ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
October 30, 2007
3:17 p.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Bob Roses, Vice Chair
Representative Anna Fairclough
Representative Wes Keller
Representative Paul Seaton
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

All members present

OTHER LEGISLATORS PRESENT

Senator Bettye Davis
Senator Fred Dyson
Senator Joe Thomas

COMMITTEE CALENDAR

SUBSTANCE ABUSE AND MENTAL HEALTH STRATEGIES

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to report

WITNESS REGISTER

JEFF JESSEE, Chief Executive Officer
Alaska Mental Health Trust Authority (AMHTA)
Department of Revenue
Anchorage, Alaska
POSITION STATEMENT: Presented an overview on behalf of the Alaska Mental Health Trust Authority (AMHTA).

WILLIAM HOGAN, Deputy Commissioner
Office of the Commissioner
Division of Behavioral Health

Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Presented background on the existing systems of care within the Department of Health & Social Services (DHSS).

MELISSA STONE, Director
Division of Behavioral Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint report titled "Behavioral Health in Alaska".

GORDON HANES, Vice President
Behavioral Services Division
Southcentral Foundation (SCF)
Anchorage, Alaska
POSITION STATEMENT: Presented a report on behalf of Southcentral Foundation (SCF).

DWAYNE PEEPLES, Deputy Commissioner
Office of the Commissioner
Department of Corrections (DOC)
Juneau, Alaska
POSITION STATEMENT: Presented a report from the Department of Corrections (DOC).

COLLEEN PATRICK-REILLY, Mental Health Clinician
Department of Corrections
Anchorage, Alaska
POSITION STATEMENT: Provided additional information from the Department of Corrections (DOC).

SUSAN OHMER, Executive Director
Petersburg Mental Health Services, Inc.
Petersburg, Alaska
POSITION STATEMENT: Presented a report from the Petersburg Mental Health Center.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 3:17:02 PM. Representatives Wilson, Roses, Fairclough, Keller, Seaton, Cissna, and Gardner were present at the call to order. Also in attendance were Senators Davis, Dyson, and Thomas.

Substance Abuse and Mental Health Strategies

3:17:29 PM

CHAIR WILSON announced that the only order of business would be a presentation regarding Alaska's mental health care history and the challenges of providing behavioral health care.

3:21:00 PM

JEFF JESSEE, Chief Executive Officer, Alaska Mental Health Trust Authority (AMHTA), Department of Revenue, informed the committee that Alaska's behavioral health system is severely challenged to meet the needs of the state. However, a positive step toward moving forward has been taken in the recognition of the connection between mental health and substance abuse. This recognition has resulted in the critically important realignment of the administrative and budget structures to reflect behavioral health, which integrates both substance abuse and mental health services. This is critical because of the need for providers to work together, and also because of the large overlap of people with co-occurring disorders. In the past, procedures have prevented people from getting the integrated care that is needed. However, there are still challenges to be met; for example, funding mechanisms still reflect the past systems for delivering care and are not meeting the needs of today. In fact, mental health systems grew up under a medical model and can still be successfully billed under a primary third party mechanism like Medicaid. But, unlike mental health, substance abuse services are poorly reimbursed by the Medicaid system. Mr. Jessee reminded the committee that, a number of years ago, the state refinanced the vast majority of general fund mental health and substance abuse grants into the Medicaid program in order to achieve the benefits from leveraging the funds. There were problems with this and AMHTA advised that the Medicaid program is a dependent-creating entity because a patient must demonstrate a permanent disability; a health system that gives an incentive for a patient to declare permanent disability is not desirable. Also, with Medicaid dependence, patients are dependent upon federal policy decisions. The federal government is very concerned with the cost of Medicaid and thus is systematically ratcheting back on eligibility and reimbursements, which will result in additional expense to the state budget. Additionally, when funding for care is dependent on Medicaid, providers must wait for people to get worse and destitute before they can be served. Intervention and prevention grants no longer exist. This is not an issue of

whether the state will pay for services or not; the state will pay for the needs of these patients, either through the behavioral health system or through the Department of Corrections (DOC) and in emergency room visits. These costs are often unreimbursed and are spread across the rest of the system of care. Nevertheless, he expressed his belief that there is a promising future.

3:27:37 PM

MR. JESSEE stated that AMHTA, in cooperation with the Native health system, the legislature, and the Denali Commission, worked very hard on the Bring the Kids Home initiative. By reinvesting dollars in community services that had been going to out-of-state services and focusing on results, the number of kids placed out-of-state has been reduced from 425 to 260. The same can be done with behavioral health and the DOC. He opined that the DOC is the largest mental health provider in Alaska and incurs ever increasing expenses to build additional prisons and to place prisoners out-of-state. Furthermore, 40 percent of prisoners experience significant mental illness, 18 percent experience severe mental illness, and the recidivism rate is substantially higher for those identified with behavioral health issues. Mr. Jessee emphasized that these statistics can be changed with a sufficient investment strategy.

3:30:45 PM

REPRESENTATIVE GARDNER asked whether these changes can come with a redistribution of existing funds, with the addition of more funds, or both.

MR. JESSEE stated that the first step is a focused capacity expansion within the behavioral health system and AMHTA is capable of developing a plan, similar to the Bring the Kids Home initiative, to accomplish this. However, very few initiatives will save a lot of money; what they do is invest in the community by keeping the funds spent on care within the state. He advised that the DOC expansion should be used as a benchmark and to demonstrate that strategic investments in the community behavioral health system can dramatically reduce long term capital and operating costs to the state.

3:32:37 PM

CHAIR WILSON observed that the committee is studying possible solutions for the future.

3:33:10 PM

REPRESENTATIVE CISSNA shared her realization that the state has had the same problems over the course of many years; alcohol abuse and climbing suicide rates. She opined that the manner of the delivery of service is paramount; in fact, if the state partnered with the people of Alaska and had a different attitude with services, there would be a huge difference. She then asked whether legislation can encourage good health among fellow citizens.

MR. JESSEE replied yes. He stated that encouraging peer support does not have to be a large expensive government program; in fact, in Anchorage there is a community emergency system, built for $15 million by smart investments in community services. There is a proven track record of accomplishment when organizations work together and make strategic investments.

3:37:37 PM

WILLIAM HOGAN, Deputy Commissioner, Office of the Commissioner, Division of Behavioral Health, Department of Health and Social Services (DHSS), related his background in mental and behavioral health care. In 2003, DHSS was reorganized so that the Division of Mental Health and the Division of Alcoholism and Drug Abuse were merged to create the Division of Behavioral Health. Additionally, management of Medicaid dollars was given to that agency and an integrated service delivery system was created throughout Alaska. The force behind the merger was the recognition that nearly 60 percent of mental health patients have co-occurring mental and substance abuse disorders. The intent behind integration was to develop a system to better serve those individuals. Previously, substance abuse patients with mental disorders were referred for mental health treatment and their addictions were not addressed. Conversely, mental health patients with addictions were deferred treatment until their substance abuse disorder was mitigated. This merger established a system where standardized screening and comprehensive treatment for both behavioral and mental health is the reality. Ideally, the agencies are staffed with providers who are trained to treat both types of conditions and to facilitate the full continuum from treatment to recovery. In addition, those designing the merger also envisioned an array of services, from the smallest villages to large hub communities, that will begin the first steps of prevention and intervention before serious problems develop. Mr. Hogan explained that it

was felt that the merger could change the entire system; develop a model behavioral health statute, and write regulations that made clear what the eligibility requirements are and what providers, services, and rates were available. He agreed that, in some instances providers overly rely on Medicaid due to the nationwide lack of grant funding currently available for behavioral health reimbursement. This is a special challenge in Alaska, where Medicaid payments for adult substance abuse services are limited. He then focused on performance outcomes; a system was needed to answer the criticism that money was being been allocated to services that have no way to illustrate their effectiveness. Therefore, now DHSS has a mechanism by which providers can report whether a patient returns to work or school, has successful relationships, and stays out of the criminal justice system. Mr. Hogan expressed his value of the vision of DHSS that was begun in 2003.

3:45:00 PM

MELISSA STONE, Director, Division of Behavioral Health, Department of Health and Social Services, began the presentation by stating that the mission of the Division of Behavioral Health is to provide a comprehensive and integrated system that works from a basis of sound policy, effective practices, and partnerships. A review of the indicators of behavioral health conditions and social impact indicates: suicide is the highest cause of death for youth aged 14 to 19; the highest rate in Alaska is in the Northwest Arctic; and 72 percent of the suicides involve drug and alcohol use. Furthermore, suicide rates across the state are significantly higher for Natives. A national telephone health survey from 2006 illustrates the relationship between physical health and behavioral health. She noted that in Mat-Su, Soldotna, Wrangell, and Petersburg there is indicated clear partnerships between primary care and behavioral health. Ms. Stone pointed out that alcohol is the most widely used substance of abuse among American youth, although there is concern about methamphetamines and inhalants, alcohol remains the most prevalent problem nationally and in Alaska. She referred to the PowerPoint presentation "Behavioral Health in Alaska" that provided the estimates of behavioral health conditions throughout the state; the number of Alaskan adults and children experiencing severe mental illness; those with mild to severe mental illness; those with substance abuse problems; and those who did not receive treatment for alcohol [abuse]. Further, an online survey indicated that mental health illness is the most significant health related impact on lost productivity in the workplace. She continued to say that the

national societal cost is higher not to treat those who abuse alcohol and drugs than to treat them. Costs of the untreated are spread out and shared by social services, employers, prisons, hospitals, [the threat to] public safety, and insurance companies. The percentage of traffic fatalities related to alcohol is 38.9 percent nationally and 48.6 percent in Alaska. Societal costs in Alaska are costs to: productivity, the criminal justice system, the health care system, the public assistance system, and public safety.

3:52:16 PM

MS. STONE introduced the idea of a comprehensive array of services throughout the state; the organization of services breaks down the vast areas of the state into levels 1 through 5, from the frontier village through the metropolitan areas. Citizens living in Level I areas expect a community health aide and itinerant health care services to provide health and social services; in Level 3, citizens would expect private and government health care, and a social services system. The capacity of levels throughout the state, relative to government, economy, and health and social services access, indicates where the level of behavioral health care services is warranted. Ms. Stone stated the DHSS goals of performance based funding: the assessment of access to an array of services throughout the state, from prevention to outpatient treatment for substance abuse and mental health; the comparison of clients served; the prevalence estimates; and the funding received in each region. Ms. Stone continued to explain that the current behavioral health provider system is an integrated system, consisting of 103 behavioral health treatment and recovery providers, 64 prevention and early invention grantees, and a staff supported psychiatric hospital licensed for 80 beds. In 2007, 5,413 substance abuse clients were served; 9,034 seriously emotionally disturbed youth were served; 15,384 adults with serious mental illness were served; 42,000 emergency contacts were made; and 1,231 clients were admitted to the Alaska Psychiatric Institute (API).

3:57:04 PM

REPRESENTATIVE SEATON asked whether the emergency contacts are also counted in the number of clients served for various levels of treatment.

MS. STONE responded that an emergency contact may, or may not, be a person with a serious illness.

REPRESENTATIVE SEATON surmised then that there may be 20,000 emergency contacts that are not in any other category.

MS. STONE said yes. She clarified that the emergency system is set up throughout the state for crisis intervention. These contacts do not necessarily involve a seriously ill mental patient who is receiving services; the calls are simply a crisis contact and are counted each time a call is received.

3:58:56 PM

CHAIR WILSON asked whether an emergency room or a clinic's call for support is counted.

MS. STONE replied yes. A telephone contact may be a client, a health care provider, an agency, a jail, or a person walking into a clinic or emergency room.

3:59:55 PM

REPRESENTATIVE ROSES asked whether subsequent referrals were included in the count.

MS. STONE said no.

4:00:17 PM

MS. STONE continued to explain that the DHSS screening indicates that 57 percent of clients statewide show signs of a dual diagnosis. The client satisfaction status review results for 2006 is the collection of aggregate data for the state and indicates that 78 percent of adults, and 81 percent of youth, were satisfied with service from the provider. She informed the committee that consumer satisfaction surveys are compiled from youth, children, and adults.

4:01:59 PM

REPRESENTATIVE GARDNER asked when the satisfaction surveys are collected after treatment.

MS. STONE answered that the surveys are mailed to clients annually.

4:02:46 PM

MS. STONE spoke again about the success of the Bring the Kids Home initiative. She then pointed out that the telemedicine delivery of psychiatric care is important to reach rural areas of the state. A brief discussion of the challenges to care begins with the shortages of qualified providers, and directors, in the workforce.

4:04:12 PM

REPRESENTATIVE CISSNA asked whether there is adequate funding for health care training programs.

MS. STONE deferred this question to Mr. Jessee.

4:05:07 PM

MS. STONE acknowledged that a further challenge is performance based funding; the need to be accountable is recognized by providers and requires changes in the way they do business. In 2009, there will be more data available on which to base decisions for performance based granting. Other challenges to providing care include: geographic challenges; distribution of grants throughout the regions to provide an array of services; economies of scale; outreach; and transportation. Outreach and transportation are necessary costs uncompensated by Medicaid. The significance of cultural differences, particularly when standardizing data and accounting for patient care down to the minute, is great. Finally, Ms. Stone pointed out the challenge of balancing support and accountability with providers. Providers are running businesses that are becoming more complex and challenging; it is important to support providers so that they can provide service and thrive in order to meet needs of the people across the state.

4:09:33 PM

GORDON HANES, Vice President, Behavioral Services Division, Southcentral Foundation (SCF), presented his review of the Alaska Native health care system and the emerging opportunities that are possible when SCF is able to partner with the state. He reminded the committee of the legislative landmarks that are the keys to understanding the Native health care system: the Alaska Native Claims Settlement Act (ANCSA); the Indian Self-determination and Education Assistance Act of 1975, Public Law 93-638, that provides tribes three options for the delivery of health care; and the Indian Health Care Improvement Act, Public Law 94-437.

4:12:30 PM

CHAIR WILSON asked which option for the delivery of health care was chosen under the Indian Self-determination and Education Assistance Act.

MR. HANES answered that the Alaska Native tribes elected to compact health care with the government.

4:12:49 PM

MR. HANES further highlighted key dates. The SCF was chartered by the state in 1982 under the direction of the Cook Island Region, Inc., (CIRI). He explained that SCF is the designated tribal health care authority and is responsible for the health care functions for that region. In 1994, the Alaska Native Tribal Health Compact was established to begin self-governance over the federal financial health care resources designated for the Indian people and Alaska Natives. Mr. Hanes pointed out that the Alaska Native Tribal Health Consortium (ANTHC) was formed in 1997 and provides specialty medical care, community health services, construction of water and sanitation facilities, information technology, training and educational support, and further statewide Indian Health Service (IHS) functions. In addition, with SCF, ANTHC co-owns and co-manages the Alaska Native Medical Center. He noted that ANTHC is owned by all Alaska Natives and their regional corporations. He compared the early days of Southcentral Foundation with today and stated that SCF's annual budget is $150 million. Further, SCF owns and operates the Alaska Native Primary Care Center (PCC) on the campus of the University of Alaska, Anchorage (UAA). Thirty percent of all Alaska IHS beneficiaries are active users of SCF facilities.

4:16:28 PM

MR. HANES continued to explain that the Behavioral Services Division of SCF includes two out-patient clinics, residential treatment for adolescents, group homes for adolescents, transitional living support, and a residential treatment program for pregnant women and new mothers, a day treatment center for the mentally ill, an elder program, and two head start programs. SCF sources of revenue come from IHS compacting funds, Medicaid, federal grants, and the small state grants that open the door to Medicaid. Mr. Hanes stated that IHS funds are disbursed annually on a regional basis and SCF is struggling to provide

services for those who are coming into the Anchorage area from other regions.

4:18:55 PM

CHAIR WILSON asked for a breakdown of the third party revenue.

MR. HANES answered that third party revenue consists of Medicaid, Medicare, and private insurance. In response to a question, he further clarified that IHS money is an annual appropriation that SCF augments with third party revenue.

CHAIR WILSON surmised that a problem is created when regional money does not follow a patient to Anchorage or another urban area.

MR. HANES said that, unfortunately, [the funding] is a federal issue.

4:20:29 PM

REPRESENTATIVE CISSNA related that costs are increasing in rural areas; for example, Dillingham mail cost increased $1 per pound. Managers of rural health facilities complain that, even with increased administration costs, there is still population growth, although some areas are losing the breadwinners. She also pointed out that, especially in the university medical area, the number of patients is weakening the capacity for service.

MR. HANES noted that SCF has determined that a disproportionate number of elders, with their higher medical expenses, are moving to urban areas.

4:22:51 PM

MR. HANES informed the committee that the federal government's appropriations to fund American Indian and Alaska Native health care are far below what is provided to other populations and has been for quite some time. Further information on funding revealed that the Federal Medical Assistance Percentage (FMAP), Early & Periodic Screening, Diagnosis and Treatment (EPSDT) and continuing care agreements are the basis for the funding that enables SCF to provide services. FMAP reimburses to the state a portion of Native health cost to Medicare. As a part of Medicaid reform, the Pacific Health Policy Group identified $220

million currently paid to non-tribal providers for services to tribal members.

REPRESENTATIVE GARDNER surmised that the state could save money if tribal organizations were providing services to tribal members.

CHAIR WILSON clarified that a doctor, providing service through SCF, would receive payment from Medicaid and not the state.

4:26:17 PM

MR. HANES continued to explain that EPSDT is a federal law that requires that all Medicaid eligibles, under the age of 21, receive early and periodic screening and treatment. He reported that Alaska has not been meeting this requirement; in fact, the state Medicaid office established continuing care agreements in order to improve screening rates. These agreements provide cost-based reimbursement for screening and treatment and have resulted in the present success in identifying Medicaid eligibles, registration, and screening. When these services are provided by a tribal organization, there is no cost to the state.

4:28:10 PM

CHAIR WILSON asked whether a physician, working under SCF, maintains independence.

MR. HANES said that he would discuss this subject later in the report.

4:28:41 PM

REPRESENTATIVE FAIRCLOUGH informed the committee that American Indians and Alaska Natives are disproportionately represented in populations with pre-diabetes symptoms. She asked whether pre-diabetes checks are performed even though the screening is not covered.

MR. HANES expressed his belief that EPSDT is for Medicaid eligibles under 21, and thus a complete screening, one that seeks to identify pre-diabetic conditions, is done.

REPRESENTATIVE FAIRCLOUGH asked whether diabetes is more prevalent in Alaska due to the high rate of obesity. She said she was glad for EPSDT screening and that there has been

pressure on the state to consider including pre-diabetes screening in insurance coverage; money would be saved in the long run. She expressed her interest in the success rate of pre-diabetes screening for youth.

MR. HANES stated that he could provide that information.

4:31:09 PM

MR. HANES related that the EPSDT screening began at below the state average; now, Alaska is well above the state average for eligibles under 21.

4:32:06 PM

REPRESENTATIVE FAIRCLOUGH asked for the number of children, under 21, that are insured versus those who have access to health care. She recalled that testimony from DHSS has been unable to provide the exact number of Native Alaskans, under 21 years of age, who have access to care; specifically the contrast of how many youth, 21 and under, whom have access to service versus how many are insured for service.

MR. HANES agreed that eligibility is very different than access; however, he felt that the information could be determined through the regional corporations.

REPRESENTATIVE FAIRCLOUGH made a formal request for the aforementioned information.

CHAIR WILSON concurred.

MR. HANES said SCF would try.

4:35:13 PM

REPRESENTATIVE CISSNA observed that the tribal health consortium has a huge responsibility; however, in many very small communities, telemedicine provides better care than in Anchorage because everyone is working together, at one time, with the screening information. She asked whether there has been an effort to put together the current status of health care on a community-by-community basis.

MR. HANES agreed about the difficultly of coordinating care. He acknowledged that telemedicine is a growing entity and

behavioral care is pushing ahead with telepsychiatry resulting in exciting outcomes.

4:37:43 PM

MR. HANES discussed an on-going pilot project between SCF and the state that looks at managed behavioral health care for tribal beneficiaries. Another specific partnership, the Bring the Kids Home Initiative and the Residential Psychiatric Treatment Center (RPTC) development, is the result of unprecedented partnerships between the Denali Commission, the state, and a tribal organization. The RPTC will bring care for kids, 40 percent of which are Native, home to Alaska. Furthermore, care provided by in-state tribal organizations will reap financial and health benefits to the state. The projected opening for the RPTC, located in Eklutna, is two years from now. He concluded by emphasizing the importance of FMAP, EPSDT, continuing care agreements, and the state's partnership, to the SCF and its efforts to provide services.

4:41:48 PM

DWAYNE PEEPLES, Deputy Commissioner, Office of the Commissioner, Department of Corrections (DOC), informed the committee that the DOC operates 12 in-state facilities and is one of five states that operate unsentenced jail services and sentenced prison services in all facilities except for Spring Creek in Seward; additionally, prison services are leased at Red Rock Correctional Center in Arizona. The incarcerated population is beginning to accelerate in the number of bookings and will likely hit 38,000 bookings and 22,000 offenders, in and out, which is up from about 16,000 offenders in 2001. He mentioned that, historically, DOC experiences spikes such as now, and included in that percentage is a higher percentage of bookings from the mentally ill. He explained that services provided by DOC include mental health clinicians, or contractors, in all facilities and telepsychiatry. He stated that there is a total of 43 staff in the mental health field. In fact, there are two major acute mental health units; one at the Anchorage jail with 28 beds, and one at the Hiland facility with 18 beds. There are three sub-acute units: Spring Creek in Seward, Hiland Mountain, and Palmer Correctional. He stated that the mental health release programs target individuals returning to society so that they may receive support systems in the mental health environment in order to stop recidivism. Some of increases in bookings are associated with the increased failure of released inmates in a community setting. Mr. Hogan stated that the DOC

can lay claim to being the largest single mental health care provider; a draft study of the DOC and mental health inmates revealed that approximately 40 percent to 43 percent of the inmate population would qualify for mental health care under the trust. This is growth from a previous benchmark of about 35 percent. He continued to say that the mental health staff has about 12,000 mental health inmate contacts annually and there has been a 40 percent jump in mental health contacts from 2001 through 2006. Many inmates have had previous contact with the Alaska Psychiatric Institute (API); in fact, approximately 15 percent of the mentally ill offenders have been admitted to API at one time. He concluded that the increase of former API patients in the offender population is due to inadequate community housing and poor follow-up with drugs and services to the mentally ill.

4:49:19 PM

MR. PEEPLES stated that the DHSS is attempting to qualify existing clients for pre-release by establishing Medicaid eligibility under the social security system; in fact, it is trying to put more effort in providing outpatient pre-release planning and services.

4:49:47 PM

COLLEEN PATRICK-REILLY, Mental Health Clinician, Department of Corrections, informed the committee that she has seen some positive changes by the DOC. She explained that the DOC now has in place four targeted mental health release programs. One is for felony offenders who are going to be released on felony probation or parole and who have a psychotic disorder. This is a mandatory program and staff work closely with probation officers and community providers to establish effective programs to prevent new offenses. In addition, there is the Anchorage Mental Health Court; DOC manages the Jail Alternative Services (JAS) portion of that program which has a total caseload of 80. She noted that the committee will probably be approached to expand the service provided by the Anchorage Mental Health Board. There is also (indisc.) mental health court program that operates with a broad diagnostic caseload. Also, Ms. Patrick-Reilly described a new initiative called Assess, Plan, Identify, Coordinate (APIC) and that is based on a national best practices initiative through the national New Freedom Commission on Mental Health. In 2007, APIC funds will be used to include other agencies with contracts for management and services. She said that the DOC feels strongly that interagency collaboration is a

key component for success. APIC will link individuals to services, medication, housing, and benefits, and will begin assisting inmates pre-release and after release. Community providers will continue services directly with the beneficiary. Ms. Patrick-Riley stated that the state has a real problem with connecting individuals to the appropriate array of community-based services, including safe and sober housing; currently there is no halfway or transitional housing that is acceptable for mentally ill and behaviorally challenged individuals. Furthermore, there are no housing options in the community for the most seriously mentally ill and behaviorally challenged individuals. Management after release for these sub-populations, such as mentally ill offenders who have committed sex offenses, is not working well.

4:55:38 PM

MS. PATRICK-RILEY continued to explain that the delivery of services, from 2002 to the present, has changed. She opined that a reduction in mental health services directly correlate to the increased DOC booking numbers. The DHSS budget shift to Medicaid does not target all individuals and even individuals who are covered by Medicaid lack the level of services that were available prior to the shift. Thus, DOC is the default provider of mental health services. She expressed her belief that agencies are discussing options to improve critically needed funding for community based services. Ms. Patrick-Riley continued to explain that agencies have a Memorandum of Understanding in place to expedite social security applications for individuals exiting DOC who have severe mental illness; this program is the first in the nation. Additionally, Alaska was selected for funding as a SSI/SSDI Outreach, Access and Recovery (SOAR) Project site; a special program that will assist homeless mentally ill individuals to complete social security applications. Ms. Patrick-Riley turned to the subject of the mental health workforce and said that, in her experience, mental agencies are losing workers due to the size of caseloads, lower pay, and challenging clients. She concluded by saying that the 66 percent recidivism rate within the DOC is a community problem that lessens with the implementation of mental health release programs.

4:59:34 PM

MR. PEEPLES added that the DOC has three residential substance abuse treatment program sites: Wildwood, on the Kenai Peninsula; Red Rock, in Arizona; and Hiland Mountain.

5:00:02 PM

REPRESENTATIVE CISSNA asked for the presenters to send information on the linkage of what the DOC is doing with the dual diagnosis with alcoholism. She shared that inmates have a difficult time getting services, such as Alcoholics Anonymous (AA), in the correction system.

MR. PEEPLES said that the information will be forthcoming.

5:01:56 PM

MR. JESSEE informed the committee of the possible role of the AMHTA; it can be the venture capital funder for an initiative around rebuilding the state's community behavioral health system. He stated that AMHTA has the experience to provide the venture capital once the legislature makes the policy decision to act on this issue. AMHTA can fund studies and front pre-development costs. He emphasized the challenge of maintaining a balance between grants and Medicaid; refinancing in mental health is accepted, but Medicaid is not enough. Sufficient grant resources are also needed to provide comprehensive services and early intervention services. Mr. Jessee reiterated how critical the Native health organizations are in the successful treatment of behavioral issues in the community. Substantial funding can be gained by getting Native health organizations fully engaged as partners with the state and much more can be done. He turned to the subject of the workforce and said that there is no way to retain a workforce when salaries and benefits are limited because of a rate structure that is decades old. In fact, at least two community mental health centers are struggling with deficits due to inflation and increased costs of overhead. The closures of community mental health centers will be an unwelcome shock to the public welfare. Secondly, the lack of training programs will continue to contribute to the statewide 13 percent vacancy rate. At the Anchorage Mental Health Center there is a 24 percent vacancy rate due to a rate reimbursement structure that does not support salaries sufficient to recruit and retain qualified staff. A further challenge continues to be housing; if not provided with safe, affordable, and supported housing, those who exit corrections and API will be returning to the system at a high percentage. Case management and 24 hour backup is needed for behavioral health clients to prevent their eviction and homelessness.

5:08:35 PM

REPRESENTATIVE CISSNA recalled that the state has repeatedly funded wonderful programs; however, they are episodic, such as the Alaska Youth Initiative Program (AYIP), and are discontinued when funding is cut. She emphasized that the legislature must be educated as to what is needed to continue these programs.

5:11:21 PM

SUSAN OHMER, Executive Director, Petersburg Mental Health Services, Inc., informed the committee that, in the last 14 years, Petersburg Mental Health has transformed from a satellite office that served less than 40 people per year to an independent center serving over 400 people per year. She said that the center does whatever is necessary to assist clients to live independently, avoid institutionalization, and function at the highest level possible. The center receives funding from the state for operations and also generates revenue from Medicaid, third party billings, and fundraising. Her agency works hard and is accountable to the legislature for its funds. However, many recent accountability efforts have resulted in reducing the center's ability to provide services to its clients, have negatively affected clinical care, and have weakened the center's effectiveness. Ms. Ohmer explained that the result of these changes is devastating. She suggested that, without a base funding for small, regional, mental health centers, the state must build more prisons and hospitals. Some of the issues are: revenues have not kept pace with expenses over the past ten years; unfunded mandates such as the Management Information System and the onerous Medicaid documentation requirements; the consolidation of substance abuse and mental health components that resulted in the loss of staff and funding yet tripled the number of clients; increasing administration requirements that have resulted in the elimination of one clinical position. Her frustration is that her center will continue to gain auditors and lose clinicians to serve clients. Ms. Ohmer pointed out that the center must reduce its clients from 400 to 300 annually, due only to the additional administrative costs.

5:14:00 PM

MS. OHMER continued to say that, as a director, she is unable to continue to serve a full caseload and must spend more time on administrative tasks. She also stressed that her time is increasingly spent on bolstering the morale of her staff who are

bogged down with administrative demands that are in conflict with appropriate clinical care. Unlike many rural centers, her center has had high staff retention and a high employee satisfaction rate until recently. Furthermore, she pointed out that the state is moving from a grant based to a performance based system of funding; what that means for a small center is that money has been cut based on a formula that is flawed. From the community perspective, this process does not reflect a system of accountability, but is a rationale for making budget reductions. Ms. Ohmer stated that the funding reductions will further hamper her ability to provide the accounting necessary to prove results. She cautioned that state accountability expectations are high, even though there has been little advance notice given to providers, limited involvement of providers in developing the system, and no time for providers to build capacity to respond to the initiative. Ms. Ohmer expressed her disappointment that funding will be based on criteria that she did not have sufficient time to prepare for. Furthermore, this performance matrix system requires accuracy and a validity of judgment; the variety of environments across the state makes these judgments very difficult to understand. She emphasized that one behavioral health center in a small community must serve all of the community and cannot limit its care to priority populations. If decision makers are mislead by the measurement instruments, service to prevent clients from moving into severe mental illness may end. She emphasized that improving the quality of behavioral health care statewide is important; nevertheless, quality improvement should also entail a devotion of resources and a process of preparation.

5:24:18 PM

MS. OHMER continued to explain that the Division of Behavioral Health announced that providers need to be nationally accredited. This action, although welcomed, is another unfunded mandate placed on local agencies. She observed that providers are being pulled in opposite directions; staff is working 50 hours per week, including Saturday and Sunday, and is on call 24 hours per day. The reduction of grants will mean that more cases are refinanced under Medicaid; however, the scope of Medicaid eligibility is being limited by state budget constraints. She re-stated that mental health care in the state will be provided by prisons and hospitals if local centers and clinics are forced to close. This is the most expensive way to care for behavioral health constituents. She assured the committee that everything is being done to ensure accuracy in accounting, particularly for Medicaid billing. Ms. Ohmer

concluded by saying that providers look to the committee to consider the issues in funding and to advocate for a reasonable base amount of funding to support services in the smaller communities.

5:29:20 PM

REPRESENTATIVE ROSES commented that his investigation into this new accountability system will continue.

5:29:48 PM

CHAIR WILSON recalled that the grants will pay only for emergency mental health clients; others are not included. This results in a low funding base that is not sufficient to cover clients not in crisis, such as those in schools.

MS. OHMER confirmed that there are priority populations for services and state grant funds must only be used to provide services for those priority populations. This system provides a way for the state to record whether providers are effective and efficient. However, providers see many clients who need services, but do not qualify as a member of a priority population and thus, the center has to raise money in other ways to support the staff to serve those people. Essentially, the providers are penalized for providing services that might prevent those not in priority populations from becoming severely mentally ill.

5:32:22 PM

REPRESENTATIVE CISSNA recalled visiting Petersburg and seeing the amazing work being done there and in other communities; there is a need to make sure that these small health care clinics survive.

5:33:23 PM

CHAIR WILSON requested, from each presenter, a list of things that need to be accomplished either with, or without, action by the legislature.

5:34:32 PM

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 5:34:42 PM.