



Telehealth in Alaska Hospitals – Identified Issues, Needs & Opportunities October 2014

The following is a brief summary of telehealth issues and needs identified as part of the telehealth collaborative project between the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska Department of Health and Social Services.¹ These were identified through interviews with hospital administrators, research, and hospital training opportunities including webinars and conferences. Also included are ideas and possible strategies for next steps.

Limited Collaboration

- There is no single organization that has a focus on statewide telehealth development. The AK Collaborative for Telehealth and Telemedicine is just getting started. The Telehealth Technology Assessment Resource Center (TTAC) is a national organization, although based in Alaska, and the Alaska Native Tribal Health Consortium (ANTHC) telemedicine program serves only the tribal organizations. This contrasts with other states, such as Arizona, that have focused resources on promoting the development of telemedicine across the state, and consequently have a well-developed network.
- There is interest in learning more about how systems in a competitive market manage to work cooperatively in telemedicine. Some systems are more evolved and sophisticated than Alaska's (e.g. Spokane, Arizona) and it would be good to learn from them how the systems developed and what organization (i.e. university, state or other organization) took the lead.
- There is a need for a "registry" of providers who are licensed and willing to provide telemedicine services to rural hospitals and patients. Creating a telemedicine provider registry would require collaboration and information sharing and an organization willing to take the lead in compiling the information, updating, and disseminating.

Payment/Financing Issues

- Reimbursement issues and questions are significant. There is a need for more information and discussion on how to finance telehealth services and what reimbursement options exist. Payers have been expanding the telehealth services they will cover (e.g. Medicare recently added new physician codes and Premera is working to expand payment for telehealth). Medicaid pays for many telehealth services. The reimbursement for the originating facility is often small making it difficult for rural facilities to develop services that are financially sustainable.
- Payers identified a number of issues: how to share risk and cost of providing case management, difficulty of determining the cost/benefits of various telemedicine options, and payment parity (mandated in many states).
- It's difficult and not optimal to continue the fee-for-service model in a telemedicine environment. Telemedicine may be an opportunity as part of payment reform to increase access to care and improve care coordination and home monitoring.
- Determining the return on investment and sustainability of telehealth services can be difficult, especially with uncertain reimbursement. The cost of telemedicine implementation may be substantial and requires careful analysis to determine feasibility.
- In-home monitoring to promote health among vulnerable populations has a lot of potential and will probably become more prevalent. Similarly, home-based case management using telecommunications may be very useful, especially with "super-users" to reduce hospitalizations.

However, at this point it is difficult for hospitals to make a business case to invest in these types of services without a partnership with payers.

- Although EMR adoption is outside the scope of this project, it is a significant requirement that is costly and time-consuming, and probably is/will be funded from the same resources that telemedicine would/could utilize.

Regulatory Issues

- Online prescribing and provider to patient tele-consultation are considered “unprofessional conduct” and are prohibited by Alaska regulations: 12 AAC 40.967(27) and (29). This is not the case in many other states. At least one payer is seeking to develop direct provider to patient services (using vendor like MD Live) and sees this regulation as a major obstacle.
- There is no “parity” legislation in Alaska, requiring the same payment for telemedicine services as for face-to-face. Many other states have adopted this concept.

Connectivity Issues

- There are numerous issues with connectivity in the state, and many creative solutions. Satellite is taking the place of broadband connection in many communities, but has delays and outages that must be endured.
- Hospitals have access to Universal Service funds (USAC) that significantly reduce the cost of connectivity in rural communities. These funds are essential in Alaska, but it is uncertain how long these funds will be available. The cost of connectivity is significant and without USAC funds, services would be unsustainable in rural facilities.

Technology Issues

- The rapid evolution of new technologies presents great opportunities and great confusion. It can be difficult to choose the appropriate technology to meet identified needs.
- “The devil is in the details.” Some telemedicine applications, e.g. physical therapy, may be very labor, technology, and time intensive. The cost must be balanced against the alternative of not providing the service at all.
- Not all mobile apps are as helpful or useful as their marketing departments would have us believe. Currently, most mHealth interventions lack a foundation of basic evidence, let alone data that would permit evidence-based scale up.
- There are security and privacy issues that have been identified with the remote transmission of patient data. These issues are probably outside the scope of this group to address, but awareness of their existence is important as it may impact the adoption of telemedicine.
- Equipment and other technology applications can be costly.

Training/Human Resource Issues

- Provider engagement is an issue in some communities, as they may have a hard time adapting to technology and understanding the need for it.
- Many hospitals expressed the need and desire for specialty consults by videoconference. Would also like to do pre- and post-surgery consults by videoconference. The challenge is finding the specialty providers willing to deliver care.
- More telepsychiatry support across the state would be helpful.
- Patient acceptance of telehealth is an issue that hospitals will have to address.

Availability of Resources

- There are a number of “readiness assessment” and “need/demand assessment” tools available. These could be useful to hospitals as they emphasize the many facets of readiness; leadership, human resources, technology availability, environment, infrastructure, funding, provider buy-in, etc.

- National and regional resources provide helpful information and advocacy: e.g. ATA, CTEL, TTAC, Northwest Regional Telehealth Resource Center.
- The American Telemedicine Association has developed standards and guidelines for a number of telemedicine applications; many other professional organizations (e.g. CTEL) offer standards, guidelines, and cautions as well.

Next Steps

The following is a summary of some ideas for action for both the short term and the longer term to support continued learning and development of telehealth services by small/rural hospitals in Alaska.

Short Term (1-4 months)

1. Continue to sponsor webinars including: Providence telehealth services offered to Alaska hospitals such as e-ICU and telestroke; payers not able to participate in the telehealth workshop panel - Premera and Medicare; best practices in developing telehealth programs from Spokane and Arizona.
2. Contact Alaska Collaborative for Telehealth and Telemedicine to determine their mission and goals and to consider joining/supporting the group.
3. Assist hospitals with “readiness assessments” for telemedicine if desired.
4. Analyze HB281: "An Act relating to prescription of drugs by a physician without a physical examination." This was transmitted to the governor for signature in August.
5. Determine if there are advocacy issues to present to ASHNHA membership.
6. Begin planning a meeting or conference to explore telemedicine collaboration in a competitive environment. This could have application for the tribal/non-tribal areas of overlap in the state, and various other areas of competition (e.g Anchorage, Southeast Alaska).
7. Disseminate information on the UAS telehealth classes available.

Longer Term (4-12 months)

1. Create a telehealth registry that allows sharing of services, providers, specialists between hospitals.
2. Consider a mini-ATA (American Telemedicine Association) conference, with vendors, presenters, and networking possibilities. Arizona is sponsoring a similar state conference in October in Phoenix (www.ttspsworld.com).
3. Create a “payer work group” to work with stakeholders on regulatory and other barriers, and to promote collaboration and communication. Consider alternatives to fee-for-service and/or telehealth pilot projects in collaboration with payers.
4. Investigate QI data collection challenges to determine importance and legitimacy.
5. Continue to investigate cost/benefits of various telemedicine applications, using information from providers across the state who are using many different applications.
6. Facilitate development of a network of specialty consultants willing to provide care via telemedicine.
7. Explore status and feasibility of home-based monitoring systems.

¹ Project supported with funding from the HRSA Office of Rural Health Policy F-CHIP program, DHSS F-CHIP contract to ASHNHA, and the Denali Commission Rural Policy Analysis project.



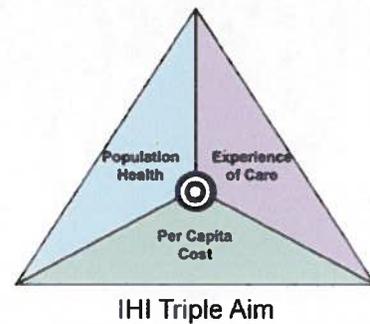
TELEHEALTH: PROMISE AND PRACTICE IN ALASKA

JUNE 2014

This briefing paper defines telehealth concepts, reports some of the current use of telehealth in Alaska hospitals and other locations, and explores possible uses of telehealth in a variety of Alaska settings.

Advantages of Telehealth

Perhaps more than any other recent innovation in health care, telehealth is believed to hold great promise for increasing the likelihood that the American health care system will achieve the Institute for Health Care Improvement Triple Aim:¹ better patient care, improved population health, and lower per-capita cost. According to former Senator Bill Frist, now a senior fellow at the Bipartisan Policy Center, the rapid ascent of the newly empowered health care consumer, and the great advances in information technology together will “channel our chaotic, fragmented, and wasteful health care sector toward a more seamless, transparent, accountable, and efficient system.”² Lee Schwamm of the Partners TeleStroke Network observes that telehealth appears to threaten traditional health care delivery but has the potential to reform and transform the industry by reducing costs and increasing quality and patient satisfaction.³



Telehealth has particular utility in rural and other underserved areas, by connecting patients in remote areas to specialists and intensivists (specialists in critical care medicine) in larger hospitals, while reducing the need to travel to receive services. School-based telehealth has the potential to help schools increase access to health care and collaborate with health care providers, without putting financial burdens on the school.

All Alaskan hospitals use at least some telemedicine applications (typically radiology is outsourced), but they vary widely in their adoption and use of telemedicine. The rapidly-changing landscape will present new opportunities and challenges for Alaskan health systems as more savvy consumers expect increasing convenience and value. Telehealth is often termed a “disruptive” innovation; challenging the health care delivery status quo and fundamentally altering the patient experience.

Telemedicine, Telehealth, Connected Health, mHealth?

The *American Telemedicine Association (ATA)* defines **telemedicine** as the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health

¹ <http://www.ihio.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

² Frist, William H., *Connected Health and the Rise of the Patient-Consumer*. Health Affairs, February 2014, pp. 191-193.

³ Schwamm, Lee H., *Telehealth: Seven Strategies to Successfully Implement Disruptive Technology and Transform Health Care*. Health Affairs, February 2014, pp. 200-205.

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status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

Telehealth is a broader term that often includes telemedicine, health education, and self-management through the internet, although it is often used interchangeably with telemedicine. Patient consultations



via video conferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education, consumer-focused wireless applications, and nursing call centers, are all considered part of telemedicine and telehealth.⁴

Connected health is an increasingly common umbrella term that includes telemedicine, telehealth, and health care delivered by mobile devices, or mHealth. Technology-enabled care is a way to engage patients and provide care using tools that are already familiar, comfortable, and ubiquitous, giving the patient more control over their own health and health care. Mobile devices are also increasingly used in the traditional health care setting, blurring the traditional divisions between home-based telehealth and brick-and-mortar based care.

Delivery Methods

Store and Forward: Clinical information provided through the transference of digital images, sounds, or previously recorded video from one location to another to allow a consulting provider to obtain information, analyze it, and report back to the referring provider at a later time.⁵ Store-and-forward communications primarily take place among medical professionals to aid in diagnoses and medical consultations when live video or face-to-face contact is not necessary.

Live (Real-Time) Consultation: Technology to facilitate a patient visit with both service provider and patient present at the same time; the use of a telecommunications system substitutes for an in-person encounter. Interactive audio and video telecommunications are used, permitting real-time communication between the distant site physician or practitioner and the patient.

Self-monitoring or Testing: Services provided by a telemedicine application based in the recipient's home or mobile device, with the provider only indirectly involved in the provision of the service.

Mobile Technologies

Many existing telemedicine vendors are integrating mobile software for telemedicine using smart phones or tablets, as consumer apps for self-monitoring proliferate. Innovation is happening quickly, with new health care applications available daily (over 2,000 telehealth apps are available in the Apple store). However, there is some concern that regulatory, security, and privacy issues are lagging behind.⁶ Mobile phones and tablets can help make health care more personal and convenient, and are contributing to a rapid expansion in home telehealth applications.

⁴ <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.U49srVldXiM>

⁵ Source: AK Admin. Code, Title 7, 110.625(a)(2012).

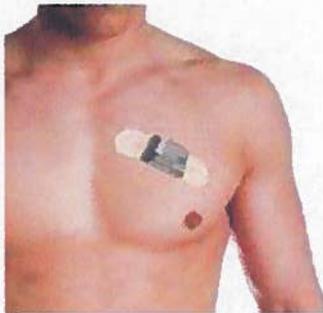
⁶ National Telehealth Technology Assessment Resource Center; <http://www.telehealthtechnology.org/toolkits/mhealth-app-selection>

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Home telehealth is no longer confined to elderly, frail, or homebound individuals. Instead, various cell phone apps and online services now let patients communicate precise information directly to providers. Following are some examples of portable devices or mobile apps (with no assurance of their utility or accuracy) presented simply as examples of the diagnostic and treatment tools becoming available. For example, a photo of a rash, mole, or acne can be sent by text or email to a dermatologist. Or, an otoscope attachment on a smartphone can allow a patient to examine, photograph, and transmit a picture of an ear drum or ear canal (*Figure 1*). Many basic diagnostic tools (e.g. thermometers, blood pressure cuffs) can be easily attached to smart phones to transmit information.



Figure 1: The Cellscope Oto



ECGnano is a programmable ECG device that physicians can use to remotely monitor their patient's physical condition for analysis and diagnosis. ECGnano's wireless module plugs into a disposable patch (*Figure 2*).

Figure 2: ECGnano by SolutionMD

Some smartphone or tablet apps enable healthcare professionals to create custom treatment plans that patients follow on their mobile devices, such as physical therapy exercises. Patients can electronically report program adherence and other relevant information back to the healthcare professional (*Figure 3*).

Blood sugar monitoring devices for diabetic patients that communicate either directly or via Bluetooth technology to a cell phone can collect information on blood sugar levels for a period of time. Once the data is captured, the app allows the patient to email their data via their smart phone's Wi-Fi or cellular signal to the recipient of their choice.



Figure 3: Wellpepper: physical therapy instructions being recorded under the provider's guidance, to be used for exercises back in the home.

There are a number of online consulting services (e.g. consultadr.com, Healthcaremagic.com, InteractiveMD.com, Teledoc) patients can access to receive answers to questions, immediate consultation, an appointment for a telephone

consultation, or an e-consult (*Figure 4*). Some insurance companies have used these or similar online consulting services as a low-cost alternative to enhance access to care outside regular business hours. An analysis of Teledoc visits in California concluded that it appears to be expanding access to younger patients who are not connected to other providers and who are less likely to have used health care before.⁷

Speak to a Doctor

Licensed doctors can help you
by Video, Phone or Email

[click now](#)

Figure 4: InteractiveMD.com

⁷ Uscher-Pines, Lori, and Mehrotra, Ateev, Analysis of Teladoc Use Seems to Indicate Expanded Access to Care for Patients Without Prior Connection to a Provider." Health Affairs 33, February 2014: 258-264.

Pristine EyeSight is a HIPAA compliant video streaming solution built for Google Glass that's optimized for healthcare settings. It can be used for education, wound care, field trauma consultation, and specialty consultations, possibly including surgery and ICU.⁸

Facility-Based Telemedicine



Figure 5: Neurological video consult

In stroke telemedicine, also called telestroke, a vascular neurologist/stroke specialist remotely evaluates people who've had acute strokes and makes diagnoses and treatment recommendations to providers at other sites (Figure 5). Having a prompt neurological evaluation increases the possibility of receiving clot-dissolving therapies in time to reduce disability and death resulting from stroke.⁹ A telestroke network can improve access to stroke care for rural patients. Providence Alaska Medical Center has partnered with Providence Kodiak Medical Center, Providence Valdez Medical Center, Providence Seward Medical and Care Center, Bartlett Regional Hospital, and Central Peninsula General Hospital to provide acute stroke care services to patients in these communities and plans additional partnerships to provide telestroke services throughout the state.¹⁰

The AFHCANcart (Figure 6), developed at Alaska Native Tribal Health Consortium and widely used by the Alaska Tribal Health System, is a compact cart designed to capture data from integrated medical equipment, including a digital camera, spirometer, stethoscope, otoscope, 12-lead ECG, and videoconferencing equipment. The software itself does not require a physical cart to be used, a PC or even a laptop will suffice. It is primarily used to create cases for review by a distant specialist. AFHCANweb is an email-like interface designed for consulting providers. AFHCANmobile is available for Android and iOS, allowing providers to create, view or consult on clinical cases from their smartphone or tablet over Wi-Fi or cellular networks. This helps providers stay connected with their telehealth caseload while they are on the go. Providers also have the option of going to a live videoconferencing session using Vidyo while viewing and sharing clinical information from a telemedicine case.

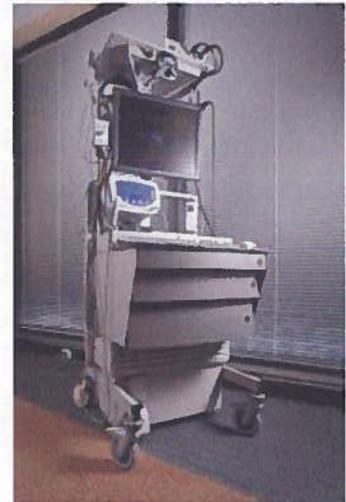


Figure 6: AFHCAN cart



Figure 7: Theranos blood sample

Laboratory services, too, are subject to innovation. Silicon Valley based Theranos needs only a small amount of blood (Figure 7), drawn in the physician's office or at one of their laboratory sites (often located in Walgreens), to perform more than 1,200 different Medicare-reimbursed blood tests at a significant lower cost than traditional laboratory services.¹¹

⁸ <https://angel.co/pristine-1>

⁹ <http://www.mayoclinic.org/tests-procedures/stroke-telemedicine/basics/definition/prc-20021080>

¹⁰ <http://alaska.providence.org/locations/pamc/services/stroke/Pages/emergencystroke.aspx>

¹¹ <http://www.theranos.com/for-providers>

According to Howard Reis at the American Telemedicine Association Conference in 2013, Nighthawk has become the generic term for the practice of having an outside service company read emergency room medical images, primarily at night and on weekends. Nighthawk permits an in-house radiology group or solo practitioner to sleep at night, and offers multi-specialty capability which small staff radiology groups often cannot provide. Over the past few years, a second model has evolved. Dayhawk teleradiology firms have begun to provide daytime radiology services primarily to imaging centers, urgent care companies, mobile medical companies and individual physician offices such as orthopedists and ENT practices.¹²



Figure 8: A telebehavioral health visit

Alaska has the highest rate of suicide per capita in the country, and more than 90% of people who die by suicide have depression or another diagnosable, treatable mental or substance abuse disorder, according to the American Association of Suicidology.¹³ To meet the pressing need for behavioral health services in Alaska, the Alaska Psychiatric Institute (API) launched its Telebehavioral Health Care Services Initiative, “to create, promote, and maintain access to behavioral health services through advanced technology in rural and frontier Alaska.” By offering care to people in or near their home communities, access is greatly enhanced and the risk and cost of travel is reduced. API is connected to more than 200 locations statewide. All across the state, patients and providers can access a real-time videoconference with psychiatrists, psychologists, and social workers in Anchorage.¹⁴ Figure 8 shows an example of a telebehavioral health visit using a laptop computer.

Telepharmacy services are also widespread throughout Alaska. The Alaska Native Medical Center provides remote, secure pharmacy services to small clinics throughout the state. SEARHC and Maniilaq also use telepharmacy (Figure 9) to safely dispense medications and consult with patients and providers in remote locations.



Figure 9: a telepharmacy camera, PickPoint bulletproof medication dispensing machine (similar to a vending machine), scanner, bar code reader, and computer.

Conclusions

The trend of do-it-yourself examinations and tests, and customized applications, are part of a shift in health care toward greater consumer participation and responsibility that began with online health information sites and is accelerating with advances in mobile technology. Consumers see at-home digital tools as yet another level of convenience. Given the inconvenience and lost working hours associated with a trip to the doctor’s office, patients, their employers, and their insurance agencies are increasingly interested in the potential that connected health has for saving time and money.¹⁵

Much of Alaska is rural and isolated, and specialty health care is understandably clustered in urban areas. The cost and risk of transportation to obtain needed health services can be partially offset by

¹² Howard Reis, “Nighthawk v Dayhawk – Two Models for Teleradiology,” American Telemedicine Association Conference, 5/2013.

¹³ http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/AKSuicideStatistics.pdf

¹⁴ <http://dhss.alaska.gov/dbh/Pages/api/telepsychiatry.aspx>

¹⁵ http://www.nytimes.com/2014/04/26/your-money/health-care-apps-offer-patients-a-more-active-role.html?_r=4

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increasing the use of appropriate telemedicine. A robust telehealth system will allow providers to see more patients across the state, mitigating the effects of distance, easing the pressure on rural systems to provide all services to all people, and increasingly putting patients in charge of their own health with familiar, readily accessible tools. By effectively utilizing connected health applications, Alaska has the potential to demonstrate the achievement of the IHI Triple Aim: better patient care, improved population health, and lower cost.

This paper has summarized some of the exciting opportunities and innovations that telehealth can offer to improve health care in Alaska. Follow-up briefing papers will address the challenges faced by Alaska hospitals as they work to expand telehealth services. Many real challenges exist as health care organizations seek to use technology to improve care. Challenges include regulatory, licensing and reimbursement issues specific to Alaska.

More information on telehealth in Alaska is available at the [ASHNHA website](http://www.ashnha.com/policy-and-advocacy/telehealth/) - <http://www.ashnha.com/policy-and-advocacy/telehealth/>

Connected Health: Examples in Alaska Hospitals

Both real-time videoconference and store-and-forward telemedicine modalities are used as care delivery and communication methods for primary care, acute care, and consultations in a wide range of specialties. The following are explanations of some of the ways that connected health is being utilized in Alaskan hospitals, with examples of some hospitals providing or utilizing the service.

Telebehavioral Health – The use of videoconferencing equipment to provide private, secure real-time face-to-face therapy, social work, drug/alcohol counseling, and/or crisis intervention between a provider in a hub site and a patient in a remote location (*Cordova, Ketchikan, Wrangell, Maniilaq, VA, YKHC, API*).

Telepharmacy - The delivery of care via to patients in locations where they may not have direct contact with a . Telepharmacy services include therapy monitoring, remote dispensing, patient counseling, prior authorization and refill authorization for drugs, and monitoring of compliance with the aid of or videoconferencing (*ANMC, Maniilaq, SEARHC*).

Telestroke – The use of telephone, Internet and videoconferencing capabilities by a vascular neurologist/stroke specialist to remotely evaluate patients who've had acute and make diagnoses and treatment recommendations to providers at distant sites (*Bartlett, Central Peninsula, Kodiak, Seward, Valdez*).

v-ICU – The remote monitoring of patients' data in critical care by an expert critical care nurse and board certified critical care physician (intensivist) who analyzes data trends and monitors patients by camera. (*Providence, Kodiak, Bartlett*).

Telerehabilitation – The use of an interactive telecommunication system by a physical therapist in order to provide physical therapy to patients who are located at distant sites (*SEARHC*).

Teleradiology – The transmission of radiological patient images, such as x-rays, CTs, and MRIs, from one location to another for the purposes of sharing studies with other radiologists and physicians (*Petersburg, South Peninsula, Wrangell, Cordova, Sitka, Central Peninsula, SEARHC, Kodiak, Bartlett, Kakanak, Samuel Simmonds, BBAHC, ANMC*).

Teledentistry – The use of digitized and electronically transmitted drawings, diagrams, photographs, and x-rays by a local dental practitioner to a specialist for review and consultation (*Maniilaq, SEARHC, YKHC*).

Tele-Screening for Diabetic Retinopathy – The screening for diabetic retinopathy by electronic transmission of digital photographs of the retina. Often accomplished in a primary care clinic instead of an ophthalmologist's office (*VA*).

Teledermatology – The use of telecommunication technologies to exchange medical information concerning conditions and of the skin over a distance using audio, visual and data communication for diagnoses, consultation and treatment (*ASNA, YKHC*).

Home Telehealth – The delivery of health and education services to patients in their homes by telecommunication devices like the telephone and telecommunication-ready healthcare monitors to check on symptoms, measure vital signs, and provide case management. Daily readings are often transmitted by the patient to a central call center where outliers are quickly identified for follow-up services (*VA*).

Patient Education – The use of videoconference technology to connect dietitians, nurses, and health educators to patients to provide nutrition and other patient education and supportive services (*Kodiak, SEARHC, VA*).

June 30, 2014

Bill Streur, Commissioner
Alaska Department of Health and Social Services
3601 C Street
Anchorage, Alaska 99503

BY EMAIL AND FIRST CLASS MAIL

Re: Streamlining Initiative Report

Dear Commissioner Streur,

At the start of the year, the Advisory Board on Alcoholism and Drug Abuse (ABADA), Alaska Mental Health Board (AMHB), and Alaska Behavioral Health Association (ABHA) began an initiative with the help of our partners in the Division of Behavioral (DBH) and several representatives from behavioral health providers throughout Alaska. The purpose of the Streamlining Initiative was to examine why we are doing what we are doing and determine if the administrative cost outweighed the benefit to the client and their family, the community, and the State.

We started with an ambitious set of objectives – to survey Federal and State law and regulation, examine requirements from our national accreditors, and review current policy and procedures. We reviewed requirements, collected information from two larger workgroup meetings, worked with individual providers on their data collection and processes, and solicited input from key informants for more in-depth information. Our aim was to deliver a product that could immediately be put into practice to improve our system's efficiency and effectiveness. It was important to us that we deliver this final report to you on time.

The Streamlining Initiative provided two distinct benefits. Working with the people who collect data from clients, prepare for site visits and audits, and input data into our systems, we learned how their efforts inform the system and helped close the gap between their efforts and our collective intention. Comparing current practice against requirements and standards helped us quickly identify activities that were not contributing to quality service delivery.

We encourage the Department to consider a system where information about how we might improve efficiency and effectiveness is continually collected and periodically, and purposefully, analyzed. We recognize there will be resistance to change (there always is), but we believe the enclosed findings and recommendations will improve our system of care by focusing on what is important rather than what is familiar. We conferred with leadership from the Division of Behavioral Health on these recommendations, and it seems that the greatest consensus and opportunity for immediate implementation exists around policy recommendations. We look forward to the more public discussion on other proposed changes.

On behalf of the entire workgroup who dedicated time to this project in a sincere effort to improve the quality and efficiency of our behavioral health system of care, we provide the following 11 recommendations from the Streamlining Initiative.



Kate Burkhart
AMHB and ABADA



Tom Chard
ABHA

cc: Craig Christenson, DHSS Deputy Commissioner
Albert Wall, Division of Behavioral Health, Director



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

**Department of
Health and Social Services**

DIVISION OF BEHAVIORAL HEALTH
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MEMORANDUM

DATE: June 30, 2014

TO: William J. Streur
Commissioner

THRU: Craig J. Christenson
Deputy Commissioner

FROM: Albert E. Wall *AW*
Director

SUBJECT: Streamlining Initiative

At your request, the Alaska Mental Health Board, in cooperation with the Alaska Behavioral Health Association, has finalized a report concerning the Streamlining Initiative (Initiative) for the Division of Behavioral Health (DBH or the Division). As you know, the Initiative was 1) to identify the various reporting requirements placed upon grantees of DBH, 2) to identify areas where reporting requirements were too stringent or duplicative, and 3) to make recommendations concerning potential changes that may streamline the reporting process.

The Division of Behavioral Health would like to extend its thanks to the Alaska Mental Health Board and to the Alaska Behavioral Health Association for the thorough work they have done on this project and for reaching out to many different types of grantees for their input. I would particularly like to thank them for the matrix they put together that summarizes statutory, regulatory, and other reporting requirements in one place for reference. Some of the recommendations in their report are changes that DBH has already started to initiate or have been in progress and can be sped up to implement. Other recommendations will take time and consideration to evaluate and develop.

The Division has a vested interest in both adequate reporting for tracking performance based measures and program management AND making those requirements realistic for the wide variety of grantees we support. We are committed to continuing to work with our grantees as we address issues of reporting and streamlining.

STREAMLINING INITIATIVE
RECOMMENDATIONS
JUNE 30, 2014

Summary:

The purpose of this Streamlining Initiative is to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) on ways to consolidate information gathering and documentation practices that comply with federal and state law, regulation, and policy while reducing administrative burden. The scope of work and methodology used are attached (*see Appendix A*).

This process helped clarify what was required of providers and the State of Alaska and why. Closing the gap in understanding and practice about activities and intended outcomes helps improve effectiveness and ensure efficiency. It is strongly recommended that this analysis be repeated periodically and that an interim mechanism be established to collect input on potentially ineffective and inefficient requirements.

Recommendations (overview):

- 1) Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports
- 2) Eliminate Logic Models in Grant Application and Reporting Process
- 3) Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports
- 4) Eliminate Pro Forma Quarterly Narrative Reports
- 5) Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)
- 6) Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS
- 7) Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040
- 8) Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits
- 9) Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort
- 10) Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services
- 11) Eliminate Discharge Requirement for SMI Clients

Recommendation (detail):

Recommendation 1: Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports

The data elements required in quarterly reports for the Comprehensive Behavioral Health Treatment and Recovery Grants, as well as specialty service grants, revealed that at least 40% of the information submitted by grantees each quarter was duplicative of information already entered by grantees into AKAIMS. (See Exhibit A.) These reporting requirements are in addition to the quarterly AKAIMS Summary Report required of grantees.

DHSS and the provider community have invested significant resources in developing AKAIMS and learning how to use it effectively. There are providers currently taking advantage of AKAIMS functionalities in their quality assurance and improvement efforts. However, the current grant management and reporting structure does not effectively use this resource, instead creating redundant processes for both DHSS staff and providers.

We recommend that quarterly grant reports focus on information not already available through AKAIMS. Report elements such as the number of client demographics; clients admitted, served, and discharged; referrals to and from other agencies; client employment and housing status, etc. are all available to DHSS grant managers through AKAIMS. We recommend that DHSS staff use the information available contemporaneously in AKAIMS for ongoing management and monitoring of grantee services. We also recommend that provider managers use AKAIMS for program management and monitoring.

What is not available to DHSS staff is the information about the agency itself and the community/communities it serves. See Recommendations 3-4 for more on enhancing narrative reporting value to providers and DHSS.

Recommendation 2: Eliminate Logic Models in Grant Application and Reporting Process

There is little evidence that the logic model framework used for grant application and reporting adds value to either the providers' management of treatment programs or DHSS management of the overall behavioral health system. While DHSS has supported, and continues to support, use of logic models, the department has shifted focus and resources to a core service and results-based accountability (RBA) framework. (See Exhibit B.)

The Division of Behavioral Health is working to align the long-standing Performance Based Funding system with the indicators and measures adopted by in the departmental RBA framework. As these efforts appear to be far more likely to support effective management and

quality improvement within the behavioral health system that the logic model framework, we recommend that:

- a) Logic models no longer be required for applying for any behavioral health treatment grant from DHSS;
- b) Logic model reporting no longer be required of behavioral health treatment grantees;
- c) Providers be informed about the DHSS core service and RBA frameworks at the Fall/Winter Change Agent Conference;
- d) Providers be given the opportunity to participate in current efforts to align the Performance Based Funding system with the RBA framework;
- e) The treatment grant application and reporting process be aligned with the core service and RBA frameworks in a way that is efficient for and provides value to DHSS and providers.

Recommendation 3: Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports

Currently, all treatment grantees must submit a Community Action Planning report. This results in a pro forma process by grantees with multiple submissions of the same report every quarter. As discussed above, the opportunity to collect more substantive and timely information about the context and environment in which providers operate through narrative reports can be gained by reducing requirements that do not add value to either side of the reporting relationship. We recommend that locally designed, comprehensive community action plans be submitted, as required by state law (AS 47.30.530(a)(8); AS47.37.040(1)), with grant applications and then reported on at the end of each fiscal year. We also recommend that DHSS allow this information to be submitted by one party on behalf of the entire Community Action Planning Team/Group to one point of contact within the department.

Recommendation 4: Eliminate Pro Forma Quarterly Narrative Reports

Information about recruitment and retention of staff, continuing education needs, changes in board leadership, community need, the effect of changes made to the larger behavioral health system as well as within the community, and unexpected developments (sudden resignations, financial issues, natural disasters, etc.) is important for the effective management of the behavioral health system but is currently not well collected. We recommend that grantees be asked for more substantive grant narratives, in a format flexible enough to permit a true picture of the context and environment of their practice to be shared. We recommend that grantees continue to provide the minutes/records of full board and board committee meetings to DHSS –

and we also recommend that DHSS grant managers attend (in person or telephonically) the board and finance committee meetings of providers for which they are responsible.

Recommendation 5: Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)

We recommend adjusting the required administration of the CSR after admission to every 6 months, or removing the requirement to update the treatment plan after each CSR, for adult clients. Federal reporting standards require information collected on the CSR every six months.¹ While there may be benefits from the decision to collect the information more frequently (every 90-135 days per 7 AAC 135.100(c)(6)), the cost to providers and clients has proven substantial.

With the increased frequency of CSRs comes the requirement of more frequent updates of treatment plans (7 AAC 135.120(a)(6)). While providers report that completing the CSR with clients can take just 15 minutes, updating the treatment plan takes an average of 1 hour per client per clinician. For medication management only clients (adults experiencing SMI who are stable), the requirement to update the treatment plan is often without any clinical significance and/or resisted by these clients. The additional burden of CSR and treatment planning – absent any clinical basis for the updating of the treatment plan – results in a significant reduction in clinical capacity and access to services.

The benefit of more frequent CSRs must be weighed against the cost to the client, provider, and State. Without compelling evidence of the clinical benefit of the more frequent treatment planning schedule, we recommend that DHSS separate the requirement to update the treatment plan from administration of the CSR or collect information every 6 months only.

Recommendation 6: Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS

AKAIMS data is not as precise as it could be. Currently, grantees are asked to enter data for clients that are receiving services paid for with public resources *as well as* for those who pay for their own treatment or whose treatment is paid for by private insurance or other means. As a consequence of this policy, data does not accurately describe the behavioral health system managed by DHSS.

¹ Core Client Outcome Measures (reflected in the National Outcomes Measures (NOMS)) reporting is required by the Government Performance Results Act (GPRA) and GPRA Modernization Act of 2010 (GPRAMA), which require the Substance Abuse and Mental Health Services Administration to set program-specific performance targets, to measure program performance on a regular basis against those targets, and to report annually to Congress on the Agency's results. Block grant recipients must comply with NOMS reporting requirements.

The current policy – reporting on all clients – is not fairly enforced. Tribal behavioral health providers have consistently argued against reporting on services delivered to customer owners/tribal members funded exclusively by the Indian Health Service or by non-state payers. Those tribal providers who have chosen not to report all behavioral health clients through AKAIMS have not reported any penalty or funding consequences. Thus, this policy creates an unfair and disparate burden on community behavioral health centers not affiliated with tribal authorities.

In addition to being inconsistently implemented, the current policy creates a barrier to developing third party and other reimbursement streams. Providers are required to collect information and complete processes that are not reimbursed by private payers, and that inconvenience clients used to the private behavioral health system. The policy has been identified as an impediment to achieving the obligation to determine individuals' and private payers' shared role in the behavioral health system.

We recommend that DHSS withdraw the requirement for AKAIMS reporting on all clients served. Instead, providers should be required to report the minimum data set only on clients that are a) Medicaid eligible; b) Medicare eligible; or c) receiving services at reduced or no cost pursuant to a Comprehensive Behavioral Health Treatment, specialty service grant, or other funds from DHSS.

Recommendation 7: Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040

Service Authorizations were originally intended to act as a Prior Authorization of services, to help ensure that only medically necessary services were delivered to Medicaid eligible individuals. Current practice – by providers and the Division of Behavioral Health – has evolved to make this process moot, while still achieving the intent of cost containment and ensuring only medically necessary services are provided.

Providers must submit a service authorization any time services exceed the annual service limit. Originally, these Authorizations were contemplated as occurring before services were initiated (serving as Prior Authorizations). However, given the needs of the client population served, services are typically begun even before the authorization was received.

Current business practice is that Service Authorizations are typically submitted as clients begin services or while services are ongoing. This results in a shifting of risk from the State of Alaska to providers, who assume financial responsibility for services delivered pending authorization.

Providers report that, prior to the transition to the new MMIS system, Service Authorizations for behavioral health Medicaid services were denied at an extremely low rate. Troubleshooting efforts during the MMIS transition have included automatic approval of certain types of service authorizations, rendering this process a pro forma requirement in many instances.

The low denial rate for Service Authorizations and the use of automatic approvals of service authorizations during the current MMIS situation lead to the recommendation that annual service limits for standard clinical and rehabilitative services be raised based on review of the actual Service Authorization data from FY2012-2014. Service Authorizations require an immense amount of time and effort from providers, DHSS, and Xerox – without actually serving as the mechanism to contain costs and ensure only medically necessary services are provided.

Providers report that the majority of clients' treatment plans show medically necessary services exceeding the current regulatory annual limits. We recommend that the Division of Behavioral Health and Health Care Services work together with providers to determine annual service limits pursuant to 7 AAC 135.040 that are more aligned with the medically necessary treatment needs of clients served, with the goal of reducing the need for pro forma Service Authorizations. We also recommend that DHSS explore whether Service Authorizations for standard behavioral health services (therapy, etc.) provide any value to the system (and if not, act to remove the requirement entirely). This recommendation does not extend to travel/transportation or pharmacy/prescription prior authorization processes.

Recommendation 8: Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits

Behavioral health providers are subject to a variety of site visits and audits by state, federal and accrediting entities. DHSS is required by law to “visit each [mental health] treatment facility at least annually to review methods of care or treatment for patients” (AS 47.30.660(b)(11)), investigate patient complaints (AS 47.30.660(b)(12)), and “inspect, on a regular basis, approved public and private [substance abuse] treatment facilities at reasonable times and in a reasonable manner” (AS 47.37.140(b)).

The director of the Division of Behavioral Health has asserted that providers should look forward to visits from DHSS staff. However, state audits and site visits have come to be seen as punitive and laborious by providers, especially when multiple audits and site visits occur at the same or within a short period of time. These visits can divert scarce resources from treatment services, so every effort should be made to reduce the overall number and impact to clients and providers.

These authorities are interested in the same (or very similar) information. Audits frequently overlap, and site visits occur at times that do not take into account staff capacity or other

authorities' visits. Findings from the site visits and audits, presumably meant to improve quality of care and compliance, are delayed for sometimes years with little to no communication providing updates.

We recommend that DHSS develop clear and concise policies outlining both the process and intended outcome of DHSS audits and site visits – to include standardized information gathering and reporting protocols. We also recommend that DHSS designate a coordinator of state audits and site visits of behavioral health providers, to ensure coordination and reduce the number and overlapping nature of efforts. We recommend that the coordinator and behavioral health program manager work together toward consistent information sharing with providers – and to allow providers to elect to share information from audits/site visits with their colleagues if it promotes system improvements.

Recommendation 9: Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort

National accreditors, specifically those expressly required in regulation governing delivery of behavioral health services, are independent and well-respected experts in the field of quality assurance and continuous quality improvement for behavioral health services. The Joint Commission has been recognized as the leader in health care standards of care and accreditation for over 50 years. CARF has international experience and recognition related to accrediting substance abuse treatment providers and human services facilities. The Council on Accreditation, founded in 1977, specializes in behavioral health and family-services accreditation. These accreditors constantly solicit input from the industry and revise their standards to keep pace with national trends.

DHSS has mandated accreditation – to ensure Alaskans receive the best services possible. However, DHSS continues to engage in quality assurance efforts that duplicate those of the accreditation processes that behavioral health providers spend a lot of money, time and effort to go through. We recommend that DHSS deem all duly accredited providers as meeting the requirements of Title 47 related to being “approved” treatment facilities under the Uniform Alcoholism and Intoxication Treatment Act and/or the Community Mental Health Services Act.

Recommendation 10: Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services

Not all people who seek services from community behavioral health centers are within priority populations. A significant number of people seeking services are eventually determined to have mild or moderate disorders (if their problems even rise to the disorder threshold at all). Thus any services delivered are not eligible for reimbursement.

Providers' current practice is that every person who presents for services complete a standard intake including screening (AST) and assessment, an initial CSR, and a treatment plan before services can be offered. The actual amount of time spent on the intake process can easily exceed the value it offers when dealing with individuals needing only brief direction (non-clinical referrals up to very brief case management, etc.) or who decide that they do not want to enter treatment.

It appears that short-term brief crisis intervention services can also be provided to adults experiencing emotional disturbances (*see* 7 AAC 135.020), which would allow providers to address the needs of these clients without incurring unreimbursed costs. We recommend that DHSS clarify whether and how these short-term brief crisis intervention services can be used and then offer training to providers on appropriate use of this service type. If this service type does not offer a solution to this problem, we recommend eliminating the requirement for enrollment prior to brief non-emergency services.

Recommendation 11: Eliminate Discharge Requirement for SMI Clients

Both the federal government and DHSS have committed to the integration of behavioral health and primary care services as a way to improve client health outcomes. This integration of health care requires alignment of clinical and business practices, as well as state policy and regulation. One concrete example of where behavioral health policy is contrary to the practices and policies of integrated care is the emphasis on discharge/disenrollment.

In the context of primary care (physical health), a person is encouraged to have a consistent provider whom they see on a regular basis (not just when he is sick). For those individuals with chronic health care conditions, like diabetes, this stable ongoing health care relationship is even more strongly encouraged. Thus, a primary care patient is "empaneled for life" (or until they move to a new provider or die).

In our system, the emphasis is on discrete and time-limited episodes of care rather than providing services for on-going mental and emotional health care. Not only is this emphasis out of sync with the larger health care perspective, it does not reflect the dynamic and variable nature of recovery for people experiencing behavioral health disorders. Neither does this policy create an environment that promotes individual help-seeking when there is a risk relapse or crises (or after relapse/crisis).

Requiring discharge of clients creates an unnecessary burden on providers who must re-empanel clients who return for services. Providers have access to clients' information and clinical histories through AKAIMS and their own clinical records. Yet providers must begin all over

again with a client who has not recently accessed services, instead of more efficiently updating the client's information and moving more quickly into services.

Medicaid eligible Alaskans receiving primary care services, or services for chronic health conditions, are not required to "start from scratch" each time they seek services. Therefore, this policy treats Medicaid recipients and Medicaid providers differently on the basis of disability.

We recommend that DHSS eliminate those policies and requirements that prevent behavioral health clients from being "empaneled for life" and having ready access to necessary services as needed. This recommendation will allow DHSS policies and practice to better support integration of health care, acknowledge and support the unique nature of recovery in behavioral health, and provide for equitable treatment of Medicaid recipients and providers across the health care system.

For Ongoing Streamlining Efforts:

- **Recommendation 1: Develop Suite of Standardized Forms That Meet All State, Federal, Accreditor Requirements**
- **Recommendation 2: Develop Guidance Documents for Implementation of Electronic Health Records in Conjunction with AKAIMS and the Health Information Exchange**

These were intended deliverables from the Streamlining Initiative. Unfortunately, the ambitious scope of work exceeded the six-month timeframe. The Streamlining Initiative has begun comprehensive review of providers' forms and documents, in order to determine what elements will meet the needs of all entities exerting oversight. The Streamlining Initiative has also begun intensive stakeholder interviews about the use of AKAIMS and EHRs. The Alaska Behavioral Health Association, the Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse will continue to work with Initiative partners and DHSS to develop these forms and guidance documents for consideration.

Appendix A

APPENDIX A

AMHB AND ABADA STREAMLINING INITIATIVE

PROPOSED SCOPE AND WORK PLAN

Purpose:

The purpose of this Streamlining Initiative is, by building and expanding upon similar efforts, to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) of ways to consolidate information gathering and documentation practices to comply with federal and state law, regulation, and policy while reducing administrative burden. We intend to complete this work by June 30, 2014.

Scope of Work:

1. Identify all federal and state laws and regulations governing intake, assessment, treatment, and discharge policies and practices.
2. Identify all policies and expectations related to intake, assessment, treatment, and discharge required by accrediting bodies (Joint Commission, CARF, etc.).
3. Create a comprehensive list of baseline information required by law, regulation, and accreditation.
 - a. Identify the reason such information is collected.
 - b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
 - c. Identify data elements that contribute to trend analyses.
4. Create a comprehensive list of information needed to meet state policy and/or accepted standards of care.
 - a. Identify the reason such information is collected.
 - b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
 - c. Identify data elements that contribute to trend analyses.
5. Define the current "minimum dataset" and recommend any changes.
6. Acquire and review all intake, assessment, treatment, and discharge forms and policies currently implemented by Alaska behavioral health providers.
 - a. Identify those components that meet requirements of law and accreditation.
 - b. Identify those components that meet policy and standard of care expectations.
 - c. Identify additional components to meet requirements of law and accreditation.
 - d. Identify additional components that meet policy and standard of care expectations.
7. Quantify the cost of collecting data and information under current structures.
8. Review all AKAIMS data fields.
 - a. Identify those components that meet requirements of law and accreditation.
 - b. Identify those components that meet policy and standard of care expectations.

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- c. Identify additional components to meet requirements of law and accreditation.
 - d. Identify additional components that meet policy and standard of care expectations.
9. Develop a suite of standardized and accessible model intake, assessment, treatment, and discharge forms that comply with legal and accreditation requirements.
 - a. Develop standard language for treatment plans and other documentation that meets legal and accreditation requirements.
 10. Identify AKAIMS data fields that can be removed or made optional.
 11. Identify AKAIMS data fields that should be added to meet legal and accreditation requirements.
 12. Quantify the cost of collecting data and information under recommended structures.
 13. Develop guidance documents related to behavioral health electronic health records and the health information exchange to promote streamlining.
 - a. Identify business practices to promote efficient and effective use of AKAIMS

Timeline: (dates are "by when")

February 5, 2014	Invitations to participants
February 10, 2014	Federal and State Requirements Identified (DBH,Boards)
February 17, 2014	First work group meeting – focus on statutory authority
February 28, 2014	Accreditation Requirements Identified (ABHA)
March 10, 2014	Second work group meeting – focus on accreditation requirements
March 31, 2014	Provider intake etc. paperwork acquired, provided to work group (ABHA)
April 30, 2014	In-person third work session – minimum data set (10-4:30)
May 15, 2014	AKAIMS data fields provided (DBH)
May 30, 2014	In person fourth work session – AKAIMS recommendations (10-4:30)
June 5, 2014	Draft standardized forms, tools to workgroup
June 15, 2014	Fifth work session – review draft forms, recommendations
June 25, 2014	Draft of all recommendations, tools to work group
June 30, 2014	Approval of work group products to forward to DHSS

Streamlining Initiative Participants

Representing	Agency	Contact (lead in bold)
Behavioral Health Providers	ABHA	Tom Chard, Co-Chair tom.abha@gmail.com
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