FY96 accomplishments

The key goal for 1996 was to generate over $1 million in revenue for the Trust at a cost of no more than $700,000. The Trust Land Office exceeded this goal by generating approximately $1.4 million in revenues at a cost just under $560,000. The principal sources of 1996 revenue were timber sales, land leases and mining claims as described in the figure above. Other accomplishments are summarized below:

Trust Land Management Report Card

INCOME

√ Increased Trust land revenues by over 250% from FY95 with receipts coming from activities associated with over 20% of the Trust land portfolio.

SETTLEMENT CLOSURE

√ completed final preparations for the conveyance of approximately one million acres to the Alaska Mental Health Trust Authority.

√ published regulations for management of Trust lands, with adoption expected by January 1997.

LAND

√ actively managed over 130 existing land leases by inspecting sites, enforcing non-compliance and revising agreements as necessary to ensure consistency with Trust management principles.

√ increased land lease rents from approximately $170,000 due in 1996 to over $500,000 in 1997 (over 200 percent increase).

√ initiated a school site land exchange with the Municipality of Anchorage.

√ sold 25 subdivision parcels scattered throughout the state.

TIMBER

√ sold five million board feet of Trust land timber, worth approximately $1 million, as the first in a series of timber sales at Icy Cape (received approx. $500,000 in FY96).

√ completed an assessment of Trust land statewide timber resources for use in developing long-term timber management strategies.

√ sold 324,000 board feet of Trust land timber at Moose Pass.

MINERALS

√ managed over 1,500 valid existing mining claims on Trust land.

√ approved mineral policies and initiated a program to encourage mineral exploration interest in Trust land.

√ monitored Fort Knox developments and prepared for commencement of gold production and associated royalty payments.

√ issued three mineral exploration licenses which affect over 20,000 acres of Trust land.

COAL, OIL AND GAS

√ leased 1,600 acres of Trust oil and gas resources involving three leases in the Cook Inlet region.

√ facilitated the assignment of two coal leases containing Trust land and the issuance of a coal mine permit in the Matanuska Valley.

√ prepared to offer for lease in December 1996 approximately 70,000 acres of Trust land in the Cook Inlet Basin.

OTHER

√ ensured that applicants for use of Trust land pay the actual cost of processing the use applications.

√ completed a full set of color, GIS Trust Land maps to identify Trust land locations and opportunities.

√ developed and implemented standard form documents to be used in Trust land transactions, including lease, sale, assignment, license and rights-of-way documents.

√ received the first donation of real estate to the Trust: 26 acres on the Kenai Peninsula.

FY97 goals

Primary FY97 Trust Land Office goals are to adopt regulations by January 1997; increase revenues by 38 percent to $2 million with operating costs of less than $700,000; and to develop a long-term asset management plan with the Trustees. Revenue increases will be related primarily to the new waterfront lease in Juneau and gold royalties associated with the Fort Knox mine. The Trust Land Office will place emphasis on developing new opportunities associated with timber, oil, gas and mineral resources, as well as actively managing existing permits, leases and contracts. Adoption of regulations is necessary to facilitate increased revenue production.

Beyond FY97

Beginning in FY98, the Trust Land Office intends to manage Trust land in accordance with the adopted regulations and the long-term asset management plan. Revenues are expected to increase by an average of about 18 percent through 2001. While operating costs will increase in FY98 and likely remain stable through 2001, the Trust Land Office expects to make significant investments in the development of new revenue-generating activities consistent with the asset management plan approved by the Trust Authority. Examples of investments are real estate subdivision costs, minerals marketing costs and increased timber sale planning.

Context for Implementing the Comprehensive Integrated Mental Health Program

Overview

The Department of Health and Social Services, in conjunction with the Trust Authority, is responsible for writing a plan that describes the Comprehensive Integrated Mental Health Program. The Comprehensive Integrated Mental Health Program includes more than traditional mental health services. It includes services for people who have mental illnesses, developmental disabilities, alcoholism, Alzheimer's disease and related dementia, and services for children, youth, adults, and seniors with mental disorders. The mental health program also includes but is not limited to 24-hour emergency services; screening and evaluation services required for involuntary commitment; inpatient care; crisis stabilization; a variety of treatment, case management, daily structure and support, residential, vocational, outpatient screening, and diagnostic services; prevention and education services; and the administrative costs of providing services.

According to statute, the Comprehensive Integrated Mental Health Program must give priority in service delivery to persons who, as a result of a severe and pervasive disorder, may require or are at risk of hospitalization; or experience such major impairment of self-care, self-direction, or social and economic functioning that they require continuing or intensive services. The Comprehensive Integrated Mental Health Program includes services to non-beneficiaries.

Guidelines for Establishing Services

To establish service priorities for the Comprehensive Integrated Mental Health Program, the Trust Authority and four boards each follow their own principles and guidelines. Each board or commission has general principles in common with the others. The boards base service priorities on all or a combination of several of these:

- state plans for services;
- documented need from providers and advocates;
- documented need from beneficiaries, from testimony and waiting lists;
- whether services meet that board's desired outcomes and service principles;
- whether the service has been funded historically in the GF/MH base;
- whether the service enhances the level of care received by beneficiaries in their community; and
- whether eligibility for the service or benefit is based on criteria other than Trust beneficiary status.

The Trust Authority's guidelines are derived from the settlement statute, which states in part:

> *...provision of services shall be based on the principle that services paid for from the trust are provided to recipients as close to the recipient's home and family as practical with due consideration of demographics, mental health service requirements, use of mental health services, economic feasibility, and capital expenditures required for provision of minimum levels of service...AS 47.30.046(b)(5)*

Guiding Principles

In February 1996, the Trust Authority adopted guiding principles for the Comprehensive Integrated Mental Health Program, the plan that describes the program, and Trust funding. These principles serve as a guide for recommending program changes and funding, and will be reviewed annually. The guiding principles are:

CREATING THE COMPREHENSIVE PLAN	
Agent for change	The plan is for use as an agent for change.
Inclusion	Planning needs to be an inclusive process—including inviting many people to participate in the process.
Common principles	The plan should use principles shared by Boards and administration, such as providing services close to home, etc.
Outcome-oriented	The plan should be oriented to consumer functional outcomes rather than defined by detail/process.
Data	There must be accurate data for planning use. The purpose of this data is to assist in creating & evaluating the comprehensive plan.
Measurable	The plan must have benchmarks and be measurable.
A blueprint	The plan should be a working document and used as a blueprint to work from, toward funding, priority, concepts of service rather then too many specifics.
COMPREHENSIVE PROGRAM	
Innovation	An integrated Mental Health Program must be innovative, imaginative, and forward thinking.
Integration	Integrating services and resources where efficiency, effectiveness, and access are enhanced is a priority.
Early intervention and prevention	The mental health program may include services for populations broader than the beneficiary groups without expanding beneficiary group definitions. It could include prevention or early intervention services for persons at risk of becoming beneficiaries. The Trust considers prevention of these conditions, where possible, to be part of its mandate.
Education	Educate the public and beneficiaries regarding the needs of the beneficiaries, resources available to meet those needs, and strategies for prevention.
Targeted resource use	We should target time-limited resource use at appropriate level at time of need in order to prevent higher level long term use of resources.
Customer driven services	The program is for beneficiaries, not services, and is of value to individuals/ families/ groups of beneficiaries.
Parity	Program outcomes address service system parity.
FUNDING SYSTEM	
Time-limited	We maximize Trust Income for time-limited short term operating and capital funds, using general fund-mental health for ongoing funding.
Change agent	Trust income is used for Comprehensive Integrated Mental Health Program change.
Funding is customer-driven	The funding system provides consumers with a choice of services and providers. Program funding should follow customers.
Cost sharing	Beneficiaries should share the costs of services.

Forecast of the Number of Persons Requiring Services

Defining the beneficiaries of the Trust

Alaska Statute 47.30.056 defines the four groups of people considered Trust beneficiaries, usually described as people with mental illness, developmental disabilities, Alzheimer's disease and related dementia (ADRD), and chronic alcoholics with psychosis. To further define these populations, the Trust asked the relevant planning boards to explain how they each define the beneficiary groups for which they plan.

Each board defines the group for which they plan slightly differently, which results in significantly different counts of beneficiaries and the services they use.

Each board defines the group for which they plan slightly differently, which results in significantly different counts of beneficiaries and the services they use. For example, one board defines the group of Trust beneficiaries for which it plans by medical diagnosis as identified by providers in treatment, and further screens them by behaviors they must exhibit. Individuals with similar needs but who have different diagnoses are not considered to be Trust beneficiaries. Another board uses a functional definition to identify and describe beneficiaries and their needs, and does not consider diagnosis significant. Tables describing the differences between the Trust's statutory descriptions of the beneficiaries and the boards' descriptions and interpretations follow in the appendix.

To identify the number of beneficiaries, three of the four boards use variations on national prevalence data. The Advisory Board on Alcoholism and Drug Abuse provided national data, but is refining that information to ensure its relevance to Alaska. This information about chronic alcoholics with psychosis is particularly suspect because the federal agencies proposing the prevalence rate use indicators that are different from those of the state's Advisory Board on Alcoholism.

Alaska-specific prevalence data are difficult to identify, however, and each board uses a combination of the national data compared with use of some services by the people they define as Trust beneficiaries. Each board and the state departments and divisions which administer the services state that the information they have available is less than accurate. Prevalence data is not necessarily an indicator of service need, however. Some individuals do not need publicly funded services because they have private supports. Conversely, some require assistance but do not seek out help from which they could benefit. Alaska's alcoholics, for example, do not identify substance abuse treatment as a need in proportion to federal prevalence estimates.

If the prevalence data were correct, then almost 69,000 Alaskans would have been beneficiaries of the Alaska Mental Health Trust in 1995—fully 11 percent of the state's population.[1]

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[1] Williams, J.G. (1996). Alaska Population Overview: 1995 estimates. State of Alaska, Department of Labor: Juneau.

Prevalence Estimates of Trust Beneficiaries

Beneficiary group	*age group*	*FY95 prevalence*	*Totals*
People w/ mental illness	3-18	9,322[2]	
	19+	19,645[3]	
subtotal			*28,967*
People w/ DD[4]	birth-2	626[5]-3,500	
	3-21	3,165-3,500[6]	
	22-64	6,527	
	65+	468	
subtotal			*10,786*
Chronic alcoholics with psychosis	adults	26,280[7]	
subtotal			*26,280*
People with ADRD	65-74	757[8]	
	75-84	1,184	
	85+	840	
subtotal			*2,781*
Total			**68,814**

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[2] The Alaska Mental Health Board used both draft federal Substance Abuse and Mental Health Services Administration (SAMHSA) national estimates and state DMHDD estimates of prevalence of serious emotional disturbance among children.

[3] AMHB used draft SAMHSA prevalence estimates to determine the number of Alaskan adults who are beneficiaries of the Trust. AMHB applied that estimate to the non-military population of the state, and considers 93% of the resulting population to be Trust beneficiaries based on a sample of community mental health center client bases. The number of adults with mental illness that AMHB does not consider to be Trust beneficiaries is 1,479. Using the same process, AMHB considers 702 children and youth with severe emotional disturbance to be outside of Trust beneficiary status.

[4] The actual prevalence rate of children with developmental disabilities may be much higher than the national average. Approximately 2,400 births per year of babies with fetal alcohol-related neurological deficits(State Division of Alcoholism and Drug Abuse, according to Governor's Council report). As many as 19,570 Alaska children experience health problems requiring special care (Dick, S.E., 1992, An Estimate of the Number of Children with Special Health Care Needs in the State of Alaska, University of Illinois: Chicago). According to the Division of Public Health, Section of Maternal, Child and Family Health, roughly 3,500 infants and toddlers require early intervention services to prevent or ameliorate disabilities, reducing the need for more intrusive and extensive supports, not 626 as national prevalence rates would imply.

[5] Gollay, E. (1981). Summary report on the implications of modifying the definition of a developmental disability. U.S. Department of Health, Education, and Welfare.

[6] 3,500 children with developmental disabilities received services through the public education system in FY95. Department of Education, Annual Data Reports Part 1: 1994-95 School Year, Juneau, Alaska, as reported by the Governor's Council. 12,815 children with disabling conditions were served solely within the educational system, comprising 6.83% of the population of all children and youth ages 3 through 21.

[7] Grant, B.F. et al (1992). Prevalence of DSM-iV alcohol abuse and dependency. NIAAA Epidemiological Bulletin (35). According to the federal National Institute on Alcoholism and Alcohol Abuse, 4.38% of Americans are considered to be alcohol dependent using criteria similar to that of ABADA's definition of a chronic alcoholic with psychosis. The national criteria are slightly more generous than the ABADA's definition of a chronic alcoholic with psychosis, so the percentage could be considered slightly higher than actual prevalence. At the same time, the percentage could be considered conservative. It is based on national demographics which are not entirely relevant to the state of Alaska, which has a lower African American population base and a significantly higher population of Alaska Natives. Statistically, Alaska Native people have higher addiction rates. ABADA staff believe that the 4.38% prevalence rate is fairly accurate, although they will be adjusting the rate in the next few months to test accuracy.

[8] Estimates derived from Evans, D.A. et al. (1990) Estimated prevalence of Alzheimer's Disease in the United States. The Milbank Quarterly v.68(2):267-290, as cited by ACoA.

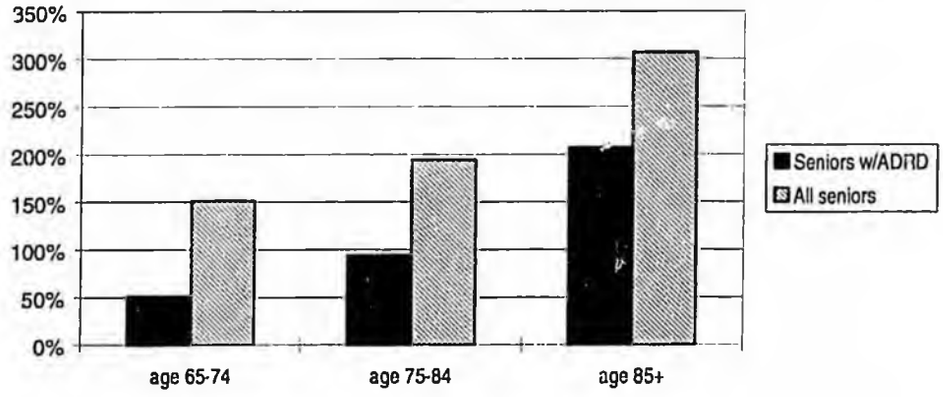
The Trustees intend to continue to persuade the system to develop more accurate, consistent, and comprehensive information. Some planning and funding issues, however, rise from existing information. For example, when prevalence data are overlaid with estimates of senior population growth in the next fifteen years, it can be seen that the demand for services for people with Alzheimer's disease and related dementia (ADRD) will increase significantly. The following table describes projected growth of the numbers of older Alaskans and Alaskans with ADRD based on Department of Labor population statistics and the national prevalence data estimates for ADRD.

Population increase 1995 to 2010
Estimated percent

	All seniors	Seniors w/ADRD
age 65-74	151%	51%
age 75-84	194%	94%
age 85+	307%	207%
total 65+	172%	116%

Presented graphically, the same information shows a substantial impending growth.

Alaska's senior population and people with ADRD: Growth projections 1995 to 2010



Use of Services by Trust Beneficiaries

Trust beneficiaries served in FY95	*Service type*	*People with mental illness*	*People with developmental disabilities*	*Chronic alcoholics with psychosis*	*People with Alzheimer's disease and related dementia*
Children	residential care	153			
	foster care	241	30		
	AK Youth Initiative	126			
	psychiatric hospital care	120			
	Dept. of Education	711	3,500		
	CMHCs	2,605			
	Infant Learning Program		1,291		
	DD services		762		
Adults	corrections	1,531		1,346	
	CMHCs	5,289			
	Hospital DET	113			
	API	826			
	DD services		768		
	Harborview Dev. Ctr.		36		20
	substance abuse treatment			1,289	
	home & community based senior services				557
	Pioneer Home services				488

It would appear simple to compare the prevalence estimates of beneficiaries to the number of people using services. Unfortunately these numbers cannot yet be compared effectively. Some issues that came forward as the four boards grappled with identifying the numbers of people for whom they plan and consumers' needs for services included: types of information the boards collect, the information that is available, accuracy of data, and duplication of information.

First and foremost is the types of information the four boards collect. Some boards collect information about service use from entitlement programs, such as education, vocational rehabilitation, and financial assistance, for which beneficiary status is not a requirement. Others do not collect similar kinds of information, or the information for that group does not currently exist. Establishing service parity among beneficiary groups based on this information becomes difficult at best.

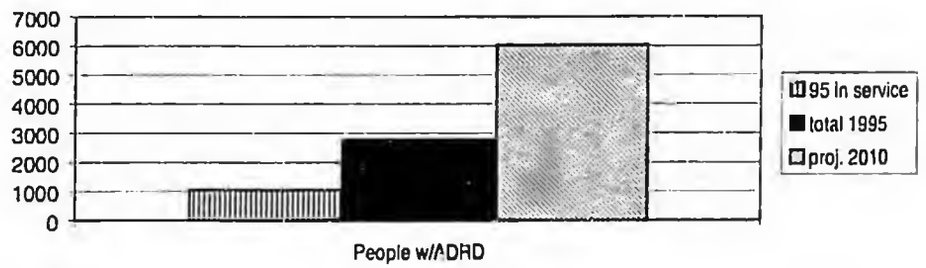
Public funding for services carries with it some demand by the state to collect information about the people who receive these services. However, while the state funds a substantial number of services to thousands of Trust beneficiaries, many people receive services and supports outside the state system. Other important providers of services are Indian Health Services/tribal health providers, the military, and private, for profit providers. Information on the number of people served by these systems and the kinds of services provided has rarely been available to the four boards.

Data inaccuracy stems from a variety of problems. State divisions have no or few mandates to capture comprehensive information, particularly about programs not funded by the state. Even when state divisions mandate data for funding, programs rely on direct service and line staff to collect information. Such staff may be reluctant to diagnose or label the people whom they assist, or do not identify data collection as an important part of their job. Aggregation of data is highly technical, requiring specialized staff with well-considered relational databases. Many of the state's databases were developed when computer sophistication was less than it is now, and require substantial upgrades. Other state sources of information are counted by hand or on spreadsheets, allowing many possibilities for error.

The departments and divisions administering funding have different reporting requirements, and have rarely coordinated with each other enough for the boards to identify an unduplicated count of people receiving services across more than one service category. Indeed, providers sometimes have participated in data efforts unwillingly, contributing to data inaccuracy or lack of data. Even when unduplicated counts within divisions or programs exist, they usually do not include information that assists in planning or projecting service needs over time.

Existing prevalence and service use information does, however, reveal some utilization issues. Individuals become beneficiaries due to genetics, accidents, abuse, illness, organic brain syndromes, or as a result of addiction. Their use of services depends very much on the type of disorders they have and the services that are available to them. When we consider the projected growth of Alaska's population of senior citizens and of people with Alzheimer's disease and related dementia, and compare that with service use in FY95, we see a dramatic increased need coming quickly.

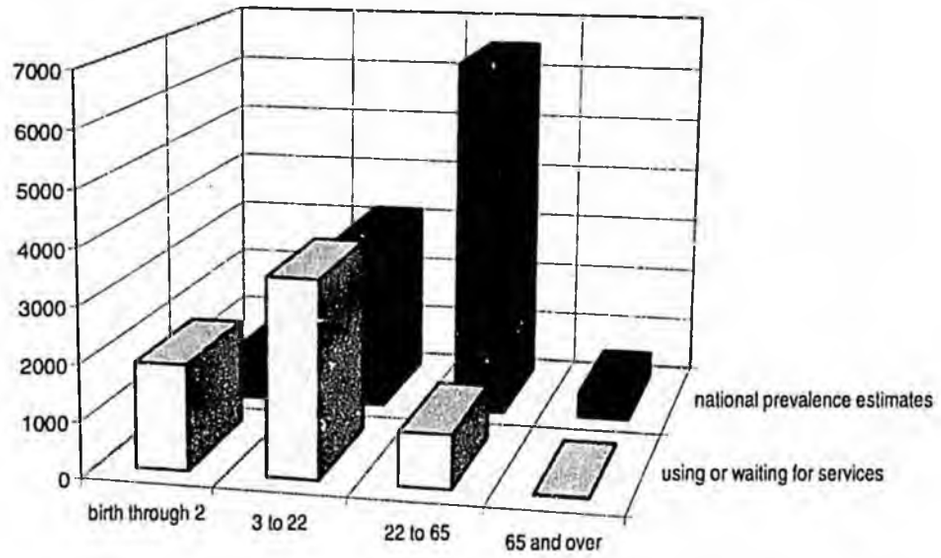
ADRD population v. service availability



Since fewer than half of people with ADRD receive services now, it is clear that Alaskans with ADRD will have an unprecedented need for services when their numbers triple in the next 12 years.

Comparing national prevalence data for people with DD and the numbers of people with developmental disabilities using or seeking services beyond the mental health program, it is clear that the national prevalence statistics undercounts children with developmental disabilities in Alaska. At the same time, adults with developmental disabilities appear significantly underserved.

Alaskans with developmental disabilities:
Comparing prevalence estimates v. service use in FY95

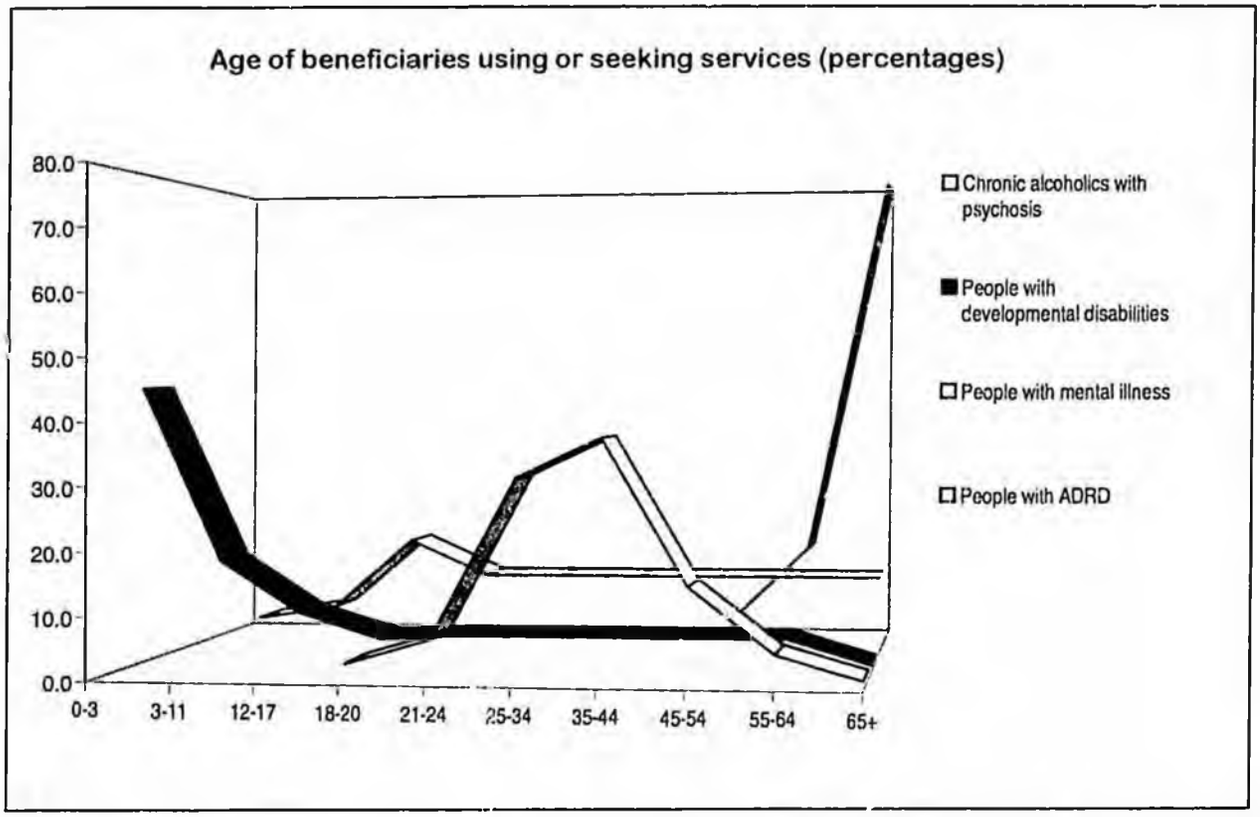


It is not clear whether adults with developmental disabilities seek or use fewer services because they do not require additional assistance following intervention in their youth, if their families and communities are able to provide minimal or adequate supports, or if they do not expect state-funded supports. It is possible that applying the national prevalence rate of 1.8 percent of the state's population of adults may overestimate the number of adults with developmental disabilities.

The Trustees are assisting the Department of Health and Social Services by funding a study of options for the replacement of the Alaska Psychiatric Institute. This study will examine and compare the costs of operating institutional beds and community services for the target populations.

Demographics: The Lives and Circumstances of Trust Beneficiaries

Information about the Trust's beneficiaries is received by the four boards from a variety of sources, mostly provider surveys and self-reporting by consumers. The available information is of limited use because it cannot be generalized statewide. This section offers some approximate information about the lives and circumstances of the Trust's beneficiaries based on reports from the Alaska Mental Health Board (AMHB), Alaska Commission on Aging (ACoA), Advisory Board on Alcoholism and Drug Abuse (ABADA), and Governor's Council on Disabilities and Special Education (Governor's Council). The senior service system has not historically tracked the life circumstances of people with ADRD; therefore, information about this group is largely excluded from the following pictorial discussion of demographics. The true demographics of the Trust's beneficiaries could change dramatically if information about private use of services were available. Trust beneficiaries with higher levels of income could use privately funded services rather than publicly funded services. Their service use is not reflected in this report, and requires further research.

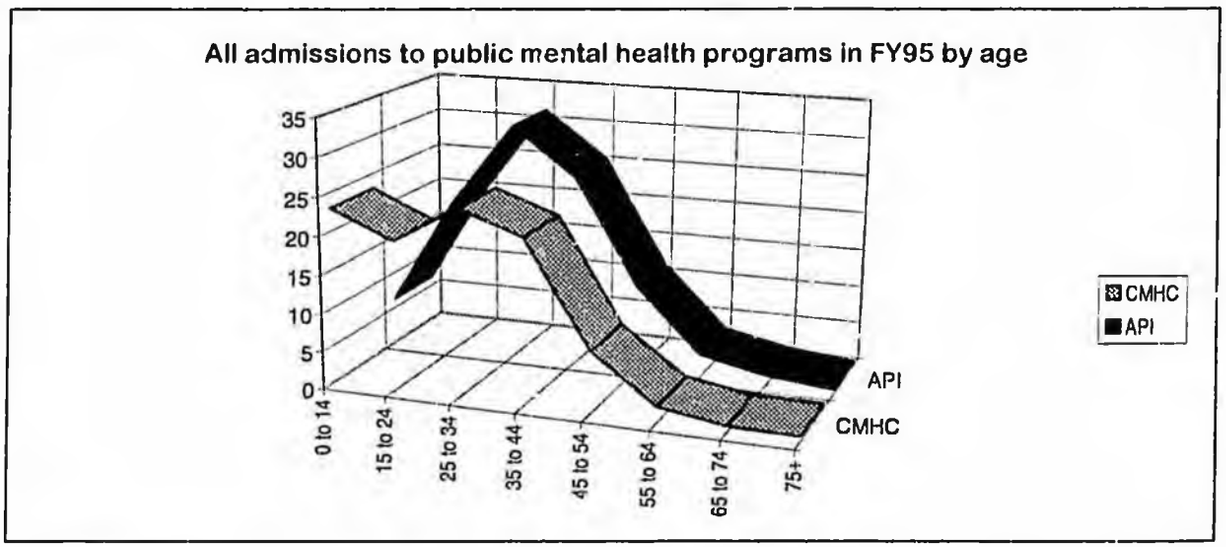


Trust beneficiaries require services at different times in their lives, depending on their disabling conditions. Information about service use by age reflects the onset of disabling conditions, help-seeking behavior, and service availability. For example, Alzheimer's disease and related dementia affect adults exclusively.

Developmental disabilities are identified before an individual reaches age 22, usually when the people who experience them are quite young. The parents of infants and toddlers with disabilities and delays seek services aggressively. These children receive significant support through the public education system, and either require, receive, or seek fewer services as they age.

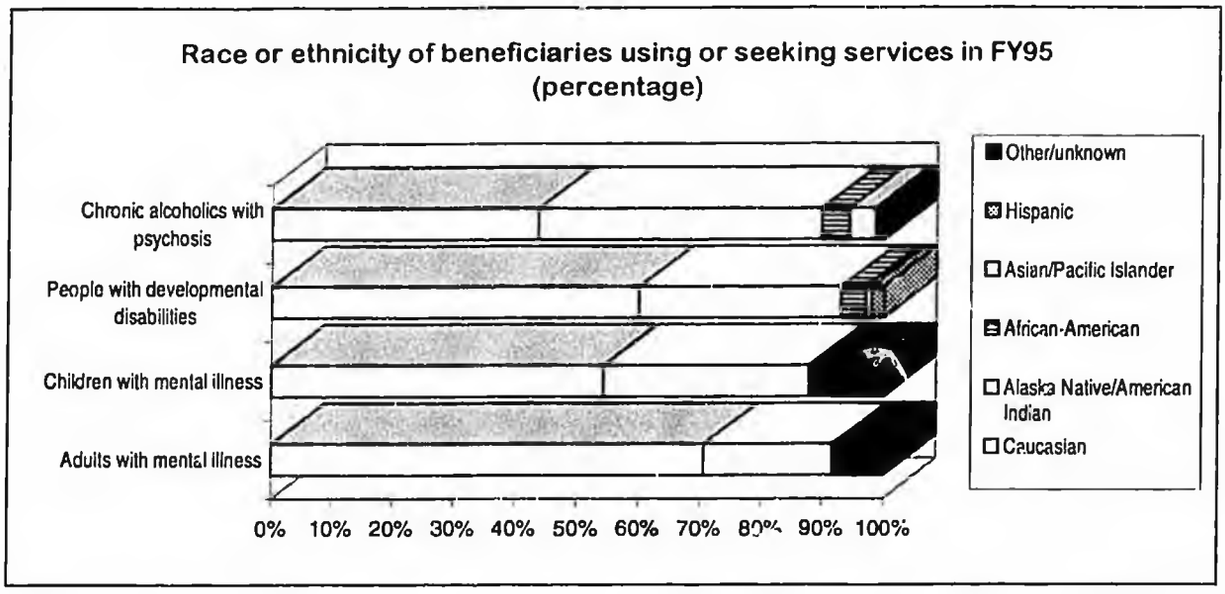
People with chronic alcoholism who use state-funded services are distinct in their age group. Virtually all are in their middle adulthood by the time their addiction is considered chronic and they develop psychosis because of their substance abuse.

Mental illnesses often appear in adolescence and early adulthood, as demonstrated by information summarized by the AMHB. Admissions data show consistent service use patterns at specific ages, according to the Division of Mental Health and Developmental Disabilities (DMHDD). If the number of people who have mental illness is similar to the number of people who use mental health services, it would appear that Alaskans with mental illness discover and adjust to their mental illnesses over the course of their young and middle adulthood.

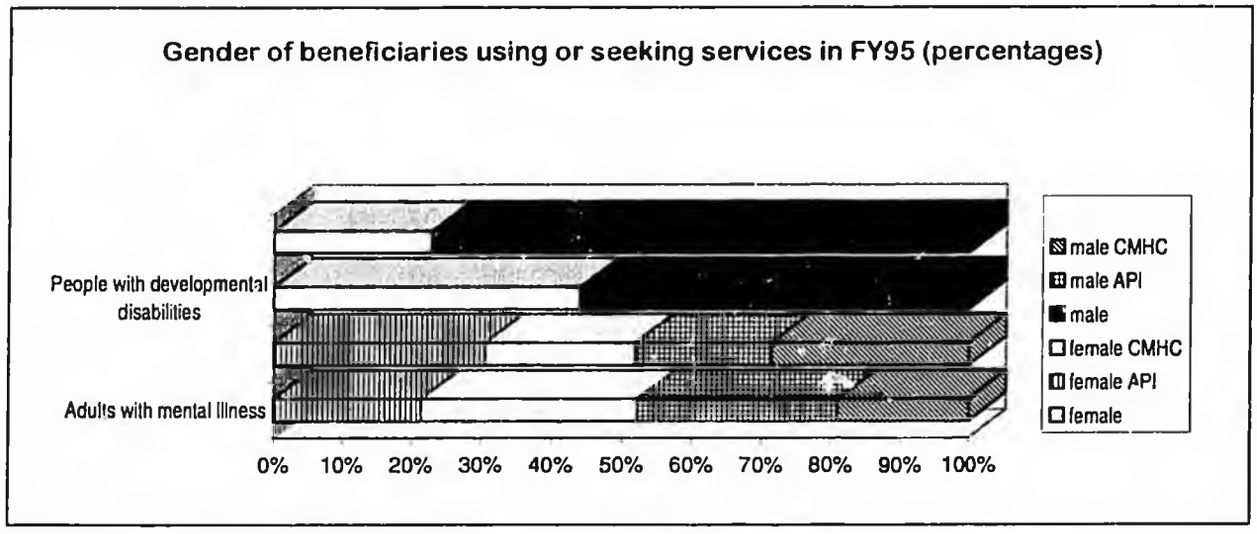


Although the state's population of Caucasians is about 75 percent, they make up less than that percent of Trust beneficiaries who use publicly funded services. Alaska Natives appear to be significantly over-represented as Trust beneficiaries in using publicly funded services compared to their population in the state. This presents questions about the nature and diagnoses of the disabling conditions which beneficiaries experience: socioeconomic status, cultural disruption, genetic predisposition, environmental affects, and over- and under-diagnosis.

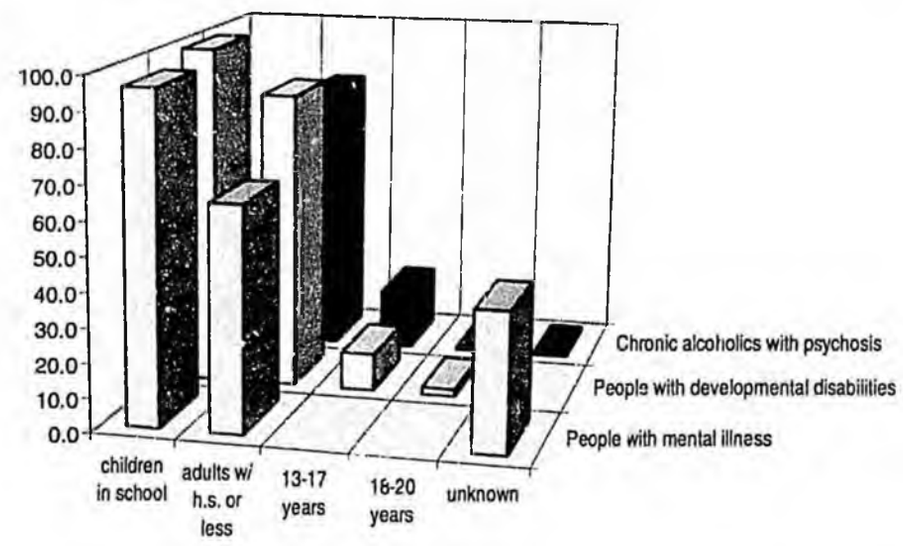
Inadequate information is available about people of other ethnicities who have mental illness, and no information is currently available about the ethnicity of people with ADRD.



It appears that adults with mental illness use institutional and community mental health services quite differently than do children and youth. Children use Alaska Psychiatric Institute (API) at a much higher rate than do adults. Males and females use API and Community Mental Health Centers (CMHCs) at inverse proportions depending on their age. This gender and age differential in service use bears further study. Gender information about people with ADRD was not available for this report.

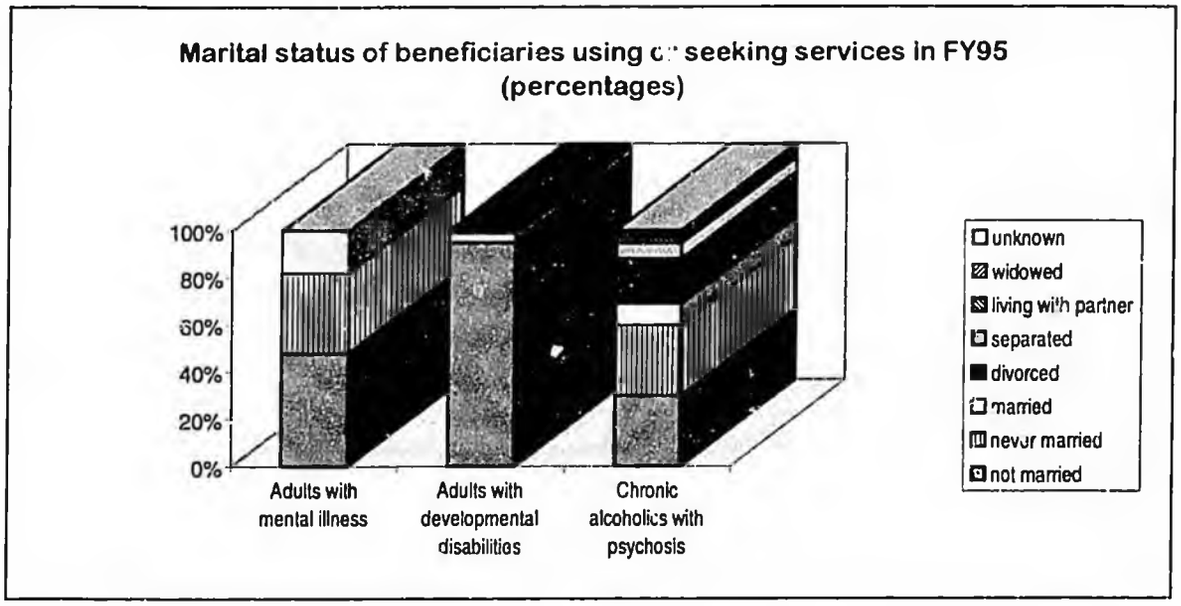


Educational status of beneficiaries using or seeking services in FY95 (percentages)

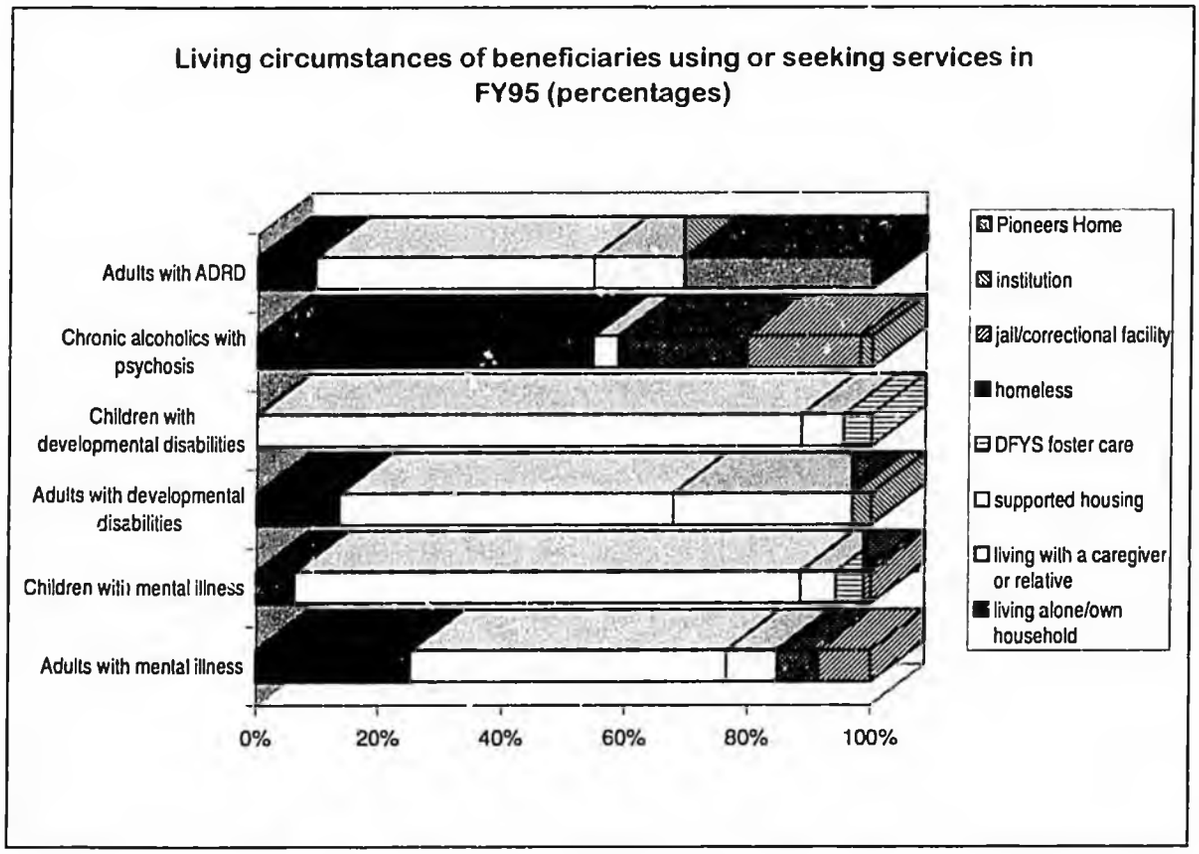


The years of education mean different things based on beneficiary group. All children with special needs are entitled to a free, appropriate public education until age 22. For most, that means up to 17 years of education to complete high school. By contrast, 13 to 17 years of education for other beneficiaries probably means college education. We have no information about education past high school for adults with mental illness who use publicly funded services, and no information about the educational status of people with ADRD. It appears that a significant number of beneficiaries do not have higher education. This limits their lifetime capacity to become economically independent, forcing them to use public services.

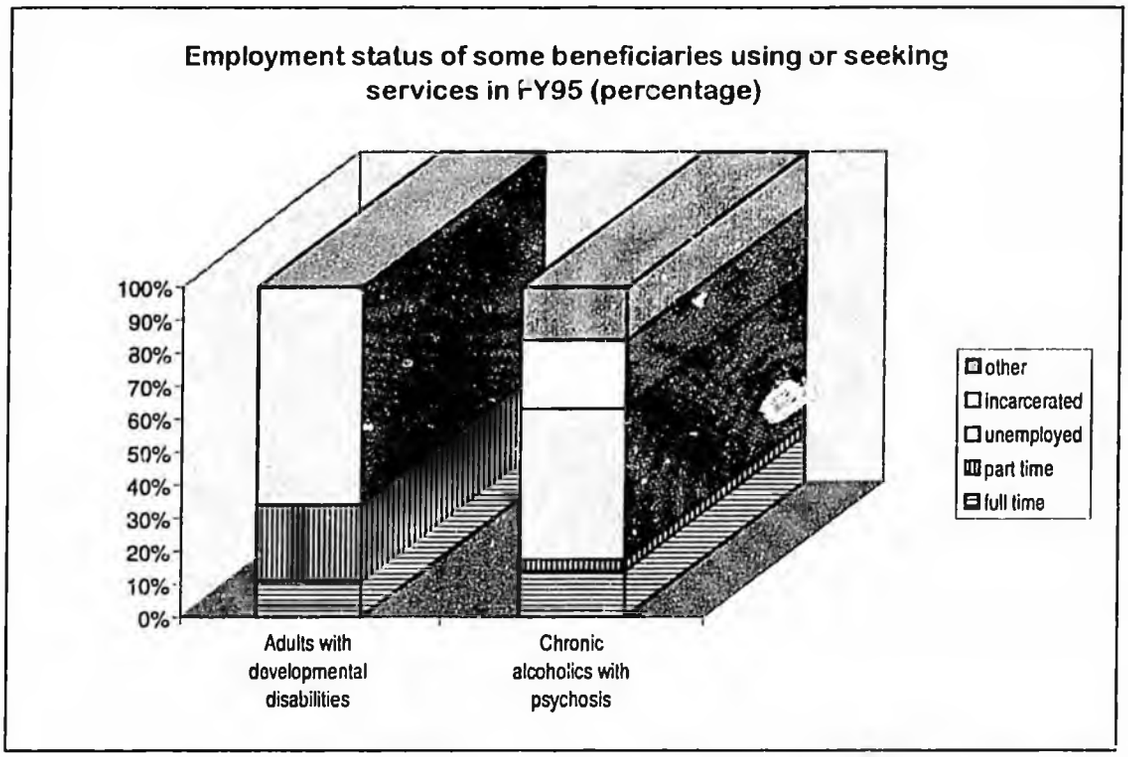
It is encouraging to note that children with mental illness or developmental disabilities who use publicly funded services appear to stay in school rather than dropping out.



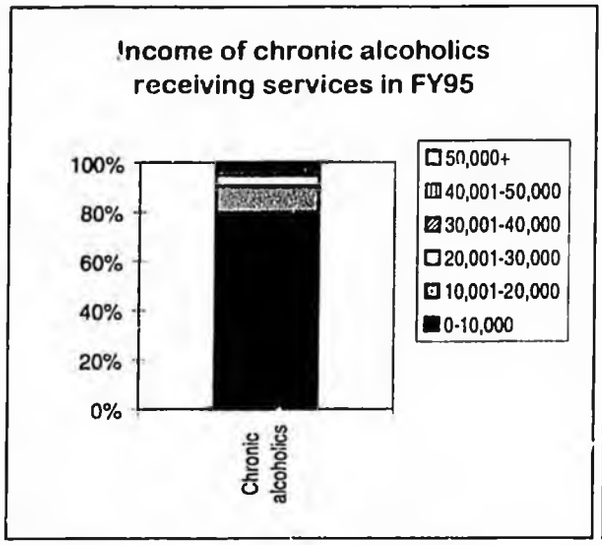
It is striking that all three groups of beneficiaries above are relatively unattached, with very limited primary relationships to assist them in their daily lives. Trust beneficiaries who do not use publicly funded services may, however, demonstrate different relationship status. This information is more interesting when compared with the living circumstances of beneficiaries, which follows.

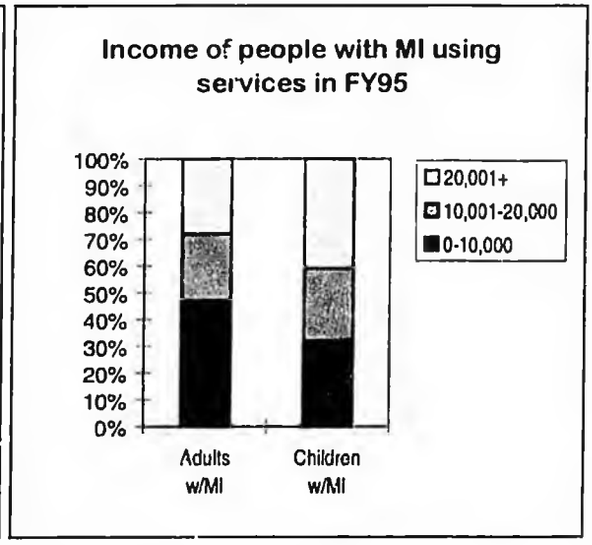


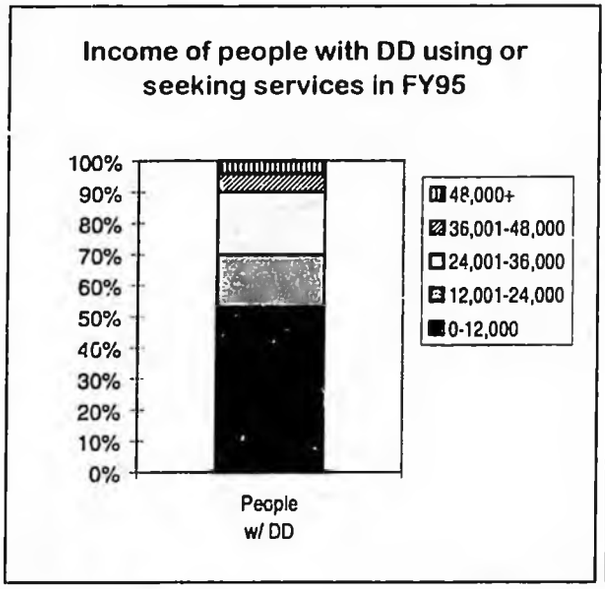
All four groups of beneficiaries require some support in their daily living by definition. From provider surveys, it appears that most receive some living supports through family, community based care, or facility based providers. Chronic alcoholics with psychosis appear to be unique in their social isolation.

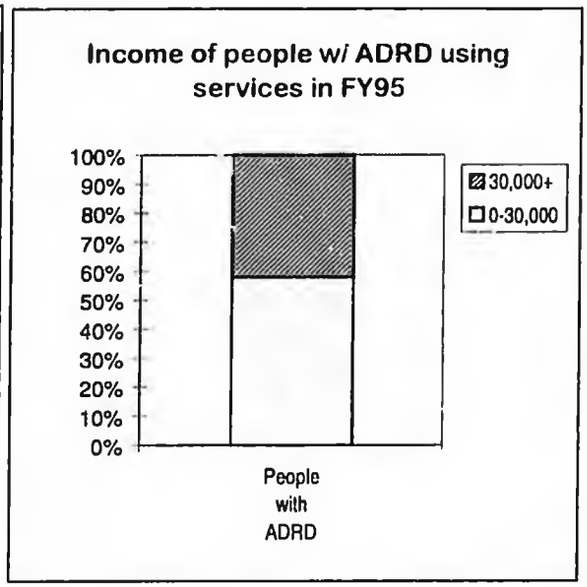


People with developmental disabilities who use publicly funded services are employed more than are chronic alcoholics with psychosis. It will be important to compare employment rates with chronic alcoholics post-treatment, and to compare these rates with those of people who have mental illness. As one might expect, most people with Alzheimer's disease and related dementia are retired.









Trust beneficiaries who use publicly funded services are notable because of their poverty. However, the Trust Authority has no information about individuals who paid for or used services in the private sector or about incomes above the poverty level for people with ADRD or mental illness who use publicly funded services. It is likely that individuals who have more income make higher use of private services, and are not adequately reflected in the data currently available to the Trust Authority. Beneficiaries with low incomes could also have low levels of employment and education. For example, a chronic alcoholic is not likely to participate in a work setting consistently—nor is an adult with active psychosis. For some beneficiaries, the cost of care related to their long-term condition requires them to quickly spend down resources to become eligible for public assistance. We hope in the future to compare income levels with costs of care and payment for services.

Review of the Mental Health Program

Describing the current program

The Department of Health and Social Services and Trust Authority are for the first time defining the scope of Alaska's Comprehensive Integrated Mental Health Program.

This program includes a variety of services which were conceived, developed, and implemented for widely differing reasons. Most informal surveys of policy makers, program administrators, service providers, and consumers of services will quickly result in concerns that Alaska's service systems are not coordinated with each other, and that the systems contain substantial gaps. A new approach to these systems is necessary as the numbers of beneficiaries continue to grow, populations continue to have significant unmet needs, and yet the amount of resources to build capacity and new services becomes more scarce and more difficult to spread among beneficiaries who require assistance. A key component of the Trust settlement, therefore, was creating a mental health program that is both *comprehensive* and *integrated.*

The current policy and service delivery systems are fragmented and often planned and funded without significant community or consumer input. The services have traditionally been created based on categories of populations or on funding streams, rather than as a system of care for all populations in need in a particular area or community.

Some communities in Alaska lack the infrastructure or commitment necessary to develop and support ongoing service delivery systems. Beneficiaries wish to have those services close to home, but currently the system supports major programs to meet significant complex treatment needs only in urban areas.

In addition, each provider group has developed separate service delivery systems in each community. At the least, this means duplication of administrative and overhead expenses. There is some thought that even some service delivery systems should be integrated among the beneficiary groups. It is clear that in order to develop additional service capacity, efficiencies in the current systems must be found. This means thoughtful analysis of the current system, with major revisions to the entire system of care, not just new patches or minor adjustments. Communities must become partners with state agencies and the boards in order to solve their own local issues and needs.

Planning the comprehensive integrated program

The Department of Health and Social Services has described the existing mental health program in its draft Comprehensive Integrated Mental Health Plan, In Unison. The mental health program, as described in the Plan, strives to follow values and principles which build on and further develop the Trust Authority's guiding principles. In the Department's plan, the components of the mental health program are noted by:

- services they provide to beneficiaries of the Trust;
- the numbers of individuals served, where that information is available;
- the costs of such services to the state;
- related databases, where they exist;
- methods used to ensure program and service quality, and related outcome measures;
- a summary of related needs assessments and program evaluations;
- a description of collaborative activities among publicly funded programs;
- activities conducted to include the public in program development; and
- programs mandated by state and federal statute or regulation.

In Unison will allow the Trustees and other policy makers to gauge the goals and effectiveness of the mental health program over time because it describes the components of the desired mental health program as well. The desired program is illustrated by level of community in which beneficiaries reside, shifting the focus from the component of service the state administers. Variations on levels of community are used by two of the four boards, and have been used by a third in the past to describe how and where individuals access services.

Overall effectiveness

A few of the services in the mental health program have significant ways to ensure effective outcomes. The Division of Alcoholism and Drug Abuse has been lauded for its work documenting the key components necessary to successfully treat substance abuse, and the measurable social outcomes related to successful treatment. The Healthy Families Alaska program hopes to document the positive outcomes from aggressive early intervention services with families of at-risk children. The Developmental Disabilities program of DMHDD evaluates consumer satisfaction and use of local resources in its site reviews.

The four boards and Trust Authority engage in ongoing discussion about methods of determining effectiveness. Program audits, consumer satisfaction, utilization rates, consumer functional outcomes, social outcomes, and decreased service costs have all been mentioned as ways to measure effectiveness.

Services must be planned and supported so that they are available to all beneficiaries in the least restrictive manner appropriate, and as close to their homes as possible. In-home support services must be expanded so that the need for costly, less effective institutional care can be decreased and so that beneficiaries can stay in their home communities.

Next steps

Discussion of the desired service system and comparing that with the existing services will be a topic of Trust Authority Town Meetings with beneficiaries, their families, and providers of services. The Trust Authority, DHSS, and administrative agencies will work with consumers, Trust beneficiaries, providers, and policy makers to identify ways to change the current mental health program to move more closely to a comprehensive and integrated program. Finally, the Trustees and members of the four boards will meet with each other, the AHFC board, and selected state staff to identify common outcomes that they may use to influence the program and its funding.

Resources required for the Mental Health Program

Implementing the full scope of the desired Comprehensive Integrated Mental Health Program would require fiscal, human, and structural resources not easily available even with massive change in the existing system. Rather than dismantle programs that, while flawed in structure continue to provide necessary services, the Trust Authority has focused on incremental structural changes to the program. These structural changes include system reform and capacity building; information system development, integration, and use to analyze outcomes; encouraging partnerships with communities and collaboration among providers and state agencies; and Trust asset development.

System Reform and Capacity Building

Opportunities for administration and service integration must be explored in each community. Beneficiaries must be surveyed in order to develop a profile of their desires for service delivery, and their knowledge of programs that are most effective. Innovative methods of delivering services must be sought, implemented and evaluated from both the system and beneficiary's perspectives. Funding sources from the federal and state governments must be leveraged to help develop services and to expand the continuum of care.

Policy makers and program administrators should develop new ways to reward service providers for advancing innovative service delivery systems that are expanded, integrated, and more efficient. Ongoing quality assurance and technical assistance must be available and used. The recommendations of the Governor's Conference on Youth and Justice must be considered. Federal funding streams, such as the TEFRA Medicaid option for severely emotionally disturbed children and youth must be implemented by state program administrators and advanced by the legislature.

The Trust Authority must initiate thoughtful discussions and recommend action regarding new ways to integrate and deliver services to its beneficiaries. State departments must do the same. The planning boards must review and create new plans for devel-

oping service systems to address the unmet needs of each beneficiary, and bring forward their recommendations to the Trust Authority, Governor, legislature, and other policy makers.

Information system development, integration, and use for outcome analysis

The Department of Health and Social Services has begun a process to develop better linking information for more efficient resource allocation and management decisions. The Data Integration Steering Committee of DHSS has identified a departmental data warehouse as a key method for developing timely and accurate management and planning information. In addition, the Departments of Administration and Corrections have also begun data collection initiatives.

The Alaska Mental Health Trust Authority, in conjunction with the four planning boards, has begun to consider appropriate data needs and outcome measures for the beneficiaries of the Trust. A Training Institute in the fall of 1996 will focus attention on developing outcome standards that can be used for analysis of services. Funding priority has been given to support these initiatives. Consideration of the use of good data to promote system reform and innovation must be further explored.

Encouraging partnerships with communities and collaboration among providers and state agencies

Communities must be targeted to develop key relationships among the service providers, community leaders, beneficiaries and state departments and planning boards. These relationships should be encouraged and used to review data regarding their community and to provide recommendations regarding service delivery reforms and capacity building within their community. Funding priority should be given to proposals developed at the community level, with partnerships demonstrated among several local groups, with significant beneficiary involvement.

Trust asset development

Because of the state's declining revenue base, resources to meet the current needs of beneficiaries as well as resources for beneficiary population growth will be very difficult to find. The Alaska Mental Health Trust is one major avenue for funding these beneficiary needs. In order for the Trust Authority to meet these obligations, there must be a concerted effort to maximize Trust assets—both cash and natural resources. Protecting the principal of the Trust, while leveraging the assets to create a strong funding stream for service delivery on an annual basis, is a significant challenge.

The Future

Based on the information and planning available at this time, the Trustees made the following recommendations for the FY98 mental health budget:

- Recommended FY98 GF/MH Base and Proposed Adjustments
- Recommended FY98 Operating Increments and
- Recommended FY98 Capital Budget

Recommended FY98 GF/MH Base and Proposed Adjustments

KEY	Department/BRU/ Component	FY97 GF/MH Authorized	FY98 AMHTA Base Adjustments	FY98 AMHTA GF/MH Base*
	DEPT. OF ADMINISTRATION (DOA)			
	Senior Services			
	Pioneer Homes	$415.7		$415.7
	Protection, Comm. Svcs, & Admin.	$208.8		$208.8
	Home & Community Based Care	$1,871.6		$1,871.6
	Office of Public Advocacy	$612.8		$612.8
	DOA TOTAL	$3,108.9		$3,108.9
	DEPT. OF CORRECTIONS (DOC)			
	Statewide Operations			
	Inmate Health Care	$3,046.1		$3,046.1
	Inmate Programs	$369.3		$369.3
	DOC TOTAL	$3,415.4		$3,415.4
	DEPT. OF EDUCATION (DOE)			
	Basic Ed & Instructional Improvement	$227.5		$227.5
	DOE TOTAL	$227.5		$227.5
	DEPT. OF HEALTH/SOC. SVCS (DHSS)			
	Medical Assistance			
B-1, B-3	Medicaid Non-Facility	$10,952.5	$2,792.0	$13,744.5
B-1, B-4	Medicaid Facility	$9,731.2	$3,097.4	$12,828.6
B-5	Waivers Services	$0.0	$3,074.0	$3,074.0
	Purchased Services			
	Foster Care	$1,547.9		$1,547.9
	Residential Child Care	$3,522.0		$3,522.0
	Family and Youth Services			
	Northern Region	$80.7		$80.7
	Youth Facility Services			
	McLaughlin Youth Center	$62.1		$62.1
	Fairbanks Youth Facility	$81.6		$81.6
	Maniilaq			
	Alcohol & Drug Abuse Svcs	$522.4		$522.4
	MH/DD Services	$350.0		$350.0
	Norton Scund			
	Public Health Services	$98.3		$98.3
	Alcohol & Drug Abuse Svcs	$232.2		$232.2
	MH/DD Services	$402.4		$402.4

KEY	Department/BRU/ Component	FY97 GF/MH Authorized	FY98 AMHTA Base Adjustments	FY98 AMHTA GF/MH Base*
	SEARHC			
	Alcohol & Drug Abuse Svcs	$140.6		$140.6
	MH/DD Services	$125.2		$125.2
	Tanana Chiefs Conference			
	Alcohol & Drug Abuse Svcs	$202.4		$202.4
	MH/DD Services	$529.8		$529.8
	Tlingit-Haida Central Council			
	Alcohol & Drug Abuse Svcs	$6.0		$6.0
	YK Health Corp.			
	Alcohol & Drug Abuse Svcs	$418.5		$418.5
	MH/DD Services	$907.4		$907.4
	State Health Services			
	Maternal, Child, and Family Health	$73.6		$73.6
	Infant Learning Program	$3,503.3		$3,503.3
	Alcohol & Drug Abuse Svcs			
	Administration	$916.6		$916.6
	Alcohol/Drug Abuse Grants	$7,928.8		$7,928.8
	Corrections Alc/Drug Abuse Svcs	$331.5		$331.5
	Rural Services Grants	$1,624.8		$1,624.8
	Community Mental Health Grants			
	Gen'l Comm Mental Health Grants	$888.4		$888.4
B-6	Psychiatric Emergency Services	$5,731.1	($5,731.1)	$0.0
B-6	Designated Evaluation & Treatment	$1,046.3	($1,046.3)	$0.0
B-6	NEW: Crisis Intervention Services		$6,777.4	$6,777.4
	Services to Chronic Mentally Ill	$10,918.7		$10,918.7
	Services for Seriously Emotionally Disturbed Youth	$6,213.5		$6,213.5
	Community DD Grants			
B-2, B-5	Community DD Grants	$21,058.4	($2,153.3)	$18,905.1
	Institutions and Administration			
	MH/DD Administration	$2,992.4		$2,992.4
B-4	Alaska Psychiatric Institute	$5,782.7	($5,782.7)	$0.0
B-2, B-3	Harborview Developmental Center	$1,854.9	($1,027.4)	$827.5
	Mental Health Trust Boards			
	Alaska Mental Health Board	$379.8		$379.8
	Advisory Board on Alcohol & Drug Abuse	$323.4		$323.4
	DHSS TOTAL	$101,481.4		$101,481.4
	DEPT. OF LAW (DOL)			
B-7	General Legal Services	$66.3	$52.7	$119.0
	DOL TOTAL	$66.3	$52.7	$119.0
	UNIVERSITY OF ALASKA (UA)			
	Anchorage Campus	$200.8		$200.8
	UA TOTAL	$200.8		$200.8
	ALASKA COURT SYSTEM (ACS)			
	Trial Courts	$79.3		$79.3
	ACS TOTAL	$79.3		$79.3
	Total	**$108,579.6**	**$52.7**	**$108,632.3**

** Base amounts do not include OMB adjustments for salaries, risk management, or data processing charge-backs.*

GF/MH FY98 Adjustments to the base: Descriptions

B-1. Hope Cottages ICFs-MR Decertification *$2,685,300*

From Medical Assistance/Medicaid Facilities

To Medical Assistance/Medicaid Non-Facility

Narrative Hope Cottages is in the process of closing all five of their Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) and moving all 40 residents out of existing facilities into their communities of choice with individualized plans for services. Effective July 1, 1996, Hope Cottages is providing assisted living services in its ICFs-MR with special permission until they can move the individuals out of these facilities. The re-organization of the 5 ICFs-MR will result in savings to the state. Savings will be reinvested to offset Hope Cottages' cost of living increases and operating expenses and take at least 50 people off the statewide wait list.

B-2. Harborview Closure *$920,700*

From Institutions and Administration/HDC

To Community DD Grants/Community DD Grants

Narrative This General Fund/Mental Health funding will provide for the total community placement of the remaining 16 residents. This base adjustment includes $31.8 in FY98 savings from closure and $888.9 in FY98 funds transferred for community placement. The FY96 budget included a 3-year plan to discharge 44 individuals residing at Harborview Developmental Center (HDC) into their community of choice. The remaining 16 residents will be moved during FY98 and the facility closed by December 31, 1997.

B-3. Harborview Closure *$106,700*

From Institutions and Administration/HDC

To Medical Assistance/Medicaid Non-Facility

Narrative This General Fund/Mental Health funding will provide for Medicaid Match for the total community placement of the four Sourdough unit residents. The FY96 budget included a 3-year plan to discharge 44 individuals residing at Harborview Developmental Center (HDC) into their community of choice. The remaining 16 residents will be moved during FY 98 and the facility closed by December 31, 1997.

B-4. Increase Capture of DSH Funds. Transfer API funding to Medical Assistance/Medicaid Facility to maximize federal Disproportionate Share Hospitalization (DSH) funds. *$5,782,700*

From Institutions and Administration/API

To Medical Assistance/Medicaid Facility

Narrative This transfer of funds from one budget request unit to another will allow API to increase its capture of DSH funds to the full amount possible. As the result of a rather complicated formula involving a number of non-GF/MH funding sources, transferring API's GF/MH funding to the Medicaid program should allow the capture of additional federal Medicaid funds, which would bring API up to its full authorized funding level.

B-5. Transfer Waiver Match *$3,074,000*

From Community DD Grants/Community DD Grants

To Medical Assistance/Waivers Services

Narrative Match for the waiver program has been provided through the Reimbursable Services Agreement (RSA) process from Community DD Grants to Medical Assistance Waivers. The amount budgeted in FY 98 for RSA transfer is $3,074.0. This transfer of funds provides match for the Children with Complex Medical Conditions and the Mental Retardation/Developmental Disabilities waivers.

B-6. Create New Crisis Intervention Component. Combine Psychiatric Emergency Services and Designated Evaluation and Treatment components into Crisis Intervention Services component. *$6,777,400*

From	Community Mental Health Grants/ Psychiatric Emergency Services	$5,731,100
From	Community Mental Health Grants/ Designated Evaluation & Treatment	$1,046,300
To	Community Mental Health Grants/Crisis Intervention Services	6,777,400

Narrative The two existing components fund overlapping services involving intervention during psychiatric crises. Combining the components would allow greater flexibility in developing community crisis intervention services and provide more efficient use of public funds. The Trust Authority supports this combination with the understanding that the Division will establish policy ensuring that funds will not be directed to other uses, such as expanding designated evaluation and treatment services at the expense of existing crisis services.

B-7. Dept. of Law - Personal Services and Overhead. *$52,700*

BRU/Component Law/ General Legal Services

Changes source from General Fund

To General Fund Mental Health

Narrative The Dept. of Law has requested GF/MH funding commensurate with the actual costs related to its mental health work. Based on their federally approved FY96 cost allocation plan and FY96 hourly rates for attorneys, Dept. of Law projects annual costs at $119,000. This figure does not include "direct out-of-pocket" costs or legal services from other attorneys diverted to assist with mental health cases. This project will benefit multiple beneficiary groups.

Recommended FY98 Operating Increments

To implement the Comprehensive Integrated Mental Health Program in fiscal year 1998, the Trustees recommend that the Governor and legislature increase the General Fund Mental Health appropriation for operating funds by $4,775,200. This represents an increase of 4.4 percent in the GF/MH operating budget for the mental health program. The Trustees arrived at this increase by considering the total need of beneficiaries as represented by the four boards, Alaska's population growth, which is 2 percent, and the cost of living as measured by the consumer price index at 3.5 percent.

KEY	Dept.	BRU/Component	Beneficiary Service	MHTAAR*	GF/MH
O-1	DOA	Senior Services/ HCB Grants	Increased Respite Care for Seniors	$0.0	$400.0
O-2	DHSS	State Health Svcs/ ILP/ Grants	Infant Learning Program Wait list Reduction	0.0	750.0
O-3	DHSS	Community DD Grants	Increased Respite Care for DD Clients	0.0	217.0
O-4	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Emergency Services - Seven new Detox Beds	0.0	254.0
O-5	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Commitment Legal Costs	0.0	50.0
O-6	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Inhalant Prevention Project	0.0	50.0
O-7	DHSS	Community MH/ Crisis Intervention Services	MH Crisis/Respite Services - New Models	0.0	500.0
O-8	DHSS	State Health Svcs/ Maternal, Child, Family Health	Healthy Families Program	250.0	0.0
O-9	DOA	Senior Svcs/ HCB Grants	Care Coordination for Seniors	0.0	750.0
O-10	DHSS	Community DD Grants	Vocational DD Individual Assistance	0.0	167.0
O-11	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Aftercare Increased Capacity by 5%	0.0	46.2
O-12	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Vocational Services for Clients	0.0	75.0
O-13	DHSS	Community MH -Crisis Intervention Services	Implementation of Services in Accepted Regional Plans	0.0	500.0
O-14	DHSS	Inst. & Admin/ DMHDD/ Comm. MH Svcs	Disability Law Center - Increase Grant for MH Client Legal Services	0.0	35.0
O-15	DHSS	Inst. & Admin/ Harborview	Harborview offset for Community Placement of remaining 16 HDC clients	995.6	0.0
O-16	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Alcohol/Drug Abuse Long Term Care Convert Beds to Dual Diagnosis	0.0	81.0
O-17	DHSS	Alcoholism and Drug Abuse Svcs/ Grants	Long Term Care - Domiciliary	0.0	300.0
O-18	DOC	Statewide Operations/ Inmate Health Care	Inpatient Psychiatric Unit for Female Mentally Ill Offenders	0.0	600.0
			TOTAL	**$1,245.6**	**$4,775.2**

** MHTAAR means Mental Health Trust Authority Authorized Receipts*

GF/MH Increments Project Descriptions

O-1. Increased Respite Care for Seniors *$400,000*

BRU Senior Services

Component Home and Community Based Grants

Impact New services for six individuals, and increases respite care for 140 people currently receiving services

Narrative This increment would allow for increased hours to existing clients, enable clients limited access to 24 hour respite, and provide respite for new clients in underserved areas. This amount would allow for an additional 20,000 hours of respite. Respite clients are asked to share in the cost of services.

O-2. Infant Learning Program Wait list Reduction *$750,000*

BRU State Health Services

Component Infant Learning Program

Impact 177 children would receive new services. Some would receive increased services.

Narrative This increment will enable the Infant Learning Program to serve some of the 586 children on the statewide wait list. It also includes $20,000 to maintain the specialty pediatric clinics for an additional year.

O-3. Increased Respite Care for People with DD *$217,000*

BRU Community DD Grants

Component Community DD Grants

Impact Approximately 87 people at an average of $2,500 per person

Narrative This will purchase increased respite care services for people with developmental disabilities and their families. Respite care keeps families together, maintaining the individual with a serious disability in their own home instead of in residential care.

O-4. Emergency Services - Seven New Detoxification Beds *$254,000*

BRU Alcohol and Drug Abuse Services

Component Alcohol and Drug Abuse Grants

Impact 818 encounters with individuals using services for the first time and those who have used services in the past.

Narrative This will replace lost detoxification services in FY94-95. Utilization rates indicate that these services are needed in either western Alaska or the Anchorage bowl area or Southeast Alaska. The placement of these services will be determined in part, by the placement of services from last year's funding process. This operating increment has an associated capital request (C-2).

O-5. Commitment Legal Costs *$50,000*

BRU Alcohol and Drug Abuse Services

Component Alcohol and Drug Abuse Grants

Impact 97 individuals will receive new services

Narrative The Advisory Board, during the last legislative session, authored and supported legislation revamping the Involuntary Commitment Statute. This new law had an accompanying fiscal note for $50,000 to insure that legal costs to families, physi-

cians and programs are met. This increment will provide funds to defray those costs via Request for Proposals solicited by the Division of Alcoholism and Drug Abuse.

O-6. Inhalant Prevention *$50,000*

BRU Alcohol and Drug Abuse Services
Component Alcohol and Drug Abuse Grants
Impact Undetermined
Narrative This project would focus on the use of media to deliver the prevention message to citizens of the state. Television, radio and print media has a powerful effect on lifestyle and lifestyle change. It can be used to provide outreach by improving service access by educating the public on treatment successes and can provide the public with treatment access information. These funds will be solicited by the Division of Alcoholism and Drug Abuse via the Request for Proposal process.

O-7. Mental Health Crisis/Respite Services - New Models *$500,000*

BRU Community Mental Health Grants
Component Crisis Intervention Services (New)
Impact: Undetermined
Narrative This increment will fund the development of new crisis/respite models. In many cases, crisis/respite services are delivered in institutional settings, albeit usually locally and often with some measure of family support. With this increment DMHDD will fund new approaches to crisis/respite such as emergency foster care homes for short-term placements, "small facility-based" crisis/respite in rented homes with on-call staff, and training and support for other residential programs in a community (substance abuse, women's shelter, etc.) to provide mental health care. The last approach has been implemented in Kotzebue. Competitive grants would be available for any clinically appropriate model creatively providing effective client centered care using local resources.

O-8. Health Families Alaska *$250,000 MHTAAR*

BRU State Health Services
Component Maternal, Child and Family Health
Impact Undetermined
Narrative This provides continuing MHTAAR funding for the second year of a three year commitment by the Trust to the Healthy Families Alaska program. The Healthy Families Program provides home visits to parents of newborns to prevent child abuse and neglect while promoting family health. The program also provides access to mental health services for these at-risk families.

0-9. Care Coordination for Seniors *$750,000*

BRU Senior Services
Component Home and Community Based Grants
Impact 26 to 227 Alaskans with Alzheimer's disease will receive new services
Narrative This increment provides Care Coordinators and funds to purchase (broker) services. The number of older Alaskans served in new programs would be dependent on whether funds are allocated to purchase services, hence the large variation in the estimates of number of individuals impacted. Consumers of care coordination services are asked to share in the cost of services.

O-10. DD Individualized Vocational Assistance *$167,000*

BRU Community Developmental Disabilities Grants

Component Community DD Grants

Impact 16 individuals, estimated at an average of $10,000 per person

Narrative This operating increment would assist people with developmental disabilities in securing and maintaining employment. Using these funds, service providers would provide job training, employment support and supervision to ensure employment success.

O-11. Increase Capacity of Aftercare Services by 5% *$46,200*

BRU Alcohol and Drug Abuse Services

Component Alcohol and Drug Abuse Grants

Impact 26 individuals will receive new services

Narrative This project will increase aftercare capacity by 5%. Aftercare participation is the single best outcome indicator for treatment success. Aftercare service capacity has traditionally been a place to compensate for losses in program funds. Funding of this increment will offer programs the opportunity to provide innovation in delivery of this service.

O-12. Vocational Services for substance abusers *$75,000*

BRU Alcohol and Drug Abuse Services

Component Alcohol and Drug Abuse Grants

Impact 100 people in treatment will receive new services

Narrative The single most important ancillary service needed by treatment programs is vocational training. This is especially true among chronic alcoholics whose long term addiction has left them homeless, with poor education and often without any job skills. Removing alcohol from their lives does not necessarily insure recovery as their other needs impinge on their recovery. This project will allow programs to develop materials and supplies to enhance delivery of vocational services in conjunction with short term residential programs.

O-13. Implementation of Services in Accepted Regional Plans *$500,000*

BRU Community Mental Health Grants

Component Crisis Intervention Services (New)

Impact Undetermined

Narrative Regional plans for inpatient psychiatric care are a key element of the API 2000 plan. Plans establish the range of services needed at the community and regional level to permit the treatment of a wide variety of consumers locally, diverting them from more expensive, restrictive care at API. Regional groups with plans accepted by the AMHB could apply for grants to implement services identified in the plan. Because of the wide variety of services that may be requested, various components will need to receive a portion of these funds. Several regions will likely qualify for grants by the time funding is available in FY 98. These plans contain services which will divert patients from the new, smaller API. This increment has an associated capital request (C-4).

O-14. Disability Law Center - Increase Grant for Mental Health Client Legal Services *$35,000*

BRU Community Mental Health Grants

Component General Community Mental Health Grants
Impact Undetermined
Narrative Individuals with mental illness ineligible for Disability Law Center's (DLC) federal programs experience difficulty obtaining Social Security and Medicaid benefits. Twenty-five percent of DLC's mental health clients report denial of financial entitlements. Legal advocacy for this growing list of individuals is important and many may have to wait for services. This increment will allow services to be offered to those who may otherwise be placed on a wait list.

O-15. Harborview Operating Funds *$995,600 MHTAAR*
BRU Institutions & Administration
Component Harborview Developmental Center
Impact 16 individuals currently served at Harborview
Narrative This increment provides operating funds for Harborview prior to its closure on December 31, 1997. These Trust funds will offset an equivalent GF/MH amount that DHSS has agreed to use to provide the annualized costs of community placements of the final 16 clients at Harborview.

O-16. Conversion of Long Term Care Beds to Dual Diagnosis Treatment *$81,000*
BRU Alcohol and Drug Abuse Services
Component Alcohol and Drug Abuse Grants
Impact 10 individuals with dual diagnoses will receive new services
Narrative This increment will provide for the conversion of 5 existing beds from Long Term Treatment beds to Long Term Treatment of Dually Diagnosed. This project will require program changes and the addition of mental health staff or contract services to provide for mental health treatment of chronic alcoholics with an Axis I diagnosis secondary to the alcohol dependency diagnosis. This component will also include medication and medication management.

0-17. Long Term Care - Domiciliary Care *$300,000*
BRU Alcohol and Drug Abuse Services
Component Alcohol and Drug Abuse Grants
Impact 26 chronic alcoholics will receive new services
Narrative This increment will provide for the establishment of domiciliary care for chronic alcoholics whose physical debilitation is so severe that traditional treatment is not applicable. In this approach rehabilitation will take a back seat to habilitation. Focus will be on the provision of protected living as well as meeting long term health and vocational needs. Treatment will be provided in a non-traditional concrete steps. Long term outcomes will be to provide clients with skills necessary to live unsupported in society either through the treatment regimen provided or to transfer from this program to traditional long term care after a course of treatment. This increment has an associated capital request.

O-18. DOC Inpatient Psychiatric Unit for Female Mentally Ill Offenders *$600,000*
BRU Department of Corrections
Component Statewide Operations/Inmate Health Care

Impact 140 female offenders with mental illness will receive treatment

Narrative This increment will provide new programming for the treatment of female offenders with mental disorders. The lack of a therapeutic environment undermines effective treatment of female inmates. This issue takes on larger implications since male offenders are provided inpatient mental health treatment services, and the Cleary Settlement requires that mental health services be available to all offenders. Failure to provide these beds requires that these services be provided by API on a correctional transfer basis. There is a waiting list for correctional transfers now. The new API will not have the forensic unit originally envisioned.

Recommended FY98 Capital Budget

To determine the amount of funding necessary to meet the capital needs of beneficiaries and the programs that serve them, the Trustees considered recommendations of the four boards. They reviewed several potential funding sources, and determined that many of the capital expenses of the mental health program would be funded appropriately from Alaska Housing Finance Corporation funds. The Trustees expect to allocate Trust income to match GF/MH and AHFC corporate receipts in capital expenditures of the mental health program.

KEY	Dept.	Description	GF/MH	MHTAAR*	AHFC**
C-1	DHSS	Competitive Grants for Grantee Facility Modifications - all beneficiaries	$1,500.0	$0.0	$0.0
C-2	DHSS	Facility Modifications to provide 7 New Detox Beds	150.0	0.0	0.0
C-3	DHSS	Facility Modifications to provide Domiciliary Care for Chronic Alcoholics with Psychosis	300.0	0.0	0.0
C-4	DHSS	Facility Modifications to implement Mental Health Regional Plans	400.0	0.0	0.0
C-5	DHSS	Competitive Grants for American Disabilities Act Upgrades - all beneficiaries	500.0	0.0	0.0
C-6	DOT/PF	Competitive Grants for Beneficiary Transportation/Vehicles - all beneficiaries	250.0	0.0	0.0
C-7	DHSS	Competitive Grants for Program Equipment - all beneficiaries	750.0	0.0	0.0
C-8	DHSS	Special Needs Housing - home improvements and modifications	0.0	0.0	4,500.0
C-9	DOA	State Facility Modifications - Complete the renovation of Pioneer Homes	105.0	0.0	0.0
C-10	DHSS	Grantee New Facility - Hope Cottages ICF/MR Decertification	480.0	0.0	0.0
C-11	DHSS	DHSS Data Integration Project	287.5		0.0
		TOTAL	$4,722.5	$0.0	$4,500.0
		MHTAAR* CAPITAL MATCH		2,000.0	

**MHTAAR means Mental Health Trust Authority Authorized Receipts.*

***AHFC means Alaska Housing Finance Corporation*

Capital Project Descriptions

C-1. Competitive Grants for Grantee Facility Modifications *$1,500,000*

Impact Undetermined

Narrative The Department of Health and Social Services will solicit proposals for competitive grants for grantee facility modifications. These facility modifications will be solicited from and rewarded to service providers who provide services to beneficiary groups. Emphasis will be placed on increasing the quantity and/or quality of services to all four Trust beneficiary groups.

C-2. Facility Modifications for Seven New Detox Beds *$150,000*

Impact 818 encounters with individuals using services for the first time and those who have used services in the past.

Narrative This project, when combined with the operating component proposed by Trustees, will provide 7 new detoxification beds in critical areas (Anchorage, Mat-Su, or Western Alaska). The funds will be used to buy capital equipment such as hospital beds or surveillance camera systems for patient monitoring and to renovate facilities to make them appropriate for detox services. This may include tasks such as expansion of heating, ventilation, or utilities, enlarging rooms, establishing nursing stations, purchase of major medical equipment, etc. Projects will be funded based on competitive bids following a Request for Proposal by the DHSS Division of Alcoholism and Drug Abuse. This proposal has an associated operating increment (O-4).

C-3. Facility Modifications to Provide Domiciliary Care for Chronic Alcoholics with Psychosis *$300,000*

Impact 26 chronic alcoholics will receive new services

Narrative This project, when combined with the companion operating increment, would provide domiciliary care for those chronic alcoholics whose primary need is habilitation over a long period of time, particularly those with severe cognitive damage. These funds will be used to purchase and renovate a suitable building in which to house up to 28 clients at a time and to purchase necessary capital equipment such as a vehicle and major program equipment. The location of this program would likely be in either Anchorage or Fairbanks to ensure access to clients from around the state. The facility would be set up in a supportive living arrangement with a program concentration on developing the necessary skills for independent living given the level of cognitive impairment. This would include job and life skills and attendance to health and medical needs. The project will be funded based on competitive bids following a Request for Proposals by the DHSS Division of Alcoholism and Drug Abuse. This capital proposal has an associated operating increment (O-17).

C-4. Facility Modifications to Implement Mental Health Regional Plans *$400,000*

Impact Undetermined

Narrative The AMHB and DHSS manage a multi-year process of regional mental health plan development to ensure that community inpatient services are available to complement a downsized API. Other services necessary for a minimum continuum of care are also targeted in this planning process. This funding would pay for competitive grants for capital projects identified in accepted regional plans. Such projects could in-

clude facilities for crisis/respite, residential treatment for children, or transitional housing. This proposal has a related operating increment (O-13).

C-5. Competitive Grants for American Disabilities Act Upgrades *$500,000*

Impact Undetermined

Narrative With these funds, the Department of Health and Social Services will solicit competitive grants from service providers for upgrades of facilities used by all four Trust beneficiary groups, to comply with accessibility requirements of the American Disabilities Act.

C-6. DOT/PF Competitive Grants for Beneficiary Transportation/Vehicles *$250,000*

Impact Undetermined

Narrative The Department of Transportation/Public Facilities will utilize these funds for competitive grants for coordinated transportation services for all four Trust beneficiary groups whenever possible, or to purchase vehicles for beneficiaries where coordinated services are not yet available or appropriate. These vehicles will be purchased with the proviso that if coordinated usage becomes possible within the usable life of the vehicle it shall be used in a coordinated way for as many beneficiary groups as possible.

C-7. DHSS Competitive Grants for Program Equipment *$750,000*

Impact Undetermined

Narrative The Department of Health and Social Services will solicit competitive grants for program equipment (purchases less than $25,000) to provide increased quality of services to all four Trust beneficiary groups. These will be solicited from and rewarded to service providers for all beneficiary groups.

C-8. Special Needs Housing *$4,500,000 AHFC*

Impact Estimated at 45 to 75 individuals with disabilities

Narrative Originating from AHFC and the Trust Authority, the Department of Health and Social Services will administer these funds for the purchase, construction or renovation of a range of transitional or permanent residential units housing two or more disabled individuals per site. These funds will assist in community placement of persons currently housed at the Harborview Developmental Center or aid in the downsizing of the Alaska Psychiatric Hospital, as well as provide an alternative to institutional residential treatment and detention for youth.

C-9. Completion of renovations to Pioneer Homes *$105,000*

Impact Improves quality of services to 25 individuals with ADRD

Narrative These are grants to the named recipients, Sitka Pioneer Home and Palmer Pioneer Home. DOA Senior Services/Pioneer Homes will manage these funds to allow the Sitka and Palmer Pioneer Homes to complete the renovations of their dementia units.

C-10. Hope Cottages ICF-MR Decertification *$480,000*

Impact 40 people with DD currently in service

Narrative This is a named recipient grant, managed through DHSS, to Hope Cottages, Inc. Hope Cottages is in the process of closing all five of its ICFs-MR and moving all 40 residents out of the existing facilities into the community of their choice with individualized plans for community-based services. The $480.0 will be used to leverage financing, remodel as necessary and purchase furnishings and equipment. This proposal will result in cost savings to the state operating budget described in the base adjustments.

C-11. DHSS Data Integration Project *$287,500*

Impact This funding allows for better tracking of beneficiaries and services provided to them, but provides no direct increase in services to beneficiaries.

Narrative This project is designed to allow linkage of the Department's more than 70 administrative and program data bases at the client level. This will allow the Department to track clients across division and program lines for the first time thus allowing identification of patterns of service use as well as overlap among services and relationships among net conditions. DHSS will use these funds to provide planning and equipment for providers who serve multiple beneficiary groups as well as non-beneficiaries. Trustees propose to use $287.5 from MHTAAR for beneficiaries which represents half of the total amount proposed, with the other half from GF/MH. This project was previously funded with one-time Robert Wood Johnson Foundation funds.

Appendices

Investment Policy Statement

Beneficiary Group Definitions

References

Investment Policy Statement

For

ALASKA MENTAL HEALTH TRUST AUTHORITY

c

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Type of Plan: ..... Endowment

Current Assets: $224,900,000

Planning Time Horizon: ..... Greater than 5 years

Expected Return: ..... Set by APFC Board of Trustees at 8.36%

Risk Tolerance: ..... Set by APFC Board of Trustees at 8.57%

Asset Allocation[9] .....

Domestic Equities	36% -+4
International Equities	12%
Domestic Bonds	40%
Non-Dollar Bonds	2%
Real Estate	12%

The Alaska Mental Health Trust Authority has a fiduciary obligation to ensure that the assets of the trust are properly managed. The mental health trust cash corpus and corpus reserve fund (Fund) consists of the cash assets of the principal of the trust. The Trust Authority is required by statute (AS 37.14.009 (a)(3)) to contract with the Alaska Permanent Fund Corporation for the management of this Fund. The Alaska Mental Health Trust Authority and the Alaska Permanent Fund Corporation have entered into a Memorandum of Agreement covering the management of the Fund.

[9] As adopted by the Alaska Permanent Fund Resolution 96-4

The purpose of this Investment Policy Statement (IPS) is to assist the Alaska Mental Health Trust Authority Board of Trustees (Board) in effectively supervising, monitoring and evaluating the investment of the Alaska Mental Health Trust Authority's corpus and corpus reserve assets in the mental health trust fund (Fund). The Fund's investment program is defined in the various sections of the IPS by:

- Stating in a written document the Board's attitudes, expectations, objectives and guidelines for the investment of the Fund.

- Setting forth an investment structure for managing the Fund. This structure includes various asset classes, investment management styles, asset allocation and acceptable ranges that, in total, are expected to produce a sufficient level of overall diversification and total investment return over the long-term.

- Encouraging effective communications between the Board, the Alaska Permanent Fund Corporation (APFC), and the investment consultant.

- Establishing formalized criteria to monitor, evaluate and compare the performance results achieved by the APFC on a regular basis.

- Complying with all applicable fiduciary, prudence and due diligence requirements that experienced investment professionals would utilize, and with all applicable laws, rules and regulations from various local, state, federal and international political entities that may impact Alaska Mental Health Trust Authority assets.

This IPS has been formulated, based upon consideration by the Board of Trustees of the financial implications of a wide range of policies, and describes the prudent investment process that the Board deems appropriate.

Mission Statement:

The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementing and funding of a Comprehensive Integrated Mental Health Program to improve the lives and circumstances of its beneficiaries.

Key Information:

ALASKA MENTAL HEALTH TRUST AUTHORITY

Board of Trustees:

Chairman:	Nelson Page
Vice Chairman:	John Pugh
Secretary:	Tom Hawkins
Members:	Kay Burrows
	John Malone
	Evelyn Tucker
	Phil Younker, Jr.

Executive Director:	Jeff Jessee
Custodian:	Alaska Permanent Fund Corporation
Investment Manager(s):	Set by APFC
Investment Consultant:	Callan Associates

The objectives of the Alaska Mental Health Trust Authority (Trust Authority) have been established by the Board of Trustees (Board) in conjunction with a comprehensive review of the current and projected financial requirements. The objectives are:

(1) To maintain the purchasing power of the current assets and all future contributions.

(2) To maximize return within reasonable and prudent levels of risk.

(3) To maintain an appropriate asset allocation policy that is compatible with the spending policy, while still having the potential to produce positive real returns.

(4) To control costs of administering and managing the investments.

(5) To provide a steady reliable income stream from the Trust Fund to ensure the development of a Comprehensive Integrated Mental Health Program for the beneficiaries.

The investment earnings from future contributions are expected to be used to implement annual program funding strategies. Investment results are the critical element in achieving the investment objectives.

Spending Policy:

The targeted annual disbursement rate for the Fund will be 3% of the corpus and corpus reserve account balance at the close of the fiscal year. This 3% disbursement, plus 100% of the same fiscal year earnings from Trust lands which are allocated as income, constitutes the available funds for use by the Trustees in subsequent fiscal years to ensure the creation of a Comprehensive Integrated Mental Health Program.

Time Horizon

The investment guidelines are based upon an investment horizon of greater than five years, so that interim fluctuations should be viewed with appropriate perspective. Similarly, the Trust Authority's strategic asset allocation is based on this long-term perspective.

Risk Tolerances

The Board recognizes the difficulty faced by the APFC in meeting its investment objectives because of the uncertainties and complexities of contemporary investment markets. The Board also recognizes that some risk must be assumed to achieve the APFC's long-term investment objectives as established by the APFC in Resolution 96-4.

In commingling our assets with the APFC, the ability to withstand short and intermediate term variability were considered.

Performance Expectations

The desired investment objective is a long-term rate of return on assets that are at least 8.36%, which is 4.86% greater than the anticipated rate of inflation as measured by the Consumer Price Index (CPI). The target rate of return for the Trust Authority has been based upon the assumption that future real returns will approximate the long-term rates of return experienced for each asset class in the IPS.

The Board realizes that market performance varies and that an 8.36% rate of return may not be meaningful during some periods.

Over a complete business cycle, the Trust Authority's overall annualized total return, after deducting for advisory, money management, and custodial fees, as well as total transaction costs, should perform above the median of Callan's Endowment/ Trust Authority fund universe and above a customized index comprised of market indices weighted by the strategic asset allocation of the Fund.

Asset Allocation Constraints

The Board has reviewed the long term performance, risk and liquidity characteristics of the APFC and believes that the APFC provides an asset allocation strategy that meets the Strategic Asset Allocation objectives of the Trust Authority.

Liquidity

The Board believes that Liquidity will not be a problem under the current Memorandum of Agreement with the APFC. The size and diversification of the APFC should meet the liquidity needs of Trust Authority.

Securities Guidelines and Selection of Money Managers

The Board has delegated responsibility for these areas to the Alaska Permanent Fund Corporation.

Duties and Responsibilities of the Alaska Permanent Fund Corporation

The duties and responsibilities of each money manager retained by the Board include the following:

(1) Managing the Trust Authority's assets under its care, custody and/or control in accordance with the IPS objectives and guidelines set forth herein, and also expressed in separate written agreements when deviation is deemed prudent and desirable by the Board.

(2) Exercising investment discretion [including holding cash equivalents as an alternative] within the IPS objectives and guidelines set forth herein.

(3) Promptly informing the Board in writing regarding all significant and/or material matters and changes pertaining to the investment of Trust Authority's assets, including, but not limited to:

a. Investment strategy
b. Portfolio structure
c. Tactical approaches
d. Ownership
e. Organizational structure
f. Financial condition
g. Professional staff
h. Recommendations for guideline changes
i. All legal material, SEC and other regulatory agency proceedings affecting the trust.

(4) Promptly voting all proxies and related actions in a manner consistent with the long-term interests and objectives of the Trust Authority set forth herein. Each manager shall keep detailed records of said voting of proxies and related actions and will comply with all regulatory obligations related thereto.

(5) Utilize the same care, skill, prudence and due diligence under the circumstances then prevailing that experienced, investment professionals acting in a like capacity and fully familiar with such matters would use in like activities for like Trust Authority and Endowment Funds with like aims in accordance and compliance with all applicable laws, rules and regulations from local, state, federal and international political entities as it pertains to fiduciary duties and responsibilities.

(6) Acknowledge and agree in writing to their fiduciary responsibility to fully comply with the entire IPS set forth herein, and as modified in the future.

Performance Objectives

Investment performance will be reviewed at least annually to determine the continued feasibility of achieving the investment objectives and the appropriateness of the IPS for achieving those objectives.

It is not expected that the IPS will change frequently. In particular, short-term changes in the financial markets should not require adjustments to the IPS.

Beneficiary Group Definitions

Beneficiary group	***Statutory definition***	***AMHB definition***
the mentally ill	"the mentally ill" includes persons with the following mental disorders: (1) schizophrenia; (2) delusional (paranoid) disorder; (3) mood disorders; (4) anxiety disorders; (5) somatoform disorders; (6) organic mental disorders; (7) personality disorders; (8) dissociative disorders; (9) other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and (10)persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection. [AS 47.30.056(d)]	In the last year, the Alaska Mental Health Board (AMHB) has refined and clarified the way it defines the group of people whose mental health diagnoses place them within these ten categories. The original definition, compiled in 1995, consisted of a listing of DSM-IV codes that describe diagnoses within each of the statutory beneficiary categories. However, this definition appeared to undercount beneficiaries. The AMHB expanded the definition to include diagnoses described in some DSM-III, DSM-IIIR, and ICD-9 codes. The AMHB has also clarified the way it identifies people with childhood disorders. AMHB's position is that all individuals under the age of eighteen with a mental illness are considered at risk of developing a mental disorder, except those with V Code diagnoses (relational problems, problems related to abuse or neglect, etc.).

Beneficiary group	Statutory definition	GCDSE definition
the mentally defective and retarded	"the mentally defective and retarded" includes persons with the following neurologic or mental disorders: (1) cerebral palsy; (2) epilepsy; (3) mental retardation; (4) autistic disorder; (5) severe organic brain impairment; (6) significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection; (7) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection. [AS 47.30.056(e)]	The Governor's Council on Disabilities and Special Education uses the state's definition of a person with a developmental disability to define the Trust's beneficiaries. Alaska's definition of a developmental disability, amended in 1992, is consistent with the federal definition. According to AS 47.80.900 (7): "...person with a developmental disability" means a person who is experiencing a severe, chronic disability that (A) is attributable to a mental or physical impairment or combination of mental and physical impairments; (B) is manifested before the person attains age 22; (C) is likely to continue indefinitely; (D) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and (E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. In addition, the Council considers infants and toddlers who have developmental delays and who are at risk of acquiring developmental disabilities to be Trust beneficiaries. These children ages birth to three have disabilities or delays which can be significantly ameliorated or whose function can be maximized at an early age, but who would otherwise require more intensive long term services.

Beneficiary group	Statutory definition	ABADA definition
chronic alcoholics suffering from psychoses	"chronic alcoholics suffering from psychoses" includes persons with the following disorders: (1) alcohol withdrawal delirium (delirium tremens); (2) alcohol hallucinosis; (3) alcohol amnesiac disorder; (4) dementia associated with alcoholism; (5) alcohol-induced organic mental disorder; (6) alcoholic depressive disorder; (7) other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection. [AS 47.30.056(f)]	The Advisory Board has developed an "operational definition" of alcoholism with psychosis which translates the above data into assessment features collected in the State's Management Information system, which is collected by all state funded treatment programs along with those previously funded by the Indian Health Service and those private providers who choose to collect and report the data. These criteria are as follows: • Alcohol is first drug of choice (information collected from initial assessment) • Client assessed as either dysfunctional or dependent • Client reports consuming alcohol at least six days per week (this question is eliminated for persons receiving services while incarcerated in the penal system)

Beneficiary group	Statutory definition	ACoA definition
Senile people who as a result of their senility suffer major mental illness	"senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders: (1) primary degenerative dementia of the Alzheimer type; (2) multi-infarct dementia; (3) senile dementia; (4) presenile dementia; (5) other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection. [AS 47.30.056(f)]	The ACoA finds that, in the case of Alzheimer's' Disease, there is no definitive diagnostic test and the diagnosis becomes one of exclusion. In defining the population for which they advocate, the Commission includes people with Alzheimer's disease, stroke, frail with no cognitive impairment, and other ADRD including Supra Nuclear Palsy, cerebral atrophy, Huntington's chorea, brain tumor, attention deficit disorder with cognitive impairment, Pick's disease, multiple sclerosis, organic brain disorder, multi-infarct dementia, Parkinson's disease, cancer-related dementia, hydrocephalus, and hypoxia. A very few people with cognitive impairments related to other diagnoses qualify in this population: people with alcohol-related dementia, chronic mental illness, major depression, brain injury, developmental disability, DD-related Alzheimer's, and AIDS-related dementia. The common denominator among these diagnoses is cognitive impairment, except for the frail category.

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For more information about the Trust, please contact:

Alaska Mental Health Trust Authority

3601 C St. Suite 742
Anchorage, AK 99503
(907) 269-7960 phone
(907) 269-7966 fax

for more information about Trust land, please contact:

Alaska Mental Health Trust Land Office

3601 C St., Suite 880
Anchorage, AK 99503
(907) 269-8656 phone
(907) 269-8905 fax

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1/24/97

State of Alaska
Department of
Health & Social Services

Fiscal Year 1998
Budget Overview

Tony Knowles,
Governor

Karen Perdue,
Commissioner

Table of Contents

Department of Health & Social Services

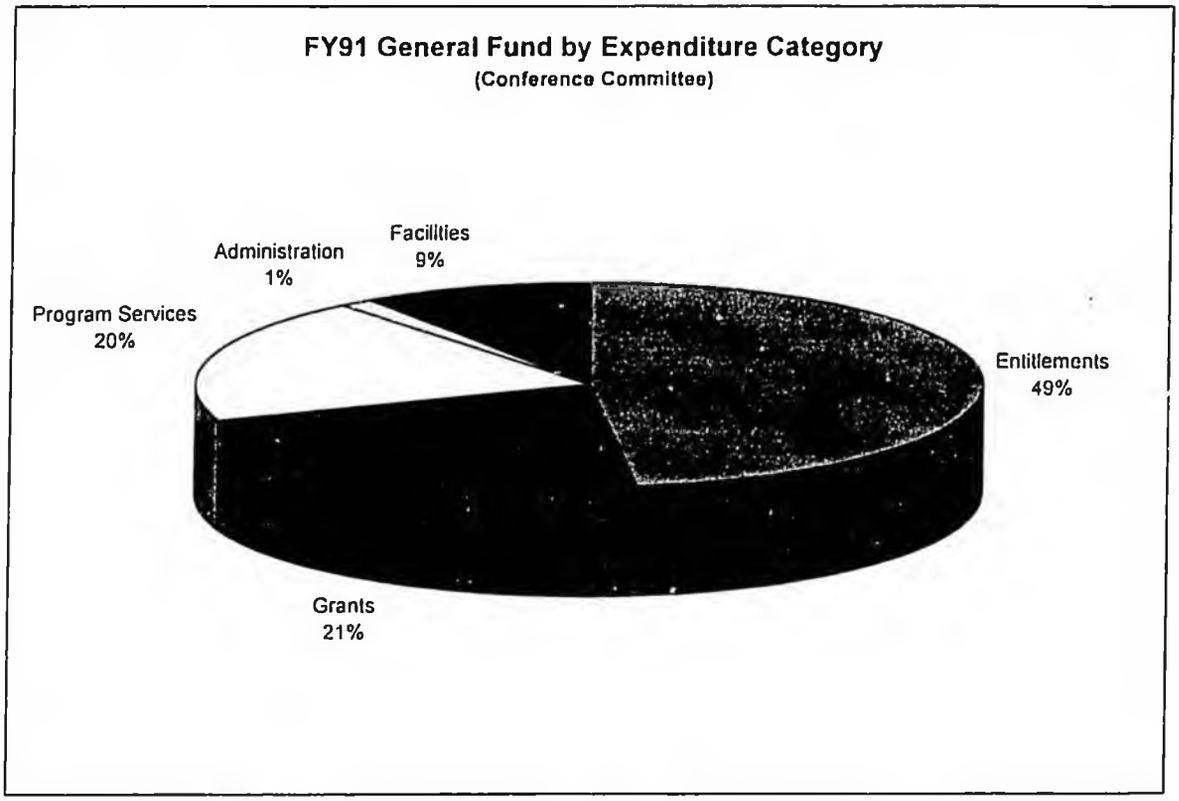
FY98 Operating Budget Highlights

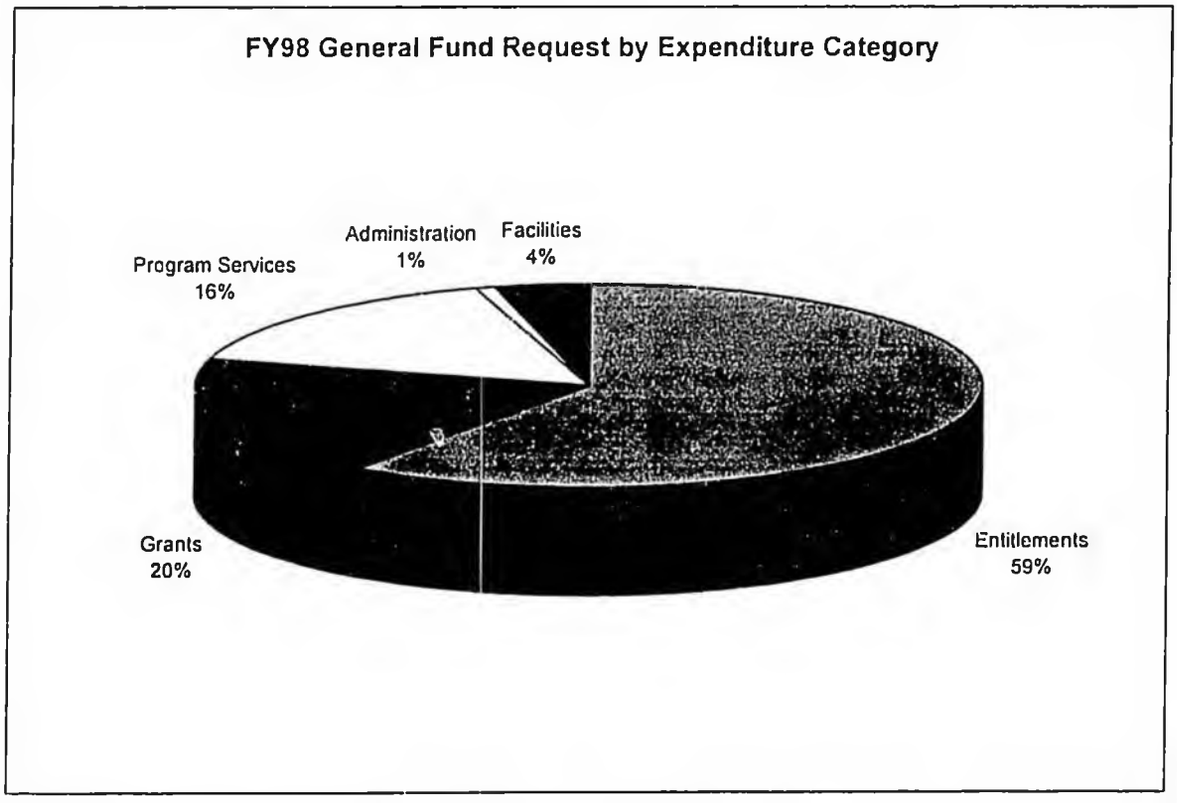
Development of FY98 Governor's Budget Request

	GF	Total
FY97 Conference Committee Report	**$ 448,684.3**	**$ 857,258.1**
Fiscal Notes and Other Appropriations Bills	$ 2,718.3	$ 3,774.2
FY97 COLA	$ 384.7	$ 1,368.7
FY97 Authorized Budget	**$ 451,787.3**	**$ 862,401.0**
Adjustments	$ 1,440.2	$ 2,072.3
Inter-Departmental Transfers	$ (1,510.8)	$ (1,510.8)
FY98 Adjusted Base	**$ 451,716.7**	**$ 862,962.5**
Increments and Decrements		
Formula Programs		
Increments	$ 6,332.5	$ 30,977.0
Decrements	$ (1,099.5)	$ (8,083.7)
Non-Formula Programs		
Increments	$ 2,722.0	$ 12,102.9
Decrements	$ (119.8)	$ (1,663.4)
FY98 Governor's Request	**$ 459,551.9**	**$ 896,295.3**
Net Agency Change (FY97 Auth to FY98 Req)	**$ 7,764.6**	**$ 33,894.3**
Net % Change	1.72%	3.93%

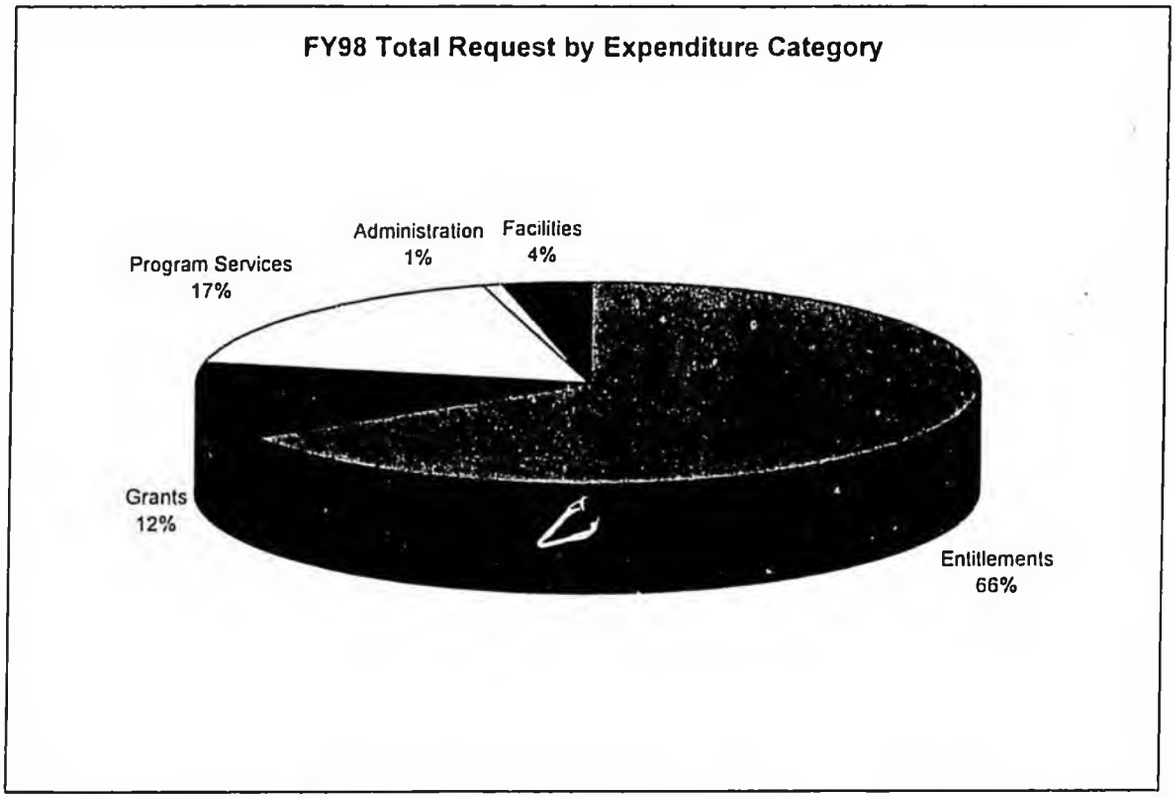
FY98 Postitions	**PFT**	**2078**
	PPT	**61**
	TMP	**11**

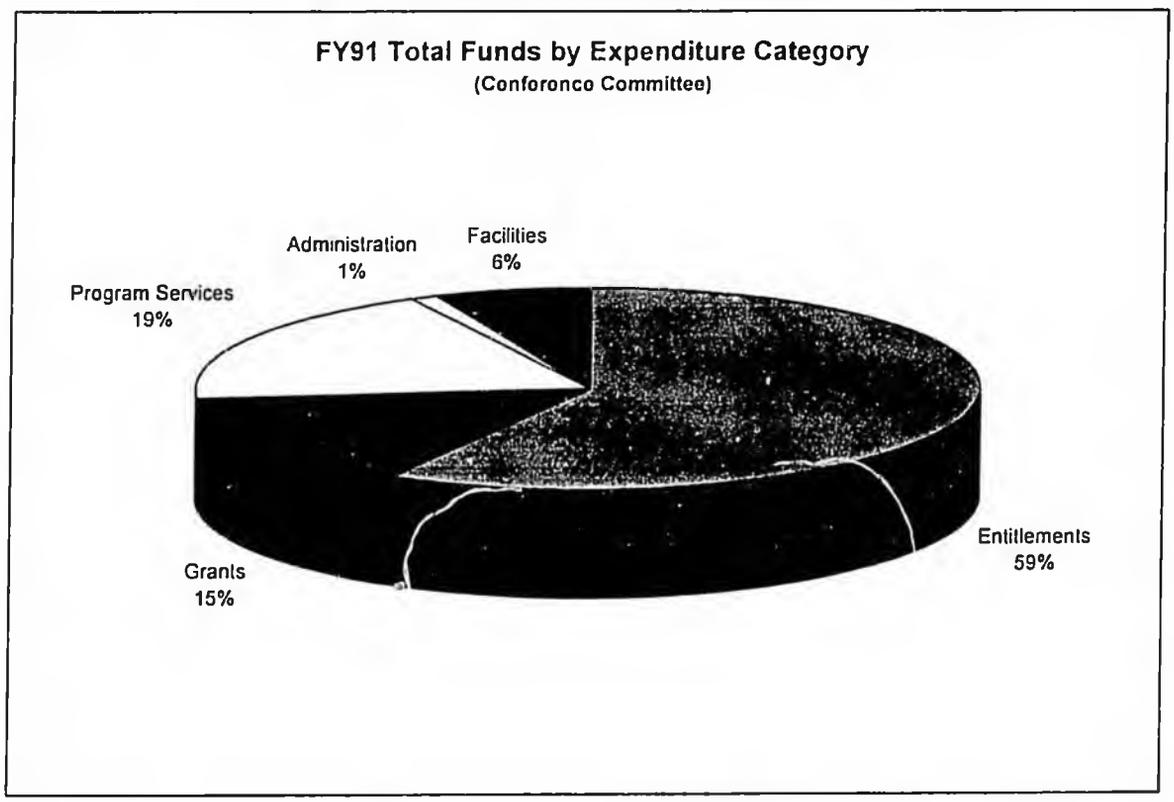
Categorical Comparisons of General Fund Authorization





Categorical Comparison of Total Authorization





Categorical Definitions

Entitlements include all of the formula programs: ATAP, Adult Public Assistance, General Relief Medicaid, General Relief Assistance, Medicaid, Foster Care, Subsidized Adoption and Guardianship, and others.

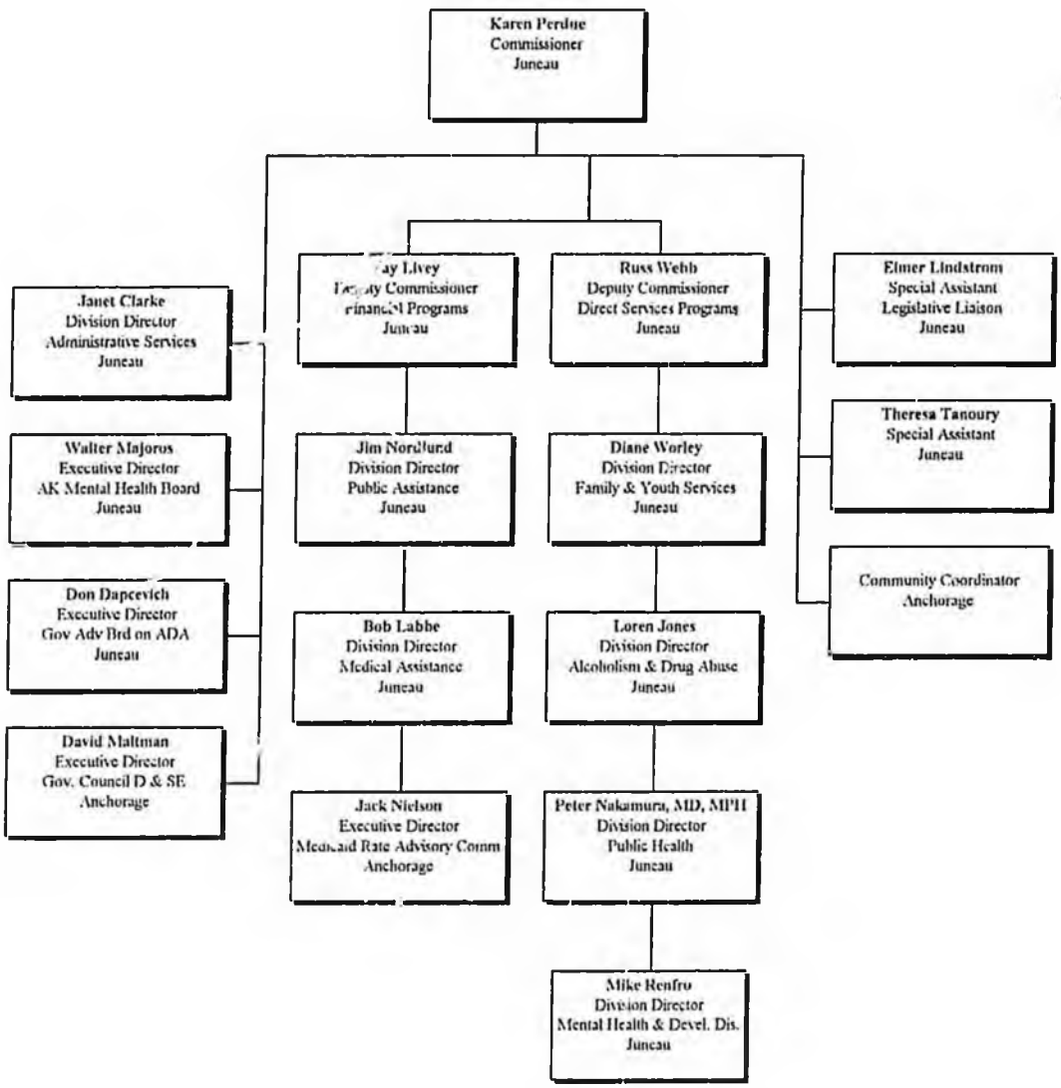
Program Services include both administration and delivery of direct services, such as public health nursing and social services, as well as the administration of entitlements and community grants.

Community Grants include most of the components with major grants to other organizations, major contracts for service delivery, and the Energy Assistance Program.

General Administration services include the Commissioner's Office, and other components of the Division of Administrative Services, the three Mental Health Trust boards—the Alaska Mental Health Board, the Governor's Council on Developmental Disabilities and Special Education, and the Advisory Board on Alcoholism and Drug Abuse—and the new Children's Trust Programs component.

Facilities include youth correctional facilities, the Alaska Psychiatric Institute, and Harborview

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
EXECUTIVE MANAGEMENT ORGANIZATION
August 1996



Juvenile Justice

Governor's Conference on Youth and Justice Recommendations

The Governor's Conference on Youth and Justice recommended many changes in the way Alaska responds to its juvenile offenders and those at risk of becoming offenders. The Administration is responding to those recommendations both by introducing legislation this session and by adding select items to the budget. The legislative and budget items involving the Department of Health & Social Services are as follows.

Legislation

"An Act relating to juvenile delinquency proceedings and to the confidentiality of juvenile records." This is the Governor's main "juvenile justice" bill. It:

1) Authorizes communities to set up diversion programs for minor acts of juvenile delinquency, such as youth courts, a hearing officer system, village community courts, etc.

2) Opens juvenile records for those who are 16 or older and have been charged with a felony offense against a person or, after already having a felony adjudication, are now charged with burglary in the first degree.

- Fiscal Note: $700.0 to replace the federal dollars Alaska will lose if the state's confidentiality laws are amended this session to grant public access to the records of some juvenile offenders.

- Fiscal Note: $410.0 to reorganize the Division of Family and Youth Services so as to prevent losing an additional $7 million in federal funds if the state's confidentiality laws are amended this session.

3) Creates a "dual sentencing" procedure whereby certain juveniles can be given both a juvenile and an adult sentence.

"An Act relating to the revocation of driver's licenses for alcohol-related offenses." This bill creates a mechanism to ensure that minors whose licenses have been revoked for alcohol-related offenses

are being properly screened and monitored for compliance with education and treatment programs before their licenses are reinstated.

- Fiscal Note: To generate revenues to pay for this, the bill raises from $100 to $250 the fee for reinstating any driver's license that has been revoked for an alcohol or drug-related offense.

"An Act establishing the Healthy Families Alaska program." This bill codifies the department's Healthy Families Alaska program and identifies the program's services as an optional medical service available to the recipients of medical assistance.

"An Act relating to Foster Care Review Panels." This bill restructures the state's foster care review panels so that they can be utilized statewide and not just in Anchorage.

Budget

Provide grants for diversion programs in communities around the state, allowing them to respond quickly and appropriately to minor juvenile offenses ($410.0)

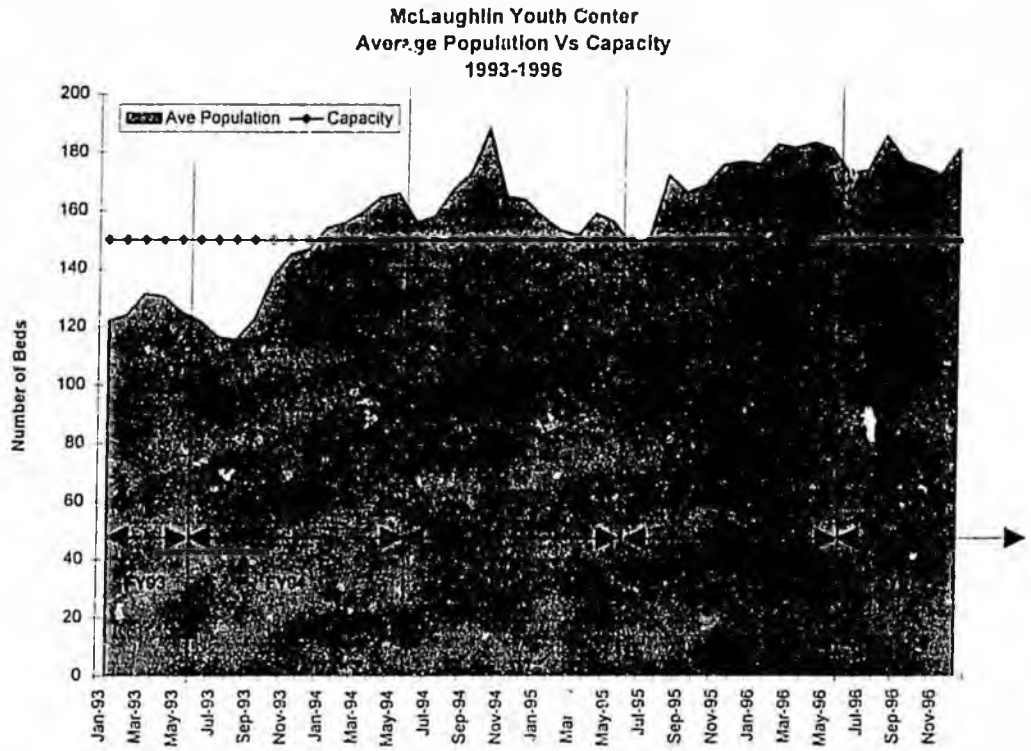
Fund inhalant abuse prevention activities to stop the tragedy of brain damage caused by inhalants, which are especially popular in rural Alaska ($50.0 GF/MH)

Provide additional funding for the Healthy Families program to provide education and support services to pregnant women and the families of newborn infants ($614.0)

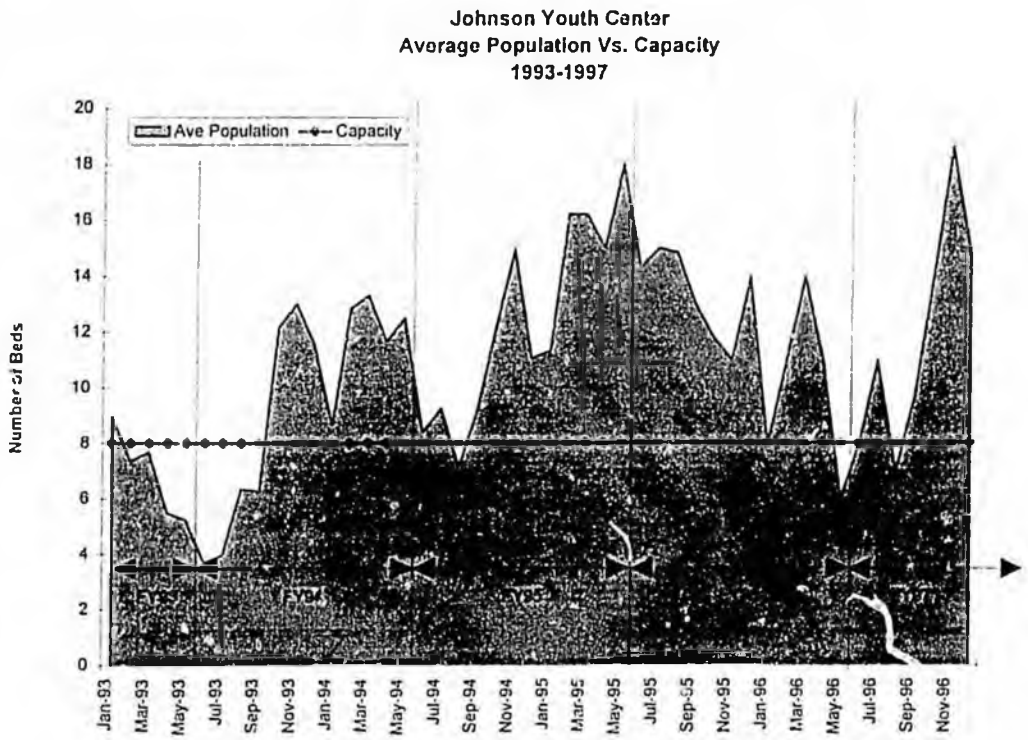
Improve the state's compliance with ICWA (the Indian Child Welfare Act) and coordination with tribal entities ($100.0)

Fund more juvenile probation officers ($398.0)

Facility overcrowding continues to be a major problem in all facilities with MYC recently exceeding the previous all-time high. (See charts page 9.)



Youth Facilities Population vs. Capacity-Chart



How the Welfare World Changed in 1996

State/SB 98 *May 1996*	*Federal/HR 3734* *August 22, 1996*
◊ Rewrites AFDC to ATAP two way bill	◊ AFDC to TANF
◊ Child Support	◊ Child Support
	◊ Food Stamps & ◊ Commodities
	◊ Social Security Income
	◊ Child Protection
	◊ Child Care
	◊ Child Nutrition
	◊ Non-Citizens
	Related Issues
	Housing Immigrant Legislation Earned Income Tax Credit Minimum Wage

Key Implementation Dates

12/96	Food Stamp work provision clock begins
1/97	Disability payments and Medicaid ends for SSI recipients with primary diagnosis of alcohol or drug abuse
2/97	New welfare rules for teens begin
4/97	Employable adults begin to lose food stamps if not working (1800 may be impacted)
4/97	New definition of childhood disability used by Social Security kids will start losing benefits and be denied (approx 250)
4/97	Legal alien food stamp recipients begin losing benefits
Spring 97	Alaska TANF State plan submitted to federal government 60 Month clock begins  recipients must work before 25th month of assistance
7/97	Most provisions of ATAP program (SB98) begin
8/97	Most disabled and elderly legal immigrants lose SSI benefits (approx 675 impacted)

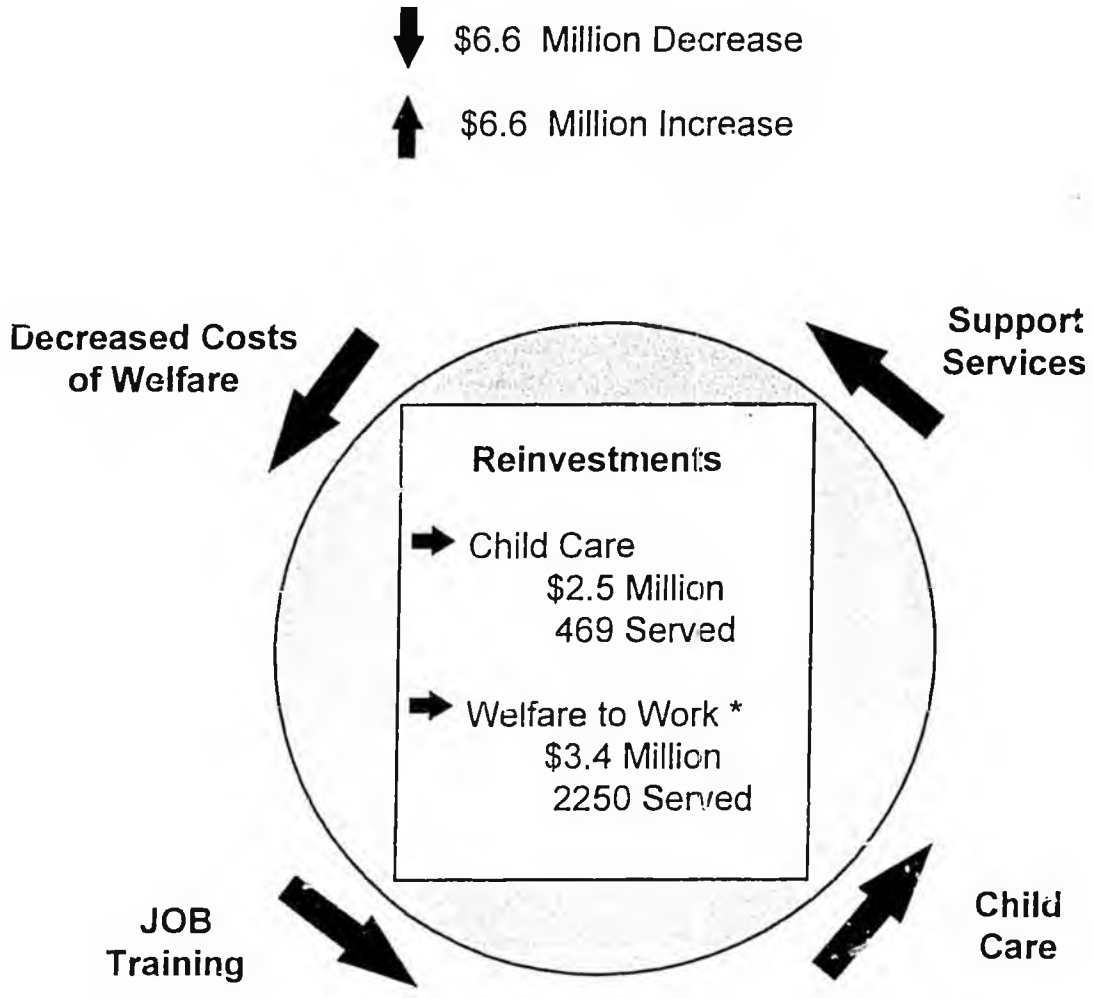
Major Policy Issues

- Alaska Temporary Assistance Program - ATAP
  - * Block Grant Begins
  - * Reinvestment of $2.5M GF benefit dollars
- Work requirements, preparing recipients for work and keeping them there.
- Job Creation for Recipients:- Incentives
  - * Wage Subsidies - portion of welfare benefit to subsidize wages
  - * Tax Credits - federal Worker Opportunity Tax Credit program
  - * Workstar - recognition program for employers who hire welfare recipients
- Administrative Issues
  - * Computer Systems - substantial changes required.
  - * Staff Training. - new training programs to be developed
  - * Work Simplification; application form reduced from 42 pages to 8, computer case management tools
- Electronic Benefits Transfer (EBT)

  Reduces foodstamp fraud, simplify paperwork for vendors and provides a platform for other related applications

  Planning: June 96 - December 96
  Design: April 97 - September 97
  Implementation: October 97 - June 98
  (issue cards, enroll vendors and deploy point of service (POS) devices)

Reinvestments in Welfare Reform



* Represents new recipients who must enter work activities in FY98.

Reinvestments in Welfare Reform-Chart

Mandated Work Requirements

Federal welfare reform established mandatory work requirements for states. If the defined targets are not met, the state may be eligible for fiscal sanctions. The Department has estimated that to meet these targets, approximately 4200 clients need to be in work activities in FY98, an increase of 2000 clients over our current level of effort.

	Average Monthly Cases			
	FY97	FY98	FY99	FY00
AFDC UP	2,000	1,960	1,911	1,854
AFDC Basic*	8,579	8,669	8,413	8,112
Total Cases Subject to Work Reqs.	10,579	10,629	10,324	9,966
Two Parent Participation Rates	75%	75%	90%	90%
All Families Participation Rates	25%	30%	35%	40%
Two Parent Cases to meet rates	1,500	1,470	1,720	1,669
AFDC Basic Cases to meet	1,145	1,719	1,894	2,318
Total Cases to meet rates	2,645	3,189	3,613	3,986
Active cases needed **	3,526	4,252	4,818	5,315
Recipients currently in work Activities		2,000		
New Clients in Work Activities		2,252		

Example:

In the Fairbanks North Star Borough, an estimated 180 ATAP (AFDC) cases currently meet Federally mandated work activity requirements. On July 1, 1997 an estimated 150 additional ATAP cases become subject to Federally mandated work activity requirements.

Other program Issues

- **Alaska Impacts from Changes to Supplemental Security Income**

Disabled Drug Addicts and Alcoholics

Federal law changes eliminated eligibility for Supplemental Security Income recipients for when alcoholism or drug addiction is a contributing factor to their disability determination. As a result, **300** residents (on January 1, 1997) have lost both cash support and Medicaid. Following is descriptive data on this population:

Community of Residence:		**Gender:**	
Anchorage	168	Male	195
Southeast	45	Female	105
Fairbanks	30		
Mat-Su	21	**Age:**	
Other	36	Under 18	0
		18 - 64	297
		Over 65	3

SSI Children

Federal Law changed the criteria for determining eligibility of children under the Supplemental Security Income program. As a result of this change:

* Approximately 250 children will potentially lose their eligibility for SSI benefits under P.L. 104-193
* One-half of these 250 potentially ineligible children will become eligible for cash assistance from the ATAP program and also retain Medicaid
* Up to 50 children may qualify for Medicaid but no longer receive a cash benefit
* 75 children will likely lose all cash assistance and Medicaid

Legal Aliens

On August 22, 1996 President Clinton signed into law P.L. 104-193, The Personal Responsibility and Work Opportunity Act of 1996. This law has a substantial impact on immigrant eligibility for public assistance and medical assistance benefits. The table below compares the benefits to be received by legal aliens under current law and proposed legislation

Program	Current Law	Proposed Change
Food Stamps	Most legal aliens no longer eligible	No change; Fed only program
Supplemental Security Income	Most legal aliens no longer eligible	No change; Fed only program
Medicaid	Most legal aliens barred form Medicaid coverage regardless of entry date into country.	Legal aliens receiving Medicaid as of 8/22/96 grandfathered; legal aliens arriving after 8/22/96 barred for 5 years.
Alaska Temporary Assistance Program (ATAP)	Legal aliens eligible for benefits regardless of date of entry; legal alien benefits all general funds.	Legal aliens receiving benefits as of 8/22/96 grandfathered; legal aliens arriving after 8/22/96 barred for 5 years. Continue federal/state funding.
Adult Public Assistance	All legal aliens continue program eligibility.	Grandfathered eligibility to only those legal aliens in country as of 8/22/96 - legal aliens arriving after 8/22/96 barred for 5 years

FY 97 Budgeted Expenditures
(Legal Immigrants)

Program	General Fund	Total
Food Stamps	$0.0	$812.3
Medicaid	$418.8	$837.5
AFDC/ATAP	$1,349.7	$2,699.4
APA	$3,123.9	$3,123.9
Totals	$4,892.4	$7,473.1

Individual Impacts on Legal Immigrants

Benefits for Blind/Disabled/Elderly

	Before Federal Legislation	After Federal Legislation (current state law)	Under Proposed State Legislation	
			Date of Arrival before 8/22/96	Date of Arrival after 8/22/96
FS	$70	$0	$0	$0
SSI	$484	$0	$0	$0
APA	$362	$362	$362	$0
Medicaid	Yes	No	Yes	No

Benefits for Children & Families

	Before Federal Legislation	After Federal Legislation (current state law*)	Under Proposed State Legislation	
			Date of Arrival before 8/22/96	Date of Arrival after 8/22/96
FS	$70	$0	$0	$0
AFDC/ATAP	$825	$825	$825	$0
Medicaid	Yes	No	Yes	No

* Under current state law, benefits paid to aliens under the ATAP program are all general funds.

Public Assistance Data on Statewide Immigrant Population

(for Immigrants on Public Assistance Only)
as of January 1, 1997

Programs

Program Type	ATAP Only	ATAP/ FS	APA Only	APA/ FS	FS Only	FS/ MED	GRA/ GRM	MED Only	Total
# of Persons	167	651	639	162	154	69	7	256	2,105

Heritage

Heritage	Asian	Black	Hispanic	Pacific Islander	White	Other/ Unknown	Total
# of Persons	1,069	44	429	119	360	84	2,105

Time on Assistance

Less than 5 Years	461
More than 5 years	644
Total	2,105

Alien status:

Currently Sponsored :	81
Non-sponsored:	2,024
Total	2,105

Age:

Under Age 18:	439
18 - 64:	1,025
Over Age 64:	641
Total	2,105

Community of Residence:

Anchorage	1,414
Kodiak	160
Mat-Su	134
Fairbanks	106
Southeast	99
Other	192
Total	2,105

SSI Status:

SSI Recipient	669
Non-SSI Recipient	1,436
Total	2,105

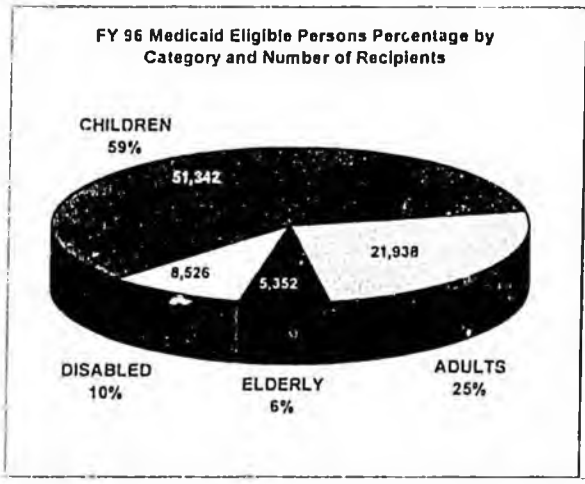
Sex:

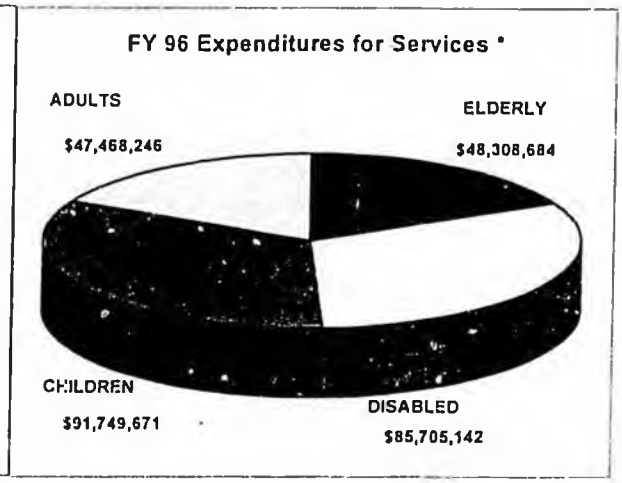
Male:	784
Female:	1,321
Total	2,105

Type of Recipient:

Children & Families	1,304
Aged & Disabled	801
Total	2,105

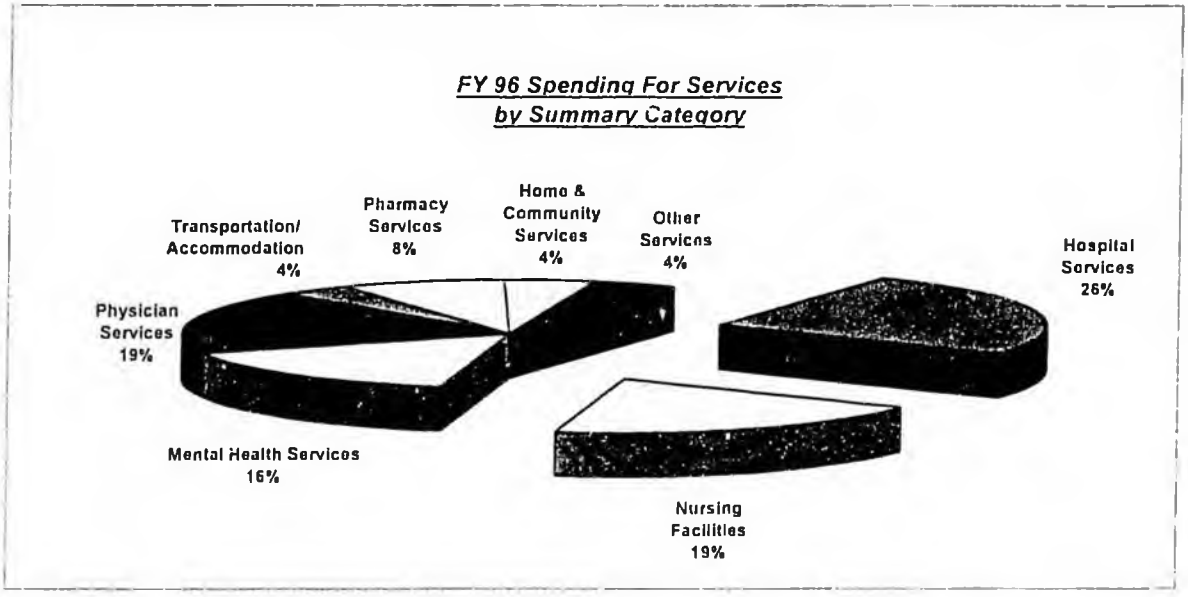
FY 96 Medicaid Program Summary





FY 96 Average Cost of Direct Services per Eligible

ELDERLY	$9,026	DISABLED	$10,052	CHILDREN	$1,787	ADULTS	$2,164



FY96 Medicaid Program Summary-Tables

The FY98 Medicaid budget assumes that the number of new eligibles to the Medical Assistance programs will remain fairly flat, if:

- the Alaskan economy does not enter a period of recession,
- medical and other inflationary factors continue to moderate, and
- no new unfunded federal mandates or cost shifts to the states.

Other economic and population based factors (price and utilization), based on historical trends, create formula growth ($10.9M) for FY98

Given several assumptions listed here, the FY98 Medicaid budget will:

- not require a General Fund increment except for the restoration of optional services and

- provide medical services for 88,000 Alaskans

While it appears that the GF change for FY98 is large, it is primarily due to transfers of existing GF match from other BRUs in order to more accurately reflect costs and improve program management efficiency.

- $5.8M API transfer
- $3.1M Hope Cottage ICF/MR decertification

Managing Medicaid Spending - Cost Management

FY97:

- Formula growth projected total costs absorbed in FY97 ⇒$ 4M (Legislative reduction)

- Revised regulation packages limiting amount paid to hospital and nursing home providers

  - Basing facility costs on 3 yrs. rather than 2 yrs.
  - Allowable costs clarified - advertising, drugs etc.
  - Payment for long term care capital based on occupancy

- Implement a fee schedule for physicians
- Upgrading the "Claim Check" software in the MMIS
- On-site reviews for quality assurance of services
- Expansion of the Lock-In program
- Managed Care pilot projects

FY98:

- Formula growth projected total costs absorbed in FY98 ⇒$10.9M
  - * Pre-admission screening
  - * Primary care case management
  - * Expand on-site medical reviews
  - * Review transportation costs

- Increase in federal authority ($15.6M) for Indian Health Service (IHS) due to rate increases and a shift in costs to the federal government for IHS eligible clients.

Restoring Optional Services

- Restoration of emergency dental services, speech-language pathology services, audiology services, hearing aids, vision examinations and eyeglasses, and occupational therapy services
- Optional services will be provided to over 15,000 people in FY98
- * Approx. 2,300 elderly, 3,100 disabled, 9,600 adults going to work
- Restoration co-funded by the AMHTA which allows leveraging the $1.2M in GF Match into $4.6M in services for Alaskans.

Long Term Care

The demographics of Alaska are changing as the number of Alaskans over the age of 65 is increasing rapidly. Following are FY96 long term care expenditures and tables which illustrate how Long Term Care (LTC) services could grow over the next few years for recipients over the age of 65.

Long Term Care Expenditures and Clients Served - Ages 65 and over
FY96

	Persons Served	Expenditures	GF Expenditures
Nursing Homes	630	$ 34,737,440	$ 17,368,720
Pioneers Homes	693	$ 29,842,300	$ 24,718,800
Home Based Services	1,814	$ 6,970,742	$ 4,839,313

- Nursing Home Expenditures do not include co-payments, also does not include some payments not yet made by Medicaid due to late billing etc.
- Pioneer Homes: Persons served are a close estimate based on the monthly Pioneer Home report of occupancy, admissions and discharges

- Pioneer Homes Expenditure is FY96 Authorized and includes $5,123,500 in program receipts
- Home Based Services includes:
  - ◊ Commission on Aging Home and Community based grants
  - ◊ Developmental Disability Grants (FY96 authorized)
  - ◊ Older Alaskan Waivers
  - ◊ Personal Care Services funded by Medicaid

Low Range Projection - Cost Increase of 2%, Population Growth Rate of 2%

#Clients	Year	Total Cost
3137	1996	$ 71,550.5
3338	2000	$ 81,170.0
4253	2015	$131,991.8

Medium Range Projection - Cost Increase of 5%, Population Growth Rate of 5.4%[1]

#Clients	Year	Total Cost
3137	1996	$ 71,550.5
3713	2000	$ 98,915.9
7370	2015	$363,345.0

[1] Equals growth experienced for this population from 1990-1995

High Range Projection - Cost Increase of 8%, Population Growth Rate of 6.5%

#Clients	Year	Total Cost
3137	1996	$ 71,550.5
3884	2000	$ 111,389.7
9414	2015	$694,281.6

The long term care (LTC) needs of elderly and disabled people in Alaska represent a major cost center within the state's health care system, today and in the future. DHSS is actively involved in an interdepartmental effort to manage these high cost services efficiently and to plan the development of an effective, affordable long term care system.

LTC Effort Shared Mission and Goals

- **Mission**

  Vulnerable Alaskans must have access to the appropriate help needed to live safely in their homes and communities. The ongoing mission of the state's long-term care policy is to help plan for and provide this access.

The focus of the Knowles Administration, in FY97 and FY98, is to respond to the impending crisis in the need for affordable long-term care services in community-based settings, within an environment of limited resources.

- **Goals**

  * Respond quickly to vulnerable Alaskans' community-based long-term care service needs.

  * Make long-term care more accessible by making it more affordable.

  * Promote long-term care services that preserve the integrity, independence, and safety of individuals and families.

  * Improve the climate for private development of home and community-based care businesses.

  * Expand local communities' ability to increase home and community-based services.

Current Activities:

Waiver Streamlining

* Improvements to the waiver process has reduced waiver processing from six months to two months

* By the end of FY97, a reduced application for Medicaid long term care will be implemented, from 32 pages to 8 pages

Participate in development of assisted living services

* In cooperation with the Division of Senior Services (DSS) and Alaska Housing Finance Corp. (AHFC), implement assisted living in Bethel

FY98 Budget

Consolidation of long term care programs

* DMA waiver management functions transferred to DMHDD and DSS
* Personal care is being transferred to DSS
* DPH and DMA will be removed from the application and authorization process

Helping Communities Manage Their Health Care System

The rural health care delivery system is facing serious problems:

- Declining hospital utilization is shrinking revenues.
- Available professional resources are diminishing.
- Alaska rural facilities are resources are stressed attempting to comply with regulations.
- Rural hospitals can no longer provide the comprehensive services Alaskans have come to expect.

The department explored solutions through regulatory relief working with rural hospital administrators in response to the urgent situation facing the Seward Hospital in 1996.

Although the state is allowing hospitals to downsize by limiting services, changes to federal laws are needed to guarantee the continued survival of the rural health care delivery system.

Phase I - State Licensing Regulations

Hospital licensing regulations have been adopted to create two types of hospitals:

General Acute Care, full service hospitals;
and
Rural Primary Care, limited service hospitals. (i.e. surgical procedures, perinatal care)

Rural Primary Care Hospitals will continue to be licensed and Medicare certified without the need for any waivers of federal or state requirements.

Regulations are under priority review in the Department of Law.

Phase II - Federal Medicare Certification Law

The Department will seek a change in federal law on Medicare certification of hospitals,

or

Get Congressional approval of Alaska as a pilot project for a new rural hospital designation under Medicare.

Medicare certification is critical to guarantee access to Medicare, Medicaid and other insurance.

The phase II plan will develop a third level of hospital that would be:

- For rural communities only.
- Licensed by the State.
- Staffed by mid-level practitioners and RNs,
- Linked to a General Acute Care Hospital with telemedicine,
- It would have two to six beds for short term inpatient care under the direction of the mid-level practitioners.
- It will provide an option for some patients to stay in their communities for care.
- Provide the staff and facilities for emergency stabilization.

Bills similar to this rural hospital concept have been introduced in both Houses of Congress in recent years with fairly wide support.

It is time to seek a change in Medicare certification laws for rural hospitals in Alaska.

Partnership with the Alaska Mental Health Trust Authority

DHSS is partnering with the AMHTA in achieving shared missions, principals and goals

- To improve and protect the well-being of Alaskans including
  - * People with mental illness
  - * People with developmental disabilities
  - * Chronic alcoholics suffering from psychoses
  - * People who as a result of senility suffer major mental illness
- To develop a community-based and consumer-centered service delivery system that is accountable, effective, and built on successful outcomes.
- To fulfill the Department's responsibility as lead agency to facilitate development of the Comprehensive Integrated Mental Health Plan (CIMHP)

Moving from Institutions to Community Care

- **By December 1997, No ICF/MR institution in Alaska**
  - **Closure of Harborview Developmental Center (HDC):**
    - * 20 former residents now community based placements, 12 more to follow in FY97
    - * 12 individuals will remain in HDC on July 1, 1997, and will be moving by December 1997
  - **Conversion of Hope Cottages Intermediate Care Facility for the Mentally Retarded (ICF/MR)** (40 Beds)
  - **Waiver Streamlining**
    - * Improvements to waiver process reduces waiver processing to no longer than 60 days.
- **Serving children in their own home**
  - **TEFRA (The Tax Equity and Fiscal Responsibility Act: PL 97-248) for Children who are Severely Emotionally Disabled (SED)**
    - * Provides Medicaid eligibility for approximately 80 children
    - * Services are home based and avoid more costly institutionalization

Quality Assurance

- Beef up the oversight of adult and children mental health programs

MHTAAR funding

- **AMHTA funding a number of projects in FY98 with $4,053.7 of MHTAAR**

- **Restoration of Medicaid Options**
  * To provide services for basic health needs of beneficiaries

Increments to the GF/MH Base

- Inhalant Prevention Project ($50.0 GF/MH)

* Recent survey showed Alaskan youth inhalant use at a greater rate than U.S.
* This primarily rural project will do the following in the first year:

  1. Develop and assure delivery of mass media prevention messages targeted at children, adolescents, and adults; and
  2. Provide information to adults on how to access intervention/treatment services for inhalant abusers.

Infant Learning Grants ($100.0 GF/MH)

* Currently, there are approximately 550 children waiting for ILP services
* The FY98 increment would take approximately 30 children and their families

Healthy Communities

Protect Basic Core Services

Protection and promotion of the public's health is a major responsibility of the Department of Health and Social Services.

Public Health Laboratory Infrastructure Upgrade

- The Anchorage and Juneau laboratories are unable to meet the demands of modern laboratory technologies.
- The buildings have mechanical system and structural inadequacies for conducting laboratory testing and analysis.
- Additional space is needed to house the State Medical Examiner program which must vacate space in the State Crime Detection Laboratory in Anchorage so that the Department of Public Safety can develop a DNA analysis laboratory.
- Co-location of the Juneau and Anchorage labs along with the State Medical Examiner's lab in a new facility in Anchorage will both increase operational efficiency and save operating costs.

Healthy Families Alaska

The Governor's budget includes an increase of $614.0 GF for the Healthy Families program. Healthy Families Alaska is a voluntary, community based and community run, home visiting program for families with infants who are at risk of poor childhood outcomes including abuse and neglect. The program follows closely the Healthy Families America model promoted through the National Committee to Prevent Child Abuse by working with at risk families long term (three to five years).

The program serves 263 families in eight (8) sites: Kenai, Anchorage, Mat-Su Borough, Mountain View, Dillingham and surrounding communities, Juneau and the two newest sites, Fairbanks and Bethel.

The program is relatively new so outcomes are difficult to assess, but initial results show promise.