Alaska Mental Health Board (AMHB)
Advisory Board on Alcoholism & Drug Abuse (ABADA)
Alaska Behavioral Health Association (ABHA)

Materials for presentation to:

House Health & Social Services
14 February 2017

1. Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries (Dec 2015).
2. Utilization of Community Based Substance Abuse Services by Type (SFY 2012 – SFY 2016).
3. Continuum of Care (FY16). Costs by Funding Source and Avg. Cost/Person by Service Type.
4. Alaska Screening Tool (AST) – 2011.
5. Client Status Review (CSR) – 2014.
6. Integrated Behavioral Health Assessment (example for reference).
7. American Society of Addiction Medicine (ASAM) Level of Care "Cheat Sheet."
8. Division of Behavioral Health – Clinical Record Evaluation Tool.
9. Alaska Behavioral Health Reform 1115 Waiver Concept Paper.
10. DBH FY18 Overview – Presentation to House HSS (Jan 31, 2017).
11. FY17 Total DBH Grant Funding by Service Area and Grant Type.
12. Medicaid in Alaska Dashboard (Medicaid Expansion data through Jan. 31, 2017).

Alaska Scorecard

Key Issues Impacting Alaska Mental Health Trust Beneficiaries

Trust
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 Alaska Data	Most Current Alaska Data	Status
Health				
Suicide				
1 Suicide deaths (rate per 100,000 population)	13.0	23.5	22.3	✗
2 Percent of adults reporting serious thoughts of suicide	3.9%	4.2%	4.2%	⇔
Substance Abuse				
3 Alcohol-induced deaths (rate per 100,000 population)	8.2	29.5	33.6	✗
4 Percent of adults who engage in heavy drinking	5.9%	7.7%	9.1%	✗
5 Percent of adults who engage in binge drinking	16.0%	18.5%	20.2%	✗
6 Percent of population (age 12 and older) who use illicit drugs	9.8%	12.9%	13.2%	✗
Mental Health				
7 Days of poor mental health in past month (adults)	3.6	3.1	3.1	✓
8 Percent of teens who experienced depression during past year	29.9	27.2%	33.6%	✗
Access				
9 Percent of population without health insurance	11.7%	18.5%	17.2%	✗
Safety				
Protection				
10 Children abused and neglected (rate per 1,000 children 0-17)	9.4	13.0	13.3	✗
11 Founded reports of harm to adults (rate per 1,000 adults 18+)	*	1.2	1.7	⇔
12 Injuries to elders due to falls, hospitalized (rate per 100,000 population)	1,472	1,061	924	✓
13 Traumatic brain injury, hospitalized non-fatal (rate per 100,000 population)	91.7	79.5	85.6	⇔
Justice				
14 Percent of incarcerated adults with mental illness or mental disabilities	*	42%	65%	✗
15 Recidivism rate for incarcerated adults with mental illness or mental disabilities	*	39.2%	38.9%	⇔
16 Percent of arrests involving alcohol or drugs	*	29.5%	40.2%	⇔
Living With Dignity				
Accessible, Affordable Housing				
17 Chronic homelessness (rate per 100,000 population)	26.1	28.0	24.7	⇔
Educational Goals				
18 Difference between high school graduation rates for students with & without disabilities	*	33.0%	21.0%	⇔
19 Percent of youth who received special education who are employed or enrolled in post-secondary education one year after leaving school	*	72.0%	58.8%	⇔
Economic Security				
20 Percent of minimum wage income needed to afford average housing	*	90.7%	83.8%	✗
21 Average annual unemployment rate	6.2%	6.9%	6.8%	⇔
22 Percent of SSI recipients who are blind or disabled and are working	4.3%	6.8%	6.5%	✓

Prevalence Estimates: Alaska Mental Health Trust Beneficiaries

Alaska Mental Health Trust Beneficiary Population	Estimate	Population Rate
Serious Mental Illness (ages 18+)	21,300	3.9%
Serious Emotional Disturbance (ages 0 to 17)	12,725	6.7%
Alzheimer's Disease (ages 65+)	6,400	9.0%
Traumatic brain injury (all ages)	11,900	1.6%
Developmental disabilities (all ages)	13,200	1.8%
Dependent on alcohol (ages 12 to 17)	500	0.8%
Dependent on alcohol (ages 18+)	19,100	3.5%

** No comparable U.S. data available*

Health: Suicide

1. Suicide mortality rate per 100,000 population, age-adjusted (2014).[a]
2. Percentage of non-institutionalized adults aged 18 and older reporting serious thoughts of suicide in the past year (2013-2014).[b]

Health: Substance Abuse

3. Alcohol-induced deaths per 100,000 population, age-adjusted. Includes fatalities from alcoholic psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning; does not include traumatic injury such as motor vehicle crashes or homicide (2014 Alaska, 2013 U.S.).[a]
4. Percentage of adults who reported heavy drinking in past 30 days; defined as two or more drinks daily for men and one or more daily for women (2014).[c]
5. Percentage of adults who reported binge drinking in past 30 days; defined as drinking five or more drinks (men) or four or more drinks (women) on one occasion (2014).[c]
6. Percentage of population age 12 and older who report using illicit drugs in the past month. Used here, "illicit drugs" includes marijuana/ hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically (2013-2014).[b]

Health: Mental Health

7. Mean number of days during the previous 30 days for which respondents aged 18 years or older report that their mental health (including stress, depression, and problems with emotions) was not good (2014).[c]
8. Percentage of students in grades 9-12 who 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 past 12 months (2015 Alaska, 2013 U.S.).[d]

Health: Access

9. Percent of population without health insurance for the entire year (2014).[e]

Safety: Protection

10. Children aged 0-17 abused and neglected, rate per 1,000. (2014).[f]
11. Founded reports of harm, rate per 1,000 adults. (FY2015).[g]
12. Non-fatal injuries due to falls, ages 65+, hospitalized 24 hours or more, rate per 100,000 (2014 Alaska, 2013 U.S.).[h]
13. Non-fatal traumatic brain injury requiring hospitalization of 24 hours or more, rate per 100,000 (2014 Alaska, 2010 U.S.).[h]

Safety: Justice

14. Percent of incarcerated adults with mental illness or mental disabilities (2012).[i]
15. Statewide recidivism rates for incarcerated adults with mental illness or mental disabilities; defined as a post-conviction re-incarceration within one year of exiting Alaska Department of Corrections custody (2012).[i]
16. Percent of arrests by Alaska State Troopers or Wildlife Troopers that were flagged as being related to alcohol and/or drugs (2014).[j]

Living With Dignity: Housing

17. Chronically homeless persons, defined as individuals with disabilities who have been continuously homeless for a year or more or who have experienced at least four episodes of homelessness in the past three years, per 100,000 population (2015).[k]

Living With Dignity: Education

18. Difference between high school graduation rate for students with and without disabilities. Statewide cohort graduation rate (2014-2015).[l]
19. Percent of youth who received special education who are employed and/or enrolled in post-secondary education one year after leaving high school (2014).[m]

Economic Security

20. Percent of minimum wage income needed to afford fair-market rent of two-bedroom housing in Alaska (2015).[n]
21. Annual unemployment rate, not seasonally adjusted. (2014).[o]
22. Percent of SSI recipients with blindness or disabilities who are working (2014).[p]

Data Sources

a. Alaska Department of Health and Social Services, Division of Public Health, Bureau of Vital Statistics; U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics.

b. Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH).

c. Alaska Department of Health and Social Services, Division of Public Health, Behavioral Risk Factor Surveillance System; U.S. Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System.

d. Alaska Department of Health and Social Services, Division of Public Health, Youth Risk Behavior Survey; U.S. Centers for Disease Control and Prevention, Youth Risk Behavior Survey.

e. U.S. Census Bureau, Current Population Survey, *Health Insurance Coverage in the United States.*

f. U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment Report.*

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

h. Alaska Department of Health and Social Services, Division of Public Health, Alaska Trauma Registry; U.S. Centers for Disease Control and Prevention (CDC), Injury Prevention & Control, Data & Statistics.

i. Hornby Zeller Associates, Inc. (May 2014), *A Study of Trust Beneficiaries in the Alaska Department of Corrections.*

j. Alaska Department of Public Safety, Divisions of Alaska State Troopers and Wildlife Troopers; Alaska Public Safety Information Network (APSIN) case data.

k. U.S. Department of Housing and Urban Development (HUD) Office of Community Planning and Development, *Annual Homeless Assessment Report.*

l. Alaska Department of Education & Early Development, Report Card to the Public.

m. Governor's Council on Disabilities & Special Education, *Indicator 14 – Post-School Outcomes Status Report.*

n. National Low Income Housing Coalition *Out of Reach.*

o. Alaska Department of Labor & Workforce Development, Research and Analysis, Labor Force Data; U.S. Department of Labor, Bureau of Labor Statistics.

p. U.S. Social Security Administration, Office of Retirement and Disability Policy, *SSI Annual Statistical Report.*

Alaska Population Rates: Alaska Department of Labor & Workforce Development, Population Estimates.

Prevalence Data – Sources

Mental Illness (SMI and SED). Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH) (2013-2014 estimates).

Alzheimer's Disease. Alzheimer's Association, *Alaska Alzheimer's Statistics* (2015).

Traumatic Brain Injury. University of Alaska Center for Human Development, *The Alaska Traumatic Brain Injury Planning Grant Needs & Resources Assessment, June 2001 – January 2003* (2003).

Developmental Disabilities. U.S. Department of Health and Human Services, Office of Human Development Services and Gollay, E., *Summary Report on the Implications of Modifying the Definition of a Developmental Disability* (1981).

Alcohol dependence. Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH) (2013-2014 estimates).

Key to Scorecard symbols

Alaska vs. U.S. % Difference		Alaska Year-to-Year Trend		Assessment		Status
If	Less than 15%	and	getting better	then	satisfactory	✓
If	Less than 15%	and	getting worse or flat	then	uncertain	⟷
If	Greater than 15% to the positive	and	getting better or flat	then	satisfactory	✓
If	Greater than 15% to the positive	and	getting worse	then	uncertain	⟷
If	Greater than 15% to the negative	and	getting better	then	uncertain	⟷
If	Greater than 15% to the negative	and	getting worse or not clear	then	needs improvement	✗
If	Unacceptably large rate to the negative	then	trend becomes irrelevant	then	needs improvement	✗

How did we determine the status of Scorecard indicators?

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

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

Between 2014 and 2015 the status of most of the 22 indicators remained the same; two moved from "satisfactory" to "uncertain," and one moved from "uncertain" to "needs improvement."

Status information by Scorecard indicator

1. **Suicide rate**. The 2014 Alaska rate is 72% higher than the U.S. rate, and the Alaska rate has varied too much year-to-year to show a clear trend. The resulting status is "needs improvement." This is the same as last year's Scorecard status.
2. **Serious thoughts of suicide**. The 2013-2014 Alaska rate is 7% higher than the U.S. rate, and the Alaska rate has remained generally flat. The status is "uncertain." This is the same as last year's Scorecard status.
3. **Alcohol-induced mortality rate**. The 2014 Alaska rate is 310% higher than the 2013 U.S. rate (the most recent year for which data are available), and the Alaska data show no clear trend. The status is "needs improvement." This is the same as last year's Scorecard status.
4. **Heavy drinking (adults)**. The 2014 Alaska rate is 54% higher than the U.S. rate, and the Alaska rate does not show a clear trend, so the status is "needs improvement." This is the same as last year's Scorecard status.
5. **Binge drinking (adults)**. The 2014 Alaska rate is 26% higher than the U.S. rate, and the yearly Alaska data show no clear trend, so the status is "needs improvement." This is worse than last year's Scorecard status.
6. **Illicit drug use**. The 2013-2014 Alaska rate is 35% higher than the U.S. rate, and the yearly Alaska data show no clear trend, so the status is "needs improvement." This is the same as last year's Scorecard status.
7. **Days of poor mental health**. The 2014 Alaska rate is 15% lower than the U.S. rate and the Alaska data show no clear trend, so the status is "satisfactory." This is the same as last year's Scorecard status.

8. **Teens that experienced depression**. The 2015 Alaska rate is 12% above the 2013 U.S. rate (the most recent available) and the rate is unacceptably high, so the status is "needs improvement." This is the same as last year's Scorecard status.

9. **Population without health insurance**. The 2014 Alaska rate is 47% higher than the U.S. rate, and although it is an improvement over the 2013 rate, there is no clear trend. The status is "needs improvement." This is the same as last year's Scorecard status.

10. **Children abused and neglected**. While the Alaska data show as possible downward trend, the 2014 Alaska rate is 41% higher than the U.S. rate. The status is "needs improvement." This is the same as last year's Scorecard status.

11. **Founded reports of harm to adults**. There is not enough information to identify a trend in Alaska data and no comparable U.S. data; the status is "uncertain." This is the same as last year's Scorecard status.

12. **Injuries to elders due to falls**. The 2014 Alaska rate is 37% below the 2013 U.S. rate (the latest year of data available), and the data show a possible downward trend; the status is "satisfactory." This is the same as last year's Scorecard status.

13. **Non-fatal traumatic brain injury**. There are limited U.S. data for comparison, and the Alaska rate does not show a clear trend. The status is "uncertain." This is worse than last year's Scorecard status.

14. **Incarcerated adults with mental illness or mental disabilities**. There are not enough Alaska data to identify a trend. However, the consensus is that the rate is unacceptably high, so the status is "needs improvement." This is the same as last year's Scorecard status.

15. **Criminal recidivism for incarcerated adults with mental illness or mental disabilities**. There are not enough Alaska data to identify a trend; there are no comparable U.S. data. The status is "uncertain." This is the same as last year's Scorecard status.

16. **Arrests involving alcohol or drugs**. The Alaska rate has decreased in the last year and over the past six years; however, this may be due to record keeping. There are no U.S. data for comparison. The status is "uncertain." This is the same as last year's Scorecard status.

17. **Chronic homelessness**. The 2015 Alaska rate is 5% lower than the U.S. rate, but the Alaska data vary too much year-to-year to show a clear trend, so the status is "uncertain." This is the same as last year's Scorecard status.

18. **Difference between high school graduation rate for students with and without disabilities**. The 2014-2015 rate shows a smaller difference than the previous year; however, there is no evidence of a trend. The status is "uncertain." This is the same as last year's Scorecard status.

19. **Percent of youth who received special education and are employed and/or enrolled in post-secondary education**. There is not enough information to identify a trend in Alaska data and no comparable U.S. data; the status is "uncertain." This is the same as year's Scorecard status.

20. **Percent of minimum wage needed to afford housing**. The consensus is that the percentage of income spent on housing in Alaska is unacceptably high, so the status is "needs improvement." This is the same as last year's Scorecard status.

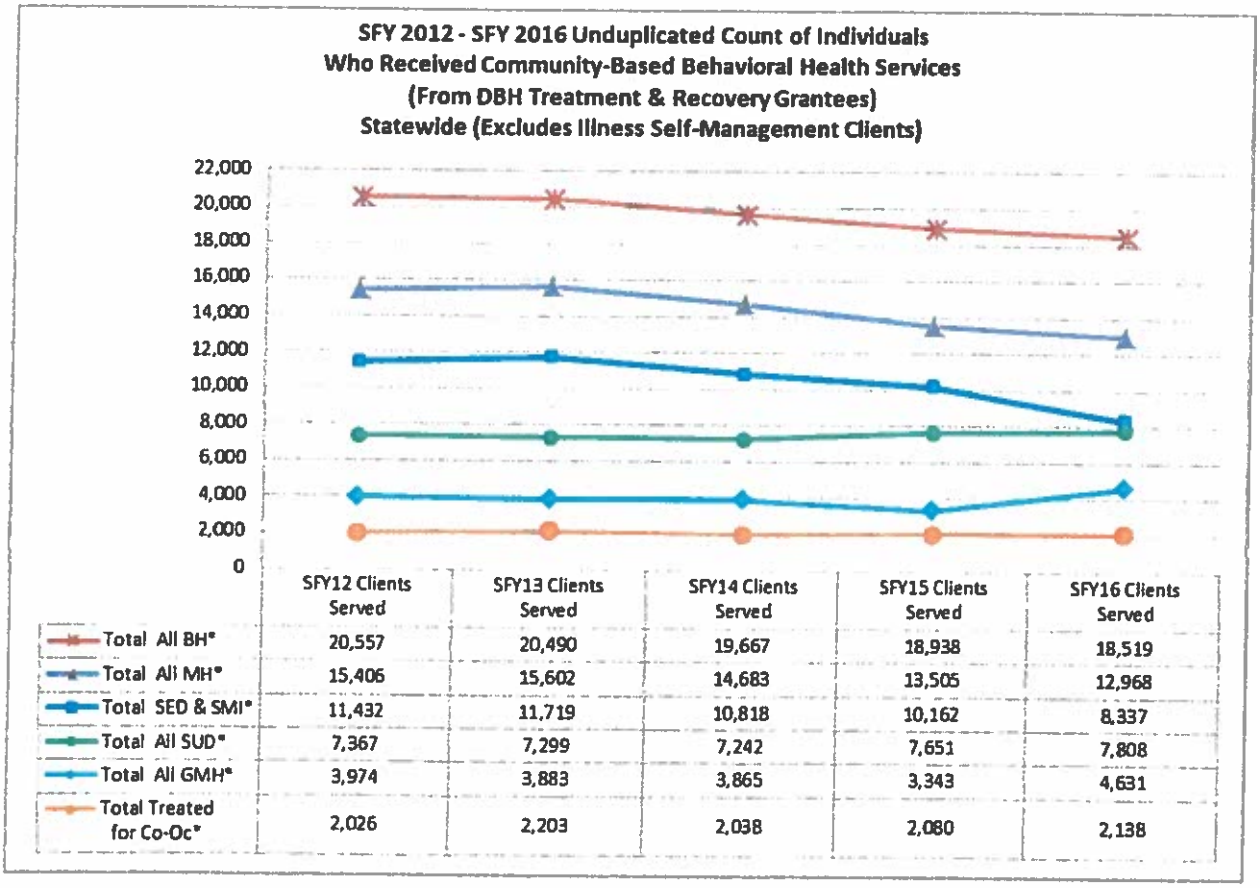
21. **Unemployment rate**. The 2014 Alaska rate is 10% above the U.S. rate and the data show a possible downward trend; the resulting status is "uncertain." This is worse than last year's Scorecard status.

22. **SSI recipients who are blind or disabled and are working**. The 2014 Alaska rate is 51% higher than the U.S. rate; the status is "satisfactory." This is the same as last year's Scorecard status.

SFY 2012 – SFY 2016 Statewide Unduplicated Counts of Individuals Who Received Community-Based Behavioral Health Services* from DBH Treatment & Recovery Grantees

*Community-Based Behavioral Health Services include mental health and substance use disorder services provided by the Division's Treatment and Recovery grantees; this includes services that are supported through grant and/or DBH Medicaid funds, including therapeutic foster or group home settings and behavioral rehabilitation services (BRS levels 2-4) for providers who enter data into AKAIMS. The counts shown in the charts below do not include illness self-management (ISM) clients. The ISM clients are typically non-traditional clients who do not want to receive clinical services, and information on these clients is not entered into AKAIMS. Limited information on ISM clients is collected through quarterly reports; due changes in reporting methodologies, the reported numbers of ISM clients served has fluctuated significantly over time and they are not included in the chart below.

Statewide Recipients of Behavioral Health Services Provided by DBH Treatment & Recovery Grantees:

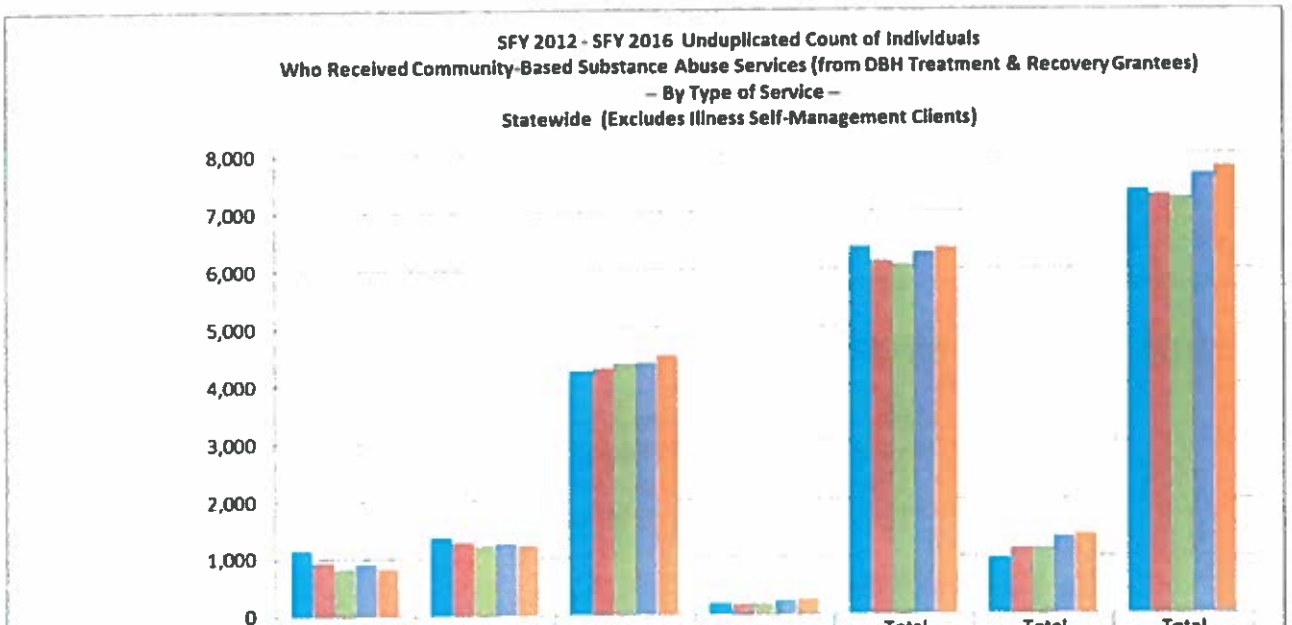


	SFY12 Clients Served	SFY13 Clients Served	SFY14 Clients Served	SFY15 Clients Served	SFY16 Clients Served
Total All BH*	20,557	20,490	19,667	18,938	18,519
Total All MH*	15,406	15,602	14,683	13,505	12,968
Total SED & SMI*	11,432	11,719	10,818	10,162	8,337
Total All SUD*	7,367	7,299	7,242	7,651	7,808
Total All GMH*	3,974	3,883	3,865	3,343	4,631
Total Treated for Co-Oc*	2,026	2,203	2,038	2,080	2,138

***Data Source:** Alaska Automated Information Management System (AKAIMS/EDI), DBH Uniform Reporting (UR) Client Profile Tables.
Total All BH: All youth and all adults who received Behavioral Health (BH) services (i.e., mental health and/or substance use disorder services); includes individuals with Co-Occurring disorders (Co-Oc).
Total All MH: All youth (SED and Non-SED) and all adults (SMI and Non-SMI) who received Mental Health (MH) services; includes individuals with Co-Occurring disorders.
Total SED & SMI: Youth with Severe Emotional Disturbance (SED) and Adults with Serious Mental Illness (SMI) who received mental health services; includes individuals with Co-Occurring disorders.
Total All SUD: Youth and adults who received Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders.
Total All GMH: Non-SED Youth and Non-SMI Adults who received General Mental Health (GMH) services; includes individuals with Co-Occurring disorders.

Statewide Recipients of Substance Abuse Services Provided by DBH Treatment & Recovery Grantees:

By Type of Service:



	Detox (24 hr)	Residential	Outpatient	Opioid	Total SUD Treatment*	Total Other SUD Service*	Total Any SUD Service*
SFY12 Counts	1,156	1,368	4,246	190	6,394	973	7,367
SFY13 Counts	956	1,307	4,301	193	6,152	1,147	7,299
SFY14 Counts	837	1,220	4,378	187	6,085	1,157	7,242
SFY15 Counts	928	1,267	4,397	229	6,301	1,350	7,651
SFY16 Counts	856	1,252	4,535	282	6,398	1,410	7,808
% Change FY12 to FY13	-17.3%	-4.5%	1.3%	1.6%	-3.8%	17.9%	-0.9%
% Change FY13 to FY14	-12.4%	-6.7%	1.8%	-3.1%	-1.1%	0.9%	-0.8%
% Change FY14 to FY15	10.9%	3.9%	0.4%	22.5%	3.5%	16.7%	5.6%
% Change FY15 to FY16	-7.8%	-1.2%	3.1%	23.1%	1.5%	4.4%	2.1%

***Data Source:** Alaska Automated Information Management System (AKAIMS/EDI), DBH Uniform Reporting (UR) Client Profile Tables.

SUD: Individuals who received Substance Use Disorder (SUD) services; includes individuals with Co-Occurring disorders.

Detoxification, Residential, Outpatient, and Opioid are reported as types of Substance Use Disorder *Treatment*.

Total SUD *Treatment* client count is the unduplicated count across the four types of SUD treatment.

Total Other SUD Service client count is the unduplicated count of persons who received an SUD service, but did **not receive an SUD *treatment*** service. Other SUD Services include:

- Clients who received assessment only
- Clients who received substance abuse case management only
- Co-occurring clients enrolled in mental health programs but **not SUD *treatment*** programs

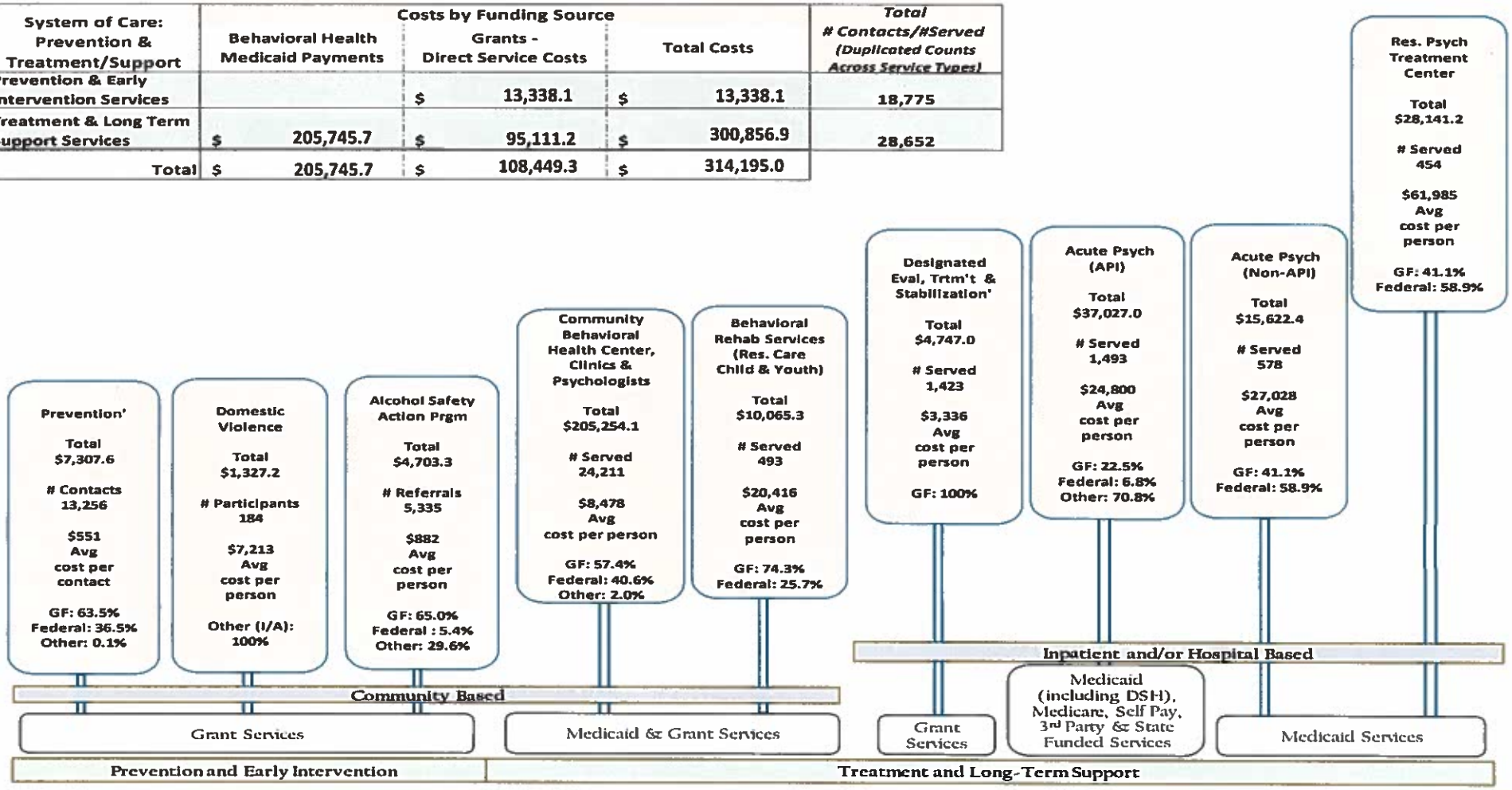
Total Any SUD Service client count is the unduplicated count of persons who received **any** SUD service, including ***treatment*** **or other SUD services.**

Continuum of Care FY2016 Actuals

Behavioral Health System of Care

SFY 2016 Costs by Funding Source and Average Cost per Person by Service Type

System of Care: Prevention & Treatment/Support	Costs by Funding Source: Behavioral Health Medicaid Payments	Costs by Funding Source: Grants - Direct Service Costs	Costs by Funding Source: Total Costs	*Total # Contacts/#Served (Duplicated Counts Across Service Types)*
Prevention & Early Intervention Services		$ 13,338.1	$ 13,338.1	18,775
Treatment & Long Term Support Services	$ 205,745.7	$ 95,111.2	$ 300,856.9	28,652
Total	$ 205,745.7	$ 108,449.3	$ 314,195.0	



ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer from their view. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered "Yes", did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

    If you answered "Yes" to 21 or 22, please answer a-c:

    a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
    b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
    c. Did you receive treatment for anything that changed? ..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. If Yes, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage? ..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step? ..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much? ..... ☐ Yes ☐ No
37. Do you think you might have a problem with your drinking, drug or inhalant use? ..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

CLIENT STATUS REVIEW

Case Number: _____

Date completed: ____/____/____ Name _____

If you are filling this out for someone else, please answer from their view.

# of Days

1. How many days during the past 30 days was your physical health (including physical illness and/or injury) not good? ..... _____
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) not good? ..... _____
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation? ..... _____
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? ..... _____
5. How many days during the past 30 days have you used alcohol? ..... _____
6. How many days during the past 30 days have you used illegal drugs (including medications not as prescribed/directed)? _____
7. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, emergency medical technicians or health aides for physical, substance abuse, or mental health problems? ..... _____
8. Which one of the following best describes your housing situation? (please check one)
   - ☐ Adult in private residence – independent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Adult in private residence – dependent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Child living with family/extended family or with non-relative
   - ☐ Foster home/foster care
   - ☐ Homeless or shelter
   - ☐ Jail or correctional facility
   - ☐ Crisis residence (short term stabilization)
   - ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
   - ☐ Residential treatment facility for:
     - ☐ Mental health ☐ Substance abuse ☐ Co-occurring disorder
   - ☐ Institutional care facility – 24 hour, 7 days/week (nursing facilities/homes, psychiatric health facilities, hospitals)
   - ☐ Other (please describe) _____
9. If you are a student (attending elementary through high school), which one of the following best describes your school?
   - ☐ Public/private school ☐ Home schooled

   If you attend a public/private school, how many days have you been absent during the past 30 school days? ..... _____
10. Which one of the following best describes your employment status? (please check one)
    - ☐ Employed full time working for money (30 or more hours per week including supported employment)
    - ☐ Employed part time working for money (less than 30 hours per week including supported employment)
    - ☐ Unemployed (looking for employment during the past 30 days or on layoff from a job)
    - ☐ Not in labor/work force (not looking for employment during the past 30 days); if you checked this box, please check one of the following:
      - ☐ Homemaker
      - ☐ Retired
      - ☐ Engaged in subsistence activities
      - ☐ Student
      - ☐ Disabled
      - ☐ Inpatient/inmate (otherwise unable to enter labor force)
      - ☐ Job training program
      - ☐ Volunteer
      - ☐ Other (please describe) _____
11. In a typical week over the past 30 days, how many hours were you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? ..... Total hours: _____
12. In the past 30 days, have you had any legal involvement? (Legal charges, court appearance, arrests, probation, parole) ..... ☐ Yes ☐ No

CLIENT STATUS REVIEW

Case Number: _____

13. In the past 30 days, have you been arrested? ☐ Yes ☐ No
14. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No
15. In the past 12 months, have you been arrested? ☐ Yes ☐ No
16. Below are questions about your life. Please answer each question by putting an X in the space that best describes how you feel about each issue. Please use only one X for each question.

How do you feel about:	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
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?							

17. Who filled out this survey? (please check one)
    - ☐ I filled this out by myself
    - ☐ I filled this out for a child
    - ☐ Someone helped me fill this out (Person's name) _____
18. Please respond to these statements if you have received services from this agency.

How do you feel about the services you received? (Place an X in the space that best describes your level of agreement with each statement)	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
I was treated with respect.							
I was able to get all the services I needed.							
The services improved the quality of my life.							

19. What did you like about the services you received? _____
20. What did you dislike about the services you received? _____

CLIENT STATUS REVIEW

Case Number: _____

Type of CSR: ___Initial ___90-135 Day Follow-Up ___Discharge Administered by:_____

Date Completed: _____/_____/_____ Name: _____

Are you completing this survey for? (Please check one) ☐ I filled this out by myself (age 12 and older) ☐ I filled this out for a child/youth (Under age 12) ☐ Someone helped me fill this out

What best describes the reason you came in for services today? **Select all that apply...**

☐ I decided on my own ☐ I was encouraged by others (like family, friends, etc.)
☐ I was required to come (including court order, Office of Children's Services, etc.)

Health and Quality of Life

	# of Days
1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good?	
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not** good?	
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation?	
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself?	

	# of Times
5. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, or emergency medical technicians/health aides?	

6. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No

Substance Use

	# of Days
7. How many days during the past 30 days have you had at least one alcoholic beverage?	
8. How many days during the past 30 days have you had 4 or more alcoholic beverages?	
9. How many days during the past 30 days have you used marijuana or illegal drugs (including medications not as prescribed or directed)?	

Legal Involvement

10. In the past 30 days, have you had any legal involvement (legal charges, court appearance, arrests, probation or parole) ☐ Yes ☐ No

	# of Times
11. In the past 30 days, how many times have you been arrested?	
12. In the past 12 months, how many times have you been arrested?	

Health Behavior

	# of Days
13. How many days during the past 30 days have you smoked cigarettes, pipes, or cigars AND/OR used chewing tobacco, snuff, or snus?	
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day?	
15. How many days during the past 7 days did you participate in any physical activities or exercise such as running, sports (basketball, baseball etc.), swimming, bicycling or walking for exercise?	

	# of Times
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit?	
17. During the past 7 days, how many times did you eat vegetables?	

CLIENT STATUS REVIEW

Case Number: _____

18. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question

How do you (or your child) feel about:	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
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?							

Please Answer Questions 19 – 21 if you have received services from this agency.

19. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

How do you feel about the services you (or your child) received?	Terrible	Unhappy	Dissatisfied	Mixed	Satisfied	Pleased	Delighted
I was treated with respect.							
I was given information about my rights.							
I helped to choose my treatment goals.							
I felt comfortable asking questions about my treatment.							
I was able to get all the services I needed.							
Because of the services I received:							
I am better able to handle daily life.							
I am getting along better with other people.							
I am better able to cope when things go wrong.							
The quality of my life has improved.							

20. What did you like about the services you received? _____

_____

21. What did you dislike about the services you received? _____

_____

Please Answer Questions 22 – 25 with the assistance of agency staff.

CLIENT STATUS REVIEW

Case Number: ☐

22. Which one of the following best describes your housing situation/living arrangement? (In the past 30 days, where have you been living most of the time?) (please check one)

- ☐ Adult in private residence – independent living (may live with others, but capable of self-care)
- ☐ Adult in private residence – dependent living (heavily dependent on others for daily living assistance)
- ☐ Child living in private residence (not in foster home)
- ☐ Foster home/foster care
- ☐ Homeless or shelter
- ☐ Jail or correctional facility
- ☐ Crisis residence (short term stabilization)
- ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
- ☐ Residential treatment facility for:
  - ☐ Mental Health ☐ Substance Abuse ☐ Co-occurring Disorder
- ☐ Institutional care facility (care provided 24 hours, 7 days/week) (hospital, other inpatient psychiatric facility, nursing facility/home)
- ☐ Other (please describe) _____

23. Did you attend school at any time in the past three months? Yes ☐ No ☐

If you checked 'Yes,' please indicate below the grade/educational level you attended in the past three months.

If you checked 'No,' please indicate below the highest grade/educational level you have completed.

- ____ Grade Level (Write in Grade Level 1-12 or GED)
- ☐ No years of schooling
- ☐ Nursery School/Pre-School (Including Head Start)
- ☐ Kindergarten
- ☐ Self-Contained Special Education Class (No equivalent grade level)
- ☐ Vocational School
- ☐ College Undergraduate Freshman (1st year)
- ☐ College Undergraduate Sophomore (2nd year)
- ☐ College Undergraduate Junior (3rd year)
- ☐ College Undergraduate Senior (4th year)
- ☐ Graduate or Professional School (Master's, Doctoral, Medical, Law)

24. Which one of the following best describes your employment status during most of the previous week? (please check one)

- ☐ Employed full time working for money (30 or more hours per week); includes Supported Employment and Armed Forces
- ☐ Employed part time working for money (less than 30 hours per week); includes Supported Employment and Armed Forces
- ☐ Unemployed - actively looking for employment or laid off from job (and awaiting to be recalled) in the past 30 days
- ☐ Not in labor/work force (not employed and not actively looking for employment during the past 30 days); if you checked this box, please check one of the following:
  - ☐ Homemaker
  - ☐ Retired
  - ☐ Disabled
  - ☐ Volunteer
  - ☐ Sheltered/Non-competitive employment
  - ☐ Not Yet School Age
  - ☐ Student
  - ☐ Job training program
  - ☐ Engaged in subsistence activities
  - ☐ Other (please describe) _____
  - ☐ In Residential Care Facility
  - ☐ In Residential Treatment Facility
  - ☐ Inpatient of Institutional Care Facility
  - ☐ Inmate of Jail or Correctional Facility

25. Over the past 7 days, which one of the following best describes the number of hours you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? (Please check one of the boxes below)

☐ less than 10 hours ☐ 10-20 hours ☐ 21-30 hours ☐ 31-40 hours ☐ 41-50 hours ☐ More than 50 hours

Integrated Behavioral Health Assessment
TEMPLATE – FOR REFERNCE ONLY

Patient Name:				
DOB:				
Address:				
Phone Number:				
Date of Assessment:				
Examiner/Credentials:				
Assessment Time:	**Start:**		**Stop:**	
Referral Source:				
Referral Contact:				

Identifying Data/Patient Data:
(The client in a nutshell; overview for staffing; name, age, marital status, children, has residence, had employment, has medical needs, has mental health, etc)

Patient's Statement of Presenting Problem:
(Describe problem in patient's words, then include description of presenting problem as described by patient. If client denies they have a problem with substances, have them describe why they are here.)

Substance Use; Current and History

Substance Abuse History
(Age of first use, age when use became a problem, age amount of use at its heaviest, description of substance use history, description and amount of use in past 3 to 6 months, method of intake, age/date of last use.)

Alcohol	Patient stated first drinking alcohol at age Age of heaviest use was age Patient states the date of last use on Tolerance increase? Withdrawal? Blackouts? Spending lots of time getting or doing it? Cravings? Did it cause problems? Cont. use even when problematic? Wanting to stop? Slacking at work? Relationship Problems?

Cannabis	Patient stated first using cannabis at age Age of heaviest use was age Patient states the date of last use on Tolerance increase? Withdrawal? Blackouts? Spending lots of time getting or doing it? Cravings? Did it cause problems? Cont. use even when problematic? Wanting to stop? Slacking at work? Relationship Problems?
Opioids	Patient stated first started using opioids at age Age of heaviest use was age Patient states the date of last use on Tolerance increase? Withdrawal? Blackouts? Spending lots of time getting or doing it? Cravings? Did it cause problems? Cont. use even when problematic? Wanting to stop? Slacking at work? Relationship Problems?
Methamphetamines	Patient stated first started using methamphetamines at age Age of heaviest use was age Patient states the date of last use on Tolerance increase? Withdrawal? Blackouts? Spending lots of time getting or doing it? Cravings? Did it cause problems? Cont. use even when problematic? Wanting to stop? Slacking at work? Relationship Problems?

Cocaine	Patient stated first using cocaine at age Age of heaviest use was age Patient states the date of last use on Tolerance increase? Withdrawal? Blackouts? Spending lots of time getting or doing it? Cravings? Did it cause problems? Cont. use even when problematic? Wanting to stop? Slacking at work? Relationship Problems?
Benzodiazepines	Patient stated first started using benzodiazepines at age Age of heaviest use was age Patient states the date of last use on
Hypnotics	
Nicotine	Patient stated first started using nicotine at age Age of heaviest use was age Patient states the date of last use on
Inhalants	
Hallucinogen	
Caffeine	
Club Drugs	
Other/Process Addictions	

Other Information gathered by Clinician:

(If not already described above; Include; Onset and pattern of progression of use. Include history of seizures/blackouts/DTs/withdrawal/symptoms Are they at risk for withdrawal symptoms? Acute? Do they require hospitalization? Are the symptoms mild, moderate, severe? Are the withdrawal symptoms manageable? You can talk about withdrawing from other behaviors in this section (esp. valuable with regard to onset and progression) but the ASAM Dimension-I needs to be coded with reference to substance abuse, if any.)

History of substance use treatments/medical detoxes:
(Include at minimum; approximant dates, kind of treatment, length and time clean and sober after.)

Patient describes past treatment by stating, "

Descriptions of how the patient views his/her substance use:
(Does patient endorse criteria for dependence/abuse? Does patient see his/her use as a problem? Does patient believe that his/her substance use has affected his/her life and those close to him/her?)

When asked if the patient believes that substance use has caused problems he/she stated, "

When asked if patient believes that substance use has affected his/her life and the people closest to him/her patient stated, "

Bio-Medical History

Medical History:

(Include past illnesses/injuries, TBI, note if condition is a result of substance abuse and client's awareness of this relationship. Include history of traumatic pregnancy, miscarriage, or abortions. Include consumption of alcohol during pregnancy)

Patient describes past medical history by stating, "

Current Medical Conditions:

(Note if condition may be a result of substance abuse and client's awareness of this relationship. Is client under medical care? If so, with who? Is client on medication? Compliant? Regular exercise. **List current prescribed/over the counter medications/Directing physician and if there is an ROI on file.)**

Patient describes current medical conditions by stating, "

Medications:
(Note what condition the medication is addressing)

Chronic or Acute Pain:

(Include and rate chronic pain from 0-10. Note if there is any acute pain. Does patient self medicate with drugs/alcohol)

Patient describes chronic or acute pain by stating, "
Current pain is 0 out 10....
Patient states any past self-medicating with drugs or alcohol included

Nutritional Screening:

(Typical Food intake for the past month.)

When asked to describe typical food intake within the past month patient stated, "

Weight change of more than 10 pounds in past 6 months:	☐ Yes	☒ No
Recipient significantly overweight/underweight:	☐ Yes	☒ No
Drugs used for weight control:	☐ Yes	☒ No
Past diagnosis of an eating disorder/high risk diagnosis:	☐ Yes	☒ No
Nausea/vomiting/diarrhea for more than 7 days:	☐ Yes	☒ No

Mental Health Status Screening and History

Orientation For:

☒ Person ☒ Place ☒ Date

Presentation:

☒ Clean/Neat ☐ Unkempt/Messy ☐ Overly Dressed
☐ Appropriate for situation

Speech:

☒ Normal ☐ Slow ☐ Racing ☐ Halting

Memory:

Immediate:	☒ Normal	☐ Impaired	☐ Uncertain
Recent:	☒ Normal	☐ Impaired	☐ Uncertain
Remote	☒ Normal	☐ Impaired	☐ Uncertain

Thought Process:

☒ Logical/Coherent ☐ Obsessional ☐ Tangential
☐ Disorganized ☐ Circumstantial ☐ Black & White Thinking

Mood (Emotional State):

☒ Normal/Calm ☐ Depressed ☐ Anxious ☐ Euphoric
☐ Angry/Hostile ☐ Agitated ☐ Resistant ☐ Irritated
☐ Peaceful/Relaxed/Content ☐ _____

Attitude/Behavior:

☒ Cooperative ☐ Withdrawn ☐ Evasive ☐ Hyperactive
☐ Guarded ☐ Distracted ☐ Defensive ☐ Attentive
☐ Self-Deprecating

Judgement

☒ Good ☐ Fair ☐ Poor ☐ Impulsive
☐ Immature ☐ age appropriate

Observations of behavior during the interview:

Current and historical psychiatric/mental health conditions

Mental health diagnosis and treatments as described by patient:
(History of past mental health symptoms, diagnosis, dates and effectiveness of past treatment, who diagnosed and treated; effectiveness of past treatments/medications.)

When asked to describe any mental health diagnoses and treatment patient stated, "

Current mental health condition:
(Describe current mental health symptoms, clinician justification for DSM Diagnosis, does patient self-medicate mental health with substances, is mental health condition substance induces, who is currently treating, current medication, is client compliant and is patient satisfied with current treatment? Is client emotionally/behaviorally, cognitively stable for treatment?))

History or Current Suicidal/Homicidal attempts/ideation:

Patient denied any history of current suicidal/homicidal ideation or attempts.
Patient describes past suicidal ideation or attempts by stating, "

Family History

Childhood History/Development until Patient enters Adulthood:
(Include client description of family/sibling. Include family history of mental health/substance abuse issues, including grandparents of available and how client was affected by it. Include history pf physical, sexual or emotion abuse. Include major losses that impacted client, or emotional abuse. For Youth; include developmental milestones, pre, post, and prenatal problems.)

When asked to describe childhood patient stated, "
Patient describe siblings by stating, "
Patient describes addiction history within the family by stating, "
Patient describes physical, emotional or sexual abuse during childhood by stating, "
Patient describes loses during lifetime by stating, "

Description of Adulthood:
Major milestones that impacted patient: Include marriages, divorces, major accomplishment, setbacks, losses, history of abuse, physical and/or emotional, children from previous relationships.)

Patient describes adulthood by stating, "
Patient describes physical, emotional or sexual abuse during adulthood by stating, "

Recovery Living Environment/Sober Support System:

Current Living/Family Situation:
(Where living, children, custody issues, current relationship, is client satisfied with current life situation? Other life stressors? Does client feel safe in current situation? Has client been hit or abused, other signs of abuse?)

Patient describes current living situation by stating, "
Patient describes current relationship as "
Patient describes current stressors as "
Patient describes current social support as "
Patient states he/she feels safe/unsafe in current situation.

Recreational/Leisure Activities/Social Peer Group;
(Describe social group. Do they have using peers? How does the patient spend their free time?)

Patient describes social group by stating, "
Patient states he/she spends her free time by "

Education, Employment, Legal

Education/Military Service:
(Describe patient's education and/or military service background.)

Patient denied any prior military service of any kind.
Patient describes his/her education by stating, "

Employment History/Other Sources of Income:
(Describe patient's employment history and/or other sources of income)

Patient describes past employment history by stating, "
Patient describes current employment history and sources of income by stating, "

Legal Involvement History:
(Describe patient's legal involvement (current and past.)
Patient describes legal involvement by stating, "

Patient Strengths:
(Resources, social support, gifts, and talents? What does the patient like about themselves?)

Patient describes strengths by stating, "I am

Counselor Impressions/Interpretations of Screenings

Alaska Screening Tool:	
Section I	Patient indicated that over the last two weeks he/she has felt Little pleasure or interest in doing things for Felt down, depressed or hopeless for Had trouble falling asleep or sleeping too much for Felt tired or had little energy for Had poor appetite or ate too much for Felt bad about herself/himself or that they were a failure and had let themselves or their family down for Had trouble concentrating on things, such as reading the newspaper or watching TV for Moved or spoken so slowly that other people have noticed for Been so fidgety or restless that they were moving around a lot more than usual for Remembered things that were extremely unpleasant for Were barely able to control their anger for Felt numb, detached or disconnected or Felt distant or cut off from other people for
Section II	Patient indicated they have Lived where they have felt like they didn't have enough to eat, had to wear dirty clothes, or were not safe

	Lived with someone who was a problem drinker or alcoholic, or used street drugs Lived with someone who was depressed or seriously mentally ill Lived with someone who has attempted or completed suicide Lived with someone who has been sent to prison They have personally or have had a family member placed in foster care Have lived with someone while they were physically mistreated or seriously threatened They have been physically mistreated or seriously threatened It did/did not involve an intimate partner
Section III	Patient indicated they have had a blow to the head It was/was not sever enough to cause a concussion They did receive treatment for head injury They did/did not have lasting changes Patient indicated mother did/did not consume alcohol Mother did/did not drink while pregnant
Section IV	Patient states in the last 12 months they have Had a major change like death of a loved one, moving, or loss of job Sometimes feel afraid, panicky, nervous or scared Often finds themselves in situations where their heart pounds and they feel anxious and want to get away Have tried to hurt themselves or commit suicide Destroyed property or set fire that has caused damage Physically harmed an animal or a person on purpose Hear voices or see things that other people tell them they cannot see or hear Think people are out to get them and they have to watch their every step
Section V	Patient indicates that over the last 12 months they have Gotten into trouble at home, at school, or in the community because of using alcohol, drugs, or inhalants Have missed school or work because of using alcohol, drugs, or inhalants Have had 6 or more drinks at one time Makes them angry if someone tells them that they drink or use drugs too much Patient does/ does not think they might have a problem with alcohol, drugs, or inhalants

Client Status Review:
Observations noted in the CSR that have not already been described are
Patient reported feeling delighted in the areas of Patient reported feeling pleased in the areas of Patient reported feeling satisfied in the areas of Patient reported feeling mixed in the areas of Patient reported feeling dissatisfied in the areas of Patient reported feeling unhappy in the areas of Patient reported feeling terrible in the areas of

SASSI-3	SASSI results indicate a high/low probability of mild to severe substance use disorder.

HIV/STD/HEP-C Risk Assessment	HIV risk assessment indicates that patient has/has not received an HIV test Has/has not had unprotected anal, vaginal, or oral sex with one or more than one partner within the last year

UA Results	UA results were positive for

DSM-5		
		Include Diagnosis

ASAM PPC-2 Criteria

		Risk Assessment
DIM 1	**Acute intoxication and/or withdrawal potential:**	**0 1 2 3**
	*0 No signs or symptoms of intoxication or withdrawal symptoms *1 Mild to moderate symptoms, can cope *2 Some difficulty tolerating and coping with symptoms. . *3 Poor ability to cope/tolerate with withdrawal discomfort. Severe signs/symptoms of intoxication may pose imminent danger to self/others.	

DIM 2	**Biomedical conditions and complications:**	**0 1 2 3**
	*0 No biomedical signs or symptoms are present. *1 Mild to moderate signs or symptoms but patient has adequate ability to cope.	

	*2 Some difficulty tolerating/coping with physical problems and/or biomedical problems. Problems may interfere with recovery and mental health tx. *3 Poor ability to tolerate/cope with physical problems, general health condition is poor. PT. has serious medical problems which he neglects.	

DIM 3	Emotional/Behavioral conditions and complications	0 1 2 3
	*0 No mental health or has a diagnosed but stable mental health disorder full functioning, can cope *1 Mental health that needs intervention but will not interfere with addiction treatment; adequate impulse control and coping skills, relationships and social functioning are impaired but not endangered, can meet responsibilities and maintain meaningful relationships despite mild symptoms, mild to moderate signs and symptoms. * 2 Impairment at decompensation or decompensation at baseline, symptoms and disability that significantly interfere with addiction treatment but not immediate threat to safety or prevents independent functioning, significant history of suicidal or violent behavior that requires more than routine monitoring. Emotional, behavioral or cognitive problems distract from recovery efforts. Relationships and social functioning impaired by substance use but linked to psychiatric disorder. Moderate difficulty in managing relationships, moderate or minimal skills to cope, frequent or intense symptoms *3 recovery efforts are negatively affected by patient's emotional problems in significant and distracting ways, up to and including inability to focus on recovery efforts.	

DIM 4	Readiness for change:	0 1 2 3
	*0 Willing to engage in treatment, is committed to change substance use, and/or mental functioning. *1 willing to enter treatment, explore strategies for change but is ambivalent about need for change, is willing to explore the need for treatment and strategies to reduce or stop substance use, or willing to change substance use, but believes it will not be difficult to do so, or does not accept a full recovery treatment plan. (same for mental health) *2 reluctant to agree to treatment is able to articulate negative consequences of substance use but has low commitment to change use of substances, assessed as low readiness to change and only passively involved in treatment variable compliant with attendance at op sessions, meetings of other support groups. (same for mental health) *3 inconsistent follow through and shows minimal awareness of	

	substance use disorder and need for treatment, appears unaware of need to change this is unwilling or partially able to follow through with treatment recommendations. (Same for mental health)	

DIM 5	**Relapse/continued use potential:**	**0 1 2 3**
	*0 low potential for substance use problems, or low relapse potential, good coping skills. *1 minimal relapse potential, some vulnerability, some vulnerability fair management and relapse prevention skills, same for mental health. *2 impaired recognition and understanding of substance use relapse issues but is able to self-manage with prompting, (same for mental health) *3 little recognition and understanding of substance use relapse issues, has poor skills to cope with and interrupt addiction problems or to avoid or limit relapse. (Same for mental health)	

DIM 6	**Recovery/living environment:**	
	*0 supportive environment or able to cope with poor supports. *1 passive support, or significant others are not interested in his or her addiction recovery, but patient is able to cope, (same for mental health) *2 Patient's environment is not supportive of addiction recovery, but with clinical structure, the patient is able to cope mist of the time. (same for mental health) *3 environment is not supportive of addiction recovery and he or she finds coping difficult even with clinical structure. (same for mental health)	

Stages of Change

- ☐ Pre-contemplation: Does not recognize a problem
- ☐ Contemplation Aware of a problem & thinking about change
- ☐ Preparation: Preparing to change
- ☐ Action: Engaged in the change process
- ☐ Maintenance: Relapse prevention to maintain change
- ☐ Relapse: Active use/decomposition

Counselor Prognosis and Recommendations for treatment

Preliminary Problem List and Goals list; as described by Patient: (Patient's own words)

- **Problem 1**:
  Goal:
- **Problem 2**:
  Goal:
- **Problem 3**:
  Goal:
- **Problem 4**:
  Goal:

Additional Problems and Goals as identified and described by Clinician:

- **Problem 1**:
  Goal:
- **Problem 2**:
  Goal:
- **Problem 3**:
  Goal:

Hope and Help

When patient was asked what would give you hope in your life right now she/he stated, "To have."

When patient was asked what help do you need to accomplish this she/he stated, "I need to."

Level of Care recommended:
(Included if client is accepting or not of recommendations and provide justification for why level of care may be different than recommendation.)

Clinician's Prognosis and additional thoughts/concerns to be noted:

Counselor Justification for DSM diagnosis:
Patient endorsed criteria for DSM-5 Substance Use Disorder based on:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger

9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

Eligibility Requirements:
Patient meets eligibility for clinical services based on being

A child experiencing an emotional disturbance
A child experiencing a severe emotional disturbance
An adult experiencing an emotional disturbance
An adult experiencing a serious mental illness

Patient meets eligibility for rehabilitation services based on being:

An individual experiencing a substance use disorder characterized by a maladaptive pattern of substance use
or an individual experiencing cognitive, behavioral, or physiological symptoms indicating that the individual will continue to use a substance despite significant substance-related problems associated with its use
being a child experiencing a severe emotional disturbance.

Service recommendations:

- Group Psychotherapy
- Individual Psychotherapy
- Family Psychotherapy
- Comprehensive Community Support Services for Adults
- Care Coordination/Case Management
- Medication Management

_____ _____
(Insert Name and Credentials)
Date:
Directing Clinician

_____ _____
Date:
Supervising Clinician

ASAM Level of Care (LOC)
Cheat Sheet

This "cheat sheet" contains summaries of the various Levels of Care. Use this information to help you determine which LOC is appropriate for a patient. You can also use this information to plan treatment when a particular LOC is unavailable.

Level of Care	Hours	Necessary Staff	Structure	Intensity	Length
0.5 Early Intervention Services	Varies	For adults and teens: Staff must be knowledgeable about the Dimensions, able to recognize substance-related disorders, and provide education and motivational counseling. For teens: Staff must be knowledgeable about developmental issues and mental health concerns of youth.	Education classes review signs, symptoms, and risk factors. May also include group and/or family counseling.	Low	Brief
I Outpatient Services	Adults = fewer than 9 hours per week Teens = fewer than 6 hours per week	For adults and teens: Staff must be professionals with the necessary credentials to treat substance-related disorders. They must be able to assess readiness for change, knowledgeable about the Dimensions, and capable of monitoring mental health issues. For teens: Staff must be able to engage, assess, and treat teens. They must be knowledgeable about co-occurring psychiatric issues and able to recognize the need for intoxication and withdrawal services.	Similar to Level 0.5, but should also include an ER available by phone 24 hours a day, 7 days a week. Medical and psychiatric care should be available within 24 hours by phone or, if in person, within a time frame appropriate to the severity and urgency of the consultation requested.	Low to medium	Based on client's treatment plan and progress made toward individual goals.
2.1 Intensive Outpatient	Adults = at least 9 hours per week Teens = at least 6 hours per week	Staff must be professionals with the necessary credentials to treat substance-related disorders, including at least one physician. Some members of the staff should be trained to deal with mental health issues, including co-occurring disorders and the use of medications.	Similar to Level I, but medical and psychiatric care should be available by phone within 24 hours and in person within 72 hours.	Medium to high	Based on client's treatment plan and progress made toward individual goals.

Level of Care (LOC) Cheat Sheet (page 2)

LOC	Hours	Necessary Staff	Structure	Intensity	Length
2.5 Partial Hospitalization	20 or more hours per week	Same staff requirements as Level 2.1.	Similar to Level I, but with direct access (within 8 hours by phone, within 48 hours in person) to psychiatric, medical, and lab services so that issues in Dimensions 1, 2, and 3 can be monitored daily.	Medium to high	Based on client's treatment plan and progress made toward individual goals
3.1 Clinically-Low-Intensity Residential	24 hours per day, 7 days a week	All staff must be knowledgeable about substance abuse and mental health issues. They must be available 24 hours a day, 7 days a week, and be able to assess and treat co-occurring disorders for medication adherence. Staff must be able to access other services as needed through collaboration or consultation. Lab services should be available as needed.	Similar to Level 2, but stresses interpersonal and group-living skills so that a positive recovery environment can be established and maintained (for example, a halfway house). At least 5 hours a week of professional treatment.	Medium to high	Based on client's treatment plan and progress made toward individual goals
3.3 Clinically-Population-High-Intensity Residential Criteria Only)	24 hours per day, 7 days a week	In addition to staff requirements in Level III.1. 3.1, substance-abuse treatment professionals must be available on-site or by phone 24 hours a day, 7 days a week. Staff should have specialized training in behavior management techniques, be knowledgeable about treatments for substance abuse and mental health issues, and be able to identify acute psychiatric symptoms. Medical, lab, and toxicology services should be available as needed.	Similar to Level 3.1, but focus is on clients with cognitive impairments, poor abstract skills, and those who need repetitive, slower-paced treatment until they stabilize—clients who cannot make use of a more active residential environment and may need more individualized care in the safety of a residential setting (for example, DDE residential care).	High	Based on client's treatment plan and progress made toward individual goals.

Level of Care (LOC) Cheat Sheet (page 3)

LOC	Hours	Necessary Staff	Structure	Intensity	Length
3.5 Clinically-Managed High-Intensity Residential	24 hours per day, 7 days a week	Same staff requirements as Level 3.3. In addition, staff should be able to make arrangements for additional services if necessary.	Similar to Level 3.1, but includes services for clients who have significant social and psychological problems that cause multiple deficits, including criminal activity and disaffiliation from mainstream values, but whose cognitive abilities are less impaired than those in Level 3.3.	High	Based on client's treatment plan and progress made toward individual goals.
3.7 Medically-Monitored Intensive Inpatient Services	24 hours per day, 7 days a week	Same staff requirements as Level 3.5. In addition, a physician or other appropriate medical clinician should assess clients within 24 hours of admission and be able to monitor as needed. Psychiatric services should be available, through consultation or referral, within 8 hours by phone or within 24 hours in person. Staff needs to be able to provide a continuous, planned regimen of professional evaluation, care, and treatment.	Care similar to Levels 3.1, 3.3, and 3.5, but it is delivered by an interdisciplinary staff including physicians and nurses who are trained to treat addiction-related medical problems.	High	Based on client's treatment plan and progress made toward individual goals.
4 Medically-Managed Intensive Inpatient Services	24 hours per day, 7 days a week	Same staff requirements as Level 3.7. In addition, an interdisciplinary team of addiction professionals, physicians, and nurses should be available for counseling 16 hours a day and should be available for care 24 hours a day, 7 days a week. All staff members should be aware of the symptoms of substance abuse and mental health disorders and knowledgeable about medication use.	Includes treatment for clients with co-occurring disorders, such as an acutely suicidal client who needs medical detox—the focus is on stabilization and preparation for transfer to a less intensive LOC.	High	Based on client's treatment plan and progress made toward individual goals.

Clinical Record Evaluation Tool

Provider Name:	Recipient Initials:
Reviewer Name & Date:	Medicaid Recipient: (Circle) Yes or No

#	Yes	No	ALASA SCREENING TOOL REQUIREMENTS	Comment	Regulation
A.			Is the AST Present & Complete?	Enter Date:	135.130(a)(1)
B.			Was the AST completed before the assessment was conducted for the recipient?		135.100(a)
C.			Is there documented evidence that the results of the AST was reviewed and considered during the assessment?		135.110(h)

#	Yes	No	CLIENT STATUS REVIEW REQUIREMENTS	Comment	Regulation
A.			Is the CSR present as part of the clinical record?	Enter Date:	135.130(a)(2)
B.			Was the initial CSR completed with the recipient physically present and administered using the department's current CSR form?		135.100(c)(1)
C.			Was the CSR used by the directing clinician in making treatment decisions?		135.100(c)(4)
D.			Was the CSR administered and reviewed every 90 to 135 days?		135.100(c)(6)(A)&(B)
E.			Was the CSR used by the directing clinician to assist in measuring the outcomes of the behavioral health treatment provided?		135.100(c)(3)
F.			Was the CSR used by the directing clinician to revise the recipient's behavioral health treatment plan?		135.100(c)(5)
G.			Was the CSR used to assist in determining a recipient's functioning in the life areas identified on the form?		135.100(c)(2)

#	Yes	No	TREATMENT PLAN REQUIREMENTS	Comment	Regulation
A.			Is there a date that TX plan implementation will begin?	Enter Date:	135.130(a)(7)(B)
B.			Does the TX plan document the recipient's identifying information?		105.230(b); & 135.130(a)(7)(A)
C.			Are the TX goals directly related to the findings of the behavioral health assessment?		135.130(a)(7)(C)
D.			Are the services and interventions that will be employed to address the written goals documented?		135.130(a)(7)(D)
E.			Does the TX plan identify the goals, objectives, services, and interventions selected to address a recipient's behavioral health needs identified by a professional behavioral health assessment under 7 AAC 135.110?		135.990(7)(A)(i)
F.			Do the selected services and interventions detail the frequency and duration?		135.990(7)(A)(ii)
G.			If the recipient is under 18 years of age, did the TX plan document the treatment team members and their ability to participate in the TX planning session?		135.120(a)(5); & 135.120(c)
H.			Is the TX plan remaining current based upon the periodic client status review?		135.120(a)(6)
I.			Are the name, signature, and credentials of the directing clinician present on the TX plan?		135.130(a)(7)(E)
J.			Is the name and signature of the recipient or the recipient's representative present on the TX plan?		135.130(a)(7)(F)

Clinical Record Evaluation Tool

#	Yes	No	MENTAL HEALTH ASSESSMENT REQUIREMENTS	Comment	Regulation
A.			Was the assessment conducted upon admission?	Enter Date:	135.110(b)(3)
B.			Does the assessment document the recipient's mental status, social and medical history?		135.110(b)(3)(A)
C.			Does the assessment document functional impairments? (that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills)		135.110(b)(3)(E); & 135.990(92).
D.			Is there a complete DSM diagnosis consistent with multi-axial classification? (If a diagnosis exists)		135.110(b)(3)(C); 135.130(a)(3)(A); & 105.230(d)(1)
E.			Does the written report document the problems identified during the professional behavioral health assessment and client status review processes, including functional deficits that require mental health treatment?		135.130(a)(3)(B)
F.			Does the assessment document the nature and severity of any identified mental health disorder?		135.110(b)(3)(B)
G.			Are treatment recommendations that include services identified as treatment needs, which form the basis of a subsequent behavioral health treatment plan documented within the assessment?		135.110(b)(3)(D); & 135.130(a)(3)(C) 135.010(a)(3)(A)
H.			Does the assessment document recipient's eligibility for the recommended services?		70.050; & 135.020
I.			If, during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services, did the provider refer the recipient to a provider that provides behavioral health rehabilitation services in the community?		135.020(c)
J.			Was the assessment conducted by a mental health professional clinician?		135.010(b)(1)
K.			Was the assessment updated as new information became available?		135.110(b)(4)

#	Yes	No	SUBSTANCE USE ASSESSMENT REQUIREMENTS	Comment	Regulation
A.			Was the assessment conducted upon admission?	Enter Date:	135.110(c)(3)
B.			Does the assessment document functional impairments? (that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills)		135.110(c)(3)(E); & 135.990(92)
C.			Does the written report document the problems identified during the professional behavioral health assessment and client status review processes?		135.130(a)(4)(B)
D.			Does it document the recipient has a substance use disorder?		135.110(c)(3)(A)
E.			Does it identify the correct diagnosis?		135.110(c)(3)(C); 135.130(a)(4)(A); & 105.230(d)(1)
F.			Does it document the nature and severity of any identified substance use disorder?		135.110(c)(3)(B)
G.			Are treatment recommendations that include services identified as treatment needs, which form the basis of a subsequent behavioral health treatment plan documented within the assessment?		135.110(c)(3)(D); & 135.130(a)(4)(C) 135.010(a)(3)(A)
H.			Does the assessment document recipient's eligibility for the recommended services?		70.050; 135.020
I.			If, during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services, did the provider refer the recipient to a provider that provides behavioral health rehabilitation services in the community?		135.020(c)
J.			Was the assessment conducted by a substance use disorder counselor, social worker, or other qualified program staff member performing duties regularly within the scope of the individuals authority, training and job description; however, if substance use intake assessment is conducted as part of detoxification services subject to 7AAC 70.110 and 7AAC 135.190, the assessment must be conducted by an individual identified in 7AAC 70.110 for the type of detoxification service provided.		135.110(c)(2)
K.			Was the assessment updated as new information became available?		135.110(c)(4)

#	Yes	No	INTEGRATED BH ASSESSMENT REQUIREMENTS	Comment	Regulation
A.			Was the assessment conducted upon admission?	Enter Date:	135.110(b)(3); & 135.110(c)(3)
B.			Does the assessment document the recipient's mental status, social and medical history?		135.110(b)(3)(A)
C.			Does the assessment document functional impairments? (that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills)		135.110(b)(3)(E); 135.110(c)(3)(E); & 135.990(92)
D.			Does the written report document the problems identified during the professional behavioral health assessment and client status review processes, including functional deficits that require mental health treatment?		135.130(a)(3)(B)
E.			Is there a complete DSM diagnosis consistent with multi-axial classification? (If a diagnosis exists) (both mental health & substance use diagnoses if applicable)		135.110(b)(3)(C); 135.130(a)(3)(A); & 105.230(d)(1)
F.			Does the assessment document the nature and severity of any identified mental health disorder and/or substance use disorder?		135.110(b)(3)(B); 135.110(c)(3)(B)
G.			Are treatment recommendations that include services identified as treatment needs, which form the basis of a subsequent behavioral health treatment plan documented within the assessment? (In relation to both mental health and substance use)		135.110(b)(3)(D); 135.130(a)(3)(C); 135.110(c)(3)(D); & 135.130(a)(4)(C) 135.010(a)(3)(A)
H.			Does the assessment document recipient's eligibility for the recommended services?		70.050; & 135.020
I.			If, during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services, did the provider refer the recipient to a provider that provides behavioral health rehabilitation services in the community?		135.020(c)
J.			Was the assessment conducted by a mental health professional clinician?		135.010(b)(1)
K.			Was the assessment updated as new information became available?		135.110(d)(4); & 135.110(c)(4)

#	Yes	No	PSYCHIATRIC ASSESSMENT REQUIRMENTS	Comment	Regulation
A.			Does the assessment include a date that the assessment was conducted?	Enter Date:	135.130(a)(6)(B)
B.			Does the assessment document the recipient's identifying information?		135.130(a)(6)(A)
C.			Does the assessment include a description of the symptoms that need medical care?		135.130(a)(6)(C)(i)
D.			Does the assessment include a description of how the symptoms established the medical necessity for, and clinical appropriateness of, treatment?		135.130(a)(6)(C)(ii)
E.			If medication is prescribed, a description of the symptoms that the medication is intended to target?		135.130(a)(6)(D)
F.			Does the assessment include relevant recipient history?		135.110(e)(3)
G.			Did the assessment include a review of any general medical and psychiatric history or problem(s) the recipient is presenting?		135.110(e)(2)
H.			Was a mental status examination completed?		135.110(e)(4)
I.			During the mental status examination, was the recipient's: thoughts, moods, self-identity, insight, judgment, memory, speech, intellectual functioning, time-and-place orientation, and reasoning or problem-solving ability to assist in establishing a diagnosis and case formulation, assessed?		135.990(18)
J.			Does the assessment document functional impairments? (that substantially interferes with or prevents them from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills)		135.110(e)(6); & 135.990(92)
K.			Does the assessment include a list of psychiatric problems?		135.110(e)(6)
L.			Is a complete diagnosis present and consistent with multi-axial classification used in the DSM?		135.110(e)(5); & 135.130(a)(6)(E)
M.			Are treatment recommendations that include services identified as treatment needs, which form the basis of a subsequent behavioral health treatment plan documented within the assessment?		135.110(e)(6) 135.010(a)(3)(A)
N.			Does the assessment document recipient's eligibility for the recommended services?		70.050; 135.020
O.			If, during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services, did the provider refer the recipient to a provider that provides behavioral health rehabilitation services in the community?		135.020(c)
P.			Was the assessment completed by a licensed physician, licensed physician assistant, or licensed ANP who is enrolled as a dispensing provider and who has prescription authority?		135.010(b)(2)
Q.			Does the assessment include the name, signature, and credentials of the medical professional conducting the assessment?		135.130(a)(6)(F)

#	Yes	No	PROGRESS NOTE REQUIREMENTS	Comment	Regulation
A.			Is the date of service included in the note?	Enter Date:	105.230(d)(6); & 135.130(a)(8)(B)
B.			Does the note identify the service rendered?	Circle: Clinic or Rehab Enter Service Type:	105.230(d)(6)
C.			Is the duration of the service expressed correctly in either units or clock time?	Enter # of units: or Enter Start Time: & Enter Stop Time:	105.230(d)(5); & 135.130(a)(8)(C)
D.			Does the note document a description or listing of the active TX provided? To document active treatment, the provider must set out a description or a listing of the active pre-planned specific interventions that the provider provides to, or on behalf of, the recipient to assist them in achieving the goals documented in the treatment plan.		135.130(a)(8)(A); 135.130(b); & 135.990
E.			Are the treatment goals that the service is targeted for documented?		135.130(a)(8)(D)
F.			Is a description provided for the recipient's progress toward the TX goals?		135.130(a)(8)(E)
G.			Are the name, signature, and credentials of the individual who rendered the service present?		105.230(d)(6); & 135.130(a)(8)(F)

Comments:

ALASKA BEHAVIORAL HEALTH REFORM
1115 WAIVER CONCEPT PAPER

Preface: Martha's Story

Martha[1] is a 30 year old Alaskan. She lives in a remote community on an island in the far western part of Alaska. The nearest healthcare facility is located nearly 300 miles away when traveling by plane, and the nearest acute behavioral health services are located more than 1,000 miles by air.

When Martha was 16 years old, she was diagnosed with a fetal alcohol spectrum disorder (FASD). She experiences chronic consequences of trauma and multiple Adverse Childhood Experiences including her parents' addiction, sexual abuse, neglect, witnessing domestic violence, her parents' separation, and her father's incarceration. Martha was in and out of foster care and the juvenile justice system while growing up. Eventually, she entered the adult corrections system due to several charges of driving under the influence and acts of domestic violence. Martha's two children are currently in child protective services custody.

Martha experiences a chronic polysubstance use disorder, along with serious and recurring depression. She has attempted suicide several times. She has a history of very poor self-care and extensive health issues: obesity, borderline diabetes, chronic migraines, and an overall sense of "not feeling well." Martha receives individual counseling for her behavioral health disorders *via* telemedicine – when the equipment is working – along with occasional in-person treatment with her clinician during periodic field visits. Martha has had three different counselors in the past year due to staff turnover, and that has made it hard for her to make any progress. The only health provider in her community is a Community Health Aide.[2] There are no social services other than the Village Public Safety Officer available to respond to crises.

Martha goes to the primary care clinic frequently with somatic complaints of stomach aches and headaches. She often feels like she is dying and seeks medical attention, requesting pain medication to cope. When she is denied a prescription, she requests referrals to providers only available in Anchorage. (Anchorage is Alaska's largest city and the medical services hub for the state.) On more than one occasion, Martha arrived in Anchorage and met with the specialist, only to have her somatic complaints be unsubstantiated after bloodwork and invasive procedures.

Martha recently disclosed to her new counselor that she has been using opioids for a long time. She shared that she has come close to experimenting with heroin when pills aren't available on demand. She wants to quit, but she is scared of the awful effects of withdrawal. Martha is ready to take action and admit herself to in-patient treatment. Her counselor is having difficulty referring her to a withdrawal management program because there is no treatment locally and long waits at the few options available in Alaska. Even if she was able to find an open withdrawal management bed, it would be critical to also find a place in a residential treatment

[1] Martha is a hypothetical behavioral health consumer whose story is based on the experiences of people throughout Alaska.
[2] The Community Health Aide Program is a network of about 550 Community Health Aides/Practitioners (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center.

facility that could provide treatment appropriate for someone also experiencing mental health disorders and intellectual disabilities. Martha will also need quality aftercare and supportive services to help her maintain her sobriety.

Eventually, Martha gives up waiting. She no longer wants to seek treatment. She is avoiding her counselor and continues to use opioids. Martha remains unemployed. She has been unable to make the progress needed in order to reunite with her children.

Martha's story is all too common in Alaska. This concept paper aims to describe how the State of Alaska will transform its behavioral health system to better serve people like Martha. Alaska's unique geography, diverse population, lack of infrastructure, struggling economy, and limited healthcare resources make it extremely challenging to provide a person-centered and culturally responsive system. However, the 1115 Behavioral Health Waiver Demonstration Project ["Demonstration Project"] will support more effective, cost-efficient, integrated care that ensures access to the right services at the right time in the right setting.

I. Introduction: The Need for Behavioral Health Transformation in Alaska

Alaska is navigating a period of dramatic adversity and opportunity. After years of prosperity from the state's oil wealth, the State of Alaska faces a fiscal crisis precipitated by the decline of oil prices and production. In just two years, the State of Alaska has reduced its budget 22% (with further cuts expected in SFY2018) and cut almost 1,500 state employees (with more proposed for SFY2018). The state economy is in recession, creating greater demand for publicly-funded safety net services like Medicaid. The Department of Health and Social Services (DHSS) budget has been reduced by more than $200 million dollars in state general funds over the past two years, restricting the ability to address increasing needs.

The Behavioral Health Medicaid system does not meet the demands of Alaskans who experience mental health and substance use disorders. For individuals like Martha, with complex co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities, the current system is seriously inadequate. Behavioral health services are difficult to access due to geography, long wait times, lack of workforce, and high costs of service. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities are medically underserved for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center, and individuals like Martha have to travel for services.

Until Medicaid Expansion on September 1, 2015, Alaskans had to be categorically eligible (usually due to federal-determined disability status or having dependent children) to qualify for Medicaid, leaving out many adult Alaskans experiencing significant behavioral health disorders. As of November 30, 2016, 25,695 Alaskans have enrolled in Medicaid as a result of Expansion. Of Medicaid claims paid for Expansion enrollees, $17.92 million (6.2% of all Expansion population claims) were for behavioral health treatment services.

Alaska has significant challenges with recruitment and retention of a qualified behavioral health workforce due to high turnover in the field. Recruitment/retention of professionals and direct service providers in the more rural parts of the state is particularly difficult, as seen in how often Martha has had to start over with a new counselor due to turn over. Psychiatry and other behavioral health specialties pose unique recruitment and retention problems. This, compounded with low numbers entering the behavioral health field, results in a trajectory of continued workforce shortages. Alaska's workforce is predicted to become even more essential given enrollment growth through Expansion. The workforce will need retraining to become proficient in a changing behavioral health environment.

Technology is both an asset and a source of stress for Alaska's behavioral health system. Tribal health organizations in Alaska have pioneered telemedicine and tele-behavioral health services. The Alaska Medicaid program currently pays for services through telemedicine if the service is covered under traditional, non-telemedicine methods and is provided by an eligible provider. Unfortunately, broadband capacity is limited in rural Alaska. Electronic health record (EHR) systems vary across the state and do not always communicate well with one another. Not all health care providers use the health information exchange (HIE), which the State of Alaska is actively working to expand. Complicating matters further, state-funded behavioral health providers report data *via* a separate system which does not communicate with Alaska's Medicaid Management Information System (MMIS).

Costs for the Behavioral Health Medicaid program have grown since 2005, but at a slower rate than other Medicaid programs in Alaska. Until Expansion, Behavioral Health Medicaid primarily covered mental health services. Costs rose 43% between 2005 and 2011. Cost containment and quality improvement efforts since 2011 helped reduce that growth, so that the 2015 Behavioral Health Medicaid spend was only 23% more than that in 2005. Despite these efforts, many Alaskans with behavioral health disorders utilize more costly hospital-based services, with 18% of individuals with five or more hospitalizations between 2012 and 2015 having a behavioral health diagnosis – the most common disease category across all admissions.[3] It is important to note that the system's lack of capacity to meet the growing demand for services has been a *de facto* utilization control contributing to lower growth. Efforts to manage utilization and control cost, while effective, have been hindered by a lack of integration and coordination in the behavioral health system and among other systems serving individuals experiencing behavioral health disorders.

In 2016, the Alaska Legislature passed two monumental reform mandates. Senate Bill 74 (SB 74) is a multi-dimensional Medicaid reform package that includes direction to apply for an 1115 Waiver under 42 USC 1315(a). The State of Alaska is directed to efficiently manage a comprehensive and integrated behavioral health system that partners with diverse providers and disciplines to provide evidence and data-driven practices, with the goal of achieving positive outcomes for children, youth, and adults experiencing behavioral health disorders. SB 74 includes direction to reduce operational barriers, minimize administrative burden, and improve the behavioral health system's effectiveness and efficiency.

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[3] The Menges Group. *Assessment of Medicaid Reform Options.* Report for Alaska Legislative Budget and Audit Committee. March 24, 2016.

The second large reform mandate, Senate Bill 91 (SB 91), is a comprehensive criminal justice reform effort based on a number of strategies, including reducing sentencing lengths for non-violent offenders and reinvesting savings into programs that increase the likelihood of success outside of the correctional system. Of particular concern is how the mandates in SB 91 will change the demand for behavioral health services. An expanded need for mental health and substance use disorder treatment, as well as additional community-based recovery supports, will add pressure to an already limited behavioral health system.

All of these activities require action now to transform our Medicaid-supported behavioral health system of care. Alaska has worked diligently over the past year to prepare for this challenge and, with the assistance of a Demonstration Project, the State will develop a data-driven, integrated system of care that focuses on quality, outcomes, and costs. The following represent efforts to lay the foundation for change in Alaska's behavioral health system:

- In 2015-2016, the Division of Behavioral Health (DBH) contracted for two readiness assessments – one for DBH staff and one for 29 community behavioral health providers – for the purpose of identifying capacities and infrastructures necessary to succeed in a transformed system of care. Both assessments have been completed and DBH is initiating training and technical assistance to prepare Alaska for the impending transformation.
- The Alaska Medicaid Coordinated Care Initiative (discussed in Goal #2 below) and the Medicaid Pharmacy and Therapeutics Committee (responsible for the preferred drug list and drug utilization review process) are established programs that will provide experience and guidance for the utilization control efforts planned for the demonstration project.
- Extensive training and technical assistance to embed trauma-informed practices in community behavioral health, corrections, domestic violence, and juvenile justice settings will support efforts to integrate systems and improve the quality of services.
- Years-long research and planning supported the statewide Early Childhood Comprehensive Systems (ECCS) Plan currently serving Kodiak, Nome and surrounding villages, and the Matanuska-Susitna Borough. This plan and lessons learned from implementation will support the effort to enhance early intervention services.
- The 2016 Tribal/State comprehensive strategic plan to transform child welfare outcomes for Alaska Native and American Indian children, including the provision of culturally specific services and supports to children in state custody, provides context for aligning behavioral health reform efforts.
- The Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Behavioral Health Association gathered stakeholders in 2014 to conduct an in-depth review of reporting and administrative requirements on community behavioral health providers. Eleven concrete recommendations were made to alleviate some of the administrative burden on providers; of these, DBH has implemented three and made significant progress on four others.

II. Vision for Alaska's 1115 Behavioral Health Waiver Demonstration Project

Vision: Alaskans will have a transformed Behavioral Health Medicaid system that provides effective, cost-efficient, and high-quality integrated care and ensures access to the right services at the right time in the right setting.

Alaska envisions a system that is integrated and coordinated to help people like Martha earlier, and more easily, so that they are able to achieve a higher level of functioning and better quality of life. Parents like Martha's (and like Martha became) will have access to the primary and behavioral health care services they need to support their children's healthy development. Children like Martha will have access to early childhood screening and referrals to early childhood mental health services – especially for childhood trauma – as well as services through adolescence so that acute emotional disturbances and mental illnesses can be avoided. Children, youth, and adults who have complex needs like Martha's will be able to access specialty services, directly and through telemedicine. Adults who need substance use disorder treatment will be able to get in when they have that readiness for treatment – they won't have to wait, and risk eventually giving up, like Martha. All services will be culturally appropriate and provided in a way that honors clients' cultures.

Alaska has established five goals for this Demonstration Project to achieve the vision of a transformed behavioral health system of care (presented in Section V):

1. Expansion of treatment capacity and improved access to services;
2. Integration of care;
3. Cost and outcomes reform;
4. Provider payment and accountability reform; and
5. Delivery system reform.

These goals, and the articulation of the vision for the Demonstration Project, are aligned with Alaska's broader redesigned Medicaid system, as the demonstration project is part of a larger effort to improve the efficiency and effectiveness of the entire Medicaid system. Together with other redesign efforts, the Demonstration Project will ensure Medicaid recipients have access to the appropriate levels of care, coordinated across sectors to improve health and contain costs. (See Appendix A for an overview of the comprehensive Medicaid Redesign effort.)

III. Target Populations for the 1115 Behavioral Health Waiver

The exact target population(s) to be proposed are pending full analysis of claims data and other ongoing Medicaid initiatives. (There are sixteen Medicaid redesign initiatives from SB 74, and the Demonstration Project target populations must take these initiatives into consideration to align with these comprehensive Medicaid Redesign and Reform efforts.) Discussions of the target populations for the Demonstration Project have included both broad and narrow service populations.

It is essential to include high needs populations. These include individuals who experience serious mental illness and/or chronic substance use disorders who also have had more than three hospitalizations per year, or who are involved with the justice, homelessness, and child protection systems. Alaska's population level data supports the need to also include Medicaid recipients experiencing mild-to-moderate behavioral health needs, to avoid the costs and consequences of chronic and acute disorders later:

- 66% of Alaskan adults report one or more adverse childhood experiences growing up;
- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or more adults abusing alcohol and/or other drugs;
- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experience growing up;[4]
- Alaska children are twice as likely to be in foster care, compared with children nationwide;[5]
- 11% of Alaskan adults experience a diagnosable substance use disorder each year;
- 20% of Alaskan adults experience a diagnosable mental health disorder each year;[6]
- Alaska's suicide rate of 27.1/100,000 (2015) is more than twice the national rate (12.32 per 100,000);[7]
- 22% of the Alaska Corrections population in SFY2012 experienced a mental health disorder; and
- 19% of the Alaska Corrections population in SFY2012 experienced a chronic substance use disorder.[8]

The current Behavioral Health Medicaid service population includes children and youth experiencing severe emotional disturbance, adults experiencing serious mental illness, and youth and adults experiencing acute and chronic substance use disorders (7 AAC 135.020). In SFY2016, the Behavioral Health Medicaid system served 42,123 individuals in SFY2016.[9] Of these, 9,799 (23%) were children or youth under age 18; 1,997 (5%) were youth age 18-20; and 30,327 (72%) were adults over 21. Of adults, 2,477 were over age 65.

Of the 42,123 Medicaid recipients served in SFY2016, 28,937 received mental health disorder treatment and 19,282 received substance use disorder treatment. Of these, 6,075 (14%) received treatment for co-occurring behavioral health disorders. In all three categories, adults made up the

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[4] Adverse Childhood Experience data is a three year average of 2013-2015 Alaska Behavioral Risk Factor Surveillance System responses, reported by the Alaska Division of Public Health.

[5] The Alaska Office of Children's Services reports that, between 2006 and 2013, almost 1% of Alaskan children were in foster care, compared with approximately 0.5% of children nationally.

[6] Prevalence data is derived from a special report run for the State of Alaska by SAMHSA's Center for Behavioral Health Statistics and Quality using 2009-2011 National Survey on Drug Use and Health data.

[7] Bureau of Vital Statistics, Alaska Division of Behavioral Health (provided September 2, 2016).

[8] Corrections population data is reported in *Trust Beneficiaries in Alaska's Department of Corrections,* Hornby Zellar Associates, Inc. for the Alaska Department of Corrections, May 2014.

[9] Medicaid claims information is based on analysis of data downloaded and analyzed September 2-4, 2016. The number may change, as Medicaid providers have one year to file a timely claim for payment

majority of the client population. Children and youth were more likely to receive mental health disorder treatment (comprising 32% of that client population).

IV. Alaska's Current Behavioral Health System of Care

The State of Alaska does not provide a continuum of behavioral health care – it provides a spectrum of services which expands and contracts based on time, geography, and funding. Medicaid supports behavioral health services delivered in community behavioral health centers, federally qualified health centers, tribal health organizations, hospitals, specialty clinics, and primary care practices. The predominant providers in Alaska's behavioral health Medicaid system are community behavioral health centers, hospitals, and specialty clinics.

Alaska defines Behavioral Health Medicaid services as medically necessary and clinically appropriate active treatment services delivered by eligible providers (acting within their scope of practice) to eligible recipients (7 AAC 135.010(a)). Behavioral health clinic services include: behavioral health assessments, psychotherapy, short-term crisis intervention, and pharmacologic management (7 AAC 135.010(b)). Most substance use disorder treatment services are considered "rehabilitation services" rather than clinical services. Behavioral health rehabilitation services include: behavioral health screening, substance use intake assessment, case management, withdrawal management (detoxification), comprehensive community supports for adults, therapeutic behavioral health services for children, recipient support services, medication administrations, developing and reviewing treatment plans, conducting a medical evaluation, methadone/antabuse, peer support, day treatment for children, residential substance use disorder treatment, daily behavioral rehabilitation, short-term crisis intervention, and facilitating telemedicine encounters (7 AAC 135.010(c)).

The Behavioral Health Medicaid system serves the most acutely disabled children, youth, and adults. Community behavioral health services include clinic and rehabilitative services, as well as peer support. Some community behavioral health providers also offer residential treatment for youth and/or supportive housing for adults. Acute inpatient mental health services (primarily involuntary at admission) are limited to:

- Alaska Psychiatric Institute in Anchorage (80 beds);
- two mental health Designated Evaluation and Treatment/Stabilization units under contract with DHSS in community hospitals in Fairbanks (20 beds) and Juneau (12 beds);
- one for-profit inpatient adolescent hospital in Anchorage; and
- two acute adult (12 beds) and adolescent (15 beds) units in Anchorage's largest medical center.

Alaska also has one hospital-based residential psychiatric treatment center in Anchorage, leaving the rest of the state without this service. Primary care providers are an important *de facto* part of the overall service system.

Outpatient substance use disorder treatment is available through community behavioral health providers statewide. Residential treatment is available in less than ten communities statewide.

Limited withdrawal management (detoxification) services are available in Juneau, Fairbanks, and Anchorage. In some communities, emergency departments can serve patients needing medically monitored withdrawal management, if required. Medication Assisted Treatment (MAT) is available in some communities. MAT is provided by Office Based Opioid Treatment (OBOT) providers, tribal health organizations, and federally qualified health centers. There are three methadone providers in Fairbanks, Anchorage, and Wasilla. Clearly there are many gaps in our statewide continuum of services.

Tribal health organizations are a critical part of Alaska's health care delivery system. Alaska is home to 229 of the 566 federally recognized tribes in the United States. The tribal health system of thirteen tribally owned and operated health organizations serves more than 158,000 Alaska Native and American Indian people across the state. Tribal behavioral health providers serve approximately 27,000 Alaska Native and American Indian clients, as well as non-native clients in rural Alaska. Tribal health organizations serve about 6% of all Behavioral Health Medicaid recipients.

Medicaid is the primary source of funding for acute mental health services in Alaska. Peer support, certain recovery supports, and services for adults not enrolled in Medicaid have relied on state general funds. Until Medicaid Expansion in September, 2015, state general funds and the SAMHSA Substance Abuse Prevention and Treatment Block Grant were the primary (almost exclusive) sources of funding for adult substance use disorder treatment and recovery services.

In SFY2016, a total of 42,123 Medicaid recipients received behavioral health services totaling $311,630,030 in Medicaid claims payments across all health care settings.[10] Of total payments, services for children/youth under age 21 accounted for 51%, and services for adults age 21 years and older accounted for 49%. Services for adults 65 and older comprised 2.4% of the total adult payments.

Of Medicaid claims payments for behavioral health services provided in SFY2016, community behavioral health centers received 41% ($128,740,347), providing services to 12,464 Medicaid recipients. Non-tribal inpatient hospitals received 12% ($38,055,993), providing services to 2,726 Medicaid recipients. Non-tribal outpatient hospitals received 9.5% ($29,859,543), providing services to 14,283 Medicaid recipients. Primary care providers (physicians, nurse practitioners, physician assistants who may or may not be affiliated with community behavioral health centers or hospitals) received 9.5% ($29,623,732), serving 23,422 Medicaid recipients.

Residential psychiatric treatment centers and other residential treatment settings for children and youth received 10.5% ($32,624,063) for services to 772 Medicaid recipients. Tribal clinics and rural health clinics received 3% and 1%, respectively, of all behavioral health payments. Tribal

[10] Medicaid claims information is based on analysis of data downloaded and analyzed September 2-4, 2016. The data includes behavioral health claims with a service date in SFY2016 where the payment date was in SFY2016 or by the date that the claims data were downloaded. This number is unduplicated across all provider types and service settings. Individuals may have received services in multiple settings—for example, one Medicaid recipient may have received outpatient behavioral health treatment, primary care medication management, and had an inpatient hospitalization in the same year.

outpatient hospitals received 2.3% of all payments, serving 6,106 Medicaid recipients, and tribal inpatient hospitals received 2.4% of all payments for 792 Medicaid recipients.

API received 1% of the total claims payments for behavioral health services in SFY2016, for services to 240 Medicaid recipients. Psychologists received 1% of all payments. Physician (psychiatrist) mental health clinics received less than 1% of all payments for services to 1,663 Medicaid recipients. Payments for school-based services, community health aides, and licensed clinical social workers were *de minimus*.
Based on data from the National Survey on Drug Use and Health,[11] approximately 25% of all Alaskans (145,000) have a diagnosable behavioral health condition. The Behavioral Health Medicaid system described above served at least 42,000 unique individuals (adults and youth) in SFY2016. This suggests that over 100,000 Alaskans did not seek treatment or were served by grant programs, corrections centers, private/for-profit or faith-based behavioral health providers, primary care practices, 12-step or other self-help programs, or other services.

The current system lacks integration and coordination not only with different provider types but also across state service systems. Primary care, child protection, juvenile justice, corrections, public assistance, housing and homelessness, and public safety systems all interact with behavioral health consumers in different ways – yet the services provided are often delivered in silos. This fragmentation makes it difficult to manage and coordinate the system, and nearly impossible for consumers and families to navigate.

The wait for treatment services is generally long for all but the highest priority populations. Someone like Martha can spend months waiting for access to treatment, especially higher intensity substance use disorder treatment. Referrals from courts, primary care, schools, police, and clergy are bottlenecked in a behavioral health service system that is overworked. Criminal justice reform efforts will soon increase that bottleneck, by expanding referrals as behavioral health clients are released and/or diverted from the corrections system to treatment.

While state and federally funded clinical and rehabilitation services are the core of behavioral health in Alaska, the system branches out to include a far more diverse and equally essential system of private providers. This system incorporates a significant number of private physicians, psychiatrists, psychologists, other licensed clinical professionals, and private substance abuse professionals offering rehabilitation services. People who are unable to endure the long wait at community behavioral health providers often seek help from private providers. These agencies collect fees from third-party health plans or directly out-of-pocket from clients. DBH provides significantly less support and oversight to these providers. Data from these providers is not accurately counted or included in most state reports. Estimates from tracked Alaska court referrals, the only current data available, suggest that upwards of 50-75% of outpatient substance abuse treatment services are provided by private provider types. It is unknown what portion of mental health services they provide.

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[11] Prevalence data is derived from a special report run for the State of Alaska by SAMHSA's Center for Behavioral Health Statistics and Quality using 2009-2011 National Survey on Drug Use and Health data.

The behavioral health system also includes limited prevention, screening, and brief intervention and education services. State funded community prevention services are managed separately from the treatment system, presenting yet another opportunity for service integration and continuum of care expansion. Prevention grantees enhance Strategic Planning Framework community coalition efforts to address issues such as fetal alcohol spectrum disorders, suicide, underage drinking, opioid addiction, and other substance abuse related issues. DBH also manages the Alcohol Safety Action Program (ASAP), a statewide network of screening, monitoring and technical assistance providers supporting misdemeanants referred by the courts for substance abuse screening, education, and referral to assessment and treatment. ASAP also oversees a statewide network of therapeutic courts that support more intensive case management for both special populations and for those that have failed to succeed in meeting their court ordered requirements.

In sum, Alaska's needs are great, the geography and cultural issues are unique, the spectrum of behavioral health services has large gaps, and resources are dwindling. The Demonstration Project, along with the larger Medicaid Redesign, will change the current system of care to identify those at risk, intervene earlier in a variety of service settings, move a crisis-focused system to a recovery-focused system, and develop the necessary infrastructures to manage the system of care based on quality, outcomes, and costs.

V. Behavioral Health Reform – A Transformed Behavioral Health System of Care

The transformed Behavioral Health Medicaid system will evolve over the course of the Demonstration Project to offer Martha and every other recipient effective, cost-efficient, high-quality integrated care. Services will be available when people seek care, wherever and whenever that care will be most effective. This will ultimately reduce the need for and costs of acute care services due to untreated or ineffectively treated mental health and substance use disorders.

Alaska is committed to providing individualized, person-centered services that promote recovery, recognizing that physical, mental, emotional, social, spiritual, and cultural elements are all integral to overall health. Alaska is committed to providing trauma informed care that addresses the needs of victims of violence, as well as the unique needs of peoples who have experienced historical trauma. Recovery is possible for everyone – though how that recovery is defined and achieved is as unique as the individuals being served. The redesigned system of care will honor the dignity and worth of every individual and is committed to informed and shared-decision making *with* patients (as opposed to making decisions *for* them). Every goal and strategy described in this section is based on these commitments and beliefs. The goals are part of a greater whole; none is isolated from the others. Recognizing the interdependence of these goals is important – an improvement in one goal can affect the others.

The foundation of Alaska's transformed system will be the partnership with the Administrative Services Organization (ASO). The completed readiness assessments indicate that Alaska does not currently possess the capacities necessary to manage the system of care envisioned. An ASO will provide the specialized expertise to manage a comprehensive behavioral health system. The ASO will have explicit contractual responsibilities for each Demonstration Project goal. As

described in Goal #5, the ASO will provide services such as utilization management, claims processing, network management and provider recruitment, quality and data management, cost management, and other functions.

Goal #1: Expand Treatment Capacity and Improve Access to Services

The transformed behavioral health system will provide improved access to care for:

1. prevention and early intervention services to individuals at-risk of developing behavioral health disorders;
2. mild to moderate behavioral health disorders;
3. serious mental illness and chronic substance use disorders;
4. complex co-occurring mental health and substance use disorders;
5. complex dual diagnoses of intellectual/developmental disabilities and behavioral health disorders; and
6. chronic co-morbid conditions (diabetes, hypertension, Hepatitis C, physical disabilities, etc.) along with behavioral health disorders.

Strategies for improving the system's capacity to provide services for these individuals include:

1. integration of behavioral health and primary health care (*see Goal #2*);
2. increased screening, assessment, and early intervention services;
3. increased provider types and service settings;
4. access to community-based crisis intervention and stabilization services;
5. increased access to peer support services for youth, families, and adults;
6. expanded access to medication assisted treatment and withdrawal symptom management (detoxification) services, particularly ambulatory detoxification services;
7. expanded access to intensive outpatient treatment and partial hospitalization services (sub-acute and step-up and step-down treatment);
8. expanded use of Assertive Community Treatment in communities with high utilizers of emergency department and inpatient hospital services;
9. culturally appropriate wrap-around behavioral health treatment and rehabilitative services where the client is (*in vivo*) as well as clinic settings;
10. increased coordination of services with tribal health providers (*see Goal #2*); and
11. increased use of telemedicine and use of digital and mobile technologies in delivery of services.

Critical to transforming Alaska's crisis-driven behavioral health system is to expand capacity to provide services before chronic and acute conditions develop. Uniform evidence-based screening, assessment, and early intervention services offered in diverse health care settings will help identify at-risk individuals and those with early stages of behavioral health disorders, and allow for early intervention and referral to treatment when appropriate — addressing an important gap in our current system. These are services that can be effectively provided in community-based settings, both rural and urban, reducing use of more costly acute care. Requiring use of common evidence-based screening and referral tools will make accessing treatment and coordination of care easier. Increasing utilization of Screening, Brief Intervention,

Referral to Treatment (SBIRT) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, especially through adolescence, is also essential.

Just as important as identifying and addressing behavioral health disorders before they become acute conditions will be providing crisis intervention and stabilization services to avoid self-harm or harm to others, hospitalization, or incarceration. Mobile crisis intervention will augment facility-based and telephonic crisis intervention and stabilization services where the need is greatest. Availability of more community-based crisis respite services will improve outcomes, allow individuals to remain in their communities for stabilization, and reduce costs. Peer support specialists will be an integral component to these services. These services will reduce the incidence of psychiatric boarding in emergency departments, jails, and other inappropriate settings, especially in smaller communities and outlying villages where safe alternatives are not available. By intervening to de-escalate crises and connect individuals to community-based treatment and supports, individual outcomes will be improved and costs will be controlled.

The State of Alaska is currently expanding access to MAT with support from federal grants in order to address an important gap in the substance use disorder treatment system. Tribal health organizations are also implementing or expanding existing MAT programs, often in integrated settings. Withdrawal symptom management (detoxification) has received heightened scrutiny from Alaskans, in the context of the opioid epidemic afflicting our communities (and the entire nation). Extremely limited access to facility-based withdrawal symptom management for opioids has fueled discussion of widening access to ambulatory detoxification as well as traditional facility-based withdrawal symptom management. While there is a role for both to address the diversity of individuals' readiness levels and clinical needs, DBH will prioritize ambulatory detoxification services where appropriate.

Expanding access to partial hospitalization and intensive outpatient treatment complements crisis intervention and stabilization improvements. Short-term step-up and step-down services will help individuals transition between levels of care and between treatment and the community. These services will be provided in a supportive and gradual way to reduce the likelihood of relapse, mitigate the impact of relapse, and improve recovery outcomes. Greater partial hospitalization and intensive outpatient treatment options also complement the planned expansion of withdrawal symptom management services by supporting access to MAT along with psycho-social treatment and rehabilitative services and provides more appropriate step-up services when outpatient services alone are not working. Rural residents should have wider and timelier access to the full continuum of behavioral health care.

Assertive Community Treatment (ACT) is currently being provided in Anchorage in conjunction with a peer support services organization. Recognizing that outreach and relationship building are fundamental to helping homeless and at-risk individuals experiencing serious mental illness and chronic substance use disorders successfully access and benefit from treatment, ACT will be expanded in three important ways:

- As an adjunct to crisis stabilization services designed to reduce the high use of emergency departments and inpatient care;
- In communities with significant homeless populations; and

- By developing forensic ACT models for mentally ill individuals involved in so-called "nuisance crimes."

ACT can also serve as a bridge for those leaving the corrections system, reducing costs to the corrections and public safety net systems and reducing recidivism. For these reasons, ACT is envisioned to be an important part of ensuring positive health outcomes for the potential target populations.

To truly transform Alaska's behavioral health system, there will need to be culturally appropriate wrap-around treatment and rehabilitative services, as well as recovery supports, in communities statewide. No Alaskan should have to move away from his or her home and family to receive the services needed to live safely and productively. No child should be denied a meaningful opportunity to learn and explore at school due to a mental or emotional disability. Providing evidence- and research-informed treatment and rehabilitative services at school, at home, at work, and in the community will result in better outcomes and more stable recovery for individuals. Expanding these services outside of Alaska's urban centers is critical.

Alaska's geography, weather, workforce limitations, and resources will not allow the continuum of services envisioned to be in every community. These limitations will not impede the ability to provide **access** to those services in every community. Alaska's tribal health system has designed and developed telehealth solutions to provide general and specialty health care services in rural Alaska. Tribal and community behavioral health providers have increased use and expertise of telepsychiatry over the past 15 years. The Demonstration Project will build on these successes to expand access to psychiatry and other treatment services. It will also provide capacity for remote monitoring and support for individuals with severe needs and in isolated villages through use of digital and mobile technologies. Building bridges with state licensing agencies and boards will ensure that important professional roles and responsibilities related to telemedicine are addressed and improve access to care, rather than limit it.

Goal #2: Integration of Care

Just as a person's health is the result of the effective operation of interdependent systems, the health care system must operate in the same way. The Demonstration Project will build upon existing efforts to integrate mental health and substance use disorder treatment systems, as well as efforts to integrate behavioral health and primary care systems. Learning from the integration processes undertaken by tribal health organizations and rural health care centers can further the goal of a health care system that provides whole person as well as person-centered care. Supporting the integration of care will be an explicit contractual requirement of the ASO.

The Demonstration Project will include multidimensional integration within and across health care settings and across social service systems (education, child protection, public safety, corrections, homelessness, juvenile justice, tribal, etc.). This will build upon and expand the array of integration models in Alaska, such as health homes, patient centered medical homes, and others. It will also strengthen connections between behavioral health providers and the senior and disability service systems to foster integration of care for complex, medically fragile, and dually diagnosed individuals.

The Demonstration Project will focus on providing services earlier and more consistently to individuals like Martha who experience complex co-occurring and/or co-morbid conditions that contribute to overutilization of emergency departments and acute inpatient services, as well as interactions with legal systems. This will expand upon the benefits already realized by patients and the State through the Alaska Medicaid Coordinated Care Initiative.[12]

The Demonstration Project will help coordinate tribal and non-tribal health care delivery systems. Updated federal policy regarding circumstances in which 100% federal funding is available for services "received through" facilities of the Indian Health Service, including tribal health organizations, is already improving coordination between tribal and non-tribal health care providers. Alaska will continue to work together with tribal and non-tribal Medicaid providers to avoid duplication of services. Outcomes will be improved through the use of culturally appropriate and informed care and community-based care that can include family, extended kinship systems, and Elders.

Achieving effective integration will require reforming and strengthening infrastructure to improve coordination of care. Alaska's partnership with the ASO will allow the State to move quickly to mandate uniform evidence-based screening and assessment tools, which will be used in all settings. Conducting root cause analyses to determine why certain individuals are frequently admitted to emergency and/or inpatient services and then identifying and addressing those causes will help reduce the frequency of acute care episodes. Identified services, social supports, and rehabilitation options can then be provided in the right setting, rather than expensive emergency and acute care settings. Enhancing EHR capabilities (specifically including integrated clinical records and use of the HIE) between health care providers will support better outcomes for patients through efficient coordination and effective clinical practice. It will also support the goals of reduced administrative burden for providers and reduced costs to the State of Alaska.

An essential component of integration is ensuring that all health care services are trauma-informed. The Demonstration Project will build upon the extensive trauma-informed training investments in the Alaska behavioral health system to extend that professional capacity in pediatric practices, general family practices (including advance-practice clinical practices), certain specialty practices that focus on high frequency co-morbid conditions, and others. The Demonstration Project will also support continuing education and training in team-based health care practice.

[12] The Alaska Medicaid Coordinated Care Initiative (AMCCI) began in 2014 to reduce the costs of overutilization of emergency department services by Medicaid recipients. A voluntary program offering individualized case management, care coordination and referral to specialty health care (including but not limited to behavioral health treatment) and social services, the AMCCI serves approximately 5,500 Medicaid recipients. In SFY 2016, AMCCI saved $2.5 million by reducing emergency department use by 25% and reducing costs by 20%. AMCCI is being expanded to more than 80,000 Medicaid recipients (many of whom experience primary or secondary behavioral health diagnoses) in SFY 2017.

Goal #3: Cost and Outcomes Reform

The transformed behavioral health system will reduce overall Medicaid expenditures by reducing costs due to over-utilization of high intensity services. This will be achieved by reducing the need for expensive acute and emergency services by providing increased access to more cost-effective treatment, crisis intervention and stabilization, and sub-acute services before the individual is in crisis. The ASO's care management infrastructure will ensure cost-effectiveness and accountability across all levels of care. Health outcomes will be improved through earlier interventions and better coordination of care and the system will, by the end of the Demonstration Project, be managed on the basis of outcomes.

The transformed system of care must be managed through data-driven decision making. While the MMIS provides service utilization and cost by provider, service recipient, and population, it does not provide outcomes data by provider, service recipient, and population. State-funded providers report data *via* a separate system that generates limited outcomes data, but not systematic reports by provider/service recipient or population. Therefore, we cannot analyze statewide utilization/cost/outcomes patterns. The two data systems do not communicate with each other. They do not have the capacity to track long-term client outcomes, relapse and recidivism, or recovery after discharge.

The current data systems do not provide the accountability envisioned for the transformed system of care. Data, outcomes, and cost management capacities need to be improved. This is another important reason to contract with an ASO with established data systems that report service utilization, costs, and outcomes. Data, cost, and outcomes management, like service integration and access management, will be contract requirements of the ASO.

Evidence- and research-informed practices, which support the outcomes management function, will also be an ASO priority. Despite a long-standing commitment to the use of evidence-based practices, the provider readiness assessment indicated that not all behavioral health providers rely on them. The Demonstration Project will identify the best ways to deliver and reimburse evidence-based practices system-wide. DBH will work with the ASO to improve patients' outcomes by defining and supporting evidence- and research-informed practices *that produce successful outcomes*, so that individuals receive the highest quality and most effective services relevant to their diagnosis, culture, and life situation.

Goal #4: Provider Payment and Accountability Reform

The Demonstration Project will build upon streamlining efforts initiated by the Alaska Behavioral Health Association and state behavioral health planning councils in 2014. Easing the administrative burden imposed on Alaska's Medicaid behavioral health and primary care providers is essential to successful reform. Screening, assessment, and documentation will be standardized to reduce duplication of effort and facilitate coordination of care across all providers.

Simultaneously, Alaska will reform its provider payment systems by moving from a fee-for-service method to a value-based method by the end of the Demonstration Project. This will

eliminate duplicate data entry which currently places significant staffing burdens on providers. Providing training and technical assistance to improve financial management infrastructures in order to succeed in a value-based payment environment is critical, as indicated in the provider readiness assessment results. Understanding the current infrastructure capacity as well as the infrastructure needs will help the Demonstration Project to align training and support services for providers. The provider readiness assessments indicate that few providers have experience with performance and value-based payment methods. Specialized training will be offered to providers in the Spring of 2017. Support from the ASO over the course of the Demonstration Project will develop provider infrastructures in this area.

Alaska's current fee-for-service Medicaid payment system incentivizes volume over value, which continues to result in long waits and unmet need. This payment system lacks the tools and incentives that drive improved health outcomes, effective discharge planning, and overall efficiency. By the end of the Demonstration Project, our transformed behavioral health system will pay for value, not volume. Tribal behavioral health providers already receive an encounter rate, providing insight to the State of Alaska and community behavioral health providers as we move from fee-for-service reimbursement to standardized and transparent performance-based payment. Alaska is considering Delivery System Reform Incentive Payments (DSRIP) to implement some delivery system and payment reforms, such as the expansion of primary care services or implementation of telehealth. DSRIP could also incentivize reductions in avoidable hospital use. Various health care delivery models can be used to help providers work together to coordinate care, achieve quality measures, and receive performance bonuses for improved patient outcomes. The gradual evolution of the transformed payment models will build upon behavioral health rate adjustment and rebasement efforts currently underway. Important criteria for selection of the ASO will be the ASO's experience with performance-based payment methods.

Goal #5: Delivery System Reform

Delivery system reform will be based in a contractual partnership with an ASO to manage the transformed behavioral health system of care. The Demonstration Project goals and strategies are aligned with stakeholder expectations and the overall Medicaid system redesign mandated by the Alaska Legislature. Careful consideration has been given to a variety of options over the past year, including onsite visits to two states with ASOs to learn how they operate and are managed.

The ASO, performing according to specified standards and contractual requirements, will provide the staffing and expertise to implement and manage the reforms described herein. The readiness assessments of DBH and 29 behavioral health providers makes clear that the division and many behavioral health providers simply do not have the infrastructure necessary to succeed in the transformed system of care envisioned. The ASO will have a clear focus on infrastructure development during the Demonstration Project.

DHSS will contract with an ASO with experience supporting similar state transformations, with specific experience managing a Medicaid-funded behavioral health system based in strong community based services. The ASO will assure access to behavioral health screening and interventions, treatment and recovery supports. It will also have expertise in care management

for individuals with serious mental illness and chronic substance use disorders. The ASO will support integration efforts through coordination of care and network development, while also ensuring continued access to appropriate specialty behavioral health care. While it has not been decided which functions Alaska wants the ASO to provide, it is being considered that the ASO will provide utilization management, network management, quality management, data management – including outcomes and performance management, claims processing, cost management, and coverage services to manage the State's behavioral health system of care.

VI. Demonstration Financing and Budget Neutrality

The State of Alaska has invested time, energy, and money to lay the groundwork for the Demonstration Project. In SFY2017, the Alaska Mental Health Trust Authority contributed $10 million to Medicaid Redesign efforts. This funding has allowed DBH to hire contractors, funded site visits to two states with ASOs, and supported technical assistance and training (beginning in the Spring of 2017) for DBH staff and providers. Additional site-visits to two states with ASOs are being planned for April 2017.

Also in SFY2017, the Alaska Legislature appropriated $6 million to be invested over three years in acute substance use disorder treatment services (withdrawal management, residential treatment, and/or sobering centers). The Legislature has invested in additional child protection services workers over the past three years, and appropriated an additional $1.7 million to the base budget in SFY2017 for family preservation and child welfare services.

The State can bend the cost curve, achieve sustainability, and achieve budget neutrality by reinvesting savings and cost offsets from the Demonstration Project. The ASO will help to create savings by reducing duplication of services, better coordinating care, and helping to avoid relapse and readmissions to Alaska Psychiatric Institute and other inpatient treatment settings. Savings are also expected to come from enhanced preventative care and early intervention services, to further reduce hospitalizations and unnecessary emergency department visits, arrests and incarcerations, and child protection interventions.

The State of Alaska also plans to request the full allotment of Disproportionate Share Hospital payments (something historically not received). These funds will be used as an additional incentive for hospitals to work with behavioral health providers to implement care management strategies to decrease emergency department and inpatient hospital utilization. As discussed in Goal #4, Alaska is considering DSRIP to implement some of the identified reform efforts. Alaska is also exploring the use of safety net care pools, designated state health programs, cost sharing, etc. as a way to reduce costs.

VII. Potential Authorities to be Waived

At this point in time, Alaska will consider requesting the following Medicaid Act provisions be waived:

- Freedom of Choice, 42 U.S.C. § 1396a(a)(23) – to allow the ASO to assign particular people to particular providers, and to allow those providers to be those people's primary care providers or patient-centered health homes.
- Comparability and Amount, Duration, and Scope, 42 U.S.C. §§ 1396a(a)(10)(B) and (10)(C), 42 C.F.R. §§ 440.230 and 440.240 – to allow particular behavioral health services to be provided to the target population without requiring that the same level of services be provided to people who are not part of the target population.
- Services with Reasonable Promptness, 42 U.S.C. § 1396a(a)(8) – to the extent necessary to allow services to be provided to the target population without requiring services to go to "all [Medicaid-]eligible individuals."
- Single State Agency, 42 U.S.C. § 1396a(a)(5) – to allow the ASO to make final, judicially reviewable decisions about coverage, medical necessity and provider participation without a complete re-review by DHSS.

VIII. Public Notice and Comment Process

Tribal health organizations are essential partners in our statewide health care system, often operating the only health care services in rural communities. Tribal health representatives have been invited to participate in every level of the Medicaid reform and redesign efforts, and are active contributors to the planning and development of the Demonstration Project. The State of Alaska will continue to partner with tribal health organizations throughout this process. Formal tribal consultation will also be conducted. DHSS will, not less than 60 days prior to submission of the application, provide an electronic and hard copy of the Demonstration Project Application and invitation to comment to the Alaska Native Health Board, tribal health directors, members of the State/Tribal Medicaid Task Force and the Director of the Alaska Area Indian Health Services.

DHSS will, not less than 60 days prior to submission of the application, publicly notice and post the Demonstration Project Application and invitation to comment so that Medicaid recipients, providers, and the public can contribute their input.

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, the state behavioral health planning councils, actively engage Medicaid recipients, health care provides, and community members in the Medicaid Redesign and in planning for the 1115 Waiver. The state planning councils' efforts augment the extensive stakeholder engagement undertaken by DHSS and its contractors. The state planning councils will continue to provide this level of interactive stakeholder engagement throughout the development of the application and during implementation if the waiver.

Appendix A – Medicaid System Redesign

An overview of the comprehensive Medicaid System Redesign effort, and progress made in the first year of implementing Senate Bill 74, is available online at: http://dhss.alaska.gov/HealthyAlaska/Documents/2_FY2016_Annual_Medicaid_Reform_Report_11152016.pdf

Figures 1 and 2 on the following pages provide visual representations of the comprehensive Medicaid System Redesign effort.

Figure 1. Vision for Medicaid Redesign in Alaska

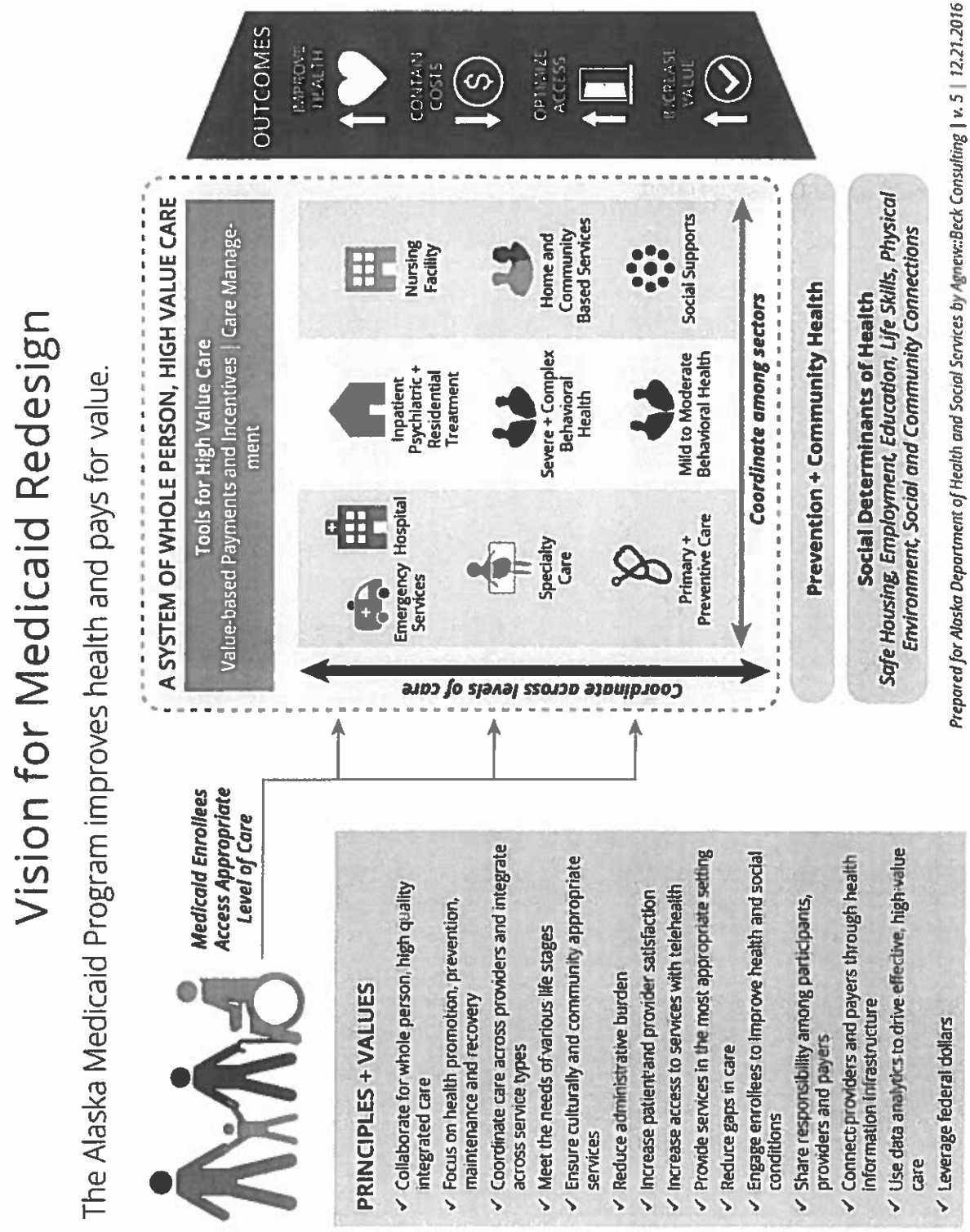
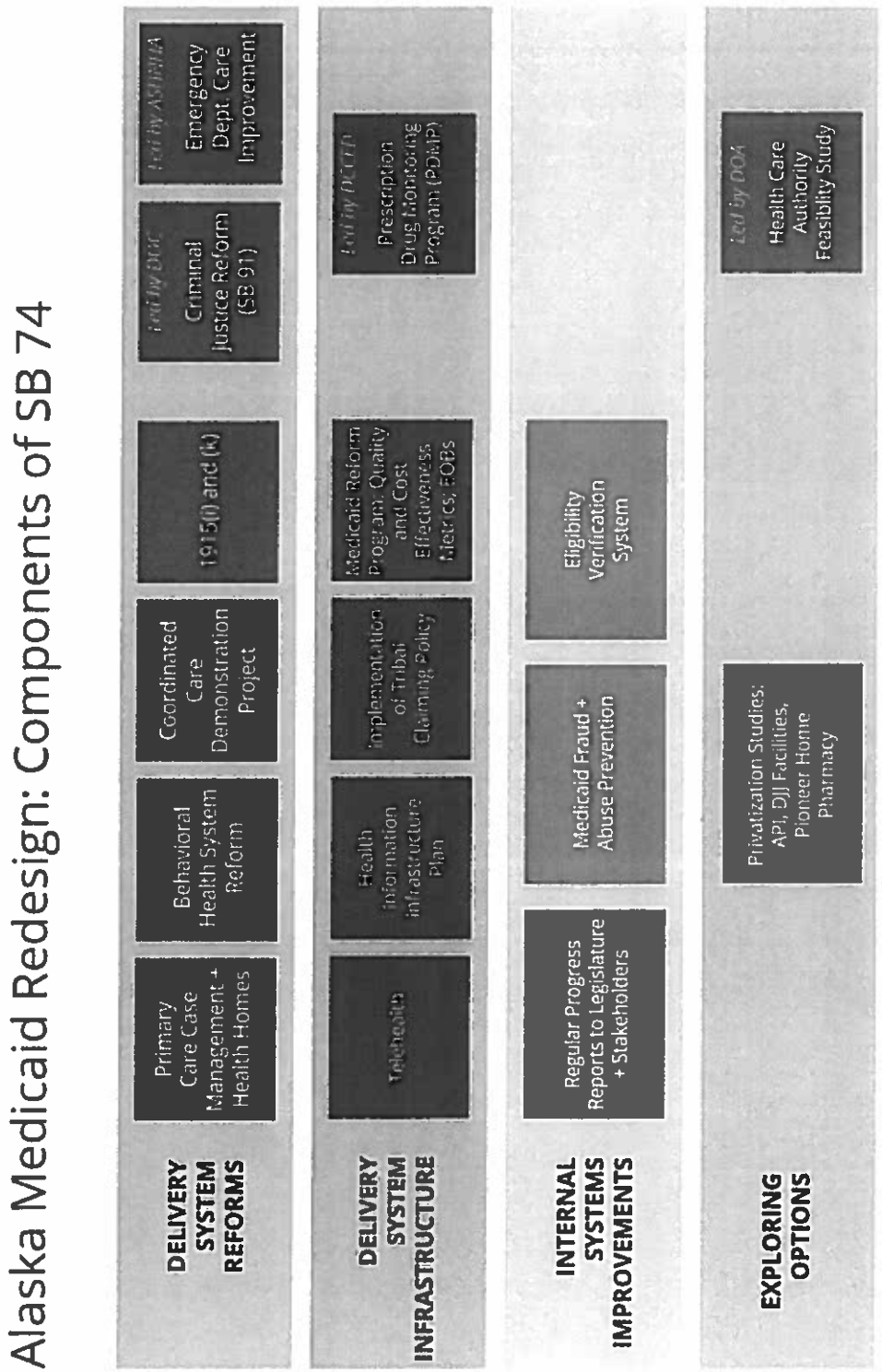


Figure 2. Components of Medicaid Redesign in Alaska: Current Initiatives



Acronyms List
API: Alaska Psychiatric Institute | ASHNHA: Alaska State Hospital and Nursing Home Association | DCCED: Alaska Department of Commerce, Community and Economic Development | DHSS: Alaska Department of Health and Social Services | DJJ: Alaska DHSS, Division of Juvenile Justice
DOA: Alaska Department of Administration | DOC: Alaska Department of Corrections | EOB: Explanation of Benefits

Prepared for Alaska Department of Health and Social Services by Agnew::Beck Consulting, September 2016

Health & Social Services | Division of Behavioral Health Overview

Randall Burns | Director

Linda Brazak | Administrative Operations Manager

Behavioral Health

January 31, 2017

FY2018 Behavioral Health Overview

- **Mission**: Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and partnerships.
- **369 Positions: 343** PFT **/26**Non-Perm
- API's 246 PFT / 5 NP staff account for 68% of the Division's staff positions
- **$134,237.4** - FY2018 Operating Total Budget Request, including $60,186.4 in UGF
- Total FY2016 Treatment service population: **28,652**
- Total FY2016 Prevention service population: **18,775**

	Allocation and/or Program	Funding (in thousands)	# of Employees	# of Alaskans Served	% Cost through Fees	Rating of Importance to Mission	Rating of Effectiveness	Constitution Requirement	Federally Required	Required by Statute
5	**Behavioral Health (483)**	**$134,237.4: $60,186.4 UGF $27,128.3 DGF $15,803.0 Fed $31,127.7 Other**	**349**							
6	Behavioral Health Treatment and Recovery Grants (3099)	$63,787.4: $33,836.9 UGF $20,937.7 DGF $ 7,020.5 Fed $ 1,992.3 Other	-	21,852	0.00%	Critical	1	No	Federal Block Grant Management and Maintenance of Efforts (MOE)	47.30.011 - 061, Alaska Mental Health Trust Authority 47.30.470 - 500, Alcoholism and Drug Abuse 47.30.520 - 620, Community Mental Health Services Act 47.30.655 - 915, State Mental Health Policy 47.37, Uniform Alcoholism and Intoxication Treatment Act
7	Alcohol Safety Action Program (ASAP) (305)	$5,185.1: $1,859.7 UGF $1,010.8 DGF $ 597.1 Fed $1,717.5 Other	28	5,335	9.85%	Critical	1	No	Federal Block Grant Management and MOE (Tobacco Enforcement)	28.35.030, Operating a vehicle, aircraft, or watercraft while under the influence of an alcoholic beverage, inhalant, or controlled substance 47.30.011 - 061, Alaska Mental Health Trust Authority 47.30.470 - 500, Alcoholism and Drug Abuse 47.37, Uniform Alcoholism and Intoxication Treatment Act
8	Behavioral Health Administration (2665)	$10,795.7 $6,834.2 UGF $ 985.0 DGF $2,348.9 Fed $ 627.6 Other	81	44,036	1.72%	Critical	2	No	Federal Block Grant Management and MOE Oversight	44.29.020, Duties of department 44.29.210 - 230, Alcoholism and Drug Abuse Revolving Loan Fund 47.30.011 - 061, Alaska Mental Health Trust Authority 47.30.470 - 500, Alcoholism and Drug Abuse 47.30.520 - 620, Community Mental Health Services Act 47.30.655 - 915, State Mental Health Policy 47.37, Uniform Alcoholism and Intoxication Treatment Act
9	Behavioral Health Prevention and Early Intervention Grants (3098)	$11,936.1: $2,105.3 UGF $4,186.8 DGF $5,469.0 Fed $ 175.0 Other	-	13,440	0.00%	Critical	1	No	Federal Block Grant Management and MOE Oversight	28.35.030, Operating a vehicle, aircraft or watercraft while under the influence of an alcoholic beverage, inhalant, or controlled substance 47.30.011 - 061, Alaska Mental Health Trust Authority 47.30.470 - 500, Alcoholism and Drug Abuse 47.37, Uniform Alcoholism and Intoxication Treatment Act
10	Designated Evaluation and Treatment (1014)	$3,794.8: $3,794.8 UGF	-	1,423	0.00%	Critical	1	Yes	Yes	18.65.400 - 490, Security Guards 47.07.030, Medical services to be offered 47.07.040, State plan for provision of medical assistance 47.07.073, Uniform accounting, budgeting and reporting 47.30.011 - 061, Alaska Mental Health Trust Authority 47.30.520 - 620, Community Mental Health Services Act 47.30.655 - 915, State Mental Health Policy
11	Alaska Psychiatric Institute (311)	$33,250.2: $ 7,147.3 UGF $26,102.9 Other	251	1,493	22.22%	Critical	2	Yes	Yes	08.64, Medicine 08.68, Nursing 08.84, Physical Therapists and Occupational Therapists 08.86, Psychologists and Psychological Associates 08.95, Clinical Social Workers 12.47, Insanity and Competency to Stand Trial 18.20, Hospitals and Nursing Facilities 18.70, Fire Protection 47.30.655 - 915, State Mental Health Policy
12	Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse (2801)	$1,050.7: $438.0 UGF $100.3 Fed $512.4 Other	6	All Alaskans	0.00%	Critical	1	No	Federal Block Grant	44.29.100 - 140, Advisory Board on Alcoholism and Drug Abuse 47.30.470(8), Powers and duties of the department 47.30.530(a)(9), Duties of department 47.30.661 - 669, Alaska Mental Health Board 47.37, Uniform Alcoholism and Intoxication Treatment Act
13	Suicide Prevention Council (2651)	$654.5: $654.5 UGF	1	All Alaskans	0.00%	Critical	1	No	No	44.29.300 - 390, Statewide Suicide Prevention Council
14	Residential Child Care (253)	$3,782.9: $3,515.7 UGF $ 267.2 Fed	2	493	0.00%	Critical	2	Yes	Yes	47.05.010, Duties of department 47.10, Children in Need of Aid 47.17, Child Protection 47.30, Mental Health 47.40, Purchase of Services

FY2018 Governor's Operating Budget Decrements ($4,499.1)UGF

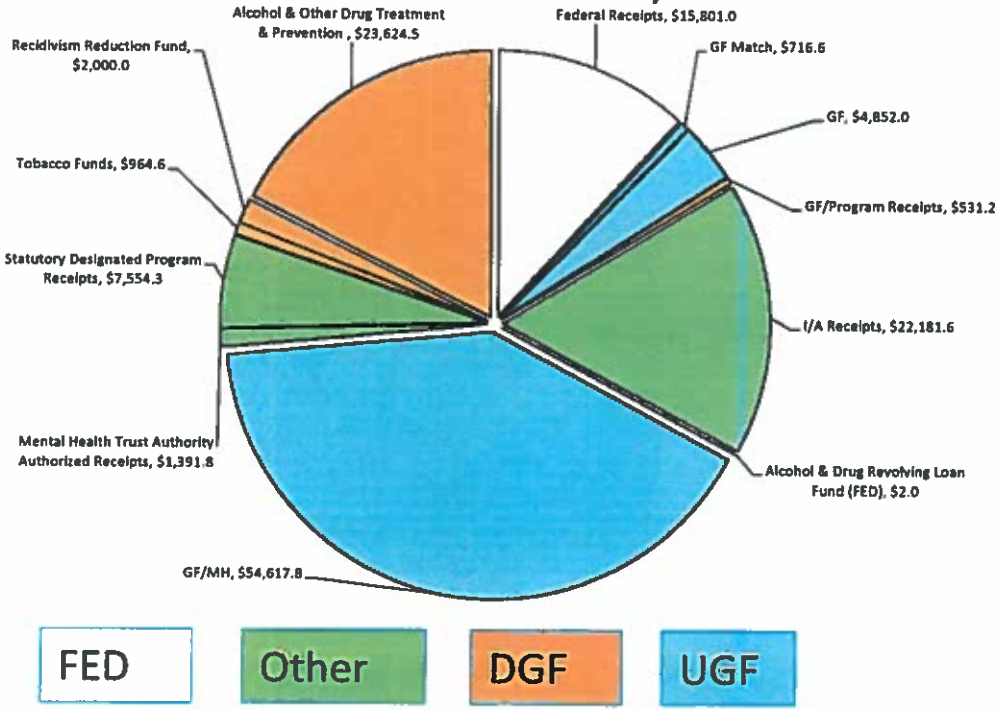
Behavioral Health Treatment and Recovery Grants	($3,000.0)	UGF	Due to Medicaid Expansion
Behavioral Health Prevention & Early Intervention Grants	($306.3)	UGF	Reduce Unexpended Grant Authority
Alaska Mental Health Board and Advisory Board on Alcohol and Drug Abuse	($48.7)	UGF	Personal Services & Travel Authority
Designated Evaluation & Treatment	($862.9)	UGF	Due to Medicaid Expansion
Residential Child Care	($281.2)	UGF	Due to Declining Provider Participation

FY2018 Governor's Operating Budget Increments $4,000.0

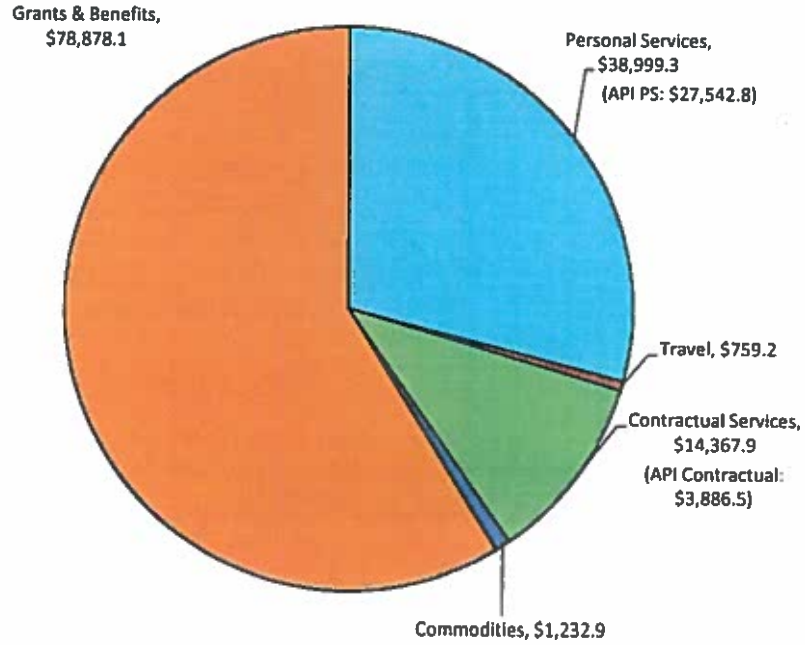
Behavioral Health Treatment and Recovery Grants	$2,185.0	DGF/FED	**$1,000.0** in FED Authority for new SAMHSA Grant Award **$185.0** due to Increased Substance Abuse Prevention & Treatment, and Community Mental Health Services, Block Grant Funds **$1,000.0** in DGF for Second Year Omnibus Crime Bill (SB 91)
Alcohol Safety Action Program	$280.0	FED	**$280.0** in FED Authority due to Increase in Federal funds in the Substance Abuse Prevention & Treatment Block Grant
Behavioral Health Prevention & Early Intervention Grants	$1,405.0	FED	**$1,000.0** in FED Authority for new SAMHSA Grant Award **$405.0** in FED Authority due to Increased Substance Abuse Prevention & Treatment, and Community Mental Health Services, Block Grant Funds
Behavioral Health Administration	$130.0	FED	**$130.0** in FED Authority in Personnel Services

FY2018 Governor's Budget

Revenue Authority



Expenditure Authority

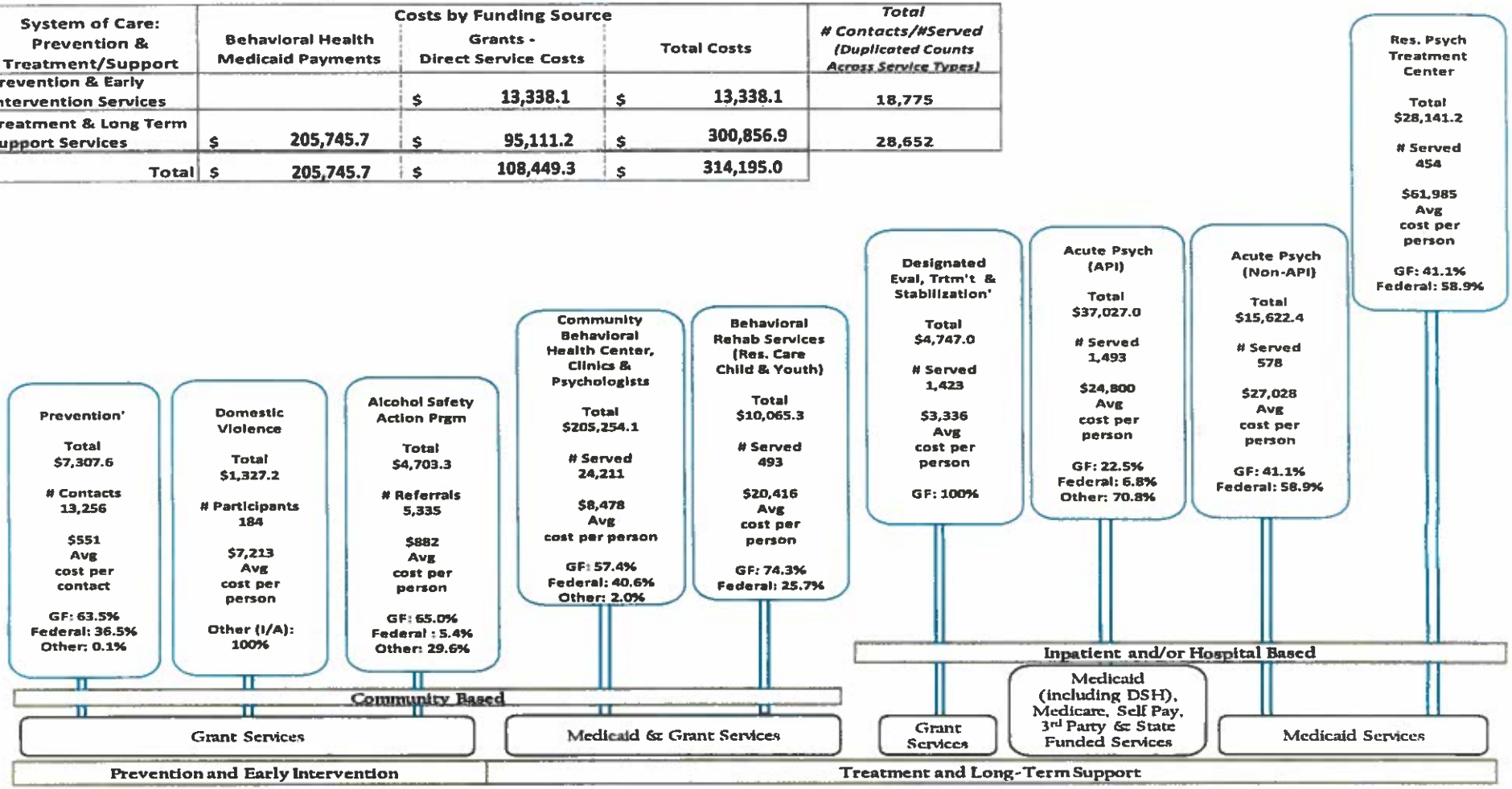


Continuum of Care FY2016 Actuals

Behavioral Health System of Care

SFY 2016 Costs by Funding Source and Average Cost per Person by Service Type

System of Care: Prevention & Treatment/Support	Costs by Funding Source: Behavioral Health Medicaid Payments	Costs by Funding Source: Grants - Direct Service Costs	Costs by Funding Source: Total Costs	*Total # Contacts/#Served (Duplicated Counts Across Service Types)*
Prevention & Early Intervention Services		$ 13,338.1	$ 13,338.1	18,775
Treatment & Long Term Support Services	$ 205,745.7	$ 95,111.2	$ 300,856.9	28,652
Total	$ 205,745.7	$ 108,449.3	$ 314,195.0	



FFY 2017 Federal Behavioral Health Grant Awards

- Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grants
  - Mental Health $1,071.2
  - Substance Abuse Prevention and Treatment $5,889.1 ($1,120.7 to Methadone Programs)
- Strategic Prevention Framework – Partnerships for Success (SAMHSA)
  - Opioid Prevention (5 years) $1,648.2
- Alaska Partnership to Improve Outcomes for Adolescents and Families (SAMHSA) $949.9
- Projects for Assistance in Transition from Homelessness (SAMHSA) $300.0
- Alaska's Project Hope - Naloxone Distribution (SAMHSA - 5 years) *NEW* $1,000.0
- Expanding Medication Assisted Treatment (MAT) Alternatives to Address Prescription And Opioid Addiction *NEW*
  - MAT Grant (SAMHSA - 3 years) $1,000.0

NEW SAMHSA Grants for DHSS

Medication-Assisted Treatment Prescription Drug and Opioid Addiction (MAT-PDOA) Grant Program

MAT-PDOA is a three-year grant program to address the opioid misuse and addiction problem in this country.

MAT-PDOA provides funding to states to:

- Enhance or expand their treatment service systems to increase access to MAT by building capacity
- Provide MAT and recovery services that are accessible, effective, comprehensive, coordinated, and evidence-based
- Target populations include people with opioid use disorders who are seeking or receiving MAT, with a particular focus on racial, ethnic, sexual, and gender-identity minority groups. Examples of some of these populations include pregnant and parenting women, people in the criminal justice system, veterans, and rural communities.

As a result of the program, SAMHSA expects to:

- Increase the number of admissions for MAT
- Increase the number of clients receiving integrated care and treatment
- Decrease illicit opioid drug use at six-month follow-up
- Decrease the use of prescription opioids in a non-prescribed manner at six-month follow-up

Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths

The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

FY2017 State Substance Use Disorder Grants $6,000.0 in New Funds

- The Department received a total of $6,000.0 in Legislative funding to support new substance use disorder treatment programs in Alaska. The $6,000.0 can be spread over a three year period, beginning in FY2017 and ending in FY2019.
- The grants awarded to **the Tanana Chiefs Conference and Central Peninsula General Hospital** provide $500.0 for the remainder of FY2017, to be used in accordance with agency proposals to pay for start-up and initial operational costs, with the intent to continue the award at $1,000.0 each in FY2018 and FY2019 to support continued operations of the programs.
- The third grant, awarded to **Set Free Alaska, Inc.** will provide $250.0 for the remainder of FY2017, to be used in accordance with their proposal to pay for start-up and initial operational costs, and then $375.0 in FY2018 and FY2019 to support continued operations of the program.

Recidivism Reduction Services Funded with SB91 Dollars

The Division of Behavioral Health received **$1.0 million in SB 91 funding, to support, enhance and expand the states community reentry center and community reentry coalitions.**

Currently Alaska has one full-service Reentry Center located in Anchorage and four (4) funded community reentry coalitions.

New funding was allocated in the following way:

- **$250.0 added to a current Division of Behavioral Health contract with Partners Reentry Center in Anchorage;**
- **$750.0 being awarded through a competitive Request for Proposal (RFP) for community reentry coalitions.** The RFP was divided into 3-tiers: current coalitions, developing coalitions and emerging coalitions:
  - Enhancement and case management expansion for current reentry coalitions awarded to Fairbanks [Interior Alaska Center for Non-Violent Living], Juneau [National Council on Alcoholism & Drug Abuse], Mat-Su [Valley Charities, Inc.] and Anchorage [Neighborhood Housing Services];
  - Development grant for one community reentry coalition in Kenai/Soldotna [Bridges Community Resource Network]; and
  - Emerging grant for the community of Nome [Norton Sound Health Corporation], just beginning the development of a community reentry coalition.

Assessing the Current State of the Behavioral Health System of Care

1. **The Psychiatric Emergency Response System Issues:**
   - Alaska Psychiatric Institute (API)
   - Designated Evaluation & Treatment (DET)
   - Transportation
   - Forensic Evaluations
   - API Feasibility Study
2. **Grant Reformation:**
   - Responding to Grant Reductions through Medicaid Expansion
3. **Working to Cure the Gaps in Service:**
   - The 1115 Demonstration Waiver Application to Centers for Medicare & Medicaid Services (CMS)
   - Teams
   - Concept Paper
   - Administrative Services Organizations (ASO) and Readiness Assessments

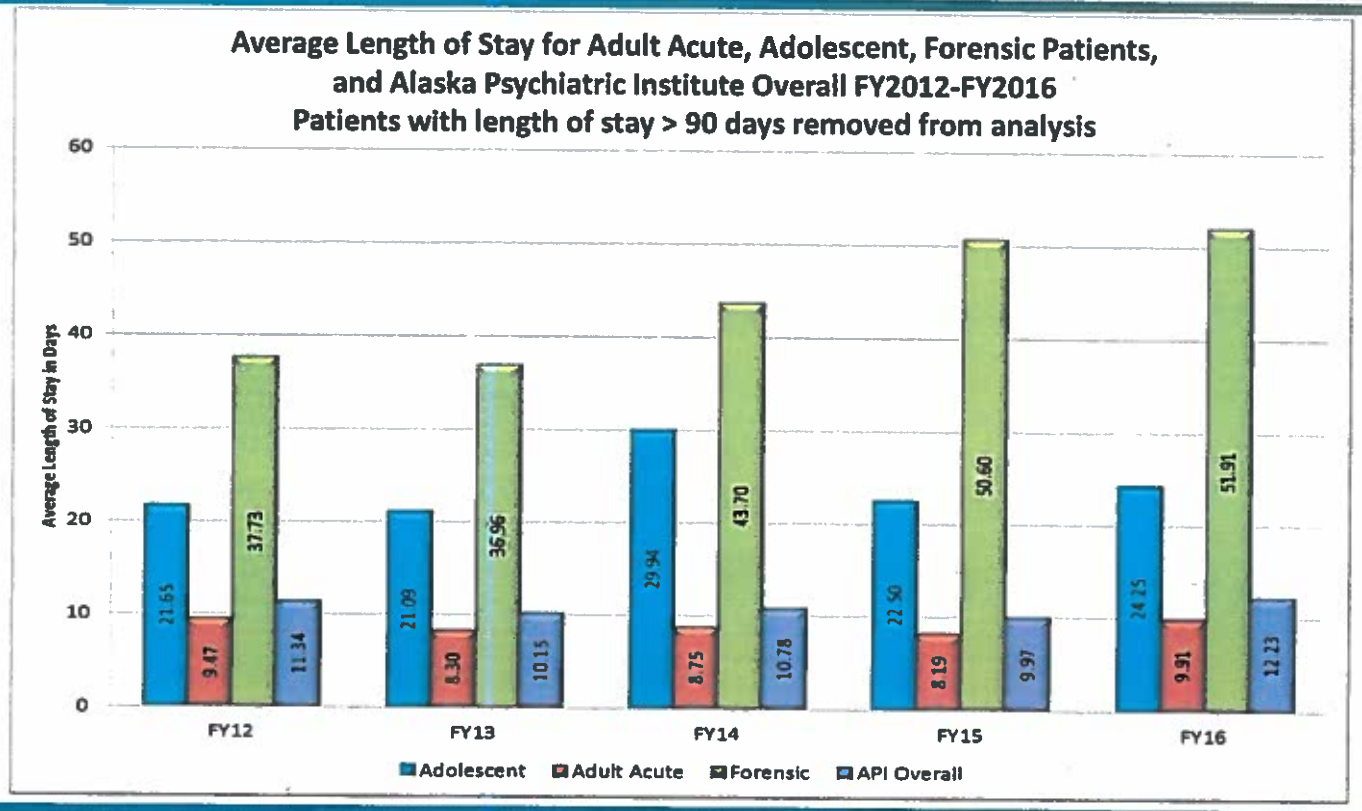
1. The Current Vulnerable State of Psychiatric Emergency Response and Care in Alaska

Here are the current stakeholders in the "system":

- Local community emergency response staff (Emergency Medical Technician, Police, Village Public Safety Officers)
- Community BH centers and larger Community Health Centers (primary care)
- Psychiatric Emergency Services (PES) Grants from the Division
- Local detention centers (including jails)
- Local Community Hospitals
- Local Courts (probate masters/magistrates and superior court judges)
- Designated Evaluation & Treatment hospitals
  - Bartlett Regional Hospital (12 bed Mental Health unit)
  - Fairbanks Memorial Hospital (20 bed Mental Health unit)
- Alaska Psychiatric Institute (API)

This fragile response system stumbles when Alaska Psychiatric Institute – the treatment facility of last resort – is at capacity.

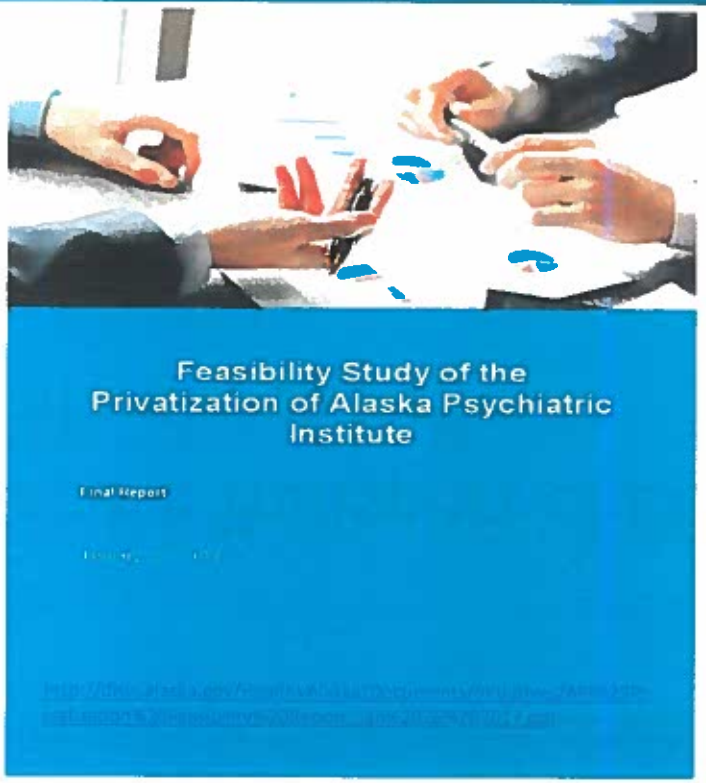
Alaska Psychiatric Institute Census Pressure Impacts: Short Average Lengths of Stay



Alaska Psychiatric Institute Census Pressure Impacts:

- Secure Transport of Court-Ordered Psychiatric Emergency Patients
- Forensic Evaluation Issues Facing Alaska

The Alaska Psychiatric Institute Feasibility Study



Privatization Option	Feasibility	Findings and Recommendations
1: Full Privatization		Cost-benefit analysis revealed that, even after significant staff reduction, when all transition costs, contract monitoring costs, and provider margins are considered, this option proves to be more expensive to the state over a likely 5-year contract period. The additional staff reductions needed for budget neutrality would likely diminish the quality of service delivery.
2: Joint Operating Agreement		As a variation of full privatization, this option failed to generate cost savings for the same reasons.
3: State Management		Cost-benefit analysis showed that implementing greater efficiencies in administrative functions and nursing staffing patterns could deliver the greatest amount of cost savings of all the options.
4a: Communication Center		While this option involves relatively few hospital personnel, expected changes to compensation and the need for fewer staff under a private contractor would yield the highest percentage of savings for any of the options. These services could also be supplied by a viable marketplace of competing vendors.
4b: Facility and Material Management		This option involves roughly a tenth of hospital personnel and appears to deliver only modest cost savings. However, like security services, these maintenance and environmental services can be readily procured from a viable marketplace of vendors.
4c: Psychiatric and Medical Services		Unlike many categories of hospital staff, levels for psychiatric and medical staff are not typically reduced under privatization, nor is their compensation significantly decreased. In many cases, private entities will increase compensation to better support recruitment and retention of these scarce personnel. While these changes may improve service delivery, they do not yield cost savings. Aside from the potential for increased cost, PCG also cautions against privatizing these services due to concerns over a lack of clear providers, aside from locum tenens agencies.
4d: Nursing Services		From a fiscal perspective, nursing services are a potentially fruitful area for privatization, due to the fact that nursing staff make up 58% of all API personnel, with the greatest potential for savings through staff reductions and changes to benefits and compensation levels. While cost-benefit analysis showed that modest staff reductions—and associated cost savings—could be achieved without diminishing service delivery, it is not clear that a private provider could significantly lower overall compensation levels for nursing personnel without affecting recruitment and retention. Nor is it clear that a robust marketplace for these services exists in Alaska. Many of the identified improvements in nursing services could also be implemented under current state management.
4e: Comprehensive Outsourcing		Cost-benefit analysis revealed that this option failed to produce cost savings, making it infeasible on fiscal grounds. The higher cost was due largely to expense of privatizing psychiatric services.

2. Grant Reformation – How Grant Reductions are Impacting Providers

- $5,800.0 reduction to its $61,000.0 Comprehensive Behavioral Health Treatment and Recovery budget component for FY2017 (equal to an overall 9.5% reduction to that component).
- This reduction reflects the State's efforts to begin shifting from a reliance on grants funded by General Fund (GF) dollars to program funding via Medicaid dollars. The total reduction was made applying the following two scenarios:
- The first was a ***proportional reduction to all eligible grants***, with the intent of maintaining continuity of services and applying a consistent allocation formula to the majority of grants funded by the Treatment and Recovery component.
- The second was ***an additional reduction*** to those behavioral health agencies that were able to benefit from access to new revenue via Medicaid Expansion payments received between September, 2015 and the end of May, 2016.

3. Working to Cure the Gaps in Service

- Our focus is on Behavioral Health System Reform and Redesign
- The Alaska effort was, from the first, described as a "Behavioral Health Access Initiative"
- From the Medicaid Reform and System Reform perspectives, the reasons are clear:
  - For the economy – the need to reduce General Fund expenditures (including grants to Behavioral Health providers) and manage Medicaid costs.
  - For the consumer – Alaska's high rates of suicide, drug and alcohol consumption, the current opioid crisis, the incarceration of persons with behavioral health diagnoses, the rates of adverse childhood experiences, and increasing concerns around the homeless – all call for a less fragmented, less crisis-driven system of care and the need for more access to a broader range of mental health and Substance Use Disorder treatment and support options.

It Takes a Village for the 1115

- Six 1115 Waiver Teams Have Been Created with a total of 96 Members:
  - Benefit Design: 20 members
  - Cost: 20 members
  - Data: 13 members
  - Quality: 17 members
  - Writing: 9 members
  - Policy: 17 members

Behavioral Health Reform – The Goals for a Transformed Behavioral Health System of Care

- Expand Treatment Capacity and Improve Access to Services
- Integration of Care (between primary care and behavioral health and between and across the behavioral health and intellectual and developmental disabilities systems, as well)
- Cost and Outcomes of Reform
- Provider Payment and Accountability Reform
- Delivery System Reform

A Lot is Riding on Plans for the 1115 Behavioral Health Demonstration Waiver

- What the Department of Health and Social Services Expects from a Transformed Behavioral Health System of Care
- The Strategies the Department of Health and Social Services will Deploy in its Transformational Efforts
- A Key Component: the Administrative Service Organization (ASO) and the Readiness Assessments

A Key Component of the Redesign is the Administrative Service Organization

- As a part of its BH System reform, DHSS intends to contract with an Administrative Services Organization (ASO)
- Administrative Services Organizations are private (generally for-profit), third party organizations with special expertise in (behavioral) health systems management with whom a state contracts in order to obtain the specified administrative services – and Medicaid costs savings – identified by the state as necessary to manage the state's system of care on its behalf.
- Primary Functions of an Administrative Services Organization:
  - Provider utilization management
  - Provider network management
  - Management of service quality and outcomes
  - Data management
  - Claims processing
  - Member (client/patient) enrollment services

Alaska Opioid Policy Task Force

- Final Recommendations Issued January 19, 2017
- 23 Members of the Task Force and 3 Staff, including Dr. Jay Butler, Chief Medical Officer, Department of Health and Social Services , and Erin Narus, State Medicaid Pharmacist, Department of Health and Social Services
- The recommendations were derived from information provided to task force members by Alaskan and national experts, public comment at task force meetings and other forums around the state, input from local community heroin/opioid coalitions, research and evidence.
- The recommendations are organized according to a public health framework promoted by the Association of State and Territorial Health Officials.

The Framework for the Task Force's Recommendations

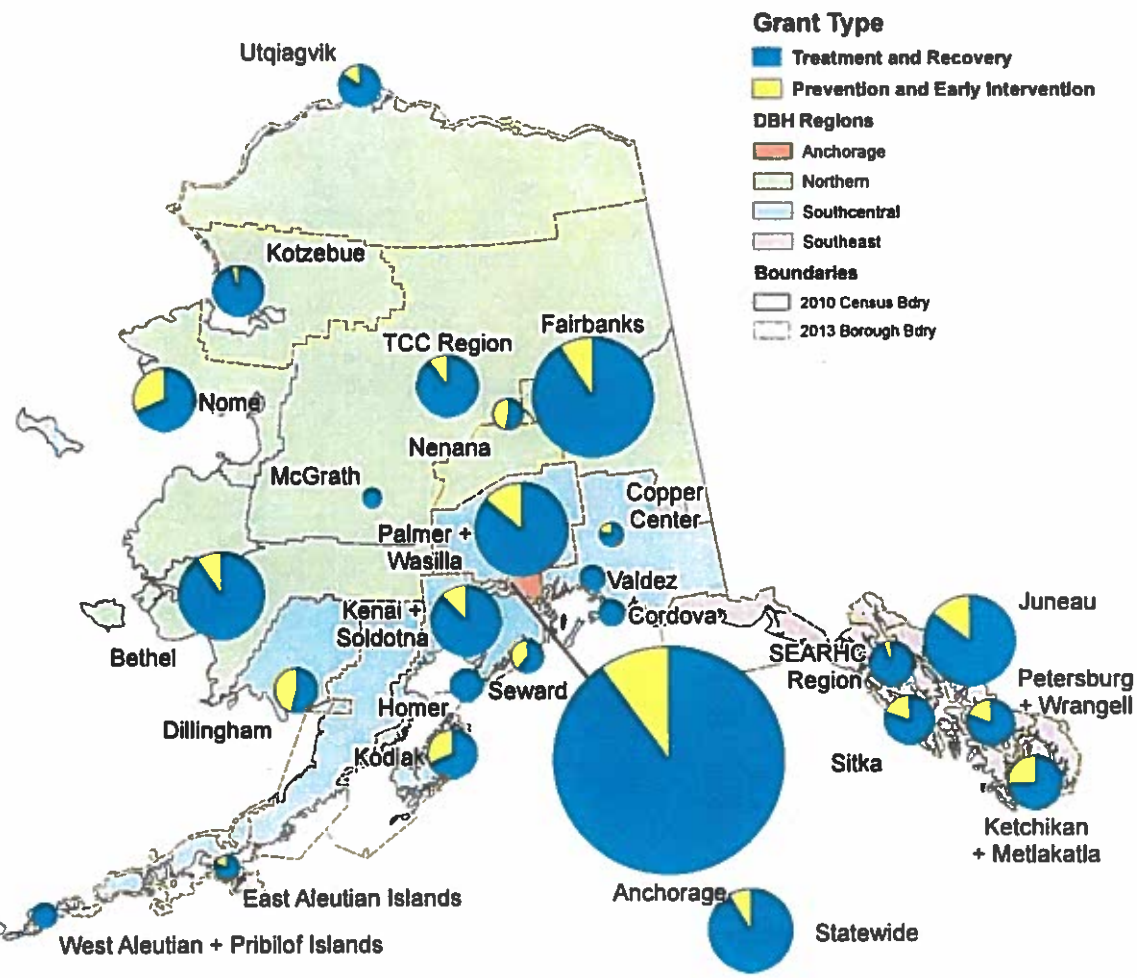
- Environmental Controls and Social Determinants of Health
- Chronic Disease Screening, Treatment, and Management
- Harm Reduction
- Recovery
- Collaboration

Thank You!

QUESTIONS?

FY 2017 Total DBH Grant Funding by Service Area and Grant Type

Service Area	Treatment & Recovery	Prevention & Intervention	TOTAL
Anchorage	$24,375,577	$2,647,744	$27,023,321
Bethel	$3,414,213	$360,000	$3,774,213
Copper Center	$216,013	$60,000	$276,013
Cordova	$333,574		$333,574
Dillingham	$513,866	$432,000	$945,866
East Aleutian Islands	$261,086	$60,765	$321,851
Fairbanks / Fort Yukon	$6,659,033	$667,297	$7,326,330
Homer	$514,449		$514,449
Juneau	$3,570,991	$611,151	$4,182,142
Kenai / Soldotna	$2,166,051	$300,680	$2,466,731
Ketchikan / Metlakatla	$1,094,607	$374,802	$1,469,409
Kodiak	$840,602	$385,000	$1,225,602
Kotzebue	$1,253,380	$60,000	$1,313,380
McGrath	$167,943		$167,943
Nenana	$242,423	$212,000	$454,423
Nome	$1,352,834	$622,000	$1,974,834
Palmer / Wasilla	$3,793,104	$607,092	$4,400,196
Petersburg / Wrangell	$909,790	$219,062	$1,128,852
SEARHC Region	$968,468	$55,000	$1,023,468
Seward	$327,597	$210,000	$537,597
Sitka	$1,022,365	$250,000	$1,272,365
TCC Region	$1,737,339	$194,848	$1,932,187
Utqiagvik	$742,246	$134,942	$877,188
Valdez	$304,102		$304,102
West Aleutian / Pribilofs	$283,343		$283,343
Other Statewide Grants	$3,250,897	$306,000	$3,556,897
TOTAL:	$60,315,713	$8,770,383	$69,086,096

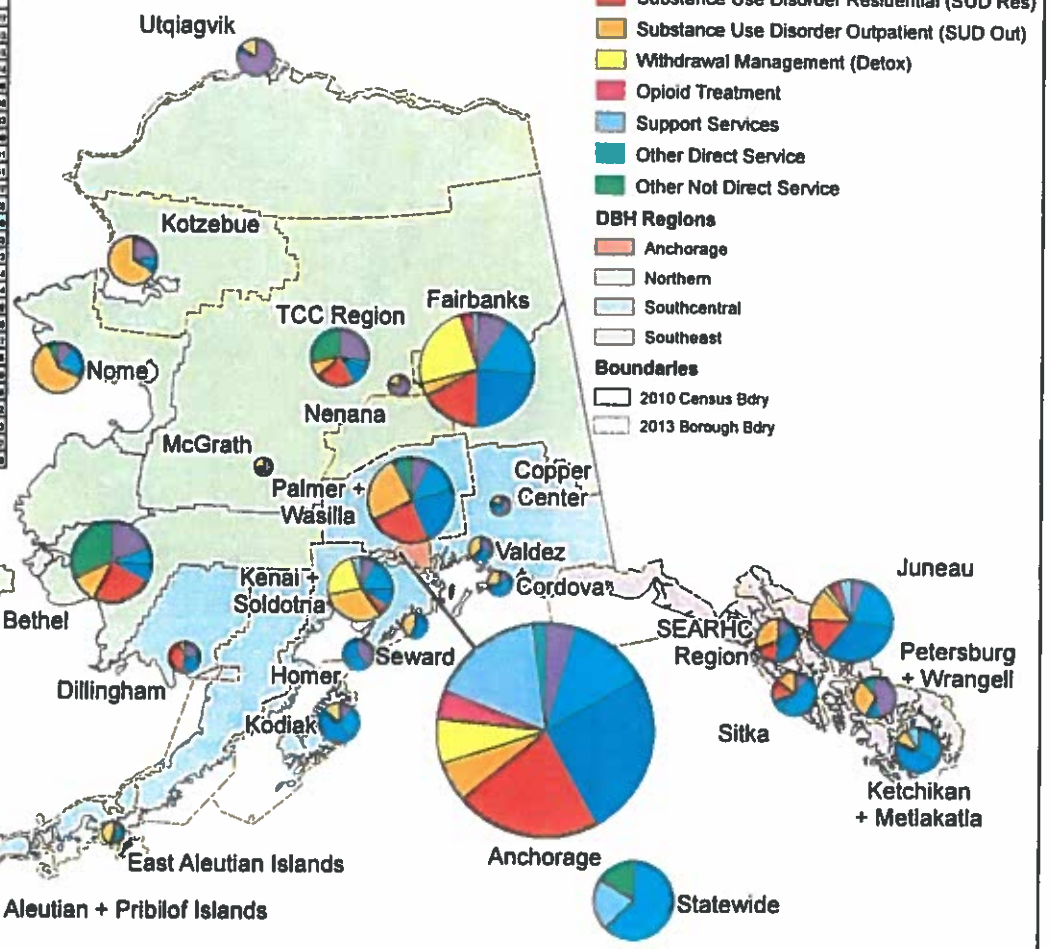


Source: FY17 Grantee Database as of 1-24-2017 - Division of Behavioral Health

Treatment and Recovery Grant Funding for FY2017 by Service Area and Program Type

Service Area	PES	SED	SMI	SUD Res	SUD Out	Detox	Opioid	Support	Direct	Not Direct	TOTAL
Anchorage	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Bethel	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]					[illegible]	[illegible]
Copper Center	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Cordova	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Dillingham	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]						[illegible]
East Aleutian Islands	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Fairbanks / Fort Yukon	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]
Homer	[illegible]	[illegible]	[illegible]								[illegible]
Juneau	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]
Kenai / Soldotna	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]			[illegible]
Ketchikan / Metlakatla	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]			[illegible]
Kodiak	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Kotzebue	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
McGrath	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Nenana	[illegible]				[illegible]						[illegible]
Nome	[illegible]	[illegible]			[illegible]						[illegible]
Palmer / Wasilla	[illegible]	[illegible]	[illegible]		[illegible]					[illegible]	[illegible]
Petersburg / Wrangell	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]	[illegible]	[illegible]
SEARHC Region	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]						[illegible]
Seward	[illegible]		[illegible]		[illegible]						[illegible]
Sitka	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
TCC Region	[illegible]	[illegible]	[illegible]		[illegible]					[illegible]	[illegible]
Utqiagvik					[illegible]						[illegible]
Valdez	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
West Aleutian / Pribilof	[illegible]	[illegible]	[illegible]		[illegible]						[illegible]
Other Statewide Grants		[illegible]						[illegible]		[illegible]	[illegible]
TOTAL:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

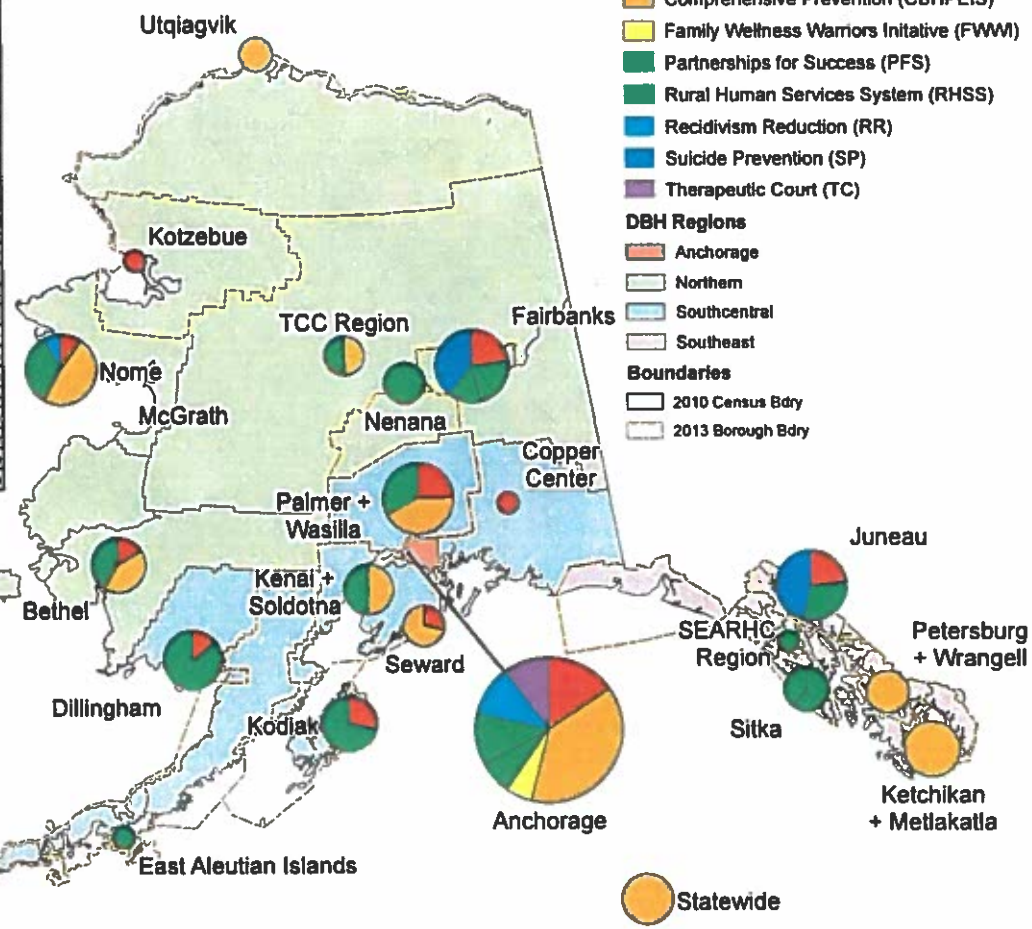
Program Type Grouping	
PES	
Psychiatric Emergency Services	
SED	
SED Youth & Family Outpatient - MH	
Youth Residential - MH	
SMI	
Adult Residential/Supportive Housing - MH	
SMI - Outpatient - MH	
SUD Residential	
Adult Residential - SA	
Women & Children Residential - SA	
Youth Residential - SA	
SUD Outpatient	
Adult - Outpatient - SA	
Women & Children - Outpatient - SA	
Youth & Family Outpatient - SA	
SA Treatment for OCS	
Withdrawal Management	
Detoxification	
Opioid	
Outpatient Opioid Treatment Program - SA	
Support Services	
Peer and Consumer Supports	
Other Direct Services	
Trauma Informed Behavioral Health Services	
Therapeutic Court	
Other Not Direct Services	
Sobering Center, Service Patrol, Referral, etc.	



Source: FY17 Grantee Database as of 1-24-2017 - Division of Behavioral Health

Prevention and Early Intervention Grant Funding for FY2017 by Service Area and Program Type

Service Area	ASAP	CBHPEIS	FWWI	PFS	RHSS	RR	SP	TC	TOTAL
Anchorage	$410,000	$1,017,744	$150,000	$200,000	$305,000	$300,000		$265,000	$2,647,744
Bethel	$80,000	$150,000			$150,000				$380,000
Copper Center	$80,000								$80,000
Dillingham	$80,000				$372,000				$452,000
East Aleutian Islands					$80,785				$80,785
Fairbanks / Fort Yukon	$150,000			$157,297	$100,000		$200,000		$607,297
Juneau	$140,723			$196,428			$264,000		$611,151
Kenai / Soldotna		$150,000		$150,000					$300,000
Ketchikan / Metlakatla		$374,802							$374,802
Kodiak	$110,000				$275,000				$385,000
Kotzebue	$80,000								$80,000
Nenana					$212,000				$212,000
Nome	$80,000	$300,000			$212,000	$50,000			$642,000
Palmer / Wasilla	$150,000	$257,082		$200,000					$607,082
Petersburg / Wrangell		$219,082							$219,082
SEARHC Region					$65,000				$65,000
Seward	$80,000	$150,000							$230,000
Sitka				$150,000	$100,000				$250,000
TCC Region		$95,848			$99,000				$194,848
Utqiagvik		$134,942							$134,942
Other Statewide Grants		$308,000							$308,000
TOTAL	$1,320,723	$3,156,170	$150,000	$1,043,725	$1,940,785	$350,000	$544,000	$265,000	$8,770,383



Source: FY17 Grantee Database as of 1-24-2017 - Division of Behavioral Health

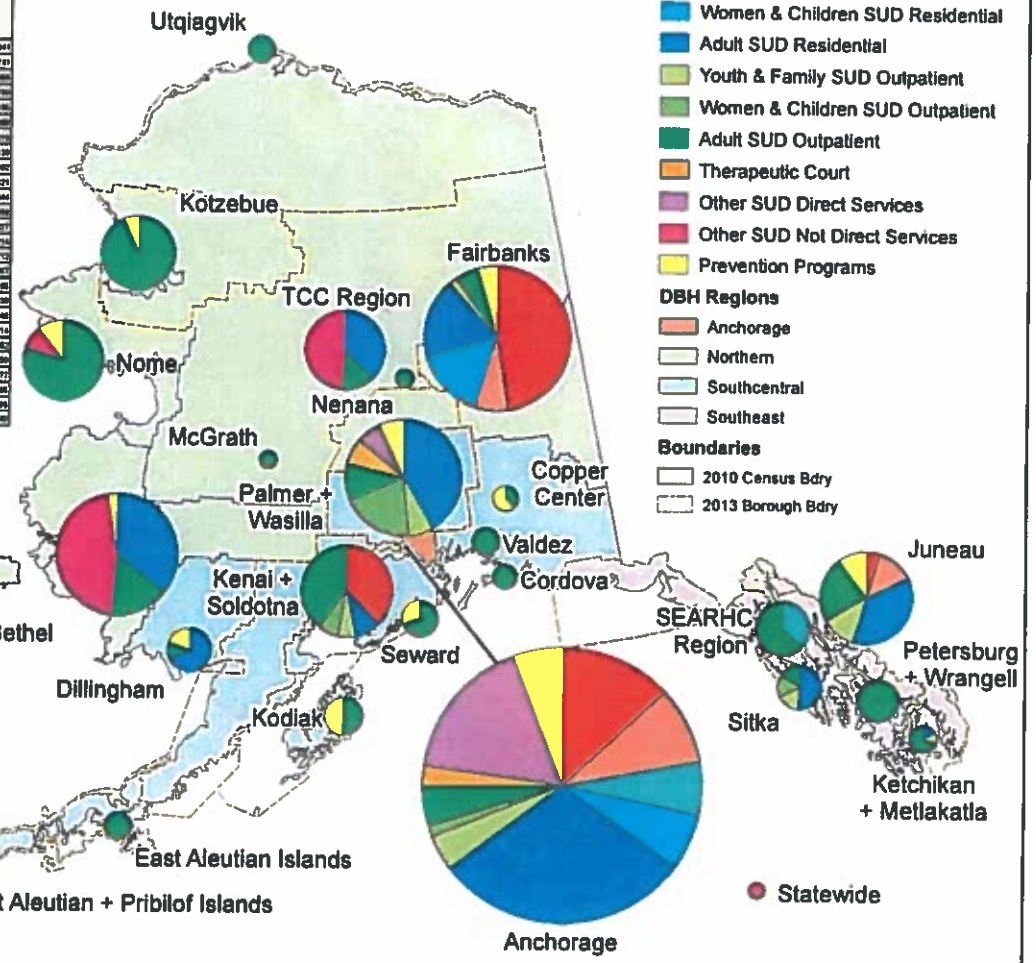
Substance Use Disorder (SUD) Funding for FY2017 by Service Area and Program Type

Service Area	Other	Opioid	Youth SUD Res	Women and Children SUD Res	Adult SUD Res	Youth and Family SUD Out	Women and Children SUD Out	Adult SUD Out	Therapeutic Court	Other SUD Direct Client	Other SUD Not Direct	Prevention Programs	Total
Anchorage	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
Bethel					[illegible]			[illegible]					[illegible]
Nome								[illegible]			[illegible]	[illegible]	[illegible]
Copper Center								[illegible]					[illegible]
Cordova					[illegible]			[illegible]				[illegible]	[illegible]
Dillingham								[illegible]					[illegible]
East Aleutian Islands	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]		[illegible]				[illegible]	[illegible]
Fairbanks / Fort Yukon	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]		[illegible]				[illegible]	[illegible]
Juneau	[illegible]				[illegible]	[illegible]	[illegible]	[illegible]					[illegible]
Kenai / Soldotna					[illegible]	[illegible]		[illegible]					[illegible]
Kodiak / Homer								[illegible]				[illegible]	[illegible]
Kotzebue								[illegible]					[illegible]
McGrath								[illegible]					[illegible]
Nenana								[illegible]					[illegible]
Nome								[illegible]			[illegible]	[illegible]	[illegible]
Palmer / Wasilla					[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			[illegible]	[illegible]
Petersburg / Wrangell			[illegible]					[illegible]					[illegible]
SEARHC Region								[illegible]					[illegible]
Seward					[illegible]	[illegible]	[illegible]	[illegible]					[illegible]
Sitka					[illegible]			[illegible]					[illegible]
TCC Region								[illegible]			[illegible]		[illegible]
Valdez								[illegible]					[illegible]
West Aleutian / Pribilof								[illegible]					[illegible]
Other Statewide Grants								[illegible]			[illegible]		[illegible]
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Other SUD Direct Services
- Substance Use Disorder Treatment for OCS Engaged Families
- Permanent Supportive Housing Intensive Case Management

Other SUD Not Direct Services
- Chemical Dependency Professionals Certification
- SUD Planning Grant for Building a Treatment Center
- Sobering Center
- Bethel Community Service Patrol

Prevention Programs
- Alcohol Safety Action Program (Adult & Juvenile)
- Recidivism Reduction



Program Type
- Withdrawal Management (Detox)
- Opioid Treatment
- Youth SUD Residential
- Women & Children SUD Residential
- Adult SUD Residential
- Youth & Family SUD Outpatient
- Women & Children SUD Outpatient
- Adult SUD Outpatient
- Therapeutic Court
- Other SUD Direct Services
- Other SUD Not Direct Services
- Prevention Programs

DBH Regions
- Anchorage
- Northern
- Southcentral
- Southeast

Boundaries
- 2010 Census Bdry
- 2013 Borough Bdry

Source: FY17 Grantee Database as of 1-24-2017 - Division of Behavioral Health

MEDICAID IN ALASKA

January 31, 2017 Report Month

28,950

Lives covered by Medicaid expansion

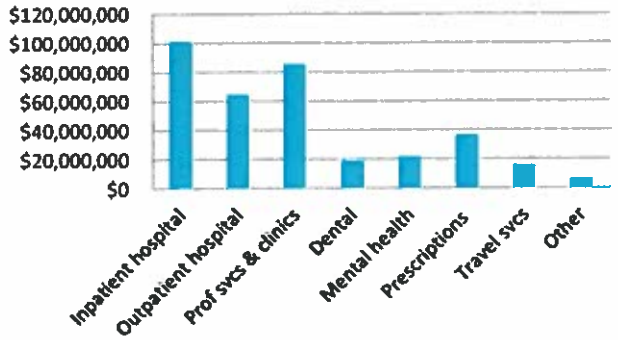
Demographics of Medicaid expansion enrollees

	19-34	35-44	45-54	55-64
Enrollee count	11,151	4,661	6,494	6,644

Male	16,511	Female	12,439

Medicaid expansion began on Sept. 1, 2015 in Alaska.

Medicaid expansion claims paid to date

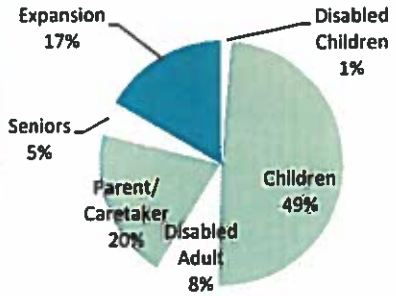


Total
$352,368,674

100% federally funded through CY16 and will transition to 90% in 2020 and beyond.

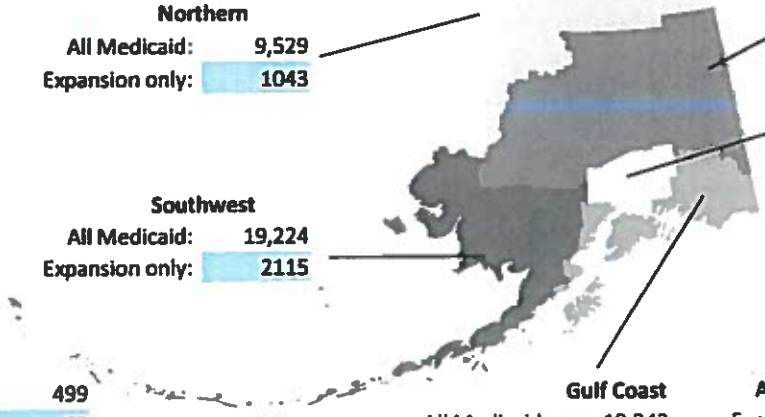
Medicaid provides health benefits to many Alaskans.

All Medicaid enrollees by category



Medicaid enrollees by region

Alaskans across the state benefit from Medicaid.



Northern
All Medicaid: 9,529
Expansion only: 1043

Interior
All Medicaid: 19,210
Expansion only: 3196

Anchorage/Mat-Su:
All Medicaid: 89,044
Expansion only: 15,398

Southwest
All Medicaid: 19,224
Expansion only: 2115

Out of state*
All Medicaid: 499
Expansion only: 62
*Temporarily absent or in an out of state medical institution.

Gulf Coast
All Medicaid: 19,343
Expansion only: 3,642

Southeast
All Medicaid: 16,851
Expansion only: 3,494

173,700

Lives covered by all Medicaid

Demographics of all Medicaid enrollees

	18 or less	19-34	35-44	45-54	55-64	65+
Enrollee count	82,557	37,193	16,334	14,387	13,552	9,677

Male	83,869	Female	89,831