ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672
10046 SENATE HEALTH EDUCATION & SOCIAL SERVICES

Mental Disorders Are Disabling

	% of Disease Burden
All cardiovascular conditions	18.6
All mental illness	15.4
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

Sen Wilken -
what other
diseases

Mental Disorders Are Disabling

	Years of Lost Life
All cardiovascular conditions	~~18.6~~
All mental illness	~~15.4~~ (are attributed to mental illness)
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

Facts About Mental Illness

- ***Up to half*** of all visits to primary care physicians are due to conditions caused by or exacerbated by mental health problems.
- ***Approximately 15%*** of all adults who have a mental disorder in one year also have a co-occurring substance abuse disorder.
- ***One in five*** children has a diagnosable emotional disorder.
- The incidence of suicide among 15-24 year olds has ***tripled since 1960***.
- ***Nearly half*** of those with severe mental illnesses do not seek treatment.

Mental Health Treatment Works!

- Many have experienced mental health problems and succeeded through effective intervention.
- Science shows treatment is effective.
- New medications are more powerful with less side effects.
- Getting help is the key!

Barriers to Mental Health

- Stigma
  "If I had a heart attack people would be concerned, but since I have a mental illness people laugh at me."

- Culture/Ethnicity/Gender/Age factors

- Financial challenges

Surgeon General's Call To Action

- Continue to Build the Science Base
- Overcome Stigma
- Improve Public Awareness of Effective Treatment
- Ensure the Supply of Mental Health Services and Providers
- Ensure Delivery of State-of-the-Art Treatments
- Tailor Treatment to Age, Gender, Race, and Culture
- Facilitate Entry Into Treatment
- Reduce Financial Barriers to Treatment

Alaska Mental Health Initiatives

Four Important Themes

- Making more services available locally
- Providing programs to serve all ages
- Recognizing that mental health consumers hold the keys to success
- Increasing service accountability

Making More Services Available Locally

- ***Community Mental Health/API 2000:*** This project moves services from API to community-based care.

- ***Rural Services:*** AMHB, DMHDD and AMHTA are pursuing more training and support for rural communities.

- ***Decriminalization*:** Programs are developing to decriminalize the mentally ill by providing more appropriate supports in the community.

Providing Programs To Serve All Ages

- ***Children's Services:*** DHSS has initiated many children's programs to improve mental health care in Alaska. Denali KidCare
- ***Supported Housing:*** Housing with support services is being developed to divert mentally ill adults from API and DOC. Jail diversion program pilot project.
- ***Behavioral Health:*** More efforts are taking place at the state and local level to integrate mental health and substance abuse treatment services.
- ***Long Term Care Task Force:*** The Task Force has taken a leadership role in improving the care system for vulnerable adults and the elderly.

Mental Health Consumers Hold The Keys to Success

- ***Consumer Leadership:*** Significant consumer involvement is becoming a way of life in the planning, implementing and monitoring of mental health services throughout Alaska.

- ***Recovery Focus:*** Standards for mental health services focus on the "recovery model"--building on the strengths of the consumers and assisting them to successfully live independent and productive lives.

Increasing Service Accountability

- ***Quality Assurance:*** DMHDD initiated an intensive quality assurance monitoring process in 1996.

- ***Legislative Performance Indicators:*** The Alaska State Legislature implemented Performance Indicators for measuring outcomes of service delivery.

- ***Mental Health Performance Measure Project:*** The AMHB and DMHDD are leading a statewide effort to develop common performance measures for public-funded mental health services.

How Legislators Can Help

- ***Fund Mental Health Services:*** To successfully address mental illness in Alaska, it is critical that there be adequate funding for mental health grants and Medicaid. Ref. Omnibus Bill - allocated almost $1 million in support

- ***Continue the Mental Health Parity Debate:*** Many Alaskans cannot get the mental health services they need due to limitations in insurance coverage. ***Parity*** for mental health and substance abuse coverage needs to be addressed. Bring parity bill back to table. Sen Elton's bill not as comprehensive as others)

- ***Fund Basic Support Services:*** Individuals with severe mental illnesses struggle daily to function safely in the community. Basic supports to address needs such as food, shelter and healthcare are critical to their survival.

- ***Be a Mental Health Leader in Your Community:*** As legislators, you can take a leadership role in addressing mental health issues in your own communities.

Overview:

Dept.

H & SS

3/17/99

Department of Health and Social Services
Goals -- March 1999

Child Protection

By implementing revisions to Alaska's child protection laws and continuing other system reforms, Family Services will:

- Improve responses to reports of harm: respond to an additional 1,400 reports of harm within the next two years;
- Move at least 150 of the children currently "stuck in the system" to permanent, safe homes and decreasing the time all children spend in temporary foster care in FY 00;
- Make sure all child protection workers get quality orientation and training;
- Better coordinate and assist in child abuse and neglect investigations by putting in place six multi-disciplinary teams in FY 00;
- Boost the capacity to provide safe alternative care for children who cannot stay at home by recruiting an additional 100 foster homes and adding 30 additional emergency shelter beds in FY 00.

Child Health Reform

- Through outreach efforts following implementation of Denali KidCare, the state will make health care coverage available to an additional 11,600 children and 800 pregnant women.

- By the year 2000, 90 percent of Alaska's children will be fully immunized by their third birthday.

Alaska Psychiatric Institute

- Create a more responsive mental health system by replacing the old API and developing an array of community-based mental health services.

Vulnerable adults and children

- Make sure vulnerable adults and children have safe places to live by raising the pay for caregivers and by putting in place quality review systems.

Youth Corrections

- Add 80 beds to the state's youth corrections 240-bed system by 2001 and reduce overcrowding from its current level of 120 percent of capacity to 110 percent of capacity.

- For first time misdemeanor offenders, increase local intervention efforts by enlisting the help of Native organizations and local governments.

Welfare Reform

- By FY 02, 50 percent of Temporary Assistance cases will be in a job or other approved work activity.

- Pass legislation authorizing Native organizations to run their own public assistance programs.

- By implementing new Medicaid law, individuals with disabilities may return to the workforce without fear of losing health coverage.

Unintended Births

- Reduce the rate of unintended births to 35 percent by the year 2000.

Substance abuse

- Develop substance abuse treatment and prevention programs for pregnant women and women with children in areas not now served.

State of Alaska

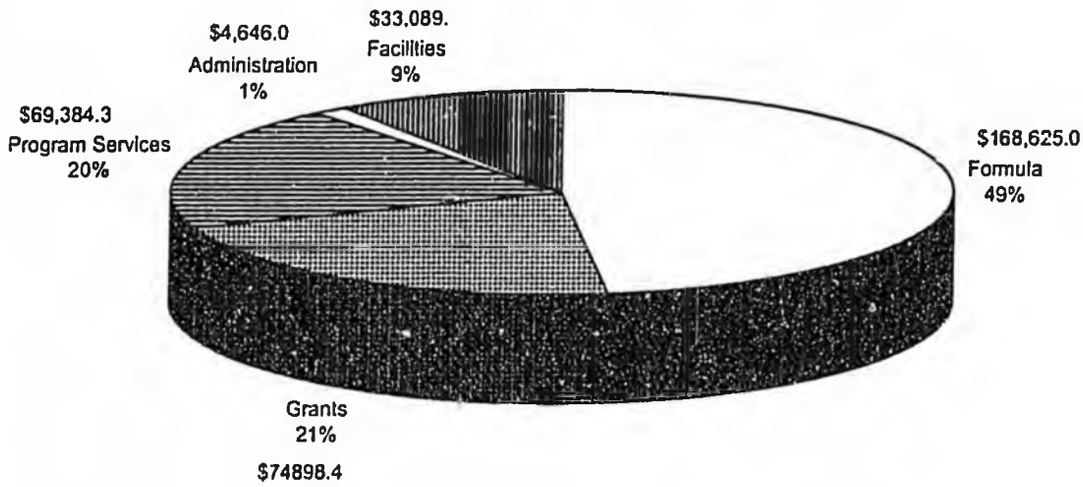
Department of Health & Social Services

Fiscal Year 2000 Budget Overview

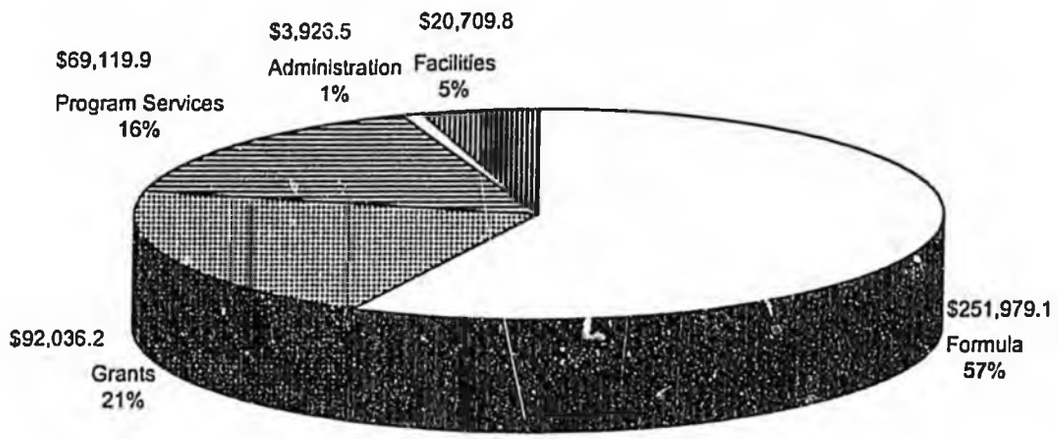
Tony Knowles
Governor

Karen Perdue
Commissioner

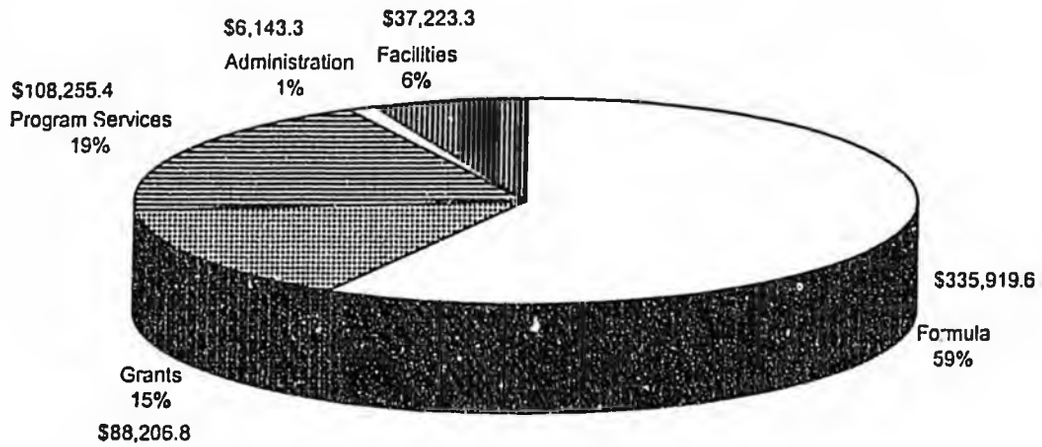
FY91 General Fund by Expenditure Category
(Conference Committee)



FY2000 General Fund by Expenditure Category
(Governor's Request)



FY91 Total Funds by Expenditure Category
(Conference Committee)



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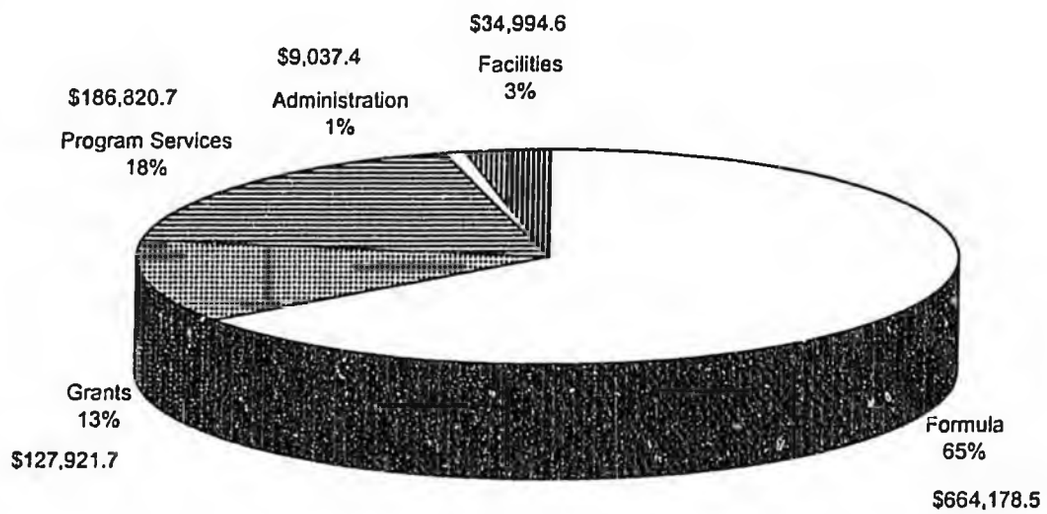


Formula Components
ATAP
Adult Public Assistance
General Relief Assistance
OAA-ALB Hold Harmless
PFD Hold Harmless
Medicaid Service
Chronic Acute Medical Assistance
Child Care Benefits
Foster Care Base Rate
Foster Care Augmented Rate
Foster Care Special Need
Foster Care AYI
Subsidized Adoption & Guardianship

Development of FY 2000 Governor's Budget Request

	GF	Total
FY99 Conference Committee Report	**$ 422,708.2**	**$ 922,126.0**
Fiscal Notes & Other Appropriations	2,644.1	15,890.3
FY99 Authorized Budget	**425,352.3**	**938,016.3**
Adjustments	0.0	2,581.7
Inter-Departmental Transfers	(1,080.1)	(1,080.1)
FY 2000 Adjusted Base	**424,272.2**	**939,517.9**
Increments and Decrements		
GF $13,499.3		
TSF 20,073.4		
MHTAAR (379.7)		
FED 44,966.2		
OTH 5,275.8		
Total Increments	13,690.2	85,843.2
Total Decrements	(190.9)	(2,408.2)
FY 2000 Governor's Request	**$ 437,771.5**	**$ 1,022,952.9**
Net Agency Change (FY99 Auth to FY 2000 Request)	**$ 12,419.2**	**$ 84,936.6**
Net % Change	2.92%	9.05%

FY 2000 Positions	PFT	2250
	PPT	68
	TMP	18

Welfare Caseload

27%

(Dec 96 – Dec 98)

SPECIAL POINTS OF INTEREST:

- Welfare caseload has declined 14% from the past year.
- Welfare savings for Fiscal Year 1998 topped $24 million.
- Since July, 1997, 3,300 families have left welfare for jobs.
- The welfare caseload has dropped to under 9,000 for the first time since 1991.

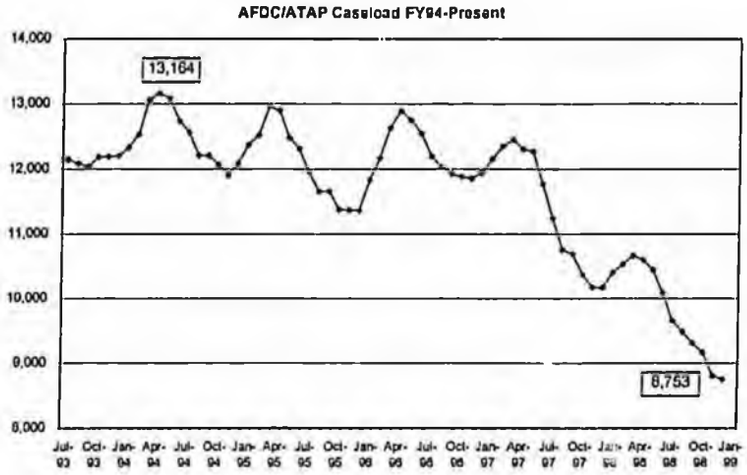
DIVISION OF PUBLIC ASSISTANCE

Welfare Reform Update

Caseload Down 27% in Five Years

In December 1998, the Temporary Assistance caseload declined to 8,753, its lowest point since February, 1991. This figure is 33% below the historical peak of 13,164 in April of 1994.

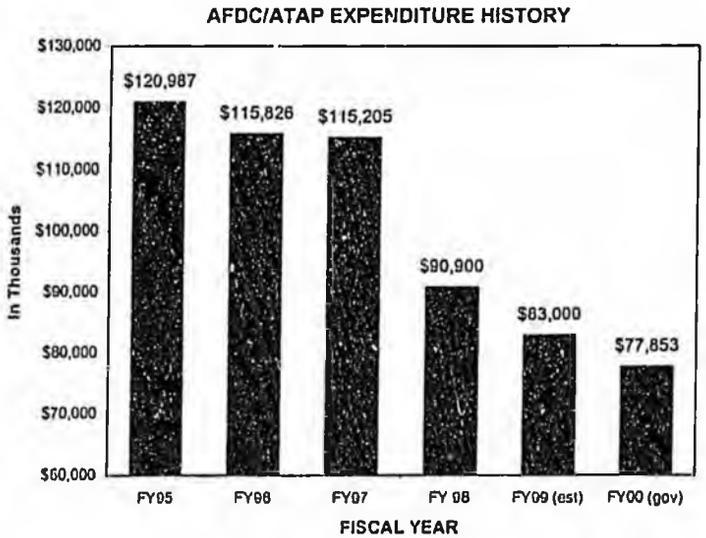
The decline began in February 1997 when the first ATAP provisions took effect and has continued interrupted only by the regular seasonal upswing during the winter months.



Spending Down 36% in Five Years

Spending on welfare payments is down. In FY98, these expenditures declined to $90.9 million, a 21% reduction from FY97. Projected for FY99 are expenditures of $83 million, and the Governor's request for FY2000 anticipates a further decline to $77 million.

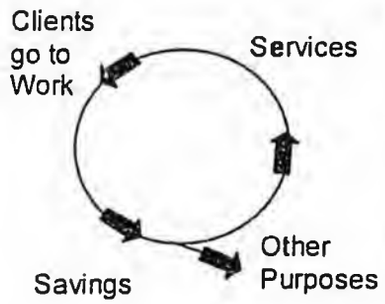
Lower expenditures can be attributed to more recipients leaving welfare for work, more recipients working, benefit cuts to two-parent families, and reductions due to lower housing costs.



Spending down **$37** Million from FY97

January 22, 1999

Reinvestments Critical to Welfare Reform



For the past few years, the State of Alaska has pursued a reinvestment strategy that has been critical to the early success of welfare reform. Under this strategy, as recipients leave the caseload, there are savings in benefit dollars. A portion of these savings are reinvested in services to help even more recipients off welfare, which in turn, results in more savings, and the cycle continues.

From FY97 thru FY99 the level of spending for welfare benefits will drop by an estimated $37 million. From this savings pool, last session the legislature reinvested $9.27 million in child care and work services for welfare recipients.

This year, the Governor has requested a reinvestment of $11.5 million which will help recipients achieve and sustain self-sufficiency and keep welfare benefit costs down.

The entire reinvestment is federal funds. State general funds for benefits and other services has reached the federally required minimum level.

Child Care Key to Gaining Self-Sufficiency

The Governor's FY2000 budget proposes reinvesting $8.02 million into Child Care.

Providing access to child care is a key component in the state's efforts to move more parents into full-time jobs and more families toward self sufficiency.

Over the past four years, total spending on child care subsidies has grown by more than $10 million -- to $29 million in the current fiscal year. And, during that same period, the average number of children who recieve subsidized care has risen from about 5,900 to nearly 8,000 per month.

This year the governor has requested a reinvestment of $7.0 million for child care subsidies and $1.0 million for working parents and for improvements to the quality of child care.

Training opportunities are offered to more child care providers to improve the quality of care. Projects are under way to increase the capacity of care for infants, toddlers, and school-age children.

A specific program has been developed to promote the care of young children with special needs.

The state's continued commitment to improving the quality, availability, and affordability of child care will help ensure that even more families are able to become self-sufficient.

Work Services Moves Recipients into Jobs

The Governor's FY2000 budget proposes reinvesting $3.50 million into Work Services.

With welfare reform's concerted focus on moving welfare recipients into the workforce, it is evident there is greater need to help individuals with low skills, a lack of work history and other barriers from welfare to work. The services intended to help recipients into the workforce are referred to as Work Services.

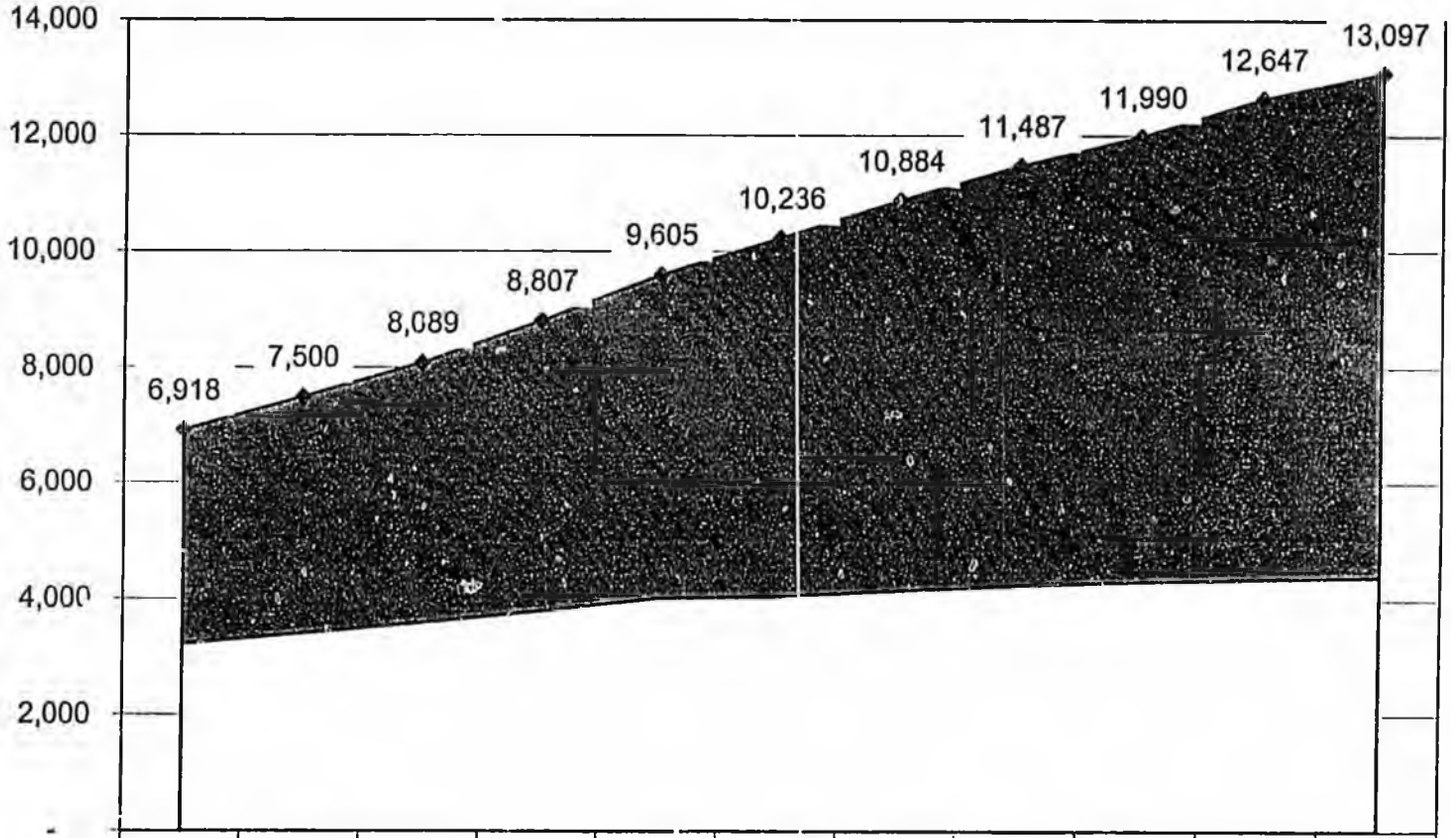
Recognizing that many welfare recipients have substantial challenges to employment, Alaska's Work Services include programs for skill building, post-employment services, basic education, counseling, and training combined with work.

Recognizing the importance of community ownership, DPA has increased community based Work Services grants and contracts sevenfold since FY96.

Over 30 grants and contracts, blending Federal Welfare-to-Work and State funds, provide case management, work search, and other services designed to move recipients into the workforce and off of public assistance.

This year the governor has requested $3.5 million to expand case management and supportive services for recipients, to fortify the training of case managers, to assist in the transportation of welfare recipients to work, and to provide job training for needed occupations in Alaska.

APA Caseload Projection



	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98	proj. FY99	GOV FY00
Aid to the Disabled or Blind	3,690	4,086	4,491	5,005	5,581	6,172	6,722	7,227	7,670	8,282	8,692
Old Age Assistance	3,228	3,414	3,598	3,802	4,024	4,064	4,162	4,260	4,320	4,365	4,405
FY Caseload avg	6,918	7,500	8,089	8,807	9,605	10,236	10,884	11,487	11,990	12,647	13,097

CHRONIC AND ACUTE MEDICAL ASSISTANCE (CAMA) PROGRAM

NEW PROGRAM WITH NO ABORTION SERVICES AUTHORIZED BY THE LEGISLATURE AS REPLACEMENT TO THE GENERAL RELIEF ASSISTANCE (GRM) PROGRAM

WHO IS ELIGIBLE?

- A person with a monthly income of less than $300 and assets of $500.
- A person with an immediate need for medical care for a terminal illness, chemotherapy treatment for cancer, or a chronic condition such as diabetes, a seizure disorder, and chronic mental illness, or hypertension

WHAT SERVICES ARE COVERED?

- Hospital, nursing home care, physician services, laboratory, x-rays, prescription drugs, and medical transportation.
- Physician services are limited to 12 visits per year and hospitalization is limited to eight days per year.
- A CAMA recipient must pay $50 per day up to a maximum of $200 per hospital admission, and $1 copayment on each prescribed drug or medical supply.
- Payment for facility services is limited to 28.7% of the Medicaid rate.

FY98 DEMOGRAPHICS OF THE CAMA PROGRAM (FORMERLY GRM)

- 76% are White, 9% are Black, 4% are Hispanic
- 61% are between the ages of 21 and 44; 37% are between the ages of 45 and 64.
- 45% reside in Anchorage, 12% in Fairbanks, 9% in Wasilla, 4% each in Juneau and Palmer

FY98 – FY2000 EXPENDITURES (ACTUAL AND PROJECTED)

FY98	$3.174.1	Actual expenditures (GRM w/o Abortion Services)
FY99	$3,100.0	Projected expenditures (FY99 Authorized $1,900.0)
FY2000	$3,537.5	Governor's Request

FY2000 MEDICAID SERVICES BASE PROGRAM ANALYSIS

	Elderly	Disabled	Children	Adults	Total Funds
FY98 Actual Served					
FY98 Eligible Beneficiaries (actuals)	5,991	9,616	51,539	21,699	
Cost Per Beneficiary	$9,948	$12,734	$2,135	$2,479	$ 345,889,642
FY99 Authorized (Projection)					
FY99 Eligible Beneficiaries (Aug-98)	6,175	10,152	52,265	21,617	
FY99 Authorized Budget per Beneficiary	$9,968	$12,590	$2,164	$2,622	$ 359,135,100
Projected FY00 Base Medicaid Program					
FY00 Projected Beneficiaries	6,364	10,717	53,001	21,535	
FY00 Cost per Beneficiary	$10,207	$13,127	$2,196	$2,661	$ 379,302,280
Total Projected Base Program Growth FY99 - FY00					
Beneficiaries Growth	189	565	736	-82	
% Change Beneficiaries	3.06%	5.57%	1.41%	-0.38%	
Incremental Cost per Beneficiaries	$238	$537	$32	$39	
% Change Cost per Beneficiaries	2.39%	4.27%	1.46%	1.47%	
Change in Total Funds	$ 3,404,948	$ 12,848,635	$ 3,288,736	$ 624,861	$ 20,167,180
% Change in Total Funds	5.5%	10.1%	2.9%	1.1%	5.62%

Cost Containment Areas - FY2000

- Limiting service scope and duration
- Increasing provider surveillance

FY99 Authorized	$ 359,135,100
Formula Growth	$ 20,167,180
Cost Containment	$ (7,376,100)
Governor's Request	$ 371,926,180

FY1998 Medicaid Expenditures by Provider/Service Type

Category of Service	Expenditures (in thousands)	Expenditure Percent
Hospitals*	$98,352.6	25%
Nursing Homes**	$42,803.7	11%
Inpatient Psychiatric***	$38,464.7	10%
Mental Health Clinics	$35,956.0	9%
EPSDT	$13,558.5	4%
Physicians*	$57,820.1	15%
Pharmacy	$30,781.0	8%
Waivers	$25,035.0	6%
Other Services	$31,910.8	8%
Transportation	$12,250.3	3%
Total	**$386,932.7**	**99%**

* Indian Health Service Pmts Included

** Includes $469,679 GF match in DMHDD Budget

*** Includes $13.7 million GF match in DMHDD Budget

INPATIENT FACILITIES

EXPENDITURES AND PATIENT DAYS UTILIZED

FISCAL YEARS 1996 THRU 1998

(Based on Dates of Service)

INSTITUTION	*TOTAL DAYS FY 96	AVG DAILY COST	**TOTAL PAID FY 96	*TOTAL DAYS FY 97	AVG DAILY COST	**TOTAL PAID FY 97	*TOTAL DAYS FY 98	AVG DAILY COST	**TOTAL PAID FY 98
Alaska Children's Srvs.	14,583	$253	$3,687,020	12,249	$250	$3,064,432	9,355	$251	$2,346,594
Alaska Psychiatric	723	$491	355,347	754	$529	398,716	1,425	$643	915,868
Alaska Regional	4,551	$1,333	6,064,926	5,110	$1,561	7,976,010	3,619	$1,493	5,403,457
Bartlett Memorial	1,723	$1,039	1,790,317	1,699	$1,125	1,911,479	1,066	$1,163	1,239,720
Central Peninsula	1,469	$1,232	1,809,357	1,482	$1,163	1,723,987	1,380	$1,219	1,682,041
Charter North	6,723	$802	5,391,700	7,194	$765	5,502,219	8,513	$768	6,537,669
Cordova Community	45	$1,206	54,256	37	$923	34,133	32	$961	30,751
Fairbanks Memorial	4,895	$945	4,623,411	5,428	$1,104	5,995,172	4,675	$1,206	5,637,143
Ketchikan General	991	$1,128	1,117,969	1,116	$1,164	1,299,525	922	$1,143	1,053,718
Kodiak Island	614	$1,204	739,428	663	$1,287	853,163	540	$1,353	730,441
North Star	3,917	$884	3,461,063	931	$855	796,110	1,107	$254	281,265
Norton Sound	305	$1,437	438,208	245	$1,613	395,197	293	$1,706	499,751
Petersburg General	55	$1,062	58,433	20	$1,289	25,781	38	$1,010	38,385
Providence	16,352	$1,455	23,796,218	17,363	$1,620	28,122,618	15,832	$1,474	23,331,368
Providence Seward	45	$1,462	65,776	23	$1,050	24,150	21	$1,499	31,474
Sitka Community	221	$1,306	288,531	208	$1,184	246,339	120	$1,266	151,946
South Peninsula	635	$1,151	730,834	752	$1,259	946,826	524	$1,541	807,586
Valdez Community	44	$1,298	57,113	101	$999	100,915	82	$1,081	88,643
Valley	1,892	$1,326	2,508,830	1,938	$1,482	2,872,244	1,839	$1,291	2,373,659
Wrangell General	45	$1,489	$66,990	55	$1,552	$85,363	46	$1,242	$57,136
Totals	59,828	$954	$57,105,727	57,368	$1,087	$62,374,378	51,429	$1,035	$53,238,615
%change from previous	-6%	-3%	-8%	-4%	14%	9%	***-10%	-5%	***-15%

*Excludes EMC crossover days

**Excludes crossover expenditures

***Because of processing delay time FY98 information may not be truely representative.

LONG-TERM CARE FACILITIES
EXPENDITURES AND PATIENT DAYS UTILIZED
FISCAL YEARS 1996 THRU 1998
(Based on Dates of Service)

INSTITUTION	*Total Days FY96	Ave Daily Cost	**Total Paid FY96	*Total Days FY 97	Ave Daily Cost	**Total Paid FY 97	*Total Days FY 98	Ave Daily Cost	**Total Paid FY 98
SNF and ICF Facilities:									
Cordova Comm. Hosp.	2,859	$392	$1,119,686	3,143	$398	$1,251,573	3,189	$406	$1,294,585
Denali Center	24,071	$263	6,339,772	22,148	$291	6,455,519	21,259	$305	6,474,426
Harborview Dev. Center	5,384	$298	1,603,892	3,689	$320	1,181,048	321	$391	125,607
Heritage Place	13,938	$154	2,149,315	14,031	$157	2,204,542	13,095	$157	2,061,287
Ketchikan Gen. Hospital	4,954	$307	1,520,975	4,666	$320	1,494,706	4,181	$319	1,335,292
Kodiak Island Hosp.	4,296	$294	1,263,407	4,417	$380	1,677,654	4,199	$357	1,499,673
Kotzebue Sr. Center	0	$0	0	0	$0	0	0	$0	0
Mary Conrad	30,751	$200	6,156,705	29,617	$206	6,108,986	28,880	$209	6,037,703
Petersburg Gen. Hosp.	4,196	$263	1,104,622	4,256	$258	1,097,170	4,509	$275	1,239,114
Providence Extended Care	68,375	$192	13,139,104	62,028	$197	12,200,072	62,148	$203	12,587,845
Quyaana Care Center	5,052	$448	2,261,137	5,104	$475	2,426,136	4,804	$534	2,564,395
South Peninsula Hosp.	6,682	$349	2,329,810	6,749	$301	2,032,611	6,576	$316	2,076,116
Sitka Comm. Hosp.	1,608	$216	347,382	1,197	$396	473,963	1,401	$521	729,306
St. Ann's Nursing Home	12,001	$222	2,659,913	10,873	$225	2,444,571	10,662	$231	2,467,716
Wesleyan Nursing Home	15,422	$193	2,978,125	13,159	$196	2,584,082	10,617	$212	2,249,711
Wrangell Gen. Hosp.	3,945	$271	1,070,937	3,936	$277	1,090,395	3,612	$289	1,045,393
Subtotal ICF & SNF	203,534	$226	$46,044,778	189,013	$237	$44,723,029	179,453	$244	$43,788,171
ICF/MR Facilities:									
Harborview Dev. Center	8,302	$416	3,453,031	4,746	$455	2,159,478	1,128	$557	628,317
Hope Cottages, Inc.	13,823	$357	4,929,592	0		0	0		0
Subtotal ICF/MR	22,125	$379	$8,382,622	4,746	$455	$2,159,478	1,128	$557	628,317
Totals	225,659	$241	$54,427,401	193,759	$242	$46,882,507	180,581	$246	$44,416,488
% Change	0%	9%	0%	-14%	0	-14%	-7%	2%	-5%

(Admin. Wait Days Not Included, GRM days included above)

*Excludes EMC Medicare crossovers

**Excludes Medicare crossovers

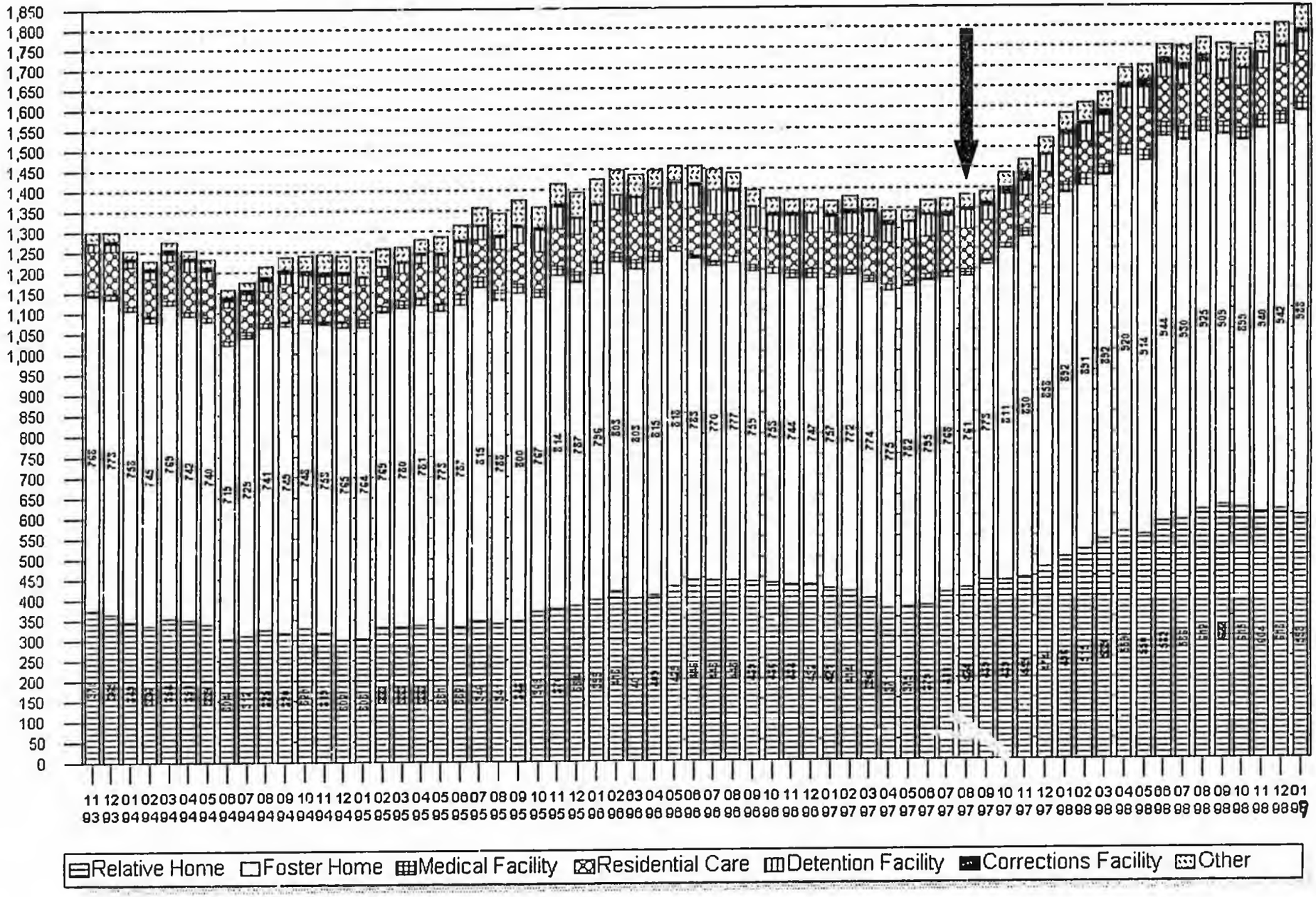
***Because of processing delay time FY98 information may not be truely representative.

SNF:Skilled Nursing Facility

ICF: Intermediate Care Facility

ICF/MR: Intermediate Care Facility for the Mentally Retarded

Family Services Children in Out of Home Care by Placement Category November 1993 through January 1999



Source: Division of Family and Youth Services - PROBER

Youth Facility Current and Planned Capacity

Facility	Existing Capacity	New Beds	New Staff	Facility Open	Total Beds
McLaughlin Youth Center	170	30	19	May 2000	200
FairbanksYouth Facility	40	4	0		44
Johnson Youth Facility	8	22	14	Feb 1999	30
Bethel Youth Facility	19	0	0		19
Nome Youth Facility	6	4	4	Feb 1999	10
Mat-Su Youth Facility	0	15	18	Apr 2000	15
Total	**243**	**75**	**55**		**318**

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
REPORT TO THE LEGISLATURE ON PERFORMANCE MEASURES

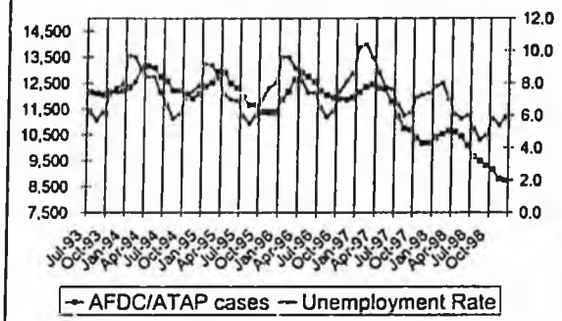
JANUARY 1999

SUBMITTED BY

COMMISSIONER KAREN PERDUE

PROGRAM AND MISSION

Alaska Temporary Assistance Program: To provide needy Alaskan families the financial assistance for which they qualify and to assist clients in reaching economic self-sufficiency.

Measure	Status	Data
Caseload Comparison: Change in Adult ATAP caseload compared to change in umemployment rate. Measure is expressed as a comparison between the change in caseload and the change in umemployment during a fiscal year. The measure reveals the relationship betweeen these those two indicators.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	FY98 Unemployment change = -16% ATAP Caseload Change = -14% ALASKA AFDC/ATAP CASELOAD VS. ALASKA UNEMPLOYMENT RATE 

Measure	Status	Data
Case Closure 1: ATAP cases closed with earnings compared to total ATAP caseload. Measure provides the total number of cases that are closed with earnings as compared to the total ATAP cases closed and is expressed as a percentage on a quarterly basis.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	January 1998 .....38% March 1998 .....36% June 1998 .....42% September 1998 .....46% December 1998 .....46%

Measure	Status	Data
Case Closure 2: ATAP cases closed with earnings and child support compared to total. Measure provides a comparison among factors that relate to case closure and is expressed as a percentage on a quarterly basis. This measure is closures with earnings and child support and is expressed as a percentage that describes the percent of total cases closed that had both earnings and child support.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	January 1998 .....6% March 1998 .....5% June 1998 .....5% September 1998 .....5% December 1998 .....10%

Measure	Status	Data
Case Closure 3: ATAP cases closed due to earnings without child support. Measure provides a comparison among factors that contribute to case closure. This measure is closures due to earnings without child support. The measure describes the percent of total cases closed that had earnings but no child support	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	January 1998 .....32% March 1998 .....31% June 1998 .....37% September 1998 .....41% December 1998 .....36%

Measure	Status	Data
Earned Income: ATAP cases with earned income compared to total ATAP caseload. Measure is expressed as a percentage on a quarterly basis and provides a measure of the number of cases with earned income compared to the total number of cases. An increasing percentage demonstrates success in work support efforts.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	January 1998 .....29% March 1998 .....30% June 1998 .....34% September 1998 .....36% December 1998 .....37%

Measure	Status	Data
Employment Length: ATAP clients employed longer than three,six, twelve, eighteen months compared to total ATAP caseload. Measure compares groups with differing lengths of employment and provides a measurement of job retention of temporary assistance adults.	☑ Measure Defined ☐ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The way this measure is worded does not allow for calculation and presentation. We recommend changing this measure to mirror the Federal High Performance Bonus measure on job retention which is a fiscal year measure.

Measure	Status	Data
Wages: ATAP clients average hourly wage. Measure provides a trend of the average hourly wage for work program ATAP clients. Measure is expressed as an average on a quarterly basis.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	January 1998 .....$8.56 March 1998 .....$8.40 June 1998 .....$8.25 September 1998 .....$8.13 December 1998 .....$8.28

Measure	Status	Data
Payment Accuracy: ATAP payment accuracy rate. Measure is expressed as a percentage during a fiscal year and provides a measure of quality as it relates to the eligibility determination and payment process.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	FY1997 – 98% FY1998 – 98%

PROGRAM AND MISSION		
Medicaid Services: The mission of the Medicaid program is to maintain access to quality health care for all Alaskans and to provide health coverage for needy Alaskans.		
Measure	Status	Data
Provider Enrollment: Percent of Alaska Providers, by type and region, participating in the Medical Assistance program in the previous fiscal year. Measure expressed as a percentage that compares the number of providers participating in the Medicaid program to the total number of providers in the State of Alaska.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The division has limited its initial efforts to developing provider participation measures for certain mandatory services including hospitals (inpatient and outpatient), long-term care facilities, and physicians. In subsequent periods, the Division will expand this effort to include other provider types. Data sources: Medicaid Management Information System (MMIS) Provider enrollment file, Occupational Licensing health practitioners licensing records, PHS/IHS health personnel data, VA and military health personnel data. The Division has secured the MMIS and licensing data and is developing a method for matching individual providers from these sources. Other data are pending. Baseline period is FY 98.

Measure	Status	Data
Client Enrollment: Percent of needy Alaskans as defined in AS 47.07.010 who are enrolled or have other health coverage: percent children; percent adults; percent seniors; percent disabled. Measure(s) expressed as a percentage that compare the total number of persons who are enrolled in the Medicaid Program compared to the total number of all persons in Alaska who meet Medicaid eligibility standards but who are not enrolled; comparisons by beneficiary category; elderly, disabled, children and adults.	☑ Measure Defined (1) ☐ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: (1) Measures that compare Medicaid beneficiaries with the total population of "needy" Alaskans present unique problems in that no reliable estimates of the number of Alaskans in poverty by demographic characteristics are available. The Division continues to research the availability of baseline studies and/or data regarding the poor in Alaska. To date the most likely data source will be the 2000 Census. Data source to date includes the MMIS Recipient Eligibility file for FY 98.

Measure	Status	Data
Licensure Surveys: Percent of licensure surveys conducted in nursing homes annually, hospitals bi-annully, and home health agencies annually. Measure is expressed as a percentage and compares the number of provider/facility type licensure surveys conducted during the period specified to the total number of providers or facilities of that type subject to licensure surveys.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☐ Comparison Data Available	Annual Surveys Completed - FY 98 Nursing Homes - Surveyed 100% Home Health Agencies - Surveyed 86% Biannual Surveys - FY 98 - 99 To Date Hospitals - Surveyed 32%

Additional Explanation or Comments: Comparisons include surveys for Nursing Homes and Home Health Agencies in FY 98 and for Hospitals from Jul-97 thru Dec-98.

PROGRAM AND MISSION
Youth Services: The mission of youth corrections is to protect the public from, and reform, juvenile offenders.

Measure	Status	Data
Percent of juvenile intakes completed in 30 days or less will improve from the current baseline of 55% in order to ensure swift action and promote accountability. This measure rates the Division's ability to respond to delinquency referrals within thirty (30) days of receipt from a law enforcement agency. It is based on the length of time between the date DFYS received a delinquency report and the date an intake decision is determined.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☐ Comparison Data Available	First Quarter, Fiscal Year 1999 ... 86%

Additional Explanation or Comments: The baseline of 55% was based on FY97 delinquency referrals. Unfortunately, the prevailing data entry procedures during this time do not allow for accurate and meaningful reporting of this measure. Data entry procedures were changed on July 1, 1998, which allows for accurate reporting of this measure. 1st Quarter data from FY 99 will thus be used as a baseline.

NOTE: This 1st quarter figure of 86% should be considered preliminary since, when the data was obtained, there were still 478 (about 23% percent of the total) referrals where an intake decision had not yet been determined. Sometime during the second week of February, 1st quarter figures will be recalculated.

Measure	Status	Data
Percent of referrals to youth corrections that will be met with an active response to include either a conference, referral for services, informal supervision or formal court action will improve from the current baseline of 92%. This measure rates the Division's ability to respond actively to delinquency referrals. It is based on percentage of delinquency referrals that were closed at the intake determination point with an outcome of something other than Adjust with a Letter.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☐ Comparison Data Available	1st Quarter, Fiscal Year 1999 ..... 95%

Additional Explanation or Comments: The baseline of 92% was based on FY97 delinquency referrals. An intake decision was not determined for all of the FY97 delinquency referrals at the time this baseline was established. 1st Quarter data from FY 99 will thus be used as a baseline.

NOTE: This 1st quarter figure of 95% should be considered preliminary since, when the data was obtained, there were still 478 (about 23% percent of the total) referrals where an intake decision had not yet been determined. Sometime during the second week of February, 1st quarter figures will be recalculated.

Measure	Status	Data
Percent of restitution paid will be at least 80 % of the amount ordered and the number of community work service hours completed will be at least 80% of the number of hours ordered. It is the belief of Youth Corrections that an essential aspect of rehabilitation of juvenile offenders is being held accountable for their actions, and making amends to the victim. Paying restitution for damages caused as a result of their crime is part of this. Community Work Service is also an important element of being held accountable. Community Service Work also serves the function of having youth participate with other community and/or social service agencies, and raising the offenders awareness and sense of being a part of the larger society.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	Restitution / Work Service Hours Baseline 80% 80% 1st Qtr, FY99 79% 83%
Additional Explanation or Comments: The baseline for this measure is 1st quarter FY 99 data, since the information was not tracked prior to this period.		

Measure	Status	Data
Reading and math grade levels for youth in institutional programs will improve by 1.25 months for every month a youth is in the school program.	☑ Measure Defined ☐ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments:
Information received from education specialists suggest that this may be an attainable measure for those residents who are significantly behind in school but not for those residents who are at or above appropriate grade level upon entry into the program. Continued refinement of this measure will be required and is in progress.

Measure	Status	Data
Number of events of escapes from institutions will be maintained or reduced as measured against the historic pattern averaged over the last three year period of 9 per year. Escapes are defined as a resident leaving an institutional program or a staff-supervised activity (i.e. court, medical etc.) without permission.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	Previous 3 Years.....9 escapes per year on average 1st Qtr, FY99 ..... 1 escape 2nd Qtr, FY99 ..... 1 escape

Additional Explanation or Comments: It is the duty of Youth Corrections to protect the public from youth who have been deemed by the courts to be in need of a locked facility, to meet this duty improvements have been made in security procedures, and general policy and procedure.

Measure	Status	Data
Percent of residents leaving institutions receiving aftercare services will increase from the current baseline of 47%. This measure rates the Division's ability to provide follow-up services to youth released from secure juvenile institutions. This could include the use of electronic monitoring; referral to vocational and educational services; intensive supervision and individual contact with a case manager; delivery of group and/or individual sessions focused on transitioning successfully into the community.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	Baseline.....47% 1st Qtr, FY99 .....67% 2nd Qtr, FY99.....58%

Additional Explanation or Comments: The baseline of 47% is based on FY 97 data and represents only those juveniles released from McLaughlin Youth Center, since this facility is the only one in the state that has a formalized aftercare program for youth being released from the institution.

The goal is to broaden the availability of aftercare services to the remaining juvenile treatment facilities in the state, including Fairbanks, Bethel and Juneau. The actual delivery of these services in these sites will be a process that occurs over time.

Measure	Status	Data
Recidivisim data will be maintained for both **probation field services** and all juvenlle facilities including the aftercare component, and the current recidivism rate will be maintained or decrease from the established baseline. This measure provides information about whether juveniles who come in contact with Youth Corrections (through an arrest by law enforcement for a delinquent offense) do so more than once. It is thus a measure of whether a youth is reoffending following contact with the array of services that may be received from Youth Corrections. This performance measure is in fact two components of the overall measure of recidivism. **To facilitate ease of discussion and understanding, recidivism data for probation field services and data for juvenile facilities will be referred to as separate measures.**	☑ Measure Defined ☑ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: Reoffense data for youth who get referred to Youth Corrections are not yet available. A protocol for collecting this information has been developed and the computer programs to extract the data from the MIS system are being written by the Division's research analyst. It is anticipated that recidivism information for probation youth will be available by later on in the fiscal year.

Measure	Status	Data
Recidivisim data will be maintained for both probation field services and all **juvenlle facilities** including the aftercare component, and the current recidivism rate will be maintained or decrease from the established baseline. This measure provides information about whether juveniles who come in contact with Youth Corrections (through an arrest by law enforcement for a delinquent offense) do so more than once. It is thus a measure of whether a youth is reoffending following contact with the array of services that may be received from Youth Corrections. This performance measure is in fact two components of the overall measure of recidivism. **To facilitate ease of discussion and understanding, recidivism data for probation field services and data for juvenile facilities will be referred to as separate measures.**	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☐ Comparison Data Available	Baseline, 1987-1996 ..... 44.4%

Additional Explanation or Comments: Reoffense data has been maintained for those youth being released from McLaughlin Youth Facility for 10 years. For this recidivism study the criteria required to be considered a recidivist are that the resident 1) obtains a new juvenile or criminal conviction, or 2) be re-institutionalized (in a long term Youth Corrections facility). The data are collected after the resident has been released from a long term youth corrections for two years. Adult criminal records and Department records are reviewed for each former resident and the data compiled from these.

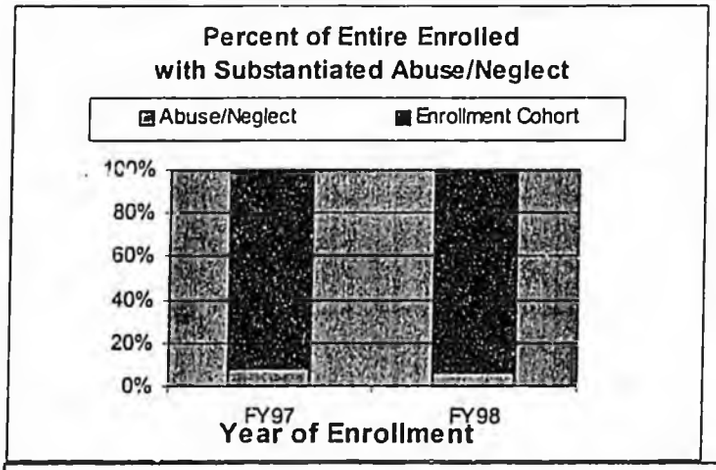
The baseline is established using McLaughlin data for the years 1987 through 1996. The recidivism for residents released during these years was 44.4% and ranged from 54% to 26% in different years. A 44.4% recidivism rate is considered very good when using the strict measures established for this study. Bethel Youth Facility and Fairbanks Youth facility are developing recidivism studies based on the criteria established at McLaughlin.

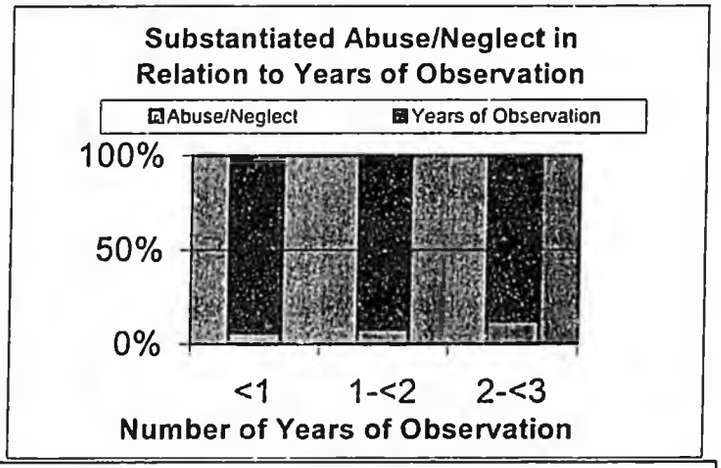
Caution: Not all recidivism data are created equal. Comparison of data from different studies can be misleading without using the same measures.

PROGRAM AND MISSION

Healthy Families: To prevent and remedy abuse, neglect and explotation of children through family centered services.

Measure	Status	Data
Rate of substantiated abuse and neglect among families served. Measures the rate of substantiated reports of abuse and neglect in families enrolled in and receiving services from the Healthy Family program.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☐ Comparison Data Available	**Updated data elements:** The baseline for this measure will be the rate of substantiated abuse and neglect for families enrolled during FY98. These families will be followed as a cohort on a long-term basis. Studies suggest that programs like HFAK show the greatest gains 15-30 years post intervention. Short-term evaluations have been unremarkable.





Additional Explanation or Comments: Kenai Parent Support Program and Southcentral Foundation's New Beginnings Program data are not included due to unavailability of critical data elements.

In the charts above, the enrollment cohort refers to the number of children enrolled in the program in the specified fiscal year. Substantiated abuse or neglect refers to the percent of an enrollment cohort that was ever subsequently reported for substantiated abuse or neglect.

Any child whose family ever received at least one home visit from Healthy Families Alaska prior to an initial report of abuse and neglect is included in the charts above. A portion of these families never engaged in services, i.e., received three or fewer home visits and terminated services thereafter.

It is important to keep in mind when examining the data that because Healthy Families staff are in the home on a weekly basis there is a strong surveillance bias, i.e., staff are observing and reporting concerns to DFYS.

Measure	Status	Data
Rate of substantiated abuse and neglect statewide as compared to the rate of those served. Measures the rate of substantiated abuse and neglect between families that receive Healthy Family services and the rate of abuse and neglect statewide with a matched group of families not served.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	**Updated Data Elements:** To determine the implicit impact of HFAK, a controlled random assignment study of the program will be conducted. The study will be done by a contractor and will begin on May 1, 1999. Baseline data for both the case group and the control group will be available no earlier than 12/01/01.

Additional Explanation or Comments: The measure was changed from comparing abuse and neglect rates of HFAK participants with statewide abuse and neglect rates to a case/control study for the following reasons.

- General population estimates of children "at-risk" for child abuse and neglect is approximately 20%.
- The HFAK population "at-risk" for child abuse and neglect is 100%

Thus, we would anticipate that the child abuse and neglect rate in the HFAK population will be significantly greater than in the general population even with the HFAK intervention. These two distinctly different groups should NOT be compared.

- Families served by HFAK have a high prevalence of substance abuse and domestic violence – both, very high risk factors for child abuse and neglect. These problems are recalcitrant to treatment and require sustained effort to impact.

Limitations of the Randomized case/control study

- Limited time to build sufficient numbers in both the treatment (case) group and the control group. This will be a significant problem because several programs have full enrollment and are closed to intake except when attrition "opens" treatment or control slots.
- Small numbers of families participating in the study (program funding and study funding limitations). Proving statistical significance of findings may be difficult given limited numbers of participants.

Measure	Status	Data
Rate and duration of out of home placements of children from families who make use of the services provided. Measure provides the rate and the average time or duration of out-of-home care for children in families that are receiving Healthy Family services. Measure deals with families receiving services who have reports of substantiated abuse and neglect which result in temporary out-of-home care placement.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	The rate and duration for out of home placements is currently through FY96. Updating of this information is in process. FY98 data will be used as the baseline.

PROGRAM AND MISSION		
General Community Mental Health Grants: The mission of the mental health program is to enhance the the ability of persons with mental illness to live in their communities with the highest quality of life available to them.		
Measure	Status	Data
Increase in the percentage of children and adults receiving community based services who show improved functioning as a result of services. Using the Global Assessment of Functioning (GAF) score as the metric by which improved functioning will be measured, MHDD will be applying this assessment at admission and at three month intervals throughout the course of treatment. The GAF score is a numerical score the represents overall clinical performance and the severity of symptoms. The scale ranges from zero to one hundred with a higher score equating to a higher level of functioning. A numerical composite score for clients receiving services in a period will be generated on a monthly basis.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	Mean GAF score for the last two quarters of FY1998 was 56 for all clients and 55 for children.
Measure	Status	Data
Increase in the percentage of people receiving mental health services who become employed. Measure is expressed as a percentage and compares the number of consumers who become employed while receiving mental health services.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	An average of 24.25% of clients were employed during the last two quarters of FY98.

Measure	Status	Data
Decrease in the total number of psychiatric hospital days used per person that are publicly funded (i.e. chronically mentally ill adults). Measures the total number of psychiatric hospital days during a six month period that are fully funded with public money. Measure is expressed as the average number of days per person that meets this funding criteria.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	Second Half FY1998 .....13 Days First Half FY1999.....12 Days

Measure	Status	Data
Decrease in the percentage of consumers that receive mental health services outside their community. Measure expressed as a percentage that measures the number of consumers receiving mental health services outside of their community compared to the total number of consumers receiving mental health services.	☑ Measure Defined ☑ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Measure	Status	Data
Consumer satisfaction measure as defined by stakeholder committee developing quality assurance standards. Consumer satisfaction survey will be developed and implemented that measures five target areas: accessibility, respect and dignity, consumer voice and choice, provider acting in the consumer's best interest, and consumer benefit from services.	☑ Measure Defined ☑ Data Development ☐ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

PROGRAM AND MISSION

Front Line Social Workers: To protect children by preventing and remedying repeated abuse, neglect, and the exploitation of children.

Measure	Status	Data
Average length of time spent in out of home care for children who have been abused or neglected.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☑ Baseline Data Available ☑ Comparison Data Available	See table below

Month	Average Months
January 1998	24.1
February 1998	23.7
March 1998	23.8
April 1998	23.8
May 1998	23.3
June 1998	23.3
July 1998	23.2
August 1998	23.5
September 1998	23.8
October 1998	24.5
November 1998	24.2
December 1998	24.6
January 1999	24.6

Additional Explanation or Comments: Data provided represents average months in out of home care for children in DFYS custody during the month reported. The "average" has limited value in presenting a true picture of the experience of most children who are in out of home care. The average is heavily skewed by the relatively small number of children who remain in out of home care for lengthy periods of time. Some of these children remain in out of home care because they are hard to place in adoptive homes or because long-term foster care is the most appropriate permanent plan. Most children are in out of home care for relatively short periods - less than three years. To more fully illustrate the experience of children we will be reporting on the distribution of time children spend in out of home care as well as the average length of out of home care. For January 1999 the distribution is:

Months in Out of Home Care	Number of Children	Percent of Children
0-11	663	36%
12-23	506	27%
24-35	224	12%
36-47	208	11%
48+	247	13%

Measure	Status	Data
Average number of out of home placements before a permanent home is found for a child.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: Data for this measure is under development. Limitations in the management information system require a sophisticated data extraction process to provide relevant data. These issues are expected to be resolved within a few weeks and both baseline and comparison data will be available at that time. Relevant data approximating the intent of this measure is available at this time. The table below illustrates the number of placements experienced by children currently in custody.

Month	Average Placements
January 1998	5.8
February 1998	5.7
March 1998	5.7
April 1998	5.7
May 1998	5.7
June 1998	5.7
July 1998	5.8
August 1998	5.7
September 1998	5.8
October 1998	5.8
November 1998	5.8
December 1998	5.8
January 1999	5.7

Measure	Status	Data
Percent of closed cases for children served in their home in which a recurrence of substantiated abuse and neglect occurs 6, 12, and 24 months following case closure. The number and percentage of children who were the subject of a substantiated CPS report of harm investigation whose family had previously received ongoing services from DFYS.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The recommended baseline year is FY97. The division is working on gathering data for this measurement. Data is available for closed cases which re-enter the child protection system during a specified period of time. For example, all cases closed during FY97 can be compared with cases that had substantiated investigations during FY98.

One complication in gathering the data is the backlog of data entry that exists in the field offices. There are a number of investigations that are completed but not entered into PROBER. This backlog creates problems in identifying closed cases and in determining whether the investigation was substantiated.

Measure	Status	Data
Percent of closed cases for children placed in alternative permanent homes in which a recurrence of substantiated abuse and neglect occurs 6, 12, and 24 months following case closure.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The recommended baseline year is FY97. The division is working on gathering data for this measurement. Data is available for closed cases which re-enter the child protection system during a specified period of time. For example, all cases closed during FY97 can be compared with cases that had substantiated investigations during FY98. This measure examines children placed in out-of-home care, returned to their parents' home with a case closure status.

Like Performance Measure 1, a complication in gathering the data is the backlog of data entry that exists in the field offices. There are a number of investigations that are completed but not entered into PROBER. This backlog creates problems in identifying closed cases and in determining whether the investigation was substantiated.

Measure	Status	Data
Percentage of permanent adoptive and guardianship homes that are disrupted 6, 12, and 24 months after placement. The number and percentage of children that were released from DFYS custody as a result of adoption or guardianship, who return to DFYS custody.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The recommended baseline year is FY97. The division is working on gathering data for this measurement. Data is available on children that were released from custody as a result of adoption or guardianship and who later return to custody.

Measure	Status	Data
Percentage of children placed in temporary care who experience substantiated abuse or neglect. The number and percentage of children who, while in DFYS custody and out of home care, were the subject of a CPS investigation that was substantiated, regardless of the perpetrator.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: The recommended baseline year is FY97. The division is working on gathering data for this measurement. Data are available but more time consuming to gather since this is reported and tracked differently in PROBER. PROBER does not differentiate type of licensed facility or home, but does track the number of children who are in custody and placement and are a subject of a CPS investigation that was substantiated, regardless of the perpetrator.

Measure	Status	Data
Average time required to place children in a safe, permanent home after determining that they can not be returned to their own home.	☑ Measure Defined ☑ Data Development ☑ Baseline Defined ☐ Baseline Data Available ☐ Comparison Data Available	

Additional Explanation or Comments: Data are under development. Limitations in the management information system require development of sophisticated data extraction processes to provide relevant data for this measure. Work to develop these processes will be completed no later than March 1 and both baseline and comparison data will be available at that time.

Present.:

Health

Care

Comm.

Alaska State Legislature

Senator Mike Miller, Chairman
Senator Pete Kelly, Vice Chairman
Senator Drue Pearce
Senator Gary Wilken
Senator Kim Elton

State Capitol, Rm 119
Juneau, Alaska 99801-1182
(907) 465-3762

Senate Committee on
Health, Education and Social Services

Senator Miller,
Schedule for today, 2/9/00

Agenda

1:30-2:30 PM

✓ HCR 15 Developmental Disability Awareness Month (Staff-Jennifer Strickland)
✓ SCR 12 Sobriety Awareness Month (Staff- Angela Moss)
✓ SB 204 Extend the Commission on Aging- (Admin. -Jane Demmert, ACA)
SB SB 198 Increase Base Allocation for Education (Sen. Wilken)
✓ SB 85 Teacher's Licensure & Professional discipline-(DOE-Sana Green)
Senator Donley has (1) amendment,but he is @another meeting; will not offer amendment if he doesn't show up to Hess personally.

SB 127 Scholarship's To University of Alaska **(CANCELLED-moved to 2/16/00)**

2:30-3:00 PM

= Health Care Commission Presentation - (Red Folder)
Jerry Near, Chairman, Community Care Foundation
Gary Schwartz, CCF, Board of Directors

= Bills previously Heard/Scheduled
*** Teleconference**

Creation of a Statewide Health Care Commission

PREAMBLE

The intent of the legislature is to encourage the creation of a health care market more directly driven by consumers and health care providers who are responsive to consumer needs.

Under the health care delivery system, envisioned for Alaska, consumers would be able to choose their physician within a regional delivery system encompassing an integrated panel of providers. The providers electing to participate on these regional panels would meet participation criteria involving credentials, performance in areas of quality and customer service, and mutually agreed upon fee for service compensation uniformly applied to all providers within a geographic region.

The regional delivery systems would be primary care centered, relying on family practitioners, pediatricians, obstetricians and general internists with affiliated specialty/subspecialty physicians, hospitals, and allied health professionals. These regional provider panels would provide a full continuum of medically necessary services for the enrolled Alaska population. It is not the intent to overhaul the health care delivery system, but rather to fine-tune the existing system. The regional delivery systems could be existing provider networks, medical care organizations, regional public health centers, physician hospital organizations, or a consortium of provider entities electing to provide services.

Pricing and performance information for consumers will be organized around the regional delivery systems. A standard basic benefits program would be provided by the regional provider panels to those Alaskans selecting this option. The statewide plan to be fully developed within a year will provide coverage for medically necessary services throughout Alaska. If Alaskans desire benefits beyond the basics, the private health entity to be established by the Alaska Legislature will recommend supplemental insurance options. There could be several levels of benefit coverage (supplemental options) available to Alaskans, with varying benefits, different co-payments and deductibles, and different insurance premium costs. Alaska residents may elect to purchase expanded benefits, beyond the basic level of services, by paying additional fees. Features of the basic benefit program envisioned include physician services, inpatient care, emergency care, outpatient procedures, preventative services, and prescription drugs.

In order to progress beyond the initial steps of community volunteers embraced by the Community Care Foundation, it is believed that legislation is required to create a statewide private/public health care commission to conduct intensive study and public hearings culminating in a report to the legislature containing recommended health services for Alaskans to be covered in a statewide plan; projected health insurance premium costs; and administrative services and powers required to provide health services under a statewide Alaska health plan. Start up funds (private and public) will be

needed to begin this initiative in concert with the Alaska citizenry and health care providers. The ultimate goal is to establish a self funded state health care delivery entity to administrator a basic benefit plan available to all Alaskans. The state health care delivery entity will recommend cost efficiencies and the elimination of duplicative services in programs offered under current state, federal, or private administration. This entity will assume responsibility for health plan oversight and administration and may assume responsibility for the approval of proposed services requiring state or federal pass through funds and improvements in the credentialing of health care professionals.

Legislative passage of a state resolution, this upcoming session, to create a Statewide Health Care Commission with powers to investigate, design, offer, and administer a statewide health benefits plan available to all Alaskans is needed by the Alaska citizenry and health care providers.

A RESOLUTION

Creating the Statewide Health Care Commission

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS there are a limited number of health insurance companies competing in the Alaska market which seriously impacts the cost, availability of coverage, and patient access to quality medical care; and

WHEREAS there are more than 100,000 uninsured Alaskans residing in the state; and

WHEREAS more than forty percent of the health and hospital services are provided out of state; and

WHEREAS private and public health insurance administration, paid for by Alaskans, is provided out of state; and

WHEREAS there are no means available to Alaskans to compare existing health insurance plans according to their relative costs of operation, medical and hospital services provided, and administrative efficiency; and

WHEREAS the Alaska citizenry has not had an opportunity to provide their views or develop a health benefits program involving consumers and health care providers who are responsive to consumer needs in Alaska;

BE IT RESOLVED that the Alaska State legislature establish a Statewide Health Care Commission to provide a focal point for further discussion and action concerning the health insurance needs of Alaskans, the development of a basic health benefit plan for the State of Alaska, and the creation of a publicly held trust with administrative powers to oversee health care delivery and administer a plan responsive to the citizens of Alaska; and be it

FURTHER RESOLVED that the Statewide Health Care Commission, after twelve months of study and public hearings, prepare a report for the legislature which addresses cost of health insurance, availability of coverage, and patient access to quality medical care in Alaska and contains specific recommendations on health insurance needs of Alaskans, basic services required in a benefit plan for the State of Alaska, the establishment of a public/private entity within the state having administrative powers to oversee health care delivery and state plan administration; and be it

FURTHER RESOLVED that the Statewide Health Care Commission shall consist of nine voting members:

(1) three members shall be appointed by the Speaker of the House of Representatives; at least one member shall be a member of the House of Representatives; at least one public member shall be chosen from among Alaska residents who represent the interests of people in need of health care coverage; and at least one public member shall be chosen from among Alaska residents who provide health or hospital services within the state;

(2) three members shall be appointed by the President of the Senate; at least one member shall be a member of the Senate; at least one public member shall be chosen from among Alaska residents who represent the interests of people in need of health care coverage; and at least one public member shall be chosen from among Alaska residents who provide health or hospital services within the state; and

(3) three members shall be appointed by the Governor, the Speaker of the House of Representatives, and the President of the Senate from among Alaska residents who represent the interests of the insurance industry, State of Alaska public health programs, and Federal health programs rendered in the state; and be it

FURTHER RESOLVED that the following persons may serve on the Statewide Health Care Commission as nonvoting members:

(1) the Commissioner of Health and Social Services or the Commissioner's designee;

(2) the Commissioner of Administration or the Commissioner's designee;

(3) the Chair of the Commission on Rural Governance and Empowerment or the Chair's designee;

(4) the President of the Alaska State Medical Association or the President's designee; and

(5) the President of the Alaska State Hospital Association or the President's designee; and be it

FURTHER RESOLVED that the public members of the Statewide Health Care Commission shall serve without compensation but are entitled to per diem and travel expenses authorized for boards and commissions under **AS 39.20.180**; and be it

FURTHER RESOLVED that the Statewide Health Care Commission shall elect a chair, vice-chair, and secretary from among its voting members with at least one of the positions being comprised of a legislator and two of the positions being comprised of public members, shall meet as frequently as the Statewide Health Care Commission determines necessary to perform its work and may meet and vote by teleconference; and be it

FURTHER RESOLVED that a small professional staff be retained to support the Statewide Health Care Commission in fulfilling its charge; and be it

FURTHER RESOLVED that the Statewide Health Care Commission review the April, 1999 Special Report to the Alaska Legislature entitled "Access for Alaskans" which contains a business plan and material supporting the establishment of a publicly endowed foundation which would sponsor and administrator a statewide health plan to extend health care and wellness services to all residents in Alaska. The Statewide Health Care Commission shall continue the efforts of the community volunteers represented by the Community Care Foundation who prepared the special report; and be it

FURTHER RESOLVED that the Statewide Health Care Commission begin work upon the appointment of its full voting membership and be terminated upon receipt of its report to the Alaska Legislature or upon the convening of the First Regular Session of the Twenty-fourth Alaska State Legislature.

Testimony Before the HESS Committee

Jerry A. Near, Chairman
Community Care Foundation
Board of Directors

Mr. Chairman, members of the Committee, and Committee guests, thank you for the opportunity to discuss the creation of a Statewide Health Care Commission.

A statement from the World Health Organization identifies the key elements to achieve health. It is not just being free of disease. Instead it is peace, shelter, education, decent income, stable ecosystem and economy, sustainable resources, social justice and equity.

This seems to be somewhat of a departure from the traditional thinking which would probably include physicians, hospitals, clinics, and other support industries which make up our current health care system. There is mounting evidence that the contribution of medicine towards improving health care is becoming quite limited. Spending more money on health care will not result in improvements in the overall health of a population. Many believe we are approaching the end of low-cost high-impact medical breakthroughs. Further, many believe that a society that spends so much on health care, may in fact be reducing the health of its population because it begins to reduce its support towards the key elements mentioned above, those being peace, shelter, education, and the others.

Our comments today are to encourage the State of Alaska to begin the process of analyzing how the health care system functions within this state. We do not think that more money is the answer. We do believe that there is much room for creating greater efficiencies, improving access, lowering costs, and retaining more resources, allowing more jobs for Alaskans. We believe that enough financial resources already exist to care for all Alaskans.

What Gary Schwartz presented provides a spectrum of what a statewide health plan could be, what it could do, and certainly provided the rationale to create a Statewide Health Care Commission. The next portion of my presentation will discuss how it could go together and what will be the requirements and benefits that could be expected. At the conclusion of my remarks, Mike McLane, a member of the Community Care Foundation, will speak to the importance of the community as a voice in the future of health care (by teleconference from Anchorage).

What is a self-funded insurance system? New federal efforts blanket everyone (HCAA and the patient bill of rights). No federal program, however; can replace a local program. All health care is local, not national.

Who would own the system/plan? The plan may be owned by enrollees, a co-operative, or a voluntary organization, but it must be member directed (responsive) and governed by a member elected board of directors.

What is involved in health plan development? Adherence to actuarial principles, a regional systems approach, involvement of consumers and providers at a minimum. The following points will need to be addressed by the Statewide Health Care Commission:

- Go it alone? Selecting support personnel, computer systems, etc. High initial cost factors. Educational challenges.

- Request for proposal for a contributing insurance company partner who has substantial development expertise in the areas identified below:

    a. Conceptualization of goals and the feasibility of an Alaskan structure?
    b. Community involvement
    c. Preliminary design and affordability
    d. Prototype design and test model
    e. Implementation, marketing, enrollment
    f. Evaluation of what works, what doesn't, and changes necessary for success
    g. Modifications and redesign

What part might an Insurance Partner Play?

a. Actuarial expertise
b. Sound insurance principles
c. Eligibility management for Alaskans only
d. Plan administration (day to day plan operation overseer)
e. Marketing and enrolling capability (300 Alaska agents)
f. Re-insurance to offset risk
g. Assistance with plan design
h. Supplemental programs
i. Consolidation of payer groups
j. Claims adjudication and payments to providers
k. Premium collections and electronic funds transfer.
l. Provision of utilization and expense data
m. Access to capital
n. Utilization management
o. Health risk assessments of Alaska population
p. Credentialing of providers
q. Physician specialty referral networks
r. Hospital referral networks (same)

Insurance partner selection from a request for proposal should:

a. Be open to a long term strategic partnership
b. Demonstrate openness and commitment to educate and work with the plan administrators and enrollees
c. Provide staff and technical support for local delivery systems.

d. Be able to offer a range of management services and willingness to share financial risk with the partners.
e. Offer flexibility and guidance to accommodate different enrollment needs for assimilation into the plan as it matures.
f. Willingness to collect and compile all financial and utilization information.
g. Commitment to grow the plan within the state.
h. To administer the plan within the state involving Alaskans in their work force.
i. Willingness to participate in capital contributions, plan development, and start-up.
j. Be able to administer the plan for a set percentage of premium which includes re-insurance costs.

What will be the appropriate legal structure for offering and operating a statewide health plan? In my view, the legal structure must be insulated (isolated) from political elements, vested interests, turf battles, and outside domination. Its focus must be to serve Alaskan enrollees first.

By what means could greater financial efficiencies be achieved?

a. Regional delivery systems can retain greater resources locally helping to offset the cost of units of care by spreading fixed costs.
b. Premiums can be retained within the State, not sent outside using Alaskan owned banks. Interest earnings could be reinvested in the plan.
c. Electronic technology that brings 21st century efficiencies to operate the statewide health plan. The Alaska telemedicine system could serve as a platform in this regard.
d. Jobs can be created within Alaska to operate the statewide health plan.
e. Availability of health data to understand the total utilization of health care and its costs within Alaska.
f. Self-funded allows for the elimination of many costly regulations (ERISA).
g. Flexible benefits accommodating participants needs.
h. Collaboration with the many overlapping, competing, duplicative delivery systems as now exist can reduce costly competition (the medical arms race).
i. Patients will have an increased awareness regarding elements which are driving costs. They will have available information to inform them through the health plan's administrative center in Alaska.

Other than financial efficiencies what are some associated benefits?

a. Centralized state-wide mediating capability. Close to a dozen separate systems each on their own tracks. Greater citizen involvement and input.
b. Eventually a unified payer authority (not a "single payer system"). A clearing house for scores of different payers. Hawaii has only two insurers which eliminates duplicating overhead factors.
c. Single basic health plan with voluntary supplemental options.
d. Regional delivery systems responsive to local needs and conditions.

e. Alaska employment! Jobs in Alaska instead of Hartford, Connecticut or Seattle, Washington.
f. Broader access.
g. Greater choice than now offered by employer sponsored plans.
h. Modified medical savings accounts.
i. Eventual ability to contract and administer government pass-through programs instead of outside administration.
j. Retain more financial resources in Alaska. Currently 30% or more of Alaska health care dollars exit the state.

Alaska deleted a State Health Board years ago. We believe it is time, to once again rekindle a centralized, coordinating, mediating body to pull the multiple delivery systems into a collaborative unified coordinated structure. Your support in creating the Statewide Health Care Commission with powers to address these complex and expensive health care issues is welcome.

Thank you.

Testimony Before the HESS Committee

Gary B. Schwartz, MPH
Community Care Foundation
Board of Directors

Mr. Chairman, members of the Committee, and Committee guests, thank you for the opportunity to discuss the creation of a Statewide Health Care Commission. The Commission's purpose, as some of you are aware, is to conduct intensive study and public hearings regarding the establishment of a self funded state health care delivery organization that could offer and administrator a basic health benefit plan available to all Alaskans. A draft bill has been prepared and provided to you which would create the Commission (the draft is attached to these comments).

The Statewide Health Care Commission, after approximately a year's work, would report its recommendations to the legislature on appropriate and affordable health services for Alaskans to be covered in a statewide plan; projected health insurance premium costs; and the powers required to provide health services under a statewide health plan.

We ask that you encourage the creation of a health care market more directly driven by consumers and health care providers who are responsive to the needs of Alaskans.

Under the statewide health care delivery system, envisioned for Alaska, consumers would be able to choose their physicians from a panel of providers who meet certain participation criteria and desire to provide health care services to Alaskans. The physician panels would provide a full continuum of medically necessary services for the enrolled population.

The Alaska health care delivery system does not need to be overhauled, but rather; we need to fine-tune the existing system. We have excellent physicians and hospitals in Alaska who are committed to providing high quality, accessible, and cost effective services. They need the support and encouragement from Alaskans to improve efficiencies in delivering health and medical care.

We believe a standard benefit program that provides medically necessary services throughout Alaska that covers physician services, inpatient care, emergency care, outpatient procedures, preventative services, and prescription drugs would create the market and climate for improvements in provider productivity and efficiencies. In Alaska, for Alaskans, by Alaskans is a far better solution than in the lower 48, for Alaskans, by outside providers.

In addition to addressing a statewide health plan, the Statewide Health Care Commission will also, recommend cost efficiencies and the elimination of unnecessary services in

programs offered under current state, federal, or private initiatives. The ultimate goal is to ensure that every Alaskan has access to affordable and appropriate health care services. The Alaska Health Plan should become the obvious choice for health care financing, by virtue of its affordability, quality of services, superior health outcomes, and demonstrated commitment to excellence in consumer health care.

Statement of Need

This state is facing a critical point in our history. Many hard choices must be made concerning our state's budget, our resources, and our long-term development. The cost of health care is increasing dramatically for all Americans as well as citizens of the state. By identifying cost savings and enhancing opportunities to collaborate and cooperate, the Statewide Health Care Commission can improve the quality of life for all Alaskans through the prudent use of health care resources.

The realities of rising health care costs, an expensive and ever growing administrative bureaucracy, failed attempts at new delivery and cost containment systems, lack of medical access for approximately 80,000 uninsured Alaskans, and increasing pressure from industry and community leaders to control costs are causing government, payers, and policy-makers to permit and encourage more rational solutions to emerge.

The inability of Alaskans to obtain coverage for themselves, and their children, has been exacerbated by the higher costs for health insurance within our state. It also creates a dignity of life issue for our working neighbors to be dependent on charity or to go without health care when they need it for themselves or their family.

Background Information

The U. S. health care industry is a $900+ billion industry which, for the past ten years, has been growing at an annual rate of nearly two times the general rate of inflation. It is a unique industry in which three-quarters of all services are paid for by a "third party" versus the patient who receives the services. This payment phenomena has effectively severed the traditional price control mechanisms normally found in other American industries and has significantly contributed to runaway industry costs.

Controlling health care costs is further complicated by an industry which is very labor-intensive, driven by new technology and an expanding base of scientific knowledge that must satisfy patient expectations of high-quality services without regard to cost.

To understand the health care industry, is to understand the key participants. Individually and in the aggregate, these participants will need to evaluate accepted practice patterns, new therapies, different delivery approaches, and innovative business relationships in light of "cost-benefit" relationships. In short, the industry must focus itself on doing a better job of balancing quality and cost and rid itself of the "vested participant positions" which can stifle change and challenge control. These next two years will be devoted to health care nationally. Now is a good time for Alaskans to craft their own plan

particularly when the economy is continuing its robust performance with relatively low unemployment.

Health Industry Participants

Patients are being encouraged to become more astute clients and to demand cost effectiveness and service/delivery excellence from their health care providers. It is no longer unusual for a patient to ask questions about quality, expected outcomes, costs, appropriateness, risk, the need for second opinions, and alternative therapies. Health plans, employers, and the federal government have established incentives and policies aimed at encouraging patients to become more sophisticated consumers.

Employer purchasers are adopting a "buy right" strategy for their employees or enrollees. It is common for employers to use benefit plan specifications during their group contracting discussions with health plans, third party administrators, and individual providers. Some health care purchasers are beginning to use indices such as quality, medical outcomes, service satisfaction, and cost effectiveness as the basis for contracting. Purchasers are beginning to incorporate quality and utilization management concepts in their bid specifications with health plans.

In Alaska, medium and small employers have less buying power, infrastructure, and internal expertise to properly handle health care purchasing, and in many instances, are at the mercy of their third party insurers to perform these functions. The Statewide Health Care Commission will assist the small businesses in securing adequate and affordable services with the design of the Alaska Health Plan.

Public officials and policy-makers across all political boundaries are committed to controlling health care consumption and appetite. They recognize tax dollars and employer spending cannot continue to support the current patterns of use, let alone the projected expenditures for the mushrooming population of seniors, indigent and immigrants. The federal and state governments are appropriating hundreds of millions of dollars annually for both applied research and "demonstration projects" aimed at studying utilization, quantifying outcomes and quality, and developing data bases for health care decision-making which contain more accurate "cost-of-care" information.

Physicians, dentists, other health care providers, and institutions are concerned about the movement of "outsiders" systematically taking control of the Alaska health care industry and usurping Alaskan resources, as evidenced by the trend of "for-profit" corporations and health plans directing the provision of services out of state. Out of state tertiary care services, mental health, rehabilitation, home care, insurance claims administration, practice management, health care staffing, durable medical equipment, and free-standing ambulatory surgery businesses are but a few examples of concern to the provider community.

In order for the health care industry to become more efficient and cost effective, it is imperative for patients, purchasers, and providers to have more meaningful and usable

information about the services and "health improvements" they are supporting. Unfortunately, the vast majority of health care providers do not routinely collect and provide cost and health outcomes information. This "information void" has created a situation where it is extremely difficult for purchasers to appraise the overall value of health services.

Patient, physician, employer, and payer decisions all dramatically impact a patient's health status and the associated costs of care. The inability to understand and measure the dynamics of such decision-making, results in uninformed patients, frustrated physicians, angry employers, frustrated payers, and beleaguered policy-makers. Patients primarily judge their medical and dental care based upon "servicing considerations" such as waiting time, comfort, courtesy, and communications. Additionally, the principal method for patients to evaluate cost effectiveness is based upon their out-of-pocket expenditures.

Providers are adamant in their belief that financial concerns are already jeopardizing quality patient care and they look forward to cost containment approaches with better options than are currently available. Health care purchasers are becoming impatient with the health industry's inability to control its costs and of being asked to manage quality and outcome without any usable information. Payers do not understand why they see dramatic variances in practice styles and resource consumption without appreciable differences in the end result.

Depending on the situation, each major health care "participant" can be considered a customer, even though each tends to view cost and quality differently and, thereby, desires to measure and control these factors in varying fashions. However, the health care business is no longer a "cottage" industry. The industry will by necessity function more economically and rationally without having to sacrifice service and quality. It will no longer be adequate for providers to deliver their services at acceptable levels of quality at "fair market" prices. Buyers are becoming more informed and selective. Patients are more sophisticated and demanding. Payers are being required to manage overall costs. The end results of this marketplace scenario will be an array of providers committed to a strategy of promising the highest quality services at the lowest possible price.

The Health Insurance Environment

Health insurance organizations include a wide range of potential state partners, such as Aetna U.S. Healthcare, Blue Cross/Blue Shield, Principal Health and Hospital Insurance Company, Private Health Care Systems, Inc., and the like. Generally, in return for some financial consideration, these organizations could assist the state with initial administration of an Alaska plan for group and individual purchasers of health care services encompassing employers, government programs such as Medicare and Medicaid, union trusts and individual or family policyholders). They could agree to provide administrative services (in Alaska) responsive to a defined set of health care services for covered persons recommended by the Statewide Health Care Commission.

Several trends are prevalent in the health insurance industry:

- Health insurance organizations are seeking out and establishing strategic partnerships with physicians, dentists, and others who share a commitment to delivering high-quality, cost-effective services;

- The focus is shifting from short-term cost reduction strategies to an emphasis on longer-term goals;

- There is an increasing focus on local or community integrated systems of care, which emphasize continuity and coordination in the delivery of health care services;

- Buyers are demanding that health care organizations be able to document improvements in quality, service delivery, outcomes, and cost containment.

On the political scene, health care proposals are market-based, but revolve around accountability. The centerpiece unique to these proposals encourages providers and insurers to form networks that would compete for patients on the basis of price and quality. We believe this can be accomplished in Alaska by the Statewide Health Care Commission.

Issues Facing the Statewide Health Care Commission

In conclusion, the reality of rapidly increasing health care costs and increasing pressure from both the private and public sector to offer choice, demonstrate real dollar savings, and improve access to quality services will stimulate the Statewide Health Care Commission to recommend changes which will positively address the following issues and problems:

- Failed attempts at implementing cost containment mechanisms which embody misaligned financial incentives.

- Limited accountability and a "void" of meaningful and usable information necessary to appraise the value of health care services being offered in Alaska.

- Unacceptable levels of inappropriate, ineffective, and inefficient health care being delivered in Alaska.

- Burdensome, inefficient, and costly administrative systems.

- Limited sense of individual responsibility on the part of patients.

- Lack of a consistent and cost-effective approaches to evaluate, test, adopt, and control the dissemination of new technologies and/or delivery solutions.

- Inability to obtain the accurate "direct cost of care" information necessary to accommodate providers and to recommend acceptable levels of reimbursement.

- Access to information documenting patient outcomes.

- Access to utilization and medical information as it relates to provider performance. As the race to formulate the "best" accelerates, necessary information regarding the provider performance, efficiency, effectiveness, and appropriate use of resources becomes a benchmark for provider participation.

- The ability to distinguish providers who share a commitment to achieving cost containment within the context of quality management in Alaska.

- Providing reasonable access to health care facilities for physicians and their patients, both from a geographic and scheduling perspective.

- Providing a competitive balance to hospital systems where there is a decreasing ability to buy services on a cost controlled basis.

Introduction and passage of a state legislative resolution during this session, to create a Statewide Health Care Commission with powers to investigate, design, offer, and administer a statewide health benefits plan available to all Alaskans is needed by the Alaska citizenry and health care providers. Your leadership and action is needed and appreciated.

Thank you.

(See attached bill to create a Statewide Health Care Commission)

Present:

State Indep. Living . . .

Alaska State Independent Living Council (SILC)

Tony Knowles, Governor

Independent Living for Alaskans with Disabilities

Annual Report

Federal fiscal year, 1999
(Oct. 1, 1998 – Sept.30, 1999)

Mission Statement

The Alaska Statewide Independent Living Council (SILC) is committed to promoting a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and systems advocacy, in order to maximize leadership, empowerment, independence, productivity and to support full inclusion and integration of individuals with disabilities into the mainstream of American society.

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State Independent Living Council (SILC)

Background:

The federal Rehabilitation Act Amendments of 1992 required all states that accept federal independent living funds to establish a Statewide Independent Living Council (SILC) appointed by the Governor. The Alaska SILC was established by Executive Order in 1993, then by statute in 1995 (AS 47.80.030). For administrative purposes, the SILC is located in the State Department of Education. The Council's purposes are set forth in this statute as well as 29 U.S.C. 796(d), and are meant to maximize the State's receipt of federal financial assistance for independent living services and centers of independent living for residents with significant disabilities.

Duties:

- Jointly, with the Division of Vocational Rehabilitation (DVR), develop the State Plan for Independent Living (SPIL) and evaluate the implementation of the Plan;
- Develop a plan for the provision of resources, including staff and personnel, that may be necessary to carry out the council's function with funds from the federal government and other public and private sources; and
- Coordinate the Council's activities with other state agencies that address the needs of specific disability populations and issues under federal law.

SILC Members and Council Budget:

In FY 99 the SILC had, on average, 10 members. Currently there are 12 SILC members, a majority of whom experience a disability, including physical, cognitive and sensory disabilities. The Council is minimally staffed having one full-time Executive Director hired by the SILC itself and a half-time Administrative Clerk. The budget for the Council in FY 99, including "personnel", "travel", "contractual", "commodities" and "equipment", was $148,067, down by over 5% from FY 98. The budget approved for the SILC in FY 2000 is $150,000. All funds used for Council activities in FY 99 and FY 00 come from federal sources through the state Division of Vocational Rehabilitation; not independent living funds. ***It has always been and continues to be the SILC's intent that all IL funds, both from the State and federal government, be used for the direct provision of services by Centers for Independent Living and Specialized Service Providers, and not for administrative functions.***

Highlights of SILC Activities in FY 1999:

- **Redesigning our PCA Program** -- The SILC's primary accomplishment for the year was helping to redesign the states Medicaid funded personal care attendant program. The SILC Vice-Chair is the chair of a broad-based group of policy-makers, providers and consumers called the PCA Design Team. With the Division of Senior Services and the Governor's Council on Disabilities and Special Education, we hosted a PCA Summit in Anchorage in November, 1998. Over 80 people attended the summit, in which the principles and tenets of a new "self-directed" program were discussed and debated. The Summit helped refine a plan, which is scheduled to begin July 1, 2000.

- **Consumer Satisfaction Survey** - The SILC was able to accomplish a major consumer satisfaction survey statewide. Consumers of IL services gave independent living providers very high marks overall, with 91% of respondents claiming they "received quality services" from the provider.

- **SILC Website** - The SILC finished the development of our first website with major links to IL services and information throughout the state and country. The website can be accessed at: < www.labor.state.ak.us/silc/index.htm>.

- **Working Disabled/Medicaid Buy-in Program** - The SILC saw the implementation of the rules for our State's Medicaid Buy-in Program for the "working disabled" on July 1, 1999. To date, over 30 persons with disabilities have accessed the Medicaid Buy-In program.

- **Independent Living Awards** - The SILC held its third annual "Independent Living Awards", recognizing the work of outstanding personal care attendants, independent living providers, and consumers throughout the state.

- **IL Net Award** - The Alaska SILC was recognized by the national IL Net Project in recognition of it's exemplary advocacy efforts, specifically our role in planning and implementing the Alaska Disability Policy Summit in 1997.

- **Region X Award** - One of our Center directors was recognized by the National Council on Independent Living as an outstanding advocate for Region X, which includes Alaska, Idaho, Oregon and Washington.