Trust
Alaska Mental Health Trust Authority

3745 Community Park Loop, Suite 200
Anchorage, AK 99508
Tel 907.269.7960
www.mhtrust.org

MEETING AGENDA

Meeting: Program & Planning Committee
Date: October 17, 2018
Time: 10:45 am
Location: Trust Authority Building, 3745 Community Park Loop, Anchorage
Teleconference: (844) 740-1264 / Meeting Number: 805 579 170 # / Attendee Number: #
http://thetrust.webex.com
Trustees: Chris Cooke (Chair), Verné Boerner, Laraine Derr, Paula Easley, Mary Jane Michael, Jerome Selby, Carlton Smith

Wednesday, October 17, 2018

		Page No.
10:45	**Call to order (Chris Cooke, Chair)** Announcements Approve agenda Ethics Disclosure Approval of Minutes: August 1-2, 2018	5
10:50	**COMP Plan Update** • Monique Martin, Deputy Director DHSS • Jillian Gellings, Policy Analyst DHSS • Michael Baldwin, Senior Evaluation & Planning Officer • Autumn Vea, Evaluation & Planning Officer	41
11:30	**Recess**	
1:30	**Approval**	54
1:45	**Developing Projects Update** • Hiland Mountain Women's Mental Health Unit Trust Staff • Peer Support Services Building Acquisitions Trust Staff • Crisis Stabilization Center Trust Staff	59
2:10	**Trustee Comments**	
2:15	**Adjourn**	

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Future Meeting Dates

Full Board of Trustee / Program & Planning / Resource Management / Audit & Risk / Finance 2018 / 2019 / 2020

(Updated – September 10, 2018)

• Program & Planning Committee	October 17, 2018	(Wed)
• Resource Mgt Committee	October 17, 2018	(Wed)
• Audit & Risk Committee	October 17, 2018	(Wed)
• Finance Committee	October 17, 2018	(Wed)
• Full Board of Trustee	November 15, 2018	(Thu) – Anchorage

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• Program & Planning Committee	January 3, 2019	(Thu)
• Resource Mgt Committee	January 3, 2019	(Thu)
• Audit & Risk Committee	January 3, 2019	(Thu)
• Finance Committee	January 3, 2019	(Thu)
• Full Board of Trustee	January 30-31, 2019	(Wed, Thu) – JUNEAU
• Program & Planning Committee	April 17, 2019	(Wed)
• Resource Mgt Committee	April 17, 2019	(Wed)
• Audit & Risk Committee	April 17, 2019	(Wed)
• Finance Committee	April 17, 2019	(Wed)
• Full Board of Trustee	May 8, 2019	(Wed) – TBD
• Program & Planning Committee	July 30-31, 2019	(Tue, Wed)
• Resource Mgt Committee	August 1, 2019	(Thu)
• Audit & Risk Committee	August 1, 2019	(Thu)
• Finance Committee	August 1, 2019	(Thu)
• Full Board of Trustee	September 4-5, 2019	(Wed, Thu) – Anchorage
• Program & Planning Committee	October 16, 2019	(Wed)
• Resource Mgt Committee	October 16, 2019	(Wed)
• Audit & Risk Committee	October 16, 2019	(Wed)
• Finance Committee	October 16, 2019	(Wed)
• Full Board of Trustee	November 14, 2019	(Thu) – Anchorage

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Future Meeting Dates

Full Board of Trustee / Program & Planning / Resource Management / Audit & Risk / Finance 2018 / 2019 / 2020

(Updated – September 10, 2018)

• Program & Planning Committee	January 3, 2020	(Fri)
• Resource Mgt Committee	January 3, 2020	(Fri)
• Audit & Risk Committee	January 3, 2020	(Fri)
• Finance Committee	January 3, 2020	(Fri)
• Full Board of Trustee	January 29-30, 2020	(Wed, Thu) – JUNEAU
• Program & Planning Committee	April 22, 2020	(Wed)
• Resource Mgt Committee	April 22, 2020	(Wed)
• Audit & Risk Committee	April 22, 2020	(Wed)
• Finance Committee	April 22, 2020	(Wed)
• Full Board of Trustee	May 7, 2020	(Thu) – TBD
• Program & Planning Committee	August 4-5, 2020	(Tue, Wed)
• Resource Mgt Committee	August 6, 2020	(Thu)
• Audit & Risk Committee	August 6, 2020	(Thu)
• Finance Committee	August 6, 2020	(Thu)
• Full Board of Trustee	September 2-3, 2020	(Wed, Thu) – Anchorage – TAB
• Program & Planning Committee	October 21, 2020	(Wed)
• Resource Mgt Committee	October 21, 2020	(Wed)
• Audit & Risk Committee	October 21, 2020	(Wed)
• Finance Committee	October 21, 2020	(Wed)
• Full Board of Trustee	November 19, 2020	(Thu) – Anchorage – TAB

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Future Meeting Dates

Statutory Advisory Boards - 2018

(Updated – October 9, 2018)

Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse

- Executive Committee – monthly via teleconference (First Wednesday of the Month)
- October 9-10, 2018 - Kodiak
- March 4-8, 2019 – Juneau <tentative>

Governor's Council on Disabilities and Special Education

- November 15, 2018 – Anchorage – Supported Decision Making Agreements Summit

Alaska Commission on Aging

- December 12 by video/teleconference <tentative>
- February 11-13, 2019 (face-to-face) or February 13 by video/teleconference <tentative>
- May 1, 2019 by video/teleconference <tentative>

ALASKA MENTAL HEALTH TRUST AUTHORITY

PROGRAM & PLANNING COMMITTEE
Volume 1

August 1, 2018
8:30 a.m.

Taken at:
Alaska Mental Health Authority
3745 Community Park Loop, Suite 120
Anchorage, Alaska 99508

OFFICIAL MINUTES

Trustees present:
Chris Cooke, Chair
Mary Jane Michael
Carlton Smith
Laraine Derr
Paula Easley
Verne' Boerner

Trust staff present:
Mike Abbott
Steve Williams
Miri Smith-Coolidge
Kelda Barstad
Andy Stemp
Luke Lind
Michael Baldwin
Carrie Predeger
Katie Baldwin-Johnson
Jimael Johnson
Valette Keller
Eric Boyer
Travis Welch
Autumn Vea

Also participating:
Kathy Craft; Brenda Moore; Pat Sidmore; Adam Rutherford; Josh Arvidson; Jared Parrish; Monique Martin; Julie Davies.

PROCEEDINGS

CHAIR COOKE calls the Program & Planning Committee meeting to order and asks for a roll call. He notes that all trustees are present, except for Trustee Selby, who may call in. He asks for any announcements. There being none, he moves to the agenda and asks for any additions, changes or corrections.

TRUSTEE DERR makes a motion to approve the agenda.

TRUSTEE MICHAEL seconds.

There being no objection, the motion is approved.

CHAIR COOKE asks for any ethics disclosures. There being none, he moves to the minutes from April 20, 2018.

TRUSTEE DERR makes a motion to approve the minutes of the April 20, 2018, meeting.

TRUSTEE MICHAEL seconds.

There being no objection, the motion is approved.

CHAIR COOKE states that the next item on the agenda is a presentation made by Jimael Johnson, and asks Ms. Baldwin-Johnson to make the introduction.

INVESTING IN EARLY CHILDHOOD AND PREVENTION

MS. BALDWIN-JOHNSON reminds all that early intervention and prevention is one of the principles for the Trust. She states that Ms. Johnson coming on to the Trust is a wonderful opportunity for her to help frame, work with, give some guidance on how to consider the kinds of initiatives that need to be invested in, and to find the right partners to be a part of those conversations. She continues that this is another step in that direction, and additional information will be provided for consideration and thought. She adds that there is no action necessary, and this is just informational.

MS. JOHNSON begins by introducing Josh Arvidson, a child trauma expert with the Anchorage Community Mental Health Services, and Jared Parrish, a senior epidemiologist with Alaska's maternal child health program. She points out that the history of the Trust and what was needed at the time really pointed out the efforts and resources downstream. It was considered downstream where there were many people with developmental disabilities, mental health issues, including substance use, that were sent to the State, institutionalized, and were making an effort to return to Alaska. She adds that this focus was very important at the time. She recaps who the Trust beneficiaries are, the five primary beneficiary groups: People with mental illness; developmental disabilities; chronic alcoholism, substance abuse; Alzheimer's-related dementia; and traumatic brain injury. With those in mind, it is imperative to work in prevention and early

intervention, which is a priority for the Trust. She states that this is relative now because there is a much better understanding of brain science. The upstream concepts that will be presented are based on the brain science and data. She continues that it is known that 90 percent of a child's brain development happens before the age of five. She moves on and presents some brief Alaska-specific data around the early childhood population, the families, in the context of Trust beneficiary categories.

TRUSTEE DERR asks if the population on the chart represents all the people or just the ages of children two to 15.

MS. JOHNSON explains the chart, identifying the population and states that it could be adults, children, or both. She continues her presentation talking about the data results. She talks about the program developed by Nobel Laureate James Heckman, an economist in social investment in young children. She continues that he has done decades of research, and has conducted and analyzed countless longitudinal studies that look at various programs that support young children and families and watching those kids over time and seeing the differences in their development that clearly point back to the early intervention received as young children and the support that their families received. She adds that the highest return on investment is for younger kids, and those preschool programs specifically where there is a lot of evidence. She asks Josh Arvidson to talk about the neuroscience.

MR. ARVIDSON states that he is the director of the Alaska Child Trauma Center and is part of the Alaska site called the National Child Traumatic Stress Network, which is funded by the Substance Abuse and Mental Health Services Administration. He adds that the network has been around for 18 years, and we have been a site within that network for the last 15. He presents some data from the network and states that they have had the opportunity to collect longitudinal data on 21,000 kids being treated by about 70 treatment centers across the National Child Traumatic Stress Network. He adds, that effort was organized by doing a clinical research institute, and his center was part of that study. He continues that the center is also part of a training and technical assistance network within the National Child Traumatic Stress Network. This focuses on complex trauma, which is trauma that occurs throughout early childhood, typically, and occurs within caregiving systems, repetitive exposure to trauma. He talks about stress response and explains that when folks are exposed to chronic stress, particularly in critical developmental periods of early childhood, there can be some profound and damaging effects. There is a need to start the conversation by acknowledging that the stress response enables us to survive as human beings. He states that this is very important, particularly in reference to the role in reducing shame and stigma and helping people get the help that is needed. He talks about the way the brain responds to the stress, explaining what happens with examples from his experiences. He moves to explaining and understanding exposure to stress within the attachment system, the caregiving system. He states that one of the things that is happening is that trauma neuroscience and tactic research are coming together to help better understand how critical it is for kids to have good caregiving systems. This is parents and extended family; the people who provide care and the sense of safety and security for kids. He adds that when there are strong, good caregiving systems, stress is buffered, and kids are profoundly resilient. He moves on and talks about the Complex Trauma Treatment Network. He states that over the last ten years they

have talked about what happens when kids are exposed to repetitive chronic stress, and some of the serious issues include domestic violence, physical abuse, sexual abuse, neglect. The problem when kids experience physical and sexual abuse is that they tend to blame themselves. He continues that some of the stories he hears are about, "This is your fault. It is because of you. It is all about you and you deserve it." He adds that sometimes the message was explicit, but in chronic abuse, that message is always implicit. He states that is the story part of it. The data says that it affects these different areas of development that are critical to long-term success, occupational, academic, educational, and in personal success. He encourages the board to think about all of this and these kids as priorities, especially in funding. Those events tend to co-occur and overlap, and does change the way to think of programming. He concludes stating that the fundamental problem of chronic exposure to traumatic experiences in childhood is that overwhelming stress turns a learning brain into a surviving brain. But the brain and the physiological impact of the trauma is only the beginning of the problem. Development is the context in which the impact of childhood trauma is fully realized. He adds the need to move past thinking about symptoms and diagnoses, and to think about the development context.

CHAIR COOKE thanks Mr. Arvidson and recognizes Dr. Parrish.

DR. PARRISH states that he is an epidemiologist in the Alaska Division of Public Health in the Maternal and Child Health epidemiology unit, and will talk about the Alaska Longitudinal Child Abuse and Neglect Linkage Project. He adds, that project originated when it was recognized that there was no adequate data source to answer the questions that we were interested in. He explains that we have taken the Pregnancy Risk Assessment Monitoring System survey, or PRAMS, which measures about one out of every six live births that occur in Alaska each year. Alaskan Native or indigenous populations and low-birth-weight babies are over-sampled to be sure that there is enough from the smaller populations to be able to make inferences about that population. He states that one of the challenges is that the moms who give birth in some cases have not provided consent to do that; and, second, there is limited information contained on the birth record that is not useful or specific for predicting many of the negative health outcomes that there is an interest in preventing in the first place. He continues that PRAMS moms answer a lot of questions related to the pre-birth experience, the birth experience, and the after-birthing experience. There is also a three-year follow-up survey to PRAMS called CUBS. He explains that it is an early childhood problem that needs to be addressed to support families and children, and he discusses the data and what it shows.

CHAIR COOKE asks the trustees for any questions.

TRUSTEE MICHAEL states that it is enlightening to see the number of children that are impacted. She asks what can be done to have the biggest impact.

DR. PARRISH replies that the challenge is that information is powerful and is consumed at an incredible rate. He states that one of the challenges is the need to know the extent of the problem, where to target the resources most effectively. He continues that being able to support efforts to package these data in a way that makes sense and sharing it so that it is incredibly useful and will get others to start identifying solutions.

MR. ARVIDSON states the need to change the way these problems are thought about and misusing the brilliance of the public health approach in terms of prevention, intervention, primary, secondary, tertiary; those types of things. He continues that these problems are oversimplified because a public health approach is misappropriated.

TRUSTEE EASLEY states that this is great information but, on the PRAMS questions, she did not see the question of whether the mother wanted the child in the first place.

DR. PARRISH replied that question, if the pregnancy was intended, is not one of the stressor questions, and the information was not necessary for this analysis.

TRUSTEE BOERNER states appreciation for the presentation. She adds that this is a population that is actively seeking services.

TRUSTEE SMITH asks if both gentlemen collaborate on a regular basis, and states that he is intrigued by the reference to what a great position the State of Alaska is in because these individuals can be tracked. He asks about the tools needed to drill down to make this data more meaningful.

DR. PARRISH replies that he and Mr. Arvidson do collaborate regularly, and continues that he is in need of a research analyst to look at these data and develop products that can be put on a Web site. He adds that some extra analysts would make these data pop, and would put them into products that would be useful to the right audience.

TRUSTEE SMITH asks Mr. Arvidson about complex trauma and where to find more information to read on that topic.

MR. ARVIDSON replies that there is a white paper on complex trauma that was developed by colleagues in the National Child Traumatic Stress Network and there is a bunch of associated reference materials through the Web page, which he will forward to trustees.

TRUSTEE DERR states that she had been a school administrator 30 years ago, and the data was there and being discussed then. She continues that society does not allow identifying separately children who have ACEs. She asks if any thought on how to do that in a school system has been discussed.

MR ARVIDSON replies that there are universal practices that work for all the kids in the classroom which are really critical for those five or so kids that are having a rough time.

CHAIR COOKE comments that the contact with OCS is not a good outcome or a solution, and it can often be the source of more trauma for a child. He states that this model seems to end with OCS contact.

DR. PARRISH replies that that is why he said it is a sentinel event. The trauma had been occurring before that and is something that rose to the level that can be detected in a systematic way that is resistant to the policies and procedures that change within the child welfare system or any sort of system. He continues that there are some other analyses being done by some researchers at the University of North Carolina that are looking at the impact of that event, or the repeat event, on various different outcomes.

MS. JOHNSON states that she was glad to hear questions that are very much in line with the conversations with partners, and some of the solutions have been brainstormed with partners as far as opportunities for future investment. She does a quick wrap-up and talks about some of the opportunities for investment, and then thanks all for the time.

CHAIR COOKE calls a ten-minute break.

(Break.)

CHAIR COOKE states that the next item on the agenda is the report on the Integrated Comprehensive Mental Health Program Plan update.

INTEGRATED COMPREHENSIVE MENTAL HEALTH PROGRAM PLAN UPDATE

MR. BALDWIN states that the Integrated Comprehensive Mental Health Program Plan has been abbreviated to "Comp Plan." Statutorily, it is the responsibility of the Department of Health and Social Services to make sure there is an integrated comprehensive mental health program. He continues that the Trust statutes state responsibility for ensuring there is a comp plan or a comp program, working in conjunction with each other to ensure this. Also, within the statutory advisory boards, they are responsible for providing information that will help inform the comprehensive program. He adds that the program is focused around funding of services. He states that Alaska is the only state that has specific requirements to develop such a plan around mental health services and beneficiary-related services and that this helps define the publicly funded system within Alaska. The other benefit of this is it helps establish priorities in terms of programs, funding, and advocacy. He states that it should be a living document, and that it is included in the Tribal healthcare system. He goes through a short history of the first comp plan and how it changed through the years. He moves to the Scorecard, which is on the Trust's and the Department's Web sites containing a list of 23 indicators organized around domains that are within the comprehensive program plan. There are some key indicators there that are tracked and monitored over time.

MS. VEA states that the Scorecard seems to have a tremendous value for the community partners. It is on the DHSS Web site and gets about 1500 hits per year.

MR. BALDWIN adds that the other feedback received is that people are using it for the grant applications, and for data. One of the things recognized, especially with the advisory boards and partners, is that the advisory boards have a plan. He states that all of the things funded in the '17/'18 budget were looked at, and the majority of things that were funded were related to

treatment and intervention services. He continues that the comp program efforts and the analyses help to plan around the reform initiatives, the focus area goals, advocacy, and results. He asks Autumn Vea to share a bit about some of the work that is being done.

MS. VEA states that she has been with the Trust for two months, and since starting has formed the new bank to work on the comprehensive program plan. She continues that part of that was developing the leadership work group. The Department of Health and Social Services has appointed Lauree Morton as the program coordinator to lead the Department's efforts into developing the comprehensive plan. She adds, that work group also includes Monique Martin from the Commissioners office, Deb Etheridge from Senior and Disabilities Services, along with the Trust advisory boards, their respective planners, as well as other Department of Health and Social Services program managers and research analysts. She states that one of the key goals identified in reinvigorating the comp plan was to have the right folks at the table to get the program started and this plan written. The team met for the first time in June of 2018, and the first draft target date of the plan is January 1, 2019.

TRUSTEE MICHAEL asks to take a pause because the thought was that the Trust was doing the comprehensive plan. She states that this administration may be over in November. If not, then the plan could be gone. She continues that when Heidi was hired, the idea was to establish the comprehensive plan and that they Trust would be the lead on it so that it would transcend administrations. She adds that Heidi was here to develop a plan, or the steps to develop a plan, and now we need some time to for discussion.

TRUSTEE EASLEY states that the problem in getting a comprehensive plan together has always been who would actually lead the effort. She continues that the Commissioner at DHSS has affected that decision. A lot of work on this has been done over the years, and we were kind of equal partners. She adds that her concern is that a lot of money was put into this, and it is still nowhere.

TRUSTEE SMITH states that this is great material and asks when the next meeting is, and if it would be possible for some of the board to be involved.

MR. BALDWIN replies that the leadership group meets on the fourth Wednesday of every month, and the next one will be August 22nd.

TRUSTEE BOERNER asks if there is Tribal representation in that leadership group.

MR. BALDWIN replies that currently there is not, but there is discussion on how to bring someone on board. He states that having the active collaboration with the Department is bringing this along, even with the changes of Administration.

TRUSTEE MICHAEL states that it will be difficult to have a future governor adopt the previous administration's plans. She continues that it may be lost again.

MR. BALDWIN states that the intention is to keep it going, and the need is to step up and own it.

TRUSTEE DERR asks what Heidi accomplished while working here.

MR. WILLIAMS replies that she was hired to work and look at the efforts that were currently going on within the Medicaid reform system at the Department of Health and Social Services, to look at historically what had been done with the comp plan, look at all of the various plans that exist, and to help to establish a vision, which the trustees had heard a number of times on how to integrate all of those efforts and put together a package that fit in with the reforms that were underway in conjunction with the Department. He states that the Department did not have the manpower at that time, and it still does not, to push it with the level of effort that was going to be required. He continues that his second point is that this is a good dialogue with the trustees. The staff can come up with a comp plan, but if the partners are not engaged, with public input, then it will be viewed as not a partnership. He adds that he wants to make sure that people do not underestimate the amount of time and work it takes to go through all of that information, to weave it together, and then to come up with a path forward that the partners will join in on.

TRUSTEE EASLEY states that the statute clearly states that the Department shall prepare and periodically revise and amend the plan for the Integrated Comprehensive Mental Health Program. However, the rest of the wording in the statute says that this shall be made in conjunction with the Mental Health Trust Authority, which will coordinate with federal, state, regional, private and local entities.

MR. ABBOTT states that the vision of the plan is to have a draft of a comp plan by the end of the calendar year so that it is far enough along so that whichever commissioner and administration is dealing with this from 2019 forward will have a product that can be embraced. He explains more fully and adds that this will be mostly staff-level work over the next couple of months, with periodic updates and reviews for trustees, and hopefully policy-level folks at the State, as well.

MR. WILLIAMS adds that in terms of timeline, staff is working to set up having an MOA in place prior to any potential administration change. He states, for historical context, when the new position was created it was to add additional evaluation and research capacity to the Trust. There were discussions with the trustees as to whether to go in that direction or adding program staff direction or support. He continues that, at that time, the trustees selected adding the research and evaluation piece, and were pushing data-driven decision-making. He adds that the capacity was focused on the comp plan and was also to enhance the capacity from an evaluation and research perspective.

CHAIR COOKE asks where the base is when talking about revision and modifications and updates and so forth.

MR. BALDWIN replies that the plan was on the Department's Web site, called "Moving Forward," with a lot of materials around it.

TRUSTEE EASLEY congratulates staff on getting this far.

CHAIR COOKE moves to the budget.

BUDGET

MR. WILLIAMS begins by laying the foundation for how staff put together the FY20 and ’21 budget recommendations that the trustees received. He states that there is a new trustee and several Trust staff that have not gone through the budget process, and begins with a high-level overview of what has been happening since May. He explains that the process started as soon as the Legislature adjourned, which gives time to coordinate with the stakeholders that are deeply engaged in the Legislative process. That is where this begins today, and it will be brought to the September board meeting. He continues that a host of other information was provided to trustees a week in advance, much of which is included in the slides as highlights. He goes through the slide presentation and talks about the two-day stakeholder meeting that tapped into the expertise of all of the partners to try and implement either program, or change that has direct impact on the beneficiaries. He adds that the Trust Land Office staff participated and appreciated hearing about the work that happens in the Trust Authority Office, which has also led into an exchange of giving information at joint staff meetings about the programs funded and how what they are doing has an impact on beneficiary lives.

TRUSTEE DERR comments that she had occasion to attend a meeting where there was really good feedback from two different groups that had been at the meeting. They said it was one of the best meetings they had ever attended. She adds that a good job was done at that meeting.

MR. WILLIAMS states that a survey was done of all the attendees, and the feedback received from the attendees that participated will be highlighted at the end of the presentation. He moves on and continues his presentation, going over the framework, and then talks about the second day of the meeting, which was a deep-dive table discussion where each executive director was at a table with a Trust staff and co-facilitated the discussion. He states that this was a chance for people to get to meet and interact with Mr. Abbott and hear what the financial status of the Trust is in terms of stability, where revenues will be going in the future, and how that impacts the funding decisions and abilities. The presentation continues with Mr. Williams sharing and commenting on what was discussed, the focuses and results of some of the conversations. He moves to the table discussions and asks the program officer staff and the co-facilitators to continue.

MS. BALDWIN-JOHNSON begins with the whole personal health-care topic and states that the conversation went to defining whole-person care, and that people are not getting their services all in one place. Most organizations are not able to provide all of those services and how to get to the place of providing the necessary care and services for the whole individual. She continues, that led to the conversation on the way to have effective care coordination between the various entities that a beneficiary is receiving services from, and the need for effective communication leading to coordination. She adds that sharing health information, data, and other types of

individual information enables a whole-person approach to care. There were some specific recommendations, and the Trust has been engaged in supporting some of this effort through partner initiatives, working with the Department in various ways. She states that the group felt that continued support for access to funding, technical assistance and training related to care coordination models was important. She moves on to the committee that was focused on reducing substance abuse. She states that the nature of the conversation covered some broad areas. There was recognition of the need to do more with earlier identification intervention and referral to treatments; expanding enhanced access to recovery support and interventions that could be approached in a number of ways. She continues that it could be actually funding supports for the individual to be able to access treatment directly, or it could be supporting models that bring those interventions into other settings.

MR. BOYER talks about the diverse group of folks at his table that represented State entities, some of the stakeholder associations, university system and beneficiaries. He continues that the primary theme was the direct service provider. He states that OCS was there and talked about the current state of affairs for them as a state agency with 52 or 53 open positions across the state. Those are the ones that are helping the children and families, the intervention. He continues that the subject of the Trust and how the role of the care provider in the state to the families, to the communities is marketed was also discussed.

MR. WELCH states that he was at the table that discussed reducing criminal involvement. His group was represented by people from UAA, the court system, juvenile justice, and CDVSA was also there. The primary thing identified is that beneficiary youth are overexposed to the criminal justice system, as victims or witnesses of domestic violence or whatever aspect of the criminal justice system. He continues that questions about how to come together and identify these kids was discussed, as well as coming together and identifying sequential intercept points for diversion or prevention.

MS. JOHNSON states that she was the Trust staff at the employment and peer-support table and had a nice contingency, cross-sector group that talked about everything from disability rights to Department of Labor, the barriers on the labor side to the criminal justice side, touching everything that was talked about in the other groups, but through the lens of employment. She continues that the main takeaway, as one of the primary barriers to employment for the beneficiary populations, is around perceptions and stigma, in addition to just pure miscommunication. One of the misperceptions is that if you work, the benefits for housing, food and healthcare will be lost. She states that the high-level recommendations that the group came up with around employment include implementation of the Employment First legislation that actually passed in 2014. There was a lot of discussion around barrier crimes and the policies that prevent some of the justice-involved from gaining employment. Also discussed was the lack of childcare, lack of transportation, and the need for flexible funding to support people in those areas to gain and keep employment. The final takeaway was the need to convene an employment summit. She states that in conjunction with the employment conversation was the discussion on peer support, which is a related but separate concept. Peer support is an effective therapeutic service that is paid for by Medicaid. She states that the recommendations included continuing working with the Department and others on policy development and the workforce

initiatives around peer support, standardizing training and obtaining credentialing to professionalize peer support, looking at what is working in other states and applying those lessons around peer support in Alaska.

CHAIR COOKE calls a break for lunch.

(Lunch break.)

CHAIR COOKE asks to continue.

MS. BARSTAD states that there was great participation about housing and long-term services and supports with representatives from the Division of Behavioral Health, the Division of Senior and Disabilities Service, the Office of Public Advocacy, as well as Alaska Housing Finance Corporation, the City of Juneau, and the Alaska Pioneer Homes. The overall consensus on housing was that the biggest challenge is the need for safe, affordable housing greatly outstrips what is available. She adds that the Alaska Housing Finance Corporation opened up their vouchers in Anchorage for two or three months in the spring, and when it closed there were so many applications that it will take them two years to address that need. She states that Trust beneficiaries have additional housing barriers with an overrepresentation of people with disabilities, in general, and specifically of the beneficiaries who are homeless and have that challenge. Also identified during the discussion were the special challenges in rural Alaska because homelessness does not look like homelessness in some of the cities. She states that there were a lot of conversations about really making sure that there was good information around long-term services and supports so that the complex system can be navigated to figure out what was needed.

MR. BALDWIN continues that a follow-up survey and reachout was done in those two days of meetings. There were 87 participants, which included staff and the three trustees that were there. He continues that about a third of the people that participated responded to the follow-up survey. The survey asked, on a scale of 1 to 5, for feedback on how satisfied they were with the overall process, and the average rating was 4.48. He adds they were pretty positive about the information and resources provided. He notes that the important thing is that sometimes people are intimidated with the Trust and do not feel comfortable in sharing. He continues that there was encouragement on continuing the focus and outputs in the area of workforce development. One thing asked for was to expand the diversity of the folks that were invited. He adds that they are in the process of summary documents of this meeting and will send that out and put them on the Web site as soon as they are available.

MS. BALDWIN-JOHNSON transitions into talking specifically about Medicaid reform. She states that Monique Martin, from the Department of Health and Social Services, is here to talk about the recommendation that was included in the budget.

CHAIR COOKE welcomes and thanks Ms. Martin, and asks her to proceed.

MS. MARTIN states that she is the health care policy adviser at the Department of Health and Social Services, and much of her time there has revolved around all things Medicaid expansion and Medicaid reform. She talks about Senate Bill 74 and touches on what that $10 million investment has really allowed the Department to do. She states that the initial investment from the Trust helped through the stakeholder engagement process around Medicaid redesign and what was needed to be covered. Then going through a large stakeholder engagement process, we all came together and helped to come up with a report. She continues, that report was the driving force behind a bill the Governor introduced for Medicaid reform, which goes hand in hand with Medicaid expansion. She adds that the report was produced as a part of the process that was a driving force around what was ultimately included in SB 74. An important part of the bill's passage is the trustees' commitment to fund the $10 million for reform; and she is certain that would not have passed without that support. She states that $10 million has given almost $20 million in reform at the Department; everything from some long-term non-perm employees to actuarial services. She moves on and highlights the impacts of those funds on everyday happenings. She states that one of the things coming soon will be a continuation of the weekly meetings with CMS on the 1115 waiver application and an ASO RFP will be released by the end of August. There is a public stakeholder meeting to allow the Department, providers, community groups and everyone to come to the table and talk about what has been learned about ASOs. The hope is for the result of a better response to those proposals and ultimately a better contractor. She continues that one of the other things that will be coming soon, due to the ability to have Milliman on board to do the actuarial services from funding from the Trust, is working on a budgetary impact. She adds that an important transition with the 1115 is moving from that reliance on a grant system to be able to get federal dollars as a match. There will also be some clarity provided so folks can really see what the impact of the 1115 is going to be. She states that they are working with their counterparts at the Department of Commerce, Community and Economic Development on licensing recommendations from the work group. In the end, the quality and cost effectiveness work group continues to meet.

TRUSTEE MICHAEL states that the Trust provided the money, but it would not have happened without the heart and soul that was put into it. She continues that she had never seen it at that level of the State, and thanks them because they are the power behind it and it is pretty remarkable.

MS. MARTIN replies that it has been exciting to work on and there is rarely a dull moment when talking about Medicaid reform at the Department.

CHAIR COOKE asks if the entire Medicaid program expansion is a product of the Trust's $10 million investment.

MS. MARTIN responds that, regardless of how Medicaid expansion got in our state, the impacts of the Department have been seen. Almost 44,000 Alaskans have health-care coverage under Medicaid expansion, the impact to the behavioral health system, and having more folks covered.

CHAIR COOKE states that the $10 million was invested over a three-year period, which is coming to an end. He asks if there is an expectation to ask the Trust for more, and if the State

able to take over the administrative costs that were the purpose of this funding initially.

MS. MARTIN replies that she did sit down and talk a bit about this budget ask before you and wanted to be conscientious of the fact that this was an incredible contribution by the Trust to Medicaid reform. She states that they want to not just keep this model rolling, but to insure completion of this discussion and commitment by the Trust, and we are thinking about not broadening the pool of asks to Medicaid reform.

CHAIR COOKE asks if the sunset idea still lives.

MS. MARTIN replies affirmatively.

TRUSTEE EASLEY asks what the Department is doing to investigate the legitimacy of applications from Medicaid.

MS. MARTIN responds that was actually part of Senate Bill 74, as well; to implement a third-party eligibility verification system that would look at applicants to make sure the income is right, and if they are the parent caretaker for children that they list. Another is the expansion population or parent caretaker for the age/blind/disabled population. She states that the CMS requires an asset verification test for those populations.

CHAIR COOKE moves to Part B.

MS. BALDWIN-JOHNSON begins with the budget spreadsheet on Page 4 under Medicaid reform and redesign. She provides a little background on some of the assumptions that were agreed to when putting these recommendations in. She explains that, at a prior meeting, some of the funds were redirected in FY19, and we calculated an estimate of what that was; roughly $1.75 million. She continues that we sat down with the Department and came to the agreement that any adjustments or recommendations in FY20 or ’21 would be within that threshold.

MR. ABBOTT explains that the initial Trust commitment was $10 million in three years, and that has morphed into $10 million over five years. The effort took longer than expected. Although almost all the $10 million was originally allocated, it was not spent. He continues that much of the money in FY17 and FY18 lapsed. That means that it was not used for that purpose. The recommendation in FY20, the balance of the $10 million be allocated in the four accounts, which includes money from FY16, ’17, and ’18. In FY19 there is more Medicaid reform money and we are assuming the Department spends all that was allocated to that. He adds, that leaves $1.75 million unspent from the original $10 million, and Trust staff recommends it be allocated for FY20. He states that the big benefit that the beneficiaries have received has already taken place, and that was Medicaid expansion. Some tens of thousands of Alaskans are now covered that were not.

CHAIR COOKE asks if the money is carried over, or is it deferred from these other budget years.

MR. ABBOTT replies that it is a bit of both. He explains that if it did not get spent in the fiscal years in which it was intended that it lapsed, it then would have rolled back into spending through the four-year averaging of the lapse. That is one of the revenue streams that counts toward Trust money. He continues that in FY19, '20, and '21, it would be new money. It still represents the same commitment. He adds that, in his opinion, too much money is lapsed. He states that staff is going to make sure that the money allocated actually gets out on the street and makes a difference.

A discussion explaining lapsed funds ensues.

CHAIR COOKE asks if there are any other questions about the details of the proposed budget as it applies to the Medicaid expansion investment. There being none, he thanks all.

MR. WILLIAMS moves on to do some final foundational work before going into the budget. He goes through a short history around focus areas for the benefit of trustees, new staff, and others who have not participated in the process. He states that, by regulation, the Trust has to do a two-year budget cycle. The first year in this cycle is an even-numbered year, and will begin '20. The focus for today and in September will be FY20. The FY21 budget is completed, basically, to satisfy the regulation.

MR. ABBOTT clarifies that there will be a '20 and '21 number, and that is what will be submitted to the State after the trustees endorse it in September.

MR. WILLIAMS states that a basic flat budget will be set, compared to FY19. He begins and walks through the major line items and then explains the columns as he goes through them.

TRUSTEE DERR asks, in consort with looking at the budget recommendations, if there a projected revenue.

MR. SMITH replies that there will be a projected revenue forecast during the Finance Committee. He gives a capsule summary that the outlook is positive and there will be a more detailed discussion on the different drivers during the Finance Committee meeting. He states that his assessment of the recommendations that are presented today is they are sustainable with the expected revenues for the coming year.

CHAIR COOKE asks why the General Fund/Mental Health money and others, such as AHFC money, are included in the Trust budget.

MR. WILLIAMS replies that, by statute, the board of trustees can make recommendations to the State on how it should be spending General Fund/Mental Health dollars. He adds that there are places in the budget that there are some Trust funding recommendations to be matched by State General Fund dollars.

(Telephone interruption.)

A short discussion ensues.

MR. WILLIAMS plans on going through the line items in the budget sort of chunk by chunk. He states that he will point to projects that have a slide, and the appropriate staff who is working on that project will speak to it. He adds that this is a collective effort, and we have some of the partners, plus other folks, on the line if additional information is needed. In FY18 there was a total of roughly $18 million in partnerships that all go out. He states that the recommendation for FY20 is to bump up the partnership grant line by $500,000.

A short discussion ensues.

MR. WILLIAMS moves on to the dental projects.

CHAIR COOKE asks how these dental projects come about and how the tribal system operates dental clinics that are located throughout the state in rural areas. He states that, in the past the emphasis was on preventative dentistry for children. He asks Trustee Boerner if she could talk a little bit about services for nonchildren in rural Alaska in dental clinics, and if there is a way to reach out and get to these folks.

TRUSTEE BOERNER replies that she would have to go back and look at that specifically. She states that adult dental services, as far as an optional item in the Medicaid program, has been critically important to the programs and is one area advocated to maintain throughout this entire process with the fiscal crisis and looking at the overall cadre of benefits that the State does offer. She knows it is a critical concern and will have to research it a bit more.

CHAIR COOKE asks how other dental providers in other parts of the state get grants and how do they know that there are grants available and then asks if there are grants available.

MR. LIND replies that a provider outside of Anchorage, Fairbanks could apply for a mini-grant program.

MR. WILLIAMS moves on to the mini-grant programs. The trustees have approved the amounts for FY19, and the FY18 breakout of mini-grants for the three beneficiary groups have been expended. He states that a beneficiary can apply once a year for up to $2500 and the applications are received on a monthly basis. He explains that there is a PDC, which includes the advisory boards, which reviews the applications, and then the applications are awarded to beneficiaries.

TRUSTEE MICHAEL asks if the $2500 amount is still a good number. The second question is that there were 300 people that were not able to be served, and should more money be put into this.

MR. WILLIAMS replies that he thinks the $2500 amount is probably adequate for now.

MR. LIND adds that if a mini-grant comes in over $2500, where it seems prudent to go over that,

it will be approved. That amount of money is used as a guideline.

MR. WILLIAMS moves on to the Trust statutory advisory boards and explains that these are the funding amounts given to each of the boards for research analyst, planners, operations. He goes over traumatic brain injury; Bring the Kids Home, maintenance and monitoring; then moves to consultive technical assistance.

MS. BALDWIN-JOHNSON highlights a couple of specific contracts included under this category and explains them in more detail.

TRUSTEE EASLEY asks if they have recommendations for either increasing or decreasing amounts on this and if this is the time to give that information.

MR. WILLIAMS replies that this is a great place to have the dialogue, because no final decisions are being made.

A short discussion ensues.

TRUSTEE DERR states that there was $150,000 in that budget and asked who got most of the $150,000.

MS. BALDWIN-JOHNSON replies that the current contractor is Agnew::Beck, and they have the contract to do the proposal development work. She states that they have been a primary consultant for this for years.

TRUSTEE DERR asks about the technical assistance for groups and who gets the majority of that money.

MS. BALDWIN-JOHNSON replies that is another contract and states that there are multiple contractors that are part of it. She continues that there is $360,000 available for that contract, and within that contract there are a number of consulting organizations that are part of that.

MR. WILLIAMS states that the next block is the data evaluation and planning block and asks for any questions on data evaluation and planning. After a few questions and clarifications, the budget presentation continues.

TRUSTEE DERR asks about the increase in rural and community outreach, and the discussion around that.

MR. WILLIAMS replies that this goes back to 2015, the last time the Trust did a rural outreach trip. He explains that this $200,000 would be used to plan and implement another rural outreach trip to a targeted region in FY21. He describes the rural outreach trips for the benefit of new folks.

TRUSTEE EASLEY moves to early childhood prevention and intervention. She states that she would like to see some more money go to that. She continues that early childhood has a more direct impact on the beneficiaries and was thinking of taking it from Alaska 211.

TRUSTEE DERR comments that before putting more money into this she would like to see what will be done with the $200,000 that was already put in there before increasing it.

TRUSTEE MICHAEL asks to consider changing Bring the Kids Home maintenance and monitoring to the early childhood prevention and intervention as its own line item since more focus has been placed on it. She explains that she is not taking the money out; just putting it in a different place.

A short discussion ensues.

TRUSTEE DERR states that there is $300,000 designated for emerging psychiatric service system. She would like to look at how that problem is evolving and adding perhaps more money. She explains that her general practitioner doctor has ended up lobbying for help with psychiatric services around the state the last two times she had appointments. She would like to look at putting more money into this area.

CHAIR COOKE calls a break.

(Break.)

CHAIR COOKE calls the meeting back into session and states that, before the break, Trustee Derr had raised a question about psychiatric services.

MS. BALDWIN-JOHNSON states that there will be more opportunity to discuss the crisis psychiatric service system issue tomorrow. There are multiple angles to that, and multiple partners engaged in those conversations, including boards and other stakeholders.

MS. JOHNSON talks more about the $200,000 identified in the budget for the system of care for children and families and for youth. She states the need on a state level in both the Maternal Child Health Program as well as the Division of Behavioral Health to increase the data analytics capacity, to provide planning for youth and the beneficiaries in general.

TRUSTEE MICHAEL asks if infant learning is federally funded.

MS. JOHNSON replied that it is largely federally funded. She states that there is a threshold of a 50-percent delay in two or more domains to actually qualify for that federal funding. She adds that a lot of states have reduced that eligibility threshold to 25 percent, so a lot of the at-risk children, age zero to 3 can be reached. She continues, that is not something Alaska has done to date, but there has been a lot of opportunities to be able to provide intervention for more children and youth, and at the level-of-care need, and they end up not getting any services until they are school-aged.

TRUSTEE DERR states that, thinking of the beneficiaries, the aged, the severe alcoholics, mental disabilities, and mental health, the whole discussion on prevention comes under only one category. She continues that early childhood does not affect Alzheimer's, severe alcoholics or developmentally disabled and is under one category of beneficiaries. She adds that the Department of Education is the Department of Education and Early Childhood. She has a struggle with this whole prevention thing and thinks that a discussion is needed on how the money for that area is categorized. She states that, as a group of trustees, there is a need to talk about how it does fit in. It does only fit with one, and adds that in the Trust's mission it talks about prevention.

TRUSTEE MICHAEL states that the conversation this morning put it into better context of the relationship to the parent, the early onset of trauma in babies. It could fall under mental health; it could fall under substance abuse; babies are born addicted.

CHAIR COOKE suggests not losing focus in walking through the proposed budget. He states that this is an area where it is proposed to allocate money, and simply to have a budget category available for proposals that may come along to address some of the issues that were identified this morning.

A short discussion ensues.

MR. WILLIAMS moves on to Medicaid and systems on policy development, home- and community-based Medicaid reform program.

MS. BARSTAD mentions that this has been a project that has been funded for a long time. She states that it transitioned from focusing on traumatic brain injury to looking at Medicaid reform. SDS has implemented a vast majority of their Medicaid reforms and has also implemented a Medicaid administrative claim for the position, and has incorporated it into their general staff.

MR. WILLIAMS moves down to increased capacity, training and competencies. He asks Mr. Boyer to continue.

MR. BOYER begins with some specifics on how the Trust funds are being utilized by some of these programs and talks about how it is working and actually impacting the beneficiaries around the state. He notes that Kathy Craft's position as the workforce director was funded and she has transitioned out and is full-time with the university. The theory of change has been talked about, and one of the results is that Alaska's workforce meets beneficiary and employer needs. He talks about the focus areas and the existing workforce strategies with a little more detail about the Training Cooperative and how the funds are being utilized.

CHAIR COOKE states that this is a million dollars, and he has heard from three different trustees that want to better understand why the Trust is spending a million dollars on the Training Cooperative.

MR. BOYER goes through the information, explaining as he went along. He moves to SHARP, Supporting Health Access Repayment Program, which is a federal/state and partner match to help folks who have education get repayment on loans, and is a program that has been in existence for several years in Alaska. He also talks about the Alaska Psychology Internship Consortium, and the change in the internship certification standards that the American Psychological Association implemented. The money is needed to have the Western Interstate Commission for Higher Education come in and help get over the hurdles of getting recertified. He adds, that project is ongoing through this fiscal year and then will end.

CHAIR COOKE asks about the assisted living home transitions and institutional diversion. That funding is being eliminated in the future budgets and asks if it is going somewhere.

MS. BARSTAD explains that this project was paired with the federal grant opportunity, the 811 project rental assistance. It was applied for several years ago and had delayed implementation. She states that it has been funded up through FY19, but past funds have not been able to be spent because the first transitions just occurred this year. She adds that there is adequate funding to be able to last through the duration of the five-year program.

MR. WILLIAMS states that $100,000 was reprogrammed into other areas of the budget, but not a line-for-line replacement.

TRUSTEE BOERNER asked where it was moved to.

MR. WILLIAMS replied that it got folded into the budget.

A short discussion ensues about the sunsetting of some of the programs.

MR. WILLIAMS states that the next grouping is home- and community-based services.

TRUSTEE DERR asks about ABIN.

MS. BARSTAD replies that the support to ABIN in their assessment clinics is continuing. She explains that ABIN has started an interesting project to bring assessment resources and clinical and neuropsychological resources to smaller communities in Alaska, to set up clinics to understand the prevalence, really addressing people's needs and assessing them on the spot because not everyone can travel to Anchorage or Fairbanks to get their needs met. She states that the resource navigator position project is ending in FY19. She continues going through the slides and explaining the budget lines and answering questions.

TRUSTEE DERR asks about Alzheimer's beneficiaries.

MS. BARSTAD replies that the Alzheimer's disease and related dementia work is just getting started and states the need to support this beneficiary group. She then talks about how this money will be used.

TRUSTEE MICHAEL comments that the providers have gone through trauma with all the changes in the system. She states that she is really proud of this group because rather than providers competing, they came together to figure it all out. They did all the work, with the Trust's contribution being small compared to the outcomes. She hopes that this works with other groups because it is a healthy thing to do.

MR. WILLIAMS wraps up the Medicaid and reform piece. He moves on to the criminal justice reform and goes through the process section by section. He states that the slides have a lot of good information around criminal justice reform efforts.

TRUSTEE MICHAEL states that she hears from the community that we are doing a better job at getting people out of prison or diverting them, but they have no place to go. She asks if there is something else that has to be done to help provide more services on the outside.

MR. WILLIAMS replies that there is money to provide access to substance abuse treatment services, but there is no workforce there to be able to put the money into play.

MR. RUTHERFORD states that he is the chief mental health officer at Alaska Department of Corrections and adds that it is a combination of both housing, which is always as issue, and then the stigma of being involved in the criminal justice system. He continues that there are a lot of difficulties in finding placement, especially for the more vulnerable populations, the severe and consistently mentally ill folks. He adds that finding housing for those folks in the community is becoming more and more challenging. He states that another challenge is in terms of treatment providers within the community; there are just not enough resources because of the workforce development issues.

MR. WILLIAMS moves to the next section, which is increased capacity training and competencies.

TRUSTEE DERR states that her comment is about adding $110,000 for training. She continues that in 2001 Anchorage was trained and 96 percent are still there; Juneau was trained, and they are still there. She asks if training will be expanded to other communities, and if people have to be retrained.

MR. WELCH replies that the expansion is expanding to the Department of Public Safety, then training within the Mat-Su Valley will be provided, and then also an expansion as far as the Juneau program. He continues that Juneau, as part of their crisis intervention team, CIT, is looking to partner with other organizations to bring in mental health professionals as part of that program. Being able to have the CIT training in the toolbox when responding to someone in crisis is a huge benefit to the beneficiaries and the officers in the state, in general.

MR. WILLIAMS moves to the next grouping; community prevention and then he moves to the community intervention diversion, serving the ACT teams, and then the next big section is facility practices, and he has pulled together a bunch of information on any of those projects.

TRUSTEE DERR states the need to put as much money as possible towards the mental health courts because those programs are working.

MR. WELCH begins with the Palmer Family Infant and Toddler Court, also known as PFIT. The first family who opted in this court was in February. The whole purpose of this court is to take families who are into the Child in Need of Aid process, CINA, with kids between the ages of zero and 36 months and working with those families to help them reunify and do so where the parents are able to get the help and support needed to overcome things such as substance abuse issues, mental health issues, and things of this nature.

MR. WILLIAMS adds that Mat-Su Health Foundation, Rasmuson Foundation, Casey Family Foundation, the State and the Trust are funding this project.

TRUSTEE EASLEY states that somewhere in the PFIT it needs to say that it is also for beneficiaries.

MR. WILLIAMS states that the next section is about areas around re-entry, he asks for any questions.

TRUSTEE SMITH states that the Juneau coordinator position is very effective. He continues that he would like to see someone come and share what their experience has been. He adds that those community leaders need to be engaged in their work, need to be in front of the Juneau Assembly, and need to have the members involved.

TRUSTEE DERR states that the trustees keep hearing about treatment and the lack of treatment facilities and then took out $500,000. She would like an explanation.

MS. BALDWIN-JOHNSON explains that the $500,000 reduction was moved over to the substance abuse and prevention treatment focus area. That money is not being eliminated from the budget; it was just relocated.

MR. WILLIAMS moves to the housing and long-term services and supports focus areas and goes through the slides and data. He states that this is where the housing and homeless coordinators will be found.

MR. ABBOTT states that the three-year commitment to the Municipality of Anchorage to fund Nancy's position will be completed. From FY20 forward, the expectation is that the Municipality will continue that funding on their own, and they are aware of that. He adds that they should be challenged to meet their obligation.

TRUSTEE DERR agrees, and continues that was firmly stated at the time that position started.

TRUSTEE MICHAEL states that she would rather have it in the budget and not use it.

MR. WILLIAMS proceeds going through the rest of the categories, explaining and answering

questions as they come up. He concludes with the beneficiaries employment and engagement focus area and explains the three items there.

TRUSTEE MICHAEL asks a general question about a substance abuse program where all the employees are recovering substance abuse users. She states that there is a successful program in Juneau called Haven House which got a lot of attention because of its success. She asks if there is any way to do some kind of incentive from the Trust to help re-create some of those kinds of situations.

MS. BALDWIN-JOHNSON replies that the Haven House Model appears to be successful and very highly thought of, and is a very well supported program. She states that the challenge is how to sustain it. Staff is working with the executive director, Kara Nelson, to understand what the operating requirements are in terms of the financial model, the partnerships, and what funding opportunities are available that support those types of organizations, specifically. A transitional housing recovery environment is what it is, and that is its own unique animal. She continues that the technical assistance contract is being used to help with that because there is the potential of replication of that in other places. She adds that the Community Foundation in Juneau has been supportive of it. She states that a majority of the drug and alcohol programs around Alaska do hire individuals that have their own history of addiction and recovery. It is kind of the standard practice. She adds that it is an opportunity to tie that question into the whole discussion of peer certification and how that is interfacing with the whole substance-use-disorder-direct-service-provider conversation which will be discussed tomorrow.

MR. WILLIAMS moves to the historical Trust BPI programs and the information about those from a budget perspective. It is a change from the way it has been presented before. He states that instead of having the lump sum of $1.4 million, it was broken out to show how that $1.4 million is being allocated to the various programs there.

MR. ABBOTT explains that by calling them out individually, they will not have to be brought back for individual grant allocations later on. He states that these were considered and approved for FY19. He continues that, if approved, when reviewed in September, then at the beginning of FY20 the grants staff will start the process of setting up FY20 grant agreements with these six organizations. He adds that it will just save a step of having to make another decision later on. He states that nothing else will change and will continue to provide performance information on them just as it is done currently.

MR. WILLIAMS states that the next category is beneficiaries increase self-sufficiency with social enterprise and microenterprise, and gives a quick overview of both. He then continues on to the last category: focus area administration.

MS. JOHNSON explains that this goes to the Governor's Council on Disabilities and Special Education and is to support the efforts that are specific to this focus area. That is to provide technical assistance, outreach, support around various legislation being enacted such as the supported decision-making agreements which was part of last session. The Governor's Council provides leadership in this area across beneficiary populations.

CHAIR COOKE states that the agenda calls to reconvene tomorrow at 8:30, and the meeting stands in recess.

(Alaska Mental Health Trust Authority Program & Planning meeting recessed at 5:00 p.m.)

ALASKA MENTAL HEALTH TRUST AUTHORITY

PROGRAM & PLANNING COMMITTEE
Volume 2

August 2, 2018
8:30 a.m.

Taken at:
Alaska Mental Health Authority
3745 Community Park Loop, Suite 120
Anchorage, Alaska 99508

OFFICIAL MINUTES

Trustees present:
Chris Cooke, Chair
Mary Jane Michael
Carlton Smith
Laraine Derr
Paula Easley
Verne' Boerner

Trust staff present:
Mike Abbott
Steve Williams
Miri Smith-Coolidge
Kelda Barstad
Andy Stemp
Luke Lind
Michael Baldwin
Carrie Predeger
Katie Baldwin-Johnson
Jimael Johnson
Valette Keller
Eric Boyer
Travis Welch
Autumn Vea

Also participating:
Kathy Craft; Brenda Moore; Pat Sidmore; Adam Rutherford; Alison Kulas; Denise Daniello; Kristin Vandagriff; Patrick Reinhart; Lesley Thompson; Randall Burns; Gennifer Moreau; Nancy Burke; Dr. Richard Mandsager; Sam Kruse; Jake Segal; Andy Geer; Laura Brooks; Cliff Reagle; Dan Aicher.

PROCEEDINGS

CHAIR COOKE states that six trustees are present, and asks for any additions to the agenda or any other matters that need to come forward. There being none, he asks Mr. Williams to continue the budget proposals for FY20 and '21.

MR. WILLIAMS begins with the last two pages of focus areas and asks Ms. Baldwin-Johnson to continue.

MS. BALDWIN-JOHNSON talks about the Recover Alaska partnership. She states that Recover Alaska is a cross-sector collaborative coalition of grass tops that sits at the table. This group was formed to try to create and impact lasting change in Alaska to try to mitigate the harmful effects of alcohol abuse in Alaska. She identifies the partners and the successes that have been worked on. She asks for any questions.

TRUSTEE SMITH states that he is aware of the statewide media and asks what the horizon was that was envisioned in the program.

MS. BALDWIN-JOHNSON replies that it is an initiative that folks are hoping that Recover Alaska is going to be around, and sunsetting it has not been discussed.

MR. ABBOTT adds that Recover Alaska has not been established as an independent corporation. He explains that it is an initiative, a funded group, that lives within a fiscal sponsor called Sultana, which is an arm of the Foraker Group. He suggests that it will be around for a while.

CHAIR COOKE understands that it is a consortium and the Trust is not the only funder.

MR. ABBOTT states that Mat-Su Foundation, Southcentral Foundation, and the Rasmuson Foundation are all putting in about as much or more than the Trust is. He adds that there are State contributions, as well. He continues that Recover Alaska's budget is between a half million and a million dollars a year from those different streams, and the Trust is about a $100,000 contributor.

CHAIR COOKE asks if they can also act as a bridge between service providers and resource people who deal with treatment and funding sources such as the Trust.

MR. ABBOTT replies that they can, and they do bring people together. The operations board includes substance abuse treatment providers, as well as entities like the Trust.

TRUSTEE EASLEY states that in the past few years, about 250 people were lost to drug abuse overdoses. This is a serious problem, and she is wondering if there is any extra money that could possibly be reallocated for FY19 for substance abuse treatment access.

MS. BALDWIN-JOHNSON states that the demand and the need exceeds the current resources. She continues that more money can always be put into this, and we might want to think about

this in terms of all of these types of efforts that are moving forward and getting recommendations that are specific to the strategy.

CHAIR COOKE moves on to focus area administration.

MS. BALDWIN-JOHNSON states that is the general administration funds that facilitates the work for staff, and it is actually a decrease.

MR. WILLIAMS moves to the Disability Justice focus area and states that the Office of Public Advocacy, particularly the guardians and staff who support them, presented an overarching plan that would allow the caseloads to come from a little over 100 down to where the national level is. He asks Travis Welch to talk about that.

MR. WELCH states that this position will focus on Bethel, Dillingham, and the communities and beneficiaries who live in those areas. He continues that it will be an Anchorage position, due to hiring and training issues, and the guardians will travel to those areas.

TRUSTEE DERR asks why this is not in the whole criminal justice area.

MR. WILLIAMS replies that, for September, there will be a different way that this information is presented. He continues that this is part of the Office of Public Advocacy's plan and there are several positions that the Trust is helping in an incremental way; the other way is to advocate when they go before the Legislature for increased funding for positions.

CHAIR COOKE recognizes Alison Kulas.

MS. KULAS states that the advisory boards worked together to put together some recommendations looking at the overall budget request, and she asks Denise Daniello to continue.

MR. DANIELLO states that, on behalf of the four advisory boards, she will present the joint capital budget recommendations for FY20 and '21. She continues that there are a total of four budget recommendations, and these grant funds are available to agencies that serve at least one of the Trust beneficiary populations that include people who experience mental illness, intellectual and developmental disabilities, chronic alcohol or drug addiction, Alzheimer's disease and related dementias, and related brain injuries. She states that the first recommendation is the deferred maintenance and accessibility improvement program. This has been an ongoing program of the Department of Health and Social Services Facilities Section that administers these grant funds. She continues that they are provided through a competitive process of the agency serving Trust beneficiaries and are able to have the resources to make improvements and repairs to ensure the health and safety and accessibility of services for recipients. She states that the Department has five years to award these funds for deferred maintenance. She continues that budget recommendations are made every other year, and for this program it is for even years. She states that, for FY2020, the recommendation is of $250,000 MHTAAR and $250,000 GF/MH to the Department to help agencies make those improvements. She adds that the maximum grant for this program is $50,000, and matching

funds are not required, but are strongly encouraged. The Department Facilities Section awarded deferred maintenance grants to 13 agencies, with a total of $607,947 awarded. According to DHSS Facilities, the projects that received funding this year included roof repairs, bathroom accessibility modifications, electrical upgrades, plumbing upgrades, fire suppression systems, upgraded lighting, an acceptable entrance ramp, some repairs on parking lots, floor repairs and other types of projects. She continues that there were 22 applicants that did not receive awards because of insufficient funding. She moves to the next recommendation, which is for medical appliances and assistive technology. This one is for both FY2020 and 2021, and the recommendation is for $500,000 GF/MH. Pending legislative approvals, this funding will help to expand access to such things as pocket talkers, white canes, hearing aids, dentures, automated medication reminders, motion sensor, lighting to help prevent falls, GPS location and tracking devices such as smart phones and watches, and other types of devices. She asks Mr. Reinhart to continue.

MR. REINHART discusses coordinated transportation funding, stating that last year there was $1 million in GF/MH and $300,000 of MHTAAR funding put into this. He continues that the requests that come in for those dollars is much more than is available. He adds that it was discussed to recommend additional funding for this area. He states the need to distribute this funding so there is a bigger bang for the buck and has more flexibility. He continues that communities need to have flexibility because there is no good transit program.

MS. DANIELLO moves to the final capital budget recommendation, which is for the essential program equipment. This is another ongoing program of the Department of Health and Social Services that is administered by Financial Management Services. She states that the recommendation is for zero funding for FY2020 and $250,000 MHTAAR and $250,000 GF/MH for FY2021. These funds are awarded on a competitive basis. Agencies apply and there is a proposal evaluation committee that makes funding recommendations. She continues that these are typically small grants, up to $25,000 and, like deferred maintenance, while matching funds are not required, they are strongly encouraged. She adds that technology is not covered by Medicare, Medicaid or most private insurance, so people with low income do not have funding for those types of devices.

CHAIR COOKE asks if that finishes the budget.

MR. WILLIAMS replies affirmatively. He has taken a few notes for the next steps in preparation for the September board meeting, and goes through them with the trustees to make sure that is what they are looking for. He continues that if there are any other things to bring forward, he asks that it be emailed so staff has time to put it all together.

MR. ABBOTT states that the next time the budget will be dealt with officially is at the September trustee meeting. One of the primary tasks of that meeting will be the adoption for the FY20 and ’21 budgets. He continues that the statutory requirement is to submit that by September 15th. He adds that the Trust operating budget and then the TLO operating budget would be presented, and a motion to adopt will be made. He continues that there would be a discussion about any potential amendments, and then a final action.

A brief discussion ensues.

CHAIR COOKE thanks staff for all the work that went into this effort and calls a break.

(Break.)

CHAIR COOKE reconvenes the meeting, and moves into the section of developing projects.

MR. ABBOTT states that there are a couple of things that staff has been hearing about that are of interest to the trustees. He asks Randall Burns to continue.

MR. BURNS states that he is just back from attending the National Association of State Mental Health Program Directors where there was a lot of talk about the strategies around mental health and substance abuse on a national level. He does mention that, after two years, a deputy director for the Division has been found, Gennifer Moreau. He adds that Brian Fechter is the head of the research and systems section who was the economist for the Office of Management and Budget in the Governor's Office. He continues that the National Association of State Mental Health Program Directors, NASMHPD, complimented Alaska for its 1115 application, and adds that its vision is very similar to many of the national goals that are before NASMHPD and SAMHSA. He states that the focus of the meeting was on the continuum of care, and he shares copies of four of the presentations. He continues to the real need for crisis treatment and stabilization in the communities, mobile teams and ACT teams, and the need to address the homeless, mentally ill population. He adds that, finally, and most importantly, they talked about behavioral health workforce shortages, combined with the need to help persons with mental illness and substance abuse to find employment if they really want to work. He states that all of this is familiar, and is being worked on, and that it was good to have this confirmed. He continues that there was also conversation on the real need for crisis treatment and stabilization in the communities, mobile teams and ACT teams, and the need to address the homeless mentally ill population. Finally, they talked about behavioral health workforce shortages combined with the need to help people with mental illness and substance abuse find employment if they want to. He states that '20 and '21 fiscal years are going to be huge and complex years for the mental health and the behavioral health systems. He stresses the importance of planning in advance with budgets, and he has no idea what will happen as the 1115 is rolled out and the work to get these programs into each of the regional hubs begins. He states the importance of thinking about funding around crisis stabilization plans and programs. He mentions that besides the ACT team in Anchorage, they applied with JAMI in Juneau for the creation of an ACT team in Juneau. He continues that Juneau is a rural community and is hoping the application made a good case for this ACT team. He adds that the ASO will finally be a reality in 2020, and states the need to talk about what may be needed to do the support, that rollout over the first year. He spends some time talking about the discussions at the NASMHPD meeting and their pertinence to the Trust. Seven goals were adopted using three criteria: It had to be achievable with some previous success and private support; had to be measurable; and had to be far-reaching, covering youth, adults and families. The seven goals are: early screening; access to effective medication and other evidence-based therapies for individuals with psychiatric conditions; compliance with legal requirements for healthcare networks to make the full continuum of psychiatric care available; access without delay to the most appropriate 24/7 psychiatric emergency, crisis stabilization, inpatient or

recovery bed; diversion from arrest, detention or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected; homeless people with serious mental illness permanently housed; and the last goal was that 100 percent of suicides be prevented. He goes through some of the slides and thanks the trustees for their time.

CHAIR COOKE asks for any questions or comments.

TRUSTEE MICHAEL states that it was refreshing to see, looking at national projects, that boundaries are not needed in the approaches. She continues that just by changing the mindset about the sensitivity and levels of medication can be the simple things that change the whole paradigm. She asks if there are any updates from the architects on API and that whole reassessment.

MR. BURNS replies that there are two different approaches that would get up to 28 beds, and that information and report is being planned for September.

TRUSTEE MICHAEL asks about a respite center.

MR. BURNS replies that Providence does still run the crisis respite center and has eight adolescent beds and eight adult beds.

TRUSTEE BOERNER thanks Mr. Burns for the presentation and appreciates the materials from the national meeting. She states that in moving forward hand in hand as partners in addressing the crises that are in the communities, his message is spot on with regards to remaining nimble and being able to respond. She thinks that Alaska has been a great model for stretching and stepping forward in that and looks forward to working through this process.

MS. BALDWIN-JOHNSON asks Mr. Burns to briefly highlight the $12 million for SUD-related treatment.

MR. BURNS states that the focus will be on withdrawal management, detox in Anchorage and Mat-Su. He continues that the unknown is the commitment, and we are thinking of two programs; somewhere around $3 million of the $12 million would be committed to the withdrawal management facilities. Also, there is a commitment to some additional residential treatment beds. He adds that we are leaving up to $5 million for a crisis stabilization facility in Anchorage, and we are not making this grant-based. The RFP will be a contractual one to see if anyone wants to see this. There may be for-profit entities that are interested in providing these services, as opposed to grantees.

TRUSTEE EASLEY states that Portugal has done a unique program of decriminalization of substance abuse which some states have modeled their programs after. She asks if there is any possibility of Alaska moving toward decriminalization.

MR. BURNS replies that this was the goal of what DOC is doing now, but there is still the need for more treatment programs.

TRUSTEE SMITH thanks Mr. Burns, and states that he is supportive of the trustees going out and seeing some of these facilities.

CHAIR COOKE asks about indications of when the 1115 waiver application will be acted upon.

MR. BURNS replies that the calls to CMS continue on a weekly basis, and we should be talking about it in a few weeks.

CHAIR COOKE asks what the timeline looks like.

MR. BURNS replies that they are looking at sometime by the end of the year, and we want the SUD application to also be completed by the end of the year.

CHAIR COOKE states that there is no current comprehensive mental health plan. The trustees talked about the need for updating and having a current plan and asks, from the Department's standpoint, when that may occur.

MR. BURNS replies that the Department has committed to working with the Trust staff on moving forward. He states that it is a huge undertaking, and his suggestion would be to work on it.

CHAIR COOKE moves to the Pay for Success presentation.

MS. BURKE states that she is with Mayor Berkowitz's office and is the housing and homeless services coordinator. She introduces the others on the team. She continues that the topic of the project is homelessness in Anchorage and is an overlapped area. She adds that the mayor's initiative in the first three years has brought together a cross-sector group of participants to support the needs of people who are falling through the cracks in the community. She states that the area she has been most involved in has been around adults who are single or couples who are homeless and have higher needs for mental health and substance use treatment services. Over the course of time, the mayor has recognized that if all sectors of the community are not engaged, then relying on one or two payor resources does not work. She continues that the mayor is supporting a broader team to reinforce and energize the community plan to end homelessness. She introduces Mr. Mandsager, a senior fellow with the Rasmuson Foundation, who will help roll out the strategic plan in the next phase of this work in Anchorage.

MR. MANDSAGER states that he recently retired as a hospital administrator over at Providence, and then started conversations with Rasmuson about ideas about helping with incentives to inspire more funding sources, investment, and analysis to help the system work more efficiently and effectively, and to recognize some of the gaps in system design and in services.

MS. BURKE states that the mayor's approach over the first term was to bolster the community system for finding people, getting them connected to housing resources, and helping staff with success in the community for community-based living. She continues that it was here that Housing First was given the resources to test in Anchorage, Fairbanks, and now Juneau. It is a very exciting project that appears robust and is moving forward nicely. She adds that Housing

First has been used across many different contexts based on the work the Mental Health Trust Authority did and looking at it in terms of how to move a system to a Housing First-focused system has been the real challenge. She explains the process that was developed in greater detail. She summarizes that the homeless in Anchorage are the beneficiaries of the Mental Health Trust Authority and the community is going forward with a strategic plan that will incorporate and embrace this project. She turns the presentation over to Social Finance.

CHAIR COOKE asks Ms. Burke to give some background on the next presenter.

MS. BURKE explains that United Way is the project sponsor and intermediary; and Agnew::Beck has been invaluable in helping with the feasibility study. The Anchorage Coalition to End Homelessness is the broader planning home for projects like this. The Corporation for Supportive Housing is going to be working on resources and adjustment of the service side of things. And Social Finance is an organization whose special niche is working in social impact bond projects or Pay for Success across the country. She continues that they are here to develop the finance side of the transaction and help set outcomes with the payors. Jake Segal is the lead for the organization.

MR. SEGAL states that he is the vice president at Social Finance, which is a nonprofit with offices around the country and different communities to help put together Pay for Success projects. He continues that a lot of nonprofit leaders are talked with who have two pretty different jobs: one is to go out and accomplish the mission, do the things that they said they are going to do; and the other way is to go out and raise money. He adds that, often times, their payment and performance are not well-linked. He states that at the same time, the philanthropic partners talk about the policy gap that is seen. Really great programs are identified and tested, and very rarely are those programs integrated into sustainable government funding streams to bring them up to scale. Much of the time the governments that are kind of core partners have tough budget challenges. He continues that Pay for Success is a mechanism that tries to shift from a fee-for-service funding model to trying to fund an outcome stage funding model. The way it works is parties base outcomes into success, how to measure them and put a price on how valuable each outcome is. These parties are bound together -- the government, the funders and the nonprofits -- in to a performance-based contract. He states that they have 21 of these projects around the country, and about 110 worldwide. One that is similar to what is being explored in Anchorage is a developing project focused in Austin. He continues that this is a multi-year contract and is looking out over five years in order to fund the services for increasing permanent supportive housing in the Austin area. It is looking to expand it by 200-250 units, with outcomes that range across housing stability, but also to increase healthcare utilization and improve recidivism, actually reducing returns back to jail or prison. He adds that the total size of this project is a little over $15 million in terms of outcomes payments that may be made if positive outcomes are actually achieved. He states that homelessness is an incredibly complex issue and one of the challenges is that complex is very diffuse. He continues that the project in Austin, as with this one in Anchorage, brings together the city, the county, and also a handful of healthcare funders who have agreed to pay for these better outcomes to the extent that they are actually achieved. He moves on to the timeline and explains that over the last few months the transaction structure and process has begun. He states that the different parties have been identified, and we are in the middle of the process of the structure of the project and how to make the financing

work. He continues that the team will be in town about a week a month for the foreseeable future, and they will try to push this forward. He adds that he is excited about the possibility of expanding permanent supportive housing in the community.

MS. BURKE states that the exciting thing about Pay for Success is that it really moves an entire system, and we will be looking at the entire system of support for community-based services for people in the high-need categories. She explains that it is not project by project because the struggle is looking at doing a 50-unit project here and another one there. She continues that the scale of the community needs or the parts of the system that are weak, where the people are falling through is never looked at. She adds, that allows the money upfront to fully implement a robust model and then trace it back and work with each outcome payor on where the system needs shoring up, and fixing it.

TRUSTEE MICHAEL asks about the finances and if they need to be paid back.

MS. BURKE replies that the projects are outside of this Pay for Success contract, and the resources are needed for the outcome. She states that capital costs or units will be a separate calculation that will happen in parallel with the project, because without units and rental resources, a foundation for the project, it will not be feasible.

MR. SEGAL explains that there are two different funding flows being thought of, and one is the folks who provide the upfront capital. Up front they get paid back to the extent that all the outcomes are achieved by outcome payors, or the State.

TRUSTEE BOERNER states that there are upfront costs, and it seems like those are the ones absorbing the performance risk because if the outcomes are not achieved, then the payors do not come back and pay.

TRUSTEE DERR states that she is trying to understand the difference between a payor and a funder.

MR. SEGAL states that funders are the organizations, high-worth individuals, community development financing. They provide the upfront working capital for the intervention, and take on the performance risk of whether that actually gets achieved. He continues that outcomes payors are often the governments or collection of government health organizations that are trying to achieve a given policy aim and agree to repay those funders to the extent that positive outcomes are actually achieved over the course of time.

MS. BURKE gives an example and states that in the Municipality of Anchorage there is a contract that provides resources to pick people up who are intoxicated. It is the Anchorage Safety Patrol, and then there is the Anchorage Safety Center. She states that it is a success because of the focus on that list, and then housing people who hit that sleep-off center repeatedly. She continues that if this project is successful it may be one of the outcome payors when not as much money is needed to continue the services.

DR. MANDSAGER states that there is an opportunity in recession with the availability of more rental units. It turns out that this can be launched and get people into housing. Another example is hospitals. There is a possibility, if hospitals can discharge people that are homeless quicker and reduce the uncompensated care, there is the possibility of negotiation. He explains that Mr. Segal's expertise is in negotiating with different entities that want some outcome and are willing to negotiate a dollar value.

A short discussion ensues.

DR. MANDSAGER states that, at this point, the two largest hospitals, not the Native hospital, have a great interest and want to talk.

TRUSTEE EASLEY states that she has heard comments that many homeless people come from other areas of the state to Anchorage because they know they will be taken care of. She continues that this is not just an Anchorage problem, but also a state problem. She asks if there is a possibility of the State recognizing this or the Legislature recognizing it and being willing to put more money into the situation for Anchorage.

MS. BURKE replies that the State understands those needs and is engaged. Corrections is a main partner on this project. She adds that this is a new concept for the community.

CHAIR COOKE thanks Ms. Burke for the presentation.

MS. BURKE states that the team will be in town the week of August 13th, and if there is an opportunity for a specific work session, she would be pleased to do that in person.

CHAIR COOKE states that an update will be provided on the issue of the Hiland Mountain Women's Health Mental Health Unit, and asks for an introduction.

MR. ABBOTT states that staff has been talking to the Department of Corrections for several months on this project. He adds that the PowerPoint was distributed during the last break, and the trustees may follow along.

MS. BROOKS states that the Health and Rehabilitation Services Division oversees the mental health unit or the mental health section for the Department of Corrections. She introduces April Wilkerson, director of administration, and Adam Rutherford, the chief mental health officer for the Department. Also from facilities and management is Cliff Reagle and Dan Aicher. She states that the Department of Corrections is the largest provider of mental health services in the state. There are about 21,000 direct-care contacts annually in 11 facilities from Nome to Ketchikan. She continues, that number continues to rise, almost 20 percent in the last ten years. She adds that this is a population that, unfortunately, continues to come with more and more dually diagnosed individuals in the system. The addition of some of the street drugs, synthetic drugs, the spice, heroin, and now the prescription medication and the opiate crisis has further complicated the psychiatric needs of this population. There have been a number of opioid-related overdoes in the system. The number of individuals who withdraw and go through serious medical withdrawals within the system is also growing in tandem with the population and the

incidents in the community. She states that there are no beds available for women to detox, and this is the fastest growing section of the female population. She adds that this is today's focus: that female population. She explains that this project is looking at a new mental health unit for Hiland Mountain facility, which is the women's facility. She continues that this project is essential in the efforts to continue to aid these women, stabilize them, and provide treatment in a safe and therapeutic environment. She adds that the female Trust beneficiaries in the system represent about 30 percent of the beneficiaries overall in the system. About 65 percent of the population overall are Trust beneficiaries. She states that, on any given day, there are 840 women, female beneficiaries, receiving care in the system, and that number continues to grow.

MR. RUTHERFORD states that he is chief mental health officer for the Department of Corrections and reiterates the tremendous increase in the more acute mental health services for the females. One of the results is that more and more of the female beneficiaries awaiting acute care end up in segregation environments. He extends an invitation for the trustees to come out and visit the unit. He states that it is important to be able to see the environment that mental health services are provided and where the beneficiaries are being served. He adds that he has a staff that is very passionate about providing care and advocating for the severe, persistently mentally ill, the beneficiaries that are served. He goes through his presentation and talks about the huge movement and litigation associated with placing mentally ill folks in segregation. One of the reasons we are here today is because we do not want mentally ill beneficiaries placed in segregation. He states that the current mental health unit is housed in a unit that is adjacent to segregation. Because there is such a demand for the acute mental health unit, there is often an overflow into that segregation environment. He talks about the state of emergency related to the opioid-related incidents and the impact it has had on this system. It is also important to realize that the alcohol problem did not go away and is still a major concern within Alaska, especially with the populations that are coming in and detoxing within the system. He adds that the Alaska Department of Corrections is one of the largest detox units statewide. There are more females coming in and using, and there is a need for female detox. He states that Hiland Mountain was not designed to have a detox unit, and the females are being detoxed in a male infirmary unit. That means that the Department is not providing the equal services or options to its female population that is being provided to the male population. He adds that detox is being provided, not just in an environment designed specifically for the female population.

MS. BROOKS states that the issue is people think there is more to offer than there really is. She continues walking through what this unit looks like. She adds that this unit is always full, always over capacity, and it is time that is addressed.

MR. RUTHERFORD states that it is important to know Corrections, in general, shifts in terms of how it manages its population. 21 years ago, this was the cutting edge and how folks and the mentally ill population was being managed in Correction. Now, there is a lot of litigation that is saying the environment needs to be more therapeutic; more like a treatment unit. And we agree 100 percent. The ultimate goal is to modify that environment and make it more conducive to actually providing treatment to beneficiaries.

CHAIR COOKE asks if the proportion of people with severe and persistent mental illness is the same among the male residents.

MR. RUTHERFORD replies that he is not sure and will get that information and pass it through to staff.

MS. BROOKS states that it is known that the female beneficiary population is growing more quickly than the male.

MR. RUTHERFORD continues explaining the situation and the crowded conditions in the unit. He states that there is no direct line of sight for the nursing staff working on that unit, and there are only a few cameras to monitor those individuals.

MS. BROOKS states that the individuals that come in from the rural communities have to wait in Bethel, in Nome, in Fairbanks, in Ketchikan, in segregation, while waiting for a bed at the Hiland Mountain women's mental health unit to open up. She continues that this is the plan developed to remodel an existing area at Hiland Mountain and move both the mental health unit and the medical unit. She adds that the goal is a more therapeutic environment, much more conducive to stabilization.

CHAIR COOKE asks if this is an active or live proposal to the Trust.

MR. ABBOTT replies that a funding decision is not being recommended today. He states that the Department is hoping that a funding decision will be made in the near future.

MS. WILKERSON states that this has been a project for the Department of Correction for about five years, and we hope, with the Trust's commitment and support, to move this forward into the FY2020 budget. She continues that it will take about 12 to 18 months to complete, and the overall project costs are just over $3.9 million. To date, almost $300,000 has been invested.

TRUSTEE EASLEY asks if this has been brought before the Legislature.

MS. WILKERSON replies not at this time, and we have had those conversations with the Governor's Office. It has not met the priority list. She states that over the last three years, the Department of Corrections has only been able to receive deferred maintenance for the capital projects; and were able to get a security funding out of Bethel because of the escape. She continues that if they partner with the Trust, this would be considered a deferred maintenance project. That conversation has not be had with the Governor's Office at this time.

MR. ABBOTT asks, if the Trust provided some funds, how would the State contribute the balance of the funds.

MS. WILKERSON replies there are two options: there is the need to talk to the Governor's Office and to the Legislature. She states that their goal is to try and identify the resources and to get the approval to start this project now rather than later, and seek any supplemental funds through the Legislative process, allowing this project, and have it completed by the end of the calendar year of 2019.

TRUSTEE SMITH asks for a bit of time to give the site selection history of Hiland Mountain and what the original concept was.

MR. REAGLE states that he is the facilities management section chief and, as of yesterday, he retired and is here on his own time. He introduces Dan Aicher, who will be taking over this project. He explains that Hiland Mountain was built in 1972 as a men's facility, and was not really built for the application used today. It was a segregation unit, an old archaic design which has morphed into where this is today. He states that five years ago the director recognized the need and wanted something done. Plans were started to find out if the infrastructure, support, mechanical, electrical and all that would support it. It was proved that it will in that space, and a big cost of this was done. The design and redesign was done with Steve Fishback's help, and it has morphed into what it is today, a very comprehensive, cohesive unit. It has been quite a journey.

CHAIR COOKE asks about the ongoing litigation and what the scope of it is.

MS. BROOKS replies that there are two different types of litigation; one on the national level. The ACLU and the Disability Law Center have focused on correctional facilities and the segregation issue, and the Disability Law Center comes in when it is the mentally ill who are in segregation. There are two cases where the family members of female offenders died in our custody during withdrawal.

MR. RUTHERFORD mentions that, because of litigation that has been happening in the Lower 48, a more proactive approach with the ACLU and the Disability Law Center has been taken.

MR. WILLIAMS adds that this is an expansion of an existing footprint; it is not a full-blown adding space that is not already there. He states that the other thing the Department of Corrections has indicated, that no additional operating costs for the staffing will be needed.

TRUSTEE MICHAEL refreshes everyone's memory by reminding them that a presentation and requested assistance was made about a year ago. Staff was asked to go back, help with the predevelopment, figure out what was possible, and come back with a recommendation. She states that a terrific job was done in being prepared, and we like the design. She adds that this is a good project and thanks all for the effort put into it.

TRUSTEE DERR makes a motion to adjourn the meeting.

TRUSTEE MICHAEL seconds.

There being no objection, the motion is approved.

(Alaska Mental Health Trust Authority Program & Planning Committee meeting adjourned at 12:25 p.m.)

Comprehensive Plan to Promote Independent and Healthy Alaskans

Plan Vision: Alaskans receive comprehensive prevention, treatment, and support services at the appropriate level of care across the lifespan to lead to meaningful lives in their home communities.

Authority for Plan: Alaska Statute 47.30.660 requires the Department of Health and Social Services, in conjunction with the Alaska Mental Health Trust Authority, to develop and revise a plan for a comprehensive integrated mental health program for Alaska. Under the statute, the preparation of this plan is to be coordinated with federal, state, regional, local, and private entities involved in mental health services.

Purpose of Plan: The purpose of this Comprehensive Integrated Mental Health Plan (Comp. Plan) is to guide resource allocation decisions in the development of services, workforce, and facilities to meet the needs of Alaskans who have a severe mental illness, a developmental disability, experience chronic alcoholism or Alzheimer's disease or related dementia or have experienced a traumatic brain injury. The overall goal is creation of a service system that quickly meets the needs of each individual, where highly qualified staff from state, federal, tribal and private agencies have the resources necessary to work together to provide seamless care for the best outcome possible for each person. Another goal is to reduce the incidence of disabling conditions through prevention and early intervention.

This Plan is coordinated with other plans addressing specific services developed by the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Governor's Council on Disabilities and Special Education, the Governor's Advisory Board on Alcoholism and Drug Abuse, and the Alaska Commission on Aging.

Target Population of Plan: The Comp Plan has a vision to provide comprehensive services across the lifespan, especially for those Alaskans who receive services under the Comprehensive Mental Health Program (AS 47.30). By law, these service recipients (also called Trust Beneficiaries) are Alaskans who have a mental illness, or a developmental disability or who experience chronic alcoholism or Alzheimer's disease or related dementia, or have experienced a traumatic brain injury. Efforts include prevention, to the extent possible, of these disabling conditions. Since prevention is the surest way to limit human suffering and is usually the least costly strategy, the Plan also addresses prevention efforts.

I. Goal: Invest in early childhood programs that address trauma, promote educational attainment and provide access to early intervention services.

Early childhood social emotional development underlies all areas of development. Brains are not born; they are built throughout childhood, with experiences and interactions creating lifelong foundations. Effective primary preventative programs and early identification decreases future high-risk behaviors and their associated costs by reducing the impacts of Adverse Childhood Experiences (ACEs). Supporting caregivers, including the high number of grandparents caring for grandchildren, is vital in the success of this goal.

1. Objective: Promote evidence based universal screening efforts and early intervention services for Trust beneficiaries.
    a. Strategy: Develop a statewide outreach campaign which makes developmental screenings a normal part of the well-child process for all Alaska children.
    b. Strategy: Utilize a centralized hub for developmental screening with a standardized developmental screening tool (such as Ages and Stages Questionnaire/ASQ).
    c. Strategy: Provide training and technical assistance on trauma-engaged strategies for early childhood providers to assess children for service needs.
    d. Strategy: Promote training for pediatricians in a tiered screening process for neurodevelopmental disabilities.
2. Objective: Provide ongoing support to ensure accurate identification of social-emotional and maternal health needs for children and their care givers.
    a. Strategy: Develop and provide common guidance to childcare and preschool providers supporting young children and their caretakers.
    b. Strategy: Ensure access to trauma informed services for children and their caretakers.
    c. Strategy: Provide training on social-emotional development to early childhood providers.
    d. Strategy: Support programs in having qualified staff representing diverse cultures & disciplines.
    e. Strategy: Increase access to National Family Caregiver Support Program (NFCSP).
    f. Strategy: Create resources and opportunities for caregivers, including grandparents, to access community supports.
3. Objective: Reduce the instances of Adverse Childhood Experiences (ACEs) through community engagement.
    a. Strategy: Support services that address resiliency through reducing early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, and self-regulation.

b. Strategy: Support community efforts with training and technical assistance on evidence-based practices for trauma- engaged communities.
c. Strategy: Promote trauma-informed schools through cross agency collaboration with Department of Education and Early Development (DEED), developing consistent referral guidance to teachers across the state.

II. Goal: Prevent drug and alcohol misuse through collaborative effective informed strategies.

4. Objective: Reduce the impact of mental health and substance use disorders through increased prevention, early intervention, treatment and recovery supports.
5. Objective: Develop research-based health education campaigns to increase awareness, improve knowledge, and change behaviors to prevent young people from using substances during critical brain development years.

III. Goal: Individuals, families, communities, and governments take ownership to prevent suicides and self-harm in Alaska.

6. Objective: Prevention efforts across all departments and divisions are coordinated to ensure that Alaskans have access to a comprehensive prevention system that recognizes the connections between suicide, substance abuse, domestic violence, bullying, child abuse, teen risk behaviors, poor school performance, and health outcomes as adults.
7. Objective: Expand evidence-based crisis intervention training and supports to the entire public safety system (law enforcement, village police/public safety officers, EMTs, firefighters) and maintain effective Careline services to all Alaskans in crisis.
8. Objective: Provide financial and technical support through the State of Alaska for innovative implementation of evidenced-based prevention and research-based suicide prevention practices that provide a sense of hope and opportunity for communities.

IV. Goal: Access to integrated healthcare options that promote optimal health, wellness and independence.

9. Objective: Ensure Alaskans have timely access to appropriate levels of intervention(s) and can access Medicaid providers to meet the needs of all age groups in their region or communities of choice.
10. Objective: Incentivize providers to employ multi-disciplinary teams to provide the right services at the right time and connect Alaskans to a continuum of care.
11. Objective: Ensure responsible financial management of Alaska's Medicaid system by accurately estimating need, by connecting recipients to other payment systems as appropriate, and by fully funding the federally required Medicaid services.
12. Objective: Advocate to keep funding for optional Medicaid services which includes dental, vision, occupational therapy and speech, hearing and language disorder services, home and community based services, and over 40 other optional services.

13. Objective: Develop a coordinated approach to measuring quality of services in Alaska.
14. Objective: Promote evidenced based screening for individuals who experience a traumatic brain injury and provide training and resources to rural and primary care providers statewide.
15. Objective: The system is mindful of the cultural and linguistic diversity for the care of the beneficiary population.
16. Objective: Promote information formats that are plain language accessible throughout the system of care.
17. Objective: Promote effective and collaborative Medicaid Reform and Redesign strategies to ensure a sustainable system of care.

V. Goal: Improve maternal health through access to quality comprehensive services.

18. Objective: Provide effective pre-pregnancy and prenatal education and community awareness of disability risk factors including parental drug and alcohol use (i.e. FASD) and the effects of ACEs and trauma on lifelong health.
19. Objective: Support parenting skill development through community programs and activities.
20. Objective: Opioid strategic plan strategy (OSMAP).

VI. Goal: Strengthen the economic and social well-being of Trust beneficiaries.

21. Objective: Ensure Trust beneficiaries, that are able to work, are employed in competitive part-time or full-time jobs in integrated settings that pay minimum wage and above.
22. Objective: Promote efforts to have beneficiaries meaningfully engaged in their communities.
23. Objective: Alaskans have stable, safe housing with appropriate community-based social supports to maintain tenancy.
24. Objective: Provide training and information to promote financial literacy for all ages.
25. Objective: Increase supported decision-making options for beneficiaries.
26. Objective: Expand resources around the interplay of benefits and work.
27. Objective: Promote volunteer and peer driven opportunities for beneficiaries.
28. Objective: Maximize 811 opportunities and look at how to incorporate the new Anchored Home initiatives/strategies.

VII. Goal: End the cycle of substance misuse, incarceration and protect vulnerable Alaskans from harm.

29. Objective: Increase the use of pre-charge and pre-arrest diversion without incarceration and expand immediate access to treatment and support services for individuals who encounter law enforcement and the legal system.
30. Objective: Increase the number of residential substance abuse treatment facilities and beds available in Alaska.
31. Objective: Effectively accommodate the needs of victims and offenders who are beneficiaries and involved in the criminal justice system.
32. Objective: Build a comprehensive case management system to assess client needs and facilitate referrals and assistance.
33. Objective: Protect vulnerable Alaskans from abuse, neglect, self-neglect, and exploitation.
34. Objective: Encourage criminal justice reforms and reinvestment that encourage Alaskan's to be healthy successful members of their families and communities.
35. Objective: Provide support to kinship and grandparent caregivers of children whose parents are incarcerated trust beneficiaries.

VIII. Goal: Support the needs of Trust beneficiaries to avoid institutional settings and ensure those who are in an institutional setting can live with dignity.

36. Objective: Ensure all Alaskans who are in psychiatric residential settings or out-of-state care are provided the appropriate therapy and supports, including transitional supports, including aftercare and follow-up.
37. Objective: Increase access to effective and flexible person-centered long-term services and supports in urban and rural areas.
38. Objective: Ensure all individuals residing in an institutional long-term care setting receive information on less restrictive setting options.
39. Objective: Create person-centered after care plans for Alaskans leaving residential treatment services, nursing homes, assistive living homes, and provide case management ongoing follow up for adjustments to plans as needed.
40. Objective: Provide mechanism for individuals to receive timely assessment and installation of environmental modifications
41. Objective: Utilize appropriate assistive technologies to improve safety and health outcomes for vulnerable Alaskans living in the community.
42. Objective: Ensure that the Office of the Long-Term Care Ombudsman visits a minimum of 90% of assisted living and nursing homes that are licensed to serve seniors.

IX. Goal: Provide high quality, person-directed, culturally sensitive, accessible, flexible, and affordable services for Alaskans to live healthy, independent, meaningful lives in the place and manner of their choosing.

43. Objective: Promote healthy aging and provide access to comprehensive and integrated health care including providing behavioral health services, nutrition and other health promotion services.
44. Objective: Ensure effective and efficient management of dual eligible Alaskans (those who receive both Medicare and Medicaid) by improving coordination of their care which will enhance quality of care, improve health outcomes, and reduce costs.
45. Objective: Provide a comprehensive and coordinated approach to address the multiple and complex challenges that Alzheimer's disease and related dementias present to individuals, families, caregivers and the long-term care system in Alaska.
46. Objective: Improve access to end of life care including hospice and palliative care.
47. Objective: Improve access to culturally sensitive food supplies for beneficiaries.

X. Foundational goal: State of Alaska provides adequate resources and funding to support the comprehensive program to promote independent, healthy Alaskans.

48. Objective: Encourage a culture of data-driven decision making that includes data sharing, data analysis and management to link support services across Divisions and Departments.
49. Objective: Optimize information technology investments to improve process efficiency and enable innovation.
50. Objective: Strengthen workforce capacity with improved recruitment and retention to obtain and maintain knowledge, support innovation and modernization.
51. Objective: Provide specialized training or career paths to new and existing workforce to support beneficiaries with high needs in a community based setting.
52. Objective: Optimize the role of the Alaska Pioneer Homes within the statewide array of long-term services and supports.

Comprehensive Integrated Mental Health Program Plan

Status Update by DHSS
10-17-18

DHSS is enthusiastic of the progress being made in the updated Comp Plan and the resource capabilities that the Comp Plan will provide to Trust Beneficiaries

The DHSS Comp Plan Leadership group along with the Alaska Mental Health Trust Authority and the Advisory Boards have been working towards revitalizing the Comp Plan infrastructure.

DHSS Comp Plan Vision

Utilize the Comprehensive Mental Health Program Plan as a tool that looks at services and the impact of services on the lives of Trust Beneficiaries and integrates it into a web based platform that's modern for today's user.

I. **Goal: Invest in early childhood programs that address trauma, promote educational attainment and provide access to early intervention services.**

Early childhood social emotional development underlies all areas of development. Brains are not born; they are built throughout childhood, with experiences and interactions creating lifelong foundations. Effective primary preventative programs and early identification decreases future high risk behaviors and their associated costs by reducing the impacts of Adverse Childhood Experiences (ACEs). Supporting caregivers, including the high number of grandparents caring for grandchildren, is vital in the success of this goal.

1. Objective: Promote evidence based universal screening efforts and early intervention services for Trust beneficiaries.

A. Develop a statewide outreach campaign which makes developmental screenings a normal part of the well-child process for all Alaska children.

B. Utilize a centralized hub for developmental screening with a standardized developmental screening tool (such as Ages and Stages Questionnaire/ASQ).

C. Provide training and technical assistance on trauma-engaged strategies for early childhood providers to assess children for service needs.

D. Promote training for pediatricians in a tiered screening process for neurodevelopmental disabilities.

Example of Efforts and Progress

Continued work will be done on Goals 1-10 similar to the above example

Public and Stakeholder Input

DHSS will solicit feedback from other stakeholders and will host community public comment forums this winter. It is important that the Comprehensive Mental Health Program Plan meets the needs of the community as a whole and acts as a driver for decision making and aids in funding decisions.

Timeline Summary:

November 15th 2018 – Present 1st draft to the Mental Health Trust Board
December 31st, 2018 – Complete the 2nd draft of the Comp Plan
January 7, 2019-February 4, 2019 – Public Comment
March 1, 2019 – Final Comp Plan Completed
April 1, 2019 – Website Developer Procurement
May 1, 2019 – Begin Website Development
June 30, 2019 – Complete Website
July 1, 2019 – Distribute Comp Plan & Website goes live

Thank you

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MEMO

To:	Chris Cooke, Program and Planning Committee Chair
Date:	October 16, 2018
Re:	FY19 Substance Abuse Prevention & Treatment Focus Area Allocation
Fund Source:	FY19 Substance Abuse Prevention & Treatment; Treatment Access
Amount:	$300,000
Grantee:	Volunteers of America Alaska
Project Title:	VOA – Treatment Programs Bridge/Enhancement Funding

REQUESTED MOTION:

Approve a $300,000 FY19 Substance Abuse Prevention & Treatment focus area allocation to Volunteers of America Alaska for the Treatment Programs Bridge/Enhancement Funding project.

Assigned Program Officer: Katie Baldwin-Johnson

STAFF ANALYSIS

Volunteers of America of Alaska recently has had a transition to new CEO leadership within the past 8 months, resulting in a substantial look at the agencies financial stability, services, staffing and standing in the community as a primary provider of adolescent residential and outpatient treatment services. With this renewed leadership, VOA has focused on the financial health and sustainability of their treatment services given substantial financial losses and erosion of reserves over the past several years caused by a number of factors including decreased referrals, underutilization, programmatic inefficiencies and billing practices, state grant reductions, delays in Medicaid rate-rebasing and workforce challenges - all notably contributing to a perfect storm of programmatic and financial instability. VOA anticipates additional uncertainty with changes underway with behavioral health reform and implementation of the 1115 behavioral health waiver and Administrative Service Organization.

At the request of current VOA leadership, the Trust provided technical assistance to: 1) identify challenges and potential solutions within service delivery and resource management processes; 2) model fiscal sustainability of programs and services through the expansion or enhancement of current services; and 3) identify potential community-based partnerships to enhance client referral and staff recruitment.

These efforts have included developing and refining proformas for the Treatment Division to accurately project financial impact of changes to the programming, with the ultimate goal of ensuring quality services are sustainable over the long run. This review indicated a financial gap necessary to bridge services in FY19, and requires an investment in service enhancements in the amount of $300.0 to build out and stabilize programming during this time period. It is expected based on projections and modeling of different Medicaid rates and timing of implementation of rate changes that these service enhancement investments will stabilize the program by FY2020 with substantially increased revenues.

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Staff recommend funding of this request to pair agency technical assistance with grant funding to support stabilization of services to Trust beneficiaries. Without the additional Trust support, VOA will continue to experience financial losses that put the agency's stability at risk. This additional funding provides the agency funding to enhance staff and services to re-establish services and revenue generation at a stable level. VOA provides essential mental health and addiction treatment services to at-risk youth and young adults statewide between the ages of 13 and 24 via outpatient and residential treatment. Improving and stabilizing access to treatment services for this population is an appropriate and important investment of Trust resources.

PROJECT DESCRIPTION

Volunteers of America's treatment programs serve youth statewide ages 13-24 who are struggling with addictions. Due to erosion of reimbursement rates, declining grant funds, changing needs of populations, and management challenges, the agency has struggled to put the appropriate resources in place to address beneficiary needs. This bridge/enhancement funding will allow VOA the opportunity to re-stabilize the residential and outpatient treatment programs to provide quality and sustainable services to Trust beneficiaries. These funds will be used to address staffing shortages, training, technology, and basic program supplies.

This will increase overall access to services, increase quality of services, and use technology to streamline for efficiency (such as streamline intake process to increase timely access to care). With additional staffing and resources in place, the treatment division programs will be able to stabilize financially and operationally, and focus on quality outcomes.

EVALUATION CRITERIA

The expected outcomes of this project include an increase in number of beneficiaries served by VOA, an increase in staffing levels available to provide mental health and substance abuse treatment services, and re-stabilization of VOA's treatment programs.

1) How much did you do?
   a. Number (#) of unduplicated Trust beneficiaries served over the grant period, broken down by beneficiary category.
   b. Number (#) of transition-aged youth (ages 18-24) who were provided individualized behavioral health services.

2) How well did you do?
   a. Provide a brief narrative describing the timeline, activities, successes, challenges, and any lessons learned during the project.
   b. Number (#) and percentage (%) of transition-aged youth who felt the case management and behavioral health services they received were rendered in a non-judgmental, respectful and comfortable environment.

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3) Is anyone better off as a result of this project? (for example, # and % of people demonstrating improved quality of life)
   a. Number (#) and percentage (%) of individuals reporting an increase in their quality of life as a result of participating in the project.
   b. Number (#) of transition-aged youth (ages 18-24) assessed for behavioral health services and engaged in services within three months following the assessment.

SUSTAINABILITY

With Trust support, VOA began working with Agnew::Beck technical assistance formerly in June 2018 to conduct a comprehensive financial and programmatic review, to review all options for sustainability of VOA's behavioral health treatment services. These efforts have included developing and refining proformas for the Treatment Division to accurately project financial impact of changes to the programming, with the ultimate goal of ensuring quality services are sustainable over the long run. This review indicated a financial gap necessary to bridge services in FY19, and requires an investment in service enhancements in order to build out programming during this time period. It is expected based on projections that these service enhancement investments will contribute significantly to sustainability.

WHO WE SERVE

The individuals to be served by this project include adolescents and young adults age 13-24 who are struggling with mental health and substance abuse challenges. A primary referral source to the ARCH and Assist programs is the Division of Juvenile Justice. Referrals for ARCH residential originate from all over Alaska, including rural communities.

Trust beneficiaries will be better off as a result of this project through increased access to behavioral health services. This bridge funding will allow VOA the time and resources to re-build and stabilize programs, in order to provide long-term and sustainable services to the community. VOA's behavioral health continuum is a critical piece of the service array for adolescents statewide. Several years of financial losses have eroded the agency reserves. A comprehensive review indicated a financial gap necessary to bridge services in FY19, and requires an investment in service enhancements in order to build out programming during this time period. Without this strategic investment, these programs will continue to suffer struggle and will put at risk these services continuing.

Therefore, young Trust beneficiaries who are in need of residential substance abuse treatment services statewide will have increased access to these services. Outpatient and step-down services in Anchorage and Eagle River will be provided through VOA's Assist programs, which consists of outpatient and intensive outpatient services. The Assist outpatient program currently does not offer mental health services; this grant will invest in mental health services thereby increasing access for youth to needed mental health services. This grant will also be used to increase timely access to services, by streamlining the intake/assessment process through use of technology. This will ensure that when services are needed, beneficiaries are able to access these services in a timelier manner. Additionally, these funds will allow a focus on quality outcomes by partially funding a CQI manager position to focus on service quality across the agency. Therefore, the

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services received by beneficiaries agency-wide is expected to improve, with focus on and development of additional quality/outcome measures.

ESTIMATED NUMBER OF BENEFICIARIES SERVED EXPERIENCING	
Mental Illness:	45
Substance Abuse	130

BUDGET	
Personnel Services Costs	$145,386.00
Personnel Services Costs (Other Sources)	$3,479,213.00
Personnel Services Narrative:	CQI Manager (funds to increase salary of existing QA position into CQI manager) $20,000 Mental Health/Substance Abuse Clinician - Assist Outpatient Program $59,305 Mental Health/Substance Abuse Clinician - ARCH Residential Program $59,305 Billing Manager $3,747 Billing Assistant $3,029

Travel Costs	$0
Travel Costs (Other Sources)	$24,323.00
Travel Narrative:	No travel funds are requested.

Space or Facilities Costs	$35,600.00
Space or Facilities Costs (Other Sources)	$396,392.00
Space or Facilities Narrative:	Office space rent $25,600 Telecommunications: cost of mobile phones, landlines, internet $10,000

Supplies Costs	$14,500.00
Supplies Costs (Other Sources)	$215,233.00
Supplies Narrative:	Program supplies - Includes program supplies such as EBP workbooks, items needed for clients including hygiene $14,500

Equipment Costs	$15,500.00
Equipment Costs (Other Sources)	$47,980.00
Equipment Costs Narrative:	Purchase of equipment, including laptops, tablets, other equipment infrastructure needs to upgrade to cloud-based secure platform $15,500.00

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Other Costs	$89,014
Other Costs (Other Sources)	$644,437.00
Other Costs Narrative:	Training: access to increased training opportunities for individual service providers, focus on EBP training. $15,000 Professional fees: includes accounting, compliance, IT, psychiatric services $27,324 Insurance: Agency insurance for property/casualty and workmen's comp $41,690 EHR: consulting to re-configure EHR and upgrades such as reporting features for outcomes reporting $5,000

Total Amount to be Funded by the Trust	$300,000.00
Total Amount Funded by Other Sources	$4,807,578

Other Funding Sources	
DHSS - Secured	$2,032,453.00
United Way - Secured	$82,078.00
HUD - Secured	$175,000.00
Anchorage School District - Secured	$37,995.00
DHSS - Medicaid (pending)	$2,001,933.00
Rasmuson Foundation - Secured	$21,000.00
Wells Fargo Foundation - Pending	$50,000.00
Alaska Community Foundation - Secured	$5,000.00
Premera-pending	$250,000.00
Brookdale Foundation – Secured	$10,000.00
SOA DEED - National School Lunch Program – (billed monthly)	$30,000.00
Earned income/housing – (billed monthly)	$112,119.00
Total Leveraged Funds	**$4,807,578.00**

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MEMO

To: Chris Cooke, Program and Planning Committee Chair
Through: Mike Abbott, Chief Executive Officer
From: Steve Williams, Chief Operating Officer
Date: October 10, 2018
Re: Hiland Mountain Correctional Center – Women's Mental Health Unit Remodel - Update

STAFF ANALYSIS

The Department of Corrections (DOC) provides acute mental health services to approximately 200 female trust beneficiaries at the Hiland Mountain Correctional Center (HMCC) annually. Hiland Mountain is DOC's only correctional facility with an acute mental health unit for females. Incarcerated female trust beneficiaries from other institutions around the state requiring acute mental health care are transferred to HMCC. The current mental health unit was a built in 1998 and is undersized to meet current beneficiary needs.

Trust staff recommend providing capital funding in partnership with DOC to expand and enhance Hiland Mountain Correctional Center's women's mental health unit. The expanded and enhance unit will include mental health and detoxification beds as well as integrating HMCC's existing medical unit and its services. This will result timely access and improved mental and physical healthcare for trust beneficiaries. The executive directors of the Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging and the Governor's Council on Disabilities on Special Education support this project.

BACKGROUND

Between SFY98 - 01, the Trust partnered with DOC to retrofit Hiland Mountain Correctional Center's existing segregation unit to a female mental health unit with the requisite staffing and programs. Over the four-year period the Trust granted DOC $1,071.8 of MHTAAR funds ($914.0 for capital and $167.8 of operations). That partnership resulted in a 850 sf/ft mental health unit with 18 beds and a 425 sq/ft day room. Detoxification beds were not included in the project.

Since that time the needs of female beneficiaries have changed. According to the 2014 report, *Trust Beneficiaries in Alaska's Department of Corrections*, Trust beneficiaries account for more than 40 percent of the Department of Corrections' incarcerations each year. During the report period, July 1, 2008 and June 30, 2012, 32.5% of the identified Trust beneficiaries were female. Since 2008, the Department of Corrections has seen a 5.7% increase in the female beneficiary population requiring acute mental health services. This increase has resulted with female beneficiaries being placed temporarily on the segregation unit when the mental health unit is full. This placement could be for several days. In addition, there has been an increase in female beneficiaries requiring acute detoxification services. For those beneficiaries,

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they receive detoxification services at the Alaska Correctional Center- West (ACC-W) male infirmary. The Department of Corrections reports that two-three times per week female beneficiaries are placed at ACC-W for acute detoxification services.

To address the changed needs of female beneficiaries, DOC has analyzed its historical population data, identified population trends, and forecasted for future growth over the next ten years. This analysis resulted in the development and architectural design for remodeling existing space into an expanded women's mental health and medical unit at HMCC. The proposed remodel design will create a:

1. 3,801 sq/ft mental health and detoxification unit,
2. twenty-seven beds (23 mental health and 4 acute detoxification),
3. 905 sq/ft day room,
4. 427 sq/ft outdoor recreation area,
5. a group treatment room, and
6. three private interview/consultation rooms.

It is important to note this remodel will not require any additional staff positions or operating expenditures. DOC is able to accomplish this through integrating mental health and medical services in a central location. This allows for reallocation of current resources to meet the needs of beneficiaries housed on this unit.

Beneficiary Impacts

The construction of this new unit will positively impact those female incarcerated beneficiaries in the following ways:

1. Updated more therapeutic mental health unit environment
2. Increased access to acute mental health services for beneficiaries from rural areas
3. Decreased risk of beneficiaries needing acute mental health services being placed on the segregation unit
4. A safe place for beneficiaries requiring acute detoxification services
5. Integrated mental health and medical service space
6. Integrated space for beneficiaries with dementia, palliative care needs and suicide monitoring
7. Increased space for group programming and individual consultation

Project Budget Cost

Mental Health Unit	$2,290,000
Medical Unit	$1,600,000
Total	**$3,890,000**

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Project Budget Revenues

Department of Corrections	$2,745,000
Alaska Mental Health Trust*	$1,145,000
Total	**$3,890,000**

*This represents 50% of the cost for the mental health unit.

The Department of Corrections has the balance of the required funding $2,745,000 to fully fund this project.