

Prepared for:

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

Alaska Behavioral Health Integration Stakeholder Committee Report

Section I – Report Summary

June 1, 2004



Information Insights, Inc.
212 Front Street, Suite 100
Fairbanks, Alaska 99701
(907) 450-2450

<http://www.infoinsights.com>

Contents

Contents	2
Executive Summary	3
Overview.....	6
Committee process.....	8
Recommendations.....	9
Communications Recommendations	9
Outcomes Recommendations.....	9
Continuity of Care Recommendations.....	11
Provider Network Recommendations.....	12
Financing Recommendations.....	13
Licensing, Certification & Workforce Development Recommendations.....	18
Statutory and Regulatory Change Recommendations	19
Mission of Behavioral Health System	21
Appendix I: Levels of Community	22
Appendix II. Draft Levels of Community Care	24
Appendix III: Stakeholder Work Groups.....	26

Executive Summary

In 2000 the Alaska Department of Health and Social Services, following a national trend, initiated efforts to begin looking at the integration of mental health and substance abuse treatment services. Out of those initial planning efforts emerged specific recommendations for state level change strategies including the need to get broader stakeholder input in the integration process. Acting on that recommendation the Division of Behavioral Health (DBH) teamed with the Alaska Mental Health Trust Authority (The Trust) to convene the Alaska Behavioral Health Integration Stakeholder Committee.

Committee purpose and goals

The purpose of the Behavioral Health Integration Stakeholder Committee is to provide a public process for broad stakeholder input into the development of a consensus vision of a comprehensive, well-integrated community based behavioral health service system. The intent is for the development of a strategic plan to articulate, in a user-friendly format, the vision, goals and actions needed to develop a sound behavioral health system in Alaska. The process has been intended to provide the framework for integration at every level and by all parts of the behavioral health system, both private and public.

The goals of the process include:

- Communicate the change process to service providers and clients/consumers. (*Communication*)
- Communicate information about available services and how to access those services. (*Communication*)
- Recommend tools and outcome measures relevant to the effectiveness of service, movement toward recovery and satisfaction with services. (*Outcomes*)
- Recommend a process for approaching treatment in an integrated system. (*Continuity of Care*)
- Identify ways to develop the behavioral health human resource capacity to meet the needs of an integrated behavioral health system. (*Workforce Development*)
- Suggest ways in which providers, state policy makers and other stakeholders can work together to integrate services. (*Provider Collaboration*)
- Recommend financing of an integrated behavioral health system. (*Finance*)
- Outline a process for making statutory and regulatory changes necessary to carry out recommendations. (*Statutory Change*)

To accomplish this work the committee divided into seven workgroups each comprised of committee members and other interested parties. Through the workgroup efforts the committee outlined a total of one hundred and sixty (160) recommendations. A summary of the recommendations relevant to each workgroup include:

- **Communications Workgroup** –The communications group recommended ways that DBH can increase communication between the division and various stakeholder groups. Specific recommendations include:
 - DBH develop a **behavioral health services resource guide**.
 - DBH revamp the **DBH web site**.
 - DBH develop a **newsletter**.
- **Outcomes Workgroup** – The recommendations from the outcomes group cover issues related to planning & evaluation of behavioral health services including the recommendation that:
 - **Planning and evaluation** be a simple, easy to describe, relevant to life domains and wellness measures using uniform data that is supported by evidenced-based practice.
 - DBH develop **performance measures** that are simple, responsive, and focus on recovery
 - The **AKAIMS** (Alaska Automated Information Management System) data collection be flexible in its ability to report under various different data characteristics and modalities using the client status review form as the ongoing measuring tool.
 - DBH ensure **consistent data** by requirements for providers to use all required fields via AKAIMS or electronic data interface.
 - **DBH program quality assurance** efforts mix with externally managed quality assurance (QA)(and provider self-evaluation.
- **Continuity of Care Workgroup** – The continuity of care workgroup explored issues related to defining core services within a unified continuum of care as well as the need for community planning in the regionalization of services. Other specific recommendations included:
 - Services go **beyond emergency response** and include prevention and ongoing intervention.
 - A **uniform screening and assessment** process be developed for services and **clinical standards** be adopted based on evidence based practices, blending the best aspects of mental health and substance abuse services.
 - **Consumer / family / peer support** and advocacy efforts be supported.
- **Provider Network Workgroup** – Related to integrating services, several of the provider network recommendations focused on the need for collaboration and partnership among stakeholders including providers, DBH, the Department of Corrections (DOC) and consumers. Other recommendations included:
 - Consideration be given to **integrating behavioral health with primary care** services.
 - DBH define level of service relevant to community size and location across a defined **continuum of care**
 - DBH clearly define **state budgetary constraints** and provide incentives for programs that have already moved toward integration.
 - **Consumer / client input** be considered in the planning process.

- **Financing Workgroup**– The financing workgroup outlined specific recommendations on issues related to state grants, state quality assurance and oversight, and federal funds. Relevant to Medicaid financing, the committee looked at concerns related to tribal and Alaska Native Health Corporation (ANHC) financing, out of state residential psychiatric treatment, Community Mental Health & Substance Abuse services and School-based Medicaid. Specific recommendations included:
 - The **state grant** request for proposal (RFP) process be simplified allowing for electronic submission and that grants be consolidated and extended.
 - The **program oversight process** be simplified, integrated and include consumer/family input.
 - With regards to **Medicaid financing**:
 - There be a coordinated, thoughtful effort to support agencies in the movement to maximize the use of federal funding through **tribal 638 providers**.
 - Efforts be increased to keep **children’s services in-state** using the Medicaid reimbursement structure efficiently and effectively.
 - DBH develop **new regulations** regarding community mental health and substance abuse services should include input from stakeholders and training/support to providers.
 - DBH rack and **coordinate other federal/state funding** opportunities
 - DBH support agencies in **maximize other funding** sources including 3rd party billing and private grants/foundations
 - The legislature enact **insurance parity** legislation.
- **Licensing, Certification and Workforce Development Workgroup** – Recommendations from this group centered on both program approval/licensing and individual training and credentialing including recommendations that:
 - **Integrated program standards** be developed that would include how, when and which programs would be licensed/approved.
 - An **integrated credentialing process** be developed outlining individual staff competencies
 - There be increased access to **integrated and single-service training** for all program staff with particular attention paid to credentialing and supervision needs.
 - An **ongoing workgroup** with representatives from the certification commission and licensing entities continue to address workforce development issues working closely with the University of Alaska.
- **Statutory and Regulatory Change Workgroup** – This group outlined suggestions for the development of a **model legal framework** for implementing a system of integrated behavioral health care that can be used then introducing policy change to the legislature. The committee suggested:
 - The system be **comprehensive, community-based, accessible, holistic, consumer/client centered and accountable**.
 - **Key areas for policy change** include equity in access to services, defining authorities, roles and responsibility throughout the integrated service system and outlining client rights/responsibilities relevant to service provision.

Overview

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.¹

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.

¹ State of Alaska Consensus Document – Behavioral Health Services Integration, working draft 12/12/01

STAKEHOLDER COMMITTEE MEMBERSHIP

The division established a coordinating committee consisting of Bill Hogan, DBH Division Director; Jeff Jessee, Executive Director, the Trust; Karen Pearson, DBH Associate Director; Richard Rainery, AMHB Executive Director; and Pam Watts, ABADA Executive Director. The coordinating committee selected stakeholder representatives and directed the work of the committee contractor, Information Insights. Appointed stakeholder representatives, in addition to the steering committee members, included:

State of Alaska:

- Michelle Bartley, Health Facilities Supervisor I DHSS DBH
- Bill Herman, Trust Program Officer, the Trust
- Karleen Jackson, Deputy Commissioner DHSS

Providers:

- Patrick Hefley, Director Southeast Alaska Regional Health Center
- Walter Majoros, Executive Director Juneau Youth Services
- Kevin Murphy, Executive Director Gateway Human Services
- Diana Weber, Vice President, Rural Mental Health Association

Clients / consumers / family representatives:

- Kimber Jackson, Community Resources
- Jeri Lanier, Chair AMHB
- Trish McDonald, Youth Advocate Alaska Youth & Family
- Cristy Willer Tilden, Chair, ABADA

Other stakeholders:

- Ed Krause, Member, Alaska Native Health Board
- Karen Perdue, Associate Vice President, University of Alaska
- Scot Prinz, Behavioral Health Consultant Alaska Native Tribal Health Consortium (ANTHC)

Other active consumer/client representatives in the Stakeholder Committee process included

- Susan Trapp, Consumer advocate
- Frances Purdy, Program Manager, Alaska Youth and Family Network

Significant assistance to the process was provided by Work Group members and Division of Behavioral Health staff. Several members of the group designated alternates to participate in meetings, including Lonnie Walters (for ABADA), Joe Lind and Annette Freiburger (for the Alaska Rural Alcohol and Drug Abuse Providers – ARANDAP), and Torie Foote (for UA).

COMMITTEE PROCESS

The first stakeholder committee meeting was held on Aug. 14-15, 2003. The meeting was held in Anchorage and broadcast via webscription and teleconference. During the meeting the group identified and defined the major issues and outcomes related to the behavioral health integration process. After specifying key areas for further consideration, work groups were identified and assigned to define, problem solve and make recommendations in key areas relevant to carrying out the integration plan. The work groups and their conveners are as follows:

- **Communications** – Richard Rainery
- **Outcomes** – Bill Herman
- **Provider Network** – Pam Watts
- **Finance** – Walter Majoros
- **Continuity of Care** – Kevin Murphy
- **Licensing/Certification/Workforce Development** – Michelle Bartley
- **Statutory Change** – Jeff Jessee

Each work group expanded its membership by inviting interested parties and recruiting specialists and experts in their area of concentration. (See Appendix III for a list of work group members). Over the course of the next three months each work group met telephonically an average of four times. With the following goals in mind, each group then developed and submitted a report to the larger group outlining recommendations relevant to their area of concentration.

The stakeholder committee met by teleconference in late September 2003 to chart progress and make new assignments. It then met in Anchorage on November 20-21, 2003 to review each of the work group reports, expand and refine the issues identified, and adopt recommendations. The committee met in a final teleconference December 16, 2003 to review the report and adopt final recommendations.

Recommendations

The recommendations in this report are organized by work group areas.

COMMUNICATIONS RECOMMENDATIONS

- **BH Resource Guide** - Design and produce a Behavioral Health resource guide to be made available in both hard copy and through the DBH website.
- **Web Site** - DBH should revamp their web site to make it more user friendly making specific recommendations for reconstruction.
- **Feedback** - Create feedback loop to 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.
- **Newsletter** - Produce a newsletter to be made available both in paper and electronic format and use it to draw attention to BH news and specific topics as appropriate.
- 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 RECOMMENDATIONS

Planning and evaluation should:

- Be simple, easy to describe, reviewed frequently by the boards, Trust and 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 (five to ten 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.
- Use the “cross walk of life” domain areas to ensure that the Trust, AMHB and ABADA are using a common language and construct and therefore enhances the communication power of all.

Performance Measures Recommendations

Performance measures should:

- Provide an estimation of need;
- Be simple and representative;
- Be focused on recovery; and
- Measure improvements and degradations in client / consumer life domain areas.

Client Status Review Domains Form should:

- Be part of AKAIMS (Alaska Automated Information Management System) and *required* of *all* providers;
- Be deemed as *critical* for understanding the effectiveness of all behavioral health programs and for measuring client / consumer recovery; and
- Be utilized at admission, during treatment, at discharge and for at least a year after discharge.

AKAIMS Reports:

- Ensure AKAIMS Reports are helpful in program evaluation and policymaking.
- 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 management information system (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. number of clients in each component;
- Report of admissions & types of terminations by client characteristics by component and 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.

DBH Quality Assurance should:

- Ensure consumer/client satisfaction;
- Ensure public, client and staff safety; and
- Ensure recovery (i.e. life domain improvements among consumers/clients).

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
 - Utilization of AKAIMS data for ensuring recovery and consumer satisfaction.
- **Provider managed:** Use AKAIMS to monitor efficiency (staff, bed or outpatient slot utilization, etc.) and effectiveness (tracking client recovery and consumer / client satisfaction) within their organizations.

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, and should ensure the system keeps its focus of avoiding “Data Black Holes” – if we aren’t using data then we should quit gathering data.

CONTINUITY OF CARE RECOMMENDATIONS

- **Core services** – Core services in the behavioral system go beyond emergency services. Prevention/intervention needs to be included as well as special population groups in the continuum. The continuum also needs to include screening/assessment, rehabilitation/recovery and aftercare. It is easiest to cut prevention / entry which increases cost of services later / intensive.
- 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.

- **Screening** - The behavioral health system should make use of the unified screening tools that were developed by the co-occurring screening disorders committee.
- **Community Planning** - There be extensive community planning to meet the mandates of regional planning stated within the current State of Alaska documents. There needs to be a regional planning document, as it is dictated by the statutes.
- **Regulatory changes** – Regulatory changes fully integrate Mental Health and Substance Abuse. This change becomes particularly crucial in terms of creating an integrated set of Medicaid behavioral health regulations.
- **Clinical Standards** – Clinical standards for programs be addressed at a system level and with this change in standards, similar expectations for all grantees.
- Develop and foster a **common language** between Mental Health and Substance Abuse. This becomes especially important in regard to thorough and comprehensive assessments.
- **Evidence based practices** along with promising, emerging, innovative and value-based practices be the standard for programs funded by DBH.
- 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.”
- **Continuum of Care** - 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.
- Using the “levels of community” and “levels of community care” documents (attachments A and B) 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 should be completed by January 15, 2004.
- **Funding** - When looking at expectations of programs include federal and other monies flowing into communities, currently there is no coordination with SAMHSA grants.
- **Consumer / Family** - Support consumer/family advocacy/education efforts for both mental health and substance abuse treatment recipients.

PROVIDER NETWORK RECOMMENDATIONS

- **Community Planning** - Approve proposal for Behavioral Health Community Planning Process (Outcome: completed)

- 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.
- **Budgets** - 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%, 3) budget decreases 25%.)
- The **Department of Corrections** will become a partner in this planning process since so many mental health consumers/clients and persons with substance use disorders or co-occurring disorders are in jails and other correctional institutions.
- **Client / consumer input** - A means to gather and disseminate client / consumer input as part of planning process be developed.
- **Regionalization** - DHSS work in collaboration with ABADA / AMHB to define service areas looking into different definitions of regions
- When looking at regionalization, strategies focus on collaboration as well as administrative cost reduction.
- Identify options for how providers might be organized using a regionalization concept.
- **Collaboration** - The process fosters provider collaboration encouraging the provider groups to work together.
- Look at collaborating on an administrative level to develop tools and models to use across programs – especially in the process of assessment.
- **Continuum of care** - Develop a well-defined continuum of care to guide service providers in defining their services.
- **Primary care** -Explore the possibilities of the additional integration of primary care.

FINANCING RECOMMENDATIONS

State grants

- Resolve some of the issues originally identified in 2001 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.

- Simplify RFP and quarterly reporting (for example, automated AKAIMS reporting). Cumulative fiscal reporting/narrative reports. Streamline Notification of Grant Award (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, alcohol and drug 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).
- DBH (DHSS) should consolidate/blend funding streams after 1-2 year start-ups.

Quality assurance and program oversight

- Simplify and align regulations governing 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 (as in the Infant Learning Program (ILP)).
 - 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 / client, 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.
 - Evaluate transportation costs/client requirements before deciding upon regional hubs.
 - Pilot alternative reimbursement mechanisms, such as 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.

Medicaid financing of behavioral health services

Tribal and Alaska Native Health Corporation Financing

- **638 Contracts** - To the extent that the State moves toward 100 percent federal reimbursement for services to Alaska Natives through 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.
- That Alaska DBH staff carefully review the Arizona model for aspects that may be possible to implement in Alaska to maximize federal revenue for services and improve service delivery.

Out of state residential psychiatric treatment

- 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 capacity of regions and communities throughout the state.
- Support the Division of Behavioral Health'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 Residential Psychiatric Treatment Center (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.

Community mental health and substance abuse services

- 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.

School-based Medicaid

- 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. This model should 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.

Federal funding

- Coordinate federal funding sources and opportunities.
- Track Substance Abuse and Mental Health Services Administration (SAMHSA) grant applications and have applicants copy the state and get state and SAMHSA grantees together.

Other funding sources

- Create enhanced ability for programs to generate revenue for client services.
- 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 University of Alaska (UA) billing coding certificate program – expand to BH.
- Ask providers to 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.
- 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 exemptions for employers with fewer than 20 employees.
- Analyze service demand vs. service capacity and include 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. The state should work with the Federal government, tribal organizations, and city and borough governments to organize this plan.
- Partner with the Denali Commission to encourage changes in funding practices consistent with the rapidly changing needs in the service sector. 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. Ensure that programs/services drive facility requirements. Link facilities to BH needs assessment.

Other financing recommendations

- The Trust should act as the clearinghouse to track all behavioral health money.
- Efforts should be made to integrate physical and behavioral health issues when looking at primary care.
- The Department should encourage behavioral health partnership and collaboration with Federally Qualified Health Centers (FQHC's).

- The Alaska Community Mental Health Services Association (ACMHSA) should analyze the Medicare reform bill for impacts on the BH system.

LICENSING, CERTIFICATION & WORKFORCE DEVELOPMENT RECOMMENDATIONS

Ongoing work

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

Program approval and licensing

- Integrated program standards for use by the State should be developed/adopted for the program approval/licensing process.
- A process for determining how agencies are licensed or approved should be developed. In addition, 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 the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).
- A process for determining which agencies are licensed or approved should be developed.

Individual licensure and certification

- Behavioral Health standards of competency need to be reviewed for adaptation for the certification/licensure process.
- Develop a co-occurring disorder credentialing process.

Training and 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.
- Statewide training be made available to meet any gaps created once behavioral health standards of competency are developed.
- Ensure that all programs have access to training for credentialing.
- Streamline training availability to ensure accessibility for all providers.
- 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 at conferences scheduled throughout the year.
- Consider substance abuse training needs for master's level and licensed providers when developing a statewide training plan. 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.
- Have UA 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.
 - Explore ways to provide clinical supervision using distance delivery methods.
 - Seek to align state funded and other public, private, federal, and university workforce development efforts.

Longer-term issues that will need to be addressed include:

- Parity in benefits and pay to mental health and substance abuse professionals;
- Examination ways which adequate training impacts recruitment and retention of quality staff;
- The need for adequate funds to invest in staff.

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 that 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 client / consumer interests and rights are primary and consumer / client 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 that 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 / clients; and the relationship of the boards to the Trust, State and community agencies.
- DBH and the Trust should jointly sponsor a 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. This process would be concluded by November 2005 and provide the basis for draft legislation, 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, which defined as model statutes are developed.

Mission of Behavioral Health System

DBH, the Trust, AMHB and ABADA need to codify a Mission and Core Values or Guiding Principles for Alaska’s behavioral health system. As a starting point for discussion, the stakeholders recommend the following Mission:

Alaska’s behavioral health system provides “no wrong door” access to the range of publicly funded services that promote recovery for Alaskans experiencing mental health and substance abuse problems, their families, and their communities.

As a starting point for discussion, we offer the following Core Values:

1. **Consumer/Client-Centered.** Any successful service system must be client/consumer-centered. A consumer/client-centered system is one in which mental health and substance use disorder consumer/clients and their families are actively involved not only in treatment decisions, but also in program design, administration, and evaluation.
2. **Availability of Services.** Individuals should have access to a comprehensive array of services appropriate to their needs. Treatment of co-occurring disorder should be individualized to accommodate the needs of different sub-types and different phases of treatment for all established diagnoses.
3. **Culturally Competent.** Service systems should observe and respect the values and beliefs of the diverse cultures of our client/consumers and should be provided by staff that are culturally competent.
4. **No Wrong Door.** Services for persons with co-occurring disorders must be available and accessible wherever, and whenever, the person enters into the service system. The “no wrong door” approach ensures an individual will be treated or referred for treatment, whether he or she seeks help for mental health, substance use disorder, or a general medical condition.
5. **Administrative Systems.** Administrative systems and procedures should not present a barrier to effective delivery of services to persons with co-occurring disorders.
6. **Respectful Partnership.** In order to deliver the most appropriate services to persons with co-occurring disorders, substance use disorder and mental health professionals must work together in a respectful partnership. This partnership must honor the strengths that each sector brings to the table and respects the values, professional standards, and achievements that each sector has developed.
7. **Resources for Services.** Any system for delivery of services to persons with co-occurring disorders should have adequate resources to ensure a safe, comfortable physical setting with appropriate program materials, and a trained and appropriately compensated staff.

Appendix I: Levels of Community

(AMHB rev. 8/93)

Characteristics	Level I Village	Level II Sub-Regional Center or Town	Level III Regional Center or Small City	Level IV Urban Center	Level V Metropolitan Area
Government	Community or city council, Native council, incorporated city or unincorporated community.	Incorporated city may have health powers and may provide health and social services.	Incorporated city or unified municipality may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000.	25,000+ in immediate community providing services to a larger regional or statewide population.	200,000+ in immediate community.
Economy	Subsistence, government services (e.g. school)	A developing private sector, some government services; provides some service to surrounding areas.	Regional trade and service center, mixed economy with multiple private and government employers.	Major trade and service center, broad based multi-sector economy.	Principal trade and service center; broad based, multi-sector economy.
Health & Social Services	Community Health Aide, para-professional and itinerant services.	Health and social services may be provided by the private and public sector, community clinic and mid-level provider or MD.	Health care and social service agencies, including both private and government programs; community hospital and physicians.	Multiple providers of health care and other services including both private and government programs; health care specialists; hospitals with full continuum of care.	Level IV plus highly specialized medical and rehabilitation services, specialized hospitals and consultive services.

Characteristics	Level I Village	Level II Sub-Regional Center or Town	Level III Regional Center or Small City	Level IV Urban Center	Level V Metropolitan Area
Access	Usually, more than 60 minutes by year-round ground transportation from a Level II or III community; limited air and/or marine highway access to Level II or III community.	Usually, less than 60 minutes by year-round ground transportation from a Level III community; marine highway or daily air access to closest Level III community; airline service to Level I communities in the area.	Daily air service to closest Level IV or V community; airline service to Level I and II communities in the region; road or marine highway access all year.	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Daily airline service to Level II-IV communities; road or marine highway access all year.
Communities	Too numerous to list, includes Anvik, Eagle, Houston, Ruby, Hydaburg, Wales, Skagway, etc.	Aniak, Craig, Delta Junction, Tok, Emmonak, Fort Yukon, Galena, Haines, Hoonah, Hooper Bay, King Cove, King Salmon/Naknek, Nenana, McGrath, Metlakatla, Mountain Village/St. Mary's, Sand Point, Togiak, Unalaska, Unalakeet, Glennallen/Copper Center	Barrow, Bethel, Dillingham, Homer, Kenai/Soldotna, Ketchikan, Kodiak, Kotzebue, Nome, Palmer/Wasilla, Sitka, Cordova, Petersburg, Wrangell, Valdez, Seward	Fairbanks, Juneau	Anchorage

Appendix II. Draft Levels of Community Care

	Community Based Services	Residential Services	Inpatient Services
Level I Village	Advocacy/self-help outreach crisis response screening/assessment/ evaluation/referral/(maybe I) prevention/intervention supportive relationship family support supported living school/home-based services individualized services community education protective services/ guardian/public advocate services vocational rehabilitation (I) medication management (I) case management (maybe I) treatment planning (I) 24 hour telephone screening, assessment, triage face-to-face assessment /triage transportation for emergencies in-home crisis support	respite foster home emergency foster care semi independent living therapeutic/specialized foster homes (possible)	

	Community Based Services	Residential Services	Inpatient Services
Level II Sub-Regional Center or Town	Case management treatment planning chemotherapy/nursing medication management psychosocial rehabilitation skill training therapy activity therapy diagnosis vocational rehabilitation day treatment	family teaching homes (possible) crisis beds board and care homes therapeutic group homes (possible) staff secure crisis/respice group homes	crisis/respice (facility based)
Level III Regional Center	see Level II outpatient specialized drug/alcohol evaluation/treatment	see Level II residential crisis management specialized drug/alcohol evaluation/treatment	community hospitals
Level IV Urban Center	see Level III specialized vocational rehabilitation	see Level III nursing homes Pioneers Homes	see Level III
Level V Metro Area	see Level IV	see Level IV	API geriatric mental health assessment/treatment facility

Appendix III: Stakeholder Work Groups

Work Group	Purpose & Issues	Members (convener*)
Communications	<ul style="list-style-type: none"> ▪ Communicate change process to providers and consumers ▪ Communicate about services and access to service 	<ul style="list-style-type: none"> ▪ Richard Rainery* ▪ Pam Watts ▪ Kevin Murphy ▪ Susan Trapp ▪ Anna Sappah
Outcomes	<ul style="list-style-type: none"> ▪ System outcomes ▪ Outcomes for individuals, families, communities, populations ▪ Outcomes measurement ▪ AkAIMS 	<ul style="list-style-type: none"> ▪ Patrick Hefly* ▪ Pam Watts ▪ Bill Herman ▪ Jeri Lanier ▪ Kimber Jackson ▪ Becky Fowler ▪ Anna Sappah
Screening / assessment / continuum of care	<ul style="list-style-type: none"> ▪ Service continuum 	<ul style="list-style-type: none"> ▪ Kevin Murphy* ▪ Walter Majoros ▪ Michelle Bartley ▪ Kimber Jackson ▪ Ann Henry
Licensing / certification / workforce development	<ul style="list-style-type: none"> ▪ Provider licensing & certification ▪ Practitioner licensing & certification ▪ Education & training ▪ Recruitment & retention 	<ul style="list-style-type: none"> ▪ Michelle Bartley * ▪ Karen Perdue ▪ Cheryl Mann ▪ Scot Prinz ▪ Diana Weber ▪ Lonnie Walters
Provider network / collaboration	<ul style="list-style-type: none"> ▪ Collaboration between providers ▪ Network of providers ▪ Collaboration with other systems, including primary care, corrections 	<ul style="list-style-type: none"> ▪ Pam Watts* ▪ Patrick Hefley ▪ Doug Viet ▪ Scot Prinz ▪ Jeri Lanier ▪ Mark Walker ▪ Lonnie Walters

Work Group	Purpose & Issues	Members (convener*)
Financing	<ul style="list-style-type: none"> ▪ Methods for financing behavioral health system ▪ Sources of funding – use of federal, foundation, private funds 	<ul style="list-style-type: none"> ▪ Walter Majoros* ▪ Richard Rainery ▪ Kevin Murphy ▪ Karen Perdue ▪ Diana Weber ▪ Bill Herman ▪ Pat Hjellen ▪ Mark Walker ▪ Patrick Hefley
Statutory change / regulations	<ul style="list-style-type: none"> ▪ Existing statutory framework ▪ Development of new legislation 	<ul style="list-style-type: none"> ▪ Jeff Jessee & Russ Webb* ▪ Karen Perdue ▪ Pam Watts ▪ Lonnie Walters