Executive Summary

Alaska Behavioral Health Systems Assessment

January 22, 2016

The data analyzed over the course of this project tell an important story about the behavioral health system in Alaska and the barriers and opportunities to meet the behavioral health needs of Alaskans.

The goals of the Alaska Behavioral Health Systems Assessment were to describe the system, assess the need for services and capacity to meet the need, develop a framework for regular monitoring of the system, and identify barriers, opportunities and recommendations for system improvement.

Prepared for the Alaska Mental Health Trust Authority
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PARTNERS: Alaska Department of Health and Social Services Division of Behavioral Health | Alaska Native Tribal Health Consortium | Mat-Su Health Foundation | Alaska Mental Health Board | Advisory Board on Alcoholism and Drug Abuse

Trust
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ESTIMATED PREVALENCE | Behavioral Health Issues Among Alaskans in 2013

YOUTH

Risk Behaviors [1]

Approximately One in Five

4,641 traditional high school students had a moderate or high-risk behavior for substance use.

- The prevalence of this behavior was similar for male and female students (20.3% compared to 16.4%)

Mental Health Issues [1, 2]

Approximately One in Four

7,214 traditional high school students experienced a mental health issue in the past year.

- The prevalence of mental health issues among female students was higher than among male students (37.8% compared to 19.4%)

Among 9 to 17 year olds, 5,550 (6%) were estimated to have had a serious emotional disturbance in the past year.

ADULTS

Total Prevalence [3]

Approximately One in Four

145,790 adults needed treatment for illicit drug or alcohol use and/or experienced a mental illness in the past year.

Alcohol & Illicit Drug Use [3]

Approximately One in Nine

62,815 adults needed treatment for an illicit drug or alcohol problem.

- Estimated need for treatment among low income adults was higher than among adults above 138% of the federal poverty level (16.7% compared to 11.5%)
- Estimated need for treatment among adult males was higher than among adult females (15.5% compared to 7.5%)
- About one-third of those that needed treatment (22,990 adults) also experienced a mental illness in the past year

Mental Illness [3]

Approximately One in Five

105,966 adults had a mental illness in the past year.

- 61,176 adults (11.2%) had a mild mental illness, 23,487 adults (4.3%) had a moderate mental illness and 21,302 (20%) had a serious mental illness
- Estimated mental illness among low income adults was higher than among adults above 138% of the federal poverty level (23.8% compared to 19.4%)
- Estimated mental illness among adult females was higher than among adult males (24% compared to 15%)

UTILIZATION | Behavioral Health Services Provided with Support from State Medicaid and Grant Funds in State Fiscal Year 2013

Youth Clients Served [4]

Approximately One in Nine

12,147 unique youth clients were served with support from state Medicaid and/or behavioral health grant funds.

Breakdown of Youth Served

By diagnosis category:

- Substance Use Disorder: 1,324 (11%)
- Serious Emotional Disturbance: 9,350 (77%)
- Mild or Moderate Mental Illness: 2,215 (18%)
- Co-occurring Disorders: 482 (4%)

By gender:

Male: 7,129 (59%) | Female: 5,018 (41%)

Adult Clients Served [4]

Approximately One in Twenty

27,728 unique adult clients were served with support from state Medicaid and/or behavioral health grant funds.

Breakdown of Adults Served

By diagnosis category:

- Substance Use Disorder: 14,442 (52%)
- Serious Mental Illness: 16,841 (61%)
- Mild or Moderate Mental Illness: 2,061 (7%)
- Co-occurring Disorders: 3,690 (13%)

By gender:

Male: 11,480 (41%) | Female: 16,232 (59%)

Behavioral health services in Alaska are funded through a mix of Medicaid, state and federal grants, Indian Health Service Compact and other Tribal funds, private insurance, self-pay and uncompensated care so the utilization data analyzed tells only part of the story. Nonetheless, the report's findings reinforce what we heard from stakeholders: the behavioral health needs of many Alaskans are going unmet resulting in higher costs and poorer health outcomes.

OPPORTUNITIES, BARRIERS AND RECOMMENDATIONS

Ten priority opportunities and barriers facing the Alaska Behavioral Health System are presented here along with recommended strategies. These recommendations were developed with input from stakeholder interviews, survey results and qualitative and quantitative analyses performed during 2014 and the first half of 2015.

1. Statewide gaps in the continuum of care combined with gaps in health care coverage perpetuate a cycle of crisis response and create costly inefficiencies.

RECOMMENDATIONS

- Increase health insurance coverage by expanding Medicaid.
- Continue to explore ways to secure funding to address statewide gaps in the continuum of care and maximize federal Medicaid reimbursement.
- Identify strategies to promote greater financial stability among providers, including the possibility of increasing state match to capture Alaska's full entitlement to federal Disproportionate Share Hospital funds.
- Support regional continuum of care assessments to identify service gaps and strategies at the regional level.
- Ensure the necessary linkages are in place to 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.

RECOMMENDATIONS

- Establish a Medicaid rate structure for non-tribal providers that adequately compensates for care.
- Step up efforts to provide technical assistance and training to providers to optimize their Medicaid billing capacity and reduce the risk of Medicaid denials and paybacks.
- Develop strategies to tap the Medicaid billing potential that exists within the current community behavioral health Medicaid billing regulations.

3. Behavioral health systems leaders must develop a coordinated vision and efficient pathway for integrated care and payment reform.

RECOMMENDATIONS

- Address regulatory barriers to billing for behavioral health services in primary care settings. Expand efforts to integrate primary and behavioral health care.
- Update the comprehensive integrated mental health plan to establish a vision and approach for meeting more of Alaska's behavioral health needs.
- Support provider efforts to share essential client health data across settings. Assist with navigating federal health information privacy and confidentiality requirements and ensure current efforts by Alaska Division of Behavioral Health to develop capacity to exchange data through the Health Information Exchange remain a priority.

4. Documentation requirements place excessive administrative burden on providers.

RECOMMENDATIONS

- Continue efforts to streamline Alaska Division of Behavioral Health reporting requirements.
- Support development of standard documentation guidelines, templates, and practices and increase availability of trainings and technical assistance to reduce time associated with documentation.

5. In a time where information technology and data analysis are needed more than ever, Alaska Division of Behavioral Health's technology, research and analysis staffing model is insufficient and unsustainable; analytic capacity is key to system transformation.

RECOMMENDATIONS

- Data must be the basis for decision-making at all levels; prioritize investments in technology infrastructure and data analysis.
- Develop an annual assessment cycle. Explore possibilities for external analysis resources that could assist Alaska Division of Behavioral Health with 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.
- Advocate for the addition of at least one senior analyst position at Alaska Division of Behavioral Health to move beyond the current staffing model, where an enormous amount of institutional knowledge about the system's data rests with a limited number of individuals.

6. Limited access to the electronic data interface and delays in rolling out the Medicaid billing module have severely capped the utility of the Alaska Automated Information Management System (AKAIMS) and resulted in costly inefficiencies.

RECOMMENDATIONS

- Prioritize efforts to modernize reporting infrastructure and eliminate costly inefficiencies.
- Implement the billing module in AKAIMS and expand data exchange capabilities to providers that do not use AKAIMS as their electronic health record.

7. Continued focus on workforce development is key to closing existing gaps in training and meeting the increased demand for behavioral health services.

RECOMMENDATIONS

- 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.
- Work at all levels of the system to fill key gaps in the behavioral health workforce and tap the full potential of behavioral health aides and other paraprofessionals to deliver needed care close to home.

8. Geographic distances can make it difficult to know which resources are available in the statewide continuum of care.

RECOMMENDATIONS

- Explore methods for increasing awareness of available resources, including a web-based directory of resources and/or expansion of 211 web-based services.
- Implement system-wide reports that foster awareness and dialogue about utilization patterns.
- Consider creating a learning community using facilitated monthly teleconference calls on topics such as optimizing Medicaid billing and making clinical improvements.

9. Divides still exist between the community behavioral health system, other healthcare providers and systems that serve individuals with behavioral health needs.

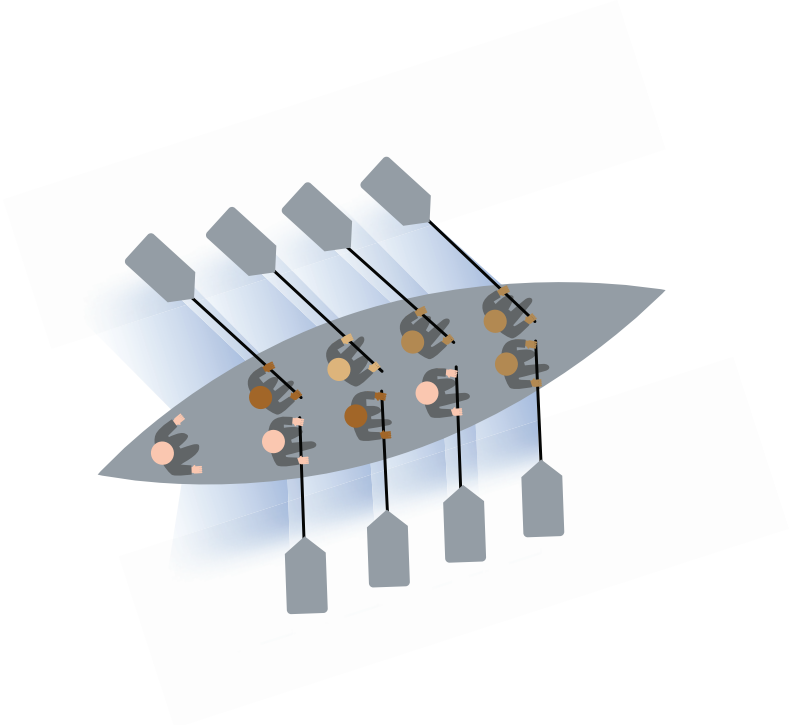
RECOMMENDATIONS

- Work across departments, sectors 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.

10. The behavioral health system is like a canoe that needs all of the paddles in the water pulling in the same direction to move forward.

RECOMMENDATIONS

- Embrace the call to action issued in 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 plan to clarify roles and responsibilities and leverage the full capacity of the system's leadership and partner resources.



Alaska Behavioral Health Systems Assessment Resources

To access the full report, regional data reports and methodology documents, please visit:
http://mhtrust.org/impact/behavioral-health-systems-assessment/

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Executive Summary Footnotes

[1] Alaska Youth Risk Behavior Surveillance System 2013. Based on analysis completed for the Alaska Behavioral Health Systems Assessment by the Section of Chronic Disease Prevention and Health Promotion, Alaska Department of Health and Social Services, 2015. A respondent was categorized as having "moderate/high risk behavior" if they met the criteria for one or more of the below: (1) Used cocaine, inhalants, heroin, methamphetamines, or ecstasy drugs three or more times for at least one of the drugs in their life; (2) 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; (3) OR used marijuana and unprescribed drugs three or more times in the past 30 days. A respondent was categorized as having a "past year mental health issue" if the student reported feeling 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 had seriously considered attempting suicide during the past 12 months.

[2] The estimated prevalence of Serious Emotional Disturbance was generated using a methodology recommended by the Center for Mental Health Services that applies a prevalence rate based on the percentage of children living in poverty for the state or region. As with Serious Mental Illness, prevalence rates for Serious Emotional Disturbance take into account the presence of psychiatric diagnosis and significant functional impairment. Caution is advised when comparing these estimates to utilization data, which is based solely on diagnosis and not level of functioning. Poverty estimates are from U.S. Census Small Area Income and Poverty Estimates for 2012. More details on methodology can be found in Costello , E.J., Messer, S.C., Bird, H.R., Cohen, P., Reinherz, H.Z. (1998). The prevalence of serious emotional disturbance: a re-analysis of community studies. Journal of Child and Family Studies, 7(4): 411-432.

[3] All Adult Prevalence Rates were created for DBH by Special Data Request in April 2014 and are from the Substance Abuse and Mental Health Services Administration's Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH), 2009-2011 (revised 10/13). Rates are specific to adult (18+) population and based on a survey conducted each year in-person by professional interviewers throughout Alaska using a scientific random sample of households. Prevalence rates were multiplied by Alaska Department of Labor 2013 population estimates. 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. 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.
As with Serious Emotional Disturbance , prevalence rates for Serious Mental Illness take into account the presence of psychiatric diagnosis and significant functional impairment. Caution is advised when comparing these estimates to utilization data, which is based solely on diagnosis and not level of functioning.

[4] State Fiscal Year 2013 utilization figures based on analysis of combined service data from five different datasets: Alaska Automated Information Management System (AKAIMS); data submitted to DBH through their 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. All data was provided by DBH. 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 with a primary or secondary behavioral health diagnosis. The DET dataset included only clients who received hospital services that were paid for by DBH (transport services excluded). Client counts are unduplicated. Percentages do not equal 100 percent because of co-occurring disorders. Our method used diagnostic code to assign clients to diagnosis categories and, thus, does not include a level of functioning assessment (in contrast to prevalence estimates), which may result in an overcount of individuals served with Serious Mental Illness and Serious Emotional Disturbance. For planning purposes, however, this methodology paints a clear picture of a system that serves predominantly higher levels of mental health need. Youth client counts include clients ages 0 to 17 and adult client counts include clients ages 18 and older.