

Planning Committee

Date: January 27, 2015

Alaska Permanent Fund Corporation

Hugh Malone Board Room

801 West 10th Street, Juneau, AK 99801

**Trustees: Paula Easley (Chair), Laraine Derr, Larry Norene, Mary Jane Michael,
Russ Webb, John McClellan, Mike Barton (ex-officio)**

Call in number: (866)-469-3239; Session Number: 807 319 372 #; Attendee Number: #

	<u>Page No.</u>
10:15	
Call to order (Paula Easley, Chair)	
• Announcements	
• Approve agenda	
• Approve minutes	
• October 22, 2014	3
10:25	
Medicaid Expansion Update	12
11:05	
Marijuana Policy Initiative Update	
11:35	
FY14 MHTAAR Status Report Performance Summary	21
11:45	
Adjourn	
Written Informational Updates	
• Focus Area Activity and MMIS Update – Alaska Association on Developmental Disabilities	29
• Focus Area Update: Disability Justice – Offender Management Plan	37
• Focus Area update: Employment Initiative Planning Framework	41
• 2015 Trust Rural Outreach Trip	46
• Trust Rural Outreach Trip History Map	49

The Planning Committee (Bylaws, Sept 2011):

Identifies & forecasts the status and needs of beneficiaries

Develops program policies and plans to meet needs and improve the circumstances of beneficiaries; and recommends to the Trust Authority for approval as appropriate

Evaluates the implementation of approved policies and plans affecting beneficiaries

Future Meeting Dates

Full Board of Trustee / Finance / Resource Management / Planning

(updated 12/08/14)

FY15/16 - Finance Committee Dates:

- January 27, 2015 (Tue) – JUNEAU
- April 16, 2015 (Thu)
- August 4, 2015 (Tue)
- October 21, 2015 (Wed)
- January 26, **2016** (Wed)
- April 14, **2016** (Thu)
- August 2, **2016** (Tue)
- October 20, **2016** (Thu)

FY15/16 – Resource Management Committee Dates:

- January 27, 2015 (Tue) – JUNEAU
- April 16, 2015 (Thu)
- August 4, 2015 (Tue)
- October 21, 2015 (Wed)
- January 26, **2016** (Tue) – JUNEAU
- April 14, **2016** (Thu)
- August 2, **2016** (Tue)
- October 20, **2016** (Thu)

FY15/16 – Planning Committee Dates:

- January 27, 2015 (Tue) – JUNEAU
- April 16, 2015 (Wed)
- August 5-6, 2015 (Wed, Thu)
- October 21, 2015 (Wed)
- January 26, **2016** (Tue) – JUNEAU
- April 14, **2016** (Thu)
- August 3-4, **2016** (Tue)
- October 20, **2016** (Thu)

FY 15/16 – Full Board of Trustee Meeting Dates:

- January 28-29, 2015 (Wed, Thu) – JUNEAU
- May 7, 2015 (Thu) – TBD
- August 26-27, 2015 (Wed, Thu) – Anchorage
- November 18, 2015 (Wed) – Anchorage – TAB
- January 27-28, **2016** (Wed, Thu) – JUNEAU
- May 5, **2016** (Thu) – TBD
- August 24-26, **2016** (Wed, Thu, Fri)
- November 17, **2016** (Thu) – Anchorage – TAB

ALASKA MENTAL HEALTH TRUST AUTHORITY
PLANNING COMMITTEE

October 22, 2014

10:20 a.m.

Taken at:

Alaska Mental Health Trust Authority
3745 Community Park Loop, Suite 120
Anchorage, Alaska 99508

OFFICIAL MINUTES

Trustees present:

Paula Easley, Chair
Mike Barton (via telephone)
Laraine Derr
Larry Norene
John McClellan
Russ Webb
Mary Jane Michael (via telephone)

Trust staff present:

Jeff Jessee
Miri Smith-Coolidge
Kevin Buckland
Michael Baldwin
Marilyn McMillan
Katie Baldwin-Johnson
Nancy Burke
Amanda Lofgren
Natasha Pineda
Carrie Predeger
Lucas Lind

Others participating:

Theresa Holt, Long-Term Care Ombudsman; Patrick Reinhart, Governor's Council on Disabilities & Special Education; Heidi Wailand, Agnew:Beck; Dr. Melissa Kemberling, Mat-Su Health Foundation; Lizette Stiehr, Alaska Association of Developmental Disabilities; Michael Bailey, Alaska Association of Developmental Disabilities; Kathy Craft; Denise Daniello, Alaska Commission on Aging (via telephone); Tom Chard, ABADA (via telephone).

PROCEEDINGS

CHAIR EASLEY calls the Planning Committee to order. She begins with a few announcements. She states that the new long-term care ombudsman is Theresa Holt, and Patrick Reinhart will be taking her place on the Governor's Council on Disabilities & Special Education.

MS. HOLT states that today is her last day, and she is helping Mr. Reinhart out.

MR. REINHART states that he looks forward to working with the Trust, and gives a short background on himself.

CHAIR EASLEY thanks both and moves on. She asks for any changes or additions to the agenda. There being none, the agenda is approved. She moves on to the minutes of April 23, 2014, and then the minutes of August 6 and 7, 2014.

TRUSTEE WEBB makes a motion to accept the minutes of April 23, 2014.

TRUSTEE MICHAEL seconds.

There being no objection, the motion is approved.

TRUSTEE WEBB makes a motion to accept the minutes of August 6 and 7, 2014.

TRUSTEE MICHAEL seconds.

There being no objection, the motion is approved.

CHAIR EASLEY states that there is one more announcement, and calls on Mike Baldwin.

MR. BALDWIN states that HB 30 was passed into law that set out a schedule for all state departments and divisions to undergo a performance review and an audit. The first one sets up the divisions and departments to be reviewed every ten years. He continues that the first audit and review was of the Department of Corrections, and that is in the process of being finalized. He explains more in detail and states that as more is learned, it will be passed on to the Trustees.

TRUSTEE WEBB asks for a copy of the contract for that performance review.

MR. BALDWIN replies affirmatively. He states that Heidi Wailand will talk about the behavioral health assessment.

CHAIR EASLEY introduces Heidi Wailand with Agnew:Beck.

MS. WAILAND thanks all for the invitation, and asks Mr. Baldwin for a quick introduction of the project.

MR. BALDWIN states that a large project assessing the publicly funded behavioral health system in Alaska has been undertaken. He continues that the question that comes up is: What is the publicly-funded behavioral health system and what does it do. He adds that over the last two years, folks have come together to develop the project. Agnew:Beck was awarded the contract, and are about eight months into the project.

MS. WAILAND shares some slides that were created for the second steering committee meeting. It gives a refresher on the overall scope of the project, some of the work done to date, and where it is all headed. She states that the first and foremost goal of this project is to describe the behavioral health system. She continues that the second goal is to assess the needs of Alaskans for publicly funded behavioral health services. She adds that the third goal is to assess the current capacity of the system to deliver those services. She states the hope to develop a methodology that can be reviewed and used on an ongoing basis. She continues that the final goal is to identify barriers and make recommendations for systems change. She states that Agnew:Beck was awarded the contract with subcontractors Hornby Zeller Associates. She continues that Hornby Zeller has primarily been focused on the quantitative analysis, and Agnew:Beck on the project management and the quality of analysis. She states that she is proud and excited to share that some strong relations have been established. She continues that as part of the RFP design, there was a concept that there would be a data work group with a cross-section of individuals from the boards. She adds, that is working really well, and she is also proud to have been able to establish a strong connection with ANTHC and the Tribal Behavioral Health Executive Committee and directors. She states that the Mat-Su Health Foundation has worked on the environmental scan and has data needs, which are trying to be met. She continues that a lot of the work over the first eight months was getting the data. She adds that they will be working with the most accurate Medicaid dataset available, which is called JUCE.

CHAIR EASLEY asks what the acronyms EDI and DET stand for.

MS. WAILAND replies that DET is the emergency stabilization treatment data, and EDI is electronic data interface. She states that organizations that are not using AKAIMS are able to transfer data through an interface. She shares some of the graphics that were created to describe systems. She states that the first draft of the provider survey has been completed. She goes through the project breakdown of the different tasks, and describes them as she goes along. She continues that Hornby Zeller Associates and Agnew:Beck talked a lot about not wanting to overestimate the need for capacity expansion and recognizing that unused capacity is important to look at before making any recommendations for expansion. She states the hope to produce, at the end of laying this out, three types of needs: First, would be unmet need; second, the concept of unmet demand; and third, the need for capacity expansion, which is being defined as total likely demand, minus total capacity. She concludes her presentation, stating that the survey results should be available soon, and December will be a great time for another steering committee meeting. She thanks all.

CHAIR EASLEY asks when the project is supposed to be completed.

MS. WAILAND replies originally June/July, 2015, but hopes to do it as early as early March.

CHAIR EASLEY thanks Ms. Wailand, and asks for any questions from the committee or Trustees.

TRUSTEE WEBB states congratulations on getting the data, which is huge and very important.

A short discussion ensues.

CHAIR EASLEY states that the Planning Committee will have some interesting challenges when the report is completed. She moves on to Melissa Kemberling, who will be representing the Mat-Su Health Foundation, which is a partner in this study.

DR. KEMBERLING states that she is the director of program planning and evaluation at the Mat-Su Health Foundation, the nonprofit arm of Mat-Su Regional Medical Center. She continues that the foundation seats half the governing board, and receives a quarter of the profits to reinvest in the community in the form of grants and special projects to promote health. She states that a community health needs assessment was done recently, and the top five priority issues were all related to behavioral health. She lists them as: Alcohol and substance abuse; child trauma, domestic violence and sexual assault; suicide and depression; and access to mental health. She states that this resulted with the foundation creating two new focus areas: A Healthy Minds Focus Area, which is focused on the behavioral health treatment system in Mat-Su; and a healthy foundation for families, which is focused on preventing adverse childhood experiences and helping parents that are dealing with them. She continues that a behavioral health environment scan was needed to see what was going on with behavioral health in the Mat-Su. She states, that was broken up into three separate reports: the crisis response system; the whole treatment system; and prevention. She talks about the crisis response system stating that a report will be published in about two weeks. She goes through a draft executive summary and chart, which she refers to throughout her presentation, explaining the methodology used. She states that the Mat-Su Health Foundation is focused on creating system change, and they want their money to impact the system. She continues that the plan is to share this information so that people will know that the data is out there. She adds that it will be combining this with a larger treatment system.

A short question-and-answer period ensues.

TRUSTEE WEBB thanks Dr. Kemberling for all of the work.

CHAIR EASLEY states that this is some amazing information. She asks Michael Baldwin to introduce the next presentation.

MR. BALDWIN states that next is an update on the research project with the Alaska Association of Developmental Disabilities on the MMIS projects. He introduces Lizette Stiehr, executive director of the Alaska Association on Developmental Disabilities, and Mike Bailey, the vice president of AADD.

MR. JESSEE states that the MMIS problem had a very significant impact on the provider system and, therefore, on the Beneficiaries as well. He continues that the Association approached the

Trustees about trying to dig into some of that impact information. He adds that the study was funded by the Trust and this is the report.

MR. BAILEY states a heartfelt sincere thanks from the provider community for the Trust's recognition of the challenges, and stepping up to provide some independent research. He continues that everyone is very pleased with the quality of the report produced by Information Insights. He adds that it validated a lot of the things that providers have been saying along the way. He continues that the director of Health Care Services, Margaret Brodie, took very seriously all the recommendations from this report, and stated that she would make sure that Xerox incorporated all of these recommendations in the corrective action plan. He adds that there will be ongoing discussions with the provider community to gather other provider associations together and collaborate. He states that this provides some objectivity to what is being explained to the auditors and the banks. Because it is an independent study, it has a lot more merit than just what the providers tell them.

CHAIR EASLEY states that it has bankers recognizing that it is not the fault of people who found themselves in disastrous situations.

MR. BAILEY states that it has validated it as an external factor.

MS. STIEHR states that Ellen Ganley does a good job in this report narrative of talking about how programs have had to hire extra staff, pay overtime, and how many people have quit in frustration. She adds that this has been a tremendous help for provider organizations in terms of understanding the problem and sharing it.

CHAIR EASLEY thanks both for their report.

TRUSTEE WEBB states that Margaret Brodie directed Xerox to implement all of the recommendations. He continues that this has resulted in some action.

A short question-and-answer period ensues.

CHAIR EASLEY moves on and recognizes Mr. Baldwin.

MR. BALDWIN states that next on the agenda is an update of the Medicaid waiver information. He continues that this was a request from the Planning Committee for a clear summary of what the Medicaid waiver programs are, and we will use this as a starting point for a larger discussion around Medicaid waivers and Medicaid.

MS. LOFGREN states that putting together a brief synopsis of what the waivers are and how they fit into the State plan was difficult because there is nothing existing out there. She continues that the brochure is something that Senior and Disability Services has, and gives a brief overview of what the document says. She states that the State plan is the agreement between the Department of Health and Social Services and CMS that allows them to bill for the federal matching funds, FMAP, Federal Medical Assistance Percentage. She continues that the agreement between CMS and that State identifies how the program will be administered, who is

eligible, and what programs are available. She adds that the State plan is an evolving document and can change at any time. She states that it is important to recognize that in order to get into Medicaid waiver programs individuals have to apply for regular Medicaid first. She continues that then Senior and Disability Services actually administers the four existing waivers in the state. She states that those four waivers are separated into two separate areas; one is for individuals that qualified for the intermediate care facility; and the other is for individuals with intellectual and developmental disabilities. She continues that the criteria for this program, the services available, and the assessment used to assess eligibility, are all entirely separate. She adds that the IDD waiver program looks at diagnosis, functional ability, and need for support. She states that the second category of waiver services is based on an individual's nursing facility level of care, and the three other waivers fit under this criteria. She continues that this one is based on an individual's sole functional abilities based on bed mobility, eating, transferring, location, and toileting. She adds that the three waivers that support that is adults living independently. She explains this is adults 21 and older who experience physical disability or functional needs. She then moves to the adults with physical and developmental disabilities waiver, and states that these individuals must meet that functional level of care again, based on those five ADLs, but this group also has to have a developmental disability diagnosis. She continues that the last waiver is the children with complex medical conditions. She explains that these are children under the age of 22 that are oftentimes born with very severe medical conditions. She states that the 1915(k) is actually one of the recommendations under the Medicaid Reform Advisory Group that requires nursing facility level of care. She continues that the incentive is that it increases the federal financial participation rate by 6 percent. Instead of 50 percent, the State would get 56 percent of reimbursement from the federal government on that. She notes that not all services that are currently available under the waiver services are available under the (k) option. She continues that if the State does move to adopt the 1915(k) to replace existing waiver services, there could be some changes in that. She states that at the November board meeting we are looking at a two-hour meeting to do a Medicaid 101 and hit these, in addition to just SDS services, and also look at behavioral health services and how they fit together.

MS. BURKE states that the distinction that Medicaid serves our beneficiaries in many settings, in hospital and doctors' offices, in behavioral health, and in Senior and Disability Services, is important to be made. She continues that the programs that utilize waiver services are all located on the Senior and Disability Services side of the house. She adds that Medicaid is a much broader topic than waivers; although waivers are a frequent topic, because they provide critical resources. She thinks that the presentation in November will really benefit everyone.

MR. BALDWIN states that if there are any questions or anything about the context of the November board meeting, please send questions and topics you would like included.

A discussion ensues.

CHAIR EASLEY asks the Trustees about the presentation for November.

TRUSTEE DERR states that there is already direction.

CHAIR EASLEY moves on to updates, beginning with PRI.

MS. BURKE states that the PRI Committee has met, and the program-related investments conversation has been excellent. She continues that there is definitely progress being made on the policies and the framework for what is being done.

CHAIR EASLEY moves on to Focus Area updates.

MS. BURKE states excitement in speaking of Medicaid services and how the State may move forward in providing services to people with behavioral health issues. She continues that the Division of Behavioral Health released a request for funding proposals for an assertive community treatment team combined within intensive case management services. She adds that this is targeted at the Anchorage area, and is a tremendous advancement in the system. She states that it should really assist the community in addressing the needs of the folks with behavioral health. She continues that there will be rental match vouchers that will be available for the people in the program.

CHAIR EASLEY recognizes Natasha Pineda.

MS. PINEDA goes over some of the highlights of what is going on in the Substance Abuse Prevention and Treatment focus area. She reports that she and Katie had the opportunity to host a lunch with the Division of Behavioral Health Prevention grantees that came together last month in Anchorage for their annual conference. She states they used that opportunity to help inform the focus area around the needs of coalitions in the State to move towards a more effective advocacy. She states that the three topics covered in the coalition behaviors were: how they are being currently advocated; how that works for them; and how data is used in decision-making. She moves on to the polling strategy, stating that the PEC was held on October 13, and a notice of intent to award was put out on October 14. She continues that they are currently in the protest period, and when that ends, they expect to move forward with the contract. She adds that it is a pretty excellent product. She states that the Positive Community Norms Campaign was funded in FY14 and FY15. She continues that there will be an annual report coming soon. She adds that Carley is actively participating on the marketing and media team, and she is actively participating on the evaluation team, as well as the leadership team. She states that the first media is anticipated to be produced and delivered in the spring.

TRUSTEE WEBB asks what a “world café style meeting” is.

MR. BALDWIN replies that it is a focus group methodology that creates an opportunity to have some pointed conversations with a more diverse group of folks and creates a round-robin process of addressing questions basically.

CHAIR EASLEY moves on and recognizes Katie Baldwin-Johnson.

MS. BALDWIN-JOHNSON states that they continue to engage in the Title 4 review initiative with the folks that have been participating on the various subcommittees that have been made up of representatives of industry, public safety, public health, the Trust, and many other partners, and

folks that have been engaged in that work. She continues that in moving forward into the legislative session, the intent is to form a legislative watchdog committee.

MS. LOFGREN announces that there is going to be a first annual Alzheimer's conference for long-term services and supports. She continues that it will be November 12-13, called Vision to Reality. In terms of bringing awareness and education in the state on Alzheimer's disease and related dementia, a small group put together a draft of a roadmap. She continues that the six goals from the roadmap are: Promote awareness and early diagnosis; improve access to appropriate housing services and support; optimize quality and efficiency of services; develop workforce trained in dementia care; improved quality of life for caregivers; and data development to monitor ADRD prevalence, cost and care, in addition to research. She adds that the hope is to finalize that draft and have it released in November, which is Alzheimer's Awareness Month, as well as Caregiver Awareness Month. She states that the second large stakeholder planning meeting was held in September, which was an opportunity to meet with the stakeholders to review the initial findings of the policy recommendation from the Institute for Community Inclusion. She continues, that also facilitated a hybrid world café model strategic visioning that identified work groups, the roles and responsibilities in terms of establishing strategies, indicators, and performance measures for the initiative to move forward. She adds that the work groups will start meeting in November. She talks about the opportunity of meeting with the State Vocational Rehab Council in Fairbanks and presenting on the initiative. She states that the Governor's Council has done a lot of great work with their Alaska Integrated Employment Initiative around transition-aged youth with intellectual and developmental disabilities, which is exciting. She states that anyone who is a certified benefits counselor has to be certified by one organization in the nation that is out of Virginia Commonwealth University. She continues that there are nine in Alaska.

MS. BURKE states that the Trustees are all invited to a presentation tomorrow morning on the core competencies program, which has been a major emphasis in the training cooperative. She adds that Kathy Craft is here.

MS. CRAFT states that a meeting with key substance abuse providers to talk about workforce was held on October 10. She continues that the 2016 to 2019 action agenda is being worked on, and we have the trends report for the projections for need in health workforce. She reports that the career and technical education group has been meeting with mining, oil, gas, maritime, and the health industries on working together with high school teachers and university faculty. She adds that they are working with the Department of Labor on the details of a 2014 scope of work. She states the need to make sure that the data usage agreements between DOL and the Trust can receive individualized data from each agency, and not just by region.

CHAIR EASLEY hopes that the Trustees can attend that meeting.

TRUSTEE WEBB states that one of the biggest issues around workforce issues relates to substance abuse issues. He continues that it is a huge cost for people who, if they lose a driver's license, are out of employment. He asks what has been done on that.

MS. CRAFT replies that the update on that would come from Carley, who has taken that over to work with the Alliance. She states that she is not sure. She continues, that was a large topic of discussion at the CTE, Career Technical Ed Conference. She adds that it is critical because kids are not coming out of high school with this knowledge.

MS. BURKE states that funding went into the public education campaign to target those people who might be at risk. She adds that this is an area that should be looked at and to think about how to use the resources to address the costs that come from substance use.

A short discussion ensues.

MR. BALDWIN states that last is about the Authority Grant roll-up. He asks that the documents be read and contact staff if there are any questions.

CHAIR EASLEY states that time has run out.

MR. BALDWIN apologizes for overpacking the agenda.

CHAIR EASLEY asks Carrie Predeger for her presentation.

MR. JESSEE states that there is no time. He continues that it will be added to the Full Board agenda.

CHAIR EASLEY adjourns the Planning Committee meeting.

(Planning Committee meeting adjourned at 12:31 p.m.)

December 15, 2014

Medicaid Expansion & Reform

Overview

Alaska's Medicaid program provides services to Alaskans in the following demographic categories for a total annual expenditure of nearly \$1.7 billion. If Alaska were to opt for expansion of Medicaid, as many other states have done, it would increase the overall expenditure of the program. However, there are many reasons to consider expansion and reform of the existing Medicaid and emergency response systems. First, is to take advantage of the increased federal match through the Patient Protection and Affordable Care Act. The match rate for newly eligible recipients is as follows (in calendar years):

- 2014-2016: 100 percent
- 2017: 95 percent
- 2018: 94 percent
- 2019: 93 percent
- 2020 and beyond: 90 percent

This timing is critical given that some programs that have provided funds for hospitals to care for indigent populations are being phased out over this same period of time. Without these funds, there will be fewer resources available for the uninsured and more of this type of care will need to be covered by state programs. A second compelling reason for expansion is that it will allow a shifting of high needs individuals who are currently impacting state general-funded grant programs to Medicaid. In an environment where state general funds will be the lowest they have been in many years, this is the time to expand and reform Alaska's Medicaid system.

PRIMARY SERVICE POPULATION

Total service population **145,279** individuals.



SNAPSHOT OF ALASKANS SERVED

- 87,506 (60%) are children
- 2,759 (2%) are disabled children
- 8,197 (6%) are elderly
- 17,011 (12%) are disabled adults
- 29,806 (20%) are adults

Medicaid Service populations, February 2013

FY13 Medicaid Direct Services Expenditures by state agenciesⁱⁱ:

Area	Medicaid	Percentage
Senior and Disabilities Services	\$477,755.5	33%
Behavioral Health	\$168,860.7	12%
Office of Children's Services	\$8,333.0	.5%
Adult Preventative Dental	\$11,653.8	1%
Health Care Services	\$782,188.8	54%

I. How many Trust beneficiaries will be in the new eligible group of recipients? How do we know what systems they use?

Projections vary (between 10,000 to 40,000)^{iii iv} on the total number of individuals who will be added to under expansion of the Medicaid program.

	Limits Under Expansion	Current Limits
Federal Poverty Level	138%	110%
Adults without dependent children	Eligible	Only with documented disability

Additionally, in the Trust's focus area planning, particularly with the homeless population, the people who will be covered by expansion are considered very likely to be Trust beneficiaries with alcohol or substance use issues or some form of mental illness or disabling condition. For instance, the assessment of chronically homeless people with addictions who were homeless in two Alaskan communities revealed populations of people with multiple mental health and physical disabilities ranging from head injury to chronic health problems and severe mental illness^{vvi}. Many of these individuals have not qualified for Medicaid programs despite likely being eligible for a positive disability determination. They have been homeless or in crisis and have been unable to complete the medical determination processes. Some have prior work histories while others may have never been able to maintain stable employment so they remain below the income eligibility for private insurance options recently made available. Many were previously in foster placements as children and young adults. Medicaid expansion would bring these single adults into the program under the expanded financial eligibility and allow them to access Medicaid-funded programs and services with matching federal dollars rather than attempting to piece together services for this high needs population through scarcely funded homeless and behavioral health outreach programs.

The disability justice area has focused on the procedures that need to be in place for a person with a mental illness to re-establish Medicaid once they are discharged from the Department of Corrections or while involved in mental health court. Many of these individuals would qualify for Medicaid as they discharge from the institution. Having social services immediately available has been proven to prevent people from cycling through emergency service systems when there are not consistent community

services available^{vii}. The substance abuse prevention and treatment focus area has been in discussion with Department of Corrections and substance treatment providers about how to increase access to treatment services and the expansion of Medicaid would certainly bring a new layer of resources and workforce challenges to the field. These may be the resources needed to reform this system and to increase the ranks of service providers needed to adequately address the needs in our state.

In addition to these circumstances, there are other examples where people who would qualify for expanded Medicaid are using emergency safety net systems. The General Relief (GR) program, totaling \$11 million annually in state general funds, provides funding for people who come to the attention of Adult Protective Services and need assistance in becoming stabilized, primarily through assisted living home placements. Medicaid expansion would allow beneficiaries who are using state general fund programs such as the General Relief program to transition to lower level services and receive Medicaid reimbursement.

Impact on beneficiaries

Beneficiaries covered under expansion will have access to the same Essential Health Benefits current Medicaid recipients access, including inpatient and outpatient facilities/services, nursing facilities, clinical services, pharmacy, dental, mental and behavior health services.^{viii} The new population eligible for coverage will include many beneficiaries with chronic substance abuse and mental health issues as well as many homeless adults^{ix} and incarcerated persons^x. Those who qualify will have access to mental health and substance use disorder services and are subject to parity requirements.^{xiii} There will be increased access to low cost pharmacy services^{xiv}, expanded services in rural regions and access to support services like transportation.^{xv} Additionally, healthier beneficiaries can contribute to the healthier workforce^{xvi}. Furthermore, Alaska can expect a decrease in statewide mortality^{xvii}.

II. What do we know about expansion and how it will impact the Medicaid system infrastructure?

In Alaska three key groups have worked to identify how and why to expand Medicaid including the AK Health Reform, Alaska Native Tribal Health Consortium and Alaska Department of Health and Social Services. Four key documents to understanding their perspectives are:

1. Medicaid in Alaska: The Opportunities and Challenges of Health Reform released in April 2011 by a consortium of health providers, including the Trust, Alaska State Hospital and Nursing Home Association, Mat-Su Health Foundation, Rasmuson Foundation, and others
2. Healthier Alaskans Create a Healthier State Economy released by ANTHC February 2013
3. State of Alaska Department of Health and Social Services released a summary of Medicaid expansion, State of Alaska Health and Social Services Study prepared by The Wilson Agency February 2013
4. An Analysis of the Impact of Medicaid Expansion in Alaska prepared by the Lewin Group in April 2013 for the Department of Health and Social Services

These reports highlight the complexities and potential framing of the economic and health factors related to increased access to care for all of Alaska's citizens. Issues such as enrollment of new eligible recipients, shifting of state resources, and access to the workforce needed to meet the new demand are all components. However, the payoffs are extremely promising in terms of economic opportunities for local communities, potential federal dollars to leverage for state expenditures currently paid by general fund programs in a declining budget environment, and the potential of increasing the health and wellbeing of Alaskans.

Enhanced safety net services: additional care in primary care locations

Community health centers are the main source of primary care for medically underserved populations. Expansion will enable health centers to expand capacity to serve the uninsured as well as those newly covered by Medicaid. Many of the would-be eligible Medicaid patients are already served by health centers, but their care is currently uncompensated^{xviii}. With cuts to state and federal uncompensated care funding (Federal Disproportionate Share Hospital funds), expansion is timely.

Alaska must leverage market power and expansion to create payment methods that simultaneously contain costs and improve care. Alaska is currently undergoing a redesign of the delivery system to a holistic patient-centered approach, through Patient Centered Medical Homes (PCMH), which is able to meet the full spectrum of a patient's physical and behavioral health care needs. The efforts the state, Trust and Alaska Primary Care Association have placed on PCMH must continue, because this provides the structure, appropriate tools, evidenced based care practices and data to effectively manage newly covered Alaskans.

As the Affordable Care Act changes the landscape of available resources, e.g., reduction of the Disproportionate Share Hospital funds (DSH payments), the Medicaid program must undergo a fundamental reform to be able to sustain an influx of new enrollees. It is Trust staff opinion that we need to focus on both efforts – expansion and better use of the existing program and resources available to us and capitalize on expansion as a catalyst for necessary reform to the behavioral health and seniors and disabilities service systems. This falls in line with our goal to serve as a catalyst for change and to assist with improvement in Alaska's mental health program continuum of care. Medicaid expansion provides an opportunity to accomplish this by engaging as a leader to promote long-term system change to improve the lives and circumstances of Trust beneficiaries.

III. What is Medicaid Reform and how does it relate to Medicaid Expansion?

The Affordable Care Act mapped out new strategies that have helped other states in addressing the needs of people who are cycling through the emergency levels of service delivery and in managing their Medicaid program more efficiently. These changes have been considered and some have occurred in various amounts in the Department of Health and Social Services around the broad categories of *state plan options, rate structures and care settings (location of service)*. These areas will address many of the places where the total Medicaid and grant program systems break down and are less effective. If several

of these changes don't occur, then adding 10,000 – 40,000 new Medicaid enrollees into the system will certainly reduce effectiveness to a greater extent.

Optional State Plan Services

There are two main new state plan options that should allow the state to zero in on people who are physically able to meet assessment standards for independent living but because of a cognitive condition or a dementia and sometimes a lower level mental illness, these people are unfortunately not eligible for some of our most effective home and community based services. These options are 1915 (i) and 1915 (k) of the act.

1915 (i) – serving those who are “falling through the service delivery system cracks”

The implementation of a Section 1915 (i) of the Social Security Act is the State Plan Home and Community-Based Service (referred to 1915(i) hereafter) can provide an array of services for Trust beneficiaries who are at risk of being placed in inappropriate care settings or transitioning out of programs such as a skilled nursing facility, Alaska Psychiatric Institute, intermediate care facilities for individuals with intellectual disabilities, residential psychiatric treatment center, Department of Corrections, and for those who are/at-risk of being homeless.

For beneficiaries who “fall through the cracks” and are not eligible for long-term community supports there can be increased costs resulting from emergency room visits, hospitalizations, and cycling in and out of institutional settings. The 1915 (i) would allow for access to more appropriate and less restrictive community-based services for beneficiaries. This could also be an opportunity for DHSS to refinance some of the existing programs that are funded by general fund, such as:

- General Relief Assisted Living program, which is intended for emergency and temporary placement but has become a default long-term supported housing program for many Trust beneficiaries by placing them in assisted living homes with no clear path out of this level of care.
- The Pioneer Homes for elderly residents with ADRD who do not meet the Nursing Facility eligibility and rely on the State's Payment Assistance Program to fund their care.
- Over half of individuals receiving services through the Personal Care Assistance (PCA) program do not meet nursing facility eligibility but could receive PCA under a 1915 (i).
- Grant services: senior grants, developmental disabilities and traumatic brain injury grant services are currently available to serve beneficiaries to provide a safety net to keep beneficiaries in their home and community. Some of the activities under these grants could be happening through the 1915 (i) program with a federal share in reimbursement.

To implement a 1915 (i) option, states must define criteria based on need, typically a combination of acute medical services (dental, skilled nursing, clinical needs) and long-term services. States have the flexibility to target one or more specific target groups by diagnosis, e.g., people with Alzheimer's disease or related dementia, traumatic brain injuries, serious mental illness or intellectual or developmental disabilities), disability (cognitive impairment or mentally ill), age (65+), or Medicaid-eligible groups (disabled, working disabled). The program can serve multiple target groups with differing sets of services,

but all individuals must meet the same eligibility criteria. Eligibility criteria can be developed to reflect points in the service system where the system fails rather than planning for individual populations of people. Services may include: case management, homemaker, personal care, habilitation, psychosocial rehabilitation, supported employment, supported housing and assistive technology.

1915 (k) – reducing our existing waiver program costs by balancing the system through new options

Section 1915 (k) of the Social Security Act is the Community First Choice Option for Home and Community Based Services (1915 (k) hereafter) service plan option. An implementation plan and cost impact analysis by DHSS has already been completed and it is estimated that this option would save the state over \$15 million annually; due in part to an increased federal matching rate FMAP of 6 percent for this option. The 1915 (k) requires individuals to meet institutional level of care creating an opportunity to replace much of the existing waivers (1915 (c)) in addition to serving those on the Personal Care Attendant (PCA) program that meet Nursing Facility Level of Care. This program wraps in several federal initiatives such as person centered care, use of the Aging and Disability Resource Centers, and is a method to assist states in reforming Medicaid programs. Services include a wide range of home- and community-based services, including hands on assistance, supervision and cueing, supported employment, day habilitation, chore, respite, adult day, residential supported living, and case management.

Rate Restructure

Senior and Disabilities Services Rate Setting:

DHSS contracted with Myers and Stauffer to perform research on effective reimbursement methodologies and to recommend revisions to incorporate acuity adjustment strategies into the rate setting process for certain home- and community-based services. In May 2014, the report was released with recommendations and proposed next steps, which included establishing a tiered reimbursement based on an individual's acuity level of functioning for services under the provision of Senior and Disabilities Services. Follow up projects have been ongoing to help determine a realistic structure for a tiered system and to determine specialized rates, such as assisted living homes for people with dementia.

- **Acuity Based Rate Methodology.** For Residential Supported Living services (Assisted Living Homes, Group Homes, etc.) the recommendations from Myers and Stauffer was to adopt an acuity based rate which is strongly consistent with the request of providers. However, to do so a review of existing assisted living homes needed to identify what level of services and supports are currently provided and how many current licensed homes would meet the criteria of the four tiers established.

Division of Behavioral Health Rate Setting

The Division of Behavioral Health has worked to ensure viability of outreach and engagement programs through the use of some Medicaid services, federal grant programs and housing resources for tenant rental subsidies to ensure stability in permanent supported housing for people with severe mental illness.

The Trust has recently partnered with DBH to have a consultant, the Technical Assistance Collaborative (TAC) review the rates and system structures for a permanent supported housing strategic plan. This will assist DBH in developing the needed state plan options to assist those providers working in the current fee for service system.

- Assertive Community Treatment team funding. The startup of the evidence-based program will be funded on one-time capital resources expiring in 2016. The program model calls for a combined or “day rate” for a large range of needed services in this flexible housing and engagement program for people with the most severe mental illnesses in the community. DBH needs to have the state plan amendment or some other funding option for this program in 2016.

Other Settings Requiring Rate Development:

- Payment reform through a state plan amendment must address allowable reimbursement models which include reimbursement for care coordination, case management, and brief screening and interventions for children and adults in primary care settings.
- Patient Centered Medical Home will be expanded, allowing for those Medicaid eligible persons to access health centers and mental and substance abuse treatment as identified.
- ANTHC identified expanded telemedicine for services which would be used for both traditional care and mental health services.

Care Settings and Case Management

The federal government has issued new rules for how case management and care coordination services are administered and on when services can be considered “community based.”

- Conflict Free Case Management System Design – requires all Medicaid waiver programs to ensure conflict free case management for recipients. This has significant impact on how services are currently being delivered in Alaska, and it is essential that the changes are managed well to minimize disruption for service recipients and retains continuity and knowledge with the existing care coordinators.
- Home setting rule – both CMS (Centers for Medicare and Medicaid) and Housing and Urban Development have come out with guidance about community-based care being in the most integrated settings as possible. This new rule calls into question several program strategies and practices in the state: Assisted Living Home placements need to be justified; co-located housing programs must have qualities of “home” and not mini-institutions, etc. These rules will greatly impact the service system and need attention in the next six months as the federal government begins to monitor progress on reform of systems.

IV. What is the Catch?

There are several points of consideration for the Administration and the Legislature prior to agreeing to expand Medicaid:

- Administration costs
 - Total administration of the Medicaid program costs about 8.2 percent of the total costs of Medicaid. There are concerns that the administrative costs will increase over time to cover needed functions
- Enhancement of the new system to interface with the Health Benefit Exchanges
- Increased time for enrollment
- Outreach to the newly eligible
- Increased need for staff for accommodating new enrollment and program maintenance
- Increased service levels and investment in expanding service levels

Other things to consider include the cost of needed updates to our existing technology system(s) that support eligibility and billing, reviewing current eligibility categories and how new programs will interact with the federal exchange.

It may be tempting to look for quick cost savings to cover these changes over costs with offsets that impact Alaskans negatively in the short run.

Potential long-term offsets identified include:

- Behavioral health grants
- Senior and Disabilities services grants
- Homeless services grants
- Federal health care programs for indigent populations
- Introduce a self-certification of income^{xix}
- Elimination of the Chronic & Acute Medical Assistance^{xx} program
- Costs associated with substance abuse counseling, mental health hospitals, and inpatient services to prisoners^{xxi}

In an initial report on states that have expanded Medicaid and who are serving homeless populations hosted December 15, 2014, the Kaiser Family Foundation reported that several sites with Medicaid expansion reported challenges in the same areas being highlighted in Alaska – there are limited flexible resources that allow for outreach and engagement of hard to serve populations (Trust beneficiaries). A base of grant programs allows Medicaid to be effective at the core service provision for which it was designed. The Trust will work with the Department of Health and Social Services, the Legislature and our stakeholders on implementing Medicaid expansion with an eye toward the best use of state resources, federal programs to reform our system, and increasing the efficiency of our service providers in the process.

- ⁱ Alaska Medicaid Director Report to the Alaska State Senate February 12, 2014. Margaret Brodie, Director DHSS Health Care Services. <http://dhss.alaska.gov/Commissioner/Documents/mrag/Alaska-Medicaid-Overview.pdf>
- ⁱⁱ Alaska Medicaid Director Report to the Alaska State Senate February 12, 2014.
- ⁱⁱⁱ Alaska Native Tribal Health Consortium, Medicaid Expansion Fact Sheet. www.anthc.org/medicaid
- ^{iv} The Wilson Group Gap report, State of Alaska Health and Social Services Medicaid Study
<http://dhss.alaska.gov/Commissioner/Documents/mrag/june24/Wilson%20Group%20gap%20report.pdf>
- ^v Alaska Coalition on Housing and Homelessness: Vulnerability Index, Juneau 2012.
- ^{vi} Anchorage Coalition on Ending Homelessness, Vulnerability Index Sept 2011
- ^{vii} Alaska Mental Health Trust Authority Status Reports: Bridge Home program, Discharge Incentive Program and the HUB program reports have all shown decreased DOC days and admissions when active supportive services are available for people with mental illness and addictions.
- ^{viii} http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf
- ^{ix} http://www.akhealthreform.org/wp-content/uploads/AKHR_medicaid.pdf
- ^x http://justice.uaa.alaska.edu/forum/26/2summer2009/b_homelessness.html
- ^{xi} <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/10/18/medicaid-expansion-seen-covering-nearly-all-state-prisoners>
- ^{xii} [ANTHC Medicaid expansion summary report](#)
- ^{xiii} http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf
- ^{xiv} http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf
- ^{xv} [ANTHC Medicaid expansion summary report](#)
- ^{xvi} <http://www.alaskachamber.com/files/831.pdf>
- ^{xvii} [ANTHC Medicaid expansion summary report](#)
- ^{xviii} National Association of Community Health Centers “State Medicaid Expansion-Considerations for Health Centers”, 1/11/13
- ^{xix} http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf
- ^{xx} http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf and
<http://www.anthctoday.org/news/ANTHC%20Summary%20Report%202013-02-03v%20FINAL%20DRAFT%20dm.pdf>
- ^{xxi} http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf and
<http://www.anthctoday.org/news/ANTHC%20Summary%20Report%202013-02-03v%20FINAL%20DRAFT%20dm.pdf>

To: Paula Easley, Chair
Planning Committee
From: Carrie Predeger, Grants Accountability Manager
Date: 1/27/2015
Re: FY14 Mental Health Trust Authority Authorized
Receipts Performance Summary

MEMO

FY14 MENTAL HEALTH TRUST AUTHORITY AUTHORIZED RECEIPTS PERFORMANCE SUMMARY

General Overview

Each fiscal year, Trustees approve Mental Health Trust Authority Authorized Receipts (MHTAAR) funds to be granted to state agencies for specific operating and capital projects. These entities must have legislative approval to receive and expend Trust funds. In FY14, there were 47 MHTAAR grants awarded, for a total of \$8,899,200. Each of the 47 grants was categorized into one of the following four categories:

- Direct Service – projects that provide services that directly impact the lives of Trust beneficiaries and their family members.
- Planning and Research – projects that support data collection and analysis to aid in the strategic planning of systems improvements.
- Workforce Development – projects that support strategies to build a capable and competent workforce.
- Capital – projects that provide material infrastructure, develop system capacity, and support the improvement in the quality of life for Trust beneficiaries.

Of the \$8,899,200 awarded, project funds were categorized and distributed as follows:

- *Direct Service* projects encompassed nearly 38% (18) of the projects, and received 40.8% (\$3,629,400) of the funding.
- *Planning and Research* projects accounted for almost 32% (15) of the projects, and received 22.9% (\$2,034,800) of the funding.
- *Workforce Development* projects made up 23.4% (11) of the projects, and received 20.6% (\$1,835,000) of the funding.*
- *Capital* projects represented 6.4% (3) of the total projects and received 15.7% (\$1,400,000) of the funding.

* The Workforce Development grants category consists of projects from the Workforce Development Focus Area, as well as the Disability Justice Focus Area that addressed workforce issues.

Grants by Focus Area

Approximately 74.5% (35) of the 47 MHTAAR projects in FY14 were associated with a specific focus area, for a total of \$7,157,400 in funding. The remaining 25.5% (12) of projects fell outside a focus area, totaling \$1,741,800 or 19.6% of total MHTAAR funds.

Of the 35 projects linked to a focus area:

- 45.7% (16) were associated with *Disability Justice* and totaled \$1,830,100 in funding.
- 20.0% (7) were *Housing*-related and totaled \$2,465,000 in funding.
- 17.1% (6) addressed *Workforce Development* and totaled \$1,487,000 in funding.
- 8.6% (3) centered on the *Beneficiaries Project Initiative* and totaled \$575,300 in funding.
- 8.6% (3) were related to *Bring The Kids Home* and totaled \$800,000 in funding.

Grants by Government Entity

Amount of Funding and Number of Projects

For FY14, Department of Health & Social Services, Division of Behavioral Health (DBH) and programs within the University of Alaska (UA) system received the greatest amount of MHTAAR grant funding, receiving 22.4% and 19.4% of total MHTAAR funds, respectively. Similar to previous years, the entities receiving the highest number of grants were the Division of Behavioral Health and the University of Alaska system, each with nine grant projects. A breakdown of the dollar amount and percentage of FY14 MHTAAR funding by government entity is as follows (a description of acronyms is included at the end of this section). A breakdown of the dollar amount of MHTAAR funding, percentage of total MHTAAR funding, percentage of total MHTAAR grants, and the number of MHTAAR grant projects by government entity for FY14 is as follows (a description of acronyms is included at the end of this section):

	\$ Amount	% of Total MHTAAR \$	# of MHTAAR Grants	% of Total MHTAAR Grants
DBH	\$1,994,200	22.4%	8	17.0%
UA	\$1,745,000	19.6%	8	17.0%
AHFC	\$850,000	9.6%	1	2.1%
SDS	\$651,300	7.3%	4	8.5%
GCDSE	\$522,000	5.9%	5	10.6%
ACS	\$465,300	5.2%	3	6.4%
ABADA/AMHB	\$446,000	5.0%	1	2.1%
DOC	\$342,200	3.9%	3	6.4%
DJJ	\$338,800	3.8%	3	6.4%
FMS	\$300,000	3.4%	1	2.1%
OCS	\$280,000	3.1%	2	4.3%
DPH	\$275,000	3.1%	2	4.3%
DOT	\$250,000	2.8%	1	2.1%
PDA	\$138,800	1.6%	1	2.1%
ACoA	\$110,600	1.2%	1	2.1%
EED	\$100,000	1.1%	1	2.1%
API	\$75,000	0.8%	1	2.1%
OPA	\$15,000	0.2%	1	2.1%
TOTAL	\$8,899,200	100%	47	100%

Acronym	Description
ABADA/AMHB	Advisory Board on Alcohol and Drug Abuse/Alaska Mental Health Board
ACoA	Alaska Commission on Aging
ACS	Alaska Court System
AHFC	Alaska Housing Finance Corporation
API	Alaska Psychiatric Institute
DBH	Division of Behavioral Health
DJJ	Division of Juvenile Justice
DOC	Department of Corrections
DOT	Department of Transportation and Public Facilities
DPH	Division of Public Health
EED	Department of Education and Early Development
FMS	Finance and Management Services, Department of Health & Social Services
GCDSE	Governor's Council on Disabilities and Special Education
OCS	Office of Children's Services
OPA	Office of Public Advocacy, Department of Administration
PDA	Public Defender Agency, Department of Administration
SDS	Senior and Disabilities Services
UA	University of Alaska (includes UA statewide, UA Anchorage-Center for Human Development, UA Anchorage-School of Social Work)

Number Served—How Much Did We Do?

The number of individuals served is provided below broken down by project type and the following categories:

- Primary Beneficiary – the traditional Trust Beneficiaries (i.e. individuals with Mental Illness, Alcohol or Substance Related Disorders, Alzheimer's Disease and Related Dementia, Developmental Disabilities, and/or Traumatic Brain Injury).
- Secondary Beneficiary – family members or caregivers providing support to the Primary Beneficiaries.
- Outreach & Education – members of the general public who were the focus of outreach, prevention or education activities (i.e., health fairs, screenings, media campaigns, etc.).
- Professionals Trained – individuals with professional training and various educational backgrounds that are paid to provide care.

When completing their annual MHTAAR Status Report, grantees are asked to provide the number of unduplicated individuals served in each of the four categories (Primary Beneficiary, Secondary Beneficiary, Outreach & Education, and Professionals Trained). Trust staff understands that grantees may be serving individuals that fall into more than one category. However, grantees are asked to pick the primary category that best describes the individuals served through their project. If duplication is not avoidable, grantees are asked to provide an explanation in the *Executive Summary* or *Performance Measure* section of their report.

The following table provides an estimate of the number of individuals served by the FY14 MHTAAR projects. The totals from FY11 – FY13 are included for comparison. It is important to note that the number of grants and types of projects that are funded vary from year to year; thus, contributing to the variance in the total number served each fiscal year.

Project Category	FY14 MHTAAR - Number Served					
	Primary Beneficiary	Secondary Beneficiary	Total Beneficiary	Outreach & Education	Professionals Trained	Total Served
Capital	2,207	0	2,207	0	0	2,207
Direct Service	6,339	2,486	8,825	441	4,872	14,138
Planning/Research	124	0	124	0	0	124
Workforce	111	118	229	0	5,132	5,361
FY14 Total Served	8,781	2,604	11,385	441	10,004	21,830
FY13 Total Served	11,082	7,235	18,317	10,959	9,587	38,863
FY12 Total Served	10,295	4,666	14,961	16,687	7,793	39,441
FY11 Total Served	18,119	3,736	21,855	2,425	7,954	32,234

Project Performance—How Did the Grantees Do?

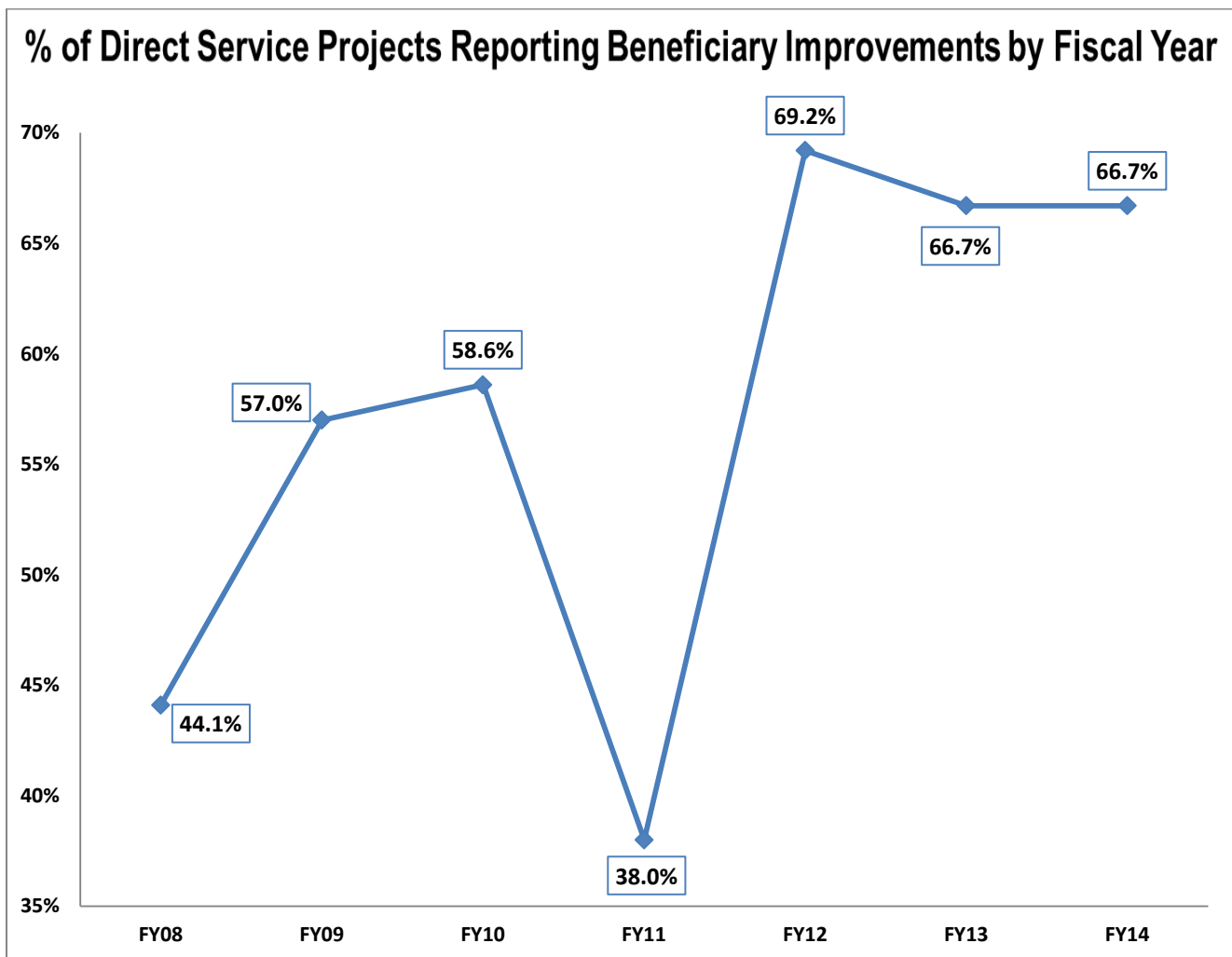
The Trust staff evaluated the FY14 MHTAAR project Status Reports and assigned a rating of Red Light, Yellow Light, or Green Light status. Grants receiving the Red or Yellow Light status rating are projects of concern for Trust staff. For projects rated as Red or Yellow, Trust staff worked with grantees where possible to address relevant project issues and concerns.

Of the 47 FY14 MHTAAR grants awarded:

- one (1) project (2.1%) received a Red Light status rating
- four (4) projects (8.5%) of the projects earned a Yellow Light status rating, and
- the remaining 42 projects (89.4%) were assessed as achieving the Green Light status.

Are Trust Beneficiaries Better Off?

In FY14, 66.7% of direct service projects reported direct beneficiary improvements in quality of life. The percentage reported for FY14 is identical to the percentage reported in FY13, indicating a steadiness of success in reporting project outcomes, as well as a general upward trend since FY08, as shown in the table below for comparison purposes.



There continues to be some suggestion that variance in percentages reported are related to personnel, stability or changes in the project, grantee effort, and timeliness of completing the Status Report. The process of report completion will be reviewed to identify strategies for improving the reporting of outcomes and direct beneficiary improvements in quality of life.

FY14 Mental Health Trust Authority Authorized Receipts Performance Summary

Project Highlights

Project Category: Direct Service

- ***GIFTS ID 124.09, BPI: Mini-Grants for Beneficiaries with Developmental Disabilities (FY14)*** The Department of Health & Social Services – Division of Senior and Disabilities Services served 206 individuals with intellectual and developmental disabilities by the mini-grant program during FY14. The average award was \$1,165 per beneficiary. The mini-grant program provides qualified individuals with a broad range of equipment, supplies and services to improve their quality of life and increase independency. Mini-grant recipients received a range of medical, dental, vision, hearing, physical, occupational, and speech therapy equipment and services, as well as home improvements and environmental modifications.
- ***GIFTS ID 200.10, BPI: Micro-Enterprise Funds (FY14)*** The Governor’s Council on Disabilities and Special Education, through the University of Alaska Anchorage – Center for Human Development, provided \$88,264 worth of funding through the Micro-Enterprise program to assist 17 beneficiaries across Alaska to start their own business. The business types that were funded include: three (3) construction/handyman services, two (2) transportation services, four (4) media/advertising/publishing services, three (3) arts and crafts, two (2) food services, one (1) animal care services, one (1) lodging services, and one (1) hair/nail services.
- ***GIFTS ID 1934.05, Justice: Fairbanks Juvenile Therapeutic Court (FY14)*** The Alaska Court System – Fairbanks Juvenile Therapeutic Court (FJTC) provided treatment to 19 youth involved in the juvenile justice system during FY14. Participants of the FJTC were provided treatment and services from a wide variety of community providers throughout the year, such as substance abuse and mental health counseling services. Through these community treatment providers, underlying treatment-related reasons for an individual’s contact with the juvenile justice system are identified, addressed, and monitored through an individualized court ordered treatment plan in hopes of avoiding the future costs of more expensive treatment services or costs associated with the adult correctional and judicial systems. In FY14, participants experienced positive outcomes (i.e., reduction in the number of days spent in a Juvenile Justice Youth Facility and a reduction in the total number of arrests during participation) and reduced risk of future contacts with the juvenile or adult justice systems. For those who graduated in FY14, all charges were dismissed.

- ***GIFTS ID 575.08, Housing: Bridge Home Program and Expansion (FY14)***

The Bridge Home project, through the Department of Health & Social Services – Division of Behavioral Health, provided assistance to 63 beneficiaries in FY14. Approximately 95% of those individuals in the program (n=60) have stable housing and are living independently or with family members. Participants who were admitted into inpatient psychiatric care during FY14 reduced the number of days spent under care by 86%, when compared to the year prior to participating in the Bridge Home program. For participants who were incarcerated during FY14, a reduction of 36% was achieved in the number of days spent incarcerated, when compared to the year prior to participating in the Bridge Home program. Of the 63 individuals served during FY14, 22 unduplicated individuals engaged in some sort of employment or job training activity.

Project Category: Planning and Research

- ***GIFTS ID 151.09, Alaska Commission on Aging Planner (FY14)***

The Alaska Commission on Aging has been working closely with a core team of stakeholders throughout FY14 to develop Alaska's Roadmap to Address Alzheimer's Disease and Related Dementia (ADRD) in order to increase awareness about ADRD and ways to address this condition. The Trust will be kept informed on the progress as the Roadmap effort continues on into FY15. Additionally during FY14, the Alaska Commission on Aging, along with their advocacy partners, was successful in securing an additional \$545.0 GF/MH for the Nutrition Transportation and Support Services senior grant program, which serves senior Trust beneficiaries who live in the community, but do not qualify for home and community-based waiver services.

- ***GIFTS ID 5175, Workforce: Disability Employment Initiative (FY14)***

Efforts provided by the Governor's Council on Disabilities and Special Education, through the Disability Resource Coordinator, have successfully engaged 40 participants in the Ticket to Work program at the Alaska Job Centers. This program assists individuals receiving Social Security Disability benefits in returning to work and reducing their reliance on benefits. Additionally, benefits analyses were provided to Trust beneficiaries throughout FY14 at the Job Centers to help them better understand how wages impact their benefits, and how to use the Social Security's work incentives in order to keep their medical benefits due to income gained from employment.

- ***GIFTS ID 605.08, Advisory Board on Alcohol and Drug Abuse/Alaska Mental Health Board Joint Staffing (FY14)***

The Advisory Board on Alcohol and Drug Abuse/Alaska Mental Health Board reports that the Advocacy Coordinator position provided advocacy training and assistance with capitol visits during the 2013-2014 legislative session for beneficiary fly-ins and/or local capitol visits for: FASD and Family Voice Summit participants, Youth Policy Summit participants, Meeting the Challenge, the Juneau ReEntry Coalition, the Alaska Peer Support Consortium, NAMI-Juneau, the UAA LEND program, UAF Social Workers, and others.

Project Category: Workforce Development

- ***GIFTS ID 2347.05, Workforce: Workforce Coordinator (FY14)***

In FY14, the Workforce Development Coordinator led the Alaska Health Workforce Coalition (AHWC) members in data and information gathering for the preparation of the 2016-2019 Action Agenda update. Members of the AHWC also continued to make progress with the implementation of the 2012-2015 Action Agenda's forty-three (43) strategies. By the end of FY14, 77% of the strategies were either completed or on track to be completed. Additionally, 30 presentations of Alaska's Health Workforce Vacancy Study – 2012 Findings Report were provided across the state. The study provides a snapshot of the healthcare industry's demand for workers during the fall of 2012 through the winter of 2013. The data has implications for policymakers, healthcare employers and educational institutions and can be used in identifying and addressing key health workforce issues and needs throughout the state.

- ***GIFTS ID 582.08, Justice: Technical Assistance and Implementation of DART Teams in Targeted Communities (FY14)***

Through the University of Alaska Anchorage – Center for Human Development, the Disability Abuse Response Teams (DART) in Fairbanks, Juneau, Kenai, Anchorage, Dillingham, and Ketchikan trained 1,179 providers and 101 primary and secondary Trust beneficiaries across Alaska on interpersonal violence and safety specific to victims with disabilities during FY14. The trainings and outreach within local communities increased awareness of the prevalence of victimization for Trust beneficiaries and the local resources available to assist victims with disabilities to safety, as well as increased confidence in the local experts (the DART teams) in their home community to better assist victims with disabilities.

- ***GIFTS ID 1384.06, Workforce: Trust Training Cooperative and Alaska Rural Behavioral Health Training Academy (FY14)***

The Trust Training Cooperative (TTC) continued to provide statewide coordination and brokering of trainings via distance, blended, and in-person formats for direct service providers and their supervisors. The trainings are focused on non-academic, professional development and continuing education programs to the Alaska workforce that provides services to Trust beneficiaries. In FY14, 3,102 unduplicated participants from 469 provider agencies in 99 communities across the state received training. A new endeavor in FY14 was the TTC's collaboration with the Adverse Childhood Experience (ACE) Interface project, led by the Alaska Children's Trust. The TTC was contracted to support ACE training through the Learning Management System database for statewide management, tracking, and marketing. Also this fiscal year, Mental Health First Aid training continued to expand, with the TTC leading the statewide coordination. Over the course of FY14, there were 37 trainings held in 13 communities throughout Alaska, resulting in a total of 759 individuals being certified in Mental Health First Aid. Based on increased national and state interest in the training, the TTC was also invited to present on the topic of Mental Health First Aid to Alaska legislators during a "Lunch and Learn" session in February.

Project Category: Capital

- In FY14, Trust funds were used to leverage funds for the Special Needs Housing Grants program and the Basic Homeless Assistance Program. Through the Special Needs Housing Grants program, 212 households received housing assistance. In FY14, the Housing First Program evaluation concluded that the annual cost per tenant for the usage of safety services decreased by 57%. Additionally, tenants of the Housing First project reported drinking significantly less frequently, having an improved sense of safety, and spending less time feeling depressed or anxious. Through the Basic Homeless Assistance Program, 2,207 beneficiaries received prevention and intervention assistance to prevent and reduce homelessness.

To: Paula Easley, Chair
Planning Committee
From: Michael Baldwin, Evaluation & Planning Officer
Date: 1/27/2015
Re: Focus Area – MMIS Updates from Program Officers

MEMO

The following informational updates on the MMIS system impacts on the Developmental Disabilities providers, and key Focus Area related activities, outcomes and events was collected from the program officers and key focus area staff.

MMIS update - Alaska Association on Developmental Disabilities – Amanda Lofgren

MMIS IMPACT STUDY

- Information Insights has developed a survey for the nine providers originally interviewed to develop the report. It asks for information regarding additional work hours, staff hired and other issues required of providers due to the problems with the Enterprise system. Information Insights intends to develop a formula that could be used by providers to quantify the costs experienced with reduced reimbursements and multiple denial claims for more than one year. The survey being used to collect information is to be completed by January 9th.
- AADD providers continue to struggle working with the Xerox agency. In January, Xerox is changing their billing cycle. Prior to the change, bills were due to Xerox by Thursday and payment was made the following Wednesday. Now bills will be due on Mondays and payment will be on Fridays. There was no mention of this change through E-Alerts, or state updates, nor was it mentioned during the most recent monthly Webinar held on Xerox issues. Notice was buried in Medicaid updates and no explanation was made as to why this change had to be made.
- Xerox notified providers that for bills which exceed timely filing (over 12 months old) will require an appeal process. Because of the multiple errors on the fault of the Xerox system, some services (such as group habilitation) were not able to be billed for nine months (October to the following July). The multiple error codes caused approximately 30% of claims to be rejected for errors, the majority of which were caused by Xerox. Due to these problems and concerns, former Commissioner Streur wrote a letter, dated Feb. 2, 2014 stating that providers would not be penalized for bills past timely filing dates if the delay was caused by Xerox. Having to complete an appeal on each bill which has exceeded timely filing will require research and a report documenting the cause of the rejection, which the provider will now have to compile to explain Xerox's error. We are hopeful of working out an expedited system with Margaret Brodie and the Commissioner for this process.

- The January Webinar on the Xerox Enterprise site was spent addressing the multiple errors still impacting payment of claims. Providers continue to struggle with the difficulty in getting recipients eligibility accepted into the system so their services can be billed. While providers may have been notified that a recipient is eligible, the Xerox system still returns bills with an error code saying they are not eligible. This difficulty is combined with the well-known issue of delayed eligibility determination for Medicaid services within Public Assistance.

Long Term Services and Supports – Amanda Lofgren

Acuity Rates

- The Department of Health & Social Services contracted with Myers and Stauffer to research the Medicaid Home and Community Based Services Waiver reimbursement methodologies to provide recommendations for Residential Supported Living (Assisted Living Homes) to include acuity adjustment strategies into the rate setting process. In order to build upon this work, January through June, SDS and providers will begin to review the regulations and Conditions of Participation to clearly define service expectations to develop the rate methodology. Additionally, there is significant variation on business models employed in the delivery of over 630 Assisted Living Homes (e.g., “mom and pop”, shift staff, nursing staff, specialized population, etc.) that affect cost.

Of significant concern are beneficiaries with dementia or behavioral health needs because the current capacity to serve them in an Assisted Living Home without an acuity structure in place puts them at risk for institutionalization. The current acuity add on is an all or nothing rate requiring 24/7 one on one care, for which very few beneficiaries qualify, despite needing additional care beyond the standard rates currently in place by DHSS. Senior and Disabilities Services indicated its preference to adopt a four level tier designation as recommended by Myers and Stauffer. This includes:

Tier 4: An individual meeting presumed Nursing Facility level of care with skilled nursing needs consisting of at least one of the following:

- Seven (7) days a week of injections/IV feeding, feeding tube, suctioning/tracheostomy care, treatments/dressing, oxygen, assessment/management, catheter care, or comatose condition defined in the Consumer Assessment Tool (CAT) Section A, items 1 through 8.
- At least 3 days per week of ventilator respirator care defined in CAT Section A, item 9.
- At least 1 day per week of uncontrolled seizures defined in CAT Section A, item 10.
- At least 5 days a week of therapy as defined in CAT Section A, item 11.
- At least 3 Activities of Daily Living (ADL) requiring extensive assistance or total dependence in CAT Section E.

Tier 3: An individual who meets Nursing Facility level of care with either impaired cognition or behavior problems, with at least one ADL need in areas including: bed mobility, transfer, locomotion, eating and toilet use.

Tier 2: An individual who meets Nursing Facility level of care with professional nursing needs below the level of presumed eligibility, and is without an identified cognitive or behavior problem.

Tier 1: An individual with ADL needs below the extensive assistance level in at least three of the areas including bed mobility, transfer, locomotion, eating and toilet use OR not meeting the definitions for any of the above defined tiers.

Conflict Free Case Management

- A group from the Community Care Coalition, which includes representation from AADD, PCA Provider's Association, AgeNet, Care Coordinator Association, Alaska Behavioral Health Association and the Assisted Living Association of Alaska began meeting with SDS to start looking at how conflict free case management (CFCM) changes now required by CMS will affect the current service delivery system and proactively identify strategies to adopt a CFCM system.

With multiple efforts underway within DHSS to implement case management/service coordination for Medicaid recipients, it was felt that this was a great opportunity to look more broadly than just the Home and Community Based Waiver case management services to mitigate confusion or duplication of services for the service recipient.

The group convened a stakeholder meeting for two days on Jan. 12 and 13, with statewide representation and national experts to understand the CMS requirements regarding Conflict-Free Case Management and to address the following objectives:

- Understand the ways in which Alaska's current case management approach is out of compliance with the CMS regulations.
- Identify and describe the various case management approaches currently operating in Alaska.
- Share case studies of conflict-free case management approaches from other states.
- Identify the decisions that must be made to design a conflict-free case management system for Alaska.
- Identify goals for conflict-free case management in Alaska.
- Identify key components for system design.

Following this meeting, the group will meet one additional time in order to have a completed report which will outline a conflict free case management system design by February 18th. This will allow for the Community Care Coalition, Senior and Disabilities Services and other stakeholders to develop an advocacy plan in the event there needs to be a capital fund request. Senior and Disabilities Services will also need to immediately begin drafting the regulations so they can be submitted to CMS by January 2016 so they can be approved prior to submitting the Home and Community Based Waiver State Plan renewal which is due July 1, 2016.

ADRD Roadmap

- The ADRD Roadmap was finalized in December, in which the core planning team identified 7 strategies to be implementing. Some of these strategies align with the Long Term Services and Supports strategies identified within the Housing focus area.

STRATEGY	CONVENER
1.1.1 Educate Alaskans about prevention, diagnosis, treatment, costs and appropriate care for people with ADRD through all possible media, in-person presentations, and policy advocacy.	Alzheimer's Resource of Alaska
2.1.1 Assess feasibility and design an implementation plan for a potential 1915 (i) and 1915 (k) HCBS State Medicaid Plan amendments.	The Trust

2.4.1 Identify the DHSS resources needed through 2025 and 2035 to ensure those with ADRD can remain living safely in their own home or family caregiver's home for as long as possible.	Senior and Disabilities Services
3.2.1 Develop and implement regulations for quality standards for assisted living homes and other residential settings so that caregivers' skills are appropriate to the population they serve.	Office of the Long Term Care Ombudsman
4.2.1 Increase dementia care training across the continuum of care and in complementary fields such as police, emergency services, finance, justice system, nursing, dental, optometry, social work and mental health.	Pioneer Home
5.1.1 Increase training to caregivers about ADRD, resources available and approaches and strategies for providing care and reducing stress and fatigue.	AARP
5.1.2 Increase in-home respite and adult day services to meet caregiver needs for appropriate breaks in providing care.	Alaska Commission on Aging

Beneficiary Employment – Amanda Lofgren

- In January, the Beneficiary Employment Initiative began hosting time limited workgroups to identify population level indicators, strategies and performance measures to increase employment outcomes for beneficiaries. This will include using the recommendations from the Institute for Community Inclusion policy review. All of the workgroups will report back to a large stakeholder group on May 12, 2015 to review all of the work completed.
- Please see the attached employment initiative planning framework document, which provides an overview of the Employment Initiative structure and process, including roles and responsibilities for stakeholder workgroups, and a timeline.

Disability Justice – Steve Williams

Training or Criminal Justice Personnel

- The Alaska Court System held a three day training for team members of the adult mental health courts (Anchorage, Juneau, and Palmer). The training covered a variety of topics including mental health and cognitive disorders, psychotropic medications, integrating criminal risk assessments with mental health and substance abuse assessments, and use of incentives/sanctions. It was a great opportunity for the individual teams to receive training as a collective. Furthermore, teams were able to discuss challenges, identify solutions and share success stories with each other.
- The Anchorage Police Department (APD) held its 15th *Crisis Intervention Team* training academy in December. There were over 25 graduates from this academy including seven members of the Anchorage Police Department and five members of the Alaska State Troopers. To date there have been approximately 160 APD staff trained including 75 APD patrol officers.

- A relationship with the Alaska State Troopers (AST) has been established and the Trust is in discussion with AST on ways to expand their training curriculum on mental health disorders in the Trooper Academy.

Sustaining & Expanding Therapeutic Courts

- Through the *Criminal Justice Workgroup's Therapeutic Court* subcommittee, work continues to enhance the current standards and guidelines for the therapeutic courts statewide as well as monitoring capacity utilization and participant outcomes.
- The Juneau Mental Health Court's case coordinator position is open. During the recruitment and hiring period no new referrals are being accepted.
- In an effort to identify options for addressing the needs of criminally justice involved beneficiaries in Barrow Trust staff met with Judge Jeffery and Quinlan Steiner and Liz Pedersen from the Public Defender Agency. The preliminary outcome of the meeting was to investigate the possibility of replicating Bethel's *Social Services Specialist* model in Barrow.

Reentry Efforts

- An operational review and analysis of the Department of Corrections' *Assess, Plan, Identify and Coordinate (APIC)* program is underway. The goal of this review is to assess if the program as structured is optimal and identify any areas for possible improvement. Any needed program changes will be made and implement by the start of FY16.
- Trust staff is working closely with the Department of Corrections as it launches its *Alaska Prisoner Reentry Initiative* and implements its Offender Management Plan (see attached policy). Towards that end, the Department held its first steering committee related to these efforts in November. The committee is comprised of department staff, other state agencies, and community providers. An area that the Trust might support these efforts is through the local reentry coalitions that have been developed in Anchorage, Dillingham, Fairbanks, Juneau, and Mat-Su, for example supporting a local reentry coordinator in these communities. The committee is scheduled to meet again in late March.

Key Upcoming Event

- Annual Offender Conference - March 31st & April 1st

Workforce Focus Area – Kathy Craft

AK Health Workforce Coalition Planning

- The Alaska Health Workforce Coalition continues to revise the AHCW Action Agenda for 2016-2019. At present, the following priority occupations are being recommended: Direct Support Professionals; Behavioral Health (including Behavioral Health Aides); Primary Care Providers/Practitioners (including Community Health Aides & Medical Assistants); Oral Health; Health Informatics; Pharmacists (including Aides and Assistants); Nurse and Nurse Educators; and Therapies (including Physical Therapy, Speech & Language, Occupational; including Aides & Assistants). The Systems Change and Capacity Building strategies being considered include: Healthcare System Infrastructure; Training & Professional Development; Engage and Prepare Alaskan Youth for Health Careers; Health Workforce Recruiting & Retention; Health Workforce Data; and Health Workforce Policies.

Competent Workforce and Training Infrastructure

- During the winter and spring of 2015, the McDowell Group will conduct a 360 review of the Trust Training Cooperative in an effort to ensure statewide customers are satisfied with the services received and trainings offered. Once the review is completed the TTC will be rebranded with a new name, recommendations will be implemented and the website will be refreshed.
- Alaska hosted five webcast sites for the 6th Annual Rural Behavioral Health Practice Conference: Integrated Care in Rural Practice in late fall 2014. The sites included: Homer, Ketchikan, Juneau, Fairbanks and Anchorage. Individuals in remote locations also participated via single sites.
- Marketing efforts continue to enhance implementation of the Alaska Core Competencies for Direct Support Professionals. Strategies being considered include, an implementation workgroup for oversight of the project; two public education “a day in the life of ...” (health careers) efforts will be done through a digital process; a professional article describing Alaska’s Core Competencies best practices will be released; a presentation at an Alaska based conference will be conducted; and outreach to various health employers throughout Alaska will be completed.

FY15 Alaska Healthcare Workforce Coalition Legislative Priorities

- The AHCW FY15 Legislative Priorities include:
 - Alaska’s Area Health Education Centers
 - UAA Licensed Marriage and Family Therapy Program
 - Family Living Wage for Direct Support Professionals
 - Health Workforce Recruitment & Retention
 - Alaska Medical Resident Training

Substance Abuse Prevention and Treatment Focus Area – Katie Baldwin and Natasha Pineda

Overview

The primary work related to the SAPT focus area includes continued collaboration on joint Recover Alaska strategies, continued focus on the Title 4 statute rewrite and attention on Alaska’s implementation of Proposition 2 (Marijuana). Trust staff attended the Colorado Chief of Police’s Conference, in January, focused on the impact of marijuana on public health and safety in Colorado along with a fairly large group of public health, behavioral health, court and police representatives from Alaska.

Focus Area:

Emerging Issues:

- Considerable effort among our partners and the Department of Corrections Recidivism and Reduction plan has provided opportunities for the Trust to consider engaging and supporting mutual strategies through the SAPT focus area. Presently we are waiting for the Governor to appoint a Commissioner of Department of Corrections and for the department to release the final Recidivism and Reduction Plan. Areas of potential support include:
 - Prisoner re-entry coalitions;
 - Access to effective treatment; and
 - Prevention strategies focused on children of incarcerated parents are strategies.


Strategies:

- *Title 4 Initiative:* Now that the final recommendations are drafted and the report has been released, the ABC board and Trust are gearing up for the upcoming legislative session.
 - The ABC board members, staff, and Trust have and will continue to provide presentations on the Title 4 rewrite recommendations to a number of stakeholder groups including the Alaska Native Health Board, Alaska Tribal Behavioral Health Directors, Alaska Association of Chiefs of Police, Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board, Municipality of Anchorage Assembly Committee on Alcohol and Substance Abuse and the Alaska Municipal Attorneys.
 - Cindy Franklin, ABC Executive Director, also met individually with Governor Walker to provide an overview of the Title 4 review process and recommendations.
- *Alaska Wellness Coalitions & PCN Media Project Funder Collaboration:* the AWC media campaign to reduce underage alcohol use is fully underway.
 - The media team, comprising AWC members and Northwest Strategies has been working hard to produce a campaign that can be launched within the established timeline. The initial launch is set for March 2015.
 - The evaluation team, comprising Alaska Research and Evaluation Services and AWC members have reviewed baseline data and will shortly have the formative evaluation completed.
- *Marijuana:* We are continuing to work on tracking and engaging on this issue through convening stakeholder dialogue, attending community meetings, engaging the public health community to identify data of importance in tracking the short and long term impact of the issue and engaging in identifying opportunities to engaging in education and outreach.
 - This will be a continuing area with increasing staff effort over time.
 - Here is the link where you can sign up to receive regular updates as marijuana regulation and enforcement develop,
<http://commerce.state.ak.us/dnn/abc/Resources/MarijuanaInitiativePublicInterestForm.aspx>.

Recover Alaska:

- Recover Alaska recently funded a data journalism media project with the Alaska Press Club. Seven news organizations from around the state gathered in Anchorage for a week long intensive training on data journalism. Experts from the Knight Foundation and Al Jeerza America were on hand to instruct and help the journalist
- Subcommittees:
 - Positive Social Norms was convened by Roald Helgeson and Elizabeth Ripley on December 16. The agenda included updates from active/upcoming social norms campaigns and a facilitated discussion on how to constructively work together. Presentations by many partners covering many topics contributed to a robust dialogue.
 - Polling Strategy: On December 15, 2014, the Trust executed contract with Westat to complete comprehensive collection of knowledge, attitudes and beliefs of Alaskans related to substance abuse. It is anticipated this project will be completed and available for release in September 2015.
 - Recovery Resource Center: Under the Recover Alaska subcommittee leadership of Michele Brown (United Way of Anchorage) and Tom Chard (Alaska Behavioral Health Association), the committee is moving forward with concept development of a "Recovery Resource Center."
 - **The intent of the strategy is to:**
 - Improve access and reduce confusion about where to get information and referral for assessment and treatment to decrease alcohol dependency.

- Provide assistance to reduce barriers (internal and external) that hinder ability to access assessment and treatment services.
 - Collect and document real time information on Alaskans' needs, availability of services and billing options.
- Staffing:
 - Pending arrangement with Foraker, Recover Alaskan's new fiscal agent, Recover Alaska will be hiring a permanent Executive Director to replace Aleesha Towns-Bain who is the current acting director. Aleesha will resume her position of program officer with Rasmuson in June 2015.

	State of Alaska Department of Corrections Policies and Procedures		Index #:	818.01	Page 1 of 4	
			Effective:	9/2/2014	Reviewed:	
			Distribution:	Public	Due for Rev:	9/2018
	Chapter:	Classification				
	Subject:	Offender Reentry Program				

I. Authority

In accordance with 22 AAC 05.155, the Department will maintain a manual comprised of policies and procedures established by the Commissioner to interpret and implement relevant sections of the Alaska Statutes and 22 AAC.

II. References

Alaska Statutes:

33.30.011

33.20.030

III. Purpose

To establish procedures and set forth conditions that provide for a seamless plan of services and supervision that encompass the reentry process from remand through the institutional and community phases of reentry. This process includes the screening and assessment of an offender's risk/needs and strengths, the offender's enrollment in programs that reduce risk and address his or her needs during confinement, and provides for reentry interventions and services that continue through an offender's transition, reintegration and aftercare in the community.

IV. Application

All Staff and offenders

V. Definitions

As used in this policy the following definitions shall apply:

- A. Reentry: The evaluation, planning, and programming conducted, along with the support services provided, to prepare and assist offenders to return safely to the community and successfully discharge from supervision.
- B. Offender Reentry Program: A comprehensive three-phased approach to offender management and reentry services. This three-phased approach consists of initial screening, assessment and referral to inmate programming (Phase One), program completion, release preparation and planning (Phase Two), and release to community supervision, services and ultimately discharge from supervision (Phase Three).
- C. Risk/Needs/Strengths Screening Instrument: An objective validated screening version of the department's full assessment instrument that provides for initial screening of risk, need and strengths.
- D. Risk/Needs/Strengths Assessment Instrument: An objective validated assessment instrument that measures an offender's risk to reoffend and identifies the criminogenic needs that are associated with the management and reduction of offender risk.
- E. Offender Management Plan (OMP): An offender-specific supervision and services plan developed with the offender and probation staff that is based on the assessment of an

offender's risks/needs and strengths which detail the offenders programming, supervision and reentry expectations. The OMP is designed to assist the offender by identifying and addressing specific criminogenic needs that are a barrier to behavioral change and successful transition from confinement to integration to the community.

- F. Notice of Release (NOR): The Notice of Release to supervision is a document prepared by the Institutional Probation Officer for all offenders releasing to formal community supervision. The document is prepared at least 30 days prior to an offender's release from custody, or 90 days prior to release of sex offenders.
- G. Institutional Probation Officer (IPO): The IPO is responsible for case management of all incarcerated offenders. The officer is responsible for processing classifications, furlough applications, parole reports, release planning, and the oversight and development of the Offender Management Plan (OMP).
- H. Field Probation Officer (FPO): The FPO is responsible for case management of all offenders released into the community on probation and/or parole supervision. The officer is responsible for ensuring compliance with conditions of release and the reentry process as indicated in the OMP.
- I. Reentry Provider: A community-based group of agencies and/or individuals formally or informally organized to address the programming services and supervision needs for offenders as part of the State's prisoner reentry framework.
- J. Institution Reentry Committee (IRC): A committee, led by the Institutional Probation Supervisor/Officer, established within each institution that reviews, updates and assists in the development of each offender's OMP. Committee membership includes representatives who can address the areas of an offender's risks and needs including, but not limited to, education, vocation, mental health, medical, substance abuse, security, probation and, where available, community providers of reentry services and programs that will be part of the offender's aftercare and continued treatment upon their release.

VI. Policy

The Department of Corrections (DOC) shall develop an OMP for all sentenced offenders who score low moderate or higher on the Department's Risk/Needs/Strengths Assessment instrument. The OMP shall be based upon the offender's assessed risks, needs and strengths. It will detail programming activities, enrollment and referrals which guide internal Departmental processes that are necessary for successful community reintegration.

VII. Procedures

The Offender Reentry Program shall consist of a three (3) phase approach:

- A. Phase One shall address assessment, classification and programming
 - 1. Within the first 24 hours of admission all newly remanded offenders shall receive an initial Mental Health/Medical screening and PREA screening, and will be considered for eligibility for community residential center (CRC) placement.
 - 2. Within five working days of remand all offenders shall receive an initial classification pursuant to P&P 700.01 to determine each offender's housing by custody placement. If identified during the initial classification, they will be referred to education and substance abuse to determine placement need and additional services, which may include parenting for offenders with children under the age of 18, GED/ABE services for offenders without a high school diploma.

3. All pre-trial programming placements are reserved for those un-sentenced offenders who are court-ordered, or have been recommended for treatment by the parole board. All other offenders may access available programming if space is available.
 4. All offenders sentenced to 30 or more days, within five days of completion of their time accounting, will receive the department's identified initial Risk/Needs/Strengths screening. If a current Risks/Needs/Strengths screening has been completed within the past year, you may use that screening for placement and referral.
 5. All offenders who scored medium risk or higher on the initial Risk/Needs/Strengths screening instrument shall receive the department's full Risk/Needs/Strengths assessment within 30 days of arrival at their designated facility. Offenders who score low-moderate or higher on this instrument shall be referred to the education department to determine placement need for the Cognitive/Behavioral and/or Anger Management programs. Offenders with current or untreated substance abuse issues shall be referred for substance abuse screening and referral. The IPO shall use this assessment to begin the development of each individual OMP.
 6. The OMP (Phase One) is initiated within 30 days of arrival at the designated facility and continues until transition to community supervision. It is the first step in the offender reentry process. Phase One shall include:
 - a. Screening/assessment results;
 - b. Referrals, start dates, progress notes, pre-test scores for all program areas that use pre- and post-testing, to include; TABE (education), HIQ (anger management), CSS-M (Criminal Attitudes Program), substance abuse initial screening placement, and others as indicated;
 - c. Sex offender risk assessment if there is a current sex offense;
 - d. Evaluation of career compatibility and vocational interests and programming needs;
 - e. If the offender has children 18 years or younger, referral to parenting class;
 - f. Post-test scores for completed programs, completion dates and program summary notes for completed programs.
- B. Phase Two consists of release planning and preparation.
1. The updated OMP shall be completed prior to an offender's release and/or placement on furlough, or at a minimum, three months prior to an offender's official release date. The updated OMP shall include:
 - a. Summary of treatment programs/services completed;
 - b. Summary of treatment programs/services that continue to be needed;
 - c. Summary of community services and programming needed to include reentry providers, services and programming;
 - d. A community release plan that shall include Risks/Strengths/Needs in the following areas:
 - i. Housing;
 - ii. Employment;
 - iii. Positive social support;
 - iv. Family reunification;
 - v. Substance abuse treatment needs;
 - vi. Education;
 - vii. Finances;
 - viii. Legal obligations;
 - ix. Transportation;

- x. Medical/Mental Health support;
- xi. Other, as indicated by the Risk/Needs/Strengths assessment.
- 2. Description of specific programming and service activities that need to occur in order to help ensure a successful community reintegration.
- 3. All felony offenders releasing to formal community supervision will receive a NOR.
- 4. When releasing to formal community supervision the IPO shall notify the FPO 30 days prior to release of the offender, unless the offender is classified as a sex offender in which case they will be notified at 90 days prior to release. This notification will be made by e-mail to the field office to which the offender will be releasing. In addition the IPO is expected to make direct contact with the FPO or the designated office to ensure this transition. At a minimum this should occur no later than seven days prior to an offender's release. A printed/signed copy of the NOR shall be placed in the institutional file with a signed copy forwarded to the field office.
- 5. Phase Three consists of release and supervision services.
- C. The community phase begins upon release. It involves immediate and short-term enrollment and/or referrals for services and also involves long-term stabilization of the offender and the development or establishment of relationships with appropriate community support networks.
 - 1. For offenders being released to community supervision this phase is pursuant to Policy & Procedure 902.03 and includes:
 - a) FPO support and supervision;
 - b) OMP review;
 - c) Updated Risks/Needs/Strengths assessment, if indicated;
 - d) Completion of court and/or Parole Board requirements;
 - e) Enrollment in community provider and after-care services.

VIII. Implementation

This policy and procedure is effective as of the date signed by the Commissioner. Each manager shall incorporate the contents of this document into local policy and procedure within fourteen (14) days of the effective date. All local policies and procedures must conform to the contents of this document.

9/2/2014

Date

SIGNATURE ON FILE

Joseph D. Schmidt, Commissioner

Department of Corrections

Applicable forms: 818.01A Notice of Release

Original 7/18/1986

Revised 7/19/1995

Revised 12/28/2011 (renamed Offender Reentry Program)

Revised 7/1/2014

AMHTA Beneficiary Employment Engagement Focus Area

Employment Initiative Planning Framework

December 24, 2014

Overall Purpose

Increase employment outcomes for beneficiaries.

Result Areas/Overarching Goals

1. Beneficiaries have increased employment outcomes through access to community services and supports.
2. Businesses increase the hiring of beneficiaries.
3. Beneficiaries have increased self-sufficiency or meaningful activities.
4. Increased utilization of employment programs by beneficiaries.
5. Increased capacity for providers to support beneficiaries seeking employment.
6. Policy, data development and program evaluation.

Stakeholder Group

Structure/Composition/Process

- Consistent engaged group of 30-40 stakeholders (e.g., attendees from September 26th meeting).
- Meet a minimum of two times a year to hear report outs from workgroups and related activities.

Roles/Responsibilities

- Informs and provides input on beneficiary employment planning efforts.
- Updates from the Trust, other stakeholders, on beneficiary employment activities.

Workgroups

Structure/Composition/Process

A. Structure and preliminary ideas re: direction and intersection with other groups

Note: These workgroups will encompass all beneficiary groups; however, when needed and/or appropriate, convene around specific service delivery systems or beneficiary groups. This is in addition to working in collaboration with the Alaska Integrated Employment Initiative, Disability Employment Initiative and various Criminal Justice groups working to reduce recidivism.

Workgroups will include but not limited to: Trust advisory boards, advocacy and provider organizations, beneficiaries, families, and businesses, respective divisions within the Departments of: Labor and Workforce Development, Health and Social Services, Corrections, Education and Early Development, and other stakeholders.

The purpose of these groups will be to identify population level indicators, strategies and performance measures for the Trust's Employment Initiative. *Please note- majority of these groups are time limited and are for initiative planning only.*

1. Data Management and Employment and Service Definitions

The primary purpose of the Data Management / Service Definitions workgroup is to examine existing data collection and management across service delivery systems and to

extrapolate data elements that are relevant population level indicators of employment for Trust beneficiaries. As relevant and useful data points are identified, the group will identify data that may be useful yet are not currently being collected and make recommendations to data management systems on incorporating them in future research.

As data often drives service delivery options within systems, identifying common service definitions across state departments and agencies and facilitating adoption of those definitions in policy will assist with streamlining provider qualifications and certifications and provide a basis for quality assurance and standards in service delivery to beneficiaries.

2. Policy

Members of the policy workgroup will be tasked with examining existing employment policies in Alaska and work with stakeholders to identify potential areas for improvement.

The recent policy review completed for the Trust by the Institute for Community Inclusion has a significant amount of recommendations on policy and regulation that can assist the group with defining areas of priority based on their overall impact, current and future potential for positive changes and developing an action plan to work with agencies in enacting these changes.

3. Workforce Development

This group examines the capacity of the service provider network in Alaska while at the same time look at what type skills is needed to support beneficiaries to obtain and maintain suitable employment leading to increased independence and the ability to build assets and become more self-sufficient.

Through increased access to provider training with common core competencies that are recognized and adopted across systems, and evidence based practices, this will create a streamlined; there will be a more efficient provider training network statewide.

4. Beneficiary Training and Self Sufficiency

This group will work with beneficiaries to ensure access to user friendly training such as: understanding benefits, employment programs, economic literacy and budgeting, asset building and other training that improves access to quality information and skill development training for beneficiaries.

This is essential for beneficiaries to understand how working may impact their benefits, develop a skill set that is conducive to finding suitable employment and becoming more self-sufficient.

5. Transition Age Youth

The Transition Age Youth workgroup will focus on systems affecting successful transition from school to adult life for beneficiaries with an increased focus in coordination between schools, Division of Vocational Rehabilitation and Department of Health and Social Services to create opportunities for blending and braiding of funding. This includes looking at Pre-Employment Transition Services, services and supports, programs offered through the school system, evidence based best practices, family supports, engaging employers to participate in school to work programs and other opportunities for youth to access and maintain competitive employment.

6. Behavioral Health

This group will focus on best practices and strategies to increase and/or implement employment services throughout the behavioral health system and collaborate closely with the newly formed Integrated Housing and Services Office within the Division of Behavioral Health. Strategies this group may consider include:

- Increase collaboration with employment service system and programs such as: Vocational Rehabilitation, Job Centers, Social Security Ticket to Work program that is sustainable,
- Implement evidence based practices such as Individual Placement and Support, and other practices that benefit individuals experiencing mental illness and/or substance abuse.

The group can also consider potential Medicaid policy changes that would support provision of employment services.

7. Community Engagement and Meaningful Activities

This workgroup will explore effective community engagement strategies for beneficiaries to engage in meaningful activities as a possible opportunity to lead to employment. While traditional competitive wage employment has been shown to have many positive effects on the overall mental and physical well-being of individuals, activities such as subsistence, increased social engagement in community activities and organizations and other life skills components are also significant in recovery and well-being. Through a review of policy and billable services, recommendations from the group can lead to clear definitions of meaningful activity and community engagement activities that are often a precursor or a critical component to obtaining or maintaining employment which can lead to more self-sufficiency and improvement in an individual's overall quality of life. In other words, they go "hand-in-hand" and the system needs to address both to achieve the most successful outcomes for beneficiaries.

8. Business Engagement

The workgroup will identify strategies to educate business on disability awareness, support services that can assist beneficiaries in the workplace, and reduce stigma that creates barriers for beneficiaries seeking employment.

The group will look at successful models both locally and nationally and work with business leaders who are successfully hiring and retaining beneficiaries.

B. Composition + Recruitment

Amanda or Rich will send out invitations to potential workgroup members for participation in one or more workgroups. However if members have a preference and/or interest in one of the workgroups listed above; they should contact Trust Program Officer, Amanda Lofgren, directly at amanda.lofgren@alaska.gov or 907-269-3409.

C. Process, Schedule + Meetings

Process:

- All workgroups, with exception of the data, policy and business engagement, will use the **Results-Based Accountability (RBA)** framework.
- In short, from *Fiscal Policy Studies Institute*:

Results-Based Accountability™ (RBA), also known as Outcomes-Based Accountability™ (OBA), is a disciplined way of thinking and taking action that community can use to improve the lives of children, youth, families, adults and the community as a whole. RBA is also used by organizations to improve the performance of their programs or services. Developed by Mark Friedman and described in his book *Trying Hard is Not Good Enough*, RBA is being used throughout the United States, and in countries around the world, to produce measurable change in people's lives. The focus is on moving from "Talk to Action" and includes seven basic steps that ask communities, cities, countries, states and nations that are working to make positive community/population level change, to ask themselves the same set of questions every time they meet:

1. What are the quality of life conditions we want for the children, adults and families who live in our community?
 2. What would these conditions look like if we could see or experience them?
 3. How can we measure these conditions?
 4. How are we doing on the most important measures?
 5. Who are the partners that have a role to play in doing better?
 6. What works to do better, including no-cost or low-cost ideas?
 7. What do we propose to do?
- Two helpful online resources that explain the RBA process, including specific steps, can be found online at:
 - <http://raguide.org/>
 - <http://resultsaccountability.com/about/what-is-results-based-accountability/>

Schedule:

- December 2014:
 - Workgroup recruitment
- January 2015:
 - Workgroup meetings:
 - Data Management and Employment/Service Definitions
 - Policy
 - Transition Age Youth around behavioral health system
 - Note: The data workgroup will meet first to allow for employment/data experts to share what employment data exists at the population level, what interim measures exist, and where there are gaps. This information will be shared with other workgroups to identify a preliminary set of indicators or dashboards for each workgroup and for identifying the initiative's data development agenda.
- February 2015:
 - Workgroup meetings:
 - Workforce Development
 - Beneficiary Training and Self Sufficiency
- March 2015:

- Workgroup meetings:
 - Behavioral Health
 - Business Engagement
 - Community Engagement and Meaningful Activities
- April 2015
 - Second series of workgroup meetings, as necessary, to accomplish meeting outcomes outlined below.
- May 12, 2015:
 - Reconvene large stakeholder group. Focus on workgroup report back and collective strategizing regarding workgroup ideas and next steps
- June 2015:
 - Review Beneficiary Employment and Engagement budget documents to present to Trustees.

Meetings:

As part of the RBA process for some but not all workgroups, workgroups will hold two meeting before the large stakeholder group convenes in May.

- Meeting #1 – Focus on education re: RBA process and prioritizing population-level indicators that have been identified by the data workgroup.
- Meeting #2 – Focus on strategy development, project idea and performance measures tied to population indicators and result areas.
- Meeting #3 – TBD

Roles/Responsibilities

- Convene around each result area to identify indicators, strategies and performance measures.
- Develop a timeline and associated benchmarks for implementation of the identified strategies that will achieve the result following the Results Based Accountability framework.
- Identify pilot projects that are: 1. primed and ready to go; 2. need further development prior to implementation and 3. share back results with policy and higher level groups.

To: Paula Easley, Chair
Planning Committee
From: Michael Baldwin, Evaluation & Planning Officer
Date: 1/27/2015
Re: Trust Rural Outreach Trip 2015

MEMO

2015 Trust Rural Outreach Trip

Planning has been initiated for the 2015 Trust rural outreach trip. After review and discussion of the attached information, the region selected for the visit will be Nome and its adjacent villages.

In February, the Trust Rural Technical Assistance contractor will begin planning work on logistics, and coordinating with key stakeholders in the region.

Background Information

Every two years the Alaska Mental Health Trust Authority undertakes an outreach visit to a rural region of Alaska. The trip is a way of sensitizing policy and decision makers to the needs of rural Alaskan Trust beneficiaries, as well as providing a method for rural Alaskans to directly express their needs.

Generally, during the year in which the rural trip occurs, the region to be visited is selected in the January to March time period, with the actual trip happening during September or October. After a rural outreach visit, the region is then prioritized for rural technical assistance or when considering funding requests and opportunities for the next two years.

Regional Information

As part of the Trust's rural outreach initiative there are three regions that have not been visited: the Nome, North Slope, or Kenai Peninsula/West Cook Inlet/Prince William Sound areas. See attached map.

The following highlights some of the information considered in selecting the Nome region.

1. Nome Region

- | | | | |
|------------------|-----------------|------------|---------------|
| • Nome | • Wales | • Elim | • Stebbins |
| • White Mountain | • Shishmaref | • Koyuk | • Gambell |
| • Brevig Mission | • Shaktoolik | • Savoonga | • Teller |
| • Unalakleet | • Little Diomed | • Golovin | • St. Michael |

Regional Information:

- DBH Reporting Region Population: 9,875
- 16 potential communities that could be visited.
- Easily identifiable hub community (Nome) to travel from to outlying villages.

- Tribal Health Care Corporation: Norton Sound Health Corporation
- Census Area/Borough: Nome
- Trust has actively been working in this area through several initiatives over the past several years (i.e., Housing, Hospital, Nome Sleep Off Center Planning).
- There is a hub community that visitors can travel from for the rural experience.
- Matches the traditional concept of rural or frontier experience
- Community readiness: There has been a strong history of the Trust working on initiatives in this region (e.g., Hospital, Housing etc.), and MHTAAR or Authority Grant funding.

2. North Slope Region

- | | | | |
|------------------|-------------|------------|--------------|
| • Anaktuvuk Pass | • Nuiqsut | • Atqasuk | • Point Hope |
| • Barrow | • Point Lay | • Kaktovik | • Wainwright |

Regional Information

- DBH Reporting Region Population: 9,876
- 8 potential communities that could be visited
- Potential for a hub village to travel to other regional villages
- Tribal Healthcare Organization: Barrow – Arctic Slope Native Association
- Census Area/Borough: North Slope Borough
- Matches the traditional concept of rural or frontier experience
- Community readiness – region hasn't been appeared receptive to working with the Trust in the past. There is a minimal history of Trust work or granting in the region.

3. Southcentral Region (Kenai Peninsula/West Cook Inlet, Prince William Sound)

Kenai Peninsula Main Communities

- | | | | |
|---------|---------|------------|----------|
| • Homer | • Kenai | • Soldotna | • Seward |
|---------|---------|------------|----------|

Census – Designated Places

Western Kenai Peninsula & Kachemak Bay

- | | | | |
|--------------------|---------------|----------------|-----------------|
| • Anchor Point | • Clam Gulch | • Cohoe | • Diamond Ridge |
| • Kalifornsky | • Kasilof | • Happy Valley | • Fox River |
| • Fritz Creek | • Funny River | • Halibut Cove | • Nikiski |
| • Nanwalek | • Port Graham | • Niolaevsk | • Ninilchick |
| • Point Possession | • Ridgeway | • Salamatof | • Seldovia |
| • Sterling | | | |

Northern/Eastern Kenai Peninsula

- | | | | |
|----------------|--------------|------------------|--------------|
| • Hope | • Sunrise | • Cooper Landing | • Moose Pass |
| • Lowell Point | • Bear Creek | • Crown Point | • Primrose |

Cook Inlet

- Tyonek

Unincorporated Communities

- | | | | |
|---------------|-----------------|------------|--------------|
| • Jakolof Bay | • Kachemak Selo | • Razdolna | • Voznesenka |
|---------------|-----------------|------------|--------------|

Prince William Sound

- | | |
|----------|-----------|
| • Valdez | • Cordova |
|----------|-----------|

Regional Information

- DBH Reporting Region Population: 56,862
- 36 potential communities that could be visited on the road system and off.

- No clearly defined hub community for the Kenai Peninsula. Depending upon the focus and mix of communities selected, Anchorage might be the travel hub.
- There are several different tribal organizations, depending on upon the region of the Kenai Peninsula/West Cook Inlet/Prince William Sound selected; Chugachmuit, Kenaitze Indian Tribe, Seldovia Village Tribe, Native Village of Tyonek, Ninilchick Village Traditional Council
- Census Area/Borough: Kenai Peninsula Borough, Valdez/Cordova
- For the most part this is “road system rural”, and would not necessarily give the typical Rural Outreach Trip experience.
- Depending on the mix of communities chosen to visit, without having done any price comparisons, travel costs likely to be less than other rural regions.
- Community readiness – there hasn’t been a coordinated effort in this region, however there is a history of Trust working with individual non-profit organizations, beneficiary groups or tribal organizations on a range of projects that resulted in Trust grant funding.

Trust Rural Outreach Trip - History of Regions Visited
(Regions in red have not been visited)

