State of Alaska
FY2006 Governor's Operating Budget

Department of Health and Social Services
Behavioral Health
Results Delivery Unit Budget Summary

Behavioral Health Results Delivery Unit

Contribution to Department's Mission

The mission of the Behavioral Health RDU is to plan, implement, and manage a behavioral health service delivery system that functions as a “Comprehensive, Continuous, and Integrated System of Care” (CCISC) to address substance abuse disorders, mental disorders, and co-occurring disorders.

Core Services

This component provides the overall administrative and organizational structure for the Division. The more than 200 million dollars granted, contracted, or otherwise utilized by the Division are managed through this component towards the identified mission. Funds are awarded, disbursed and monitored by this component. Senior Management of DBH, and administrative support staff who are not employed by the Alaska Psychiatric Institute (API) are located and funded in this component. This component provides centralized support for the Alaska Psychiatric Institute and grant-funded community-based behavioral health services/programs. Component services include service system planning and policy development, programmatic oversight of behavioral health grantees’ service provision, general administration, budget development and fiscal management, and development and program staff support of grantees in training and implementation of the Alaska Automated Information Management System (AKAIMS). The leadership in this component works closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority to determine policy governing the planning and implementation of services and supports for people who experience mental illness, substance abuse disorders, or both. Direct services include quality assurance, technical assistance and consultation.

API is located in Anchorage, and is the only publicly funded facility providing high level inpatient psychiatric care to the people of Alaska. These services are available when no other service is adequate to meet the needs of a severely ill individual or individual in crisis. It is a seven-day-a-week, 24-hour-a-day treatment facility. Clients are admitted either voluntarily or involuntarily through a Peace Officer Application or Ex Parte Commitment. API provides diagnosis, evaluation and treatment services in accordance with its statutory mandates and the strict health care industry standards and requirements set by the Joint Commission on Accreditation of Healthcare Organizations, Centers for Medicare and Medicaid Services, and the State of Alaska's Certification and Licensing section. API provides outreach, consultation, and training to mental health service providers, community mental health centers, and Pioneer Homes. In addition, API serves the entire Alaska community mental health system, including coordinating the transition of patients between inpatient and outpatient care, when appropriate.

End Results	Strategies to Achieve Results
A: Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder. Target #1: 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained. Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.	**A1: Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.** Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years. Measure #1: Percent of children reported in out-of-state care from Medicaid MMIS. **A2: Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.** Target #1: Increase the number of Tribal entities providing

	behavioral health services to Alaska Natives by 10% annually for each of the next four years. Measure #1: number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services **A3: Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.** Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes. Measure #1: Outcome data will be collected from the Alaska Automated Information Management System (AKAIMS) and Client Status Review Forms. Target #2: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% increase in consumer satisfaction with services. Measure #2: Outcome data on consumer satisfaction will be collected from the AK Automated Information Management System (AKAIMS) as part of the Mental Health Statistics Improvement Program.

FY2006 Resources Allocated to Achieve Results

FY2006 Results Delivery Unit Budget: $235,396,200

Personnel:	
Full time	287
Part time	17
Total	304

Performance Measure Detail

A: Result - Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.

Target #1: 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.
Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.

Analysis of results and challenges: No data is available, this measure is still under development. The Client Status Review (CSR), as of July 1, 2004, has been built into practice standards as a requirements for all behavioral health providers. As agencies are brought online with the Alaska Automated Information Management System (AKAIMS), the CSR will be entered as a routine data practice. NOTE: The implementation of AKAIMS is occurring at a slower rate than anticipated, however, data extraction is expected to begin no later than March, 2005.

A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.

Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years.
Measure #1: Percent of children reported in out-of-state care from Medicaid MMIS.

Analysis of results and challenges: This new measure is proposed for FY05, with data collection to begin in the first quarter. The DBH Policy & Planning section has successfully worked in aligning planning processes with the Alaska Mental Health Trust Authority (AMHTA) and planning boards, creating a master planning document, and supported multiple workgroups that address capacity building for the Alaska system of care. These work groups are on the DBH website for public review and comment.

As of fall 2004, there are approximately 445 children in out-of-state inpatient psychiatric care.

A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.

Target #1: Increase the number of Tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.
Measure #1: number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services

Analysis of results and challenges: This new measure is proposed for FY05, with data collection to begin in the first quarter. These tribal entities have a varied history in providing behavioral health services. However, they are identified as having substantially increased levels of service delivery, and contact and consultation with DBH during FY04. Particular efforts continue in pursuing formal relationships between Tribal and non-Tribal providers. These efforts are challenging with significant legal hurdles that slow potential collaborations. Currently there are 4 Tribal entities providing behavioral health services to Alaska Natives, they are: Kenaitze Indian Tribe of Kenai; Kodiak Area Native Association; Ketchikan Indian Corporation; and, the Council of Athabascan Tribal Governments or CATG of Fort Yukon.

A3: Strategy - Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.

Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes.
Measure #1: Outcome data will be collected from the Alaska Automated Information Management System (AKAIMS) and Client Status Review Forms.

Analysis of results and challenges: The Alaska Automated Information Management System (AKAIMS) continues to be implemented, however, at a slower rate than initially projected. Currently 23 agencies are in various stages of implementation, while DBH is currently on an accelerated training schedule for the remaining agencies. The Client Status Review (CSR), as of July 1, 2004, has been built into practice standards as a requirement for all behavioral health providers. As agencies are brought online with AKAIMS, the CSR will be entered as a routine data practice.

Target #2: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% increase in consumer satisfaction with services.
Measure #2: Outcome data on consumer satisfaction will be collected from the AK Automated Information Management System (AKAIMS) as part of the Mental Health Statistics Improvement Program.

Analysis of results and challenges: The Alaska Automated Information Management System (AKAIMS) continues to be implemented, however, at a slower rate than initially planned. Currently 23 agencies are in various stages of implementation, while DBH is currently on an accelerated training schedule for the remaining

agencies. The Mental Health Statistics Improvement Program (MHSIP), as of July 1, 2004, has been built into practice standards as a requirement for all behavioral health providers. As agencies are brought online with AKAIMS, the MHSIP will be entered as a routine data practice.

Key RDU Challenges

Alaska Automated Information Management System (AKAIMS)
The development, testing and implementation of the new system is critical to the success of the integration of former mental health, substance abuse and fetal alcohol syndrome programs. AKAIMS offers, by design, one standard and consolidated behavioral health information collection and delivery system serving approximately 90 behavioral health provider agencies and many hundreds of users. Managed by the Division, the system will generate reports per federal and state regulation, including full HIPAA compliance. This system will improve patient service through the design of the screens and the system information requirements. However, as a new and complex system, AKAIMS has required significant training – of both in-house and service provision staff – and considerable adjustment as implementation problems have become known. AKAIMS also requires ongoing staff support for software maintenance and enhancements, training provision to providers, and operation of an application help desk – the funding of which directly competes with dollars for service provision.

The challenge of planning and implementing an integrated behavioral health service delivery system is challenging with a landscape that includes diminishing resources, increased costs, and an ever-demanding public need. One example of this challenge is in the area of cost containment for the DET program. This is a program that has assisted in reducing the admissions to API. The Division has attempted to lower the DET (a) rates for inpatient care, (b) cost of transportation, and (c) utilization rates. However, the end result is that those costs listed are increasing. This is due in part to the cost of doing business going up, the cost of fuel increasing, and the passionate support of providers.

The certification process for both individuals and agencies who provide counseling and other services to individuals with substance abuse problems needs review and updating. Standards currently in use were adopted in the 1970's and the practice has changed dramatically since that time. Additionally, allowing certification for individual counselors to be voluntary is an issue that needs attention. It is the responsibility of the Division to ensure that clients are served only by trained and qualified staff.

Significant Changes in Results to be Delivered in FY2006

- Integration

During FY06, we expect further integration of mental health and substance abuse services, both at the Division and service provision levels. All staff will be cross-trained and both substance abuse and mental health staff will work with all grantees in their service area. Service providers will form themselves into networked, cross-referring entities, and will become more proficient at serving all their clients, including and especially those with co-occurring disorders.

- Continuum of Care

The Division of Behavioral Health has developed a "continuum of care" matrix as an initial planning tool for a conceptual model of service delivery. This prototype will be developed into a final continuum of care that addresses the application of levels of service with the level of community. This will further clarify the relationship of regional communities and the potential to share resources in service delivery, as needed.

- Bring the Kids Home

The Bring the Kids Home (BTKH) project highlights multiple challenges facing the current system of care. Effective solutions must address these challenges at each different level of the system. The scope of this project is defined with an understanding that there are 4 levels of the system of care that must be addressed concurrently: community, regional, in-state, and out-of-state care. In collaboration with the Mental Health Trust Authority, targeted work areas will

be used to facilitate the planning process that will contribute to the development of a children's system of care. Additional related scheduled activities will include:

a. Increasing the care coordination activities provided by First Heath Services (the utilization review contractor). This will improve discharge planning.

b. Develop a Research and Analysis team to improve program evaluation.

c. Implementation of a web-based authorization system for inpatient services. This will improve program efficiency.

d. Hire a "gate-keeper" staff to work in conjunction with First Health Staff to reduce the number of children sent out-of-state for treatment.

- Evidenced Based Practices

During FY05, grantees of this division are expected, through the Request for Proposal (RFP) process, to use best-, promising-, or Alaska-value-based-practices for service delivery. Widespread use, analysis, and evaluation of these program designs will ultimately improve outcomes for clients of these programs.

- Workforce Development

Collaboration between AMHTA and DBH has been progressing, through the Integrated Behavioral Health Training Project. This contract will extend the BHIP goals with the establishment of a training project to promote effective services for people with dual diagnoses (mental health and substance abuse). This training project will also promote the skills necessary to promote additional Evidenced Based Practices (EBPs) or best practices as identified by SAMHSA, CMHS, CSAT, CSAP and services to children and youth supported by similar levels of evidence. This will involve a combination of training, consultation, and evaluation activities at the state, regional, community, and agency levels. The training will include a highly prescribed and structured methodology that embodies practice improvement expectations of organizational and practice change.

- Training

DBH has underwritten a new position called the "DBH Practice Improvement Coordinator". This position will develop a DBH training plan to identify and meet current and future training needs of behavioral health care agencies statewide, that contribute to the successful implementation of an integrated behavioral health care system; match training events, develop agendas/curriculum, with DBH priorities and themes for multiple levels of training: system, agency/provider, and clinician; and assist behavioral health care providers/agencies and individuals statewide with understanding the training and licensing process, developing the core competencies which will lead to certification or licensure in the delivery of behavioral health services to individuals with co-occurring disorders.

DBH is currently in collaboration with the AMHTA , the University of Alaska, and the Western Interstate Commission for Higher Education (WICHE) to address the multitude of workforce issues facing the state of Alaska. A key initial starting point was the Behavioral Health Workforce Conference that was held in Girdwood, on May 17-18, 2004.

- System Development and Alignment

DBH has collaborated with the Alaska Mental Health Board (AMHB) and the Advisory Board on Alcoholism and Drug Abuse (ABADA) to co-develop a strategic plan that defines measurable objectives for a 6, 12, 18, and 24-month period at the system, program clinical practice and clinician level into the ABADA-AMHB joint plan.

In its emerging role, the *Policy and Planning Section* has engaged the Mental Health Trust Authority around the *Bring the Kids Home Initiative*. As a result, the MHTA is working with the *Policy and Planning Section* in the development of a common *Master Planning Document* to increase communication, collaboration, and reduce redundancy in parallel planning processes. Further, the AMHTA has expressed an interest in placing its BTKH workgroups on the DBH website for public notification and feedback. This level of parallel planning is the model DBH plans on operationalizing in future planning processes, relative to the BHIP project.

- BHIP Workgroups and Initiatives

The BHIP External Implementation Task Force has been developed and implemented. The External Task Force will coordinate planning efforts with the senior management team and the member participants will provide stakeholder representation and input in the planning and implementation of future changes of the "Behavioral Health Integration

Project."

The BHIP workgroups that have been initially identified, and will be implemented include: "financing", integrated standards and regulations, and identification. As a preliminary step in forming a workgroup for integrated standards and regulations, BHIP has underwritten a letter of solicitation for the development of community-based BH standards.

- Data and Reporting
By FY06, AKAIMS should be fully implemented throughout the state providing the grantee agencies with accurate client data and local management information. Additionally, Division staff and stakeholders alike will receive performance data – including outcome measures -- vital to responsible planning and decision-making processes and further shaping of the service system.

Major RDU Accomplishments in 2004

1. The *COSIG* grant is being used to fund the DBH Behavioral Health Integration Project (BHIP). This project continues to develop an integrated behavioral health care of service delivery, using the Comprehensive, Continuous, Integrated System of Care (CCISC) model. The first year (FY '04) has focused on the system level of change.

2. In the early stages of a *communication plan,* BHIP has underwritten the redesign of the DBH portal website. This website has been configured to function as a primary communication tool, linking the Behavioral Health Integration Project with provider agencies and other stakeholders. This includes a *Workgroup Online* web page that informs the reader of a workgroup description, scope, membership, and planning documents related to the project. In addition, each workgroup page allows for public review and comment on the planning process.

3. Collaboration between DBH, AMHTA, and the AMHB continues through the Behavioral Health Community Planning Project (BHCPP). This project provides multi-disciplinary support to communities as they move towards integrating mental health and substance abuse services at the local level. Fifteen (15) communities will receive onsite technical assistance from clinical, organizational and legal experts. As state-wide training conferences occur, the Contractor will present findings and recommendations to date, as a means of extending the transfer of information.

4. In efforts to promote an integrated behavioral health care system, DBH has successfully initiated the integration of both federal and state funds, and the integration of mental health and substance abuse services into a single grant award. Essentially 5 community providers are now considered to be multi-grant agencies. These include Manillaq Health Corporation (Kotzebue), Norton Sound Health Corporation (Nome), Southeast Regional Health Corporation, Tanana Chiefs Conference (northern region), Yukon-Kuskokwim Health Corporation (Bethel).

5. In the promotion of an integrated behavioral health care system, DBH designed an RFP process that integrated the previous separate mental health and substance abuse services into a single grant application. This was project to have a direct impact on 23 communities who would receive integrated behavioral health grants beginning FY'05. This achieved administrative efficiencies for the division, as well as for grantees in the oversight of these grants. Further it fueled ongoing community level discussions and planning processes in the clinical efficiencies in delivering services.

Contact Information

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Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2004 Actuals				FY2005 Management Plan				FY2006 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
Formula Expenditures												
Behavioral Hlth Medicaid Svcs	37,375.9	75,165.6	6,095.8	118,637.3	43,365.9	73,462.7	1,500.0	118,328.6	57,172.1	85,400.4	1,500.0	144,072.5
Non-Formula Expenditures												
AK Fetal Alcohol Syndrome Pgm	0.0	6,434.9	0.0	6,434.9	0.0	6,924.4	0.0	6,924.4	596.0	5,828.4	500.0	6,924.4
Alcohol Safety Action Program	907.5	0.0	156.1	1,063.6	0.0	241.9	260.9	502.8	0.0	241.9	380.9	622.8
Behavioral Health Grants	2,195.6	4,911.3	10,394.9	17,501.8	1,959.6	4,746.3	21,885.0	28,590.9	1,959.6	4,746.3	17,240.0	23,945.9
Behavioral Health Administration	1,860.7	3,168.2	513.2	5,542.1	1,827.0	4,899.3	2,017.3	8,743.6	1,584.4	5,044.8	1,957.8	8,587.0
CAPI Grants	1,392.8	478.5	0.0	1,871.3	1,229.7	1,172.0	56.5	2,458.2	1,229.7	1,172.0	56.5	2,458.2
Rural Services/Suicide Prevent'n	464.2	235.0	1,981.1	2,680.3	414.3	500.0	1,986.8	2,901.1	414.3	500.0	1,986.8	2,901.1
Psychiatric Emergency Svcs	4,665.4	146.7	730.0	5,542.1	6,103.4	670.8	358.5	7,132.7	6,103.4	670.8	50.0	6,824.2
Svcs/Seriously Mentally Ill	6,187.7	1,475.2	675.0	8,337.9	8,345.1	1,498.6	929.0	10,772.7	8,345.1	1,498.6	900.0	10,743.7
Designated Eval & Treatment	1,347.3	985.3	146.7	2,479.3	1,211.9	0.0	0.0	1,211.9	1,211.9	0.0	0.0	1,211.9
Svcs/Severely Emotion Dst Yth	3,033.9	0.0	0.0	3,033.9	4,483.2	219.2	100.0	4,802.4	4,483.2	219.2	2,193.0	6,895.4
Alaska Psychiatric Institute	6,730.2	98.4	12,845.1	19,673.7	5,148.9	0.0	13,597.1	18,746.0	5,612.0	0.0	14,597.1	20,209.1
Alaska Youth	280.0	0.0	0.0	280.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Behavioral Health
RDU Financial Summary by Component

All dollars shown in thousands

	FY2004 Actuals				FY2005 Management Plan				FY2006 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
Initiative												
Totals	**66,441.2**	**93,099.1**	**33,537.9**	**193,078.2**	**74,089.0**	**94,335.2**	**42,691.1**	**211,115.3**	**88,711.7**	**105,322.4**	**41,362.1**	**235,396.2**

Behavioral Health
Summary of RDU Budget Changes by Component
From FY2005 Management Plan to FY2006 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2005 Management Plan	**74,089.0**	**94,335.2**	**42,691.1**	**211,115.3**
Adjustments which will continue current level of service:				
-AK Fetal Alcohol Syndrome Pgm	596.0	-1,096.0	500.0	0.0
-Behavioral Health Grants	0.0	0.0	-1,000.0	-1,000.0
-Behavioral Health Administration	-265.9	122.3	65.6	-78.0
-Alaska Psychiatric Institute	445.8	0.0	1,000.0	1,445.8
Proposed budget decreases:				
-Behavioral Health Grants	0.0	0.0	-5,500.0	-5,500.0
-Behavioral Health Administration	0.0	0.0	-125.1	-125.1
-Psychiatric Emergency Svcs	0.0	0.0	-308.5	-308.5
-Svcs/Seriously Mentally Ill	0.0	0.0	-29.0	-29.0
Proposed budget increases:				
-Alcohol Safety Action Program	0.0	0.0	120.0	120.0
-Behavioral Hlth Medicaid Svcs	13,806.2	11,937.7	0.0	25,743.9
-Behavioral Health Grants	0.0	0.0	1,855.0	1,855.0
-Behavioral Health Administration	23.3	23.2	0.0	46.5
-Svcs/Severely Emotion Dst Yth	0.0	0.0	2,093.0	2,093.0
-Alaska Psychiatric Institute	17.3	0.0	0.0	17.3
FY2006 Governor	**88,711.7**	**105,322.4**	**41,362.1**	**235,396.2**