State of Alaska
Department of Health and Social Services

To promote and protect the health and well-being of Alaskans.

Fiscal Year 2007 Budget Overview

Karleen Jackson
Commissioner

Frank Murkowski
Governor

Mission

To promote and protect the health and well-being of Alaskans.

The Department of Health and Social Services was originally established in 1919 as the Alaska Territorial Health Department. At Statehood, the Department was expanded to include public welfare responsibilities and continues today to have responsibility for public health, public welfare and public protection. These core principles are reflected in the mission of the Department (to promote and protect the health and well being of Alaskans) and stem from Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

The Department has three main guiding principles for the service delivery system: Self sufficiency for Alaskans; a strong safety net for those who cannot provide for themselves; and local access to care.

FY2007 marks the fourth budget developed by the Murkowski Administration. The first two years, FY2004 and 2005 focused on major program reorganization of the department and budget reductions including cost containment of Medicaid. FY06 focused on refining the department organization structure and stabilizing funding in key areas. FY07 focuses on maintaining service levels for Medicaid and expanding services in key areas that have documented results.

The department has the following organization structure:

Alaska Pioneer Homes
Behavioral Health
Office of Children's Services
Health Care Services
Juvenile Justice
Public Assistance
Public Health
Senior and Disabilities Services
Commissioner's Office
Commissioner's Office-Finance and Management Services

In order to carry out our mission, program support is offered in the following areas:

Core Services

- Provide quality assisted living in a safe, home environment.
- Provide an integrated behavioral health system.
- Promote stronger families, safer children.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Promote self-sufficiency and provide basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the Department's mission.

While the core services serve as the basis for the department's service delivery system the Department has three main guiding principles: self sufficiency for Alaskans, a strong safety net for those who cannot provide for themselves, and local access to care.

We Create Public Value By

- Ensuring Alaskan children are healthy
- Ensuring Alaskan children are safe
- Assisting low income Alaskans to become as economically self-sufficient as possible
- Keeping children with mental health issues close to their community support networks
- Preventing and mitigating threats to public health
- Providing access to healthcare for eligible Alaskans.

In carrying out these services, we provide the following contributions to the economy of Alaska:

- Benefit payments to over 110,000 Alaskans in the upcoming year.
- Health Coverage for over 131,000 eligible persons.
- Management of 43 buildings statewide including six pioneer homes with a total square footage exceeding 928,000 square feet. We also occupy 71 leased spaces that the Department is responsible for equipping and configuring.
- Management of $146.0 million in grants to communities and non-profit entities throughout Alaska.
- Oversight of over $980 million in federal funds, which flow through the department on an annual basis every year, for Medicaid, Temporary Assistance, Title IV-E Child Welfare funds as a few examples.

The department has over 3,400 positions budgeted, of which approximately 1,900 are direct field workers including:

106	Public Health Nurses
304	Social Workers and Children's Service Specialists
300	Eligibility/Work Services
268	Alaska Psychiatric Institute (API) staff
660	Pioneer Homes staffing
266	Youth Detention/Treatment workers
91	Juvenile Probation Workers

Non-direct field staff fall into two categories: program support services such as benefit payment processing and administrative or management support. Although many employees do not have direct contact with clients, their work is an integral part of program operations in the department.

Position Information

Permanent Full-Time:	3,295
Permanent Part-Time:	105
Nonpermanent:	181

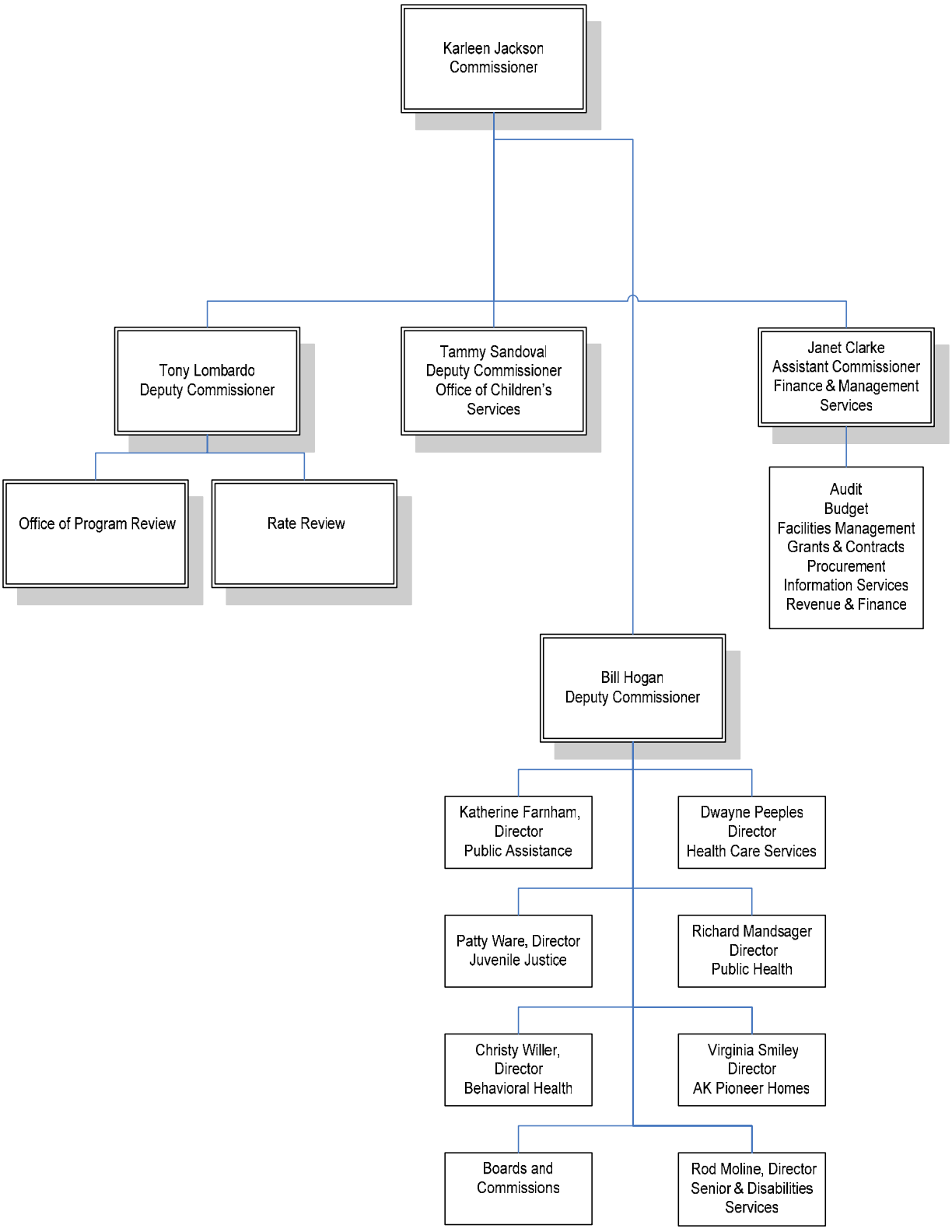
Department employees are located across the state as shown below. Additionally, many staff provide itinerant service, i.e. public health nurses, in the smaller rural communities.

FY2007 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1589	31	80	1700
Aniak	4	0	0	4
Barrow	7	0	0	7
Bethel	95	0	2	98
Cordova	2	1	0	3
Craig	6	0	0	6
Delta Junction	6	1	0	7
Dillingham	11	1	0	12
Eagle River	1	0	0	1
Fairbanks	357	7	16	380
Fort Yukon	0	1	0	1
Galena	2	1	0	3
Haines	2	0	0	2
Homer	12	2	0	14
Juneau	597	27	40	663
Kenai	80	2	1	83
Ketchikan	107	13	15	135
King Salmon	2	0	0	2
Kodiak	14	2	0	16
Kotzebue	9	0	0	9
McGrath	3	0	0	3
Nome	38	1	1	40
Palmer	119	15	15	149
Petersburg	4	0	0	4
Saint Marys	4	0	0	4
Seward	3	0	0	3
Sitka	96	0	11	107
Soldotna	2	0	0	2
Tok	2	0	0	2
Unalaska	1	0	0	1
Valdez	5	0	0	5
Wasilla	112	0	0	112
Wrangell	3	0	0	3
Totals	**3,295**	**105**	**181**	**3,581**

Executive Management Organization

January 2006



Major Accomplishments in 2005

- Received approval from the federal Veteran's Administration, broke ground and secured funds to remodel and convert the Palmer Pioneer Home into the State Veteran's Home.
- Migrated the Alaska Psychiatric Institute (API) into a new facility and re-named the adult Program the Alaska Recovery Center;
- Developed an integrated RFP and integrated service delivery system for Behavioral Health integrated project which integrated substance abuse and mental health programs for 23 different communities;
- Achieved four of seven outcome areas for the OCS performance improvement plan and received a letter of commendation from the U.S. Department of Health and Human Services on these accomplishments.
- The new Child Protection Management Information System, ORCA went live in 2005 and OCS received two awards from the Center for Digital Government and the American Public Human Services Association for bringing the system up and for its functionality.
- Completed the extensive renovation and expansion of the Nome Youth Facility, which expanded operations to a 14 bed facility.
- Juvenile Justice successfully completed two successful pilot site demonstrations with the research-based Youth Level of Service/Case Management Inventory which is a tool designed to aid in assessing the likelihood of a youth's risk to re-offend.
- Public Assistance was awarded a federal TANF High Performance Bonus for its exceptional performance in moving welfare recipients to the workforce.
- Public Assistance was awarded a Food Stamp Bonus Award for improvements in Food Stamp accuracy rates.
- The Temporary Assistance caseload continued its decline, reducing by 7%, thus saving the State three million dollars between 2004 and 2005.
- The Department working with the Governor's Office and lawmakers won passage of three vital pieces of public health legislation: A comprehensive new public health law, replacement of the Fairbanks virology lab and consolidation of state certification and licensing functions.
- Public Health continued to invest in prevention by distributing 4,188 smoke alarms to help prevent deaths from house fires, by installing and maintaining 408 "Kids Don't Float" life jacket loaner sites to prevent drowning, and maintaining certification of over 3,500 Emergency Medical Technicians.
- Improved Vital Statistics turnaround time for 60,000 requests for vital records from two weeks of previous years to three business days.
- Increased and improved the timeliness of Medicaid audits, particularly for the Personal Care Attendant program which has led to efforts to improve overall quality assurance and identified regulatory changes to curb program growth.
- Provided Home and Community Based Care to over 4,000 individuals and their families.
- Successfully integrated department IT services to improve customer service and provide a more efficient and effective use of technology;
- Successfully implemented the change to a centralized Medicaid Budget unit and departmental support services as an integrated cohesive unit;
- Awarded a contract and began work on the long-term Medicaid projection report and database;
- Was successful in 100% of procurement appeals including 15 grant award appeals and 4 protests of professional services contracts.

Program Prioritization

Statutory Reference AS 37.07.050(a)(13)

Prioritization of programs is based on importance to:

- Providing direct services to clients.
- Protection of vulnerable populations.
- Areas where State Government is ultimately responsible for providing service.
- Relevance of the activity to the department's mission.

1. Alaska Psychiatric Institute
2. Protection and Community Services
3. Epidemiology
4. Alaska Temporary Assistance Program
5. Tribal Assistance Programs
6. Pioneer Homes
7. HCS Medicaid Services
8. Senior and Disabilities Medicaid Services
9. Behavioral Health Medicaid Services
10. Children's Medicaid Services
11. Senior Care
12. Probation Services
13. Adult Public Assistance
14. Community Developmental Disabilities Grants
15. Foster Care Base Rate
16. Foster Care Augmented Rate
17. Foster Care Special Need
18. McLaughlin Youth Center
19. Delinquency Prevention
20. Fairbanks Youth Facility
21. Johnson Youth Center
22. Bethel Youth Facility
23. Nome Youth Facility
24. Ketchikan Regional Youth Facility
25. Mat-Su Youth Facility
26. Kenai Peninsula Youth Facility
27. Public Health Laboratories
28. Residential Child Care
29. Psychiatric Emergency Services
30. Behavioral Health Grants
31. Rural Services and Suicide Prevention
32. Services for Severely Emotionally Disturbed Youth
33. AK Fetal Alcohol Syndrome Program
34. Services to the Seriously Mentally Ill
35. Catastrophic and Chronic Illness Assistance
36. Nursing
37. Subsidized Adoptions & Guardianship
38. Child Care Benefits
39. Work Services
40. Chronic Disease Prevention/Health Promotion
41. Energy Assistance Program
42. Bureau of Vital Statistics
43. Emergency Medical Services Grants
44. Human Services Community Matching Grant
45. Senior Community Based Grants
46. Women, Infants and Children
47. Family Preservation
48. Infant Learning Program Grants
49. Youth Courts
50. Certification and Licensing
51. State Medical Examiner
52. Senior Residential Services
53. General Relief Assistance
54. Community Health Grants
55. Community Action Prevention & Intervention Grants
56. Designated Evaluation and Treatment
57. Commissioner's Office
58. Administrative Support Services
59. Facilities Management
60. Office of Program Review
61. Information Technology Services
62. Rate Review
63. Quality Control
64. Fraud Investigation
65. Hearings and Appeals
66. Health Planning & Infrastructure
67. Facilities Maintenance
68. Pioneers Homes Facilities Maintenance
69. Children's Services Training
70. Public Assistance Field Services
71. Child Protection Legal Svcs
72. Community Health/Emergency Medical Services
73. Tobacco Prevention and Control
74. Assessment and Planning (Medicaid)
75. Women, Children & Family Health
76. Medicaid School Based Administrative Claims
77. HSS State Facilities Rent
78. Alaskan Pioneer Homes Management
79. Behavioral Health Administration
80. Children's Services Management
81. Medical Assistance Administration
82. Public Assistance Administration
83. Public Health Administrative Services
84. Senior and Disabilities Services Administration
85. Permanent Fund Dividend Hold Harmless
86. Council on Faith Based & Community Initiatives
87. Children's Trust Programs
88. Alcohol Safety Action Program (ASAP)
89. Alaska Mental Health/Alcohol & Drug Abuse Brds
90. Commission on Aging
91. Governor's Council on Disabilities
92. Pioneers Homes Advisory Board
93. Suicide Prevention Council

FY07 Budget
The Department of Health and Social Services (DHSS) faced tremendous challenges in the last few years to provide a balance between reducing the reliance on state general funds and providing services to vulnerable populations.

Proposed budget for 2007 compared to 2006

	2006	2007 Proposed
DHSS budget		
General Fund	**$ 608.3 million**	**$ 751.3 million**
Federal Funds	**984.3 million**	**1,083.6 million**
Other Funds	**211.5 million**	**173.1 million**
Total	**$ 1.804 billion**	**$ 2.008 billion**
Increased Federal revenue		**99.3 million**
Increased General Fund		**142.9 million**

Cost Savings:
The Department has identified one major change to save general funds. That is to change the policy on pharmacy from one where Medicaid pays first and collects later (pay and chase) to where Medicaid waits for other 3rd party insurers to pay first before paying the claim. We estimate this change will save over $600.0 GF.

Hope and Opportunity:
The Department recommends an investment of $15.5 million in programs to bring Hope and Opportunity to a variety of Alaskans of all ages and circumstances in need of critical services.

This includes: 1) Opening Veterans beds in Pioneer Homes; 2) Rural Human Services for village counselors; 3) significant services for kids who need help including Youth for Success, Bring the Kids Home, FAS services, Post Adoptive Services, and Substance Abuse prevention and finally 4) key investment for three largest communities in Alaska that qualify for the Human Services Community Matching Grant program.

Safety and Security:
Safety and Security needs of the Department have risen to a level where the need is significant. The Department proposes almost a $12 million general fund investment across the department. Investments in this area include: 1) providing a safe and secure environment for the Pioneer Homes, Crisis Treatment Center, and Medicaid detoxification; 2) supporting Public Health Emergency Preparedness efforts including infectious disease control, immunization registry and stock pile of antiviral drugs; 3) Enhancing offender responsibility and accountability with investments in Juvenile Justice; 4) Implementing year two of state medical examiner improvement plan; providing a one range salary increase for DHSS nurses; and 5) improving DHSS revenue management and information technology security.

Maintain Services:
Significant investment of $98.7 million is required just to maintain the same levels of service in FY07 as in FY06. Most of this increase is needed in the Medicaid program for a variety of purposes.

Infrastructure:
DHSS is requesting $8.6 million to help support infrastructure in a variety of areas: 1) Primary among these increases is $6.5 million to provide a Disproportionate Share to Hospital (DSH) payment to qualified hospitals to compensate them for high levels of charity care; 2) a series of requests are included in the FY07 budget due to increases in fuel and electricity costs for state buildings; 3) additional resources for ORCA ownership costs; and 4) final settlement on Pioneer Home certified nurses assistance settlement.

DHSS SUMMARY FY2007
BUDGET BY CATEGORY

Category	Division	Budget Item	GF
Cost Savings			
	HCS	Change in Policy Moving from Pharmacy Pay-and-Chase to Cost Avoidance	(646.7)
		COST SAVINGS SUBTOTAL	(646.7)
Hope and Opportunity			
	AKPH	Opening Veteran's Beds in the Palmer Pioneer Home	904.0
	DBH	Rural Human Services Systems Program - Add 10 New Counselors in Villages	550.0
	DBH	DHSS Youth Success Program	5,000.0
	DBH	Bring the Kids Home (BTKH) Expansion	2,120.0
	DBH	Fetal Alcohol Spectrum Disorders (FASD)	500.0
	DBH	Substance Abuse Prevention Proposal	2,000.0
	DBH	Bring The Kids Home (BTKH) Expansion	190.0
	DJJ	Bring the Kids Home (BTKH) Care Coordination Project	100.0
	DPA	Early Childhood Development	750.0
	OCS	Bring the Kids Home - Expand Behavioral Rehabilitation Services (BRS)	1,250.0
	OCS	Bring the Kids Home - Regional Out-of-State Placement Committees	100.0
	OCS	Enhanced Post-Adoptive Services	140.3
	OCS	Expand Adoption and Guardianship Home study Contract	91.8
	HSCMG	Human Svc Community Match Grant Increment	1,764.7
		HOPE AND OPPORTUNITY SUBTOTAL	15,460.8
Safety and Security			
	AKPH	Increased Staffing for Resident Safety and Security	1,510.0
	DBH	Create 5 Social Detoxification Beds	300.0
	DBH	Expand Crisis Treatment Center from 8 to 16 Beds	662.5
	DJJ	Public Safety and Security Through Offender Accountability	933.3
	DPH	Public Health Protection: Infectious Disease Control and Emergency Preparedness - Epidemiology	1,000.0
	DPH	Public Health Protection: Infectious Disease Control and Emergency Preparedness - Nursing	960.0
	DPH	Public Health Protection: Protecting the health and safety of Alaska's vulnerable individuals - Certification and Licensing	150.0
	DPH	Public Health Protection: Immunization and Disease Registries	450.0
	DPH	Public Health Protection: Pandemic Influenza Preparedness AK Stockpile of Antiviral Drugs - Epidemiology	922.5
	DPH	Public Health Protection: State Medical Examiner Improvement Plan	500.0
	DPH	Public Health Protection: Infectious Disease Control and Emergency Preparedness - Public Health Labs	1,000.0

FMS	Improve Revenue Management/Cost Allocation System	310.0
FMS	Salary Increases for DHSS Nurses	2,115.3
FMS	Provide Security and Training Enhancements to DHSS Networks per Independent Assessment	550.0
FMS	Crisis Treatment Center Lease Amount	350.0
	SAFETY AND SECURITY SUBTOTAL	11,713.6

Maintain Services

AKPH	Switch GF to Federal Receipts from Veteran's Domiciliary Care Per Diem	(144.7)
DBH	SCHIP Shortfall	761.2
DBH	Projected FY07 Medicaid Growth	2,954.1
DBH	API Pharmacy Cost increase	150.0
DBH	API Increment for Loss of Medicare Revenue due to Rate Change	500.0
HCS	90% Medicare Part D Clawback	4,360.0
HCS	SCHIP Shortfall	1,413.6
HCS	Projected FY07 Growth	16,876.6
HCS	Premium Increases for Medicare Part A and Part B	1,522.3
HCS	Replacement of Fairshare SDPR	45,000.0
OCS	Medicaid Behavioral Rehabilitative Services Rate Increase for Kids in Custody	928.3
OCS	Medicaid Behavioral Rehabilitative Services Rate Increase for Non-Custody Kids	580.0
SDS	Projected FY07 Growth	23,307.6
SDS	Increase Medicaid Assessment Contracts to Manage Medicaid costs	300.0
SDS	Enhance Adult Protective Services and Quality Assurance Integrity	150.0
	MAINTAIN SERVICES SUBTOTAL	98,659.0

Infrastructure Support

AKPH	Certified Nurse Aide Reclass Settlement Costs	284.0
AKPH	Assistance for Increased Fuel/Electricity Costs	154.0
DBH	Expand Alaska Automated Information Management System (AKAIMS) Support	340.0
DBH	Assistance for Increased Fuel/Electricity Costs - API	44.5
DJJ	Increased Infrastructure Support Costs	108.1
DJJ	Assistance for Increased Fuel/Electricity Costs - all Youth Facilities	88.4
DPH	Assistance for Increased Fuel/Electricity Costs - Nursing	30.4
DPH	Assistance for Increased Fuel/Electricity Costs - Labs	27.6
FMS	Assistance for Increased Fuel/Electricity Costs	492.7
HCS	Increase Disproportionate Share Hospital (DSH) Authorization	6,502.6
OCS	ORCA Services Ownership and Upgraded Infrastructure	495.0
OCS	Assistance for Increased Fuel/Electricity costs	6.9
	INFRASTRUCTURE SUPPORT SUBTOTAL	8,574.2

One-Time Items

OCS	One-time Item - Child in Need of Aid Second Year Fiscal Note Reduction, Ch 64, SLA 05	(60.0)

OCS	One-Time Item - Child in Need of Aid Second Year Fiscal Note Reduction, Ch 64, SLA 05	(41.9)
	ONE-TIME ITEMS SUBTOTAL	(101.9)

Salary Adjustments

DEPT	FY 07 Wage Increases for Bargaining Units and Non-Covered Employees	2,607.9
DEPT	FY 07 Health Insurance Cost Increases for Bargaining Units and Non-Covered Employees	353.9
DEPT	FY 07 Retirement Systems Cost Increase	4,691.9
DEPT	Risk Management Self-Insurance Funding Increase	1,456.6
DEPT	FY2007 Wage, Health Insurance, Retirement, and Risk Management Increases for Division of Personnel	193.8
	SALARY ADJUSTMENT SUBTOTAL	9,304.1

	TOTAL DEPARTMENT GF ADJUSTMENTS	**142,963.1**

UNCOMPENSATED CARE FOR HOSPITALS FROM DSH

BUDGET SUMMARY	GENERAL FUND MATCH	$ 6,502.6
	FEDERAL FUNDS	$ 6,724.9
	TOTAL	$ 13,227.5

WHAT IS THE ISSUE

- Many Alaska hospitals have a high amount of uncompensated care. The State of Alaska can use the Medicaid disproportionate share hospital (DSH) program to provide an additional payment to hospitals to compensate them for the high charity care levels. The state plans to negotiate agreements with qualifying hospitals on DSH payments to preserve or expand how hospitals can benefit the state or local community in exchange for DSH.

- Alaska's allotment of federal DSH funds will increase by 16% for FFY2007. The Department estimates SFY07 DSH funding of approximately $27 million (including $13.7 million federal and $13.3 state match). IMD and DET payments are expected to be about $14 million, leaving approximately $13 million to distribute as payments in other categories to hospitals. Additional GF needed to match the federal dollars is $6.5 million.

PROPOSAL

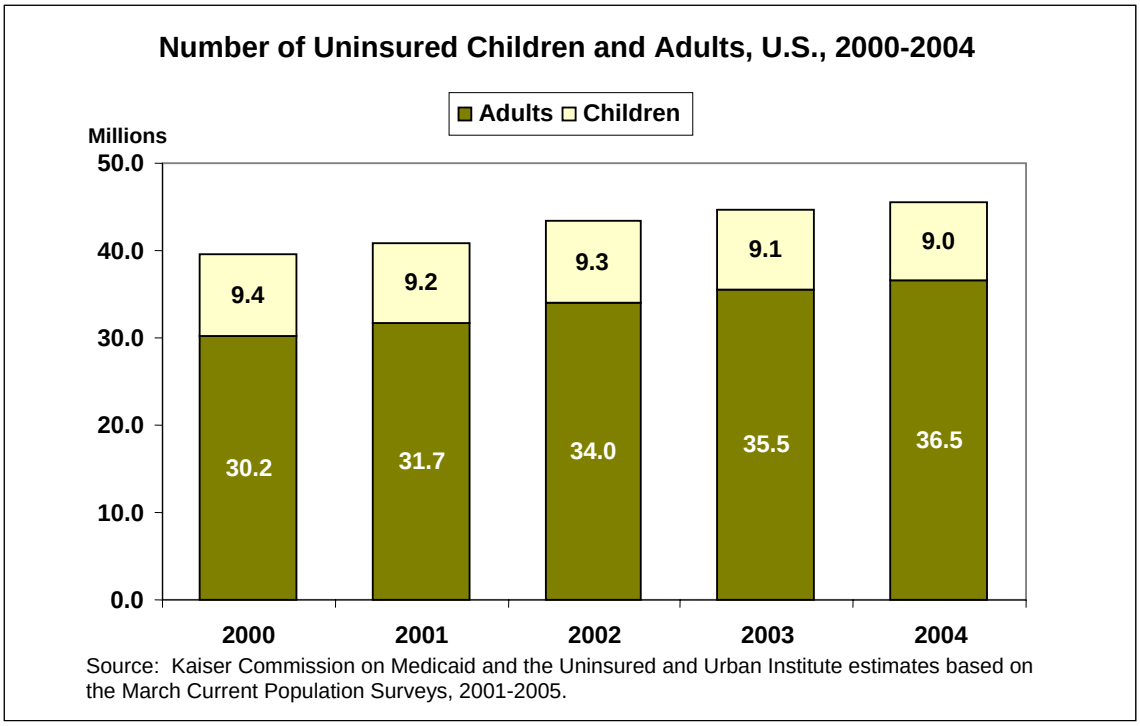
- The proposal is for an increment of $6,724.9 in federal receipts and $6,502.6 in general fund match. This is based on SFY07 regular FMAP of 50.84%.

WHY THIS NEEDS TO BE DONE

- Hospitals rendering high volumes of care to low-income and indigent Alaskans have high levels of uncompensated care and lose money because of low Medicaid reimbursement rates. These hospitals often have low private caseloads and are thus less able to shift the cost of uncompensated care to privately insured patients.

- The health care needs of the uninsured and underinsured have a huge impact on hospitals and other health care providers in Alaska, as well as on the Department of Health and Social Services. The number of uninsured adults has grown steadily since 2000. Many underinsured and uninsured patients wait to seek needed care until it becomes an emergency, increasing the cost of their care and placing pressure on the health care system. They are seriously impacted by waiting until they have a health care emergency – their recovery may take longer, and sometimes they will put their lives in jeopardy.

- The Social Security Act allows the state to make DSH payments to qualifying hospitals.



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on the March Current Population Surveys, 2001-2005.

YOUTH SUCCESS INITIATIVE

BUDGET SUMMARY	GENERAL FUND MENTAL HEALTH	$ 5,000.0
	OTHER FUNDS	$ 1,000.0
	TOTAL	$ 6,000.0

WHAT IS THE ISSUE

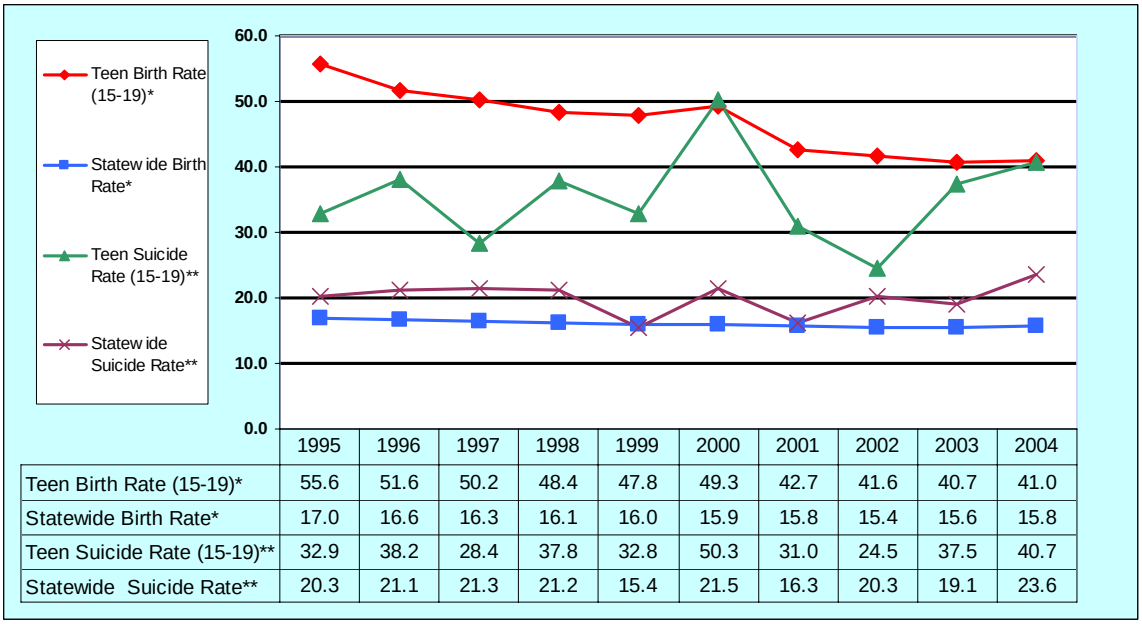
- This investment is targeted to turn the curve on some of the following indicators where Alaska's Youth rates are high:
  - Substance Abuse
  - Suicide Rate
  - Teen birth Rate
- This program will impact thousands of youth in Alaska who are at risk of substance abuse, suicide, teen pregnancy, or adopting criminal behavior by providing them alternatives, productive activities, good role models and appropriate mentors.
- A significant investment of this type will change youths' lives with higher teen employment rates and lower teen births, suicide, and substance abuse rates.

BUDGET PROPOSAL

- The requested funds will be granted to non-profit agencies. These non-profit agencies will be required to propose specific programs and outcomes to achieve success, employing innovative approaches with proven results and outcomes measures including:
  - Alcohol, drug abuse prevention programs. These activities could take many forms, but one model is to use small group activities designed to increase participants' resiliency and strengthen leadership skills.
  - Suicide Prevention. Implement activities and interventions that work to prevent suicide.
  - Establish new clubhouses or programs throughout the state.
  - Encourage healthy lifestyles, promote positive behavior. There are many models for these activities including Passport to Manhood, and SMART Girls.
  - Teen births. Implement activities and interventions that work to prevent teen pregnancy.
  - Job ready, work preparedness. Provide adolescents with the skills to secure employment and to be successful in the world of work.
- Through a competitive process the Department of Health and Social Services has already identified four non-profit entities for this program. They are: Boys & Girls Clubs of Alaska, Big Brothers/Big Sisters, Rural Alaska Community Action Program and the Alaska Association of School Boards.

WHY THIS NEEDS TO BE DONE

- To ensure that thousands of Alaska youth will succeed in life.
- Cut the underage drinking rate. Most recent data (2003) shows 75.1% of high school students have used alcohol.
- Reduce Alaska Youth (15-19 yrs) suicide rate. Currently, Alaska's statewide suicide rate is the highest it has been in ten years, more than double the national average (Alaska is 23.6 per 100,000 population, US is 10.5 per 100,000 population). The Alaska Youth suicide rate is almost double the statewide rate.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Teen Birth Rate (15-19)*	55.6	51.6	50.2	48.4	47.8	49.3	42.7	41.6	40.7	41.0
Statewide Birth Rate*	17.0	16.6	16.3	16.1	16.0	15.9	15.8	15.4	15.6	15.8
Teen Suicide Rate (15-19)**	32.9	38.2	28.4	37.8	32.8	50.3	31.0	24.5	37.5	40.7
Statewide Suicide Rate**	20.3	21.1	21.3	21.2	15.4	21.5	16.3	20.3	19.1	23.6

* Teen birth rate is the number of births to females age 15-19 divided by the estimated population of females ages 15-19, multiplied by 1,000. Statewide birth rate is the number of live births to women divided by the entire population (women and men), multiplied by 1,000

**Teen suicide rate is the number of deaths for teens age 15-19 divided by the population for the same specific age group, multiplied by 100,000. Statewide suicide rate is the number of suicides of both men and women divided by the entire State population, multiplied by 100,000.

Data source –H&SS Bureau of Vital Statistics (12/12/05)

- Reduce the teen birth rate in Alaska. The 2004 rate was 41.0 (based on initial 2004 data; Rate of births to Alaska teens 15-19 per 1,000 population).
- Improve success rate of teenagers in the local labor market. 2001 reflects 43% of the 14 to 17-year old populations were employed some time during the year while in 2003 45% were employed.

INFECTIOUS DISEASE CONTROL AND EMERGENCY PREPAREDNESS

BUDGET SUMMARY	GENERAL FUND	$ 4,332.5
	FEDERAL FUNDS	$ 847.5
	TOTAL	$ 5,180.0

WHAT IS THE ISSUE

- Our capacity to detect outbreaks of disease and to respond rapidly and effectively to control the spread is insufficient.
- We need to ensure the state is ready for public health emergencies, that rising demands of infectious disease prevention are met, that infectious diseases are diagnosed rapidly, and that there are sufficient resources to allow for rapid response in disease outbreaks.

BUDGET PROPOSAL

The new funds in the FY07 Governor's budget will:

- increase the number of public health nurses on the front lines to help communities plan for emergencies, conduct investigations of disease outbreaks, and deliver treatment and immunizations when necessary ($1.5 million for Public Health Nursing);
- support the medical expertise necessary to diagnose and control the spread of dangerous infectious diseases; improve our ability to communicate with medical providers across the state so we know about new or unusual health events as soon as they occur in a community ($1 million for Epidemiology);
- strengthen our public health laboratory system so it is even more capable of identifying deadly pathogens swiftly and safely ($1 million for Public Health Labs);
- establish a small stockpile of antiviral medications in Alaska to help minimize the death rate and decrease recovery time in the event of an influenza pandemic ($1,230.0 for a medical stockpile).
- develop an immunization registry and strengthen communicable disease surveillance capacities to help ensure that each child is protected from devastating vaccine-preventable diseases, and to support rapid identification and control of disease outbreaks ($450.0 operating and $2,049.9 capital).

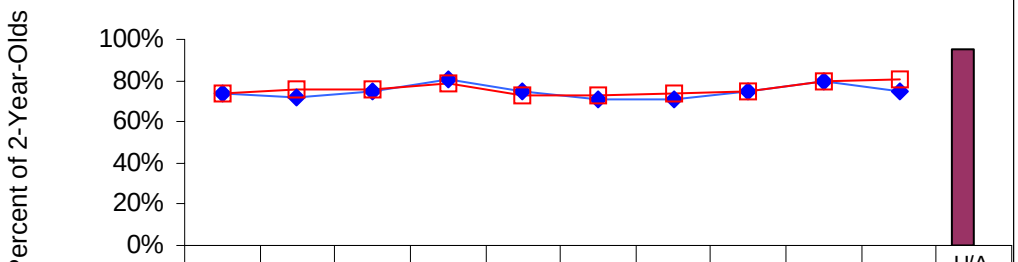
WHY THIS NEEDS TO BE DONE

- Over the past 30 years, more than 30 new infectious diseases have been discovered. Recent examples include SARS and the H5N1 avian influenza strain.
- An influenza pandemic has the potential to cause more disease and death than any other public health threat. The risk that the H5N1 avian influenza strain will trigger a pandemic is real.
- The Division of Public Health must remain vigilant for on-going infectious disease problems.
    - During the first nine months of 2005, 82 cases of pertussis (whooping cough) have been identified in Alaska, in spite of an effective childhood vaccine.
    - In 2000, Alaska reported the highest rate of tuberculosis in the country because of several large outbreaks. There have been no large outbreaks since 2002, but Alaska continues to be among the top five states with the highest TB rates in the U.S.

- Alaska had the highest rate of Chlamydia disease in the U.S. in 2003. There were 3,900 cases for a rate of 606 cases per 100,000 people.

- In 2004, Alaska ranked 45 of 50 states with only 75.3 percent of 0-to-3-year old children who were fully immunized. A statewide immunization registry is needed to help ensure that each child is protected from devastating vaccine-preventable diseases.

Fully Immunized 2-Year-Olds: Alaska and the U.S.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											95.0%
AK's Rank	26	41	31	22	27	27	35	30	27	45	
Alaska	74.0%	71.5%	75.0%	81.0%	74.5%	71.0%	71.0%	75.0%	80.0%	75.0%	
U.S.	74.0%	76.0%	76.0%	79.0%	73.0%	73.0%	74.0%	75.0%	80.0%	81.0%	

Data Source: National Immunization Survey
Note: Annual percentages are based on CDC recommendations at the time, which have changed over the years as new vaccines have been added to the "basic immunization series."

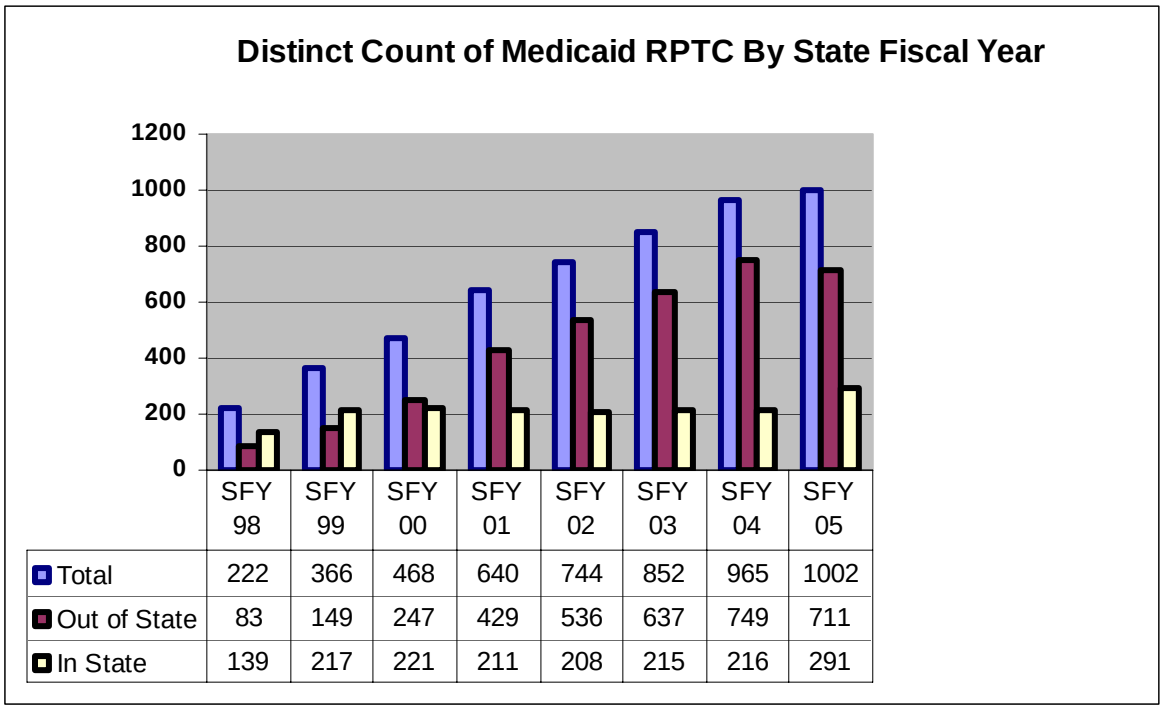
- The value of an immunization registry crosses state boundaries, especially in a disaster. For example, following Hurricane Katrina many children displaced to other states from Louisiana lost their medical records. The Louisiana Immunization Registry was quickly reconfigured to provide interstate access to facilitate these children's entry into their new schools.
- An electronic communicable disease surveillance system is needed for input and analysis of reportable diseases to allow rapid detection of unusual disease trends and rapid detection of an outbreak.

BRING THE KIDS HOME

BUDGET SUMMARY	GENERAL FUND/ MENTAL HEALTH	$ 3,760.0
	FEDERAL FUNDS	$ 1,550.0
	MHTAAR	$ 50.0
	TOTAL	$ 5,360.0

WHAT IS THE ISSUE

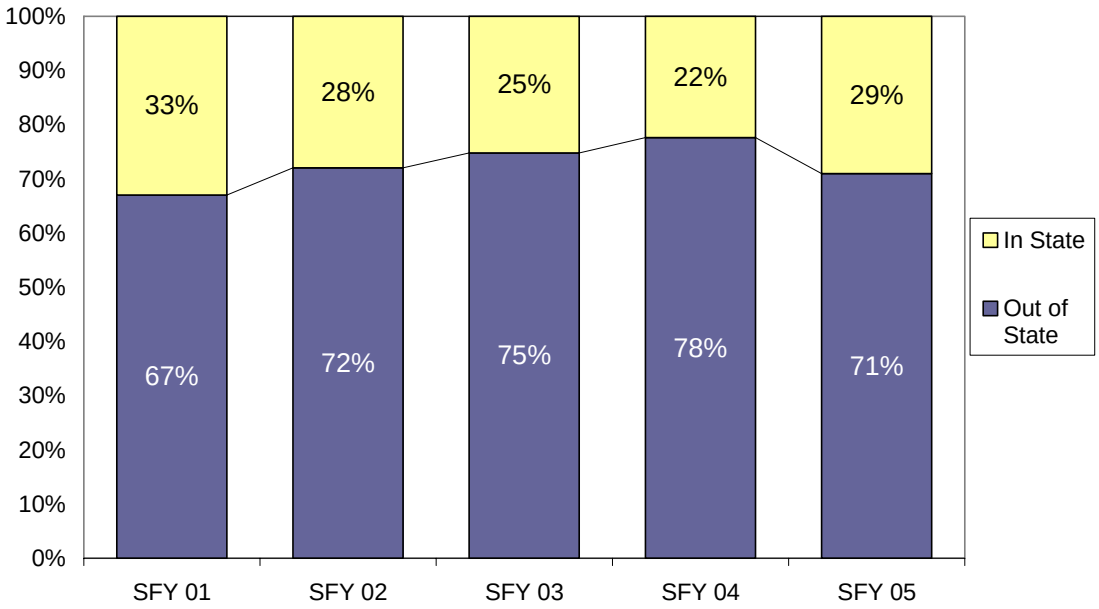
- Over the past seven years the children's behavioral health system in Alaska has become increasingly reliant on institutional care - inpatient hospital and Residential Psychiatric Treatment Center (RPTC) care - especially out-of-state RPTC care, for treatment of severely emotionally disturbed youth.
- In FY05, the proportion of children served out of state dropped 7%. In SFY05 711 children received out-of-state services, compared to 749 children in SFY04 which is a decrease of 38 children. Each child was assigned their location and counted once as in or out-of- state based on their first Medicaid RPTC claim in each respective fiscal year.



	SFY 98	SFY 99	SFY 00	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05
Total	222	366	468	640	744	852	965	1002
Out of State	83	149	247	429	536	637	749	711
In State	139	217	221	211	208	215	216	291

***Bring the Kids Home* Turns the Corner in 2005**

More Alaskan Children Received RPTC Services In-State during SFY 2005



Source: DBH Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries. December 23, 2005

- Research shows that children have better long-term results if treated closer to home, where parents and the extended family can be involved in their treatment plan.
- At any given time, approximately 350-400 children are being served in out-of- state placements. Alaska Native children represent 49% of the custody children sent to out-of-state placements and 22% of the non-custody children sent to out- of-state placements.

BUDGET PROPOSAL:

- The most consistent initial approach to addressing over-reliance on out-of-state residential care by non-custody children is to implement a consistent system of gate keeping for all children. This requires sufficient staffing for the regional and out of state placement/resource committees to serve referrals for non-custody children. These committees currently provide this function only for custody children. This is an effort shared between three divisions: Behavioral Health, Children's Services, and Juvenile Justice. ($300.0 GF/MH and $300.0 Federal)
- Funding will provide additional grants to the Community Mental Health Centers (CMHCs) to work with families and youth prior to consideration by the placement/resource committees for residential care. Currently, children and youth from rural and outlying areas have limited access to CMHCs and may not receive a thorough evaluation and access to an array of behavioral health services before moving into residential care. In addition, privately funded behavioral health services seldom cover the costs of care coordination to develop complex community based services. Granting funds will ensure the CMHCs ability to develop and implement complex service packages for an increasing service load. ($1,250.0 GF/MH)
- Funding will ensure that Severely Emotionally Disturbed (SED) youth are being served as close to their community as possible, providing clinically necessary services to prevent institutional care. Individualized Service Funds will be managed by the regional resource committees to reinforce lower levels of care. Funds will be routed through providers for services to youth that cannot be reimbursed through Medicaid fee-for-service or Behavioral

Rehabilitation Services (BRS) financing, or for youth that do not qualify for Medicaid. ($870.0 GF/MH).

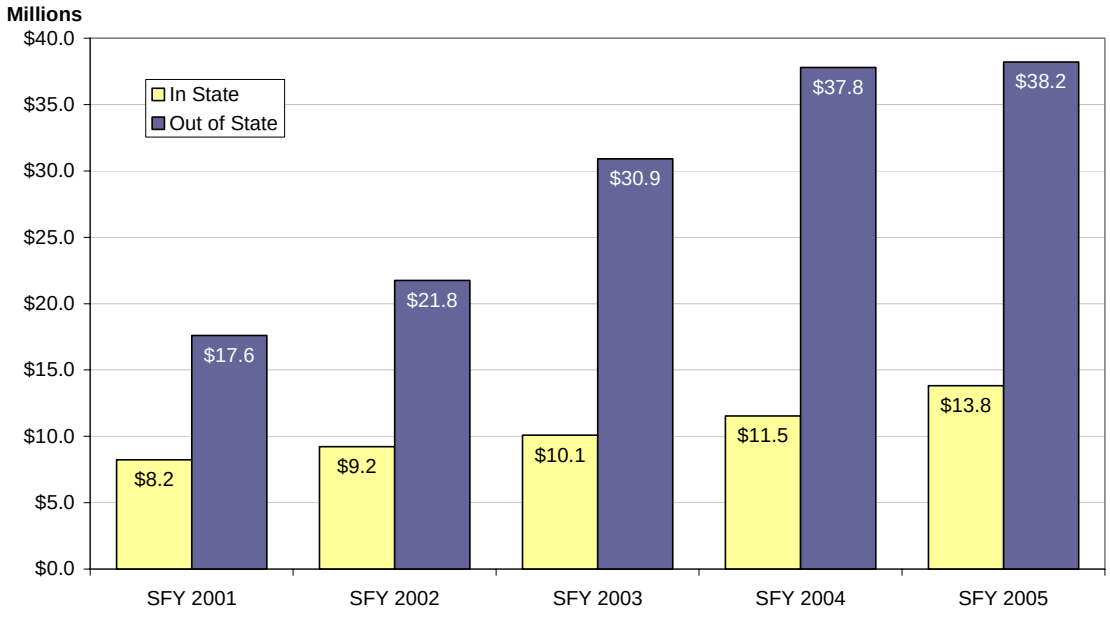
- The Office of Children's Services (OCS) currently purchases a set number of Behavioral Rehabilitation (BRS) beds for in-custody children. However, some facilities are licensed for more beds than have been purchased by OCS. In the past, there was no funding mechanism/source to allow the facility to utilize these beds to serve non-custody children. Through this funding, these in-state beds will become available to non-custody children. Purchase of these approximately 50 beds, will make existing, but un-utilized, BRS residential beds accessible to non-custody children, who may otherwise be placed in a higher level of care than is justified, and/or placed in an out of state institution. ($1,250.0 GF/MH and $1,250.0 Federal).
- Currently project management for the Bring the Kids Home Project is shared between the Alaska Mental Health Trust Authority and the Division of Behavioral Health. The Project Manager position will be responsible for the coordination of the project and ensuring that all factions are moving toward outcome oriented results. ($90.0 GF/MH)

WHY THIS NEEDS TO BE DONE

- Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska.
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate.
- Increase the service days children are treated by in-state RPTC facilities or community based programs.

More RPTC Medicaid Dollars Stayed in Alaska in 2005

Medicaid Billings for In-State RPTC Providers Increased in SFY 2005



Source: DBH Policy and Planning using MMIS-JUCE data, RPTC Medicaid claim payments. December 23, 2005

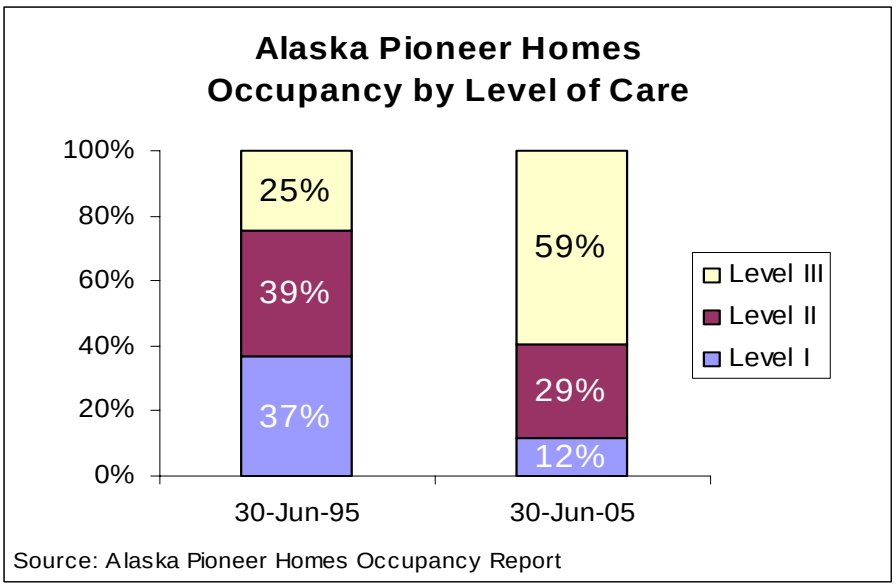
- Reinvest funding that currently provides expensive distant care to in-state services and capacity development to serve children closer to home, keep families more involved and intact, and more effectively carry out transitions and discharges.

PIONEER HOME STAFFING FOR SAFETY

BUDGET SUMMARY	GENERAL FUND	$ 1,510.0
	TOTAL	$ 1,510.0

WHAT IS THE ISSUE

- The average age of a Pioneer Home resident is currently 84.5. There is a direct correlation between increasing age and the need for higher levels of care.
- The majority of Pioneer Home residents have a primary, secondary or tertiary diagnosis that includes some form of dementia.
- The percentage of Pioneer Home residents requiring the highest level of care (Level III) has risen from 25 to 59 percent over the last 10 years.
- Staffing levels to provide the more intensive physical, functional and emotional services required at the higher care level have not risen proportionately to the need for higher level care.
- Maintaining residents' safety becomes more difficult as residents are less able to care for themselves and rely on staff to perform much of the effort involved with the activities of daily living.
- As demonstrated in the following chart, there has been a dramatic increase in Level III care and a commensurate reduction in Levels I and II over the last 10 years.



PIONEER HOME STAFFING PROPOSAL

- The $1.5 million proposal adds 24 positions statewide to provide high quality care for a complex resident population. Increased staffing will assure families, residents and staff that a safer environment is being provided for Pioneer Home residents.
- New positions include 14 Certified Nurse Aides to provide direct care tasks such as bathing, help with transfers and feeding assistance, seven registered nurses to provide for increased medication administration, monitoring physical needs, and meeting the documentation requirements of Medicaid and Medicare, one Social Worker to perform skilled clinical work and increase the number of residents receiving the Medicaid Waiver, one Pharmacy Technician to assist with ordering, packaging and distribution of increased medication

demands, and one Environmental Services Journey to provide in house maintenance and repair work.

- Increased staff will allow 10 additional existing beds in Sitka, for which there are currently not sufficient staff to support, to be made available to people on the active waiting list in the higher level of care.

WHY THIS NEEDS TO BE DONE

- The Alaska Pioneer Homes mission is to provide a safe home environment to its residents. This goal becomes increasingly difficult as the population ages and dementia levels increase. Adverse events increase with age and decreasing cognitive function. Staff responsibilities for residents increased parallel to the higher level of care required by current residents. Today staff deal with more residents who are confused, disruptive and combative, and require increased physical monitoring, medication administration and hands-on assistance.
- Falls in older adults are five times more likely to lead to hospitalization than other injuries (National Safety Council). One third of adults over 65 fall each year, increasing to 50% for adults over 80. Pioneer Home residents, with an average age of 84.5, are, therefore, in the highest risk category for fall related injuries. In FY05 only 33% of the falls that occurred were in the presence of a staff member. 66% of the falls occurred when the resident was unsupervised.
- In FY05 seven deaths in the Pioneer Homes were related to falls. Six of the seven falls were unwitnessed.
- In addition to current residents, the Homes have active waiting lists for Alaskans who are no longer able to care for themselves safely in their own homes. The applicants on the lists are primarily waiting for space in the higher levels of care.
- Existing vacant beds in the Sitka Home are unavailable due to inadequate staff patterns needed for higher levels of care.
- The increase in medication needs contrasts with the difficulty in recruiting for and filling professional Pharmacist positions. The addition of a Pharmacy Technician to handle lower level duties will allow the existing Pharmacists to focus on the more essential consultation, medication distribution, resident chart review, and documentation responsibilities.

PUBLIC SAFETY & SECURITY THROUGH OFFENDER ACCOUNTABILITY

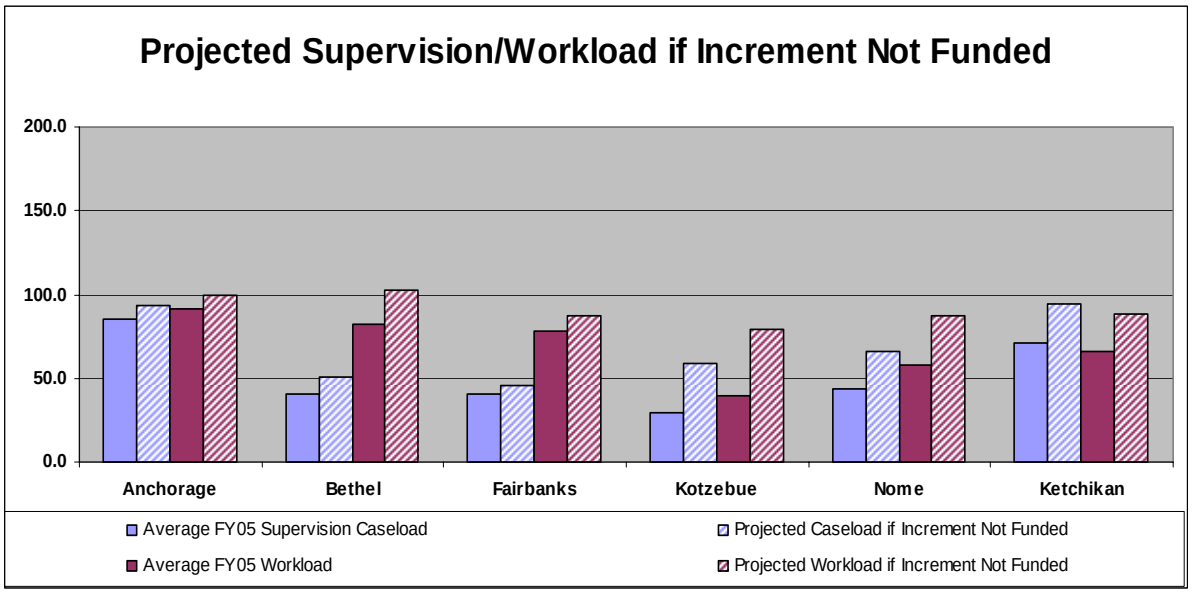
BUDGET SUMMARY	GENERAL FUND	$ 933.3
	TOTAL	$ 933.3

WHAT IS THE ISSUE

- Juvenile Probation Officers (JPOs) are one of the most important community-based resources deployed by DJJ to ensure that juvenile offenders are supervised, pay restitution, perform community work service and develop the skills required to reduce the likelihood of re-offense.
- The Division of Juvenile Justice is continuing its work to develop a system that uses resources effectively, is based on best practice, and where decisions are based on data, are defensible and ensure desirable outcomes.
- Juvenile crime in Alaska is being transformed by establishing prompt and responsive early intervention activities at the front end of the system for better outcomes for children and communities.

JUVENILE JUSTICE PROPOSAL

- The $933.3 proposal will avoid layoffs of up to eight juvenile justice probation officer staff members and ensure a proactive response to juvenile crime, including rural Alaska.
- The proposal will ensure an adequate and timely response to juvenile offenders who warrant active supervision and monitoring of their behavior in order to prevent repeat or more serious juvenile crime.



WHY THIS NEEDS TO BE DONE

- Focusing on timely and responsive early intervention produces safer communities and fewer victims.
- Improved ability to intervene at the front end of the juvenile system produces better outcomes for juvenile offenders.
- Providing services to hold juveniles accountable and providing them skills to return them to society reduces the likelihood of re-offense and further criminal activity as adults.
- Ensure continued public safety and security in both urban and rural Alaska.

SENIOR CARE PROGRAM AND MEDICARE PART D

BUDGET SUMMARY	GENERAL FUND	$ 11,962.6
	TOTAL	* $ 11,962.6

*It is anticipated that the FY07 GF capitalization deposit to the Alaska Senior Care fund will be contained in language section of the operating budget bill.

WHAT IS THE ISSUE

- Alaska's growing senior population is facing increased healthcare costs, including costly prescription drugs.
- Currently, Alaska's SeniorCare program provides a cash or prescription drug subsidy for low-income seniors until January 1, 2006. Almost 7,000 seniors currently receive the $120 cash benefit each month. The SeniorCare drug benefit currently covers seniors whose income is 150 percent or less of the federal poverty level.
- Effective January 1, 2006, the SeniorCare cash benefit will be provided for seniors who have a household income that does not exceed $16,133 a year for a household of one person and $21,641 a year for a household which consists of two people and the SeniorCare drug benefit will begin covering Medicare Part D or comparable insurance prescription drug premiums and deductibles for Alaska seniors with annual incomes up to $20,913 for a single individual or $28,053 for a couple.
- The Department estimates a monthly average of 7,000 seniors will be eligible for and continue to receive the $120 cash benefit each month when the program is extended on January 1, 2006. The Department estimates an additional 3,900 seniors will become eligible for the new SeniorCare drug benefit.

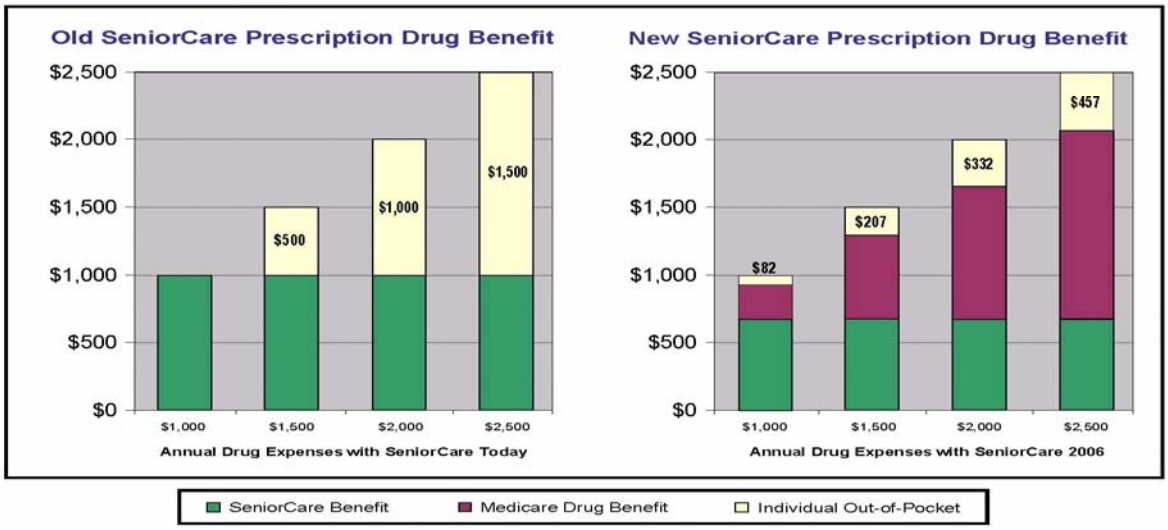
BUDGET PROPOSAL

- Continue the SeniorCare cash benefit beyond January 1, 2006, for seniors with incomes below 135 percent of the federal poverty level.
- Beginning January 1, 2006, the SeniorCare drug benefit would change and cover Medicare Part D or comparable insurance prescription drug premiums and deductibles for Alaska seniors with incomes between 135 to 300 percent of the poverty level.

WHY THIS NEEDS TO BE DONE

- Continues to provide a cash benefit to the neediest of Alaska's seniors.
- The Medicare Part D prescription drug plan will require most beneficiaries to pay premium and deductible expenses out-of-pocket.
- The current SeniorCare drug benefit with an income limit of 150% of federal poverty guidelines is very limited.

Strengthening and Improving Drug Coverage for Alaska Seniors



Expenditure Category Comparisons

For purposes of historical comparisons we have broken out expenditures into five categories of funding:

Program Services
Includes both administration and delivery of direct services, such as public health nursing and social services, and the program management of entitlements and grants.

Formula Programs
Includes all programs with specific eligibility standards which guarantee a specific level of benefits for any qualified recipient: Alaska Temporary Assistance Program (ATAP), Adult Public Assistance, General Relief Assistance, Tribal Assistance Programs, Medicaid Services, Catastrophic and Chronic Illness Assistance, Child Care Benefits, Foster Care, and Subsidized Adoption and Guardianship.

Grants
Includes the components with major grants to other organizations or major contracts for service delivery, such as Residential Child Care, Energy Assistance Program, Community Health Grants, and various treatment programs.

Facilities
The department manages and operates 24-hour facilities or institutions. These include youth correctional facilities, Alaska Psychiatric Institution, and Pioneer Homes.

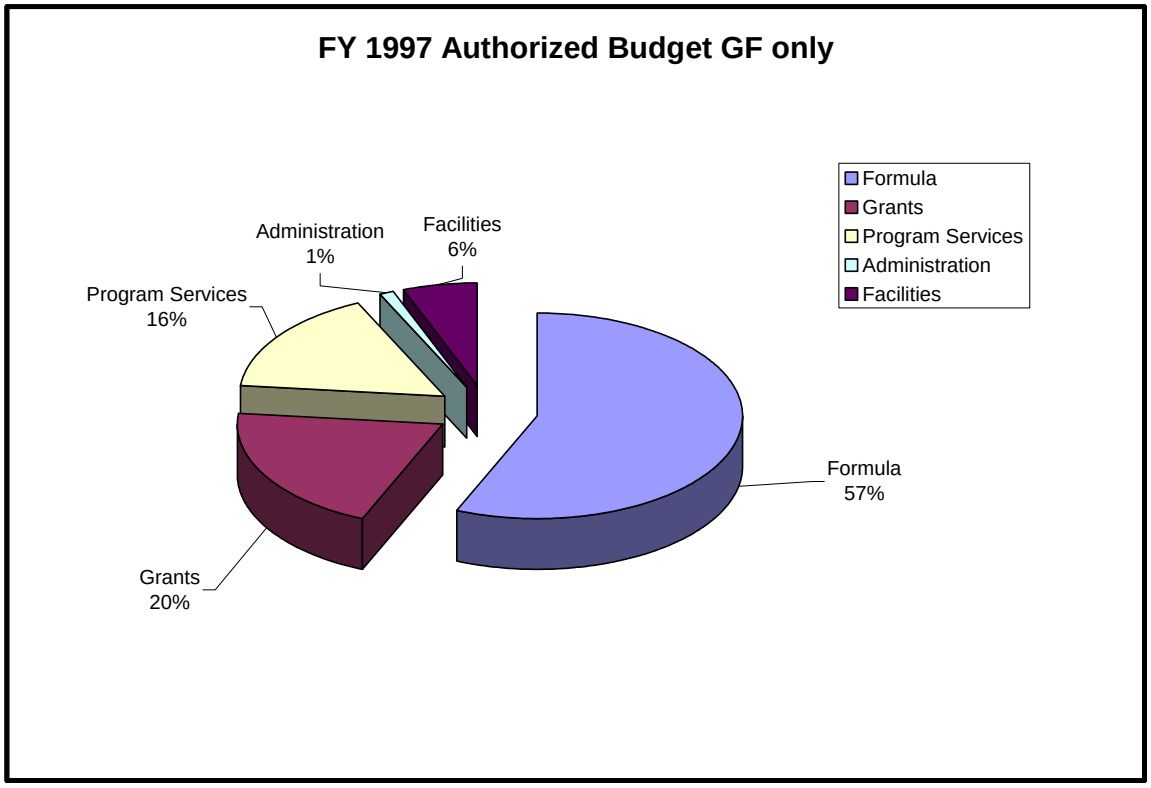
Administration
Administration includes departmental administrative oversight and support programs, including the Commissioner's Office, Administrative Services, and Boards and Commissions.

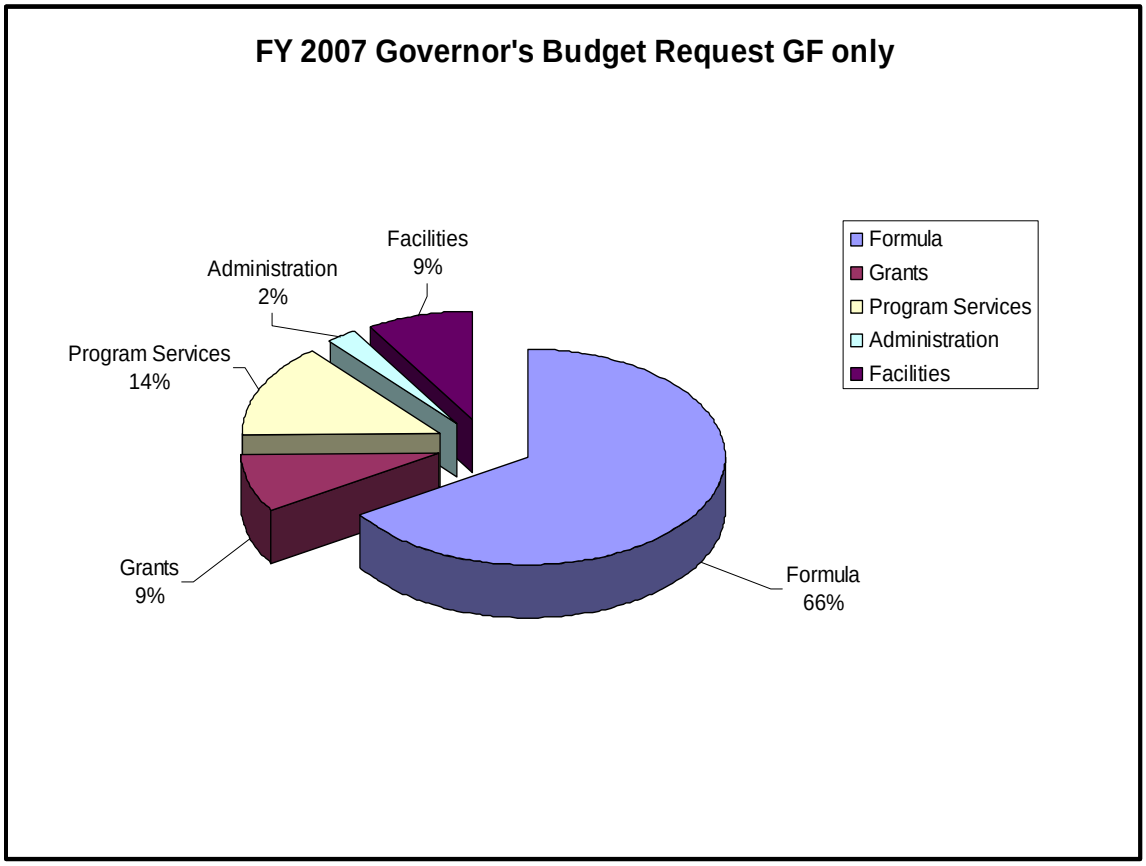
Budget Charts and Graphs

The Table below shows the comparison of total funds of FY2007 to FY1997.

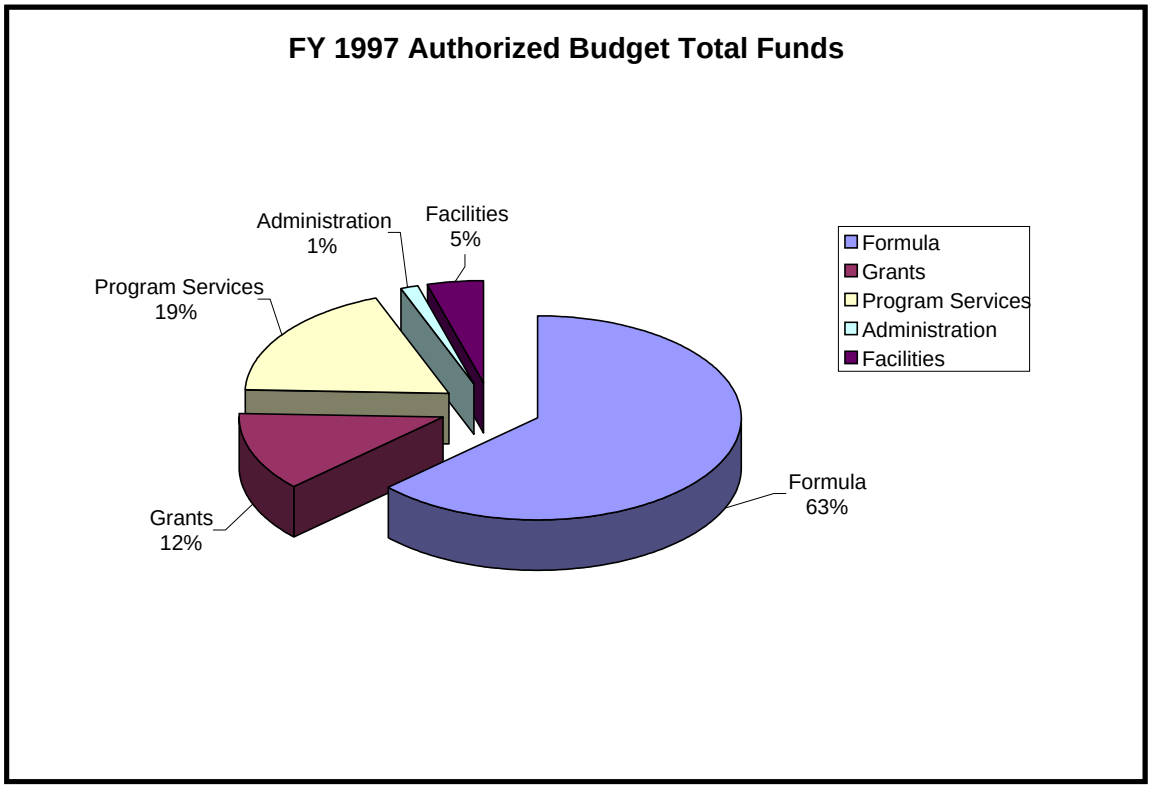
	FY1997		**FY2007**		
	Total Funds	**% of Total**	**Total Funds**	**% of Total**	**07 to 97 Change**
Formula	543,955.8	63.1%	1,445,610.4	72.0%	166%
Grants	106,570.4	12.4%	129,771.9	6.5%	22%
Program Services	162,611.1	18.9%	289,089.1	14.4%	78%
Administration	9,738.4	1.1%	42,189.2	2.1%	333%
Facilities	39,525.3	4.6%	101,297.2	5.0%	156%
Total	**862,401.0**		**2,007,957.8**		**133%**

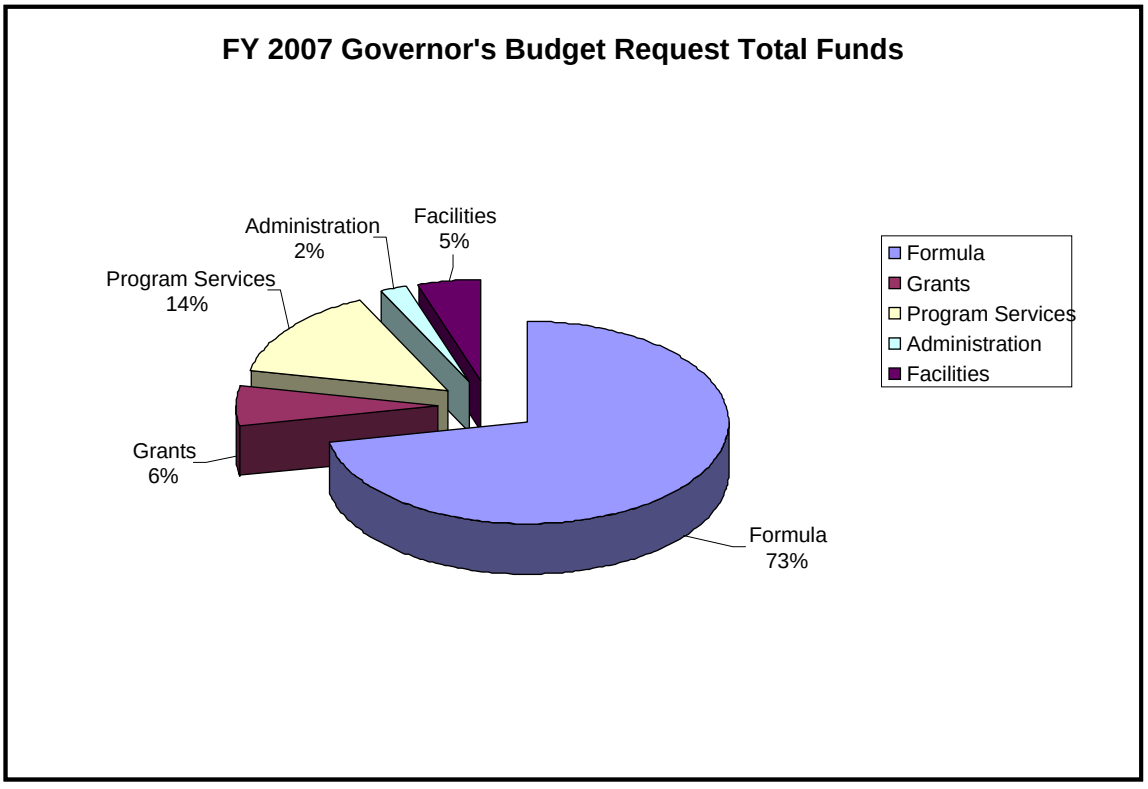
Expenditure Category Comparisons of General Fund Authorization





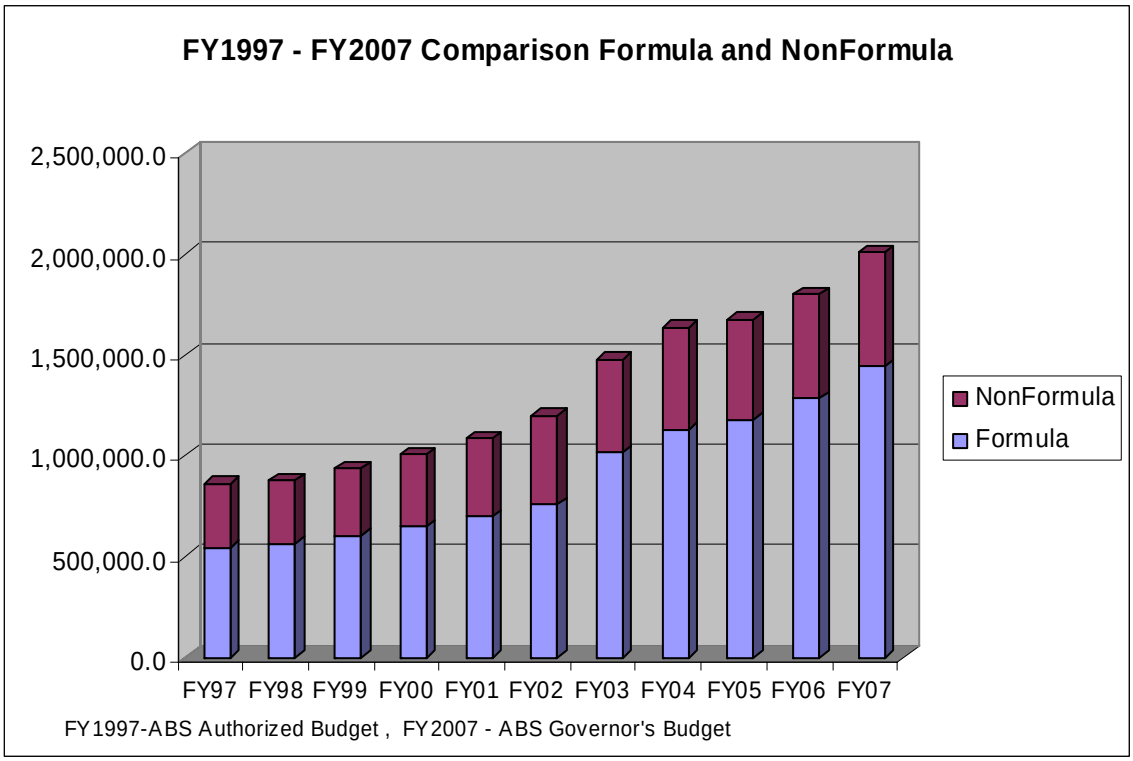
Expenditure Category Comparisons of Total Funds Authorization





As the previous charts show, formula programs make up more than half of the department's expenditures. Looking back to FY91, formula programs made up approximately 48% of the department's general fund budget in comparison to FY2007 of 63% of the general fund budget.

The chart below breaks out formula and nonformula categories of budget.



From FY1997 – FY2002 formula programs were fairly consistent between 63% - 65% of the department's overall budget. In FY2003 and FY2004 it was closer to 69% and FY2007 is 73% as reflected on the earlier charts. Medicaid is the largest formula program in the department, totaling 84% of the total Formula program category in the proposed FY2007 budget.

Medicaid

Introduction

Alaska's Medicaid program affects the service delivery of every division within the Department of Health and Social Services, as well as six[1] other departments within the state government. In this section, we review the Medicaid program department-wide. More detailed descriptions of programs and budget changes, as well as more in-depth statistical analyses, are found in later chapters of the Budget Overview covering the four divisions that oversee direct service delivery: Behavioral Health, Children's Services, Health Care Services, and Senior and Disabilities Services.

In order to receive federal matching dollars for medical services under the Medicaid program, states must maintain a Medicaid state plan. The state plan details the scope of each state's Medicaid program by listing the eligibility groups and standards, the services the state will provide, any applicable service requirements, and payment rates for those services. While states generally have flexibility in forming their Medicaid programs, Medicaid state plans must be consistent with mandates detailed in federal statutes.

Program Overview

Medicaid is an entitlement program created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into specified eligibility categories. It covers aged, blind, or disabled persons and single parent families. In addition, Medicaid expanded coverage in 1998 to children and pregnant women whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance.

The Department administers the Medicaid program through four main divisions which manage benefits: Health Care Services, Behavioral Health Services, Senior and Disabilities Services, and Office of Children's Services. All other divisions have Medicaid administration activities, which Health Care Services oversees. Prior to SFY 2004, the Division of Medical Assistance provided all Medicaid services and administrative functions.

Medicaid Benefit Programs by Division

Behavioral Health	Mental health, substance abuse, residential psychiatric treatment centers, and inpatient psychiatric facilities
Children's Services	Behavioral rehabilitation
Health Care Services	Hospitals, physician services, pharmacy, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, laboratory, X-ray, state-only Medicaid, premium assistance, third-party recoveries, supplemental hospital payments, and Medicaid administrative management
Senior and Disabilities Services	Nursing homes, personal care, and four home and community based waiver programs

[1] Departments of Administration, Courts, Corrections, Education and Early Development, Law, and Labor and Workforce Development.

In SFY 2005, one in five Alaskans was enrolled in the state's Medicaid program. Enrollment has remained relatively stable, growing only 2% since SFY 2000. Ninety-six percent of the enrollees utilized services in SFY 2005, up 9 percentage-points from SFY 2000.

Participation in Medicaid

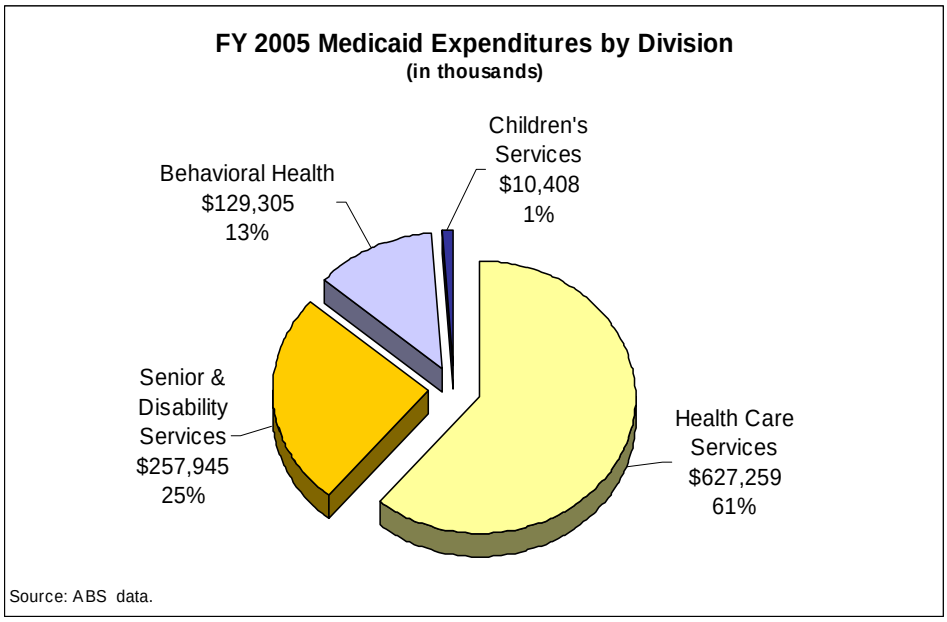
Fiscal Year	Alaska Population *	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	625,504	110,219	96,033	18%	87%
2001	632,389	116,226	104,730	18%	90%
2002	640,841	121,582	109,571	19%	90%
2003	648,243	126,632	116,008	20%	92%
2004	655,435	129,528	118,466	20%	91%
2005	662,604	131,136	125,318	20%	96%

* Average annual calendar year population as of July 1. 2004 is provisional and 2005 is a projection.

Source: MMIS-JUCE and AK Dept. of Labor and Workforce Development.

Many enrollees receive services through more than one division since clients, once enrolled, can receive any services for which they are eligible. For example, a client receiving mental health counseling through the Division of Behavioral Health can also get a flu shot through the Division of Health Care Services.

The majority of expenditures are in Health Care Services, which accounted for 61% of the costs in SFY 2005. Ninety-nine percent of enrollees received benefits through Health Care Services, 11% received benefits through Behavioral Health Services; Senior and Disabilities Services assisted 5%; and Children's Services provided care to 1% of the enrollees.



A Profile of Medicaid in SFY 2005

Enrollees		Expenditures (in thousands)	
Individuals Enrolled	131,136	Total Medicaid Services	$1,024,207.4
Gender		Division of Health Care Services	$ 626,953.9
Male	45%	Pharmacy	$ 95,697.3
Female	55%	Physician Services	$ 115,014.3
		Hospital Services	$ 191,642.0
Race		Transportation	$ 45,215.3
White	42%	Dental	$ 22,512.7
Alaska Native/Am. Indian	38%	Medicaid (State-only)	$ 575.2
Asian/Pacific Islander	8%	Other Medicaid Direct Services	$ 32,847.5
Black	5%	Non-MMIS Services	$ 35,882.4
Hispanic	3%	Medicaid Refinancing	$ 87,567.2
Unknown	4%		
		Division of Seniors & Disabilities Svcs	$ 257,748.5
Age		Personal Care Services	$ 79,575.3
Less than age 1	6%	Nursing Homes	$ 68,417.1
1 - 10	34%	AD Waiver	$ 15,351.6
11 - 14	13%	CCMC Waiver	$ 7,569.5
15 - 20	15%	MRDD Waiver	$ 59,610.2
21 - 44	19%	OA Waiver	$ 26,176.4
45 - 64	8%	Other LTC	$ 1,048.4
65 - 74	3%		
75 - 84	2%	Division of Behavioral Health	$ 129,305.0
Age 85 and older	1%	Res. Psych. Treatment Center	$ 55,504.6
		Inpatient Psychiatric Facilities	$ 15,337.1
Special Populations of Interest		General Mental Health	$ 58,463.3
Disabled	12%		
Pregnant/Post partum	7%	Office of Children's Services	$ 10,200.0
Denali KidCare	54%	Behavioral Rehabilitation	$ 10,200.0
SCHIP eligible	14%		

Source: Enrollees are an unduplicated count from MMIS-JUCE. Expenditures are from AKSAS.

As a joint federal-state program, the federal and state governments share the cost of Medicaid. There are six sources of federal funding with varying federal participation rates, allotments, and reimbursements. Each has its own federal and state regulatory processes.

The federal government's share for state Medicaid program expenditures is generally claimed under two categories: 1) medical assistance claims payments and 2) medical assistance administration. The federal funding participation (FFP) rate for Medicaid administrative activities are federally matched at a base rate of 50%. This means the federal government reimburses the state one-half of the total expenditures incurred by the state to administer Medicaid. However, higher matching rates of 75% and 90% are authorized by law for certain administrative functions and activities. For most Medicaid eligibility groups and services, the share of state Medicaid benefits paid by the federal government is called the Federal Medical Assistance Percentage, or FMAP. There are higher reimbursement rates, however, for certain Medicaid eligibility subgroups and services. Where possible, the state takes advantage of reimbursement rates that are higher than the regular FMAP.

Federal Medical Assistance Percentages for Claim Payments

	Federal Fiscal Year Statutory Rate		State Fiscal Year Average Rate	
Year	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
1998	50.00	71.86	50.00	71.86
1999	59.80	71.86	57.35	71.86
2000	59.80	71.86	59.80	71.86
2001	60.13	72.09	60.05	72.03
2002	57.38	70.17	58.07	70.65
2003	59.75	70.79	58.79	70.64
2004	60.60	70.87	61.31	70.85
2005	57.58	70.31	57.78	70.45
2006	50.16	65.11	52.02	66.41
2007	51.07	65.75	50.84	65.59

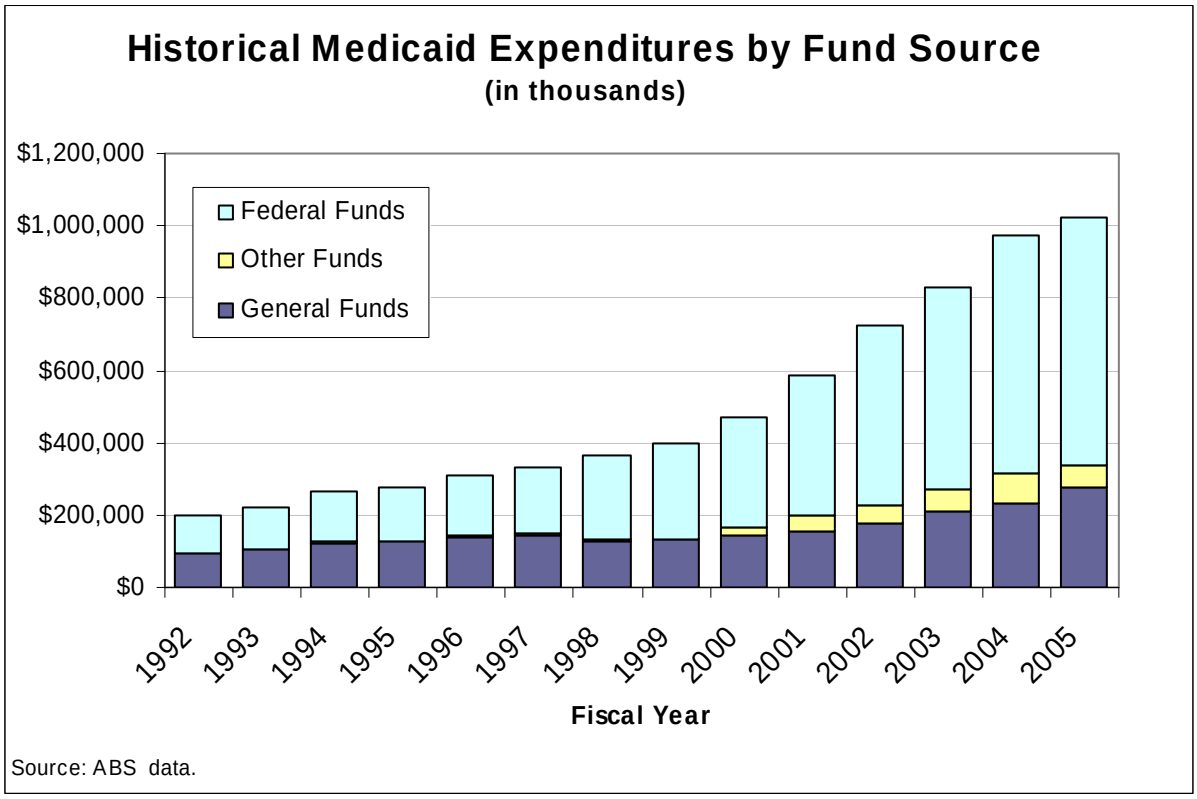
Source: Medicaid Budget Group.

The proportion of Medicaid expenditures funded with state funds has steadily dropped since SFY 1997. State matching funds accounted for 45% of Medicaid funding in SFY 1997. In SFY 2005, state matching funds supported only 33% of the Medicaid program. The State's obligation to cover a recipient's Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. The decrease in state matching funds reflects changes in the FMAP rate, the addition and growth of eligibility categories with higher match rates, like SCHIP and breast and cervical cancer groups, and the increased participation of tribal health providers eligible for 100% federal reimbursement.

There are two Federal Medical Assistance Percentage rates, or FMAP, which change each federal fiscal year: regular FMAP for Medicaid and enhanced FMAP for the State Children's Health Insurance Program, or SCHIP. The regular FMAP is the "default" reimbursement rate for Medicaid benefits. It is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, the regular rate can be no lower than 50% and no higher than 65%.

Federal financial participation rates are set at the federal level, and are largely outside of state control. IHS, Family Planning, and State-Only are fixed percentages and not subject to adjustment without changes in federal law. The regular and enhanced FMAP rates vary from year to year. In the past Alaska benefited from special legislation that adjusted the FMAP to better reflect Alaska's high cost of living. The omnibus budget bill of 2000, which expired September 30, 2005, reduced Alaska's per capita personal income by 5% before calculating the FMAP for federal fiscal year 2001-2005. Prior to that, Alaska's FMAP was set in the Budget Balancing Act of 1997.

The FFY 2006 regular FMAP rate is falling 6.5 percentage points from 57.58% to 50.16% and the enhanced FMAP is dropping 5.2 points from 70.31% to 65.11%. The rates for FFY 2007 are slightly more favorable with a regular FMAP of 51.07% and an enhanced FMAP of 65.75%. The estimated increase in state matching funds required to offset the loss of federal dollars is $53 million in SFY 2006 and $66 million in SFY 2007. *This fund change is not included in the Governor's Budget proposal*.

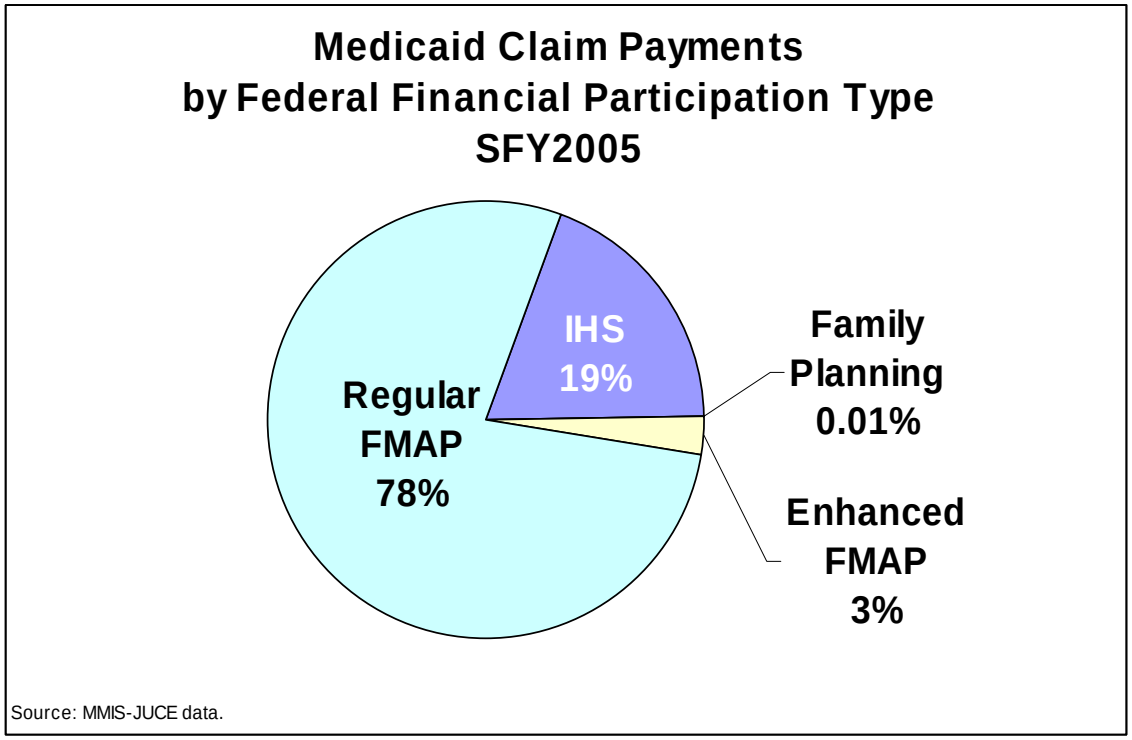


In the federal budget reconciliation bill currently being debated in Congress, there is a provision that allows Alaska to keep the FFY 2005 FMAP (57.58% regular/70.31% enhanced) for FFY 2006 & FFY 2007. The House passed the bill, followed by the Senate in late December; however, because the Senate version struck some provisions, the House must vote again on the modified version before it can be sent to the President for his signature. The House is expected to take up the bill in January or February of 2006.

The State Children's Health Insurance Program or SCHIP uses an enhanced FMAP, which changes each federal fiscal year but cannot be lower than 65%. SCHIP provides coverage to children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. In Alaska,

the SCHIP program is administered through DHSS' Denali KidCare office. SCHIP funding is capped, that is, the amount reimbursed at the enhanced FMAP is limited to the state's total SCHIP allotment. Since Alaska operates its SCHIP as an expansion of Medicaid instead of a stand-alone program, any claims in excess of the allotment are reimbursed at the regular FMAP.

There are three other types of federal financial participation (FFP) for Medicaid benefits. For services provided to Natives in or through a qualified 638 Indian Health Service (IHS) provider, the FFP rate is a fixed 100%. For individuals receiving certain family planning services, the FFP rate is a fixed 90%. Breast and cervical cancer treatment for women identified under the Centers for Disease Control and Prevention screening program is reimbursed at the enhanced FMAP. A few Medicaid benefits are only funded with state general funds and are not eligible for any federal reimbursement.



The Department has successfully responded to the impact ever-increasing expenditures have on limited state funds by minimizing the need for additional state general funds while still meeting its mission. Although costs, including total general funds, have grown yearly, federal dollars have covered the majority of the increases. The Department accomplished this by taking full advantage of enhanced match rates and federal refinancing programs.

One of the refinancing measures the Department has implemented is to increase the proportion of Medicaid services eligible for Indian Health Service 100% federal reimbursement. For every dollar shifted to the tribal system from regular FMAP in FFY 2007, the State saves 49 cents in state matching fund. The Department continues to work with tribal health corporations to maximize the benefits of this refinancing program.

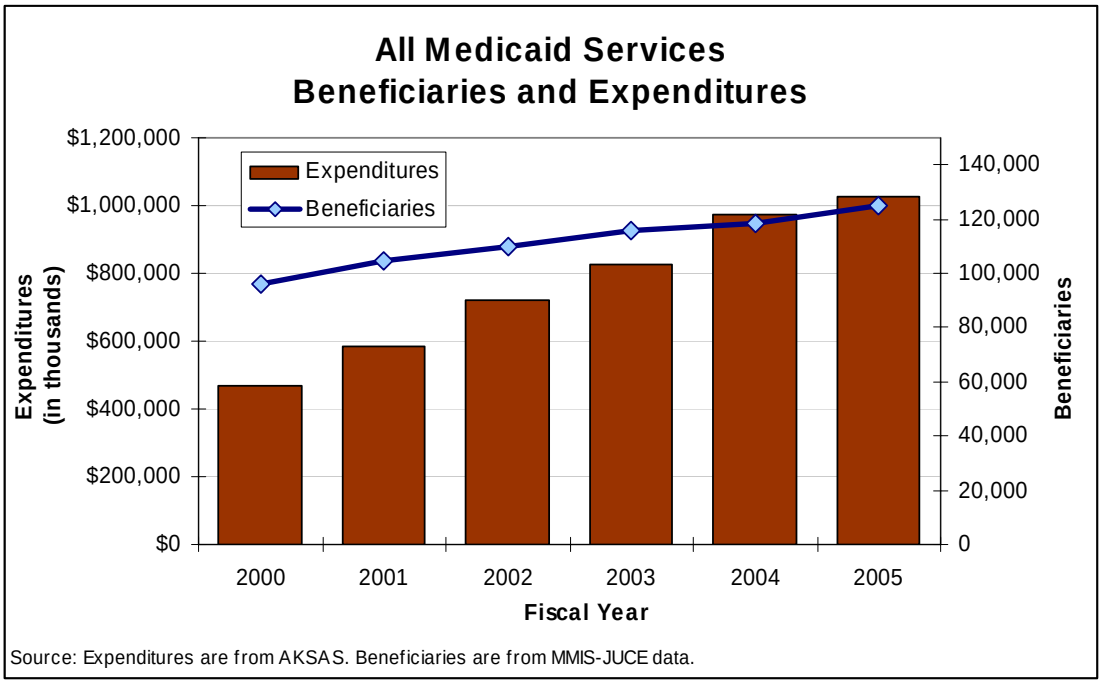
The actual amount of expenditures reimbursed by the federal government depends on the utilization patterns of services and beneficiaries. While most claims are regular FMAP, components and categories of service receive varying levels of federal reimbursement depending on how many claims are IHS, family planning, or enhanced FMAP. For example, in SFY 2005, 72% of the cost of hospital claims was paid by the federal government because of their substantial tribal participation. In comparison, nursing home claims are almost all regular FMAP, so their federal reimbursement averaged only 60%.

		2006 Mgmt Plan	2007 Proposed	07 to 06 Change
Total All Medicaid Services	General Funds	278,799.8	384,009.4	105,209.6
	Federal Funds	702,835.4	802,506.0	99,670.6
	Other Funds	79,749.0	34,905.3	-44,843.7
	Total	**1,061,384.2**	**1,221,420.7**	**160,036.5**
Behavioral Health Medicaid Services	General Funds	57,172.1	61,287.4	4,115.3
	Federal Funds	85,400.4	92,417.2	7,016.8
	Other Funds	1,500.0	1,500.0	0.0
	Total	144,072.5	155,204.6	11,132.1
Children's Medicaid Services	General Funds	4,322.3	7,080.6	2,758.3
	Federal Funds	6,529.4	9,065.1	2,535.7
	Other Funds	0.0	0.0	0.0
	Total	10,851.7	16,145.7	5,294.0
Health Care Medicaid Services	General Funds	115,431.9	190,460.3	75,028.4
	Federal Funds	463,741.6	521,477.3	57,735.7
	Other Funds	76,874.0	32,030.3	-44,843.7
	Total	656,047.5	743,967.9	87,920.4
Senior and Disabilities Medicaid Services	General Funds	101,873.5	125,181.1	23,307.6
	Federal Funds	147,164.0	179,546.4	32,382.4
	Other Funds	1,375.0	1,375.0	0.0
	Total	250,412.5	306,102.5	55,690.0

For SFY 2007, the Department is requesting an increase of $160 million from SFY 2006 authorized amount for Medicaid services department-wide. Of the $160 million increase, $145.6 million, or 90%, is for program growth. In the last ten years, total costs for Medicaid have risen at an average annual rate of 11% from $278.5 million in SFY 1995 to $1,024.9 million in SFY 2005. The SFY 2007 request is 15% more than our SFY 2006 authorization (which increased authorization only 4% above actual expenditures in SFY 2005) but represents an annual average increase of only 9% from SFY 2005.

Medicaid expenditures have been rising due to the increased cost of medical services and increased utilization of services by greater numbers of Alaskans. The cost of health care is rising faster than the inflation rate. The Consumer Price Index for all items in Alaska increased 4.2 percentage points between 2003 and 2004 (the most recent data available), while the inflation rate for medical care jumped 10.8 points.

The number of Alaskans enrolled in Medicaid has risen 13% over the last five years. Demand for medical services has also climbed as the proportion of enrollees utilizing services has increased. Growth has been greatest in three categories: personal care services, residential psychiatric treatment centers, and hospitals.



Source: Expenditures are from AKSAS. Beneficiaries are from MMIS-JUCE data.

Cost containment is an important method of holding down increases in Medicaid expenditures. Strategies to control costs have been successful as demonstrated by the slowing rate of growth in Alaska's Medicaid costs. Medicaid expenditures for Alaska climbed an average of 20% per year from SFY 2000 to SFY 2003 compared to 8% nationally (calendar years 2000 to 2003). The projected growth rate from SFY 2006 to SFY 2007 is just 9%--the same rate of change projected nationally.

Medicaid Expenditures by Fund Source
(in thousands)

Fiscal Year	General Funds	Federal Funds	Other Funds	Total Funds
1991	$80,094	$91,990	$1,796	$173,880
1992	$93,582	$105,740	$934	$200,256
1993	$103,447	$119,602	$708	$223,757
1994	$123,553	$142,729	$1,401	$267,684
1995	$127,125	$149,589	$1,792	$278,506
1996	$138,013	$167,280	$3,105	$308,398
1997	$141,517	$183,355	$6,568	$331,440
1998	$125,542	$231,330	$5,476	$362,347
1999	$131,523	$261,316	$2,851	$395,690
2000	$145,515	$307,508	$17,686	$470,709
2001	$152,791	$387,432	$43,671	$583,894
2002	$177,701	$497,428	$46,926	$722,054
2003	$211,077	$558,581	$58,460	$828,117
2004	$230,119	$658,741	$82,631	$971,491
2005	$276,089	$685,474	$63,355	$1,024,918
2006	$278,800	$702,835	$79,749	$1,061,384
2007	$384,009	$802,506	$34,905	$1,221,421

Source: Alaska Budget System. FY05 and earlier are actual expenditures. FY2006 is the Management Plan. FY07 is from the Governor's Budget scenario.

SFY 2007 Budget Change Record Summary for All Medicaid Services

For additional information on these change records, please see the division(s) listed in parentheses after the title.

	General Funds	Federal Funds	Other Funds	Total
Total All Change Records for Medicaid Services	**$105,209.6**	**$99,670.6**	**($44,843.7)**	**$160,036.5**

FairShare Program Discontinued (HCS)

$45,000.0 $0.0 ($45,000.0) $0.0

The FairShare program will be discontinued by SFY07 due to a September 12, 2005 ruling by the U.S. Court of Appeals for the Ninth Circuit. Due to the ruling, the department will not be collecting the estimated $45 million in SDPR on the estimated $50.2 million in FairShare payments. The FairShare program was a key part of the department's refinancing efforts and the SDPR receipts generated were used to provide matching funds for other Medicaid programs. GF will be required to replace the lost SDPR.

Projected SFY07 Growth (DBH, HCS, SDS)

$43,138.3 $102,433.8 $0.0 $145,572.1

For SFY07, the Department projects a 9% increase due to program growth. This is the same rate of increase experienced between SFY04-05 and projected for SFY05-06, and is less than the 11% average annual rate of growth for the past 10 years. This request also includes $18.7 million for exceptional relief payments and tribal continuing care agreements. Medicaid expenditures have been rising due to the increased cost of medical services and increased utilization of services by greater numbers of Alaskans. Another reason for increased expenditures is that the cost of health care is rising faster than the inflation rate. Growth has been greatest in three categories: personal care services, residential psychiatric treatment centers, and hospitals.

Increase Disproportionate Share Hospital (DSH) Authorization (HCS)

$6,502.6 $6,724.9 $0.0 $13,227.5

During SFY05 and SFY06, the Department made payments to hospitals in the institution for mental disease and designated evaluation and treatment categories using GF from HCS and DBH to leverage the DSH federal funds. However, there currently is no GF available to make payments to hospitals in other categories. The Department estimates DSH funding for SFY07 of approximately $27 million. Institution for mental disease and designated evaluation and treatment payments are expected to be about $14 million, leaving approximately $13 million to distribute as payments to hospital in other categories. GF needed to match the federal dollars would be $6.5 million.

Medicare Part D Clawback (HCS)

$4,360.0 ($16,866.2) $0.0 ($12,506.2)

Once Medicare Part D begins January 2006, direct spending on drugs for dual eligibles will decrease, but savings are offset by the state's phased-down contribution (also known as the "clawback"), a provision of the new law requiring states to pay the federal government according to a formula intended to estimate those savings. The department estimates the SFY07 clawback (or phase down) payment for Alaska to be $20.7 million based on a calculation of a $145.35 per capita cost and estimate of 11,850 dual eligibles. Pharmacy expenditure and drug rebate reductions are estimated at $33.2 million in SFY07 due to Part D implementation.

Behavioral Rehabilitative Services (OCS)

$2,758.3 $2,535.7 $0.0 $5,294.0

Alaska's behavioral rehabilitation service providers have not received a rate increase since 1999/2000 when the program was developed. This request increases the behavioral rehabilitation service rate 18% per day per bed for both custody and non-custody children, bringing custody and non-custody rates into alignment. Addition funding is requested to make 50 in-state beds available to non-custody children.

	General Funds	Federal Funds	Other Funds	Total
SCHIP Shortfall (DBH, HCS)				
	$2,174.8	**($2,174.8)**	**$0.0**	**$0.0**

Alaska's annual federal allotment for the State Children's Health Insurance Program (SCHIP) has remained between $7 and $9 million while our redistributed funds have shrunk from a high of $38 million in FFY 2002 to just $3 million in FFY 2006. SCHIP benefit costs are reimbursed at an enhanced federal match rate; however, if costs exceed total available federal funds, claims are reimbursed at the regular rate. In SFY07, our federal share of SCHIP total benefit costs is projected to be $24 million. Our total available federal SCHIP funds are projected to be only $14 million, for an excess of $10 million in costs. Applying the difference in regular and enhanced rates, state matching funds will have to increase $2, million to make up the shortfall in federal funds.

Miscellaneous (DBH, HCS)				
	$1,275.6	**$7,017.2**	**$156.3**	**$8,449.1**

Additional change records include adding tribal targeted case management services ($4.7 million); increases to Medicare Part A and Part B premiums ($3.1 million); transferring authorization for the First Health Mental Health contract from HCS to DBH ($1.6 million); expanding school-based therapy and hearing services to more school districts ($300 thousand); and changing pharmacy third-party collections from pay-and-chase to cost avoidance (savings of $1.3 million).

Department of Health and Social Services

Mission

To promote and protect the health and well being of Alaskans.

Core Services

- Provide quality assisted living in a safe home environment.
- Provide an integrated behavioral health system.
- Promote stronger families, safer children.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the Department's mission.

A: Result - Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.

Target #1: Injury rate below half the national standard, which is two to six percent.
Measure #1: Pioneers Home sentinel event injury rate.

Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	2.9%	.7%	0%	0.37%	.99%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2004	1.2%	0.44%	0.49%	1%	0.78%
2005	2.46%	2.4%	1.85%	2.26%	2.24%
2006	0.6%	0	0	0	0

The Sentinel Event injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing the number of Sentinel events to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to sentinel events, those with "serious and undesirable occurrences," the problem is even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death. The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.5. Since this puts our residents in the highest risk category, they are more likely to suffer a major injury from a fall and experience significant morbidity thereafter.

The Division will respond to sentinel events with root cause analysis investigations and corrective action plans to address underlying causes.

A1: Strategy - Provide sufficient staffing for safe environment in the homes.

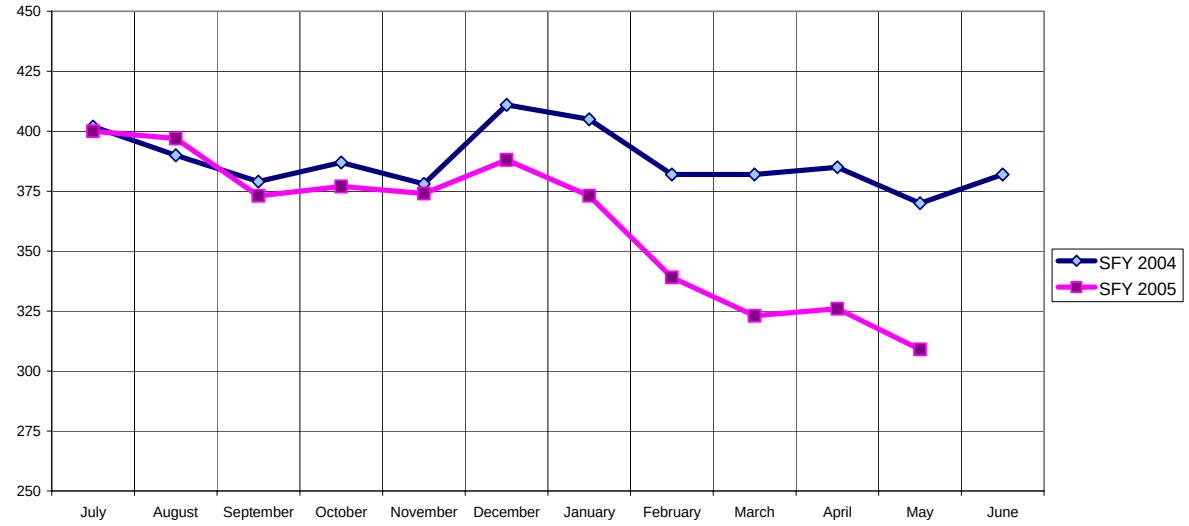
B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

Target #1: To reduce the number of kids in out-of-state placement by 50 children annually over the next seven years.

Measure #1: Change in percent of children reported in out-of-state care from Medicaid MMIS.

Chart 1:

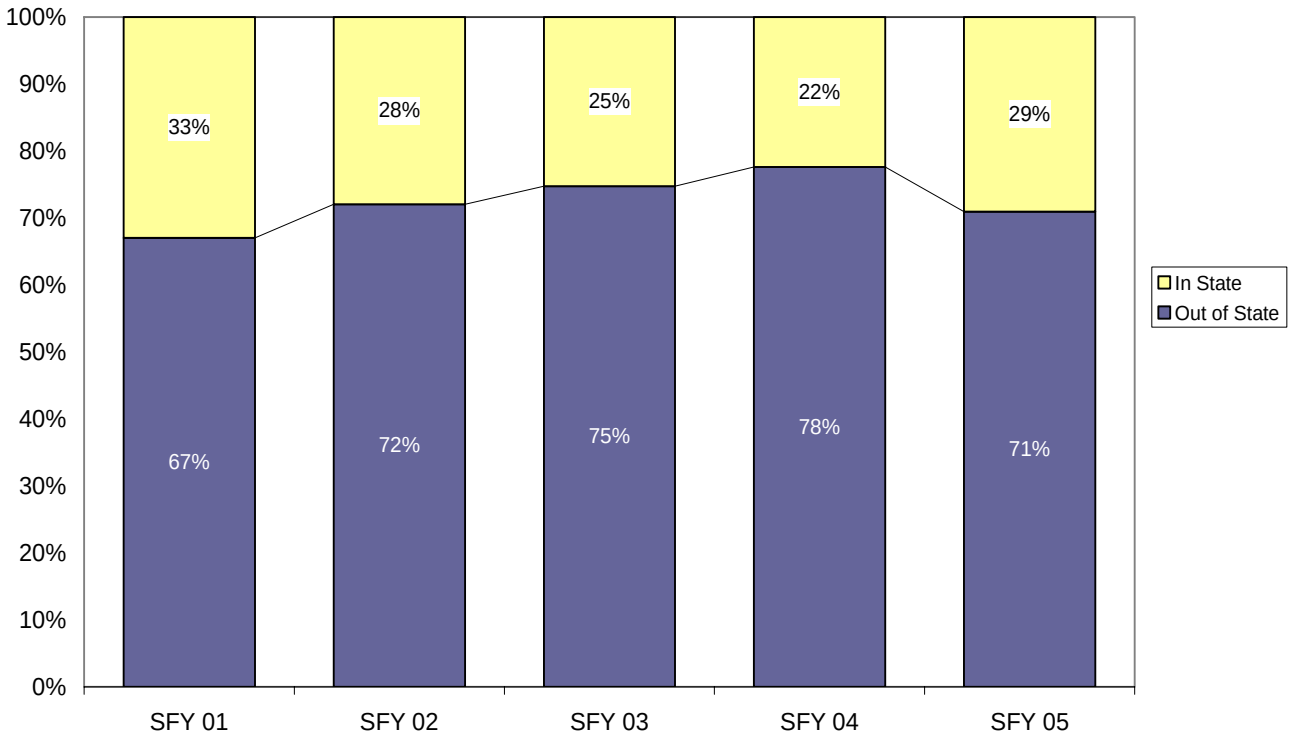
Children in Out-of-State Residential Psychiatric Treatment Centers
At Any Given Time in SFY 2004-2005



Source: DBH Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Chart 2:

Percent of Children in Out-of-State Residential Psychiatric Treatment Centers



Source: DBH Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries. December 23, 2005

Unduplicated Counts of Out-of-State Medicaid RPTC Recipients

Year	Out of State Placements
2003	637
2004	749
2005	711

Analysis of results and challenges: The DBH Policy & Planning section has successfully worked in aligning planning processes with the Alaska Mental Health Trust Authority and planning boards, creating a Master Planning Document, an Expansion of Services and Facilities that includes a timeline by fiscal year, and supported multiple workgroups that address capacity building for the Alaska system of care. These work groups are on the DBH website for public review and comment. To visit these workgroups online go to: https://dbhssweb.state.ak.us/sites/SSA/default.aspx

The data for this performance measure is being reported in two different ways to describe a more complete picture of children receiving out-of-state residential psychiatric treatment center (RPTC) care. The first means of reporting includes an unduplicated count of children receiving out-of-state RPTC services during a state fiscal year. The second report is an unduplicated number of children by month which provides the number of children receiving out-of-state RPTC services at any given time.

The comparison data represents the unduplicated number of children in out-of-state care at any given time for SFY 2004 and SFY 2005. As lower levels of care are developed, the newly hired care

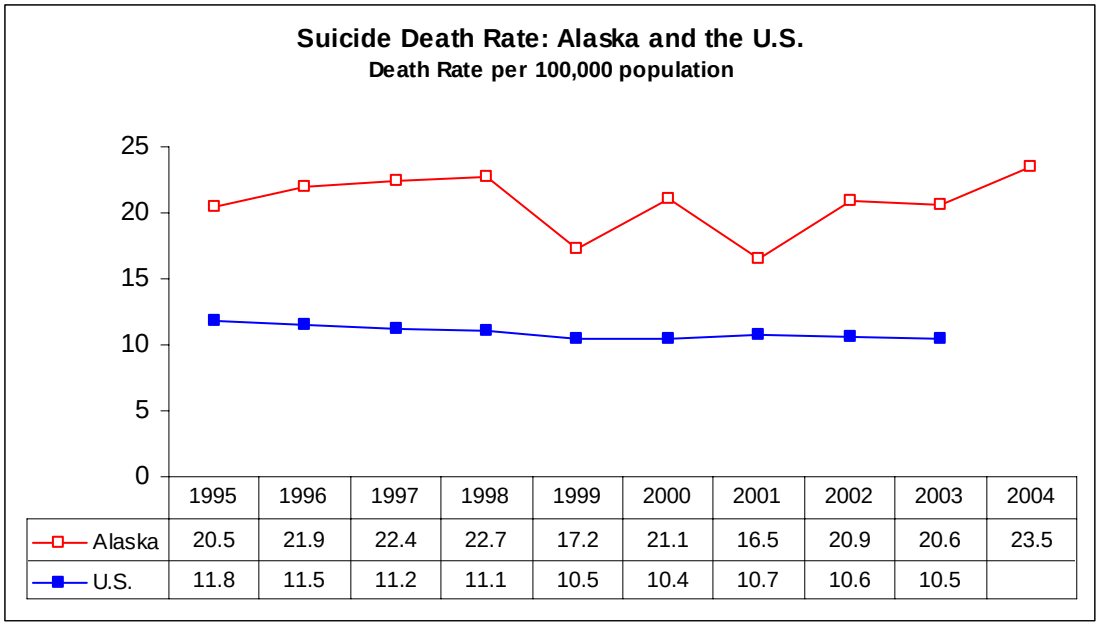
coordinators ramp up diversion activities, and the Anchorage and Fairbanks provider groups continue to bring the kids home, the reductions under this data view will be more pronounced. (See Chart 1)

As we await Medicaid claims payments to process for the final months of SFY 2005, the Division is anticipating a decrease in the number of children receiving out-of-state RPTC services from efforts related to the Bring the Kids Home Initiative.

For the past five years there has been a steady increase in the number of children receiving out-of-state RPTC services. The Bring the Kids Home Initiative was initiated during SFY 2004. The preliminary data is beginning to indicate positive change. Between SFY 2004 and 2005 there is a 7% reduction in the number of children receiving out-of-state RPTC care. (See Chart 2)

This reduction was achieved by successful diversion activities on the part of the Division. This would include the hiring of three utilization review staff as well as implementing policy changes in the RPTC placement criteria. The reduction from SFY 2004 to SFY 2005 was also achieved through collaborative efforts with the Division of Behavioral Health, the Anchorage Providers Group and the Fairbanks Provider Group. These reductions reinforce the importance of the work around this Initiative.

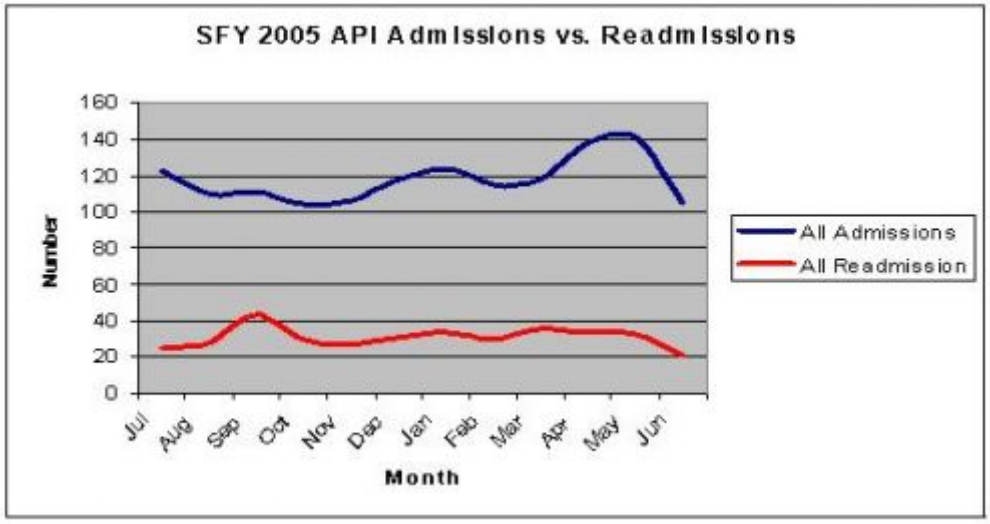
Target #2: To reduce the rate of suicides in Alaska by 10% by 2010.
Measure #2: Alaska's suicide death rate compared to National rate.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alaska	20.5	21.9	22.4	22.7	17.2	21.1	16.5	20.9	20.6	23.5
U.S.	11.8	11.5	11.2	11.1	10.5	10.4	10.7	10.6	10.5	

Analysis of results and challenges: Alaska averages about 125 suicides per year and has a suicide rate double the National suicide rate. The Healthy Alaskans 2010 target is to reduce Alaska's rate to 10%.

Target #3: Reduce 30 day readmission rate for API by 10% on an annualized basis.
Measure #3: # of API re-admissions as compared to hospital bed days divided by the number of months.



Analysis of results and challenges: Percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions.

This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

B1: Strategy - Provide enhancements to prevention and early intervention services.

C: Result - Outcome Statement #3: Children are, first and foremost, protected from abuse or neglect.

Target #1: Reduce child abuse rate in Alaska.
Measure #1: Percent change in rate of substantiated protective service reports in Alaska compared to last three years.

Protective Service Reports

Fiscal Year	Rate	% Change
FY 1999	27.3	0
FY 2000	29.4	7.7%
FY 2001	32.2	9.5%
FY 2002	27.6	-14.3%
FY 2003	23.0	-16.7%
FY 2004	22.3	-3.0%
FY 2005	11.0*	0

With the implementation of ORCA, new methods of measurement in compliance with federal standards have been used. As a result, FY 2005 data is not comparable to FY 1999 through FY 2004. The FY 2005 measure represents an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. Population equals the number of children under the age of 18 years as of July 1, 2004, as estimated by the Department of Labor. Data reported prior to FY 2005 can be duplicative.

Analysis of results and challenges: Since 2003, the OCS has been operating under a program improvement plan (PIP) developed in response to findings of the Federal Child and Family Services Review (CFSR). A major focus of the PIP has been to improve the safety of children including reducing repeat child abuse and neglect, reducing the recurrence of maltreatment, reducing the incidence of maltreatment by out-of-home care providers, establishing sufficient staffing levels to meet national caseload standards, and increasing services to families. The number of substantiated protective service reports is one measurement that will indicate improvement in these areas.

OCS has transitioned from the old "PROBER" data system to the new ORCA data system. As a result, the method of measuring these reports has changed, and data definitions between the two systems are not comparable. New measurements are in compliance with federal requirements and count protective services reports and investigations by case. This is a change from the Report of Harm measurement used in FY 1999 through FY 2004 which counts by child. Measures listed below will begin to establish a new base line for protective service reports measurements.

SFY 2005 Protective Services Reports
Received 9,576
OCS Jurisdiction 6,944
Investigated 3,493
Substantiated 1,310
Other Finding 2,183

“Received” includes 1) referrals where no maltreatment is found, 2) that are not under OCS’s jurisdiction, 3) those still in the screening process.

“OCS Jurisdiction” includes reported allegations of harm that could lead to an OCS investigation -- those assigned for an OCS investigation; those referred to dual track, a tribe, or the military; and those that cannot be assigned because there is not enough information to identify or locate the child and/or family. Multiple referrals for the same incident are counted as one referral.

“Investigated” counts the number of completed investigations, but excludes responses provided by dual track, a tribe, or the military.

“Substantiated” counts the number of investigations in which at least one allegation of harm was substantiated.

“Other Finding” includes investigations where no allegation was substantiated as well as those without finding. Investigations without findings include, for example, a report that does not include enough information to locate the child/family.

Target #2: Maintain rate of recurrence of maltreatment at 16% or less.

Measure #2: Of all children for whom a substantiated or indicated report of child abuse and/or neglect was received during the first six months of the period under review, for what percentage was another substantiated or indicated report received within 6 months?

Repeat Maltreatment by Federal FY (from CFSR/PIP reporting)

Fiscal Year	Alaska Rate	National Standard
FFY 2000	23.6%	6.1%
FFY 2001	25.4%	6.1%
FFY 2002	22.6%	6.1%
FFY 2003	17.6%	6.1%
FFY 2004	17.3%	6.1%

FFY04 information includes only April 2003-March 2004.

The OCS is unable to update this measure for 2005. Data is expected to be available March, 2006. ORCA code and data for this measure is currently being tested.

Analysis of results and challenges: Repeat Maltreatment by Federal Fiscal Year

OCS exceeded its initial target of 22% or less by December 2004 and continues to implement strategies to reduce the rate even further setting a new target at 16%.

An important goal for OCS during the past year has been to reduce safety and risk factors for children by improving assessments. A statewide computerized safety and risk assessment system has been developed to provide structure to decision making at the most critical stages in a child protection case. Further improvements in the assessment process will be implemented during the next year with technical assistance from the National Resource Center for Child Protection Services.

Policies, procedures, and definitions for in-home cases have been clarified. Standards for in-home casework have been developed and casework on in-home cases has been implemented statewide. Team Decision Making (TDM) has been implemented in the Anchorage Region. Community-based family preservation service contracts have been redesigned to focus on services to families that prevent removal and to decrease the repeat maltreatment rate.

Target #3: Increase the rate of children reunified with their parents or caretakers within 12 months to 57.91% by September 2006.

Measure #3: The number of children reunified with their parents or caretakers at the time of discharge from foster care, in less than twelve months from the time of the latest removal from home.

Rate of Reunification

Fiscal Year	Alaska Rate	National Standard
FFY 2001	62.4%	76.2%
FFY 2002	53.3%	76.2%
FFY 2003	59.3%	76.2%
FFY 2003	55.6%	76.2%
FFY 2004	54.7%	76.2%

2003 at 55.6% represents January - December 2003
2004 at 54.7% represents April 2003 - March 2004

Data source: Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) files. The change in time period reported corresponds to AFCARS submissions produced from ORCA.

NOTE: With the transition from the OCS PROBER data system to the new ORCA data system, data definitions, policies, and collection procedures have changed. The data extraction methodology used for this measure has also changed. While the underlying federal methodology for computing this measure remains the same, measures computed from different systems should not be considered comparable.

Analysis of results and challenges: This measure represents the length of time to achieve reunification: Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percent were reunified in less than twelve months from the time of the latest removal from home?

In August 2005 a new baseline of 56.7% was established for this measure. The newly approved federal PIP goal is 57.91% within one year.

OCS has taken the following steps to address reunification issues within the past year:

•Administrative case review policies and procedures have been reviewed and revised to ensure that reunification efforts are being made and to ensure that reunification assessments are being completed;
•The Supervisory review process has been improved to address the frequency of supervisory meetings with workers and the quality of casework and appropriateness of the case plan and services.
•Requirements for private providers that provide Family Preservation and Time-Limited Family Reunification services have been more clearly delineated regarding the type of services OCS will require to help families meet their case plan goals towards reunification; and
•Alaska has participated in the Casey Family Program's Breakthrough Series collaborative on Supporting Kinship Care. In this series, child welfare agencies and tribes share a commitment to improving the way we identify, partner with and support kinship caregivers

During the next year OCS will continue work to:

•Increase the use of reunification assessments through SDM, and continue training workers on these assessments;

•Continue to fund Time-Limited Family Reunification programs and develop process for evaluating efficacy of these programs;
•Increase access and availability of services in parents' home communities, especially substance abuse treatment and follow-up services;
•Further develop a Kinship Care Program; and
•Collaborate with tribal partners to develop safety net services in remote areas.

C1: Strategy - Reduce caseloads of frontline workers.

D: Result - Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.

Target #1: Decrease average response time from receiving a claim to paying a claim.
Measure #1: Change in average number of days per annum from receipt of claims to payment of claims.

Average Days Entry Date to Claims Paid Date

Fiscal Year	Claims	Avg Days
FY 2000	3,720,254	10.15
FY 2001	4,409,121	12.14
FY 2002	4,959,864	12.43
FY 2003	5,615,072	10.27
FY 2004	6,690,344	10.12
FY 2005	7,903,523	12.69
FY 2006	2,095,565	16.33

Note: Between FY01 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 report uses year-to-date data from the September summary. Source: MARS MR-0-08-T.

Analysis of results and challenges: The average days-to-pay increased during the three months since the end of FY05, from 13 days to 16 days. When the first three months of FY06 are compared with the same period of FY05, we see an increase of 11% in the number of claims processed. This is a significant increase in volume, which means increased workloads for all those involved with the claims process. There is a likely relationship between more claims and longer overall processing time. The length of processing time would depend on the types of claims received and the edits those claims trigger.

One explanation for the overall annual volume increase relates to the program change within the personal care services area to require providers to bill single dates of service rather than span dates. Single dates of service vastly improve the ability to edit the claim over spanned dates billing (it takes the guess work out of determining when a service might have occurred).

The entry to adjudication time was longer in the first three months of FY06, but the time from approval to pay decreased slightly. Adjudication to approval took less than one day on the average. So the increase in time seems to have occurred primarily in the entry to adjudication period.

Additionally, the error distribution analysis report (MR-0-11-T) shows a better error rate for the first quarter of 06 compared to the same period of 05.

Target #2: Increase average number of claims submitted without error to promote timely and accurate payment.

Measure #2: Change in average number of HCS Medicaid claims paid with no errors.

% Claims Paid with No Errors

Fiscal Year	Claims Pd	% No Errors
FY 2000	3,076,978	71.75%
FY 2001	3,670,331	72.64%
FY 2002	4,202,677	74.43%
FY 2003	4,776,730	73.46%
FY 2004	5,106,692	76.33%
FY 2005	6,150,027	72.15%
FY 2006	1,614,369	73.60%

Chart Notes: Between FY00 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 report is based on claims paid through September 2005. Source: MARS MR-0-11-T.

Analysis of results and challenges: The percent of claims paid without error increased from FY2005 to the first quarter of FY2006. The error-free percentage gained one and one-half points, from 72.15% in FY 2005 to 73.60% in the first quarter of FY 2006.

Target #3: Reduce the rate of Medicaid payment errors

Measure #3: Improper payment estimates as provided to Center for Medicare and Medicaid Services

Divisions Responsible for review	Files to be completed	Files completed Medical Review	Files completed processing review
Health Care Services	190	190	190
Behavioral Health Service	78	78	32
Senior and Disability Services	29	0	0
Buy-in claims [2]	3	NA	3
Total Number of Claims	300	268	225

1. Process refers to the claims in the processing review as of 11/30/05

2 "Buy-in" is referring to Medicare premiums that are paid by the Medicaid Program.

Status of PERM Pilot Project as of December, 2005.

Analysis of results and challenges: CMS has proposed changes to 42 CFR Part 402 related to Payment Error Rate Measurement (PERM). This will apply to Medicaid and the State Children's Health Insurance Program (SCHIP).

Background:
The PERM program was created in response to the Improper Payments Information Act of 2002 (Public Law 107-300) and the Government Performance and Results Act (CPRA). The Improper

Payments Information Act (IPIA) requires each federal executive agency to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments and submit those estimates annually to Congress. This proposal is limited to the evaluation of improper payments in the Medicaid and SCHIP programs.

Pilot Project:
The department was awarded a one-time federal grant to begin a pilot project that would select random claims from the Medicaid program's universe and use those selected claims to identify payment errors. The department agreed to review the sampled claims for any payment that should not have been made or that was made in an incorrect amount, including both overpayments and underpayments, under statutory, contractual, administrative or other legally applicable requirements.

Project Status:
Phase I, Notification and Record Collection - collection of 300 randomly selected claims samples and medical records from providers was begun in May of 2005 and completed in September, 2005.

Phase II, Initial Review - HCS staff began initial review of the claims samples for completeness and entering of demographic data into the Medquest database in July, 2005. This phase was completed in September, 2005.

Phase III, Claim Review - This phase, currently in process, covers Eligibility, Claims Processing, and a Comprehensive Medical Review and is scheduled to be completed by mid December.

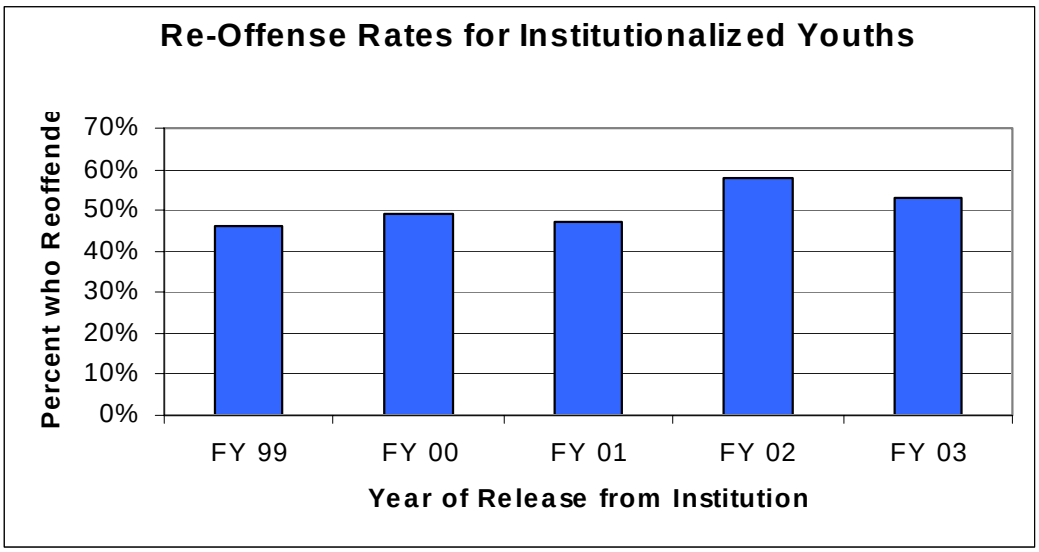
Phase IV, Final Report - The final report will be prepared and submitted to the Center for Medicaid and Medicare Services by the end of January, 2006.

D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).

E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend within a 24-month period following release from institutional treatment facilities to no more than 40% of the total.

Measure #1: Percentage change in re-offense rate within a 24-month period following release from institutional treatment.



Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Re-offenses are defined as: any offenses resulting in a new juvenile institutional order, a new juvenile adjudication, or an adult conviction. Adjudications and convictions for traffic offenses, Fish & Game violations, violations of Minor in Possession/Consuming Alcohol and Driving While Intoxicated are excluded. Adjudication and convictions received outside Alaska are excluded from analysis.

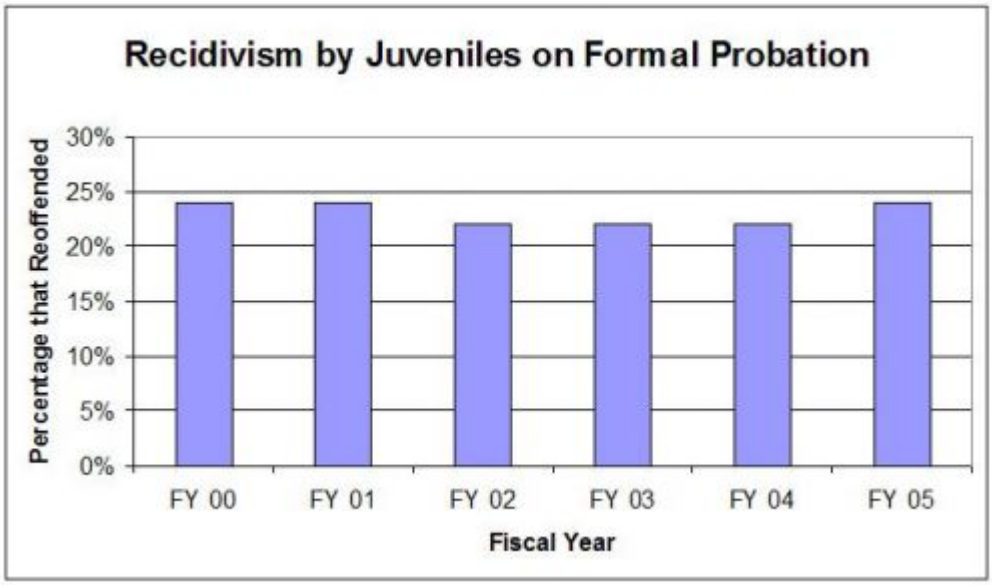
Race	Number Released in FY03	Number of Re-offenders 24 Months After Release	Percentage Offenders
Caucasian	65	33	51%
African American	10	6	60%
Native Alaskan/American Indian	44	25	57%
Asian	1	0	0%
Pacific Islander	2	2	100%
Multiple Races	8	3	38%
Other	3	1	33%
Total	**133**	**70**	**53%**

Facility	Number Released in FY03	Number of Re-offenders 24 Months After Release	Percentage Offenders
Johnson Youth Center	12	4	33%
McLaughlin Youth Facility	95	55	58%
Fairbanks Youth Facility	20	7	35%
Bethel Youth Facility	6	4	67%
Total	**133**	**70**	**53%**

Analysis of results and challenges: The percentage of youths who were released from Alaska's youth facilities in FY03 and who re-offended within a subsequent 24-month period was slightly reduced compared with last year's percentage. However, the small numbers of youth who are released each year from Alaska's four treatment facilities make it difficult to determine whether this decrease represents a significant or genuine trend. The Division will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Target #2: Reduce percentage of juveniles who re-offend within a 24-month period following completion of formal court-ordered probation supervision to 20% of the total.

Measure #2: Percentage change in re-offense rate within a 24-month period following completion of formal court-ordered probation supervision.

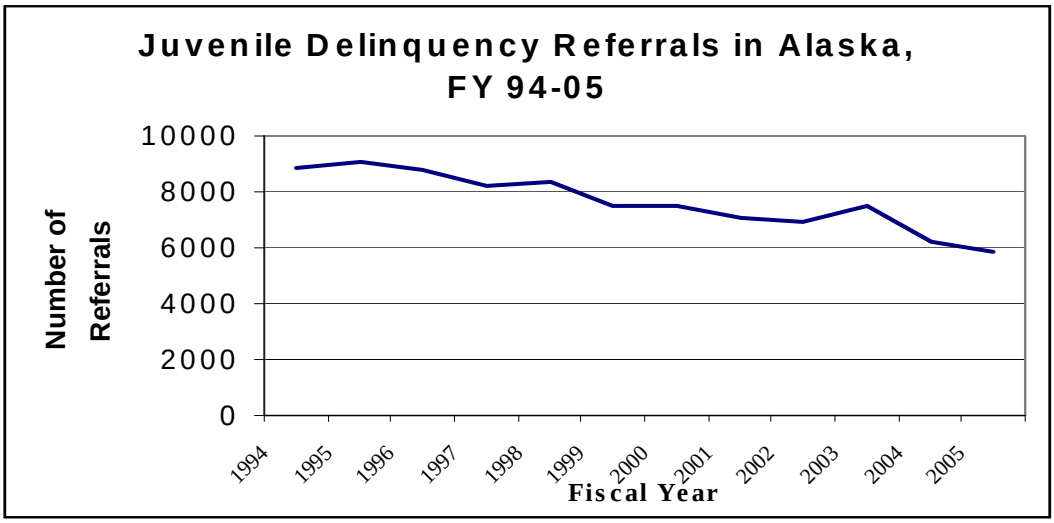


Analysis of results and challenges: The percentage of juveniles who re-offended in the 24-month period following closure of their formal probation episode has remained relatively constant over the past several years. In 2003, the number of youth on formal probation was significantly increased compared with the year before, reflecting an increase in overall referrals that year. However, the rate of re-offense remained consistent with previous years.

The Division intends to evaluate this measure in the coming year to determine whether limiting the term "re-offense" to those offenses resulting in a formal adjudication or conviction (as is done with

the institutional population performance measure) provides a more accurate picture of re-offense activities than when all referrals to the Division are included in the analysis. Additionally, in FY06 DJJ will be working with the Department of Public Safety to determine how information from the Alaska Public Safety Information Network can be used to track recidivism by those juveniles who have aged out of the juvenile justice system. Given that the data reported in this measure currently do not include adult information, it is anticipated that once this information is included the rate of re-offense will increase.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



Numbers of Juveniles, Referrals, and Charges by Region and Office, FY 05

Region		Juveniles	Referrals	Charges
ANC	**ANCHORAGE**	1505	2094	3140
NRO	**BARROW**	96	175	244
	BETHEL	235	400	754
	FAIRBANKS	477	701	1191
	KOTZEBUE	51	79	157
	NOME	110	175	277
SCRO	**DILLINGHAM**	56	89	162
	HOMER	37	46	66
	KENAI	333	475	946
	KODIAK	111	191	353
	MAT-SU	393	535	925
	VALDEZ	79	110	237
SERO	**JUNEAU**	238	382	567
	KETCHIKAN	125	203	352
	PETERSBURG	36	62	110
	PRINCE OF WALES	22	33	50
	SITKA	68	95	128
State Total		3972	5845	9659

Alaska Juvenile Referrals per 100,000 Juvenile Population (ages 10-17)

Fiscal Year	Referrals	Juvenile Pop	per 100,000
FY 1999	7484	85477	8756
FY 2000	7497	86958	8621
FY 2001	7056	88607	7963
FY 2002	6932	89966	7705
FY 2003	7471	91651	8152
FY 2004	6225	92699	6716
FY 2005	5845	89746	6513

Note: Population data is based on projections from the Alaska Department of Labor. Juvenile referral data is provided by DJJ JOMIS database and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Analysis of results and challenges: Both the number of referrals (5,845) and the number of these referrals per 100,000 juvenile population (6,513) decreased in FY05, resulting in a decline of juvenile crime referrals of 3% per 100,000 juveniles compared with FY04 and a decline of 20.1% compared with FY03. The decline in overall juvenile crime has been a consistent trend for several years (except for a brief increase in FY03). Definitive reasons for this decrease are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

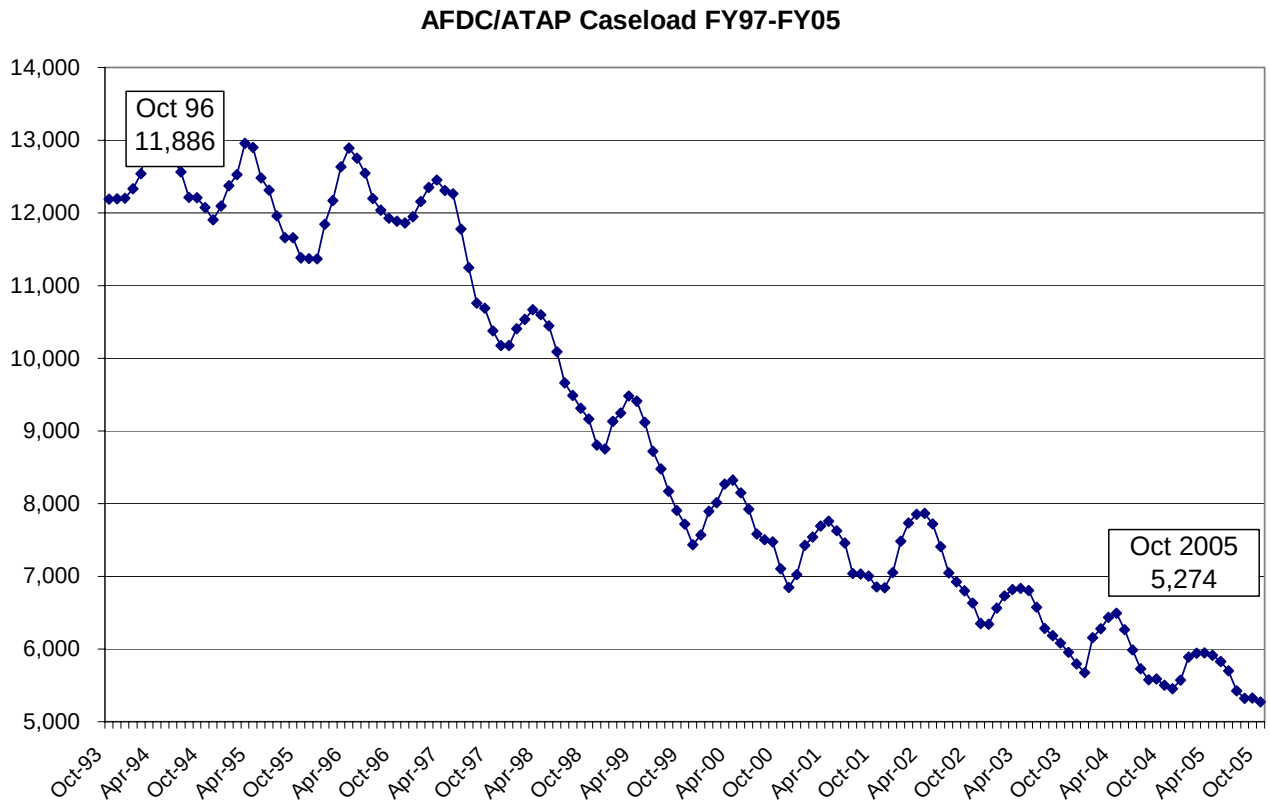
E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.

F: Result - Outcome Statement #6: Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Measure #1: Rate of change in self-sufficient families.

Changes in Self Sufficiency

Year	September	December	March	June	YTD Total
2002	-16%	6%	4%	3%	-2%
2003	-1%	-11%	-14%	-13%	-9%
2004	-12%	-7%	-6%	-9%	-9%
2005	-6%	-7%	-8%	-6%	-7%
2006	-6%	0	0	0	0



Analysis of results and challenges: The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program.

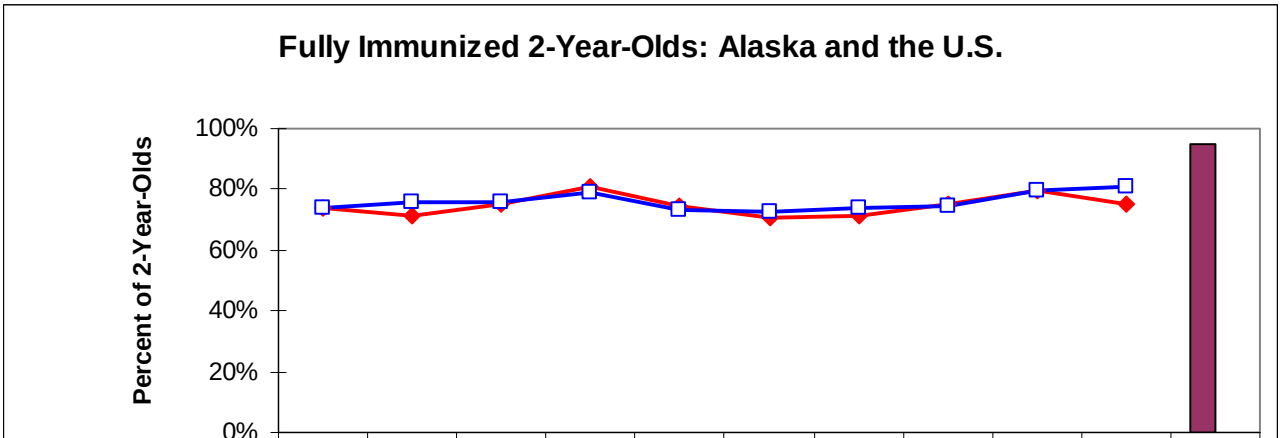
As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

The rate of change is calculated for the number of families receiving Alaska Temporary Assistance Program benefits compared to the same time period in the previous state fiscal year. Thus September of SFY2003 had a 1% decline in the Alaska Temporary Assistance Program caseload compared to September of SFY2002. The YTD column compares the average annual caseload to the prior year average annual caseload.

F1: Strategy - Use TANF high performance bonus funds for families approaching 60-month time limit.

G: Result - Outcome Statement #7: Healthy people in healthy communities

Target #1: 80% of all 2 year olds are fully immunized
Measure #1: % of all Alaskan 2 year olds fully immunized



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											95%
AK's Rank	26	41	31	22	27	41	35	30	27	45	
Alaska	74.0%	71.5%	75.0%	81.0%	74.5%	70.6%	71.2%	75.3%	79.7%	75.3%	
U.S.	74.0%	76.0%	76.0%	79.0%	73.2%	72.8%	73.7%	74.8%	79.4%	80.9%	

Data Source: National Immunization Survey
Note: Annual percentages are based on CDC recommendations at the time, which have changed over the years as new vaccines have been added to the "basic immunization series."

Analysis of results and challenges: Chart Note: Source National Immunization Survey, Centers for Disease Control and Prevention.

In 2004, 75.3% of Alaska two year olds had completed their basic vaccine series, a percentage considerably below the national average of 80.9. These results indicate the need to re-emphasize the importance of timely immunizations for our youngest children.

Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010
Measure #2: Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)

Post-Neonatal Death Rate - AK and US

Year	Alaska	US
1999	3.3	2.3
2000	3.0	2.3
2001	3.6	2.3
2002	3.8	2.3
2002	4.0	2.3
2004	3.5	0

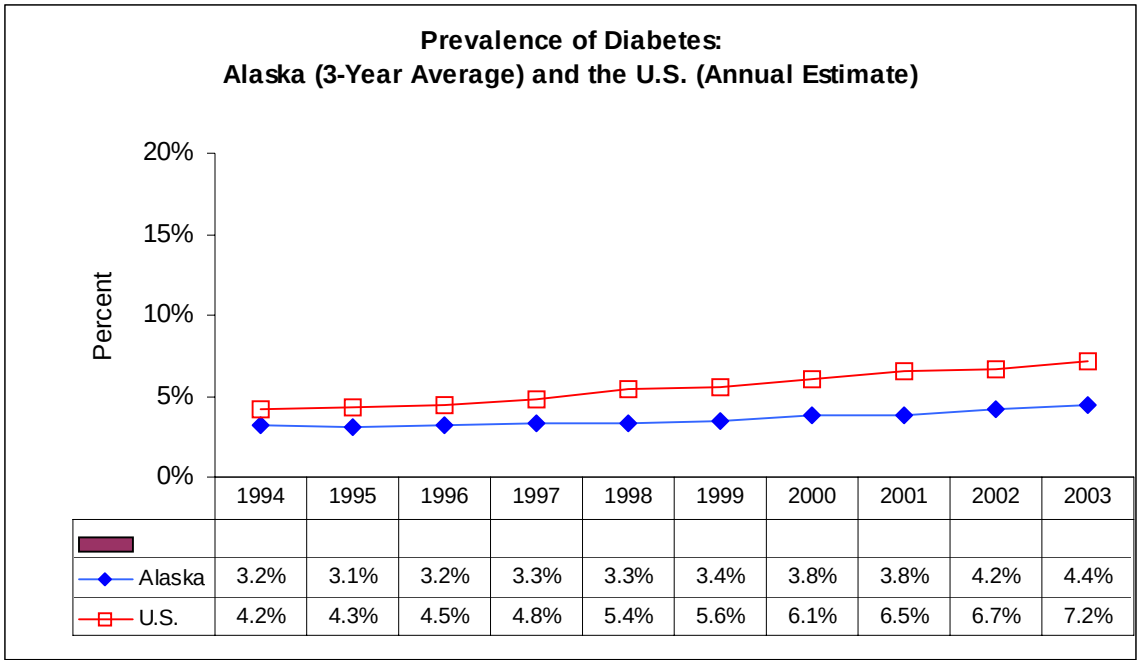
Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects two year rate, i.e. 2003 represents 2001-2003.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries.
•The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time.
•While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Target #3: Decrease diabetes in Alaskans
Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages

Estimated Annual Prevalence of Diabetes Among Adults (18+) in Alaska Based upon Three-Year Averages

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%



Data source: BRFSS - Behavioral Risk Factor Surveillance System Note: 2003 data is average of 2002-2004

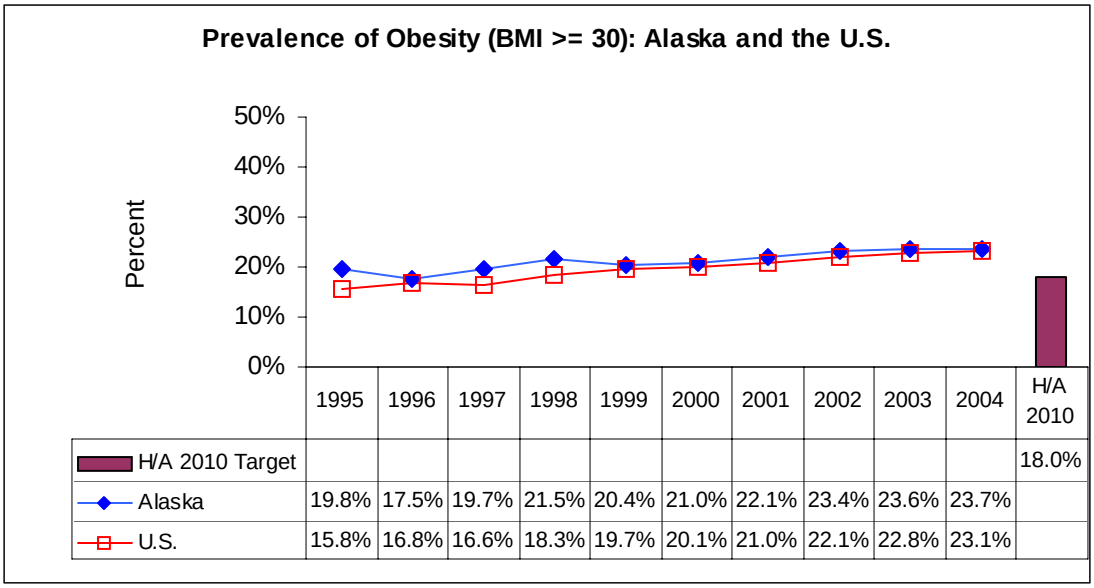
Analysis of results and challenges: Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

Target #4: Decrease Alaska's adult obesity rate to less than 18%
Measure #4: Obesity rate of Alaskans

Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.1%



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											18.0%
Alaska	19.8%	17.5%	19.7%	21.5%	20.4%	21.0%	22.1%	23.4%	23.6%	23.7%	
U.S.	15.8%	16.8%	16.6%	18.3%	19.7%	20.1%	21.0%	22.1%	22.8%	23.1%	

Analysis of results and challenges: The trends in Alaska show growing numbers of overweight and obese adults.
•From 1991 to 2004, the prevalence of overweight and obese adults in Alaska rose from a combined 49% to 63%.
•In 2004, 39% of Alaskans met the criteria for being overweight and nearly 24% met the criteria for obesity, well above the Healthy Alaskans 2010 targets of 30% for overweight and 18% for obesity.

Overweight is defined as Body Mass Index (BMI) of 25 or greater, up to 29.9. Obese is defined as BMI of 30 or greater. BMI is determined by dividing weight in kilograms by height in meters.

Premature death and disability, increased heath care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

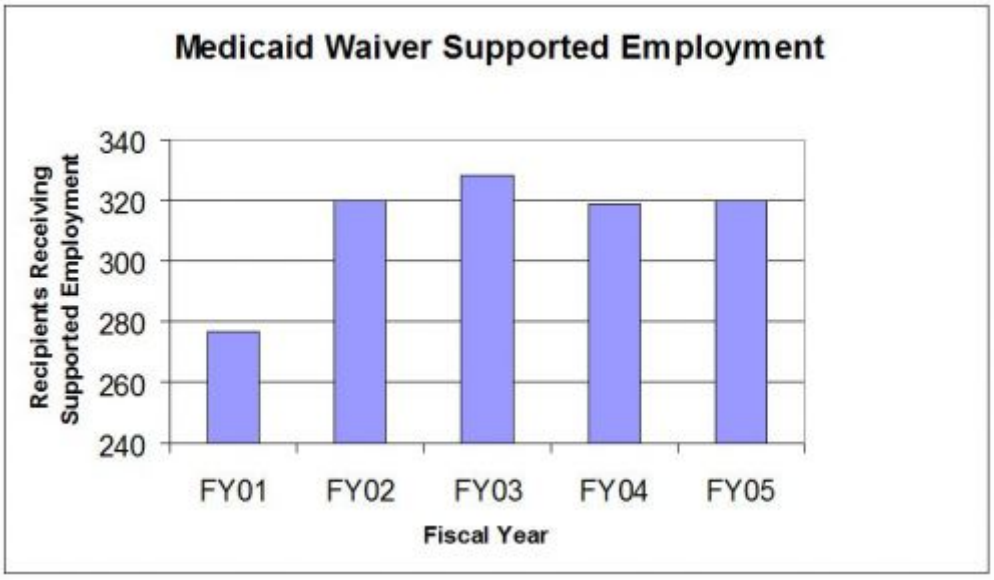
National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

G1: Strategy - Strengthen public health in strategic areas.

H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live as independently as long as possible.

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services.

Measure #1: % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



% Change in Recipients Receiving Supported Employment

Fiscal Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%

Analysis of results and challenges: Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services is looking into why the number of beneficiaries receiving Supported Employment Services has hit a "plateau" over the last few years and will try to determine how to increase the number of people receiving this service.

H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

Target #1: Increase by 5% the percentage of customers that report FMS is meeting their needs.
Measure #1: Percentage of customer service survey respondents that report FMS is meeting their needs.

% of Survey Respondents rating that FMS met their needs

Year	FMS Overall %	% Change	Avg % of All Services	% Change
2003	58.7%	0	70.6%	0
2004	64.7%	6%	70.6%	0%
2005	64.%	-0.7%	71.5%	0.9%

Analysis of results and challenges: A customer survey on Finance and Management Services performance is conducted annually.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed, however only the overall results are shown in the above table. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the % of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall % did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

Target #2: Reduce the average response time for complaints/inquiries to 14 days.
Measure #2: Department Complaint log response times.

# of Inquiries/Complaints

Fiscal Year	Opened	Closed
FY 2005	552	503

Analysis of results and challenges: In FY2005, the Department developed a database for all Inquiries or Complaints. The response log will be monitored by the Commissioner's Office.

The average # of days to close for FY05 is 15.18.

Target #3: Number of days to Process Payments/Responses.
Measure #3: Index timeliness and accuracy for: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

Timliness and Accuracy

	Fiscal Year 2005	
	# Processed	Days to Process
Purchase Requisitions	652	9.4
Operating Grant Awards	778	20.5
DHSS Invoices	150,474	14.4
Capital Grant Awards	87	3.16
Legislative Logs	236	4

Analysis of results and challenges: The department has developed an index for calculating this measure by recording the number and days to process each category above. Each one is given a weight to measure based on the ease of processing. An average is then calculated.

I1: Strategy - Implement results of Business Process Review.

Alaska Pioneer Homes

Mission

Provide quality assisted living in a safe, home environment.

Introduction

To meet this mission, the Division of Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer and Juneau to qualified Alaska seniors. The services are designed to maximize independence and quality of life by addressing the physical, emotional and spiritual needs of Pioneer Home residents. The Pioneer Home system served 573 Alaskan seniors during FY05 and as of June 30, 2005, 236 and 5,303 Alaskan seniors were on the active and inactive wait lists, respectively.

Core Services

Administration of the six statewide Pioneer Homes and the Pioneer Home central Pharmacy.

The following table describes the three levels of service provided by the Pioneer Homes.

Level I Formerly Coordinated Services	Provision of housing, meals, emergency assistance and opportunities for recreation; level I services do not include staff assistance with activities of daily living, medication administration, or health-related services, although the pioneer home pharmacy may supply prescribed medications.
Level II Formerly Basic Assisted Living	Provision of housing, meals, emergency assistance, and, as stated in the resident's assisted living plan, staff assistance, including assistance with activities of daily living, medication administration, recreation and health-related services; assistance provided by a staff member includes supervision, reminders, and hands-on assistance, with the resident performing the majority of the effort; during the night shift, the resident is independent in performing activities of daily living and capable of self-supervision.
Level III Combined the Enhanced Assisted Living, Alzheimer's Disease & Related Disorders and Comprehensive Services care levels.	Provision of housing, meals, emergency assistance, and, as stated in the resident's assisted living plan, staff assistance, including assistance with activities of daily living, medication administration, recreation and health-related services; assistance provided by a staff member includes hands-on assistance, with the staff member performing the majority of the effort; the resident may receive assistance throughout a 24-hour day, including the provision of care in a transitional setting.

Medicaid Benefits and Providers

In FY 2005, all six Pioneer Homes and the Pioneer Home central Pharmacy became licensed Medicaid providers and Pioneer Home residents became eligible to apply for and receive Medicaid benefits. This significant change allows the division access to federal funding thereby reducing general funds the division expends to operate the homes and subsidize residents who are unable to pay the full monthly charges.

Regulations, effective December 31, 2006 require Pioneer Home residents to apply for Medicaid, Medicare or any program the department identifies which may reduce the amount of state payment assistance needed under AS 47.55. Residents were notified of the need to apply for other program benefits and have a reasonable amount of time to do so. This regulation change was made in response to legislative intent provided late in the 2005 session (CCS HB 67,CH 4, FSSLA 05, Sec. 1, page 16 & 17).

As of November 2004, 58 percent of Pioneer Home residents were subsidized by the state through the division's Payment Assistance Program.

The following table shows the number of residents receiving assistance through the Pioneer Home Payment Assistance Program, Medicaid and the Older Alaskans Waiver as of November 2005.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Residents Receiving State Assistance	38	47	47	76	30	23	261
Medicaid Approved	16	15	12	18	10	9	80
Older Alaskan Medicaid Waiver Approved	4	7	8	6	5	7	37

The Pioneer Home system billed and collected $486.1 in Medicaid Waiver receipts in FY 2005 and is expected to collect the $2.78 million authorized for FY 2006. Additionally, the central pharmacy billed Medicaid and received $103.8 for medication reimbursement in FY 2005. Beginning in FY 2006, all 3rd party receipts for pharmaceuticals are posted as statutory designated program receipts (SDPR).

As of December 31, 2005, Medicaid payment for drugs will cease as a new federal program (Medicare Part D) to help pay for the majority of medications used by seniors takes effect. Seniors who rely on Medicaid to cover the cost of their medications must transition to the new program, Medicare Part D, as the source of payment for most of their drugs. To date, the Pioneer Home Pharmacy negotiated agreements with five of the eleven Prescription Drug Plans (PDPs) that the federal Medicare agency approved for Alaska. Negotiations with the other PDPs are in process, with three additional PDPs nearing agreement. Not all PDPs cover medications that are suited for the elderly and some medications such as sleep aides and weight control drugs are not covered at all. It is not possible to assess what impact this change will have on pharmaceutical receipts from the federal government, but it is not expected to be positive. Rather, it is more likely that some recent costs shifted to Medicaid will revert back to the state's payment assistance program.

Pioneer Homes Wait List

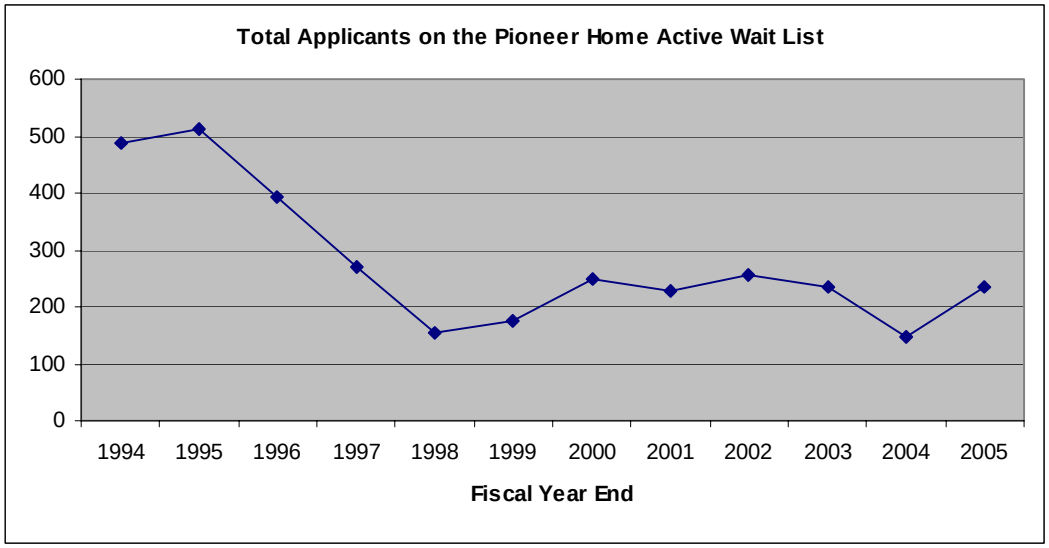
Individuals apply for admission to an Alaska Pioneer Home by completing and submitting an application. An individual who is a resident of the state and has attained 65 years of age may submit an application. The date and time of the application's submission determines the order of admission into the Pioneer Home system. An applicant may choose to move onto the "active branch" of the wait list when they are willing and ready to move into a Pioneer Home within 30 days. Invitations to enter a Pioneer Home are only offered to those on the active branch of the wait list.

When a bed becomes vacant in a particular level of service, the applicant offered admission is the person whose name is listed on the active branch of the wait list as having the earliest date of application. The applicant is admitted if the level of service the applicant requires matches the level of service of the available bed.

At present, most people on the active branch of the wait list require Level II or Level III services and there are few vacancies in those levels. The number of applicants on the active wait list for each home increased over the past year, due in part to outreach by both management at the division level and the individual Pioneer Home administrators. The inactive wait list decreased by just over 300 applicants over the past year, with some applicants moving to the active wait list. The number of seniors on the Pioneer Homes active wait list over the years is shown in the table and chart below.

Pioneer Home Applicants on the Active Wait List

Fiscal Year End	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
1994	37	67	103	190	39	52	488
1995	50	84	111	153	55	58	511
1996	39	75	79	111	30	58	392
1997	34	39	55	58	24	59	269
1998	16	24	27	15	25	49	156
1999	14	24	26	44	18	51	177
2000	11	44	52	64	28	50	249
2001	6	44	44	46	34	53	227
2002	8	90	31	68	29	29	255
2003	15	89	12	56	27	36	235
2004	4	78	16	21	7	20	146
2005	15	84	24	76	16	21	236
Nov 2005	11	97	25	91	14	44	282



The following provides the composition of the Pioneer Homes wait list by facility as of November 2004.

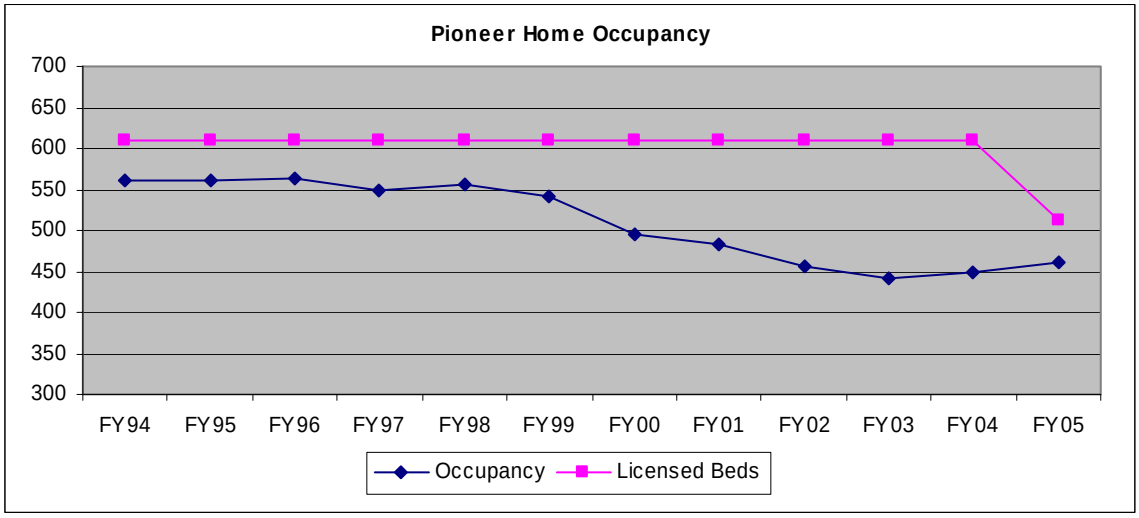
	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	11	97	25	91	14	44	282
Inactive Branch	700	860	933	1,321	488	859	5,161
Total	**711**	**957**	**958**	**1,412**	**502**	**903**	**5,443**
Number of Applicants Choosing More than One Home (Duplicates)							2,654
Number of Actual Applicants on Active Wait List (Not Duplicated)							187
Number of Actual Applicants on Inactive Wait List							2,602

Historical Pioneer Home Occupancy

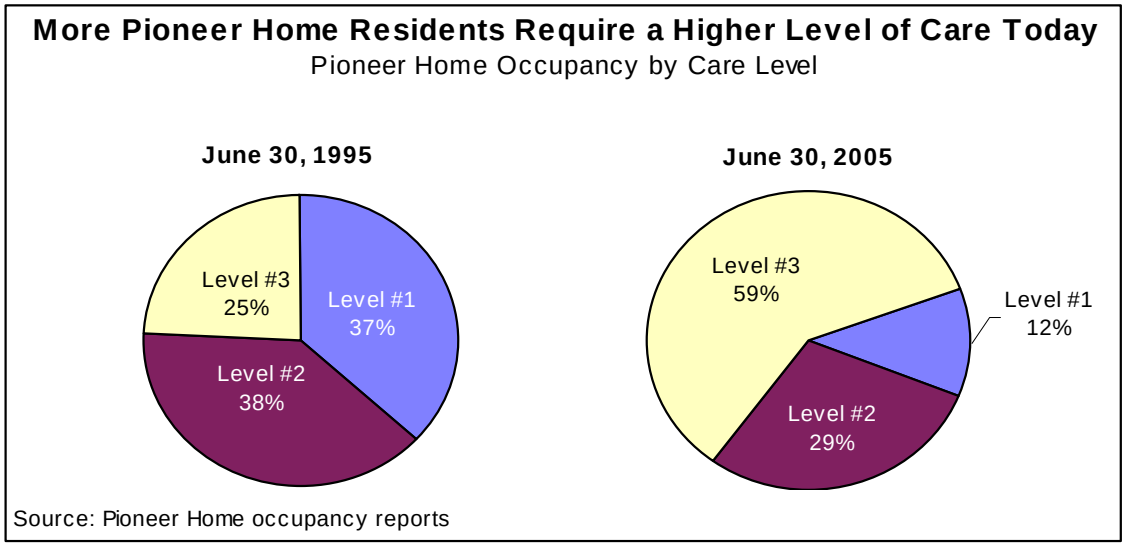
During FY 2005 the division reduced the number of its licensed beds to more accurately reflect the number of beds that meet current licensure requirements and are available for occupancy.

The majority of vacancies are in the Level I care units and there is not a demand for these beds. With the family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. Those on the Pioneer Home active wait list require Level II and Level III services and those level beds are occupied. Use of Level I beds for Level II or Level III residents would require additional staffing and some remodeling of these areas for this occupancy.

The following two graphs display 1) actual occupancy to the total number of licensed Pioneer Home beds and 2) the residents and the percentage of residents in each of the three care levels in 1995 and 2005. The gap between licensed and occupied beds was decreased in FY 2005 when the division decreased the number of licensed beds to more accurately reflect those that are available to fill.



The change in the level of service provided to Pioneer Home residents over the past ten years is significant and is shown in the following two pie charts. Those residents requiring the highest level of service, Level III, increased from 25 to 59 percent, while those requiring Level I care decreased from 29 to 12 percent.



Current Pioneer Homes Occupancy

The table below shows the November 2005 occupancy figures for each of the six Pioneer Homes by level of service. Totals towards the bottom of the chart compare occupied beds and available beds to the licensed beds.

Service Level	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Occupied/Assigned							
Level #1	10	11	2	26	3	1	53
Level #2	20	14	14	48	12	17	125
Level #3	32	60	53	76	29	23	273
Total	**62**	**85**	**69**	**150**	**44**	**41**	**451**
Licensed Beds	75	96	79	165	48	48	511
Occupied/Assigned	62	85	69	150	44	41	451
Non-Occupied	13	11	10	15	4	7	60
% Licensed Beds Filled/Assigned	**82.70%**	**88.50%**	**87.30%**	**90.90%**	**91.70%**	**85.40%**	**88.30%**

Pioneer Home Rate History

The chart below shows the history of monthly rates within the Pioneer Home system. The July 1996 rate increase was the first increase in the Pioneer Homes Advisory Board's seven year plan to move towards charging Pioneer Home residents the full cost of care. The final increase of the seven-year plan occurred in FY03 and there was no increase in FY04.

In FY05 the rate structure and service levels were changed to reflect current utilization. This rate change resulted in a rate decrease for those residents formerly receiving Comprehensive Care Services and an increase for the other levels of service. There was not an increase in FY 2006 and the division has not proposed adjusting the rates in FY07.

Assistance from Medicaid and the division's payment assistance program are available for residents whose income and resources are insufficient to pay the full monthly rate. However, effective December 31, 2005, Pioneer Home residents must apply for other public benefits for which they may be entitled, before receiving assistance from the state's payment assistance program.

Effective Date	Coordinated Services	Basic Assisted Living	Enhanced Assisted Living	Alzheimer's & Dementia Related Disorders	Comprehensive Care
July 1996	$934	$1,289	$1,553	$1,579	$1,864
July 1997	$1,140	$1,720	$2,140	$2,200	$2,630
July 1998	$1,340	$2,150	$2,730	$2,815	$3,395
July 1999	$1,540	$2,580	$3,315	$3,430	$4,160
July 2000	$1,735	$3,005	$3,905	$4,040	$4,920
July 2001	$1,935	$3,435	$4,490	$4,655	$5,685
July 2002	$2,135	$3,865	$5,080	$5,270	$6,450
July 2003	$2,135	$3,865	$5,080	$5,270	$6,450

Effective Date	Level I	Level II	Level III
July 2004	$2,240	$4,060	$5,880
July 2005	$2,240	$4,060	$5,880

Pioneers Homes AS 47.55

The state maintains and operates six Pioneer Homes. The history of services over time ranges from room and board to skilled nursing care, however, the focus today is on provision of residential supported living under "The Eden Alternative™" care concept within facilities licensed as assisted living homes. Any Alaskan age 65 or over, who has been an Alaskan resident for more than one year immediately preceding application for admission and is in need of aid is eligible for admission.

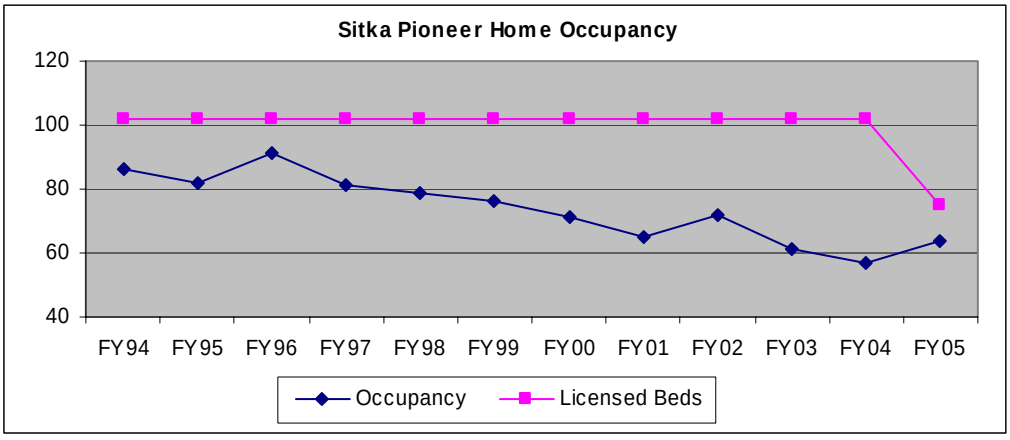
The Pioneer Homes are primarily funded by resident payments (receipt supported services) and the general fund. However, a change in federal law and department policy now allows Pioneer Home residents to receive Medicaid benefits and the Homes and the central Pharmacy to be licensed Medicaid providers. With this change, federal funds (reflected in the budget as I/A) will also support the operating costs of the Pioneer Homes. The Homes received $486.1 in Medicaid Waiver receipts in FY 2005 and expects to collect the $2.78 million authorized for FY 2006.

Pioneer Home residents pay the State a monthly rate based on their assessed level of care. If an individual's income and assets are insufficient to pay the monthly rate, they may apply for and receive payment assistance through the division's Payment Assistance Program. Effective December 31, 2005 all residents must apply for other public benefit programs for which they may be eligible before receiving assistance from the division's program. The amount of payment assistance received by a resident is that portion of the monthly rate they are unable to pay.

The Eden Alternative™ is a well-developed concept and approach to elder care that emphasizes enlivening the environment to eliminate loneliness, helplessness, and boredom. Important facets of the approach include opportunities for interaction with others, plant life, animals, and children and assuring the maximum possible decision-making authority remains in the hands of the residents or in the hands of those closest to them.

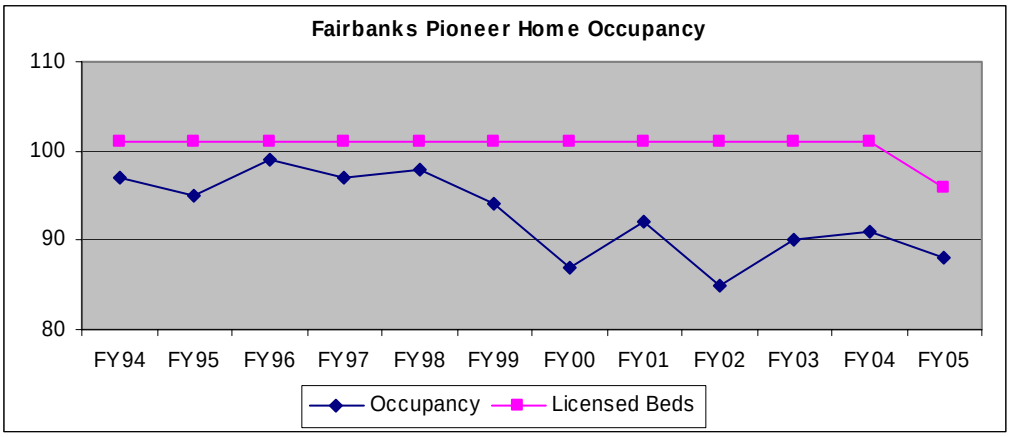
Sitka Pioneer Home

The Sitka Pioneer Home opened in 1913 when Alaska had been a Territory for just one year. The Home was established in the abandoned Sitka Marine Barracks building which was built in 1892. In 1934 a new main building, manager's house and nurses quarters were constructed. An addition was built on the north side of the building in 1954. The Sitka Pioneer Home is on the National Historic Register, which requires all renovations to adhere to stringent federal guidelines. Of the 75 licensed beds in the Sitka Pioneer Home, 62 were occupied as of November 2005.



Fairbanks Pioneer Home

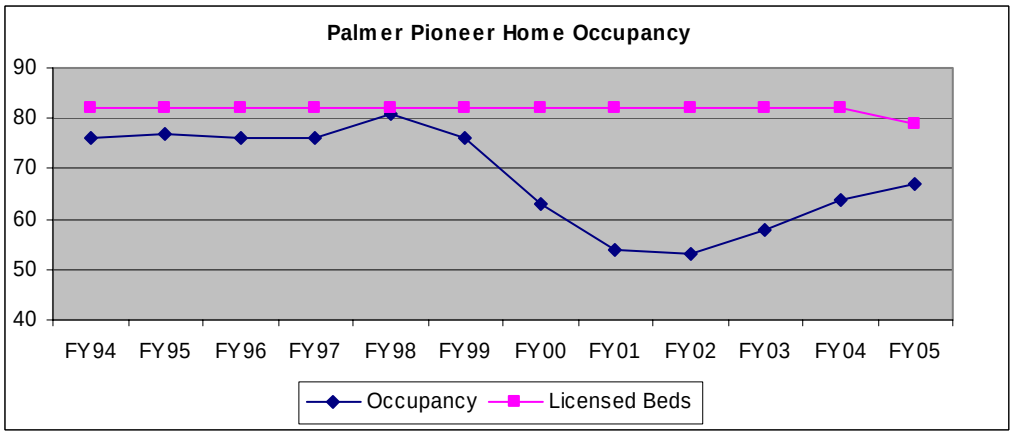
The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. As of November 2005, 88 of the 96 licensed beds were occupied.



Palmer Pioneer Home

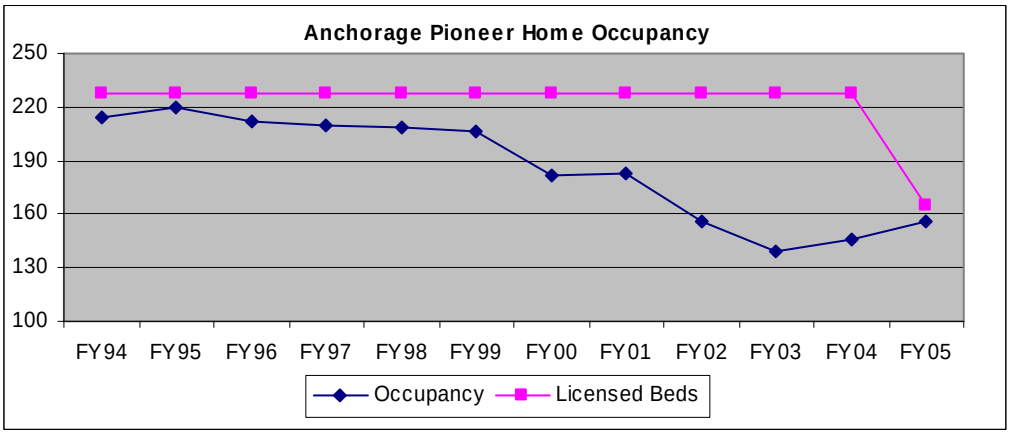
The Palmer Home, located in the Matanuska Valley, was built in 1971. It is a single level, ranch-style building and encompasses 11 acres of lawn and gardens. Within six years of opening, it became apparent more space was needed and an addition was built. As of November 2005, 69 of the 79 licensed beds were occupied.

The Palmer Home is currently under renovation to become Alaska's first State Veterans Home. Groundbreaking took place in August 2005 and construction is expected to conclude late spring 2006. The Veteran's Administration will then certify the Home for 79 beds of which approximately 19 beds will be available for non-veterans. The State Veterans and Pioneers Home in Palmer will operate under the same guidelines as the other five Pioneer Homes, requiring one year residency and residents who are 65 years of age or older.



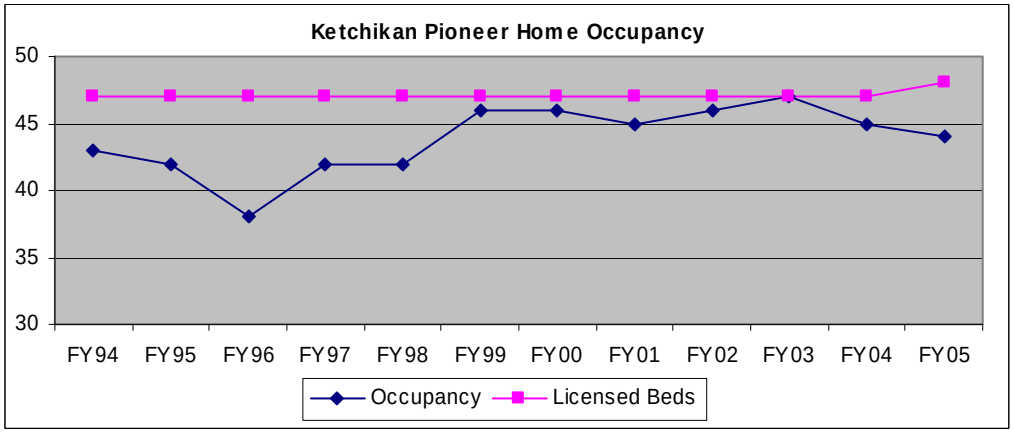
Anchorage Pioneer Home

The Anchorage Home is the largest Pioneer Home with 165 licensed beds. The Home was built in two stages. The five story south side was built in 1977 and the two-story north wing opened in 1982. As of November 2005, 150 beds were occupied.



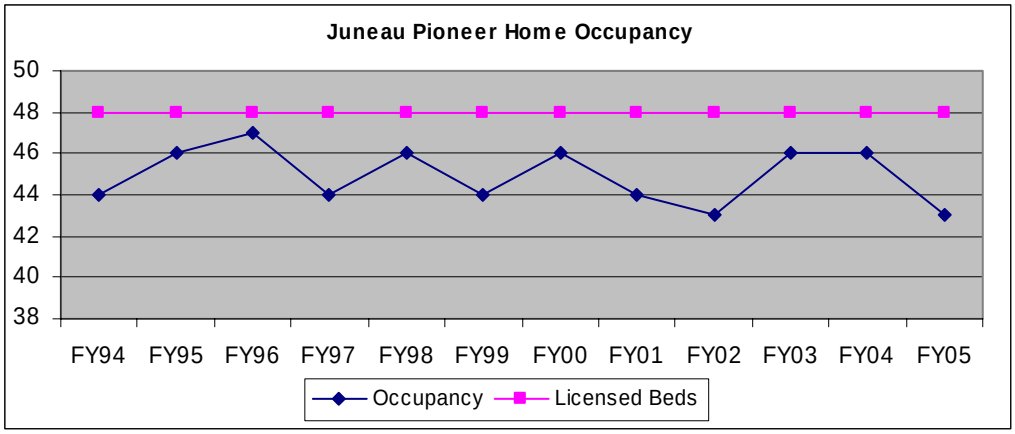
Ketchikan Pioneer Home

The doors of the Ketchikan Home opened to accept residents in November 1981. The resident rooms are located on the upper two floors of the three-story building. Ketchikan maintains a high census. In November, 44 of the 48 licensed beds were occupied.



Juneau Pioneer Home

The newest Pioneer Home opened in 1988 as a skilled nursing facility. Today, it is home to 43 Alaskan seniors as an Assisted Living Home and is licensed for 48 beds.


Juneau Pioneer Home Occupancy
50
48
46
44
42
40
38
FY94
FY95
FY96
FY97
FY98
FY99
FY00
FY01
FY02
FY03
FY04
FY05
Occupancy
Licensed Beds

Alaskan Pioneer Homes	2006	2007 Proposed	06 to 07 Change
General Funds	25,572.0	29,826.3	4,254.3
Federal Funds	27.4	348.9	351.5
Other Funds	17,007.6	19,236.3	2,228.7
Total	**42,607.0**	**49,411.5**	**6,804.5**

Alaska Pioneer Homes Management Component

Decrease Interim Assistance Program ($118.0) Interagency Receipts
Administration of the Interim Assistance Screening Program transferred from the Alaska Pioneer Homes (AKPH) to the Division of Public Assistance during FY 2005. The Nurse Consultant PCN responsible for performing the secondary medical assessments also transferred to Public Assistance. This transaction deletes the unneeded funding from AKPH.

Decrease funding for the SeniorCare Program ($82.2) Senior Care Funds
The SeniorCare Program that provides financial assistance or medication benefits to low income seniors transferred from AKPH to the Division of Public Assistance January 1, 2006. This transaction deletes the unneeded funding from AKPH.

Fund Change for Project Coordinator Position ($77.3) Interagency Receipts; $77.3 Federal
The project coordinator is partially funded with federal receipts. In FY 2006, it was thought that these receipts would be paid to the division as inter-agency receipts from the Division of Senior and Disabilities Services. This is not the case and the federal receipts supporting this position are posted directly to the component's appropriation.

Increase Federal Receipt Authority to Fund the Project Director $99.4 Federal
The incumbent's time will be spent almost exclusively on the State Veterans and Pioneer Home issues including the transition, completing the required federal paperwork and other documentation and maximizing the division's federal reimbursement.

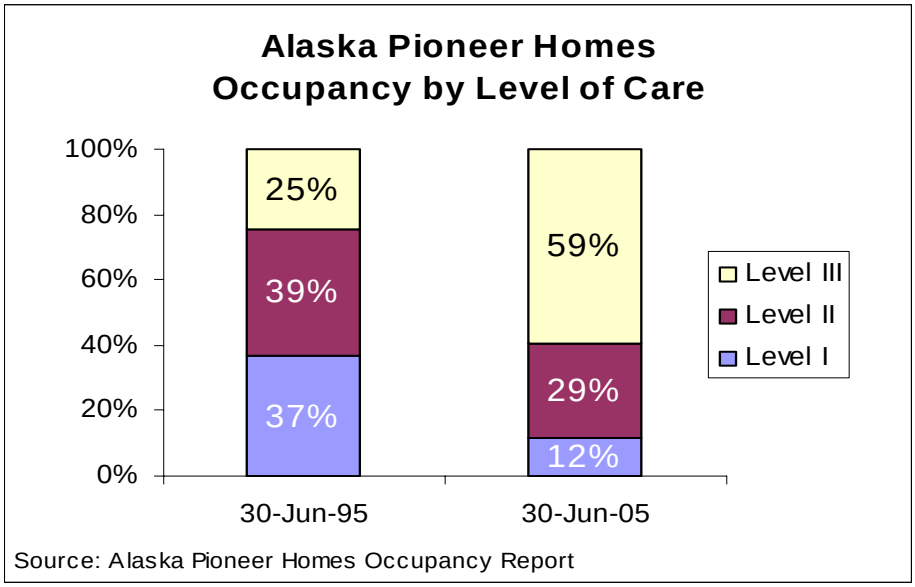
Alaska Pioneer Homes

Increment to Cover the Increasing Cost of Medications $1,966.4 Statutory Designated Program Receipts
The Pioneer Home central pharmacy serves the residents of all six Pioneer Homes. The FY06 budget included a $1.5 million increment to cover the cost of the medications and the authority to receive resident payments to cover these costs. These costs have increased dramatically in part due to the residents increasing acuity levels and the increased occupancy.

The increment is calculated based on the cost increase estimated between FY 2005 actual and FY 2006 estimated medication purchases. This estimated increase of 46% is applied to the estimated FY 2006 costs. This results in an estimated $3.47 million need for medication purchases in FY 2007. The resulting increment in $1.97 million ($3.47 less the $1.5 already in the budget).

The transition from Medicaid and other third party insurance to Medicare Part D will impact the amount of SDPR. The potential increase of this transition is unknown and not included in this increment.

Increment for Increased Staffing for Resident Safety and Security $1,510.0 General Fund
The acuity level of Pioneer Home residents continues to increase. Over the past ten years the percentage of Pioneer Home residents requiring very little or no care dropped from 37 to 12 percent while the percentage of residents requiring the highest level of care increased from 25 to 59 percent. The homes need additional staff to provide the level of resident care and safety required with the increasing needs of the residents.



This increment adds 21 direct-care positions, a social worker, pharmacy technician and a housekeeper.

Increment to Open Beds in the Palmer Pioneer Home $904.0 General Fund
In FY04, legislation passed authorizing the conversion of the Palmer Pioneer Home to a State Veterans Home and the use of Veteran's benefits within the Pioneer Home system. The necessary construction for the Home to become a certified State Veterans Home is anticipated to last through April 2006.

Once the Palmer home is certified, steps will be taken to fill 18 vacant beds. Additional staff is needed to care for these residents. This increment covers the personal service costs of five PFT and two PPT direct care staff, two food service workers, two housekeepers and a maintenance staff member. It also includes funding to transport Veteran residents to visit VA doctors in Anchorage, equipment and consumable supplies.

Increment for Nurse Aide Reclass Settlement Costs $153.2 General Fund, $28.6 Interagency Receipts; $130.8 General Fund/Mental Health; $55.0 Receipt Support Services
This $367.6 increment will cover the settlement costs for certified nurse aides and makes these employees whole for the difference in pay between their step placement as a class/range change and an individual job class reallocation.

Increment for Increased Utility Costs $154.0 General Fund
The DH&SS anticipates a 28% increase in utility costs in FY 2006 over the FY 2005 utility expenditures and has factored just half that amount or a 14% increment into the FY 2007 budget for DH&SS state-owned buildings.

Fund Change General Fund to Federal Receipts from Certifying the Palmer Home as a Veteran's Home ($144.7) General Fund; $144.7 Federal
As stated above, legislation passed authorizing the use of Veteran's benefits within the Pioneer Home system. The budget includes a fund switch from GF to federal receipts. Once the home is certified, the state will bill the VA a daily rate for services provided to qualifying Veterans. This calculation is based on 18 qualifying veterans, a 95% occupancy rate and a daily rate of $27.19.

Increment to increase I/A from DJJ for Medication Distribution $20.0 Interagency Receipts
The Pioneer Home Central Pharmacy dispenses medications for those housed in Johnson Youth Center. This increment increases the amount of the budgeted RSA with the Division of Juvenile Justice.

Contribution to Department's Mission

Alaska Pioneer Homes assist older Alaskans and Veterans to have the highest quality of life by providing assisted living in a safe home environment.

Core Services

- Provide residential assisted living services.

Department Level Measures

A: Result - Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.

Target #1: Injury rate below half the national standard, which is two to six percent.
Measure #1: Pioneers Home sentinel event injury rate.

See division level A2: Strategy-2, Target #1, Measure #1 as it provides more detail.

Division Level Measures

A: Result - Outcome statement - Provide a safe assisted living environment for eligible Alaskan Pioneers.

Target #1: Track and trend adverse events.
Measure #1: Stabilize numbers of adverse events.

Analysis of results and challenges: Increasing age and acuity levels of the residents in the Pioneer Homes system creates a challenge for the reduction of adverse events. By properly utilizing the strength of trending and tracking information available in the risk analysis program, the Homes will be able to identify times, places, staff and conditions that hold inherent risk. Action plans to address risk will help the Homes to prevent errors or stabilize the number of events and reduce the severity of injury.

A1: Strategy - 1) Improve accuracy of medication administration system.

Target #1: Less than 2% medication error rate.
Measure #1: Percent of medication administration errors.

Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	0.07%	0.08%	0.04%	0.05%	0.06%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2006	0.19%	0	0	0	0.19%

The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

Analysis of results and challenges: All care processes are vulnerable to error, yet several studies have found that medication-related events are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The Division will use a system wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying error prone steps (risks). Trending the cause of the error tends to provide the most useful information in designing strategies for future error prevention.

The Centers for Medicare and Medicaid Services (CMS), which oversees and surveys nursing facilities throughout the United States, considers a 5% medication error rate as acceptable.

The Pioneers' Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the Division level. From FY2002 through FY2005, the actual number of medications administered in the Pioneer Homes was between 344,664 to 418,505 individual medications per reporting quarter. Both the medication passes and the occupancy rate of the Homes has remained stable over this period of time.

A2: Strategy - 2) Reduce number of sentinel event occurrences in the Pioneers Homes.

Target #1: Injury rate below half the national standard, which is two to six percent.
Measure #1: Pioneers Home sentinel event injury rate.

Sentinel Event injury rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	2.9%	0.7%	0.0%	0.37%	0.99%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2004	1.2%	0.44%	0.49%	1%	0.78%
2005	2.46%	2.4%	1.85%	2.26%	2.09%
2006	0.6%	0	0	0	0.6%

The Sentinel Event Injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing the number of Sentinel injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to sentinel events, those with “serious and undesirable occurrences,” the problem is even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death. The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.5. Since this puts our residents in the highest risk category, they are more likely to suffer a major injury from a fall and experience significant morbidity thereafter.

The Division will respond to sentinel events with root cause analysis investigations and corrective action plans to address underlying causes.

The Pioneer Homes system collects sentinel event information at the individual Pioneer Home level and aggregates the numbers for reporting at the Division level.

Sentinel Event Injury Rate FY 2005
Expressed in Percentages

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Sitka	5.3	2.8	4.0	4.0
Fairbanks	0.0	1.2	1.85	0.0
Palmer	0.0	2.9	2.2	4.2
Anchorage	1.5	0.0	3.1	1.9
Ketchikan	0.0	4.3	0.0	0.0
Juneau	8.0	3.2	0.0	3.5
Average	2.46	2.4	1.85	2.26

Overall Fall Rate FY06

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Sitka	4			
Fairbanks	10			
Palmer	7			
Anchorage	6			
Ketchikan	4			
Juneau	3			

The Fall Rate is a measurement of risk. It tells you how many falls you can expect for every 1000 bed days of care.

Deaths from Falls FY05-FY08

	FY05	FY06	FY07	FY08
Sitka	0			
Fairbanks	2			
Palmer	3			
Anchorage	0			
Ketchikan	1			
Juneau	1			
Total	7			

To date, the number of resident deaths attributed to Sentinel Event falls.

Witnessed/Unwitnessed Falls

FY06	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Witnessed	33%			
Unwitnessed	66%			

The percentage of falls for the quarter that were or were not witnessed.

Behavioral Health

Mission

Provide an integrated behavioral health system.

Introduction

Alaska's behavioral health system includes both the public and the private sectors. The public sector is responsible for serving those who do not have access to private services because of cost and/or location. Every location in the state, no matter how remote, falls into a service delivery area. The Department of Health & Social Services (DHSS), Division of Behavioral Health (DBH) is responsible for the State's public behavioral health system which includes the community mental health and substance disorder programs. DBH administers the statewide system of community behavioral health programs for delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute (API), the state's only public psychiatric hospital; administers grants to the state's network of local community mental health and substance abuse programs; and coordinates with other government, tribal and private providers of behavioral health services to ensure the provision of comprehensive behavioral health services to Alaska residents. DBH works closely with the Alaska Mental Health Board (AMHB), the state's mental health and substance abuse planning councils, and the provider organizations (Alaska Behavioral Health Association and Alaska's Substance Abuse Directors) on system planning and evaluation. The AMHB provides public forums at their quarterly meetings for discussion of matters pertinent to the budgeting process, the mental health and substance abuse block grants, reports to the Legislature, the Governor and the Commissioner of DHSS, and advocates before the executive and legislative branches of government on behalf of persons served by Alaska's behavioral health continuum of care.

Core Services

- Conduct needs assessments, plan and evaluate services to ensure appropriate services are provided to those most in need and determine the extent to which services provided are effective;
- Maximize funding to enable the greatest number of individuals and families to receive care at the appropriate level of service;
- Award, disburse, and monitor grants, and provide essential programmatic over-sight of community-based substance abuse and mental health prevention, early intervention, treatment and recovery programs and services provided by an array of non-profit organizations and contractors;
- Operate Alaska Psychiatric Institute (API), the state's only psychiatric hospital.

The Division of Behavioral Health has limited historical client data but is currently implementing the Alaska Automated Information Management System (AKAIMS) for improved data collection. With this new system fully in place the Division will be able to better track client outcomes in the alcohol, drug abuse, and mental health program areas. The Division has already been able to collect and analyze preliminary outcome data, and as AKAIMS becomes fully implemented, more comprehensive data will be available for analysis. Alaska is the first state to use this Web based management information system to collect integrated behavioral health information.

Behavioral Health Medicaid Services

- In SFY05 Behavioral Health Medicaid provided services to more than 13,500 Alaskans, 10% of the 131,000 enrolled.

- Behavioral Health Medicaid costs grew 9% from FY04 to FY05. Growth is due to increases in the number of patients served, utilization of services, and facility rates. The average monthly number of beneficiaries rose 6% while the cost-per-recipient rose 3%.

- Most of the increase can be attributed to Residential Psychiatric Treatment Center services (RPTC) and Inpatient Psychiatric Facility services provided to children. Residential Psychiatric Treatment Centers experienced a 14% increase in expenditures from FY04 to FY05. Inpatient Psychiatric Facilities grew slightly faster than RPTC, making it the fastest growing category of service in Behavioral Health Medicaid with a 15% increase from FY04 to FY05.

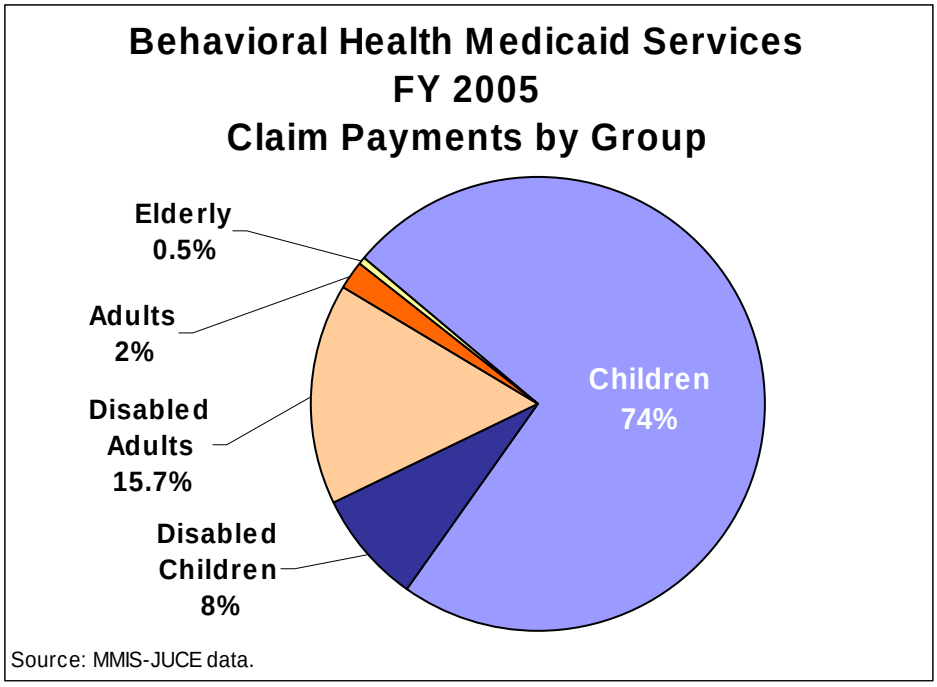
- Children received four out of every five dollars spent on behavioral health Medicaid benefits.

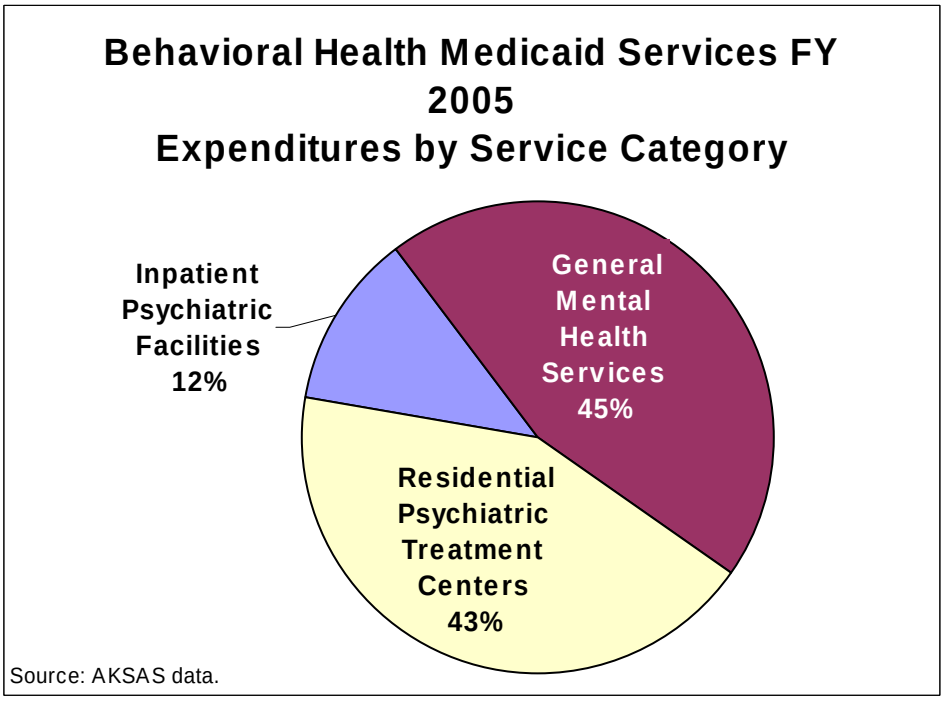
Number of Medicaid Beneficiaries in FY 2005

	General Mental Health Services	Inpatient Psychiatric Services	Residential Psychiatric Treatment Centers	Total*
Children	6,909	1,211	1,014	9,134
Adults	2,139	0	0	2,139
Elderly	196	5	0	201
Disabled Children	392	103	75	570
Disabled Adults	3,461	18	8	3,487
Total*	13,097	1,337	1,097	15,531

Source: MMIS-JUCE

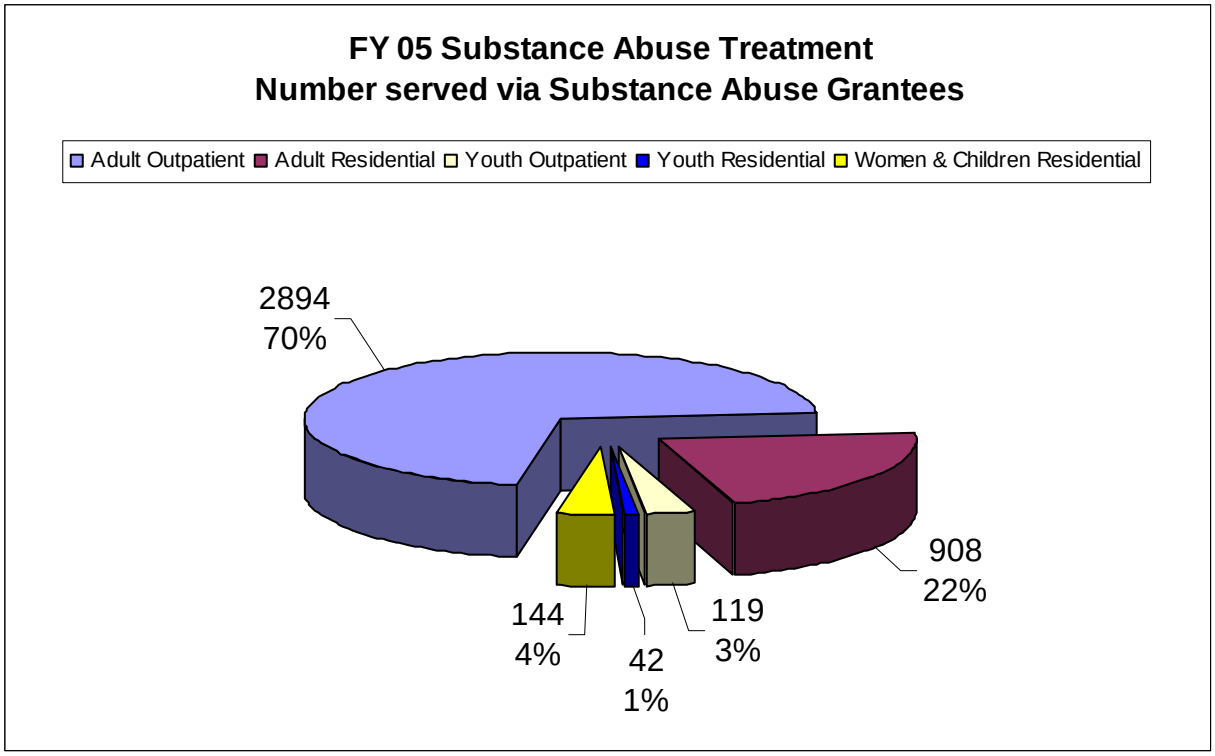
***For each service/eligibility combination, counts of beneficiaries are unduplicated. The total is the sum of the column or row and not the actual number of individuals. Because beneficiaries may receive services in multiple categories the total will overstate the unduplicated count of beneficiaries.**


Behavioral Health Medicaid Services
FY 2005
Claim Payments by Group
Elderly
0.5%
Adults
2%
Disabled
Adults
15.7%
Disabled
Children
8%
Children
74%
Source: MMIS-JUCE data.


Behavioral Health Medicaid Services FY
2005
Expenditures by Service Category
Inpatient
Psychiatric
Facilities
12%
General
Mental
Health
Services
45%
Residential
Psychiatric
Treatment
Centers
43%
Source: AKSAS data.

Services for Seriously Mentally Ill
Approximately 9,000 individuals are receiving mental health services at any one time.

Substance Abuse Services



Designated Evaluation and Treatment

- Under-funded in excess of $750K a year. This has occurred consistently over the past 5 years, and causes DBH to seek budget increments to cover the costs incurred. Because the DET program is legislatively-mandated, the services must continue despite a lack of funding.

Total FY04 reimbursement to providers for this program:

- 1,580 bed days
- 681 transports
- 650 consumers

To date for FY05 reimbursement to providers for this program:

- 1,293 bed days, and
- 652 transports for
- 644 consumers

(Providers have until December 31, 2005 to submit bills for reimbursement approval of FY05 claims.)

The Alaska Fetal Alcohol Syndrome (FAS) Program AS 47.30.470-500, AS 47.37
This project seeks to prevent alcohol-related birth defects, increase diagnostic services in Alaska, improve the delivery of services to those individuals already affected by Fetal Alcohol Spectrum Disorders (FASD), and to evaluate the outcomes of statewide efforts. Services include training, public education, development of statewide diagnostic services, community support through grants and contracts, and the ongoing development of partnerships with other divisions, departments, community agencies, Native Health Corporations and parents/caregivers to decrease the prevalence of FAS and the secondary disabilities that occur when appropriate services are not provided.

Currently there are 12 trained community-based diagnostic teams across Alaska and one specialized team located at the Alaska Psychiatric Institute (API). Since 2000, over 850 Alaskans have received diagnoses related to prenatal alcohol exposure. Of those who completed a diagnosis approximately 10% had full FAS (with facial features and growth deficiencies); 84% received a diagnosis indicating significant brain damage; and approximately 6% did not show signs of an alcohol-related disability. The average age at diagnosis is between 10-12 years of age.

As the department continues with the momentum developed by the federally-funded Alaska FAS project, the division will focus on developing substance abuse prevention programs with clear outcomes, evidence-based research, and promising programs as identified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). To the extent possible, development will be encouraged within existing service delivery systems such as child protective services, juvenile justice, community mental health centers, residential treatment programs, job training centers, schools, and substance abuse treatment programs, to provide for long-term sustainability. Programs will be selected to represent regional, cultural, ethnic and discipline diversity.

Alcohol Safety Action Program (ASAP) AS 28.35.030, 47.30.470-500, AS 47.37
This program screens, refers and monitors both adult and juvenile offenders to ensure that they complete their substance abuse education or treatment program that is prescribed by the courts, Division of Motor Vehicles, and/or Division of Juvenile Justice. The ASAP is both a direct service provider in the Anchorage area and the oversight office for the Division's statewide ASAP grant programs. The program facilitates entry of all misdemeanor defendants ordered by the court into substance abuse education and/or treatment, monitors court requirements, and provides data regarding those defendants. During FY05, the state ASAP staff provided direct services in the Anchorage area and quality assurance, technical assistance, grant monitoring, planning and policy development, and data collection for their program and the seven ASAP grantees. The Anchorage ASAP experienced a slight decrease in new cases ordered for screening and referral services by the Alaska Court System from 3,298 in FY04 to 3,178 cases in FY05.

Behavioral Health Medicaid Services AS 47.07
A combination of federal and matching state Medicaid funds support behavioral health services to Medicaid eligible individuals with a mental disorder or illness and/or a substance abuse disorder. These funds are managed by the Division to maximize financial support for mental health treatment and substance abuse intervention and treatment services for Medicaid eligible youth and adults, in both inpatient and outpatient settings.

Behavioral Health Grants AS 47.30.520-620, AS 47.30.655-915, AS 47.30.011-061, AS 47.30.470-500, AS 47.37
These grants are provided to reduce alcoholism and substance abuse and to treat mental illness by funding prevention, intervention and treatment services through local grantee organizations. They

also provide funds for services to assist individuals who suffer from a traumatic brain injury to attain their highest possible functioning level. These publicly funded programs primarily serve those Alaskans without insurance or the ability to pay for services.

Prevention services delivered by the local providers include information, general education, alternative activities, problem identification and referral, community based processes, and environmental strategies.

Behavioral Health Administration AS 47.30.520-620, AS 47.30.665-915, AS 44.29.020, AS 44.29.210-230, AS 47.30.470-500, AS 47.37
This component supports the administrative operation of the Division and the programmatic oversight of all programs and services funded by the Division, with the exception of services delivered at API. The more than 230 million dollars granted, contracted or otherwise utilized by the Division to provide services to individuals and their families are managed, awarded, disbursed, and monitored by this component. All Divisional staff positions, except those employed by the Alaska Psychiatric Institute, are budgeted in this component.

Community Action Prevention & Intervention Grants AS 47.30.470-500, AS 47.37
The goal of this component is to ensure that effective community-based prevention and early intervention services are available statewide. These services strive to incorporate research-based strategies that demonstrate positive outcomes for individuals and communities. The intent is to provide the foundation funding for Alaska's effort to prevent substance abuse within the State, with a focus on preventing youth from experimenting with and becoming addicted to alcohol and other drugs. Prevention services include information, general education, alternative activities, problem identification and referral, community based processes, and environmental strategies.

Rural Services and Suicide Prevention AS 47.30.470-500
Programs funded through this component include the Community-Based Suicide Prevention Program (CBSPP), which provides small grants directly to communities; and the Rural Human Services System Project (RHSSP) which provides funds to regional agencies to hire, train and supervise village-based counselors. These counselors provide integrated substance abuse and mental health outpatient, aftercare and support services as well as prevention and education activities. The RHSSP training program is administered by the University of Alaska, College of Rural Alaska and an additional part of the mission is to encourage rural Alaskans to pursue higher degrees in human services fields. Both the Community-Based Suicide Prevention Program and the Rural Human Services System Project focus on ensuring that needed services are both available in and culturally appropriate to the villages and towns of rural Alaska. CBSPP coordinators provide a wide range of prevention and intervention services. RHS trained village-based counselors provide a full range of paraprofessional services from screening to aftercare under the supervision of more advanced practitioners. They also provide prevention and education programs in their communities.

Psychiatric Emergency Services AS 47.30.520-620, AS 47.30.655-915, AS 47.30.011-061
This funding supports competitive grants to community mental health agencies for services intended to aid people in psychiatric crisis. The service array may include crisis intervention, brief therapeutic interventions for stabilization, and follow-up services. Specialized services such as outreach teams and residential crisis/respite services are also included. In addition, there were approximately 35,000 emergency services contacts in FY05. Many of these individuals received other services funded by the Division when not in crisis.

Services for the Seriously Mentally Ill AS 47.30.520-620, AS 47.30.655-915, AS 47.30.011-061

Competitive grant funding is made available to community mental health agencies for an array of support services for adults with severe mental illnesses. This is the population that impacts the census limits at API and services delivered in the community are critical to keeping this population out of the hospital. Past formal, published evaluations of services to this population have proved the effectiveness of these services to keeping people out of API and Correctional facilities (IDP study). Core services are assessment, psychotherapy, case management, and rehabilitative services. Specialized services include residential services, vocational services and drop-in centers.

Designated Evaluation and Treatment AS 47.30.520-620, AS 47.30.655-915

The state, as a payer-of-last resort, makes these funds available to designated local community and specialty hospitals for evaluation and treatment services for people under court-ordered commitment and to people who meet those criteria, but have agreed to accept services voluntarily in lieu of commitment.

Using this funding, a local facility may provide up to 72-hour inpatient psychiatric evaluations, up to 7 days of crisis stabilization, or up to 40 days of inpatient hospital services close to the consumers home, family, and support system. Component funding also supports consumer and escort travel to designated hospitals and back to their home community.

Services for Severely Emotionally Disturbed Youth AS 47.30.520-620, AS 47.30.655-915, AS 47.30.011-061

This component provides competitive grant funding to community mental health agencies for a range of services for severely emotionally disturbed youth and their families. Core services provided are assessment, psychotherapy, chemotherapy, case management and rehabilitation. Specialized services include individual skill building, day treatment, home-based therapy, residential services and individualized services.

SED grants prioritize services in the least restrictive environment and as close to home and family as possible. In FY2006 changes were made to this component to enhance the in-state service continuum for children with SED and decrease the number of children moving into out of state placements and restrictive in-state environments: 1) Funding was increased on an “as needed” basis to support individualized services required to divert children from out of state/out of community placements. 2) Requirements for collaboration, planning and coordination of care were increased. 3) 10 new grants were awarded for start up pilot projects to increase in-home services and residential alternatives for children at risk of movement into more restrictive care and/or stepping down from out of state care.

Alaska Psychiatric Institute AS 12.47.010-130, AS 47.30.655-915, AS 18.20.010-390, AS 08.86.010-230, AS 08.68.010-410, AS 08.64.010-380, AS 08.95.010-990, AS 08.84.010-190

Alaska Psychiatric Institute provides twenty-four hour inpatient psychiatric care to individuals from all regions of the state. API serves Alaskans with severe and persistent psychiatric disorders or serious maladaptive behaviors including adults and adolescents whose need for psychiatric services exceeds the capacity of local service providers. API also provides longer-term care for organic or highly complex and difficult to place patients and provides court-ordered competency evaluations of persons accused of crimes, and treatment for patients found incompetent to stand trial or not guilty by reason of insanity. API staff makes special efforts to transition patients with serious, persistent mental illness into community settings. In partnership with patients, families, and their communities, Alaska Psychiatric Institute will provide appropriate, quality, individualized treatment services that assist patients to achieve their goals and be successful in their communities. API provides outreach,

consultation, and training to mental health service providers, community mental health centers, and nursing, social work, psychology, rehab, and medical student interns.

Services provided at API include:

- screening and referral
- medication stabilization
- psychosocial rehabilitation services
- multidisciplinary assessments
- individualized and group therapy and counseling
- patient and family education
- inpatient psychiatric treatment with an increasing focus on the role recovery approach
- Tele-psychiatry services

Behavioral Health	2006	2007 Proposed	06 to 07 Change
General Funds	89,258.1	106,599.2	17,341.1
Federal Funds	105,427.0	103,904.0	(1,523.0)
Other Funds	39,689.2	42,161.9	2,472.7
Total	**234,374.3**	**252,665.1**	**18,290.8**

Alaska Fetal Alcohol Syndrome Program

Fetal Alcohol Spectrum Disorders (FASD) $500.0 General Fund/Mental Health
Over the past 5 years, the DHSS has laid the foundation for a sustainable, statewide, comprehensive FASD project. The addition of these funds will enhance and develop new community-based services for prevention of prenatal exposure to alcohol and improving services for individuals and families impacted by an FASD.

These new funds will begin addressing these identified gaps in services:

- Adult diagnostic services
- Job-training and job-coaching for youth and adults with an FASD
- In-state residential treatment options for children and youth with an FASD
- Statewide prevention messaging - educating Alaska about the dangers of drinking alcohol during pregnancy.

Reduce Federal Authority for Alaska FAS Grant ($4,128.4 Federal)
Alaska's 5 -Year Fetal Alcohol Spectrum Program Federal Grant has ended. This change record reduces federal authority to the anticipated level of $1,800.0 for a no-cost extension of federal funds to be expended by September 30, 2006.

The division anticipates that most of these funds will be expended through contracts, with some funds allocated for personal services to complete this project.

Behavioral Health Medicaid Services

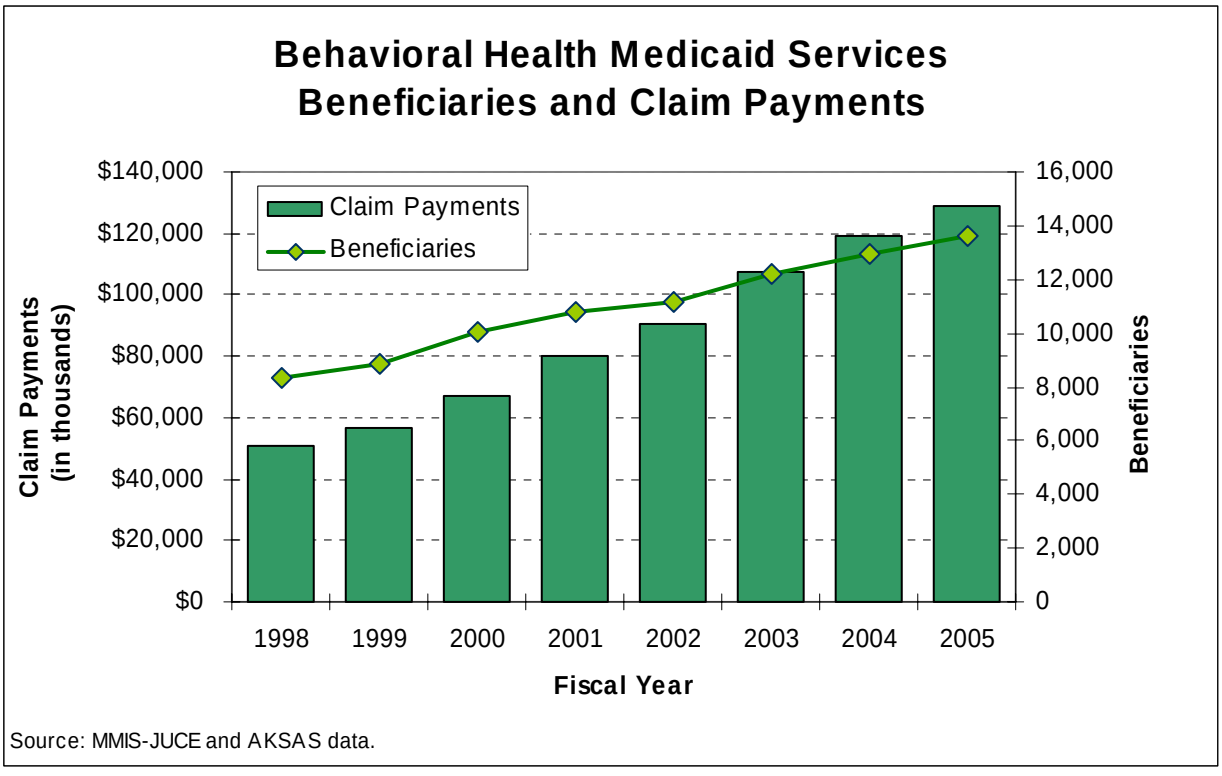
Projected FY07 Growth $2,954.1 General Fund; $6,578.0 Federal
The Behavioral Health Medicaid Services component funds three types of services: residential psychiatric treatment centers, inpatient psychiatric facilities, and general mental health services. Behavioral Health Medicaid Services have experienced significant continued growth. This increment request is necessary to maintain the current level of behavioral health services provided to Alaskans.

Behavioral Health Medicaid Services
Historical Utilization

	Enrollment	Beneficiaries	Claim Payments (in thousands)
FY 1999	94,500	8,821	$56,771
FY 2000	111,100	10,082	$67,281
FY 2001	118,100	10,823	$80,101
FY 2002	124,920	11,143	$90,655
FY 2003	126,632	12,199	$107,216
FY 2004	129,528	12,935	$119,350
FY 2005	131,136	13,607	$129,057

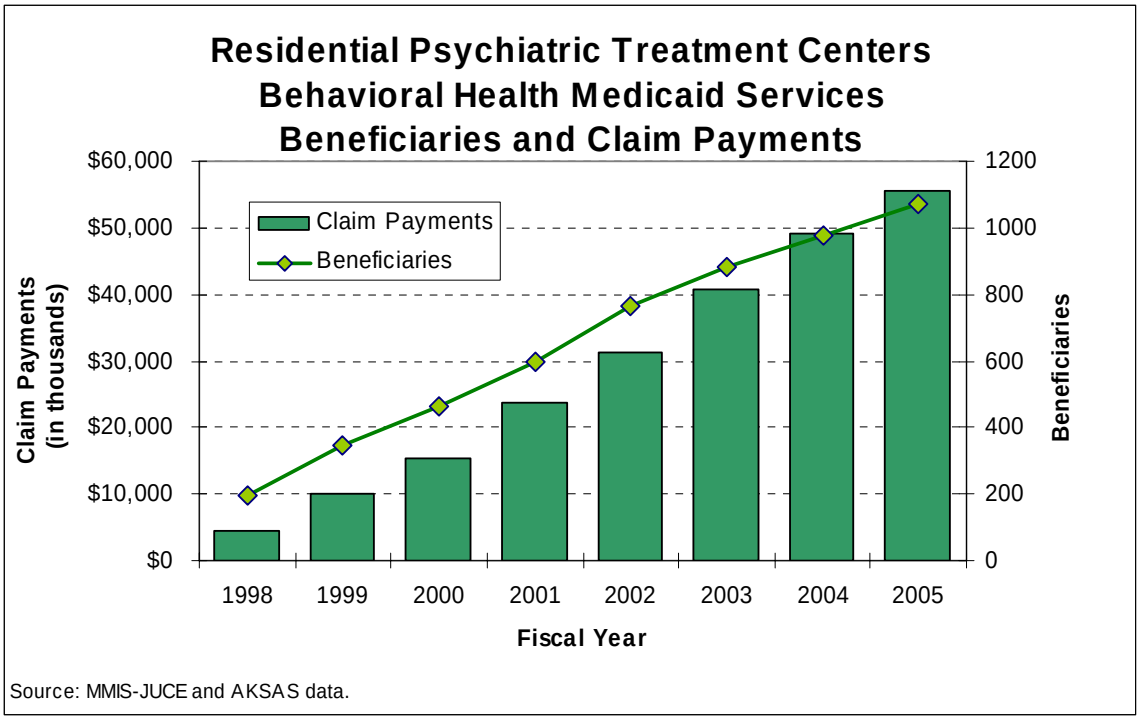
Source: MMIS-JUCE data. Prior to FY 2004 Medicaid services were in the Division of Medical Assistance.

DBH Medicaid costs grew 9% from SFY04 to SFY05. The same rate of growth is anticipated for SFY06 & SFY07. Growth is due to increases in the number of patients served, the utilization of services, and facility rates. The average monthly number of beneficiaries rose 6% while the cost-per-beneficiary rose only 3%.

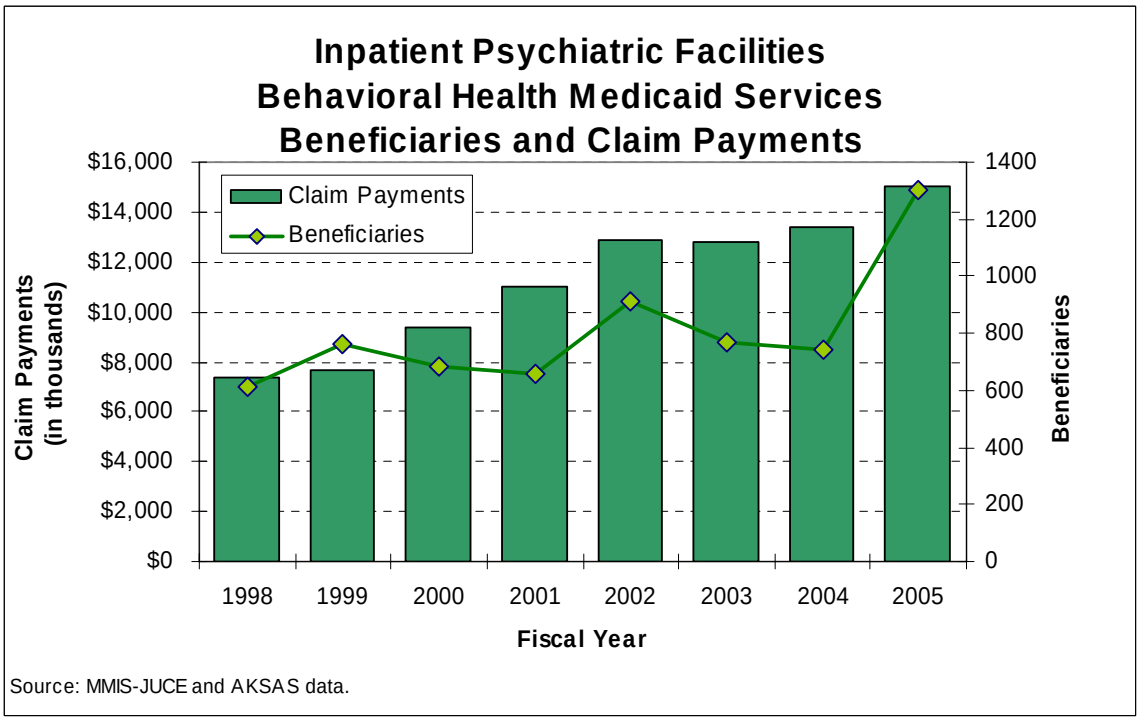


Source: MMIS-JUCE and AKSAS data.

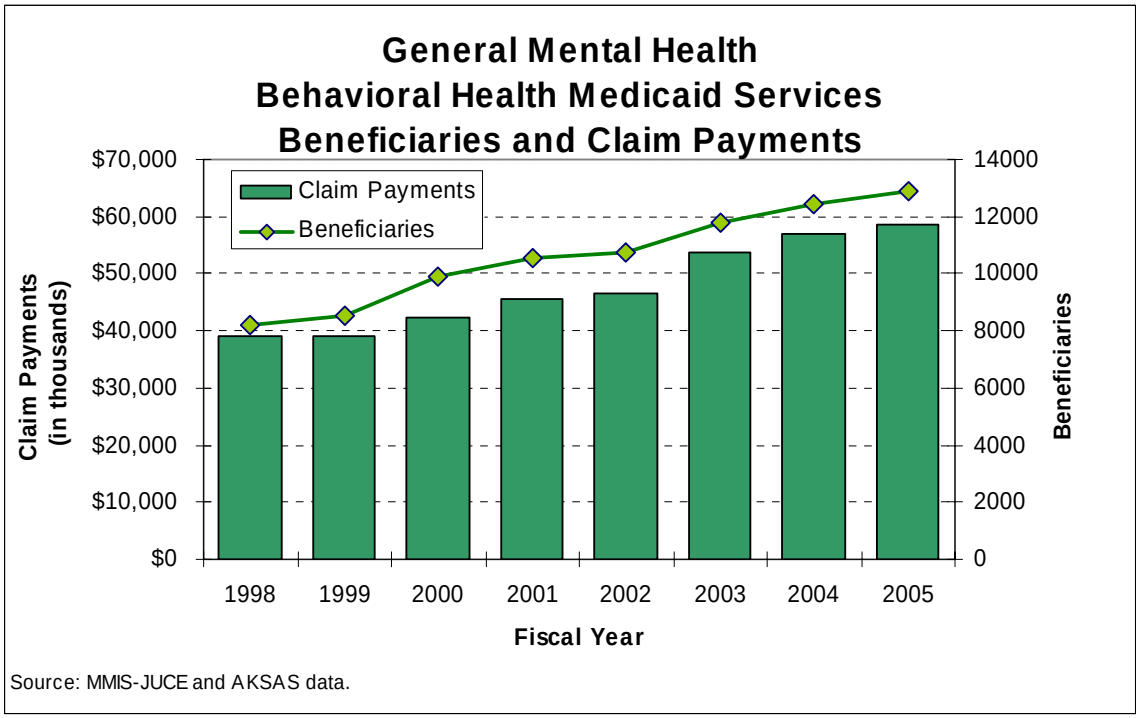
Most of the increase can be attributed to services provided to children in Residential Psychiatric Treatment Centers (RPTC) and Inpatient Psychiatric Facilities. RPTC experienced a 14% increase form SFY04 to SFY05. Inpatient Psychiatric Facilities grew slightly faster than RPTC, with a 15% increase during the same period.



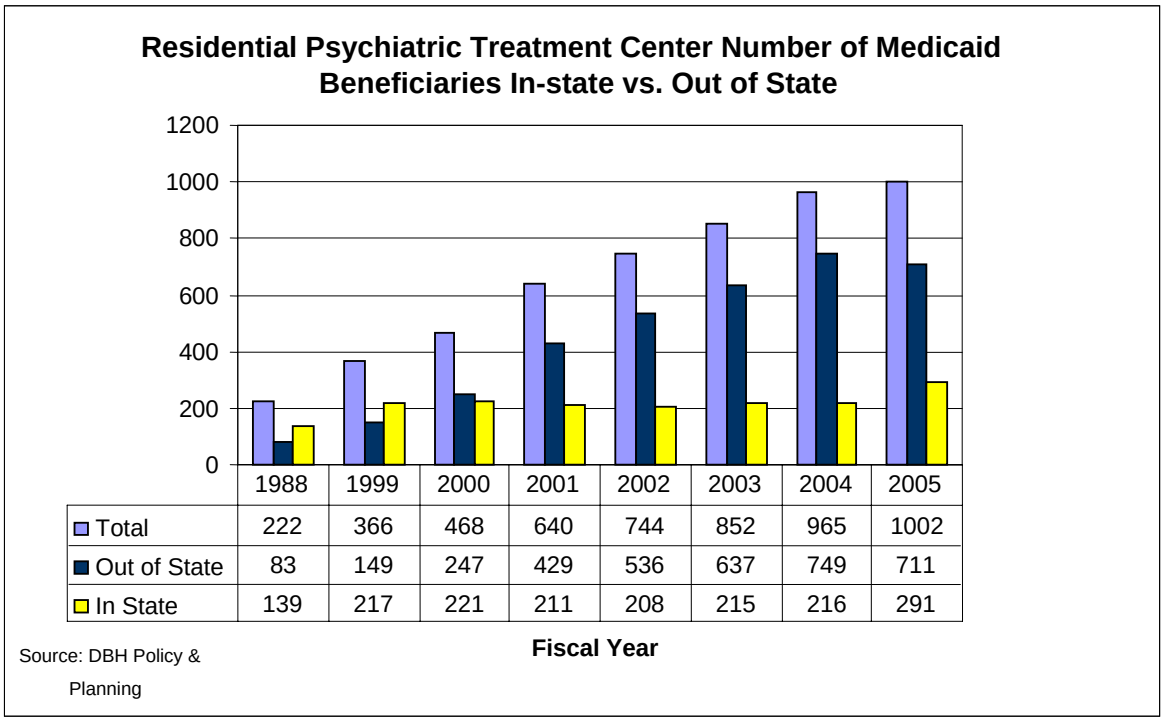
Source: MMIS-JUCE and AKSAS data.



Source: MMIS-JUCE and AKSAS data.



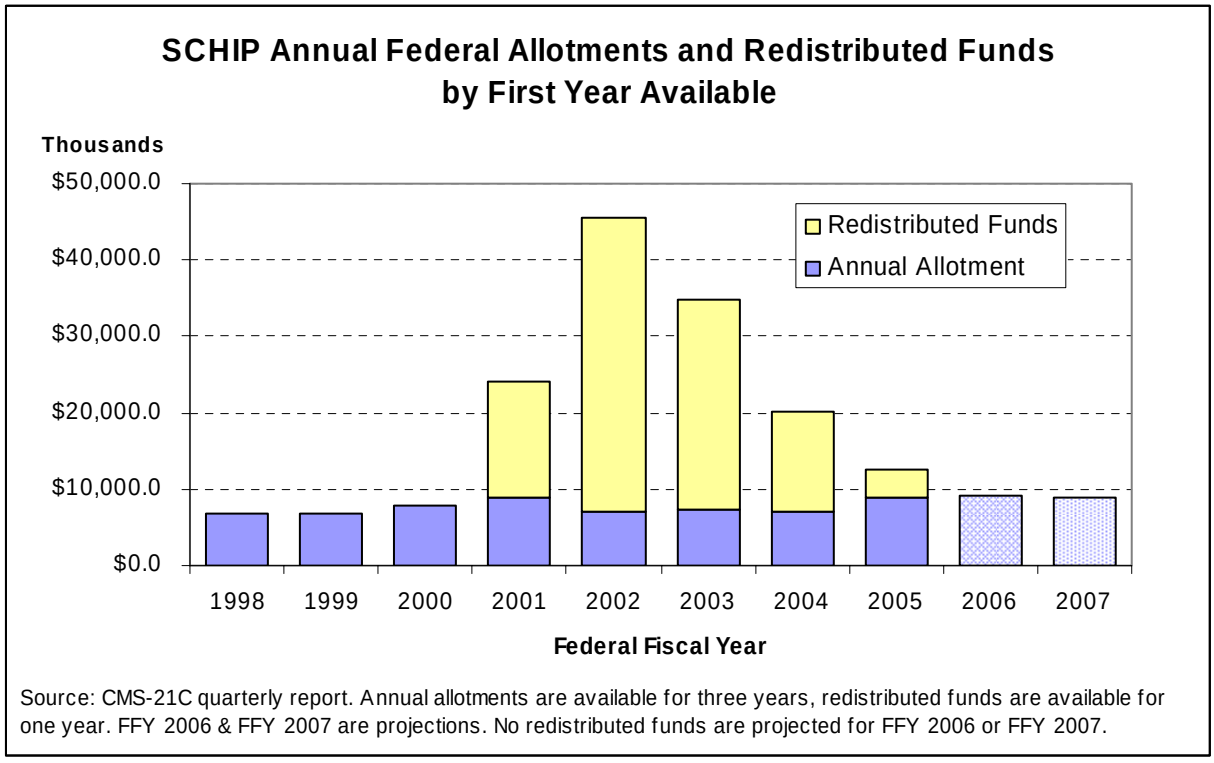
Both RPTC and Inpatient Psychiatric Hospital services provide a higher level of care than outpatient services. The department anticipates that the Bring the Kids Home initiative will begin to slow the growth in these areas as in-state capacity for lower levels of care increases. The requested increment is necessary to support the expected growth in outpatient services in their home communities.



SCHIP Shortfall $761.2 General Fund; ($761.2) Federal

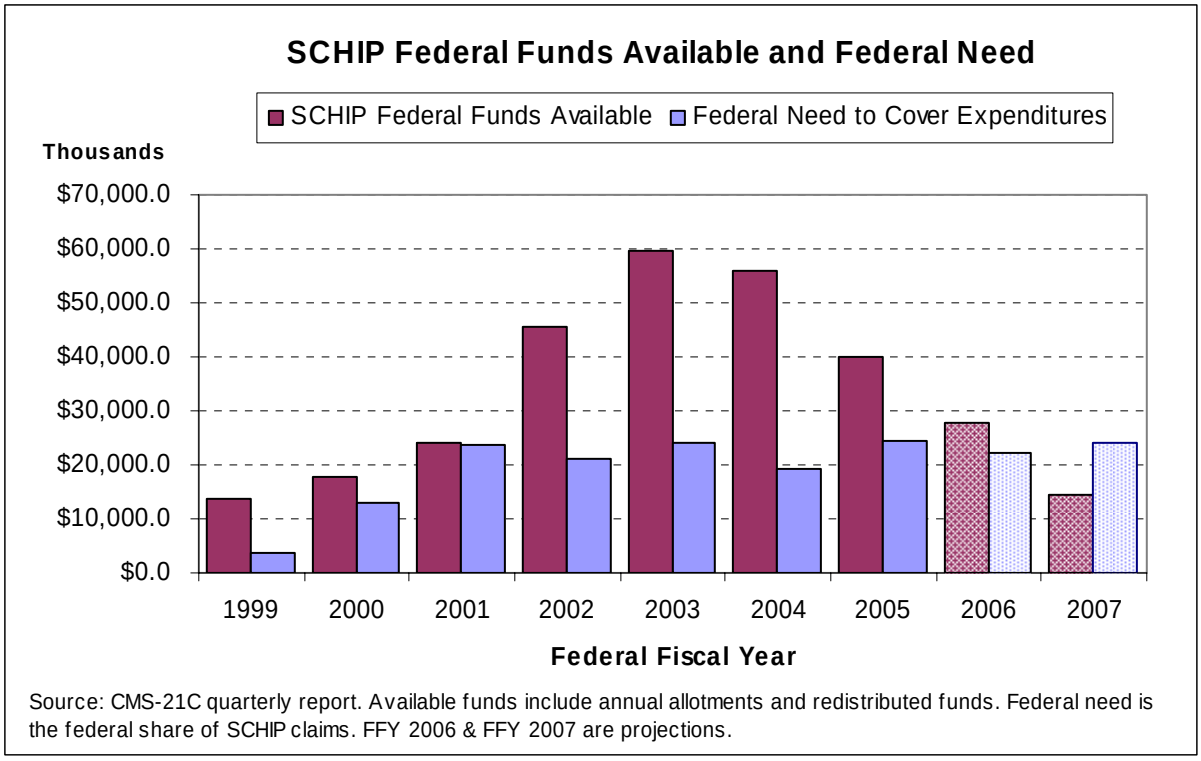
The State Children's Health Insurance Program (SCHIP), operated through Denali KidCare, each month provides health insurance for nearly 11,000 uninsured children under age 19. SCHIP helps reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Since its implementation in August 1998, SCHIP has provided over $230 million in medical benefits to more than 46,700 Alaskan children.

Each federal fiscal year states receive an SCHIP allotment from the federal government, which must be spent within three years. SCHIP allotments are determined by a formula based on a national ranking of the number of low-income children and average wages in the health industry. After three years, unspent allotments from all the states are combined into a redistribution fund, which is then reallocated to states according to need. States must spend redistributed funds in the year they are awarded. While Alaska was quick to get its program started, many states were slow to implement. This meant large sums of unspent allotments from other states were available to Alaska for redistribution. Since Alaska's annual allotment represents only about 25% of our costs, we have relied heavily on redistributed funds to support our program. In recent years the allotment has remained between $7 and $9 million; meanwhile, as more states have ramped up their programs, our redistributed funds have shrunk rapidly from a high of $38 million in FFY 2002 to just $3 million in FFY 2006.



Source: CMS-21C quarterly report. Annual allotments are available for three years, redistributed funds are available for one year. FFY 2006 & FFY 2007 are projections. No redistributed funds are projected for FFY 2006 or FFY 2007.

SCHIP benefit costs are reimbursed at an enhanced FMAP. If costs exceed total allotted and redistributed funds, claims are reimbursed at the regular FMAP. In SFY07, SCHIP total benefit costs are projected to be $34,485.0, of which $24,246.4 is federal. Our total available federal SCHIP funds are projected to be only $14,335.4, for an excess of $9,911.0 in costs. Applying the difference in regular and enhanced FMAP rates, state matching funds will have to increase $2,174.8.0 to make up the shortfall in federal funds. Behavioral Health Medicaid Services accounts for about 35% of SCHIP expenditures, so DBH's portion of the shortfall is $761.2.



Source: CMS-21C quarterly report. Available funds include annual allotments and redistributed funds. Federal need is the federal share of SCHIP claims. FFY 2006 & FFY 2007 are projections.

Transfer First Health Mental Health Contractual Authorization $400.0 General Fund; $1,200.0 Federal

This change record transfers authorization from the HCS MAA component to the DBH Medicaid component for funding of the First Health Mental Health contract. During the reorganization of DHSS in SFY04, the authorization for this contract was not transferred to DBH. The transfer of expenditure authorization is consistent with the decentralization of Medicaid financial management to those areas directly responsible for client services.

Behavioral Health Grants

Substance Abuse Prevention Proposal $2,000.0 General Fund/Mental Health; $1,000.0 Interagency Receipts

This request for $3 million will develop an integrated, comprehensive and community-driven program to promote healthy individuals, families and communities by focusing on the prevention of underage alcohol use. Substance abuse and particularly alcohol abuse by Alaska's youth is a critical and devastating problem.

This initiative will focus on community-based services, programs and practices that are evidence-based, and the development and monitoring of successful outcome and performance measures - are the programs accomplishing what they said they would accomplish; is the use of alcohol and drugs among youth decreasing; is the age of first use decreasing; are youth more connected at school and in their community?

Reduce Federal Authorization for SAPT Block Grant (1,638.7 Federal)

This change record reduces federal receipt authorization by $1,638.7. This reduction is in line with anticipated receipts for this component.

Mental Health Trust Project Additions $275.0 MHTAAR
In FY07 the Alaska Mental Health Trust Authority will fund the following additional projects in FY07 in the Behavioral Health Grants component:

Expand treatment for therapeutic court participants with co-occurring disorders $150.0
These increased funds would provide an immediate expansion of this critically needed treatment capacity while the impact of other actions (such as the Department of Corrections/Social Security Administration effort to maintain and rapidly re-instate disability benefits of offenders) can be incorporated into plans for sustainable funding of this capacity.

AK Automated Information Management System (AK AIMS) Provider Electronic Data Interface $50.0
AKAIMS is a standardized and consolidated behavioral health information collection and delivery system serving approximately 90 behavioral health provider agencies and many hundreds of users. This funding will provide an additional $50.0 to providers who use non-AKAIMS data systems. They will utilize the Electronic Data Interface (EDI) to connect with AKAIMS.

AK AIMS Provider Computers/Internet $50.0

These funds will be used to help providers to purchase computer hardware and computer infrastructure for connection to the internet to access AKAIMS. At this point there are many service providers who lack up-to-date hardware to be able to access the internet in order to interface with the AKAIMS.

Pre-trial Diversion project implementation $25.0
Pre-trial diversion provides an effective means of avoiding criminalization for many beneficiaries whose minor criminal offenses stem from their disability. The addition of new MHTAAR funds in FY07 will support case coordination and/or bridge funding for treatment capacity needed to implement pre-trail diversion efforts not restricted by federal requirements in up to two communities where prosecutors, defense counsel, community providers and correctional facility staff demonstrate need, desire, and collaboration to support pre-trial diversion projects.

Create 5 Social Detoxification Beds $300.0 General Fund/Mental Health
A social detoxification program offers room, board and specialized rehabilitation services to persons who are in an intoxicated state. In social detoxification, individuals are assisted in acquiring the sober and drug-free condition necessary for living in the community. The program places an emphasis on helping the individual obtain further care after detoxification.

The Municipality of Anchorage and a local provider have noted interest in providing social detoxification services. Funds requested would cover the treatment costs only for clients served; the Municipality may have a building with space to accommodate up to 5 beds for social detoxification. This has the potential to increase community capacity for detoxification services by as much as 350 - 600 people annually and reduce the strain on medical detoxification beds.

Behavioral Health Administration

Expand Alaska Automated Information Management System (AKAIMS) Support $340.0 General Fund/Mental Health

The AKAIMS system is essential for collecting data necessary to report on DBH client activity, outcomes, and satisfaction. Data from this system is used to accurately report to the Alaska legislature and federal grantors, for DBH planning efforts, and for grantees to evaluate their own service delivery systems. The requested increment allows for 2.0 FTE Program Support personnel, help-desk capability, 1.0 FTE training/implementation staff, and travel funds for an itinerant trainer.

Bring The Kids Home (BTKH) Expansion $100.0 Federal; $190.0 General Fund/Mental Health

Regional and Out of State Placement Committees staffing $200.0

This funding will provide adequate staffing of the regional and out of state placement/resource committees to increase their capacity to provide gate keeping functions. These teams currently provide these functions only for custody children. Through this funding, the teams will begin to serve non-custody children looking for referrals to residential care.

Bring The Kids Home (BTKH) Project Manager $90.0

This position will be authorized and tasked with complete project management of the BTKH Project. At present, there are several factions all working for this initiative, with minimal coordination of the overall effort. This position will be responsible for the coordination of the project and ensuring that all factions are moving toward outcome oriented results.

Reduce Federal Authorization for Multiple Grants ($1,055.6 Federal)

This decrement decreases federal authorization for the following grants:

Substance Abuse, Prevention, and Treatment (SAPT) Block Grant
Community Mental Health Services (CMHS) Block Grant
Alaska Fetal Alcohol Spectrum Program Grant
SAMHSA Co-Occurring State Incentive (CoSIG) Grant

Community Action Prevention & Intervention Grants

Rural Human Services Systems Program – Add 10 New Counselors in Villages $550.0 General Fund/Mental Health

The Rural Human Services System Program is a partnership between DBH and the University of Alaska Fairbanks (UAF) School of Rural Services. This program began over 10 years ago with the goal being to develop a trained, local and competent social services workforce across rural Alaska. The overarching goal is a "counselor in every village." With these new dollars the Rural Health Services System program (RHSS) will be able to add ten new positions to the existing RHSS program and in the process provide 10 new villages with paraprofessional behavioral health services. This funding will enable each paraprofessional counselor to attend the UAF Rural Human Services certification program and it will pay for a portion of these paraprofessional positions to provide supervised services within their home community.

As of May, 2005, there are counselors in the following villages served through grantees:

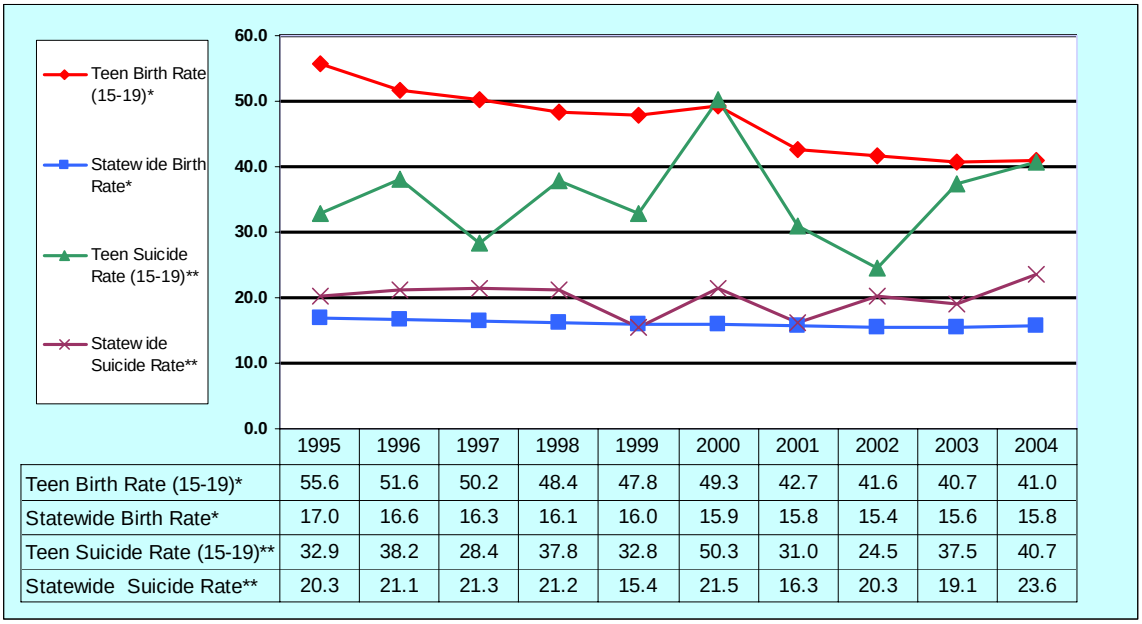
- City of Galena (grantee): Galena; Huslia; Kaltag; Koyukuk; Nulato
- BBAH Corporation (grantee): Kokhanok; Manokotak; Naknek; New Stuyahok; Newhalen; Nondalton; Perryville; Pilot Point; Port Heiden; South Naknek; Togiak
- Railbelt Mental Health Assoc. (grantee): Anderson; Cantwell; Clear; Denali Park; Healy; Nenana

- Southeast Alaska Regional Health Consortium (grantee): Angoon; Haines; Hydaburg; Juneau; Kake; Klawock; Klukwan; Pelican; Petersburg; Skagway
- Norton Sound Health Corporation (grantee): Brevig Mission; Elim; Gambell; Golovin; Island of Little Diomede; Koyuk; Nome; Savoonga; Shaktoolik; Shishmaref; St. Michael; Stebbins
- Seaview Community Services (grantee): Seward; Chenega Bay; Port Graham
- Chugachmiut (grantee): Tatitlek
- Kodiak Area Native Association (grantee): Akhiok; Karluk; Larsen Bay; Old Harbor; Ouzinkie; Port Lions
- Tanana Chiefs Conference (grantee): McGrath; Holy Cross; Tok; Fort Yukon; Galena; Fairbanks
- Kenaitze Indian Tribe (grantee): Kenai and surrounding areas; Aniak; Bethel; Emmonak
- Yukon-Kuskokwin Health Corporation (grantee): St. Mary's; Toksook Bay
- Eastern Aleutian Tribes (grantee): Adak; Akutan; Cold Bay; False Pass; King Cove; Nelson; Lagoon; Sand Point; St. George Island; Whittier
- Maniilaq (grantee): Ambler; Buckland; Deering; Kiana; Kivalina; Kobuk; Kotzebue; Noatak; Noorvik; Point Hope; Selawik; Shungnak

DHSS Youth Success Program $1,000.0 Interagency Receipts; $5,000.0 General Fund/Mental Health

The requested funds will be granted to non-profit agencies to:

- Ensure that thousands of Alaska youth will succeed in life.
- Cut the underage drinking rate. Most recent data (2003) shows 75.1% of high school students have used alcohol.
- Reduce Alaska Youth (15-19 yrs) suicide rate. Currently, Alaska's statewide suicide rate is the highest it has been in ten years, more than double the national average (Alaska is 23.6 per 100,000 population, US is 10.5 per 100,000 population). The Alaska Youth suicide rate is almost double the statewide rate.
- Reduce the teen birth rate in Alaska. The 2004 rate was 41.0 (based on initial 2004 data; Rate of births to Alaska teens 15-19 per 1,000 population).



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Teen Birth Rate (15-19)*	55.6	51.6	50.2	48.4	47.8	49.3	42.7	41.6	40.7	41.0
Statewide Birth Rate*	17.0	16.6	16.3	16.1	16.0	15.9	15.8	15.4	15.6	15.8
Teen Suicide Rate (15-19)**	32.9	38.2	28.4	37.8	32.8	50.3	31.0	24.5	37.5	40.7
Statewide Suicide Rate**	20.3	21.1	21.3	21.2	15.4	21.5	16.3	20.3	19.1	23.6

* Teen birth rate is the number of births to females age 15-19 divided by the estimated population of females ages 15-19, multiplied by 1,000. Statewide birth rate is the number of live births to women divided by the entire population (women and men), multiplied by 1,000

**Teen suicide rate is the number of deaths for teens age 15-19 divided by the population for the same specific age group, multiplied by 100,000. Statewide suicide rate is the number of suicides of both men and women divided by the entire State population, multiplied by 100,000.

Data source –H&SS Bureau of Vital Statistics (12/12/05)

- Continue to improve success rate of teenagers in the local labor market. 2001 reflects 43% of the 14 to 17-year old populations were employed some time during the year while in 2003 45% were employed.

Through a competitive process the Department of Health and Social Services has already identified four non-profit entities for this program. They are: Boys & Girls Clubs of Alaska, Big Brothers/Big Sisters, Rural Alaska Community Action Program and the Alaska Association of School Boards. These non-profit agencies will be required to propose specific programs and outcomes to achieve success, employing innovative approaches with proven results and outcomes measures.

Reduce Federal Receipt Authorization for SAPT Block Grant ($236.7 Federal)
This request reduces federal receipt authorization to anticipated receipt levels in FY07.

Rural Services and Suicide Prevention

Eliminate Federal Authorization for AK Suicide Prevention Grant ($500.0 Federal)
This request eliminates federal authorization from this component due to the termination of the Alaska Suicide Prevention Target/Gatekeeper grant.

Psychiatric Emergency Services

Eliminate Federal Authority for the Community Mental Health Services Block Grant ($572.3 Federal)
This request eliminates $572.3 of federal authorization in this component. Placement of federal authorization in this component was an error.

Services to the Seriously Mentally Ill

Reduce Federal Authorization for the Co-SIG Grant and Potential Grants ($509.1 Federal)
This request reduces federal authorization for the following grants/items:
SAMHSA Co-Occurring State Incentive (Co-SIG) Grant ($420.0)
Federal Authority for Potential Grants ($89.1)

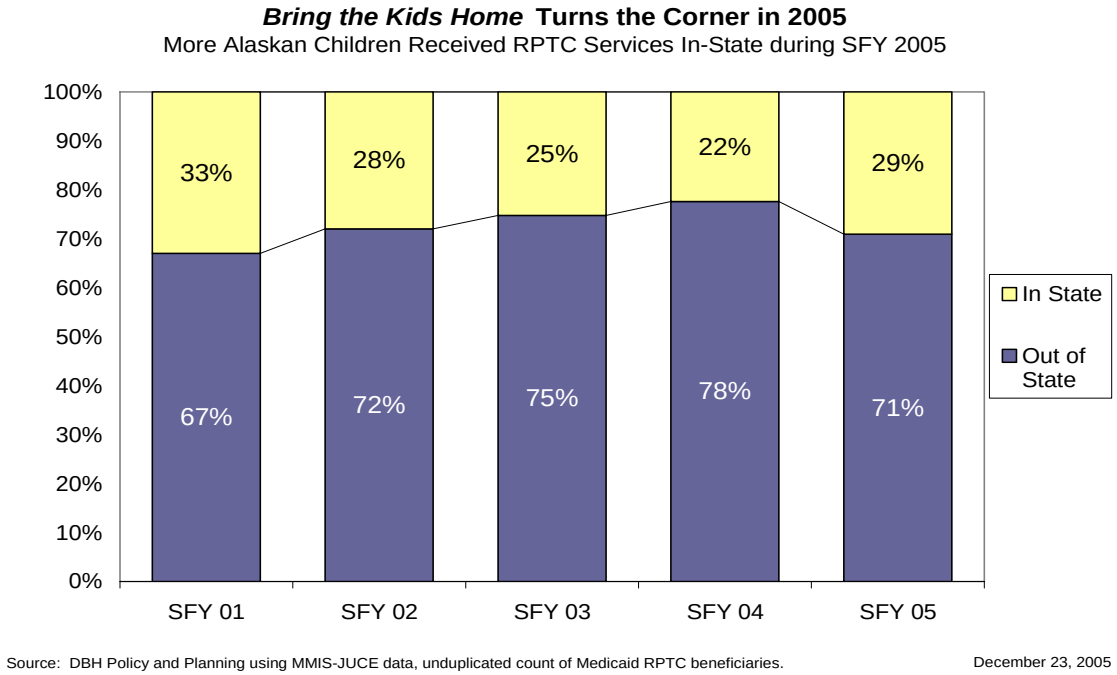
The Co-SIG grant is nearing its completion, so the division will receive less funding in FY07. The CMHS grant has excess federal authorization recorded in this component. The authority for potential grants is simply being eliminated.

Mental Health Trust Funding Adjustments $550.0 MHTARR and decrements of ($277.9) MHTARR

$300.0 Flexible Special Needs Housing Rent Up
$250.0 Rent Subsidy: Replicate "Bridge" Funding Model
($50.0) Maintenance of Independent Case Management Project for DBH Medicaid Sustainability Assistance
($50.0) Beyond Shelter – Outpatient Services Homeless
($89.2) Independent Case Management
($88.7) Behavioral Health Community Planning Project

Seriously and Emotionally Disturbed Youth

Bring The Kids Home (BTKH) Expansion $2,120.0 General Fund/Mental Health
Bring The Kids Home (BTKH) is an initiative to return children with severe emotional disturbances from behavioral health care in out-of-state residential facilities to in-state or community-based care. It will reinvest funding that currently provides expensive distant care to in-state services and capacity development to serve children closer to home, keep families more involved and intact, and more effectively carry out transitions and discharges.



The proposed increment will build upon the success of accomplishments in the prior year to expand the BTKH initiative into the following areas:

Individualized Service Fund $870.0
The purpose of Individualized Service Agreements (ISA) is to ensure that Severely Emotionally Disturbed (SED) youth are being served as close to their community as possible, providing clinically necessary services to prevent institutional care. Individualized Service Funds may be distributed either through a community behavioral health provider or through individualized provider agreements, and will be managed by the regional resource committees to reinforce lower levels of care.

Individualized Service Funds (ISF) are connected with the Bring the Kids Home (BTKH) Project. The BTKH project intends to reinvest funding now going to out-of-state care to in-state services and develops the capacity to serve children closer to home.

BTKH CMHC Grant Support for Care Management for SED Youth $1,250.0
This funding will provide additional grants to the Community Mental Health Centers (CMHCs) to work with families and youth prior to consideration by the placement/resource committees for residential care. The CMHCs or Regional Health Corporations will play a pivotal role in working with the family and youth to develop a local placement. Currently, non-custody children (and some few custody children) may never connect with a CMHC prior to moving into residential care.

Mental Health Trust Funding Adjustment ($310.5 MHTAAR)
The Alaska Mental Health Trust will reduce funding for the following projects in FY07:

Bring The Kids Home (BTKH) Care Coordination and CANS Screening Tool ($62.5)
BTKH Individualized Services ($233.0)
Develop a Standardized Level of care Guide ($15.0)

Mental Health Trust Funding for Additional Projects
Bring The Kids Home (BTKH) Data Collection $50.0 MHTAAR
AKAIMS is a standardized and consolidated behavioral health information collection and delivery system serving approximately 90 behavioral health provider agencies and many hundreds of users. AKAIMS will be critical in providing for BTKH outcome measurement of indicators established for the BTKH focus area that document client satisfaction and client life domain improvement.

Alaska Psychiatric Institute

Adjust I/A for API DSH Allotment $665.0 Interagency Receipts
This increment will provide budgeted Interagency Receipts for Medicaid Disproportionate Share Hospital allotment funds available to API. In past years these funds have been received via unbudgeted Reimbursable Services Agreement (RSA) receipts.

API Pharmacy $150.0 General Fund/Mental Health
The API Pharmacy budget has remained under funded over the past 4 years with no increment; however, estimated operating costs each year exceed the budgeted authority. The rising costs of pharmaceuticals have significantly impacted the budget and despite use of generics, prescribing the safest and most effective medications has required an increase in the request for funding. This funding will benefit patients and help provide better care to Alaskans.

Expand Crisis Treatment Center From 8 to 16 Beds $662.5 General Fund/Mental Health
This facility is to support an expanded treatment program incorporating crisis and sub-acute step-down beds. The purpose of the facility is to provide an alternative setting for 24/7 care for consumers who can manage outside of an acute psychiatric hospital setting. The program does not include detox services.

This expansion of crisis beds and/or step-down beds to acute care at API is necessary because (a) the greater Anchorage geographic area is expanding the population base by 2 ½ % per year; (b) ANMC notes a migration of approximately 100 persons per month into Anchorage from rural areas for medical and related social services (this is a vulnerable population at risk for behavioral health issues).

Increment for Loss of Medicare Revenue due to Rate Change $500.0 General Fund/Mental Health
API serves both acute, short-term patients, and longer-term care patients who have organic or highly complex case diagnoses that would make it extremely difficult to place them in a community setting for care. Most of the Medicare patients API serves are either over 65 years of age or they may be the more complex cases. In many instances these patients exceed the Medicare 90 day limit for payment for psychiatric days. Because of this, for FY 07 API anticipates a loss of close to $500.0.

Contribution to Department's Mission

The mission of the Behavioral Health division is to provide an integrated behavioral health system.

Core Services

This division works closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority to determine policy governing the planning and implementation of services and supports for people who experience mental illness, substance abuse disorders, or both, to provide an integrated behavioral health system.

Department Level Measures

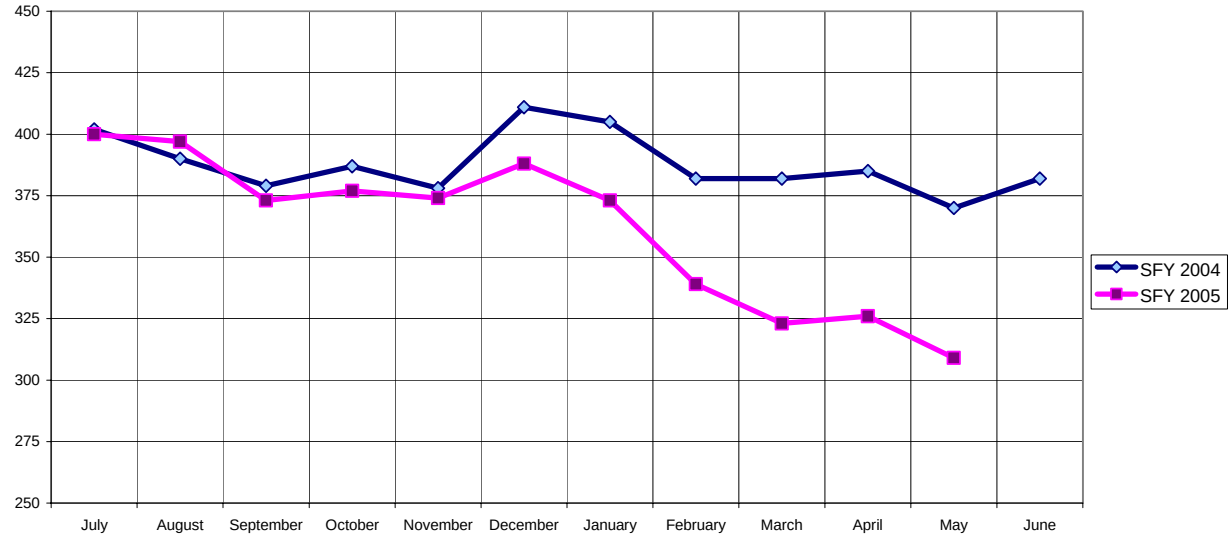
B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

Target #1: To reduce the number of kids in out-of-state placement by 50 children annually over the next seven years.

Measure #1: Change in percent of children reported in out-of-state care from Medicaid MMIS.

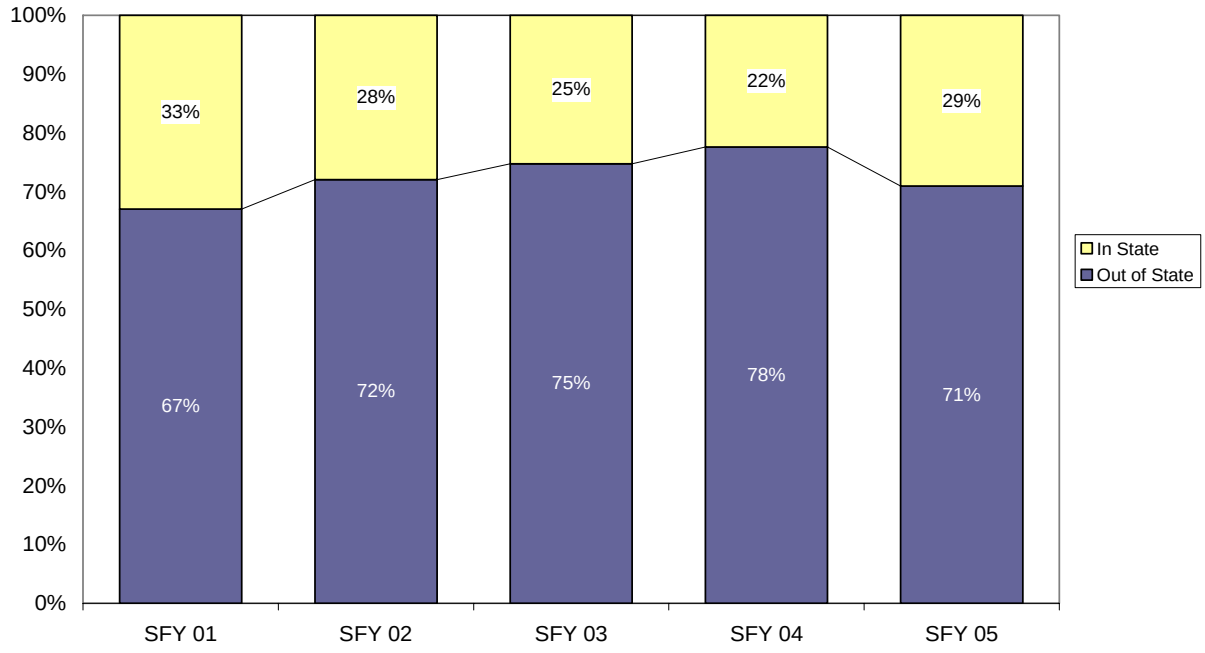
Chart 1:

Children in Out-of-State Residential Psychiatric Treatment Centers At Any Given Time in SFY 2004-2005



Source: DBH Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Chart 2:
Percent of Children in Out-of-State Residential Psychiatric Treatment Centers



Source: DBH Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries. December 23, 2005

Unduplicated Counts of Out-of-State Medicaid RPTC Recipients

Year	Out of State Placements
2003	637
2004	749
2005	711

Analysis of results and challenges: The DBH Policy & Planning section has successfully worked in aligning planning processes with the Alaska Mental Health Trust Authority and planning boards, creating a Master Planning Document, an Expansion of Services and Facilities that includes a timeline by fiscal year, and supported multiple workgroups that address capacity building for the Alaska system of care. These work groups are on the DBH website for public review and comment. To visit these workgroups online go to: https://dbhssweb.state.ak.us/sites/SSA/default.aspx

The data for this performance measure is being reported in two different ways to describe a more complete picture of children receiving out-of-state residential psychiatric treatment center (RPTC) care. The first means of reporting includes an unduplicated count of children receiving out-of-state RPTC services during a state fiscal year. The second report is an unduplicated number of children by month which provides the number of children receiving out-of-state RPTC services at any given time.

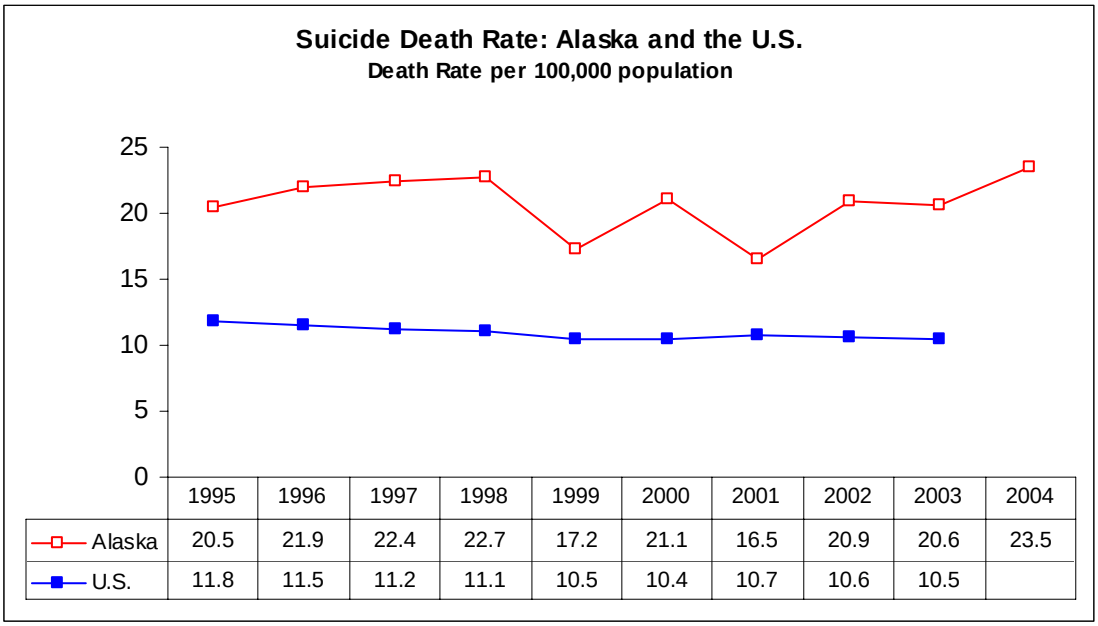
The comparison data represents the unduplicated number of children in out-of-state care at any given time for SFY 2004 and SFY 2005. As lower levels of care are developed, the newly hired care coordinators ramp up diversion activities, and the Anchorage and Fairbanks provider groups continue to bring the kids home, the reductions under this data view will be more pronounced. (See Chart 1)

As we await Medicaid claims payments to process for the final months of SFY 2005, the Division is anticipating a decrease in the number of children receiving out-of-state RPTC services from efforts related to the Bring the Kids Home Initiative.

For the past five years there has been a steady increase in the number of children receiving out-of-state RPTC services. The Bring the Kids Home Initiative was initiated during SFY 2004. The preliminary data is beginning to indicate positive change. Between SFY 2004 and 2005 there is a 7% reduction in the number of children receiving out-of-state RPTC care. (See Chart 2)

This reduction was achieved by successful diversion activities on the part of the Division. This would include the hiring of three utilization review staff as well as implementing policy changes in the RPTC placement criteria. The reduction from SFY 2004 to SFY 2005 was also achieved through collaborative efforts with the Division of Behavioral Health, the Anchorage Providers Group and the Fairbanks Provider Group. These reductions reinforce the importance of the work around this Initiative.

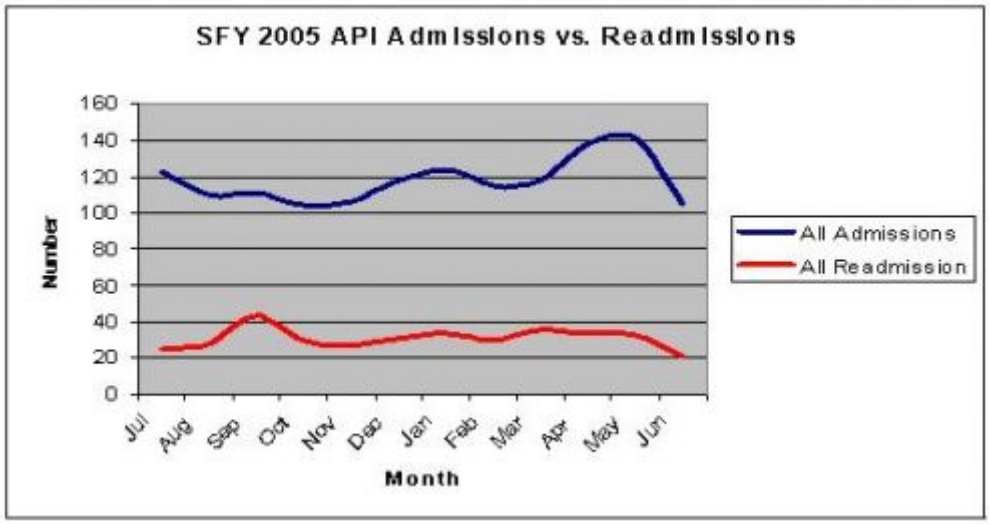
Target #2: To reduce the rate of suicides in Alaska by 10% by 2010.
Measure #2: Alaska's suicide death rate compared to National rate.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alaska	20.5	21.9	22.4	22.7	17.2	21.1	16.5	20.9	20.6	23.5
U.S.	11.8	11.5	11.2	11.1	10.5	10.4	10.7	10.6	10.5	

Analysis of results and challenges: Alaska averages about 125 suicides per year and has a suicide rate double the National suicide rate. The Healthy Alaskans 2010 target is to reduce Alaska's rate to 10%.

Target #3: Reduce 30 day readmission rate for API by 10% on an annualized basis.
Measure #3: # of API re-admissions as compared to hospital bed days divided by the number of months.



Analysis of results and challenges: Percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions.

This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

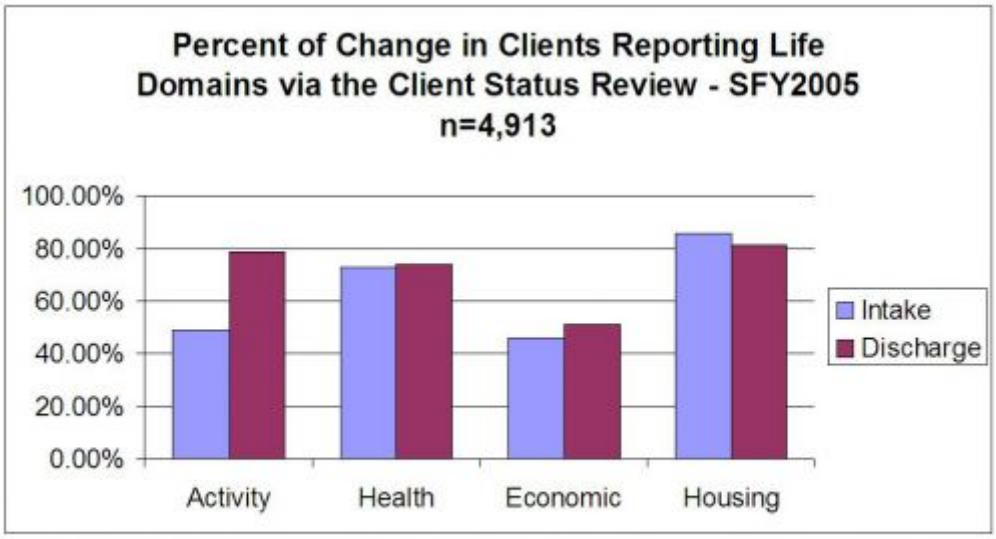
B1: Strategy - Provide enhancements to prevention and early intervention services.

Division Level Measures

A: Result - Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.

Target #1: 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.

Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.



Analysis of results and challenges: The following data is provided as a baseline for use as comparison information in the years to follow. The Client Status Review (CSR) provides a status of the client in relationship to the life domain questions at different intervals during their treatment process- intake, interim, discharge, and post discharge. Five questions within the CSR are used to evaluate the effectiveness of treatment. These five life domains are: level of productive activity, health status, economic status, and housing situation, and education attained.

The CSR does not contain a question which enables reporting around education attained as indicated in the performance measure. The CSR was developed with the National Outcomes Measures (NOMS) in mind, and has not changed with the numerous changes at the federal level. In fact, many of the NOMS are still developmental and subject to change at the federal level.

During SFY 2006, the Division will build protocol around how to use the CSR and disseminate this to providers to build consistency in how the instrument is administered. The Division has also contracted with Western Interstate Commission on Higher Education (WICHE) to assist with development of reporting methodology. Currently the Division and WICHE are working with the CSR to improve it as an instrument, realign the CSR with the currently defined NOMS, move from a population based analysis to a client by client analysis which looks at the change in a client from intake to discharge, as well as reduce the number of non-responses. Additionally, around February 2006, 11 of the Divisions largest providers are expected to begin using the Electronic Data Interface to transmit CSR data from their information systems to AKAIMS, which will exponentially compound the number of CSR submissions, improving the sample size and providing a data set which will represent the population as a whole.

A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.

Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years.

Measure #1: Change in percent of children reported in out-of-state care from Medicaid MMIS.

Analysis of results and challenges: This measure is reported at the Department level.

A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.

Target #1: Increase the number of Tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.

Measure #1: Number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services

# of Tribal Entities

Fiscal Year	# Providing Service
FY 2004	4
FY 2005	8 +100%

Analysis of results and challenges: During SFY 2004, there were four Tribal entities providing and billing for behavioral health services. During SFY 2005 the number of Tribal entities providing and billing for behavioral health services increased to 8.

These include Bristol Bay Area Health Corp., Copper River Native Assoc., Kenaitze Indian Tribe, Maniilaq Assoc., Norton Sound Health Corp., Southcentral Foundation, Tanana Chiefs Conference, Yukon Kuskokwim Health Corp.

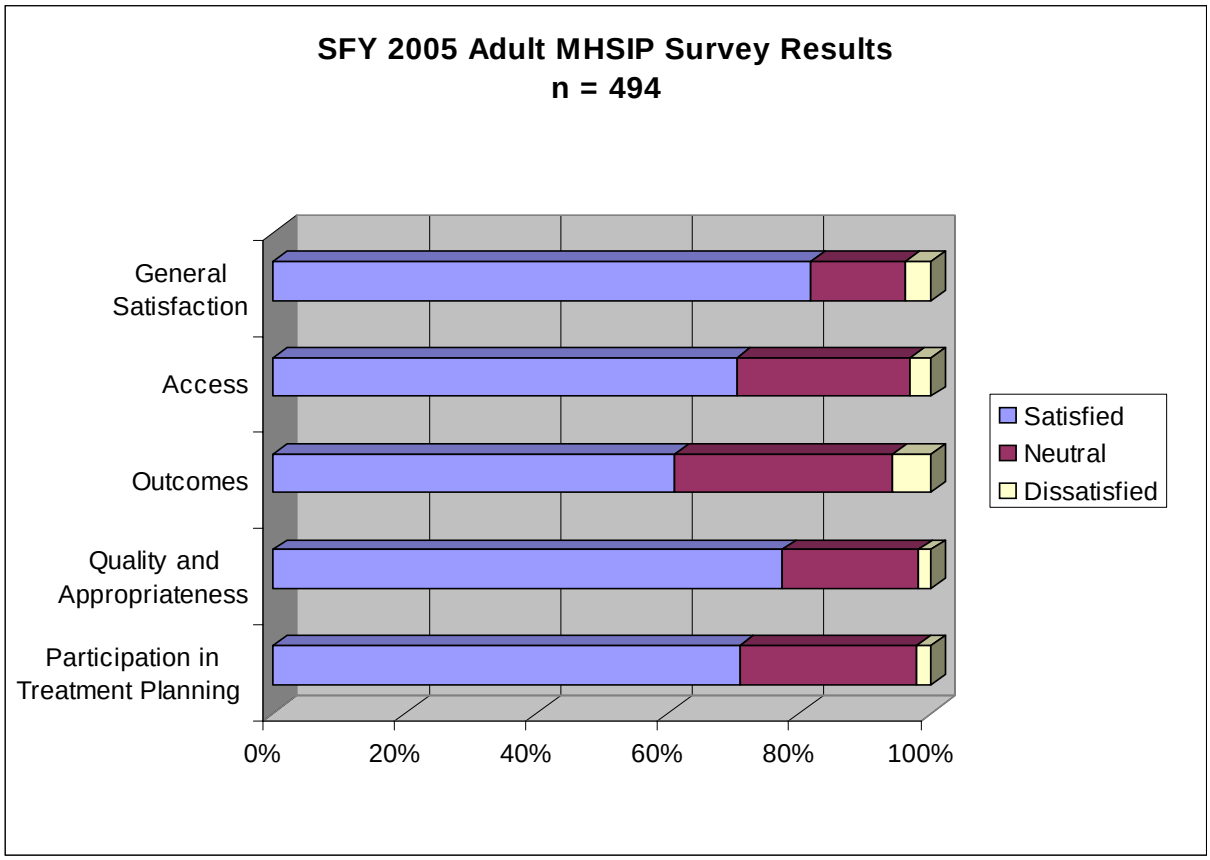
This new measure is proposed for FY05, with data collection to begin in the first quarter. The DBH Policy & Planning section has successfully worked in aligning planning processes with the Alaska Mental Health Trust Authority (AMHTA) and planning boards, creating a master planning document, and supported multiple workgroups that address capacity building for the Alaska system of care. These work groups are on the DBH website for public review and comment. To visit these workgroups online go to: https://dbhssweb.state.ak.us/sites/SSA/default.aspx

As of fall 2004, there were approximately 445 children in out-of-state inpatient psychiatric care. As we await Medicaid claims payments to process for the final months of SFY 2005, the Division is anticipating a decrease in the number of children receiving OOS RPTC services from efforts related to the Bring the Kids Home Initiative.

A3: Strategy - Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.

Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.

Measure #1: Outcome data from Adult Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.



	ADULT MHSIP SURVEY RESULTS					
	2004			2005		
DOMAINS	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
Participation in Treatment Planning	67.30%	29.10%	3.60%	70.90%	26.90%	2.20%
Quality and Appropriateness	69.00%	27.60%	3.40%	77.30%	20.80%	1.90%
Outcomes	55%	39.60%	5.70%	61%	33.10%	5.80%
Access	67.80%	22.00%	10.20%	70.40%	26.50%	3.10%
General Satisfaction	77.10%	16.40%	6.50%	81.70%	14.40%	3.90%

Analysis of results and challenges: The Mental Health Statistics Improvement Project (MHSIP) Survey is an instrument completed by mental health consumers post treatment. The survey is sent directly to consumers and returned to the Division of Behavioral Health for processing. DBH struggled with low historical response rates at the beginning of fiscal year 2004 and through improved efforts have increased the response rate eightfold over fiscal year 2005. During SFY 2006 the DBH has expanded the MHSIP survey to include substance abuse consumers and through improved communication with Providers expects a much higher survey return rate, providing a higher quality data set for analysis which will cover both mental health and substance abuse consumers. There was a 47% increase in the percentage of respondents reporting satisfaction with outcomes. Additionally there was a 6% increase in consumers reporting "satisfied" with general satisfaction between 2004 and 2005 on the Adult MHSIP. A formal MHSIP report is scheduled for release April 2006.

Children's Services

Mission

Promote stronger families, safer children.

Introduction

The Office of Children's Services (OCS) works in partnership with families and communities to support the well being of Alaska's children and youth to provide a wide range of services and support systems. These services include child abuse and neglect prevention services, child protective services, foster care, residential care, family support and family preservation services, adoption and guardianship, permanency planning, and health and nutrition services. Services focus on enhancing families' capacities to give their children a healthy start, to provide their children with safe and permanent homes, to maintain their cultural connections, and to help them realize their potential.

The Office of Children's Services reflects the strengths of the past and the opportunities for the future. Since the department's reorganization in FY 2004, OCS continues to work to bring together the four programs that support children, youth, and families: child protection and permanency, Early Childhood Comprehensive Systems planning, Family Nutrition Services, and the Infant Learning Program.

The Alaska Children's Trust also falls within the OCS. The Trust generates funds and commits resources to community-initiated projects that strengthen families and prevent child abuse and neglect. The Children's Trust awards grants from the net income of the Trust Fund to community-initiated projects on a competitive basis and monitors the approved grant projects for compliance and effectiveness. The Trust solicits contributions through fund-raising activities, gifts and bequests and applies for private and federal grants to increase the value of the fund.

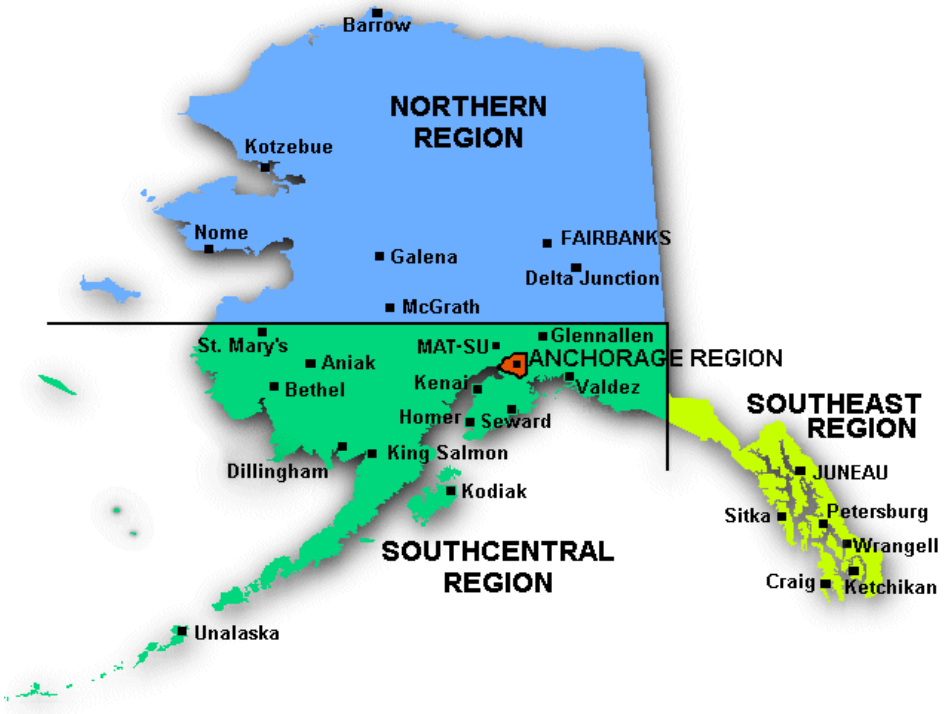
Core Services

- Family Nutrition Services to promote optimal health habits through education, breastfeeding support, obesity prevention, and supplemental food packages (Women, Infants, and Children (WIC));
- Early, home-based intervention and family services coordination to children at risk for developmental delays and their families;
- Development and coordination of community services to strengthen and support families;
- Public awareness and education about reportable harm;
- Child Protective Services to prevent and remedy child abuse and neglect through the assessment of protective services reports and placement with relatives or foster families for those children that are not safe in their own homes;
- Family Preservation and Family Support to allow, when appropriate, a child remain safely with their families;
- Recruitment, training, and licensing of foster and adoptive families;
- Placement options to preserve a child's connection to family, culture, and community that will also meet physical and mental health needs;
- Services that support permanency for children when a return home is not possible;
- Behavioral rehabilitation services for youth who need mental health care; and

- Transitional living services that prepare adolescents in foster care to independent living so that they have the ability to achieve success at the age of independence.

The OCS supports 27 local offices in Alaska that deliver child welfare services. These local offices are managed and supported regionally:

- Northern Regional Office (NRO) in Fairbanks: Nome, Kotzebue, Barrow, and surrounding towns and villages;
- Southcentral Regional Office (SCRO) in Wasilla: Mat-Su Valley, Kenai Peninsula, Bethel, Valdez, Kodiak, Dillingham, Aleutian Islands, and surrounding areas;
- Anchorage Regional Office (ARO) is responsible for Anchorage; and
- Southeastern Regional Office (SERO) in Juneau: Sitka, Petersburg, Ketchikan, and surrounding communities.



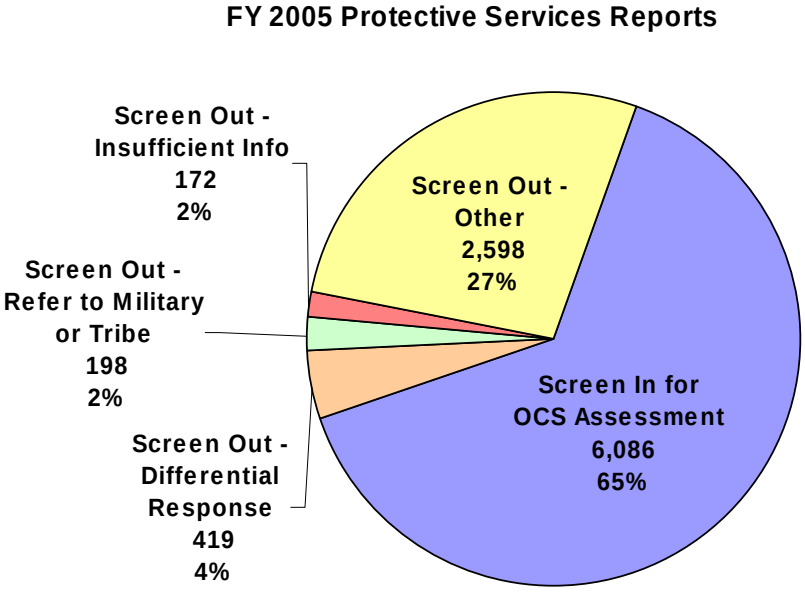
Protective Services Reports

Front Line Workers deliver services to carry out Alaska's legal mandates to prevent and remedy the abuse, neglect, and exploitation of children reported to OCS. This significant responsibility includes the receipt and assignment of protective services reports and the assessment of allegations of child abuse and neglect to determine whether they are substantiated or not substantiated and whether children are safe in their own homes.

During FY 2005 the Office of Children's Services (OCS) received over 9,500 protective services reports.

Chart #1 below shows that 27 percent of protective services reports received were "Screened Out – Other", meaning they did not contain allegations that would lead to an assessment. The remaining percentages illustrate the results of continuing efforts by the state to ensure that all reports that rise to the level of an assessment, and include sufficient information to locate a family, receive a response. This response may include assignment to OCS staff or referral to the Differential Response program (explained below), a Tribal organization, or military agency for assessment.

Chart #1



Source: DHSS Office of Children's Services

Screened In for OCS Assessment includes reports with allegations that meet the criteria for assessment and are assigned to an OCS Front Line Worker.

Screened Out – Other includes duplicative reports and all reports that did not include allegations meeting the criteria for an OCS assessment as follows:

Screened Out - Other	
No alleged maltreatment	1,481
Law enforcement jurisdiction	795
Referred to another state	18
Multiple referrals on the same incident	122
Created in error	182

Screened Out – Insufficient Information reports are not assigned for assessment because there is not enough information to identify and locate the child or the family. OCS received 172 reports that did not provide enough information necessary for assignment to an OCS worker.

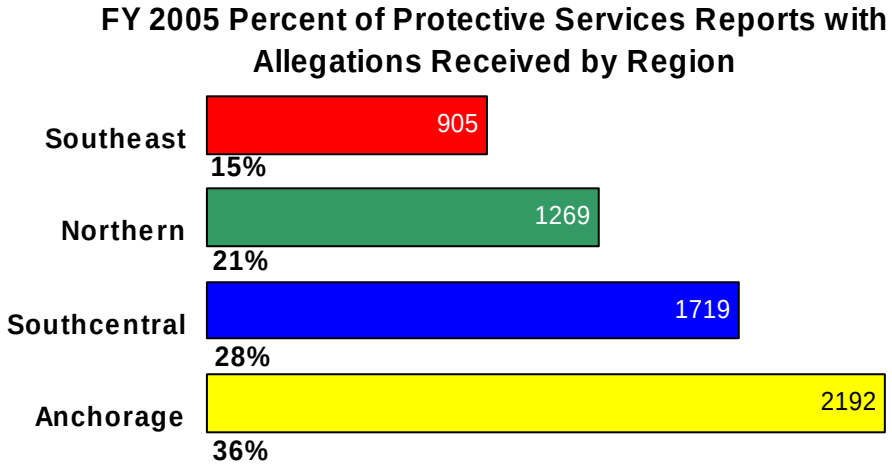
Screened Out – Refer to Military or Tribe includes 134 reports that fall under the jurisdiction of the Military or a Tribe.

Screened Out – Differential Response utilizes the services of community agencies in Wasilla, Anchorage, and Kotzebue to assess low-level protective services reports within their respective areas. The agencies contact families, conduct assessments, and provide preventive services when deemed necessary. Agencies are required to report back to the OCS regarding their contacts and services provided. OCS determines whether the intervention is successful or additional monitoring by OCS is necessary. In FY 2005, OCS referred 419 reports to the Differential Response program.

Protective Service Reports by Region

Protective services reports, as shown in Chart #2, are received by, or directed to, one of the Alaska's four regional offices: Northern Regional Office (NRO), Southcentral Regional Office (SCRO), Anchorage Regional Office (ARO), or the Southeast Regional Office (SERO).

Chart #2



	1997	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*
Southeastern Region	**11%**	**11%**	**12%**	**11%**	**10%**	**11%**	**12%**	**12%**	**15%**
Northern Region	**23%**	**27%**	**25%**	**24%**	**25%**	**26%**	**23%**	**21%**	**21%**
Southcentral Region	**29%**	**27%**	**27%**	**26%**	**29%**	**32%**	**31%**	**31%**	**28%**
Anchorage Region	**37%**	**36%**	**36%**	**39%**	**37%**	**31%**	**34%**	**36%**	**36%**

Source: AK DHSS, Office of Children's Services

Number of Children in Out-of-Home Care by Placement Category

When it is necessary to remove a child from unsafe situations, out-of-home care is required. Front Line Workers investigate allegations contained within protective services reports, and when necessary, arrange for placement in the least restrictive setting.

Options for placement include relative or non-relative foster homes (including unlicensed relatives), pre-adoptive homes, group homes, residential care, or other placements that consist primarily of closely monitored trial home visits. The point-in-time number of children in each out-of-home placement on October 25, 2005 is shown in Chart #3 below. Forty-one percent of children requiring placement were placed in non-relative foster homes and forty-one percent were placed with family members or at home.

Chart #3

Placement Setting/Type	Count	Percent
Foster Family Non-Relative Home	770	41%
Foster Family Relative Home	575	30%
Trial Home Visit	205	11%
Residential Care & Other Facilities	176	9%
Group Home	102	5%
Pre-Adoptive	31	2%
Runaway - Custody Retained	31	2%
Supervised Independent Living	5	0%
Total	**1,895**	**100%**

Source: AK DHSS, Office of Children's Services

Recurrence of Maltreatment

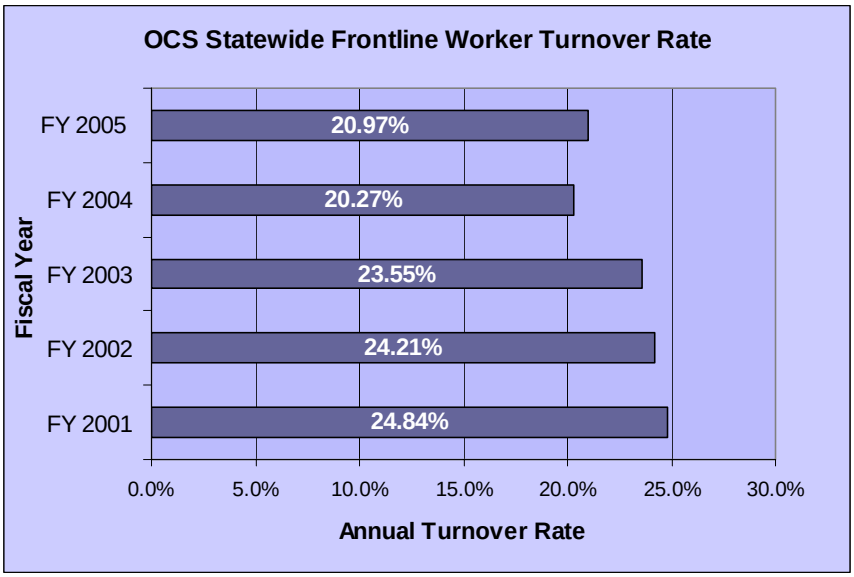
A child is considered to have a recurrence of maltreatment if two or more substantiated protective services reports are received within a six month period and findings indicate that the child had been maltreated.

In 2002, the baseline for substantial compliance with federal criteria was set at 74 percent of cases with no recurrence of maltreatment. OCS has surpassed this goal with 90 percent of cases without recurrence for the quarter ending February 2005, 80 percent for the quarter ending May 2005, and 88 percent for the quarter ending August 2005. Progress in this area will continue as OCS continues to achieve manageable caseloads, builds a well-trained stable workforce, and clear performance standards for staff and grantees are realized.

Front Line Worker Turnover

A key indicator of the successful implementation of the OCS mission is a well-qualified and stable work force with manageable caseloads. The following chart provides a picture of the rate at which the agency's Front Line Worker force turns over.

Chart # 4



Increased workforce retention remains one of OCS's significant challenges and commitments. The OCS continues to focus on improving leadership and accountability by supervisors and management skills. New supervisors are required to attend training one day per quarter during their first year, then quarterly meetings and trainings thereafter. Training and technical assistance has been requested through the National Resource Center on Child Protective Services for assistance in needs assessment and planning to improve supervision. The OCS will continue to utilize training opportunities available through the federal government, Family and Youth Services Training Academy (FYSTA), and the State.

With support from the administration and the legislature, OCS has been able to increase the number of social worker positions and is working toward caseloads that allow the time needed to achieve positive outcomes for children and families and that meet national standards set by the Child Welfare League of America. Standards vary by caseload type, but are generally accepted at 12 to 15 cases per month per worker. More information regarding case loads can be accessed at http://www.cwla.org.

Of the 26 positions OCS received in FY 2005, all are filled. Of the 31 positions received in FY 2006, 21 are filled or in the process of being filled and the remaining are in the process of being developed or are being held for assignment pending the outcome of the workload study. (These numbers are subject to change at any given time.)

The OCS has also contracted with Hornby Zeller Associates, Inc. for a workload study to provide management with the basis for assigning caseworkers reasonable workloads. The study is scheduled to be completed by December 31, 2005, with the final report available by January 30, 2006.

OCS Subsidized Adoption and Guardianship Program

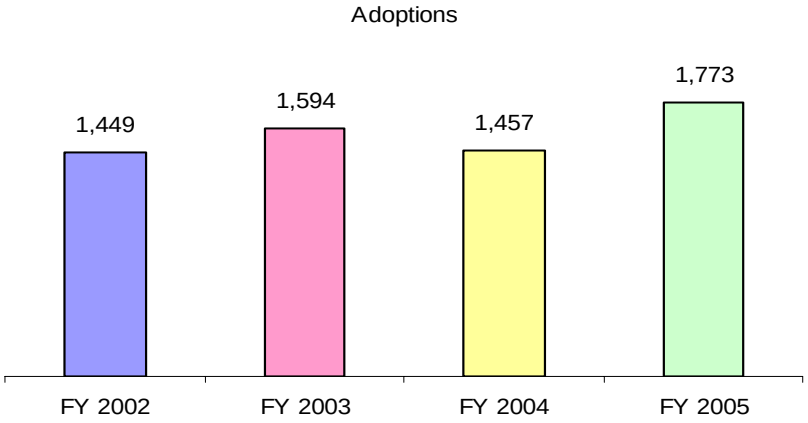
The Subsidized Adoption & Guardianship program facilitates permanent placements in adoptive homes or stable guardianships for the increasing number of children in state custody whose special needs make them hard-to-place. Adoption is viewed as the most permanent placement for a child and is therefore generally the preferable option.

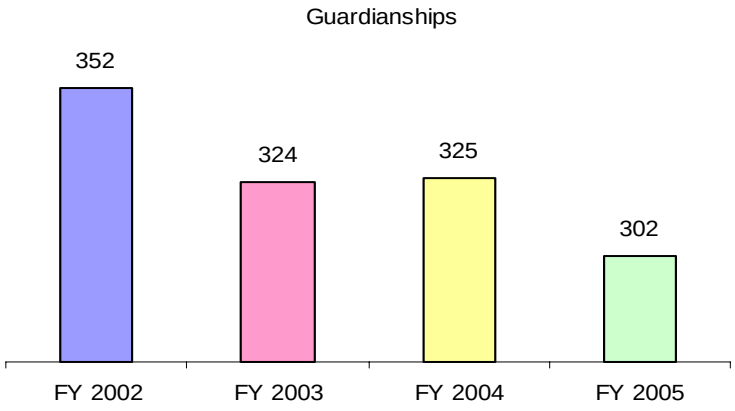
Guardianships are considered for children who cannot be freed for adoption, but for whom a reasonably permanent home can be provided through guardianship. This is often the best choice for children who cannot live with their parents but continue to have an important emotional tie with their families that should not be severed.

Approximately 2,100 children are currently living in permanent homes provided under the Subsidized Adoption & Guardianship program.

The following chart outlines the continued growth of the Subsidized Adoption and Guardianship program at the Office of Children's Services since FY 2002. Over the past four and a half years, the OCS has implemented policy changes to the subsidy program that further defined the parameters of legal guardianship versus adoption for children in OCS custody. OCS is seeing a greater increase in the number of children who are finding permanency through adoption; these numbers are reflected in the following chart.

Chart # 5





Unfortunately, Alaska experiences approximately 75 out of 235 (or 43%), unsuccessful adoptions or guardianships annually for a multitude of reasons. Approximately 40 percent of Alaska's failed adoptions and guardianships occur in rural areas. In an effort to increase the number of successful adoptions in Alaska, the OCS has requested legislative support through appropriated funds that will allow for increases to existing level of support services available to adoptive families. Successful adoption, the desired outcome, could mean the difference between a child becoming a productive citizen or remaining in the social services system throughout the remainder of their lives.

Early Intervention/Infant Learning Program (EI/ILP) Quality Indicators

The following chart shows national trend data related to very young children and EI/ILP services. Identifying children under the age of one is considered a quality-monitoring indicator that illustrates success related to child find (outreach activities that identify children who may qualify for EI/ILP services) and collaboration with primary care such as Newborn Intensive Care Unit centers.

Children, from birth to 36 months, who meet one of the following criteria are eligible for services:

- Developmental delay of 50 percent or greater in one or more areas of development;
- Disabling condition with a high probability of resulting in a 50 percent or greater developmental delay;
- Child's development appears atypical and a multi-disciplinary team determines that the child is likely to have a severe developmental delay.

Children Birth to 1 Year Receiving EI/ILP (Part C) Services in Alaska and in States with Similar Eligibility Definitions
Number and Percent of the State Population

State	2000		2001		2002		2003		2,004	
	#	%	#	%	#	%	#	%	#	%
Average of Moderate States		1.0		0.9		1.0		0.9		0.9
Alaska	102	1.1	94	0.9	92	0.9	90	0.9	83	0.8
Other Moderate States/Territories										
Colorado	825	1.3	466	0.7	453	0.7	444	0.7	505	0.7
Delaware	194	1.9	179	1.7	205	1.9	201	1.8	148	1.3
Illinois	1,450	0.8	998	0.5	1,291	0.7	1,675	0.9	1,954	1.1
Indiana	1,267	1.5	1,501	1.7	1,593	1.9	1,395	1.6	1,456	1.7
Kentucky	500	0.9	473	0.9	432	0.8	325	0.6	251	0.5
Minnesota	384	0.6	388	0.6	457	0.7	472	0.7	282	0.4
Missouri	486	0.7	309	0.4	417	0.6	465	0.6	514	0.7
New Jersey	554	0.5	672	0.6	631	0.6	677	0.6	629	0.5
New York	1,912	0.8	2,313	0.9	2,837	1.1	2,640	1.0	2,793	1.1
Puerto Rico	516	0.9	222	0.4	231	0.4	187	0.3	213	0.4
Rhode Island	165	1.3	181	1.5	220	1.8	227	1.9	214	1.7
South Dakota	59	0.6	82	0.8	62	0.6	70	0.7	97	0.9

Source: Federal Resource Center, Table 8-6 (http://www.federalresourcecenter.org/frc/artbl8_6.xls

The state of Alaska EI/ILP program has made tremendous progress in the reduction of children on the waitlist for services. Only five of the seventeen regional programs had any children waiting for services at the end of June 2005.

In addition to other rigorous targets the EI/ILP system is committed to ensuring that 100 percent of all eligible children receive services including evaluation and the first Individualized Family Services Plan meeting for program planning within 45 days. This ensures that children and families have timely access to services such as special instruction and therapy services.

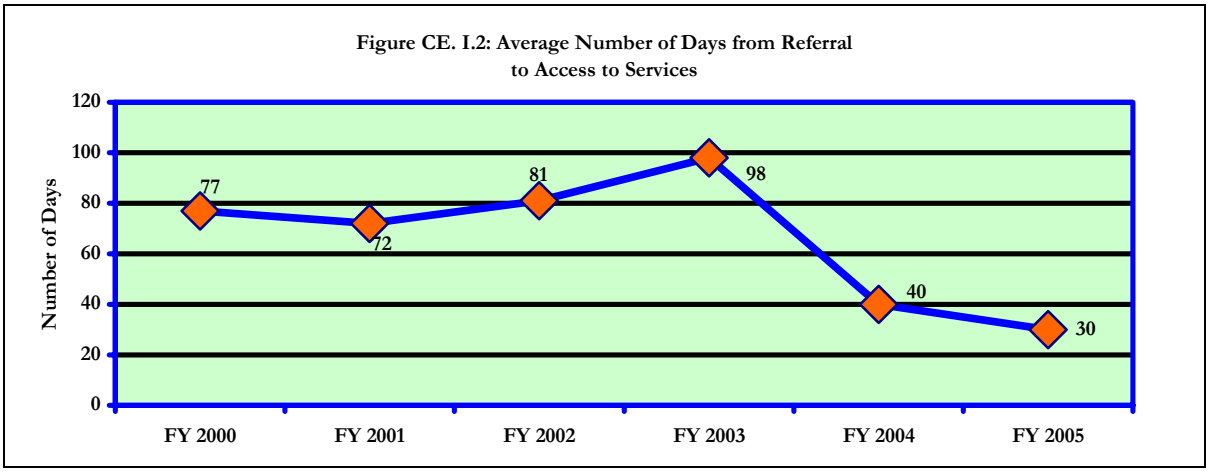


Figure CE. I.2: Average Number of Days from Referral to Access to Services
Number of Days
120
100
80
60
40
20
0
77
72
81
98
40
30
FY 2000
FY 2001
FY 2002
FY 2003
FY 2004
FY 2005

Children in Need of Aid AS 47.10
The Office of Children's Services provides the following child welfare services to meet the mandates of Alaska's child protection and child welfare statutes. These statutes direct that the department shall "arrange for the care of every child committed to its custody" and "pay the costs necessary to ensure adequate care of the child."

Child Protective Services
The purpose of Child Protective Services (CPS) is to identify, treat, and reduce child abuse and neglect, as well as to ensure that reasonable efforts are made to protect and maintain children in their own homes. The OCS staff provides protective services for children by assisting families in assessing allegations of abuse and neglect by protective services reports, referring families to community resources, providing in-home services when available, initiating legal intervention if children are unable to remain safely in their own homes, and providing out-of-home placements and permanency planning when necessary.

Permanency Planning for Children
The child protection workers conduct a comprehensive case planning process directed toward the goal of a permanent, stable home for every child. These case planning activities are directed toward assuring that every child in the state's care has a permanent family, capable of providing them with nurturance and protection.

Licensing AS 47.32
The licensing of community care facilities is a preventive service that reduces predictable risks to the health, safety and well-being of children in out-of-home care through a comprehensive assessment process. Licensing requirements establish acceptable standards of care, while the assessment and monitoring processes provide support and quality control services to the care providers.

Foster Care AS 47.14.100
AS 47.14.100 mandates the Department to provide for the "…care of every child committed to its custody by placing the child in a foster home or in the care of an agency or institution providing care for children inside or outside the state." The Office of Children Services is responsible for finding temporary and permanent homes for children who have been abused and neglected. OCS licenses foster parents, places children in foster homes and helps make sure foster parents get the support they need.

Foster Care Transition Program AS 47.18
AS 47.18 300-390 requires the Department to provide support and services to youth in custody, who reach or have reached the age of 16 and older while in foster care and who are likely to remain in foster care until reaching the age of 18, to support their successful transition from state custody to self-sufficiency. AS 47.18 also authorizes the Department to provide continuing support and appropriate services to former state foster care recipients, age 16 to 21, to achieve self-sufficiency.

Subsidized Adoption & Guardianship AS 25.23 and AS 47.10
The Subsidized Adoption & Guardianship program is an adoption incentive program for children with special needs. This program transitions children from foster care into permanent homes. The subsidy payment covers the cost of the child's special needs and is available to the family until the child reaches age 18. Post adoption services are provided to families that need assistance in

adjusting to the family changes that often occur as a result of adoption or guardianship.

Residential Care AS 47.07
Residential care facilities provide treatment services within a therapeutic environment that is staffed 24 hours a day. Residential care facilities may offer short-term emergency assessment and evaluation as well as more long-term and intensive residential treatment. Placement in a residential facility is for a specified period of time, and generally occurs only after less restrictive placement options have been found inappropriate or have been exhausted. Regional placement committees, chaired by a psychiatric nurse, determine the necessity for residential treatment. The OCS monitors the quality of treatment provided by residential facilities and currently funds approximately 190 beds.

Family Support Services AS 47.10
Family preservation and support services help families (including adoptive and extended families) at risk or in crisis. These programs help children return home after removal, provide follow-up care to families after a foster care placement, provide temporary respite care to parents and other caregivers and provide services to improve parenting skills in matters such as child development, family budgeting, coping with stress, health, and nutrition.

Infant Learning Program AS 47.20.005-050
The Infant Learning Program provides early intervention services to children, birth to three years of age, with disabilities or developmental delays or at risk for developmental delays and their families. Services may include screening, assessment, special instruction, family support and therapies and are designed to meet each child's unique developmental needs.

Developmental screenings provide an opportunity for CPS and EI/ILP to work together to enhance family supports. Findings from these developmental screenings are used to identify children and families who are eligible and could benefit from specialized services to improve early childhood outcomes. In Alaska, in FY05, 13.2% of children referred to the Infant Learning Program were made by child protective services.

Family Nutrition Services (WIC) AS 18.05.010-070; AS 44.29.020
Family Nutrition Services encompass six programs that provide $26 million in federal grants and $3 million in program receipts to program participants in the form of food, nutrition education, breastfeeding support, and resources on obesity and chronic disease prevention. The six programs are the Farmers' Market, Senior's Farmers' Market, Commodity Supplemental Food, 5 A Day for Better Health, Alaska Food Coalition, and the Women, Infants and Children's Supplemental Nutrition Program or WIC. Participants include pregnant, breastfeeding, or postpartum women and their children 0 to age 6 who must also meet income and nutrition risk criteria as well as income eligible senior citizens. During FFY 05, WIC had a yearly caseload of **321,899** clients with average monthly participation of 26,838. Every $1.00 spent in WIC saves $3.00 in Medicaid costs. A measure of the program's success is Alaska's breastfeeding initiation rate of 81.8%, the 8th highest in the nation.

The **Early Childhood Comprehensive Systems Project (ECCS)**
The ECCS is funded through the federal Maternal and Child Health Bureau. It is designed to bring partners from around the state together in a collaborative effort to review existing systems for children prenatal through age eight and plan for their improvement. The critical components of the ECCS plan will include access to 1) comprehensive pediatric services and medical homes; 2) social-emotional development and mental health services for young children; 3) early care and education, 4) parenting education, and 5) family support. The goal is to ultimately implement more

family-centered, coordinated, prevention-oriented, and adequately financed systems of services to support the health and development of young children.

Alaska Children's Trust (ACT) Program AS 37.14

The ACT is housed in the Office of Children's Services. The OCS supports the ACT in carrying out its mission to prevent child abuse and neglect through grants to community-based projects. In FY06, there are eight community-based prevention grants that focus on parenting education and/or community approaches to prevention and wellness. The ACT is also the recipient of a federal 2005 earmark through the Department of Justice, Office of Juvenile Justice and Delinquency Prevention to conduct a statewide social marketing campaign. Currently, radio, television and newspaper advertisements speak to the public about positive parenting messages and early brain development, and funds a Parent Line to answer parenting questions.

Office of Children's Services	2006	2007 Proposed	06 to 07 Change
General Funds	54,991.7	59,568.5	4,576.8
Federal Funds	76,920.9	80,955.1	4,034.2
Other Funds	9,741.1	9,901.7	160.6
Total	**141,653.7**	**150,425.3**	**8,771.6**

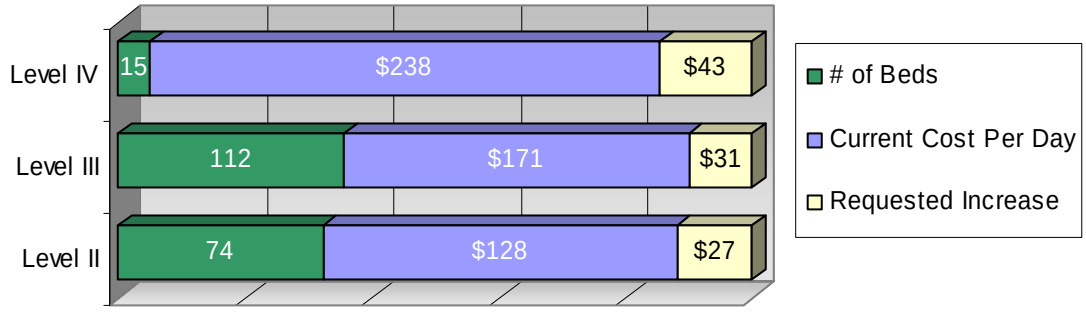
Children's Services Medicaid

Medicaid Behavioral Rehabilitative Services Rate Increase for Children in Custody $1,285.7 Federal; $928.3 General Fund Match

Medicaid Behavioral Rehabilitative Services (BRS) include crisis intervention, family, group, and individual psychotherapy, and pharmacological management. Children in need of BRS may have mental, emotional, and behavioral disorders or developmental disabilities resulting from substance abuse and/or mental illness of the parents. They may exhibit symptoms such as anti-social behaviors; mental disorders; drug and alcohol abuse; or sexual behavior problems that impair their ability to function in family or community roles.

Alaska's BRS providers have not received a rate increase since development of the program in 2000. An estimated 65 percent of our BRS providers are diverting other funds to keep services in place for custody children. Diverted funds could otherwise provide services to children with needs currently met out-of-state, facility infrastructure; workforce development; and staff training and development.

Behavioral Rehabilitative Services Rate Increase for Children in Custody



The OCS has asked the Legislature to fund a rate increase of 18 percent per day per bed to reimburse providers for their costs and for an augmented rate of $3.70 per day for Level II beds. Level II facilities serve youth with the most egregious behaviors in emergency placements and stabilization capacity until the appropriate acute care services are arranged.

Bring the Kids Home – Expand Behavioral Rehabilitation Services (BRS) $1,250.0 Federal; $1,250.0 General Fund/Mental Health

Bring The Kids Home (BTKH) is an initiative to return children with severe emotional disturbances from behavioral health care in out-of-state residential facilities to in-state or community-based care. It will reinvest funding that currently provides expensive distant care to in-state services and capacity development to serve children closer to home, keep families more involved and intact, and more effectively carry out transitions and discharges.

Funding for existing services has often been inadequate and has led to the lack of a fully implemented continuum of care in Alaska. With financial support, this initiative will focus on successfully building upon the existing infrastructure. This approach is intended to assist in the development of expanding existing programs to treat children and youth in their own community and state.

This funding will also allow utilization of additional beds that exist in residential facilities for non-custody children. It has been determined that there are approximately 50 additional beds at a variety of levels of care which will become available and will provide access for non-custody children to a wider range of in-state care, allowing families and children to remain closer together, keeping families engaged in their children's care, and facilitating transitions and shorter lengths of stay.

If funding is received it will enable existing, but un-utilized, BRS residential beds to be "purchased" and accessible to non-custody children, who may otherwise be placed in a higher level of care than is justified, and/or placed in an out of state institution.

Bring the Kids Home – Regional Out-of-State Placement Committees $100.0 Federal; $100.0 General Fund/Mental Health

From 1998 to 2004 there was an across the board increase to the number of Alaska children served in out-of-state residential psychiatric treatment centers. During this period, the increase for custody children went from 17 children in 1998 to 56 children in 2004. During this same time period, the utilization increase for non-custody children went from 66 children in 1998 to 693 children in 2004.

This funding will provide adequate staffing of the regional and out-of-state placement/resource committees to increase their capacity to provide gate keeping functions. These teams currently provide these functions only for custody children. Through this funding, the teams will begin to serve non-custody children looking for referrals to residential care.

Based on the current level of referrals, two new staff in the OCS will be required to serve non-custody children.

Medicaid Behavioral Rehabilitative Services Rate Increase for Non-Custody Children $580.0 General Fund/Mental Health

The Department is about to complete a rate study for residential care, which will identify the actual cost of providing Behavioral Rehabilitation Services (BRS) at each level of care. This BRS Rate Study will form the basis for an anticipated rate increase at all levels of care.

OCS has proposed an overall rate increase of approximately 18% for beds for kids in their custody. This proposal would provide the same increase for the 50 non-custody beds proposed in a separate increment in this component, and 88 new beds, half of which are currently in development around the state under BTKH funds or are proposed for development in FY 07. This would let us bring

custody and non-custody rates into alignment. We can take into account the desire to prioritize services for custody children by ensuring that the core capacity rate for custody children is higher than the core capacity payment for non-custody children. This will allow for consistency in the rate for the actual treatment services.

ORCA (Online Resources for the Children of Alaska) Services Ownership and Upgraded Infrastructure $255.0 Federal; $255.0 General Fund Match; $240.0 General Fund

The ORCA information system went live in September 2004, only six weeks behind its original schedule. The extremely complex financial and payment system went live in February 2005, 22 months after project inception. Typical system development time nationwide is 4 to 5 years. Alaska's achievement is noteworthy.

On September 7, 2005, the ORCA system was recognized by two prestigious, independent organizations, the Center for Digital Government and the American Public Human Services Association - Information Systems Management:

> "The Center for Digital Government Award" honored Alaska's new Online Resource for the Children of Alaska (ORCA) system, which provides the State's over 450 social workers spread across 33 geographically dispersed locations with the ability to instantly share information on the more than 10,000 child abuse and neglect cases that are investigated annually.
>
> Richard Varn, senior fellow at the Center for Digital Government, presented the award to CGI-AMS noting that, "the Center recognizes CGI-AMS and the State of Alaska for its transformational ORCA system. We conducted a thorough nationwide review and the ORCA project stands as one of the finest examples of technology advancing a critical public service offering."
>
> Alaska's social workers can access case records in real-time through a Web-based system that supports child abuse, foster care, adoptions, and financial processing. Best practices in areas of risk assessment, placement, and payment processing are fully supported. ORCA was implemented in 14 months [sic]."

www.cgi.com/web/en/news_events/news_flashes/2005/65192.htm (OCS Note: the actual implementation took 17 months.)

In September 2005, the U.S. Department of Health and Human Services conducted an assessment of ORCA. Federal reviewers visited 5 locations and interviewed nearly 100 OCS staff about ORCA. The review, while in draft status, notes that

1. Prior to ORCA, Alaska had spent over $6.0 million in federal funds and made no significant progress toward implementing a system;

2. Alaska has made significant progress in meeting federal requirements and is no longer in jeopardy of having to pay back matching Title IV-E funds expended during the previously failed development effort;

3. OCS workers are embracing ORCA as a system that supports the OCS business model;

4. Performance related concerns relate to bandwidth issues; and

5. Preliminary findings have identified that staff need additional help desk and training support to leverage the functionality available in the ORCA system.

This request will provide the OCS adequate funding to continue contracted services for the more complex and high profile portions of the ORCA application such as financial processing, financial reporting, and provider payments; funds the level of help desk support required for the OCS to function at an optimal level; and network infrastructure upgrades for regional sites that experience extreme communication delays and productivity loss due to the slow performance of network connections.

Enhanced Post-Adoptive Services $89.7 Federal; $89.7 General Fund Match; $50.6 General Fund

OCS is requesting additional funds to support Post-Adoption Services (PAS) for Adoptive and Guardianship families. These services prevent the disruption and dissolution of finalized adoptions and guardianships through the provision of necessary services and support to families. Successful adoptions and guardianships could mean the difference between a child becoming a productive citizen or remaining in the social services system throughout the remainder of their lives.

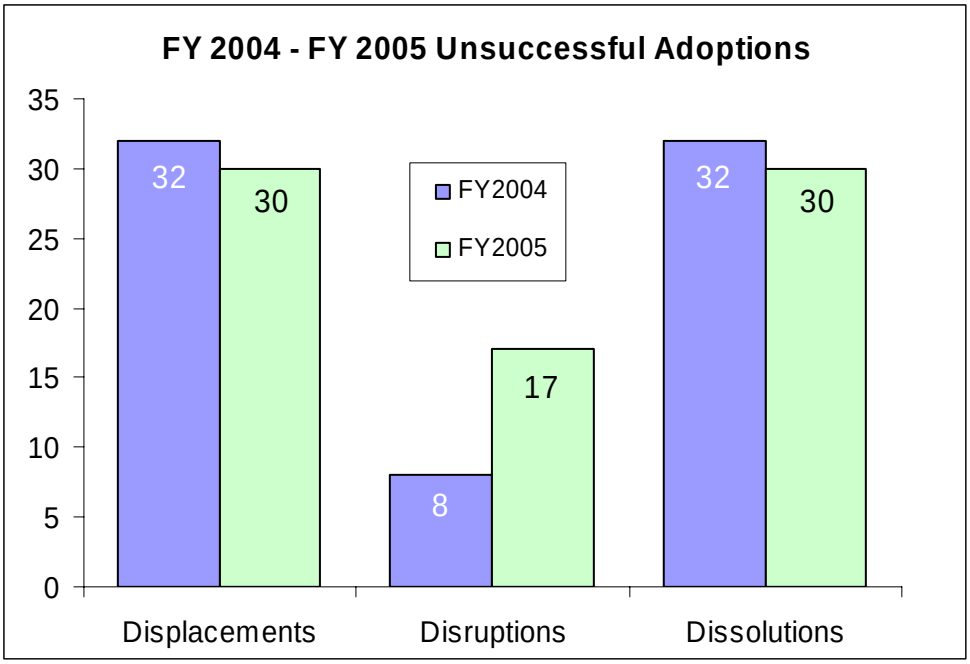
This funding will allow OCS to increase the existing level of support and, in particular, to the rural areas of Alaska. Approximately 40 percent of Alaskan adoptions and guardianships that disrupt, dissolve, or are displaced occur in rural areas.

An adoption or guardianship is disrupted when the adoption process ends after a child is placed with a family but before the adoption is finalized; a dissolution is an adoption that ends after the legal adoption is finalized; and a displacement occurs when a child is placed outside of the adoptive home, but the adoptive parents are still involved. An adoption is most likely to disrupt or dissolve within the first 3 years. Adoptive families undergo enormous struggles and face serious barriers in obtaining needed services. (Source: "Adoption Disruption and Dissolution: Numbers and Trends", National Adoption Information Clearinghouse, 2004.)

Alaska's adoption "pipeline" serves approximately 1,800 continuing adoptions, 200 new adoptions, 325 continuing guardianships, and 35 new guardianships annually. Most adoptions have positive outcomes for children and their families, but many families need supportive services during some part of their child's development.

Alaska specific data is provided below:

	FY 2004	FY 2005
Displacements	32	30
Disruptions	8	17
Dissolutions	32	30
Total	72	77



In FY 2005, 77 of 235 children's adoptions or guardianships were displaced, disrupted or dissolved for the following reasons:

18	Children were returned to the custody of OCS
4	Placed in a Youth Facility
4	Parents/guardians dissolved the adoption/guardianship
16	Children ran away
5	Children returned to biological family
7	Adoptive/guardian parent died
23	Children were placed in residential care facilities with adoptive parents still Involved

In Alaska, current services do not adequately meet the needs for adoptive or guardianship families, in particular, those outside of the major urban areas (Anchorage, Fairbanks, Juneau) of Alaska. With increased services, the OCS expects to see fewer displacements, disruptions, and dissolutions than currently occur.

Expand Adoption and Guardianship Homestudy Contract $55.5 Federal; $55.5 General Fund Match; $36.3 General Fund

The OCS contracts with Catholic Community Services and Fairbanks Counseling and Adoption to complete homestudies for permanent families and guardianships. Homestudies are conducted on every potential adoptive family. In essence, homestudies find the home safe for the child, determine what type of child is best suited for the family, and what training or support the family may need to meet the child's needs.

Current contract amounts no longer cover the increased number of homestudies required under the OCS federal Program Improvement Plan, which mandates improvement in the state's ability to find permanent homes for children who cannot be returned to their homes within a 24-month period. Nor do the current contracts cover increases in the costs associated with costs such as travel, criminal

background checks, and fingerprinting. This request increases funding to the level necessary to cover actual costs of the homestudies and an estimated 30 additional homestudies required in FY07.

WIC Information System Replacement $287.0 Capital Improvement Project Receipts
The Women, Infants, and Children (WIC) Program requests Capital Improvement Project receipt authority to support the development and implementation of the new federally-funded Management Information System. The comprehensive information system will automate the following functions: certification, nutrition risk assessment and issuance of supplemental food vouchers and will support the department's commitment to provide nutrition education and supplemental foods to income-qualified WIC participants

This request includes the addition of three positions, one Project Coordinator and two Project Assistants. These positions are critical to the success of the project and will ensure that the contractor's deliverables are reviewed and approved in a timely manner. These positions will coordinate with the programming staff and the implementation contractor, participate in both the development and implementation of the system, and serve as part of the management team to complete the plan. These positions are also necessary to analyze, design, code, test, debug, document, and modify the WIC Information System, and to support and install workstations and servers.

Contribution to Department's Mission

Promote stronger families, safer children.

Core Services

- Investigate reports of harm and in-home services to children at-risk.
- Permanency planning for children in out of home care.
- Treatment services, early intervention and family nutrition services.
- Prevent and remedy child abuse and neglect.

Department Level Measures

C: Result - Outcome Statement #3: Children are, first and foremost, protected from abuse or neglect.

Target #1: Reduce child abuse rate in Alaska.
Measure #1: Percent change in rate of substantiated protective service reports in Alaska compared to last three years.

Protective Service Reports

Fiscal Year	Rate	% Change
FY 1999	27.3	0
FY 2000	29.4	7.7%
FY 2001	32.2	9.5%
FY 2002	27.6	-14.3%
FY 2003	23.0	-16.7%
FY 2004	22.3	-3.0%
FY 2005	11.0*	0

With the implementation of ORCA, new methods of measurement in compliance with federal standards have been used. As a result, FY 2005 data is not comparable to FY 1999 through FY 2004. The FY 2005 measure represents an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. Population equals the number of children under the age of 18 years as of July 1, 2004, as estimated by the Department of Labor. Data reported prior to FY 2005 can be duplicative.

Analysis of results and challenges: Since 2003, the OCS has been operating under a program improvement plan (PIP) developed in response to findings of the Federal Child and Family Services Review (CFSR). A major focus of the PIP has been to improve the safety of children including reducing repeat child abuse and neglect, reducing the recurrence of maltreatment, reducing the incidence of maltreatment by out-of-home care providers, establishing sufficient staffing levels to meet national caseload standards, and increasing services to families. The number of substantiated protective service reports is one measurement that will indicate improvement in these areas.

OCS has transitioned from the old "PROBER" data system to the new ORCA data system. As a result, the method of measuring these reports has changed, and data definitions between the two systems are not comparable. New measurements are in compliance with federal requirements and count protective services reports and investigations by case. This is a change from the Report of Harm measurement used in FY 1999 through FY 2004 which counts by child. Measures listed below will begin to establish a new base line for protective service reports measurements.

SFY 2005 Protective Services Reports
Received 9,576
OCS Jurisdiction 6,944
Investigated 3,493
Substantiated 1,310
Other Finding 2,183

"Received" includes 1) referrals where no maltreatment is found, 2) that are not under OCS's jurisdiction, 3) those still in the screening process.

"OCS Jurisdiction" includes reported allegations of harm that could lead to an OCS investigation -- those assigned for an OCS investigation; those referred to dual track, a tribe, or the military; and those that cannot be assigned because there is not enough information to identify or locate the child and/or family. Multiple referrals for the same incident are counted as one referral.

"Investigated" counts the number of completed investigations, but excludes responses provided by dual track, a tribe, or the military.

"Substantiated" counts the number of investigations in which at least one allegation of harm was substantiated.

"Other Finding" includes investigations where no allegation was substantiated as well as those without finding. Investigations without findings include, for example, a report that does not include enough information to locate the child/family.

Target #2: Maintain rate of recurrence of maltreatment at 16% or less.
Measure #2: Of all children for whom a substantiated or indicated report of child abuse and/or neglect was received during the first six months of the period under review, for what percentage was another substantiated or indicated report received within 6 months?

Repeat Maltreatment by Federal FY (from CFSR/PIP reporting)

Fiscal Year	Alaska Rate	National Standard
FFY 2000	23.6%	6.1%
FFY 2001	25.4%	6.1%
FFY 2002	22.6%	6.1%
FFY 2003	17.6%	6.1%
FFY 2004	17.3%	6.1%

FFY04 information includes only April 2003-March 2004.

The OCS is unable to update this measure for 2005. Data is expected to be available March, 2006. ORCA code and data for this measure is currently being tested.

Analysis of results and challenges: Repeat Maltreatment by Federal Fiscal Year

OCS exceeded its initial target of 22% or less by December 2004 and continues to implement strategies to reduce the rate even further setting a new target at 16%.

An important goal for OCS during the past year has been to reduce safety and risk factors for children by improving assessments. A statewide computerized safety and risk assessment system has been developed to provide structure to decision making at the most critical stages in a child

protection case. Further improvements in the assessment process will be implemented during the next year with technical assistance from the National Resource Center for Child Protection Services.

Policies, procedures, and definitions for in-home cases have been clarified. Standards for in-home casework have been developed and casework on in-home cases has been implemented statewide. Team Decision Making (TDM) has been implemented in the Anchorage Region. Community-based family preservation service contracts have been redesigned to focus on services to families that prevent removal and to decrease the repeat maltreatment rate.

Target #3: Increase the rate of children reunified with their parents or caretakers within 12 months to 57.91% by September 2006.

Measure #3: The number of children reunified with their parents or caretakers at the time of discharge from foster care, in less than twelve months from the time of the latest removal from home.

Rate of Reunification

Fiscal Year	Alaska Rate	National Standard
FFY 2001	62.4%	76.2%
FFY 2002	53.3%	76.2%
FFY 2003	59.3%	76.2%
FFY 2003	55.6%	76.2%
FFY 2004	54.7%	76.2%

2003 at 55.6% represents January - December 2003
2004 at 54.7% represents April 2003 - March 2004

Data source: Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) files. The change in time period reported corresponds to AFCARS submissions produced from ORCA.

NOTE: With the transition from the OCS PROBER data system to the new ORCA data system, data definitions, policies, and collection procedures have changed. The data extraction methodology used for this measure has also changed. While the underlying federal methodology for computing this measure remains the same, measures computed from different systems should not be considered comparable.

Analysis of results and challenges: This measure represents the length of time to achieve reunification: Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percent were reunified in less than twelve months from the time of the latest removal from home?

In August 2005 a new baseline of 56.7% was established for this measure. The newly approved federal PIP goal is 57.91% within one year.

OCS has taken the following steps to address reunification issues within the past year:

- Administrative case review policies and procedures have been reviewed and revised to ensure that reunification efforts are being made and to ensure that reunification assessments are being completed;
- The Supervisory review process has been improved to address the frequency of supervisory meetings with workers and the quality of casework and appropriateness of the case plan and services.
- Requirements for private providers that provide Family Preservation and Time-Limited Family Reunification services have been more clearly delineated regarding the type of services OCS will require to help families meet their case plan goals towards reunification; and

- Alaska has participated in the Casey Family Program's Breakthrough Series collaborative on Supporting Kinship Care. In this series, child welfare agencies and tribes share a commitment to improving the way we identify, partner with and support kinship caregivers

During the next year OCS will continue work to:

- Increase the use of reunification assessments through SDM, and continue training workers on these assessments;
- Continue to fund Time-Limited Family Reunification programs and develop process for evaluating efficacy of these programs;
- Increase access and availability of services in parents' home communities, especially substance abuse treatment and follow-up services;
- Further develop a Kinship Care Program; and
- Collaborate with tribal partners to develop safety net services in remote areas.

C1: Strategy - Reduce caseloads of frontline workers.

Division Level Measures

A: Result - Outcome Statement - Children who come to the attention of OCS are, first and foremost, protected from abuse or neglect.

Target #1: Improve the ability of at-risk families to care for their children safely (free from abuse or neglect).
Measure #1: Decrease the rate of repeat maltreatment.

Analysis of results and challenges: From September 2003 through August 2005, the Office of Children's Services (OCS) has been operating under a Program Improvement Plan (PIP) developed in response to findings of the Federal Child and Family Services Review. A major focus of the PIP has been to improve the safety of children, including reducing repeat child abuse and neglect. Goals included reducing the recurrence of maltreatment, reducing the incidence of maltreatment by out-of-home care providers, establishing sufficient staffing levels to meet national caseload standards, and increasing services to families aimed at keeping children in their homes or to be reunified whenever possible.

A1: Strategy - Reduce the percentage of children placed outside the home who are the subject of maltreatment by a provider.

Target #1: The target for this measure is to meet the national standard of .57% or less.
Measure #1: Of all children placed outside the home during federally defined periods, what percentage were victims of substantiated or unconfirmed maltreatment by the out-of-home care provider.

Percentage of Children Maltreated by an Out-of-Home Care Provider

Year	YTD Total
1998	1.87%
1999	1.29%
2000	1.91%
2001	2.00%
2002	2.09%
2003	1.35%
2004	1.20%

This measure represents the percentage of children placed in out-of-home care who are maltreated by a provider as compared to the total number of children in out-of-home care.

To conform to federal standards, the percentage for this measure is calculated on the nine month period from January through September.

Analysis of results and challenges: Since 2003, OCS has been operating under a program improvement plan (PIP) developed in response to findings of the Federal Child and Family Services Review (CFSR). One goal of the PIP was to reduce maltreatment by out-of-home care providers. The agency has developed standards for unlicensed relative caregivers and has worked to improve foster parent screening and training. OCS has also worked to improve consistency in classifying these incidents and data quality.

At the time of the federal CFSR, the rate of abuse in out-of-home care was 1.91 percent. During the past two years, OCS has been able to reduce the rate to 1.20 percent, which exceeded its original target of 1.77 percent. Alaska's rate, while improved, is still high, and the ultimate goal is to meet the national standard at 0.57 percent.

OCS continues efforts to reduce the maltreatment of children by out-of-home care providers. Currently, a major initiative is underway, known as the Resource Family Assessment. This initiative provides for more comprehensive assessment and training of potential out-of-home care providers designed to better ensure the safety of children placed in these homes. Initially implemented in the Anchorage Region, OCS is in the process of expanding the new assessment process throughout the state.

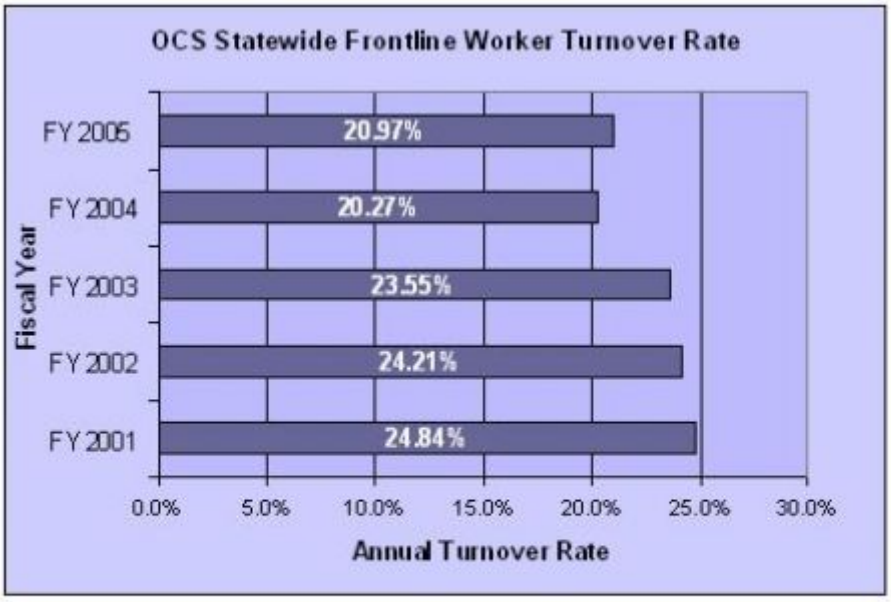
Standards for unlicensed relatives were developed and implemented during the past year. Unlicensed relative caregivers have also been included in the FLAG project, which enables OCS to receive notification if an unlicensed relative has an interaction with law enforcement.

It should be noted that in 2004, the federal government's reporting period of January through September crossed Alaska's conversion dates for the new OCS management information system, ORCA (Online Resources for the Children of Alaska). Therefore, the 2004 percentage is calculated on the nine-month period October 2003 through June 2004.

Data for the period from January through September, 2005 is expected to be available March, 2006. ORCA code and data for this measure is currently being tested.

A2: Strategy - Retain an effective and efficient workforce.

Target #1: Reduce the turnover rate to 15 percent.
Measure #1: Annual employee turnover rate.



Front Line Social Workers Statewide Turnover Rate by State Fiscal Year

Year	YTD Total
2001	24.84%
2002	24.21%
2003	23.55%
2004	20.27%
2005	20.97%

Analysis of results and challenges: With support from the administration and the legislature, OCS has been able to increase the number of social worker positions and is working toward caseloads that allow the time needed to achieve positive outcomes for children and families and that meet national standards set by the Child Welfare League of America. Standards vary by caseload type, but are generally accepted at 12 to 15 cases per month per worker. More information regarding case loads can be accessed at http://www.cwla.org.

The OCS has also contracted with Hornby Zeller Associates, Inc. for a workload study to provide management with the basis for giving caseworkers reasonable workloads. The study is scheduled to be completed by December 31, 2005.

Of the 26 direct service positions OCS received in FY 2005, all are filled as of this date. Of the 31 direct service positions received in FY 2006, 21 are filled or in the process of being filled and the remainder are in the process of being developed or are being held for assignment pending the outcome of the workload study.

OCS continues to focus on improving leadership and accountability by supervisors and management skills. New supervisors are required to attend statewide quarterly meetings and training sessions. Training and technical assistance has been requested through the National Resource Center on Organizational Improvement for assistance in a needs assessment and planning process to improve supervision. The OCS will continue to utilize training opportunities available through the federal government, the Children's Services Training Academy, and the state.

A3: Strategy - Provide nutrition intervention to improve health status of women, infants, and children in Alaska (Clients eligible under WIC).

Target #1: Pregnant, breastfeeding, and postpartum women, infants, and children age 0 to 5 years eligible for WIC are receiving benefits.

Measure #1: Target population of 80 percent of Alaska's WIC USDA eligible population is served or exceeded.

Percentage of Target Served by State Fiscal Year

Year	YTD Total
2000	102%
2001	95%
2002	101%
2003	103%
2004	106%
2005	109%

Analysis of results and challenges: The agency's target is to serve 80 percent of Alaska's eligible population. In SFY 2005, WIC provided benefits and services to an average of 26,865 participants per month. This represents 109 percent of the agency's 80 percent target.

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Health Care Services

Mission

Manage health care coverage for Alaskans in need.

Introduction

Under the Department of Health and Social Services (DHSS), the Division of Health Care Services (HCS) maintains the Medicaid core services including hospitals, physician services, pharmacy, dental services, and transportation. Other Medicaid core services maintained by the division include physical, occupational, and speech therapy; laboratory; radiology; durable medical equipment; hospice; and, home health care. On a department-wide basis, HCS administers the following:

- State Children's Health Insurance Program (SCHIP)
- Medicaid Management Information System (MMIS)
- Claims payments and accounting
- Third-party liability collections and recoveries
- Federal reporting activities
- Medicaid financing activities
- Chronic and Acute Medical Assistance Program

In addition, the division's major goal has been to support services through management efficiencies and the capitalization of Medicaid financing.

Health Care Medicaid Services

- In SFY05 Health Care Services Medicaid provided benefits to nearly 125,000 Alaskans, 95% of the 131,000 enrolled.

- Health Care Medicaid Services experienced an approximate 6% rate of growth from FY04 to FY05. While the overall growth was about 6%, growth in direct services was around 11%. Direct service's growth is mostly due to increases in the number of clients served. The number of recipients rose an average of 9% while the cost-per-recipient rose 1%.

- Most of the increased cost for FY05 can be attributed to Physician Services and Hospitals. Hospitals and Physician Services comprise 61% of the total costs for this component. Physician Services grew 18% from FY04 to FY05. Hospitals grew 7% during the same period.

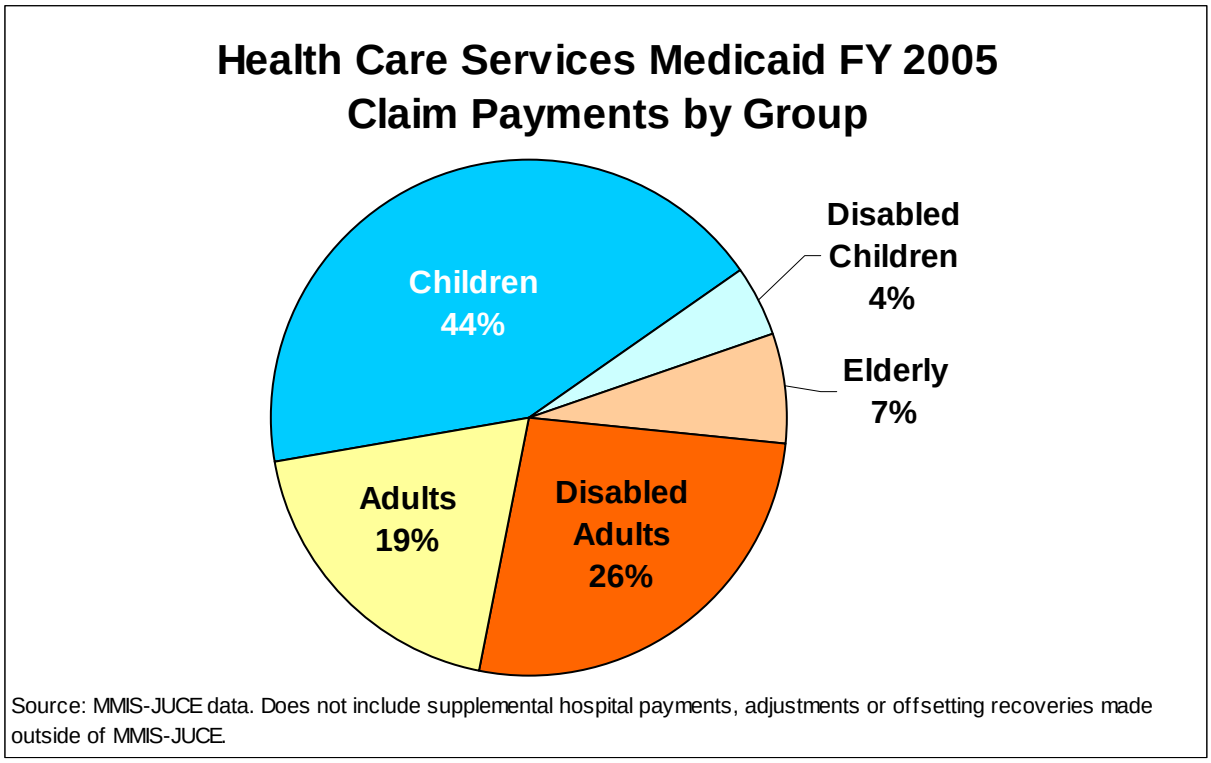
- Children received nearly half (48%) of the dollars spent on Health Care Services Medicaid claim payments. Claim payments for Adults represented 45% of Medicaid payments for benefits, while the Elderly accounted for just 7%.

Number of Medicaid Beneficiaries in FY 2005

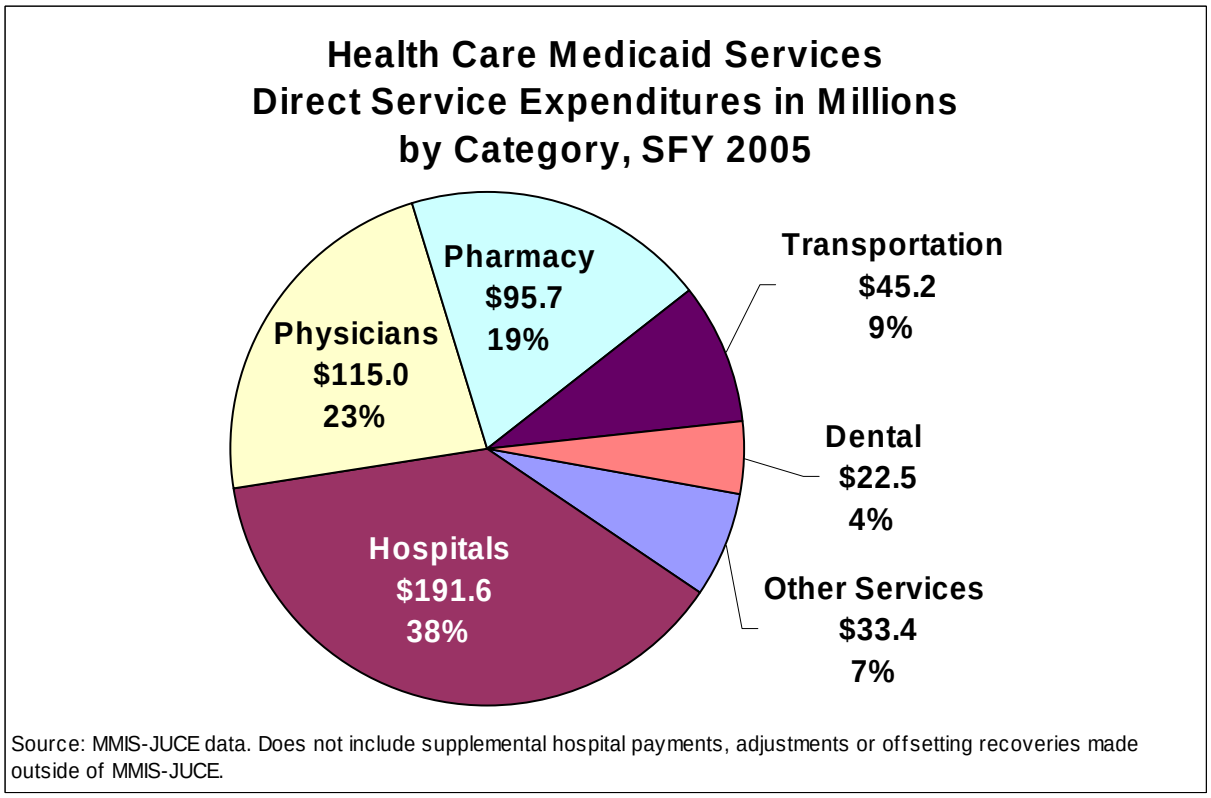
	Hospital Services	Physician Services	Prescription Drugs	Transportation Services	Dental Services	Total*
Children	43,798	66,798	43,548	12,898	35,337	202,379
Adults	15,885	19,178	15,101	4,674	4,181	59,019
Elderly	4,951	6,035	6,327	2,456	674	20,443
Disabled Children	982	1,438	1,288	464	654	4,826
Disabled Adults	9,561	11,475	11,232	3,412	2,411	38,091
Total*	75,177	104,924	77,496	23,904	43,257	324,758

Source: MMIS-JUCE

***For each service/eligibility combination, counts of beneficiaries are unduplicated. The total is the sum of the column or row and not the actual number of individuals. Because beneficiaries may receive services in multiple categories the total will overstate the unduplicated count of beneficiaries.**



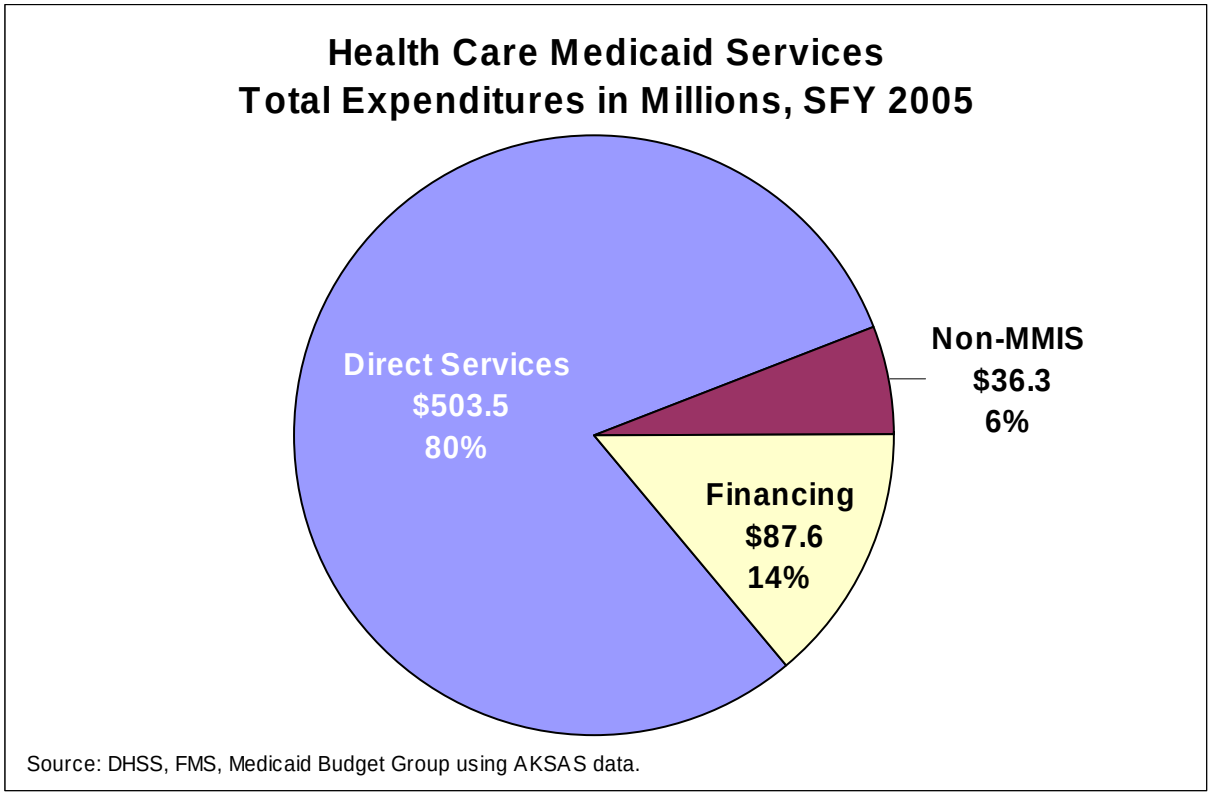
Source: MMIS-JUCE data. Does not include supplemental hospital payments, adjustments or offsetting recoveries made outside of MMIS-JUCE.



Source: MMIS-JUCE data. Does not include supplemental hospital payments, adjustments or offsetting recoveries made outside of MMIS-JUCE.

- Of the $627 million Health Care Services spent on Medicaid services in SFY05, 80% was for payments to health care providers for direct service claims.

- Hospitals garnered the largest share of direct services claims (38%); physician services accounted for 23% and pharmacy was responsible for another 19% of claims. The remaining 20% was split between transportation, dental, and other services (including durable medical equipment, vision, and physical/occupational/speech therapy, home health and hospice, and chiropractic care).



Medicaid Services

Alaska Statutes
AS 47.07 Medical Assistance for Needy Persons
AS 47.08 Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions

Social Security Act
Title XVIII Medicare
Title XIX Medicaid
Title XXI Children's Health Insurance Program

Administrative Code
7 AAC 43 Medicaid
7 AAC 48 Chronic and Acute Medical Assistance

Code of Federal Regulations
Title 42 CFR Part 400 to End

AS 47.07 Medical Assistance for Needy Persons
This statute provides for needy persons of Alaska who are eligible for medical care at public expense to seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. This statute also states that providers of these services shall operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program.

AS 47.08 Chronic and Acute Medical Assistance (CAMA)
The CAMA program is a state funded program designed to assist needy Alaskans who have specific illnesses to get the medical care they need to manage their chronic or acute illness. This program is primarily for individuals age 21 through 64 who do not qualify for Medicaid benefits, fall into the low income category, and have inadequate or no health care insurance. The Division of Health Care Services is responsible for provider and recipient payments.

SeniorCare Program AS 47.300
SeniorCare helps low-income seniors who are at least 65 years of age remain independent in the community by providing a cash benefit or paying for the premium and deductibles of Medicare Part D or similar prescription drug coverage. The Division of Health Care Services is responsible for premium and deductible payments. The Division of Public Assistance is responsible for cash benefit payments, eligibility, policy and access to the program.

Title XVIII Medicare
Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare has Part A Hospital Insurance, Part B Medical Insurance, and Part D Prescription Drug Coverage.

Title XIX Medicaid
Medicaid provides federal funding available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to the recipient; instead, it sends payments directly to their health care providers. Depending on eligibility, recipients may also be asked to pay a small part of the cost (co-payment) for some medical services. Medicaid is a state administered program and Alaska sets its own guidelines regarding eligibility and services.

Title XXI Children's Health Insurance Program
SCHIP is jointly financed by the Federal and State governments and is administered by the State. Within broad federal guidelines, Alaska determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to states on a matching basis for federal fiscal years (FFY) 1998 through 2007. Federal payments under Title XXI to states are based on state expenditures under approved plans effective on or after October 1, 1997.

Medicaid Programs

Pharmacy and Ancillary Services Unit
Provides management including researching, analyzing and implementation changes in coverage of services for the following Medicaid Provider service programs: Pharmacy, Durable Medical Equipment, Hospice, Home Health, Private Duty Nursing, Hearing and Audiology, Orthotics and Prosthetics, Home Infusion Therapy, Respiratory Therapy. This unit provides policy, planning, regulation development, oversight, and management. Other programs administered in this unit include Drug Utilization Review, Preferred Drug List, Pharmacy and Therapeutics Committee, and the Behavioral Pharmacy Management Service.

Facility Relations Unit (FRU)
Performs policy and program management for Medical Assistance services performed at institutional facilities such as hospitals and ambulatory surgical centers and services performed by end-stage renal disease dialysis centers, federally qualified health centers, and rural health clinics. It is the responsibility of the FRU to ensure that the applicable federal and state regulations are applied to the provision and reimbursement of these services, evaluate program policy, procedures and operations to assure effective and efficient compliance, and develop and implement new or revised programs or initiatives for these service categories. In addition to the provision of contract monitoring and oversight of the full spectrum of fiscal agent services for all these provider types, the FRU is responsible for oversight and monitoring of the quality improvement organization (QIO) contracted to perform both utilization management through the prior authorization of inpatient stays and case management services for clients with complex medical conditions.

Practionier Relations Unit (PRU)
The PRU is responsible for assuring that program policies are consistent with current medical standards of practice; and, ensures the relationships with consumers and medical providers are maintained at the highest possible level. The PRU has developed and maintained relationships with various professional organizations and seeks their professional input into policies and programs. The PRU assists in answering difficult clinical questions which arise from medical providers, recipients, and the fiscal agent. The PRU is responsible for reviewing and determining coverage of services to assure that they are in compliance with both state and federal regulations and statutes.

Program Integrity (PI) Unit
The PI Unit is responsible for complaint investigations, reviews, and audits. Program integrity processes and activities are designed to provide for efficient, economical, and effective administration of the Medicaid Program. The PI unit assures that processes are in place to identify inappropriate activity, investigate, and refer to the Medicaid Fraud Control Unit suspected cases of fraud and abuse. Through contract management assures that complaints are received and investigated. Complaints may involve either recipient conduct or a providers Medicaid billing practices. PI staff periodically analyze and profile providers to determine which providers may need investigation.

Accounting and Recovery Section
The accounting and recovery section is currently comprised one manager and two sub-sections, an Accounting unit and a third party liability and recovery (TPL) unit. The TPL unit consists of one supervisor, three technical support staff and one clerical support staff. The accounting and collections sub-unit consists of, one professional accountant and two technical support staff. The Accounting and Recovery section provides financial services to support the Division of Health Care Services as well as the other Medicaid Divisions.

The primary responsibilities of the TPL sub-unit includes working pended claims related to TPL, collection of third party payments, working Pay and Chase claims, administration of the Medicare buy-in and Drug Rebate programs, and the oversight of our post payment review and cost avoidance contractor, Public Consulting Group. The TPL unit also administers the disabled working program, the estate recovery program and works with the Department of Law on Subrogation cases. TPL recoveries are made on behalf of the Division of HealthCare Services (DHCS) Division of Senior and Disability Services (DSDS) the Division of Behavioral Health (DBH).

The primary responsibilities of the Accounting unit include the oversight and management of the accounting interface between the Medicaid Management Information System and the State Accounting System, ensuring weekly check writes are approved, reconciled, and issued. The internal accounting functions are provided for the DHCS, DSDS and DBH.

Recipient Services Unit (RSU)
The RSU is responsible to assist Medicaid recipients and health care providers in appropriately accessing benefits and resolving grievances. RSU monitors recipient travel under the State Travel Office, manages the statewide Early Prevention, Screening, Diagnosis, and Treatment program, coordinates Fair Hearing requests, represents the Agency at Fair Hearing, and monitors the Fiscal Agent's performance with prior authorization, the Recipient Helpline, provider enrollment and the Care Management Program. Recipient Services intercedes in recipient and provider disputes regarding eligibility and claims processing.

Health Care Services	2006	2007 Proposed	06 to 07 Change
General Funds	125,450.9	200,141.4	74,690.5
Federal Funds	485,018.8	541,739.7	56,720.9
Other Funds	77,091.3	32,224.6	-44,866.7
Total	**687,561.0**	**774,105.7**	**86,544.7**

Health Care Services Medicaid

Loss of FairShare SDPR ($45,000.0 Statutory Designated Program Receipts)
This decrement reflects the discontinuation of the FairShare program by SFY07 due to a September 12, 2005 ruling by the U.S. Court of Appeals for the Ninth Circuit. The FairShare program allows Tribal hospitals to receive a higher rate than non-Tribal hospitals to provide relief for uncompensated care. The additional payment is 100% federally funded. Tribal hospitals return 90% of the FairShare payment as Statutory Designated Program Receipts (SDPR). Two hospitals participate currently in FairShare.

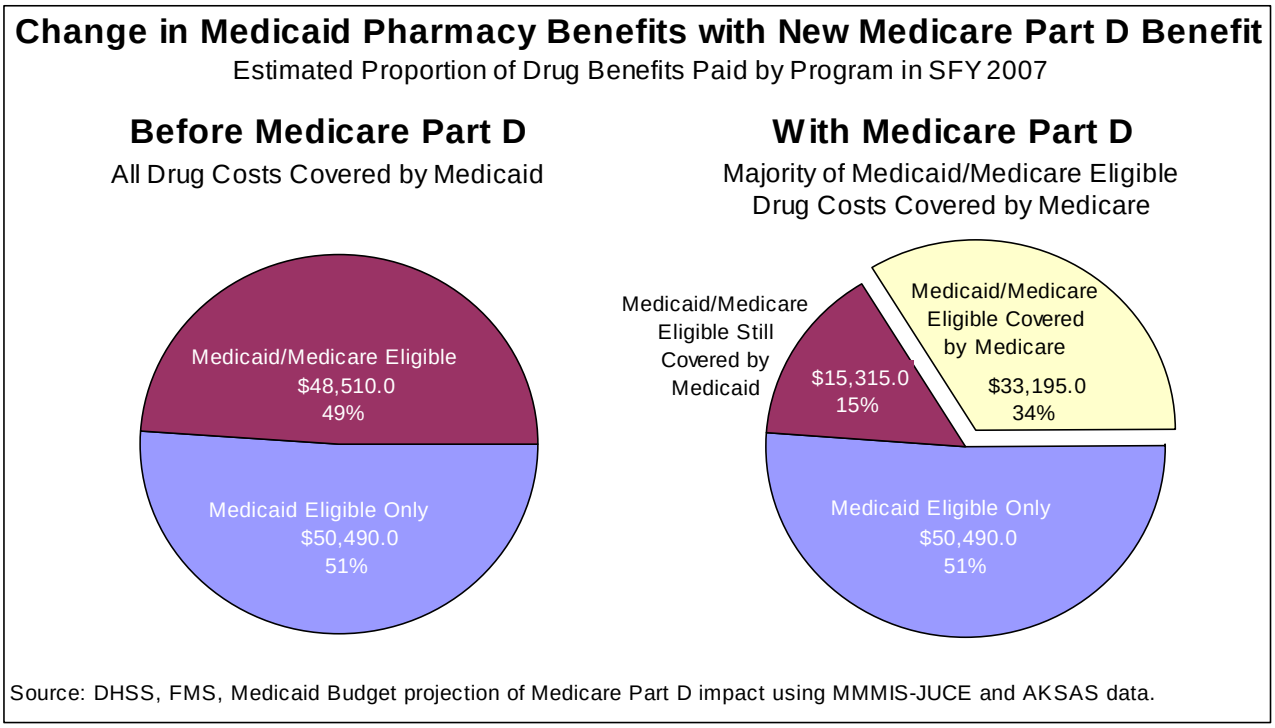
Due to the ruling, the department will not be collecting the estimated $45 million in SDPR on the estimated $50.2 million in FairShare payments. The FairShare program was a key part of the department's refinancing efforts and the SDPR receipts generated were used to provide matching funds for other Medicaid programs. GF will be required to replace the lost SDPR.

Medicare Part D Pharmacy Costs and Drug Rebates Reduction ($16,866.2 Federal)
The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a new Medicare Part D prescription drug benefit available to all Medicare recipients, effective January 1, 2006. With the implementation of Part D, Medicaid full-benefit enrollees who are also enrolled in Medicare ("dual-eligibles") will begin receiving nearly all their drug benefits through Medicare instead of Medicaid. This will reduce the amount of Medicaid expenditures for pharmacy claims and their associated drug rebates.

The nearly 12,000 dual-eligibles currently enrolled per month account for approximately 49% of all Medicaid pharmacy benefits. Not all drugs are covered under Part D—only about 80% of dual-eligibles' pharmacy drugs will be covered under Part D. Medicaid will continue to pay for dual-eligibles' drugs not covered by Part D. For SFY07, pharmacy expenditures are expected to drop approximately $33.2 million (16,886.2 fed, 16,308.8 GF) from the FY06 budgeted amount. This represents approximately 39% of pharmacy costs (80% of 49%).

While spending on drugs for dual eligibles will decrease, savings are offset by the state's phased-down contribution (also known as the "clawback"); a provision of the new law requiring states to pay the federal government according to a formula intended to estimate those savings. States are required to pay 90% of the estimated savings in the first year, phasing down to 75% in 10 years.

The department estimates the SFY07 GF clawback (or phase down) payment for Alaska to be $20,668.8. The projected *net* impact of Part D drug savings and clawback payments is a decrease of $16,866.2 federal and an increase of $4,360.0 general funds. (The GF net clawback payment increment is in a separate change record.)



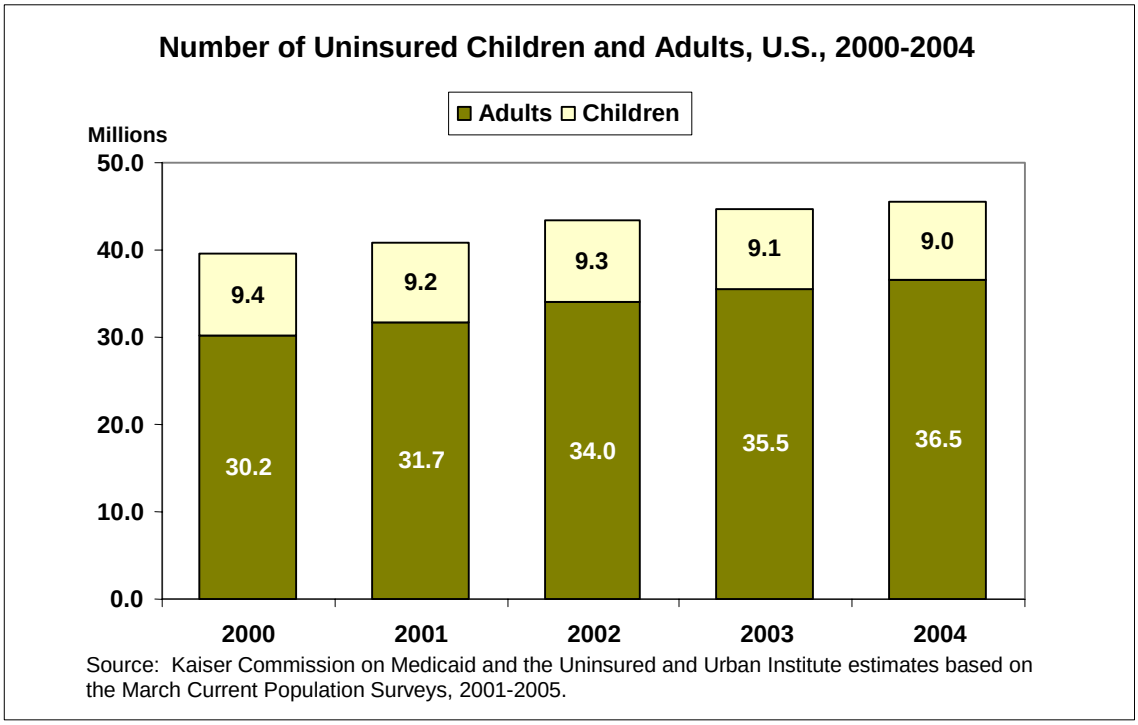
Increase Disproportionate Share Hospital (DSH) Authorization $6,502.6 General Fund; $6,724.9 Federal

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for qualifying hospitals. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. These payments are in addition to the Medicaid payment rate.

The rationale behind the DSH program is that hospitals rendering high volumes of care to low-income Americans often lose money because of low Medicaid reimbursement rates. They also lose money because these same hospitals generally provide high volumes of care to indigent patients and thus have high levels of uncompensated care. In addition, hospitals with large caseloads of low-income patients frequently have low private caseloads. Hence, they are less able to shift the cost of uncompensated care to privately insured patients.

During FY05 and FY06, the Department made payments to hospitals in the institutions for mental disease (IMD) and designated evaluation and treatment (DET) categories. These payments utilized GF match from HCS and DBH to leverage the DSH federal funds. However, there currently is no GF match available to make payments to hospitals in other categories.

The Department estimates total Federal DSH funding allocation for SFY07 is approximately $27 million (federal and state funds). IMD and DET payments are expected to be about $14 million, leaving approximately $13 million to distribute as payments to hospital in other categories. General Fund needed to match the federal dollars would be $6.5 million.



90% Medicare Part D Clawback $4,360.0 General Fund

The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a new Medicare Part D prescription drug benefit available to all Medicare recipients, effective January 1, 2006. Medicare recipients who qualify for Medicaid will no longer be eligible to receive prescription drug coverage through Medicaid.

States' direct spending on drugs for dual eligibles will decrease, but savings are offset by the state's phased-down contribution (also known as the "clawback"), a provision of the new law requiring states to pay the federal government according to a formula intended to estimate those savings. States will be required to pay 90% of the estimated savings in the first year, phasing down to 75% in 10 years.

There are a number of reasons why the clawback payments are expected to exceed our savings.

- The formula uses gross Medicaid expenditures for prescription drugs in 2003, inflated forward using a national inflation factor for prescription drugs, rather than individual state Medicaid drug inflation. This rate may be higher than the rate experienced by an individual state. States, including Alaska, have taken aggressive measures to reduce prescription drug spending since 2003. We have used a prescription drug list (PDL) since SFY2005 to achieve savings that are not reflected in 2003 spending.

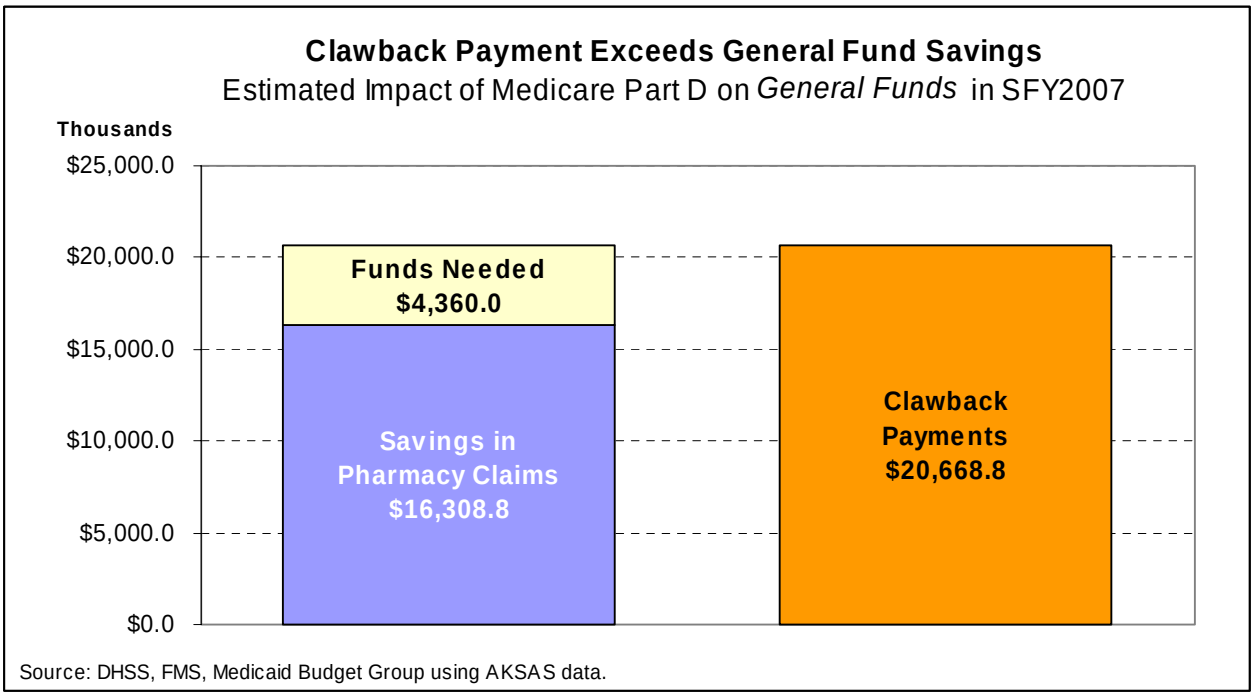
- The state's general fund share of savings for the clawback formula is computed by the Centers for Medicaid and Medicare Services (CMS) using its statutory FMAP rate. No adjustment is made for prescription drugs provided by tribal pharmacies, for which we receive 100% federal reimbursement. This will overestimate Alaska's savings, resulting in a higher payback for Alaska.

- Some cost containment measures, such as the PDL, take advantage of volume purchasing to achieve their savings. As states experience a significant reduction in the amount of

prescription drugs they are purchasing, they may find that the net price available through a PDL, or other volume discount arrangement, increases for the drugs they continue to purchase. No adjustment is made for this impact on drug pricing in the savings estimate.

The department estimates the FY07 clawback (or phase down) payment for Alaska to be $20,668.8 (90% of CMS' estimated savings based on 2003 actual spending). The clawback estimate is based on CMS' calculation of a $145.35 per capita cost, times DHSS estimate of 11,850 dual eligibles, times 12 months.

Pharmacy expenditure and drug rebate reductions are estimated at $33.2 million in SFY07 (16,866.2 fed, 16,308.8 GF) due to Part D implementation. The *net* impact of Part D drug savings and clawback payments is a decrease of $16,866.2 federal and an increase of $4,360.0 general funds. The net GF increment is shown here and the federal savings are in a separate change record.

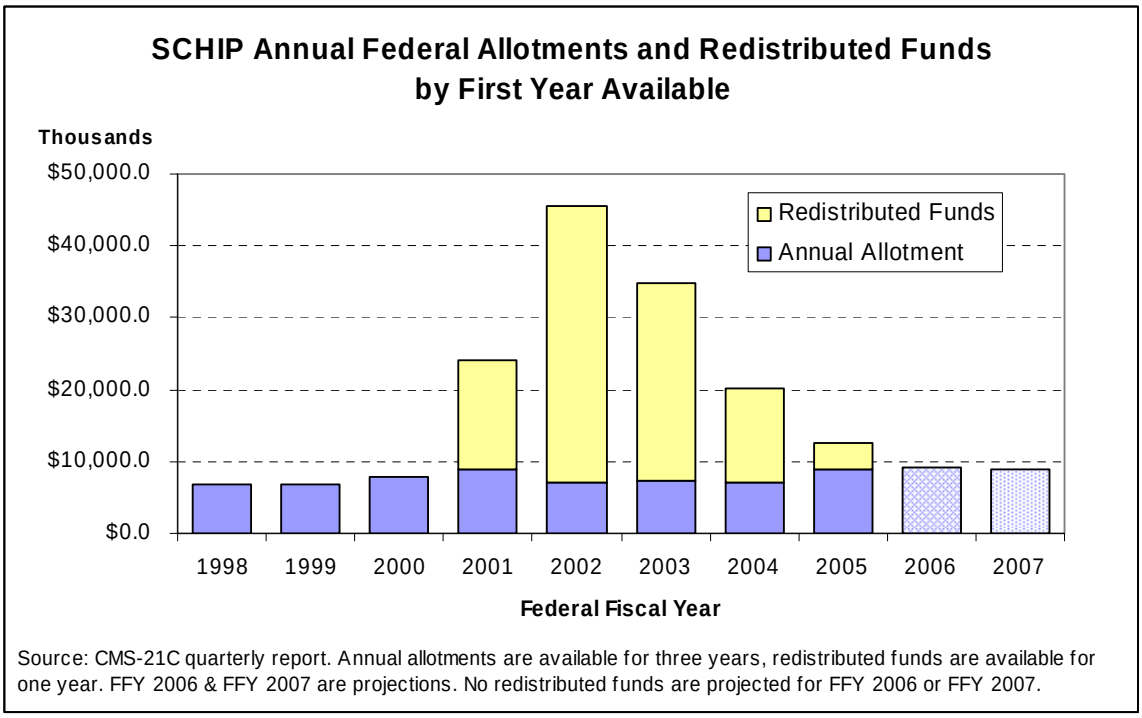


SCHIP Shortfall $1,413.6 General Fund; ($1,413.6 Federal)

The State Children's Health Insurance Program (SCHIP), operated through Denali KidCare, each month provides health insurance for nearly 11,000 uninsured children under age 19. SCHIP helps reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Since its implementation in August 1998, Alaska has provided over $230 million in medical benefits to more than 46,700 Alaskan SCHIP eligible children.

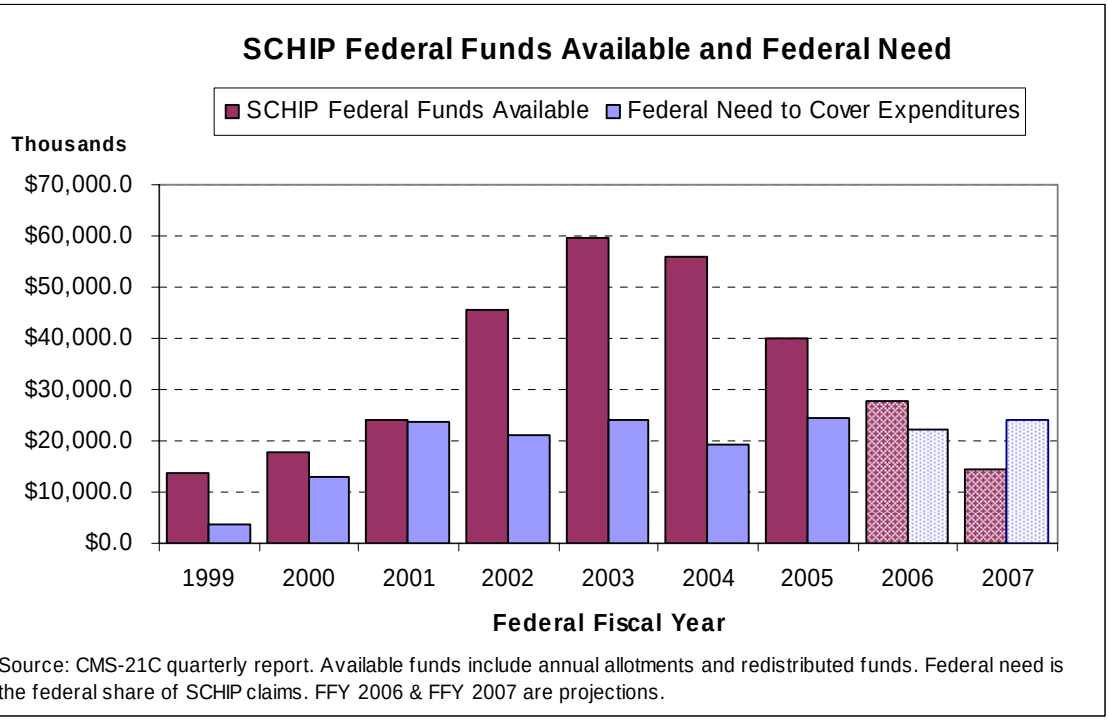
Each federal fiscal year states receive an allotment, which must be spent within three years. SCHIP allotments are determined by a formula based on a national ranking of the number of low-income children and average wages in the health industry. After three years, unspent allotments from all the states are combined into a redistribution fund, which is then reallocated to states according to need. States must spend redistributed funds in the year they are awarded. While Alaska was quick to get its program started, many states were slow to implement. This meant large sums of unspent allotments from other states were available to Alaska for redistribution. Since Alaska's annual allotment represents only about 25% of our costs, we have relied heavily on redistributed funds to support our program. In recent years the allotment has remained between $7 and $9 million; meanwhile, as more

states have ramped up their programs our redistributed funds have shrunk from a high of $38 million in FFY 2002 to just $3 million in FFY 2006.



Source: CMS-21C quarterly report. Annual allotments are available for three years, redistributed funds are available for one year. FFY 2006 & FFY 2007 are projections. No redistributed funds are projected for FFY 2006 or FFY 2007.

SCHIP benefit costs are reimbursed at an enhanced FMAP. If costs exceed total allotted and redistributed funds, claims are reimbursed at the regular FMAP. In SFY07, SCHIP total benefit costs are projected to be $34,485.0, of which $24,246.4 is federal. Our total available federal SCHIP funds are projected to be only $14,335.4, for an excess of $9,911.0 in costs. Applying the difference in regular and enhanced FMAP rates, state matching funds will have to increase $2,174.8.0 to make up the shortfall in federal funds. Health Care Services comprises about 65% of SCHIP expenditures, so HCS' portion of the shortfall is $1,413.6.



Source: CMS-21C quarterly report. Available funds include annual allotments and redistributed funds. Federal need is the federal share of SCHIP claims. FFY 2006 & FFY 2007 are projections.

Projected FY07 Growth $16,876.6 General Fund; $63,473.4 Federal

The Medicaid Services component in Health Care Services manages these "core" medical services: hospitals, clinics, physicians, prescription drugs, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, laboratory and x-ray, home health and hospice, durable medical equipment, and other direct services. In addition, the component also includes the supplemental hospital payment programs, third-party liability recoveries, and premium assistance programs. This increment request is necessary to maintain the current level of health care services provided to Alaskans.

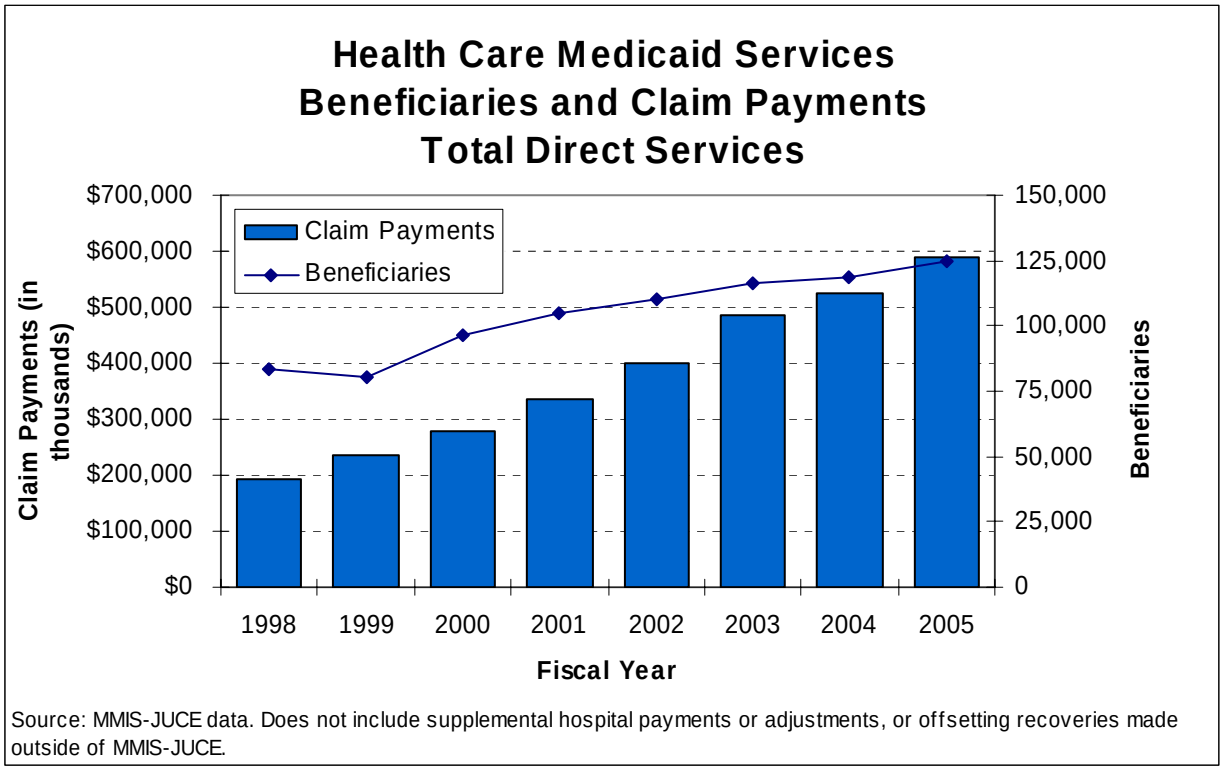
Health Care Services Medicaid
Historical Utilization of Direct Services

	Enrollment	Beneficiaries	Claim Payments (in thousands)
FY 1998	88,716	83,275	$193,989,321
FY 1999	95,816	80,099	$235,260,201
FY 2000	110,219	96,263	$277,807,576
FY 2001	116,226	105,185	$333,979,465
FY 2002	121,582	109,946	$398,598,095
FY 2003	126,632	116,151	$484,435,837
FY 2004	129,528	118,575	$525,882,460
FY 2005	131,136	124,978	$588,067,086

Source: MMIS-JUCE data. Prior to FY 2004 Medicaid services were in the Division of Medical Assistance. Claim payments do not include supplemental hospital payments, adjustments, or offsetting recoveries not processed through MMIS-JUCE.

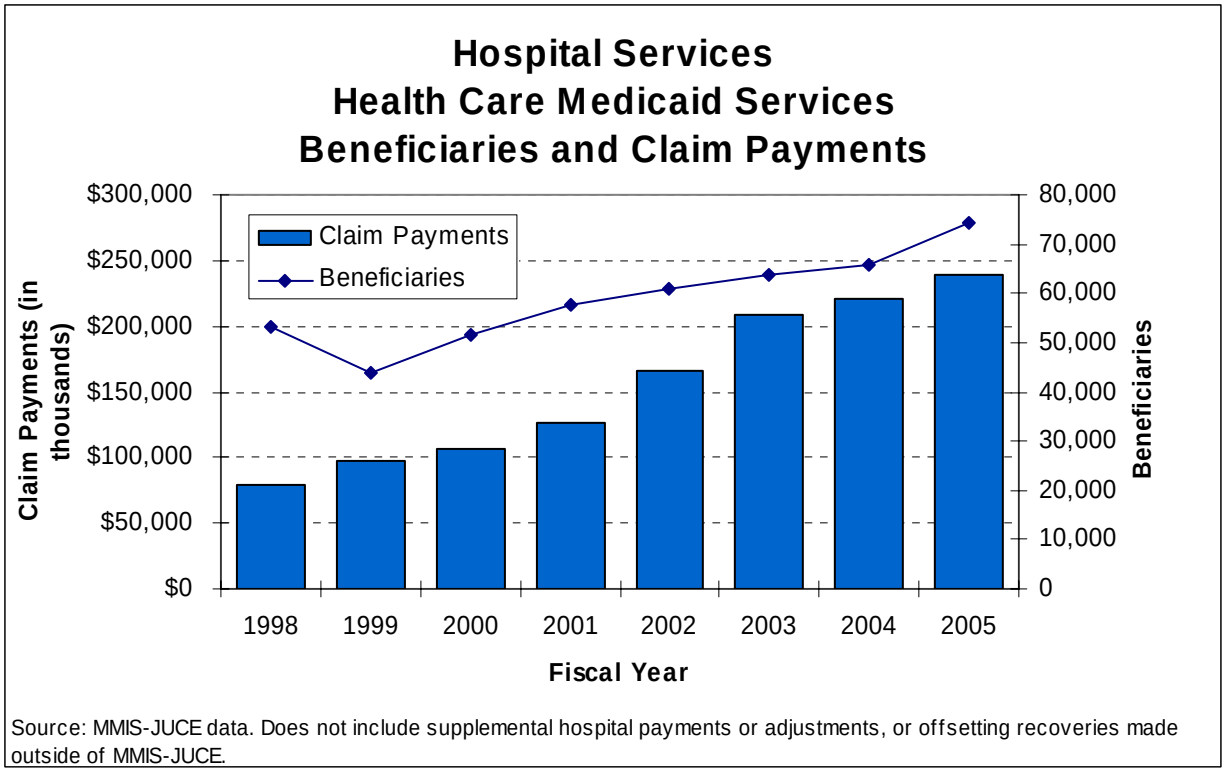
Health Care Medicaid Services experienced an approximate 6% rate of growth from FY04 to FY05, considerably less than the 17% from FY02 to FY03. The projection for growth of $61.8 million (16,113.1 GF, 45,636.9 federal) assumes the same growth rate from FY05 projected to FY07. While the overall growth was about 6%, growth in direct services was around 11%. Direct service's growth

is mostly due to increases in the number of clients served. The number of recipients rose an average of 9% while the cost-per-recipient rose 1%.

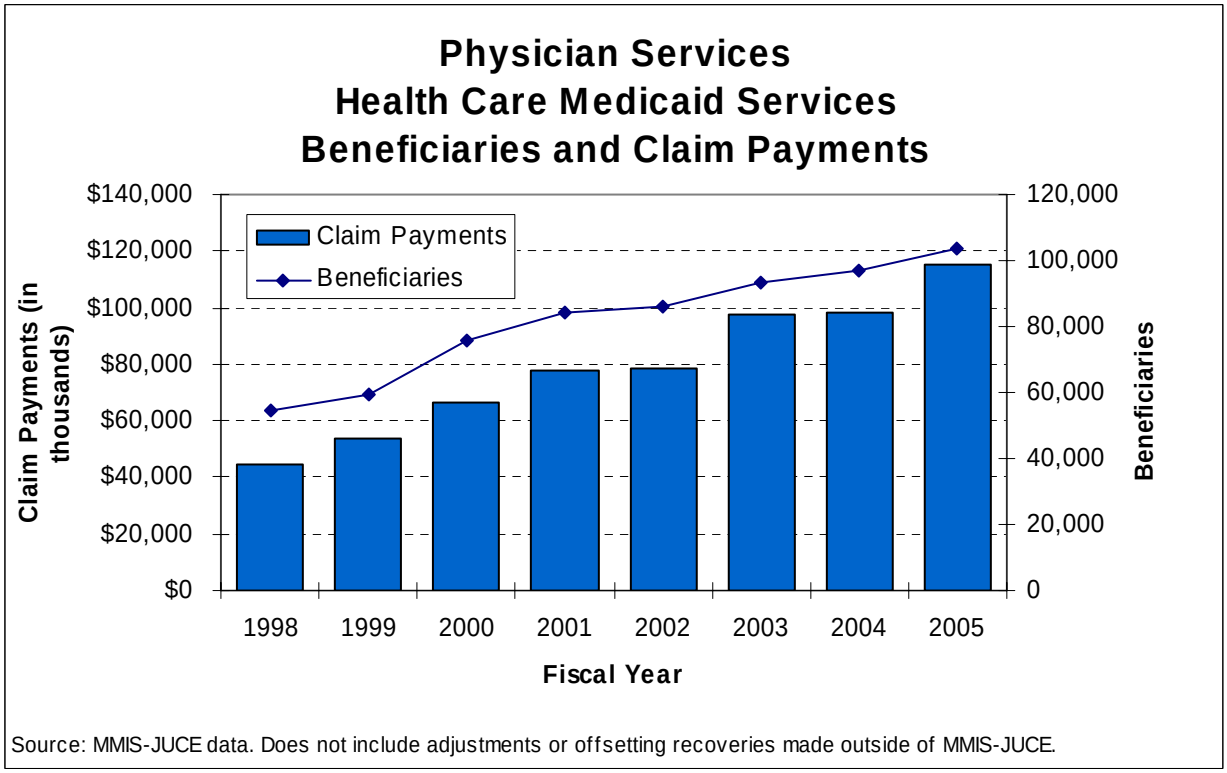


Source: MMIS-JUCE data. Does not include supplemental hospital payments or adjustments, or offsetting recoveries made outside of MMIS-JUCE.

Most of the increased cost for FY05 can be attributed to Physician Services and Hospitals. Hospitals and Physician Services comprise 61% of the total costs for this component. Physician Services grew 18% from FY04 to FY05. Hospitals grew 7% during the same period. Durable Medical Equipment and Audiology Services grew at the fastest rate, 22%; however, this is a relatively small category and therefore does not have much impact on total expenditures.

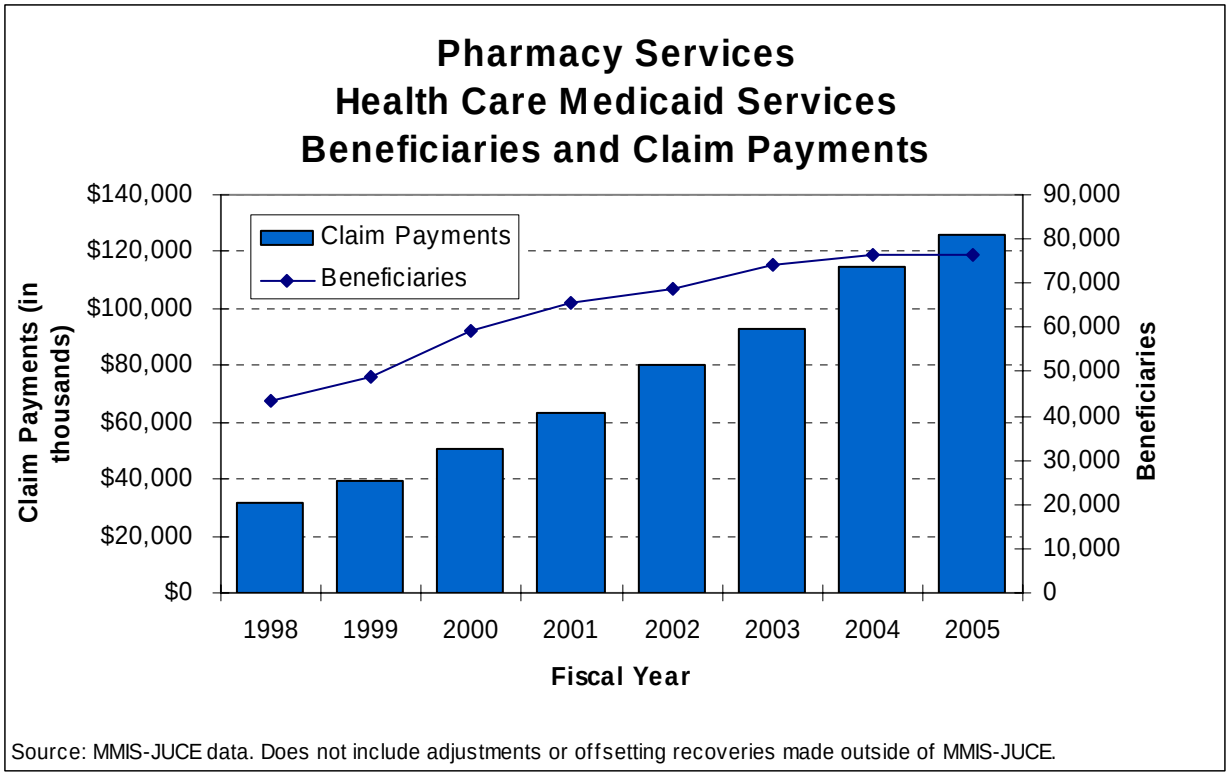


Source: MMIS-JUCE data. Does not include supplemental hospital payments or adjustments, or offsetting recoveries made outside of MMIS-JUCE.



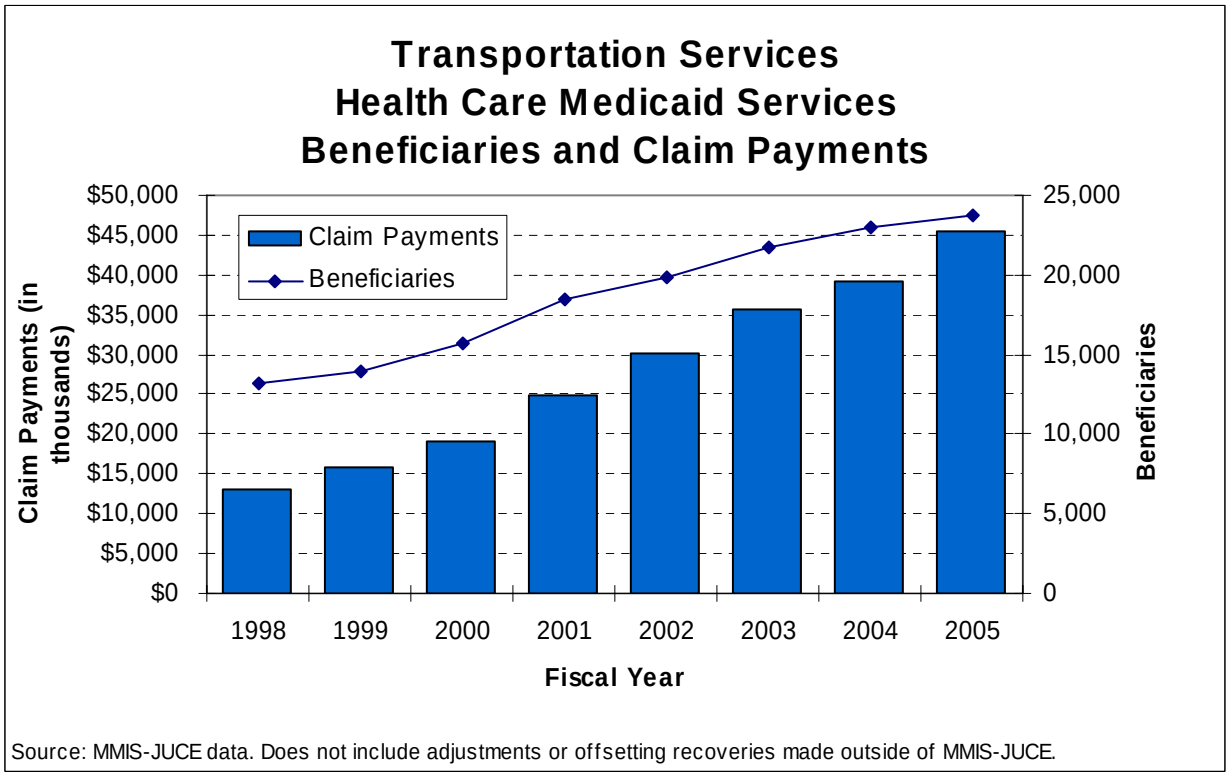
Source: MMIS-JUCE data. Does not include adjustments or offsetting recoveries made outside of MMIS-JUCE.

Pharmacy claim costs increased 10% from SFY04 to SFY05. Pharmacy services grew 4% after rebates. (The impact of Medicare Part D, which is expected to reduce drastically pharmacy claims, is addressed in other change records.).



Source: MMIS-JUCE data. Does not include adjustments or offsetting recoveries made outside of MMIS-JUCE.

Transportation Services saw a 16% increase in costs from FY04 to FY05. In January 2005, the Department of Administration's State Travel Office began arranging all non-emergency air transportation for Medicaid clients. The State Travel Office saved money by getting a better airfare than was generally available; however, because overall ticket prices increased, the best efforts of the STO could not prevent the cost-per-recipient from rising 16%.



Source: MMIS-JUCE data. Does not include adjustments or offsetting recoveries made outside of MMIS-JUCE.

This increment also includes

- $16.9 million federal authorization for funding Continuing Care Settlements to Tribal Hospitals which provide ongoing care for EPSDT (early, periodic, screening, diagnosis, and treatment) related medical costs of children at 100% federal reimbursement; and
- $1.8 million (763.5 GF and 1036.5 federal) for Exceptional Relief rate adjustment payments to providers.

Premium Increases for Medicare Part A and Part B $1,522.3 General Fund; $1,574.3 Federal
Medicare Part A covers hospital care for approximately 750 recipients and Part B covers outpatient treatment, physician office visits and physician administered therapies for approximately 11,000 recipients.

By paying the premiums for Medicare Part A and Part B, the department is able to shift costs for medical benefits from the state to the federal government. Medicare is a federal program that provides health insurance to anyone age 65 or over (and people under 65 with certain disabilities) who enroll. The program is voluntary and beneficiaries must pay monthly premiums. If Medicare beneficiaries have low-income, they may also be eligible for benefits under Medicaid. Because Medicaid is the payer of last resort, Medicare pays for 'dual-eligible' beneficiaries' claims before Medicaid does. Medicaid pays the premium for low-income Medicare Part A and Part B beneficiaries who cannot afford the insurance because it costs substantially less to pay the premium than to pay the claim. In addition to the cost savings benefit, the state is federally required to pay these premiums for the majority of recipients.

Actual payments for Part A increased on average 1.84% p/year (based on the five years preceding FY06) and are estimated to increase 2.4% in the five years preceding FY07, for a combined increase in FY07 of $123.7.

Actual payments for Part B increased on average 14.22% p/year (based on the five years preceding FY06) and are estimated to increase 15.39% in the five years preceding FY07, for a combined increase in FY07 of $2,973.0.

Medicare Part A and B
Total Premium Expenditures
(in thousands)
by State Fiscal Year

	Part A	Part B
2000	$2,632.0	$4,824.6
2001	2,605.5	5,228.5
2002	2,616.4	6,011.3
2003	2,692.9	6,845.4
2004	2,737.5	8,299.7
2005	2,879.9	9,349.3

Source: AKSAS data.

Medicare Part A and B
Monthly Premiums
by Calendar Year

	Part A	Part B
2000	$301	$46
2001	300	50
2002	319	54
2003	316	59
2004	343	67
2005	375	78

Source: DHSS, Health Care Services.

The increasing cost of Medicare Part A and B over the last several years is due both to premium increases as well as the growing number of persons over 65 eligible for Medicare.

There has been a steady growth in premium costs in Alaska. Part A premiums grew from $301 in FFY 2000 to $375 in FFY 2005 while Part B increased from $46 in FFY 2000 to $78 in FFY 2005.

Add Tribal Targeted Case Management Services (TCM) $17,280.0 Federal
Targeted case management services (TCM) are provided to Medicaid-eligible recipients who are Alaska Native/American Indians served through an IHS 638 facility. The Tribal TCM state plan amendment was approved in June 2005. (One other TCM program, Infant Learning, is served through Office of Children's Services and does not fall under this component.) Tribal TCM services are reimbursed 100% by the federal government. Payments are based on a monthly encounter rate of $200.00. Implementation of TCM will be phased in during FY06 and FY07 due to necessary system changes and staff training. By FY07 nearly 2,000 persons a month (5.6% of the approximately 36,000 eligible enrollees) are expected to receive Tribal TCM benefits.

TCM services that will be covered include:

- Assessment
- Case Planning
- Case Plan Implementation
- Case Plan Coordination
- Case Plan Reassessment

Change in Policy Moving from Pharmacy Pay-and-Chase to Cost Avoidance ($646.7 General Fund); ($668.8 Federal)
By January 2006, Medicaid should have cost avoidance in place for pharmacy claims. As payer of last resort, Medicaid has relied on the pay-and-chase method of recovering costs from third-party payers. Under pay-and-chase, Medicaid pays the claim and then tries to recover its costs from the other payer. Under cost avoidance, Medicaid tries to identify third-party claims at the point-of-sale and thereby avoid the claim entirely. It is estimated to save 2% of pharmacy expenditures.

Expand School-Based Therapy and Hearing Services $161.7 Federal; $156.3 Statutory Designated Program Receipts
In FY05 the Department began paying for School Based Services for Medicaid eligible children with a disability. The match portion for the federal funds is collected as SDPR from participating schools. The services covered are physical therapy; occupational therapy; speech-language pathology; and hearing services.

During FY05 Kenai Peninsula school district began providing School Based Services in late fall. Juneau School District began providing services in the spring. Total expenses for School Based Services in FY05 were $174.8. Estimated expenses for FY07 are projected to increase 82% to $317.9, if no new schools enroll as providers.

Replacement of FairShare SDPR $45,000 General Fund
This increment reflects the discontinuation of the FairShare program by SFY07 due to a September 12, 2005 ruling by the U.S. Court of Appeals for the Ninth Circuit. The FairShare program allows Tribal hospitals to receive a higher rate than non-Tribal hospitals to provide relief for uncompensated care. The additional payment is 100% federally funded. Tribal hospitals return 90% of the FairShare payment as Statutory Designated Program Receipts (SDPR). Two hospitals participate currently in FairShare.

Due to the ruling, the department will not be collecting the estimated $45 million in SDPR on the estimated $50.2 million in FairShare payments. The FairShare program was a key part of the department's refinancing efforts and the SDPR receipts generated were used to provide matching funds for other Medicaid programs. GF will be required to replace the lost SDPR.

Medical Assistance Administration

Transfer out First Health Mental Health Contractual Authorization to the Division of Behavioral Health $1,200.0 Federal Funds; $400.0 General Fund/ Match

This transfers authorization to the Division of Behavioral Health component for funding of the First Health Mental Health contract. This follows the DHSS reorganization to maximize federal funds through alignment of program and budget responsibilities with the entities whose customers are the major users of the services.

Transfer out funds to Office of Program Review to fund PCN 06-5136 $25.0 General Fund/Match

Health Care Services is contributing $25.0 General Fund/Match to fund PCN 06-5136 for review and writing of regulations to support the statewide Medicaid program.

Contribution to Department's Mission

To manage health care coverage for Alaskans in need.

Core Services

- Provide access to appropriate health care services.
- Assure access to a full range of health care service information to our customers.

Department Level Measures

D: Result - Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.

Target #1: Decrease average response time from receiving a claim to paying a claim.
Measure #1: Change in average number of days per annum from receipt of claims to payment of claims.

Average Days Entry Date to Claims Paid Date

Fiscal Year	Claims	Avg Days
FY 2000	3,720,254	10.15
FY 2001	4,409,121	12.14
FY 2002	4,959,864	12.43
FY 2003	5,615,072	10.27
FY 2004	6,690,344	10.12
FY 2005	7,903,523	12.69
FY 2006	2,095,565	16.33

Note: Between FY01 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 report uses year-to-date data from the September summary. Source: MARS MR-0-08-T.

Analysis of results and challenges: The average days-to-pay increased during the three months since the end of FY05, from 13 days to 16 days. When the first three months of FY06 are compared with the same period of FY05, we see an increase of 11% in the number of claims processed. This is a significant increase in volume, which means increased workloads for all those involved with the claims process. There is a likely relationship between more claims and longer overall processing time. The length of processing time would depend on the types of claims received and the edits those claims trigger.

One explanation for the overall annual volume increase relates to the program change within the personal care services area to require providers to bill single dates of service rather than span dates. Single dates of service vastly improve the ability to edit the claim over spanned dates billing (it takes the guess work out of determining when a service might have occurred).

The entry to adjudication time was longer in the first three months of FY06, but the time from approval to pay decreased slightly. Adjudication to approval took less than one day on the average. So the increase in time seems to have occurred primarily in the entry to adjudication period.

Additionally, the error distribution analysis report (MR-0-11-T) shows a better error rate for the first quarter of 06 compared to the same period of 05.

Target #2: Increase average number of claims submitted without error to promote timely and accurate payment.

Measure #2: Change in average number of HCS Medicaid claims paid with no errors.

% Claims Paid with No Errors

Fiscal Year	Claims Pd	% No Errors
FY 2000	3,076,978	71.75%
FY 2001	3,670,331	72.64%
FY 2002	4,202,677	74.43%
FY 2003	4,776,730	73.46%
FY 2004	5,106,692	76.33%
FY 2005	6,150,027	72.15%
FY 2006	1,614,369	73.60%

Chart Notes: Between FY00 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 report is based on claims paid through September 2005. Source: MARS MR-0-11-T.

Analysis of results and challenges: The percent of claims paid without error increased from FY2005 to the first quarter of FY2006. The error-free percentage gained one and one-half points, from 72.15% in FY 2005 to 73.60% in the first quarter of FY 2006.

Target #3: Reduce the rate of Medicaid payment errors

Measure #3: Improper payment estimates as provided to Center for Medicare and Medicaid Services

Divisions Responsible for review	Files to be completed	Files completed Medical Review	Files completed processing review
Health Care Services	190	190	190
Behavioral Health Service	78	78	32
Senior and Disability Services	29	0	0
Buy-in claims [2]	3	NA	3
Total Number of Claims	300	268	225

1. Process refers to the claims in the processing review as of 11/30/05

2 "Buy-in" is referring to Medicare premiums that are paid by the Medicaid Program.

Status of PERM Pilot Project as of December, 2005.

Analysis of results and challenges: CMS has proposed changes to 42 CFR Part 402 related to Payment Error Rate Measurement (PERM). This will apply to Medicaid and the State Children's Health Insurance Program (SCHIP).

Background:
The PERM program was created in response to the Improper Payments Information Act of 2002 (Public Law 107-300) and the Government Performance and Results Act (CPRA). The Improper Payments Information Act (IPIA) requires each federal executive agency to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments and submit those estimates annually to Congress. This proposal is limited to the evaluation of improper payments in the Medicaid and SCHIP programs.

Pilot Project:
The department was awarded a one-time federal grant to begin a pilot project that would select random claims from the Medicaid program's universe and use those selected claims to identify payment errors. The department agreed to review the sampled claims for any payment that should not have been made or that was made in an incorrect amount, including both overpayments and underpayments, under statutory, contractual, administrative or other legally applicable requirements.

Project Status:
Phase I, Notification and Record Collection - collection of 300 randomly selected claims samples and medical records from providers was begun in May of 2005 and completed in September, 2005.

Phase II, Initial Review - HCS staff began initial review of the claims samples for completeness and entering of demographic data into the Medquest database in July, 2005. This phase was completed in September, 2005.

Phase III, Claim Review - This phase, currently in process, covers Eligibility, Claims Processing, and a Comprehensive Medical Review and is scheduled to be completed by mid December.

Phase IV, Final Report - The final report will be prepared and submitted to the Center for Medicaid and Medicare Services by the end of January, 2006.

D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).

Division Level Measures

A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses replacing them with alternate funds.
Measure #1: Percent of general funds replaced with alternate funding.

HCS Medicaid Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
1999	66.0%	34.7%	.8%
2000	65.3%	25.5%	9.2%
2001	66.4%	22.7%	10.9%
2002	66.6%	27.8%	6.1%
2003	67.5%	25.5%	7.1%
2004	71.1%	16.6%	12.4%
2005	71.5%	17.5%	11.0%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Services (HIS), Breast and Cervical Cancer (BCC), and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in ABS as percentages. Note FY04 is the first year reported after the reorganization. Prior year actuals will include the complete Medicaid Program and therefore do not provide exact comparisons between fiscal years.

A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian health services (IHS) participation by 5% in expenditures.
Measure #1: Change in percentage of IHS participation.

Health Care Services IHS Participation (in millions)

Year	Total Exp	IHS	% of Total	% Increase
1999	228.6	37.5	16%	
2000	268.4	49.4	18%	2%
2001	323.0	73.3	23%	5%
2002	385.9	89.3	23%	0%
2003	466.6	134.9	29%	6%
2004	503.6	154.5	31%	2%
2005	558.2	177.8	32%	1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. Direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: The Department of Health & Social Services has created a unit dedicated to working with Tribal organizations to maximize IHS federal fund participation in the Medicaid Program and to assure Native beneficiary access to a continuum of care through Tribal health services. Some of the work in progress includes the transition of services in the YKHC Delta to the Tribal health care system while sustaining funding for these services during this transition;

maximization and improvement to the Medicaid billing capacity of Tribal organizations; and assistance to Tribal health organizations in the expansion of community-based services in addition to primary care.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability Collections (in millions)

Year	Drug Rebates	TPL	Total	% Increase
2003	17.0	8.0	25.0	N/A
2004	19.4 +14.12%	10.1 +26.25%	29.5 +18%	18%
2005	30.2 +55.67%	8.7 -13.86%	38.9 +31.86%	24%

Analysis of results and challenges: Health Care Services has been able to increase collections on drug rebates and third-party liability by 24% from FY2004 to FY2005. Efforts continue to enhance contracted services as well as in-house collections.

B: Result - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled.
Measure #1: Change in number of providers enrolled.

Number of Providers in Selected Provider Types Enrolled in Medicaid

	FY2003	FY2004	FY2005	YTD FY2006	Same Time Last FY (05)
Physicians	6,440	7,076	6,486	5,365	5,487
Dentists	587	597	578	501	517
Pharmacies	359	356	287	206	263
Hospitals	734	841	739	605	598
Nursing Facilities	36	33	29	29	28
Sum	8,156	8,903	8,119	6,706	6,893

Source: MARS MR-0-06-T

Analysis of results and challenges: The number of providers of selected types enrolled in Medicaid declined by 17.4% from the end of FY05 to the end of the first quarter of FY06 (YTD). The decline was less, 9.7% when the same point in FY 2005 (end of the first quarter) is compared to FY 2006 year-to-date.

Provider enrollment is difficult to compare year-to-year for a variety of reasons.

a) Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons.
b) The time limit for submission of claims is one year from the date services were rendered and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year.
c) Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters.
d) In the prior division and structure, DMA included a unit dedicated to provider and beneficiary customer service. Within that unit, the Participation and Access Coordinator was tasked with ensuring adequate provider participation in the Medical Assistance programs through the analysis of provider enrollment activities. Management and staff functions responsible for administration of the Medical Assistance programs changed in DHSS at the time of reorganization. There is presently no one individual tracking all provider types.
e) In response to the following Legislative Audit finding contained in a letter dated February 18, 2003, the department instituted procedures whereby providers who do not submit claims in 18 months or longer are placed in an inactive status.

1) Audit Finding: "Almost half of the providers, currently active in MMIS, have had no claim activity for more than a year….these numerous active members increase MMIS's susceptibility to fraudulent claim submissions…DMA should regularly inactivate unused provider numbers."

2) Response: There have been two major efforts to identify providers in all provider types which were without claim activity for 18 months or longer and place them in an inactive status. Result was that 1,375 providers were inactivated in September 2003; 1,271 providers were inactivated in October 2004.

In prior reporting periods, results for this measure included data for both provider enrollment and participation for the selected provider types. Since the measure is stated in terms of enrollment and provider participation is voluntary a decision was made to change the measure analysis methodology and discontinue use of participation data.

There are other differences in the way this measure is reported for FY 2006. Provider enrollment data for FY 2006 includes both in-state and out-of-state providers, while the data for previous years was restricted to in-state. Use of in-state provider data was linked to the use of occupational licensing data, which has also been discontinued this year. Some providers are not required to be licensed in Alaska, which caused discrepancies in the reported data. The analysis at the end of FY2005 included the following statement:

A single professional license may be the basis for multiple Medicaid provider id's. For example, a physician with a private practice may also be a member of a hospital physicians group or a member of a clinic or other group practice, and would have a separate Medicaid provider id for each. Methodology used to produce the 2005 data for this performance measure produced one unduplicated count for each professional license provided by Occupational Licensing that matched license data on MMIS provider records. Data does not represent the number of unique provider ids used for claims billing or the number of locations where services were provided.

Differences in enrollment reported for 2004 and 2005 may be influenced by methodology. We used the last documented methodology and were unable to duplicate data previously reported for 2004. Data for 2003 and 2004 is presented as previously published.

Since we observe less of a decline from FY 2005 to FY 2006 when we compare the same point in time during each year, it is reasonable to expect that the number of enrolled providers may continue to increase during FY 2006 to reach a level close to that which was reached at the end of FY 2005.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease by .5% the average time HCS takes to pay a claim.
Measure #1: Change in the average time HCS takes to pay a claim.

Analysis of results and challenges: This measure is reported at the department level.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the % of error-free claims by .5%.
Measure #1: Percent of error-free claims by service type.

Error Distribution Analysis – Percent Claims Paid with No Errors by Primary Providers[1]

	FY01	FY02	FY03	FY04	FY05	Year-to-Date FY06
Total Claims Paid (fiscal year) [2]	3,670,331	4,202,677	4,776,730	5,106,692	6,150,027	1,614,369
Percent Paid with No Errors (total claims)	72.64%	74.43%	73.46%	76.33%	72.15%	73.60%
Hospitals	57.45%	60.29%	64.71%	63.55%	64.52%	65.13%
Physicians	69.01%	67.40%	65.39%	63.94$	62.94%	64.58%
Dentists	72.96%	73.24%	74.35%	74.28%	73.26%	78.39%
Nursing Home Facilities	69.75%	65.28%	61.80%	61.68%	48.52%	47.14%
Pharmacy	80.23%	83.34%	80.13%	77.45%	76.51%	76.58%
Mental Health	70.28%	72.67%	75.55%	76.94%	73.56%	71.64%
Transportation	88.84%	87.89%	86.12%	86.36%	74.80%	80.57%
HCBC	73.27%	76.94%	78.16%	80.65%	86.59%	87.20%
Vision	82.09%	79.73%	76.67%	68.57%	76.47%	83.47%
Psych	68.67%	70.85%	42.36%	46.57%	55.13%	58.72%
Clinics	64.78%	96.25%	57.92%	48.26%	65.44%	64.47%
BRS	87.16%	91.15%	86.32%	84.25%	87.44%	81.29%
Chiropractic	60.68%	60.09%	48.76%	51.30%	53.29%	54.27%

Notes
[1] Between FY01 and FY03 reports were based on six months of data. The FY04 and FY05 reports were based on annual data. The FY06 report uses year-to-date data from the September summary. Source: MARS MR-0-11-T.

[2] 106,400 of the total claims are from provider types not listed above. These claims are from "Other" provider types such as DME (durable medical equipment) and therapy (physical, speech, and occupational).

Analysis of results and challenges: The percent of claims paid without error increased from FY2005 to the first quarter of FY2006. The error-free percentage gained one and one-half points, from 72.15% in FY 2005 to 73.60% in the first quarter of FY 2006. The FY 2006 year-to-date percent of claims paid without error showed improvement over FY 2005 in the following eight areas: Hospitals, Physicians, Dentists, Pharmacy, Transportation, Vision, Psychiatric, and Chiropractic. Five areas showed a decline in the error-free percentage (Nursing Home Facilities,

Mental Health, HCBC, Clinics, and BRS). The highest error-free rate was HCBC, at 87.20% (despite a slight decline during the reporting period), while Nursing Home Facilities was lowest at 47.14%. Six areas have error-free rates above 75% year-to-date: Dentists, Pharmacy, Transportation, HCBC, Vision, and BRS. Only one area, Nursing Home Facilities, has an error-free rate below 50%.

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Juvenile Justice

Mission

Address juvenile crime by promoting accountability, public safety and skill development.

Introduction

The Division of Juvenile Justice (DJJ) provides services to juveniles who commit a delinquent offense. The Division responds to the needs of juvenile offenders in a manner that supports community safety; prevents repeated criminal behavior; restores the community and victims; and develops youth into productive citizens. Services are provided in the least restrictive setting that will both ensure community protection and promote the highest likelihood of success for the juvenile offender.

Core Services

The core services provided by DJJ are:

- Short-term secure detention
- Court-ordered institutional treatment for juvenile offenders
- Intake investigation and outcome
- Probation supervision and monitoring
- Juvenile offender skill development

The Division is continuing its efforts to improve the state's juvenile justice system through implementation and ongoing review and management of the system improvement process initiated in the latter part of FY03. The DJJ system improvement plan continues to focus on ensuring that:

- Alaska has a balanced juvenile justice continuum that uses its resources effectively and efficiently
- The state's juvenile justice system makes decisions based on objective criteria
- DJJ is a data-driven agency and uses information to improve quality of services and ensure desirable outcomes for offenders, victims and the public

There are a variety of components to the system improvement plan that DJJ will emphasize in the latter part of FY06 and throughout FY07. Although the specific focus areas are discussed in more detail at the end of this, a summary of the DJJ system improvement plan achievements is outlined below:

1) Adoption of the Detention Assessment Instrument (DAI), a risk-based, structured decision-making tool to assist professional staff in determining whether to place youths in secure detention beds statewide.

2) Adoption of the Youth Level of Service/Case Management Inventory (YLS/CMI), an internationally recognized and validated instrument for identifying those youth at high risk of re-offending and the case management they need to end their criminal behavior.

3) Participation in Performance-based Standards (PbS), a national, ongoing quality-assurance process to ensure the delivery of safe and effective services in juvenile facilities.

4) Implementation of Aggression Replacement Training (ART), a highly regarded curriculum proven to change behavior of youth demonstrating chronic aggressiveness.

5) Improved use of Treatment Units as a Statewide Resource. Consolidation of two treatment cottages at Anchorage's McLaughlin Youth Center and procedural changes around the state have allowed treatment beds to be managed as a statewide rather than regional resource.

6) Development of Non-Secure Detention Resources, such as non-secure shelters, foster care, and electronic monitoring for youth who do not pose a risk to the community that requires secure detention.

7) Enhancement of Transitional Services for youths making the difficult transition between long-term confinement and return to their home communities.

Probation Services

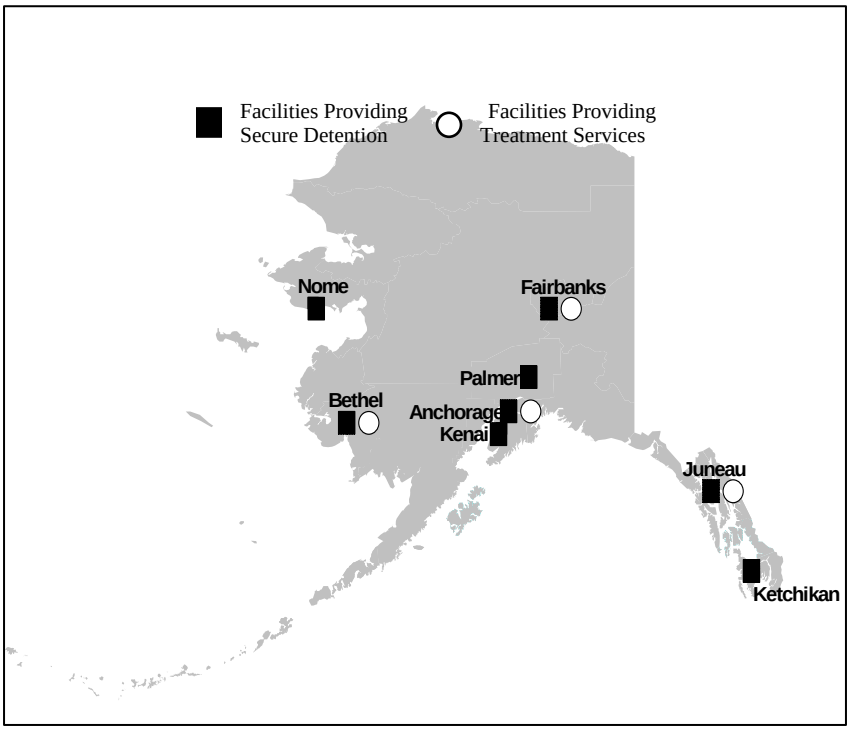
Juvenile probation officers provide preventive and rehabilitative services by conducting intake investigations of youth who are alleged to have committed delinquent acts, including determining legal sufficiency to take further action; completing detention screening; implementing diversion plans; initiating formal court action against juvenile offenders; contacting victims; providing formal community probation supervision services for adjudicated youth; assisting in reentry into the community following release from secure juvenile institutional care. Alaska's juvenile probation officers work out of offices based in 17 communities around Alaska.

Juvenile Detention and Treatment Facilities

Youth facilities in Alaska perform two primary functions:

1) Detention Units are designed as short-term secure units for youth who are awaiting court hearings; and

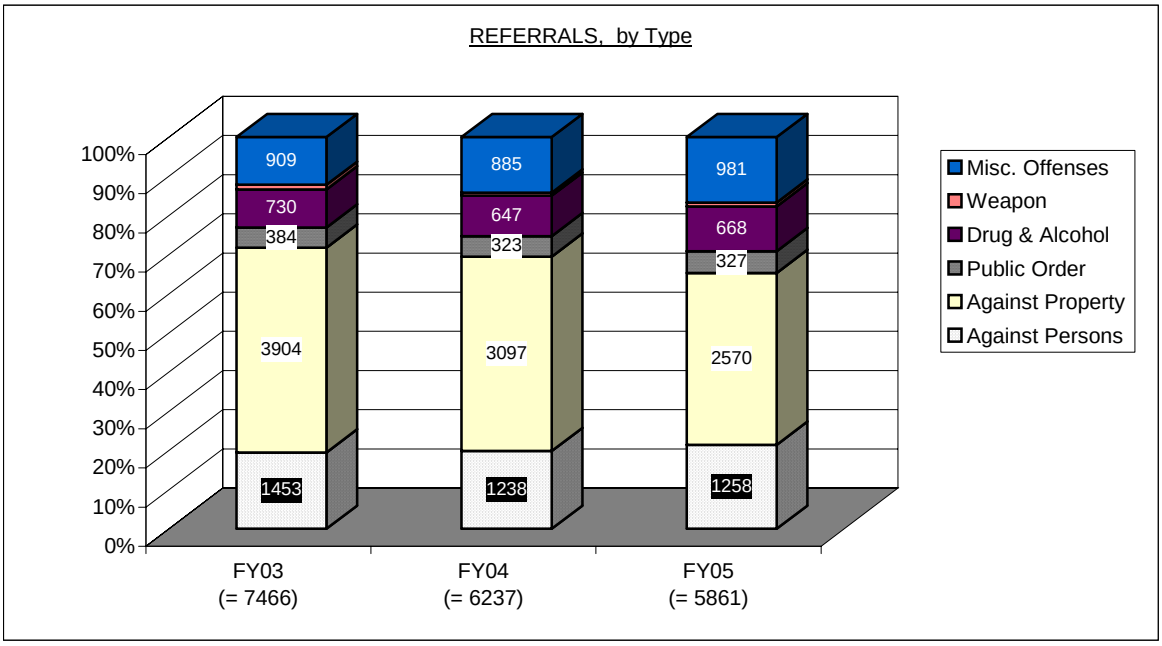
2) Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment.

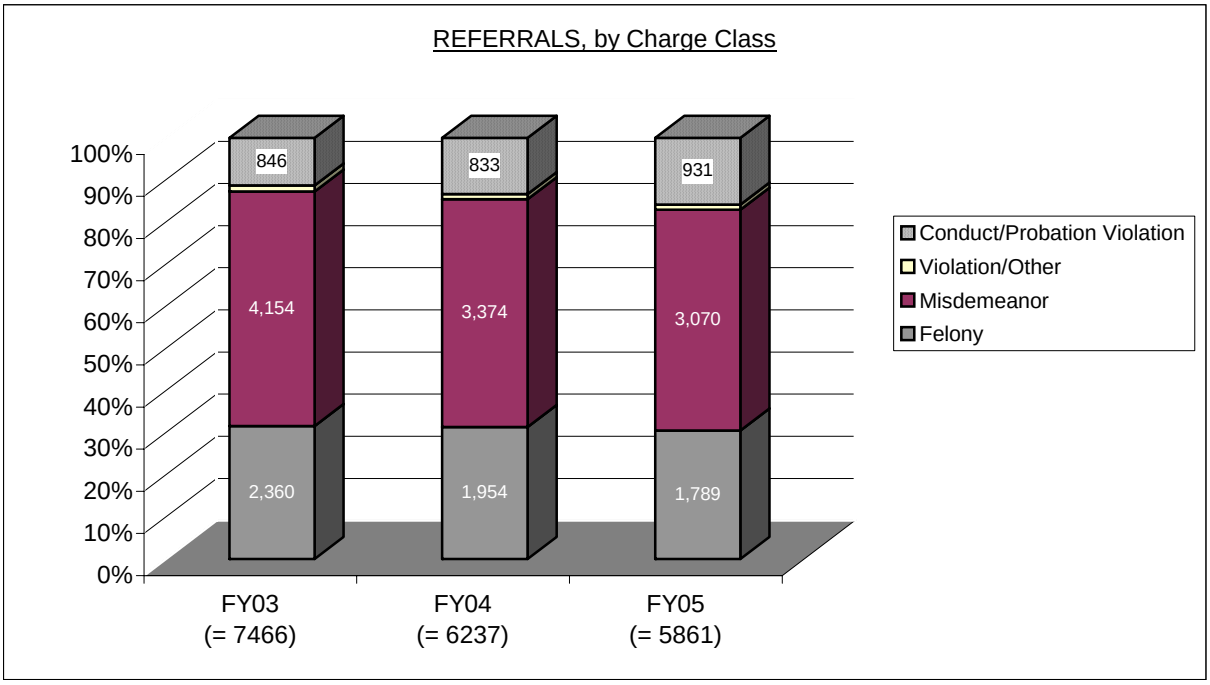


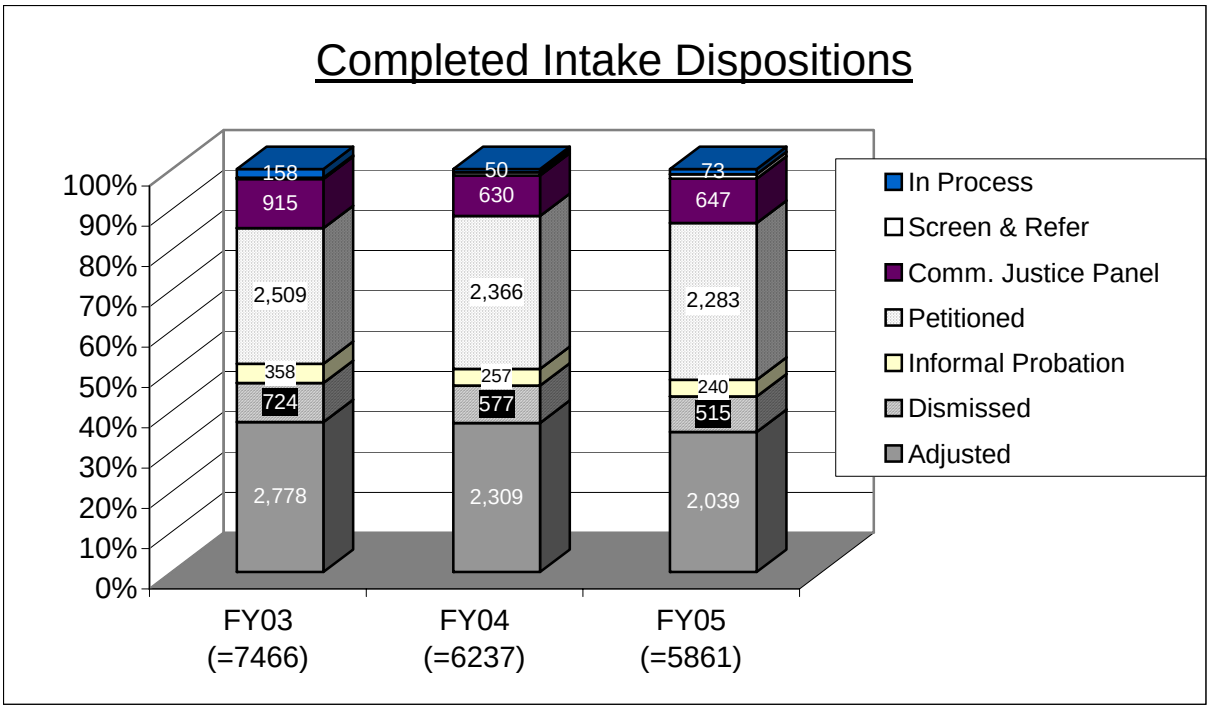
There are eight Detention Units and four Treatment Units around the State. The Division is continuing the process begun last fiscal year to have stand- alone detention facilities develop a continuum of detention services that will include some facility staff providing non-secure detention and transitional, re-integration services in the community.

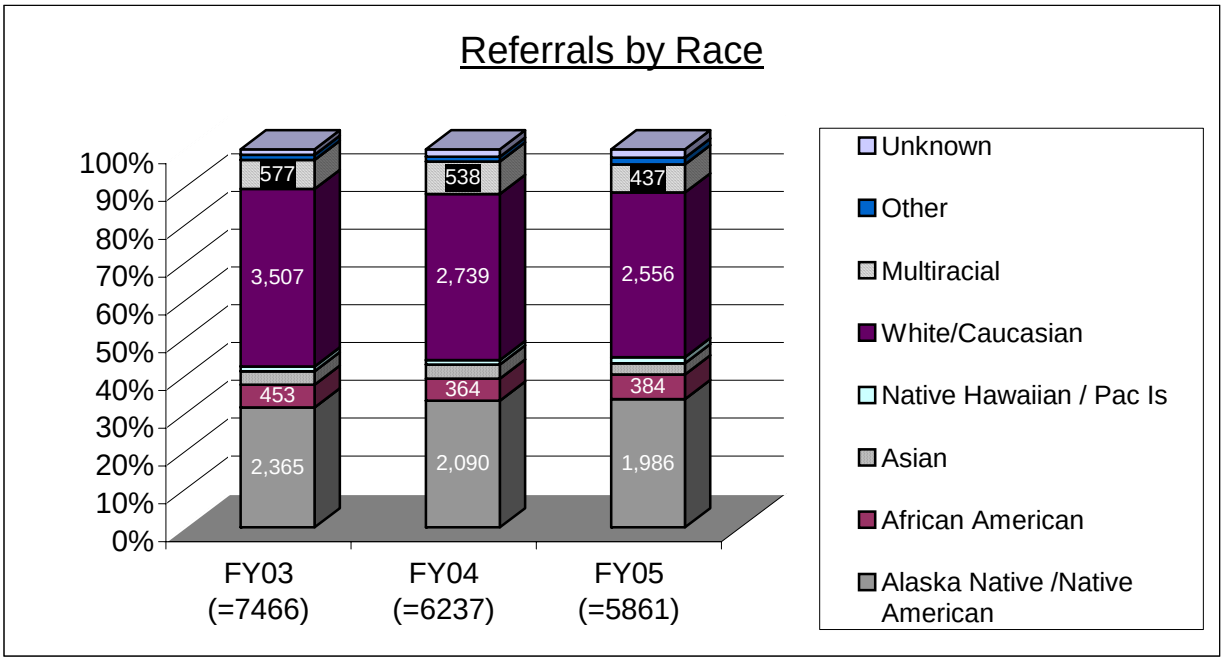
FY2005 Delinquency Referral Summaries

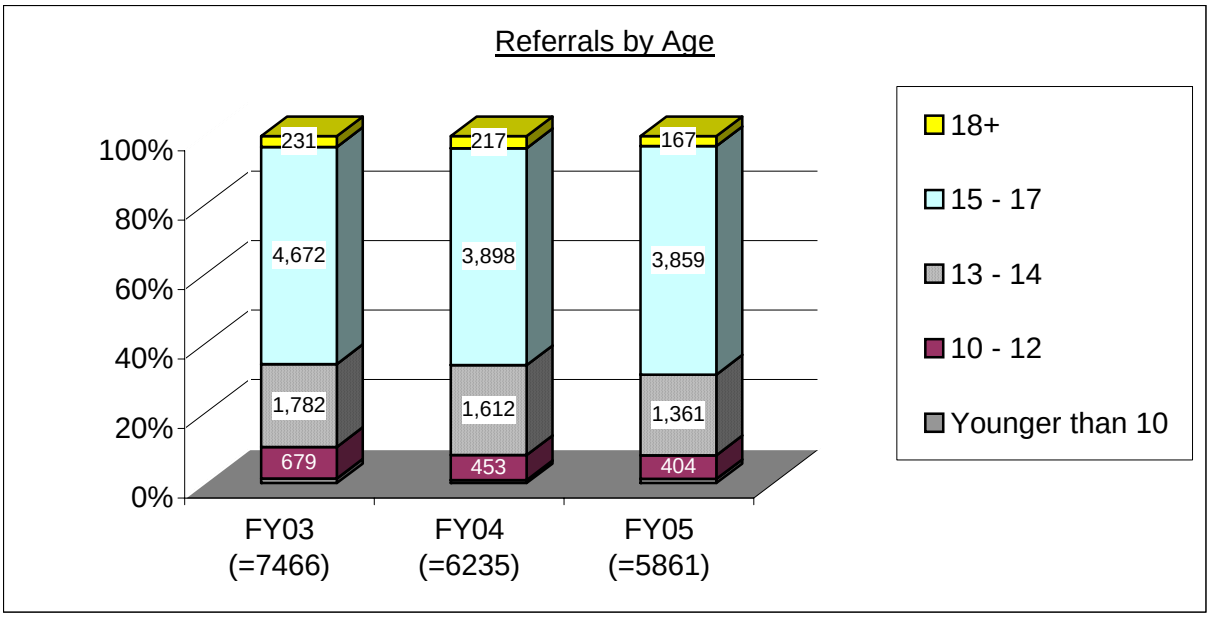
The following charts provide a summary of referrals for fiscal years 2002-2005.

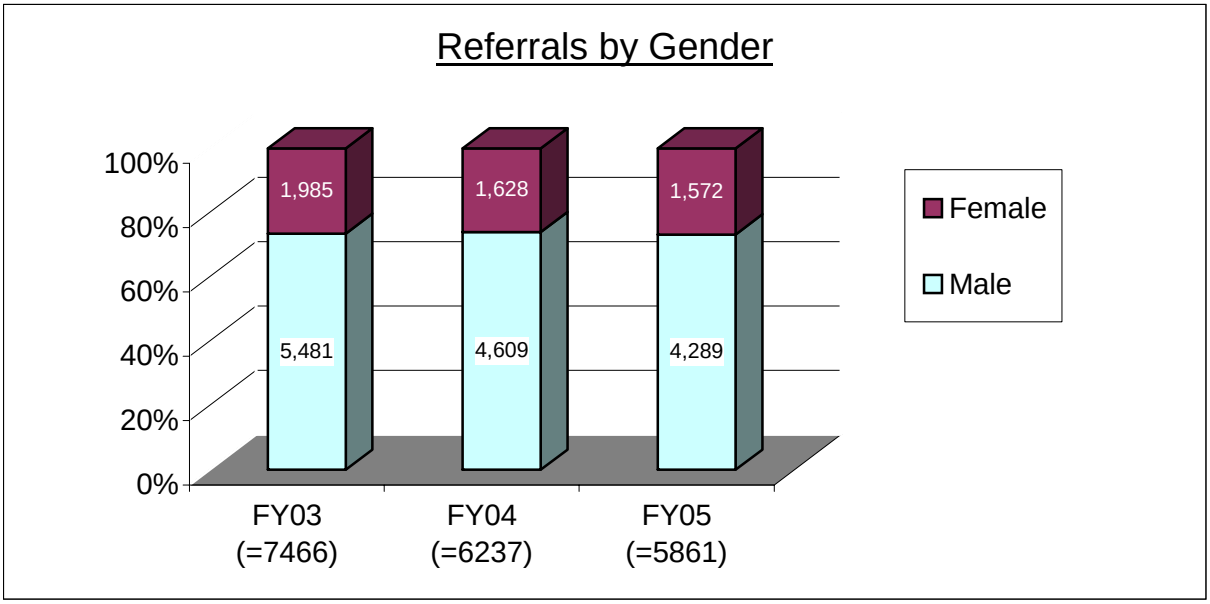





Completed Intake Dispositions
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
158
915
2,509
358
724
2,778
50
630
2,366
257
577
2,309
73
647
2,283
240
515
2,039
FY03
(=7466)
FY04
(=6237)
FY05
(=5861)
In Process
Screen & Refer
Comm. Justice Panel
Petitioned
Informal Probation
Dismissed
Adjusted


Referrals by Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
577
3,507
453
2,365
538
2,739
364
2,090
437
2,556
384
1,986
FY03
(=7466)
FY04
(=6237)
FY05
(=5861)
Unknown
Other
Multiracial
White/Caucasian
Native Hawaiian / Pac Is
Asian
African American
Alaska Native /Native American


Referrals by Age
100%
80%
60%
40%
20%
0%
231
4,672
1,782
679
217
3,898
1,612
453
167
3,859
1,361
404
FY03
(=7466)
FY04
(=6235)
FY05
(=5861)
18+
15 - 17
13 - 14
10 - 12
Younger than 10


Referrals by Gender
100%
80%
60%
40%
20%
0%
1,985
5,481
1,628
4,609
1,572
4,289
FY03
(=7466)
FY04
(=6237)
FY05
(=5861)
Female
Male

This next table indicates the number of hard beds that existed during FY05. The table shows the Nome Youth Facility's bed capacity increased by 8 beds. This increase occurred with the completion of the renovation of that facility.

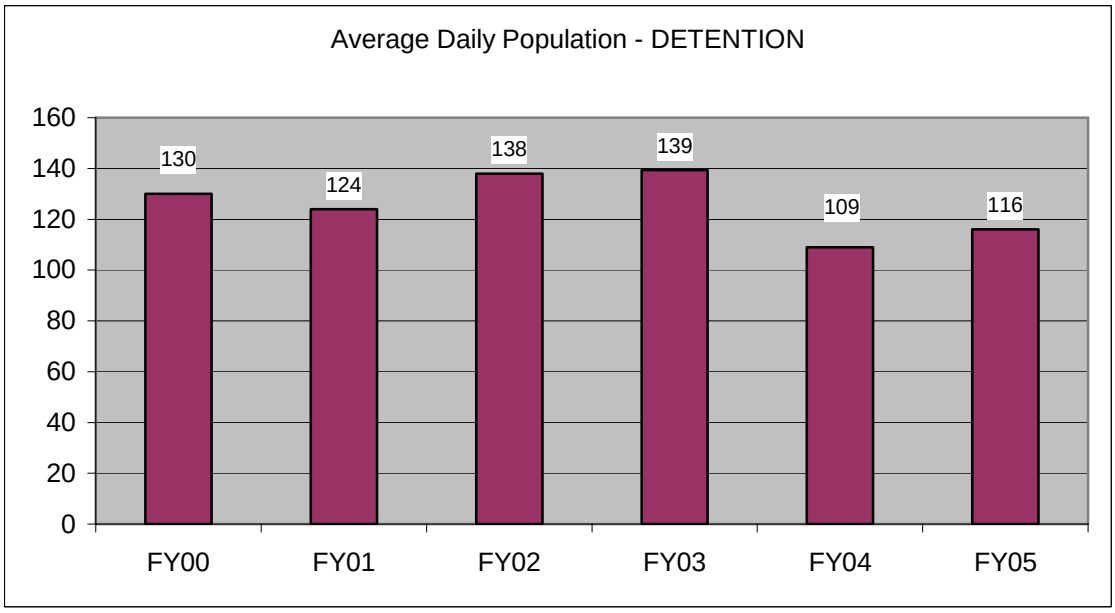
Youth Facility Existing Hard Bed Capacity			
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	160		160
Fairbanks Youth Facility	40		40
Johnson Youth Center	28		28
Bethel Youth Facility**	19	(1)	18
Nome Youth Facility*	6	8	14
Mat-Su Youth Facility	15		15
Ketchikan Youth Facility	10		10
Kenai Peninsula Youth Facility	10		10
Total	288	7	295

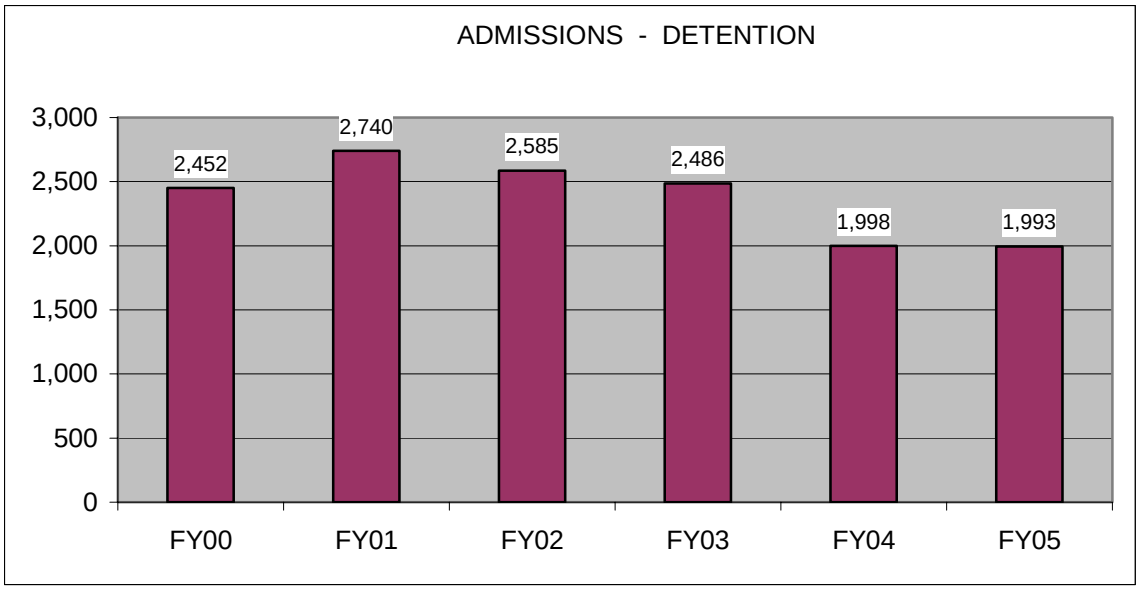
***** Although the Nome Youth Facility shows an increase of 8 beds, the beds were not utilized until FY06 because the renovation was not completed until late in FY05.

****** In FY06, to make room for the Mental Health Clinician, one of the treatment beds will be turned into an office.

Facility Data

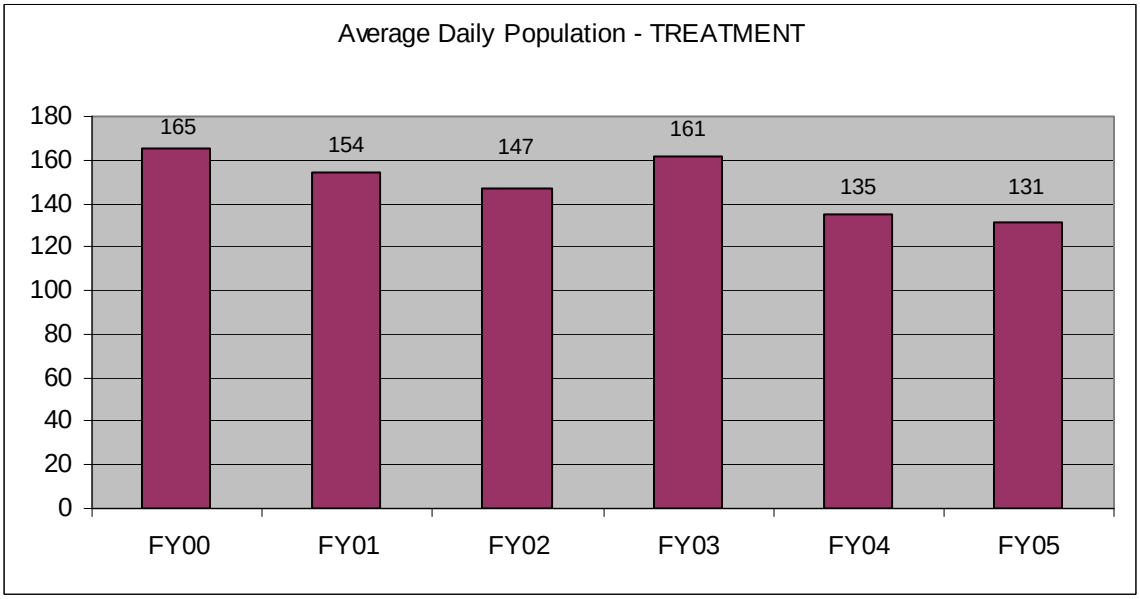
Detention Units – Detention and Treatment Units
Below are charts showing juvenile detention average daily population and admissions for FY00 through FY05. Detention Units are designed as short-term secure units for youth who are awaiting court hearings. Statewide detention capacity in FY05 was 133 beds.

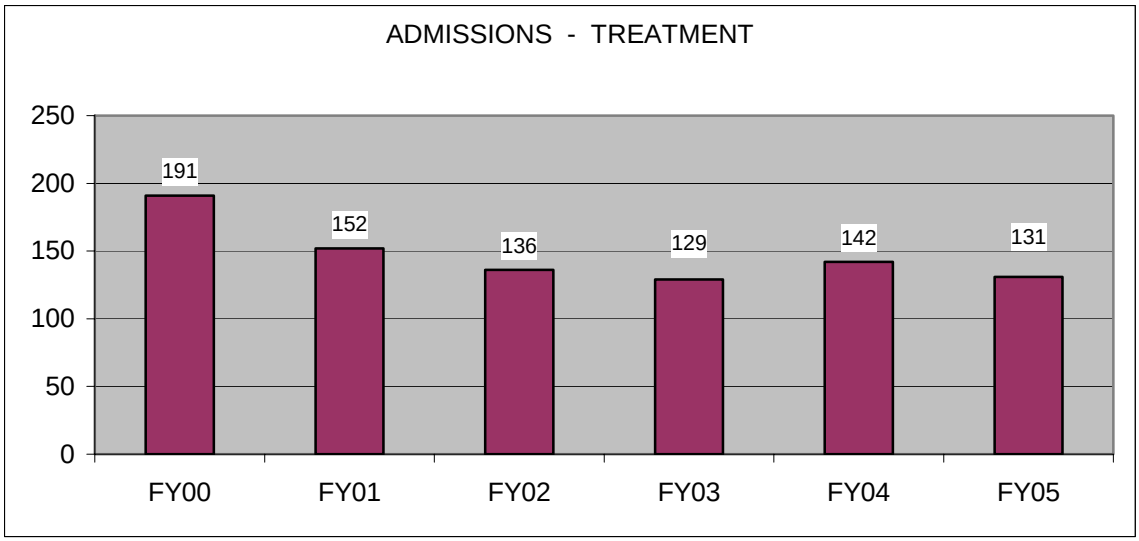




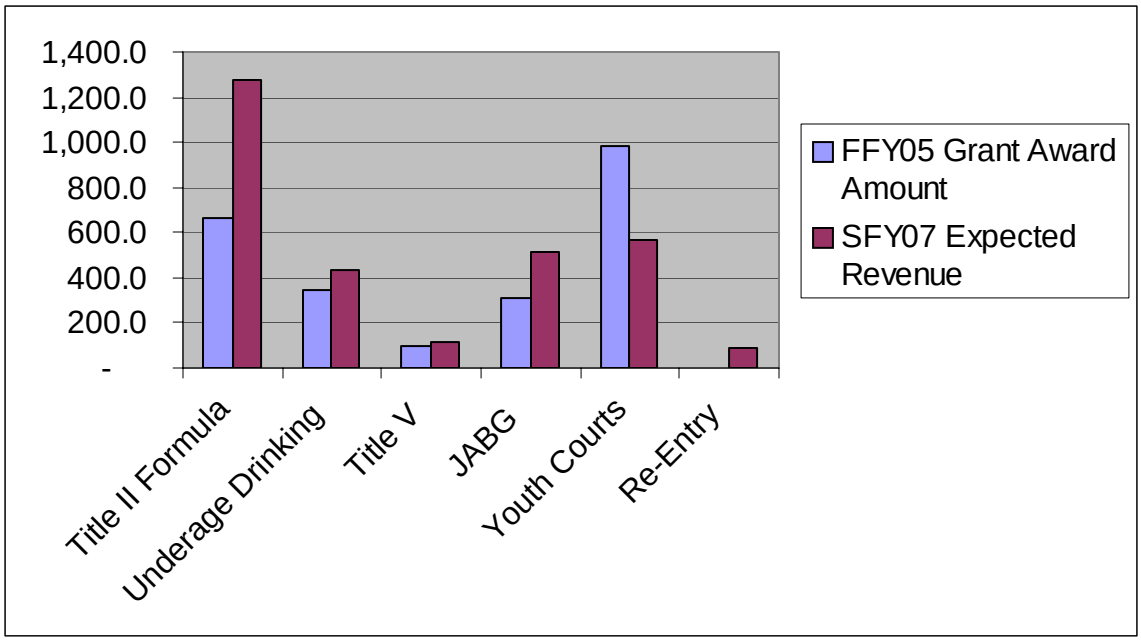
Treatment Units

Below are charts showing juvenile program average daily population and admissions for FY00 through FY05. Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY05 was 151, excluding the 4 unlocked crisis stabilization beds in Ketchikan.





The Alaska Juvenile Justice Advisory Committee (AJJAC) serves as the congressionally mandated state advisory group to the Division in its use of federal funds and juvenile justice programming. The following chart provides a visual breakdown of the FY2005 grant programs funded and the revenue we expect to receive in SFY07. Note that in some cases the expected revenue exceeds the award amounts. This is because of carryover from previous years of various grant awards. DJJ received a one-time federal grant award for youth courts in FFY05. This is a two-year grant award in the amount of $986.6. It is still unclear as of this writing whether the Re-entry grant will be funded in FFY06 for revenue in FY07.



*Office of Juvenile Justice and Delinquency Prevention

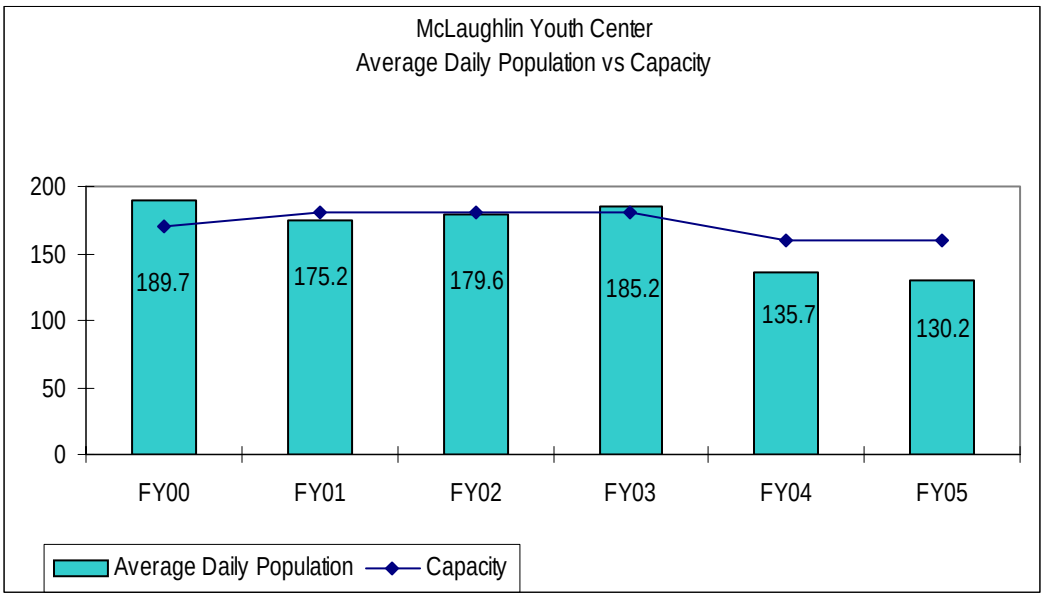
Delinquent Minors AS 47.12
The Division, through its Juvenile Probation Officers, determines whether juvenile cases are handled informally through community diversion programs or for more serious offenses, through the court system. This statute also allows for the temporary detention of minors and long-term institutional care.

Juvenile Programs and Institutions AS 47.14
The Division operates youth facilities in Anchorage, Mat-Su, Fairbanks, Juneau, Bethel, Ketchikan, Nome and Kenai. Probation offices are located in the same communities as the above-referenced facilities. In addition, there are probation offices in Sitka, Prince of Wales, Kodiak, Dillingham, Homer, Valdez, Barrow, and Kotzebue.

McLaughlin Youth Center (MYC)
MYC currently has 160 beds (60 detention beds, 95 longer-term treatment/training school beds and 5 beds which can be used as either detention or treatment). The Detention Units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Cordova, Valdez, Kodiak, Dillingham and Aleutian/Pribilof Islands. The Training School (three Cottage Programs, Classification Unit, Closed Treatment Unit, Transitional Services Unit and Intensive Community Supervision) provides long-term residential services for institutionalized delinquent adolescents, primarily from the Third Judicial District. MYC, because of its size and history as the State's first facility, has developed a range of program options that do not exist in most of the smaller facilities. In addition to secure detention and long-term treatment, MYC also provides community detention, sex offender treatment, a separated female detention and treatment unit, a closed treatment unit (CTU) for juveniles whose behavior or history require a high level of security and treatment, and transitional services for youth leaving long-term institutional treatment.

McLaughlin Youth Center has gotten off to a successful start in implementing the national quality assurance process of PbS. MYC met data collection requirements and developed improvement plans that are being used to improve facility operations and programming. Among other accomplishments, a mental health clinician joined the staff of the facility in FY05 to better develop and provide the appropriate continuum of services for detention and program residents with mental health needs. The MYC Transitional Services Unit (TSU) that was created in FY04 continued to refine and expand its program. Staff members of the TSU assisted staff in other units at McLaughlin and in other youth facilities statewide in helping youths make the transition to their home communities following long-term confinement. The critical challenge for McLaughlin Youth Center staff is in working effectively despite serious maintenance needs at the facility. The medical and nursing staff and the Anchorage Juvenile Probation Office are located in severely undersized and inadequate offices, significantly compromising both medical and probation staff's nurses' ability to work effectively with youths and families. Two of McLaughlin's four treatment cottages are in such need of extensive repair and a cost analysis completed by the Department demonstrated that a significant renovation or replacement of the cottages is needed.

The chart below indicates the average daily population and capacity during several fiscal years. In FY01, the classification unit moved to a new location and increased the capacity for that unit by five; that same year Cottage 5 increased the bed number by five also, bringing the total capacity to 180. In FY04, the total capacity was reduced to 160 with the closure of Cottage 3 and conversion of the program to the Transitional Services Unit. Community Detention opened in FY01 with a capacity of 20; however these are now classified as "soft" beds and not counted in the overall capacity.

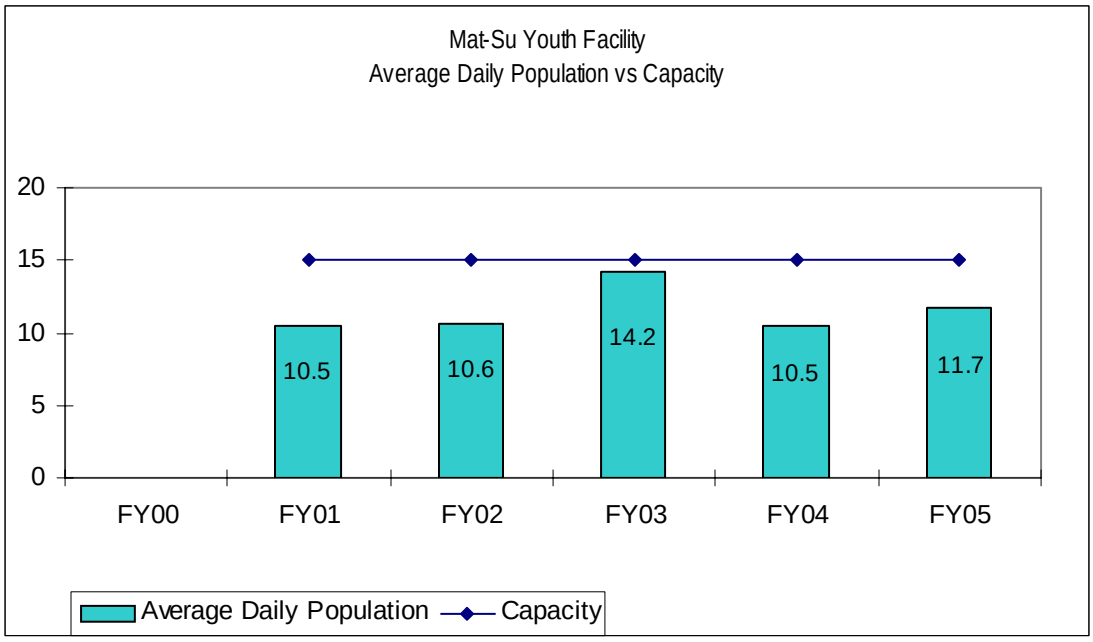


Mat-Su Youth Facility (MSYF)
MSYF is a 15-bed juvenile detention center located in the city of Palmer, Alaska, serving a population base exceeding 64,000 in addition to the outer lying areas of the Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. The facility provides secure detention to juveniles alleged to have committed a crime and MSYC also developed a transitional services unit (TSU) in FY05 to assist juveniles from the region transition more successfully from long term secure treatment into a community based setting. The facility also houses the DJJ Mat-Su Juvenile Probation offices.

Services provided to residents of the facility focus on education, physical and mental health, substance abuse and a variety of related activities and groups geared toward competency development and the restoration of victims of juvenile crime and the communities in which these crimes occur. A primary service to the community is that of public safety as we house juvenile offenders who are awaiting legal proceedings, placement or diagnostic evaluation to help determine a longer term plan of intervention and rehabilitation that is appropriate to their needs. In an effort to closely address substance abuse and mental health issues present with many Mat-Su kids, active planning and implementation of educational and support services to mitigate these circumstances are part of the programming at the MSYF. This requires active participation by community partners inside the facility as they assess the immediate and long-term treatment needs of kids.

Continued progress in the national quality assurance program of PbS will help to ensure that ongoing operational changes identified by the data are incorporated into facility practices to improve both program/system outcomes and those outcomes for individual youths and their families. MSYF has successfully completed the candidacy phase of PbS.

MSYF continues the effort to develop alternatives to detention resources based on local need. This is a critical component of the Division's overall system improvement plan to ensure that sufficient community-based resources are available in order to prevent "default" use of secure detention resources. These resources will also help to bolster the Transitional Services Unit by enhancing supportive community resources for kids re-entering the community from long-term treatment.



Kenai Peninsula Youth Facility (KPYF)
This is the newest facility within DJJ, with the first residents admitted to the facility in December 2003. The KPYF provides a ten-bed, secure placement setting for youth from the Kenai Peninsula area who are awaiting further court action, or pending transfer to or from an institutional program. The facility also houses the DJJ Kenai Juvenile Probation Offices and provides educational services in partnership with the local school district. Services provided to the residents of the facility and to the community focus on the restorative justice principles of community safety, offender accountability, skill development, and restoration of communities and victims.

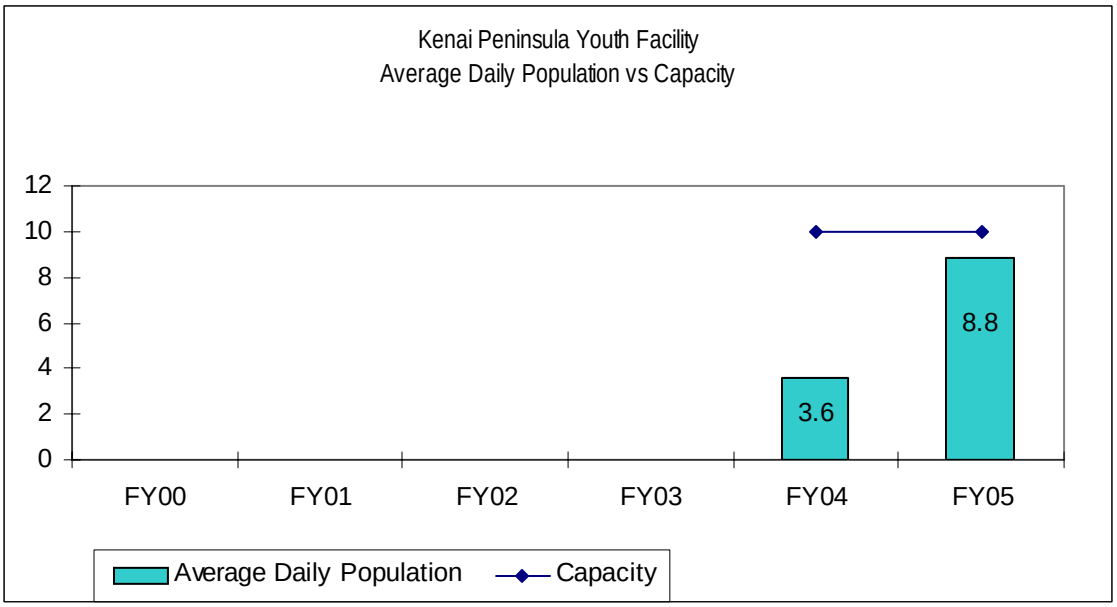
Core services include basic community protection, through the detention of youth with the highest potential to further harm the community, and the provision of basic physical needs for detained youth, such as food, shelter, and clothing. Services also include the provision of educational, recreational, and psychological services to promote the growth and maturation of the youth, with the intent of reducing the likelihood of further harm to the community.

The facility continues to face challenges in recruiting, training, and maintaining professional staff, as do other small rural facilities in Alaska.

Programmatically, key challenges continue to be the use of facility staff for community outreach and the transitioning of youth back into the community. The development of transition services for these youth remains a significant agency strategy to improve youth outcomes. This will include the development of mentoring, programming and supervision partnerships. Refinements in the delivery of transitional programming will include the development of a Transitional Services handbook that outlines the program and services offered to youth leaving secure care and an evaluation of the program's effectiveness.

Another key challenge is the translation of national performance based standards into improvements in ongoing operations. KPYF successfully completed the first year "candidacy" phase of the national quality assurance program of PbS. KPYF will continue to work on the data integrity aspect of PbS and will focus on integrating the outcome-oriented standards into the ongoing operations of the program.

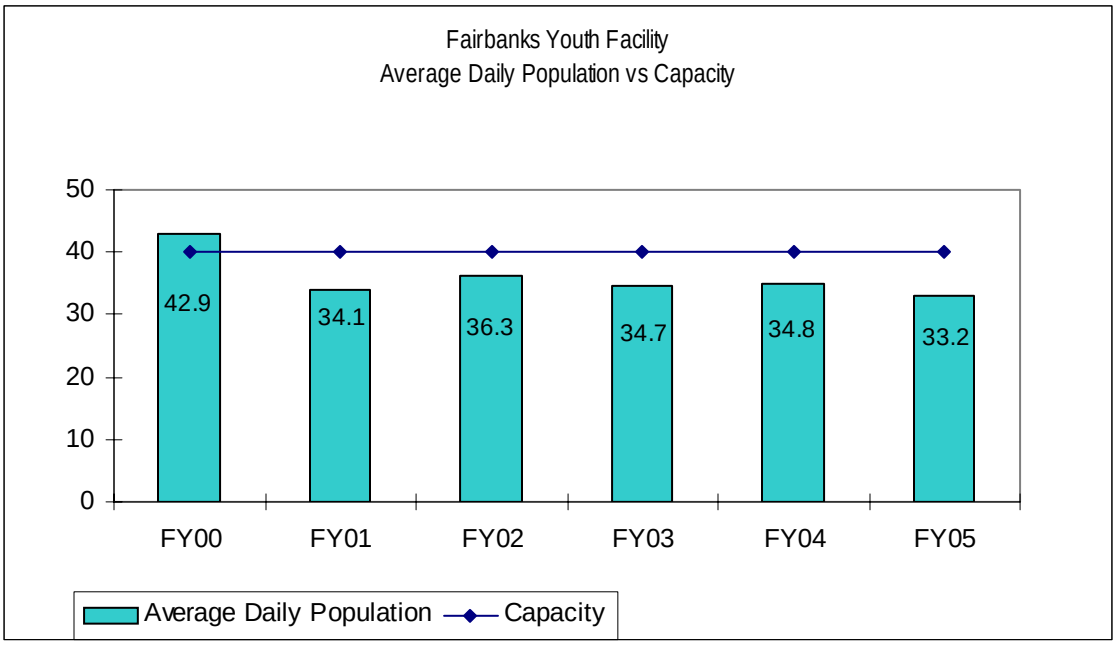
In keeping with DJJs system improvement plan to maximize agency resources and ensure quality services for youth, the facility has become an integral part of the community and provides a broad range of services to youth and their families.



The Kenai Peninsula Youth Facility opened in December of 2003. The data collected in FY04 is for 6.5 months.

Fairbanks Youth Facility (FYF)
FYF consists of a twenty-bed Detention Unit and a twenty-bed Treatment Unit. The Detention Unit houses and offers services to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court. The Treatment Unit houses and makes rehabilitative services available to adjudicated offenders who have been institutionalized by the Court for long-term treatment. The Fairbanks Youth Facility is the second largest of Alaska's juvenile correctional facilities and the Northern Region is the largest geographical area served by the Division in the State.

In FY07, FYF will increase the focus on working with Native organizations to improve culturally relevant services for youth in or transitioning out of the facility and will formalize the vocational/technical curriculum developed in collaboration with community partners to provide individualized training opportunities for youth. This will assist juveniles in a gradual and successful re-entry to the community following institutionalization and treatment. Youth with mental health needs or experiencing Fetal Alcohol Spectrum Disorders increasingly require one-on-one supervision and individualized programming, resulting in staff resource challenges. Continued implementation of PbS, a national best practice ongoing quality assurance program, will result in policy and operational changes to improve facility operations. In addition, FYF is one of the state's oldest facilities and continues to need repair and renovation of its physical plant, as well as sufficient conference and office space.



Bethel Youth Facility (BYF)

The Bethel Youth Facility (BYF) is the only youth facility in the entire Yukon-Kuskokwim Delta, an area the size of Oregon. The facility consists of an eight bed Detention Unit and an 11-bed Treatment Unit. To provide work and treatment space for the Mental Health services, a bedroom has been converted to a treatment room and office. This has reduced the facility treatment capacity to ten treatment beds.

The Detention Unit houses and offers services to alleged and adjudicated offenders who are either involved in the court process or awaiting other placement. The Treatment Unit houses and provides rehabilitative services to adjudicated offenders who have been institutionalized by the Court. Both Units are co-ed; the Treatment Unit is the only co-ed institutional treatment program in the Northern Region of Alaska. The facility's population is largely Alaska Native, particularly Yup'ik Eskimo, and comes to the facility from a wide geographical area including Southwestern and Southcentral Alaskan communities as well as Barrow, Nome, Kotzebue, and Fairbanks.

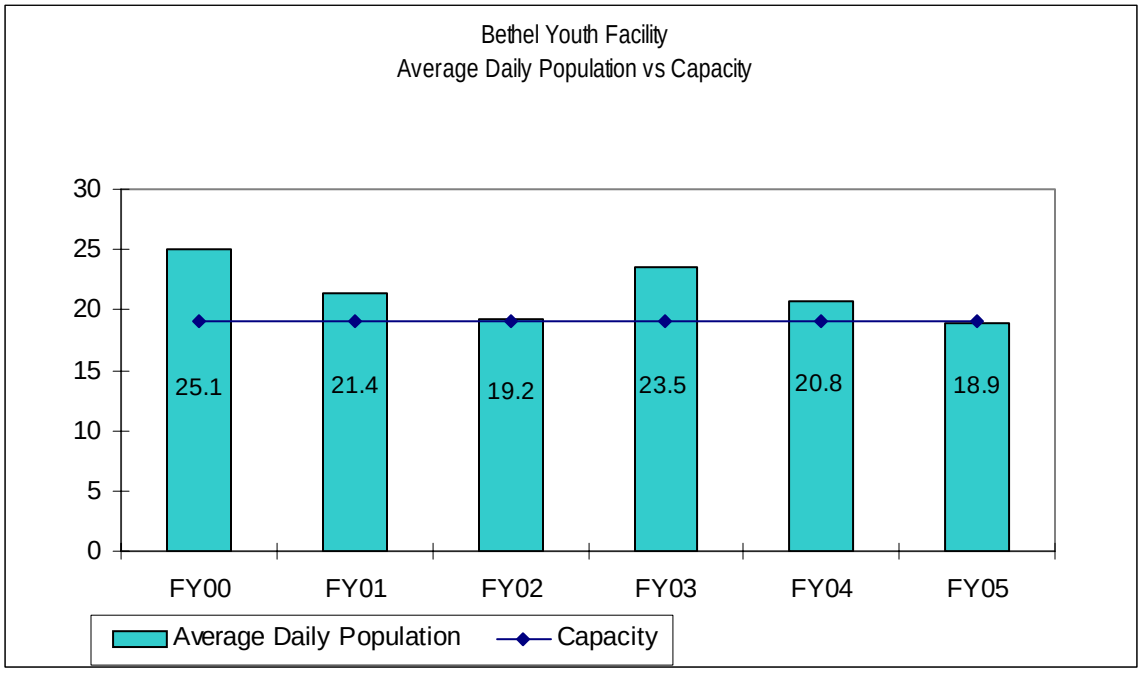
During FY05, juvenile offenders were housed at BYF for a broad range of offenses, including adjudications for murder charges. A significant percentage of residents have Fetal Alcohol Spectrum Disorders and other mental health needs. The average population on BYFs historically overcrowded eight-bed Detention Unit has continued to decrease, from 10.17 in FY04 to 9.51 in FY05. This represents a decrease of about 6%, due in part to an internally imposed "cap" of 10, which was instituted for the Detention Unit. When the population reaches 11, if no releases are imminent, youth are transferred to other detention facilities in the state. For the last six months of the fiscal year, the daily average of Bethel youth in other facilities was 4.95. Without the transfer of Bethel residents to other DJJ facilities, the average daily population of detention would be closer to 14.5.

The average population on the Treatment Unit declined in FY05. That Unit housed an average of 9.24 youth in FY05, down from 10.15 in FY04. Ten youth were released from Treatment in FY05. The average length of stay for those youth was 14.41 months, a decrease of approximately a month and a half from the FY04 average of 15.99 months. Again this year, one of the youth released had

been institutionalized for a murder charge, and had a length of stay of 56.31 months. Excluding this one young man, the average length of stay for the nine remaining youth was 9.75 months.

The lack of adequate space for staff continues to pose a significant challenge for the facility staff and the juvenile probation officers who work there. Probation Officers are required to share offices and, for one position, to sit at the reception desk in an open hallway, significantly compromising the ability to work effectively with multi-needs and high-risk youth and their families. Visiting contract service providers must use offices of facility staff (compromising the ability of both workers to perform their duties), and the maintenance worker for the facility remains without a work place. Other visitors, such as attorneys and clinicians, must frequently see their clients in the Detention time-out room.

BYF is now a 20-year-old building, and is showing wear and tear of the years. There are a multitude of deferred maintenance needs, including renovations to walls and floors in the kitchen and bathroom, window replacement, carpet replacement, security systems upgrades, and exterior siding. The lift station, which is currently housed beneath a classroom, needs to be relocated and renovated, as their servicing has become so frequent that the work regularly disrupts classes. Much of the furniture in the facility dates to the facility's opening, and needs to be replaced or repaired.



Nome Youth Facility (NYF)

NYF operates as a short-term detention facility for juveniles of the Nome and Kotzebue region. Treatment services have steadily grown for the residents in the past few years with a program that emphasizes offender accountability. The facility is considered minimum security and in FY06 expanded from a 6-bed to a 14-bed detention program upon completion of an extensive renovation and expansion project begun in FY05. The program in FY06 has been expanded to include training staff to deliver ART, to building relationships with families, and the initial steps to begin the new NYF Aftercare/Transitional Services program.

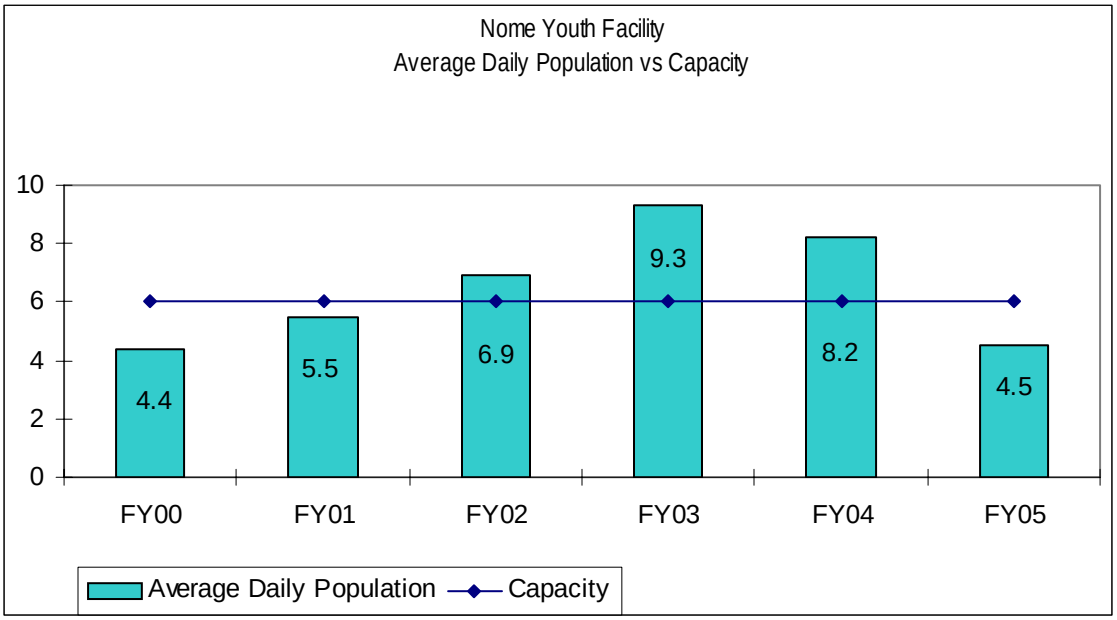
The resident population is primarily male and nearly all Alaska Native. The residents are commonly detained for property crimes but there has been an increase in the number of residents charged with

major assaults and/or sexual crimes. Many of the youth have a history of substance abuse and/or inhalant abuse. The facility has continued to experience significant overcrowding, operating at 150% capacity in FY03 and at 137% of capacity for FY04. In FY05, they operated at 32.11% capacity due to the closure for the renovation. Now that the renovation is complete, it is anticipated that the overcrowding will no longer be a problem.

The Average Daily Population vs. Capacity chart shows that the capacity at the facility increased in FY99 from three to six. During the time that the facility was closed (due to budget reasons) it was being used only as a short-term holding unit until the youth were sent to Fairbanks or Anchorage for placement.

An increment for FY06 was requested to fully staff the newly renovated and expanded facility, including one Juvenile Justice Officer III position, three additional juvenile justice officer line staff, one administrative clerk and a part-time nurse. The additional staff has allowed NYF to maintain the minimum staffing pattern required in order to meet the safety and security standards established for all of Alaska's juvenile detention facilities, and at the same time continue to operate a program that holds each youth accountable for his behavior.

The primary challenge facing NYF in FY07 will be to train and prepare the staff for operating a small treatment program based on the data received from the YLS/CMI assessment tool. In addition, the NYF staff will implement an electronic monitoring program in FY06 as another important element in using DJJ facility staff to effectively monitor and supervise youth throughout phases of their institutional stay while maintaining community safety.



During FY05, the NYF was partially closed due to the renovation of the building. The renovation was complete at the end of FY05; the increased capacity is not reflected on this chart.

The newly renovated Nome Youth Facility

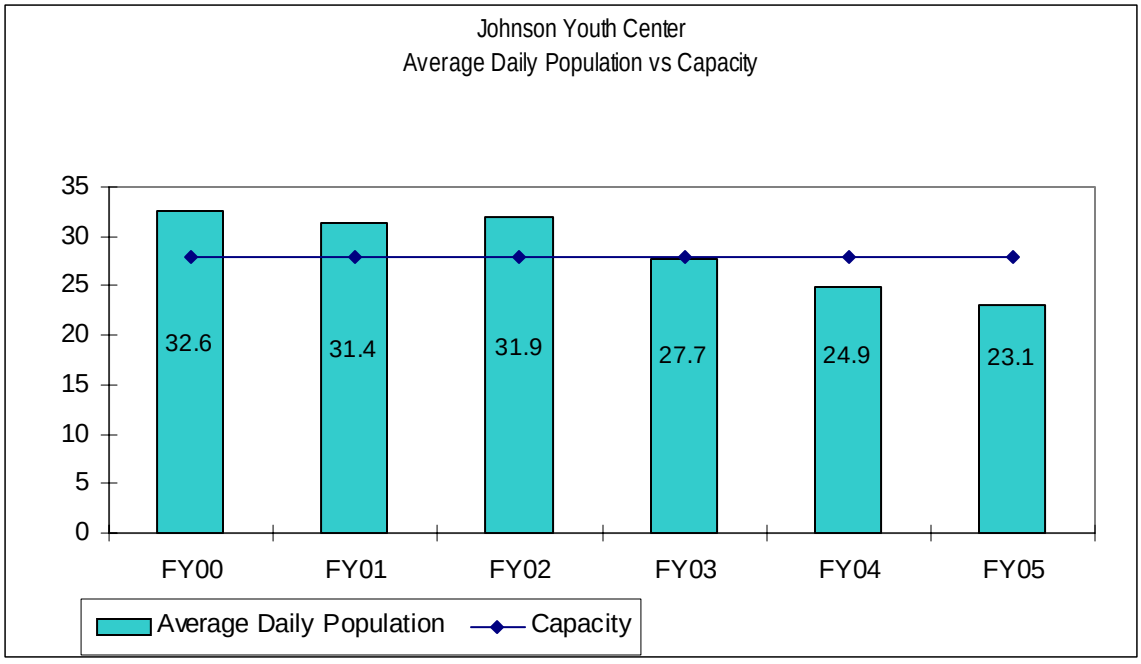
Johnson Youth Center (JYC)

JYC is a 28-bed facility (8 detention and 20 treatment) that provides short-term, pre-trial detention, control and intervention for juveniles who have been ordered confined by the Superior Court due to the danger they present to the public and/or to themselves. The Johnson Youth Center Detention Unit provides an array of basic and specialized delinquency intervention services. The Treatment Unit provides rehabilitative services to adjudicated offenders who have been institutionalized by the Court.

In FY07 there are several activities JYC will focus on. Detention Unit staff will continue working on the development of the Alternatives to Detention program. This program will enable facility staff to monitor and assist juveniles currently on probation, to successfully remain out of detention and in the community. Participation in the PbS will continue, ensuring positive program outcomes and enhanced public safety. And the development of a full-time Probation Aftercare case manager will be a primary focus. This position will assist with the re-entry of juveniles to their communities are being released from long-term treatment in the southeast region.

During FY05, the staff turnover rate was reduced to 6.88%, which is within the targeted percentage for staff turnover. Turnover and retention issues are a constant challenge for facilities and will continue to be an area of emphasis for JYC, ensuring staff stability and positive resident outcomes.

The former facility Superintendent retired from state service in late FY05 and the position has operated for approximately 6 months using rotating existing DJJ leaders. The new Superintendent comes from DJJs management team from another part of the state and will be adjusting to the myriad of new job responsibilities required of a superintendent. He will be focusing on key component challenges, ensuring a smooth transition in the facility culture after months of the position being vacant and reviewing the facility's adherence to the DJJ system changes that have been initiated in the past few years.

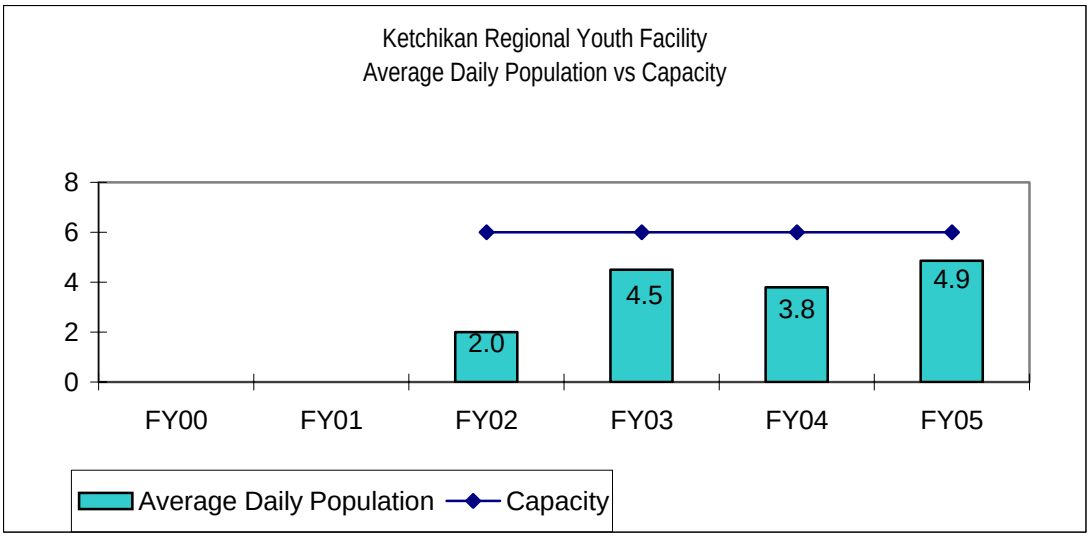


Ketchikan Regional Youth Facility (KRYF)

The Ketchikan Youth facility is a 10-bed dual function facility that provides detention of youth who are awaiting a court hearing or who are court-ordered into the facility (six locked detention beds) and a short-term-crisis respite and stabilization services for youth experiencing a mental illness (four bed staff secure). The unique combination of a detention unit and a crisis stabilization unit (CSU) in one location is an innovative feature for a youth facility, both in Alaska and in the United States. To date, the majority of the youth served in detention have been drug-affected and in serious conflict with their community, as evidenced by either suspension, expulsion or drop out educational status and a pattern of frequent violations of prior court orders.

The CSU program, due to its uniqueness, originally took some time to develop and integrate into the community of Ketchikan and the surrounding areas. During the past year the CSU maintained its utilization goal of approximately 75% capacity. This goal was established as a result of regional meeting held in 2004 between DJJ, Ketchikan, and regional mental health providers. In coordination with the Juvenile Probation Office in Ketchikan, KRYF implemented an electronic monitoring program for five youth beginning in the latter part of FY04. Electronic monitoring has always been a program favored by the Ketchikan courts as an alternative to detention. The facility staff installs the equipment and provides youth and parent groups scheduled check-ins to ensure that youth are being held accountable. They also provide contact with the schools and respond to any alarms from the electronic monitoring equipment. This program is aligned with DJJs system reinvestment plan to develop a balanced juvenile justice service continuum that uses resources effectively and efficiently. The electronic monitoring program in Ketchikan has been modified and adapted for use by other detention facilities across Alaska.

The challenge for Ketchikan in FY07 will be continue to build upon the new management team that was established in FY06, and the implementation of the DJJ System improvement plans. Continued implementation of PbS, a national best practice ongoing quality assurance program, will result in policy and operational changes to improve facility operations.



*The capacity for KRYF includes only the six locked detention beds.

Juvenile Justice	2006	2007 Proposed	06 to 07 Change
General Funds	36,554.4	39,810.0	3,255.6
Federal Funds	3,087.4	3,187.4	100.0
Other Funds	932.6	920.6	-12.0
Total	**40,574.4**	**43,918.0**	**3,343.6**

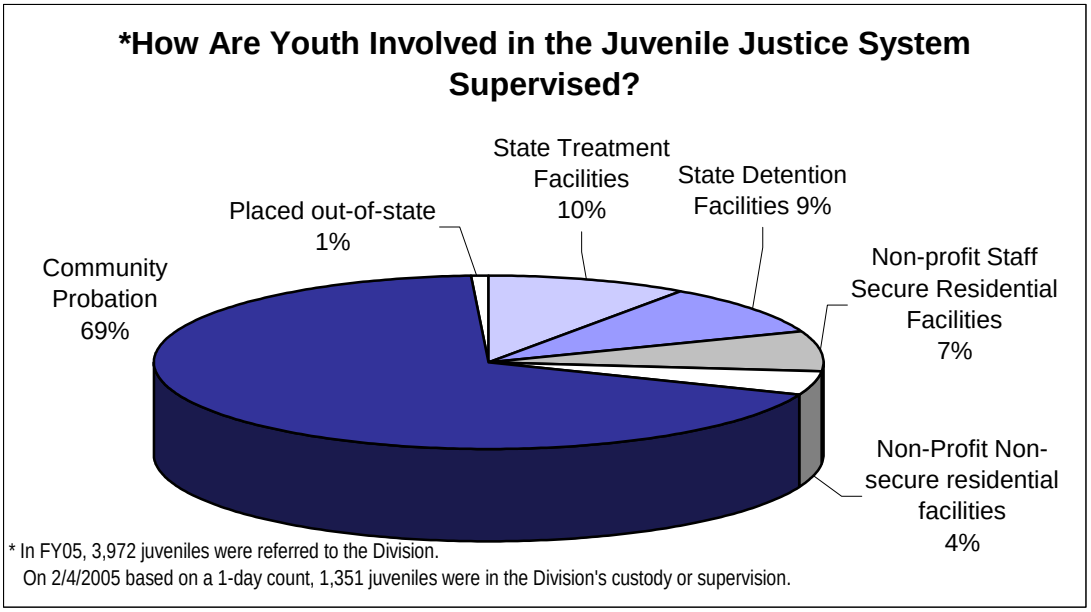
The Division is statutorily mandated to protect the public, hold juvenile offenders accountable, restore victims and communities and develop offender competencies to reduce the likelihood of re-offense. A balanced and restorative justice approach to services and programming ensures that juvenile offenders take personal responsibility for repairing the harm caused to victims and communities as a result of their delinquent conduct.

Probation Services

Public Safety Through Offender Accountability $933.3 General Fund

Juvenile Probation Officers (JPOs) are one of the most important community-based resources deployed by DJJ to ensure that juvenile offenders are supervised, pay restitution, perform community work service and develop the skills required to reduce the likelihood of re-offense. JPOs review every single delinquency referral (report from law enforcement) and make critical public safety decisions and recommendations to the court. These positions are vital to the community as they are the first responders to juvenile law violations. Once a report is received from law enforcement, the JPOs ensure that responses are timely and appropriate to the level of seriousness of the offense.

The majority of youth who commit law violations and receive services from DJJ are served in the community and not in a secure setting, as may be seen in the chart below. These youth are supervised by a juvenile probation officer, who clearly comprise a significant component of providing offender accountability within Alaska.



This request is critical to ensure continued public safety and security in both urban and rural Alaska. The increment will ensure an adequate and timely response to juvenile offenders who warrant active supervision and monitoring of their behavior in order to prevent repeat or more serious juvenile crime. If this request is not funded, the reduced number of JPOs will result in the inability to continue the following services:

- Intake investigation and outcome
- Formal assessment of youth level of risk and need;
- Formal court processing, including reports and appearances in support of juvenile prosecution
- Supervision and monitoring of juvenile offenders in the community
- Supervision of community work service and restitution for youths on informal probation

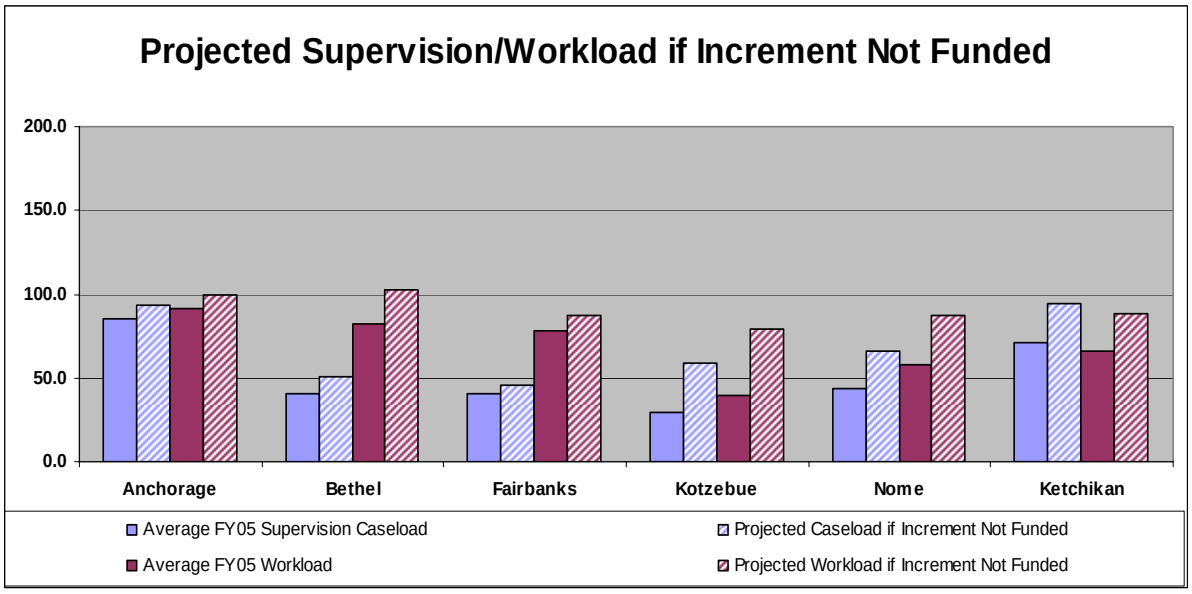
Since FY01, several positions within the division have been paid for with federal Juvenile Accountability Block Grant (JABG) funds. At that time, the yearly federal award amounts were well over $1 million dollars ($1.6 million in FY01; $1.3 million in FY02; $1.0 million in FY03). In FY03, the division learned that the funding for the JABG grant was going to be greatly reduced. The division initiated active and aggressive efforts to begin transferring the funding of these positions to general fund in order to avoid significant service reductions in the urban and rural locations where the JPOs were located. The division has succeeded in absorbing this significant federal reduction with no general fund increase.

Over the past few years, DJJ has relied on a variety of approaches to pay for the services of Juvenile Probation Officers due to historically not having sufficient operating funds to cover total costs in the probation services component. Specifically, in FY03, DJJ imposed an agency wide hiring freeze for 4.5 months, including in secure 24-hour facilities. This enabled us to charge some of these personal service costs to general fund dollars.

In FY04 the division received a full year's worth of funding for the new Kenai Peninsula Youth Facility. But due to construction delays, it did not open until mid-year. The operating funds that were available due to the delayed opening were used to pay for probation officers and corresponding costs to youths in communities in the probation services component.

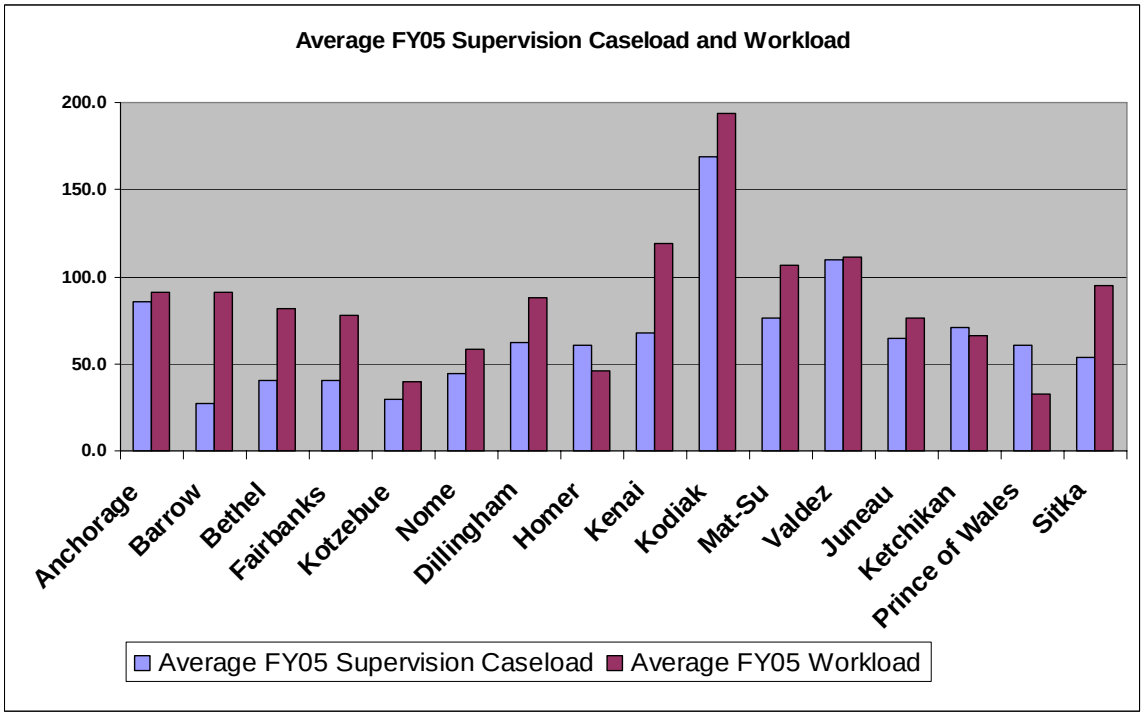
In FY06, in order to avoid significant service reductions or disruptions, all of the new positions the division received in the FY06 budget in all components were kept vacant until at least January 1, 2006. As an added precaution, all other vacancies within the RDU, including in 24-hour facilities, were required to be held open for a minimum period of one month prior to filling the position.

Once the new positions are filled, DJJ will need additional general fund dollars to maintain them in FY07. The Division cannot continue to depend on excess funds available from building projects or hiring freezes to keep us within our budget. Without this increment, we will be forced to lay off several juvenile probation officers throughout the state, seriously hampering the division's progress in implementing the system improvement efforts of the past few years, all of which are geared toward increasing the agency's ability to make data-driven decisions that improve overall outcomes and performance. Additionally, the inability to maintain the existing number of JPOs due to layoffs will increase the caseloads of remaining JPOs to unacceptable levels, resulting in reduced levels of supervision of juveniles and the inability to hold offenders accountable in a timely manner. Although it is difficult to predict which communities will be impacted by layoffs, it is certain that there will be increases to caseloads in those areas where layoffs will be necessary.



If we receive the full amount of the increment, the division will be able to continue to provide critical public safety services to communities with no reduction in service.
Receipt of this increment will also enable DJJ to move forward with implementation of the YLS/CMI system initiative outlined earlier in this overview, which requires probation staff for implementation.

This chart identifies the Supervision Caseloads and Workloads during FY05 for all of our offices statewide. The new positions received in the FY06 budget were not filled until January 1, 2006; thus not reflected in the FY05 data.



Bring the Kids Home Care Coordination Project $100.0 General Fund/Mental Health; $100.0 Federal

The Alaska Mental Health Trust initiated four work groups the end of FY04 to inform the Trust's FY06 Budget Planning Process. One work group, comprised of multiple stakeholders across Alaska, was formed to address the significant problem of so many Alaskan youth being sent out-of-state to receive residential psychiatric services. This began the initiative now called "Bring The Kids Home" in which the Department of Health and Social Services is a major partner along with the Alaska planning boards, parent advocacy groups, behavioral health provider agencies and others.

The multi-year plan (FY06-FY12) has identified seven outcomes that are being tracked and monitored: They are:

1. **Client Shift**. Reduction in the total number of seriously emotionally disturbed (SED) children/youth being sent out of state by 90% by FY12 (15% per year).
2. **Funding Shift**. 90% reduction in Medicaid/GF match dollars from out of state services to SED children/youth with corresponding increase in Medicaid/GF match dollars in in-state services by FY12 (15% per year).
3. **Length of Stay**. Reduction in the average length of stay in in-state and out-of-state institutions by 50% by FY12 (8% per year).
4. **Service Capacity**. Increase in the number of beds/slots in home and community based services in communities or regions of meaningful ties by 60% by FY12 (10% per year).
5. **Effectiveness**. Decrease in number of children/youth returning to residential care by 75% by FY12. Defined as youth/child returning within one year to the same (or higher) level of residential care (recidivism measure). This is to be reduced by 12.5% per year.
6. **Client Satisfaction**. Via annual reporting, 85% of kids and families report satisfaction with services received.
7. **Functional Improvement**. 85% of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge.

Through the Bring The Kids Home collaboration, a master-planning document was developed which identified a number of strategies to further build the continuum of care in Alaska for youth experiencing severe emotional disturbances and their families. One of the eight strategies outlined in this comprehensive plan is related to assessment and care coordination. Specifically Strategy #7 is to "develop gate-keeping policies and practices and implement regional networks to divert kids from psychiatric residential care". For FY06, the Trust agreed to add an additional $933.0 to fund this effort.

The Care Coordination subcommittee has proposed a statewide system or structure, which is designed to review and provide approval of (if appropriate) requests for placement of youth in Alaska-based residential centers or in out-of-state residential psychiatric treatment centers. This structure has been in place for many years for youth in the custody of the Department of Health and Social Services. With this current structure, very few youth who are in DHSS custody are placed in treatment out-of-state. Instead, this review and approval process results in "custody" youths being served as close to their home communities in Alaska as possible. The Care Coordination subcommittee's proposal expands the current system to include those youths who are *not* in the custody of DHSS and who instead remain in parental custody. Since "non-custody" youth make up the bulk of the youth placed out-of-state, it makes sense to build on a system that is already working by expanding it to include a process of review for these youth.

In order to expand the Department's current review structure, which includes four "Regional Placement Committees" and one statewide "Out-of-State Placement Committee," two additional positions must be added to DJJ. As a partner in the current review processes for "custody" youth, it is imperative that DJJ also be a partner in the review process for "non-custody" youth. Many of these youth are involved with DJJ services, even if they are not in DJJ custody. Further, with DJJ expertise, the expanded review structure may result in diversion from DJJ services. Working together through this review structure with provider agencies, parents, advocates and other DHSS agencies such as the Office of Children's Services, we anticipate being able to help these youth and families access the most appropriate services as close to their home communities as possible.

The positions needed within DJJ to facilitate this expanded system include an Associate Coordinator at the Range 18 level, and a Social Services Program Coordinator, Range 20. The Associate Coordinator will be tasked with participating at a statewide level for review of youth and families or guardians seeking in-state placement; the Social Services Program Coordinator's duties will be focused on participating in the review for youth seeking out-of-state placement. Again, given the extreme proportion and high number of youth in parental custody currently in out-of-state residential psychiatric treatment, these positions are necessary to expand this system for "custody" youth to "non-custody" youth. Both positions are critical to meeting Strategy #7 which is to implement networks or systems to divert youth from residential psychiatric treatment centers.

All Components

Assistance for Increased Fuel/Electricity Costs $88.4 General Fund

The significant increase in oil prices have caused various infrastructure costs within the division to increase exponentially. Specifically, the cost of heating oil, natural gasoline and electricity has risen sharply.

The DH&SS anticipates a 28% fuel increase in FY06 over the FY05 fuel cost expenditures and has factored only half of that amount (14%) for the FY07 increment for DHSS state-owned buildings.

Based on this calculation, DJJ will need an additional $88.4 to cover anticipated cost increases for FY07 in their facilities. The breakdown is as follows:

McLaughlin Youth Center:	$38.8
Mat-Su Youth Facility:	$3.5
Kenai-Peninsula Youth Facility:	$4.0
Fairbanks Youth Facility:	$14.0
Bethel Youth Facility:	$12.3
Nome Youth Facility:	$2.1
Johnson Youth Center:	$9.9
Ketchikan Regional Youth Facility:	$2.6
Probation Services:	$1.2

If the division does not receive these increments, the operations of the programs in the state's juvenile facilities and probation field offices will be adversely affected. These increased fuel and electricity costs are beyond the agency's ability to control but must be paid as part of the cost of keeping 24-hour institutions operational and of supporting the critical services provided by probation officers supervising juvenile offenders in the community.

If funds for the above stated purpose are not received, then operating funds that currently pay for holding juvenile offenders accountable for their behavior, promoting the safety and restoration of victims and communities and assisting offenders and their families in developing skills to prevent crime, will need to be diverted. In short, the Division will be forced to use funds that pay for front-line Juvenile Probation officers or Juvenile Justice Officers in facilities to cover the increased cost of fuel and electricity. This would result in reduced service levels. Depending upon how the division allocated these costs, this could translate into a smaller number of JPOs to respond to juvenile delinquency with resulting loss of community protection. Other alternatives include reducing facility staff numbers, exposing both staff and residents to greater likelihood of injury, escape, serious incidents and resulting higher liability to the state.

McLaughlin Youth Center

Increased Infrastructure Support Costs $108.1 General Fund
Ongoing operating costs to the division continue to rise. In FY05, we paid increased costs of $325.1 from FY04 for various ongoing operating costs, including human resource services, computer resource charges and legal representation as well as internal departmental charges for services. The total amount paid in FY04 for these various services totaled $520.4; in FY05, these same services cost the division $845.5, an increase of 62 percent. The division is requesting $108.0 (21% of the actual increase) to pay for these additional costs in FY07.

The $108.1 will be broken out by facility components, all of which are represented in this request.

McLaughlin Youth Center: $52.1
Mat-Su Youth Facility: $7.0
Kenai Peninsula Youth Facility: $5.7
Fairbanks Youth Facility: $12.7
Bethel Youth Facility: 10.1
Nome Youth Facility: $4.4
Johnson Youth Center: $11.5
Ketchikan Regional Youth Facility: $4.6

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Division of Juvenile Justice System Improvement Update

Overall Goals:

- Ensure that Alaska has a balanced juvenile justice service continuum that uses resources effectively and efficiently.
- Ensure that the state's juvenile justice system makes decisions that are based on objective criteria, are defensible, and ensure desirable outcomes.

1. **Improve Gate-keeping and Oversight Function for Secure Detention and Develop Appropriate Alternatives:**

   A. Objective, risk-based DAI implemented (November 2003) and automated (May 2004) to ensure appropriate use of secure detention resources.
   B. Policy and procedure requiring additional oversight and management of length of stay in secure detention implemented (July 2003).

   FY06 and FY07 Follow-up:

   - Quality Assurance process needs to be implemented to ensure compliance with existing policy and reduce the percentage of detentions done without completion of a DAI
   - Quality improvement effort needs to emphasize adherence to policy goal of reserving detention for youth posing risk to the community.
   - Data review of DAI decisions since implementation needs to be completed, with specific emphasis on use of overrides and resulting policy implications.
   - Continue efforts to expand community-based alternatives to detention and redirect existing resources to front end of service continuum based on ongoing review of data to drive decision-making.

2. **Emphasize research-based, data-driven approaches to improve decision-making and agency outcomes:**

   A. Implemented (pilot sites 2004, statewide October 2005) and automated (October 2005) the YLS-CMI, a research-based risk needs instrument and process that allows for use of risk and need to more appropriately make juvenile case decisions based on data.

   FY06 and FY07 Follow-up:

   - Review YLS-CMI implementation throughout FY06-07, making necessary implementation and policy adjustments based on data review and feedback from agency field staff.
   - Implement Quality Assurance process to ensure compliance with existing YLS policy and use data to appropriately target agency resources, both on an individual youth level and system wide.
   - Train remainder of juvenile probation staff in YLS implementation to ensure consistent application of data-driven approach to assessing risk and need and determining appropriate course of action and use of resources.

- Incorporate YLS-CMI information into ongoing probation field work, including case planning, referral for services, management audits regarding decision-making and use of agency resources.

B. Implemented PBS, a national, data-driven system of quality improvement for juvenile justice facilities (detention and treatment), in all DJJ secure facilities. DJJ youth facilities successfully completed two PbS data collection cycles (October 2004, April 2005), ending their status as "candidates. Each site is now a fully engaged participant in the national PbS process.

FY06-FY07 Follow-up:

- DJJ quality assurance coordinator position was hired September 2005. Position will emphasize ongoing continuous improvement and standardization in practice across all DJJ facilities, using PbS data.
- Focus on PbS data integrity and the need to use data to drive development and implementation of individualized facility improvement plans (FIP's), with overall goal of improving outcomes for both facility residents and staff at each facility.
- PbS required data elements and reports need to be interfaced with JOMIS to minimize duplication of effort and maximize use of existing database. Efforts will continue to automate the PbS process as much as possible.

C. Implement ART, a research-based curriculum designed to improve outcomes for chronically aggressive youth who are moderate to high risk to re-offend.

FY06-FY07 Follow-up:

- Deliver ART in 4 pilot sites (Anchorage, Juneau, Fairbanks, Nome) through FY06 consistent with required program elements to ensure positive youth outcomes.
- Implement quality assurance protocols, to include videotaping of sessions and feedback from program developer, with a view toward development of internal capacity for monitoring ongoing program integrity.
- Implement a training of trainers (TOT) within DJJ to develop internal agency capacity for program sustainability and eventual expansion, based on data.
- Evaluate the possibility of ART implementation with broader group of youth based on initial pilot site implementation and feedback and resource availability.

3. Develop a balanced continuum of juvenile justice services to maximize existing DJJ resources and ensure quality service delivery across all facets of the system:

A. Enhanced community-based juvenile justice services with existing resources to expand non-secure shelters, electronic monitoring and community-based accountability contact and juvenile monitoring.
B. Consolidated McLaughlin Youth Center's resources and reconfigured a treatment cottage into a Transitional Services Unit to better prepare youth to transition back to the community.
C. Implemented enhanced step-down/re-entry services at stand-alone Mat-Su and Kenai detention facilities.

FY06 and FY07 Follow-up:

- Continue to refine and implement site-specific plans and services to use facility staff to provide additional community services when facility counts are under-capacity
- Finalize the definition of research-based approaches to probation services to drive all facets of policy implementation and training
- Define community resource gaps by region and work with local providers and DJJ staff to implement necessary services to ensure improved outcomes

See Juvenile Justice Service Delivery System flow chart on the following pages.

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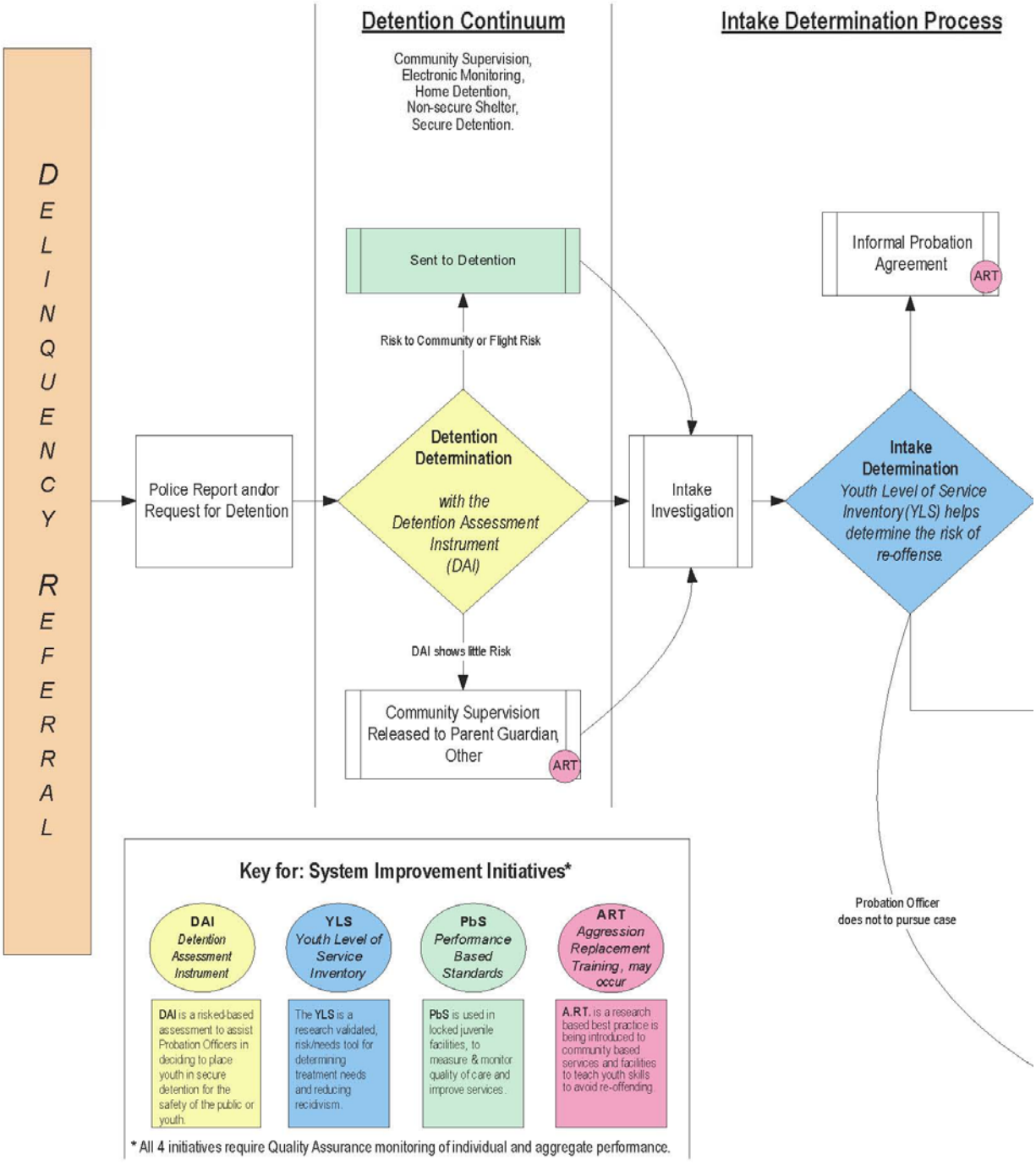
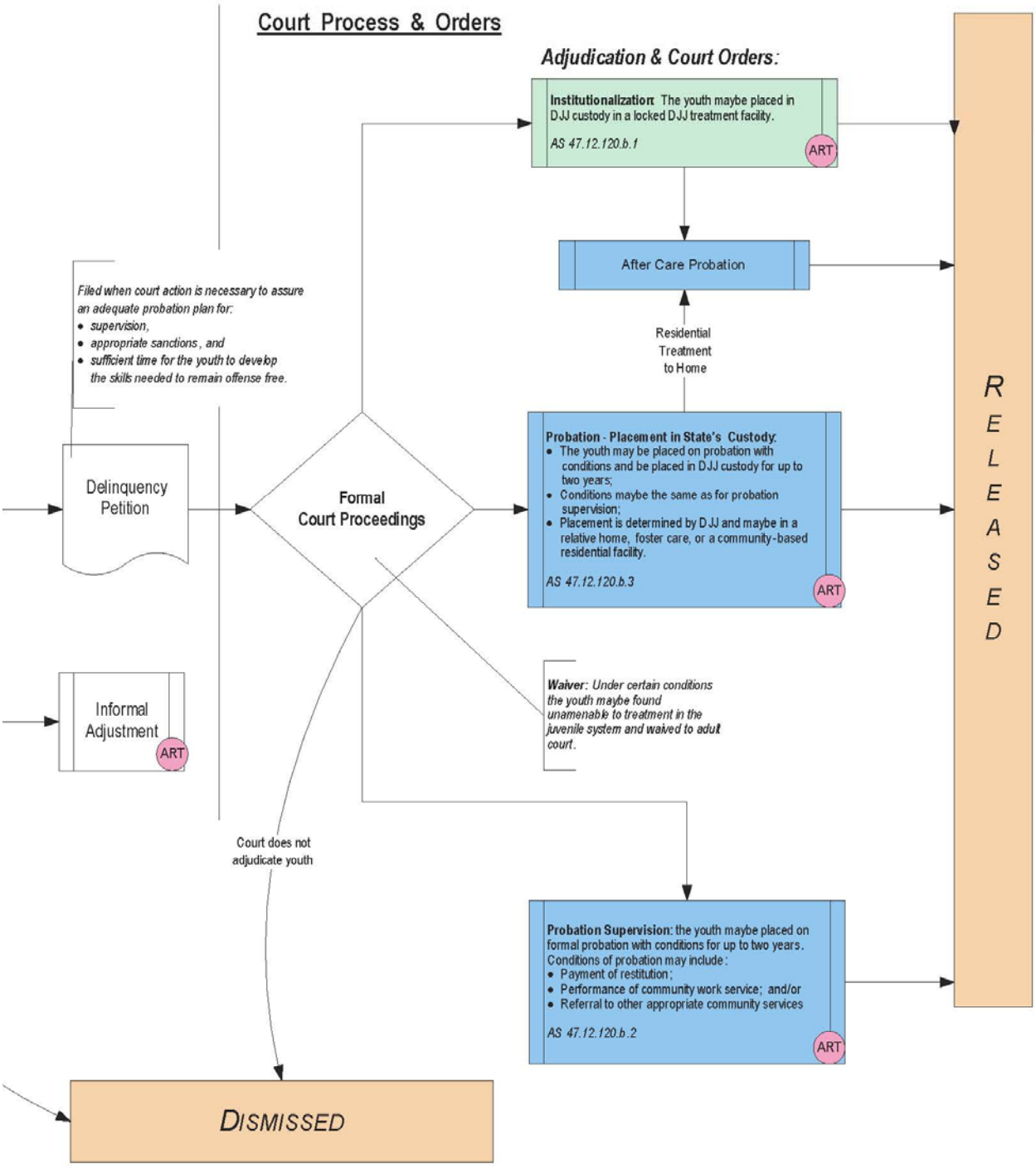
Juvenile Justice - Service Delivery System




Court Process & Orders
Adjudication & Court Orders:
Institutionalization: The youth maybe placed in DJJ custody in a locked DJJ treatment facility.
AS 47.12.120.b.1
ART
After Care Probation
Residential Treatment to Home
Filed when court action is necessary to assure an adequate probation plan for:
• supervision,
• appropriate sanctions, and
• sufficient time for the youth to develop the skills needed to remain offense free.
Delinquency Petition
Formal Court Proceedings
Probation - Placement in State's Custody:
• The youth may be placed on probation with conditions and be placed in DJJ custody for up to two years;
• Conditions maybe the same as for probation supervision;
• Placement is determined by DJJ and maybe in a relative home, foster care, or a community-based residential facility.
AS 47.12.120.b.3
ART
RELEASED
Informal Adjustment
ART
Waiver: Under certain conditions the youth maybe found unamenable to treatment in the juvenile system and waived to adult court.
Court does not adjudicate youth
Probation Supervision: the youth maybe placed on formal probation with conditions for up to two years.
Conditions of probation may include:
• Payment of restitution;
• Performance of community work service; and/or
• Referral to other appropriate community services
AS 47.12.120.b.2
ART
DISMISSED

Contribution to Department's Mission

The mission of the Division of Juvenile Justice is to address juvenile crime by promoting accountability, public safety and skill development.

Core Services

- Short-term Secure Detention
- Court ordered institutional treatment for juvenile offenders
- Intake investigation and outcome
- Probation Supervision and Monitoring
- Juvenile Offender Skill Development

Department Level Measures

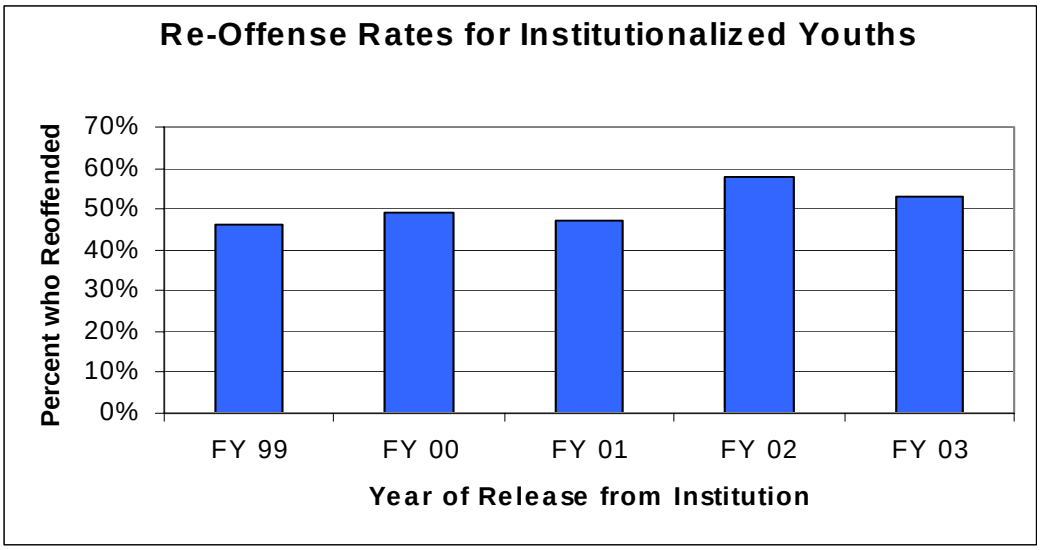
E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend within a 24-month period following release from institutional treatment facilities to no more than 40% of the total.

Measure #1: Percentage change in re-offense rate within a 24-month period following release from institutional treatment.

Race	Number Released in FY03	Number of Re-offenders 24 Months After Release	Percentage Offenders
Caucasian	65	33	51%
African American	10	6	60%
Native Alaskan/American Indian	44	25	57%
Asian	1	0	0%
Pacific Islander	2	2	100%
Multiple Races	8	3	38%
Other	3	1	33%
Total	**133**	**70**	**53%**

Facility	Number Released in FY03	Number of Re-offenders 24 Months After Release	Percentage Offenders
Johnson Youth Center	12	4	33%
McLaughlin Youth Facility	95	55	58%
Fairbanks Youth Facility	20	7	35%
Bethel Youth Facility	6	4	67%
Total	**133**	**70**	**53%**

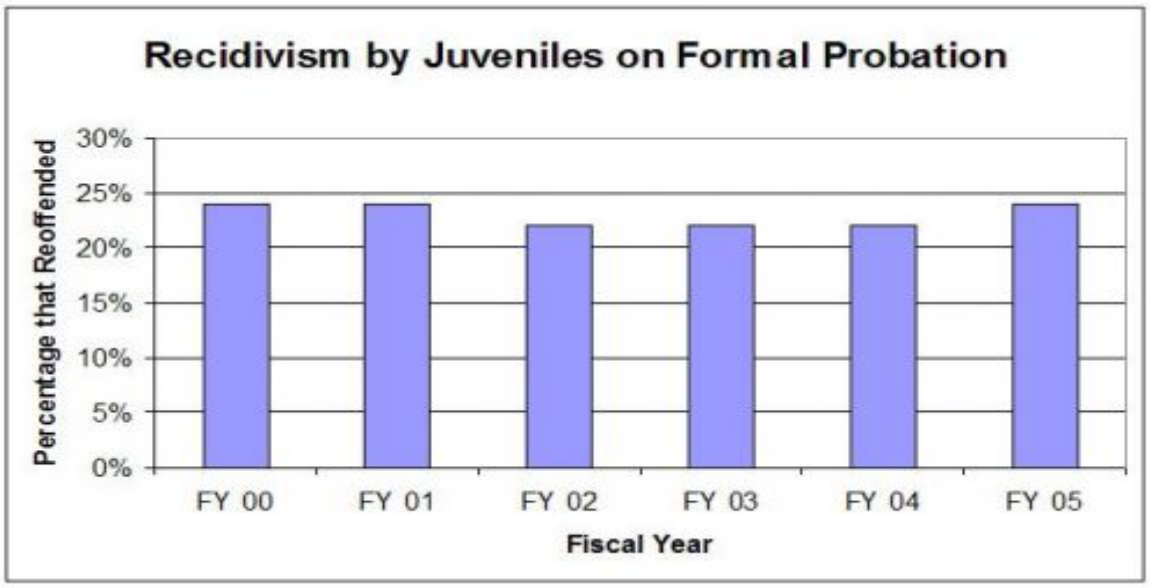


Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Re-offenses are defined as: any offenses resulting in a new juvenile institutional order, a new juvenile adjudication, or an adult conviction. Adjudications and convictions for traffic offenses, Fish & Game violations, violations of Minor in Possession/Consuming Alcohol and Driving While Intoxicated are excluded. Adjudication and convictions received outside Alaska are excluded from analysis.

Analysis of results and challenges: The percentage of youths who were released from Alaska's youth facilities in FY03 and who re-offended within a subsequent 24-month period was slightly reduced compared with last year's percentage. However, the small numbers of youth who are released each year from Alaska's four treatment facilities make it difficult to determine whether this decrease represents a significant or genuine trend. The Division will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Target #2: Reduce percentage of juveniles who re-offend within a 24-month period following completion of formal court-ordered probation supervision to 20% of the total.

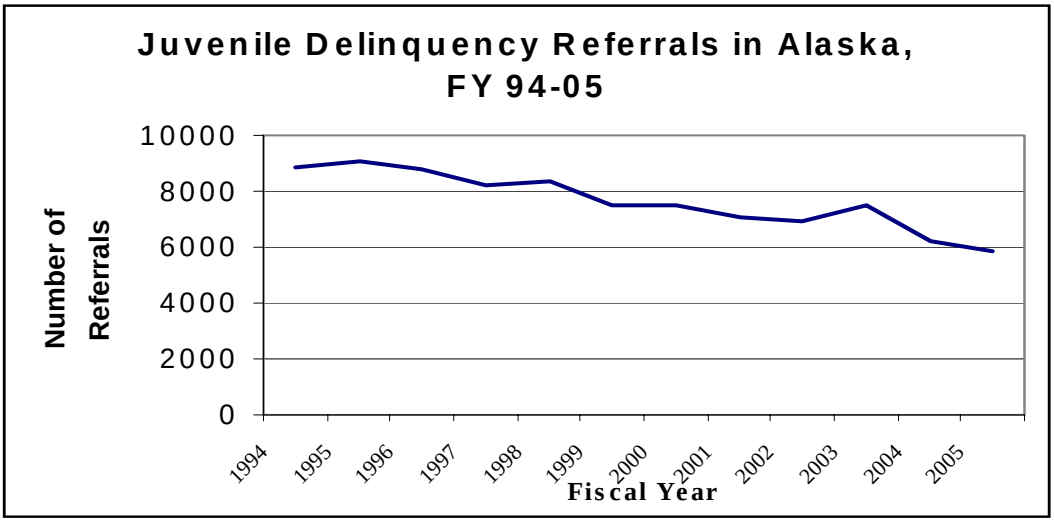
Measure #2: Percentage change in re-offense rate within a 24-month period following completion of formal court-ordered probation supervision.



Analysis of results and challenges: The percentage of juveniles who re-offended in the 24-month period following closure of their formal probation episode has remained relatively constant over the past several years. In 2003, the number of youth on formal probation was significantly increased compared with the year before, reflecting an increase in overall referrals that year. However, the rate of re-offense remained consistent with previous years.

The Division intends to evaluate this measure in the coming year to determine whether limiting the term "re-offense" to those offenses resulting in a formal adjudication or conviction (as is done with the institutional population performance measure) provides a more accurate picture of re-offense activities than when all referrals to the Division are included in the analysis. Additionally, in FY06 DJJ will be working with the Department of Public Safety to determine how information from the Alaska Public Safety Information Network can be used to track recidivism by those juveniles who have aged out of the juvenile justice system. Given that the data reported in this measure currently do not include adult information, it is anticipated that once this information is included the rate of re-offense will increase.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



Numbers of Juveniles, Referrals, and Charges by Region and Office, FY 05

Region		Juveniles	Referrals	Charges
ANC	**ANCHORAGE**	1505	2094	3140
NRO	**BARROW**	96	175	244
	BETHEL	235	400	754
	FAIRBANKS	477	701	1191
	KOTZEBUE	51	79	157
	NOME	110	175	277
SCRO	**DILLINGHAM**	56	89	162
	HOMER	37	46	66
	KENAI	333	475	946
	KODIAK	111	191	353
	MAT-SU	393	535	925
	VALDEZ	79	110	237
SERO	**JUNEAU**	238	382	567
	KETCHIKAN	125	203	352
	PETERSBURG	36	62	110
	PRINCE OF WALES	22	33	50
	SITKA	68	95	128
State Total		3972	5845	9659

Alaska Juvenile Referrals per 100,000 Juvenile Population (ages 10-17)

Fiscal Year	Referrals	Juvenile Pop	per 100,000
FY 1999	7484	85477	8756
FY 2000	7497	86958	8621
FY 2001	7056	88607	7963
FY 2002	6932	89966	7705
FY 2003	7471	91651	8152
FY 2004	6225	92699	6716
FY 2005	5845	89746	6513

Note: Population data is based on projections from the Alaska Department of Labor. Juvenile referral data is provided by DJJ JOMIS database and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Analysis of results and challenges: Both the number of referrals (5,845) and the number of these referrals per 100,000 juvenile population (6,513) decreased in FY05, resulting in a decline of juvenile crime referrals of 3% per 100,000 juveniles compared with FY04 and a decline of 20.1% compared with FY03. The decline in overall juvenile crime has been a consistent trend for several years (except for a brief increase in FY03). Definitive reasons for this decrease are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.

Division Level Measures

A: Result - Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.

Target #1: Improve the ability to collect ordered restitution at the time of case closure to 95% of what was ordered.

Measure #1: Percentage of ordered restitution collected at the time of case closure compared to what was ordered.

Restitution

Fiscal Year	Amount Ordered	Amt complete at closure	Percentage	Goal
FY 2004	$160,165.43	$144,140.73	90%	95%
FY 2004	$70.911.28	$6,343.23	97.7%	95%

Analysis of results and challenges: In FY05, the amount of restitution ordered outside the formal court system was $70,911.28; the amount collected was $69,343.23. This is a collection total of 97.8%. The goal is 95%.

This measure provides a gauge of the Division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their criminal behavior. Juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system. Restitutions requested through youth courts and other community panels are included, as are

assignments of Permanent Fund Dividends made by juvenile probation officers. The amount of restitution reported as paid is that amount provided by the youth at the time of case closure. Since January 1, 2002, restitution payments by juveniles who are processed formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections & Support Unit. Those restitution payments are not included in this analysis.

While the amount of restitution ordered and paid in FY05 decreased significantly compared with last year's amounts, overall the percentage collected by DJJ staff increased, indicating that DJJ staff continue to demonstrate a high degree of effectiveness in collecting on restitution payments they order. The reason for the decrease in raw dollar amounts ordered is believed due to the following factors: 1) Last year probation officers were still managing a number of formal restitution collections ordered before the Department of Law took over management of new cases in 2002. These restitution orders are usually much larger than those restitutions ordered informally. As these older cases close there are fewer large restitution orders remaining for probation officers to manage, hence the reduction in overall amount. 2) This year's data collection revealed significant differences in the way local DJJ offices are collecting and reporting restitution. The Division will be addressing this statewide variation for FY06 through specific, clear instructions for Division staff on how restitution is to be monitored and reported. This may result in data fluctuations for the FY07 report but is nonetheless critical if we are to improve the integrity of the data.

Target #2: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.

Measure #2: Percentage of community work service hours performed by juvenile offenders compared to what was ordered.

Community Work Service Hours

Fiscal Year	Hrs Ordered	Hours Completed	Percentage	Goal
FY 2004	24,379	23,720	96%	
FY 2005	34,167	30,642	90%	100%

Hours completed are at closure of service record.

Analysis of results and challenges: For this measure the Division examines community work service records that have been closed because youth either completed or did not complete the service hours ordered. In FY05, 34,167 community work service hours met this definition. Of these hours, 30,642 were indicated as completed, for a 90% completion rate.

This performance measure is another way the Division of Juvenile Justice reports on offender activity to repair the harm caused to those impacted by juvenile crime. This measure reports the percentage of community work service performed for the cases where community work service was ordered either by the court, a juvenile probation officer, or a community justice panel or other alternative justice process. The record of community work service must have been closed in FY05 to be included in this measure.

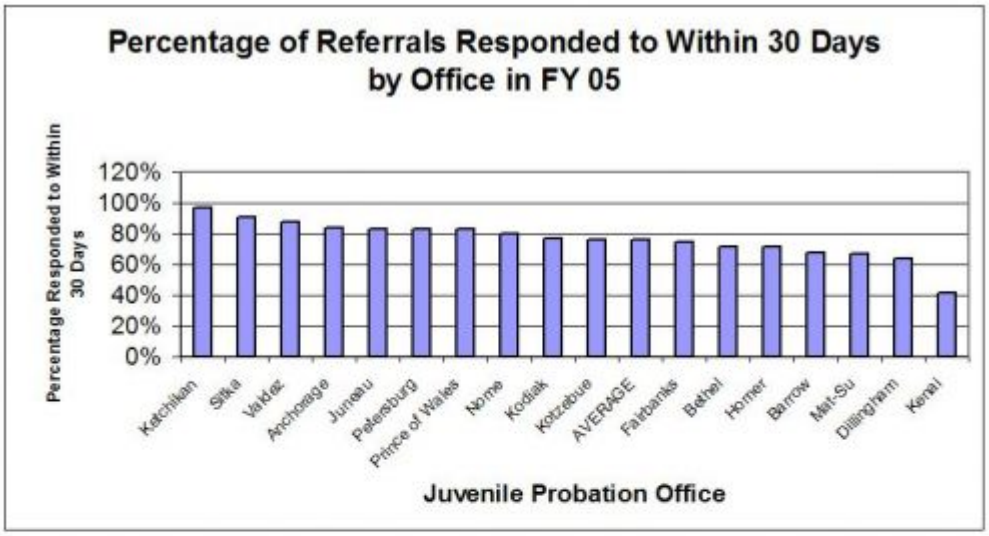
A marked increase in the raw amount of community work service hours ordered and completed was noted compared with FY04's figures. However, the percentage completed declined. Both these changes are not necessarily attributable to more community work service actually being ordered or a smaller percentage actually being completed, but rather to the fact that in FY05 the Division migrated the tracking of community work service into its new Juvenile Offender Management Information System (JOMIS). This year's data collection revealed several inconsistencies regarding the way community work service is tracked in JOMIS. The Division has recognized these concerns

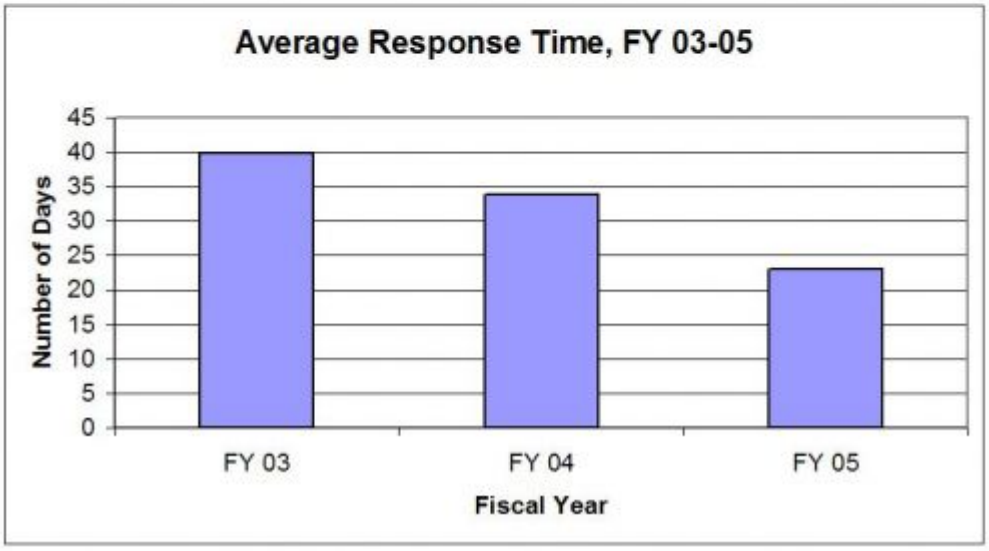
and will be working with probation staff this year to set explicit guidelines on how this information is to be entered in JOMIS.

A1: Strategy - Strategy 1a: Improve the timeliness of response to juvenile offenses.

Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement (see note below).

Measure #1: The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement.





Analysis of results and challenges: This measure enables the Division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the Division as one of three possible actions by staff to deal with the delinquency report (see note below). Research indicates that in order to be effective, responses to juvenile crime must be timely and appropriate to the level of the offense. The first chart above illustrates the percentage of referrals that received a response within 30 days of the date the referral

was received, by each office and as a statewide average. The statewide average percentage of referrals that received a response within 30 days was 76%, exceeding the goal of 75%. The second chart illustrates the average number of days it took to actually respond to all referrals relative to previous years' data. The average response time in FY05 was 23 days, a considerable improvement from prior years.

The improvements in response time noted this year are believed to be due to the efficiency and accuracy with which probation officers were able to report their response to juvenile referrals through JOMIS. This year the Division made a dedicated effort to improving the procedure for reporting response time in the Juvenile Offender Management Information System (JOMIS). This experience has provided a good roadmap as the Division seeks to improve the accuracy with which it tracks and reports its other performance measures.

Note: Referrals are reports from law enforcement for specific offenses by an identified juvenile. Referrals included in this analysis were those received in the fiscal year that had one of the following case actions recorded in the Division's management information system: Referral Screening (resulting in review of the police report and either closing of the referral or it being forwarded to a community accountability program, such as youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

A2: Strategy - Strategy 1b: Improve the satisfaction of victims of juvenile crime.

Target #1: In FY 05 DJJ will develop a process to track victims' satisfaction with juvenile justice services.

Measure #1: Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services.

Analysis of results and challenges: The Division made significant progress this year in meeting this qualitative objective. Working in collaboration with the state's Office of Victims Rights, other states, and the Division's own probation officers and senior managers, the Division has developed a victims satisfaction survey that will gauge victim satisfaction both soon after the juvenile delinquency episode and two years after their case has been processed. This will enable the Division to monitor its effectiveness in providing services to victims both in the short and long term. Implementation of this survey is targeted to occur in FY06. The Legislature approved funding for four victims' services associates to be hired in FY06 to assist the Division in improving services to victims of juvenile crime by performing a broad array of tasks. FY06 will focus on the development of agency strategies to assist services to victims while also ensuring the ability to individualize the approaches based on the different challenges and issues faced by urban and rural offices/regions.

A3: Strategy - Improve the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ field probation policy and procedure manual.

Target #1: All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.

Measure #1: Average % of all probation audit standards met by probation officers over the course of the fiscal year.

FY05 Avg Audit Compliance Rate

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total	Target	Variance
FY 2005	95.2	95.8	94.3	94.7	95%	95%	0

In FY05, the division had 84 juvenile probation officer positions. Not all of those positions carry caseloads and at the time that the probation officers were audited, some of the positions were vacant. The total number of case carrying probation officers is approximately 75.

Analysis of results and challenges: This measure monitors the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload are conducted on a quarterly basis. These are used as a constructive means to assess an officer's performance in carrying out the required duties of the position and to ensure the delivery of appropriate services to each client. Data was collected for each quarter of the fiscal year as demonstrated above. The data indicates that juvenile probation officers have been successful in meeting the goal of 95% audit compliance. In the coming year, the Division will be examining the format and method used to conduct audits of probation casework to attempt to make these audits an even more effective tool in determining the quality of juvenile probation officers' work.

The table above a total of 258 audits performed during the year. Qtr 1 - 60; Qtr 2 58; Qtr 3 - 66; and Qtr 4 64.

Public Assistance

Mission

Promote self-sufficiency and provide basic living expenses to Alaskans in need.

Introduction

To meet this mission, the Division administers programs that provide temporary economic support to needy families and individuals, financial assistance to the elderly, blind and disabled, benefits to supplement nutrition, medical benefits, and supportive services that enable and encourage welfare recipients to pursue economic independence and self-sufficiency.

Core Services

The Division provides services to help Alaskans remain safe and healthy by:

- Providing temporary financial assistance to low-income Alaskan families with children working towards self-sufficiency to help them meet their basic needs.
- Providing employment assistance to low-income Alaskan families with children to help them become more self-sufficient and increase stability through employment.
- Providing financial assistance to low-income aged, blind, or disabled Alaskans to help them meet their basic needs.
- Providing food assistance to low-income Alaskans to decrease their incidence of food insecurity.
- Providing home heating assistance to low-income Alaskans to reduce their disproportionate burden of home heating costs.
- Providing child care subsidies to families who need child care to work or participate in approved training activities
- Licensing child care providers to increase the safety and quality of child care in Alaska.
- Making eligibility determinations for medical assistance programs.

Unemployment, illness, and other personal emergencies can threaten the well-being of any Alaskan and create the need to seek public assistance. One out of every eight Alaskans requests some type of cash, food, medical, or heating assistance from the Division. In the last fiscal year, the division assisted approximately 66,000 families each month. While many families and individuals are served only seasonally or for a short period of need, an estimated 110,000 persons will receive some form of assistance in the coming year.

Comparison of Public Assistance Programs

	ATAP/TANF		Adult Public Assistance		General Relief		Food Stamps	
FY05 Cases avg. mo.	4,660		16,019		160		20,103	
# of clients avg. mo.	12,899		16,019		209		56,166	
Race Distribution	White	34%	White	49%	White	N/A	White	35%
	Alaska Native	47%	Alaska Native	29%	Alaska Native	N/A	Alaska Native	47%
	Black	7%	Asian	9%	Black	N/A	Black	5%
	Asian	5%	Black	5%			Hispanic	3%
							Asian	4%
Recipients by Location (District area)	Anch / Mat-Su	52%	Anch / Mat-Su	53%	Anch / Mat-Su	57%	Anch / Mat-Su	43%
	Northern	14%	Northern	13%	Northern	17%	Northern	13%
	Southeast	11%	Southeast	11%	Southeast	12%	Southeast	11%
	Balance of State	23%	Balance of State	23%	Balance of State	14%	Balance of State	33%
Expenditure By Category of Service	Single parent	71%	Disabled	74%	Burial service	83%	FS and ATAP	18%
	Two parent	16%	Aged	25%	Rent assistance	14%	FS only	40%
	Child only	12%	Blind	1%	Other	3%	FS and APA	17%
							FS and Med	25%
Persons by age group								
Children 0 - 18 yrs	8,859		0		31		28,433	
Adults 19 - 59 yrs	4,019		9,214		162		25,332	
Adults 60 - older	21		6,805		17		2,402	
Total Expenditures	$45,662,400		$54,567,500		$1,244,000		$79,241,700	
Federal	$10,988,421		$1,299,481				$79,241,700	
GF	$32,179,379		$49,475,719		$1,244,000			
Other	$2,494,600		$3,792,300					

Notes:

1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) ATAP/TANF caseload and expenditure includes the Alaska Temporary Assistance Program and the Native Family Assistance Program.
3) The Child Care Subsidy information includes PASS I (child care for families also receiving ATAP), PASS II/III child care subsidy and Child Care Grant Program Expenditures.
4) Several areas of Alaska receive Heating Assistance through tribal organizations funded directly by the federal government.
5) In FY05 Heating Assistance Program expenditures include special emergency LIHEAP funds for the high cost of fuel.

Comparison of Public Assistance Programs

	Heating Assistance		Child Care (PASS I, II, III)	
FY05 Cases avg. mo.	9,055			
# of clients avg. mo.	27,165		7,350	children
Race Distribution	White	51%	N/A	
	Alaska Native	37%		
	Black	3%		
	Asian	4%		
Recipients by Location (District area)	Anch / Mat-Su	36%	N/A	
	Northern	12%		
	Southeast	6%		
	Balance of State	46%		
Expenditure By Category of Service	Employed, retired or temp unemployed	61%	PASS I	22%
			PASS II	12%
			PASS III	66%
	Receiving ATAP	13%		
	Receiving APA	26%		
Total Expenditures	$7,750,300		Pass I	$6,582,833
			Pass II/III	$25,373,303
Federal	$7,750,300		$25,012,236	
GF			$6,943,900	
Other				

Notes:
1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) ATAP/TANF caseload and expenditure includes the Alaska Temporary Assistance Program and the Native Family Assistance Program.
3) The Child Care Subsidy information includes PASS I (child care for families also receiving ATAP), PASS II/III child care subsidy and Child Care Grant Program Expenditures.
4) Several areas of Alaska receive Heating Assistance through tribal organizations funded directly by the federal government.
5) In FY05 Heating Assistance Program expenditures include special emergency LIHEAP funds for the high cost of fuel.

Alaska Temporary Assistance Program AS 47.27.005
The Alaska Temporary Assistance Program (ATAP) was created by the state and federal welfare reform laws passed in 1996. The program provides temporary financial assistance to eligible needy families that helps them care for their children in their own homes. This assistance provides for basic needs in shelter, home heating, clothing, transportation and food when the parents or caretaker relatives are temporarily unemployed, under-employed, or facing significant barriers to employment. The adults are required to participate in work or activities that will help them become self-sufficient and leave the program. They receive supports to help them seek, secure and retain employment, described under the Work Services section. Families are limited to a lifetime total of 60 months of assistance.

Child Care Services AS 47.25.001
Providing access to child care is a key component in the state's efforts to move more parents into full-time jobs and more families toward self-sufficiency. The federal Temporary Assistance for Needy Families (TANF) block grant, the Child Care Development Fund (CCDF) and the required state general fund maintenance of effort provide child care subsidies for families in welfare-to-work activities; families moving off of welfare due to increased earnings; and working families whose low-income places them at risk of needing public assistance. The division's administrative effort and program financing help make quality child care more available and more affordable. This, in turn, has helped families avoid reliance on public assistance. The state's continued commitment to improving the quality, availability, and affordability of child care will help ensure that even more families are able to become self-sufficient.

Work Services AS 47.27.005
With the Temporary Assistance program focus on moving welfare recipients into the workforce, there is greater need to help individuals with low skills, a lack of work history and other challenges to self-sufficiency. The array of services intended to help recipients into the workforce is referred to as Work Services. The level of benefit is designed to ensure it is always a financial incentive for a recipient to work rather than to be on Temporary Assistance. Recognizing that many recipients must overcome substantial challenges in order to find employment, Temporary Assistance Work Services include job readiness and job search, case management, job retention and advancement, referrals to basic education and vocational training, wage subsidies and supportive services payments such as work clothing, transportation, special tools, etc., that recipients need to enter or stay in the workforce. Community-based grantees and contractors deliver a majority of the Work Services. In FY06, 20 different grants or contracts were issued to Native organizations and other non-profit organizations to assist recipients in their communities move from welfare to work.

Native Family Assistance Program AS 47.27.070
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform law) authorizes certain Alaska Regional Native non-profit organizations, to administer Temporary Assistance for Needy Families (TANF) programs and to receive direct funding. Four organizations, the Tanana Chiefs Conference (TCC), Association of Village Council Presidents, Inc. (AVCP), Central Council of Tlingit & Haida Indian Tribes of Alaska (CCTHITA) and Cook Inlet Tribal Corporation (CITC) have taken advantage of this opportunity to implement their own culturally relevant and regionally focused welfare programs. A fifth organization, Bristol Bay Native Association (BBNA), is in the planning stages to implement a Native Family Assistance Program in FY2007. Funding for Native Family Assistance program operation comes from the

federal TANF block grant and is supplemented by state funds that would otherwise be spent to serve the same Native recipients. Funds provided by the state grant are used to provide temporary assistance benefits to eligible families through the organizations now administering the Native Family Assistance programs.

Adult Public Assistance AS 47.25.430
Adult Public Assistance (APA) is a state funded program that provides cash assistance to needy aged, blind, and disabled persons who meet certain income and resource requirements. People who receive APA financial assistance are over 65 years old or have severe and long-term disabilities that impose mental and physical limitations on their day-to-day functioning. Continued APA funding provides critical financial assistance to enable program participants to live as independently as possible.

Food Stamp Program AS 47.25.975
The Food Stamp Program helps low-income households maintain adequate nutrition. Food Stamp benefits are used to purchase food products from more than 500 retail grocery stores throughout Alaska. Benefits vary with household size, income and place of residence. Participants in rural communities get larger monthly benefits to compensate for higher food costs. Benefits are 100 percent federally funded by the U.S. Department of Agriculture. The state and federal government share the administrative cost of the program equally.

Heating Assistance Program
The Heating Assistance Program (HAP) is 100 percent federally funded by the Low-income Home Energy Assistance Program (LIHEAP) Block Grant. The program provides seasonal help with home heating costs to low-income households. In FY05, around $7 million was provided to approximately 9,055 households. Benefits are based on family income, home heating costs, housing type and geographic region. Heating assistance payments—primarily made to home heating suppliers on behalf of eligible households—cover the cost of heating oil, natural gas, electricity, propane, wood, and coal. The grants are given once per program year per household.

General Relief Assistance AS 47.25.120
Alaska's General Relief Assistance (GRA) program provides for the most basic needs of many Alaskans who haven't the personal resources to meet an emergent need and who are not eligible for assistance through other assistance programs offered by the state. GRA is designed to meet the immediate, basic needs or burial expenses of Alaskans in extreme financial crisis. Examples of basic needs are shelter and utilities. Under limited circumstances, GRA can provide assistance for clothing and food for persons not eligible to receive food stamps. Approximately 83% of the GRA appropriation funds indigent burials.

Medicaid Eligibility AS 47.07.020
Medicaid, an entitlement program created by the federal government, is the primary public program financing basic health and long-term care services for low-income Alaskans. The Division of Health Care Services is responsible for provider payments. The Division of Public Assistance (DPA) is responsible for eligibility policy and access to the program, determining the eligibility of individuals and families in need of Medicaid benefits, including children and pregnant women under the Denali KidCare Program. The majority of Medicaid recipients are beneficiaries of other programs and services administered and delivered by DPA. Most recipients on the Alaska Temporary Assistance Program receive family Medicaid benefits. Many children, young adults, and elderly or disabled persons receiving Medicaid also receive food stamps or adult public assistance benefits.

Chronic and Acute Medical Assistance Eligibility AS 47.08.150
The Chronic and Acute Medical Assistance (CAMA) program is a state funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage those illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance. The Division of Health Care Services is responsible for provider payments. The Division of Public Assistance is responsible for eligibility policy and access to the program.

SeniorCare Program AS 47.300
SeniorCare helps low-income seniors who are at least 65 years of age remain independent in the community by providing a cash benefit or paying for the premiums and deductibles of Medicare Part D or similar prescription drug coverage. Effective January 2006, responsibility for determining eligibility for the SeniorCare program transferred from the Division of Alaska Pioneer Homes to the Division of Public Assistance. The Division of Health Care Services is responsible for premium and deductible payments. The Division of Public Assistance is responsible for cash benefit payments, eligibility, policy and access to the program.

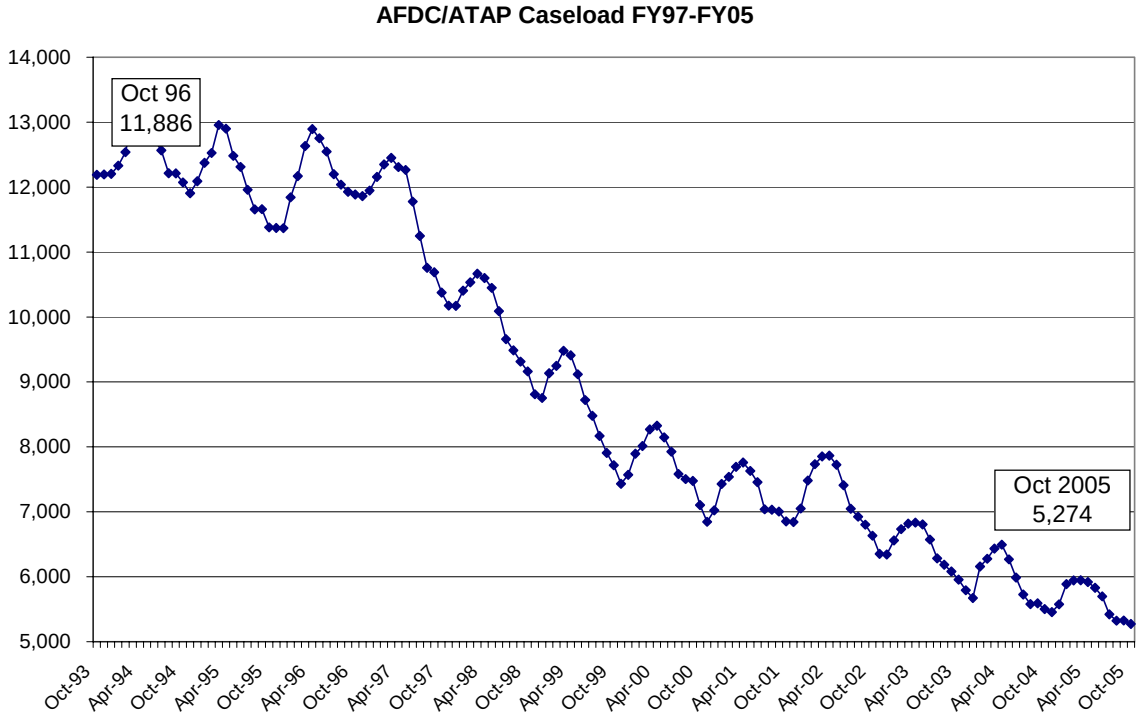
Public Assistance	2006	2007 Proposed	06 to 07 Change
General Funds	110,625.8	112,329.0	1,703.2
Federal Funds	94,788.6	99,385.2	4,596.6
Other Funds	35,498.1	35,114.8	(383.3)
Total	**240,912.5**	**246,829.0**	**5,916.5**

ATAP Component

The focus of the Alaska Temporary Assistance Program (ATAP) is to provide temporary economic assistance to poor families and to help those families find employment that will allow them to become self-sufficient, leave assistance and get out of poverty.

Due to declining caseloads since the beginning of the Temporary Assistance program and the reduced demand for cash benefit payments, millions of dollars have been made available to provide child care and work services for low-income recipients and working families.

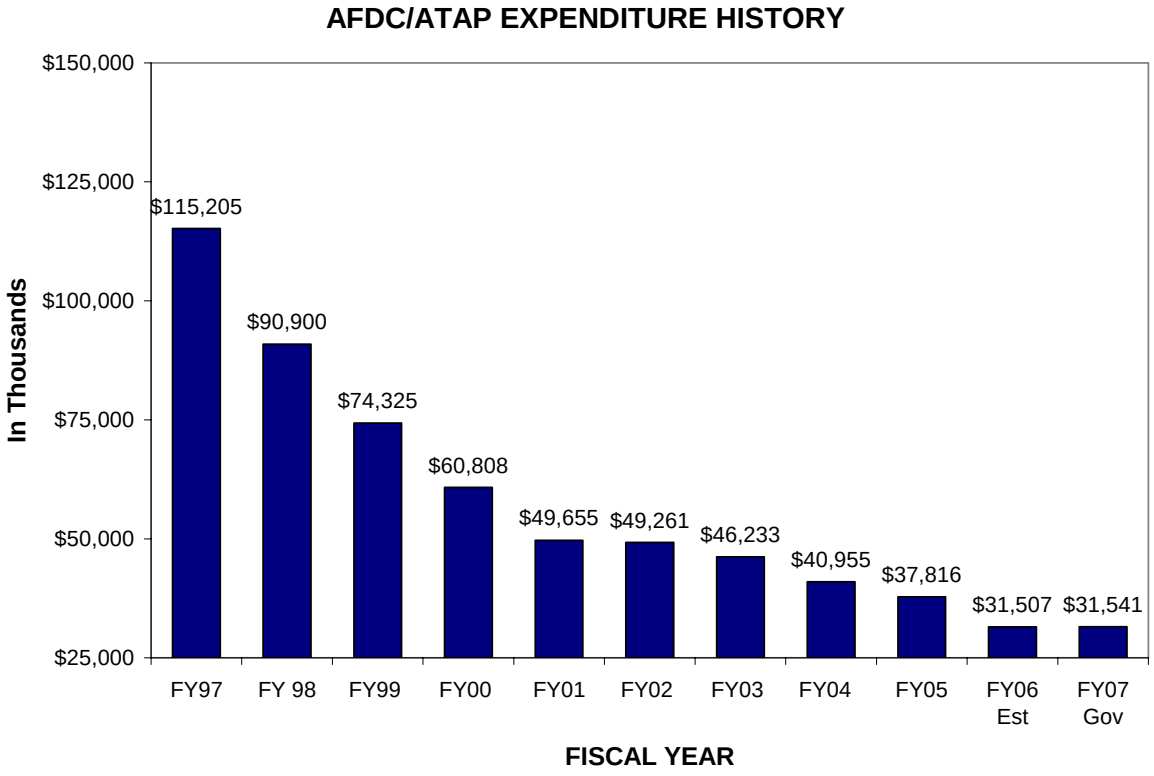
ATAP Caseload Continues to Decline
In October 2005, the Alaska TANF caseload declined to 5,274. This figure is 60% below the historical peak of 13,164 in April of 1994. The ATAP caseload has dropped 56% from October 1996 to October 2005. The decline began in February 1997 when the state's first welfare reform provisions took effect and has continued, interrupted only by the regular seasonal upswing during the winter months.



ATAP Benefit Expenditures Down

Spending on Temporary Assistance payments is down. In FY05, these expenditures declined to $38 million, a 67% reduction from FY97. Declining expenditures since Temporary Assistance was implemented in 1997, can be attributed to more recipients leaving welfare for work, more recipients working while receiving assistance, benefit cuts to two-parent families, and reductions due to low housing costs.

It is important to note that the early caseload reductions were the easiest. Caseload reductions have slowed down as a larger proportion of recipients who remain on the caseload are those with more serious barriers to employment. Some states are experiencing rising caseloads due to changes in their economic conditions. It is hard to predict how the economy will affect future ATAP caseloads.



Adjust Federal Funding: Transfer from Alaska Temporary Assistance Program to Child Care Benefits $1,500.0 Federal
The FY2007 Governor's request reduces the ATAP formula authorization reflecting the projected decline in ATAP payments. We expect ATAP caseloads will continue an overall annual decline interrupted only by the regular upswing during the winter months as a result of Alaska's seasonal economy. The FY2007 ATAP benefit savings from continued caseload reduction are needed to sustain budgets for work services, child care, and other TANF funded services.

Alaska Temporary Assistance Program Formula Caseload Reduction ($973.5) Federal; ($60.0) Interagency Receipts
In FY07, a portion of the ATAP savings that would otherwise be needed for ATAP benefit payments will be reinvested in child care. Child care assistance for families transitioning from public assistance can often make the difference between unemployment and a return to public assistance, and employment leading to self-sufficiency. The FY07 Governor's request transfers $1,500.0 of ATAP payments savings to Child Care Benefits to meet the growing demand for child care for extremely low-income working families.

State Maintenance of Effort (MOE) under TANF
The state's TANF MOE requirement is based on the state's share of AFDC (Aid to Families with Dependent Children) expenditures in FFY1994. In order to earn the annual TANF block grant, states must spend at least 75-80 percent of their FFY 1994 spending. Federal law allows designated Native organizations to operate their own TANF programs and to receive TANF grants directly from the federal government. The federal grants for Native TANF reduce the state block grant amount dollar for dollar. In addition, the required state maintenance of effort (MOE) is reduced.

To qualify as state maintenance of effort (MOE) for TANF the state general fund expenditure must be made to or on behalf of a family eligible for ATAP. The majority of the state GF MOE expenditures help finance ATAP cash payments, Native Family Assistance state grants, ATAP eligibility determination and case management activity, work services intended to help ATAP recipients into the workforce, and child care for ATAP families working their way off welfare.

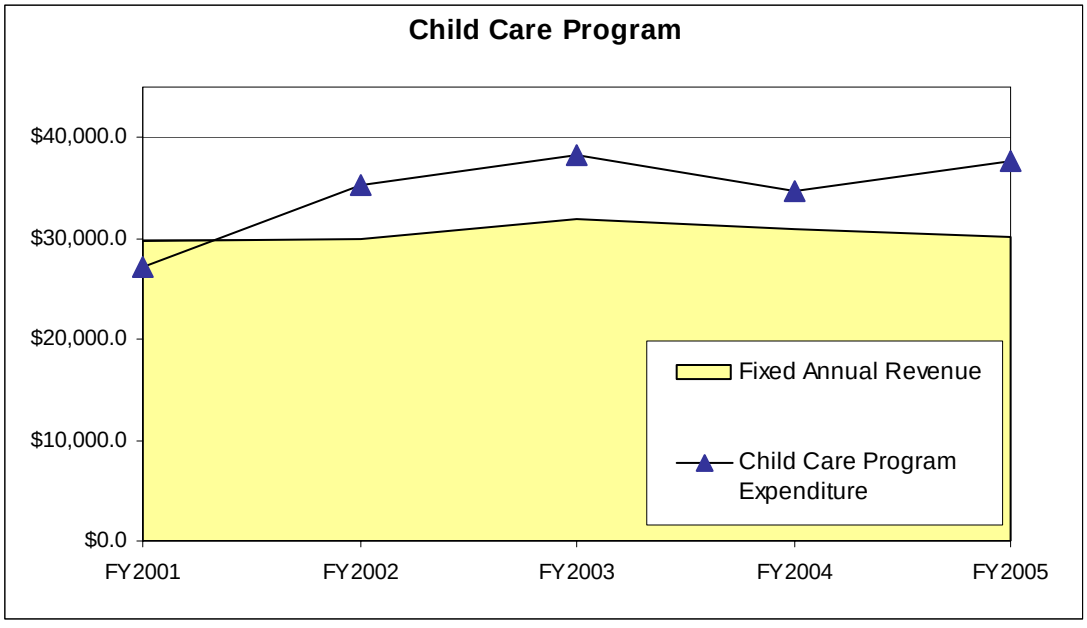
For Alaska, this MOE establishes a floor of approximately $38.0 million GF that must be met to comply with federally mandated MOE. State general fund savings of roughly $27 million from falling ATAP caseloads have been previously deleted from the ATAP budgets to a level equal to the minimum MOE amount. We are currently in compliance with federal participation requirements that allow the 75% MOE floor.

Federal TANF Reauthorization and Supplemental grants for High Population Growth
Federal funding for the TANF block grant expired in FY2003 and Congress continues to pass extensions to current TANF law. In FY06 Congress will continue to debate reauthorization of the federal welfare reform law. The entire law may be reconsidered including the purpose, block grant funding level, work requirements, time limits and performance bonuses. States seek to retain their current federal funding and the flexibility that has allowed them to be so successful in welfare reform.

Alaska was one of seventeen states who qualified for supplemental TANF grants (based on population increases in 1990-1994). Alaska's "High-Population" supplemental award is $6.9 million representing 11% of Alaska's total annual federal TANF amount. DPA has been able to maintain federal TANF balances by continued ATAP caseload reductions, continued TANF block grant base funding, the supplemental high population award and more recently Alaska's receipt of four High Performance bonus supplemental awards. Federal reauthorization of TANF could include reductions in federal TANF block grant funding or high performance bonus opportunities, impacting the ability to sustain TANF financing for ATAP and non-ATAP services.

Child Care Benefits Component

Transfer from Alaska Temporary Assistance Program to Child Care Benefits $1,500.0 Federal
The FY07 Governor's request transfers $1,500.0 federal from ATAP payment savings to Child Care Benefits to meet the demand for child care for the lowest-income working families. While Alaska's TANF caseload has been decreasing, the number of very low-income working families needing help with child care costs has increased. Child care assistance for families transitioning from public assistance can often make the difference between unemployment and a return to public assistance, versus employment leading to self-sufficiency.



Child care subsidies are provided to families who need child care to work or to participate in approved training activities. The subsidy program is called Parents Achieving Self-Sufficiency (PASS). There are three PASS programs:

PASS I – for families on Temporary Assistance, these families receive one-hundred percent of the subsidy rate for authorized child care.
PASS II – for families within one year of leaving Temporary Assistance. These families pay a co-pay, based on their income.
PASS III – for low-income families who may or may not have been on Temporary Assistance. These families also pay a co-pay, based on their income.

As the welfare caseloads have dropped, the demand for child care has risen dramatically. Alaska has always been able to fully fund child care for ATAP families while they are on ATAP and for one year after they leave. Wait lists for the child care subsidy program for low-income families had been the norm prior to FY02 but have not been since. The FY07 request for child care subsidy fully funds projected formula subsidies and should allow the state to avoid subsidy reductions or creation of wait lists for the lowest income families.

Child care rates that the state pays have not been raised since July of 2001; they are not keeping up with rates that child care providers charge. We will be implementing cost containment measures in the hopes that a few specific rates can be raised. However, we are experiencing an increased caseload, which may prohibit any rate increases. Careful analysis of the upward pressure of both child care rates and program growth is ongoing.

In FY2004, Child Care functions were consolidated in the Department of Health and Social Services by means of a transfer from the Department of Education and Early Development to the Division of Public Assistance. Having all child care functions in one office promotes collaboration between programs, consistency of policies, and coordination of child care quality improvement efforts. The funding for child care programs is primarily federal dollars, including CCDF (Child Care Development Fund) funding, TANF transfers into CCDF, and direct TANF expenditures.

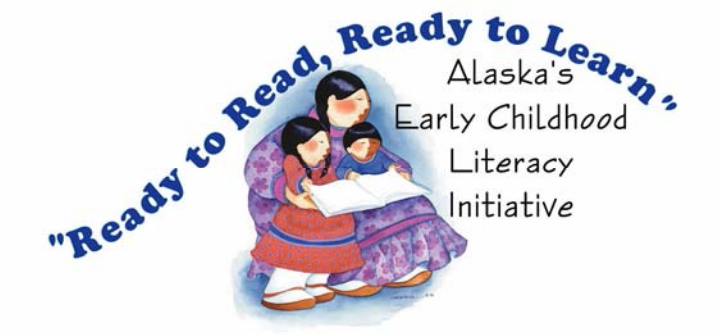
Early Childhood Development $750.0 General Fund
Lifelong learning, health, and self-sufficiency can be best achieved by investments in our youngest citizens, which provides the greatest returns on our human capital investments. However, the programs serving and advocating for young children in Alaska are varied, located in multiple agencies/organizations, and are too often fragmented, incomplete and ineffective. Alaska needs a clear and comprehensive strategy for investments in early childhood development. The time has come to strengthen the early childhood development system in Alaska, that will:

- ensure that all aspects of children's development are being met
- ensure that children enter school ready to read and ready to learn
- support families in raising healthy young children
- connect programs and initiatives while avoiding duplication
- ensure that the state's early learning guidelines are embedded in all programs
- inform the governor and legislature of system gaps and strategies to develop children

The state needs clear and accountable leadership to set direction, build system linkages and ensure outcomes are delivered. This could be provided through coordinated leadership with representation from consumers and parents, business leaders, state agencies and private providers of early childhood development programs.

This proposal establishes a plan for coordination of efforts. It would fund key initiatives such as the development and implementation of federally required early learning guidelines and the implementation of a quality rating system for early learning programs and providers. The Ready to

Read, Ready to Learn Task Force, comprised of public and private leaders, will inform the investment of these funds to focus on improving early childhood literacy and learning.



Public Assistance Administration Component

Temporary Assistance to Needy Families (TANF) Allocations for Abuse Prevention, Youth Success Initiatives, CDVSA Support $3,000.0 Federal

In October 2005, the Department of Health & Social Services, Division of Public Assistance (DPA) was awarded its fourth federal TANF High Performance Bonus of $2.67 million. DPA received this bonus payment for its exceptional performance in federal fiscal year 2004.

The following represents the Department's proposed spending plan for investing the federal TANF performance bonus funds in services and initiatives promoting self-sufficiency, family stability, and reduction of teen pregnancy:

1. Youth Success Initiative - $1,000.0
2. Prevention Plans-Behavioral Health Grants - $1,000.0
3. Council on Domestic Violence and Sexual Assault - $1,000.0 one-time funding

*The FY07 incremental amounts above represent the use of the FFY04 and a portion of the FFY03 bonus.

Department of Health and Social Services Youth Success Initiative $1,000.0 Federal

This request will provide funds to employ innovative approaches to invest in the Youth of Alaska. The goals of the program are to provide mechanisms where young Alaskans can realize their full potential by offering them, hope, opportunity and a safe environment. We expect this program will impact thousands of youth in Alaska who are at risk of substance abuse, suicide, or adopting criminal behavior by providing them alternatives, productive activities, good role models and appropriate mentors. A significant investment of this type will change lives and has a proven return on investment.

Specifically the Youth Success Initiative will invest funds in statewide non-profit organizations that have a solid record of success with adolescents and have proven results and outcome measures. Through a competitive process the Department of Health and Social Services has already identified four non-profit entities for this program. They are: Boys & Girls Club of Alaska, Big Brothers/Big Sisters, Rural Alaska Community Action Program and the Alaska Association of School Boards. These non-profit agencies will be required to propose specific programs and outcomes to achieve success.

The type of services intended to be funded are:

- Alcohol, drug abuse prevention programs. These activities could take many forms, but one model is to use small group activities designed to increase participants' resiliency and strengthen leadership skills.
- Encourage healthy lifestyles, promote positive behavior. There are many models for these activities including Passport to Manhood, SMART Girls.
- Suicide Prevention. Implement activities and interventions that work to prevent suicide.
- Job ready, work preparedness. Provide adolescents with the skills to secure employment and to be successful in the world of work.
- Establish after-school programs throughout the state.

Outcomes expected are:

- Thousands of Alaska youth will succeed in life.
- Suicide attempts and the suicide rate will be reduced. Currently, Alaska's suicide rate is the highest it has been in ten years, more than double the national average (Alaska is 23.3 per 100,000 population, US is 10.5 per 100,000 population).
- Cut the underage drinking rate, most recent data (2003) shows 75.1% of high school students have used alcohol.
- Reduce the teen pregnancy rate in Alaska, currently the rate is 41.0 (based on initial 2004 data; Rate of Alaska teens 15-19 per 1,000 female population).
- Improve success rate of teenagers in the local labor market, as of most recent data (2001) 43% of the 14 to 17-year old populations were employed some time during the year.

Prevention Plans-Behavioral Health Grants $1,000.0 Federal

This funding will assist in the development of an integrated, comprehensive and community-driven program to promote healthy individuals, families and communities by focusing on the prevention of underage alcohol use. Substance abuse and particularly alcohol abuse by Alaska's youth is a critical and devastating problem. Prevention is both the elimination of risk factors (poor self-esteem, peer pressure, access to alcohol/drugs, etc.) and the development and enhancement of protective factors (school success, positive peer and adult relationships, social and family support systems).

This initiative focuses on community-based services, programs, and practices that are evidence-based. The initiatives will use outcome-based performance metrics capable of measuring decreases in the use of alcohol and drugs among youth and decreases in the age of first use. Measures will also determine the success of efforts to increase the percentage of youth connected at school and in their community. Evaluations will also attempt to validate existing research which shows a clear relationship in staying in school and lower teen pregnancy rates, which reduces out-of-wedlock pregnancies.

Council on Domestic Violence and Sexual Assault $1,000.0 Federal

This one time funding is for family supports for victims of domestic violence, which will provide services to families in domestic violence shelters. Allowable services include: non-recurring short-term services provided by the shelter, such as emergency shelter, 24 hour hotline, information and referral, case management, assessment and training to provide these services.

Work Services Component

Expand Family Centered Services $880.0 Federal

Phase I of the Division's Family Centered Services (FCS) uses a "Customized Employment" (CE) model to serve 15 families in both Fairbanks and the Mat-Su Valley. The Phase II proposal will expand FCS based on the results and evaluation currently underway for Phase I. We expect that project outcomes will improve the following Division outcome measures:

- Increase the percentage of Temporary Assistance families who leave the program with earnings and do not return for 6 months.
- Increase the percentage of Temporary Assistance families with earnings.
- Increase the percentage of Temporary Assistance families meeting the federal participation rates.

Phase II will also introduce national best practices to improve service delivery and outcomes for families with complex issues and multiple barriers to self-sufficiency. Phase II builds on Phase I by adding the following elements:

Client Identification - Development and use of a universal screening tool for rapid identification of families appropriate for FCS.

FCS Expansion - In addition to Fairbanks & Mat-Su, Phase II extends FCS to Juneau, Kenai and the Muldoon Job Center. These sites directly correspond to where the CE model has been in place and proven effective in servicing seriously disabled clients.

Employer Partnership - Provide increased resources for Job Carving / Job Development and employer outreach in each community where FCS is implemented. Experience indicates that the work with employers is beyond both the current capacity and skill of the local teams, yet employer partnerships are critical links to successful long-term placements.

Dedicated FCS Team - Establish a dedicated multi-disciplinary, cross-agency team for the provision of FCS in the Anchorage service area, a community with high numbers of complex cases. This allows for a comparison of a dedicated work team versus the 'service coordination' approach in the current FCS model. Partners may include experienced staff or providers from Division of Public Assistance, Division of Behavioral Health, Division of Juvenile Justice, and Office of Children's Services, as well as Department of Education and Early Development, Department of Labor and Workforce Development (DOLWD) and community partners.

Building Assets to Promote Self-Sufficiency for Alaskans $680.0 Federal

Asset poverty is a significant barrier to self-sufficiency for working poor families. Although asset ownership is a critical component of financial security, almost half of America is asset poor, with less than $1,000 in assets. More than one-third of the United States population have no investable assets. In all but one state, asset poverty exceeds income poverty. Research suggests that asset building:

- supports household economic stability
- enhances educational attainment
- decreases marital dissolution
- decreases the risk of intergenerational poverty
- increases health and satisfaction among adults
- decreases residential mobility

The Division proposes three initiatives to help build financial assets for needy Alaskan families as well as create employment opportunities that provide the earnings families need to create savings and opportunities for investment in the future; Individual Development Accounts (IDA), Micro-enterprise loans, and Rural Economic Development Grants. With support from other public and private partners, asset building could promote economic security for all Alaskans and promote long-term self-sufficiency for public assistance clients. Incentives and matched funds may be available from banking and other partners.

Contribution to Department's Mission

The mission of the Division of Public Assistance is to promote self-sufficiency and provide basic living expenses to Alaskans in need.

Core Services

- Provide temporary financial assistance to low income Alaskan families with children who are capable of self-sufficiency to help them meet their basic needs.
- Provide employment assistance to low income Alaskan families with children to help them become more self-sufficient.
- Provide financial assistance to low income aged, blind, or disabled Alaskans to help them meet their basic needs.
- Provide food assistance to low income Alaskans to decrease their incidence of food insecurity.
- Provide home heating assistance to low income Alaskans to reduce their disproportionate burden of home heating costs.
- License childcare providers to increase the safety and quality of childcare in Alaska.

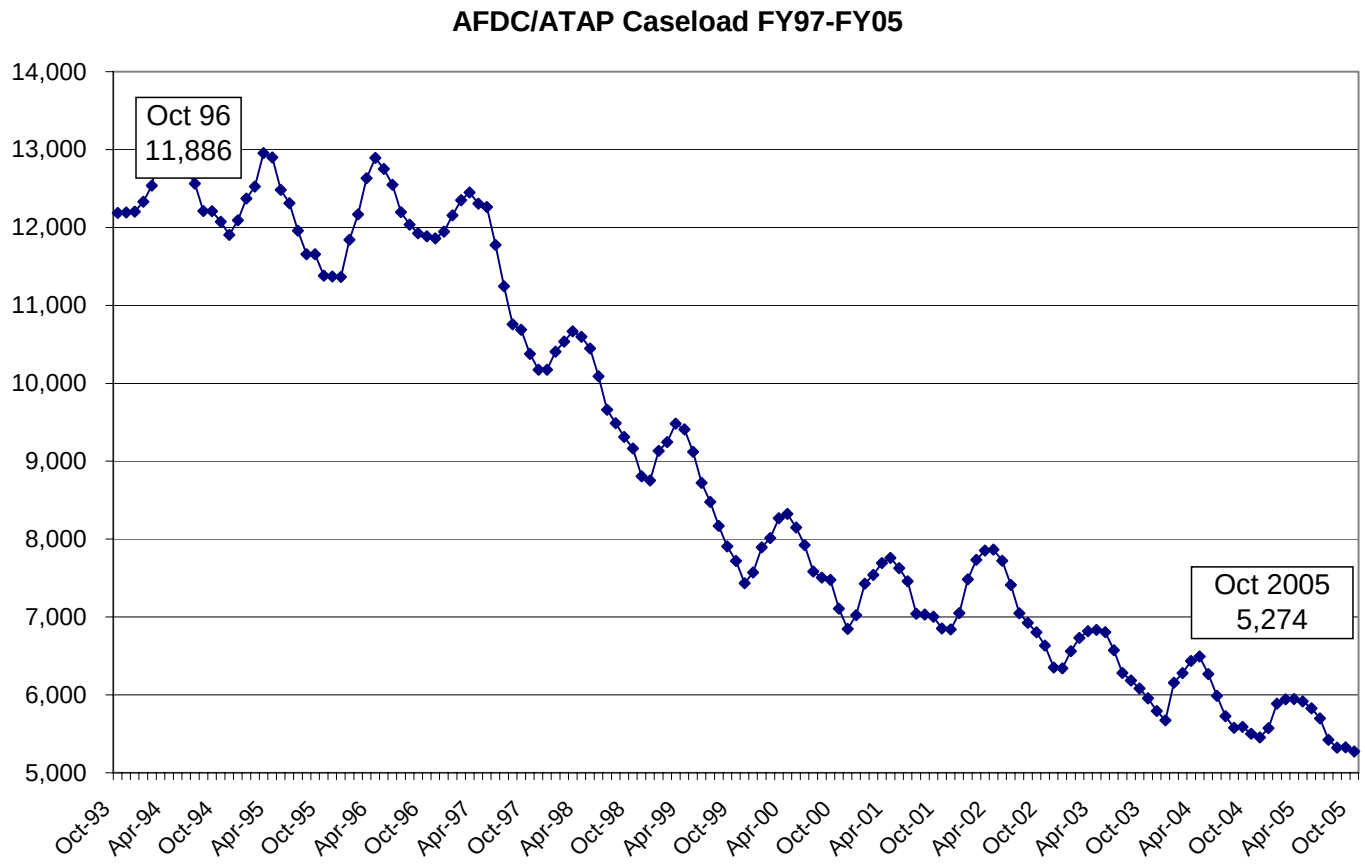
Department Level Measures

F: Result - Outcome Statement #6: Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Measure #1: Rate of change in self-sufficient families.

Changes in Self Sufficiency

Year	September	December	March	June	YTD Total
2002	-16%	6%	4%	3%	-2%
2003	-1%	-11%	-14%	-13%	-9%
2004	-12%	-7%	-6%	-9%	-9%
2005	-6%	-7%	-8%	-6%	-7%
2006	-6%	0	0	0	0



Analysis of results and challenges: The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program.

As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

The rate of change is calculated for the number of families receiving Alaska Temporary Assistance Program benefits compared to the same time period in the previous state fiscal year. Thus September of SFY2003 had a 1% decline in the Alaska Temporary Assistance Program caseload compared to September of SFY2002. The YTD column compares the average annual caseload to the prior year average annual caseload.

F1: Strategy - Use TANF high performance bonus funds for families approaching 60-month time limit.

Division Level Measures

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Measure #1: Rate of change in self-sufficient families.

Analysis of results and challenges: This target and measure are reported at the Department level. See Result F: Outcome Statement #6. See previous pages.

A1: Strategy - Increase the percentage of temporary assistance families who leave the program with earnings and do not return for 6 months.

Target #1: 90% temporary assistance families leave with earnings and do not return for 6 months.
Measure #1: Percentage of families that leave temporary assistance with earned income and do not return for 6 months.

Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	83%	76%	81%	81%
2003	85%	87%	82%	82%	84%
2004	90%	85%	79%	80%	84%
2005	88%	85%	80%	82%	84%
2006	87%				

Analysis of results and challenges: The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. The measurement ties in job retention, since retaining employment is directly related to remaining off Temporary Assistance.

The Division provides childcare and supportive services to support employed families during the transition to self-sufficiency. Supportive services include case management support to continue coaching the employed client during this vulnerable period.

To calculate this measure, we divide the number of cases that closed with earnings 6 months ago by the number of cases that closed with earnings 6 months ago who are not in the current caseload. The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY06 target is 90%.

A2: Strategy - Increase the percentage of temporary assistance families with earnings.

Target #1: 40% of temporary assistance families with earnings.
Measure #1: Percentage of temporary assistance families with earnings.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	31%	28%	27%	31%	29%
2003	30%	28%	27%	32%	29%
2004	31%	29%	29%	35%	31%
2005	34%	31%	30%	35%	33%
2006	34%				

Analysis of results and challenges: This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare-to-work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient.

The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY06 target is 40%.

A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50% of temporary assistance families meet federal work participation rates.
Measure #1: Percentage of temporary assistance families meeting federal work participation rates.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	38%	37%	36%	36%	36%
2003	32%	33%	33%	34%	34%
2004	36%	36%	36%	37%	37%
2005	39%	37%	39%	40%	40%
2006	42%				

Analysis of results and challenges: Temporary Assistance (TA) is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

The quarterly figures are YTD figures. The federal participation rate calculation is a running YTD figure.

The FY06 target is 50%.

A4: Strategy - Improve timeliness of benefit delivery.

Target #1: 95% of food stamps expedited service applications meet federal time requirements.
Measure #1: Percentage of food stamps expedited service households that meet federal time requirements.

Percentage of food stamps expedited service households that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	95.4%	94.5%	93.4%	93.4%	93.4%
2003	94.0%	90.5%	90.8%	92.1%	92.1%
2004	93.2%	93.8%	94.5%	94.7%	94.7%
2005	90.9%	92.3%	92.7%	93.5%	93.5%
2006	95.0%				

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures. The FY06 target is 95%.

Target #2: 96% of new food stamps applications meet federal time requirements.
Measure #2: Percentage of new food stamps applications that meet federal time requirements.

Percentage of new food stamps applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	93.0%	94.2%	94.3%	94.7%	94.7%
2003	95.9%	95.1%	95.1%	95.5%	95.5%
2004	96.2%	96.1%	96.3%	96.5%	96.5%
2005	95.2%	95.5%	95.7%	95.9%	95.9%
2006	95.4%				

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY06 target is 96%.

Target #3: 99.5% of food stamps recertification applications meet federal time requirements.
Measure #3: Percentage of food stamps recertification applications that meet federal time requirements.

Percentage of food stamps recertification applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	99.8%	99.8%	99.7%	99.6%	99.6%
2003	99.5%	99.5%	99.4%	99.4%	99.4%
2004	99.6%	99.6%	99.6%	99.6%	99.6%
2005	99.5%	99.5%	99.5%	99.6%	99.6%
2006	99.4%				

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY06 target is 99.5%.

Target #4: 90% of temporary assistance applications meet time requirements.
Measure #4: Percentage of temporary assistance applications that meet time requirements.

Percentage of Temporary Assistance applications that meet time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	86%	85%	86%	86%
2003	90%	88%	89%	90%	90%
2004	88%	88%	88%	88%	88%
2005	85%	84%	85%	85%	85%
2006	88%				

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY06 target is 90%.

Target #5: 90% of Medicaid applications meet federal time requirements.
Measure #5: Percentage of Medicaid applications that meet federal time requirements.

Percentage of Medicaid applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	89%	90%	89%	89%	89%
2003	91%	90%	90%	90%	90%
2004	88%	91%	91%	91%	91%
2005	92%	91%	91%	90%	90%
2006	89%				

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY06 target is 90%.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.
Measure #1: Percentage of accurate food stamp benefits.

Percentage of accurate food stamp benefits

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	90.4%	92.4%	90.5%	89.2%	89.2%
2003	86.2%	84.7%	85.6%	86.4%	86.4%
2004	90.8%	94.2%	93.5%	93.3%	93.3%
2005	92.2%	93.2%	93.0%		93.2%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY05 target is 93%.

Target #2: 95% of temporary assistance benefits are accurate.
Measure #2: Percentage of accurate temporary assistance benefits.

Percentage of accurate temporary assistance benefits.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	88.2%	93.7%	93.6%	92.0%	92.0%
2003	94.4%	93.6%	94.5%	93.6%	93.6%
2004	96.7%	97.5%	98.2%	98.1%	98.1%
2005	98.5%	95.9%	95.7%		95.9%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY05 target is 95%.

Target #3: 93% of Medicaid eligibility determinations are accurate.
Measure #3: Percentage of accurate Medicaid eligibility determinations.

Percentage of accurate Medicaid eligibility determinations

Year	YTD Total
2002	96%
2003	99%
2004	99%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities.

The FFY05 target is 93%.

A6: Strategy - Increase the percentage of subsidy children in licensed care.

Target #1: 76% of subsidy children are in licensed care.
Measure #1: Percentage of subsidy children in licensed care.

Percentage of subsidy children in licensed care

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	0	60%	58%	64%	64%
2003	65%	66%	68%	75%	75%
2004	75%	76%	76%	76%	76%
2005	74%	81%	77%	80%	77%
2006	80%				

Analysis of results and challenges: The first available data regarding this measure is the second quarter in 2002.

The FY06 target is 76%.

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Public Health

Mission

Protect and promote the health of Alaskans.

Introduction

The Division of Public Health (DPH) operates programs that are primarily population-based and focused on protecting and promoting the health of entire communities and of all Alaskans. DPH employees conduct disease surveillance and investigation and provide treatment consultation, case management and laboratory testing services to control outbreaks of communicable diseases and prevent epidemics.

The Division uses data and other scientific information and expertise to develop sound policy and deliver disease control and health promotion services to protect and improve the health of Alaskans and those who visit Alaska. Professional staff monitor and assess health status through the collection and analysis of vital statistics, behavioral risk factor data, and data on disease and injury, including forensic data from postmortem examinations.

DPH strives to improve public health by encouraging, supporting and sometimes requiring the development of health services by others, and by providing services directly when unavailable from the private sector or other health organizations. Outreach activities are conducted to link high-risk and disadvantaged people to needed services. The Division promotes healthy behaviors by educating citizens and supporting community actions to reduce health risks.

Core Services

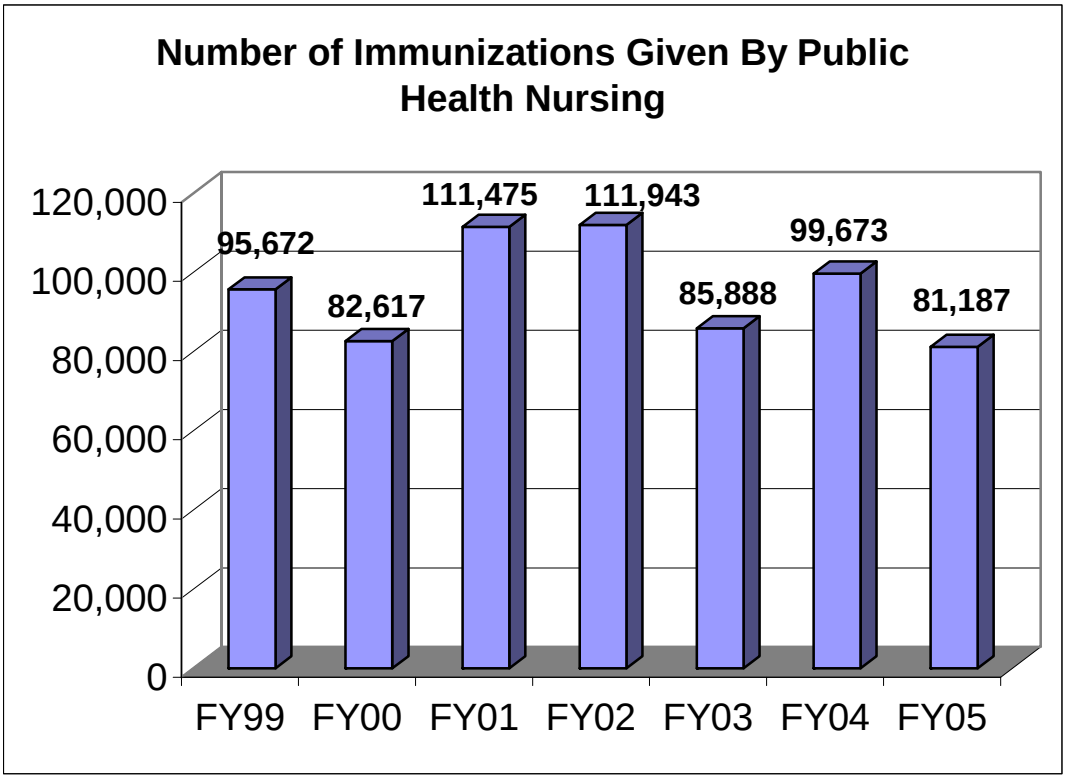
The Division has identified seven core services that help it achieve its mission of protecting and promoting the health of the public. The core services are:

- Prevent and control epidemics and the spread of infectious disease;
- Prevent and control injuries;
- Prevent and control chronic disease and disabilities;
- Respond to public health emergencies, disasters and terrorist attack;
- Assure access to early preventive services and quality health care;
- Protect against environmental hazards impacting human health; and
- Ensure effective and efficient management and administration of public health programs and services.

Many of the services and programs delivered by the Division of Public Health serve the population as a whole, rather than individuals, so statistics on individual services do not complete the picture of the Division's work. Activities such as disease outbreak response, preparation and dissemination of epidemiology bulletins to all health practitioners in the state, planning and development of health systems, and educational campaigns such as those to influence children not to smoke are but a few examples of DPH efforts to protect, promote and improve the health of hundreds of thousands of Alaskans every day. Some of the easy to quantify results from FY05 are provided below.

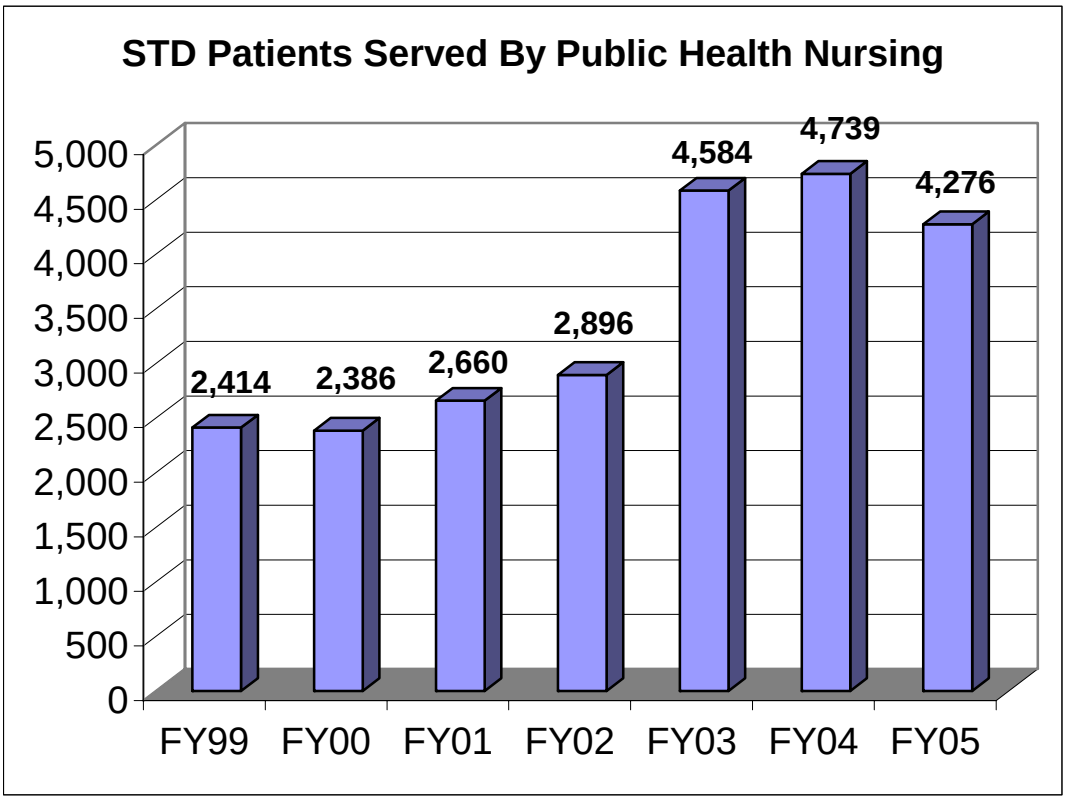
Public Health Nursing

Public health nursing staff provides the Division's community based service delivery for disease prevention and protection, health promotion, and health assessments. Public health nurses are on the front lines in emergency preparedness and response mobilization. They provide the focused surge capacity to respond to infectious disease outbreaks. Essential public health services are provided or assured by the state in the absence of local governments with the necessary health powers to serve as local public health authorities.



Public health services are provided by nursing staff in public health centers in 23 communities and by itinerant public health nurses serving more than 250 communities. Grantees in four areas of Alaska – Norton Sound Health Corp., Maniilaq Association, the North Slope Borough, and the Municipality of Anchorage – are supported through grant funding and technical assistance to assure that public health nursing services are available statewide. Four expert public health nursing specialists assigned at the regional level assure the performance of staff across the state, assure or provide backup for locations with a public health nurse vacancy, and provide public health leadership at the regional and statewide levels.

Public health nurses devoted significant time in FY05 to community assessment and development activities as work continued to transition clinical client services to other health care providers wherever possible. Despite staff reductions and time devoted to working with communities and other health care providers on efforts to transition services, public health nurses delivered significant numbers of basic essential health care services to Alaskans.



In FY05, public health nurses statewide*:

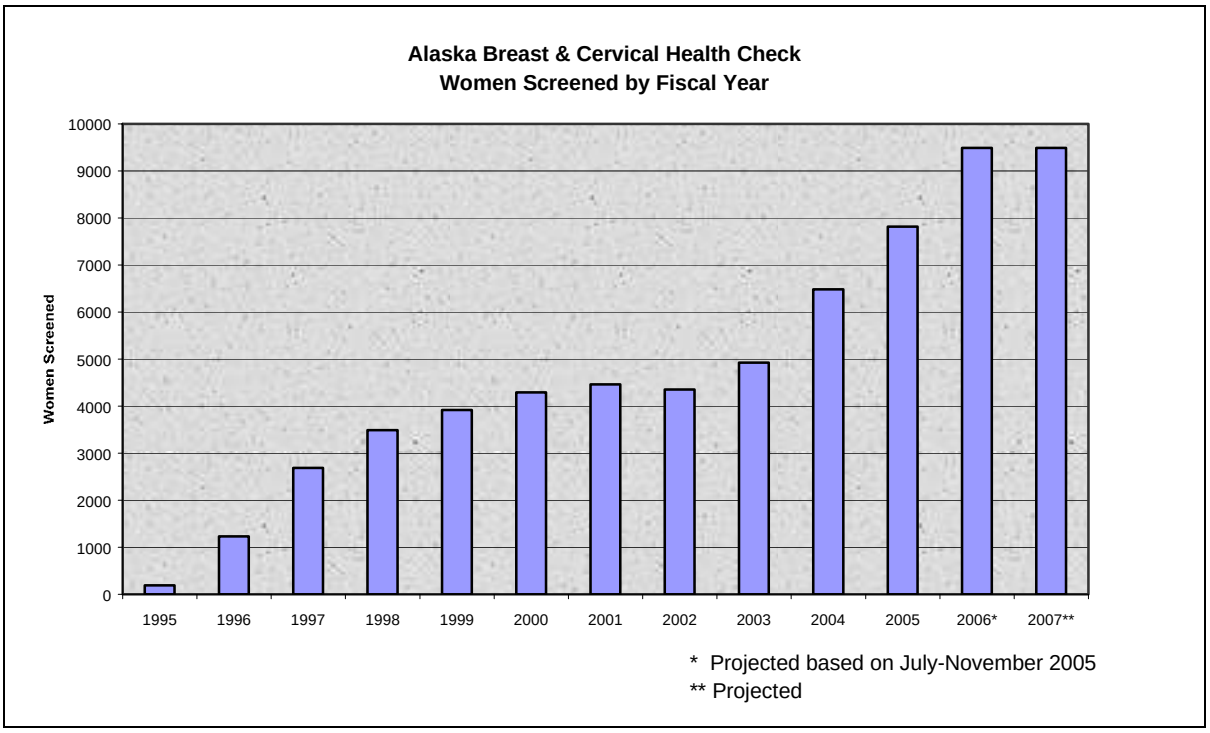
- Provided 130,721 health care visits to 78,784 patients of whom 42,769 were children and youth (birth to 19 years old).
- Administered 81,187 doses of vaccine.
- Gave and read 27,814 tests for TB.
- Provided 2,097 Pap Smears for detection of cervical cancer in Alaskan women.
- Provided 15,140 visits for family planning to 6,339 individuals.
- Provided 7,911 visits to 4,276 patients for Sexually Transmitted Diseases.
- Provided 3,882 visits for HIV/AIDS services including blood testing for 2,178 patients.

*Data does not include the Municipality of Anchorage, a Public Health Nursing grantee, except for doses of vaccine given. Anchorage uses a different data system for all but immunizations

Women's, Children's and Family Health

The section's mission is to promote optimum health outcomes for all Alaskan women, children and their families. This is accomplished by providing leadership and coordination with primary and specialty health care providers and public entities within the state's health care system to develop infrastructure and access to health services; and to deliver preventative, rehabilitative and educational services targeting women, children and families.

Services and programs delivered statewide include Breast and Cervical Health Check; Family Planning; Perinatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening; Early Hearing Detection, Treatment and Intervention Program; Pediatric Specialty Clinics; and Genetics and Metabolic clinics. In addition, the MCFH Epidemiology unit collects, analyzes and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaskan women, children and their families.



Examples of services supported or coordinated by the section of Women's, Children's and Family Health in FY05 include:

- Over 7,800 women were served in the Breast and Cervical Health Check program. Since the program inception in 1995, over 60,000 cancer screenings have been provided to nearly 25,000 medically underserved women.
- Over 5,500 low-income women and men were provided family planning and reproductive health services as a result of federal Title X and Title V MCH block grant funds at public health center family planning clinics.
- The baseline oral health survey of 2,000 third graders in several Alaskan communities across the state was completed and work is underway to complete the state plan.
- 100 percent of all newborns in Alaska were screened for over 30 different metabolic disorders.
- Over 87 percent of all newborns in Alaska were screened for hearing loss, the most common congenital defect.
- 120 children received multidisciplinary evaluation for Cleft Lip and Palate clinics in Anchorage, Bethel and Fairbanks; 59 children received evaluations at the Neurodevelopmental Clinics held in Dillingham, Fairbanks, Juneau, and Ketchikan; and 39 children received consultations at the Neurology clinic in Fairbanks.

- 334 clients were seen for an initial visit at the Genetics and Metabolic clinics and 30 clients were seen more than once for a total of 364 visits during 29 clinic days held in Anchorage, Bethel, Fairbanks, Dillingham, Kodiak, Juneau, Ketchikan, and Sitka.

Certification and Licensing

The mission of the Section of Certification and Licensing is to protect the life, health and safety of vulnerable populations. The Governor signed an executive order in 2003 to consolidate certification and licensing functions in the Division of Public Health. Along with centralized funding and staff came the responsibility to ensure that statutory and regulatory standards are met by assisted living homes, nursing homes and other health care facilities. Through passage of Senate Bill 125 last session, a clear definition of the principles for how and when an entity is to be licensed has been established. The Section of Certification and Licensing is now in the process of developing a Background Check Unit that will ensure barrier crimes are defined and conditions that will disqualify someone from working in a home or facility are reviewed.

Examples of services provided in FY05*:

- Made 836 site visits to license, monitor or investigate assisted living homes;
- Granted certification and licensure to 97 health care facilities;
- Responded to 221 complaints/incidences regarding health care facilities.

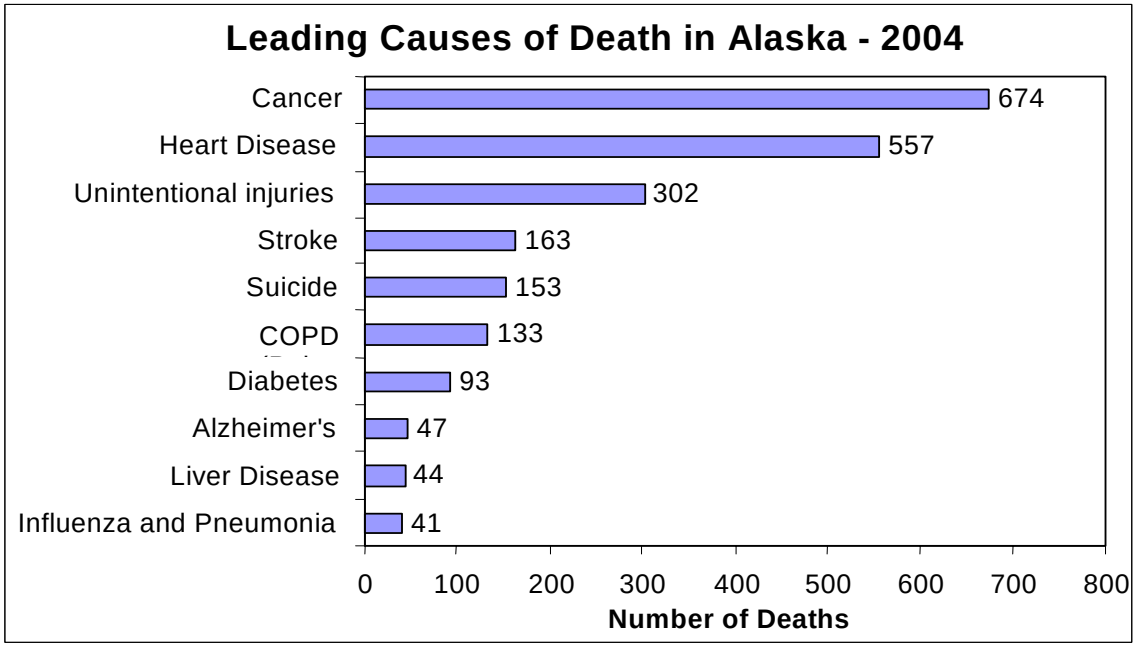
(*Data are from November 2004 to November 2005)

Chronic Disease Prevention and Health Promotion

The Section of Chronic Disease Prevention and Health Promotion was just established in July 2005. Before then, its programs were part of the Section of Epidemiology. This overview describes the activities and service deliverables of the chronic disease programs that were housed in the Section of Epidemiology during FY05.

Through its programs (Diabetes Control and Prevention, Cancer Control and Prevention, Heart Disease and Stroke, Arthritis, Obesity Prevention, Tobacco Control, Surveillance and Chronic Disease Epidemiology, Community Preventive Services, Health Survey Lab and School Health) the Section of Chronic Disease Prevention and Health Promotion works to reduce the social, economic and health impacts of chronic disease by:

- Assessing the chronic disease burden;
- Educating the public and health professionals;
- Collaborating with communities and other partners in the planning, implementation and evaluation of science-based strategies and interventions; and
- Advocating for the prevention and control of chronic diseases.



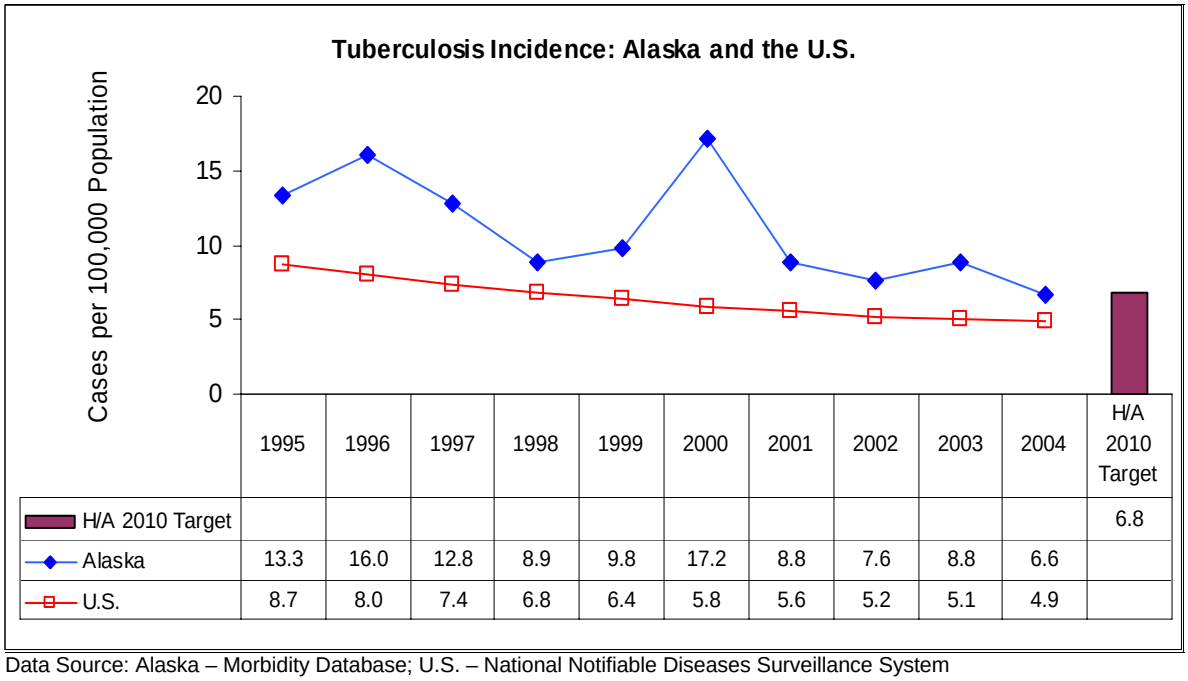
Examples of services provided by Chronic Disease Prevention and Health Promotion programs in FY05 include:

- Provided technical expertise related to chronic disease prevention and control, in the areas of diabetes, cancer, arthritis, obesity, heart disease and stroke to communities, partners and Native health organizations statewide.
- Worked with communities to assess the burden of chronic diseases and their associated risk factors and develop disease intervention activities to prevent and control chronic disease.
- Developed and disseminated a report on the height and weight status of students in the Anchorage School District.
- Completed a statewide diabetes system assessment to better understand the gaps and barriers to diabetes care and prevention.
- Provided training to 24 public health nurses on community assessment and program planning.
- Completed the first year of a cholesterol and blood pressure quality improvement project with 15 community health centers.
- Maintained data systems to support surveillance, so as to provide an accurate picture of the health status of Alaskans, and enable improved evaluation of program activities related to chronic disease and its associated risk factors. These data systems include the Cancer Registry System, the Behavioral Risk Factor Surveillance System and the Health Survey Lab.
- Provided technical expertise related to school health education and the Youth Risk Behavior Survey to school districts statewide.
- Develop anti-tobacco curricula for use in our schools.
- Develop and distribute educational materials that provide information specific to tobacco cessation resources in each community.

Epidemiology

The Section of Epidemiology provides surveillance for reportable health conditions to accurately assess the health of Alaskans, to detect disease outbreaks requiring intervention, and to assess the effectiveness of prevention strategies, such as immunization programs. It also detects, investigates and controls disease outbreaks through defining causal factors, and by identifying and directing

prevention and control measures. The section provides scientific data through epidemiological studies and data interpretation to form the basis of policy development and prevention program planning and evaluation; medical and epidemiological expertise required for infectious disease control and epidemic response in disease outbreaks and following natural or manmade disasters; contact identification, education, and diagnosis and treatment support for persons exposed to tuberculosis, HIV, sexually transmitted diseases, and other infectious diseases; and risk assessment of environmental health threats to Alaskans.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010 Target
H/A 2010 Target											6.8
Alaska	13.3	16.0	12.8	8.9	9.8	17.2	8.8	7.6	8.8	6.6	
U.S.	8.7	8.0	7.4	6.8	6.4	5.8	5.6	5.2	5.1	4.9	

Data Source: Alaska – Morbidity Database; U.S. – National Notifiable Diseases Surveillance System
H/A = Healthy Alaskans 2010

Examples of services provided by Epidemiology in CY04 include:

- Responded to 100 percent of 305 after-hours calls within 15 minutes.
- Investigated outbreaks of infectious diseases, including:
  - *Vibrio parahaemolyticus* gastroenteritis involving at least 62 persons after consuming Alaska oysters and determined that rising water temperature in Prince William Sound may have contributed to this unprecedented outbreak. Established a monitoring program with the Department of Environmental Conservation to reduce the risk of future outbreaks.
  - Norovirus gastroenteritis that affected at least 50 persons affiliated with the 2004 Iditarod race and provided guidance for limiting spread.
  - Pertussis (whooping cough) at a rural daycare center and in a Head Start program, and limited further spread of infection by identifying contacts and providing preventive antimicrobial drugs to 79 people.
  - *Clostridium perfringens* gastroenteritis involving 30 workers at a Valdez cannery.
  - Infectious syphilis involving 16 confirmed cases, of which 6 were identified through interviews and testing by Public Health Disease Intervention Specialists. Provided treatment counseling to infected persons to prevent disease progression and further spread.
  - 2 separate outbreaks of food-borne botulism in rural Alaska.
- Evaluated 43 cases of active tuberculosis and provided testing and, when appropriate, preventive therapy for 532 contacts of persons with active tuberculosis.

- Investigated lead poisoning among 4-H and teen-aged members of a rifle team at an indoor shooting range to identify sources of lead exposure, and provided guidance on remediation and methods to reduce additional exposure.
- Located, notified, and interviewed 1,304 partners of persons with *Chlamydia trachomatis* infection and 210 partners of persons with gonorrhea to prevent further spread of infection. Where appropriate, offered partners onsite diagnostic testing and treatment for these infections.
- Interviewed 64 persons with newly reported HIV infection and tested 184 partners of these persons, identifying 23 persons with previously unknown HIV infection. Provided education, counseling and other services to prevent illness and further spread of infection.
- Published *The Use of Traditional Foods in a Healthy Diet in Alaska: Risks in Perspective*, 2nd edition, providing the scientific rationale for DPH's recommendations for consumption of subsistence foods containing trace amounts of mercury and PCBs.
- Distributed 361,387 doses of vaccine through the Alaska Immunization Program, including 108,945 doses of influenza vaccine.
- Published 40 issues of the Section of Epidemiology *Bulletin*, providing timely updates and recommendations for addressing health threats to Alaskans. The *Bulletin* is distributed free-of-charge to health care and public health service providers throughout the state and is available on-line.

Bureau of Vital Statistics

The Bureau of Vital Statistics oversees the registration of vital events in Alaska and is responsible for the preservation and security of the records. Bureau staff work in partnership with hospitals, funeral directors, physicians, and the court system to ensure all vital events are properly recorded, that they satisfy the legal requirements of Alaskans and their families, and that the information contained in vital records meet the statistical needs of researchers or health officials at the state and national level. To help ensure vital events are properly registered and to maintain the integrity of the vital records system, the Bureau maintains a statewide program to train local officials, hospital staff, physicians, and funeral home staff on the procedures to properly complete birth, death and divorce certificates.

The Bureau issues certified copies of vital events and operates walk-in offices in Juneau, Anchorage and Fairbanks that Alaskans can use to receive same-day service when requesting certified copies of vital events. Mailed and faxed requests are also accepted. Certified copies of vital events are necessary for many legal purposes, such as obtaining a driver's license, a passport, or a permanent fund dividend for a child; receiving health or retirement benefits for family members; or settling an estate. Bureau staff assist Alaskans who need help or have questions related to vital records. Single mothers may have questions or need help establishing paternity for their child, tribal councils may need assistance completing cultural adoption paperwork, or Alaskans in rural areas may require assistance registering a home birth. The Bureau also maintains the state's Medical Marijuana Registry.

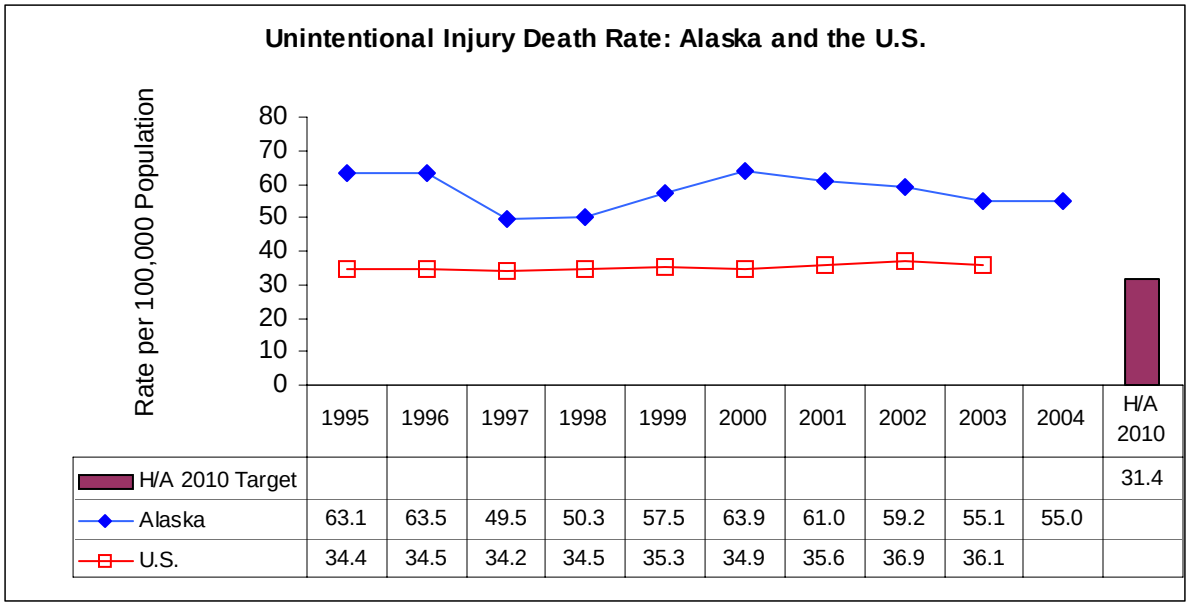
Information from vital records is used to monitor and assess the health status of Alaskans and help guide health policy issues affecting the state. The Bureau publishes an annual report of vital events in Alaska and provides public health statistics on its web site. These reports include statistics on births, fetal and infant deaths, induced terminations, adoptions, marriages and divorces, and deaths. Teen birth rates, chronic disease mortality, leading causes of death, infant mortality, pregnancy and fertility rates, local health profiles, and Healthy Alaskans 2010 statistics are examples of information published on the Bureau's web site.

Examples of services provided in FY05 include:

- Adoptions of Alaska-born children processed: 560
- Establishments of paternity of Alaska-born children processed: 3,726
- Funds generated for the Alaska Children's Trust through heirloom birth and marriage certificates: $23,540
- Applications for the Medical Marijuana Registry processed: 156
- Processed approximately 60,000 requests for vital records
- Recorded these events in Alaska:
    - Births: 10,315
    - Deaths: 3,201
    - Marriages: 5,438
    - Divorces: 2,529

Community Health and Emergency Medical Services

This section provides services and outreach training to reduce human suffering and economic loss to society resulting from disability and premature death due to injuries and to assure access to community-based emergency medical services. The section is charged with increasing public awareness and promoting long-term positive behavior toward safety and health, and encouraging interventions statewide in injury prevention and control. The section also maintains the Alaska Trauma Registry and the Alaska Violent Death Reporting System and provides detailed analyses of its injury databases to community, municipal, state, federal and private sector agencies and organizations to assess current prevention efforts and planning.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											31.4
Alaska	63.1	63.5	49.5	50.3	57.5	63.9	61.0	59.2	55.1	55.0	
U.S.	34.4	34.5	34.2	34.5	35.3	34.9	35.6	36.9	36.1		

Data Source: Bureau of Vital Statistics

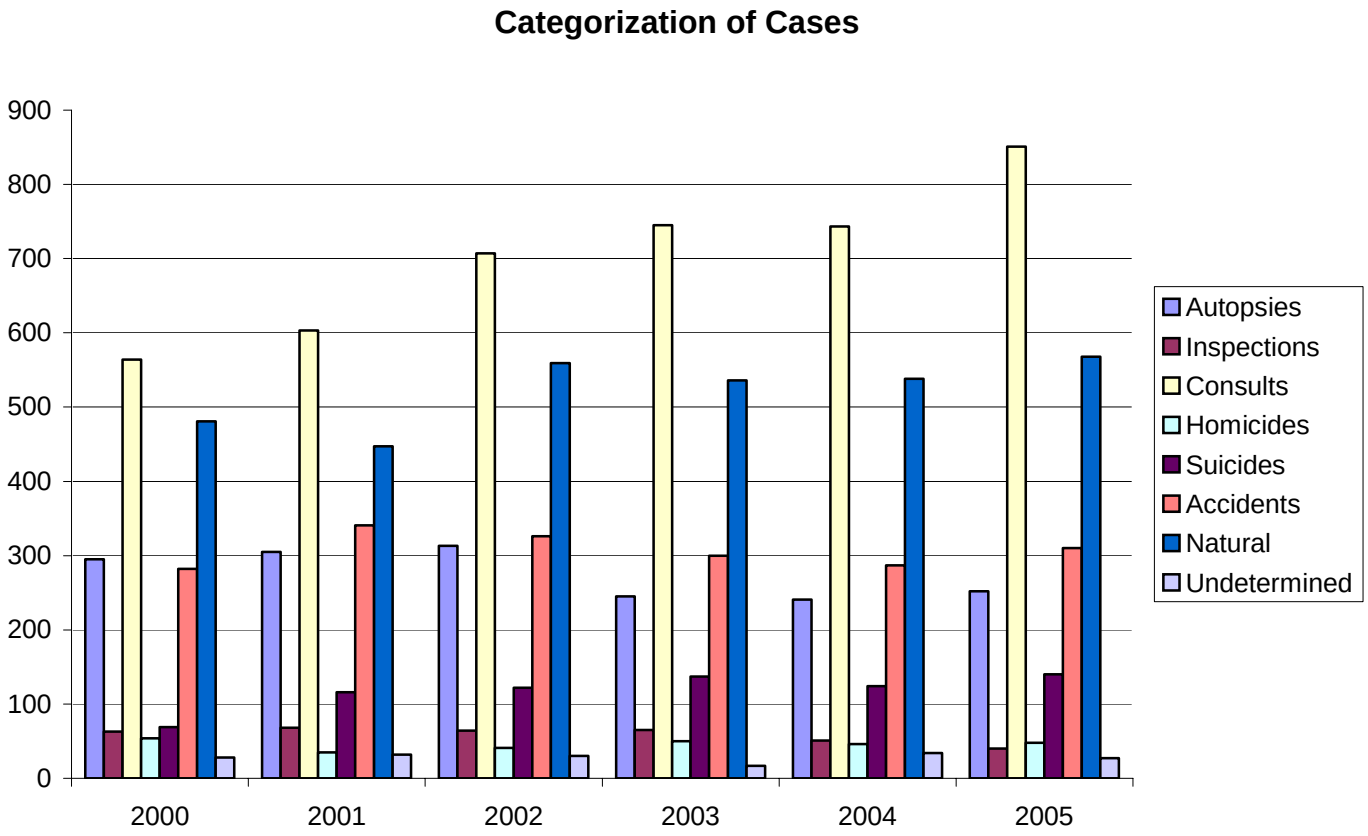
Examples of services provided in FY05 include:

- Maintained a certified Alaska EMS corps of nearly 3,500 Emergency Medical Technicians (EMT), Emergency Medical Services (EMS) Instructors, Emergency Medical dispatchers, and Defibrillator Technicians;
- Certified, recertified, and provide technical support for approximately 88 ground EMS, 22 air medical services, and 3 hospital trauma centers (5 additional hospitals are working toward certification);

- Provided training and re-certification for over 120 Child Passenger Safety (CPS) technicians located in several state agencies and health organizations;
- Collaboration on a parent guidebook for the Alaska graduated driver's license for Teens;
- Collected information from more than 4,800 injury cases requiring hospitalization and their associated in-patient costs;

State Medical Examiner

The State Medical Examiner's Office is responsible for investigating and certifying all deaths that occur within the State of Alaska that are the result of violence, suspected violence, deaths due to accidental causes, deaths that occur during incarceration, deaths that are associated with conditions that pose a hazard to public safety or health, and all unattended or unexplained deaths. The medical examiner ensures appropriate follow-up on all child deaths; establishes the identity of the deceased; maintains records and evidence; provides legally defensible determinations of the cause and manner of death; presents findings of the investigation to courts, law enforcement agencies, and other parties with legitimate interests in the death.



Over the past 10 years of operations, the Medical Examiner's Office has become increasingly involved with communities throughout Alaska. There has been an increase in cases brought in from the villages, and remote areas of the state. This provides for a more accurate tracking of cases in all manners of death. It also provides a stable environment for tracking and prevention of hazardous health problems in the state.

Examples of services provided in FY05 by the Medical Examiner's Office include:

- Number of cases autopsied: 252
- Number of consult cases: 851
- Number of inspection cases: 40

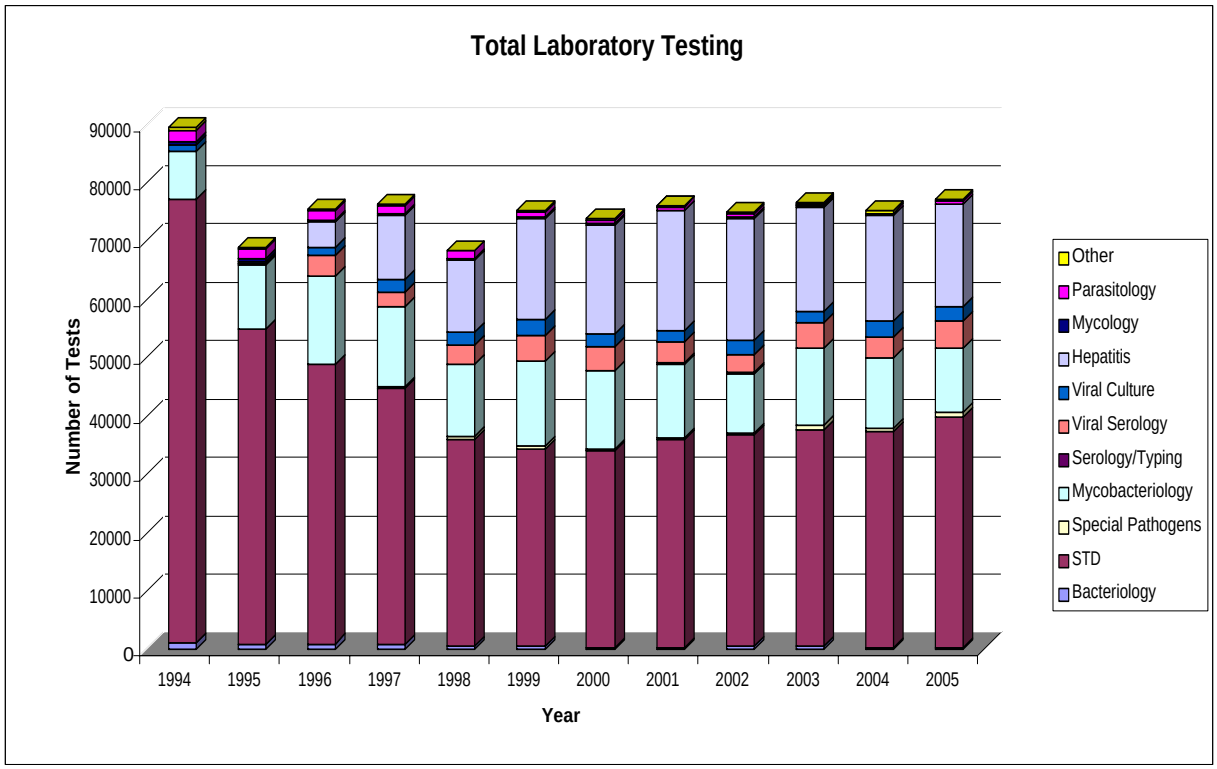
Public Health Laboratories

The Section of Laboratories provides analytical and technical laboratory testing and information to support disease prevention programs, services and activities. The Anchorage laboratory provides testing for microbial, parasitic and fungal infectious agents, as well as testing for disease antibodies in the blood and for chemical and toxic agents. The Fairbanks lab provides virology testing.

In addition to laboratory testing, this section provides technical consultation and continuing education to clinical laboratorians throughout Alaska, and quality assurance and reference testing for Alaska's clinical laboratories to ensure the safety and efficacy of their services.

Examples of services provided in FY05 include:

- Total number of lab tests: 77,006, representing a 3 percent increase over FY04 and a 13 percent increase since FY98.
- Total number of tests for STDs: 39,506
- Total number of tests for Hepatitis: 17,570
- Total number of tests for Tuberculosis: 11,069



Preparedness for Public Health Emergencies Program

The Program was developed to ensure that Alaskans are protected in the event of a public health emergency – whether natural or manmade. The Program's efforts are focused in several key areas, including: emergency preparedness planning and readiness assessment, disease surveillance and epidemiology capacity, biological and chemical laboratory capacity, communications and information technology, public communication and health information dissemination, training and exercises, and hospital preparedness. The Division coordinates extensively with such agencies as the FBI; CDC; Federal Emergency Management Agency; Alaska Division of Homeland Security and Emergency Management; Municipality of Anchorage; Alaska Native health organizations; and private health care providers to assess Alaska's public health preparedness needs, develop

appropriate plans, and conduct training and exercises. The Division of Public Health also receives federal grants from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration in support of these activities.

During FY05 and the past calendar year, DPH has greatly increased its capabilities in public health preparedness and response. Recent activities include:

- Supported four community mass vaccination clinic exercises, demonstrating the ability to process up to 500 patients per hour;
- Supported development of the 1st edition of the Alaska Pandemic Influenza Plan;
- Conducted training workshops and preparedness exercises in six communities as part of the Strategic National Stockpile hub site visit program;
- Developed and implemented the Public Health Preparedness Training Plan;
- Developed and exercised the DPH Emergency Operations Plan, including annexes for Biological Agent Response, Chemical Agent Response, Mass Prophylaxis, Alternate Care Site Operations, Mass Casualty Response, and Risk Communication;
- Participated in Alaska Shield / Northern Edge statewide, a multi-agency emergency response exercise;
- Continued partnership with Alaska Division of Homeland Security and Emergency Management, Alaska Native Tribal Health Consortium, Municipality of Anchorage, and the Alaska State Hospital and Nursing Home Association for all planning, training and exercise activities;
- Developed new state regulations supporting public health emergency response activities.

Public Health Nursing AS 8.68; AS 18.05; AS 18.15; AS 44.29
Public Health Nurses serve as the front line workforce of public health at the local level, providing a variety of services. Public health nursing collaborates with the division's sections of epidemiology and public health laboratories, as well as with local health care providers to control communicable disease outbreaks. Direct clinical and preventive services are provided in 23 community public health centers, and through visits to communities and families statewide. Services are provided in the Norton Sound region, Northwest Arctic Borough, North Slope Borough, and the Municipality of Anchorage through grants.

Women's, Children's and Family Health AS 08.36; AS 09.25; AS 18.05; AS 18.15-16; AS 18.50 AS 44.29; AS 47.20
The Section of Women's, Children's and Family Health contributes to the delivery of population-based services and the building of health care system infrastructure so Alaska's women, infants, children, and families can achieve the best possible health and well-being.

Certification and Licensing AS 18.20; AS 47.05; AS 47.07; AS 47.08; AS 47.25; AS 47.32
The Section of Certification & Licensing inspects hospitals; nursing facilities; assisted living homes; and other health-related care facilities and requires that necessary corrections or improvements be implemented to protect the safety of residents. Through the development of a program to conduct criminal background checks for employees in these facilities, the section will provide safeguards against abuse and neglect of the state's elderly, children and adults with disabilities.

Chronic Disease Prevention and Health Promotion AS 18.05; AS 18.15; AS 44.29
The Section of Chronic Disease Prevention and Health Promotion consists of the following programs: Diabetes Control and Prevention, Cancer Control and Prevention, Heart Disease and Stroke, Arthritis, Obesity Prevention, Tobacco Control, Surveillance and Chronic Disease Epidemiology, Community Preventive Services, Health Survey Lab and School Health. Together these programs provide the foundation of State of Alaska's efforts to prevent and control chronic diseases.

Epidemiology AS 18.05; AS 18.15; AS 44.29
Surveillance, epidemic response, investigation, and control of infectious, vaccine-preventable, and environmental diseases, whether naturally occurring or manmade, are the major responsibilities of the epidemiology programs. They provide a scientific basis for policy development by defining and identifying factors contributing to the cause and risk of disease and by assessing the effectiveness of prevention strategies.

Bureau of Vital Statistics AS 17.37; AS 18.05; AS 18.50; AS 25.05 – 25.25; AS 44.29
The Bureau is responsible for the registration, certification, security, and protection of permanent records of vital events (births, deaths, marriage, divorce, and adoptions), maintaining the medical marijuana registry, and receiving reports of induced terminations of pregnancy.

Community Health and Emergency Medical Services AS 18.05; AS 18.08; AS 18.15; AS 18.25; AS 18.28; AS 44.29
The Section consists of two programmatic units: The Injury Prevention Unit works to prevent injuries from occurring in the first place by identifying causal factors and implementing policies and strategies for prevention; the EMS Unit strives to ensure that qualified and properly equipped

emergency medical services personnel are available to respond to the emergency medical needs of Alaskans and visitors to our state.

State Medical Examiner AS 12.65; AS 18.05; AS 18.15; AS 44.29
As a key element of the public health mission to prevent injury, disease and death**,** the Office of the State Medical Examiner designs and manages a statewide system of medical legal investigation of unanticipated, sudden, or violent deaths. Activities include providing accurate, legally defensible determination of the cause and manner of death; and, conducting comprehensive medical legal death investigations.

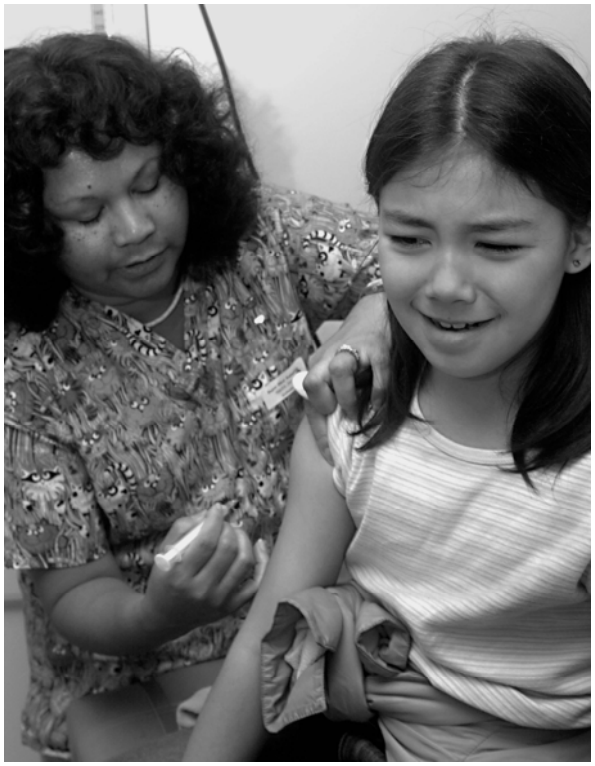
Public Health Laboratories AS 18.05; AS 18.15; AS 18.60; AS 44.29
The State Public Health Laboratories provide analytical and technical laboratory testing and information in support of state and national public health disease prevention programs. This is a first line of defense in the rapid recognition and prevention of the spread of communicable diseases.

Public Health	2006	2007 Proposed	06 to 07 Change
General Funds	23,805.8	30,009.9	6,204.1
Federal Funds	31,602.9	33,149.9	1,547.0
Other Funds	18,216.1	20,024.5	1,808.4
Total	**73,624.8**	**83,184.3**	**9,559.5**

Public Health Nursing

Infectious Disease Control and Emergency Preparedness $1,500.0 ($960.0 General Funds, $540.0 Interagency Receipts)

The control of infectious diseases has become increasingly complex and challenging. Over the past 30 years more than 30 new infectious diseases have been discovered; recent examples are SARS and the H5N1 strain of avian influenza. To truly protect the health of Alaskans, the Division of Public Health must sustain well-established core public health programs such as tuberculosis control and immunizations, while taking on new challenges, such as pandemic influenza planning and bioterrorism preparedness. To accomplish these critical objectives, the Division is taking a multi-pronged approach. Besides Public Health Nursing, the Sections of Epidemiology and Public Health Laboratories are each integral and interdependent when it comes to disease control – working together in a continuous cycle of discovery, investigation, intervention, monitoring and reporting. Thus, associated requests to fund a comprehensive approach to infectious disease control are found in the Epidemiology and Public Health Laboratories components. Specifically, this request for Nursing will modernize and strengthen an aging and under-funded infectious disease control system. Additional personnel (8 new positions and funding for 4 existing PCN's) located in communities throughout Alaska will address rising demands of infectious disease prevention, control, intervention and treatment for Alaskans across the state. They also will provide needed surge capacity to respond to infectious disease outbreaks or other public health emergencies.



Certification and Licensing

Protecting Alaska's Vulnerable Individuals $550.0 ($150.0 General Fund; $400.0 Receipt Supported Services)

When a loved one is no longer able to care for him or herself, families are faced with excruciatingly difficult decisions. Deciding whether to bring a personal care attendant into the home or enter a long-term care institution is challenging enough. Alaskans shouldn't need to worry whether their elderly or frail family member is safe and well cared for when entrusted to a caregiver. The first part of the request is for a $400.0 RSS increase to support implementation of the new Background Check

Program, which will be phased into operation beginning in March 2006; at full capacity, about 14,000 background checks will be processed annually. Also, an additional $150.0 GF is requested to replace MHTAAR funding previously used to support staffing for the Assisted Living Licensure program. These dollars will help continue licensing of assisted living homes, the numbers of which are increasing about 15 percent per year, and for timely evaluation and response to complaints. Together, these funds will improve the safety and security of vulnerable Alaskans.

Chronic Disease Prevention and Health

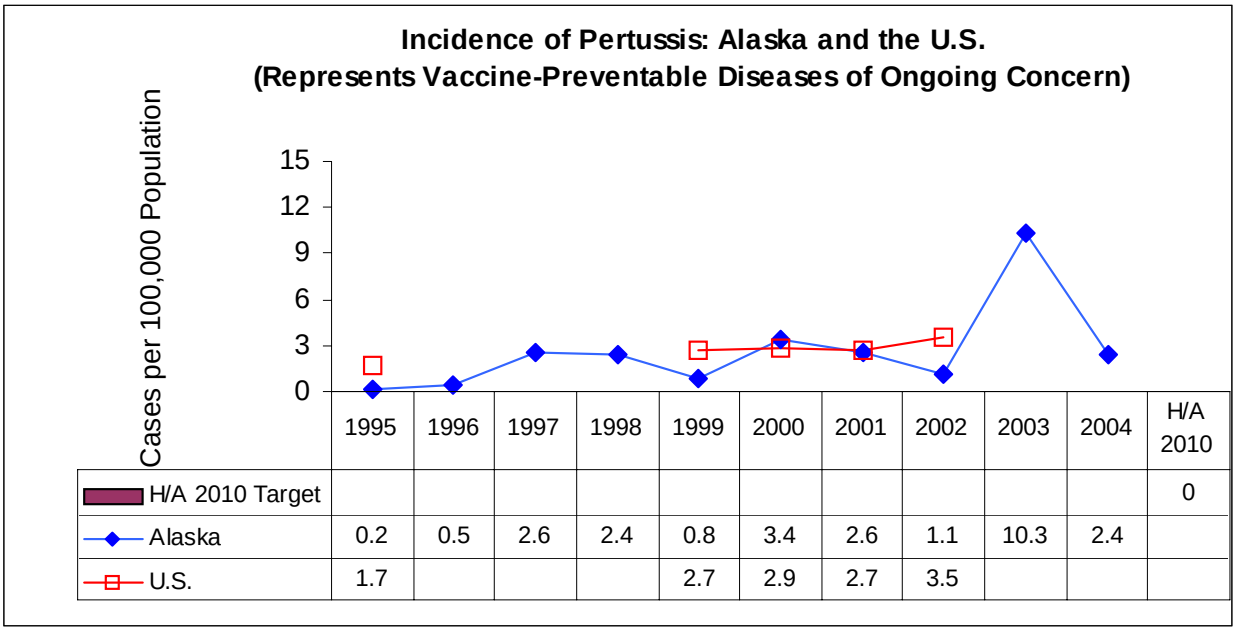
Create new Chronic Disease component with transfer of positions and funding from Epidemiology $6,440.7 Total Funds

This change record transfers 52 positions and funding for the Chronic Disease Prevention and Health Promotion programs from the Section of Epidemiology into the new Chronic Disease Prevention/Health Promotion component. The reorganization will better focus on chronic disease programs and risk factors by using an integrative and collaborative approach to chronic disease in the Division of Public Health.

Epidemiology

Infectious Disease Control and Emergency Preparedness $1,000.0 General Fund

It is essential to sustain well-established core public health programs such as tuberculosis control and immunizations, while taking on new challenges, such as pandemic influenza planning and bioterrorism preparedness. This $1,000.0 GF request (3 new positions and funding for 4 existing medical positions) and will help modernize and strengthen an aging and under-funded infectious disease control system to keep Alaskans safe and secure from old and new infectious disease threats and public health emergencies.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											0
Alaska	0.2	0.5	2.6	2.4	0.8	3.4	2.6	1.1	10.3	2.4	
U.S.	1.7				2.7	2.9	2.7	3.5			

Associated requests for infectious disease control are included in the Nursing and Public Health Laboratories components. Strengthening tracking and outbreak response will assure that communicable diseases are detected earlier and that fewer Alaskans become ill. A stronger epidemiologic outbreak team will give us a better response to a disease outbreak, and will provide each contact with a timely health evaluation, education and preventive treatment. This core public

health activity will help provide a strong foundation to respond to public health emergencies, to track emergency events, to mount mass vaccination and prevention clinics, to rapidly diagnose cases and to quarantine and isolate to contain disease.

Develop Immunization and Disease Registries $450.0 General Funds
A statewide immunization registry is necessary to allow providers to quickly and accurately determine which vaccines each Alaskan child needs, anywhere in the state. A registry will improve the efficiency of vaccine administration by saving time searching for medical records and by eliminating repeated, unnecessary vaccinations

The value of an immunization registry crosses state boundaries. Following Hurricane Katrina, children were displaced throughout the country. Many lost everything, including their immunization records, and faced challenges meeting immunization requirements to get into schools in other states. The Louisiana Immunization Registry was quickly reconfigured to provide interstate access, which has proved invaluable in getting these children into school.

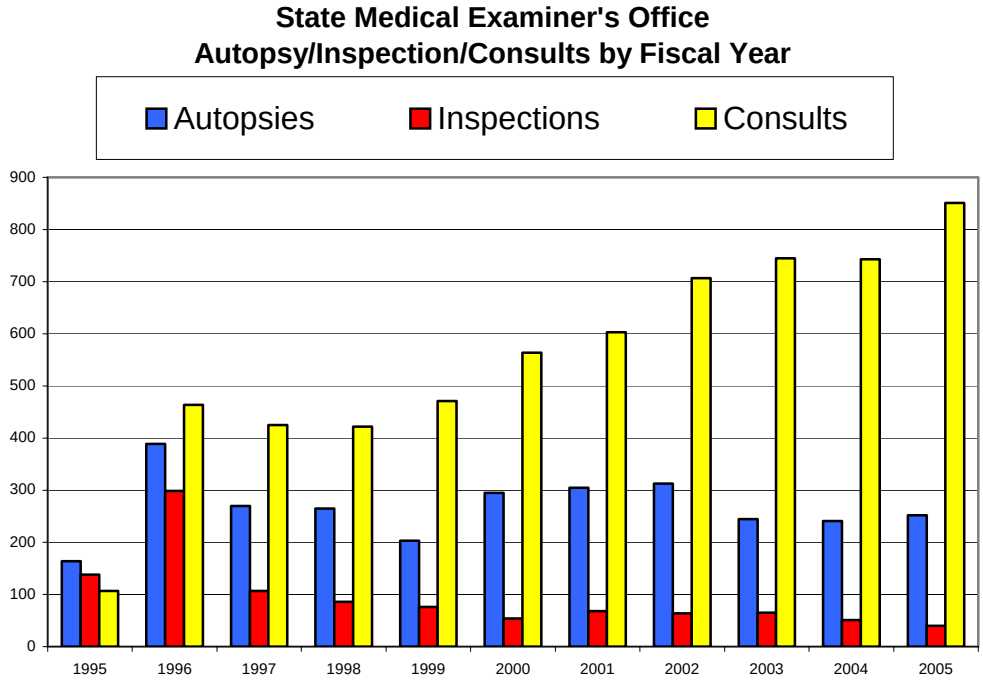
In addition, a robust, adaptable electronic communicable disease surveillance system is needed for input and analysis of reportable diseases to allow rapid detection of unusual disease trends and rapid detection of an outbreak. This $450.0 request will provide staff support for registry program development, implementation and maintenance. A capital budget request of $2,049.9 ($1,680.9 GF, $369.0 Fed) has been submitted to support the one-time development costs of these two electronic systems. The capital budget request will pay for hardware, software and other services necessary to purchase a pre-built system in use in other states and modify it to adapt to Alaska's unique needs.

Stockpile of Antiviral Drugs for Pandemic Flu $1,230.0 ($922.5 General Funds; $307.5 Federal)
An influenza pandemic has the potential to cause more disease and death than any other public health threat. In the absence of intervention, a severe influenza pandemic, such as the Great Pandemic of 1918-19, could sicken nearly 200,000 Alaskans and kill as many as 4,000 over a period of several months. Although recent instances of bird-to-human and limited human-to-human transmission of H5N1 influenza in Asia have raised concerns that a new pandemic may occur soon, the timing and severity of the next pandemic, as well as the viral strain responsible, cannot be known with certainty. Preparedness is vital in reducing sickness and death. Antiviral drugs are an important part of the national Pandemic Influenza Plan preparedness plan issued by the U.S. Department of Health and Human Services. The plan calls for national stockpiles of antiviral medications, as well as stockpiles of antiviral drugs within states. To comply with the plan, Alaska needs approximately 62,000 courses of antiviral drug. In order to stockpile 30 percent of this need in state (the remaining 70 percent will come from the Strategic National Stockpile), 18,600 courses would need to be procured by the state at $50/course. In addition to the purchase for treatment of ill priority groups, an additional 6,000 courses should be purchased for preventive treatment for a limited number of essential workers before onset of illness.

Transfer Positions and Funding to Create a New Chronic Disease component
The creation of a new Chronic Disease Prevention and Health Promotion component will provide a better focus on chronic disease issues and risk factors by using an integrative and collaborative approach to chronic disease in the Division of Public Health. The creation of this component will coincide with the restructuring efforts to integrate the health promotion and disease prevention activities and more effectively and efficiently address chronic disease and health promotion in Alaska. The programs that remain in the Epidemiology component will focus on infectious disease.

State Medical Examiner

State Medical Examiner Improvement Plan Continuation $500.0 General Fund
This request is to provide the State Medical Examiner's Office (SME) with sufficient staffing to perform the full range of death investigations under its mission, and to support needed improvements in safety and operations at the SME facility. At full capacity, the Medical Examiner's Office will benefit Alaskans by providing more information on causes of unexplained fatalities, resulting in improved efforts to reduce the rates of early and violent deaths in Alaska. It would also benefit Alaskans by supporting grieving families searching for answers to unexpected deaths. In FY06, the Legislature initiated expansion of SME capacity by adding a new statutory requirement for a deputy medical examiner, and increasing funding.

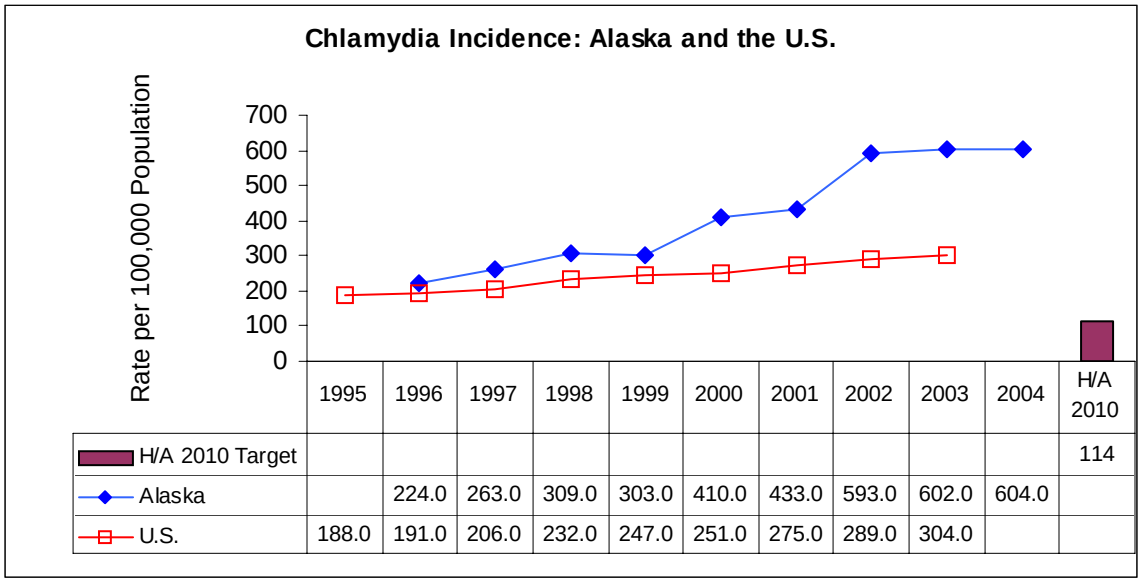


This $500.0 increment for FY07 will fund a third medical examiner (existing position), an additional autopsy assistant, and an additional investigator, providing capacity to perform 750 autopsies per year, up from 252 in FY05 and a projected 400 in FY06. This also will allow for investigation of more non-natural deaths and sudden natural deaths – adding important knowledge about suicide, and assisting in public health surveillance, epidemiological research and assisting consumer safety initiatives.

Public Health Laboratories

Infectious Disease Control and Emergency Preparedness $1,000.0 General Fund
The Section of Public Health Laboratories is critical to the rapid and accurate identification of diseases (such as West Nile virus, influenza and tuberculosis), as well as for effective disease tracking. Strengthening our outbreak response and surveillance capacity will assure that communicable diseases are detected earlier and that fewer Alaskans become ill. These are core public health activities. This increment will modernize and strengthen an aging and under-funded infectious disease control system to keep Alaskans safe and secure from old and new infectious disease threats and public health emergencies. The request includes 4 new positions and funding for

3 existing positions. Associated requests for infectious disease control are included in the Nursing and Epidemiology components.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											114
Alaska		224.0	263.0	309.0	303.0	410.0	433.0	593.0	602.0	604.0	
U.S.	188.0	191.0	206.0	232.0	247.0	251.0	275.0	289.0	304.0		

Provide More Testing Services to Hospitals and Other Agencies $200.0 Statutory Designated Program Receipts

In 2002 the Alaska Public Health Laboratory added capacity to utilize a new testing technology for gonorrhea and Chlamydia – by far the most common sexually transmitted diseases in Alaska. Infertility, pregnancy complications, and spontaneous abortion are just a few of the possible consequences of infection. The new testing system is a cost-effective, non-invasive technique utilizing urine samples, and the state lab currently tests over 20,000 specimens annually. A current agreement to perform these lab tests for the Alaska Native Medical Center has generated interest from other organizations, such as hospitals and the university. Because they currently procure these testing services from a commercial laboratory in the Lower 48, utilizing the state lab would decrease the turnaround time for test results and get clients important information sooner. Advantages to the State include access to additional epidemiological data for improving disease surveillance and control, increased laboratory capacity for responding to public health threats and emergencies, and retention of Alaska dollars and jobs in state. The request is to increase authority to collect statutory designated program receipts (SDPR).

Tobacco Prevention and Control

Communities Keeping Alaska's Kids Tobacco-Free $500.0 Tobacco Educ/Cess

Too many Alaskan children begin tobacco use at a young age. Some are addicted before they even reach high school. Reducing and eventually eliminating tobacco use among youth is one of the State's highest public health priorities. The entire $500.0 request will be provided to communities for activities specially targeted to helping schools, parents, and students in their efforts to protect our children from tobacco addiction. We should be encouraged that Alaska's 2003 Youth Risk Behavior Survey demonstrated that far fewer of our high school youth are smoking now than in the mid 1990's (down to 19 percent from 37 percent just a decade ago). But we cannot become complacent because, eventually, sustained investment in youth tobacco prevention will result in reduced early deaths, more years of productive life, decreased disability and suffering, and increased quality of life as our children reach their later years free from lung cancer, emphysema, heart disease, and other tobacco-related illnesses.

Percentage of High School Youth Who Smoke Cigarettes: Alaska & the U.S.

	1995	1997	1999	2001	2003	H/A 2010 Target
Alaska	36.5%				19.2%	
U.S.	34.8%	36.4%	34.8%	28.5%	21.9%	
H/A 2010 Target						17%

Data Source: Chronic Disease Prevention and Health Promotion, YRBS
H/A = Healthy Alaskans 2010

Contribution to Department's Mission

To protect and promote the health of Alaskans.

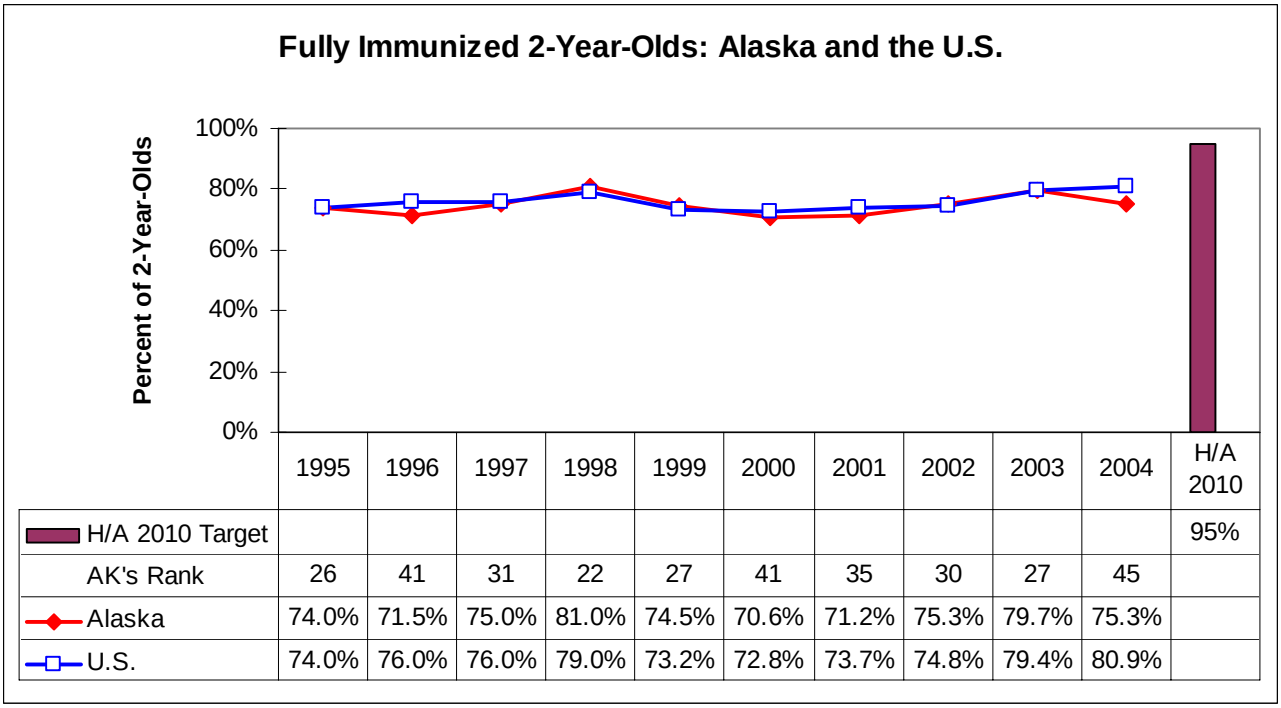
Core Services

- Prevent and control epidemics and the spread of infectious disease.
- Prevent and control injuries.
- Prevent and control chronic disease and disabilities.
- Respond to public health emergencies, disasters and terrorist attack.
- Assure access to early preventative services and quality health care.
- Protect against environmental hazards impacting human health.
- Effective and efficient management and administration of public health programs and services.

Department Level Measures

G: Result - Outcome Statement #7: Healthy people in healthy communities

Target #1: 80% of all 2 year olds are fully immunized
Measure #1: % of all Alaskan 2 year olds fully immunized



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010
H/A 2010 Target											95%
AK's Rank	26	41	31	22	27	41	35	30	27	45	
Alaska	74.0%	71.5%	75.0%	81.0%	74.5%	70.6%	71.2%	75.3%	79.7%	75.3%	
U.S.	74.0%	76.0%	76.0%	79.0%	73.2%	72.8%	73.7%	74.8%	79.4%	80.9%	

Data Source: National Immunization Survey
Note: Annual percentages are based on CDC recommendations at the time, which have changed over the years as new vaccines have been added to the "basic immunization series."

Analysis of results and challenges: Chart Note: Source National Immunization Survey, Centers for Disease Control and Prevention.

In 2004, 75.3% of Alaska two year olds had completed their basic vaccine series, a percentage considerably below the national average of 80.9. These results indicate the need to re-emphasize the importance of timely immunizations for our youngest children.

Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010
Measure #2: Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)

Post-Neonatal Death Rate - AK and US

Year	Alaska	US
1999	3.3	2.3
2000	3.0	2.3
2001	3.6	2.3
2002	3.8	2.3
2002	4.0	2.3
2004	3.5	0

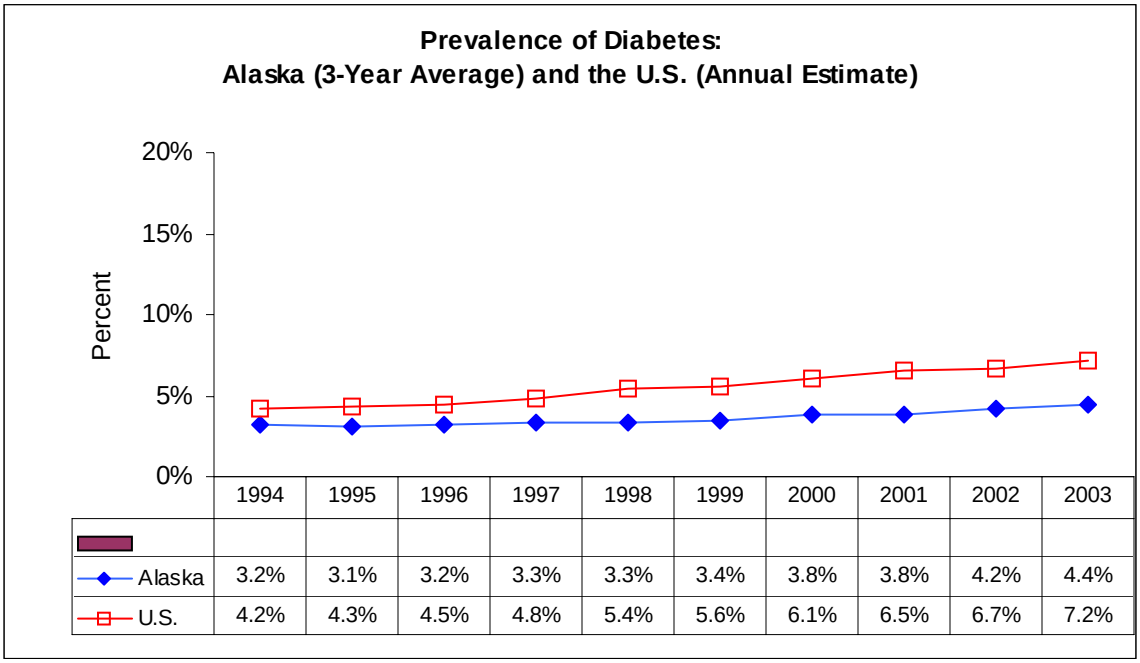
Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects three year rate, i.e. 2003 represents 2001-2003.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries.
•The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time.
•While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Target #3: Decrease diabetes in Alaskans
Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages

Est Annual Prevalence of Diabetes Among Adults (18+) in Alaska Based upon Three-Year Averages

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Alaska	3.2%	3.1%	3.2%	3.3%	3.3%	3.4%	3.8%	3.8%	4.2%	4.4%
U.S.	4.2%	4.3%	4.5%	4.8%	5.4%	5.6%	6.1%	6.5%	6.7%	7.2%

Data source: BRFSS - Behavioral Risk Factor Surveillance System Example: The 2003 data is average of 2002-2004.

Analysis of results and challenges:

Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

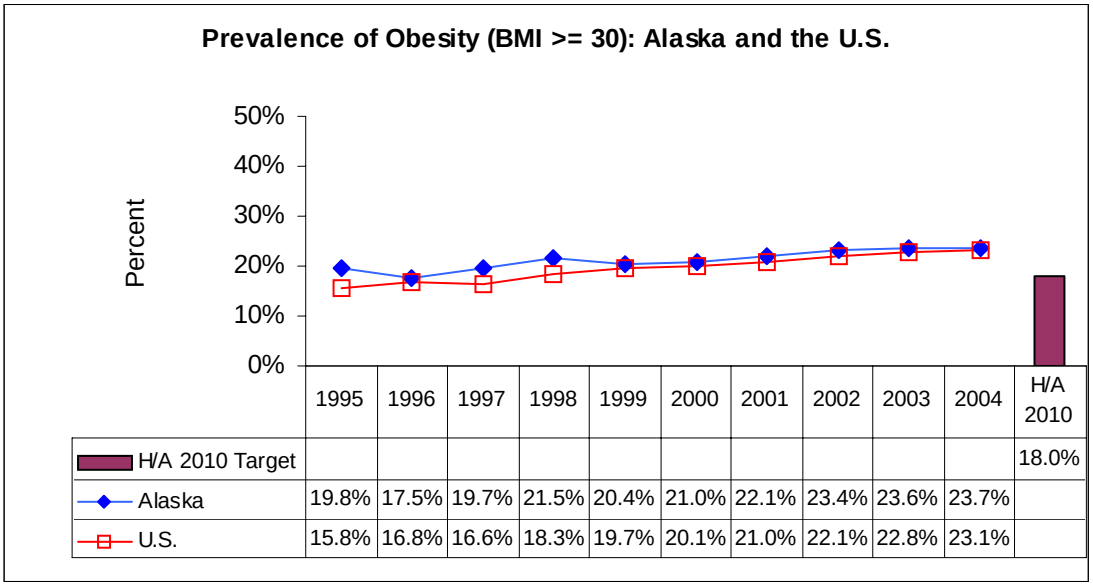
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

Over the past decade, an increasing number of Alaskan adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29% of all diabetes cases that go undiagnosed, yields our best estimate of the true prevalence of diabetes in Alaska. One limitation of this prevalence estimate is that, with improving surveillance and detection, prevalence will continue to increase independent of any real increase in morbidity.

Target #4: Decrease Alaska's adult obesity rate to less than 18%
Measure #4: Obesity rate of Alaskans

Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.1%



Analysis of results and challenges: The trends in Alaska show growing numbers of overweight and obese adults.

- From 1991 to 2004, the prevalence of overweight and obese adults in Alaska rose from a combined 49% to 63%.
- In 2004, 39% of Alaskans met the criteria for being overweight and nearly 24% met the criteria for obesity, well above the Healthy Alaskans 2010 targets of 30% for overweight and 18% for obesity.

Overweight is defined as Body Mass Index (BMI) of 25 or greater, up to 29.9. Obese is defined as BMI of 30 or greater. BMI is determined by dividing weight in kilograms by height in meters.

Premature death and disability, increased heath care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading

causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

G1: Strategy - Strengthen public health in strategic areas.

Division Level Measures

A: Result - Outcome Statement: Healthy people in healthy communities

Target #1: Alaska's TB rate is less than 6.8/100,000 population.
Measure #1: TB rate.

Annual TB Rate per 100,000 population

Year	US	Alaska
2000	5.8	17.2
2001	5.6	8.5
2002	5.2	7.6
2003	5.1	8.8
2004	4.9	6.6

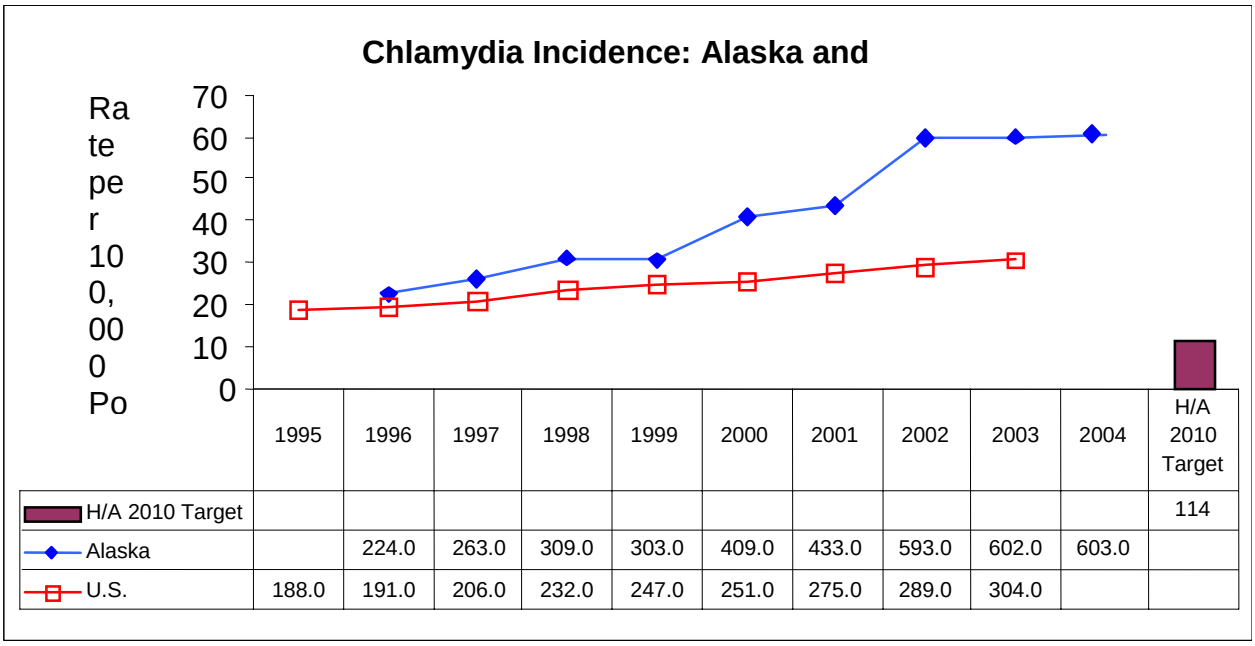
Analysis of results and challenges: Tuberculosis has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment - three Alaska Native elders and a Laotian. On an ongoing basis, even when there are no outbreaks, significant resources are needed to do the TB case finding, diagnostic tests and treatment follow-up necessary to keep this disease in check. In addition, for every person with TB, there are, on average, 16 people who were exposed and must also be found, evaluated, and often treated as well.

Despite the outbreak and deaths in 2004, Alaska still had the lowest rate of TB ever recorded for the State. However, we can expect to see additional outbreaks in the future. Tuberculosis remains a major public health problem in many regions of Alaska and will remain so for the foreseeable future. A strong public health team, knowledgeable about current issues of TB control, is necessary if we hope to eradicate the disease once called the "Scourge of Alaska."

Target #2: Alaska's Chlamydia rate is less than 590/100,000 population.
Measure #2: Chlamydia rate.

Chlamydia Rate Per 100,000 of Population

Year	Annual
1999	303
2000	409
2001	433
2002	593
2003	602
2004	603



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010 Target
H/A 2010 Target											114
Alaska		224.0	263.0	309.0	303.0	409.0	433.0	593.0	602.0	603.0	
U.S.	188.0	191.0	206.0	232.0	247.0	251.0	275.0	289.0	304.0		

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may have serious health consequences. New infectious agents and diseases are being detected, and some diseases once under control have reemerged in recent years. In addition, antimicrobial resistance is evolving over time.

Many challenges remain. Targeted screening with more sensitive technologies, as well as increased disease investigation activities, have actually increased the total numbers of STD cases diagnosed. These activities effectively identify infected individuals with no symptoms and also allow identification and treatment of other exposed individuals before they develop symptoms or further transmit infection. Case numbers are expected to decline over time as these activities reduce the reservoir of infected individuals in the population.

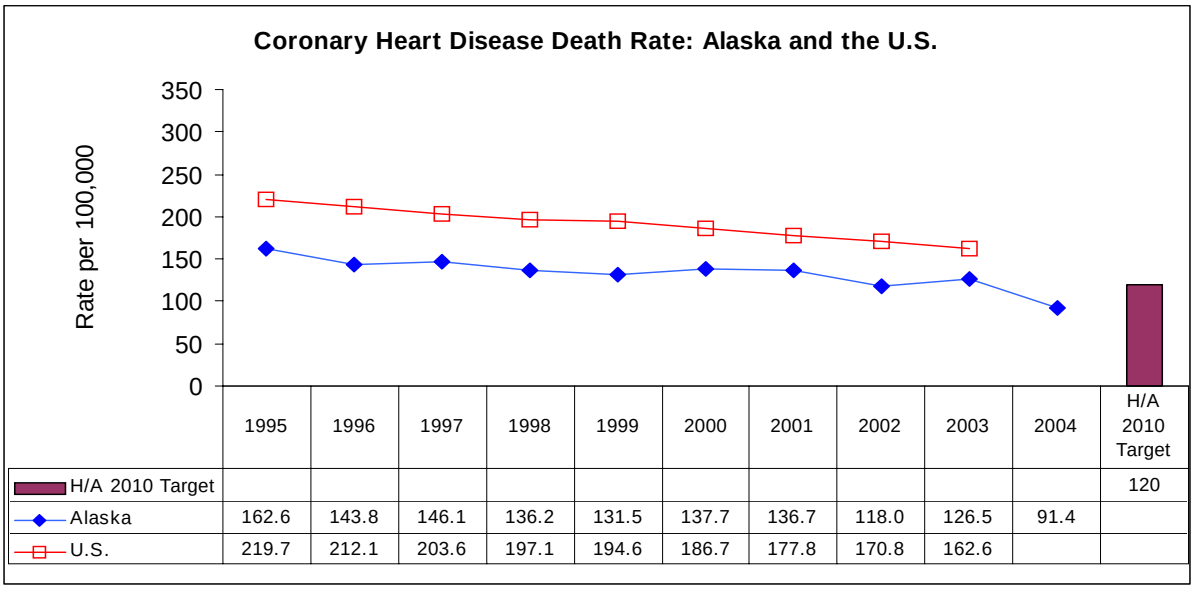
After three years with the highest chlamydia infection rate in the United States, Alaska ranked second nationally in annual chlamydia rates in 2004. Alaska's 2004 chlamydia infection rate was 603 cases per 100,000 population, with 3,954 cases reported. This represented a 1% increase over the 3,900 cases reported in 2003, and was the smallest annual increase since 1999. Identification, notification, testing, and treatment of sexual contacts of STD cases are time-tested, effective strategies for the HIV/STD Program. In combination with targeted screening and treatment

activities, these strategies are effective in containing chlamydia and many other sexually transmitted infections. The basic public health infrastructure for STD and HIV prevention and control is in place: public health laboratory services, public health capacity for patient and partner follow up, and capacity to provide epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure (e.g., partner notification services) currently need additional resources to strengthen and expand them to respond to increased needs; all elements require ongoing maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal, and funding has declined over time.

Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population.
Measure #3: Heart disease death rate.

Coronary Heart disease death rate per 100,000

Year	Alaska	US
1999	131.5	194.6
2000	137.7	186.7
2001	136.7	177.8
2002	118	170.8
2003	126.5	162.6
2004	91.4	N/A



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	H/A 2010 Target
H/A 2010 Target											120
Alaska	162.6	143.8	146.1	136.2	131.5	137.7	136.7	118.0	126.5	91.4	
U.S.	219.7	212.1	203.6	197.1	194.6	186.7	177.8	170.8	162.6		

Analysis of results and challenges: Nationally, heart disease is the leading cause of death for all Americans. An estimated 12 million men and women have a history of coronary heart disease (the most common form of heart disease). In 1998, almost 460,000 people died of coronary heart disease (44% of these deaths were from heart attacks). Although death rates from coronary heart disease have declined since the late 1960s, the decline has slowed since 1990. The lifetime risk for developing this disease is very high in the United States. One of every two males and one of every three females aged 40 years and under will develop it sometime in their life.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (most commonly referred to as stroke) is the fourth leading cause of death in Alaska. Over the past decade, Alaska's age-adjusted mortality rate for coronary heart disease has continued to decline. This mirrors the national trend, although Alaska's rates fall consistently below those found in the U.S. overall. In 2002 and again in 2004 (albeit with preliminary data only), Alaska's coronary heart disease death rates fell below the Healthy Alaskans 2010 target.

The target for Healthy Alaskans 2010 is 120.

Target #4: Alaska's overall cancer death rate is less than 180/100,000 population.
Measure #4: Cancer death rate.

Cancer death rate per 100,000 of population

Year	Alaska	US
1999	192.5	200.8
2000	209.6	199.6
2001	192.2	196.0
2002	189.4	193.5
2003	187.7	189.3
2004	172.8	N/A

Analysis of results and challenges: Cancer is not a single disease, but rather a constellation of more than 100 related diseases. Everyone is at risk of cancer. In the United States, half of all men and one-third of all women will develop cancer during their lifetimes. Of the approximately 491,000 Americans who are diagnosed with cancer in any given year, four of every ten are expected to still be living five years after diagnosis. Cancer was rarely seen in Alaska during the 1950s, but in the 1990s cancer was the leading cause of death in Alaska.

Over the past 10 years, the overall cancer death rate in Alaska has declined, closely mirroring the decline seen in U.S. cancer mortality rates for the same period.

The Healthy Alaskans 2010 target is 162.

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population.
Measure #5: Unintentional injury death rate.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
1999	57.5	35
2000	63.5	34.8
2001	61.1	35.7
2002	59.3	37
2003	55.1	36.3
2004	52.3	N/A

Analysis of results and challenges: Injuries are a significant public health and social services problem because of the prevalence of injuries, the toll of injuries on the young, and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries were the third leading cause of death in Alaska in 1998. Unlike heart disease and cancer, which are the leading causes of death among the elderly, injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float are only two examples of the activities that contribute to success in reaching and maintaining this target. The Division of Public Health's Injury Control Program will continue to partner with others and to use surveillance and prevention strategies to understand and target interventions.

A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.

Target #1: 95% of persons with TB complete adequate treatment regimen.
Measure #1: Percent of persons with TB completing treatment regimen.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2002	95%
2003	93%
2004	63%*

**Treatment requires up to 1 year. 2004 data are preliminary. A final completion rate of 90% or greater is expected when all cases are closed.*

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early, and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Target #2: At least 98% of Chlamydia cases will complete adequate treatment, as defined by CDC's STD Treatment Guidelines.
Measure #2: Percent of persons with STD completing treatment regimen.

% of Chlamydia cases completing adequate treatment

Year	Annual
2003	99.5%
2004	99.6%

Analysis of results and challenges: HIV/STD Program staff follow-up to assure treatment for all reported cases. Given such follow-up, very few cases are identified that are not treated consistent with the current national recommendations. Challenges include maintaining resources necessary to assure identified infections are appropriately treated, and carefully evaluating recommended treatment modalities to assure they are efficacious.

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 19% of high school youth in Alaska use tobacco products.
Measure #1: Prevalence of tobacco use in Alaskan youth.

Prevalence of tobacco use in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
1999		34.8
2001		28.5
2003	19.3	21.9

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20 years. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19% in 2003. Data is available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the State. This has been the case in 1995 and 2003. Surveys occurred in other years, however, they did not have enough participants to provide statewide results. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

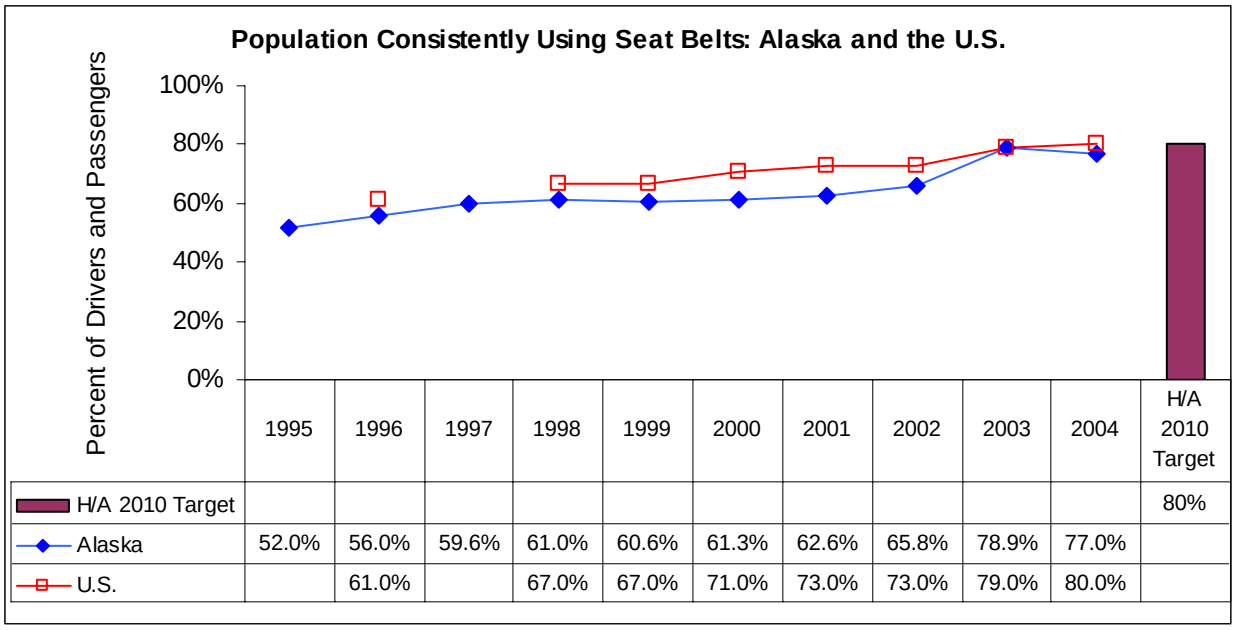
Healthy Alaskans 2010 target is 19.0%.

A3: Strategy - Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%.
Measure #1: Percent of properly restrained occupants in a motor vehicle.

Seat Belt Use by Drivers and Passengers

Year	Alaska	US
1999	60.6	67.0
2000	61.3	71.0
2001	62.6	73.0
2002	65.8	73.0
2003	78.9	79.0
2004	77.0	80.0



Analysis of results and challenges: Injuries are a significant public health and social services problem because of their prevalence, the toll of injuries on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and death. Unintentional injuries were the third leading cause of death in Alaska in 2004.

Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance. The Alaska Legislature ended its 2005 session with such a bill close to – but still awaiting – final passage. Efforts are ongoing to increase seatbelt use through public information messages and other targeted activities. However, a legislative change and additional resources may be needed to achieve the target.

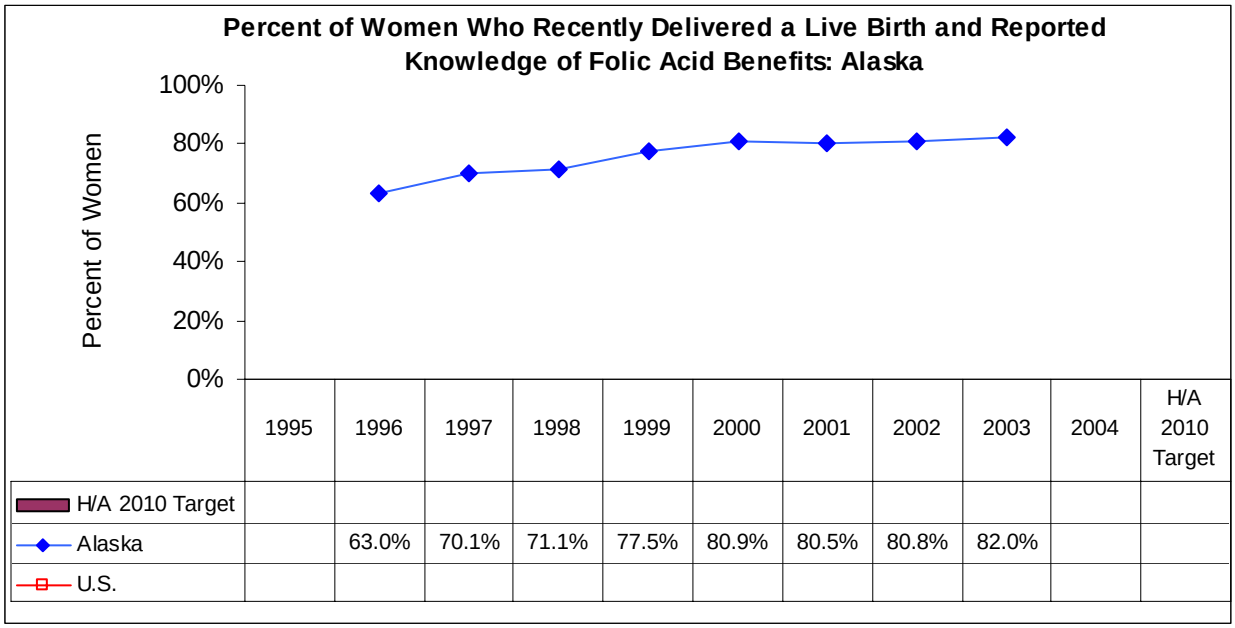
The Healthy Alaskans 2010 target is 80 percent.

A4: Strategy - Assure access to early preventative services and quality health care.

Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.
Measure #1: Percent of women reporting knowledge of folic acid benefits.

Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
1999	77.5	60.9
2000	80.8	62.3
2001	80.5	63.1
2002	80.8	63.5
2003	82.0	65.3



Analysis of results and challenges: Folic acid knowledge among Alaskan mothers is increasing. The proportion of women who indicated that they knew about the benefits of folic acid increased from 63.0% in 1996 to 82.0% in 2003.

The proportion of Alaska Native mothers who knew about the benefits of folic acid increased by 65% between 1996 and 2003. While the prevalence of folic acid knowledge among Alaska Native mothers of newborns was still substantially lower than overall levels, the gap in knowledge between Alaska Natives and Alaskan mothers overall appears to be closing.

Starting in 2000, the proportion of mothers of newborns who are knowledgeable about the benefits of folic acid appears to have plateaued around 80%.

For women of childbearing age, increasing folic acid use by taking multivitamins before and during pregnancy can reduce the risk of neural tube birth defects. Numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation and educate them especially about the importance of the timing (pre-pregnancy supplementation is ideal). Efforts should focus on increasing the overall knowledge prevalence to 90% and minimize racial disparities.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually.

Measure #2: Percent of licensed and certified long-term care facilities surveyed and recertified annually.

% of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	42.86	21.43	21.43	14.29	100%
2003	21.43	42.86	14.29	21.43	100%
2004	35.71	21.43	21.43	14.29	92.86%
2005	26.67	33.33	13.33	20	93.33%

Analysis of results and challenges: The annual required schedule for nursing home surveys is driven in large part by federal certification requirements. Surveys are to be completed within a 9- to 15-month period. Certification and Licensing may not appear to meet the licensing and certification within a given calendar or fiscal year. However, it will consistently meet federal and state certification and licensing survey requirements. The Section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.

Target #1: 25% of the Division of Public Health staff is trained in disaster response techniques and procedures.

Measure #1: Percent of DPH staff trained.

 # and % of DPH staff trained in disaster preparedness

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2005			70	103	27%

Analysis of results and challenges: Disaster response training for DPH staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action and permits all concerned to maintain a common knowledge base. While training did take place in the first half of fiscal year 2005, significant strides were made in the second half with the appointment of a disaster response training coordinator and staff. Further progress is expected in FY06.

The percentage above reflects these numbers: 484 total DPH employees at the end of FY05; 70 received training in the 3rd Quarter and 103 received 4th Quarter training. The total, unduplicated, number of employees who received training in the second half of FY05 was 130. (Of 484 total employees, the 130 who received training is 27 percent.)

A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.
Measure #1: Each new testing method validated as required by CLIA.

% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2005	75%	50%
2004	10%	10%

Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. This testing measures human exposure to contaminants and verifies the safety of traditional foods. For years, the federal government, through the Clinical Laboratory Improvement Amendments (CLIA) process, has certified the state lab. However, no chemical testing (for PCBs, etc.) was offered at the lab until 2004.

Senior and Disabilities Services

Mission

Promote independence of Alaska Seniors and people with physical and developmental disabilities.

Introduction

To carry out this mission, the Division of Senior and Disabilities Services provides institutional and home and community-based services for older Alaskans and persons with disabilities as well as protection of vulnerable adults. The division administers four Medicaid Waiver programs and Senior Services and Community Developmental Disabilities Grants programs.

Core Services

- Institutional and community based services for older Alaskans and persons with disabilities.
- Protection of vulnerable adults

Senior and Disabilities Medicaid Services

- In SFY05 Senior and Disabilities Medicaid provided services to more than 7,300 Alaskans, nearly 6% of the 131,000 enrolled.

- Senior and Disabilities Medicaid expenditures grew 15% from SFY04 to SFY05. Growth is due mostly to increases in the number of patients served and facility rates.

- Most of the increase can be attributed to personal care attendant services. Personal care services experienced a 23% increase in expenditures from SFY04 to SFY05 making it the fastest growing category of service in Senior and Disabilities Medicaid component.

- Growth in Personal Care Attendant services slowed dramatically to 23% between SFY04-05 from its peak of 187% between SFY02-03.

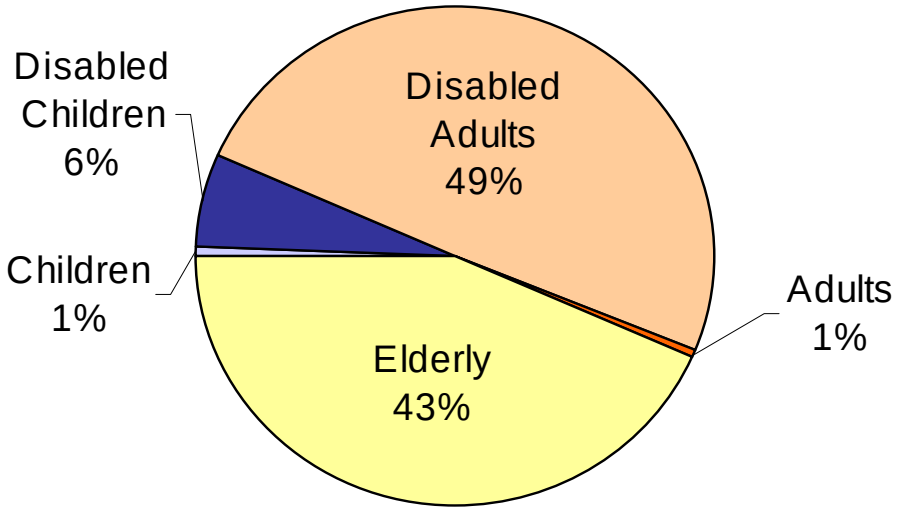
- Over half of the claim payments were for benefits provided to disabled adults and children. The elderly accounted for 43% of the benefit costs. Home and Community Based Waiver services comprised 42% of the Senior and Disabilities Medicaid Services component in SFY05.

Number of Medicaid Beneficiaries in FY 2005				
	Nursing Homes	Home and Community Based Waivers	Personal Care Attendants	Total*
Children	6	78	44	128
Adults	6	23	106	135
Elderly	741	2,004	1,983	4,728
Disabled Children	4	717	121	842
Disabled Adults	339	2,214	1,827	4,380
Total*	1,096	5,036	4,081	10,213

Source: MMIS-JUCE

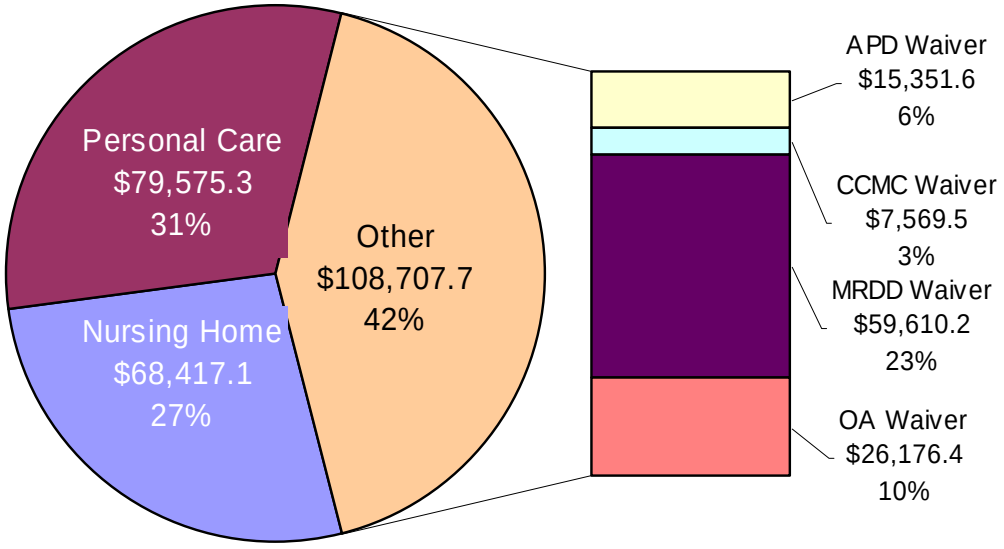
***For each service/eligibility combination, counts of beneficiaries are unduplicated. The total is the sum of the column or row and not the actual number of individuals. Because beneficiaries may receive services in multiple categories the total will overstate the unduplicated count of beneficiaries.**

Senior and Disabilities Medicaid Services FY 2005 Claim Payments by Group



Source: MMIS-JUCE data.

Senior and Disabilities Medicaid Services FY 2005 Expenditures by Service Category

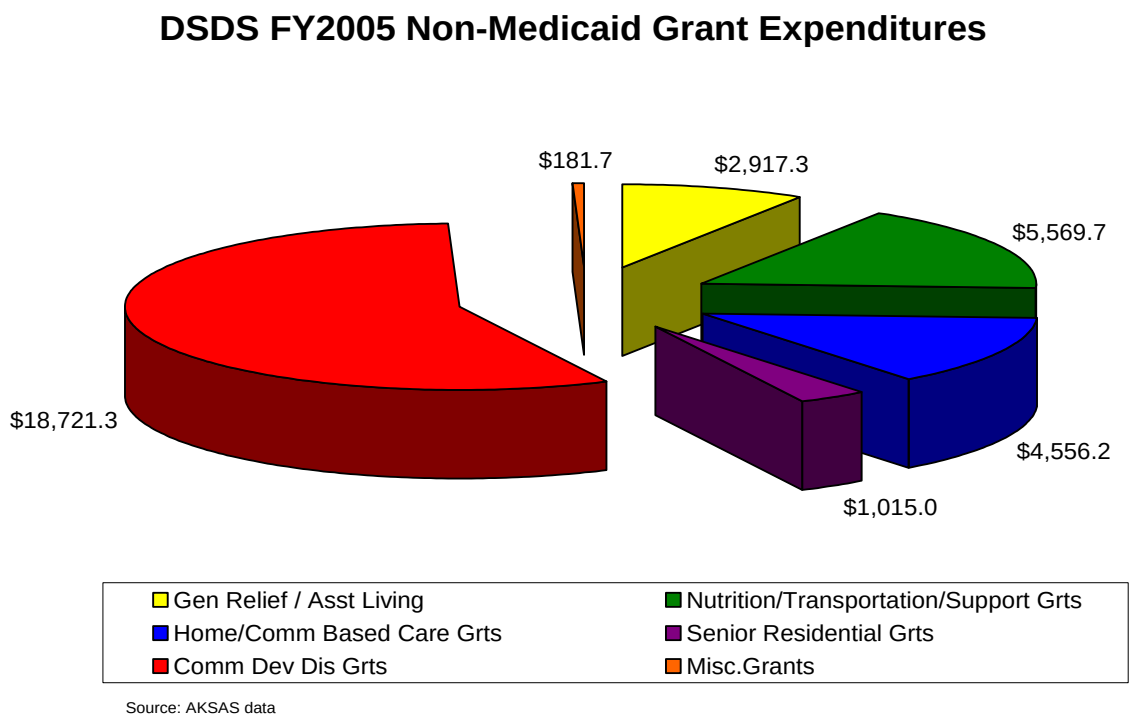


Source: AKSAS data.

Non-Medicaid Grants/Services

The table below shows how funds were spent in FY05 for non-Medicaid SDS grant services:

Grant Name	Primary Service	# of Clients Served	Client Population	Total Exp:
Gen Relief / Asst Living	Asst Living	2,964	Adults 18+	$2,917.3
Nutrition/Transportation/Support Grts	Meals/Transport	17,750	Seniors	$5,569.7
Home/Comm Based Care Grts	Non-Institution	14,013	Seniors	$4,556.2
Senior Residential Grts	Elder Residential	18	Tribal Elders/Seniors	$1,015.0
Comm Dev Dis Grts	Dev Disabilities	3,200	Dev Disabled	$18,721.3
Misc.Grants	Nursing Facilities Transition	47	Seniors	$181.7
*Dollar amounts are in thousands	Total Clients Served:	37,992	**Total Expenditures:**	**$32,961.2**



Source: AKSAS data

Home and Community Based Waiver Medicaid Services Programs AS 47.07.030
In response to the high costs of nursing facility care, Medicaid has evolved into a program that allows the state to provide long-term care in less restrictive, more cost effective services that enable people to live in home and community settings. If determined eligible by meeting specific target population criteria, level of care, and financial guidelines, a person may apply to receive services under one of the 4 Medicaid waiver programs described below. Reimbursable waiver services include care coordination, chore services, adult day care, day habilitation, environmental modifications, meals, respite care, residential care in alternatives such as Assisted Living or Group Homes, specialized equipment, specialized private duty nursing, supported employment, and transportation to waiver services. The Division manages 4 Medicaid waivers as shown below:

The Adults with Physical Disabilities (APD) Waiver
APD provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home and (2) be financially eligible for Medicaid to access the program. The program serves clients between the ages of 21 and 64 years of age.

The Children with Complex Medical Conditions (CCMC) Waiver
CCMC is for children, (1) birth through age 21, (2) having a severe chronic physical condition that is expected to continue for more than 30 days. The condition is (3) life threatening and needs (4) careful all day everyday monitoring. The child is (5) dependent upon medical care or technology and (6) requires the same sort of care usually found in a hospital or nursing home.

The Mental Retardation/Developmental Disability (MRDD) Waiver
MRDD is specifically for (1) individuals with mental retardation, autism, cerebral palsy, a seizure disorder, or a condition that means the person functions as if having mental retardation. In addition to these diagnoses, the individual (2) must have a serious limitation on how they function in everyday life. For example, it might be difficult for the person to make safe decisions or take care of personal needs without supervision. And, (3) the person requires the same level of care provided in an Intermediate Care Facility for the Mentally Retarded.

The Older Alaskan (OA) Waiver
OA provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home and (2) be financially eligible for Medicaid to access the program. The program serves clients who are 65 years and older.

Additional Medicaid Services:
In addition to the 4 Medicaid waivers above, the Division operates the Personal Care Assistance and Nursing Home Authorization Medicaid programs:

Personal Care Assistance AS 47.07.030
Home care services are provided statewide in Alaska through the Personal Care Assistant (PCA) Program. PCA providers determine, with Division oversight, the level of need for services that help recipients with functional limitations perform activities of daily living which may include bathing, dressing, grooming and problems with instrumental activities of daily living such as shopping and cleaning. Also, the Division certifies qualified agencies as PCA providers. The division has submitted new (proposed) regulations to the Lieutenant Governor's office for approval which will help to stabilize costs in the Personal Care Attendant Program by requiring a Medicaid assessment for every recipient and prior authorization of services by the Division to ensure beneficiaries receive only the services they are eligible to receive. It is anticipated that new regulations will become effective early in calendar year 2006.

PCA services are typically provided in a consumer's home by health care paraprofessionals called personal care assistants. These services enable functionally disabled and handicapped Alaskans of all ages, and frail elderly Alaskans, to live in their own home or community, instead of being placed in a more costly and restrictive long-term care setting. Recipients may choose from 2 methods of delivering PCA Services. The Agency-Based PCA model allows consumers to use one of the qualified agencies that oversee, manage and supervise their care. Or, consumers may choose the Consumer Directed PCA model that allows them to select, train, supervise, and discharge their PCA.

Nursing Home Authorizations 07 AAC 43.210
The Division is responsible for the initial admitting authorizations of Medicaid eligible consumers to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those consumers staying in these facilities (depending on level of care) throughout the state of Alaska and in other states if the appropriate care is not available in this state. The Division is also responsible for authorizing Await & Swing beds for hospitals, in state and out of state, while Medicaid clients are waiting for admittance to a skilled nursing facility or if a skilled nursing facility is not available in the community. There are 14 skilled nursing facilities around the state. The average yearly cost for a patient in a nursing home in FY05 was approximately $164,742.

Adult Protective Services (APS) / General Relief
The Adult Protective Services Unit protects adults over the age of 18 from abuse, neglect and exploitation. APS staff investigates reports of harm and takes appropriate action (up to and including removal from the client's home) to ensure that vulnerable adults are safe. The APS Unit also administers the General Relief Program which pays for temporary assisted living home costs for clients who need "emergency placement" and may qualify for but are not currently approved to receive services under a Medicaid waiver.

Nutrition, Transportation, and Support Services Grants for Seniors
The U.S. Department of Health and Human Services, Administration on Aging grants federal funds to the Division each year to provide for Nutrition, Transportation and Support services for Alaskan Seniors. These grants provide funding for the following services:

- Congregate Meals
- Home Delivered Meals
- Nutrition Services Incentive Program (NSIP)
- Assisted and Unassisted Transportation
- Homemaker Service
- Information and Assistance
- Outreach
- Nutrition Education and Counseling
- Health Education and Counseling
- Health Promotion / Medication Management
- Foster Grandparent / Elder Mentor Program
- Senior Companion Program
- Retired Senior Volunteer Program
- Legal Assistance
- Media Services (provides partial funding for the *Senior Voice*)

These services are selected through the State Plan process from a menu of services available under Title III of the Older Americans Act. These services are available to Alaskan seniors that are over age 60 and targets populations with the greatest social and economic need. This includes seniors that live in rural areas, are members of minority groups and are physically frail.

Home and Community Based Care Grants for Seniors
Home and Community based services provide a safety net for seniors and their caregivers who wish to remain in their homes and would not otherwise qualify for services under the Older Alaskans Medicaid Waiver program. Grants for these services are provided by State general fund / mental health funds, the AOA Title III federal grant for National Family Caregiver services and MHTAAR funds authorized by the Alaska Mental Health Trust Authority. Services provided under this grant include:

- Adult Day services
- National Family Caregiver Support
- Alzheimer's Disease and Related Dementias (ADRD) Education, Support and Mini-Grants
- Senior In-Home Services (Care Coordination, Chore, Respite and Extended Respite Services)
- Geriatric Education
- Treatment for Seniors with Co-Occurring Substance Abuse and Mental Health Disorders

Senior Residential Services
Through designated funding from the Alaska State Legislature, the Division of Senior and Disabilities Services oversees grants that support assisted living facilities for elders in Tanana and Kotzebue. By definition, assisted living facilities provide meals and assistance with daily activities to enable seniors to remain in or near their community of choice.

Community Developmental Disabilities Grants (CDDG)
The Community Developmental Disabilities Grant Program minimizes institutionalization and provides care for people with developmental disabilities (DD). In FY05 developmental disabilities grants provided services to nearly 2,200 recipients in 90 communities across the state with conditions such as mental retardation, autism, or cerebral palsy. Services funded by these grants result in the acquisition or maintenance of skills to live with independence and improved capacity and reduce the need for long-term residential care. Services include but are not limited to:

- Care Coordination
- Chore Services
- Day Habilitation
- Independent Living Support
- In-Home Supports
- Behavioral Training
- Intensive Active Treatment
- Residential Services
- Respite Care
- Specialized Adaptive Equipment
- Vocational Services

For those beneficiaries that meet the diagnostic and income limits, one of the Division's 4 Home and Community Based Waiver Programs may provide similar services. However, not everyone having a developmental disability qualifies for Medicaid under a Waiver Program or meets the threshold for long-term residential care that the MRDD Waiver is designed to provide.

Other grant programs in the CDDG component include:

Core Services- Offered to individuals on the Waitlist who receive no other services from the Division. Core Services grants are limited to an annual amount of $3,000 of services per recipient and are used to alleviate crisis and delay the need for long-term care. About 500 people receive Core Services each year.

Short Term Assistance and Referral Program (STAR). In FY 05, 16 organizations were awarded funds to operate a STAR program to assist people with developmental disabilities and their families address short-term needs before a crisis occurs and to defer the need for more expensive residential services or long-term care. Many people who are on the DD Waiting List access STAR services.

Mini-grants for beneficiaries with developmental disabilities. With funds from the Mental Health Trust Authority, mini-grants are a one-time award made to individuals not to exceed $2,500 per recipient for health and safety needs not covered by grants or other programs to help beneficiaries attain and maintain healthy and productive lifestyles. Adult dental care is the most frequently requested service by those who receive mini-grants.

Specific grants that address the severe statewide shortage of qualified direct care staff and assure that critical expertise is available in the state to deliver services required in AS 47.80.130.

Behavioral Risk Management Services address difficult behaviors by providing technical assistance and training for the personnel working in community DD programs, or family members and guardians. Additionally, funds are used for personal safety training for women with DD.

The **ARC of Anchorage Student Living Center for the Deaf** provides students who are deaf living in rural areas of Alaska with residential services and daily support while they attend the Alaska State School for Deaf and Hard-of-Hearing in Anchorage.

Dental Training is an MHTAAR project to train direct service staff employed by developmental disabilities providers in techniques of oral hygiene for people with DD. Many adults with developmental disabilities have never learned good oral hygiene techniques and the majority of direct service providers have never had any training in how to teach people to care for their teeth. Oral Hygiene is a major issue in the overall health status of people with DD.

Under the Federal DD Act, the state must have a system of **protection and advocacy** that has the capacity to provide administrative and legal remedies to civil rights concerns for people with developmental disabilities. Priority services for this program, administered through the **Disability Law Center**, is to provide people with developmental disabilities and their families training and assistance in methods to resolve grievances they may have with providers of developmental disability community services.

Miscellaneous Grants: Grants under the Nursing Facilities Transition Program which help keep seniors in their homes and communities at a cost which is typically far less than paying for a residential nursing home.

Senior & Disabilities Services	2006	2007 Proposed	06 to 07 Change
General Funds	122,156.5	146,049.6	23,893.1
Federal Funds	158,896.4	192,181.1	33,284.7
Other Funds	3,015.4	2,818.7	-196.7
Total	**284,068.3**	**341,049.4**	**56,981.1**

Senior and Disabilities Medicaid Services

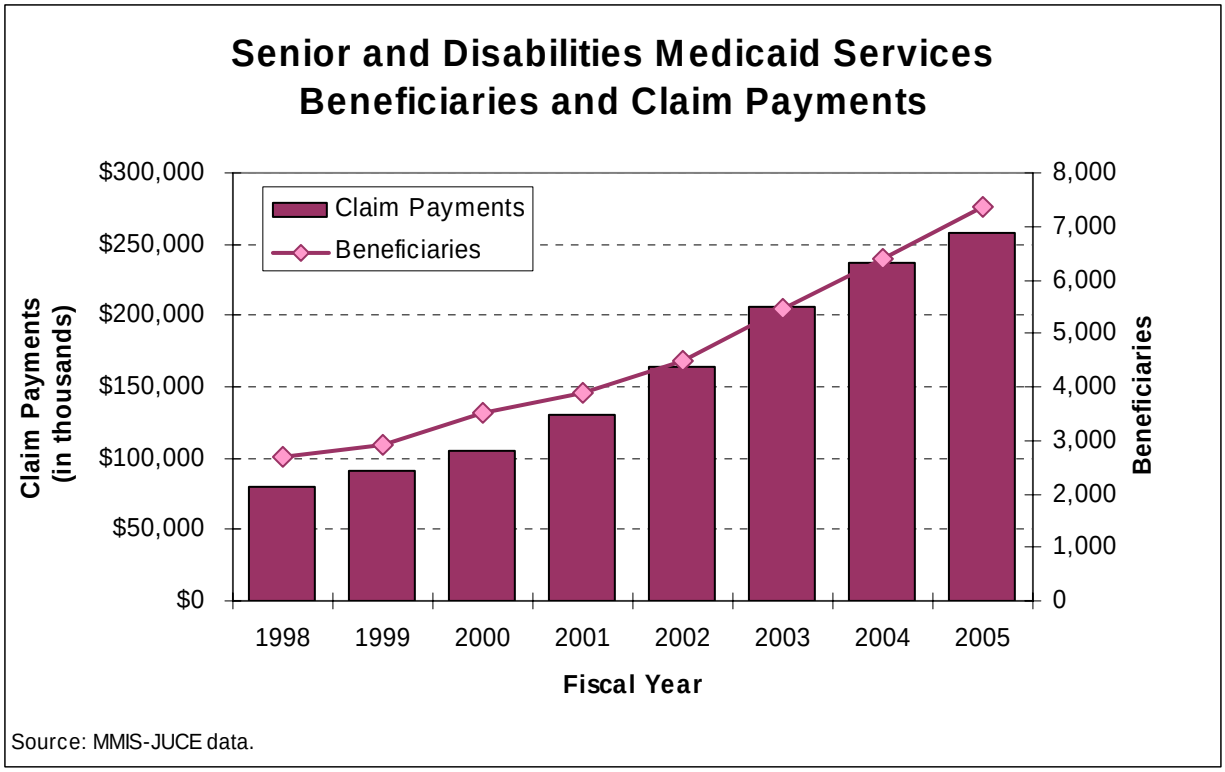
Projected FY07 Growth - $23,307.6 General Fund; $32,382.4 Federal

The Senior and Disabilities Medicaid Services component funds three types of services: nursing homes, personal care attendants, and home and community-based waiver services. Senior and Disabilities Medicaid Services have experienced significant continued growth. This increment request is necessary to maintain the current level of long-term care provided to Alaskans.

Senior and Disabilities Medicaid Services
Historical Utilization

	Enrollment	Beneficiaries	Claim Payments (in thousands)
FY 1998	88,716	2,688	$79,351.7
FY 1999	95,816	2,914	$90,587.8
FY 2000	110,219	3,504	$105,834.3
FY 2001	116,226	3,902	$130,887.3
FY 2002	121,582	4,484	$163,925.3
FY 2003	126,632	5,460	$205,790.8
FY 2004	129,528	6,395	$236,357.6
FY 2005	131,136	7,358	$257,777.8

Source: MMIS-JUCE data. Prior to FY 2004 Medicaid services were in the Division of Medical Assistance.

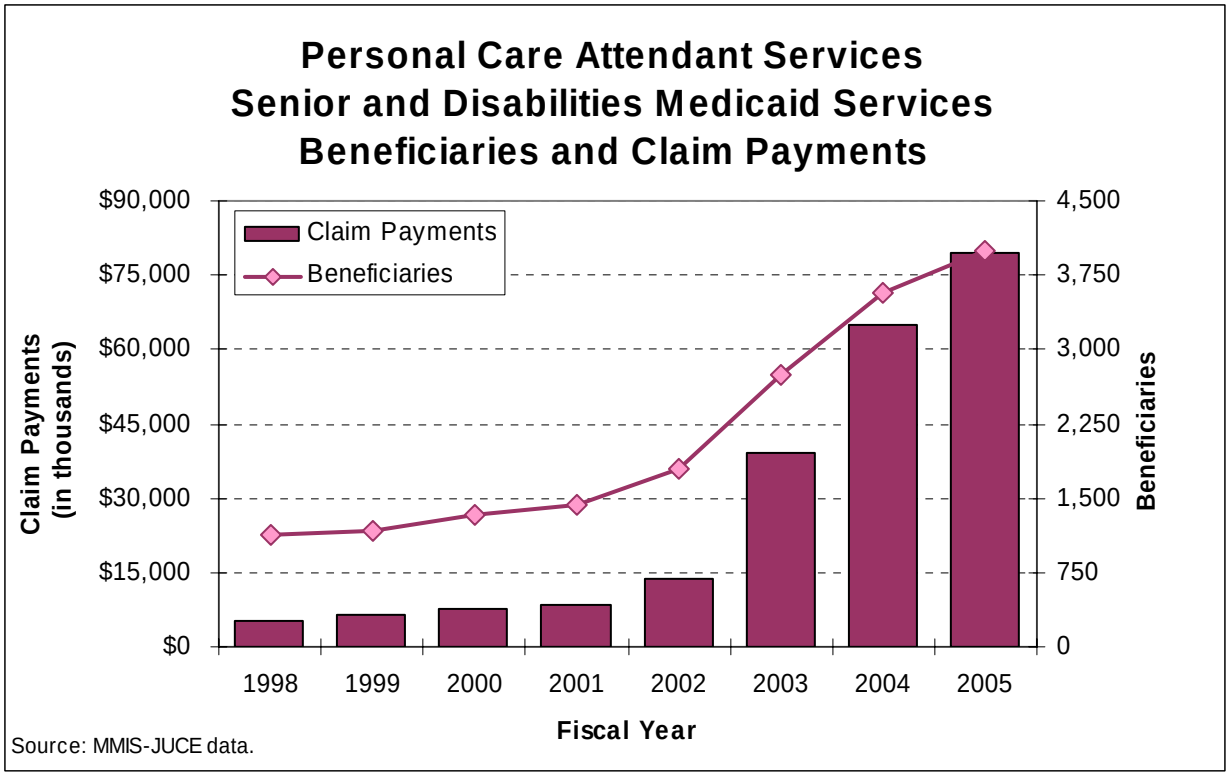


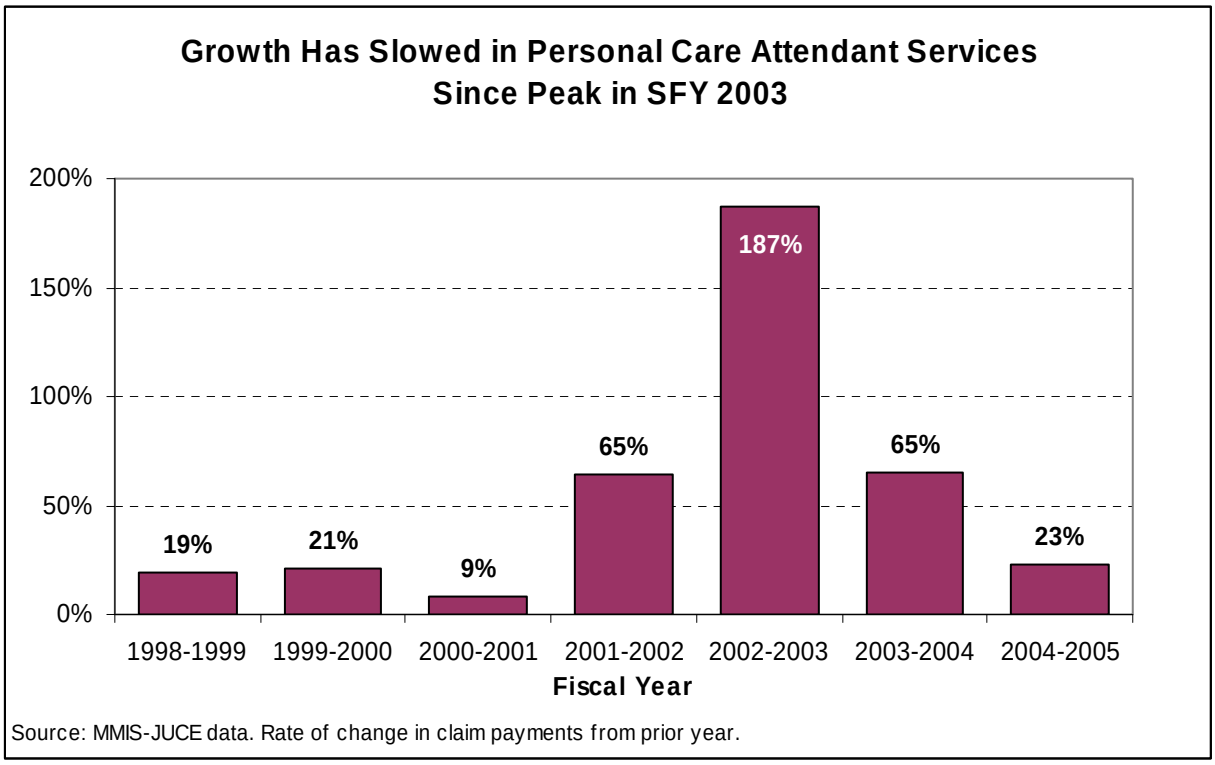
Growth for the component slowed to 9% in SFY05 from the near 25% annual increases seen in SFY01 to SFY04. The same 9% growth rate is projected for SFY06 and SFY07. Growth is due mostly to an increase in the number of clients. The number of recipients rose an average of 32% while the cost-per-recipient decreased 16%. The rapid increase in Senior & Disabilities Medicaid Services client base is not surprising since they serve the fastest growing segment of the population--those aged 65 and over.

Personal Care Services accounted for 70% of the increased cost in SFY05. Personal Care was the fastest growing category of service with a 23% increase from SFY04 to SFY05. However, this is a substantial improvement from the 65% increase Personal Care experienced between SFY03-04.

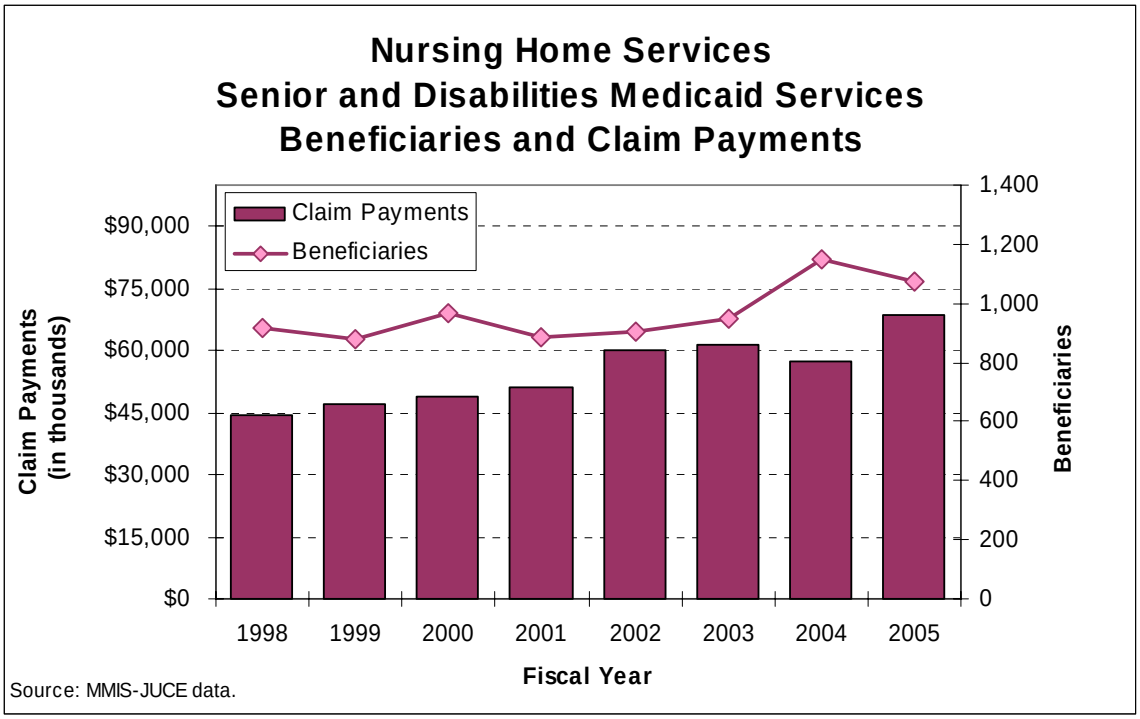
Personal Care Attendant services experienced a meteoric increase after 2001 when the program added a consumer-directed option. Consumer-directed care allows the client--instead of an agency--to select, train and direct the attendant of their choice.

Even with increases in the 65+ population the rate of growth in Personal Care Services is expected to slow to between 12% and 15% due to increased controls and new regulations limiting eligibility and services.

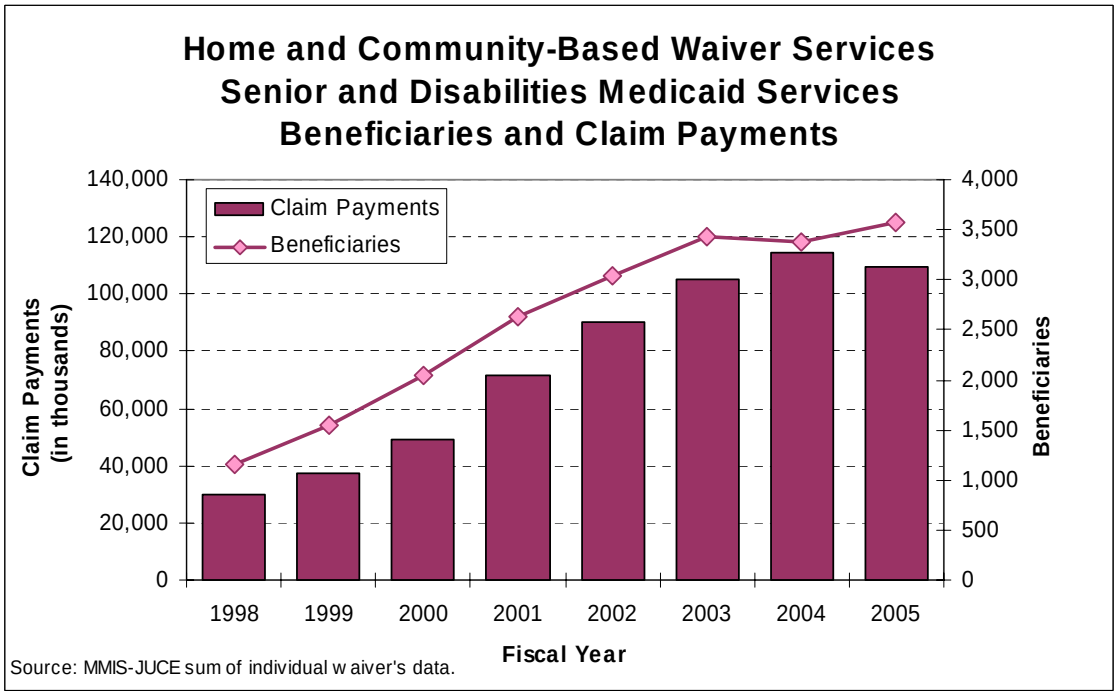




Nursing Home services experienced an increase of 21% from SFY04 to SFY05. The average cost increased because of facility rate adjustments. Rates are recalculated every four years and inflation adjusted in interim years. Nursing home rates will not be recalculated again until SFY08.



Home and community-based waiver services saw a slight dip in SFY05 due to billing delays, which have been remedied. Waivers are expected to rebound from their SFY05 level and return to their slow but steady growth pattern in SFY2006 & SFY07.



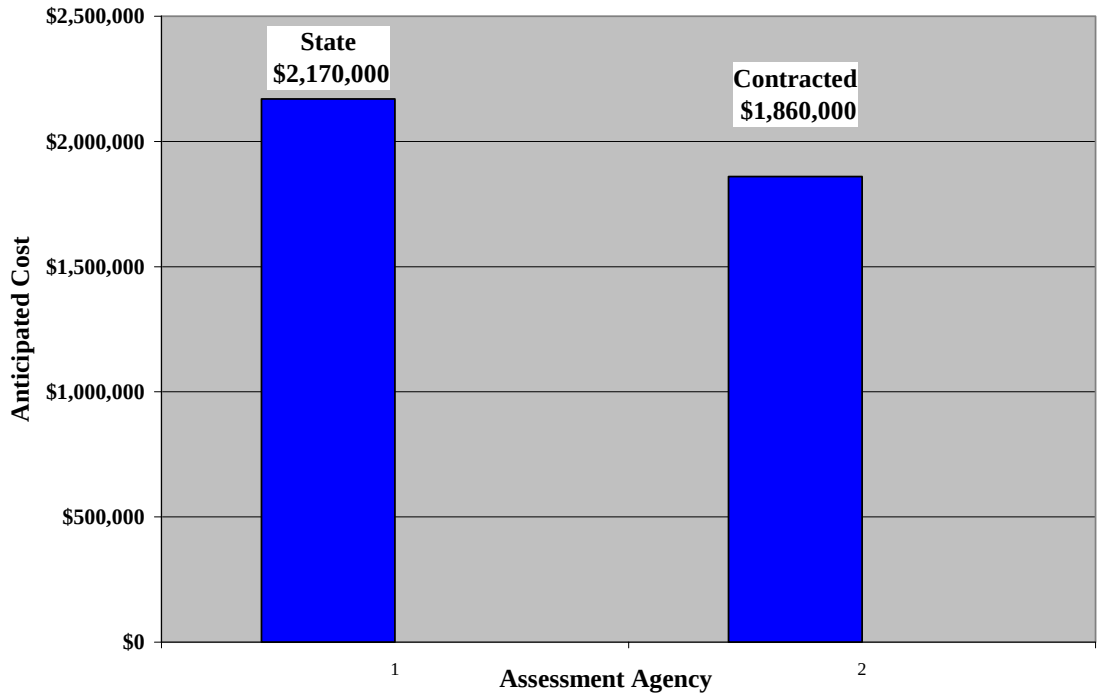
Senior and Disabilities Services Administration

Medicaid Assessment Contracts Increase $300.0 General Fund; $600.0 Federal

The Division of Senior and Disabilities Services (DSDS) contracts with a private contractor to perform Medicaid assessments for beneficiaries receiving services under the Personal Care Attendant (PCA) program and the four (4) Medicaid waivers in the DSDS RDU. These assessments determine the client's Medicaid eligibility, help determine the level of care required by that individual and indicate what services are required to improve their quality of life. They also help to manage costs to these Medicaid programs, by ensuring that beneficiaries are only receiving services to which they are entitled. This helps ensure that the greatest number of beneficiaries can be served with the resources that are available.

DSDS had originally intended to hire staff to perform this function, but it has become apparent that the current contractor is better able to perform these assessments because they currently employ more than 30 nurses who are trained to administer the assessment tool at a fraction of what it would cost to employ full time Division staff. They also frequently live closer to the communities where assessments are required, thereby cutting down on travel costs. These nurses are instrumental in helping the Division win fair hearings because they are an unbiased third party and they administer the assessment tool in a consistently objective manner. The cost of these contracts is increasing because the contractor has had to increase what they charge per assessment to help offset the rising cost of travel due to fuel price increases and to provide pay increases to the nurses performing the assessments to keep them from seeking alternate employment once they have been trained.

Cost Comparision for SDS Medicaid Assessments

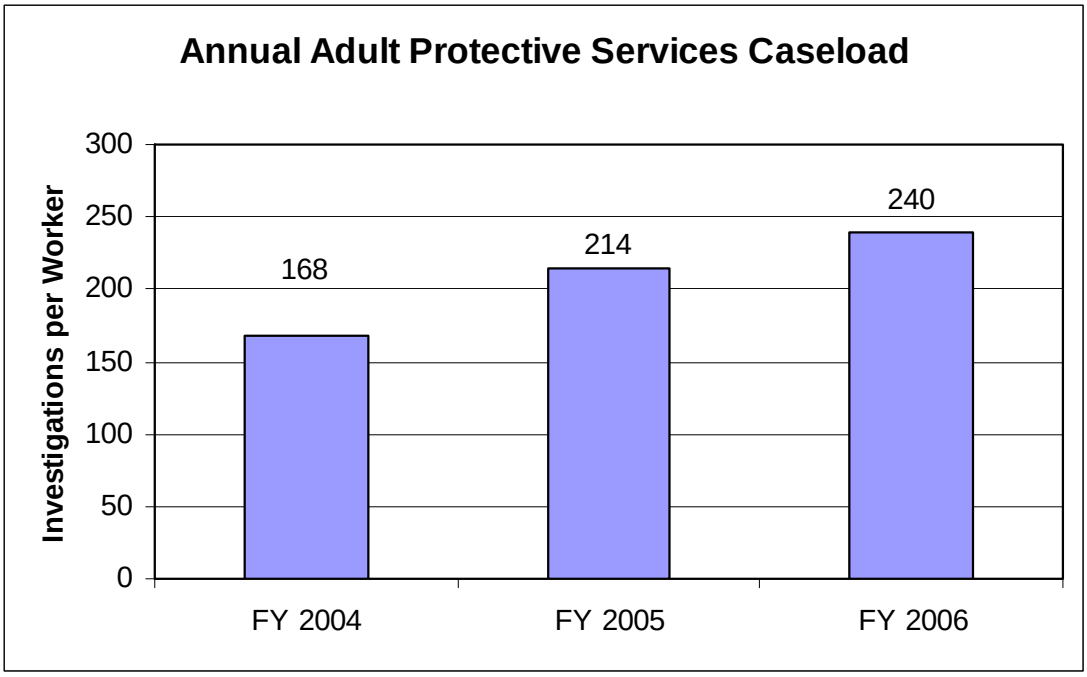


Adult Protective Services / Quality Assurance Program Increases $150.0 General Fund; $150.0 Federal

According to U.S. Census Bureau reports, Alaska has the second fastest growing senior population in the nation (Nevada is #1). Alaska's senior population age 65 and older grew nearly 60% from 1990 to 2000 compared to 12% for the U.S. Alaska is projected to remain ranked #2 in senior

population growth over the next 25 years. The state's senior population is projected to grow more than six times faster than its total population. Population growth for seniors in Alaska is projected to grow at more than twice the rate of the U.S. (www.census.gov)

To keep up with this increased senior population, four new positions have been requested in the FY07 budget, two for Adult Protective Services (APS) and two for Quality Assurance (QA). The APS positions will help protect vulnerable adults who cannot or will not take care of themselves. Reported cases of harm and subsequent caseloads assigned to APS staff have grown in recent years, both as a result of the increase to the elderly population (a national trend) in Alaska and as a result of an increase in age-related disorders such as Alzheimer's and Dementia. Case loads per case worker in the APS unit are estimated to increase from an average intake of 102 cases per month in FY04 to 140 new cases per month in FY06. To keep up with this large volume of new cases, the Division is requesting two new APS positions in the FY07 budget. If each report of harm/neglect cannot be given the attention it requires, Alaskan seniors will suffer and may experience injury or death.



The Quality Assurance positions will help ensure the quality and integrity of programs and services provided to seniors and beneficiaries with developmental disabilities. By ensuring funds are being appropriately spent, this unit assists provider agencies in maximizing their available funds and providing services to the greatest number of beneficiaries possible.

Decrease to Authorized MHTAAR Funds- ($75.0) MHTAAR

The Alaska Mental Health Trust Authority reduced funding for the Geriatric Education and Training project for FY07.

Contribution to Department's Mission

The mission of the Division of Senior and Disabilities Services is to promote independence of Alaskan Seniors and people with physical and developmental disabilities.

Core Services

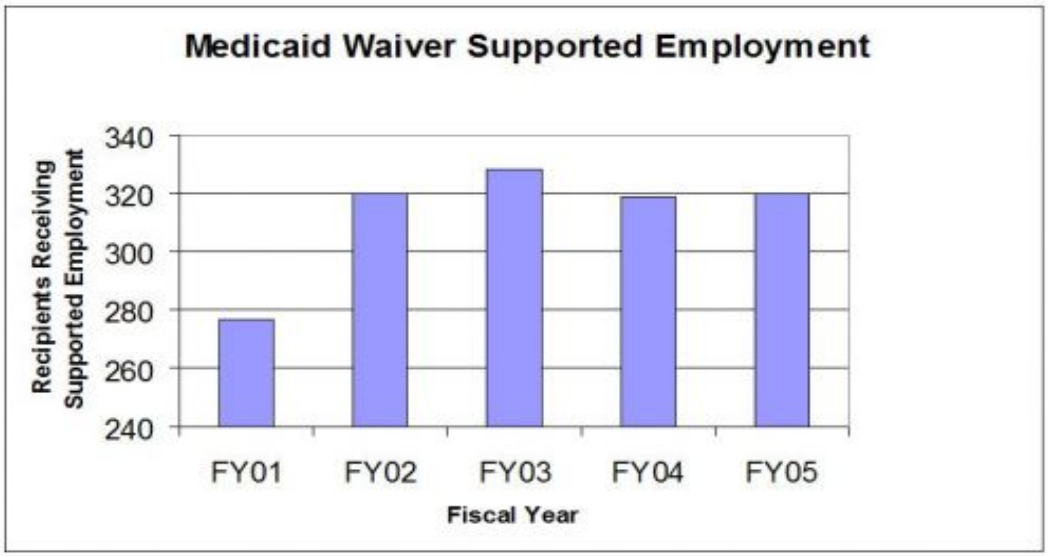
- Institutional and community based services for older Alaskans and persons with disabilities.
- Protection of vulnerable adults

Department Level Measures

H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live as independently as long as possible.

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services.

Measure #1: % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



% Change in Recipients Receiving Supported Employment

Fiscal Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%

Analysis of results and challenges: Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services is looking into

why the number of beneficiaries receiving Supported Employment Services has hit a "plateau" over the last few years and will try to determine how to increase the number of people receiving this service.

H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

Division Level Measures

A: Result - Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipient not receiving medical assessments to less than 5%.
Measure #1: % of clients not receiving medical review.

DSDS FY05
Medicaid Recipients
Medical Review by State Staff or Contractor

Medicaid Programs	Unduplicated Counts	Oversight Status
Adults with Physical Disabilities	887	Oversight
Older Alaskans	1336	Oversight
Mental Retardation and Developmental Disabilities	988	Oversight
Children with Complex Medical Conditions	208	Oversight
Skilled Nursing Facilities	1024	Oversight
PCA	1987	No Oversight
Total Recipients:	**6430**	

The table shows that 1,987 of 6,430 recipients (30.9%), did not receive a medical review by state staff or contractor.

% of Clients who have not received a Medical Review

Fiscal Year	% Not Reviewed
FY 2005	30.9%

Analysis of results and challenges: The Personal Care Attendant Program is the only Medicaid program that has not required a state-approved medical assessment to receive services. Implementation of new regulations in early 2006 will require a state-approved medical assessment and prior authorization of Medicaid benefits ensuring that beneficiaries are only receiving the services they are eligible to receive.

A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.

B: Result - Promote improved service and compliance with federal/state regulations through provider agencies.

B1: Strategy - Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide 8 care coordination training sessions each year in Alaskan communities.

Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies.

Measure #1: Show an overall reduction in error rates from audit findings for current rate by 10%.

PCA Summary of Meyers & Stauffers November 14,2005	Population Claims		Sample Claims			
	Paid Claims	Medicaid Payments	Claims	Medicaid Payments	Sample Overpayments	Error Rate
	C	D	E	F	G	H=G/F
Skilled Nursing	906	$9,460,643	117	$1,297,000	$110,841	8.55%
HCB	24058	$29,994,121	351	$947,169	$175,471	18.53%
Assisted Living	558	$1,450,814	274	$692,416	$181,935	26.28%
Care Coordination	3229	$670,320	240	$49,745	$8,075	16.23%
Personal Care	8255	$9,805,574	212	$242,476	$34,958	14.42%
DSDS Totals	37006	$51,381,472	1194	$3,228,806	$511,280	15.83%

Analysis of results and challenges: The chart shows programs that have been audited by Myers & Stauffer and the dollar amount of the audit exceptions that have been assigned to each program. These audit numbers are preliminary until the provider agencies have had a chance to respond, so these numbers should decrease as providers respond to the findings. However, it does give us a base line to work from.

C: Result - Ensure manageable caseload number in Adult Protective Services and Quality Assurance Units to provide timely investigations.

Target #1: Reduce APS staff assigned case loads by 10% and length of time a case is "open" by 10%.

Measure #1: Average length of time required to close a case in days per worker.

Annual Adult Protective Services Caseloads

Fiscal Year	Total Investigations	# Full-time Workers	Annual Cases per Worker
FY 2004	1173	7	168
FY 2005	1497 +27.62%	7 0%	214 +27.38%
FY 2006	1683 +12.42%	7 0%	240 +12.15%

** FY06 reflects estimates only.*

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) Worker has grown by more than 20% between FY04 and FY05. In FY05 the annual number of cases per worker was 214. The case workers averaged more than 100 open cases at any given time. APS case workers are handling a case load of more than 4 times the national average. This means that the average case was not investigated for 6 days and was not concluded for 63 days. It is the goal of the Division to keep the caseload down to FY04 levels or lower. While APS workers practice triage in managing their caseloads the resulting average of 6 days waiting for initial contact to be made is too slow and may lead to very negative results for a vulnerable adult.

In FY05, the average response time for Investigations was 6 days, and the average days a case was open is 63 days.

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Department Support Services

Mission

Provide quality administrative services in support of the Department's programs.

Introduction

To meet the mission and goals of the Department and the Unit, the Division serves both external and internal customers. By administering all the department's budgetary, grants, contracts, planning, financial and management needs, this Unit provides unified assistance statewide. Our goal is to assist all of the Department of Health and Social Services (DHSS) in meeting its fiduciary responsibilities.

Core Services

The core service of this Unit is to assist and be responsible for all the administrative service and management functions of the department. These responsibilities range from managing department policy to insuring all the DHSS external and internal customer needs are met in an effective and efficient manner.

Component Name:	Location and Number of Positions: Juneau	Anchorage	Fairbanks	Wasilla
Commissioner's Office	7	1		
Office of Program Review	8	8	1	
Rate Review		11		
Administrative Support Services:				
Administrative Office	10			
Audit	2			
Budget	10			
Division Support Services	54	25		
Finance	21	6		
Grants and Contracts	32	4		
Hearing and Appeals		5		
Health Planning & Facilities Management	6	3		
Health Planning & Infastructure	14	5		
Information Technology	66	71	4	1
Total	230	139	5	1

Commissioner's Office
The Commissioner's Office component funds upper-level management and policy development for the entire department. (AS 18.05: Health, Safety and Housing)

Office of Program Review
The Office of Program Review component ensures that DHSS programs accomplish their goals, and will help Divisions find ways to refinance programs to ensure that, to the maximum extent possible, services continue during difficult financial times. (AS 37.10: Financial Management)

Rate Review
The Rate Review component establishes efficiency in rate-setting functions throughout the Department. (AS 47.07: Medical Assistance for Needy Persons).

Assessment and Planning
The Assessment and Planning component is tasked with planning, assessment and forecasting improvements for the Medicaid program. (AS 47.07: Medical Assistance for Needy Persons).

Administrative Support Services
The Administrative Support Services component funds financial, budget, procurement, grant and professional service contract administration, and information services as well as human resource liaison functions. (AS 37.10: Financial Management; AS 37.07: Budget Section; AS 36.30 Procurement Section, 7 AAC 78 and 81 Grant Regulations; Audit Section PL 98-502 Single Audit Act Amendments of 1996, PL 104-156 and OMB Circular A-133.

Hearings and Appeals
The Hearings and Appeals component conducts appeals for Medicaid, Chronic & Acute Medical Assistance, and Division of Public Assistance regarding rates and recipient benefit appeals. (AS 47.07; AS 47.08 and AS 47.25)

Facilities Management
The Facilities Management component includes the management of the department's capital programs. (AS 37.07.062 Capital Projects - Responsible for preparation, submission and competent management of annual capital budget requests.)

Health Planning and Infrastructure
The Health Planning and Infrastructure component core services include community health needs assessments, health indicators tracking, data analyses and reports, technical assistance, health plan development, community health grants, and Certificate of Need (CON) (AS 18.07 and AS 18.20 – Health, Safety and Housing, Certificate of Need)

Medicaid School Based Claims
The Medicaid School Based Claims component improves health services access and availability for Medicaid-eligible children and families. (AS 18.05 Health, Safety and Housing)

Information Technology
The Information Technology component's focus is to improve the efficiency and effectiveness of IT services and develop a more capable IT organization for the department.

Facilities Maintenance
The Facilities Maintenance component, Pioneer Homes Facilities Maintenance, and HSS State Facilities Rent component record dollars spent to operate state facilities. These units collect costs for facilities operations, maintenance and repair, renewal and replacement as defined in Chapter 90, SLA 98 and pay rent fees for Rent Project.

Human Services Community Matching Grants
The Human Services Community Matching Grants component makes grants to qualified municipalities. (AS 29.60.600 Human Services Community Matching Grants)

Department Support Services	2006	2007 Proposed	06 to 07 Change
General Funds	19,333.2	26,317.2	6,984.0
Federal Funds	26,581.7	27,119.7	538.0
Other Funds	9,055.8	9,050.2	-5.6
Total	**54,970.7**	**62,487.1**	**7,516.4**

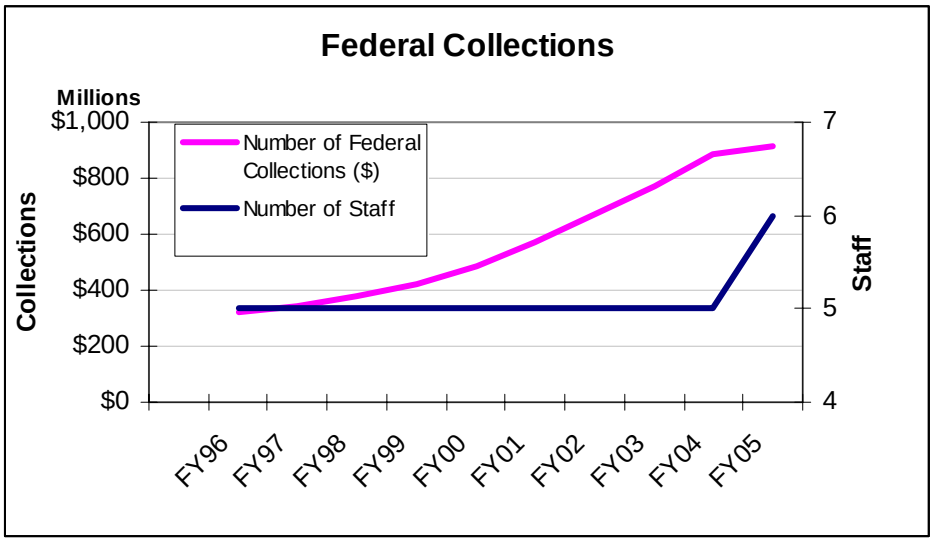
*Includes Human Services Community Matching Grants

Administrative Support Services

Improve Revenue Management/Cost Allocation System $310.0 General Fund

The Administrative Support Services component is requesting an increment of $310.0 general fund authorization to improve the Revenue Management/Cost Allocation functions. A revised management structure is necessary to ensure funds are earned, claimed and posted accurately. The Department currently uses a set of Microsoft Excel spreadsheets which are outdated and prone to error. The Department is putting itself at great risk of failure that will cripple the ability to earn federal revenue. The importance to the Department for this fundamental process and the instability of the current solution, it is critical that we develop a more stable and robust system. Losing our ability to accurately earn federal revenue would seriously impact the service delivery for the entire department.

The spreadsheets periodically become corrupted and must be restored from backup, losing hours of valuable time and work product. Federal reports are due 45 or 60 days after the end of the quarter and DHSS has had difficulty complying with that requirement.



The Department of Health and Social Services earns over $900 million in federal funds annually. The current antiquated system of allocating costs, federal reporting and federal claiming causes delays in posting revenue as well as some inaccuracies in the revenue. A 1% claiming error is over $9 million, the State of Alaska and the Department need to make certain that our federal financial system is as close to 100% as possible so that Alaska receives its appropriate and fair share of federal funding.

Salary Increases for DHSS Nurses $2,115.3 General Fund

The Department of Health and Social Services is requesting additional funding to provide for a wage increases for nursing positions in the department. DHSS is experiencing difficulties in recruiting and keeping nursing staff across the department. The current salary levels paid to nurses employed by the State of Alaska are not competitive with the private sector.

Approved funds will be allocated to Public Health Nursing, Alaska Psychiatric Institute (API), Alaska Pioneer Homes and the Division of Juvenile Justice to implement a one range salary increase. As you can see from the table below, the State of Alaska is 7 to 10% behind other comparable salaries.

Compilation of Nurses Salary Information as January 2005	Starting Pay of Nurses with no Experience (aka Nurse I)	Base Pay of Nurses with about 1 year experience (aka Nurse II)
Ketchikan General Hospital	$22.43	$23.11
Central Peninsula General Hospital	$22.50	$23.00
Providence Alaska Medical Center	$22.51	$23.37
Bartlett Regional Hospital	$21.21	$22.32
State of Alaska (A Step)	$20.51	$21.78

Information Technology Services

Provide Security and Training Enhancements to DHSS Networks Per Independent Assessment $550.0 General Fund

Security: The Department conducted an independent assessment of its IT security. This increment funds two positions (a Security Officer and another information technology position) and support costs to bolster the department's security on the network. The independent assessment has recommended this new structure.

The Department of Health and Social Services requires a Department Security Officer to ensure the department adheres to federal and state regulations regarding security of its electronic data and a technician to help build the security infrastructure. Specifically, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security regulations requires assigned security responsibility in 45 CFR 164.308(a)(2). This position will have the overall responsibility of ensuring that the appropriate information technology and non-information technology security safeguards are in place, the policies and procedures are developed, reviewed, agreed upon, rolled-out, and up-to-date, and that all users of information systems understand their responsibilities. This position will provide independent oversight for the Department's electronic data security.

The department manages many databases with highly confidential personal or medical information concerning clients. Any security breach would not only be devastating for DHSS clients, but would put DHSS at great liability and risk. Putting an adequate system in place is a key prevention strategy to reduce the risk to the state. If DHSS is not HIPAA compliant, serious federal fines could be levied.

Training: Currently, we have staff that Department Support Services, Information Technology Services has inherited with skill sets specific to their legacy areas of responsibility and these need to be expanded to more efficiently support our infrastructure. This training request will provide funding for IT staff to train within Customer Services, Business Applications & Network Services. Below is

a map showing all the locations where DHSS has active networks. The three large dots (Anchorage, Fairbanks and Juneau) represent multiple network junctions.

DHSS Network Environment:	
Number of Desktops:	**3025**
Number of Servers:	**450**
Number of Networks Statewide:	**161**
Number of Facilities Networks are Housed:	**118**

HSS State Facilities Rent

Crisis Treatment Center Lease Amount $305.0 General Fund/Mental Health
This facility is to support an expanded treatment program incorporating crisis treatment and step-down beds. The purpose of the facility is to provide an alternative setting for 24/7 care for consumers who can manage outside of an acute psychiatric hospital setting. The program does not include detox services. The clinical programming will be recovery-based and it is envisioned to be a flexible use facility. The base concept is for 8 beds in an open unit and 8 beds in a semi-secure unit (delayed/monitored egress), but the ability to swing beds from one category to another should be maintained. The current plan is to house this unit in the ground floor, west wing of the old Alaska Psychiatric Institute building. It is anticipated that the service will be completely separate from other tenant areas with its own public and service entries. The facility is not expected to be Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited.

Assistance for Increased Fuel/Electricity Costs $492.7 General Fund
The significant increase in oil prices have caused various infrastructure costs within the division to increase exponentially. Specifically, the cost of heating oil and natural gasoline has risen dramatically. Additionally, the cost for electricity has also increased. Without these additional funds to offset these increases for basic needs, the department will not be able to effectively run its building operations. These increases are based on 3.35% cost price index for state leases and

14.15% for state owned facilities put out by Department of Administration, Division of General Services. This increment is for state owned buildings in the public fund and state leases.

Human Services Matching Community Matching Grants

Human Services Community Match Grant Increment $1,764.7 General Fund
The Municipality of Anchorage, the Matanuska-Susitna and the Fairbanks North Star Boroughs have requested that the Department of Health and Social Services request an increase for essential human services, i.e., those services whose unavailability would subject persons needing the services to serious mental or physical hardship. Their needs have not been met.

Based on their needs that they are currently experiencing, the Governor is requesting an additional $1,764.7 to increase these grants to $3 million from the current $1,235,300. The amounts would be allocated by population among the three communities, who in turn, provide a 30% match with local dollars. Funds are then allocated to non-profit organizations that provide the services.

These grants save the state considerable money by providing services in a cost effective manner. Using non-profits organizations to deliver services adds more value to the grant. Non-profit organizations use grant dollars to leverage other funds and in-kind donations. The return on investment can be tremendous. For example, in FY04, for every $1 of state funds a return of $17 was generated by the non-profit organizations in Fairbanks.

Human Services Community Matching Grant

	2004 Cert Population	FY2004	FY2005	FY2006	Proposed FY2007
Anchorage	277,498	760,300	749,727	798,884	1,920,000
Fairbanks	84,979	239,700	224,954	239,703	600,000
Mat-Su	70,148	0	184,620	196,725	480,000
	432,625	$1,000,000	$1,159,300	$1,235,312	$3,000,000

Contribution to Department's Mission

Provide quality administrative services in support of the Department's mission.

Core Services

- Promote cost containment. Maximize revenue.
- Provide Divisions with necessary information to improve compliance with federal and state laws/policies to ensure our fiduciary responsibilities are met.
- Improve DHSS staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.
- Provide efficient centralized administrative support to 9 DHSS Divisions; offices in Juneau and Anchorage.

Department Level Measures

I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

Target #1: Increase by 5% the percentage of customers that report FMS is meeting their needs.
Measure #1: Percentage of customer service survey respondents that report FMS is meeting their needs.

% of Survey Respondents rating that FMS met their needs

Year	FMS Overall %	% Change	Avg % of All Services	% Change
2003	58.7%	0	70.6%	0
2004	64.7%	6%	70.6%	0%
2005	64.%	-0.7%	71.5%	0.9%

Analysis of results and challenges: A customer survey on Finance and Management Services performance is conducted annually.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed, however only the overall results are shown in the above table. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the % of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall % did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

Target #2: Reduce the average response time for complaints/inquiries to 14 days.
Measure #2: Department Complaint log response times.

# of Inquiries/Complaints

Fiscal Year	Opened	Closed
FY 2005	552	503

Analysis of results and challenges: In FY2005, the Department developed a database for all Inquiries or Complaints. The response log will be monitored by the Commissioner's Office.

The average # of days to close for FY05 is 15.18.

Target #3: Number of days to Process Payments/Responses.
Measure #3: Index timeliness and accuracy for: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

Timliness and Accuracy

	Fiscal Year 2005	
	# Processed	Days to Process
Purchase Requisitions	652	9.4
Operating Grant Awards	778	20.5
DHSS Invoices	150,474	14.4
Capital Grant Awards	87	3.16
Legislative Logs	236	4

Analysis of results and challenges: The department has developed an index for calculating this measure by recording the number and days to process each category above. Each one is given a weight to measure based on the ease of processing. An average is then calculated.

I1: Strategy - Implement results of Business Process Review.

Division Level Measures

A: Result - Facilitate the Department's Mission Through Superior (effective & efficient) Delivery of Administrative Services.

Target #1: Maintain percentage of DHSS Administration to Department overhead.
Measure #1: Percentage administration personal services is to total department budget.

Percentage administration personal services is to total department budget

Year	YTD Total
2003	0.36%
2004	0.43%
2005	0.13%

Analysis of results and challenges: Department administration personnel services equal all of Department Support Services RDU. This number is compared to the total DHSS Expenditures.

As a result of recruitment and retention difficulties in FY05, numerous vacancies occurred within the Department Support Services RDU resulting in a lower percentage for the year. The department continues to recruit for qualified candidates including out-of-state when necessary.

Target #2: Process capital grant payments within 15 days.
Measure #2: Number of days to process a grant payment after receiving reports.

Number of days to process a grant payment after receiving reports.

Year	YTD Total
2003	5.60 days
2004	4.89 days
2005	3.11 days

Analysis of results and challenges: There were 87 capital grant payments with only 5 that did not process within 15 days.

A1: Strategy - Implement Business Process Reviews.

A2: Strategy - Implement Department's Administrative Training Plan Curriculum.

B: Result - Improve Customer Service

Target #1: Increase by 2% the percentage of customers that report that Finance and Management Services is meeting their needs from FY05 to FY06.
Measure #1: Percentage of survey respondents to each Finance and Management Section (FMS) that report FMS is meeting their needs.

Finance and Management Service Functions - % Agree or Strongly Agree meeting service needs:

Service	2003	2004	% Change	2005	% Change
Grants & Contracts	68.2%	64.9%	-5.1%	65.4%	0.8%
Procurement	70.6%	66.5%	-6.2%	71.3%	6.7%
Facilities Management	75.7%	76.1%	0.5%	76.5%	0.5%
Audit	74.0%	81.9%	9.6%	78.3%	-4.6%
Finance	63.1%	64.8%	2.6%	62.7%	-3.3%
Information Services	72.4%	71.4%	-1.4%	70.9%	-0.7%
Budget	66.8%	67.4%	0.9%	70.8%	4.8%
Assistant Commissioner's Office	74.3%	71.9%	-3.3%	76.7%	6.3%
Human Resources*	60.0%	57.0%	-5.3%	65.2%	12.6%

* No longer in DHSS but still tracking.

Analysis of results and challenges: A customer survey on Finance and Management Services performance is conducted annually.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed, however only the overall results are shown in the above table. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the % of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall % did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

B1: Strategy - Establish and Maintain Guaranteed Standards.

B2: Strategy - Continue Customer Service Plan.

C: Result - Improve overall management of DHSS budget processes.

Target #1: Increase percentage of federal collections by 1% a year.
Measure #1: Percentage of federal collections.

Percent of DHSS Budget that is Federal

Year	YTD Total
2002	51.4%
2003	53.6%
2004	54.5%
2005	55.6%

Target #2: Improve Legislative understanding of the DHSS budget.
Measure #2: Respond to 80% of legislative inquiries by Budget Unit within 5 working days.

% of Responses for Legislative Requests made within 5 working days

Year	YTD Total
2002	83%
2003	83%
2004	78%
2005	79%

Analysis of results and challenges: The Budget Section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported on calendar year but now (2005) the data is collected by fiscal year. The average processing time is 4.0 days and 79% were completed within 5 working days.

C1: Strategy - Increase federal collections.

C2: Strategy - Improve Legislative understanding of the budget.

D: Result - Facilitate the Department's day-to-day operations through effective and efficient delivery of Information Technology Services.

Target #1: Reduce the length of time and number of hours to respond and close out service calls.
Measure #1: Number of hours to close out service calls.

Average Number of Days to Complete Service

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2005	N/A	14.2	6.3	5.6	8.2

Analysis of results and challenges: This measure was developed in FY05. There are a total of 15 categories of work/service performed that have been used to calculate the above averages. (In the 2nd quarter there were only 13 categories tracked.)

Examples of categories are, but not limited to:

Setting up Accounts; Application work; password setup; procurement of equipment; relocation of equipment; security; software; web; hardware or file maintenance, etc.

Target #2: Anticipate 75% of IT Business Application projects completed on time and within budget.
Measure #2: Projects completed within 10% of estimated timeline and funding.

Analysis of results and challenges: This is a new measure in FY05 and the department is still working on the various aspects of tracking and defining the response/delivery time of business applications.

Thus far the division has tracked the number of calls for the following categories of work:

# of New Business Application requests - 45
# of Unassigned - 22
# of Assigned Requests (in-house) - 10
# of Assigned Requests (contractor/Task Order) - 8
# of completed projects - 15
# of Projects in Progress - 40

The division is also tracking application maintenance separately:

# of maintenance requests - 2,126.
completed - 1,582 or 74%

Staff is working to develop a target for response time in this area; however with the varying levels of application development a weighted score will need to be developed.

D1: Strategy - Improve IT service call turn around time by implementing and maintaining software tracking system.

Mission

Boards, commissions and councils of the RDU play an important role in government by providing a mechanism for broad-based, on-going public input to planning, policy development and program evaluation.

Introduction

The Boards and Commissions are statutorily required to advocate, plan, evaluate, advise, partner, and actively involve the citizens of Alaska with regard to alcoholism and drug abuse, Alzheimer's and other related disorders, developmental and other severe disabilities, special education, infant learning program/early intervention, mental health, suicide prevention and faith-based initiatives.

Core Services

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse
The Alaska Mental Health Board is the state planning and coordinating agency for purposes of federal and state laws relating to the mental health program. The Alaska Mental Health Board is responsible for evaluating the mental health program and provides a policy forum for and advocates for Alaskans with mental illness.

The Advisory Board on Alcoholism and Drug Abuse is the state planning agency that advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.

Alaska Commission on Aging
The Alaska Commission on Aging (ACOA) advocates for policies, programs and services that promote the dignity and independence of Alaska's seniors and help them maintain a meaningful quality of life. ACOA participates in the planning of the comprehensive integrated mental health plan, and is available to provide recommendations when the department develops other health or service plans that impact the quality of life of older Alaskans.

Governor's Council on Disabilities and Special Education
The Governor's Council on Disabilities and Special Education (GCDSE) is charged with creating change that improves the lives people with developmental and other severe disabilities, students receiving special education, and infants and toddlers with disabilities and their families. The Council serves as the State Council on Developmental Disabilities, the Special Education Advisory Panel and the Interagency Coordinating Council for Infants and Toddlers with Disabilities.

Governor's Advisory Council on Faith-Based and Community Initiatives
The Governor's Advisory Council on Faith-Based and Community Initiatives advises the Governor on policies and practices to meet the workforce and health and social services needs of Alaskans.

Pioneer's Home Advisory Board
The Pioneer's Home Advisory Board is charged with conducting annual inspections of the Alaska Pioneer's Homes and making recommendations for changes and improvements.

Suicide Prevention Council

The Suicide Prevention Council component is charged with advising the Governor and Legislature with respect to what actions can and should be taken to reduce suicide and its effects in Alaska and developing a state suicide prevention plan.

Alaska Mental Health Board AS 47.30.661-666
By state statute, the Board is required to accomplish the following:

Prepare and maintain a comprehensive plan for state mental health services. This plan is known as A Shared Vision II. The revision under development is known as the Integrated Strategic Plan for Behavioral Health.

Propose an annual implementation plan for A Shared Vision II based on findings from the evaluation of existing programs.

Provide a public forum to discuss mental health service issues for which the Board has planning and coordinating responsibility.

Advocate for the needs of Alaskans with mental disorders before the governor, executive agencies, the legislature and the public.

Advise the legislature, the governor, the Alaska Mental Health Trust Authority, and other state agencies in matters affecting Alaskans with mental disorders. This includes, but is not limited to: developing necessary services for diagnosis, treatment and rehabilitation; evaluating the effectiveness of programs in the state providing diagnosis, treatment and rehabilitation; legal processes that affect screening, diagnosis, treatment and rehabilitation.

Provide to the Alaska Mental Health Trust Authority recommendations concerning the integrated, comprehensive mental health program for persons with mental disorders and the use of money in the mental health trust income account.

Report periodically regarding its planning, evaluation, advocacy and other activities.

Advisory Board on Alcoholism and Drug Abuse AS 47.30.470-500; AS 47.37
Provide adequate staff support and facilities to maximize the effectiveness of the Advisory Board's work.

Provide advice to the Governor, legislature and departments within the State on alcohol and drug related issues.

Monitor the effectiveness of state-funded programs and services.

The Board shall prepare and maintain a comprehensive plan of services for the prevention and treatment of alcohol, drug, and other substance abuse and, for chronic alcoholics suffering from psychosis.

Provide board member and staff expertise to the Division of Behavioral Health in the process or reorganization and integration of statewide behavioral health service delivery system.

Assist the Department of Health and Social Services in the development of the Comprehensive Integrated Mental Health Plan.

Provide recommendations for service delivery and funding to beneficiaries of the Alaska Mental Health Trust Authority.

Advocate for the development of community-based solutions to these problems.

Monitor legal processes that affect the treatment and rehabilitation of alcoholics and drug abusers.

Alaska Commission on Aging AS 44.21.200-240
Responsibilities of the Alaska Commission on Aging include:

Prepare a comprehensive statewide plan for services and program development as required by statute and the Older Americans Act, to address the current and future needs of older Alaskans and their caregivers. This plan is known as the Alaska Commission on Aging State Plan for Services.

Gather data and conduct public meetings to ensure broad based public interaction from older Alaskans, caregivers, providers, direct service workers, educators, local and tribal governments, and the private sector to analyze policy issues and service systems, to advocate for change to meet the future needs of older Alaskans and caregivers. Public meetings will be held across regions, and include rural communities, to ensure broad based public interaction.

Recommend legislation, regulations, and appropriations to provide services and program development for older Alaskans and caregivers.

Advocate for and encourage the development of municipal and other local and regional commissions or advisory boards representing older Alaskans and their caregivers, which will assess local or regional needs and make recommendations to the ACOA.

Prepare an annual report for submission to the governor and legislature that analyzes existing services and programs, and includes recommendations for the future needs of older Alaskans and caregivers.

Provide to the Alaska Mental Health Trust Authority recommendations concerning the integrated comprehensive mental health program for persons identified with Alzheimer's disease or Related Disorders (ADRD) and their caregivers, a statutory requirement under the terms of the Alaska Mental Health Trust Authority settlement.

Provide necessary staff and adequate funding to carry out the statutory responsibilities of the Alaska Commission on Aging.

Governor's Council on Special Education and Developmental Disabilities PL 106-402; PL 105-17 Part B and C; AS 14.30.231; AS 14.30.610; AS 47.20.020; AS 47.80.030-090
State statute requires that the Governor's Council:

Advocate the needs of individuals with disabilities before the executive and legislative branches of the state government and before the public.

Advise the executive and legislative branches of the state government and the private sector on programs and policies pertaining to current and potential services to individuals with disabilities and their families.

Work with the Departments of Health and Social Services and Education and Early Development, to develop, prepare, adopt, periodically review, and revise as necessary an annual state plan prescribing programs that meet the needs of persons with developmental disabilities.

Review and comment on state plans and proposed regulations relating to programs for persons who are experiencing disabilities before the adoption of a plan or regulation.

Submit budget recommendations for services to individuals with disabilities.

Provide information and guidance for the development of appropriate special educational programs and services for a child with a disability.

Monitor and evaluate budgets or other implementation plans and programs for individuals with disabilities to assure non-duplication of services and encourage efficient and coordinated use of federal, state, and private resources in the provision of services.

Provide recommendations to the Alaska Mental Health Trust Authority for the integrated comprehensive mental health program and the use of the money in the mental health trust settlement income account.

Other duties of the Council include the following:

Implement the activities listed in the 5-year strategic plan for individuals with disabilities and their families.

Evaluate programs for consumer satisfaction, efficiency and effectiveness.

Collect and analyze data about programs, and services impacting the quality of life of people with developmental and other severe disabilities, students receiving special education, and infants and toddlers with disabilities.

Review in-state and outside programs for people with disabilities, students receiving special education, and infants and toddlers with disabilities.

Solicit public comments about public policy and state-funded programs.

Convene stakeholder groups to study issues affecting the lives of people with disabilities and make recommendations for change.

Submit findings and recommendations to policymakers in administration and the legislature and advocate for needed changes.

Assist individuals with disabilities and their families to speak on their own behalf and on behalf of others in the development of regulation and legislation.

Provide support to assist individuals with developmental disabilities to become leaders and to participate in cross-disability coalitions.

Governor's Advisory Council on Faith-Based and Community Initiatives Administrative Order #221 State statute requires that the Council: Advise the Governor on policies and practices to increase the contributions of faith-based and community organizations.

Promote service partnerships between faith, community and governmental entities.
Coordinate faith-based and community initiatives programming among the executive branch departments.

Provide a single point of contact for faith-based and community organizations to receive information, assistance and referrals within the executive branch of state government.

Provide guidance, direction and support for increased collaboration among faith-based and community organizations and between faith-based and community organizations and the executive branch of state government.

Seek financing to support faith-based and community initiative programs and services.

Facilitate or provide grant writing training, organizational development and other technical assistance and training to help faith-based and community organizations develop increased capacity to provide services and programs to those in need in Alaska.

Provide training to state employees in the executive branch on how to work with faith-based and community organizations.

Develop intergovernmental agreements among state agencies in the executive branch necessary to implement faith-based and community initiatives programming across departmental lines.

Pioneer's Home Advisory Board AS 44.21.100-130
State statute requires that the Advisory Board hold meetings or teleconferences regarding inspections of the property and policies and procedures of the Alaskan Pioneer Homes for recommendations to the Governor.

Suicide Prevention Council AS 44.29.300-390
The Council is the state planning and coordinating agency for issues surrounding suicide and suicide prevention as established by Alaska Statute 44.29.300-390.

As established by Alaska Statute 44.29.350, the powers, duties, and responsibilities of the Council are to act in an advisory capacity to the governor and the legislature with respect to what actions can and should be taken to:

- improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities;
- broaden the public's awareness of suicide and the risk factors related to suicide;
- enhance suicide prevention services and programs throughout the state;
- develop healthy communities through comprehensive, collaborative, community-based and faith-based approaches;
- develop and implement a statewide suicide prevention plan; and
- strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

Boards & Commissions	2006	2007 Proposed	06 to 07 Change
General Funds	607.6	668.0	60.4
Federal Funds	1,945.4	1,586.0	-359.4
Other Funds	1,250.0	1,628.4	378.4
Total	**3,803.0**	**3,882.4**	**79.4**

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse Component

Alaska Mental Health Trust Authority (AMHTA) Project $90.7 MHTAAR
This net increment represents the gain of MHTAAR funding for one project and the loss of MHTAAR funding for three projects. $194.5 is the AMHTA bundling together the joint staffing, infrastructure and board trust partnership into one project. The decrement portion then decreases the Board Trust Partnership ($18.0); the Infrastructure Improvements ($85.4); and the Integrated Family Voice (0.4) projects.

Alaska Commission on Aging Component

Transfer PCN 02-1545 and Funding from the Division of Senior and Disability Services $110.0 MHTAAR
This increment of MHTAAR funds $110.0 is to fund the Rural Long Term Care Coordinator to work with remote villages and communities throughout Alaska to help them more fully utilize state and federal health programs, including Medicaid. The Department of Health and Social Services and the Alaska Mental Health Trust Authority have decided that it will be a better fit to have this position located in the Alaska Commission on Agency. This transfers all funding for this project, including salary to fund an associate coordinator position that administers this program.

Governor's Council on Special Education and Developmental Disabilities Component

Decrement of Excess Federal Funds $298.2 Federal
The Governor's Council on Disabilities and Special Education lost two federal grants which makes it necessary to delete excess federal funds.

Decrement of Multiple AMHTA Project Funding and Non-Permanent Position $101.4 MHTAAR
This decrement represents the loss of MHTAAR funding from the Alaska Mental Health Trust Authority (AMHTA) for three projects: The Partners in Policymaking is decreased ($50.0); Recruitment Direct Service Worker is decreased ($50.7); and the Research Analyst project is decreased ($0.7). One non-permanent position is also deleted.

Governor's Advisory Council on Faith-Based and Community Initiatives Component

Transfer I/A from Alaska Temporary Assistance Program and Transfer Two Positions from Office of Program Review $270.0 Interagency Receipts
The focus of the Faith-Based and Community Initiatives is to provide support and technical assistance to faith and community organizations to increase their capacity to serve, and to form collaborative partnerships with other groups and government agencies that work to improve the lives of people around the state.

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RDU/Component Listing FY2007

Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Behavioral Health	AK Fetal Alcohol Syndrome Program
Behavioral Health	Alcohol Safety Action Program (ASAP)
Behavioral Health	Behavioral Health Medicaid Services
Behavioral Health	Behavioral Health Grants
Behavioral Health	Behavioral Health Administration
Behavioral Health	Community Action Prevention & Intervention Grants
Behavioral Health	Rural Services and Suicide Prevention
Behavioral Health	Psychiatric Emergency Services
Behavioral Health	Services to the Seriously Mentally Ill
Behavioral Health	Designated Evaluation and Treatment
Behavioral Health	Services for Severely Emotionally Disturbed Youth
Behavioral Health	Alaska Psychiatric Institute
Children's Services	Children's Medicaid Services
Children's Services	Children's Services Management
Children's Services	Children's Services Training
Children's Services	Front Line Social Workers
Children's Services	Family Preservation
Children's Services	Foster Care Base Rate
Children's Services	Foster Care Augmented Rate
Children's Services	Foster Care Special Need
Children's Services	Subsidized Adoptions & Guardianship
Children's Services	Residential Child Care
Children's Services	Infant Learning Program Grants
Children's Services	Women, Infants and Children
Children's Services	Children's Trust Programs
Children's Services	Child Protection Legal Svcs
Health Care Services	Medicaid Services
Health Care Services	Catastrophic and Chronic Illness Assistance (AS 47.08)
Health Care Services	Medical Assistance Administration
Health Care Services	Health Purchasing Group
Health Care Services	Women's and Adolescents' Services
Juvenile Justice	McLaughlin Youth Center
Juvenile Justice	Mat-Su Youth Facility
Juvenile Justice	Kenai Peninsula Youth Facility
Juvenile Justice	Fairbanks Youth Facility
Juvenile Justice	Bethel Youth Facility
Juvenile Justice	Nome Youth Facility
Juvenile Justice	Johnson Youth Center
Juvenile Justice	Ketchikan Regional Youth Facility
Juvenile Justice	Probation Services
Juvenile Justice	Delinquency Prevention
Juvenile Justice	Youth Courts
Public Assistance	Alaska Temporary Assistance Program

Public Assistance	Adult Public Assistance
Public Assistance	Child Care Benefits
Public Assistance	General Relief Assistance
Public Assistance	Tribal Assistance Programs
Public Assistance	Senior Care
Public Assistance	Permanent Fund Dividend Hold Harmless
Public Assistance	Energy Assistance Program
Public Assistance	Public Assistance Administration
Public Assistance	Public Assistance Field Services
Public Assistance	Fraud Investigation
Public Assistance	Quality Control
Public Assistance	Work Services
Public Health	Nursing
Public Health	Women, Children and Family Health
Public Health	Public Health Administrative Services
Public Health	Certification and Licensing
Public Health	Chronic Disease Prevention and Health Promotion
Public Health	Epidemiology
Public Health	Bureau of Vital Statistics
Public Health	Community Health/Emergency Medical Services
Public Health	Community Health Grants
Public Health	Emergency Medical Services Grants
Public Health	State Medical Examiner
Public Health	Public Health Laboratories
Public Health	Tobacco Prevention and Control
Senior and Disabilities Services	Senior and Disabilities Medicaid Services
Senior and Disabilities Services	Senior and Disabilities Services Administration
Senior and Disabilities Services	Protection and Community Services
Senior and Disabilities Services	Nutrition, Transportation, & Support Services
Senior and Disabilities Services	Senior Community Based Grants
Senior and Disabilities Services	Home and Community Based Care
Senior and Disabilities Services	Senior Residential Services
Senior and Disabilities Services	Community Developmental Disabilities Grants
Departmental Support Services	Commissioner's Office
Departmental Support Services	Office of Program Review
Departmental Support Services	Rate Review
Departmental Support Services	Assessment and Planning
Departmental Support Services	Administrative Support Services
Departmental Support Services	Hearings and Appeals
Departmental Support Services	Audit
Departmental Support Services	Medicaid School Based Admin Claims
Departmental Support Services	Facilities Management
Departmental Support Services	Health Planning and Infrastructure
Departmental Support Services	Information Technology Services
Departmental Support Services	Facilities Maintenance
Departmental Support Services	Pioneers' Homes Facilities Maintenance
Departmental Support Services	HSS State Facilities Rent
Boards and Commissions	AK Mental Health & Alcohol & Drug Abuse Boards
Boards and Commissions	Alaska Mental Health Board
Boards and Commissions	Advisory Board on Alcoholism and Drug Abuse

Boards and Commissions	Commission on Aging
Boards and Commissions	Governor's Council on Disabilities and Special Education
Boards and Commissions	Governor's Advisory Council on Faith-Based and Community Initiatives
Boards and Commissions	Pioneers Homes Advisory Board
Boards and Commissions	Suicide Prevention Council
Human Services Community Matching Grant	Human Services Community Matching Grant

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ABADA .....Advisory Board On Alcoholism And Drug Abuse
ABDR .....Alaska Birth Defects Registry
ABS.....Alaska Budget System
ACOA…….Alaska Commission On Aging
ACT.....Alaska Children's Trust
ADRD .....Alzheimer's Disease and Related Dementias
ADTPF.....Alcohol and other Drug Treatment and Prevention Fund
AFHCAN .....Alaska Federal Health Care
AJJAC.....Alaska Juvenile Justice Advisory Committee
AKAIMS……Alaska Automated Information Management System
AKPH…….Alaska Pioneer Homes
AKSAP .....Alaska Senior Assistance Program
AKSAS .....Alaska State Accounting System
AMHB.....Alaska Mental Health Board
AMHTA.....Alaska Mental Health Trust Authority
APA.....Adult Public Assistance
APD.....Adults with Disabilities (Waivers)
API .....Alaska Psychiatric Institute
APHIP.....Alaska Public Health Improvement Process
ARND .....Alcohol and Related Neurodevelopmental Disorder
ARBD .....Alcohol Related Birth Defects
ART.....Aggression Replacement Training
ASAP .....Alcohol Safety Action Program
ASTHO .....Association of State & Territorial Health Officials
ATAP .....Alaska Temporary Assistance Program
ATCA.....Alaska Tobacco Control Alliance
ATSDR .....Agency for Toxic Substances and Disease Registry
AVCP.....Association of Village Council Presidents
BB .....Better Beginnings
BBNA .....Bristol Ban Native Association
BCC.....Breast and Cervical Cancer
BH.....Behavioral Health
BMI.....Body Mass Index
BRFSS.....Behavioral Risk Factor Surveillance System
BRS.....Behavioral Rehabilitation Services
BTKH.....Bring the Kids Home
BVS.....Bureau of Vital Statistics
CAHPS.....Consumer Assessment of Health Plans Survey
CAMA.....Chronic and Acute Medical Assistance

CAPI .....Community Action, Prevention and Intervention
CCDF .....Child Care Development Fund
CCISC.....Comprehensive, Continuous, Integrated System of Care
CCMC.....Children with Complex Medical Conditions (Waiver)
CCTHITA .....Central Council of Tlingit and Haida Indian Tribes of Alaska
CD.....Chronic Disease Prevention and Health Promotion component
CDC .....Center for Disease Control
CDDG .....Community Developmental Disabilities Grants
CDFA.....Catalogue of Federal Domestic Assistance
CDVSA.....Council on Domestic Violence and Sexual Assault
CFR.....Code of Federal Regulations
CFSR.....Federal Child and Family Services Review
CHATS .....Community Health Aide Training and Supervision
CHEMS.....Community Health & Emergency Medical Services
CHIP .....Children's Health Insurance Program
CIMHP.....Comprehensive Integrated Mental Health Plan
C&L .....Certification & Licensing
CITC .....Cook Inlet Tribal Corporation
CLIA .....Clinical Laboratory Improvement Amendments
CMHC.....Community Mental Health Center
CMHS .....Community Mental Health Services Block Grant
CMI.....Chronically Mentally Ill
CMS .....Center for Medicare and Medicaid Services
COFIT.....Outcome Fidelity and Implementation Tool
COMPASS.....Community Partnership for Access Solutions and Success
COPD.....Chronic Obstructive Pulmonary Disease
COSIG.....Co-Occurring State Inventive Grants
CPS .....Child Protective Services (Office of Children's Services)
CPS .....Child Passenger Safety (Public Health)
CQI.....Continuous Quality Improvement
CSAT .....Center for Substance Abuse Treatment
CSM .....Children's Services Management
CSN.....Children with Special Needs
CSR.....Client Status Review
CSU.....Crisis Stabilization Unit
CTC.....Crisis Treatment Center
DAI .....Detention Assessment Instrument
DBH .....Division of Behavioral Health
DD.....Developmentally Disabled
DE&ED.....Department of Education & Early Development
DET.....Designated Evaluation & Treatment

DHSS .....Department of Health and Social Services
DJJ.....Division of Juvenile Justice
DKC .....Denali KidCare (State Children's Health Insurance Program)
DOL/WD.....Department of Labor and Workforce Development
DOT .....Direct Observed Therapy
DPA.....Division of Public Assistance
DPH.....Division of Public Health
DSDS .....Division of Senior and Disabilities Services
DSH.....Disproportionate Share Hospital
DSS .....Department Support Services (aka Finance and Management Services)
DWI.....Driving While Intoxicated
EAP .....Energy Assistance Program
EBT .....Electronic Benefit Transfer
ECCS.....Early Childhood Comprehensive Systems Project
EI.....Early Intervention
EIEIO .....Early Intervention, Enhancement and Improvement Opportunity
EI/ILP.....Early Intervention/Infant Learning Program
EIS.....Eligibility Information System
EMS .....Emergency Medical Services
EPI.....Epidemiology
EPSDT .....Early & Periodic Screening, Diagnosis and Treatment
FAE .....Fetal Alcohol Effects
FARS.....Fatal Accident Reporting System
FAS .....Fetal Alcohol Syndrome
FASD .....Fetal Alcohol Spectrum Disorder
FBCI.....Faith Based and Community Initiatives
FLSW.....Front Line Social Worker
FMAP.....Federal Medical Assistance Program
FMS.....Finance and Management Services
FS .....Food Stamps
FTE .....Full Time Equivalent
GCDSE .....Governor's Council on Disabilities and Special Education
GRA .....General Relief Assistance
HAIL .....Healthy Alaskans Information Line
HAN.....Health Alert Network
HAP.....Heating Assistance Program
HCBC.....Home and Community Based Care
HCBW.....Home and Community Based Waivers
HCP.....Health Care Program
HCS.....Health Care Services
HF .....Healthy Families

HIFA .....Health Insurance Flexibility and Accountability
HIPP.....Health Insurance Premium Payment (Medicaid)
HIPPA.....Health Insurance Portability and Accountability Act
HIV .....Human Immunodeficiency Virus
HPG.....Health Purchasing Group
HRSA.....Health Resource Services Administration
HSCMG .....Human Services Community Matching Grants
IA .....Interim Assistance
I/A .....Interagency Receipts
IDEA.....Individuals with Disabilities Education Act
IDP .....Institutional Discharge Planning
IEP.....Individualized Education Plan
IFSP.....Individual Family Service Plan
IHS .....Indian Health Services
ILLECP.....Local Law Enforcement & Community
ILP.....Infant Learning Program
IMD.....Institution for Mental Disease
IOP .....Intensive Outpatient Program
ISA .....Individualized Service Agreements
IT.....Information Technology
ITG.....Information Technology Group
JABG.....Juvenile Accountability Block Grant
JCAHO.....Joint Commission on Accreditation of Healthcare Organizations
JJDP .....Office of Juvenile Justice and Delinquency Prevention
JOMIS.....Juvenile Offender Management Information System
JPO.....Juvenile Probation Officer
JTPA .....Job Training Partnership Act
LCSW .....Licensed Certified Social Worker
LIHEAP .....Low Income Home Energy Assistance Program
LTC.....Long Term Care
MBU .....Medicaid Budget Unit
MCAC.....Medicaid Care and Advisory Committee
MCFH .....Maternal, Child, & Family Health
MCH .....Maternal, Child Health (Block Grant)
MHDD .....Mental Health and Developmental Disabilities
MHSIP .....Mental Health Statistics Improvement Project
MHTAAR .....Mental Health Trust Authority Authorized Receipts
MIS .....Management Information System
MMIS.....Medicaid Management Information System
MMIS-JUCE.....MMIS – Juneau Claims and Eligibility System
MOA .....Municipality of Anchorage or Memorandum of Agreement

MOE.....Maintenance of Effort
MRDD.....Mental Retardation/Developmental Disability (Waiver)
MYC .....McLaughlin Youth Center
NPS .....National Pharmaceutical Stockpile
NRO .....Northern Region Office
NSH.....North Star Hospital
NSIF .....Nutrition Services Incentive Program
NTSS.....Nutrition, Transportation and Support Services
OA.....Older Alaskans
OAA.....Older Alaskan's Act
OCS.....Office Of Children's Services
OEP .....Office of Emergency Preparedness
OOS.....Out of State
OPR.....Office of Program Review
ORCA .....Online Resource for the Children of Alaska
ORR .....Office of Rate Review
OSEP.....Office of Special Education Programs
PA .....Public Assistance
PASS .....Parents Achieving Self-Sufficiency
PASS Grant.....Personal Assistance, Supports and Services (Sr. & Disabilities Services)
PC.....Personal Computer
PCA.....Personal Care Attendant
PCBs .....Polychlorinated Biphenyls
PCCM .....Primary Care Case Management
PCN.....Position Control Number
PCSA.....Protection, Community Services and Administration
PDL .....Preferred Drug List
PDPs.....Prescription Drug Plans
PEC .....Proposal Evaluation Committee
PERM.....Payment Error Rate Measure
PES.....Psychiatric Emergency Services
PFDHH .....Permanent Fund Dividend Hold Harmless
PFT.....Permanent Full Time
PHAB.....Pioneers' Homes Advisory Board
PHN.....Public Health Nursing
PIC .....Private Industry Council
PIP.....Performance (or Program) Improvement Plan
POP .....Persistent Organic Pollutants
PPC .....Prevention Policy Committee
PPT.....Permanent Part-Time
PRAMS .....Pregnancy Risk Assessment Monitoring System

PRWORA .....Personal Responsibility and Work Opportunity Reconciliation Act
PSR .....Protective Service Reports
RCC.....Residential Child Care
RDT.....Residential Diagnostic Treatment
RDU .....Results Delivery Unit
RFP .....Request for Proposal
RFR.....Request for Recommendations
RHSS.....Rural Health Services System
RPMS.....Resources and Patient Management System
RPTC.....Residential Psychiatric Treatment Center
RSA.....Reimbursable Services Agreement
RSS .....Receipt Supported Services
RSSP .....Rural Services and Suicide Prevention
SAG.....Subsidized Adoption and Guardianship
SAMHSA.....Substance Abuse and Mental Health Services Administration
SAPT.....Substance Abuse Prevention and Treatment Block Grant
SCHIP .....State Children's Health Insurance Program
SCRO .....Southcentral Region Office
SDPR.....Statutory Designated Program Receipts
SDS .....Senior and Disabilities Services
SECC.....State Emergency Coordination Center
SED.....Seriously Emotionally Disturbed
SERO .....Southeast Region Office
SIG/ACT .....State Incentive Grant/Alaskans Collaborating for Teens
SME .....State Medical Examiner
SMI .....Supplementary Medical Insurance
SSBG.....Social Services Block Grant
SSI.....Supplemental Security Income
STAR Grants.....Short Term Assistance and Referral
STD.....Sexually Transmitted Disease
SVCS/SMI .....Services to the Seriously Mentally Ill
TANF .....Temporary Assistance to Needy Families
TB .....Tuberculosis
TCC.....Tanana Chiefs Conference
TCM.....Targeted Case Management
TDM.....Team Decision Making
TEFRA.....Tax Equity and Fiscal Responsibility Act of 1982
TFAP.....Tribal Family Assistance Programs
Title V .....Maternal, Child Health Block Grant
Title X .....Family Planning (Federal)
Title XIX.....Medicaid

Title XXI.....SCHIP/Denali KidCare
T&H.....Central Council of Tlingit and Haida Indian Tribes
TPL .....Third Party Liability
TWWIIA.....Ticket to Work and Work Incentives Improvement Act of 1999
USDA.....U. S. Department of Agriculture
WAS.....Women and Adolescent Services
WIA.....Workforce Investment Act
WIC.....Women, Infants and Children
WSEA .....Western States EBT Alliance
WtW.....Welfare to Work
YF .....Youth Facility
YKHC .....Yukon-Kuskokwim Regional Health Corporation
YRBS .....Youth Risk Behavior Survey