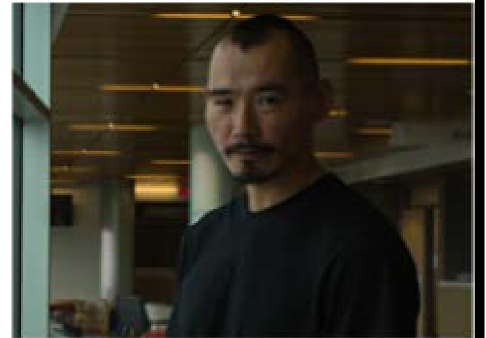
Trust FY20/21 Stakeholder Input Session Summary Notes

June 20-21, 2018



Trust
Alaska Mental Health Trust Authority

Trust FY20-21 Stakeholder Input Session Summary Notes, June 20-21, 2018

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Welcome and Introductions

The Alaska Mental Health Trust Authority's overall purpose is to help beneficiaries thrive in their communities and avoid long-term institutionalization. The Trust does this through focusing on:

- Whole person health care
- Decreasing substance abuse
- Workforce
- Reducing criminal involvement
- Employment and peer supports
- Safe and affordable housing and long-term services and supports

On June 20 and 21, 87 stakeholders convened at the BP Energy Center to provide input and prioritization for Trust staff to craft budget and policy recommendations for trustees in the FY20-21 budget periods. The purpose was not to identify which specific programs or initiatives to fund, or not fund, but to help staff review focus areas, and provide input on where to focus in the next two years to help beneficiaries thrive in their communities. Stakeholders were asked to provide input from their respective areas of expertise by looking at the system holistically, not just what impacts a specific beneficiary group. The key questions stakeholders were to consider over the two days were: 1) How do we help beneficiaries thrive in their communities? and 2) How do we mitigate the risk of institutionalization?

Participants and Acronyms

A complete list of participants and organizations is located in Appendix I. A list of acronyms used throughout this document is located below. The Alaska Mental Health Trust Authority is referred to as the Trust throughout this document.

Acronym	Meaning
AADD	Alaska Association on Developmental Disabilities
ABHA	Alaska Behavioral Health Association
ACE	Adverse Childhood Experience
ADRD	Alzheimer's Disease and Related Dementia
AgeNet	Alaska Geriatric Exchange Network
AHEC	Area Health Education Centers
AHFC	Alaska Housing Finance Corporation
AK-PIC	Alaska Psychology Internship Consortium
ALCANLink	Alaska Longitudinal Child Abuse and Neglect Linkage Project
AMHB/ABADA	Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse
ANTHC	Alaska Native Tribal Health Consortium
ASO	Administrative Service Organization
CEO	Chief Executive Officer
DBH	Division of Behavioral Health

DD	Developmental Disability
DHSS	Department of Health and Social Services
DJJ	Division of Juvenile Justice
DOC	Department of Corrections
DSP	Direct Support/Service Professional
DPH	Division of Public Health
HUD	U.S. Department of Housing and Urban Development
KANA	Kodiak Area Native Association
MAT	Medication-assisted treatment
NADSP	National Alliance for Direct Support Professionals
OCS	Office of Children's Services
OSMAP	Office of Substance Misuse and Addiction Prevention
PSR	Protective Service Report
RPTC	Residential Psychiatric Treatment Center
SCF	Southcentral Foundation
SFY	State Fiscal Year
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCC	Tanana Chiefs Conference
TLO	Trust Land Office
UAA	University of Alaska Anchorage
VA	Department of Veterans Affairs

State of the Trust

Trust Financial State

Alaska Mental Health Trust Authority (the Trust) Chief Executive Officer (CEO) Mike Abbot started the two-day stakeholder meeting with a presentation about the Trust's financial state. The Trust began the meeting with this presentation as it provides an important foundation for stakeholders. The Trust seeks to establish common ground, so all stakeholders understand how Trust revenue and spendable income is generated and understand the relationship between the Trust Land Office (TLO) and the Trust Authority Office. The Trust's cash assets are invested and managed by the Alaska Permanent Fund Corporation and the Department of Revenue Treasury Division, which both invest the Trust's money in a mix of stocks, bonds and other investments to generate income. The TLO is responsible for managing non-cash assets, which include approximately one million acres of land and a portfolio of properties in Alaska, Washington, Utah and Texas.

Trust CEO Mike Abbot reported that the Trust's assets are strong and stable with projected Trust investments at the close of state fiscal year (SFY) 2018 at $667 million. The SFY19 Trust budget total is $30.3

million. The total amount available each year for trustees to allocate is a combination of the four-year average from the following sources:

- Principal and Budget Reserves (4.25% of net asset values of the Trust fund)
- Lapsed appropriations
- Trust Land Office Spendable Income
- Interest income from other cash investments

The Trust's annual base payout of 4.25% of the average value of the fund's cash assets is typical for foundations.

Trust Mission and Theory of Change

Steve Williams, the Trust's Chief Operating Officer, presented the Trust's Theory of Change and introduced the State of our Community presentations. The Trust's mission is to improve the lives of beneficiaries through advocacy, planning, implementing and funding a Comprehensive Integrated Mental Health Program. Trust beneficiaries include groups of Alaskans with: mental illness, developmental disabilities, chronic alcohol or drug addiction, Alzheimer's disease and related dementia, and traumatic brain injuries. The Trust also works in prevention and early intervention services for individuals at risk of becoming beneficiaries. The Trust is systemically tackling criminal justice reform and reinvestment through Medicaid expansion and redesign and behavioral health system reform. These investments and others are identified in the Trust's Theory of Change. The Trust's Theory of Change identifies key outputs related to target areas. These outputs shaped the formation of panel topic areas and small group discussion groups. The six key outputs are:

- Beneficiaries access quality, integrated, whole person health care
- Decrease in youth alcohol and substance use and adult binge drinking and illicit substance use
- Reduce adult and youth involvement in the criminal justice system and reduce criminal recidivism
- Beneficiaries achieve integrated employment and have access to quality peer support services
- Beneficiaries can access safe and affordable housing with appropriate community-based social services to maintain tenancy
- Beneficiaries access effective and flexible person-directed long-term services and supports

For more information on the State of the Trust, see the *Trust Budget Priorities* presentation located here. To view the Trust's Theory of Change, see Appendix II, or view online here.

State of Our Community

Trust beneficiaries, and thus the stakeholder organizations that work with them, span ages, life stages and a myriad of community and state resources. The Trust organized panels in key interest areas to provide these diverse stakeholders with a foundational knowledge of beneficiary needs and resources across sectors. Feedback from previous stakeholder meetings identified that a foundational knowledge of the key areas of the Trust's work was necessary to understand the needs and resources available across communities and systems.

Stakeholders from children and youth services, psychiatric crisis care and substance use disorder treatment, housing and homelessness, the criminal justice system and tribal organizations were called upon to participate in panel discussions at the start of day one to help stakeholders understand the drivers and gaps that are

pushing beneficiaries out of communities and into higher levels of care. Indicators and trends suggest an increase in beneficiaries receiving services/supports in more restrictive environments. The Trust's Theory of Change centers around community strategies and capacity building and the day one opening panels sought to inspire stakeholders to think about what services, supports or funding mechanisms are needed to help beneficiaries thrive in their communities.

How do we help beneficiaries thrive in their communities? What are the trends?

Following is a summary of the State of our Community panel presentations. The opening panel focused on trends for key beneficiary groups across the lifespan, beginning with children and youth services and culminating in presentations on issues facing adult beneficiaries – mental health and substance abuse treatment, housing and homelessness and criminal justice involvement. For a PowerPoint presentation associated with the topics below, please see the *State of our Community* file here.

Children and Youth Services

Department of Health and Social Services, Division of Public Health (DPH)

Jared Parrish, Senior Epidemiologist

Dr. Jared Parrish presented data on the prevalence of child maltreatment reports in Alaska, gathered as part of the Alaska Longitudinal Child Abuse and Neglect Linkage Project (ALCANLink). The annual prevalence of reports to the Office of Children's Services (OCS) is approximately 10% of the child population. ALCANLink allows a deeper look and revealed that 32% of Alaskan children have an OCS report made before the age of 8. This number more closely matches the 34% of adults who recall experiencing maltreatment during childhood. ALCANLink data also provides insight into maternal stressors that increase the risk of child maltreatment. Of the 13 stressors identified, the more stressors a mother had, the more likely a child was to experience child welfare contact. Dr. Parrish also provided an overview of the OCS workload from 2013-2017:

- 29.6% increase in Protective Service Reports (PSRs)
- 57.8% increase in initial assessments
- 45.8% increase in out-of-home placements

From 2014-2017 OCS funding increased 8.7% and staff positions increased 7.4%. However, due to increased reporting over this time period, the number of workers per PSR, initial assessment and out-of-home placement has not decreased, despite the increase in staffing.

Department of Health and Social Services, Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse (AMHB/ABADA)

Alison Kulas, Executive Director

In this presentation, data from the Adverse Childhood Experiences (ACEs) study was put into the context of Trust beneficiaries. Alison Kulas provided an overview of population attributable risk, or the reduction in incidence that would be observed if the population were entirely unexposed to ACEs compared with the current exposure pattern. If ACEs were removed from a person's experience, the effects on beneficiaries would be profound, due to eliminating:

- 80% of suicide attempts
- 79% of substance abuse in childhood

- 67% of injection drug use

Beneficiary populations with Alzheimer's Disease and related dementias (ADRD), developmental disabilities, and traumatic brain injuries (TBIs) would also be impacted if ACEs were eliminated. As many of these health and social challenges share the same root causes, primary prevention strategies such as: supporting quality early childhood programs, ensuring access to health and behavioral health care, and strengthening capacity of social emotional learning in schools are recommended. A recent policy success, SB105, AS 47.05.060, identified that "it is the policy of the state to acknowledge and take into account the principles of early childhood and youth brain development and…consider the concepts of early adversity, toxic stress, childhood trauma and the promotion of resilience…".

Department of Health and Social Services, Division of Behavioral Health

Brita Bishop, Community Mental Health Services Program Administrator

This presentation provided an overview of Alaska Medicaid Residential Psychiatric Treatment Center (RPTC) information for children and youth who are being placed in and outside of Alaska. While there has been a decrease in Medicaid RPTC placements for children over all since state fiscal year (SFY) 2006, in recent years there has been an increase in out-of-state placements and a decrease for in-state placements.

- In SFY14 71% of youth were in in-state placements and 32% were in out of state placements
- In SFY17, only 53% of youth were in in-state placements and 50% were out of state.
- Overall numbers of children in any RPTC decreased from SFY14-17 the number of children aged 6-11 years in out-of-state placements increased from 32 to 57.

Out-of-state Medicaid RPTC payments surpassed in-state payments in SFY16 and out-of-state costs per participant were $11,000 higher than in-state costs in SFY17. Thirty-four (34) of the children in out-of-state placements were in OCS or Division of Juvenile Justice (DJJ) custody in May 2018, while the remaining 113 were in parental custody. Alaska Native children are disproportionally sent to out of state placements, representing 34% of out-of-state placements, but only 19% of the population.

Department of Health and Social Services, Division of Juvenile Justice (DJJ)

Shannon Cross-Azbill, Mental Health Clinician IV

This presentation provided information on children and youth in DJJ facilities including counts of delinquency referrals and offenses, felony charges, and treatment admissions and diagnoses. From SFY15 to SFY18 the percentage of beds filled increased from 67.2% to 76.1%. From FY13 to FY17 there was an increase in felony against person charges; however, delinquency referrals and offenses have decreased over that same time period. Of juvenile admissions in SFY18:

- 63% had a primary substance abuse diagnosis
- 91% had a primary behavioral health diagnosis
- 63% had co-occurring substance abuse and behavioral health diagnoses.

Juvenile beneficiaries make up the majority of the DJJ population.

Psychiatric Crisis Care + Substance Use Disorder (SUD) Treatment

Department of Health and Social Services, Division of Behavioral Health (DBH)

Randall Burns, Division Director

Randall Burns provided a funding snapshot of DBH for SFY18, including the number of treatment grantees (76) and non-grantee behavioral health providers (25) serving youth and adults and the number of prevention grantees (43). In SFY18, DBH grant funding totaled over $64 million dollars:

- Over $9 million dollars for prevention
- $55.7 million for treatment

In SFY17 behavioral health treatment grantees provided Medicaid services to 4,337 youth and 10,801 adults for a total of 15,138 unduplicated clients. The average cost was $9,532 per person. In the first nine months of SFY18 treatment grantees have seen 14,839 unduplicated clients. Randall stated there is $12 million is new funding for SUD treatment in the next fiscal year. This new funding could be used for the following services: Medically-monitored withdrawal management (detoxification), ambulatory withdrawal management, residential and intensive outpatient substance use disorder treatment and recovery, sobering center or 72-hour substance misuse crisis evaluation services and housing assistance and supports.

Housing + Homelessness

Alaska Housing Finance Corporation (AHFC)

Daniel Delfino, Director of Planning and Program Development and Mike Courtney, Director of Housing Operations

Daniel Delfino and Mike Courtney shared information about housing and homelessness. AHFC identified that it is challenging for their organization to find non-profit partners to work with, especially outside of Anchorage. AHFC shared information on available vouchers and housing programs (such as Moving Home and Housing First) and shared that they have applied for the U.S. Department of Housing and Urban Development's Mainstream Voucher program which, if received, would add 200 more vouchers for those who are transitioning out of institutional or other segregated settings, at serious risk of institutionalization, homeless, or at risk of homelessness. There is a need for housing assistance for single adults, as roughly 2/3 of the individuals on their waitlist are single.

Criminal Justice System

University of Alaska – Anchorage, Justice Center

Brad Myrstol, Director

Brad Myrstol shared information on property and violent crime rates in Alaska from 1986-2016. He emphasized that the data represent only crimes known to police and that only about half of all crimes are ever reported. Reported property crimes decreased from 1986-2016 while reported violent crimes (murder, non-negligent homicide, aggravated assault, rape) increased over that same time.

Department of Corrections (DOC)

Adam Rutherford, Mental Health Clinician IV

Adam Rutherford shared trends within the criminal justice population. He reviewed population trends and stated that by default, DOC is the state's largest provider of mental health services, substance abuse treatment; and drug and alcohol detoxification services. Alaska is one of only six states that operate a unified correctional system, a combination of jails and prisons. The percent of unsentenced offenders has grown from 24% of the prison population in 2008 to 45% in 2018.

- 65% of DOC's offender population are Trust beneficiaries

- Trust beneficiaries were significantly more likely to be convicted of felony crimes (34.6%) than the rest of the DOC population (21.4%).
- The median length of stay for Trust beneficiaries is significantly longer than for other offenders.

Rutherford noted that 22% of the offender population experience a severe and persistent mental illness and the number of offenders diagnosed as such has increased 19% since SFY08.

Question + Answer

Topic: Substance use disorder treatment
Q: What types of supports will the $12 million in new substance use disorder treatment be used for and is there a possibility to integrate or use the funds for housing assistance and support for coordinated entry?
A: Randall Burns stated that currently, DBH does not know how much funding will go towards housing, but it is a possibility that housing funds could be used for coordinated entry.

Q: How many beds are currently available for detox and how many does DBH hope will be available with the increase in substance use disorder treatment funding?
A: Randall Burns stated that today there are 16 beds in southcentral Alaska. In terms of what is to come, it depends on what programs want to do. DBH would be interested in seeing an additional 16-bed facility in Anchorage and 16 more beds in Mat-Su. Mat Su Regional Hospital has said that when they finish their expansion, they may have one 9-bed pod for withdrawal management.

Topic: Increase in children going out of state for residential; mental health treatment

Q: Why has there been an increase in kids going out of state for residential mental health treatment?
A: Brita Bishop stated that there are a variety of factors, including losing 44 in-state beds for youth (Boys and Girls Home closure); losing all beds for kids under 12 (this population is more expensive and difficult to serve and provider payment rates didn't keep up); workforce issues; payment rates for services have not been reassessed; and many of these children are people with intellectual and developmental disabilities and very few in-state residential placements are able to care for this population.

Q: Will the Bring the Kids Home stakeholder group be brought back together?
A: Brita Bishop stated that DBH is in the process of putting a meeting together this fall to talk about the data and increase in children going out-of-state for residential treatment. In addition, DBH and OCS are looking at putting together a data sharing agreement to get more data about children who are going out-of-state.

Topic: Office of Children's Services

Q: What does the acronym PSR stand for?
A: Jared Parrish stated that PSR stands for Protective Service Report which is when a report of harm is made to the Office of Children's Services (OCS).

Q: What happens to the 53% of Protective Service Reports (PSR's) that do not go to Initial Assessment?
A: Jared Parrish stated that this was a question for OCS. An OCS representative was not present at the meeting. Thea Agnew Bemben added that OCS is starting to look at what happens in these cases, which leads to the question "Does OCS have the authority/permission to refer for services when they screen out a case?"

Topic: Title 47 holds

Randall Burns responded to a point in Adam Rutherford's presentation. In Adam Rutherford's presentation, he mentioned a drop in Title 47 commitments. This Randal Burns stated there are two different types of Title 47 holds. One type is taking individuals into protective custody for substance abuse. The other is for a mental

health commitment which places someone in a hospital (API, Bartlett, Fairbanks Memorial, etc.) Randall Burns clarified that the decrease Adam Rutherford mentioned in his presentation refers to the Title 47 placing individuals in protective custody for substance abuse. DOC made a policy change where they stopped taking as many individuals into facilities for protective custody.

How are tribal health organizations helping beneficiaries?

Tribal health organizations serve beneficiaries across the spectrum, often in remote or underserved areas. To understand the resources available to beneficiaries across the state, a panel of representatives from the Alaska Native Tribal Health Consortium, Tanana Chiefs Conference, Kodiak Area Native Association and Southcentral Foundation provided overviews of their organizations, services and notable trends.

Alaska Native Tribal Health Consortium (ANTHC)

Tina Woods, Senior Director of Community Health Services

Tina Woods shared the ANTHC vision which is *Alaska Native people are the healthiest people in the world*. The organization is broken out into four main areas of Alaska Native Medical Center, Community Health Services, Environmental Health & Engineering and Business Support Services. Woods walked through who ANTHC serves, 45% of whom are from the Anchorage/Mat-Su Service Unit. She shared information about the Community Health Services division which weaves together culturally responsive programs, research, resources and care to promote health equity across the lifespan. The Community Health Services Division is comprised of: The Alaska Native Epidemiology Center, Wellness and Prevention, Clinical and Research Services, Community and Environmental Health, Distance Learning Network, Dental Therapy Educational Program, Behavioral Health Aide Program and the Community Health Aide Program. For more information about ANTHC, see the *Holistic Health – Helping People Thrive* presentation here or visit https://anthc.org/.

Tanana Chiefs Conference (TCC)

Luann Strickland, Home Care Manager

TCC serves 39 villages in a region the size of Texas; the TCC region overlaps with Yukon-Kuskokwim Health Corporation (YKHC) and Southcentral Foundation (SCF). Two key TCC service areas are tribal client services and health.

- Tribal client services include: Village Public Safety Officer program, family services and housing
- Health services include: Home Care Program, Behavioral Health, Prevention
    - Home Care Program services: respite, chores, personal care, waiver and care coordination.

TCC partnered with Fairbanks Native Association and others to open and provide services through a Sobering Center in the region. TCC partners with Athabascan Tribal Government and the Division of Senior and Disabilities Services on other service offerings. TCC is also working on an electronic visit program as the organization needs greater technological capacity. For more information about TCC, please visit https://www.tananachiefs.org/.

Kodiak Area Native Association (KANA)

Gwen Sargent, Tribal Vocational Rehabilitation Administrator

KANA is a 501c3 and was incorporated in 1966. There are 10 board directors and around 150 people employed at KANA. KANA serves the six outlying villages on Kodiak Island which is the second largest island in the United States. There are three focus areas of services at KANA: Health Services, Community

Services and Administration. KANA utilizes a patient-centered care team model and relies on federal and state grants to provide services. Current highlighted initiatives include:

- A HRSA grant to expand behavioral health services, including suboxone treatment.
- Main sponsor of a Transition Age Youth program and annual conference designed to "educate, prepare and support under-served youth in the villages so that they have a better chance to engage in successful careers."
- Collaboration with ANTHC and the local housing authority to address homelessness and create a web of services for people on the island.

Sargent stated that when a school closes, the village dies; therefore, KANA is working to mobilize communities, encourage partners, and help students develop soft skills to advocate for and become a voice for their village and school. For more information about KANA, please visit http://kodiakhealthcare.org/.

Southcentral Foundation (SCF)

Michelle Baker, Senior Director of the Behavioral Services Division

SCF serves Anchorage, Mat-Su and Cook Inlet Region Inc. villages. Over 65,000 customer-owners are served in the primary care setting. SCF employs 40 behavioral health consultants who provide screenings, brief intervention and referral (via SBIRT) to customer-owners across the life span. SCF has tracked a 20% increase in individuals coming in for behavioral health services. Current investments and focus areas include:

- Substance use treatment
    - Doubling their outpatient substance abuse treatment program (Four Directions) and will be moving into a new building this fall.
    - Increasing the percentage of primary care providers waivered to provide medication-assisted treatment to 80%
    - Hiring more nurses and providers for admissions to SCF Detox
- Behavioral health services:
    - Partnering with Covenant House and Brother Francis to provide medical care and brief intervention to improve behavioral health services on-site at these shelters.
- Recidivism reduction:
    - Working with Department of Corrections (DOC) to help reentrants successfully re-enter their communities.
    - Family Wellness Warriors Initiative conducts trainings in the prisons to reduce recidivism.
    - Native Men's Wellness Program to support men coming out of DOC to find worth; this program helps men connect to full-time employment.
- Workforce development:
    - Learning and Wellness Center focused on "growing our own"
    - Training workforce in chemical dependency

Baker identified housing as a barrier for customer-owners seeking outpatient substance use treatment and workforce issues as a challenge for the organization as a whole. Case management is a gap in some areas of SCF services. There are programs where case management is working well (ex. Quyana Clubhouse) and other programs where SCF really wants to support and re-think how to provide case management/care coordination services that best meet the needs of customer owners. For more information about SCF, please go to https://www.southcentralfoundation.com/.

State of the State

Update on Major Reforms and Investments

Medicaid Reform + Redesign

Major system changes impacting beneficiaries are underway. The Trust provided the transitional funding necessary to support Medicaid expansion and enrollment. Following this expansion, in conjunction with the Legislature, administration and other partners, the Trust recognized the need to reform the Medicaid system to better serve Alaskans and create a sustainable continuum of integrated care for beneficiaries. In 2016, the Trust's board of trustees approved $10 million in multi-year funding for the start-up costs of Medicaid reform. The goal of this panel is to provide stakeholders with a common understanding of the current status of Medicaid reform as well as trends and future impacts. Through participation in this panels, state entities seek to inform stakeholders of current efforts to help beneficiaries thrive in their communities as well as offer insight into state priorities over the next two to three years.

Department of Health and Social Services (DHSS)
Monique Martin, Health Care Policy Advisor

DHSS selected two Coordinated Care Demonstration Projects, as required by law as part of Medicaid Redesign. The purpose of the demonstration projects is to assess the efficacy of proposed health care delivery models with respect to cost for access too, and quality of care for Medicaid recipients. The selected projects are:

- Providence Family Medical Center, will implement a patient centered medical home that will serve approximately 6,000 Alaskans.
- United HealthCare, serving as Alaska's first managed care organization. The demonstration covers Anchorage and Mat-Su and the go-live date is estimated at early 2019. United HealthCare will not manage behavioral health or pharmacy services or long-term services and supports.

Martin also provided an update on the tribal claiming policy as the federal government made a new interpretation of when states are eligible to receive a 100% federal match. Under the updated policy, if care starts at a tribal health organization but needs a referral to a non-tribal provider, with a care coordination agreement in place between the two providers, the State will get reimbursed at 100% federal match.

Department of Health and Social Services, Division of Behavioral Health (DBH)
Randall Burns, Division Director

The Division of Behavioral Health's Medicaid Redesign and Reform efforts include putting in place a 1115 Behavioral Health Medicaid Demonstration Waiver to provide greater system flexibility and offer a broader range of alternative services to fill existing service gaps and reduce Alaska's reliance on crisis services. As part of this effort, the State will contract with an Administrative Services Organization (ASO) to offer an improved system of care management. The 1115 Waiver will not be used for people in the corrections system.

Question + Answer

Topic: Treatment services

Q: Will there be a duplication of services between the Providence Family Medical Center coordinated care project and other care management programs?

A: Monique Martin stated that a list of individuals was reviewed name by name to ensure that individuals served by Providence were not getting services elsewhere.

Q: The substance abuse disaster has been going on for years and treatment facilities are maxed out. What is being done to expand capacity?
A: Randall Burns identified that the $12 million in new substance use disorder funding is meant to address these issues, specifically by focusing funding in the Southcentral region where there is a huge need.

Q: What efforts are being made to incentivize primary care to treat the whole person, including behavioral health?
A: Randall Burns identified that this is some of what Medicaid reform is about, and the 1115 Waiver is focused on this issue. There is a need to intervene and intercept earlier. It is important to have a treatment infrastructure in place so that people are not waiting homeless on the streets for services. Steve Williams seconded Randall Burn's point about the 1115 Waiver and its focus on early intervention so we don't continue a cycle of reacting to things that could have been prevented.

Topic: 1115 Waiver

Q: Where will staffing for services under 1115 Waiver come from?
A: Randall Burns identified that DBH is producing a list so that each community and providers in that community will have an idea of what staffing needs are to make services a reality.

Psychiatric + Substance Use Disorder (SUD) Care System

Department of Health and Social Services, Division of Behavioral Health (DBH)

Katie Chapman, Health Program Manager IV

The Substance Use Disorder Path to Recovery was used to frame this conversation, including available resources and gaps for each step in the process.

- Detox/withdrawal management services were identified as a need (currently three programs in the state, with two of those being alcohol focused).
- Assessment/intake services are available but the timeframe for access varies (some programs have same day access, but usually it is a two week wait for an assessment).
- Residential treatment is at full capacity. There are just under 300 beds statewide spread among 18 residential programs with waitlists at all programs.
  - Identified barriers to expanded residential treatment are the Medicaid IMD Exclusion which bars programs with more than 16 beds from billing Medicaid, and an insufficient workforce.
- Transitional housing was identified as a need, and one of the categories that the $12 million in new SUD funding could go toward.
- Outpatient services are generally available quickly, after an individual receives an initial assessment.

Priority populations are identified as pregnant women, IV drug users and OCS involved families. Due to the prioritization of these groups, it can be more difficult for others to get services as they may be bumped down on waitlists by prioritized populations. DBH is working on a website redesign for a more useful landing page; the DBH website now includes bed availability and waitlist information which is updated daily. Challenges include limited treatment capacity, insufficient workforce and stigma. Opportunities include the 1115 Waiver, the Recovery Movement, expanding telemedicine and integration of care. The number of medication-assisted treatment (MAT) waivered prescribers has increased from 100 to 277. More information on the *State of our State – Care Systems and Reform* is available here.

Department of Health and Social Services, Office of Substance Misuse and Addiction Prevention (OSMAP)
Andy Jones, Director

OSMAP uses a public health approach to prevent and reduce substance use disorders and supports community-based activities across Alaska. Key initiatives include:

- Project HOPE: assembly, training and distribution of Narcan kits
- Marijuana misuse prevention
- Youth engagement: A youth is working in the OSMAP office as part of the coalition to address substance misuse

For more information, please visit OSMAP's website and related resource links here.

Housing + Homelessness

Alaska Housing Finance Corporation (AHFC)
Daniel Delfino, Director of Planning and Program Development, Mike Courtney, Director of Housing Operations

AHFC is a statewide organization with offices in 16 Alaskan communities. AHFC works in a variety of areas including providing affordable loans, public housing programs, energy efficiency and weatherization programs, senior housing programs and professional development opportunities. Highlighted initiatives and resources include:

- Moving to Work: A cutting-edge program that is changing the availability of public housing and incentivizing households to maintain employment and increase income.
- Alaska Corporation for Affordable Housing: AHFC's non-profit arm that can develop affordable housing.
- Planning and Program Development Department: Offers 13 different programs. The Statewide Homeless Housing Office is a resource for identifying which of these programs is the best fit for a given situation/person.

The populations AHFC works with fall into two categories, the elderly and disabled, for whom there are no time limits, and the working population, for which there are five-year time limits. The working population is offered robust case management services. Implementing time limits has allowed AHFC to leverage money to serve more households and to offer new vouchers. For more information on AHFC, please go to www.ahfc.us.

Question + Answer

Topic: Housing and homelessness

Q: What can be done for AHFC to work with the Governor's office around housing?
A: Elizabeth Schultz with the Governor's Office identified at the housing summit there were seven workgroups that met, numerous conversations were started and that collaboration between housing, mental health and AHFC programs is ongoing.

Q: How is AHFC supporting a generation of people who want to "age in place"?
A: Daniel Delfino identified the Governor's Office and Rasmuson Foundation collaborated on funding for a home modification program that allows $15,000-20,000 modifications on existing homes. The Senior House Program was identified as an additional resource.

Criminal Justice Reform and Reinvestment

Major system changes impacting beneficiaries are underway, including SB 91. SB 91, passed in 2016, invests in programs and services that support successful reentry for people with substance use and mental health disorders (Trust beneficiaries). Criminal justice reform and reinvestment is important to Trust beneficiaries because, according to a 2014 Hornby Zeller Associates study, beneficiaries represent more than 40% of the incarcerations in Alaska's corrections system each year and their median length of incarceration is longer than for non-beneficiary offenders. The goal of this panel is to provide stakeholders with a common understanding of the current status of criminal justice reform as well as trends and future impacts. Through participation in these panels, statewide entities seek to inform stakeholders of current efforts to help beneficiaries thrive in their communities as well as offer insight into organizational priorities over the next two to three years.

For more information on the State of our State, see the *State of our State – Criminal Justice Reform* presentation here.

Alaska Judicial Council

Susanne DiPietro, Executive Director

In this panel, Susanne DiPietro provided an update on the commission recommendations around reasons for criminal justice reform, the process of reform and reinvestment savings. Primary reason for reform include unsustainable prison growth, a need for improved public safety outcomes and the need for a fairer justice system. Trust beneficiaries were greatly impacted by the prior system, with:

- longer pre-trial stays
- more supervision violations, and
- longer length of stays compared to non-beneficiaries.

Alaska's sentencing model changed in 2005 and from 2005-2014 Alaska's prison population grew 27%. Department of Corrections (DOC) spending increased 60% from 1995-2014. The Alaska Criminal Justice Commission was created by the legislature and instructed to reduce recidivism and save money. Reforms included basing pretrial release decisions on risk of pretrial failure, not ability to pay, relying less on incarceration and more in community-based sanctions and treatment, focusing probation resources on higher-risk individuals and enhancing supports for citizens returning to their communities. Savings are being reinvested in DOC treatment, parole and pretrial programs, Division of Behavioral Health services, the Center for Domestic Violence and Sexual Assault violence prevention initiatives, and the Alaska Judicial Council/Alaska Criminal Justice Commission.

Department of Corrections (DOC)

Adam Rutherford, Mental Health Clinician IV

Adam Rutherford provided an overview of the substance use disorder treatment expansion services currently in place in DOC facilities, such as expansion of medication-assisted treatment (MAT), partnership with wellness courts, dual diagnosis clinicians, sober living units, crisis recovery center-based community intensive outpatient services, peer-based interventions, and more.

Department of Health and Social Services, Division of Behavioral Health (DBH)

Alysa Wooden, Program Coordinator I

Alysa Wooden shared information on community reentry reinvestment. Thirty-five percent of available reinvestment funds are being used to fund DBH community-based reentry services. There are three components of these services:

- Direct service – reentry case management, reentry center, Alaska Medicaid Coordinated Care Initiative, Alaska Housing Finance Corporation Returning Home vouchers (64% of SFY17 funding)
- Prevention and early intervention – rural community reentry coalitions (13% of SFY17 funding)
- Program infrastructure – AKAIMS Module data tracking fee, ACOMS Reentry Pre-Release Referral Module, Vivitrol study, Medicaid Expansion enrollment funding (23% of SFY17 funding)

Wooden identified that Partners for Progress provides direct service to reentrants in the Anchorage area such as housing, employment and food assistance. There are four reentry case managers, located in Anchorage, Fairbanks, Mat-Su and Juneau, who provide in-reach services prior to release and when individuals re-enter the community to provide ongoing case management. DBH worked with DOC to create an automated referral system which has made it easier to know when an individual will be released. There are reentry coalitions in Anchorage, Fairbanks, Juneau, Mat-Su and they have recently expanded coalitions to include rural areas such as Dillingham, Kenai, Ketchikan and Nome.

Department of Health and Social Services, Commissioner's Office

Gennifer Moreau-Johnson, Project Coordinator

Gennifer Moreau-Johnson shared information about the SB91 and SB74 integration initiative, which is the intersection and integration of key components of criminal justice reform and Medicaid/behavioral health redesign and reform. Focus areas include:

- Medicaid enrollment for all justice involved individuals
- Reentry planning and coordination to support transition and reentry from correctional facilities to the community and reduce recidivism
- Programming strategies to increase access to evidence-based rehabilitation programs
- Coordination and alignment with the work of the Alaska Criminal Justice Commission

Workgroup objectives, action steps and success metrics for each focus area were reviewed.

University of Alaska – Anchorage, Justice Center

Brad Myrstol, Director

Brad Myrstol addressed assessing the progress and impact of criminal justice reform, noting that criminal justice reform is not a quick fix. He stressed the importance of relying on rigorous research and investing in what works. Myrstol noted that recidivism reduction enhances public safety, but that this should not be confused with crime rate reduction. Criminal justice reform also has impact on justice equity and disability justice. Examples of this include bail reform and investments in prisoner reentry and behavioral health programs.

Question + Answer

Topic: DOC and Trust beneficiaries.

Q: Are the number of Trust beneficiaries broken out by type in the DOC system?
A: Adam Rutherford identified the answer is yes; however, he did not know the numbers off hand. He referenced a Trust study that lists beneficiaries by type and breaks out people with disabilities in DOC facilities. The referenced report is available here.

Q: Are people with developmental disabilities treated differently while incarcerated and is DOC doing anything different with this population?
A: Adam Rutherford stated that reinvestment funds focus on substance abuse, which include people with developmental or intellectual disabilities. Providers are coming into DOC facilities prior to release for warm hand-offs to get people connected to resources. It is hard to connect people with developmental disabilities with treatment providers because providers want to get the waiver first. DOC is partnering with DHSS to provide a discharge incentive grant to pay for assisted living facilities until people with developmental disabilities get connected to resources and benefits. In DOC facilities there are sub-acute mental health units to aid folks who are getting victimized in the prison system. This is a safer environment to reside in. Identification of a developmental or intellectual disability can be challenging. Because Alaska has a unified corrections system all institutions are integrated meaning that there is constant mixing of short and long-term offenders. For example, on any given day, DOC moves 80 offenders from the Anchorage Jail to Goose Creek to balance capacity among facilities.

Workforce + Provider Perspectives

Workforce has long been a focus of the Trust, recognizing that without a skilled Alaskan workforce, beneficiaries will not have needed supports. The Trust's Theory of Change identifies "Alaska workforce meets beneficiary and employer needs" as a key result. A theme across impact areas is the need for quality employees as well as enough staff to meet the current demands. Workforce development is a critical area for the Trust to continue to invest.

For more detail information, please view the *State of our State: Workforce and Provider Perspectives*, found here.

Alaska Mental Health Trust Authority
Eric Boyer, Program Officer

This presentation offered an overview of the Trust's core foundation and strategies for workforce development. The Trust's workforce core foundation involves engaging and preparing Alaska's youth for health careers, training competencies and professional development, loan repayment, incentives and support for service, in-state doctoral internships and clinical placements and health workforce data. Existing funding for workforce strategies includes:

- Coordinated leadership
- Alaska Training Cooperative
- SHARP I Loan Repayment and Incentive Program
- Alaska Psychology Internship Consortium (AK-PIC)
- Area Health Education Centers (AHEC)
- Workforce data monitoring

Success from these strategies include: 80% of youth participating in AHEC programs reporting increased interest in behavioral health careers, 3,753 unduplicated training participants in events organized by the Alaska Training Cooperative, 254 behavioral health, dental and medical providers participating in the loan repayment and incentive programs and 44 behavioral health positions filled by AK-PIC interns.

University of Alaska – Anchorage (UAA), Center for Rural Health and Health Workforce
Kathy Craft, UAA Director of the Alaska Health Workforce Coalition

This presentation offered an overview of the Alaska Health Workforce Coalition, a public-private partnership launched to develop a coordinated, cohesive and effective approach to addressing Alaska's health workforce. Occupational priorities for the coalition include:

- Direct Support Professionals
- Peer Support Professionals
- Behavioral Health Practitioners/Providers
- Nurses
- Primary care practitioners/providers
- Physical therapists
- Healthcare administrators

The coalition also works in systems change and capacity building in the areas of: preparing youth for health careers, training, competencies and professional development, policies an infrastructure, recruitment and retention and workforce data. The fastest growing health services occupations are expected to be home health aides, personal care aides, physician assistants and nurse practitioners.

Alaska Association on Developmental Disabilities (AADD)

Lizette Stiehr, Executive Director

AADD works with 50 organizations statewide. Workforce challenges for developmental disabilities services include frozen rates for the last five years, increases in unfunded compliance mandates and living wages being unavailable to direct support personnel. A living wage was identified as $22/hr. A top concern for providers and consumers is the lack of high quality and trained direct support professionals (DSPs). As such, the Shared Vision for Developmental Disability Services identified a project team to address this issue. Noted accomplishments of the DSP Workforce Development project team include presenting a formal request to AADD to adopt the National Alliance for Direct Support Professionals Code of Ethics, surveying of DSPs attending the Full Lives conference and mapping of "the DSP Journey".

Alaska Behavioral Health Association (ABHA)

Tom Chard, Executive Director, Jerry Jenkins

ABHA has statewide membership. A proposal to increase behavioral health rates is out right now and this is a huge need.

- For behavioral health providers, workforce is their number one cost and when funding is capped or flat funded, the money can only stretch so far before workforce cuts are needed.

The community behavioral health rates are based in the 1990s and have only been updated twice. A 2009-2010 survey identified that many direct service professionals are working two to three jobs to make ends meet. Jerry Jenkins spoke to the complex training process required for this service area. Not only do organizations have to find people to hire, they must conduct background checks, on-board individuals and train them. Due to learning decay, organizations must continue to train staff, so they don't lose skills. There are also credentialing challenges due to differing requirements for continuing education across professions.

Alaska Geriatric Exchange Network (AgeNet)

Karl Garber

Karl Garber noted the senior population is growing faster in Alaska than anywhere in the nation. AgeNet currently provides services for over 10,000 seniors. There are approximately 75,000 seniors (65+) in Alaska

today and by 2025 there will be 136,000 seniors. This growth will substantially increase the need for services, including services for Trust beneficiaries.

- ADRD population is expected to grow from 9,000 today to 14,000 in 2025.

The workforce will need to grow substantially to match the increase in growth projections for the senior population. Currently, direct service professionals are paid too low and turnover is high. Senior centers need cooks and drivers.

Question + Answer

Topic: Workforce needs and strengths

Q: Kathy Craft opened the Workforce panel by asking attendees "What are the workforce needs?".
A: Attendees identified needs as: continued training, funding for people to attend trainings, salary schedule that compares positions, training Trust beneficiaries to work in the field, incentives for high schoolers to consider a social services career track, moving people in direct service into higher paying positions so people see a career path, incentives for people to work in health shortage areas, incentivizing natural supports, and adjusting behavioral health reimbursement rates.

Q: Kathy Craft opened the Workforce panel by asking attendees "What is working well in the workforce?".
A: Attendees identified things that are working well as: continued training on evidence-based practices, the Complex Behavior Collaborative, and the tribal health model for BHAs, CHAs, and DHATs which grows a community workforce to remain in the community to provide services.

Topic: Workforce training needs

Randall Burns commented that an issue for behavioral health and workforce development is that it is not just that you have to hire someone with the right degree and credentials, but they have to be able to document what they do, and document it so that Medicaid finds the claims substantiated. He noted a lack of training in this area and that documentation is never addressed at an undergraduate or graduate level. There was a response affirming that this is needed in nursing programs as well. Nurses are graduating with good skills, but don't enter the workforce knowing about Joint Commission (formerly JCAHO) and other accreditation and quality compliance standards.

Topic: Coordination with tribal providers

Q: What is being done to coordinate workforce efforts with tribal providers?
A: Collaboration is happening with Ilisagvik College and Alaska Pacific University. ABHA identified they work closely with tribal providers and have talked about workforce being a priority.

Topic: The SHARP program

Q: What is the status of the SHARP program been and what are agency contributions to the payment?
A: There are two SHARP programs: SHARP-I is federally sponsored, SHARP-II is state sponsored. SHARP-III is currently in the works and hopefully there will be legislation next session to get it up and running. The employer contribution will be a little higher for SHARP-III and it is privately sponsored. The goal is to get more people into the program, so the tradeoff is employers must pay more into it. SHARP-I is limited to tribal health and health professional shortage areas. Shannon Cross-Azbill commented that SHARP is too expensive for DJJ. Additional information about SHARP can be found here.

Topic: Direct Support/Service Professionals (DSPs)

There was a comment about different factors that contribute to the workforce. It was noted that DSPs are often spouses or family members of those in the oil and gas industry or military, so when those industries change, the availability of DSPs changes. Burnout also noted as a concern and burnout is tied to supervision. The thought is that good supervision helps prevent burnout. A strategy to consider is operating like the Sand Point Trooper post which uses a schedule of three weeks on, three weeks off.

There was a comment about the needs of Direct Support Professionals (DSPs). DSPs need benefits and respect for the work that they do. Supervisors need to be able to help and support DSPs. There is a thought that DSPs don't quit the work, they quit the supervisor.

Developmental Disabilities Shared Vision Update

Alaska Association on Developmental Disabilities (AADD)

Lizette Stiehr, Executive Director, Michael Bailey, President, Kim Champney, Consultant

The Shared Vision for Developmental Disability Services is: *Alaskans share a vision of a flexible system in which each person directs their own supports, based on their strengths and abilities, toward a meaningful life in their home, their job and their community. Our vision includes supported families, professional staff and services available throughout the state now and into the future.* This vision and its priorities are at the center of the systems change work with no owner.

Over 200 stakeholders have shared their input in this process, including people who receive services, their family members, as well as direct support staff. There have been key results so far in culture, workforce, community, and legislative with the successful passage of Shared Vision into State statue. Project teams for the Shared Vision include:

- Person-directed culture change
- Direct support professional workforce development
- Community awareness
- Legislative Engagement
- Measuring success

Alaska has the highest rate of people with disabilities who have guardians (95%) with the largest caseloads in the country. The national average is 45% of people with disabilities who have full guardianship. There are alternatives to full guardianship.

The Developmental Disabilities (DD) Systems Collaborative, the steering committee for the shared vision, recently reviewed the past year and community input received, reflected on the intent of the vision and brainstormed next steps. The barriers that need to be removed to implement this vision are as follows: build toward livable wage for direct support professionals; widen safety net for beneficiaries losing services during state's grant-to-Medicaid transition; advocate for increased capacity within SDS to implement changes needed to accomplish our vision; and continue to educate, talk about, inspire, support, commit to making the Share Vision a reality. For more information about the DD Shared Vision Update, see *Shared Vision for Developmental Disabilities* presentation here.

Question + Answer

Topic: Living wages

Q: What is the definition of a living wage?
A: Several answers and comments emerged:

- $22/hour in Anchorage.
- This was not defined with Direct Support Professionals (DSPs). A survey in 2010 among DD service delivery field showed that one-third of DSPs qualified for one or more federal or state benefit.
- It depends on family size and what it takes to support each family.
- This is a tricky issue. Wages need to be increased incrementally. If we increase wages, it could take away other benefits that are needed. Certain regulatory changes need to be made. This could ripple through the system, DSPs could make more than their supervisors, etc. This issue needs to be dealt with across the board for all workers and fields.
- We need to look outside of silos and look at these challenges in a much broader way as they impact everything we are doing.

Topic: Self-determination

There was a comment around the basic understanding of self-determination which is applicable to so many groups of people, like Alaska Native people. Could we think about children this way? If we start to think about children and their caregivers having foundational choices in how we live, it would change ACEs/outcomes. If you look at Jared Parrish's study, there is a sector of children in our state who have no status and no ability to determine their own way of life. What the DD Shared Vision is doing is so powerful; how can we use this model for changing our whole system? All children would benefit from this thinking: all children and their caregivers should feel that they are in charge of their own lives and are able to live in safety and wellbeing.

Topic: Wards of the State

Chad Holt with the Office of Public Advocacy shared that current wards of the state have gone up each year since 2007. Currently each caseload per guardian is around 100 (the national recommended caseload is 40). The good news is there are seven (7) new public guardian positions open, one of which is funded by the Trust for the Bethel area. These positions will be posted soon. Please spread the word!

Veterans Administration Update

Trust beneficiaries may also be Veterans; thus, it is important to have an understanding of the resources available to Veteran beneficiaries. Specifically, Department of Veterans Affairs services may be helpful for beneficiaries in need of safe and affordable housing, substance misuse services, employment, and criminal justice/reentry services.

Department of Veterans Affairs (VA)

John Pendrey, Jeremiah Newbold and Toni Trend

Alaska's VA system provides a variety of specialized programs for homeless and at-risk Veterans. The January 2018 Point in Time Count identified a total of 132 homeless veterans in Alaska, 19 of whom were identified as chronically homeless. Sixty-two (62) veterans were in Anchorage and 70 in the balance of state. 2018 was the first year that the balance of state numbers exceeded Anchorage numbers. Highlighted resources include:

- Domiciliary Care for Homeless Veterans Program: A 35-bed domiciliary care facility for homeless veterans and a 15-bed residential substance abuse treatment program for homeless and non-homeless veterans

- Outreach: Full-time outreach worker who goes into camps and shelters and uses the by-name list to identify veterans on the streets. An outreach worker also works in all of the correctional facilities.
    - In correctional facilities, there is no system for identifying veterans who are incarcerated which creates a barrier to outreach. The outreach worker must do an open call at each facility and inmates self-select if they wish to speak with the worker.
- HUD/VASH Vouchers: There are 326 vouchers available, representing the largest scattered site housing first program in Alaska. It was identified that 88% of those who go in to housing through this program stay housed. There are specific tribal vouchers available, 20 in Southeast Alaska and 20 in the Cook Inlet region, with plans to bring 20 more vouchers to the Bethel region.
- Homeless Veteran Community Employment Services: Compensated Work Therapy, which is comprised of transitional work and supported employment programs. Employment programs include a 24-bed transitional housing program for veterans in one of the VA's Compensated Work Therapy programs.
- Grant and Per Diem Program: Payments to other entities to develop and operate transitional housing and/or service centers for homeless veterans. Veterans do not have to be eligible for VA healthcare to access these benefits.
    - The Fairbanks Rescue Mission serves homeless veterans with children.
- Veteran's Court: The program length is 9+ months with a focus on reducing legal charges via encouraging mental health or addiction treatment. Misdemeanor domestic violence charges are common in the court. There are probation officers that work specifically with this court.

More information can be found at here.

Question + Answer

Topic: Coalition work

Q: How is the VA connected to area homeless coalitions?
A: VA staff identified they use the by name list, participate in the re-entry coalitions and are part of the Legal Alliance (a coalition for veterans with legal issues).

Topic: Employment services

Q: How does the VA find employers to develop positions for their Compensated Work Therapy programs?
A: VA staff identified they have a job development coordinator who goes door-to-door to get employers on board. The VA subsidizes the position for 4-6 months.

Topic: Coordinated entry

Q: In relation to coordinated entry, how do our systems ensure Veterans are not being double counted or missed?
A: Both the VA and Anchorage use the by name list. The VA does not enter data in AK HMIS as they use the HOMES system.

Small Group Discussion

Presentations and panel discussions in day one set the stage for the small group discussions in day two by providing an overview of current policies, programs and systems change efforts that affect each of the key areas the Trust works in. For small group discussions, participants broke into six small groups, one for each

key area, as identified in the Trust's Theory of Change. Groups were: 1) whole person healthcare; 2) decreasing substance abuse; 3) workforce; 4) reducing criminal involvement; 5) employment and peer supports; and 6) safe and affordable housing and long-term services and supports. Each small group was assigned a note taker and a facilitator.

The first task of each group was to identify key issues that must be addressed to ensure beneficiaries thrive in their communities. Each group was to identify the barriers or risks that prevent beneficiaries from thriving in their communities and prioritize these issues from most pressing to least. The second task of each group was to start with the most pressing issue and define the financial, policy and human resources needed to address each issue. Lastly, each group was to discuss if the Trust's current investments and policy initiatives addressed each issue. If not, each group was to recommend changes that need to be made over the next two years.

The overarching purpose of these small group discussions was to identify policy and systems shifts that currently impact or could impact beneficiaries. Conversations were not focused on individual programs and projects, although these efforts could be identified as part of a larger problem or solution.

While stakeholders who were present for the two-day meeting come from a variety of agencies and backgrounds and bring many years of experience in the field to the table, it is acknowledged that individuals participating in these small group discussion process may not have the requisite information to identify the full scope of the problem or to identify solutions or implementation steps. Furthermore, it should be noted that the problems and solutions identified by this process may require further assessment and discussion with broader groups of stakeholders. Despite attempts to include as many stakeholders as possible, not everyone who is needed was at the table.

Whole Person Health Care

Katie Baldwin-Johnson (the Trust) and Denise Daniello (the Alaska Commission on Aging) facilitated this group's discussion. This small group started the discussion with defining whole person health care. The group defined social determinants of health as the medical, psychological, social, economic, spiritual, and family aspects of a person. It was stated that this key area intersects with all other focus areas.

Prioritized Key Issues

The key issues identified for whole person health care from most pressing to least are as follows:

Prioritized Key Issues for Whole Person Heath Care	
1	Care coordination / navigation across systems to achieve whole person care
2	Total cost of healthcare and increasing costs of not being able to integrate care
3	Equal access for all (health equity)
4	Sharing of information tied to whole person care across providers/discipline
5	Need for crisis stabilization (current crises: homelessness, substances, mental illness)

Identified Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources
1. Care Coordination / navigation across systems to achieve whole person care	• Advocate for a reimbursement rate (state, insurance companies) to show value of care coordination • Identify who will pay for this service • Federal match / employer pays for training benefits • Test models to see what works (in progress)	• Advocate for reimbursement rate (state, insurance companies) to show value of care coordination • Statutory or regularly changes • Health home concept, ex: PACE model (health home addressing social determinants of health) or ADRC model; patient-centered medical home; demonstration projects (in progress)	• Training workforce (no bachelor's degree needed); employer pays for training benefit of employees • Implementation of models in system; implementation science so the model is sustainable
2. Total cost of healthcare and increasing cost of not integrating care (siloed healthcare)	• Support current efforts • Alaska Health Reform which is a broader group of legislators, payers, providers, hospitals are looking into this currently • Consolidate health plans; State of Alaska healthcare benefits / retirees	• Support current efforts • Look at some of the things already in movement and involve national experts, insurance payers, national and state scans / analysis	• Support current efforts
3. Sharing of information tied to whole person care across providers / discipline	• Merge databases and analyze data; identify cost of systems to collect / manage data; cost of technical assistance and training; cost of health information recording and connecting to share data • Consistent database needed to merge data and make meaning out of data	• Data will drive decisions around care / treatment / policy to move us to connected databases • How are we seeing patient outcomes improve along the way to adjust interventions / services appropriately? • Legislature may see results and support funding and/or statute changes to direct funding / legislation to support sustainability	• Education about HIPAA / confidentiality; aggregate vs. individual data; • Technical expertise and capacity needed • Workforce trained in data analytics and who can translate data into practice

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Care Coordination / navigation across systems to achieve whole person care	No	• Define and educate the state / providers on care coordination; what is it, what can/cannot be billed, what are the parameters, what can be expected from terms; AMHB/ABADA are thinking about this too, partner together • Support access to funding, technical assistance and training on coordinated care models; become an expert on different models that are successful • Utilize telehealth and assisted technology management for whole person health
2. Sharing of information tied to whole person care across providers / discipline	No	• Investment in resources and support of data analytics (hardware, costs associated with increasing competency of staff to use systems and conduct data analytics, make sure data is collected and analyzed in same way) • More support from the Trust Training Cooperative for staff and providers (training / technical assistance) as the state transitions and this service is in greater need • Look at data analytic capacity at the Trust and Trust partners • Software to link up and merge databases

Decreasing Substance Abuse

Alison Kulas (Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse / Statewide Suicide Prevention Council) facilitated this discussion and Becky Bitzer (Agnew::Beck Consulting) was the note-taker for the group.

Prioritized Key Issues

The key issues identified for decreasing substance abuse from most pressing to least are as follows:

Prioritized Key Issues for Decreasing Substance Abuse	
1	Power dynamics that prevent equitable distribution of power
1	Investment in reactionary systems (lack of investment in upstream work)
2	Lack of family systems and community approaches to healing
3	Trauma, which increases stigma, shame, and fear of punishment
4	Lack of access to services across the continuum
5	Government

Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources
1. Power dynamics that prevent distribution of power	• Funding for community organizing (not a coalition, something like Alaska Faith and Action Congregations Together) • Require grantees to conduct an equity assessment (Addresses question: How are you doing with, not for?)	• Advocate for changes in conflict of interest laws for legislature • Advocate for changes in what lobbyists can do • Change policies to limit/ban alcohol advertising in spaces where people under 21 are likely to be influenced • Ensure the Trust Land Office values align with The Trust and beneficiary values, especially as it relates to perpetuating historical trauma • Dept. of Law limiting who gets in to therapeutic courts	• Trust staff attend diversity/cross-cultural trainings, then offer these resources to other organizations • Investment in high schools to foster student voices (youth advocacy) • Mental Health First Aid (MHFA) for all first responders
1. Investment in reactionary systems (lack of investment in upstream work)	• Funding for transitional housing • Focus on transitions • Interim solutions for treatment while waiting for a bed	• Require recess/physical activity in schools (physical activity as a protective factor)	• Enhancing ADRC across the state for warm hand off and follow up • Facilitate meetings between different divisions (communicate between silos)
2. Lack of family systems and community approaches to healing	• Fund parent education • Fund supports for families • Rethink how we fund/where we place value • Invest in building social fabric of health	• Every FQHC & community mental health center works in an integrated way (Sunshine Clinic model) • Visitation: Policies that support children's ability to visit parents in prison	• The Trust community-driven regional plans • Role models for healthy living • Define what co-occurring means for agencies; What does it mean for agencies to say they are co-occurring capable? • Organizational health • Value shift around healthy work environments • Address secondary trauma (develop better models for self-care)

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Power dynamics that prevent distribution of power	Needs further exploration	• DOL limiting who gets in to therapeutic courts: Instead, make DBH a gatekeeper for who gets access to therapeutic courts; expand legal service supports around the state • Diversity equity and inclusion assessment: Look at who is on the board, in the staff • Regional non-profit networks that negotiate with for-profit networks (protection for quality of care): Support for BH provider networks to thrive in ASO/managed care model
1. Investment in reactionary systems (lack of investment in upstream work)	Needs further exploration	• Scaling behavioral health in schools – look at what's happening around the state, look at what's working, see what could work around the state • Fund peer supports that are not medically necessary • Recovery drop in centers • Increase alcohol tax
2. Lack of family systems and community approaches to healing	Needs further exploration	• Circles of Security - looking at evidence-based models that are already going on – scaling. • Expand peer to peer certification (tie to college credit) • Scale crisis intervention model • Scale ADRC for referrals

One group member shared thoughts following the stakeholder input session that were not captured in the tables above. The approach taken was to break "decreasing substance abuse" into three sections: Prevention, Early Intervention, and Moderation and Abstinence. *Prevention* would focus on using epidemiological data to identify protective and risk factors that lead to initial use and later misuse, noting that successful prevention programs need to focus on education and expanding protective factors with an emphasis on life skills, social impacts and norms. The education component would include engaging the public education system. *Early Intervention* would ask the question, "When someone moves from use to misuse, what has changed? Which protective factor needs a reboot?" Good early intervention always has an enforcement side that includes consequences. Early intervention could look like including SBIRT in schools and early childhood settings or could mean an SBIRT worker connecting with families screened out by OCS. Additional thoughts on *Moderation and Abstinence* were not included.

Workforce

Eric Boyer (the Trust) and Kathy Craft (University of Alaska Anchorage) facilitated this small group.

Prioritized Key Issues

The key issues identified for workforce from most pressing to least are as follows:

Prioritized Key Issues for Workforce	
1	**Value of direct service professionals** by society at large, and played out through the state, communities and employers. It needs to be demonstrated at the state level with policy and reimbursement as well as at the employer level, functioning at a healthy position of support for the DSPs.
2	**Lack of coordinated support between statewide entities** to push systems change (statewide policy campaign: quality standards, training, money, caseloads, competency, hiring processes)
3	**Lack of funding in the system for direct care** to do what is needed to support a viable workforce (unfunded mandates, regulatory demands, administrative burdens)
4	**Lack of professional support** (coaching, mentoring, education, flexible work schedules, family friendly, training)

Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources
1. Value of DSPs	• Financial support and rate reimbursement to meet the true needs of the workforce. Support for this from the legislature, state and communities. • Work to break down entities silos around training and share resources for training and professional development • Develop a career ladder that helps DSPs move up professionally, but allows them to stay with the same beneficiary over time, creating more stability and continuity	• Legislation that says we value our DSPs; need from a state level, guidelines on how to treat DSPs at an agency level with incentives built in on the financial side • Policy level support for young people to experience the DSP workforce as a volunteer to gain experience in the health field continuum	• Career ladders within systems to retain staff so they do not leave for other higher paying systems • Incentivize retention with longevity financial support • Apprenticeship type programs (DOL is working to support DBH with this, but it needs some finessing) • Person receiving services should have more control over the budget of their DSP • More exposure of young people to the health field industry; focus on fields where workforce issues exist
2. Lack of coordinated support between statewide entities	• Financial support to bring this coordinated effort together + reinvestment in the workforce basics to bring together existing fragmented efforts	• Legislation that focuses leaders and community members to look at policy from a collaborative and coordinating vision – a vehicle to pull this together and push it forward	• Include supervisory level in DSP workforce discussions to take in to account the whole spectrum when discussing coordinated policy support for the workforce • DOL apprenticeship models for behavioral health that are adapted to this industry

3. Lack of funding in the system	• If entities meet certain requirements, allow extra funding to be utilized to provide DSPs with benefits	• Needs further exploration	• Needs further exploration

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Value of DSPs	Yes	• A unified DSP workforce development approach to address needs and issues; more integrated development across systems and strategically statewide so that the coordinated and collaborative efforts can address this issue by expanding on some of the current systems
2. Lack of coordinated support between statewide entities	Yes	• Utilize the Alaska Healthcare Workforce Coalition (AHWC) to field a focus group of workforce stakeholder and additional workforce sub-groups that represent the various DSP disciplines and hear from them what the needs, issues, and opportunities are to support the workforce statewide.
3. Lack of funding in the system	Yes	• Workforce summit on behavioral health to include an outside economist's input a perspective on how we develop and support a DSP workforce

Reducing Criminal Involvement

Steve Williams and Travis Welch, both with the Trust, facilitated the discussion for this topic area.

Prioritized Key Issues

The key issues identified for reducing criminal involvement from most pressing to least are as follows:

Prioritized Key Issues for Reducing Criminal Involvement	
1	Beneficiary youth involvement with and overexposure to the criminal justice system
2	Community provider workforce capacity and skillsets for working with beneficiaries and families who are criminal justice involved
3	Timely access to community-based treatment
4	Lack of capacity to assess and identify beneficiaries who experience FASD, TBI and other cognitive impairments
5	Timely access to housing with appropriate services and supports

Additional key issues of concern not included in the top five were identified as: working with parents and families of beneficiaries, competency processing (Title 12), legal strategies, identification of trauma and victimization, lack of diversion (keeping people out of formal institutional systems) access to benefits such as Social Security and Medicaid, and access to prosocial activities.

Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources
1. Beneficiary youth involvement with and overexposure to the criminal justice system	• Requires data collection and assessment	• Identify youth at sequential intercept points who are at risk of becoming involved with the criminal justice system and collaborate with partnering agencies to divert and prevent the involvement • Trust conduct an environmental scan to identify different agencies' efforts (to include the Child in need of aid improvement project). • Crack the code to access OCS Protective Service Reports screen out without intervention to provide early intervention services to children and families.	• Requires data collection and assessment
2. Community provider workforce capacity and skillsets for working with beneficiaries and families who are criminal justice involved	• Requires data collection and assessment	• Work with and support UAA, OCS, DJJ with the development of their proposed collaborative campus. • Work with OCS, DOC and other agencies on a positivity campaign.	• Requires data collection and assessment
3. Timely access to community-based treatment	• Small fee per assessor	• Universal screening assessment tool	• Needs further exploration

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Beneficiary youth involvement with and overexposure to the criminal justice system	For each issue, this is an area for further stakeholder exploration.	For each issue, this is an area for further stakeholder exploration.
2. Community provider workforce capacity and skillsets for working with beneficiaries and families who are criminal justice involved		
3. Timely access to community-based treatment		
4. Lack of capacity to assess and identify beneficiaries who experience FASD, TBI and other cognitive impairments		

5. Timely access to housing with appropriate services and supports

Employment and Peer Supports

Jimael Johnson (the Trust) and Patrick Reinhart (Governor's Council on Disabilities and Special Education) facilitated the discussion for this topic area.

Prioritized Key Issues

The key issues identified for employment and peer supports from most pressing to least are as follows:

Prioritized Key Issues for Employment and Peer Supports	

1	**Perceptions/Communication - Stigma**
	• Cycle of dependency
	  o Not an expectation for people to work (everyone)
	  o Fear of losing benefits - misinformation (including health insurance)
	  o Clinical team members may not believe that beneficiaries can achieve competitive employment
	• Lack of understanding of employer needs
	• Peer support – lack of understanding with clinical/medical model
	• Employer hesitancy related to stigma, though can be overcome through initial approach and ensure
	• Lack of connection between provider agencies and DOL/DVR (i.e. peer support apprenticeship, etc.)

2	**Training**
	• Beneficiary skill sets / inventory of strengths
	• Competitiveness of positions (due to economy)
	• Employment workforce – need skilled employment specialists who can approach
	  o Training is available but need to be accessed
	• Peer support – currently on the job but standardized training/credentialing development in process
	  o Limited agency support to provide adequate on-boarding/mentorship for new staff

3	**Concrete Supports** • Child care availability/cost • Lack of living wage – enter other systems because they can't meet their basic needs o No savings / no buffer or safety net • Transportation
4	**Policies** • Barrier crime matrix – "informal extension of punishment" o UA requirements • Reimbursement for supported employment services (i.e. requirement for 1:1 and job development) • Siloed state agencies - data systems not integrated to measure progress

Other conversations focused around the issues of meaningful engagement (which may lead to employment), self-employment, and braided funding (i.e. IPS, and Project SEARCH).

Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources

1. Perceptions/Communication -Stigma
 	
(i.e. people with disabilities can't work; I will lose benefits if I work)
	• Funding for public information campaign/PSA "fighting the myth"
	• Rates need to incentivize policy shift towards Employment First implementation on service level
	• SDS
	• DVR
	• DBH
	• Schools (pre-employment training)
		• Employment First Legislation: Push Employment First policy to client level (assessments, treatment plans/of care, etc.)
		  • Agencies/care coordinators incorporate employment goals, document that the quest has been asked (across state agencies/systems)
		  • Shift away from deficit-based model
			• Clinical students working with teams
			• Agency by agency training
			• Educating younger students – inclusive classrooms

2. Hiring policies/barrier crimes matrix (background checks)	• Program/funding to reward successful programs	• Explore policy change to reduce barriers related to criminal history – current policy is counterproductive related to peer support • Engage Alaska Criminal Justice Commission	• Hire "our own" (peers/beneficiaries) to set example for rest of the community
3. Concrete supports (transportation)	• Medicaid (SDS) • Federal (routed through independent living centers?)	• SDS shift (waiver to pay friend/family member to reimburse for mileage to/from employment (in addition to bus pass/taxi voucher/other) • Incentivize natural supports • Environmental: sidewalks, trail accessibility (safer walkways, plowing, etc.)	• Travel training – use of public transportation

4. Training	• Employment summit
	  • Educate on Medicaid buy-in, etc.
	• Explore best practices for peer support models
	  • Respite house
	  • Referral program with police
		• Needs further exploration	• Needs further exploration

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Perceptions/Communication – Stigma	No	• Employment First legislation: Push Employment First policy to client level (assessments, treatment plans/of care, etc.) • Incentivize agencies/providers to ensure beneficiaries direct their services – Evaluate this • Communication plan/public information campaign • Promote positive employment expectations (public, provider and family expectations) • AMHB/ABADA & GCDSE partnership • Employment Summit
2. Hiring policies/Barrier crimes matrix (background checks)	No	• Review barrier crime policies/develop recommendations to improve employment outcomes for beneficiaries (without creating dangerous situations)
3. Concrete Supports (transportation, child care)	No	• Identify flexible funding opportunities to provide gap filling service needs to enable beneficiaries to gain and maintain competitive employment
4. Training	No	• Employment Summit

Safe and Affordable Housing and Long-Term Services and Supports

Kelda Barstad (the Trust) and Thea Agnew::Bemben (Agnew::Beck Consulting) facilitated this small group discussion. During introductions the Safe and Affordable Housing and Long-Term Services and Supports discussion group identified the following opportunities and resources:

- Homelessness is big issue for OPA clients both in Child in Need of Aid and other wards
- Pioneer Homes seeing elders coming in because of evictions and being moved out of ALH; level one is basically supported housing
- AHFC allocation is $10m/year for supportive housing, wide range of populations and services; integrate with Mortgage division and Public Housing divisions
- Juneau working on Coordinated Entry and braided, coordinated funding and homelessness services
- Arctic Access in NW Arctic, housing is top issue in villages: heating, structural, food; younger generation having children and then leaving elders to care for children while they go find work or leave for hub communities

Prioritized Key Issues

The key issues identified for safe and affordable housing with appropriate supports from most pressing to least are as follows:

Prioritized Key Issues for Safe and Affordable Housing and Long-Term Services and Supports	
1a	Enough safe, functional, affordable housing for everyone who needs it
1b	A robust, barrier free continuum of care to support people's individual service and support needs
2	Timely access to benefits and connection to living wage employment to increase income

3	System to assess and identify needs and match with appropriate housing and long-term services and supports
4	Community engagement to build public will to house all Alaskans

Financial, Policy and Human Resources Needed to Address Issue

Issue	Financial	Policy	Human Resources
1a. Enough safe, functional, affordable housing	• Form a funders' collaborative statewide that includes lenders and other capital partners and regional investors • Use the housing needs assessment to quantify the actual need for number of units by region, funding need; assess existing funding and opportunity for consolidation of weatherization and accessibility funding; identify gaps and a timeline for aggressively bringing in resources to build housing. • Explore use of General Relief funds for rental assistance.	• Increase understanding and ability for rural organizations and communities to leverage funding through financing and other sources to bring in other public resources • Identify locally-appropriate housing models and types that could be developed in villages that are cost-effective and match family sizes and lifestyles • Consider small housing alternatives including manufactured homes, Connex units, create incentives for developing these units. • Support property tax incentives and zoning changes for constructing accessory dwelling units. • Require housing + homelessness elements in all community and regional comprehensive planning efforts. • Institute property tax incentives and other incentives to develop smaller units and more affordable housing	• Additional builders and developers are needed, especially in rural areas • Identify staff member/time to spread the knowledge of other models that work to communities across Alaska

1b. A robust, barrier free continuum of care to support people's individual service and support needs *(Sub-population: People with disabilities who do not meet Nursing Facility Level of Care and therefore will qualify for 1915c waivers but who need significant supports to maintain housing)*	• Explore Medicaid refinancing options for state funded services, including General Relief, to expand the continuum of care. • Increase resources for case management to serve a range of vulnerability levels to maintain housing • Review and coordinate all current federal, state and private payment mechanisms for case management services to address gaps in populations served and periods of time with no insurance such as the Medicaid enrollment period.	• Continue the work of Medicaid Reform to change regulations that create barriers to services and supports. • Change regulations and policies for grant programs that create barriers to services and supports or development of a more robust continuum of care. • Develop an agreement to pair housing vouchers funded through AHFC with services and supports to create seamless access to both systems for people needing permanent supportive housing. • Ensure providers use mobile crisis support services to support people in their homes as a first response	• Develop 24-hr. urgent care for behavioral health services/ crisis support alternative to the Psych ED, for people who are experiencing behavioral health crises not acute enough for ED. • Create robust mobile crisis services to support tenancy. • Develop case management and care coordination workforce to meet population needs.
2. Timely access to benefits and connection to living wage employment to increase income *(Notes: Use 40% of income for housing costs to calculate living wage; AK has the highest denial rate [87% are denied on application] of SSI/SSDI applications)*	• Increase funding for supportive employment • Identify agencies/insurance that pays for supportive employment (Medicaid, DOL, DVR) and coordinate the funding and development of these services to maximize available jobs. • Advocate for adequate funding for DPA to process public benefits in a timely manner. • Fund legal assistance to obtain SSI/SSDI benefits for qualified applicants.	• Advocate with federal delegation to address the high denial rate of SSI/SSDI benefit applications • Establish a MOA between DBH and DVR to require and identify supportive employment services to increase employment for people with behavioral health issues and other disabilities.	• Legal assistance to access SSI/SSDI benefits and manage appeals • Focus case management efforts on accessing benefits and increasing employment and earned income • Train supportive employment workers to use evidence-based practice models • Educate behavioral health providers to focus on employment as part of a recovery model

3. System to assess and identify needs and match with appropriate housing and long-term services and supports	• Support implementation of Coordinated Entry in Anchorage and Balance of State • Invest in connecting various information and referral sources and processes to a central hub, and to create an interconnected network to access resources through a connected network • Maximize use of Medicaid technology funds to support database connections. • Explore funding options for single site community information and referral	• Develop standard releases of information that support coordination and where possible, memorandums of agreements between agencies or systems. • Develop policies and procedures for a shared intake process across programs • Encourage leadership across social service agencies to make these policies a priority.	• Publicize Alaska 2-1-1 and ADRCs to make the public aware of information and referral • Build capacity of ADRCs • Connect the various intake processes and people for different information and referral sources • Develop consistent referral processes to standard assessments necessary to access services. • Skilled workers needed for robust information, referral and assessment.

Recommended Changes to Trust's Current Investments and Policy Initiatives

Issue	Are current investments + policy initiatives addressing this issue?	Recommended changes
1. Lack of safe, functional, affordable housing	Yes, but more is needed	• Support planning for rural Alaska housing development; ensure seed funding to address findings from planning efforts • Consolidate application and intake process for housing programs, use AHFC • Increase funding allocation on an ongoing basis for more Permanent Supportive Housing units to house people with disabilities who are homeless • Maintain flexibility of partnership funds
1b. Lack of capacity and funding for supportive services to help people maintain housing; support continuum of care	Yes, but more is needed	• Analyze SDS, DBH and other state policies and procedures to ensure and facilitate person-centered service allocation and delivery • Analyze case management capacity across systems. Identify opportunities to coordinate to increase capacity. • Transition funds for crisis services, facility based and mobile.
2. Timely access to benefits and connection to living wage employment to increase income	Yes	• Needs further exploration

Conclusion

Information gathered during the June 20 and 21 Stakeholder Input Session will inform Alaska Mental Health Trust Authority staff to craft budget and policy recommendations for trustees in the FY20-21 budget periods. Trust staff will incorporate work session results, follow-up with key stakeholders, and include information from the stakeholder survey into the draft budgets. Overall, stakeholders agreed that the Trust is focused in the right areas and the issues facing beneficiaries are being addressed through systems, policy, and programmatic work that is beneficiary focused; however, there is a great deal of additional work in these areas to be done given the breadth and complexity of the Trust's initiatives and focus areas.

Key Take-Aways

The top issues and solutions identified in small group discussions are summarized here. It should be noted that although "workforce" was its own key discussion area, workforce issues and concerns crossed all small group discussions and rose to the top in almost every panel or presentation. There is a sense that without workforce initiatives, to both increase the quantity and quality of those serving beneficiaries, the beneficiaries will continue to cycle in to higher levels of care.

- Whole person health care: Care coordination across systems was identified as the top issue. Strategies to address barriers to whole person health care include: Educate the state/providers on care coordination, support access to funding, technical assistance and training on coordinated care models, and utilize telehealth and assisted technology management.
- Decreasing substance abuse: Issues that rose to the top were power dynamics that prevent distribution of power and a lack of investment in prevention work. To address power dynamics, the stakeholder group recommended: making the Division of Behavioral Health the gatekeeper for who gets access to therapeutic courts, a diversity equity and inclusion assessment for funded organizations and support for behavioral health provided networks so they can thrive under the ASO/managed care model. Recommended investments in prevention work include scaling behavioral health in schools, funding for peer supports that are not medically necessary, funding recovery drop-in centers and increasing the alcohol tax.
- Workforce: A key issue is valuing direct service professionals (DSPs). To address this, stakeholders recommend a unified DSP workforce development approach to address needs and issues, including more integrated development across systems and strategically statewide.
- Reducing criminal involvement: Over exposure of beneficiary youth to the criminal justice system is a huge concern. Areas to address are: identification of youth at sequential intercept points who are at risk of becoming involved with the criminal justice system and collaborate with partnering agencies to divert and prevent the involvement, conducting an environmental scan to identify different agencies' efforts in this area, and data sharing to be able to access OCS Protective Service Reports screen out without intervention to provide early intervention services to children and families.
- Employment and peer supports: The top issue is perceptions, communication and stigma. To combat this, investment is needed to push the Employment First policy to the client level, to incentivize agencies/providers to ensure beneficiaries direct their services, development of a communication plan/public information campaign, to promote positive employment expectations, support partnerships between AMHB/ABADA and GCDSE and to host an employment summit.

- Safe and affordable housing and long term services and supports: To address the lack of safe and affordable housing, investment is needed to support planning for rural Alaska housing development, ensure seed funding to address findings from planning efforts, consolidate application and intake process for housing programs, increase funding allocation on an ongoing basis for more Permanent Supportive Housing units to house people with disabilities who are homeless and maintain flexibility of partnership funds.

Next Steps

August 2018: Trust staff will present draft budgets to the Trust program and planning committee. Trust staff will also spend several weeks gather additional information and data identified as needed during the June 2018 Stakeholder Input Session.

September 2018: Trust staff will present draft FY20/21 budgets to the Trust Board of Trustees for approval.

Appendix I: Participants

Name	Organization
Anne Dennis-Choi	AK Child & Family
Michael Bailey	Alaska Association on Developmental Disabilities
Lizette Stiehr	Alaska Association on Developmental Disabilities
Tom Chard	Alaska Behavioral Health Association
Jerry Jenkins	Alaska Behavioral Health Association
Julie Davies	Alaska Brain Injury Network
Denise Daniello	Alaska Commission on Aging
Michelle Bartley	Alaska Court System
Judge Pat Hanley	Alaska Court System
Kathy Craft	University of Alaska Anchorage, Alaska Health Workforce Coalition
Mike Courtney	Alaska Housing Finance Corporation
Daniel Delfino	Alaska Housing Finance Corporation
Jennifer Smerud	Alaska Housing Finance Corporation
Susanne DiPietro	Alaska Judicial Council
Alison Kulas	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse / Statewide Suicide Prevention Council
Bev Schoonover	Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
Tina Woods	Alaska Native Tribal Health Consortium
Connie Beemer	Alaska State Hospital and Nursing Home Association
Dennis Murray	Alaska State Hospital and Nursing Home Association
Paul Cornils	Alaska Youth and Family Network
Karl Garber	Alzheimer's Resource of Alaska
Pamela Kelley	Alzheimer's Resource of Alaska
Josh Arvidson	Anchorage Community Mental Health Services, Alaska Child Trauma Center
Jim Myers	Anchorage Community Mental Health Services
Kim Champney	Champney Consulting
Alan Green	Choices, Inc.
Irene Gallion	City and Borough of Juneau, Homeless Services
Harold Heinze	Consultant
Diane Casto	Council on Domestic Violence and Sexual Assault
Chad Holt	Department of Administration, Office of Public Advocacy
Dunnington Babb	Department of Administration, Public Defender
Adam Rutherford	Department of Corrections
Gen Moreau-Johnson	Department of Health and Social Services, Commissioner's Office
Amanda Lofgren	Department of Health and Social Services, Division of Alaska Pioneer Homes

Tony Piper	Department of Health and Social Services, Division of Behavioral Health
Randall Burns	Department of Health and Social Services, Division of Behavioral Health
Brita Bishop	Department of Health and Social Services, Division of Behavioral Health
Katie Chapman	Department of Health and Social Services, Division of Behavioral Health
Lynn Squires-White	Department of Health and Social Services, Division of Behavioral Health
Susan Musante	Department of Health and Social Services, Division of Behavioral Health
Beth Wilson	Department of Health and Social Services, Division of Behavioral Health
Alysa Wooden	Department of Health and Social Services, Division of Behavioral Health
Shannon Cross-Azbill	Department of Health and Social Services, Division of Juvenile Justice
Jared Parrish	Department of Health and Social Services, Division of Public Health
Caroline Hogan	Department of Health and Social Services, Division of Senior and Disability Services
Duane Mayes	Department of Health and Social Services, Division of Senior and Disability Services
Monique Martin	Department of Health and Social Services, Healthcare Policy
Travis Erickson	Department of Health and Social Services, Office of Children's Services
Andy Jones	Department of Health and Social Services, Office of Substance Misuse and Addiction Prevention
Tamika Ledbetter	Department of Labor and Workforce Development
Donald Revels	Department of Labor and Workforce Development
Robert Henderson	Department of Law
Ric Nelson	Governor's Council on Disabilities and Special Education
Patrick Reinhart	Governor's Council on Disabilities and Special Education
Elizabeth Schultz	Governor's Office
Michele Girault	Hope Community Resources
Dave Branding	JAMHI Health & Wellness, Inc.
Gwen Sargent	Kodiak Area Native Association
Elizabeth Ripley	Mat-Su Health Foundation
Steve Ashman	Municipality of Anchorage, Public Health Initiatives and Partnerships Division
Tiffany Hall	Recover Alaska
Michelle Baker	Southcentral Foundation
Luann Strickland	Tanana Chiefs Conference
Meghan Johnson	thread, Learn and Grow
Jusdi Doucet	Trust Land Office
Wyn Menefee	Trust Land Office
Gloria Burnett	University of Alaska, Alaska Area Health Education Centers Program

Lisa Cauble	University of Alaska, Center for Human Development, Alaska Training Cooperative
Karen Ward	University of Alaska, Center for Human Development
Jeff Jessee	University of Alaska, College of Health
Brad Myrstol	University of Alaska, Justice Center
Jeremiah Newbold	Veterans Affairs, Veteran Justice Outreach
John Pendrey	Veterans Affairs, Homeless Veterans Services
Toni Trend	Veterans Affairs
Chris Cooke	Alaska Mental Health Trust Authority Trustee
Paula Easley	Alaska Mental Health Trust Authority Trustee
Mary Jane Michael	Alaska Mental Health Trust Authority Trustee
Steve Williams	Alaska Mental Health Trust Authority
Katie Baldwin-Johnson	Alaska Mental Health Trust Authority
Michael Baldwin	Alaska Mental Health Trust Authority
Mike Abbott	Alaska Mental Health Trust Authority
Andy Stemp	Alaska Mental Health Trust Authority
Kelda Barstad	Alaska Mental Health Trust Authority
Eric Boyer	Alaska Mental Health Trust Authority
Jimael Johnson	Alaska Mental Health Trust Authority
Autumn Vea	Alaska Mental Health Trust Authority
Travis Welch	Alaska Mental Health Trust Authority

Appendix II: Theory of Change

A catalyst for change to improve the lives of beneficiaries

Mission & Principles

The Trust's mission is to improve the lives of beneficiaries through advocacy, planning, implementing and funding a Comprehensive Integrated Mental Health Program.

The Trust is committed to:

- Education of the public and policymakers on beneficiary needs
- Collaboration with consumers and partner advocates
- Maximizing beneficiary input into programs
- Continually improving results for beneficiaries
- Prioritizing services for beneficiaries at risk of institutionalization or needing long-term, intensive care
- Useful and timely data for evaluating programs
- Inclusion of early intervention and prevention components

Investments

Beneficiary, Community and System

SYSTEM REFORMS TO INCREASE EFFECTIVENESS OF COMMUNITY STRATEGIES AND BENEFICIARY SUPPORTS

$6.0
MEDICAID
Reform + Redesign
Results in a sustainable system of integrated care for beneficiaries to achieve optimal health, wellness and independence in their community

Health Information Technology + Data Analytics

Early Detection + Prevention

Home- and Community-Based Services

Integrated Behavioral Health + Primary Care

COMMUNITY STRATEGIES AND CAPACITY BUILDING

Substance Abuse Prevention + Treatment

Housing and Long-term Services + Supports

Direct Beneficiary Support
$1.7

Disability Justice

Beneficiary Employment + Engagement

Community Prevention

Community Aftercare

Community Intervention/ Diversion

Reentry

Booking + Screening Practices

In-Facility Practices

$3.8
CRIMINAL JUSTICE
Reform + Reinvestment
Reduces recidivism, improves access to services and health care, and creates safer communities

FY19 budget numbers in millions as approved September 7, 2017.

Key Outputs

- Beneficiaries access quality, integrated, whole person health care
- Decrease in youth alcohol and substance use and adult binge drinking and illicit substance use
- Reduce adult and youth involvement in the criminal justice system and reduce criminal recidivism
- Beneficiaries achieve integrated employment and have access to quality peer support services
- Beneficiaries can access safe and affordable housing with appropriate community-based social services to maintain tenancy
- Beneficiaries access effective and flexible person-directed long-term services and supports

Results

Beneficiaries have improved health

Adults and children are free of the burdens created by alcohol and substance abuse

Alaska's workforce meets beneficiary and employer needs

The criminal justice system effectively accommodates the needs of victims and offenders who are Trust beneficiaries

Beneficiaries are employed or meaningfully engaged in their communities

Beneficiaries maintain stable, safe housing

Beneficiaries live the lives they choose with supports they direct