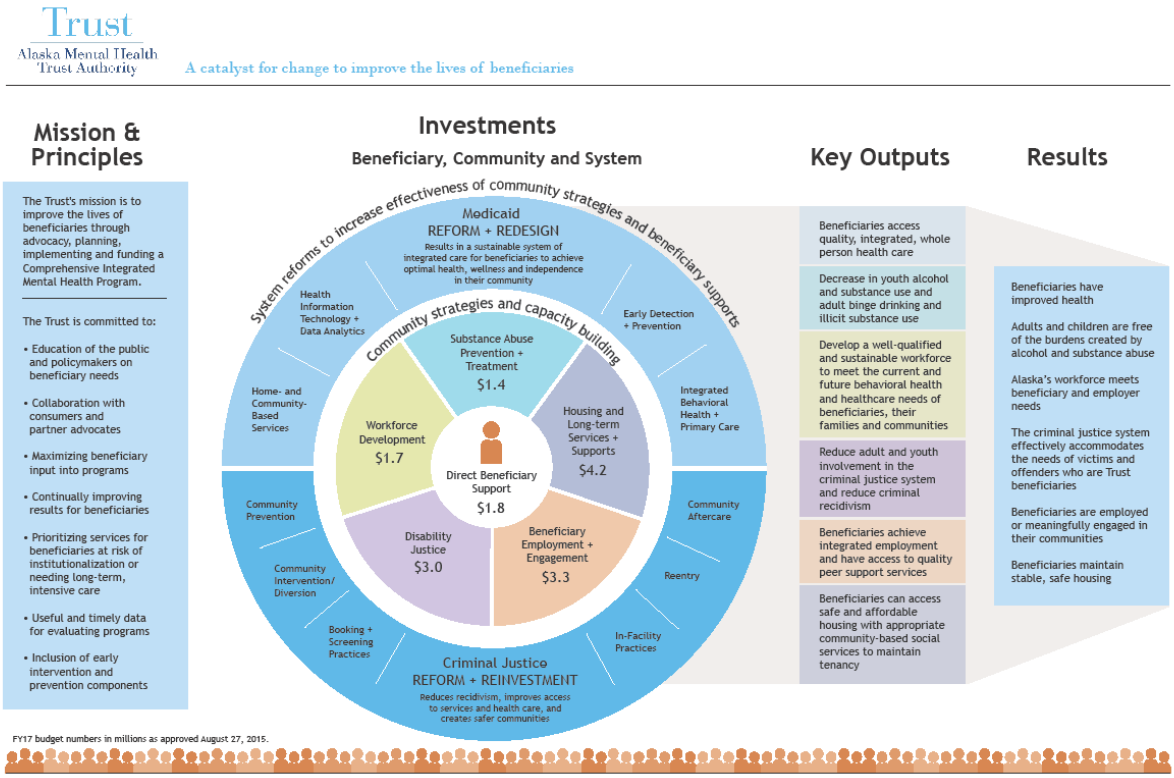
# TRUST FY18/19 BUDGET PROCESS

## JULY 6-7 STAKEHOLDER MEETING NOTES

*Introduction*

On July 6 and 7, 39 stakeholders convened at the Alaska Mental Health Trust Authority to consider how best to support Medicaid reform and criminal justice reform and reinvestment and to develop budget recommendations for FY18/19. This resource contains the detailed notes produced from the two-day meeting. A webinar recording summarizing key themes is available on the Trust's website.




## Contents

## Participants

| | |
|---|---|
| Brian Wilson | Alaska Coalition on Housing and Homelessness |
| Denise Daniello | Alaska Commission on Aging |
| Michelle Bartley | Alaska Court System, Therapeutic Court |
| Mariko Selle | Alaska Health Education Center |
| Kathy Craft | Alaska Health Workforce Coalition |
| Daniel Delfino | Alaska Housing Finance Corporation |
| Carrie Collins | Alaska Housing Finance Corporation |
| Sherrie Hinshaw | Alaska Housing Finance Corporation |
| Nikole Nelson | Alaska Legal Services |
| Kate Burkhart | Alaska Mental Health Board and ABADA |
| Brenda Moore | Alaska Mental Health Board and Suicide Prevention Council |
| Tina Woods | Alaska Native Tribal Health Consortium |
| Karl Garber | Alzheimer's Resource of Alaska |
| Mike Sobocinski | Anchorage Community Mental Health Services |
| Stephanie Rhoades | Anchorage Mental Health Court |
| Scott Ciambor | City and Borough of Juneau, Chief Housing Officer |
| Debbie Miller | Department of Corrections |
| Morgen Jaco | Department of Corrections |
| Laura Brooks | Department of Corrections |
| Adam Rutherford | Department of Corrections, Mental Health Officer |
| Zack Fields | Department of Labor and Workforce Development |
| Diane Casto | DHSS Behavioral Health Policy |
| Tony Piper | DHSS, Division of Behavioral Health, ASAP Program |
| Rob Wood | DHSS, Division of Juvenile Justice |
| Pat Carr | DHSS, Division of Public Health |
| Duane Mayes | DHSS, Division of Senior and Disability Services |
| Monique Martin | DHSS, Medicaid Reform |
| Randall Burns | Division of Behavioral Health |
| John Cannon | DOWLD, Division of Vocational Rehabilitation |
| Patrick Reinhart | Governor's Council on Disabilities and Special Education |
| Elizabeth Schult | Governor's office |
| Roy Scheller | HOPE Community Resources |
| Gwen Sargent | Kodiak Area Native Association |
| Paul Cornils | Alaska Youth and Family Network |
| Lance Johnson | Norton Sound Health Corporation |
| Dave Branding | South Peninsula Hospital Behavioral Health |
| Lisa Cauble | UAA, Center for Human Development |
| Karen Ward | UAA, Center for Human Development |
| Brad Myrstol | UAA, Justice Center |
| Paula Easley | Alaska Mental Health Trust Authority Trustee |
| Mary Jane Michael | Alaska Mental Health Trust Authority Trustee |
| Jeff Jessee | Alaska Mental Health Trust Authority |
| Steve Williams | Alaska Mental Health Trust Authority |
| Katie Baldwin-Johnson | Alaska Mental Health Trust Authority |
| Michael Baldwin | Alaska Mental Health Trust Authority |
| Heidi Wailand | Alaska Mental Health Trust Authority |
| Carley Lawrence | Alaska Mental Health Trust Authority |
| Amanda Lofgren | Alaska Mental Health Trust Authority |

## Day 1 Overview

During the first part of the meeting, participants heard about the current financial position of the Trust and why Medicaid and criminal justice reforms are so important for Trust beneficiaries. Afterward, several speakers presented on the current status of the reforms. These presentations can be found on the Trust website. Later in day 1, participants were divided into two groups. Each group partook in two 90-minute breakout sessions, one regarding Medicaid Reform and the other regarding Criminal Justice Reform and Reinvestment. In each session, participants were asked three questions:

1. How will system reforms affect Trust beneficiaries?
2. What are the opportunities and the risks?
3. How can we ensure reforms are successful and produce positive results for beneficiaries?

Notes from these dialogues are document below.

## Medicaid Reform Breakout Session

### *Key Themes*

- Invest in workforce capacity: training, recruitment and retention, cross-training and inter-disciplinary work.
- Better coordination among sectors, provider teams, and working as a team.
- Improve information systems, information sharing, and ability to use data to track outcomes.
- Invest in housing, especially permanent supportive housing.
- Reduce emergency/crisis care by helping people enter the system at routine level of care, prevention, crisis respite care.

### *Question 1: How will Medicaid system reforms affect Trust beneficiaries?*

| **Overall** |
| --- |
| • Education and improved understanding among providers and beneficiaries about the changes in reforms—new opportunities for access, what is available, how to access.<br>• Better access to appropriate level of care.<br>• Integration of primary care and behavioral health will lead to improved health.<br>• Greater flexibility in programs to meet beneficiary needs.<br>• Increased coordination of care will lower costs and improve health outcomes.<br>• Fill in gaps that are currently making services less effective.<br>• A lower per-capita cost of care and more people cared for in their homes and communities.<br>• Housing is fundamental: stabilizes people, improves health, we need more of it. |

| | |
|---|---|
| • Implementing reform and working in the reformed system requires new skill sets and staff capacity at the State and provider organizations, and new types of workers such as Community Health Workers and peer supports. | |
| **Home and Community Based Services** | |
| Help people remain part of the community, through permanent supportive housing. | • Reduce overutilization of emergency and crisis services.<br>• Help people live with a lower level of care and be part of their community, not homeless.<br>• Increase supportive housing and establish stronger coordination among community funders and policy makers. The Strategic Plan for Permanent Supportive Housing developed by DHSS and the Technical Assistance Collaborative has identified need for 450-650 new housing units.<br>• Need this specifically for reentry population and chronically homeless population.<br>• Question: how will small assisted living homes, or other small scale providers of supportive services, provide services through Medicaid if they don't have the capacity to bill for services, and meet Medicaid requirements and if their service doesn't fit with a 15-minute increment? Response: this will depend on reformed payment model, e.g. bundled payment, daily rate for outreach, other models to support operations. There is a daily rate for residential supportive living and an acuity rate being developed. Also, the 1915(i) and (k) options will help pay for supportive services. The 1915 k will launch July 2017, for those who meet nursing facility level of care. |
| More programs in rural areas. | • Better services in villages, whether through trained workforce or through telehealth.<br>• More culturally appropriate services and approaches used in care.<br>• Develop a 'community health worker' who is culturally astute and part of the communities they serve. |
| More people able to stay in their homes and be served. | • Need to figure out how to improve housing services, especially for people who are homeless and not engaged with supportive services. Need to help more people into permanent housing so they aren't in perpetual crisis cycle.<br>• ACT team is working with population, even if not in housing, try to keep them stable and out of crisis. |

| | |
|---|---|
| | • Medicaid Reform and Criminal Justice Reform may help financially sustain supportive housing programs that are currently receiving grants for operating and services. |
| Payment reform may increase ability to pay for needed services, especially at lower levels. | • By incentivizing lower levels of care, preventive care, and services in less intensive settings, may be able to make these services, provided by lower-billing providers, more feasible.<br>• Challenge will be ensuring quality of services with higher volumes and team approach to providing staffing that is necessary for integrated care.<br>• Peer support workers must also be incorporated into the provider team to provide long-term recovery supports. |
| Use regulatory tools to improve and maintain quality of home and community based services. | • Regulations must require adequate training for workers in assisted living homes, especially when serving people with difficult and dangerous behaviors.<br>• Quality assurance and monitoring requires state staff and capacity to do oversight, which requires adequate staffing at SDS. |
| **Health Information and Technology and Analytics** | |
| Use data to better proactively identify at risk people, invest in housing, etc. | • Identify clusters of need, for example, housing providers use HMIS, which could be used in partnership with DOC to look at locations with high number of parolees and create housing there. For homeless population, look at housing opportunities.<br>• There are some clear risk factors for possible future corrections involvement, better analysis could help target preventive services.<br>• DHSS has a lot of data but it is separated by different divisions and programs. The same family is served by multiple programs. Use this data to identify at-risk families and children and provide preventive services to them. |
| Improve the Health Information Exchange | • We have invested a lot into the HIE and we all need to get behind it if it is going to work in order to get organizations on-board and help it succeed. Bad PR around its launch and early days has eroded confidence that it is good, but it is very necessary and is already being implemented. Smaller entities need financial and technical assistance in order to join the HIE. |

| | |
|---|---|
| | • Also need behavioral health providers to connect to the HIE, possibly through AKAIMS if they are not using another electronic health record. |
| Ability to share information among systems | • Court system and DOC would benefit from knowing more about an individual's health history in order to provide appropriate services while incarcerated and to plan for release from the start. Providers could potentially continue to provide services while a person is incarcerated to maintain the continuity of the service and assist with reentry.<br>• Knowing what different facilities/institutions are doing for the same person, being able to share health information and other information that impacts care<br>• Streamline information, especially if care plans conflict and providers are pursuing different avenues |

| **Early Detection and Prevention** | |
|---|---|
| Engagement of eligible Medicaid enrollees, assistance with enrollment and education about benefits available and how to access them | • Consumers who have historically not been eligible for Medicaid, sometimes don't believe they are eligible.<br>• 70% of DOC population is now eligible, but there is no effective process for enrolling people while they are incarcerated so they can access Medicaid services while they are incarcerated and when released. |
| Better access to health care, especially routine and preventative care, rather than entering at the crisis level. | • Increase access to mild and moderate behavioral health by reducing barriers to treatment created by the assessment step, which has been used to determine who can and cannot be served. Ends up delaying onset of services.<br>• Normalize access to mild-to-moderate level mental health care, increases utilization. |
| Better identify people earlier on and help them access preventative care or early interventions (at risk) | • Pre-screening, help navigate people toward needed services. This was very successful with the ADRD First pilot project on the Kenai. |
| Work more closely with education and employment sectors, as a prevention measure. | • Need strong pathways to education and life skills.<br>• Increase use of Medicaid funded services for students identified for special education services in school-based settings as identified in the Individual Education Plan (IEP)<br>• More school-based clinics: there are only a few in state, these may be a good way to provide services. |
| Need to increase resources for behavioral health treatment. | • Difficult to just talk about prevention when there is a serious need for treatment.<br>• As more people can access treatment, there are still limited resources. |
| Increase workforce development, both for beneficiaries themselves and for providers. | • Increase training for specialties relevant to Alaska issues, such as traumatic brain injury (TBI).<br>• DOLWD is doing training programs (through SCF and ANTHC) for behavioral health workers, need to make more trainings available for more providers, to increase workforce.<br>• Need better training and/or more representation for culturally appropriate care. |

| **Integrated Behavioral Health and Primary Care** | |
|---|---|
| Need to address structural and regulatory barriers to integration. | • Current impediment: behavioral health documentation in state regulations is burdensome, more so than in primary care or private practice.<br>• Many providers are not eligible to bill for Medicaid services, the process to enroll as a provider is difficult and is a barrier for those in private practice.<br>• Lack of parity between reimbursement rates for physical and behavioral health services. |
| Telehealth and tele-behavioral health | • Will not be able to sustain a diverse specialized workforce in all areas, need to provide more services via Internet.<br>• Find innovative ways to increase access to telehealth for families, such as paying for their internet service, or sending them a tablet, as the VA does.<br>• Need to build education, support, trust in this as a method of care, in addition to in-person work. |
| Reduce/make better use of medications in behavioral health | • Physicians are missing from this meeting and similar dialogues. Medication is perhaps the number one issue for behavioral health clients and we need better access to prescribers and better care coordination. |
| Better able to address some of the social determinants of health | • Having care team including other disciplines such as legal aid, housing, social workers, peer supports.<br>• Addressing housing, workforce and access to employment, other important areas that impact successful health outcomes. |
| Connect to Health Homes, better integrate primary care, long term services and supports, and behavioral health. | • Community Health Worker could assist people with solving issues that prevent them from getting care, e.g. arranging childcare and finding transportation to get to an appointment.<br>• Expanded definition of health homes, coordination for people with complex needs and chronic conditions.<br>• Having behavioral health as a health home, not just primary care. |
| The Complex Behavioral Health Collaborative addresses care for people who are difficult to serve and maintain in a care setting to avoid institutionalization. Should the findings from | • Currently the funding is in DBH's base grant funding, but this collaborative has provided a model for addressing care needs and these lessons should be applied as reforms are designed and implemented. |

| **Integrated Behavioral Health and Primary Care** | |
|---|---|
| this program be replicated, how can they be factored into reform? | • Beneficiaries are aging and it is often difficult to assess and address the changing care needs of individuals with intellectual disabilities or serious mental illness, particularly if the person develops dementia; better integration of primary care, behavioral health and LTSS is necessary. |

*Question 2: What are the opportunities? What are the risks?*

| Opportunities | Risks |
|---|---|
| • Help more people enter stable, permanent housing (with or without supportive services) and stop cycle of crisis.<br>• Focus on the education system, and integrate better with prevention and early detection.<br>• Increased use of telehealth and tele-behavioral health.<br>• Payment reform can help better match the available payments to the cost of care, especially incentivizing care at lower level settings.<br>• Integration between primary care and behavioral health, if successful, can solve significant barriers to better care.<br>  ○ Can also include integration of other methods, e.g. traditional healing, physical therapy, other disciplines that are important.<br>  ○ Pediatric care: pilot projects or other ways to have pediatric health homes, or more focus on pediatric care and integrate other services.<br>• More focus on social determinants of health: for example, having multiple disciplines involved. Health Home could include medical as well as other forms of care and support.<br>  ○ For example, include Community Health Workers in the state plan amendment to allow Medicaid billing for certain services like care coordination.<br>• Increase access to behavioral health system, and better health information sharing.<br>  ○ Able to get in for assessment sooner, or getting an initial behavioral health assessment at a primary care visit then referral to services. Similarly, having more people eligible for Medicaid could help more people get initial assessment and then care. | • If people do not have access to supportive housing, it will be very difficult to stop the crisis cycle and reduce emergency services. A softer housing market may provide more options for affordable housing, but when the economy rebounds it may be more difficult in a stronger market. Must address impediments to housing development that increase costs and limit feasibility.<br>• May be difficult for small community-based providers to provide supportive services (in a rural area, and/or a small property) billed to Medicaid, due to difficulties with documentation, wait time to payment and other administrative requirements.<br>• Failure to actually achieve successful integration between cultures, systems, payment structures of primary care and behavioral health<br>  ○ If providers/physicians/health industry representatives are not directly involved in the planning, it will undermine ability or feasibility of reform.<br>  ○ It is currently challenging to work together (in one organization, as well as across organizations) between primary care and behavioral health, and finding agreement on common terms and payment structures.<br>  ○ Regulations and other requirements, as well as other structural barriers to integration, such as who can provide services and who can bill Medicaid for them.<br>  ○ 42 CFR (substance use confidentiality rule) is a possible barrier to useful exchange of information.<br>• Current limitations of the intake system:<br>  ○ Backlog in scheduling or receiving services; it can take weeks to get in for an assessment, but when people don't show up for appointments it creates a gap between |

| Opportunities | Risks |
|---|---|
| ○ Apply the lessons learned through the Complex Behavioral Collaborative to address care needs of difficult to serve individuals and avoid institutionalization.<br>• Normalize mental health care, especially use of mild to moderate MH care, and reduce stigma.<br>• More people could benefit from long-term employment services funded by Medicaid (through 1915i and k).<br>• Political will and momentum to make meaningful reform, especially in different fiscal climate. | schedule and reality. Unless it is possible to do assessments sooner or get more information while someone is already in a care appointment, will be difficult to effectively bring people in for care.<br>○ Currently, a provider is triaging to evaluate whether person is SMI or SED (for billing purposes, serving highest need), creates barriers to care for low to moderate because there isn't sufficient capacity to serve everyone, and system incentivizes serving higher levels.<br>• Lack of qualified, skilled workforce to meet current and increased demand for services in the near future, especially if workers are less experienced or educated, and/or have higher turnover. Without more capacity will be difficult.<br>• Lack of quality services, a person may have access to services now, but not necessarily high quality services. With higher demand and access, may not be accompanied by higher quality unless we work to improve training and quality improvement/quality assurance.<br>• Lack of parity in Medicaid rates between behavioral health and other health services so that the rates are not sufficient to cover cost of services. This stymies the development of services and capacity to meet the need.<br>• Medicaid fraud provisions may scare off providers that do not currently bill Medicaid, or create significant barriers to getting more providers to accept Medicaid.<br>• With changes in political administrations and climates, need to have core group to "carry the torch" and ensure that the pace of reform does not stall or drop off. Need to build into comprehensive integrated mental health plan. |

*Question 3: How can we ensure Medicaid reforms are successful and produce positive results for beneficiaries? [highlight = "top 5" priority]*

| **Group 1** |
|---|
| A. Payment reform: for smaller communities especially, in order to make operations "pencil" need to have sufficient payment to make supportive housing sustainable. |
| B. Reduce administrative burden on providers, make more efficient. |
| C. Increase workforce capacity connected to employment opportunities (education and training, standards, cross-training) as well as the size and quality of workforce (recruitment, retention). |
| D. Improve collaborative decision making in a cross-sector case management team. |
| E. Expand telehealth, including telemedicine, other care (e.g., Project Echo, waiver re-assessments in rural areas, care coordination). Quality control of telehealth through licensing boards. |
| F. Educating providers, community, beneficiaries about changes to the system that can improve their access to care, and health outcomes. |
| G. Improve crisis care: Help people understand what options they have, other than the emergency room or prison. Help crisis-level providers better connect people with the appropriate level of care. Reentry from institution and crisis level care. Find ways to safely care for hard-to-serve people with complex needs in home and community based settings. |
| H. Make needed changes to regulations to drive quality improvement in home and community based services, balanced with workforce capacity. |
| I. Increase workforce opportunities for beneficiaries. |
| J. Educate and support unpaid caregivers who serve seniors, including those with ADRD. |
| K. Invest in skill sets needed to make reform happen successfully. |
| L. Ensure leadership is taking systems-level view and monitoring progress in integration: housing, behavioral health, education, workforce. Make sure reforms continues to work toward the ultimate outcomes. (the ASO?) |
| M. Continue to integrate these reforms into Comprehensive Mental Health Plan. |
| N. Ensure systems reforms are designed for both urban and rural settings, and continue to engage rural representatives so reforms will work. |

| **Group 2** |
|---|
| A. Implement permanent supportive housing strategic plan and the housing continuum, coordinated with Medicaid reform. |
| B. Workforce: Skilled workforce for integrated care through training for new professionals, and inter-professional training for existing providers (integrating primary care and behavioral health, help them work as a team). Increase workforce capacity at all levels, such as peer support, to ensure workforce can provide appropriate/lowest level of care. Improve education and training opportunities for unpaid caregivers, for families caring for adults, elders, kids. |
| C. Improve access to Medicaid for the corrections population and other Medicaid-eligible people, help them enroll and access services. Includes better education and outreach about their eligibility, as well as how to access. |
| D. Support implementation of behavioral health homes (section 2703 in ACA) |
| E. Improve crisis response in emergency rooms; increase crisis respite to prevent accessing emergency-level care. |
| F. Continue to invest in the Health Information Exchange and improve confidence in its efficacy. |
| G. Reduce administrative burden: streamline process for providers to become Medicaid-billable providers, and help them begin providing services more quickly and easily. Improve parity in documentation between existing and private (non-Medicaid) providers. Provide technical assistance for complying with Medicaid fraud provisions. |
| H. Payment reform to support actual cost of needed services. |
| I. Invest in strategies that will improve access to the appropriate level of care: pre-screening, aging and disability resource centers, case management. |
| J. Find creative ways to pay for needs and reduce Medicaid spending in other ways: such as, non-emergency medical transportation, (mileage reimbursement for a family member), or in-home telehealth and assistive technology (e.g., Internet service). |
| K. Continue to champion reforms through the Comprehensive Integrated Mental Health Plan, so that the process is sustainable and not tied to political cycle. |
| L. Find ways to increase economy of scale for billing: for example, allow one entity to bill on behalf of multiple housing providers |

## Criminal Justice Reform Breakout Session

### *Key Themes*

- Need for an ideological shift by DOC/public safety and the public to viewing prisons as part of the community and the issues faced by individuals involved in the correctional system as health issues
- Importance of inter-agency collaboration
- Importance of implementing culturally relevant evidence-based practices, including a comprehensive diversion system
- Housing is essential and not ready for the influx of prisoners that will be released under SB91; need more data about the volume and type of housing that will be needed. We should be posed to take advantage of new housing opportunities as the state housing market shifts during the economic down-turn.
- Communities need to improve coordination and collaboration with the criminal justice system to ensure access to services is available to individuals who will no longer be pulled into the correctional system as a result of SB91 – community behavioral health provider capacity is already strained. Medicaid reform will help increase access to services but will take time. Can we think of non-traditional ways to meet the mild and moderate mental health and substance use treatment needs of this population?
    - Combining reentry and housing coalition forces
    - Expansion of pre-employment transition services
    - Bolstering peer and family support
    - Care coordination and use of criminogenic assessments in community systems
    - Promoting continuity of care by providers even after individuals enter the correctional system
    - Identifying practitioners outside of the community behavioral health system that may be willing to step in
    - Continued role of DOC in working with the misdemeanor population
    - Telehealth and data sharing
- Importance of not focusing on re-entry to the exclusion of community prevention and taking preventative steps during pre-trial diversion to avoid incarceration

### *Question 1: How will criminal justice system reforms affect Trust beneficiaries?*

- Greater emphasis on proactiveness and community prevention
    - Our system is very reactive, we could be much more proactive – we want to look at prevention before individuals enter the system; it's the lack of services in communities that allow the criminogenic behaviors to take hold. In rural areas, we have minimal mental health services spread thinly in a rural region.
    - When we serve someone through a 1915c waiver that person may have been involved with corrections in past or in the future; that's community prevention – making the connection more explicitly can help reduce incarceration/recidivism.
- Greater role of community behavioral health in criminal thinking
- Greater focus on housing and positive employment experiences
- Greater demand on LTSS, housing supports, and other services
    - Inmates who are older – 60/65+ - will be coming into the community and are unlikely to recidivate but will need supports; may be looking for work, or need to sign up for Medicare, etc.

*Question 2: What are the opportunities? What are the risks?*

| Opportunities | Risks |
|---|---|
| • Criminogenic risks and needs are not currently screened for in community behavioral health – by using an assessment tool behavioral health practitioners can predict criminogenic behavior. (Individuals are screened in DOC/DJJ screening but now individuals will be filtered out because of the higher threshold.)<br>• A large number of folks that come into the correctional system, would not if they had housing – what can we do to bolster the housing for the homeless programs and implement the strategic supportive housing plan?<br>• Not everyone needs long-term housing – can we bolster rental assistance programs and provide vouchers to individuals coming out of prison? Investing in housing, particularly rehab housing, might be an important area to invest in now with SB91.<br>• Housing market is changing – there will be higher rental vacancy rates and more hotels coming on the market; there may be foreclosures, etc. This is an opportunity that we should be thinking about.<br>• Community reentry coalitions have an opportunity to collaborate with homeless coalitions. How can we marry housing and reentry/diversion efforts? Coordinated entry pilots that are being managed by the Anchorage coalition needs to be aligned with the work the housing coalition is doing with the work that the prisoner re-entry coalition is doing.<br>• DOLWD has a federal requirement to spend a portion of WIOA funds – we didn't have the capacity to spend the money. We need to gear up the infrastructure to develop pre-employment transition services more broadly and maximize use of available resources and community transition-age youth coalition efforts in rural areas; Tribal voc rehab could be a model.<br>• With Medicaid expansion, we can offer a lot more services to beneficiaries who are not seriously ill. We can offer far more services to individuals with mild and moderate mental health issues.<br>• How can we consolidate victim services and have a stronger voice for Trust beneficiaries who are victims? | • SB91 has a focus on people coming out of the criminal justice system; we have to make sure that as a community and a provider system that we don't prevent individuals that are not exiting from the criminal justice system from accessing community prevention services (in the ideal world, we'd have more front end services; let's make sure we get dual benefit from the resources that are being invested in reentry)<br>• Can't underestimate the workforce need that we are going to have across the system; we are going to need workforce development across the board<br>• Pre-trial is going to be moved from Corrections; the ability of DOC to monitor the people who will now not going into the system will be strained. In many states only 5% of the inds on pre-trial services, get services – that's a lot of people who will no longer be placed in monitoring/support services<br>• If funding is going to individuals exiting prison; we risk limiting services available to individuals not involved in prison; we don't want to squeeze anyone out, but the providers do not currently have sufficient capacity<br>• Community services are not ready for the floodgates – you talk about the misdemeanor population with mental illness and SUD |

| Opportunities | Risks |
|---|---|
| • Pre-trial services is a great platform for a jail diversion program that diverts individuals from jail in the first 24 hours; right now we have a lot of focus on re-entry, but we need to make sure that we focus on the front side too; every individual should be assessed for diversion opportunities.<br>• Assessment for pre-trial diversion could be combined with an assessment and referral to services; so many people end up where they end up because they don't know how to access or can't afford services.<br>• How can we encourage/support community providers in providing continuity of care even after individuals enter the correctional system?<br>• We need every organization to be looking at what they are doing in their organizations – how can we streamline, consolidate, improve the way we do business? Example of woman taking 20 hours per week away from her job to undergo drug testing.<br>• Providers need to begin to change their operational behaviors. Who are there clientele, how have they been served, and how can they get ahead of these reform efforts by staying engaged with clients over time? Communities and providers need to adjust and step in.<br>• We have employers in natural resources and manufacturing that are offering recovery sessions during the workday and are interested in supporting ex-offenders; how can we strengthen our work with employers that are interested in this area?<br>• Peer support; even the most casual peer support program can effectively support staying in the community; peer support that is reinforced by structured case management is really effective.<br>• Support for families when individuals are exiting back into the community.<br>• Inter-agency collaboration – how can we help each other survive? Not just government agencies, but provider agencies as well.<br>• Community coalitions has led to more openness than ever before on behalf of DOC. Collaboration on the community level with behavioral health providers and DOC is a positive step to build on. It's not going to solve the | • Provider capacity is strained – providers simply don't have the capacity to serve individuals earlier, especially with workforce challenges<br>• Many of these beneficiaries are exiting corrections and going right into the homelessness cycle; we have scarce resources for supportive housing and will be adding more people from the criminal justice system when the housing system is not fully developed<br>• Older returning citizens risk falling through the cracks<br>• We have a population of ADRD beneficiaries who should never be imprisoned; how can we prevent that cycle?<br>• We teach skills in prison but then set up barriers outside of the system with state requirements to employment, etc.<br>• Individuals are stuck in communities that are not their own because the services don't exist in their communities<br>• We see youth aging out of services and going to homeless shelters<br>• The community not being ready to serve the individuals who are now going to not be pulled into the correctional system; beneficiaries could be worse off in 15 years then they are today. When we downsized API, we talked about building community services, etc. then you get changes of the guard and the community services were |

| Opportunities | Risks |
|---|---|
| issue of gaps for the population that will no longer be involved in the DOC system. We need to build these services.<br>• An ideological shift will be required by DOC and public safety; you can't just walk away from an individual. Proper training of staff is key. Changing the culture and standard operating procedure from "custody and control" to "custody and care."<br>• Public relations – prisons are a part of the community; we can't lose this message. Right now, the concern is around increased crime, etc.<br>• Private behavioral health practitioners and non-profits are an untapped resource; can we engage individuals with licenses to serve this population? We don't have to just look to the traditional community behavioral health providers. The adults that are now likely to be in the gap are now eligible for Medicaid; now we may be able to attract new providers to serve this population.<br>• Can re-entry coalitions be tapped to assist with misdemeanor population?<br>• We need to begin creating behavioral health specific re-entry plans. Behavioral health practitioners in communities and state agencies could be helping to develop reentry tools and plans that recognize the needs of individuals coming out.<br>• Building Tribal relationships and tapping the tremendous talent and resources available within the Tribal health system.<br>• Loan repayment efforts – we have a hard-time making sure that DOC staff are eligible. How can we support state government employees in these areas? DOC facilities can't qualify for our loan programs.<br>• Leveraging reform and our assessment tools to better support FASD service delivery; many people with FASD are following through the cracks. FASD individuals are in prison in significant numbers.<br>• We have one of the largest per capita veteran populations – how can we improve their care coordination and help them reintegrate in a healthy manner into the community? | never made available. We need to make sure that the reinvestment part is in place.<br>• Medicaid reform is not going to happen in the immediate term, DOC needs to step up and make sure their staff are prepared to support these individuals in crisis. Who will serve this population during the next 2-3 years? We can't lose DOC's BH capacity – we can't afford to lose the capacity that is available through DOC.<br>• How do we stabilize individuals and help them not recidivate? We haven't seen an increase in our housing budgets since 2009; decrease in 2011. We've had three transitional housing units close. There will be increasing housing demands with SB91.<br>• We need to know what the anticipated need is? What is the timing? We don't know how big the problem is and haven't done and assessment of whether our program can meet it.<br>• How can we ensure that we don't lose individuals across geographies?<br>• Let's not forget to focus on the victims; we don't want to lose the progress we've made supporting beneficiaries who are victims. |

| **Opportunities** | **Risks** |
|---|---|
| • Need to increase access to SUD treatment; today, you can get them an assessment, but then you have to wait. When you have children involved with OCS and you have parents who are required to get SUD services. When they have to wait, we lose their motivation<br>• Reshaping the system to address criminal behavioral health issues as health issues could be a game changer. Collaborative opportunities for DOC and BH agencies to conduct the assessment jointly or joint assessments with training<br>• How can we really clearly communicate the changes that we anticipate with SB91 – what is the timeline? Who is the population? And what is our plan for meeting those needs.<br>• When we talk about capacity not being there – the population we are talking about often have mild and moderate behavioral issues rather than serious issues; the things that best address the needs of this population are basic (employment and meaningful engagement, cognitive behavioral health therapy, SUD treatment, etc – this is not a PhD-level workforce.) When you talk about the capacity that needs to be built; we need to get providers able to bill Medicaid and then get individuals accurately assessment for criminogenic needs. | |

*Question 3: How can we ensure Medicaid reforms are successful and produce positive results for beneficiaries? [highlight = "top" priority]*

| **Group** |
|---|
| A. Supporting development of a diversion system that emphasizes intervention and includes evidence-based crisis response center to support street level diversion |
| B. Combine prevention and reentry efforts – pool resources to address similar issues and ensure prevention is adequately addressed in redesign |
| C. Housing – really leveraging data to bolster and focus housing efforts to support the individuals who will be exiting the system |
| D. Job training and placement/access to pro-social activities |
| E. Leveraging technology (information sharing and telehealth) to provide more services |
| F. Leveraging case management to help ensure access to available services |
| G. Qualified workforce |
| H. Collaboration within and across organizations |
| I. Use of criminogenic assessment tool in community behavioral health |
| J. Bolster homeless housing programs and rental assistance programs; support implementation of the strategic supportive housing program |
| K. Pursue opportunities presented by housing market changes to purchase properties or rent |
| L. Expand work with employers interested in supporting the individuals exiting the correctional system |
| M. Invest in public relations around the role of prisons in communities; shape the narrative; it's not just a public safety issue |
| N. Connect reentry and homeless coalitions |
| O. Greater inter-agency collaboration and provider collaboration |
| P. Develop infrastructure to leverage pre-employment transition services |
| Q. Workforce training for public safety officers |
| R. Combine pre-trial assessment / jail diversion with an assessment and referral to behavioral health services |
| S. Leverage experience of the re-entry coalitions bridging the gap between inside and outside prison |
| T. Develop strategies and mechanisms for providers to maintain continuity of services to individuals who are imprisoned |
| U. Increase access to peer support, case management, and family support |
| V. Develop behavioral health provider capacity outside of the community behavioral health system |
| W. Strengthen Tribal relationships and tap tremendous resources available through the Tribal health system |

| **Group 2** |
|---|
| A. Training for DOC and public safety – supporting cultural/ideological shift from custody and control to custody and care |
| B. Implement culturally relevant evidence-based practices; Build system capacity to assess and address criminogenic needs |
| C. Building community provider capacity to bill Medicaid – this will require new providers or expansion of existing provider capacity |
| D. Collaboration between organizations and coalitions at a local level (and across geographies) is essential –support for coalitions to play a stronger role in readying communities to address need |
| E. Addressing critical gaps in the continuum of care (detox, etc.) |
| F. Leveraging expansion and reform to build capacity of the system (service, provider community, and workforce) – workforce may not be as big a barrier as we think if we are willing to invest in workforce development |
| G. Review ADOC contracts for reinvestment opportunities |
| H. Identify and pursue interim strategies for serving individuals who will no longer be served by DOC |
| I. Ensure parents involved with OCS have timely access to behavioral health services |
| J. Communicate the projected impact of SB91 and the anticipated service needs; overlay Medicaid reform timeline with SB91 impacts |
| K. Seek new providers to add capacity to serve individuals who cannot be served with today's community behavioral health capacity |
| L. Maximize pre-employment transition services, ensure resources are fully utilized |
| M. Support provider efforts to get ahead of reform and address gaps |
| N. Support workforce development of staff in state agencies |
| O. Increase investment in housing |
| P. Invest in information sharing across systems and data analysis |
| Q. Develop behavioral health-specific re-entry plans |
| R. Support prevention efforts within prisons in addition to community prevention on the outside; a continuum |
| S. Maintain focus on cost savings and cost control; invest in programs that we know work (prioritize evidence-based policy making and budgeting) |
| T. Develop structures to better support populations that have challenging integrating into community supports, e.g. veterans |

## Day 2 Overview

Day 2 began with participants sharing and discussing key themes from the prior day's discussion. Participants were then asked to join two of four breakout sessions.

Breakout session 1:

- Disability Justice and Substance Abuse Prevention and Treatment, Part 1
- Housing and Long-term Services and Supports

Breakout session 2:

- Disability Justice and Substance Abuse Prevention and Treatment, Part 2
- Beneficiary Engagement and Employment

Participants were provided with an overview of FY17 investments by Focus Area as a reference and asked four questions:

1. What is working?
2. What do we need to do differently?
3. Which are the most important existing strategies?
4. Which are the most important new strategies?

The following pages include an overview of key themes discussed during the share back session and notes from each of the breakout sessions.

### *Share Back from Day 1: Criminal Justice Reform*

- Need a fundamental social shift in thinking about people returning from prison, both within DOC and other systems, and the general public.
- Need to develop more robust alternatives to the existing systems: diversion (before) and reentry (after).
- Housing is essential, as are other issues related to more returning citizens. Combining reentry and housing efforts is essential, such as coalitions cross-pollinating in their work.
- Coordination, collaboration, and access to services for individuals no longer pulled into the corrections system. We know there is a gap in capacity, and strained capacity already, and how do we meet those needs?
- Need to prepare the health, behavioral health, and community services systems to use criminogenic assessments in order to identify and address risks of involvement with corrections.
- Workforce capacity: are we prepared? How do we become prepared?
    - We need to be prepared to address the increased volume of people diverted or returning out of corrections.
    - Based on workforce vacancy and retention rates, we know we have gaps in workforce capacity. DOC paying for substance use disorder treatment in the community speaks to the lack of services. There are capacity issues.
    - However, the types of treatments that have shown to be effective especially for this population need (e.g., Cognitive Behavioral Therapy, Moral Reconation Therapy) can be learned through the right trainings and coaching. We can build a workforce that is more effective at addressing criminogenic issues.
- Important to have resources in a person's home community ("community of tie") not just in larger areas like Anchorage or Fairbanks, where they may not want to remain for the long term.

### *Share Back from Day 1: Medicaid Redesign and Reform*

- Need continued and better outreach to eligible individuals both in Corrections (enrolling on their behalf, if they are hospitalized for more than 24 hours while in custody, about 150-160 people per year) and other people who have in the past not been eligible.
    - DOC staff emphasized there are 10,000 or 12,000 people leaving the system annually who are now Medicaid eligible and who must consent and apply for coverage. There is a workgroup with Division of Public Assistance working on how to better enroll and help connect with other services for people leaving prison, and fill out the application. Mat Su Health Services enrollment specialists are talking about going to the prison to help enroll people. The Juneau reentry coalition is also pursuing this.
- Additionally, parents whose children are taken into OCS custody are now eligible for Medicaid if they meet the income requirements and this coverage can help them access the services they need to reunite with their children. Families still sometimes lose housing when children go into custody because their family size changes, which changes the income eligibility. Stable housing is a major problem for this population.
- Increasing access to and availability of community-based services is very important, and increasing the number of providers who accept Medicaid will rely on effective payment reform to actually pay for those services and incentivize the shift.
- Integrating primary care, behavioral health, other types of care will require working as a team, overcoming differences in professional cultures, languages, and perspectives to providing care.
- Housing is fundamental, we have a strategic plan for Permanent Supportive Housing and need to implement this plan.
- Quality assurance, particularly with a more distributed home-based model, need to have a lot of oversight to ensure that services are effective. Also important for lower-level and telehealth services.
- Health information is very important, and will help use data in order to make better health system decisions. For example, looking at housing needs and priorities near probation offices.
- How do we ultimately achieve cost containment, and sustainably-funded systems, and how do we avoid the Trust having to continually fund things that are intended to be sustainable in the long term? Focus investments on helping organizations transition to new finance sources, like Medicaid, and develop clear financial plans for services.
- For all discussions, need to continually remember that solutions may look different in rural Alaska. State discussions often are statewide or based in urban areas; we need to remember to consider the differences and challenges experienced in rural areas.

## Disability Justice and Substance Abuse and Prevention

### *Introduction*

The disability justice focus area began in 2005-2006 with therapeutic courts and crisis intervention team training. The focus area has had many successful programs started and transitioned to other organizations/funding sources. Examples include mental health clinical capacity within DOC and therapeutic court general funding. There have also been challenges. One advantage for the Trust is that we are able to identify programs based on national evidence, that we believe should work, and try it. If a project is not having sufficient impact, we can let it go. We worked on the therapeutic court project in Barrow for at least 4 years and we recognized that it just wasn't working for a variety of reasons. Another important note is that the role of the Trust is much broader than providing funding. There may be strategies that do not include financial investment.

The substance abuse prevention and treatment focus area is a new focus area. We have broad strategies, but we really haven't defined the details. We are currently supporting Recover Alaska and the inclusion of ACES in the BRFSS. We have also supported the Title 4 revision process. SB65 is the paired down version of that effort (maybe 15% was accomplished so we have another chunk of important work to do for next session).

We have tremendous opportunity with the substance abuse prevention and treatment focus area focus area. We are essentially working with a blank slate. We don't have to keep these same strategies. We can reformulate based on what our needs are now. It's a prime opportunity for us to think about what we should be doing with these funds in a targeted and intentional way.

*Questions 1 and 2: What is working? What should we do differently?*

| **Discussion Notes, Disability Justice** |
|---|
| **1. Training for criminal justice personnel** |
| • We need to remain committed to the strategy, but there is a lot of room to change the way we deliver the program. When you look at the training we are offering, the impact is either undocumented, negligible, or we know it is working. We need to really look at the specifics. Why exactly are we educating them, what is the point? "You need to know how to work with this person so that…" We need to add the "so that…"<br>• The crisis intervention training is great and it is evidence-based. We probably don't have enough people who attend to have a significant impact. Right now, it's a voluntary program. It's for frontline law enforcement and is a great opportunity for people to understand these disabilities so they don't immediately turn to force, but it's not consistently done with everyone so the quality of the interactions are dependent upon the officer that shows up.<br>• Is there a way that the Trust can lobby for the police department to incorporate crisis intervention training into the academies? Anchorage does that now. Models like that will make it more sustainable. |

## Discussion Notes, Disability Justice

- Would like to see train the trainer programs that build capacity directly into institutions. Agencies have to commit to building training capacity within their operations and to training personnel.
- Train the trainers programs can be challenging – we place a lot of responsibility on the trainers often without providing the necessary resources. How do we help the trained trainers actually apply their skills? How can we really perpetuate the trainings? In suicide prevention, we have a lot of train the trainers that have received the initial training but that lack the capacity to implement.
- When we look at the trainings, we need to look at how to develop collaborative training efforts. How can we get the best bang for our bucks by working across agencies so that we are all working in the same modalities?

## 2. Sustain and expand therapeutic court models and practices

- Utilization of Fairbanks Juvenile Therapeutic Court is very low; in part, because DJJ numbers are low**.**
- Is the intent of this strategy to expand in new locations? Response: It's a challenging conversation right now. When we talk about therapeutic courts, it's like an octopus. The person is the head of the octopus and then you need all these other players connected to the head of the octopus and all these other players' perspectives is based on an adversary approach. When the ability of these players to come together breaks down, the therapeutic court breaks down or it prevents one from being able to come together.

## 3. Continuity of service and care

- Holistic defense model has local support and is in the first year of implementation in Bethel. This is the first year of implementation. Holistic defense model is a different way of doing business within the justice system. It's looking at the individual, their criminal and civil charges, as well as their other needs. The model is based off of a national model that originated in the Bronx and is being operationalized in Bethel – allows for the focus of a full-time lead criminal attorney, part-time of the civil attorney, a social worker, and evaluation.
- Continuity of care is a big issue. There may be coalitions in communities that could refer individuals to resources, but those resources just aren't in place. Part of these strategies has to be creating the capacity for services and then paying for these services. Similar to how APIC works. Steve: That is how the coalitions are supposed to work. Their scope of work is to identify gaps and needs and leverage the coalitions to figure out what needs to happen and how to remove barriers.
- There is a lot of opportunity for the Trust to work not just with financial resources in this arena, but to inform policies. For example, how can we support more community providers in meeting with clients even when they are in prison? If there is one thing that ACMHS could do in Anchorage it would be to get into the correctional system 60-90 days before someone is being discharged. We could do so much better. Response: this program is already there with APIC. Norton Sound is starting to do exactly this work through APIC with DOC. Additional response: APIC is proven to work but is very limited and is just barely scratching the surface when it comes to need. Right now, there is no funding mechanism to expand the program. The community mental health centers would

## Discussion Notes, Disability Justice

essentially be doing this for free – how can we support them financially and otherwise to do this?

- Can we look at the ADOC contracts and really explore how they can be best utilized? Could their local SUD treatment funds be wrapped into a position that could be based out of a community behavioral health center and leverage other funds / be integrated rather than using separate, outside contracts?
- Any time any community agency wants to come in 60-90 days before, DOC is open arms. We actually have some funding in the APIC funds to support just that. ACMHS does it to some degree now, but with only a very small number of individuals. At Anvil Mountain, Norton Sound will be the provider within and outside of the correctional system.
- Lower hanging fruit might be just taking advantage of existing resources. It's very difficult for DOLWD staff to reach out to DOC and work with reentering individuals. In the absence of the reentry coordinators, I don't think it would work. It's getting better, but how can we strengthen that partnership and ensure that we are using the resources available to us? We should also acknowledge that DOLWD has a new staff person that is focused on reentry and that is great. We have new opportunities emerging with these changes in staffing.

### 4. Re-entry services

- We are currently funding four re-entry coalitions, in Juneau, Fairbanks, Mat-Su, and Anchorage. SB91 includes $1million for community coalitions. These are funds that we need to coordinate and make sure they are spent in a way that gets the most bang for the buck.
- Reentry coalitions may be able to help returning citizens with completing Medicaid applications. At one time, we worked on a national Medicaid eligibility program called SOAR – not sure what the status of that project is. The housing coalitions got technical assistance to help work with their population to complete disability applications and get individuals a disability determination.
- Trustee Paula Easley notes that trustees would like to better understand what is happening with the coalitions and explore how to publicize their success in other communities so the model can be replicated.

### 5. Prevention and support for beneficiaries who are victims of crime

- There are two different strategies employed to support beneficiaries who are victims of crimes. The first is focused on building community capacity to work with adolescents and young adults with intellectual developmental disabilities or serious emotional disturbance around sexuality. It's a preventative model where skills are taught to prevent inappropriate behaviors.
- The second focuses on services for victims, through two programs called ASPEN and DART. What we have found is that these two programs go together – first you do the community building ASPEN component and then communities are ready to develop DART teams using technical assistance.
- There may be opportunities with SB91, which allocates $1M in FY17 and more in Fy18 for victims (see p114 in SB91 around domestic violence and sexual assault). How can we use these resources to develop community capacity to support victims of crime?

## Discussion Notes, Disability Justice

### 6. Develop alternatives to incarceration for beneficiaries who require protective custody

- Trust investment of $100k has leveraged 10 times that from DBH and Norton Sound, which has been focused on building treatment capacity within the region in a culturally relevant way. Nome has done amazing work, but there's still not a sleep off center. We may want to rename this line item to be more reflective of the great work that is happening in the Norton Sound region. That said, we want to express our commitment to the project that is being funding.
- Sleep off centers are very important – we need them in a lot of regions. DOC's commissioner is very committed to making sure that there is a change and the feeling from our administration is that jail is an inappropriate place to keep people for 12 hour holds to become sober. Under this strategy, the Trust could play an valuable role in helping communities resolve the issue.
- We've got to have minimal social detox places for folks to go. It is not as simple as planning it and it will happen. All of our communities need a safe place for individuals to go, but it is hard to imagine how that will happen in the economic times we are in with no funding available for capital and limited operational funding. Norton Sound can serve as a consultant and share what we have learned from the barriers and successes and we need to continue to support the correctional center in our community.
- Title 47 protective custody is not a court order, it's something that a local law enforcement order can utilize related to a substance use issue. That's what this strategy has been focused on. There are two types of title 47s. One is protective custody and it is not a court order – it's a 12 hour alcohol hold that allows law enforcement personnel to take individuals to jail for their safety. The other is a mental health commitment by a magistrate for a 72 hour hold– these individuals are typically held in hospitals not jails, although they may be temporarily. DOC can't decide not accommodate protective custody holds under our existing statutes. For some communities, there simply are not alternative solutions and jail is better than freezing to death. The government needs to respond to this complex social issue with care.
- A long term DOC goal is to achieve statutory change but we recognize that we can't pull this carpet out from under the communities. Nobody thinks a jail cell is appropriate – if this group can't come up with some kind of alternative solution, I don't know who else will.
- We need to be looking at how to support communities with coming up with solutions – the communities will need to identify how to do this. In Nome, community volunteers took it upon themselves to walk the streets and make sure that people get out of the cold. Is that a long-term solution? Maybe / maybe not. We need to make sure though that we are empowering communities. DOC has been a de facto behavioral health provider for a long time. DOC policy is changing – jail beds are not appropriate for these title 12 holds. How can we facilitate creative solutions to this issue? It's hard because it's been DOC for so long. It's become institutionalized.

| **Discussion Notes, Substance Abuse Prevention and Treatment** | |
|---|---|
| **New Strategy Brainstorming** What can we do now, for what population, and what results do we want to achieve? We need to be targeted both in the short-term and the long-term. | |
| School-based interventions: support for implementation of health curricula | • Who is going into the school systems to do that intervention now? In most communities, it's either done through health curricula (e.g. Anchorage has the "Good Body Shop") and through community partners who hopefully implement evidence-based curricula (although there are plenty that do not). The Alaska Safe Children's Act mandates certain educational programs in Alaska schools and it makes reference to substance abuse education (although it doesn't mandate it in the same way it does child abuse and sexual assault). The boards have made recommendations to school districts to incorporate organized, comprehensive health curriculum. This would shift the current approach from a piece-meal and ad hoc model to a rigorous education and prevention model. Alaska Children's Trust and Rasmuson represented to schools that they would make funding available. Otherwise, schools were concerned that the Act included an unfunded mandate and the school districts won't be able to do it. But the funding has not materialized. We've tried to provide free options using DEED's e-learning program. There are also opportunities to partner with law enforcement. Law enforcement appears to grieve the loss of DARE and wants to get involved. In Anchorage, the FBI has expressed interest in getting into schools. |
| Expanding mental health services in prisons | • We have APIC and the reentry services so access to treatment services has to be inside of the jail by bringing in mental health services to those inside (it's great that they have SUD services currently, but we've got have at least one mental health clinician) – funding for mental health clinician access inside and then to work with reentry coalitions and all of the Medicaid claims.<br>• DOC: We have significant challenges recruiting on-site mental health providers. Anvil Mount is where we have a contract and then APIC – could we combine those funds. Bethel is another area where it's really challenging. Can we justify a full-time clinician? We use telemedicine for psychiatry since 1998. but we don't use it otherwise. |
| 211 | • Information and referral is so key. 211 is supposed to be a community resource but it's like they've created this in a vacuum. The taxonomy is supposed to allow for printing of resource manuals etc. Everybody's asking for these resource manuals in every coalition meeting I'm in, they say – people are falling through the cracks because they don't know what resources are available. We have a lot of |

| **Discussion Notes, Substance Abuse Prevention and Treatment** | |
|---|---|
| | folks really frustrating because they are trying to find the service they need and it's really hard to do.<br>• 211 is an awesome resource but they are under-resourced. They always refer to AYFN. They don't have enough staff to accomplish what they've been tasked with. |
| Target individuals at risk of incarceration or institutionalization with prevention services | • To the extent that we are trying to apply limited resources – we should be targeting the prevention side before anyone gets into corrections. Target individuals who are at risk of being institutionalized in a correctional or psychiatric facility. (Difficult to get specific enough to really measure outcomes. This has been a Trust challenge for a long time.) Target population – people who are ready for SUD treatment and are at risk of entering the institutions without that help.<br>• Another strategy would be to focus on individuals who are or would be using sleep off centers. Take a braided, wrap around approach - pull in housing, etc. |
| Coordinating and strengthening services for OCS-engaged families | • We have a number of general fund allocations that are directed toward SUD treatment and other family interventions for OCS-engaged families. Are families being reunited? We have all these little pots of money. Are they accomplishing what we want and what can we do to better accomplish the outcomes? One opportunity may be to go far upstream and work with the data that we have now. The most prevalent adverse experience in Alaska is having a parent in jail. What are we doing to serve the families who have parents in jail?<br>• Alaska Youth and Family Network serves hundreds of families per year. 70% will have turned out to be involved with Corrections. They have high ACEs scores – foster children have high rates of adverse experiences and OCS involvement. It becomes intergenerational. We can help families and youth break the cycle. We need to define what successful treatment is – there is a very punitive aspect to what the system is now. We know that separating children from their families never turns out well. We have a readily identifiable population. We know who these families are because OCS is identifying them. We start with "are you safe, do you have housing/food/transportation?" When they don't have access to these basic things, they become hopeless. We need services that work with entire families. The family system is not working, we send children to treatment and then back to unhealthy families. Tired of watching our kids and families move further downstream. We have 600 families this year that we will serve voluntarily. |

| **Discussion Notes, Substance Abuse Prevention and Treatment** | |
|---|---|
| Infrastructure development | • We need strategies that address infrastructure development – documenting and billing for services and building a capable workforce. The Trust has committed to helping providers build their capacity to bill Medicaid for behavioral health resources – that'll probably take a number of years. |
| Expanding use of evidence-based SUD practices | • SUD services must be evidence based – when DOC looked at its services, we found that they weren't necessarily evidence based. |
| Goal-driven strategies | • Alcohol strategies – we need some direct, specific strategies for SUD. What are our objectives with this focus area? We need to do this first. The current strategies are too visionary. Are we looking for a 10% reduction in teen binge drinking? Need very clear objectives, that can be supported through rigorous evaluation. |
| Improve statewide waitlist data | • There is quite a bit of research around readiness for treatment. Right now, we don't keep good waitlist data – can we define and mandate a waitlist system? |
| Healthy communities | • We can build a million treatment centers and it won't solve the issues. Individuals are being served and when they return to their communities, they do not have a healthy, safe community to return to. A community can be very sick with SUD issues. Drink until you black out community culture. We have to equip our children with evidence-based coping skills (DBT) and teach children what's right from wrong. They may not be able to change their families but they can develop the coping skills not to commit suicide, etc. We are trying to combine western science and cultural/elder knowledge. Millions of dollars are going into SUD treatment but we need to treat families and communities not just individuals. We need to help people break the cycle. We need to have strong conversations with our children. |

| **Criminal Justice / Substance Abuse Workforce Strategy Discussion** | |
|---|---|
| Policies and legislation that mandate training | • When we were looking at assisted living facilities, we asked: Why is the care provided through assisted living facilities and PCAs so inadequate – the answer was that they are not required to. We need more emphasis on policies and legislation that can incentivize competency building. |
| Support for non-degreed professionals; expanding BHA model | • Working with ANTHC's BHA program has been very impactful. We can learn from this model. ANTHC is moving to an on-the-job apprenticeship model and they found that UAF just simply wasn't meeting their workforce needs. The |

| | |
|---|---|
| | university falls short often when something doesn't fit in the degree program. The university is challenged with implementing on-the=job/apprenticeship programs. The Trust could be helpful in providing policy support related to how the university treats non-degree programs. We'd love for individuals to be able to go to degreed programs after they participate in apprenticeships. |
| Tapping existing infrastructure to build necessary skillsets and competencies | • You don't need a credential from an institution in the justice field. People don't need a degree to get a job. One of the challenges is how to integrate what already exists into training and education delivered at academies and advocating for the incorporation of curriculum delivered when going through certification. DOC runs its own academies for probation officers and Law enforcement agencies run their own academies. How do we leverage existing infrastructure. Alaska bar Association – whether you are talking about criminal or civil side (family law, competency etc) there are lots of opportunities for CLEs. When we think about workforce development, we think about starting something new, but we have to be focused on employers. ANTHC is good example. AHEC provides great training. I don't think there is a single occupation where we'd have to start from scratch. |
| Building system capacity for internships and practicums, attracting individuals at a young age | • One of the things we've struggled with is how to support university programs in the community. There are requests for practicums and internships – it'd be really helpful if there was a way to incentivize providers for the time they invest in really training a student. Making it easier to secure of finding preceptorships across the board would be great. AHEC needs help thinking about how to grow opportunities. We know that kids self-select out of health careers at a young age. We need to start really growing kids that want to be behavioral health providers. |
| Peer support workforce development | • How can we do a better job growing and retaining peer support workers? ACMHS has periods of time where we do well with peer support workers but generally it's not something we do well. A lot of providers would benefit from assistance integrating peer support workers. |
| Alaska Training Cooperative | • How can we leverage this resource?<br>• We bring a well-oiled machine to the table. We are working very closely with DBH in regards to their assessment process and looking at areas where providers might need support. We have well-seasoned experts on our team, and excel at training coordination.<br>• Ability to require mandatory competencies and then to set targets and track completion of training. |
| Beneficiary workforce | • Must not forget or underestimate the capacity of beneficiaries to become part of the workforce at all levels. |

## Housing and Long Term Services and Supports: Summary of Discussion

- Medicaid reform is linked to criminal justice reform and housing is fundamental to both, especially supportive housing for hard to house individuals
- Housing with supports to maintain housing is fundamental to health
- We want a deep impact, not shallow and wide
- Focus: implement Permanent Supportive Housing strategic plan
- Focus on hard to house populations such as returning citizens, Trust beneficiaries; take a by-name approach and work through lists of hardest to serve, most at risk for institutionalization; allocate funding person and coordinate supports around individuals
- Catalyze and coordinate funders to increase development: local governments, private developers, funders, government agencies, services providers, hospitals, tribal health providers, regional housing authorities
    - Workforce: capacity to manage property development and certified, quality case management
- Use HMIS, DOC data and other sources to show concrete results, bring individuals where they need to go, specific results to show legislators and policymakers.
- We are doing the right thing, need to scale up already successful programs: reentry, re-housing, more TBRA from AHFC (already committed to this).
- Need to clearly align between reentry and housing needs.
- Build skills and certification in case management and connecting people with services, including housing. Homeless coalitions are working on this now.
- Reentry coalitions are working on housing, employment, transportation, and in-reach (connecting before people leave).
    - Homeless and reentry coalitions are trying to work together more, cross-representation (not duplication).
- Governor's Council on Homelessness brings high level leaders together; staffed by AHFC
    - Trust is funding multiple positions; consider how best to use these to deepen impact, increase units and successful placements in housing
- Could there be an immediate solution? Could we realistically connect everyone?
    - Need to incentivize providers and work with providers who are willing to serve people who are hard to house and need ongoing supports
    - Could we look specifically at where we haven't been successful to date? Specifically, people who need behavioral health services and housing.

*Questions 1 and 2: What is working? What should we do differently?*

| **Overview of Housing + Long Term Services and Supports** | |
|---|---|
| Overview of Focus Area | • There are three areas: housing, community-based services, and long term services behavioral health services and home and community based services.<br>• LTSS is relatively new as a part of this focus area but conflict free case management has been a big project of the focus area, as well as rate re-basing and participating in a community innovation accelerator grant and national technical assistance program. |
| Needs identified on Day 1 | • Housing and services for aging people with complex needs, esp. higher risk for ADRD.<br>• Housing and more permanent situations for people leaving API, or alternatives for people cycling through API. In St. Paul, person wanting treatment contacts clinic: then Central Bering Sea Fishing Assn, tribe, corporations, others provide funding for treatment, or other e.g. travel. |
| **1 and 2. Beneficiaries can access appropriate community-based behavioral health services, long term services and supports (HCBS).** | |
| Medicaid as a funding opportunity | • For supportive housing, HCBS may make it more possible to pay for these services via waivers.<br>• Waiver and fee for service payments do not cover the cost of services overall, but with more availability of Medicaid reimbursement, these services may become more sustainable. |
| Tribal organizations, advantages and disadvantages of their structure | • Being in one organization (or closely related) can be helpful, able to use one line of business to support or complement others<br>• IHS funding does not support HCBS services or LTSS, but could qualify for Medicaid and get waiver services<br>• Providing housing, with some services, at a subsidy but could pay for supportive services with Medicaid. Finding ways to plan for the entire continuum instead of parceling out higher versus lower level services. |
| **3. Beneficiaries live in safe, affordable housing** | |
| Less funding for transitional housing, before going to permanent housing | • There is less HUD funding for transitional housing but continued need; hard to address this need without funding.<br>• AK CHH (CoC) seeing less HUD funding, very concerned about funding losses and defunding transitional housing.<br>• Has been uphill battle to build support for Housing First, especially with state level funding agencies.<br>• About 3,000 affordable housing units statewide (transitional, PSH, etc.) and 700 of those are transitional. Flat funding in |

| | |
|---|---|
| | 2009, and decrease in 2011; SNHG funding not increase until 2020.<br>• We are using a "1980s" model of mainly emergency shelters and transitional, not enough PSH. People are traveling from rural to hubs, homelessness issue moving from place to place. |
| Need to be creative about financing, e.g. gap financing even with LITHC funding (tax credits). | • Need more coordination and unified priorities of funders.<br>• Need to build support at local government level, Municipal League, individual organizations, housing authorities.<br>• Need to continue to build support for new models in AHFC, legislature, other funders.<br>• Grassroots work coming together, coalitions getting organized, but top-level coordination and advocacy needed to implement strategic plan.<br>• Trust has considered 0% or low-interest loans to organizations to provide financing for more housing.<br>• Need to figure out how to do gap funding (even with subsidies, still doesn't become feasible to build).<br>• Example: APIA Elders Conference, region is ready to invest at a grassroots level. |
| Types of housing, where to focus efforts in the overall market | • Rental assistance and case management are also needed, or rapid re-housing. There is a portion of the population that needs that, versus higher intensity of care.<br>• AHFC would like help giving technical assistance about housing, especially talking about permanent supportive housing, or figuring out alternatives if it doesn't pencil.<br>• Continuum of housing is needed, there are very different populations. Therapeutic courts have better success working with landlords because the tenants are accountable. |
| Housing for hard-to-house populations, especially funding to develop and sustain this housing | • Need to find ways to connect housing and services: e.g., there is money to build assisted living homes but it doesn't work financially, especially in rural areas.<br>• Need to be creative about combining sectors and working together, e.g. Medicaid services as a way to connect with housing, providing transitional housing with health care.<br>• Moving population out of institutions is possible, requires even moving individual people into other places. Pay for Success funding will take that approach, very targeted PSH for specific population in corrections with BH issues.<br>• Hope Community Resources is good example of an innovative housing provider, previously didn't own houses, but got funding (per person, ~$25k) and have a pool of flexible funding that they are able to use as down payment, transportation, etc. Could we figure out a per-person dollar amount for hard to serve individuals and fund accordingly in order to incentivize providers? |

| | |
|---|---|
| Permanent Supportive Housing Strategic Plan and Governor's Housing Summit<br><br>Governor's Council on Housing and Homelessness | • AHFC had workgroups regarding how to increase housing in the state, including development; services; workforce development; needed payment structures. Looked at funding sources available in all areas.<br>• How can we carry this work forward? If the Trust is a convener, how do we connect funds with organizations, to accomplish what is in the plan?<br>• There were a lot of ideas to achieve higher economy of scale, e.g., ordering bulk materials. Could also focus on homeownership, sweat equity, and other ways to improve housing overall.<br>• AK CHH has been increasing activities in last five years, more advocacy, more information and data esp. about populations. |

### *Determining Priorities for Focus Area*

- Need to determine how the Trust can use this focus area to strategically invest. Don't want to be "inch deep, mile wide."
- Multiple studies have shown that permanent supportive housing is the best practice and most effective, at state and national level. How can we implement this plan? Who is implementing and what resources exist for individual organizations to make this type of housing? There was a recommendation to create a Housing Policy Coordinator that oversees and aligns multi-agency policies.
- Trust is funding multiple positions, e.g., Anchorage Coalition on Housing and Homelessness coordinator and the BHAP program, to connect people with housing.
- AHFC estimates that of the 13,000 served people in the BHAP/SNHG program 30% are beneficiaries, but the data is self-reported so the number is likely much higher. The overall program is $6 million. SNHG operating grants also serve about 220 households.
- To date, much of the solution has been funding staff positions to do work in other settings. Is there another way to think about how to address this issue?
- Housing market is an overall issue and has many facets, from private market-rate to subsidized and hard-to-house individuals.
    - Should focus on Trust beneficiaries: permanent supportive housing is a wide range, from previously-homeless to people with other special needs.
    - Embedding subject-level experts in other departments could continue to work.
    - Having a high-level coordinator who can work across departments is needed, and there isn't one now, other than the Governor's Council on Housing and Homelessness (commissioners, has one staff person in AHFC). Council has been urged to implement the plan.
    - Follow up with Joel Niemeyer to have a "funders' summit" for housing
    - DOC releases individuals knowing they will go to Brother Francis Shelter; would like to focus on people who are likely to recidivate at a very high level. Need to measure impact and build the case, "This number of people were able to be placed in housing, and did not return to custody in the last six months." There are results from the tenant-based rental assistance program that AHFC has with returning citizens, and other programs like Partners for Progress

| **Existing Strategies** |
|---|
| A. Systems change/housing policy coordination; focus area administration and data<br>a. Technical assistance for various projects (conflict-free, rate/acuity)<br>b. Work with local-level and state-level coalitions to align efforts and resources |
| B. Beneficiaries access appropriate community-based behavioral health services |
| C. Beneficiaries access appropriate community-based long term services + supports (HCBS)<br>a. Assertive Community Treatment (ACT) team<br>b. Telehealth, including assessment to be able to qualify<br>c. Aging and disability resource center<br>d. Focus on care coordination and case management as important support for housing: training, competencies |
| D. Beneficiaries live in safe, affordable housing<br>a. Permanent supportive housing; Housing First model (best practices)<br>b. Development of new housing models<br>c. DOC discharge incentive grants<br>d. Flexible special needs housing "rent-up" |
| **New Strategies** |
| A. "Smart home" technology and other age-in-place strategies (incl. with family) |
| B. Comprehensively implement statewide Strategic Plan for Permanent Supportive Housing |
| C. Work more directly in the entire market: real estate, providers, builders, financing, make those connections between development world and services world. |
| D. Rapid re-housing and transitional housing focus |
| E. Increase capacity of workforce, including unpaid workforce (family caregivers) |
| F. New voucher-based 811 program (housing, case mgmt., supports) for 200 hard-to-serve individuals to move off of General Relief and better serve: support and expand this pilot |
| G. Macro strategy change: focus on one success at a time, share success stories as model to build on, working first with who is ready to try new projects (APIA example) |
| H. Macro strategy change: Trust as convener. Develop unified approach and message for what should be invested, integrating housing and other systems (health, supports). Fully align state-level housing investments, agency priorities, funding, and take a data-focused systems approach. And communicate back at the local level. |
| I. Focus more specifically on social determinants of health, including other segments or aspects of housing: infrastructure, financing, energy costs, making living affordable. Connecting this more directly with health. |
| J. Link more directly with other medical reforms, and work with hospitals (non-profit with Community Benefit requirements) and health care providers. |

## Beneficiary Engagement and Employment: Discussion Summary

- As an Employment First state, the expectation is that employment is possible and vital for all beneficiaries, should be part of all treatment planning and any State-funded services; need to spread this message with beneficiaries, parents, providers, policymakers. Bust the myth around maintaining benefits vs employment
- Track outcomes with simple measures, easy to share: how many employed for how many hours/months, level of pay, how many engaged in community activities developing skills for high-demand jobs with willing employers
- Increase activity to engage employers and develop internship and apprenticeships
- Connect peer run organizations who do employment and engagement with vocational rehab activities; peers are a critical part of the workforce, especially for system reforms
- Beneficiary run organizations are critically important for connecting beneficiaries with housing and employment, providing social engagement and activities, work on advocacy
- Opportunity: pre-employment for youth still in school, focus on youth in foster care, rural youth
- While volunteering is not a replacement for employment it is a critical need for preparation for employment; unpaid caregivers are volunteers
- Seniors are working longer and also need employment and engagement opportunities

*What is working? What should we do differently? What new or existing strategies should be used in this focus area?*

| **Beneficiary Engagement and Employment: Overview** | |
|---|---|
| Overview of focus area (new as of FY15) | • Created a plan, had workgroups to try to figure out where are currently and how to measure what is needed, e.g. workforce development, potential/misunderstandings about losing benefits, vocational rehabilitation.<br>• Plan strategies:<br>  ○ Beneficiaries are employed<br>  ○ Beneficiaries use programs available, including other options like microfinance<br>  ○ Beneficiaries have options for meaningful activity (employment or otherwise)<br>• Activities<br>  ○ Funding outreach as part of mental health services, ask people if they want to work and connect them.<br>  ○ Individual job placements.<br>  ○ Social enterprise, reinvesting into a social good.<br>  ○ Micro enterprise funding, beneficiaries wanting to start their own business.<br>• Governor's Council on Disability and Special Education is staff/coordinating this work. |

| | |
|---|---|
| How can any of these strategies be funded in another way, other than continued Trust funding? How can peer support fit into Medicaid reform? | • The funding is necessary, but could find other sources.<br>• Several organizations could not bill Medicaid previously, so there was not another way to pay for it. Services are not necessarily Medicaid billable either way.<br>• If Accountable Care Organization existed, could have a subcontract eventually with a peer support org. to provide service for a specific fee. |
| Alaska is an "employment first" state | • Means that every person receiving services must be asked whether they want to be employed, what they are interested in. (versus assuming they cannot work).<br>• Intended to be paid employment, inclusive and not segregated. |
| **1. Beneficiaries have increased employment outcomes through access to community services and supports** | |
| Peer role | • Need to involve peers as a way to encourage people to engage, especially in non-traditional work.<br>• Peers are also critical in helping people show up to work, show up to appointments, find meaningful engagement in other ways. Can help people find direction. |
| Peers as part of the workforce | • BPI programs (peer run) – almost done with assessment of all of these programs<br>• There are several organizations doing this, have had very good results so far. Beneficiary-run projects, peer support, and so far has been successful.<br>• Several organizations work across the state<br>• CHOICES now also provides Assertive Community Treatment (ACT) as well for the next three years |
| Schools and families | • Important to help kids get work experience before leaving school, and also change expectations for parents and students.<br>• Program this past year to help build kids in employment in multiple rural communities, brought kids together.<br>• Starting to work with foster kids and transition age youth, once on their own. PETS project partners with OCS and Trust for transition age youth. |
| **2. Businesses increase the hiring of beneficiaries** | |
| Working with Gov Council to connect individuals with businesses | • Currently, working with other organizations to encourage beneficiary hiring, work with others like veterans, connect beneficiaries with a variety of options.<br>• Have held job fairs, but not followed up on how many people hired, whether they stay, etc. Need better data regarding outcomes. |

| | |
|---|---|
| | • Conducted a survey of employers about past activities hiring beneficiaries, need to follow up on this data. |
| Who is hiring beneficiaries? How are they faring, are they being retained? | • Need clear, simple measures to show progress and measure success in this area.<br>• Have good data on attendance at fairs and overall interest, but have not yet followed up on who is hiring.<br>• Did a survey of employers about whether they have hired beneficiaries, their experience. Can follow up. |
| **3. Beneficiaries have increased self-sufficiency or meaningful activities** | |
| Volunteerism and non-paid service | • Are there other ways to have non-employment focus? Nursing homes, planting trees, cleanup, a bunch of other needed services apart from employment.<br>• Is there a way to think differently about Medicaid and health care, given that so many people are not paid for health care provided, caregiver?<br>• Also can be challenging because volunteers end up having more requirements, or require licensing, and then become paid staff.<br>• Need to avoid the "trap" of readiness, not want to assume that someone isn't "ready" to employ – should always have the expectation that someone can engage in some way. |
| Culture and expectation change about employment and meaningful engagement | • Can start with parents, engaging with parents of kids with disabilities or other issues, and changing the expectation that everyone can have a job if they want one. |
| Senior population and changes in needs of aging beneficiaries | • Seniors needing to work longer and many are beneficiaries, especially if also have ADRD or other issues<br>• Need to reach out to seniors, especially those with two or more barriers to employment (age, SMI, etc.)<br>• Seniors volunteer at very high rates in Alaska |
| Social benefits of engagement | • Connecting intergenerational, elders and youth<br>• Social connections important part of employment |
| **4. Increased utilization of employment programs by beneficiaries** | |
| **5. Increased capacity for providers to support beneficiaries seeking employment** | |
| **6. Policy and data development** | |
| **7. Ongoing support for projects with strong consumer choice and expanded service delivery** | |

## Closing Discussion

At the conclusion of day 2, participants were asked to share their response to the following question: What one thing do you feel is most important for the Trust to work on?

Responses and their frequency are summarized in the following table.

| **Top priority** | **Freq.** |
|---|---|
| Housing in general, very much needed in all communities | x 2 |
| Implement permanent supportive housing strategic plan: conference in October, better higher-level coordination (with existing staff or more resources to accomplish this goal) | x 5 |
| Support successful reentry and educate communities about it | x 2 |
| Specifically housing supports, e.g., TBRA and BHAP: increase these programs to allow for more vouchers, and include vouchers in more communities demonstrating need through DOC discharge data | |
| Support new 811 program partnership between DHSS and AHFC | |
| Build on resources in rural areas, especially where resources are fewer | x 3 |
| Youth recidivate because we take them away from culture, families and communities and don't send them back with added values; need to send them back with skills and values to help develop rural communities | |
| Access to care! (related to many other items on this list) | |
| Workforce development and capacity, to meet needs from reforms and billing | x 6 |
| Workforce recruitment and retention, especially in health fields | |
| Personalized case management and navigation, from health services to job training | |
| Technology, investment in telehealth, long term supports, other ideas | x 2 |
| Primary care and behavioral health integration | x 2 |
| Strong healthy communities, for before and after to provide supports | |
| Peer support, empower and build networks, beneficiaries as part of the system | x 3 |
| Culturally responsive care and practices, e.g. "Doorway to a Sacred Place" (ANTHC) | |
| Meaningful employment, engagement, volunteer opportunities, to help recovery, give purpose, help people improve quality of life | x 4 |
| Addressing substance use, both prevention and treatment. | |
| Pilot projects, using data, focused on one group. | |
| Specific funding in prevention, community-based prevention, social determinants of health, and including diversion away from corrections, who is currently treating people with mental illness that causes their involvement with corrections. Mitigates need for future treatment. | x 6 |
| More investment in treatment, need to increase capacity. Daily work of many organizations, funded by DBH | x 3 |
| Help more behavioral health providers bill Medicaid and private insurance | |
| Macro level or policy level strategies | |
| Reframe: communities need to be inclusive of all people, we are making reforms because they are the right thing to do to improve health and wellbeing, not only because they will save money | |
| Focus on measurable outcomes, not just outputs: Alaska evidence-based practices, and commitment to evidence based practices. | x 2 |
| Better coordination and alignment high-level policy directions | |

| | | |
|---|---|---|
| | Find other sources and ways to fund programs, including through Medicaid and criminal justice work; work toward sustainability and cost containment | x 2 |
| | Advocacy and information aspect of the Trust, helping public conversation, raise discussion about "they are my neighbor, I want them to have what I have" | x 2 |
| | Continue to be a convener, have forums, and make connections | x 2 |

## Next Steps for FY18-19 Budget Process

- Over the next several weeks, Trust staff will be processing information from last two days, getting more information from participants.
- Webinar scheduled for Wednesday, July 20 will share back the summary of what was discussed and how it will inform the budget process.
- This work will ultimately result in recommendations for the FY18-19 budget, presented by Trust staff to the Trustees in August and help to inform the final budget adopted in September.