

### Planning Committee

#### Agenda

3745 Community Park Loop, Room 120

April 16, 2015

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: 803 901 883 #; Attendee Number: #

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| 09:00 | <b>Call to order (Paula Easley, Chair)</b>  |                 |
|       | • Announcements   |                 |
|       | • Approve agenda  |                 |
|       | • Approve minutes   |                 |
|       | • January 27, 2015  | 3               |
|       | • Feb 23, 2015  | 9               |
| 09:10 | <b>AK Behavioral Health Systems Assessment – Update</b>   |                 |
| 09:35 | <b>Medicaid Expansion &amp; Reform – Update</b>   |                 |
| 10:15 | <b>Focus Area (Long Term Support &amp; Services) – Conflict Free Case Management</b>                        | 15              |
| 11:00 | <b>Break</b>  |                 |
| 11:10 | <b>Focus Area (Substance Abuse Prevention &amp; Treatment) – Re-Entry Coalition</b>                         | 83              |
| 11:30 | <b>Focus Area Updates (Disability Justice, Housing, Beneficiary Employment &amp; Engagement, Workforce)</b> | 107             |
| 12:00 | <b>Adjourn</b>  |                 |
|       | <b>Written Informational Updates</b>  |                 |
|       | • Alaska Scorecard 2014 Update  | 111             |

#### **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 03/12/15)

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#### **FY15/16 - Finance Committee Dates:**

- 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:**

- August 4, 2015 (Tue)
- October 21, 2015 (Wed)
- April 14, **2016** (Thu)
- August 2, **2016** (Tue)
- October 20, **2016** (Thu)

#### **FY15/16 – Planning Committee Dates:**

- 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:**

- May 12-14, 2015 (Tue, Wed, Thu) – Kenai
- 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

January 27, 2015

10:30 a.m.

Taken at:

Permanent Fund Corporation  
Hugh Malone Board Room  
801 West 10<sup>th</sup> Street  
Juneau, Alaska 99801

**OFFICIAL MINUTES**

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Trustees present:

Paula Easley, Chair  
Mike Barton  
Laraine Derr  
John McClellan  
Russ Webb

Trust staff present:

Jeff Jessee  
Steve Williams  
Miri Smith-Coolidge  
Kevin Buckland  
Michael Baldwin  
Katie Baldwin-Johnson  
Nancy Burke (via Speakerphone)  
Amanda Lofgren  
Natasha Pineda (via Speakerphone)  
Carrie Predeger (via Speakerphone)  
Valette Keller (via Speakerphone)  
Carly Lawrence

Others participating:

Brenda Knapp; Monique Martin; Chris Ashenbrenner; Tawny Buck (via Speakerphone); Kate Burkhardt; Kathy Craft (via Speakerphone); Britteny Howell (via Speakerphone).

## PROCEEDINGS

CHAIR EASLEY calls the Planning Committee to order. She asks the people present and on the phone to go around and introduce themselves. She asks for any announcements. There being none, she asks for a motion to approve the agenda.

TRUSTEE DERR makes a motion to approve the agenda.

CHAIR EASLEY moves to the minutes of the October 22, 2014, meeting. If there are no objections, they are considered approved. She then moves to the Medicaid Expansion Update and states that Nancy Burke will be leading the discussion. She continues that also here is Chris Ashenbrenner with DHSS, the Medicaid expansion project director, and Monique Martin, the health-care policy adviser in DHSS.

## MEDICAID EXPANSION UPDATE

MS. BURKE begins her presentation, stating that the current priorities of both the boards and the Trust include Medicaid expansion reform, recidivism and substance abuse. She adds that they are the areas where talking about expansion and reform changed the playing field for what is being dealt with in the services for Beneficiaries. She continues that the expansion will definitely impact thousands of Trust Beneficiaries. She states that the new population of eligible for coverage will include Beneficiaries who have chronic substance abuse and mental health issues and homeless adults, people who are incarcerated. She continues that the unknown is how many new Beneficiaries may be identified in the covered population. She adds that Medicaid expansion and reform will result in offsets and savings of General Funds. She states that the expansion will bring increased demands on the system, but will provide extra resources from the federal government, and will provide a bigger pool of people to use Medicaid more efficiently. She continues that one of the concerns expressed is that going for expansion first may compromise the activities that would lead to reform. She explains in greater detail.

TRUSTEE DERR asks how many of the 150,000 people in the Medicaid service population are Trust Beneficiaries.

MS. BURKE replies that the Department partners may have a more specific answer.

MS. ASHENBRENNER replies that the answer through the general population is unknown; but the expansion population at ages 19-65 are probably all Beneficiaries, because they are all adults. She states when this was put together, a lot was matched against the BRFSS, Behavioral Health Risk Survey. She continues that all the BRFSS is self-reported, and talks about some of the indicators.

MR. BALDWIN states, as part of the statewide behavioral health systems assessment, the contractor should be providing an estimate based on their prevalence estimates that are currently being worked on.

MS. ASHENBRENNER gives a brief overview of what has been done in the past eight weeks on the Medicaid expansion which is making the system efficient, effective, partnering with people, making it more collaborative, and finding efficiencies in that way. She states that to really figure out what works and what people want, providers have to be consulted to see what their systems are like and if they can support this. The hope is to start this process soon with the help of some technical assistance contractors. She adds that the target day is still July, 2015. She states that she has been asked about the need for a statute change, and the answer is no because in the Affordable Care Act it is actually written as a mandatory Medicaid eligibility, and says that any mandatory eligibility group has to be covered. She continues that what is needed is a budget authority to take in all that new federal money, and approval of the decrements. She states that one partnership in conjunction with the expansion is the Federal Marketplace, which is allowed to determine eligibility.

MS. MARTIN states that the federally facilitated Marketplace is healthcare.gov. The navigators at community health centers are already enrolling people. They enter the information and allow healthcare.gov to make an assessment. She adds that this helps reduce that administrative burden and the costs associated with more people coming into the system.

MS. ASHENBRENNER introduces herself and Monique Martin, stating that they are the team on this project.

CHAIR EASLEY asks if there are any questions at this time.

TRUSTEE WEBB asks about the General Fund offsets, the savings.

MS. ASHENBRENNER replies with a few examples, and explains why the savings will not be attained during the first year.

MS. LOFGREN asks Ms. Martin to speak to the work that has been done up to date by the Medicaid Reform Advisory Group and the Healthcare Commission, how it relates to the expansion efforts, and where is the crossover.

MS. MARTIN states that Commissioner Davidson is going to charge the Healthcare Commission with looking at all of the opportunities and options that are available to the State in the Affordable Care Act. She continues that the Medicaid Reform Advisory Group has been asked to come together one more time to give them the opportunity to finalize their recommendations. They are scheduled to meet on January 29, 2015. She adds that their input on starting this dialogue of reform is wanted.

CHAIR EASLEY states that she has talked to some people in the medical field, and they are very happy about the expansion. She continues that a number of them are looking for employees for this and asks if this is being addressed.

MS. MARTIN replies that this is huge for Alaska, and ANTHC has looked at this impact and the new economic opportunities not only in the health-care sector, but also to the hospitality industry and the travel industry.

CHAIR EASLEY asks if anyone in the Department is working with the Alaska Health Workforce Coalition.

MS. MARTIN replies that those dialogues are happening now.

A discussion ensues.

CHAIR EASLEY thanks both, and recognizes Michael Baldwin.

MR. BALDWIN states that tomorrow Margaret Brodie will give an update on the MMIS system, and will also give a current status update.

CHAIR EASLEY moves on, stating that the Marijuana Policy Initiative Update will not be discussed today. She moves into the MHTAAR Status Report Summary, and recognizes Carrie Predeger.

#### **MHTAAR STATUS REPORT SUMMARY**

MS. PREDEGER states that the Trust issues grants from two different funding sources: The Authority Grant funds, which go to the community organizations around Alaska; and the MHTAAR funds, the Mental Health Trust Authorized Receipts, which are funds that go to State agencies for specific operating and capital projects. She continues that she will review the FY14 MHTAAR grants for folks' performance summaries, which provides an overview of the MHTAAR projects that make up about 53 percent of the total funding that was awarded by the Trust in FY14. She states that in FY14, 47 MHTAAR grants were awarded, for a total of nearly \$8.9 million. She explains that grants are categorized by project type, either direct service, planning and research, workforce development, or capital projects; and the majority of the projects for FY14 were direct service in nature. They encompassed 38 percent of all projects, and 40 percent of all total MHTAAR funding. She goes through the grants by specific focus areas and then continues to the numbers that were served. She states that in FY14, 11,385 Trust Beneficiaries were served with a total of 21,830 individuals served or impacted by MHTAAR projects. She moves on to project performance, stating that the Trust staff evaluates each project and assigns a rating of red light, yellow light, and green light. The grants receiving the yellow or red-light status are projects of concern, and staff is assigned to work with these grantees to address any areas of concern. She continues that of the 47 MHTAAR grants, one project received a red-light rating, and four projects received a yellow-light rating. The remaining 42 projects received green-light status ratings. She states that looking back at FY13, these numbers were pretty similar.

TRUSTEE DERR asks who received the red light.

MS. PREDEGER replies that it was the Criminal Justice Technicians which grants funds to the Department of Corrections to hire research analysts for data collection evaluation. She states that Steve Williams was assigned to this project.

MR. WILLIAMS states that the Department of Corrections was unable to get a PCN approved to be able to actually recruit and hire.

CHAIR EASLEY asks for an update.

MR. WILLIAMS replies that the funds in FY15 are available, and the Department of Corrections, as a whole, is implementing an electronic health records database. He states that a portion will be used for that; and then another portion will be used for partnership with the University Social Work Program to have student interns do some of the backfilling from the paper records, as well as dumping what is currently electronic into the new database system. He explains that a portion of those funds will be used to pay student stipends to fill the database with the information once it is on-line.

TRUSTEE DERR asks if that is a change of intent.

MR. WILLIAMS replies that it is still within the original scope of work, which was the overall research data component for helping the Department of Corrections.

CHAIR EASLEY asks Ms. Predeger to continue.

MS. PREDEGER states that the next section looks at whether Trust Beneficiaries are better off as a result of these projects. She goes through those numbers. She states that there has been a steady success over the past three years, in particular, as grantees get more familiar with reporting project outcomes to the Trust. She points out a few project highlights that demonstrate both the systems and Beneficiary impacts from the MHTAAR projects in FY14 that the Trustees can read over. She concludes her memo.

CHAIR EASLEY thanks Ms. Predeger for a good report. She moves on to the memo which addresses the MMIS situation, and states that Amanda Lofgren will give an update.

## **MMIS UPDATE**

MS. LOFGREN states that, in preparation, she asked Liz, the executive director of AADD to prepare some points to give an update. She states that there are significant barriers with the reimbursement, but Healthcare Services is working very closely with the AADD Association and providers to work with the issues as they come up.

CHAIR EASLEY states that the conflict-free case management and ADRD road map are interesting.

MS. LOFGREN reports that the ADRD started out with 97 recommendations that have been narrowed down to seven, which are identified in the report. She states that one of the partners took the lead in convening each of the strategies to move and implement each of them. She continues that the conflict-free case management, the ruling set forth by the Center for Medicare and Medicaid, CMS, were issued in March. One of the plans with Senior and Disability Services

to adopt the new rulings was to implement a transition plan to CMS, which is due in March. She continues, explaining as she goes along.

CHAIR EASLEY asks if there will be a need for new employees in that field.

MS. LOFGREN states that one of the strategies moving forward is looking at having some kind of regional care coordination organization. She continues that there are also independent care coordinators, and that system will not change. She states that there is still a lot of work to be done, and the plan is to have a final report with the design on February 18, 2015, because Senior and Disability Services has to rewrite their regulations and put that out for public comment. She continues that a more comprehensive case management program is needed so Beneficiaries end up with two or four case managers. She adds that this also creates more diversified funding for the case management organizations to move forward toward sustainability.

CHAIR EASLEY thanks Ms. Lofgren.

TRUSTEE DERR asks about the rural trip.

CHAIR EASLEY states that no decision has been made. She recognizes Mr. Baldwin.

MR. BALDWIN states that there was interest in the Kenai Peninsula region, but more work to sort it out needs to be done. He continues that it is a region with a lot of subregions and takes more coordination. He adds that Nome has been focused on as an upcoming target.

CHAIR EASLEY comments that she is glad to see attention given to the need for care coordination and case management and improving service delivery.

TRUSTEE WEBB agrees, and gives a specific example of the importance of a case manager.

CHAIR EASLEY asks for a motion to adjourn.

TRUSTEE BARTON makes a motion to adjourn the meeting.

TRUSTEE MCCLELLAN seconds.

*CHAIR EASLEY adjourns the meeting.*

(Planning Committee meeting adjourned at 11:48 a.m.)



ALASKA MENTAL HEALTH TRUST AUTHORITY  
PLANNING COMMITTEE MEETING

February 23, 2015  
2:00 p.m.

Taken at:

Alaska Mental Health Authority  
3745 Community Park Loop, Suite 200  
Anchorage, Alaska 99508

**OFFICIAL MINUTES**

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Trustees present:

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

AMHTA staff:

Jeff Jessee  
Steve Williams (via Speakerphone)  
Nancy Burke  
Carrie Predeger  
Carley Lawrence  
Amanda Lofgren  
Katie Baldwin-Johnson  
Mike Baldwin  
Natasha Pineda  
Valette Keller  
Luke Lind  
Marilyn McMillan

**PROCEEDINGS**

CHAIR EASLEY calls the Planning Committee meeting to order. She asks for any announcements. There being none, she asks for any changes to the agenda. There being none, she moves on to roll call and asks people on-line to introduce themselves. She commends the

staff for the outstanding job on revising the proposal to the Trustees, making it much easier to comprehend. She recognizes Jeff Jessee, who will introduce the topic.

MR. JESSEE states that the main topic is around the marijuana issue. He continues that staff has put together a policy draft and some strategies. He states that the Board needs to discuss this more fully and come to a policy direction that will be communicated to staff to do what is wanted and needed. He states that there are some big changes coming up in the Board makeup when Carlton and Christopher get confirmed. He continues that as soon as they are confirmed, there will be no chair, no vice-chair, and no chair of the Finance Committee. He adds that the by-laws state when the Board chair leaves, then the vice chair steps in; and they are both leaving. He states that he hopes that coming out of this meeting, there will be pretty clear directions from the Board on where to go on the marijuana issue, and start the discussion on how to deal with the upcoming changes.

CHAIR EASLEY begins with page 1 on the draft of the substance abuse prevention and treatment policy, and asks if anyone has a problem with the first three paragraphs. There being none, she moves on to the specific strategies. The first one looks at what the Trust staff could do to support the substance abuse prevention and treatment policy.

TRUSTEE DERR asks if this will be setting up policy for the focus area.

MR. JESSEE replies yes, and explains that even though the focus area title is Substance Abuse Prevention and Treatment, alcohol is specifically mentioned because it is a major piece of all of that. He adds that it was the intent to keep the overall policy fairly broad.

CHAIR EASLEY gets into the first alternative proposition strategy, which will be both with the Trust, the staff, and the public, and is the most controversial aspect of it. She reads: "Continue to license medical marijuana production, processing and distribution. Further decriminalize marijuana and repeal the commercial/recreational licensing structure due to the allowance of legal small individual sales."

MR. JESSEE states that this sort of takes off on the resolution the Trustees passed which was that the Board was not opposed to medical marijuana, but was not in favor of creating a commercial/recreational industry. He goes into greater detail.

TRUSTEE DERR states that under this alternative proposition strategy would be a plan to bring forward an alternative proposition that is currently under development. She asks who is developing it.

MR. JESSEE replies that Kristina and Tim Woolston have not formed a new group, but it is the remnants of the "No on 2."

TRUSTEE DERR states that the plan is not necessarily under development.

TRUSTEE MICHAEL adds that they have no money to work with.

TRUSTEE McCLELLAN states having no problems with 1, 2 and 3, but the lead-in sentence where it says "a plan to bring forward an alternative proposition" is bothersome. He continues that the approval of a plan at the last Board meeting was more data generation and support of other people's positions; but not having the Trust lead an initiative or lead a position. He states that without the Legislature directing, being the lead on bringing forward an initiative, giving the funding, and that this position will be taken on as part of the Trust then. Anything else would be tainting the Trust as part of being a reliable support organization.

CHAIR EASLEY thanks Trustee McClellan and looks at the other two strategies: the Legislative amendment strategy, and the regulation development strategy.

TRUSTEE WEBB asks if the Trust has a process in place for taking formal positions on individual pieces of legislation.

A discussion begins.

TRUSTEE WEBB states that staff has mapped out a number of potential strategies that could be taken to try to mitigate the harm that is believed can result from Ballot Measure 2. He continues that it seems to be appropriate for the Trust to put a formal written document, the concerns and suggestions to make changes to amending Ballot Measure 2, or to change the regulator process that would mitigate the potential for harm. He adds that this should be done as quickly as possible to show where the Trust stands and what the concerns are, and then leave the issue of an alternative proposition for someone else to deal with.

The discussion continues, and the Trustees all agree to a written document, which is discussed in greater detail.

TRUSTEE WEBB suggests giving staff consensus direction to get something formally developed to transmit to the Legislature the concerns and issues that the Trust would like to see addressed in the legislation.

TRUSTEE MICHAEL adds that there will also be an opportunity to respond to public comment if the prioritizations are given now.

MR. JESSEE asks if this is something that would be endorsed as a committee or a Board. He continues if this should be brought back for approval, or does staff have the delegation of responsibility and ability to put those forward.

CHAIR EASLEY asks to discuss the third strategy before considering any motions -- the regulation development strategy. She states that maximizing the public health considerations in the regulatory process and ensuring protections for Trust Beneficiaries needs to be the focus of what is done.

The discussion continues.

TRUSTEE BARTON states that, in going forward, it needs to constantly be tied back to the Beneficiaries.

MR. JESSEE states that will be prepared and asks where to bring this back, a committee or the Full Board.

TRUSTEE BARTON states that it is important enough to be brought back to the Full Board.

MR. JESSEE asks for further instruction, and refers to several different scenarios.

TRUSTEE BARTON suggests going forward, as earlier discussed, and be careful not to preclude an alternative proposition.

The discussion continues.

CHAIR EASLEY comments on the financial aspects of an initiative, which is that initiatives cost a huge amount of money. She continues that to oppose any initiative would mean having to raise a lot of money, which would be a difficult challenge.

TRUSTEE WEBB states that the best strategy is to try to amend the legislation that passed in the initiative to get what is wanted out of it. He adds, trying to repeal will cost an arm and a leg.

CHAIR EASLEY states that the Legislature would appreciate the information that the Trust is able to provide, as they are in a difficult position. She adds that many of their constituents voted in favor of the initiative, which places them in an awkward position.

The discussion continues on to decriminalization.

CHAIR EASLEY moves to recommending staggering licensing to ensure the development of revenue streams for the regulatory oversight, and asks Mr. Jessee to talk about that.

MR. JESSEE asks Natasha Pineda to take that.

MS. PINEDA states that in other states the problem is that they did not have the funds to do any of the enforcement, monitoring, or management of the licensees. And it was a good year and a half beyond once they were legalized that actual revenues were coming in. She continues that Washington had problems where shops were opening up, but there was not enough product. This caused market price problems and then an influx into the black market where product was available. She states that to open on a certain day, the laboratories are ready to go way before the retail licenses are ready. There has to be production and the ability to test all the products and be able to meet all the requirements before opening up.

MS. BALDWIN-JOHNSON adds that a primary concern was generating the revenue to be able to hire the staff to manage marijuana between enforcement and administration and licensing. She states that they are looking at hiring two in this year, and maybe adding another four next year.

MS. PINEDA states that does not deal with the fact that the Legislature is going to have to function as the regulatory for the entire unorganized borough.

MR. JESSEE adds that they are not quite aware of that as their responsibility. He talks about the inconsistencies that were sold, versus what is had.

The discussion continues.

MR. JESSEE states that he has direction and asks if the Trustees would like to talk about the larger organizational issues.

TRUSTEE NORENE replies that there are two absent people for future organizational issues.

MR. JESSEE states that there are committee meetings on April 16, 2015. He states that there is a potential interim period to deal with, because both the chair and the vice chair will be lost at the same time.

TRUSTEE McCLELLAN states that the board meeting is the day after the committee meetings, and there will be no committee chair in the Finance Committee.

A discussion ensues on the subject, and then moves to setting a date for a retreat.

MR. JESSEE states that there is no consensus, and a motion is needed.

TRUSTEE BARTON states that he is uncomfortable with having the new appointees present without being confirmed by the Legislature.

MR. JESSEE states that if the Legislature has a problem, he will explain that it is an unusual circumstance for the Trust to lose the chair, the vice chair, and the Finance Committee chair all at the same time.

CHAIR EASLEY agrees to a Full Board meeting on March 11, 2015 at 11:00 a.m. to 4:00 p.m. She asks for anything else to come before the Planning Committee. There being none, she asks for a motion to adjourn.

TRUSTEE WEBB makes a motion to adjourn the Planning Committee meeting.

TRUSTEE MICHAEL seconds.

CHAIR EASLEY adjourns the meeting.

(Planning Committee adjourned at 3:40 p.m.)

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February 23, 2015

To whom it may concern:

Home- and community-based services (HCBS) provide opportunities for Alaskans to receive services and supports in their own home or community while maximizing one's independence. The Division of Senior and Disabilities Services (SDS) manages four HCBS Medicaid waivers that support Alaskans who are elderly or experience a physical, intellectual or developmental disability. Multiple service providers made up of tribal health organizations, nonprofits, for-profits, and other agencies across Alaska provide these services and supports which include: care coordination, chore, respite, day habilitation, meals, transportation, supported employment, residential services, environmental modifications, etc. Alaska's current service delivery system was built around providing comprehensive services and supports to individual service recipients and their families, which has historically included agencies providing both the case management and direct services.

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) who provides federal oversight of the Medicaid Waiver programs, issued the final rule for home- and community-based services that defines and describes the qualities and characteristics of a "home and community-based setting" and "person centered planning" which mandates that all waiver services adhere to these new requirements in order to be considered for reimbursement. States are required to submit a transition plan and timeline by March 17, 2015, to address how each of these new components will be implemented. The changes in federal regulation around "person centered planning," which is the process by which waiver recipients and their supports develop a plan of care should include the opportunity to freely choose their services providers. This change from CMS reflects the belief that recipients have real choice of providers only if that choice is made free from provider influence or pressure. To achieve this "conflict-free case management" (CFCM) as it is described by CMS, provider agencies that offer case management services (or care coordination, as we now call it in our waiver system) will not be able to provide direct services. There is one exception to this. If any locality has only one agency willing and able to serve waiver recipients, the state will waive the "conflict-free" requirements and allow the agency to provide both case management and other waiver services.

In August, the Division of Senior and Disabilities Services (SDS) hosted community forums to provide information on the new rule, address questions and hear feedback from the communities. Adapting the required changes for CFCM was identified as having the most impact on the current service delivery system. In September, at the National Association of States United for Aging and Disabilities conference, CMS clarified that states were expected to have already implemented CFCM, and would be currently out of compliance if care coordination is provided by an agency that also provides direct home and community based services. This also means that CFCM is **not** to be included in the transition plan that states submit March 2015. CMS stated that upon Waiver renewals for states' Home and Community Based Service, CFCM must be in place, which for Alaska is due July 1, 2016.

Significant changes to the existing service delivery system will be required to ensure CFCM is in compliance, however most importantly, it is essential that the transition minimizes disruption for service recipients and retains continuity and knowledge with the existing care coordinators who are employed

by agencies that are considered to have a conflict. SDS reports that approximately 42% of clients are currently receiving conflict free case management. Below is the breakout by waiver type:

- Alaskans Living Independently: 68% served by Independent Care Coordinators
- Intellectual and Developmental Disabilities: 17% served by Independent Care Coordinators
- Children with Complex Medical Conditions: 19% served by Independent Care Coordinators
- Adults with Physical and Developmental Disabilities: 41% served by Independent Care Coordinators

In October, the Community Care Coalition, which includes representation from the Alaska Association on Developmental Disabilities, PCA Provider's Association, AgeNet, Alaska Behavioral Health Association and the Assisted Living Association of Alaska began meeting with SDS to seek clarification on the final rule and how these changes will affect the current service delivery system. The Community Care Coalition committed to proactively partner with SDS to identify strategies to adopt CFCM and become in compliance. Due to the shortened timeframe and changes that will need to occur, the Community Care Coalition requested funding from the Trust to hire a consultant to fully understand the CMS rule on conflict free case management, learn what four other states have done to address CFCM, develop options for a sustainable case management system, and an implementation plan that is streamlined for recipients and providers across the spectrum of Medicaid recipients. With multiple efforts underway within DHSS to implement case management/service coordination for Medicaid recipients, it was also felt that this was an opportunity to look more broadly than just the HCB Waiver case management services to mitigate confusion or duplication of services for the service recipient.

On December 8, 2015, the Trust awarded a grant to the Alaska Association for Developmental Disabilities on behalf of the Community Care Coalition. Agnew:Beck, who subcontracted with HCB Strategies, was awarded the contract in December with the final report due February 18. Two large stakeholder work groups were facilitated by the contractors on January 12-13 and February 5, to review preliminary results of research and case studies, review and comment on the proposed design options and timeline for person centered CFCM. Those who participated in the meetings included, service providers across the state who represented nonprofits, for-profits, Independent Care Coordinators, tribal health organizations, Governor's Council on Disabilities and Special Education, Alaska Mental Health Board, Advisory Board on Alcohol and Drug Abuse, Alaska Commission on Aging, DHSS staff, and the Trust. Camille Dobson, the Deputy Director of National Association of States United for Aging and Disabilities, who formerly worked for CMS, also attended the January meetings to provide technical assistance. A third stakeholder meeting is scheduled for February 27 to review the final report which includes design options, a timeline and communication plan. It is important to note that these are only recommendations to SDS. The desired outcome of the report was to ensure a system design that minimizes the effect on the capacity of care coordinators and maximize a smooth transition towards conflict free case management which will ultimately result in limited disruption to beneficiaries receiving services.

This has certainly been an open and transparent process despite the tight timelines. If you have any further questions please contact Amanda Lofgren, Program Officer at 269-3409 or [Amanda.Lofgren@alaska.gov](mailto:Amanda.Lofgren@alaska.gov).

Sincerely,

Jeff Jessee  
CEO



# CONFLICT-FREE CASE MANAGEMENT SYSTEM DESIGN

Prepared for Alaska Association for Developmental Disabilities  
By Agnew::Beck Consulting and HCBS Strategies  
February 18, 2015



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# I. INTRODUCTION

## PURPOSE AND STRUCTURE OF THE REPORT

### PURPOSE

Alaska currently funds its Medicaid-funded Home and Community Based Services (HCBS) Waivers under the 1915(c) waiver authority. US Centers for Medicare & Medicaid Services (CMS) published final rules that were effective on March 17, 2014 that affect these waivers. These rules have major implications for how case management, called ‘care coordination’ in Alaska, is provided under Alaska’s waivers because they require that providers of HCBS direct services cannot also provide case management, except in very limited circumstances. While person-centered planning has long been standard practice for many of Alaska’s providers, separating case management from service provision will require additional focus on person-centered planning and a restructuring of case management activities.

It is important to note that other major initiatives in Alaska are also seeking to restructure case management. The State has engaged in a number of systems change efforts aimed at integrating case management and making it more comprehensive. In developing a plan for complying with the conflict-of-interest requirement, it will be important to understand these other plans to help ensure the conflict-of-interest compliance plan does not undermine or complicate other plans.

This project is an opportunity to build upon person-centered planning and values, to improve quality of case management and to increase accountability in Alaska’s HCBS system. It is also an opportunity to design a streamlined and comprehensive case management system that is effective for recipients and providers across all Department of Health and Social Services (DHSS) structures and that has the potential capacity to meet needs across the spectrum of Medicaid recipients. In a comprehensive case management system, participants would not have multiple case managers and the model would be scalable to serve other individuals, potentially including those not covered by Medicaid. For example, private insurers are increasingly using case management to monitor quality, reduce cost and improve health outcomes. Ideally, this will result in a more effective model that improves health and functioning for the individual and reduces costs for the system.

In this effort, we took a two-pronged approach. One, we sought to develop a plan for complying with the conflict-free requirements of the CMS rule that must be addressed as soon as feasible. We have developed a draft plan for compliance, and we note areas that may be problematic. Two, we tried to determine if there was a consensus regarding a longer-range vision for how case management for individuals with disabilities and older adults should be structured. We found that there was strong consensus regarding a vision for building comprehensive, integrated case management infrastructure.

## TIMELINE

The timeline for this project was from December 2014 to February 2015. The consultant team performed a series of key informant interviews to learn about case management in Alaska currently and to identify pertinent lessons from other states also transitioning to conflict-free case management. This was followed by a stakeholder work session in January 2015 where the group reviewed the decisions required to comply with the CMS rules and worked in small groups to identify key elements of the conflict-free case management system design for Alaska. The work session also addressed the timeline for reforms.

Building from the results of the first work session, the consultant team and the steering committee for this project developed a draft set of recommendations and an implementation plan that was reviewed by the stakeholders at a second work session in February 2015. This report compiles the results of the work completed by stakeholders and State representatives and provides key directions for developing the conflict-free case management system for Alaska.

## STRUCTURE OF REPORT

This report includes five main sections:

- This first section introduces the report.
- The second section describes the CMS rules that require conflict-free case management, current case management practices in Alaska, lessons learned from other states, the reforms needed to comply with the CMS rules and the case management activities that will be altered as Alaska responds to the CMS mandates.
- The third section provides a draft plan for complying with the CMS conflict-free requirements and includes four possible options for developing infrastructure to support conflict-free case managers. This section also includes an implementation plan for the period from March 2015 to June 30, 2016.
- The fourth section describes a longer-term vision for a major restructuring of case management in Alaska supported by the stakeholders convened for this process. This section includes an implementation plan for the period from July 2016 to July 2017 during which additional reforms may be undertaken to achieve a comprehensive approach to case management for additional Medicaid.
- The final section describes the level of stakeholder support for the key issues and identifies areas of concern where agreement was not reached.

## 2. CMS RULES DRIVING THE NEED FOR CHANGE

### FEDERAL CHANGES THAT REQUIRE CHANGES IN CASE MANAGEMENT IN ALASKA

There have been several major changes at the federal level that are driving the need to modify how Alaska structures case management for older adults and individuals with disabilities. Complicating the process is the difference in language between CMS and Alaska used to describe the same services. CMS uses the term ‘case management’ for the service that in Alaska is called ‘care coordination’. In Alaska, some service provider agencies use the term ‘case management’ to describe the oversight of services provided to an individual participant. In this document, we will use ‘service management’ to describe the oversight by providers that is not funded as part of care coordination.

The Centers for Medicare & Medicaid Services (CMS) and the Administration for Community Living (ACL) (then the Administration on Aging (AoA)) started encouraging states and Area Agencies on Aging (AAAs) to transform how they provide home and community based services (HCBS) more than ten years ago. A major milestone in this effort was the creation of the Aging and Disability Resource Center (ADRC) initiative for which CMS and AoA offered a joint solicitation in 2002. The primary goal of the ADRC effort was to allow individuals to make informed choices about their long-term service and support options and prevent institutions from being the default LTSS choice. This movement continues with the 2010 Affordable Care Act (ACA), which included a provision in Section 2402(a) that is transforming the delivery of long-term service and supports (LTSS). This section has been translated into rules and guidance that are at the heart of why Alaska Senior and Disabilities Services (SDS) must take immediate action.

Section 2402(a) requires that the U.S. Department of Health and Human Services (HHS) create regulations that:

- Respond to beneficiary needs and choices;
- Provide strategies to maximize independence, including client-employed providers; and,
- Provide support and coordination necessary for “individualized, self-directed, community-supported life”.

These rules mark a fundamental shift in the federal requirements for HCBS. Previously, federal agencies only had regulatory authority to enforce health and welfare requirements. Now, under 2402(a), states will likely be required to implement programs that offer participant-direction, person-centered planning and greater opportunities for community integration. Participant-direction means offering services in which individuals have greater control over services, including the ability to hire

and fire workers and, in some cases, determine how much workers will be paid. The sections later in this document discuss the federal definition of a person-centered planning process.

HHS issued guidance to all of its agencies, including ACL and CMS, about how to implement these requirements. This guidance provides strategies for changing HCBS delivery, such as the provision of support coordination, which is often known by other names, such as ‘care coordination’ and ‘case management’, to assist individuals in living in the community. This guidance also requires that entities receiving federal funds achieve consistent and coordinated policies and procedures across HCBS programs and providers.

CMS has published rules to apply the 2402(a) mandate to the largest portion of Medicaid funded HCBS, 1915(c) HCBS Waivers. ACL has also issued guidance and other HHS agencies are presumably determining how to act upon these requirements. So far, rules and guidance have only mandated a person-centered planning process, including requirements to limit financial conflicts of interest. None of the rules or guidance has mandated that states or AAAs offer participant-directed services.

## UNDERSTANDING THE CONFLICT-FREE REQUIREMENTS AND PERSON-CENTERED PLANNING INCLUDED IN CMS'S HCBS RULES

CMS published final rules for HCBS that became effective on March 17, 2014. The rules apply to 1915(c) HCBS Waivers, such as those operated by SDS and 1915(i) State Plan HCBS. There are similar rules that are in place for 1915(k), also known as the Community First Choice (CFC) Option.

The CMS rule requires a separation of the provision of HCBS direct services, such as assistance with personal care, from the provision of case management (called ‘care coordination’ in Alaska) and the service plan development. The rule states, “Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS.” In reviewing this language, it is important to understand the major components within this language:

- The rules do not appear to explicitly prohibit agencies or individuals who provide HCBS from also providing case management and service planning. However, the rules clearly do not allow an agency or individual to provide both to the same person.
- If a state is proposing to allow exceptions to the rule, it must have a mechanism for demonstrating that in a particular geographic area, there is no independent case management and service planning option.

- If a state allows exceptions, they will need to have clear requirements for how providers will mitigate conflicts of interest.
- The rule prohibits “providers of HCBS” from providing case management and service planning. It is important to note that the rule talks about service planning and case management broadly and does not only apply to service planning and case management paid for as a waiver service. Therefore, paying for service planning and case management through another source, such as Medicaid administrative funds or State-only dollars, would likely not be acceptable.
- It is also important to note that the prohibition is limited to providers of HCBS. In Alaska, that includes services provided through any of the waivers or Personal Care Assistant (PCA) or Consumer-Directed Personal Care Assistance (CDPCA) programs. The rule does not appear to create a prohibition against providers of other services.

Alaska’s current case management structure for its 1915(c) waivers, which allows service providers to also provide service planning and case management, **clearly violates these requirements.**

Alaska will need to make major changes to its infrastructure, and this report provides recommendations for doing so. The prohibition does not appear to apply to the activities that providers may call ‘case management’ that we refer to as ‘service management’ performed by direct service providers. However, it is impossible to rule out a conflict entirely because it is not entirely clear what ‘service management’ includes and it is likely that these practices differ across providers. This highlights the need to not only address what is being reimbursed as ‘care coordination,’ but to also clarify when ‘service management’ crosses over into ‘care coordination’ and should, therefore, be supplied by an independent entity.

Alaska already uses a person-centered approach to service planning; however, the rules include very specific requirements. SDS will need to build infrastructure so that it can assure that this planning meets the following requirements:

- Be directed by the participant to the maximum extent possible
- Provide necessary information and support the participant in making decisions and leading the process
- Include a participatory role for the participant’s representative(s)
- Include people chosen by the participant in the planning process
- Include participant-identified goals and desired outcomes
- Identify participant strengths, preferences, and clinical and support needs
- Include services and supports and their providers

- Identify risk factors and measures in place to minimize them
- Prevent provision of unnecessary/inappropriate services and supports
- Be written in a plain/accessible manner
- Be distributed to the participant and other people involved in the plan

The State will need to make changes to service planning, currently performed in Alaska by care coordinators, to comply with these requirements. The State may consider developing tools and templates to ensure these requirements are met. The State will also need to change the requirements for case management to ensure that service planning complies with the new rule. The new requirements will likely substantially change the amount of time it takes to develop a service plan. Therefore, the State will need to evaluate whether the reimbursement structure for case management is adequate to support these additional activities.

Lastly, the HCBS rule also sets requirements for what can be considered a HCBS setting. The rule allows the State to grant exceptions to these requirements, such as limiting access to food, if this restriction is justified in the individual's person-centered plan. Case managers will need to assume much of the responsibility for operationalizing this requirement. This will likely require closer oversight of residential and adult day settings by the case manager to ensure that any exceptions to the settings requirements are justified and that they are being implemented in a manner that is consistent with the individual's person-centered plan.

Our proposed plan does not include tasks that address the person-centered planning or settings requirements in the rules because 1) this was beyond the scope of our project and 2) SDS likely has other planning efforts to address these requirements and we did not wish to create potentially conflicting plans.

## ALASKA'S CURRENT DELIVERY OF CASE MANAGEMENT

### PROGRAMS AFFECTED BY CHANGE IN CMS RULES

Many departments and divisions at the State of Alaska provide case management services. However, the HCBS rule currently only affects the Medicaid waiver program under the Department of Health and Social Services, Division of Senior and Disabilities Services. The waiver program reimburses "care coordinators" to manage the process of planning for services, developing a plan of care, providing ongoing monitoring of services, and renewing the plan of care annually. The care coordinator must make two contacts per month with the participant, one of which is in-person. If the participant is living in a remote community, the care coordinator must seek approval to make one quarterly in-person visit. SDS pays a flat rate of \$240.77 per month per participant served for care coordination. This rate is adjusted by geographic differentials. In addition, the care coordinator

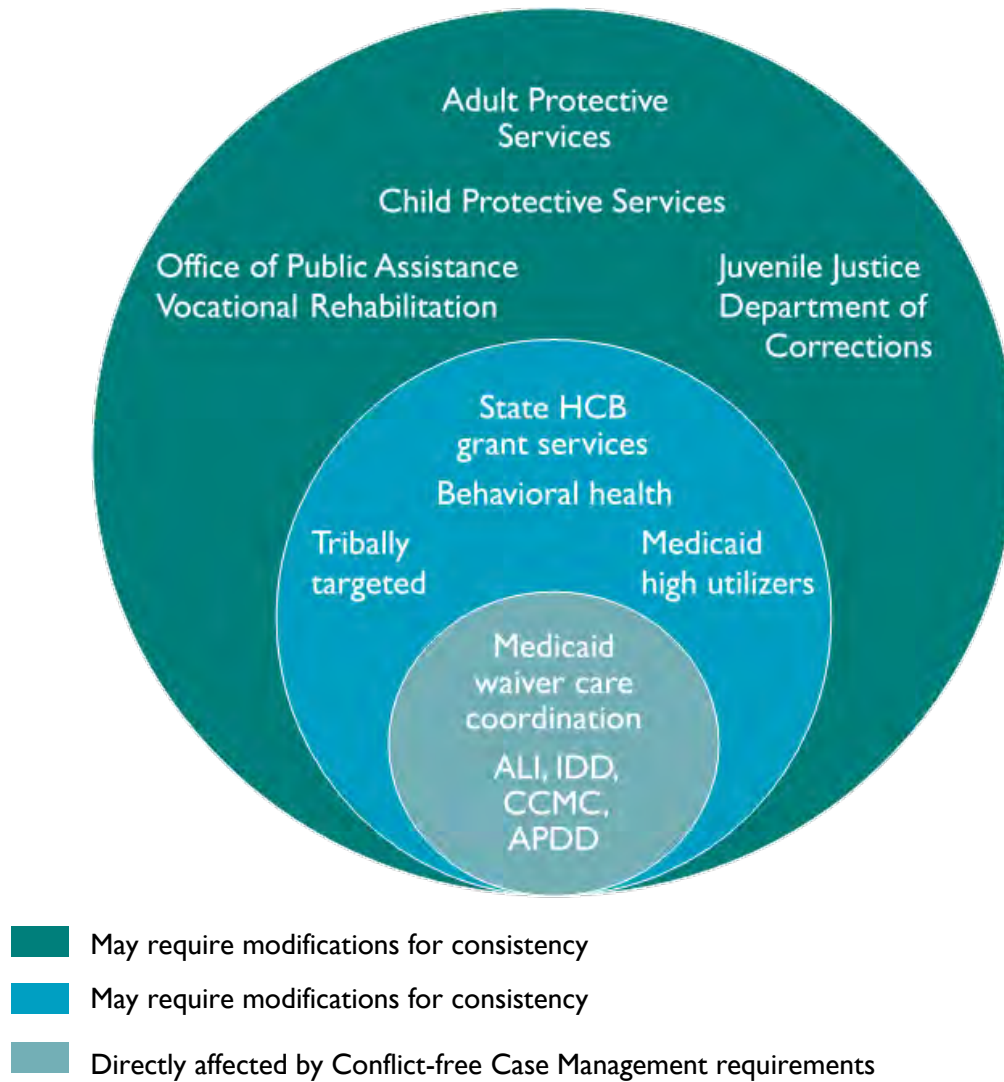


can bill for a one-time fee of \$90.33 for the initial screening and an annual fee of \$384.81 for Plan of Care development and renewal.

SDS staff conduct assessment and eligibility determinations for the waiver. The care coordinator works with the participant to develop the plan of care, which is used to authorize services. The State currently requires that a waiver participant work with a care coordinator to develop the plan of care in order to receive waiver services.

Though not directly affected by the change in CMS rules, case management delivered as part of the State's Medicaid-funded behavioral health services, Medicaid high utilizers and targeted case management may also require modifications once CMS provides guidance regarding how the 2402(a) requirements described earlier will be applied to these funding streams. In addition, because the federal guidance for implementing 2402(a) also requires that states achieve consistent and coordinated policies and procedures across HCBS programs and providers, theoretically, these requirements could be applied to Alaska's HCBS grant services. Additional case management programs, including those provided by Adult and Child Protective Services, Public Assistance, Juvenile Justice, Department of Labor, Vocational Rehabilitation, and the Department of Corrections, also might require future modification and discussion to best meet the needs of individual and the requirements of federal rules. For a more complete comparison of case management services, including grant services, tribally targeted case management, behavioral health case management and Medicaid high utilizers' case and care management, see the matrix included in the Appendices.

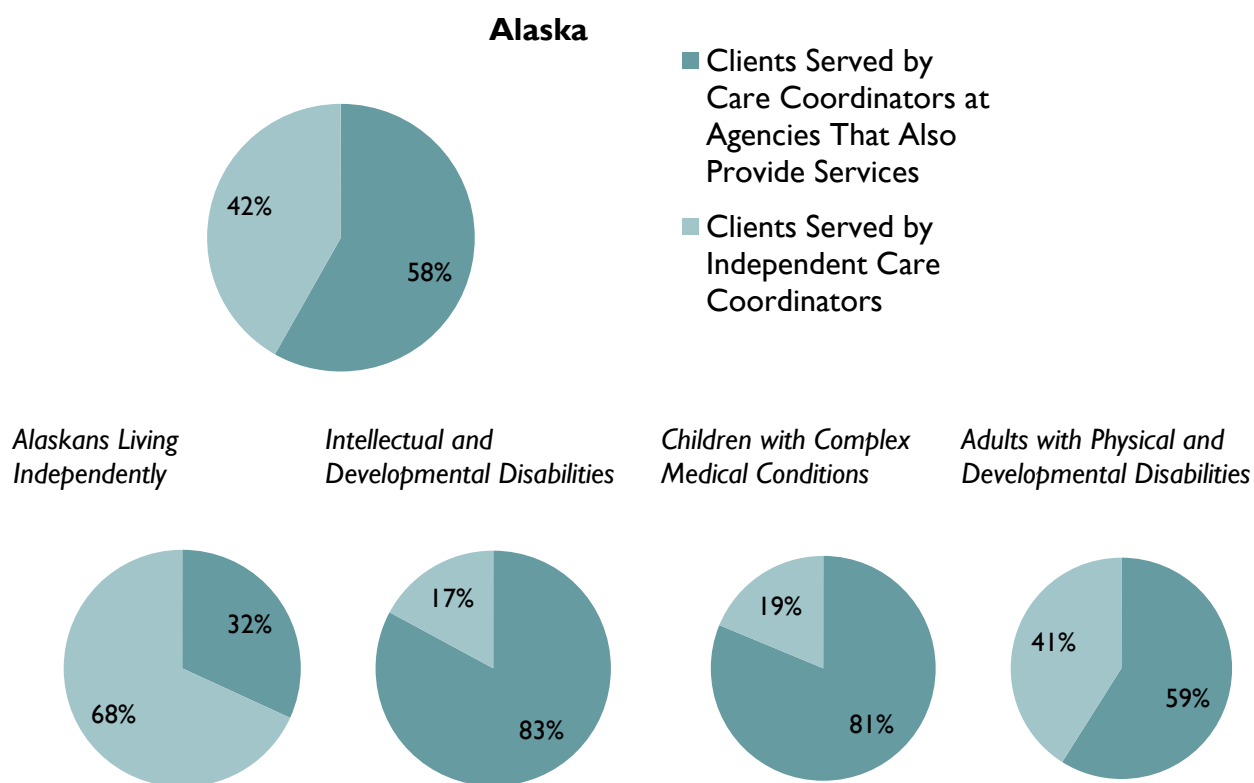
Figure 1: Alaska Case Management Programs + Conflict-free Requirements



## ANALYSIS OF WAIVER PARTICIPANTS CURRENTLY SERVED BY AN INDEPENDENT CARE COORDINATOR

Currently, the State offers four waiver programs. The Adults Living Independently (ALI) waiver primarily serves seniors; sixty-eight percent of the 2,059 ALI waiver clients are currently served by a care coordinator who does not work for an agency that provides waiver-funded services. The Intellectual and Development Disabilities (IDD) waiver serves 1,963 clients; of these, only 17 percent are served by a care coordinator who does not work for an agency that provides waiver-funded services.

Figure 2: Percent Independent Care Coordinators by Waiver Type



Source: Alaska Department of Health and Social Services Data Transmittal 12.18.14

## CARE COORDINATORS BY REGION AND BY WAIVER TYPE

In Alaska, there are 592 care coordinators and 359 agencies offering care coordination serving 4,343 clients. Approximately 42 percent of clients are served by an independent care coordinator. 2,518 individuals are served by care coordinators who work within service provider agencies and are therefore not conflict-free, as defined by the HCBS rule. In more rural areas, it is less common for a participant to work with an independent care coordinator. For example, fifty-one percent of

Anchorage's waiver clients are served by independent care coordinators compared with only four percent in Northwest Alaska.

Figure 3: Clients Served by Independent Care Coordinators, by Region and Waiver Type<sup>1</sup>

| Region              | Number of<br>Care<br>Coordinators | Number of<br>Agencies<br>Providing Care<br>Coordination | Number of<br>Clients | Number of Clients<br>Served by<br>Independent Care<br>Coordinator | Percent of Clients<br>Served by<br>Independent Care<br>Coordinator |
|---------------------|-----------------------------------|---|----------------------|---|--|
| <b>Anchorage</b>    |                                   |   | <b>2,197</b>         | <b>1,114</b>  | <b>51%</b>   |
| IDD                 | 83                                | 38  | 925                  | 195   | 21%  |
| ALI                 | 87                                | 62  | 1,144                | 882   | 77%  |
| APDD                | 26                                | 17  | 36                   | 18  | 50%  |
| CCMC                | 38                                | 18  | 99                   | 21  | 21%  |
| <b>Southcentral</b> |                                   |   | <b>1,360</b>         | <b>586</b>  | <b>43%</b>   |
| IDD                 | 72                                | 37  | 538                  | 89  | 17%  |
| ALI                 | 76                                | 54  | 716                  | 471   | 66%  |
| APDD                | 25                                | 18  | 31                   | 9   | 29%  |
| CCMC                | 33                                | 15  | 76                   | 17  | 22%  |
| <b>Southeast</b>    |                                   |   | <b>320</b>           | <b>64</b>   | <b>20%</b>   |
| IDD                 | 31                                | 16  | 192                  | 34  | 18%  |
| ALI                 | 21                                | 16  | 98                   | 18  | 18%  |
| APDD                | 4                                 | 3   | 6                    | 4   | 67%  |
| CCMC                | 13                                | 9   | 24                   | 8   | 33%  |
| <b>Interior</b>     |                                   |   | <b>326</b>           | <b>47</b>   | <b>14%</b>   |
| IDD                 | 24                                | 14  | 206                  | 16  | 8%   |
| ALI                 | 12                                | 11  | 95                   | 29  | 31%  |
| APDD                | 5                                 | 3   | 5                    | 1   | 20%  |
| CCMC                | 10                                | 4   | 20                   | 1   | 5%   |
| <b>Northwest</b>    |                                   |   | <b>45</b>            | <b>2</b>  | <b>4%</b>  |
| IDD                 | 5                                 | 4   | 31                   | 0   | 0%   |
| ALI                 | 2                                 | 2   | 2                    | 2   | 100%   |
| APDD                | 0                                 | 0   | 0                    | 0   | n/a  |
| CCMC                | 4                                 | 2   | 12                   | 0   | 0%   |
| <b>Southwest</b>    |                                   |   | <b>95</b>            | <b>3</b>  | <b>3%</b>  |
| IDD                 | 12                                | 8   | 71                   | 2   | 3%   |
| ALI                 | 3                                 | 3   | 4                    | 1   | 25%  |
| APDD                | 0                                 | 0   | 0                    | 0   | n/a  |
| CCMC                | 6                                 | 5   | 20                   | 0   | 0%   |
| <b>Alaska Total</b> |                                   |   | <b>4,343</b>         | <b>1,816</b>  | <b>42%</b>   |
| IDD                 |                                   |   | 1,963                | 336   | 17%  |
| ALI                 |                                   |   | 2,059                | 1,403   | 68%  |
| APDD                |                                   |   | 78                   | 32  | 41%  |
| CCMC                |                                   |   | 251                  | 47  | 19%  |

<sup>1</sup>Source: Alaska Department of Health and Social Services Data Transmittal 12.18.14. Note: Total number of clients is unduplicated. Regional totals for care coordinators and agencies providing care coordination are not available as unduplicated counts.

## LESSONS FROM OTHER STATES

The consultant team conducted interviews with four states that are transitioning, or have recently transitioned, to conflict-free case management in order to learn lessons from their experiences that will inform Alaska's reforms. We selected the following states:

- **Colorado:** We selected Colorado because the State is actively engaged in a planning effort to determine how to comply with the CMS conflict-free requirements.
- **Wyoming:** Wyoming engaged in a strategic planning effort to establish a conflict-free system and is currently implementing its plan.
- **Hawaii:** Hawaii transitioned from a conflicted system in the late 90s. Hawaii, like Alaska, serves diverse cultural populations, many of whom live in remote, difficult to access locations.
- **Minnesota:** Minnesota has a conflict-free system in which they are separating the roles of assessment and support planning from ongoing case management and service provision. They are engaged in a number of efforts to try to facilitate seamless handoffs among all of the players involved. These efforts may serve as models for how Alaska can minimize disruptions caused by the separation of case management from service provision.

In this section, we summarize the major lessons learned from interviews with state representatives. A summary of the interviews with each of the states is included in the Appendices.

The first lesson from other states is that it is very hard to achieve a consensus plan for how to comply with the CFCM requirements. In Colorado, the State and its stakeholders are struggling to reach a consensus regarding how to comply with the conflict-free requirements. After extensive discussions, it appears that a consensus plan will not be possible and the State will need to make a decision that will displease some stakeholders. Wyoming chose to move forward with its plans despite objections from stakeholders, notably providers. The representative from Hawaii recalled how the switch to conflict-free case management was very acrimonious and included a temporary return to conflicted case management.

A second major lesson is that reforming conflict-free case management should be done in conjunction with other reforms to case management, including the following:

- **Refinement of CM requirements, qualifications, and training:** Simply separating the case manager from the direct service provider may create problems if the State does not clearly define the role and performance expectations for the case managers. If performance measures are not explicit, participants may be harmed by delays in having service plans developed, authorizing services, and renewing and changing service plans. Wyoming instituted a major refinement to the requirements and reimbursement for case

management in conjunction with the conflict-free requirements. Wyoming also emphasized the need for extensive training to ensure that case managers understood the new requirements. Because Hawaii chose to replace provider case management with case management done by State employees, it addressed this issue by creating clear job descriptions and training for the State case managers.

- **Increasing monitoring and enforcement capabilities:** In a system in which case management is provider-based, providers have a strong incentive to ensure that service plans and authorizations are completed in a timely manner in order to be able to bill for direct services. A participant with an independent case manager who is delinquent in updating plans and authorizations may be pressured by providers to switch to the provider-based case manager to prevent gaps in services. When only independent case management is an option, much of this pressure may go away. Wyoming recognized and responded to this by building increased monitoring and enforcement capabilities as part of its restructuring. Hawaii addresses this by having timeliness of service authorizations as part of its performance expectations for its State case managers.
- **Reimbursement strategies:** The four states interviewed recognized that how case management is reimbursed influences the amount of case management that is provided. Therefore, they have moved away from per day or per month rates that incentivize providing the least amount of case management to fill the basic case management requirements. Instead, they are moving to billing on 15-minute increments with the total amount of billing subjected to service caps.
- **Clear roles and processes for sharing information across providers, case managers, and assessors:** As more individuals are involved in managing the supports for individuals with disabilities, it is more important to clarify roles and information-sharing processes. When provider-based case management is allowed, the case manager may directly perform many of the functions necessary to actually implement supports (e.g., identifying and scheduling staff, etc.) or work closely with the staff who perform these functions. Clarifying the role of the case manager was a major component of Wyoming's plans. Minnesota has done the most work in this area, including developing IT solutions to facilitate the sharing of information across entities.

Finally, we obtained from each of the states their perception of the pros and cons of allowing service providers to continue to supply case management as long as they did not provide both direct services and case management to the same person. None of the states interviewed supported this arrangement. They acknowledged that the separation could create coordination challenges, however, they supported a complete separation of case management and service planning from service provision for the following reasons:

- **Concerns about quid pro quo arrangements and collusion:** All of the states were concerned that providers in their case management role might be hesitant to aggressively

monitor or challenge plans being developed by another provider because of concerns about retaliation when the roles were reversed. One state provided an example in which several providers had acknowledged that they planned to collude to minimize any changes and maximize revenues.

- **De-emphasis of case management:** State staff interviewed were concerned that staff who conduct both case management and provide direct services may give a higher priority to the direct service role rather than the case management role. This is especially a concern among very small provider agencies where the case manager may also be providing the direct support.
- **Ability to establish a professional workforce:** The states emphasized that they were trying to develop a workforce of professional case managers who had greater training and skills and were more carefully monitored. In states in which smaller provider agencies performed multiple functions, it was more burdensome for part-time case managers to participate in trainings. In addition, it was more burdensome for the State to oversee a larger number of case managers.

## OVERVIEW OF REFORMS NEEDED TO COMPLY WITH CMS RULES

To comply with the CMS rules, SDS will need to make the following decisions:

- **Establish a definition for conflict-free case management:** Alaska will need to clarify what will and will not be approved as case management. As discussed earlier, the rules do not explicitly rule out the provision of case management by provider agencies, only the provision of both by the same entity to the same participant. However, the other states interviewed encouraged a complete separation of case management from service provision. SDS has made an initial decision that a complete separation will be required in Alaska.

A key component of this definition will be to establish the criteria for whether service providers can own and/or serve on the boards of directors of case management agencies. Other sections of the CMS rules appear to prohibit ownership of the case management agency by an individual or entity that also owns an agency that provides HCBS. SDS may want to explicitly include this in its rules and include a disclosure form as part of the application.

Sharing board members may be a more complicated issue especially in the smaller communities. In many cases, there may be only a limited number of people with knowledge about HCBS delivery and forbidding any crossover in board membership may be extremely challenging and exclude individuals who could make a valuable contribution. As an alternative, SDS could require that if an agency has a board of directors, the board must include representation by participants, family members and/or

advocates. Recent federal guidance in the form of grant solicitations and rules (e.g., the CFC Development and Implementation Council) have set a goal or requirement of having a least 50% of advisory bodies consisting of participants, family members and/or advocates.

- **Establish a process to identify areas where provider-based case management will be allowed:** The rules allow for provider-based case management in areas where the state has demonstrated that there is no other “willing and qualified entity to provide case management.” A state could consider trying to meet this criterion by establishing thresholds based on factors such as population density. However, this approach has two primary drawbacks. One, there are many factors that could limit the number of providers such as population density, accessibility to other population centers, cultural and language diversity of the population, other competing employers, etc. If a state goes this route, it will likely need to develop a process for addressing these exceptions. Two, how will a state address instances in which a conflict-free case management option is available in an area deemed excepted? Does the criteria need to be adjusted? Is it invalidated? Will the state need to make exceptions to the exception? If so, what will be the process for doing so?

A second option would be to systematically detail the areas for which conflict-free case management is provided and deem that exceptions will be allowed in areas where no option exists. If this route is taken, a state will want to be able to demonstrate to CMS that it made a good faith effort to enroll conflict-free case management entities. This effort will likely include two components. One, a state will need to demonstrate that it made the desire widely known to have conflict-free case management entities enroll. This could be accomplished through outreach efforts including a solicitation and/or advertising about the availability of the opportunities. Two, a state will need to demonstrate that there are no structural barriers, such as overly burdensome administrative requirements and/or insufficient reimbursement, to attract case managers who are not also providers.

- **Establish mitigation strategies for where a conflict is allowed:** States will need to establish requirements and policies for mitigating potential conflicts of interest. Descriptions of potential mitigation strategies can be found in the CMS-sponsored Balancing Incentives Program (BIP) Implementation Manual, which can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Downloads/BIP-Manual.pdf>. Potential mitigation strategies include:
  - Internal firewalls which dictate if and when staff conducting case management interact with staff responsible for direct service provision.



- Complaints and grievance processes that allow participants to easily identify when they believe a provider is not acting in their best interests.
- State monitoring of conflicted providers to identify any potential conflicts.

SDS will need to describe clearly how it will address each of these design questions in the waiver applications they file to renew the existing waivers.

## CLARIFYING CASE MANAGEMENT ACTIVITIES THAT MAY BE ALTERED AS ALASKA RESPONDS TO THE CMS MANDATES

Earlier, we discussed the conflict-free requirements included within CMS's HCBS rule. This rule explicitly discussed service planning and case management. Alaska now faces the challenge of translating that definition into specific policies and rules that guide program operations. In doing so, we believe that a necessary first step is to break out the specific activities that may be considered case management so that the State and its stakeholders can have an informed discussion about each component.

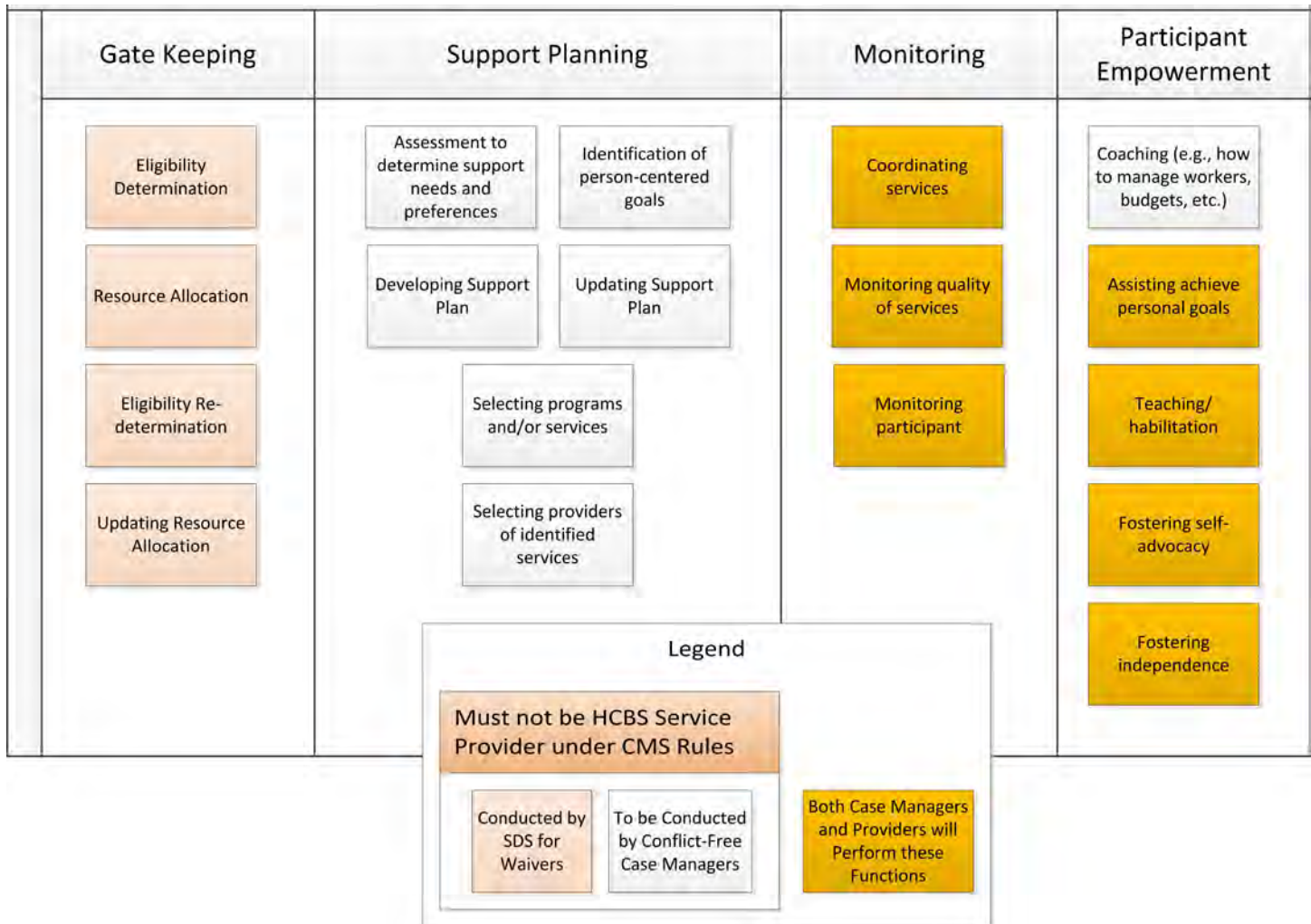
This effort's review of the different types of case management in Alaska revealed substantial differences about what is and is not considered case management. This highlights that there are a number of business processes that may be included under the case management rubric.

Figure 24 provides a summary of the different business processes that may be considered case management. Case management services, such as the case management offered under the HCBS Waivers, consists of all or a subset of these services. We have broken these functions into four major categories:

- **Gate keeping:** This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.
- **Support planning:** These are the processes that lead to a service or support plan. Under the CMS rules, these processes must be restricted to be consistent with the person-centered approach described in the rules including addressing potential conflicts of interest.
- **Monitoring:** These are the processes for ensuring that services are delivered according to guidance included in the support plan. Activities include coordinating services, monitoring the quality of the services (e.g., verifying staff showed up on time and performed the activities in the manner described in the support plan), and monitoring the participant (e.g., watching for changes in needs or preferences).
- **Participant empowerment:** Traditionally, this role was known as advocacy. Under the new rules that emphasize a person-centered approach and fostering participant independence and control, this role is shifting. The role now includes activities such as

habilitation and building the ability to self-advocate, which will allow participants to assume more choice and control.

Figure 4: Core Functions that could be Considered Case Management and Service Management



In this chart, we have color-coded the activities (as identified in the legend) to reflect the following:

- In Alaska, SDS conducts the gate keeping functions for the HCBS waivers.
- The CMS conflict-free requirements clearly require that the gate keeping and support planning activities must not be conducted by the HCBS service provider.
- Coaching, which can be considered a type of case management, is often used as a model for self-directed programs.<sup>2</sup> Coaching involves teaching individuals how to manage workers and other services and provides support to the participant as she or he assumes

<sup>2</sup> Alaska's Consumer-Directed Personal Care Assistance (CDPCA) program is an example of a self-directed program. At this time, Alaska does not have a case management or coaching option that is focused solely on CDPCA. However, CDPCA participants who are also enrolled in a waiver receive case management, but SDS does not require that case managers use a coaching approach.

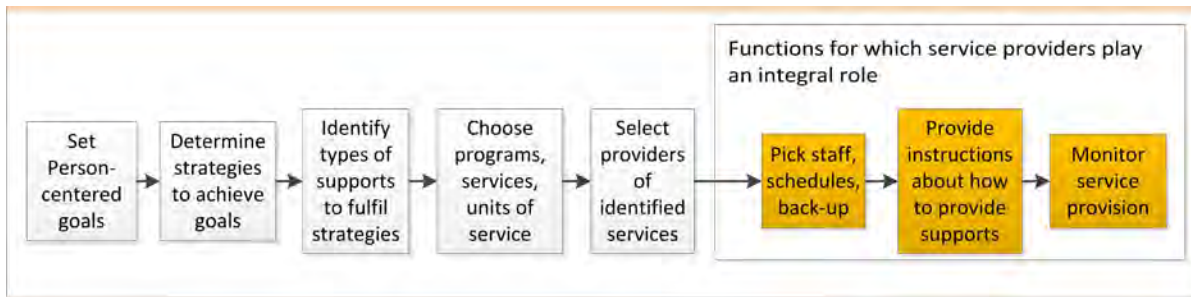
these management tasks. This differs from traditional case management, in which a case manager will typically manage services and supports directly. Coaching is not an approach that is required, specifically endorsed, or independently financed by SDS. In reforming case management, SDS could consider offering coaching as an option to participants receiving self-directed services. If this service is offered, under the CMS rules, the function would need to be offered by a conflict-free entity.

- It is important to recognize that both case managers and service managers, employed by the service provider agency, perform all of the monitoring and most of the participant empowerment functions.

It will be important to recognize and address the overlap in monitoring and participant empowerment. Minnesota described the separation of these roles as being the development versus the implementation of the support plan. The provider is responsible for the implementation of the plan. Figure 3 helps clarify this separation by showing the core steps necessary to implement a person-centered plan. Once Alaska implements changes to comply with the conflict-free requirements, the conflict-free case manager will play a major role in all of the steps. However, the service provider will likely play a central role in the last three steps:

- While the case manager may help the individual identify preferences for which types of staff they want and when they want to receive supports, providers will likely retain primary responsibility for identifying the actual staff, setting schedules and ensuring that back-up supports are available.
- The support plan will likely include guidance about the participant's preferences about how supports are provided. However, it will be up to the provider to flesh out the details of these instructions and ensure that staff are trained and instructed to provide supports in a manner that is consistent with the person-centered support plan.
- The case manager will play a monitoring role through regular contact with the participant likely including observing the provision of services. However, the provider will be monitoring daily service provision and will be responsible for notifying the case manager of any issues or critical incidents.

Figure 5: Core Steps in Implementing a Person-centered Plan



The CMS rules do not recognize the necessary overlap in the monitoring and participant empowerment roles. This has created confusion in the states regarding how to implement the requirements. In restructuring case management, SDS and the stakeholders will need to carefully delineate the respective roles, responsibilities, information sharing, and hand-offs for each of these functions. Wyoming and Minnesota provide the best guidance for how to approach this delineation. To avoid unnecessary federal concern, the State should avoid using terms that could be considered as pseudonyms for case management if and when it labels these activities when they are performed by providers.

### 3. DRAFT PLAN TO COMPLY WITH THE CMS CONFLICT-FREE REQUIREMENTS

SDS has made a policy decision that case management will need to separate completely from service provision. Therefore, our plan does not include the option of allowing HCBS service providers to offer case management even when they do not provide other HCBS services for or with that participant. However, stakeholders raised the question of whether an agency that provides direct services to participants in one region of the state would be allowed to provide case management in a different region of the state. This will need to be determined during the design phase in 2015.

When SDS renews the state's waiver plan it will need to describe how care coordination will comply with the HCBS rules. Therefore, to avoid being subject to a Corrective Action Plan, the State must have a care coordination system that is compliant by July 1, 2016. Communications with participants, caregivers, service providers and policymakers will be ongoing during 2015 and 2016 in order to encourage transition over that period. By January 1, 2016, all **new** waiver participants will be served by a conflict-free case manager. By June 30, 2016, case management and service provision will be separated completely, except in areas where conflict will be allowed as defined by CMS for rural and frontier areas, where no conflict-free case manager exists.

This section provides an overview of the key issues addressed in the implementation plan below.

#### COMMUNICATION

The State must keep multiple stakeholders informed throughout this transition. The first steps of the Implementation Plan focus on communication between the State and participants, caregivers, current care coordinators, service providers, policy makers and legislators.

Because each region of the state has different factors that will determine the optimal way to provide conflict-free case management to participants, stakeholders strongly support regional and community-level forums to weigh options and identify local resources to provide conflict-free case management. These forums will also provide the opportunity to publicize the process for participants and families and to identify infrastructure needed in each region to support conflict-free case management, as well as available resources to provide it.

In addition, the stakeholders that have been engaged to date would like to continue to meet as an advisory body to provide feedback and guidance throughout this transition.

## CLARIFYING THE CORE REQUIREMENTS FOR CONFLICT-FREE CASE MANAGEMENT AND SUPPORTING INFRASTRUCTURE IN THE SHORT TERM

This section identifies the short-term steps to comply with the conflict-free requirements of the HCBS rule. In the short term, SDS must address two objectives to implement a conflict-free case management system:

- One, SDS must establish a process for determining whether a conflict-free case management option exists in all areas of the state. This will allow SDS to determine where it will be necessary to grant exceptions that will allow service providers to continue to provide case management in rural and frontier areas. It appears that a solicitation will be the most efficient process for making this determination. This solicitation process should also address mitigation measures that must be in place when conflicted case management is allowed.
- Two, SDS must determine whether it needs to take action to ensure there is adequate case management capacity once provider case management is removed as an option. It is unclear whether market forces alone will adequately increase the supply of conflict-free case management. In addition, some stakeholders and SDS has expressed concern about its ability to train and monitor a large number of independent conflict-free case managers.

To address the second concern, SDS should consider whether to facilitate the development of infrastructure to support high quality conflict-free case management. The goals for developing this local, regional or statewide infrastructure to support conflict-free case management include:

- Improve value for State resources and increase efficiency of State oversight.
- Improve and monitor performance of case management.
- Sustain capacity to provide case management during the transition to conflict-free case management, and beyond.

We discuss four options for addressing this issue in the next section. The Draft Implementation Plan to Comply with CMS Conflict-Free Requirements, included below, identifies the following steps to develop needed infrastructure, however, the State will work with stakeholders to determine the specifics of whether and which type of regional infrastructure to incent or require.

Between March and September 2015, the State must identify the requirements for conflict-free case managers and case management agencies. This includes the following steps:

- SDS will need to clarify specific requirements for conflict-free case management. This will include addressing issues such as the following:

- Will an agency that provides direct waiver services in one region be allowed to provide conflict-free case management in another region where it does not provide direct services?
  - To what extent can non-profit agencies include members of their Boards of Directors who have an affiliation with a service provider agency?
  - Can a conflict-free case management agency offer a service to an individual when no other direct service provider option is available?
- The State will work with tribal health organizations and other community agencies serving rural areas to determine mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists, as allowed by CMS for rural and frontier areas. In these same areas, it will also be critical to identify where service providers are and are not able to provide HCBS services.
  - Stakeholders will convene and facilitate regional and community-level dialogues to publicize the process and identify needed infrastructure to provide conflict-free case management to participants in area. The State will work with stakeholders to determine how to develop regional or statewide infrastructure to deliver high-quality case management. Based on the outcome of this process the State will identify requirements, if any, for affiliation between independent case managers and case management agencies.
  - Based on this report and the subsequent work with stakeholders, the State will identify performance measures against which the quality of case management will be monitored.
  - The State will expedite the rate-setting process in order to provide the necessary information to potential conflict-free case management providers to evaluate the business case. This may be especially important because SDS will likely need to change requirements for care coordinators to comply with the person-centered planning portion of the CMS rules. These changes will likely impact the amount of time that care coordinators need to spend on core activities. This potential combination of removing provider case management from the market while increasing care coordination requirements could dramatically impact the availability of case management if the current reimbursement structure remains unchanged. To address this, and to match CMS expectations, the State will need to investigate moving from a flat fee to a billing model that uses a 15-minute increment for case management. This structure is considered a best practice in order to address different participants' acuity levels and to monitor the performance of case managers.
  - The steps needed to research, propose, refine and develop regulations for a revised rate structure may not be possible in the timeframe identified in this plan. SDS will



need to identify the steps that will be possible in order for providers to determine the business case for conflict-free case management.

- The State will also determine changes to documentation and billing requirements and processes.

By September 2015, once requirements are determined, the State will draft and release a solicitation of interest to determine availability of conflict-free case management in all census areas, allowing 45 days for response. If possible, the State will release the solicitation earlier and allow the response to extend to 90 days to allow maximum time for providers to organize their responses.

The solicitation will, at minimum, identify rural and frontier areas where conflict-free case management does not exist and where mitigation measures will be needed to allow service providers to provide case management in these areas.

The State will evaluate responses to the solicitation against certification requirements and identify conflict-free case managers for each waiver and each census area. The State will also identify the areas of the state where no conflict-free case management exists for each waiver type. For these areas, the State will work with the tribal health organizations, Community Health Centers and other organizations in those regions to secure conflict-free case management for participants in these regions, using the mitigation measures identified above.

On January 1, 2016, the State will publish the list of conflict-free case managers for each census area and for each waiver. A conflict-free case manager will serve any new participants from this date forward. Current care coordinators will establish that they are conflict-free, or will be in the process of moving to a conflict-free employment setting. Participants will work with their current care coordinators to determine if transition is needed to receive conflict-free case management.

By June 30, 2016, all waiver participants will be served by a conflict-free case manager. Any entity that provides case management will no longer be allowed to provide waiver-funded direct services, unless exempted from the requirement by the process outlined above.

## IDENTIFYING MECHANISMS TO ENSURE ADEQUATE CASE MANAGEMENT CAPACITY

Stakeholders were concerned that the pending changes were causing current care coordinators to seek other positions and that the knowledge and capacity of current care coordinators would be lost in the transition to conflict-free case management. Stakeholders believe that SDS needs to take action to ensure that there are a sufficient number of care coordinators after the transition occurs.

There was consensus that the State needed to develop infrastructure that would allow new approaches for organizing case management and providing the administrative support for case managers. Stakeholders vary in their views as to which type of local, regional or statewide



infrastructure would best achieve this goal. The State and The Trust may choose to help facilitate regional forums to gather additional input to determine whether regional or statewide infrastructure is needed to deliver high-quality case management.

The State and the stakeholders should together consider the four options described below and in

Figure 6, which notes the advantages and disadvantages of each option, as identified in the work sessions convened for this project.

**Option 1 Market-Driven, State performs Quality Improvement / Quality Assurance:** Set the Conditions of Participation to require professional-level case management and to set performance measures to monitor quality. SDS directs Quality Improvement and Assurance activities using new on-line platform and sanction processes when performance measures are not met. The solicitation would allow multiple case managers and agencies per census area and would leave it to the market to determine the volume for case managers and agencies. The State would also leave it to the market to determine how best to meet the quality standards and administrative requirements, for example, by a group of independent case managers forming a co-op to share billing and administrative functions.

- **Advantages:** Minimizes change from existing system; allows case managers and agencies to determine appropriate business size and volume; maintains participant choice in case managers.
- **Disadvantages:** Does not necessarily decrease the number of case managers or agencies for the State to oversee; does not provide organizational infrastructure for current care coordinators to move to; does not work towards the long-term goal of a comprehensive case management system.

**Option 2 Regional CFCM Agencies, one per region:** State solicits regional umbrella organizations to oversee delivery of conflict-free case management. Identify one per region and require all case managers in that region to affiliate with regional organization. The regional organization serves all waiver participants in the region.

- **Advantages:** Guarantees volume to case management agencies, which may improve feasibility of business; provides organizational infrastructure for current care coordinators to move to; decreases the number of case managers or agencies for the State to oversee; allows for expansion to all types of case management to different populations to meet the long-term goal of a fully coordinated case management system.
- **Disadvantages:** Significant change from existing system; does not allow case managers to remain independent and determine business size and volume; may limit participant choice and will require a 1915(b)(4) waiver.

**Option 3 Statewide or regional administrative support:** The State contracts with an entity or entities to provide support to case managers without itself providing case management. ADRCs, Centers for Independent Living, tribal health organizations, the Trust Training Cooperative or a Quality Improvement Organization (QIO) could provide these services. Functions include training, monitoring, administrative support, and other functions. SDS could likely receive Medicaid administrative match to support these contracts, but would have to receive approval from CMS before doing so.

- **Advantages:** Provides central source for quality improvement and assurance activities; provides administrative support for case management statewide; minimizes change from existing system; maintains participant choice in case managers; allows for expansion to all types of case management to different populations to meet the long-term goal of a fully coordinated case management system
- **Disadvantages:** Does not provide organizational infrastructure for current care coordinators to move to; does not necessarily decrease the number of case managers or agencies for the State to oversee.

**Option 4 Regional organizations, multiple per region, provide CM and administrative**

**support:** Regional or local entities, which could be non-profit, for profit, or co-operative organizations, provide infrastructure and administrative oversight for each region or local area.

These organizations could both employ case managers and/or provide support to independent case managers.

- **Advantages:** Provides organizational infrastructure for current care coordinators to move to; may improve quality of case management; maintains participant choice; minimizes change from existing system; allows case managers to remain independent and determine business size and volume;
- **Disadvantages:** Does not guarantee volume so may not improve feasibility of case management business; does not necessarily decrease the number of case managers or agencies for the State to oversee.

Figure 6: Criteria to Evaluate Options

| <b>Criteria to Evaluate Options</b>  | <b>Option 1</b><br>Market-driven,<br>State performs<br>QI/QA | <b>Option 2</b><br>Regional CFCM<br>Agencies, one<br>per region                                  | <b>Option 3</b><br>Statewide or regional<br>training, monitoring and<br>administrative support | <b>Option 4</b><br>Regional organizations,<br>multiple per region,<br>provide CM and<br>administrative support |
|--|--|--|--|--|
| <i>Improve value for State resources and increase efficiency of State oversight.</i>                                   | Low  | High   | Medium   | Medium   |
| <i>Improve and monitor performance of case management.</i>   | Low  | High   | Medium   | Medium   |
| <i>Sustain capacity to provide case management during the transition to conflict-free case management, and beyond.</i> | Medium   | Medium   | Medium   | Medium   |
| <i>Level of change from existing to reformed system.</i>   | Minimal change   | High change  | Minimal change   | Moderate change  |
| <i>Is participant choice maintained?</i>   | Yes  | Not entirely, participants could choose case manager but would be limited to one regional agency | Yes  | Yes  |
| <i>Allow case managers and agencies to determine appropriate business size and volume.</i>                             | Yes  | No   | Yes  | Yes  |
| <i>Could require additional approval from CMS (e.g., 1915(b)(4) waiver).</i>   | No   | Yes  | No ( <i>SDS could seek Medicaid Administrative Match</i> )                                     | Yes, if do not approve any willing provider  |

In addition to discussing the four options above, the following questions should be considered:

- Would regional case management agencies serve participants from all four waivers?
- What would be the optimal manner for reimbursing these entities? In doing so, SDS will need to consider the following:
  - If the option includes the provision of case management, SDS will want to consider both the rate and rate structure and the potential volume to ensure that these entities are financially viable. There may need to be a tradeoff between the rate structure and volume. For example, Option 2 should help ensure higher volume, which in turn should allow the regional case management entities to be more efficient. Alternatively, if the State would like to foster multiple regional entities, each entity

may have lower volume. To compensate for this, the State may wish to consider a reimbursement structure that allows for more of the administrative costs to be covered for entities with lower volume (i.e., a higher rate for entities with lower volume). In conducting these analyses, SDS may want to consider differences in travel time and costs for rural locations.

- If the State chooses Option 3, which only pays for administrative and other support, but not actual case management, the State will likely want to do so using an administrative contract that is eligible for Medicaid administrative federal financial participation (FFP).
- Will short-term grant funding be available to facilitate transition to new model and incentivize start-up of regional entities?
- How will the infrastructure model selected ensure participant choice?
- What will be the best way to maximize the role of tribal providers?

## SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS

| Action Step  |  | Who   | Timeframe              | Status | Notes   |
|--|--|---|------------------------|--------|---|
| Short Term Reforms: Participants Transition to a Conflict-free Case Manager, March 1, 2015 – June 30, 2016 |  |   |                        |        |   |
| 1  | State communicates key dates in implementation plan to participants, care coordinators and service providers.  | State of Alaska Senior and Disabilities Services  | March 30, 2015         |        | Convene a Conflict-free Case Management Advisory Group, using current stakeholders and participants, to advise the process. |
| 2  | State develops and implements communication plan for policymakers and legislators.   | State of Alaska Senior and Disabilities Services  | Ongoing 2015-2016      |        |   |
| 3  | Stakeholders facilitate regional and community-level dialogues to publicize the process and identify needed infrastructure to provide conflict-free case management to participants in area.               | Stakeholders, The Trust   | March – September 2015 |        |   |
| 4  | State works with stakeholders to determine how to develop regional or statewide infrastructure to deliver high-quality case management.  | State of Alaska Senior and Disabilities Services, Participants and caregivers, conflict-free case managers and agencies | March – June 30, 2015  |        | See narrative for four options to consider.   |
| 5  | Depending on outcome of process, State determines criteria for regional or statewide infrastructure.   |   | March – June 30, 2015  |        |   |
| 6  | State determines requirements for conflict-free case managers and case management agencies. This includes identifying performance measures against which the quality of case management will be monitored. | State of Alaska Senior and Disabilities Services  | March – June 30, 2015  |        |   |

## SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS

| Action Step |  | Who  | Timeframe             | Status | Notes  |
|-------------|--|--|-----------------------|--------|--|
| 7           | State determines requirements, if any, for affiliation between independent case managers and case management agencies.   | State of Alaska Senior and Disabilities Services | March – June 30, 2015 |        |  |
| 8           | State expedites the rate-setting process for basic conflict-free case management.  | State of Alaska Senior and Disabilities Services | March – June 30, 2015 |        |  |
| 9           | State determines if one agency is allowed to provide waiver services in one region and conflict-free case management in another region.  | State of Alaska Senior and Disabilities Services | March – June 30, 2015 |        |  |
| 10          | State determines mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists, as allowed by CMS for rural and frontier areas. | State of Alaska Senior and Disabilities Services | March – June 30, 2015 |        | <p>Consult with tribal health organizations and Community Health Centers to determine mitigation measures.</p> <p>Internal firewalls and policies to substantiate conflict-free status may include:</p> <ul style="list-style-type: none"> <li>▪ Cannot share supervisors</li> <li>▪ Separate office space and records storage</li> <li>▪ Review all plans of care for conflict and biases</li> <li>▪ Allow shared board members to the extent that it is allowed under corporate law</li> </ul> |
| 11          | State determines documentation and billing requirements and processes.   | State of Alaska Senior and Disabilities Services | March – June 30, 2015 |        | Determine frequency and type of communication between conflict free case management performed by care coordinators and service management conducted by provider agency staff.  |

## SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS

| Action Step   | Who  | Timeframe                       | Status | Notes   |
|---|--|---------------------------------|--------|---|
| 12 State drafts and releases a solicitation of interest to determine availability of conflict-free case management in all census areas.   | State of Alaska Senior and Disabilities Services | July 2015                       |        | Provide 90-days for response.   |
| 13 In responding to solicitation, conflict-free case managers and agencies will identify census areas of the state they will serve and which waiver participants they will serve.   | Case managers and agencies                       | August 1 – October 15, 2015     |        |   |
| 14 State evaluates responses to solicitation against certification requirements and identifies conflict-free case managers for each waiver type and each census area.   | State of Alaska Senior and Disabilities Services | October 15 -November 15, 2015   |        | Determine if multiple case managers per census area will be allowed, or if a regional model will be developed that limits the number of case managers per region. |
| 15 State identifies areas of the state where no conflict-free case management exists for each waiver type. <ul style="list-style-type: none"> <li>State works with the tribal health organizations, Community Health Centers and other organizations in those regions to secure conflict-free case management for participants in these regions, using mitigation measures identified above.</li> </ul> | State of Alaska Senior and Disabilities Services | November 15 – December 15, 2015 |        |   |
| 16 State publishes list of conflict-free case managers for each census area and for each waiver type.   | State of Alaska Senior and Disabilities Services | January 1, 2016                 |        |   |



## SHORT TERM IMPLEMENTATION PLAN TO COMPLY WITH CMS CONFLICT-FREE REQUIREMENTS

| Action Step  | Who  | Timeframe               | Status | Notes |
|--|--|-------------------------|--------|-------|
| 17 Participants work with current care coordinators to determine if transition is needed to a conflict-free case manager and to facilitate transition, if needed.        | Current participants and care coordinators       | January – June 30, 2016 |        |       |
| 18 All new participants are served by a conflict-free case manager.  |  | January 1, 2016         |        |       |
| 19 State develops and implements second round of communication plan for participants and caregivers.   | State of Alaska Senior and Disabilities Services | Spring 2016             |        |       |
| 20 All waiver participants are served by a conflict-free case manager. Any entity that provides case management is not allowed to provide waiver-funded direct services. |  | June 30, 2016           |        |       |



## 4. VISION FOR CASE MANAGEMENT SYSTEM IN ALASKA

In our work sessions with the stakeholders and State representatives, in addition to discussing how to comply with the CMS rules, we spent time trying to determine whether there was a consensus vision for how case management should be delivered in Alaska.

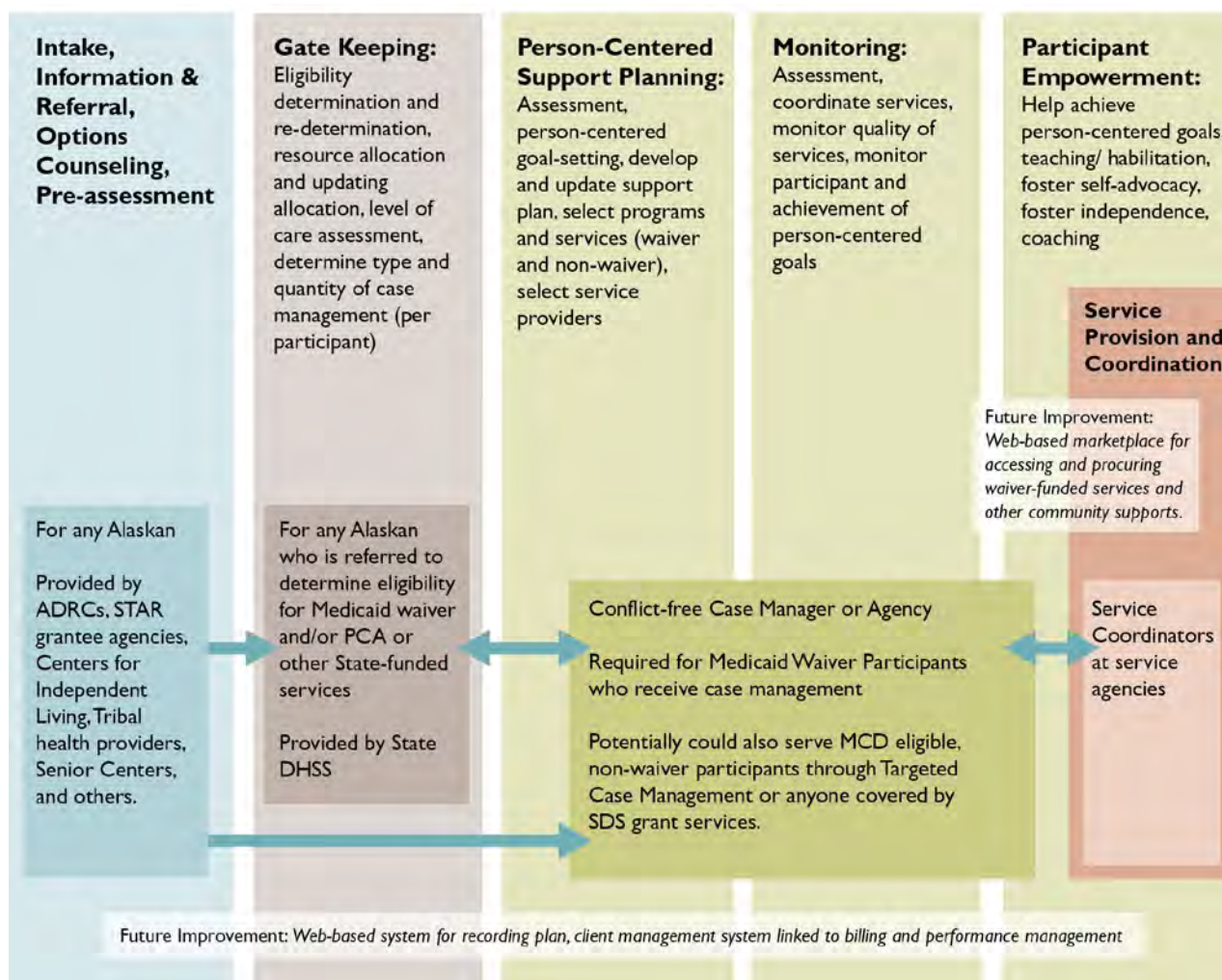
We found that there was a strong consensus among State staff and stakeholders for an approach that included the following components:

**A fully coordinated case management system that is integrated and seamless from the participant's point of view.** The system should be easy to access and clearly identify the role of ADRCs, the Short-term Assistance and Referral (STAR) grantee agencies and other referral sources. Define the core functions of the participant, family, case manager, service manager, service provider, and the State and the processes through which they interact. The case management model developed to serve participants in Medicaid Waiver programs should be flexible enough to be able to add on new participants, such as behavioral health clients, in order to move to a comprehensive case management approach, over time. Done well, this model could serve additional payers including private insurers. See Figure 7.

**The systems should operationalize the following values:**

- Be person-centered.
- Build participant empowerment, emphasizing choice and goal setting; respecting participant choice, including the refusal of services.
- Case managers must avoid personal bias and judgment of participants.
- Case managers must act with compassion, humility, self-awareness and respectfulness.
- The case management workforce must be competent to serve participants across diverse cultures, ages, diagnoses, and functional abilities.
- Case managers must incorporate person-centered interviewing skills into their practice to help participants determine goals and make informed choices.
- Case management must include family caregivers and build upon natural supports.

Figure 7: Conflict-free Case Management Within Coordinated Person-centered System



**The needs and preferences of the participant should drive the level, type and frequency of case management.** The State would develop an assessment and approval process that identifies which type and how much case management to allocate for each participant, as part of a person-centered plan. The process should include the following options: 1) minimal or no case management; 2) a coaching model of case management; 3) basic case management; and, 4) specialized comprehensive (including medical) case management. The State is currently working to develop an acuity-based system for long-term services and supports in Alaska. These acuity levels may inform the level and type of case management required by a participant. However, additional factors should also be considered including the strength and competency of the participant's natural supports.

The State may also determine the frequency of contact between the case manager and the participant as part of the assessment. The current requirement of two contacts per month, one of which is face to face, is high compared to other states; quarterly requirements are more typical. It may also be beneficial to allow telemedicine for some contacts with participants in remote communities. This

practice is increasingly accepted in rural areas in order to increase access to specialized consultation that is not available in the community or region. This will require a DHSS regulation change.

To meet the needs for basic and specialized case management, the State should develop tiers of case management with various levels of qualifications that can be matched with participant needs, associated with tiered reimbursement rates. Specific certifications such as the Qualified Developmental Disabilities Professional or Qualified Intellectual Disabilities Professional (QDDP/QIDP), the Care Management Certificate (CMC), degrees in nursing or other medical field, and the Certified Brain Injury Specialist may be required for a person to provide specialized case management to specific populations of participants. Depending on the availability of case managers with specialized certifications, it may be beneficial to develop a consultant model for specialized case management where a participant could receive case management during periods of higher acuity or as a coach for the basic case manager in order to build skills.

In order to create an entry-level for new case managers, it may also be beneficial to identify a ‘case management assistant’ with lower qualifications than the basic case manager. The case management assistant would assist with coordination, scheduling, logistics and administrative duties and could provide support to a number of case managers.

**Improve and monitor quality of case management and ensure case management and services are driven by participants’ goals and evaluated against progress towards participants’ goals.** Stakeholders agreed that the education and experience qualifications, specified in the current Care Coordinator Conditions of Participation, were adequate to provide a professional case management workforce. However, there are a number of ways in which the monitoring of quality of case management should be improved. Stakeholders identified the following suggestions that should be evaluated for their benefit and effectiveness:

- Specify components of continuing education and an annual number of units to be completed.
- Require each case manager to identify a mentor or supervisor.
- Require and facilitate each case manager to participate in an annual 360 degree evaluation where participants, family members, service providers and service managers would provide feedback on quality of case management services to the State.
- Identify performance measures for case managers and institute a clear process to monitor enforcement and impose sanctions when measures are not met. Performance measures should monitor timeliness of plan submission, responsiveness to participants and service managers, completion of visits, and evaluation against participants’ goals.

Some stakeholders expressed concern that increasing the professional requirements for case managers will make recruitment difficult. Others strongly expressed that improving the quality of

case management necessitates strengthening the requirements and performance measures for case managers and that this should be required statewide.

**Clearly define plan for transition from current practice to conflict-free case management; build upon what is working well now.** In order to ensure that participants and care coordinators have the maximum amount of time to transition to conflict-free case management, as needed, and to ensure that the case management workforce is maintained and increased, the State should draft and publicize an implementation plan that clearly communicates the steps towards conflict-free case management with participants, family caregivers, current care coordinators, service providers and other stakeholders.

Stakeholders voiced significant concern that the transition to conflict-free case management be handled in a manner that ensures there is sufficient capacity to provide case management during the transition and beyond. Some agency representatives reported that current care coordinators were considering leaving the field or leaving their agencies to form independent care coordination agencies. Others voiced concern that participants would experience gaps in services if plans of care expire and are not renewed in a timely manner.

In keeping with the values articulated through this process, it is important to ensure a person-centered rollout of conflict-free case management for each participant. Strategies identified by stakeholders to ease the transition included identifying organizations that can provide interim conflict-free case management during the transition such as tribal health organizations, community health centers or Aging and Disability Resource Centers.

Stakeholders agreed to continue to meet in order to advise the State on the transition to conflict-free case management and to facilitate regional and community-level meetings in order to identify for the various regions of the state how best to structure this service.

**Provide high quality conflict-free case management to participants across Alaska, including rural and remote communities.** Stakeholders strongly agreed that improving the quality of case management, increasing the efficiency of the system and maintaining participant choice were important goals to balance as the State transitions to conflict-free case management.

**Revise reimbursement structures to support the more expansive view of case management.** In order to maintain capacity to provide case management and to incentivize new businesses and organizations to provide conflict-free case management, stakeholders need to be able to assess the business case for providing this service. The State should expedite the rate-setting process in order to determine a reasonable rate to provide this service in Alaska. Specific elements of the rate include:

- Geographically adjusted rates by location of waiver participants rather than the location of the agency; ensure travel costs are built into rates for rural participants and ensure rate exists for telemedicine visits.

- Higher rate for specialized case management and possibly a lower rate for case management assistance.
- Ensure there are no barriers to case managers also serving additional populations including participants in HCBS grant-funded services, those receiving PCA, other Medicaid participants and potentially other populations such as high utilizers and behavioral health clients.
- Ensure documentation requirements are not burdensome.

The following Long-term Implementation Plan for Building Comprehensive Case Management Infrastructure identifies the preliminary steps in the process. This will need to be refined and added to as the implementation phase unfolds.

## LONG-TERM IMPLEMENTATION PLAN FOR BUILDING COMPREHENSIVE CASE MANAGEMENT

| Action Step   | Who  | Timeframe  | Status              | Notes  |
|---|--|--|---------------------|--|
| <b>Medium Term Reforms:</b> Building Capacity to Improve and Assure Quality of Conflict-free Case Management, July 2016 – July 2017 |  |  |                     |  |
| 21  | State determines qualifications and tiered rate structure for Specialized Case Management.   | State of Alaska Senior and Disabilities Services | July – October 2016 |  |
| 22  | State determines rate structure that bills using a 15-minute increment for case management, both basic and specialized.  | State of Alaska Senior and Disabilities Services | July – October 2016 |  |
| 23  | State determines assessment and approval process for participants to identify which type and how much case management to allocate for each participant.  | State of Alaska Senior and Disabilities Services | July – October 2016 | Consider including amount and frequency of face-to-face requirement as part of assessment, to tailor to individual needs and location. |
| 24  | State identifies criteria for receiving different levels of case management as part of a person-centered plan. Options may include 1) no or minimal case management; 2) a coaching model of case management; 3) basic case management; and 4) specialized comprehensive (including medical) case management. | State of Alaska Senior and Disabilities Services | July – October 2016 |  |
| 25  | State identifies process for interface between ADRC, STAR grantee agencies and other intake staff and conflict-free case managers to develop person-centered plans.  | State of Alaska Senior and Disabilities Services | July – October 2016 |  |
| 26  | Conflict-free case management agencies and case managers renew certification with new requirements and billing structure.  |  | July 2017           |  |



| Action Step   | Who         | Timeframe | Status | Notes |
|---|-------------|-----------|--------|-------|
| <b>Long term: Comprehensive Case Management Across Programs for Medicaid Participants, July 2016 and ongoing</b>  |             |           |        |       |
| 27 Once conflict-free case management system is operational, DHSS identifies additional areas where conflict-free case management would improve participant outcomes. As these programs are renewed and new RFPs are developed, DHSS will direct opportunities to the conflict-free case managers and agencies. | Alaska DHSS |           |        |       |



## 5. CONCLUSION

### AREAS OF CONCERN

As we noted earlier, this brief process did not result in a consensus plan for meeting the conflict-free case management requirements. The following are the areas of concern expressed during the interviews and stakeholder meetings that may be preventing a consensus from emerging:

- The first, and perhaps most notable, focuses on the type of infrastructure needed to organize the services and support the case managers. Opinions vary amongst stakeholders about which type and level of infrastructure would be most effective to achieve the goals identified in this report. Because client needs and provider capacities are so diverse across the different regions of the state, stakeholders recommended holding facilitated regional forums through which the State could gather additional information. In this report, we have tried to clarify the options and their pros and cons to facilitate a decision.
- Providers also expressed concern about whether or not there was a solid business case for organizations to choose to start up (or transition to) a case management organization. Many felt that current reimbursement rates, coupled with low client numbers in some areas, could prove challenging. Understanding that the rate change was unlikely to happen in the short term, recommendations included possible grant funding to incentivize the start-up of regional entities to support conflict-free case management. Potentially, Medicaid Administrative match funds could be used for this purpose.
- A related but separate concern is the transition to a 15-minute increment for billing case management. This is a significant departure from the current flat monthly fee structure. CMS will likely encourage Alaska to use a 15-minute increment for billing because it allows the volume of service to better match the acuity of participant needs and it allows for more direct oversight and performance management of case management. This will need significant discussion with stakeholders as this transition occurs.
- A particular concern of providers focused on maintaining case manager capacity during the implementation phase. Depending on decisions made around training requirements, caseloads, supervision, and administrative oversight, providers expressed concern that the pool of existing case managers could shrink. The State must provide clear and consistent communication including transition options for existing care coordinators and case managers during the planning and implementation phases to assure a smooth transition to a conflict-free case management system.
- Finally, the short amount of time that remains before the deadline for compliance with the conflict-free case management requirement is of concern to all stakeholders. The number of decisions that need to be made, processes to be developed, and regulations to be changed or

modified requires that a fast and focused pace be kept when defining and implementing the plan. The State should continue to work with stakeholders to monitor the timeline for reform and to communicate clearly when the timeline changes.

## NEXT STEPS

The initial work to shift Alaska's Medicaid waiver programs to a conflict-free case management model involves a series of short-term actions that will ensure the State is compliant with the requirement that all waiver participants have a conflict-free case manager by July 1, 2016. Immediate next steps that will bring the State to a July 2015 solicitation to determine the availability of conflict-free case management in all census areas are listed below.

1. The informal group of stakeholders who have advised this report, should continue to meet on a regular basis. This group should consider the inclusion of waiver participants in their discussions. Key tasks for these stakeholders will be to:
  - Continue to advise the State on the transition process.
  - Coordinate and facilitate regional and community level meetings to help each region of the state identify how best to structure services.
2. SDS is responsible for most of the initial work between March and July 2015. Tasks include:
  - Communication and alignment
    - Identify and communicate to participants, care coordinators and service providers the key dates in the implementation plan.
    - Develop and implement a communication plan that will align policy makers and legislators with the project and ensure an understanding of the need to work quickly to ensure compliance.
  - Determine the infrastructure to support conflict-free case management
    - Conduct regional forums to identify local resources and solutions to deliver conflict-free case management.
    - Begin to develop the identified infrastructure.
  - Begin the rate-setting process for basic conflict-free case management.
  - Work closely with stakeholders to determine criteria for the following:
    - Supporting infrastructure.

- Requirements for conflict-free case managers and case management agencies.
- Affiliation between independent case managers and case management agencies, if any required.
- Whether and how to regionalize services
- Mitigation strategies for establishing conflict-free case management in areas where no conflict-free agency exists
- Documentation and billing requirements and processes.

With the above tasks completed, the State should be in a good position to draft and release a July 2015 solicitation of interest to determine the availability of conflict-free case management in all census areas.



## APPENDICES

- List of Steering Committee members
- Matrix of current case management models in Alaska
- Summaries of Interviews with Other States





## LIST OF STEERING COMMITTEE MEMBERS

|                  |   |
|------------------|---|
| Lizette Stiehr   | Alaska Association on Developmental Disabilities  |
| Amanda Lofgren   | Alaska Mental Health Trust Authority              |
| Sandra Heffern   | Community Care Coalition                          |
| Karl Garber      | Alzheimer's Resource of Alaska + AgeNet           |
| Allison Lee      | ResCare Alaska + Alaska PCA Providers Association |
| Rachel Greenberg | Mat-Su Senior Services+ AgeNet                    |
| Angela Salerno   | DHSS Senior and Disabilities Services             |

## MATRIX OF CURRENT CASE MANAGEMENT MODELS IN ALASKA

The consultant team conducted a series of key informant interviews in December 2014 and January 2015 and review of regulations to gather the information in this matrix.

|   | A  | B   | C                  | D   | E   | F   | G                   | H  | I   |
|---|--|---|--------------------|---|---|---|---------------------|--|---|
| 1 | Case Management Program  | Population  | What is it Called? | Description of Services   | CM Core Components  | Oversight   | Funding             | Reimbursement  | Gate Keeper   |
| 2 | <b>Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)</b> Medicaid waiver care coordination | For Medicaid-eligible people who meet Nursing Facility Level of Care (NFLOC). ALI Waiver is available to adults age 21 and over. The APDD waiver is available to persons age 21 and over who have been determined to be Developmentally Disabled. The Children with Complex Medical Conditions (CCMC) waiver serves children and young adults under the age of 22 years who experience medical fragility and are often dependent on frequent life saving treatments or interventions and/ or are dependent on medical technology. | Care Coordination  | Develop plan of care; submit level of care; two visits per month; ensure plan of care is being followed, suggest additions.   | Support planning<br>Monitoring                            | SDS Nursing Facility Level of Care Waiver Unit                  | Medicaid            | As of July 2014 for care coordination:<br><b>Case Management:</b> Per Month \$240.77 for ALI, APDD, CCMC, IDD<br><b>Screening:</b> one initial and one additional, per SDS approval, \$90.33 for ALI, APDD, CCMC (no IDD)<br><b>Plan of Care Development:</b> one annual \$384.81 for ALI, APDD, CCMC, IDD | SDS assessment  |
| 3 | <b>Intellectual and Developmental Disabilities (I/DD)</b> Medicaid Waiver care coordination  | Individuals with intellectual and developmental disabilities under the following diagnoses 1) Intellectual Disability; 2) Other Intellectual Disability – Related Condition; 3) Cerebral Palsy; 4) Epilepsy; 5) Autism  | Care Coordination  | Develop plan of care; submit level of care; two visits per month; ensure plan of care is being followed, suggest additions.   | Support planning<br>Monitoring<br>Participant Empowerment | SDS Intellectual & Developmental Disabilities (IDD) Waiver Unit | Medicaid            | See above.   | State assessment  |
| 4 | <b>State HCB grant services case management</b>  | Seniors, people with developmental disabilities or TBI who do not qualify for the waiver.   | Case Management    | Develop plan of care; care coordination for those not covered by Medicaid services, e.g. for people on GR, some oversight of PCA, helping find homes; case notes on individuals; no requirements for documentation or monitoring.                                 | Gate Keeping<br>Support Planning                          | SDS   | State General Funds | Grant pays salaries of grantee organization case managers based on percentage of time spent doing case management, reporting is done in 15m increments.  | Referred by other service providers, if they are receiving PCA, they can access care management through grant services. |
| 5 | <b>Tribally targeted case management</b>   | Tribal members; target population varies  | Case Management    | Tribes present target group case management strategy for MCD approval. For example, TCC provides documented check in on all elders using PCA each year, make sure they are getting services they need and are eligible for; two contacts per month once enrolled. | Gate Keeping<br>Support Planning<br>Monitoring            | SDS   | Medicaid 100% FMAP  | Varies   | TCC: Nurse case manager provides functional assessment of each elder during community visit.                            |

|    | A  | B  | C                           | D   | E   | F         | G                   | H   | I   |
|----|--|--|-----------------------------|---|---|-----------|---------------------|---|---|
| 1  | Case Management Program                        | Population   | What is it Called?          | Description of Services   | CM Core Components  | Oversight | Funding             | Reimbursement                                 | Gate Keeper   |
| 6  | Behavioral health case management              | People with serious mental illness, TBI or substance abuse   | Case Management             | Models are often blended: brokered case management, assertive case management, clinical case management, general case management; some services.  | Gate Keeping<br>Support Planning<br>Monitoring<br>Participant Empowerment | DBH       | Medicaid            | \$16/15 minute increment                      | Clinical assessment by provider agency; court order.                          |
| 7  | Medicaid high utilizers utilization management | High utilizers, voluntary enrollment   | Case Management             | Telephonic "soft touch" case management goal is to get people to use appropriate medical resources for their needs; getting people to apt; follow up; offer case management services for family if desired. | Gatekeeping<br>Support Planning<br>Monitoring<br>Participant Empowerment  | HCS       | Medicaid            | Flat rate per person: \$3.34/member per month | Cold call of high utilizers (5+ in 18 mos.); Voluntary; asked to participate. |
| 8  | Medicaid high utilizers care management        | High utilizers, involuntary program, "lock-in."  | Care Coordination           | Designated insurance card, pharmacy, doctor for high utilizers.   | Support Planning<br>N/A   | HCS       | Medicaid            | Flat rate per month built into contract       | Limited to the 300 highest utilizers.   |
| 9  | Medicaid high utilizers case management        | High utilizers   | Case Management             | Clinical case management  | Gatekeeping<br>Support Planning   | HCS       | Medicaid            | Billed on monthly, billed by the hour         | Anyone who is in hospital 3 days or more.                                     |
| 10 | SDS General Relief Assisted Living             | Very low income, at risk for homelessness.   | No case management provided | No case management provided.  | No case management provided   | SDS       | State General Funds | No case management provided                   | SDS   |
| 11 | DBH General Relief Assisted Living             | Very low income, at risk for homelessness, behavioral health diagnosed and referred by community behavioral health provider. | Case Management             | Case management provided as part of behavioral health services.   | Support Planning<br>Monitoring<br>Participant Empowerment                 | DBH       | Medicaid            | \$16/15 minute increment                      | DBH   |

|   | A   | J  | K                                  | L         | M               |
|---|---|--|------------------------------------|-----------|-----------------|
| 1 | Case Management Program   | Who Provides?  | Number Served                      | Case Load | How Often?      |
| 2 | Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC) Medicaid waiver care coordination | Individuals and provider orgs/agencies.  | ALI: 2059<br>APDD: 78<br>CCMC: 251 | 20-40     | Twice per month |
| 3 | Intellectual and Developmental Disabilities (I/DD) Medicaid Waiver care coordination  | Individuals and provider orgs/agencies.  | IDD: 1,963                         | 15-35     | Twice per month |
| 4 | State HCB grant services case management  | Grantee organizations  | Senior: 1,235<br>DD: 954           | 30-50     | Flexible        |
| 5 | Tribally targeted case management   | Currently Tanana Chiefs Conference (TCC) and Southcentral Foundation; tribal organizations | Varies                             | Varies    | Flexible        |

|    | A  | J   | K  | L             | M                                   |
|----|--|---|--|---------------|-------------------------------------|
| 1  | Case Management Program                        | Who Provides?   | Number Served  | Case Load     | How Often?                          |
| 6  | Behavioral health case management              | Community Behavioral Health Providers                       | Data not collected   | 15-60         | Once per month (very min)-5/week    |
| 7  | Medicaid high utilizers utilization management | Medical expert, private contractor                          | 6, 500 high utilizers; 149 called, 44 in-depth conversations; 30 people asked to call back; 3 currently "enrolled" | Team approach | As needed                           |
| 8  | Medicaid high utilizers care management        | Primary care physician                                      | 300  | N/A           | N/A                                 |
| 9  | Medicaid high utilizers case management        | Medical professionals, hospital staff through Qualis Health | 715 in 2014; 544 in 2013   | Team approach | For duration of hospital stay.      |
| 10 | SDS General Relief Assisted Living             | -   | -  | -             | -                                   |
| 11 | DBH General Relief Assisted Living             | Community Behavioral Health Providers                       | Data not collected   | 15-60         | Once per month (very min) to 5/week |

|   | A  | N  | O  | P   | Q   | S   | T   |
|---|--|--|--|---|---|---|---|
| 1 | Case Management Program  | For How Long?  | Where?   | Percent of Clients Served by Independent Care | Potential Conflict  | Qualifications + Training   | Strengths   |
| 2 | <b>Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC)</b> Medicaid waiver care coordination | Indefinite   | Once per month in person, once via telephone<br>Quarterly in person if remote. | ALI: 68%<br>APDD: 41%<br>CCMC:19%             | Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency. | Must complete the SDS basic training course once every two years. | Works well with PCA for most part; ensures quality of care is high.   |
| 3 | <b>Intellectual and Developmental Disabilities (I/DD)</b> Medicaid Waiver care coordination  | Indefinite   | Once per month in person, once via telephone<br>Quarterly in person if remote. | IDD: 17%                                      | Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency. | Must complete the SDS basic training course once every two years. | Care coordinators are with people for a long time and know their needs, know their communities, and their school; CC is consistent person in life. Helpful to have people trained to waiver type (IDD CCMC have a bigger menu, goal directed). Networks are driving the professionalism of care coordination up. CC gather information for the State for document coordination and submittal. |
| 4 | <b>State HCB grant services</b> case management  | Work with someone intensely in the beginning and then tapers off | Flexible   | N/A   | Funding from state subsidizes cost of providing Medicaid waiver care coordination; sustainability of care/case management is intertwined.   | Unknown   | Grant funds supplement CC/waiver services; grant funds can be used for travel, subsidize cost of Medicaid waiver care coordination, if traveling to same area, gets access to people who aren't receiving care coordination or case management through waiver.  |
| 5 | <b>Tribally targeted</b> case management   | Indefinite   | In person + other options  | N/A   | Rural areas more likely to have exemption from conflict-free requirements.  | Varies  | TCC model: Covers all elders that the provider reaches, and then looks for first way to get billing through; less duplicative.  |

|    | A  | N                             | O               | P   | Q   | S  | T   |
|----|--|-------------------------------|-----------------|---|---|--|---|
| 1  | Case Management Program                        | For How Long?                 | Where?          | Percent of Clients Served by Independent Care                               | Potential Conflict  | Qualifications + Training                                  | Strengths   |
| 6  | Behavioral health case management              | Indefinite                    | Face to face    | Case management is a direct service so not thought of in terms of conflict. | Agencies that provide both case management and direct services might directly or indirectly persuade case managers to prescribe more direct services than necessary, or only share/know about services within the agency. | Bachelors degree + work experience.                        | Conflict of interest is not really an issue, because case management is a service, it is the nature of the approach. Issues are more around whether agency can actually provide that much service. Case manager is often the main person a client works with. Not seeing duplication. |
| 7  | Medicaid high utilizers utilization management | Indefinite                    | Telephone       | N/A   | None. Often people on Medicaid are part of other case management program such as through BH or Southcentral. When they find out there is another case manager, they work directly with the case manager.                  | 844 CMS panels, all types, pharmacy, etc.                  | Very new program, but response has been positive, if the individual wants them to case manage the whole family, they will.  |
| 8  | Medicaid high utilizers care management        | One year                      | N/A; policy     | N/A   | N/A   | N/A  | Allows highest utilizers to have access to primary care to prevent unnecessary use of ER and save money.  |
| 9  | Medicaid high utilizers case management        | For duration of hospital stay | Hospital        | N/A   | N/A   | Medical professional degrees: RNs, pharmacist, physicians. |   |
| 10 | SDS General Relief Assisted Living             | -                             | Assisted Living | N/A   | No incentive for ALH providers to help individuals get to more independent housing.   | -  | ALH providers work on behalf of GR clients to get them on the waiver so that they can get reimbursed for ALH services. ALH providers work as de facto, if conflicted, case managers.  |
| 11 | DBH General Relief Assisted Living             | Indefinite                    | Assisted Living | N/A   | Same as BH services, in general.  | Bachelors degree + work experience.                        | Case managers help residents get on waiver or find more suitable housing.   |



|   |   |  |
|---|---|--|
|   | A   | U  |
| 1 | Case Management Program   | Weaknesses   |
| 2 | Adults Living Independently (ALI), Adults with Physical and Developmental Disabilities (APDD) and Children with Complex Medical Conditions (CCMC) Medicaid waiver care coordination | Mostly focuses on waiver services, so some things get missed. Some clients don't communicate well via phone. State PCA program is outside of waiver, one of few states like this. There is a difference in care coordination between ALI and IDD waiver; minimal care coordination in a lot of rural communities; more care coordinators for IDD in rural areas (much longer, person centered planning has been in place longer). Sometimes a rural community has services, but there are no care coordinators - they need a care coordinator, can't have services without a plan, can't bill for adult day, respite. Hard to do care coordination in rural areas outside of grant. Independent care coordinators don't pencil in rural areas. Independents not paid for travel time. Agencies aren't either but they have grants and in-house referrals. People expect case management but are getting care coordination. |
| 3 | Intellectual and Developmental Disabilities (I/DD) Medicaid Waiver care coordination  | Turnover means one person writes the goal, but the next person doesn't know why. Lack of expertise, when someone doesn't have expertise, some people don't know what they are monitoring. First training is overwhelming, rely on agencies for next level of training. Hard to move between children and adults. IDD care coordinators have lower case loads. Care coordinators don't have any authority, if they don't work for the agency, the agency doesn't have to abide. Once they have the waiver, care coordination is on a tight timeline to get services. More turnover in Anchorage and urban areas than in rural areas   |
| 4 | State HCB grant services case management  |  |
| 5 | Tribally targeted case management   | There is so much turnover in smaller organizations with limited capacity. Organizations want to focus on clinics, not HCBS, which are fee rather than flat rate. Tribal organizations reluctant to get into HCBS. Also, HCBS not funded through IHS historically. If the services aren't available through entity, or in community, why would you provide case management? Lack of ability of tribes to come up with cost reporting for that specific service; hard to break out cost center for case management. Hard to find care coordinators to serve rural areas.   |

|    |  |  |
|----|--|--|
|    | A  | U  |
| 1  | Case Management Program                        | Weaknesses   |
| 6  | Behavioral health case management              | Large case loads mean that once people get to a certain level of independence, they don't get additional services. If people get services from more than one provider, they also have multiple case managers/plans of care. Constantly having to train new staff, staffing levels. Not able to provide case management beyond when basic needs are met. For example, when in BH ALH, sometimes not able to help get into a more independent living situation. DBH is limited in funds, so there are people on the SDS ALH list that could benefit from DBH assisted living, accompanying case management, but can't move over. |
| 7  | Medicaid high utilizers utilization management | Voluntary program, might not be able to case manage the highest utilizers.   |
| 8  | Medicaid high utilizers care management        | More care management; case management is not available other than the coordination the primary care provider can provide.  |
| 9  | Medicaid high utilizers case management        | Does not extend beyond the hospital; there can be overlaps with other case managers.   |
| 10 | SDS General Relief Assisted Living             | No incentive for ALH providers to help individuals get to more independent housing. Intended as a temporary program but often becomes long-term due to lack of other housing options or case management support to find them.  |
| 11 | DBH General Relief Assisted Living             | General Relief is paying for a services that could potentially be covered through a 1915(i) Medicaid waiver.   |

## SUMMARIES OF INTERVIEWS WITH OTHER STATES

### COLORADO

The Colorado Department of Health Care Policy and Finance (HCPF) is also going through an evaluation of their case management and service delivery system in order to address the conflict-free case management (CFCM) requirements. We spoke with representatives from the Developmental Disabilities (DD) section of HCPF about how they are working to meet these requirements under their 1915(c) waiver, through which case management services are offered via targeted case management.

Case management and service provision for individuals with developmental disabilities in Colorado is provided by non-profit Community Centered Boards (CCBs). Each of the CCBs have a provider arm, some of which have different names than the CCB and appear to be separate, but are still part of the same non-profit organization. In conversations with the 20 statewide CCBs, HCPF said that the agency representatives acknowledged that they were out of compliance with the CFCM requirements and wanted to work with the Department to align with the rules. In order to do this, HCPF created a task group comprised of CCB representatives, non-CCB providers, advocates, consumers and other community members. A detailed report has been developed based upon the non-voting group's recommendations, and three primary models were proposed. The HCPF representatives said that while all recommendations were documented in the report, not all of them aligned with the rules, and it will be the job of the Department to make the final say about how to address them. The models proposed by the group were:

- The local agency would be able to provide case management and services, but not for the same person. This was a method that providers in Alaska were interested in further exploring. The CCBs in Colorado liked this approach, but the advocates, consumers, community members, and non-CCB providers did not. They feared that there would be a bias towards agencies that the CCB has friendly relationships or service agreements with, which may result in collusion between provider and case management agencies. HCPF has emailed CMS for further guidance about this approach, but has not heard back as of 12/22/14.
- A second suggestion was that participants could waive their right for CFCM in order to keep the same case manager. This grandfathering system does not appear to be allowable under the rules, and HCPF has received guidance from CMS staff that this would not align with the regulations.
- The third option would be to completely separate the responsibilities, and allow the CCBs to choose whether they wanted to provide case management or direct-care services. This would allow HCPF to meet the CFCM requirements, however, the CCBs had concerns about this strategy, in particular about the impact on funding. CCBs

receive a majority of their funds from local county mill levies. While the funds would support the case management function, how the other functions the CCBs provide, such as the Human Rights Committee, investigations, and waiting list management, would be funded after the case management and service provision split occurred were less clear. The CCBs were also concerned that there would be major disruptions to services for people who have been receiving services and case management on a long-standing basis after the split.

An additional consideration proposed by this group was around how any of the above changes may impact rural populations. The CCB representatives recommended that there be an exceptions process in rural areas that would allow them to provide both case management and direct-care services, as there are fewer providers in the areas and the CCBs could provide the most appropriate services and case management. However, non-CCB providers and other group members said that there would be enough providers even in the rural areas to provide both case management and direct-care services separately, and that it even may allow for the creation of new agencies and expansion of existing agencies.

HCPF has just finished creating the report based on the recommendations of the task work group, and at this time does not have a timeline for implementing the changes. Department representatives said that there will need to be legislative input on the proposed changes, which will not occur for at least another year. They agreed to continue to share guidance with Alaska as they moved forward with the process.

## WYOMING

The Wyoming Department of Health, Behavioral Health Division (BHD), is currently in the process of transitioning its Developmental Disabilities and Acquired Brain Injury programs to meet the requirements for conflict-free case management (CFCM). This move predates the publication of the CMS HCBS rules. In 2013, a review of the Medicaid program led to a legislative mandate to make the system conflict free. BHD has developed a plan to comply with this mandate, which is scheduled to be complete implementation by July 2015.

Prior to these changes, the case management system in Wyoming included a mix of both independent and provider employed case managers. In both cases, some of the case management was provided by individuals and some provided through agencies.

State staff cited the following as factors that lead to the decision to change the case management structure:

- Because many of the case managers only do so part-time, the State has a large number of case managers relative to the number of participants they serve. In many cases, a case manager may only be serving a few individuals. This has created issues because 1) a part-time case manager with competing priorities may be less willing to devote the time necessary to learn all of the case management requirements and 2) the larger the number of case managers, the greater the training and monitoring burden on State staff.
- State staff observed that case managers were billing for improper and unallowable activities. This appeared to be related both to a lack of clarity in the policies and rules for case management and a lack of understanding regarding the existing policies and rules.
- Providing case management was a low priority for provider agencies, especially among the smaller provider agencies who may lack the capacity to fulfill the functions of plan development and providing subsequent direct support.

BHD felt that these conflicts impact participant choice and was a barrier in building a person-centered system. In order to determine the most appropriate approach for changing the system, the State conducted research on other states and sought guidance from the National Association of State Directors of Developmental Disabilities Services (NASDDDS).

BHD's original plan excluded providers of HCBS services from also providing case management. However, stakeholders, especially provider case management agencies, reached out to the governor and legislature, and after collaboration with the Behavioral Health Division the plan was altered so that HCBS providers could continue to provide case management, but not provide both services and case management to the same individual.

While BHD staff have concerns about providers playing both roles, they concede that they change may increase flexibility and offer more options in rural and frontier areas.

BHD staff believe that the most important part of the plan is that it provides a stronger definition for case management and more clearly delineates what activities can and cannot be billed as case management. The implementation effort includes and extensive training and monitoring component.

BHD staff believe that as the requirements and oversight are enforced, case managers who are not able to meet these minimum quality standards will self-select out.

BHD staff had several recommendations for Alaska as the State moves forward with its CFCM plan:

1. Allow sufficient time for transition. In most cases, meeting the CFCM requirements requires substantial changes throughout the state. Alaska needs to ensure that it has allotted sufficient time to develop a comprehensive plan in order to think through potential challenges and barriers and effectively address them. It will also be imperative to establish a realizable timeline for agencies to implement the changes so that clear expectations are laid out and enforcement of the requirements can occur. Additionally, in order to facilitate effective planning and subsequent implementation, these changes must include affected parties in order to build buy-in for the effort.
2. Develop effective training and monitoring infrastructure. To ensure that individuals are having a consistent experience regardless of where they are in the system, it is crucial to ensure that all case managers receive standardized training. As implementation occurs, developing quality management and monitoring plans will be essential to ensure that the plan is carried out and sustained.
3. Set clear requirements for case managers to review provider documentation. Case managers will be at the core of ensuring that services are coordinated and that the individual is receiving the most appropriate services.
4. Work closely with your CMS Regional office. Regional offices can provide a tremendous amount of guidance, both about implementing new initiatives and anticipating how current efforts may need to be modified to comply with upcoming change.

## HAWAII

The State of Hawaii's Department of Health, Developmental Disabilities Division (DDD), has been reviewing federal requirements around Conflict Free Case Management (CFCM) and person-centered planning in order to determine what steps need to be taken to come into compliance. DDD is housed within the Department of Health (DOH), while the Medicaid agency resides within the Department of Human Services (DHS).

Hawaii has a statewide case management system in which all case managers are State employees. Because the case managers are State employees, the Hawaii DD system already complies with the conflict-free requirements in the CMS rules. The DDD case managers able to serve approximately 1,700 individuals with DD on Oahu (which includes Honolulu) and 900 in the other three counties.

Hawaii had provider case management until the late 1990s. At this time, the State assumed responsibility for case management because there was concern that many of the functions that providers were calling case management were actually functions that benefited the provider agencies more than the individuals receiving services. These concerns were based on several factors, including:

- Providers appeared to be case management funds to perform administrative activities for other services that were not considered by the State to be case management.
- Providers were only offering services that they provided. Individuals did not have the ability to learn about additional services that may be offered by other providers.
- Because they had a financial incentive, provider case managers appeared to be over-estimating client needs to obtain more funding.
- Case managers of the provider agencies were tasked with both advocacy and gatekeeping and were having difficulty meeting both functions.

Upon taking over the case management responsibilities, the State was in a position to mitigate these concerns and better ensure that all individuals were receiving the most appropriate services.

The representative from DDD recommended that Alaska discuss concerns the State may have about providers maintaining control of both case management and direct-care services further with community stakeholders, such as DD Council. This will better allow stakeholders to understand why change may be necessary, and potentially build support for the change.

DDD also said that the change to the State controlling the provision of case management allowed them to standardize and refine the process to ensure that federal standards were being met and individuals were able to make informed decisions about the most appropriate services. Additionally, having control of the case management function at the State level helped DDD develop better

quality measures to ensure that goals laid out in the service plans are being met. The onus is now on the providers to demonstrate progress towards these goals.

Similar to Alaska, Hawaii has a diverse population and many residents are located in remote settings. DDD emphasized that the ability to provide oversight through case management has allowed them to ensure that these potentially vulnerable populations are appropriately served.

As Hawaii moves forward with developing assessment processes and meeting the CMS person-centered requirements, they have been utilizing the experience they have gained through this case management development. They are learning when and how to best involve providers in the feedback process. They are also involving a wider group of stakeholders, including the DD Council and Behavior Committee Review, to obtain feedback and build buy in.



## MINNESOTA

The Minnesota Department of Human Services, Disabilities Division, has developed a system that meets the Conflict Free Case Management (CFCM) requirements. Within Minnesota's system, case management is offered across 87 counties by entities known as Lead Agencies. For individuals under age 65, Lead Agencies are typically the counties. Because these agencies are not service providers, they are not out of compliance with the CFCM requirements. However, issues around quality control have arisen due to the preference of many of the counties to contract out case management services. Minnesota is attempting to address these quality control issues and ensure full compliance with federal regulations through a number of initiatives.

Minnesota began transforming its system to meet CMS' person-centered planning requirements and improve processes related to CFCM through the development of the comprehensive, person-centered assessment and support planning system known as MnCHOICES. The policies and procedures related to MnCHOICES also facilitated the separation of the assessment and resource allocation functions from the case management role within the Lead Agencies. The separation of the duties has resulted in "professionalizing" the role of the assessor to better facilitate the development of the person-centered plan. As a result, the State is better able to understand barriers and they are now considering creating new resources to assist the case managers in developing the plans. This is especially important because case managers generally still play the lead role in developing the Community Support Plan.

In addition to the development of the MnCHOICES tool, Minnesota has been working to develop information technology (IT) to support the flow of information from the tool to the case managers and other relevant individuals, such as providers. The Division is now clarifying how and when case managers and providers should be able to access, update, and provide information for the assessment.

To support the enhancement of the system, the Division has been developing mechanisms and protocols to collect provider input. The Division is focusing on transitioning individuals out of more restrictive settings, and has been developing protocols that support an appropriate, safe approach for this process and incorporating provider input.

The Division is also looking at expanding populations receiving case management. This discussion has included moving away from providing case management directly in the waivers and utilizing Targeted Case Management (TCM).

With statewide automation, the Division is able to obtain data for quality control from the assessment and support plan to obtain a view of how well services are meeting individual goals. The Division is also working to develop a process to determine how this data could be used to establish whether unique interventions should become a part of the regular support planning process.

The Division representatives said that they would have some hesitation in allowing service providers to provide case management to clients who they do not provide direct services to. They said that quid pro quo arrangements with other entities would be a primary concern. If Alaska does decide to move forward with this arrangement, Minnesota recommended a strong separation of the administrative functions related to case management and service provision. They also emphasized that having separation of support plan development and implementation is very important, as it helps minimize perverse incentives.

# **The Alaska Department of Corrections** **Recidivism Reduction Plan**

*Safer Neighborhoods, Better Citizens*

**Providing Tools and Resources to  
Alaska's Returning Citizens -  
Reducing Crime and Averting the Need  
for Additional Prison Construction**

**A Report to Governor William M. Walker  
The Alaska Department of Corrections**

**March 2015**

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# The Alaska Department of Corrections Recidivism Reduction Plan

March 2015

## INTRODUCTION

The Alaska Department of Corrections (DOC) has supported for many years adult criminal justice reform. In 2014, building on the work conducted for the past several years in the DOC, the department entered into a contract with the Michigan-based Center for Justice Innovation (the Center) to conduct an internal review of Alaska's reentry services. This review concluded that, while a good deal of laudable work was underway, increased coordination among the various efforts was needed to overcome the barriers to reducing recidivism. Given that finding, the DOC utilized its contract with the Center to help facilitate development and implementation of a comprehensive reentry improvement. After preliminary data analysis and facilitated meetings with state and local stakeholders, the Alaska Prisoner Reentry Initiative (AK-PRI) has been launched. The AK-PRI represents the foundation for a five-year effort expected to make Alaska a national leader in recidivism reduction of its citizens who are returning to their communities following a prison term.

In the meantime, following the 2014 legislative session, Senate Bill 64 was signed into law by Governor Sean Parnell in July 2014, creating the 13-member Alaska Criminal Justice Commission (ACJC) with a three-year mandate to promote public safety through better oversight and management of the adult correctional systems. Concurrently, the Legislature provided additional guidance to the executive branch through HB 266 that required the Department of Corrections, the Department of Health & Social Services, the Department of Labor & Workforce Development, the Alaska Housing Finance Corporation, the Alaska Court System, and the Alaska Mental Health Trust Authority to:

*"...Develop and implement a comprehensive, complementary, non-duplicative institutional community-based plan for providing substance abuse, mental health, housing and employment services to those who are released from correctional institutions... (that will improve) treatment and other outcomes for recently released inmates with the goal of reducing correctional system recidivism rates".*

**The Alaska Prisoner Reentry Initiative (AK-PRI) is the executive branch's Recidivism Reduction Plan and is intended to reduce the recidivism rate of returning citizens so that system and individual offender performance is improved and the state can avoid the need for additional prison construction.**

Subsequently, in March of 2015, under the leadership of Corrections Commissioner Ronald Taylor, the DOC created an Office of Prisoner Reentry (OPR) using existing resources within the agency to implement prisoner reentry reforms as the primary focus of recidivism reduction in the agency. The primary responsibilities of OPR are to ensure successful offender reentry to the State of Alaska, to reduce recidivism, to enhance public safety through collaboration among stakeholders and to assist in ensuring the appropriate and responsible use of cost savings realized by justice reforms through reinvestment in evidence-based, community-centered services.

## THE ALASKA PRISONER REENTRY INITIATIVE

The Alaska Department of Corrections launched the Alaska Prisoner Reentry Initiative in November 2014 with the vision that every returning citizen released from prison will have the tools and support needed to succeed in the community. In order to make this vision a reality, the mission of the Alaska Prisoner Reentry Initiative (AK-PRI) is to improve public safety by reducing crime through implementation of a seamless plan of services and supervision developed with each returning citizen—delivered through state and local collaboration—from the time they enter prison through their successful transition, reintegration, and aftercare in the community. The initiative gives Alaska the tools to become a national leader among states in recidivism reduction.

The fundamental goals of the AK-PRI are to:

1. Promote public safety by reducing the threat of harm to persons, families and their property by citizens returning to their communities from prison; and
2. Increase success rates of returning citizens who transition from prison by fostering effective, evidence-based risk and need management and treatment, returning citizen accountability, and safe family, community and victim participation.

Performance measures to determine the degree that these goals are met include measurements of increased public safety through the reduction of recidivism (as measured by re-conviction or conditional release violation and return to prison) and successful completion of community supervision.

At the heart of the initiative is the Alaska Prisoner Reentry Initiative Framework (See Tabs 1 & 2). The AK-PRI Framework (the Framework) was designed for Alaska but builds on approaches for reentry improvement developed by the National Prisoner Reentry Council, as outlined in its Reentry Policy Council Report,<sup>1</sup> and the National Institute of Corrections through its Transition from Prison to Community (TPC) Framework.<sup>2</sup> These approaches provide guidance for specific justice policies that will be considered in Alaska as the “Targets for Change” to improve prisoner reentry.

These Targets for Change are categorized within the three TPC Framework phases (Getting Ready, the Institutional Phase; Going Home, the Pre-Release Phase; and Staying Home, the Community Supervision and Discharge Phase) and seven primary decision points that comprise the reentry process. For each Target for Change, goals and operational expectations are included, as well as references for further reading to specific pages within the voluminous Reentry Policy Council Report and other publications that pertain specifically to the Target for Change that is being addressed. Thus, the Framework provides a practical guide to help direct Alaska’s plan to meet the policy goals and operational expectations of this Council. The Framework also frees state agencies to begin to focus immediately on implementation.

<sup>1</sup> Reentry Policy Council. *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*. New York: Council of State Governments, January 2005.

<sup>2</sup> Peggy Burke, *TPC Reentry Handbook: Implementing the NIC Transition from Prison to the Community Framework*. Washington D.C.: U.S. Department of Justice. National Institute of Corrections, August 2008.

Importantly, the Framework underscores the three overarching policy and practice considerations that must be in place to truly reform a returning citizen's behavior: Offender Management Planning, Case Management and Evidence-Based Practices.

Alaska benefits from a wealth of technical assistance that was provided for the development and implementation of the AK-PRI Framework. These technical partners include the Council of State Governments-National Reentry Resource Center and the Michigan Council on Crime and Delinquency - Center for Justice Innovation.

The Framework provides state agencies and local partners with the tools to move from planning to implementation and to accurately measure changes in recidivism. By moving reentry planning beyond high-level strategy to a focus on carefully scripted actions, the AK-PRI can quickly make Alaska a leader in recidivism reduction.

### PRIORITIES FOR REENTRY REFORM

The priorities for implementation of the AK-PRI Framework include an improved offender management and accountability planning process (OMP) with each returning citizen, from the point of imprisonment through successful discharge from post-release community supervision,<sup>3</sup> with an emphasis on safe, affordable housing and employment.

This careful case planning will be driven by a validated, objective assessment of each returning prisoner's risks, needs and strengths.

#### Offender Management and Planning

Offender Management Plans (OMP) are concise guides, driven by a validated assessment of risks, needs and strengths, that describe goals for each returning citizen's successful transition along

### Alaska Prisoner Reentry Initiative Framework

#### PHASE 1: GETTING READY

1. **Assessment And Classification**
  - 1.1. Development of Intake Procedures
2. **Returning Citizen Behavior And Programming**
  - 2.1. Development of Programming Plan (OMP1)
  - 2.2. Physical Health Care
  - 2.3. Mental Health Care
  - 2.4. Substance Abuse Treatment
  - 2.5. Children & Family Support
  - 2.6. Behaviors & Attitudes
  - 2.7. Education
  - 2.8. Technical Training
  - 2.9. Work Experience

#### PHASE 2: GOING HOME

3. **Returning Citizen Release Preparation**
  - 3.1. Development of Parole & Reentry Plan (OMP2)
  - 3.2. Housing
  - 3.3. Continuity of Care Planning
  - 3.4. Working with Potential Employers
  - 3.5. Employment Upon Release
  - 3.6. Identification and Benefits
  - 3.7. Release Preparation for Families
  - 3.8. Release Preparation for Victims
4. **Release Decision Making**
  - 4.1. Advising the Releasing Authority
  - 4.2. Release Decision

#### PHASE 3: STAYING HOME

5. **Supervision And Services**
  - 5.1. Design of Supervision & Treatment Strategy (OMP3)
  - 5.2. Implementation of Supervision & Treatment Strategy
  - 5.3. Maintaining Continuity of Care and Housing
  - 5.4. Job Development and Supportive Employment
6. **Revocation Decision Making**
  - 6.1. Graduated Responses
7. **Discharge And Aftercare**
  - 7.1. Development of Discharge/Aftercare Plan (OMP4)

2015 PRIORITIES HIGHLIGHTED IN RED

<sup>3</sup> In Alaska, post-release community supervision includes probation supervision, parole supervision as well as for some cases, who have concurrent active cases, concurrent probation *and* parole supervision, and for cases who max-out from prison, no supervision.

with a corresponding schedule of actions for the returning citizen, institutional staff, the parole board, probation/parole staff, and partnering agencies. The OMP spans the phases of the transition process and agency boundaries to ensure continuity of services and supervision between institutions and community. Increased certainty will motivate returning citizens to participate in the OMP process and to become engaged in fulfilling their responsibilities and will ensure that all parties are held accountable for timely performance of their respective responsibilities.

***Goal:*** To establish the comprehensive and standardized use of assessment-driven OMP at four critical points in the returning citizen transition process that succinctly describe for the returning citizen, the staff, and the community exactly what is expected for returning citizen success: (1) At reception as part of the prison intake process, (2) As part of the release decision process when the returning citizen is approaching the end of their confinement, (3) When the returning citizen re-enters the community, and (4) When the returning citizen is to be discharged from probation/parole supervision.

***Policy Expectations:*** Prisoner reentry policies are defined as formal, written rules and agreements that define standard practices for agencies engaged in the transition process. Alaska's policies regarding the OMP process currently include or are expected to include, the following provisions:

- OMPs are driven by a validated risk, needs and strengths assessment instrument that is used at prison intake and at subsequent major decision points in the corrections/parole/post-release supervision process.
- As a result of these assessments, the OMPs consist of the returning citizen's Treatment Plan updated at critical junctures in the transition process and are prepared at prison intake, at the point of the release decision, at the point of return to the community, and at the point of discharge from probation/parole supervision.
- OMPs are a collaborative product involving institutional staff, the returning citizen, the parole board, community supervision officers, human services providers (public and/or private), victims, and neighborhood and other community organizations.
- The OMP policy clearly states that the objective of the OMP is to increase both overall community protection by lowering risk to persons and property and by increasing each returning citizen's prospects for successful return to and self-sufficiency in the community.

### **Safe, Affordable, and Supportive Housing**

Following incarceration, many returning citizens join the growing number of individuals in the general population struggling to obtain safe, affordable, and supportive housing. But former offenders face additional barriers in seeking access to the scarce housing options available.

Court orders, state laws, local ordinances, and conditions of release often restrict the locations in which a returning citizen can seek housing. In the private rental market, many landlords are unwilling to rent to individuals with a criminal record. Due to exclusions in federal housing assistance policy and the broad discretion of local public housing authorities to add exclusions, individuals with a criminal history are not eligible for many forms of public housing assistance.

Finally, although family is a key resource for many returning citizens, staying with relatives is not always an option. Some families are unwilling, perhaps as a result of prior criminal behavior, to welcome an individual back into the home. In other cases, families may not have the resources to support another



unemployed family member or may be putting their own public housing assistance in jeopardy by opening their home to a relative with a criminal record.

Given such barriers, it is not surprising that incarceration puts returning prisoners at greater risk of homelessness. A certain proportion of incoming prisoners were homeless before their incarceration, and at least as many end up homeless for some period of time after leaving prison. For those with histories of mental illness, the likelihood is still greater. Nationally, surveys of homeless assistance providers and individuals who use their services have found that about 54 percent of currently homeless clients had been in jail or prison at some point in their lives.<sup>4</sup> The consequences of insufficient housing extend beyond the prisoner. Research indicates that parolees without stable housing may face a higher risk of parole failure, whether through re-arrest for a new crime or failure to meet basic parole requirements. Studies indicate that the likelihood of arrest increases 25 percent each time a parolee changes address.<sup>5</sup>

Goal: To facilitate access to safe, affordable and supportive housing upon reentry into the community.<sup>6</sup>

Policy Expectations: Formal written rules and agreements defining the standard practice for agencies engaged in improving access to stable housing should include the following provisions:

- Facility staff, probation/parole staff and community-based transition planners work with returning citizens to assess individual housing needs and identify the appropriate housing option for each incarcerated individual well before release. The housing planning process includes an assessment of the feasibility, safety and appropriateness of an individual living with family members after his or her release from prison.
- A full range of housing options (i.e. supportive housing, transitional housing, affordable private rental housing) will be accessed to accommodate individuals returning to the community.
- In order to make certain that returning citizens are not discharged from prison into homelessness, individuals leaving prison without a documented housing plan and those with histories of homelessness are included among the homeless priority population in order to facilitate their access to supportive housing and other housing services.
- Returning citizens receive information and training on strategies for finding/maintaining housing and their legal rights as tenants.

### **Job Development and Supportive Employment**

Research has consistently shown that offenders who find stable employment soon after release from incarceration are less likely to recidivate.<sup>7</sup> Employment not only provides the income needed to meet basic needs but also provides the means to become a productive member of the community.

<sup>4</sup> M.R. Burt, Y.A. Laudan, T. Douglas, J. Valente, E. Lee, and B. Iwen, *Homelessness: Programs and the People They Serve: Findings From the National Survey of Homeless Assistance Providers and Clients* (Washington, DC: U.S. Department of Housing and Urban Development, 1999).

<sup>5</sup> Tammy Meredith, John Speir, Sharon Johnson, and Heather Hull, *Enhancing Parole Decision-Making Through the Automation of Risk Assessment*, (Atlanta, GA: Applied Research Services, Inc., 2003).

<sup>6</sup> Report of the ReEntry Policy Council, pgs. 256-281

<sup>7</sup> For example, see: Miles D. Harer, *Recidivism of Federal Prisoners Released in 1987*, (Federal Bureau of Prisons, Office of Research and Evaluation: Washington, D.C., 1994); Mark W. Lipsey, *What Works: Reducing Reoffending*, (West Sussex, U.K.: Wiley, 1995); Robert J. Sampson and John H. Laub, "A Life Course Theory of Cumulative Disadvantage and the Stability of Delinquency," Terence P. Thornberry (ed.) *Developmental Theories of Crime and Delinquency, Advances in Criminological Theory, Volume 7*, (New Brunswick, NJ: Transaction, 1997, p 133 – 161); and Christopher Uggen, "Work as a Turning Point in the Life Course of Criminals: A Duration Framework of Age, Employment and Recidivism." *American Sociological Review* 67 (2000) 529-546.

However, among job seekers, individuals with criminal records, particularly those recently released from incarceration, face unique hurdles. Compared to the general population, returning offenders tend to have less work experience, less education, and fewer marketable skills.<sup>8</sup> They frequently return to communities already hit hard by unemployment, where job prospects and access to employment services are limited and contact with a social network that can provide job leads is rare.<sup>9</sup> Furthermore, the stigma of a criminal record, spotty work histories, low education and skill levels, and physical and mental health problems take many jobs out of reach for returning offenders.<sup>10</sup>

Many returning citizens also lack necessary identification documents, access to transportation, and childcare for dependent children. To a lesser extent, many recently released prisoners have unstable housing situations that may prevent access to employment. Restrictions on the type of employment a former prisoner may obtain, and practices of probation/parole agencies may pose additional obstacles to obtaining and holding a job for those under supervision.

Predetermined reporting requirements and supervision fees may be particularly burdensome. Estimates show that the proportion of prisoners who have a job secured before release ranges from 14 percent to just under 50 percent.<sup>11</sup> For those lacking employment upon release, job placement organizations can play a key role. Transitional employment can provide released prisoners with access to income, structure, and additional supervision to assist in the transition from custody to freedom.

**Goals:** To recognize and address the obstacles that make it difficult for a returning citizen to obtain and retain viable employment while under community supervision; and to connect returning citizens to employment, including supportive employment and employment services, before their release to the community.

**Policy Expectations:** Formal written rules and agreements that define the standard practice for agencies engaged in improving employment outcomes among returning citizens are expected to include the following provisions:

- Supportive transitional employment programs are supported and promoted across agencies.
- Staff charged with community supervision work towards sustainable employment for returning citizens.
- Work-release programs are available as a transition between work inside a correctional facility and work after release into the community.
- Community members and community-based services act as intermediaries between employers and job-seeking individuals who are incarcerated.

**"We are embarking on a new and exciting path to reform the ways we manage and support Alaska's returning citizens. Supporting the transition and re-entry for those who have been in prison is an undertaking that government alone can't do and we need the support of every community in the state"**

*DOC Commissioner Ronald Taylor*

<sup>8</sup> Abigail Coppock, "Transitional jobs: Overcoming barriers to employment" *Advocates Forum* (2007) 34-48.

<sup>9</sup> *Report of the ReEntry Policy Council*, pgs. 306-316; 383-389.

<sup>10</sup> Harry J. Holzer, Steven Raphael, and Michael A. Stoll, "Employment Barriers Facing Ex-Offenders" (paper presented at The Urban Institute's Reentry Roundtable, Washington, DC, May 19-20, 2003).

<sup>11</sup> Christy Visser, Nancy G. La Vigne, and Jill Farrell, *Illinois Prisoners' Reflections on Returning Home* (Washington DC: The Urban Institute, 2003) and Steven Steurer, Linda Smith, and Alice Tracy, *Three-State Recidivism Study* (Lanham, MD: Correctional Educational Association, 2001).

- Returning citizens receive written information about prospective employers in their community and/or community employment service providers well in advance of the anticipated release date.
- Prior to discharge, returning citizens receive official documentation of their skills and experience, including widely accepted credentials.

### **Graduated Sanctions and Incentives for Offender Behavior**

It is essential in the application of supervision and responses to violations that corrections and community supervision agencies have a well-developed and documented policy that directs staff to include incentives and sanctions in their arsenal of responses. These “graduated sanctions and incentives” must also be understood and supported by the full range of stakeholders in the justice system (judges, prosecutors, defense attorneys, and parole board members) and with the larger community.

In a risk reduction driven system such as Alaska is pursuing, community supervision staff will obviously take offenders’ risk level into account when determining responses to behavior that may be positive (using incentives) or negative (using sanctions). Research shows that it is important to match responses as not doing so can have negative results and *increase* aberrant behavior.<sup>12</sup>

Corrections and supervision agencies should thoughtfully document into policy and procedures expectations to use sanctions and incentives to improve offenders’ behavior when possible. Research shows that the use of incentives and encouragements, in addition to sanctions, reduces criminal activity when used as part of a transformation from a “tail ‘em, nail ‘em, jail ‘em” philosophy to one that is driven by offender success and assumes more a coaching role for supervising officers.<sup>13</sup>

According to one of the most useful manuscripts on the subject, the Ten Step Guide for Transforming Probation Departments:<sup>14</sup>

*Incentives and graduated sanctions give probation officers a range of responses to probationers’ behavior that helps build accountability and discourage recidivism. They also help ensure that each officer responds to violations with a level of swiftness and severity that is directly related to the probationer’s risk level and the condition of supervision that has been violated...Standardizing responses provides a measure of fairness while giving officers necessary flexibility.*

This Guide includes Travis County’s “Violation Response Table,” which identifies the different levels of graduated sanctions depending on the type of infraction. The Guide recommends a four point process that Alaska should consider as another step in the process of redesigning their system based on the ADOC’s case logic.

<sup>12</sup> Edward Latessa, Lori Brusman Lovins, and Paula Smith, *Follow-up Evaluation of Ohio’s Community Based Correctional Facility and Halfway House Programs—Outcome Study* (Cincinnati: University of Cincinnati Center for Criminal Justice Research, February 2010); Christopher Lowenkamp and Ed Latessa, “Increasing the Effectiveness of Correctional Programming Through the Risk Principle: Identifying Offenders for Residential Placement,” *Criminology and Public Policy* 4(2) (2005): 263–90.

<sup>13</sup> See for, example, Crime and Justice Institute, *Implementing Evidence-Based Policy and Practice in Community Corrections*, second edition (Washington, DC: National Institute of Corrections, 2009), [http://www.cjinsitute.org/files/Community\\_Corrections\\_BoxSet\\_Oct09.pdf](http://www.cjinsitute.org/files/Community_Corrections_BoxSet_Oct09.pdf).

<sup>14</sup> Ten Step Guide for Transforming Probation Departments to Reduce Recidivism; Fabelo, Nagy, Prins; Council of State Governments Justice Center, New York (2011).

***Redesigning Incentive and Sanctioning Strategies Checklist<sup>15</sup>***

- ✓ Work with judges, prosecutors, parole board members and other stakeholders to develop a range of supported options and new procedures for employing incentives and graduated sanctions that are tailored to probationers'/parolees' level of criminogenic risk and identified need.
- ✓ Issue a comprehensive report that details the transparent procedures to be followed.
- ✓ Train officers to ensure the procedures are carried out fairly and in swift response to a violation. Emphasize the use of incentives rather than relying exclusively on punitive sanctions.

Goal: To ensure that probation officers have a range of options available to them to reinforce positive behavior and to address, swiftly and certainly, failures to comply with release conditions.

***Policy Expectations***

- An organized structure guides the imposition of sanctions.
- Revocation and re-incarceration are the most serious of many different options available for addressing violations.
- Individuals who violate conditions of release are assessed to gauge the level of response needed.
- Policies governing the sharing of information consider privacy and confidentiality issues.
- Meaningful positive reinforcements exist to encourage compliance with the terms of release.
- Victims are given an opportunity to inform the imposition of graduated responses.

**STATE LEVEL ORGANIZATIONAL STRUCTURES TO SUPPORT REFORM EFFORTS**

States which have been more successful at implementation of prisoner reentry improvements that result in long term, sustainable reductions in recidivism of former prisoners create organizational structures at the state and local level that are strong enough to support the weight of the reforms. In order to address the legislative directive for statewide collaboration, the OPR is developing a state level organizational structure that will fully engage reentry stakeholders across the state to participate in the on-going development and implementation of the AK-PRI. This state level structure – which will be built gradually over the course of 2015, begins with the statewide *Alaska Prisoner Reentry Council* and the *AK-PRI Implementation Steering Team (IST)* which will guide prisoner reentry reforms at the strategic and tactical (operational) levels through community –based work groups and department-based operational teams. (See page 11 for an illustration of the State Structure).

**The Alaska Prisoner Reentry Statewide Council (the Reentry Council)**

The Reentry Council is comprised of individuals and organizations from whom the Council has sought – and will continue to seek - advice and counsel on how to improve the success of Alaska's returning citizens. These supporters and stakeholders will assist the reentry reforms by acting as conduits for communication and a mechanism for building community awareness, support, and participation. The Reentry Council will develop work groups and sub-committees, as needed, to address pertinent issues from the varied perspectives of community leaders – many of whom have been engaged in improving prisoner reentry for many years. Committees of the Statewide Council will focus on specific issues around implementation. It is recommended that the first committee focus on Alaska Natives.

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<sup>15</sup> Ibid

- *The Alaskan Native Focus Group:* The Alaskan Native Advisory Committee will be comprised of representatives from groups and organizations which are dedicated to addressing the over-representation of Alaskan Natives in the adult prison system to help determine the most effective ways to address this enormous concern.

### **The AK-PRI Implementation Steering Team**

In November of 2014, the initial phase of work on the AK-PRI involved a core team of state agency representatives from the Department of Corrections, the Parole Board, the Alaska Mental Health Trust Authority and community reentry stakeholders. This core team, the *AK-PRI Implementation Steering Team* (IST), is chaired by Ronald Taylor, the Acting Commissioner of the DOC, whose office provides staff support. Once the Statewide Reentry Council convenes in 2015, it will be recommended that the IST become formalized and report to the *Statewide Reentry Council*.

When the Council adopts the Framework as the roadmap for the AK-PRI, the IST will expand to include human services organizations, non-profit institutions and faith-based partners. These additions will enhance the team's perspective and help it expand and become firmly established statewide. Thus, for practical purposes, the Framework should be viewed as a *preliminary* plan that will be strengthened dramatically through full community engagement. The IST will function through three Workgroups, one representing each of the three Phases in the AK-PRI. Each of the workgroups has co-chairs appointed by Acting Commissioner Taylor and will be facilitated and staffed by the OPR. The IST will:

- Identify barriers in each department or agency that may hinder the successful transition of returning citizens and develop policies, procedures, and programs to overcome such barriers.
- Identify methods to improve collaboration and coordination of offender transition services, including cross-training, information-sharing systems, and policies, procedures, and programs that measure offender reentry management with well-defined, performance-based outcomes.
- Consult with state and local agencies, organizations, and community leaders with expertise in the areas of prison facilities, parole decision-making, reentry, and community supervision to collaborate on offender transition issues and ways of improving operations.
- Consult with representatives from professional associations, volunteer and faith-based organizations, and local treatment and rehabilitation agencies to collaborate on offender transition issues and ways of improving operations.
- Provide recommendations as to how the Governor and other state departments and agencies may assist the Council in overcoming the barriers it has identified to the successful transition and reintegration of offenders returning to communities.
- Provide recommendations on how state laws and may be improved in order to contribute to the successful transition and reintegration of offenders into society and reduce recidivism.

In order to meet these responsibilities, the IST will over time implement a committee structure that focuses on policy and practice barriers to the full and robust implementation of the AK-PRI, and specific activities to overcome those barriers. The committee structure will be built as needed throughout 2015.

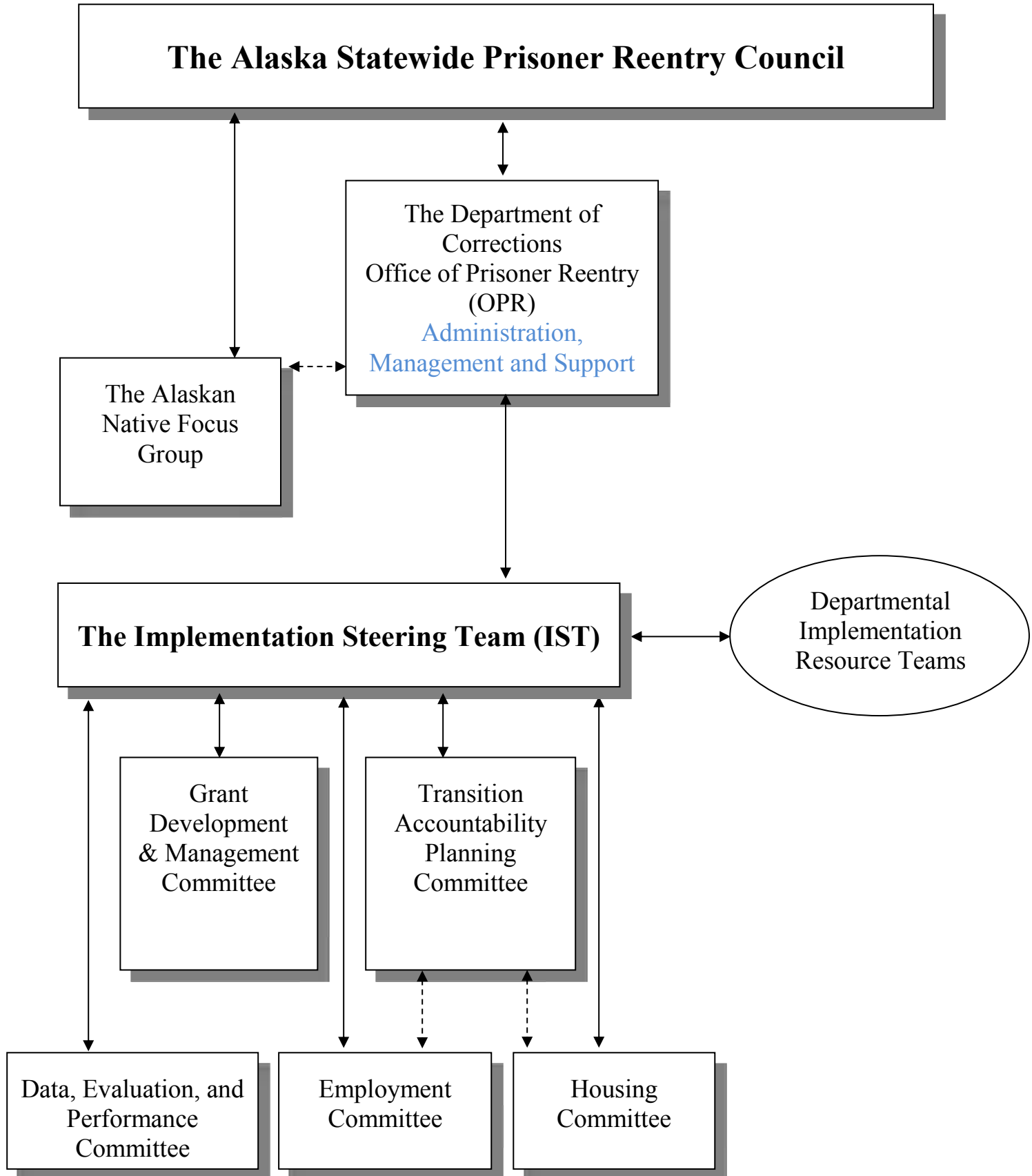
- *Departmental AK-PRI Implementation Resource Teams:* In order to effectively implement the AK-PRI Framework, each department that is responsible for any type of service that affects returning citizens will be represented on the IST and be asked to form in their state agency an

Implementation Resource Team (IRT). This team would be comprised of top level managers who are responsible for moving the AK-PRI Framework into the policies and procedures of their department and assuring that the Framework is fully implemented at both the state and local level. The Implementation Resource Teams will be responsible for interpreting how their departments' functions will need to be adapted to correspond with every aspect of the AK-PRI Framework and assuring efficient implementation. Active participation of the IRT Team Leader on the IST will be critical for their clear understanding of the forces driving the development and implementation of the Framework. AK-PRI Implementation Resource Teams will propose solutions to their department directors on how to respond to the challenges that inevitably will arise as their departments' reform their approaches to addressing the needs of citizens returning to Alaska's communities so that crime in Alaska is reduced. **This process represents the way that the AK-PRI Recidivism Reduction Plan will become, as House Bill 266 requires, "...comprehensive, complementary, and non-duplicative..."**

- *The Transition Accountability Planning Committee:* Given the critical important of transition planning across the spectrum of the reentry process from intake to prison through discharge from correctional authority, the Offender Management Planning (OMP) process requires, a work group that is comprised of prison, community supervision and community justice leaders and service providers is needed to implement the process with fidelity. This committee will work to ensure that all stakeholders' perspectives and inputs are taken into account when developing the new processes and policies around transition planning.
- *The Housing and Employment Committees:* Housing and employment for returning citizens are paramount for improved offender and system outcomes. These two service areas are the top priority of the Reentry Council and as such will benefit from specific forums for agency and community stakeholders to meet and determine the state's and each community's assets, barriers and gaps around housing and employment and work to maximize the assets, overcome the barriers, and eventually reduce the gaps in the service milieus of these two service areas.
- *The Grants Development and Management Committee:* One of the benefits of having explicit expectations for improving prisoner reentry through the AK-PRI and its state and local structures and guidelines is an enhanced ability to be very competitive for local, state, federal and foundation grant dollars. This committee will serve the purpose of determining the availability of funding from all sources, determine those that are important to pursue and provide the structure, discipline and capacity to pursue and achieve enhanced funding. Federal grant making for prisoner reentry under the Second Chance Act, for example, has grown dramatically over the past decade and states with clear designs, strategies and tactics to reduce recidivism have an excellent track record for grant awards.
- *The Data, Evaluation, and Performance Committee:* The ability to track, record, monitor, report and share data between stakeholders that provides needed accountability for improved reentry services is paramount to success. This committee will serve as the forum for policies, processes and protocols for data system development and implementation.



*The State Organizational Structure of the AK-PRI*



## LOCAL LEVEL ORGANIZATIONAL STRUCTURES TO SUPPORT REFORM EFFORTS

The state will implement the Alaska Prisoner Reentry Initiative (AK-PRI) Framework locally beginning with a number of Community Pilot Sites in 2015, and then adding additional sites until the entire state is engaged. Community Pilot Sites will be organized under a structure that parallels the state-level organizational structure. Each Community Pilot Site has three key groups of stakeholders who will be instrumental to the wide range of activities needed for full implementation of the AK-PRI Initiative. The local organizational structure requires clear definition of roles and responsibilities with guidance for development by the Alaska Department of Corrections Office of Prisoner Reentry (OPR).

### **The Local AK-PRI Implementation Steering Team**

Develops, oversees, and monitors the local implementation process and coordinates local community involvement in the overall statewide AK-PRI development process. The Steering Team is organized under three co-chairs and will be staffed by a Community Coordinator:

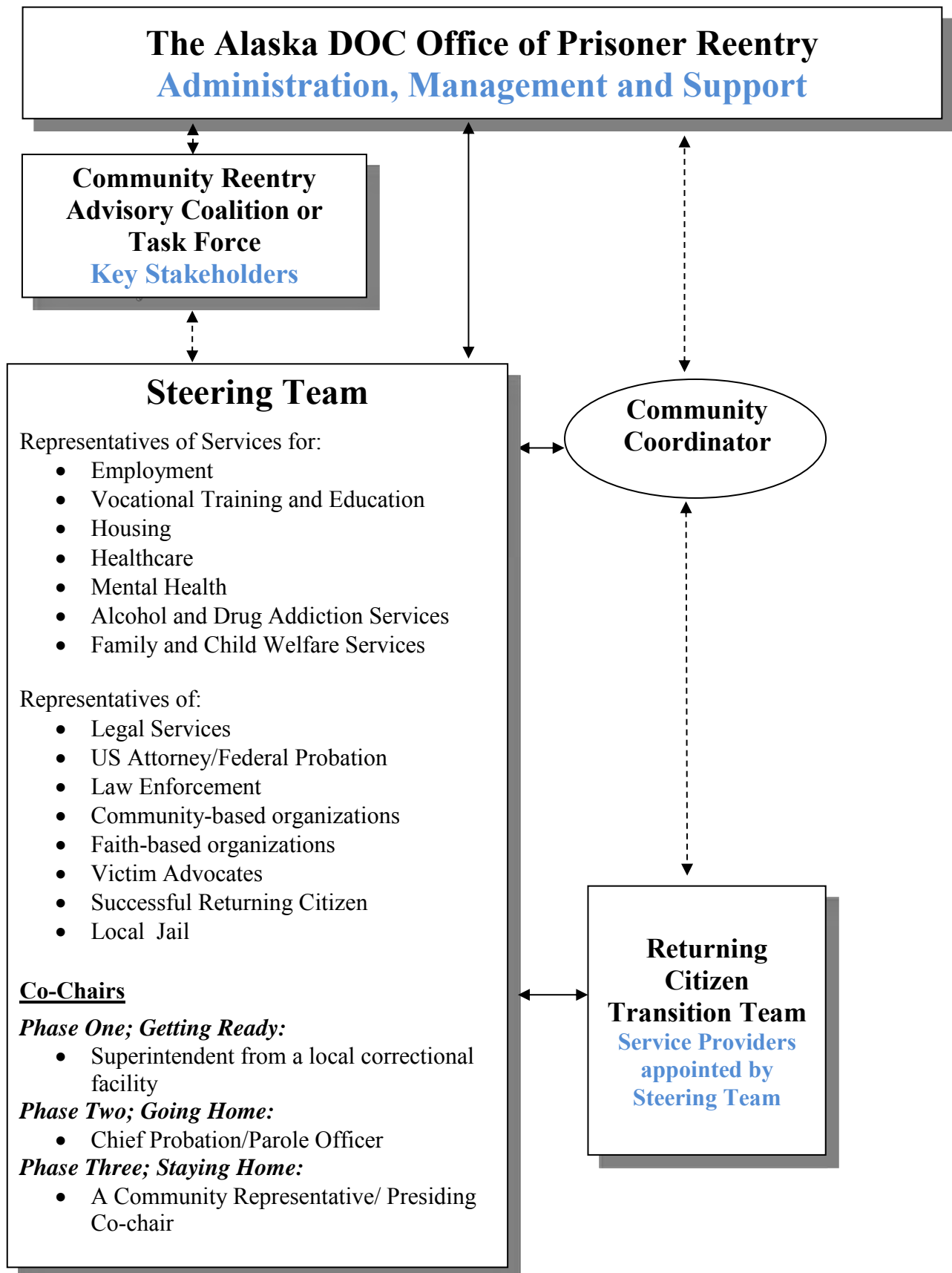
1. The *Superintendent* of a local Correctional Facility or designee;
2. The *Chief Probation/Parole Officer* or designee;
3. A *Community Representative* drawn from the large number of local faith, human service, and planning organizations who are critical to the local effort who will act as the “presiding co-chair to lead the meetings and to represent the local face of prisoner reentry.

Each Steering Team includes representatives or service providers associated with the AK-PRI partner government agencies representing the service modalities that must be included in successful reentry planning. These representatives are active on the Steering Team because of the critical need for multi-agency collaboration and the encouragement and support of agency leaders who empower their active participation. The three co-chairs of the Steering Team will work with the local Community Coordinator who will be resourced for each site as the AK-PRI is implemented using a combination of local, state, federal and/or foundation funds. The Community Coordinator will staff the Steering Team under the guidance of the co-chairs. (See next section)

- *The Returning Citizen Transition Team:* Supports returning citizens in the transition planning process and guides the individual from the institution back into the community through a case-management approach. The Transition Teams are comprised of key local service providers, drawn from the membership of the Steering Teams, whose major responsibilities include the local and essential input needed to develop and implement the Offender Management Plan (OMP) for three phases of the AK-PRI, Reentry (OMP2), Community Supervision (OMP3) and Discharge (OMP4) as part of collaborative case management (See Tab 3, *The AK-PRI Collaborative Case Supervision and Management Model* for more detail)
- *Local Reentry Advisory Council:* Advises, informs, and supports the implementation process. The purpose of the councils are help build support for the local implementation of the AK-PRI Model and will work to educate the community on how the initiative will create safer neighborhoods and better citizens. Many jurisdictions already have councils and they will be invited to participate; in other jurisdictions they will be developed by the community with support from the OPR.



### Local Organizational Structure of the AK-PRI



## COORDINATING COMMUNITY DEVELOPMENT: THE HEART OF THE AK-PRI

Strong and sustained local capacity is the single most critical aspect of the implementation of the Alaska Prisoner Reentry Initiative (AK-PRI). Pilot Site communities will become dedicated champions of improved reentry that will result in less crime through determined and specific preparation for inmates who will transition back to their communities. Local efforts at education, training, planning, and implementation need significant guidance and support in order to build the capacity for system reform. Each Pilot Site will have the benefit of a local Community Coordinator to help the community effectively prepare for reentry while the Alaska Department of Corrections (DOC) is better preparing returning citizens for release. The Community Coordinator will be assisted by local post-release supervision agencies.

Community convening and organizing will serve to elicit community buy-in and investment, plan for sustainability, and ensure quality results throughout the transition process. The Community Coordinators will receive training and technical support from the Alaska DOC Office of Prisoner Reentry (ORP) so that they are clear on how to manage the process based on the AK-PRI Framework. The four key ingredients for successful community organizing that the Community Coordinator will assist with are:

- *Capacity.* Each Community Coordinator must have the capacity to work on reentry. Indicators of adequate capacity include experience, staff capacity, resources to apply to the work, and relationships with key stakeholders.
- *Commitment.* Each Community Coordinator must demonstrate a dedicated commitment to reentry. Additionally, the community must develop a commitment to reentry. The development of community commitment may be fostered by the Community Coordinator. How is this level of interest perceived by other key community stakeholders?
- *Credibility.* The Community Coordinator must demonstrate credibility within the community. What is the demonstrated historic experience and credibility of the Community Coordinator in playing a catalytic role?
- *Knowledge.* What is the Community Coordinator's understanding of reentry and its implications?

*The Skills of Community Coordinators:* Local community-development efforts to implement the AK-PRI Framework will require a precise and extensive set of skills that will be the hallmarks of the Community Coordinators, who will staff the local development process. (See Tab 4, *Coordinating Community Development- the Heart of the AK-PRI* for more detail).

- *Communication.* The Community Coordinators must have excellent communications (both written and verbal) skills to facilitate connectedness among all implementation stakeholders. Communications must be facilitated both from the local communities to the statewide AK-PRI managers and from AK-PRI to the local communities.
- *Community convening.* The Community Coordinators must possess the skills to bring diverse stakeholders together, build consensus around reentry issues, and catalyze action and leadership within communities toward transition planning.
- *Community organizing.* Organizing within pilot communities involves training Steering Team members and Transition Team members, facilitating Reentry Advisory Council meetings, and building partnerships among key stakeholder groups.
- *Brokering.* When acting as a broker within communities, the Community Coordinator can benefit from maintaining a degree of neutrality to negotiate effectively through community conflict.

Extensive skills in brokering and fostering neutrality will be a central requirement of a Community Coordinator.

- *Coordinating.* The implementation planning associated with AK-PRI is challenging to coordinate. Maintaining connectedness to community activities will require extensive coordinating by the Community Coordinator.
- *Systems building.* Building systems and shepherding cross-systems change requires a complex set of skills. The Community Coordinator must have experience in building and managing system-wide change.

*The Responsibilities of Community Coordinators:* The involvement of communities in the AK-PRI includes three “focus areas” for Community Coordinators.

**Focus Area One:** Coordination and communication regarding the evolving design of the AK-PRI Framework so that each of the seven primary decision points is deeply influenced by the community perspective. The iterative process of refining the Framework will require open communication and effective coordination to ensure that community input is captured, the community has an accurate understanding of the Framework, and expectations for implementation are clearly defined. The affected policies and practices provide a rich context for an examination of the community’s role in the AK-PRI and thus a guide to the work.

- **Task 1.** The Community Coordinator will be responsible for facilitating communication with local stakeholders and with ORP to ensure that the evolving design of AK-PRI Framework is informed by the community perspective.

**Focus Area Two:** Facilitation and coordination regarding the identification of: (1) community assets that can be applied to improve returning citizen success, (2) policy and operational barriers among state and local agencies, and (3) service gaps that must be filled.

- **Task 2.** The community-assessment task of evaluating the assets, barriers, and gaps will be organized by the Community Coordinator. (See Tab 5 for the *AK-PRI Community Assessment Instrument*).
- **Task 3.** Committees will be formed to address these issues. Community representation on the AK-PRI committees will be coordinated by the Community Coordinator.

**Focus Area Three:** The design and implementation by local Pilot Sites of Comprehensive Reentry Plans that will provide the framework, rationale, and funding – when it is available from local, state, federal and private sources - for improved policies, practices, and programs whose success will be measured by reduced crime and fewer returns to prison. The Community Coordinator will facilitate the local process and provide the staff support needed to write the Comprehensive Plan.

The local Comprehensive Plan is developed from two primary sources of information. First, state DOC “pipeline data” that provides the community with the number and characteristics of citizens expected to return in the planning year. Second, the results of the community assessment process described above.

- **Task 4.** Coordinating the completion of the Comprehensive Community Reentry Plans utilizing DOC “pipeline data” and the result of the local community assessment process. .

**Focus Area Four:** The Offender Management Plan (OMP) process must be coordinated with prison officials, release authorities, supervising agencies and the local steering team.

- **Task 5.** The Community Coordinator will be responsible for making certain the information from the first Offender Management Plan (OMP1) is in the hands of the local AK-PRI Steering Team.
- **Task 6.** The Community Coordinator will be responsible for making certain that the expected release date and location of the offender is communicated to the local Steering Team.
- **Task 7.** The Community Coordinator will be responsible for ensuring that the local reentry Chief Parole and the Chief Probation Officer coordinates the logistics for the interaction of the Transition Team and the local prison and for the convening and facilitation of local Team meetings to develop the OMPs.
- **Task 8.** Since the Community Coordinators will be acting as staff for the local Steering Teams and their Reentry Councils, one of their many responsibilities will be to coordinate the planning and implementation of the fourth and final OMP (OMP4: The Discharge OMP) that will be the explicit “hand off” of the parolee’s case to responsible parties in the community who will continue providing services and guidance to the returning citizen.

## OFFENDER MANAGEMENT PLANS AND THE IMPORTANCE OF PRISON IN-REACH

The lynchpin of the AK-PRI Model is the development and use of Offender Management Plans (OMPs) at four critical points in the transition process. Each of the OMPs succinctly describe for the returning citizen, the corrections and/or field staff and the community exactly what is expected for a successful re-entry process. Under the Alaska Prisoner ReEntry Initiative (AK-PRI) Model, the OMPs, which consist of summaries of the returning citizen’s case management plan at critical junctures in the transition process, are prepared with each returning citizen at reception as part of the prison intake process (Phase I), as part of the release decision process when the returning citizen is approaching the end of their confinement (Phase II), when the returning citizen re-enters the community (Phase III), and when the returning citizen is to be discharged from probation/parole supervision (Phase IV). So, OMPs serve as concise guides for returning citizens, corrections and field staff and community service providers:

- **OMP1:** The expectations while imprisoned that will help returning citizens prepare for release.
- **OMP2:** The terms and conditions of the returning citizen’s release to communities.
- **OMP3:** The supervision and services returning citizens will experience in the community.
- **OMP4:** The Case Management Plan for eventual discharge from parole and/or probation.

The OMP integrates transition from prisons to communities by spanning phases in the transition process and agency boundaries. The OMP is a collaborative product that at any given time may involve institutional staff, the returning citizen, the parole board, parole/probation officers, human services providers (public and/or private), victims, and neighborhood and community organizations. The OMP describes actions that must occur to prepare individual returning citizens for release to the community, defines terms and conditions of their probation/parole supervision, specifies both the type and degree of supervision and the array of services they will experience in the community, and describes their eventual discharge to aftercare upon successful completion of supervision from probation and/or parole.

The objective of the OMP process is to increase both overall community protection by lowering risk to persons and property and by increasing individual returning citizen’s prospects for successful return to

and self-sufficiency in the community. The OMP process begins soon after returning citizens enter prison and continues during their terms of confinement, through their release from prison, and continues after their discharge from supervision as an evolving framework for aftercare provided by human service agencies or other means of self-help and support. The OMP1 is developed by institutional probation officers and education staff in the prisons that form the OMP1 Transition Team. Beginning with the OMP2, the OMPs are developed by a Transition Team that includes institutional staff, probation/parole supervision staff, and community agencies and service providers.

Thus, the membership of the Transition Team and their respective roles and responsibilities change over time as the returning citizen moves through the reentry process. During the institutional phase (OMP1) institutional probation officers leads the team. During the reentry and community supervision phases (OMP2 and OMP3) Prison In-Reach specialists – if they are available – or probation/parole offices lead the team with both institutional staff and community services providers as partners in the collaborative process. After returning citizens have successfully completed community supervision, their OMP will continue as needed and be managed by staff of human services agencies as the returning citizen continues to receive services and support (OMP4). At each stage in the process Transition Team members will use a collaborative case management model to monitor progress in implementing the OMP.

The OMP reduces uncertainty in terms of release dates and actions (and timing of actions) that need to be taken by returning citizens, prison staff, the parole board, parole and probation agents, and partnering community agencies. Increased certainty will motivate returning citizens to fully participate in the OMP process and to become engaged in fulfilling their responsibilities and will ensure that all parties are held accountable for timely performance of their respective responsibilities. *(See the illustration on page 19)*

The most pivotal activity that distinguishes the old way of doing business from the new way is the Prison In-Reach process that is the centerpiece of AK-PRI Phase II, the Reentry Phase. Prison In-Reach is the process by which community-based human service organizations work with the department on the development of the OMPs. When reviewing the Policy Statements and Recommendations that comprise the AK-PRI Model, the importance of the Prison In-Reach process becomes more focused. There are a series of Policy Statements in the AK-PRI Model that require an aggressive and productive Prison In-Reach process followed by an equally aggressive supervision strategy – especially during the pivotal first month of release.

## **PRINCIPLES THAT GUIDE THE OMP DEVELOPMENT PROCESS**

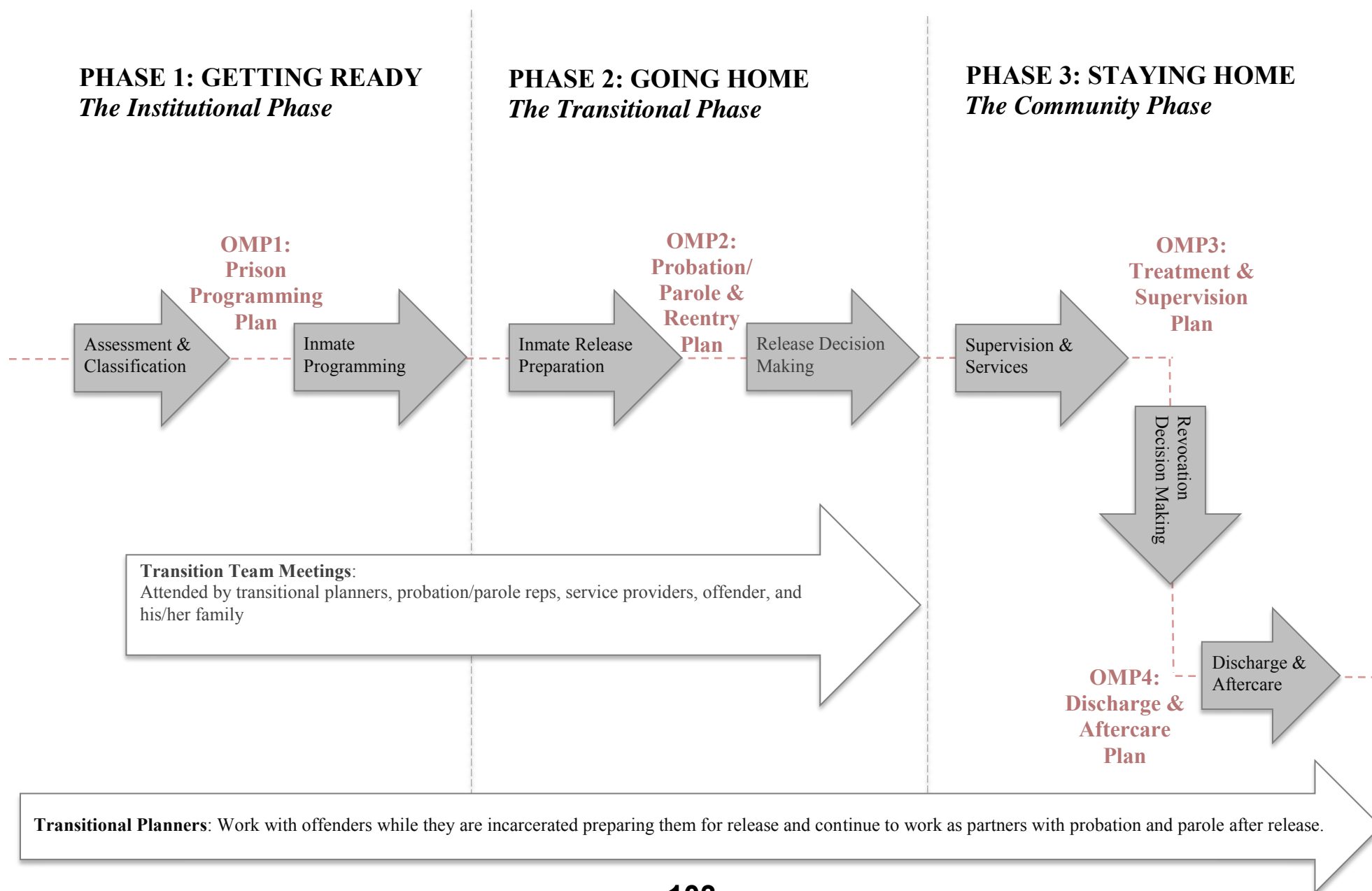
1. The OMP process starts during returning citizen's classification soon after their admission to prison and continues through their ultimate discharge from community supervision.
2. OMPs define programs or interventions to modify returning citizen's dynamic risk factors that were identified in a systematic assessment process; address the returning citizen's needs and build on the identified strength of each individual. The returning citizen is at the center of the process.
3. OMPs are sensitive to the requirements of public safety, and to the rational timing and availability of services. In an ideal system, every returning citizen would have access to programs and services to modify dynamic risk factors. In a system constrained by finite resources, the rational access to services and resources requires using risk management strategies as the basis for that allocation.

4. Appropriate partners should participate in the planning and implementation of individual returning citizen's OMPs. These include the returning citizen, institutional staff, parole board authorities, supervision authorities, victims, returning citizen's families and significant others, community-based treatment agencies, housing organizations and other human service agencies, and volunteer and faith-based organizations. While corrections staff lead the Transition Team, community representatives are vital partners in the process. The design of the OMP is a collaborative process.
5. Individual OMPs delineate the specific responsibilities of returning citizens, correctional agencies and system partners in the creation, modification, and effective application of the plans. The OMPs hold them accountable for performance of those responsibilities. While all four OMPs should include the types of services that are needed to address identified needs, reduce identified risks and build on identified strengths, beginning with the OMP2, they should encompass the enrollment of the returning citizen in the agencies responsible for the services. The OMP2 is the first OMP that is developed as a "prison in-reach" process that brings community representatives into the prisons to interact with the returning citizens. **Prison In-Reach – the process through which community-based human service agencies work with the DOC to develop the OMP - is a major distinction between the way business has been done in the past and the way it is improved and the single most important innovation of the AK-PRI Initiative.**
6. OMPs provide a long-term road map to achieve continuity in the delivery of treatments and services, and in the sharing of requisite information, both over time and across and between agencies. This is particularly essential during the re-entry phase (Phase II) when the boundaries between agencies are literally fences and brick walls. The OMP2 must serve as more than a plan – it must serve as a highly specific schedule of events beginning with the first hour that a returning citizen is released and has his or her Orientation Session with the probation/parole officer, and must include the expectations of how the returning citizen will spend his or her time during at least the first month of release. Perhaps the most vulnerable time for returning citizens is their first month in the community.
7. The Collaborative Case Management and Supervision (CCMS) process is used to arrange, advocate, coordinate, and monitor the delivery of a package of services needed to meet the specific returning citizen's needs. During the prison portion of the OMP process, institutional probation officers function as case managers. As returning citizens prepare for release and adjust to community supervision, their field probation/parole officer serves as the central and primary case manager. When they are successfully discharged from supervision, a staff member from a human service agency may assume case management responsibilities for returning citizens who continue to need services and support.

(See Tab 6, *Offender Management Plans and the Critical Importance of Prison In-Reach*; and Tab 3, *Collaborative Case Management and Supervision*).

# Offender Management Planning (OMP) Flowchart

*For more detail, see Tab 7, AK-PRI Case Logic Model*





The Alaska DOC Recidivism Reduction Plan

**ADDENDA** (available upon request)

Tab 1: *AK-PRI Framework, Summary*

Tab 2: *AK-PRI Framework, Targets for Change*

Tab 3: *AK-PRI Collaborative Case Supervision and Management Model*

Tab 4: *Coordinating Community Development- the Heart of the AK-PRI*

Tab 5: *AK-PRI Community Assessment Instrument*

Tab 6: *Offender Management Plans and the Critical Importance of Prison In-Reach*

Tab 7: *AK-PRI Case Logic Model*



## *About The Center for Justice Innovation*

The Michigan Crime and Delinquency's Center for Justice Innovation specializes in adult corrections and justice policy issues and seeks to build capacity within state and local jurisdictions to improve both system and individual offender outcomes through the use of evidence-based practices. These improved outcomes include:

- (1) Fewer crimes committed by formerly incarcerated individuals and individuals who have been or are currently under correctional supervision in the community;
- (2) Community and institution-based programs that demonstrate increased fidelity to the standards of evidence-based practices;
- (3) Prevention of unnecessary confinement of offenders in jail and prisons; and,
- (4) Reduced costs and improved efficiencies.

The Center is led by Dennis Schrantz, who has worked in ten states over the past 10 years to assist state and local jurisdictions in improving their policies and practices for prisoner reentry. One of Mr. Schrantz's major accomplishments in prisoner reentry was his work over seven years in the Michigan Department of Corrections (MDOC) where, as chief deputy director and an appointee of Governor Jennifer M. Granholm, he led efforts to design, implement, monitor, and evaluate the Michigan Prisoner ReEntry Initiative (MPRI).

MPRI contributed to a decline in the prison population of nearly 17% in six years, allowing the closure of 21 prisons and a projected cost savings to the state of \$339 million annually in averted prison costs;<sup>16</sup> all while the reinvesting over \$50 million annually in supervision and reentry services. Based on data from nearly 33,000 former prisoners who participated in MPRI from 2005 through 2011, Michigan has witnessed unparalleled successes: a 38% reduction in parolee revocations to prison; an increase in the parole approval rate from an average of 48% to nearly 75% because of the Parole Board's increase confidence in Michigan's reentry strategy; and, a 42% decrease in technical violations despite a 40% increase in the parolee population.<sup>17</sup>

Michigan's ability to integrate research into the policies and practices that reduce recidivism has been highlighted in numerous publications<sup>18</sup> and has established MCCD as a leading national expert on how to reduce the return-to-prison recidivism rate of former prisoners, reduce prison populations, and reinvest prison dollars into communities.

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<sup>16</sup> The Sentencing Project, *On the Chopping Block: State Prison Closings*, 2012.

<sup>17</sup> Michigan Department of Corrections, *Trends in Key Indicators*, 2013.

<sup>18</sup> See, for example: *Downscaling Prisons; Lessons from Four States* (The Sentencing Project, 2010), *On the Chopping Block: State Prison Closings* (The Sentencing Project, 2012); *Michigan Breaks the Political Logjam: A New Model for Reducing Prison Populations* (The ACLU, 2009) and, from the *Washington Monthly*, "Prison Break: How Michigan Managed to Empty its Penitentiaries while Lowering its Crime Rate."; The Council of State Governments, *States Report Reductions in Recidivism*.

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Include any comments regarding the survey instrument here



Department of Labor and  
Workforce Development  
Administrative Services Division  
Research & Analysis

PO Box 115501  
Juneau, Alaska 99811-5501  
Main: 907.465.4500  
Fax: 907.523.9654

Unique Company ID: 622110-2279

April 2, 2015

BANNER HEALTH SYSTEM  
MIKE POWERS  
1650 COWLES ST.  
FAIRBANKS, AK 99701

Dear Mike:

This survey is designed to determine the occupations for which you are having the most difficulty hiring because of a shortage of qualified, available workers. You are one of a handful of employers we chose to test the survey. We anticipate that it will take 30 minutes or less to complete.

Please let us know if any part of the survey is unclear or if it takes more than 30 minutes. We will use your feedback to finalize the survey and, if it was clear to you, we will use your responses with the final results (in other words, you will not receive an additional survey unless it changes significantly as a result of testing).

Please return this survey by mail in the attached envelope, by FAX at 907.523.9654, or by emailing it to [kathleen.ermatinger@alaska.gov](mailto:kathleen.ermatinger@alaska.gov).

Sincerely,

A handwritten signature in black ink that appears to read "Dan Robinson".

Dan Robinson, Chief  
Research and Analysis Section



Use the space below to provide your input on the health care workforce in Alaska and its effect on your company

|       |               |
|-------|---------------|
| Name: | Phone number: |
|-------|---------------|


This survey contains a list of typical occupations in your industry. If you have a health-related occupation not on the list, add it in the section provided. When determining your level of difficulty in recruiting and hiring for a position, exclude difficulties related to your internal hiring practices. Occupational definitions are available online at [laborstats.alaska.gov/survey/HS15.htm](http://laborstats.alaska.gov/survey/HS15.htm).

**Do Not Employ This Occupation**  
**No Openings in 2014:** Did not recruit/hire in 2014.  
**Not Difficult:** Recruitment/hiring process resulted in a satisfying list of qualified applicants.  
**Difficult:** Recruitment/hiring process resulted in an applicant pool you prefer not to or cannot hire from. The inability to hire for the position did not impact your ability to provide health services to your clients.  
**Critical:** Recruitment/hiring process resulted in an applicant pool you prefer not to or cannot hire from. The inability to hire for the position impacted your ability to provide health services to your clients.

| Do Not Employ This Occupation  |                       | No Openings in 2014   |                       | Level of Difficulty   |  |
|--|-----------------------|-----------------------|-----------------------|-----------------------|--|
|  |                       | Not Difficult         |                       | Difficult             |  |
|  |                       |                       |                       | Critical              |  |
| Health Care Administration, cont.  |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Occupational Health and Safety Specialists (3880)                |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Operations Managers and Officers, Health Care-Specific (4105)    |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Professional Medical Coders (CPC, CCS, or CCS-P required) (4825) |
| Health Care Educators  |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Community Wellness Advocates (1810)                              |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Nurse Educators (Health Care Facility or Multi-Site) (3700)      |
| Health Care Social Workers and Community Health Workers  |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Behavioral Health Case Managers and Care Coordinators (1135)     |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Community Health Representatives (Indian Health Services) (1765) |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Health Care Social Workers (2845)                                |
| Nurses   |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Case Management Nurses (1270)                                    |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Certified Nurse Midwives (CNM) (1360)                            |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Critical Care Nurses (CCU) (1900)                                |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Emergency Room Nurses (ER) (2395)                                |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Family Nurse Practitioners (2485)                                |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Geriatric Nurses (2665)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Licensed Practical Nurses (LPN) (3070)                           |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Nurse Managers (patient care setting) (3745)                     |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Obstetric Nurses (3790)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Perioperative Nurses (4420)                                      |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Psychiatric Nurse Practitioners (4915)                           |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Psychiatric Nurses (4960)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Public Health Nurses (5050)                                      |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Registered Nurses, General (RN) (5140)                           |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Women's Health Care Nurse Practitioners (5545)                   |
| Physician Assistants   |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Physician Assistants (PA-C) (4780)                               |
| Physicians, Surgeons, and Other Related Practitioners  |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Anesthesiologists (1000)   |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Emergency Physicians (2350)                                      |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | General Practitioners and Family Physicians (2620)               |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hospitalists (2980)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Internists, General (3025)                                       |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Obstetricians and Gynecologists (3835)                           |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ophthalmologists (4150)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Optometrists (4240)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pediatricians, General (4375)                                    |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Psychiatrists (5005)   |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Radiologists (5095)  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Surgeons (5455)  |
| List any health-related occupations not included above.  |                       |                       |                       |                       |  |
| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
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| <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Add your comments regarding the health care workforce in Alaska and its effect on your company on the back page. |                       |                       |                       |                       |  |

|   |  |
|---|--|
|   | <p><b>Program Performance – Demonstrating Value</b></p> <p>Update: March 20<sup>th</sup>, 2015</p> |
|---|--|

Alaska’s SHARP Program addresses the worsening shortage of health professionals in Alaska by improving the availability and distribution of direct patient care providers in the areas of greatest need. It does this by providing loan repayment and direct incentives to healthcare practitioners through a unique collaboration of state, federal, and employer partners. SHARP works to improve access to healthcare especially for those Alaskans who face substantial barriers such as living in a remote location, being uninsured or who have safety-net insurance coverage (e.g. Medicaid, Medicare, or tribal health benefits). SHARP is working, and we are making progress.

| <b>Progress to Date</b>   |  |
|---|--|
| <p><b>SHARP – One Program, Two Components</b><br/>196 = Clinicians overall (as of 3/20/15)</p> <ul style="list-style-type: none"> <li>• 33 = Oral Healthcare (17%)</li> <li>• 55 = Behavioral Health (28%)</li> <li>• 108 = Medical Care (55%)</li> </ul> <p><b>SHARP-I:</b> federal partnership component<br/>First clinician contracts started in 2010<br/>3<sup>rd</sup> competitive grant to-date; sunsets in 2019</p> <ul style="list-style-type: none"> <li>• 113 = Clinicians to-date (58%)</li> </ul> <p><b>SHARP-II:</b> non-federal component<br/>First clinician contracts started in 2013<br/>Established by AS 18.29; sunsets end of 2018</p> <ul style="list-style-type: none"> <li>• 83 = Clinicians to-date (42%)</li> </ul> <p><b>Clinician Retention:</b> SHARP-I as of 3/20/15</p> <ul style="list-style-type: none"> <li>• 98% = Contract completions (73 of 74)</li> </ul> | <p><b>Public-Private Funding Partnership</b></p> <p>US Health Resources &amp; Services Administration<br/>Alaska Dept of Health &amp; Social Services<br/>Alaska Mental Health Trust Authority<br/>Alaska Statute AS 18.29<br/>Partial Employer Match (collection rate: 100%)</p> <p><b>Interagency Leadership – SHARP Council</b></p> <p>15 voting member organizations:<br/>ABHA, ACPE, ADS, AK DOLWFD, AMHTA, ANTHC, ANA, AkPharm, APCA, ASHNHA, NASW, ANA, AAPA, AK FMRP, NASW-AK, UA-Health and the United Way<br/>2 more agencies ex-officio: ANHB, &amp; AK DPH</p> |
| <b>Sites &amp; Locations</b>  |  |
| <p>Broad range of practice settings, such as community health centers, community behavioral health centers, tribal health facilities, critical access hospitals, and Alaska Psychiatric Institute</p> <ul style="list-style-type: none"> <li>• Rurality: 71% Rural (F+R), [Frontier 103; Rural 36; Suburban 8; Urban 45; Statewide 4]</li> <li>• Tribal: 57% Tribal healthcare positions, [Tribal 111; Non-tribal 85]</li> </ul>  |  |
| <b>The Road Ahead</b>   |  |
| <ul style="list-style-type: none"> <li>• Institutionalizing SHARP within Alaska’s system-of-care</li> <li>• Partnering with other system initiatives, such as the primary care medical home, behavioral health – primary care integration, and, oral health workforce innovations</li> </ul>  |  |
| <p><b>For more information, contact:</b><br/>Robert Sewell, Ph.D., Program Manager<br/>E-mail: <a href="mailto:robert.sewell@alaska.gov">robert.sewell@alaska.gov</a>, ph (907) 465-4065<br/>Section of Health Planning &amp; Systems Development<br/>Division of Public Health, Alaska DHSS<br/><a href="http://dhss.alaska.gov/dph/healthplanning/pages/sharp">http://dhss.alaska.gov/dph/healthplanning/pages/sharp</a></p>  |   |

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# Alaska Scorecard

Key Issues Impacting  
Alaska Mental Health Trust Beneficiaries



Click on the title of each indicator for a link to complete sources and information

Key to symbols:

- ✓ Satisfactory
- ↔ Uncertain
- ✗ Needs Improvement

| Most<br>Current<br>U.S. Data | Previous<br>Year's<br>AK Data | Most<br>Current<br>AK Data | Status |
|------------------------------|-------------------------------|----------------------------|--------|
|------------------------------|-------------------------------|----------------------------|--------|

## Health

### Suicide

|   |      |      |      |   |
|---|------|------|------|---|
| 1 Suicide (rate per 100,000)                              | 12.6 | 23.6 | 24.2 | ✗ |
| 2 Percent of adults reporting serious thoughts of suicide | 3.9% | 4.4% | 4.2% | ↔ |

### Substance Abuse

|  |       |       |       |   |
|--|-------|-------|-------|---|
| 3 Alcohol-induced deaths (rate per 100,000)                      | 8.8   | 33.0  | 29.4  | ✗ |
| 4 Percent of adults who engage in heavy drinking                 | 6.2%  | 6.5%  | 7.7%  | ✗ |
| 5 Percent of adults who engage in binge drinking                 | 16.8% | 17.3% | 18.5% | ↔ |
| 6 Percent of population (age 12 and older) who use Illicit drugs | 9.2%  | 14.0% | 12.9% | ✗ |

### Mental Health

|  |      |       |       |   |
|--|------|-------|-------|---|
| 7 Days of poor mental health in past month (adults)            | 3.7  | 3.3   | 3.1   | ✓ |
| 8 Percent of teens who experienced depression during past year | 29.9 | 25.9% | 27.2% | ✗ |

### Access

|  |       |       |       |   |
|--|-------|-------|-------|---|
| 9 Percent of population without health insurance | 14.5% | 19.0% | 18.5% | ✗ |
|--|-------|-------|-------|---|

## Safety

### Protection

|  |       |       |       |   |
|--|-------|-------|-------|---|
| 10 Children abused and neglected (rate per 1,000)                    | 9.1   | 15.6  | 13.0  | ✗ |
| 11 Substantiated reports of harm to adults (rate per 1,000)          | †     | 1.1   | 1.2   | ↔ |
| 12 Injuries to elders due to falls, hospitalized (rate per 100,000)  | 1,472 | 1,166 | 1,061 | ✓ |
| 13 Traumatic brain injury, hospitalized non-fatal (rate per 100,000) | †     | 79.9  | 81.2  | ✓ |

### Justice

|   |   |       |       |   |
|---|---|-------|-------|---|
| 14 Percent of incarcerated adults with mental illness or mental disabilities                      | † | 42.0% | 65.0% | ✗ |
| 15 Rate of criminal recidivism for incarcerated adults with mental illness or mental disabilities | † | 39.2% | 38.9% | ↔ |
| 16 Percent of arrests involving alcohol or drugs  | † | 42.9% | 29.5% | ↔ |

## Living With Dignity

### Accessible, Affordable Housing

|  |      |      |      |   |
|--|------|------|------|---|
| 17 Chronic homelessness (rate per 100,000) | 26.4 | 25.1 | 28.0 | ↔ |
|--|------|------|------|---|

### Educational Goals

|   |   |       |       |   |
|---|---|-------|-------|---|
| 18 Difference between high school graduation rate for students with and without disabilities  | † | 32.7% | 33.0% | ↔ |
| 19 Percent of youth who received special education who are employed or enrolled in post-secondary education one year after leaving school | † | 58.0% | 72.0% | ↔ |

## Economic Security

|  |      |       |       |   |
|--|------|-------|-------|---|
| 20 Percent of minimum wage income needed to afford average housing     | †    | 89.6% | 90.7% | ✗ |
| 21 Average annual unemployment rate                                    | 7.4% | 7.0%  | 6.5%  | ✓ |
| 22 Percent of SSI recipients who are blind or disabled and are working | 4.3% | 6.6%  | 6.8%  | ✓ |

## Prevalence Estimates: Alaska Mental Health Trust Beneficiaries

| Alaska Mental Health Trust Beneficiary Population | Number | Population Rate |
|---|--------|-----------------|
| Serious Mental Illness (ages 18+)                 | 21,754 | 4.0%            |
| Serious Emotional Disturbance (ages 0 to 17)      | 12,725 | 6.7%            |
| Alzheimer's Disease (ages 60+)                    | 6,100  | 9.0%            |
| Traumatic brain injury (all ages)                 | 11,900 | 1.6%            |
| Developmental disabilities (all ages)             | 13,270 | 1.8%            |
| Dependent on alcohol (ages 12 to 17)              | 1,000  | 1.6%            |
| Dependent on alcohol (ages 18+)                   | 20,000 | 3.7%            |

December 2014

† No comparable U.S. data available

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/scorecard>

## Health: Suicide

1. **Suicide rate per 100,000** (2013).<sup>a</sup>
2. **Serious thoughts of suicide.** Adults aged 18 and older reporting serious thoughts of suicide in the past year (2012-2013).<sup>b</sup>

## Health: Substance Abuse

3. **Alcohol-induced deaths per 100,000.** Includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning (2013).<sup>a</sup>
4. **Adults who engage in heavy drinking.** Percentage of adults who reported heavy drinking in past 30 days; defined as two or more drinks daily for men and one or more daily for women (2013).<sup>c</sup>
5. **Adults who engage in binge drinking.** Percentage of adults who reported drinking five or more drinks on one occasion in past 30 days (2013).<sup>c</sup>
6. **Population aged 12 and older using illicit drugs.** Percentage of population age 12 and older who report using illicit drugs in the past month, including marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically (2012-2013).<sup>b</sup>

## Health: Mental Health

7. **Days of poor mental health in past month (adults).** Mean number of days during the previous 30 days for which respondents aged 18 years or older report that their mental health (including stress, depression, and problems with emotions) was not good (2013).<sup>c</sup>
8. **Teens who experienced depression during past year.** Percentage of high school students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during past 12 months (2013).<sup>d</sup>

## Health: Access

9. **Population without health insurance.** Percent of population without health insurance for the entire year (2013).<sup>e</sup>

## Safety: Protection

10. **Children abused and neglected, rate per 1,000.** Child victims aged 0-17, unique counts (2013).<sup>f</sup>
11. **Substantiated reports of harm to adults, rate per 1,000.** (FY2014).<sup>g</sup>
12. **Injuries to elders due to falls, rate per 100,000.** Non-fatal injuries, ages 65+, hospitalized 24 hours or more (2013).<sup>h</sup>
13. **Rate of non-fatal traumatic brain injury per 100,000.** Hospitalized 24 hours or more (2013).<sup>h</sup>

## Safety: Justice

14. **Percent of incarcerated adults with mental illness or mental disabilities** (2012).<sup>i</sup>

15. **Statewide criminal recidivism rates for incarcerated adults with mental illness or mental disabilities.** Rate of re-entry into ADOC for a new crime occurring within one year of initial date of discharge (2012).<sup>j</sup>
16. **Percent of arrests involving alcohol or drugs.** Arrest offenses with Division of AK State Troopers or Wildlife Troopers that were flagged as being related to alcohol and/or drugs (2013).<sup>j</sup>

## Living With Dignity: Housing

17. **Rate of chronic homelessness per 100,000 population.** A person with a disabling condition who has been continuously homeless for a year or more or who has had at least four episodes of homelessness in the past three years is considered chronically homeless (2014).<sup>k</sup>

## Living With Dignity: Education

18. **Difference between high school graduation rate for students with and without disabilities.** Statewide cohort graduation rate (2013-2014).<sup>l</sup>
19. **Percent of youth who received special education who are employed and/or enrolled in post-secondary education one year after leaving school** (2013).<sup>m</sup>

## Economic Security

20. **Percent of minimum wage income needed for average two-bedroom housing in Alaska.** Affordable housing is defined as not more than 30% of one's gross income (2014).<sup>n</sup>
21. **Average annual unemployment rate.** Rate represents the number unemployed as a percent of the labor force (2013).<sup>o</sup>
22. **Percent of SSI recipients with blindness or disabilities who are working** (2013).<sup>p</sup>

## Data Sources

- a. Alaska Department of Health and Social Services, Division of Public Health, [Bureau of Vital Statistics](#).
- b. Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, [National Survey on Drug Use and Health](#).
- c. Alaska Department of Health and Social Services, Division of Public Health, Behavioral Risk Factor Surveillance System; U.S. Centers for Disease Control and Prevention (CDC).
- d. Alaska Department of Health and Social Services, Division of Public Health, [Youth Risk Behavior Survey](#); U.S. Centers for Disease Control and Prevention, [Youth Risk Behavior Survey](#).
- e. U.S. Census Bureau and Bureau of Labor Statistics, Current Population Survey, [Health Insurance Coverage Status](#).
- f. Alaska Department of Health and Social Services, Office of Children's Services; [Statistical Information](#). U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau, [Child Maltreatment 2013](#).

- g. Alaska Department of Health and Social Services, Senior and Disabilities Services, [Adult Protective Services](#).
- h. Alaska Department of Health and Social Services, Division of Public Health, [Alaska Trauma Registry](#); U.S. Centers for Disease Control and Prevention (CDC), Injury Prevention & Control, [Data & Statistics](#).
- i. Hornby Zeller Associates, Inc. (May 2014), [A Study of Trust Beneficiaries in the Alaska Department of Corrections](#).
- j. Alaska Public Safety Information Network (APSN) case data for [Alaska Department of Public Safety](#), Division of Alaska State Troopers and Wildlife Troopers.
- k. HUD Continuum of Care Homeless Assistance Programs, [2013 HUD Annual Homeless Assessment Report](#).
- l. Alaska Department of Education & Early Development, [Statistics and Reports](#).
- m. [Governor's Council on Disabilities & Special Education](#); Alaska Department of Education & Early Development, [FFY 2012 Annual Performance Report](#).
- n. National Low Income Housing Coalition (2014). [Out of Reach 2014](#).
- o. Alaska Department of Labor & Workforce Development, Research and Analysis, [Labor Force Data](#); U.S. Department of Labor, Bureau of Labor Statistics, [Labor Force Statistics from the Current Population Survey](#).
- p. U.S. Social Security Administration, Office of Retirement and Disability Policy, [SSI Annual Statistical Report, 2013. Table 41, Recipients Who Work](#).

**Alaska Population Rates:** Alaska Department of Labor & Workforce Development, [Population Estimates](#).

## Prevalence Data – Sources

**Mental Illness (SMI and SED).** WICHE Mental Health Program and Holzer, Charles (2008). [2006 Behavioral Health Prevalence Estimates in Alaska: Serious Behavioral Health Disorders in Households](#).

**Alzheimer's Disease** (2014 estimate). Alaska Department of Health and Social Services. [Alaska's Roadmap to Address Alzheimer's Disease and Related Dementias](#) (12/31/14).

**Traumatic Brain Injury.** University of Alaska Center for Human Development (2003). [The Alaska Traumatic Brain Injury \(TBI\) Planning Grant Needs and Resources Assessment, June 2001 – January 2003](#) and AK Brain Injury Network (via e-mail 12/16/11).

**Developmental Disabilities.** Gollay, E. (1981). [Summary Report on the Implications of Modifying the Definition of a Developmental Disability](#). U.S. Department of Health, Education and Welfare; and GCDSE (via e-mail 10/21/11).

**Alcohol dependence.** U.S. DHHS, SAMHSA, National Survey on Drug Use and Health. Estimates based on 2010-2011 NSDUHS.



## Key to Scorecard symbols

| Alaska vs. U.S. % Difference |   | Alaska Year-to-Year Trend |                            | Assessment |                   | Status |
|------------------------------|---|---------------------------|----------------------------|------------|-------------------|--------|
| If                           | Less than 15%                           | and                       | Getting better             | then       | Satisfactory      | ✓      |
| If                           | Less than 15%                           | and                       | Getting worse or flat      | then       | Uncertain         | ↔      |
| If                           | Greater than 15% to the positive        | and                       | Getting better or flat     | then       | Satisfactory      | ✓      |
| If                           | Greater than 15% to the positive        | and                       | Getting worse              | then       | Uncertain         | ↔      |
| If                           | Greater than 15% to the negative        | and                       | Getting better             | then       | Uncertain         | ↔      |
| If                           | Greater than 15% to the negative        | and                       | Getting worse or not clear | then       | Needs Improvement | ✗      |
| If                           | Unacceptably large rate to the negative | then                      | Trend becomes irrelevant   | then       | Needs Improvement | ✗      |

## How did we determine the status of Scorecard indicators?

The Alaska Department of Health and Social Services, in conjunction with the Trust and the related advisory boards and commission, has produced this Alaska Scorecard annually since 2008.

To determine the status of an indicator, the most current Alaska data is compared to U.S. data to see if it is more than 15% higher or lower. Then, the year-to-year Alaska data is examined to see if it shows a clear trend or if it varies so much that a clear trend cannot be determined.

Between 2013 and 2014 the status of most indicators remained the same; one moved from “needs improvement” to “uncertain,” one moved from “uncertain” to “satisfactory,” and one moved from “uncertain” to “needs improvement.”

## Status information by Scorecard indicator

- Suicide rate per 100,000.** The 2013 Alaska rate is 92% higher than the U.S. rate, and the Alaska rate has varied too much year-to-year to show a clear trend. The resulting status is “needs improvement.” This is the same as last year’s Scorecard status.
- Serious thoughts of suicide.** The 2012-2013 Alaska rate is 8% higher than the U.S. rate, and the Alaska rate has remained generally flat. The status is “uncertain.” This is better than last year’s Scorecard status.
- Alcohol-induced deaths.** The 2013 Alaska rate is 234% higher than the U.S. rate, and the Alaska data show no clear trend. The status is “needs improvement.” This is the same as last year’s Scorecard status.
- Heavy drinking (adults).** The 2013 Alaska rate is 24% higher than the U.S. rate, and the Alaska rate does not show a clear trend, so the status is “needs improvement.” This is worse than last year’s Scorecard status.
- Binge drinking (adults).** The 2013 Alaska rate is 10% higher than the U.S. rate, and the yearly Alaska data show no clear trend, so the status is “uncertain.” This is the same as last year’s Scorecard status.
- Illicit drug users.** The 2012-2013 Alaska rate is 40% higher than the U.S. rate, and the yearly Alaska data show no clear trend, so the status is “needs improvement.” This is the same as last year’s Scorecard status.
- Days of poor mental health.** The 2013 Alaska rate is 16% lower than the U.S. rate and the Alaska data show no clear trend, so the status is “satisfactory.” This is better than last year’s Scorecard status.
- Teens that experienced depression.** Although the 2013 Alaska rate is 9% below the U.S. rate, the rate is unacceptably high, so the status is “needs improvement.” This is the same as last year’s Scorecard status.
- Population without health insurance.** The 2013 Alaska rate is 28% higher than the U.S. rate, and the Alaska data show an increase in the rate of population without insurance, so the status is “needs improvement.” This is the same as last year’s Scorecard status.

10. **Children abused and neglected.** While the Alaska data show as possible downward trend, the 2013 Alaska rate is 42.9% higher than the U.S. rate. The status is “needs improvement.” This is the same as last year’s Scorecard status.
11. **Substantiated reports of harm to adults (rate per 1,000).** There is not enough information to identify a trend in Alaska data and no comparable U.S. data; the status is “uncertain.” This is the same as last year’s Scorecard status.
12. **Injuries to elders due to falls.** The 2013 Alaska rate is 28% below the U.S. rate, and the data show a possible downward trend; the status is “satisfactory.” This is the same as last year’s Scorecard status.
13. **Non-fatal traumatic brain injury.** Although there are no U.S. data for comparison, the Alaska rate appears to have improved in the past decade. The status is “satisfactory.” This is the same as last year’s Scorecard status.
14. **Incarcerated adults with mental illness or mental disabilities.** There are not enough Alaska data to identify a trend. However, the consensus is that the rate is unacceptably high, so the status is “needs improvement.” This is the same as last year’s Scorecard status.
15. **Criminal recidivism for incarcerated adults with mental illness or mental disabilities.** There are not enough Alaska data to identify a trend; there are no comparable U.S. data. The status is “uncertain.” This is the same as last year’s Scorecard status.
16. **Arrests involving alcohol or drugs.** The Alaska rate has decreased in the last year and over the past six years; however, this may be due to record keeping. There are no U.S. data for comparison. The status is “uncertain.” This is the same as last year’s Scorecard status.
17. **Chronic homelessness.** The 2014 Alaska rate is 6% higher than the U.S. rate, but the Alaska data vary too much year-to-year to show a clear trend, so the status is “uncertain.” This is the same as last year’s Scorecard status.
18. **Difference between high school graduation rate for students with and without disabilities.** The 2013-2014 rate shows a greater difference than the previous year; however, there is no evidence of a trend. The status is “uncertain.” This is the same as last year’s Scorecard status.
19. **Percent of youth who received special education and are employed and/or enrolled in post-secondary education.** There is not enough information to identify a trend in Alaska data and no comparable U.S. data; the status is “uncertain.” This is the same as year’s Scorecard status.
20. **Percent of Minimum Wage needed for Average Housing.** The consensus is that the percentage of income spent on housing in Alaska unacceptably high, so the status is “needs improvement.” This is the same as last year’s Scorecard status.
21. **Average annual unemployment.** The 2013 Alaska rate is 12% below the U.S. rate and the data show a possible downward trend; the resulting status is “satisfactory.” This is the same as last year’s Scorecard status.
22. **Percent of SSI recipients who are blind or disabled and are working.** The 2013 Alaska rate is 58% higher than the U.S. rate; the status is “satisfactory.” This is the same as last year’s Scorecard status.

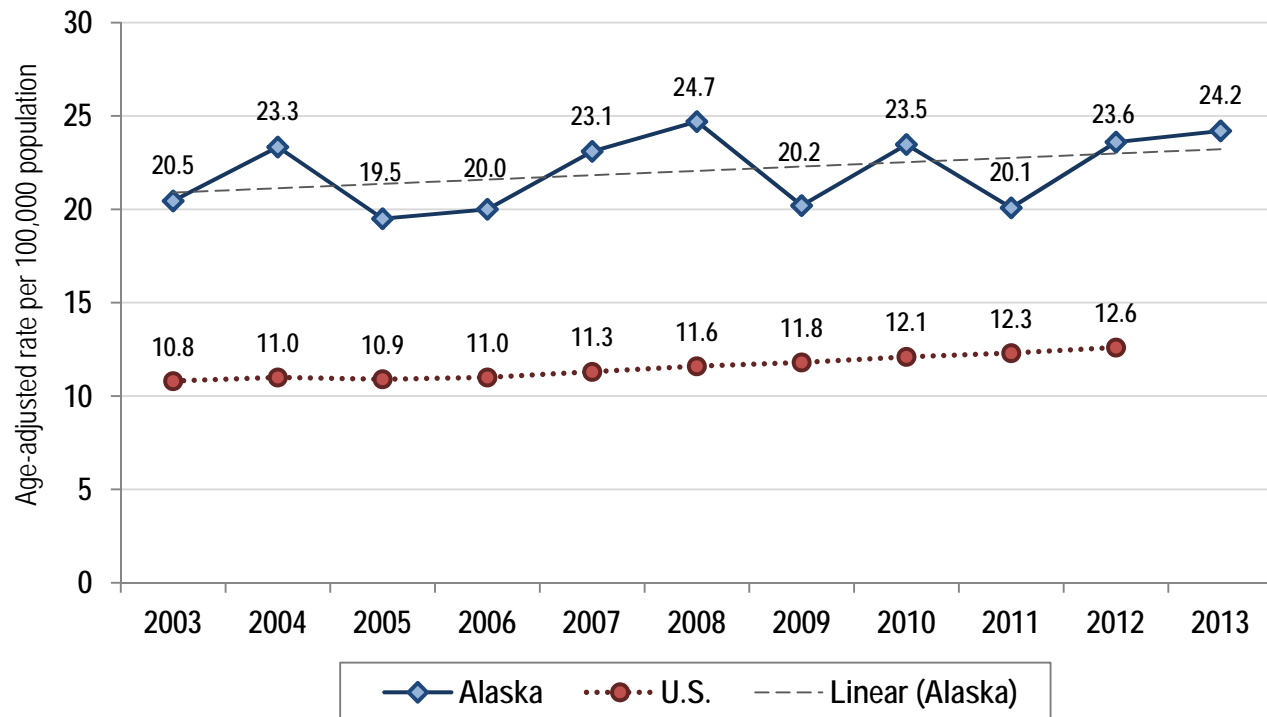
For further information and data, refer to the Drilldown section of the scorecard at

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/scorecard>

## Health: Suicide

### 1. Suicide Rate

Suicide rate, Alaska and U.S., 2003 – 2013



**Source:** Alaska: Alaska Department of Health and Social Services, Bureau of Vital Statistics (via e-mail 10/24/2014); U.S.: Centers for Disease Control and Prevention (2013). *National Vital Statistics Report*, Vol. 61, No. 6, Table 11.<sup>1</sup>

#### Summary and Explanation:

- Between 2000 and 2013, the age-adjusted rate of death by suicide in Alaska averaged nearly twice the U.S. rate.
- During the period 2003 – 2008, the suicide rate for Alaska Native people (40.4 per 100,000) was more than twice that of Alaska non-Natives (17.7 per 100,000).<sup>2</sup>
- Suicide rates during this period were highest for Alaska Native people living in Northwest Arctic (93.1 per 100,000) and Norton Sound (77.2 per 100,000). Rates were significantly higher in non-“hub communities” (60 per 100,000) than in “hub communities” (25.8 per 100,000).<sup>2</sup>
- According to interviews with families of 56 Alaskans who died by suicide:
  - More than half of the decedents had a disability or illness that made it difficult for them to take care of normal daily activities.

<sup>1</sup> National Vital Statistics Reports, Forthcoming. Available at: [www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63\\_09.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_09.pdf).

<sup>2</sup> Alaska Department of Health and Social Services (July 30, 2012). *Epidemiology Bulletin: Characteristics of Suicide Among Alaska Native and Alaska non-Native People, 2003-2008*. Available at [http://www.epi.hss.state.ak.us/bulletins/docs/rr2012\\_01.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/rr2012_01.pdf).

- 43 percent of interviewees said the decedents drank alcohol daily and many indicated binge drinking.
- Almost a quarter had an alcohol problem or dependency.
- More than a quarter had a documented mental health problem.
- Almost all had a serious life stressor, either a physical health, criminal/legal, or financial problem.
- Almost a quarter were current or former U.S. military personnel.<sup>3</sup>

### Statutory Information:

- Per Alaska Statute, the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The Alaska suicide rate is a key indicator because there is a concern that Trust beneficiaries are at higher risk, due to experiencing major life impairment from one or more clinical conditions defining Trust beneficiary status (including: schizophrenia; delusional (paranoid) disorder; mood disorders; anxiety disorders; somatoform disorders; organic mental disorders; personality disorders; dissociative disorders; and other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with (such) mental disorders, as well as substance abuse.) AS 47.30.056(c-d).

### Additional Information:

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/Pages/default.aspx>

Statewide Suicide Prevention Council.

<http://dhss.alaska.gov/suicideprevention/>

Alaska Center for Health Data & Statistics. *Topic: Suicide.*

<http://dhss.alaska.gov/dph/InfoCenter/Pages/topics/suicide.aspx>

*Casting the Net Upstream: Promoting Wellness to Prevent Suicide: Alaska State Suicide Prevention Plan, FY 2012-2017.*

[http://dhss.alaska.gov/dbh/Documents/02\\_Department/suicideprevention/SSPC\\_2012-2017.pdf](http://dhss.alaska.gov/dbh/Documents/02_Department/suicideprevention/SSPC_2012-2017.pdf)

Healthy Alaskans 2020 Leading Health Indicator 7: Suicide Mortality Rate.

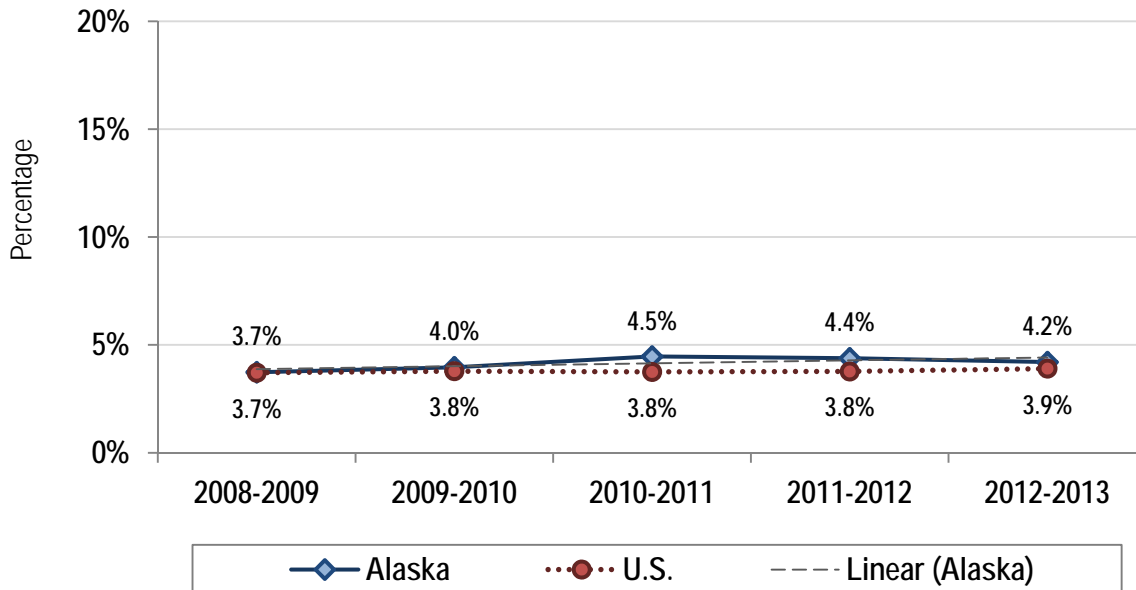
[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/Suic25up.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/Suic25up.html)

<sup>3</sup> Alaska Injury Prevention Center, Critical Illness and Trauma Foundation Inc., and American Association of Suicidology. (February 2007). *Alaska Suicide Follow-back Study Final Report*. The study was based on interviews about 56 suicide cases of the total 426 suicide cases during the reporting period of 9/1/03 to 8/31/06. There were proportionally fewer rural and Native cases than urban and non-Native cases interviewed. Available at [http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs\\_sspc/sspcfollback2-07.pdf](http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/sspcfollback2-07.pdf).

## Health: Suicide

### 2. Serious thoughts of suicide

#### Suicidal thoughts in the past year, adults aged 18 or older Alaska and U.S., 2008 – 2013



**Source:** Alaska and U.S.: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. *National Survey on Drug Use and Health (NSDUH)*<sup>4</sup>

#### Summary and Explanation:

- The National Survey on Drug Use and Health (NSDUH) measures the prevalence of suicidal thoughts and behavior among civilian, noninstitutionalized adults aged 18 or older in the United States. This question asks all adult respondents if at any time during the past 12 months they had serious thoughts of suicide.
- According to the 2013 Youth Risk Behavior Survey, 8.4% of Alaskan students in traditional high schools attempted suicide one or more times in the past year.<sup>5</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. (AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- Serious thoughts of suicide is considered a key indicator because of the concern that, because they experience a major life impairment from one or more of the clinical conditions defining beneficiary status, Trust beneficiaries may be at a higher risk of suicide. These clinical conditions

<sup>4</sup> Available at: <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>.

<sup>5</sup> Alaska Department of Health and Social Services, Division of Public Health, 2013 *Alaska Youth Risk Behavior Survey Results*: Available at [http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS\\_Graphs.pdf](http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS_Graphs.pdf).

include: schizophrenia; delusional (paranoid) disorder; mood disorders; anxiety disorders; somatoform disorders; organic mental disorders; personality disorders; dissociative disorders; other psychotic or severe, persistent mental disorders, and substance abuse. AS 47.30.056 (c-d).

- The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001 and is responsible for advising legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, and improving public awareness of suicide and risk factors, enhancing suicide prevention. AS 44.29.350(a).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/Pages/default.aspx>

Statewide Suicide Prevention Council.

<http://dhss.alaska.gov/suicideprevention/>

Alaska Center for Health Data & Statistics. *Topic: Suicide.*

<http://dhss.alaska.gov/dph/InfoCenter/Pages/topics/suicide.aspx>

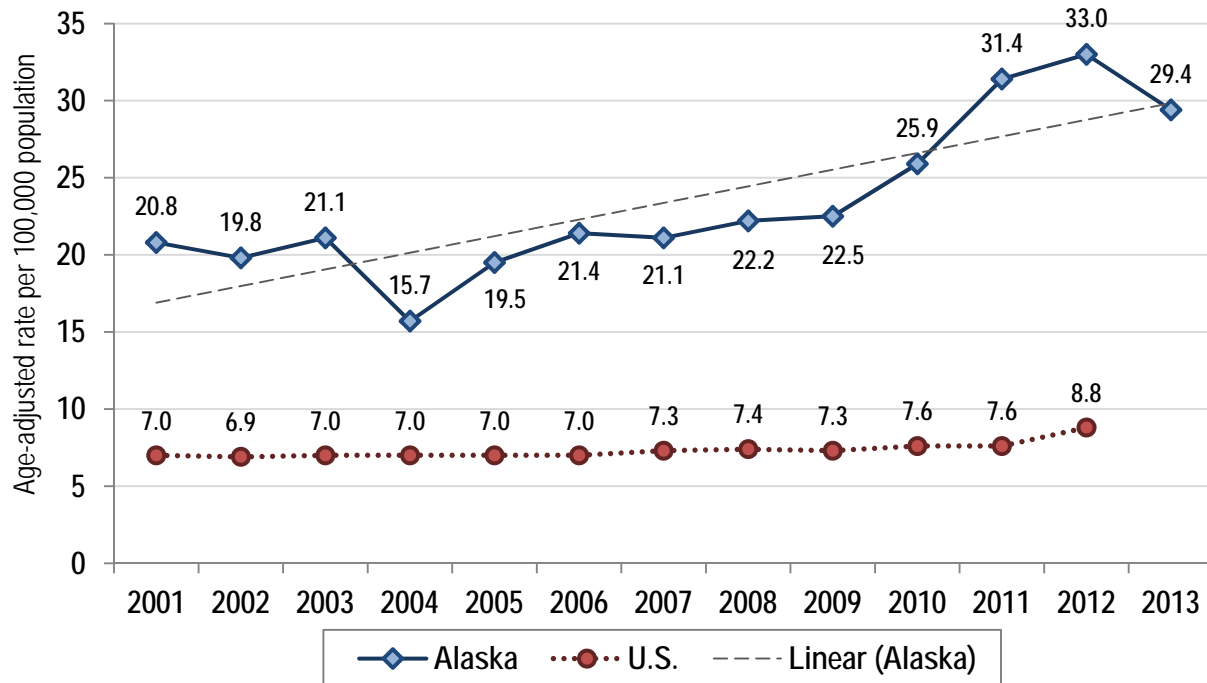
*Casting the Net Upstream: Promoting Wellness to Prevent Suicide: Alaska State Suicide Prevention Plan, FY 2012-2017.*

[http://dhss.alaska.gov/dbh/Documents/02\\_Department/suicideprevention/SSPC\\_2012-2017.pdf](http://dhss.alaska.gov/dbh/Documents/02_Department/suicideprevention/SSPC_2012-2017.pdf)

## Health: Substance Abuse

### 3. Alcohol-Induced Deaths

Alcohol induced deaths, Alaska and U.S., 2001 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health, Bureau of Vital Statistics (via e-mail 10/24/2014);

U.S.: *National Vital Statistics Report*, Vol. 63, No. 9, Table 11.<sup>6</sup>

#### Summary and Explanation:

- Alcohol-induced deaths include fatalities from causes such as degeneration of the nervous system due to alcohol, alcoholic liver disease, gastritis, myopathy, pancreatitis, poisoning, and more. It does not include accidents, homicides, and other causes indirectly related to alcohol use.<sup>7</sup>

<sup>6</sup> Available at: [http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63\\_09.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_09.pdf).

<sup>7</sup> The list of codes for alcohol-induced causes was expanded in the 2003 data year to be more comprehensive. Causes of death attributable to alcohol-induced mortality include ICD-10 codes E24.4, Alcohol-induced pseudo-Cushing's syndrome; F10, Mental and behavioral disorders due to alcohol use; G31.2, Degeneration of nervous system due to alcohol; G62.1, Alcoholic polyneuropathy; G72.1, Alcoholic myopathy; I42.6, Alcoholic cardiomyopathy; K29.2, Alcoholic gastritis; K70, Alcoholic liver disease; K86.0, Alcohol-induced chronic pancreatitis; R78.0, Finding of alcohol in blood; X45, Accidental poisoning by and exposure to alcohol; X65, Intentional self-poisoning by and exposure to alcohol; and Y15, Poisoning by and exposure to alcohol, undetermined intent. Alcohol-induced causes exclude newborn deaths associated with maternal alcohol use. See CDC (2008). *National Vital Statistics Reports*, Volume 56, Number 10, p. 109. Available at [http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf).



- The alcohol-induced death rate is significantly higher for Alaska Natives than for non-Natives.<sup>8</sup>
- Alcohol remains by far the most commonly identified substance of abuse in Alaska violent death victims.<sup>9</sup>

**Statutory Information:**

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- Alcohol-induced deaths is a key indicator because many of these deaths are of persons with one or more clinical conditions defining Trust beneficiary status, including: alcohol withdrawal delirium (delirium tremens); alcohol hallucinosis; alcohol amnestic disorder; dementia associated with alcoholism; alcohol-induced organic mental disorder; alcoholic depressive disorder; and other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with (such) disorders. AS 47.30.056(c) and (f).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>

Advisory Board on Alcoholism and Drug Abuse.

<http://dhss.alaska.gov/abada/Pages/default.aspx>

Centers for Disease Control and Prevention. *Alcohol and Public Health, Additional Resources.*

<http://www.cdc.gov/alcohol/resources.htm>

Healthy Alaskans 2020 Indicator 14: Alcohol-Induced Mortality Rate.

[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/AlcInducedDth.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/AlcInducedDth.html)

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<sup>8</sup> Alaska Bureau of Vital Statistics, *2009 Annual Report*, p. 41. Available at <http://dhss.alaska.gov/dph/VitalStats/Pages/data/2009ar.aspx>.

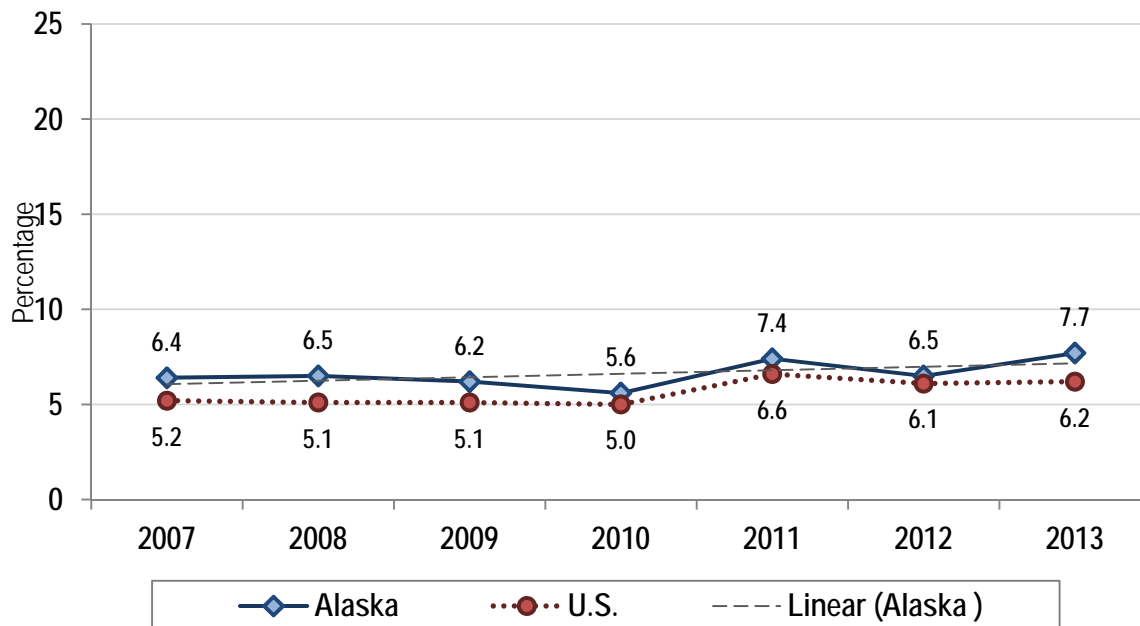
<sup>9</sup> Department of Health and Social Services, Section of Epidemiology (2014). *Toxicology Findings Associated with Violent Deaths — Alaska, 2003–2012*. Available at: [http://www.epi.hss.state.ak.us/bulletins/docs/b2014\\_24.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/b2014_24.pdf).



## Health: Substance Abuse

### 4. Adults who Engage in Heavy Drinking

Percentage of adults who engage in heavy drinking, Alaska and U.S., 2007 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health. Behavioral Risk Factor Surveillance Survey (BRFSS)<sup>10</sup> (via e-mail 11/21/2014);  
U.S.: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System.<sup>11</sup>

#### Summary and Explanation:

- Heavy drinking is defined as consuming more than two alcoholic drinks (men) or more than one drink (women) *each* day during the past 30 days. Both heavy drinking and binge drinking are associated with a number of health problems, including chronic disease, unintentional injury, violence, and harm to a developing fetus.<sup>12</sup>
- For Anchorage data about public inebriate pick-up, transport and sleep-off, refer to the Anchorage Safety Patrol program. ASP staff take persons incapacitated by drugs or alcohol in public places into protective custody and transport them to the Safety Center located in the Anchorage Jail Complex. Clients are assessed using basic physiological parameters, and those

<sup>10</sup> With the reporting of 2011 BRFSS data, the CDC introduced a new method of sampling (to include cell phone as well as landline phone numbers) and a new weighting methodology referred to as “raking.” These changes improve the overall representativeness of the BRFSS data, and provide a more accurate reflection of the health behaviors and conditions of the population. These changes in methods mean changes in the way data can be used. Trend analyses will eventually focus on years of data (2011 and later) that include both landline and cell phone respondents, and which are weighted using raking methodology.

<sup>11</sup> Available at <http://apps.nccd.cdc.gov/brfss/>.

<sup>12</sup> Centers for Disease Control and Prevention (CDC). *Alcohol and Public Health: Frequently Asked Questions*. Available at <http://www.cdc.gov/alcohol/faqs.htm#10>.

falling outside safe standards for sleep-off are taken to hospitals for medical clearance or further care.<sup>13</sup>

**Statutory Information:**

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of adults who engage in heavy drinking is a key indicator because these persons experience, or are at heightened risk of experiencing, major life impairment from one or more clinical conditions defining Trust beneficiary status, including: alcohol withdrawal delirium (delirium tremens); alcohol hallucinosis; alcohol amnestic disorder; dementia associated with alcoholism; alcohol-induced organic mental disorder; alcoholic depressive disorder; and other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with (such) disorders. AS 47.30.056(c) and (f).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>

Advisory Board on Alcoholism and Drug Abuse.

<http://dhss.alaska.gov/abada/Pages/default.aspx>

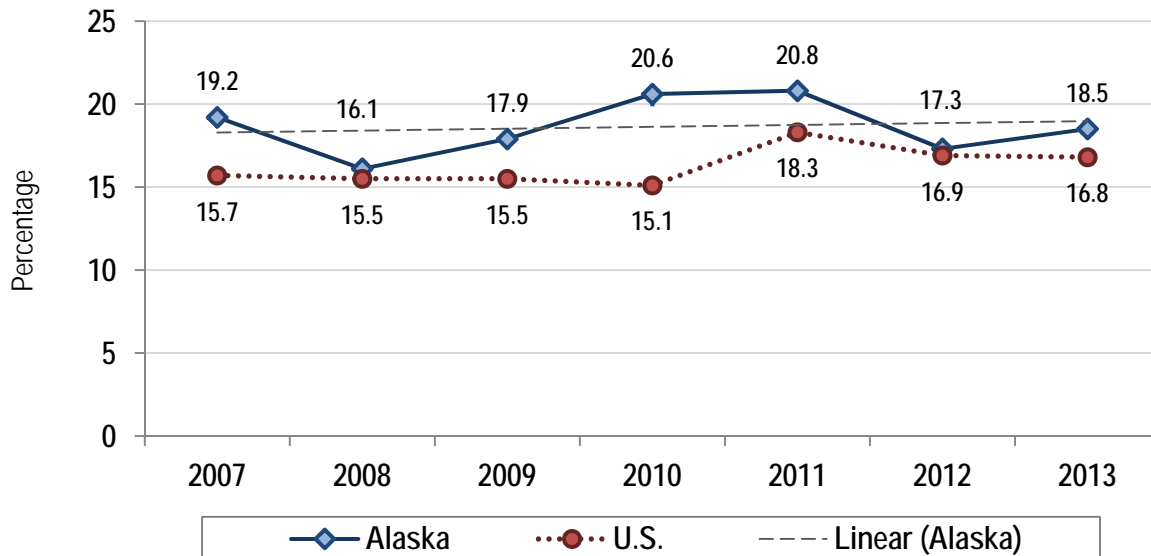
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<sup>13</sup> Municipality of Anchorage, Health and Human Services, Anchorage Safety Patrol and Center.  
<http://www.muni.org/Departments/health/services/Pages/AnchorageSafetyPatrol.aspx>.

## Health: Substance Abuse

### 5. Adults who Engage in Binge Drinking

#### Percentage of adults who engage in binge drinking, Alaska and U.S., 2007 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health. Behavioral Risk Factor Surveillance Survey (BRFSS) (via e-mail 11/21/2014).<sup>14</sup>  
 U.S.: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System.<sup>15</sup>

#### Summary and Explanation:

- Binge drinking is defined as having five or more drinks (men) or four or more drinks (women) on one or more occasions in the past 30 days.<sup>16</sup>
- Binge drinking in Alaska is significantly higher among men (28%) than among women (13%).<sup>17</sup>
- According to the 2013 Youth Risk Behavior Survey (YRBS), 13% of Alaska's high school students engaged in binge drinking during the past 30 days.<sup>18</sup>
- Youth who begin drinking at age 14 or younger are four times more likely to develop dependence.<sup>19</sup>

<sup>14</sup> With the reporting of 2011 BRFSS data, the CDC introduced a new method of sampling (to include cell phone as well as landline phone numbers) and a new weighting methodology referred to as "raking." These changes improve the overall representativeness of the BRFSS data, and provide a more accurate reflection of the health behaviors and conditions of the population. These changes in methods mean changes in the way data can be used. Trend analyses will eventually focus on years of data (2011 and later) that include both landline and cell phone respondents, and which are weighted using raking methodology.

<sup>15</sup> Available at <http://apps.nccd.cdc.gov/brfss/>.

<sup>16</sup> Centers for Disease Control and Prevention. *Alcohol and Public Health, Frequently Asked Questions*. Available at <http://www.cdc.gov/alcohol/faqs.htm#heavyDrinking>.

<sup>17</sup> Alaska Department of Health and Social Services, Division of Public Health (2010). *Alaska BRFSS Highlights*. <http://dhss.alaska.gov/dph/Chronic/Documents/brfss/pubs/BRFSSum10.pdf>.

<sup>18</sup> Percent of YRBS respondents who had five or more drinks of alcohol in a row, that is, within a couple of hours, on at least one day during the 30 days before the survey. See: [http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013YRBS\\_PreliminaryHighlights.pdf](http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013YRBS_PreliminaryHighlights.pdf).

- Underage drinking is a factor in nearly half of all teen automobile crashes, the leading cause of death among teenagers.<sup>20</sup>

### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of adults who engage in binge drinking is a key indicator because these persons experience, or are at heightened risk of experiencing, major life impairment from with one or more clinical conditions defining Trust beneficiary status, including: alcohol withdrawal delirium (delirium tremens); alcohol hallucinosis; alcohol amnestic disorder; dementia associated with alcoholism; alcohol-induced organic mental disorder; alcoholic depressive disorder; and other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with (such) disorders. AS 47.30.056(c) and (f).

### Additional Information:

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>

Advisory Board on Alcoholism and Drug Abuse. <http://dhss.alaska.gov/abada/>

Alaska Department of Health and Social Services, Alaska Center for Health Data and Statistics. Informed Alaskans.

<http://dhss.alaska.gov/dph/infocenter/Pages/default.aspx>

Healthy Alaskans 2020 Leading Health Indicator 15: Binge Drinking

[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/AlcConBinDri.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/AlcConBinDri.html)

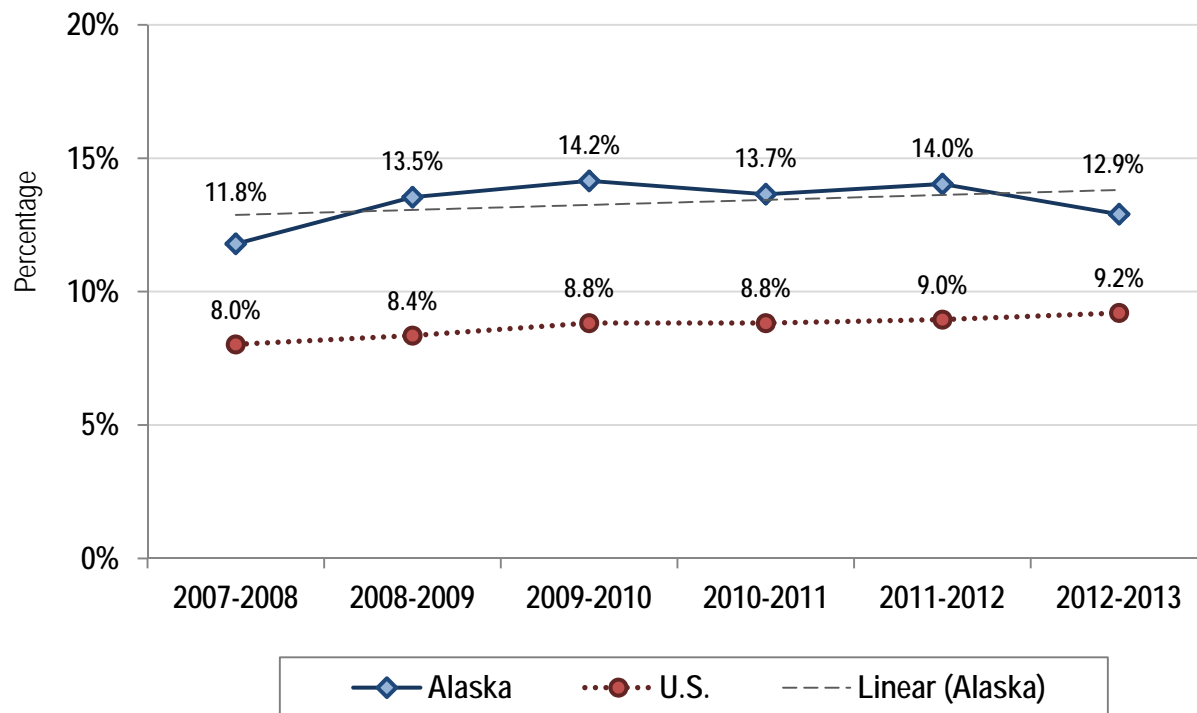
<sup>19</sup> Grant, B.F. & Dawson, D.A. (1997). Age at onset of alcohol abuse and its association with DSM-IV alcohol abuse and dependence: results from the National Longitudinal Alcohol Epidemiological Survey. *Journal of Substance Abuse*, 9:103-10. <http://www.sciencedirect.com/science/article/pii/S0899328997900092>.

<sup>20</sup> American Medical Association (2009). *Facts About Youth and Alcohol*. <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/alcohol-other-drug-abuse/facts-about-youth-alcohol.page>.

## Health: Substance Abuse

### 6. Illicit Drug Use

Percentage of population aged 12 and over engaging in illicit drug use, Alaska and U.S., 2007 – 2013



Source: Alaska and U.S.: Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). *Results from 2013 National Survey on Drug Use and Health*.<sup>21</sup>

#### Summary and Explanation:

- Illicit drugs, as reported here, include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.<sup>22</sup>
- Although the percentage of Alaskans ages 12 and older who reported using illicit drugs dropped in 2012-2013 (12.9%), illicit drug use is consistently at least 25% above the national percentage.
- In Alaska, the 18 to 25 age group has the highest rates of illicit drug use.<sup>23</sup>
- The percentage of Alaskans using illicit drugs other than marijuana was 2.9% in 2012-2013. This percentage is lower than the national average of 3.36%.<sup>24</sup>

<sup>21</sup> Available at <http://www.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/Index.aspx>.

<sup>22</sup> SAMHSA. *Key Definitions for the 2013 Detailed Tables and National Findings Report*. Available at <http://www.samhsa.gov/data/NSDUH/2013SummNatFindDetTables/DetTabs/NSDUH-DetTabsGlossary2013.htm>.

<sup>23</sup> SAMHSA, *National Survey on Drug Use and Health, 2011-2012 NSDUH State Estimates of Substance Use and Mental Disorders*. Available at <http://www.samhsa.gov/data/NSDUH/2k12State/NSDUHsae2012/Index.aspx>.

- According to the National Survey on Drug Use and Health (NSDUH), Alaska ranked 7th among the states and D.C. for illicit drug use in 2012-2013 in the 12 and older age group. However, when illicit drug use other than marijuana is taken into account, Alaska is not in the top ten.<sup>25</sup>
- According to the 2013 Alaska Youth Risk Behavior Survey of students in grades 9–12:
  - 39.0% had used marijuana one or more times in their life;
  - 19.7% had used marijuana one or more times during the past 30 days;
  - 13.5% had taken a prescription drug (such as OxyContin, Percocet, codeine, etc.) without a doctor's prescription one or more times in their life; and,
  - 6.6% had sniffed glue, breathed the contents of aerosol spray cans, or inhaled paint or sprays to get high one or more times in their life.<sup>26</sup>
- Drug-induced deaths can be expressed as Years of Potential Life Lost (YPLL), an estimate of the average time a person would have lived had he/she not died prematurely due to drug use. According to a 2009 Alaska Bureau of Vital Statistics report, drug-induced deaths resulted in 4,219.5 years of potential life lost, or an average 32 years per decedent.<sup>27</sup>

### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of illicit drug use by Alaskans 12 and older is a key indicator because individuals who use illicit drugs can experience, or be at heightened risk of experiencing, major life impairment from with one or more clinical conditions defining Trust beneficiary status, including: schizophrenia; delusional (paranoid) disorder; mood disorders; anxiety disorders; somatoform disorders; organic mental disorders; personality disorders; dissociative disorders; and other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with (such) mental disorders. AS 47.30.056(c-d).

### Additional Information:

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Advisory Board on Alcoholism and Drug Abuse. <http://dhss.alaska.gov/abada/>

Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>

Alaska Youth Risk Behavior Survey. <http://dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbs.aspx>

<sup>24</sup> SAMHSA, National Survey on Drug Use and Health, 2012-2013 NSDUH State Estimates of Substance Use and Mental Disorders. Available at <http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.pdf>

<sup>25</sup> SAMHSA, National Survey on Drug Use and Health, 2012-2013 NSDUH State Estimates of Substance Use and Mental Disorders. Available at <http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.pdf>.

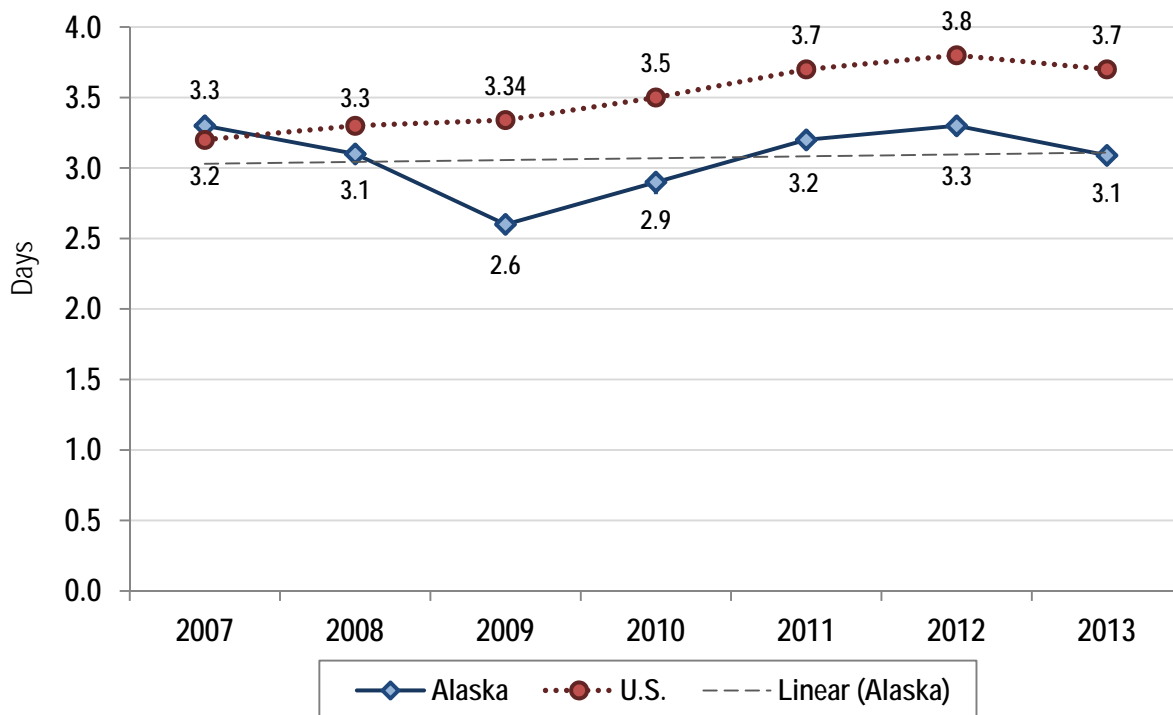
<sup>26</sup> Alaska Youth Risk Behavior Survey. Available at: <http://dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbsresults.aspx>.

<sup>27</sup> Alaska Department of Health and Social Services, Bureau of Vital Statistics. 2009 Annual Report. Available at [http://dhss.alaska.gov/dph/VitalStats/Documents/PDFs/2009/2009\\_Annual\\_Report.pdf](http://dhss.alaska.gov/dph/VitalStats/Documents/PDFs/2009/2009_Annual_Report.pdf).

## Health: Mental Health

### 7. Days of Poor Mental Health in the Past Month (Adults)

Mean number of days in past month when mental health was not good, adults, Alaska and U.S., 2007 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health, Standard and Supplemental Behavioral Risk Factor Surveillance Survey (BRFSS).<sup>28</sup>

#### Summary and Explanation:

- According to the 2013 BRFSS, Alaskan adults reported experiencing mental distress an average of 3.1 days out of the past 30 days.<sup>29</sup>

<sup>28</sup> With the reporting of 2011 BRFSS data, the CDC introduced a new method of sampling (to include cell phone as well as landline phone numbers) and a new weighting methodology referred to as “raking.” These changes improve the overall representativeness of the BRFSS data, and provide a more accurate reflection of the health behaviors and conditions of the population. These changes in methods mean changes in the way data can be used. Trend analyses will eventually focus on years of data (2011 and later) that include both landline and cell phone respondents, and which are weighted using raking methodology.

<sup>29</sup> Alaska’s Behavior Risk Factor Surveillance System (BRFSS).  
<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>. For technical information about the indicator, see:  
<http://apps.nccd.cdc.gov/cdi/ViewIndDefinition.aspx?IndicatorDefinitionId=88>.



- The BRFSS does not collect data from those who are living in an institutional setting. Consequently, those who are experiencing poor mental health days and are living in an institutional setting are not included in these data.

**Statutory Information:**

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001 and is responsible for advising legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, and improving public awareness of suicide and risk factors, enhancing suicide prevention. AS 44.29.350(a).
- The Alaska Mental Health Board and the Advisory Board on Alcoholism were established by the Alaska Legislature in 1995 and are jointly charged with planning and coordinating behavioral health services funded by the State of Alaska. The joint mission of AMHB and ABADA is to advocate for programs and services that promote healthy, independent, productive Alaskans. AS 47.30.666(a); AS 44.29.140(a).
- Days with poor mental health is a key indicator because there is a concern that persons experiencing days of poor mental health may be at heightened risk of experiencing, major life impairment from with one or more clinical conditions defining Trust beneficiary status, including: schizophrenia; delusional (paranoid) disorder; mood disorders; anxiety disorders; somatoform disorders; organic mental disorders; personality disorders; and dissociative disorders. AS 47.30.056(c), (d) and (g).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska's Behavioral Risk Factor Surveillance System (BRFSS).

<http://dhss.alaska.gov/dph/Chronic/Pages/brfss/default.aspx>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/Pages/default.aspx>

Healthy Alaskans 2020 Leading Health Indicator 9: Mental Health

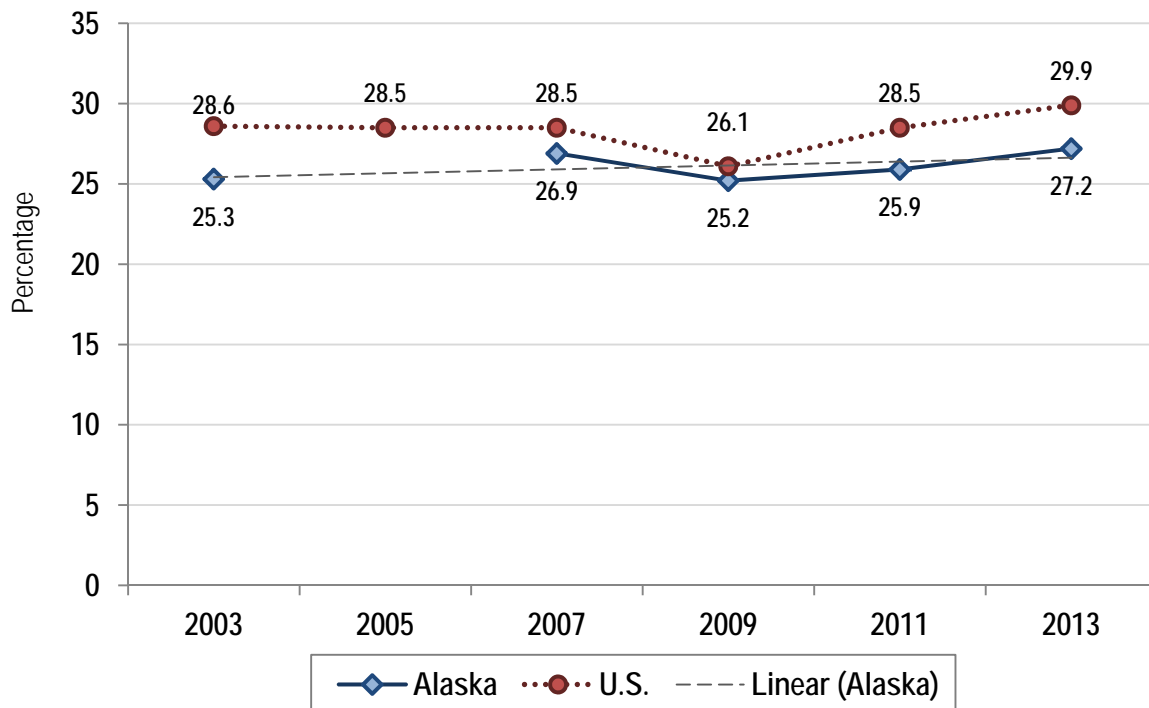
[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/HlthStatMent.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/HlthStatMent.html)



## Health: Mental Health

### 8. Teens who Experienced Depression during the Past Year

Percentage of high school students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months, Alaska and U.S., 2003 – 2013



**Source:** Alaska: Alaska Department of Health and Social Services, Division of Public Health, *Youth Risk Behavior Survey Results*;<sup>30,31</sup>  
 U.S.: Centers for Disease Control and Prevention (2014). *Youth Risk Behavior Surveillance—United States, 2013. MMWR Surveillance Summaries*, Vol. 63, No. 4. Table 23.<sup>32</sup>

#### Summary and Explanation:

- According to the 2013 Youth Risk Behavior Survey, 27.2% of Alaskan students in traditional high schools felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during past 12 months.

<sup>30</sup> Available at [http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS\\_Graphs.pdf](http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS_Graphs.pdf). The Youth Risk Behavior Survey (YRBS) is a national survey developed by the Division of Adolescent and School Health, Centers for Disease Control and Prevention (CDC) in collaboration with 71 state and local departments of education and 19 federal agencies. The survey is a component of a larger national effort to assess priority health risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among youth and adults in the United States. These results are needed to evaluate the effectiveness of programs in reducing negative student behaviors. The survey provides valuable information about positive behaviors among students. In Alaska, survey participation requires parental consent. For more information see: <http://dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbs.aspx>.

<sup>31</sup> Weighted statewide data is not available for 2005.

<sup>32</sup> Available at <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>.

- The 2013 rate of depression was significantly higher among females (35.7%) than males (19.0%) in traditional high schools in Alaska.
- The 2011 rate was higher among students in alternative (39.8%) than traditional (27.2%) high schools in Alaska.
- Among students attending a traditional Alaska high school, the 2013 Youth Risk Behavior Survey reported that in the prior 12 months:
  - 13.9% had made a plan about how they would attempt suicide
  - 20.7% had been bullied on school property
  - 9.1% had been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend.<sup>33</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001 and is responsible for advising legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, and improving public awareness of suicide and risk factors, enhancing suicide prevention. AS 44.29.350(a).
- The Alaska Mental Health Board and the Advisory Board on Alcoholism were established by the Alaska Legislature in 1995 and are jointly charged with planning and coordinating behavioral health services funded by the State of Alaska. The joint mission of AMHB and ABADA is to advocate for programs and services that promote healthy, independent, productive Alaskans. AS 47.30.666(a); AS 44.29.140(a).
- Teens who experience depression is a key indicator because of a concern that students experience, or are at risk of experiencing, major life impairment from one or more clinical conditions defining Trust beneficiary status, including: schizophrenia; delusional (paranoid) disorder; mood disorders; anxiety disorders; somatoform disorders; organic mental disorders; personality disorders; and dissociative disorders. AS 47.30.056 (c), (d) and (f).

#### Additional Information:

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

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/Pages/default.aspx>

Alaska's Youth Risk Behavior Survey (YRBS).

<http://dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbs.aspx>

Centers for Disease Control and Prevention (CDC). Adolescent and School Health. Youth Risk Behavior Surveillance System (YRBSS). <http://www.cdc.gov/healthyyouth/yrbs/index.htm>

Healthy Alaskans 2020 Leading Health Indicator 8: Mental Health: Adolescents

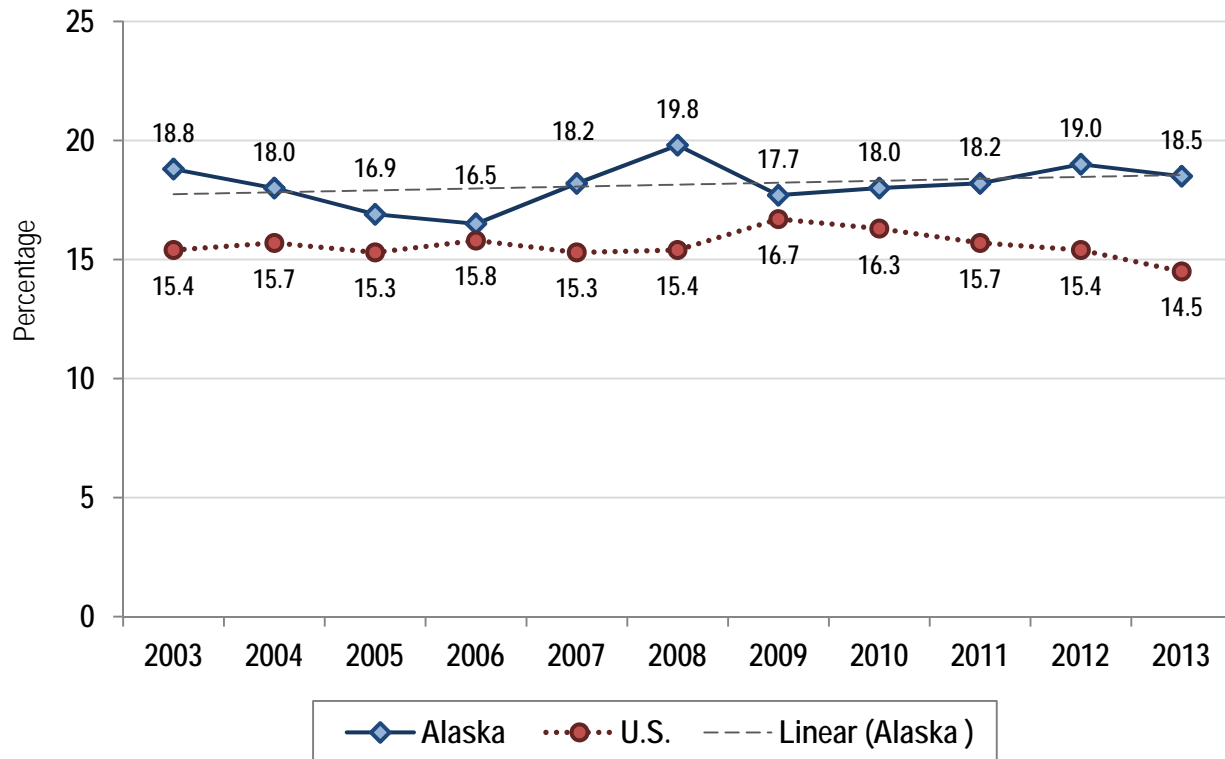
[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/AdolSad.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/AdolSad.html)

<sup>33</sup> Department of Health and Social Services, Division of Public Health. 2013 Youth Risk Behavior Survey Results. [http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS\\_Graphs.pdf](http://dhss.alaska.gov/dph/Chronic/Documents/School/pubs/2013AKTradHS_Graphs.pdf)

## Health: Access

### 9. Population without Health Insurance

Percentage of population not covered by health insurance for the year,  
Alaska and U.S., 2003 – 2013



Source: U.S. Census Bureau, American Community Survey (ACS). (2014). Table HI05. Health Insurance Coverage Status and Type of Coverage by State for All People: 2013.<sup>34</sup>

#### Summary and Explanation:

- Eighteen and a half percent of Alaska's population was counted as uninsured in 2013. This number has remained generally flat since 2003.
- Alaska's percentage of people without health insurance is generally higher than the U.S. average.
- People most likely to be uninsured are those who are:
  - Self-employed
  - Part-time workers
  - Seasonal workers and/or
  - People who work for small firms
  - Young adult males<sup>35</sup>

<sup>34</sup> Available at <https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html>.

<sup>35</sup> Alaska Department of Health and Social Services, Health Planning and Systems Development (2007). *Alaskans' Health Insurance Coverage: Local and Regional Perspectives* (Presentation). Available at <http://dhss.alaska.gov/dph/HealthPlanning/Documents/planninggrant/assets/July2007Presentation.pdf>.

- More than half of the uninsured work for small firms.<sup>36</sup>
- The Census definition of “uninsured” includes American Indian/Alaska Native (AI/AN) people who may have access to IHS-funded services. If otherwise-uninsured American Indians and Alaska Natives are re-categorized as “covered,” Alaska’s uninsured rate drops to 14%.<sup>37</sup>

### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The percent of people without health insurance for the entire year is a key indicator because those without health insurance who experience one or more clinical conditions defining Trust beneficiary status cannot access, or have significant difficulty accessing, reasonable levels of necessary services authorized by Alaska Statute, including: emergency services; screening examination and evaluation services; inpatient care; crisis stabilization services; treatment services; dispensing of psychotropic and other medication; detoxification; therapy and aftercare; case management; development of individualized treatment plans; daily living skills training; socialization activities; recreation; transportation; day care support; residential services; crisis or respite care; services provide via group homes, halfway houses or supervised apartments; intermediate care; long-term care; in-home care; vocational services; outpatient screening, diagnosis, and treatment; individual, family, and group psychotherapy, counseling, and referral; and prevention and education services. AS 47.30.056(b-i).

### Additional Information:

Alaska Department of Health and Social Services, Health Planning and Systems Development, *Alaska’s State Planning Grant to Identify Options for Expanding Coverage for Alaska’s Uninsured*.

<http://dhss.alaska.gov/dph/HealthPlanning/Pages/PlanningGrant/default.aspx>

Key Informant Interviews – Assessing the high rate of Alaskans without Health Insurance.

<http://dhss.alaska.gov/dph/HealthPlanning/Documents/planninggrant/assets/keyInformantsReport.pdf>

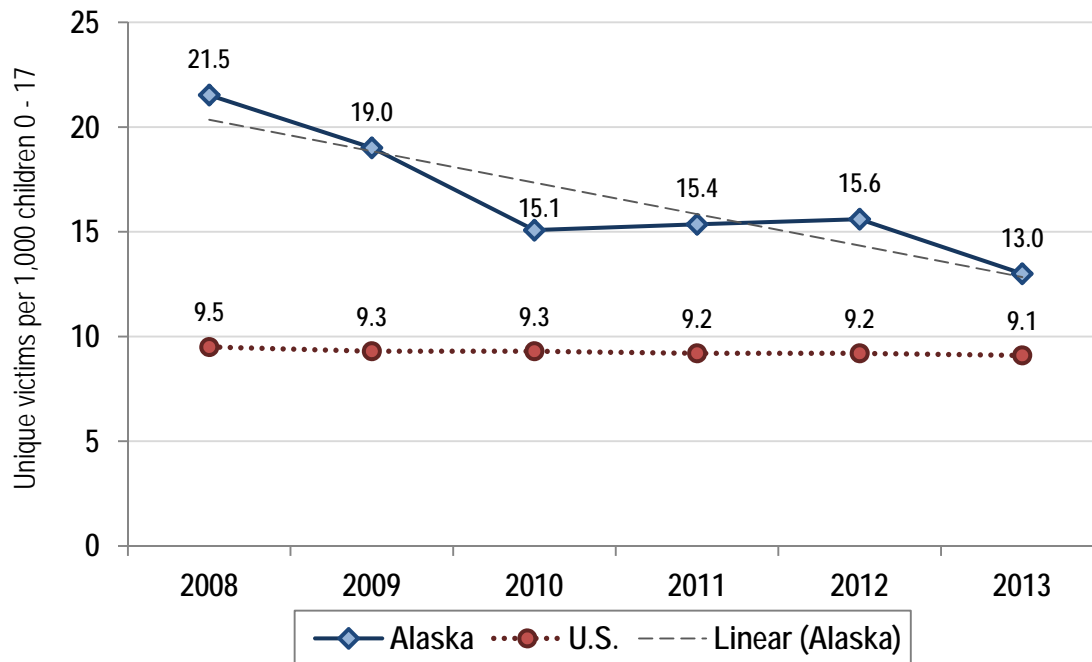
<sup>36</sup> Alaska Department of Health and Social Services, Health Planning and Systems Development (2007). *Alaskans’ Health Insurance Coverage: Local and Regional Perspectives* (Presentation). Available at <http://dhss.alaska.gov/dph/HealthPlanning/Documents/planninggrant/assets/July2007Presentation.pdf>.

<sup>37</sup> U.S. Census Bureau. American Community Survey. *Health Insurance Coverage Status, Table S2701*. American Fact Finder. Available at <https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html>.

## Safety: Protection

### 10. Child Maltreatment

Rate of child maltreatment, substantiated cases, unique victims aged 0 – 17 years, Alaska and U.S., 2008 – 2013



Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015).<sup>38</sup>

#### Summary and Explanation:

- Child abuse and neglect is defined as:
  - Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
  - An act or failure to act which presents an imminent risk of serious harm.<sup>39</sup>
- According to a national report, Alaska's rate of child abuse and neglect ranks eleventh in the U.S., improving from last year's ranking of fifth.<sup>40</sup> Caution should be used in interpreting this figure. Although the differences among state rates may reflect actual abuse or neglect, these data can also be impacted by state-to-state variation in statutory jurisdiction, agency screening processes and definitions, and the ability of states to receive, respond to, and document investigations.

<sup>38</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015). *Child maltreatment 2013*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

<sup>39</sup> Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. §5106g), as amended by the Keeping Children and Families Safe Act of 2003.

<sup>40</sup> U.S. DHHS, Administration for Children and Families, *Child Maltreatment 2013*, Table 3-3 *Child Victims*. Available at <http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2013-data-tables>.

- Adverse Childhood Experiences include abuse, neglect, and household disruption (divorce, incarceration, substance abuse, or mental health problems).<sup>41</sup>
- The Adverse Childhood Experiences (ACE) Study was a major investigation conducted on the links between childhood maltreatment and later-life health and well-being. The ACE Study findings suggest that adverse childhood experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. The study shows a strong correlation between ACEs and risk behaviors such as early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts.<sup>42</sup>
- The ACE Study used a scoring method to determine the “dose” of each study participant’s exposure to childhood trauma. Experiencing one category of ACE qualifies as one ACE. When points are added up, the ACE score is determined; an ACE score of zero would mean that a person reported no exposure to any of the categories of trauma listed as ACE. An ACE score of 8 would mean that a person reported exposure to all of the categories of trauma from the list. The greater the number of ACEs experienced, the more likely an individual is to experience any number of poor health related outcomes.<sup>43</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of child abuse and neglect is a key indicator because a significant amount of child abuse and neglect is committed by persons suffering major life impairment from one or more clinical conditions defining Trust beneficiary status. It is also an important indicator because child abuse and neglect often results in the victim experiencing major life impairment from one or more clinical conditions defining Trust beneficiary status, both in childhood as well as later in life. See AS 47.30.056(c-f).

#### Additional Information:

Alaska Department of Health and Social Services, Office of Children’s Services.

<http://dhss.alaska.gov/ocs/>

U.S. Department of Health and Human Services, Children’s Bureau. *Child Maltreatment 2012*.

<http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2012>

Healthy Alaskans 2020 Leading Health Indicator 11: Child Abuse and Neglect.

[http://ibis.dhss.alaska.gov/indicator/complete\\_profile/ChildAbuse.html](http://ibis.dhss.alaska.gov/indicator/complete_profile/ChildAbuse.html)

<sup>41</sup> Centers for Disease Control and Prevention (2011). *Adverse Childhood Experiences (ACE) Study*. Available at <http://www.cdc.gov/ace/index.htm>.

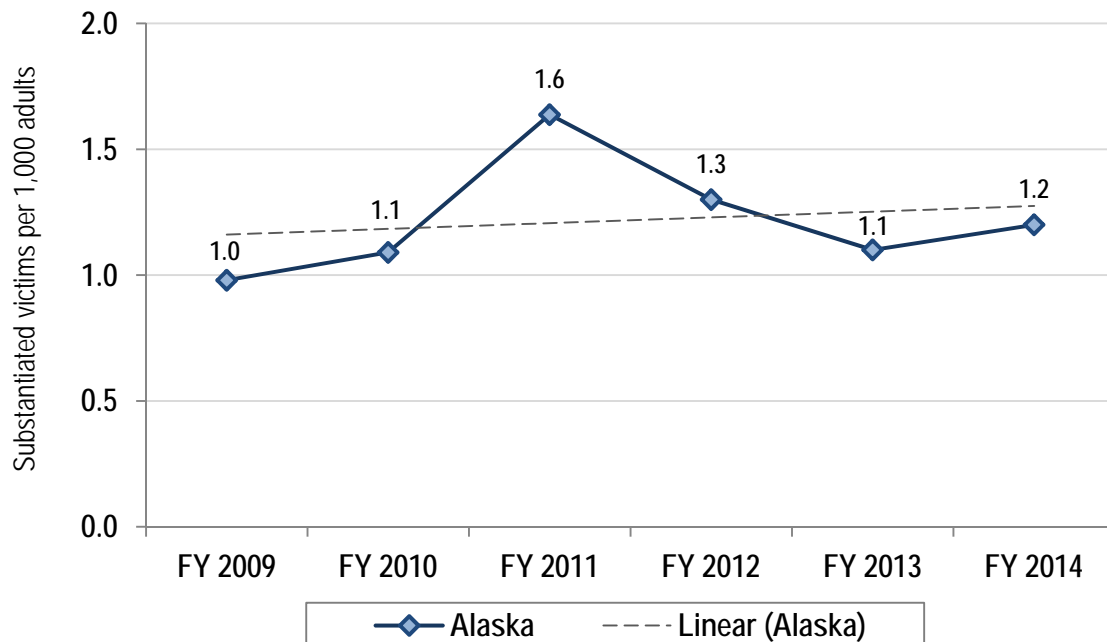
<sup>42</sup> Centers for Disease Control and Prevention (2011). *Adverse Childhood Experiences (ACE) Study*. Available at <http://www.cdc.gov/ace/index.htm>.

<sup>43</sup> 2013 Alaska Behavioral Risk Factor Surveillance System. *Adverse Childhood Experiences of Alaskan Adults*. <http://dhss.alaska.gov/abada/ace-ak/Documents/2013-BRFSS-ACEdata201502.pdf>

## Safety: Protection

### 11. Substantiated Reports of Harm to Adults (rate per 1,000)

#### Rate of Substantiated Reports of Harm to Adults, Alaska, 2009 – 2014



**Source:** Alaska Department of Health and Social Services, Senior and Disabilities Services, Adult Protective Services (via e-mail 12/08/2014).

#### Summary and Explanation:

- The mission of Adult Protective Services (APS) is to prevent or stop harm to vulnerable adults resulting from abandonment, abuse, exploitation, neglect or self-neglect.<sup>44</sup>
- APS is a voluntary service, and Alaska law prohibits APS from interfering with adults who are capable of caring for themselves.
- APS works closely with several partner agencies to better serve Alaska's vulnerable adults. These agencies include Office of the Long Term Care Ombudsman, Office of Elder Fraud and Assistance, Medicaid Fraud Control Unit, Certification and Licensing, Office of Public Advocacy and Alaska Disability Resource Center.
- APS has increased outreach efforts by hosting resource fairs, offering trainings to organizations and securing Federal funding for a three year grant to pilot Elder Services Case Management utilizing the Critical Time Intervention model.

#### Statutory Information:

- Alaska law defines a vulnerable adult as a person 18 years of age or older who, because of incapacity, mental illness, mental deficiency, physical illness or disability, advanced age, chronic

<sup>44</sup> For more information, see <http://dhss.alaska.gov/dsds/Pages/default.aspx>.



use of drugs, chronic intoxication, fraud, confinement, or disappearance, is unable to meet the person's own needs or to seek help without assistance. AS 47.24.016.

- Legislation passed in 2012 requires more professionals, including employees of nursing homes and other health care facilities and educators and administrative staff of educational institutions, to report concerns of harm, and expands the definition of harm to include “undue influence” of a vulnerable adult's finances, property, health care, or residence. AS 47.24.100(a).<sup>45</sup>

**Additional Information:**

Alaska Department of Health and Social Services, Senior and Disabilities Services, Adult Protective Services.

<http://dhss.alaska.gov/dsds/Pages/aps/default.aspx>

Making Reports to Adult Protective Services (Report of Harm).

<http://dhss.alaska.gov/dsds/Pages/aps/apsreportinfo.aspx>

*Indicators of Adult Abuse, Neglect, or Exploitation.*

[http://dhss.alaska.gov/dsds/Documents/pdfs/Indicators\\_adult\\_abuse\\_neglect\\_exploitation.pdf](http://dhss.alaska.gov/dsds/Documents/pdfs/Indicators_adult_abuse_neglect_exploitation.pdf)

Alaska Disability Resource Center.

<http://dhss.alaska.gov/dsds/Pages/adrc/default.aspx>

U.S. Administration on Aging, National Center on Elder Abuse, Aging and Disability Resource Centers.

<http://www.ncea.aoa.gov/index.aspx>

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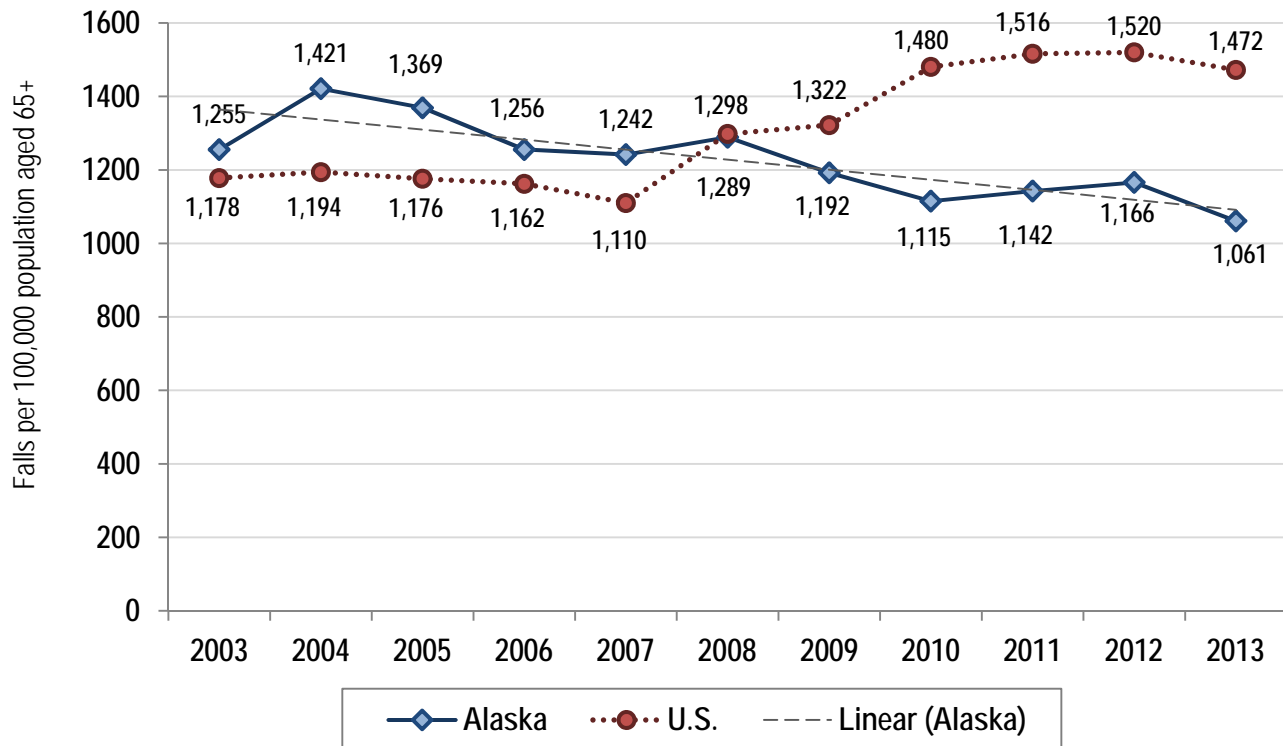
<sup>45</sup> New Legislation passed to protect Alaska's vulnerable adults. <http://dhss.alaska.gov/dsds/Pages/aps/apslaws.aspx>.



## Safety: Protection

### 12. Injuries to Elders due to Falls

#### Non-fatal injuries requiring hospitalization due to falls, adults 65 and over, Alaska and U.S., 2003 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health, Section of Emergency Programs, Alaska Trauma Registry (via e-mail 11/24/2014);  
U.S.: Centers for Disease Control and Prevention, Injury Prevention and Control, Data and Statistics.<sup>46</sup>

#### Summary and Explanation:

- The rate of hospitalized falls by elders in Alaska was higher than the national rate in 2000, but has been lower than the national average each year since 2008.
- Falls are the leading cause of hospitalized injury in Alaska; falls are the leading cause of fatal injury for Alaskans 75 and older.<sup>47</sup>
- In the U.S. each year, one in every three adults age 65 and older falls.<sup>48</sup>

<sup>46</sup> WISQARS Database, Non-fatal injury data. Available at <http://www.cdc.gov/injury/wisqars/nonfatal.html>.

<sup>47</sup> Alaska Department of Health and Social Services, Chronic Disease and Health Promotion. *Alaska Fall-Related Injury Prevention: About*. <http://dhss.alaska.gov/dph/Chronic/Pages/InjuryPrevention/Falls/about.aspx>.

<sup>48</sup> Centers for Disease Control and Prevention (CDC). *Falls Among Older Adults: An Overview*. <http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html>.

- Twenty to 30 percent of those who fall experience moderate to severe injuries, such as hip fractures, head traumas, or lacerations. Injuries from falls can make it harder to live independently, and can increase the risk of early death.<sup>49</sup>

**Additional Information:**

Alaska Department of Health and Social Services, Division of Public Health, Chronic Disease Prevention and Health Promotion.

<http://dhss.alaska.gov/dph/Chronic/Pages/InjuryPrevention/default.aspx>

Alaska Department of Health and Social Services, Alaska Commission on Aging.

<http://www.alaskaaging.org/>

Alaska Department of Health and Social Services, Division of Public Health, Section of Emergency Programs, Alaska Trauma Registry.

<http://dhss.alaska.gov/dph/Emergency/Pages/trauma/default.aspx>

Alaska Senior Fall Prevention Campaign.

<http://dhss.alaska.gov/acoa/Pages/falls/default.aspx>

Centers for Disease Control and Prevention. Injury Prevention & Control: Traumatic Brain Injury. *Help Seniors Live Better, Longer: Prevent Brain Injury.*

<http://www.cdc.gov/traumaticbraininjury/seniors.html>

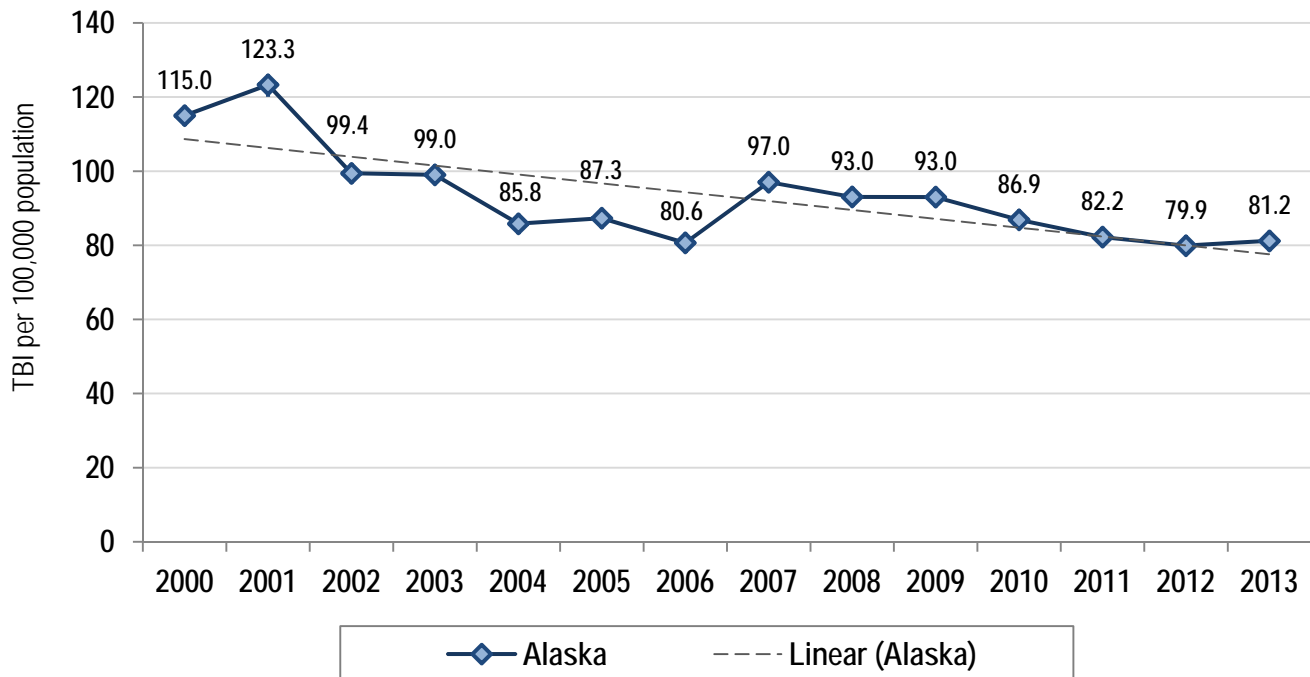
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<sup>49</sup> Centers for Disease Control and Prevention (CDC). *Falls Among Older Adults: An Overview.*  
<http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html>.

## Safety: Protection

### 13. Non-Fatal Traumatic Brain Injury

#### Non-fatal traumatic brain injury requiring hospitalization, Alaska, 2000 – 2013



**Source:** Alaska: Department of Health and Social Services, Division of Public Health, Section of Emergency Programs, Alaska Trauma Registry (via e-mail 12/04/2014)

#### Summary and Explanation:

- The rate of non-fatal traumatic brain injury (TBI) in Alaska has decreased from 115.0 per 100,000 population in 2000 to 81.2 in 2013.
- Traumatic brain injury is an injury caused by a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI.<sup>50</sup>
- Individuals who with TBI-related disabilities may have physical, cognitive and/or emotional difficulties; these may affect the individual's ability to return to home, school or work, and to live independently. Cognitive difficulties often have more impact on an individual's recovery and independence than physical limitations.<sup>51</sup>

<sup>50</sup> Centers for Disease Control and Prevention (2011). *Traumatic Brain Injury*. <http://www.cdc.gov/traumaticbraininjury/>.

<sup>51</sup> Alaska Department of Health & Social Services, Division of Behavioral Health, Senior and Disability Services, Alaska Mental Health Trust, and Alaska Brain Injury Network, Inc. (October, 2008). *Brain Injuries in Alaska: 10 Year TBI Plan*. Available at <http://www.alaskabraininjury.net/wp-content/uploads/10-Year-TBI-Plan1.pdf>.

- In Alaska, the highest rates of TBI are among Alaska Natives, residents of rural Alaska, youth ages 15-19 involved in motor vehicle crashes, and elders who fall.<sup>52</sup>
- Among Alaska residents, the top three causes of TBI among those admitted to a hospital between 2001 and 2005 were falls, motor vehicle traffic accidents, and assault.<sup>53</sup>
- Nine of the 28 respondents to the Alaska Injury Prevention Center's Suicide Follow-back Study who were asked about TBI (32%) reported that the decedent had suffered a traumatic brain injury at some point.<sup>54</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of non-fatal traumatic brain injury is a key indicator because TBI is a major cause of severe organic brain impairment, a clinical condition defining Trust beneficiary status. AS 47.30.056(e).
- The State of Alaska Traumatic and Acquired Brain Injury (TABI) program funds non-profit agencies to provide services to individuals who have been diagnosed with a traumatic or acquired brain injury. The state has goals in place to expand case management services into rural Alaska, compile a statewide registry of TABI individuals for longitudinal data collection and evaluation of service delivery, and establish standards and recommendations for improvement of prevention, assessment, and care of persons with TABI in the state. AS 47.80.500; AS 47.07.030.

#### Additional Information:

Alaska Department of Health and Social Services, Division of Public Health, Chronic Disease Prevention and Health Promotion, Injury Prevention.

<http://dhss.alaska.gov/dph/Chronic/Pages/InjuryPrevention/default.aspx>

Alaska Department of Health and Social Services, Division of Behavioral Health, Traumatic Brain Injury Initiative. <http://dhss.alaska.gov/dbh/Pages/Initiatives/tbi/default.aspx>

Alaska Department of Health and Social Services, Division of Senior and Disabilities Services, Traumatic and Acquired Brain Injury Program.

<http://dhss.alaska.gov/dsds/Pages/tabi/default.aspx>

Alaska Brain Injury Network. <http://www.alaskabraininjury.net/>

Alaska Brain Injury Network. *Ten Year Plan for TBI in Alaska.*

<http://www.alaskabraininjury.net/programs/tbi-advisory-board/planning/>

Alaska Department of Health and Social Services, Division of Public Health, Section of Emergency Programs, Alaska Trauma Registry.

<http://dhss.alaska.gov/dph/Emergency/Pages/trauma/default.aspx>

<sup>52</sup> Ibid.

<sup>53</sup> Alaska Department of Health & Social Services, Division of Behavioral Health, Senior and Disability Services, Alaska Mental Health Trust, and Alaska Brain Injury Network, Inc. (October, 2008). *Brain Injuries in Alaska: 10 Year TBI Plan*. Available at <http://www.alaskabraininjury.net/wp-content/uploads/10-Year-TBI-Plan1.pdf>.

<sup>54</sup> Alaska Injury Prevention Center (2007). *Suicide Follow-back Study Final Report*. (p. 33). Available at [http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs\\_sspc/sspcfollowback2-07.pdf](http://dhss.alaska.gov/SuicidePrevention/Documents/pdfs_sspc/sspcfollowback2-07.pdf).

## Safety: Justice

### 14. Percent of Incarcerated Adults with Mental Illness or Mental Disabilities

#### Summary and Explanation:

- Approximately 65 percent of adults incarcerated in the Alaska correctional system are Trust beneficiaries with mental illness and/or mental disabilities, mostly incarcerated for misdemeanors. This is significantly higher than the 42 percent rate identified in 2007.<sup>55,56</sup>
- The Alaska Department of Corrections has become the largest provider of mental health services in the State of Alaska.<sup>57</sup>
- Alaska has the highest growth rate for incarceration per capita in the U.S.; since 2000, the average number of sentenced inmates in Alaska has increased each year an average of 2.4% per year higher than the national average.<sup>58</sup>
- Trust beneficiaries are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in the community emergency response, treatment, and support systems make criminal justice intervention the default emergency response to the conditions and resulting actions of many Trust beneficiaries.<sup>59</sup>
- Of incarcerated Trust beneficiaries with identifiable mental health disorders, 70.1 percent were substance abuse-related.<sup>60</sup>
- The median length of stay for Trust beneficiaries is significantly longer than for other offenders. For those committing felonies, it is double that of a non-Trust offender; for misdemeanors, it is 150 percent longer.<sup>61</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).

<sup>55</sup> Hornby Zeller Associates, Inc. (December 2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*. [http://www.mhtrust.org/layouts/mhtrust/files/documents/reports\\_studies/DOC%20Study%20of%20Trust%20Beneficiaries%20-%20Exec%20Summary.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/reports_studies/DOC%20Study%20of%20Trust%20Beneficiaries%20-%20Exec%20Summary.pdf)

<sup>56</sup> Hornby Zeller Associates, Inc. (May 2014). *Trust Beneficiaries in Alaska's Department of Corrections*. [http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf)

<sup>57</sup> Ibid.

<sup>58</sup> Ibid.

<sup>59</sup> Alaska Mental Health Trust, Disability Justice Focus Area (2008). *Justice for Trust Beneficiaries Initiative*. [http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/Disability%20Justice%20Planning\\_Overview\\_%20Implementation\\_Strategies\\_.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/Disability%20Justice%20Planning_Overview_%20Implementation_Strategies_.pdf)

<sup>60</sup> Hornby Zeller Associates, Inc. (May 2014). *Trust Beneficiaries in Alaska's Department of Corrections*. [http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf)

<sup>61</sup> Ibid.

- The percent of incarcerated adults with mental illness or mental disabilities is a key indicator because it illustrates the magnitude and effects of major life impairments suffered by persons who experience clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c).
- This rate is also a key indicator because it illustrates the significant economic costs related to mental health with regard to incarceration of Trust beneficiaries. Finally, it is a key indicator because it highlights the need for and economic benefits of timely provision (i.e., prior to the need for incarceration) of reasonable levels of necessary services for people at risk due to mental illness, substance abuse, developmental disabilities, and/or traumatic brain injury. Services to be provided include alcoholism services; housing support services; and vocational services, including prevocational services, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Department of Health and Social Services, Division of Juvenile Justice.

<http://dhss.alaska.gov/djj/>

Alaska Department of Corrections.

<http://doc.alaska.gov/>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/>

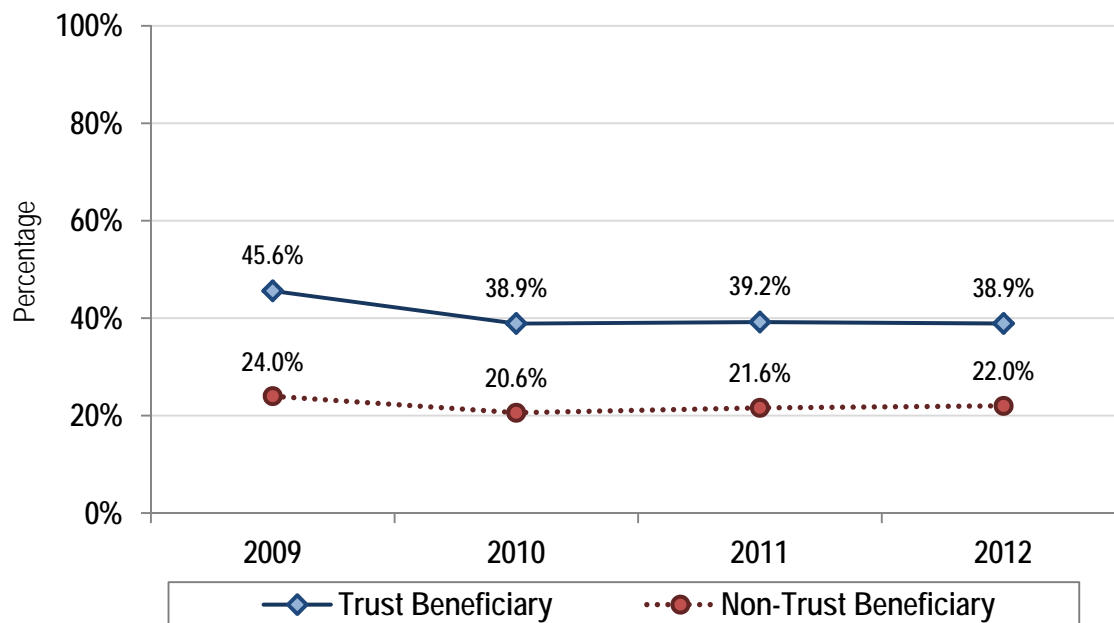
Alaska Mental Health Trust, Disability Justice Focus Area.

[http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/Disability%20Justice%20Planning\\_Overview\\_%20Implementation\\_Strategies\\_.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/Disability%20Justice%20Planning_Overview_%20Implementation_Strategies_.pdf)

## Safety: Justice

### 15. Criminal Recidivism Rates for Incarcerated Adults with Mental Illness or Mental Disabilities

Recidivism Rates for Incarcerated Adults in Alaska, 2009 – 2012



Source: Hornby Zeller Associates, Inc. (May 2014). *Trust Beneficiaries in Alaska's Department of Corrections*.

#### Summary and Explanation:

- The criminal recidivism rate within the first year of release for Trust beneficiaries averaged 40.9 percent between the years 2009-2012, while the rate for other offenders released (from Alaska Department of Corrections) averaged 22 percent during the same period according to the 2014 study.<sup>62</sup>
- Trust beneficiaries are more likely to recidivate during the first six months post-release.<sup>63</sup>
- Having a criminal history and a substance abuse disorder increased the odds of a Trust beneficiary recidivating.<sup>64</sup>
- Nome had the highest recidivism rate at 50.3 percent.<sup>65</sup>

<sup>62</sup> Hornby Zeller Associates, Inc. (May 2014). *Trust Beneficiaries in Alaska's Department of Corrections*. Available at: [http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/ADOC%20Trust%20Beneficiaries%20May%202014%20FINAL%20PRINT.pdf).

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

**Statutory Information:**

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- Criminal recidivism rates for incarcerated adults with mental illness or mental disabilities are a key indicator because they illustrate the nature and magnitude of major life impairments suffered by persons who experience clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c).
- Rates are also a key indicator because they illustrate the significant economic costs related to mental health with regard to incarceration of Trust beneficiaries. Finally, they are a key indicator because they highlight the need for and economic benefits of timely provision (i.e., during and immediately following release from incarceration) of reasonable levels of necessary services for people at risk due to mental illness, substance abuse, developmental disabilities, and/or traumatic brain injury. Services to be provided include alcoholism services, housing support services, and vocational services, including prevocational services, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Department of Health and Social Services, Division of Juvenile Justice.

<http://dhss.alaska.gov/djj/>

Alaska Department of Corrections.

<http://doc.alaska.gov/>

Alaska Mental Health Board.

<http://dhss.alaska.gov/amhb/>

Alaska Judicial Council (2011). *Criminal Recidivism in Alaska, 2008 and 2009*.

<http://www.ajc.state.ak.us/reports/recid2011.pdf>

Alaska Judicial Council (2007). *Recidivism in Alaska's Felony Therapeutic Courts*.

<http://www.ajc.state.ak.us/reports/recidtherct07.pdf>

Alaska Mental Health Trust, Disability Justice Focus Area.

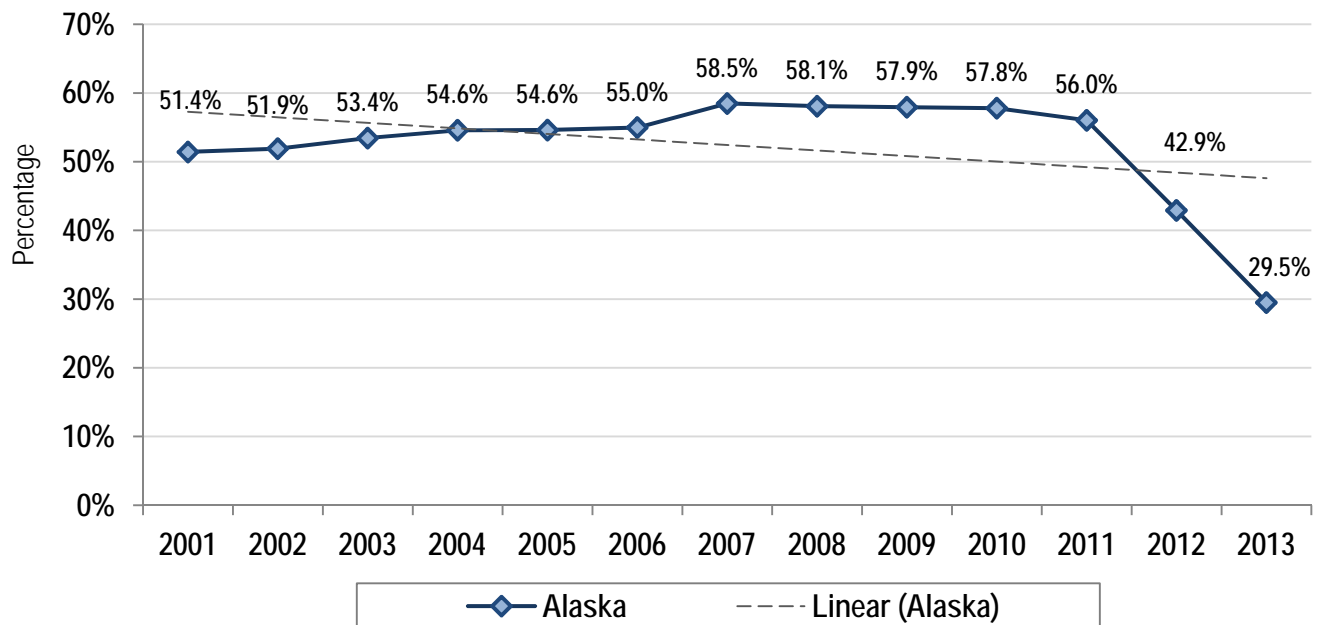
[http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/Disability%20Justice%20Planning\\_Overview\\_%20Implementation\\_Strategies\\_.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/Disability%20Justice%20Planning_Overview_%20Implementation_Strategies_.pdf)



## Safety: Justice

### 16. Percent of Arrests Involving Alcohol or Drugs

Percentage of Total Arrests Flagged as Involving Alcohol or Drugs,  
Alaska, 2001 – 2013



**Source:** Alaska Public Safety Information Network (APSIN) case data for Alaska Department of Public Safety, Division of Alaska State Troopers and Wildlife Troopers (via e-mail 10/28/2014).

#### Summary and Explanation:

- The percentage of arrest offenses flagged by State Troopers or Wildlife Troopers as being related to alcohol or drugs was 29.5% in 2013; however, this may be attributed to a change in the records management system.<sup>66</sup>
- This chart does not include charges by local jurisdictions within the state, which are the source of most arrests. For related data in the Anchorage Municipality, refer to the Anchorage Safety Patrol and Center.<sup>67</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).

<sup>66</sup> In FY13, DPS transitioned to a new records management system which necessitated the blending of data between the old system and the new system. As a result, some anomalies were discovered in the ability to retrieve comprehensive, accurate statistics, this trend is anticipated to continue through FY14.

<sup>67</sup> <http://www.muni.org/Departments/health/services/Pages/AnchorageSafetyPatrol.aspx>.

- The percent of arrests involving alcohol or drugs is a key indicator because it illustrates the magnitude and effects of major life impairments suffered by persons who experience clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c). It is also a key indicator because it illustrates the significant costs related to mental health with regard to Public Safety resources. Finally, it is a key indicator because it highlights the need for and economic benefits of timely provision (i.e., prior to the need for arrest) of reasonable levels of necessary services for people at risk due to mental illness, substance abuse, developmental disabilities, and/or Traumatic Brain Injury. AS 47.30.056(i)(1) and (i)(2)(I).

**Additional Information:**

Alaska Department of Health and Social Services, Division of Behavioral Health.

<http://dhss.alaska.gov/dbh/Pages/default.aspx>

Alaska Department of Corrections.

<http://doc.alaska.gov/>

Alaska Department of Public Safety, Division of Alaska State Troopers.

<http://www.dps.state.ak.us/AST/>

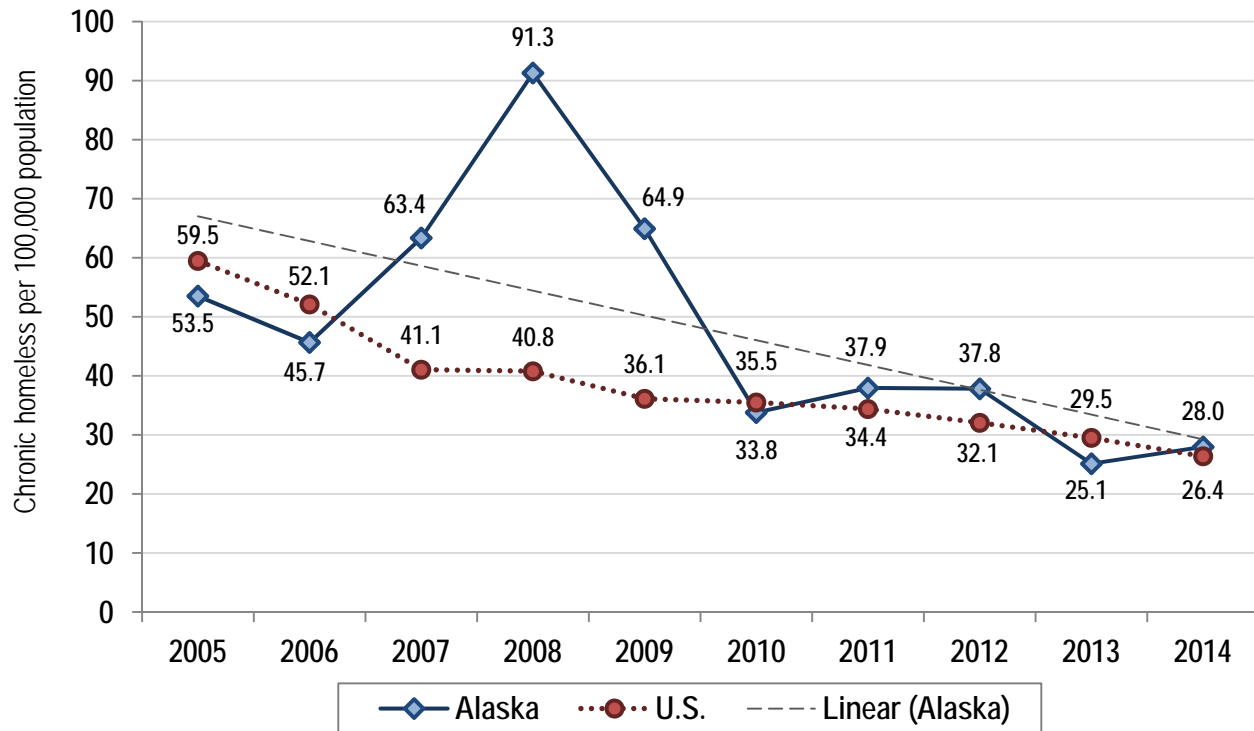
Alaska Mental Health Trust, Disability Justice Focus Area.

[http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_DisabilityJustice/Disability%20Justice%20Planning\\_Overview\\_%20Implementation\\_Strategies\\_.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_DisabilityJustice/Disability%20Justice%20Planning_Overview_%20Implementation_Strategies_.pdf)

## Living with Dignity: Accessible, Affordable Housing

### 17. Rate of Chronic Homelessness

Rate of Chronic Homelessness, Alaska and U.S., 2005 – 2014



Source: Alaska and U.S.: Department of Housing and Urban Development (HUD) (2014). *Annual Homeless Assessment Report to Congress*.<sup>68</sup>

#### Summary and Explanation:

- The January 2014 Point-in-Time survey counted 182 chronically homeless individuals in Alaska, both sheltered and unsheltered. The count takes place across the country on a specified day in January each year.<sup>69</sup>
- A chronically homeless person is defined as someone who has either been continuously homeless for more than one year or experienced at least four episodes of homelessness in the past three years and experiences a disability.
- According to the Alaska Housing Finance Corporation, the 2008 spike could be attributed to a number of factors, including: (1) the loss of substance abuse treatment beds; (2) "Project Homeless Connect," a one-day, one-stop service fair for the homeless held in Anchorage which

<sup>68</sup> Available at <https://www.hudexchange.info/resource/4074/2014-ahar-part-1-pit-estimates-of-homelessness/>.

<sup>69</sup> Housing and Urban Development, 2014 *Annual Homeless Assessment Report (AHAR)*, available <https://www.hudexchange.info/resource/4074/2014-ahar-part-1-pit-estimates-of-homelessness/>.

brought more people out of the shadows to be counted; and (3) new information received from Immaculate Conception Church's Breadline soup kitchen in Fairbanks.<sup>70</sup>

- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), about 30 percent of chronically homeless persons have mental health conditions, and about half also have co-occurring substance use issues.<sup>71</sup>
- Families are an increasingly represented among Alaska's homeless, and Alaska's composite rank for risk of child homelessness is 23rd among the 50 states. Homeless children are four times as likely to have delayed development, twice as likely to have learning disabilities, and eight times more likely to repeat a grade. They also have double the rate of emotional and behavioral problems and higher rates of physical disabilities and ailments such as asthma, and ADHD.<sup>72</sup>

### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The rate of chronic homelessness is a key indicator because it illustrates the magnitude and effects of major life impairments suffered by persons who experience clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c). It also highlights the need for and benefits of timely provision of services for people at risk of homelessness due to mental illness, substance abuse, developmental disabilities, and/or brain injury. These services include mental health and substance use disorder treatment, housing support, and vocational rehabilitation, including prevocational rehabilitation, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

### Additional Information:

Alaska Housing Finance Corporation. <http://www.ahfc.us/home/index.cfm>

Alaska Mental Health Trust. *Affordable Housing Focus Area Fact Sheet*.

[http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_affordablehousing/Housing%20Fact%20Sheet%20Housing%20Jan%202013.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_affordablehousing/Housing%20Fact%20Sheet%20Housing%20Jan%202013.pdf)

Alaska Homeless Management Information System.

<http://www.anchorahomeless.org/hmis>

SAMHSA Homelessness Resource Center.

<http://homeless.samhsa.gov/>

U.S. Interagency Council on Homelessness. *People Experiencing Chronic Homelessness*.

<http://www.usich.gov/population/chronic>

<sup>70</sup> Alaska Housing Finance Corporation (via e-mail correspondence with K. Duncan, 11/28/2008).

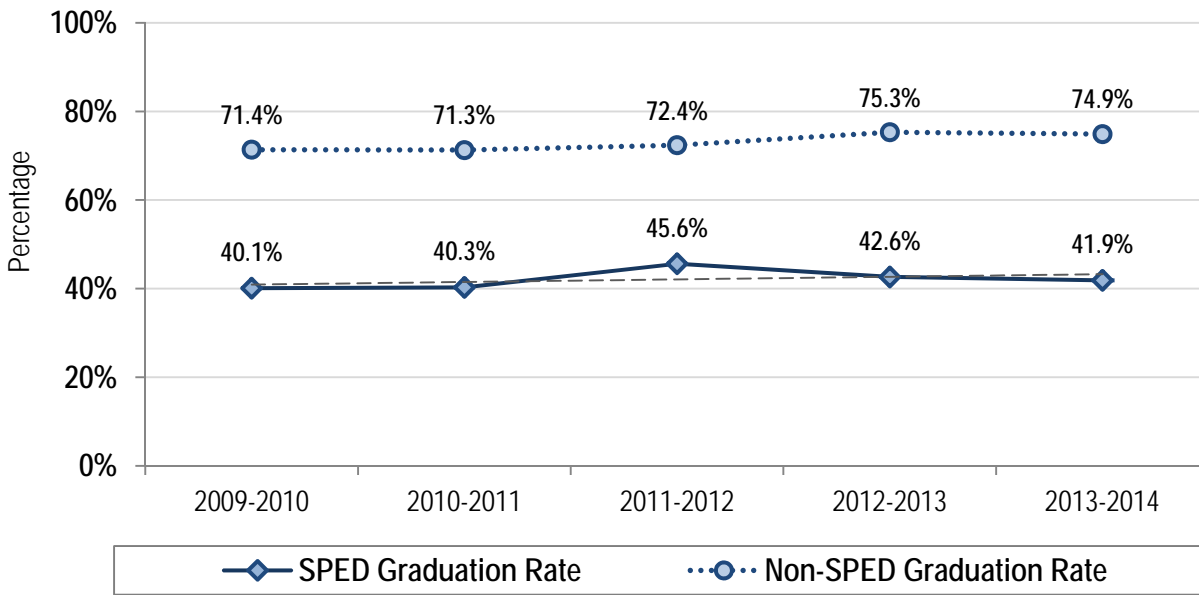
<sup>71</sup> SAMHSA (2011). *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States*. Available at [http://homeless.samhsa.gov/ResourceFiles/hrc\\_factsheet.pdf](http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf).

<sup>72</sup> The National Center on Family Homelessness (2014). *America's Youngest Outcasts*. Available at <http://new.homelesschildrenamerica.org/mediadocs/280.pdf>.

## Living with Dignity: Educational Goals

### 18. High School Graduation Rates

#### High school graduation rate for students with and without disabilities, Alaska, 2009-2014



**Source:** Alaska Department of Education and Early Development, Statistics and Reports (via e-mail, 2014).

Note: 2010-2011 and following years calculated using 4-year cohort rate method.

#### Summary and Explanation:

- The 2014 high school cohort graduation rate for Alaska students without disabilities was 74.9%, compared to a rate of 41.9% for students with disabilities.<sup>73</sup>
- “Students with disabilities” is used to describe students receiving special education (SPED) services; these students are served under Part B of the Individuals with Disabilities Education Act.
- The calculation of graduation rates changed between 2009-2010 and 2010-2011 school years shown in the chart above.
  - Through 2009-2010, the department used a method referred to as the “leaver rate,” calculated by dividing the number of graduates by the sum of the following: 1) the number of graduates, 2) the number of dropouts from the current school year’s 12th-grade class, 3) unduplicated dropouts from the previous year’s 11th-grade class, 4) unduplicated dropouts from the tenth-grade class from two years’ prior, and 5) unduplicated dropouts from the 9th-grade class from three years’ prior.
  - Beginning with the 2010-2011 academic year, the department has published “cohort” graduation rates, which are calculated by dividing the number of graduates in a cohort

<sup>73</sup> Alaska Department of Education & Early Development, via email (2014) and 2012-2013 *Graduation Rates by Subgroup*. Available at <http://education.alaska.gov/stats/GradRatesSub/2013GradRatesSubgroup.pdf>.

group by the number in the cohort group For example, the 2011 four-year cohort group is defined as all students who first entered grade nine in 2007-2008, attended a public high school in Alaska during the cohort period, and did not transfer to a private school or to a public school outside Alaska, or die before the end of the 2010-2011 school year.

**Statutory Information:**

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The high school graduation rate is a key indicator because it illustrates the magnitude and effects of major life impairments suffered by persons who experience clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c). It is also a key indicator because it highlights the need for and potential benefits of timely provision of reasonable levels of necessary services for youth at risk due to mental illness, substance abuse, developmental disabilities, and/or brain injury. AS 47.30.056(i)(1) and (i)(2)(I).

**Additional Information:**

Alaska Department of Education and Early Development. <http://education.alaska.gov/>

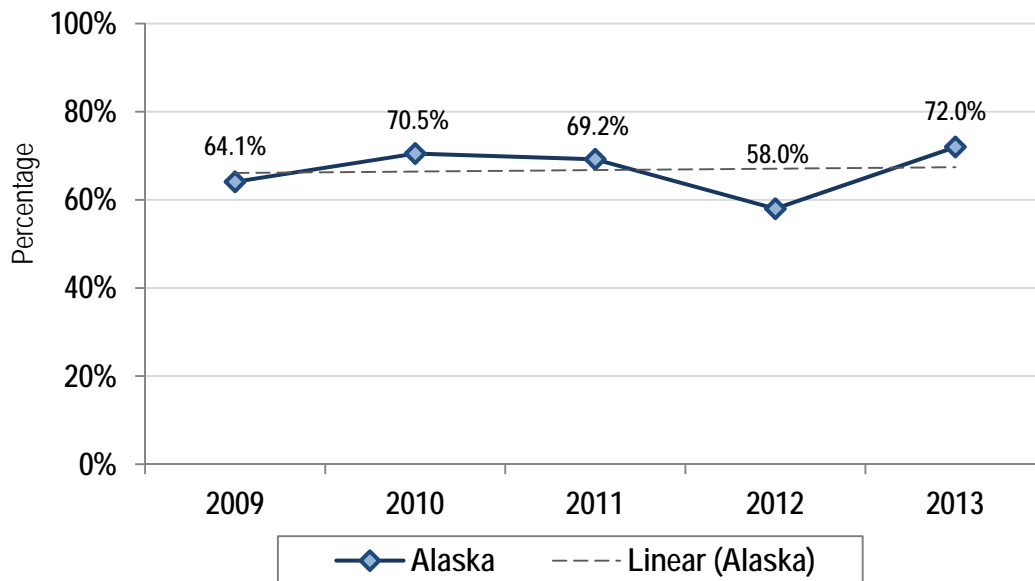
Alaska Department of Education and Early Development. *Special Education Handbook 2013*.  
<http://education.alaska.gov/TLS/SPED/pdf/FY13%20Handbook/AK%20SPED%20Handbook%20130208.pdf>

Alaska Department of Education and Early Development. *Report Card to the Public, State Report Cards*.  
<http://education.alaska.gov/reportcard/>

## Living with Dignity: Educational Goals

### 19. Youth who Received Special Education and are Employed and/or Enrolled in Post-Secondary Education One Year After Leaving School

Percentage of youth who had Individualized Education Plans in effect at the time they left school and were enrolled in postsecondary education or training program, and/or employed within one year of leaving high school, Alaska, 2009 – 2013



**Source:** Alaska Department of Education and Early Development. *Individuals with Disabilities Education Act (IDEA) Annual Performance Report (Revised April 30, 2014)*.<sup>74</sup>

#### Summary and Explanation:

- This indicator tracks outcomes of youth who had Individualized Education Plans (IEPs) in effect at the time they left school.
- In 2013, 72% of Alaskan youth in this category were enrolled in higher education or another type of post-secondary education or training program within one year after leaving high school.

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The percent of youth who received special education who are employed and/or enrolled in post-secondary education one year after leaving school is a key indicator because it illustrates the magnitude and effects of major life impairments suffered by many persons who experience

<sup>74</sup> Available at [http://education.alaska.gov/TLS/SPED/pdf/FY14%20General%20Updates/AK\\_B\\_FFY\\_2012\\_APR.pdf](http://education.alaska.gov/TLS/SPED/pdf/FY14%20General%20Updates/AK_B_FFY_2012_APR.pdf).

clinical conditions defining Trust beneficiary status. AS 47.30.056(b-c). It is also a key indicator because it highlights the need for and potential benefits of timely provision of reasonable levels of necessary services for people at risk due to mental illness, developmental disabilities, and/or brain injury. Services to be provided include alcoholism services; housing support services; and vocational services, including prevocational services, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

**Additional Information:**

Alaska Department of Education and Early Development, Data and Statistics.

<http://education.alaska.gov/stats/facts.html>

Governor's Council on Disabilities and Special Education.

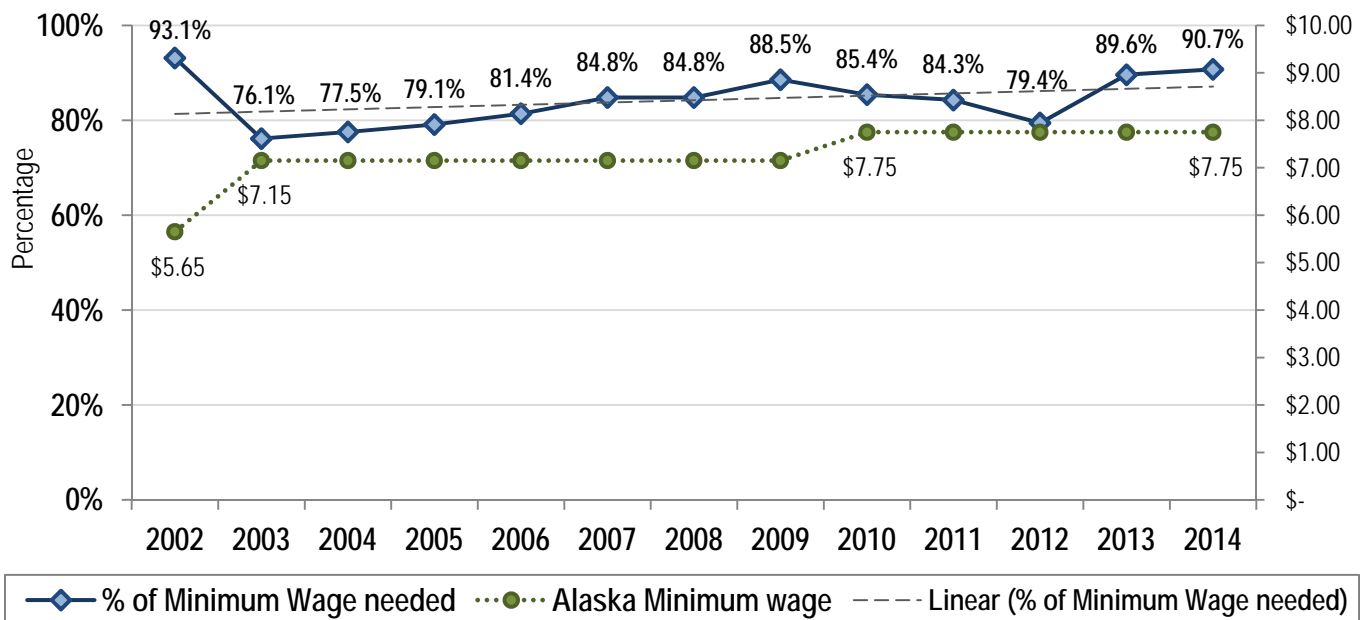
<http://dhss.alaska.gov/gcdse/>



## Economic Security

### 20. Percent of Minimum Wage Income Needed for Average Two-Bedroom Housing in Alaska

Percent of monthly minimum wage needed to afford average two-bedroom apartment in Alaska, 2002 - 2014



Source: National Low Income Housing Coalition, (2014). *Out of Reach*.<sup>75</sup>

#### Summary and Explanation:

- The proportion of minimum wage income needed to afford housing in Alaska rose steadily between 2003 (when minimum wage increased from \$5.65 to \$7.15) and 2009; during this period housing costs increased while the minimum wage stayed the same. It dropped slightly in 2010 when the minimum wage was increased to \$7.75 per hour, but increased with housing prices to 90.7% in 2014.<sup>76</sup>
- The current Fair Market Rent (FMR) for a two-bedroom apartment in Alaska is \$1,125. In order to afford such a rent at not more than 30 percent gross income, a household must earn a “Housing Wage” of \$21.63, assuming a 40-hour work week, 52 weeks per year. Alaska ranks 9th most expensive among the states for housing by this measure.<sup>77</sup>
- In November of 2014 Alaska approved minimum wages increases through a ballot measure. The first increase will take place in February 2015, with a \$1.00 increase, bringing the state

<sup>75</sup> Available at <http://nlihc.org/oor/2014>.

<sup>76</sup> Wage data from Alaska Department of Labor and Workforce Development (2011) *Summary of Alaska Wage and Hour Act*. Available at <http://labor.alaska.gov/lss/forms/sum-wh-act-1.pdf>.

<sup>77</sup> National Low Income Housing Coalition (2014). *Out of Reach*. Available at <http://nlihc.org/oor/2014>.

minimum wage to \$8.75. Another \$1 increase is scheduled for January 1, 2016, followed by indexed annual increases beginning January 1, 2017.<sup>78</sup>

- A housing unit is considered affordable if it costs no more than 30 percent of one's income.<sup>79</sup>
- In 2014, an Alaskan earning minimum wage (\$7.75 per hour) would need to work 112 hours per week, 52 weeks per year to afford the Fair Market Rate for an average two-bedroom apartment in Alaska.<sup>80</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The percent of minimum wage income needed for an average two-bedroom housing in Alaska is a key indicator because it illustrates the significance and effect of a major life impairment suffered by many persons who experience clinical conditions defining Trust beneficiary status—the difficulty of being able to afford decent housing. AS 47.30.056(b-c). It is also a key indicator because it highlights the need for and potential benefits of timely provision of reasonable levels of necessary services for people at risk due to mental illness, developmental disabilities, substance abuse, and/or brain injury. Services to be provided include alcoholism services, housing support services, and vocational services, including prevocational services, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

#### Additional Information:

Alaska Department of Health and Social Services, Division of Public Assistance.

<http://dhss.alaska.gov/dpa/Pages/default.aspx>

Alaska Mental Health Trust. *Affordable Housing Focus Area Fact Sheet*.

[http://www.mhtrust.org/layouts/mhtrust/files/documents/focus\\_affordablehousing/Housing%20Fact%20Sheet%20Housing%20Jan%202013.pdf](http://www.mhtrust.org/layouts/mhtrust/files/documents/focus_affordablehousing/Housing%20Fact%20Sheet%20Housing%20Jan%202013.pdf)

Alaska Housing Finance Corporation.

<http://www.ahfc.us/home/index.cfm>

National Low Income Housing Coalition. *Out of Reach Reports*.

<http://nlihc.org/orr/>

<sup>78</sup> National Conference of State Legislatures. State Minimum Wages 2014-2015. Available at <http://www.ncsl.org/research/labor-and-employment/state-minimum-wage-chart.aspx>

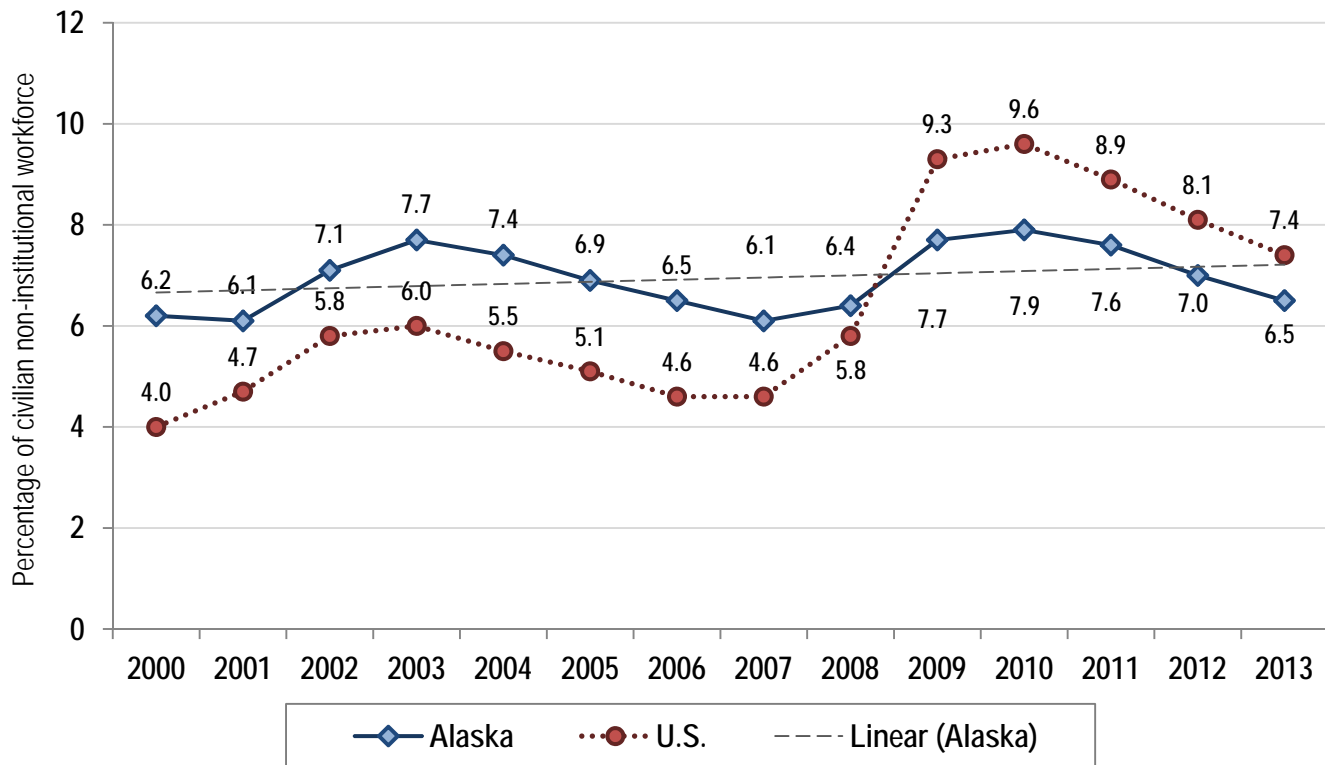
<sup>79</sup> National Low Income Housing Coalition. (2014). *Out of Reach*. Available at <http://nlihc.org/orr/2014>.

<sup>80</sup> National Low Income Housing Coalition. (2014). *Out of Reach 2014: Alaska*. Available at <http://nlihc.org/orr/2014/AK>.

## Economic Security

### 21. Unemployment Rate

**Average annual unemployment rate, Alaska and U.S., 2000 – 2013**



**Source:** Alaska: Alaska Department of Labor and Workforce Development (2014). *Annual Unemployment Rates for Alaska and U.S. 2000 to 2013*.<sup>81</sup>

U.S.: U.S. Department of Labor (2014). *Labor Force Statistics from the Current Population Survey*.<sup>82</sup>

#### Summary and Explanation:

- Persons are classified as unemployed if they do not have a job, have actively looked for work in the prior four weeks, and are currently available for work. Persons who are not working and are waiting to be recalled to a job from which they had been temporarily laid off are also included as unemployed. The unemployment rate represents the number unemployed as a percent of the labor force.<sup>83</sup>
- Data presented in these charts are not seasonally adjusted. Seasonally adjusted rates tend to be slightly higher.<sup>84</sup>

<sup>81</sup> Available at <http://live.laborstats.alaska.gov/labforce/labdata.cfm?s=2&a=0>.

<sup>82</sup> Available at <http://www.bls.gov/cps/>.

<sup>83</sup> U.S. Department of Labor (2013). *Labor Force Statistics from the Current Population Survey*. Available at <http://www.bls.gov/cps/>.

<sup>84</sup> Alaska Department of Labor and Workforce Analysis. *Seasonal adjustment and how it works*. Available at <http://live.laborstats.alaska.gov/labforce/seasonal.cfm>.

**Statutory Information:**

- The average annual unemployment rate is a key indicator because it reflects underlying economic conditions that might disproportionately affect Trust beneficiaries and their opportunities for work, decent housing, and adequate health care.
- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).

**Additional Information:**

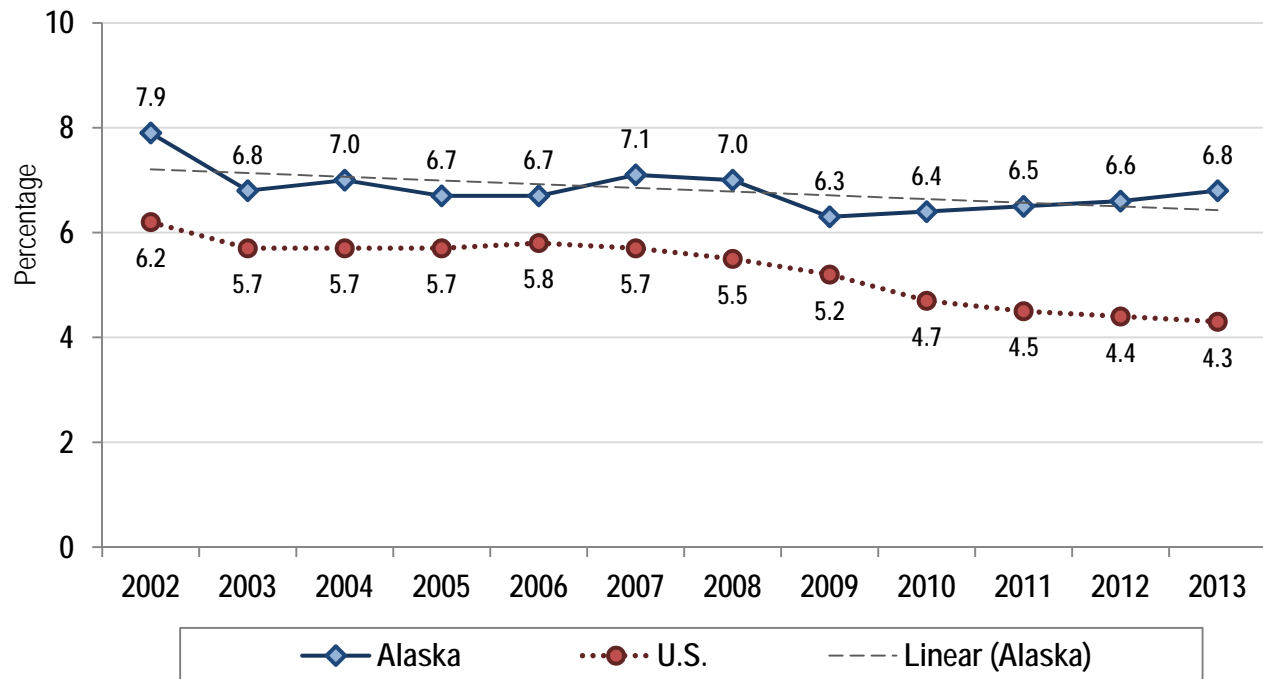
Alaska Department of Labor and Workforce Development.

<http://labor.alaska.gov/>

## Economic Security

### 22. Percent SSI Recipients who are Blind or Disabled and are Working

Percent of SSI recipients who are blind or disabled and are working,  
Alaska and U.S., 2002 – 2013



Source: U.S. Social Security Administration, Office of Retirement and Disability Policy. *SSI Annual Statistics Report, 2013*.  
Table 41: Blind and disabled recipients who work.<sup>85</sup>

#### Summary and Explanation:

- The percent of Supplemental Security Income (SSI) recipients who are blind or disabled and who work has remained relatively consistent throughout the decade. In 2013, the Alaska rate was 6.8% and the national average was 4.3%.
- According to the Social Security Administration, less than one-half of one percent of SSI<sup>86</sup> and/or Social Security Disability Insurance (SSDI)<sup>87</sup> recipients secures employment at a level sufficient to leave the SSI or SSDI program.

<sup>85</sup> Available at [http://www.ssa.gov/policy/docs/statcomps/ssi\\_asr/2013/sect07.html#table41](http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2013/sect07.html#table41).

<sup>86</sup> SSI is a federal financial assistance program, financed through general tax revenues, that provides monthly payments to adults and children with qualifying disabilities who have limited income and resources, which meet the living arrangement requirements, and are otherwise eligible. Monthly payment varies up to the maximum federal benefit rate which is standardized in all States, but not everyone gets the same amount because it may be supplemented by the State or decreased by other income and resources. For more information, see <http://www.ssa.gov/pgm/ssi.htm>.

<sup>87</sup> SSDI is a federal disability insurance program that is financed with Social Security taxes paid by workers, employers and self-employed persons. To be eligible, the worker must earn sufficient "work credits" based on taxable work. Disability benefits are payable to workers who are disabled, widow(er)s or adults who have been disabled since childhood, who are otherwise eligible. Auxiliary benefits may be payable to a worker's dependents. Monthly disability benefit payment is based on the Social Security earnings record of the insured worker on whose Social Security number the disability claim is filed. For more information, see <http://www.socialsecurity.gov/pgm/disability.htm>.

- Programs such as the Working Disabled Medicaid Buy-in and other Social Security Administration work incentives exist to help people go to work, but studies have found that many SSI and SSDI recipients are afraid they might lose cash assistance and Medicaid-funded services if they seek work.<sup>88</sup>
- Some individuals with disabilities need continued services and supports often available only through Medicaid. Needed services include personal care assistance, in-home supports, ongoing supported employment services, and rehabilitation services.
- Surveyed Alaskans with disabilities rated the following supports and services as most important in their decisions to either get or stay at a job:
  - Transportation
  - Ability to take time off for health-related reasons
  - Paid personal assistant services at home
  - Affordable health insurance
  - Assistive technology services and devices.<sup>89</sup>

#### Statutory Information:

- Per Alaska Statute, the Department of Health and Social Services, the Alaska Mental Health Trust Authority and partner organizations work cooperatively to plan, budget and implement an integrated comprehensive mental health program for Alaska. AS 47.30.660(a); AS 47.30.011(b); AS 37.14.003(a); AS 47.30.046(a).
- The percent of SSI recipients who are blind or disabled and working is a key indicator because it illustrates the significance and effect of a major life impairment suffered by many persons who experience clinical conditions defining Trust beneficiary status—the difficulty of securing and holding down a job. AS 47.30.056(b-c). It is also a key indicator because it highlights the need for and potential benefits of timely provision of reasonable levels of necessary services for those at risk due to mental illness, developmental disabilities, and/or Alzheimer’s Disease and related disorders (such as traumatic brain injury). Services under statute include housing support services and vocational services, including prevocational services, work adjustment, supported work, sheltered work, and training in which participants achieve useful work experience. AS 47.30.056(i)(1) and (i)(2)(I).

#### Additional Information:

Governor’s Council on Disabilities and Special Education. <http://dhss.alaska.gov/gcdse/>

Alaska Department of Labor and Workforce Development. <http://labor.alaska.gov/>

Alaska Works Initiative. <http://www.alaskaworksinitiative.org/>

UAA Center for Human Development. <http://www.uaa.alaska.edu/centerforhumandevelopment/>

Social Security Administration, Disability Benefits. <http://www.ssa.gov/pgm/disability.htm>

<sup>88</sup> University of Alaska, Anchorage, Center for Human Development (2012). *Employment Barriers Survey for Adults with Physical Disabilities*. Available at [http://www.uaa.alaska.edu/centerforhumandevelopment/Employment\\_Barriers\\_Survey/upload/EBS\\_report\\_FINAL\\_report-2.pdf](http://www.uaa.alaska.edu/centerforhumandevelopment/Employment_Barriers_Survey/upload/EBS_report_FINAL_report-2.pdf).

<sup>89</sup> Ibid.