Alaska Behavioral Health Systems Assessment Final Report

Prepared for the Alaska Mental Health Trust Authority

by Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc.

Updated 10.22.2015

"When we initiated this effort, we had high hopes for what we were going to get out of it; and I think, honestly, not only have we achieved what we wished to get out of it, in many respects, I think we've exceeded that. The insights provide us with an opportunity to have a comprehensive plan and to make continuous progress to move the system forward. It's a tremendous gain for us. It's probably one of the biggest and best things we've done to make long-term system change."

- *Russ Webb, Chair of the Board of Trustees, Alaska Mental Health Trust Authority*

"The Behavioral Health Systems Assessment provides a foundation for us to understand the continuum of Alaskans' behavioral health needs at many levels (e.g., individual, community, and professional). With such rich data, these findings and recommendations offer many opportunities to inform systems change, maximize resources, and enhance collaborations, all in the name of improving the health of Alaskans statewide. This is the only statewide behavioral health assessment that has included firsthand input from the Tribal Behavioral Health Aides; their voice is represented here and it is our duty to follow their lead and ensure a better behavior health system in our state."

- *Laura Baéz, Director of Behavioral Health, Alaska Native Tribal Health Consortium*

"'In a time where data is needed to inform every step of transformation, building the analytic capacity of the system is critical. The groundwork laid by this project creates the road map for building analytic capacity and producing regular (annual) behavioral health systems assessments.' (Page 3) I found myself often recalling and reflecting on this statement while reviewing this report. The recurring thought was that this is just the beginning… The Alaska Behavioral Health System is complex and it is evolving. One snapshot does not do it justice or capture all the nuances. Quite the contrary, it points out where data refinement is needed and that we need to evaluate transformation in order to inform future decisions and directions."

- *Jerry Jenkins, President of the Alaska Behavioral Health Association and Chief Executive Officer of Anchorage and Fairbanks Community Mental Health Services*

"The information gathered in this assessment will be invaluable to the Division of Behavioral Health as we move toward a future in which all Alaskans live in healthy communities and have access to the care they need – high-quality, person-centered, culturally relevant, and as close to home as possible. Supporting Alaska's behavioral health system will always be a team effort. This assessment is a great tool to help us move forward, together."

- *Albert E. Wall, Director, Division of Behavioral Health*

"Questions remain as to who this will go to and how they will best understand it. That said, this is a remarkable achievement! I am thrilled with all of the information compiled, and I already know certain ways I can use it. I applaud each of the people who worked on this, and I look forward to continued discussions on this assessment!! Thank you for all of the hard work!!!"

- *Lance Johnson, Behavioral Health Services Director, Norton Sound Health Corporation*

"I think the report is wonderful – it is nicely comprehensive, very clear to understand, and provides such great data and information. I look forward to our continued dialogue… on how we can work together to see the recommendations realized."

- *Melissa Kemberling, Director of Programs, Mat-Su Health Foundation*

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LIST OF ACRONYMS

Acronym	What it Stands For
ABADA	Advisory Board on Alcoholism and Drug Abuse
ABE	Adult Basic Education
ACA	Patient Protection and Affordable Care Act
ACE	Adverse Childhood Experience
AFHCAN	Alaska Federation Health Care Network Telehealth Solutions
AI/AN	American Indian / Alaska Native
AK	Alaska
AKAIMS	Alaska Automated Information Management System
AMHB	Alaska Mental Health Board
AMHTA	Alaska Mental Health Trust Authority
ANP	Advanced Nurse Practitioner
ANSAT	Alaska Native-Based Substance Abuse Treatment
ANSCA	Alaska Native Settlement Claims Act
ANTHC	Alaska Native Tribal Health Consortium
API	Alaska Psychiatric Institute
API	Alaska Psychiatric Institute
APTC	Advanced Premium Tax Credits
ASAP	Alcohol Safety Action Program
AST	Alaska Screening Tool
BHA	Behavioral Health Aide
BRFSS	Behavior Risk Factor Surveillance System
CAP	Criminal Attitudes Program
CBHS	Community Behavioral Health System/Comprehensive Behavioral Health Services
CBHS	Community Behavioral Health System
CBHSQ	Center for Behavioral Health Statistics and Quality (SAMHSA)
CBHTR	Comprehensive Behavioral Health Treatment and Recovery
CDC	Centers for Disease Control and Prevention
CI	Confidence Interval
CMHS	Center for Mental Health Services
CNM	Certified Nurse Manager
CNS	Clinical Nurse Specialist
CSR	Client Status Review
DBH	Division of Behavioral Health (State of Alaska)
DET	Designated Evaluation and Treatment
DHSS	Department of Health and Social Services (State of Alaska)
DJJ	Division of Juvenile Justice
DOC	Department of Corrections
DSM	Diagnostic and Statistical Manual
DV	Domestic Violence
EDI	Electronic Data Interface

ESL	English as a Second Language
FMAP	Federal Medicaid Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAF	Global Assessment of Functioning
GED	General Education Diploma
HRSA	U.S. Health Resources and Services Administration
IHS	Indian Health Service
ISDEAA	Indian Self-Determination and Education Assistance Act
JUCE	Juneau Claims and Eligibility
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
LSSAT	Life Success Substance Abuse Treatment
MAGI	Modified Adjusted Gross Income
MD	Medical Doctor
MH	Mental Health
MHBG	Community Mental Health Services Block Grant
MMIS	Medicaid Management Information System
MSHF	Mat-Su Health Foundation
NSDUH	National Survey of Drug Use and Health
OCS	Office of Children's Services
PA	Physician Assistant
PSFA	Programs, Services, Functions and Activities
RCCY	Residential Care for Children and Youth
RSAT	Residential Substance Abuse Treatment
SA	Substance Abuse
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Severe Emotional Disturbance/Serious Emotional Disturbance
SFY/FY	State Fiscal Year/Fiscal Year
SMI	Serious Mental Illness
SU	Substance Use
SUD	Substance Use Disorder
TBHS	Tribal Behavioral Health System
THO	Tribal Health Organization
TSGP	Tribal Self-Governance Program
VA	Veterans Administration
YRBS	Youth Risk Behavior Survey

ACKNOWLEDGEMENTS

Project Sponsors

THIS PROJECT WAS SPONSORED BY:

ALASKA MENTAL HEALTH TRUST AUTHORITY

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

MAT-SU HEALTH FOUNDATION

ALASKA DIVISION OF BEHAVIORAL HEALTH

ALASKA MENTAL HEALTH BOARD

ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE

A Note from the Consultant Team

This project required extensive stakeholder engagement, thoughtful planning, and exploratory data analysis to assess Alaska's State-funded behavioral health system. Fulfilling the project's goals has been no small feat and we are proud of the groundbreaking work we have completed with the help of many, many partners. That said, conducting an assessment is an iterative process and this assessment represents just a step in a much larger dialogue about how to produce, publish, and use data to ground decision making and drive positive systems change. Our hope is that the data produced through this effort (included here, as well as in the Alaska Behavioral Health Systems Assessment Regional Data Reports) will be used to inform regional and state level planning efforts and we anticipate that additional questions will be developed through those processes. Five years from now, we hope to look back at this initial effort as a humble, but effective shift in the way the system analyzes and publishes data and the way in which partners engage with data and with one another to inform systems change.

With that, Agnew::Beck and Hornby Zeller Associates, Inc. would like to express our gratitude to the steering committee, the data committee, and the many staff members from the Alaska Department of Health Social Services who helped bring the first iteration of the Alaska Behavioral Health Systems Assessment to completion. Two individuals, in particular, dedicated tremendous time and energy to these efforts: thank you, Kathleen Carls and Michael Baldwin! We would also like to thank the Tribal Behavioral Health Directors and their Executive Committee, as well as the staff at the Alaska Native Tribal Health Consortium who provided insight and leadership to the Tribal components of this assessment.

Consultant Team

Name	Role	Organization
Heidi Wailand, MRP, LSSGB, PMP	Project Manager, Quality Analysis and Data Quality Assurance Lead	Agnew::Beck
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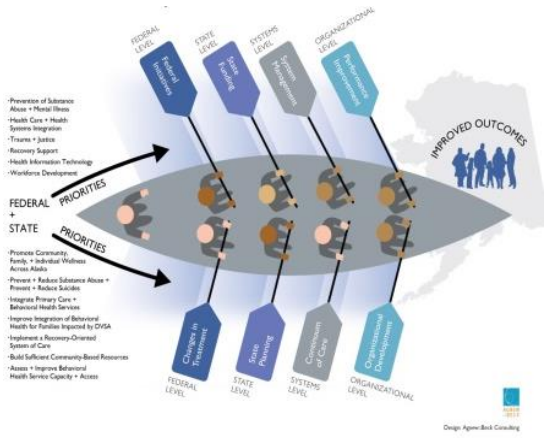
Lisa Fousek	Associate Graphic Designer	Agnew::Beck

Project Leadership



STEERING COMMITTEE MEMBERS

A small team of systems leaders helped guide this project from beginning to end. We are grateful for their support and direction over the course of this eighteen month effort.

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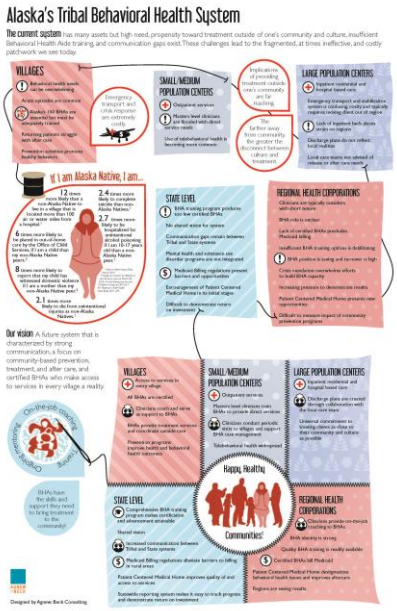
Name	Role	Organization
Russ Webb	Board of Trustees Member and Chair	Alaska Mental Health Trust Authority
Paula Easley	Board of Trustees Member	Alaska Mental Health Trust Authority
Jeff Jessee	Chief Executive Officer	Alaska Mental Health Trust Authority
Michael Baldwin	Evaluation and Planning Officer and Contract Lead	Alaska Mental Health Trust Authority
Katie Baldwin-Johnson	Program Officer	Alaska Mental Health Trust Authority
Kate Burkhart	Executive Director	Alaska Mental Health Board/ Advisory Board on Alcoholism and Drug Abuse
Tom Chard	Executive Director	Alaska Behavioral Health Association
Laura Baéz	Director of Behavioral Health	Alaska Native Tribal Health Consortium
Albert Wall	Director of Behavioral Health	State of Alaska Division of Behavioral Health
Mark Haines-Simeon	*Former* Policy & Planning Section Manager	State of Alaska Division of Behavioral Health
Melissa Kemberling	Director of Programs	Mat-Su Health Foundation

TRIBAL BEHAVIORAL HEALTH DIRECTORS EXECUTIVE COMMITTEE



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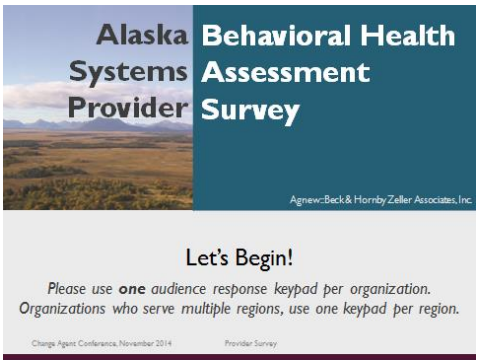
Early in the project, project manager Heidi Wailand established a series of five weekly meetings with Laura Baéz at the Alaska Native Tribal Health Consortium (ANTHC) to discuss their goals for the assessment and develop an approach to engage all levels of the Tribal behavioral health system. That engagement quickly expanded to tap the leadership and guidance of the Tribal Behavioral Health Directors Executive Committee. The Tribal Behavioral Health Directors Executive committee contributed to the development of the Tribal Behavioral Health Systems Assessment quilt graphic and final recommendations and helped ensure the success of our engagement efforts with the Tribal Behavioral Health Directors and Behavioral Health Aides. It has been a great honor working with this team of dedicated individuals and learning about behavioral health service delivery in rural Alaska.

Name	Role	Organization
Cindy Baldwin-Kitka	Behavioral Health Director	Southeast Alaska Regional Health Consortium
Cody Chipp	Behavioral Health Director	Aleutians Pribilof Islands Association
Ginessa Sams	Behavioral Health Director	Tanana Chiefs Conference
Lance Johnson	Behavioral Health Director	Norton Sound Health Corporation
Laura Baéz	Director of Behavioral Health	Alaska Native Tribal Health Consortium
Perry R. Ahsogeak	Behavioral Health Director	Fairbanks Native Association
Tina Woods	Behavioral Health Director	Aleutians Pribilof Islands Association

In addition, we are grateful to the Tribal Behavioral Health Directors, who invited us to participate in their quarterly meetings and provided key feedback to the project at several junctures. We are also thankful to Xiomara Owens, Lakota Holman, and Janie Ferguson, in particular, as well as the entire team at ANTHC's behavioral health department for leading the planning and coordination of the world café sessions with Behavioral Health Aides from across the state and contributing to the work products created through this effort.

Qualitative Data Support



PROVIDER SURVEY REVIEW COMMITTEE

We would like to thank the individuals who joined our ad hoc provider survey review committee and reviewed and refined the provider survey over the course of two work sessions. The review committee also helped to guide the facilitation approach.

Name	Role	Organization
Kate Burkhart	Executive Director	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
Lance Johnson	Behavioral Health Services Director	Norton Sound Health Corporation
Laura Baéz	Director of Behavioral Health	Alaska Native Tribal Health Consortium
Melissa Kemberling	Director of Programs	Mat-Su Health Foundation
Michael Baldwin	Evaluation and Planning Officer and Contract Lead	Alaska Mental Health Trust Authority
Pat Sidmore	Planner	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
Rick Calcote	Policy and Planning	State of Alaska Division of Behavioral Health
Tom Chard	Executive Director	Alaska Behavioral Health Association

In addition, we are grateful for survey feedback we received from Rosalie Nadeau, Chief Executive Officer of AKEELA, and Jim McLaughlin, DBH Behavioral Health Grant Program Manager, and, of course, to the many providers who actively participated in the session. The ability to ask and review questions in real-time and the earnestness with which providers participated contributed to the top notch quality of the conversation and feedback about system capacity.

BEHAVIORAL HEALTH AIDE SURVEY REVIEW COMMITTEE

Many individuals made this survey, which marked the first time BHAs had been asked questions of this nature, a success. On behalf of the Alaska Mental Health Trust Authority and the Alaska Behavioral Health Assessment project team, we would like to thank:

- The Tribal Behavioral Health Directors Executive Committee for leading the development of the Tribal Behavioral Health System graphic and providing valuable input into the BHA survey's content and format.
- The Behavioral Health Academic Review Committee for their guidance in how to administer the survey, including their excellent suggestion to recruit BHAs to facilitate the sessions.
- Brenda Wilson, an experienced and highly skilled Behavioral Health Aide from King Cove, Alaska who works for Eastern Aleutian Tribes. Brenda spent time learning about the Alaska Behavioral Health Systems Assessment and gave us the great honor of sharing the project's goals and the Tribal Behavioral Health System graphic with the Behavioral Health Aides at the annual BHA Forum.
- The BHAs and recorders who facilitated and documented the world café sessions with great care and skill. Their names are listed under each topic area.
- The BHA workforce who eagerly shared their thoughts on how to improve the system and achieve the vision described in the Tribal Behavioral Health Systems Graphic.
- Laura Baéz, Xiomara Owens, and the entire team at ANTHC's behavioral health department for leading the planning and coordination of 15 very well attended world café sessions with Behavioral Health Aides from across the state.

KEY INFORMANTS

Describe

Recommendations

We relied on many key informants to inform our efforts to describe the Alaska Behavioral Health System and make recommendations for positive systems change. Some of these individuals were engaged for the express purpose of the assessment and others were engaged through other efforts that contributed to our understanding of the opportunities and barriers facing the system. We could not have been successful without their collective insights and willingness to share their expertise.

Name	Role	Organization
Albert Wall	Director of Behavioral Health	State of Alaska Division of Behavioral Health
Angel Dotomain	Director, Office of Tribal Programs	Alaska Area Native Health Service
Angela Cox	VP of Administration	Arctic Slope Native Association
Anthony Cravalho	Director of Planning and Development	Maniilaq Association
Bill Herman	*Former* Senior Program Officer	Alaska Mental Health Trust Authority
Bree Swanson	Administrator of Social Services	Maniilaq Association
Cody Chipp	Behavioral Health Director	Aleutians Pribolof Islands Association
Dale Dates	Program Officer	HRSA Bureau of Primary Health Care
Janice Hamrick	Behavioral Health CFP Program Manager	Southeast Alaska Regional Health Consortium
Janie Ferguson	Special Projects Coordinator, Behavioral Health Aide Program	Alaska Native Tribal Health Consortium
Jeff Jessee	Chief Executive Officer	Alaska Mental Health Trust Authority
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Justina Wilhelm	Deputy Director, Behavioral Health	North Slope Borough Health & Social Services
Karen Sidell	Director of Statewide IT Services	Alaska Native Tribal Health Consortium
Kathleen Carls	Research Unit Manager, Policy and Planning Section	State of Alaska Division of Behavioral Health

Name	Role	Organization
Katy Branch	Director of the Alaska Center for Rural Health and Area Health Education Center	University of Alaska Anchorage
Lance Johnson	Behavioral Health Director	Norton Sound Health Corporation
Laura Baéz	Director of Behavioral Health	Alaska Native Tribal Health Consortium
Mark Haines-Simeon	*Former* Policy & Planning Section Manager	State of Alaska Division of Behavioral Health
Melissa Kemberling	Director of Programs	Mat-Su Health Foundation
Michael Baldwin	Evaluation and Planning Officer and Contract Lead	Alaska Mental Health Trust Authority
Natalie Lewis	Behavioral Health Director	Maniilaq Association
Pat Sidmore	Senior Planner	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
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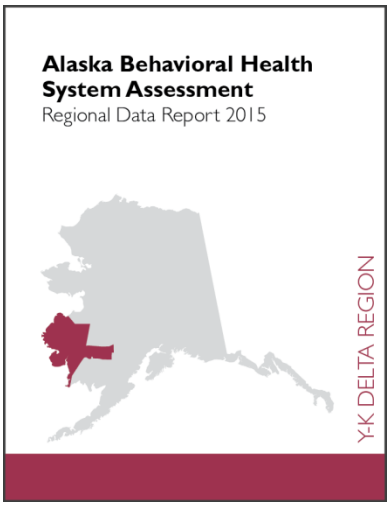
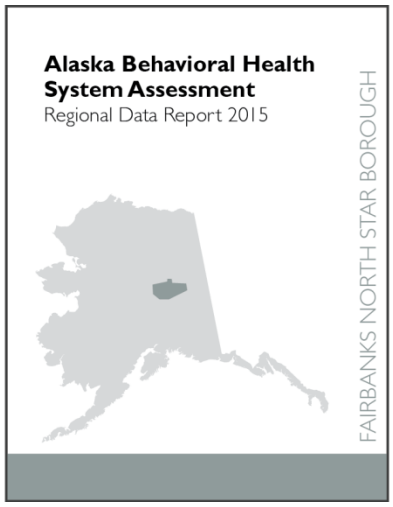
Rick Calcote	Policy and Planning	State of Alaska Division of Behavioral Health
Rosalie Nadeau	Chief Executive Officer	Akeela
Sarah Freeman	Telehealth Program Development Director - AFHCAN	Alaska Native Tribal Health Consortium
Shaun Wilhem	Chief of Risk and Research Management	State of Alaska Division of Behavioral Health
Sherry Wilson Hinshaw	*Former* Social Services Program Officer Integrated Housing & Services	State of Alaska Division of Behavioral Health
Tammy Hansen	Vice President of Health Services	Kodiak Area Native Association
Terry Hamm	Medicaid and Quality Section Tribal Medicaid Liaison	State of Alaska Division of Behavioral Health
Xiomara Owens	Behavioral Health Aide Program Manager	Alaska Native Tribal Health Consortium

Quantitative Data Support





This assessment and accompanying series of data reports are the product of many years of effort and would not have been possible without a small army of individuals. Agnew::Beck and Hornby Zeller Associates would like to express our gratitude to our data committee members, as well as the many staff from the Alaska Department of Health Social Services Division of Behavioral Health and Section of Chronic Disease and Health Promotion who helped inform and/or assisted with the production these reports. These individuals are listed below. Two individuals, in particular, dedicated tremendous time and energy to these efforts and we could not be more appreciative of their wisdom and constant support over the course of the past year plus. Thank you, Kathleen Carls and Michael Baldwin!

DATA COMMITTEE MEMBERS

Name	Role	Organization
Kathleen Carls	Research Unit Manager Policy and Planning Section	State of Alaska Division of Behavioral Health
Mark Haines-Simeon	*Former* Policy & Planning Section Manager	State of Alaska Division of Behavioral Health
Melissa Kemberling	Director of Programs	Mat-Su Health Foundation
Michael Baldwin	Evaluation and Planning Officer and Contract Lead	Alaska Mental Health Trust Authority
Pat Sidmore	Planner	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
Shaun Wilhem	Chief of Risk and Research Management	State of Alaska Division of Behavioral Health

We would also like to thank Bill Herman, Former Senior Program Officer at the Alaska Mental Health Trust Authority, who was instrumental in the early data planning phases of this project.

Additional Data Team Contributors

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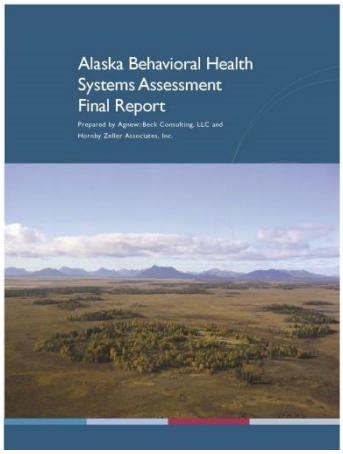
Terry Hamm	Medicaid and Quality Section Tribal Medicaid Liaison	State of Alaska Division of Behavioral Health

We also received valuable input and insights from a number of DBH Program Staff throughout the course of this effort as we sought to make sense of the data and we are very grateful for the time and efforts of these individuals.

Final Draft Review Team



In addition to the project's steering committee members, a handful of individuals were invited to review a draft of the final report. We are extremely appreciative of their time, comments, and assistance ensuring the integrating of this report and its contents. We hope the resulting products prove valuable tools for positive systems change.

Name	Role	Organization
Bradley Grigg	Treatment and Recovery Section Manager	State of Alaska Division of Behavioral Health
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Lance Johnson	Behavioral Health Director	Norton Sound Health Corporation
Pat Sidmore	Senior Planner	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
Randall Burns	Emergency Services Specialist	State of Alaska Division of Behavioral Health
Rick Calcote	Policy and Planning	State of Alaska Division of Behavioral Health
Shaun Wilhem	Chief of Risk and Research Management	State of Alaska Division of Behavioral Health
Stacey Toner	Deputy Director	State of Alaska Division of Behavioral Health
Terri Keklak	Medicaid and Quality Section	State of Alaska Division of Behavioral Health
Terry Hamm	Medicaid and Quality Section Tribal Medicaid Liaison	State of Alaska Division of Behavioral Health
Xiomara Owens	Behavioral Health Aide Program Manager	Alaska Native Tribal Health Consortium

EXECUTIVE SUMMARY

Project History and Purpose

A system is a set of interconnected elements working together to achieve a set of outcomes. A systems assessment is a process that uses qualitative and quantitative data to understand how and how well a system is working. In March of 2014, the Alaska Mental Health Trust Authority (The Trust) issued a Request for Proposals in partnership with the Alaska Department of Health and Social Services Division of Behavioral Health (DBH), the Alaska Native Tribal Health Consortium (ANTHC), and the Mat-Su Health Foundation (MSHF), for the completion of a comprehensive behavioral health systems assessment. The last comprehensive assessment of Alaska's behavioral health system was completed in 2005 and assessed rural areas of the state only.[1] The needs of Alaskans and the capacity of the behavioral health system to meet those needs have evolved substantially over the last ten years. The State-funded behavioral health system has also improved the collection and analysis of quantitative data over that period, which enables a more data-driven analysis of capacity and utilization of services.

Like any good systems assessment, the ultimate aim of this effort is to inform decision-making, at the regional and statewide levels, and improve system functioning so that it can produce better outcomes for the people it serves. This assessment builds upon previous and ongoing efforts by DBH and others to assess the behavioral health system funded by State of Alaska Medicaid and behavioral health funds. One of the many strengths of Alaska's behavioral health system is the way in which service organizations leverage these funds with multiple other funding streams to provide behavioral health services to a range of clients. This blending of funds and leadership did not always make it easy to establish the clear boundaries for our analysis, but the data we amassed and analyzed over the course of the project tell an important story about a system in transformation, a system that is both fragile and robust, and a system facing many opportunities and barriers to increasing its capacity to meet the behavioral health needs of Alaskans.

[1] 2005 Rural Behavioral Health Needs Assessment produced by NBBJ through a collaborative effort between the DBH, the Denali Commission, The Trust and ANTHC.

The goals of the Alaska Behavioral Health Systems Assessment are to:

1. Describe the behavioral health system.

Describe

2. Assess the need of Alaskans for behavioral health services.

Need

3. Assess the current capacity of Alaska's behavioral health system to meet the need.

Capacity

4. Develop a methodology and framework for regular monitoring of the behavioral health system

Monitoring

5. Identify opportunities and barriers to increased capacity and make recommendations for system improvements.

Recommendations

The effort undertaken to accomplish these goals involved many committed individuals and marked a number of firsts, including:

- Estimating the need of Alaskans for behavioral health services within each of ten reporting regions established for this study, as well as among the population who will be newly eligible for Medicaid under expansion, using prevalence data provided by the National Survey on Drug Use and Health (NSDUH) by special request.

- Leveraging Youth Risk Behavior Survey (YRBS) data to estimate substance use risk behaviors and mental health issues among high school students statewide and in each of the ten reporting regions.
- Merging service records from five behavioral health service datasets to produce an unduplicated treatment dataset with over 6.9 million records from FY09 through FY13. The datasets included in this study are the Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI); the Alaska Psychiatric Institute's (API) electronic health record system, Meditech; the DBH Designated Evaluation and Treatment (DET) database; and the Alaska Medicaid JUCE (Juneau Claims and Eligibility) database.
- Producing unduplicated client counts by diagnosis category, age, gender, and race for five continuous years statewide and by each of the ten reporting regions.
- Producing unduplicated client counts by provider type for Medicaid clients and all clients.
- Producing Medicaid payment data by provider type for five continuous years statewide, as well as aggregate (across all provider types) Medicaid payment data for each of the ten reporting regions.
- Analyzing statewide behavioral health workforce data, credentialing requirements, and billing capacity by position type.
- Comparing current statewide service data to an ideal continuum of care.
- Comparing utilization trends with need to identify potential areas where capacity expansion is needed.
- Engaging Behavioral Health Aides in the question of how to improve the system and better support this important workforce.

The product of these groundbreaking efforts follows. In a time where data is needed to inform every step of transformation, building the analytic capacity of the system is critical. The groundwork laid by this project creates a road map for building analytic capacity and producing regular (annual) behavioral health systems assessments.

Calls to Action

In June 2014, Jeff Capobianco, MA, PhD, LLP, who is the Director of Performance Improvement for the National Council for Community Behavioral Health, presented at the DBH Change Agent Conference, a biannual conference held in Anchorage for DBH Treatment and Recovery grantees. Dr. Capobianco issued three calls to action that have helped to frame the approach to this assessment (paraphrased here):

- Behavioral health systems tend to be extremely complex systems that are difficult to understand and manage. It is imperative for behavioral health stakeholders to work together to simplify and delineate the system so that it can be more broadly understood and actively managed.

"At times [the behavioral health system] seems like an onion with all the layers and sometimes the tearfulness it causes with all its complexities."

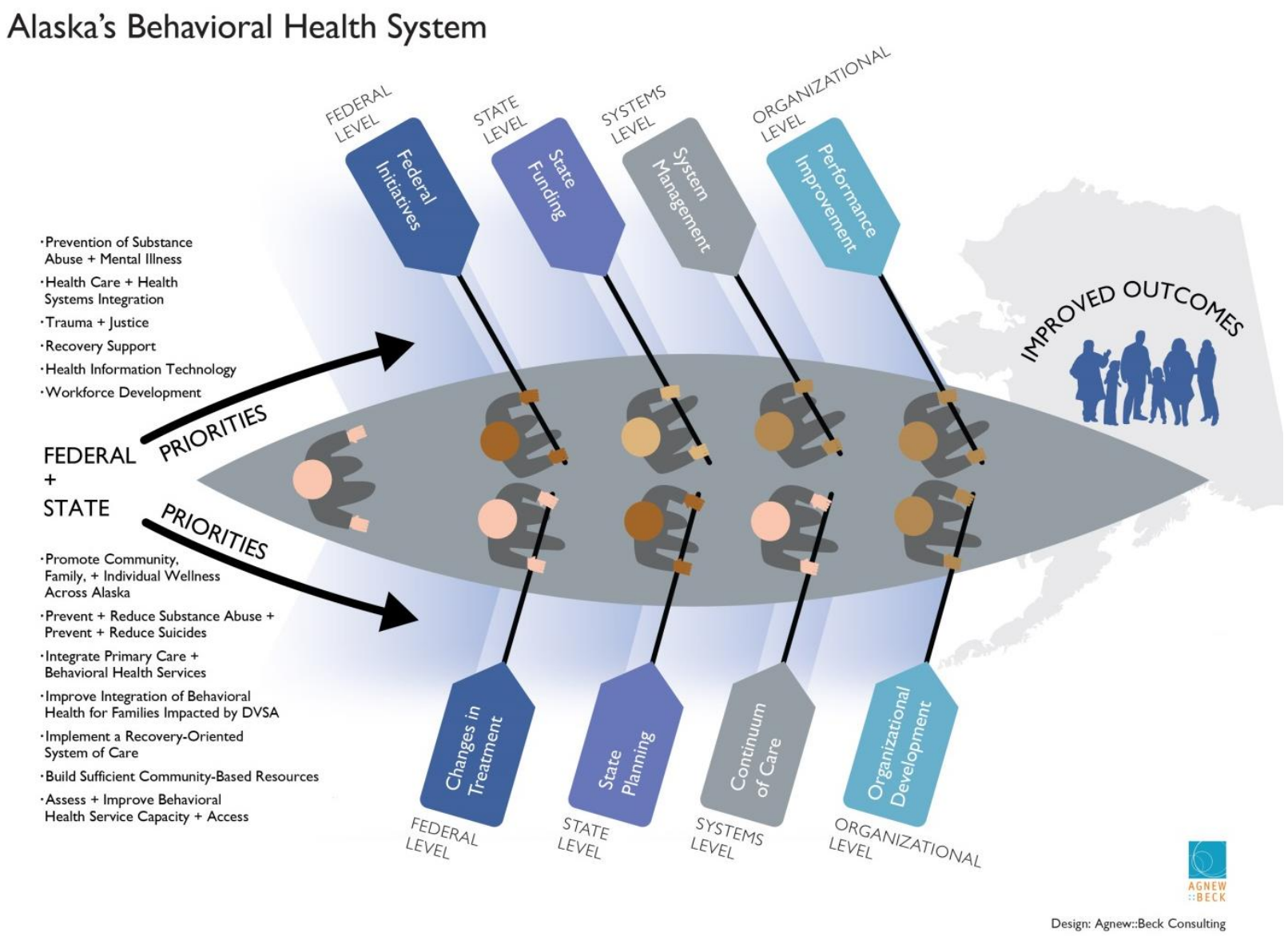
CEO of a Community Behavioral Health Center

- Primary care must be the mainstay of the behavioral health system.
- More and more, hospitals and primary care organizations are embracing the call to deliver integrated behavioral health services. Accountable care organizations and other types of value-based and population-based payment reforms are increasingly common and, unless behavioral health organizations can demonstrate their results, medical organizations will choose to source internally for behavioral health services. Being data-driven is a pre-requisite to being invited to Accountable Care Organization negotiations.

Inspired by Capobianco's calls to action, this assessment seeks to piece together the parts of Alaska's State-funded behavioral health system into a comprehensible whole; explore the current and prospective role of primary care in the behavioral health delivery system; and, understand the competitive influences that shape the State-funded behavioral health system. This collaborative and extensive effort documents a highly complex system so that it can be actively managed for the benefit of consumers, providers and payers.

We hope that policymakers, program managers and system leaders will use this report to inform improvements at all levels of the system, from the federal level to the organizational level. Over the course of completing this assessment, the project team developed the analogy of a canoe for Alaska's State-funded behavioral health system. Alaskans have used canoes and other types of watercraft for centuries to bring in food and other resources from the ocean and coastlines. These watercrafts brought in Alaska's bounty and preserved communities; they also carried people safely through treacherous waters and storms. A large canoe requires many paddlers, all working together, to navigate and propel the craft. This same alignment is needed for the State-funded behavioral health system to support wellness in Alaska. Currently, the canoe is well equipped with many powerful paddles in the water, but the paddlers are not always moving together, and are sometimes working against the current rather than with it, to propel the boat forward (ES Figure 1).

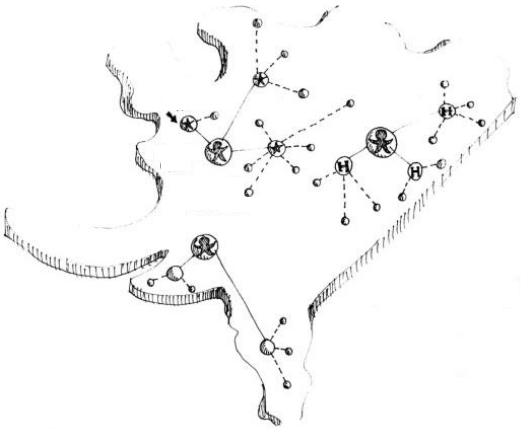
ES Figure 1 Alaska's Behavioral Health System



Summary of Methodology

In late February 2014, the Alaska Mental Health Trust Authority contracted Agnew::Beck Consulting and Hornby Zeller Associates (HZA) to complete an assessment of Alaska behavioral health system. Extensive planning and work took place over the year and a half leading up to the issuance of the RFP to develop a methodology for the assessment.

ES Figure 2 The analysis plan and original RFP served as a compass for this project



To ensure alignment before embarking on the assessment, a project steering committee was established to guide the contract team's work. The RFP also required the contract team to submit an analysis plan within two months of initiation of the contract. The analysis plan included a description of:

- The quantitative methodologies and datasets.
- How qualitative surveys would be conducted and integrated into the final report.
- The kinds of recommendations that would result from the assessment.

Most importantly, the analysis plan laid out our vision for how this project can create an enduring framework for the many stakeholders of behavioral health system to measure need and capacity on an ongoing basis.

The analysis plan and original RFP have served as a compass for this project as have the many committees and champions that have taken this project under their wings. Here we include a brief overview of our methods.

QUALITATIVE ANALYSES

Agnew::Beck led the qualitative analysis for this project.

Stakeholder Interviews and Ongoing Engagement

The contract team conducted many interviews and made efforts to engage a broad range of stakeholders in the project on an ongoing basis. Early in the project, project manager Heidi Wailand established a series of five weekly meetings with Laura Baéz at the Alaska Native Tribal Health Consortium (ANTHC) to discuss their goals for the assessment and develop an approach to engage all levels of the Tribal behavioral health system. This approach included presenting at the quarterly Tribal Behavioral Health Directors Meetings, participating as needed in Tribal Behavioral Health Directors Executive Committee meetings, attending the Behavioral Health Aide forum and hosting a webinar with Tribal Behavioral Health Directors to review and prioritize the opportunities/barriers and corresponding recommendations.

Project manager Heidi Wailand also established a series of five meetings early in the project with Mark Haines-Simeon, Director of Policy and Planning, DBH and Michael Baldwin, Evaluation and Planning Officer, Alaska Mental Health Trust Authority (AMHTA) to develop a better understanding of the state-funded behavioral health system. These meetings informed the analysis of

forces influencing system capacity and culminated in a meeting with Jeff Jessee, CEO of the AMHTA, Albert Wall, Director of Behavioral Health, DBH, and Rick Calcote, Policy and Planning, DBH.

The project team participated in periodic steering committee meetings and AMTHA Trustee meetings to provide updates and solicit feedback on project direction and progress. Additionally, the project team was invited on several occasions to present on the project, including a Webinar for the Statewide Prevention Framework (SPF) grantees and a presentation at 2014 Annual School of Addictions conference.

Provider and Behavioral Health Aide Surveys

We conducted two surveys to learn about system capacity directly from DBH Treatment and Recovery grantees and the Behavioral Health Aide (BHA) workforce. These surveys helped identify how and how well the system works, and where opportunities for systems improvements might lie.

- In November 2014, ANTHC and Agnew::Beck collaborated to conduct a world-café-style survey with BHAs in order to collect feedback that would help us better understand system capacity and inform recommendations for systems improvements. These questions were then reviewed and refined by ANTHC staff and the Tribal Behavioral Health Directors Executive Committee.
- In November 2014, DBH and Agnew::Beck collaborated to conduct an interactive provider survey at the DBH Change Agent Conference using Audience Response Technology in order to collect information about provider and organizational capacity and inform recommendations for systems improvements. The survey questions were informed and reviewed by a small committee convened for this purpose.

Review of Medicaid Billing Models

Agnew::Beck completed a systematic review of the various billing mechanisms for behavioral health services within the Alaska Medical Assistance Program (Alaska Medicaid). Terry Hamm at DBH discussed and reviewed the matrix developed from this research. Katie Baldwin-Johnson at The Trust also provided review and discussion of the research. This research provided insight into the multiple ways in which behavioral health services can be provided in different settings, and the differences in provider credentialing, billing revenue, and billable services in each of those settings. This informed the discussion of opportunities and barriers related to integrating behavioral health services into primary care and other service settings.

Review of Continuum of Care

Agnew::Beck followed the lead of the Mat-Su Health Foundation and used the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2011 description of a "Good and Modern Addictions and Mental Health Service System" to analyze the continuum of behavioral health services in Alaska and identify improvements to the continuum. "The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a 'good' and 'modern' system of care is to provide a full

range of high quality services to meet the range of age, gender, cultural and other needs presented."[2] Coding procedure data to the areas of the continuum identified the frequency of services consumers currently use.

QUANTITATIVE ANALYSES

Hornby Zeller Associates, Inc. (HZA) led the quantitative analyses for this project. A quantitative data committee, led by Kathleen Carls, DBH's Research Unit Manager, worked closely with the contract team throughout the direction of this project to ensure the accuracy and integrity of the data produced and to assist with analyses. Agnew::Beck worked closely with DBH and HZA to coordinate quality assurance and to develop the tables and charts included in this report.

Reporting regions

Borough and census area boundaries were used to create reporting regions with at least 20,000 residents for each of the five years considered in this analysis to ensure compliance with HIPAA reporting requirements for protected health information. These regions have been used historically by DBH when conducting regional analyses. Reporting regions and their corresponding population estimates for each of the years covered by this analysis are illustrated in ES Figure 3.

Prevalence tables

Together with DBH, the project team produced the following:

- Adults: Regional and statewide estimates of the number of Alaska adults that have behavioral health issues were generated statewide and for each region. Regional estimates are available in the Regional Data Reports.
- Youth: Regional and statewide estimates of the prevalence of reported risk behaviors among high school students, including rates for having a substance use risk behavior present; a substance use moderate/high risk behavior; a past year mental health issue; a past year mental health issue and substance use moderate/high risk behavior present.
- Youth: Regional and statewide estimates of children ages 9-12 with Severe Emotional Disturbance.
- Youth: Statewide prevalence rates for youth ages 12-17 who needed treatment for illicit drug or alcohol use in the past year (Substance Use Disorder).

Sources

- Substance Abuse Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2010 (revised 3/12), and 2011; Alaska NSDUH, DBH Special Data Request April 2014.
- Mental Health and Co-Occurring Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2011 (revised 10/13); Alaska NSDUH, DBH Special Data Request April 2014.

[2] Description of a good and modern addictions and mental health service system, 2011, http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

- Alaska Youth Risk Behavior Survey, Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services, 2015.
- Alaska Department of Labor 2013 population estimates by gender, age and race for each reporting region.
- U.S. Census Poverty data.

Service Utilization and Cost Analyses

The project team analyzed data from Alaska's various administrative systems to determine the services used, by whom, where and at what cost between State Fiscal Years 2009 and 2013. To facilitate analysis, HZA developed a Microsoft Access database capable of merging and de-duplicating the records from the sources listed above. Project manager Heidi Wailand helped to coordinate extensive quality assurance efforts with HZA and DBH to ensure integrity and accuracy of all reports.

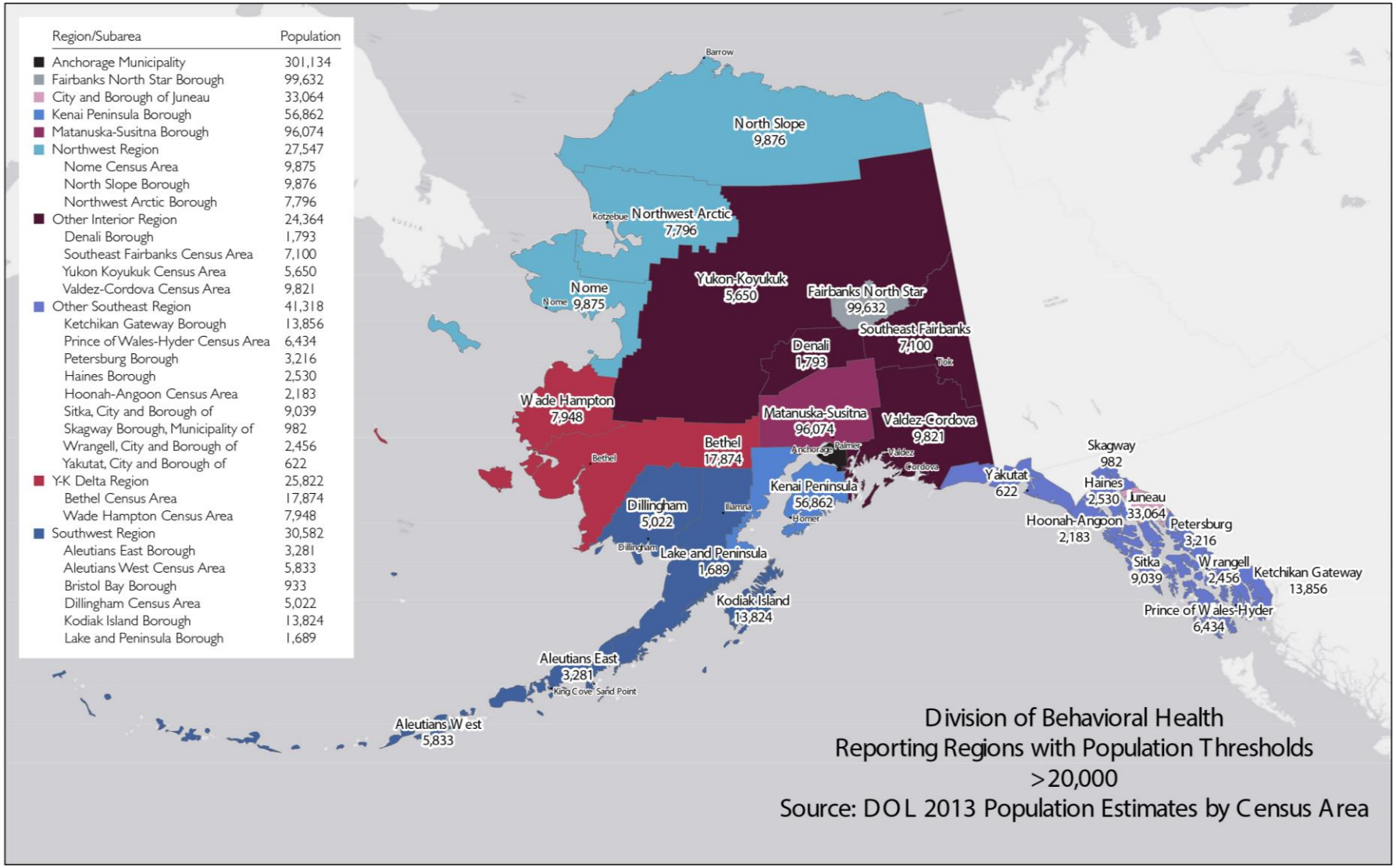
Sources

Extracts of the following data sets were used:

- The Alaska Medicaid Management Information System (MMIS) Juneau Claims and Eligibility or "JUCE" database,
- Alaska's Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI);
- Alaska Psychiatric Institute's (API) electronic health record system, Meditech; and,
- Division of Behavioral Health's Designated Evaluation and Treatment (DET) Program database.

The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health-specific provider types and for individuals who received services from other providers of behavioral health services and had a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by the Division of Behavioral Health (clients receiving only transport services were excluded). The API Meditech dataset included only partial data for 2009. The Alaska Department of Health and Social Services' Division of Behavioral Health provided all data.

ES Figure 3 Alaska Behavioral Health Systems Reporting Regions



Key Findings

This assessment endeavors to answer these basic questions for behavioral health leaders, consumers, providers, and policymakers:

1. What is behavioral health, what is the State-funded behavioral health system, and which forces influence its capacity?
2. What is the prevalence of behavioral health issues in Alaska?
3. Who are the current users of the State-funded behavioral health system?
4. Where are clients being served and by whom?
5. Which services do clients use?
6. Are State-funded behavioral health services effective?
7. Who pays, and how much does it cost?
8. How do current utilization trends compare with the behavioral health needs of Alaskans?
9. What can we learn from providers and Behavioral Health Aides about improving system capacity?

A summary of key findings from each of these analyses is included below. These findings helped inform the identification of opportunities and barriers to capacity, as well recommendations for systems improvement.

1. WHAT IS BEHAVIORAL HEALTH, WHAT IS THE STATE-FUNDED BEHAVIORAL HEALTH SYSTEM, AND WHICH FORCES INFLUENCE ITS CAPACITY?

What is behavioral health?

The true breadth of Alaska's State-funded behavioral health system spans many sub-systems and related programs. The system has matured over the past six decades into a sophisticated continuum of care that addresses substance abuse and mental health issues with services offered by a range of provider types, using an integrated approach with an emphasis on community-based care.

The term "behavioral health" refers to a state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders.[3] This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and substance use disorders (SUDs), which are often chronic in nature but people can and do recover from.

What is the State-funded behavioral health system?

A myriad of Alaska statutes establish the legislative framework under which mental health services are provided in the state. Together, these statutes provide the statutory guidance and obligation for developing, funding, managing, and maintaining the State-funded behavioral health continuum of

[3] From the FY15-16 Draft Federal Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. Draft provided by DBH 6.22.15.

care described throughout this assessment, including by: directing the Department of Health and Social Services to develop a plan for and implement an integrated comprehensive mental health program in the state [AS 47.30.660]; creating a Mental Health Trust Authority and Alaska Mental Health Board, responsible for ensuring a comprehensive mental health program [AS 47.30.011 *et seq.*; AS 47.30.661 *et seq.*]; and establishing a community mental health program to supplement state-operated mental health services [AS 47.30.520 *et seq.*].[4]

The term "State-funded behavioral health system" refers to the service systems supported through State Medicaid and behavioral health funds. The Alaska Department of Health and Social Services (DHSS) oversees a continuum of statewide behavioral health (mental health and substance use) services ranging from prevention, screening, and brief intervention to outpatient and inpatient treatment and recovery services to acute psychiatric care. These services are delivered by a wide range of provider types.

Alaska's State-funded Community Behavioral Health System (CBHS) currently serves as the mainstay of Alaska's State-funded behavioral health system. The Community Behavioral Health System offers prevention and early intervention services for the general population and treatment and recovery services for target populations. Outlined in statute,[5] the principles of the state's Community Behavioral Health program specify that:

- Persons have ready and prompt access to necessary screening, diagnosis and treatment;
- Persons in need of community mental health services be provided treatment and rehabilitation services designed to minimize institutionalization and maximize individual potential;
- Persons be treated in the least restrictive alternative environment consistent with their treatment needs, enabling the person to live as normally as possible;
- Persons be provided necessary treatment as close to the person's home as possible.

Beyond population-based prevention efforts, the Community Behavioral Health system of care prioritizes specific populations and sets specific conditions for receipt of grant-funded behavioral health treatment and recovery services. These include the following populations as defined in Alaska Administrative Code:

- Children Experiencing an Emotional Disturbance [7 AAC 135.990(9)]
- Adults Experiencing an Emotional Disturbance [7 AAC 135.990(3)]
- Children and Adults Experiencing a Substance Use Disorder [7 AAC 160.990(b)(102)]
- Children Experiencing a Severe Emotional Disturbance (SED) [7 AAC 160.990(b)(88)]

> *If the grant money went away our Medicaid revenues wouldn't be enough. Right now, all of us in this field treat the grant money as the core funding and it is not enough to run your programs. It will take care of 50-75% of the costs, without that grant money you couldn't operate. We all depend on it to pay core functions, like facility costs.*
>
> *CEO of a Community Behavioral Health Center*

[4] These examples are illustrative only. A complete review and analysis of statutes and regulations relating to mental health services is beyond the scope of this assessment.

[5] AS 47.30.523. Community Mental Health Program Policy and Principles.

- Adults Experiencing a Serious Mental Illness (SMI) [7 AAC 160.990(b)(85)]

DBH funds the Community Behavioral Health System through Prevention and Early Intervention grants, Comprehensive Behavioral Health Treatment and Recovery grants, and its State Medicaid program. This assessment focuses on Treatment and Recovery grants and their intersection with State Medicaid-funded services (provided from within and outside of the Community Behavioral Health System). Together, the Treatment and Recovery grants result in a network of service providers across the state that deliver Community Behavioral Health Services to youth and adults. Treatment and Recovery grantees are automatically eligible to bill for services provided to Medicaid enrollees through the DBH-administered State Medicaid Program. In FY13, nearly 80 organizations received DBH Treatment and Recovery grants to provide Community Behavioral Health Services.

Alaska's Community Behavioral Health System is shaped in part by two complementary sets of guiding federal and state priorities that together seek to propel the system toward improved outcomes (ES Figure 1).[6] Six federal priorities or initiatives set by the Substance Abuse and Mental Health Services Administration (SAMHSA) aim to better meet the behavioral health care needs of individuals, communities and service providers:

1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development

Seven priorities identified by DBH reflect the State's commitment to improving the quality of life of Alaskans:

1. Promote Community, Family, and Individual Wellness Across Alaska
2. Prevent and Reduce Substance Abuse and Prevent and Reduce Suicides
3. Integrate Primary Care and Behavioral Health Services
4. Improve Integration of Behavioral Health for Families Impacted by Domestic Violence and Sexual Assault
5. Implement a Recovery-Oriented System of Care
6. Build Sufficient Community-Based Resources
7. Assess and Improve Behavioral Health Service Capacity and Access

In addition to these priorities, SAMHSA target populations and the Alaska Medical Assistance Program (Alaska Medicaid Program) eligibility requirements have a fundamental impact on who the system serves and how system efficacy is reported and monitored.

In Alaska, we know that many provider types work to meet the needs of Alaskans experiencing a behavioral health crisis or living with a behavioral health issue. Depending on the individual and the provider, these services can be funded by Medicaid, Medicare, Indian Health Service (IHS) Compact

[6] Discussion and priorities provided by Kathleen Carls, Research Unit Manager, Division of Behavioral Health. 6.26.15.

or other Tribal funds, private insurance, multiple other federal and private funding sources, self-pay, or uncompensated care. By design, the data analyzed through this assessment include clients who are Medicaid-enrolled and who receive behavioral health services through DBH Treatment and Recovery grantees, as well as a range of other providers. To capture behavioral health services by non-DBH Treatment and Recovery grantees, we analyzed all API records, all Designated Evaluation and Treatment (DET) records, and all Medicaid records for individuals with a primary or secondary behavioral health diagnosis in general (non-behavioral health specific) service settings. Medicaid data was our exclusive source of service information for providers outside of the Community Behavioral Health System.

Leadership of the State-funded behavioral health system is shared across a number of entities, from policymakers to service providers. Five entities have a statutory charge to provider oversight and leadership to the State-funded behavioral health system:

- The Alaska State Governor
- The Alaska State Legislature
- Alaska Department of Health Social and Services Division of Behavioral Health (DBH)
- The Alaska Mental Health Trust Authority
- The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB)

Leadership is also shared with Tribal Health Organizations due to the interwoven nature of Alaska's State-funded behavioral health system (many Tribal Health Organizations receive DBH grant funds to operate Community Behavioral Health Centers and conduct prevention efforts). Likewise, federally qualified community health centers funded by the U.S. Health Resources and Services Administration (HRSA) are providing increasing levels of behavioral health services. Indeed, two of Alaska's strongest assets to improve the behavioral health of all Alaskans are the Tribal Health System and the HRSA-funded community health system. While this assessment touches only lightly on the HRSA-funded community health system, assessing both the Tribal and non-Tribal parts of Alaska's Behavioral Health System was an important component of the scope of work that shaped this effort.

Depending on the entity, the growth of a Tribal behavioral health program may be covered with a combination of Indian Health Service Compact funds, which are allocated to the provision of behavioral health services at the discretion of each Tribal Health Organization, State grant funds, Behavioral Health Aide grant funds, and Medicaid reimbursable services. In 2015, the Tribal behavioral health system is perhaps best described as a collection of independently operated Regional and Village Health Corporations with a shared vision and shared commitment to meeting the behavioral health needs of Alaska Natives. The graphic of Alaska's Tribal Behavioral Health System on the following page (ES Figure 4) was created during the fall of 2014 through a series of weekly interviews and work sessions with the ANTHC Behavioral Health Program Director, her staff, and the Tribal Behavioral Health Directors Executive Committee. This vibrant visual starts with a spool of thread at the foot of an Alaska Native woman highlighting a selection of behavioral health disparities faced by Alaska Native people. The thread is woven through a fragmented patchwork that depicts the challenges facing the current Tribal Behavioral Health System at each level, from the village to the state. As the graphic shifts to the future, a Behavioral Health Aide sews the system together into a cohesive quilt with a healthy community at its center. The future vision

symbolizes the importance of harnessing the full potential of the Behavioral Health Aide workforce in Alaska.

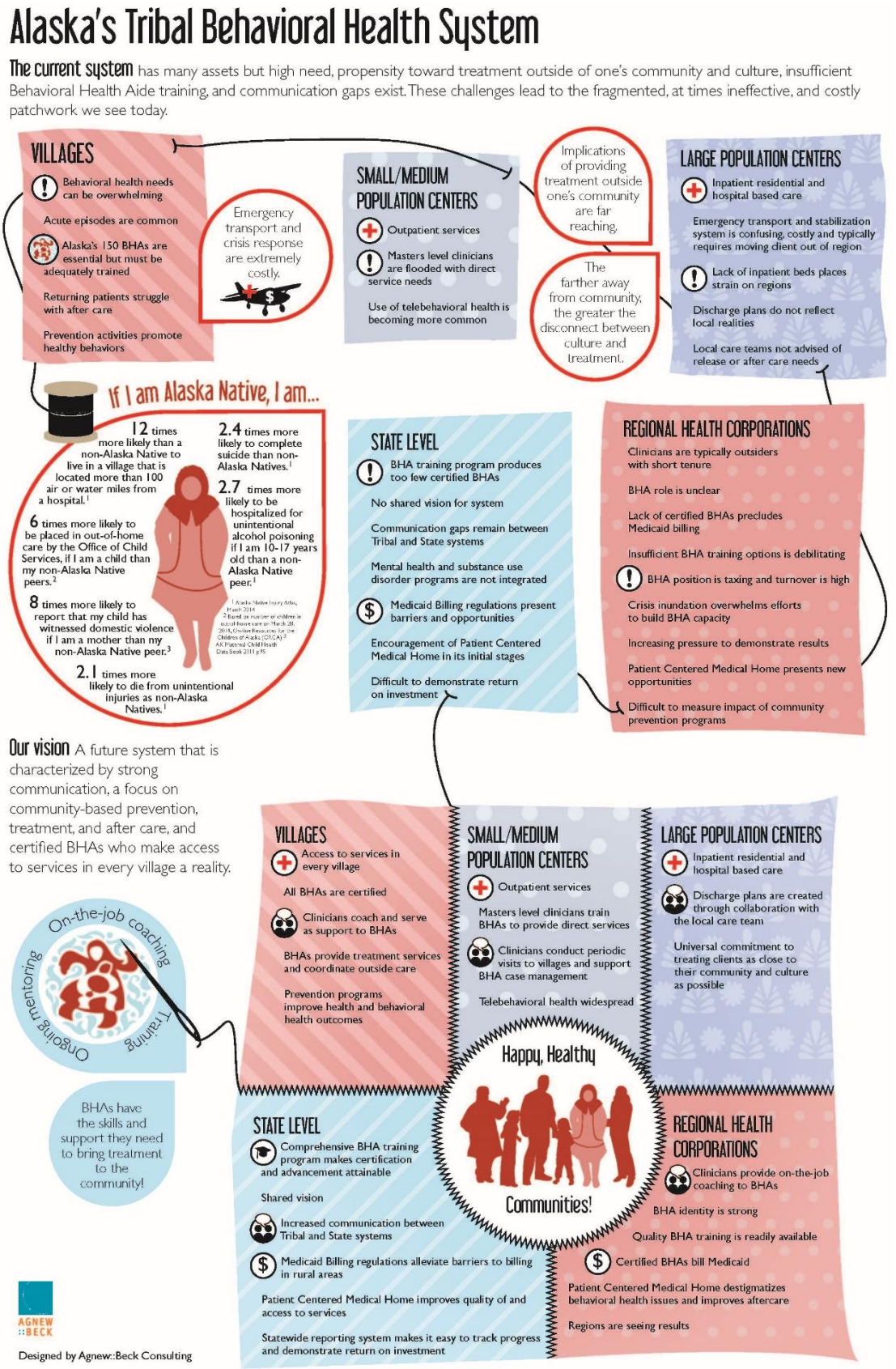
What forces influence system capacity?

The behavioral health system is a system undergoing tremendous change and transformation. To better understand the system forces influencing system capacity, we conducted a series of interviews with systems leaders during the summer and fall of 2014 and produced a one-page graphic outlining the results of these interviews (the graphic was updated again in June of 2015). We found that there are many forces, both positive and negative, influencing the capacity of the system to meet the behavioral health needs of Alaskans.

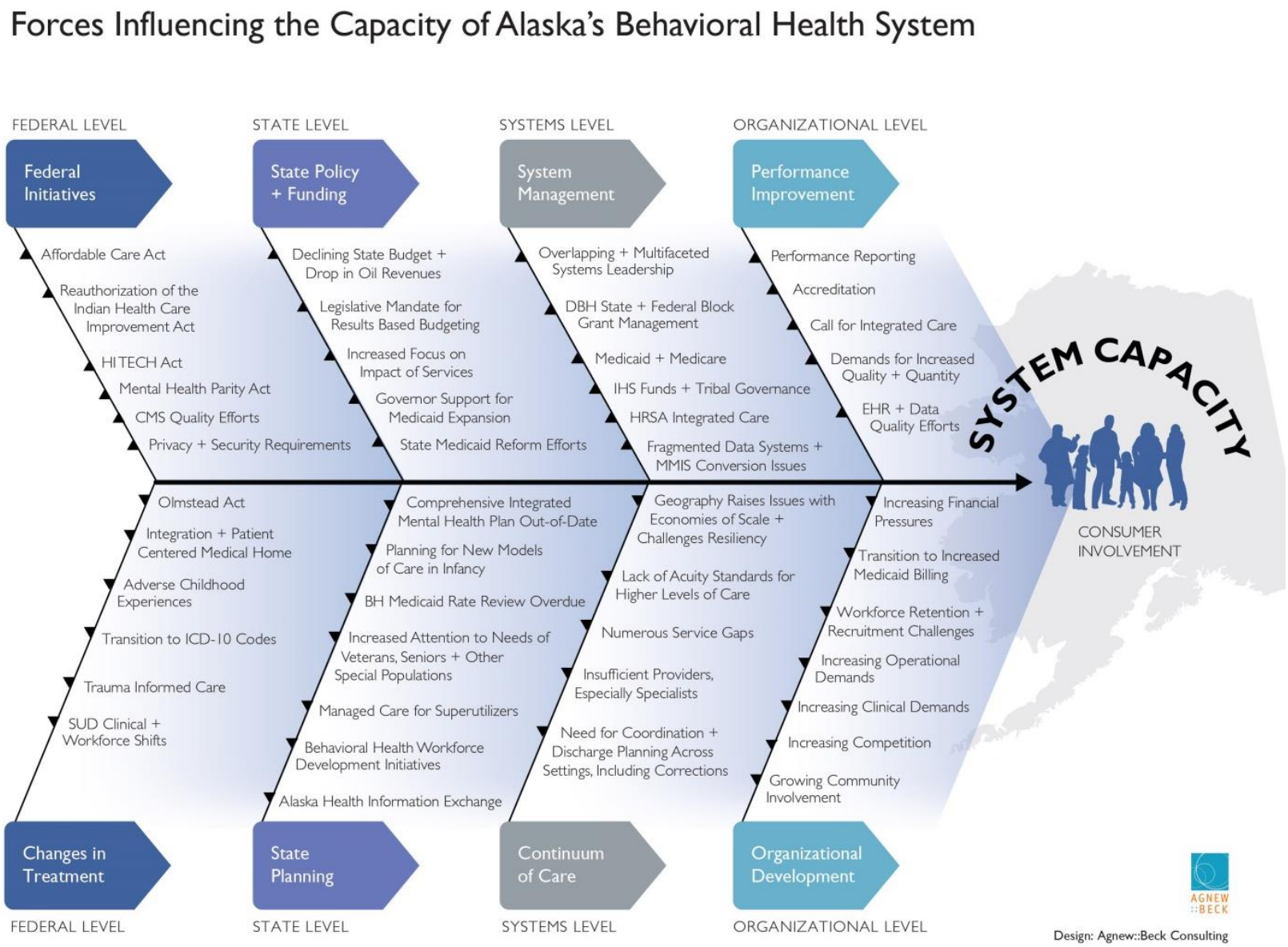
ES Figure 5 represents the collection of forces we documented at the federal, state, systems, organizational, and, ultimately, consumer levels.[7] We also heard that at the community level, infrastructure, the presence of an available and affordable workforce, seasonality, economy, flows of trade, and NIMBY-ism ("Not In My Back Yard") can influence system capacity. The direction and flow of the graphic indicates that each level of the system influences the next and, in their totality, these forces influence system capacity in both positive and negative ways. Documenting these forces is an important first step to being able to tame and manage change within the system.

[7] Based on a series of interviews about the factors influencing system's capacity with Mark Haines-Simeon, former Director of Policy and Planning for DBH and Rick Calcote, DBH, fall 2014. The analysis was then shared with DBH Director Albert Wall and The Trust's CEO, Jeff Jessee. Additional insights from the provider survey and provider feedback were incorporated subsequently.

ES Figure 4 Alaska's Tribal Behavioral Health System

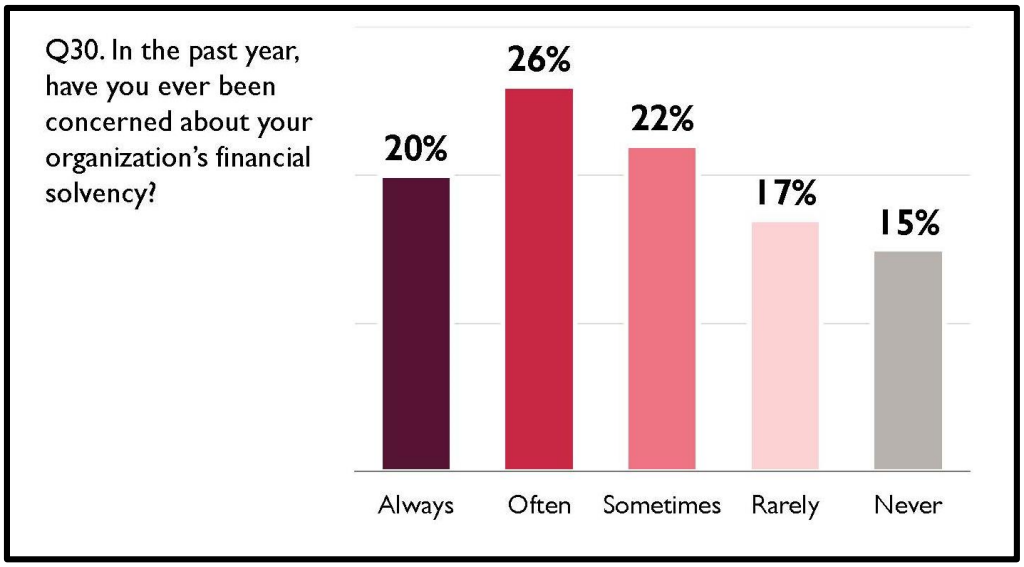


ES Figure 5 Forces Influencing the Capacity of Alaska's Behavioral Health System



In addition to interviewing systems leaders, we conducted a survey of DBH-funded providers using an audience response system at the November 2014 Change Agent Conference. Representatives from fifty-four DBH provider organizations participated. We asked providers 'What do you believe will be the three most important challenges facing your organization in the next five years?' Changes in funding streams, reduction in public funds, maximizing service capacity with limited revenue, and workforce development issues ranked highest. We also asked providers 'In the past year, have you ever been concerned about your organization's financial solvency?' Forty-six percent of DBH-funded service providers responded "Always or Often" (ES Figure 6).

ES Figure 6 Results from DBH Provider Survey, Change Agent Conference November 2014



While these responses underscore the financial vulnerability of providers, the data shared in subsequent sections of this assessment speak to the strength and resiliency of the system during a period of unprecedented change.

Affordable Care Act and Estimations of Prevalence among Expansion Populations

Without a doubt, one of the most prominent forces influencing the behavioral health system is the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act has brought behavioral health care onto center stage, elevating the importance of access to treatment and recovery services and emphasizing the need to integrate behavioral health and primary care services. The Act has also brought Medicaid expansion to Alaska with Governor Walker's announcement on July 16, 2015 that he would use his executive power to expand the Medicaid program starting in September of 2015.

One of the goals of this assessment was to estimate the need for behavioral health services among the newly eligible adult population under Medicaid expansion. Evergreen Economics estimated the newly eligible population at 41,910 individuals.[8] By applying National Survey on Drug Use and Health (NSDUH) prevalence rates for adults under 138 percent of the federal poverty to the population projections included in the Evergreen report, we found that an estimated 13,782 individuals within the newly eligible for Medicaid Expansion population have a behavioral health

[8] Medicaid Expansion Population Estimates: Project Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016, Evergreen Economics, February 2015, http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

need (see ES Figure 7 – please note that these rates vary from the rates included in subsequent adult prevalence estimates because they are specific to the low income adult population). Of these, 6,999 adults are estimated to need treatment for illicit drug or alcohol use and 9,975 adults are estimated to have experienced a mild, moderate or serious mental illness in the past year. Nearly half (45.6 percent) of the individuals who needed treatment for illicit drug or alcohol use are estimated to also have a mental illness (co-occurring disorder).

Amidst concerns about wait lists and costly patterns of usage, a key question facing for the behavioral health system is how it will meet the service demands of this newly enrolled population. One important consideration is how many individuals within the expansion population are currently receiving behavioral health and other health care services and what their patterns of usage are. Medicaid expansion will bring a new payer source for newly eligible existing clients and the additional revenue can help providers expand service capacity and/or offset the impact of reductions in behavioral health grant funding.[9]

Even more fundamentally, if regulatory barriers are lifted to allow for integration of behavioral health services in primary care settings to better serve individuals with SUD and mild and moderate mental illness, the behavioral health continuum of care could expand dramatically and shift access patterns to bring substantial improvements to health outcomes in the state. Medicaid expansion presents an important opportunity to finance new positions and programs that can meet the anticipated increase in demand for services that will come with health insurance coverage among low-income adults.

Medicaid Expansion has the potential to expand services to adults with SUD and Any Mental Illness and, with the right leadership and policy-making, achieve access to behavioral health services through both the medical and Community Behavioral Health doorways. Conversely, lack of affordable health insurance has created a gap in coverage that perpetuates ineffective utilization patterns and contributes to financial insecurity among providers.

[9] The Department of Health and Social Services' Healthy Alaska Plan (February 2015) proposes a $1 million dollar reduction in Behavioral Health Grants in SFY 2016 increasing to $16 million in SFY 2020 to offset the costs expanding Medicaid.

ES Figure 7 Estimated Prevalence of Behavioral Health Issues Among Medicaid Expansion Population Using Evergreen Economics Projections

Estimated Prevalence of Behavioral Health Issues Among Medicaid Expansion Population Using Evergreen Economics Projections								
		Needed Treatment for Illicit Drug or Alcohol Use in Past Year (SUD)	**Past Year Any Mental Illness** *(Includes Mild, Moderate, and Serious Mental Illness)*	**Past Year Serious Mental Illness** (SMI)	**Past Year Moderate Mental Illness**	**Past Year Mild Mental Illness**	**Past Year Any Mental Illness and SUD** (COD; Of those needing treatment for a drug or alcohol problem)	**Total Est. Individuals with a Behavioral Health Need** (unduplicated)
		Rate *16.7%*	**Rate** *23.8%*	**Rate** *3.9%*	**Rate** *6.1%*	**Rate** *13.8%*	**Rate** *45.6%*	
		Count	**Count**	**Count**	**Count**	**Count**	**Count**	**Count**
Evergreen Newly Eligible Population								
2016	41,910	6,999	9,975	1,634	2,557	5,784	3,192	13,782
2017	41,980	7,011	9,991	1,637	2,561	5,793	3,197	13,805
2018	42,050	7,022	10,008	1,640	2,565	5,803	3,202	13,828
2019	42,120	7,034	10,025	1,643	2,569	5,813	3,208	13,851
2020	42,190	7,046	10,041	1,645	2,574	5,822	3,213	13,874
2021	42,260	7,057	10,058	1,648	2,578	5,832	3,218	13,897
Evergreen New Enrollee Population								
2016	20,075	3,353	4,778	783	1,225	2,770	1,529	6,602
2017	23,257	3,884	5,535	907	1,419	3,209	1,771	7,648
2018	26,492	4,424	6,305	1,033	1,616	3,656	2,017	8,712
2019	26,536	4,432	6,316	1,035	1,619	3,662	2,021	8,726
2020	26,580	4,439	6,326	1,037	1,621	3,668	2,024	8,741
2021	26,624	4,446	6,337	1,038	1,624	3,674	2,027	8,755

Notes: Rates are based on Alaska-specific National Survey on Drug Use and Health (NSDUH) data for the adult (18+) population below 138% of Federal Poverty Level. The survey is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) using a sampling methodology in order to estimate prevalence. These estimates vary from subsequent estimates because they are specific to the low income adult population. New Enrollee projections assume 48% take up rate in 2016, 55% take up rate in 2017, and 63% take up rate in 2018-2021 per Evergreen Economics' memo cited below. NSDUH prevalence rates from 2009-2011 for specific to adult (18+) population below 138% of Federal Poverty Level were multiplied by the Evergreen population estimates to determine the approximate population with a behavioral health need. The total estimated individuals with a behavioral health need was calculated by adding individuals with SUD and Any Mental Illness and subtracting individuals with Any Mental Illness and SUD (COD). The sum of the individuals in each cell are greater than total estimated need due to co-occurring disorders.

SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) classified respondents as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

Sources: Substance Abuse Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2010 (revised 3/12), and 2011; Alaska NSDUH, DBH Special Data Request April 2014.

Mental Health and Co-Occurring Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2011 (revised 10/13); Alaska NSDUH, DBH Special Data Request April 2014.

Medicaid Expansion Population Estimates: Project Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016, Evergreen Economics, February 2015, http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

2. WHAT IS THE PREVALENCE OF BEHAVIORAL HEALTH ISSUES IN ALASKA?

This assessment identified statewide prevalence rates for the number of adult individuals who needed treatment for illicit drug or alcohol use in the past year (Substance Use Disorder or SUD); past year any mental illness (includes Mild, Moderate, and Serious Mental Illness); past year Serious Mental Illness (SMI); past year moderate mental illness; past year mild mental illness; past year co-occurring disorder, and, total estimated adults with a behavioral health need (unduplicated). Regional estimates were also produced and are available in the Regional Data Reports. These estimates are all based on 2009-2011 NSDUH data.

For youth, NSDUH data is only available for SUD prevalence. Because of the downward trend in SUD prevalence among Alaska youth, we chose not to apply the 2009-2011 prevalence data to 2013 youth population due to concerns that we might overestimate prevalence. Instead, we shared statewide prevalence trends and drew from YRBS data to estimate the prevalence of reported risk behaviors among high school students, including rates for having a substance use risk behavior present; a substance use moderate/high risk behavior; a past year mental health issue; a past year mental health issue and substance use moderate/high risk behavior present. Regional estimates were also produced using the YRBS dataset and are available in the Regional Data Reports. For adults and youth, prevalence is categorized by gender, race and region.

> *People need services when they are in crisis. From a systems perspective, it is all about access. For many clients, behavioral health services should be as time-limited as possible – we need to treat clients in their moment of need with the right level and length of supports. The purpose of clinic and rehabilitative services is to help individuals recover and as quickly as possible transition to the organic supports that exist within communities.*
>
> *Paraphrased from a discussion with the CEO of a Community Behavioral Health Center*

Prevalence estimates indicate a potential need for behavioral health treatment services; however, it is important to consider when planning that need is very different from demand. For example, an individual that registers as having a need for SUD treatment may not desire treatment and may be unlikely to present for treatment. An important area for future investigation will be looking closer at likely *demand* for treatment in addition to *need* for treatment. Whether considering need or demand for treatment, ensuring access to appropriate services at the right level of the continuum of behavioral health care is imperative. In Alaska, this means identifying ways to catch individuals before entry into the system's higher levels of care.

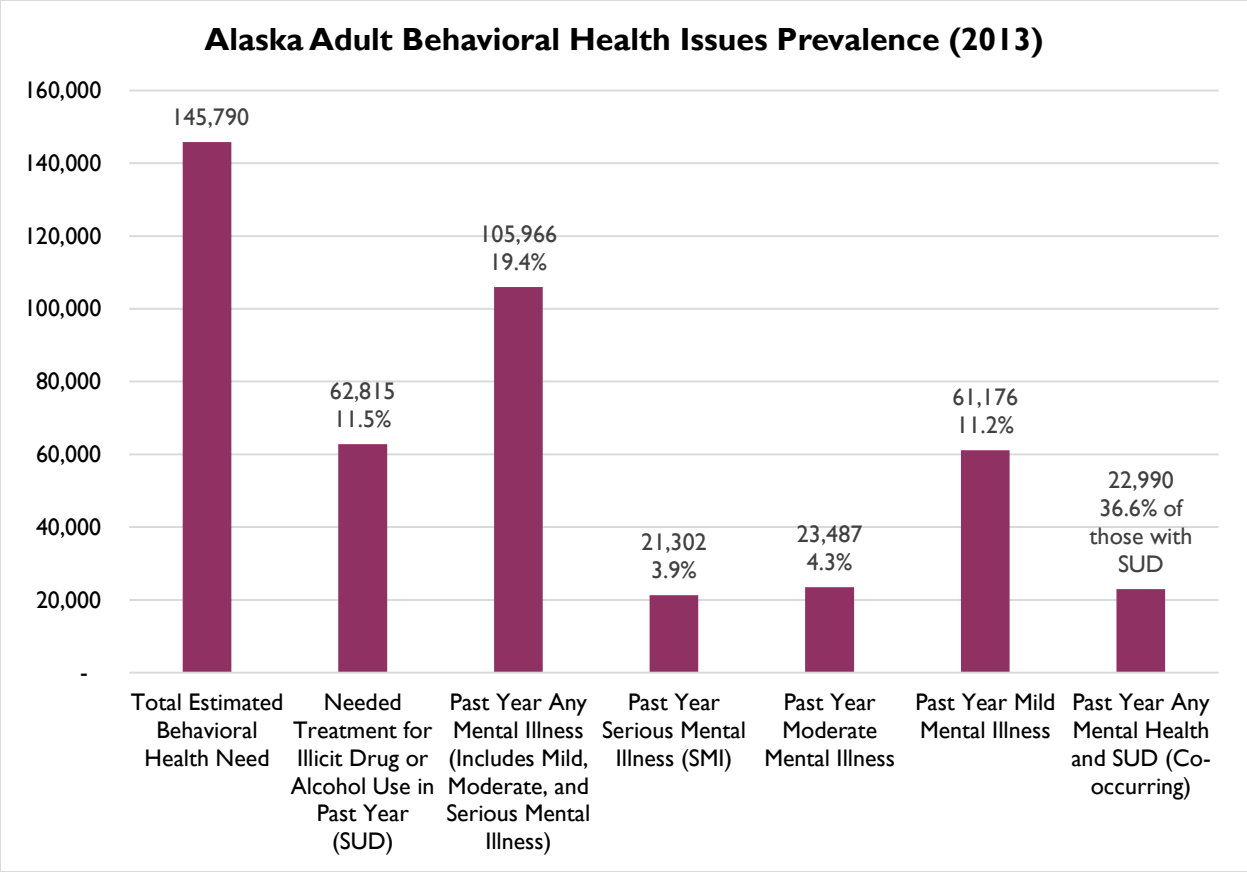
Due to Alaska's small population, even more caution than usual must be used when working with behavioral health prevalence estimates. With small populations, confidence intervals tend to run very wide, meaning the point estimate is more uncertain, numbers are often suppressed, and two to three years of data at a minimum must be combined depending on the question at hand.

Prevalence of Behavioral Health Issues among Alaska Adults

Total Estimated Behavioral Health Need

The prevalence estimates presented in this section reflect an important public health issue for the state. As shown in ES Figure 8, 145,790 Alaska adults were estimated to have a behavioral health issue in 2013. Prevalence rates by diagnosis, gender, and race can be found in ES Figure 11 at the end of this section.

ES Figure 8 Alaska Adult Behavioral Health Issues Prevalence (2013)



Substance Use Disorder

As shown in ES Figure 11:

- 62,815 or 11.5 percent (CI 9.1-13.7%)[10] of Alaska adults are estimated to need treatment for an illicit drug or alcohol problem in the past year.
- The prevalence of Substance Use Disorder (SUD) among Alaska males is significantly higher than among females, 15.5 percent (CI 11.9-20%) compared to a rate of 7.5 percent (CI 5.8-9.5%).
- The prevalence of SUD among Alaska Native adults, including any mention of Alaska Native in the two or more race category, is significantly higher than among White adults, 21 percent (CI 15.5-27.7%) compared to 10.5 percent (CI 8.1-13.5%). The prevalence rate of SUD among adults in the All Other Races category (4.7 percent (CI 2.4-8.8%)) appears to be lower than among White adults and is significantly lower than for Alaska Native adults.

[10] The confidence interval (CI) reflects the range of values within which NSDUH estimates a 95 percent probability that the actual or correct prevalence value lies within it. When the CI, or range of values, is wide it indicates less certainty of the correct value, when it is narrow, it indicates greater certainty. Estimates are considered to be significantly different if confidence intervals do not overlap. This is a conservative threshold for significance.

Any Mental Illness

As shown in ES Figure 11:

- 105,966 or 19.4 percent (CI 16.6-22.6%) of Alaska adults are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year.
- The prevalence of Past Year Any Mental Illness among Alaska females is significantly higher than among males, 24 percent (CI 20.3-28%) compared to a rate of 15 percent (CI 11.8-19%).
- The prevalence of Past Year Any Mental Illness among Alaska Native adults (15.9 percent (CI 11.6-21.6%)) appears to be lower than among White adults (20.3 percent (CI 16.9-24.1%)) and adults in the All Other Races category (19 percent (CI 11.8-29.1%)); however, differences across races in this category are not significant.

Serious Mental Illness

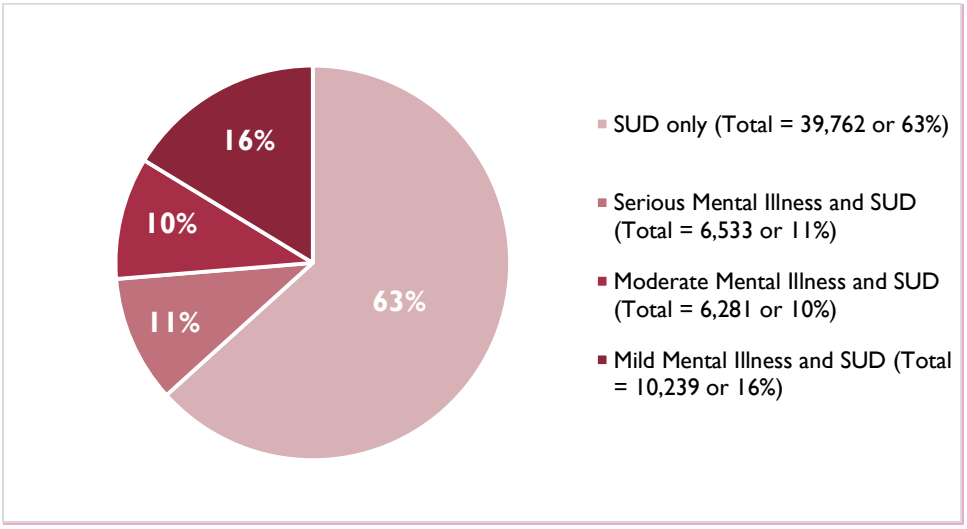
As shown in ES Figure 11:

- 21,302 or 3.9 percent (CI 2.8-5.3%) of Alaska adults are estimated to have had Serious Mental Illness in the past year. Statewide, there is no significant difference between males and females or across races.

Co-Occurring Disorders

- Of the approximately 62,815 adults who needed treatment for an illicit drug or alcohol problem in the past year, 22,990 or 36.6 percent (CI 28.4-45.7%) are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year; 6,533 or 10.4 percent (5.9-17.7%) are estimated to have had Serious Mental Illness in the past year (see ES Figure 9 for breakdown).

ES Figure 9 Co-Occurring Disorder: Alaska Adult Past Year Mental Health Prevalence Among the Estimated 62,815 Persons Needing Treatment for Illicit Drug or Alcohol Use in 2013

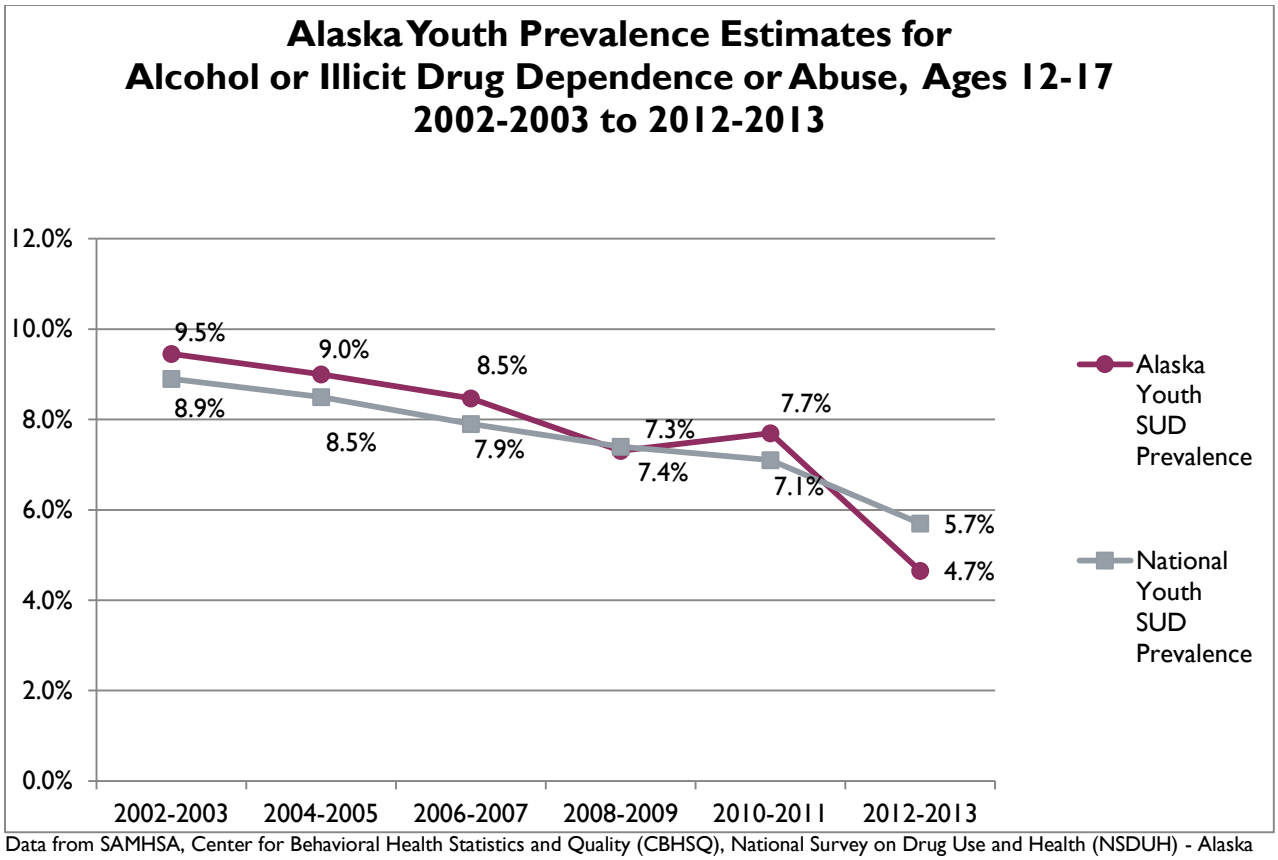


Prevalence of Behavioral Health Issues among Alaska Youth

Substance Use Disorder

- As shown in ES Figure 10, past year alcohol or illicit drug dependence or abuse among Alaskans ages 12 to 17 steadily declined between 2002-2003 and 2012-2013 from 9.5 percent (CI7.7-11.6%) to 4.7 percent (CI 3.5-6.1%). This decline mirrors the national trend, which declined from 8.9 percent (CI 8.5-9.2%) to 5.7 percent (5.4-6%) over the same period. The variation between Alaska and the nation is not significant.

ES Figure 10 Alaska Youth Prevalence Estimates for Alcohol or Illicit Drug Dependence or Abuse, Ages 12-17



Data from SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH) - Alaska 2 Year State Estimates; provided by the State of Alaska Division of Behavioral Health June 2015.

Serious Emotional Disturbance

- 5,550 or 6 percent of Alaska youth ages 9-17 are estimated to have had a Severe Emotional Disturbance (SED) in the past year.[11]

[11] The estimated prevalence of Severe Emotional Disturbance was generated using a methodology recommended by the Center for Mental Health Services (CMHS) for state-to-state comparisons and adapted to generate rates specific to reporting regions. The methodology calculates prevalence using a rate based on the percentage of children living in poverty for the state or region.

Self-reported Risk Behaviors for Substance Use and Mental Health Issues

The Youth Risk Behavior Survey (YRBS) collects a wealth of information from Alaska high school students about risk behaviors and mental health issues. In an effort to use this information in a way that would be helpful to systems and regional planners, we worked closely with the DBH Research Unit and DHSS Section of Chronic Disease Prevention and Health Promotion Public Health Data Unit to create a set of indicators that allow us to look at trends by gender, race and across regions. The statewide results of this analysis are included in ES Figure 12.[12]

- Among Alaska traditional high school students, 8,450 or 33.5 percent are estimated to have a risk behavior for substance use present and 4,641 or 18.4 percent are estimated to have a moderate or high-risk behavior for substance use present.
- Among Alaska traditional high school students, 7,214 or 28.6 percent are estimated to have had a past year mental health issue and 2,396 or 9.5 percent are estimated to have a moderate or high risk behavior for substance use present and a past year mental health issue.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are stressful or traumatic childhood experiences including abuse, neglect, and household dysfunction such as growing up with substance abuse, mental illness, or crime in the home, separation or divorce, and witnessing domestic violence.[13] The more ACEs an individual has, the more likely he or she is to experience negative health, including behavioral health, outcomes. For example, an individual with three ACEs is 2.5 times more likely to use illicit drugs, while an individual with five ACEs is 6.5 times more likely to use illicit drugs.[14]

- When compared to a five state composite (consisting of Arkansas, Louisiana, New Mexico, Tennessee, and Washington), Alaska adults had a higher average ACE score in every ACE category.[15]
- The incidence of adults experiencing five or more ACEs is significantly lower in Alaska among 18-24 year old adults (in 2013) compared to adults age 35-44 at that same time.[16]

According to Senior Planner Pat Sidmore, with the Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse, "our ACE scores are the highest of any state, but [these scores] are concentrated in the older population."[17] This evidence presents some hope that the impacts of specific historical events that produced significant and broad-ranging trauma may lessen over time.

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[12] Regional versions of this table are available in the Regional Data Reports. A summary of definitions for each YRBS indicator is included in chapter 2.

[13] The Adverse Childhood Experiences Study, SAMHSA Prevention Training and Technical Assistance. http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1

[14] As cited by Alaska Screening Tool FY2011 and Initial Client Status Review FY2011: Supporting Clinical Decision-Making and Program Performance Management. 6/30/11. Alaska Division of Behavioral Health. Available at: http://dhss.alaska.gov/dbh/Documents/Resources/pdf/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf

[15] Adverse Childhood Experiences: Overcome ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015. http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf

[16] Advisory Board on Alcoholism and Drug Abuse. PowerPoint Presentation on Adverse Childhood Experiences. State of Alaska Department of Health and Social Services.

[17] Key informant interview, August 8, 2014.

ES Figure 11 Estimated Prevalence of Behavioral Health Issues among Alaska Adults

Alaska Adult Behavioral Health Issues Prevalence

Total Population (2013)		Needed Treatment for Illicit Drug or Alcohol Use in Past Year (SUD)		Past Year Any Mental Illness *(Includes Mild, Moderate, and Serious Mental Illness)*		Past Year Serious Mental Illness (SMI)		Past Year Moderate Mental Illness		Past Year Mild Mental Illness	
		Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Adults											
Alaska	546,215	11.5%	62,815	19.4%	105,966	3.9%	21,302	4.3%	23,487	11.2%	61,176
Alaska – Adult by Gender											
Male	282,804	*15.5%*	43,835	*15.0%*	42,421	*3.2%*	9,050	*3.0%*	8,484	*8.8%*	24,887
Female	263,411	*7.5%*	19,756	*24.0%*	63,219	*4.6%*	12,117	*5.6%*	14,751	*13.8%*	36,351
Alaska – Adult By Race**											
White	388,379	*10.5%*	40,780	*20.3%*	78,841	*4.3%*	16,700	*4.6%*	17,865	*11.4%*	44,275
AI or AK Native	91,659	*21.0%*	19,248	*15.9%*	14,574	*4.0%*	3,666	*4.6%*	4,216	*7.4%*	6,783
Other	66,177	*4.7%*	3,110	*19.0%*	12,574	*1.1%*	728	*2.2%*	1,456	*15.7%*	10,390

Notes: Rates are based on Alaska-specific National Survey on Drug Use and Health (NSDUH) data for the adult (18+) population (all incomes). The survey is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) using a sampling methodology in order to estimate prevalence. SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) classified respondents as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. The sum of the individuals in each cell are greater than total estimated need due to co-occurring disorders.

Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. Any mental illness includes persons in any of the three categories.

**Other Race includes Black or African American, Native Hawaiian or Other Pacific Islander, Asian, and Two or More Races with no selection of American Indian or Alaskan Native.

Source for Substance Abuse Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2010 (revised 3/12), and 2011; Alaska NSDUH, DBH Special Data Request April 2014.

Source for Mental Health and Co-Occurring Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2011 (revised 10/13); Alaska NSDUH, DBH Special Data Request April 2014.

ES Figure 12 Estimated Prevalence of Behavioral Health Risk Behaviors and Issues among Alaska High School Students

Alaska Youth Behavioral Health Issues Prevalence									
Total Population (2013 High School Enrollments)		**Substance Use - Risk Behavior Present** *YRBS*		**Substance Use - Moderate/High Risk Behavior** *YRBS*		**Past Year Mental Health Issue** *YRBS*		**Past Year Mental Health Issue and Substance Use - Moderate/High Risk Behavior** *YRBS*	
		Rate	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**
Youth									
*Alaska**	25,225	33.5%	8,450	18.4%	4,641	28.6%	7,214	9.5%	2,396
Alaska – Youth by Gender									
Male	13,083	34.9%	4,566	20.3%	2,656	19.4%	2,538	9.1%	1,191
Female	12,142	32.1%	3,898	16.4%	1,991	37.8%	4,590	10.0%	1,214
Alaska – Youth By Race**									
White	12,785	34.2%	4,372	17.5%	2,237	25.3%	3,235	9.6%	1,227
AI or AK Native	5,711	37.1%	2,119	23.2%	1,325	34.0%	1,942	11.9%	680
Other	6729	27.9%	1,877	14.9%	1,003	30.1%	2,025	6.8%	458

General Notes: Data restricted to respondents in 2013 with valid responses to all questions and providing gender. Counts may not sum to total for state due to rounding of the rates. Regional versions of this table are available in the Regional Data Reports. A summary of definitions for each YRBS indicator is included in chapter 2.

* Weighted results for statewide traditional high school students.

**Race based upon white (only, non-Hispanic), American Indian or Alaska Native (any mention), and other consisting of other races, multi-racial, or unknown responses.

Source: Alaska Youth Risk Behavior Surveillance System, Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services, 2015.

3. WHO ARE THE CURRENT USERS?

To answer this question, the project team analyzed service data from Alaska's various administrative systems between FY2009 and FY2013. The scale of this effort is difficult to describe. It included:

- Merging service records from five behavioral health service datasets to produce a de-duplicated treatment dataset with over 6.9 million records from FY09 through FY13. The datasets included in this study are the Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI); the Alaska Psychiatric Institute's (API) electronic health record system, Meditech; the DBH Designated Evaluation and Treatment (DET) database; and the Alaska Medicaid JUCE (Juneau Claims and Eligibility) database.
- Producing unduplicated client counts by diagnosis category, age, gender, and race for five continuous years statewide and by each of the ten reporting regions.
- Producing unduplicated client counts by provider type for Medicaid clients and all clients.

The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health-specific provider types and for individuals who received services from other providers of behavioral health services and who had a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by the Division of Behavioral Health (clients receiving only transport services were excluded). The API Meditech dataset included only partial data for 2009. The Alaska Department of Health and Social Services' Division of Behavioral Health provided all data.

Critical to interpreting this data is understanding which services are captured and which are not. This assessment analyzed data for behavioral health services provided with support from State Medicaid and behavioral health funds. Some exceptions apply: the data do not include Alaskans who used services provided by the Department of Corrections or the Division of Juvenile Justice; DBH-funded prevention programs; Alaska therapeutic courts; Alcohol Safety Action Program (ASAP); DET transport services; DBH's Illness Self-Management pilot (these client counts are included in a table at the end of this section).

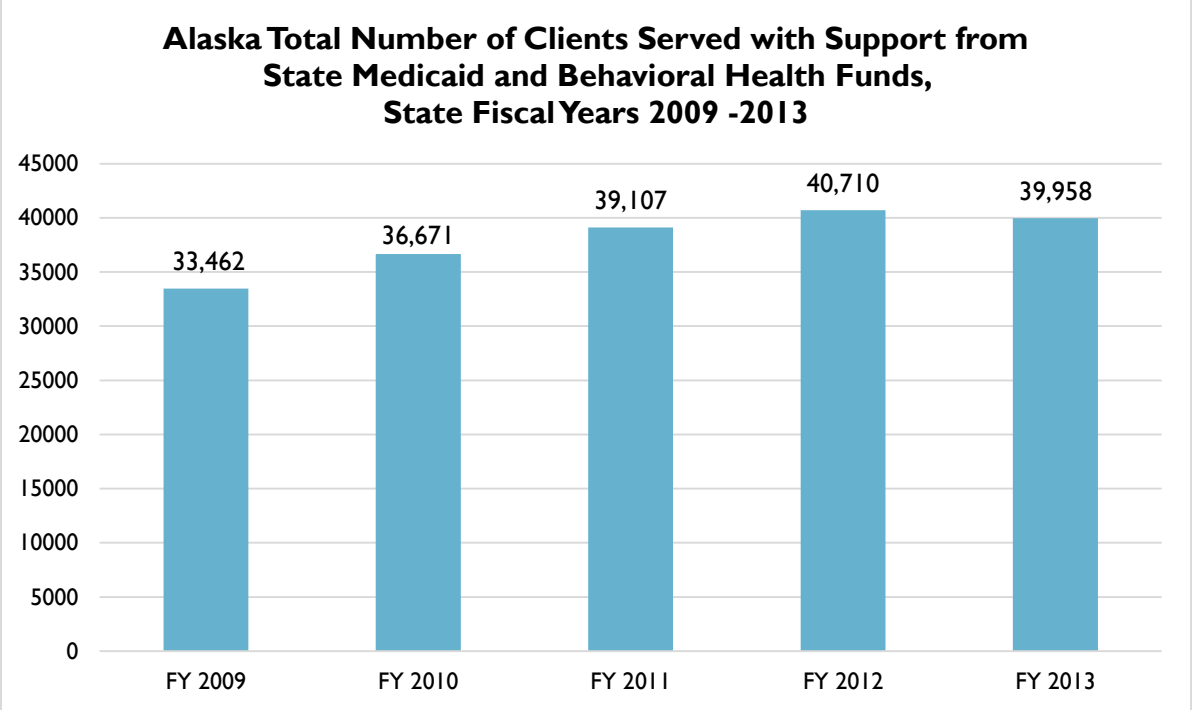
Notably, behavioral health services paid for through private insurance, self-pay or uncompensated care are not included. Until an all payers claims database is available in Alaska, it will be difficult if not impossible to aggregate a complete picture of behavioral health service utilization.

Total Unique Clients

- In FY13, 39,958 unique clients were served with support from Alaska Medicaid and/or Behavioral Health funds.[18] This total represents 6,496 more clients than in SFY09. ES Figure 13 shows the growth in unique clients over the five-year period.

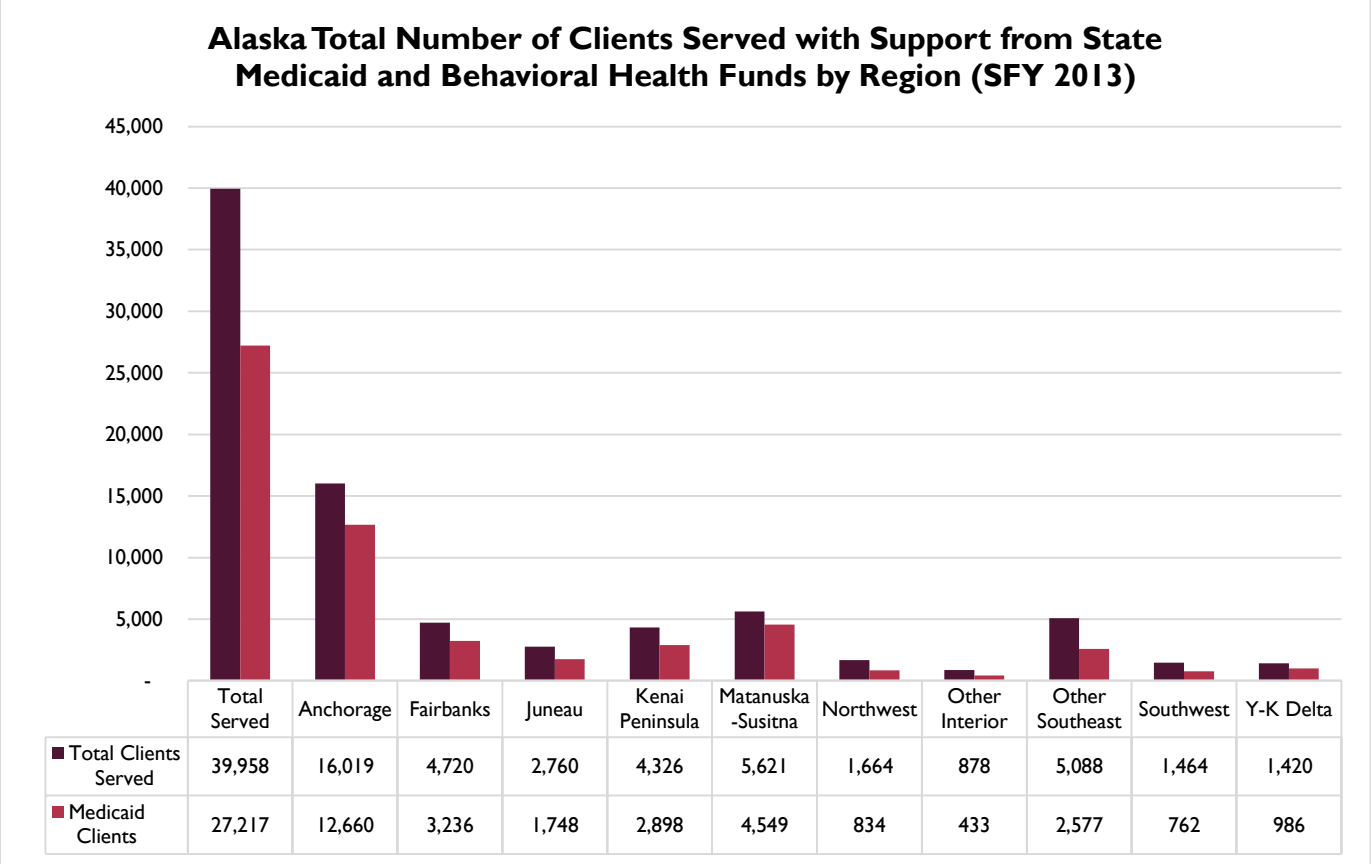
[18] Total unique clients includes more individuals than simply adding the total number of adults and the total number of youth. This is because some records do not include a date of birth and therefore cannot be classified as adult or youth; in addition, some individuals turned 18 during the year counted and would therefore be identified as both and adult and a youth for that year.

ES Figure 13 Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds, State Fiscal Years 2009 -2013



- ES Figure 14 shows the breakdown of clients served with support from State Medicaid and Behavioral Health funds by region and compares total unique clients served and total Medicaid clients served at the regional level (these counts are unduplicated at the regional and statewide levels). In SFY13, Anchorage providers served 16,019 clients or 40 percent of clients served by the system (note that many clients are served in more than one region).

ES Figure 14 Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Region (SFY 2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
Total Clients Served	39,958	16,019	4,720	2,760	4,326	5,621	1,664	878	5,088	1,464	1,420
Medicaid Clients	27,217	12,660	3,236	1,748	2,898	4,549	834	433	2,577	762	986

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total clients in the region in 2013).

Utilization of Behavioral Health Services by Alaska Adults

- In FY13, 27,728 unique adult clients were served with support from State Medicaid and/or behavioral health funds (ES Figure 15). The majority of behavioral health services for adults are provided to clients with a Substance Use Disorder (SUD) (14,442 or 52%) or a diagnosis indicating SMI status[19] (16,841 or 61%), with a relatively small proportion to clients with diagnoses related to other mental health (7%) and co-occurring disorder (13%).[20] These

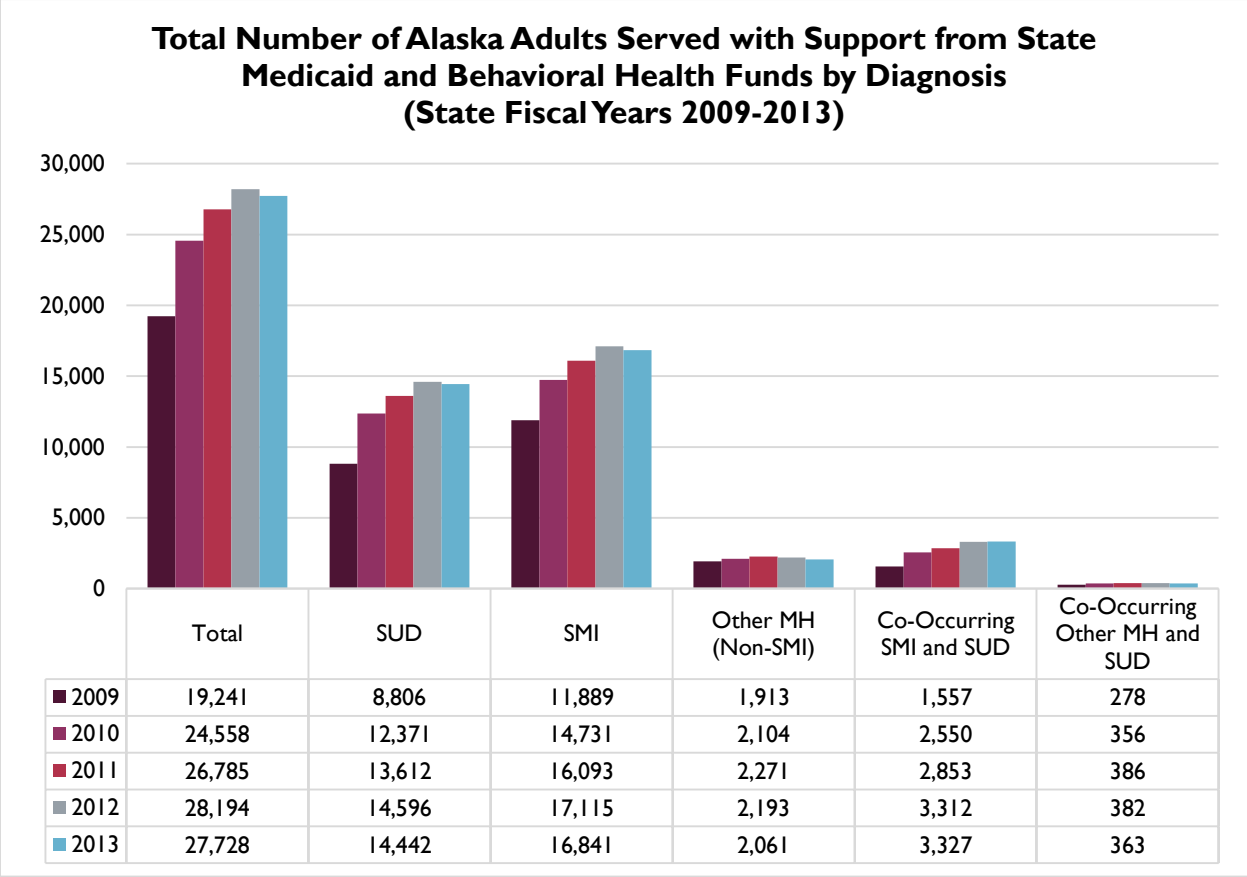
[19] Aligning prevalence and client utilization data is not an easy task. Our method for classifying clients uses diagnostic code and does not include a level of functioning assessment, as would be included in prevalence estimates, therefore, the number of SMI served is likely inflated compared to prevalence estimates. Some individuals with a diagnosis indicating SMI status may, in fact, fall into the moderate mental illness prevalence category. Hereafter, we refer to these cohort simply as having SMI diagnoses.

[20] The counts of individuals with co-occurring disorder (COD) may also be slightly low. Co-occurring in this methodology meant a diagnosis of SUD and MH at least once in the same year. See Alaska Behavioral Health Systems Assessment Data Packet for detailed notes on methodology.

percentages do not equal 100% because of the overlap in populations with co-occurring disorder.

- Interesting demographic trends include:
  - 16,232 or 59% of the unique adult clients served were female.
  - Statewide, males and females with SUD diagnoses were served in equal numbers.
  - More females were served with a SMI diagnosis than males (66% compared to 34%).
  - 85% of the adult clients served fell into the 21-64 age category, while the remaining pool of clients was split equally between 18-20 and 65+ age categories.
  - 48% of the adult clients served were White while approximately 38% of the adults clients served were Alaska Native (any mention).

ES Figure 15 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis (State Fiscal Years 2009-2013)



	Total	SUD	SMI	Other MH (Non-SMI)	Co-Occurring SMI and SUD	Co-Occurring Other MH and SUD
2009	19,241	8,806	11,889	1,913	1,557	278
2010	24,558	12,371	14,731	2,104	2,550	356
2011	26,785	13,612	16,093	2,271	2,853	386
2012	28,194	14,596	17,115	2,193	3,312	382
2013	27,728	14,442	16,841	2,061	3,327	363

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SMI, SUD, and Co-Occurring SMI and SUD categories).

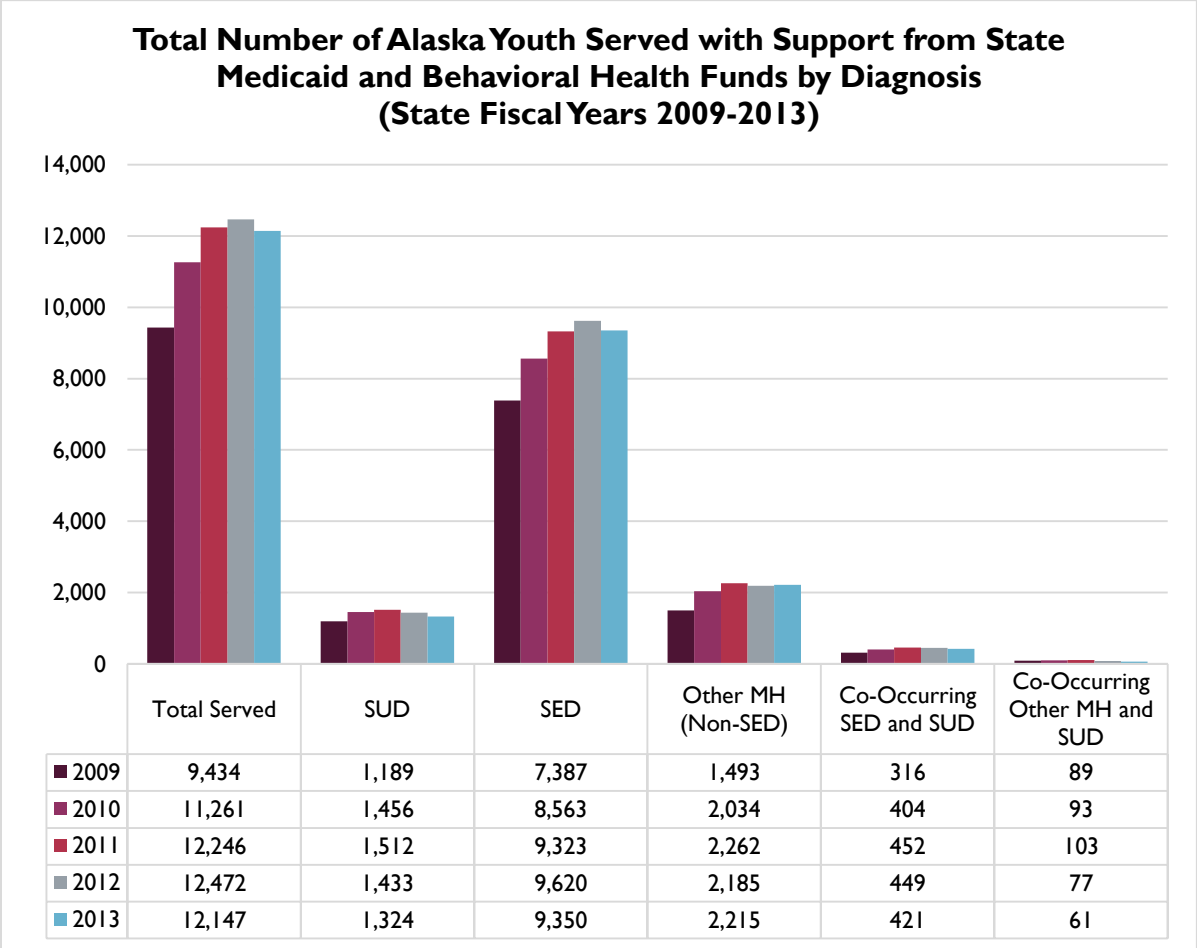
Utilization of Behavioral Health Services by Alaska Youth

- In SFY2013, 12,147 unique youth clients were served with support from State Medicaid and/or behavioral health funds (ES Figure 16). The vast majority (9,350 or 77%) of the behavioral health services for youth are provided to clients with a diagnosis related to Severe Emotional Disturbance (SED), with a relatively small proportion to clients with diagnoses related to other mental health (2,215 or 18%), SUD (1,324 or 11%), and co-occurring (482

or 4%). These percentages do not equal 100% because of the overlap in populations with co-occurring disorder.

- Interesting demographic trends include:
  - 7,129 or 59% of the unique youth clients served were male.
  - Statewide, more youth males with SUD diagnoses were served than females.
  - More males were served with a SED diagnosis than females (60% compared to 40%).
  - Half (52%) of the youth clients served fell into the 12-17 age category, 34% fell into the 6-11 age category, while 14% fell in the 0-5 age category.
  - White and Alaska Native Youth (any mention) were served in roughly equal numbers (each race made up approximately 40% of the total youth served) although White youth make up approximately 56% of the Alaska population under 18 and compared to 27% for Alaska Native youth.[21]

ES Figure 16 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis (State Fiscal Years 2009-2013)



	Total Served	SUD	SED	Other MH (Non-SED)	Co-Occurring SED and SUD	Co-Occurring Other MH and SUD
2009	9,434	1,189	7,387	1,493	316	89
2010	11,261	1,456	8,563	2,034	404	93
2011	12,246	1,512	9,323	2,262	452	103
2012	12,472	1,433	9,620	2,185	449	77
2013	12,147	1,324	9,350	2,215	421	61

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

[21] Based on Alaska Department of Labor population data for 2013.

4. WHERE ARE CLIENTS BEING SERVED AND BY WHOM?

In Alaska, behavioral health services are provided in a number of different settings and by a variety of provider types. Both Tribal Health Organizations and non-Tribal health organizations operate these settings and provider types; however, the Medicaid billing models and credentialing requirements vary by setting and by the type of health organization that operates them.

While many behavioral health services are provided through the Community Behavioral Health system of care, behavioral health services are also provided in medical settings. Physicians, for example, are an integral part of the service provision model. Our findings underscore the important role of both the community behavioral health and the medical systems in meeting the behavioral health needs of Alaskans.

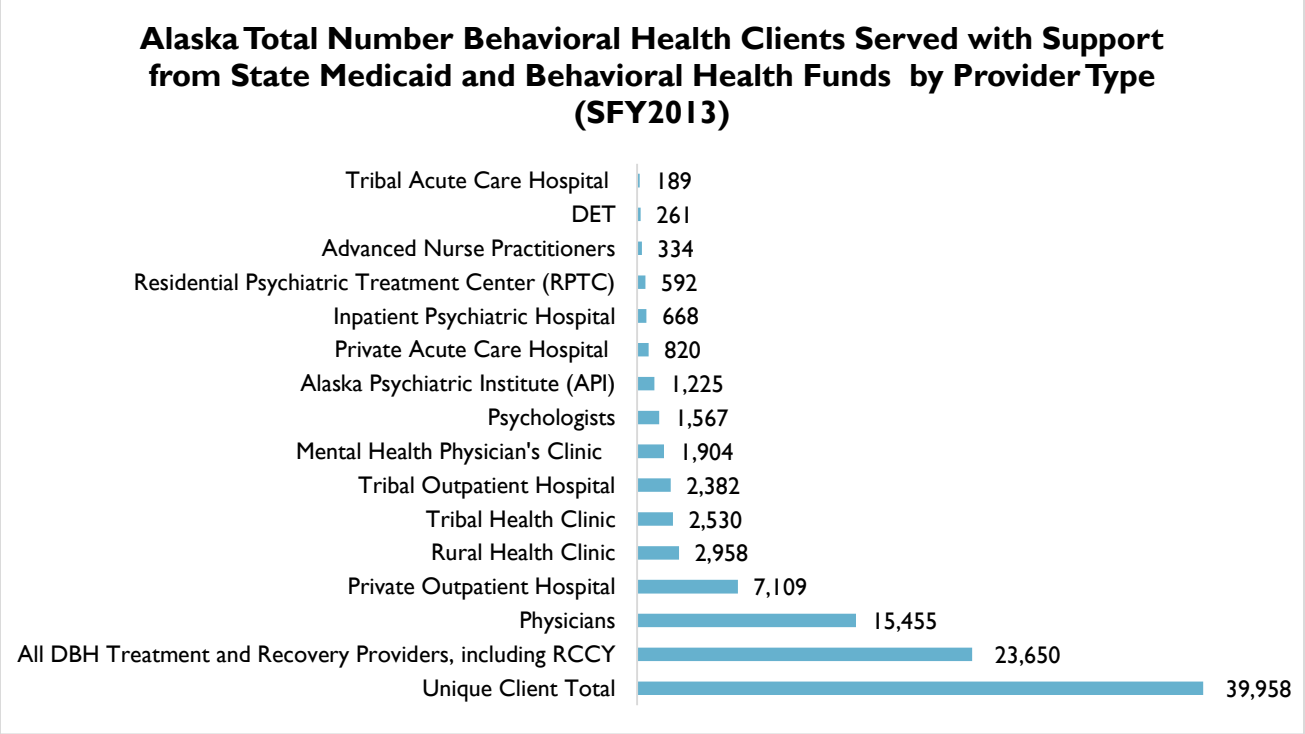
As the demand for behavioral health services increases, behavioral health system leaders must ensure that two front doors, one through the Community Behavioral Health Centers for individuals with a range of needs and one through primary care for individuals with mild and moderate needs, are as open and as connected as possible. Creating these two front doors will require a concerted effort to remove the barriers that currently exist to billing Medicaid for behavioral health services. Integration and data sharing are also vital pieces to the puzzle, otherwise we will continue to see costly patterns of use and inefficiencies in the way we care for individuals with behavioral health needs.

Clients Served by Provider Type

- As shown in ES Figure 17, state-funded behavioral Health clients are served by 14 different provider types across a range of service settings.[22] In FY13, these provider types served 39,958 unique clients or a cumulative sum of 61,642 (duplicated) clients.
- DBH Treatment and Recovery grantees served 59 percent or 23,650 unique clients (adults and youth) and physicians served 39 percent or 15,455 unique clients in FY13.
- Outpatient hospitals, which include emergency departments, represent the third most prominent provider type. Private Outpatient Hospitals served 18 percent or 7,109 unique clients and Tribal Outpatient Hospitals served 6 percent or 2,382 unique clients of the total unique clients served in FY13.
- Alaska Psychiatric Institute (API) served 1,225 unique clients in FY13, about 3 percent of the total clients served in that year.
- Of these total clients, Medicaid claims were paid for 27,217 unique clients during SFY13, an increase from 22,403 in SFY09.

[22] DET Services are not included in this count because they are delivered in Private and Tribal Acute Hospitals.

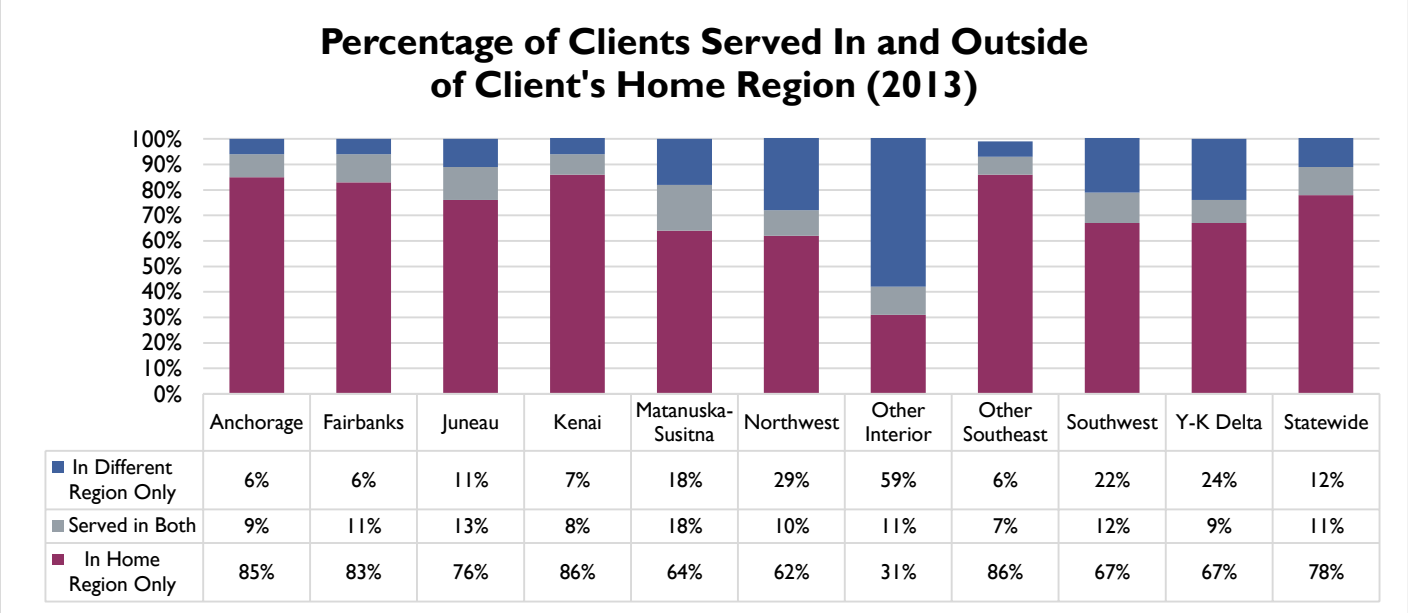
ES Figure 17 Alaska Total Number Behavioral Health Clients Served with Support from State Medicaid and Behavioral Health Funds by Provider Type (SFY2013)



Patterns of Use

- Client access patterns are important to understanding where and by whom clients receive services. ES Figure 18 shows the percentage of individuals within each region who receive services only in the region of their home community, only in a different region, and in both.
- Clients living in the more urban areas of the state (for example, Anchorage, Fairbanks, Juneau, Kenai) are more likely to receive services in their home region only, whereas a greater percentage of clients living in rural regions (for example, Northwest and Other Interior) are receiving services in a different region only.

ES Figure 18 Percentage of Clients Served In and Outside of Client's Home Region, 2013



	Anchorage	Fairbanks	Juneau	Kenai	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta	Statewide
In Different Region Only	6%	6%	11%	7%	18%	29%	59%	6%	22%	24%	12%
Served in Both	9%	11%	13%	8%	18%	10%	11%	7%	12%	9%	11%
In Home Region Only	85%	83%	76%	86%	64%	62%	31%	86%	67%	67%	78%

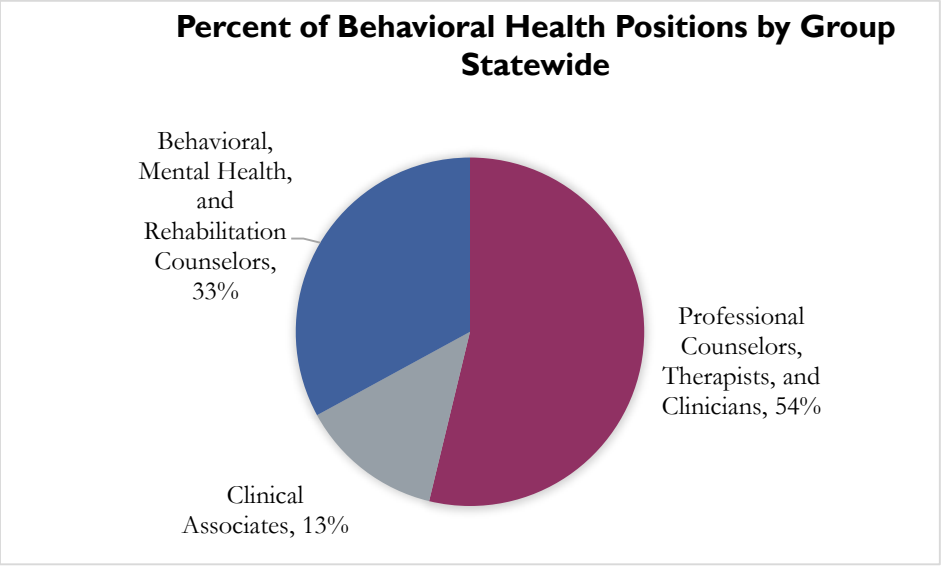
Alaska's Behavioral Health Workforce

In August 2014 the Alaska Center for Rural Health/Area Health Education Center within the University of Alaska Anchorage released the Alaska Workforce Vacancy Study, 2012 Findings Report.[23] This study was conducted to estimate health workforce vacancies in Alaska and contributes to our understanding of the behavioral health system and its potential workforce needs.

- According to the Alaska Workforce Vacancy Study (ES Figure 19), over half (54%) of Alaska's behavioral health workforce consists of professional counselors, therapists and clinicians, who are required to have an advanced degree and a clinical license to practice.
- A third (33%) of the behavioral health workforce is behavioral, mental health, and rehabilitative counselors, such as Behavioral Health Aides (BHA), Rehabilitation Counselors, Substance Use Disorder Counselors, and other behavioral health counselors. Rehabilitation counselors require a certificate from a training program.
- The remaining 13 percent consist of Behavioral Health Clinical Associates. Behavioral Health Clinical Associates have less than a master's degree (typically trained to the associate's or bachelor's level) in psychology, social work, counseling, or a related field with specialization or experience providing rehabilitation services to clients and may consist of a psychiatric or mental health nurse, baccalaureate social worker, and peer support specialists.
- Many behavioral health positions experience high vacancy rates. Vacancy rates tend to be markedly higher in rural regions. Notably, the estimated statewide vacancy rate for psychiatrists is 22 percent. Psychiatrists and physicians serve a critical role prescribing and overseeing treatment of individuals requiring medication-assisted therapies.

[23] Alaska Health Workforce Vacancy Study: 2012 Findings Report. Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska. Prepared by Katherine Branch, 2014. http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/upload/2012ak-hlth-workforce-vacancy-study_12-23-14_FINAL.pdf

ES Figure 19 Percent of Behavioral Health Positions by Group Statewide



Source: Alaska Health Workforce Vacancy Study

Statewide, Alaska's behavioral health system requires professional counselors, therapists, and clinicians (advance degreed professionals). Advanced degreed professionals conduct assessments, develop treatment plans, deliver clinical services, direct the delivery of treatment and recovery supports, like rehabilitation services, and respond to crises in the community. Strengthening the supervisory role of advanced degreed professionals is a key opportunity identified through the assessment for two reasons. First, many of the individuals interviewed for this project spoke about the ideal mix of clinic services to rehabilitation services. For individuals with serious mental health and substance abuse issues, all agreed the appropriate service mix was rehabilitation heavy/clinic light (rehabilitation services are contraindicated for mild behavioral health issues[24]). And yet, the service data we analyzed (presented in chapter 5) suggests we are not yet delivering services in these proportions.

Second, as part of the assessment, we conducted a world café with the Tribal behavioral health system's BHA workforce to understand what recommendations they had for improving system capacity. Participating BHAs called out the need for greater supervision if they are to begin delivering Medicaid billable services in their communities. Strengthening the supervisory function of advanced degree professionals can empower behavioral, mental health and rehabilitation counselors (non-degreed professionals) to deliver a greater proportion of the services provided today and expand providers' capacity to meet the needs of the clients they serve. Non-degreed professionals have many benefits, including requiring less formal education, lower salaries, being more likely to be recruited locally, and very often holding strong ties to the communities within which they live and work.

Actively pursuing ways to shifting the ratio so that behavioral health clinical associates and behavioral, mental health, rehabilitation counselors deliver a larger share of the direct services may be a potential way to expand system capacity for individuals with higher levels of behavioral health need. Doing so would increase the number of qualified staff able to bill for services, tap into the

[24] Discussion with reviewer Jerry Jenkins, Chief Executive Officer, Anchorage and Fairbanks Community Mental Health Services. 9/3/15.

additional Medicaid billing potential that exists within DBH's current Medicaid billing regulations, and redirect current usage patterns to lower levels of care. For expansion of services to individuals with mild and moderate behavioral health conditions, time-limited clinical services, which must be provided by licensed clinicians, will be essential.[25] Thus, it is important to note that the ideal workforce for a population with serious behavioral health needs could vary significantly from the ideal workforce for a population with mild to moderate behavioral health needs. Growth of the workforce in all professions will likely be necessary to meet demand, but this growth should be accompanied with a concerted effort to leverage non-degreed professionals in service delivery where appropriate and beneficial.

Medicaid Billing Models

Behavioral health services are reimbursed through a number of different Medicaid billing models and each Medicaid billing model requires a different level of professional to provide behavioral health services to clients. By design, the community behavioral health centers are currently the mainstay of the State-supported behavioral health system and exist to fulfill the State's statutory requirement to serve individuals with high levels of behavioral health need. Services delivered by community behavioral health centers help individuals with moderate to serious behavioral health needs stay in their communities and can be provided by a range of degreed and non-degreed professionals and in both office and community settings. In order to be eligible for services within a community behavioral health center, an individual must receive an assessment and meet a threshold of medical necessity to receive services. For individuals with serious behavioral health needs that meet this threshold, a wide range of clinic and rehabilitation services are available. To bill Medicaid, all services must be documented within the individual's treatment plan. Many behavioral health needs are episodic. For these individuals, clinic and rehabilitation services are complementary billable services that help individuals recover quickly from crisis and access the treatment, medication, and supports they need to live healthy and productive lives. Individuals with chronic behavioral health needs may require long-term clinic and rehabilitation services. These services are also billable and are often accompanied with annual caps to limit overuse.

For individuals with more serious behavioral health needs, rehabilitation services, in particular, are key to recovery and re-integration into the natural supports that exist within communities. Currently, service data suggests there may be additional need for rehabilitation services, which can be delivered by non-degreed professionals such as Substance Use Disorder Counselors and Behavioral Health Aides. Medicaid expansion, stronger connections with the Criminal Justice System, and efforts to improve access to Alaska's continuum of behavioral health care, particularly to lower level supports that can prevent crises from occurring, are all likely to increase demand for rehabilitation services, as well as other community-based behavioral health services.

Our analysis of Medicaid billing models outside of the community behavioral health billing model indicates that major barriers exist to billing for behavioral health services that impede provider efforts to integrate primary care and behavioral health care. In many settings that could serve individuals with mild and moderate mental illness and substance abuse disorders, the credentialing requirements for behavioral health professionals able to render services creates frequently insurmountable financial and workforce barriers. Such barriers significantly limit the health care system's capacity to meet the behavioral health needs of Alaskans and improve health outcomes. Indeed, the inability to bill for services makes achieving the goal of having two front doors, one

[25] Discussion with reviewer Jerry Jenkins, Chief Executive Officer, Anchorage and Fairbanks Community Mental Health Services. 9/3/15.

through the community behavioral health centers for individuals with a range of needs and one through primary care for individuals with mild and moderate needs, into behavioral health services impossible.

Given the significant need for substance use disorder and mild and moderate mental health services among Alaskans, it is imperative that health care systems leaders work to remove barriers to billing for behavioral health services and allow for a greater range of behavioral health professionals to bill for services outside of the community behavioral health system. It is also important to grow and retain a strong behavioral health workforce with a mix of position types that aligns with Alaskans' needs and the evidence base on how recovery works.

5. WHICH SERVICES DO CLIENTS USE?

Health, home, purpose, and community are central to recovery from mental and substance use disorders. These elements are defined below.

- Health: overcoming or managing one's disease(s) or symptoms — for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem — and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live.
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community: relationships and social networks that provide support, friendship, love, and hope.[26]

To prevent and treat behavioral health issues and to support individuals in recovery requires a comprehensive continuum of services. Which services do clients served with State Medicaid and behavioral health funds use and what does that tell us about the state-funded continuum of behavioral health care?

To answer these questions, we compare actual State Fiscal Year (SFY) 2013 service data (number of unique clients served by procedure type) to the services outlined in a model continuum of care produced by Substance Abuse and Mental Health Services Administration (SAMHSA) in a 2011 paper entitled: Description of a Good and Modern Addictions and Mental Health Service System.[27] Our analysis highlights gaps and areas of opportunity for expansion of services and increased Medicaid billing. We also review a range of data that help to identify and/or substantiate gaps in the State-funded continuum of care. We found that statewide gaps in the continuum of care perpetuate a cycle and culture of crisis response.

There are many services in the continuum for which our dataset is not the right source of data, but for behavioral health-specific services, this analysis produces some helpful information to system planners and providers alike. In reviewing this information, it is important to note that institutional

[26] Excerpt from the FY15-16 Draft Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Draft provided by DBH 6.22.15.

[27] Description of a good and modern addictions and mental health service system, 2011, http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

provider types serving clients with behavioral health diagnoses do not use procedure codes in the same way that professional provider types do; thus, there are many services provided that would not be captured in this dataset. The data included in the tables that follow largely reflect the services provided by professional provider types (with limited service data from the institutional provider types). Moreover, there is evidence that some agencies underreport their service encounter notes in the Alaska Automated Information Management System (AKAIMS) using, for example, program enrollment as a proxy. This means that the number of services documented is likely lower than the number provided. Thus, the analysis of unique client counts and percentage of clients receiving services must be reviewed with an eye toward higher level trends (for instance, looking at relative proportions of services) and identifying gaps and areas of opportunity for expansion of services and Medicaid billing.

Key findings:

Services Used

- About 33 percent of adults and 33 percent of youth served received the procedure code Office or Other Outpatient Visit for Evaluation and Management of Established Patient, which falls under the category of outpatient medical services. Nineteen percent of adults and 17 percent of youth served received Pharmacologic Management. This data underscores the important role of the medical profession in meeting the needs of behavioral health clients.
- Psychotherapy was the most common (post-assessment) behavioral health service in 2013. Twenty-three percent of adults and 31 percent of youth served received psychotherapy; 16 percent of adults and 16 percent of youth served received individual psychotherapy in 30-minute sessions while 10 percent of adults and 10 percent of youth served received individual psychotherapy in 60-minute sessions. In contrast, 17 percent of youth received group psychotherapy compared to seven percent of adults. These percentages are based on unique counts by procedure type so they cannot be summed, but the trend suggests a proclivity within the system towards individual counseling. DBH and evidence based practices encourage use of group sessions both to enhance treatment and recovery efforts and increase access to services.[28] Group services have the added benefit of reducing the impact of No Shows and have greater revenue potential. Expanding group psychotherapy offerings as a routine course of treatment is one strategy that could increase system capacity.
- Community Comprehensive Support Services (CCSS) and Therapeutic Behavioral Health Services (TBHS) are rehabilitation services that can be delivered in any community setting. About 19 percent of adults served received CCSS individual services whereas just five percent received CCSS group services. About 24 percent of youth served received TBHS individual services and 20 percent of youth served received TBHS group services. Only three percent of youth served received TBHS family services with the patient present and two percent received TBHS family services without the patient present. Here again, group and family services present a potential opportunity for expanding system capacity and improving behavioral health outcomes in communities.

[28] Discussion with Mark-Haines Simeon, former Division of Behavioral Health Director of Policy and Planning, fall 2014. For further reading into the benefits of group therapy, see: Brief Interventions and Brief Therapies: Time-Limited Group Therapy. SAMSHA Treatment Improvement Protocols. 1999. http://www.ncbi.nlm.nih.gov/books/NBK64936/

- Providers served 84 unique adult clients and 11 unique youth clients (less than 1%) with peer support services and billed Medicaid[29] or documented the procedure in AKAIMS. We know from interviews and discussions with the Tribal Behavioral Health Directors that Peer Support services are routinely provided by Behavioral Health Aide's (BHA's) across the state. Likewise, peer-run organizations provide peer support services throughout the state and do not bill Medicaid for this service or document the procedure in AKAIMS. Peer-run organizations receive other grant funding to provide this service in communities.

Gaps in the Continuum of Care

Statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, step down/after care services) combined with gaps in insurance coverage perpetuate a cycle and culture of crisis response. One clinician referred to this cycle as the revolving door: the client is sent out of the region, returns home to an unsupportive environment and the option of once or twice weekly services, relapse inevitably occurs, and the cycle starts again.

DBH produces a daily census count of bed availability within all inpatient psychiatric hospitals, including Fairbanks Memorial Hospital Mental Health (MH) and Bartlett Regional Hospital MH (Designated Evaluation and Treatment) Units, the Providence Psychiatric Emergency Room, the Providence Crisis Recovery Center, North Star Behavioral Health, and Alaska Psychiatric Institute (API) and distributes via email. This daily census report includes a chart comparing a monthly snapshot of the API midnight census to the same time during the prior year (ES Figure 20).[30] This chart highlights the heavy demands placed on API and other inpatient psychiatric services in the state.

A major challenge facing the behavioral health system is how to treat individuals before crisis occurs and how to help individuals stop the cycle of crisis once it begins. Based on ASAM levels of care, SAMHSA's ideal continuum of behavioral health care, community health outcomes, utilization data, procedure data, and stakeholder interviews, it appears that the system as a whole is serving many clients too late, leading to increased demand for crisis and acute services and corresponding shortages. The data amassed and interviews conducted throughout this assessment indicate a need for more upstream services, from Early Intervention and Engagement to Intensive Outpatient Services.

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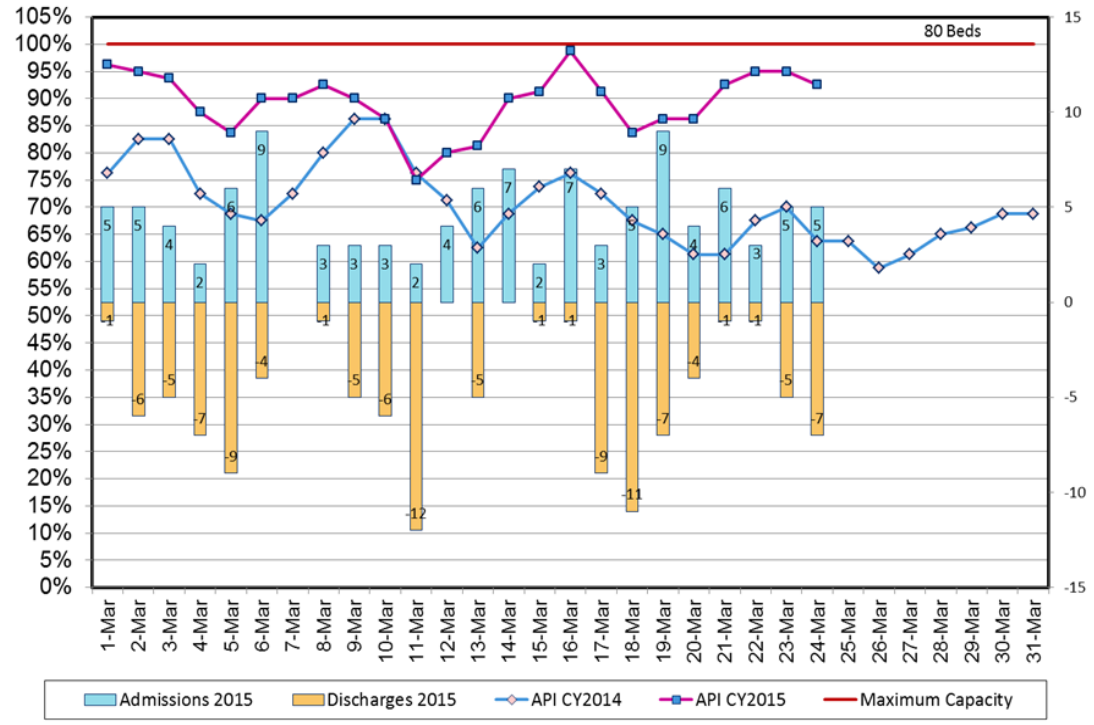
[29] In order to bill Medicaid for peer support services, Alaska regulation 7 AAC 135.210 (c) specifies: "(c) Subject to the limitation in 7 AAC 135.040, peer support services may only be offered in combination with (1) individual therapeutic behavioral health services for children under 7 AAC 135.220; (2) family therapeutic behavioral health services for children under 7 AAC 135.220; or (3) individual comprehensive community support services under 7 AAC 135.200. (Eff. 10/1/2011, Register 199). In addition, peer support services must be delivered by individuals with lived, personal experience with behavioral health issues, including mental illness or addiction.

[30] The DBH Comprehensive Daily Census Report (CDRC), including Fairbanks Memorial Hospital MH and Bartlett Regional Hospital MH (DET) Units, the Providence Psychiatric Emergency Room, the Providence Crisis Recovery Center, North Star Behavioral Health, and the Alaska Psychiatric Institute. This figure is from the census report dated March 25, 2015.

ES Figure 20 API Midnight Census as a Percentage of Total Occupancy – A One Month Comparison



Untapped Medicaid Billing Potential

Many billable services appear to be underutilized, including group services, family services, peer support services, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. This assessment has led us to conclude that there is significant untapped Medicaid billing potential among providers, especially if clinical associate and rehabilitative support staff can be tapped to offer the array of recovery and rehabilitative services currently allowable under the Community Behavioral Health System (CBHS) billing regulations.

Medicaid is not an easy revenue stream to leverage. Tapping this potential will require strong commitment at all levels of the system, technical assistance, ongoing staff training, supervision and mentorship, dedicated behavioral health Medicaid billing specialists, and ideally, the rollout of the Medicaid billing module in AKAIMS.[31] Additionally, for non-Tribal providers, a fair rate schedule and payment structure that adequately compensates for care is needed to incentivize care at the right levels and reduce reliance on grant funding.

[31] DBH leadership has expressed general concern about conflicts of interest that may exist with supporting a billing module and specifically about the rolling out a billing module for AKAIMS until the State's Medicaid Management Information System is free from issues that could potentially expose the division to financial liability if provider claims were incorrectly processed and/or paid. Conversation with Shaun Wilhelm, Chief of Risk and Research Management, Spring 2015.

6. ARE STATE FUNDED BEHAVIORAL HEALTH SERVICES EFFECTIVE?

Key Findings

System Governance

A robust system governance and performance management framework exists to guide the priorities and assess the performance of the community behavioral health system. A key part of that framework, the comprehensive integrated mental health plan has not been updated since the 2006-2011 plan Moving Forward expired. A new comprehensive integrated mental health plan is needed to guide the system through this tremendous period of change and to expand capacity in the areas that need it most.

Population Level Outcomes

Population level outcomes are perhaps the ultimate proxy of the how well the State-funded continuum of care is meeting the behavioral health needs of Alaskans. According to the 2013 Alaska Scorecard, health status is declining or uncertain in eight of the nine behavioral health indicators included. These indicators look at suicide, substance abuse, mental health, and health insurance access. The status of days of poor mental health in the past month (among adults) receives a green check mark for satisfactory. Of the 13 behavioral health-related indicators in Healthy Alaskans 2020 leading health indicators status report, the state has met five of its Healthy Alaskans goals already, is on track to meet two more of its Healthy Alaskans goals by 2020, and is not on track to meet its goal for five of the indicators by 2020. At the population level, more work remains.

Performance-Based Funding

For DBH Treatment and Recovery grantees, legislative mandates in 2007 set in place a series of performance-based funding processes.[32] The DBH performance management system uses the Results Based Accountability framework to answer three questions: How much do we do? How well do we do it? Is anybody better off? A performance-based Treatment and Recovery funding report with systems and provider-level report cards is produced annually and is available online.[33]

- In FY15, 42 of 69 grantees (61 percent) experienced increased funding as a result.[34] The minimum change was $75, the maximum change was $42,632 and the average change was just under $5,000.
- Thirty-seven of 69 grantees (39 percent) experienced decreased funding as a result. The minimum change was (-$11), the maximum change was (-$48,948) and the average change was just (-$7,735).

[32] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

[33] Results for each fiscal year are available for download here: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

[34] FY2015 Treatment and Recovery Performance-Based Funding Summary. Final. June 27, 2015. Alaska Division of Behavioral Health Services. Available at: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

Client Level Outcomes

According to a 2014 analysis by the Western Interstate Commission on Higher Education (WICHE) on the validity of DBH's performance outcomes,[35] meaningful, positive change was found amongst adult mental health clients in all categories measured including: mentally unhealthy days, quality of life, use of alcohol and drugs, physically unhealthy days, activity limitation days, legal involvement, arrest past 30 days, and arrest past 12 months.

Additionally, adult clients who were in treatment for mental health who were discharged reported a decrease in mentally unhealthy days of 9.7 days at four months, 10.1 days at eight months, and 11.3 days at twelve months (for those who stayed in treatment long enough to report at those intervals). This analysis relied on client data from State Fiscal Years 2011 to 2013.

While more work needs to be done, the available evidence suggests DBH-funded Treatment and Recovery grantees are providing services that improve the lives of clients when clients engage in services. Increasing access to services is essential.

7. HOW MUCH DOES IT COST IN STATE MEDICAID AND BEHAVIORAL HEALTH FUNDS TO PROVIDE BEHAVIORAL HEALTH SERVICES?

Key Findings

One of the many strengths of Alaska's behavioral health system is the way in which service organizations leverage State Medicaid and Behavioral Health funds with multiple other funding streams to provide behavioral health services to a broad range of clients. Behavioral health services are funded through State general funds, the Alaska Mental Health Trust Authority, as well as a number of federal entities that award funds to the State of Alaska or to Tribal Health Organizations to manage and distribute. Ten major funding streams support Alaska's state-funded behavioral health system. Our analysis explores in detail the cost of state-funded behavioral health services by provider type and region, specifically State Medicaid payments for behavioral health services and DBH Treatment and Recovery grants.

A strong behavioral health system that is capable of tapping its full Medicaid billing potential is essential to meeting existing and anticipated demand for behavioral health services enabled by Medicaid expansion, increased private insurance coverage through the individual exchange, efforts for mental health parity, and Patient-Centered Medical Home and coordinated care initiatives. It is also critical to improving the health of Alaskans and reducing health care costs overall.

State Medicaid Payments for Behavioral Health Services

- In State Fiscal Year 2013, the State of Alaska issued a total of $197,034,641 in State Medicaid payments for behavioral health services (not including Tribal settlement dollars, which represent the monetary difference between fee for service payments and Tribal encounter rate payments due). DBH uses 50 percent FMAP to estimate the breakdown of State General Funds and federal funds for all non-Tribal service settings and 100 percent FMAP

[35] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

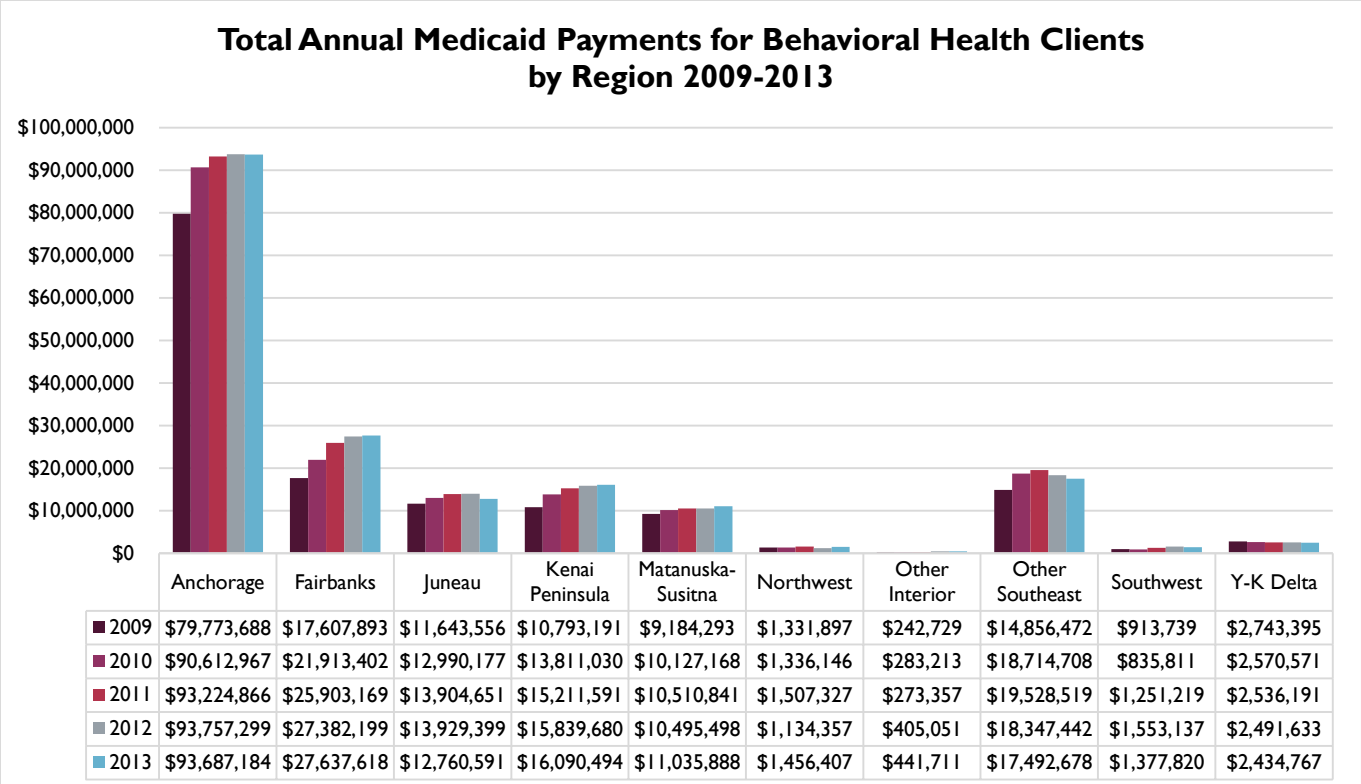
for Tribal service settings.[36] Using DBH's FMAP allocations for FY13, we estimate that $92,253,210 or 47 percent of the $197,034,641 total Medicaid dollars spent were paid for by State General Funds.

- In State Fiscal Year 2013, payments to DBH Treatment and Recovery grantees, including Residential Care for Children and Youth totaled $106,340,860 or 54 percent of the total payments made.
- The statewide average annual Medicaid payments per behavioral health client was $7,239 in State Fiscal Year 2013. The Residential Psychiatric Treatment Center (RPTC) provider type marks the highest average payment per client at $56,768. In State Fiscal Year 2013, the average annual payment per Medicaid client served by DBH Treatment and Recovery grantees, including Residential Care for Children and Youth, was $10,379. The average payment per Medicaid client served at API was $11,118. Note that Medicaid payments do not necessarily equate to cost of care. For example, DBH estimated the average annual cost per client at $24,831 in FY14. This figure takes into account all payers: Medicaid, Medicare, self-pay, third party and State general funds.[37]
- Trends in total annual Medicaid payments by region are illuminating (ES Figure 21) and point to areas where Medicaid billing capacity may be lagging. Nearly half (47.5 percent) of all Medicaid payments in 2013 were made for services rendered in Anchorage. Other Interior, Southwest, Northwest, and the Y-K Delta reporting regions have the lowest levels of Medicaid billing. While this trend corresponds with smaller population sizes, we also see the lowest per capita Medicaid payments in these regions (ES Figure 22).

[36] The 100 percent FMAP is used for modeling even though not all Medicaid enrollees served by Tribal Health Organizations are Alaska Native and, thus, eligible for the 100 percent match. Referenced from SY09-SFY14 Lollipop Charts Data Sheets 1-29-15 v5, provided by DBH on 7/1/15. DBH roll-up estimate for the FMAP percentage breakdown for DBHTR grantee Medicaid payments was 53.5%. We applied this percentage to the DBHTR provider type to produce the estimate of general to federal dollars included in this paragraph.

[37] Referenced from SY09-SFY14 Lollipop Charts Data Sheets 1-29-15 v5, provided by DBH on 7/1/15.

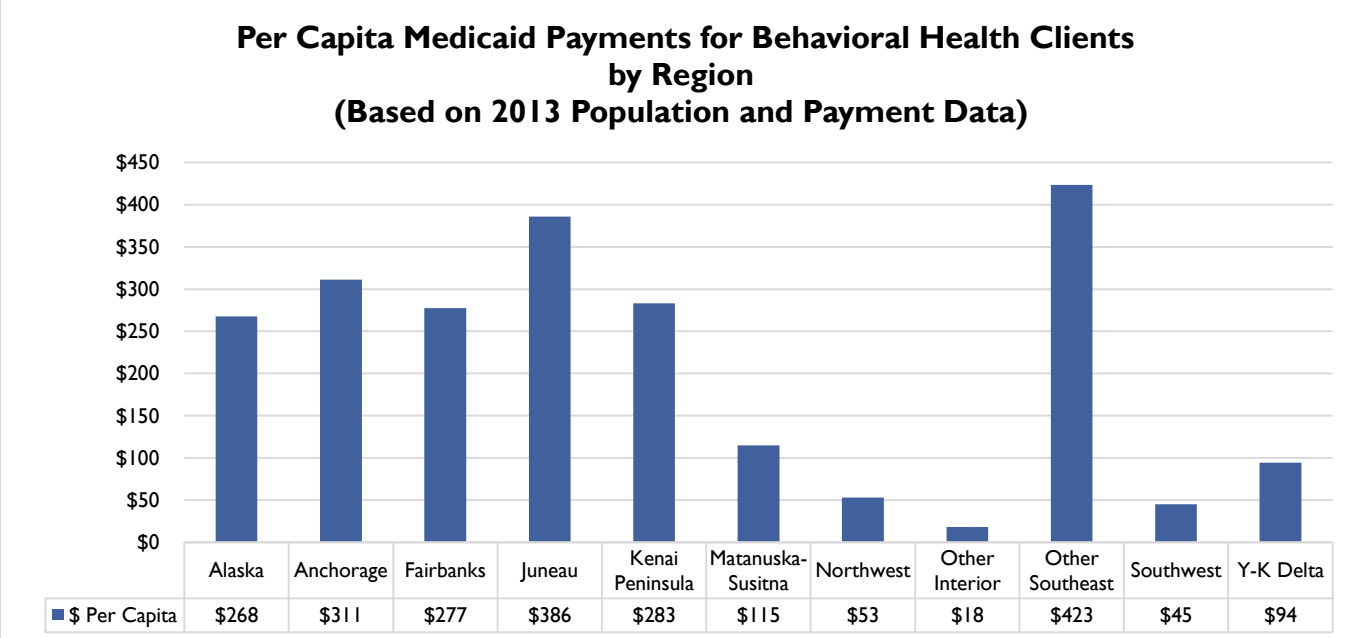
ES Figure 21 Total Annual Medicaid Payments for Behavioral Health Clients by Region 2009-2013



	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
2009	$79,773,688	$17,607,893	$11,643,556	$10,793,191	$9,184,293	$1,331,897	$242,729	$14,856,472	$913,739	$2,743,395
2010	$90,612,967	$21,913,402	$12,990,177	$13,811,030	$10,127,168	$1,336,146	$283,213	$18,714,708	$835,811	$2,570,571
2011	$93,224,866	$25,903,169	$13,904,651	$15,211,591	$10,510,841	$1,507,327	$273,357	$19,528,519	$1,251,219	$2,536,191
2012	$93,757,299	$27,382,199	$13,929,399	$15,839,680	$10,495,498	$1,134,357	$405,051	$18,347,442	$1,553,137	$2,491,633
2013	$93,687,184	$27,637,618	$12,760,591	$16,090,494	$11,035,888	$1,456,407	$441,711	$17,492,678	$1,377,820	$2,434,767

Note: In order to gauge regional provider capacity, Medicaid Payments are based on service location not the client's home community.

ES Figure 22 Per Capita Medicaid Payments for Behavioral Health Clients by Region

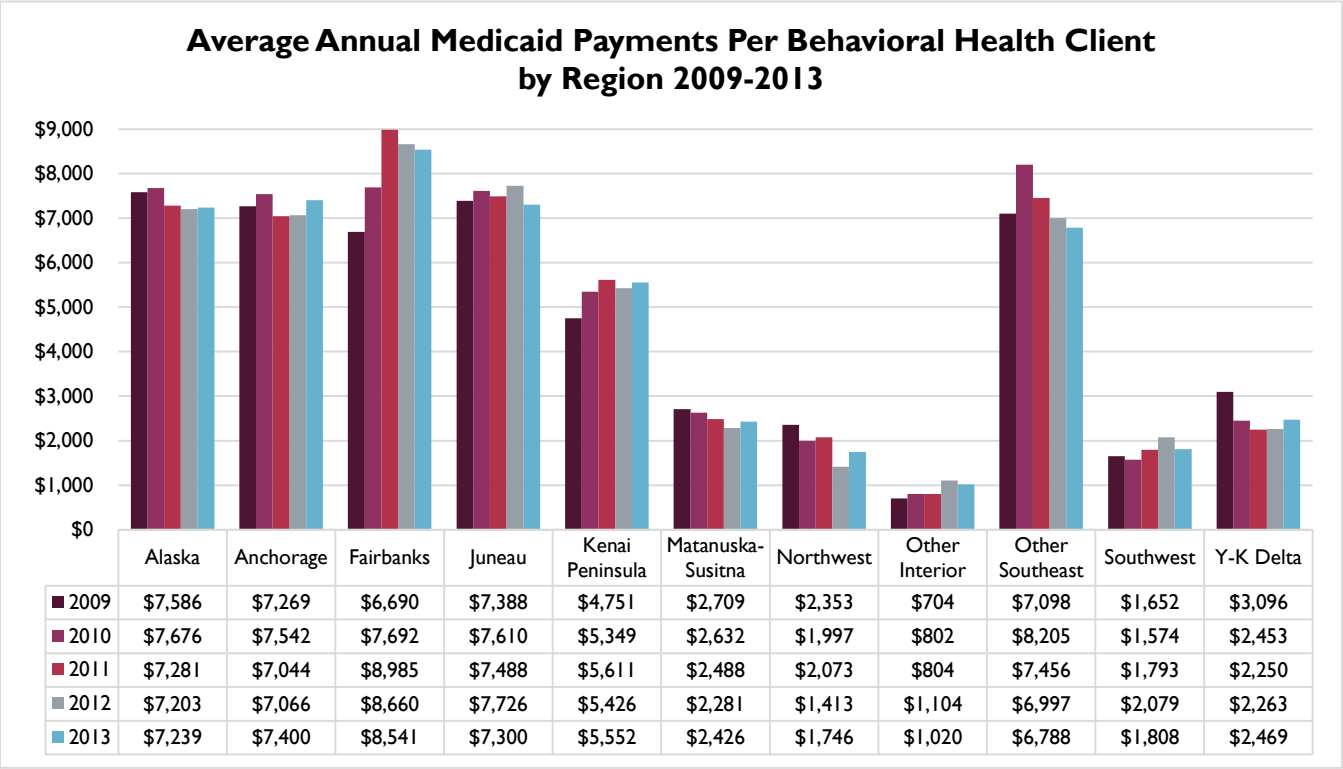


	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
$ Per Capita	$268	$311	$277	$386	$283	$115	$53	$18	$423	$45	$94

Note: In order to gauge regional provider capacity, Medicaid Payments are based on service location not the client's home community.

- In ES Figure 23, we see that the statewide average annual Medicaid payments per behavioral health client was $7,239 in State Fiscal Year 2013. Among the reporting regions, Other Interior, Northwest, Southwest, Y-K Delta, and Mat-Su Borough have the lowest average annual Medicaid payments per behavioral health client.

ES Figure 23 Average Annual Medicaid Payments per Behavioral Health Client by Region 2009-2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
2009	$7,586	$7,269	$6,690	$7,388	$4,751	$2,709	$2,353	$704	$7,098	$1,652	$3,096
2010	$7,676	$7,542	$7,692	$7,610	$5,349	$2,632	$1,997	$802	$8,205	$1,574	$2,453
2011	$7,281	$7,044	$8,985	$7,488	$5,611	$2,488	$2,073	$804	$7,456	$1,793	$2,250
2012	$7,203	$7,066	$8,660	$7,726	$5,426	$2,281	$1,413	$1,104	$6,997	$2,079	$2,263
2013	$7,239	$7,400	$8,541	$7,300	$5,552	$2,426	$1,746	$1,020	$6,788	$1,808	$2,469

Note: In order to gauge regional provider capacity, Medicaid Payments are based on service location not the client's home community.

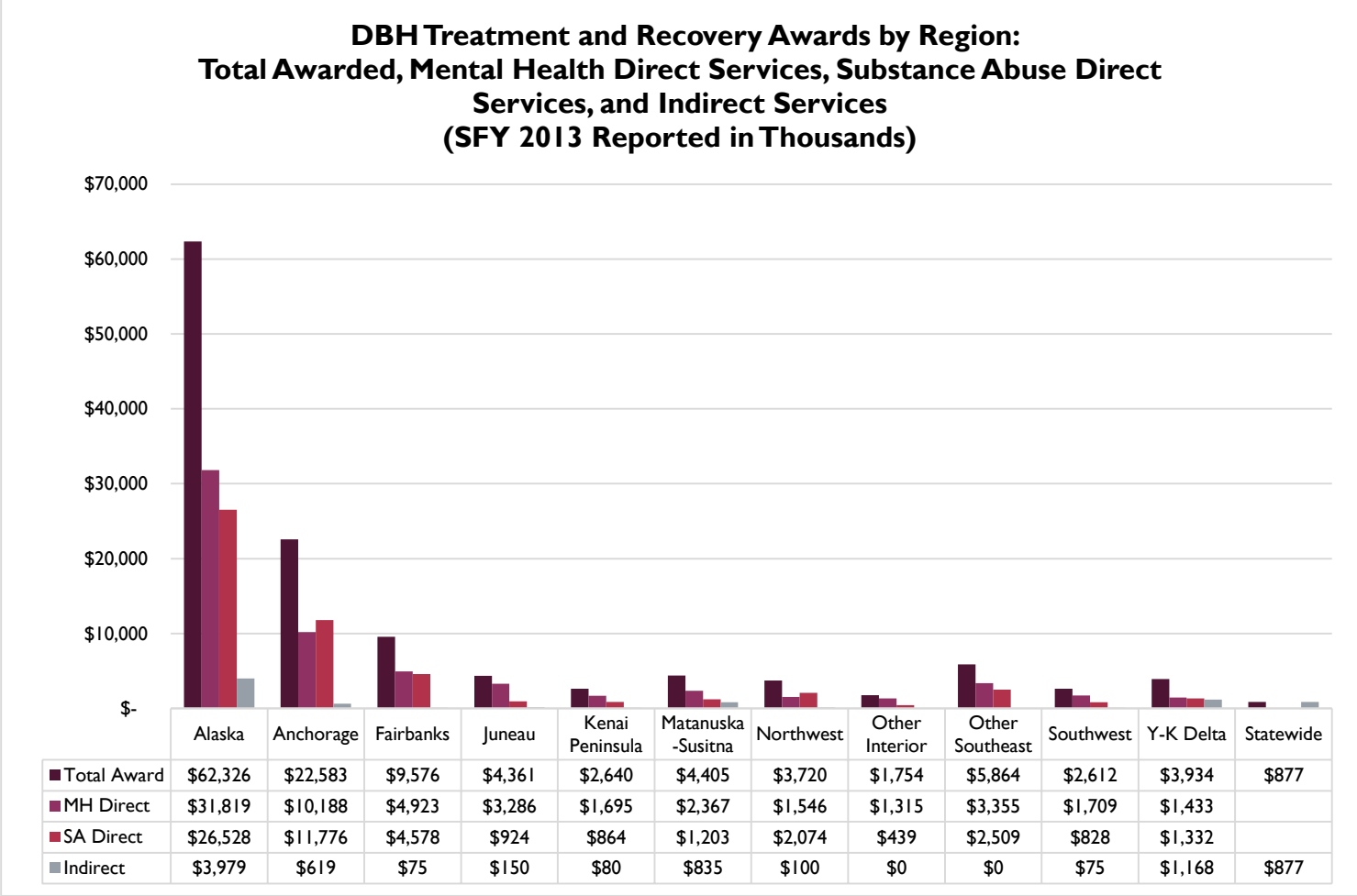
DBH Treatment and Recovery Grant Awards

- In State Fiscal Year 2013, the State of Alaska awarded a total of $62,325,826 in Treatment and Recovery Grants across the state.[38] This figure represents about a quarter (24 percent of $259,078,267) of the combined total State Medicaid and Treatment and Recovery Behavioral Health Grant funds in State Fiscal Year 2013. The revenue sources for these awards are split across three broad categories: State General Funds, federal funds, and other funds.

- ES Figure 24 shows the distribution of total DBH grant awards across the reporting regions, mental health direct services and substance abuse direct services, and indirect services (in thousands). Direct services include funds that went to direct services that clients received when enrolled in a program or during the pre-admissions process. Indirect services include services provided outside of screening, assessment, and treatment and rehabilitation services. Examples include provider training, sleep off centers, and referral services.

38 All data for this analysis provided by Division of Behavioral Health 7/2/15 and based on Excel file: All FY13 T R Grants 11-21-13.

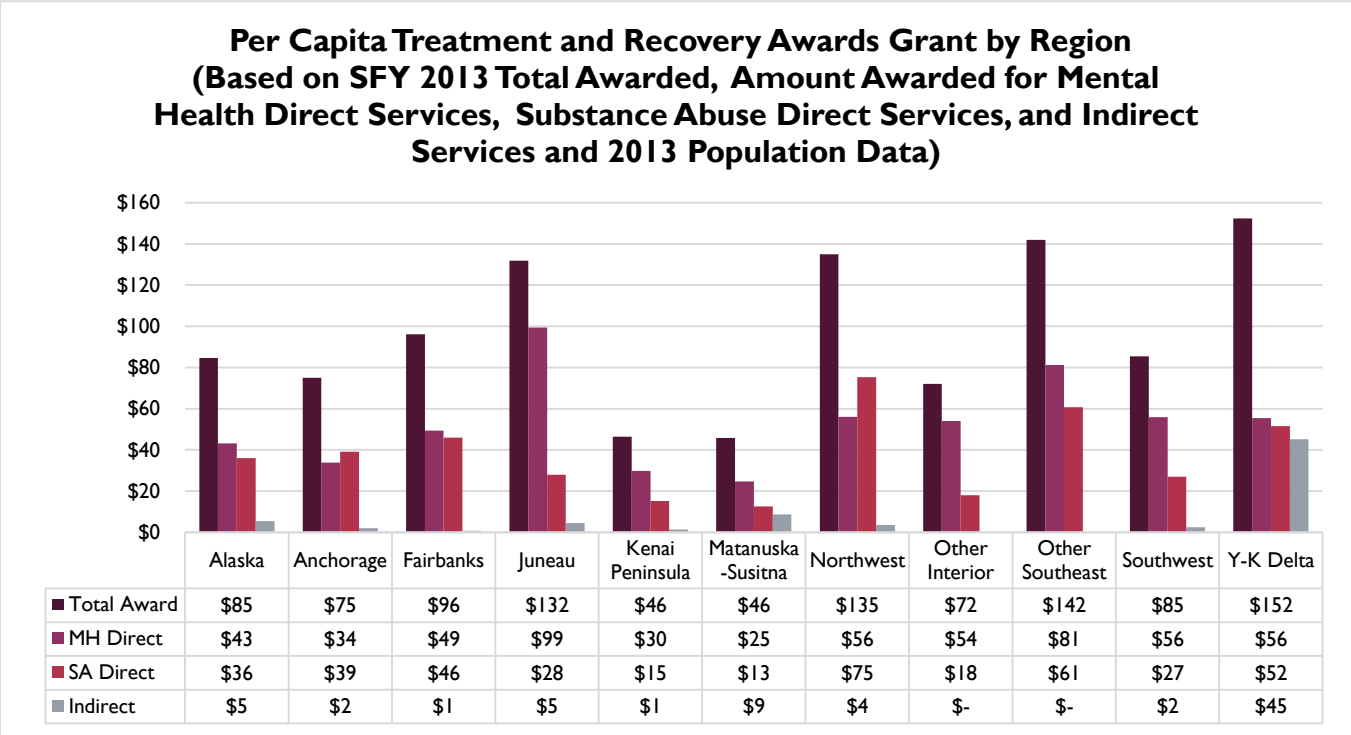
ES Figure 24 DBH Treatment and Recovery Awards by Region SFY2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta	Statewide
Total Award	$62,326	$22,583	$9,576	$4,361	$2,640	$4,405	$3,720	$1,754	$5,864	$2,612	$3,934	$877
MH Direct	$31,819	$10,188	$4,923	$3,286	$1,695	$2,367	$1,546	$1,315	$3,355	$1,709	$1,433	
SA Direct	$26,528	$11,776	$4,578	$924	$864	$1,203	$2,074	$439	$2,509	$828	$1,332	
Indirect	$3,979	$619	$75	$150	$80	$835	$100	$0	$0	$75	$1,168	$877

- ES Figure 25 shows the total average DBH Treatment and Recovery grant allocations per capita across reporting regions, as well as for mental health direct services and substance abuse direct services. The total average grant allocation per capita for all Alaska residents was $85 in State Fiscal Year 2013. The total average treatment and recovery grant allocation per capita within the regions ranged from $46 per capita in the Kenai Peninsula and Mat-Su Borough reporting regions to $152 per capita in the Y-K Delta reporting region.
- The average grant allocation per capita for mental health direct services for all Alaska residents was $43 in State Fiscal Year 2013. The average grant allocation per capita for mental health direct services within the regions ranged from $25 per capita in Mat-Su Borough reporting region to $99 per capita in the Juneau reporting region.
- The average grant allocation per capita for substance abuse direct services for all Alaska residents was $36 in State Fiscal Year 2013. The average grant allocation per capita for substance abuse direct services within the regions ranged from $13 per capita in Mat-Su Borough reporting region to $75 per capita in the Northwest reporting region.

ES Figure 25 Per Capita Treatment and Recovery Awards Grant by Region SYF2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
Total Award	$85	$75	$96	$132	$46	$46	$135	$72	$142	$85	$152
MH Direct	$43	$34	$49	$99	$30	$25	$56	$54	$81	$56	$56
SA Direct	$36	$39	$46	$28	$15	$13	$75	$18	$61	$27	$52
Indirect	$5	$2	$1	$5	$1	$9	$4	$-	$-	$2	$45

- In State Fiscal Year 2013, DBH allocated $31,819,179 to direct mental health services; this presents 51 percent of the total grant awards made that year. Thirty-nine percent of mental health direct service grant awards were allocated to services for individuals with Serious Mental Illness, 35 percent to Serious Emotional Disturbance services, 20 percent to Psychiatric Emergency Services, and six percent to Other Mental Health.
- In State Fiscal Year 2013, DBH allocated $26,527,902 to direct substance abuse services; this represents 43 percent of the total grants awarded. Thirty-six percent of direct substance abuse services grant awards were allocated to adult residential services, 33 percent to adult outpatient services, 13 percent to detox services, five percent to youth residential services, five percent to other direct services, four percent to outpatient youth, and four percent to opioid treatment services.

This level of funding supports approximately 29 state-funded detoxification and 308 State-funded substance abuse beds across the state.

8. HOW DO CURRENT UTILIZATION TRENDS COMPARE WITH THE BEHAVIORAL HEALTH NEEDS OF ALASKANS?

One of the goals of this assessment is to better understand utilization trends and the extent to which the current system meets the behavioral health needs of Alaskans. Chapter 2 identifies the prevalence of behavioral health issues, which we use in this section to indicate a potential need for behavioral health services. For planning purposes, it is important to note that *Need* for services is not the same as *Demand* for services, because not all individuals who have behavioral health conditions seek or wish to receive treatment. Demand for services might stem from a variety of sources:

- Medicaid Expansion – Increase in the number of insured individuals;
- Increased Screening in Primary Care Settings – Additional screening and partnerships within/with primary care providers could increase client referrals to DBH Treatment and Recovery grantees, especially if client data sharing becomes standard practice;
- Integration of Behavioral Health Services into Primary Care – If barriers to billing are removed, more behavioral health professionals will likely be hired to deliver behavioral health services to clients in the primary care settings;
- Medicaid Payment Reform – Greater emphasis on paying for value could increase demand for behavioral health services;
- The Criminal Justice System – Including court referrals and referrals at discharge (as well as pathways for family members and victims to receive services);
- Office of Children's Services – Children and families in state custody or at risk of being taken into custody;

Exploring areas of potential demand for behavioral health services and establishing clear pathways and business models to meet that demand is an important area for future focus by systems leaders and regional health planners.

In assessing potential areas of unmet need and analyzing service patterns, we must also remember the limitations of the current dataset. This assessment analyzed prevalence data for all adults and utilization data for individuals served by API, DBH Treatment and Recovery grantees, and/or Alaska Medicaid. It does not include data on individuals who received behavioral health services paid for by commercial insurance, other third party payers, or self pay. That kind of analysis will likely require the implementation of an all payers claims database.

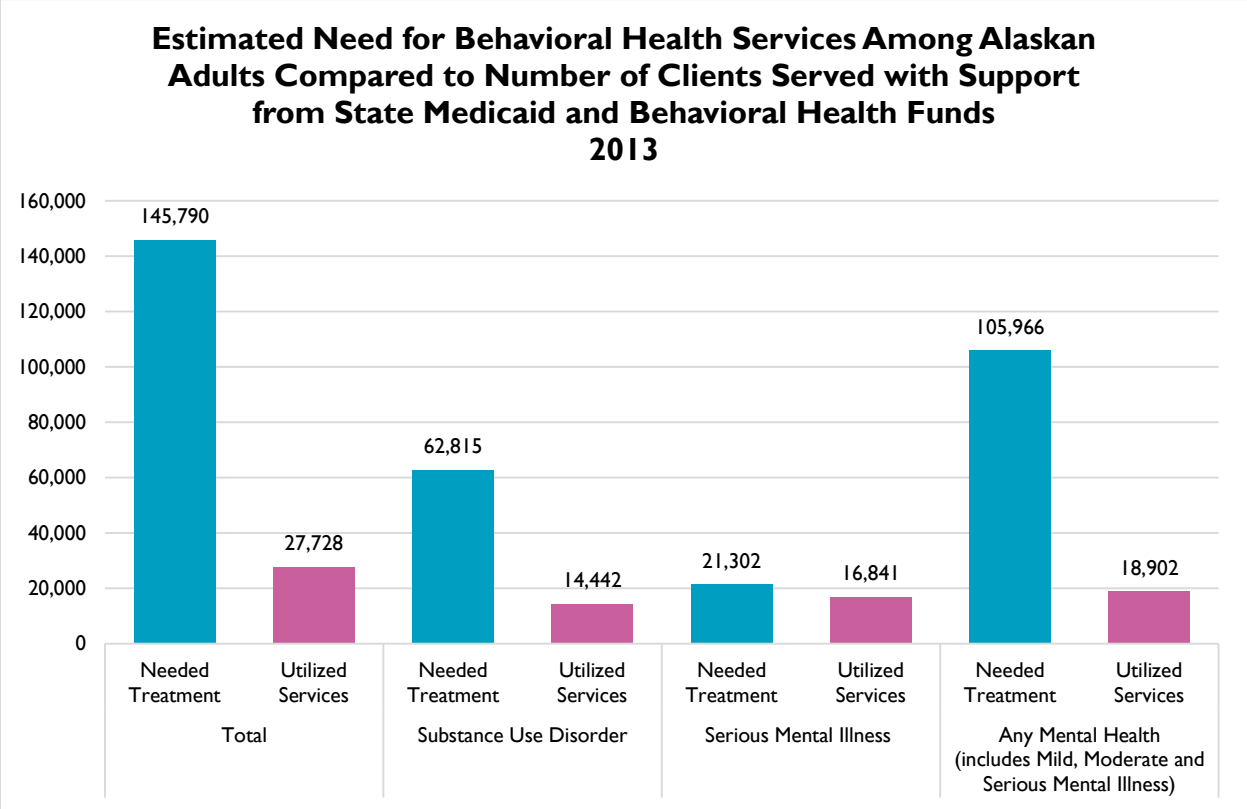
It is also important to note that these counts of clients served represent just that. Understanding how clients are served and how they might be better served is the subject of Chapter 5 and, hopefully, many future discussions at the state and regional levels. That said, comparing prevalence and utilization data highlights the potential need for increased services across populations, as well as within certain regions and begins to paint a more nuanced picture of what increasing system capacity means. Indeed, the goal of increasing system capacity starts to take on two meanings: first, how to optimize service patterns among existing clients, who tend to have higher levels of behavioral health needs, and, second, how to open access to services for clients with mild and moderate mental health issues or individuals with SUD before their needs escalate.

Key Findings

Comparison of Need and Numbers Served Statewide

- In 2013, an estimated 145,790 Alaska adults needed behavioral health services (ES Figure 26). Estimated need is calculated by applying NSDUH prevalence rates for a substance use disorder or mental health issue in the past year to DOL 2013 population estimates. In comparison, 27,728 clients were served with support from State Medicaid and/or behavioral health funds. Many of these individuals may, in fact, be receiving services through other payer sources, while others are truly falling into a gap of unmet need.

ES Figure 26 Estimated Need for Behavioral Health Services Among Alaska Adults Compared to Number of Clients Served with Support from State Medicaid and Behavioral Health Funds 2013



- Across all diagnosis categories, Alaska adults received services paid for with support from State Medicaid or behavioral health funds at a rate of 51 clients per 1,000 adults in 2013. This rate varies by region with a high of 98 clients per 1,000 adults in the Other Southeast reporting region to a low of 36 clients per 1,000 adults in the Other Interior reporting region.
- The smallest gap between estimated need (21,302 adults) and numbers served (16,481 clients) is seen for individuals with an SMI diagnosis. However, as described previously, our methodology for classifying individuals does not align perfectly with prevalence methodology and, thus, some SMI clients served may, in fact, have a level of functioning more akin to moderate mental illness. Statewide, the rate of service to clients with mild, moderate and serious mental illnesses (labeled Any Mental Illness) was 35 per 1,000 adults in

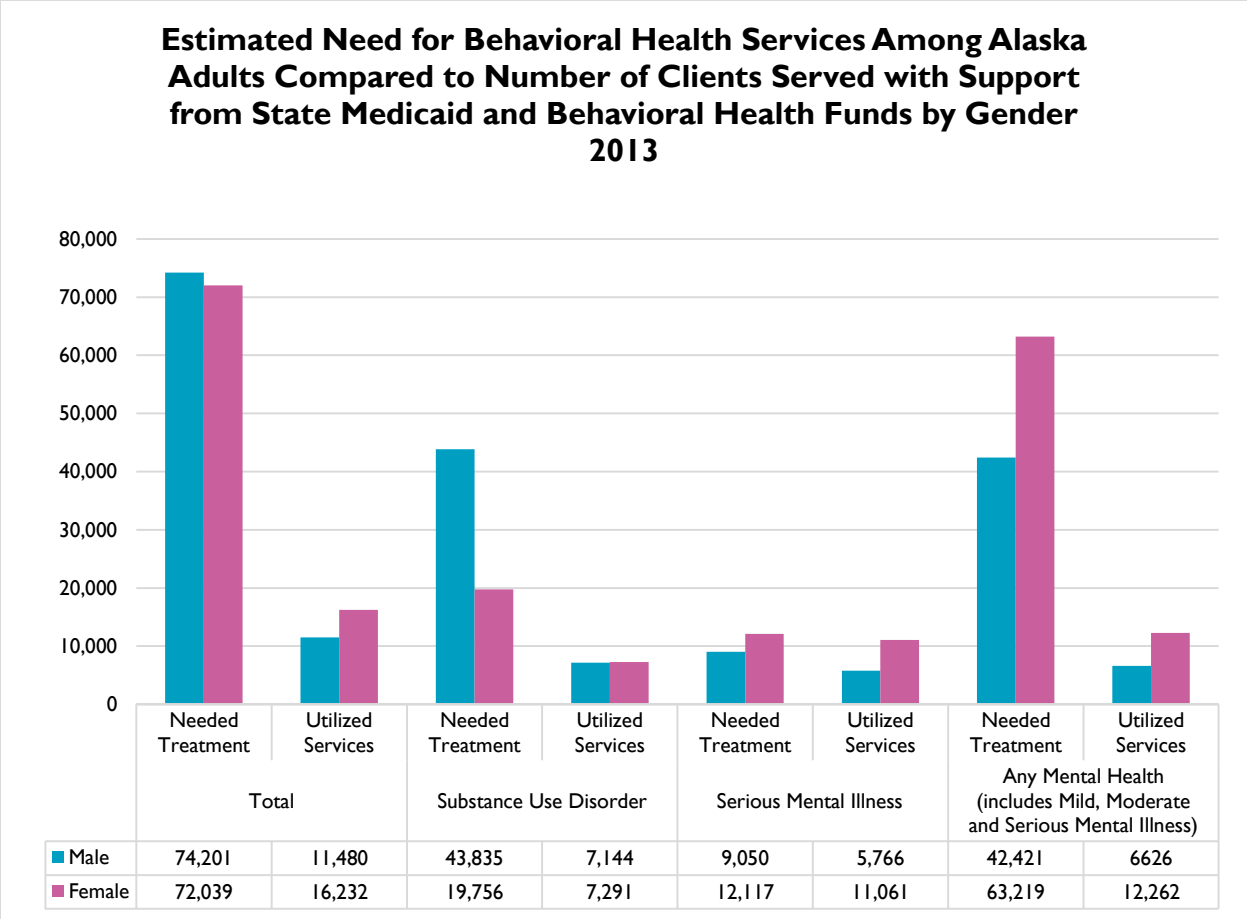
2013. This rate is just slightly higher than that of clients served with serious mental illness alone (31 clients per 1,000).

- The largest gap between estimated need (105,966 adults) and numbers served (18,902 clients) is seen in the Any Mental Health category, which includes Mild, Moderate, and Serious Mental Illness. This gap points to a potential for significant unmet need among low-income, uninsured individuals with moderate and mild mental illness.
- The gap between estimated need (62,815 adults) and numbers served with support from State Medicaid and behavioral health funds (14,442 clients) for SUD is also large. Alaska adults with SUD diagnoses received services paid for with support from State Medicaid or behavioral health funds at a rate of 26 clients per 1,000 adults in 2013. This rate varies by region with highs of 55 clients, 51 clients, and 47 clients per 1,000 adults in the Other Southeast, Juneau, and Northwest reporting regions.

Comparison of Need and Numbers Served Among Adult Males and Adult Females

- Across all diagnosis categories, Alaska adult males received services paid for with support from State Medicaid or behavioral health funds at a rate of 41 clients per 1,000 male adults in 2013 while adult females received services at a rate of 62 per 1,000 female adults (ES Figure 27).

ES Figure 27 Estimated Need for Behavioral Health Services Among Alaska Adults Compared to Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Gender 2013



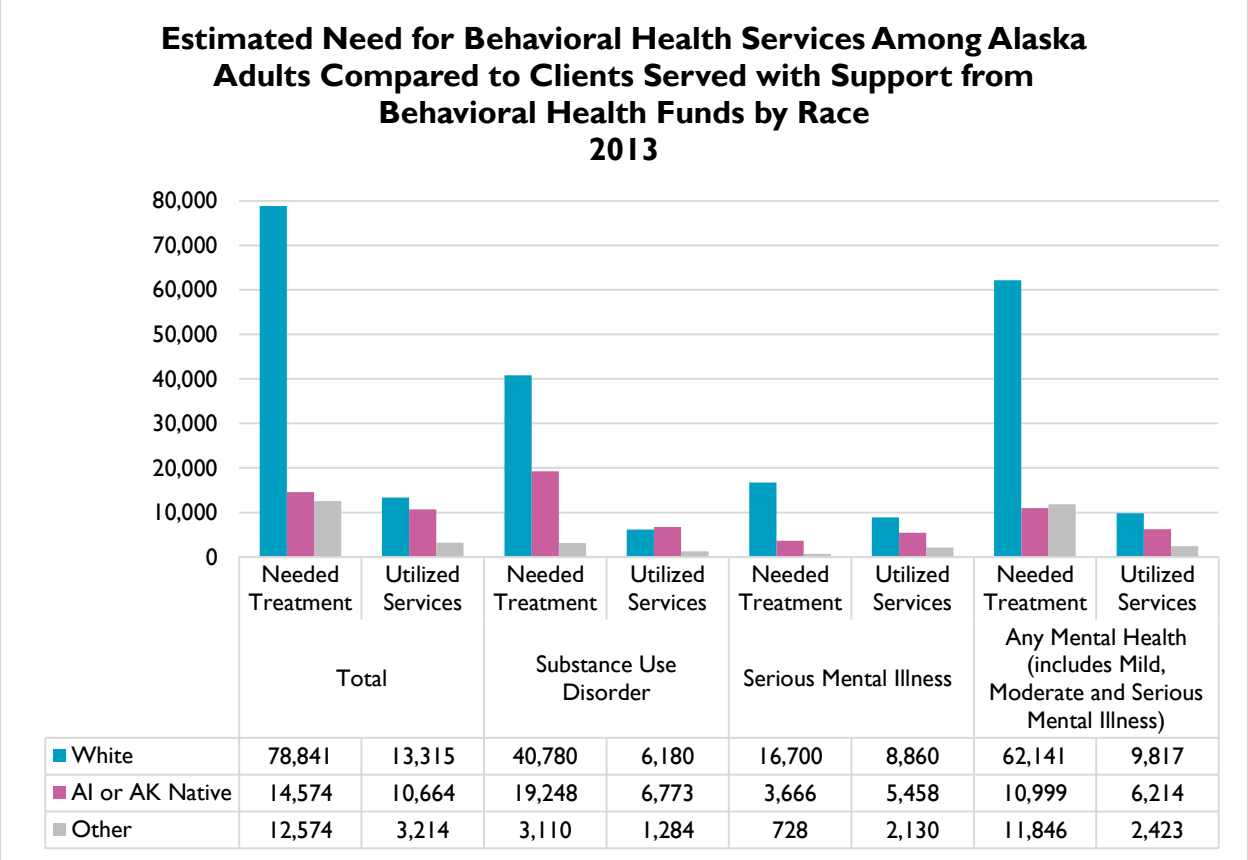
	Total		Substance Use Disorder		Serious Mental Illness		Any Mental Health (includes Mild, Moderate and Serious Mental Illness)	
	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services
Male	74,201	11,480	43,835	7,144	9,050	5,766	42,421	6626
Female	72,039	16,232	19,756	7,291	12,117	11,061	63,219	12,262

- An estimated 43,835 males (15.5 percent) needed treatment for illicit drug or alcohol use in 2013 compared to 19,756 females (7.5 percent) and, yet, about the same number of males (7,144) and females (7,291) were served for SUD with support from State Medicaid and behavioral health funds in 2013. This is likely reflective of Medicaid eligibility and program priorities.
- Far more adult females (63,219 or 24 percent) were estimated to have a mild, moderate or serious mental health issue in the past year (labeled Any Mental Health) than adult males (42,421 or 15 percent). Adult females received nearly double the services (12,262 female clients versus 6,626 male clients) in this category; however, it is important to note that service counts are inclusive of individuals with diagnoses related to SMI, which represent the vast majority of client diagnoses.

Comparison of White Alaska Adults and American Indian / Alaska Native adults

- In 2013, an estimated 78,841 White adults, 14,574 American Indian / Alaska Native adults, and 12,574 adults in the all Other Races category needed behavioral health services. In comparison, 13,315 White adult clients, 10,644 American Indian / Alaska Native adult clients, and 3,214 adult clients in the all Other Races category were served with support from State Medicaid and/or behavioral health funds (ES Figure 28).
- Across all diagnosis categories, American Indian / Alaska Native adults received services paid for with support from State Medicaid or behavioral health funds at a much higher rate per 1,000 than White adults (116 clients per 1,000 compared to 34 clients per 1,000) in 2013. This trend speaks to the strength and capacity of Alaska's Tribal Behavioral Health System.

ES Figure 28 Estimated Need for Behavioral Health Services Among Alaska Adults Compared to Clients Served with Support from Behavioral Health Funds by Race 2013



	Total		Substance Use Disorder		Serious Mental Illness		Any Mental Health (includes Mild, Moderate and Serious Mental Illness)	
	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services
White	78,841	13,315	40,780	6,180	16,700	8,860	62,141	9,817
AI or AK Native	14,574	10,664	19,248	6,773	3,666	5,458	10,999	6,214
Other	12,574	3,214	3,110	1,284	728	2,130	11,846	2,423

9. WHAT CAN WE LEARN FROM PROVIDERS AND BEHAVIORAL HEALTH AIDES ABOUT IMPROVING SYSTEM CAPACITY?

As part of the Alaska Behavioral Health Systems Assessment, we conducted two surveys in order to learn directly from DBH Treatment and Recovery grantees and the Behavioral Health Aide workforce about system capacity. These surveys helped us better understand how and how well the system works, as well as where opportunities lie for systems improvements. We are extremely appreciative and honored by the commitment made by so many to contribute their thoughts and time to this effort. That said, we recognize that this assessment only scratches the surface of what can be learned from providers, BHAs, and the many other behavioral health professionals that support the system. Much more engagement and discussion will be needed to interpret the data included in this assessment, determine future assessment questions, and build a comprehensive plan for improving systems capacity. Included here are the key findings from the surveys we conducted.

Key Findings: Provider Survey

Access to Care

- Timely access to care is imperative. A same-day appointment has a 10 percent chance of not being kept while almost 25 percent of patients with next-day appointments cancel or do not show up.[39] Providers ranked too few staff as the number one reason why clients experience long waits for service, followed by too few time slots, and no beds.
- Streamlining the intake process (n=31 of the 54 responding organizations), raising staff awareness of access (n=28), management of No Shows and cancellations (n=25) were the top three actions providers reported having taken to improve client access to the necessary level of care. Fewer providers reported using centralized scheduling (n=14), policies to reduce paperwork and reporting (n=13), open access scheduling (n=12), collaborative documentation (n=10) and triage to group services (n=5). The results from this question point to possible opportunities for increasing access and improving system capacity.
- The majority of providers reported that No Shows were very problematic (36 percent) or somewhat problematic (52 percent). Providers have employed a range of actions to address No Shows and late cancellations, the most common of which is reminder calls. Eighteen respondents reported analyzing No Show data, 13 reported using waitlists, and only four reported overbooking of slots to help address No Shows and late cancellations. Given the reported impact of No Shows and late cancellations, DBH might consider bringing in a national expert and dedicating time to sharing promising practices at the next Change Agent conference to this topic.
- Providers ranked transitional/supportive housing as the number one service they would develop in their communities and regions if they could. This response reinforces our finding that lack of supportive housing is a major gap in Alaska's continuum of behavioral health care.

[39] Same day access to behavioral health services. Chuck Ingoglia, National Council. David Lloyd, Scott Lloyd, Joy Fruth, and Annie Juve, MTM Services. https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/

Tele-behavioral Health

- Thirty-five percent of respondents use tele-behavioral health regularly, 20 percent periodically, 13 percent have explored its use, and the remaining third of respondents do not use tele-behavioral health at all. Non-Tribal providers were more likely to respond 'not at all' or 'have explored'; Tribal providers were more likely to respond regularly or periodically.
- The top three uses for tele-behavioral health were psychotherapy, medication management, and assessment/diagnosis. Use of tele-behavioral health for group services presents an emerging opportunity.

Crisis Care

- Sixty-two percent of providers responded that the most common course of action in their community or region when a person experiences a psychiatric crisis is to stabilize and treat locally. Twenty-six percent of providers hold at an emergency department and then transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. Twelve percent of providers transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. These responses reinforce the regional service patterns seen in the quantitative data analysis.

Quality improvement

- Ninety-eight percent of respondents reported collecting data to inform improvement efforts. Data is used for a wide range of performance-related efforts, such as monitoring program effectiveness (n=29), staff productivity (n=29), treatment effectiveness (n=27) and consumer outcomes (n=26). Optimizing billing fell toward the end of this list (n=18) and may present an opportunity for providers.
- Quality improvement is a formal process of analyzing an organization's performance and deploying systematic efforts to improve performance in many ways. Providers use continuous quality improvement in a range of areas, including clinical record management (n=37), treatment effectiveness (n=30), and staff productivity (n=29). The average number of uses per organization was five.

Integrated Care

- Thirty-eight percent of respondents said they often shared client data and coordinated treatment with the client's primary care provider, approximately half said they sometimes shared data and coordinated treatment. Providers shared concerns about the confidentiality requirements associated with alcohol and drug abuse patient records (42 CFR) limiting their ability to share data.

Revenue Management

- Two-thirds of providers were always, often, or sometimes concerned about their organization's financial solvency in the past year.
- In an effort to better understand the challenges facing providers, we asked what they believed the three most important challenges facing their organizations in the next five years would be. Changing in funding streams (n=49), reduction in public funds (n=45), maximizing service capacity with limited revenue (n=38), and workforce development issues (n=28) were the top responses. These responses far out-ranked issues like creating a trauma-

capable organization (n=3), changes in federal law (n=6), and integration with primary care (n=7).

This finding is evidence of the difficult financial state that many behavioral health providers find themselves operating in and speaks to the need to increase Medicaid reimbursement rates for non-Tribal providers, set Medicaid billing targets at the organizational level and provide Medicaid billing training and technical assistance to all providers, and tread carefully when weighing the timelines and possible implications of reducing grant funding.

Key Findings: Behavioral Health Aide (BHA) Survey

Being a BHA

- Behavioral Health Aides are great listeners, bridges between western and traditional Alaska Native cultures, leaders in their communities, safety nets, community healers, providing critical services in the village so clients do not need to leave home, and first responders in a crisis. They are drawn to their work by inspiration to help others, interest in marrying traditional knowledge with professional skills, and are sometimes in recovery themselves.
- BHAs provide prevention and early intervention, cultural knowledge, substance abuse services, intake and substance abuse assessments for new clients. BHAs say the most important of these is community and youth development through cultural activities, and individual and group counseling. More prevention, more mentoring and support for males, and more knowledge about intergenerational trauma is needed.
- To excel in their roles, Behavioral Health Aides need support, supervision, training, community trust and readiness, increased connection with other BHAs for peer support and mentoring, continuing to pursue their own education and certifications all the way to Master's level for some. Paperwork, lack of support and supervision, and poor facilities / lack of office space are the biggest obstacles for BHAs.

BHA Certification

- Behavioral health Aides recognize many benefits to certification and training. Barriers to certification are that the pathway is often not clear and some organizations do not provide adequate support for BHAs to become certified or advance certification. A training academy with a mix of in person and online classes would work best.

BHA Workforce

- Tiered pay increases, and connecting with other BHAs more frequently, and increasing the certification of BHAs would help retain BHAs. Also, more recognition and reward for the work BHAs do in their communities.

Crisis Response

- BHA comfort with crisis was mixed; many felt comfortable or at least felt that support was available but personal safety was a pervasive concern. BHAs would feel more comfortable handling a crisis with additional training and support from supervisors, working in a more coordinated fashion with the community's other responders, establishing steps to ensure staff/office safety, access to transportation vehicles, and time and experience on the job.

Behavioral Health Services

- Tele-behavioral health works best when the internet connection is solid; when it is easy to coordinate, when bad weather prevents travel, when a client needs support right away. It can also be great as a tool for staffing, as an alternative to planned travel, and for assessments. Tele-behavioral health does not work well when you lose the personal connection, when spaces do not allow for privacy, when the connections are bad, when it is not included in the treatment plan, or when the BHA does not have sufficient training.
- In many regions, BHAs are not yet integrated into primary care or working as closely as might be desirable with Community Health Aides.
- What is missing to be able to provide good care to patients in rural Alaska (from beginning to end)? Dedicated space/infrastructure for delivery of behavioral health services, access to services, staff consistency, whole family engagement, and quicker turnaround times for intakes.

Summary of Opportunities, Barriers, and Recommendations

SYSTEM OPPORTUNITIES, BARRIERS, AND RECOMMENDATIONS

One of the goals of the Alaska Behavioral Health Systems Assessment was to develop recommendations for systems change for the overall system, as well as for the Tribal Behavioral Health System. This section includes a series of opportunities and barriers and corresponding recommendations developed with input from stakeholder interviews, survey results and the other qualitative and quantitative analyses performed during the course of this, and other projects, in 2014 and the first half of 2015. Ten priority opportunities and barriers facing the Alaska Behavioral Health System are presented here along with recommended strategies. The top three opportunities and barriers selected by the Tribal Behavioral Health Directors are shared here as well. Additional opportunities, barriers, and recommendations are included in Chapter 10.

Assessment Questions:

- What opportunities and barriers exist to meeting more of Alaska's need for behavioral health services?
- Where is there unused capacity in the system and how might this capacity be tapped?
- Which recommendations can be made for improving the behavioral health system in Alaska?
- How can unmet need, unmet demand, unused capacity and progress toward systems improvements be monitored and assessed over time?

Priority Opportunities, Barriers, and Recommendations

#	Opportunities/Barriers	Recommendations
Priority Opportunities and Barriers with Recommendations		
1	Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle and culture of crisis response and create costly inefficiencies.	• Expand Medicaid, ensure non-Tribal providers have a rate structure that adequately compensates for care; explore behavioral health payment models through DHSS's Medicaid Redesign and Expansion. • Support regional continuum of care assessments using the results from this assessment to identify service gaps and identify priorities/strategies to address gaps at the regional level. • Continue to explore ways at the state level to secure funding to address gaps in the continuum of care and maximize the 100 percent Federal Medical Assistance Percentage (FMAP) rate for Tribal Health Organizations when serving Alaska Native Medicaid enrollees. • Identify additional ways to promote greater financial stability among providers, including increasing State match to capture Alaska's full entitlement to federal Disproportionate Share Hospital (DSH) funds. • Ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.
2	Medicaid presents a challenging, yet essential, revenue opportunity for Alaska's behavioral health system; optimizing the system's Medicaid billing capacity will be particularly important as grant funding declines in the years to come.	• Establish a non-tribal rate structure/payment model that adequately compensates for care. • Step up efforts to provide technical assistance and training to providers to optimize their billing capacity and ensure compliant billing while moving from a grant-based system. • Work at all levels of the system to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current Community Behavioral Health Medicaid billing regulations. • Consider creating a learning community, supported by regular systems reports, to enhance peer-to-peer learning by hosting a monthly, facilitated teleconference on topics such as optimizing Medicaid revenue and operational/clinical improvement efforts.

3	Behavioral health systems leaders recognize and support both doors of the system, the medical door and the community behavioral health service door, and develop a vision and pathway free of regulatory barriers for integrated care and payment reform.	• DHSS must address the regulatory barriers to billing for behavioral health services in primary care settings and establish a plan for meeting more of Alaska's behavioral health needs. • Leaders and providers must work across departments and sectors to expand the PCMH initiative beyond its current pilot. • A more concerted effort to assist behavioral health and health care providers in their efforts to navigate 42 CFR and 45 CFR and share data across provider types. • Ensure current efforts by DBH to develop AKAIMS capacity to exchange data with Alaska eHealth Network exchange remain a priority. • Update the comprehensive integrated mental health plan and include a vision and model(s) for behavioral health service delivery in primary care.
4	Documentation requirements that exceed those on the medical side present challenges.	• Evaluate the degree to which SAMHSA block grant funding requirements conflict with or support the State's goals and data reporting needs. • Ensure current efforts by DBH to expand grantee access to electronic interface through Alaska eHealth Network (or otherwise) remain a priority. • Revive efforts to roll out the Medicaid billing module in AKAIMS and increase the utility of system.[40] • Continue to explore documentation guidelines (e.g. page limits, use of bullet points), standard templates, and collaborative documentation efforts to reduce time burden and help to manage risks of Medicaid denials and paybacks. • Increase trainings and technical assistance to increase comfort and reduce time associated with documentation; work on training clinicians and BHAs on the concept that "less is more" and documentation of active interventions is essential.

[40] DBH leadership has expressed concern about the rolling out a billing module for AKAIMS until the State's Medicaid Management Information System is free from issues that could potentially expose the division to financial liability if provider claims were incorrectly processed and/or paid. Conversation with Shaun Wilhelm, Chief of Risk and Research Management, Spring 2015.

5	In a time where information technology and data analysis are needed more than ever, DBH's technology, research, and analysis staffing model is insufficient and unsustainable; analytic power is key to system transformation.	• Data must be the basis for decision-making at all levels; develop a regular (annual) assessment cycle with alternate year goals – year one, data is cleaned and consolidated and core tables are produced; year two, additional analyses are conducted on the dataset created in year one. • Explore possibilities for external analysis resources that could assist DBH with annual production of the assessment and other analyses throughout the year; the university working in concert with a data collaborative might serve as a good permanent home for this function. • Leverage the database built during the course of this project as a prototype for producing the assessment for the two year cycle described above; this will refine the framework as DBH works on a more robust platform that will support assessment efforts in the future. • Advocate for the addition of at least one senior analysis position at DBH to move beyond the current staffing model, where an enormous amount of institutional knowledge about the system's data rests with only one person. • Update the comprehensive integrated mental health plan and include sections on technology and analysis.
6	Limited access to the electronic data interface and delays in rolling out the billing module has severely capped the utility of AKAIMS and results in costly inefficiencies.	• Reduce costly inefficiencies associated with double and triple data entry into AKAIMS by implementing the billing module[41] and expanding interface capabilities to all provider types. • Establish the capacity to share data with the Alaska's eHealth Exchange Network to assist in streamlining efforts to share data across provider types. • DBH is currently working on a pilot to test the feasibility of establishing a provider interface to the Alaska eHealth Network and AKAIMS; these efforts must continue to be a priority.

[41] DBH leadership has expressed concern about the rolling out a billing module for AKAIMS until the State's Medicaid Management Information System is free from issues that could potentially expose the division to financial liability if provider claims were incorrectly processed and/or paid. Conversation with Shaun Wilhelm, Chief of Risk and Research Management, Spring 2015.

7	Continued focus on workforce development is key to closing existing gaps in training and meet the increased demand for behavioral health services.	• Provide continued support to workforce development efforts to ensure the behavioral health workforce has the training and supervision necessary at all levels to provide evidence-based, culturally competent therapies, bill Medicaid, use data to drive improvements to care, and pursue innovations such as team-based care and integration with primary care. • Develop systems and organizational level strategies to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current Community Behavioral Health Medicaid billing regulations.
8	Geographic distances can make it difficult to know which resources are available in the statewide continuum of care.	• Explore methods for increasing awareness of available resources, including a web-based directory of resources, and/or expansion of 211 services. • Implement system-wide reports that foster awareness and dialogue about utilization patterns. • Reinstate the twice per year DBH Change Agent Conferences.
9	The behavioral health system is like a canoe that needs all of the paddles in the water pulling in the same direction to propel the craft forward.	• Embrace the call to action issued at the start of this report and work together to synchronize the many paddles on this canoe we call the Alaska Behavioral Health System. • Update the comprehensive integrated mental health plan, develop a clear vision that spans sectors and solidifies access to behavioral health services for populations in need • Leverage the comprehensive mental health plan to clarify roles and responsibilities and leverage the full capacity the system's leadership and partner resources
10	Divides still exist between the community behavioral health system and other systems that work regularly with individuals who would benefit from behavioral health services.	• Work across departments and organizations to ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.

TRIBAL BEHAVIORAL HEALTH SYSTEM PRIORITY OPPORTUNITIES, BARRIERS, AND RECOMMENDATIONS

Between April and June 2015, four meetings were held with Tribal Behavioral Health System representatives to review, refine, and prioritize the opportunities/barriers and corresponding recommendations. These meetings included two conference calls with Tribal Behavioral Health Executive Committee Members, an in-person meeting with ANTHC director, Laura Báez and BHA program manager, Xiomara Owens, and an interactive webinar during which all Tribal Behavioral Health Directors were invited to participate in an exercise to prioritize the barriers and opportunities facing the Tribal Behavioral Health System.

The Tribal Behavioral Health System is a tremendous asset with tremendous existing and potential capacity and all of the opportunities and barriers identified through our collective efforts point to areas where, if addressed, additional capacity might be found. It is our privilege to share these recommendations as part of the Alaska Behavioral Health Systems Assessment final report. Here we share the top three opportunities and barriers prioritized by the Tribal Behavioral Health Directors.

#	Opportunities/Barriers	Recommendations
1	Statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, step down/after care services) perpetuate a cycle and culture of crisis response	• Conduct regional continuum of care assessments using the results from this assessment • Offer technical assistance to support regional behavioral health continuum of care planning efforts and facilitate assessment of priority service gaps • Engage with DBH to ensure that Tribal providers are posed to leverage new state funding mechanisms that may be offered for supportive housing projects[42]
2	Increased attention to importance of behavioral health care and improving community health outcomes presents opportunity to integrate BH services into primary care setting; most Tribal providers are fortunate to have access to in-house primary care partners	• Increase efforts to maximize Medicaid billing for behavioral health services (delivered by community mental health clinic staff[43]) in Tribal primary care settings • Provide technical assistance and a toolkit to help behavioral health directors initiate these conversations and ensure that Medicaid billing potential is capitalized • Hold discussions to develop a vision and model(s) for behavioral health service delivery in primary care • Identify Tribal providers with strong integration and billing practices already in place and cultivate peer learning
3	Opportunities exist to increase collaboration with partners outside of the Tribal behavioral health system; in fact, this will be essential if and as Medicaid revenues grow	• Identify and pursue areas where increased collaboration between the Tribal behavioral health system and non-tribal partners would be beneficial

[42] In a survey conducted in November 2014, Alaskan Treatment and Recovery grantees ranked Supportive and Transitional Housing as the #1 service they would develop in their communities if it were within their power to do so. Conducted as part of the Alaska Behavioral Health Systems Assessment and available online at: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf. Slides 15+16.

[43] Aside from Short-term Crisis Intervention/Stabilization and SBIRT, all other BH services will require a full clinical record, AST, CSR, Assessment and Treatment plan to be eligible for Medicaid billing.

Report Organization

The final report for Alaska's behavioral health systems assessment is divided into chapters, one of each of the questions addressed and a final chapter outlining the opportunities and barriers to capacity and recommendations for systems change.

Chapter 1. What is behavioral health, what is the State-funded behavioral health system, and which forces influence its capacity?

Chapter 2. What is the prevalence of behavioral health issues in Alaska?

Chapter 3. Who are the current users of the State-funded behavioral health system?

Chapter 4. Where are clients being served and by whom?

Chapter 5. Which services do clients use?

Chapter 6. Are State-funded behavioral health services effective?

Chapter 7. Who pays, and how much does it cost?

Chapter 8. How do current utilization trends compare with the behavioral health needs of Alaskans?

Chapter 9. What can we learn from providers and Behavioral Health Aides about improving system capacity?

Chapter 10. Opportunities, Barriers and Recommendations

The report is also accompanied by the Alaska Behavioral Health Systems Assessment Data Packet, which includes both statewide reports and regional reports, for those wishing to further explore the data produced through this tremendous, collaborative effort.

1. WHAT IS BEHAVIORAL HEALTH, WHAT IS THE STATE-FUNDED SYSTEM, AND WHAT FORCES INFLUENCE ITS CAPACITY?

Alaska's behavioral health system includes both the State-funded and Tribal systems, but the true breadth of behavioral health services spans many sub-systems and related programs. The system has matured over the past six decades into a sophisticated continuum of care that addresses substance abuse and mental health issues with services offered by a range of provider types, using an integrated approach with an emphasis on community-based care.

What is Behavioral Health?

The term "behavioral health" refers to a state of mental and emotional being and/or choices and actions that affect wellness.[44] Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like Serious Mental Illnesses (SMIs) and Substance Use Disorders (SUDs), which are often chronic in nature but that people can and do recover from.

What is the State-funded Behavioral Health System?

In this chapter, the term "State-funded behavioral health system" refers to the service systems supported through State behavioral health and Medicaid funds, which encompass the promotion of emotional health; the prevention of mental and substance use disorders; substance use and related problems; treatments and services for mental and substance use disorders; and, recovery support.[45] The Alaska Division of Behavioral Health (DBH) under the Department of Health and Social Services (DHSS) oversees a continuum of statewide behavioral health (mental health and substance use) services ranging from prevention, screening, brief intervention, to outpatient and inpatient treatment and recovery services to acute psychiatric care. The State-funded continuum of care represents a commitment to mitigating the risk of behavioral health issues with prevention and early intervention, ensuring Alaskans in crisis or with more serious behavioral health needs are served effectively at the lowest level of care possible, while recognizing that the most acute and chronic conditions require a corresponding increased level of services, supports and resources.[46]

ALASKA STATUTES

A myriad of Alaska statutes establish the legislative framework under which mental health services are provided in the state. Together, these statutes provide the statutory guidance and obligation for

[44] This definition borrowed verbatim from the FY15-16 Draft Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Draft provided by DBH 6.22.15.

[45] This definition borrowed nearly verbatim from the FY15-16 Draft Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Draft provided by DBH 6.22.15.

[46] http://dhss.alaska.gov/dbehavioral health/Pages/coreservices/default.aspx

developing, funding, managing, and maintaining the State-funded behavioral health continuum of care described throughout this assessment, including by: directing the Department of Health and Social Services to develop a plan for and implement an integrated comprehensive mental health program in the state [AS 47.30.660]; creating a Mental Health Trust Authority and Alaska Mental Health Board, responsible for ensuring a comprehensive mental health program [AS 47.30.011 *et seq.*; AS 47.30.661 *et seq.*]; and establishing a community mental health program to supplement state-operated mental health services [AS 47.30.520 *et seq.*].[47]

COMMUNITY BEHAVIORAL HEALTH SYSTEM

Alaska's State-funded Community Behavioral Health System (CBHS) currently serves as the mainstay of Alaska's State-funded behavioral health system. The Community Behavioral Health System offers prevention and early intervention services for the general population and treatment and recovery services for target populations. Outlined in statute,[48] principles of the state's Community Behavioral Health program specify that:

- Persons have ready and prompt access to necessary screening, diagnosis and treatment;
- Persons in need of community mental health services be provided treatment and rehabilitation services designed to minimize institutionalization and maximize individual potential;
- Persons be treated in the least restrictive alternative environment consistent with their treatment needs, enabling the person to live as normally as possible;
- Persons be provided necessary treatment as close to the person's home as possible.

Beyond population-based prevention efforts, the Community Behavioral Health system of care prioritizes specific populations and sets specific conditions for receipt of behavioral health treatment and recovery services. These include the following populations and conditions as defined in Alaska Administrative Code:

CHILD EXPERIENCING AN EMOTIONAL DISTURBANCE [7 AAC 135.990(9)]

A recipient is under the age of 21 who is experiencing a non-persistent mental, emotional, or behavioral disorder that:

- is identified and diagnosed during a professional behavioral health assessment; and
- is not the result of intellectual, physical, or sensory deficits

ADULT EXPERIENCING AN EMOTIONAL DISTURBANCE [7 AAC 135.990(3)]

A recipient is 21 years of age or older who is experiencing a non-persistent mental, emotional, or behavioral disorder that:

- Is identified and diagnosed during a professional behavioral health assessment; and
- Is not the result of intellectual, physical, or sensory deficits

[47] These examples are illustrative only. A complete review and analysis of statutes and regulations relating to mental health services is beyond the scope of this assessment.

[48] AS 47.30.523. Community Mental Health Program Policy and Principles.

CHILD OR ADULT EXPERIENCING A SUBSTANCE USE DISORDER (SUD) [7 AAC 160.990(B)(102)]

A recipient of any age experiencing a disorder that is identified by a diagnostic code found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders that is related to:

- alcohol, amphetamine, or similar acting sympathomimetics;
- cannabis, cocaine, hallucinogens, inhalants, nicotine, or opioids
- analogs of phencyclidine (PCP) or similar arylcyclohexylamines; or
- sedatives, hypnotics, or anxiolytics

CHILD EXPERIENCING A SEVERE EMOTIONAL DISTURBANCE (SED) [7 AAC 160.990(B)(88)]

A recipient is under the age of 21 who:

- has or at any time in the past year had a diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified within the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders that has resulted in a functional impairment (a disorder that substantially interferes with or prevents functioning of episodic, recurrent, or continuous duration and not as a result of temporary, expected responses to stressful events in the recipient's environment) which substantially interferes with or limits the child's role or functioning (achieving or maintaining the developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills) in family, school, or community activities as indicated by a Global Assessment of Functioning (GAF) score of 50 or less[49];
- exhibits specific mental, emotional, or behavioral disorders that
- place the individual at imminent risk for out-of-home placement;
- place the individual at imminent risk for being placed in the custody of the Division of Juvenile Justice (DJJ) [AS 47.14]
- have resulted in the individual being placed in the protective custody of Office of Children's Services (OCS) [AS 47.10]

ADULT EXPERIENCING A SERIOUS MENTAL ILLNESS (SMI) [7 AAC 160.990(B)(85)]

A recipient is 21 years of age or older who:

- has or at any time in the past year had a diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified within the American Psychiatric Association's DSM of Mental Disorders that has resulted in a functional impairment (a disorder that substantially interferes with or prevents functioning of episodic, recurrent, or continuous duration and not as a result of temporary, expected responses to stressful events in the recipient's environment) which substantially interferes with or limits one or more life activities, including

[49] This may change with the adoption of the DSM-5, which dropped the GAF score. There will likely be a different definition or metric.

- Basic daily living skills, such as personal safety, eating, and personal hygiene;
- Instrumental living skills, such as managing money and negotiating transportation;
- Functioning in social, family, or vocational/educational contexts

These target population definitions highlight a key feature of the Community Behavioral Health System – the system is in place to serve individuals in crisis and/or with high levels of behavioral health needs.

Alaska's State-funded Community Behavioral Health System is shaped by two complementary sets of guiding federal and state priorities that together seek to propel the system toward improved outcomes.[50] The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two national block grants, the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant which provide DBH with technical assistance and (a small portion of) the funding necessary to carry out its purpose. SAMHSA encourages states to develop a behavioral health system that places individuals at its very core, replacing the outmoded practices of separating the diagnosis and treatment of mental health, emotional disturbances and/or substance abuse illnesses; and to develop systems that span health promotion, prevention, treatment and relapse prevention along a seamless continuum. SAMHSA's block grants were developed to give states maximum flexibility in the use of funds to address the behavioral health needs of their populations[51] and have contributed to the seed money necessary to establish Alaska's CBHS infrastructure.

Six federal priorities or initiatives set by SAMHSA aim to better meet the behavioral health care needs of individuals, communities and service providers:

- Prevention of Substance Abuse and Mental Illness
- Health Care and Health Systems Integration
- Trauma and Justice
- Recovery Support
- Health Information Technology
- Workforce Development

Seven priorities identified by DBH reflect the State's commitment to improving the quality of life of Alaskans through the right service to the right person at the right time:

- Promote Community, Family, and Individual Wellness Across Alaska
- Prevent & Reduce Substance Abuse and Prevent & Reduce Suicides
- Integrate Primary Care and Behavioral Health Services
- Improve Integration of Behavioral Health for Families Impacted by Domestic Violence and Substance Abuse

[50] Discussion with Kathleen Carls, Research Unit Manager, Division of Behavioral Health. 6.26.15.

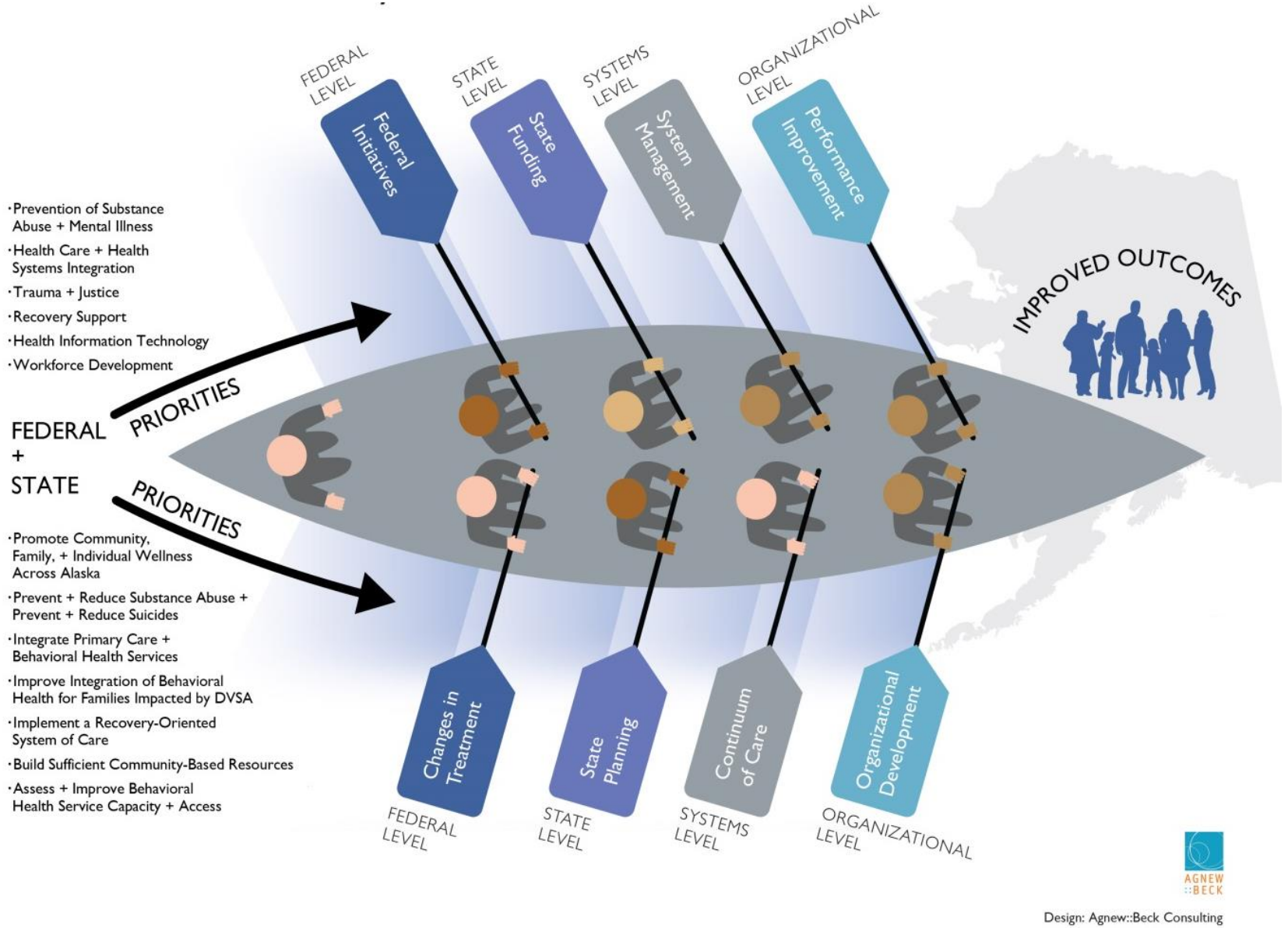
[51] FY15-16 Draft Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Draft provided by DBH 6.22.15.

- Implement a Recovery-Oriented System of Care
- Build Sufficient Community-Based Resources
- Assess and Improve Behavioral Health Service Capacity & Access

Together, these priorities influence each level of the system (Figure 1-1 Alaska's Behavioral Health System).

In addition to these priorities, SAMHSA and Alaska Medical Assistance Program (State Medicaid Program) eligibility requirements have a fundamental impact on who the system serves and how system efficacy is reported and monitored.

Figure 1-1 Alaska's Behavioral Health System



Design: Agnew::Beck Consulting

ALASKA BEHAVIORAL HEALTH GRANT PROGRAMS

DBH does not provide outpatient or residential services directly[52]; it funds organizations to provide services through its grant programs and through the Community Behavioral Health Services program within the State Medicaid Program. DBH manages a number of grant programs that span the continuum of State-funded behavioral health services:

- Comprehensive Behavioral Health Prevention and Early Intervention
- Comprehensive Behavioral Health Treatment and Recovery
- Residential Care for Children and Youth (Behavioral Rehabilitation Services)
- Alcohol Safety Action Program (Youth and Adults)
- Individual Service Agreements
- Other grant programs as funding is available.

> *If the grant money went away our Medicaid revenues wouldn't be enough. Right now, all of us in this field treat the grant money as the core funding and it is not enough to run your programs. It will take care of 50-75% of the costs, without that grant money you couldn't operate. We all depend on it to pay core functions, like facility costs.*
>
> *CEO of a Community Behavioral Health Center*

DBH funds the Community Behavioral Health System through Prevention and Early Intervention grants, and Comprehensive Behavioral Health Treatment and Recovery grants, and its State Medicaid program. This assessment focuses on Treatment and Recovery grants and their intersection with State Medicaid-funded services (provided from within and outside of the Community Behavioral Health System). Together, the Treatment and Recovery grants result in a network of service providers across the state that deliver Community Behavioral Health Services to youth and adults. Treatment and Recovery grantees are automatically eligible to bill for services provided to Medicaid enrollees through the DBH-administered State Medicaid Program.

To become a DBH-funded community behavioral health center in Alaska requires a two-step process. The DBH awards Comprehensive Behavioral Health Treatment and Recovery (CBHTR) grants on a three-year cycle. These grants are specific to a geographic area or a target population. Some grants are determined "non-competitive" due to a small number of providers in a specific area. Once DBH approves a CBHTR grant, the agency awarded the grant is provided with a Departmental Approval from DBH that allows this agency to enroll with Alaska Medicaid to bill Medicaid for Community Behavioral Health Services. DBH has designed its integrated regulations for Medicaid billing to maximize billing opportunity for providers and offers technical assistance to build organizational capacity at the provider level to leverage Medicaid revenues as a means of expanding the volume of services that are able to be delivered by any given provider.

A CBHTR Grant Agency or "community behavioral health center" is authorized to provide the following services to children experiencing an emotional disturbance; adults experiencing an emotional disturbance; children or adults experiencing a substance use disorder; children experiencing a severe emotional disturbance; and adults experiencing a serious mental illness that meet the medical necessity threshold:

- **Initial services**, which include screening with the Alaska Screening Tool (AST) and an initial Client Status Review (CSR), or Screening, Brief Intervention, and Referral to

[52] Although DBH does operate the Alaska Psychiatric Institute (API).

Treatment (SBIRT), can be provided in any setting. Initial services are available to all individuals and are required in order to receive additional services;

- **Clinic services**, which include professional behavioral health assessment; mental health intake assessment; integrated mental health and substance use intake assessment; psychiatric assessment (interview or interactive with equipment & devices); psychological testing and evaluation; pharmacologic management; psychotherapy (individual, group, family, etc.); short-term crisis intervention; and, facilitation of telemedicine sessions. These services must be provided on the premises of the Community Behavioral Health provider or through telemedicine.
- **Rehabilitative services**, which remediate and ameliorate the debilitating effect of behavioral health disorders with the goal of increasing the recipient's ability to function within their home, school, and community. These services may be provided on the premises of the provider, in the recipient's home, or any community setting appropriate for providing the services as specified in the recipient's behavioral health treatment plan. Providers ranging from substance abuse counselors and behavioral health associates to licensed clinicians may deliver these services, within the scope of their knowledge, experience, and education. These services include substance use assessment; behavioral health treatment plan development and review, including client status review; behavioral health treatment plan review for methadone treatment program services; medical evaluation for detoxification treatment program services; alcohol and drug detoxification treatment services; residential substance use disorder treatment services; short-term crisis stabilization services; case management; medication administration; comprehensive community supports for adults; therapeutic behavioral health services for children; peer support services; recipient support services; daily behavioral rehabilitation services for children; day treatment services for children[53] (combined school district and community behavioral health resources); and, facilitation of telemedicine sessions.
- Residential Substance Use Treatment; Screening, Brief Intervention and Referral to Treatment (SBIRT); and, Detoxification services.

In FY13, nearly 80 organizations received DBH CBHTR grants to provide Community Behavioral Health Services. These organizations are located throughout the state and include both Tribal and non-Tribal organizations. Alaska's Tribal and non-Tribal providers together strive to provide an integrated, adequate array of behavioral health services to meet the needs of Alaskans in behavioral health crisis, with serious mental illness, serious emotional disturbance, and substance use disorders.

DBH CBHTR grantees are exclusively eligible to participate as providers in the Community Behavioral Health Services program within the Alaska Medical Assistance Program, commonly called the Alaska Medicaid program for behavioral health services, through which authorized providers serve Medicaid-eligible individuals. Services provided through this program fall into the same three categories: Initial Services, Clinic Services, and Rehabilitative Services.

[53] This service is currently only available through a limited number of providers who have received specific Department approval.

DBH-ADMINISTERED MEDICAID PROGRAM

Over time, community behavioral health centers have moved from a mostly grant-based model of funding to a combination of grant funding and Medicaid billing for services.[54] DBH has invested significant resources into assisting providers with this transition to expand the capacity of the State-funded behavioral health system. In 2011, DBH developed regulations that integrate services for mental health and substance use issues in order to streamline service provision and eliminate barriers to service for co-occurring disorders. These regulations dovetail with the CBHTR grant conditions that specify eligibility for services. To bill the Medicaid for the service provided the client must meet the eligibility requirements for the State Medicaid Program. However, CBHTR grantees must serve *all* individuals that meet the criteria for service.

The DBH-administered Medicaid Program matches federal and state dollars to pay for behavioral health services to eligible recipients. Eligibility requirements are consistent across the State Medicaid Program, which defines eligibility for its services based on the income level and health condition of the client. The income-based eligibility requirements are based on a specific percentage of the federal poverty guidelines for Alaska, which are updated annually and defined for household size. In Alaska, children, pregnant women, and disabled adults are eligible for Medicaid at federal poverty levels ranging from 177 percent to 203 percent of the federal poverty guideline. Parents and caretaker adults and adults under 21 are eligible if their income is at or below 120 percent of the federal poverty guideline.[55]

As discussed further in this section, expanding Medicaid will increase the number of people who have health coverage for behavioral health services and, in so doing, expand the system's capacity to meet the behavioral health needs of the expansion population, a population which today is predominantly uninsured. At the same time, Medicaid expansion is also likely be accompanied by cuts to DBH grant funds. In the Healthy Alaska Plan published in February 2015, DHSS estimates general fund offsets of $6.1 million in FY 2016 through proportional reductions in programs funded by the general fund that currently serve this uninsured population; these offsets increase to $24.5 million in FY 2020 and FY 2021.[56] Notably, these assumptions include a $1 million reduction in behavioral health grant dollars in FY 2016, increasing to a $16 million reduction in FY 2020 and FY 2021.[57] These looming cuts make DBH efforts to assist DBHTR grantees in their efforts to tap Medicaid revenues and streamline reporting even more critical.

[54] Key Informant Interview with Mark Haines-Simeon, October, 2014 and underscored by Medicaid payment data produced through this effort.

[55] http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf

[56] Alaska Department of Health and Social Services. The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets. February 2015.

[57] Alaska Department of Health and Social Services. The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets. February 2015.

State-funded Behavioral Health Services Outside of the Community Behavioral Health System

MEDICAID SERVICES PROVIDED TO INDIVIDUALS WITH A PRIMARY OR SECONDARY BEHAVIORAL HEALTH DIAGNOSIS

In Alaska, we know that many provider types work in concert to meet the needs of Alaskans experiencing a behavioral health crisis or living with a behavioral health issue. Depending on the individual and the provider, these services can be funded by Medicaid or Medicare Programs, Indian Health Service (IHS) Compact or other IHS funds, private insurers, multiple other federal and private funding sources, self-pay, or uncompensated care. By design, the data analyzed through this assessment identifies clients who are Medicaid-enrolled and who receive behavioral health services through DBH Treatment and Recovery grantees, as well as a range of other providers. To capture behavioral health services by non-DBH grantees, we analyzed all Alaska Psychiatric Institute (API) records, all Designated Evaluation and Treatment (DET) records, and all Medicaid records for individuals with a primary or secondary behavioral health diagnosis in general (non-behavioral health specific) service settings.

Medicaid data was our exclusive source of service information for providers outside of the Community Behavioral Health System. These other providers bill Medicaid for behavioral health services but do not document services through Alaska Automated Information Management System (AKAIMS), and are subject to different Medicaid requirements from the Community Behavioral Health providers. Figure 1-2 describes the multiple models for billing Medicaid for behavioral health services categorized by the type of service organization.

The credentialing and staffing for services is driven, in part, by the requirements of the various Medicaid billing models as described in the Alaska Medical Assistance billing manuals located here: https://medicaidalaska.com/portals/wps/portal/BillingManuals. Behavioral health services are reimbursed through a number of different mechanisms within the Alaska Medical Assistance program and the Medicaid program administered by the DBH.

Figure 1-2 MCD Billing Models for Behavioral Health Services

Type of Billing Structure	State of Alaska Division with Oversight and Key Contact Person, if Known	Behavioral Health Services Provided	Required Supervision and Responsibility for Treatment Given	Psychiatric Diagnostic Evaluation	Evaluation and Management	Screening and Brief Intervention Services	Health and Behavior Services	Mental Health Services	CBHC only: Clinic Services	CBHC only: Rehab Services	Critical Success Factors
				90791, 90792	CPT codes 992XX	CPT Codes 99408, 99409	CPT Codes 961xx	CPT codes 907xx + 908xx	CPT codes varies	CPT codes varies	
Physician, Advanced Nurse Practitioner, Physician's Assistant	Health Care Services; contact person, unknown	**Children and Adults:** Inpatient Psychiatric (over 65, under 21), Mental Health Clinic Services, Substance Abuse Rehab Services; Prescribed Drugs **Chronic and Acute Medical Assistance**: Physician, prescriptive, and labs	Physician, ANP, PA: ANP and/or PA must be supervised by a physician (primary diagnosis is medical, not mental health)	Not allowed	MD, ANP, PA, CNM, CNS	MD, ANP, PA, CNM, CNS	Clinical psychologist (can bill directly for services if enrolled as a part of the health professional group)	n/a			
			Psychiatrist for mental health diagnosis on site 30% of the time	Psychiatrist	Psychiatrist	Clinical Psychologist (can bill directly for services if part of health provider group)	n/a	Clinical Psychologist, if part of health provider group			Sufficient volume to justify psychiatrist on site 30% of time
Federally Qualified Health Center and Rural Health Clinic	Health Care Services; contact person, unknown		Clinical Psychologist and Licensed Clinical Social Worker		Clinical Psychologist and Licensed Clinical Social Worker	Clinical Psychologist and Licensed Clinical Social Worker		Clinical Psychologist and Licensed Clinical Social Worker			Sufficient volume to justify expense of psychologist; limited availability of LCSWs

Type of Billing Structure	State of Alaska Division with Oversight	Behavioral Health Services Provided	Required Supervision and Responsibility for Treatment	Psychiatric Diagnostic Evaluation	Evaluation and Management	Screening and Brief Intervention Services	Health and Behavior Services	Mental Health Services	CBHC only: Clinic Services	CBHC only: Rehab Services	Critical Success Factors
Mental Health Physician Clinic	Behavioral Health; Teri Keklak and Terry Hamm		Psychiatrist on site 30% of the time		Psychiatrist	Psychiatrist (physician), Licensed Psychologist, Psych Associate, LCSW, PA, ANP, Psychiatric Nursing Clinical Specialist, LMFT, LPC		Yes; Psychiatrist, Licensed Psychologist, Psych Associate, LCSW, PA, ANP, Psychiatric Nursing Clinical Specialist, LMFT, LPC -- MH and SU assessment: provided by mental health professional clinician; Psychiatric assessment: provided by a licensed physician, PA, ANP			
Community Behavioral Health Center (through DBH)	Behavioral Health; Teri Keklak and Terry Hamm		Licensed physician to provide general direction			Mental Health Professional Clinician, Clinical Associate or Substance Use Disorder Counselor	NO	NO	Mental Health Professional Clinician	Behavioral Health Clinical Associate; Peer Support Specialist	Must have a DBH grant and comply with all DBH requirements including AKAIMS
Tribal Health Services	Health Care Services; Renee Gayhart		Behavioral health clinical services are billed through the other models and may be provided by MD, PA and ANP, except for Tribal Targeted Case Management (limited eligibility)								

Currently, the various billing models do not encourage integration of physical health and behavioral health services. This makes achieving the goal of having two front doors into behavioral health services impossible. The current billing models also limit the employability of certain provider types within certain settings. For example, if a Licensed Clinical Social Worker is employed at a Federally Qualified Health Center (FQHC) s/he can provide and bill for a much broader array of mental health services than s/he would be able to provide and bill for at a non-FQHC primary care clinic, even when with similar patient populations at both clinics. From the patient or client perspective, this limits the availability and quality of care dependent on which setting the patient enters. From the provider perspective, this limits the extent to which a particular credentialed position is employable, and the extent to which it is possible to offer integrated services, even when the provider recognizes that their patients would benefit from behavioral health services. Additional discussion of credentialing and workforce development is included in Chapter 5.

REFORMATIVE SERVICES PROVIDED BY THE DEPARTMENT OF CORRECTIONS

Although the services provided by the Department of Corrections (DOC) were not included in this analysis, it is worth noting that DOC offers a wide range of programs to inmates. The performance review commissioned by the legislative audit process found:

> The DOC is notable for the robust, comprehensive set of reformative programs that it has developed to aid offenders in addressing the issues that may have contributed to their incarceration. The array of programs available to offenders relative to the size of the correctional system is one of the most extensive in the United States.[58]

Here we have included an overview of the reformative programs offered by DOC. This summary and the tables that follow are excerpted from the recent audit[59]:

> *Transition from prison is tough – there is no stepping stone that helps you get from incarcerated to productive civilian. If you receive SUD treatment in prison, you might feel pretty good about yourself. But then you leave prison; you say, I don't have a job, money, a place to live, what am I going to do? You don't have enough money to buy a cup of coffee…If you are lucky, you have family who will help but many really only have their old drinking buddies. If the State wants to save money over the long-term, not this year or next year, then we need to provide a different kind of probation experience to reduce recidivism over the long-term.*
>
> *CEO of a Community Behavioral Health Center*

Substance Abuse Treatment

- 12-Step Programs: Alcoholics Anonymous/Narcotics Anonymous meetings led by community volunteers
- Alaska Native-Based Substance Abuse Treatment (ANSAT): Substance abuse treatment services from an Alaska Native cultural perspective
- Life Success Substance Abuse Treatment (LSSAT): Intensive outpatient treatment services that use a cognitive behavioral approach

[58] Performance Review of the Alaska Department of Corrections. Page 46. December 2, 2014. State of Alaska Division of Legislative Audit. Performed by CGL.

[59] Language and findings from Performance Review of the Alaska Department of Corrections. Pages 44-47. December 2, 2014. State of Alaska Division of Legislative Audit. Performed by CGL.

- Residential Substance Abuse Treatment (RSAT): Intensive residential inpatient treatment services that use a therapeutic community model

Education

- Adult Basic Education (ABE): Basic education instruction in reading, writing, and computational skills below the ninth-grade level
- English as a Second Language (ESL): Instruction on improving basic English speaking, reading, and writing skills
- General Education Diploma (GED): Secondary education and testing opportunities leading to a GED
- Vocational Services: Job training, skills development, and apprenticeships in more than 35 specific programs

Other Programs

- Alaska Reentry: Prepares inmates for reintegration and transition back into the community
- Anger Management: Provides intervention strategies that have proven effective in the management of anger
- Criminal Attitudes Program (CAP): Assists offenders in altering their criminal attitudes and behaviors
- Parenting: Provides techniques to help overcome the physical and psychological challenges that incarcerated parents face both inside and outside of prison
- Religious Services/Programs
- Sex Offender Treatment: Polygraph testing, assessments, and residential treatment for convicted sex offenders
- Domestic Violence: Education for men serving time for a domestic violence conviction; family violence intervention

Figure 1-3 shows the number of inmates served by each of the major programs offered by the DOC and the number of successful completions in FY 2013. The data reported is by program enrollment and so includes duplicate counts of inmates that may be enrolled in multiple programs and also accounts for individual inmates as they pass through the system. This accounts for the number of inmates served by programs greatly exceeding the average daily institutional population of 4,065 for FY 2013.[60]

[60] Performance Review of the Alaska Department of Corrections. Pages 44-47. December 2, 2014.State of Alaska Division of Legislative Audit. Performed by CGL.

Figure 1-3 Alaska Department of Corrections Program Enrollment and Completion Rates State Fiscal Year 2013

	Served	Completed	Completion Rate
ABE	1,309	NA	
GED	216	216	100.0%
CAP	931	596	64.0%
Parenting	470	298	63.4%
Reentry	596	386	64.8%
Vocational	3,332	2,750	82.5%
ANSAT	136	82	60.3%
LSSAT	921	482	52.3%
RSAT	231	119	51.5%
Total	8,142	4,929	

Source: Performance Review of the Alaska Department of Corrections

Figure 1-4 summarizes the distribution of programs by facility and, where available, provides a snapshot of the enrollment in these programs at the time of our review.[61] Institutions reported more than 1,700 inmates actively involved in programming.

Figure 1-4 Alaska Department of Corrections Programs and Enrollment by Facility with a Point in Time Snapshot of Participation 2014

	# in Programs	Substance Abuse 12- Step	LSSAT	RSAT	ANSAT	ABE	ESL	GED	Voc. Ed	Parenting	Religious Services	Sex Off.	Reentry	CAP	Dom. Vio.	Anger Mgt.
Anchorage	38	X				X	X	X			X					
Anvil Mountain	60				X	X		X	X	X	X		X	X		
Fairbanks	150	X	X					X	X	X	X		X	X		
Goose Creek	386	X	X			X		X	X	X	X		X	X	X	X
Hiland Mountain	290	X	X	X		X	X	X	X	X	X		X	X		X
Ketchikan	40	X				X		X	X	X	X		X	X		
Lemon Creek	160	X	X			X		X	X	X	X	X	X	X	X	X
Mat-Su Pretrial	67					X		X	X	X	X			X		X
Palmer	250			X		X		X	X	X	X	X	X	X	X	X
Spring Creek	165	X		X		X		X	X	X	X	X	X	X		X
Wildwood	118	X	X				X	X		X	X	X	X	X		X
Yukon-Kuskokwim	NA	X			X	X		X	X	X	X		X	X		
Total	1,722															

Source: Performance Review of the Alaska Department of Corrections

Performance Evaluation: The DOC has established three objectives to measure their performance in achieving a goal of providing reformative programs, pursuant to their departmental mission:

- Increase the number of individuals who complete an institutional or community-based substance abuse treatment program.
- Increase the number of offenders who receive a GED while incarcerated.

[61] Performance Review of the Alaska Department of Corrections. Pages 44-47. December 2, 2014. State of Alaska Division of Legislative Audit. Performed by CGL.

- Increase the number of sex offender probationers who complete both a sex offender management program and receive polygraph testing while on probation.

These objectives address performance in three critical programs: education, substance abuse treatment, and sex offender treatment. For the purposes of measuring performance, the DOC uses program completion as its primary metric for substance abuse treatment programs, attainment of GED certification for education, and program participation and compliance with polygraph examination requirements for sex offender treatment. Figure 1-5 shows the data over the last four years on each of these metrics.[62]

Figure 1-5 Alaska Department of Corrections Program Performance Metrics State Fiscal Year 2010 to 2013

	FY 2010	FY 2011	FY 2012	FY 2103
Assessments	81	180	501	567
LSSAT	238	386	420	482
RSAT	105	111	110	119
Aftercare	-	42	106	133
Total Substance Abuse Program Completions	**424**	**719**	**1,137**	**1,301**
GEDs Received	**247**	**254**	**251**	**216**
Polygraphed Sex Offenders	**383**	**454**	**421**	**442**

Source: Performance Review of the Alaska Department of Corrections

The performance review paints a helpful picture of the current services provided within DOC. Policymakers and systems leaders have taken a strong interest in addressing the high rate of incarceration and recidivism in Alaska. Developing the data and infrastructure to understand how the State-funded (non-corrections) behavioral health system intersects with the adult and juvenile correctional system should be a subject of future analysis. Incorporating DOC treatment and recovery services into future analyses could highlight important trends, such as access to aftercare and other patterns of use. We know that many individuals who receive treatment and recovery services while incarcerated will need them as they reenter the community.

Leadership of the State-funded Behavioral Health System

Leadership of the State-funded behavioral health system is shared across a number of entities, from policymakers to service providers. Five entities have a statutory charge to provider oversight, funding, and/or leadership to the State-funded behavioral health system:

- The Alaska Governor
- The Alaska Legislature
- Alaska Department of Health Social and Services, Division of Behavioral Health
- The Alaska Mental Health Trust Authority
- The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board

This section includes a brief overview of the entities that serve key leadership roles in managing the behavioral health system: Alaska Department of Health Social and Services, Division of Behavioral

[62] Performance Review of the Alaska Department of Corrections. Pages 44-47. December 2, 2014. State of Alaska Division of Legislative Audit. Performed by CGL.

Health, the Alaska Mental Health Trust Authority, and the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board. Leadership is also shared with Tribal Health Organizations due to the interwoven nature of Alaska's State-funded behavioral health system (many Tribal Health Organizations receive DBH grant funds to operate Community Behavioral Health Centers and conduct prevention efforts). Likewise, federally qualified community health centers funded by the U.S. Health Resources and Services Administration (HRSA) are providing increasing levels of behavioral health services. Indeed, two of Alaska's strongest assets to improve the behavioral health of all Alaskans are the Tribal Health System and the HRSA-funded community health system. While this assessment touches only lightly on the community health system, assessing both the Tribal and non-Tribal parts of Alaska's Behavioral Health System was an important component of the scope of work that shaped this effort.

For a more comprehensive list of federal and state system leaders, as well as other important system partners and brief description of roles and responsibilities, see the Appendix A.

ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF BEHAVIORAL HEALTH

Alaska Statute specifies that the Department of Health and Social Services shall:

- (1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 47.30.056 (i); the preparation of the plan and any revision or amendment of it shall
    - (A) be made in conjunction with the Alaska Mental Health Trust Authority;
    - (B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;
- (2) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan. [63]

Moving Forward is the most recent Comprehensive Integrated Mental Health Plan completed by the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority, and related state agencies, boards and commissions for 2006-2011.[64]

ALASKA MENTAL HEALTH TRUST AUTHORITY[65, 66]

Alaska Mental Health Trust Authority (The Trust) is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust, to improve the lives of beneficiaries. The Trust is an important leader of the behavioral health system in Alaska, charged by statue with the co-development of the Comprehensive Integrated Mental Health Plan described above as well as other

[63] AS 47.30.660. Powers and Duties of Department.

[64] Moving Forward: Comprehensive Integrated Mental Health Plan, 2006-2011. Alaska Department of Health and Social Services. http://dhss.alaska.gov/dph/HealthPlanning/Pages/movingforward/default.aspx

[65] Information about The Trust's history is borrowed largely verbatim from: http://mhtrust.org/about/history/

[66] Alaska Mental Health Trust Authority Annual Report 2014. http://mhtrust.org/mhtawp/wp-content/uploads/2015/01/0507_Trust-Annual-Report-2014.pdf

duties related to implementation, management, and funding and overseeing the mental health budget bill that is transmitted to the State for consideration. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program. To understand the role of The Trust, it is helpful to understand its history.[67]

Prior to statehood, individuals who experienced mental illness or development disabilities were sent to institutions out of state by the federal government. During Alaska's transition to a state, Congress passed the Alaska Mental Health Enabling Act of 1956 to bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the territory of Alaska and ultimately the state, by creating the Alaska Mental Health Trust. To fund it, the state selected one million prime acres of land that would be managed to generate income to help pay for a comprehensive and integrated mental health program in Alaska.

Though the Alaska Legislature held a fiduciary responsibility to manage the land on behalf of Alaskans with mental disabilities, it did not do so. Instead, by 1982, only about 35 percent of the trust land remained in state ownership. The majority of the land had been transferred to individuals or municipalities, or designated as forests, parks or wildlife areas.

In 1982, Vern Weiss filed a lawsuit on behalf of his son, who required mental health services that were not available in Alaska. Other beneficiary groups joined Weiss v State of Alaska in a class action suit. The case was ruled on in 1984 by the state Supreme Court, which ordered that the original trust be restored. Ten years later, a final settlement reconstructed the Trust with 500,000 acres of original Trust land and 500,000 acres of replacement land, plus $200 million in cash. As part of the settlement, the Trust's cash assets are managed under a contract with the Alaska Permanent Fund Corporation, and the land and non-cash assets are managed under a contract with the Trust Land Office within the Department of Natural Resources.

The settlement also established an independent board of trustees, which is appointed by the governor and confirmed by the Legislature.

The Trust's current focus areas include:

- Disability justice
- Substance abuse prevention and treatment
- Beneficiary employment and engagement
- Workforce development
- Housing and long-term services and supports

ALASKA MENTAL HEALTH BOARD / ALASKA BOARD ON ALCOHOLISM AND DRUG USE

The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB) are the state agencies 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.[68]

[67] Information about The Trust's history is borrowed largely verbatim from: http://mhtrust.org/about/history/
[68] http://dhss.alaska.gov/abada/Pages/mission.aspx

Alaska statute established AMHB and ABADA. The joint board is the state planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program.[69] In addition to the requirements of Alaska Statute, the SAMSHA Community Mental Health Block Grant includes a requirement that grantees form and support a state or territory mental health planning council. A mental health planning council ensures collaboration among key state agencies and facilitates consumer input into the state's mental health services and activities. The majority (51% or more) of a state's planning council should be comprised of consumer and family members.

To ensure coordination among state agencies in mental health planning, the planning council is required to:

- Include representatives from state education, mental health, rehabilitation, criminal justice, housing, and social services agencies
- Include adult members (consumers) who receive mental health services
- Include family members of children with emotional disturbances.[70]

Alaska Tribal Behavioral Health System

One of Alaska's strongest assets to improve the behavioral health of all Alaskans is the Tribal health system. Tribal Health Organizations provide behavioral health services by leveraging Indian Health Service funding with State grants, third party billing revenue, Alaska Medicaid billing revenue, and other funds to provide a comprehensive array of supports. Tribal Behavioral Health Directors, who convene on a quarterly basis, are emerging as powerful leaders and collaborators in Alaska's behavioral health system as is the Alaska Native Tribal Health Consortium (ANTHC).[71]

> *I am a BHA. My grandmother and mother were healers. My gram said I was picked for healing when I was born. I was trained from when I was very young and, growing up, I didn't want to be this, but when I grew older, I knew I needed to be a healer. I will always be a BHA. We need the support from the agencies to be able to do this work in our communities.*
>
> *Behavioral Health Aide in Rural Alaska*

Depending on the entity, the growth of a Tribal behavioral health program may be covered with a combination of Indian Health Service Compact funds, which are allocated to the provision of behavioral health services at the discretion of each Tribal Health Organization, State grant funds, Behavioral Health Aide grant funds, and Medicaid reimbursable services. Medicaid billing for community-based behavioral health services is an increasingly important revenue stream for many Tribal providers. Tribal Health Organizations are eligible to bill for specific procedures provided within Community Behavioral Health settings and are paid at the IHS clinic encounter rate which is posted annually in the Federal register. Tribal Community Behavioral Health providers benefit from

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[69] AS 47.30.661. Alaska Mental Health Board.

[70] http://www.samhsa.gov/grants/block-grants

[71] While each Tribal Health Organization is a self-governing and self-directed entity, each participates in the ANTHC, which formed in December 1997 to manage statewide health services for Alaska Native people. All Alaska Natives, through their tribal governments and through their regional nonprofit organizations, own the Consortium. ANTHC employs, for the better health of its service population, approximately 2,000 people and operate under a half-billion dollar operating budget. Source: www.anthctoday.org/about

a daily encounter rate that provides a higher reimbursement rate than the fee for service model that governs non-Tribal Community Behavioral Health Service providers. The encounter rate was negotiated in 2007 as a means of covering or offsetting the costs of prevention and other services that were not Medicaid reimbursable but essential to building and maintaining a behavioral health program that addresses Tribal needs.[72] The daily encounter rate applies to both Alaska Native Medicaid enrollees and non-Alaska Native Medicaid enrollees served by Tribal Community Behavioral Health Centers. The Federal Medicaid Assistance Percentage (FMAP) for Medicaid-eligible Community Behavioral Health Services delivered by Tribal Health Organizations to Alaska Native beneficiaries is 100 percent, which means these claims are reimbursed fully by the federal government (claims associated with non-Alaska Native Medicaid enrollees are reimbursed at 50 percent).

Increased attention to importance of behavioral health care and improving community health outcomes presents opportunity to integrate behavioral health services into primary care setting; most Tribal providers are fortunate to have access to in-house primary care partners. The table below[73] includes a list of Tribal Health Organizations broken into two categories, those that receive DBH Treatment and Recovery grants and those that do not. Additionally, an asterisk indicates Tribal Health Organizations that receive Health Resources and Services Administration (HRSA) funds to operate community health centers. This table highlights the interwoven nature of the federal, state, and Tribally-funded behavioral health services.

Figure 1-6 Inventory DBH and HRSA Grantees Among Tribal Health Providers (Completed in Fall 2014)

Tribal Behavioral Health System: Inventory of Alaska Division of Behavioral Health (DBH) and U.S. Health Resources and Services Administration (HRSA) grantees *[HRSA grantees indicated with an asterisk (*)]*	
Did Not Receive a DBH Treatment and Recovery Grant in FY13	FY13 DBH Treatment and Recovery Grantees
Akiachak Native Community	Aleutian Pribilof Island Council*
Annette Island Service Unit	Athabascan Tribal Council*
Arctic Slope Native Association	Bristol Bay Area Health Corporation*
Chickaloon Village Traditional Council	Cook Inlet Tribal Council, Inc
Chugachmiut	Copper River Native Association
Karluk IRA Tribal Council	Eastern Aleutian Tribes*
Knik Tribal Council	Fairbanks Native Association
Mt. Sanford Tribal Consortium	Kenaitze Indian Tribe
Native Village of Eklutna	Ketchikan Indian Community
Native Village of Eyak*	Kodiak Area Native Association
Native Village of Tyonek	Maniilaq Association*
Ninilchik Traditional Council	Metlakatla Indian Community
Seldovia Village Tribe*	Norton Sound Health Corporation*
Tanana IRA Council	Southcentral Foundation*
Yakutat Tlingit Tribe*	Southeast Alaska Regional Health Consortium*
	Tanana Chiefs Conference*
	Yukon Kuskokwim Health Corporation*

[72] Renee Gayhart, Tribal Health Program Manager, Office of Medicaid and Health Care Policy, 8/31/15.

[73] Compiled by Agnew::Beck in the fall of 2014in an effort to better understand the overlap between the Tribal and non-Tribal systems and HRSA-funded community health centers.

To understand the tremendous resource that is the Tribal Behavioral Health System, one must first understand the history behind Alaska's Tribal Health System and how it influences the structure and operation of the Tribal Behavioral Health System today.

A BRIEF HISTORY

Alaska is home to 228 federally recognized sovereign tribes.[74] The IHS has a longstanding obligation bound by U.S. treaty to provide comprehensive health services to Alaska Natives. The passage of two sentinel acts of federal legislation: the Alaska Native Settlement Claims Act (ANSCA) and the Indian Self-Determination and Education Assistance Act (ISDEAA) shifted dramatically how health services are delivered in Alaska.

The Alaska Native Settlement Claims Act, Public Law 92-203, was enacted in 1971 to settle Alaska Native land rights. The settlement established thirteen Regional Corporations, twelve in Alaska and one for non-resident Alaska Natives residing outside of Alaska, 203 Village Corporations and four Urban Corporations (Sitka, Juneau, Kenai, and Kodiak).[75] Although the Act focused on settling land claims, it also addressed Native health, education, and welfare. Corporations were permitted to create non-profit subsidiaries to direct health and social service-related programs previously operated by the federal government. The first two regional health corporations, the Yukon Kuskokwim Health Corporation and Norton Sound Health Corporation, were created as a result.[76]

On January 4, 1975, Congress passed the Indian Self-Determination and Education Assistance Act, Public Law 93-638, strengthening the ability of Native communities to manage their own health care resources.[77] This act, amended over time, led to a major transformation in the administration of federal health care services from an IHS-operated system of care to a tribally operated system of care.[78] By the end of 1975, all Native regions established under ANSCA had created non-profit Regional Health Corporations.

> *The Tribal Self-Governance Program (TSGP) is more than an IHS program; it is an expression of the nation-to-nation relationship between the United States and each Indian Tribe.*
>
> *– Indian Health Services*

Federal responsibility for the provision of health care to American Indians and Alaska Natives was enacted in 1976 with the Indian Health Care Improvement Act, Public Law 94-437[79] and was made permanent by the Patient Protection and Affordable Care Act.[80] To accomplish this mandate, IHS divides the country into ten geographic areas, one of which is the Alaska Area. Each area is further divided into service units. Under the ISDEAA,

[74] This history draws from the Indian Health Services' overview of the Alaska Area: http://www.ihs.gov/alaska/

[75] Alaska Society of Professional Land Surveyors Standards of Practice Manual, Chapter 3 on the Alaska Native Claims Settlement Act. Rev. 1/13/94. http://www.alaskapls.org/standards/ancsa.pdf

[76] State of Alaska Department of Health and Social Services. Under Governor Walter J. Hickel. A History of Health and Social Services in Alaska. 1993. http://dhss.alaska.gov/Commissioner/Documents/PDF/History_DHSS_1993.pdf

[77] State of Alaska Department of Health and Social Services. Under Governor Walter J. Hickel. A History of Health and Social Services in Alaska. 1993. http://dhss.alaska.gov/Commissioner/Documents/PDF/History_DHSS_1993.pdf

[78] Interview with Angel Dotomain, Director of the Office of Tribal Programs, Indian Health Service Alaska Area Office. 8.20.14

[79] Indian Health Service. History of Tribal Self-Governance legislation: http://www.ihs.gov/SelfGovernance/index.cfm?module=dsp_otsg_about

[80] http://www.ihs.gov/ihcia/

Tribes can choose among three options for obtaining health care from the Federal government. These options are non-exclusive to provide flexibility to the Tribes:

- Receive IHS-administered services;
- Contract with IHS to administer individual programs and services the IHS would otherwise provide (Title 1 Self-Determination Contracting);
- Compact with IHS to assume control over health care programs the IHS would otherwise provide (Title V Self-Governance Compacting).[81]

The latter option is facilitated by the Tribal Self-Governance Program (TSGP), which is designed to promote self-governance by transferring responsibility for Programs, Services, Functions and Activities (PSFAs).[82] As of FY2011, 33 percent of nation-wide IHS funds were transferred for the delivery of tribally-controlled health care services via Compacts.[83]

The Alaska Tribal Health Compact was established in 1995, just two years after the nation's first self-governance demonstration agreements were set in place. Typically, compacts are entered into with a single tribal entity.[84] In Alaska, a single Compact now covers 25 separate funding agreements with 25 entities, a markedly different structure from the rest of the nation.[85] The multi-party Compact was established to "preserve and strengthen the Alaska Tribal Health System and to avoid competition for limited slots in the Self Governance Demonstration Project."[86] The current self-governance Tribes are located in ten former IHS service areas, which include: Alaska Native Tribal Health Consortium (1999), Maniilaq Association (1995), Aleutian/Pribilof Islands Association, Inc. (1995), Metlakatla Indian Community (1997), Arctic Slope Native Association, Ltd. (1998), Mount Sanford Tribal Consortium (2000), Bristol Bay Area Health Corporation (1995), Native Village of Eyak (2011), Chickaloon Native Village (2011), Native Village of Eklutna (1995), Chugachmiut (1995), Norton Sound Health Corporation (1995), Copper River Native Association (1995), Seldovia Village Tribe (1995), Council of Athabascan Tribal Governments (2000), Southcentral Foundation (1995), Eastern Aleutian Tribes, Inc. (1997), SouthEast Alaska Regional Health Consortium (1995), Kenaitze Indian Tribe (2006), Tanana Chiefs Conference, Inc. (1995), Ketchikan Indian Corporation (1998), Yakutat Tlingit Tribe (2003), Knik Tribal Council (2008), Yukon-Kuskokwim Health Corporation (1995), Kodiak Area Native Association (1995).

> *The current system has many assets but high need, a propensity toward treatment outside of one's community and culture, insufficient Behavioral Health Aide training, and communication gaps still exist. These challenges lead to the fragmented and at times ineffective and costly patchwork we see today.*
>
> *Tribal Behavioral Health Directors Executive Committee*

[81] http://www.ihs.gov/SelfGovernance/index.cfm?module=dsp_otsg_about

[82] http://www.ihs.gov/dgm/documents/HHS-2011-IHS-TSGP-0001.pdf

[83] http://www.ihs.gov/SelfGovernance/index.cfm?module=dsp_otsg_about

[84] Only one other Compact covers more than a single funding agreement; the Navajo Nation Compact has three funding agreements.

[85] https://www.alaskatribalhealth.org/caucus/aths/loader.cfm?csModule=security/getfile&pageid=677
And IHS Alaska Area site (the 25, presentation is outdated)

[86] History of the Alaska Tribal Health Compact
https://www.alaskatribalhealth.org/caucus/aths/loader.cfm?csModule=security/getfile&pageid=677

Today, 99% of the Alaska Area IHS budget is allocated to Alaska Native Tribes and Tribal Organizations.[87] IHS funds are issued to Tribes and Tribal Organizations to provide services to the state's Alaska Native and American Indian populations through two mechanisms: ISDEAA Title V Compact funds (described above) and ISDEAA Title I contract funds. IHS currently holds 13 Title I contracts with a mix of Alaska Native regional and village health corporations.[88] Together, these funds provide the financial backbone to a system of autonomous regional health care providers supported by shared statewide Tribal services. In FY10, the total funding allotted to the Compact was $574 million. The amount of funding issued to each entity under the Compact is negotiated annually and based on an agreed upon formula that distributes "tribal shares" of IHS Area and Headquarter funds. The Alaska Tribal Share Formula takes into account three variables: number of communities served, population, and recurring base.

TODAY'S TRIBAL BEHAVIORAL HEALTH SYSTEM

As the capacity of Alaska's Tribal Health Care System has grown so too has the capacity of its behavioral health system. In 2011, IHS produced its first "American Indian/Alaska Native Behavioral Health Briefing Book" and described Alaska Area as follows:

Currently in Alaska, there is not a coordinated single system of behavioral healthcare for American Indian and Alaska Native people. Each Tribal Health Organization (THO) provider of behavioral health services functions independently and determines the types and amounts of services to be made available in each region. The service level in different geographic areas of the state reflect the different capacities of various THOs, including individual funding capacity, different opportunities to maximize economies of scale, and the stability and vision of individual THO leadership. Even so, most THOs operate multi-layered and complex behavioral health programs within their regions. Specific services offered in each geographical location are varied depending on regional needs, desires, funding, and capacities of individual THOs.[89]

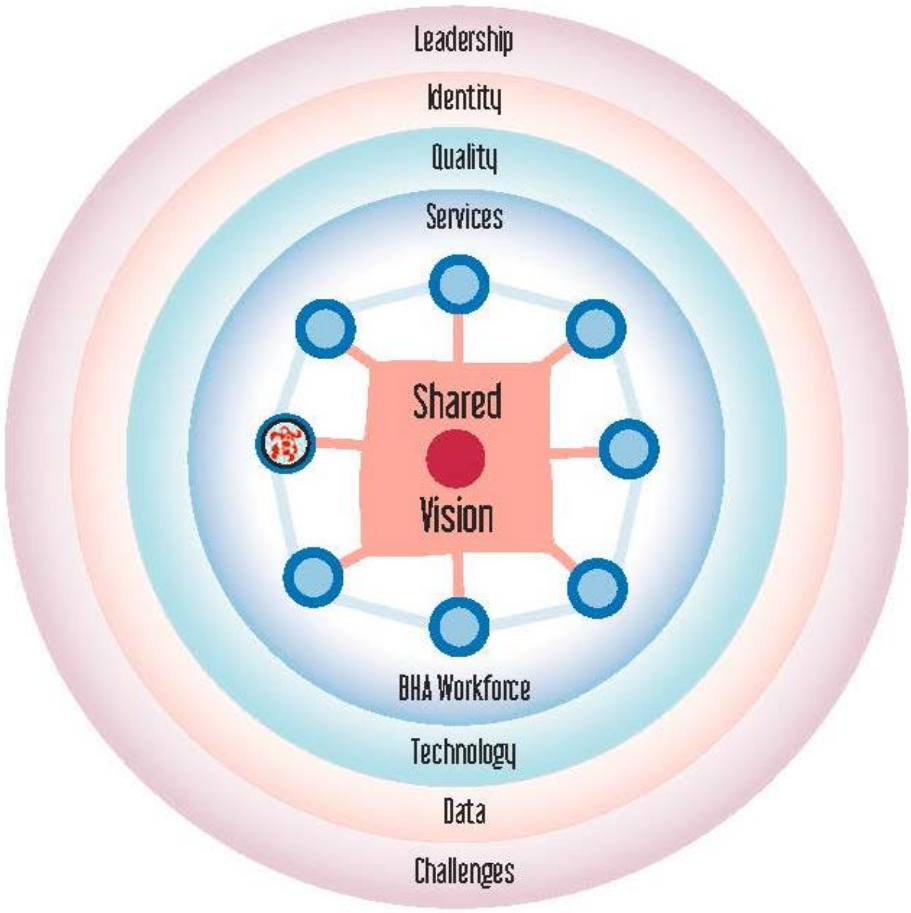
While the above description is accurate, commonalities, shared resources, and a commitment to coordination make the Tribal behavioral health system what it is today. In 2015, the Tribal behavioral health system is perhaps better described as a collection of independently operated Regional and Village Health Corporations with a shared vision and shared commitment to meeting the behavioral health needs of Alaska Natives. Figure 1-7 was designed with input from the Tribal Behavioral Health Directors and illustrates the balance between autonomy and collaboration that describes the system today. The smaller circles in the middle represent independent organizations sitting around a shared vision while the larger concentric circles represent the many commonalities that define these organizations.

[87] http://www.ihs.gov/alaska/

[88] http://www.ihs.gov/alaska/, confirmed in interview with Angel Dotomain, Director of the Office of Tribal Programs, Indian Health Service Alaska Area Office. 8.20.14

[89] American Indian/Alaska Native Behavioral Health Briefing Book. U.S. Department of Health and Social Services. Division of Behavioral Health. Office of Clinical and Preventive Services. August 2011.

Figure 1-7 Alaska's Tribal Behavioral Health System: A Shared Vision



The Tribal behavioral health system has many unique features, one of which is the BHA's. A BHA is a credentialed behavioral health position, similar to Community Health Aides, with Medicaid billing potential. BHA's live and work in communities across the state and represent a workforce of approximately 150 strong. ANTHC manages a BHA Program that provides training and technical assistance to BHA's and Tribal behavioral health programs across the state.

Tribal Behavioral Health Directors convene quarterly in person to discuss and resolve strategic issues confronting the system, their regions and organizations, and Alaska Native people. A small Tribal Behavioral Health Executive Committee, made up of four Tribal Behavioral Health Directors and the ANTHC's Director of Behavioral Health, meets regularly via telephone in the interim periods to plan and coordinate Tribal Behavioral Health Director business.

Assessing both the Tribal and non-Tribal parts of Alaska's Behavioral Health System was an important component of the scope of work that shaped this effort. In order to better understand the Tribal Behavioral Health System, we produced the graphic shown in Figure 1-9 during the fall of 2014 through a series of weekly interviews and work sessions with the ANTHC Behavioral Health Program Director and her staff and the Tribal Behavioral Health Executive Committee. This vibrant visual starts with a spool of thread at the foot of an Alaska Native woman highlighting a selection of behavioral health disparities faced by Alaska Native people. The thread is woven through a fragmented patchwork that depicts the challenges facing the current Tribal Behavioral Health System at each level, from the village to the state. As the graphic shifts to the future, a Behavioral

Health Aide sews the system together into a cohesive quilt with a healthy community at its center. The future vision symbolizes the importance of harnessing the full potential of the Behavioral Health Aide workforce in Alaska.

To better understand the opportunities and challenges facing the Tribal behavioral health system as it pursues this vision, we undertook a range of activities:

- Facilitated a World Café session with the BHA workforce
- Shared and discussed project findings with the Tribal Behavioral Health Directors
- Worked collectively with the Tribal Behavioral Health Directors to document challenges and opportunities facing the Behavioral Health System and identify recommendations for improving system capacity

This collective work is reflected throughout the report.

Figure 1-8 Alaska Tribal Health System, Behavioral Health Aide Locations by Region

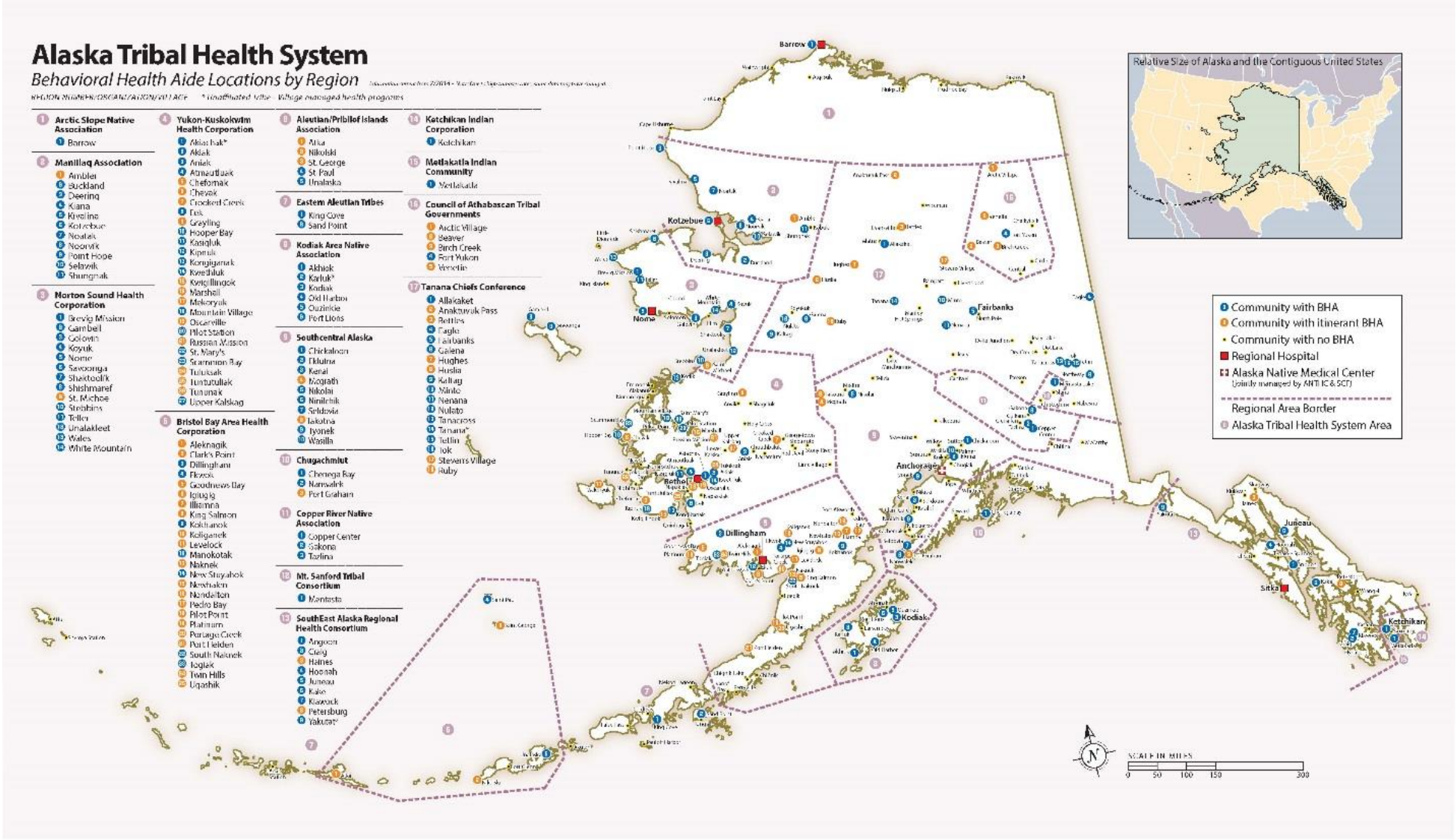
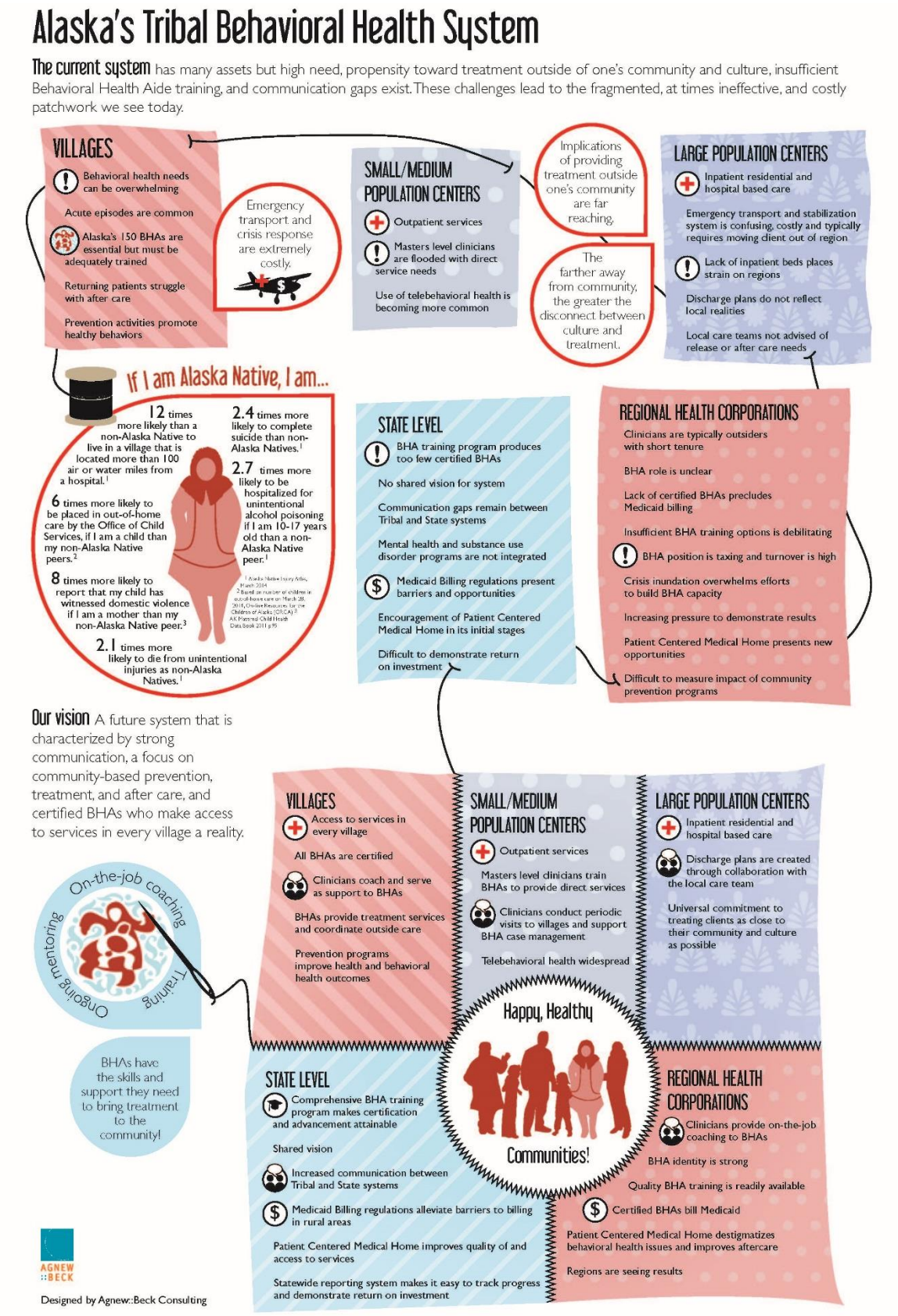


Figure 1-9 Alaska's Tribal Behavioral Health System Current and Future Vision



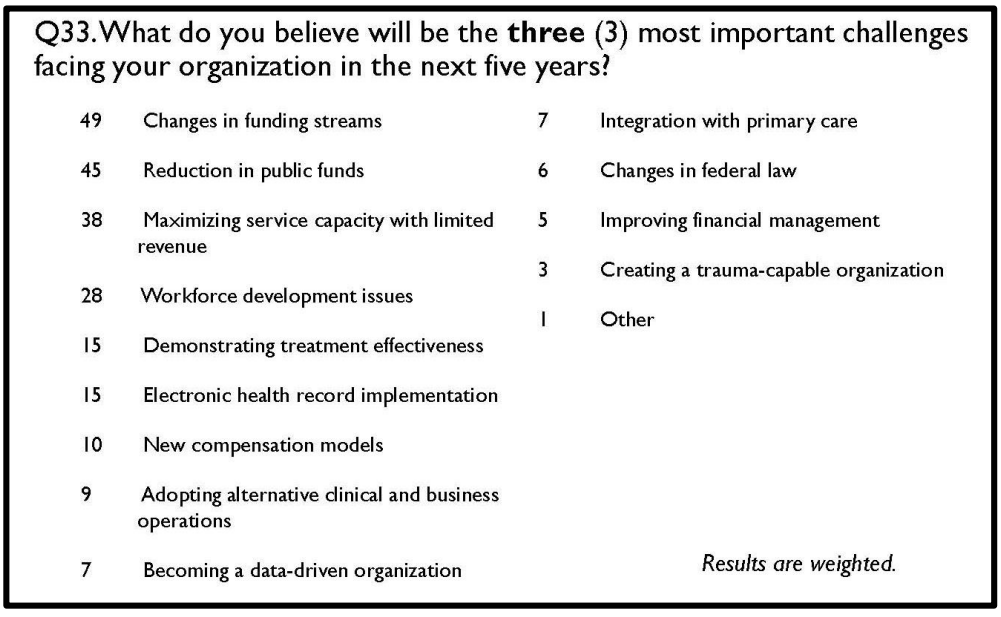
What Forces Influence System Capacity?

FORCES ANALYSIS

The behavioral health system is a system undergoing tremendous change and transformation. To better understand the system forces influencing system capacity, we conducted a series of interviews with systems leaders during the summer and fall of 2014 and produced a one-page graphic outlining the results of these interviews (the graphic was updated again in June of 2015). We found that there are many forces, both positive and negative, influencing the capacity of the system to meet the behavioral health needs of Alaskans. Figure 1-11 represents the collection of forces we documented at the federal, state, systems, organizational, and, ultimately, consumer levels.[90] We also heard that at the community level, infrastructure, the presence of an available and affordable workforce, seasonality, economy, flows of trade, and NIMBY-ism ("Not In My Back Yard") can influence system capacity. The direction and flow of the graphic indicates that each level of the system influences the next and, in their totality, these forces influence system capacity in both positive and negative ways. Documenting these forces is an important first step to being able to tame and manage change within the system.

In addition to interviewing systems leaders, we conducted a survey of DBH-funded providers using an audience response system at the November 2014 Change Agent Conference. Representatives from fifty-four DBH provider organizations participated. We asked providers: What do you believe will be the three most important challenges facing your organization in the next five years? Results are weighted and in rank order. This is what we heard:

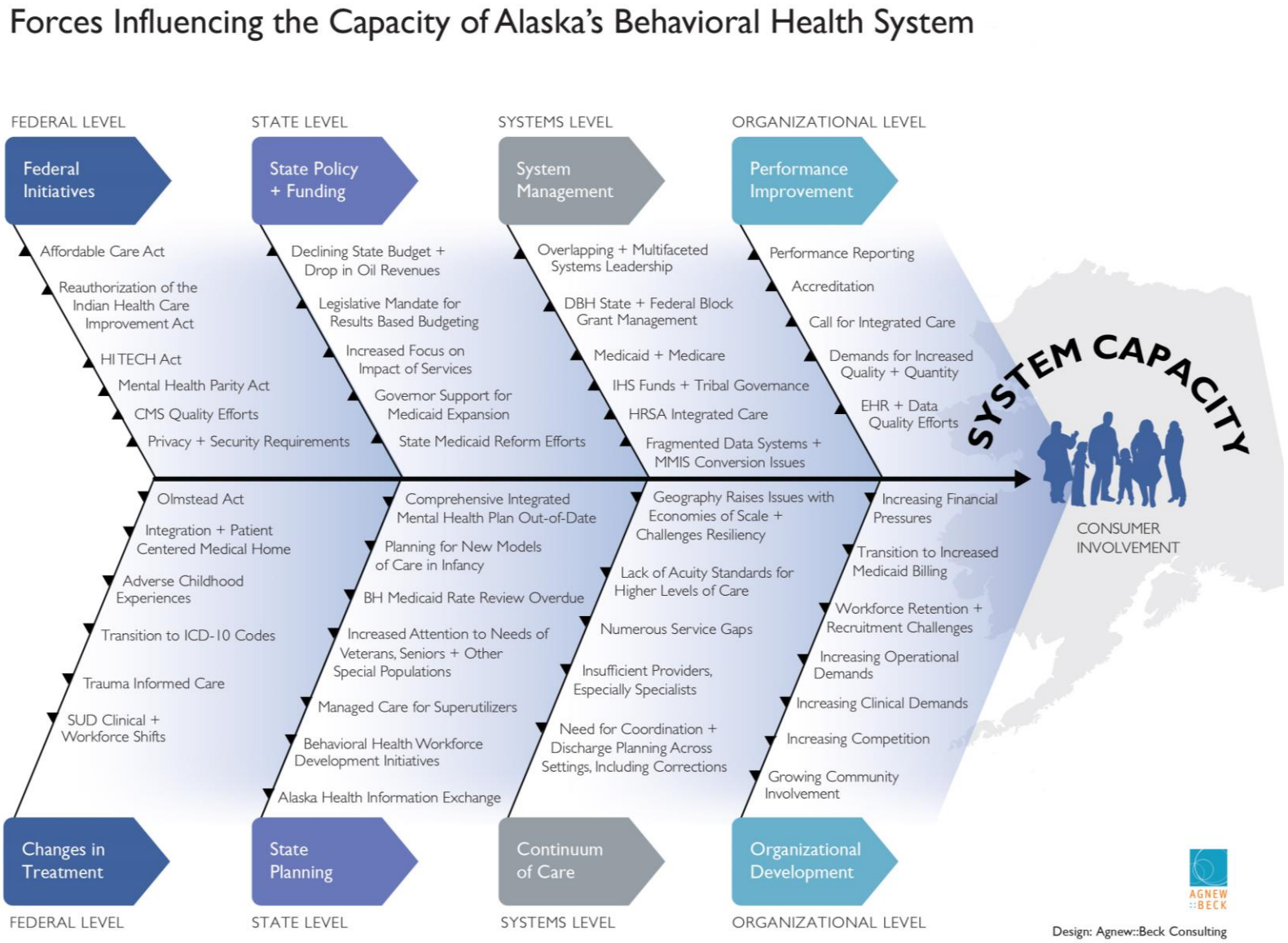
Figure 1-10 Results from DBH Provider Survey, Change Agent Conference November 2014



Changes in funding streams, reduction in public funds, maximizing service capacity with limited revenue, and workforce development issues ranked highest.

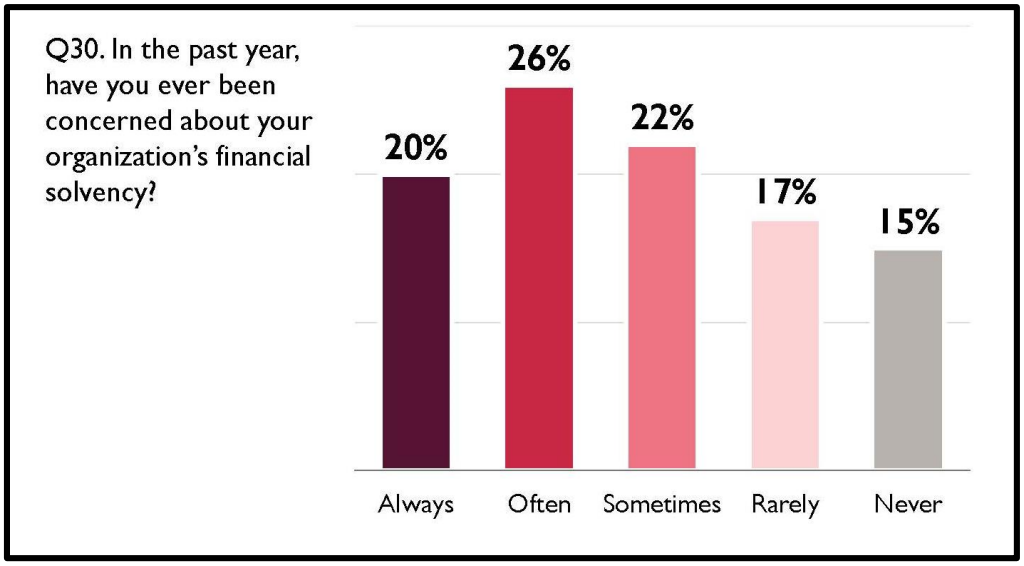
[90] Based on a series of interviews about the factors influencing system's capacity with Mark-Haines Simeon, former Director of Policy and Planning for DBH and Rick Calcote, DBH, fall 2014. The analysis was then shared with DBH Director Albert Wall and The Trust's CEO, Jeff Jessee. Additional insights from the provider survey and provider feedback were incorporated subsequently.

Figure 1-11 Analysis of Forces Influencing System Capacity



We also asked providers: In the past year, have you ever been concerned about your organization's financial solvency? Forty-six percent of DBH-funded service providers responded "Always or Often."

Figure 1-12 Results from DBH Provider Survey, Change Agent Conference November 2014



While these responses underscore the financial vulnerability of providers, the data shared in subsequent sections of this assessment speak to the strength and resiliency of the system even during a period of unprecedented change.

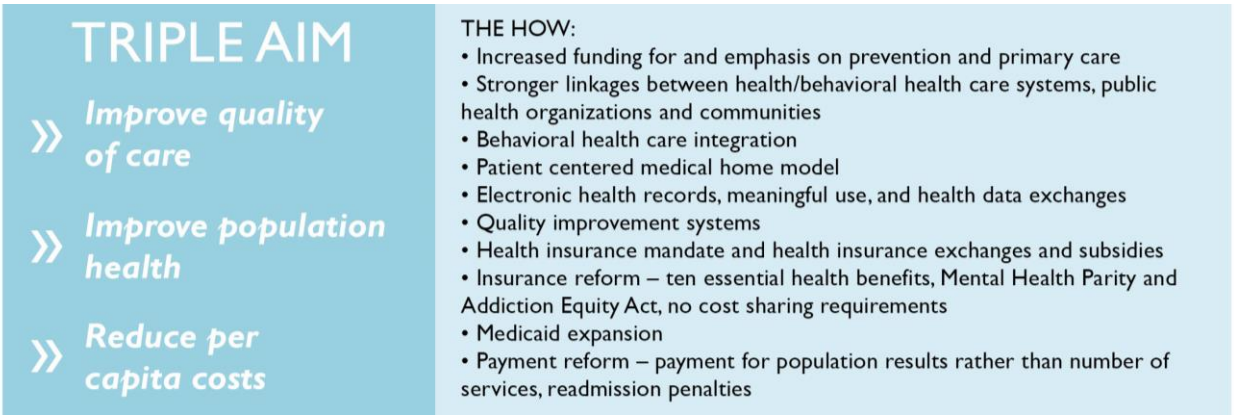
Without out a doubt, one of the most prominent forces influencing the behavioral health system is the Patient Protection and Affordable Care Act (Affordable Care Act).

THE AFFORDABLE CARE ACT

The Affordable Care Act has placed greater attention on three goals: 1) Improving quality of care, 2) Improving population health, and 3) Reducing per capita costs. These goals are known as the "triple aim." The Affordable Care Act called for a range of strategies for achieving these goals (a selection of these strategies is shown in the following box[91]).

[91] Strategies compiled by Agnew::Beck during the Spring of 2014.

Figure 1-13 The Triple Aim



The strategies have brought behavioral health care on to center stage, elevating the importance of access to treatment and recovery-oriented services and emphasizing the need to integrate behavioral health and primary care services.

Integration of Primary Care and Behavioral Health Care

The call for primary care settings to implement the patient centered medical home model means that new points of access are opening in the medical field for behavioral health services. These access points result from primary care practices integrating behavioral health into the patient-centered medical home, and from behavioral health providers adding primary care services to their practices. Integration promises to greatly expand the availability of behavioral health services and continue to reduce the stigma associated with accessing behavioral health. In order to facilitate integration, however, changes need to be considered to billing structures, provider credentialing, documentation, team-based care management structures and practice redesigns, and other aspects of health care delivery.

Although we believe we are poised to achieve the [Patient Centered Medical Home] recognition that we are pursuing, the integration of primary care and behavioral health continues to be our biggest barrier. The primary barrier to integration is the lack of reimbursement for most behavioral care services through State of Alaska Medicaid without the oversight of an on-site psychiatrist. Second, the only option for screening and brief intervention that is reimbursed by the State of Alaska Medicaid are SBIRT services which are designated for substance abuse, which is not appropriate for our patient population. Without appropriate reimbursement for behavioral health services, we cannot feasibly add new staff to provide these services.

As the demand for behavioral health services increases, behavioral health system leaders must ensure that the front doors through which Alaskans access behavioral health services are as wide open and as connected as possible. Over the course of this assessment, we frequently discussed the need for two front doors into the behavioral health system, one in which mild and moderate behavioral health needs can be met in a primary care health home that includes behavioral health services and one in which serious and severe behavioral health needs can be met in a behavioral health home that includes some primary care. Already we see this happening with federally qualified community health centers in Alaska, which are funded by the U.S. Human Resources Services Administration (HRSA). HRSA has made behavioral health

integration an important program priority.[92] Figure 1-14 shows the volume of behavioral health patients served by community health centers in Alaska in 2012.

Figure 1-14 Number of Mental Health and Substance Abuse Patients Served by HRSA-funded Community Health Centers, 2012

Community Health Center	City	Mental Health Patients	Substance Abuse Patients
ALASKA ISLAND COMMUNITY SERVICES	Wrangell	257	0
ALEUTIAN PRIBILOF ISLAND ASSOCIATIONS	Anchorage	27	0
ANCHORAGE NEIGHBORHOOD HEALTH CENTER	Anchorage	764	0
BETHEL FAMILY CLINIC	Bethel	65	0
BRISTOL BAY AREA HEALTH CORPORATION	Dillingham	357	0
BRISTOL BAY BOROUGH	Naknek	0	0
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENT	Fort Yukon	125	0
CROSS ROAD MEDICAL CENTER	Glennallen	20	0
EASTERN ALEUTIAN TRIBES, INC	Anchorage	115	-
ILIULIUK FAMILY AND HEALTH SERVICES, INC.	Unalaska	161	0
INTERIOR COMMUNITY HEALTH CENTER	Fairbanks	454	0
KODIAK ISLAND HEALTH CARE FOUNDATION	Kodiak	0	0
MANILLAQ ASSOCIATION	Kotzebue	-	-
MAT-SU HEALTH SERVICES, INC.	Wasilla	1256	-
MUNICIPALITY OF SKAGWAY	Skagway	0	0
NATIVE VILLAGE OF EYAK	Cordova	28	0
NORTON SOUND HEALTH CORPORATION	Nome	243	0
PENINSULA COMMUNITY HEALTH SERVICES OF ALASKA, INC.	Soldotna	1575	-
SELDOVIA VILLAGE TRIBE	Seldovia	-	-
SOUTHCENTRAL FOUNDATION	Anchorage	42	-
SOUTHEAST ALASKA REGIONAL HEALTH CONSORT	Sitka	270	0
SUNSHINE COMMUNITY HEALTH CENTER, INC.	Talkeetna	194	36
TANANA CHIEFS CONFERENCE	Fairbanks	153	179

Note: "-" = data cannot be calculated. Data retrieved HRSA's Public Online Grantee Data Reports http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=AK#glist

Community health centers are becoming a major access point for behavioral health services, but to tap the full potential of this expansion of services, the credentialing and billing systems must acknowledge the importance of delivering behavioral health care in primary care settings. Behavioral health systems leaders must take the lead in removing barriers to provision of behavioral health care in primary care settings.

A recent opportunity for Community Health Centers, both those that are operated by THOs and those that are stand-alone, is developing partnerships with the Veterans Administration (VA) to serve veterans who live in communities without a VA health facility. In addition, the Affordable Care Act authorized THOs to deliver services to non-beneficiaries. For THOs that opt to do so, this access could draw many non-Alaska Natives to THOs in smaller communities and break down some

[92] Interview with Dale Dates, Alaska Project Officer, HRSA Bureau of Primary Health Care. July 2014.

of the silos that currently exist in service delivery structures in rural Alaska and increasing competition among providers.

Medicaid Expansion

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act, provides the largest expansion of mental health and substance use disorder health care coverage in a generation.[93] Three types of expansion are expected to increase the demand for behavioral health services from both publicly funded and private providers, as individuals with behavioral health needs are able to procure services using their new health care coverage.

> *"All states should expand Medicaid if they are serious about meeting the needs of people with serious mental health concerns. The Medicaid coverage gap (the "Medicaid Gap") continues to leave a large number of people with behavioral health needs uninsured and untreated... Due to the failure of many states to expand Medicaid, an estimated 3.5 million adults with mental illness or substance use remain uninsured and are currently part of the "Medicaid Gap.""*
>
> *Mental Health America's Parity or Disparity: The State of Mental Health in America 2015*

First, beginning in 2014 under the law, all new small group and individual market plans are required to cover ten Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. The 2008 Mental Health Parity and Addiction Equity Act required health insurers and group health plans to provide the same level of benefits for behavioral health services that they do for primary care.

Second, the Affordable Care Act includes an individual mandate. Individuals are now required to carry health insurance. Federal subsidies are available to individuals with incomes between 100 percent and 400 percent Federal Poverty Level (FPL).

Third, the Affordable Care Act and the subsequent Supreme Court decision regarding this law fundamentally changed its structure by allowing states to choose to expand Medicaid to nearly all individuals under age 65, including non-disabled childless adults, with a Modified Adjusted Gross Income (MAGI) of up to 138 percent of the FPL. Because the Affordable Care Act anticipated that Medicaid expansion would be mandatory, many low-income individuals who would be eligible for Medicaid under expansion are not eligible for Advanced Premium Tax Credits (APTCs) to subsidize the cost of buying health insurance in the Health Insurance Marketplace, but are subject to penalties per the individual mandate provision if they do not buy insurance.

While Alaska at first declined to expand Medicaid, in February 2015, the Alaska DHSS released the report *'The Healthy Alaska Plan: A Catalyst for Reform'* that announced the intention to expand Medicaid, as the Affordable Care Act originally envisioned all states would do.[94] By far the largest group to be added to the Medicaid rolls under the proposed Medicaid expansion would be adults ages 18 to 64. The graphic below[95] illustrates the current gap in coverage:

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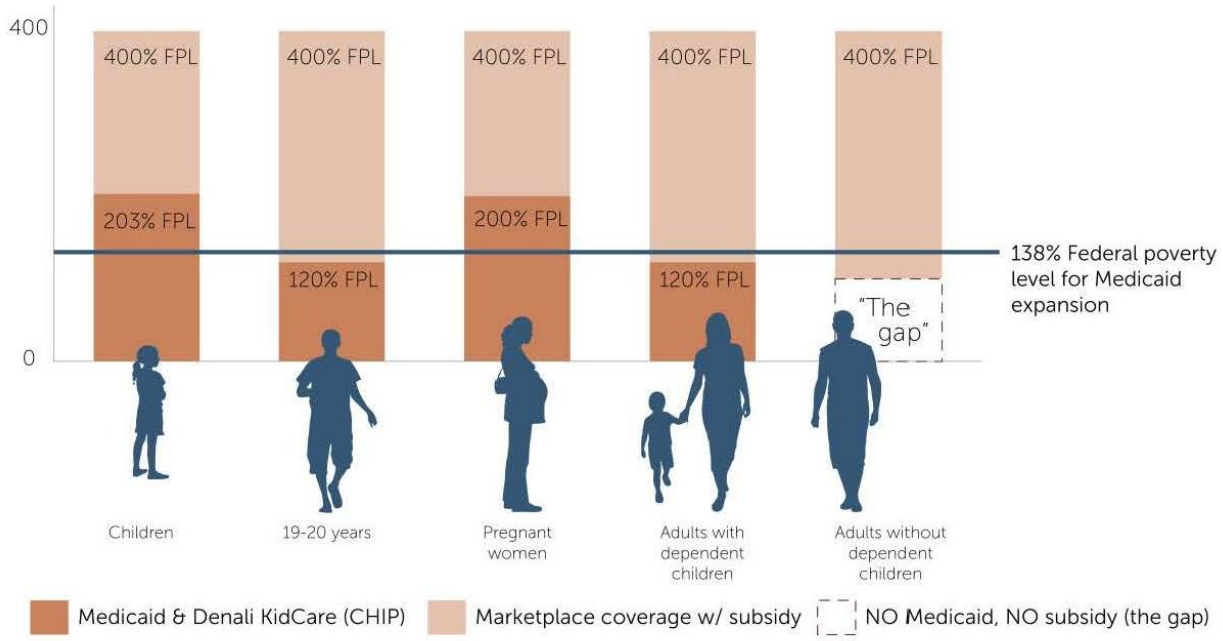
[93] ASPE Research Brief, Office of Assistant Secretary for Planning and Evaluation, DHHS, February 2013,

[94] Alaska Department of Health and Social Services. The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets. February 2015.

[95] Excerpted from Alaska Department of Health and Social Services. The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets. February 2015.

Figure 1-15 Income Eligibility for Health Coverage, excerpted from DHSS' Healthy Alaska Plan



A recent State-commissioned report by Evergreen Economics estimated that if the State chooses to expand Medicaid, 41,910 adults will be newly eligible for Medicaid and 20,075 individuals are likely to enroll in Fiscal Year (FY) 2016 (with increasing enrollment projected in subsequent years).[96] Adopting Medicaid expansion will benefit individuals, who will have greater access to coverage for health services; health providers, who will have fewer uninsured patients; and the health system as a whole, by sharpening the focus on integrated care, improving patterns of usage and health outcomes for all Alaskans, and generating additional revenue to grow the system.

Estimation of Prevalence Among Newly Eligible and Enrollee Populations

One of the goals of this assessment was to estimate the need for behavioral health services among the newly eligible adult population under Medicaid expansion. Evergreen Economics estimated the newly eligible population at 41,910 individuals.[97] By applying National Survey on Drug Use and Health (NSDUH) prevalence rates for adults *under 138 percent of the federal poverty level* to the population projections included in the Evergreen report, we found that an estimated 13,782 individuals within the newly eligible for Medicaid Expansion population have a behavioral health need (see Figure 1-16). Of these, 6,999 adults are estimated to need treatment for illicit drug or alcohol use and 9,975 adults are estimated to have experienced a mild, moderate or serious mental illness in the past year (Figure 1-16). Nearly half (45.6 percent) of the individuals who needed treatment for illicit drug or alcohol use are estimated to also have a mental illness (co-occurring disorder). Figure 1-16 also includes behavioral health prevalence estimates for projected enrollees.

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[96] Evergreen Economics. February 6, 2015 Memorandum to Valerie Davidson, Commissioner of AK DHSS, re: Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning FY2016.

[97] Medicaid Expansion Population Estimates: Project Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016, Evergreen Economics, February 2015, http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

Figure 1-16 Estimated Prevalence of Behavioral Health Issues Among Medicaid Expansion Population Using Evergreen Economics Projections

Estimated Prevalence of Behavioral Health Issues Among Medicaid Expansion Population Using Evergreen Economics Projections														
		Needed Treatment for Illicit Drug or Alcohol Use in Past Year (SUD)		**Past Year Any Mental Illness** *(Includes Mild, Moderate, and Serious Mental Illness)*		**Past Year Serious Mental Illness** (SMI)		**Past Year Moderate Mental Illness**		**Past Year Mild Mental Illness**		**Past Year Any Mental Illness and SUD** (COD; Of those needing treatment for a drug or alcohol problem)		**Total Est. Individuals with a Behavioral Health Need** (unduplicated)
		Rate	*16.7%*	**Rate**	*23.8%*	**Rate**	*3.9%*	**Rate**	*6.1%*	**Rate**	*13.8%*	**Rate**	*45.6%*	
		Count		**Count**		**Count**		**Count**		**Count**		**Count**		**Count**
Evergreen Newly Eligible Population														
2016	41,910	6,999		9,975		1,634		2,557		5,784		3,192		13,782
2017	41,980	7,011		9,991		1,637		2,561		5,793		3,197		13,805
2018	42,050	7,022		10,008		1,640		2,565		5,803		3,202		13,828
2019	42,120	7,034		10,025		1,643		2,569		5,813		3,208		13,851
2020	42,190	7,046		10,041		1,645		2,574		5,822		3,213		13,874
2021	42,260	7,057		10,058		1,648		2,578		5,832		3,218		13,897
Evergreen New Enrollee Population														
2016	20,075	3,353		4,778		783		1,225		2,770		1,529		6,602
2017	23,257	3,884		5,535		907		1,419		3,209		1,771		7,648
2018	26,492	4,424		6,305		1,033		1,616		3,656		2,017		8,712
2019	26,536	4,432		6,316		1,035		1,619		3,662		2,021		8,726
2020	26,580	4,439		6,326		1,037		1,621		3,668		2,024		8,741
2021	26,624	4,446		6,337		1,038		1,624		3,674		2,027		8,755

Notes: Rates are based on Alaska-specific National Survey on Drug Use and Health (NSDUH) data for the adult (18+) population below 138% of Federal Poverty Level. The survey is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) using a sampling methodology in order to estimate prevalence. These estimates vary from subsequent estimates because they are specific to the low income adult population. New Enrollee projections assume 48% take up rate in 2016, 55% take up rate in 2017, and 63% take up rate in 2018-2021 per Evergreen Economics' memo cited below. NSDUH prevalence rates from 2009-2011 for specific to adult (18+) population below 138% of Federal Poverty Level were multiplied by the Evergreen population estimates to determine the approximate population with a behavioral health need. The total estimated individuals with a behavioral health need was calculated by adding individuals with SUD and Any Mental Illness and subtracting individuals with Any Mental Illness and SUD (COD). The sum of the individuals in each cell are greater than total estimated need due to co-occurring disorders.

SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) classified respondents as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

Sources: Substance Abuse Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2010 (revised 3/12), and 2011; Alaska NSDUH, DBH Special Data Request April 2014.

Mental Health and Co-Occurring Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2011 (revised 10/13); Alaska NSDUH, DBH Special Data Request April 2014.

Medicaid Expansion Population Estimates: Project Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning in FY2016, Evergreen Economics, February 2015, http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

Amidst concerns about wait lists and costly patterns of usage, a key question facing for the behavioral health system is how it will meet the service demands of this newly enrolled population. One important consideration is how many individuals within the expansion population are currently receiving behavioral health and other health care services and what their patterns of usage are. For example, Tribal Health Organizations already provide broad access to health care services, including behavioral health, to their beneficiaries. Medicaid expansion will bring a new payer source for enrolled beneficiaries and the additional revenue can help Tribal Health Organizations expand service capacity and/or offset the impact of reductions in behavioral health grant funding.[98]

A recent nationwide study of the impact of Medicaid Expansion on access to mental health treatment services among adults with Serious Mental Illness (SMI) found that 46.5 percent of low-income uninsured adults with SMI received mental health treatment in the past year.[99] In contrast, 74.8 percent of low-income non-elderly adults with SMI who were enrolled in Medicaid received mental health treatment in the past year. More specifically, in the 28 states studied, researchers found that in states where Medicaid expansion had occurred, nonelderly adults with SMI who were enrolled in Medicaid for a full-year were 39.8% more likely to receive outpatient mental health treatment than their uninsured counterparts. There was no significant difference in the consumption of inpatient mental health services among the uninsured and insured adult SMI populations. The major difference from a provider perspective is financial – services to these individuals are no longer financed by grants or uncompensated care. From a capacity perspective, these findings suggest that states may actually already be serving about half of the 1,634 estimated to have SMI in the newly eligible cohort and can expect an additional quarter of the individuals in this population to become new clients. The larger change in service with this particular population might occur in the type of services these individuals access, shifting the balance from crisis and inpatient services to outpatient services.

Even more fundamentally, if regulatory barriers are lifted to allow for integration of behavioral health services in primary care settings to better serve individuals with mild and moderate mental illness, the behavioral health continuum of care could expand dramatically and shift access patterns to bring substantial improvements to health outcomes in the state. Given the high numbers of newly eligible individuals who are estimated to need treatment for illicit drug and alcohol use in Alaska, Medicaid expansion presents an important opportunity to finance new positions and programs that can meet the anticipated increase in demand for services that will come with health insurance coverage among low-income adults.

Medicaid Expansion has the potential to expand services to adults with SUD and Any Mental Illness and, with the right leadership and policy-making, achieve access to behavioral health services through both the medical and community behavioral health doorways. Conversely, lack of Medicaid expansion creates a gap in coverage that perpetuates ineffective utilization patterns and contributes to financial insecurity among providers. Understanding the prevalence of behavioral health issues and current utilization of State-funded behavioral health services in Alaska is critical for systems planning. Chapter 2 provides an overview of prevalence and Chapter 3 shares our analysis of current utilization.

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[98] The Department of Health and Social Services' Healthy Alaska Plan (February 2015) proposes a $1 million dollar reduction in Behavioral Health Grants in SFY 2016 increasing to $16 million in SFY 2020 to offset the costs expanding Medicaid.

[99] Beth Han, MD, PhD, MPH, Joe Gfroerer, BA, S. Janet Kuramoto, PhD, MHS, Mir Ali, PhD, Albert M. Woodward, PhD, MBA, and Judith Teich, MSW Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults With Serious Mental Illness. Published online ahead of print March 19, 2015 | American Journal of Public Health.

2. WHAT IS THE PREVALENCE OF BEHAVIORAL HEALTH ISSUES IN ALASKA?

This section identifies rates of prevalence of behavioral health issues in Alaska based on quantitative analysis of surveillance data. This assessment used various data sources to generate behavioral health prevalence rates. For adults, indicators and rates from the National Survey of Drug Use and Health (NSDUH) were used. For youth, the analysis relied on data from NSDUH and the Youth Risk Behavior Surveillance System (YRBS). Additionally, to calculate Serious Emotional Disturbance (SED) among the youth population, regional poverty rates were used.[100] For both adults and youth, Alaska Department of Labor data were used to determine the population estimates to which prevalence rates were applied. In addition, this section includes a series of charts and tables describing the prevalence of Adverse Childhood Experiences (ACEs) among Alaskans developed by the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board (ABADA/AMHB) using the Behavior Risk Factor Surveillance System (BRFSS) data.

This assessment identified statewide prevalence rates for the number of adult individuals who needed treatment for illicit drug or alcohol use in the past year (Substance Use Disorder); past year any mental illness (includes Mild, Moderate, and Serious Mental Illness); past year Serious Mental Illness (SMI); past year moderate mental illness; past year mild mental illness; past year co-occurring disorder, and, total estimated adults with a behavioral health need (unduplicated). Regional estimates were also produced and are available in the Regional Data Reports. These estimates are all based on 2009-2011 NSDUH data. For youth, NSDUH data is only available for SUD prevalence. Because of the downward trend in SUD prevalence among Alaskan youth, we chose not to apply the 2009-2011 prevalence data to 2013 youth population due to concerns that we might overestimate. Instead, we shared statewide prevalence trends and drew from YRBS data to estimate the prevalence of reported risk behaviors among high school students, including rates for having a substance use risk behavior present; a substance use moderate/high risk behavior; a past year mental health issue; a past year mental health issue and substance use moderate/high risk behavior present. Regional estimates were also produced using the YRBS dataset and are available in the Regional Data Reports. For adults and youth, prevalence is categorized by gender, race and region.

When people are in crisis, that is when they need services. From a systems perspective, it is all about access. For the majority of clients, behavioral health services should be as time-limited as possible – we need to treat clients in their moment of need with the right level and length of supports. The purpose of clinic and rehabilitative services is to help individuals recover and as quickly as possible transition to the organic supports that exist within communities.

Paraphrased from a discussion with the CEO of a Community Behavioral Health Center

Prevalence estimates indicate a potential need for behavioral health treatment services; however, it is important to consider when planning that need is very different from demand. For example, an individual that registers as having a need for SUD treatment may not desire treatment and may be unlikely to present for treatment. An important

[100] Use of poverty rates is integral to a methodology recommended by the Center for Mental Health Services for estimating the prevalence of SED among youth and, at the state level, is a requirement for SAMHSA block grant reporting, which uses state by state estimates to compare rates of SED prevalence nationally. We adapted this methodology to compare SED prevalence in regions across Alaska.

area for future investigation will be looking closer at likely *demand* for treatment in addition to *need* for treatment. Whether considering need or demand for treatment, ensuring access to appropriate services at the right level of the continuum of behavioral health care is imperative. In Alaska, this means identifying ways to catch individuals before entry into the system's higher levels of care.

Due to Alaska's small population, even more caution than usual must be used when working with behavioral health prevalence estimates. With small populations, confidence intervals tend to run very wide, meaning the point estimate is more uncertain, numbers are often suppressed, and two to three years of data at a minimum must be combined depending on the question at hand.

Key Findings

- Prevalence estimates indicate a potential need for behavioral health treatment services; however, it is important to consider when planning that need is very different from demand. For example, an individual that registers as having a need for SUD treatment may not desire treatment and may be unlikely to present for treatment. An important area for future investigation will be looking closer at likely demand for treatment (not just need for treatment).
- Due to Alaska's small population sizes, even more caution than usual must be used when working with behavioral health prevalence estimates (confidence intervals tend to run very wide, meaning the point estimate is more uncertain, numbers are often suppressed, and two to three years of data at a minimum must be combined depending on the question at hand).

Need Among Alaska Adults

- 145,790 Alaska adults were estimated to have a behavioral health issue in 2013.
- 62,815 or 11.5 percent (CI 9.1-13.7%)[101] of Alaskan adults are estimated to need treatment for an illicit drug or alcohol problem in the past year. The prevalence of Substance Use Disorder (SUD) among Alaska males is significantly higher[102] than among females, 15.5 percent (CI 11.9-20%) compared to a rate of 7.5 percent (CI 5.8-9.5%). The prevalence of SUD among Alaska Native adults, including any mention of Alaska Native in the two or more race category, is significantly higher than among White adults, 21 percent (CI 15.5-27.7%) compared to 10.5 percent (CI 8.1-13.5%).
- 105,966 or 19.4 percent (CI 16.6-22.6%) of Alaska adults are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year. The prevalence of Past Year Any Mental Illness among Alaska females is significantly higher than among males, 24 percent (CI 20.3-28%) compared to a rate of 15 percent (CI 11.8-19%).
- 21,302 or 3.9 percent (CI 2.8-5.3%) of Alaska adults are estimated to have had SMI in the past year. Statewide, there is no significant difference between males and females or across races.

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[101] The confidence interval (CI) reflects the range of values within which NSDUH estimates a 95 percent probability that the actual or correct prevalence value lies within it. When the CI, or range of values, is wide it indicates less certainty of the correct value, when it is narrow, it indicates greater certainty.

[102] Estimates are considered to be significantly different if confidence intervals do not overlap. This is a conservative threshold for significance.

- Of the approximately 62,815 adults who needed treatment for an illicit drug or alcohol issue in the past year, 22,990 or 36.6 percent (CI 28.4-45.7%) are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year.

Need and Risks Among Alaska Youth

- Past year alcohol or illicit drug dependence or abuse among Alaskans ages 12 to 17 steadily declined between 2002-2003 and 2012-2013 from 9.5 percent (CI7.7-11.6%) to 4.7 percent (CI 3.5-6.1%). This decline mirrors the national trend, which declined from 8.9 percent (CI 8.5-9.2%) to 5.7 percent (5.4-6%) over the same period. The variation between Alaska and the nation is not significant.
- Among Alaska traditional high school students, 8,450 or 33.5 percent are estimated to have a risk behavior for substance use present; 4,641 or 18.4 percent are estimated to have a moderate or high risk behavior for substance use present; and 7,214 or 28.6 percent are estimated to have had a mental health issue in the past year.
- 5,550 or 6 percent of Alaska youth ages 9-17 are estimated to have had a SED in the past year.

Adverse Childhood Experiences

- ACEs are stressful or traumatic childhood experiences including abuse, neglect, and household dysfunction such as growing up with substance abuse, mental illness, or crime in the home, separation or divorce, and witnessing domestic violence.[103] The more ACEs an individual has, the more likely he or she is to experience negative health, including behavioral health, outcomes. For example, an individual with three ACEs is 2.5 times more likely to use illicit drugs, while an individual with five ACEs is 6.5 times more likely to use illicit drugs.[104]
- When compared to a five state composite (consisting of Arkansas, Louisiana, New Mexico, Tennessee, and Washington), Alaska adults had a higher average ACE score in every ACE category.[105] The incidence of adults experiencing five or more ACEs is significantly lower in Alaska among 18-24 year old adults (in 2013) compared to adults age 35-44 at that same time.[106] According to Pat Sidmore, with ABADA/AMHB, "our ACE scores are the highest of any state, but [these scores] are concentrated in the older population."[107]
- Alaska adults who report Medicaid as their source of health insurance report higher ACE scores than other insured adults. Approximately 27 percent of adults who reported Medicaid

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[103] The Adverse Childhood Experiences Study, SAMHSA Prevention Training and Technical Assistance. http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1

[104] As cited by Alaska Screening Tool FY2011 and Initial Client Status Review FY2011: Supporting Clinical Decision-Making and Program Performance Management. 6/30/11. Alaska Division of Behavioral Health. Available at: http://dhss.alaska.gov/dbh/Documents/Resources/pdf/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf

[105] Source: Adverse Childhood Experiences: Overcome ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015. http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf

[106] Source: Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. PowerPoint presentation on Adverse Childhood Experiences of Alaska Adults. 9-15-2014.

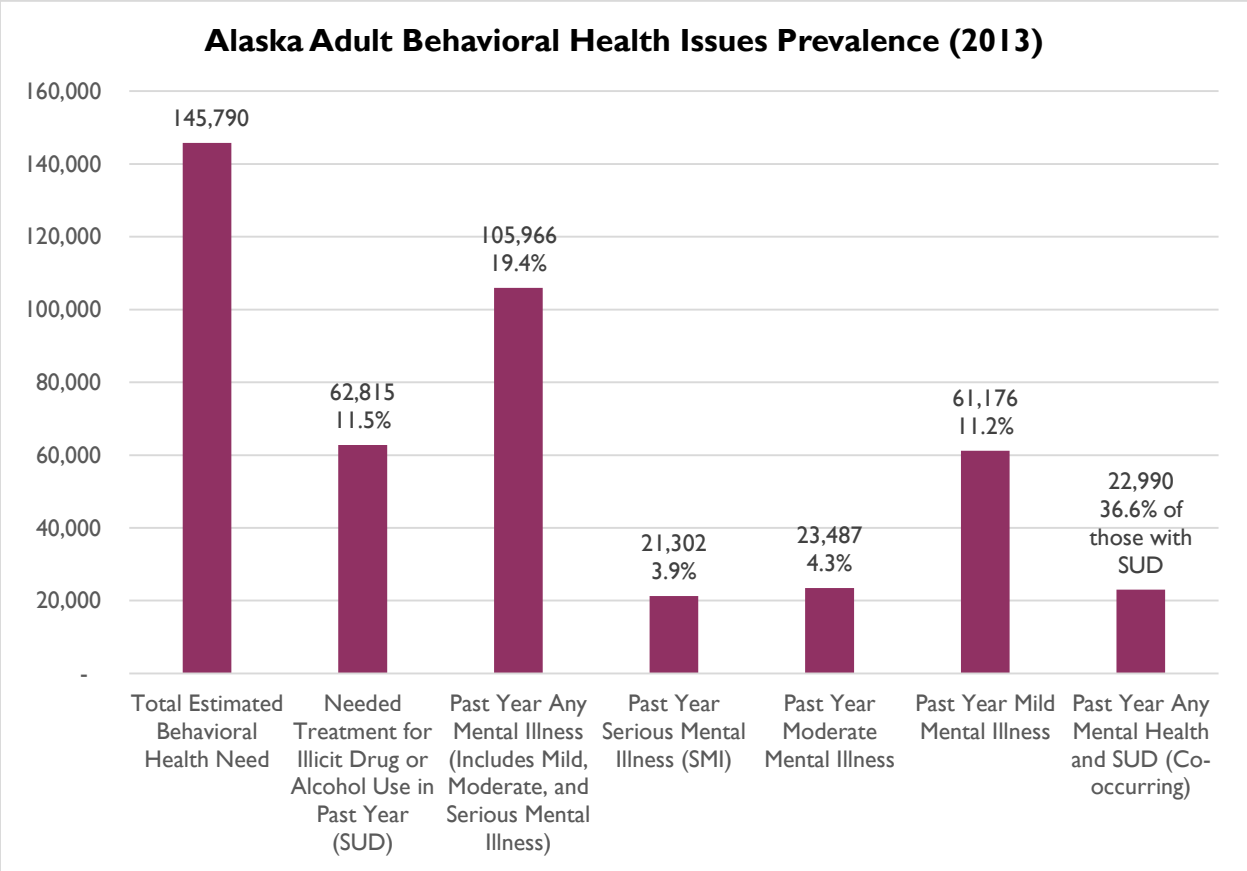
[107] Key informant interview, August 8, 2014.

as their health insurance reported having four or more ACEs, while about 15 percent of individuals who reported having employer-provided insurance and 12 percent of individuals who reported having self-purchased insurance reported having an ACE score of four or more.

Prevalence of Behavioral Health Issues Among Alaska Adults

This section outlines our findings among Alaska adults. Figure 2-1 shows prevalence across seven categories of behavioral health at the state level. Sixty two thousand eight hundred fifteen (62,815) or 11.5 percent (CI 9.1-13.7%)[108] of Alaskan adults are estimated to have needed treatment for an illicit drug or alcohol issue in the past year. One hundred five thousand nine hundred sixty six (105,966) or 19.4 percent (CI 16.6-22.6%) of Alaska adults are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year. Twenty one thousand three hundred two (21,302) or 3.9 percent (CI 2.8-5.3%) of Alaska adults are estimated to have had SMI in the past year. Of the approximately 62,815 adults who needed treatment for an illicit drug or alcohol issue in the past year, 22,990 or 36.6 percent (CI 28.4-45.7%) are estimated to have had Any Mental Illness (includes serious, moderate and mild mental illness) in the past year.

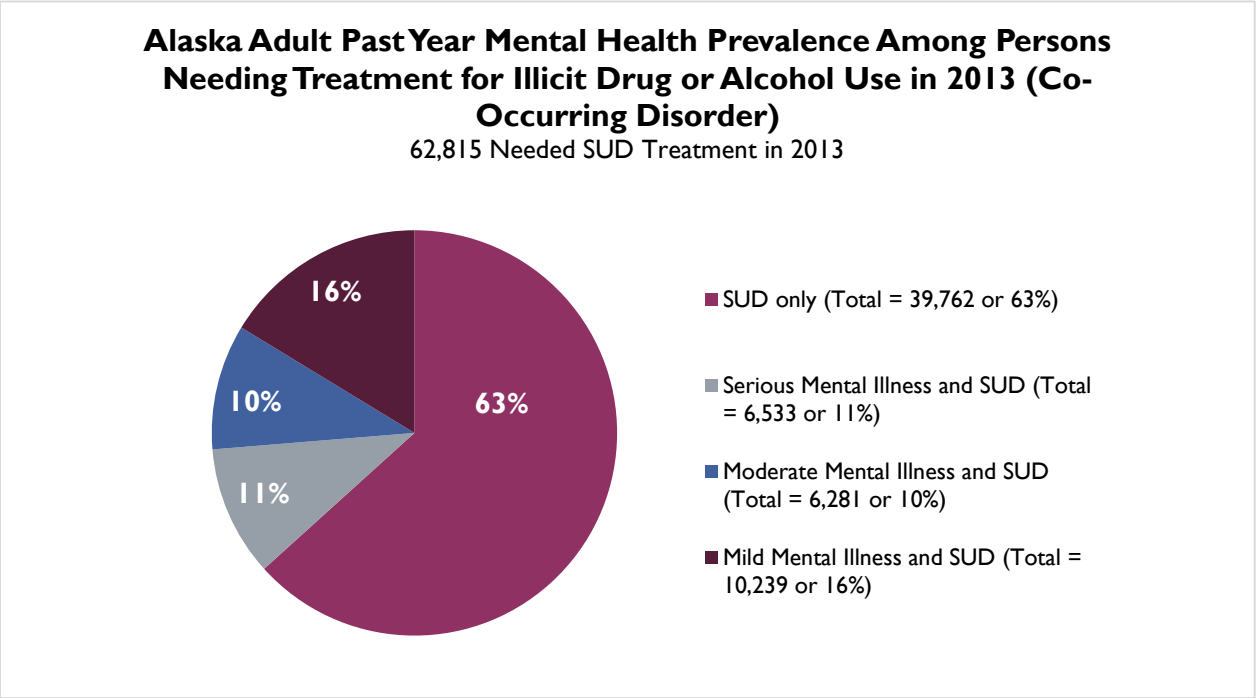
Figure 2-1 Alaska Adult Behavioral Health Issues Prevalence (2013)



[108] The confidence interval (CI) reflects the range of values within which NSDUH estimates a 95 percent probability that the actual or correct prevalence value lies within it. When the CI, or range of values, is wide it indicates less certainty of the correct value, when it is narrow, it indicates greater certainty.

Figure 2-2 looks at the prevalence of co-occurring disorders among the 62,815 adults estimated to have needed SUD treatment in 2013. Sixty-three percent of the SUD population is estimated to have SUD only. The remaining third have a co-occurring disorder. Eleven percent of adults have SUD and SMI, 10 percent of adults have SUD and Moderate Mental Illness, and 16 percent of adults have SUD and Mild Mental Illness.

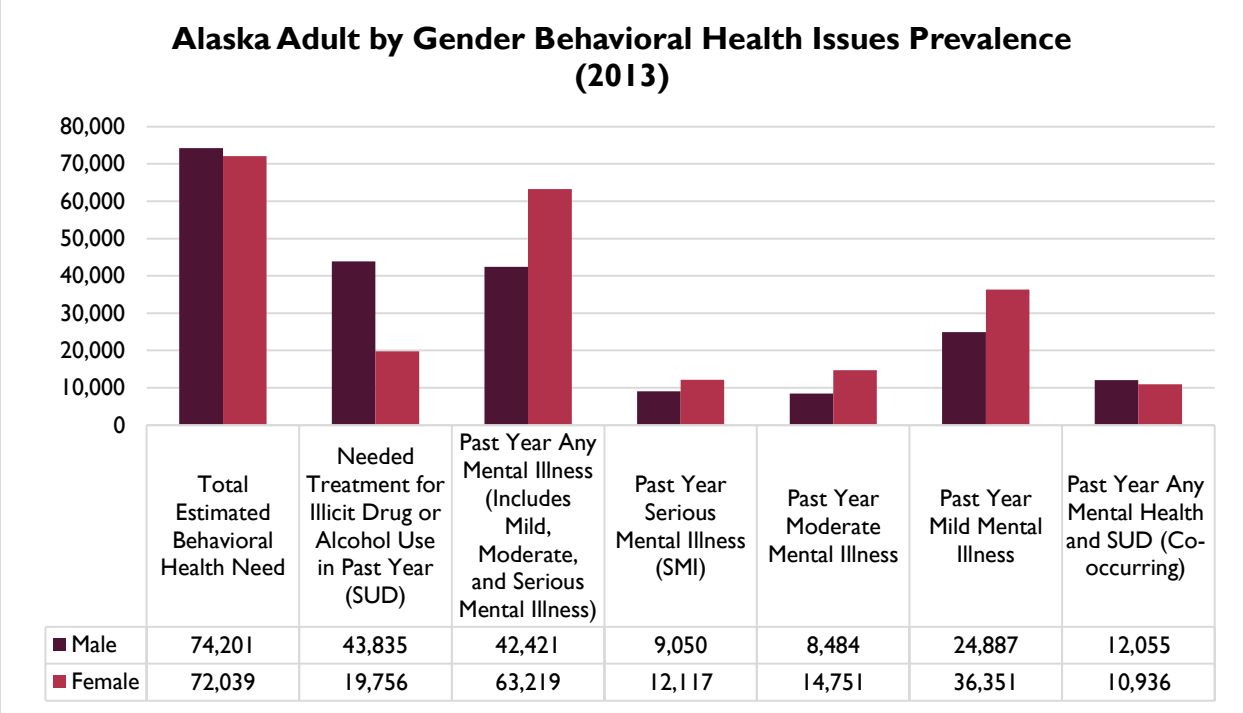
Figure 2-2 Alaska Adult Past Year Mental Health Prevalence Among Persons Needing Treatment for Illicit Drug or Alcohol Use in 2013 (Co-Occurring Disorder)



The prevalence of SUD among Alaska males is significantly higher than among females, 15.5 percent (CI 11.9-20%) compared to a rate of 7.5 percent (CI 5.8-9.5%).[109] The prevalence of Past Year Any Mental Illness among Alaska females is significantly higher than among males, 24 percent (CI 20.3-28%) compared to a rate of 15 percent (CI 11.8-19%).

[109] Estimates are considered to be significantly different if confidence intervals do not overlap. This is a conservative threshold for significance

Figure 2-3 Alaska Adult Behavioral Health Issues Prevalence by Gender (2013)



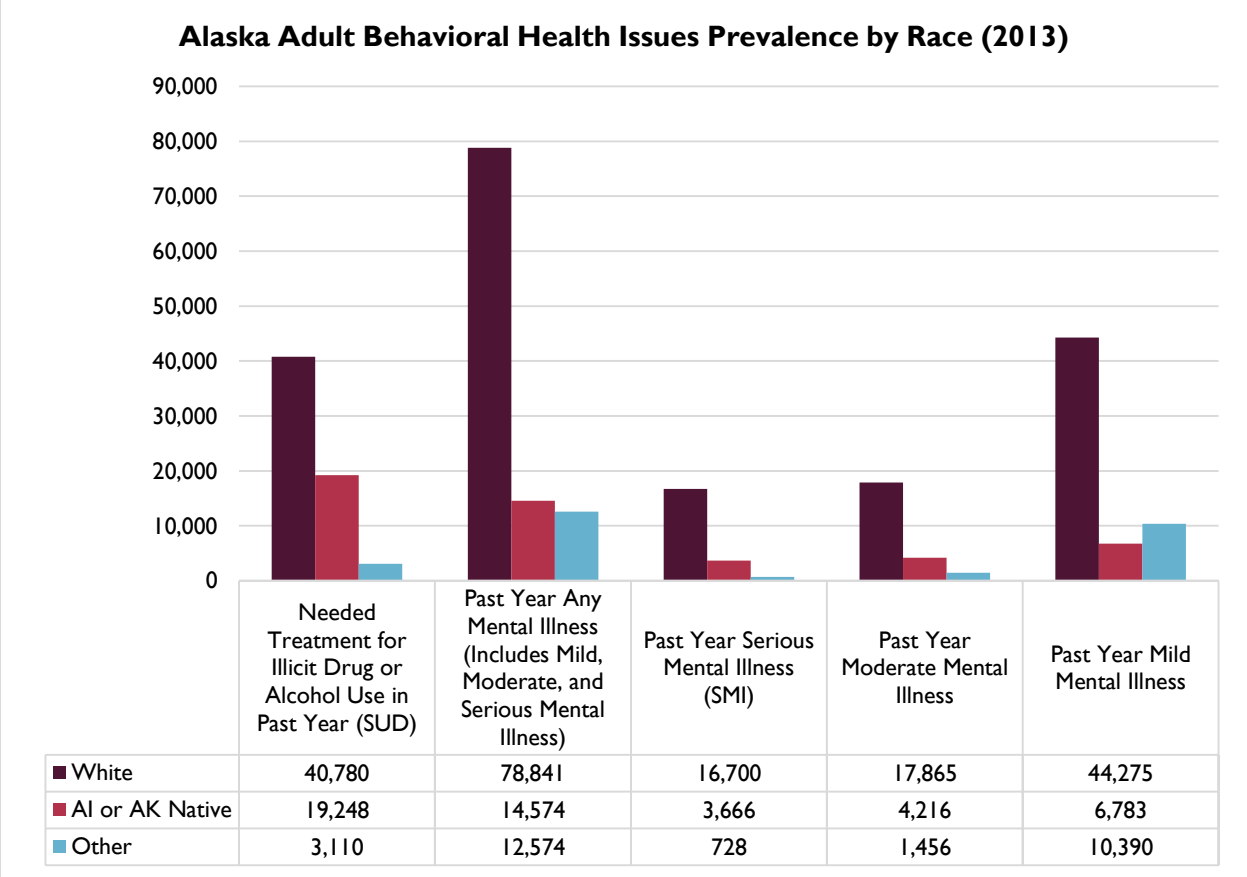
	Total Estimated Behavioral Health Need	Needed Treatment for Illicit Drug or Alcohol Use in Past Year (SUD)	Past Year Any Mental Illness (Includes Mild, Moderate, and Serious Mental Illness)	Past Year Serious Mental Illness (SMI)	Past Year Moderate Mental Illness	Past Year Mild Mental Illness	Past Year Any Mental Health and SUD (Co-occurring)
Male	74,201	43,835	42,421	9,050	8,484	24,887	12,055
Female	72,039	19,756	63,219	12,117	14,751	36,351	10,936

The prevalence of SUD among Alaska Native adults, including any mention of Alaska Native in the two or more race category, is significantly higher than among White adults, 21 percent (CI 15.5-27.7%) compared to 10.5 percent (CI 8.1-13.5%).

The prevalence rate of SUD among adults in the All Other Races category (4.7 percent (CI 2.4-8.8%)) appears to be lower than among White adults and is significantly lower than for Alaska Native adults.

The prevalence of Past Year Any Mental Illness among Alaska Native adults (15.9 percent (CI 11.6-21.6%)) appears to be lower than among White adults (20.3 percent (CI 16.9-24.1%)) and adults in the All Other Races category (19 percent (CI 11.8-29.1%)); however, differences across races in this category are not significant.

Figure 2-4 Alaska Adult Behavioral Health Issues Prevalence by Race (2013)



	Needed Treatment for Illicit Drug or Alcohol Use in Past Year (SUD)	Past Year Any Mental Illness (Includes Mild, Moderate, and Serious Mental Illness)	Past Year Serious Mental Illness (SMI)	Past Year Moderate Mental Illness	Past Year Mild Mental Illness
White	40,780	78,841	16,700	17,865	44,275
AI or AK Native	19,248	14,574	3,666	4,216	6,783
Other	3,110	12,574	728	1,456	10,390

Figure 2-5 summarizes our statewide adult prevalence findings.

Figure 2-5 Estimated Prevalence of Behavioral Health Issues Among Alaska Adults

Estimated Prevalence of Behavioral Health Issues Among Alaska Adults

Total Population (2013)		**Needed Treatment for Illicit Drug or Alcohol Use in Past Year** (SUD)		**Past Year Any Mental Illness** *(Includes Mild, Moderate, and Serious Mental Illness)*		**Past Year Serious Mental Illness** (SMI)		**Past Year Moderate Mental Illness**		**Past Year Mild Mental Illness**		**Total Est. Adults with a Behavioral Health Need** (unduplicated)
		Rate	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Count**
Adults												
*Alaska**	546,215	11.5%	62,815	19.4%	105,966	3.9%	21,302	4.3%	23,487	11.2%	61,176	145,790
Alaska – Adult by Gender												
Male	282,804	*15.5%*	43,835	*15.0%*	42,421	*3.2%*	9,050	*3.0%*	8,484	*8.8%*	24,887	74,201
Female	263,411	*7.5%*	19,756	*24.0%*	63,219	*4.6%*	12,117	*5.6%*	14,751	*13.8%*	36,351	72,039
Alaska – Adult By Race**												
White	388,379	*10.5%*	40,780	*20.3%*	78,841	*4.3%*	16,700	*4.6%*	17,865	*11.4%*	44,275	103,921
AI or AK Native	91,659	*21.0%*	19,248	*15.9%*	14,574	*4.0%*	3,666	*4.6%*	4,216	*7.4%*	6,783	*
Other	66,177	*4.7%*	3,110	*19.0%*	12,574	*1.1%*	728	*2.2%*	1,456	*15.7%*	10,390	*

Notes: Rates are based on Alaska-specific National Survey on Drug Use and Health (NSDUH) data for the adult (18+) population (all incomes). The survey is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) using a sampling methodology in order to estimate prevalence. SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) classified respondents as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. The sum of the individuals in each cell are greater than total estimated need due to co-occurring disorders.

Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. Any mental illness includes persons in any of the three categories.

**Other Race includes Black or African American, Native Hawaiian or Other Pacific Islander, Asian, and Two or More Races with no selection of American Indian or Alaskan Native.

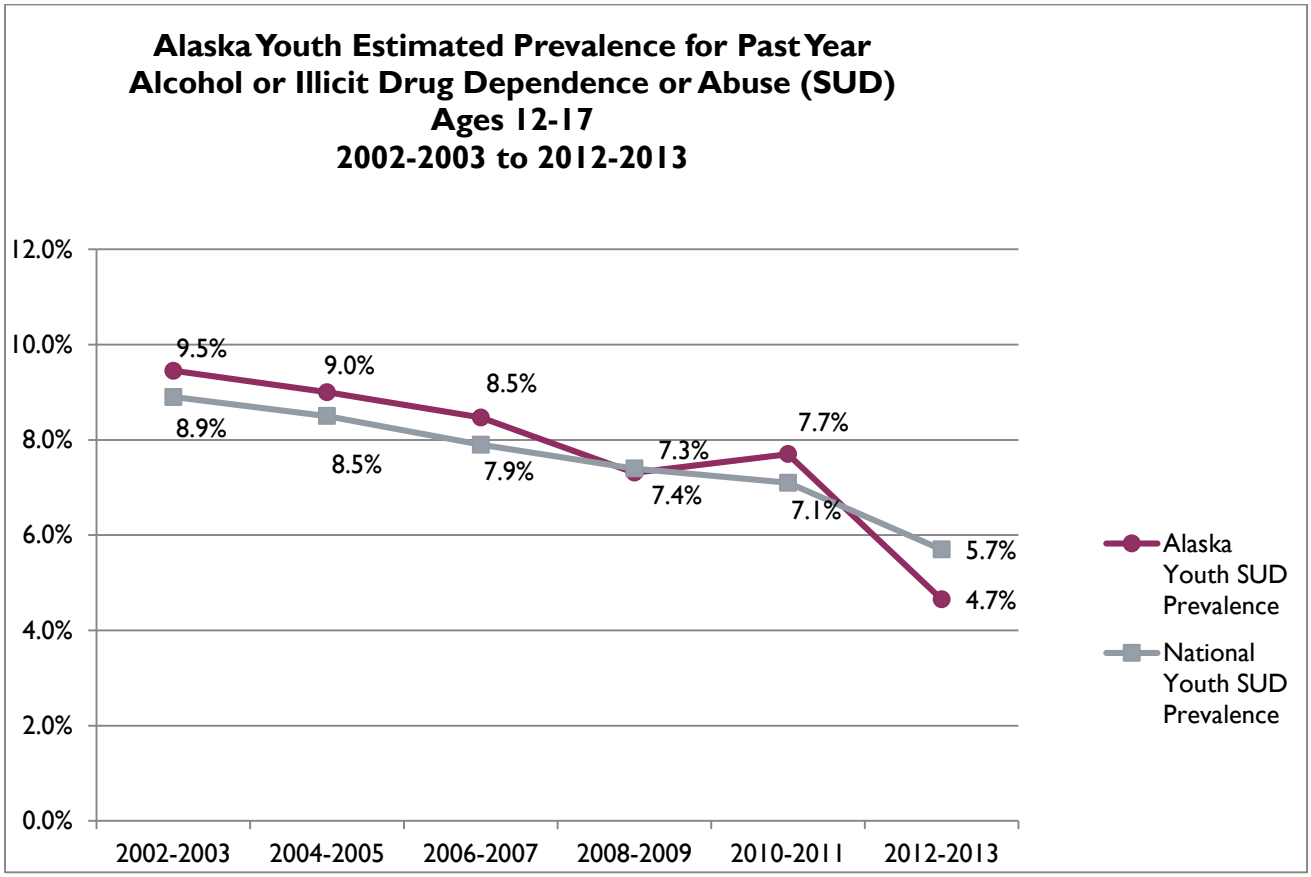
Source for Substance Abuse Prevalence Rates: SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health, 2009-2010 (revised 3/12), and 2011; Alaska NSDUH, DBH Special Data Request April 2014.

Prevalence of Behavioral Health Issues Among Alaska Youth

Substance Use Disorder

Figure 2-6 shows that past year alcohol or illicit drug dependence or abuse among Alaskans ages 12 to 17 steadily declined between 2002-2003 and 2012-2013 from 9.5 percent (CI7.7-11.6%) to 4.7 percent (CI 3.5-6.1%). This decline mirrors the national trend, which declined from 8.9 percent (CI 8.5-9.2%) to 5.7 percent (5.4-6%) over the same period.

Figure 2-6 Alaska Youth Estimated Prevalence for Past Year Alcohol or Illicit Drug Dependence or Abuse (SUD) Ages 12-17



Data from SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH) - Alaska 2 year State Estimates; provided by the State of Alaska Division of Behavioral Health June 2015.

Figure 2-7 includes confidence interval data to assist with the interpretation of the chart above. Here, we see the difference between Alaska youth SUD rates and national SUD rates is not significant.

Figure 2-7 Past Year Alcohol or Illicit Drug Dependence or Abuse Among Alaskans Ages 12 to 17

Past Year Alcohol or Illicit Drug Dependence or Abuse* Among Alaskans Ages 12 to 17; Percentages with 95% Confidence Intervals;

NSDUH (2002-2003), (2004-2005), (2006-2007), (2008-2009), (2010-2011), (2012-2013)

	2002-2003		2004-2005		2006-2007		2008-2009		2010-2011		2012-2013	
	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
Alaska	9.5%	(7.7-11.6)	9.0%	(7.1 - 11.3)	8.5%	(7.0 - 10.4)	7.3%	(5.8 - 9.1)	7.7%	(6.1 - 9.6)	4.7%	(3.5 - 6.1)
US	8.9%	(8.5-9.2)	8.5%	(8.1-8.8)	7.9%	(7.5-8.2)	7.4%	(7.0-7.7)	7.1%	(6.8-7.5)	5.7%	(5.4-6.0)

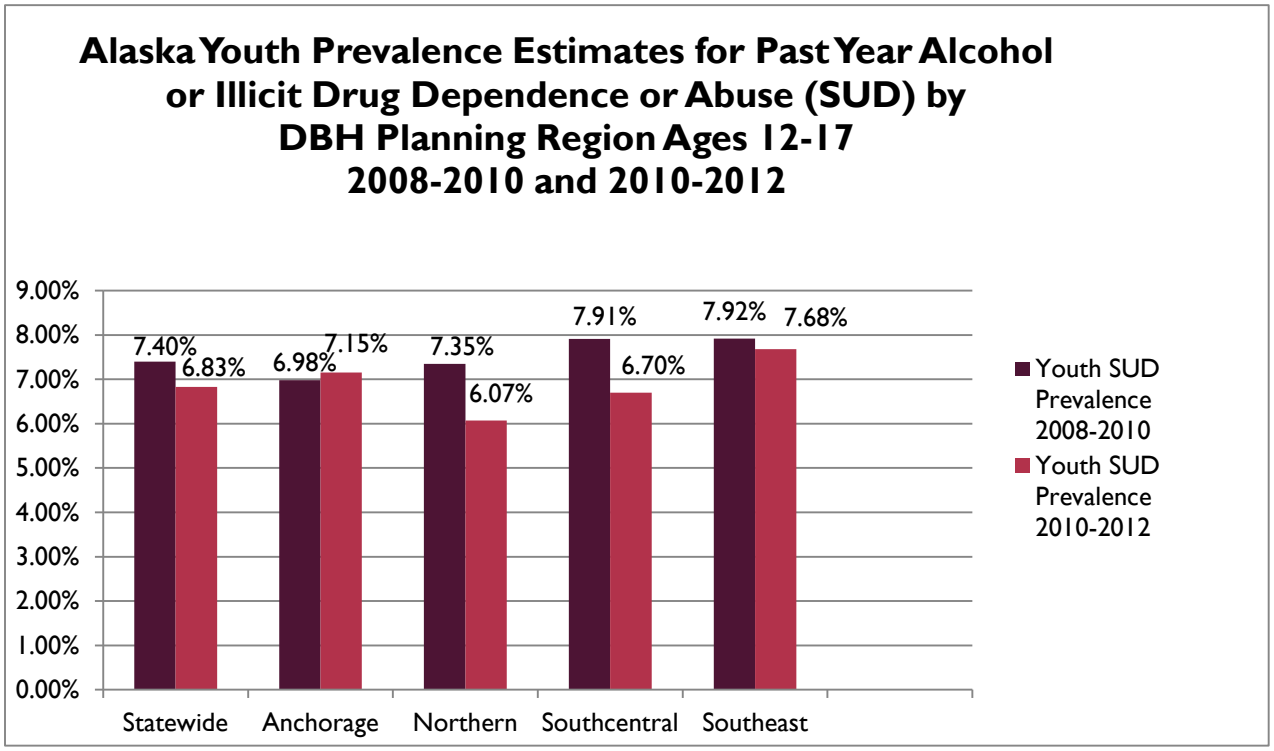
Note: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the Results from the 2008 National Survey on Drug Use and Health: National Findings.

*Dependence or Abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV)
SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2013
http://www.samhsa.gov/data/population-data-nsduh/reports

Figure 2-8 highlights SUD youth regional trends. A decline in SUD among youth occurred in every planning region in Alaska except Anchorage between 2008-2010 and 2010-2012.

Figure 2-8 Alaska Youth Prevalence Estimates for Past Year Alcohol or Illicit Drug Dependence or Abuse (SUD) by DBH Planning Region Ages 12-17

Note: Data from SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH) -



Alaska 3 year State Estimates; provided by the State of Alaska Division of Behavioral Health June 2015. Anchorage Planning Region corresponds with Municipality of Anchorage Reporting Region. Northern Planning Region includes Fairbanks, Northwest, Other Interior, and Y-K Delta Reporting Regions. Southcentral Planning Region includes Southwest, Kenai Peninsula Borough, and Mat-Su Reporting Regions. Southeast Planning Region includes City and Borough of Juneau and Other Southeast Reporting Region.

Severe Emotional Disturbance

The estimated prevalence of SED was generated using a methodology recommended by the Center for Mental Health Services (CMHS) for state-to-state comparisons and adapted to generate rates specific to reporting regions. The methodology calculates prevalence using a rate based on the percentage of children living in poverty for the state or region. Using this method, an estimated 5,550 or 6 percent of Alaska youth ages 9-17 had a SED in the past year (Figure 2-9). The rate of SED is estimated to be highest in the Northern and Yukon-Kuskokwim Delta regions, where the rate of children in poverty is higher.

Figure 2-9 Estimated Prevalence of Severe Emotional Disturbance (SED) Among Children Ages 9-17

Estimated Prevalence of Severe Emotional Disturbance (SED) Among Children Ages 9-17 Statewide and by Region

Region	Percent in poverty age 5-17 SAIPE US Census 2012	Tier *	Rate in poverty with Level of Function score less than or = 50	2013 Population age 9-17 (DOL)	Estimated SED Prevalence Ages 9-17
Alaska	0.130	Low	0.060	92,501	5,550
Anchorage, Municipality of	0.107	Low	0.060	37,151	2,229
Fairbanks North Star Borough	0.122	Low	0.060	11,768	706
Juneau, City and Borough of	0.082	Low	0.060	3,743	225
Kenai Peninsula Borough	0.120	Low	0.060	6,668	400
Matanuska-Susitna Borough	0.106	Low	0.060	13,416	805
Northern Region	0.258	High	0.080	3,934	315
Other Interior Region	0.150	Mid	0.070	3,078	215
Other Southeast Region	0.141	Low	0.060	4,584	275
Yukon-Kuskokwim Delta Region	0.333	High	0.080	4,605	368
Southwest Region	0.136	Low	0.060	3,549	213

* Rankings are as follows:

Low	0% - 14.9%	6%
Mid	15.0% - 19.8%	7%
High	19.9% and up	8%

Self-reported Risk Behaviors for Substance Use and Mental Health Issues

The Youth Risk Behavior Survey (YRBS) collects a wealth of information from Alaska high school students about risk behaviors and mental health issues. In an effort to use this information in a way that would be helpful to systems and regional planners, we worked closely with the Division of Behavioral Health (DBH) Research Unit and the Department of Health and Social Services (DHSS) Section of Chronic Disease Prevention and Health Promotion Public Health Data Unit to create a set of indicators that allow us to look at trends by gender, race and across regions. The statewide results of this analysis are included in Figure 2-10. Regional versions of this table are available in the Regional Data Reports.

We found that among Alaska traditional high school students, 8,450 or 33.5 percent are estimated to have a risk behavior for substance use present and 4,641 or 18.4 percent are estimated to have a moderate or high risk behavior for substance use present. Among Alaskan high school students, 7,214 or 28.6 percent are estimated to have had mental health issue in the past year and 2,396 or 9.5 percent are estimated to have a moderate or high risk behavior for substance use present and a mental health issue in the past year.

"Our definition for a severely mentally impaired child makes it hard to get a two-year old qualified for publicly-funded behavioral health services. If we look at treating Post-Traumatic Stress Disorder for ages 5-9, it costs on average $750/month compared to treatment for Severely Emotionally Disturbed teenagers, which runs between $2,300 and 3,000 per month. In 2010, we had 190 four-year old foster children in out of home placements; we provided behavioral health services to 54 of these children. So, about 28% got mental health services. Why not 100%?"

Systems Planner

Figure 2-10 Estimated Prevalence of Behavioral Health Risk Behaviors and Issues Among Alaska High School Students

Estimated Prevalence of Behavioral Health Risk Behaviors and Issues Among Alaska High School Students									
Total Population (2013 High School Enrollments)		**Substance Use - Risk Behavior Present** *YRBS*		**Substance Use - Moderate/High Risk Behavior** *YRBS*		**Past Year Mental Health Issue** *YRBS*		**Past Year Mental Health Issue and Substance Use - Moderate/High Risk Behavior** *YRBS*	
		Rate	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**
Youth									
*Alaska**	25,225	0.335	8,450	0.184	4,641	0.286	7,214	0.095	2,396
Alaska – Youth by Gender									
Male	13,083	0.349	4,566	0.203	2,656	0.194	2,538	0.091	1,191
Female	12,142	0.321	3,898	0.164	1,991	0.378	4,590	0.100	1,214
Alaska – Youth By Race**									
White	12,785	0.342	4,372	0.175	2,237	0.253	3,235	0.096	1,227
AI or AK Native	5,711	0.371	2,119	0.232	1,325	0.340	1,942	0.119	680
Other	6,729	0.279	1,877	0.149	1,003	0.301	2,025	0.068	458

General Notes: Data restricted to respondents in 2013 with valid responses to all questions and providing gender. Counts may not sum to total for state due to rounding of the rates. Regional versions of this table are available in the Regional Data Reports. A summary of definitions for each YRBS indicator is included in chapter 2.

* Weighted results for statewide traditional high school students.

**Race based upon white (only, non-Hispanic), American Indian or Alaska Native (any mention), and other consisting of other races, multi-racial, or unknown responses.

Source: Alaska Youth Risk Behavior Surveillance System, Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska Department of Health and Social Services, 2015.

Figure 2-11 outlines the definitions for each of the criteria included in the table above.

Figure 2-11 Summary of Definitions for each YRBS Indicator Created to Estimate the Prevalence of Behavioral Health Risk Behaviors and Issues Among Alaska High School Students

Summary of Definitions for each YRBS Indicator Created to Estimate the Prevalence of Behavioral Health Risk Behaviors and Issues Among Alaska High School Students		
YRBS Variable	**Methodology**	**Interpretation**
Substance Use – Risk Behavior Present	Percentage of students who are considered to have a risk behavior present. A respondent was categorized as having a "risk behavior present" if they met the criteria for one or both of the below criteria: Used cocaine, inhalants, heroin, methamphetamines, or ecstasy at least once in their life OR used marijuana, unprescribed drugs, or at least one drink of alcohol on at least one of the past 30 days	This variable is very inclusive and does not necessarily indicate a need for services. However, it does provide a basis for understanding trends in "any substance use" among students. This population would likely benefit from universal prevention activities.
Substance Use – Moderate/High Risk Behavior	Percentage of students who are considered to have moderate/high risk behavior. A respondent was categorized as having "moderate/high risk behavior" if they met the criteria for one or more of the below: Used cocaine, inhalants, heroin, methamphetamines, or ecstasy drugs three or more times for at least one of the drugs in their life OR had five or more drinks of alcohol in a row within a couple of hours two or more times in the past 30 days OR used marijuana and unprescribed drugs three or more times in the past 30 days	This variable was developed to hone in on the student population with moderate to high risk behaviors. Students exhibiting one or more of these criteria may be more likely to need substance use treatment services now or in the future. This population would likely benefit from selective and indicated prevention activities.
Past Year Mental Health Issue	Percentage of 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 OR who had seriously considered attempting suicide during the past 12 months.	This variable may indicate a need for mental health treatment.
Past Year Mental Health Issue and SUD (COD)	Percentage of students who used marijuana, cocaine, solvents, heroin, methamphetamines, ecstasy, unprescribed drugs five or more times in their life OR who had five or more drinks of alcohol in a row within a couple of hours on at least one of the past 30 days AND 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 OR who had seriously considered attempting suicide during the past 12 months.	This variable captures all students who might need services *for both* mental health treatment *and* substance use treatment.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are stressful or traumatic childhood experiences including abuse, neglect, and household dysfunction such as growing up with substance abuse, mental illness, or crime in the home, separation or divorce, and witnessing domestic violence. The original ACE study occurred in 1995 by the Centers for Disease Control and Prevention (CDC) in collaboration with Kaiser Permanente. ACEs are strongly related to development and prevalence of a wide range of health problems, including substance abuse, throughout an individual's life[110] and demonstrate that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life.[111]

This groundbreaking 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. An ACE score of zero would mean that a person reported no exposure to any of the ACE categories of trauma. An ACE score of eight would mean that a person reported exposure to all of the ACE categories of trauma. The study demonstrated that the more ACEs an individual has, the more likely he or she is to experience negative health, including behavioral health, outcomes. Figure 2-12 shares a small subset of data to illustrate why ACEs are important.

Figure 2-12 A Selection of Data Illustrating Why ACEs Matter

A Selection of Data Illustrating Why ACEs Matter[112]

The greater the ACE score, the greater risk of experiencing Domestic Violence (DV) as an adult:

ACE Score	Risk for DV as an adult
0	1.0
1	1.8x
2	2.4x
3	3.3x
4 or more	5.5x

The greater the ACE score, the greater risk of alcohol use before age 14:

ACE Score	Risk of alcohol use before age 14
0	1.0
1	1.5x
2	2.4x
3	3.9x
4	6.2x

[110] The Adverse Childhood Experiences Study, SAMHSA Prevention Training and Technical Assistance. http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1

[111] Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention, http://www.cdc.gov/violenceprevention/acestudy/

[112] As cited in: Alaska Screening Tool FY2011 and Initial Client Status Review FY2011: Supporting Clinical Decision-Making and Program Performance Management. 6/30/11. Alaska Division of Behavioral Health. Available at: http://dhss.alaska.gov/dbh/Documents/Resources/pdf/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf; Source, 18: RF Anda et al. (2006) Eur. Arch Psychiatry Clin Neurosci. V256: 174-86. Source, 19: S.H. Dube et al. (2001) JAMA v 286: 3089-96. Source, 2o: S,R, Dybe et ak, (2006) J Adolescent Health, v38:4444.e1-444.e10. Source,21: RD Goodwin (2004) Pscychol. Medicine v34:509-20.

A Selection of Data Illustrating Why ACEs Matter[112]

The greater the ACE score, the greater risk of attempted suicide during childhood or adolescence:

ACE Score	Risk for Suicide Attempt
0	1.0
1	1.4x
2	6.3x
3	8.5x
4	11.9x
5	15.7x
6	28.9x
7 or more	50.7x

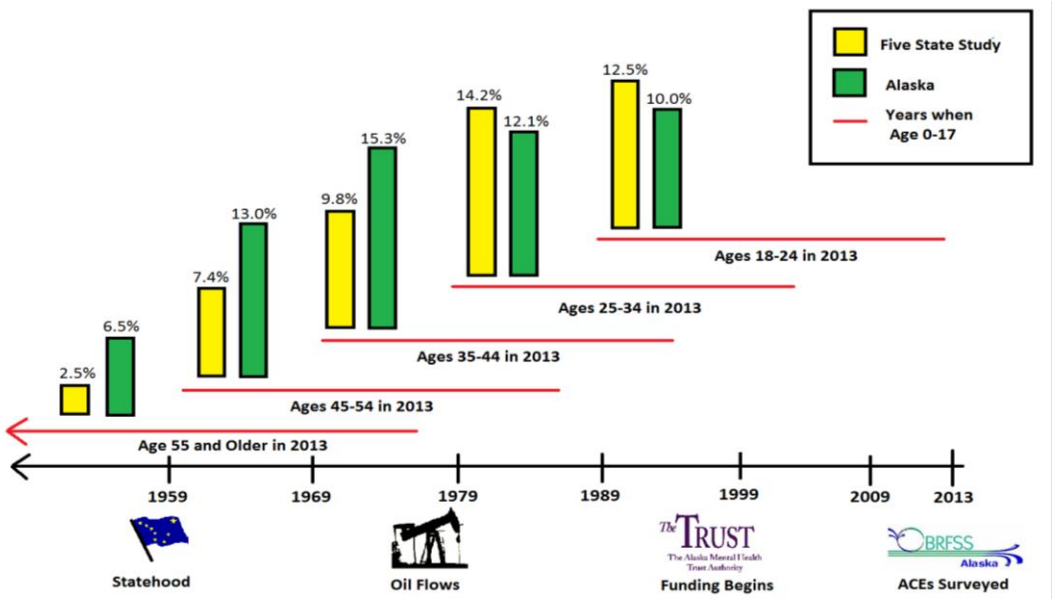
The greater the ACE score, the greater risk of illicit drug use:

ACE Score	Risk of illicit drug use
0	1.0
1-2	2.0x
3	2.5x
4	4.0x
5	6.5x

In 2013, the Alaska BRFSS included questions related to understanding the prevalence of ACEs among Alaskans. These findings may indicate the need for behavioral health services.

Figure 2-13 identifies the percentage of adults reporting five or more ACEs by generation. It shows that the incidence of adults experiencing five or more ACEs is significantly lower in Alaska among 18-24 year old adults (in 2013) compared to adults age 35-44 at that same time.[113]

Figure 2-13 Alaskan ACE Timeline: Five Plus ACEs as Reported by Adults in the BRFSS



[113] There is a statistical difference between the two geographic regions for the 45-54 & 55+ age groups. Source: Analysis completed by the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board (ABADA/AMHB) using data from the 2013 Alaska Behavioral Risk Factor Surveillance System, Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion and the Five States Study data from the Centers for Disease Control and Prevention, Adverse Childhood Experiences Reported by Adults --- Five States, 2009, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm

As shared during a key informant interview as part of this assessment, Pat Sidmore with the Alaska Mental Health Board and Advisory Board on Drug Abuse and Alcoholism, who has managed the collection of data on the incidence of ACEs in Alaska, stated that "we are the highest of any state but that is concentrated in the older population."[114]

Figure 2-14 provides a snapshot of Alaska 2013 BRFSS ACE scores compared to the average score from a 2009 five state composite (Arkansas, Louisiana, New Mexico, Tennessee, and Washington). Alaska adults' average score is higher than the five-state average in every category. The gold bars indicate that the difference is not statistically significant.

Figure 2-14 Alaska Adverse Childhood Scores Compared to CDC's Five-State Study[115]

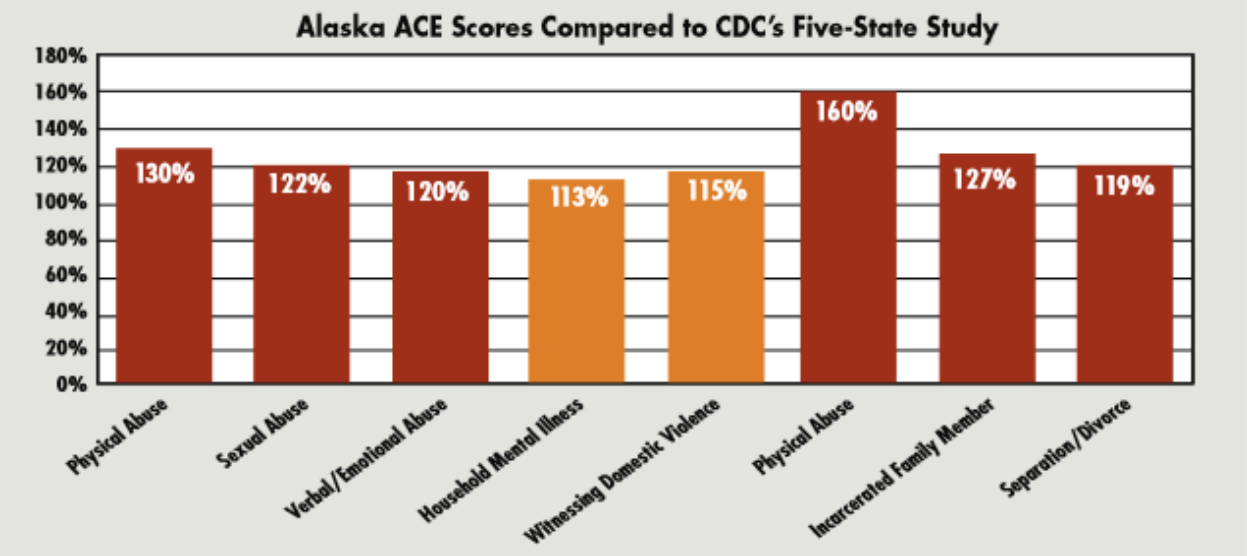
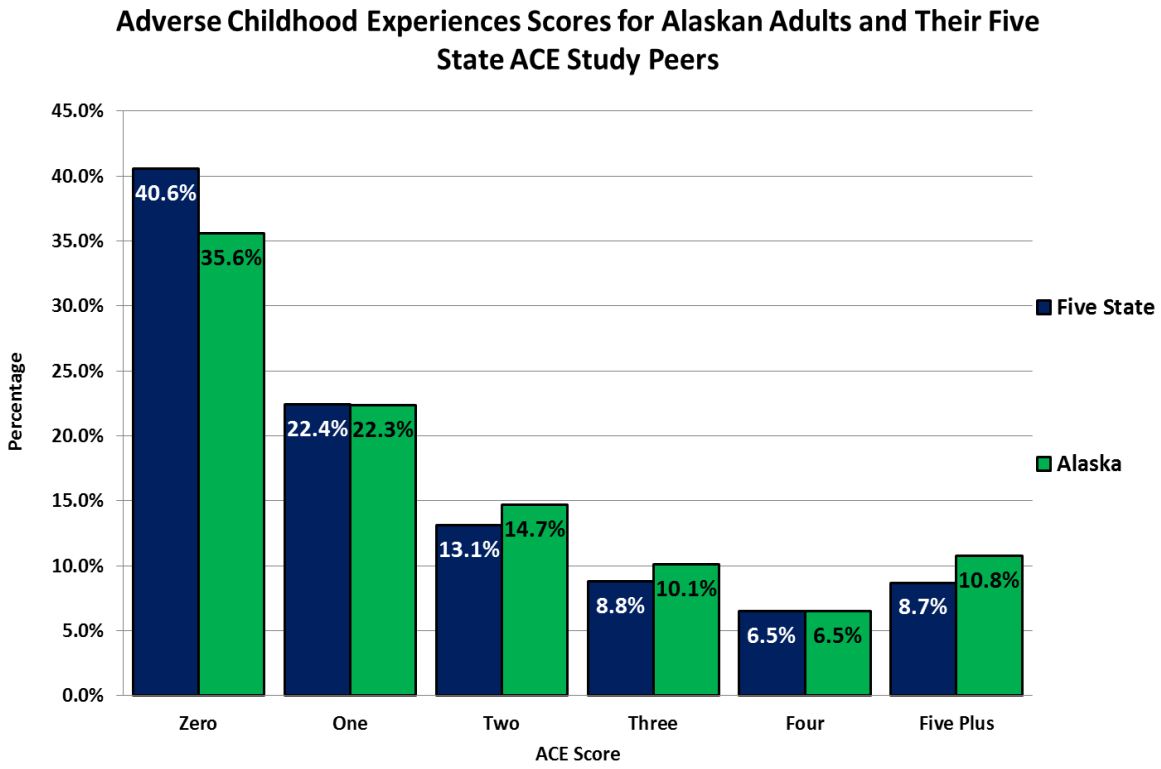


Figure 2-15 shows the difference in ACE score as a percentage between Alaska and five states (Arkansas, Louisiana, New Mexico, Tennessee, and Washington). It shows that Alaska has a lower percentage of people experiencing zero ACEs, the same amount of people experiencing one and four ACEs, and more people experiencing two, three and five or more ACEs.

[114] Key informant interview, August 8, 2014.

[115] Source: Adverse Childhood Experiences: Overcome ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015. http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf

Figure 2-15 Adverse Childhood Experiences Scores for Alaskan Adults and Their Five State ACE Study



Peers[116]

Figure 2-16 shows the difference in ACE score as a percentage between Alaskan men and women. Alaskan women have a lower percentage than men who experience and report zero and two ACEs, about the same as men who experience and report one ACE, and a higher percentage than men who experience and report three or more ACEs.

[116] Source: Analysis completed by the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board (ABADA/AMHB) using data from the 2013 Alaska Behavioral Risk Factor Surveillance System, Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion; Five States Study data from the Centers for Disease Control and Prevention, *Adverse Childhood Experiences Reported by Adults --- Five States, 2009,* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm

Figure 2-16 Adverse Childhood Experiences Scores for Alaskan Men and Women[117]

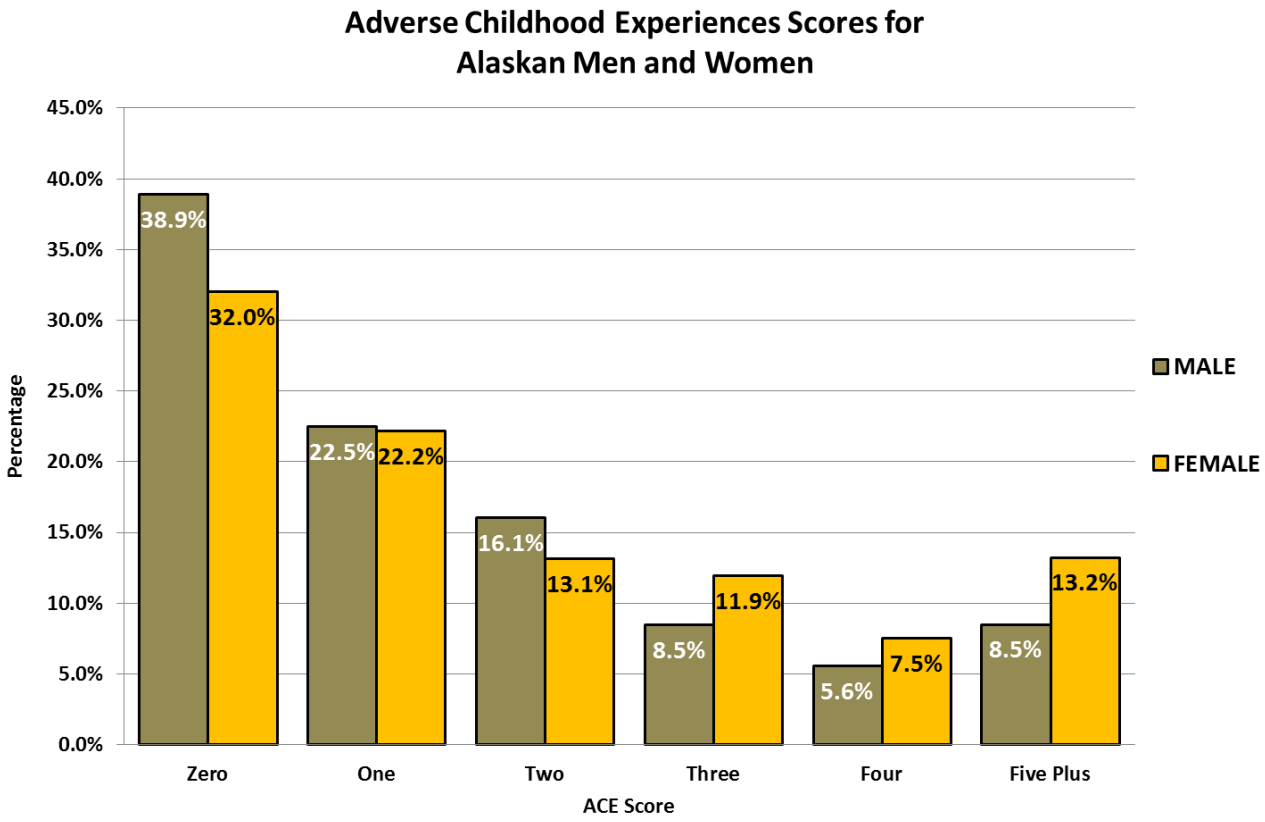


Figure 2-17 shows the distribution of ACE scores by insurance type for Alaska adults. Alaska adults who report Medicaid as their source of health insurance report higher ACE scores than other insured adults. Approximately 27 percent of adults who reported Medicaid as their health insurance reported having four or more ACEs, while about 15 percent of individuals who reported having employer-provided insurance and 12 percent of individuals who reported having self-purchased insurance reported having an ACE score of four or more.

[117] Source: Analysis completed by the Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board (ABADA/AMHB) using data from the 2013 Alaska Behavioral Risk Factor Surveillance System, Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion.

Figure 2-17 Adverse Childhood Experience Scores by Insurance Type for Alaska Adults[118]

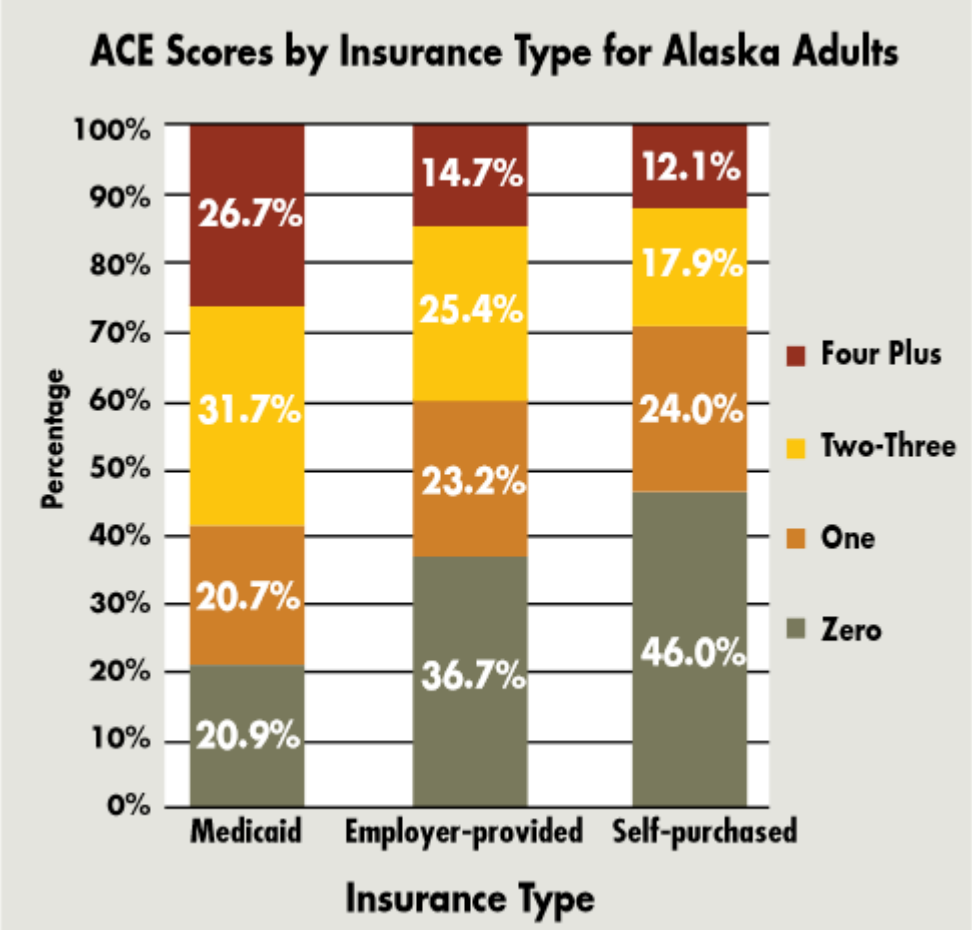


Figure 2-18 shows Alaska compared with the average percentage difference in ACE scores across the five states by age group. We see a statistically significant difference for the 45-54 and over 55 age groups who have more ACEs than the younger age cohorts. We believe this figure illustrates the profound impact of historical trauma on our older generations. On a more positive note, this trend appears to be changing in younger generations.

[118] Source: Adverse Childhood Experiences: Overcome ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015. http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf

Figure 2-18 Percentage Difference between Alaska and Five State ACE Scores by Age Group[119]

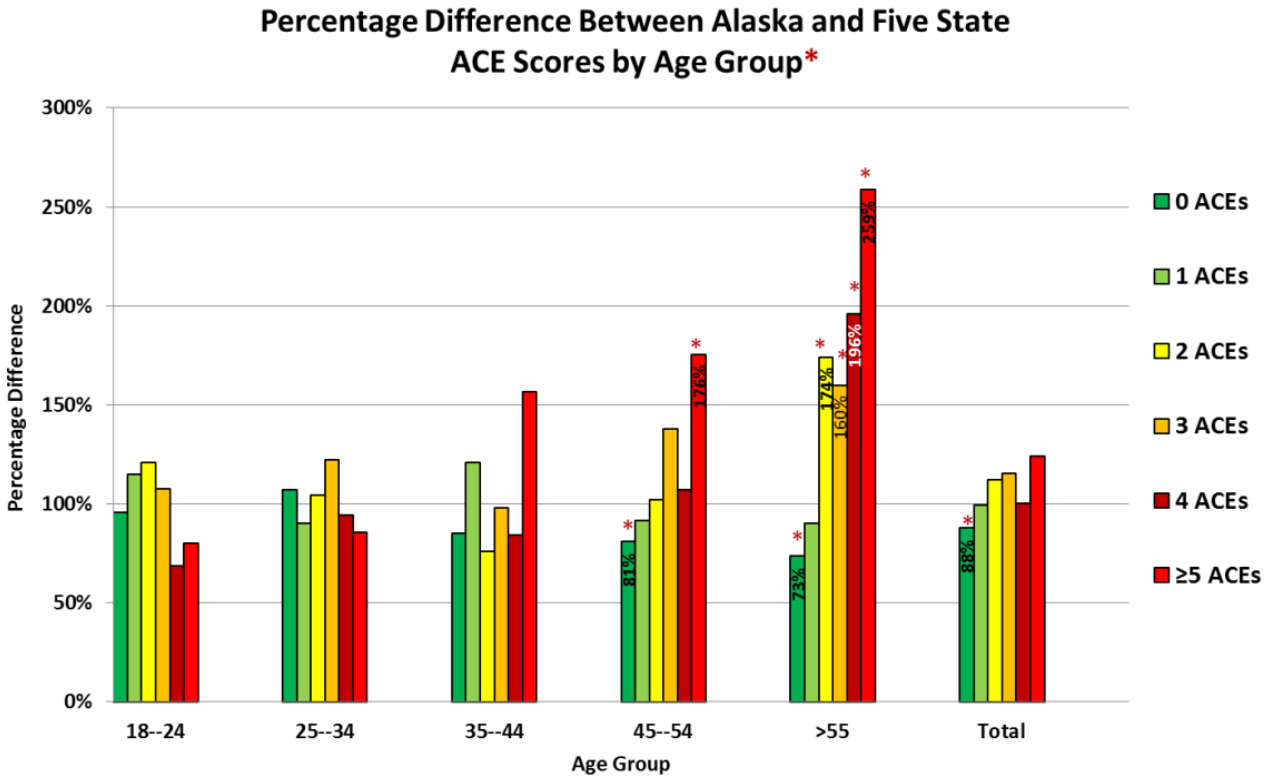


Figure 2-19 shows the percentage difference between Alaska and five other states of people reporting childhood trauma of abuse and household dysfunction. Alaska has the highest percentage of individuals who reported experiencing sexual abuse as a child compared to the other states at approximately 15 percent. The rates of emotional and physical abuse are 31 percent and 19.1 percent. Alaska has the highest percentage of individuals who reported experiencing incarcerated family members (11.5%), substance abuse in the home (33.8%) and separation or divorce (31.7%) compared to the other states.

[119] *Columns with numbers are statistically significantly different between the two studies
Source: Analysis completed by the ABADA/AMHB using data from the 2013 Alaska Behavioral Risk Factor Surveillance System, Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion and the Five States Study data from the CDC, ACEs Reported by Adults --- Five States, 2009, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm

Figure 2-19 Percentage Difference between Alaska and Five State ACE Scores for Abuse and Household Dysfunction [120]

ACE Rates in Six States						
Adverse Childhood Experience	Alaska	Arkansas	Louisana	New Mexico	Tennessee	Washington
Year study released	2013	2009				
ABUSE						
Verbal/Emotional	31.0%	24.3%	21.1%	28.1%	19.2%	**34.9%**
Physical	19.1%	14.1%	10.5%	**19.5%**	12.9%	18.1%
Sexual	**14.8%**	10.9%	9.9%	12.9%	12.7%	13.5%
HOUSEHOLD DYSFUNCTION						
Mental Illness in the Home	21.9%	17.0%	16.6%	19.4%	17.1%	**24.3%**
Incarcerated Family Member	**11.5%**	5.5%	7.2%	7.1%	8.6%	6.6%
Substance Abuse in Home	**33.8%**	25.5%	26.6%	29.9%	28.3%	32.7%
Separation or Divorce	**31.7%**	23.3%	27.1%	24.4%	29.1%	26.0%
Witnessed Domestic Violence	18.7%	15.1%	14.5%	**18.9%**	17.1%	16.6%

[120] *Percentages in red are the highest of the states compared.
Source: Adverse Childhood Experiences: Overcome ACEs in Alaska. Advisory Board on Alcoholism and Drug Abuse. State of Alaska Department of Health and Social Services. January 2015.
http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsReportAlaska.pdf

3. WHO ARE THE CURRENT USERS?

To answer this question, the project team analyzed service data from Alaska's various administrative systems between FY2009 and FY2013. The scale of this effort is difficult to describe. It included:

- Merging service records from five behavioral health service datasets -- Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an Electronic Data Interface (EDI); Alaska Psychiatric Institute's (API) electronic health record system, Meditech; the Division of Behavioral Health (DBH) Designated Evaluation and Treatment (DET) database; and the Alaska Medicaid Juneau Claims and Eligibility (JUCE) database - to produce a de-duped treatment dataset with over 6.9 million records from FY09 through FY13.
- Producing unduplicated client counts by diagnosis category, age, gender, and race for five continuous years statewide and by each of the 10 reporting regions.
- Producing unduplicated client counts by provider type for Medicaid clients and all clients.

The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and who had a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by the Division of Behavioral Health (clients receiving only transport services were excluded). The API Meditech dataset included only partial data for 2009. All data was provided by the Alaska Department of Health and Social Services' (DHSS) DBH.

Thus, this assessment analyzed data that identifies people who meet eligibility requirements for behavioral health services supported by State-funds, including DBH treatment and recovery grants and/or State Medicaid Program. These data do not include Alaskans who used services provided by the Department of Corrections (DOC) or the Division of Juvenile Justice (DJJ), DBH-funded prevention programs, Alaska therapeutic courts, Alcohol Safety Action Program (ASAP), DET transport services, DBH's Illness Self-Management pilot or Careline clients (these client counts are included at the end of this section), or services provided by medical providers that were not billed to Medicaid.

For additional information about our methodology, please see the Alaska Behavioral Health Systems Assessment Data Packet.

Key Findings

Total Unique Clients

- In State Fiscal Year (SFY) 2013, 39,958 unique clients (including adults and youth) were served with support from State Medicaid and/or Behavioral Health Funds.[121] This total represents 6,496 more clients than in SFY2009.

[121] Total unique clients includes more individuals than simply adding the total number of adults and the total number of youth. This is because some records do not include a date of birth and therefore cannot be classified as adult or youth; in addition, some individuals turned 18 during the year counted and would therefore be identified as both and adult and a youth for that year.

- In SFY2013, Anchorage providers served 11,576 unique adult clients or 42 percent of the adults served by the system and 5,201 unique youth clients or 43 percent of the youth served by the system (note that many clients are served in more than one region).

Utilization of Behavioral Health Services by Alaska Adults

- In SFY2013, the system served 27,728 unique adult clients. The majority of behavioral health services for adults are provided to clients with SUD (52%) or SMI-related diagnosis (61%), with a relatively small proportion to clients with diagnoses related to other mental health (7%) and co-occurring (13%). These percentages do not equal 100 percent because of the overlap in populations with co-occurring disorder.
- Interesting demographic trends include:
    - 59 percent or 16,232 of the unique adult clients served were female.
    - Statewide, males and females with SUD diagnoses were served in equal numbers. Females are more likely than men to meet the eligibility requirements for Alaska Medicaid, which may contribute to the higher utilization of SUD services among women compared to prevalence of SUD among women, compared to the rate of utilization among men.
    - More females were served with a SMI diagnosis than males (66% compared to 34%).
    - 85 percent of the adult clients served fell into the 21-64 age category, while the remaining pool of clients was split equally between 18-20 and 65+ age categories.
    - 48 percent of the adult clients served were White while approximately 38 percent of the adults clients served were Alaska Native (any mention).[122]
- According to analysis completed by Western Interstate Commission on Higher Education (WICHE) in June 2014, mental health adult clients have an average of 3.28 to 3.45 ACEs, co-occurring adult clients have an average of 3.27 to 3.67 ACEs, and substance abuse adult clients have an average ACEs score of 2.45 to 2.94.[123] ACEs scores can range from 0 to 8.

Utilization of Behavioral Health Services by Alaska Youth

- In SFY2013, the system served 12,147 unique youth clients. The vast majority (77%) of behavioral health services for youth are provided to clients with a diagnosis related to Severe Emotional Disturbance (SED), with a relatively small proportion to clients with diagnoses related to other mental health (18%), SUD (11%), and co-occurring (4%).

[122] Our method uses diagnostic code to assign client cohorts and does not include a level of functioning assessment; therefore, the number of SMI may be a slight over count. For planning purposes, this methodology paints a clear picture of a system that serves predominantly higher levels of mental need.

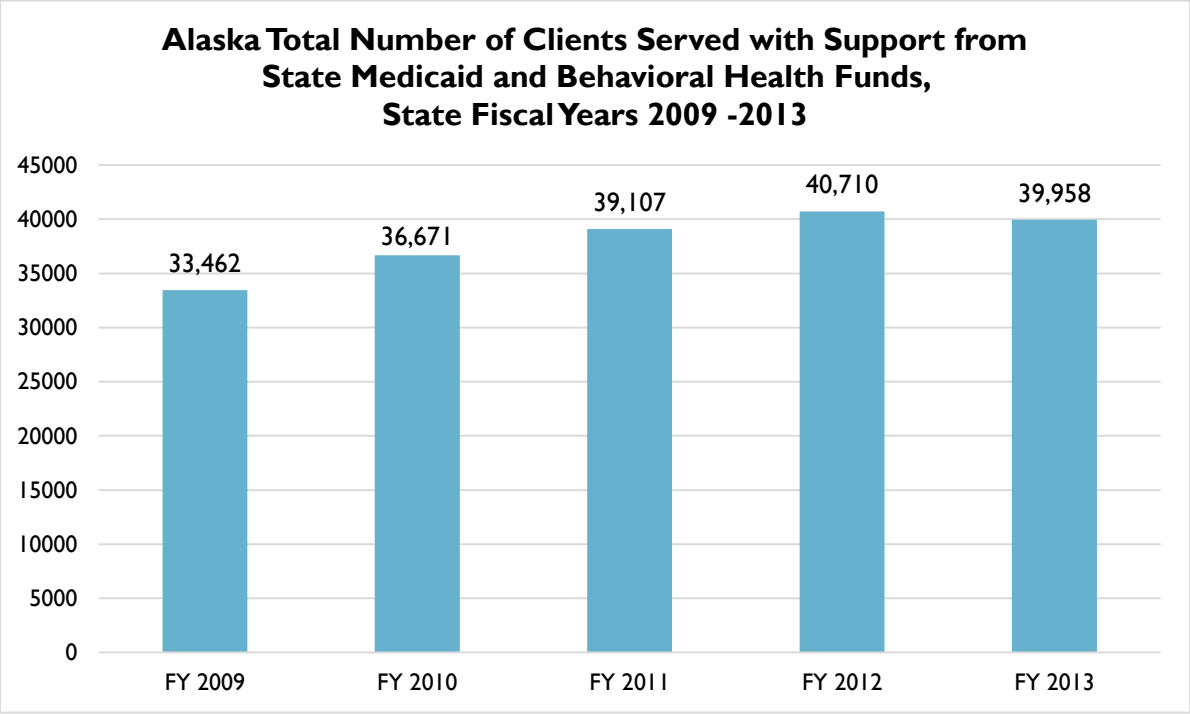
[123] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

- Interesting demographic trends include:
    - 59 percent or 7,129 of the unique youth clients served were male.
    - Statewide, more youth males were served than females in every diagnostic category.
    - More males were served with a SED diagnosis than females (60% compared to 40%).
    - Half (52%) of the youth clients served fell into the 12-17 age category, 34 percent fell into the 6-11 age category, while 14% fell in the 0-5 age category.
    - White youth and Alaska Native youth (any mention) were served in roughly equal numbers (each race made up approximately 40 percent of the total youth served) although White youth make up approximately 56% of the Alaska population under 18 and compared to 27% for Alaska Native youth.[124]

Total Unique Clients

In SFY2013, 39,958 unique clients were served with support from State Medicaid and/or Behavioral Health funds.[125] This total represents 6,496 more clients than in SFY2009. Figure 3-1 shows the growth in unique clients over this five-year period.

Figure 3-1 Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds, State Fiscal Years 2009 -2013

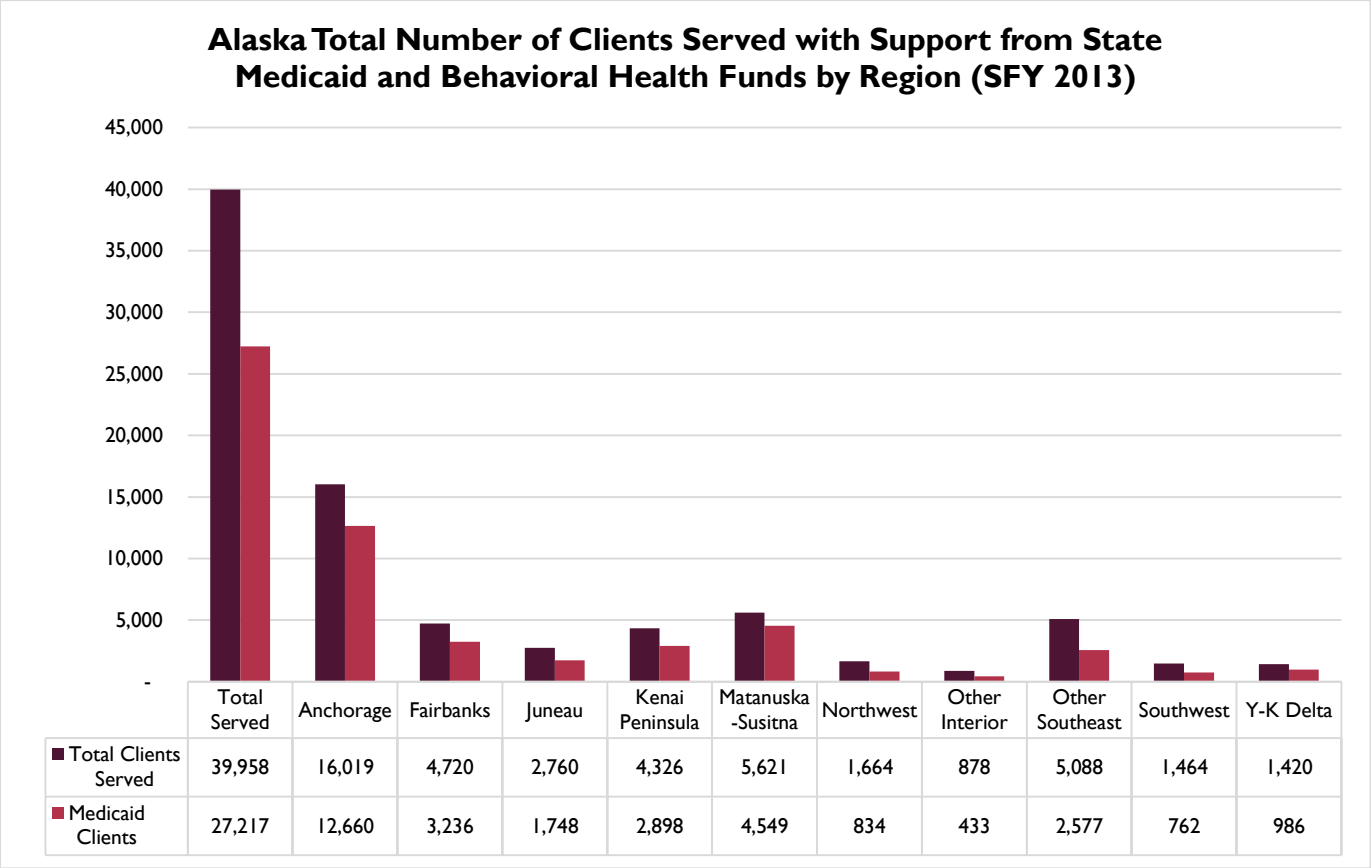


[124] Based on Alaska Department of Labor population data for 2013.

[125] Total unique clients includes more individuals than simply adding the total number of adults and the total number of youth. This is because some records do not include a date of birth and therefore cannot be classified as adult or youth; in addition, some individuals turned 18 during the year counted and would therefore be identified as both and adult and a youth for that year.

Figure 3-2 shows the breakdown of clients served with support from State Medicaid and Behavioral Health Funds by region and compares total unique clients served and total Medicaid clients served at the regional level (these counts are unduplicated at regional and statewide levels).

Figure 3-2 Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Region (SFY 2013)



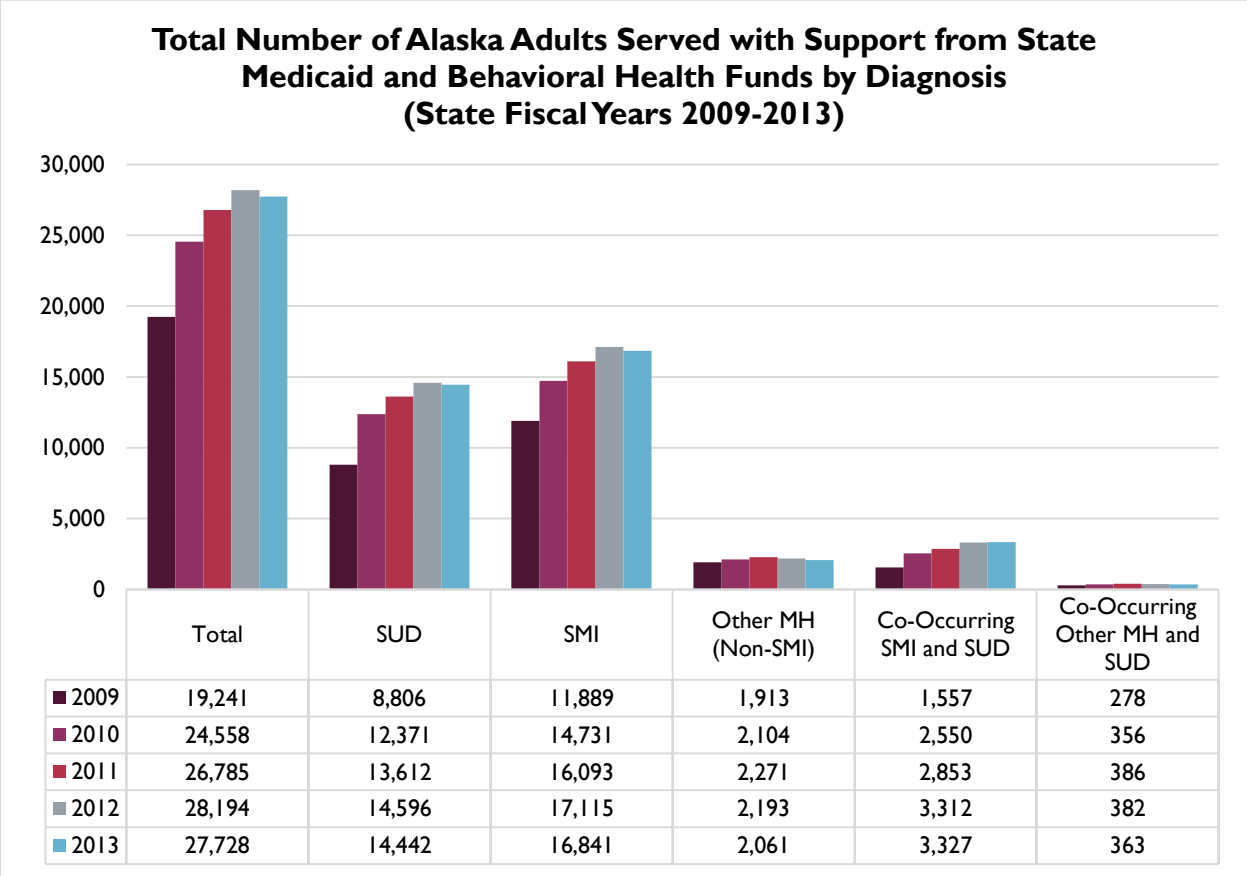
	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
Total Clients Served	39,958	16,019	4,720	2,760	4,326	5,621	1,664	878	5,088	1,464	1,420
Medicaid Clients	27,217	12,660	3,236	1,748	2,898	4,549	834	433	2,577	762	986

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total clients in the region in 2013).

Utilization of Behavioral Health Services by Alaska Adults

In SFY2013, 27,728 unique adult clients were served with support from State Medicaid and/or behavioral health funds (Figure 3-3). The majority of behavioral health services for adults are provided to clients with SUD (14,442 or 52%) or SMI-related diagnosis (16,841 or 61%), with a relatively small proportion provided to clients with diagnoses related to other mental health (7%) and co-occurring (13%). These percentages do not equal 100 percent because of the overlap in populations with co-occurring disorder.

Figure 3-3 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis (State Fiscal Years 2009-2013)

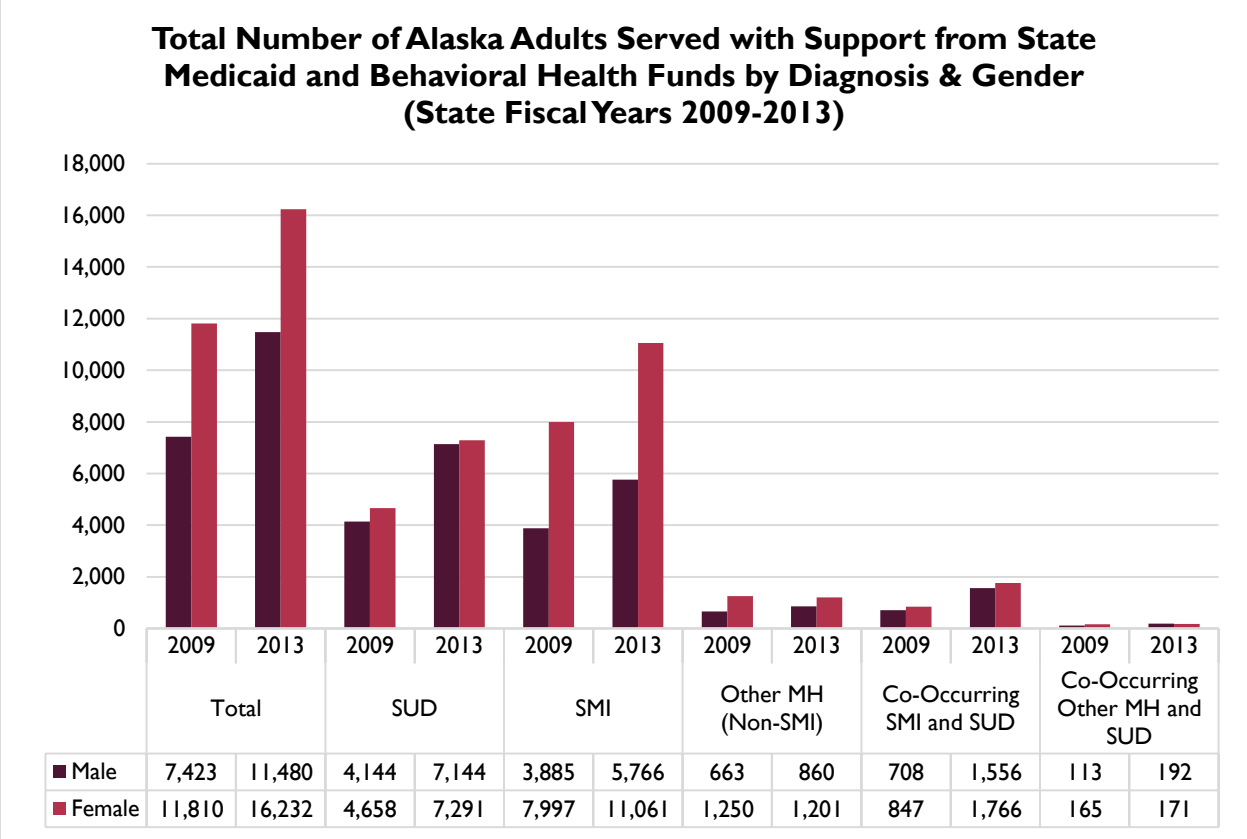


	Total	SUD	SMI	Other MH (Non-SMI)	Co-Occurring SMI and SUD	Co-Occurring Other MH and SUD
2009	19,241	8,806	11,889	1,913	1,557	278
2010	24,558	12,371	14,731	2,104	2,550	356
2011	26,785	13,612	16,093	2,271	2,853	386
2012	28,194	14,596	17,115	2,193	3,312	382
2013	27,728	14,442	16,841	2,061	3,327	363

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SMI, SUD, and Co-Occurring SMI and SUD categories).

Figure 3-4 provides the breakdown of services between adult males and adult females. Fifty-nine percent or 16,232 of the unique adult clients served were female. Statewide, males and females with SUD diagnoses were served in equal proportions despite the much higher prevalence of SUD among males. More females were served with a SMI diagnosis than males (66% compared to 34%). Females are more likely than men to meet the eligibility requirements for Alaska Medicaid and are a priority population for many funders, which likely contributes to higher utilization of behavioral health services.

Figure 3-4 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis & Gender (State Fiscal Years 2009-2013)

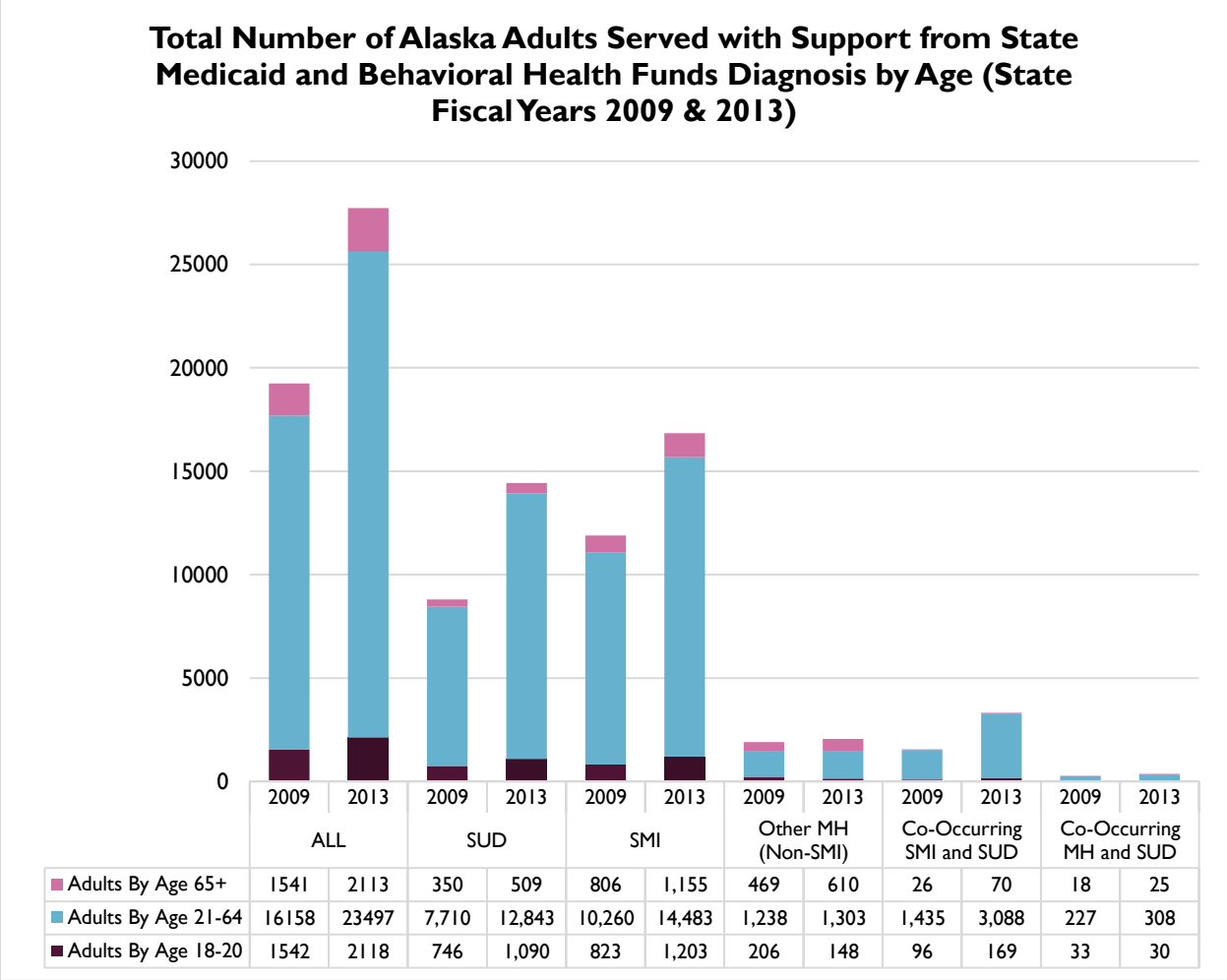


	Total		SUD		SMI		Other MH (Non-SMI)		Co-Occurring SMI and SUD		Co-Occurring Other MH and SUD	
	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
Male	7,423	11,480	4,144	7,144	3,885	5,766	663	860	708	1,556	113	192
Female	11,810	16,232	4,658	7,291	7,997	11,061	1,250	1,201	847	1,766	165	171

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

As shown in Figure 3-5, the majority of adult clients served (16,158 or 85%) fell into the 21-64 age category, while the remaining pool of clients were split equally between 18-20 and 65+ age categories. Adults age 18-20 were more likely than adults age 65+ to be served for a diagnosis related to SUD. It is important to note, however, the trend we see in the 65+ category may be reflective of our dataset not including Medicare records and clients aging out of Medicaid services therefore numbers could be higher.

Figure 3-5 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds Diagnosis by Age (State Fiscal Years 2009 & 2013)



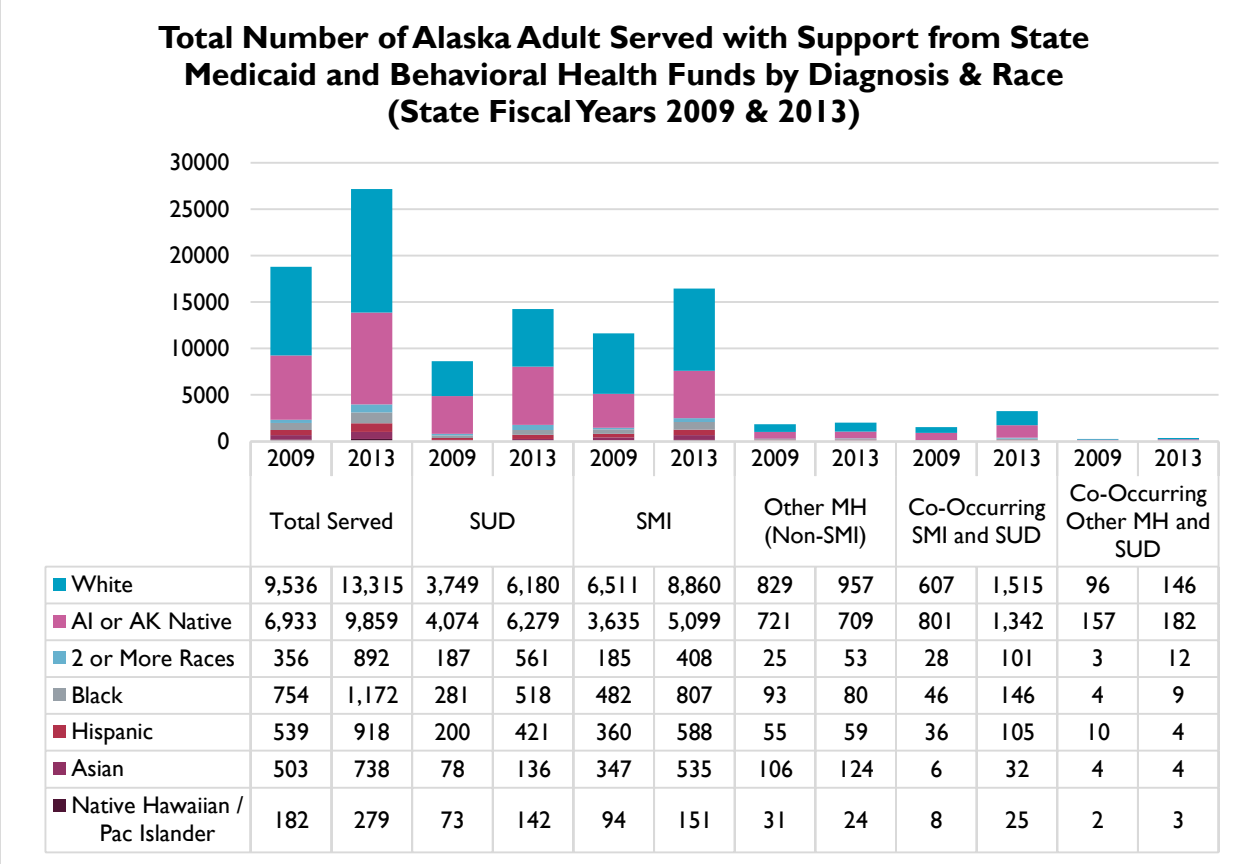
	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
	ALL		SUD		SMI		Other MH (Non-SMI)		Co-Occurring SMI and SUD		Co-Occurring MH and SUD	
Adults By Age 65+	1541	2113	350	509	806	1,155	469	610	26	70	18	25
Adults By Age 21-64	16158	23497	7,710	12,843	10,260	14,483	1,238	1,303	1,435	3,088	227	308
Adults By Age 18-20	1542	2118	746	1,090	823	1,203	206	148	96	169	33	30

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

In looking at data on race, we found that the vast majority of adult clients are either White or Alaska Native (Figure 3-6). (Because race categories did not line up across datasets, Alaska Native adults any mention are spread across two categories, American Indian (AI) or Alaska (AK) Native and the Two (2) or More Races. The Two (2) or More Races category comes from AKAIMS and this option did not exist within the Medicaid dataset. Additional investigation found that the lion's share of individuals within this category are, in fact, Alaska Native.) As shown in Figure 3-6, in SFY2013, 13,315 (48 percent) of the adult clients were White while 9,859 (38%) of the adults clients served were Alaska Native (any mention). Approximately equal numbers of White and Alaska Native adults

were served for SUD while a greater number of White adults with SMI were served. These patterns are relatively stable when you compare utilization trends from SFY2009 and SFY2013.

Figure 3-6 Total Number of Alaska Adult Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis & Race (State Fiscal Years 2009 & 2013)



	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
	Total Served		SUD		SMI		Other MH (Non-SMI)		Co-Occurring SMI and SUD		Co-Occurring Other MH and SUD	
White	9,536	13,315	3,749	6,180	6,511	8,860	829	957	607	1,515	96	146
AI or AK Native	6,933	9,859	4,074	6,279	3,635	5,099	721	709	801	1,342	157	182
2 or More Races	356	892	187	561	185	408	25	53	28	101	3	12
Black	754	1,172	281	518	482	807	93	80	46	146	4	9
Hispanic	539	918	200	421	360	588	55	59	36	105	10	4
Asian	503	738	78	136	347	535	106	124	6	32	4	4
Native Hawaiian / Pac Islander	182	279	73	142	94	151	31	24	8	25	2	3

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

Figure 3-7 provides the breakdown of clients by diagnosis and region. The number of individuals served is the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The second column is the only column that should be read vertically and shows the percentage of clients seen in each region. Percentages add to more than 100 percent because some people are served in more than one region in the same year.

In FY13, Anchorage providers served 11,576 unique adult clients or 42 percent of the adults served by the system (note that many clients are served in more than one region). Reading the rows horizontally provides a glimpse into the breakdown of clients served with support from State Medicaid and/or Behavioral Health Funds within each region by diagnosis. These patterns of usage vary. For instance, in the Northwest reporting region, 70 percent of clients served had a SUD diagnosis, 44 percent had a SMI diagnosis, and 11 percent had an Other Mental Health diagnosis (non-SMI), and 17 percent had a SMI and SUD diagnosis (co-occurring). In the Kenai reporting region, 42 percent of clients served had a SUD diagnosis, 65 percent had a SMI diagnosis, seven percent had an Other Mental Health diagnosis (non-SMI), and six percent had a SMI and SUD diagnosis (co-occurring).

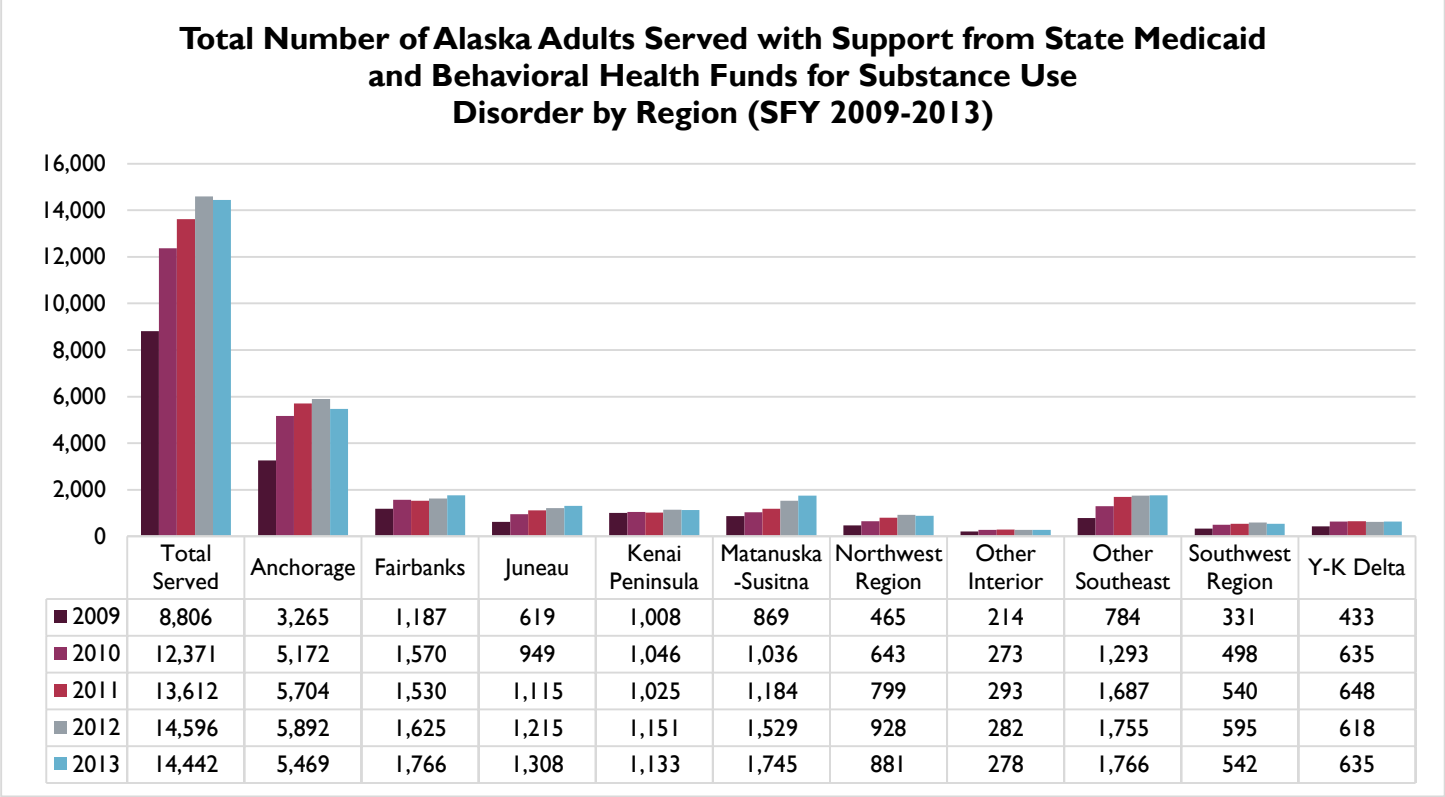
Figure 3-7 Alaska Total Number of Adult Clients Served with Support from State Medicaid and Behavioral Health Funds By Diagnosis and Region (2013)

Alaska Total Number of Adult Clients Served with Support from State Medicaid and Behavioral Health Funds By Diagnosis and Region (2013)												
	Individuals Served		SUD		SMI		Other MH (Non-SMI)		Co-Occurring SMI and SUD		Co-Occurring MH and SUD	
	#	%	#	%	#	%	#	%	#	%	#	%
Total Adults												
Alaska	27,728		14,442	52%	16,841	61%	2,061	7%	3,327	12%	363	1%
Anchorage	11,576	42%	5,469	47%	7,416	64%	974	8%	1,555	13%	124	1%
Fairbanks	3,072	11%	1,766	57%	1,729	56%	156	5%	311	10%	26	1%
Juneau	1,891	7%	1,308	69%	998	53%	61	3%	322	17%	13	1%
Kenai Peninsula	2,722	10%	1,133	42%	1,776	65%	200	7%	153	6%	22	1%
Matanuska-Susitna	3,844	14%	1,745	45%	2,612	68%	204	5%	309	8%	45	1%
Northwest Region	1,264	5%	881	70%	558	44%	135	11%	210	17%	60	5%
Other Interior	657	2%	278	42%	401	61%	79	12%	64	10%	10	2%
Other Southeast	3,124	11%	1,766	57%	1,698	54%	219	7%	348	11%	37	1%
Southwest Region	1,032	4%	542	53%	534	52%	140	14%	122	12%	25	2%
Y-K Delta	953	3%	635	67%	369	39%	67	7%	62	7%	10	1%

General notes: This table is based on combined service data by state fiscal year from the Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI); the Alaska Psychiatric Institute electronic health record system - Meditech; the DBH Designated Evaluation & Treatment (DET) databases; and the Alaska Medicaid JUCE database. Client counts represent unduplicated counts. The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and they had a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by the Division of Behavioral Health (clients receiving only transport services were excluded.) All data was provided by the Alaska Department of Health and Social Services' Division of Behavioral Health.

The following two charts highlight regional trends in adult client services from SFY 2009 to SFY 2013. Figure 3-8 includes client counts for individuals served through State Medicaid or behavioral health funds for SUD. Figure 3-9 includes client counts for individuals served through State Medicaid or behavioral health funds for SMI.

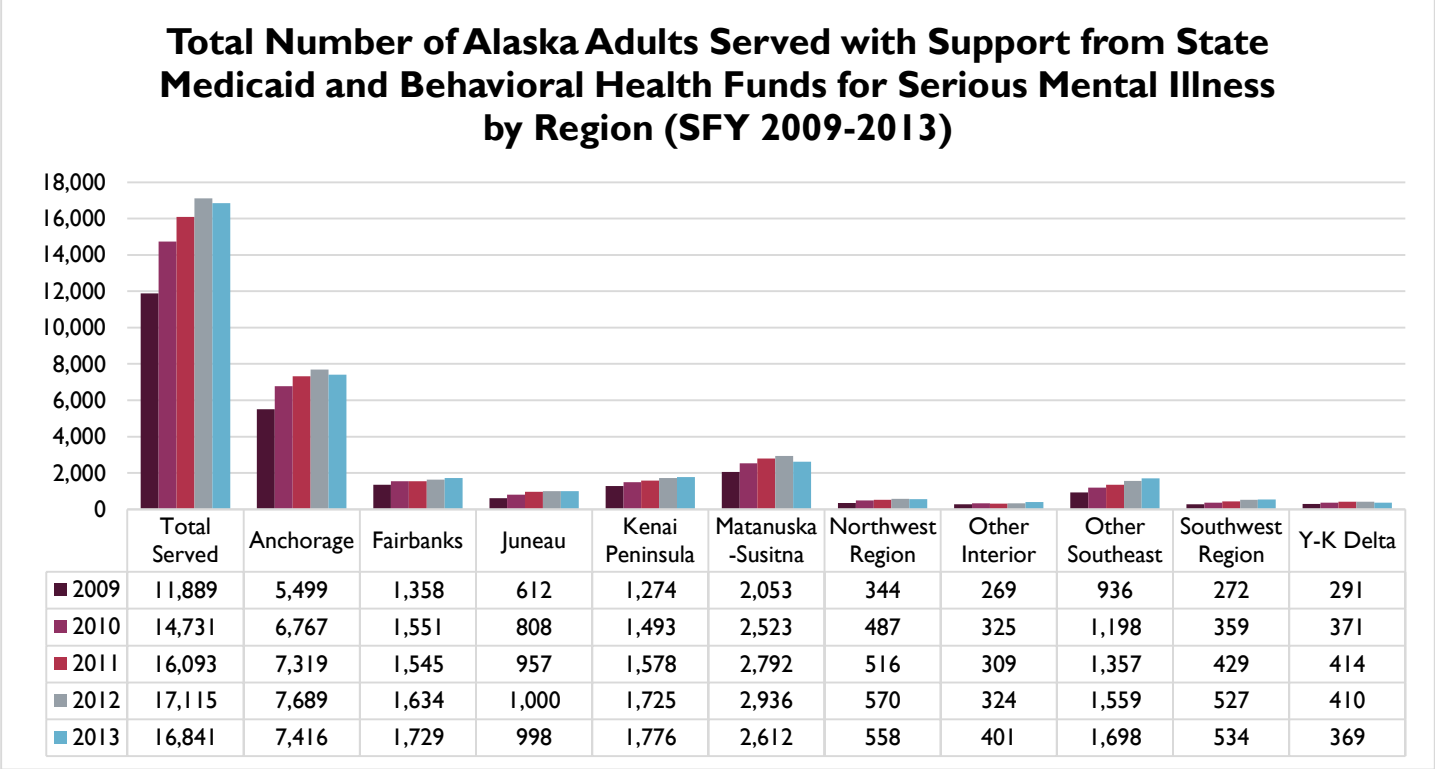
Figure 3-8 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds for Substance Use Disorder by Region (SFY 2009-2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest Region	Other Interior	Other Southeast	Southwest Region	Y-K Delta
2009	8,806	3,265	1,187	619	1,008	869	465	214	784	331	433
2010	12,371	5,172	1,570	949	1,046	1,036	643	273	1,293	498	635
2011	13,612	5,704	1,530	1,115	1,025	1,184	799	293	1,687	540	648
2012	14,596	5,892	1,625	1,215	1,151	1,529	928	282	1,755	595	618
2013	14,442	5,469	1,766	1,308	1,133	1,745	881	278	1,766	542	635

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region.

Figure 3-9 Total Number of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds for Serious Mental Illness by Region (SFY 2009-2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest Region	Other Interior	Other Southeast	Southwest Region	Y-K Delta
2009	11,889	5,499	1,358	612	1,274	2,053	344	269	936	272	291
2010	14,731	6,767	1,551	808	1,493	2,523	487	325	1,198	359	371
2011	16,093	7,319	1,545	957	1,578	2,792	516	309	1,357	429	414
2012	17,115	7,689	1,634	1,000	1,725	2,936	570	324	1,559	527	410
2013	16,841	7,416	1,729	998	1,776	2,612	558	401	1,698	534	369

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region.

Client Alaska Screening Tool Scores

In June 2014, the Western Interstate Commission on Higher Education (WICHE) released a report, commissioned by DBH, titled "Connecting the Dots: The Right Data to the Right Person."[126] The purpose of this report was to "provide a synopsis of multiple research and analysis [efforts] conducted to inform and refine the Division's Performance Management System through a continuous quality improvement process." This analysis relied on client data from State Fiscal Years 2011 to 2013. The results included in this report are interspersed through the assessment. In this chapter, we share WICHE's analysis on Alaska Screening Tool scores.

The rate of ACEs among behavioral health clients served by Treatment and Recovery grantees may be of particular interest. According to analysis completed by Western Interstate Commission on Higher Education (WICHE) in June 2014, adult mental health clients have an average of 3.28 to 3.45 ACEs, adult co-occurring clients have an average of 3.27 to 3.67 ACEs, and adult substance abuse clients have an average ACEs score of 2.45 to 2.94 (Figure 3-10).[127] Intake only clients were excluded from this analysis. Depression can range from 0 to 3, Trauma can range from 0 to 3, and ACEs can range from 0 to 8.

[126] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

[127] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

Figure 3-10 Statewide Average Alaska Screening Tool Scores by Client Type and Cohort

			Average			
Client Type	Cohort	Time in Treatment	Depression	Trauma	Adverse Experiences Count	Number in Cohort
SU	2	<6 months	0.76	0.56	2.45	2,262
SU	3	6 up to 12 mths	0.65	0.46	2.39	945
SU	4	12+ months	0.89	0.66	2.94	259
COD	2	<6 months	1.2	0.96	3.27	575
COD	3	6 up to 12 mths	1.16	0.92	3.34	354
COD	4	12+ months	1.31	1.05	3.67	215
MH	2	<6 months	1.4	1.11	3.28	1,041
MH	3	6 up to 12 mths	1.52	1.2	3.45	1,105
MH	4	12+ months	1.52	1.22	3.37	1,345

Source: WICHE 2014

Illness Self-Management Pilot

In 2012, DBH launched an illness self-management pilot. Three Anchorage-based providers participated and adults with mental illness were targeted. Number of clients served is tracked outside of AKAIMS and, thus, were not included in the counts above. Nonetheless, this pilot is promising in its reach. In Figure 3-11, we include the total number of clients served through this program in SFY2012 and SFY2013.[128]

Figure 3-11 Illness Self-Management Pilot Number of Clients Served

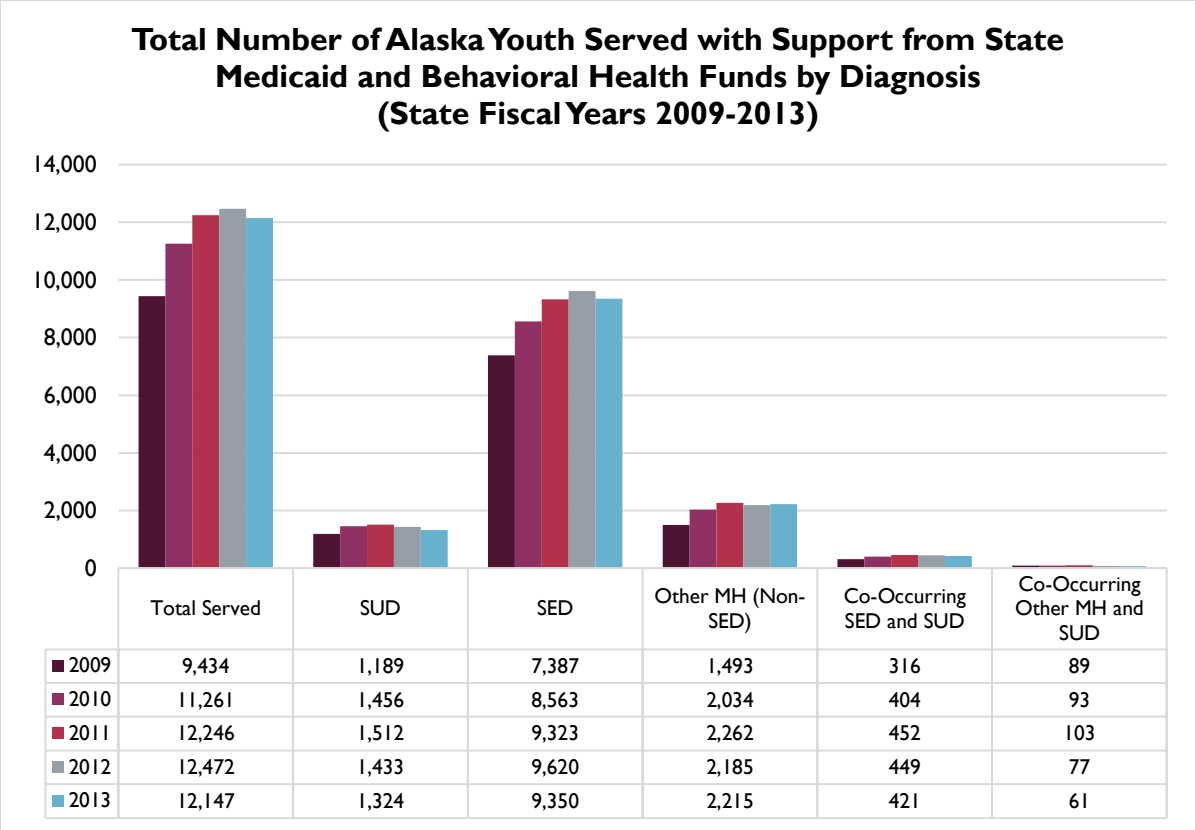
Illness Self-Management Pilot Number of Clients Served	
State Fiscal Year	# Clients
2012	2420
2013	3103

Utilization of Behavioral Health Services by Alaska Youth

In SFY2013, 12,147 unique youth clients were served with support from State Medicaid and/or behavioral health funds (Figure 3-12). The vast majority (9,350 or 77%) of the behavioral health services for youth are provided to clients with a diagnosis related to SED, with a relatively small proportion to clients with diagnoses related to other mental health (18%), SUD (11%), and co-occurring (4%). These percentages do not equal 100 percent because of the overlap in populations with co-occurring disorder.

[128] Data provided by DBH on 5/13/15.

Figure 3-12 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis (State Fiscal Years 2009-2013)

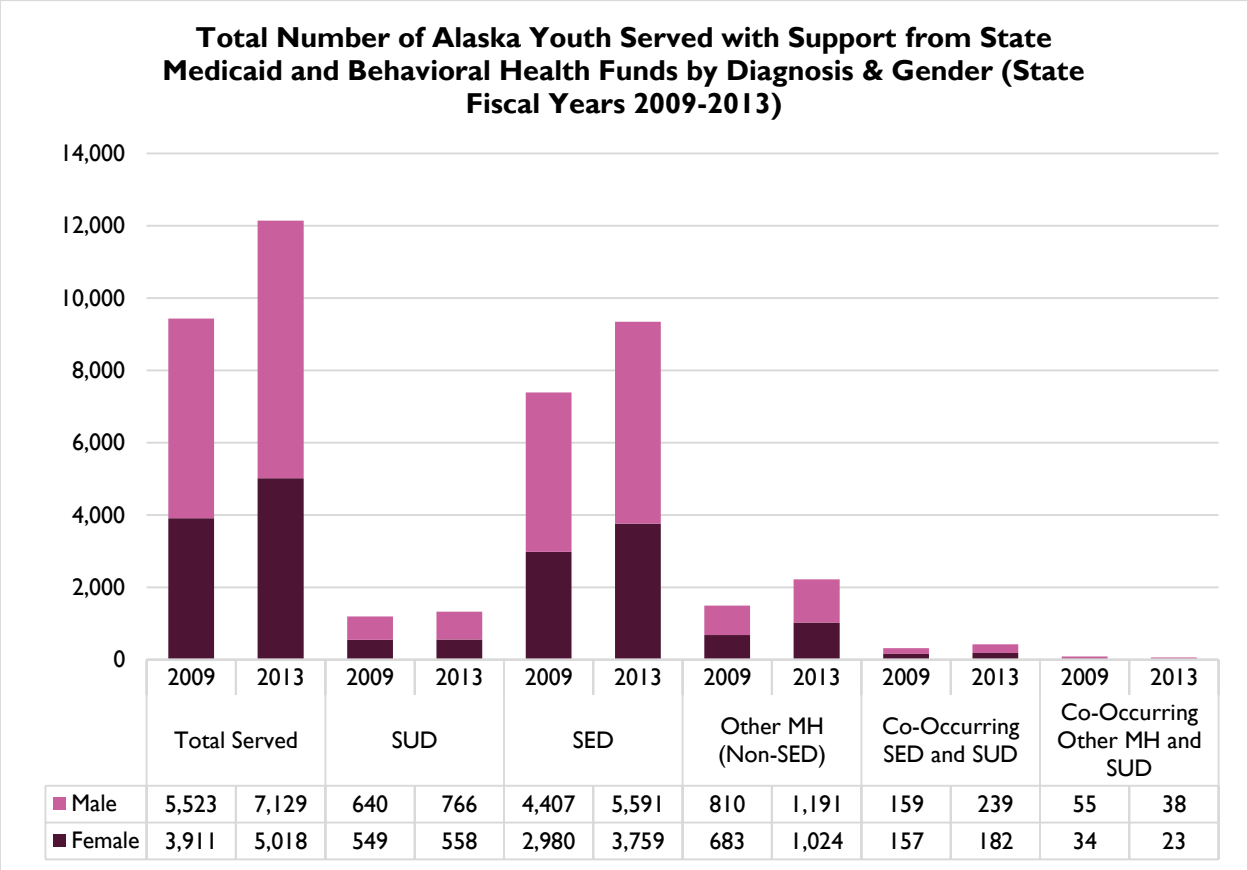


	Total Served	SUD	SED	Other MH (Non-SED)	Co-Occurring SED and SUD	Co-Occurring Other MH and SUD
2009	9,434	1,189	7,387	1,493	316	89
2010	11,261	1,456	8,563	2,034	404	93
2011	12,246	1,512	9,323	2,262	452	103
2012	12,472	1,433	9,620	2,185	449	77
2013	12,147	1,324	9,350	2,215	421	61

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

Figure 3-13 provides the breakdown of services between youth males and youth females. Fifty-nine percent (59%) or 7,129 of the unique youth clients served were male. More youth males were served in every category.

Figure 3-13 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis & Gender (State Fiscal Years 2009-2013)

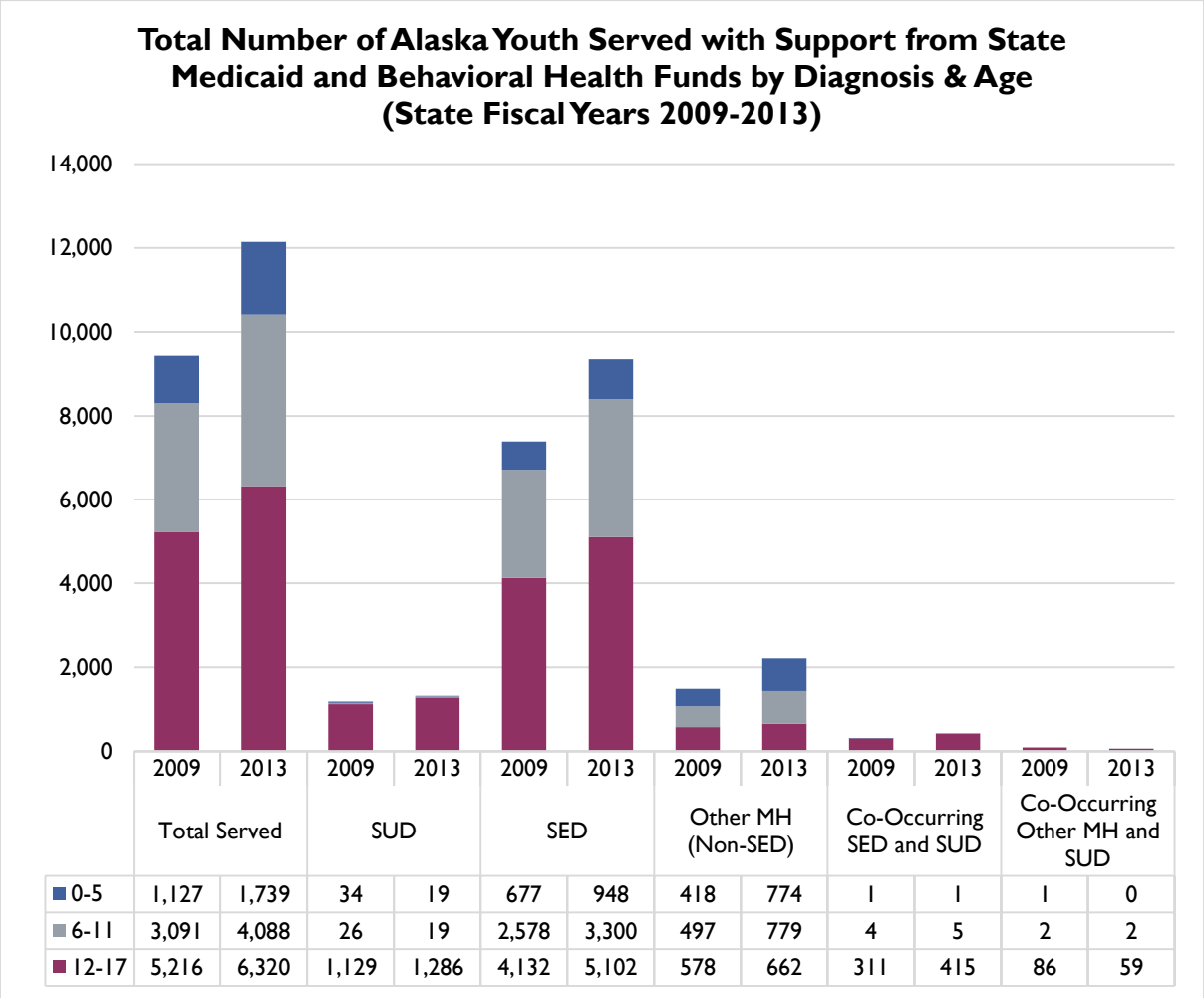


	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
	Total Served		SUD		SED		Other MH (Non-SED)		Co-Occurring SED and SUD		Co-Occurring Other MH and SUD	
Male	5,523	7,129	640	766	4,407	5,591	810	1,191	159	239	55	38
Female	3,911	5,018	549	558	2,980	3,759	683	1,024	157	182	34	23

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

Figure 3-14 provides insight into the breakdown of youth services across age categories between SFY2009 and SFY2013. Half (52%) of youth clients served fell into the 12-17 age category, 34 percent fell into the 6-11 age category, while 14 percent fell into the 0-5 age category.

Figure 3-14 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis & Age (State Fiscal Years 2009-2013)

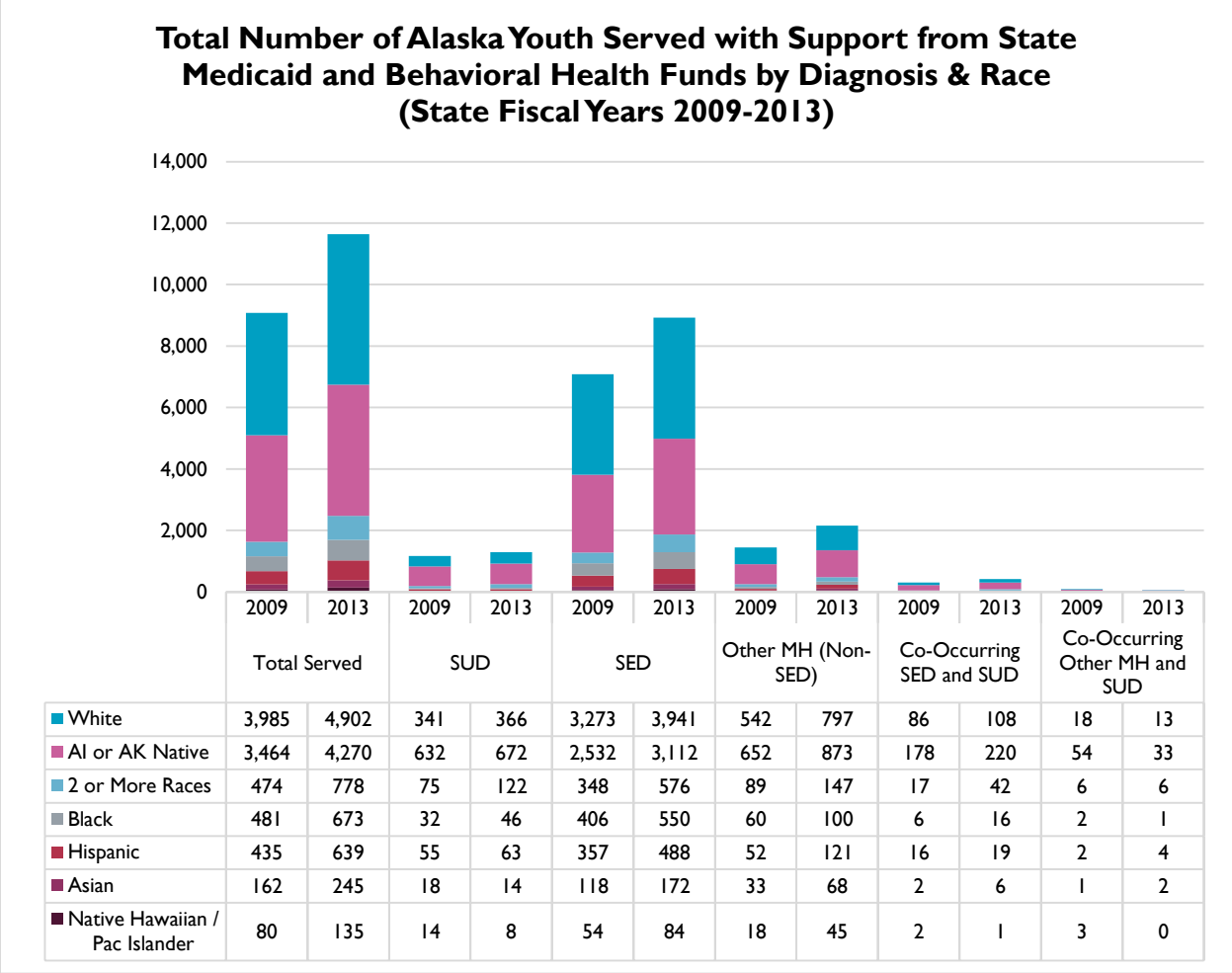


	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
	Total Served		SUD		SED		Other MH (Non-SED)		Co-Occurring SED and SUD		Co-Occurring Other MH and SUD	
0-5	1,127	1,739	34	19	677	948	418	774	1	1	1	0
6-11	3,091	4,088	26	19	2,578	3,300	497	779	4	5	2	2
12-17	5,216	6,320	1,129	1,286	4,132	5,102	578	662	311	415	86	59

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

White youth and Alaska Native youth (any mention) were served in roughly equal proportions (each race made up approximately 40 percent of the total youth served). (Because race categories did not line up across datasets, Alaska Native adults Any Mention are spread across two categories, AI or AK Native and the Two (2) or More Races. The Two (2) or More Races category comes from AKAIMS and this option did not exist within the Medicaid dataset. Additional investigation found that the lion's share of individuals within this category are, in fact, Alaska Native.) As shown in Figure 3-15, a greater number of Alaska Native Youth with SUD were served than any other race category.

Figure 3-15 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis & Race (State Fiscal Years 2009-2013)



	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013	2009	2013
	Total Served		SUD		SED		Other MH (Non-SED)		Co-Occurring SED and SUD		Co-Occurring Other MH and SUD	
White	3,985	4,902	341	366	3,273	3,941	542	797	86	108	18	13
AI or AK Native	3,464	4,270	632	672	2,532	3,112	652	873	178	220	54	33
2 or More Races	474	778	75	122	348	576	89	147	17	42	6	6
Black	481	673	32	46	406	550	60	100	6	16	2	1
Hispanic	435	639	55	63	357	488	52	121	16	19	2	4
Asian	162	245	18	14	118	172	33	68	2	6	1	2
Native Hawaiian / Pac Islander	80	135	14	8	54	84	18	45	2	1	3	0

Note: The number of clients within each category do not sum to the total number of clients served because clients with co-occurring disorder are duplicated within the categories (e.g. an individual can be included in the SED, SUD, and Co-Occurring SED and SUD categories).

Figure 3-16 provides the breakdown of youth clients by diagnosis and region. The number of individuals served is the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The second column should be read vertically and shows the percentage of clients seen in each region. Percentages add to more than 100 percent because some people are served in more than one region in the same year.

In FY13, Anchorage providers served 5,201 unique youth clients or 43 percent of the youth served by the system (note that many clients are served in more than one region). Reading the rows horizontally provides a glimpse into the breakdown of clients served with support from State Medicaid and/or Behavioral Health Funds within each region by diagnosis. For instance, in the Fairbanks reporting region, 10 percent of clients served had a SUD diagnosis, 79 percent had a SED diagnosis, and 18 percent had an Other Mental Health diagnosis (non-SMI), and four percent had a SED and SUD diagnosis (co-occurring). Client counts for the Juneau reporting region include foster care children for whom services were provided and Medicaid billed through the Office of Children's Services (OCS).

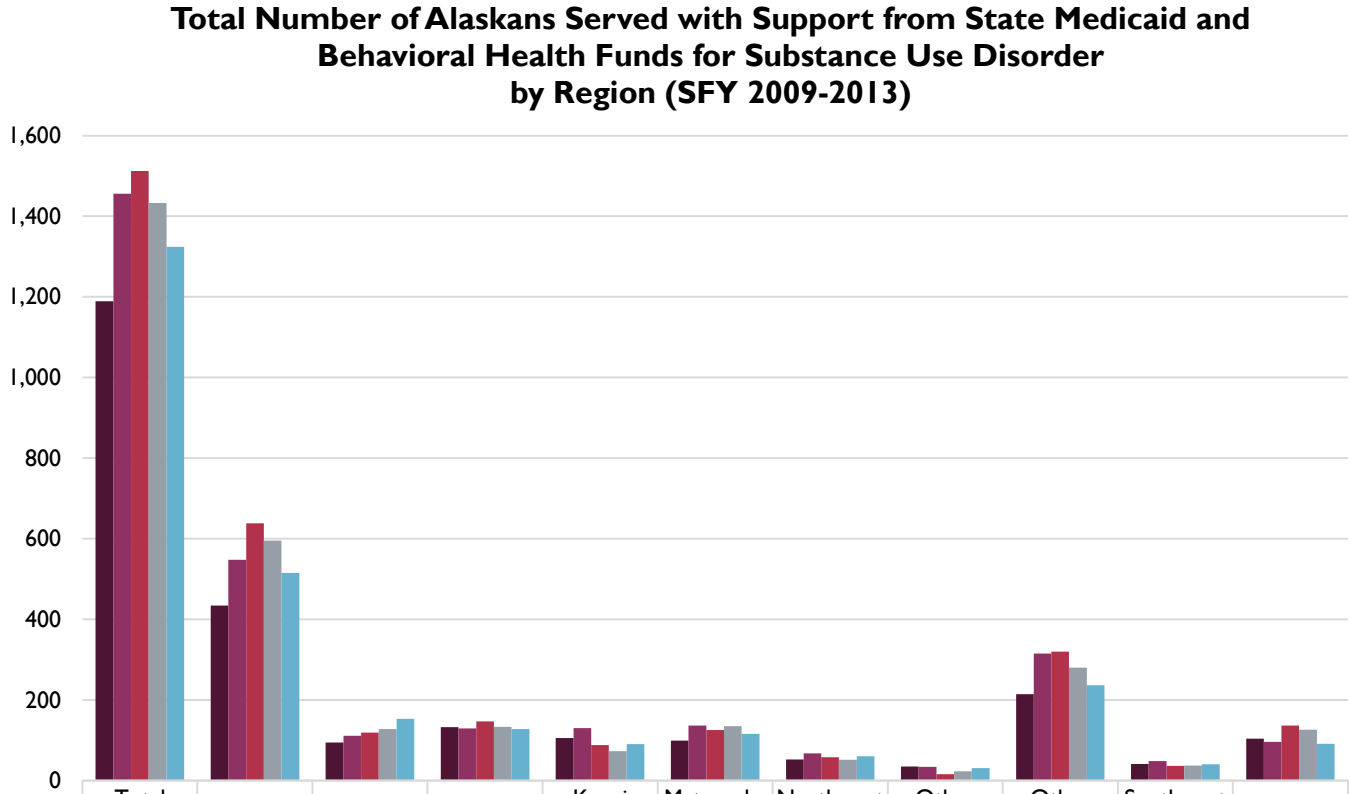
Figure 3-16 Alaska Total Number of Youth Clients Served with Support from State Medicaid and Behavioral Health Funds By Diagnosis and Region (2013)

Alaska Total Number of Youth Clients Served with Support from State Medicaid and Behavioral Health Funds By Diagnosis and Region (2013)												
	Individuals Served		SUD		SED		Other MH (Non-SED)		Co-Occurring SED and SUD		Co-Occurring MH and SUD	
	#	%	#	%	#	%	#	%	#	%	#	%
Total Youth												
Alaska	12,147		1,324	11%	9,350	77%	2,215	18%	421	3%	61	1%
Anchorage	5,201	43%	515	10%	4,061	78%	909	17%	170	3%	19	0%
Fairbanks	1,541	11%	153	10%	1,214	79%	284	18%	56	4%	10	1%
Juneau	788	6%	128	16%	633	80%	100	13%	41	5%	13	2%
Kenai Peninsula	1,488	11%	90	6%	1,118	75%	317	21%	15	1%	2	0%
Matanuska-Susitna	1,915	14%	116	6%	1,694	88%	161	8%	31	2%	4	0%
Northwest Region	271	2%	60	22%	161	59%	74	27%	11	4%	8	3%
Other Interior	203	2%	31	15%	130	64%	50	25%	1	0%	3	1%
Other Southeast	1,593	11%	236	15%	1,197	75%	313	20%	110	7%	20	1%
Southwest Region	372	3%	40	11%	266	72%	82	22%	10	3%	5	1%
Y-K Delta	362	3%	91	25%	224	62%	70	19%	10	3%	2	1%

General notes: This table is based on combined service data by state fiscal year from the Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI); the Alaska Psychiatric Institute electronic health record system - Meditech; the DBH Designated Evaluation & Treatment (DET) databases; and the Alaska Medicaid JUCE database. Client counts represent unduplicated counts. The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and they had a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by the Division of Behavioral Health (clients receiving only transport services were excluded.) All data was provided by the Alaska Department of Health and Social Services' Division of Behavioral Health. The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total clients in the region in 2013).

The following three charts highlight regional trends in youth clients services from SFY 2009 to SFY 2013. Figure 3-17 includes client counts for individuals served through State Medicaid or behavioral health funds for SUD. Figure 3-18 includes client counts for individuals served through State Medicaid or behavioral health funds for SED. Figure 3-19 includes client counts for individuals served through State Medicaid or behavioral health funds for Other Mental Health (non-SED).

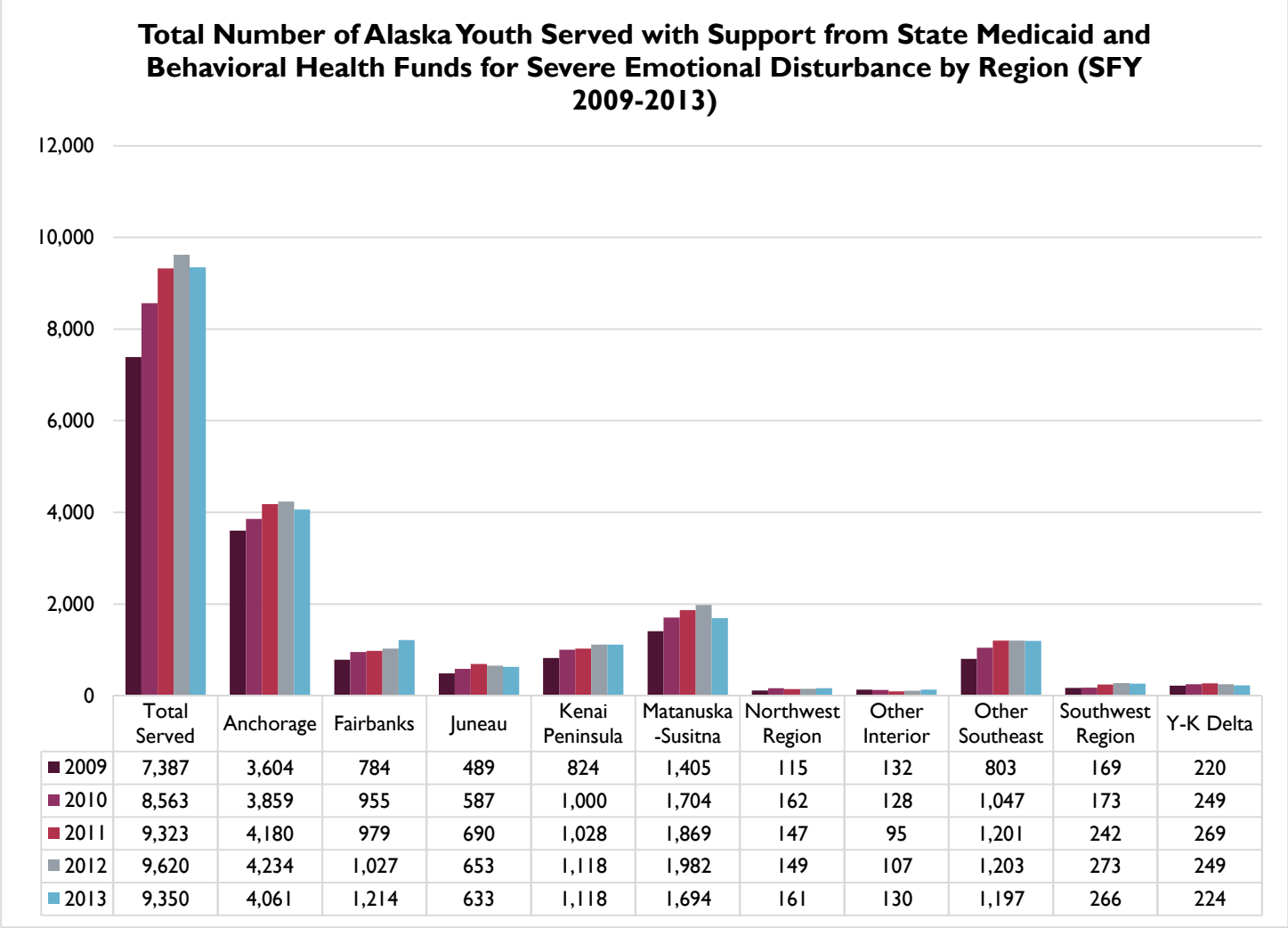
Figure 3-17 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds for Substance Use Disorder by Region (SFY 2009-2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest Region	Other Interior	Other Southeast	Southwest Region	Y-K Delta
2009	1,189	434	94	132	105	99	52	35	214	41	104
2010	1,456	548	111	129	130	136	67	34	315	48	96
2011	1,512	638	119	147	88	125	58	16	320	36	136
2012	1,433	595	128	133	73	135	51	23	280	37	126
2013	1,324	515	153	128	90	116	60	31	236	40	91

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total (adult and youth) clients in the region in 2013).

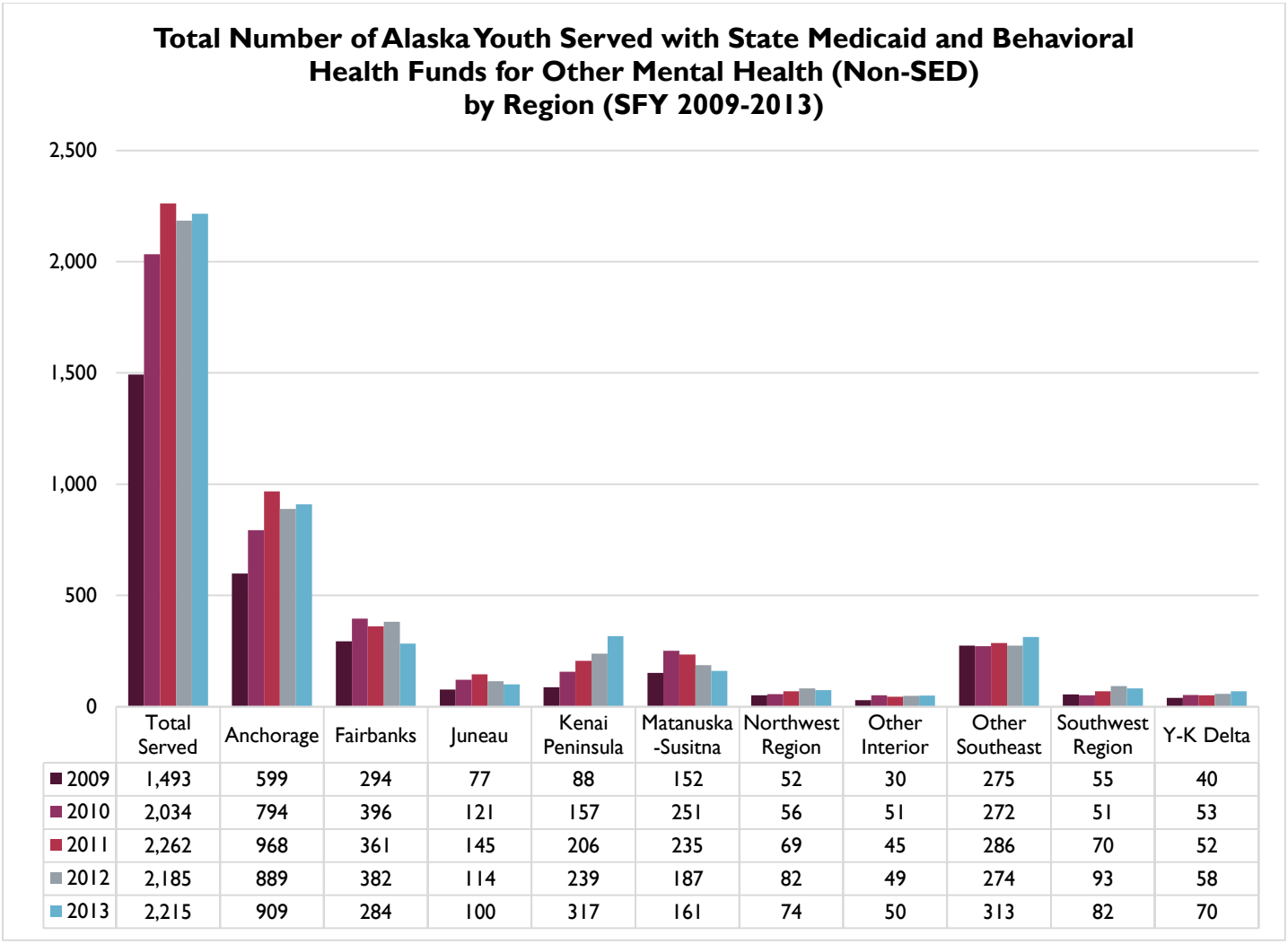
Figure 3-18 Total Number of Alaska Youth Served with Support from State Medicaid and Behavioral Health Funds for Severe Emotional Disturbance by Region (SFY 2009-2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest Region	Other Interior	Other Southeast	Southwest Region	Y-K Delta
2009	7,387	3,604	784	489	824	1,405	115	132	803	169	220
2010	8,563	3,859	955	587	1,000	1,704	162	128	1,047	173	249
2011	9,323	4,180	979	690	1,028	1,869	147	95	1,201	242	269
2012	9,620	4,234	1,027	653	1,118	1,982	149	107	1,203	273	249
2013	9,350	4,061	1,214	633	1,118	1,694	161	130	1,197	266	224

Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total (adult and youth) clients in the region in 2013).

Figure 3-19 Total Number of Alaska Youth Served with State Medicaid and Behavioral Health Funds for by Other Mental Health (Non-SED) by Region (SFY 2009-2013)



	Total Served	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest Region	Other Interior	Other Southeast	Southwest Region	Y-K Delta
2009	1,493	599	294	77	88	152	52	30	275	55	40
2010	2,034	794	396	121	157	251	56	51	272	51	53
2011	2,262	968	361	145	206	235	69	45	286	70	52
2012	2,185	889	382	114	239	187	82	49	274	93	58
2013	2,215	909	284	100	317	161	74	50	313	82	70

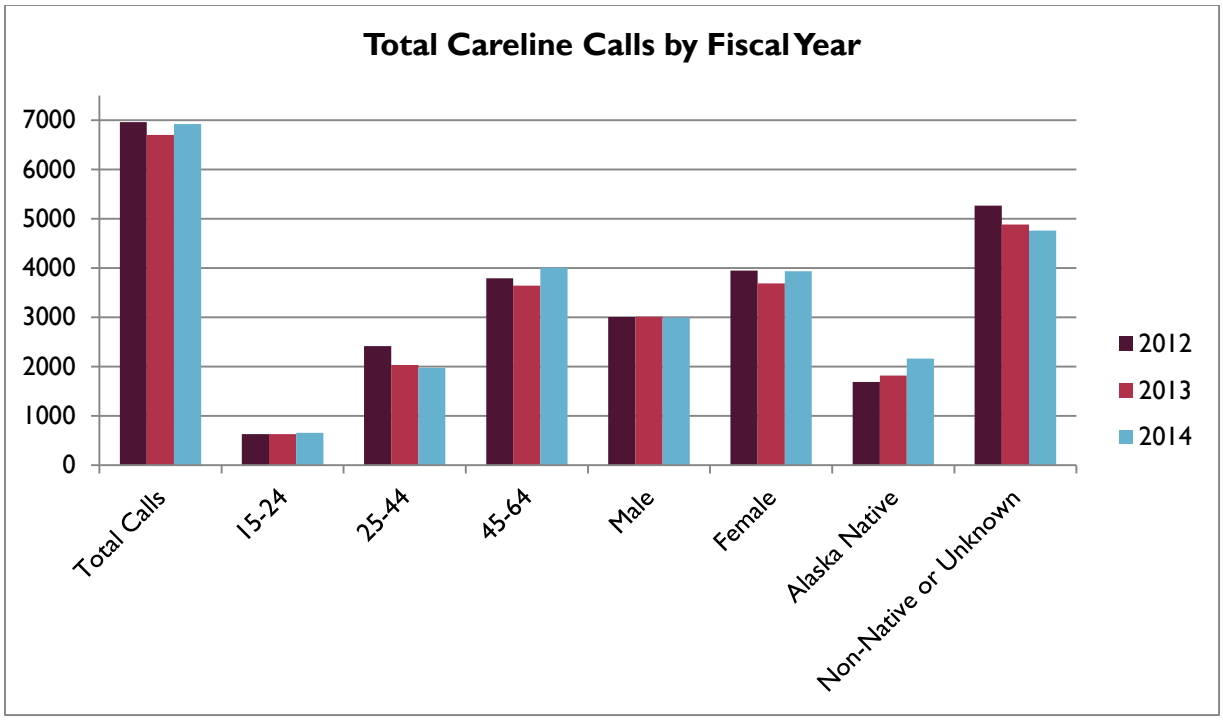
Note: The number of individuals served represents the number of people who were served by providers located in the respective region, including people who reside in the region and those who reside outside of the region. The total served represents a unique client count statewide. The clients served do not equal the total served because a client can be served in more than one region. Juneau Region client counts include services provided to children living in foster homes throughout the state that were billed through the Office of Children's Services (this population represented about 9% of the total (adult and youth) clients in the region in 2013).

Alaska Careline

The Careline is a twenty-four crisis intervention line that supports Alaskans in need. The Careline receives nearly 7,000 calls/texts per year (Figure 3-20).[129] The majority of callers are between the ages 45 to 64. In 2014, Alaska Native people represented about one-third of the call/text volume. During the provider survey, we heard that many, but not all, providers actively promote the Careline. Like with the Illness Self-Management Program, these individuals are not included in our total client counts.

[129] Call data provided by Susanna Marchuk, Director of the Careline Crisis Intervention Program. 5/28/15.

Figure 3-20 Careline Statewide Call Volume by Year



4. WHERE ARE CLIENTS BEING SERVED AND BY WHOM?

In Alaska, State supported behavioral health services are provided in a number of different settings and by a variety of provider types. This chapter explores the number of clients served with support from State Medicaid or behavioral health funds by provider type, regional client access patterns, behavioral health workforce data, and Medicaid billing models by provider type. Both Tribal and non-Tribal health organizations operate these settings and provider types; however, the Medicaid billing models and credentialing requirements vary by setting and by the type of health organization that operates them.

Throughout the report, we refer to Alaska's Tribal and non-Tribal behavioral health systems, each of which includes combinations of the various funding sources and eligibility requirements that fund behavioral health services in Alaska. For example, many Tribal Health Organizations receive grant funding from the Division of Behavioral Health for community behavioral health services; from Health Resources and Services Administration (HRSA) to operate Community Health Centers; from the Indian Health Service to provide comprehensive health services; and bill private insurance and Medicaid for treatment of clients with secondary diagnoses of behavioral health. As such, it is important to remember that the data analyzed though this assessment presents only a partial picture of the services provided to Alaskans.

While many State supported behavioral health services are provided through the community behavioral health system of care, behavioral health services are also provided in medical settings. Physicians, for example, are an integral part of the service provision model. Our findings underscore the important role of both the community behavioral health side and the medical side in meeting the behavioral health needs of Alaskans.

As the demand for behavioral health services increases, behavioral health system leaders must ensure that two front doors, one through the community behavioral health centers for individuals with a range of needs and one through primary care for individuals with mild and moderate needs, are as open and as connected as possible. Creating these two front doors will require a concerted effort to remove the barriers that currently exist to billing Medicaid for behavioral health services. Integration and data sharing are also vital pieces to the puzzle, otherwise we will continue to see costly patterns of use and inefficiencies in the way we care for individuals with behavioral health needs.

Key Findings

Clients Served by Provider Type

- Behavioral health clients are served by 14 different provider types across a range of service settings. In FY13, these provider types served 39,958 unique clients or a cumulative sum of 61,642 (duplicated) clients. Our findings underscore the important role of both the community behavioral health side and the medical side in meeting the behavioral health needs of Alaskans.
- DBH Treatment and Recovery grantees served 43% or 10,246 of the 23,650 unique clients (adults and youth) served by the publicly-funded behavioral health system in FY13. Physicians served 39% or 15,455 unique clients in FY13.

- Outpatient hospitals, which include emergency departments, represent the third most prominent provider type. Private Outpatient Hospitals served 18% or 7,109 unique clients and Tribal Outpatient Hospitals served 6% or 2,382 unique clients of the total unique clients served in FY13.
- API served 1,225 unique clients in FY13, about 3% of the total clients served in that year.
- Medicaid claims were paid for 27,217 unique clients during FY13 up from 22,403 in FY09 (an increase of 121%).

Client Access Patterns

- Client access patterns are important to understanding where and by whom clients receive services. Clients living in the more urban areas of the state (for example, Anchorage, Fairbanks, Juneau, Kenai) are more likely to receive services in their home region only, whereas a greater percentage of clients living in rural regions (for example, Northwest and Other Interior) are receiving services in a different region only.

Alaska's Behavioral Health Workforce

- In August 2014 the Alaska Center for Rural Health/Area Health Education Center (ACRH/AHEC) within the University of Alaska Anchorage released the Alaska Workforce Vacancy Study, 2012 Findings Report.[130] This study was conducted to assess the health workforce vacancies in Alaska and contributes to our understanding of the behavioral health system and its workforce needs.
- According to the Alaska Workforce Vacancy Study, over half (54%) of Alaska's behavioral health workforce consists of professional counselors, therapists and clinicians. Professional counselors, therapists and clinicians require an advanced degree and a clinical license to practice. A third (33%) of the behavioral health workforce is made up of behavioral, mental health, and rehabilitative counselors, such as Behavioral Health Aides (BHA) Rehabilitation Counselors, Substance Use Disorder Counselors, and other behavioral health counselors. Rehabilitation counselors require a certificate from a training program. The remaining 13 percent consist of Behavioral Health Clinical Associates. Behavioral Health Clinical Associates have less than a master's degree (typically trained to the associate's or bachelor's level) in psychology, social work, counseling, or a related field with specialization or experience providing rehabilitation services to clients and may consist of a psychiatric or mental health nurse, baccalaureate social worker, and peer support specialists.
- Actively pursuing ways to tap the supervisory role of licensed mental health clinicians and support Behavioral Health Clinical Associates and behavioral, mental health, rehabilitation counselors in delivering a larger share of the direct services provided to individuals with serious behavioral health issues may be a potential way to expand system capacity. Doing so would also increase the number of qualified staff able to bill for services and tap into the additional Medicaid billing potential that exists within DBH's current Medicaid billing regulations. It may also free up time within the licensed clinician workforce for delivery of clinical services to individuals with mild and moderate needs.

[130] Alaska Health Workforce Vacancy Study: 2012 Findings Report. Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska. Prepared by Katherine Branch, 2014. http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/upload/2012ak-hlth-workforce-vacancy-study_12-23-14_FINAL.pdf

- The Workforce Vacancy Study highlights the disparities between workforce vacancies in rural and urban areas. Rural regions of the state experience noticeably higher vacancy rates in the behavioral health workforce for every occupation except Behavioral Health Clinical Associates. The statewide vacancy rate for Behavioral Health Aides is highest at 17 percent. The difference in vacancy rates between urban and rural regions of the state is striking for a number of positions. For example, providers in rural areas experience a 13 percent vacancy rate for Clinical Psychologists compared to six percent in urban areas and a 15 percent vacancy rate for Clinical Social Workers compared to eight percent in urban areas. Notably, the estimated statewide vacancy rate for psychiatrists is 22 percent. Psychiatrists and physicians serve a critical role prescribing and overseeing treatment of individuals requiring medication-assisted therapies.

Medicaid Billing Models

- Behavioral health services are reimbursed through a number of different Medicaid billing models and each Medicaid billing model requires a different level of professional to provide behavioral health services to clients.
- Our analysis of Medicaid billing models indicates that major barriers to billing for behavioral health services outside of the community behavioral health billing model. Currently, the various billing models do not encourage integration of behavioral health services in primary care settings, which makes achieving the goal of having two front doors into behavioral health services impossible.
- Within the community behavioral health billing model, there appears to be additional billing capacity among non-degreed professionals to provide more rehabilitation services to behavioral health clients. Rehabilitation services are key to recovery and behavioral, mental health, and rehabilitative counselors (non-degreed professionals) require less education time, demand lower salaries, may be more easily recruited, and very often hold strong ties to the communities within which they live and work.
- Given the significant need for substance use disorder and mild and moderate mental health services among Alaskans, it is imperative that health care systems leaders work to remove barriers to billing for behavioral health services and allow for a greater range of behavioral health professionals to bill for services outside of the community behavioral health system. It is also important to grow and retain a strong behavioral health workforce with a mix of position types that aligns with Alaskans' needs and the evidence base on how recovery works.

Service Settings and Provider Types:

Clients are served by 14 different provider types across a range of service settings.[131] In FY13, these provider types served a cumulative sum of 61,642 (duplicated) clients, with 39,958 of those being unique Medicaid and behavioral health-funded clients. Figure 4-1 includes a list of the service settings and provider types included in our dataset along with a description for each provider type. Figure 4-2 shows unique Alaska clients by provider type and describes the number of clients served by provider type and setting between 2009 and 2013.

[131] Although DET clients are listed separately in the next set of reports, DET is not included in this count of service settings/provider types because these services are delivered in Private and Tribal Acute Hospitals.

Figure 4-1 Provider Type Descriptions

Service Setting/ Provider Type	Description
Inpatient Institutional	
Private Acute Care Hospital	Acute care medical hospital operated by private operators
Tribal Acute Care Hospital	Acute care medical hospital operated by Tribal Health Organizations
Inpatient Psychiatric Hospital	Inpatient psychiatric care operated by private operators
Designated Evaluation and Treatment (DET) Acute Care Hospital Services	Acute care hospitals that receive designated evaluation and treatment funding from the state for clients with no other payer
Alaska Psychiatric Institute (API)	Inpatient psychiatric care operated by the State of Alaska
Residential Psychiatric Treatment Center (RPTC)	Residential psychiatric treatment centers serving youth operated by private operators both in Alaska and outside
Outpatient Institutional - Hospital BH Services	
Private Outpatient Hospital	Outpatient medical hospital operated by private operators, includes emergency room services
Tribal Outpatient Hospital	Outpatient medical hospital operated by Tribal Health Organizations, includes emergency room services
DBH Providers – Community-based Professional BH Services	
All DBH Treatment and Recovery Providers, including RCCY	Community Behavioral health providers receive DBH grant funding to provide behavioral health services in community outpatient clinics, includes Community Behavioral Health Clinics (formerly called Community Mental Health Clinics and Alcohol and Drug Abuse Centers), Day Treatment Facilities, and Residential Care for Children and Youth Facilities (RCCY)
Other Community-based Professional BH Services	
Psychologists	Outpatient mental health services provided by group and individual neuropsychologists
Mental Health Physician's Clinic	Outpatient mental health clinics overseen by a psychiatrist or other physician
Tribal Health Clinic	Outpatient primary care clinics operated by Tribal Health Organizations
Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC)	Outpatient primary care clinics operated by FQHC/RHC's, excluding those operated by Tribal Health Organizations
Other Professional BH Services	
Physician	Outpatient medical clinics operated by group and individual physicians
Advanced Nurse Practitioners	Outpatient medical clinics operated by advanced nurse practitioners

Figure 4-2 Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Provider Type, State Fiscal Years 2009-2013

Alaska Total Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Provider Type, State Fiscal Years 2009-2013					
Provider Type	**2009**	**2010**	**2011**	**2012**	**2013**
Inpatient Institutional					
Private Acute Care Hospital	824	867	939	893	820
Tribal Acute Care Hospital	163	242	258	229	189
Designated Evaluation and Treatment^ (DET) Acute Care Hospital Services – BH Funded Clients Only	262	275	291	260	261
Other Inpatient Psychiatric Hospital	728	711	760	739	668
Alaska Psychiatric Institute (API) – Total Medicaid and BH-Funded Clients Served^^	541	1,069	1,062	1,201	1,225
API – Medicaid Clients Only	199	227	234	287	272
Residential Psychiatric Treatment Center (RPTC)	710	613	627	617	592
Outpatient Institutional - Hospital BH Services					
Private Outpatient Hospital*	5,432	6,239	6,715	7,205	7,109
Tribal Outpatient Hospital*	1,864	2,226	2,476	2,465	2,382
DBH Grantees – Community-based Professional BH Services					
All DBH Treatment and Recovery Grantees, including RCCY** Total Medicaid and BH-Funded Clients Served	20,898	22,260	22,976	23,979	23,650
DBHTR Grantees** – Medicaid Clients Only	8,956	9,475	10,153	10,330	10,246
Other Community-based Professional BH Services					
Psychologists+	928	1,191	1,354	1,549	1,567
Mental Health Physician's Clinic	2,437	2,016	2,073	2,023	1,902
Tribal Health Clinic	2,601	2,932	3,245	2,976	2,530
Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC)	1,966	2,287	2,455	2,849	2,958
Other Professional BH Services					
Physicians++	11,103	13,346	14,911	15,534	15,455
Advanced Nurse Practitioners	1,978	1,001	326	275	334
Total Unique Clients					
Sum of Unique Medicaid and BH-Funded Clients Served	52,435	57,275	60,468	62,794	61,642
Total Unique Medicaid and BH-Funded Clients Served	33,462	36,671	39,107	40,710	39,958
Sum of Medicaid Clients Served by Each Provider Type	39,889	43,373	46,526	47,971	47,024
Total Unique Medicaid Clients Served	22,403	24,661	27,026	27,846	27,217
Percentage Medicaid Clients	67%	67%	69%	68%	68%

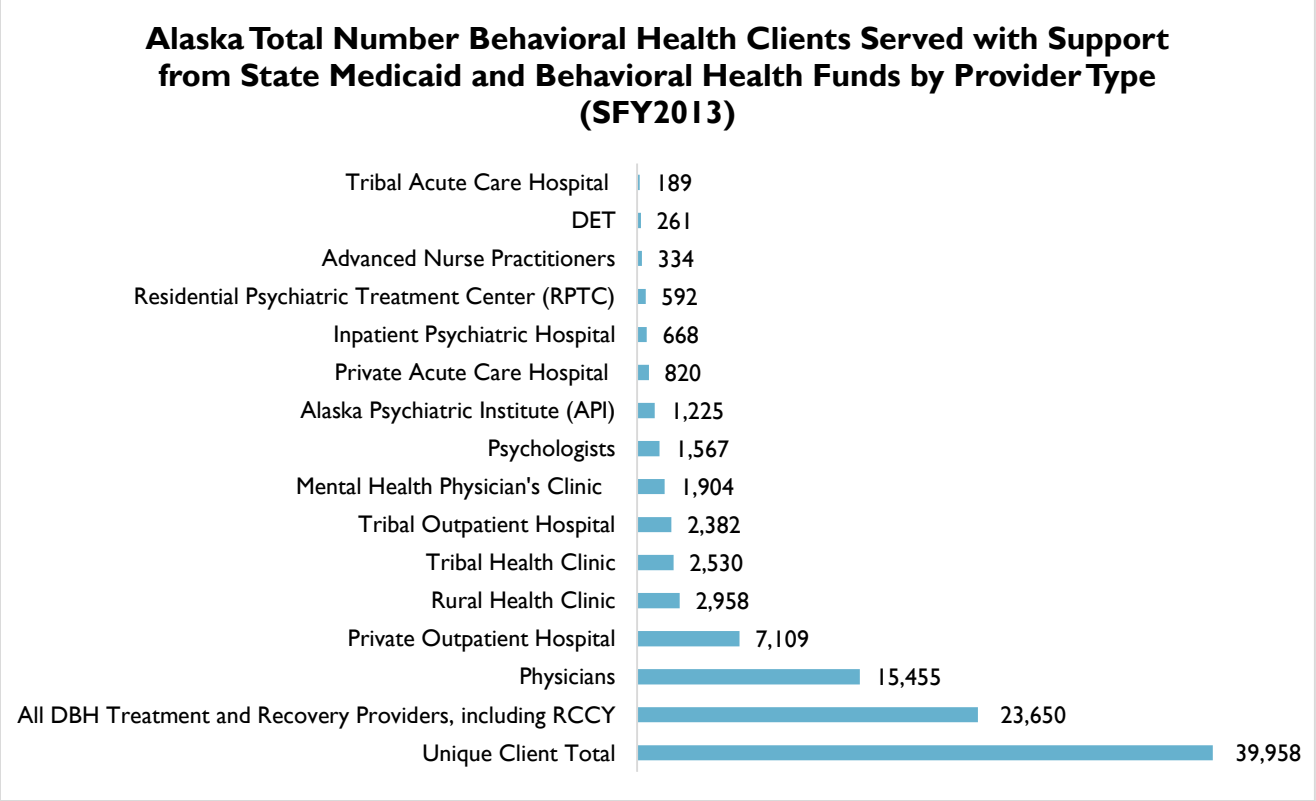
General notes: This table is based on the combined service data from the Alaska Automated Information Management System (AKAIMS), including data from agencies that submit data through an electronic data interface (EDI); the Alaska Psychiatric Institute electronic health record system - Meditech; the DBH Designated Evaluation & Treatment (DET) databases; and the Alaska Medicaid JUCE database. Client counts are unduplicated within each cell by provider type and region. The Medicaid JUCE dataset included claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and they had a primary or secondary behavioral health diagnosis. All data was provided by the Alaska Department of Health and Social Services' Division of Behavioral Health. [Notes continued on following page]

^ This row reflects only DET clients who received hospital services that were paid for by the Division of Behavioral Health at four designated Private and Tribal Acute Care Hospitals across the state. (clients receiving only transport services were excluded.).
^^ Statewide and Anchorage API service counts for 2009 are low because only a partial dataset was available.
* Includes Emergency Departments. ** Includes Community Behavioral Health Clinics (formerly called Community Mental Health Clinics and Alcohol and Drug Abuse Centers), Day Treatment Facilities, and Residential Care for Children and Youth Facilities in an unduplicated count.
+ Includes individual and group psychologists in an unduplicated count. ++ Includes individual and group physicians in an unduplicated count.

This table also shows that DBH Treatment and Recovery grantees served 43 percent or 10,246 of the 23,650 unique clients (adults and youth) served by the publicly-funded behavioral health system in SFY2013, while Physicians served 39 percent or 15,455 unique clients in SFY2013. Physicians provide a high amount of services, within the medical model, to behavioral health clients mostly in the form of medication services. Outpatient hospitals, which include emergency departments, represent the third most prominent provider type. Private Outpatient Hospitals served 18 percent or 7,109 unique clients and Tribal Outpatient Hospitals served 6 percent or 2,382 unique clients of the total unique clients served in SFY2013. API served 1,225 unique clients in FY13, about 3 percent of the total clients served in that year. Medicaid claims were paid for 27,217 unique clients during SFY2013 up from 22,403 in SFY2009.

Figure 4-3 provides a view of the relative proportions of individuals served by each provider type in State Fiscal Year 2013.

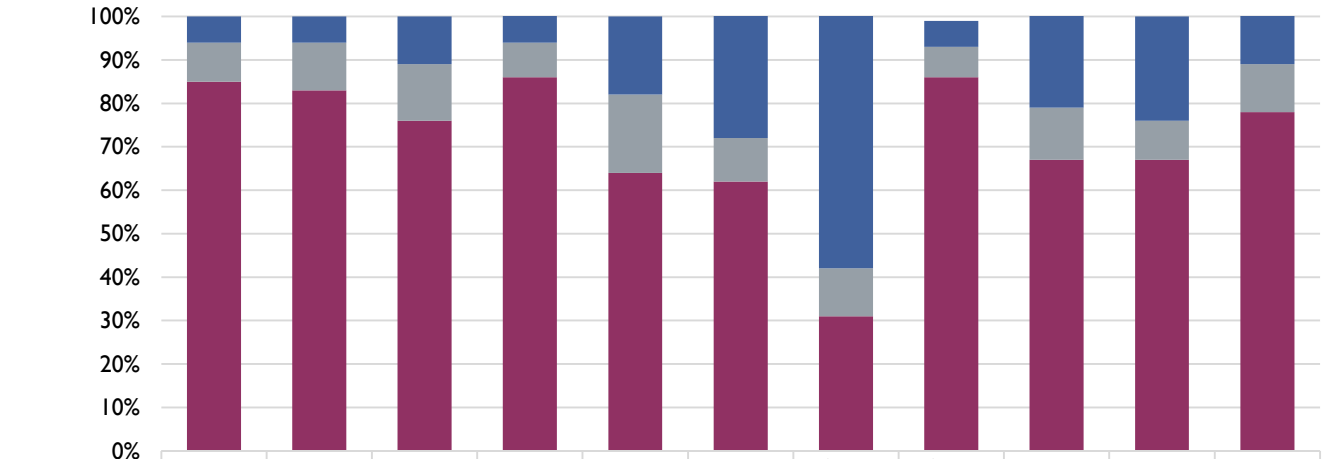
Figure 4-3 Alaska Total Number Behavioral Health Clients Served with Support from State Medicaid and Behavioral Health Funds by Provider Type (SFY2013)



Patterns of Use: Can Clients Access Services in Their Home Regions or Do They Need to Travel Outside Their Regions for Services?

Client access patterns are important to understanding where and by whom clients receive services. Figure 4-4 shows the percentage of individuals within each region who receive services only in the region of their home community, only in a different region, and in both. Clients living in the more urban areas of the state (for example, Anchorage, Fairbanks, Juneau, Kenai) are more likely to receive services in their home region only, whereas a greater percentage of clients living in rural regions (for example, Northwest and Other Interior) are receiving services in a different region only.

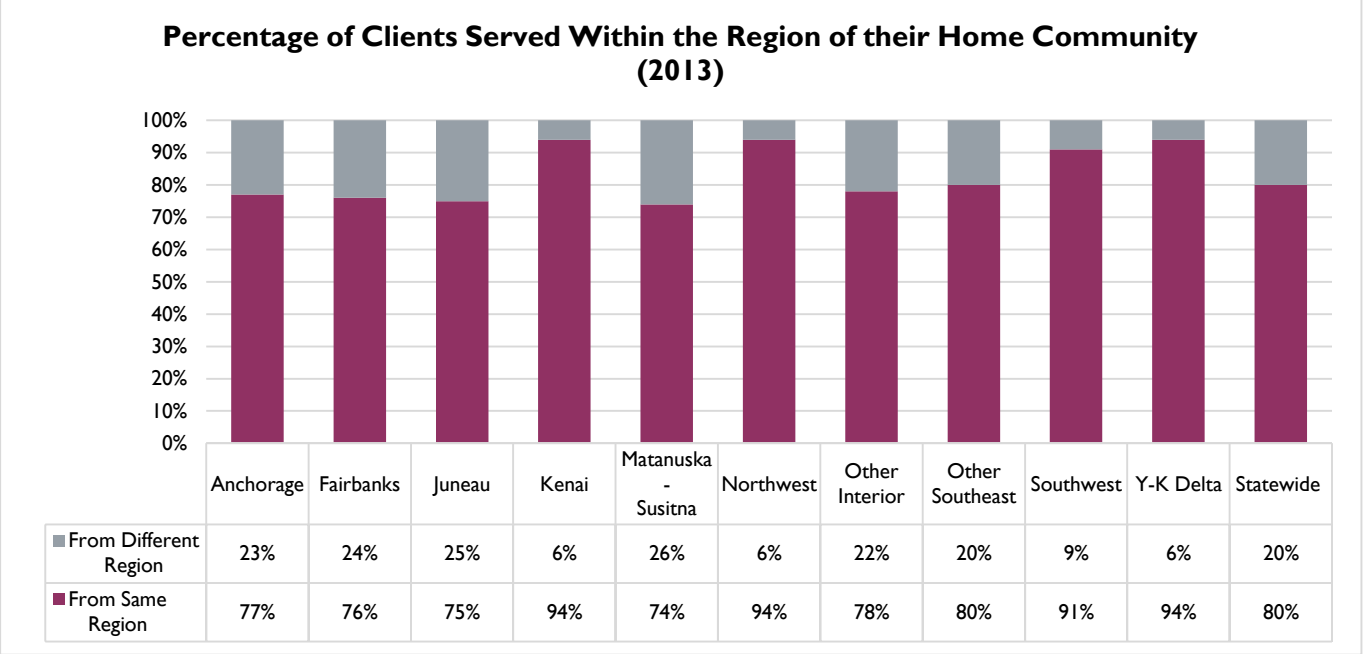
Figure 4-4 Percentage of Clients Served In and Outside of Client's Home Region, 2013



	Anchorage	Fairbanks	Juneau	Kenai	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta	Statewide
In Different Region Only	6%	6%	11%	7%	18%	29%	59%	6%	22%	24%	12%
Served in Both	9%	11%	13%	8%	18%	10%	11%	7%	12%	9%	11%
In Home Region Only	85%	83%	76%	86%	64%	62%	31%	86%	67%	67%	78%

Likewise, in Figure 4-5, we see that service providers in some regions see a greater percentage of individuals with home address information outside of their regions than others. This may be due to two distinct factors, a region that serves as a hub for behavioral health care services, like Anchorage, or a region with a high number of seasonal residents from other parts of Alaska or the world that use behavioral health services.

Figure 4-5 Percentage of Clients Served Within the Region of their Home Community, 2009 & 2013



	Anchorage	Fairbanks	Juneau	Kenai	Matanuska - Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta	Statewide
From Different Region	23%	24%	25%	6%	26%	6%	22%	20%	9%	6%	20%
From Same Region	77%	76%	75%	94%	74%	94%	78%	80%	91%	94%	80%

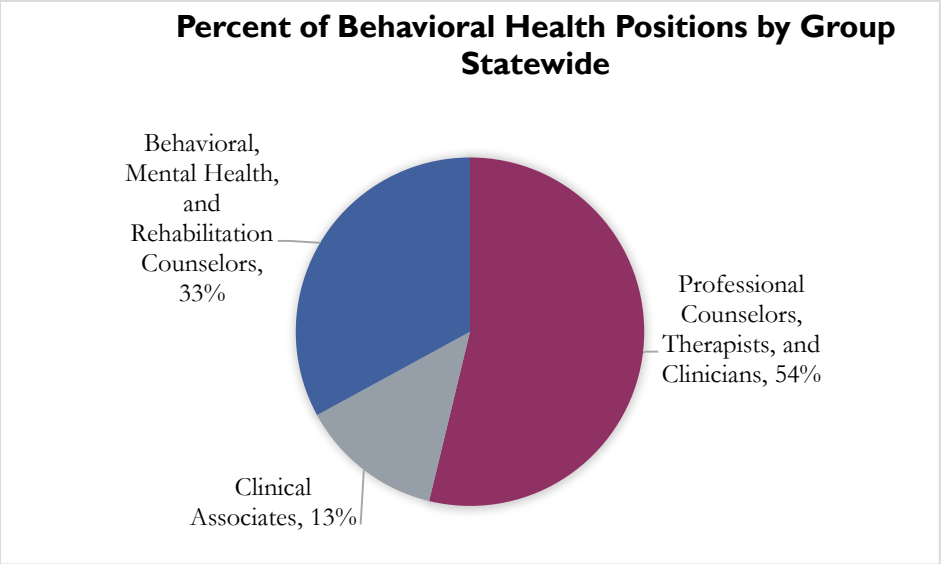
Alaska's Behavioral Health Workforce

In August 2014, the Alaska Center for Rural Health/Area Health Education Center (ACRH/AHEC) within the University of Alaska Anchorage released the Alaska Workforce Vacancy Study, 2012 Findings Report.[132] This study was conducted to assess the health workforce vacancies in Alaska and contributes to our understanding of the behavioral health system and its workforce needs.

According to the Alaska Workforce Vacancy Study (Figure 4-6), over half (54%) of Alaska's behavioral health workforce consists of professional counselors, therapists and clinicians. Professional counselors, therapists and clinicians require an advanced degree and a clinical license to practice and include Clinical and Counseling Psychologists; Clinical Social Workers; Marriage and Family Therapists; Mental and Behavioral Health Clinicians and Counselors; and other health-related therapists and clinicians. A third (33%) of the behavioral health workforce is made up of behavioral, mental health, and rehabilitative counselors, such as Behavioral Health Aides (BHA), Rehabilitation Counselors, Substance Use Disorder Counselors, and other behavioral health counselors. Rehabilitation counselors require a certificate from a training program, for example BHA's are trained through a specialized training program at a Tribal Health Organization. The remaining 13 percent consist of Behavioral Health Clinical Associates. Behavioral Health Clinical Associates have less than a master's degree (typically trained to the associate's or bachelor's level) in psychology, social work, counseling, or a related field with specialization or experience providing rehabilitation services to clients and may consist of a psychiatric or mental health nurse, baccalaureate social worker, and peer support specialists.

[132] Alaska Health Workforce Vacancy Study: 2012 Findings Report. Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska. Prepared by Katherine Branch, 2014. http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/upload/2012ak-hlth-workforce-vacancy-study_12-23-14_FINAL.pdf

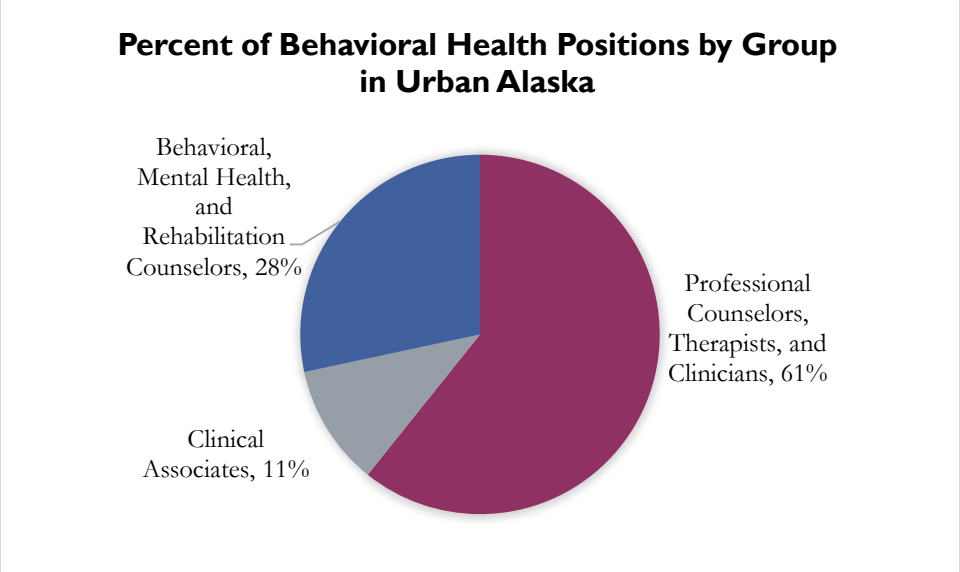
Figure 4-6 Percent of Behavioral Health Positions by Group Statewide



Source: Alaska Health Workforce Vacancy Study 2012

In urban regions of the state (Figure 4-7), the behavioral health workforce consists primarily of advanced degreed professional counselors, therapists, and clinicians (61%). Twenty-eight percent are behavioral, mental health, and rehabilitation counselors and 11% are clinical associates.

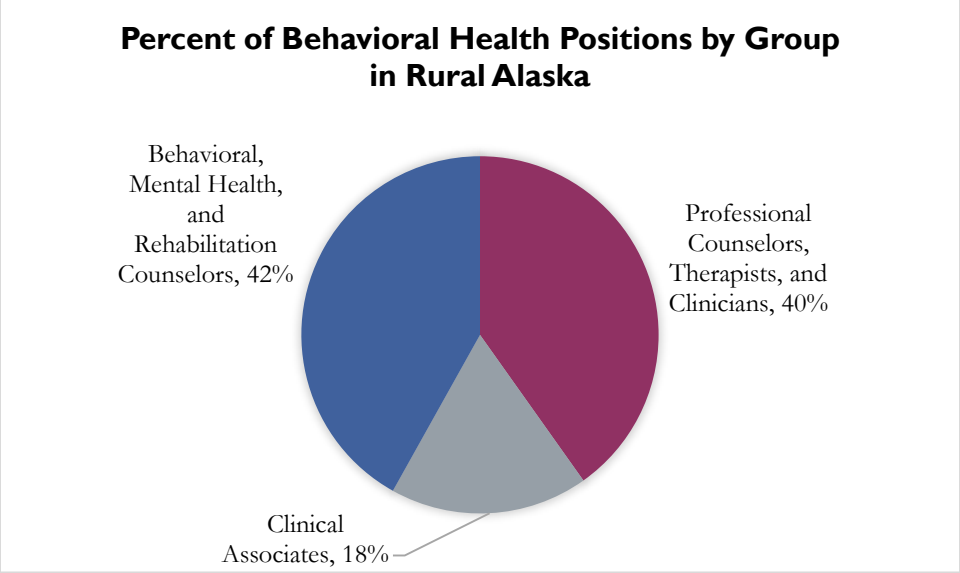
Figure 4-7 Percent of Behavioral Health Positions by Group in Urban Alaska



Source: Alaska Health Workforce Vacancy Study 2012

In rural Alaska (Figure 4-8), the behavioral health workforce is more equally split between professional counselors, therapists and clinicians (40%) and behavioral, mental health, and rehabilitation counselors (42%). Clinical associates make-up the remaining 18% of the rural behavioral health workforce.

Figure 4-8 Percent of Behavioral Health Positions by Group in Rural Alaska



Source: Alaska Health Workforce Vacancy Study 2012

Statewide, Alaska's behavioral health system requires professional counselors, therapists, and clinicians (advance degreed professionals). Advanced degreed professionals conduct assessments, develop treatment plans, deliver clinical services, direct the delivery of treatment and recovery supports, like rehabilitation services, and respond to crises in the community. Strengthening the supervisory role of advanced degreed professionals is a key opportunity identified through the assessment for two reasons. First, many of the individuals interviewed for this project spoke about the ideal mix of clinic services to rehabilitation services. For individuals with serious mental health and substance abuse issues, all agreed the appropriate service mix was rehabilitation heavy/clinic light (rehabilitation services are contraindicated for mild behavioral health issues[133]). And yet, the service data we analyzed (presented in chapter 5) suggests we are not yet delivering services in these proportions.

Second, as part of the assessment, we conducted a world café with the Tribal behavioral health system's BHA workforce to understand what recommendations they had for improving system capacity. Participating BHAs called out the need for greater supervision if they are to begin delivering Medicaid billable services in their communities. Strengthening the supervisory function of advanced degree professionals can empower behavioral, mental health and rehabilitation counselors (non-degreed professionals) to deliver a greater proportion of the services provided today and expand providers' capacity to meet the needs of the clients they serve. Non-degreed professionals have many benefits, including requiring less formal education, lower salaries, being more likely to be recruited locally, and very often holding strong ties to the communities within which they live and work.

Actively pursuing ways to shifting the ratio so that behavioral health clinical associates and behavioral, mental health, rehabilitation counselors deliver a larger share of the direct services may be a potential way to expand system capacity for individuals with higher levels of behavioral health

[133] Discussion with reviewer Jerry Jenkins, Chief Executive Officer, Anchorage and Fairbanks Community Mental Health Services. 9/3/15.

need. Doing so would increase the number of qualified staff able to bill for services, tap into the additional Medicaid billing potential that exists within DBH's current Medicaid billing regulations, and redirect current usage patterns to lower levels of care. For expansion of services to individuals with mild and moderate behavioral health conditions, time-limited clinical services, which must be provided by licensed clinicians, will be essential.[134] Thus, it is important to note that the ideal workforce for a population with serious behavioral health needs could vary significantly from the ideal workforce for a population with mild to moderate behavioral health needs. Growth of the workforce in all professions will likely be necessary to meet demand, but this growth should be accompanied with a concerted effort to tap the supervisory role of licensed clinicians and leverage non-degreed professionals in service delivery where appropriate and beneficial.

Figure 4-9 provides data from the Workforce Vacancy Study on the estimated number of behavioral positions and vacancy rates by type. There are noticeably higher vacancy rates in the rural Alaska behavioral health workforce for every occupation except Behavioral Health Clinical Associates. [135] The statewide vacancy rate for Behavioral Health Aides is highest at 17 percent. The difference in vacancy rates between urban and rural regions of the state is striking for a number of positions. For example, providers in rural areas experience a 13 percent vacancy rate for Clinical Psychologists compared to six percent in urban areas and a 15 percent vacancy rate for Clinical Social Workers compared to eight percent in urban areas.

Physicians and psychiatrists also serve critical functions within the behavioral health system. Physicians and psychiatrists prescribe and oversee clients requiring medications and are essential workforce for medication-assisted treatment therapies. Notably, the estimated statewide vacancy rate for psychiatrists is 22 percent (Figure 4-10 Rural, Urban and Statewide – Estimated Positions, Vacancies, and Vacancy Rates by Occupation).

In order to grow Alaska's behavioral health workforce, we need to understand what the ideal workforce would look like and optimize the billing capacity of each behavioral health professional.

[134] Discussion with reviewer Jerry Jenkins, Chief Executive Officer, Anchorage and Fairbanks Community Mental Health Services. 9/3/15.

[135] Alaska Health Workforce Vacancy Study: 2012 Findings Report. Alaska Center for Rural Health, Alaska's Area Health Education Center, University of Alaska. Prepared by Katherine Branch, 2014. http://www.uaa.alaska.edu/acrh-ahec/projects/vacancy/upload/2012ak-hlth-workforce-vacancy-study_12-23-14_FINAL.pdf

Figure 4-9 Estimated Positions, Vacancies, and Vacancy Rates by Occupation – Behavioral Health

Detailed Occupation by Group	Sampled Positions	Estimated Total Positions		Estimated Total Vacancies		Estimated Vacancy Rates		Estimated Statewide Vacancy Rate
		Rural	Urban	Rural	Urban	Rural	Urban	
Professional Counselors, Therapists, and Clinicians	**753**	**327**	**964**	**42**	**57**	**13%**	**6%**	**8%**
Clinical Psychologists	87	31	134	4	8	13%	6%	7%
Clinical Social Workers	61	26	62	4	5	15%	8%	10%
Counseling Psychologists	38	21	55	2	2	10%	4%	5%
Marriage and Family Therapists	57	5	101	0	5	-	5%	5%
Mental and Behavioral Health Clinicians and Counselors	417	223	442	26	25	12%	6%	8%
All Other Health Related Therapists and Clinicians	93	21	170	6	12	29%	7%	9%
Clinical Associates	**223**	**146**	**173**	**14**	**25**	**10%**	**14%**	**12%**
Behavioral Health Clinical Associates	223	146	173	14	25	10%	14%	12%
Behavioral, Mental Health, and Rehabilitation Counselors	**484**	**341**	**450**	**61**	**32**	**18%**	**7%**	**12%**
Behavioral Health Aides (BHA) including Village Counselors	66	96	25	18	2	19%	8%	17%
Rehabilitation Counselors	19	11	18	0	3	-	17%	10%
Substance Use Disorder Counselors	186	66	247	8	23	12%	9%	10%
All Other Behavioral Health Counselors	213	168	160	35	4	21%	3%	12%
Grand Total	**1460**	**814**	**1587**	**117**	**114**	**14%**	**7%**	**10%**

Source: Alaska Health Workforce Vacancy Study 2012

Figure 4-10 Rural, Urban and Statewide – Estimated Positions, Vacancies, and Vacancy Rates by Occupation – Select Physicians

Detailed Occupation by Group	Sampled Positions	Total Positions		Total Vacancies		Vacancy Rates		Estimated Statewide Vacancy Rate
		Rural	Urban	Rural	Urban	Rural	Urban	
Physicians	**1020**	**412**	**1747**	**65**	**114**	**16%**	**7%**	**8%**
Emergency Physicians	79	43	174	9	0	21%	-	4%
General Internists	26	17	29	0	2	-	7%	4%
General Practitioners and Family Physicians	355	223	352	47	18	21%	5%	11%
Hospitalists	65	3	93	0	6	-	6%	6%
Pediatricians	61	19	134	3	6	16%	4%	6%
Psychiatrists	43	13	79	2	17	15%	22%	22%
All Other Specialty Physicians	151	11	291	1	40	9%	14%	14%

Source: Alaska Health Workforce Vacancy Study 2012

Position Types and Associated Credentialing Requirements

To understand the behavioral health workforce in Alaska and the potential for expanding service capacity, we analyzed the credentialing requirements associated with position types serving behavioral health clients. Then, we examined Medicaid billing requirements by provider setting to identify barriers to behavioral health service delivery. Here, we include an overview of behavioral health positions by type, education, and credentialing requirements (see Figure 4-11). In doing so, we found that Medical Providers and Mental Health Professional Clinicians require an advanced degree, clinical or practicum requirements, as well as licensure and examination. Most of these positions also require additional training and on-the-job supervision. Behavioral Health Clinical Associates, Substance Use Disorder Counselors, and BHA's require far less education and have fewer credentialing requirements. On-the-job training or supervision is crucial for these positions.

Figure 4-11 Behavioral Health Professional Education and Credentials by Position Type

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Medical											
Physician (Family Medicine, Emergency Room)		X		X	X	Medical school degree (MD or DO)	X	X	3-7+ years	Required residency (3-7+ years) and optional fellowship, depending on subspecialty; need a federal narcotics license from the Drug Enforcement Administration (DEA) and medical license; many physicians choose to become board certified, which must be renewed after 6-10 years depending on specialty	http://commerce.state.ak.us/dnn/Portals/5/pub/MedicalStatutes.pdf
Psychiatrist		X		X	X	Medical school degree (MD or DO)	X	X	4 years	Required residency (4 years) and optional fellowship, depending on subspecialty; need federal narcotics license from the Drug Enforcement Administration (DEA) and medical license; many physicians choose to become board certified, which must be renewed after 6-10 years depending on specialty	
Physician Assistant (PA)		X	X		X		X	X			
Advance Nurse Practitioner (ANP)		X	X		X	Registered Nurse (RN) licensure plus master's OR doctorate of nursing	X	X	500 hours	Must first be licensed as an RN and have certification of nurse practitioner in the population focus of nursing for which the applicant was educated	http://commerce.state.ak.us/dnn/Portals/5/pub/NursingStatutes.pdf
Mental Health Professional Clinician (MHPC) – Note: MHPC's employed by a Community Behavioral Health Services (CBHS) provider may be licensed (to bill) or un-licensed (provide services). http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf AND http://manuals.medicaidalaska.com/cbhs/cbhs.htm											
Clinical Psychologist		X		X	X	Doctoral degree in psychology (Ph.D., Psy.D., or Ed.D.)	X	X	1 year		http://commerce.state.ak.us/dnn/Portals/5/pub/PsychologistStatutes.pdf
Psychological Associate		X	X		X		X	X	2 years		

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Licensed Clinical Social Worker (LCSW)		X	X		X	Master's (MSW) OR doctorate in social work (DSW)	X	X	2 years or minimum 3,000 hours	Two years of continuous supervised full-time employment in postgraduate clinical social work OR a minimum of 3,000 hours of less than full-time employment in a period of not less than two years	http://commerce.state.ak.us/dnn/Portals/5/pub/SocialWorkStatutes.pdf
Licensed Professional Counselor (LPC)		X	X		X	Master's OR doctorate in counseling or related professional field	X		3,000 hours	3,000 hours of supervised experience in the practice of professional counseling performed over a period of at least two years under supervision of an approved supervisor WITH at least 1,000 hours of direct counseling with individuals, couples, families or groups AND at least 100 hours of face-to-face supervision by an approved supervisor	http://commerce.state.ak.us/dnn/Portals/5/pub/CounselorStatutes.pdf
Licensed Marital and Family Therapist (LMFT)		X	X		X	Master's OR doctorate in marriage and family therapy or allied mental health field	X	X	1,500 hours	Practiced marital and family therapy, including 1,500 hours of direct clinical contact with couples, individuals, and families and been supervised in the clinical contact for at least 200 hours, including 100 hours of individual supervision AND 100 hours of group supervision	http://commerce.state.ak.us/dnn/Portals/5/pub/MFTStatutes.pdf
Psychiatric Mental Health Nurse Practitioner (PMHNP)		X	X		X	RN licensure and master's OR doctorate of nursing	X	X	500 hours	Must first be licensed as an RN AND have certification of nurse practitioner in the population focus of nursing for which the applicant was educated	http://commerce.state.ak.us/dnn/Portals/5/pub/NursingStatutes.pdf
Licensed Master's Social Worker (LMSW)		X	X		X	Master's (MSW) OR doctorate in social work (DSW)	X	X	None		http://commerce.state.ak.us/dnn/Portals/5/pub/SocialWorkStatutes.pdf

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Behavioral Health Clinical Associate http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf											
Psychiatric/Mental Health Nurse	X				X	Associate's (RN or Licensed Practical Nurse (LPN)) OR bachelor's (BSN)	X	X			http://commerce.state.ak.us/dnn/Portals/5/pub/NursingStatutes.pdf
Baccalaureate Social Worker (BSW)		X			X	Practicum hours ~ 480 hours (this may vary by school)	X	X	None		http://commerce.state.ak.us/dnn/Portals/5/pub/SocialWorkStatutes.pdf
Peer Support Specialist						Lived, personal experience with behavioral health issues, including mental illness, addiction, etc.		X		There is no state certification process. A certificate of completion is provided if participant passes the exam after completing Peer Support Worker training. A certificate of attendance is provided to those who do not pass exam. A peer support specialist must meet requirements of and be employed by the agency as a behavioral health clinical associate to provide billable services.	http://www.akpeersupport.org/PeerSupport/FAQ.aspx; http://www.dbsalliance.org/pdfs/training/Peer-Specialist-Training-and-Certification-Programs-A-National-Overview%20UT%202013.pdf
Substance Use Disorder Counselor (SUDC)											
Alcohol & Substance Abuse Counselor /	The State of Alaska recognizes four levels of competency: 1) Counselor Technician; 2) Chemical Dependency Counselor (CDC) Level 1; 3) CDC Level II; and										http://www.healthcareersinalaska.info/index.php/health_careers/info

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Chemical Dependency Counselor	4) Chemical Dependency Clinical Supervisor										/alcohol-and-substance-abuse-counselor
Chemical Dependency Clinical Supervisor					152 training hours + 100 supervised hours	Graduation from high school or GED; Training includes minimum of 152 approved contact training hours and completion of a 100 hour supervised practicum by a certified chemical dependency counselor		X	12,000 hours	12,000 hours of work experience with increasingly specialized experience in chemical dependency treatment and supervision of staff; *if individual holds a degree in a behavioral health related field (i.e. human services, social work, psychology, addiction, counseling, sociology, psychiatric nursing) this will reduce amount of work experience required.*	
CDC Level II					110 training hours + 100 supervised hours	Graduation from high school or GED; Training includes a minimum of 110 approved contact training hours and completion of a 100 hour supervised practicum by a certified CDC		X	8,000 hours	8,000 hours work experience, *6,000 hours if you have a degree in a behavioral/human services with increasingly specialized experience in chemical dependency treatment.* In order to be a CDC II, one must pass an exam provided by NAADAC, but in order to take these exams, one must first be certified as a CDC I and provide proof.	

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
CDC Level I					146 training hours + 100 supervised hours	Graduation from high school or GED; Training includes minimum of 146 approved contact training hours and completion of a 100 hour supervised practicum by a chemical dependency counselor			4,000 hours	4,000 hours of work experience with increasingly specialized experience in chemical dependency treatment; i*f individual holds a degree in a behavioral health related field this will reduce amount of work experience required.*	
Counselor Technician					100 training hours + 100 supervised hours	Graduation from high school or GED; Training includes 100 training hours in a variety of courses and 100 supervised practicum hours			Minimum 2,000 hours	Minimum of 2,000 hours of work experience; i*f individual holds a degree in a behavioral health related field this will reduce amount of work experience required.*	
Directing Clinician (SUDC or MHPC) – Note: Responsible for monitoring recipients care across all programs within an agency that are identified on a treatment plan. http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf											
See MHPC and SUDC (*specifically Chemical Dependency Clinical Supervisor description*) for detailed position types and requirements											

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Tribal											
Behavioral Health Practitioner (BHP)					100 hour clinical practicum	<u>Practicum:</u> 100 hour clinical practicum, that includes: • 60 hours of providing behavioral health clinical supervision, training and professional development; and • 40 hours of providing clinical team leadership by leading clinical team case reviews			BHP Specialized Training + Minimum 6,000 hours	<u>Training:</u> Must satisfy all requirements of a BHA III AND complete BHP Specialized Training Program OR approved alternate course of study, including: • Associate, bachelor OR master's degree with a major in human services, addictions/chemical dependency, behavioral health, psychology, social work, counseling, marriage & family therapy, or nursing with a behavioral health specialty. Prior to certification as a BHP, one must provide village-based behavioral health services for no fewer than 6,000 hours under direct or indirect (as applicable) supervision of a licensed behavioral health clinician or behavioral health professional. Clinical supervision requirements for BHA III are listed on page 41 in CHAPCB standards	Community Health Aide Program Certification Board Standards and Procedures

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Behavioral Health Aide (BHA) III					100 hour clinical practicum	<u>Practicum:</u> 100 hour clinical practicum, that includes: • 60 hours of providing behavioral health clinical evaluation, treatment planning, and case management for client with special treatment issues; • 20 hours of providing quality assurance case review with documentation of review activity; and • 20 hours of providing clinical team leadership by leading clinical team case reviews			BHA III Specialized Training + Minimum 4,000 hours	<u>Training:</u> Must satisfy all requirements of a BHA II AND complete BHA III Specialized Training Program OR approved alternate course of study, including: • Associate, bachelor OR master's degree with a major in a behavioral health related field Prior to certification as a BHA III, one must provide village-based behavioral health services for no fewer than 4,000 hours under direct or indirect (as applicable) supervision of a licensed behavioral health clinician or behavioral health professional. Clinical supervision requirements for BHA III are listed on page 39 in CHAPCB standards	

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Behavioral Health Aide (BHA) II					100 hour clinical practicum	Practicum: 100 hour clinical practicum, that includes: • 35 hours of providing client clinical evaluation using the Diagnostic and Statistical Manual (DSM) and American Society of Addiction Medicine patient placement criteria with appropriate case documentation; • 30 hours of providing treatment planning and case management with appropriate case documentation; and • 35 hours of providing community readiness evaluation and prevention plan development with case documentation			BHA II Specialized Training + Minimum 2,000 hours	Training: Must satisfy all requirements of a BHA I AND complete BHA II Specialized Training Program OR approved alternate course of study, including: • University of Alaska Rural Human Services Behavioral Health program resulting in a Behavioral Health Certificate; • Associate, bachelor OR master's degree with a major in a behavioral health related field Prior to certification as a BHA II, one must provide village-based behavioral health services for no fewer than 2,000 hours under direct or indirect (as applicable) supervision of a licensed behavioral health clinician or behavioral health professional. Clinical supervision requirements for BHA II are listed on page 37 in CHAPCB standards	Community Health Aide Program Certification Board Standards and Procedures

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Behavioral Health Aide (BHA) I					100 hour clinical practicum	<u>Practicum:</u> 100 hour clinical practicum, that includes: • 35 hours of initial intake and client orientation services with appropriate case documentation; • 30 hours of providing case management and referral with appropriate case documentation; and • 35 hours of providing village-based community education, prevention, and early intervention services with appropriate case documentation			BHA I Specialized Training + Minimum 1,000 hours	<u>Training:</u> BHA I Specialized Training Program OR approved alternate courses of study, including: • Regional Alcohol and Drug Abuse Counselor Training resulting in Counselor Technician certification from the Alaska Commission for Behavioral Health Certification; • University of Alaska Rural Human Services Behavioral Health program resulting in an Occupational Endorsement; or • Associate, bachelor OR master's degree with a major in a behavioral health related field Prior to certification as a BHA I, one must provide village-based behavioral health services for no fewer than 1,000 hours under direct supervision of a licensed behavioral health clinician or behavioral health professional. Clinical supervision requirements for BHA I are listed on page 35 in CHAPCB standards	

Behavioral Health Professional Education and Credentials by Position Type											
Positions	**Education** (A=Associate's, B=Bachelor's, M=Master's, D=Doctorate)						**Credentialing Requirements** (L=License, E=Exam)				**Source**
	A	B	M	D	Clinical/ Practicum Requirements	Other Information	L	E	Training/ Supervision Requirements	Other Information	
Tribal Case Manager									Case Management Training Curriculum	Qualifications within Provider Organizations: • Basic knowledge of issues in areas of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, chronic disease, and aging • Interviewing skills for gathering data and completing needs assessments to develop service and case plans and related reports • Individual and group communication • Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources.	https://www.alaskatribalhealth.org/system/financial/mtf/loader.cfm?csModule=security/getfile&pageid=4825
One year of full-time work is approximately 2,000 hours											

Medicaid Billing Models

To further understand the constraints and opportunities that exist for expanding the system's capacity to deliver behavioral health services covered by Medicaid, we conducted an assessment of billable services by setting and the associated credentialing requirements. We found that behavioral health services are reimbursed through a number of different Medicaid billing models and each Medicaid billing model requires a different level of professional to provide behavioral health services to clients. By design, the community behavioral health centers are currently the mainstay of the State-supported behavioral health system and exist to fulfill the State's statutory requirement to serve individuals with high levels of behavioral health need. Services delivered by community behavioral health centers help individuals with behavioral health needs stay in their communities and can be provided by a range of degreed and non-degreed professionals and in both office and community settings. In order to be eligible for services within a community behavioral health center, an individual must receive an assessment and meet a threshold of medical necessity to receive services. For rehabilitation services, the service must "involve the treatment or remediation of a condition that results in an individual's loss of functioning."[136]

For individuals with serious behavioral health needs that meet this threshold, a wide range of clinic and rehabilitation services are available. To bill Medicaid, all services must be documented within the individual's treatment plan. Many behavioral health needs are episodic. For these individuals, clinic and rehabilitation services are complementary billable services that help individuals recover quickly from crisis and access the treatment, medication, and supports they need to live healthy and productive lives. Individuals with chronic behavioral health needs may require long-term clinic and rehabilitation services. These services are also billable and are often accompanied with annual caps to limit overuse.

Rehabilitation services, in particular, are key to recovery and re-integration into the natural supports that exist within communities. Currently, service data suggests there may be additional need for rehabilitation services. "Unlike clinic or outpatient hospital services – where treatment location is proscribed – benefits provided under the rehab option can be delivered in a variety of settings, including the consumer's own home or another living arrangement. Another benefit of providing services under the rehab option is that the services can be performed by individuals who are not licensed under professional scope of practice laws, including paraprofessionals and peers."[137] Medicaid expansion, stronger connections with the Criminal Justice System, and efforts to improve access to Alaska's continuum of behavioral health care, particularly to lower level supports that can prevent crises from occurring, are all likely to increase demand for rehabilitation services, as well as other community-based behavioral health services.

Our analysis of Medicaid billing models outside of the community behavioral health billing model indicates that major barriers exist to billing for behavioral health services that impede provider efforts to integrate primary care and behavioral health care. In many settings that could provide

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[136] Centers for Medicare and Medicaid Services. August 2007. A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services. As cited in SAMHSA. Medicaid Handbook: Interface with Behavioral Health Services. Module 3: The Medicaid Behavioral Health Services Benefit Package. August 2013.

[137] O'Brien, J. Community Living Briefs. Vol. 3, Issue 2. The Medicaid Rehabilitative ("Rehab") Option. As cited in SAMHSA. Medicaid Handbook: Interface with Behavioral Health Services. Module 3: The Medicaid Behavioral Health Services Benefit Package. August 2013.

clinical services, the credentialing requirements for behavioral health professionals able to render services creates frequently insurmountable financial and workforce barriers. The requirement to be a DBH grantee in order to bill Medicaid for rehabilitation services creates further barriers to service. Such barriers significantly limit the health care system's capacity to meet the behavioral health needs of Alaskans and improve health outcomes. Indeed, the inability to bill for services makes achieving the goal of having two front doors into behavioral health services, one through the community behavioral health centers for individuals with high needs and one through primary care for individuals with mild and moderate needs, impossible.

Given the significant need for substance use disorder and mild and moderate mental health services among Alaskans, it is imperative that health care systems leaders work to remove barriers to billing for behavioral health services and allow for a greater range of behavioral health professionals and programs to bill for services outside of the community behavioral health system. It is also important to grow and retain a strong behavioral health workforce with a mix of position types that aligns with Alaskans' needs and the evidence base on how recovery works.

COMMUNITY BEHAVIORAL HEALTH SYSTEM (CBHS) MEDICAID BILLING MODEL

The Community Behavioral Health System (CBHS) Medicaid billing model requires Mental Health Professional Clinicians (or professional counselors, therapists, and clinicians) to conduct Integrated Mental Health and Substance Use Intake Assessments and Mental Health Assessments. All other screenings and assessments, including the AST, CSR, Substance Use Assessment, and SBIRT can be provided by (at a minimum) a Behavioral Health Clinical Associate or Substance Use Disorder Counselor. Clinic services (psychotherapy, psychological testing and evaluation, crisis intervention) are to be provided by a Mental Health Professional Clinician; whereas Behavioral Health Clinical Associates and Substance Use Disorder Counselors can complete most rehabilitation services (case management, CCSS/TBHS, peer support, etc.), residential services, and day treatment services under the supervision of a directing clinician. There are various services (psychiatric assessments, pharmacologic management, medication administration, methadone administration, detoxification services) that must be provided by a Physician, Physician Assistant (PA), or Psychiatric Advanced Nurse Practitioner (ANP).

Figure 4-12 Community Behavioral Health System (CBHS) Medicaid Billing Model

Community Behavioral Health System (CBHS) Medicaid Billing Model					
Services by Type	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Initial Services (Clinic or Rehab)					
Integrated Mental Health & Substance Use Intake Assessment	H0031-HH	1 assessment	300.00	At minimum, Mental Health Professional Clinician, which includes the following: Psychiatric Mental Health Nurse Practitioner; Licensed Marital and Family Therapist; Licensed Clinical Social Worker; Licensed Master's Social Worker; Clinical Psychologist; Psychological Associate	http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf; http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered
Mental Health Assessment	H0031	1 assessment	175.00		

Community Behavioral Health System (CBHS) Medicaid Billing Model					
Services by Type	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Alaska Screening Tool (AST)	T1023	1 screening	35.00	At minimum, Behavioral Health Clinical Associate or Substance Use Disorder Counselor	Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
Screening and Brief Intervention (SBIRT)	99408	15-30 minutes	43.80		
Client Status Review (CSR)	H0046	1 review	40.00		
Substance Use Assessment	H0001	1 assessment	100.00		
Clinic Services					
Psychotherapy (individual, family, group)	90804 90806 90810 90812 90846 90846-U7 90847 90847-U7 90853 90853-U7	30 minutes; 60 minutes	28.00-110.00 depending on type	At minimum, Mental Health Professional Clinician	http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf; http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
Multi-family group psychotherapy	90849 90849-U7	30 minutes; 60 minutes	55.00/30 minutes; 110.00/60 minutes		
Psychological Testing & Evaluation	96101 96101-U6 96118 96118-U6	15 minutes; 1 hour	25.00/15 minutes; 100.00/hour		
Short-Term Crisis Intervention	S9484 S9484-U6	15 minutes; 1 hour	23.00/15 minutes; 92.00/hour		
Psychiatric Assessment	90791	1 assessment	230.00	Within their scope of practice: Physician Physician Assistant Advance Nurse Practitioner	
Pharmacologic Management	90862	1 visit	75.00	Within their scope of practice: Physician with prescriptive authority Physician Assistant with prescriptive authority Advance Nurse Practitioner with prescriptive authority	

Community Behavioral Health System (CBHS) Medicaid Billing Model					
Services by Type	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Rehabilitation Services					
Case Management*	T1016	15 minutes	16.00	At minimum: Behavioral Health Clinical Associate Substance Use Disorder Counselor. For Peer Support, must have individuals with lived, personal experience with behavioral health issues, including mental illness and addiction.	http://dhss.alaska.gov/dbh/Documents/PDF/Training/RequirementsforProgramStaff.pdf; http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
Comprehensive Community Support Services (individual, group)	H2015 H2015-HQ	15 minutes	9.00 (group); 17.00 (individual)		
Therapeutic Behavioral Health Supports (individual, group, family)	H2019 H2019-HQ H2019-HR H2019-HS	15 minutes	9.00 (group); 17.00 (individual, family)		
Recipient Support Services	H2017	15 minutes	8.75		
Daily Behavioral Health Rehabilitation	H0018	1 calendar day	171.00		
Day Treatment for Children**	H2012	1 hour	25.00		
Facilitation of Telemedicine	Q3014	1 case presentation	62.43		
Behavioral Health Treatment Plan Review for Methadone Recipient**	T1007	1 review	75.00		
Peer Support Services (individual and family)	H0038 H0038-HR H0038-HS	15 minutes	17.00		
Short-Term Crisis Stabilization	H2011	15 minutes	17.00	Behavioral Health Clinical Associate Substance Use Disorder Counselor *Note: If BHCA or SUDC is unable to resolve crisis, a MHPC may assume responsibility for case and begin providing short-term crisis intervention services*	
Medication Administration (on and off clinic premises)**	H0033 H0033-HK	1 day	20.00/day (on); 30.00/day (off)	Physician Physician Assistant Advance Nurse Practitioner Registered Nurse (RN) / Licensed Practical Nurse (LPN)	

Community Behavioral Health System (CBHS) Medicaid Billing Model					
Services by Type	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Methadone Administration**	H0020	1 admin episode	12.50	Pharmacist RN or LPN may prepare and administer methadone under direction of a Opioid Treatment Program physician	
Medical Evaluation for Methadone and Non-Methadone Recipients**	H0002	1 medical evaluation	397.71 (methadone); 300.00 (non-methadone)	Within their scope of practice: Physician Physician Assistant Advance Nurse Practitioner	
Residential Services					
Clinically Managed Low-Intensity Residential Substance Use Treatment Services	H0047	1 day	200.00	Substance Use Disorder Counselor Behavioral Health Clinical Associate Mental Health Professional Clinician Physician Physician Assistant Advance Nurse Practitioner RN or LPN supervised by physician	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
Clinically Managed Medium-Intensity Residential Substance Use Treatment Services	H0047-TF	1 day	200.00		
Clinically Managed High-Intensity Residential Substance Use Treatment Services	H0047-TG	1 day	250.00		
Detoxification Services					
Ambulatory Detoxification	H0014	15 minutes	23.00	Physician Physician Assistant Advanced Nurse Practitioner RN or LPN supervised by physician	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
Clinically Managed Residential Detoxification	H0010	1 day	250.00	Substance Use Disorder Counselor Behavioral Health Clinical Associate Mental Health Professional Clinician Physician Physician Assistant Advance Nurse Practitioner	
Medically Managed Detoxification	H0011	1 day	300.00	Physician Physician Assistant Advanced Nurse Practitioner	

Community Behavioral Health System (CBHS) Medicaid Billing Model					
Services by Type	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Day Treatment Services					
Day Treatment for Children	H2012	1 hour	25.00	At minimum: Behavioral Health Clinical Associate Substance Use Disorder Counselor	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes
*A Directing Clinician may bill Medicaid for 1hr per week/per recipient of case management services for the monitoring by direct observation the delivery of services as those services are provided to the recipient.					
**Also a detox OR residential treatment service					
***Assumption that all staff are working within their scope of education, training and experience					

TRIBAL COMMUNITY BEHAVIORAL HEALTH CENTER MEDICAID BILLING MODEL

The Tribal Community Behavioral Health Center Medicaid billing model mirrors the Community Behavioral Health System Medicaid billing model with the exception of payment structure, which is based on a daily encounter rate. In this model, Behavioral Health Aides are considered Behavioral Health Clinical Associates and can provide rehabilitation services (case management, Comprehensive Community Support Services (CCSS)/Therapeutic Behavioral Health Supports (TBHS), peer support, etc.) under the supervision of a directing clinician.

Figure 4-13 Tribal Community Behavioral Health Center Medicaid Billing Model

Tribal Community Behavioral Health Center Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services***	**Source**
Initial Services (Clinic or Rehab)					
Integrated Mental Health & Substance Use Intake Assessment	H0031-HH	1 assessment	Encounter rate	At minimum, Mental Health Professional Clinician, which includes: Psychiatric Mental Health Nurse Practitioner; Licensed Marital and Family Therapist; Licensed Clinical Social Worker; Licensed Master's Social Worker;	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates,
Mental Health Assessment	H0031	1 assessment			

Tribal Community Behavioral Health Center Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services***	**Source**
				Clinical Psychologist; Psychological Associate	Program Approval)_REVISED http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes; Conversation with Terry Hamm
Substance Use Assessment	H0001	1 assessment		At a minimum: BHA I, BHA II, BHA III, BHP if he/she has training and experience to complete; Behavioral Health Clinical Associate, or Substance Use Disorder Counselor.	
Alaska Screening Tool (AST)	T1023	1 screening			
Screening and Brief Intervention (SBIRT)	99408	15-30 minutes			
Client Status Review (CSR)	H0046	1 review			
Clinic Services					
Psychotherapy (individual, family, group)	90804 90806 90810 90812 90846 90846-U7 90847 90847-U7 90853 90853-U7	30 minutes; 60 minutes	Encounter rate	At a minimum: Mental Health Professional Clinician	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes; Conversation with Terry Hamm
Multi-family group psychotherapy	90849 90849-U7	30 minutes; 60 minutes			
Psychological Testing & Evaluation	96101 96101-U6 96118 96118-U6	15 minutes; 1 hour			
Short-Term Crisis Intervention	S9484 S9484-U6	15 minutes; 1 hour			
Psychiatric Assessment	90791	1 assessment		Within their scope of practice: Physician Physician Assistant Psychiatric Advance Nurse Practitioner	
Pharmacologic Management	90862	1 visit		Within their scope of practice: Physician with prescriptive authority	

Tribal Community Behavioral Health Center Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services***	**Source**
				Physician Assistant with prescriptive authority Advance Nurse Practitioner with prescriptive authority	
Rehabilitation Services					
Case Management	T1016	15 minutes	Encounter rate	At a minimum: BHA I, BHA II, BHA III, BHP, Behavioral Health Clinical Associate or Substance Use Disorder Counselor. For peer support, must have lived, personal experience with behavioral health issues, including mental illness and addiction	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes; Conversation with Terry Hamm
Comprehensive Community Support Services (individual, group)	H2015 H2015-HQ	15 minutes			
Therapeutic Behavioral Health Supports (individual, group, family)	H2019 H2019-HQ H2019-HR H2019-HS	15 minutes			
Recipient Support Services *(services must be prescribed and meet medical necessity)*	H2017	15 minutes			
Daily Behavioral Health Rehabilitation	H0018	1 calendar day			
Day Treatment for Children *(only provided if there is an agreement with the school district to provide the service)*	H2012	1 hour			
Facilitation of Telemedicine	Q3014	1 case presentation			
Behavioral Health Treatment Plan Review for Methadone Recipient *(agency must be designated as a methadone clinic)*	T1007	1 review			
Peer Support Services (individual and family)	H0038 H0038-HR H0038-HS	15 minutes			
Rehabilitation Services					
Short-Term Crisis Stabilization	H2011	15 minutes	Encounter rate	At minimum: BHA I, BHA II, BHA III, BHP, Behavioral Health Clinical Associate Substance Use Disorder Counselor.	http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered

Tribal Community Behavioral Health Center Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services***	**Source**
Medication Administration (on and off clinic premises) *(if organization is a designated Methadone clinic)*	H0033 H0033-HK	1 day		Physician Physician Assistant Advance Nurse Practitioner Registered Nurse (RN) / Licensed Practical Nurse (LPN)	Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes; Conversation with Terry Hamm
Methadone Administration	H0020	1 admin episode		Pharmacist RN or LPN may prepare and administer methadone under direction of a Opioid Treatment Program physician	
Medical Evaluation for Methadone and Non-Methadone Recipients	H0002	1 medical evaluation		Physician Physician Assistant Advance Nurse Practitioner	
Evaluation and Management Codes					
New Patient	99201-99205			Physician Physician Assistant Advance Nurse Practitioner	http://manuals.medicaidalaska.com/docs/dnld/BillingManual_FQHC_RHC.pdf and http://www.integration.samhsa.gov/financing/Alaska.pdf
Established Patient	99211-99215				
The 2015 negotiated encounter rate is $601. For BH services to eligible for Medicaid reimbursement, the tribal provider must be a 638 provider who also receives a behavioral health grant from the state (source: interview with Medicaid office).					
*Assumption that all staff work within their scope of education, training and experience					

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)/RURAL HEALTH CLINIC (RHC) MEDICAID BILLING MODEL

The Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) provide a full range of primary care and, increasingly, behavioral health services. The Medicaid billing model for behavioral health services only requires that a Physician, Physician Assistant, or Advanced Nurse Practitioner provide a psychiatric diagnostic evaluation if the client requires medical services. If the client does not require medical services, a Psychologist or Licensed Clinical Social Worker (LCSW) can provide the psychiatric diagnostic evaluation and other behavioral health services, e.g. assessment; psychotherapy; and individual, group or family treatment.

Figure 4-14 Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHS) Medicaid Billing Model for Behavioral Health Services

Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Medicaid Billing Model for Behavioral Health Services					
Services	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Mental Health Codes					
Psychiatric diagnostic evaluation with no medical services	90791	1 evaluation	Payment is at the FQHC encounter rate	Within their scope of practice: Psychologist Licensed Clinical Social Worker (LCSW) Physician Physician Assistant Advance Nurse Practitioner	https://www.1199seiubenefits.org/wp-content/uploads/2010/11/BH-FAQs-for-Providers.pdf; http://manuals.medicaidalaska.com/docs/dnld/BillingManual_FQHC_RHC.pdf
Psychiatric diagnostic evaluation with medical services	90792	1 evaluation		Within their scope of practice: Physician Physician Assistant Advance Nurse Practitioner	
Psychotherapy, 30 minutes	90832	30 minutes		Within their scope of practice: Psychologist Licensed Clinical Social Worker (LCSW) Physician Physician Assistant Advance Nurse Practitioner	
Psychotherapy, 45 minutes	90834	45 minutes			
Psychotherapy, 60 minutes	90837	60 minutes			
Psychological Testing & Evaluation	96101 96101-U6 96118 96118-U6	15 minutes; 1 hour		Within their scope of practice: Psychologist Licensed Clinical Social Worker (LCSW) Physician Physician Assistant Advance Nurse Practitioner	
Psychiatric Assessment	90791	1 assessment		Within their scope of practice: Physician Physician Assistant Psychiatric Advance Nurse Practitioner	

Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Medicaid Billing Model for Behavioral Health Services					
Services	**Billing Code(s)**	**Duration / Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services*** **	**Source**
Pharmacologic Management	90862	1 visit	Payment is at the FQHC encounter rate	Within their scope of practice: Physician with prescriptive authority Physician Assistant with prescriptive authority Advance Nurse Practitioner with prescriptive authority	
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	99408	15-30 minutes		Within their scope of practice: Psychologist Licensed Clinical Social Worker (LCSW) Physician Physician Assistant Advance Nurse Practitioner	
Health and Behavior Codes					
Assessment	96150	15 minutes	Payment is at the FQHC encounter rate	Within their scope of practice: Psychologist Licensed Clinical Social Worker (LCSW) Physician Physician Assistant Advance Nurse Practitioner	http://manuals.medicaidalaska.com/docs/dnld/BillingManual_FQHC_RHC.pdf; http://www.integration.samhsa.gov/financing/Alaska.pdf
Reassessment	96151	15 minutes			
Individual treatment	96152	15 minutes			
Group treatment	96153	15 minutes			
Family treatment with patient	96154	15 minutes			
Family treatment without patient	96155	15 minutes			
Evaluation and Management Codes, for example:					
New Patient	99201-99205		Payment is at the FQHC encounter rate	Physician Physician Assistant Advance Nurse Practitioner	http://manuals.medicaidalaska.com/docs/dnld/BillingManual_FQHC_RHC.pdf; http://www.integration.samhsa.gov/financing/Alaska.pdf
Established Patient	99211-99215				
*Encounter rate (2007) for RHC = $124.02, Encounter rate (2007) for FQHC = $205.13					
**All-inclusive per-visit payment occurring on the same calendar day at a single location; mental health services are paid at the provider's encounter from core services.					
***Assumption that all staff are working within their scope of education, training and experience.					

MENTAL HEALTH PHYSICIANS CLINIC MEDICAID BILLING MODEL

The Mental Health Physicians Clinic (MHPC) Medicaid billing model requires that clinic services (with the exception of crisis intervention) are to be provided on the premises of the MHPC provider

or via telemedicine and under the direct supervision of a psychiatrist who is on the premises to deliver medical services at least 30 percent of the time. The psychiatrist's role is to provide direct supervision. All services, with the exception of psychiatric assessment and pharmacologic management, can be provided by a licensed operating psychiatrist or one of the following professionals: Physician Assistant, Advanced Nurse Practitioner (ANP), Licensed Psychological Associate (LPA), Psychiatric Nursing Clinical Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marital and Family Therapist (LMFT), or Licensed Professional Counselor (LPC).

Figure 4-15 Mental Health Physicians Clinic (MHPC) Medicaid Billing Model

Mental Health Physicians Clinic (MHPC) Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services****	**Source**
Initial Services (Clinic)					
Integrated Mental Health & Substance Use Intake Assessment	H0031-HH	1 assessment	300.00	Licensed operating psychiatrist OR one of the following: • Physician Assistant • Advance Nurse Practitioner • Psychological Associate, under a licensed psychologist • Psychiatric Nursing Clinical Specialist • Licensed Clinical Social Worker • Licensed Marital and Family Therapist • Licensed Professional Counselor	http://manuals.medicaidalaska.com/mhpc/mhpc.htm
Mental Health Assessment	H0031	1 assessment	175.00		
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	99408	15-30 minutes	43.80		
Psychiatric Assessment	90791	1 assessment	230.00	Within their scope of practice: Physician Physician Assistant Advance Nurse Practitioner	
*Clinic Services**					
Short-Term Crisis Intervention	S9484 S9484-U6	15 minutes; 1 hour	23.00/15 minutes; 92.00/ hour	Licensed operating psychiatrist OR one of the following: • Physician Assistant • Advance Nurse Practitioner • Psychological Associate, under a licensed psychologist • Licensed Clinical Social Worker • Licensed Marital and Family Therapist • Licensed Professional Counselor	http://manuals.medicaidalaska.com/mhpc/mhpc.htm
Psychological Testing & Evaluation	96101 96101-U6 96118 96118-U6	15 minutes; 1 hour	25.00/15 minutes; 100.00/ hour		
Psychotherapy (individual, family, group)	90804 90806 90810 90812 90846 90846-U7 90847 90847-U7 90853 90853-U7	30 minutes; 60 minutes	28.00-110.00 depending on type		
Multi-family group psychotherapy	90849 90849-U7	30 minutes; 60 minutes	55.00/30 minutes; 110.00/60 minutes		
Pharmacologic Management	90862	1 visit	75.00	Physician Physician Assistant Advance Nurse Practitioner	

Mental Health Physicians Clinic (MHPC) Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/Billing for Services****	**Source**
Other					
Facilitation of Telemedicine	Q3014	1 case presentation	62.43	Licensed operating psychiatrist OR one of the following: • Physician Assistant • Advance Nurse Practitioner • Psychological Associate, under a licensed psychologist • Psychiatric Nursing Clinical Specialist • Licensed Clinical Social Worker • Licensed Marital and Family Therapist • Licensed Professional Counselor	http://manuals.medicaidalaska.com/mhpc/mhpc.htm
*With the exception of Crisis Intervention, Clinic Services are to be provided on the premises of the MHPC provider or via telemedicine and under the direct supervision of a psychiatrist who is on the premises to deliver medical services at least 30% of the time the MHPC provider is open. The psychiatrist's role is to provide "direct supervision" **Assumption that all staff are working within their scope of education, training and experience					

PSYCHOLOGIST MEDICAID BILLING MODEL

Independently practicing Clinical Psychologists can bill Medicaid for a range of testing and evaluation services, but cannot bill Medicaid for clinic services.

Figure 4-16 Independently Practicing Psychologist Medicaid Billing Model

Independently Practicing Psychologist Medicaid Billing Model				
Services	**Billing Code(s)**	**Maximum Allowable**	**Position Providing/ Billing for Services**	**Source**
Diagnostic Interview Codes				
Psychological Testing	96101 96103	$151.11 $107.92	Clinical Psychologist	Alaska Medical Assistance. State Fiscal Year 2014 CPT Fee Schedule. Revised 7/29/13.
Assessment of Aphasia	96105	$165.79		
Developmental testing	96110 96111	$12.74 $226.04		
Neurobehavioral status exam	96116	$159.66		
Neuropsychological testing	96118	$246.05		

PHYSICIAN, ADVANCED NURSE PRACTITIONER, PHYSICIAN'S ASSISTANT MEDICAID BILLING MODEL

The Physician, Advanced Nurse Practitioner (ANP), Physician's Assistant (PA) Medicaid billing model allows Physicians (including psychiatrists), ANP's, and PA's operating within their scope of practice to provide SBIRT services and evaluation and management of behavioral health clients. ANP's and PA's must be supervised by a physician if the primary diagnosis is medical, not mental health. If the primary diagnosis is mental health, a psychiatrist must be on site at least 30 percent of the time. A psychiatrist can provide psychiatric diagnosis, psychotherapy and psychiatric services. If the Physician, ANP, PA clinic has a Clinical Psychologist on staff, the Clinical Psychologist can bill for assessment and diagnosis services only if enrolled as part of a health professional group (see above). For all other behavioral health services, a Physician, ANP, or PA must refer clients to a behavioral health outpatient clinic for further services.

Figure 4-17 Physician, Advanced Nurse Practitioner (ANP) and Physician Assistant (PA) Medicaid Billing Model

Physician, Advanced Nurse Practitioner (ANP) and Physician Assistant (PA) Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services**	**Source**
Behavioral Health Screening and Services					
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	99408 99409	15-30 minutes; over 30 minutes	43.80	Physicians Advance Nurse Practitioners Physician Assistant	http://manuals.medicaidalaska.com/physician/physician.htm
Evaluation and Management Codes Outpatient, for example:					
New Patient	99201-99205			Physician Physician Assistant Advance Nurse Practitioner	http://manuals.medicaidalaska.com/docs/dnld/BillingManual_FQHC_RHC.pdf; http://www.integration.samhsa.gov/financing/Alaska.pdf
Established Patient	99211-99215				
Evaluation and Management Codes Inpatient, for example:					
New Patient Admission	99221-99223			Physician Physician Assistant Advance Nurse Practitioner	
Post-Admission	99231-99233			Physician Physician Assistant Advance Nurse Practitioner	
Diagnostic Procedure Codes					
Psychiatric Diagnostic Evaluation (no medical services)	90791			Psychiatrist	http://www.integration.samhsa.gov/financing/Alaska.pdf http://www.thenationalcouncil.org/wp-content/uploads/2013/06/NC-CPT-FAQ-for-2013-V3.pdf
Psychiatric Diagnostic Evaluation with medical services	90792				
Therapeutic Codes					
Individual Psychotherapy	90832-90838	30 minutes; 45 minutes; 60 minutes		Psychiatrist	http://www.integration.samhsa.gov/financing/Alaska.pdf http://www.thenationalcouncil.org/wp-content/uploads/2013/06/NC-CPT-FAQ-for-2013-V3.pdf

Physician, Advanced Nurse Practitioner (ANP) and Physician Assistant (PA) Medicaid Billing Model					
Services	**Billing Code(s)**	**Duration/ Unit**	**Unit Payment ($)**	**Position Providing/ Billing for Services**	**Source**
Other Psychotherapy Codes					
Psychoanalysis	90845			Psychiatrist	http://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/coding-and-reimbursement, CPT Primer for Psychiatrists http://www.integration.samhsa.gov/financing/Alaska.pdf http://www.thenationalcouncil.org/wp-content/uploads/2013/06/NC-CPT-FAQ-for-2013-V3.pdf
Family Psychotherapy	90846 90847				
Multiple-Family Group Psychotherapy	90849				
Group Psychotherapy (other than Multiple-Family Group)	90853				
Psychotherapy for crisis	90839 90840	60 minutes; Additional 30 minutes			
Other Psychiatric Services or Procedure Codes					
Other Therapies	90865-90880			Psychiatrist	http://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/coding-and-reimbursement, CPT Primer for Psychiatrists

The Medicaid billing models illustrate that major barriers to billing for behavioral health services exist outside of the community behavioral health (DBH grantee) billing model. Within the community behavioral health billing model, there appears to be additional billing capacity for Behavioral Health Clinical Associates and behavioral, mental health, and rehabilitation counselors, e.g. Substance Use Disorder Counselors, who could provide more initial and rehabilitation services to behavioral health clients. In addition to more billing capacity, Behavioral Health Clinical Associates and behavioral, mental health and rehabilitation counselors take less time to train, are easier to retain with good management, and are recruited more locally.

It is important to grow and retain a strong behavioral health workforce in Alaska with the right mix of position types and it is imperative that behavioral health systems leaders work to remove barriers to billing for behavioral health services by position types with appropriate experience and credentials in medical settings. Both of these strategies are key to meeting the behavioral health needs of Alaskans and will be even more important as the system works to meet the increased demand for services anticipated with Medicaid expansion.

5. WHICH SERVICES DO CLIENTS USE?

Health, home, purpose, and community are central to recovery from mental and substance use disorders.[138] These elements are defined below.

- Health: overcoming or managing one's disease(s) or symptoms — for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem — and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live.
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community: relationships and social networks that provide support, friendship, love, and hope.

To support individuals in recovery, to prevent behavioral health issues and to treat them, requires a comprehensive continuum of services. What services do clients served with State Medicaid and behavioral health funds use and what does that tell us about the state-funded continuum of behavioral health care?

The continuum of care used for this analysis was produced by Substance Abuse and Mental Health Services Administration (SAMHSA) in a 2011 paper entitled: Description of a Good and Modern Addictions and Mental Health Service System.[139] SAMHSA describes the vision for the continuum as follows:

> The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a 'good' and 'modern' system of care is to provide a full range of high quality services to meet the range of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes. This vision recognizes that the U.S. health system includes publicly and privately funded organizations and managed care components that must work well together to produce desired outcomes. The integration of primary care, mental health and addiction services must be an integral part of the vision. Mental health and addiction services need to be integrated into health centers and primary care practice settings where most individuals seek

[138] Excerpt from the FY15-16 Draft Block Grant Application. Community Mental Health Services Plan and Report Substance Abuse Prevention and Treatment Plan and Report U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Draft provided by DBH 6.22.15.

[139] Description of a good and modern addictions and mental health service system, 2011, http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

> health care. In addition, primary care should be available within organizations that provide mental health and addiction services, especially for those individuals with significant behavioral health issues who tend to view these organizations as their health homes. Providing integrated primary care and behavioral health services will allow for cost effective management of co-morbid conditions.[140]

In this chapter, we compare actual State Fiscal Year (SFY) 2013 service data (number of unique clients served by procedure type) to the services outlined in SAMHSA's ideal continuum of care. This analysis highlights gaps and areas of opportunity for expansion of services and increased Medicaid billing. We also review a range of data that help to identify and/or substantiate gaps in the state-funded continuum of care. We found that statewide gaps in the continuum of care perpetuate a cycle and culture of crisis response.

There are many services in the continuum for which our dataset is not the right source of data, but for behavioral health-specific services, this analysis produces some helpful information to system planners and providers alike. . In reviewing this information, it is important to note that institutional provider types serving clients with behavioral health diagnoses do not use procedure codes in the same way that professional provider types do; thus, there are many services provided that would not be captured in this dataset. The data included in the tables that follow largely reflect the services provided by professional provider types (with limited service data from the institutional provider types). Moreover, there is evidence that some agencies underreport their service encounter notes in Alaska Automated Information Management System (AKAIMS) using, for example, program enrollment as a proxy. This means that the number of services documented is likely lower than the number provided. Thus, the analysis of unique client counts and percentage of clients receiving services must be reviewed with an eye toward higher level trends (for instance, looking at relative proportions of services) and identifying gaps and areas of opportunity for expansion of services and Medicaid billing.

Key Findings:

Services Used

- About 33 percent of adults and 33 percent of youth served received the procedure code Office or Other Outpatient Visit for Evaluation and Management of Established Patient, which falls under the category of outpatient medical services. Nineteen percent of adults and 17 percent of youth served received Pharmacologic Management. This data underscores the important role of the medical profession in meeting the needs of behavioral health clients.
- Providers served 178 unique adults (less than 1%) and 73 unique youth (less than 1%) with SBIRT services and billed Medicaid or documented the procedure in AKAIMS. We learned from interviews that SBIRT services are, in fact, occurring at much larger volumes. Our data suggests that there is potential to increase billing for these services, particularly in primary care settings.
- Psychotherapy was the most common (post-assessment) behavioral health service in 2013. Twenty three percent of adults and 31 percent of youth served received psychotherapy; 16 percent of adults and 16 percent of youth served received individual psychotherapy in 30

[140] Description of a good and modern addictions and mental health service system, 2011, http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

minute sessions while 10 percent of adults and 10 percent of youth served received individual psychotherapy in 60 minute sessions. In contrast, 17 percent of youth received group psychotherapy compared to seven percent of adults. These percentages are based on unique counts by procedure type so they cannot be summed, but the trend suggests a proclivity within the system toward individual counseling. The Division of Behavioral Health (DBH) and national evidence base encourage use of group sessions both to enhance treatment and recovery efforts and increase access to services.[141] Group services have the added benefit of reducing the impact of No Shows and have greater revenue potential. Expanding group psychotherapy offerings as a routine course of treatment is one strategy that could increase system capacity.

- Community Comprehensive Support Services (CCSS) and Therapeutic Behavioral Health Services (TBHS) are rehabilitation services that can be delivered in any community setting. About 19 percent of adults served received CCSS individual services whereas just five percent received CCSS group services. About 24 percent of youth served received TBHS individual services and 20 percent of youth served received TBHS group services. Only three percent of youth served received TBHS family services with the patient present and two percent received TBHS family services without the patient present. Here again, group and family services present a potential opportunity for expanding system capacity and improving behavioral health outcomes in communities.

- Providers served 84 unique adult clients and 11 unique youth clients (less than 1%) with peer support services and billed Medicaid[142] or documented the procedure in AKAIMS. We know from interviews and discussions with the Tribal Behavioral Health Directors that Peer Support services are routinely provided by Behavioral Health Aide's (BHA's) across the state. Likewise, peer-run organizations provide peer support services throughout the state and do not bill Medicaid for this service or document the procedure in AKAIMS. Peer-run organizations receive other grant funding to provide this service in communities.

Gaps in the Continuum of Care

- Statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, step down/after care services) combined with gaps in insurance coverage perpetuate a cycle and culture of crisis response.

- DBH produces a daily census count of bed availability within all inpatient psychiatric hospitals, including Fairbanks Memorial Hospital Mental Health (MH) and Bartlett Regional Hospital MH (Designated Evaluation and Treatment) Units, the Providence Psychiatric

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[141] Discussion with Mark-Haines Simeon, former Division of Behavioral Health Director of Policy and Planning, fall 2014. For further reading into the benefits of group therapy, see: Brief Interventions and Brief Therapies: Time-Limited Group Therapy. SAMSHA Treatment Improvement Protocols. 1999. http://www.ncbi.nlm.nih.gov/books/NBK64936/

[142] In order to bill Medicaid for peer support services, Alaska regulation 7 AAC 135.210 (c) specifies: "(c) Subject to the limitation in 7 AAC 135.040, peer support services may only be offered in combination with (1) individual therapeutic behavioral health services for children under 7 AAC 135.220; (2) family therapeutic behavioral health services for children under 7 AAC 135.220; or (3) individual comprehensive community support services under 7 AAC 135.200. (Eff. 10/1/2011, Register 199). In addition, peer support services must be delivered by individuals with lived, personal experience with behavioral health issues, including mental illness or addiction.

Emergency Room, the Providence Crisis Recovery Center, North Star Behavioral Health, and Alaska Psychiatric Institute (API) and sends it via email to service providers. This daily census report highlights the heavy demands placed on API and other inpatient psychiatric services in the state.

- A major challenge facing the behavioral health system is how to treat individuals before crisis occurs and how to help individuals stop the cycle of crisis once it begins. Based on ASAM levels of care, SAMHSA's ideal continuum of behavioral health care, community health outcomes, utilization data, procedure data, and stakeholder interviews, it appears that the system as a whole is serving many clients too late, leading to increased demand for crisis and acute services and corresponding shortages. The data amassed and interviews conducted throughout this assessment indicate a need for more upstream services, from Early Intervention and Engagement to Intensive Outpatient Services.

Untapped Medicaid Billing Potential

- Many billable services appear to be underutilized, including group services, family services, peer support services, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Our assessment has led us to conclude that there is significant untapped Medicaid billing potential among providers if the clinical associate and rehabilitative support staff can be tapped to offer the array of recovery and rehabilitative services currently allowable under the Community Behavioral Health System (CBHS) billing regulations.
- Medicaid is not an easy revenue stream to leverage. Tapping this potential will require strong commitment at all levels of the system, technical assistance, ongoing staff training, supervision and mentorship, dedicated behavioral health Medicaid billing specialists, and ideally, the rollout of the Medicaid billing module in AKAIMS. Additionally, for non-Tribal providers, a fair rate schedule and payment structure that adequately compensates for care is needed to incentivize care at the right levels and reduce reliance on grant funding.

Community-Based Treatment and Medicaid Billable Services

The Community Behavioral Health system of care was developed from the idea that individuals with Substance Use Disorder and Severe Mental Illness can be better served in community settings rather than in institutional care settings. To make this change, the Federal Government began giving states block grant funding to assist local behavioral health agencies in providing care in their communities. The community behavioral health system of care was implemented to promote the delivery of services across the continuum within individual communities and reduce the need for costly crisis and high intensity care.

As grant funding has decreased across the nation and recognition of the need for services increased, Community Behavioral Health agencies have moved from a mostly grant funded to a combined grant and Medicaid funded model. Medicaid now represents an important revenue source for community behavioral health services. As described in chapter 1, in Alaska, the DBH Treatment and Recovery Grants include authorization to bill for Medicaid services for eligible individuals. The community behavioral health system of care includes clinical, rehabilitation, and residential services delivered in a manner that supports individuals in their efforts to live healthy lives in their communities while undergoing treatment and recovery services. Clinical services include individual,

group, and family psychotherapy, short-term crisis intervention, and psychological testing, psychiatric assessment and pharmacologic management. Rehabilitation services include case management, comprehensive community support services (adults), therapeutic behavioral health supports (youth), peer support, and short-term crisis stabilization services delivered in a range of community settings. All of these services are Medicaid billable.

Alaska's Behavioral Health Continuum of Care

Using SAMHSA's continuum of care as a guide, Figure 5-1 shows the current continuum of behavioral health care in Alaska based on State Fiscal Year (SFY) 2013 service data. The blue shaded boxes indicate which services are included in the SFY2013 procedure code dataset. The procedure code analysis from SFY2013 data indicates where there are gaps in Alaska's current behavioral health system. The following data tables will illustrate how adults and youth are currently being served in the behavioral health system and where statewide service gaps exist. As noted above, the data included in the tables that follow largely reflect the services provided by professional provider types (with limited service data from the institutional provider types). Moreover, there is evidence that some agencies underreport their service encounter notes in AKAIMS using, for example, program enrollment as a proxy. This means that the number of services documented is likely lower than the number provided. Thus, the analysis of unique client counts and percentage of clients receiving services must be reviewed with an eye toward identifying larger trends, such as gaps and areas of opportunity for expansion of services and of Medicaid billing.

Figure 5-1 Comparison of SFY 2013 Service Data to SAMSHA's Ideal Continuum of Behavioral Health Care

Comparison of SFY 2013 Service Data to SAMSHA's Ideal Continuum of Behavioral Health Care

Healthcare Home/ Physical Health	Prevention including Promotion	Engagement Services	Outpatient Services	Medication Services	Community Support (Rehabilitative)	Other Supports (Rehabilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services	Recovery Supports
General and Specialized Outpatient Medical Services	Screening, Brief Intervention and Referral to Treatment	Assessment	Individual Evidenced Based Therapies	Medication Management	Parent/Caregiver Support	Personal Care	Substance Abuse Intensive Outpatient Services	Crisis Residential / Stabilization	Mobile Crisis Services	Peer Support
Acute Primary Care	Brief Motivational Interviews	Specialized Evaluations (psychological, Neurological)	Group Therapy	Pharmacotherapy (including Medication Assisted Treatment)	Skill Building (social, daily living, cognitive)	Homemaker	Partial Hospital	Clinically Managed 24-Hour Care	Medically Monitored Intensive Inpatient	Recovery Support Coaching
General Health Screens, Tests and Immunization	Screening and Brief Intervention for Tobacco Cessation	Service Planning (including crisis planning)	Family Therapy	Laboratory Services	Case Management	Respite	Assertive Community Treatment	Clinically Managed Medium Intensity Care	Peer Based Crisis Services	Recovery Support Center Services
Comprehensive Care management	Parent Training	Consumer/Family Education	Multi-family Therapy		Behavioral Management	Supported Education	Intensive Home Based Treatment	Adult SUD Residential + Adult Mental Health Residential	Urgent Care Services	Supports for Self Directed Care
Care Coordination and Health Promotion	Facilitated Referrals	Outreach	Consultation to Caregivers		Supported Employment	Transportation	Multi-systemic Therapy	Children's Mental Health Residential Services	23-Hour Crisis Stabilization Services	Continuing Care for Substance Use Disorders
Comprehensive Transitional Care	Relapse Prevention/ Wellness Recovery Support				Permanent Supported Housing	Assisted Living Services	Intensive Case Management	Youth Substance Abuse Residential Services	24/7 Crisis Hotline Services	
Individual and Family Support	Warm Line (Non-Crisis)				Recovery Housing	Recreational Services		Therapeutic Foster Care		
Referral to Community Services					Therapeutic Mentoring	Interactive Communication Technology Devices				
					Traditional Healing Services	Trained Behavioral Health Interpreters				

Dataset does not include procedure data for this service	Dataset includes procedure data for this service

FACILITATION OF TELE-BEHAVIORAL HEALTH SERVICES

In Alaska, tele-behavioral health services are an increasingly important vehicle for delivery of behavioral health services. This service is not reflected in SAMHSA's continuum of care, but its strong presence in Alaska's continuum and growing use speaks to the unique geography of the state. Currently, less than one percent (.73%) of adults served and a little more than one percent (1.18%) of youth served received facilitation of telemedicine service, billed Medicaid and documented the procedure in AKAIMS. We believe from the provider survey and key informant interviews that the actual use of tele-behavioral health is higher. That said, continuing to increase the facilitation of behavioral health services through telemedicine, including group services, can expand system capacity, increase access to services, and generate additional Medicaid revenue.

Figure 5-2 Procedure Type

Procedure Type	# of unique adults receiving procedure	% of adult clients receiving procedure	# of unique youth receiving procedure	% of youth clients receiving procedure
Facilitation of Telemedicine service	203	0.73%	143	1.18%

HEALTHCARE HOME/PHYSICAL HEALTH

Within the Healthcare Home/Physical Health section of the continuum of care, about 33 percent of adults and 33 percent of youth served received the procedure code Office or Other Outpatient Visit for Evaluation and Management of Established Patient. This data underscores the important role of the medical profession in meeting the needs of behavioral health clients.

Figure 5-3 Healthcare Home/Physical Health

HEALTHCARE HOME/PHYSICAL HEALTH				
Procedure Type	**# of unique adults receiving procedure**	**% of adult clients receiving procedure**	**# of unique youth receiving procedure**	**% of youth clients receiving procedure**
General and Specialized Outpatient Medical Services				
Office or Other Outpatient Visit for Eval & Mgmt of Established Patient	10,198	36.78%	3,956	32.57%
Office or Other Outpatient Visit for Eval & Mgmt of New Patient	1,385	4.99%	755	6.22%
Office or Other Outpatient Consultation	82	0.30%	219	1.80%
Initial Hospital Care, Per Day, for Eval & Mgmt of Patient Requires: Comprehensive History; Exam	618	2.23%	633	5.21%
Observation Care Evaluation and Management	40	0.14%	333	2.74%
Comprehensive Care Management				
Telephone call by physician to patient or consult or medical management or for coordinating with other health care professional	702	2.53%	30	0.25%
Plan of Care	11	0.04%	31	0.26%
Comprehensive Transitional Care				
Hospital Discharge	776	2.80%	722	5.94%

PREVENTION INCLUDING PROMOTION

For the Prevention including Promotion section of the continuum of care, providers served 178 unique adults (less than one percent) and 73 unique youth (less than one percent) with SBIRT services and billed Medicaid or documented the procedure in AKAIMS. We learned from interviews that SBIRT services are, in fact, occurring at much larger volumes. Our data suggests that there is potential to increase billing for these services, particularly in primary care settings, which many Tribal DBH grantees have ready access to. Receiving behavioral health services in a primary care setting can increase access to behavioral health services through another access point and may help to remove the stigma associated with receiving behavioral health care by receiving services in a medical environment.[143]

Figure 5-4 Prevention

PREVENTION				
Procedure Type	# of unique adults receiving procedure	% of adult clients receiving procedure	# of unique youth receiving procedure	% of youth clients receiving procedure
SBIRT				
Screening, Brief Intervention, and Referral for Treatment (SBIRT)	178	0.64%	73	0.60%
Brief Motivational Interviews				
Preventative medicine counseling and/or risk factor reduction intervention provided	24	0.09%	52	0.43%
Relapse Prevention/Wellness Recovery Support				
Preventative Care Services	22	0.08%	795	6.54%

[143] Reimbursement of Mental Health Services in Primary Care Settings, Kautz, Mauch and Smith, http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324.pdf

ENGAGEMENT

In the Engagement section of the continuum of care, only eight percent of adults and one percent of youth served received a Substance Use Assessment; 11 percent of adults and 13 percent of youth served received an Integrated Mental Health and Substance Use Assessment; and 7.5 percent of adults and 20 percent of youth received a Mental Health Assessment. Through interviews, we found that clinicians often experience delays in their ability to conduct Integrated Mental Health and Substance Use Assessments in a timely manner. An opportunity to get more clients through the behavioral health door, particularly for services provided in rural areas, is to share the completion of assessments amongst clinicians and BHA's or Substance Use Disorder Counselors.[144] BHA's and Substance Use Disorder Counselors can complete Substance Use Assessments with clients and write up an associated treatment plan to start providing these services. Once a clinician completes a Mental Health Assessment, the assessments can then be married and clients can receive both substance use and mental health services. This would present an opportunity to reduce time to service and elevate the role of BHA's and Substance Use Disorder Counselors. We also heard from both providers and BHA's that assessments work well via tele-behavioral health.[145] Facilitating assessments through tele-medicine could and has become standard practice by some providers.

Figure 5-5 Engagement

ENGAGEMENT				
Procedure Type	**# of unique adults receiving procedure**	**% of adult clients receiving procedure**	**# of unique youth receiving procedure**	**% of youth clients receiving procedure**
Assessment				
Alcohol and/or drug assessment	2,314	8.35%	166	1.37%
Alcohol and/or drug screening	47	0.17%	3	0.02%
Behavioral Health Screen - AK Screen Tool	4,434	15.99%	2,752	22.66%
Client Status Review	7,877	28.41%	4,700	38.69%
Drug Screen	288	1.04%	6	0.05%
Integrated Mental Health & Substance Use Intake Assessment	3,155	11.38%	1,632	13.44%
Mental Health Assessment	2,095	7.56%	2,520	20.75%
Specialized Evaluation (Psychological, Neurological)				
Neuropsychological testing by psychiatrist/physician (60 minutes)	306	1.10%	1002	8.25%
Psychiatric assessment - Interactive	21	0.08%	179	1.47%
Psychiatric assessment - Interview	2438	8.79%	905	7.45%
Psychiatric diagnostic evaluuation	1,462	5.27%	1,004	8.27%
Psychological testing by psychiatrist/physician (15 minutes)	3	0.01%	128	1.05%
Psychological testing by psychiatrist/physician (60 minutes)	263	0.95%	828	6.82%

[144] Interview with Terry Hamm, Medicaid Tribal and Quality Session, Division of Behavioral Health Services. March 2015.

[145] Alaska Behavioral Health Systems Assessment DBH Provider Survey, November 2014, and Behavioral Health Aide Survey, November 2014. See Chapter 9 for more survey specifics.

OUTPATIENT

The Outpatient section of the continuum of care shows that psychotherapy was the most common (post-assessment) behavioral health service in 2013. Twenty-three percent of adults and 31 percent of youth served received psychotherapy; 16 percent of adults and 16 percent of youth served received individual psychotherapy in 30 minute sessions while 10 percent of adults and 10 percent of youth served received individual psychotherapy in 60 minute sessions. In contrast, 17 percent of youth received group psychotherapy compared to seven percent of adults. These percentages are based on unique counts by procedure type so they cannot be summed, but the trend suggests a proclivity within the system toward individual counseling. Although all treatment plans must reflect the needs and desires of the client, individual counseling is more time intensive. The DBH and evidence based practices encourage use of group sessions both to enhance treatment and recovery efforts and increase access to services.[146] Group services have the added benefit of being more cost effective and have greater revenue potential. Expanding group psychotherapy offerings as a routine course of treatment is one strategy that could increase system capacity.

Youth were far more likely to receive family psychotherapy services with 24 percent receiving Family Psychotherapy Services with the client present and 12 percent without the client present whereas only two percent of adults received family psychotherapy services with the client present and less than one percent without the client present. This data suggests that expansion of family psychotherapy for adults with families may present another opportunity to expand service reach. For example, when a male or female family member is mandated to treatment services for assault or drug and alcohol-related crimes, all too frequently the spouse and children are not referred to or engaged in treatment.

Figure 5-6 Outpatient

OUTPATIENT				
Procedure Type	# of unique adults receiving procedure	% of adult clients receiving procedure	# of unique youth receiving procedure	% of youth clients receiving procedure
Individual Evidence Based Therapies				
Psychotherapy	6,241	22.51%	3,748	30.86%
Individual Psychotherapy (30 minutes)	4,493	16.20%	1,985	16.34%
Individual Psychotherapy (45 minutes)	382	1.38%	67	0.55%
Individual Psychotherapy (60 minutes)	2,830	10.21%	1,195	9.84%
Individual Psychotherapy (75 minutes)	51	0.18%	11	0.09%
Interactive Psychotherapy (30 minutes)	33	0.12%	1,030	8.48%
Interactive Psychotherapy (60 minutes)	38	0.14%	438	3.61%
Group Therapy				
Group Psychotherapy	2,055	7.41%	2,094	17.24%
Family Therapy				
Family Psychotherapy w/patient	642	2.32%	2,966	24.42%
Psychotherapy, Family (w/o patient present)	118	0.43%	1,432	11.79%
Multi-family Therapy				
Multiple-family Group Psychotherapy	67	0.24%	133	1.09%

[146] Discussion with Mark-Haines Simeon, former Division of Behavioral Health Director of Policy and Planning, fall 2014.

MEDICATION

Within the Medication section of the continuum of care, we see that 19 percent of adults and 17 percent of youth served received Pharmacologic Management. This data, again, underscores the important role of the medical profession in meeting the needs of behavioral health clients.

Figure 5-7 Medication

MEDICATION				
Procedure Type	# of unique adults receiving procedure	% of adult clients receiving procedure	# of unique youth receiving procedure	% of youth clients receiving procedure
Medication Management				
Oral medication administration direct observation (off premises)	159	0.57%	0	0.00%
Oral medication administration direct observation (on premises)	1,059	3.82%	130	1.07%
Unlisted psychiatric service or procedure	1,249	4.50%	178	1.47%
Pharmacologic Management	5,377	19.39%	2,144	17.65%
Pharmacotherapy (Including Medication Assisted Treatment)				
Medical Evaluation for Recipient NOT Receiving Methadone Treatr	65	0.23%	3	0.02%
Medical Evaluation for Recipient Receiving Methadone Treatment	21	0.08%	-	0.00%
Treatment plan review (methadone recipient)	3	0.01%	-	0.00%
Methadone administration and/or service	142	0.51%	-	0.00%

COMMUNITY SUPPORT (REHABILITATIVE)

Community Support (Rehabilitative) services represent a critical section of the continuum of care. About 19 percent of adults served received CCSS individual services whereas only five percent received CCSS group services. About 24 percent of youth served received TBHS individual services and 20 percent of youth served received TBHS group services. Only three percent of youth served received TBHS family services with the patient present and two percent received TBHS family services without the patient present. CCSS and TBHS are rehabiltiation services that can be delivered in any community setting. Here again, group and family services present a potential opporutnity for expanding system capacity and improving behavioral health outcomes in communtiites.

An increase in case management services presents another opportunity to expand system capacity. In SFY2013, 17 percent of adults and 29 percent of youth served received case management services. Case management is a collaborative process aimed at providing an individual with goals and support to improve overall independence. These services provide an assessment of need, care planning, linkage to services, advocacy, coordination and monitoring of activities. Successful case management results in community opportunities and increased self-sufficiency. Figure 5-8 provides specific examples of services that are billable to Medicaid, and services not billable to Medicaid. With the current emphasis on improving client outcomes through use of patient-centered medical homes, community behavioral health centers have a potentially important capacity to bill for a range of case management services that help clients attain and maintain self-sufficiency.

Figure 5-8 Examples of Billable and Non-Billable Case Management Services

Billable	Non-Billable
Assistance completing Social Security Income (SSI) application, Medicaid, or applying for public benefits (i.e., food stamps).	Linking client to other services provided by the same organization.
Assistance troubleshooting utility or other bills.	Check-in with client or reminder call about appointment.
Referral to housing authority for available affordable housing.	
Advocate for an Individual Education Plan (IEP) for a client's child or other educational services.	

Source: Conversation with Terry Hamm, DBH, March 2015

Figure 5-9 Community Support (Rehabilitative)

COMMUNITY SUPPORT (REHABILITATIVE)				
Procedure Type	# of unique adults receiving procedure	% of adult clients receiving procedure	# of unique youth receiving procedure	% of youth clients receiving procedure
Skill Building (Social, Daily Living, Cognitive)				
Comprehensive Community Support Services	5,236	18.88%	102	0.84%
Comprehensive Community Support Services - Group	1,481	5.34%	56	0.46%
Residential Habilitation	4	0.01%	25	0.21%
Therapeutic BH Services - Individual	613	2.21%	2,950	24.29%
Therapeutic BH Services - Group	182	0.66%	2,421	19.93%
Therapeutic BH Services - Family (with patient present)	22	0.08%	378	3.11%
Therapeutic BH Services - Family (w/o patient present)	10	0.04%	229	1.89%
Case Management				
Case management (15 minutes)	4,922	17.75%	3,533	29.09%
Supported Employment				
Supported Employment development	**2**	0.01%	**0**	0.00%
Supported Employment ongoing	-	0.00%	2	0.02%
Therapeutic Mentoring				
Treatment mentor	15	0.05%	30	0.25%

OUT-OF-HOME RESIDENTIAL SERVICES

Residential treatment provides intensive help in a structured environment for individuals struggling with addiction or co-occurring disorders. While receiving residential treatment, individuals temporarily live outside of their homes in a facility that is supervised and monitored by clinically trained staff. Services may include individual and group therapy; cognitive behavioral interventions; motivational interviewing; 12-step groups; medication management; education, i.e. social skills and parenting/relationship skill building; special groups tailored to the individual including relapse prevention, anger management, stress reduction, mental health; relaxation, exercise and recreational activities; wellness activities such as biofeedback; vocational training; aftercare and transitional care planning including case management and referrals to services. For clients with a higher level of need, residential treatment may be an option.

For the Out-of-Home Residential Services continuum of care section, a relatively small number of adults and youth receive Out-of-Home residential services that are documented in the procedure code data.[147] For example, a little more than one percent (1.19%) of adults served received Clinically Managed, High Intensity Residential Substance Use Disorder Treatment and about a half percent (.54%) of youth served received this service. Almost two percent of adults served received Clinically Managed, Medium Intensity Residential Substance Use Disorder Treatment and less than a half percent (.48%) of youth served received this service.

Figure 5-10 Out-of-Home Residential Services

OUT-OF-HOME RESIDENTIAL SERVICES				
Procedure Type	**# of unique adults receiving procedure**	**% of adult clients receiving procedure**	**# of unique youth receiving procedure**	**% of youth clients receiving procedure**
Crisis Residential/Stabilization				
Critical Care	52	0.19%	7	0.06%
Clinically Managed 24-hour Care				
Residential Substance Use Disorder Treatment - Clinically Managed; High Intensity	330	1.19%	66	0.54%
Clinically Managed Detoxification	24	0.09%	2	0.02%
Nursing Facility Services	212		106	
Clinically Managed Medium Intensity Care				
Residential Substance Use Disorder Treatment - Clinically Managed; Medium Intensity	551	1.99%	58	0.48%
Behavioral health; residential (hospital residential treatment program)	19	0.07%	8	0.07%
SUD Residential + Mental Health Residential				
Residential Substance Use Disorder Treatment - Clinically Managed; Low Intensity	121	0.44%	36	0.30%
Behavioral health; long-term residential (non-medical, non-acute care	32	0.12%	286	2.35%
Children's Mental Health Residential Services				
Daily Behavioral Health Residential Rehabilitation	105	0.38%	959	7.89%

[147] In efforts to analyze residential service utilization, DBH relies on program enrollment data, which is likely more reflective than procedure code data for this particular service.

ACUTE INTENSIVE SERVICES

For Acute Intensive Services section of the continuum of care, the SFY2013 procedure data shows that 2,794 unique adults (10%) served and 661 unique youth (5%) utilized the emergency department for behavioral health services. Three percent of adults served received Medically Managed Detoxification services. Although these numbers may not seem high, we know that some individuals are high utilizers of emergency department care and other types of acute and crisis services come at a high cost to the state. Analyzing and integrating data about high utilizers into practice represents an important area for future investigation.

Figure 5-11 Acute Intensive Services

ACUTE INTENSIVE SERVICES				
Procedure Type	**# of unique adults receiving procedure**	**% of adult clients receiving procedure**	**# of unique youth receiving procedure**	**% of youth clients receiving procedure**
Mobile Crisis Services				
Short-term Crisis Intervention Service (15 min)	323	1.16%	130	1.07%
Short-term Crisis Intervention Service (60 minutes)	465	1.68%	220	1.81%
Medically Monitored Intensive Inpatient				
Medically Managed Detoxification	868	3.13%	4	0.03%
Alcohol and/or drug services; acute detoxification (hospital inpatient)	102	0.37%	-	0.00%
Subsequent hospital care, per day, for evaluation and management	854	3.08%	837	6.89%
Urgent Care Services				
Emergency Department Visit	2,794	10.08%	661	5.44%
23 hour Crisis Stabilization Services				
Short-term Crisis Stabilization Service	74	0.27%	67	0.55%

RECOVERY SUPPORTS

In the Recovery Supports section of the continuum of care, providers served 84 unique adult clients and 11 unique youth clients (less than 1%) with Peer Support services and billed Medicaid or documented the procedure in AKAIMS. We know from interviews and discussions with the Tribal Behavioral Health Directors that peer support services are routinely provided by BHA's across the state. Likewise, peer-run organizations provide peer support services throughout the state and do not bill Medicaid for this service or document the procedure in AKAIMS. Peer-run organizations receive other grant funding to provide this service in communities.

To bill for these services under the CBHS billing regulations, peer support must be documented in the individual's treatment plan and be provided in combination with CCSS or TBHS services by individuals with lived, personal experience with behavioral health issues, including mental illness and addiction. Peer support services include assisting peers with articulating goals for recovery, learning and practicing new skills, helping monitor progress, modeling effective coping techniques and self-help strategies, and supporting peers with advocating for effective services. This definition means that the BHA's and others who meet these criteria could be providing peer support services to clients as long as an assessment and treatment plan indicate the need for peer support. One advantage of peer support services is that the threshold for documentation is lower than CCSS. CCSS are goal-driven, meaning that documentation must demonstrate that the client is making progress toward specified goals. Peer support services are more flexible in nature and, thus, easier to document. Peer support presents an important opportunity for Medicaid billing among BHA's and others.

Figure 5-12 Recovery Supports

RECOVERY SUPPORTS				
Procedure Type	**# of unique adults receiving procedure**	**% of adult clients receiving procedure**	**# of unique youth receiving procedure**	**% of youth clients receiving procedure**
Peer Support				
Peer Support Services - Individual	84	0.30%	11	0.09%
Peer Support Services - Family (with patient present)	2	0.01%	4	0.03%
Peer Support Services - Family (w/o patient present)	1	0.00%	4	0.03%
Continuing Care for Substance Use Disorders				
Alcohol and/or other drug testing	511	1.84%	30	0.25%

CRITICAL GAPS IN THE CONTINUUM OF CARE

> *Statewide gaps in the continuum of care combined with gaps in insurance coverage perpetuate a cycle and culture of crisis response.*
> *Alaska Behavioral Health Systems Assessment Key Finding*

While there are many services provided in Alaska that were not in our dataset, there are also gaps for which data do not exist because limited services are available, what services do exist the data is difficult to mine. One barrier to system capacity that has become very clear over the course of the nearly year and half that we have worked on this assessment is that statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, particularly for individuals with Substance Use Disorder (SUD), step down/after care services) combined with gaps in insurance coverage perpetuate a cycle and culture of crisis response. One clinician referred to this cycle as the revolving door – client is sent out of the region, returns home to an unsupportive environment and the option of once or twice weekly services, relapse inevitably occurs, and the cycle starts again.

Lack of supportive housing is a key gap in Alaska's continuum of behavioral health care. Supportive housing can be paired with assertive community treatment, intensive outpatient and other supportive services for various client populations, including: 1) clients returning from residential treatment outside the region, 2) clients waiting to access residential services outside of the region, and 3) clients who require housing while pursuing intensive outpatient treatment in the region. Clients often return to the same toxic environment after treatment and the number one relapse issue is the recovery environment. Permanent, supportive housing can offer a safe environment that supports individual and family recovery from alcohol abuse or addiction. A supportive housing setting with wraparound services can help stabilize clients and reduce the need for future interventions.[148]

Over the course of this assessment, we heard many regions express the need for transition, short-term supportive housing. Transitional, short-term supportive housing is a safe alternative for clients returning from treatment. This environment allows clients the time and support they need to effectively transition from treatment to living independently. It would allow clients time to work on the skills they learned while receiving treatment and receive additional step-down supportive services like case management and peer support to assist with community re-entry. Transitional housing can also be used as a 'step-prior' service to support clients ready to receive SUD and/or mental health treatment but who are waiting to go or get into treatment. This provides clients ready to receive treatment a safe, sober living option to prepare for treatment. A transitional, short-term supportive housing model is not considered an evidence-based practice and funding at the national and state level has moved in the direction of permanent supportive housing.[149] However, short-term supportive housing may be the more achievable option given the current housing crises in many rural regions of Alaska.

DBH is aggressively pursuing avenues to increase the availability of supportive housing in Alaska and recently issued a number of grants to finance supportive housing and assertive treatment efforts. Filling this gap in the continuum of care task will not be easy. According to Sherrie Hinshaw, the

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[148] Center for Housing Policy. "Affordable Housing's Place in Health Care: Opportunities Created by the Affordable Care Act and Medicaid Reform" June 2015.

[149] Interview with Sherrie Hinshaw, 4/30/15.

Social Services Program Officer, Integrated Housing and Services Unit at DBH, "A typical supportive housing project requires assembling seven or eight funding streams." A number of supportive housing efforts are currently underway in Alaska. The initial results from Tanana Chiefs Conference's (TCC) Housing First Project are particularly notable. In a 2012 presentation,[150] TCC Housing First program staff reported that the waitlist for entry was 300 people long for 47 existing units. A tenant snapshot demonstrates the tremendous impact permanent supportive housing can have on an individual's life and on the cost of services. Tenant A visited the emergency department 121 times in 2011 (30.25 times per quarter). In the second quarter of 2012 upon becoming a tenant, the number of visits to the emergency department dropped to one. Tenant A made 33 visits to detox in 2011 (8.25 times per quarter). In the second quarter of 2012 upon becoming a tenant, the number of visits to detox dropped to two. Tenant A was picked up by Community Safety Patrol 108 times in 2011, (27 times per quarter). In the second quarter of 2012 upon becoming a tenant, the number of visits to the emergency department dropped to five. Tenant A made contact with police 146 times in 2011, (36.5 times per quarter). In the second quarter of 2012 upon becoming a tenant, the number of police contacts dropped to zero. TCC estimates a savings of $7,312 per quarter for emergency department visits alone for Tenant A.[151]

This project is not without challenges. It can take up to two years to complete a Social Security application to establish disability status and become eligible for Medicaid.[152] The ability to bill for Medicaid services provided to tenants helps to support the array of needed services. Medicaid expansion could present an important opportunity for the sustainability of supportive housing projects in Alaska. At the conclusion of this chapter, we have included an infosheet Agnew::Beck recently created to help behavioral health care providers better understand what supportive housing is, how it is funded, and what projects are currently happening in Alaska.

Analysis on super utilizers by the Alaska Medicaid Coordinated Care initiative, a pilot program by the Alaska Department of Health and Social Services (DHSS), indicates that 6,512 individuals currently meet the criteria for super utilizer based on claims paid by the Alaska Medicaid Program between January 1, 2012 and September 17, 2013.[153] An estimated 616 individuals (just under 10%) had a serious and persistent mental health condition. Nearly half of these individuals were Alaska Native. The Alaska Medicaid Coordinated Care Initiative aims to improve access to services, improve health care outcomes and promote more efficient use of services by providing specialized case management and utilization review services to these individuals.[154] This project is currently underway.[155]

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[150] Provided to Agnew::Beck by DBH on 3/25/15. Presentation title: Housing First Fairbanks. Tanana Chiefs Conference Housing First Program in partnership with TCC Health Department, Fountainhead Development, Alaska Mental Health Trust Authority, Alaska Housing Finance Corporation, and Rasmuson Foundation.

[151] Notes from TCC's initial analysis: The 2011 data is verified. The data for the first quarter, in residence, is based on program documentation and may not include all contacts tenant had with the service providers. The number of contacts will be formally verified with service providers during our evaluation process. Formal Evaluation is being conducted.

[152] Interview with Sherrie Hinshaw, 4/30/15.

[153] State of Alaska Department of Health and Social Services. Alaska Medicaid Coordinated Care Initiative Request for Proposals. RFP No. 0614-075. Revised 4/13.

[154] State of Alaska Department of Health and Social Services. Alaska Medicaid Coordinated Care Initiative Request for Proposals. RFP No. 0614-075. Revised 4/13.

[155] Contract for services began in December 2014. Memo from Deb Erickson, Executive Director of the Alaska Health Care Commission. Department of Health and Social Services.

In an assessment of the crisis response system within the Matanuska-Susitna borough completed in 2014, the Mat-Su Health Foundation (MSHF) found similar utilization patterns, including a much larger number of high utilizer patients with a behavioral health diagnosis:[156]

- 305 high utilizer patients (5+ visits/year) with a behavioral health diagnosis visited the Emergency Department 2,492 times.
- 66 super utilizers (10+ visits/year) had 1,024 visits.
- 19 ultra-utilizers (15+ visits/year) had 477 visits.

The assessment MSHF found that the current system of care was not working for Mat-Su residents:[157]

> The Mat-Su Regional Medical Center (MSRMC) Emergency Department (ED) has only two beds for patients in behavioral health crisis. When these beds are filled the hospital diverts law enforcement and ambulances to Anchorage hospitals. In 2012, MSRMC ED was on diversion status five times. In 2013, this number more than doubled (12 times). As of October 1, 2014, MSRMC ED has already been on diversion status 14 times.
>
> Behavioral health providers in Mat-Su and Anchorage and professionals who make referrals for behavioral health services all feel there are gaps in services in Mat-Su. These gaps include lack of: substance use treatment, detox services, supportive housing, and crisis respite services. Providers also stated that many people in crisis do not have the following resources and support that would help them seek care: transportation, financial resources, supportive and helpful families, and other social support. The non-behavioral health professionals who were responding to these residents felt they were not the best option of care for patients with severe behavioral health problems. Additionally, they felt there is not enough staffing and space to handle the number of people experiencing crisis in Mat-Su.

We suspect other regions around the state experience many of the same challenges. A single crisis hotline, mobile crisis services that provide urgent care, a 12 to 16 bed crisis stabilization and respite center with detox capacity, an urgent care behavioral health walk-in clinic, and high utilizer case management services were among the recommendations in the MSHF report.[158] These recommendations are aimed toward addressing the key gaps found in the continuum of care for individuals in crisis when comparing existing services to SAMHSA's Ideal Continuum of Behavioral Health Care.

DBH produces a daily census count of bed availability within all inpatient psychiatric hospitals, including Fairbanks Memorial Hospital Mental Health (MH) and Bartlett Regional Hospital MH (Designated Evaluation and Treatment) Units, the Providence Psychiatric Emergency Room, the Providence Crisis Recovery Center, North Star Behavioral Health, and Alaska Psychiatric Institute (API) and sends it via email to service providers. This daily census report includes a chart comparing

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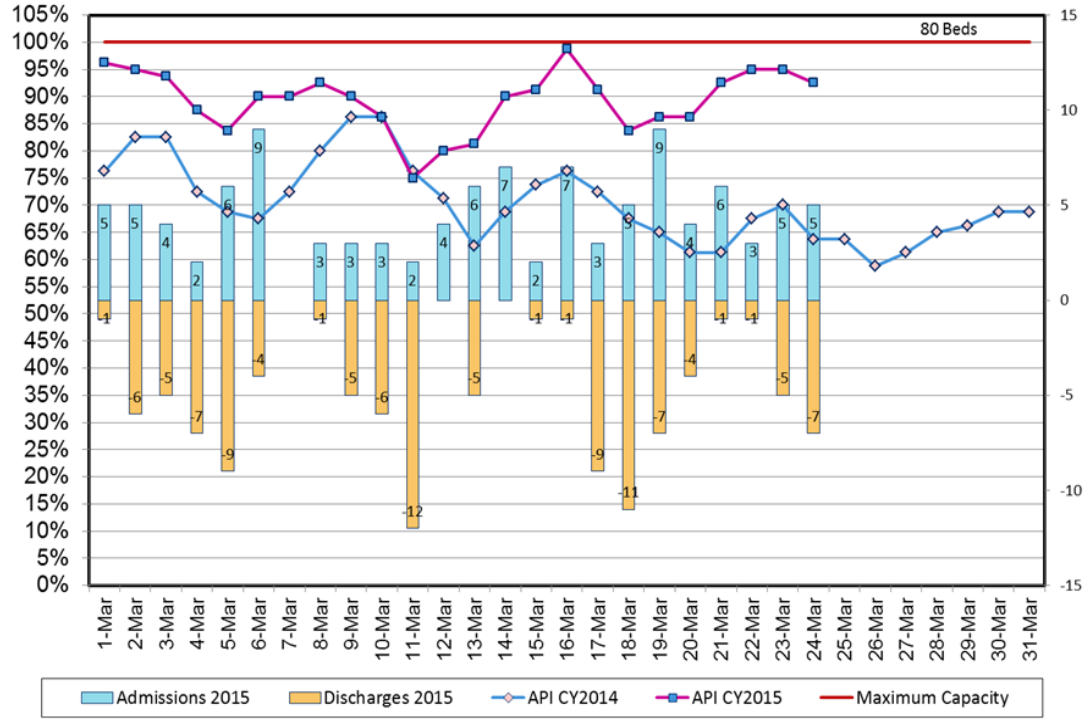
[156] Based on 2013 Service data. Mat-Su Behavioral Health Environmental Scan Executive Summary. Mat-Su Health Foundation. 2014. Available at: http://www.healthymatsu.org/focus-areas/BHES

[157] Mat-Su Behavioral Health Environmental Scan Executive Summary. Mat-Su Health Foundation. 2014. Available at: http://www.healthymatsu.org/focus-areas/BHES

[158] Mat-Su Behavioral Health Environmental Scan Executive Summary. Mat-Su Health Foundation. 2014. Available at: http://www.healthymatsu.org/focus-areas/BHES

a monthly snapshot of the API midnight census to the same time during the prior year (Figure 5-13).[159] This chart highlights the heavy demands placed on API and other inpatient psychiatric services in the state.

Figure 5-13 API Midnight Census as a Percentage of Total Occupancy – A One Month Comparison



A major challenge facing the behavioral health system is how to treat individuals before crisis occurs and how to help individuals stop the cycle of crisis once it begins.

For individuals with substance use disorder, one way to assess the level of care clients should receive is through the use of the American Society of Addiction Medicine (ASAM) criteria. The American Society of Addiction Medicine (ASAM) criteria began in the 1980s to define a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction.[160] This strengths-based assessment addresses client needs and challenges as well as strengths, resources and supports to guide placement, continued stay and transfer or discharge decisions for individuals experiencing SUD and co-occurring conditions.[161] This tool matches specific client need to five levels of treatment or "levels of care" ranging from early intervention to intensive inpatient services.

Figure 5-14 shows the ASAM levels of care for individuals with SUD across a continuum. The levels of care are as follows: .5 Early Intervention; 1 Outpatient Services; 2.1 Intensive Outpatient Services; 2.5 Partial Hospitalization Services; 3.1 Clinically Managed Low-Intensity Residential Services; 3.3 Clinically Managed Population-Specific High-Intensity Residential Services; 3.5 Clinically Managed

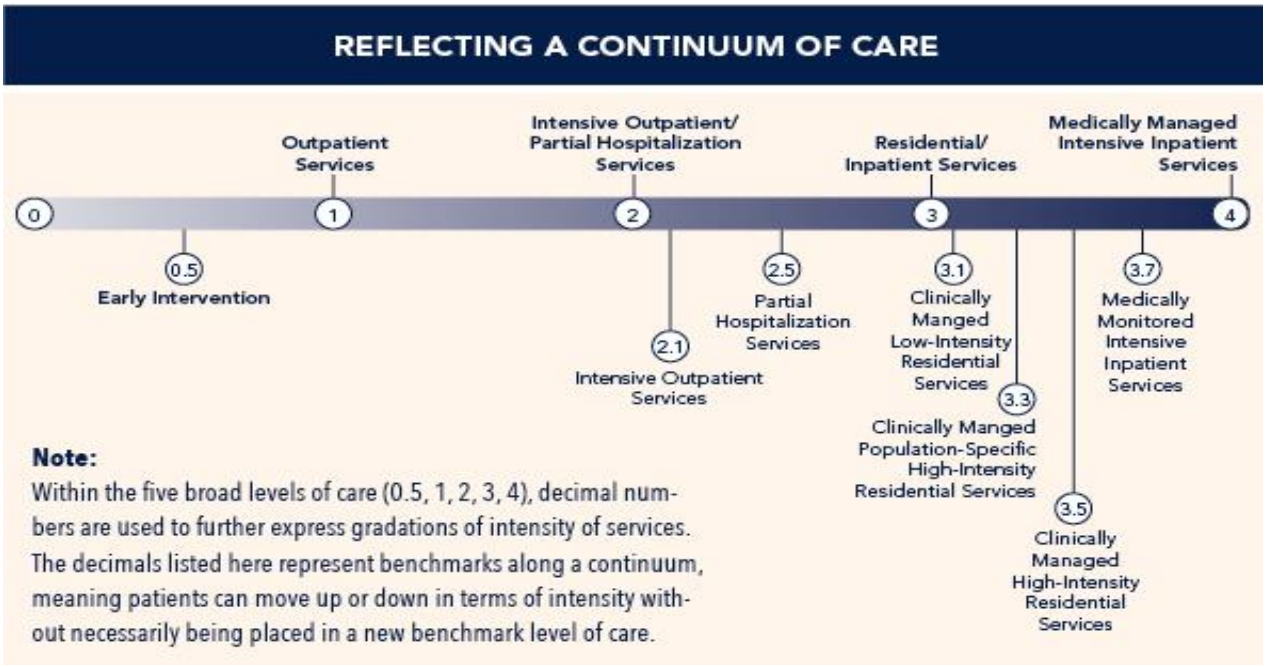
[159] The DBH Comprehensive Daily Census Report (CDRC), including Fairbanks Memorial Hospital MH and Bartlett Regional Hospital MH (DET) Units, the Providence Psychiatric Emergency Room, the Providence Crisis Recovery Center, North Star Behavioral Health, and the Alaska Psychiatric Institute. This figure is from the census report dated March 25, 2015.

[160] American Society of Addiction Medicine (ASAM) Criteria, 2015, http://www.asam.org/publications/the-asam-criteria/about

[161] Ibid.

High-Intensity Residential Services; 3.7 Medically Monitored Intensive Inpatient Services; and 4 Medically Managed Intensive Inpatient Services.

Figure 5-14 The American Society of Addiction Medicine (ASAM) Continuum of Care for Substance Use Disorders



Source: The American Society of Addiction Medicine (ASAM) Continuum of Care, 2015, http://www.asam.org/publications/the-asam-criteria/about

Significant evidence (for example, the ASAM levels of care, SAMHSA's ideal continuum of behavioral health care, community health outcomes data, prevalence data, utilization data, and procedure data and stakeholder feedback) points to a State-supported Alaska behavioral health system that is serving clients too late, leading to increased demand for crisis and acute services and corresponding shortages. The data amassed and interviews conducted throughout this assessment indicate a need for more upstream services, from Early Intervention and Engagement to Intensive Outpatient Services.

Intensive Outpatient Services help individuals recover and stay in their communities. Intensive Outpatient Services require participants to have a minimum of nine hours of therapeutic contact each week.[162] A typical Intensive Outpatient Treatment program schedules three hours of treatment on three days or evenings per week and programs vary considerably in the anticipated length of stay where many courses of treatment span 12 to 16 weeks before clients step down to a less intensive or maintenance stage.[163] Core services may include individual and group therapy, psychoeducational programming, medication management, alcohol and drug use monitoring, case management, 24-hour crisis coverage, support groups, vocational training and employment services.[164] Additional

[162] Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Chapter 4, Services in Intensive Outpatient Treatment Programs. http://www.ncbi.nlm.nih.gov/books/NBK64093/pdf/TOC.pdf

[163] Ibid.

[164] Ibid.

services that could be provided in this treatment environment are education, housing and food, recreational activities, adjunctive therapies, childcare and parenting classes.

Our assessment has led us to conclude that there is significant untapped Medicaid billing potential among providers if the clinical associate and rehabilitative support staff can be tapped to offer the array of recovery and rehabilitative services currently allowable under the CBHS billing regulations. And, yet, Medicaid is not an easy revenue stream to leverage. Tapping this potential will require strong commitment at all levels of the system, technical assistance, ongoing staff training, supervision and mentorship, dedicated behavioral health Medicaid billing specialists, and ideally, the rollout of the Medicaid billing module in AKAIMS.[165] Additionally, for non-Tribal providers, a fair rate schedule and payment structure that adequately compensates for care is needed to incentivize care at the right levels and reduce reliance on grant funding.

[165] DBH leadership has expressed general concern about conflicts of interest that may exist with supporting a billing module and specifically about the rolling out a billing module for AKAIMS until the State's Medicaid Management Information System is free from issues that could potentially expose the division to financial liability if provider claims were incorrectly processed and/or paid. Conversation with Shaun Wilhelm, Chief of Risk and Research Management, Spring 2015.

Figure 5-15 Supportive and Transitional Housing Information Sheet, Pages 1-4

SUPPORTIVE + TRANSITIONAL HOUSING

Supportive and transitional housing are critical services in the behavioral health continuum of care but are missing from most communities in Alaska.

WHAT IS SUPPORTIVE HOUSING?

Supportive housing combines **safe, affordable housing** and **flexible, voluntary support** services to provide vulnerable individuals and families with a stable base for recovery, health, employment, and personal growth.

COMMON TARGET POPULATIONS

- Individuals re-entering the community from institutional settings (residential treatment, assisted living, prison, inpatient psychiatric, long-term nursing home)
- Chronic and episodically homeless populations
- Frequent or high utilizers of health, behavioral health or other crisis resources
- Families engaged with the Office of Child Services

THREE FORMS OF SUPPORTIVE HOUSING

SINGLE-SITE HOUSING

Tenants receiving support services live in units in the same building or a group of buildings, with the support services provided either on site or off site.

SCATTERED-SITE HOUSING

Tenants live in independent apartments throughout the community, in either private or agency-owned housing; depending on the program, staff can deliver some support services through home visits, or all services may be provided at other locations in the community.

MIXED HOUSING

Tenants live in developments that contain a mixture of supportive housing tenants and other tenants not part of the supportive housing program.

TWO MAIN TYPES OF SUPPORTIVE HOUSING

no time limitation, individual decides length of stay

PERMANENT SUPPORTIVE HOUSING

The "permanent" in "permanent supportive housing" means the length of stay is up to the individual or family. Tenants may live in their homes as long as they meet the basic obligation of tenancy. While participation in services is encouraged, it is not a condition of living in the housing. Lease agreements comply with the landlord-tenant act and housing affordability is ensured either through a rent subsidy or by setting rents at affordable levels.[1] Housing is combined with support services to assist the individual with recovery and developing stability in their lives.

This model is gaining more and more traction with state and national funders.

up to 24 months

TRANSITIONAL SUPPORTIVE HOUSING

Transitional housing programs provide temporary residence, ranging from three to 24 months, for individuals or families in need. Housing affordability is ensured either through a subsidy or by setting monthly rates at affordable levels. Housing is combined with support services to assist the individual with recovery and developing stability in their lives.[2]

At the national level, funders are moving away from transitional housing in support of more permanent supportive housing initiatives.[3]

EBP Evidence-based practice

AGNEW::BECK

SUPPORTIVE + TRANSITIONAL HOUSING

Alaskan Treatment and Recovery grantees rank Supportive and Transitional Housing as the #1 service they would develop in their communities if it were within their power to do so.[4]

HARM REDUCTION-BASED SUPPORTIVE SERVICE MODELS

HOUSING FIRST

Housing First projects typically move individuals and families experiencing homelessness or re-entering the community from an institutional setting into housing without pre-conditions of treatment or abstinence and then combines housing with consumer-directed supportive services in the areas of mental and physical health, substance abuse, education, and employment. Housing First models commonly offer medium-term transitional supportive housing (12 to 18 months) or permanent supportive housing to tenants. [5]

+ PLUS

OR

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) uses a trans-disciplinary team-based approach to delivering comprehensive and flexible treatment, support, and services on a 24/7 basis to tenants with serious mental illness and substance abuse disorder in their homes and communities. Team sees clients on a regular basis and develops a strong relationship with landlords who can call the team at any time.[6]

INTENSIVE CASE MANAGEMENT

The intensive case management model offers a full range of behavioral health clinic and rehabilitation services to tenants in their homes and other community settings. Provision of intensive case management facilitates access to safe and affordable housing, employment and job skills training and primary health care.[7]

ABSTINENCE SERVICE MODELS

RECOVERY RESIDENCES

Recovery Residence is a broad term describing a sober, safe, and healthy living environment that promotes sobriety and recovery from alcohol and other drug use and associated problems. Recovery Residences are often used as a step down service.[8] Sober Living Homes[9] and Oxford Houses[10] are examples of Recovery Residences, which can be peer-run, monitored, supervised, and service provider-driven.

At the national level, funders are shifting financial support away from sober living environments in favor of harm reduction models.[11]

RAPID RE-REHOUSING (FOR MODERATE POPULATIONS)

Rapid Re-Housing programs offer short-term or medium-term rental assistance to individuals and families paired with case management, credit counseling, and other supportive services to prevent homelessness and promote stability.[12]

AGNEW::BECK

[1] Permanent Supportive Housing. United State Interagency Council on Homelessness. Retrieved from http://usich.gov/usich_resources/solutions/explore/permanent_supportive_housing
[2] http://homeless.samhsa.gov/channel/transitional-housing-450.aspx
[3] Interview with Sherrie Hinshaw, Alaska Division of Behavioral Health Social Services Program Officer, Integrated Housing and Services Unit.
[4] Conducted as part of the Alaska Behavioral Health Systems Assessment and available online at: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf See slides 15 + 16.
[5] Housing First. United State Interagency Council on Homelessness. Retrieved from http://usich.gov/usich_resources/solutions/explore/housing_first
[6,7] DBH Presentation on "Housing in Alaska" from 8/28/14.
[8] http://www.soberhousing.net/documents/NARR%20FAQ%20&%20Research%20Project%20Master%20Short%20Version%20Final%2009-20-2012a.pdf
http://narronline.org/wp-content/uploads/2013/09/NARR-Standards-20110920.pdf
[9] http://www.recovery.org/topics/recovery-homes/
[10] http://nrepp.samhsa.gov/ViewIntervention.aspx?id=223
[11] Interview with Sherrie Hinshaw, Alaska Division of Behavioral Health Social Services Program Officer, Integrated Housing and Services Unit.
[12] http://portal.hud.gov/hudportal/HUD?src=/recovery/programs/homelessness

SUPPORTIVE HOUSING CASE STUDIES

SUPPORTIVE HOUSING FUNDING

A typical supportive housing project requires assembling 7 or 8 funding sources. Funding sources are typically available for construction and operation of housing, or for services.

In Alaska, operating a supportive housing program costs between $14,000 to $20,000 per unit annually, depending on local costs and the level of service(s) provided.

Funding Source	Funder	Description	Limitations
Housing			
NAHSDA Housing Funds (Northwest Inupiat Housing Authority)	HUD	Housing funding provided to regional Housing Authorities across state for construction, maintenance of housing and provision of services	Granted to Housing Authorities; would require partnership to dedicate funds to specific Supportive Housing project
Special Needs Housing Grant (SNHG)	AHFC	Competitive grants for planning + construction of congregate, supportive and transitional housing	Alaska funds fully committed: no current funding available to new projects
AHFC Housing Vouchers	AHFC	Previously "Section 8," vouchers for households to rent private housing	Person-based, travels with client Not available in all regions
Veterans Administration Supportive Housing (VASH)	HUD/VA	Joint effort to move veterans and their families out of homelessness and into permanent housing; rental voucher, access to services	Person-based, travels with client Not available in all regions
Tenant Based Rental Assistance (TBRA)	AHFC Dept of Corrections	Financial (rental) assistance to obtain affordable housing for low-income families, up to 12 months; under Dept of Corrections supervision	Person-based, travels with client Not available in all regions Some types of criminal history disqualify
Low-Income Housing Tax Credits (LIHTC)	AHFC	Provides tax credits for rental housing with mix of market-rate and affordable housing AHFC program provides 4% credit, no-interest loans on competitive basis	Used primarily for mixed rental non-supported housing; ends after 15 years AHFC tax credits require SNHG application
Continuum of Care (CoC) Funding Programs	AHFC HUD	Combined previous programs: Shelter Plus Care, Permanent Supportive Housing, Section 8 Single Room Occupancy (SRO)	Competitive funding; must submit through Lead Agency (AHFC) in Alaska Primarily renewals for existing projects at this time
Future: HUD 811	HUD	Integrated permanent supportive housing for persons with disabilities, including developmental disabilities	Alaska funds availability pending Scattered-site, not concentrated plan to comply with Olmstead Act
Services			
Medicaid	DHSS	Enrolled individuals have a variety of services covered, either as fee for service or Tribal encounter rate.	Person-based, travels with client Eligibility requirements Cannot be billed in facilities with >16 beds, per ICM requirement
Healthcare for the Homeless	HRSA	Funding for services to homeless individuals	Provided to Federally Qualified Health Centers
State behavioral health treatment grants	DHSS-DBH	Operating grant funds for treatment services	Potential restructuring of DBH program funding, pending Medicaid expansion and/or reform
Future: General Relief/ Individual Service Agreement (ISA) Reformed	DHSS-DBH	Will provide funding for non-Medicaid services, housing assistance	Person-based, travels with client

Source: Alaska Housing Finance Corporation (AHFC), U.S. Department of Housing and Urban Development (HUD), Health Resources and Services Administration (HRSA), interview with and presentation materials shared by Sherrie Hinshaw and Lisa Rosay, Alaska DHSS Division of Behavioral Health

SUPPORTIVE HOUSING CASE STUDIES

	Transitional Housing *Akeela, Inc.*	Safe Harbor *RurAL CAP + ACMHS*	Karluk Manor *RurAL CAP*	Housing First Project *Tanana Chiefs Conference*
Location	Anchorage	Anchorage	Anchorage	Fairbanks
Project Type	Transitional Scattered site	Transitional Single site	Permanent Single site (2 buildings)	Permanent
Client Population(s)	1 site for women+children Sex offenders screened case-by-case; violent offenders not allowed.	Families experiencing homelessness w/ high rate of instability, BH issues; low level self-sufficiency Homeless for 1+ yr, or episode within 3 yr Small children (<5 yrs) Adult with SMI or child with SED diagnosis Past involved w/ OCS Receive TANF for 2+ yr	Chronic homeless; MH Trust beneficiaries; SUD, <30% AMI	Chronic homeless; MH Trust beneficiaries; SUD, <30% AMI; Alaska Native
Units	2 4-plexes, 1 6-plex; 13 2BR, 1 3BR	50 units: 46 4-person, 4 5-person	46 studio units	47 units; 6 for chronic homeless 39 studios permanent, 8 1BR transitional
Typical Stay	2 year max	6 to 9 mo	Varies	Varies
Services	Case management Step-down for Akeela House Recovery	Intensive case management 1-3 mo support + transition plan; 4-7 mo problem solving skills; 8-9 mo follow-up + safety support Group therapy, incl. brief strategic family therapy, parenting with love and limits	Assistance to access services: medical, mental health, financial, legal, employment Life skills training Crisis intervention + safety planning Community engagement Access to bus pass if qualify Onsite meals	Case management, medical, BH, social services Space available onsite to develop clinic Group counseling, talking circles Vocational training (laundry, food service)
Vacancy + Wait List	(Unknown)	Assumes 10% vacancy + uncollectable rent	(Unknown)	119 applications when built 300 on waiting list 2013
Staffing	(Unknown)	.10 Housing manager 1 janitor	(Unknown)	1 Program director 1 Clinician
Operating Revenue *-Client fees* *-Medicaid* *-DBH grant*	Akeela purchased buildings Medicaid billed as eligible Apt. rent $400/mo	Rent $550 for 4-person, $580 for 5-person unit Pay 30% AGI for 3 mo, full rent for remaining SNHG $496,241 Total revenue $1,142,980 Medicaid billed as eligible Tenant rent, SNHG, etc. TANF 3 mo emergency rental assistance	SNHG $1,399,599 FY15 Sliding scale rent on 30% income	SNHG $1,244,417 FY15; capital grant, now operating funds TCC provided significant funding (Medical Hotel section purchased for $700k) AMHTA funds Medicaid/Medicare Housing vouchers; tenants pay 30% income, voucher for remaining SSI/SSDI CAMA (Chronic & Acute Medical Assistance) Laundry income
% Clients on Medicaid	Unknown	65%	Approx. 50%	About 25%
Evidence Base	None	ICM Family critical time intervention	Housing First	Housing First

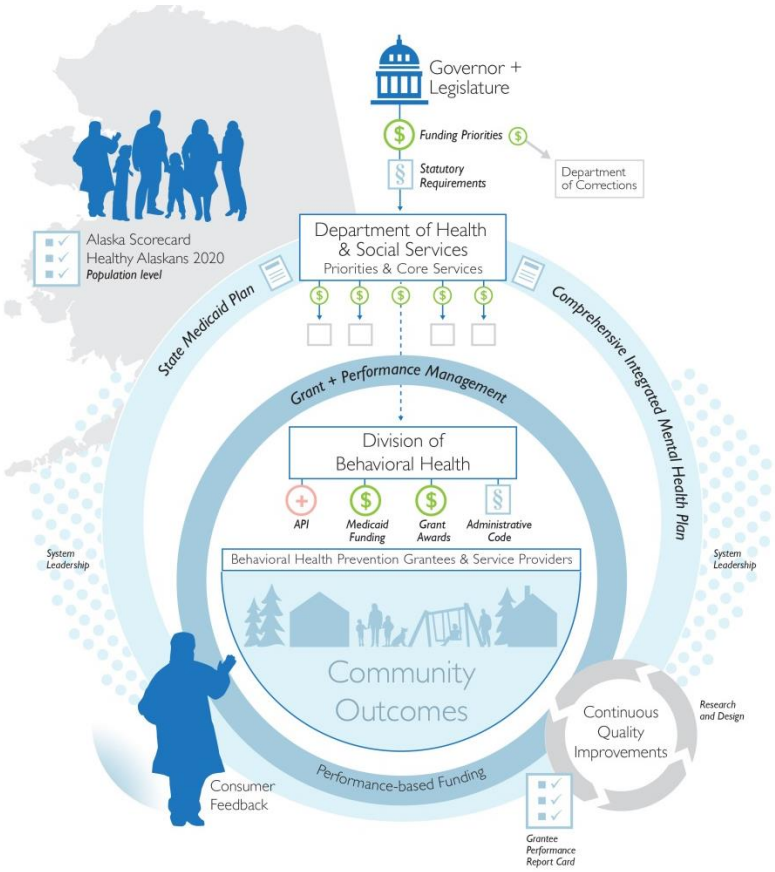
6. ARE STATE-FUNDED BEHAVIORAL HEALTH SERVICES EFFECTIVE?

Overview of System Governance and Performance Management Framework

An important question for all stakeholders is whether state-funded behavioral health services are effective. Figure 6-1 visually describes the governance and performance management framework for the community behavioral health system managed by DBH. The governor and legislature establish statutory requirements and set funding priorities at the departmental and sometimes division level. Priorities are informed by population level score cards like the Alaska Scorecard (

Figure 6-3) and statewide health targets included in Health Alaskans 2020 (Figure 6-2), as well as individual program performance data. The State Medicaid Plan and Comprehensive Integrated Mental Health Plan are structures designed to help guide priorities and spending at all levels. Systems leadership represents the many national, local, federal, state, Tribal, and private entities that help to support and/or guide the system.

Figure 6-1 Alaska Community Behavioral Health System Governance and Performance Management Framework



DBH is the leading entity responsible for oversight of behavioral health-specific State Medicaid funds, issuance and management of a wide range of grant awards from prevention to treatment and recovery services, development of administrative code, and operation of the Alaska Psychiatric Institute (API). For DBH Treatment and Recovery grantees, legislative mandates in 2007 set in place a series of performance-based funding processes.[166] The DBH performance management system uses the Results Based Accountability framework to answer three questions:

1. Quantity: How much do we do?

[166] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

2. Quality: How well do we do it?
3. Outcomes: Is anybody better off?

Each year, DBH produces a Treatment and Recovery grantee performance-based funding report outlining summary and provider level data in response to the three questions above.[167] Consumer feedback, through the Behavioral Health Consumer Survey and Client Status Review, and provider-reported screening and service data, submitted through AKAIMS or, for a small handful of grantees, an electronic data interface, drive these processes. A variety of continuous quality improvement strategies, for example a Results-Based Accountability dashboard, play an integral role in helping DBH ensure that the system and the services it delivers are performing. DBH relies on an advisory group and ongoing consulting support to review and refine its performance management system.

The goal of producing community level outcomes that make a difference in the day-to-day lives of Alaskans lies at the heart of the community behavioral health system. The continuum of behavioral health services, from prevention to treatment and recovery support, help to produce population-level improvements evidenced in prevalence data in the Alaska Scorecard and our progress toward Healthy Alaskans 2020 goals.

Key Findings

System Governance

- A robust system governance and performance management framework exists to guide the priorities and assess the performance of the community behavioral health system. A key part of that framework, the comprehensive integrated mental health plan has not been updated since the 2006-2011 plan *Moving Forward* expired. A new comprehensive integrated mental health plan is needed to guide the system through this tremendous period of change and to expand capacity in the areas that need it most.

Population Level Outcomes

- Population level outcomes are perhaps the ultimate proxy of the how well the State-funded continuum of care is meeting the behavioral health needs of Alaskans. According to the 2014 Alaska Scorecard, health status is declining or uncertain in eight of the nine behavioral health indicators included. These indicators look at suicide, substance abuse, mental health, and health insurance access. The status of days of poor mental health in the past month (among adults) receives a green check mark for satisfactory. Of the 13 behavioral health-related indicators in *Healthy Alaskans 2020* leading health indicators status report, the state has met five of its Healthy Alaskans goals already, is on track to meet two more of its Healthy Alaskans goals by 2020, and is not on track to meet its goal for five of the indicators by 2020. More work remains at the population level.

[167] Results for each fiscal year are available for download here: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

Performance-Based Funding

- A performance-based Treatment and Recovery funding report with systems and provider-level report cards is produced annually and is available online.[168] In FY15, 42 of 69 grantees (61 percent) experienced increased funding as a result.[169] The minimum change was $75, the maximum change was $42,632 and the average change was just under $5,000. Thirty-seven of 69 grantees (39 percent) experienced decreased funding as a result. The minimum change was (-$11), the maximum change was (-$48,948) and the average change was just (-$7,735).

Client Level Outcomes

- According to a 2014 analysis by Western Interstate Commission on Higher Education (WICHE) on the validity of DBH's performance outcomes, [170] meaningful, positive change was found amongst adult mental health clients in all categories measured including: mentally unhealthy days, quality of life, use of alcohol and drugs, physically unhealthy days, activity limitation days, legal involvement, arrest past 30 days, and arrest past 12 months. Additionally, adult clients who were in treatment for mental health who were discharged reported a decrease in mentally unhealthy days of 9.7 days at four months, 10.1 days at eight months, and 11.3 days at twelve months (for those who stayed in treatment long enough to report at those intervals). This analysis relied on client data from state fiscal years 2011 to 2013.
- While more work needs to be done, the available evidence suggests DBH-funded Treatment and Recovery grantees are providing services that improve the lives of clients who engage in services.

Comprehensive Integrated Mental Health Plan

Alaska Statute specifies that the Department of Health and Social Services shall

- (1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 47.30.056 (i); the preparation of the plan and any revision or amendment of it shall
    - (A) be made in conjunction with the Alaska Mental Health Trust Authority;
    - (B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;
- (2) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan. [171]

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[168] Results for each fiscal year are available for download here: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

[169] FY2015 Treatment and Recovery Performance-Based Funding Summary. Final. June 27, 2015. Alaska Division of Behavioral Health Services. Available at: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

[170] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

[171] AS 47.30.660. Powers and Duties of Department.

The last comprehensive integrated mental health plan, *Moving Forward*, was for the period 2006-2011. One of our recommendations is to use the information produced through this assessment to inform the next update of the comprehensive integrated mental health plan. A plan is needed to guide the system through this tremendous period of change and to identify and expand capacity in the areas that need it most.

Population Level Outcomes

Population level outcomes are perhaps the ultimate proxy of the how well the state-funded continuum of care is meeting the behavioral health needs of Alaskans. According to the 2013 Alaska Scorecard,[172] health status is declining or uncertain in nine of the nine behavioral health indicators included. These indicators look at suicide, substance abuse, mental health, and health insurance access. The status of days of poor mental health in past month (among adults) receives a green check mark for satisfactory.

Of the twenty-five leading health indicators identified in the *Healthy Alaskans 2020* plan, 13 are specific to behavioral health (arguably all are related to behavioral health). Of these indicators, highlighted in Figure 6-2, Alaska has met five of its Healthy Alaskans goals already, is on track to meet two more of its Healthy Alaskans goals by 2020, and is not on track to meet its goal five of the indicators by 2020.

Figure 6-2 Behavioral Health-related Leading Health Priorities from Healthy Alaskans 2020 (with Indicator #)

Behavioral Health-related Leading Health Priorities from Healthy Alaskans 2020 (with Indicator #)	Progress
2 Percentage of adolescents who have not smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days	Target Met
3 Percentage of adults who currently do not smoke cigarettes	On Track
7a Suicide mortality rate per 100,000 population: Among population aged 15 – 24 years	Target Met
7b Among population aged 25 years and older	Not on Track
8 Percentage of adolescents who felt so sad or hopeless every day for 2 weeks or more in a row that they stopped doing some usual activities during the past 12 months	Not on Track
9 Mean number of days adults aged 18 and older report being mentally unhealthy	Not on Track
10 Percentage of adolescents with 3 or more adults who they feel comfortable seeking help from	Not on Track
11Rate of unique substantiated child maltreatment victims per 1,000 children	Target Met
12 Rate of rape per 100,000 population	Not on Track
13 Percentage of adolescents who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months	n/a
14 Alcohol induced mortality rate per 100,000 population	On Track
15a Percentage of persons who report binge drinking in the past 30 days based on the following criteria: Adults: five or more drinks for men; 4 or more drinks for women on one occasion	Target Met
15b Percentage of persons who report binge drinking in the past 30 days based on the following criteria: Adolescents: 5 or more alcoholic drinks in a row within a couple of hours, at least once in the past 30 days	Target Met

[172] Available at: http://dhss.alaska.gov/dph/HealthPlanning/Documents/scorecard/assets/Scorecard2013.pdf

Of course, the prevalence of behavioral health issues is another indicator of population level health. For more discussion about trends in statewide prevalence data, see Chapter 2.

Figure 6-3 Alaska Scorecard

Alaska Scorecard

Key Issues Impacting Alaska Mental Health Trust Beneficiaries

The Trust — The Alaska Mental Health Trust Authority

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

Key to symbols:
✓ Satisfactory
⟺ Uncertain
✗ Needs Improvement

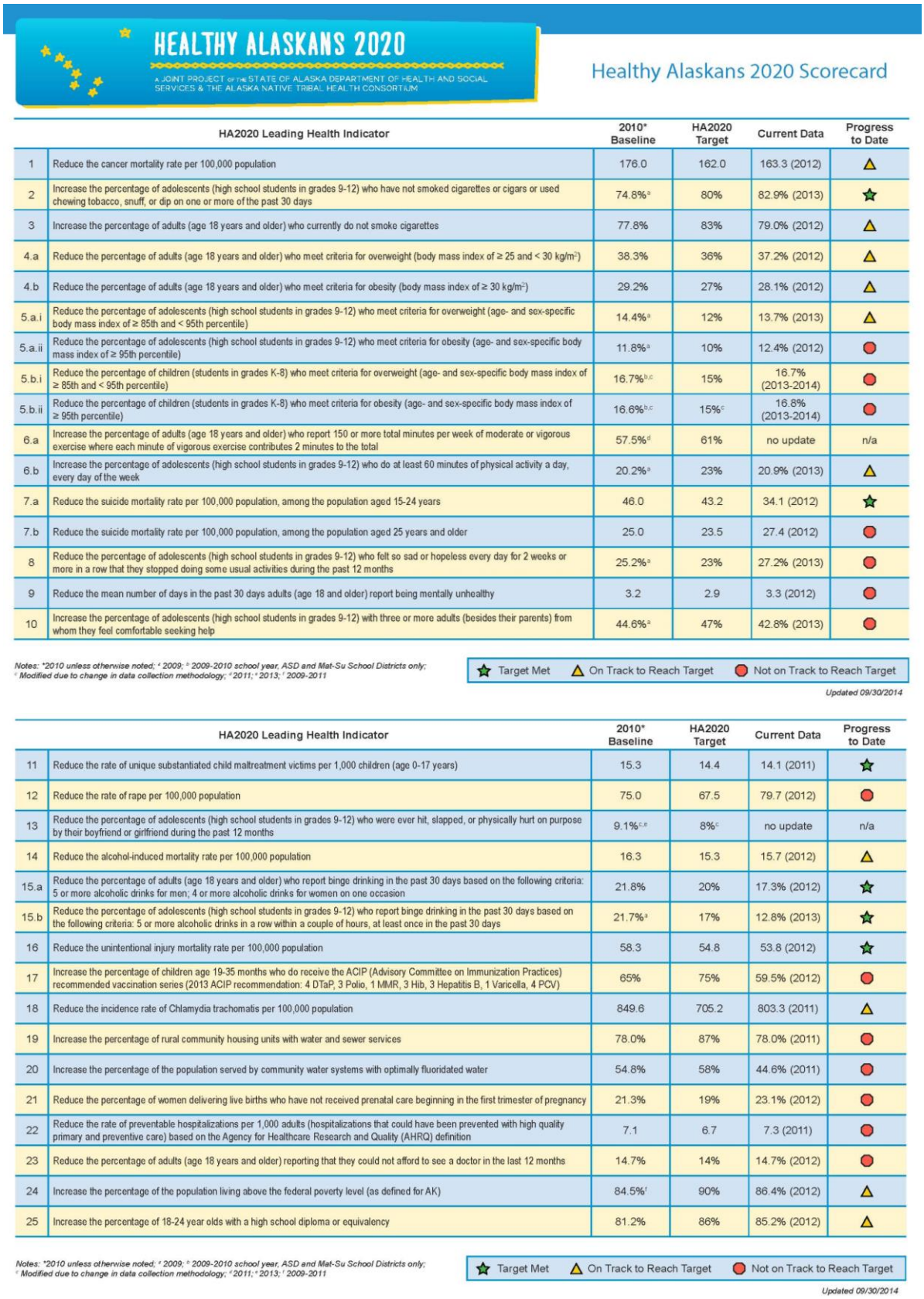
		Most Current U.S. Data	Previous Year's AK Data	Most Current AK Data	Status
Health					
Suicide					
1	Suicide (rate per 100,000)	12.0	20.1	23.2	✗
2	Percent of adults reporting serious thoughts of suicide *(revised indicator)*	3.8%	4.5%	4.4%	✗
Substance Abuse					
3	Alcohol-induced deaths (rate per 100,000)	7.6	29.3	19.2	✗
4	Percent of adults who engage in heavy drinking	6.1%	7.3%	6.5%	⟺
5	Percent of adults who engage in binge drinking	16.9%	20.2%	17.3%	⟺
6	Percent of population (age 12 and older) who use illicit drugs	9.0%	13.7%	14.0%	✗
Mental Health					
7	Days of poor mental health in past month (adults)	3.5	3.2	3.3	⟺
8	Percent of teens who experienced depression during past year	28.5%	25.9%	27.2%	✗
Access					
9	Percent of population without health insurance	15.4%	18.2%	19.0%	✗
Safety					
Protection					
10	Children abused and neglected (rate per 1,000)	9.2	14.1	15.9	✗
11	Substantiated reports of harm to adults (rate per 1,000)	†	1.2	1.2	⟺
12	Injuries to elders due to falls, hospitalized (rate per 100,000)	1,516	1,020	1,085	✓
13	Traumatic brain injury, hospitalized non-fatal (rate per 100,000)	†	86.9	82.2	✓
Justice					
14	Percent of incarcerated adults with mental illness or mental disabilities	38.7%	42.0%	no new data	✗
15	Rate of criminal recidivism for incarcerated adults with mental illness or mental disabilities	†	36.2%	no new data	⟺
16	Percent of arrests involving alcohol or drugs	†	56.0%	42.9%	⟺
Living With Dignity					
Accessible, Affordable Housing					
17	Chronic homelessness (rate per 100,000)	29.5	37.8	25.1	⟺
Educational Goals					
18	Difference between high school graduation rate for students with and without disabilities *(revised indicator)*	†	26.8%	32.6%	⟺
19	Percent of youth who received special education who are employed or enrolled in post-secondary education one year after leaving school	†	69.2%	58.0%	⟺
Economic Security					
20	Percent of minimum wage income needed to afford average housing	†	79.4%	89.6%	✗
21	Average annual unemployment rate	8.1%	7.6%	7.0%	✓
22	Percent of SSI recipients who are blind or disabled and are working	4.4%	6.5%	6.6%	✓

Prevalence Estimates: Alaska Mental Health Trust Beneficiaries

Alaska Mental Health Trust Beneficiary Population	Number	Population Rate
Serious Mental Illness (ages 18+)	21,754	4.6%
Serious Emotional Disturbance (ages 0 to 17)	12,725	7.2%
Alzheimer's Disease and Related Disorders (ages 60+)	5,000	5.5%
Traumatic brain injury (all ages)	11,900	1.8%
Developmental disabilities (all ages)	12,784	1.8%
Dependent on alcohol (ages 12 to 17)	1,000	1.6%
Dependent on alcohol (ages 18+)	20,000	3.8%

December 2013

Figure 6-4 Healthy Alaskans 2020 Scorecard



HEALTHY ALASKANS 2020

A JOINT PROJECT OF THE STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES & THE ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Healthy Alaskans 2020 Scorecard

	HA2020 Leading Health Indicator	2010* Baseline	HA2020 Target	Current Data	Progress to Date
1	Reduce the cancer mortality rate per 100,000 population	176.0	162.0	163.3 (2012)	△
2	Increase the percentage of adolescents (high school students in grades 9-12) who have not smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days	74.8%[a]	80%	82.9% (2013)	★
3	Increase the percentage of adults (age 18 years and older) who currently do not smoke cigarettes	77.8%	83%	79.0% (2012)	△
4.a	Reduce the percentage of adults (age 18 years and older) who meet criteria for overweight (body mass index of ≥ 25 and < 30 kg/m^2)	38.3%	36%	37.2% (2012)	△
4.b	Reduce the percentage of adults (age 18 years and older) who meet criteria for obesity (body mass index of ≥ 30 kg/m^2)	29.2%	27%	28.1% (2012)	△
5.a.i	Reduce the percentage of adolescents (high school students in grades 9-12) who meet criteria for overweight (age- and sex-specific body mass index of ≥ 85th and < 95th percentile)	14.4%[a]	12%	13.7% (2013)	△
5.a.ii	Reduce the percentage of adolescents (high school students in grades 9-12) who meet criteria for obesity (age- and sex-specific body mass index of ≥ 95th percentile)	11.8%[a]	10%	12.4% (2012)	●
5.b.i	Reduce the percentage of children (students in grades K-8) who meet criteria for overweight (age- and sex-specific body mass index of ≥ 85th and < 95th percentile)	16.7%[b,c]	15%	16.7% (2013-2014)	●
5.b.ii	Reduce the percentage of children (students in grades K-8) who meet criteria for obesity (age- and sex-specific body mass index of ≥ 95th percentile)	16.6%[b,c]	15%[c]	16.8% (2013-2014)	●
6.a	Increase the percentage of adults (age 18 years and older) who report 150 or more total minutes per week of moderate or vigorous exercise where each minute of vigorous exercise contributes 2 minutes to the total	57.5%[d]	61%	no update	n/a
6.b	Increase the percentage of adolescents (high school students in grades 9-12) who do at least 60 minutes of physical activity a day, every day of the week	20.2%[a]	23%	20.9% (2013)	△
7.a	Reduce the suicide mortality rate per 100,000 population, among the population aged 15-24 years	46.0	43.2	34.1 (2012)	★
7.b	Reduce the suicide mortality rate per 100,000 population, among the population aged 25 years and older	25.0	23.5	27.4 (2012)	●
8	Reduce the percentage of adolescents (high school students in grades 9-12) who felt so sad or hopeless every day for 2 weeks or more in a row that they stopped doing some usual activities during the past 12 months	25.2%[a]	23%	27.2% (2013)	●
9	Reduce the mean number of days in the past 30 days adults (age 18 and older) report being mentally unhealthy	3.2	2.9	3.3 (2012)	●
10	Increase the percentage of adolescents (high school students in grades 9-12) with three or more adults (besides their parents) from whom they feel comfortable seeking help	44.6%[a]	47%	42.8% (2013)	●

*Notes: *2010 unless otherwise noted; [a] 2009; [b] 2009-2010 school year, ASD and Mat-Su School Districts only; [c] Modified due to change in data collection methodology; [d] 2011; [e] 2013; [f] 2009-2011*

★ Target Met △ On Track to Reach Target ● Not on Track to Reach Target

Updated 09/30/2014

	HA2020 Leading Health Indicator	2010* Baseline	HA2020 Target	Current Data	Progress to Date
11	Reduce the rate of unique substantiated child maltreatment victims per 1,000 children (age 0-17 years)	15.3	14.4	14.1 (2011)	★
12	Reduce the rate of rape per 100,000 population	75.0	67.5	79.7 (2012)	●
13	Reduce the percentage of adolescents (high school students in grades 9-12) who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months	9.1%[c,e]	8%[c]	no update	n/a
14	Reduce the alcohol-induced mortality rate per 100,000 population	16.3	15.3	15.7 (2012)	△
15.a	Reduce the percentage of adults (age 18 years and older) who report binge drinking in the past 30 days based on the following criteria: 5 or more alcoholic drinks for men; 4 or more alcoholic drinks for women on one occasion	21.8%	20%	17.3% (2012)	★
15.b	Reduce the percentage of adolescents (high school students in grades 9-12) who report binge drinking in the past 30 days based on the following criteria: 5 or more alcoholic drinks in a row within a couple of hours, at least once in the past 30 days	21.7%[a]	17%	12.8% (2013)	★
16	Reduce the unintentional injury mortality rate per 100,000 population	58.3	54.8	53.8 (2012)	★
17	Increase the percentage of children age 19-35 months who do receive the ACIP (Advisory Committee on Immunization Practices) recommended vaccination series (2013 ACIP recommendation: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella, 4 PCV)	65%	75%	59.5% (2012)	●
18	Reduce the incidence rate of Chlamydia trachomatis per 100,000 population	849.6	705.2	803.3 (2011)	△
19	Increase the percentage of rural community housing units with water and sewer services	78.0%	87%	78.0% (2011)	●
20	Increase the percentage of the population served by community water systems with optimally fluoridated water	54.8%	58%	44.6% (2011)	●
21	Reduce the percentage of women delivering live births who have not received prenatal care beginning in the first trimester of pregnancy	21.3%	19%	23.1% (2012)	●
22	Reduce the rate of preventable hospitalizations per 1,000 adults (hospitalizations that could have been prevented with high quality primary and preventive care) based on the Agency for Healthcare Research and Quality (AHRQ) definition	7.1	6.7	7.3 (2011)	●
23	Reduce the percentage of adults (age 18 years and older) reporting that they could not afford to see a doctor in the last 12 months	14.7%	14%	14.7% (2012)	●
24	Increase the percentage of the population living above the federal poverty level (as defined for AK)	84.5%[f]	90%	86.4% (2012)	△
25	Increase the percentage of 18-24 year olds with a high school diploma or equivalency	81.2%	86%	85.2% (2012)	△

*Notes: *2010 unless otherwise noted; [a] 2009; [b] 2009-2010 school year, ASD and Mat-Su School Districts only; [c] Modified due to change in data collection methodology; [d] 2011; [e] 2013; [f] 2009-2011*

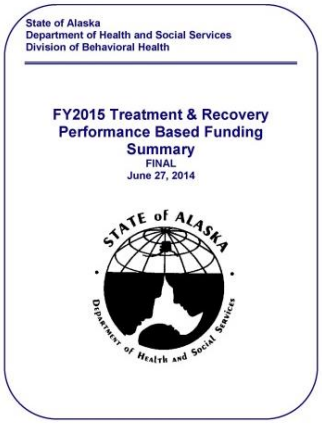
★ Target Met △ On Track to Reach Target ● Not on Track to Reach Target

Updated 09/30/2014

Performance-based Funding

The DBH performance management system uses the Results Based Accountability framework to answer three questions:

1. Quantity: How much do we do?
2. Quality: How well do we do it?
3. Outcomes: Is anybody better off?



Each year, DBH produces a Treatment and Recovery grantee performance-based funding report that includes systems-wide and grantee level report cards.[173] The reports are based on the results of nine performance measures. Each performance measure has a performance threshold and a point scheme for variances above and below the threshold. Points are weighted by question depending on their desired impact on provider funding. The weighted scores are translated into positive or negative adjustments to grantee awards. These nine measures are described here:

1. **Grant Review and Progress Report - DBH Staff Score.** DBH staff scored grantees on the following activities to determine an overall Staff Score for each grantee:

   a. Did grantee participate in community planning on a quarterly basis?
   b. Did grantee spend funds as approved in the grant agreement?
   c. Did grantee submit all required reports (including narrative, AKAIMS, and cumulative fiscal reports) in a timely manner?
   d. Did grantee submit complete quarterly reports?
   e. Did the grantee use the Logic Model to make program improvements?

   Possible PBF Points = -0.75, -0.50, 0.00, +0.25, +0.50, +0.75, +1.00

Threshold Ranges: Staff Score	PBF Points
<= 64%	-0.75
>= 65% and <= 74%	-0.50
>= 75% and <= 84%	0.00
>= 85% and <= 89%	+0.25
>= 90% and <= 94%	+0.50
>= 95% and <= 99%	+0.75
= 100%	+1.00

[173] Results for each fiscal year are available for download here: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

2. **Minimum Data Set - Annual Household Income: Percent of Served Clients with Missing or Bad Data.** This measure identifies the percent of distinct admissions of served clients with missing or bad data for the Minimum Data Set "Annual Household Income" field.

   Possible PBF Points = -1.50, -1.00, -0.50, -0.25, 0.00, +1.00

Threshold Ranges: % With Missing or Bad Data	PBF Points
>= 26%	-1.50
>= 21% and <= 25%	-1.00
>= 16% and <= 20%	-0.50
>= 11% and <= 15%	-0.25
>= 6% and <= 10%	0.00
>= 0% and <= 5%	+1.00

3. **Average Number of Days from Screening (AST) to First Treatment Service.** This measure reports the elapsed period of time from the completion of the Alaska Screening Tool (AST) to the date of the first treatment service. This measure is a proxy for the performance of the treatment system relative to timely access and engagement into treatment services.

   Possible PBF Points = -0.25, 0.00, +0.25, +0.50, +0.75, +1.00

Threshold Ranges: Avg # of Days	PBF Points
>= 36	-0.25
>= 29 and <= 35	0.00
>= 22 and <= 28	+0.25
>= 15 and <= 21	+0.50
>= 8 and <= 14	+0.75
<= 0 and <= 7	+1.00

4. **Percent of Clients Served within 30 Days of Program Enrollment.** This measure reports the percentage of an agency's clients who received a treatment service within 30 days of being enrolled into a program for treatment services. This measure is a proxy for the performance of the treatment system relative to timely access and engagement into treatment services.

   Possible PBF Points = -0.25, 0.00, +0.25, +0.50, +0.75, +1.00

Threshold Ranges: % Served within 30 Days	PBF Points
>= 0% and <= 49%	-0.25
>= 50% and <= 59%	0.00
>= 60% and <= 69%	+0.25
>= 70% and <= 79%	+0.50
>= 80% and <= 89%	+0.75
>= 90%	+1.00

7. **Percent of Clients with Improvement (or No Change) in Quality of Life Domains.** This measure looks at the percentage of clients who self-reported improvement (or no change) over time in the CSR quality of life domain questions. This measure is based on a comparison of the first follow-up CSR to the initial CSR, where the first follow-up CSR occurred during the reporting period.

   For each of the four target populations (SMI, SED, SA Adult, and SA Youth), this measure is based on the sum of the client's responses to the nine quality of life items under CSR Question #16: "How do you feel about.. "

   - Your housing?
   - Your ability to support your basic needs of food, housing, etc.?
   - Your safety in your home or where you sleep?
   - Your safety outside your home?
   - How much people in your life support you?
   - Your friendships?
   - Your family situation?
   - Your sense of spirituality, relationship with a higher power, or meaningfulness of life?
   - Your life in general?

Possible PBF Points = -0.25, 0.00, +0.50, +1.00

Threshold Ranges: Quality of Life Domains - % Improved or Stayed Same	PBF Points
>= 0% and <= 49%	-0.25
>= 50% and <= 69%	0.00
>= 70% and <= 79%	+0.50
>= 80%	+1.00

8. **Percent of Clients Satisfied with Quality of Services.** This measure looks at the percentage of clients who reported satisfaction with the quality of services received. This measure is based on the client's first follow-up CSR, where the first follow-up CSR occurred during the reporting period.

   For each of the four target populations (SMI, SED, SA Adult, and SA Youth), this measure is based on the average of the client's responses to the following two items under CSR Question #18: "How do you feel about the services you received?"

   - I was treated with respect.
   - I was able to get all the services I needed.

Possible PBF Points = -0.25, 0.00, +0.50, +1.00

Threshold Ranges: Quality of Services - % Satisfied	PBF Points
>= 0% and <= 49%	-0.25
>= 50% and <= 69%	0.00
>= 70% and <= 79%	+0.50
>= 80%	+1.00

9. **Percent of Clients Satisfied with Services: Improved Quality of Life.** This measure looks at the percentage of clients who reported satisfaction regarding an improved quality of life resulting from services received. This measure is based on the client's first follow-up CSR, where the first follow-up CSR occurred during the reporting period.

   For each of the four target populations (SMI, SED, SA Adult, and SA Youth), this measure is based on the client's response to the following item under CSR Question #18: "How do you feel about the services you received?"

   - The services improved the quality of my life.

Possible PBF Points = -0.25, 0.00, +0.50, +1.00

Threshold Ranges: Improved Quality of Life - % Satisfied	PBF Points
>= 0% and <= 49%	-0.25
>= 50% and <= 69%	0.00
>= 70% and <= 79%	+0.50
>= 80%	+1.00

Figure 6-5 provides a summary of the overall impact of performance on the redistribution of Treatment and Recovery grant funds.[174] In FY15, 42 of 69 grantees (61 percent) experienced increased funding as a result. The minimum change was $75, the maximum change was $42,632 and the average change was just under $5,000. Thirty-seven of 69 grantees (39 percent) experienced decreased funding as a result. The minimum change was (-$11), the maximum change was (-$48,948) and the average change was just (-$7,735).

Figure 6-5 FY2015 Grant Awards: Overall Impact of Performance on the Redistribution of Grant Funds, by Grant Category

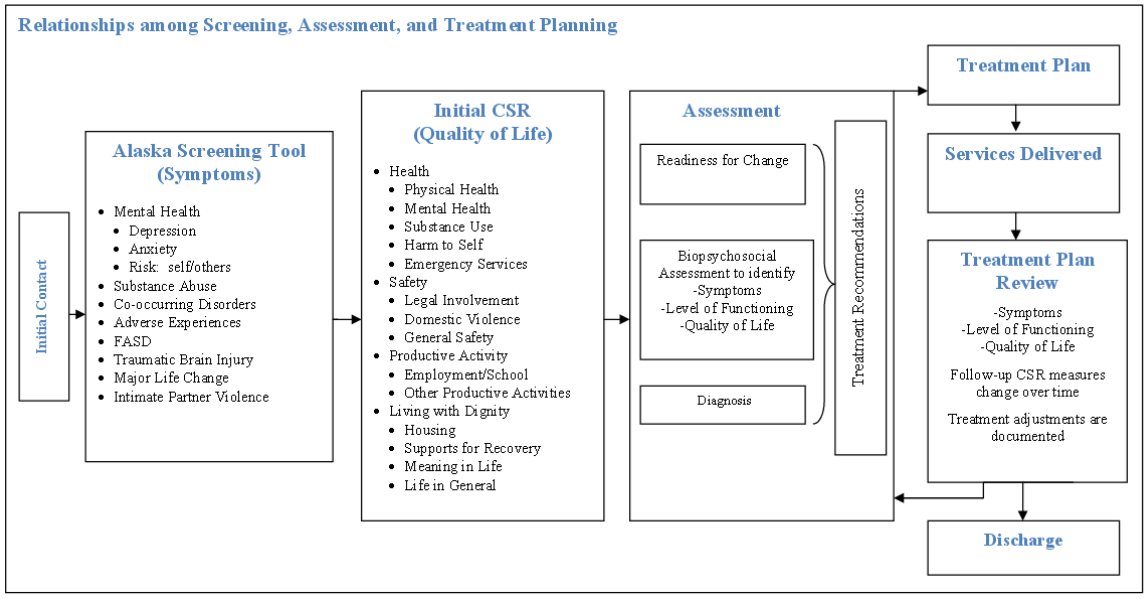
Grant Category: CBHTR (69 Grants with funding subject to PBF)		
	Increased Funding (42 of 69 Grantees = 61%)	Decreased Funding (27 of 69 Grantees = 39%)
Min $ Change	$ 75	$ (11)
Max $ Change	$ 42,632	$ (48,948)
Average $ Change	$ 4,972	$ (7,735)
Min % Change	0.11%	-0.003%
Max % Change	1.70%	-3.91%
Average % Change	0.79%	-1.02%

[174] FY2015 Treatment and Recovery Performance-Based Funding Summary. Final. June 27, 2015. Alaska Division of Behavioral Health Services. Available at: http://dhss.alaska.gov/dbh/Pages/Performance%20Measures/Default.aspx

Client Level Outcomes

DBH tracks information on client outcomes through the Alaska Screening Tool (AST), Behavioral Health Consumer Survey, and the Client Status Review survey. The Alaska Screening Tool (AST) is a tool used by providers to screen for substance abuse, mental illness, co-occurring substance abuse and mental illness, traumatic brain injury (TBI), and Fetal Alcohol Spectrum Disorders (FASD). All DBH Treatment and Recovery grantees are required to administer and submit the AST as a condition of their grant award from the Division of Behavioral Health.[175] The Client Status Review (CSR) is a clinical tool administered at assessment, at 90 to 125 day increments, and again at discharge. Completion of the CSR is Medicaid billable. Figure 6-6 shows how the AST and Initial CSR are used during a typical course of treatment.[176] The Behavioral Health Consumer Survey (BHCS) is administered in two ways: as a point-in-time survey conducted once per year with outpatient treatment clients and as a discharge survey conducted with residential clients. The survey includes questions aimed at evaluating services and outcomes. Trends in data collected show that the majority of the measurable change experienced by a client occurs within the first four to five months of treatment.[177]

Figure 6-6 Use of Alaska Screening Tool and Initial Consumer Status Report during a Typical Course of Treatment



[175] Alaska Screening Tool FY2011 and Initial Client Status Review FY2011: Supporting Clinical Decision-Making and Program Performance Management. 6/30/11. Alaska Division of Behavioral Health. Available at: http://dhss.alaska.gov/dbh/Documents/Resources/pdf/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf

[176] Alaska Screening Tool FY2011 and Initial Client Status Review FY2011: Supporting Clinical Decision-Making and Program Performance Management. 6/30/11. Alaska Division of Behavioral Health. Available at:http://dhss.alaska.gov/dbh/Documents/Resources/pdf/AST%20CSR%20Clinical%20Decision%20Making%202011%20slw%206%2030%2011.pdf

[177] Discussion with Mark Haines-Simeon, former Policy & Planning Section Manager 5/1/14.

In June 2014, the Western Interstate Commission on Higher Education (WICHE) released a report, commissioned by DBH, titled "Connecting the Dots: The Right Data to the Right Person."[178] The purpose of this report was to "provide a synopsis of multiple research and analysis [efforts] conducted to inform and refine the Division's Performance Management System through a continuous quality improvement process." This analysis relied on client data from State Fiscal Years 2011 to 2013. The results included in this report are interspersed through the assessment. In this chapter, we share WICHE's analysis on Mentally Unhealthy Days.

WICHE's analysis first examined two questions to assess the validity of DBH performance measures:

- Question 1: Does the measure discriminate among groups at Intake in ways expected?
- Question 2: Does the measure show significant change from Time 1 to Time 2 that is clinically meaningful?

The analysis included data for adults, youth and children and looked at DBH performance measures at Time 1 (Intake), Time 2 (Four Months Later) and Gain scores (improvement from Time 1 to Time 2). The improvement was profound for clients who were discharged at time 2 (four months later). Meaningful gain was also shown for clients in treatment for mental health, substance abuse and co-occurring disorders.

Figure 6-7 CSR Measures Showing Gain: From Time 1 Intake to Time 2 Four Months Later for Adults

Measure	Gain in Direction Expected	Gain Significant	Meaningful Gain
Mentally Unhealthy Days	Yes	Yes	MH: large for discharges; medium otherwise COD: medium for discharges; small to medium otherwise SA: small for discharges
Quality of Life (overall 9)	Yes	Yes	SA: small COD: medium for discharges; small otherwise MH: small-medium for discharges; small otherwise
Alcohol and Drugs Combined	Yes	Yes	SA: small to medium COD: small to medium MH: small for discharges
Physically Unhealthy Days	Yes	Yes	MH: medium for discharges COD: small-medium for discharges
Activity Limitation Days	Yes	Yes	SA: small MH: large for discharges; small otherwise COD: small to medium for discharges; small-medium not discharged
Legal Involvement	Yes	Yes	SA: small to medium COD: small to medium
Arrested Past 30 Days	Yes	Yes	SA: small COD: small
Arrested Past 12 Months	Yes	Yes	SA: small COD: small for discharges

Source: WICHE 2014.

[178] Connecting the Dots: The Right Data to the Right Person. Western Interstate Commission on Higher Education (WICHE). June 2014. Available at: http://dhss.alaska.gov/dbh/Documents/Connecting%20the%20Dots.pdf

Figure 6-8 CSR Measures Showing Gain: From Time 1 Intake to Time 2 Four Months Later for Youths and Children

Youth Mental Health			
Measure	**Gain in Direction Expected**	**Gain Significant**	**Gain Meaningful**
Mentally Unhealthy Days	Yes	Yes	MH: small-medium for discharges
Quality of Life (overall 9)	Positive to begin		
Alcohol and Drugs Combined	Yes	Yes	
Legal Involvement	Yes	Yes	Small
Child Mental Health			
Mentally Unhealthy Days	Yes	yes	Medium for discharges; small otherwise
Quality of Life (overall 9)	Positive to begin		

Source: WICHE 2014.

WICHE researchers asked a third question:

- Do adult clients report more problems than the general household population?

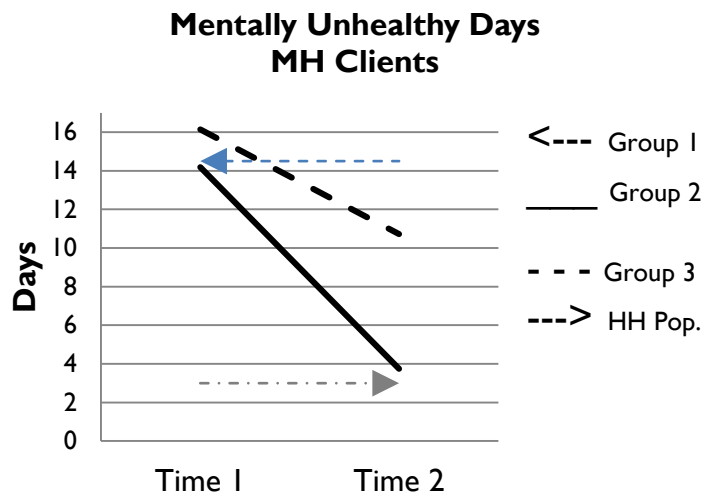
WICHE divided adult clients into three groups:

- Group 1: Includes adult mental health clients with no Time 2 CSR
- Group 3: Includes adult mental health clients with a discharge CSR at Time 2
- Group 3: Includes adult mental health clients with an ongoing CSR at Time 2

WICHE found that:

- For the general Alaskan household (not in treatment), the rate of "Mentally Unhealthy Days" is 3.2 days per month. (Based on BRFSS data)
- For Group 1 clients (at intake), the rate of "Mentally Unhealthy Days" is 14+days per month. No follow up CSR is available.
- For Group 2 clients (at intake), the rate of "Mentally Unhealthy Days" is 14+days per month.
    - Group 2 clients (at discharge) report greatest gains at Time 2. At discharge, they report approximately the same "Mentally Unhealthy Days" as in the general household population (3.2 days).
- For Group 3 clients (at intake) the rate of "Mentally Unhealthy Days" is 16+days per month. While the improvement was less than Cohort 2 at Time 2, they still reported meaningful gain.

Figure 6-9 Mentally Unhealthy Days



The chart on the left depicts *"Mentally Unhealthy Days"* for three mental health client cohorts.

Each group has an Intake (Time 1). The difference between the groups:

- Group 1: has no Time 2 CSR
- Group 2: has a discharge CSR
- Group 3: has an ongoing CSR

The number of *"Mentally Unhealthy Days"* reported by the average household population (HH Pop.)[179] is also shown.

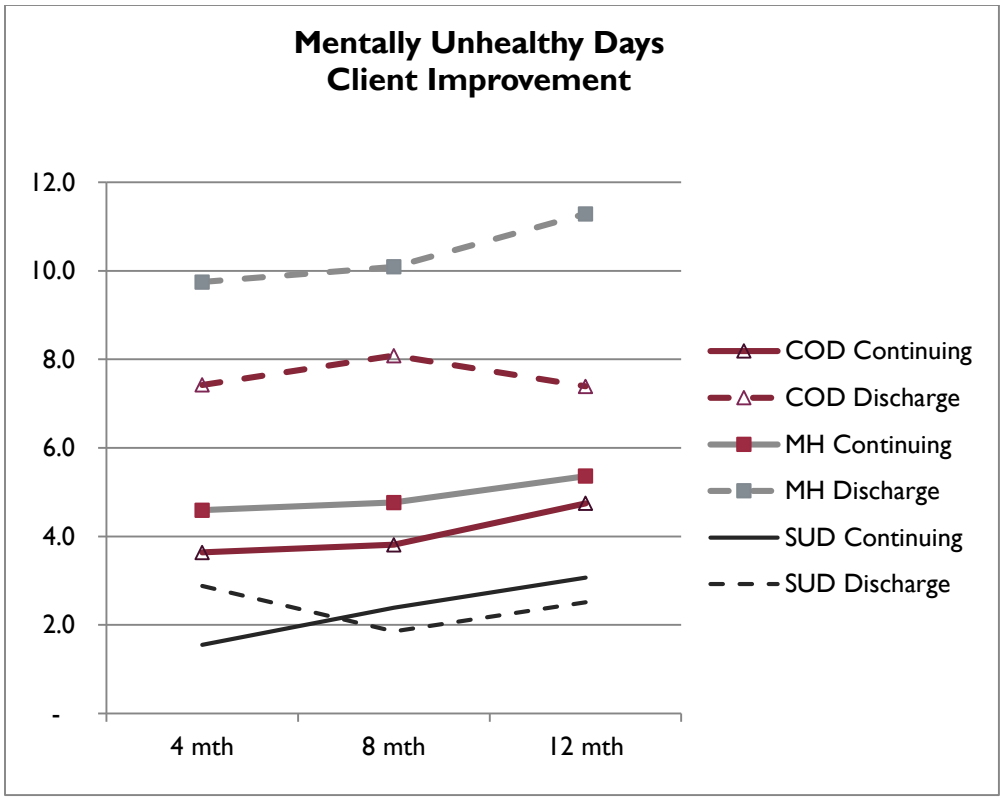
Source: WICHE 2014.

Figure 6-10 shows adult client improvement in mentally unhealthy days over time. The WICHE study found:

> *Clients who were in treatment for mental health who were discharged reported an improvement of 9.7 days at four months, 10.1 days at eight months, and 11.3 days at twelve months (for those who stayed in treatment long enough to report at those intervals). COD clients discharged reported the next highest gains. MH and COD continuing clients reported lower gains (about four days). SA clients also reported gains on this measure though less than MH and COD clients.*

[179] "Mentally Unhealthy Days" is included within the Behavioral Risk Factor Surveillance System Survey (BRFSS), conducted annually on a sampling of Alaskan households. By including BRFSS questions within the CSR, the Division is able to compare "general household" and behavioral health clients receiving treatment services.

Figure 6-10 Adult Client Improvement in Mentally Unhealthy Days at four, eight, and twelve months.



Dashed lines show clients at discharge. The most gain for each client group is reported by clients at discharge. This is reasonable and expected. Clients continuing in service are shown with solid lines. They also show improvement from Intake at Time 1 to Time 2 Four months later. Source: WICHE 2014.

While more work needs to be done, the available evidence suggests DBH-funded Treatment and Recovery grantees are providing services that improve the lives of clients who engage in services.

7. WHO PAYS AND HOW MUCH DOES IT COST?

One of the many strengths of Alaska's behavioral health system is the way in which service organizations leverage State Medicaid and Behavioral Health funds with multiple other funding streams to provide behavioral health services to a broad range of clients. This blending of funds and leadership did not always make it easy to establish clear boundaries for the analysis described in this report. This section provides a brief overview of the major funding sources contributing to the provision of publicly-funded behavioral health services and then explores in more detail State-Medicaid and Behavioral Health-funding.

Major Funding Sources

Behavioral health services are funded through State general funds, the Alaska Mental Health Trust Authority, as well as a number of federal entities that award funds to the State of Alaska or to Tribal Health Organizations to manage and distribute. Ten major funding streams support Alaska's publicly-funded behavioral health system:

Figure 7-1 Funding Sources Supporting Alaska's Publicly-funded Behavioral Health System

Funding Source	Funds Disbursed to:	Service Requirements, Eligible Clients and Additional Requirements

State of Alaska General Funds	DHSS Division of Behavioral Health, which administers the DBH State Medicaid Program and competitively grants funds to sub-recipients Alaska service providers, Tribal and non-Tribal, operates the Alaska Psychiatric Institute
	
	General funds dollars are also allocated to the DHSS Division of Healthcare Services to administer the Alaska Medical Assistance Program.
		Alaska's State Mental Health Services Act establishes the State's responsibility to provide public behavioral health services to Alaskans in need. Alaska Statute specifies that the Department of Health and Social Services shall
		• (1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 47.30.056 (i); the preparation of the plan and any revision or amendment of it shall
		  ○ (A) be made in conjunction with the Alaska Mental Health Trust Authority;
		  ○ (B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;
		• (2) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan. [180]

Centers for Medicare and Medicaid Services (CMS) Medicaid Funds (federal portion)	Alaska State Medicaid Programs administered by DHSS Division of Behavioral Health and Division of Healthcare Services	Federal Medicaid Assistance Percentages (FMAP) are the federal share of Medicaid costs. FMAP varies across service settings ranging from 50% to 100% federal match. Medicaid defines eligibility for its services based on the income level and health condition of the client. The income-based eligibility requirements are based on a specific percentage of the federal poverty guidelines for Alaska, which are updated annually and defined for household size.

[180] AS 47.30.660. Powers and Duties of Department.

Funding Source	Funds Disbursed to:	Service Requirements, Eligible Clients and Additional Requirements
		In Alaska, children, pregnant women, and disabled adults are eligible for Medicaid at federal poverty levels ranging from 177% to 203% of the federal poverty guideline. Parents and caretaker adults and adults under 21 are eligible if their income is at or below 120% of the federal poverty guideline.[181]
Centers for Medicare and Medicaid Services (CMS) Medicaid Disproportionate Share Hospital (DSH) Funds (federal portion)	DBH-Administered State Medicaid Program, and then to four hospitals, including Alaska Psychiatric Institute (API)	The Medicaid DSH program in Alaska is equally funded by the federal and state government (50% federal funds, and 50% state funds).[182] Each state receives a certain allotment of funds and Alaska used just 50 percent of its allotment in 2013. Four hospitals in Alaska are currently funded by the Medicaid DSH program to provide emergency psychiatric response and treatment. Thirty-three percent of the federal allotment must be spent on eligible Institutes for Mental Diseases (IMD), but the funds can be used to cover the costs of broader uncompensated care. API is the only hospital that meets IMD DSH criteria, and they received 33% of the 2013 federal allotment, matched by state general funds. The Affordable Care Act set in place a timetable to reduce allotments of DSH fund starting in 2014 under the theory that increased access to care and Medicaid expansion would significantly decrease uncompensated care.
SAMSHA Substance Abuse Prevention and Treatment Block Grant (SABG) [183]	DHSS Division of Behavioral Health, which competitively grants funds to sub-recipients Alaska service providers, Tribal and non-Tribal	Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. The SABG program targets the following populations and service areas: • Pregnant women and women with dependent children • Intravenous drug users • Tuberculosis services • Early intervention services for HIV/AIDS • Primary prevention services
SAMSHA Community Mental Health Services Block Grant (MHBG)	DHSS Division of Behavioral Health, which competitively grants funds to Alaska service providers, Tribal and non-Tribal	The MHBG program targets: • Adults with serious mental illnesses. Includes persons age 18 and older who have a diagnosable behavioral, mental, or emotional condition—as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Their condition substantially interferes with, or limits, one or more major life activities, such as: ○ Basic daily living (for example, eating or dressing) ○ Instrumental living (for example, taking prescribed medications or getting around the community) ○ Participating in a family, school, or workplace • Children with serious emotional disturbances. Includes persons up to age 18 who have a diagnosable behavioral, mental, or emotional issue (as defined by the DSM). This condition results in a functional impairment that substantially

[181] http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf

[182] All content pulled verbatim or close to verbatim from: Overview of DSH Funding in Alaska. Alaska State Hospital & Nursing Home Association. November 2013.

[183] http://www.samhsa.gov/grants/block-grants

Funding Source	Funds Disbursed to:	Service Requirements, Eligible Clients and Additional Requirements
		interferes with, or limits, a child's role or functioning in family, school, or community activities.
Indian Health Service (IHS)	Tribal Health Organizations through the Alaska Tribal Health Compact	The Indian Health Service is the health care system for federally recognized American Indian and Alaska Natives in the United States Eligibility, program performance monitoring, and reporting requirements vary for recipients of Title I and Title V funds. Each of the 13 Title I contracts are unique and statutory requirements include typical performance management duties on behalf of IHS and the contracting entity. In contrast, funding agreements are negotiated with Title V entities and each Title V agency has the right to budget and redistribute funds as they wish. Tribes are not required to submit expenditure or service data to IHS. Unlike with other federal monies, Government Performance and Results Act (GPRA) reporting requirements are optional. The only statutory requirement is an annual audit. [184] The Indian Health Service Division of Behavioral Health provides advocacy, guidance and program funding to Tribal Health Organizations. IHS distributes funds by formula to the participating THOs in the Alaska Tribal Health Compact; Tribal Health Organizations each determine how to allocate funding to meet the specific needs of their regions. THOs also apply for funding from other state, federal and private sources to supplement IHS funds, as well as bill third party payers. IHS funds are used by Tribal Health Organizations to cover the costs of health services that cannot be billed or allocated to other payers or grant sources.
Indian Health Service Behavioral Health Aide (BHA) grant funds	Alaska Native Tribal Health Consortium and then sub-granted to Tribal Health Organizations	The BHA Program aims to promote the behavioral health and wellness of Alaska Native people by funding the training and salaries of a village-based workforce.[185]
HRSA 330 funding for Community Health Centers	Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing.	Community Health Centers are required to provide a full spectrum of primary health services; "behavioral and mental health and substance abuse services" are considered "additional health services", which are services that are not included as required primary health services but that may be delivered as appropriate. Health centers are public and private non-profit health care organizations that comply with Federal requirements to • Serve a medically underserved population, • Provide appropriate and necessary services with fees adjusted on patients' ability to pay, • Demonstrate sound clinical and financial management, and • Be governed by a board, most of whose members are being served by the health center. Most health centers apply for and receive Health Center Program grant funding that constitutes a portion of their operating revenue. The remainder comes from Medicaid, Medicare, private insurance, patient fees and other resources.
Alaska Mental Health	The Trustees are responsible for overseeing	Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust, to

[184] Indian Health Service Alaska website: http://www.ihs.gov/alaska/, confirmed in interview with Angel Dotomain, Office of Tribal Programs Director, Indian Health Service Alaska Area Office on 8/20/14.

[185] Excerpted from a PowerPoint presentation provided by the ANTHC Behavioral Health Program on 3/19/15.

Funding Source	Funds Disbursed to:	Service Requirements, Eligible Clients and Additional Requirements
Trust Authority	the mental health budget bill that is transmitted to the State for consideration; the Trustees also provide small grants and other support to organizations that serve beneficiaries	improve the lives of beneficiaries. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program. Beneficiaries of the Trust include the following broad groups of Alaskans with:[186] • mental illness • developmental disabilities • chronic alcoholism and other substance related disorders • Alzheimer's disease and related dementia • traumatic brain injuries

State Medicaid Payments for Behavioral Health Services

In State Fiscal Year 2013, the State of Alaska issued a total of $197,034,641 in State Medicaid payments for behavioral health services (not including Tribal settlement dollars, which represent the monetary difference between fee for service payments and Tribal encounter rate payments due). This figure is based on claims data for services provided to all Medicaid clients who received services from behavioral health-specific provider types, as well Medicaid clients who received services from other providers of behavioral health services who had a primary or secondary behavioral health service. As a relative measure, in State Fiscal Year 2013, the total enacted State operating budget was $8.617 billion.[187] DBH uses 50 percent FMAP to estimate the breakdown of State General Funds and federal funds for all non-Tribal service settings and 100 percent FMAP for Tribal service settings.[188] Using DBH's FMAP allocations for FY13, we estimate that $92,253,210 or 47 percent of the $197,034,641 total Medicaid dollars spent were paid for by State General Funds.

Figure 7-2 shows the breakdown of Medicaid payments by provider type for State Fiscal Years 2009-2013. In State Fiscal Year 2013, payments to DBH Treatment and Recovery grantees, including Residential Care for Children and Youth totaled $106,340,860 or 54 percent of the total payments made.

[186] Alaska Mental Health Trust Authority website: http://mhtrust.org/about/beneficiaries/

[187] State of Alaska Office of Management and Budget https://www.omb.alaska.gov/ombfiles/13_budget/PDFs/FY2013_Enacted_Less_Vetoes_Fiscal_Summary.pdf

[188] The 100 percent FMAP is used for modeling even though not all Medicaid enrollees served by Tribal Health Organizations are Alaska Native and, thus, eligible for the 100 percent match. Referenced from SY09-SFY14 Lolipop Charts Data Sheets 1-29-15 v5, provided by DBH on 7/1/15. DBH roll-up estimate for the FMAP percentage breakdown for DBHTR grantee Medicaid payments was 53.5%. We applied this percentage to the DBHTR provider type to produce the estimate of general to federal dollars included in this paragraph.

Figure 7-2 Alaska Total Annual Medicaid Payments for Behavioral Health Clients by Provider Type SFY2009-2013

Alaska Total Annual Medicaid Payments for Behavioral Health Clients by Provider Type SFY2009-2013 Based on fee for service amounts only					
Provider Type	**2009**	**2010**	**2011**	**2012**	**2013**
Inpatient Institutional					
Private Acute Care Hospital	$10,457,410	$11,046,220	$11,424,787	$11,846,945	$10,742,832
Tribal Acute Care Hospital	$1,194,932	$1,225,166	$1,426,801	$1,261,303	$1,365,070
Inpatient Psychiatric Hospital	$14,667,019	$15,421,068	$16,152,199	$15,832,266	$15,482,534
Alaska Psychiatric Institute (API)	$3,141,201	$3,350,275	$2,803,810	$3,148,841	$3,023,999
Residential Psychiatric Treatment Center (RPTC)	$41,537,007	$35,963,899	$34,648,058	$36,998,436	$33,606,563
Outpatient Institutional - Hospital BH Services					
Private Outpatient Hospital*	$4,066,396	$5,110,439	$5,895,809	$6,092,246	$5,828,500
Tribal Outpatient Hospital*	$1,114,459	$1,329,517	$1,658,640	$1,729,384	$1,655,222
DBH Providers – Community-based Professional BH Services					
All DBH Treatment and Recovery Providers, including RCCY **	$80,825,176	$99,860,264	$105,066,567	$105,085,954	$106,340,860
Other Community-based Professional BH Services					
Psychologists+	$1,486,587	$1,824,328	$2,104,934	$2,507,805	$2,686,704
Mental Health Physician's Clinic	$1,806,893	$2,055,563	$1,974,309	$2,039,192	$1,553,299
Tribal Health Clinic	$2,491,416	$2,731,561	$3,062,757	$2,403,555	$2,064,068
Rural Health Clinic	$784,705	$1,135,256	$1,279,088	$1,554,729	$1,825,960
Other Professional BH Services					
Physicians++	$5,720,357	$7,858,304	$9,069,815	$9,906,103	$10,620,096
Advanced Nurse Practitioners	$655,532	$376,560	$198,407	$165,578	$238,934
Total	**$169,949,090**	**$189,288,420**	**$196,765,982**	**$200,572,337**	**$197,034,641**

General notes: This table includes claims data from the Alaska Medicaid JUCE database for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and they had a primary or secondary behavioral health diagnosis. All data was provided by the Alaska Department of Health and Social Services' Division of Behavioral Health.

^ This row reflects only DET clients who received hospital services that were paid for by the Division of Behavioral Health at four designated Private and Tribal Acute Care Hospitals across the state. (clients receiving only transport services were excluded.).

^^ Statewide and Anchorage API service counts for 2009 are low because only a partial dataset was available.

* Includes Emergency Departments. ** Includes Community Behavioral Health Clinics (formerly called Community Mental Health Clinics and Alcohol and Drug Abuse Centers), Day Treatment Facilities, and Residential Care for Children and Youth Facilities in an unduplicated count.

+ Includes individual and group psychologists in an unduplicated count. ++ Includes individual and group physicians in an unduplicated count.

In addition to the above Medicaid payments, Figure 7-3 shows the Tribal settlement payments (reported by calendar year) issued from 2007 through April 2013.[189] These payments are eligible for 100% FMAP and represent payments made with federal funds. The fact that our data does not reflect these payments has the benefit of providing an apples to apples view of the level of billing activity (since all payments reflect the fee for service rate schedule) across provider types.

Figure 7-3 Tribal Behavioral Health Settlements Cumulative as of April 2013

	MH 2007	MH 2008	MH 2009	MH 2010	MH 2011	MH 2012	MH 2013
	.	.	.	.	.	.	.
Alaska Native Tribal Health Consort	.	.	.	.	.	.	.
Aleutian/Pribilof Islands Association	.	.	.	.	$2,088.00	$10,763.00	.
Arctic Slope Native Association	.	.	.	.	.	.	.
Bristol Bay Area Health Corp	$478,863.75	$631,282.63	$539,429.00	$549,310.00	$681,128.75	$976,562.50	$35,978.00
Chugachmiut	.	.	.	.	.	.	.
Cook Inlet Tribal Council	$132,657.50	$256,641.75	$639,912.00	$624,814.50	$496,261.50	$312,517.00	.
Copper River Native Assoc	$141,227.50	$75,963.05	$56,488.00	$104,037.12	$54,229.00	$161,288.00	.
Council of Athabascan Tribal Govt	.	.	.	.	.	.	.
Eastern Aleutian Tribes	.	$9,834.25	$48,758.00	$19,589.50	$21,652.40	$20,543.00	.
Fairbanks Native Association	$161,617.50	$636,622.50	$356,554.00	$685,659.00	$590,897.00	$1,554,773.00	$4,310.00
Hoonah Indian Association	$13,310.00	.	.	.	.	.	.
Kenaitze Indian Tribe	$525,852.50	$1,145,400.50	$586,725.50	$908,262.00	$1,629,220.00	$1,873,497.49	$13,172.00
Ketchikan Indian Community	$400.00	$58,356.04	$269,298.14	$55,498.02	$18,450.00	$179,973.40	.
Kodiak Area Native Assoc	.	.	.	.	.	$157,314.00	.
Maniilaq Association	.	$30,070.75	.	.	$18,198.00	$24,879.00	$4,111.00
Metlakatla Indian Comm	$833,756.00	$842,301.00	$571,001.00	$368,599.00	$14,320.00	$505,820.00	.
Norton Sound Health Corp	$44,105.00	$268,961.75	$263,123.25	$280,102.50	$189,689.00	$342,032.00	$2,665.00
Seldovia Village Tribe	.	.	.	.	.	.	.
Southcentral Foundation	$4,331,183.36	$6,256,237.75	$5,991,771.25	$7,099,608.15	$7,186,884.33	$4,744,277.28	$31,339.00
Southeast AK Reg Health Consort	$126,078.74	$224,740.27	$257,916.34	$376,589.36	$940,890.05	$1,293,087.64	$1,135.00
Tanana Chiefs Conf	$235,617.50	$450,139.00	$453,960.83	$134,424.00	$180,895.00	$502,723.28	.
Yukon-Kuskokwim Health Corp	$1,447,225.05	$2,237,255.00	$2,349,352.15	$2,063,738.50	$1,507,755.25	$1,026,491.52	$855.00
Total	$8,471,894.40	$13,123,806.24	$12,384,289.46	$13,270,231.65	$13,532,558.28	$13,686,542.11	$93,565.00

Figure 7-4 includes the average annual cost per client by provider type. The average cost per client across all provider types was $7,239. The Residential Psychiatric Treatment Center (RPTC) provider type marks the highest average cost per client at $56,768. In State Fiscal Year 2013, the average annual cost per client served by DBH Treatment and Recovery grantees, including Residential Care for Children and Youth, was $10,379. The average cost per client served at API was $11,118. Note that Medicaid payments do not necessarily equate to cost of care. For example, DBH estimated the average annual cost per client at $24,831 in FY14. This figure takes into account all payers: Medicaid, Medicare, self-pay, third party and State general funds.[190]

[189] Extracted from: **Tribal Medicaid Activity Report. Federal Fiscal Year 2012.** This report provides an overview of total claims paid by the State of Alaska Medicaid program during Federal Fiscal Year 2012 for services provided by Tribal Health Organizations and is meant as a tool for use by Tribal Health Organizations and providers to identify services that may be expanded upon to maximize Tribal Medicaid Claiming Opportunities. The table included here can be found on page 18. This report has not been produced since Federal Fiscal Year 2012 (per a discussion with Renee Gayhart, DBH Tribal Health Program Manager, November 2014).

[190] Referenced from SY09-SFY14 Lollipop Charts Data Sheets 1-29-15 v5, provided by DBH on 7/1/15.

Figure 7-4 Alaska Average Annual Medicaid Payments per Behavioral Health Client by Provider Type 2009-2013

Alaska Average Annual Medicaid Payments per Behavioral Health Client by Provider Type 2009-2013 Based on fee for service amounts only					
Provider Type	**2009**	**2010**	**2011**	**2012**	**2013**
Inpatient Institutional					
Private Acute Care Hospital	$12,691	$12,741	$12,167	$13,266	$13,101
Tribal Acute Care Hospital	$7,331	$5,063	$5,530	$5,508	$7,223
Inpatient Psychiatric Hospital	$20,147	$21,689	$21,253	$21,424	$23,177
Alaska Psychiatric Institute (API)	$15,785	$14,759	$11,982	$10,972	$11,118
Residential Psychiatric Treatment Center (RPTC)	$58,503	$58,669	$55,260	$59,965	$56,768
Outpatient Institutional - Hospital BH Services					
Private Outpatient Hospital*	$749	$819	$878	$846	$820
Tribal Outpatient Hospital*	$598	$597	$670	$702	$695
DBH Providers – Community-based Professional BH Services					
All DBH Treatment and Recovery Providers, including RCCY **	$9,025	$10,539	$10,348	$10,173	$10,379
Other Community-based Professional BH Services					
Psychologists+	$1,602	$1,532	$1,555	$1,619	$1,715
Mental Health Physician's Clinic	$741	$1,020	$952	$1,008	$817
Tribal Health Clinic	$958	$932	$944	$808	$816
Rural Health Clinic	$399	$496	$521	$546	$617
Other Professional BH Service					
Physicians++	$515	$589	$608	$638	$687
Advanced Nurse Practitioners	$331	$376	$609	$602	$715
Average Cost Across All Provider Types	$7,586	$7,676	$7,281	$7,203	$7,239

General notes: This table is based claims data from the Alaska Medicaid JUCE database and includes claims data for all individuals who received services from behavioral health specific provider types and for individuals who received services from other providers of behavioral health services and they had a primary or secondary behavioral health diagnosis. The average is calculated by dividing total Medicaid payments by total Medicaid clients. All data was provided by the Alaska Department of Health and Social Services' Division of Behavioral Health.

^ This row reflects only DET clients who received hospital services that were paid for by the Division of Behavioral Health at four designated Private and Tribal Acute Care Hospitals across the state. (clients receiving only transport services were excluded.).

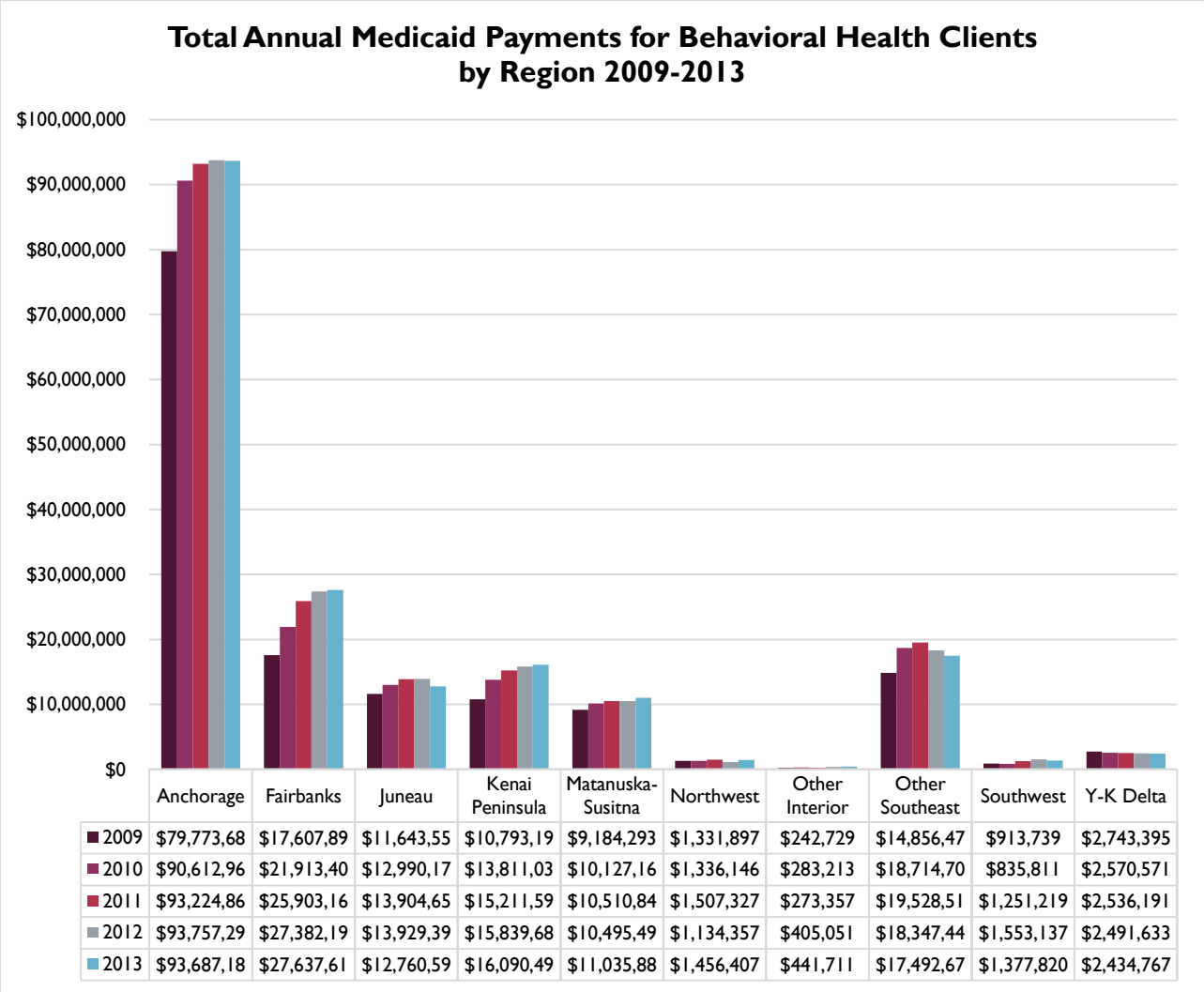
^^ Statewide and Anchorage API service counts for 2009 are low because only a partial dataset was available.

* Includes Emergency Departments. ** Includes Community Behavioral Health Clinics (formerly called Community Mental Health Clinics and Alcohol and Drug Abuse Centers), Day Treatment Facilities, and Residential Care for Children and Youth Facilities in an unduplicated count.

+ Includes individual and group psychologists in an unduplicated count. ++ Includes individual and group physicians in an unduplicated count.

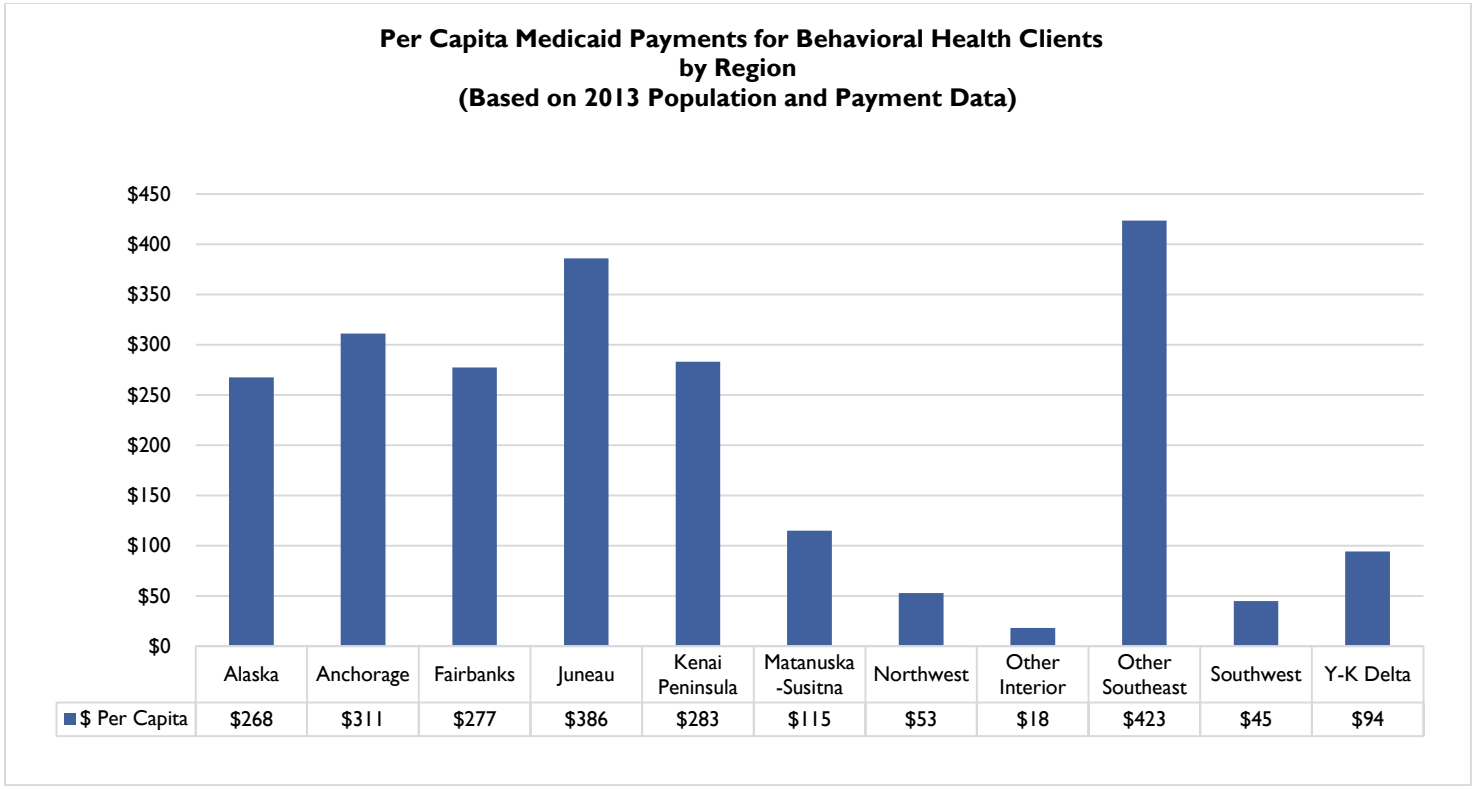
The next two tables provide a look at regional trends. Nearly half (47.5 percent) of all Medicaid payments in 2013 were made for services rendered in Anchorage. Medicaid billing activity is lowest in the Other Interior, Southwest, Northwest, and Y-K Delta reporting regions. While this trend corresponds with smaller population sizes, we also see the lowest per capita Medicaid payments in these regions. Please note that in an effort to gauge regional provider capacity, all regional Medicaid Payments are based on service location not the client's home community.

Figure 7-5 Total Annual Medicaid Payments for Behavioral Health Clients by Region 2009-2013



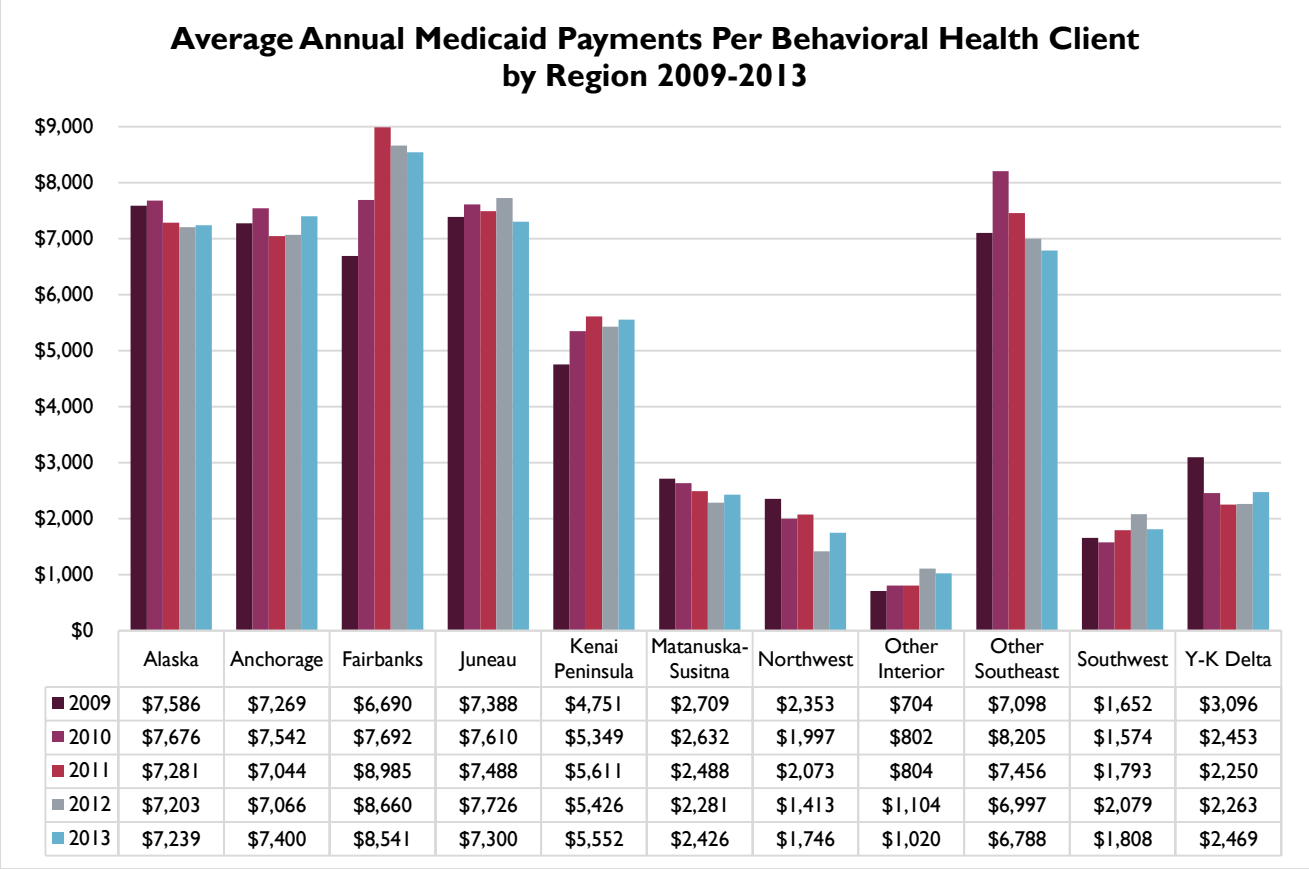
	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
2009	$79,773,68	$17,607,89	$11,643,55	$10,793,19	$9,184,293	$1,331,897	$242,729	$14,856,47	$913,739	$2,743,395
2010	$90,612,96	$21,913,40	$12,990,17	$13,811,03	$10,127,16	$1,336,146	$283,213	$18,714,70	$835,811	$2,570,571
2011	$93,224,86	$25,903,16	$13,904,65	$15,211,59	$10,510,84	$1,507,327	$273,357	$19,528,51	$1,251,219	$2,536,191
2012	$93,757,29	$27,382,19	$13,929,39	$15,839,68	$10,495,49	$1,134,357	$405,051	$18,347,44	$1,553,137	$2,491,633
2013	$93,687,18	$27,637,61	$12,760,59	$16,090,49	$11,035,88	$1,456,407	$441,711	$17,492,67	$1,377,820	$2,434,767

Figure 7-6 Per Capita Medicaid Payments for Behavioral Health Clients by Region



In Figure 7-7, we see that the statewide average annual Medicaid payments per behavioral health client was $7,239 in State Fiscal Year 2013. Among the reporting regions, Other Interior, Northwest, Southwest, Y-K Delta, and Mat-Su Borough have the lowest average annual Medicaid payments per behavioral health client.

Figure 7-7 Average Annual Medicaid Payments per Behavioral Health Client by Region 2009-2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska-Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
2009	$7,586	$7,269	$6,690	$7,388	$4,751	$2,709	$2,353	$704	$7,098	$1,652	$3,096
2010	$7,676	$7,542	$7,692	$7,610	$5,349	$2,632	$1,997	$802	$8,205	$1,574	$2,453
2011	$7,281	$7,044	$8,985	$7,488	$5,611	$2,488	$2,073	$804	$7,456	$1,793	$2,250
2012	$7,203	$7,066	$8,660	$7,726	$5,426	$2,281	$1,413	$1,104	$6,997	$2,079	$2,263
2013	$7,239	$7,400	$8,541	$7,300	$5,552	$2,426	$1,746	$1,020	$6,788	$1,808	$2,469

Regional Medicaid payment trends indicate potential for untapped Medicaid billing capacity and highlight the current dependence on State grant funds. In light of declining State revenues, grant funds are expected to decline in future years. Here too, Medicaid expansion comes into play. From a State budget perspective, the downside of expanding coverage to a larger cross-section of the population is the additional State funds that will be required as the federal match declines (from 100% in FY 2016 and reducing to 91.3% beginning in FY 2021.)[191] As of this writing, the State's timeline for Medicaid expansion is uncertain. On July 16, 2015, the Governor announced he would use his executive power to expand Medicaid expansion. In the Healthy Alaska Plan published in February 2015, DHSS estimates the resulting cost savings to be $6.5 million in FY 2016 through proportional reductions in programs funded by the general fund that currently serve this uninsured population; estimated savings from these offsets hold steady at $3.3 million in FY 2021.[192] Notably, assumptions around cost savings include a $1 million reduction in behavioral health grant dollars in FY 2016, up to a $16 million reduction in FY 2021.[193] This amount of lost revenue will not be easy for Tribal and non-Tribal behavioral health providers to absorb, especially at a time when demand for behavioral health services is expected to increase.

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[191] Evergreen Economics. February 6, 2015 Memorandum to Valerie Davidson, Commissioner of AK DHSS re Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning FY2016.

[192] Alaska Department of Health and Social Services. The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets. February 2015.

[193] Ibid.

Recognizing the increasing importance of Medicaid as a revenue source for the behavioral health system, significant capacity building measures are needed to build Medicaid billing capacity for behavioral health services across all regions and provider types. A strong behavioral health system that is capable of tapping its full Medicaid billing potential is essential to meet existing and anticipated demand for behavioral health services enabled by Medicaid expansion, increased private insurance coverage through the individual exchange, efforts for mental health parity, and Patient-Centered Medical Home and coordinated care initiatives. It is also critical to improving the health of Alaskans and reducing health care costs overall.

STATE MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

In 2013, $21,706,475 in State-behavioral health spending came from State Medicaid Disproportionate Share Hospital (DSH) funds.[194] The purpose of these funds is to help hospitals offset the costs of uncompensated care. Thirty-three percent of the funds used by a state must be spent on eligible Institutes for Mental Diseases (API is the only hospital that meets that criteria in the state). In Alaska, DSH funds are used for psychiatric emergency response and treatment services at four hospitals.[195]

Figure 7-8 Medicaid DSH Payments by the State of Alaska in 2013 to Eligible Hospitals

Medicaid DSH Payments by the State of Alaska in 2013 to Eligible Hospitals				
Name of Facility	**Federal Share DSH**	**State Share DSH**	**Total Payment Amount**	**DSH Program**
Alaska Psychiatric Hospital	$7,062,870	$7,062,870	$14,125,740	IMD
Bartlett Regional Hospital	$1,378,931	$1,378,931	$2,757,861	DET
Fairbanks Memorial Hospital	$1,145,928	$1,145,928	$2,291,855	DET
Providence AK Medical Center	$1,265,510	$1,265,510	$2,531,019	SPEP
TOTAL PAYMENTS	$10,853,238	$10,853,238	$21,706,475	

Notes: Table from Overview of DSH Funding in Alaska. Alaska State Hospital & Nursing Home Association (ASHNHA). November 2013.
Source citation: From Letter to Dennis Murray, ASHNHA, from Jared Kosin, DHSS Office of Rate Review, 10-24-2013.

According to ASHNHA, the total federal allotment for Medicaid DSH to the State of Alaska was $21,402,636 in 2013. Due to the lack of State matching funds, federal DSH spending in 2013 was just $10,853,238, leaving $10,549,398 of the federal allotment unused.[196] As described in the table at the beginning of this section, the Affordable Care Act calls for federal DSH spending to decline in future years.

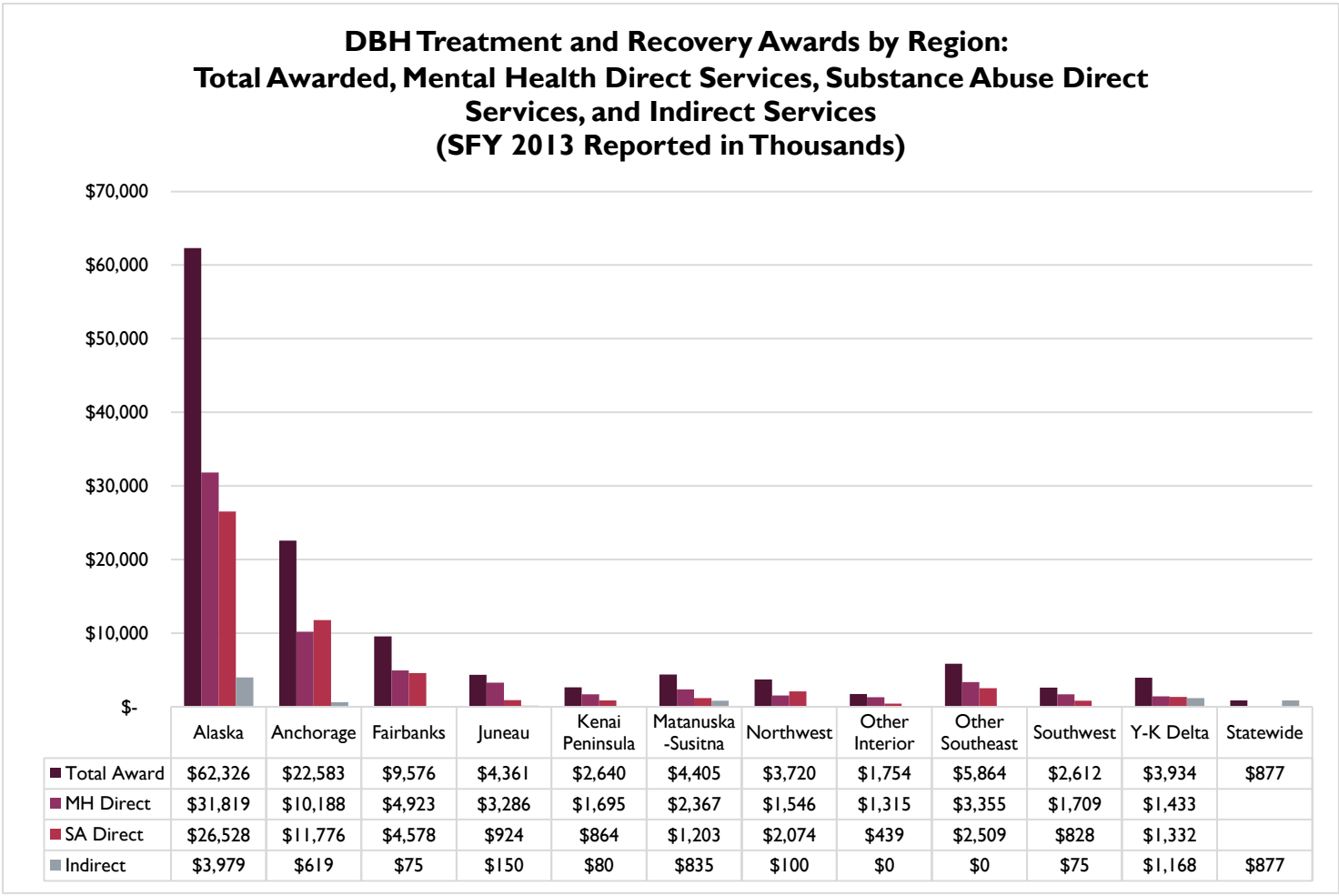
[194] Overview of DSH Funding in Alaska. Alaska State Hospital & Nursing Home Association. November 2013.
[195] Ibid.
[196] Overview of DSH Funding in Alaska. Alaska State Hospital & Nursing Home Association. November 2013.

DBH Treatment and Recovery Grant Awards

In State Fiscal Year 2013, the State of Alaska awarded a total of $62,325,826 in Treatment and Recovery Grants across the state.[197] This figure represents about a quarter (24 percent of $259,360,467) of the combined total State Medicaid and Treatment and Recovery Behavioral Health Grant funds in State Fiscal Year 2013. The revenue sources for these awards are split across three broad categories: State General Funds, federal funds, and other funds. More discussion about two important funding federal streams, SAMHSA block grants and the federal portion of State Medicaid DSH funds, follows in the next two sections.

Figure 7-9 shows the distribution of total DBH grant awards across the reporting regions, mental health direct services and substance abuse direct services, and indirect services (in thousands). Direct services include funds that went to direct services that clients received when enrolled in a program or during the pre-admissions process. Indirect services include services provided outside of screening, assessment, and treatment and rehabilitation services. Examples include provider training, sleep off centers, and referral services.

Figure 7-9 DBH Treatment and Recovery Awards by Region SFY2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta	Statewide
Total Award	$62,326	$22,583	$9,576	$4,361	$2,640	$4,405	$3,720	$1,754	$5,864	$2,612	$3,934	$877
MH Direct	$31,819	$10,188	$4,923	$3,286	$1,695	$2,367	$1,546	$1,315	$3,355	$1,709	$1,433	
SA Direct	$26,528	$11,776	$4,578	$924	$864	$1,203	$2,074	$439	$2,509	$828	$1,332	
Indirect	$3,979	$619	$75	$150	$80	$835	$100	$0	$0	$75	$1,168	$877

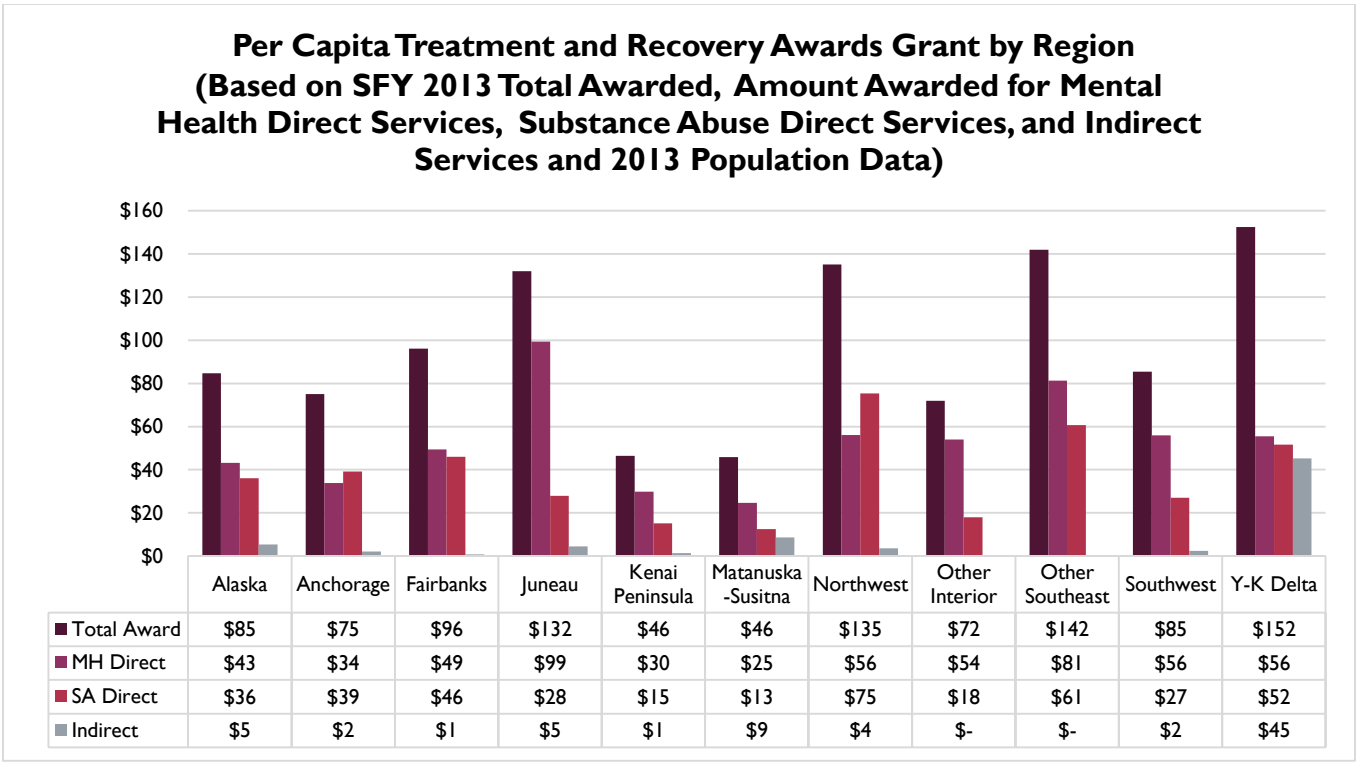
197 All data for this analysis provided by Division of Behavioral Health 7/2/15 and based on Excel file: All FY13 T R Grants 11-21-13.

Figure 7-10 shows the total average DBH treatment and recovery grant allocations per capita across reporting regions, as well as for mental health direct services and substance abuse direct services. The total average grant allocation per capita for all Alaska residents was $85 in State Fiscal Year 2013. The total average treatment and recovery grant allocation per capita within the regions ranged from $46 per capita in the Kenai Peninsula and Mat-Su Borough reporting regions to $152 per capita in the Y-K Delta reporting region.

The average grant allocation per capita for mental health direct services for all Alaska residents was $43 in State Fiscal Year 2013. The average grant allocation per capita for mental health direct services within the regions ranged from $25 per capita in Mat-Su Borough reporting region to $99 per capita in the Juneau reporting region.

The average grant allocation per capita for substance abuse direct services for all Alaska residents was $36 in State Fiscal Year 2013. The average grant allocation per capita for substance abuse direct services within the regions ranged from $13 per capita in Mat-Su Borough reporting region to $75 per capita in the Northwest reporting region.

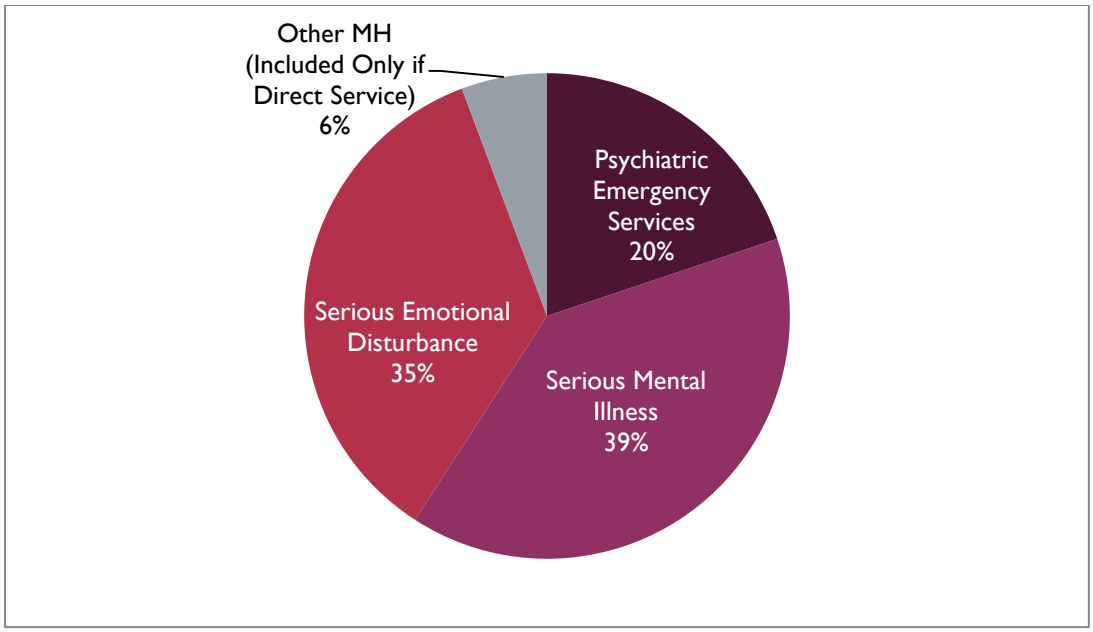
Figure 7-10 Average Per Capita Treatment and Recovery Awards Grant by Region SYF2013



	Alaska	Anchorage	Fairbanks	Juneau	Kenai Peninsula	Matanuska -Susitna	Northwest	Other Interior	Other Southeast	Southwest	Y-K Delta
Total Award	$85	$75	$96	$132	$46	$46	$135	$72	$142	$85	$152
MH Direct	$43	$34	$49	$99	$30	$25	$56	$54	$81	$56	$56
SA Direct	$36	$39	$46	$28	$15	$13	$75	$18	$61	$27	$52
Indirect	$5	$2	$1	$5	$1	$9	$4	$-	$-	$2	$45

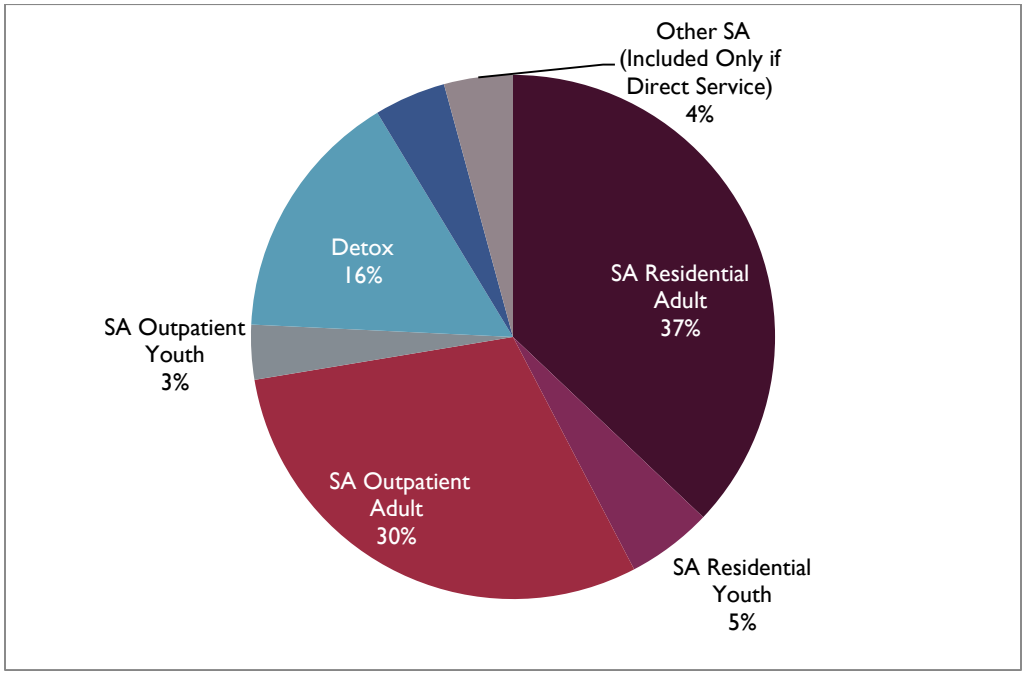
In State Fiscal Year 2013, DBH allocated $31,819,179 to direct mental health services; this represents 51 percent of the total grant awards made that year. As shown in Figure 7-11, 39 percent of mental health direct service grant awards were allocated to services for individuals with Serious Mental Illness, 35 percent to Serious Emotional Disturbance services, 20 percent to Psychiatric Emergency Services, and six percent to Other Mental Health.

Figure 7-11 Percentage Breakdown of Grant Awards for Mental Health Direct Services, Alaska SFY2013



In State Fiscal Year 2013, DBH allocated $26,527,902 to direct substance abuse services; this represents 43 percent of the total grant awards made that year. As shown in Figure 7-12, 36 percent of direct substance abuse services grant awards were allocated to adult residential services, 33 percent to adult outpatient services, 13 percent to detoxification services, five percent to youth residential services, five percent to other direct services, four percent to outpatient youth, and four percent to opioid treatment services.

Figure 7-12 Percentage Breakdown of Grant Awards for Substance Abuse Direct Services, Alaska SFY2013



This level of funding supports the following number of state-funded substance abuse residential treatment beds across the state:

Figure 7-13 Approximate Number of State-funded Residential Treatment Beds Statewide in 2013

Approximate Number of State-funded Beds Statewide in 2013	
Bed Type	Number of Beds
Detox[198]	29
SA Residential[199]	308

Figure 7-14 and Figure 7-15 show the distribution of mental health direct service fund grant awards[200] and substance abuse direct service fund grant awards across program types compared to total direct service grant awards by region in State Fiscal Year 2013. The proportion of direct service grant awards allocated to mental health versus substance abuse varies widely by region. For example, in the Juneau reporting regions, 77 percent of treatment and recovery grants awarded to the region are allocated to mental health service grant awards and 23 percent are allocated to substance abuse direct services. In the Northwest reporting region, 43 percent of treatment and recovery grants awarded to the region are allocated to mental health service grant awards and 57 percent are allocated to substance abuse direct services.

[198] Source: Shared by Shaun Wilhelm, Chief of Risk and Research Management, DBH in January 2015 (represents number in January 2015; here, we make the assumption that the same number of beds were available in 2013).
[199] Source: Report provided by Alaska Division of Behavioral Health 7/2/15, AKAIMS SFY13 grantee report (Question_7A) summarizing total number of DBH bed days available in residential treatment programs across the state.
[200] Does not include general, federal and other funds allocated to the Alaska Psychiatric Institute, which is operated by the Alaska Division of Behavioral Health. DBH estimates total expenditures for API at $31,648,500 in State Fiscal Year 2013. Source: SFY09-SFY14 Lollipop Charts Data Sheets_1-29-15 v5 Excel file provided by DBH 7/1/15.

Figure 7-14 Mental Health Direct Service Grant Awards Compared to Total Treatment and Recovery Grant Awards for Direct Services by Region SFY2013

Mental Health Direct Service Grant Awards Compared to Total Treatment and Recovery Grant Awards for Direct Services by Region SFY2013							
Region	Total Grant Awards for Direct Services	Psychiatric Emergency Services	Serious Mental Illness (Adults)	Serious Emotional Disturbance (Youth)	Other MH (Included Only if Direct Service)	Sum of MH Direct Services	% of Total Direct Awards Allocated to MH Direct Services
Anchorage	$21,963,959	$1,222,927	$4,927,195	$2,753,266	$1,285,000	$10,188,388	46%
Fairbanks	$9,500,701	$961,712	$1,657,414	$2,304,047	$0	$4,923,173	52%
Juneau	$4,210,940	$199,879	$1,455,993	$1,451,087	$179,505	$3,286,464	78%
Kenai	$2,559,769	$380,087	$379,266	$817,063	$118,871	$1,695,287	66%
Mat-su	$3,570,102	$255,360	$1,202,298	$759,512	$150,000	$2,367,170	66%
Northwest	$3,620,447	$1,000,630	$138,123	$407,630	$0	$1,546,383	43%
Other Interior	$1,754,306	$706,259	$386,601	$222,237	$0	$1,315,097	75%
Southeast	$5,864,151	$668,391	$1,264,348	$1,342,375	$80,000	$3,355,114	57%
Southwest	$2,537,068	$272,132	$819,259	$617,222	$0	$1,708,613	67%
Y-K Delta	$2,765,638	$650,114	$271,502	$511,874	$0	$1,433,490	52%
Alaska Total	$58,347,081	$6,317,491	$12,501,999	$11,186,313	$1,813,376	$31,819,179	55%

Notes: Data based on Alaska Division of Behavioral Health All FY13 T R Grants 11-21-13Excel file provided on 7/2/15.

Figure 7-15 Substance Abuse Direct Service Grant Awards Compared to Total Treatment and Recovery Grant Awards for Direct Services by Region SFY2013

Substance Abuse Direct Service Grant Awards Compared to Total Treatment and Recovery Grant Awards for Direct Services by Region SFY2013										
	Total Grant Awards for Direct Services	**Residential Adult**	**Residential Youth**	**Outpatient Adult**	**Outpatient Youth**	**Detox**	**Opioid**	**Other SA (Included Only if Direct Service)**	**Sum of SA Direct Services**	**% of Total Direct Awards Allocated to SA Direct Services**
Anchorage	$21,963,959	$4,694,872	$1,072,247	$1,887,907	$292,105	$2,145,139	$950,301	$733,000	$11,775,571	54%
Fairbanks	$9,500,701	$1,660,781	$0	$579,068	$200,000	$1,915,664	$222,015	$0	$4,577,528	48%
Juneau	$4,210,940	$577,735	$102	$159,530	$114,430	$72,679	$0	$0	$924,476	22%
Kenai	$2,559,769	$87,807	$0	$740,290	$36,385	$0	$0	$0	$864,482	34%
Mat-su	$3,570,102	$1,067,889	$135,043	$0	$0	$0	$0	$0	$1,202,932	34%
Northwest	$3,620,447	$0	$0	$2,074,064	$0	$0	$0	$0	$2,074,064	57%
Other Interior	$1,754,306	$0	$0	$394,637	$44,572	$0	$0	$0	$439,209	25%
Southeast	$5,864,151	$596,320	$193,050	$1,497,821	$105,867	$0	$0	$115,979	$2,509,037	43%
Southwest	$2,537,068	$293,348	$0	$433,702	$101,405	$0	$0	$0	$828,455	33%
Y-K Delta	$2,765,638	$855,375	$0	$199,636	$0	$0	$0	$277,137	$1,332,148	48%
Alaska Total	$58,347,081	$9,834,127	$1,400,442	$7,966,655	$894,764	$4,133,482	$1,172,316	$1,126,116	$26,527,902	45%
Notes: Data based on Alaska Division of Behavioral Health All FY13 T R Grants 11-21-13Excel file provided on 7/2/15.										

SAMHSA BLOCK GRANT EXPENDITURES

Our review of the revenues supporting the Alaska Behavioral health system were by no means exhaustive; however, this one finding took us by surprise. Only a small portion of the revenues required for DBH Treatment and Recovery grants are provided by SAMSHA block grants.

Figure 7-16 SAMHSA Block Grant Expenditures for Alaska Behavioral Health Services, State Fiscal Year 2013

SAMHSA Block Grant Expenditures for Alaska Behavioral Health Services, State Fiscal Year 2013	
SAMHSA Award Type	Total Expenditures
Substance Abuse Block Grant[201]	$4,436,986
Mental Health Block Grant[202]	$587,407
Total Block Grant Expenditures	$5,024,393
Total Treatment and Recovery Grant Awards SFY2013	$62,325,826
% of Total Grant Awards for Treatment and Recovery Services	8%

[201] Extracted from 2014 SABG Report State Expenditures Table 4a SFY13. Provided by DBH on 7/2/15. Includes approximately $200,000 for administration costs (excluding Program and Provider Level).

[202] Extracted from 2014 MHBG Report State Expenditures Table 5 SFY13. Provided by DBH on 7/2/15. Funds are designated for supported employment services.

8. HOW DO CURRENT UTILIZATION TRENDS COMPARE WITH THE BEHAVIORAL HEALTH NEEDS OF ALASKANS?

One of the goals of this assessment is to better understand utilization trends and the extent to which the current system meets the behavioral health needs of Alaskans. Chapter 2 identifies the prevalence of behavioral health issues, which we use in this section to indicate a potential need for behavioral health services. For planning purposes, it is important to note that *Need* for services is not the same as *Demand* for services, because not all individuals who have behavioral health conditions seek or wish to receive treatment. Demand for services might stem from a variety of sources, for example:

- Medicaid Expansion – Increase in the number of insured individuals.
- Increased Screening in Primary Care Settings – Additional screening and partnerships within/with primary care providers could increase client referrals to DBH Treatment and Recovery grantees, especially if client data sharing becomes standard practice.
- Integration of Behavioral Health Services into Primary Care – If barriers to billing are removed, more behavioral health professionals will likely be hired to deliver behavioral health services to clients in the primary care settings.
- Medicaid Payment Reform – Greater emphasis on paying for value could increase demand for behavioral health services.
- The Criminal Justice System – Including court referrals and referrals at discharge (as well as pathways for family members and victims to receive services).
- Office of Children's Services – Children and families in state custody or at risk of being taken into State custody.

Exploring areas of potential demand for behavioral health services and establishing clear pathways and business models to meet that demand represents an important area for future focus by systems leaders and regional health planners.

In assessing potential areas of unmet need and analyzing service patterns, we must also remember the limitations of the current dataset. This assessment analyzed data that identifies people who meet eligibility requirements for behavioral health services supported by State-funds, including DBH Treatment and Recovery grants and/or State Medicaid Program. The service utilization estimates data do not include Alaskans who received services provided by the Department of Corrections or the Division of Juvenile Justice; DBH-funded prevention programs; Alaska therapeutic courts; Alcohol Safety Action Program (ASAP); DET transport services; DBH's Illness Self-Management pilot (an additional 3,100 individuals participated in this pilot in 2013); or, services provided by medical providers that were not billed to Medicaid (for example, services paid by private insurance, self-pay or uncompensated care). For low income individuals who seek services, the eligibility criteria and programmatic priorities described in Chapter 1 determine in large part who is able to receive services.

Finally, it is important to note that the counts of clients served represent just that. Understanding how clients are served and how they might be better served is the subject of Chapter 5 and, hopefully, many future discussions at the state and regional levels. The following analyses highlight the potential need for increased services across populations, as well as within certain regions and begin to paint a more nuanced picture of what increasing system capacity means. Indeed, the goal of increasing system capacity starts to take on two meanings: first, how to optimize service patterns among existing clients, who tend to have higher levels of behavioral health needs and, second, how to open access to services for clients with mild and moderate mental health issues or individuals with SUD before their needs escalate.

Key Findings

Comparison of Need and Numbers Served Statewide

- In 2013, an estimated 145,790 Alaska adults needed behavioral health services (Figure 8-1). Estimated need is calculated by applying National Survey on Drug Use and Health (NSDUH) prevalence rates for a substance use disorder or mental health issue in the past year to Alaska Department of Labor (DOL) 2013 population estimates. In comparison, 27,728 adult clients were served with support from State Medicaid and/or behavioral health funds. Many individuals in this gap may be receiving services through other payer sources, while others are truly falling into a gap of unmet need.
- Across all diagnosis categories, Alaska adults received services paid for with support from State Medicaid or behavioral health funds at a rate of 51 clients per 1,000 adults in 2013. This rate varies by region with a high of 98 clients per 1,000 adults in the Other Southeast reporting region to a low of 36 clients per 1,000 adults in the Other Interior reporting region.
- The smallest gap between estimated need (21,302 adults) and numbers served (16,481 clients) is for individuals with a SMI diagnosis. However, as described previously, our methodology for classifying individuals does not align perfectly with prevalence methodology and, thus, some SMI clients served may, in fact, have a level of functioning more akin to moderate mental illness. Statewide, the rate of service to clients with mild, moderate and serious mental illnesses (labeled Any Mental Illness) was 35 per 1,000 adults in 2013. This rate is just slightly higher than that of clients served with serious mental illness alone (31 clients per 1,000).
- The largest gap between estimated need (105,966 adults) and numbers served (18,902 clients) is seen in the Any Mental Health category, which includes Mild, Moderate, and Serious Mental Illness. This gap points to a potential for significant unmet need among low-income, uninsured individuals with moderate and mild mental illness.
- The gap between estimated need (62,815 adults) and numbers served with support from State Medicaid and behavioral health funds (14,442 clients) for SUD is also large. Alaska adults with SUD diagnoses received services paid for with support from State Medicaid or behavioral health funds at a rate of 26 clients per 1,000 adults in 2013. This rate varies by region with highs of 55 clients, 51 clients, and 47 clients per 1,000 adults in the Other Southeast, Juneau, and Northwest reporting regions.

Comparison of Need and Numbers Served Among Adult Males and Adult Females

- Across all diagnosis categories, adult males received services paid for with support from State Medicaid or behavioral health funds at a rate of 41 clients per 1,000 male adults in 2013 while adult females received services at a rate of 62 per 1,000 female adults.
- An estimated 43,835 males (15.5 percent) need treatment for illicit drug or alcohol use in 2013 compared to 19,756 females (7.5 percent) and, yet, about the same number of males (7,144) and females (7,291) were served for SUD with support from State Medicaid and behavioral health funds in 2013. This is likely reflective of Medicaid eligibility and program priorities.
- Far more adult females (63,219 or 24 percent) were estimated to have a mild, moderate or serious mental health issue in the past year (labeled Any Mental Health) than adult males (42,421 or 15 percent). Adult females received nearly double the services (12,262 female clients versus 6,626 male clients) in this category; however, it is important to note that service counts are inclusive of individuals with diagnoses related to SMI, which represent the vast majority of client diagnoses.

Comparison of White Adults and American Indian / Alaska Native adults

- In 2013, an estimated 78,841 White adults, 14,574 American Indian / Alaska Native adults, and 12,574 adults in the all Other Races category needed behavioral health services. In comparison, 13,315 White adult clients, 10,644 American Indian / Alaska Native adult clients, and 3,214 adult clients in the all Other Races category were served with support from State Medicaid and/or behavioral health funds. This trend speaks to the strength and capacity of Alaska's Tribal Behavioral Health System.
- Across all diagnosis categories, American Indian / Alaska Native adults received services paid for with support from State Medicaid or behavioral health funds at a much higher rate per 1,000 than White adults (116 clients per 1,000 compared to 34 clients per 1,000) in 2013.

Comparison of Need and Numbers Served

In 2013, an estimated 145,790 Alaska adults needed behavioral health services (Figure 8-1). Estimated need is calculated by applying National Survey on Drug Use and Health (NSDUH) prevalence rates for a substance use disorder or mental health issue in the past year to Alaska Department of Labor (DOL) 2013 population estimates.[203] In comparison, 27,728 adult clients were served with support from State Medicaid and/or behavioral health funds. It is important to note that many of these individuals, especially those with mild and moderate behavioral health issues, may be receiving services paid for by commercial insurance, other third party payers, and self pay while others are truly falling into a gap of unmet need. Until an all payers claims database is in place in Alaska, it will likely be difficult to gauge the full extent of behavioral health services provided to Alaskans.

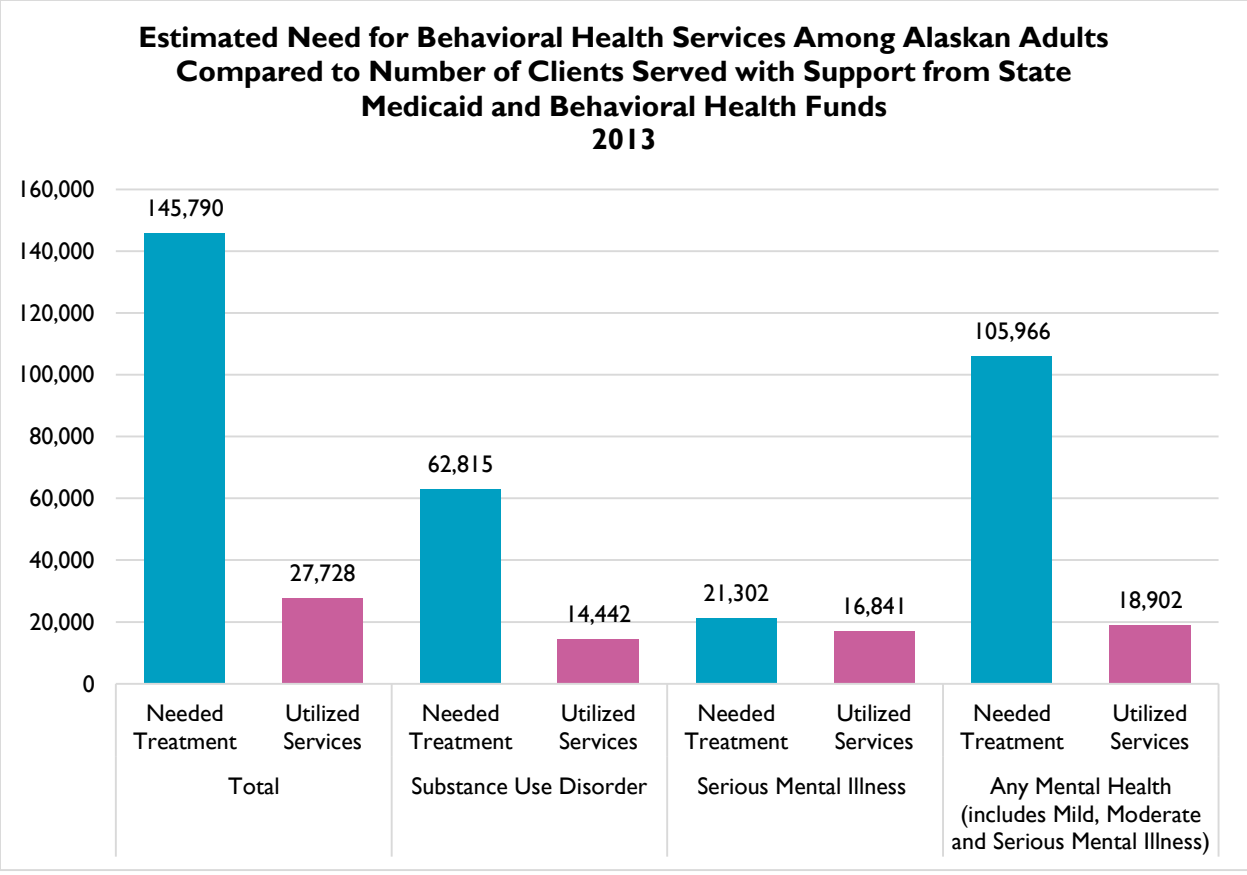
The smallest gap between estimated need (21,302 adults) and numbers served (16,481 clients) is for individuals with an SMI diagnosis. However, as described previously, our methodology for classifying individuals does not align perfectly with prevalence methodology and likely overestimates

[203] An area for future investigation may be to explore the use of population and prevalence data for low-income adults only rather than the total population.

the number of SMI clients served (in other words, some clients classified in the SMI category may have a level of functioning more akin to moderate mental illness). The largest gap between estimated need (105,966 adults) and numbers served (18,902 clients) is seen in the Any Mental Health category, which includes Mild, Moderate, and Serious Mental Illness. This gap points to a potential for significant unmet need among low-income, uninsured individuals with moderate and mild mental illness. The gap between estimated need (62,815 adults) and numbers served with support from State Medicaid and behavioral health funds (14,442 clients) for SUD is also large.

The goal of increasing system capacity thus takes on two meanings: first, to optimize service patterns among existing clients, who tend to have higher levels of behavioral health needs, so that the right resources are provided at the right time and for the right length of time and, second, to open access to services for clients with mild and moderate mental health issues or individuals with SUD before their needs escalate. Improving system capacity for populations with varied levels of need will require tailored strategies. For example, access, service needs, and workforce requirements for the population experiencing mild to moderate behavioral health issues may look quite different than for the population experiencing moderate to serious behavioral health issues. Similarly, primary care medical homes and other willing providers will need to assume a role in service provision in order for the system to meet demand for lower level behavioral health services.

Figure 8-1 Estimated Need for Behavioral Health Services Among Alaskan Adults Compared to Number of Clients Served with Support from State Medicaid and Behavioral Health Funds 2013

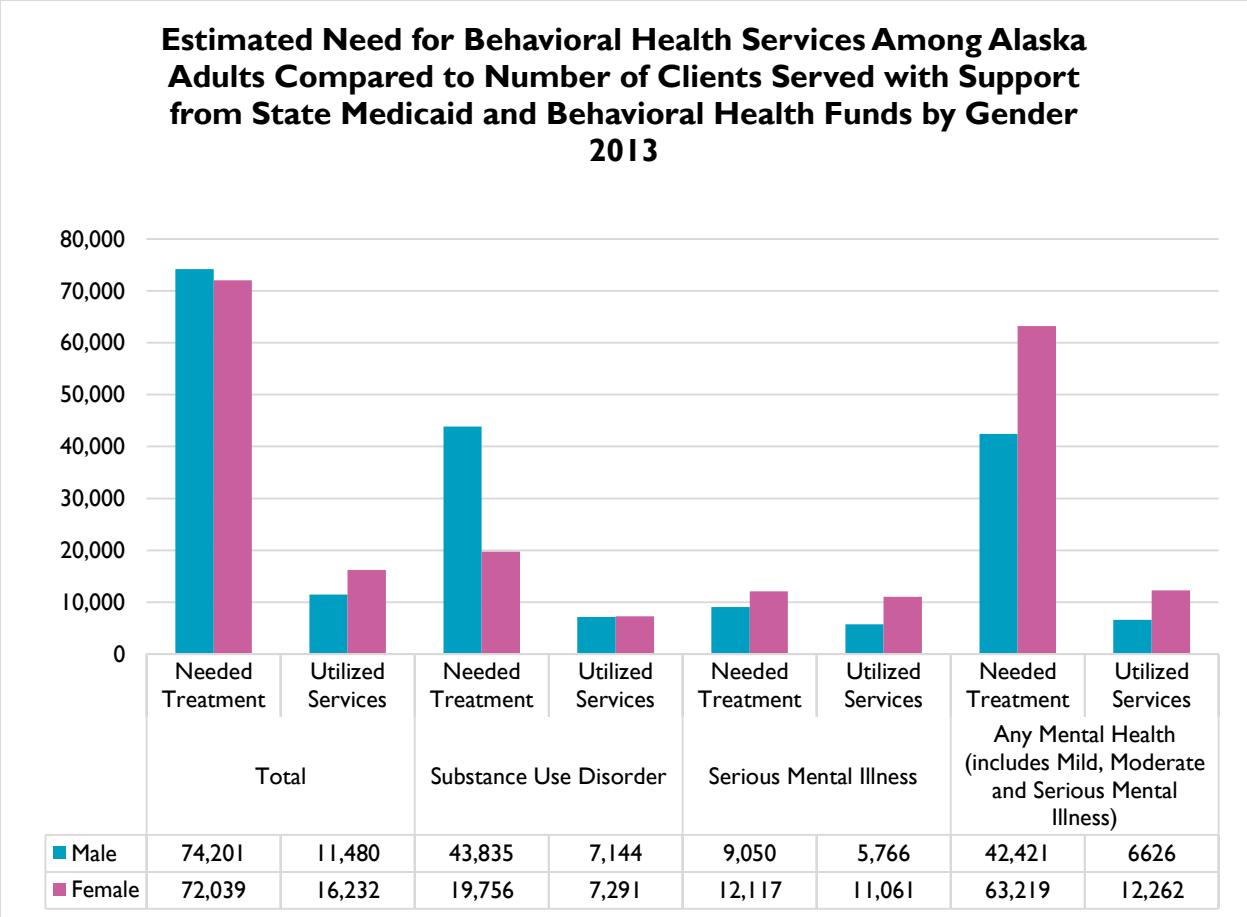


In 2013, an estimated 74,201 Alaskan adult males and 72,039 females needed behavioral health services (Figure 8-2). Estimated need is calculated by applying NSDUH prevalence rates for a substance use disorder or mental health issue in the past year to DOL 2013 population estimates. In comparison, 11,480 adult male clients and 16,232 adult female clients were served with support from State Medicaid and/or behavioral health funds. As described above, many of these individuals may be receiving services through other payer sources, while others are truly falling into a gap of unmet need.

An estimated 43,835 males (15.5 percent) need treatment for illicit drug or alcohol use in 2013 compared to 19,756 females (7.5 percent) and, yet, about the same number of males (7,144) and females (7,291) were served for SUD in 2013. This is likely reflective of Medicaid eligibility and program priorities.

An estimated 9,050 males (3.2 percent) had serious mental illness in the past year compared to 12,117 females (4.6 percent) and fewer adult males (5,766) were served for SMI than females (11,061) in 2013. Far more adult females (63,219 or 24 percent) were estimated to have a mild, moderate or serious mental health issue in the past year (Any Mental Health) than adult males (42,421 or 15 percent). Adult females received nearly double the services (12,262 versus 6,626) in this category; however, it is important to note that service counts are inclusive of individuals with SMI.

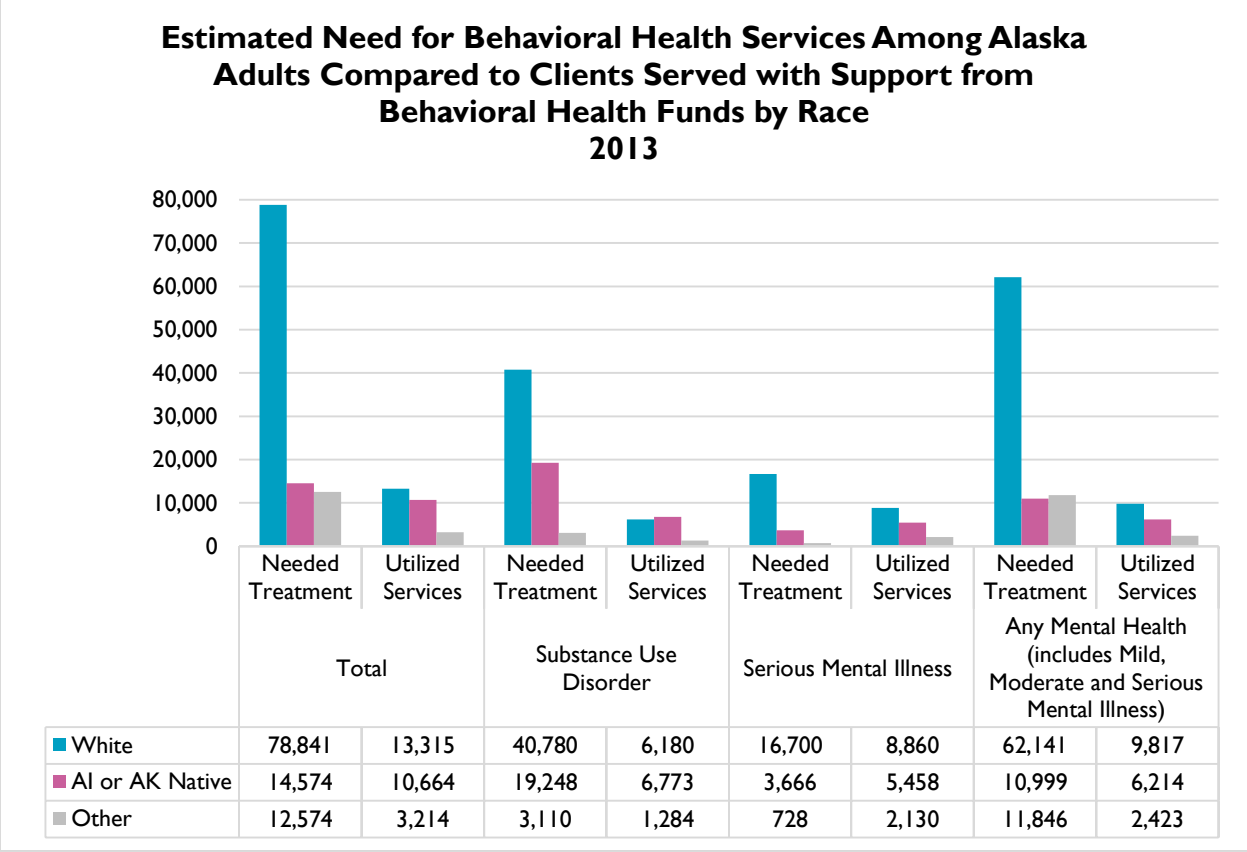
Figure 8-2 Estimated Need for Behavioral Health Services among Alaska Adults Compared to Number of Clients Served with Support from State Medicaid and Behavioral Health Funds by Gender 2013



In 2013, an estimated 78,841 White adults, 14,574 American Indian / Alaska Native adults, and 12,574 adults in the all Other Races category needed behavioral health services (Figure 8-3). Estimated need is calculated by applying NSDUH prevalence rates for a substance use disorder or mental health issue in the past year to DOL 2013 population estimates. In comparison, 13,315 White adult clients, 10,644 American Indian / Alaska Native adult clients, and 3,214 adult clients in the all Other Races category were served with support from State Medicaid and/or behavioral health funds. As described above, many of these individuals may be receiving services through other payer sources, while others are truly falling into a gap of unmet need.

An estimated 40,780 White adults (10.5 percent) need treatment for illicit drug or alcohol use in 2013 compared to 19,248 (21 percent percent) and, yet, about the same number of White adults (6,180) and American Indian / Alaska Native adults (6,773) were served for SUD in 2013.

Figure 8-3 Estimated Need for Behavioral Health Services among Alaska Adults Compared to Clients Served with Support from Behavioral Health Funds by Race 2013



	Total		Substance Use Disorder		Serious Mental Illness		Any Mental Health (includes Mild, Moderate and Serious Mental Illness)	
	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services	Needed Treatment	Utilized Services
White	78,841	13,315	40,780	6,180	16,700	8,860	62,141	9,817
AI or AK Native	14,574	10,664	19,248	6,773	3,666	5,458	10,999	6,214
Other	12,574	3,214	3,110	1,284	728	2,130	11,846	2,423

Comparison of Service Utilization Rates by Region and Demographics

Another way to inform the question of unmet need and better understand current service patterns is to analyze utilization rates by region and demographics. Three tables are included in this section that help to shed light on these topics. All service estimates are based on the number of individuals served within each region even if the client is, in fact, from another region. Looking at the data through this lens allows for analysis of regional service provider capacity compared to need in the

region. Future assessments might also explore service utilization rates by using clients' home community; however, we know from our work during this phase that home address data is incomplete.

Figure 8-4 shows the number of Alaska Adults served with support from State Medicaid and/or behavioral health funds by diagnosis and region with rates of service utilization per 1,000 persons. Across all diagnosis categories, Alaska adults received services paid for with support from State Medicaid or behavioral health funds at a rate of 51 clients per 1,000 adults in 2013. This rate varies by region with a high of 98 clients per 1,000 adults in the Other Southeast reporting region to a low of 36 clients per 1,000 adults in the Other Interior reporting region. Alaska adults with SUD diagnoses received services paid for with support from State Medicaid or behavioral health funds at a rate of 26 clients per 1,000 adults in 2013. This rate varies by region with highs of 55 clients, 51 clients, and 47 clients per 1,000 adults in the Other Southeast, Juneau, and Northwest reporting regions. Statewide, the rate of service to clients with mild, moderate and serious mental illnesses (labeled Any Mental Illness) was 35 per 1,000 adults in 2013. This rate is just slightly higher than that of clients served with serious mental illness alone (31 clients per 1,000).

Figure 8-4 Number and Rate (per 1,000 Persons) of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013

Number and Rate (per 1,000 Persons) of Alaska Adults Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013

Region	Adult Population	Utilization: Total Served							
		Overall # Served		SUD		Any Mental Illness		SMI	
		#	Rate	#	Rate	#	Rate	#	Rate
Alaska	546,215	27,728	51	14,442	26	18,902	35	16,841	31
Anchorage, Municipality of	224,786	11,576	51	5,469	24	8,390	37	7,416	33
Fairbanks North Star Borough	74,482	3,072	41	1,766	24	1,885	25	1,729	23
Juneau, City and Borough of	25,584	1,891	74	1,308	51	1,059	41	998	39
Kenai Peninsula Borough	43,754	2,722	62	1,133	26	1,976	45	1,776	41
Matanuska-Susitna Borough	69,032	3,844	56	1,745	25	2,816	41	2,612	38
Northwest Region	18,890	1,264	67	881	47	693	37	558	30
Other Interior Region	18,220	657	36	278	15	480	26	401	22
Other Southeast Region	31,973	3,124	98	1,766	55	1,917	60	1,698	53
Southwest Region	23,314	1,032	44	542	23	674	29	534	23
Y-K Delta Region	16,181	953	59	635	39	436	27	369	23

Figure 8-5 shows the number of Alaska adult males and females served with support from State Medicaid and/or behavioral health funds by diagnosis and region with rates of service utilization per

1,000 persons. Across all diagnosis categories, Alaska adult males received services paid for with support from State Medicaid or behavioral health funds at a rate of 41 clients per 1,000 male adults in 2013 while adult females received services at a rate of 62 per 1,000 female adults. Alaska adult males and females with SUD diagnoses received services paid for with support from State Medicaid or behavioral health funds at approximately the same rates (25 clients per 1,000 and 28 clients per 1,000) in 2013. Adult females received services for SMI at a much higher rate per 1,000 persons then males (42 clients per 1,000 versus 20 clients per 1,000).

Figure 8-6 shows the number of White adults and American Indian / Alaska Native adults served with support from State Medicaid and/or behavioral health funds by diagnosis and region with rates of service utilization per 1,000 persons. Across all diagnosis categories, American Indian / Alaska Native adults received services paid for with support from State Medicaid or behavioral health funds at a much higher rate per 1,000 than White adults (116 clients per 1,000 compared to 34 clients per 1,000) in 2013. American Indian / Alaska Native adults with SUD received services paid for with support from State Medicaid or behavioral health funds at a rate of 74 per 1,000 compared to 16 clients per 1,000 persons for White adults in 2013. American Indian / Alaska Native adults received services for SMI at a rate of 60 clients per 1,000 persons compared to 23 clients per 1,000 persons for White adults in 2013. These trends speak to the strength and capacity of Alaska's Tribal Behavioral Health System.

Figure 8-5 Number and Rate (per 1,000 Persons) of Alaska Adult Males and Females Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013

Number and Rate (per 1,000 Persons) of Alaska Adult Males and Females Served with Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013																	
Region	2013 Male Pop. Ages 18+	Utilization: Total Adult Males Served								2013 Female Pop. Ages 18+	Utilization: Total Adult Females Served						
		Total		SUD		Any Mental Illness (Past Year)		SMI (Past Year)			Total		SUD		Any Mental Illness (Past Year)		SMI (Past Year)	
		#	Rate	#	Rate	#	Rate	#	Rate		#	Rate	#	Rate	#	Rate	#	Rate
Alaska	282,804	11,480	41	7,144	25	6,626	23	5,766	20	263,411	16,232	62	7,291	28	12,262	47	11,061	42
Anchorage, Municipality of	112,826	4,713	42	2,681	24	3,082	27	2,688	24	111,960	6,849	61	2,781	25	5,296	47	4,716	42
Fairbanks North Star Borough	39,310	1,252	32	809	21	683	17	614	16	35,172	1,819	52	957	27	1,201	34	1,114	32
Juneau, City and Borough of	12,955	954	74	745	58	400	31	374	29	12,629	937	74	563	45	659	52	624	49
Kenai Peninsula Borough	22,885	1,056	46	561	25	631	28	556	24	20,869	1,666	80	572	27	1,345	64	1,220	58
Matanuska-Susitna Borough	35,436	1,355	38	719	20	872	25	788	22	33,596	2,489	74	1,026	31	1,944	58	1,824	54
Northwest Region	11,057	572	52	438	40	272	25	206	19	7,833	692	88	443	57	421	54	352	45
Other Interior Region	9,954	277	28	153	15	166	17	126	13	8,266	380	46	125	15	314	38	275	33
Other Southeast Region	16,473	1,255	76	844	51	593	36	505	31	15,500	1,868	121	922	59	1,323	85	1,192	77
Southwest Region	13,507	490	36	317	23	251	19	190	14	9,807	542	55	225	23	423	43	344	35
Y-K Delta Region	8,401	386	46	285	34	140	17	121	14	7,780	567	73	350	45	296	38	248	32

Figure 8-6 Number and Rate (per 1,000 Persons) of White Adults and American Indian/Alaska Native Adults Served With Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013

Number and Rate (per 1,000 Persons) of White Adults and American Indian/Alaska Native Adults Served With Support from State Medicaid and Behavioral Health Funds by Diagnosis and Region 2013																	
Region	**2013 White Pop. Ages 18+**	**Utilization: Total White Adults Served**								**2013 AI/AN Pop. Ages 18+**	**Utilization: Total AI/AN Adults Served**						
		Total		**SUD**		**Any Mental Illness (Past Year)**		**SMI (Past Year)**			**Total**		**SUD**		**Any Mental Illness (Past Year)**		**SMI (Past Year)**	
		#	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**		**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**
Alaska	388,379	13,315	34	6,180	16	9,817	25	8,860	23	91,659	10,644	116	6,773	74	6,214	68	5,458	60
Anchorage, Municipality of	159,131	4,814	30	2,507	16	3,596	23	3,230	20	24,195	4,416	183	2,639	109	1,948	80	1,697	70
Fairbanks North Star Borough	59,859	1,523	25	727	12	1,113	19	1,020	17	7,084	1,174	166	878	124	482	68	440	62
Juneau, City and Borough of	18,883	939	50	630	33	559	30	524	28	4,178	762	182	556	133	396	95	377	90
Kenai Peninsula Borough	38,022	2,057	54	825	22	1,510	40	1,365	36	4,411	485	110	240	54	329	75	288	65
Matanuska-Susitna Borough	60,185	2,932	49	1,306	22	2,198	37	2,045	34	6,190	514	83	304	49	297	48	275	45
Northwest Region	5,424	103	19	40	7	86	16	63	12	12,465	1,137	91	827	66	588	47	479	38
Other Interior Region	12,386	348	28	128	10	379	31	326	26	5,031	271	54	131	26	1,306	259	1,146	228
Other Southeast Region	22,221	1,376	62	723	33	914	41	802	36	7,631	1,477	194	855	112	888	116	795	104
Southwest Region	10,305	341	33	143	14	250	24	195	19	6,606	559	85	342	52	328	50	268	41
Y-K Delta Region	1,961	13	7	9	5	5	3	5	3	13,868	933	67	621	45	429	31	362	26

9. WHAT CAN WE LEARN FROM PROVIDERS AND BEHAVIORAL HEALTH AIDES ABOUT IMPROVING SYSTEM CAPACITY?

Overview

As part of the Alaska Behavioral Health Systems Assessment, we conducted two surveys in order to learn directly from DBH Treatment and Recovery grantees and the Behavioral Health Aide workforce about system capacity. These surveys helped us better understand how and how well the system works, as well as where opportunities for systems improvements might lie. We are extremely appreciative and honored by the commitment made by so many to contribute their thoughts and time to this effort. That said, we recognize that this assessment only scratches the surface of what can be learned from providers, BHAs, and the many other behavioral health professionals that support the system. Much more engagement and discussion will be needed to interpret the data included in this assessment, determine future assessment questions, and build a comprehensive plan for improving systems capacity.

> *In Alaska, it is very difficult to integrate with primary care. I don't know of a single doctor's clinic who will work with my clients. They don't want to affiliate with me, because that means they spend a lot more free time. We have one community health center and that clinic can't take on every mental health clinic in town. We have thought about hiring a physician but it doesn't pencil. Individually, I refer them to the native hospital or the community health center when someone needs medical attention.*
>
> *CEO of a Community Behavioral Health Center*

Key Findings: Provider Survey

Access to Care

- Timely access to care is imperative. A same-day appointment has a 10 percent change of not being kept while almost 25 percent of patients with next-day appointments cancel or do not show up.[204] Providers ranked too few staff as the number one reason why clients experience long waits for service, followed by too few time slots, and no beds.
- Streamlining the intake process (n=31 of the 54 responding organizations), raising staff awareness of access (n=28), management of No Shows and cancellations (n=25) were the top three actions providers reported having taken to improve client access to the necessary level of care. Fewer providers reported using centralized scheduling (n=14), policies to reduce paperwork and reporting (n=13), open access scheduling (n=12), collaborative

[204] Same day access to behavioral health services. Chuck Ingoglia, National Council. David Lloyd, Scott Lloyd, Joy Fruth, and Annie Juve, MTM Services. https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/

documentation (n=10) and triage to group services (n=5). The results from this question point to possible opportunities for increasing access and improving system capacity.

- The majority of providers reported that No Shows were very problematic (36 percent) or somewhat problematic (52 percent). Providers have employed a range of actions to address No Shows and late cancellations, the most common of which is reminder calls. Eighteen respondents reported analyzing No Show data, 13 reported using waitlists, and only four reported overbooking of slots to help address No Shows and late cancellations. Given the reported impact of No Shows and late cancellations, DBH might consider bringing in a national expert and dedicating time to sharing promising practices at the next change agent conference to this topic.
- Providers ranked transitional/supportive housing as the number one service they would development in their communities and regions if they could. This response reinforces our finding that lack of supportive housing is a major gap in Alaska's continuum of behavioral health care.

Tele-behavioral Health

- Thirty-five percent of respondents use tele-behavioral health regularly, 20 percent periodically, 13 percent have explored its use, and the remaining third of respondents do not use tele-behavioral health at all. Non-Tribal providers were more likely to respond not at all or have explored; Tribal providers were more likely to respond regularly or periodically.
- The top three uses for tele-behavioral health were psychotherapy, medication management, and assessment/diagnosis. Use of tele-behavioral health for group services presents an emerging opportunity.

Crisis Care

- Sixty-two percent of providers responded that the most common course of action in their community or region when a person experience a psychiatric crisis is to stabilize and treat locally. Twenty-six percent of providers hold at an emergency department and then transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. Twelve percent of providers transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. These responses reinforce the regional service patterns seen in the quantitative data analysis.

Quality improvement

- Ninety-eight percent of respondents reported collecting data to inform improvement efforts. Data is used for a wide range of performance-related efforts, such as monitoring program effectiveness (n=29), staff productivity (n=29), treatment effectiveness (n=27) and consumer outcomes (n=26). Optimizing billing fell toward the end of this list (n=18) and may present an opportunity for providers.
- Quality improvement is a formal process of analyzing an organization's performance and deploying systematic efforts to improve performance in many ways. Providers use continuous quality improvement in a range of areas, including clinical record management (n=37), treatment effectiveness (n=30), and staff productivity (n=29). The average number of uses per organization was five.

Integrated Care

- Thirty-eight percent of respondents said they often shared client data and coordinated treatment with the client's primary care provider, approximately half said they sometimes shared data and coordinated treatment. Providers shared concerns about the confidentiality requirements associated with alcohol and drug abuse patient records (42 CFR) limiting their ability to share data.

Revenue Management

- Two-thirds of providers were always, often, or sometimes concerned about their organization's financial solvency in the past year.
- In an effort to better understand the challenges facing providers, we asked what they believed the three most important challenges facing their organizations in the next five years would be. Changing in funding streams (n=49), reduction in public funds (n=45), maximizing service capacity with limited revenue (n=38), and workforce development issues (n=28) were the top responses. These responses far out-ranked issues like creating a trauma-capable organization (n=3), changes in federal law (n=6), and integration with primary care (n=7).
- This finding is evidence of the difficult financial state that many behavioral health providers find themselves operating in and speaks to the need to increase Medicaid reimbursement rates for non-Tribal providers, set Medicaid billing targets at the organizational level and provide Medicaid billing training and technical assistance to all providers, and tread carefully when weighing the timelines and possible implications of reducing grant funding.

Key Findings: Behavioral Health Aide Survey

Being a BHA

- Behavioral Health Aides are great listeners, bridges between western and traditional Alaska Native cultures, leaders in their communities, safety nets, community healers, providing critical services in the village so clients don't need to leave home, and first responders in a crisis. They are drawn to their work by inspiration to help others, interest in marrying traditional knowledge with professional skills, and are sometimes in recovery themselves.
- BHAs provide prevention and early intervention, cultural knowledge, substance abuse services, intake and substance abuse assessments for new clients. BHAs say the most important of these is community and youth development through cultural activities, and individual and group counseling. More prevention, more mentoring and support for males, and more knowledge about intergenerational trauma is needed.
- To excel in their roles, Behavioral Health Aides need support, supervision, training, community trust and readiness, increased connection with other BHAs for peer support and mentoring, continuing to pursue their own education and certifications all the way to Master's level for some. Paperwork, lack of support and supervision, and poor facilities / lack of office space are the biggest obstacles for BHAs.

BHA Certification

- Behavioral Health Aides recognize many benefits to certification and training. Barriers to certification are that the pathway is often not clear and some organizations do not provide

adequate support for BHAs to become certified or advance certification. A training academy with a mix of in person and online classes would work best.

BHA Workforce

- Tiered pay increases, and connecting with other BHAs more frequently, and increasing the certification of BHAs would help retain BHAs. Also, more recognition and reward for the work BHAs do in their communities.

Crisis Response

- BHA comfort with crisis was mixed; many felt comfortable or at least felt that support was available but personal safety was a pervasive concern. BHAs would feel more comfortable handling a crisis with additional training and support from supervisors, working in a more coordinated fashion with the community other responders, steps to ensure staff/office safety, transportation vehicles, and time and experience on the job.

Behavioral Health Services

- Tele-behavioral health works best when the internet connection is solid; when it is easy to coordinate, when bad weather prevents travel, when a client needs support right away, can be great as a tool for staffing, as an alternative to planned travel, for assessments. Tele-behavioral health does not work well when you lose the personal connection, when spaces do not allow for privacy, when the connections are bad, when it is not put in the treatment plan, when we do not have sufficient training.
- Behavioral Health Aides are not yet integrated into primary care or working closely with community health aides.
- What is missing to be able to provide good care to patients in rural Alaska (from beginning to end)? Dedicated space/infrastructure for delivery of behavioral health services, access to services, staff consistency, whole family engagement, and quicker turnaround times for intakes.

Provider Survey

INTRODUCTION AND GRATITUDE

In November 2014, DBH and Agnew::Beck collaborated to conduct an interactive provider survey at the DBH Change Agent Conference using Audience Response Technology in order to collect information about provider and organizational capacity and inform recommendations for systems improvements.

Many individuals contributed to the development and delivery of this survey. We would like to thank the following provider survey committee members:

Name	Role and Organization
Rick Calcote	Policy and Planning, Alaska Division of Behavioral Health
Laura Baéz	Behavioral Health Director, Alaska Native Tribal Health Consortium
Pat Sidmore	Planner, Advisory Board on Alcoholism & Drug Abuse and Alaska Mental Health Board

Name	Role and Organization
Tom Chard	Executive Director, Alaska Behavioral Health Association
Kate Burkhart	Executive Director, Advisory Board on Alcoholism & Drug Abuse and Alaska Mental Health Board
Lance Johnson	Behavioral Health Services Director, Norton Sound Health Corporation
Melissa Kemberling	Director of Programs, Mat-Su Health Foundation
Michael Baldwin	Evaluation and Planning Officer and Contract Lead, Alaska Mental Health Trust Authority

In addition, we are grateful for survey feedback we received from Rosalie Nadeau, Chief Executive Officer of AKEELA, and Jim McLaughlin, DBH Behavioral Health Grant Program Manager and, of course, to the many providers who actively participated in the session. The ability to ask and review questions in real-time and the earnestness with which providers participated contributed to the top notch quality of the conversation and feedback about system capacity.

METHODOLOGY

The goal of the provider survey was to collect qualitative data on a range of indicators to assist with efforts to assess the capacity of Alaska's Behavioral Health System. Questions were drafted by Agnew::Beck based on the specifications outlined for assessing the Alaska Behavioral Health System within the Request for Proposal for the Alaska Behavioral Health Systems Assessment. These questions were then reviewed and refined by the provider survey committee members listed above over the course of two work sessions. Questions were organized around the following topic areas:

Topics	Questions
I. Organizational Info	1- 2
II. Access to Care	3-8
III. Tele-behavioral Health	9-11
IV. Clinical Operations	12-16
V. Integrated Care	17-18
VI. Crisis and Suicide Response	19-23
VII. Data Utilization	24-26
VIII. Quality Improvement	27-29
IX. Revenue Management	30-32
X. The Future	33

The committee also provided feedback on the facilitation approach, the goal of which was to engage providers in a fun and informative way in the effort to assess system capacity. The committee recommended using Audience Response Technology so that results could be shared instantly. To facilitate analysis, we asked participants from each organization to sit together and limit one clicker per organization. In administering the questions, the team aspired to create a comfortable space for providers to respond to survey questions and discuss results. Heidi Wailand, Agnew::Beck facilitated

the session with support from contract lead Michael Baldwin. A microphone was circulated throughout the audience so that participants could share their ideas and experiences.

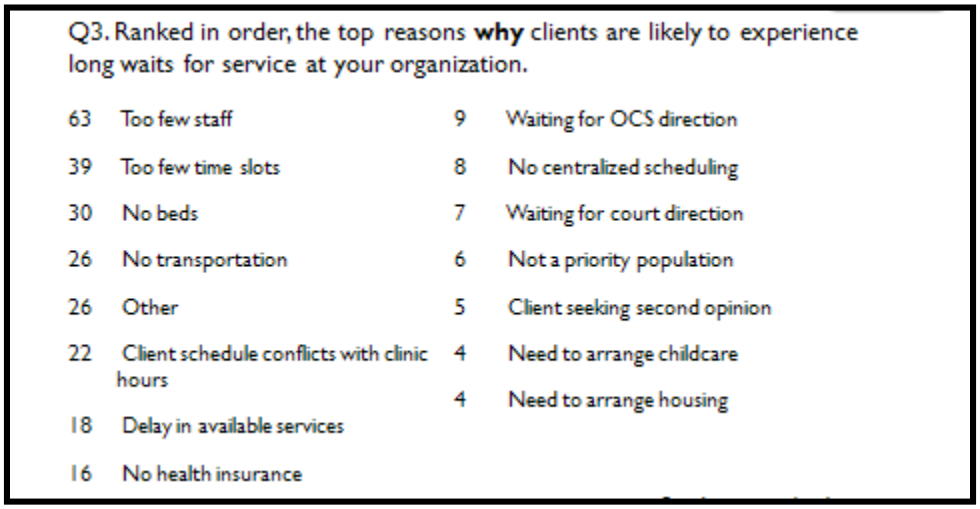
Participation was excellent with 54 provider organizations from across the state participating, including 13 Tribal Health Organizations. Results were shared immediately and posted to DBH's website following the session.[205]

WHAT WE HEARD

Access to Care

Timely access to care is imperative. A same-day appointment has a 10 percent change of not being kept while almost 25 percent of patients with next-day appointments cancel or do not show up.[206] We wanted to better understand the reasons why clients might experience waits for care within the community behavioral health care system. Providers ranked too few staff as the number one reason why clients experience long waits for service, followed by too few time slots and no beds.

Figure 9-1 Response to Provider Survey Question 3

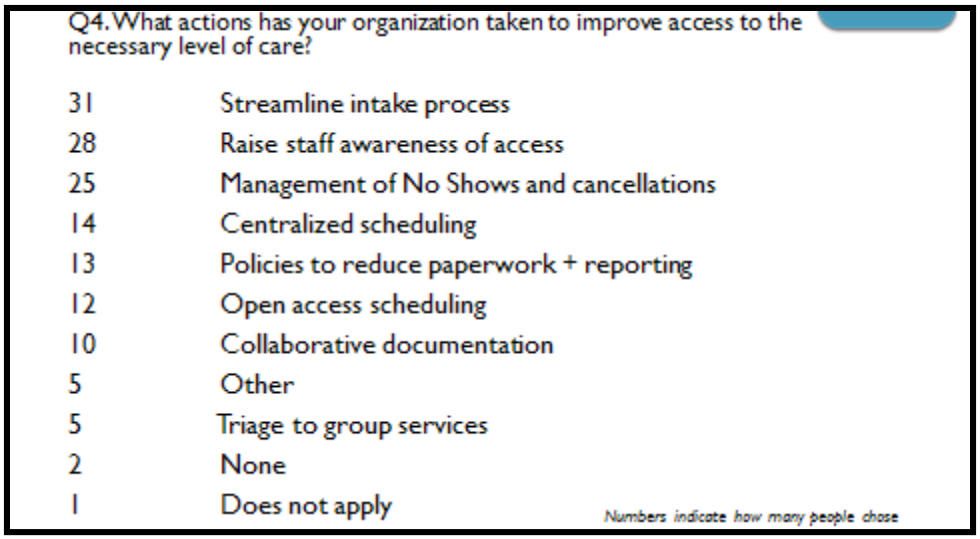


Streamlining the intake process (n=31 of the 54 responding organizations), raising staff awareness of access (n=28), management of No Shows and cancellations (n=25) were the top three actions providers reported having taken to improve client access to the necessary level of care. Fewer providers reported using centralized scheduling (n=14), policies to reduce paperwork and reporting (n=13), open access scheduling (n=12), collaborative documentation (n=10) and triage to group services (n=5). The results from this question point to possible opportunities for increasing access and improving system capacity.

[205] The complete results can be downloaded here: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf

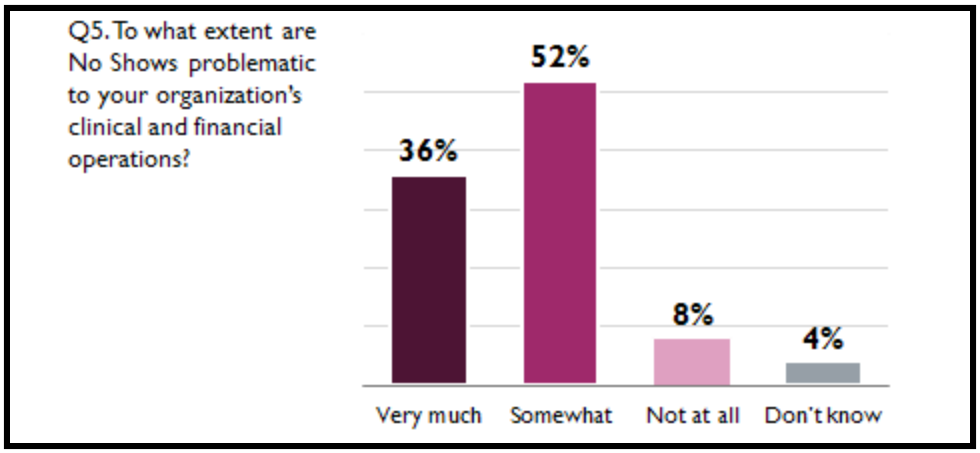
[206] Same day access to behavioral health services. Chuck Ingoglia, National Council. David Lloyd, Scott Lloyd, Joy Fruth, and Annie Juve, MTM Services. https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/

Figure 9-2 Response to Provider Survey Question 4



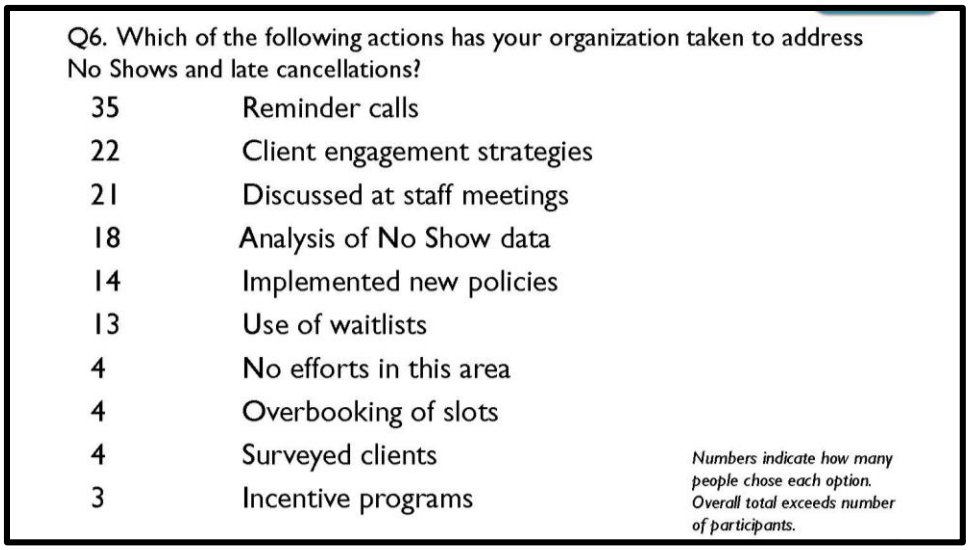
The majority of providers reported that No Shows were very problematic (36 percent) or somewhat problematic (52 percent).

Figure 9-3 Response to Provider Survey Question 5



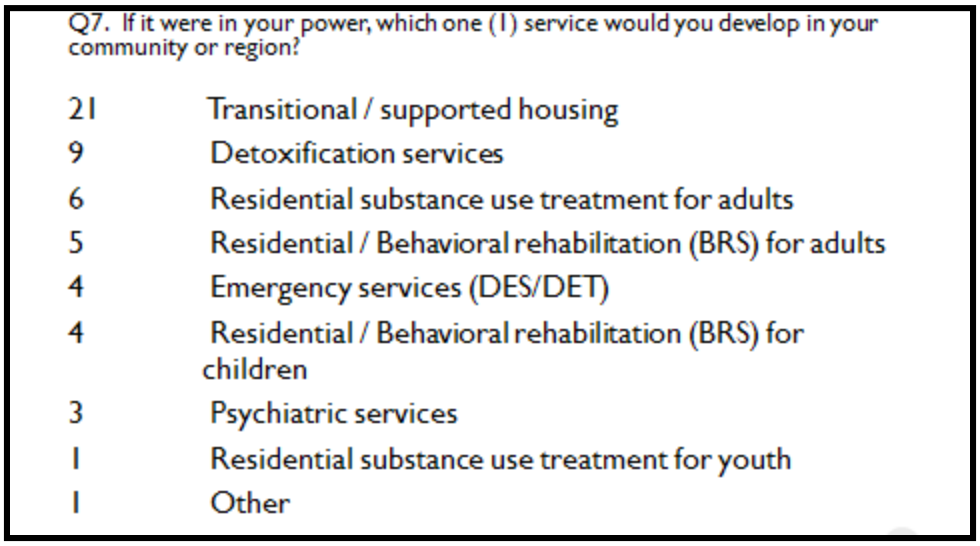
Providers have employed a range of actions to address No Shows and late cancellations, the most common of which is reminder calls. Eighteen respondents reported analyzing No Show data, 13 reported using waitlists, and only four reported overbooking of slots to help address No Shows and late cancellations. Given the reported impact of No Shows and late cancellations, DBH might consider bringing in a national expert and dedicating time to sharing promising practices at the next change agent conference to this topic.

Figure 9-4 Response to Provider Survey Question 6



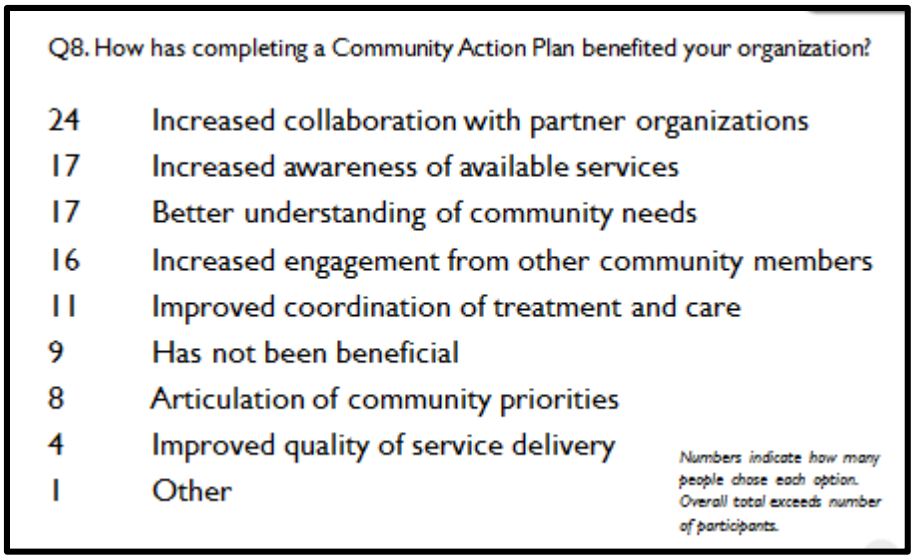
Providers ranked transitional/supportive housing as the number one service they would development in their communities and regions if they could. This response reinforces our finding that lack of supportive housing is a major gap in Alaska's continuum of behavioral health care.

Figure 9-5 Response to Provider Survey Question 7



DBH recently began requiring the completion of a Community Action Plan by grantees. Some concern has been voiced about the amount of effort this requirement adds to an already burgeoning workload. Increased collaboration with partner organization (n = 24), increased awareness of available services (n= 17), better understanding of community needs (n=17), and increased engagement from other community members (n=16) were among the top ways in which completing a Community Action Plan has benefited their organization. Nine providers reported that completing a Community Action Plan had not been beneficial.

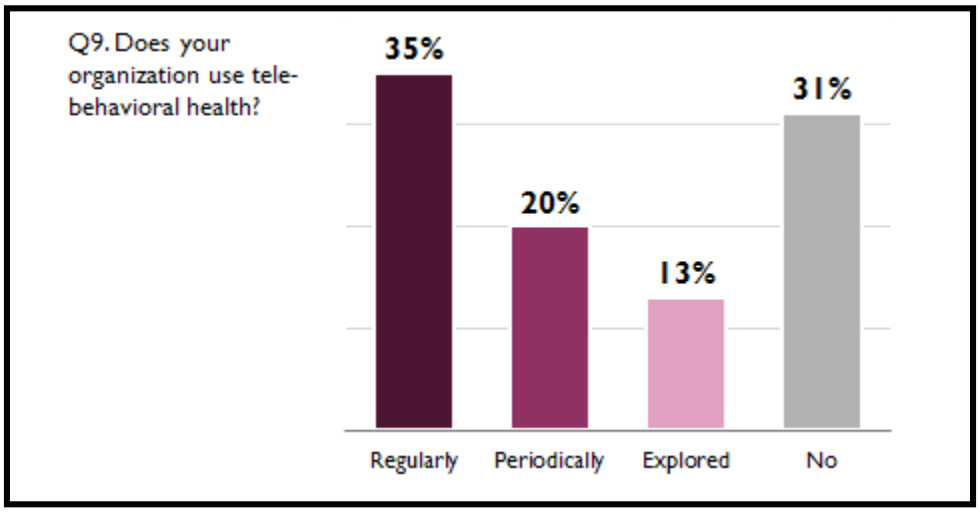
Figure 9-6 Response to Provider Survey Question 8



Tele-behavioral health

Tele-behavioral health is the use of telecommunications technology to assess, diagnose, and provide ongoing treatment to those who cannot access services in person because of rural location or other reasons. Facilitation of tele-behavioral health services is a Medicaid billable service.[207] Thirty-five percent of respondents use tele-behavioral health regularly, 20 percent periodically, 13 percent have explored its use, and the remaining third of respondents do not use tele-behavioral health at all. Non-Tribal providers were more likely to respond not at all or have explored; Tribal providers were more likely to respond regularly or periodically.

Figure 9-7 Response to Provider Survey Question 9

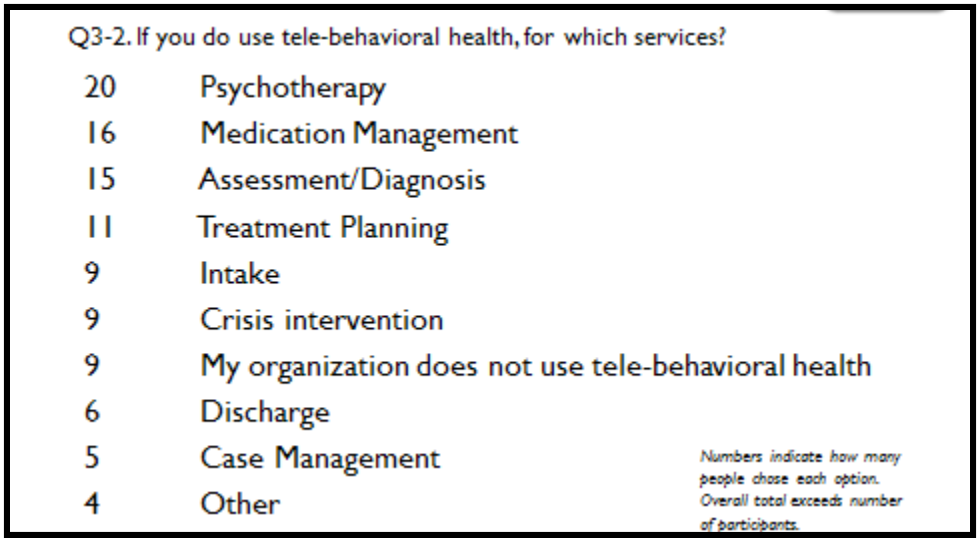


The top three uses for tele-behavioral health were psychotherapy, medication management, and assessment/diagnosis. Tribal providers were more likely to report using tele-behavioral health for crisis intervention than assessment and medication management. Use of tele-behavioral health for

[207] http://manuals.medicaidalaska.com/cbhs/cbhs.htm; Community Behavioral Health Medicaid Covered Services (Procedure Codes, Annual Limits, Payment Rates, Program Approval)_REVISED with 2013 CPT Codes

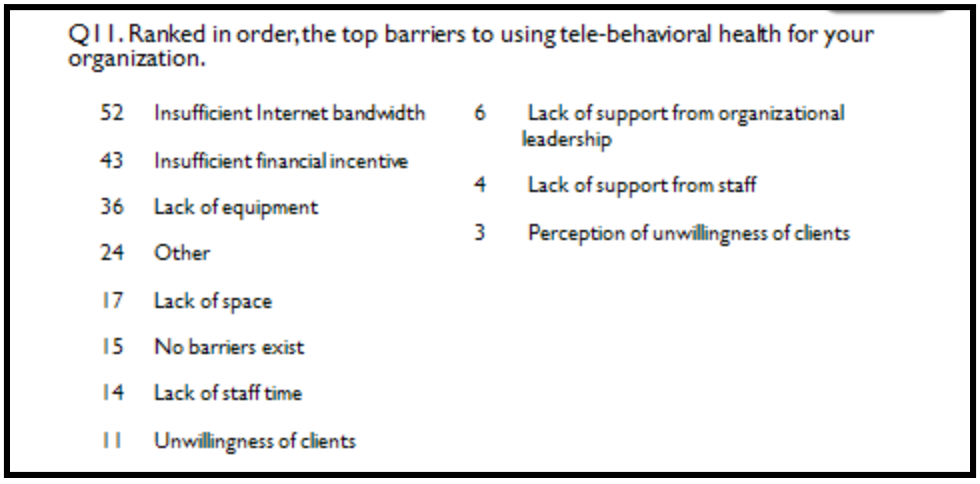
group services presents an emerging opportunity. Many Tribal providers already use tele-behavioral health for staff meetings with Behavioral Health Aides.[208]

Figure 9-8 Response to Provider Survey Question 3-2



Providers reported that insufficient internet bandwidth, insufficient financial incentive, and lack of equipment as the top barriers to using tele-behavioral health in their organizations. Fifteen providers indicated that no barriers existed. Only 11 providers called out the unwillingness of clients as a barrier to using tele-behavioral health.

Figure 9-9 Response to Provider Survey Question 11



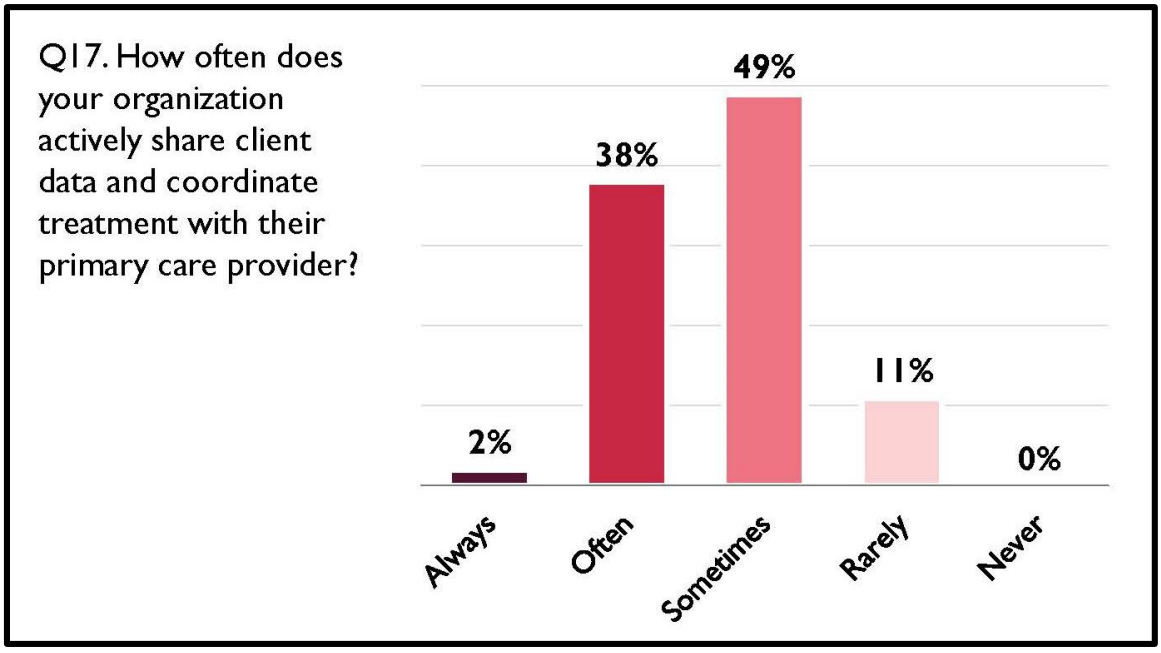
Integrated Care

During the survey, integrated care was defined as the integration of behavioral health care and primary care. Thirty-eight percent of respondents said they often shared client data and coordinated treatment with the client's primary care provider, approximately half said they sometimes shared data and coordinated treatment. Providers shared concerns about the confidentiality requirements associated with alcohol and drug abuse patient records (42 CFR) limiting their ability to share data.

[208] Discussions with Tribal Behavioral Health Directors over the course of this project.

In June 2014, Jeff Capobianco, MA, PhD, LLP, who is the Director of Performance Improvement for the National Council for Behavioral Health, presented at the DBH Change Agent Conference. During his presentation, Mr. Capobianco underscored that providers in the lower 48 were sharing client data and recommended that DBH pursue additional technical assistance to help providers navigate 42 CFR.

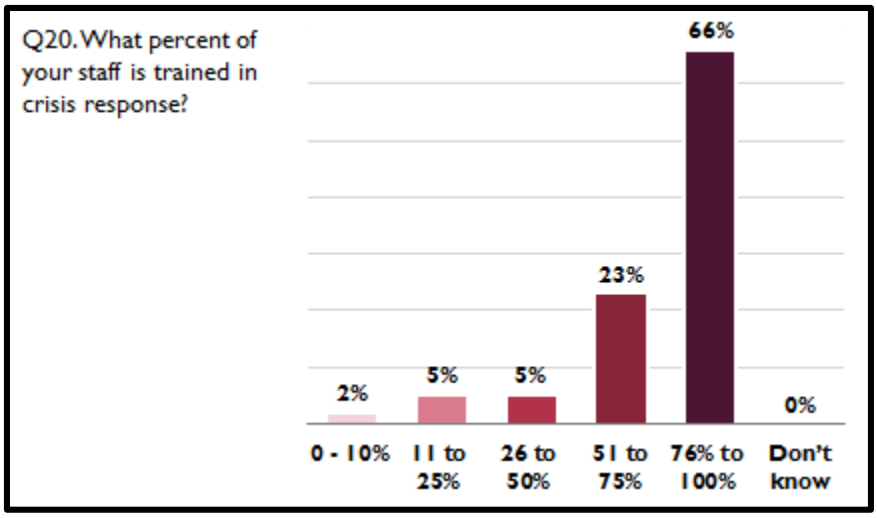
Figure 9-10 Response to Provider Survey Question 17



Crisis and Suicide Response

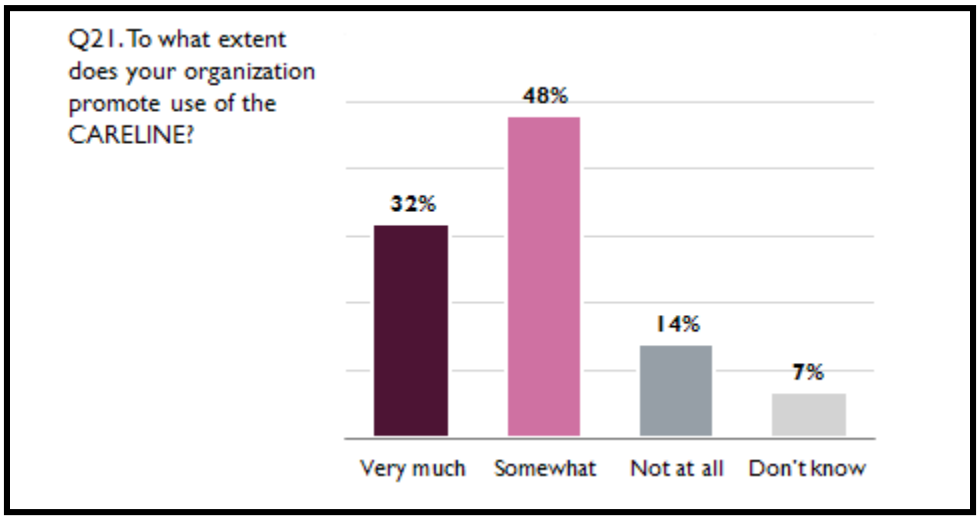
Crises refer to acute mental, emotional, behavioral, or psychiatric episodes affecting an individual, family, or community. Ninety-eight percent of responding providers reported having policies and treatment protocols for crisis response and suicide prevention. Two-thirds of providers reported that 76 to 100 percent of their staff is trained in crisis response. Only 12 percent reported that less than 50 percent of their staff is trained in crisis response.

Figure 9-11 Response to Provider Survey Question 20



The CARELINE, or "Alaska Suicide Prevention and Someone to Talk to Line" is a toll free, 24 hour service for individuals in crisis.[209] Eighty percent of providers reported that they promote use of the CARELINE very much or somewhat. Only 14 percent said they did not promote the CARELINE at all. This feedback suggests an opportunity to increase promotional efforts and useage.

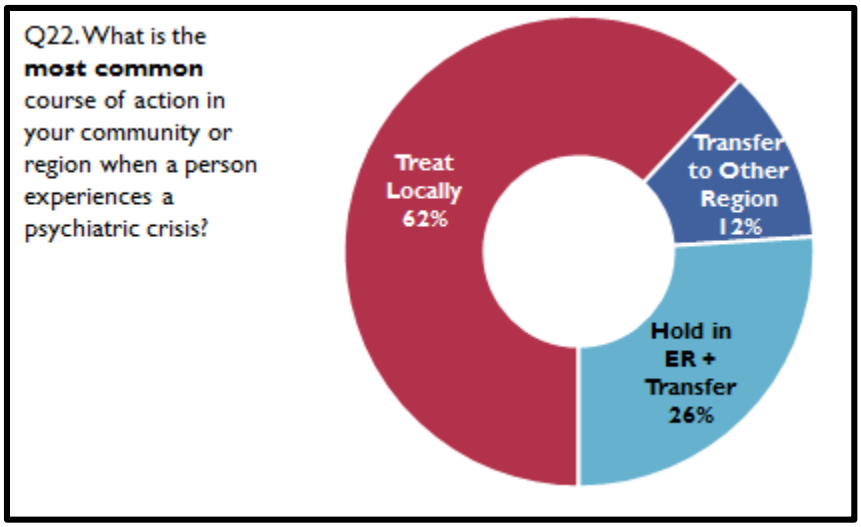
Figure 9-12 Response to Provider Survey Question 21



Sixty-two percent of providers responded that the most common course of action in their community or region when a person experience a psychiatric crisis is to stabilize and treat locally. Twenty-six percent of providers hold at an emergency department and then transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. Twelve percent of providers transfer to treatment to API, Bartlett Regional or Fairbanks Memorial Hospital. These responses reinforce the regional service patterns seen in the quantitative data analysis.

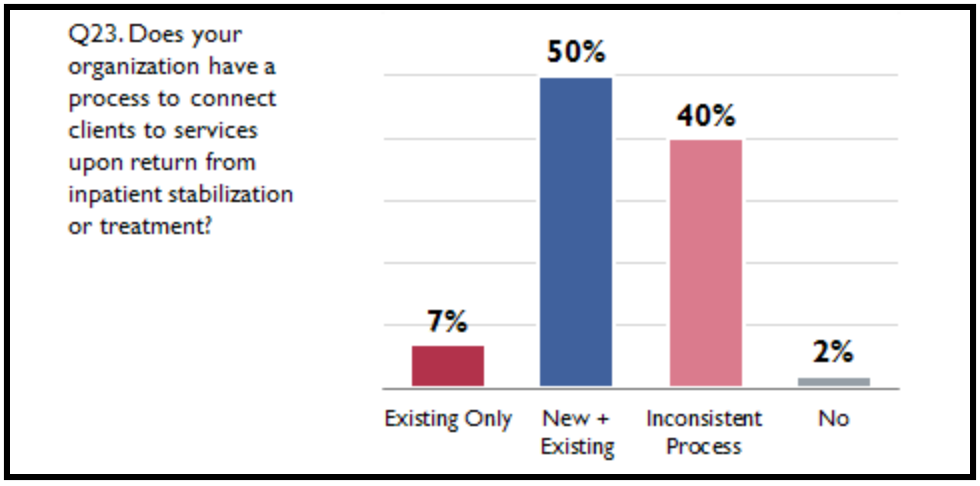
[209] http://carelinealaska.com/

Figure 9-13 Response to Provider Survey Question 22



Fifty percent of responding providers reporting that they have a process to connect new and existing clients to services upon return from inpatient stabilization and treatment. Forty percent of providers said that they have a process but it does not always work. Over the course of this project, many providers expressed frustration due to lack of communication from API upon discharge. ANTHC recently providing funding for a new care coordination position in hopes of improving the rate at which clients are connected to services upon discharge from API. This area presents an opportunity for system improvement. Regional continuum of care planning may help regions prevent entry and re-entry into inpatient stabilization and treatment services.

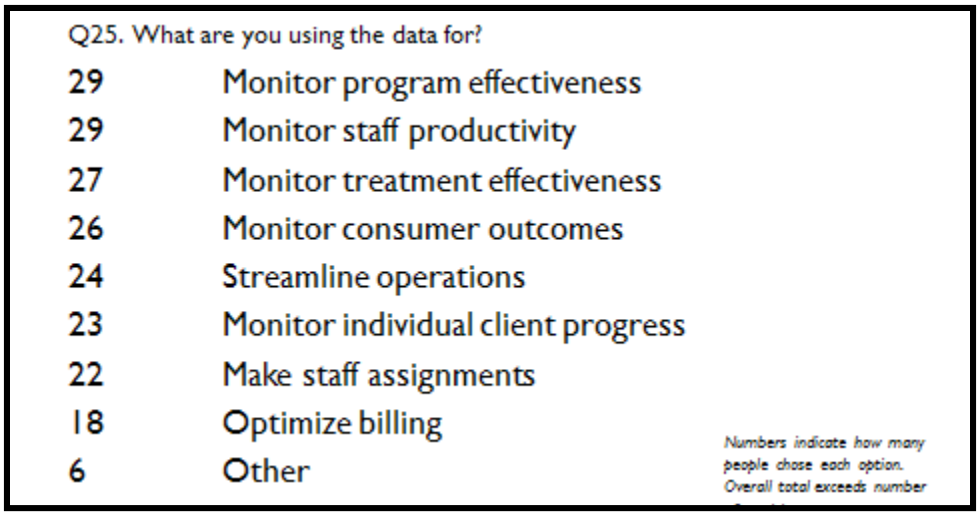
Figure 9-14 Response to Provider Survey Question 23



Data Utilization

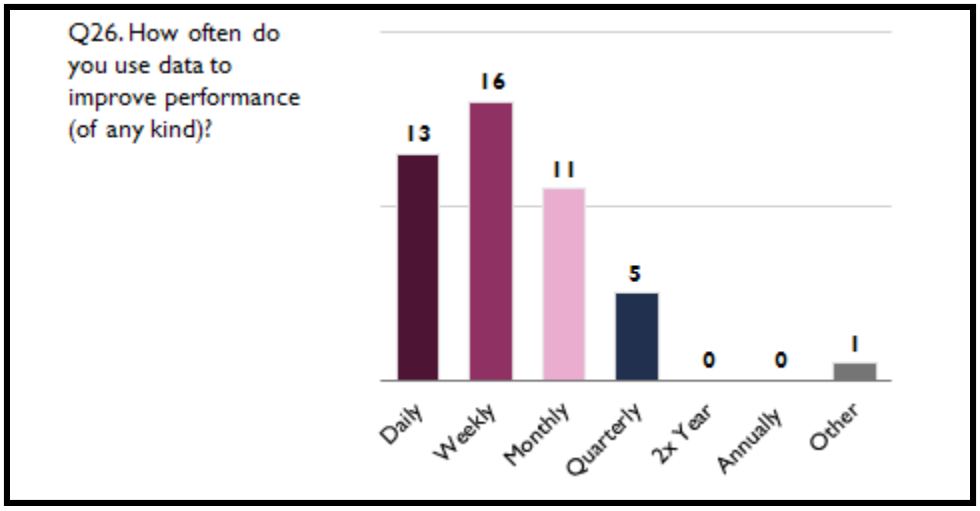
Ninety-eight percent of respondents reported collecting data to inform improvement efforts. Data is used for a wide range of performance-related efforts, such as monitoring program effectiveness (n=29), staff productivity (n=29), treatment effectiveness (n=27) and consumer outcomes (n=26). Optimizing billing fell toward the end of this list (n=18) and may present an opportunity for providers. The average number of responses per organization was 4.5.

Figure 9-15 Response to Provider Survey Question 25



We also asked how frequently providers use data to improve performance and the majority used data at least monthly.

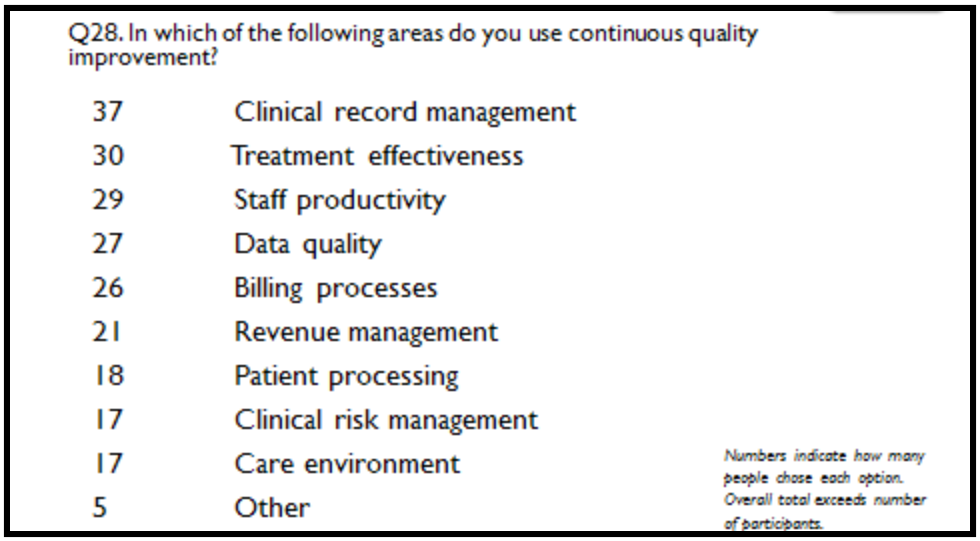
Figure 9-16 Response to Provider Survey Question 26



Quality Improvement Processes

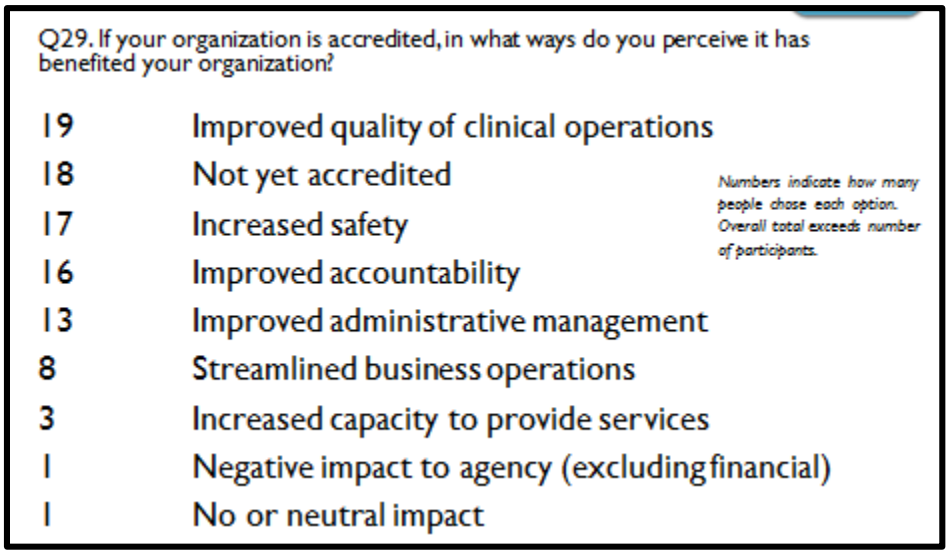
Quality improvement is a formal process of analyzing an organization's performance and deploying systematic efforts to improve performance in many ways. Ninety-eight percent of providers reported that they have one or more continuous quality improvement processes that staff regularly participate in. Providers use continuous quality improvement in a range of areas, including clinical record management (n=37), treatment effectiveness (n=30), and staff productivity (n=29). The average number of uses per organization was five.

Figure 9-17 Response to Provider Survey Question 28



DBH now requires that all grantees become accredited. We asked how accreditation had benefited provider organizations. Eighteen reported that the time of the survey that they were not yet accredited. Improved quality of clinical operations (n=19), increased safety (n=17), improved accountability (n=16), and improved administrative management were the top responses (n=13). Only two providers reported a neutral or negative impact to the agency (excluding financial).

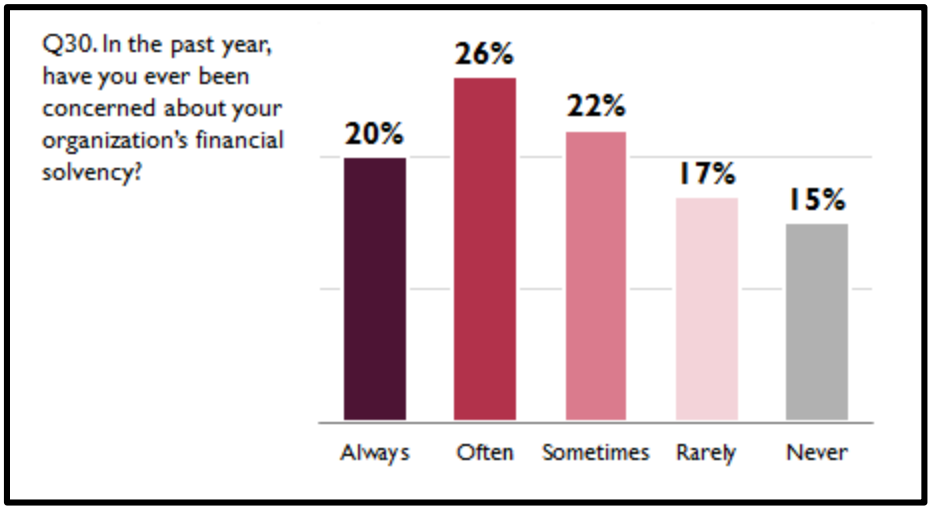
Figure 9-18 Response to Provider Survey Question 29



Revenue Management

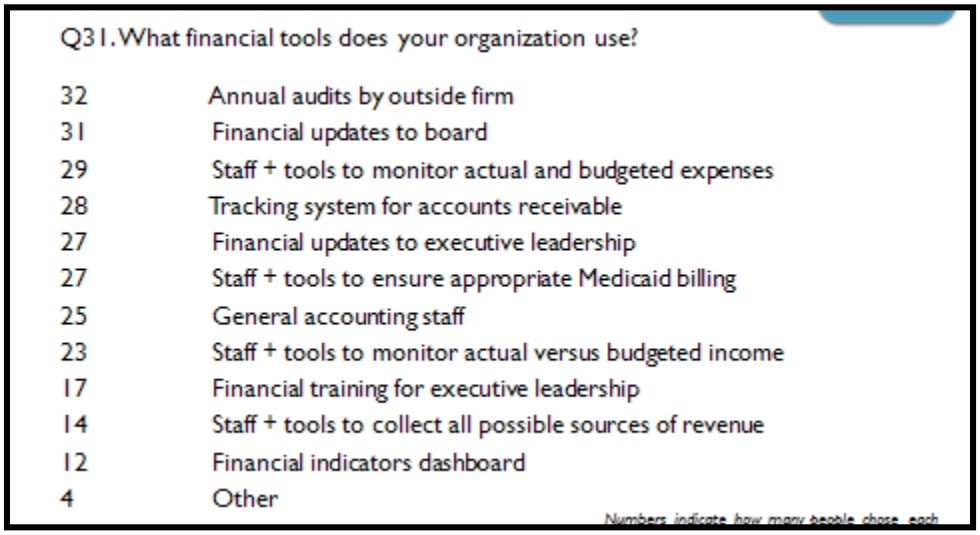
Two-thirds of providers were always, often, or sometimes concerned about their organization's financial solvency in the past year.

Figure 9-19 Response to Provider Survey Question 30



Providers use a range of financial tools for revenue management, including annual audits by outside firms (n=32) and staff and tools to ensure appropriate Medicaid billing (n=27). Financial training for executive leadership (n=17), staff and tools to collect all possible sources of revenue (n=14), and financial indicators dashboard (n=12) were among the lesser used tools. Respondents reported using an average of six of the 11 financial tools listed. Ensuring robust revenue management tools, particularly tools such as business plans that are aimed at ensuring all possible sources of revenue, may present an opportunity for enhancing systems capacity.

Figure 9-20 Response to Provider Survey Question 31

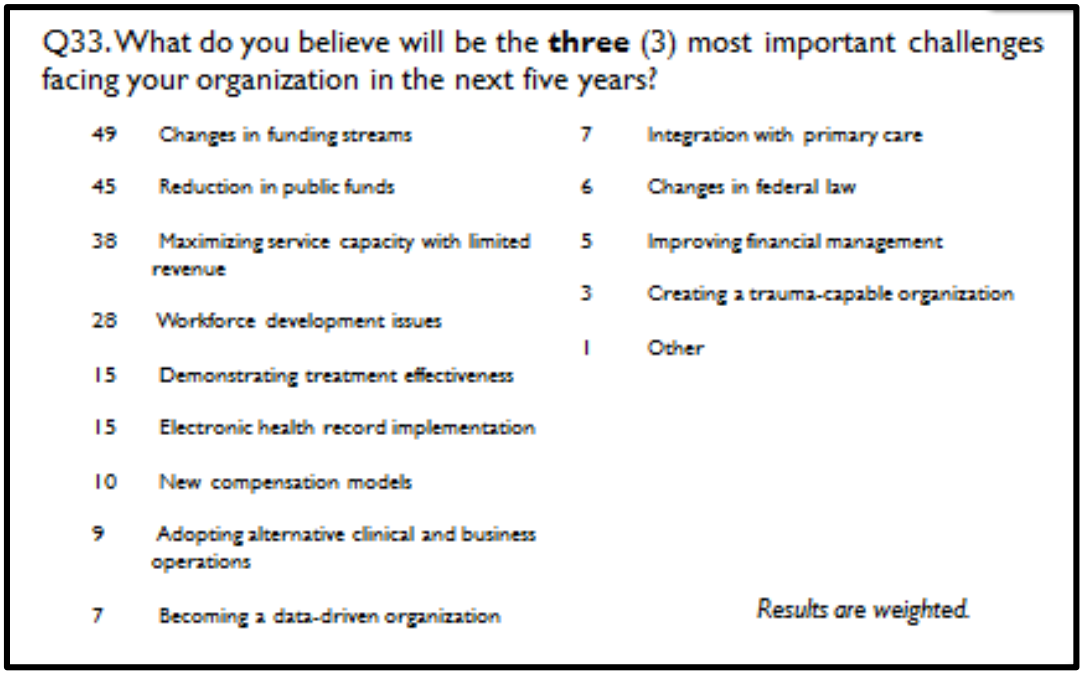


In an effort to better understand the challenges facing providers, we asked what they believed the three most important challenges facing their organizations in the next five years would be. Changing in funding streams (n=49), reduction in public funds (n=45), maximizing service capacity with limited revenue (n=38), and workforce development issues (n=28) were the top responses. These

responses far out-ranked issues like creating a trauma-capable organization (n=3), changes in federal law (n=6), and integration with primary care (n=7).

This finding is evidence of the difficult financial state that many behavioral health providers find themselves operating in and speaks to the need to increase Medicaid reimbursement rates for non-Tribal providers, set Medicaid billing targets at the organizational level and provide Medicaid billing training and technical assistance to all providers, and tread carefully when weighing the timelines and possible implications of reducing grant funding.

Figure 9-21 Response to Provider Survey Question 33



Behavioral Health Aide Survey

Figure 9-22 World Cafe Invitation

INTRODUCTION AND GRATITUDE

In November 2014, ANTHC and Agnew::Beck collaborated to conduct a world-café-style survey with BHAs in order to collect feedback that would help us better understand system capacity and inform recommendations for systems improvements. The breadth and depth of the feedback provided by the BHA workforce during these sessions paints a picture that can help to guide the path forward as the Tribal Behavioral Health System works within and across regions to achieve its vision.

Many individuals made this survey, which marked the first time BHAs had been asked questions of this nature, a success. On behalf of the Alaska Mental Health Trust Authority and the Alaska Behavioral Health Assessment project team, we would like to thank:

- The Tribal Behavioral Health Directors Executive Committee for leading the development of the Tribal Behavioral Health System graphic and providing valuable input into the BHA survey's content and format.
- The Behavioral Health Academic Review Committee for their guidance in how to administer the survey, including their excellent suggestion to recruit BHAs to facilitate the sessions.
- Brenda Wilson, an experienced and highly skilled Behavioral Health Aide from King Cove, Alaska who works for Eastern Aleutian Tribes. Brenda spent time learning about the Alaska Behavioral Health Systems Assessment and gave us the great honor of sharing the project's goals and the Tribal Behavioral Health System graphic with the Behavioral Health Aides at the annual forum.
- The BHAs and recorders who facilitated and documented the world café sessions with great care and skill. Their names are listed under each topic area.

- The BHA workforce who eagerly shared their thoughts on how to improve the system and achieve the vision descried in the Tribal Behavioral Health Systems Graphic.
- Laura Baéz, Xiomara Owens, and the entire team at ANTHC's behavioral health department for leading the planning and coordination of 15 very well attended world café sessions with Behavioral Health Aides from across the state.

METHODOLOGY

Questions were drafted by Agnew::Beck based on the specifications outlined for assessing the Tribal Behavioral Health System within the Request for Proposal for the Alaska Behavioral Health Systems Assessment. These questions were then reviewed and refined by ANTHC staff and the Tribal Behavioral Health Executive Committee. Questions were organized around the following topic areas:

1. BEING A BHA

2. BHA WORKFORCE

3. BHA CERTIFICATION

4. CRISIS RESPONSE

5. BEHAVIORAL HEALTH SERVICES

In administering the questions, the team aspired to create a comfortable space for BHAs to provide open and honest feedback about the system and their experiences and needs as BHAs. Together with ANTHC staff, we selected a "world café" survey approach. The BHA Curriculum Review Board was consulted for guidance on how best to field the survey and with their recommendation, BHAs were recruited to facilitate these sessions.

The world café approach allows for multiple sessions to occur at once, with one topic per table, and calls for individuals to move from one table and topic to the next. To create the atmosphere of a café, tablecloths and flowers were placed on each table and a sign introducing the name of the café, "150 Strong!" was placed at the front of the room. The sign invited participants to "Please Join Our World Café!" We hosted three separate sessions over two days. Feedback was provided on each of the five topic area by three different sets of BHAs, 15 world cafés in total. These sessions were 20 minutes each. The same question sets were used at each of the three sessions and facilitators could choose whether to start at the beginning or middle of the question set depending on the pace and direction of the previous dialogue. BHAs were asked to sit at a new table during each break. Participation was excellent and BHAs were eager to provide feedback during and after sessions.

To introduce the world café sessions, the Alaska Behavioral Health Systems project team was allotted thirty minutes following the plenary session on the first day of the forum to share an overview of the project and discuss the goals of the survey. Brenda Wilson, BHA from Eastern Aleutian Tribes, was recruited to present the project overview and share her thoughts with BHAs on why the project and their collective feedback is so important to the work they do each day. A copy of the Tribal Behavioral Health Systems Graphic was included in the forum packet as a two page spread and described to the BHAs during the overview. Two written questions were also included in their packet a comment box was created to collect their responses. The following pages highlight key themes each topic area, including a summary of the comments received in response to two additional written survey questions included in the forum packet.

WORLD CAFÉ SURVEY RESULTS: BEING A BHA

"I am a BHA. My grandmother and mother were healers. My gram said I was picked for healing when I was born. I was trained from when I was very young and, growing up, I didn't want to be this, but when I grew older, I knew I needed to be a healer. I will always be a BHA. We need the support from the agencies to be able to do this work in our communities."

This session was graciously facilitated by Forest Anderson. Forest is a BHA-I in Klawok and works for Southeast Alaska Regional Health Consortium. The session was recorded by Jennifer Burkhart-Owens, MS, a student in PhD Clinical-Community Psychology program (UAA).

Being a BHA Summary of Findings

A. What does it mean to be a BHA? What are the most important things BHAs do?

1. Being a good listener
2. Making access to services in every village a reality
3. Making connections; being a cultural bridge to villages
4. Being a role model
5. Being first responders to crises

B. What interest led to you becoming a BHA/P?

1. Inspired to help others
2. Part of job requirement
3. Selected by community
4. Experience with traditional healing
5. Love of culture
6. Professional interest

C. What are your clinical interests/ goals?

1. Certification / continuing education
2. Learning the job
3. Integrating traditional knowledge
4. Being a role model
5. Improved work space
6. Results

D. What are your overall career goals?

1. Having more support
2. Improving clinical skills
3. Integrating Western and traditional approaches
4. Creating an effective workforce
5. Helping others

E. What makes it easier to do the work of a BHA and what makes it harder?

1. Sufficient support and supervision (and lack of)
2. Sufficient (and insufficient) training
3. Connection with other BHAs (isolation, lack of connection)
4. (Documentation)
5. Community trust and readiness (and lack of)

6. Adequate staffing (high vacancy and turnover)
7. Sufficient program funding (and lack thereof)
8. (Reconciling Western treatment modalities and traditional ways)
9. (Practice of hiring from outside)

F. How is BHA work supported by your community and/or organization?

1. Investments in our professional growth
2. Quality supervision
3. Improvements to service accessibility
4. Heavy workload and strict protocols can make BHAs feel unsupported
5. Communities and clients that recognize need
6. Stigma can make BHAs feel unsupported
7. Lack of service availability can hinder community support

G. How could that support be increased?

1. Increased connection with other BHAs
2. Improved supervisory support
3. Increased coverage for services
4. Firsthand exposure to inpatient treatment
5. Time to undertake prevention and outreach work

WORLD CAFÉ SURVEY RESULTS: BHA WORKFORCE

"I worked in a liquor store for 9 years and I was tired of seeing people getting drunk all the time. One day a mom and her child came in and the mom was yelling at the young girl and saying she couldn't afford a 60 cent candy bar but she had $40 to buy an 18 pack. It took 9 years but in that moment I realized I wanted to do something different, I wanted to help my people."

This session was graciously facilitated by Laura Baez, MSW, at ANTHC Behavioral Health Department and Stephanie Lively, LCSW, from Ketchikan Indian Community. The session was recorded by Xiomara Owens, MS, ANTHC Behavioral Health Department, and Laura Baez.

BHA Workforce Summary of Findings

A. What are the most important services BHAs provide?

1. Community and youth development, cultural activities
2. Group, family, and individual counseling and aftercare
3. Screening and assessment
4. Crisis intervention/ stabilization

B. What services do you think your community needs (that could potentially be provided by a BHA)?

1. More prevention programs and resources, including injury prevention
2. Mentoring and support for males
3. More certified BHAs, greater connections to BHAs across communities
4. Personal care assistance services for elders
5. Assistance enrolling in Medicaid
6. More knowledge about how to address intergenerational trauma
7. More transition support for residents completing prison terms

C. What are the main reasons BHAs leave their jobs?

1. Organizational stressors, including lack of adequate workspace and pressure to bill for services
2. Need for greater cultural competency and stronger working relationships with clinicians
3. Pay rate is not commensurate with work load
4. Difficulty with technology and documentation
5. Lack of self-care supports
6. Lack of organization and community knowledge about the BHA workforce

D. What measures should be taken to reduce BHA turnover? How can we keep you in this job?

1. Higher pay, establishing tiered pay rates
2. Community and organizational support
3. Administrative support and workload balance
4. Creating space and support for self care
5. Improved collaboration across BH team
6. Reduce/streamline paper
7. Establishing a support structure for BHA families during times of community crisis
8. Better internet access
9. More training and education

WORLD CAFÉ SURVEY RESULTS: BHA CERTIFICATION

"Taking this path that I am trying to do right now, I'd just love to go to other communities and see the paths that they've taken. There are a lot of BHAs who have been BHAs for a long time and I would be honored to visit their community to see what they have learned. I would come back to my community and share how they have solved these problems. I would be honored to have someone who has been a BHA for ten years come into our community and sit down with us."

This session was graciously facilitated by Vickie Novak. Vickie is a BHA-Trainee in Ouzinkie and works for Kodiak Area Native Association. The session was recorded by Lakota Holman, MED, ANTHC Behavioral Health Department.

BHA Certification Summary of Findings

A. What are the benefits of being certified?

1. Increased knowledge and capacity to serve clients
2. Recognition and acknowledgement from community members, clients, and colleagues
3. Pay increase, schedule flexibility
4. Ability to bill Medicaid
5. Not sure

B. What might prevent a BHA from becoming certified or reaching the next level of certification?

1. Not knowing the steps to certification or how to get the right training
2. Lack of funding and/or organizational support
3. Gaps in available training/materials
4. Not having opportunities to practice skills

C. What do BHAs need to advance in certification levels?

1. More support for understanding the nuances of how to get certified
2. Knowledgeable supervisors
3. Relias works for some, not for others

D. Describe aspects of an effective training program (including mode [distance, face-to-face, online])

1. Standard, easy to follow pathways that maximize value of training time
2. Desire for a training academy modeled after the CHAP program
3. A mix of online and in-person training works well
4. Soliciting supervisor input into training
5. Training that fosters healing of one's self

E. What would be most helpful for BHAs to get/advance their level of certification?

1. An online tool for planning and tracking progress toward certification

WORLD CAFÉ SURVEY RESULTS: CRISIS RESPONSE

"No matter what community you are in, if you are in a rural community, all of us BHAs go to work facing similar rural community issues. Right now, from what I've seen talking to other BHAs, we all have the same issues, similar crises. We are all walking this path alone with our communities. If we could walk this path together, we could all benefit from it. Being a BHA can be a very strenuous job, if we supported one another things could go along more smoothly."

This session was graciously facilitated by Stephanie Lively, LCSW, living in Ketchikan and working for Ketchikan Indian Community, and Xiomara Owens, MS, ANTHC Behavioral Health Department. The session was recorded by Leah Woolard and Dabney VanLiere, ANTHC Behavioral Health Department.

Crisis Response Summary of Findings

A. Describe the crisis response protocols for your organization.

1. Crisis protocols, including how to initiate external crisis support and when to call the BHA, vary by community

B. Have you ever used the crisis response system at your organization?

1. Most BHAs reported having used crisis response systems

C. How comfortable do you feel handling a crisis?

1. BHAs comfort with crisis was mixed; many felt comfortable or at least felt that support was available but personal safety was a pervasive concern

D. What would make you more comfortable handling a crisis?

1. Additional training and support from supervisors
2. Working in a more coordinated fashion with the community other responders
3. Steps to ensure staff/office safety
4. Transportation vehicles
5. Time and experience on the job

E. Who should be involved in a crisis response and how?

1. BHAs underscored the importance of Tribal and community involvement; as well as the need to ensure BHAs themselves are called in at the right times

F. How do you think the follow-up after a crisis should be managed?

1. Immediate debriefings and follow up support for first responders and community members

G. Are there additional (local or statewide) services that would be helpful in crisis situations?

1. Local leadership with wraparound support from social services and other entities

H. Do you promote usage of the CARELINE before or after a crisis?

1. Mixed response; some yes, some always, and some no

WORLD CAFÉ SURVEY RESULTS: BEHAVIORAL HEALTH SERVICES

"I don't want to be a BHA of Metlakatla and talk to a BHA from Nome. I want to be a BHA of Alaska. I see that what we do is healing from within and every community is going through this process. If we could heal the whole state together, there is so much potential! I see BHAs having the ability to bring communities together. I see BHAs healing this state, dramatically reducing suicide and substance abuse. BHAs stopping historical trauma that is getting passed down. Our work could stop that cycle."

This session was graciously facilitated by Tasha Dunlap. Tasha is a BHA-Trainee in Old Harbor and works for Kodiak Area Native Association. The session was recorded by Jake Chapman, MS, ANTHC intern and student in PhD Clinical-Community Psychology program (UAA), Emilie Cattrell, MS, CDC-I, Research Associate for UAA Center for Behavioral Health Research and Services, and Leah Woolard, ANTHC Behavioral Health Department.

Behavioral Health Services Summary of Findings

A. What behavioral health services are most often provided in your community?

1. Cultural activities
2. Community prevention and outreach
3. Substance abuse services
4. Intake, assessment, and counseling services
5. Onboarding support to new clinicians

B. What behavioral health services are unavailable to individuals in your community?

1. Outpatient services
2. Intensive outpatient services
3. Ready access to inpatient services
4. Longer-term treatment options
5. Coordinated after care support
6. Detox services and crisis services
7. Sufficient support for BHAs / BHPs
8. Transportation to services
9. Culturally competent care
10. Integrated service delivery
11. Education
12. Not sure

C. When does telebehavioral health work best as a method for delivering behavioral health services?

1. When the internet connection is solid
2. When it is easy to coordinate
3. When bad weather prevents travel
4. When a client needs support right away
5. Can be great as a tool for staffing
6. As an alternative to planned travel
7. For assessments

D. When does telebehavioral health not work well as a method for delivering behavioral health services?

1. When you lose the personal connection
2. When spaces do not allow for privacy
3. When weather/connections are bad

4. When it is not put in the treatment plan

5. When we do not have sufficient training

E. What is missing to be able to provide good care to patients in rural Alaska (from beginning to end)?

1. Dedicated space/infrastructure for delivery of behavioral health services

2. Access

3. Staff consistency

4. Whole family engagement

5. Long turnaround times for intakes

F. How have you seen behavioral health services integrated with primary care in your community?

1. Integration has not yet meaningfully taken hold

G. How closely do you currently work with Community Health Aides or other medical professionals?

1. Collaboration with CHAs and other medical professionals is limited for many BHAs

2. While others have had much greater success

3. Confidentiality concerns limit collaboration

4. Suggestion: BHAs go to other communities that BHAs work in

H. How would you like to see that partnership strengthened?

1. Need to elevate the status of the BHA

2. CHAs are stretched too thin as it is

3. Need to use telemedicine more to support greater integration

WORLD CAFÉ RESULTS: THE BEHAVIORAL HEALTH SYSTEM

"Our supervisor is from the lower 48. We need to connect our supervisors. They have shared experiences and need to get together to discuss the similar obstacles that they are trying to overcome. We are trying to heal our communities from within and if we do this together, we can reach our goal faster. "

BHAs were asked to provide feedback about the behavioral health system via two written questions included in their conference packets:

- Name 3 things about the behavioral health system that are working well.
- Name 3 things about the behavioral health system that you would like to see improved.

Their responses are summarized in the table that follows.

Behavioral Health System Summary of Findings

Things About the Behavioral Health System That Are Working Well	Things About the BH System that You Would Like to See Improved
• Training available • Getting certified • Networking and collaborating with other BHAs that can also lead to community involvement! • Our people working with our people • Using traditional skills • It is finally recognized • Hiring our native people to help their neighbors and community better themselves • We have local natives as BHAs • We focus on being culturally relevant • People working together • Hands on training • Getting money in the grant • Helping clients stay in legal compliance • Staff support peers staying in ASAM compliance • Help from Xio, Lakota, Brenda, Dabney • Therapy • Med management with API • Purpose/intent • People/personnel • Training content	• Recognizing the mental health [status] exam and how to communicate with clinicians or hospital staff during a crisis situation • Your ability to communicate so that everyone can hear you • That you keep track of all the trainings I had so that I could stay certified. Thank you! • CISD for counselors • Counseling the counselors • Retreats • Less turnover of the BHAs and clinicians • More training, especially for BHAs who do not have clinicians in/near their villages • More higher education so we can fill the clinical roles with local natives as well (I love RHS). • More focus and education on self-care for all BHAs (wellness retreats would be awesome) • Increased inter/outer agency collaboration • Communication • Supervisors who 1) understand the BHA goals and need for 2) education and 3) support. • Staff to staff respect/honor • Program directors' support • Colleagues help each other • Certification • 35 DSM, 35 ASAM Requirement • 100 hour practicum • BHA certification • Faster care • No wait lists • Training available • Certification aide • Supervision

10. OPPORTUNITIES, BARRIERS AND RECOMMENDATIONS

Overview

An important goal of the Alaska Behavioral Health Systems Assessment was to develop recommendations for systems change. This section is broken into two sets of recommendations, one for the system as a whole and one specific to the Tribal Behavioral Health system. Each set of recommendations includes opportunities and barriers and corresponding recommendations developed with input from stakeholder interviews, survey results, and the other qualitative and quantitative analyses performed during the course of this, and other projects, in 2014 and the first half of 2015. Ten priority opportunities and barriers facing the Alaska Behavioral Health System and three priority opportunity opportunities are highlighted first, along with recommendations. These priorities are included in the executive summary of the report and repeated in the full set of opportunities, barriers, and recommendations included subsequently. The full set of opportunities, barriers and recommendations are organized into four categories: A) Policy, Regulatory, and Financial, B) Organizational / Operational, C) Geographic, and D) Cultural.

The following questions guided the development of this component of the assessment.

ASSESSMENT QUESTIONS:

- What opportunities and barriers exist to meeting more of Alaska's need for behavioral health services?
- Where is there unused capacity in the system and how might this capacity be tapped?
- Which recommendations can be made for improving the behavioral health system in Alaska?
- How can unmet need, unmet demand, unused capacity and progress toward systems improvements be monitored and assessed over time?

PART ONE: ALASKA BEHAVIORAL HEALTH SYSTEM

Like any good systems assessment, the ultimate aim of this effort is to inform decision-making, at the regional and statewide levels, and improve system functioning so that it can produce better outcomes for the people it serves. This assessment builds upon previous and ongoing efforts by DBH and others to assess the behavioral health system funded by State of Alaska Medicaid and behavioral health funds. One of the many strengths of Alaska's behavioral health system is the way in which service organizations leverage these funds with multiple other funding streams to provide behavioral health services to a range of clients. This blending of funds and leadership did not always make it easy to establish clear boundaries for our analysis, but the data we amassed and analyzed over the course of the project tell an important story about a system in transformation, a system that is both fragile and robust, and a system facing many opportunities and barriers to increasing its capacity to meet the behavioral health needs of Alaskans. Addressing the opportunities and barriers to increasing system capacity and successfully steering the system through this time of transformation will require a truly collaborative effort across all levels of the system. Through the recommendations included below, we paint a picture of what that effort might look like in Alaska.

Ten Priority Opportunities and Barriers

#	Opportunities/Barriers	Recommendations
Priority Opportunities and Barriers with Recommendations		
1	Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle and culture of crisis response and create costly inefficiencies.	• Expand Medicaid, ensure non-Tribal providers have a rate structure that adequately compensates for care; explore behavioral health payment models through DHSS's Medicaid Redesign and Expansion. • Support regional continuum of care assessments using the results from this assessment to identify service gaps and identify priorities/strategies to address gaps at the regional level. • Continue to explore ways at the state level to secure funding to address gaps in the continuum of care and maximize the 100 percent Federal Medical Assistance Percentage (FMAP) rate for Tribal Health Organizations when serving Alaska Native Medicaid enrollees. • Identify additional ways to promote greater financial stability among providers, including increasing State match to capture Alaska's full entitlement to federal Disproportionate Share Hospital (DSH) funds. • Ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.
2	Medicaid presents a challenging, yet essential, revenue opportunity for Alaska's behavioral health system; optimizing the system's Medicaid billing capacity will be particularly important as grant funding declines in the years to come.	• Establish a non-tribal rate structure/payment model that adequately compensates for care. • Step up efforts to provide technical assistance and training to providers interested in optimizing their billing capacity. • Work at all levels of the system to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current Community Behavioral Health Medicaid billing regulations. • Consider creating a learning community, supported by regular systems reports, to enhance peer-to-peer learning by hosting a monthly, facilitated teleconference on topics such as optimizing Medicaid revenue and operational/clinical improvement efforts.

3	Behavioral health systems leaders must recognize and support both doors of the system, the medical door and the community behavioral health service door and develop a vision and pathway free of regulatory barriers for integrated care and payment reform.	• DHSS must address the regulatory barriers to billing for behavioral health services in primary care settings and establish a plan for meeting more of Alaska's behavioral health needs. • Leaders and providers must work across departments and sectors to expand the PCMH initiative beyond its current pilot. • A more concerted effort to assist behavioral health and health care providers in their efforts to navigate 42 CFR and share data across provider types. • Ensure current efforts by DBH to develop AKAIMS capacity to exchange data with Alaska eHealth Network exchange remain a priority. • Update the comprehensive integrated mental health plan and include a vision and model(s) for behavioral health service delivery in primary care.
4	Documentation requirements that exceed those on the medical side present challenges to Tribal and non-Tribal providers alike.	• Evaluate the degree to which SAMHSA block grant funding requirements conflict with or support the State's goals and data reporting needs. • Ensure current efforts by DBH to expand grantee access to electronic interface through Alaska eHealth Network (or otherwise) remain a priority. • Revive efforts to roll out the Medicaid billing module in AKAIMS (this will require resolving potential conflict of interest concerns). • Continue to explore documentation guidelines (e.g. page limits, use of bullet points), standard templates, and collaborative documentation efforts to reduce time burden and help to manage risks of Medicaid denials and paybacks. • Increase trainings and technical assistance to directors and staff to increase comfort and reduce time associated with documentation; work on training clinicians and BHAs on the concept that that "less is more" and documentation of active interventions is essential.

5	In a time where information technology and data analysis are needed more than ever, DBH's technology, research, and analysis staffing model is insufficient and unsustainable; analytic power is key to system transformation.	• Data must be the basis for decision-making at all levels; develop a regular (annual) assessment cycle with alternate year goals – year one, data is cleaned and consolidated and core tables are produced; year two, additional analyses are conducted on the dataset created in year one. • Explore possibilities for external analysis resources that could assist DBH with annual production of the assessment and other analyses throughout the year; the university working in concert with a data collaborative might serve as a good permanent home for this function. • Leverage the database built during the course of this project as a prototype for producing the assessment for the two year cycle described above; this will refine the framework as DBH works on a more robust platform that will support assessment efforts in the future. • Advocate for the addition of at least one senior analysis position at DBH to move beyond the current staffing model, where an enormous amount of institutional knowledge about the system's data rests with only one person. • Update the comprehensive integrated mental health plan and include sections on technology and analysis.
6	Limited access to the electronic data interface and delays in rolling out the billing module has severely capped the utility of AKAIMS and results in costly inefficiencies.	• Reduce costly inefficiencies associated with double and triple data entry into AKAIMS by implementing the budget module and expanding interface capabilities to all provider types. • Establish the capacity to share data with the Alaska's eHealth Exchange Network to assist in streamlining efforts to share data across provider types. • DBH is currently working on a pilot to test the feasibility of establishing a provider interface to the Alaska eHealth Network and AKAIMS; these efforts must continue to be a priority.

7	Continued focus on workforce development is key to closing existing gaps in training and meet the increased demand for behavioral health services.	• Provide continued support to workforce development efforts to ensure the behavioral health workforce has the training and supervision necessary at all levels to provide evidence-based, culturally competent therapies, bill Medicaid, use data to drive improvements to care, and pursue innovations such as team-based care and integration with primary care. • Develop systems and organizational level strategies to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current Community Behavioral Health Medicaid billing regulations.
8	Geographic distances can make it difficult to know which resources are available in the statewide continuum of care.	• Explore methods for increasing awareness of available resources, including a web-based directory of resources, and/or expansion of 211 services. • Implement system-wide reports that foster awareness and dialogue about utilization patterns. • Reinstate the twice per year DBH Change Agent Conferences.
9	The behavioral health system is like a canoe that needs all of the paddles in the water pulling in the same direction to propel the craft forward.	• Embrace the call to action issued at the start of this report and work together to synchronize the many paddles on this canoe we call the Alaska Behavioral Health System. • Update the comprehensive integrated mental health plan, develop a clear vision that spans sectors and solidifies access to behavioral health services for populations in need • Leverage the comprehensive mental health plan to clarify roles and responsibilities and leverage the full capacity the system's leadership and partner resources
10	Divides still exist between the community behavioral health system and other systems that work regularly with individuals who would benefit from behavioral health services.	• Work across departments and organizations to ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.

Alaska Behavioral Health System Opportunities and Barriers (Full Set)

#	Opportunities/Barriers	Recommendations
A. Policy, Regulatory, and Financial Barriers		
A1	Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle and culture of crisis response and create costly inefficiencies.	• Expand Medicaid, ensure non-Tribal providers have a rate structure that adequately compensates for care; explore behavioral health payment models through DHSS's Medicaid Redesign and Expansion. • Support regional continuum of care assessments using the results from this assessment to identify service gaps and identify priorities/strategies to address gaps at the regional level. • Continue to explore ways at the state level to secure funding to address gaps in the continuum of care and maximize the 100 percent Federal Medical Assistance Percentage (FMAP) rate for Tribal Health Organizations when serving Alaska Native Medicaid enrollees. • Identify additional ways to promote greater financial stability among providers, including increasing State match to capture Alaska's full entitlement to federal Disproportionate Share Hospital (DSH) funds. • Ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.
A2	Concern about Alaska's lack of compliance with the Olmstead Act is indicative of the work that remains to bring needed services to communities.	• Undertake the update of a comprehensive integrated mental health plan to integrate existing efforts and clarify the path forward.

A3	Medicaid presents a challenging, yet essential, revenue opportunity for Alaska's behavioral health system; optimizing the system's Medicaid billing capacity will be particularly important as grant funding declines in the years to come	• Establish a non-tribal rate structure/payment model that adequately compensates for care. • Step up efforts to provide technical assistance and training to providers interested in optimizing their billing capacity. • Work at all levels of the system to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current Community Behavioral Health Medicaid billing regulations. • Consider creating a learning community, supported by regular systems reports, to enhance peer-to-peer learning by hosting a monthly, facilitated teleconference on topics such as optimizing Medicaid revenue and operational/clinical improvement efforts.
A4	Medicaid expansion presents an important opportunity for providers offering a revenue source for a key population that is currently served through a mix of grants, self-pay, and uncompensated care; it is also opens the door to partner with primary care organizations who might otherwise not be willing to see clients in "the gap".	• State action to expand Medicaid eligibility is needed to open this opportunity. • Ensure the non-tribal rate structure adequately compensates for care; Medicaid redesign may present an opportunity to revisit behavioral health payment models. • Pursue ways to support implementation of two front doors into behavioral health services; remove barriers to billing for behavioral health services in key settings. • Business plans that specifically address strategies for optimizing Medicaid billing potential can help providers serve more clients, more effectively.
A5	Lack of rate increases for non-Tribal providers contributes to the system's slow transition on grant-dependence Medicaid; providers report that the cost of care for Medicaid eligible services sometimes requires subsidy from grant funds.	• Recognize that the system's transition to Medicaid is dependent on a fair, adequate rate structure for all providers. • Proceed with all due speed with the rate review effort currently underway to ensure that the cost of services are adequately covered. • Explore opportunities through Medicaid to revisit behavioral health payment models, especially for non-Tribal providers.
A6	Accreditation requirements have required tremendous individual agency effort, resource, and funding.	• Celebrate the successful attainment of accreditation by DBH grantees (also acknowledging the costs) and document ways to leverage this success to strengthen capacity at the

		organizational and systems levels. • Partner with DBH to streamline State program reviews with program reviews occurring through national accreditation, avoiding duplication wherever possible.
A7	Documentation requirements that exceed those on the medical side present challenges to Tribal and non-Tribal providers alike	• Evaluate the degree to which SAMHSA block grant funding requirements conflict with or support the State's goals and data reporting needs. • Ensure current efforts by DBH to expand grantee access to electronic interface through Alaska eHealth Network (or otherwise) remain a priority. • Revive efforts to roll out the Medicaid billing module in AKAIMS (this will require resolving potential conflict of interest concerns). • Continue to explore documentation guidelines (e.g. page limits, use of bullet points), standard templates, and collaborative documentation efforts to reduce time burden and help to manage risks of Medicaid denials and paybacks. • Increase trainings and technical assistance to directors and staff to increase comfort and reduce time associated with documentation; work on training clinicians and BHAs on the concept that that "less is more" and documentation of active interventions is essential.
A8	Behavioral health systems leaders must recognize and support both doors of the system, the medical door and the community behavioral health service door, and develop a vision and pathway free of regulatory barriers for integrated care and payment reform.	• DHSS must address the regulatory barriers to billing for behavioral health services in primary care settings and establish a plan for meeting more of Alaska's behavioral health needs. • Leaders and providers must work across departments and sectors to expand the PCMH initiative beyond its current pilot. • A more concerted effort to assist behavioral health and health care providers in their efforts to navigate 42 CFR and share data across provider types. • Ensure current efforts by DBH to develop AKAIMS capacity to exchange data with Alaska eHealth Network exchange remain a priority. • Update the comprehensive integrated mental health plan and a vision and model(s) for behavioral health service delivery in primary care. • Provide technical assistance and a toolkit to help

		leaders on both the community behavioral health side and medical side initiate these conversations and ensure that Medicaid billing potential is capitalized.
B. Organizational / Operational Barriers and Opportunities		
B1	In a time where information technology and data analysis are needed more than ever, DBH's technology, research, and analysis staffing model is insufficient and unsustainable; analytic power is key to system transformation.	• Data must be the basis for decision-making at all levels; develop a regular (annual) assessment cycle with alternate year goals – year one, data is cleaned and consolidated and core tables are produced; year two, additional analyses are conducted on the dataset created in year one. • Explore possibilities for external analysis resources that could assist DBH with annual production of the assessment and other analyses throughout the year; the university working in concert with a data collaborative might serve as a good permanent home for this function. • Leverage the database built during the course of this project as a prototype for producing the assessment for the two year cycle described above; this will refine the framework as DBH works on a more robust platform that will support assessment efforts in the future. • Advocate for the addition of at least one senior analysis position at DBH to move beyond the current staffing model, where an enormous amount of institutional knowledge about the system's data rests with only one person. • Update the comprehensive integrated mental health plan and include sections on technology and analysis.
B2	Opportunities exist to explore operational and clinical improvements, such as centralized scheduling and more group services, that are likely to increase service capacity.	• Step up efforts to provide technical assistance and training to providers interested in optimizing their billing capacity. • Consider creating a learning community, supported by regular systems reports, to enhance peer to peer learning by hosting a monthly, facilitated teleconference to include topics such as optimizing Medicaid revenue and operational/clinical improvement efforts. • Investigate centralized scheduling technologies and costs and share analysis with interested providers; provide technical resources to assist with

		implementation. • Review regional service trends, especially group service trends and provide technical assistance to support increase in group services, particularly group services conducted via telemedicine (this could allow for mixing of groups across an entire region or even statewide).
B3	Limited access to the electronic data interface and delays in rolling out the billing module has severely capped the utility of AKAIMS and results in costly inefficiencies.	• Reduce costly inefficiencies associated with double and triple data entry into AKAIMS by implementing the budget module, expanding interface capabilities to all provider. • Establish the capacity to share data with the Alaska's eHealth Exchange Network to assist in streamlining efforts to share data across provider types. • DBH is currently working on a pilot to test the feasibility of establishing a provider interface to the Alaska eHealth Network and AKAIMS; these efforts must continue to be a priority.
B4	Continued focus on workforce development is key to closing existing gaps in training and meet the increased demand for behavioral health services.	• Provide continued support to workforce development efforts to ensure the behavioral health workforce has the training and supervision necessary at all levels to provide evidence-based, culturally competent therapies, bill Medicaid, use data to drive improvements to care, and pursue innovations such as team-based care and integration with primary care. • Develop systems and organizational level strategies to shift the composition of the behavioral health workforce to tap the full potential of paraprofessionals and harness the full billing potential that exists within the current community behavioral health Medicaid billing regulations.

C. Geographic Barriers and Opportunities		
C1	Tele-behavioral health is making a positive impact despite ongoing bandwidth limitations in many areas.	• Communicate the importance of being able to accurately label tele-med claims and, as data becomes available, run system-wide reports to monitor trends in tele-behavioral health usage on a quarterly basis, at each Tribal Behavioral Health Director's meeting, and share successes. • Set targets and work collectively to increase tele-behavioral health services, including group services. • Advocate with State of Alaska stakeholders and legislators to increase bandwidth capacities in all areas of Alaska to increase effective use of technologies.
C2	Improving step-down services and connectivity with API and out of region services presents an opportunity.	• Support regional continuum of care planning to ensure sufficient step-down services are in place. • Leverage new ANTHC-funded position at API to improve communication and coordination with regional care teams, especially village-based BHAs. • Implement system-wide reports that capture indicators, such as days from API and other provider types to first service by region, and review on a quarterly basis at the Tribal BH Directors meetings.
C3	Geographic distances can make it difficult to know what resources are available in the statewide continuum of care.	• Explore methods for increasing awareness of available resources, including a web-based directory of resources, and/or expansion of 211 services. • Implement system-wide reports that foster awareness and dialogue about utilization patterns. • Reinstate the twice per year DBH Change Agent Conferences.

D. Cultural Barriers and Opportunities		
D1	The behavioral health system is like a canoe that needs all of the paddles in the water pulling in the same direction to propel the craft forward.	• Embrace the call to action issued at the start of this report and work together to synchronize the many paddles on this canoe we call the Alaska Behavioral Health System. • Update the comprehensive integrated mental health plan, develop a clear vision that spans sectors and solidifies access to behavioral health services for populations in need. • Leverage the comprehensive integrated mental health plan to clarify roles and responsibilities and leverage the full capacity the system's leadership and partner resources.
D2	Divides still exist between the community behavioral health system and other systems that work regularly with individuals who would benefit from behavioral health services.	• Work across departments and organizations to ensure the necessary linkages are in place to more seamlessly meet the demands of the child welfare, criminal and juvenile justice, education, and aging systems.
D3	More work to be done to support integration of Western behavioral health therapies and traditional knowledge.	• Continue to develop and share tools that support integration of Western and traditional knowledge into behavioral health service delivery. • Consider establishing a working group to develop Alaska-based curricula for Substance Abuse treatment that are culturally relevant and a series of case studies highlighting community successes across Alaska. • Offer cultural competency training for behavioral health staff at all levels, especially clinicians, as their ability to move into a more treatment plan/supervisory role is key; acknowledge the BHA's important role in helping transfer cultural knowledge.

PART TWO: TRIBAL BEHAVIORAL HEALTH SYSTEM OPPORTUNITIES, BARRIERS AND RECOMMENDATIONS

Overview

This section includes a series of opportunities and barriers and corresponding recommendations developed with input from the Tribal Behavioral Health Directors, the Tribal Behavioral Health Executive Committee, the Behavioral Health program director and staff at ANTHC, stakeholder interviews, Behavioral Health Aide and Provider survey results, and quantitative analyses performed during the course of this, and other projects, in 2014 and the first half of 2015. Between April and June 2015, four meetings were held with Tribal Behavioral Health System representatives to review, refine, and prioritize the opportunities/barriers and corresponding recommendations. These meetings included: two conference calls with Tribal Behavioral Health Executive Committee Members, an in-person meeting with ANTHC director, Laura Báez and BHA program manager, Xio Owens, and an interactive webinar during which all Tribal Behavioral Health Directors were invited to participate in an exercise to prioritize the barriers and opportunities facing the Tribal Behavioral Health System.

The Tribal Behavioral Health System is a tremendous asset with tremendous existing and potential capacity and all of the opportunities and barriers identified through our collective efforts point to areas where, if addressed, additional capacity might be found. It is our privilege to share these recommendations as part of the Alaska Behavioral Health Systems Assessment final report.

Tribal Behavioral Health System Three Priority Opportunities and Barriers

#	Opportunities/Barriers	Recommendations
1	Statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, step down/after care services) perpetuate a cycle and culture of crisis response	• Conduct regional continuum of care assessments using the results from this assessment • Offer technical assistance to support regional behavioral health continuum of care planning efforts and facilitate assessment of priority service gaps • Engage with DBH to ensure that Tribal providers are posed to leverage new state funding mechanisms that may be offered for supportive housing projects[210]
2	Increased attention to importance of behavioral health care and improving community health outcomes presents opportunity to integrate BH services into primary care setting; most Tribal providers are fortunate to have access to in-house primary care partners	• Increase efforts to maximize Medicaid billing for behavioral health services (delivered by community mental health clinic staff[211]) in Tribal primary care settings • Provide technical assistance and a toolkit to help behavioral health directors initiate these conversations and ensure that Medicaid billing potential is capitalized • Hold discussions to develop a vision and model(s) for behavioral health service delivery in primary care • Identify Tribal providers with strong integration and billing practices already in place and cultivate peer learning
3	Opportunities exist to increase collaboration with partners outside of the Tribal behavioral health system; in fact, this will be essential if and as Medicaid revenues grow	• Identify and pursue areas where increased collaboration between the Tribal behavioral health system and non-tribal partners would be beneficial

[210] In a survey conducted in November 2014, Alaskan Treatment and Recovery grantees ranked Supportive and Transitional Housing as the #1 service they would develop in their communities if it were within their power to do so. Conducted as part of the Alaska Behavioral Health Systems Assessment and available online at: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf. Slides 15+16.

[211] Aside from Short-term Crisis Intervention/Stabilization and SBIRT, all other BH services will require a full clinical record, AST, CSR, Assessment and Tx plan to be eligible for Medicaid billing.

Tribal Behavioral Health System Opportunities and Barriers (Full Set)

#	Opportunities/Barriers	Recommendations
A. Tribal System: Policy, Regulatory, and Financial Barriers		
A1	Tribal DBH grantees have many advantages (daily encounter rate 100% FMAP, BHA workforce and having primary care under the same roof) that allows for innovation, facilitate patient centered care models, and uniquely position these organizations to lead the way toward expanding the capacity of the behavioral health system	• A system-wide strategy for maximizing these opportunities could offer many benefits, including shared leadership, shared resources, shared experiences and peer learning • Increase efforts to integrate (billable) behavioral health services delivered by community behavioral health clinic staff in Tribal primary care settings • Restart/strengthen efforts to provide technical assistance to Tribal providers to develop behavioral health business plans that include a of review existing service/billing practices and implementation plans for ensuring that services and revenues are optimized
A2	BHA workforce, 150 strong, has significant untapped Medicaid billing potential	• Realize organizational cultures where BHAs are valued for their ability to integrate traditional knowledge into evidence-based behavioral health service delivery and the revenue they generate for the organization • Promote wider use of the videos DBH produced in 2014 to orient clinician's to Tribal behavioral health system and the role of the BHA (these videos underscore the expectation that clinicians involve BHAs in treatment plans) • Set system and organizational level goals for BHA Medicaid billing and develop a plan for meeting those goals, enlist support of ANTHC BHA program and masters level clinicians/supervisors to support capacity building and mentoring • When considering Medicaid billing potential of BHAs and itinerant clinicians, be sure to set aside time for comprehensive orientation, including an introduction to the local culture, BHA system, the role of clinicians as mentors of BHAs, prevention activities, self-care, and integrating into village life • Define a core suite of services that can be delivered by all BHAs and develop trainings and tools that can be used across organizations to support documentation and billing.
A3	Medicaid expansion presents an important opportunity for Tribal providers offering a revenue source for a key population that is currently served through a mix of grant and organizational funds	• State action to expand Medicaid is needed to open this opportunity • Individualized behavioral health business plans can help Tribal providers ensure that services and revenues are optimized

A4	Accreditation requirements have required tremendous individual agency effort, resource, and funding	• Celebrate the successful attainment of accreditation by DBH grantees and document ways to leverage this success to strengthen capacity at the organizational and system levels • Partner with DBH to streamline state program reviews with program reviews occurring through national accreditation, avoiding duplication wherever possible
A5	Statewide gaps in the continuum of care (e.g. supportive housing, intensive outpatient services, step down/after care services) perpetuate a cycle and culture of crisis response	• Conduct regional continuum of care assessments using the results from this assessment • Offer technical assistance to support regional behavioral health continuum of care planning efforts and facilitate assessment of priority service gaps • Engage with DBH to ensure that Tribal providers are posed to leverage new state funding mechanisms that may be offered for supportive housing projects[212]
A6	Challenges navigating 42 CFR compliance prevents data sharing that would support integrated health care	• A more concerted effort to assist Tribal and non-Tribal providers in their efforts to navigate 42 CFR and share data across provider types is needed
A7	Documentation requirements that far exceed those on the medical side present challenges to Tribal and non-Tribal providers alike	• Continue to explore documentation guidelines (i.e. page limits, use of bullet points), standard templates, and collaborative documentation efforts to reduce time burden and help to manage risks of Medicaid denials and paybacks • Increase trainings and technical assistance to directors and staff to increase comfort and reduce time associated with documentation; work on training clinicians and BHAs on the concept that that "less is better" and documentation of active interventions is essential • Work with the State to identify and implement electronic data transfer options for organizations that do not use AKAIMS as their primary electronic health record system

[212] In a survey conducted in November 2014, Alaskan Treatment and Recovery grantees ranked Supportive and Transitional Housing as the #1 service they would develop in their communities if it were within their power to do so. Conducted as part of the Alaska Behavioral Health Systems Assessment and available online at: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf. Slides 15+16.

B. Tribal System: Organizational / Operational Barriers and Opportunities		
B1	Increasing efforts to take a business approach to managing BH programs and internal pressure to generate revenue to sustain programs does not always align with BH Director's skillsets or knowledge base	• Build on BH Directors' increasing capacity to develop financially capable BH programs • Develop a tier of BH Directors with a strong background in business and program planning • Provide technical assistance funds to programs desiring to undertake regional continuum of care assessments and develop business plans for their organizations • Leverage BH Directors meetings for peer-to-peer sharing of business planning efforts and develop a toolkit based on shared resources and experience
B2	Increased attention to importance of behavioral health care and improving community health outcomes presents opportunity to integrate BH services into primary care setting; most Tribal providers are fortunate to have access to in-house primary care partners	• Increase efforts to maximize Medicaid billing for behavioral health services (delivered by community mental health clinic staff[213]) in Tribal primary care settings • Provide technical assistance and a toolkit to help behavioral health directors initiate these conversations and ensure that Medicaid billing potential is capitalized • Hold discussions to develop a vision and model(s) for behavioral health service delivery in primary care • Identify Tribal providers with strong integration and billing practices already in place and cultivate peer learning
B3	Data quality concerns, heavy administrative burden, including manual data entry demands, and lack of regular system-wide reporting	• Develop technical assistance capabilities to ensure use and further development of tools created from the BH Assessment for regular Tribal reporting and monitoring • Work with the State to identify and implement electronic data transfer options for organizations that do not use AKAIMS as their primary electronic health record system
B4	Opportunities exist to explore operational and clinical improvements, such as centralized scheduling and more group services, that are likely to increase service capacity	• Investigate centralized scheduling technologies and costs and share analysis with interested directors; provide technical assistance to help with implementation • Review group service trends and provide technical assistance to support increase in group services, particularly group services conducted via telemedicine (this would allow for mixing of groups across an entire region)

[213] Aside from Short-term Crisis Intervention/Stabilization and SBIRT, all other BH services will require a full clinical record, AST, CSR, Assessment and Tx plan to be eligible for Medicaid billing.

B5	Recruiting and retaining directors and staff is a major challenge for rural providers	• Consider providing technical assistance to directors and staff to navigate challenges inherent in rural service delivery and explore strategies for retaining staff where possible and quickly onboarding and training new staff • Explore opportunities with ANTHC to utilize its recruitment services • Establish a statewide peer network for clinicians to share challenges and successes; this network could include facilitated quarterly conference calls or webinars group with pre-set topics and an assignment to generate recommendations or next steps during each session

B6	Gaps in training opportunities for all levels of staff exist and must be closed	• Develop a Tribal Behavioral Health System-Wide training center, similar to the CHAP training center, but for all tiers of staff. Offer blended methods of delivery, including maximizing the use of live distance-delivered courses. Implement a web-based data management system to identify and track BHAs, supervisors', and Directors' training needs, course completions, and advancement towards certification.
		• Offer regular trainings focused on:
		  ○ Orienting all training participants to the Alaska Tribal Health System, including overall structure, model of care across state/regional/subregional/village-based care
		  ○ Preparing BHAs for and supporting them through the certification process
		  ○ Integrating BHA training and on-the-job practice opportunities
		  ○ Developing skills related to industry-demand (e.g., documentation that meets Medicaid requirements)
		  ○ Preparing Directors with skills to oversee business-related demands (e.g., accreditation, billing/revenue, advocacy)
		  ○ Preparing supervisors with skills to support and encourage BHA/Ps (e.g., AK Native history, cross-cultural training)
		  ○ Providing CEUs for licensed providers which focus on industry-relevant topics and cross-cultural and community-based topics

B7	Greater professionalization of BHA role presents an opportunity	• Recognize multiple BHA roles, including a BHA trainee or BHA I role that does not proceed to the next level • Consider tiered salary standards based on certification level, Medicaid billing thresholds and cost of living; discuss overtime/weekend policies with BH directors • Cultivate organizational cultures and business practices that reinforce the role(s) of BHAs • Consider BHAs as leaders in integrating traditional knowledge into practice and community building • Create a social media campaign to promote and educate communities on the role of BHAs and their skill and knowledge levels according to their certification level
B8	BHAs require greater support from supervisors, peers and ANTHC to learn the job/integrate traditional knowledge into practice	• Sustain recent efforts to promote organizational and community-level awareness of BHAs and their scope of work and increase BHAs knowledge of how to navigate certification process • Develop common standards for supervision, mentoring and on-the-job training • Offer quarterly webinars for new clinicians to learn about BHAs and how to support them • Develop a web-based tracking system that allows all parties to track individual progress towards certification • Establish a statewide BHA peer learning community; explore ways to foster greater connectivity (Facebook, community exchanges, case studies, interactive webinars) • Create space and support for self-care and develop recommendations for establishing support structures for BHA families during times of community crisis
C. Tribal System: Geographic Barriers and Opportunities		
C1	Telebehavioral health is making a positive impact despite ongoing bandwidth limitations in many areas	• Communicate the importance of being able to accurately label telemed claims and, as data becomes available, run system-wide reports to monitor trends in telebehavioral health usage on a quarterly basis, at each Tribal Behavioral Health Director's meeting, and share successes • Set targets and work collectively to increase group telebehavioral health services • Advocate with State of Alaska stakeholders and legislators to increase bandwidth capacities in all areas of Alaska to increase effective use of technologies

C2	Improving step down services and connectivity with API and out of region services presents an opportunity	• Leverage new ANTHC-funded at API to improve communication and coordination with regional care teams, especially village-based BHAs • Implement system-wide reports that capture indicators, such as days from API and other provider types to first service by region, and review on a quarterly basis at the Tribal BH Directors meetings
C3	Geographic distances can make it difficult to know what resources are available in the statewide continuum of care	• Explore methods for increasing awareness of available resources, including a directory of resources • Implement system-wide reports that foster dialogue about utilization patterns and review on a quarterly basis at the Tribal BH Directors meetings
D. Tribal System: Cultural Barriers and Opportunities		
D1	More work to be done to support integration of Western behavioral health therapies and traditional knowledge	• Continue to develop and share tools that support integration of Western and traditional knowledge into behavioral health service delivery • Consider establishing a working group to develop Alaska-based curriculums for Substance Abuse treatment that are culturally relevant and a series of case studies highlighting community successes across Alaska
D2	Clinicians hired from outside often require significant cultural training; this task is often completed in an ad hoc manner and often falls on BHAs	• Offer cultural competency training for new clinicians as well as local staff and communities • Acknowledge the BHA's important role in helping transfer cultural knowledge to clinicians from outside
D3	Many directors report that Alaska Native people remain reluctant to enroll in Medicaid	• Revive the practice of reviewing Medicaid enrollment rates by region and share innovative enrollment efforts across regions • Develop a workforce of Medicaid enrollment specialists and Medicaid behavioral health billing specialists to provide assistance to individuals eligible for Medicaid or disability and ensure billing practices are optimized
D4	Many of the recommendations included speak to opportunities to share ideas and resources and set standards and targets within the Tribal behavioral health system, but opportunities also exist to increase collaboration with partners outside of the Tribal behavioral health system; in fact, this will be essential if and as Medicaid revenues grow	• Identify and pursue areas where increased collaboration between the Tribal behavioral health system and non-tribal partners would be beneficial

APPENDIX

A-1 Alaska Behavioral Health System Roles and Responsibilities

Alaska Behavioral Health System Roles and Responsibilities

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
FEDERAL		
Substance Abuse and Mental Health Services Administration (SAMHSA) [214]	SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.	1. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. 2. Congress established the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992 to make substance use and mental disorder information, services, and research more accessible.
Health Resources Services Association (HRSA) [215]	To improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.	1. The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. 2. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable.
Indian Health Services (IHS) [216]	To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.	1. The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. 2. The IHS is the principal federal health care provider and health advocate for Indian people. 3. The IHS provides a comprehensive health service delivery system for American Indians and Alaska Natives who are members of 566 federally recognized Tribes across the U.S. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

[214] http://beta.samhsa.gov/about-us
[215] http://www.hrsa.gov/about/index.html
[216] http://www.ihs.gov/aboutihs/overview/

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
Centers for Medicare and Medicaid Services (CMS) [217]	As an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.	1. Administer the Medicare program and work in partnership with state governments to administer Medicaid. 2. Administer additional state-managed programs such as the State Children's Health Insurance Program (SCHIP) and health insurance portability standards. 3. CMS manages the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Certification Board for Behavioral Health Aides in Alaska, Alaska Native Tribal Health Consortium (ANTHC) [218]	To promote behavioral health and wellness in Alaska Native people by training and educating village-based counselors	A Behavioral Health Aide (BHA) is a counselor, health educator, and advocate to help address community behavioral health needs which include alcohol, drug, and tobacco abuse and mental health problems such as grief, depression, suicide, and related issues. BHAs seek to achieve balance in the community by integrating their sensitivity to cultural needs with specialized training in behavioral health concerns and approaches to treatment. Under the direction of the Tribal Health Directors, ANTHC used the Community Health Aide Program (CHAP) as a model to train and deploy a workforce of Behavioral Health Aides (BHA). A partnership was formed between the federally recognized Community Health Aide Program Certification Board (CHAPCB) and a subcommittee of the Tribal Behavioral Health Directors, the Behavioral Health Academic Review Committee (behavioral healthARC), to amend the existing Standards and Procedures to include standards for Behavioral Health Aides/ Practitioners certification and practice. The Behavioral Health program is facilitated through ANTHC's Behavioral Health Department in collaboration with the behavioral healthARC. Program staff provide technical, financial, and training support to Tribal Health Organizations who have elected to integrate behavioral healthAs into their regional network of behavioral health providers. As a resource to all behavioral healthAs, the behavioral healthARC, staff from ANTHC's Behavioral Health Department and statewide team of stakeholders are developing a Behavioral Health Aide Manual (behavioral healthAM) to provide fundamental information and best practices for addressing many of the issues and concerns identified during client care visits. The behavioral healthAM is a practice manual that compliments behavioral healthA training requirements and scope of practice that have been detailed in the Standards.

[217] http://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf
[218] http://www.anthc.org/chs/behavioral/behavioral healtha.cfm

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
STATE		
State Governor		Set State funding priorities through the development of the State's annual budget.
State Legislature	To propose and enact legislation to support the vision of "Healthy Alaskans in healthy communities"[219]	1. To serve as stewards of the State's funds and advocate for legislative actions that will benefit constituents. 2. To review, modify, and approve the governor's budget.
DHSS Division of Behavioral Health (DBH)[220]	To manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.	1. Monitoring and managing the use of public funds to provide accessible, efficient and effective behavioral health prevention and treatment services for Alaskans. 2. Developing regulations and policies that govern the planning and implementation of services and supports for people who need behavioral health services. 3. Promoting program standards, utilization management measures, quality requirements, provider performance, and client outcomes.
Alaska Mental Health Trust Authority	The Alaska Mental Health Trust Authority administers the mental health trust to improve the lives of beneficiaries. Trustees have a fiduciary responsibility to protect and enhance Trust assets in perpetuity for beneficiaries. The Trust provides leadership in advocacy, planning, implementing and funding of a Comprehensive Integrated Mental Health Program and acts as a catalyst for change.	1. Enhance and protect the trust 2. Provide leadership in advocacy, planning, implementing, and funding of a Comprehensive Integrated Mental Health Program 3. Propose a budget for Alaska's Comprehensive Integrated Mental Health Program 4. Coordinate with state agencies on programs and services that affect beneficiaries 5. Report to the Legislature, the governor and the public about The Trust's activities
Alaska Mental Health Board / Alaska Board on Alcoholism and Drug Use[221]	The Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Alaska Mental Health Board (AMHB) are the state agencies charged with	1. Identify current behavioral health system strengths and gaps. 2. Support the planning, funding, and provision of a comprehensive system of care within Alaska for children, youth, and their families.

[219] http://hss.state.ak.us/ha2020/

[220] DBH Business Plan

[221] http://dhss.alaska.gov/abada/Pages/mission.aspx

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
	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.	3. Review, monitor, and evaluate behavioral health services at the community, client, provider, and state system level. 4. Advocate for a comprehensive effective behavioral health service system including housing, employment, interagency collaboration.
Alaska Court System, Therapeutic Courts[222]	The therapeutic model is an alternative justice model in which a collaborative court team oversees and closely monitors participants who chose the treatment program in lieu of incarceration.	1. A court team, including a supervising judge, district attorney, defense counsel, probation office and/or substance abuse or mental health treatment provider oversee and monitor the program(s). 2. Participants must meet eligibility standards of each court and the substance abuse or mental health treatment criteria of the provider.
Alaska Office of Children's Services[223]	The Office of Children's Services works in partnership with families and communities to support the well-being of Alaska's children and youth. Our mission to protect and serve Alaska's children and families.	1. Enhance families' capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential 2. Keeping Alaska's children safer; 3. tackle the nationwide issue of disproportionality in partnership with tribal leaders; 4. Foster a high quality and stable workforce; and 5. Building enhanced relationships with community partners.
Healthy Alaskans 2020	Provide a framework and foster partnerships to optimize health for all Alaskans and their communities.	1. Healthy Alaskans 2020 is a joint effort between the State of Alaska Department of Health and Social Services and the Alaska Native Tribal Health Consortium, to set health goals for Alaska that contribute to the vision of *Healthy Alaskans in healthy communities*. 2. Identifies top 25 leading health indicators for the State. The indicators provide a science-based framework for identifying public health priorities and are designed to guide efforts in Alaska over the next decade to improve health and ensure health equity for all Alaskans.
Governor's Council on Disabilities & Special Education[224]	The Governor's Council on Disabilities & Special Education was created to meet Alaska's diverse needs. The	1. State Council on Development Disabilities: Interdepartmental planning and coordination of services to persons with disabilities. 2. Interagency Coordinating Council for Infants and Toddlers with Disabilities (ICC):

[222] http://www.courts.alaska.gov/therapeutic/index.htm
[223] http://dhss.alaska.gov/ocs/Pages/aboutus/default.aspx

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
	Council uses planning, capacity building, systems change, and advocacy to create change for people with disabilities.	Advises and assists Alaska's statewide Early Intervention/Infant Learning Program. 3. Special Education Advisory Panel (SEAP): Advises and assists Alaska's statewide Special Education program administered through the Department of Education and Early Development. 4. Governing Body of the Special Education Service Agency (SESA): Supports the effective education of students with low incidence disabilities throughout Alaska.
TRIBAL		
Alaska Native Tribal Health Consortium[225]	Providing the highest quality health services in partnership with our people and the Alaska Tribal Health System	1. ANTHC was created in December 1997 to manage statewide health services for Alaska Native people. All Alaska Natives, through their tribal governments and through their regional nonprofit organizations, own the Consortium. We employ, for the better health of our service population, approximately 2,000 people and operate under a half-billion dollar operating budget. 2. Managed and operated by its customers, who are represented by 15 Alaska Native leaders from around the state, ANTHC is a not-for-profit health organization that provides statewide services in specialty medical care; operates the 150-bed, state-of-the-art Alaska Native Medical Center hospital; leads construction of water, sanitation and health facilities around Alaska; offers community health and research services; is at the forefront of innovative information technology; and offers professional recruiting to partners across the state. As a member of the Alaska Native Health Board, ANTHC works closely with the National Indian Health Board to address Alaska Native and American Indian health issues.
Tribal Health Organizations	Non-profit corporations providing health and social services for the Alaska Natives in their regions.	Nonprofit corporations were formed throughout Alaska after the Alaska Native Claims Settlement Act (ANCSA) was enacted. The ANCSA settlement is an agreement between the United States Government and the Alaska Native Tribes. The ANCSA legislation distributed land to regional and village entities to establish for-profit corporations. Each of the regional profit corporations formed a separate non-profit corporation to assist their members with health and social service needs.226

[224] http://dhss.alaska.gov/gcdse/Pages/aboutus/default.aspx
[225] http://anthctoday.org/about/index.html
[226] http://www.kanaweb.org/about-kana.html

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
Tribal Behavioral Health Directors Committee	The Committee performs the following functions:[227] • Statewide behavioral health planning and advocacy • Consults with the State of Alaska on funding, and service delivery for Tribal Behavioral Health, including Medicaid and grant programs; • Provides mutual support in addressing funding, workforce, and service delivery issues that all are addressing in their organizations and communities.	The Tribal Behavioral Health Directors Committee was created in 2005 as a subcommittee to the Alaska Tribal Health Directors, and approved by the Alaska Native Health Board in 2008. The TBHD Committee typically meets quarterly in person over the span of two days. An executive committee consisting of three TBHD and the Director of Behavioral Health at ANTHC meet monthly via teleconference to work on strategic interim initiatives.
ASSOCIATIONS/COMMISSIONS		
Alaska Behavioral Health Association (ABHA)	ABHA helps leadership from our mental health and substance abuse treatment providers deliver the best quality services possible in an environment of remarkable change and challenge.	Provides support to program directors of behavioral health programs in Alaska, and is a member of the National Association for Children's Behavioral Health.
Alaska Commission for Behavioral Health Certification[228]	The Alaska Commission for Behavioral Health Certification is an entity that certifies counselors within the state of Alaska in the fields of behavioral health	1. Define minimum knowledge and skill standards for practice; and to define the ethical standards and a code of conduct for addiction counselors. 2. Assess competency and knowledge of ethics by a combination of: verification of supervised professional experience and recommendations of those familiar with the

[227] http://www.anthc.org/chs/behavioral/tbehavioral healthdc.cfm
[228] http://www.akcertification.org/

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
	and addiction.	applicant's work and testing.
Alaska State Hospital and Nursing Home Association[229]	To be the premier provider advocate bringing unity to the health care community in addressing health care issues and to support our members' goal to improve Alaskan's health.	1. A unified association providing effective statewide leadership to address health care delivery challenges affecting all Alaskans. 2. Two goals: • **Advance a health care delivery system that improves health and health care in Alaska** • **Optimize the organizational effectiveness of ASHNHA and its members.**
Alaska Primary Care Association[230]	*Helping to create healthy communities by supporting vibrant and effective community health centers.*	1. APCA works with Health Centers and many partners to promote, expand and optimize access to primary care for all Alaskans. 2. Since its founding, APCA has grown to serve the 28 Federally Qualified Health Centers throughout the state, other safety net providers and stakeholders. An annual operating budget of over $1 million dollars allows APCA to provide a broad range of member services from technical assistance, policy surveillance and dissemination, to health policy analysis and education, to group purchasing benefits. 3. APCA pursues the mission through the following focus areas: • Strengthen relationships with Health Resources and Services Administration (HRSA) representatives • Provide and promote effective and meaningful communication among Community Health Centers and the PCA • Information and policy surveillance and dissemination • Board governance as strategy
INSTITUTIONS, NON-PROFITS + FOUNDATIONS		
University of Alaska	Dependent on program.	The University of Alaska provides a number of program associated with behavioral health:

[229] http://www.ashnha.com/about/mission-vision-and-goals/
[230] http://www.alaskapca.org/?page=AboutUs

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
		• Center for Human Development: Provides interdisciplinary education, community training and technical assistance, research, and information dissemination for people with disabilities. • College of Health: Provides academic and research units focused on interpersonal violence, childhood trauma, substance abuse, health care systems policy and deliver, environmental health, and biomedical science. • Rural Human Services/Human Services: Located in Fairbanks, is a program developed for Alaska village-based human service providers, and targeted at developing skills and credentials in the "helping" profession. • UAF Social Work Department: Offers programs that train professionals on how to assist individuals, families, groups, organizations, communities and society as a whole in the improvement of quality of life.
Alaska Children's Trust[231] (ACT)	The mission of the Alaska Children's Trust is to improve the status of children in Alaska by generating funds and committing resources to eliminate child abuse and neglect.	ACT's programs include the following: 1. Community Investments: ACT awards grants to organizations in Alaska that work towards the prevention of child abuse and neglect. 2. Alaska Afterschool Network (AAN): AAN is the only statewide organization dedicated to increasing afterschool and expanded learning opportunities for school-age children, youth and families. 3. Alaska Adverse Childhood Experiences (ACEs) Initiative: A partnership of nonprofit, private, tribal and government organizations working to educate and advance the dialogue on ACEs, impact of ACEs on brain development and how communities can prevent ACEs and build resiliency. 4. Prevent Child Abuse Alaska: Takes advantage of national resources and relationships that allow ACT to learn and grow from best practices.
United Way of Anchorage[232]	To advance the common good by making lasting, measurable changes in community conditions that improve lives.	United Way of Anchorage is the leader in mobilizing the resources of individuals, companies, government and labor to achieve positive and lasting change in the lives of the people in our community.

[231] http://www.alaskachildrenstrust.org/programs

[232] http://www.liveunitedanchorage.org/ViewPage.aspx?Id=9c2a49fb-b7b2-4877-a77f-6c3a728de1e8

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
Rasmuson Foundation[233]	To promote a better life for Alaskans.	Primary areas of interest: Arts & culture, health, social services
Mat-Su Health Foundation[234]	To Improve the Health and Wellness of Alaskans Living in the Mat-Su.	1. Reduce the barriers to healthcare access. 2. Make progress on Healthy Alaskans 2020 goals in the Mat-Su Borough. 3. Increase the capacity of nonprofits operating in the Mat-Su Borough to address the issues of health and wellness. 4. We provide financial and leadership support for well-managed 501(c)(3) organizations offering services and practical solutions to significant health related problems impacting the citizens of the Mat-Su Borough. 5. Increase collaborative relations with funders and stakeholders in Alaska and other states. 6. Hardwire governance policies, procedures and protocols for effective Mat-Su Regional Medical Center governance.
ADDITIONAL STAKEHOLDERS/OPPORTUNITIES FOR ENHANCED PARTNERSHIPS		
Alaska Department of Corrections[235]	The Alaska Department of Corrections provides secure confinement, reformative programs, and a process of supervised community reintegration to enhance the safety of our communities.	Operates a number of substance abuse, education, vocational and pro-social educational programs. Centers of treatment are available in Anchorage, Nome, Fairbanks, Mackenzie Point, Eagle River, Ketchikan, Juneau, Palmer, Seward, Kenai, and Bethel.
Alaska Housing Finance Corporation[236] (AHFC)	AHFC's mission is to provide Alaskans access to safe, quality, affordable housing.	AHFC provides a number of programs that assist Alaska residents find housing, improving energy performance, and promote Fair Housing. AHFC administers the Housing Choice Voucher and Tenant-based Rental Assistance (TBRA) programs, and provides housing inventories for operates public, senior, disabled and veteran populations.
Association of Alaska	AAHA provides unified state and	The Association offers a comprehensive and innovative training and technical assistance

[233] http://www.rasmuson.org/index.php?switch=viewpage&pageid=142
[234] http://www.healthymatsu.org/about-us/mission-values
[235] http://www.correct.state.ak.us/
[236] http://www.ahfc.us/about-us/

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
Housing Authorities[237] (AAHA)	federal legislative advocacy, affordable housing development and funding information, and training and technical assistance, all in an effort to increase the supply of safe, sanitary and affordable housing and community development in the state of Alaska.	program for Indian Housing Block recipients. Services include: • Comprehensive needs assessment, • Direct on-site and remote technical assistance, • A wide range of materials, tools and courses relevant to housing and community development with refinements for the Alaska housing context, and • Group learning opportunities through place-based trainings.
Housing + Urban Development (HUD)	Create strong, sustainable, inclusive communities and quality affordable homes for all. HUD is working to strengthen the housing market to bolster the economy and protect consumers; meet the need for quality affordable rental homes; utilize housing as a platform for improving quality of life; build inclusive and sustainable communities free from discrimination, and transform the way HUD does business[238].	The list of HUD programs is extensive, but most revolve around economic development and housing. Main programs include: • The Community Development Block Grant (CDBG) and Indian Community Development Block Grant (ICDBG) • HOME Investment Partnerships • Housing Choice Voucher Program (formally Section 8) • Supportive Housing for the Elderly (Section 202) • Supportive Housing for Persons with Disabilities (Section 811) • Fair Housing Act • Continuum of Care Program
Workforce Investment Board[239]	THE VISION for the Alaska Workforce Investment Board is to *"build connections that put Alaskans into good jobs."*	1. This comprehensive vision keeps the board focused on developing a workforce system that is useful, accessible and understandable to all of the system's customers, which include businesses looking for qualified workers, unemployed Alaskans looking for jobs, and incumbent workers wanting to upgrade their skills in a changing work environment. 2. The Board is tasked with reviewing plans and providing recommendations to the State of Alaska to further train and prepare Alaskans for the workforce--and help grow Alaska's economy. 3. The governor of Alaska's policy board for building connections that put Alaskans into

[237] http://www.aahaak.org/index.php, http://www.aahaak.org/training.php
[238] http://portal.hud.gov
[239] http://labor.state.ak.us/awib/

ENTITY	MISSION or PURPOSE	DESCRIPTION OF ROLES + RESPONSIBILITIES
		good jobs.
Alaska Department of Labor[240]	*The Alaska Department of Labor and Workforce Development promotes safe and legal working conditions and opportunities for employment in Alaska.*	Manages and administers Workforce Investment Act funds.

[240] http://labor.state.ak.us/home.htm