

# 2021 Alaska Scorecard

Key Issues Impacting Alaska Mental Health Trust Beneficiaries



**Trust**  
Alaska Mental Health  
Trust Authority

The Alaska Scorecard has been revised to align with Strengthening the System: Comprehensive Integrated Mental Health Program Plan 2020-2024 (Strengthening the System). The Scorecard is a data measurement tool that examines the population health outcomes of Alaskans receiving care and services as described in Strengthening the System. Historically, the Scorecard measured the desired outcomes of the previous Comprehensive Plan: Moving Forward 2006-2011; it was published annually from 2008 until 2019 with indicators corresponding with Moving Forward.

The 2020 version of the Scorecard was revised to include both new indicators and new narratives that are consistent with Strengthening the System. The revised scorecard was formatted to be consistent with the use of Results-Based Accountability Framework (RBA). As a result, new key sections include:

- **Story Behind the Baseline:** this section takes stock of both the positive and negative forces that impact an indicator, as well as what is working to address it and what is not. It also includes a look at what the population or information being measured revealed prior to planned solutions (as described in the indicator) and includes information on research and causes.
- **What Works:** this section offers a brief explanation of what works to affect measurable improvements in the indicator. This includes information, research, and solutions along with some no- to low-cost strategies to mitigate the challenges the indicator highlights.

The Scorecard remains a concentrated document detailing the key issues impacting Alaska Mental Health Trust beneficiaries and was researched and produced by a group of leaders and planners representing the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority, boards and commissions, and other related state agencies. Trust beneficiaries are Alaskans who experience mental illness, developmental and intellectual disabilities, substance use disorders, Alzheimer's disease and related dementia, and traumatic brain injuries.

For more information, please visit the [Comprehensive Integrated Mental Health Program Plan](#).

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# ALASKA SCORECARD 2021

## Key Issues Impacting Alaska Mental Health Trust Beneficiaries

| INDICATOR   | MOST CURRENT U.S. DATA | PREVIOUS ALASKA DATA | MOST CURRENT ALASKA DATA | CHANGE |
|---|------------------------|----------------------|--------------------------|--------|
| <b>EARLY CHILDHOOD</b>  |                        |                      |                          |        |
| 1. Percentage of children who received a developmental screening using a parent-completed screening tool in the past year (ages 9 months through 35 months) | 36.9% (2019-2020)      | 47.9% (2018-2019)    | 47.4% (2019-2020)        | -0.5%  |
| 2. Percentage of incoming students who regulate their feelings and impulses 80% of the time or more (grades K-1)  | *                      | 47.4% (2018-2019)    | 49.1% (2019-2020)        | +1.7%  |
| 3. Percentage of women who recently delivered a live birth who have a strong social support system during the postpartum period                             | *                      | 76.6% (2019)         | 75.2% (2020)             | -1.4%  |
| 4. Mean index score of 12 assets associated with child health and well-being that are present at birth  | *                      | 9.6 (2019)           | 9.6 (2020)               | 0      |
| <b>HEALTHCARE</b>   |                        |                      |                          |        |
| 5. Percentage of population without health insurance  | 8.6% (2020)            | 12.2% (2019)         | 12.6% (2020)             | +0.4%  |
| 6. Rate of non-fatal fall injuries (rate per 100,000; ages 65+)   | 3,263.3 (2020)         | 3,864.5 (2019)       | 3,263.3 (2020)           | -973.3 |
| <b>ECONOMIC AND SOCIAL WELL-BEING</b>   |                        |                      |                          |        |
| 7. Percentage of renter-occupied households that exceed 50% of household income dedicated to housing  | 22.1% (2019)           | 17.3% (2018)         | 18.6% (2019)             | +1.3%  |
| 8. Rate of chronic homelessness (rate per 100,000)  | 33.3 (2020)            | 31.6 (2019)          | 44.6 (2020)              | +13    |
| 9. Percentage of Alaskans who experience a disability that are employed   | 38.9% (2019)           | 42.7% (2018)         | 44.0% (2019)             | +1.3%  |
| 10. Percentage of Alaskans living above 125% of the federal poverty level   | 85.7% (2019)           | 85.6% (2019)         | 82.9% (2020)             | -2.7%  |
| <b>SUBSTANCE USE DISORDER PREVENTION</b>  |                        |                      |                          |        |
| 11. Percentage of Alaskans needing but not receiving treatment at a specialty facility for substance use in the past year (ages 12+)                        | 13.9% (2020)           | 8.9% (2018-2019)     | 15.0% (2020)             | +6.1%  |
| 12. Percentage of Alaskans who received mental health services in the past year (ages 18+)  | 16.5% (2019-2020)      | 17.1% (2018-2019)    | 17.3% (2019-2020)        | +0.2%  |
| 13. Rate of alcohol-induced mortality (rate per 100,000; age-adjusted)  | 13.1 (2020)            | 23.7 (2019)          | 24.2 (2020)              | -0.5   |
| <b>SUICIDE PREVENTION</b>   |                        |                      |                          |        |
| 14. Rate of suicide attempts (rate per 100,000; age-adjusted)   | 40.5 (2020)            | 122.4 (2019)         | 129.4 (2020)             | 7.1    |
| 15. Rate of suicide (rate per 100,000; age adjusted)  | 13.5 (2020)            | 28.7 (2019)          | 27.9 (2020)              | -0.8   |
| 16. Rate of suicide (rate per 100,000; ages 15 to 24)   | 14.2 (2020)            | 57.9 (2019)          | 49.8 (2020)              | -8.1   |

**KEY:** • Asterisk (\*): no U.S. data available at time of publication

• Calendar year (year): data represents calendar year

• Fiscal year (FY): data represents fiscal year

• Combined year (year-year): data represents year range

| INDICATOR  | MOST CURRENT U.S. DATA | PREVIOUS ALASKA DATA | MOST CURRENT ALASKA DATA | CHANGE |
|--|------------------------|----------------------|--------------------------|--------|
| <b>PROTECTING VULNERABLE ALASKANS</b>  |                        |                      |                          |        |
| 17. Rate of child maltreatment, substantiated cases, unique victims (rate per 1,000; ages 0 to 17)   | 8.4 (2020)             | 17.0 (2019)          | 18.0 (2020)              | +1.0   |
| 18. Percentage increase for youth who accessed home-based family treatment services  | *                      | Services start 2023  |                          |        |
| 19. Founded reports of harm to adults (rate per 1,000; ages 18+)   | *                      | 1.4 (FY2020)         | 1.0 (FY2021)             | -0.4   |
| <b>SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT</b>   |                        |                      |                          |        |
| 20. Percentage of Alaskans who meet criteria for an institutional level of care who were served by a home and community-based waiver   | *                      | 83.3% (FY2020)       | 82.1% (FY2021)           | -1.2   |
| 21. Percentage of criminal defendant referrals admitted to a therapeutic court   | *                      | 60.0% (FY2020)       | 62.9% (FY2021)           | +2.9%  |
| 22. Percentage of all juvenile justice referrals that were diverted from formal court action   | *                      | 43% (FY2020)         | 47% (FY2021)             | +4%    |
| <b>SERVICES IN INSTITUTIONAL ENVIRONMENTS</b>  |                        |                      |                          |        |
| 23. Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 12 to 17)   | *                      | 6.0% (2019)          | 5.5% (2020)              | -0.5%  |
| 24. Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 18+)  | *                      | 10.3% (2019)         | 10.9% (2020)             | +0.6   |
| 25. Percentage of Alaskans who meet criteria for an institutional level of care who were served in nursing homes and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) | *                      | 16.7% (FY2020)       | 17.9% (2021)             | +1.2   |
| 26. Percentage of juveniles in a Division of Juvenile Justice facility with an identified behavioral health or neurobehavioral condition in a secure treatment unit  | *                      | 96% (FY2020)         | 100% (FY2021)            | +4%    |
| 27. Percentage of incarcerated individuals diagnosed with a psychotic disorder or schizophrenia who received intensive clinical and case management reentry services   | *                      | 79.3% (FY2020)       | 86.8% (FY2021)           | +7.4%  |
| <b>WORKFORCE, DATA, AND FUNDING</b>  |                        |                      |                          |        |
| 28. Percentage change in SHARP health practitioner contracts (current calendar year compared to previous 5-year average)   | *                      | 42% (2020)           | 34% (2020)               | -8%    |
| 29. Percentage change between fiscal years of unduplicated participants served by Alaska Training Cooperative training events  | *                      | - 27.9% (FY2020)     | -20.0% (FY2021)          | +7.9%  |
| 30. Medicaid expenses as a percentage of state's budgets   | 27.2% (FY2021)         | 18.7% (FY2020)       | 16.4% (FY2021)           | -2.3%  |

**KEY:**

- Asterisk (\*): no U.S. data available at time of publication
- Calendar year (year): data represents calendar year
- Fiscal year (FY): data represents fiscal year
- Combined year (year-year): data represents year range

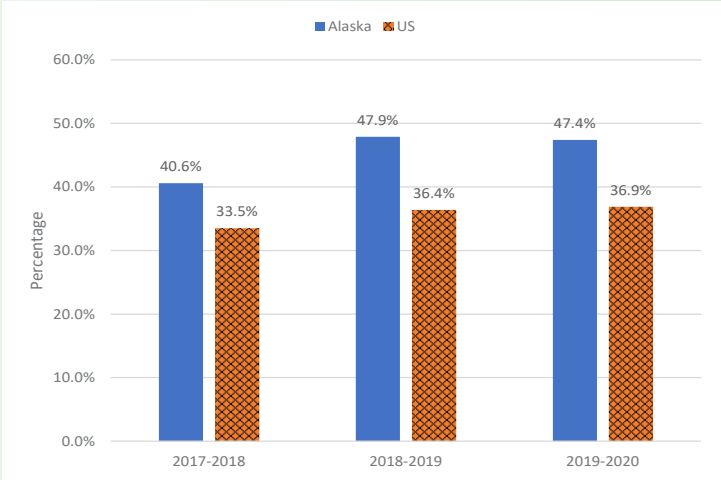
# EARLY CHILDHOOD

## INDICATOR 1: Percentage of children who received a developmental screening using a parent-completed screening tool in the past year (ages 9 months through 35 months)

### Story Behind the Baseline

Early identification of developmental and behavioral health disorders is critical to the well-being and improved outcomes of children and their families. Standardized developmental screening has been proven as an effective strategy to identify infants and young children who may benefit from early intervention services. Such screenings are also a way to identify areas in which a child’s development differs from same-age norms so healthcare professionals can determine if further evaluation is needed. Studies have shown that early intervention can significantly improve outcomes for children with developmental delays and their families. Failure to screen can lead to delays in further evaluation, diagnosis, and treatment, as well as burden families with unnecessary stress and uncertainty, making interventions less effective and more costly.

In addition, autism-specific screening is recommended at ages 18 and 24 months, and social-emotional screening is recommended at regular intervals. Alaska’s Medicaid program



Population: Alaska and U.S. (Ages 9 Months Through 35 Months)

Data Source:

- [National Survey of Children’s Health, Health Resources and Services Administration, Maternal and Child Health Bureau](#)

has adopted the American Academy of Pediatrics (AAP) Bright Futures Recommendations for Preventive Pediatric Healthcare, which includes a recommendation for developmental screening in infancy and early childhood.

Data for this measure is from the National Survey of Children's Health (NSCH) and shows rates of parent-reported standardized screening in Alaska as higher than the national average. The measure uses age-appropriate questions to verify whether young children received standardized developmental, behavioral, and social screening using a parent-reported, standardized screening tool or instrument. Parent respondents for all children between 9 months and 35 months old were asked if, during the last 12 months, a healthcare provider offered a questionnaire about specific concerns or observations about their child's development, communication, or social behaviors.

Alaska's Early Childhood Comprehensive Systems and Maternal Child Health programs have coordinated efforts over the past several years to better coordinate and improve developmental screening rates. Help Me Grow Alaska (HMG-AK) emerged from a public-private partnership between the Department of Health and Social Services (DHSS) and the All Alaska Pediatric Partnership (AAPP) to establish centralized screening access and streamline data and referrals. Expansion of these efforts will continue to increase early identification and intervention supports for Alaska's youngest children.

## What Works?

According to the Centers for Disease Control and Prevention (CDC), early detection and subsequent actions are central for referral to treatment and care for the estimated 15% of children with a developmental disability. Children who receive early interventions (services for children with disabilities from birth up to five years, as defined by U.S. federal law) often experience improved long-term outcomes. The AAP recommends that all children should be screened for developmental delays during their regular well-child visits at 9, 18, and 24 or 30 months.

Developmental screening is a standardized set of questions about different aspects of a child's abilities including language, movement, thinking, behavior, and emotions. Going through the process of a developmental screening can be both fun and educational for parents and caregivers and can contribute to a family's protective factors. Many tools use activities that children already engage in or view as games to assess milestones. When done with a health or education provider and a parent or caregiver, the screening tools and processes can give ideas for new activities for caregivers to try with their children, as well as help caregivers understand the types of skills the child may be developing at each new stage.

HMG-AK works closely with pediatricians, early interventionists, and behavioral health providers to promote healthy child development. HMG-AK is a centralized resource that offers free training and technical assistance on developmental screening and use of standardized tools for health, child care, and other community providers. HMG-AK offers free developmental screening and resource referrals directly to families and caregivers seeking information and supports.

**Sources:**

- [National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau](#)
- [Alaska Infant Learning Program](#)
- [American Academy of Pediatrics](#)
- [Help Me Grow Alaska Report - Developmental Screening in Alaska: Status | Leadership | Data | Structure - Challenges and Opportunities, March 2020](#)
- [Early Childhood Technical Assistance Center](#)



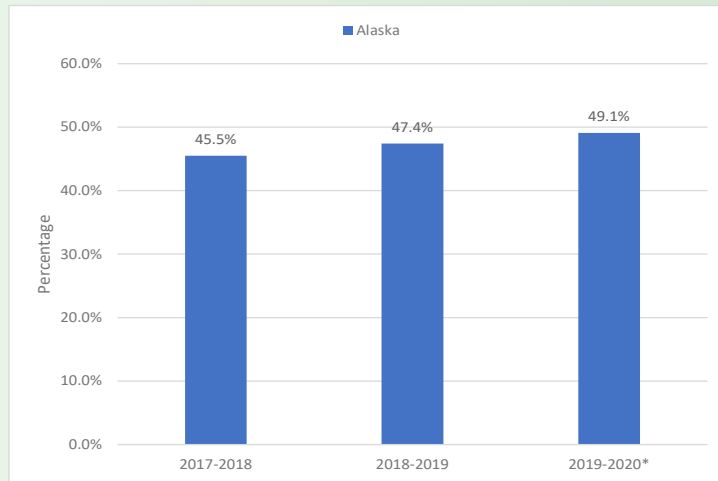
## EARLY CHILDHOOD

### INDICATOR 2: Percentage of incoming students who regulate their feelings and impulses 80% of the time or more (grades K-1)

#### Story Behind the Baseline

Social and emotional learning (SEL) is an integral part of education and human development. SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions, and achieve personal and collective goals. SEL also helps people feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.

Young children who enter kindergarten with strong foundational SEL skills, including regulation of feelings and impulses, tend to have higher academic and better lifelong health outcomes. Children who have experienced trauma, or whose families have not had access to needed supports, may have difficulty regulating their emotions when compared to peers of the same age. This difficulty is due to the effects of trauma on the brains of infants and young children, as well-documented through the Adverse Childhood Experiences (ACEs) study and decades of subsequent research. Lack of impulse control and social skills can negatively impact learning opportunities in the classroom and in interpersonal



**Population: Alaska Statewide (Grades K-1)**

#### Data Source:

- [Alaska Department of Education & Early Development - Developmental Profile Results Domain 2 Goal 4](#)

#### Data Source Contact:

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#### \*Note:

- Due to the COVID-19 pandemic and statewide school facility closures, all statewide assessments, including the Alaska Development Profile, were canceled in the spring of 2020. Data for this indicator are unchanged from the 2020 scorecard.

relationships, leading to lower academic achievement and lifelong health and employment outcomes.

The Alaska Developmental Profile (ADP) is a tool used by school districts statewide to assess the developmental skill levels of all incoming students in kindergarten. The purpose of the assessment is to identify, record, and summarize the skills and behaviors students demonstrate upon entry to school, based on teacher observations. Student skills and behaviors are defined by whether students are consistently demonstrating skill in the five domains from Alaska’s Early Learning Guidelines, including SEL. The ADP assesses a child’s ability to regulate feelings and impulses and offers insight into the level of Alaskan students’ SEL through a reliable tool used in all Alaska school districts.

Data from the ADP is being incorporated into the Alaska Longitudinal Child Abuse and Neglect Linkage Project (ALCANLink), which will allow further analysis of early childhood experiences and skills, including SEL, on early lifelong educational and health outcomes. Trends analyzed through ALCANLink currently include likelihood of a child’s involvement in special education, child welfare, and other state-funded and operated services. Findings have the potential to drive education and health policy for children and families for improved population outcomes and lower public cost.

## **What Works?**

A large body of research has demonstrated the critical importance of the first three years of a child’s life. The experiences and interactions children have in these early years significantly affect brain development and help to establish the foundation for future learning. Warm and responsive interactions can create a nurturing and stable environment that enables the development of secure attachments between children and their caregivers—both those within and beyond their families. These attachments support children as they develop a sense of self and begin to understand their emotions, and as they lay the foundation for establishing successful relationships at later ages. Early learning programs, and the people who work in them, play a critical role in supporting children's development, along with their primary caregivers. Furthermore, this crucial development must be supported from infancy when brain development is at its peak. Waiting until children enter preschool or kindergarten to introduce these vital interventions is simply too late.

SEL is highlighted in early childhood home visiting programs, such as Nurse Family Partnership, Parents as Teachers, and Early Head Start, which can have a profound impact on a young child’s ability to learn self-regulation and has the advantage of being a “two-generational approach,” an approach that also promotes positive parenting skills and caregiver relationships. Additionally, high-quality early care and learning environments for infants and young children,

coupled with infant and early childhood mental health supports, can have a positive impact on a child’s SEL prior to kindergarten.

Well-executed SEL practices, in a variety of home- and center-based environments, have the potential to move whole groups of children toward better academic and social outcomes. High-quality SEL practices are especially beneficial for vulnerable children and those who have experienced trauma.

**Sources:**

- [Coalition for Evidence-Based Policy, “Social Programs That Work: Prenatal/Early Childhood”](#)
- [Hirokazu Yoshikawa and others, “Investing In Our Future: The Evidence Base on Preschool Education” \(Ann Arbor, MI: Society for Research in Child Development; New York: Foundation for Child Development, 2013\)](#)
- [Alaska Association for Infant and Early Childhood Mental Health](#)
- [CLEAR Trauma Informed Schools White Paper - A Selected Review of Trauma-Informed School Practice and Alignment with Educational Practice, Christopher Blodgett, Ph.D., Joyce Dorado, Ph.D.](#)
- [The Collaborative for Academic, Social, and Emotional Learning](#)
- Harvard University Center on the Developing Child, “In Brief: The Science of Early Childhood Development, 2007
- [The Heckman Curve](#)

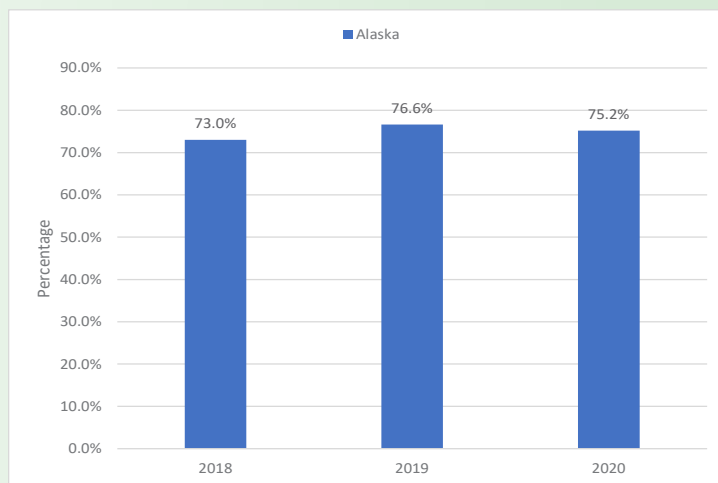
## EARLY CHILDHOOD

### INDICATOR 3: Percentage of women who recently delivered a live birth who have a strong social support system during the postpartum period

#### Story Behind the Baseline

Research shows that social support is a major buffer of postpartum depression and can improve outcomes for infants, young children, and their families. The presence of social supports, as reported by mothers after giving birth, can help predict early childhood experiences and provide an opportunity to increase individual and community-level supports at a critical developmental period. Culturally, social connections in Alaska are of particular significance. Tribal communities, which carry a greater burden of negative health outcomes, experience social connections as interwoven with other protective factors through the sharing of resources, responsibilities, cultural knowledge, and connections to ancestors and the land.

In 2020, Alaska's Pregnancy Risk Assessment Monitoring System (PRAMS) reported that approximately three-quarters (75.2%) of postpartum women state that they have access to all five social support items of inquiry. The questions asked about supports available after delivering their baby, including financial support (someone to loan her \$50), physical support



**Population: Alaska Statewide**

#### Data Sources:

- [Alaska Division of Public Health, Women's Children's and Family Health Section, Pregnancy Risk and Monitoring System](#)

#### Data Source Contact:

- Kathy Perham-Hester, MS, MPH  
Alaska PRAMS Coordinator Section of Women's, Children's and Family Health Division of Public Health Alaska Department of Health and Social Services  
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(someone to help if she were sick and needed to be in bed; someone to take care of her baby), and emotional support (someone to talk with about her problems; someone to help if she was tired and feeling frustrated with her new baby). Affirmative responses to all these questions indicated a strong social support system and increased protective factors, which can predict more positive health outcomes for children and families.

## What Works?

The presence of protective factors, such as safe, stable, and nurturing relationships, can often mitigate the consequences of Adverse Childhood Experiences (ACEs). Individuals, families, and communities can all influence the development of many protective factors throughout a child's life that can impact their development. During childhood, particularly the critical postpartum period, caregiver social supports are especially valuable to help prevent and buffer the impact of ACEs.

The State of Alaska and many community partners across the state promote the Strengthening Families approach to improve social supports and increase protective factors to improve outcomes for families and children. Strengthening Families is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. The approach is based on engaging families, programs, and communities in building five key protective factors:

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need
5. Social and emotional competence of children

The Centers for Disease Control and Prevention (CDC) recommends implementing strategies to prevent ACEs from occurring and to mitigate their affects. Research from the Alaska Longitudinal Child Abuse and Neglect Linkage (ALCANLink) project identified that the number of prebirth challenges experienced by the household is strongly associated with the accumulation of childhood ACEs. Addressing and reducing these household challenges during the prebirth period is critical for ACE prevention. The presence of protective factors, particularly safe, stable, and nurturing relationships, can help prevent or mitigate the consequences of ACEs. Individuals, families, and communities can all influence the development of many protective factors throughout a child's life that can impact their development. During childhood, particularly the critical postpartum period, caregiver social supports are especially valuable to help prevent and buffer the impact of ACEs.

**Sources:**

- [Alaska Pregnancy Risk Assessment Monitoring System](#)
- [Centers for Disease Control And Prevention Pregnancy Risk Assessment Monitoring System](#)
- Center for the Study of Social Policy: Strengthening Families Framework
- [CDC Violence Prevention](#)
- [ALCANLink Publications](#)

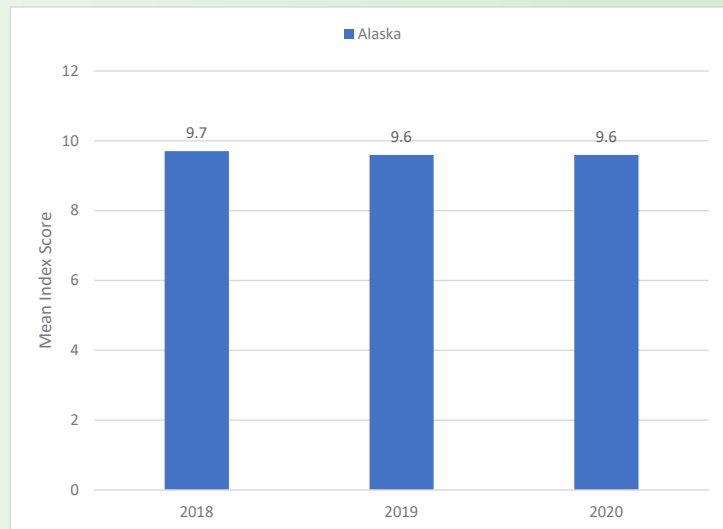
## EARLY CHILDHOOD

### INDICATOR 4: Mean index score of 12 assets associated with child health and well-being that are present at birth

#### Story Behind the Baseline

Ensuring families are supported prebirth and immediately post-birth can provide human, social, and material supports that lay a strong foundation for protective factors shown to positively impact outcomes and resilience through their lifetime. Certain human, social, and material supports are considered "assets," i.e., resources that promote resiliency.

At birth, infant's brains are not fully developed; they are built throughout childhood as experiences and interactions create a foundation for the rest of life. Adverse Childhood Experiences (ACEs) are stressful or traumatic experiences during childhood, including abuse, neglect, witnessing domestic violence, or growing up with a caregiver struggling with substance misuse, mental illness, or incarceration. New research is investigating the relationship between a family's social challenges before giving birth and the later accumulation of ACEs in their children. Some of the prebirth household challenges include situations such as financial challenges, housing stability, violence, someone close to the mother suffering from substance misuse, incarceration of a parent, divorce, mental health challenges, and other concerns. While every child should ideally have the opportunity to grow up in a strong and thriving family environment, this is not always the case.



**Population:** Alaska Statewide

**Data Source:**

- [Alaska Division of Public Health, Women's Children's and Family Health Section, Maternal and Child Health Epidemiology Unit](#)

**Data Source Contact:**

- Kaerin Stephens, Research Analyst  
Section of Women's, Children's and Family Health Division of Public Health  
Alaska Department of Health and Social Services  
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Information registered at birth can be used to document assets (resources) available to each Alaskan newborn. Specifically, information regarding infant health and circumstances surrounding the birth (e.g., birthweight, presence of birth abnormalities), family socioeconomic status (e.g., ability to afford and access healthcare), maternal health behaviors and access to services (e.g., receipt of timely prenatal care), and the age and education of both parents (if paternity is established), all provide insight into the conditions into which individual children are born.

Assets and conditions at birth do not predetermine a child's future, as shown when high-quality early intervention services are accessed. Thoughtful supports and services may be required to ensure that children with fewer assets find themselves on equal footing with their peers. Monitoring the distribution of assets among newborns in different communities can help ensure investments are intentional and equitable, as well as responsible and fiscally sound.

## **What Works?**

Just as the accumulation of certain prebirth household challenges are strongly associated with the accumulation of childhood ACEs and chronic health conditions, the positive effects of prebirth supports in a woman's life may help predict improved health for a mother and her child. Improving social determinants of health during the prebirth period and beyond may serve as a primary point of ACEs prevention. Many evidence-based, multidisciplinary intervention strategies can and should be implemented in the prebirth period to strengthen the household unit before the introduction of a new child. Addressing ACEs should focus on improving economic capacity, supporting early childhood programs, teaching parenting skills, ensuring treatment availability and use, and normalizing positive parenting behavior. Healthcare providers should consider engaging in a continuum of prevention across the lifespan and assess household challenges at multiple time points, partnering with agencies or programs providing resources to address identified challenges impacting their lives.



The Centers for Disease Control and Prevention (CDC) provides the following examples as areas of opportunity to improve social determinants and, therefore, lifelong health outcomes for children and families:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to healthcare services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder
- Socioeconomic conditions (concentrated poverty and related stressful conditions)
- Residential segregation
- Language and literacy
- Access to mass media and emerging technologies
- Culture

**Sources:**

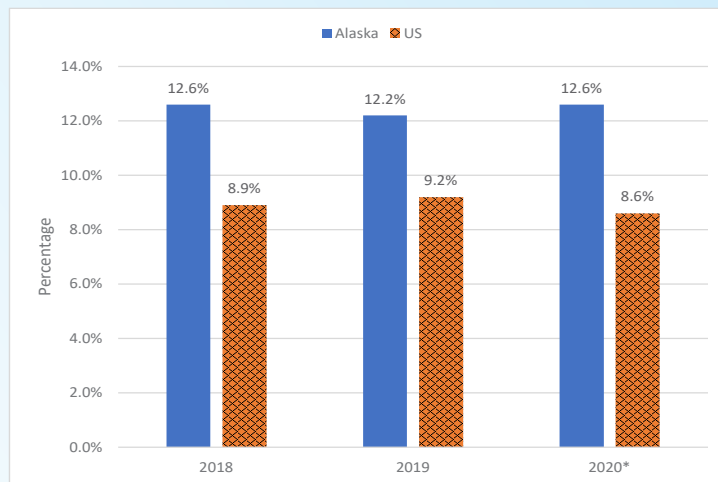
- [Alaska Division of Public Health, Women's Children's and Family Health Section, Maternal and Child Health Epidemiology Unit](#)
- [Strong Start Index](#)
- [Children's Data Network](#)

# HEALTHCARE

## INDICATOR 5: Percentage of population without health insurance

### Story Behind the Baseline

Without access and coverage for healthcare services, which include behavioral health in all geographic areas, there is an increased risk of Alaska's population having poor physical and mental health outcomes. A common goal across the healthcare industry is for all Alaskans to have adequate health insurance and access to healthcare services. In 2020, 12.6% of Alaskans were uninsured compared to 8.6% nationally. Even with access to health insurance, barriers continue to exist in receiving services statewide. There are often long wait times for the first appointment for a new patient, and many primary care providers have stopped accepting new patients on Medicare or Medicaid. Extended wait times often lead to a patient not accessing care or seeking care in a more expensive setting, such as an emergency room, or they recover from the acute illness without being examined or receiving a diagnosis. Location of services in Alaska also presents a barrier as air travel is often necessary in order to seek proper healthcare. Telehealth appointments can offer a range of necessary services; however, barriers such as the type of services offered and available technology limit telehealth capacity.



**Population: Alaska and U.S.**

**Data Source:**

- [United States Census Bureau, American Community Survey, Table S2701](#)
- [United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Table H-01](#)

**\*Note:**

- Due to the COVID-19 pandemic, 2020 results from the American Community Survey (ACS) were not available at the time of publication. Estimates are substituted with Current Population Survey Annual Social and Economic Supplement data which are similar but not directly comparable to the ACS.

## What Works?

Alaskans must be healthy if the state is to thrive. When a population is healthy, more people attend work and school, participate in their communities, engage in traditional cultural practices, and care for their families. Uninsured rates decreased between 2013 and 2018 following the introduction of the Affordable Care Act. Among states, Alaska had the fourth highest (behind Texas, Oklahoma, and Georgia) proportion of uninsured population in 2020. In many states across the nation, state health departments have partnered with federally qualified health centers (FQHCs) and rural health clinics (RHCs). These facilities can be accessed by patients with or without insurance and offer a sliding scale fee schedule to those without health insurance.

### Sources:

- [United States Census Bureau, American Community Survey, Table S2701](#)
- [United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Table H-01v](#)
- [U.S. Census Bureau American Current Population Survey](#)
- [Alaska Medicaid Dashboard](#)
- [Healthy Alaskans](#)
- [Alaska Healthcare Transformation Project](#)
- [Alaska Medicaid Redesign](#)

## HEALTHCARE

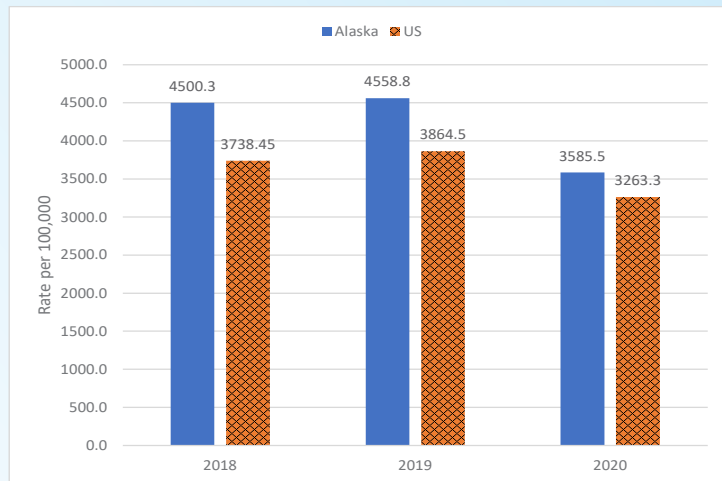
### INDICATOR 6: Rate of non-fatal fall injuries (rate per 100,000; ages 65+)

#### Story Behind the Baseline

Among Alaska residents ages 65 and over, falls are the leading cause of serious injury and loss of independence. Falls are also the most common cause of traumatic brain injury and are an especially serious risk for older adults.

When an older adult sustains a serious traumatic brain injury in a fall, the injury may result in long-term cognitive changes, reduced ability to function, and changes in emotional health. In addition to traumatic brain injury, falls can cause broken bones, including wrist, arm, ankle, and hip fractures. Many people who fall, even if they are not injured, become afraid of falling. This fear may cause a person to cut down on their regular everyday activities. When a person is less active, they become weaker and increase their chances of falling.

Risk factors for falls in older adults include lower body weakness, vitamin D deficiency, difficulties with walking and balance, vision problems, environmental hazards such as ice, uneven steps, clutter that can be tripped over, and the use of drugs and alcohol.



**Population: Alaska and U.S. (Ages 65+)**

**Data Sources:**

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting](#)
- [Center for Disease Control and Prevention, CDC WISQARS](#)

**\*Note:**

- Based on nonfatal unintentional fall emergency department visits, treated and released. Alaska data previously based on Alaska Trauma Registry injury hospitalization data. Indicator is now based on Health Facility Data Reporting data for improved data quality and consistency with national reporting standards.

## What Works?

Regardless of age group, higher percentages of older adults who reported no physical activity in the past month or reported difficulty with one or more functional characteristics (difficulty walking up or down stairs, dressing and bathing, and performing errands alone) reported falls and fall-related injuries. These risk factors are frequently modifiable, suggesting that regardless of age, many falls might be prevented. The Centers for Disease Control and Prevention (CDC) created the Stopping Elderly Accidents, Deaths & Injuries (STEADI) initiative, which offers tools and resources for healthcare providers to screen their older patients for fall risk, assess modifiable fall risk factors, and to intervene with evidence-based fall prevention interventions. These include medication management, vision screening, home modifications, referral to physical therapists who can address problems with gait, strength, and balance, and referral to effective, community-based fall prevention programs.

There are several evidence-based fall prevention programs that can be implemented by community-based organizations to decrease the number of falls experienced by older Alaskans. Currently, there are funds allocated through the Older Americans Act, which go through the Division of Senior and Disabilities Services, to implement evidence-based fall prevention activities specifically for older adults, as well as fall prevention programs implemented by the Division of Public Health.

As the proportion of older adults living in the United States continues to grow, so too will the number of falls and fall-related injuries; however, many of these falls are preventable. To help keep older adults living independently and injury-free, reducing fall risk and fall-related injuries is essential.

**Sources:**

- [Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System \(WISQARS\)](#)
- Ambrose AF, Paul G, Hausdorff JM. Risk Factors for Falls Among Older Adults: A Review of the Literature. *Maturitas* 2013; 75:51–61.
- Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of Falling and Restriction of Mobility in Elderly Fallers. *Age and Aging* 1997;26:189–193.
- [CDC Home and Recreational Safety Preventing Falls: A Guide to Implementing Effective Community Based Fall Prevention Programs](#)

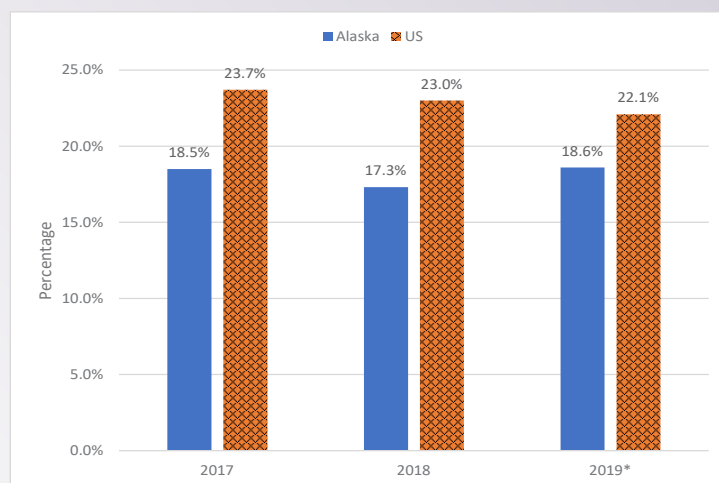
# ECONOMIC AND SOCIAL WELL-BEING

## INDICATOR 7: Percentage of renter-occupied households that exceed 50% of household income dedicated to housing

### Story Behind the Baseline

Having a safe place to call home and an income to meet one's basic needs are vital components to living a meaningful life. Limited availability of affordable housing is a problem in Alaska and nationwide. There is a shortage of rental homes available to Alaskan families at or below the poverty line, or at 30% of the area median income. Thus, there is a severe cost burden associated with housing in Alaska. Housing and Urban Development (HUD) has long considered severe shelter burden as greater than paying 50% or more of one's income on

rent. When people are forced to spend more than 50% of their income on housing, they must make sacrifices on other important spending such as healthcare, healthy food, and education. Severely shelter-burdened families are at high risk for eviction caused by not being able to pay rent. In addition to the monetary cost of eviction for both the tenant and landlord, the record of having been evicted from rental housing makes re-housing difficult. It is crucial that public health partners work with housing organizations to reduce the severe rental burden for beneficiaries and improve the health of all Alaskans.



Population: Alaska and U.S.

Data Source:

- [United States Census Bureau, American Community Survey, Table B25074](#)

\*Note:

- Due to the COVID-19 pandemic, 2020 results from the American Community Survey (ACS) are not available. Data are unchanged from the 2020 scorecard.

## What Works?

Making mortgages accessible to Alaskans has been at the core of Alaska Housing and Finance Corporation (AHFC). Over the years, responsibilities of AHFC have expanded to include affordable housing programs, energy efficiency, older adults housing, and more. AHFC is a self-supporting public corporation with offices in 16 communities statewide. AHFC has contributed more than \$2 billion to the state in the form of direct dividends for the General Fund, which is the state's funding source for all services and programs. The General Fund provides funds to the state for building and equipment improvements, bonding for projects such as university student housing, purchasing state assets, and maintenance of state-owned property.

In addition to funding for housing, the following steps can be taken to reduce shelter burden:

- Measuring the shelter burden of households to identify those at risk for housing insecurity due to high shelter burden.
- Identifying existing housing resources available.
- Developing partnerships to maximize opportunities.

Additionally, identifying barriers that may be preventing beneficiaries from effectively utilizing existing programs and collaborating with housing partners is another way to ensure that beneficiaries can overcome any challenges for securing housing.

It is also vital that renters and future homeowners are prepared for the responsibility of owning or renting. This preparation is best achieved by providing counseling and education to promote building and maintaining positive rental relationships and support. Furthermore, providing intervention for both tenants and the landlord at a point of crisis, in order to prevent eviction and promote long-term housing stability, is crucial.

As housing is so closely linked to employment and other basic needs, it is also critical to improve and maintain access to employment opportunities, education, and supports to enhance long-term economic self-sufficiency in order to overcome shelter burden.



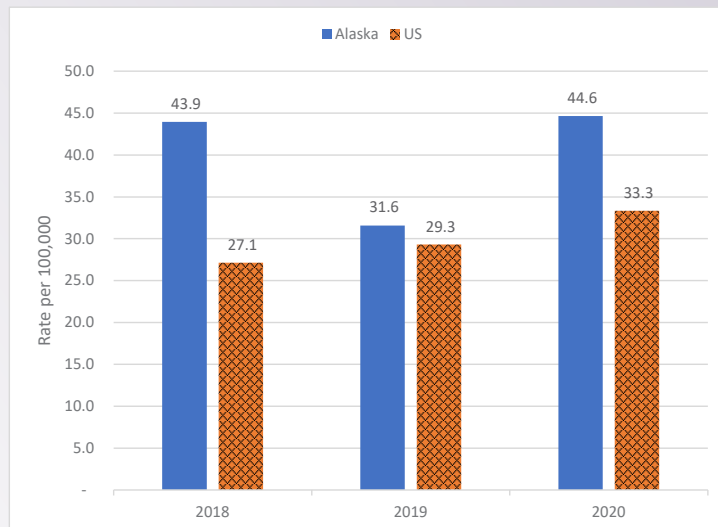
## ECONOMIC AND SOCIAL WELL-BEING

### INDICATOR 8: Rate of chronic homelessness (rate per 100,000)

#### Story Behind the Baseline

Persons experiencing homelessness are at an elevated risk for many adverse medical conditions, as well as premature death. These persons represent a diverse population facing a range of adverse situations, resulting in unstable living situations. In some cases, medical conditions or traumatic events, like domestic violence and/or sexual assault, mental illness, substance use disorder, or disability for example, can increase the likelihood an individual will experience homelessness. In other cases, families are faced with a loss of income or limited job opportunities, overcrowded living spaces, and shrinking public assistance programs, coupled with a lack of affordable housing in their community.

A smaller number of Alaskans face the more serious challenge of chronic homelessness. Chronic homelessness is defined as a homeless individual or head of household with a disability that meets the Department of Housing and Urban Development (HUD) definition of a disability who (a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; (b) and in general have been homeless and living in one of these places continuously for at least 12 months or on at least four separate occasions in the last three years. Alaskans who experience chronic homelessness are among the most at-risk for adverse health conditions.



Population: Alaska and U.S.

Data Source:

- [United States Department of Housing and Urban Development, Annual Homeless Assessment Report](#)

Many stakeholders are working together to reduce the experience of homelessness as a cornerstone of improving the health and well-being of Alaskan communities.

In Alaska, about 1,907 people were estimated to have experienced homelessness in any capacity during the 2018 calendar year. Most persons experiencing homelessness are sheltered, meaning they are served by an emergency shelter, transitional housing, or have access to housing vouchers. Across Alaska, housing and sheltering services are extremely limited, especially in rural areas. Overall, there are not enough non-domestic violence shelter beds available to meet the needs of persons experiencing homelessness. Furthermore, there is not an adequate amount of rapid re-housing services available to support their needs. According to the 2018 Housing Inventory Count, 15 of the 29 census areas in Alaska have no year-round emergency shelter, transitional housing, rapid re-housing, or permanent supportive housing facilities.

## What Works?

Reducing the factors that lead to people being in vulnerable housing situations is the best way to reduce the number of persons experiencing homelessness in Alaska. One strategy is to implement supportive housing: affordable housing paired with tenancy supports and services that may be permanent for some populations and transitional or time-limited for others. Research shows supportive housing helps people with disabilities live stably in the community, reduces their use of costly systems such as emergency healthcare and corrections, and can help them engage in health and behavioral care services.

Rapid re-housing programs are a nationwide best practice and connect families and individuals to permanent housing using time-limited financial assistance and other supportive services to help with the transition. These programs are very limited in the state. Supportive housing and rapid re-housing programs are more effective at solving homelessness when a Housing First approach is taken, removing barriers and pre-conditions to be housed, such as sobriety or enrollment in services.

Preventing homelessness, much like preventing injury or illness, not only provides better outcomes for individuals, but is the most effective, efficient, and economical approach to addressing homelessness. Homelessness prevention programs are used to prevent eviction, provide utility assistance, fix a car that is needed for employment, and meet other critical needs to ensure a person can continue their existing tenancy.

Through the Homelessness Assistance Program (HAP), funds are awarded competitively to agencies in Alaska to provide emergency or transitional housing and/or services to prevent homelessness or rapidly re-house those who have been displaced.

The Special Needs Housing Grant (SNHG) provides funds through competitive grants to nonprofit service providers and housing developers for construction and operation of housing for Alaska’s special needs populations, primarily beneficiaries of the Alaska Mental Health Trust Authority. This can include transitional housing, often used for recovery and reentry from incarceration, as well as permanent supportive housing.

**Sources:**

- [Alaska Homeless Information Center](#)
- [United States Interagency Council on Homelessness. Alaska Homelessness Statistics](#)
- [National Alliance to End Homelessness, Housing First](#)

## ECONOMIC AND SOCIAL WELL-BEING

### INDICATOR 9: Percentage of Alaskans who experience a disability that are employed

#### Story Behind the Baseline

The employment disparity between working-age Alaskans who experience disabilities, and the general population, continues to be wide. In 2019, approximately 44% of Alaskans with disabilities, ages 18 to 64, were employed, compared to 74.8% of Alaskans who are not disabled (including those not in the labor force).

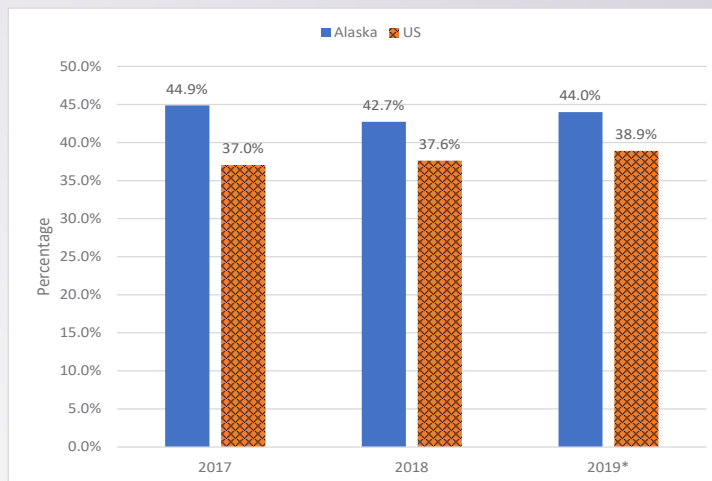
Furthermore, some Alaskans with certain disabilities, such as cognitive disabilities, have an even larger disparity, with only 36% of Alaskans with cognitive disabilities being employed in 2019.

Improving employment outcomes for individuals with disabilities has the potential to reduce reliance

on publicly funded services, as well as increase self-sufficiency. Alaska has diverse forms of employment, including subsistence activities, seasonal employment, and self-employment. Primary barriers to employment include situational (such as lack of transportation or support services needed for employment), risk of benefits loss (Medicaid and Social Security), as well as employer perceptions. A 2018 survey of Alaska human resource professionals showed perceptions that Alaskan employers largely find the idea of employing people with disabilities uncomfortable.

#### What Works?

In 2014, Alaska enacted the Employment First Bill (HB 211) making Alaska an Employment First State. This ensures that the first and preferred outcome for publicly funded services is



**Population: Alaskans and U.S. Residents Who Experience Disabilities (Ages 18 to 64)**

**Data Source:**

- [United States Census Bureau, American Community Survey, Table B18120](#)

**\*Note:**

- Due to the COVID-19 pandemic, 2020 results from the American Community Survey (ACS) were not available at the time of publication. Data for this indicator are unchanged from the 2020 scorecard.

integrated employment in the community with competitive wages. In 2018, Alaska repealed the state's sub-minimum wage regulation, only the third state in the nation to do so.

Working alongside people without disabilities, for minimum wage and above, have been important factors to successful, long-term employment outcomes for people with disabilities.

Employment services, including supported employment, provide individuals with assistance to acquire and maintain the skills necessary for employment. Successful long-term employment is strongly influenced by a myriad of situational dynamics, including access to safe and affordable housing and healthcare, appropriate vocational training and support, and financial literacy training, as well as understanding the impact of employment on public benefits, and being aware of applicable employment safety net programs. Many individuals and families are afraid of losing vital benefits, such as Medicaid and Social Security. Educating individuals and families on the interplay of benefits and work is critical to successful employment outcomes. Additionally, transition from school to adulthood is a pivotal time for people with disabilities regarding employment outcomes. Internships, apprenticeships, and Individual Placements and Supports programs are successful strategies for employing people with disabilities.

**Sources:**

- [United States Census Bureau, American Community Survey, Table B18120](#)
- [Annual Disability Statistics Compendium](#)
- [Statedata.info. \(2020\). Population Data from the American Community Survey \(Post 2007\), Any Disability. Alaska, U.S. Total: Percent of Working-Age People Who Are Employed](#)
- [Statedata.info. \(2020\). Population Data from the American Community Survey \(Post 2007\), No Disability. Alaska, U.S. Total: Percent of Working-Age People Who Are Employed](#)
- [Alaskan Employer Perspectives on Hiring Individuals with Disabilities](#)

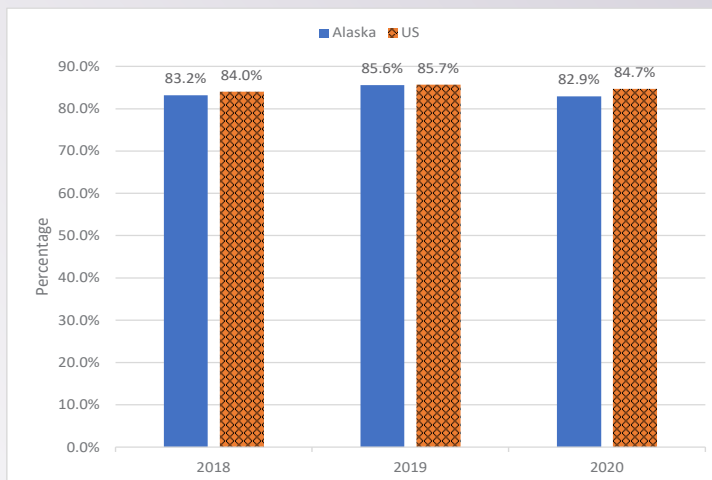
## ECONOMIC AND SOCIAL WELL-BEING

### INDICATOR 10: Percentage of Alaskans living above 125% of the federal poverty level

#### Story Behind the Baseline

Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. Economic stability is a social determinant of health. Economic stability is the connection between one's financial resources - income, cost of living, and socioeconomic status - and their health. This area includes key issues such as poverty, employment, food security, and housing stability. Poverty limits access to basic needs services for beneficiaries: housing, education, healthcare, and mental healthcare. Financial stressors can make mental health care even harder to access, compounding the risk of experiencing a serious mental health crisis.

In 2020, 82.9% of Alaskans lived above 125% of the federal poverty line. However, there is a large difference in rates between Alaskans with disabilities and the general population. This is due in part to the wide disparity in employment and wage between working-age Alaskans with disabilities and the general population. Improving employment and wage outcomes for individuals with disabilities has the potential to reduce reliance on publicly funded services and increase self-sufficiency. The high rates of poverty for Alaskans with disabilities are especially concerning. Lack of resources limits individuals' ability to obtain health insurance, pay for medical care, afford healthy food or safe housing, and access other basic goods and services.




**Population: Alaska and U.S.**

**Data Source:**

- [United States Census Bureau, Current Population Survey, Annual Social and Economic Supplement Microdata](#)

**Notes:**

- The Department of Health and Human Services acknowledges high cost of living in Alaska and Hawaii with an adjustment called the "poverty guidelines" which are applied to programmatic eligibility criteria. Alaska is 125% of the Federal poverty level and the U.S. is 100%. Alaska and U.S. estimates shown both represent 125% of the U.S. poverty level.



People experiencing disabilities are also more likely to experience material hardships, such as food insecurity, inability to pay rent, mortgage, and utilities, or barriers to access needed medical care, than people without disabilities at the same income levels. Lack of reliable, accessible transportation and difficulty finding affordable accessible housing are examples of some of the challenges they face.

## What Works?

Connecting people to basic needs services, including reducing administrative barriers or hurdles to ensure services are functioning properly, has been shown to reduce poverty. Strategies shown to help include: Social Security Disability Insurance/Supplemental Security Income, healthcare "safety net" programs such as Medicaid, Children's Health Insurance Program, as well as other programs, such as minimum wage requirements, Supplemental Nutrition Assistance Program, and Temporary Assistance for Needy Families. Additionally, job placement and development programs, such as Head Start and those that provide assistance linking people with jobs, aim to reduce poverty by increasing social functioning and self-sufficiency.

Nationwide, more than 65% of the 17.9 million working-age adults with disabilities participate in at least one safety net or income support program. Strategies that have been shown to assist vulnerable subpopulations include affordable child care, care coordination for those in transition, and ABLE accounts (Achieving a Better Life Experience). ABLE accounts help people maintain a safety net without losing benefits. Investing in affordable, accessible housing will enable more people with disabilities to obtain safe and stable housing and live independently. Finally, increasing access to reliable transportation will enable more people with disabilities to explore employment opportunities they may not otherwise seek due to the current lack of transportation options.

Healthy Alaskans 2030, the state's health improvement plan, outlines two strategies related to improving the economic well-being of Alaskans:

1. Improve wages and benefits for the Alaskan workforce so individuals and families have the income needed to meet the costs of daily living.
2. Reduce the number of unemployed and underemployed in households that fall below the poverty level.

**Sources:**

- [U.S. Department of Health and Human Services, Healthy People 2030 Economic Stability](#)
- [Complete Health Indicator Report of Poverty - All Persons At Or Above Poverty Threshold \(HA2020 Leading Health Indicator: 24\)](#)
- [Disability Is a Cause and Consequence of Poverty](#)
- [National Council on Disability: Highlighting Disability / Poverty Connection, NCD Urges Congress to Alter Federal Policies that Disadvantage People with Disabilities](#)





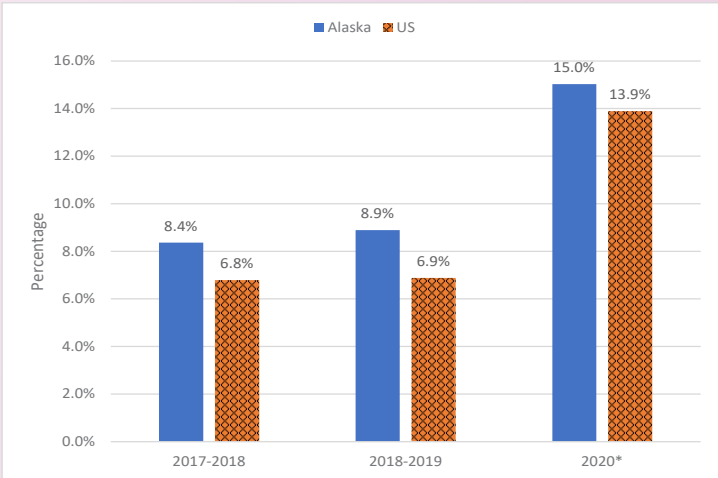
# SUBSTANCE USE DISORDER PREVENTION

## INDICATOR 11: Percentage of Alaskans needing but not receiving treatment at a specialty facility for substance use in the past year (ages 12+)

### Story Behind the Baseline

Historically, Alaska has struggled to deliver a continuum of care that meets the needs of Alaskans struggling with substance use and mental health disorders. A robust continuum of care that delivers services in the right place, and at the right time, is a priority area that will reduce the impact of behavioral health conditions that Alaskans face. Alaskans have, for many years, needed both substance misuse and mental health services above national averages.

Alaska has the 10<sup>th</sup> highest prevalence rate of adult binge drinking in the country. In 2015, Alaska had the third highest rate in the U.S. of alcohol-attributed mortality, and, in 2016, almost half of the Alaska children in foster care or in out-of-home placements came from a home with parental or guardian alcohol misuse.



Population: Alaska and U.S. (Ages 12+)

Data Source:

- [National Survey on Drug Use and Health: Model-Based Prevalence Estimates \(50 States and the District of Columbia\), Table 26](#)

\*Note:

- Substance Use Disorder (SUD) data in 2020 are based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). SUD is defined as meeting the criteria for illicit drug or alcohol use disorder. SUD and related estimates are based on only 2020 data because prior years' SUD data were based on DSM-IV criteria (two year averages). Indicator data for 2020 are not directly comparable to previous scorecards.

## What Works?

Alaskans with substance use disorders and mental health needs should have access to the full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska with an “upstream” approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area. This grant also funded the development of a Statewide Alcohol Prevention Alliance to address underage drinking and adult binge and heavy drinking. Core strategic components include community-based interventions, health equity and mass-reach health communication, promoting Screening, Brief Intervention and Referral to Treatment (SBIRT), surveillance, and evaluation.

A new array of services is available through the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver). The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, and mobile outreach and crisis response services. The 1115 Waiver seeks to increase services for at-risk families to support the healthy development of children and adults through increased outreach, prevention, and early intervention supports.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, will be crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

- [State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program \(SUD-BHP\) 1115 Evaluation Design FY19-FY24](#)
- [Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Alaska, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-20-Baro-19-AK. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020](#)
- [Healthy Alaskans](#)

# SUBSTANCE USE DISORDER PREVENTION

## INDICATOR 12: Percentage of Alaskans who received mental health services in the past year (ages 18+)

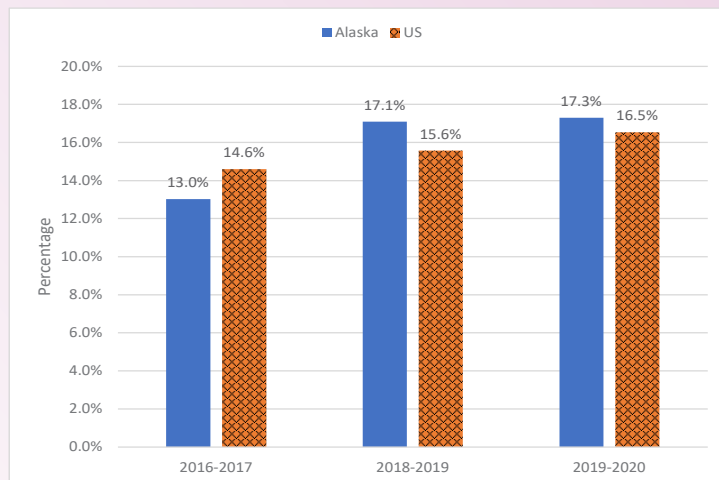
### Story Behind the Baseline

Historically, Alaska has struggled with delivering a continuum of care that meets the mental health needs of Alaskans. A robust continuum of care that delivers services in the right place, and at the right time, is a priority to reduce the impact of behavioral health conditions that Alaskans face.

According to the 2018-2019 National Survey on Drug Use and Health (NSDUH), 21.47% of Alaskan adults reported experiencing a mental illness in the past year. From 2017–2019, among adults 18 and older, the annual average prevalence of past-year mental health service use among those with any mental illness (AMI) in Alaska was 38.9%.

Data from the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS) shows that 11.3% of Alaskans reported frequent mental distress (14 or more days per month of poor mental health) and Alaska’s 2019 suicide rate of 28.7 per 100,000 was almost twice the national rate of 14.5 per 100,000.

In addition to elevated rates for many substance misuse and mental health concerns, Alaskans face special challenges related to geography, population, weather, and size, which



Population: Alaska and U.S. (Ages 18+)

#### Data Source:

- [National Survey on Drug Use and Health: Model-Based Prevalence Estimates \(50 States and the District of Columbia\), Table 29](#)

make it difficult to effectively provide services. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities are medically under-served for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center and individuals travel long distances for services. Urban areas and rural towns have more access to mental health professionals, yet Alaska still struggles with retention and recruitment of behavioral health professionals. Furthermore, significant economic disparities are prevalent in Alaska, and social determinants of health play a large role in behavioral health outcomes.

## What Works?

Alaskans with behavioral health conditions need a full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery. Risk and protective factors (conditions in people's lives that make them more or less likely to use alcohol, tobacco, or illicit drugs, or experience a mental health crisis), play an important role in successful prevention strategies. Successful prevention decreases risk factors and enhances protective factors. Using a shared risk and protective factor approach can be an effective prevention strategy and allows prevention efforts to have a greater reach across multiple areas of concern. Focusing on reducing risk factors while increasing protective factors will have the largest impact on many behavioral health challenges, including substance misuse, depression, violence, and suicide.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both among urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska, with an "upstream" approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area.

A new array of services is available through the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver). The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, and mobile outreach and crisis response services. The 1115 Waiver seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach, prevention, and early intervention supports.

Alaska's current healthcare system needs changes that empower patients and healthcare providers. Alaska's SHARP Program is the statewide support-for-service effort that provides partial financial support to healthcare practitioners in medical, dental, and behavioral health disciplines. It is a public-private partnership working to improve the recruitment, retention, and distribution of health professionals for Alaska.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, will be crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

- [State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program \(SUD-BHP\) 1115 Evaluation Design FY19-FY24](#)
- [Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Alaska, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-20-Baro-19-AK. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.](#)
- [National Survey on Drug Use and Health: Comparison of 2017-2018 and 2018-2019 Population Percentages \(50 States and the District of Columbia\)](#)
- [Alaska's SHARP Program](#)
- [Healthy Alaskans](#)

## SUBSTANCE USE DISORDER PREVENTION

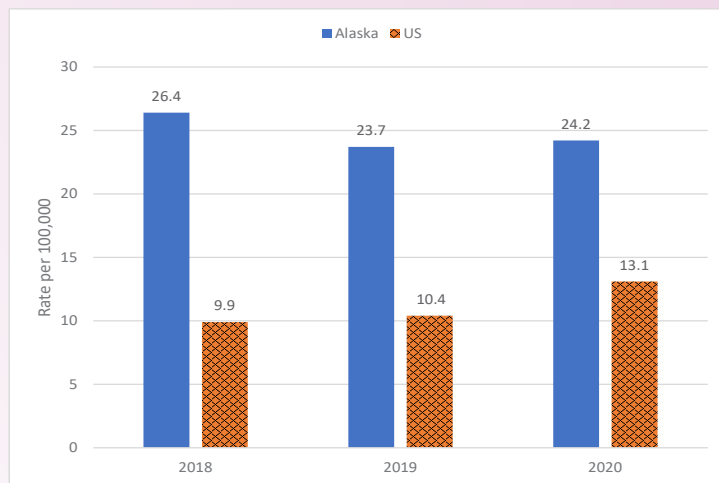
### INDICATOR 13: Rate of alcohol-induced mortality (rate per 100,000; age-adjusted)

#### Story Behind the Baseline

Alcohol misuse and alcohol use disorders negatively impacts the health of the individual, family, and the larger community. According to the 2018 Report on the Economic Costs of Alcohol Misuse in Alaska, the 2018 combined estimated direct costs of substance-use disorders – to state and local governments, employers, and residents of Alaska – totaled \$3.45 billion. Approximately \$2.39 billion (69% of total costs) were due to alcohol misuse.

Alaskans who misuse alcohol are more vulnerable to the progression of an addiction and often experience barriers to accessing treatment. These barriers can include a lack of available treatment options, lack of insurance or funds to pay for services, long waitlists, past criminal convictions, stigma, and lack of access to transportation, housing, and employment. People with co-occurring disorders (a substance use disorder combined with another disorder, such as mental illness or a developmental disability) often experience greater symptom severity that requires specialized interventions which may not be available in their community.

Alcohol use is strongly associated with a wide range of serious long-term health effects, including chronic liver disease and cirrhosis, diseases of the heart, and some cancers. All of these conditions are leading causes of death, both in Alaska and nationwide. Alaska experiences



**Population: Alaska and U.S.**

**Data Sources:**

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Vital Statistics Annual Report](#)
- [Center for Disease Control and Prevention, WONDER Online Database](#)

**Data Source Contact:**

- Rebecca Topol, Chief Health Analytics and Vital Records; Division of Public Health, Department of Health and Social Services  
[Email: rebecca.topol@alaska.gov](mailto:rebecca.topol@alaska.gov)

higher rates of alcohol-attributable mortality than most other states and the U.S. as a whole. In 2015, it was reported that Alaska's alcohol-attributable mortality rate was the third highest in the nation, and alcohol-attributable causes accounted for more deaths during 2010–2016 than methamphetamine and opioid-attributable causes combined. From 2012–2016, the age-adjusted rate of alcohol-induced deaths in Alaska was nearly double the national rate (18.6 per 100,000 persons compared to 9.8 per 100,000 persons).

Services for alcohol misuse in Alaska are funded through a variety of means, including Medicaid reimbursement, private insurance, state-funded grant dollars to community nonprofits, tribal organizations, and local government providers. State-funded Behavioral Health Treatment and Recovery grants pay for withdrawal management, outpatient treatment, and residential treatment services to low-income youth and adults with moderate to severe behavioral health disorders. Behavioral health treatment providers report that resources have not kept pace with the actual costs associated with serving the growing number of Alaskans who need addiction services. Due to ongoing flat-funding and state grant reductions for behavioral health services, providers have been facing an aging infrastructure, inability to recruit and retain treatment professionals, attrition of staff, and an increased demand from a statewide addiction epidemic.

## What Works?

Alaskans who experience substance use disorders need a full continuum of care, from prevention and early intervention to treatment and recovery services, that increase the likelihood of long-term recovery. These services can include, but are not limited to, substance use prevention and early intervention, outpatient treatment, ambulatory withdrawal management, Medication Assisted Treatment (MAT), crisis stabilization, peer support and reentry services, and long-term recovery supports.

Alaska's Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) was approved by the Centers for Medicare and Medicaid Services (CMS) in 2019. Through the 1115 Waiver, a new array of services is available. The 1115 Waiver creates a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. These services include, but are not limited to, residential treatment for substance use disorder, partial hospitalization program services for substance use disorder and behavioral health, adult mental health residential services, and mobile outreach and crisis response services. The 1115 Waiver ensures that Medicaid recipients will have options across the full continuum of care, from early intervention all the way through acute care.

The Alaska Division of Behavior Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive



Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska with an “upstream” approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area. This grant also funded the development of a Statewide Alcohol Prevention Alliance to address underage drinking and adult binge and heavy drinking. Core strategic components include community-based interventions, health equity and mass-reach health communication, promoting Screening, Brief Intervention and Referral to Treatment (SBIRT), surveillance, and evaluation.

Ensuring Alaskans have access to the full continuum of care, from early intervention all the way through acute care and treatment and recovery, is crucial to improving the health outcomes for residents. Moving upstream by increasing prevention and early intervention services will lead to cost savings and improved care for Alaskans.

**Sources:**

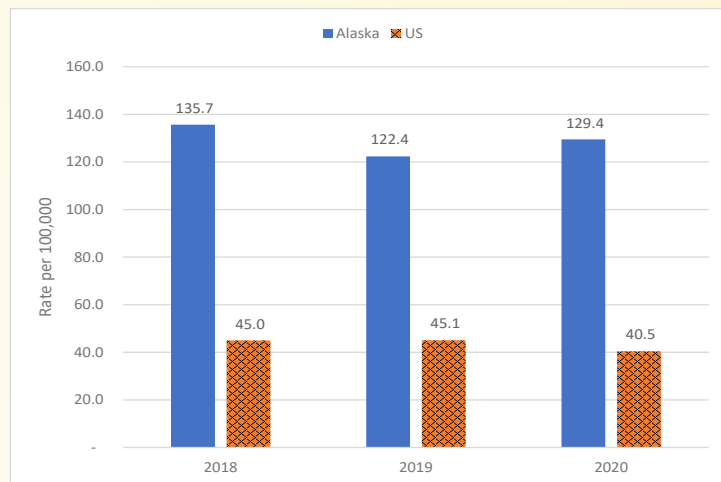
- Alaska Epidemiology Bulletin. “Health Impacts of Alcohol Misuse in Alaska”. Volume 20, No 2, May 7, 2018
- [The Economic Costs of Alcohol Misuse in Alaska Summary](#)
- [The Economic Costs of Alcohol Misuse in Alaska Full Report](#)
- Alaska Trauma Registry, the Alaska Department of Education and Early Development, and the Alaska Birth Defects Registry
- [2019 State of Alaska Epidemiologic Profile on Substance Use, Abuse, and Dependency](#)
- [Alaska Behavioral Health Provider Service Standards & Administrative Procedures For SUD Provider Services](#)

# SUICIDE PREVENTION

## INDICATOR 14: Rate of suicide attempts (rate per 100,000; age-adjusted)

### Story Behind the Baseline

Suicide impacts all Alaskans, no matter their age. Suicide is one of the leading causes of death for young adults, and they are attempting suicide at higher rates than any other age group in Alaska. Every year, many more people think about or attempt suicide than die by suicide. In addition to the number of people who are injured or die, suicide also affects the health of others and the community. When people die by suicide, their family and friends can experience shock, trauma, anger, guilt, and depression. The economic toll of suicide on society is also immense. Suicide and suicide attempts cost the nation almost \$70 billion per year in lifetime medical and work-loss costs alone. While the presence of a mental health condition may



**Population: Alaska and U.S.**

**Data Sources:**

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting](#)
- [Center for Disease Control and Prevention, CDC WISQARS](#)

**\*Note:**

- Alaska data previously based on Syndromic Surveillance emergency department self-harm data. Indicator is now based on Health Facility Data Reporting outpatient emergency department discharge self-harm data for consistency with U.S. reporting standards.

contribute to increased suicide risk, it is important to note that the majority of people who live with mental health conditions will not die by suicide. Research tells us that nine out of ten people who attempt suicide and survive will not go on to die by suicide at a later date.

Many people are impacted by knowing someone who dies by suicide or who experiences suicidal thoughts. Several life factors can increase the risk for suicide, while some life factors protect against it. For example, suicide risk is higher among people who have experienced violence, including child abuse, bullying, or sexual violence. Childhood trauma and historical trauma, often referred to as Adverse Childhood Experiences (ACEs), puts certain individuals at a higher risk of suicide. Protective factors, like family and community support or “connectedness,” and easy access to healthcare can decrease the risk for suicidal thoughts and behavior.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Barometer: Alaska, Volume 6, the annual average percentage of serious thoughts of suicide among young adults, ages 18 to 25 in Alaska, in the past year increased between 2008–2010 and 2017–2019 from 5.9% to 17.4%. During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Alaska was 17.4% (or 12,000), higher than both the regional average (13.4%) and the national average (11.1%). In Alaska, emergency department data shows that individuals who die by suicide most commonly use a firearm. This data also shows that while women are attempting suicide at a higher rate, men die by suicide at a much higher rate than women. Additionally, women are attempting suicide at a higher rate and at different times during the year than their male counterparts.

## What Works?

Suicide has no single determining cause and it cannot be prevented by any single strategy. Instead, suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time. The social-ecological model is a useful framework for viewing and understanding suicide risk and protective factors across four levels of focus: individual, relationship, community, and societal. The relevance of each risk factor can vary by age, race, gender, sexual orientation, residential geography, and socio-cultural and economic status.

Utilizing data can help support upstream prevention and intervention strategies targeted toward vulnerable populations identified through evaluating suicide attempt data. Evidence-based interventions should be chosen to specifically address the unique needs of Alaskans, taking into account homelessness, geographical barriers to accessing healthcare services, stigma, and cultural differences. It is important to have a comprehensive suicide prevention system that addresses not only risk factors representative of those who have died by suicide

but also, those who are attempting or struggling with ideation. Early detection and adequate treatment are key to reducing suicide risk. Staying connected to others and taking care of overall health are all ways to support mental health.

Improving and maintaining access to behavioral healthcare services and resources, including the Alaska Careline (877-266-HELP), the National Suicide Prevention Hotline (998), community-based crisis interventions (e.g., 1115 Waiver, Crisis Now model), and universal screening are critical components of infrastructure for community intervention. Implementation of the Zero Suicide Framework, which identifies key components of safe care for individuals with suicidal thoughts and urges, will be an important commitment for patient safety. Mobile crisis units are active in Anchorage, Fairbanks, and Juneau, and the Restore Hope in Linkage to Care Collaboration grant is working to connect individuals to services and treatments.

Both upstream and primary prevention efforts are needed to reduce suicide in Alaska and should have a strong focus on adolescents, young adults, seniors/elders, and American Indian/Alaska Native people. Strong state leadership, dedicated program efforts, collaboration, and long-term sustainable resources are needed to address suicide in Alaska and the “web of causality” that impacts the health and well-being of Alaskans.

**Sources:**

- [CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)
- [CDC Violence Prevention: Preventing Suicide](#)
- [American Foundation for Suicide Prevention](#)
- [Statewide Suicide Prevention Council](#)
- [Healthy Alaskans](#)

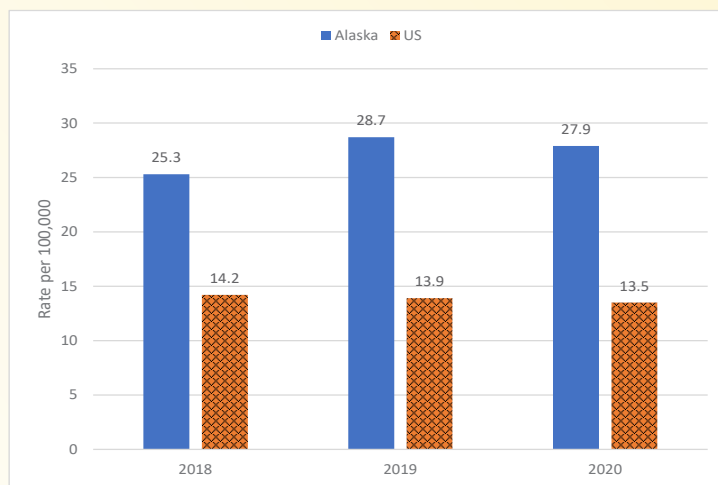
# SUICIDE PREVENTION

## INDICATOR 15: Rate of suicide (rate per 100,000; age adjusted)

### Story Behind the Baseline

Suicide is preventable. According to the American Foundation for Suicide Prevention, there is no single cause for suicide. Suicide most often occurs when stressors and health issues converge to create an experience of hopelessness and despair. Depression is the most common condition associated with suicide, and it is often undiagnosed or untreated. Conditions like depression, anxiety, and substance use problems, especially when unaddressed, increase risk for suicide, yet it's important to note that most people who actively manage their mental health conditions go on to engage in life. Efforts to reduce suicide focus on mending the support system through the entire continuum of wellness promotion, suicide prevention, crisis intervention, and postvention programs.

If every Alaskan learned about suicide and the risks and protective factors involved, they would be better prepared to prevent suicide in families and communities.



**Population: Alaska and U.S.**

**Data Sources:**

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Vital Statistics Annual Report](#)
- [Center for Disease Control and Prevention, CDC Wonder Data](#)

**Data Source Contact:**

- Rebecca Topol, Chief Health Analytics and Vital Records; Division of Public Health, Department of Health and Social Services [Email: rebecca.topol@alaska.gov](mailto:rebecca.topol@alaska.gov)

## What Works?

Providers of healthcare services to Alaskans should prioritize screening and early identification of warning signs and risk factors for suicide. Evidence-based interventions should be chosen to specifically address the special needs of Alaskans – including homelessness, geographical barriers to accessing healthcare services, stigma, and cultural differences. Use of telemedicine should be encouraged and reimbursed so that Alaskans in rural communities have better access to mental health and substance use disorder treatment services. Restriction of lethal means and effective postvention supports are also key to reducing suicide.

Improving and maintaining access to behavioral healthcare services and resources including the Alaska Careline, community-based crisis interventions (e.g., 1115 Waiver, Crisis Now model), and universal screening is critical infrastructure for community intervention. Additionally, implementation of the Zero Suicide Framework, which identifies key components of safe care for individuals with suicidal thoughts and urges, will be an important commitment for patient safety.

### Sources:

- [CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)
- [CDC Violence Prevention: Preventing Suicide](#)
- [American Foundation for Suicide Prevention](#)
- [Statewide Suicide Prevention Council](#)
- [CDC Division of Violence Prevention the Relationship Between Bullying and Suicide: What We Know and What it Means for Schools](#)
- [Healthy Alaskans](#)



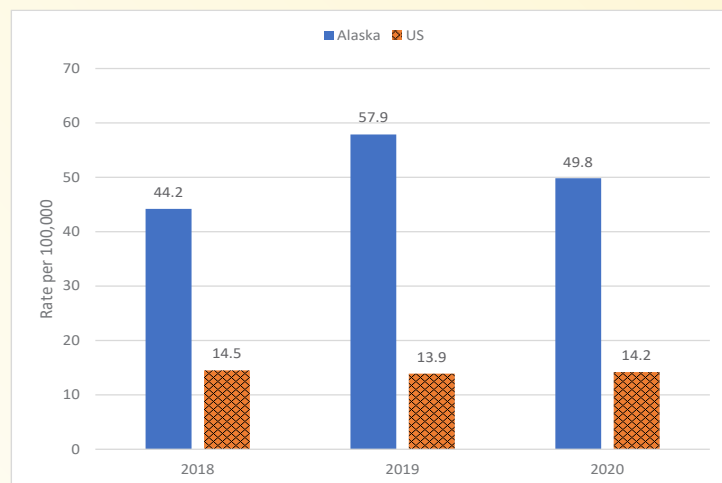
# SUICIDE PREVENTION

## INDICATOR 16: Rate of suicide (rate per 100,000; ages 15 to 24)

### Story Behind the Baseline

Childhood trauma and historical trauma, often referred to as Adverse Childhood Experiences (ACEs), puts certain individuals at a higher risk of suicide. According to SR Dube's 2001 study published in the *Journal of the American Medical Association*, 80% of attempted suicides among adolescents were directly tied to an ACE. Suicide is preventable. While each suicide or attempted suicide can be as unique as the person who experiences it, there are ways to address the “web of causality” for suicide, including the multiple social, emotional, environmental, and health factors involved.

Results from the 2019 Youth Behavioral Risk Factor Survey (YBRS) show the percentage of adolescents feeling sad and hopeless is on the rise (1 out of 3). The percentage of students attempting suicide during the past year nearly doubled, from 10.7% in 2007 to 19.7% in 2019. In fact, this measure increased significantly even from 2017 (12.1%). In 2019, suicide was the leading cause of death for youth and young adults, ages 15 to 24 in Alaska, increasing to 57.9 per 100,000. Alaska Natives and



**Population: Alaska and U.S. (Ages 15 to 24)**

#### Data Sources:

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Vital Statistics Annual Report](#)
- [Center for Disease Control and Prevention, CDC Wonder Data](#)

#### Data Source Contact:

- Rebecca Topol, Chief Health Analytics and Vital Records; Division of Public Health, Department of Health and Social Services [Email: rebecca.topol@alaska.gov](mailto:rebecca.topol@alaska.gov)

American Indians (AN/AI) continue to be one of the most at-risk populations (with a rate of 145.5 per 100,000 amongst ages 15 to 24), more than double the rate of all Alaskans.

## What Works?

Programs, services, and opportunities in schools help increase protective factors impacting adolescent depression and suicide. These protective factors include supportive adults and connections, student activities that promote feeling valued, social-emotional competence and self-regulation skills, attending a school with a positive climate, participating in quality after-school activities and structured meaningful activities, a sense of cultural identity and connection, and regular physical activity.

Statewide education on how to talk about and recognize the signs of suicide enables all Alaskans to work together to prevent and mitigate risk factors contributing to suicide. Risk factors include ACEs, easy access to firearms, use of substances (alcohol and/or other drugs), prior suicide attempts, exposure to violence, and excessive screen time and/or social media usage.

Funding provided through the Statewide Suicide Prevention Councils for the Suicide Awareness, Prevention & Postvention (SAPP) program to the Alaska Department of Education and Early Development (DEED) supports online trainings for Alaskan educators and direct grants to school districts that help implement suicide prevention programming throughout the state.

The Division of Behavioral Health, Prevention & Early Intervention provides grant funding throughout the state, serving both urban and rural service areas. The Comprehensive Behavioral Health Prevention and Early Intervention (CBHPEI) grant focuses on population-based strategies, the prevention of substance misuse and suicide, and the promotion of comprehensive wellness across Alaska, with an “upstream” approach. Prevention efforts are community driven and coalition led, with stakeholders representing the diversity of the community or service area.

DEED also provides statewide support by having staff that can respond to district requests for support during a crisis (for example: mental health, suicide prevention, crisis counseling support, and technical assistance). While DEED offers a collection of professional development resources to all districts, by far the largest and most popular are the online suicide prevention courses created since fiscal year 2016 (FY16) with SAPP funding. To date, 18,000 Alaskans have received these lifesaving trainings.



Improving and maintaining access to behavioral healthcare services and resources, including the Alaska Careline, community-based crisis interventions (e.g., 1115 Waiver, Crisis Now model), and universal screening is critical infrastructure for community intervention. Additionally, implementation of the Zero Suicide Framework, which identifies key components of safe care for individuals with suicidal thoughts and urges, will be an important commitment for patient safety.

**Sources:**

- [State of Alaska Epidemiology Adolescent Suicide Death, AKVDRS Update- Alaska 2016-2019](#)
- [CDC Division of Violence Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)
- [CDC Violence Prevention: Preventing Suicide](#)
- [American Foundation for Suicide Prevention](#)
- [Statewide Suicide Prevention Council](#)
- [CDC Division of Violence Prevention the Relationship Between Bullying and Suicide: What We Know and What it Means for Schools](#)
- [Healthy Alaskans](#)
- [Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide: Findings From the Adverse Childhood Experiences Study](#)

# PROTECTING VULNERABLE ALASKANS

## INDICATOR 17: Rate of child maltreatment, substantiated cases, unique victims (rate per 1,000; ages 0 to 17)

### Story Behind the Baseline

When children lack safe, supportive family and community environments, they are at risk of impaired development and long-term health problems. According to the data from the National Child Abuse and Neglect Data System (NCANDS), which collects and analyzes data submitted voluntarily by states, Alaska’s 2020 rate of child maltreatment was the 2nd highest in the nation (behind Maine), at 18.0 children per 1,000. Caution should be used in interpreting this figure of substantiated (proven) cases of child maltreatment. Although the differences among state rates may reflect actual abuse or neglect, this data can also be impacted by state-to-state variation in statutory jurisdiction, agency screening processes and definitions, and the ability of states to receive, respond to, and document investigations.

The term “Adverse Childhood Experiences” (ACEs) refers to categories of childhood trauma,



Population: Alaska and U.S. (Ages 0 to 17)

#### Data Source:

- [U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment](#)

such as abuse (physical, sexual, and emotional) and household dysfunction including divorce, witnessing domestic violence or living with someone who went to jail or prison, or had substance misuse or mental health problems. These experiences are major risk factors for the leading causes of illness and death, as well as poor quality of life in the U.S. The number of exposures to these traumas in childhood, known as an “ACEs score,” is highly correlated with poor health, social, and economic outcomes in adulthood.

Vulnerable Alaskans, both children and adults, need both supportive and protective services. State and local public awareness campaigns, training programs, and multi-disciplinary teams are essential when providing these supportive services. In addition to improving the systems for responding to children and adults experiencing or at risk of abuse or neglect, it is vital that we focus on preventing such individuals from ever entering the system by supporting healthy, resilient families, and healing intergenerational trauma. Concerns for the safety of Alaska’s children and vulnerable adults are reported by neighbors, teachers, nurses, treatment providers, and others to the Office of Children’s Services (OCS) and Adult Protective Services (APS).

## What Works?

Increased access to preventive care is an ongoing and a key strategy to preventing abuse, neglect, self-neglect, and exploitation. The Department of Health and Social Services (DHSS) is streamlining and diversifying the types of behavioral health services available under the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver).

The Strengthening Families Protective Factors Framework (SFPFF) is a strength-based, research-informed approach to helping families prevent child abuse and neglect. SFPFF is particularly well-suited for Alaska because of its adaptability across cultures. It is embraced by numerous nonprofit and tribal social service organizations throughout the state, helping to shape a shared understanding that children and families are most likely to be safe and healthy when key protective factors are robust in their lives, and when there are trusting, long-term relationships between service providers and families. The five protective factors that are related to the prevention of child maltreatment are:

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need

## 5. Children’s healthy social and emotional development

While OCS has a limited role in directly promoting protective factors, the office refers families to public health partners who offer a more robust continuum of care. OCS continues to encourage these prevention efforts by asking agencies and communities to make their services individualized and strength-based, culturally sensitive/competent, and trauma-informed. A recent initiative, “Circles of Support,” aims to strengthen families and prevent children from being placed out of their homes. Supervised visitation and supervised exchange programs, such as Family First on the Kenai Peninsula, can prevent families from being more deeply involved with OCS. Reducing the use of institutional-based care for children and families with complex mental, emotional, and behavioral needs can also be mitigated through methods like the "wraparound" approach, which focuses on strength-based, individualized care.

### Sources:

- [U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau. Child Maltreatment](#)
- [Centers for Disease Control and Prevention, Violence Prevention, Adverse Childhood Experiences](#)
- [Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse. Adverse Childhood Experiences in Alaska](#)
- [Wraparound Milwaukee](#)

## PROTECTING VULNERABLE ALASKANS

### INDICATOR 18: Percentage increase for youth who accessed home-based family treatment services

#### Story Behind the Baseline

Compared to the national average, children in Alaska were 77.4% more likely to be abused in 2020. Alaska also has high rates of repeat child maltreatment, making Alaskan children more likely to encounter the child welfare or juvenile justice system. 1 in every 12 births experience a first substantiated report to the Alaska Office of Children's Services (OCS) before age seven.

For those children at risk of coming into the child welfare system, there have been very limited community prevention and early intervention services, which are managed separately from the treatment system. Children and adolescents in the child welfare system are often cared for in Residential Psychiatric Treatment Centers (RPTCs), or inpatient hospital services, sometimes in combination with support services. There are a growing number of children (whether in parental or state custody) being placed in out-of-state or out-of-region facilities, making family reunification efforts challenging. Furthermore, there are very few step-up/step-down services available within the child's own home or community, which are designed to prevent repeated maltreatment.

Specific to this indicator and the Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver), home-based family treatment (HBFT) is designed to be a community-based early intervention service. These interventions include treatment and wraparound services that are provided in the home to reduce the need for inpatient hospitalization and residential services for children and adolescents. Services include family therapy, individual therapy, crisis intervention, medication services, parenting education, conflict resolution, anger management, and ongoing monitoring for safety and stability in the home.


**This service array started in 2021.  
There will be no data until 2023.**

#### Data Source:

- This home-based family treatment service array, levels 1-3, started in 2021. Data will be available in 2023. For more information on data availability, please contact the data source contact listed below.

#### Data Source Contact:

- Michael Walker, Chief of Risk & Management  
Division of Behavioral Health, Systems & Policy Section,  
Department of Health and Social Services  
[Email: michael.walker@alaska.gov](mailto:michael.walker@alaska.gov)



Alaska's unique geography, diverse population, lack of infrastructure, struggling economy, and limited healthcare resources make it challenging to provide a person-centered and culturally-responsive system.

## What Works?

The goal of the 1115 Waiver is to create a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The 1115 Waiver also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach and prevention, and early intervention supports.

The federal Family First Prevention and Services Act (FFPSA) made substantial changes to federal child welfare financing and is focused on investing in prevention and prioritizing family-based placement. The act rolls out an open-ended entitlement for reimbursement of eligible state expenditures on evidence-based programs and services for children that are at imminent risk of entering the foster care system. It also allows federal reimbursement for evidenced-based programs for in-home parent, skill-based programs that include parenting skills training, parent education, and individual and family counseling, among other services.

Behavioral health challenges often stem from childhood trauma and other adverse experiences and have downstream effects on entire families that translate to higher costs associated with subsequent acute care and chronic health needs. The 1115 Waiver and the FFPSA promote timely access to a more robust continuum of services, which is key to supporting children who need behavioral health services (or children whose family members need services) in their homes with the goal of preventing out-of-home placement whenever possible. These additional services will provide an important vehicle for strengthening the support system for these young people in hopes of anticipating and preventing crises and reducing the need for out-of-home placements over time.

### Sources:

- [State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Substance Use Disorder and Behavioral Health Program \(SUD-BHP\) 1115 Evaluation Design FY19-FY24](#)
- [Alaska's 1115 Behavioral Health Medicaid Waiver](#)
- [Parrish, J.W., Shanahan, M.E., Schnitzer, P.G. et al. Quantifying Sources of Bias in Longitudinal Data Linkage Studies of Child Abuse and Neglect: Measuring Impact of Outcome Specification, Linkage Error, and Partial Cohort Follow-Up. \*Inj. Epidemiol.\* 4, 23 \(2017\)](#)
- [Alaska Behavioral Health Provider Standards and Administrative Manual for Behavioral Health Provider Services](#)

## PROTECTING VULNERABLE ALASKANS

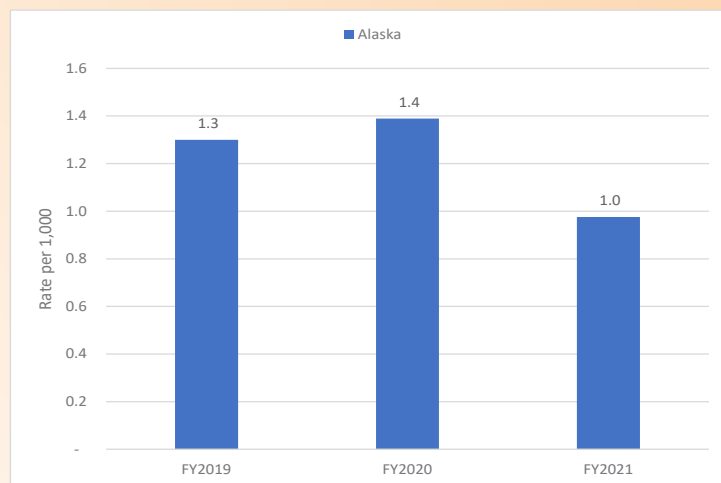
### INDICATOR 19: Founded reports of harm to adults (rate per 1,000; ages 18+)

#### Story Behind the Baseline

Protective services are intended to prevent or alleviate harm resulting from undue influence, abandonment, exploitation, neglect and self-neglect, and are provided to a vulnerable adult or child who needs protection.

Approximately 1 in 10 Americans ages 60 and older have experienced some form of abuse. Some estimates project that as many as 5 million older adults are abused each year. One study estimated that only 1 in 14 cases of abuse are reported to authorities. A study that reviewed news-feed articles collected daily by the National Adult Protective Services Association (NAPSA) through an initiative funded by the National Center on Elder

Abuse found that instances of fraud perpetrated by strangers comprised 51% of news articles related to elder financial abuse, followed by family, friends, and neighbors (34%), the business sector (12%), and Medicare and Medicaid fraud (4%). Nearly 60% of perpetrators were men, mostly between the ages of 30 and 59. The news-feed tracked media reports of all types of elder abuse through Google and Yahoo alerts over a three-month period. Seniors who experienced abuse have a 300% higher risk of death when compared to those who have not been mistreated. While likely underreported, estimates of financial abuse and fraud costs to older Americans range from \$2.9 billion to \$36.5 billion, annually; yet financial exploitation is self-reported at higher rates than emotional, physical, and sexual abuse or neglect.



**Population: Alaska Statewide (Ages 18+)**

**Data Source:**

- [Division of Senior and Disability Services, Department of Health and Social Services](#)

**Data Source Contact:**

- Jake Bozzini, Research Analyst  
Division of Senior and Disability Services, Department of Health and Social Services  
[Email: jake.bozzini@alaska.gov](mailto:jake.bozzini@alaska.gov)



Social isolation and cognitive impairment, such as dementia or Alzheimer’s disease, are two factors that increase the risk of someone experiencing abuse. Recent studies show that nearly half of those with dementia experienced abuse or neglect. Interpersonal violence also occurs at disproportionately higher rates among adults with disabilities.

Adult Protective Services (APS) and the Long Term Care Ombudsman (LTCO) are two agencies that work together to protect Alaska’s vulnerable populations. APS helps to prevent or stop harm occurring against vulnerable adults and takes reports of harm through a centralized reporting system. In addition to investigation of reports, APS makes recommendations for protective placement, guardianship/conservatorship counseling or mediation, links to community resources, and training and designation of local community resources to provide services.

## What Works?

Social support has been acknowledged as a potentially beneficial intervention. Efforts to enhance social supports of vulnerable adults have the dual benefit of building mental health resilience in response to extreme stressors and lowering the risk of interpersonal violence against the older adult members of our society. One example of a social support intervention is a community-based elder abuse intervention program called “Eliciting Change in At-Risk Elders.” The program assists suspected victims of elder abuse and self-neglect through a partnership with local law enforcement. This program involves building alliances with the elder and family members, connecting the elder to supportive services that reduce risk of further abuse, and utilizing motivational interview-style skills to help elders overcome ambivalence regarding making difficult life changes.

Given the complex nature of abuse, inter-professional teams, also referred to as "multidisciplinary teams", have been identified as a possibly successful intervention since no single discipline or sector alone has the resources or expertise needed to address the issue. These teams consist of physicians who are social workers, law enforcement personnel, attorneys, and other community participants who are working together in a coordinated fashion. Education about vulnerable adult abuse is another important way to intervene at the community level. Altering attitudes towards abuse may impact a person’s behavior toward vulnerable Alaskans.

Interventions continue to evolve with regard to reporting and data collection of abuse incidents. APS systems play a critical role in addressing the abuse, neglect, self-neglect, and financial exploitation of adults. Historically, there has been no federal “home” for APS, nor a designated federal appropriation for this critically important service. Instead, states and local agencies have developed a wide variety of APS practices resulting in significant variations



between, and sometimes within, states. In an effort to support APS agencies and enhance response, the Administration on Community Living (ACL) has been developing guidelines intended to assist states in developing efficient and effective APS systems.

The LTCO office protects the rights, safety, and welfare of individuals residing in assisted living and nursing homes across the state. The LTCO trains community volunteers to visit nursing facilities and assisted living homes. While visiting, they monitor the residents' conditions in the homes, listen to them, work with the home to resolve problems, and alert LTCO staff when they cannot resolve problems or when residents are at risk of harm.

**Sources:**

- [Alaska Adult Protective Services](#)
- [The Office of the Long Term Care Ombudsman](#)

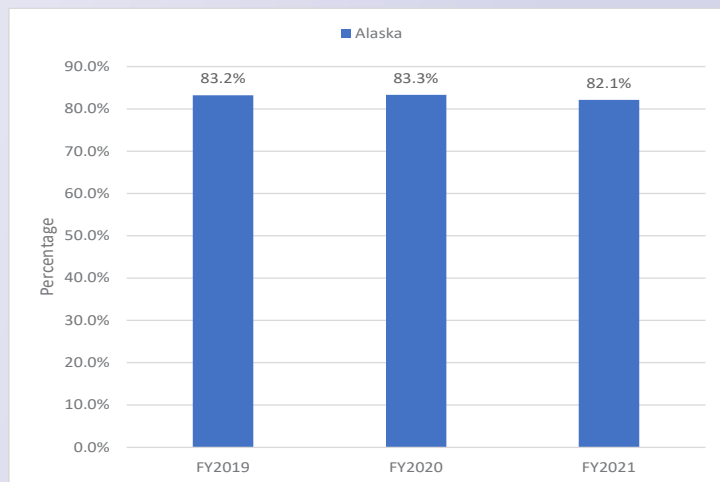
# SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

## INDICATOR 20: Percentage of Alaskans who meet criteria for an institutional level of care who were served by a home and community-based waiver

### Story Behind the Baseline

Least restrictive practices in home communities are paramount for Trust beneficiaries to be able to live meaningfully as contributing members of such communities. Receiving local services preserves existing natural supports and allows for the development of additional supports, making it the desired first choice. Long-term services and supports offer a wide range of services to help people with disabilities who need support to live more independently by assisting with personal and healthcare needs and activities of daily living, such as eating, bathing, grooming, and other related activities.

Medicaid home and community-based waivers (HCBW) allow Alaskans with disabilities to avoid institutional care, such as nursing homes, by contracting



**Population: Alaska Statewide**

**Data Source:**

- Medicaid Management Information System via COGNOS

**Data Source Contacts:**

- Anastasiya Podunovich, Research Analyst IV  
Division of Senior and Disability Services, Department of Health and Social Services  
[Email: anastasiya.podunovich@alaska.gov](mailto:anastasiya.podunovich@alaska.gov)
- Lynne Keilman-Cruz, Health Program Manager IV  
Division of Senior and Disability Services, Department of Health and Social Services  
[Email: lynne.keilman-cruz@alaska.gov](mailto:lynne.keilman-cruz@alaska.gov)

with HCBW provider agencies. The Division of Senior and Disabilities Services (DSDS) reported on the FY21 Continuum of Care report: individuals who receive HCBW and Intellectual & Developmental Disabilities (IDD) waiver services cost an average of \$87,092 per person receiving services. By comparison, if these individuals with an intellectual disability were in an intermediate care facility, at the average cost of \$185,247 per person annually, it would cost \$98,155 more per year for each individual. If these individuals were in a nursing home, at the average cost of \$147,815 per person annually, it would cost \$60,723 more per year for per each individual. Currently, the costs of home and community-based services (HCBS) are much lower because they can serve more people with the same amount of money, ensuring sustainability of services. Services provided in a least restrictive environment ultimately leads to more meaningful lives for beneficiaries, as well as cost efficiencies for state government.

## What Works?

Increased access to enhanced and timely treatment options within a robust continuum of care is necessary. To increase statewide service access and capacity, more providers, including care coordinators, service providers (such as direct service professionals), and rural providers of all types, would help reduce waitlists for services that have already been approved. Furthermore, additional providers and resources are necessary to review eligibility for individuals on an intellectual and developmental disabilities waitlist.

Ensuring that person-centered planning is taking place allows individuals to choose where they would like their care delivered, so they may remain in their home community and maintain as much independence as possible. Supporting a beneficiary's caregivers, family, and/or friends with services such as transportation, respite, and chore services utilization allows the beneficiary and their support people to remain in their home communities.

### Source:

- [State of Alaska Home and Community-Based Waiver Programs](#)

## SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

### INDICATOR 21: Percentage of criminal defendant referrals admitted to a therapeutic court

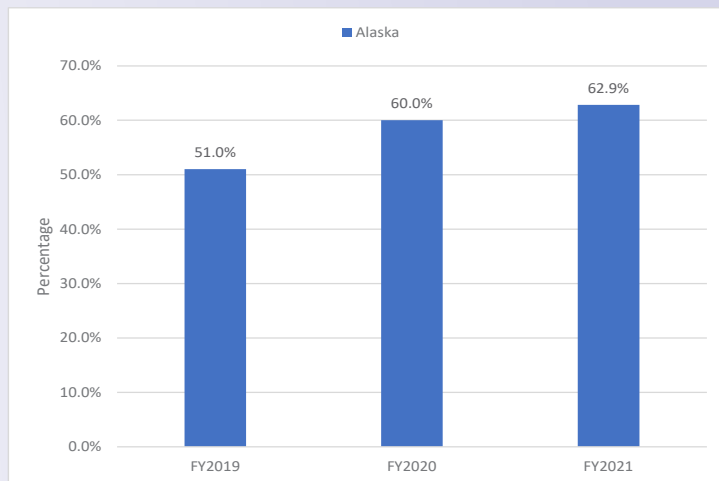
#### Story Behind the Baseline

Therapeutic courts in Alaska support participants' abstinence from drugs and alcohol and promote self-sufficiency while beneficiaries remain in the community and rebuild their lives. Mental health courts are specialized therapeutic courts that employ a problem-solving approach to criminal case processing for eligible beneficiaries with the goal of reducing the high numbers of beneficiaries in Alaska's criminal justice system.

Therapeutic courts have been working since 1998 to reduce recidivism and provide ready access to treatment for offenders with substance use and mental health disorders. Their mission

is to have a positive impact on the community by increasing public safety and reducing the cost associated with rearrest, criminal case processing, confinement, and jail overcrowding. On an individual level, therapeutic courts aim to break the cycle of criminality of people who experience drug and alcohol addiction and enhance their long-term reintegration into the community.

All therapeutic courts carry out a self-evaluation every year to measure their performance against goals and objectives aligned with national best practice standards. Additionally, court teams and stakeholders meet regularly to discuss issues that are barriers to meeting these goals.



**Population: Alaska Statewide**

**Data Source:**

- [Alaska's Automated Information Management System \(AKAIMS\)- Therapeutic Court Module](#)

**Data Source Contacts:**

- Michelle Bartley, Therapeutic Courts Program Administrator  
Alaska Court System  
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- Claire Waddoup, Administrative Program Manager  
Alaska Court System  
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Prior to fiscal year 2020 (FY20), therapeutic courts revised eligibility criteria so that referral numbers could be maintained despite the criminal justice reforms contained in Senate Bill 91 (SB 91) – a lower legal exposure meant fewer people were interested in an intensive 12 to 18-month program. The repeal of SB 91 came into effect at the beginning of FY20 and this, combined with the previous push for referrals, led to a higher percentage of people being admitted into therapeutic courts in FY20 despite complications caused by the COVID-19 pandemic.

Much of FY20 has been impacted by COVID-19. As the pandemic intensified, therapeutic courts made a concerted effort to keep up the number of referrals and, via social media and virtual meeting platforms, keep participants engaged in treatment to ensure continued program progress. This also meant developing a mobile drug and alcohol testing system that would keep participants on track while minimizing travel and public contact.

## What Works?

Therapeutic court participants require robust and readily available behavioral health services. The therapeutic court administration has developed contractual relationships with local substance use disorder treatment providers to support immediate access; however, contractual relationships for mental health services are still being developed and beneficiaries do not always have immediate access to mental health services.

Access to the behavioral health continuum of care in Alaska continues to be problematic due to a workforce shortage to meet the needs of beneficiaries. The Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) will increase access by supporting local community mental health providers to increase capacity and coordination through the use of the Administrative Services Organization.

### Sources:

- [Alaska Therapeutic Courts](#)
- [Therapeutic Courts in the Alaska Court System](#)

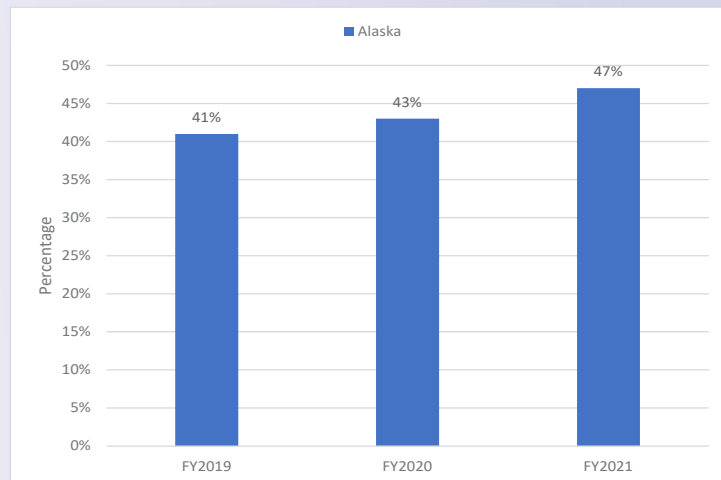
## SERVICES IN THE LEAST RESTRICTIVE ENVIRONMENT

### INDICATOR 22: Percentage of all juvenile justice referrals that were diverted from formal court action

#### Story Behind the Baseline

Research has demonstrated that introducing low-risk youth into formal interventions with the juvenile justice system can unintentionally increase the likelihood of continued delinquent behavior due to the exposure to higher-risk youth; therefore, it is important that youth are diverted from the formal juvenile justice system and are provided less restrictive interventions when appropriate. It is also important that appropriate behavioral and neurobehavioral interventions are provided to youth and families as a part of the diversion process.

For a number of years, the Division of Juvenile Justice (DJJ) has consistently diverted anywhere between 30% to 35% of all cases referred from law enforcement. Probation officers receiving these referrals have the discretion to work with youth, parents, victims, and communities to identify appropriate alternative sanctions other than formal court intervention, detention, and/or institutional treatment. Probation officers can recommend community work service, restitution, letters of apology, victim/offender mediation, behavioral health assessments, and other informal interventions to both hold youth accountable for their actions and provide interventions to



**Population: Alaska Statewide**

**Data Source:**

- Division of Juvenile Justice, Department of Health and Social Services

**Data Source Contacts:**

- Tracy Dompeling, Director  
Division of Juvenile Justice, Department of Health and Social Services  
[Email: tracy.dompeling@alaska.gov](mailto:tracy.dompeling@alaska.gov)
- Sandra DeHart-Mayor, Data Processing Manager  
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increase competency development. The DJJ also uses more formal mechanisms for diversion such as informal probation, youth courts, tribal diversion, and other structured interventions available in communities throughout Alaska. The DJJ continues to utilize such interventions to appropriately divert youth from formal court intervention.

Secure juvenile facilities in Alaska are often a default system for ensuring behavioral and neurobehavioral interventions are provided to youth Trust beneficiaries. A correctional setting is not the best environment for youth to receive these services. To ensure adequate services are available and provided in a less restrictive manner, the cooperation of community providers is essential.

## What Works?

According to the Annie E. Casey Foundation, the most recent data collected from the Office of Juvenile Justice Delinquency and Prevention shows that 41% of juveniles involved with the juvenile justice system nationwide were diverted. The purposes of diversion programs are numerous and include cost-savings, reductions in recidivism and re-offending, avoidance of labeling, least-restrictive intervention, an increase in outcomes for youth, and an attempt to reduce disproportionality. Studies have shown that low-risk youth are 45% less likely to re-offend when diverted from formal court; this also accounts for a reduction in recidivism rates. The cost-savings to the community, DJJ, victims, and the youths' families are sizable.

A 2014 study by the McDowell group, specific to the Youth Court Division programs of Alaska, reported that: "Excluding the benefit to the State of Alaska and to individuals who move away from Anchorage, the quantifiable average annual benefit to the Anchorage community alone from youth court operations is \$198,800 in savings in the cost of crime plus \$80,450 in the value of adult and youth volunteer time and defendant community-service time, for a total annual benefit of \$279,250." Tribal diversion programs also account for cost-savings and better outcomes for youth. In Alaska, there are currently 25 tribes participating in the tribal diversion programs.

### Sources:

- Alaska Department of Health and Social Services – Division of Juvenile Justice System Change Summary; January 2021
- Council of Juvenile Correctional Administrators Community-Based Mental Health Services; August 2017
- Alaska Department of Health and Social Services- Division of Juvenile Justice System Improvement Summary For 2015 State of Alaska Crime Summit; February 2015

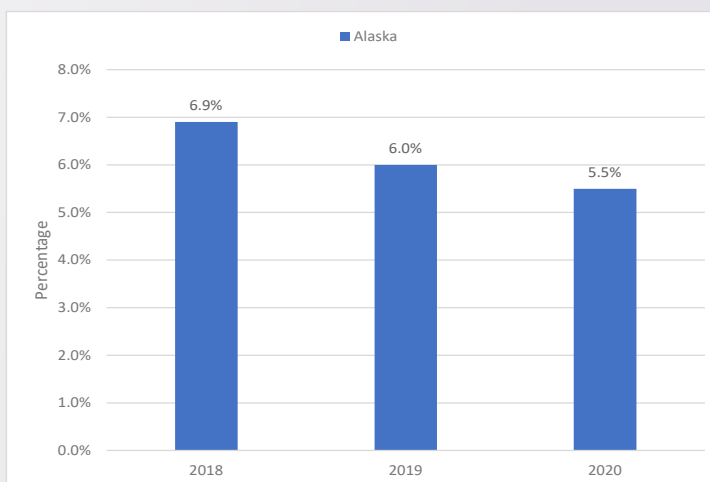
# SERVICES IN INSTITUTIONAL ENVIRONMENTS

## INDICATOR 23: Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 12 to 17)

### Story Behind the Baseline

Alaska youth with complex backgrounds, including childhood and historical trauma, can experience escalated behaviors and, as a result, are led to seek services in a psychiatric setting, sometimes out of state. At times, these psychiatric settings are not the most appropriate or do not have the capacity to serve them. Unfortunately, youth often transition from one state system to another, are placed in different homes and schools, and lack consistent providers.

It is common for youth sent to out-of-state psychiatric treatment centers to present with the following risk factors: family history of substance misuse and mental illness, multiple traumas, one or more comorbidities, education as a psychosocial risk factor, a school suspension, or an individualized education plan (IEP).



#### Population: Alaska Readmissions Statewide (Ages 12 to 17)

#### Data Source:

- Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting (HFDR) Program

#### Data Source Contact:

- Tim Homan, Research Analyst  
Section of Health Analytics and Vital Records  
Department of Health and Social Services  
Email: [tim.homan@alaska.gov](mailto:tim.homan@alaska.gov)



In Alaska, youth receive acute crisis services from psychiatric institutional settings which include the Alaska Psychiatric Institute (API), the State’s Designated Evaluation and Stabilization or Designated Evaluation and Treatment (DES/DET) facilities, and private hospitals. Furthermore, youth can receive sub-acute services from group homes, therapeutic treatment foster homes, independent living, or a behavioral rehabilitation facility.

Efficient and effective care coordination and discharge planning between the various providers, including state services systems, have historically been problematic. Utilization and capacity for each component of the continuum of care seems to fluctuate based on advocacy, funding, or variables as simple as awareness of available resources. Out-of-home placement may result in a loss of connection with family, culture, and home community. It is important that professionals work to mitigate these consequences as much as possible.

## What Works?

For youth with complex behavioral needs to transition from an institutional setting to the community of their choice in a timely and coordinated manner, a collaborative team of compassionate, trauma-informed professionals focused on effective delivery of person-centered care is considered critical. Specific programming and services that will assist in prevention of admission and readmission include: The Alaska Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver), Crisis Now model, and programs such as the Complex Behavior Collaborative and the Family Services Training Center through the Division of Behavioral Health.

To best serve Alaskan youth with behavioral health needs, enhanced strategies are needed, such as building in-state capacity for lower levels of care and for nonresidential care; expanding care coordination across all levels of care; improving reporting mechanisms to monitor system access; measuring outcomes and service utilization; developing partnerships with communities and in-state providers to organize the resources and assistance needed to serve children experiencing severe disturbances and their families; and implementing strategies to develop and maintain a skilled in-state workforce.

### Sources:

- [Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report, August 2017](#)
- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup – DHSS Office of the Commissioner
- [Out-of-Home Care Conference Powerpoint](#)
- [Alaska's 1115 Behavioral Health Medicaid Waiver](#)
- [Recovery Innovations Crisis Now Consultation Report](#)
- [Bring the Kids Home](#)

## SERVICES IN INSTITUTIONAL ENVIRONMENTS

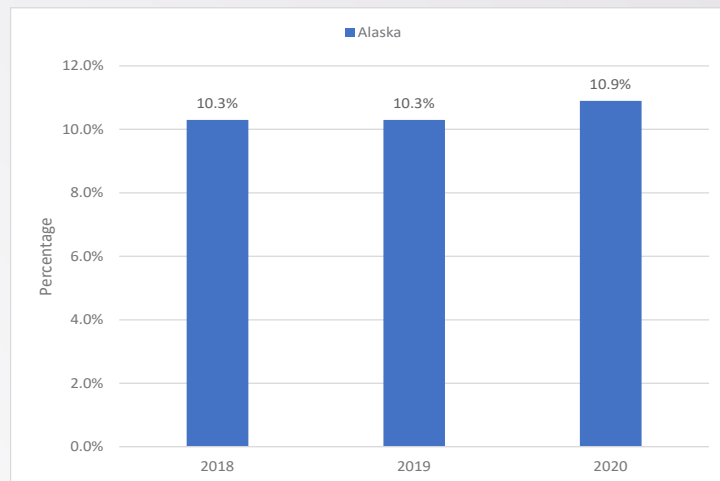
### INDICATOR 24: Percentage of inpatient readmissions within 30 days to non-military hospitals for a behavioral or neurodevelopmental diagnosis (ages 18+)

#### Story Behind the Baseline

Community-based behavioral health services and supports are the best model for preventing behavioral health crises, but most Alaskan communities lack the full continuum of care needed. Due to the lack of community-based behavioral health services, both urban and rural areas rely heavily on law enforcement, emergency responders, and hospital emergency rooms to serve people in crisis. Many patients presenting to emergency departments with behavioral health conditions have an alcohol or drug-related diagnosis, other comorbidities, and/or complex social needs in addition to their medical needs. Law enforcement officers are faced with challenging situations when beneficiaries with behavioral and/or medical

needs are also charged with crimes, often resulting in the Department of Corrections acting as a provider of psychiatric care without the proper supports.

Without strong preventive and treatment services embedded in Alaskan communities, Trust beneficiaries experience high levels of placement within psychiatric institutional settings. In Alaska, these settings include the Alaska Psychiatric Institute (API) and the state's Designated Evaluation and Stabilization or Designated Evaluation and Treatment (DES/DET) facilities.



#### Population: Alaska Readmissions Statewide (Ages 18+)

#### Data Sources:

- [Alaska Division of Public Health, Health Analytics and Vital Records Section, Health Facilities Data Reporting](#)

#### Data Source Contact:

- Tim Homan, Research Analyst  
Section of Health Analytics and Vital Records  
Department of Health and Social Services  
[Email: tim.homan@alaska.gov](mailto:tim.homan@alaska.gov)

The number of Alaskans needing mental health services is growing (mirroring national trends) and the state cannot recruit or retain an adequate number of mental health and substance use disorder treatment providers to match. Consequently, API and Alaska's DES/DET institutions are in high demand, understaffed, and are often over capacity. Alaska has experienced an increase in patients who must wait in emergency room boarding for six days or longer for evaluation, and patients needing long-term inpatient treatment may have to travel out of state.

## What Works?

Prevention and early intervention of psychiatric patients reduces the strain on institutions and improves the quality of care. Implementation of Mental Health First Aid Training is an early intervention tool, which focuses on how to identify, understand, and respond to signs of mental illness or substance use disorders. States nationwide, including Alaska, are also implementing Crisis Intervention Team (CIT) training for law enforcement, preparing officers to recognize a mental health crisis, triage the person in need to the proper medical services, and emphasize treatment rather than incarceration when possible.

State policy is another strategy to improve access to behavioral health services along with a strong continuum of care. In Alaska, the Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) emphasizes early interventions, community-based outpatient services, inpatient residential treatment when appropriate, and enhanced peer recovery supports to improve care and reduce the risk of readmission. By expanding reimbursement options for providers working along the entire continuum of care, the 1115 Waiver strategy also works to reduce the burden on acute end-of-care facilities like API.

Alaska and states across the nation are also adopting tiered crisis stabilization systems as part of strengthening institutional care. Crisis Now is an example of a model being implemented in Alaska and deploys three core elements:

1. A statewide crisis call center to coordinate services.
2. Mobile crisis teams that travel to individuals in crisis.
3. Crisis response centers to stabilize patients whose needs extend beyond the call center or crisis team.

There are several strategies to improve care and coordination for an Alaskan returning from an institutional setting, such as a warm hand-off back to the individual's local community provider. Additional strategies could include reducing the current delay in psychiatric evaluations, creating procedures to enable off-site evaluations of persons waiting for an inpatient bed, and bolstering capacity for longer-term treatments. Adding staff capacity to manage psychiatric evaluations issued by courts, track available beds, and coordinate between

the Department of Health and Social Services and other departments may reduce burdens on the institutions providing care to patients. Discharge planning with a multi-agency team is key. For example, some patients may need assistance finding safe housing, transportation to follow-up appointments, and appropriate peer support services. Strong discharge planning also ensures that providers at DES/DET facilities can focus on treating the patient's medical needs.

**Sources:**

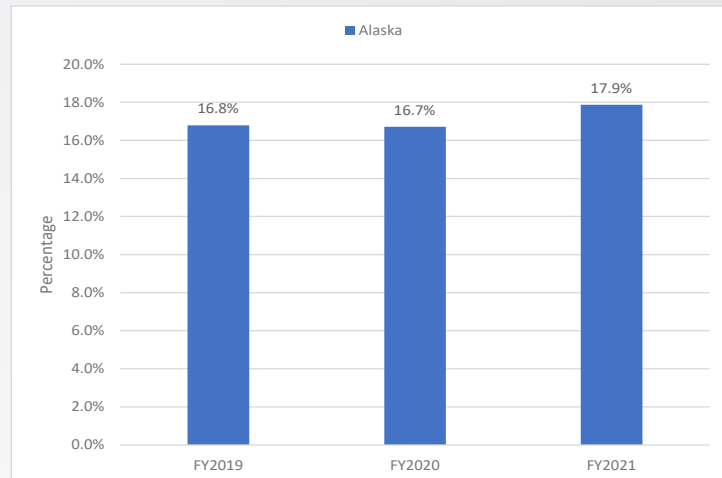
- [Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report, August 2017](#)
- Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup – DHSS Office of the Commissioner
- [Out-of-Home Care Conference Powerpoint](#)
- [Alaska Behavioral Health Reform 1115 Waiver Concept Paper](#)
- [Alaska's 1115 Behavioral Health Medicaid Waiver](#)
- [Recovery Innovations Crisis Now Consultation Report](#)

## SERVICES IN INSTITUTIONAL ENVIRONMENTS

### INDICATOR 25: Percentage of Alaskans who meet criteria for an institutional level of care who were served in nursing homes and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)

#### Story Behind the Baseline

Alaskans with intellectual disabilities experience high levels of placement within institutional settings, which may result in a loss of connection with their culture and home community. Nursing homes are residential facilities that provide a high level of long-term personal or nursing care for persons who are unable to care for themselves. The Division of Senior and Disabilities Services (DSDS) reported on the FY21 Continuum of Care report that there were 1,037 individuals in nursing homes in Alaska. The average cost per person per year residing in a nursing home is \$157,815 compared to \$81,381 for Alaskans residing in their community being served by an Adults with Physical and Developmental Disabilities waiver, or \$87,092 for an Intellectual and Developmental Disabilities waiver. Discharging individuals from a nursing home back to their home is challenging if home-based services are not available or in place, especially with individuals with behavioral or complex needs.



#### Population: Alaska Statewide

#### Data Source:

- Medicaid Management Information System via COGNOS

#### Data Source Contacts:

- Anastasiya Podunovich, Research Analyst IV  
Division of Senior and Disability Services, Department of Health and Social Services  
Email: [anastasiya.podunovich@alaska.gov](mailto:anastasiya.podunovich@alaska.gov)
- Lynne Keilman-Cruz, Health Program Manager IV  
Division of Senior and Disability Services, Department of Health and Social Services  
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Home and community-based waivers (HCBW) provide an opportunity for Alaskans experiencing disabilities to avoid institutional care such as nursing homes, which helps them to remain in their home community and pursue as much independence as possible. DSDS contracts with provider agencies statewide to help people with daily activities such as eating, bathing, dressing, finding and keeping employment, and connecting with friends and neighbors. To serve Alaskans with complex behavioral needs, increased opportunities and access to community supports are needed. Currently, Alaska does not have any Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD) in the state and very few individuals with developmental disabilities are served in nursing homes.

## What Works?

The key component for Alaskans to remain in, or return to, their community from a residential setting is local home and community-based services (HCBS). Examples of HCBS providers include direct service professionals and personal care services providers. Additionally, subsidized housing options are needed to give individuals the opportunity to stay in their own home with supports less restrictive than nursing home placements and let individuals pursue as much independence as possible at the lowest cost to the state. Furthermore, to prevent individuals from being admitted to a nursing home or to aid in discharge, access to assisted living facilities is imperative for safe transitions.

One program that has been shown to work in Alaska is the Complex Behavior Collaborative (CBC). The CBC helps providers meet the needs of Medicaid clients with complex needs who are often aggressive, assaultive, and difficult to support. The CBC program offers consultation and training to providers and clients' natural supports, including family members.

### Sources:

- [State of Alaska Home and Community-Based Waiver Programs](#)
- State of Alaska Continuum of Care – Senior and Disabilities Services: Data Source: State of Alaska Automated Budget System, Final Auth 20 Report, COGNOS

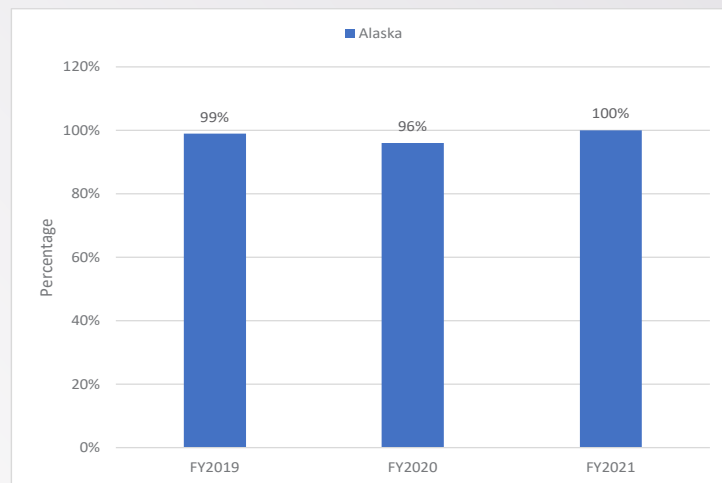
## SERVICES IN INSTITUTIONAL ENVIRONMENTS

### INDICATOR 26: Percentage of juveniles in a Division of Juvenile Justice facility with an identified behavioral health or neurobehavioral condition in a secure treatment unit

#### Story Behind the Baseline

The number of youths entering secure treatment services with the Division of Juvenile Justice (DJJ) have continued to increase for the last several years. Since 2006, the DJJ has collected data on the number of youths with an assessed behavioral health disorder. This data illustrates the story that it is imperative to provide clinical services and targeted behavioral health interventions to ensure the well-being of individuals, families, and communities after youth are released from a secure facility.

Targeting interventions to best meet the needs of delinquent youth has been effective in reducing the likelihood of re-offense. Through a grant awarded by the Office of Juvenile Justice & Delinquency Prevention (OJJDP), the DJJ is currently reviewing best practice programming options that have been recently implemented in partner states that are aimed at effectively supporting youth with mental health diagnoses as well as violent offenders. This grant enables the DJJ to examine more specialized services for youth in secure facilities, specifically targeting improved mental health and behavioral health interventions,



**Population:** Alaska Statewide Juveniles

**Data Source:**

- [Alaska Division of Juvenile Justice](#)

**Data Source Contacts:**

- Tracy Dompeling, Director  
Division of Juvenile Justice, Department of Health and Social Services  
[Email: tracy.dompeling@alaska.gov](mailto:tracy.dompeling@alaska.gov)
- Sandra DeHart-Mayor, Data Processing Manager  
Division of Juvenile Justice, Department of Health and Social Services  
[Email: sandra.dehart-mayor@alaska.gov](mailto:sandra.dehart-mayor@alaska.gov)



further allowing the DJJ to review internal assessments and screening processes to ensure that youth services are aligned.

## What Works?

Currently being developed within the DJJ is a neurobehavioral program that focuses on individual treatment needs based on one's developmental age and brain differences. Often times youth who experience neurobehavioral disorders have a lower IQ or struggle with cognitive processing. Thus, Cognitive Behavioral Therapy (which is generally the model used in the division's secure treatment programs) is often not effective. This new programming will allow staff, including mental health clinicians, to focus on understanding how an individual's brain works differently and apply interventions accordingly.

In 2015, in order to improve the youth reentry process, the DJJ began providing transitional services for juveniles using the nationally recognized Intensive Aftercare Program model, facilitating the difficult transition from long-term confinement to juveniles' home communities. This model continues to exist and includes reentry work to incorporate a continuum of care for youth to address their mental and behavioral health needs upon release into the community. The intensive reentry services within the DJJ have been a contributing factor in reducing the recidivism rates of youth leaving DJJ secure facilities.

### Sources:

- Alaska Department of Health and Social Services – Division of Juvenile Justice System Change Summary, 2018
- Alaska Department of Health and Social Services – Division of Juvenile Justice System Improvement Summary, February 2015
- The National Reentry Resource Center Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System, 2014



## SERVICES IN INSTITUTIONAL ENVIRONMENTS

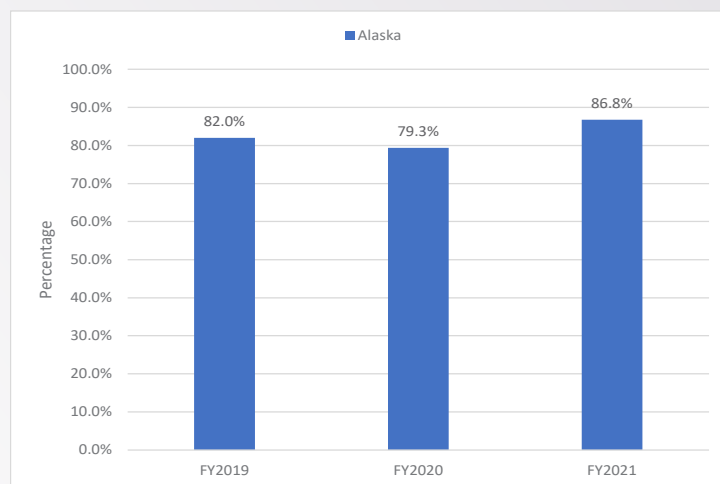
### INDICATOR 27: Percentage of incarcerated individuals diagnosed with a psychotic disorder or schizophrenia who received intensive clinical and case management reentry services

#### Story Behind the Baseline

The Department of Corrections (DOC) is one of the largest behavioral health providers in Alaska. The DOC provides services to individuals who are experiencing mental illness, developmental disabilities, chronic alcohol or drug addiction, Alzheimer's disease and related dementia, and traumatic brain injuries (herein referred to as "beneficiaries"). Beneficiaries experience high levels of placement within institutional settings like the DOC. Between July 1, 2008 (beginning of SFY 2009) and June 30, 2012 (end of SFY 2012), 60,247 unique individuals entered, exited, or resided in an Alaska Department of Corrections facility — of which

30.4% (or 18,323) were identified as beneficiaries. Of the 30.4% of the population that were identified as beneficiaries, approximately 22.3% of them were diagnosed with a psychotic disorder or schizophrenia. Some beneficiaries may have both disorders; thus, this percentage may be overestimated. Because of the potential overestimate of those that were eligible for specialized reentry services, it is possible that the percentage of those served is higher.

The DOC has specialized reentry services focused on meeting the needs of beneficiaries diagnosed with a mental illness, substance use disorder, or those who are dually diagnosed. The DOC recognizes that mentally ill offenders recidivate at more than twice the rate of non-mentally ill offenders, and it is the DOC's goal to reduce clinical relapse, reduce legal recidivism, and increase successful reentry for this vulnerable demographic. The DOC has two specialized



**Population: Alaska Statewide**

**Data Source:**

- [Alaska Department of Corrections, APIC & IDP+ Program Management Tracking Systems](#)

**Data Source Contact**

- Adam Rutherford, Chief Mental Health Officer  
Health & Rehabilitation Services, Department of Corrections  
[Email: adam.rutherford@alaska.gov](mailto:adam.rutherford@alaska.gov)

release programs designed to aid in transitioning and maintaining seriously mentally ill offenders in the community.

- **IDP+:** The Institutional Discharge Project Plus (IDP+) program is designed to aid offenders on felony probation or parole who have been diagnosed with a severe and persistent mental illness in transitioning into and maintaining a place in the community. IDP+ clinicians maintain regular contact with treatment providers, probation staff, and offenders for the purpose of monitoring stability and treatment compliance in the community.
- **APIC:** The primary goal of the Assess, Plan, Identify, and Coordinate (APIC) evidence-based program is to assist eligible beneficiaries with severe mental illness and/or cognitive disorders to access and remain engaged in community-based services following incarceration. The participant's active engagement with these services is critical and contributes to the overall reduction of recidivism. These reentry programs focus on the most acute population and the services are provided by the DOC's mental health clinicians.

These specialized reentry programs do not reflect those beneficiaries who were not enrolled in the above-mentioned programs. It is important to note that the indicator data only reflects persons with a psychotic disorder or schizophrenia diagnosis, even though both APIC and IDP+ have broader eligibility criteria as described above. Thus, it is likely that a slightly larger percentage of offenders receive release planning services upon release. Furthermore, the DOC's facility-based mental health clinicians provide reentry support regardless of program enrollment.

## What Works?

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison. Upon release from jail or prison, many people with mental or substance use disorders continue to lack access to services and, too often, become enmeshed in a cycle of costly justice system involvement. In this implementation guide, SAMHSA outlines various strategies that have been adopted to assist with reentry for those individuals diagnosed with a mental illness or substance use disorder. The model outlined in SAMHSA's implementation guide is the APIC model, which the DOC has implemented with the targeted population discussed above, but the APIC model has much broader implications that have proven to reduce recidivism.

Trust beneficiaries, inclusive of those with severe and persistent mental illness, require their communities to have robust community treatment and support services that are

readily accessible. This can be challenging for Alaskan communities due to population size, location, and workforce challenges. Most Trust beneficiaries are Medicaid eligible and access their physical and behavioral healthcare from Medicaid providers or the tribal health system. In 2015, the Department of Health and Social Services (DHSS) initiated a multi-year effort to reform and redesign the state's Medicaid system, create cost efficiencies, improve access to services, and achieve improved Alaskan health outcomes.

To reach these goals, DHSS implemented Alaska's Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver) in 2020. The 1115 Waiver redesigned community services aimed at improving access to the integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. It ensures that Medicaid recipients, including those returning to communities from incarceration, will have options across the full continuum of care; however, there will always be a portion of Alaskans reentering the community from a correctional setting that will be unable to access these resources and will continue to require support and services that aid them in successful reentry.

Having resources to expand the APIC model to a broader portion of beneficiaries exiting the DOC, and ensuring collaboration between state agencies and community providers, could have a significant impact on the success of beneficiaries. When state, tribal, and community-based systems identify a beneficiary's treatment needs and supports, communicate that information effectively across systems, provide ongoing case management and monitoring, collaborate with one another to promote beneficiary success, and design and support community-based treatment and service systems, beneficiaries reentering communities from incarceration will have a solid foundation from which to succeed. The DOC, DHSS, and other key stakeholders will continue working together to improve Alaska's reentry programs so beneficiaries can be successful, criminal recidivism is reduced, and public safety is increased. Future improvements being explored include virtual in-reach options, increased reentry services in rural communities, increased peer supports, and increased release planning, including identification options for releasing inmates.

#### Sources:

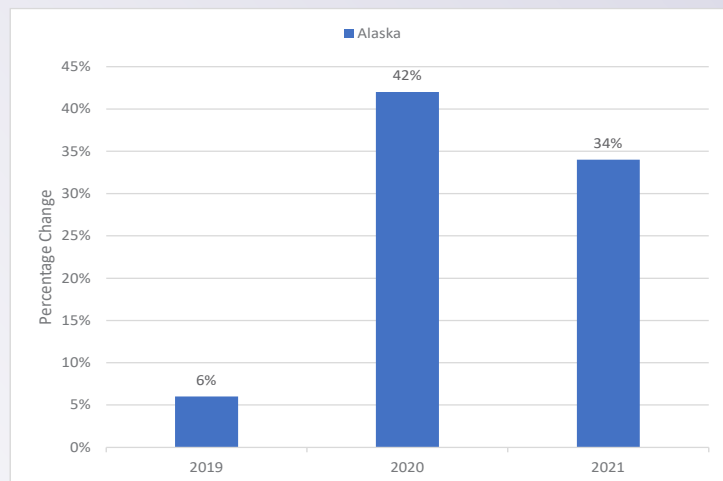
- [Assess, Plan, Identify, Coordinate \(APIC\): Number of Beneficiaries Served in APIC FY08 - FY13. Data Source: FY08-FY13 MHTAAR Status Reports](#)
- [Hornby H., Rubin M., & Zeller, D. \(2014\). Trust Beneficiaries in Alaska's Department of Corrections](#)
- DHSS & DOC Recidivism Reduction Joint Annual Report Fiscal Year 2020
- [Substance Abuse and Mental Health Services Administration. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. \(SMA\)-16-4998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017](#)
- [Alaska's 1115 Behavioral Health Medicaid Waiver](#)

# WORKFORCE, DATA, AND FUNDING

## INDICATOR 28: Percentage change in SHARP health practitioner contracts (current calendar year compared to previous 5-year average)

### Story Behind the Baseline

Healthcare is one of the leading industries in the state. Unfortunately, Alaska has a workforce shortage across many health and behavioral health-related disciplines and has difficulty meeting the healthcare industry's demand. Without a capable and competent workforce, the continuum of services and care is at risk of not being able to meet the needs of the most vulnerable Alaskans. Key workforce development strategies include increasing the availability of growth opportunities for local professionals through primary and secondary education, training, support-for-services programs (like loan repayment), recruitment, and retention. The latest iteration of Alaska's direct incentive and loan repayment program for healthcare workers, referred to as SHARP-3, builds on previous success and broadens the types of occupations,



**Population: Alaska Statewide**

#### Data Sources:

- [Alaska Division of Public Health, Section of Rural and Community Health Systems, Office of Healthcare Access, SHARP](#)

#### Data Source Contact:

- Robert Sewell, Ph.D., Program Manager  
Office of Healthcare Access, Division of Public Health,  
Department of Health and Social Services  
[Email: sharp.inquiry@alaska.gov](mailto:sharp.inquiry@alaska.gov)

practice settings, and locations available to health professionals. Tracking the number of SHARP contracts across all SHARP iterations over time provides a glimpse into the health and sustainability of this key recruitment and retention effort.

Mirroring national trends, Alaska's older adult population and their complex care needs are expected to increase. This growth will be felt by healthcare entities, especially those who employ healthcare professionals, like home health aides who work directly with older adults. Additionally, there is continued emphasis in Alaska on home and community-based service (HCBS) professions, such as direct support professionals. Legislation also shapes the workforce landscape by increasing the number and variety of health professionals needed to accommodate Alaskan communities. For example, the growing emphasis on early intervention and crisis stabilization will create a significant number of peer support specialist positions statewide.

A large portion of healthcare jobs in Alaska are entry-level and can lead to long-term, stable, and attractive careers if offered within a supportive environment. Ensuring adequate pay and benefits, access to professional development and advancement, and connecting workers to emotional and administrative supports are key components of retaining a strong healthcare workforce and reducing turnover.

## What Works?

Alaska provides accelerated training and certification programs to harness local talent. In addition to funneling healthcare workers from both in and out of state, Pre-Apprenticeship Training in Healthcare (PATH) Academies — funded by the Alaska Department of Labor — offer three-week intensive courses where graduates earn certifications to become direct support professionals (DSPs). In January 2021, the Alaska Commission for Behavioral Health Certification Board began certifying peers with lived experience. Peers will have the opportunity to be certified as a peer support professional in a variety of different levels and certification types.

Due to Alaska's size and cultural diversity, workforce recruitment and retention efforts must draw on the cultural expertise of locals, especially in rural Alaska. Some state education resources, like the University of Alaska Fairbanks' Rural Human Services Program, offers a culturally informed training path for rural residents to earn a certificate and start working full-time. In other states with large rural populations, promising low-cost models for addressing workforce shortages include legislative initiatives to collect statewide survey data from behavioral health providers to inform policy decisions and using distance technology to host regular mentoring sessions between high school and college-aged youth and health professionals.

Technology can assist with finding placements for healthcare workers. One example is Health TIE's DSP Hire app that aims to mitigate administrative barriers for hiring DSPs. The app simultaneously helps employers find DSPs in their region and simplifies the application process for the professional. The app also connects DSPs to peers working in the field and provides instant access to training. Alaska can also increase workforce capacity through technology to account for a shortage in-state. For example, Motivo is an online clinical supervision platform used in Alaska to help therapists earn licensure.

**Sources:**

- [Aitschul, D. B., Bonham, C. A., Faulkner, M. J., Pearson, A. W. F., Reno, J., Lindstrom, W. et al. \(2018\). State Legislative Approach to Enumerating Behavioral Health Workforce Shortages: Lessons Learned in New Mexico. American Journal of Preventive Medicine, 54\(6\), S220-S229.](#)
- [Keeler, H., Sjuts, T., Niitsu, K., Watanabe-Galloway, S., Mackie, P. F. E., & Liu, H. \(2018\). Virtual Mentorship Network to Address the Rural Shortage of Mental Health Providers. American Journal of Preventive Medicine, 54\(6\), S290-S295.](#)

## WORKFORCE, DATA, AND FUNDING

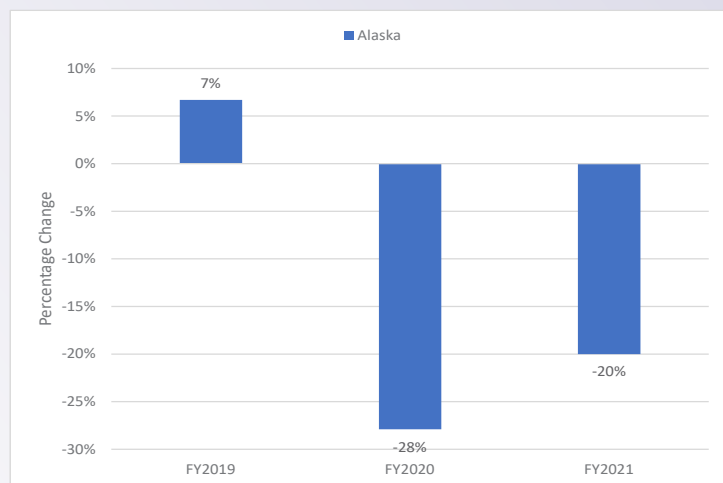
### INDICATOR 29: Percentage change between fiscal years of unduplicated participants served by Alaska Training Cooperative training events

#### Story Behind the Baseline

Training and professional development opportunities are an important component of building a capable and competent workforce in Alaska. For the healthcare workforce to deliver culturally and linguistically appropriate care across Alaska, providers need access to a wealth of enhanced training options whether they work in an urban or remote community. Factors that affect access to training include changing revenue and funding resources and major events like COVID-19, which increased the state's reliance on telehealth and distance learning opportunities.

#### What Works?

Building a web-based hub for training and professional development promotes ease of access for users and consolidates resources for those delivering training. The Alaska Training Cooperative (AKTC), administered by the University of Alaska Anchorage College of Health's Center for Human Development, is responsible for providing non-academic trainings, professional development, and continuing education to Alaska's behavioral health and long-term care, community and home-based professionals who serve Trust beneficiaries. The AKTC delivers enhanced training methods such as distance-delivered, blended, and in-person formats that accommodate professionals across the state. Access to increased opportunities for distance-delivered training options instead of in-person offerings saves the healthcare workforce money, resources, and time. As state policies continue to change how providers



**Population:** Alaska Statewide

**Data Source:**

- [University of Alaska Anchorage, Center for Human Development, Alaska Training Cooperative](#)

**Data Source Contact:**

- Center for Human Development  
[Email: info@alaskachd.org](mailto:info@alaskachd.org)

operate, the AKTC offers relevant trainings to ensure that the workforce is prepared to adapt to an evolving healthcare landscape.

**Source:**

- [The Alaska Training Cooperative](#)



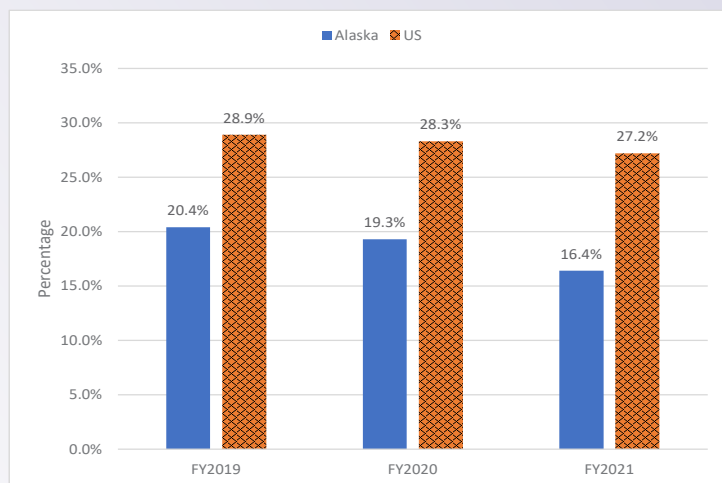
## WORKFORCE, DATA, AND FUNDING

### INDICATOR 30: Medicaid expenses as a percentage of state's budgets

#### Story Behind the Baseline

Through Medicaid, the Department of Health and Social Services (DHSS) provides essential healthcare coverage for low-income Alaskans. Medicaid is a valuable component of healthcare delivery for beneficiaries in Alaska, including older adults and people who experience disabilities. Medicaid enrollment in Alaska is growing due to an economic recession and Medicaid redesign and expansion initiatives. Total state and federal spending have increased since Medicaid expansion in 2016, but legislative reforms have enabled DHSS to maintain a flat general fund per enrollee expenses year-to-year. Almost three-quarters of Medicaid spending in the state goes toward acute care, and about one-quarter to long-term care. Compared to the U.S., Alaska shows a lower percentage of state budget spending on Medicaid due to federal match.

The Center for Medicare & Medicaid Services (CMS) approved DHSS's application for a Medicaid 1115 Behavioral Health Demonstration Waiver (1115 Waiver), which aims to establish a network of behavioral health services at the community and regional levels in order to reduce the need for crisis-driven and urban-based emergency, acute, and residential care in Alaska. This includes approval for both a Substance Use Disorder (SUD) and Behavioral



**Population: Alaska and U.S.**

**Data Source:**

- [National Association of State Budget Officers, National State Expenditure Report](#)

Health component, with an Administrative Services Organization (ASO) administering waiver benefits, services, and claims processing.

Relevant spending in the Medicaid budget for Trust beneficiaries includes telehealth, which has increased by 522% since fiscal year 2016 (FY16). Behavioral health is the leading condition treated, resulting in improved access to care for beneficiaries. Additional Medicaid waiver programs allow Alaska to offer Medicaid services outside of institutional care settings, which is particularly important in Alaska as many remote and rural communities lack institutional settings. Home and community-based services (HCBS) offer non-institutional treatment options and allow beneficiaries to remain in their home or community.

## What Works?

Medicaid waivers allow states the flexibility to offer programs and services for increased quality of care and to achieve cost savings through innovative programs that reduce the need for institutional care. For example, Alaska's 1115 Waiver is a significant effort to establish a network of behavioral health services at the community and regional level, reducing the need for crisis-driven and urban-based emergency, acute, and residential care by supporting the development of missing components of the care continuum.

Additionally, DHSS offers varying waiver options, such as the 1915(k) option, which provides enhanced personal care services for individuals who meet nursing facility level of care criteria. They also provide services under the 1915(c) intellectual development disorder waiver to provide more HCBS at a lower level. Utilizing waiver programs captures federal funding reimbursement at a higher rate for these services than for regular personal care services, allowing DHSS to capture additional savings of state general fund dollars.

In Alaska, the implementation of care coordination agreements (CCAs) between tribal and non-tribal providers allows the state to claim the enhanced federal match for services provided to an Alaska Native Medicaid enrollee by a non-tribal provider. Alaska is leading the nation in refinancing claims at this level and provides national leadership in this area. Another care coordination strategy is to streamline care for Medicaid recipients with excessive hospital emergency department utilization through individualized case management services and referrals to specialists and social service supports. Other cost-saving factors include managing fraud, waste, and abuse in the Medicaid system.

Partnerships across public health and Medicaid sections can improve Medicaid service delivery. For example, DHSS explored costs of a Continuum of Coverage for low-income Alaskans that would ease transitions between public health coverage programs and private market coverage. The Centers for Disease Control and Prevention (CDC) provides guidance on how state public health agencies can partner with Medicaid staff to implement evidence-based prevention interventions.

**Sources:**

- [Kaiser Family Foundation, Medicaid in Alaska](#)
- [Understanding Public Health's Role in CDC's 6 | 18 Initiative: A Primer for Medicaid Partners: Technical Assistance Tool](#)





# Trust

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Alaska Mental Health  
Trust Authority