KELLER: You mentioned and used 2014 as a
10 trigger to your presentation, and I just would like you to
11 expand on that. In light of Supreme Court pending and that
12 kind of thing, what do you figure we're in for dealing with
13 these or are we going to get off the hook, if the Supreme
14 Court judges -- you know, how do you think about that?

15 MR. ADLER: I don't watch attorneys and courts. I watch
16 the insurance companies and the managed care companies in the
17 Lower 48, and they're way ahead of the courts. They're acting
18 as if this is going to happen. They've put their money in
19 that direction.

20 By the way, Representative Keller, that's why I also
21 believe, when disproportionate share funding stops, that every
22 licensed medical facility in the state needs to be able to
23 deal with somebody to stabilize an acute psychiatric condition
24 within three to five days instead of just sending somebody to
25 API within the first 24 hours of presentation. My friends at

1 ASHNHA are really going to love me for making that statement.

2 COMMISSIONER STINSON: Ron, what's the cost-savings of
3 the outpatient program versus inpatient treatment at API?

4 MR. ADLER: Inpatient treatment at API runs \$1,187.50 a
5 day. That does not include physician fees.

6 I think, whenever you take somebody that has had long-
7 term institutionalization and begin to transition them to
8 community-based care, your first three to six months of that
9 community-based care is probably somewhere between half to 70%
10 of the inpatient rate. And as the individual becomes more
11 acclimated and reintegrated to community-based living and sits
12 alongside of you in church and is the individual in front of
13 you when you shop at Safeway, I think what happens is that the
14 service level goes down.

15 COMMISSIONER STINSON: Obviously from Melissa's
16 presentation when she put up the API statistics, something is
17 heading in the right way. You could see that from that
18 presentation. Is this part of the reason why it's heading
19 that way?

20 MR. ADLER: Well, I think, for API, we went to a short-
21 term acute care inpatient model, based on the Qualis standards
22 for medical necessity. So people are leaving the hospital
23 sooner. Our inpatient bed utilization rate has gone down,
24 which helps with census management. And Melissa has brought
25 resources to bear to help fix the back end, people who are

1 languishing in the hospital, and I think those are the effects
2 of that. I think -- our hypothesis is that community
3 providers will incrementally begin to develop more and more
4 front end services for post-discharged patients, and I think
5 there is evidence that that's happening.

6 CHAIR HURLBURT: Is that current census low for optimal
7 (indiscernible - voice lowered) utilization in your facility?

8 MR. ADLER: Well, that census in January was getting me
9 worried, but we -- the good news is that we're fixing a lot of
10 things. The bad news is that our admissions are climbing on
11 an upward trajectory, and we will probably have an all-time
12 high with admissions this year of over 1,600 admissions, and
13 the problem with that is that there is still an offset effect
14 into the state hospital. And I think, as 2014 comes around,
15 we want to make sure that people are treated effectively and
16 efficiently in UBS (ph) and in remote-licensed medical
17 facility. With the technology available in health care
18 services now, with videoconferencing and the ability to do
19 curbside consultation, I think that we have the technology and
20 the clinical tools to make that a reality, if we put some
21 effort to it.

22 COMMISSIONER CAMPBELL: Ron, you mentioned the services
23 that are available (indiscernible - voice lowered) and some
24 more here in Anchorage. How robust is this system in the
25 outlying hinterlands for these kind of referrals and services?

1 MR. ADLER: I think they are places that are fine
2 examples of things functioning well, and I only can tell you
3 anecdotally those regions that don't have high admission rates
4 into API. Something is happening well in Nome, besides the
5 Iditarod. They have found a way to deal effectively with
6 bringing people in from remote villages and stabilizing them
7 inside the hospital.

8 I think that there is a -- things are working well in
9 Dillingham. I think the same for Kotzebue, and to some
10 extent, Bethel. So I think the tribal health corporations,
11 which are really integrated service delivery systems, are
12 finding a way to move forward and provide more cost-effective
13 care. I think there are other areas of the state that are
14 very troublesome, to me, and need some attention. So it is
15 possible.

16 COMMISSIONER MORGAN: This is a general question, and
17 probably I should have asked the first speaker, but is AK
18 AIMS, basically -- have the ability to be certified for
19 meaningful use, to be integrated into the standard electronic
20 health record systems or is it going to stay a standalone
21 system unto itself?

22 MR. ADLER: I can't answer that, I'm sorry to say. I'm
23 not part of the planning process, but I will make sure you get
24 an answer.

25 COMMISSIONER MORGAN: And the other thing is, I was

1 waiting for Jerry to reach down to his briefcase, which is
2 very large, but he never did.

3 MR. ADLER: You know, you have to build partnerships to
4 get along in life, and ACMHS has a rather large enrollment of
5 our members that we mutually serve. So it's not about him
6 paying me off, but it's about serving the person. But he can
7 pay me off, if he'd like to.

8 MR. JENKINS: (Indiscernible - away from mic)

9 MR. ADLER: You know, we make good music together for the
10 benefit of Alaskans and that's what counts. And I'm glad to
11 share success stories. God knows we need hear about them.

12 CHAIR HURLBURT: Thank you, Ron, very much. We better
13 move on, and I think this will be the next chapter in an
14 evolving story that we're hearing.

15 Jerry Jenkins, who is CEO for Alaska Community Mental
16 Health Services?

17 MR. JENKINS: I must have an outdated schedule. For
18 Commissioner Davidson and Commissioner Morgan, some of this
19 you may have heard on Sunday.

20 I'm Jerry Jenkins. I'm Executive Director of Anchorage
21 Community Mental Health Services, and thank you for the
22 opportunity to talk about what we do and some ideas that we
23 have about health care and helping Alaskans be healthy and
24 more engaged in outstanding opportunities we have to live
25 here.

1 Anchorage Community Mental Health Services provide span
2 of life mental health services. Our mission is to promote
3 recovery and wellness by providing consumer-driven behavioral
4 health care. That's been in place since 2003, talking about
5 consumers being charged with their health care. As a
6 consumer, I want to be in charge of my health care. As a
7 consumer, I want to be healthy and self-determining. So we
8 want that for our population as well. I noticed that in some
9 of the literature.

10 Last year, our age range was three to 103. So when I say
11 span of life, I mean span of life. Commissioner Ennis, we do
12 the biopsychosocial spiritual model of treatment because just
13 one facet doesn't work necessarily well. And Dr. Stinson,
14 many times what you do is office-based, and you need things
15 for the other 23 hours and 45 minutes in a day to help with
16 the care. So we use a lot of different types of support.

17 So I want to get into that, and I want to talk about four
18 areas that we focus on, and I also want to reiterate something
19 that Mr. Adler said and that is the life expectancy of a
20 consumer that we serve currently is 25 years less than a
21 person who has not been diagnosed with mental illness. So we
22 have some opportunities.

23 Now as the Health Care Commission, you're saying, how
24 does that impact us? Because those 25 years that are lost
25 have a lot to do with chronic illnesses, and as Ms. Burkhart

1 said, not just substance use but other illnesses, like
2 obesity, cardiovascular GI, neurological issues that our
3 population has, sometimes as a result of behaviors.
4 Sometimes, due to injuries or accidents, that happens because
5 of associated activities with illnesses that I'll talk about.

6 I'm going to go in chronological order. We have four
7 specializations. First is serving children with severe
8 emotional disturbance, and as I said, that age group starts
9 somewhere between ages two and three and goes until they
10 transition out at age 18.

11 I'll talk about us being a National Child Trauma Center,
12 having been one since 2005. We specialize in treating
13 children that have been impacted by traumatic events.
14 Traumatic events: neglect, abuse of all types that you even
15 think of and many that you haven't even thought of, things --
16 and again, I won't get into that, but children that have been
17 impacted by traumatic or adverse events.

18 From our experience, it drove us from serving primarily
19 adolescents in 2003 to serving and specializing in young
20 children and working with our partners at the Division, with
21 Ms. Stone, and other parts of the Department of Health and
22 Social Services saying, ladies and gentlemen, we need to
23 recognize we have a great opportunity to impact health care,
24 if we treat children early and often for things that impact
25 them. And they need primary care, obviously. They also need

1 to be taken care of, if they've gone through traumatic events.
2 And we have specialization in ages three to five and are
3 pushing it in Anchorage and Alaska and across the United
4 States saying, ladies and gentlemen, we have a great
5 opportunity to do prevention, intervention, mitigation, and
6 reduce the cost of the health care, if we recognize that. And
7 how do I know that? Because seeing our adults and our
8 children, our adolescents, we recognize these children were
9 clearly identifiable before the age of five. So I'll move on.

10 Early childhood transitional age youth. What happens
11 when they leave state custody or DJJ and they go into the
12 wonderful world? So we're working with those children or
13 those youth, I should say, those transitional age youth to
14 make sure they're linked to health care or that they have a
15 safe place to live. And now I'll start talking about housing
16 and the importance of that.

17 I'll move on to the next age group would be adults and
18 key partners include the Alaska Psychiatric Institute,
19 Department of Corrections, psychiatric emergency rooms,
20 SouthCentral Foundation, Anchorage Neighborhood Health because
21 what we do is we provide specialized health care for people
22 that are impacted by serious mental illness.

23 Our focus is one thing; that's recovery. People get
24 better. When people are well, their health care costs go
25 down. And that's one of the things that I've pushed for years

1 because -- and again, I'll use the example. I don't go to the
2 doctor to stay sick. I go to the doctor to get well and
3 that's what needs to be the expectation of the system.

4 When people -- we have some secrets about recovery. Here
5 are the secrets. They need to be housed. They need food.
6 They need clothes. They need health care. Once you get those
7 things into place, their life gets a lot more manageable. And
8 think about it today. If you didn't have a place to live, if
9 you didn't have adequate clothing and you didn't have food,
10 what would your mental health be? So you see my point there.

11 The other thing we emphasize is people being engaged in
12 meaningful activity. That's volunteering. That's support
13 groups. That's going to school. That's working. And that's
14 the reason we encourage our consumers to go get a job. That
15 helps the mental health sometimes more than medication. Let
16 me move on.

17 Another group that we work with, chronic public
18 inebriates, something we picked up over the last couple of
19 years. Yes; we're affiliated with Karluk Manor, if you're
20 here in Anchorage. But we know that these folks -- we know a
21 cohort that we surveyed in October of 20 people that had 100
22 ER visits in the previous 90 days. That's pretty substantial.
23 What we know now is that has gone down substantially now that
24 they've been housed. I think Regional, Providence, ANMC are
25 happier now in their ER because those folks aren't showing up

1 at the frequency that they were.

2 The last group we work with, Alzheimer's. We have an
3 Alzheimer's (indiscernible - voice lowered), have had it for
4 30 years. We just doubled the size of it; why? Because the
5 tsunami is coming. They call it the gray tsunami is coming.
6 And it's a health care issue, we'll say -- and this is going
7 to sound morbid, but this is the only group that we don't
8 expect to get better. We expect maintenance. And if a person
9 passes while they are in our care, that's a good thing because
10 they weren't institutionalized. They weren't in skilled
11 nursing or something like that. We've been able to maintain
12 them in the community with either their spouse or their
13 children. And I've got a lot of stories there, but I'll go
14 on.

15 The areas I would like to leave you thinking about are
16 the workforce. We need workforce. We need providers in
17 Alaska to treat Alaskans. Whether it be peers, as Ms.
18 Burkhart talked about -- by the way, when people get better
19 and then they get into recovery, then they become peers and
20 that's the reason we've emphasized that. But workforce. We
21 need providers. That's my major challenge today. And once we
22 get them, that they're skilled and sophisticated to deal with
23 the issues that are before us in Alaska, and we have some
24 great opportunities to help people get better.

25 Secondly, I'll leave with you that we have a system that

1 has an expectation that people get well, that they get a
2 physical a year. I harp with that with my employees as well
3 as myself and our consumers. That is the expectation. We
4 need annual physicals. We need to make sure that people have
5 linkage to primary care. And in some other places I've been,
6 the standard was that there was an exchange of information
7 with any other provider. That was the standard of care. As a
8 Commission, you can help influence that in Alaska.

9 And then we get into my dirty little secrets, and Ms.
10 Sweet (ph), if she's here, she's heard me talk about these
11 before. Here's our dirty little secrets, that for people with
12 mental illness or with addictive disorders to get better, they
13 need two things. They need housing, housing, housing,
14 housing, and they need trauma-informed care.

15 Trauma-informed care allows us to deal with what's
16 happened because, many times when a person presents to us,
17 something has happened in their background that, if you
18 understand that, where they're at today makes perfect sense,
19 but it's meeting them where they're at and understanding that.
20 And the science of it is, if I've been through traumatic
21 events, my biology actually changes. It's not just in my
22 head. It's in my body as well.

23 I think, Dr. Hurlburt, the term is called cortisol
24 changes. The cortisol levels change as a result of repeated
25 trauma.

1 We know, from a study that occurred in California called
2 ACE, Adverse Childhood Events, that they could predict health
3 care costs just from knowing how many adverse events a person
4 had been through as a child. It was the leading indicator of
5 obesity. As a matter of fact, the study started out of an
6 obesity study for obesity, cardiovascular, suicide. There
7 were so many things that this study showed -- and by the way,
8 Dr. David Driscoll at UAA is proposing that study be
9 replicated in Alaska, and I keep saying AK AIMS has some of
10 that data because we know, as Ms. Stone said, 69% of the folks
11 that have come into services in the last 18 or so months have
12 indicated adverse events in their lives. As a matter of fact,
13 half of that number has said they have three or more. Once
14 you hit that benchmark, your health care costs start going up.

15 So I'd leave with you and encourage you to consider
16 housing. I know that doesn't sound like a health issue, but
17 it's something that we can help leverage from the Alaska
18 Housing Finance Corporation and other places, but it's very
19 important people have a safe, affordable accommodating place
20 to live, and last, that understand the impact of trauma on
21 health care costs, period. I'll be quiet there.

22 CHAIR HURLBURT: I'll start off with a question. My
23 experience has been the kind of folks that you describe, you
24 often have a challenge in obtaining primary medical care for
25 their medical co-morbidities for several reasons. One that

1 can't do a whole lot about is there are a number of complex
2 medical co-morbidities, so they're challenging. But the other
3 reasons are that they're often challenging patients for the
4 primary care provider otherwise, in that they may be not
5 compliant and they have a high "no show" rate so that there is
6 downtime for a person who is running a business. How much of
7 a problem is for you for your clients to obtain the primary
8 medical care that they need for their co-morbidities, and are
9 you able to impact, particularly on the last two things that I
10 mentioned, to make it more likely that you could get a primary
11 care provider to accept them?

12 MR. JENKINS: Well, I'd like to say, thanks to
13 Neighborhood Health and SouthCentral Foundation, I don't have
14 a problem accessing primary care and that's for any of the
15 populations that I've described. If a person doesn't have
16 access or doesn't have an existing relationship, we're able to
17 do that, and I'm very glad of that. So that's not an issue.

18 The second one though, we like for people to be
19 independent, self-determination, and responsible, but
20 sometimes it's necessary to provide a case manager who
21 literally -- or a peer, as Ms. Burkhart described -- to go
22 pick them and take them and go with them, and many times, take
23 their health records with them. That's the ideal situation,
24 and we've got room for improvement. We're also recognizing
25 that we need to make sure that we honor your time, if you're a

1 provider in the community, and get that person to that
2 appointment.

3 Conversely, it's the same thing internally to our shop
4 where we have psychiatrists who have appointments. We have to
5 do the same thing. The case manager or the peer goes and
6 picks them up and brings them in, but that ultimately, we'd
7 like for the individual to be able to do that, but sometimes
8 that doesn't work. And your point is well made.

9 CHAIR HURLBURT: Other questions? Yes, David?

10 COMMISSIONER MORGAN: This is not necessarily a question.
11 It's more of a reminder to the Commission. If you look at the
12 medical home choice that the set up that North Carolina is
13 using, the small stipend for case management does not
14 necessitate having, necessarily, medical or Medicaid paid
15 activities on that case plan, and if you go to the website --
16 which, by the way I find interesting they haven't taken away
17 my password yet; sooner or later -- they will now, probably --
18 you can find a section for housing, job assistance,
19 connections, and even a separate section to help VA
20 individuals who are eligible for VA benefits to hook up with
21 VA benefits.

22 So when we go forward over the next year or shorter in
23 designing or making suggestions on medical home concepts to
24 the Legislature and the Governor, I would hope we would have
25 that component in it that the case management services would

1 have all that, have all those sections, and not necessarily
2 restrict it, only the medical or Medicaid reimbursed
3 activities in that.

4 So I borrowed some of your time, but I wanted to throw
5 that in there, and we do have a small program in tribes called
6 Tribal Medicaid Case Management. It's a small program, and
7 it's cost-base reimbursed, but as long as there is a plan and
8 everyone agrees to it and you're following it, there is no
9 restriction on what's in the plan as long as it's reasonable,
10 like housing, like jobs. I always envisioned those small
11 group-targeted tribes of VA individuals, you know, living on
12 the street or dislocated and targeting them to get them
13 housing, connected up to VA medical services or tribal medical
14 services, and it sort of -- you know, it's one of those things
15 on my Christmas list this year to kind of work, but we
16 appreciate what you do. And at the U-Med district meeting, I
17 will say you did a very good job at interacting there, and
18 we've always had a good relationship. Anybody that wants to
19 have a relationship with you will find it very easy to have
20 one. You work tirelessly to expand these programs, or at
21 least, connect them up in partnership. So usually, I talk
22 about costs, but I thought, once, you know, I'd wake everyone
23 up and not do that.

24 MR. JENKINS: Well, the reality is, if people are
25 healthy, they cost less. I mean, that's the bottom line. And

1 as an employer, you know, we look at this all the time, and
2 it's the reason we're very proactive in health promotion and
3 things of this nature. Dr. Hurlburt?

4 CHAIR HURLBURT: I think we probably better move on.
5 Thank you very much for that presentation, Jerry. Anna
6 Sappah, the Executive Director of the Alaska Addiction
7 Professionals Association. Anna, thank you for coming.

8 MS. SAPPAH: Thank you for having me. Good morning. As
9 Kate mentioned, not only do I serve as the Executive Director
10 for the Alaska Addiction Professionals Association, I also
11 serve as a consumer board member on the Advisory Board for
12 Alcoholism and Drug Abuse, and basically, the reason I do that
13 is because I am a past consumer of substance abuse treatment
14 services. I'm a person in long-term recovery and so I get the
15 unique perspective of getting to work with providers that are
16 providing services and also be able to look at it through the
17 lens of somebody who has accessed those services and how those
18 services have changed over the years.

19 In Alaska today, most people will access substance abuse
20 treatment services either through self-referral, family
21 interventions. Many more people will access those services
22 via the court system or Office of Children's Services as a way
23 of getting into, or at least, getting connected with the
24 treatment system here. The therapeutic court system has been
25 really valuable in helping people get into treatment services

1 a little more quickly. As many of us that working in the
2 field know, there is pretty extensive wait lists for substance
3 abuse treatment services in the state.

4 When I went through the system in 1995, the wait list was
5 about six weeks, and I can tell you that was the most painful
6 six weeks of my life. Now people are waiting to seek
7 services. Often times, unless they are a pregnant woman, an
8 IV drug user, some people will wait upwards of a year, between
9 six months and a year to access services. In some cases, they
10 may be able to supplement their needs by either attending
11 outpatient treatment rather than residential services that
12 they need. Some people will be able to access the recovery
13 community. You know, here in Anchorage, we're fairly
14 fortunate. Anchorage and the larger communities have fairly
15 robust 12-step communities that, you know, will help people
16 kind of bridge that gap in some ways, but in most of our rural
17 communities, that's not the case. Many rural communities
18 don't have, you know, a local AA or NA meeting, and you know,
19 people are just left kind of sitting and waiting to try and
20 get in somewhere.

21 One of the groups that often falls between the cracks is
22 adult males with no children or adult females with no children
23 that may not be Medicaid eligible. For folks that do have
24 private resources, whether it's their own money or a really
25 good insurance plan that covers residential treatment

1 services, many of those folks will actually access treatment
2 in facilities outside the state, and you know, what this means
3 for them is, in many cases, they can access treatment more
4 quickly, but the downside of that is that they don't get
5 connected with their community-based support services for
6 after they get out of treatment, where, if somebody receives
7 here in the state, you know, they are likely to get connected
8 with their local 12-step community or other peer support
9 services in their home communities, but if they access their
10 services out of state, a lot of people I know go to Lakeside-
11 Milam in Seattle or Sundown M Ranch or other West Coast-based
12 services, and they learn all about the recovery community in
13 those areas. They don't learn where to connect, you know,
14 once they come home, or if they go home to a smaller rural
15 community, you know, there are no recovery-based services, no
16 peer support for them and that's something that we're hoping
17 to address through the new peer support programs and
18 initiatives that are included in the Medicaid regs and that
19 the Division of Behavioral Health has been working on. So
20 we're hoping that we'll be able to achieve some parity in
21 that, along with the mental health services.

22 For those that are accessing services here in the state,
23 we do have residential services, intensive outpatient, and
24 regular outpatient services that provide, you know, a nice
25 array for people that -- I'm currently doing internship in a

1 couple of different programs for my degree, and we've got
2 folks that are working on the Slope, working on fishing boats,
3 fishing in a variety of areas where they really cannot afford
4 -- because they are their family's primary breadwinner, they
5 really can't afford to be in a residential service for, you
6 know, a month or more at a time and so these intensive
7 outpatient or outpatient services help bridge that gap for
8 them and allow them to access services, allow them to maintain
9 their jobs, stay within their families in many cases, and you
10 know, help maintain that family structure that's so important
11 as well as allowing them to access other community supports
12 that I spoke about earlier.

13 Some of the trends that we see in treatment services,
14 we're seeing a huge upswing in, of course, what was
15 prescription opiate abuse that had been on the upswing for
16 many years. Many of those people are transitioning over to
17 street heroin because it's cheaper and easier to access, and
18 many of treatment programs are simply not equipped to handle
19 some of those issues around opiate use. For many programs,
20 there has been a strong focus on serving primarily alcoholics
21 rather than addicts. So there is, you know, a definite need
22 there to make sure that the service system that we do have in
23 place does have the capacity to address a broad scope of
24 problems, and over the years, I know we've seen a decrease in
25 detox services kind of across the board and across the state.

1 At one point, we were down to, I believe, it was around eight
2 beds for the entire Southcentral region for detox services.
3 So people were actually accessing care through emergency
4 rooms, doctors' offices, trying to seek help through those
5 channels at a much higher cost of service. We do know that,
6 you know, when folks are allowed to receive treatment
7 services, for every one dollar we spend in treatment services,
8 we save approximately seven dollars and other related costs
9 around higher cost health care, drug court issues, domestic
10 violence issues, lost productivity and jobs. So really, for
11 every dollar that we spend in treatment, that seven dollar
12 savings, you know, really makes long-term financial sense, to
13 me. And when we do our advocacy work with legislators and
14 other policymakers, that's one thing that we like to point is,
15 you know, for the little bit you spend now, you can save so
16 much in the future, and especially in terms of families and
17 the devastation that addiction brings to families.

18 Some of the strengths that we have in the system, there
19 really has been some great opportunities for collaboration
20 between programs, between types of agencies, especially with
21 the behavioral health integration. The last several years has
22 seen a lot of opportunity for collaboration with different
23 groups, including folks that are providing services to
24 domestic violence and sexual assault victims. OCS has really
25 developed some good partnerships with treatment programs to

1 make sure that parents are getting the treatment that they
2 need, so that they are able to actually parent their children,
3 and you know, perhaps reduce the number of kids that are being
4 sent off to state custody as well.

5 One of the challenges that we had for a few years was
6 that people were being sort of mandated by OCS to receive
7 treatment services, but then there wasn't a treatment service
8 readily available for them to get into. So they were running
9 into conflicts of time constraints, where OCS would give them
10 six months to get treatment, but the treatment program
11 couldn't get them in for six months to a year. So there has
12 been a lot of work around bridging some of those gaps and
13 finding ways to get folks into services a little more quickly.

14 The electronic health records and the AK AIMS system that
15 we discussed earlier have some definite pros and cons. There
16 is a lot of support within the providers, but there is also
17 some pushback from providers in terms of fear of having more
18 paperwork to do and being able to spend less time with
19 clients. We're hoping that the AK AIMS system and whatever
20 electronic health records system that providers choose to use,
21 whether they stay just with AK AIMS or try and integrate
22 another system, that they'll be able to interface well. There
23 are some concerns around that.

24 And with substance abuse treatment programs, the clients
25 that they serve, the confidentiality requirements are so much

1 more stringent than in primary care and mental health services
2 that, as Melissa mentioned, you know, with the right amount of
3 releases of information, that information can be exchanged,
4 but you know, sometimes it's just that one lacking piece of
5 paper that keeps a provider from talking to another provider
6 whether it's primary health care, or you know, a dentist, or
7 you know, any number of hurdles, but it's not something that's
8 insurmountable. It's just something that needs to be
9 addressed and worked about in a systematic way.

10 Accreditation of program is another issue that's looming
11 on the horizon for substance abuse treatment providers. Many
12 programs are already accredited and have been for many years.
13 There's also a large number that are just now in the process
14 of getting their first accreditation, and for many programs,
15 especially some of the smaller programs, it's proving to be
16 something of a costly endeavor that's taking manpower away
17 from other needed services to really focus on the
18 accreditation process. You know, finding resources to pay for
19 consultants to help them through the process or pay for the
20 systems or the accreditation reviews themselves, many programs
21 are finding themselves in a position of having to spend
22 resources on that, that they might use, you know, more towards
23 direct services. So there are some challenges. You know,
24 once again, I don't think it's insurmountable, but they do
25 provide some pretty significant challenges, especially in the

1 smaller rural communities, you know.

2 At one point, I know we had considered providing some
3 opportunity for some of the smaller agencies to be umbrellaed
4 under a larger provider agency in the accreditation process,
5 but I think that kind of fell by the wayside. So that's one
6 of the challenges that we definitely face.

7 There has been a lot of talk today about peer services,
8 and you know, the history of substance abuse treatment
9 programs, to a large extent, you know, was really founded in
10 sort of an extended model of peer services. You know, a lot
11 of the folks that got into the treatment program business
12 early on were folks in recovery that wanted to help other
13 folks in recovery, and as years have gone on, it's become more
14 standardized, more -- there has been more training available.
15 There has been a level of accountability that didn't exist
16 early on. So you know, in terms of peer support, that's
17 something that substance abuse has done well for a long time;
18 now you're starting to see more of shift, especially with the
19 changing Medicaid regulations and that to, you know, the
20 requirement for more Master's level clinicians, maybe people
21 that, you know, don't have personal experience, but I think
22 there is -- we need to be cognizant of making room for the
23 folks that, you know, are those folks that have been working
24 in the field as paraprofessionals for many years that bring a
25 great deal of historical knowledge about substance treatment

1 and what's worked and what hasn't worked over the years and
2 making sure that we leave room for that. So thank you.

3 CHAIR HURLBURT: Thank you. Are there questions? I have
4 one. What is your sense, either subjective or objective --
5 and maybe breaking it into children and adolescents and adults
6 -- is the problem related to substance abuse, defined broadly,
7 getting worse in Alaska, getting better, or are we holding our
8 own?

9 MS. SAPPAAH: I know one trend that we've seen over the
10 years is a lowering of the median age of folks that we're
11 seeing in treatment programs. For instance, the program that
12 I went through in 1995, at that point, the median age was 37,
13 and I've since served on the Board of Directors for that same
14 program for 12 years, and our median age is now 23. So we're
15 starting to see folks a lot younger coming in with a lot
16 higher sense of need, a lot higher acuity in terms of the
17 level that their addiction has gotten to a lot younger. I
18 think there is a real need for adolescent services in terms of
19 residential. Many times, folks are faced with having to send
20 their adolescents out of state for residential substance abuse
21 treatment services because we're fairly limited here in Alaska
22 for that, and getting them when they're at a much lower level
23 of acuity rather than getting them when they're at that high
24 end, high cost for services.

25 CHAIR HURLBURT: Allen? Thank you.

1 COMMISSIONER HIPPLER: Thank you. You mentioned the
2 increase in heroin abuse as people switch from prescription
3 drugs to heroin. Is that correlated with the decrease in
4 median age or is that a different issue?

5 MS. SAPPAN: I think they could be correlated. I don't
6 have any specific data on it to indicate that, but I think,
7 you know, a lot of the people that we see in programs today,
8 you know, started out either through farming their parents'
9 medicine cabinets. Many of them experienced injuries when
10 they were in their late teens and early 20s that required
11 extensive pain management medication, and they became hooked
12 on those and then, you know, went through the cycle of doctor
13 shopping and that and then have turned to street heroin since.

14 CHAIR HURLBURT: Larry?

15 COMMISSIONER STINSON: A few weeks ago, myself and
16 another pain management physician and some other physicians
17 met with several people, including the Commissioner of Public
18 Safety and the Commander of the Troopers, and they are
19 specifically targeting females in junior high and high school
20 with heroin because, if they can get them on it, apparently,
21 the program really grows rapidly. We were contacted for some
22 other issues, but also because we also do standard urinalysis
23 screening on our patients, and they were giving us tips about
24 what we should be looking for. For example, PCP is not --
25 doesn't penetrate into Alaska for whatever reason, or at

1 least, not in a big way, but they wanted -- among other things
2 we were discussing is including heroin and beginning to start
3 thinking about anybody 12 and up on looking for things like
4 that.

5 MS. SAPPAN: Yeah (affirmative). Absolutely. And then
6 in addition to the heroin, we're starting to see a lot of
7 folks presenting to treatment with issues around what they
8 call bath salts and the synthetic marijuanas. We're also
9 starting to -- anecdotally, I'm hearing from providers they're
10 starting to get a lot of people into their treatment services
11 that have obtained medical marijuana cards and expect to
12 receive treatment services, but continue to partake in their
13 medical marijuana. So that's another issue that's coming up
14 that, you know, there is a lot of people shaking their heads
15 with no idea what we're going to do with that.

16 CHAIR HURLBURT: Thank you very much, Anna. Appreciate
17 it. The last presentation is Melody Price-Yonts, the
18 Behavioral Health Director of Southeast Alaska Regional Health
19 Consortium and the Chair of the Alaska Tribal System
20 Behavioral Health Directors, and we're going to hear about
21 some interesting things that SEARHC has been doing there in
22 Southeastern. So welcome and thank you for coming up here,
23 Melody.

24 COMMISSIONER ERICKSON: Ward, before we get started with
25 Melody's presentation, just for a quick time check, what we're

1 going to do -- we want to allow plenty of time to hear from
2 Melody and have a chance to ask her her questions, but I don't
3 want to lose the time that we had allocated for capturing just
4 some preliminary thoughts from the Commission right
5 afterwards. So what we're going to do is just, essentially,
6 cut out that last 15 minutes on our agenda for the wrap-up.
7 We'll wrap up in one minute instead of 15; how's that?

8 MS. PRICE-YONTS: So thank you, Dr. Hurlburt and members
9 of the Commission. I'm really honored to be here today. Most
10 of you are familiar with the Tribal Behavioral Health
11 Directors, so I'm just going to go over some highlights real
12 quickly.

13 The Tribal Behavioral Health Directors formed in 2005,
14 and we're composed of the Tribal Behavioral Health Directors
15 throughout the state. I represent the Southeast Region,
16 primarily. We also have members that come in from Metlakatla,
17 out in Bethel, Nome. Just all the major areas of Alaska are
18 represented. We meet on a quarterly basis.

19 Right now, we're doing a lot of work with statewide
20 behavioral health planning and advocacy. We are consulting
21 with the State of Alaska on funding and service delivery for
22 tribal behavioral health, including Medicaid and grant
23 programs. We're providing mutual support in addressing
24 funding, workforce issues, service delivery issues that we're
25 all addressing it in all of our organizations and throughout

1 our communities.

2 As Melissa mentioned, you know, we are faced -- we're
3 plagued with the suicide prevention, the substance abuse
4 issues, the drug issues. You know, it's throughout the state.
5 It's rampant, and of course, all of our staff are working,
6 addressing all of those issues.

7 Of course, we're working with some work in domestic
8 violence and sexual assault, and we are -- we've done some
9 work with the "Bring the Kids Home." We're really doing some
10 really, really great work in our collaboration with the State
11 on the "Bring the Kids Home" initiative.

12 In the Workforce Development area, we have a model that
13 we are trying out now. It's called the Behavioral Health
14 Aide. Many of you are familiar with the Community Health Aide
15 or the Dental Health Aide. The Behavioral Health Aide is very
16 similar. A lot of our Behavioral Health Aides, they go
17 through the certification process. They become Certified
18 Behavioral Health Aides. We can take someone, as we did in
19 one of our smaller communities, brought them out of school
20 with a high school diploma, and one of our individuals has
21 recently been accepted in the Master's program here in
22 University of Anchorage. So we're really excited about that.
23 We can really, from a grass roots effort, take someone from
24 their own community and train them up, and they're there,
25 working with people in their own community, and the people in

1 the community really appreciate that because they've got
2 someone that they can trust that they can go to and will
3 really understand, from a cultural perspective, where they
4 are.

5 And again, you know, one of the advantages of the Tribal
6 Behavioral Health is that the culturally component in what we
7 do is huge. We use talking circles. We use healing circles.
8 We use sweat lodges. We use dance and ceremony. In our
9 residential programs, we use art therapy. It's just -- it's
10 embedded in what we do, and it actually becomes a part of the
11 active treatment plan as we're working with our clients.

12 You've heard some talk today about AK AIMS, and I'm
13 really looking forward to future opportunities in working with
14 the State and how we can make AK AIMS a better tool to work
15 better for all of us. As you know, AK AIMS has some really
16 good data, but it's also important to note that, unless you're
17 a state grantee, you're not going to be entering data into AK
18 AIMS. So I don't think it's a true representation of what's
19 out there. We need to find a better way of collecting data.

20 Some of the areas that -- I have my little talking guide
21 here. We talked a little bit about integrated behavioral
22 health into primary care. Many times in the tribal health
23 care facilities, we're right there. We could be in the same
24 building with our primary care partners and that can be good
25 and maybe not so good. For us, working -- you know, it's nice

1 because our primary care providers will screen. They'll
2 screen for depression. They'll screen for substance abuse,
3 and hopefully, get that referral to us. Sometimes, the client
4 won't follow through. They won't come over. Of course, if
5 there is a more urgent matter, it's really nice to have the
6 behavioral health provider right there in the same building
7 with you. In many of our clinics, that is the case, and our
8 providers stay very busy just attending to urgent matters.

9 And you know, I think we have a long way to go on the
10 integration of behavioral health into primary care, and all of
11 the agencies across the state are looking at how we can do
12 this a little bit better because we understand. We understand
13 how important it is with the large numbers of patients that
14 are showing up at the emergency rooms and through urgent care
15 that really have a behavioral health emergency, when you drill
16 down to it, that could be the basis of the complaint.

17 We talked a little bit about the culture component,
18 dealing with the holistic view, the mind, the body, and the
19 spirit, and again, that is very important in the behavioral
20 health world.

21 Working on system level improvements, you know, it's been
22 very important for the Tribal Behavioral Health Directors, in
23 our partnership with the State and with the Mental Health
24 Trust, to join to together and work on initiatives together.
25 That has been just an ongoing process, and we really

1 appreciate our partnership. The State has really stepped up
2 and helped us through. In the tribal behavioral health world,
3 we're able to have a lot of our agencies participate in a gap
4 analysis. We're able to track a client when they come through
5 the door to make sure that we're capturing everything. Are we
6 making sure that that client is registered from Medicaid? Is
7 there an opportunity there? Is there a funding opportunity
8 that we could have missed? They are also following up with us
9 and helping us for those agencies that are not accredited in
10 developing a template model for a policy and procedure, which
11 is huge for those organizations that are not accredited.

12 And we also work with them in coordinating trainings.
13 You've heard a little bit about the new Medicaid regs, and on
14 the service side of the house, it's quite an opportunity for
15 all of us to make sure that we are closing the loop and that
16 we are doing a good job with our documentation. I tell our
17 staff, all the time, you know, that the documentation should
18 read like a book and we should be able to tell where that
19 client came in through the front, and what the story was, and
20 just to make sure that our documentation is meeting the
21 Medicaid requirements.

22 Now I get to brag. One of the areas that I was asked to
23 talk about was telebehavioral health, and at SEARHC in
24 Southeast Alaska, we've been working with telebehavioral
25 health for a number of years now. We are able to do -- we

1 offer full mental health assessments, diagnosis, psychiatric
2 services, medication management, individual family and group
3 therapy, treatment planning and review, psychiatric and
4 behavioral health consultation, behavioral health referral
5 services, hospital admissions, and a little bit of substance
6 abuse treatment. We could be doing better. We had a business
7 plan in place to increase our telebehavioral health activities
8 by 200% within a two-year period. At the six-month marker, we
9 were at 60%. The clients seem to -- they like it. They
10 appreciate it, that they can be in their hometown, that they
11 don't have to travel, that they can go in and they can talk on
12 a video, and they can talk to a psychiatrist or a family
13 therapist and that person is not their auntie, their uncle,
14 their cousin or their neighbor. You know, when you're talking
15 about the smaller communities, you know, that anonymity piece
16 is really appreciated by the clients.

17 We're kicking it up a notch in SEARHC. Over a three-year
18 period for our outpatient mental health center in Juneau, we
19 had an increase in the number of visits by 67%. We've
20 noticed, with the economy changing, or what we believe, is
21 that a lot of the villagers are moving to the larger cities,
22 and we're seeing that. We're seeing that in the behavioral
23 health world. And so they're knocking on our doorstep, and
24 they need help.

25 In order to meet that, the increase in the number of

1 visits, even though I added an additional five FTE, we're
2 still holding a mental health waiting list of about 90 and a
3 substance abuse, at times, at 70 and that's just simply not
4 okay. When you have a person that's in crisis and they have
5 come to us for help, we really want to do our best to help
6 them.

7 So last year, I wrote a business plan to contract out the
8 assessments. We've got an organization that we're working
9 with in St. Louis, and we use a videoconferencing system,
10 which is approved by Medicaid because it's actually a
11 videoconferencing process.

12 So we have a client that comes in the door in Juneau. We
13 set them up for a two-and-a-half hour visit. They have to
14 come in. They've got to do their documentation. Their
15 counselor that they're talking to is a Master's level
16 clinician located in St. Louis that has come up to us and
17 received the cultural training and met with our staff and
18 learned how we do business, and the clients are there.
19 They're there for two-and-a-half hours, and they complete a
20 full integrated mental health assessment, which is just really
21 amazing. What this allows us is to get work down on our
22 waiting list, and it allows our other providers to be
23 providing services. You know, that frees up -- for each
24 mental health assessment, that frees up three hours of
25 provider time.

1 Right know, this is a pilot project. We're doing about
2 nine assessments a week, and the "no-show" rate is actually
3 lower for the videoconferencing system than it is for the
4 walk-in appointments, which, you know, I'm not sure what the
5 relationship is there, but you know, it's great, and the
6 clients seem to like it, you know, and this might be
7 something, if I -- at the end of the year, the fiscal year,
8 I'm able to show it to the SEARHC board that this is, you
9 know, a fiscally responsible way of doing business and that I
10 can sustain this, that I would be hoping to move it out to the
11 rest of the Division because, again, it seems -- I don't know
12 -- you're hearing that the numbers are high, and there is just
13 not enough of us to provide those services. So this seems
14 like a really great way to approach that, that issue.

15 So that was quick. Was that eight minutes or less?

16 CHAIR HURLBURT: Great. Thank you. That was
17 interesting. Are there some questions? David, please?

18 COMMISSIONER MORGAN: Since Medicaid is usually the
19 largest reimbursement system -- oh, I'm not close enough?
20 Since Medicaid is your primary or largest reimbursed payer, is
21 the way reimbursement happens for telemedicine or
22 telepsychiatry, is that a problem, is that a barrier, or is
23 that working okay for you?

24 MS. PRICE-YONTS: The -- what we're finding is that a lot
25 of our clients are not Medicaid eligible at this time. So

1 Medicaid is not reimbursable. With most of the tribal
2 organizations, our source of funding right now is about 40%
3 from Indian Health Services, and the rest we make up with
4 third-party billing.

5 CHAIR HURLBURT: Valerie, please?

6 COMMISSIONER DAVIDSON: I don't have a question. Well, I
7 do have a question, but first, I want to answer that one. So
8 on the provider end, the person who is actually doing the --
9 providing the service -- so in this case, it would be somebody
10 in the Lower 48, if that person was eligible for Medicaid,
11 that provider would receive it, but there is not, necessarily,
12 anything on the sending end, which is a problem. It's one of
13 our biggest inhibitors for telemed utilization at the local
14 level because there is really no financial incentive for you
15 to be able to do that. The person on the receiving, the
16 referral facility, gets the consult, gets the fee, but there
17 is nothing on the sending end, which is a problem. So that's
18 something that needs to be fixed.

19 And then I'm going to go back to my question. So you
20 mentioned Behavioral Health Aides. Can you describe sort of
21 their scope of service and the extent of their training? I
22 know, but I'm not sure that others on the Health Care
23 Commission do.

24 MS. PRICE-YONTS: Yes. I will do my best, and if not, I
25 understand that we've got some guests here that work a little

1 bit closer with the Behavioral Health Aide program than I do.

2 The Behavioral Health Aide program -- again, I don't know
3 how many of you are familiar with the Community Health Aide
4 program, but the criteria, the competencies that the
5 Behavioral Health Aides do have to go through are very, very
6 extensive. They've got to have certified training in just
7 about every area that they service, and they're at different
8 levels. We've got a Behavioral Health Aide at the entry
9 level, the Behavioral Health Aides I, II, III, IV, and
10 practitioners. And it's really lining up their years of
11 experience and also the competencies that they take their
12 trainings, whether that be motivational interviewing,
13 substance abuse training, mental health training, it's very
14 similar to the Alaska Behavioral Health Substance Abuse
15 Counselor model. It's very exciting, you know. It's a way
16 that we can get out to the communities, and some of those
17 communities, if there is a small community of 500 folks, more
18 than likely, you're going to have a hard time getting a
19 Master's level clinician recruited to go out there, and we
20 have this ability to grow our own and to train them, and they
21 are supervised by a Master's level clinician.

22 COMMISSIONER DAVIS: Thank you, Melody. I just had a
23 question. You mentioned the "Bring the Kids Home" initiative.
24 I'm sorry; I'm not familiar with that. Could you describe
25 that a little to us, please?

1 MS. PRICE-YONTS: I can give a broad description. The
2 "Bring the Kids Home" initiative came from -- a lot of the
3 kids -- you've heard talk, from some of the other speakers
4 today, that many of the kids were needing services that could
5 not be provided in state, and they were sent out of state. So
6 we were sending a lot of our kids out of state to receive
7 services. The "Bring the Kids Homes" initiative really talks
8 about bringing the kids back to the state of Alaska and making
9 those services available here within the state.

10 CHAIR HURLBURT: Valerie?

11 COMMISSIONER DAVIDSON: Typically for residential
12 psychiatric treatment centers. So there was a time in our
13 state where we had a very limited number of beds available for
14 children. There were services available for adults, but
15 really none for children. And so Medicaid children and other
16 children were really being sent out of state, where they were
17 receiving care.

18 COMMISSIONER CAMPBELL: Maybe this is a question for the
19 broader group, but are we finding that the stigmatization of
20 mental health is becoming less over the years with the
21 exposure of the public to treatment facilities and programs?

22 MS. PRICE-YONTS: That's a really good question. I might
23 open that question up to my fellow panel members. I should
24 have put a disclaimer when I came up here. Although I am a
25 Native Alaskan, I'm also new back to Alaska and new into my

1 position within the last three years. So some of the more
2 historical knowledge, I would want to refer to my colleagues.

3 UNIDENTIFIED MALE: Do you want to phone a friend?

4 MS. PRICE-YONTS: I do.

5 MR. JESSEE: Well, not exactly. I mean, witness what
6 happened just the last two weeks when Anchorage Community
7 Mental Health and the Trust started to propose purchasing a
8 hotel.....

9 UNIDENTIFIED MALE: (Indiscernible - away from mic)

10 MR. JESSEE: It's been for sale for a year -- to house
11 people with mental illness who are now sleeping in the foyer
12 of Brother Francis -- and the outpouring of negative attitude
13 from that community. So I mean, we've been trying to chip
14 away at it, but it's still a huge problem, and I don't know
15 exactly what it will take to start to turn around that public
16 attitude and perception. And of course, it's just as true
17 with folks with chronic alcoholism. I mean, the problems we
18 had opening the "Housing First" project were (indiscernible -
19 voice trailed off).

20 MS. BURKHART: I think it's also relevant, given the
21 aging of our population, to understand that the stigma related
22 to mental and health substance abuse among older Alaskans
23 still is highly -- it's -- they don't want to receive services
24 from a behavioral health center. We've heard that in
25 communities around the state, that seniors that clearly need

1 mental health services or treatment for an over-reliance on
2 alcohol or pain medication, they'll go see their doctor, but
3 they will not go to the mental health center. And so I think
4 that's where integration is going to be a great benefit to
5 folks who need services because they don't have to go to a
6 separate place. They're going to the same place where
7 everybody else goes. We've heard that.

8 Kenaitze Tribe in Kenai really pointed out that they had
9 a hard time getting elders to go to their behavioral health
10 center, but they would definitely go to the primary care
11 center, and we see that in most of our communities. So that's
12 -- I think integration is going to be a great solution there,
13 but I mean, I think that we see the continued stigmatization,
14 even for good reasons.

15 For example, the behavioral health center in Dillingham
16 is separate from the hospital campus, and it's set over here.
17 And I think a lot of people thought, oh, that will be good;
18 nobody will know you go. Well, that's the whole problem is
19 that there is a problem with someone knowing you go to receive
20 behavioral health services. So I think sometimes the stigma
21 is not necessarily malicious, but the fact that we're worried
22 that somebody knows we see a therapist is an indication that
23 there is a problem, and the fact that we would build a whole,
24 beautiful facility separate from the hospital campus so nobody
25 will know, I think that shows we still have work to do.

1 COMMISSIONER DAVIDSON: But how much of that is
2 necessarily the funding limitations? So for example, we
3 talked earlier about silos. So historically, the Indian
4 Health Service did not fund behavioral health services at all,
5 and in a lot of the rural communities, the only providers of
6 behavioral health services were independent non-profits who
7 were not affiliated with the tribal health system who received
8 grants from the State and who received other grants. Because
9 those services were not available, they were not funded by the
10 Indian Health Service.

11 And I think, as we're moving forward, we're seeing a lot
12 of those programs be combined or integrated, et cetera, but it
13 has been a challenge where those resources have simply not
14 been available.

15 And then the other thing that's happening, since we
16 talked earlier about the challenge of what happens if those
17 grants go away, then what does that new reality look like? Is
18 there a sufficient safety net of funding available in a rural
19 community that has relied upon that grant to be able to
20 maintain their operations? That is a very different reality
21 than a provider in Anchorage or Fairbanks or Juneau because,
22 in a rural community, you not only have a higher cost of
23 living, a higher cost of keeping that facility open where the
24 cost of heating oil is seven dollars a gallon, if you're
25 lucky, but you also have supplies that have to be shipped in,

1 and if the facility doesn't have the ability to deal with
2 biohazard or Hazmat, those supplies also have to be shipped
3 out. So the reality is very different throughout the state,
4 and it's sort of what we talked a little bit about yesterday,
5 that our health care delivery system, as we know it right now
6 in Alaska, has evolved over time. And you know, we can either
7 continue to shape it intentionally, which is the best
8 scenario, or it will continue to limp along and not be
9 everything that our citizens deserve, no matter where they
10 live in this state.

11 CHAIR HURLBURT: I'd like to thank all the -- okay,
12 Melissa?

13 MS. STONE: I just want to make a correction. I checked
14 with Terry Checklak (ph), and in our new regulations, we are
15 able to bill for the person who is presenting the
16 consultation, and I think that's at \$62 per consultation, and
17 in fact, the presenter has been able to bill in the non-
18 behavioral health center, she said, since 2002.

19 CHAIR HURLBURT: Thank you, Melissa. We'll move into, in
20 the time left, discussion among the Commissioners on where we
21 are. I'd like to thank all of the panelists that were here.
22 It was very helpful, and you fulfilled what our hopes would be
23 as far as sharing information, enhancing our understanding of
24 resources, issues, challenges. So thank you. Deb?

25 COMMISSIONER ERICKSON: In the 15 minutes we have left, I

1 thought I just to give you all a few minutes to share any
2 preliminary thoughts that you captured that you want to make
3 sure that we don't lose, but we'll be following up over
4 teleconference and in subsequent face-to-face meetings as
5 well. So just brainstorming, throwing out ideas, remember to
6 please hold the mic really close to your mouth. Folks are
7 still -- they're able to hear better on the phone if you're
8 mouth is really close to the mic. Does somebody want to
9 start? Allen?

10 COMMISSIONER HIPPLER: One thing that struck me was the
11 idea that everybody agrees that information is really easy to
12 share between medical professionals, but then, in practice, it
13 doesn't work out that way. It seems as if that's the case.
14 And I'm not sure if that's a regulatory issue or perhaps a
15 cost issue where a physician simply doesn't have the time to
16 do this because there is no revenue associated with him
17 sharing this information with another physician; why should he
18 do that? Well, that's -- there is a problem there. I'm not
19 sure what the solution is, but it's either a regulatory
20 problem or an incentive problem.

21 CHAIR HURLBURT: I think, related to that partly, what I
22 heard was a desire for and a perceived need for both more, as
23 appropriate, collaboration and integration between the
24 behavioral health care system and the medical care system and
25 a hope that the concepts embodied in the medical home that

1 we're talking about can be a mechanism for making progress
2 towards those goals.

3 COMMISSIONER DAVIS: One of the things that struck me --
4 and it's probably obvious, and I just wasn't smart enough to
5 figure this out before -- is that, when we talk about
6 integration of behavioral health in primary care, we have to
7 think more broadly than we normally would. At least from my
8 background, I'm thinking a health care approach to it, but the
9 importance of employment and housing and those sorts of things
10 as part of the treatment of the whole person really stood out
11 as something we have to incorporate.

12 COMMISSIONER ENNIS: And I'm following on that, the
13 discussion or planning, perhaps, of a conceptual design of an
14 integrated health care system for people with cognitive and
15 developmental disabilities as well as our seniors who are
16 experiencing disabling conditions, particularly Alzheimer's
17 disease and dementia, and related mental health and drug and
18 alcohol problems that are currently not being well-served. I
19 think the behavioral health and substance abuse programs are
20 demonstrating some real progress in that area, but in the DD
21 and Senior world, we're really not -- we're not addressing it
22 adequately.

23 COMMISSIONER MORGAN: Since we're still waiting on the
24 answer on AK AIMS, I think we should encourage, recommend,
25 suggest that all these systems, whether it's AK AIMS or the

1 public health statistical system, all are integrated with the
2 safeguards that need to be there with the electronic medical
3 records systems and the e-Network. Behavioral health, I do
4 understand just enough to know that they do have certain -- a
5 heavier burden on restrictions on who has access, but I don't
6 think there is a burden on their primary care physician
7 knowing what drugs or changes in drugs or what's going on,
8 especially on that end, especially.

9 And the second end, we've had some experience with
10 telehealth, and the problem with -- I threw a softball
11 question; Valerie answered it. There needs to be a look at
12 that. If you look at Scandinavian countries that have huge
13 areas with bad weather, they tend to have a more robust
14 system, more of a 50/50 share at each end or something to
15 encourage and to support telemedicine, especially in this
16 state. With AFCAN and other systems we have, you know, I
17 would think we could sit down with Medicaid and even insurance
18 carriers and kind of look at that. It doesn't necessarily
19 mean that you spend a whole lot more. It just means possibly
20 the way it is spent is a little more equitable through the
21 process.

22 But more important than anything else, everything we want
23 to recommend, from medical home to this, always come down to,
24 where is the patient's information, who can get it, and how
25 quickly can we process it through to make their health better?

1 And I would hope that the State, working on their management
2 information system, is also looking at all the other systems
3 that they're working with to get rid of the silos. The silos
4 are creating real problems, and I think, creating a lot of
5 waste throughout the system, but that's just my view right
6 now.

7 COMMISSIONER CAMPBELL: Well, we, last year, stepped off
8 a pretty deep diving board into some water with our cost study
9 of institutions and cost of medical care, direct physicians'
10 fees and things like that. Do we have the budget to go ahead
11 and gore some more oxen in that particular aspect this year?

12 My view is that, if we can't understand where the costs
13 are, if we don't cover those and understand those things, then
14 we're just going to squeeze the balloon to where the spotlight
15 doesn't shine, and I think, to understand the system, we've
16 got to know where all the costs are, if we can. And I don't
17 know where we go with this, quite frankly.

18 COMMISSIONER ERICKSON: I'm just wondering if one of the
19 two studies that Melissa mentioned to us earlier this morning,
20 the one related to the rates might help, at least partially,
21 answer the question of cost analysis, cost comparison. I
22 don't know, Keith, if you were suggesting the exact same
23 thing, where we might do a comparison of costs and pricing
24 between Alaska and some other states or.....

25 COMMISSIONER CAMPBELL: Well, that's what we did last

1 time, and I don't know that that's totally appropriate in this
2 thing, but we just need to know what things cost because
3 patients can't make a judgment, if we're looking at some sort
4 of hybrid model here from the standpoint of health care reform
5 and payment reform and things like that. Again, like Valerie
6 said, it can happen to us or we can try to plan for it, and
7 you can't plan for it if you don't know what the basic
8 underlying costs are.

9 CHAIR HURLBURT: Valerie, yeah (affirmative)?

10 COMMISSIONER DAVIDSON: I think, at our last couple of
11 meetings over the last year, we had lots of conversation that,
12 once we did the cost, we were going to, next, turn to benefits
13 and so I would respectfully ask that we start turning to the
14 benefits of what our health care delivery system has provided
15 us.

16 The other is that, I guess, one of our preliminary
17 findings certainly should be that it takes too darn long for a
18 person who needs treatment to get in. The six to nine-month
19 wait or a year is unacceptable. I mean, that's true from -- I
20 mean, it was said here, but I know every single person in my
21 family who has ever said, I want treatment, has not been able
22 to get in, in less than six months and that's here in
23 Anchorage.

24 COMMISSIONER STINSON: To Valerie's point, and also
25 several of the presenters brought this up, part of this is

1 workforce; part of this is having the professionals to provide
2 the care that's necessary. When Ron was talking about locum
3 tenens, they're very expensive. Jerry touched on it, too.
4 You know, supporting the psychiatric residency program up here
5 would be huge and would be a big benefit to all these people
6 who are trying to do some good work. You know, behavioral
7 health is another area, or radiology, that is probably the
8 most amenable to telemedicine, and maximizing telemedicine
9 with these specialties would be excellent. You know, they
10 were talking about the issues about who gets paid on each end.
11 It sounds like they're doing work for that. Another issue
12 would be probably not with what Valerie was saying, but
13 malpractice. If you have somebody from another state, are
14 they licensed in the state? So there are some other
15 regulatory issues. I don't think those are great obstacles to
16 overcome, and probably, they've been overcome elsewhere. But
17 telemedicine could be a force multiplier, but we still need
18 more force.

19 COMMISSIONER DAVIDSON: Deb, on the first bullet, can you
20 -- I mentioned treatment. I'm not sure why you chose
21 substance abuse over alcohol, but if you're going to
22 include.....

23 COMMISSIONER ERICKSON: I think.....

24 COMMISSIONER DAVIDSON: I think alcohol includes a
25 bigger.....

1 COMMISSIONER ERICKSON: Yeah (affirmative). Well, I
2 include -- in my mind, I lump them all together.....

3 COMMISSIONER DAVIDSON: Okay.

4 COMMISSIONER ERICKSON:but if others don't, I will
5 be more specific. Thank you.

6 COMMISSIONER ENNIS: I would just second that, Deb.
7 We've talked a lot today about drug use, prescription drug
8 use, and street drug use and that is, certainly, I think, in
9 our heightened public attention, but alcohol still continues
10 to be a huge looming problem. So I think we should take
11 advantage of separating it out, as a separate word. Thank
12 you.

13 COMMISSIONER KELLER: I've been reflecting on Melissa's
14 statement on the challenge of acuity measures, and I would
15 like to pursue that further, acuity measures, as related to
16 rate review.

17 CHAIR HURLBURT: Yes, Jeff?

18 COMMISSIONER DAVIS: Thank you. Both Ms. Stone and Mr.
19 Adler mentioned, if I was following Mr. Adler correctly, the
20 impact of the Affordable Care Act, particularly the Medicaid
21 expansion and the strain it will put on the ability to provide
22 services, and you know, to exacerbate the waiting issue. I
23 assume that's not unique to the behavioral health arena, but
24 it sounds like it may be acute here than in others. So a
25 plan, and I didn't hear Mr. Jessee volunteering to do that,

1 but you know, a plan in advance of that rather than waiting
2 for the train to just run us over might make sense.

3 COMMISSIONER ENNIS: I wanted to add to the requests
4 regarding rate review and acuity measures. One thing we need
5 to realize is that, often, the acuity rate is related to the
6 capacity to serve, and often, in my experience, we've been
7 sending individuals out of state for services because the
8 local providers are not receiving the adequate funding to
9 build a capacity to serve in state. So it's definitely
10 related to protection of costs, but again, developing capacity
11 in state is very important for us. So again supporting the
12 (indiscernible - away from mic).

13 COMMISSIONER DAVIDSON: So I keep going back to comments
14 that were made earlier today about -- and you even hear about
15 it TV ads -- early intervention, early childhood is really
16 where you can make the biggest bang for your buck in terms of
17 catching kids early, making sure that they get their right
18 interventions as early as possible. And I don't know
19 necessarily what we're doing as a state. Does every child in
20 every community have those opportunities available? I'm just
21 asking because I don't know.

22 COMMISSIONER ENNIS: Thank you. I don't believe we've
23 addressed the issue of long-term care for people who are
24 dangerous, at risk of hurting themselves or others, and I do
25 think we need to study that, and that, again, is across is all

1 beneficiary groups. We do work with people who have cognitive
2 and developmental disabilities that can be very, very
3 dangerous. There are seniors, we're beginning to notice, that
4 also can present a serious dangerousness in our community, in
5 their assisted living home, and their family settings.

6 So whether it's long-term care residency or some short-
7 term, but definitely crisis-related residency, we do need that
8 in Alaska, and again, we are starting to see people being sent
9 to the Lower 48 simply because they are too dangerous to be
10 served on community. We don't have the resources.

11 CHAIR HURLBURT: Any other comments? David, please?

12 COMMISSIONER MORGAN: We're back to that dynamic tension.
13 As economists say, markets abhor a vacuum. How things are
14 reimbursed and paid for can shape the market, but the cost per
15 individual to do these things -- and then you look at what you
16 would pay to get those services in Portland or Seattle --
17 could be half, a third, 70%, but significantly lower and
18 that's the rational allocation of resources. If you have X
19 dollars -- I mean, we're all economists, so we would act as
20 rationally, I would hope. If you have X dollars and by
21 sending an individual out of state -- we see this in the
22 prison system, too -- you can do 1,000 versus those same
23 amount of dollars and only do 400 year. So that -- and the
24 double funding problem, that, as you're changing what you're
25 doing, you'll have to double fund it in order to transition to

1 the internal part. I'm not making an argument not to do it.
2 I'm just making an observation, as to the economic effect,
3 that we have to really understand, when we delve into this
4 issue, it's an economic that, if we could deliver those
5 services probably economically or equal to what it costs per
6 person out, they'd probably be happening here, but the
7 reimbursement level is at X position. It's too low because
8 the costs will be a third to a half higher than what you can
9 get down there. And we've already experienced building a
10 large prison and cannot afford the operational cost of the
11 people in it.

12 So of course, we should look at it, and of course, we
13 need to understand it and make recommendations, but let's all
14 go into it with a clear understanding that there is a reason
15 why we don't do it here, and I think we all know why. We just
16 haven't put it up there yet. So I don't know how -- I'm not
17 saying don't. I'm not saying do. I'm just saying be prepared
18 for what you're about to find out.

19 COMMISSIONER ENNIS: Right, and I certainly don't want to
20 get into a debate because I think the whole room would get
21 involved very quickly, but we certainly have some history we
22 would not like to repeat. The services that we provided in
23 our state and it's (indiscernible - voice lowered) territorial
24 in state days in which the only form of therapy was an
25 airplane ticket out of the state, away from families and home.

1 And I agree. I know we're dealing with that right now, where
2 the costs of services in Idaho are less than even community-
3 based services with an acuity rate. And so we do have to
4 address that, but I would hope that it's part of that
5 integrated comprehensive design in which we can intervene long
6 before someone needs the high cost institutional care in
7 Alaska, that we all can begin developing our own expertise,
8 and this is across all beneficiary groups, so that we have
9 more, whether it's Behavioral Health Aides that have gone
10 through certification or we can develop our Master's degree
11 Social Workers that can respond to the needs of our
12 beneficiaries on up. I mean, the whole -- sort of whole array
13 that will provide more intensive support so that, really, I
14 think as Ron said, only a few people might need that long-term
15 residential program here. You know, the numbers are not going
16 to be as great as we might predict today because we have these
17 different levels of intervention that can assist in the
18 prevention or the management in our community-based services,
19 and again, I would hope that we're not ever warehousing, that
20 we're not going into that concept.

21 Right now, when someone is going outside, it's one to two
22 years and then the transition back is so difficult for them
23 that, often, there is not high success. So again, it's not, I
24 guess, a one-size-fits-all, that we would have an institution
25 that we could simply somehow justify, but that we would have

1 it, but it's not going to be on the size of, you know, a big
2 facility, and we have so many other options that will help
3 people manage their issues in the community-based services,
4 and only this is for a limited number. In a real perfect
5 world, but we'd like to move toward that.

6 CHAIR HURLBURT: We probably should close. You folks
7 have been very good about being here, but I know a lot of
8 folks have soon-appointments. Yeah (affirmative). Like now,
9 Jeff said. So yes. The benediction from Valerie?

10 COMMISSIONER DAVIDSON: No, but we didn't say anything
11 about suicide, and I think, in our state, we would -- I think
12 we would look foolish, if we didn't, at least, address it as a
13 topic.

14 CHAIR HURLBURT: Thank you, to make your issue.

15 COMMISSIONER ERICKSON: As folks are leaving -- we didn't
16 adjourn quite yet, even if one of our members is running out
17 the door -- just a couple of things. We will be setting our
18 next meeting dates. If we don't have our new members onboard
19 within the next week or two, we're just going to go ahead and
20 schedule without them. So be looking for that email from me,
21 and hopefully, we'll have the next meeting scheduled soon, by
22 the end of this month, at least.

23 I also wanted to apologize for those who stuck with us on
24 the phone and anybody who was in the room who was trying, at
25 one point, to listen over the phone, with the challenges we

1 had trying to get through the University switchboard and
2 through the teleconference bridge and how it compromised the
3 ability to hear over teleconference, but we will be taking the
4 audio recordings as well as the written transcripts and
5 posting them on the Commission's website when they're
6 available. It might be a couple weeks for the audio and a
7 month or so for the transcript, but those will be available
8 for folks.

9 Other than that, are there any final questions from the
10 Commission before we wrap up? Well, thank you all again very
11 much.

12 CHAIR HURLBURT: Thank you all.

13 12:04:04

14 (Off record)

15 **END OF PROCEEDINGS**

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