State of Alaska
Department of Health and Social Services
Division of Behavioral Health

Infrastructure Analysis Project

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ECI
ARCHITECTURE
DESIGN
STRATEGY

This Project is a collaboration between:

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Alaska Psychiatric Institute
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Community Connections
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Daybreak
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Fairbanks Native Association
Family Centered Services of Alaska
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Frontier Community Services
Gastineau Human Services
Hope Community Resources
Interior AIDS Association
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Juneau Youth Services
Kawerak Inc.
Kenai Peninsula Community Care Center
Kenaitze Indian Tribe Dena'ina Wellness
Ketchikan Indian Community
Kodiak Area Native Association
Kodiak Mayor's Summit Coalition
Kodiak Women's Resource Center
Maniilaq Association
Maniilaq Health Services
Matsu Foundation for Health
Mat-Su Health Services
Matsu Regional Medical Center
Ninilchik Traditional Council
No Limits
Nome Community Center
North Slope Borough
Northwest Arctic Borough School District
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Providence Crisis Recovery Center
Providence Kodiak Island
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SE Alaska Regional Health Consortium
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Table of Contents

Executive Summary

In January 2018, the State of Alaska applied to the Centers for Medicare and Medicaid Services (CMS) for approval of a 1115 Behavioral Health Waiver at the direction of the Alaska Legislature through Senate Bill 74. The 1115 Behavioral Health Waiver adds reimbursement for new substance disorder and mental health services in Alaska.

This infrastructure analysis project was developed to identify, locate and estimate costs for infrastructure investments that could improve service delivery and access to the new 1115 Waiver. A team composed of representatives from the State of Alaska's Division of Behavioral Health, the Office of Children's Services and ECI Alaska, an architecture and strategy firm based in Alaska, collected the information for this report. This report was written by ECI Alaska.

The team questioned over 75 organizations across the state, most of them behavioral health providers. The behavioral health providers responded to our questions in face-to-face meetings and questionnaire responses. Meetings were held prior to the release of 1115 Medicaid reimbursement rates. Without rates, providers were able to respond directly to their beneficiary's and client's needs without reimbursement rates affecting their response. The majority of responses were consistent across Alaska.

Providers repeatedly stressed the need for treatments that address clients' behavioral health needs comprehensively and with a preventative focus, such as finding ways to stabilize home environments and find reliable transportation for regular meetings with providers. Providers also iterated that critical behavioral health services are entirely missing from most communities and from entire regions in Alaska. Missing services include crisis stabilization, partial hospitalization, home-based treatment, children's residential, assertive community treatment, and residential 3.1, 3.3 and 3.5 services. Fairbanks needs a significant infusion of new providers and service locations.

Providers emphasized that investing in facilities alone would not be enough to effectively and permanently bring missing services to their communities. They stressed the need for additional qualified staff, better housing and reliable transportation for their clients to successfully implement and deliver the 1115 services.

... introduce missing services, more qualified staff, better housing and reliable transportation.

Project Timeline

July 31, 2017	Alaska Medicaid 1115 Demonstration Concept Paper submitted
January 31, 2018	Alaska Medicaid 1115 Demonstration application submitted
November 20, 2018	Center for Medicaid Services allows Initial Approval of "Substance Use Disorder Treatment and Alaska Behavioral Health Program"

Infrastructure Analysis Survey Phase

February 11, 2019	First Survey Meeting for this report
March 20, 2019	Center for Medicaid Services Approves the Substance Use Disorder Implementation Plan
June 19, 2019	Last Survey Meeting for this report
June 26, 2019	Substance Use Disorder Rates Proposed
July 11, 2019	Emergency Regulations affecting Medicaid rates for State Fiscal Year 2020 distributed
September 2, 2019	Center for Medicaid Services Approves the Behavioral Health 1115 Demonstration
August 15, 2020	Start Pre-development (step 2)
December 31, 2022	End Statewide Implementation (step 3)

Recommended Next Steps

see chapter 1 of this report

Up-to-date 1115 Behavioral Health Medicaid Waiver documents and their distribution dates can be found on the Division of Behavioral Health's website: *http://dhss.alaska.gov/dbh/Pages/1115/default.aspx*

Initial Goals and Adjustment

Goals

The initial goal of this project was to quantify infrastructural improvements needed to improve 1115 services (the word *infrastructure* refers to a building or space that a provider would use to administer their services). Specifically the intent was to:

- Identify the demand for a service.
- Locate a building or space that a service provider could use to deliver services.
- Estimate the cost of construction for occupying each location.

Process

The project team sent behavioral health providers across Alaska a questionnaire and then held face-to-face meetings with them individually. Staff from the Division of Behavioral Health and the Office of Children's Services were present in every meeting. During meetings the project team reviewed 1115 services and draft questionnaire responses, listened to and recorded provider comments and then tried to assist providers in completing the questionnaire by reviewing its questions and topics.

The questionnaire contained three sections. The first asked about service demand and services missing from a provider's community. The second section verified the readiness of the provider and the provider's community to support those missing services. The third assisted the provider in identifying a potential future location for a missing service by identifying the appropriate building type and its relation to existing services.

Provider Responses

It quickly became apparent to the report team that providers paid particular attention to the portions of the survey related to a provider's and a community's ability to meet demand for behavioral health services. Providers raised a number of questions related to staffing, barriers to care (which often were identified as a lack of support or resources in lieu of a barrier), transportation, food distribution, education, housing, emergency services and employment. These provider responses to the questionnaire and the 1115 Waiver had much less to do with buildings than with a provider's and community's capacity to provide services.

Adjustment

The provider responses surprised the survey team. The survey team was also surprised to realize that the providers did not have concrete plans for offering 1115 services at the time of our meetings. In response, the project team altered its approach both by broadening the scope of questions to identify barriers to services that were not directly infrastructural such as lack of staffing, housing and transportation, and tried to help inform providers about the resources and process of the 1115 Waiver itself.

Chapter 1

Next Steps

This report team recommends that a pre-development process be initiated to:

- verify provider input gathered for this report
- better understand gaps related to service and access to the 1115 Waiver
- gather better data on 1115 Waiver missing services, particularly in rural areas
- develop solutions

Six case studies are recommended as the next step: one rural and one urban case study for each of the three Population Groups, six case studies total. It is also recommended that the rural and urban case study for each respective Population Group be conducted simultaneously and by the same pre-development coalition team. This will allow patterns, exceptions, details and shared services between urban and rural areas to be more easily identified.

It is important to note that pre-development is not an additional or supplemental step in a business planning or infrastructure design process. It is a fundamental part of any capital improvement process that is needed to generate a business plan, identify capital improvements and investment needs, and solicit funding. Pre-development also helps - in a behavioral health provider context - evaluate prevalence and treatment rates and help ensure that revenue generation is balanced against capital and operational costs to create financially sustainable organizations long term.

Pre-development is often grouped into an overall planning process immediately preceding design and construction. In the case of the 1115 Waiver, however, because so many of the gaps in 1115 Waiver related services are not directly infrastructure related, it is important to conduct a pre-development process prior to any facility design efforts to try to better understand how the state should invest and prioritize 1115 Waiver improvements.

The following is a summary of the recommendations, schedule, and preliminary cost assumptions related to pre-development.

Pre-development & Statewide Implementation

Based on provider feedback, this report recommends a multifaceted investment strategy for 1115 Waiver improvements: a strategy that not only invests in facilities but also in staffing, housing, transportation, and missing services. In order to properly evaluate the holistically intertwined needs and costs of improving the facets related to the 1115 Waiver, the report team recommends the following process (Step 1 - this report is already complete).

1

Step 1. The Providers' Perspective. This report is a first step in a longer process that will be needed to improve access and services for the 1115 Waiver; it involved the following:

- gathering provider feedback
- recording - from providers' perspectives - a point-in-time snapshot of what is needed in Alaska to better support 1115 Waiver behavioral health services
- developing cost estimating tools and metrics that can be used to identify planning and investment strategies for the 1115 Waiver
- creating an overall cost estimate for the investment needed statewide to improve services and access under the 1115 Waiver

Capital investments toward improvements for staffing, housing and transportation should accompany any behavioral health facility investment to reduce the barriers to service delivery.

completed

2

Step 2a. Establish Pre-Development Case Study Teams and Providers – 3 month

1. Identify a State of Alaska Steering Committee for the pre-development case study project. This would likely be comprised of key members from behavioral health organizations and possible housing and/or transportation groups. Identify who on the Steering Committee is the primary point of contact for the pre-development team and overall manager.
2. Issue a Request for Proposals for the pre-development coalition team that would conduct the pre-development studies for each Population Group. Develop an organization chart for the team that identifies individual team member roles as well as who would manage the overall process and be the primary contact for the Steering Committee. Each coalition team should have an expert/s who could gather data and assess the following components of the pre-development process for their respective case study/s:
   - prevalence and treatment rates
   - space needs
   - service types
   - staff and client housing needs
   - staffing needs and employment strategies
   - staff and client transportation needs
   - business plan
   - cost estimate
3. Issue a state-sponsored Request for Expressed Interest to identify specific providers who would participate in the six case studies. The following parameters are suggested based on information gathered for this report:

Step 2b. Conduct the Pre-Development Case Studies – 6-8 months

1. Conduct on-site observations, interviews, and data collection
2. Plan capital improvements and develop cost estimates
3. Provide draft pre-development reports to the Steering Committee for review
4. Issue a final pre-development report for each case study

It is projected that each rural case study would cost roughly $150,000 and that each urban case study would cost roughly $300,000 for the labor and expenses of the pre-development teams. Therefore, the projected labor and expenses costs for the six case studies would be approximately $1.35 million dollars. This excludes any costs related to State of Alaska project management, Steering Committee efforts, or provider involvement, salaries, travel, expenses, etc.

Once the case studies have been completed, they can be used to develop a pre-development implementation plan that would define how pre-development studies could be conducted on a broader scale to better understand how to improve and invest in 1115 Waiver services statewide.

Step 2c. Develop a statewide 1115 waiver pre-development implementation plan and re-evaluate the costs and metrics used in this report. – 3 months

1. Based on the case-study reports and the experiences of the pre-development team and providers, an implementation plan could be developed that would make recommendations related to:
   - Pre-development team composition and acquisition process
   - Schedule and scope of the studies
   - Data gathering and recording processes
   - Cost of pre-development studies – this may vary between rural and urban areas and types of services or providers
2. The cost metrics used in this report are high-level and preliminary. The case studies will likely reveal nuances that allow those metrics to be refined. For instance, this report uses construction costs based on new construction. The case studies may reveal that it is more likely for providers to be able to take advantage of existing spaces or utilize low-cost space efficiency measures and allow cost metrics to be reduced. Conversely, because rural providers did not provide substantive or detailed feedback for this report, the cost assumptions in this report (step 1) for rural areas may be too low once the appropriate data is gathered as part of pre-development (step 2).

3

Step 3. Statewide implementation and cost projections

Finally, a statewide implementation of 1115 Waiver improvements could be initiated, including:

1. Once cost metrics are refined, the overall statewide cost estimate for improving service delivery and access to the new 1115 Waiver that is included in the beginning of this report can be adjusted.
2. Funding procurement and project implementation can be initiated for the six completed case studies if that is deemed appropriate by the state.
3. Pre-development studies can be initiated on a statewide basis, and they can be prioritized based on the six pre-development case study reports and data.
4. Funding procurement and project implementation can be initiated more broadly statewide to improve 1115 waiver services and access.

Chapter 2

1115 Waiver Information

This chapter summarizes the basic elements of the 1115 Behavioral Health Waiver. The service definitions are provided for reference only: see official State of Alaska documents for the most up-to-date information.

Regions: The Department of Health and Social Services divided the state into nine regions and sixteen regional hubs to allow Medicaid data tracking and reporting.

Services[1] and Populations Groups: The 1115 Behavioral Health Medicaid Waiver services are split into four categories serving three different population groups:

- Shared Services for the Substance Use Disorder/Opioid Use Disorder Program, at-risk Children and adolescents ages 0-21 and individuals 18 years and older.
- Population Group 1 Services for at-risk children and adolescents ages 0-21 Children, Adolescents and their Parents or Caretakers with or at risk of Mental Health and Substance Use Disorders (any member of the family, including parents and caretakers, are eligible to receive Group 1 services if they or their children/siblings meet Group 1 eligibility criteria).
- Population Group 2 Services for individuals 18 years and older, Transition Age, Youth and Adults with Acute Mental Health Needs.
- Population Group 3 Substance Use Disorder/Opioid Use Disorder Program Services.

1 Service Definition Source: Lynch, Calder, U.S. Department of Health & Human Services, Center for Medicaid & CHIP Services, "1115 Demonstration Approval: Letter of Approval and Special Terms and Conditions," (September 3, 2019), *http://dhss.alaska.gov/dbh/Pages/1115/default.aspx* (accessed December 2019)

1115 Waiver
Regions and Hub Communities

Regions are not intended to contain or correspond to provider's catchment areas. Populations are based on Alaska Department of Labor 2018 Population Estimates by Census Subarea.[1]

Region 1 - Anchorage Municipality
population: 295,365
hub: Anchorage

Region 2 - Fairbanks North Star Borough
population: 97,121
hub: Fairbanks

Region 3 - Northern and Interior Region
population: 24,018
hubs: Fairbanks and Utqiagvik

Region 4 - Kenai Peninsula Borough
population: 58,471
hubs: Soldotna and Homer

Region 5 - MatSu Borough
population: 105,743
hub: Wasilla

Region 6 - Western Region
population: 44,206
hubs: Kotzebue, Nome, and Bethel

Region 7 - Northern Southeast Region
population: 52,782
hubs: Juneau and Sitka

Region 8 - Southern Southeast Region
population: 20,094
hub: Ketchikan

Region 9 - Gulf Coast/Aleutian Region
population: 38,439
hubs: Anchorage, Dillingham, and Kodiak

1 State of Alaska, "Alaska Medicaid Section 1115 Behavioral Health Demonstration Waiver Regions," Map, 2018

1115 Waiver
Shared Services

Shared Services applicable to all 3 population groups: the Substance Use Disorder/ Opioid Use Disorder Program; at-risk Children and adolescents ages 0-21; and individuals 18 years and older.

Screening and assessment as clinically appropriate for each target population
Definitions and regulations are currently under development.

Mobile Outreach and Crisis Response Services (MOCR)
Services designed to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders. A multi-disciplinary team will meet face-to-face with the individual experiencing the crisis (and when appropriate their family or support system) wherever the crisis occurs, to assess and deescalate the situation, provide mediation (if appropriate), refer and if possible, connect to the appropriate services or potentially resolve the crisis. MOCR services may be provided in any location where the provider and the individual can maintain safety.

23 Hour Crisis Observation and Stabilization (COS)
Services for up to 23 hours and 59 minutes of care in a secure and protected environment- an unlocked secured facility designed to allow staff to stay in close contact with clients (staff are trained in "Suicide Safe" procedures with suicide-safety considerations). The program is medically staffed, psychiatrically supervised and includes continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress.

Crisis Residential/Stabilization
A medically-monitored, short-term, residential program in an approved (10- to 15-bed) facility that provides 24/7 psychiatric stabilization.

Community Recovery Support (CRSS)
Services for skill building, counseling, coaching, and support services to help prevent relapse and promote recovery from behavioral health disorders (mental health disorders, SUD, or both).

1115 Waiver
Population Group 1 Services

Services for at-risk children and adolescents ages 0-21 Children, Adolescents and their Parents or Caretakers with or at risk of Mental Health and Substance Use Disorders (any member of the family, including parents and caretakers, are eligible to receive Group 1 services if they or their children/siblings meet Group 1 eligibility criteria).

Home-based Family Treatment
Services to reduce use of child/youth inpatient hospitalization and residential services by providing treatment and wrap-around services in the child/youth's home. Home-based family treatment (HBFT) services are available for children/youth ages 0-20 who are at risk for out-of-home placement or detention in a juvenile justice facility and for whom a combination of less intensive outpatient services has not been effective or is deemed likely not to be effective. There will be three progressively intensive levels of HBFT.

Intensive Case Management
Services that include evaluation, outreach, support services, advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching individuals to become self-sufficient. For children/youth at risk of out-of-home placement, community- based wraparound intensive case management service.

Partial Hospitalization Program (PHP)
Services provide diagnosis or active treatment of a child/youth's psychiatric disorder when there is a reasonable expectation for improvement or when it is necessary to maintain the child/youth's functional level and prevent relapse or full hospitalization. PHP services for children/youth are provided in a highly structured treatment environment and must have the capacity to treat children/youth with substantial medical and SUD problems.

Intensive Outpatient (IOP)
Services include structured programming provided to individuals when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment is focused on clinical issues which functionally impair the child/youth's ability to cope with major life tasks.

Children's Residential Treatment Level 1 (CRT)
Treatment services provided by an interdisciplinary treatment team in a therapeutically-structured,supervised environment for children and youth whose health is at risk while living in their community. This authority does not apply to IMDs.

Therapeutic Treatment Homes
Trauma-informed clinical services which include placement in a specifically-trained therapeutic treatment home for children/youth who have severe mental, emotional, or behavioral health needs and who cannot be stabilized in their home settings.

1115 Waiver
Population Group 2 Services

Services for individuals 18 years and older, Transition Age, Youth and Adults with Acute Mental Health Needs

Assertive Community Treatment Services (ACT)
An evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The staff-to-recipient ratio is small (one clinician for every ten recipients), and services are provided 24-hours a day, seven days a week, for as long as they are needed

Intensive Case Management
Services that include evaluation, outreach, support services, advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching individuals to become self-sufficient. Intensive case management is envisioned as a comprehensive case management service for adults with acute mental health needs who require on-going and long-term support but have fewer intensive support needs than ACT.

Partial Hospitalization Program (PHP)
Services provide diagnosis or active treatment of an individual's psychiatric disorder when there is a reasonable expectation for improvement or when it is necessary to maintain the individual's functional level and prevent relapse or full hospitalization. In addition to assisting the individual in managing the stress and anxieties of daily life, PHPs must have the capacity to treat individuals with substantial medical and SUD problems.

Adult Mental Health Residential (AMHR)
Services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for adults with acute mental health needs whose health is at risk while living in their community. This authority does not apply to IMDs. AMHR services are appropriate for those who have not responded to outpatient treatment, who have therapeutic needs that cannot be met in a less-restrictive setting, or who are in need of further intensive treatment following inpatient psychiatric hospital services. Payment for room and board are prohibited.

Peer-based Crisis Services (applies also to population group 3)
Services are faclitated by a peer, someone who has lived with a mental illness and/or substance use disorder or has had experience with substance use disorder (includes parents with experience parenting a child with a mental illness or a substance use disorder). Peer-based crisis services serve as a community-based diversion from emergency department and psychiatric hospitalization use. Peer crisis services delivered in community settings with medical support. These services are coordinated within the context of an individualized person-centered plan.

1115 Waiver
Population Group 3 Services

Substance Use Disorder/Opioid Use Disorder Program Services

Opioid Treatment Services (OTS)
Services for persons experiencing an Opioid Use Disorder (OUD). Physician supervised daily or several times weekly pharmacotherapy and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to state requirements.

Substance Use Care Coordination
Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, behavioral health, educational, social, or other services.

Peer-based Crisis Services (applies also to population group 2)
Services to help divert an individual avoid the need for hospital from emergency department services or the need for partial hospitalization services psychiatric hospitalization through services identified in a crisis plan by a mental health professional clinician or a substance use disorder counselor.

ASAM 0.5 Early Intervention
Alaska Medicaid will pursue a State Plan Amendment (SPA) to modify the current screening coverage to specify universal use of evidence-based, SUD- specific screening instruments. The plan is to use the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST), two evidence- based, SUD-specific instruments, to identify any person who presents with symptoms indicating possible or potential substance use or misuse requiring further assessment. Universal screening will commence when Waiver services are initiated.

ASAM 1.0 Outpatient Services (OP)
Alaska Medicaid provides coverage for outpatient SUD individual, family, and group therapies. These services are available to all Alaska Medicaid recipients, limited to 10 hours per State Fiscal Year per recipient, with extensions upon authorization. No changes are expected at this ASAM Level of Care.

ASAM 2.1 Intensive Outpatient Services
Intensive outpatient includes structured programming services provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment is focused on major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without use of substances.

ASAM 2.5 Partial Hospitalization Program (PHP)
Services will be specifically designed for the diagnosis or active treatment of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the person's functional level and prevent relapse or inpatient hospitalization. Services within the PHP are more clinically intense than IOP and, in addition to addressing major lifestyle, attitudinal, & behavior issues which impair the individual's ability to cope with major life tasks without the addictive use of alcohol and/or other drugs, have the capacity to treat individuals with substantial medical and psychiatric problems.

Residential Treatment Services
Treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an institution for mental diseases (IMD), are provided to Alaska Medicaid recipients with a SUD diagnosis when determined to be medically necessary and in accordance with an individualized treatment plan.

ASAM 3.7 Medically Monitored Intensive Inpatient Services
These are services provided in a residential setting or a specialty unit of an acute or psychiatric hospital. Individuals receiving services at this level of care require 24-hour services, professionally directed.

ASAM 4.0 Medically Managed Intensive Inpatient
These are services provided during a 24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital. Medically Managed Intensive Inpatient services differ from Medically Monitored Intensive Inpatient services due to the requirement of medically directed evaluation and treatment services provided in a 24-hour treatment setting under a defined set of policies, procedures, and individualized clinical protocols.

ASAM 1 and 2 Ambulatory Withdrawal Management
These are outpatient services that may be delivered in an office setting, a health care facility, an addiction treatment facility, or a patient's home for individuals at mild withdrawal risk and with a high commitment to withdrawal management process. Services delivered by physicians and nurses require training in managing intoxication and withdrawal states and clinical staff knowledgeable about the biopsychosocial dimensions of SUDs. Physicians are available via telephone or in-person for consultation; physician and emergency services consultation are available 24/7.

ASAM 3.1, 3.2, 3.3 and 3.5
Clinically Managed Residential Withdrawal Management
These are services provided in a residential treatment setting that include supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal and require 24-hourstructure and support but do not require the medical and nursing care specified for medically monitored/managed inpatient withdrawal management services.

ASAM 3.7 Medically Monitored Inpatient Withdrawal Management
Services will consist of severe withdrawal and needs 24-hour nursing care and physician visits as necessary. This service is necessary because the patient is unlikely to complete withdrawal management without medical and nursing monitoring.

ASAM 4 Medically Managed Intensive Inpatient Withdrawal Management
Services are for severe, unstable withdrawal needs. This can include 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Chapter 3

Buildings

Chapter Summary:

The 1115 Demonstration Services can be administered by behavioral health providers in a variety of building types as well as a client's home and community.

Cost estimates for construction and annual energy consumption are provided for four common service building types. Using an Anchorage benchmark, multipliers are used to estimate costs in hub communities.

Each service is listed against the building types utilized for its administration. Some services can be administered in more than one type. Each service has a cost ($) per square foot (sf).

Lastly, two tools are provided to help size a building: first, a tool to determine the profitability of a building; second, a tool to minimize a building's footprint.

Building Types for Services

The buildings described here are the four most common facilities for providing behavioral health services. Each building is described with a list of its typical rooms and their sizes. These descriptions are used as the basis for cost estimates. The lists are neither intended to capture all possibilities or limit provider opportunities, nor do they set a standard or minimum requirement.

The building descriptions are based on the U.S. Department of Veteran's Affairs 2016 space planning criteria[1] along with the observations made during this project's survey phase; the report team visited more than 75 buildings across Alaska.

- nsf / net square feet. The actual occupied floor area, not including unoccupiable areas or circulation areas such as corridors and stairways
- gsf / gross square feet. The floor area within the outside perimeter of a building's exterior walls.

Office
single provider, 8-person office
(class b commercial space)

100	waiting room
60	reception
60	toilet
100	director's office
(2) 100	office
(4) 56	associate workstation
80	admin waiting
(2) 56	admin workstation
200	team room
60	storage
80%	nsf / gsf efficiency ratio
1,500	**Total gsf**

Outpatient
single provider, 15 to 20 person facility
(class b commercial space)

160	waiting room
100	reception area
120	exam room
160	treatment room
300	group therapy / team room
140	medical laboratory
100	medical office
60	patient toilet
100	program director's office
(4) 100	clinician's office
(8) 56	administration workstation
200	records room
60	staff toilet
60	mechanical and electrical
80%	nsf / gsf efficiency ratio
3,000	**Total gsf**

1 U.S. Department of Veterans Affairs, "Veteran Heath Administration Space Planning Criteria," Chapters 110, 260, 261, 282, (last updated October 3, 2016), *https://www.cfm.va.gov/til/space.asp* (accessed December 2019)

Residential Treatment
(16-bed, independent facility)

60	porch
120	entry vestibule
160	waiting room
120	interview room
60	public toilet
(12) 180	single bed patient rooms
(4) 230	double bed patient rooms
(16) 85	patient bathroom
675	day room
350	exercise room
225	group room
60	patient storage
120	quiet room
70	wheelchair / stretcher alcove
360	dining room
360	kitchen
250	serving line
150	nonfood storage
80	bulk food storage
80	cooler
80	freezer
150	laundry room
60	housekeeping closet
80	medication room
120	exam room
100	nurse office
(2) 120	consult room
100	program director
(8) 56	workstations / team room
300	records room
100	storage room
80	staff lounge
80	staff locker room
60	staff toilet
300	team conference room
80	recycling area
80	trash room
150	mechanical room
80	electrical room
120	data and telecom room
75%	nsf / gsf efficiency ratio
14,075	**Total gsf**

Medical Inpatient
(16-bed, hospital dependent facility)

60	porch
120	entry vestibule
(2) 160	visitor / patient waiting rooms
(2) 120	interview room
(2) 60	public toilet
(10) 180	single bed patient rooms
(4) 230	double bed patient rooms
(14) 85	patient bathroom
(2) 80	isolation patient room
(2) 100	isolation patient anteroom
(2) 80	isolation patient bathroom
675	day room
350	exercise room
225	group room
60	patient storage
120	quiet room
360	dining room
260	serving line
150	nonfood storage
80	bulk food storage
(2) 80	clean / soiled utility
(2) 80	clean / soiled linen
90	laundry room
60	housekeeping closet
(2) 120	consult room
120	exam room
80	medication room
100	equipment storage
50	medical gas storage
20	crash cart alcove
80	environmental management
70	wheelchair / stretcher alcove
100	program director
100	head nurse office
300	nurse's station
(10) 56	workstations / team room
300	records room
100	storage room
80	on-call room
80	on-call bathroom
80	staff lounge
80	staff locker room
60	staff toilet
200	mechanical room
80	electrical room
120	data and telecom room
65%	nsf / gsf efficiency ratio
16,985	**Total gsf**

Building Type Capital Costs

The charts below list the capital cost for each building type if constructed in Anchorage; multipliers calibrate costs for the same building type in each regional hub. The multipliers take into account factors such as shipping costs, weather delays and regional labor markets.

The office and outpatient costs are tenant construction costs, because these spaces will likely be constructed as renovations to existing commercial space instead of as new buildings. The residential treatment and medical inpatient building costs are for new building construction costs, since they will likely be built as new facilities.

Capital costs (in 2019 dollars) include furniture, fixtures and equipment, move-in logistics and labor, financing, legal and professional services, construction administration, special inspections and fees, owner (10%) and builder (15%) construction contingencies, Title 36 wages and a builder's general conditions (percentage varies by location). Capital costs exclude land acquisition.

Region	Hub	Multiplier
Anchorage Municipality	Anchorage	**1.00**
Fairbanks North Star Borough	Fairbanks	**1.11**
Northern and Interior	Fairbanks	**1.11**
	Utqiagvik	**2.02**
Kenai Peninsula Borough	Soldotna	**1.08**
	Homer	**1.17**
MatSu Borough	Wasilla	**1.08**
Western	Kotzebue	**2.02**
	Nome	**1.85**
	Bethel	**1.90**
Northern Southeast	Juneau	**1.14**
	Sitka	**1.55**
Southern Southeast	Ketchikan	**1.14**
Gulf Coast Aleutian	Anchorage	**1.00**
	Dillingham	**1.52**
	Kodiak	**1.17**

see previous pages for building description and size

Region	Office (1,500gsf) $/gsf	Office (1,500gsf) Total	Outpatient (3,000gsf) $/gsf	Outpatient (3,000gsf) Total	Residential (14,075gsf) $/gsf	Residential (14,075gsf) Total	Medical (16,985gsf) $/gsf	Medical (16,985gsf) Total
Anchorage	$243	$363,971	$272	$816,176	$346	$4,864,154	$667	$11,323,333
Fairbanks	$269	$404,007	$302	$905,956	$384	$5,399,211	$740	$12,568,900
Utqiagvik	$490	$735,221	$550	$1,648,676	$698	$9,825,592	$1,347	$22,873,133
Soldotna	$262	$393,088	$294	$881,471	$373	$5,253,287	$720	$12,229,200
Homer	$284	$425,846	$318	$954,926	$404	$5,691,061	$780	$13,248,300
Wasilla	$262	$393,088	$294	$881,471	$373	$5,253,287	$720	$12,229,200
Kotzebue	$490	$735,221	$550	$1,648,676	$698	$9,825,592	$1,347	$22,873,133
Nome	$449	$673,346	$503	$1,509,926	$639	$8,998,686	$1,233	$20,948,167
Bethel	$461	$691,544	$517	$1,550,735	$657	$9,241,893	$1,267	$21,514,333
Juneau	$277	$414,926	$310	$930,441	$394	$5,545,136	$760	$12,908,600
Sitka	$376	$564,154	$422	$1,265,074	$536	$7,539,439	$1,033	$17,551,167
Ketchikan	$277	$414,926	$310	$930,441	$394	$5,545,136	$760	$12,908,600
Anchorage	$243	$363,971	$272	$816,176	$346	$4,864,154	$667	$11,323,333
Dillingham	$369	$553,235	$414	$1,240,588	$525	$7,393,515	$1,013	$17,211,467
Kodiak	$284	$425,846	$318	$954,926	$404	$5,691,061	$780	$13,248,300

Building Type Annual Operating Costs

The charts below list the annual operating costs for each building type. To calculate the total operating costs, hub-specific energy cost indices[1] (heating and electric costs per square foot) are combined with costs for water and sewer, building insurance, deferred building maintenance, waste and recycling removal, janitorial and other service contracts, equipment operations and maintenance, and snow removal. These costs, excluding the energy cost index, are estimated for the Anchorage market per square foot. The multipliers found on the previous page are applied to calibrate costs for each regional hub.

Hub	Energy Cost Index	Multiplier	Other Building Costs/gsf	Total Operating Costs/gsf
Anchorage	$2.92	**1.00**	$5.00	$7.92
Fairbanks	$2.98	**1.11**	$5.47	$8.45
Fairbanks	$2.98	**1.11**	$5.47	$8.45
Utqiagvik	$1.98	**2.02**	$13.71	$15.69
Soldotna	$2.09	**1.08**	$6.35	$8.44
Homer	$2.09	**1.17**	$6.80	$8.89
Wasilla	$2.09	**1.08**	$6.35	$8.44
Kotzebue	$5.22	**2.02**	$12.63	$17.85
Nome	$4.35	**1.85**	$12.14	$16.49
Bethel	$4.92	**1.90**	$11.59	$16.51
Juneau	$2.35	**1.14**	$7.92	$10.27
Sitka	$2.35	**1.55**	$11.31	$13.66
Ketchikan	$2.35	**1.14**	$9.26	$11.61
Anchorage	$2.09	**1.00**	$5.83	$7.92
Dillingham	$2.57	**1.52**	$12.03	$14.60
Kodiak	$2.53	**1.17**	$6.46	$8.99

1 Alaska Housing Finance Corporation, "Energy Use in Alaska's Public Facilities," page 30, figure 6, (November 7, 2012), *https://www.ahfc.us/application/files/7213/5760/3457/public_facilities_whitepaper_102212.pdf* (accessed December 2019)

	Office (1,500gsf) Total	Outpatient (3,000gsf) Total	Residential (14,075gsf) Total	Medical (16,985gsf) Total
Anchorage	$11,880	$23,760	$111,474	$134,521
Fairbanks	$12,675	$25,350	$118,934	$143,523
Fairbanks	$12,675	$25,350	$118,934	$143,523
Utqiagvik	$23,535	$47,070	$220,837	$266,495
Soldotna	$12,660	$25,320	$118,793	$143,353
Homer	$13,335	$26,670	$125,127	$150,997
Wasilla	$12,660	$25,320	$118,793	$143,353
Kotzebue	$26,775	$53,550	$251,239	$303,182
Nome	$24,735	$49,470	$232,097	$280,083
Bethel	$24,765	$49,530	$232,378	$280,422
Juneau	$15,405	$30,810	$144,550	$174,436
Sitka	$20,490	$40,980	$192,265	$232,015
Ketchikan	$17,415	$34,830	$163,411	$197,196
Anchorage	$11,880	$23,760	$111,474	$134,521
Dillingham	$21,900	$43,800	$205,495	$247,981
Kodiak	$13,485	$26,970	$126,534	$152,695

Service Environments

This table lists each 1115 Waiver service against the four building types commonly utilized for its administration. Some services can be administered in more than one type. Based on the charts from the previous pages, each service has a cost per square foot.

Many of the 1115 services, especially services focused on early intervention and engagement, can be offered in a client's home or community; this report adds a fifth service environment type.

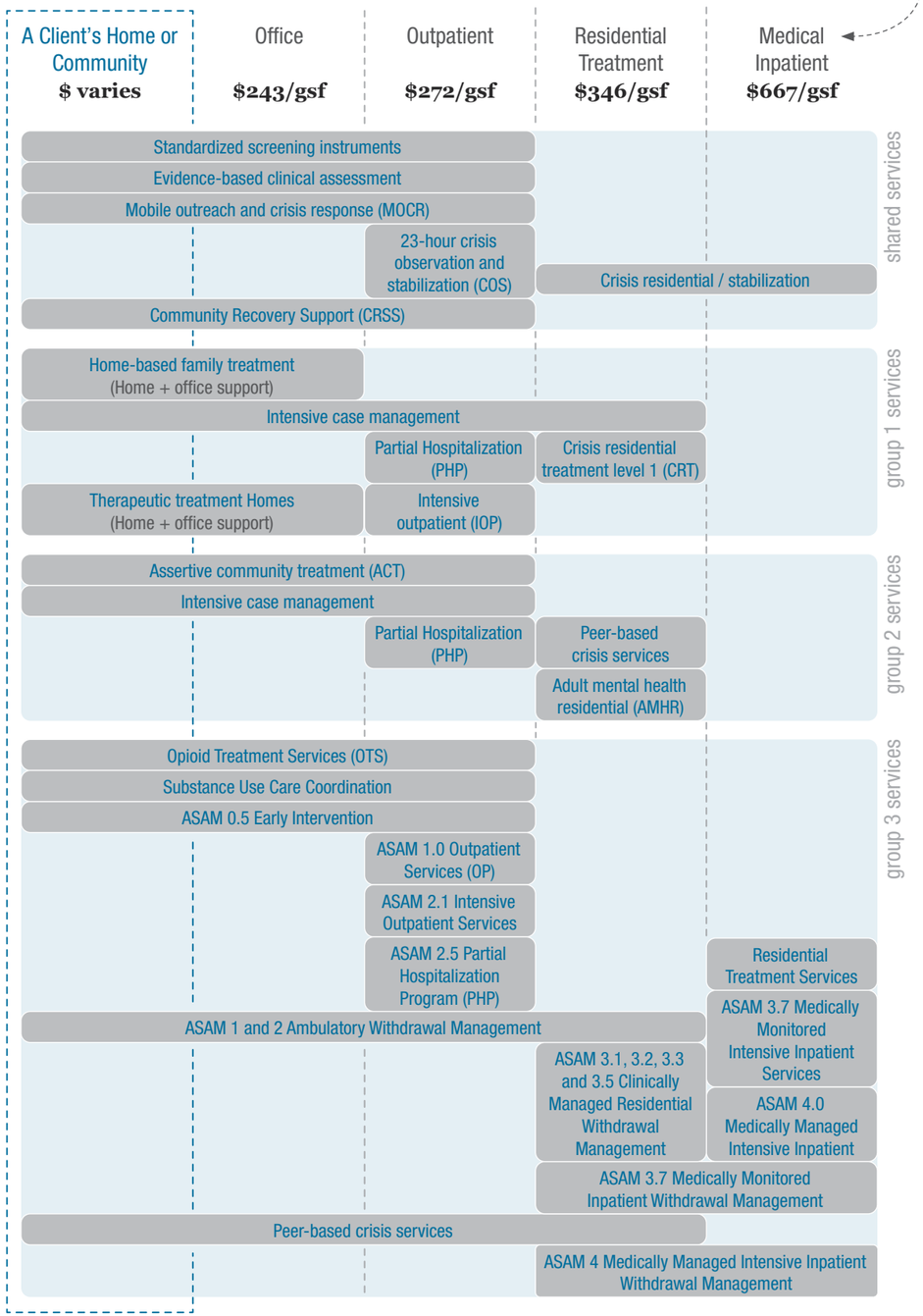
While the cost for the fifth type (a clients' home or community) is included in this report's overall cost estimate, it is not itemized as a cost per square foot in the table, because it will vary by region and service. However, this report recommends that the future pre-development process identifies methods to invest in the fifth type by reallocating traditional infrastructure investments. Some first attempts at reallocating infrastructural investments are identified in this report.

Traditionally infrastructural investment for behavioral health infrastructure is limited to the initial four building types. The adjacent table shows which services could utilize the fifth service environment type.

Allowing for investment outside the traditional clinic model of patient care, provides a unique opportunity to improve and diversify behavioral health services in Alaska. The 1115 Waiver allows:

1. Diversification of treatment types and locations.
2. A more holistic approach to client care and the treatment of clients in their broader life, home, and community, with an emphasis on preventative and ongoing consistent care.
3. A more nuanced approach to infrastructural development that may allow:
    - clinics to be smaller with better returns on investment and longevity
    - investment into client and staff housing
    - investment into transportation
    - investment into community-based behavioral health resources

Building Types and their Anchorage $/gsf benchmarks



Utilization Rates

Buildings are expensive to construct and operate. Before constructing a building, utilization rates and employee area ratios should be considered. To minimize overall building size and costs, spaces should generally be utilized at maximum capacity.

The U.S. department of Veteran's Affairs (VA) 2016 space planning criteria considers the maximum capacity for a room used for outpatient psychology services to be 85%. To define capacity, VA criteria identifies the maximum number of clinic stops per year per room then multiplies that number by an 85% utilization rate. Therefore the number of rooms required is understood through the number of annual clinic stops estimated.

$$\frac{\text{operating days per year} \times \text{hours of operation per day}}{(\text{minutes per clinic stop} \div 60 \text{ minutes})} \times 85\% = \text{maximum capacity}$$

The VA criteria then considers that the utilization rate needed to generate one room is 30% of the annual clinic stops per room. One of their exam rooms operating 8 hours a day, 250 days a year should have a minimum workload of 765 clinic stops and a maximum of 2,550 clinic stops.[1]

To not over-commit to building costs, independent organizations providing 1115 services could define their minimum utilization rate to help maintain positive net income. In other words the minimum annual clinic stops for the room multiplied by revenue generated by clinic stops should equal the operational costs of the room combined with the operational costs of all non-revenue generating spaces. Operational costs are defined on the previous pages.

$$\text{room's annual clinic stops} \times \text{revenue per stop} \geq \text{room} + \text{associated non-revenue generating spaces}$$

If a room is not profitable, the service should be delivered in a less costly space. A less costly space is not necessarily a space of lesser quality but a space that can serve multiple functions, thus pay for itself through other or multiple means.

Due to the small population in many Alaskan communities, organizations should assume the following as general rules:

- Most clinical rooms will not be profitable if used for a single purpose, therefore all or most rooms should serve multiple purposes and have multiple revenue sources.
- Organizations serving a small population should anticipate high and low appointment scheduling fluctuations. They will be booked beyond expectation and below expectation on a more frequent basis than an organization handling a larger population. This is unavoidable and increases the need for multi-purpose rooms with multiple revenue sources.

1 U.S. Department of Veterans Affairs, "Mental Health Clinic," page 3, (last updated October 3, 2016), *https://www.cfm.va.gov/til/space.asp* (accessed December 2019)

Employee Ratios

Workstation-to-employee and floor-area-to-employee ratios should define the smallest amount of space required to operate and therefore smallest financial (capital and operational) burden upon an organization. The building types in this report assume a mix of private offices and workstations.

Most employees will not use a workstation all day. Many 1115 services can be delivered outside a clinic, which may require an employee to frequently leave their workstation. A workstation-to-employee ratio can easily be 1:4, meaning employees may only occupy their workstation 25% of the day or four employees may utilize one workstation.

Most employees do not need a private office to complete their work. Private office designs can easily require 100 or 200gsf per employee; considering the space occupied by office walls, circulation around a desk, door swings, hallways accessing the offices, and individual mechanical and electrical systems per office. Team workstations with a small number of versatile two-person conference rooms, often referred to as "talking rooms," can reduce floor areas to 50 or 75gsf per employee. Combined with efficient workstation ratios, organizations can all but eliminate unused space in a facility.

The following is a cost comparison utilizing different full-time equivalent (FTE) work areas in an Anchorage-leased office suite with an 80% net-gross efficiency ratio.

Office vs Workstation Costs	**floor area**	**Capital Costs**	**FTE**	**Capital Costs per FTE**	**Annual Operating Costs**
Private office	118gsf	$28,547	1	$28,547	$932
Workstation	66gsf	$15,986	1	$15,986	$522
Two-person talking room	75gsf	$18,270	-	varies	$596
Office Configuration Cost Comparison					
4x workstation + two-person talking room	339gsf	$82,215	8	$5,138	$2,683
	utilizing a 1:2 workstation-to-employee ratio				
Private office	941gsf	$228,374	8	$28,547	$7,454
Cost Difference	75gsf	$146,159	-	$23,408	$4,771

At eight FTEs, the savings yielded from a workstation environment with a 1:2 workstation-to-employee ratio instead of a traditional office design will fund three company vehicles for three years at $1,200 per month, each (includes vehicle purchase cost).

Chapter 4

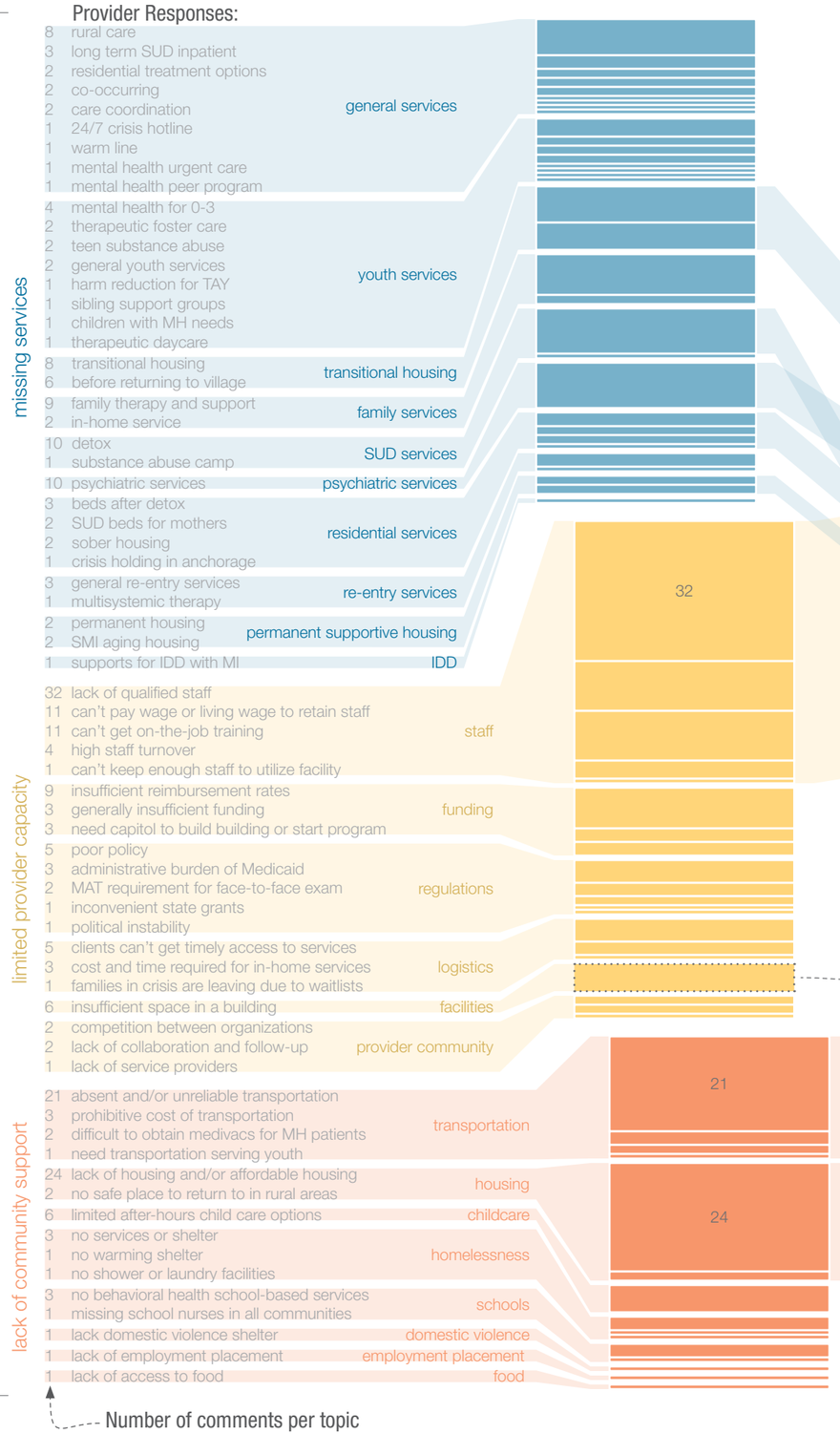
Barriers to Care

Chapter Summary:

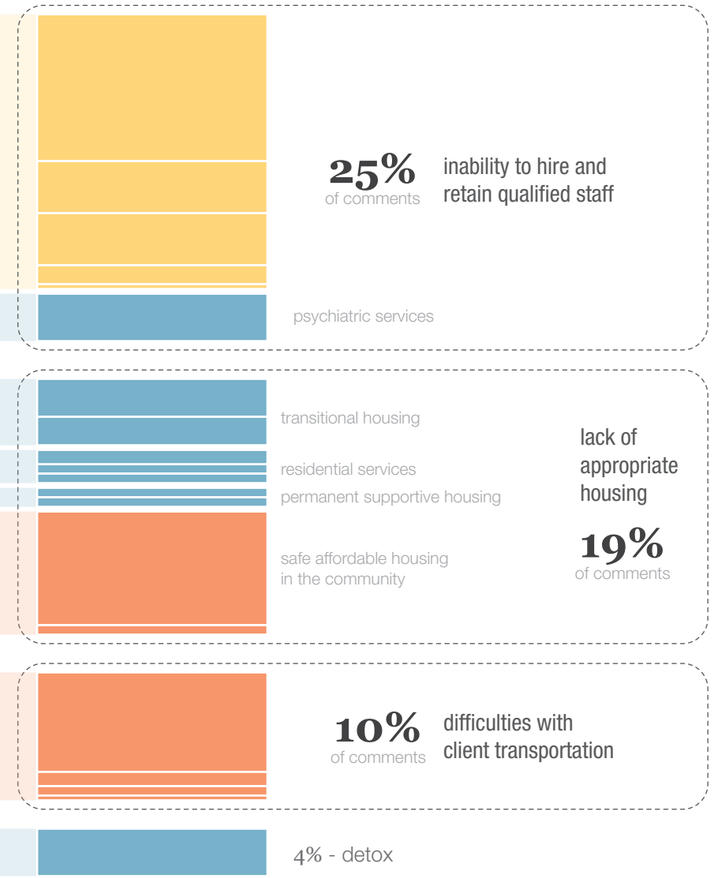
Behavioral health providers were asked a number of questions about their ability to provide services and the ability of their community to support them. Data from other agencies and reports supports the providers concerns. 54% of all provider responses related to the following three topics.

Staff: providers lack the ability to recruit and retain qualified staff.
Housing: clients and staff lack appropriate housing.
Transportation: providers struggle with client and staff transportation.

What Prevents a Complete Continuum of Care?

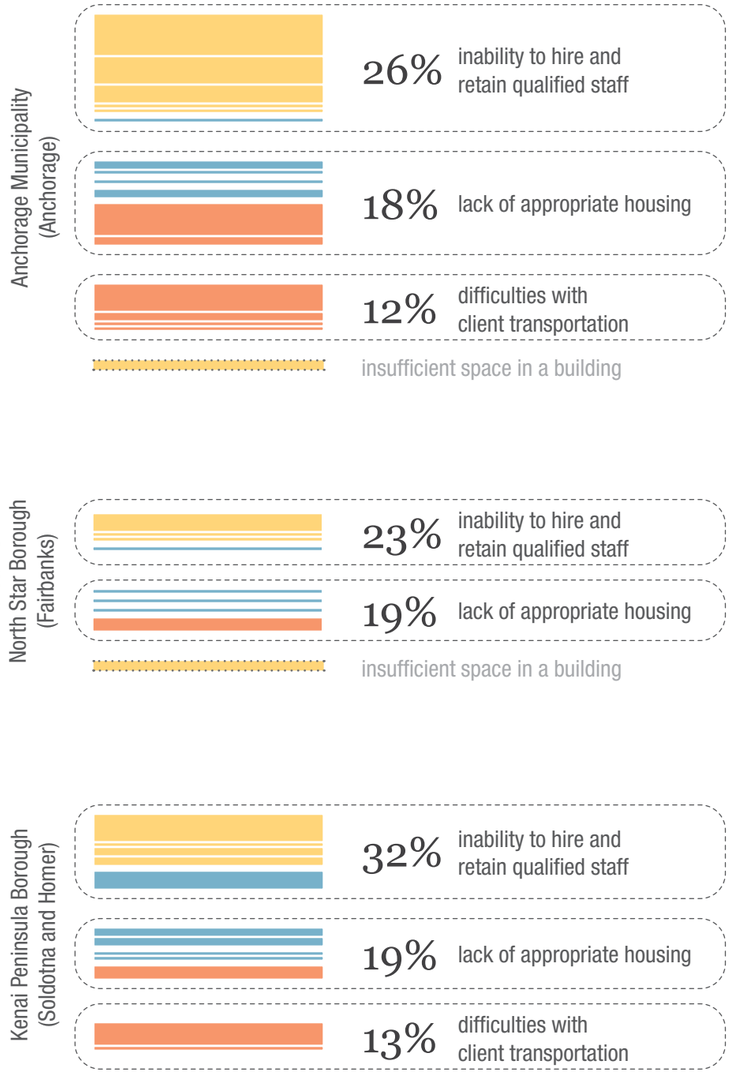


Organizations say that inadequate staffing, scarce housing for clients and staff and unreliable client transportation will prevent them from providing the 1115 continuum of care.



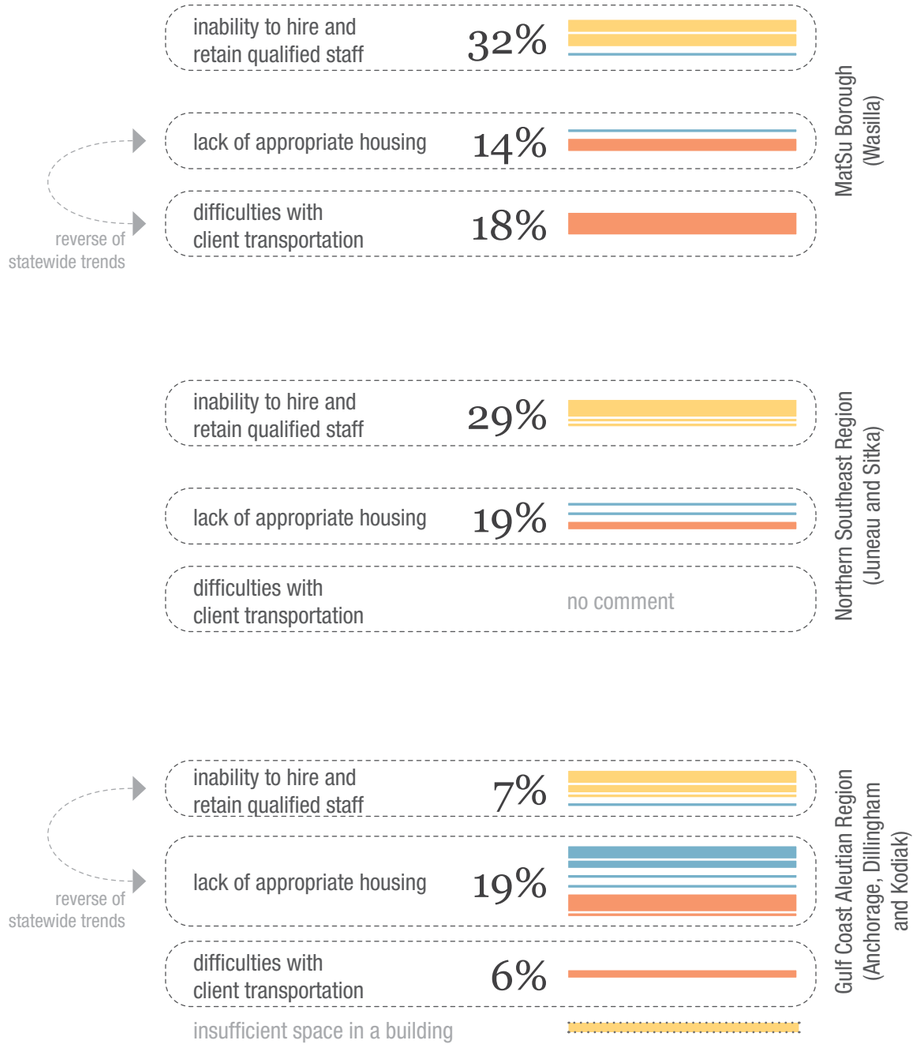
even with an Architect attending all meetings with providers, only 2% of comments said an organization's building was too small or unsuited to facilitate care.

What Prevents a Complete Continuum of Care, per Region?



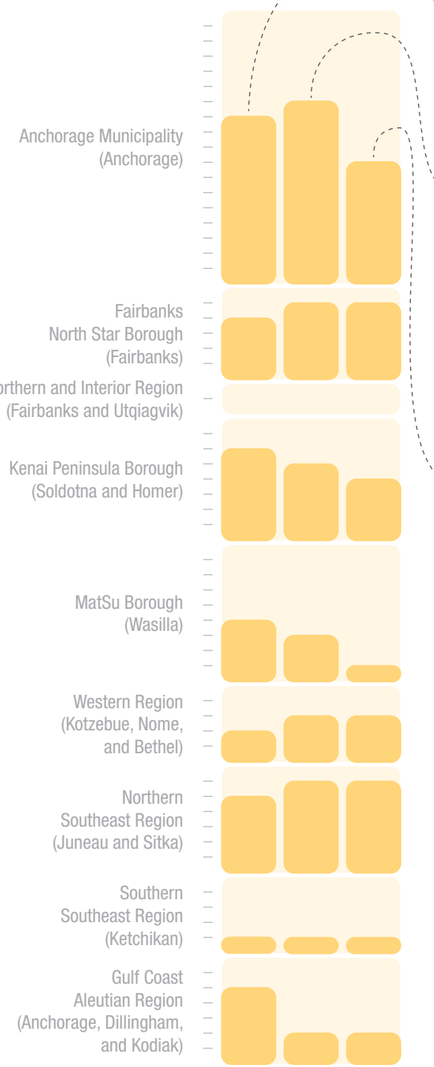
not shown:

- Northern and Interior Region (Fairbanks and Utqiagvik)
- Western Region (Kotzebue, Nome, and Bethel)
- Southern Southeast Region (Ketchikan)



Staff Recruitment

The majority of organizations report that their inability to hire and retain qualified staff will prevent them from offering the 1115 continuum of care.



Organizations are operating with 10-30% staff positions vacant, some with more than 50% vacant in a single location.

38 of 43 organizations said one of their primary struggles is hiring and retaining qualified staff.

37 of 43 organizations plan to expand staffing in order to provide the 1115 services.

Those organizations will expand staff by an average of 18%, some as high as 44%.

30 of 37 organizations anticipate a nationwide hiring exercise.

When asked to identify barriers to successful collaboration with governing state agencies, 31% of responses said the major obstacle was high staff turnover and under-staffing.

86% of reporting organizations plan to increase their staff numbers to provide 1115 services.

But they struggle to hire and retain qualified staff to address their current needs.

A fundamental change in recruitment and retention strategies is needed in the Alaskan behavioral health sector. Many areas in Alaska are remote with challenging working and living conditions compared with much of the lower 48, and behavioral health problems in Alaska are long-standing. Staff recruitment and retention, particularly in remote communities, will likely always be a concern. Therefore, staffing strategies may need to vary from the traditional models. The dramatic introduction of new services and programs offered through the 1115 presents an opportunity to develop those strategies.

A pre-development process (as described earlier and in chapter 6 of this report) should be held for each new 1115 program listed in this report. These processes should provide alternative strategies for staffing, such as:

- training locals
- team-based approaches
- short-term, goal-based staff positions

This may offer one way to work with the high level of staff turnover common to the Alaska behavior health system. Staffing strategies should also focus on ways to improve safety, comfort and environmental challenges for staff and make staff as comfortable and welcome in their communities as possible.

Pre-development teams should include the behavioral health professionals who will staff and direct the programs under review. In other words, behavioral health staff should be encouraged to help design their future environments.

Staff Salary and Shortage Background Information

Behavioral Health organizations' difficulties with staffing are well documented. Currently there are 24 Health Professional Shortage Areas (HPSA) and 262 HSPA Facilities for mental health disciplines in Alaska. The tables below show the scores for each HPSA area and HPSA facility. The higher the score, the greater the need.[1]

Regions	HPSA Area	HPSA Score	
3 - Northern and Interior Region	Yukon-Koyukuk Census Area	15	
	Southeast Fairbanks Census Area	14	
	North Slope Borough	13	
	Denali Borough	8	
4 - Kenai Peninsula Borough	Kenai Peninsula Borough	17	
5 - MatSu Borough	Matanuska-Susitna Borough	13	
6 - Western Region	Kusilvak Census Area	18	highest need
	Bethel Census Area	18	
	Northwest Arctic Borough	17	
	Nome Census Area	15	
7 - Northern Southeast Region	Petersburg Borough	17	
	Wrangell City and Borough	17	
	Hoonah-Angoon	9	
	Yakutat Borough	9	
	Haines Borough	8	
	Skagway Municipality	7	
8 - Southern Southeast Region	Prince of Wales-Hyder Census Area	17	
	Ketchikan Gateway Borough	17	
9 - Gulf Coast Aleutian Region	Bristol Bay Borough	14	
	Dillingham Census Area	14	
	Lake and Peninsula Borough	14	
	Valdez-Cordova Census Area	14	
	Aleutians West Borough	10	
	Aleutians East Borough	9	

	HPSA Facilities	Addresses	Average Score	
1 - Anchorage Municipality	11	12	15	
2 - Fairbanks North Star Borough	5	5	17	highest need
3 - Northern and Interior Region	47	86	13	
4 - Kenai Peninsula Borough	12	18	12	
5 - MatSu Borough	16	12	5	
6 - Western Region	82	141	16	
7 - Northern Southeast Region	14	32	12	
8 - Southern Southeast Region	12	23	12	
9 - Gulf Coast Aleutian Region	63	105	10	

1 U.S. Health Resources & Services Administration, "HPSA Find," *https://data.hrsa.gov/tools/shortage-area/hpsa-find* (accessed December, 2019)

The tables below collect data from the Alaska Department of Labor and Workforce development. Job openings for social workers and counselors in Alaska are rated moderate to high: Alaskan behavioral health social workers and counselors are paid the same or slightly less than providers in the lower 48.[1]

2016 Employment	Growth	Opportunities	Average Annual Openings
Social and Community Service Managers	low	moderate	33
Community and Social Service Specialists, All Other	low	high	71
Psychiatrists	strong	low	3
Psychologists, All Other	low	low	2
Clinical, Counseling, and School Psychologists	low	low	9
Child, Family, and School Social Workers	low	high	102
Mental Health and Substance Abuse Social Workers	strong	moderate	55
Social Workers, All Other	moderate	moderate	43
Mental Health Counselors	moderate	moderate	53
Substance Abuse and Behavioral Disorder Counselors	moderate	moderate	30
Counselors, All Other	moderate	moderate	39

2018 Average Hourly Wage	US	Alaska	Mat-Su	ANC & of Alaska	Balance
Social and Community Service Managers	34.46	35.3	36.29	34.5	
Community and Social Service Specialists, All Other	22.14	20.79	20.74	25.33	
Psychiatrists	105.95	106.88	118.37	no data	
Psychologists, All Other	45.97	no data	no data	no data	
Clinical, Counseling, and School Psychologists	41.03	43.97	42.7	61.36	
Child, Family, and School Social Workers	23.92	23.55	23.87	23.44	
Mental Health and Substance Abuse Social Workers	23.86	22.32	21.43	23.77	
Social Workers, All Other	30.12	33.91	38.41	25.42	
Mental Health Counselors	no data	no data	no data	no data	
Substance Abuse and Behavioral Disorder Counselors	no data	no data	no data	no data	
Counselors, All Other	22.95	28.27	31.32	27.89	

Considering the high cost of living in Alaska, a pay increase for these professions may help fill open positions.

1 State of Alaska Department of Labor and Workforce Development, Research and Analysis, "May 2018 Wages in Alaska - Alaska Statewide," *http://live.laborstats.alaska.gov/wage/* (accessed December, 2019)

Housing Strategy and Background Information

Behavioral Health organizations' concerns about housing are well founded. Alaska does not have enough housing for its residents. Overcrowding in Alaska is twice that of the lower 48. The Alaska Housing and Finance Commission estimates over 16,000 housing units are needed to address current overcrowding in the state.[1] The table below locates the overcrowded units per 1115 region. According to providers, overcrowding can inhibit recovery after receiving services.

The Overcrowding Gap	Hub	Housing Units	Total Area (1,284 gsf per)
1 - Anchorage Municipality	(Anchorage)	4,370	5,610,757
4 - Kenai Peninsula Borough	(Soldotna)	439	563,245
	(Homer)	439	563,245
5 - MatSu Borough	(Wasilla)	1,613	2,070,994
2 - Fairbanks North Star Borough	(Fairbanks)	2,200	2,824,800
3 - Northern and Interior Region	(Utqiagvik)	550	706,200
6 - Western Region	(Kotzebue)	800	1,027,200
	(Nome)	800	1,027,200
	(Bethel)	2,500	3,210,000
7 - Northern Southeast Region	(Juneau)	705	904,929
	(Sitka)	190	243,668
8 - Southern Southeast Region	(Ketchikan)	305	392,203
9 - Gulf Coast Aleutian Region	(Dillingham)	350	449,400
	(Kodiak)	400	513,600
	-	250	321,000
	-	150	192,600
	-	50	64,200
Total		**16,111**	**20,685,241 gsf**

1 Alaska Housing Finance Corporation, "2018 Housing Assessment," figure 3, page 13, *https://www.ahfc.us/efficiency/research-information-center/alaska-housing-assessment/2018-housing-assessment* (accessed December, 2019)

Because there is a significant housing shortage in Alaska, behavioral health providers recommend a safe residence for respite and to transition clients from treatment to the home. Behavioral health providers consistently noted that high-cost treatments are not effective if the transition back home is abrupt or if the home environment is not adequately stable.

Providers need a transition home to reduce recidivism.

Many providers have the ability to manage transitional homes. Nearly 1/4 of the providers surveyed already own or manage housing for their clients. The table below lists costs for eight multi-family style housing units constructed in Anchorage, Fairbanks, Wasilla and Juneau, and two housing units for each remaining regional hub. The pre-development process for each population group should analyze the demand for housing as well as identify potential owners and service providers.

Hub	$/gsf	Capital Cost (1,284 gsf per)	Total Operating Costs/gsf	Annual Operating Costs
Anchorage	$338	$3,474,353	$7.09	$72,828
Fairbanks	$375	$3,856,532	$8.53	$87,620
Utqiagvik	$683	$1,754,548	$12.08	$31,021
Soldotna	$365	$938,075	$7.49	$19,234
Homer	$396	$1,016,248	$7.94	$20,390
Wasilla	$365	$3,752,301	$7.49	$76,937
Kotzebue	$683	$1,754,548	$15.32	$39,342
Nome	$626	$1,606,888	$13.60	$34,925
Bethel	$643	$1,650,318	$14.42	$37,031
Juneau	$386	$3,960,762	$8.05	$82,690
Sitka	$524	$1,346,312	$10.10	$25,937
Ketchikan	$386	$990,191	$8.05	$20,672
Dillingham	$514	$1,320,254	$10.17	$26,117
Kodiak	$396	$1,016,248	$8.38	$21,520
Totals		**$28,437,578**		**$596,264**

Client Transportation

Client Transportation: Behavioral health organizations consistently expressed concerns over client transportation. The pre-development process should develop transportation plans for each client population as part of their service plans.

To this end, in combination with facility cost, capital investment should also provide vehicles for each home-based family treatment, partial hospitalization program and assertive community treatment listed as a missing service in this report. These are all programs in larger communities with regular client transport shortages. They also provide home-based services requiring provider travel between the clinic and home.

Reimbursements rates: home-based service reimbursements rates should include the cost of vehicles and the reduced reimbursement opportunities. Reimbursement for services administered at home should be three times that of outpatient rates plus the cost of a vehicle.

> "A home-based therapist can serve 3 families a day. An outpatient therapist can serve 9-10" -- Behavioral Health Provider

Current Medicaid transportation spending: The state is currently analyzing data to understand the percent of total Medicaid transportation spending dedicated to behavioral health services. The pre-development process should look for opportunities to invest in local behavioral health infrastructure and services to minimize travel costs.

For example more than $60,000,000 was spent on Medicaid reimbursed air travel to and from western Alaska last year. Reducing just a small percentage could easily justify the costs of a residential treatment building or similar.

In 2017, Medicaid reimbursed more than $164,000,000 for transportation in Alaska: $130,000,000 in air and $34,000,000 in ground.[1]

1 State of Alaska, Department of Health and Social Services, Robert M. Damler, Jeremy A Cunningham, Milliman Inc., "Alaska Medicaid Data Book, SFY 2016 and STY 2017," October 2, 2018, *http://dhss.alaska.gov/HealthyAlaska/Pages/Redesign/Milliman.aspx* (accessed December 2019)

2017 Alaska Medicaid Transportation Costs

		Non-Tribal Provider Total Dollars	Tribal Provider Total Dollars
1 - Anchorage Municipality	Ground	$5,291,512	$2,618
	Air	$3,677,772	$74,264
2 - Fairbanks North Star Borough		$1,069,969	$287
		$2,572,465	$5,989
3 - Northern and Interior		$960,119	$488
		$7,947,953	$11,729
4 - Kenai Peninsula Borough		$1,691,606	$861
		$2,939,621	$23,459
5 - MatSu Borough		$2,134,024	$574
		$1,144,135	$21,637
6 - Western		$3,729,353	$42,558
		$30,349,041	$1,461,952
7 - Northern Southeast		$1,345,014	-
		$6,599,859	-
8 - Southern Southeast		$867,953	-
		$4,220,480	-
9 - Gulf Coast Aleutian		$862,223	-
		$6,549,826	$234,878
Statewide Totals	Ground	**$17,952,047**	**$47,385**
	Air	**$66,002,362**	**$1,833,907**

Actual costs are double the Statewide totals, because Alaska pays 50% of all Medicaid claims for non-tribal providers, the federal government pays the remaining 50%.

Chapter 5

Precautionary Case Study

Chapter Summary:

The costs listed in this report represent preliminary estimates of 1115-related investments. Each service and potential program should be scrutinized as part of a pre-development process in which existing prevalence and treatment rates are investigated and revenue generation is balanced against capital and operational costs to create a financially sustainable organization long-term.

The planning of new infrastructure should be done with caution and with a long-term vision. Pre-develpment should consider alternatives to new facilities, such as reuse of existing spaces, collaboratives and shared work environments, and opportunities for smaller facility footprints. All planning should consider how spaces could be used differently, should demand for programs change or end.

These steps may help safeguard a provider from the possible future burden of an underused, underfunded asset.

Ketchikan Regional Youth Facility

A building may not help a program, it may overburden and end the program.

In the mid- to late 1990's the Alaska Division of Juvenile Justice (DJJ) identified increasing daily populations and overcrowding in their youth facilities, as well as a gap in their service coverage in Southeast Alaska. DJJ worked to resolve these challenges in 2002, in part by building the Ketchikan Regional Youth Facility.

The facility provided four detention beds, four mental health diagnostic beds and two swing beds. However, actual youth detention trends did not follow the projections; youth detention dropped nationwide, and the Ketchikan Regional Youth Facility mental health beds were rarely used.[1]

The mental health beds were shuttered between 2008 and 2010, leaving only six beds in use in the entire building. In 2016 the entire facility was closed. In its final ten years, the building housed on average 4.5 daily occupants (45% of its capactiy) and cost over $1,800,000 million per year to operate.[2]

The reason for the facility's short life is not clear. Staffing problems, decreased demand, its remote location, politically motivated funding and incorrect demand projections have been blamed. The help the facility provided DJJ and Southeast Alaska and the very real needs it was constructed to address should not be disregarded. This report lists this building because it was unable to adapt.

At its closing the State turned over ownership of the building to the City of Ketchikan. In 2018 the building was assessed at $1.4 million. The City of Ketchikan has not been able to find another occupant or buyer. Because of its detention-specific design, which includes concrete block interior partitions for instance, the building is simply too expensive to operate or renovate.[3]

Ketchikan Regional Youth Facility

Estimated Development Cost	$5,000,000 - $9,000,000
Annual cost	$1,800,000 - $2,000,000
Lifespan	14 years

Total Lifetime Cost
$30,000,000 - $37,000,000

This report recommends taking incremental and cautious steps toward building new facilities. Any new buildings should be designed in a manner that anticipates future use, such as possible future conversion to permanent housing or other community-based uses, so that if demand for services changes, facilities can adapt to new uses that benefit their communities.

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1 State of Alaska, Department of Health and Social Services, Division of Juvenile Justice "Annual Report FY99," pages 2 and 4. *http://dhss.alaska.gov/djj/Pages/GeneralInfo/publications.aspx* (accessed December 2019)

2 CGL Companies, Feasibility Study for the Privatization of Alaska Juvenile Justice Facilities, January 26, 2017, pages 32 and 33. *http://www.akleg.gov/basis/Meeting/Detail?Meeting=SHSS%202017-02-06%2013:30:00#tab4_4* (accessed December 2019).

3 Leila Kheiry, KRBD - Ketchikan, February 16, 2018 "City of Ketchikan to Try Again to Sell Former Youth Facility"

This is the end of the report. Thank you.

Infrastructure Analysis Project

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