Prepared for:

ALASKA MENTAL HEALTH TRUST AUTHORITY
550 WEST 7TH AVE., SUITE 1820
ANCHORAGE, ALASKA 99501

Alaska Behavioral Health Integration Stakeholder Committee Report

Section II – Recommendations Detail

June 1, 2004

Information Insights, Inc.
212 Front Street, Suite 100
Fairbanks, Alaska 99701
(907) 450-2450
http://www.infoinsights.com

Contents

Overview from Section I

In 2000, the Department of Health and Social Services Division of Mental Health and Developmental Disabilities (DMHDD) and the Division of Alcoholism and Drug Abuse (DADA) collaborated with the Alaska Mental Health Board (AMHB) and the Advisory Board on Alcoholism and Drug Abuse (ABADA) to establish a Steering Committee comprised of representatives from the spectrum of the behavioral health service delivery system in the state.

The mandate of the Steering Committee was to build upon previous pilot efforts by the Rural Mental Health Providers and by Alaska Psychiatric Institute to develop a framework for improving integration of mental health and substance use disorder treatment for individuals with co-occurring disorders throughout the state, with an emphasis on improving access and outcomes, and increasing efficiency of resource utilization.

The Steering Committee commissioned a comprehensive study of this issue, resulting in the completion and dissemination of a formal report – Substance Abuse/Mental Health Integration Project Final Report – in 2001. These efforts provided a foundation for the 2002 development of the co-occurring screening tool, and for new training efforts. The Department Implementation Team developed a Consensus Document containing specific recommendations for implementing a range of state level system change strategies to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals with co-occurring disorders.

As the new State administration moved to consolidate state-funded services in early 2003, specific steps were taken to move swiftly toward integrating mental health and substance abuse services. These steps included the merging of the mental health services portion of DMHDD with DADA into one state division – the Division of Behavioral Health (DBH), with the eventual goal to the extent possible, of merging the service delivery system as a whole.

The process of integrating the mental health and substance abuse service delivery systems is recognized as having far-reaching ramifications for all parties involved, especially for service providers and persons receiving those services. The Alaska Mental Health Trust Authority (the Trust) and the new DBH felt it was critical to involve service system stakeholders in the process of planning for system change, and formed the Behavioral Health Integration Stakeholder Committee.

This report provides an overview of the work of that committee. Section I, the Report Summary, details the membership, process, purposes and goals of the Stakeholder Committee, provides an executive summary of the committee's work, and outlines the recommendations of each of the committee's eight work groups. It concludes with a mission statement and set of core values for Alaska's behavioral health system offered by the committee as a starting point for discussion.

Section II, the Recommendations Detail, provides the background and details to the recommendations outlined in Section I.

Communications

COMMUNICATING THE BEHAVIORAL HEALTH STAKEHOLDER INTEGRATION PROCESS[1]

The work group recommended two key means of communicating project progress:

- The project should distribute periodic single page information fliers by listserv throughout the life of the project, to include wrap-up. The use of other media should be considered to publicize the project outcome and a toolkit developed to addresses whys, wherefores, and how to's at the end of the process.
- Formal public input into the BH Stakeholder process is key. This should include a specific and well publicized public comment period at the November 20-21, 2003 face-to-face meeting (in addition to the web cast and teleconference lines).

The final message communicated to those with an interest in the project should cover:

- Project description and purpose;
- Project's affect on individuals, organizations, and systems;
- Project process and activities;
- Project outcomes.

Feedback from the community on all of the above elements should be a key part of the project. A key part of the toolkit addressing most of these will be a comprehensive set of frequently asked questions (FAQ).

The group reviewed and modified a grid listing target audiences by category. Grid categories broke down audiences into about ten groups of related organizations, a number of which are not represented on the BH Integration team or work groups at this time. The grid also cataloged means of communication, which led the group to discuss what means of communication most effectively reached specific audiences. For example, legislators are a key audience that likely will most effectively be reached through one on one communication. Key information disseminators should be identified for each major group. This information will be useful in developing an ongoing communication plan.

The group requested that Information Insights (with approval of the Behavioral Health Integration Steering Committee) undertake two tasks as soon as possible and this was accomplished:

[1] The recommendations in this section were met during the committee process

1. Develop a comprehensive listserv of organizations and individuals that should know about the project's mission, goals, and progress on an ongoing basis. The work group list of target audiences was the basic source for this listserv.
2. Proactive outreach was achieved by the development and distribution via the listserv of periodic one-page project information sheets detailing project mission, goals, and progress. The info sheets also included information on who's involved to date, how others can become involved, and how to find other information and to communicate with the project.

ONGOING BEHAVIORAL HEALTH COMMUNICATION PLAN AND RESOURCES

The work group did not have the time to address a communications plan for Behavioral Health, but passes along resources to necessary to plan development. In addition, to its work on audience and media, the work group identified the key tools for communicating information about services, access to services, and services change. These are a resource guide, a web site, and a newsletter. Each is addressed below separately, but the three should be deployed as elements of a coordinated communications strategy.

Behavioral Health Resource Guide

The Communications Work Group recommends the design and production of a Behavioral Health resource guide. The guide should use the mental health resource guide produced by the AMHB as a model. In general, the work group endorses format and content of the AMHB guide, with additions and variations:

- Expand focus to behavioral health.
- The guide should be available and distributed in hard copy, which has a comparatively short shelf life, but is vital to reaching certain groups of people, such as homeless or transients. It should be updated regularly, perhaps annually.
- The web version of the guide would be kept updated on a close to real-time basis.
- Initial editions of the guide should highlight changes wrought by service integration.
- The web guide should include current information on meetings of entities such as the AMHB, ABADA and the Trust, with web links to those organizations. Both guides should encourage consumer/family and other participation in the advocacy forums.
- The guide should highlight upfront the philosophy that treatment pays dividends and that recovery is an achievable goal, despite relapses.
- The hard copy guide should be distributed by mail, at conferences, through agencies, etc.
- Outside sponsors should be sought to defray production and distribution costs.

Behavioral Health Web Site

The work group evaluated the utility of the DBH Web Site as a source of information on services, access to services, and changes in services:

Format

- The website format should be simplified and user-friendly for both providers and consumers/families. The ABADA web site was identified as a model of simplicity and utility. One way to achieve simplicity is through use of recognizable symbols.
- Use of pictures should be appropriate - smiling children may send a message that does not draw consumers in.
- Overuse of Alaska Natives in web page graphics many convey the message that services are focused predominantly on Natives.
- The web site should feature the resource guide prominently.
- Minimize number of links.
- Have a meetings page.
- The committee recommended that a feedback loop be incorporated in the website so that service users can provide direct feedback to DBH and so that service users can tell their story and provide on-line support to each other.

Content

- The web site home page should contain only basic information; too much information is an obstacle.
- A judicious number of links on the home page should lead viewers to help; advocacy boards; and other useful links.
- Site content should be geared to providers, consumers and to other interested parties.
- FAQs are useful, but should be geared to folks with perhaps limited knowledge about the system and services. Additional links would take interested users to more specific information.
- The web site should feature an emergency phone number on the home page.
- A community locator with map icon would facilitate a quick search for services by community (rendering the resource guide into electronic form).
- Keep the content Alaska-focused.

Newsletter

- A newsletter should be available both in paper and electronic format and used to draw attention to news and specific topics as appropriate.
- The newsletter should be general enough to be useful to different audiences, leading them to more specific information if needed.
- The newsletter should be published on a regular schedule rather than event driven.
- Format should be simple, including pictures.
- Community input to newsletter should be encouraged - providers/consumers/etc.; perhaps through a Bulletin board feature

Committee Note: When providing information about Behavioral Health service it is important to keep in mind the distinctions and differences between mental health and substance abuse services and communicate those differences.

Outcomes

OUTCOMES WORK GROUP'S BASIC FRAMEWORK

Definitions

- **Life Domains**: broad areas of life needs common to all individuals (Ex:, food & clothing, safety, health, housing, productive engagement)
- **Results**: A condition of well-being within the life domain areas for children, adults, families or communities (Ex: individuals free of mental illness)
- **Indicators**: measures which help us quantify the achievement of a result (Ex: suicide rate)
- **Strategies**: program service areas or projects that are intended to impact indicators, are evidenced based, and that use performance measures to evaluate effectiveness and efficiency
- **Performance measures**: measures of how well agency or program service delivery is working (Ex: Our project reduced the rate of suicide for their targeted communities by 50 per cent)

Planning and evaluation should:

- Be simple, easy to describe, reviewed frequently by the boards, the Trust and the division throughout the year and be shared with the public and legislature
- Provide a basis for developing state budget recommendations

- Provide both a short term (annual) and long-term (5 to 10 years) agenda for program priorities & budget development, and for further planning and evaluation.
- Begin with broad statewide population-based life domain and result areas and related indicators that measure the "wellness" of our state, regions and communities.
- Quantify statewide behavioral health needs,
- Identify evidenced-based strategies of service delivery
- Monitor performance measures that measure the effectiveness and efficiency of agency and program service delivery
- Have a data development agenda to ensure that data sources are in place to measure the above with sufficient frequency for good planning, evaluation and budget development
- Be done collaboratively between the AMHB, ABADA, the Trust and DBH in a way that all use similar planning and evaluation constructs, identifying need and reinforcing improved evaluation and service delivery

Cross walk of life domain areas (Attachment #1)

- Ensures that the Trust, AMHB and ABADA are using a common language and construct and therefore enhances the communication power of all
- Acknowledges that each board may want to delve deeper into subcategories of life domains for special populations

Life Domain & Result Area Indicators measuring the behavioral health "wellness" of Alaska (Attachment #2)

Document provides a beginning array of indicators that have been utilized in the past or are identified as having:

- **Communication power**: communicates well with the general public,
- **Proxy power**: represents well changes in the life domain/result areas
- **Data power**: are gathered frequently enough to assist in planning, evaluation and budget development

SUGGESTED PERFORMANCE MEASURES FOR DBH

The work group felt that performance measures should:

- Provide an estimation of need

- Be simple and representative
- Be focused on recovery
- Measure improvements and degradations in client/consumer life domain areas and measure overall wellness with a consideration for those in and out of the system.

Client Status Review Domains Form (Attachment #3)

- Should be part of AKAIMS and required of all providers
- Deemed as critical for understanding the effectiveness of all behavioral health programs and for measuring client/consumer recovery
- Should be utilized at admission, during treatment, at discharge and for at least a year after discharge

Ensuring AKAIMS Reports are helpful in program evaluation & policy making

DBH should ensure that sufficient data fields are available within AKAIMS, and that these data fields are required by **all** substance abuse and mental health providers via AKAIMS or via Electronic Data Interface (EDI) if the provider is using a different MIS than AKAIMS, to ensure at least the following reports:

- Report that sorts by provider program components, client characteristics & life domain improvements
- Report of provider and their service components by legislative district/census area
- Report of staffing levels and credentials by component and provider
- Report of Service delivery staff (full-time equivalents – FTEs) in each component vs. no. of clients in each component
- Report of admissions & types of terminations by client characteristics by component/provider
- Report of bed and outpatient slot utilization by each component & provider
- Referrals in/out of program and follow-ups that are completed with follow-up results

OTHER COMMENTS ON EVALUATING BEHAVIORAL HEALTH SERVICES

ABADA, AMHB, DBH and the related providers should work toward increased equal consistency in quality assurance and evaluation between substance abuse & mental health. Should be done with understanding that different special populations will have different levels of recovery due to chronicity and severity of presenting problems

DBH Quality Assurance should be to ensure:

- **Safety**: public, client and staff safety
- **Recovery**: i.e. life domain improvements among consumer/clients
- **Consumer/client satisfaction**

DBH should partner with the AMHB, ABADA and the Trust to balance the mix of externally managed evaluation with division-managed or provider-managed evaluation.

- **Externally managed**: Periodic spot checks that are scientifically valid, correlated with national research efforts, done independently from the providers and the division
- **Division managed:** DBH should do quality assurance on:

    - Life and safety,
    - Compliance for licensing and certification, and
    - Utilize AKAIMS data for ensuring recovery and consumer satisfaction.

    DBH should manage AKAIMS and reports generation for policy makers and encourage and train for effective use of AKAIMS as a management tool by providers

- **Provider managed**: use AKAIMS to monitor efficiency (staff, bed or outpatient slot utilization, etc.) and effectiveness (tracking client recovery and consumer satisfaction) within their organizations

Focus: No Data Black holes! – "If we aren't using data then we should quit gathering data"

Continuity of Care

Continuity of Care Group Recommendations

- As core services are looked at they need to be defined from a behavioral health viewpoint. They need to include both substance abuse and mental health issues. (One of the questions the committee discussed was, "at what level does service happen? Is the village the primary, with region as secondary and urban as the third level? What are the priorities we want to recommend to the Division.")
- We recommend the behavioral health system make use of the unified screening tools that were developed by the Co-occurring Screening Disorders Committee,

chaired by Ann Henry. Training/technical assistance should also be provided in the proper use of the assessment tool.

- We recommend that there needs to be extensive community planning to meet the mandates of regional planning stated within the current State of Alaska documents. This planning process can be facilitated through the Behavioral Health Community Planning Project. We recommend that there needs to be a more specific rendering of planning direction. In reviewing the statutes and regulations, much of what we have initially found was "guiding principles and un-funded mandates"). There needs to be a regional planning document, as it is dictated by the statutes.
- We recommend that regulatory changes are needed to fully integrate mental health and substance abuse. Moving toward a uniformity and standardization across DBH and the respective stakeholders will provide the direction for these changes. This change becomes particularly crucial in terms of creating an integrated set of Medicaid behavioral health regulations.
- We recommend clinical standards for programs be addressed at a system level and with this change in standards, there needs to be similar expectations for all grantees.
- We recommend fostering and develop a common language between mental health and substance abuse. This becomes especially important in regard to thorough and comprehensive assessments.
- Recommend "evidence based practices" along with "best practices", "promising/emerging practices", and "value based" be the standard for programs funded by the Division. (There must be room for exceptions to pre-existing evidence based practices; i.e. something like if the Division can approve a program evaluation process then it may be approved before actual evidence based status has been achieved.)
- Recommended that the entire system benefit from the approach developed or followed in each philosophy. Two examples that were discussed for substance abuse to learn from mental health approach the "evidence based treatment" and mental health to take more of a "community based approach."
- Define "base", "secondary" and "tertiary" services and what service areas and location would be expected to do what levels of services.
- Review AMHB / ABADA levels of care and marry the levels and descriptions of intensity to come up with uniform BH descriptions.
- When looking at mandates consider substance abuse and mental health, and consider service location regional & community.
- When looking at expectations of programs include federal and others dropping money flowing into communities, right now there is zero coordination with SAMHSA grants.
- Using the "levels of community" and "levels of community care" documents (attachments 3 and 4) outlined by the AMHB as a starting point, develop a

behavioral health continuum of care that includes mental health, substance abuse and integrated services. This it to be completed by January 15, 2004.

- Support consumer/family advocacy/education efforts for both mental health and substance abuse treatment recipients.

Provider Networking/Collaboration

The purpose of the work group was to address:

- Collaboration among providers
- Networking of providers
- Collaboration with other systems, including primary care, Department of Corrections
- Reduce administrative expense through organizational collaboration
- Integration of services with "no wrong door" philosophy.

Recommendations

- Approve proposal for Behavioral Health Community Planning Process (Outcome: completed)
- Develop centralized reporting function for this project to which all working groups would report and receive information from to reduce confusion, duplicated efforts, and misinformation, and increase cooperation and collaboration. (Outcome: completed; Infoinsights website).
- That DBH give the field and planners some budgetary targets around which to develop service delivery scenarios. (Outcome: Division suggested planning efforts might involve approximately 3 scenarios; 1)Budget remains the same, 2)budget decreases 10 per cent, 3) budget decreases 25 per cent.)
- That Department of Corrections become a partner in this planning process since so many mental health consumers and persons with substance use disorders or co-occurring disorders are in jails and other correctional institutions. Concern was expressed about offenders being released into communities with serious and often un-addressed substance abuse and/or mental health needs placing them and communities at risk. (Outcome: This recommendation was forwarded to the steering group along with discussion of including the Courts. There was clarification that all can participate in multiple work group efforts but that to open the door to increasing numbers of participants in the original steering group may make the steering group too large to accomplish its' tasks).
- That a means to gather and disseminate service-user/consumer input as part of planning process be developed. Options discussed included teleconference and possible use of LIO teleconferencing equipment to accommodate large numbers

of callers. It was noted that there are limited funds to support large numbers of participants for call in participation.

- That consideration be given to incentivizing programs that are close to, or partially integrated by using some contractual funds for technical assistance in the near term. This was to be for legal or management assistance. Those projects would have been used as pilots and possibly teaching programs for others later on. A project coordinator would need to have been hired at that point. (Outcome: A decision was made to transfer management of the project to the AMH and the ABADA with a small steering committee of providers, consumers, the Trust, and Division representation. The plan was to write the Request for Proposals (RFP) scope of work for a contractor when the steering group determined that there was insufficient information about desired/possible parameters of the project available from the Division to complete the scope of work so a contractor could proceed in an informed, directed manner. The group also decided that to let any funds out to some providers before the project scope of work was completed could have negative consequences for other providers or have a contractor proceed with an inadequate or inaccurate picture of what the administration expected of integration and/or consolidation)
- Committee recommendations:
- DHSS work in collaboration with ABADA / AMHB to define service areas looking into different definitions of regions
- The process foster provider collaboration encouraging the provider groups work together.
- When looking a rationalization, strategies focus on collaboration as well as administrative cost reduction.
- A well-defined continuum of care be developed to guild service providers in defining their services. – Also see the Continuum of Care section for work in this area.
- Identify options for how providers might be organized using a regionalization concept. Rural providers in particular have expressed concern regarding the process of regionalization and the fear that such a move will reduce service access in the smallest communities in the state. This should be considered when looking at the process of regionalization.
- Explore the possibilities of the additional integration of primary care.
- Look at collaborating on an administrative level to develop tools and models to use across programs – especially in the process of assessment.

Finance

STATE GRANTS

This paper addresses issues around the general topic of state grants. The starting point for discussion was recommendations from the 2001 Substance Abuse/Mental Health Integration Project Final Report. The key issues below originate principally from that report with additions by the Finance Work Group.

Data Collection

Issue Description: While the 2001 report identified a number of concerns with data collection and analysis capacities, it appears that the AKAIMS project, which is still in process, addressed the key concerns identified in the 2001 report by consolidating SA and MH data collection and including outcome data.

Recommendations: Support AKAIMS completion and ensure appropriate coordination with the Behavioral Health Stakeholder Project. AKAIMS should incorporate capacity and the flexibility to integrate data from other relevant grant programs.

Grant Administration

Issue Description: Service providers encounter a variety of administrative barriers including multiple grant applications, criteria, conditions, and reporting.

Recommendations: Resolving some of the issues originally identified in 2001 is in process within DBH and DHSS, including grant consolidation and a single grant administration unit. These should be carried to appropriate conclusion. Other potential solutions include:

- Extend Grant Period (currently 2 years) to minimize administrative workload by state and agencies.
- Revisit grant regulation requirements for simplification
- Simplified RFP and quarterly reporting (for example, automated AKAIMS reporting). Cumulative fiscal reporting/narrative reports. Streamline Notification of Grant Awards (NGA) process and limit points of contact.
- One set of financial reporting forms for all granting agencies (not just substance abuse and mental health).
- Consolidate funding streams into a single grant per agency.
- Consider multi-service hubs, including local non-profit programs outside mental health and substance abuse to save administrative dollars.

- Utilize a simple letter of interest to determine interest and capacity to provide services; utilize RFPs only in "certified" competitive situations.
- Develop electronic submission (consider capacity of various communities).

QUALITY ASSURANCE/PROGRAM OVERSIGHT

Issue Description: Program evaluation processes for mental health and substance abuse programs are not integrated. Although both have employed some form of site visits, these have been based on distinct standards, processes, schedules, and criteria (obviously governing regulations differ). Program oversight now (other than Medicaid audits) is essentially on hold, pending development.

Recommendations: Simplify and align regulations governing quality assurance (QA and other program oversight standards to the extent possible. Develop an integrated QA) program in DBH. In the long-term, develop a standardized (to the extent possible) QA regime for all DHSS grant programs. Possible options include:

- Alternate on-site reviews and self-evaluations (per ILP program).
- Consider national accreditation options as substitutes for certain aspects of state oversight.
- Eliminate or ameliorate regulatory and other standards that conflict across disciplines (reimbursement rates, credentialing, billing privileges, supervision, etc).
- Include mechanism to elicit and consider consumer, family, and community input, beyond that provided by data collected by AKAIMS.
- Address DBH staffing issues such as differences in credentials and training.
- Establish stakeholder (Boards, Trust, providers, etc) work group to assist DBH in regulation review and program oversight development.
- Provide technical assistance and other preparation to grantees for Medicaid audits.

ALTERNATIVE FINANCING MODELS

Issue Description: This topic is, to some extent, covered in various other sections. The emphasis of the 2001 report was on billing barriers (how providers in one arena bill for treatment in the other) and the problems associated with multiple funding streams. Rural programs in particular face issues related to qualifications/supervision required to bill Medicaid.

Recommendations

- Evaluate transportation costs/client requirements before deciding upon regional hubs
- Pilot alternative reimbursement mechanisms, such a case rate for reimbursement (done in some lower 48 states already). Such pilots must account for differences in community capacity and social norms (for example, in rural communities, the client may not be an individual, but the community). Serious attention must be paid to rate setting and other questions.
- Provide fiscal incentives for consolidation/integration

Demographic Shift: Implications on Medicaid Expenditures

This section addresses implications that demographic shifts have on Medicaid expenditures. Multiple studies reveal direct correlations of an aging population with increasing health care utilization. Alaska's population is aging. Medicaid expenditures are increasing. While multiple public and private funding sources exist for health services utilized by older adults, Alaska's unique health care delivery system may inadvertently provide incentives to rely more on Medicaid. There are 5 major areas of federal funding that support health services for the older population: Medicaid, Medicare, Title XX of the Social Security Act (Block Grants), the Older Americans Act, and the Veterans Administration. For the purpose and scope of this section, however, implications of an aging population, Medicare, and Veterans Administration on the growth of Medicaid spending are addressed, highlighting related behavioral health.

Issue Description: From 1990 through 2000, the number of Alaskans age 65 and older increased nearly 60 per cent, ranking Alaska second in the nation as having the greatest increase in its older adult population.[2] Its rapidly aging population has profound implications for health care service delivery and resulting expenditures, particularly when one considers the nature of growth within this population and its relationship to health care utilization.
Of the older adult population, the age group 65-74 increased by 46 per cent; 75-84 by 92 per cent; and 85+ by 120 per cent.[3] Among those age 65-74, an estimated 4 per cent have Alzheimer's Disease and Related Disorders (ADRD); 75-84, 16 per cent; and 85+, 48 per cent.

Nationally, per capita expenditures were found to be higher for the elderly for every health service and increase with age from $1,946 per person under 65 years to $18,877 at age 85 or over. Over 75 per cent of nursing home expenditures were incurred at ages 75 or over: Twenty-three per cent of all expenditures among persons age 75-84 and 46 per cent of the total for those 85+.[4]

[2] US Census, 2000

[3] US Census 2000

[4] Hodgson, Thomas A., and Cohen, Alan J; Medical Expenditures for Major Diseases, 1995; Health Care Financing Review, Winter 1999, Vol. 21, No. 2.

Depression affects approximately 5 per cent – 20 per cent of persons over age 65 living in the community, is more prevalent among those hospitalized (25 per cent), and more so among residents of long term care facilities (25 per cent – 40 per cent). "Recent research aimed at untangling the complex relationship between chronic illness and depression in older adults is converging on primary care physicians and other healthcare professionals with this message: *Late-life depression is rampant, but it is not a natural part of aging.* Experts say it is crucial that physicians learn to recognize and diagnose the problem, because it is a major risk factor for suicide and because depressed elders are among the most frequent and costly users of healthcare resources."[5]

In 1995, mental health care expenditures ranked third (after circulatory and digestive diseases respectively) among the nations most costly diagnosis groups, with costs increasing significantly by age group. [6]

Mental Health Care Expenditures by Age Group	
Under 65 years	$205 B
65-74 years	$371 B
75-84 years	$788 B
85 years and over	$1,858 B

These data may conservatively reflect the total estimated cost burden of behavioral health as depression has been found to be associated with other medical conditions such as heart disease, cancer, and diabetes.[7]

Comparable data for Alaska are not available; however, data that do exist show some similarities. In FY2000, Alaska's Medicaid beneficiaries over age 65 made up about 6 per cent of clients, but 16 per cent of expenditures because of the high cost of hospitalization and living in long term care facilities.[8] While Alaska's FY2002 data reflect that the elderly are among Alaska's smallest and most needy between Medicaid eligible groups, it doesn't reflect the number of individuals who may be eligible for possible Medicare or Veterans coverage.[9]

> "…Medicare pays rural physicians and hospitals less for the same services and is a larger share of the payer mix…. even when controlling for all

[5] Aging Today, January/February 1998Signs of Hope, Untangling Chronic Illness and Depression

[6] Hodgson, Thomas A., and Cohen, Alan J; Medical Expenditures for Major Diseases, 1995; Health Care Financing Review, Winter 1999, Vol. 21, No. 2.

[7] Healthy People 2010

[8] Trends, December 2001

[9] State of Alaska, Dept. of Health and Social Services, Division of Medical Assistance; FY2002 Annual Report

> Medicare adjustments, average rural hospital payments are 40 per cent less than urban hospitals and 30 per cent less for physician payments.
>
> "Elderly members of rural communities are as likely to live alone as their metropolitan counterparts…. lower financial resources of the rural elderly [impose] a barrier to medical care. Therefore, the impact of low Medicare reimbursements is amplified in rural America."[10]

As a result, a paucity of participating Medicare providers exists in Alaska. Medicare beneficiaries who have no other insurance and have no access to Medicare providers, are positioned to pay out-of-pocket for their medical care; thus, unintended as it may be, the incentive to spend down and become eligible for Medicaid exists in Alaska. *By default, Medicaid is increasingly absorbing the burden.*

Medicaid programs are required to pay Medicare premiums, co-payments, and deductibles for persons covered under both programs (known at dual eligibility).[11] Alaska DHSS purchases Medicare Part B premiums for recipients of Medicaid. Nationally, Medicare Part B is growing 50 per cent faster than spending on Part A,[12](data for Alaska forthcoming).

There are over 71,500 veterans in Alaska, which represents approximately 17 per cent of the overall state population. This percentage places Alaska among the highest in the nation. Over 12,000 veterans are over age 65. "Aging veterans not only need long-term care, but health care services of all types…. VA patients are older in comparison to the general population, more likely to lack health insurance and more likely to be disabled and unable to work."[13]

The Veterans Administration (VA) health system has recognized that it is challenged to keep pace with the health care needs of its aging veterans, and has made severe funding cuts within its long-term care program. Only veterans who have service connected disabilities (and meet VA's degree of impairment criteria) or who are indigent can receive VA reimbursed long-term care.[14]

---

[10] Kriegsman, William, SEA Consulting – AK DHSS Contract, funded by Grant #6 U68 CS 0157 from HRSA. Primary Care Delivery in Frontier Alaska – A Feasibility Analysis of Delivering Primary Care Through An Expanded EMS Scope of Practice. April 2002.

[11] Ham, Richard J., MD, Sloane, Philip D., MD, Warshaw, Gregg A., MD, Primary Care Geriatrics. Mosby, Inc. 2002.

[12] Fein, Rashi, Ph.D. - Harvard Medical School, Harvard University. The Score on Medicare Reform – Minus the Hype and Hyperbole. The New England Journal of Medicine. 1995, Vol. 333, No. 26.

[13] McDowell Group, Health Dimensions Group, and ASCG Incorporated – prepared for AK Legislature, Legislative Budget and Audit Committee. Alaska State Veterans Home Feasibility Study. July 2003.

[14] Ham, Richard J., MD, Sloane, Philip D., MD, Warshaw, Gregg A., MD, Primary Care Geriatrics. Mosby, Inc. 2002.

Alaska is one of only two states that do not participate in the Department of Veterans Affairs State Home Program. Estimates indicate a demand for 55 to 65 additional nursing home beds and 65 to 75 additional domiciliary / assisted living beds to serve veterans statewide within the next decade. Further, "additional home and community-based care will be needed, particularly in the more rural areas of the state."[15]

The Alaska VA Healthcare System and Regional Office provides health care through clinics in Anchorage, Fort Wainwright (Fairbanks), Kenai, and a 50-bed domiciliary for homeless veterans in Anchorage. The VA participates in the Alaska Federal Healthcare Partnership (collaborative federal health care agencies: Army, Air Force, Coast Guard, Indian Health Services, and VA). "Alaska's VA system is more balanced in its mix of institutional and community based long-term care services than the VA overall. The Alaska VA spent approximately 47 per cent of available long-term care funding on home and community-based services as compared to 9 per cent in the VA overall."[16] Further, the VA contracts with community based providers and assisted living entities to help meet the acute and chronic health care needs of Alaska veterans.[17]

The process of partnering with federal, state, and local entities presents insight to regulatory differences and gaps, assessment protocols, eligibility criteria, and reimbursement processes. Unintended incentives to become Medicaid waiver eligible exist.

MEDICAID ISSUES AND RECOMMENDATIONS

Medicaid Issue 1: Tribal/Native Health Corporation Financing

Issue Description: The Alaska Department of Health and Social Services has adopted a "tribal agenda" that seeks to maximize federal reimbursement for Medicaid services provided to Alaska Natives. Tribal providers that are authorized under PL 93-638—also know 638 providers—are able to receive 100 per cent federal Medicaid reimbursement for services provided to Alaska Natives who are enrolled in the state Medicaid program. In contrast, services by non-638 providers receive 58 per cent federal reimbursement, with the remaining 42 per cent being paid through state general funds.

Alaska Natives currently account for nearly 40 per cent of all Medicaid clients and expenditures — approximately $250 million in FY 02. Approximately $167 million of this amount was paid to non-tribal providers; requiring $70 million is state match.

[15] McDowell Group, Health Dimensions Group, and ASCG Incorporated – prepared for AK Legislature, Legislative Budget and Audit Committee. Alaska State Veterans Home Feasibility Study. July 2003.

[16] McDowell Group, Health Dimensions Group, and ASCG Incorporated – prepared for AK Legislature, Legislative Budget and Audit Committee. Alaska State Veterans Home Feasibility Study. July 2003.

[17] www.appc1.va.gov/opa/fact/statesum/docs/akss.htm

Approximately $40.5 million was spent on mental health services in FY 02 through non-tribal entities, and therefore not eligible for 100 per cent federal reimbursement.

Funding more behavioral health services through 638 providers can save a significant amount of funding and can help prevent or alleviate service reductions in the current budgetary environment. At the same time, it is important to preserve, to the greatest extent possible, existing behavioral health programs and services. It is also important to avoid the creation of a dual or bifurcated system with separate services and programs for Native versus non-Native persons.

Recommendations

- To the extent that the State moves toward 100 percent federal reimbursement for services to Alaska Natives through tribal 638 contractors, the preferred model should be partnerships between the 638 contractors and the current private providers.
- Increase general efforts to educate providers on the process of creating multi-cultural contractual partnerships. This could include white papers, templates for creating contractual partnerships and presentations to provider organizations and consortiums. An effort should be made to foster a greater dialogue between 638 and private providers regarding the development of contractual partnerships.
- Provide extensive individualized technical assistance to those 638 and private providers that have expressed an interest in developing formal contractual partnerships. At a minimum, this technical assistance needs to address the programmatic, fiscal, legal and other structural issues involved in creating viable contractual relationships.
- Utilize a gradual, incremental approach to creating the contractual partnerships. The use of mechanisms such as pilot projects will allow the development of templates for legal, fiscal and programmatic structures. Pilots will also allow necessary adjustments to service agreements and structural arrangements, ensure greater continuity of care, and minimize any possible negative impact on recipients of service.
- Increase outreach efforts to increase the enrollment of Alaska Natives in the state Medicaid program.

Medicaid Issue 2: Out of State Residential Psychiatric Treatment

Issue Description: For the last several years, a dramatically increasing number of children under the state Medicaid program have been placed in out of state residential psychiatric treatment centers (RPTC). Currently there are approximately 400 children in out of state facilities, with over 80 per cent of the children being under parental custody. The growth rate in RPTC placements and expenditures has been astronomical—from $3.1 million in FY 97 to an FY 04 authorized level of $40.7 million; this represents a 1,200 per cent increase!

Two underlying principles of the state's mental health system are that children receive care as close to home as possible and within the least restrictive environment. We are failing to achieve these principles as more and more children are sent out of state for care in residential psychiatric facilities. There is a compelling need to reverse this trend by ensuring that a more comprehensive array of services is available in Alaskan communities. Providing viable alternatives to out of state placement could be more cost effective as well as more appropriate and less disruptive for Alaskan children and families.

Recommendations

- Encourage DHSS to complete and release the final children's mental health needs assessment report. This report will provide valuable information on the children who are being placed in out of state facilities as well as information on those services needed in Alaska to reduce out of state care.
- Target enhanced residential and community based services in Alaska, based on an assessment of the needs and services capacities of regions and communities throughout the state.
- Support the DBH's efforts to develop a reimbursement mechanism for non-custody children to move from out of state placements to in state residential care.
- Increase discharge-planning efforts for those children who are in out of state facilities to facilitate their successful return to Alaska.
- Implement a system-wide level of care assessment methodology and other appropriate gate keeping mechanisms that will ensure that the level of care provided to children more closely matches their level of need.
- Provide financial incentives for lower, less intensive levels of care to act as an alternative to more costly out of state RPTC care.
- For those children continuing to need an RPTC level of care, focus on RPTC development in Alaska as one major aspect of developing contractual partnerships between 638 tribal providers and non-tribal entities.

Medicaid Issue 3: Community Mental Health and Substance Abuse Services

Issue Description: Medicaid mental health and Medicaid substance abuse services are governed by separate sets of regulations. There are significant differences in these sets of regulations regarding intake and assessment requirements, licensing and credentialing of service providers, levels of required clinical oversight and service reimbursement. Currently only substance abuse grantee providers are authorized to provide Medicaid substance abuse services; similarly only current mental health grantee providers may provide Medicaid mental health services.

The separate mental health and substance abuse regulatory frameworks present inherent impediments to providing integrated services to person who experience co-occurring mental health and substance abuse disorders. As one means of establishing a more

integrated system of care for behavioral health services, DBH has set the goal of replacing the current Medicaid mental health and substance abuse regulations with a set of integrated behavioral health regulations. The time frame for developing these new regulations is approximately two years.

As an interim measure, DBH has begun to provide technical assistance to providers to achieve integrated service provision under the existing regulatory framework. Significant integration can be achieved under the current regulations in the areas of screening, assessment, treatment planning, treatment provision and service documentation. These efforts are important and should continue until the new behavioral health regulations are developed.

Recommendations

- Increase general information, training and individualized technical assistance to behavioral health providers to maximize integrated service provision under existing Medicaid regulations.
- Convene a multi-stakeholder work group, with significant behavioral health provider representation, to provide front-end input on the development of integrated Medicaid behavioral health regulations.
- Adopt guiding principles to guide the development of the new behavioral health regulations. Two important guiding principles include "do no harm" to current service recipients, and cost neutrality.
- Once new regulations are developed, provide intensive training and technical assistance to behavioral health providers to ensure smooth and appropriate implementation of the new requirements.

Medicaid Issue 4: School-based Medicaid

Issue Description: Senate Bill 345, which passed in the 22nd Legislature, allows school districts to enter into agreements with DHSS to provide Medicaid services to children with disabilities. The services provided by the school district must be included in the child's individualized education program (IEP). A beneficial aspect of the legislation is that school districts can refinance and enhance services to Medicaid-enrolled students with disabilities. The districts can use their existing funds to provide the state general fund match for the Medicaid payments, thereby saving additional Medicaid general fund expenditures.

DHSS has convened a multi-stakeholder work group to help guide implementation of the new legislation. Thus far, the work group has been focusing on more traditional school-district services to children with disabilities including speech, occupational and physical therapy. The group plans to address behavioral health services in approximately another year. Since many community mental health providers currently provide behavioral health and day treatment services in schools throughout the state, this is an area that will require considerable collaboration and partnerships.

Recommendations

- Continue the DHSS-sponsored work group for school-based Medicaid services and enhance the membership to include more behavioral health providers when school-based behavioral health services are addressed.
- As with 638 provider refinancing, adopt as the preferred model the building of collaborative, contractual partnerships between school districts and behavioral health providers that are designed to maintain existing school-based behavioral health services, while simultaneously taking advantage of general fund refinancing possibilities with the school-based Medicaid provisions.
- Provide technical assistance and training to school districts and behavioral health providers in building/expanding contractual partnerships regarding the provision of school-based behavioral health services.
- Establish mechanisms to ensure that school-based behavioral health services are fully integrated with other community-based behavioral health services. This will help avoid the development of dual or parallel behavioral health systems.

Medicaid Issue 5: Eligibility Issues

Changing Medicaid eligibility management and coding to enhance federal funding for substance abuse within behavioral health

Issue Description: Arizona has had a behavioral health system for 23 years, within which they have done a number of things to increase the utilization of Medicaid funding for substance abuse. Christina Dye, of their Division of Behavioral Health, and who was part of the Center for Substance Abuse Treatment technical assistance team, and who visited Alaska recently, provided this information. In his visits to Alaska in the last years, Dr. Ken Minkoff has also suggested that Medicaid funding for co-occurring disorders can be a win-win situation for both mental health and substance abuse. Arizona has done the following:

- **Established immediate, centralized eligibility determination to maximize federal Medicaid dollars and reduce State General Fund (GF) costs.** Arizona requires all providers to gather Medicaid eligibility information from all clients at admission and immediately electronically send the information to a central state-managed eligibility office. Since the state expertise in Medicaid eligibility is greater and more consistent than that managed by providers, Arizona has significantly increased the numbers of Medicaid-eligible clients especially those with a substance abuse and co-occurring diagnosis. This allows the State to maximize the use of the federal dollars to match state GF dollars in paying for treatment services. Since 45 per cent of substance abusing clients in Alaska are Alaska Native, it also follows that increased eligibility would generate revenue for

services via the 100 per cent Medicaid reimbursement for Alaska Natives, hence saving further GF. Once a client is eligible, services are paid retroactively, but services are front-funded with GF until eligibility is determined.

- **Built provider incentives to maximize Medicaid eligibility**. Arizona has managed grant funding at a flat rate to providers, and used maximizing Medicaid eligibility as a way of building provider financial incentives.
- **Established Medicaid benefit packages for mental health and substance abuse that are the same**. For example, Arizona has established only one Medicaid code for counseling, which includes both mental health and substance abuse. In that way the state does not differentiate in reimbursement which services are given to substance abusers, dual diagnosis or mental health clients. Clients can still be identified by diagnosis, and managed by staff with well-matched expertise for specialized populations.
- **Arizona has significantly fewer statutes and regulations**. Ms. Dye felt that if Alaska were to greatly simplify its statutes and regulations it would allow for more flexibility to fund and provide services in a way that would benefit mental health, co-occurring and substance abusing clients.
- **Integrating services for co-occurring clients has been beneficial**. As a sidelight, Arizona's substance abuse field was very concerned about integration of services for co-occurring clients. But Ms. Dye's estimation was that the changes have benefited the substance abuse field not detracted from its effectiveness.

Recommendations: That Alaska DBH staff carefully review the Arizona model for aspects that may be possible to implement in Alaska that will maximize federal revenue for services and improve service delivery.

FEDERAL FUNDING

> The U.S. health care system is a chaotic system…one that is going over the cliff. Everyone agrees on changing the system, not everyone agrees on how. The best way to understand what is going on is to follow the money.[18]

In an effort to begin identifying what's going on, a four volume, comprehensive report on federal funding sources prepared by the Alaska Center for Rural Health under contract with the DHSS addresses a plethora of federal grant opportunities in support of health promotion, health protection, preventive services, access to care, and public health

[18] Relman, Arnold S., MD. The Fourth Annual Herbert Lourie Memorial Lecture on Health Policy. Reforming Our Health Care System. Syracuse University, October 1, 1992.

infrastructure.[19] Federal funds for behavioral health related services and projects in Alaska continue being identified through the behavioral health integration initiative.

Issue Description: Congress established the Substance Abuse and Mental Health Services Administration (SAMHSA) under Public Law 102-321 (1992) to strengthen the Nation's health care capacity and provide prevention, diagnosis, and treatment services for substance abuse and mental illnesses. Through its centers – Center for Mental Health Services (CMHS), The Center for Substance Abuse Prevention (CSAP), and The Center for Substance Abuse Treatment (CSAT) – SAMHSA promotes partnerships with states, communities and private organizations to identify community risk factors that contribute to these illnesses and address needs.

Recommendations

- Coordinate federal funding sources and opportunities
- Track SAMHSA grant applications and have applicants copy the state and get state and SAMHSA grantees together.

OTHER FUNDING SOURCES/MECHANISM/ISSUES

Background: While State, Federal and Medicaid funds have played a major role in financing behavioral health care services in Alaska, other resources such as the Trust, the Denali Commission and third party private payers also pay an increasingly larger and important role in the service delivery system. While each of these systems have historically had missions focusing on mental health or substance abuse services it may be appropriate for these systems to evaluate their missions in terms of health care financing for a new and different integrated delivery system.

As state funding of mental health and substance abuse services is being reduced, the importance of local initiatives to maintain existing services becomes more important. Knowledge and capacities to bill for services vary widely within service agencies and a transitional phase to substantially augment this capability may be called for. Local contributions to programs from city/ village governments are also negatively affected based on reductions in funds flowing from the state to local governments.

Legislative initiatives or funding policy changes may need to be considered as a partial solution to existing funding limitations. Further reviews of deferred prosecution, insurance parity, managed care methodologies, and the perceived differences in access and availability of behavioral health services between rural and urban residents may also need to considered as the integration of services unfolds.

[19] www.ichs.uaa.alaska.edu/acrh

Issue 1: Client payment/local initiatives

Client payments for services rendered varies substantially in programs within Alaska. Programs differ substantially in their knowledge and ability to engage in billing practices. Further, there are tremendous differences in philosophies pertaining to billing for professional service, which has an impact on the amounts agencies collect. Differences in regulations for Medicaid payments between substance abuse and mental health services currently exist and need to be blended into one set of regulations for an integrated service delivery system. Local governments are finding it increasingly difficult to support local programs due to funding cuts from the state.

Recommendations

- Support 3rd party billing by providing technical assistance as needed to provider groups
- Help provider organizations work together and create a mentoring program
- Encourage use of the UA billing coding certificate program- UA to expand to BH

Issue 2: Deferred Prosecution

Deferred prosecution is a mechanism that provides incentives for participants to seek treatment and to pay for treatment. While there are some increased costs to the judicial system, it appears to be a successful model that reduces costs to correctional facilities, and increases revenue to treatment programs. Over the long haul, it may also ultimately reduce costs to the judicial system to the degree that it reduces recidivism.

Recommendations: Evaluate other states experience with deferred prosecution. To the degree that it makes for good public health policy, public safety policy and sound fiscal policy, seek cooperation with other state agencies (DOC, etc.) and propose a legislative initiative for an Alaskan version of deferred prosecution.

Issue 3: Parity/Insurance

Nine out of ten insurance policies offer unequal coverage for physical and behavioral health illnesses. Mental health and substance abuse disorders are treatable, often at less cost than common physical illnesses, with both economic and prevention benefits. Parity will reduce reliance on Medicaid and other forms of public assistance, so parity is a refinancing mechanism. The cost of parity in Alaska will be small (about equal to a 3.5 cent-per-hour raise)

Recommendations: Parity is both a good public health policy as well as a refinancing mechanism and the state should enact parity legislation establishing equal health insurance benefits for physical, mental, and substance abuse disorder, require mandatory versus voluntary coverage for employers who offer health insurance and provide for exemptions for employers with fewer than 20 employees.

Issue 4: Rural Versus Urban Concerns

There are longstanding perceptions with urban and rural provider groups that there are funding disparities between the two groups. Rural programs often express that there are greater costs for service delivery in the rural environment than in the urban environment that are not factored into their funding base. Rural providers often feel as if they cannot access complex care for their patients in the urban settings and that urban residents have easier access to admissions. Further, rural providers often feel as if they have to treat every condition that walks in the door while urban programs can refer to specialists who only exist in the urban setting. Urban providers often express frustration with what they see as lots of money being put into rural programs and do not understand the frustration expressed by rural programs. In some cases urban providers also feel that they are more isolated working in just one of many complex agencies in urban Alaska and sense that rural programs are more integrated and often managed "under one roof".

Fact and fiction exist within these perceptions. Unlike the general medical model where villages, regional hubs and urban communities have reasonably clear lines of practice capabilities and practice limits and where the existence of services in primary, secondary and tertiary facilities is clearly understood, the Alaska behavioral health model does not always follow a clearly delineated pathway for treatment services. Large rural specialized treatment services can exist in rural areas and these services may be unavailable in urban areas.

Recommendations: With resources generally becoming more scarce, there may be some merit in analyzing service demand vs. service capacity and including this information in the development of a service delivery plan. Villages, rural hubs, regional facilities and urban Alaska should have more clearly defined roles in service provision and funding should go towards the development of a more appropriate statewide delivery system. Clearly, the state would have to work with the Federal government, tribal organizations and city and borough governments to organize this plan.

Issue 5: The Denali Commission

The Denali Commission is a relatively new player in the behavioral health arena here in Alaska. It has recently expressed interests in funding facilities for a broad array of behavioral health facilities.

Recommendations: Consistent with comments expressed in other sections, the state may need to continue to closely partner with the Denali Commission to encourage changes in funding practices consistent with the rapidly changing needs in the service sector. As of this writing there appears to be substantial cooperation between some of the funding priorities of the state (ex: RPTC's) and the Denali Commission. The delivery system may look very different in five years than it looks now and it would be appropriate for the Denali Commission to direct funds to assist in this evolution of our delivery system.

OTHER FINANCING RECOMMENDATIONS

- The Trust should act as the clearing house to track all behavioral health
- Efforts should be made to integrate physical and issues when looking at primary care.
- The Department should encourage behavioral health partnership and collaboration with Federally Qualified Health Centers (FQHC's).
- Analyze the Medicare reform bill for impacts on the BH system (the Alaska Community Mental Health Services Association – ACMHSA)

Licensing/Certification/Workforce Development

The following recommendations are global in nature; it is the belief of this committee that they will require ongoing work by stakeholders to become more specific and applicable.

PROGRAM APPROVAL/LICENSING

Recommendations:

- Integrated program standards for use by the State should be developed/adopted for the program approval/licensing process. (Versus continued use of the 1974 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards as adopted by reference.)
- A process for determining how agencies are licensed/approved should be developed as well as a process for determining when agencies are licensed/approved should be developed allowing for the possibility of agencies opting to be certified by outside entities such as JCAHO or the Commission on Accreditation of Rehabilitation Facilities (CARF)
- A process for determining when agencies are licensed/approved should be developed.
- (When would an agency be required to obtain external accreditation versus State approval? Would these requirements be applied to both grantees and private providers or related to a grant-funding amount?)
- A process for determining which agencies are licensed/approved should be developed.
- (Are both grantees and private providers required to meet certain program standards in order to be able to provide services?)

INDIVIDUAL LICENSURE/CERTIFICATION

Recommendations:

- Behavioral Health standards of competency need to be reviewed for adaptation for the certification/licensure process. (There are existing competency standards already developed by a number of entities that should be reviewed and either accepted as is or revised to meet Alaska's needs.)

Training/Workforce Development

- A priority during the next year should be to ensure the provision of co-occurring disorder training in those communities where there is only one provider (no mental health or substance abuse specialists).
- We need to ensure that statewide training is available to meet any gaps created once behavioral health standards of competency are developed. Additional issues related to the development of new competencies range from the need to address billing, the necessity of addressing differences between urban and rural competencies, and the potential of developing a system for providing clinical supervision by distance delivery.
- We need to make certain that all programs have access to trainings for credentialing (more basic trainings available through distance learning?).
- Streamlining training availabilities and ensuring accessibility for all providers are issues that will need to be addressed.
- The additional financial costs to small agencies need to be considered when developing uniform credentialing/licensure requirements.
- Balanced single discipline and co-occurring training opportunities should be made available through the conferences, which are scheduled throughout the year.
- The issue of substance abuse training needs for master's level and licensed providers needs to be considered when developing a statewide training plan. Perhaps a fast-track counselor academy could be developed for master's level employees, which could include features like internships or placement at substance abuse/mental health programs where they would receive clinical supervision.
- UA could perhaps serve as a more comprehensive delivery system to support the new behavioral health approach within the state by developing a curriculum to meet the needs of a more diversified field.
- A system for providing clinical supervision by distance delivery could be developed.
- Seek to align state funded and other workforce development efforts.

Longer Term Issues

The following longer-term issues will need to be addressed:

- Parity in benefits and pay to mental health and substance abuse professionals;

- Examination of the manner in which adequate training impacts recruitment and retention of quality staff;
- The need for adequate funds to invest in staff;
- Statutes and regulations need to be reviewed and revised to address areas where they create barriers for the new system.

Recommendations: Create and ongoing work group / task force (consumers, ABADA, AMHB & providers) to continue work in this the area of licensing/certification and workforce development.

Statutory and Regulatory Change

Recommendations

- DBH should develop legislation for introduction by the Governor in the 2005 legislative session to provide a model legal framework for implementing a system of integrated behavioral health care.
- The model law should be developed through a process involving stakeholders and should establish policy and principles guiding implementation of a system which is:
    - ***Comprehensive*** – providing a complete continuum of integrated behavioral health care and supports;
    - ***Community-based*** – planned and implemented through partnerships of governmental, tribal and private organizations at the local, regional, and statewide levels to serve Alaskans as close to their homes as possible;
    - ***Accessible*** – structured, supported and deployed to provide Alaskans prompt and ready access to services that are engaging and supportive in promoting wellness and averting intensive or intrusive interventions;
    - ***Holistic*** – addressing the full range of client / consumer life needs which are fundamental to recovery;
    - ***Consumer / client- centered*** – providing policies, structures and processes in which consumer interests and rights are primary and client / consumer dignity, self-determination, and strengths are maximized in planning and implementing treatment;
    - ***Accountable*** – focused on outcomes with systems for measuring results and assuring services and practices which demonstrate effectiveness and use resources efficiently.
- Key areas of focus for attention in developing a legislative proposal to establish the statutory framework for a model integrated system of behavioral health include:

  - State policy and principles to be followed in planning, implementing and operating an integrated behavioral health care system.
  - The mandate for or "entitlement" to behavioral health services to ensure that the disparity in existing Alaska law is eliminated and that persons with mental illness and substance use disorders have equal access and financial assistance in obtaining needed care.
  - Provisions governing involuntary commitment.
  - The statutorily defined roles, responsibilities, and authorities of State government agencies, municipal or tribal governments, and private community-based agencies in planning, financing, and implementing a comprehensive system of integrated care.
  - Requirements and procedures for allocating and distributing State resources to support an integrated behavioral health system.
  - Basic or required components and responsibilities of comprehensive community behavioral health programs which serve as or replace "community mental health centers" and "regional" alcohol programs.
  - Standards for comprehensive community behavioral health programs and the responsibility and authority of State agencies and local governments in enforcing standards.
  - Patient rights and financial responsibilities.
  - Responsibilities of the advisory boards in planning, advising and advocating for programs on behalf of consumers; and the relationship of the boards to the Trust and State and community agencies.

- DBH and the Trust should jointly sponsor a work group stakeholder work group process to research the laws of other jurisdictions, review Alaska laws and regulations, and develop proposals for model laws and implementing regulations which would be concluded by November 2005 and provide the basis for draft legislation and regulations and the framework for future solicitations.
- DBH should immediately develop a process for including appropriate stakeholder input into defining the direction, requirements, and approaches of a solicitation for behavioral health services for FY05. This solicitation should be designed to achieve incremental progress toward an integrated behavioral health system without disrupting existing systems of care and without pre-determining the structures and standards of service systems 'as model statutes are developed.

ATTACHMENT #1 – LIFE DOMAIN INTEGRATION

Life Domain Integration

Comprehensive Plan
Alaska Mental Health Board
Advisory Board on Alcoholism & Drug Abuse

Comp Plan	AMHB	ABADA
1. Health 1.1 Mental Health Status 1.2 Early Life 1.3 Alcohol & Other Drugs 1.4 Suicide	d. Physical Health e. Behavioral Health	Physical Health Behavioral Health
2. Safety 2.1 Decriminalization 2.2 Safe Families 2.3 Safe Care	f. Justice g. Community	Involvement w/justice system Functional families
3. Economic Security 3.1 Basic Economic Supports 3.2 Employment	c. Employment or Economic Independence	Productively Engaged
4. Living with Dignity 4.1 Housing 4.2 Education & Training 4.3 Educated Public	a. Housing b. Education	Housing Community participation

ATTACHMENT #2 – DRAFT INDICATORS

DRAFT INDICATORS

Indicator	Comm.	Proxy	Data Quality	Data Source	Dates	Collected/Available	Use in Plans	Comments
HEALTH Life Domain: Mental Wellness								
Suicide Attempts	M	M	M	Trauma Registry	94-02	cont./ upon request	Comp Plan & CP Report	graph is cumulative over 4 years by age and race.
Suicide Rate	M	M	M	BVS	95-02	cont/annual	Comp Plan & CP Report, 2010	Information is available 9 months after the close of the calendar year.
Hospital DET beds use (# of inpatient days and # of admissions)	L	L	L	DBH	?	continuous	new	Will work with DBH on numbers - but these may be unreliable.
ER Room Admits - SA/Alcohol related injuries treated in hospital	M	M	H	Trauma Registry	91-02	cont./ upon request	Results	
ER Room Admits - Psych/SPE	M	M	M	PAMC	2001-02	continuous	new	In Anchorage this is captured in the SPE - perhaps a better measure would be disposition of patients?
Self-reported Poor Physical Health Days	L	L	M	BRFSS	97-02	survey/annual	new	It is the parallel measure for the poor mental health days
Self-reported Poor Mental Health Days	L	L	M	BRFSS	97-02	survey/annual	Comp Plan, CP report, 2010	Although it has many limitations, it is the only existing measure of the general mental health of Alaskans.
General Depression	H	H	M	BRFSS	2003	survey/annual	new	new question added to BRFSS - may only be used for one year but will provide baseline info regarding depression.

HEALTH Life Domain: Substance Abuse								
Self Report binge/chronic drinking	H	H	M	BRFSS, NIAAA, SAMHSA	91-02	survey/annual	Comp Plan, Results, 2010	self reported but long time depth and can be used in association with other measures
Per capita consumption	H	H	H	NIAAA	91-01	survey/annual	Comp Plan, Results, CP Report, 2010	
Injuries with alcohol involvement	H	H	H	Trauma Reg	91-02	cont./ upon request	Comp Plan, CP report, Results	
Deaths related to substance abuse	H	H	H	BVS	91-02	cont/annual	Comp Plan, CP report, 2010	Information is available the following year.
Motor Vehicle crashes with alcohol/drug involvement resulting in injury	H	H	H	DOTPF	95-02	cont/annual	Comp Plan, CP report, 2010	required for federal reporting on highway injuries and deaths
FAS/FAE birthrate	H	H	?	DBH			new	Not sure about availability
Alcohol consumption during preg.	M	M	M	BVS	91-02	cont/annual	Comp Plan, CP Report, 2010	self reported but long time depth and can be used in association with other measures
Use of alcohol before age 13 and current adolescent use	H	H	H	YRBS	95,99, 2003	survey	Comp Plan, 2010	Have reliable comparable numbers for three years.
SAFETY Life Domain: Avoidable Incarceration								
State Trooper arrests w/alcohol and/or drug involvement	M	M	M	DPS	98-02	cont/annual	Comp Plan	Does not include any urban areas - would be great to add APD and perhaps others as well

DWI felony case files	M	M	M	Court System	98-02	cont/annual	Comp Plan, CP report, Results	Felony only results after three convictions - is some measure of recidivism
Rate of involuntary commitment court filings and protective custody holds	M	M	M	Court System	98-02	cont/annual	Comp Plan, CP report	Need to check with Russ re: better info.
# of individuals incarcerated with mental illness and/or substance use disorders	M	M	L	DOC		sporadic		DOC does not screen for these disorders on a regular basis - can provide information on inmates treated for these disorders
Minor consuming alcohol arrests	M	M	M	Court System	98-02	cont/annual	Comp plan, CP report	Could reflect enforcement efforts as opposed to less consumption
SAFETY Life Domain: Safe Families (?)								
Legitimate, assigned and substantiated reports of harm	M	M	M	OCS	95-02	cont./ upon request	Comp plan, CP report	Best when used in association with other measures such as unduplicated count of children
Unduplicated count of children w/reports of harm	M	M	M	OCS	98-02	cont./ upon request	Comp plan, CP report	Sharp drop in numbers between 01 and 02 reflects elimination of duplicate reporting
Adult Protective Service Investigations	M	M	M	DSDS	00-02	cont./ upon request	Comp plan, CP report, 2010	Currently some confusion related to this data source, may be temporary
People experiencing domestic violence over their lifetime	M	M	M	BRFSS	97-02	survey/annual	Comp plan, CP report	self report but statistically sound, one of the few DV measures available
Complaints to long-term care ombudsman	M	M	M	AMHTA	? - 02	cont/annual	Comp plan	Reflects quality of care - developing measure
Injuries that required hospital admission related to physical assaults	M	M	H	TR	91-02	cont./ upon request	new	Is a promising measure.

ECONOMIC SECURITY Life Domain: Financial Supports/Employment								
Poverty Rates for children under age 18	M	M	M	National Kids Count	95-99	annual	Comp Plan, Kid's Count	Used as a regular measure by the Anne D. Casey Kids Count Data Book - needs to be more current
Public Assistance Participants in Alaska	M	M	M	DPA	93-02	annual	Comp Plan, CP Report	Some reflection of poverty
Participants in the Working Disabled Medicaid Eligibility Category	L	L	H	DMS	2000-03	cont./ upon request	Comp Plan, CP Report	could be considered performance measure as opposed to indicator as it only relates to the population receiving or eligible for Medicaid and SSI
Health Insurance Coverage	M	M	M	BRFSS	91-2002		new	self report - not sure of time depth of Alaska specific data
SSI recipients with earned income	M	M	M	SSA	?		new	Hard to find Alaska specific data
LIVING WITH DIGNITY Life Domain: Housing								
Rate of Homeless Adults per 100,000	M	M	L	AHFC	98-02	spot/biannual	Comp Plan, CP report	Voluntary homeless provider survey dependent on self-disclosure by homeless shelter program participants
Homeless people by disability type	M	M	L	AHFC	96-02	survey/biannual	Comp Plan	Voluntary homeless provider survey dependent on self-disclosure by homeless shelter program participants
API patients admitted and discharged homeless	M	M	M	API	96-02	cont./ upon request	Comp Plan, CP report	Also should check into CMHC data on how many homeless treated - AKAIMS/CSR?
Non-elderly on AHFC's wait list for public and section 8 housing	?			AHFC	2001 - snapshot		Comp Plan	may have no time depth - need to explore further

Inmates released from Correctional facilities homeless				DOC			new	Developing measure - needs further exploration
Inventory of special needs and support housing	?			AHFC	1995, 2000		Comp Plan	Good idea but not sure its accurate information. Need to find single source that includes Anchorage.
Long Term Care Capacity	M	M	M	DSDS	2000-02	cont./ upon request	CP report	Assisted Living, Nursing Home beds
LIVING WITH DIGNITY Life Domain: Education/Community Involvement								
Dropout Rates for Children served under IDEA compared to all Public School Children	M	M	M	DEED	96-01	annual	CP report	

Acronyms

AHFC = Alaska Housing Finance Corporation
AKAIMS = Alaska Automated Integrated Management System
AMHTA = Alaska Mental Health Trust Authority
APD = Anchorage Police Department
BRFSS = Behavioral Risk Factor Surveillance System
BVS = Alaska Bureau of Vital Statistics
CMHC = Community Mental Health Center
DBH = Division of Behavioral Health
DET = Designated Evaluation and Treatment
DMS = Division of Medical Services
DOTPF = Department of Transportation and Public Facilities
DPA = Division of Public Assistance
DPS = Department of Public Safety
DSDS = Division of Senior and Disability Services
DV = domestic violence
DWI = Driving While Intoxicated
FAS/FAE = Fetal Alcohol Syndrome and Fetal Alcohol Effects
NIAAA = National Institute on Alcohol Abuse and Alcoholism
OCS = Office of Children's Services
PAMC = Providence Alaska Medical Center
SAMHSA = Substance Abuse and Mental Health Services Administration
SSA = Social Security Administration
SSI = Supplemental Security Income
TR = Trauma Registry
YRBS = Youth Risk Behavior Survey

ATTACHMENT # 3 – CLIENT STATUS REVIEW FORM

Client Status Review/Follow Up Form
Scoring Information

SCORES ARE INVISIBLE TO USER

Please fill in the circle completely next to the answer that most closely fits your situation.
Example: ● Correct Ø Incorrect

1. In the last six months, how often have mental or emotional problems kept you from doing normal daily activities?

   ❍ Almost all the time (usually every day) 2
   ❍ Most of the time (2-5 days a week) 4
   ❍ Sometimes (5-10 days a month) 6
   ❍ Rarely (1-4 days a month) 8
   ❍ Almost never (less than 1 day a month) 10

2. How often do you do activities such as hunting, fishing, berry picking, work, school, sports, church, social or treatment activities, or any other activities?

   ❍ None 2
   ❍ Between 10 & 20 Hrs. a week 4
   ❍ Between 20 & 30 Hrs. a week 6
   ❍ Between 30 & 40 Hrs. a week 8
   ❍ More than 40 hours a week 10

3. In the last six months, how often do physical health problems keep you from doing normal daily activities?

   ❍ Almost all the time (usually every day) 1
   ❍ Most of the time (2-5 days a week) 2
   ❍ Sometimes (5-10 days a month) 3
   ❍ Rarely (1-4 days a month) 4
   ❍ Almost never (less than 1 day a month) 5

4. During the past six months, about how many times have you used emergency medical services such as the hospital, emergency room, the emergency medical

technicians or health aides for physical, substance abuse or mental health problems?

- ❍ Six or more times 1
- ❍ Four or five times 2
- ❍ Two or three times 3
- ❍ Only once 4
- ❍ Never 5

5. Which of the following statements is true about your thoughts regarding suicide or hurting yourself?

- ❍ I have attempted or have a plan. 2
- ❍ I think about it most of the time. 4
- ❍ I sometimes think about it. 6
- ❍ I rarely think about it. 8
- ❍ I never think about it. 10

6. In the last month, how often have you used alcohol or other drugs (not prescribed for you by a physician)?

- ❍ Usually every day 2
- ❍ 2-5 days a week 4
- ❍ 5-10 times a month 6
- ❍ 1-2 times a month 8
- ❍ I don't use or Clean and Sober for _____(length of time) 10

7. How much do the people in your life support you, your sobriety or recovery?

- ❍ They are not supportive 2
- ❍ They are often not supportive 4
- ❍ They are neutral, they do not support or interfere 6
- ❍ They are usually supportive 8
- ❍ They are very supportive 10

8. (Please only answer this question if you are over 21) Do you have enough money to support your basic needs like health care, food, housing, clothing, subsistence activities?

- ❍ I do not have enough income to pay for most basic needs. 2
- ❍ I do not have enough income to pay for some basic needs. 4

- ❍ I have several financial problems that I can manage. 6
- ❍ I have enough income to pay for basic needs. 8
- ❍ I have very few financial problems. 10

9. During the past three months, have you received any support from public assistance, such as food stamps, SSDI, VA Disability or temporary assistance to needy families?

- ❍ Yes NO SCORE ON THIS QUESTION
- ❍ No
- ❍ No Answer

10. (Please only answer this question if you are under 21) People are often worried or embarrassed by not being able to afford things like clothes, transportation, activities, gas, food, and rent. How often do you or family members worry about these types of things?

- ❍ Almost all the time 2
- ❍ Most of the 4
- ❍ Sometimes 6
- ❍ Rarely 8
- ❍ Almost never 10

11. Which one of the following best describes your current housing situation?

- ❍ Lock up facility 2
- ❍ Hospital 4
- ❍ Homeless (shelter, on the street, vehicle, unsafe or abandoned dwelling) 6
- ❍ Residential facility, (long-term treatment facility, group home, halfway house with 24-hour staff supervision) or Sheltered care (supervised apartment, adult foster home, assisted living facility) 8
- ❍ Live independently, with family or relatives, or in foster care 10

12. What is your current involvement with the legal system (police, court, or jail)?

- ❍ In lock-up facility, mandatory hospitalization, involuntary commitment, or youth facility 2
- ❍ On probation or parole, felony charges pending or conviction, awaiting sentencing, in a halfway house, contested divorce and/or custody issues 4

- ❍ Misdemeanor charges pending or conviction, court-ordered outpatient treatment, in detention 6
- ❍ Non-criminal problems, informal probation, truancy, minor litigation, mutually agreeable divorce/custody issues, no threat of jail 8
- ❍ No legal involvement at all 10

13. How safe do you feel in your home, school, and community or village? (General safety refers to issues such as domestic violence, homelessness, safety of community or village, bullying, prejudice, or family conflict.)

- ❍ I feel unsafe almost all the time 1
- ❍ I feel unsafe most of the time 2
- ❍ I feel safe sometimes, but feel unsafe other times. 3
- ❍ I feel safe most of the time. 4
- ❍ I feel safe almost all of the time. 5

14. During the past month, how would you rate your sense of connectedness, spirituality, relationship with a higher power, or meaningfulness of life:

- ❍ Very bad 1
- ❍ Not good 2
- ❍ Fair 3
- ❍ Good 4
- ❍ Excellent 5

15. Do you have any children under the age of 18?

- ❍ Yes NO SCORE
- ❍ No (If no, stop here)

During the last six months, have you lost custody of any of your children due to Office of Children's Services (OCS, the old DFYS) action or intervention?

- ❍ No (If no, stop here) NO SCORE
- ❍ Yes Minus 10 (-10)

If you have previously lost custody of any of your children as a result of OCS (old DFYS) action or intervention, have you regained custody in the last six months?

- ❍ No NO SCORE
- ❍ Yes 5

16. If you have previously lost custody of any of your children as a result of OCS (old DFYS) action or intervention, are you now in compliance with your OCS (old DFYS) Plan?

❍ No	NO SCORE
❍ Yes	5

Follow Up Questions to be Added To the Above after Discharge

THIS SECTION IS NOT SCORED

1. How satisfied are you with the treatment you received or are receiving?

   ❍ Not satisfied
   ❍ Somewhat unsatisfied
   ❍ Satisfied
   ❍ Very satisfied
   ❍ Extremely satisfied

2. What part of treatment has been most helpful to you?

   ❍ Counselor
   ❍ Groups/Classes
   ❍ Case Management
   ❍ Other Clients
   ❍ Other _____

3. What do you like least about the services you have received?

   ❍ Counselor
   ❍ Groups/Classes
   ❍ Case Management
   ❍ Other Clients
   ❍ Other _____

4. Were you treated with respect?

   ❍ Yes
   ❍ No

Instructions

This form should be given to all service users at intake, at every three months post intake for children, at every six months post intake for adults, and at six and twelve months post discharge.

The scores for this review form will range from 10 to 100.

There are 11 domain areas represented by the above questions. For domains that are represented by two questions, each question is valued at a possible 1-5 points. For domains that are represented by only one question, the value is a possible 2-10. This creates the possibility of ten points per domain. The exception is the set of custody questions. If you have no children under 18, there is no score. If your children are not in custody, there is no score. If you have lost custody of your children, 10 points are subtracted from your score—reflecting the increased stress caused by this situation. If you have regained custody, or are in compliance, you recoup those lost 10 points.