Trust
Alaska Mental Health Trust Authority

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

MEETING AGENDA

Meeting: Program & Planning Committee
Date: April 20, 2023
Time: 8:30 AM
Location: online via webinar and teleconference
Teleconference: (844) 740-1264 / Meeting Number: 2465 625 7945 # / Attendee Number: #
https://alaskamentalhealthtrust.org/
Trustees: Verné Boerner (Chair), Rhonda Boyles, Kevin Fimon, Brent Fisher, Anita Halterman, Agnes Moran, John Sturgeon

Thursday, April 20, 2023

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8:30	**Call to order (Verné Boerner, Chair)** Roll Call / Announcements / Approve agenda / Ethics Disclosure Approval of Minutes: January 5, 2023	5
8:35	**CEO Update** • Budget/Session Update • Trustee Confirmation • CEO Quarterly Grant Approvals Report	hand-out
9:05	**Overview Trust Data & Evaluation Process/Use** • Mike Baldwin, Senior Evaluation & Planning Officer	16
9:45	**Continuation Grant Process: Grants Accountability** • Katie Baldwin-Johnson, COO • Carrie Predeger, Grants Accountability Manager	27
10:15	**Break**	
10:30	**Comp Plan in Action: Adverse Childhood Experiences** • Joshua Arvidson, MSS LCSW, COO, Alaska Behavioral Health • Robyn Husa, PhD, Epidemiology Specialist II, DOH, Div of Public Health	40
11:30	**HB172 Report Contract Update** • Travis Welch, Trust Program Officer	75
11:45	**Lunch**	

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12:45	**FY25 Budget Development Process Overview / Update** • Katie Baldwin, COO	79
1:00	**Approvals**	
	• Alaska Medicaid Rate Setting Methodologies: Contract Funding	84
	• Maniilaq Association – Behavioral Health Crisis & Integrated Care Program	91
	• Ketchikan Wellness Coalition- Crisis Now Community Director	103
2:15	**Break**	
2:30	**Continuation of Approvals**	
	• Data Development for TABI & ADRD: Contract Funding	116
	• Southcentral Foundation – Integrated Parenting & Family Support Services	120
	• Southcentral Foundation - TABI Phasic Implementation	127
	• Community Connections – Therapeutic Foster Care: Expansion & Sustainability	136
4:00	**Trustee Comments**	
4:15	**Adjourn**	

Additional Documents:
CEO Quarterly Grant Approvals Report
Community Connections Supporting Documents

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Future Meeting Dates

Full Board of Trustees / Program & Planning / Resource Management / Audit & Risk / Finance

(Updated – April 2023)

• Audit & Risk Committee	April 19, 2023	(Wed)
• Finance Committee	April 19, 2023	(Wed)
• Resource Mgt Committee	April 19, 2023	(Wed)
• Program & Planning Committee	April 20, 2023	(Thu)
• Full Board of Trustees	May 24-25, 2023	(Wed, Thu) – MatSu

• Audit & Risk Committee	July 25, 2023	(Tue)
• Finance Committee	July 25, 2023	(Tue)
• Resource Mgt Committee	July 25, 2023	(Tue)
• Program & Planning Committee	July 26-27, 2023	(Wed, Thu)
• Full Board of Trustees	August 29-30, 2023	(Tue, Wed) – Anchorage

• Audit & Risk Committee	October 19, 2023	(Thu)
• Finance Committee	October 19, 2023	(Thu)
• Resource Mgt Committee	October 19, 2023	(Thu)
• Program & Planning Committee	October 20, 2023	(Fri)
• Full Board of Trustees	November 15-16, 2023	(Wed, Thu) – Anchorage

• Audit & Risk Committee	January 4, **2024**	(Thu)
• Finance Committee	January 4, **2024**	(Thu)
• Resource Mgt Committee	January 4, **2024**	(Thu)
• Program & Planning Committee	January 5, **2024**	(Fri)
• Full Board of Trustees	Jan 31 – Feb 1, **2024**	(Wed, Thu) – Juneau

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Future Meeting Dates

Statutory Advisory Boards

(Updated – April 2023)

Alaska Commission on Aging
ACOA: http://dhss.alaska.gov/acoa/Pages/default.aspx
Executive Director: Jon Haghayeghi, (907) 465-4879, jon.haghayeghi@alaska.gov

- Quarterly Meeting: May 25-26, 2023 / TBD

Alaska Mental Health Board / Advisory Board on Alcoholism and Drug Abuse
AMHB: http://dhss.alaska.gov/amhb/Pages/default.aspx
ABADA: http://dhss.alaska.gov/abada/Pages/default.aspx
Acting Executive Director: Leah Van Kirk, (907)465-5114, leah.vankirk@alaska.gov

- Executive Committee – monthly via teleconference 10am (2nd Wednesday of the Month)
- Quarterly Meeting: TBD

Governor's Council on Disabilities and Special Education
GCDSE: http://dhss.alaska.gov/gcdse/Pages/default.aspx
Acting Executive Director: Patrick Reinhart, (907)269-8990, patrick.reinhart@alaska.gov

- Quarterly Meeting: June 1-2, 2023 / Anchorage

ALASKA MENTAL HEALTH TRUST AUTHORITY

PROGRAM & PLANNING COMMITTEE MEETING
January 5, 2023
8:30 a.m.
WebEx Videoconference/Teleconference

Originating at:
3745 Community Park Loop, Suite 120
Anchorage, Alaska 99508

Trustees Present:
Verne' Boerner, Chair
Anita Halterman
Rhonda Boyles
Kevin Fimon
Agnes Moran
John Sturgeon

Trust Staff Present:
Steve Williams
Katie Baldwin-Johnson
Carol Howarth
Miri Smith-Coolidge
Kelda Barstad
Michael Baldwin
Eric Boyer
Valette Keller
Autumn Vea
Allison Biastock
Debbie Delong
Jimael Johnson
Kat Roch

Trust Land Office Staff Present:
Jusdi Warner

Presenters:
Renee Rafferty
Ella Goss
April Kyle
Alberta Unok

Also participating:
Amy Miller; Beverly Schoonover; Steph Hopkins; Patrick Reinhart; Lee Breinig; Laura Russell; Heidi Hedberg; Heather Carpenter; Emily Ricci; Diane Fielden; Brenda McFarlane; Stephanie Wheeler.

PROCEEDINGS

CALL TO ORDER

CHAIR BOERNER (Native language spoken.) called the meeting to order and began with a roll call. She stated that Trustee Fisher was excused. Trustee Sturgeon asked to be excused by 2:30. She continued that there was a quorum and asked for any announcements. There being none, she moved to the approval of the agenda.

APPROVAL OF THE AGENDA

MOTION: A motion to approve the agenda was made by TRUSTEE HALTERMAN; seconded by TRUSTEE FIMON.

After the roll-call vote, the MOTION was APPROVED. (Trustee Sturgeon, yes; Trustee Halterman, yes; Trustee Fimon, yes; Trustee Boyles, yes; Chair Boerner, yes.)

CHAIR BOERNER asked for any ethics disclosures. There being none, she moved to the minutes of October 20, 2022.

APPROVAL OF THE MINUTES

MOTION: A motion to approve the minutes of October 20, 2022, was made by TRUSTEE HALTERMAN; seconded by TRUSTEE BOYLES.

After the roll-call vote, the MOTION was APPROVED. (Trustee Boyles, yes; Trustee Fimon, yes; Trustee Halterman, yes; Trustee Sturgeon, yes; Chair Boerner, yes.)

CEO UPDATE

CEO WILLIAMS stated that there was a lot of important work being done this year as directed by the trustees and in partnership with many of the partners at the Administration, the Legislature and out in the community. He announced that Janie Caq'ar Ferguson is joining the team at the Trust Authority Office. She will be the new program officer beginning January 17th. He noted the importance of the two days of committee meetings. We will hear about the current efforts on the implementation of services to transform the behavioral health crisis system of care using the Crisis Now model. He continued that they were aware of the events happening in the community and the impact of the issues related to public assistance and food stamps on the beneficiaries. Trust staff has been maintaining contact with the Department of Health on those issues. He added that the Department is working on and addressing the issues related to food stamps by increasing staffing so that the backlog could be eliminated as quickly as possible. Staff is also working directly with the Department of Justice addressing their recommendations on how to move forward in addressing the issues cited in their report. He acknowledged the retirement of Gennifer Moreau Johnson, director of behavioral health, who was critical in the development and approval of the 1115 behavioral health waiver. He also noted the retirement of Laura Brooks, the Division director for health and rehabilitation services, from the Department of Corrections.

CHAIR BOERNER thanked CEO Williams and requested that cards be sent to both retirees. There being no questions, she moved to the Crisis Now update.

CRISIS NOW UPDATE

MS. BALDWIN-JOHNSON noted that there are two significant proposals that will be presented later, and she gave an update on the activities and progress made on the initiatives in communities across Alaska, as well as at the statewide systems level. She added that a copy of the Crisis Now work plan was included in the packet. The contract project management resource, currently Agnew::Beck, has been on point for managing and modifying that plan. It is a living, breathing, and evolving work plan. She reminded all that it is tied back to the 13 primary recommendations from the original Alaska Crisis Now consultation report that was developed in 2019 in consultation with RI International. She added that Ella Goss, chief executive officer, and Renee Rafferty, with Providence Alaska, were online to share the progress made with the support of a Trust planning grant received in May of 2021. The focus of that was to design and plan for crisis stabilization in Anchorage, to include the low- to no-barrier 23-hour crisis receiving center, short-term crisis residential, and a behavioral health urgent care center. She stated that the first proposal would provide support to Providence in the Phase II of implementation, specifically focusing on ramp-up and launch of services in the new year and a request seeking approval of funding for the next period of contract management resources necessary to maintain the organization, accountability, and progress for the overall initiative going forward. She continued that the Trust, the Department of Health, the Department of Family & Community Services and community partners across the state are working to build a behavioral health continuum of services, equitable and equally as responsive as the physical health emergency continuum.

MR. BOYER continued that this is an iterative process of working through contractual, the business modeling, figuring out the clinical models, the legal issues, and regulatory and passing new laws. There are new people joining this effort every day and new members taking over organizations. He went through a few highlights from the timeline for background information.

MS. BALDWIN-JOHNSON talked about the importance of continuum care in the community and building out alternatives to hospital emergency rooms, and also really improving the environment of care, the type of care provided, and enhancing more therapeutic and trauma-informed approaches to individuals that do present to hospital emergency rooms. She added that we have a very strong foundational base which will continue having very strong partnerships with both departments, as well as the Department of Corrections and the Department of Public Safety, going forward.

MR. BOYER went through some examples from the work the Crisis Now coordinators were doing in the community with the partners.

CHAIR BOERNER appreciated the update and stated that, personally, it was a very exciting presentation to go through and see.

A brief question-and-answer discussion ensued.

CHAIR BOERNER stated, for the record, that Trustee Agnes Moran had joined the meeting, and continued to the Alaska Crisis Stabilization update. She asked Ms. Baldwin-Johnson to provide opening comments.

PROVIDENCE ALASKA CRISIS STABILIZATION UPDATE
PHASE I UPDATE/PHASE II PLAN

MS. BALDWIN-JOHNSON stated they were excited to hear about the progress being made with the original planning grant and how that planning grant was leading to the next series of activities that were important in order to be prepared to open their doors early in '24.

MS. RAFFERTY stated that she is the senior director of behavioral health, and she introduced Ella Goss, the chief executive for the Providence Alaska region.

MS. GOSS noted that she moved into the role of region chief executive for Providence Alaska in September of 2022, but she was not new to either Alaska or Providence. She had been in Alaska for 27 years, and with Providence for over 25 years. When she started at Providence, she was in the emergency department. ER nursing was her background. She was acutely aware of the challenges in Alaska in looking to provide high quality, safe care. It takes a lot of collaboration, partnership and innovative planning across many groups of healthcare and community partnerships to bring in new programs. She was proud to say that Providence is a strong partner with the Alaska Mental Health Trust Authority, and she looks forward to moving this project along and being able to be strong partners bringing Crisis Now, crisis stabilization to the state. The mission of the Trust Authority is very aligned with the mission of Providence, which is to care for the most poor and vulnerable within the state. She stated that the Providence Alaska executive team is very dedicated to bringing innovative crisis behavioral health services to Alaska. An important step is being able to increase awareness around behavioral health, the needs, the challenges and some of the deficits that have been brought up. She continued that Providence Alaska had the only psychiatric emergency department in the state, which is at capacity, and has been for many years. Right now, it is a safety net for many of the patients that need that care, but it is not sustainable in the way that it was planned, and with the number of beds it actually provides. A different resource is needed for those patients. The commitment to this project is because of the collaboration and investment of many stakeholders in this community, for which they are grateful.

MS. RAFFERTY stated that the psychiatric emergency room was developed as a result of system transformation, and is one of the programs that Providence continued committing to grow even with the risks and challenges of the behavioral health system not being as funded as it needs to be. She continued that it is exciting to be at this point in the planning process where they would like to operate a crisis receiving center that operates urgent care, 23-hour, and has involuntary and voluntary in that 23-hour and 24-hour residential. She called attention to the importance of the actual healthcare system moving forward and talked about the decision to move toward these three services. She explained in more detail and then talked about the design. She stated that the clinic would allow people to walk in when medications are needed, and to continue to partner moving into other levels of care. That was a breakthrough, and we will expand that service to allow for psychiatric emergent care, emergencies associated with the urgent care level. A key goal for the stabilization center is people greeted by a peer, a nurse, a therapist that understands what is happening to them and could immediately de-escalate them.

MS. GOSS noted that these are some very challenging economic times and the need for collaboration across partnership has never been more important. Providence has provided many services to the community when no one else would step up. One of the deep partnerships that

has been a very successful program is Alaska Cares. That care was provided to the community, and they worked with the community and built a beautiful building with a very successful program for a very vulnerable population in the community.

MS. RAFFERTY walked through the expenditures planned through the year and explained the timeline of the planned expenditures through early 2024. She stated that it is important to have a full clinical team ready to engage the work flows and the regulatory landscape regarding involuntary care. She talked about the five-year financial summary and recognized the challenge in recruiting.

MS. GOSS stated that Providence would continue to provide the services needed in Alaska and were asking to have the support from community partners to be able to stand up this program knowing that they would be a strong and long-term partner to see it through.

CHAIR BOERNER stated appreciation for the presentation and asked Amy Miller if she had anything to add.

MS. MILLER stated that Providence operates in seven states, and, in each state, they take advantage of whatever billing opportunities and reimbursements for services are available. She added that one of the reasons they were present today was to ask for help with that start-up cost, which is substantial.

CHAIR BOERNER called a break.

(Break.)

CHAIR BOERNER welcomed folks back and stated that next on the agenda were the Approvals.

APPROVALS

CHAIR BOERNER continued that there were two approvals: the Providence Alaska crisis stabilization Phase II ramp up and launch; and, second, is the Crisis Now initiative project management contract funding. She explained that the first motion would be a recommendation to the Full Board, and the second would be for consideration by the committee itself. She asked for a motion.

> **MOTION:** A motion to approve that the Program & Planning Committee recommend that the Full Board of Trustees approve $1,554,269 Mental Health and Addiction Intervention focus area allocation to the Providence Health & Services Alaska, dba, Providence Alaska Medical Center, for the Crisis Stabilization Center – Phase II Ramp-up and Launch. These funds will come from the FY23 crisis continuum of care budget line and was made by TRUSTEE BOYLES; seconded by TRUSTEE MORAN.

CHAIR BOERNER asked Ms. Baldwin-Johnson to open the presentation by both staff and Providence.

MS. BALDWIN-JOHNSON stated that the updates shared showed that significant progress has been made. She continued that Providence was ready to enter the second phase of service ramp-

up and launch by early 2024. Providence proposed a campus location to host all of the programs. The facility identified had been coordinating closely with experts at RI International on design with the Providence architectural design teams and had continued to move the planning for that facility forward. She noted that while the 23-hour and crisis residential services would primarily service adults, Providence proposed serving youth, 12 years and older, in the urgent-care setting. This is critical given the parallel challenges in serving adolescents and youth with mental health crisis in the state. Trust Authority staff have worked collaboratively with Providence to bring this proposal forward for funding consideration for the second phase. She added that it was anticipated that these programs will serve the broader Anchorage community.

TRUSTEE HALTERMAN observed that this particular request supported the Court's recommendations from the DHSS gaps in psychiatric care response system report, and she was very supportive of the project.

CHAIR BOERNER asked for any other questions or comments. There being none, she moved to the roll-call vote.

After the roll-call vote, the MOTION was APPROVED. (Trustee Boyles, yes; Trustee Fimon, yes; Trustee Halterman, yes; Trustee Moran, yes; Trustee Sturgeon, yes; Chair Boerner, yes.)

CHAIR BOERNER moved to the second approval, the Crisis Now initiative project management contract funding. She asked for a motion.

MOTION: The Program & Planning Committee approves up to $250,000 for a contract for Crisis Now Initiative Project Management. These funds will come from the FY23 Crisis Continuum of Care Budget line of the Mental Health & Addiction Focus Area and was made by TRUSTEE HALTERMAN; seconded by TRUSTEE STURGEON.

CHAIR BOERNER invited Eric Boyer to provide some opening comments and staff presentation for the requested motion.

MR. BOYER stated that this was referenced at the presentation this morning about the contractual support for project management and its importance. He added that this is a data-driven project, and that data is depended on and gives some substance and weight to the work done and, ultimately, the driving of the budget. That kind of follow-through and support is huge. He also mentioned that the goals in the Comprehensive Integrated Mental Health Program Plan really dovetail nicely with this project. He added that this would come out of the FY23 Mental Health Addiction Intervention Focus Area and noted that crisis continuum of care line item.

MS. BALDWIN-JOHNSON clarified that it is not a grant, and that this request needed to be brought forward for trustee consideration.

CHAIR BOERNER asked for any other comments or questions. There being none, she moved to the roll-call vote.

After the roll-call vote, the MOTION was APPROVED. (Trustee Boyles, yes; Trustee Fimon, yes; Trustee Halterman, yes; Trustee Moran, yes; Trustee Sturgeon, yes; Chair Boerner, yes.)

MS. BALDWIN-JOHNSON specifically acknowledged that Commissioner Hedberg with the Department of Health, Deputy Commissioner Ricci, Laura Russel, and Heather Carpenter were online with us for the morning. She thanked them and stated that their presence and spending their morning reflected the partnership and the mutual support of the collaborations that were focused on this exact work that had been discussed today.

CHAIR BOERNER asked the trustees to go through the Governor's FY24 Budget Update with the time remaining before lunch.

GOVERNOR'S FY '24 BUDGET UPDATE

MS. BALDWIN-JOHNSON reminded the trustees that a high-level overview of the Governor's proposed budget was previously provided. She stated that this will further outline and detail the differences between the proposed budget and what trustees approved in the recommendations for FY24. She added that this was just one step in the process, and the Governor's amended budget is due February 15th. Also, the House version and the Senate version will also need to be reconciled later in session through the Conference Committee process. Staff will continue to work on putting items back in the amended budget where possible.

CEO WILLIAMS stated that it was not unusual to have a governor who sets forth his proposed budget and not include all of the Trust recommendations. He continued that a lot of different variables were at play with the recommendations that got included into the proposed budget, including the financial outlook for the State, as well as any change in priorities. He added that 40 percent of the recommendations were included, and staff will continue to work with the Administration and the Legislature moving forward through the process and trying to get as many of the recommendations put back into the budget.

CHAIR BOERNER asked the trustees for any questions.

A brief discussion ensued.

CHAIR BOERNER called a lunch break.

(Lunch break.)

CHAIR BOERNER welcomed all back and moved to the tribal health systems.

TRIBAL HEALTH SYSTEMS OF CARE

CHAIR BOERNER stated that the presenters were April Kyle, president and CEO for the Southcentral Foundation, and Alberta Unok, president and CEO for the Alaska Native Health Board. She asked Ms. Baldwin-Johnson to do the introductions.

MS. BALDWIN-JOHNSON stated that it had been a while since there was a presentation on the system, and appreciated Ms. Kyle and Ms. Unok putting this presentation together. She

continued that the Trust Authority staff, with the guidance of Trustee Boerner, recognizes the importance of ensuring that all are informed and educated about the tribal health system and how important it is in delivering care to Alaskans across the state. She welcomed them both and looked forward to the presentation.

MS. UNOK (Native language spoken) thanked all for including tribal health on the agenda. She stated that she is the president and CEO of the Alaska Native Health Board and is a tribal citizen of the Native Village of Kotlik, which is located at the mouth of the Yukon River and the Bering Sea in the Yukon Kuskokwim Health Corporation region.

MS. KYLE stated that she and her children, on her father's side are tribal members in Ninilchik. She continued that her mom is from California. She serves as president/CEO of Southcentral Foundation, and this week she is celebrating her 20-year anniversary. She had been in her current role for two years, and prior to this served as vice president of behavioral services. She is still super involved in behavioral health, and is enjoying leading the entire organization. She began with the long history of how health worked in the state of Alaska, and she went through a timeline of ways of supporting wellness generations ago that included traditional healing, tribal doctors, tribal medicine, understanding plants as medicine, and caring for their own communities. That changed over time, leading to the establishment of the Indian Health Service; which served to retard, rather than enhance, the progress of Indian people in their communities. That meant that the healthcare was so poor that it was actually making communities sicker. It denied an effective voice in the planning and implementation of programs that responded to the true needs of the people. It was this moment where the Government had this treaty obligation to ensure that it was providing healthcare to Native people in perpetuity. It had set up the IHS as the vehicle to do this, but recognized that the IHS system was failing. Indian self-determination means that, as Native people, they should have the right to guide, to govern, to develop the health systems as a community that best meets the community needs. Self-determination is super unique in Alaska and in the United States, and is pretty darn powerful.

MS. UNOK stated that healthcare for American Indian and Alaska Native people was not a social welfare program or insurance. Healthcare for Indigenous people in the United States had been prepaid through trades of land and resources owned by Indigenous people. This came from government treaties. Indigenous people are the only groups where there is a legal and contractual obligation to indefinitely provide healthcare services. The organizational vehicle for fulfilling this obligation is the Indian Health Service, which continues to be severely underfunded. The development of the Alaska Tribal Health System came out of innovation and to address critical needs. Contracting was the first step in tribes exercising self-determination with limited contract to provide specific services for a specific amount. Compacting was the ability for tribes and tribal organizations to assume full responsibility of programs and services. The compact with IHS was to assume full control over programs which IHS would have otherwise provided. She continued that in Alaska they coordinate one Alaska Tribal Health Compact and collectively negotiate funding agreements and common language with the Indian Health Service. This compact represents 229 tribes and over 188,000 Alaska Native and American Indian beneficiaries throughout Alaska.

MS. KYLE stated that the idea behind the system is to have local control so that local communities could design their own health systems to meet their local needs. That was

accomplished through a regionalized system. She explained this in greater detail.

MS. UNOK continued that the tribal health system is a statewide coordination of care. Tribal management of healthcare recognizes the importance of local decision-making for the unique healthcare needs and challenges. It allows for flexibility in creating culturally relevant health programs with emphasis placed on integrated and holistic healthcare. She noted that the Alaska Tribal Health System referral follows the telehealth network and is a hub from region to region for individual communities and subregional clinics. The aim of the hub-and-spoke referral pattern is to keep care as close to home as possible. The Alaska Tribal Health System is an extraordinary resource, and it focuses closely on coordination and collaboration among each other. It honors tribal sovereignty and self-determination.

CHAIR BOERNER stated that she was extremely proud of the Alaska Tribal Health Systems and what the tribes have done together; particularly with the single compact.

TRUSTEE FIMON asked about balancing all of the different distinctive issues from all over the state.

MS. UNOK talked about how the needs and recommendations from the state balance. She stated that the Alaska Health Board is a neutral facilitator of the tribal caucus. Tribal caucus is a safe place for members of the Alaska Tribal Health System, ANHB board, cosigners of the Alaska Tribal Health Compact to come together and discuss issues among themselves. Issues are worked through, and then consensus is reached on some areas.

MS. KYLE added that one of the strengths of the tribal health system is the ability to speak with one voice, and ANHB is the facilitator of that process. One of the values is the ability to pause, listen and realize the intent for the services to best meet the needs of Native people statewide.

MS. UNOK provided an overview of the Alaska Native Health Board which was established in 1968, and is now celebrating 55 years. It is the statewide voice for tribal health, and it coordinates an annual set of legislative priorities; and also provides a strong intertribal health network for communication and statewide strategic planning. The current mission centers around fostering constructive communication with government agencies, the elected officials, industry stakeholders, and fellow advocacy organizations to raise awareness of tribal health issues in order to promote meaningful dialogue and effective policy change. It provides a comprehensive policy analysis on tribal health issues and technical assistance. She continued and explained about the impact of the Alaska Tribal Health System in Alaska, which is an economic driver for Alaska's economy.

MS. KYLE stated that the Alaska Native Health Board, under Ms. Unok's leadership, has a subcommittee called the Tribal Behavioral Health Directors. It created an amazing opportunity for the heads of behavioral health from all across the state to come together and plan, share ideas, learn from each other, and advocate together. She moved to Southcentral Foundation and stated that this portion was not a representation of the full tribal health system, but just an example of one region. The Anchorage Service Unit is the area where Southcentral Foundation supports care that is delivered in a variety of ways. The biggest hub community is Anchorage, and the second hub community is in the Mat-Su Valley where the Valley Native Primary Care Center

operates. There are direct operations in 17 small villages. She continued that SCF is a vision- and mission-driven organization. It is a Native community that enjoys physical, mental, emotional, and spiritual wellness. The mission is working together with the Native community to achieve wellness. She talked about how they operationalize the idea of partnership and relationship leading to multidimensional wellness. She added that Southcentral Foundation put behavioral health as a key part of the healthcare delivery system because that is what the community told them was most important. She continued through her presentation, going into detail as she walked through the slides. She then moved to the issues that were important to tribal health and talked about them, and stated that they were ready for questions.

CHAIR BOERNER thanked both ladies for their incredible presentation with so much information. She stated appreciation for the comprehensive overview to the Alaska Tribal Health System, how it integrates primary care with the mental health. That system of care allows for a true system of behavioral healthcare as well as outside the tribal health system. There is more integration and communication within the tribal health system overall.

TRUSTEE HALTERMAN thanked the presenters for the very informative presentation and noted that she picked up a few things that she did not know. She continued that it was good to hear some perspectives about where things were going, and she looked forward to hearing more about how that integrated setting works in the tribal system.

MS. UNOK moved to the last slide which stated thank you from all of the languages in Alaska.

CHAIR BOERNER thanked them (Native language spoken) She moved to the scheduled break and wished Trustee Sturgeon safe travels.

(Break.)

CHAIR BOERNER welcomed everybody back and gave trustees a chance to pose any questions or comments on the Governor's FY24 budget process updates. There being none, she moved into the FY25 budget process updates, and recognized Ms. Baldwin-Johnson.

FY25 BUDGET PROCESS UPDATE

MS. BALDWIN-JOHNSON stated that this was an informational update for trustees to make sure that they are being informed in gearing up for the next budget development process. She continued that the trustees approved a two-year budget at the beginning of the two-year budget cycle, and the FY25 budget will be brought back at the July and August board meetings. That will include further refinements and adjustments that are based on additional developments and work that had been transpiring through the year. She asked for any questions, and concluded the last agenda item.

CHAIR BOERNER asked for a motion to adjourn.

> **MOTION:** A motion to adjourn the meeting was made by TRUSTEE HALTERMAN; seconded by TRUSTEE MORAN.

After the roll-call vote, the MOTION was APPROVED. (Trustee Boyles, yes; Trustee Fimon, yes; Trustee Halterman, yes; Trustee Moran, yes; Chair Boerner, yes.)

(The Program & Planning Committee meeting was adjourned at 2:57 p.m.)

Trust

Alaska Mental Health Trust Authority

An Overview of Trust Data & Evaluation

Michael Baldwin, Senior Evaluation & Planning Officer

Overview of Trust Data & Evaluation

- Trust as Data Consumers vs. Data Generators
- Data Pyramid and Types of Data Used
- Evaluation and Grants, Focus Areas and Priority Initiatives

Alaska Statute AS47.30.046

The Trust is required to provide a report that includes:

(6) forecasts of the number of persons needing services;

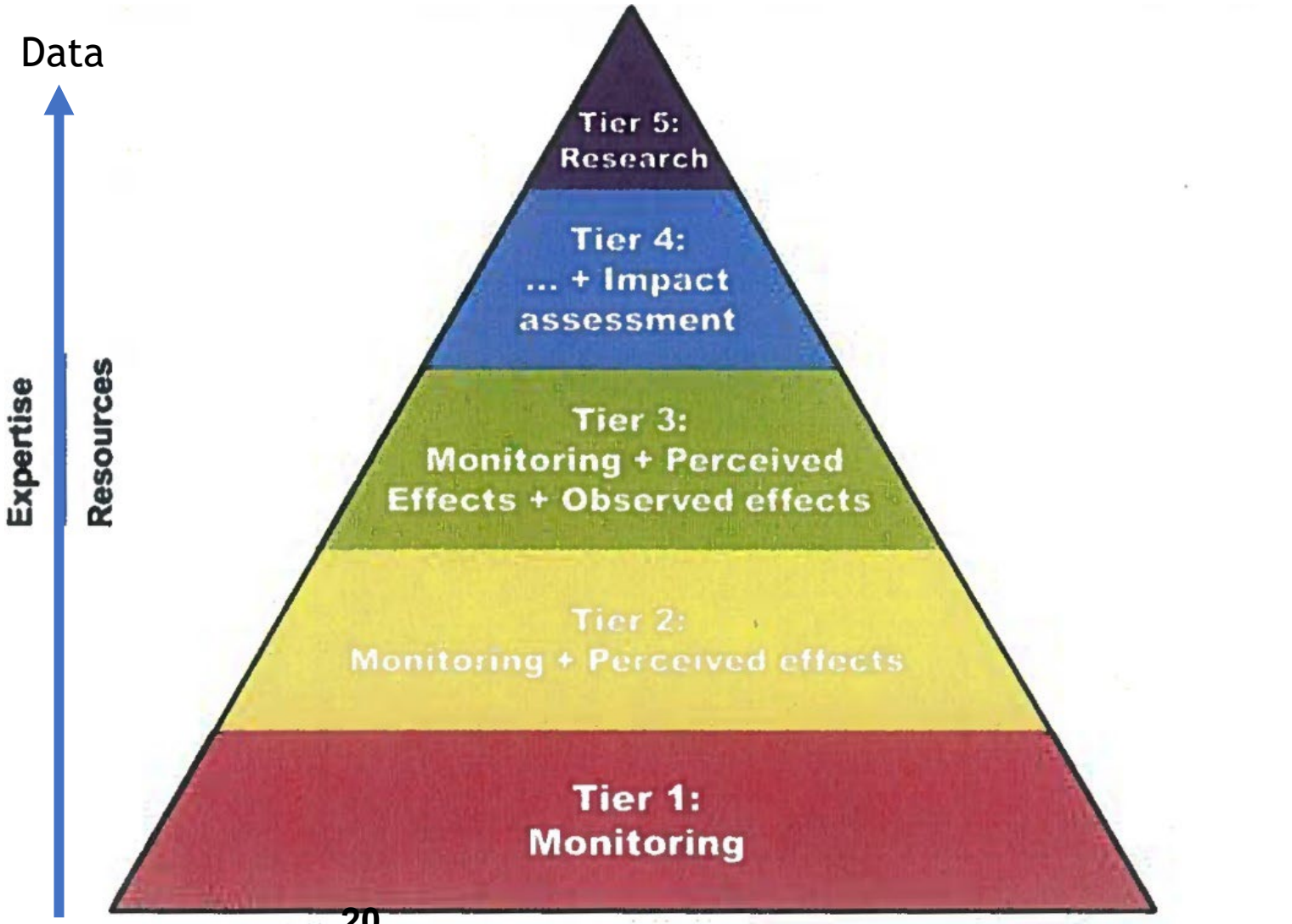
(7) projections of the resources required to provide the necessary services and facilities; and

(8) reviews of the status of the integrated comprehensive mental health program, including evaluation of program goals, objectives, targets and timelines, and overall effectiveness.

Trust Uses of Data

- Forecasting the Needs of Trust Beneficiaries
- Advocacy & Planning
- Compliance and Monitoring
- Evaluation, Outcomes, and Results

Data Pyramid



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Data Pyramid

Level	Result	Source
Tier 1 – Compliance & Monitoring	How Much Did You Do?	Grant Performance Measures Reporting
Tier 2 – Perceived Effects	How Well Did You Do?	Grant Performance Measures Reporting
Tier 3 – Observed Effects	How Well Did You Do?	Grant Performance Measures, Data from External Sources (e.g., DOH, DBH, DPH, etc.)
Tier 4 – Impact Assessment	Is Anyone Better Off?	Grant Reporting, Formal Program Evaluation, External Data
Tier 5 – Research & Data	Planning, Advocacy	Contracts for specific data, studies or needs assessment

Data Considerations

- Time Frame: Real-Time Data vs. Annual Indicators
- Focus: Population or Performance Level
- Communication Power vs. Data Power?
- Readily or Timely Available?
- Who Owns the Data?
- How much does it cost?

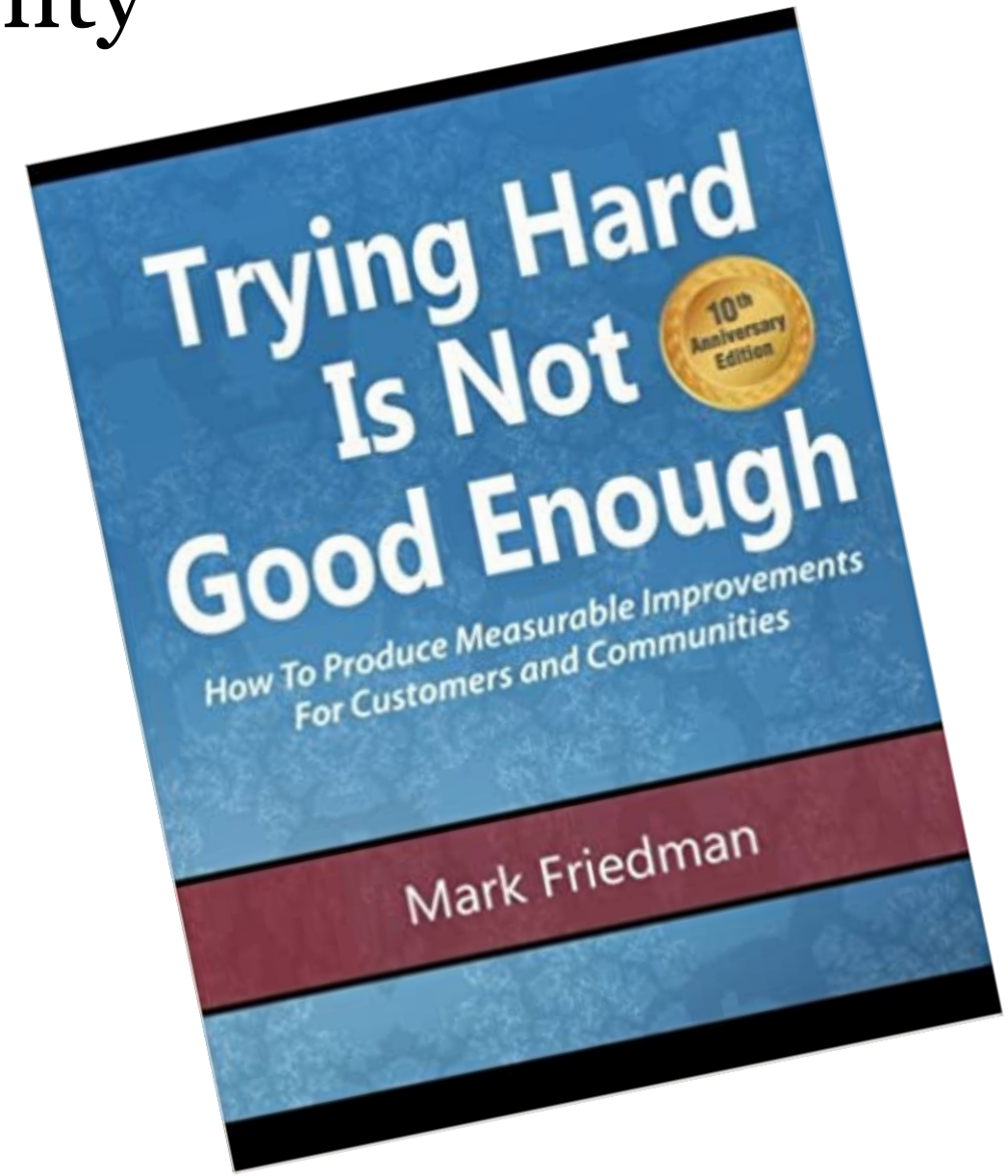
Evaluation and the Trust

- *Specific/Targeted Initiative/Program Evaluation*
- *On-Going Trust Evaluation Processes*
  - Individual Grant Review/Evaluation
  - MHTAAR & Authority Grant Performance Summaries
  - Grant Analysis and Closed Grant Reports – Budget Development Process
  - Annual Mission & Measures report to the Office of Management and Budget (OMB)
- *Results Based Accountability*

Results-Based Accountability

A framework of thinking and action used to improve the:

- lives of individuals and the community, and
- performance of programs



How do we Share the Data?

- Targeted Outreach to Partners, Stakeholders
- Stakeholder/Project/Initiative Meetings
- Trustee Meetings
- Trust Website
- Communication Plan, Social Media, Press Release

Thank You!

Questions?

Michael Baldwin
Senior Evaluation & Planning Officer
michael.baldwin@alaska.gov or 907-269-7969

Trust

Alaska Mental Health Trust Authority

Trust Grant Accountability

Katie Baldwin Johnson, COO
Carrie Predeger, Grants Accountability Manager

Grant Accountability

- Overview of accountability processes in grantmaking
- Grant Categories
- Performance measurement
- Reporting

Grant Accountability

Authority Grants

- Grant application – applicant's evaluation description
- Performance measures - Results Based Accountability (RBA) Framework
- Program Officer/grantee development of performance measures
- Consistent measures between grant types

How do we measure the performance of a Trust grant?

- Responses to established performance measures
- Completeness of executive summary and any supplementary documentation
- Project reporting: Programmatic & financial reports
- Compliance with the grant agreement

Developing Performance Measures for Trust Grants

Grant Categories

- ✓Direct Service
- ✓Capacity Building
- ✓Data/Planning
- ✓Conference/Sponsorship
- ✓Capital – Equipment
- ✓Capital – Building

Results Based Accountability
Performance Measure Examples

How much did you do?

- Quantity of effort;
- # of individuals served/trained/enrolled
- # of items distributed (books, backpacks, supplies)
- # of downloads/site visits

How well did you do it?

- Quality of effort
- # and % of participants completing an activity/training
- # and % of participants who felt they were treated with dignity and respect
- # and % of participants who were satisfied with the program/training

Is anyone better off?

- The effect of your effort;
- # and % of participants who increased their knowledge
- # and % of individuals housed
- # and % of individuals who recidivated
- # and % of participants experiencing a decrease in negative symptoms (anxiety, depression, alcohol use)
- # and % of participants who improved their quality of life (ability to trust others, increased happiness, ability to cope)

Grant Categories & RBA Framework

Grant Categories	Ability to use RBA Framework
Direct Service	Yes
Capacity Building	Partially
Data Planning	No
Conference/Sponsorship	Partially
Capital – Equipment	No
Capital – Building	No

Grant Compliance Scoring

1 - Grantee did not respond to any of the performance measures and did not comply with reporting deadlines as described in the grant agreement/Statement of Intent.

2 – Grantee did not completely and/or thoroughly respond to all performance measures and/or did not comply with reporting deadlines as described in the grant agreement/Statement of Intent.

3 – Grantee satisfactorily responded to all performance measures and complied with all reporting deadlines as described in the grant agreement/Statement of Intent.

4 – Grantee met or exceeded expectations in responding to all performance measures and complied with all reporting deadlines as described in the grant agreement/Statement of Intent.

5 – Grantee greatly exceeded expectations by thoroughly responding to all performance measures, providing additional data, support and/or documentation, and complied with all reporting deadlines as described in the grant agreement/Statement of Intent.

Grant Accountability and Reporting Challenges

- Grant term
- Grantee’s capacity for data collection and reporting
- Continuity of grantee staff
- Some large-scale projects/multiple funders
- Narrative responses to the performance measures
- Individual grant performance measures and population results
- Each grant is different
- Budget goals and strategies

Components of a Grant Report

- Executive summary
- Performance measure responses
- Numbers of individuals impacted
- Financial reporting

Communication of Grant Analyses

Grant Performance Information on Budget Development Webpage

Budget Documents

Core Budget Documents:

- FY23 Budget (Amended)
- FY24 Stakeholder Budget Survey Results (Updated July 2022)
- FY21 Mental Health Trust Authority Authorized Receipt Grant (Grants to State Agencies) Performance Summary (May 2022)
- FY24 Budget Development Stakeholder Meeting Summary Notes (July 2022)
- FY21 Trust Closed (Completed) Grant Report (July 2022)
  - Beneficiary Employment and Engagement Projects
  - Disability Justice Projects
  - Housing and Home & Community-Based Services Projects
  - Mental Health and Addiction Interventions Project
  - Other Priority Area Projects
  - Non-Focus Area Projects
- FY22 Trust Grant Analysis Report (July 2022)
- FY21 Trust Annual Report

Comprehensive Mental Health Program Plan

- 2020-2024 Strengthening the System: Alaska's Comprehensive Integrated Mental Health Program Plan

Data Scorecards

- 2021 Alaska Scorecard
- Health Alaskans 2030
- Alaska Medicaid Dashboard, DHSS

Thank You

Questions?

ALASKA BEHAVIORAL HEALTH

The Science of Traumatic Stress and Implications for Intervention
Alaska Mental Health Trust Authority
Board of Trustees Meeting Spring 2023

Joshua Arvidson, MSS., LCSW
Chief Operating Officer Alaska Behavioral Health
Director Rural Child Trauma Center, NCTSN Category II Site
Editorial Board Journal of Child and Adolescent Trauma

41

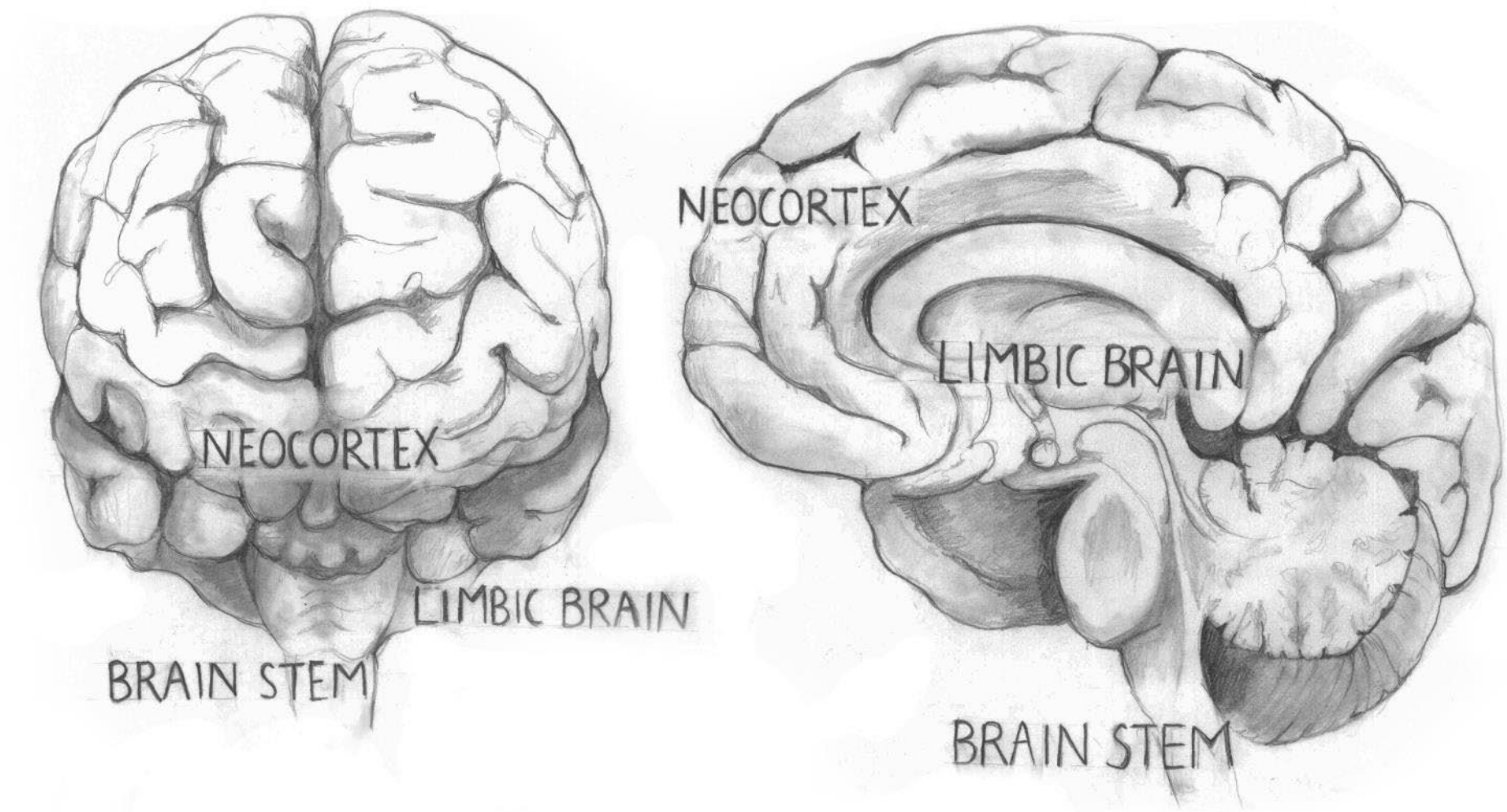


Illustration by Melanie Lombard

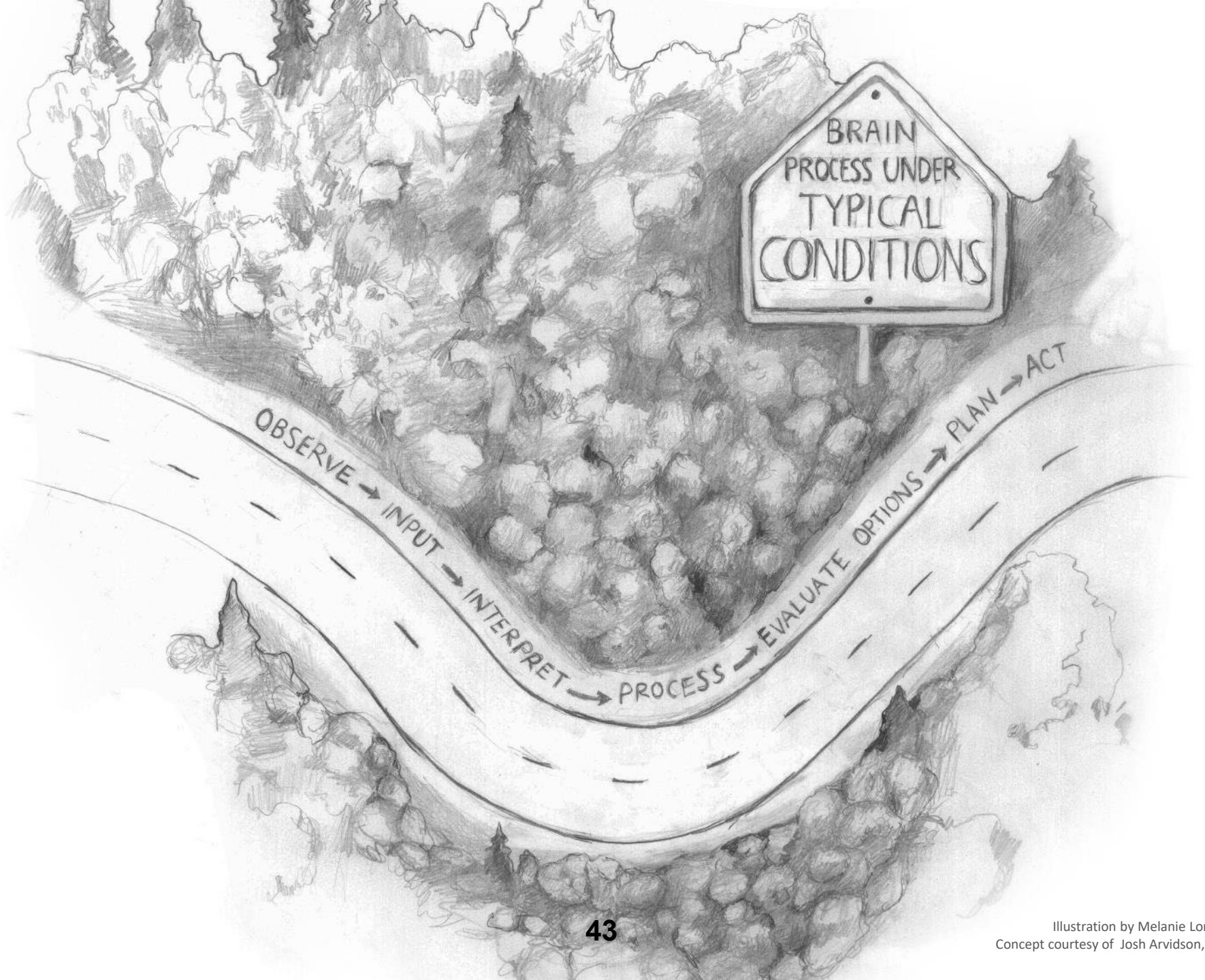


Illustration by Melanie Lombard
Concept courtesy of Josh Arvidson, LCSW

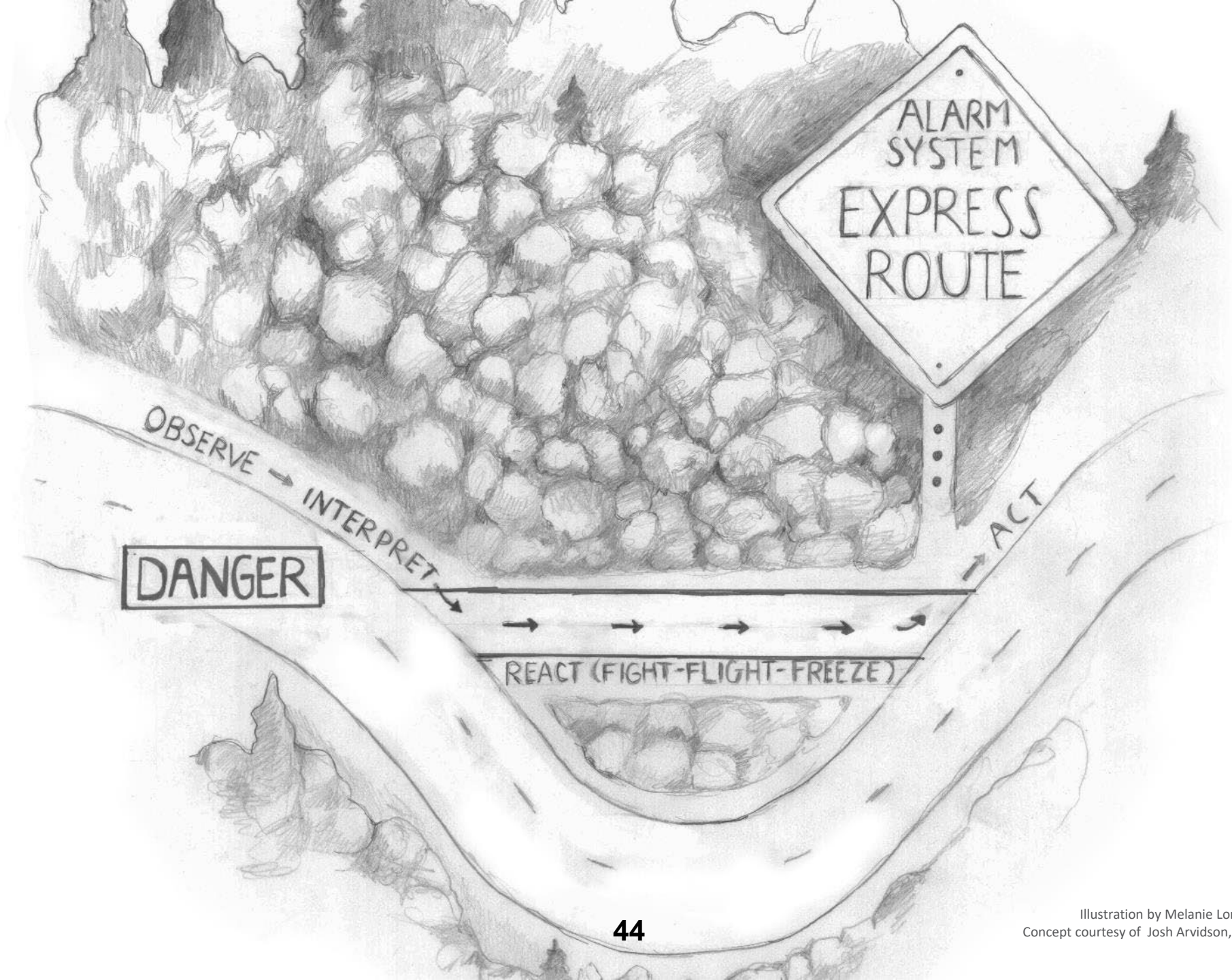


Illustration by Melanie Lombard
Concept courtesy of Josh Arvidson, LCSW

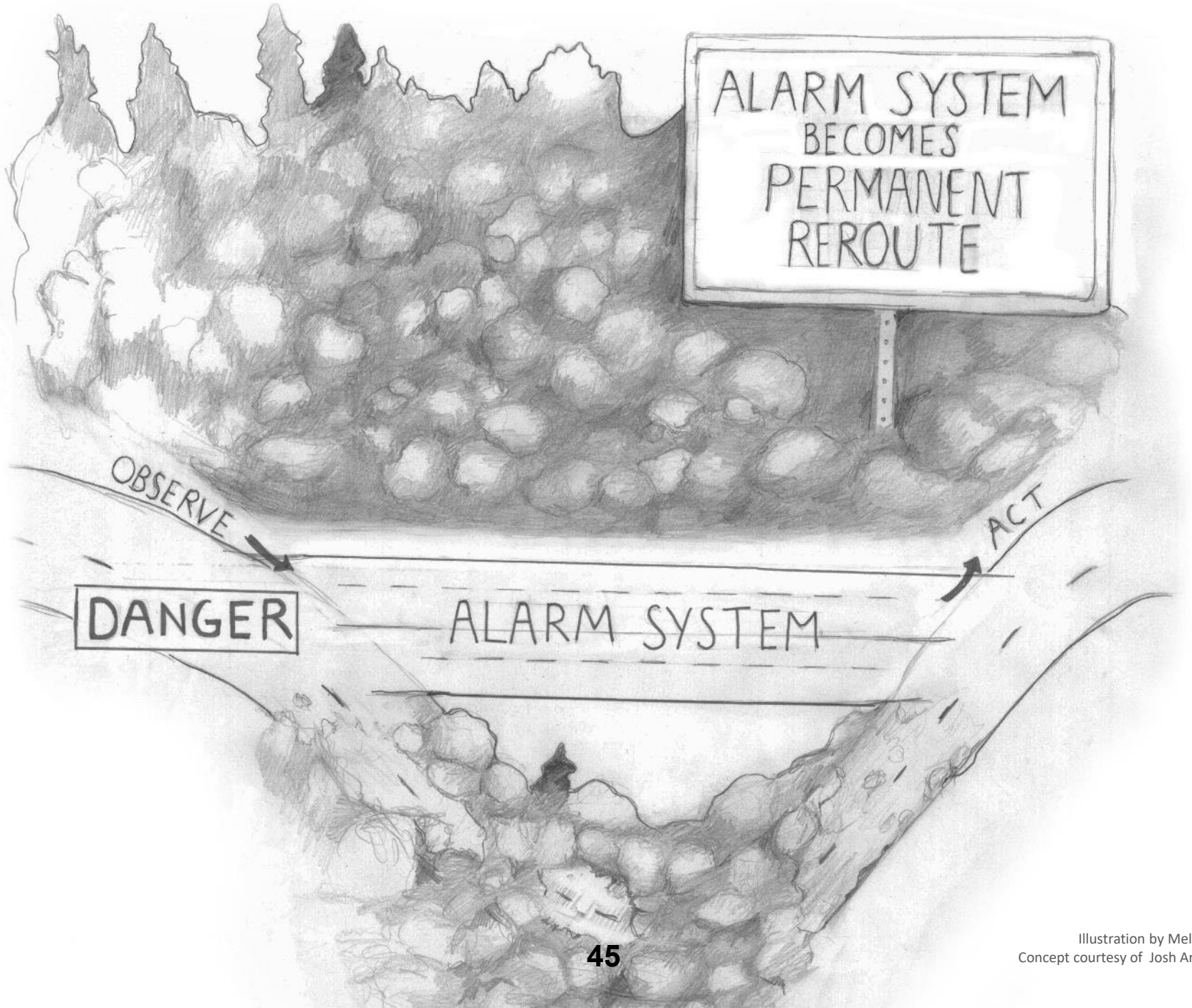


Illustration by Melanie Lombard
Concept courtesy of Josh Arvidson, LCSW

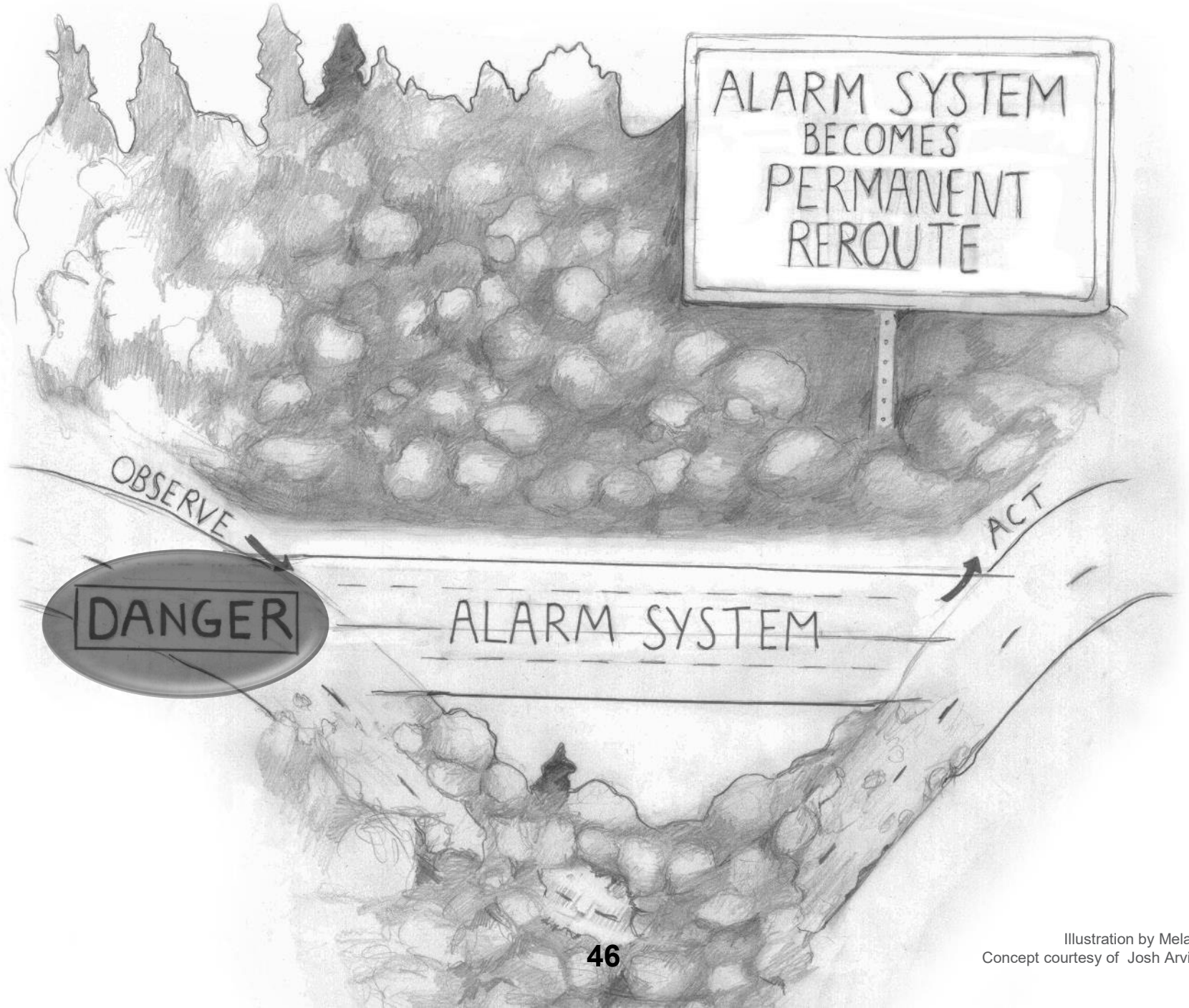
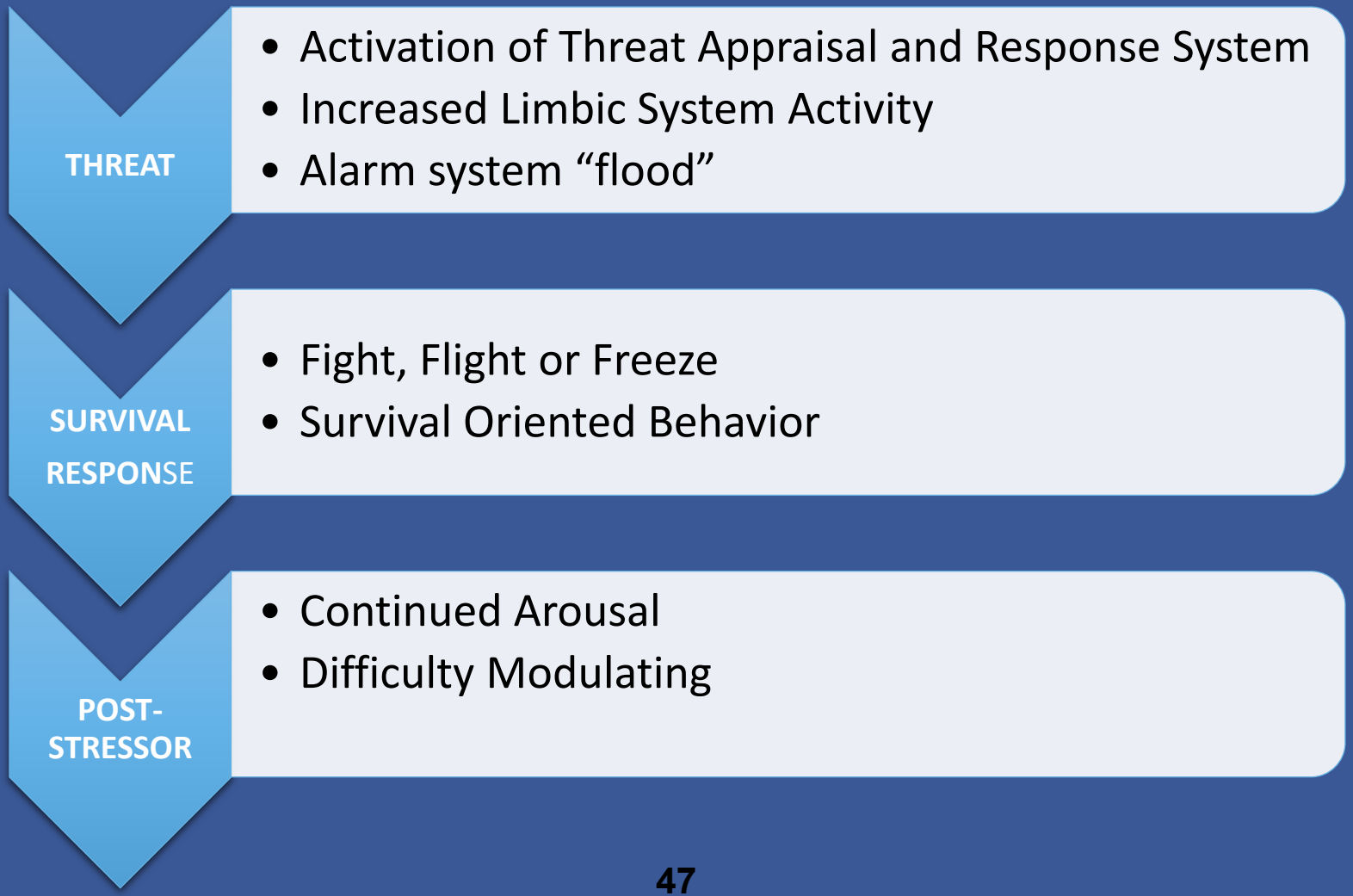
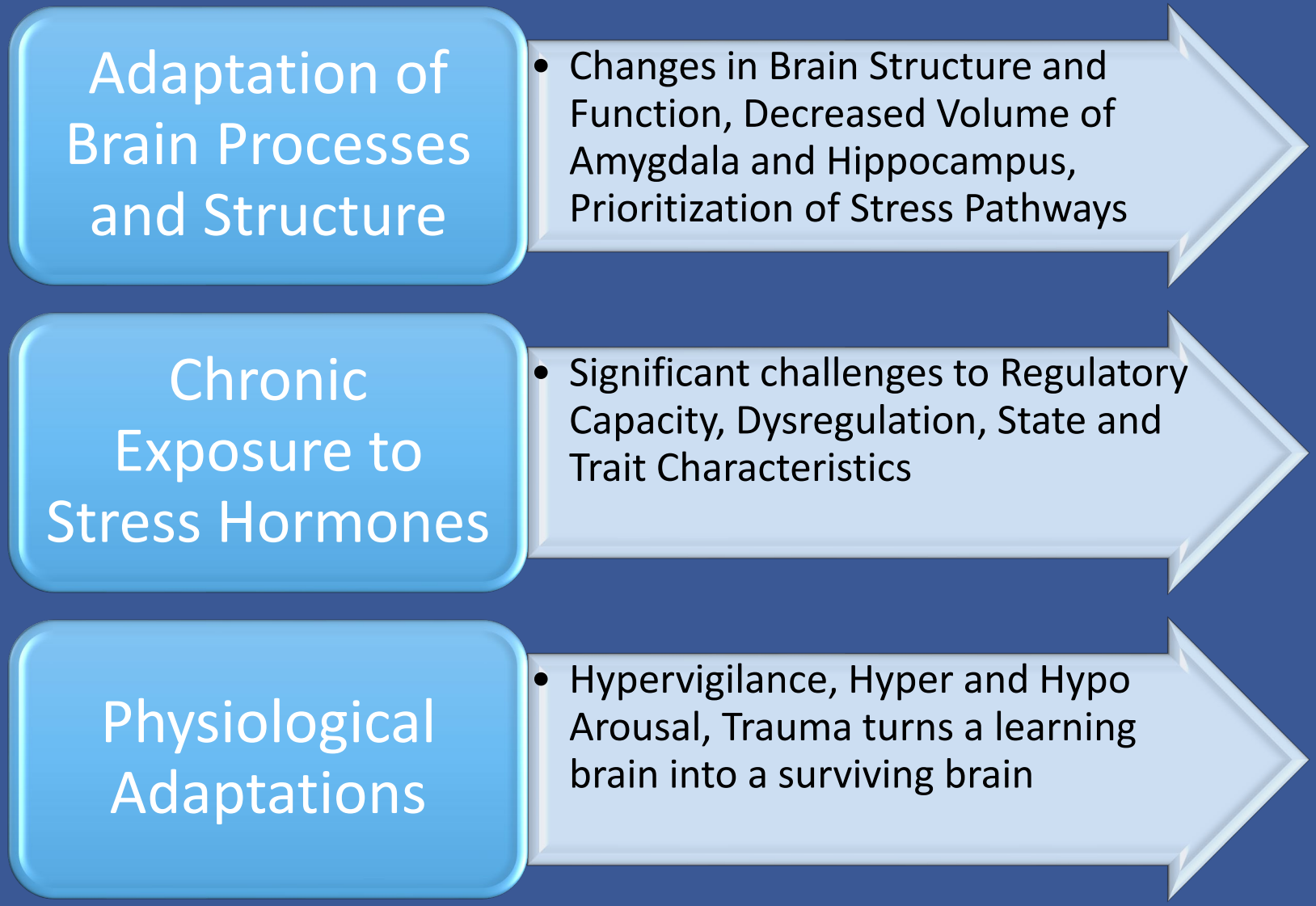
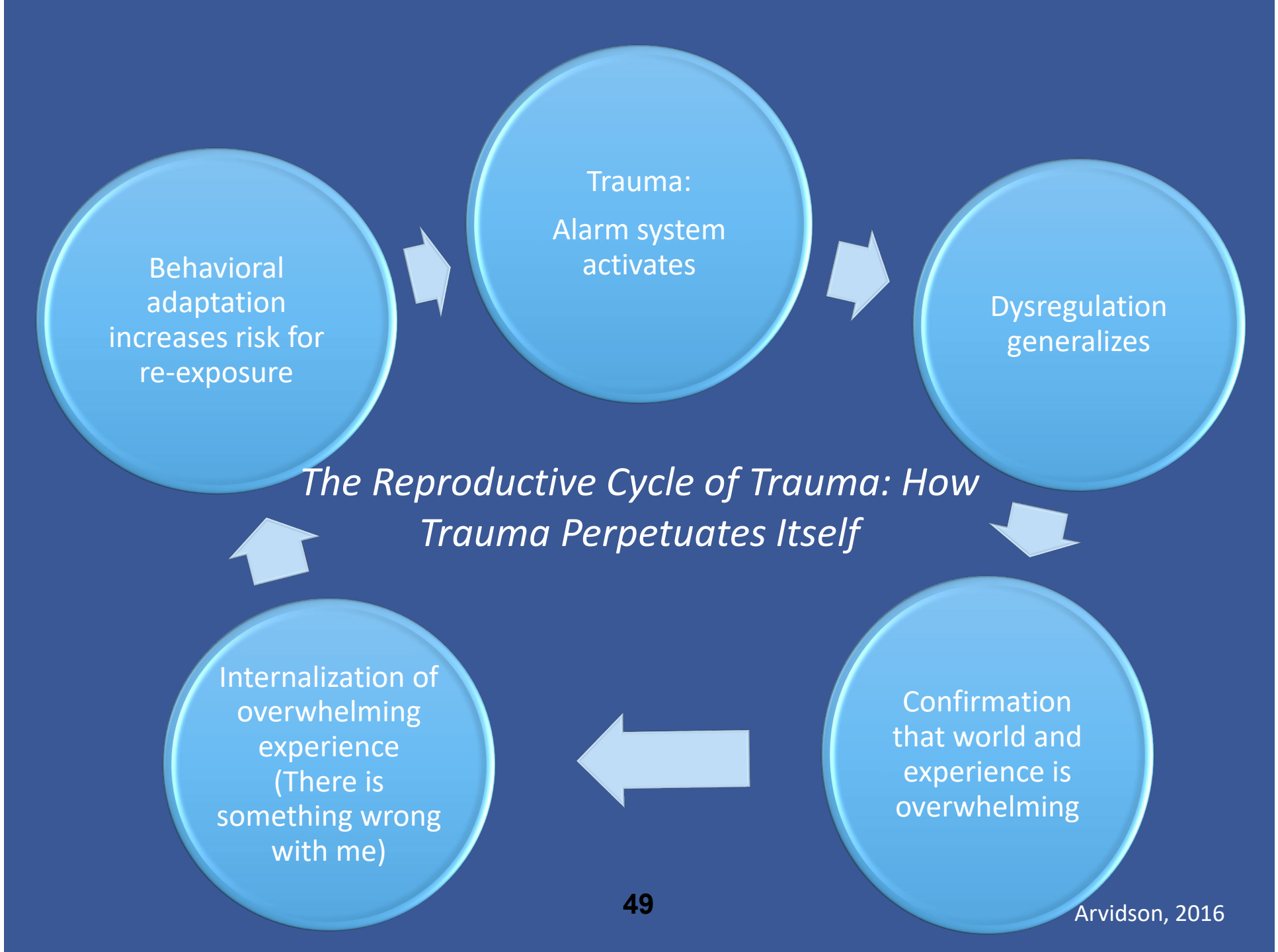


Illustration by Melanie Lombard
Concept courtesy of Josh Arvidson, LCSW

Physiology of the Human Stress Response

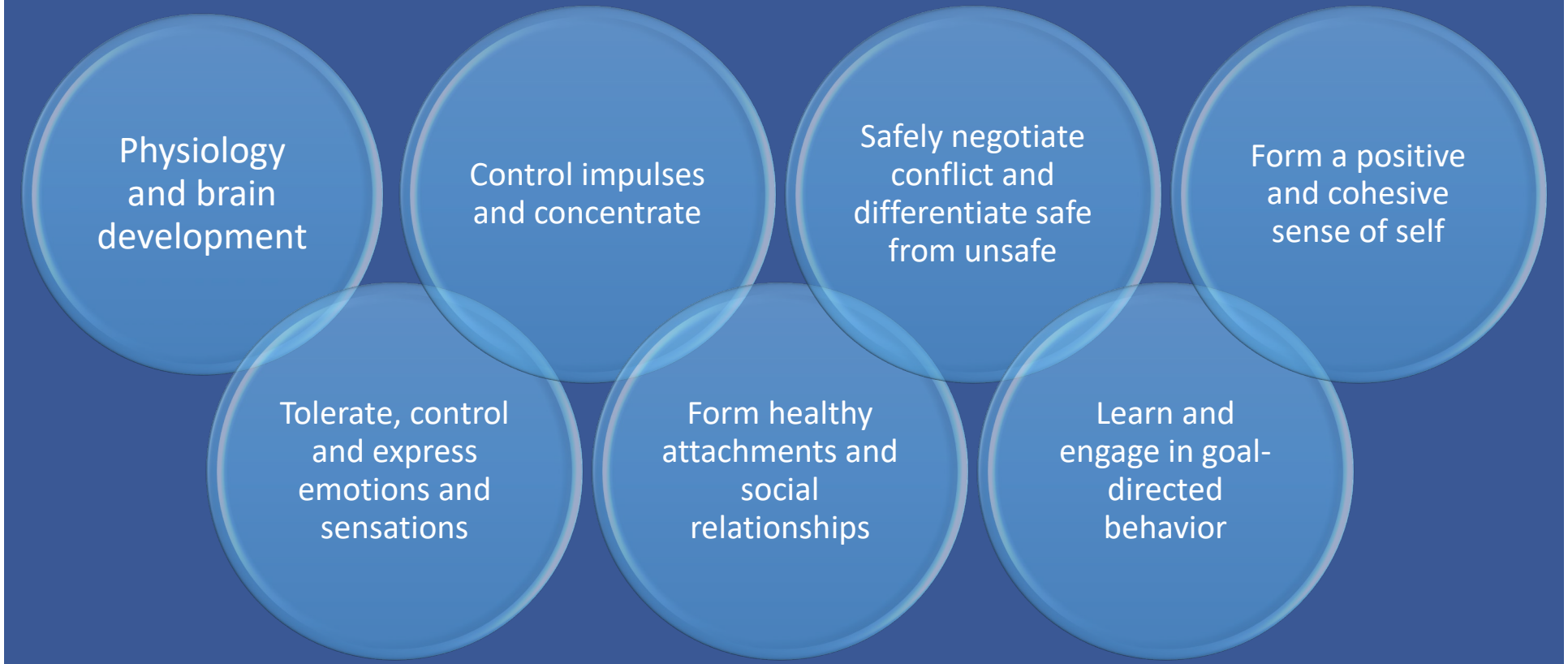



Adaptation of Brain Processes and Structure
• Changes in Brain Structure and Function, Decreased Volume of Amygdala and Hippocampus, Prioritization of Stress Pathways
Chronic Exposure to Stress Hormones
• Significant challenges to Regulatory Capacity, Dysregulation, State and Trait Characteristics
Physiological Adaptations
• Hypervigilance, Hyper and Hypo Arousal, Trauma turns a learning brain into a surviving brain



Arvidson, 2016

Areas Impacted by Complex Trauma



Arvidson et al, 2011, Cook et al, 2005, Kisiel et all, 2009 and Spinazzola et al, 2005

Smell of clothes

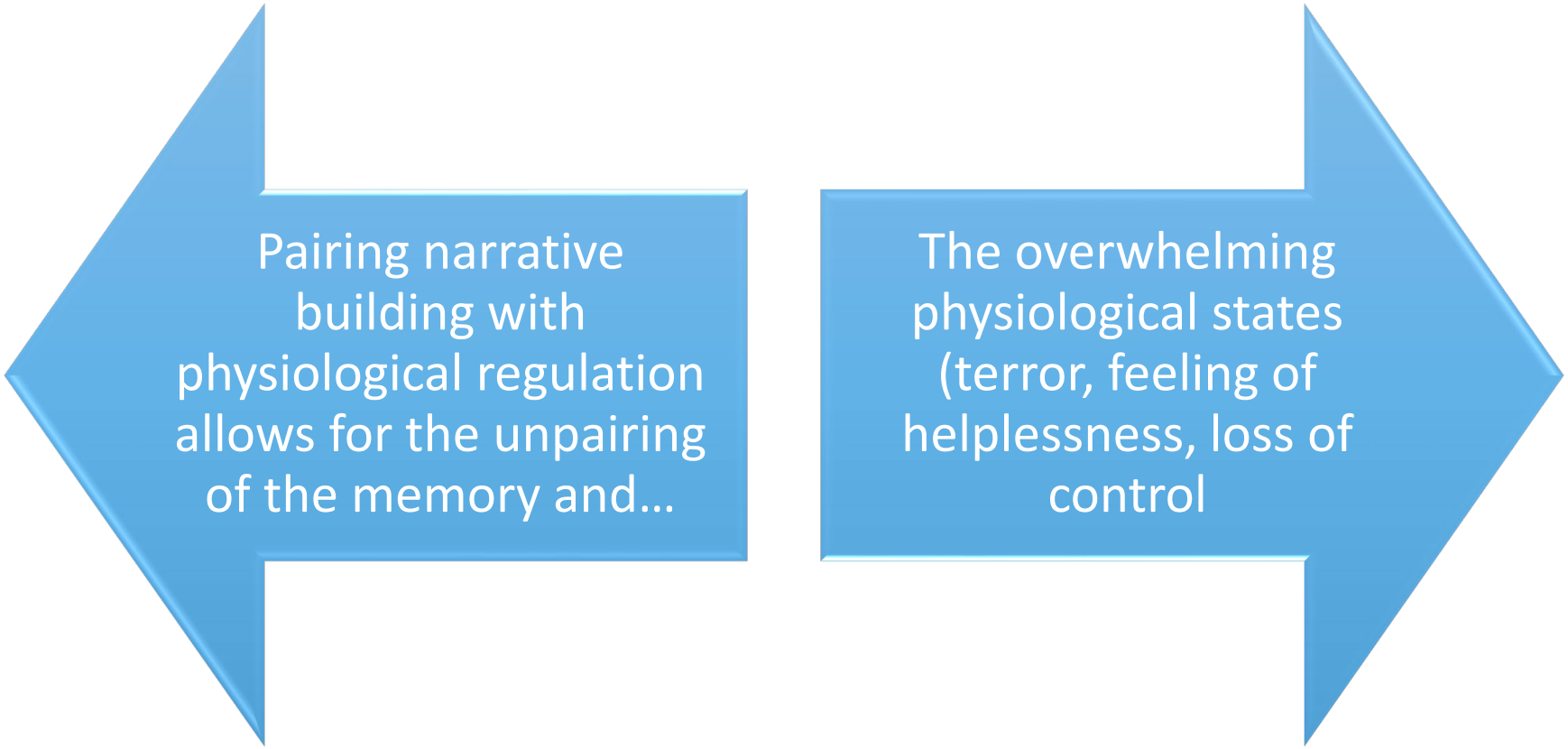
Dark place

Sound of a clock

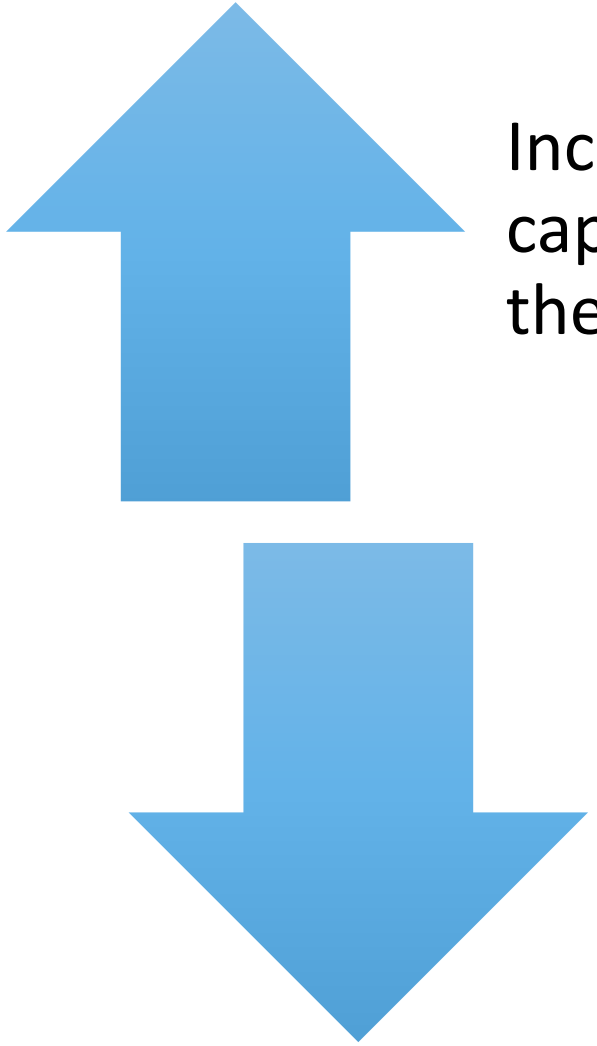
Smothered feeling

I’m afraid

Decoupling of memory and physiological dysregulation



Basic Theoretical Framework for Therapeutic Intervention for PTSD



Increased regulatory capacity (sustained in the face of stimuli)

Hippocampal capacity to respond neutrally to inherently neutral stimuli

Shifting the Paradigm

Has difficulty getting motivated to get job training, pursue education, locate a job or find housing	• Depression or anxiety combined with diminished interest in everyday activities
Avoids meetings with counselors or other support staff, emotionally shuts down	• Hyperarousal, mistrust, avoidance
Has difficulty following rules and guidelines. Is triggered in dealing with authorities. Won't accept help.	• Increased need for control following the loss of control experienced during trauma
Seems spacey, out of it, disconnected or disengaged, not motivated.	• Dissociation and or lack of self efficacy
Isolates from friend, family or other potential support systems	• Shame and secrecy associated with trauma
Ongoing substance abuse problems	• Use of alcohol or drugs to self-medicate a physiologically dysregulated system

Thank you!

ALASKA BEHAVIORAL HEALTH

Strengthening Alaska communities and improving the lives of our clients through behavioral healthcare

Joshua Arvidson, MSS., LCSW

Chief Operating Officer

Email: jarvidson@akbh.org

Office: 907-762-2817 | **Cell:** 907-891-1753

Address: 4045 Lake Otis Parkway, Suite 101.
Anchorage, Alaska 99508

Web: https://alaskabehavioralhealth.org/

Prevention Along a Continuum

ACEs & Early Childhood Trustee Presentation
Robyn Husa, Ph.D.
April 20, 2023

ALCAN Link
Alaska Longitudinal Child Abuse and Neglect Linkage Project

STATE OF ALASKA DEPARTMENT OF HEALTH

ALASKA DIVISION OF Public Health

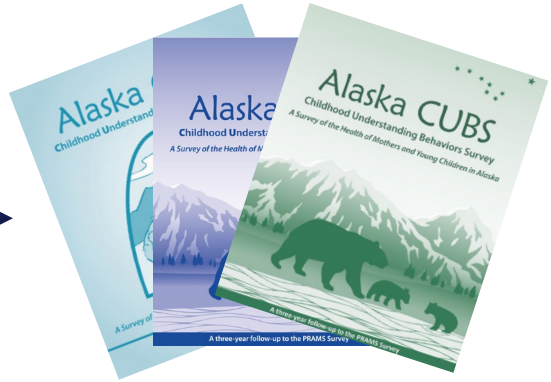
ALCANLink

Alaska Longitudinal Child Abuse and Neglect Linkage Project

1 per 6 sampled

2009 – 2018
(3 cohorts)

Linked



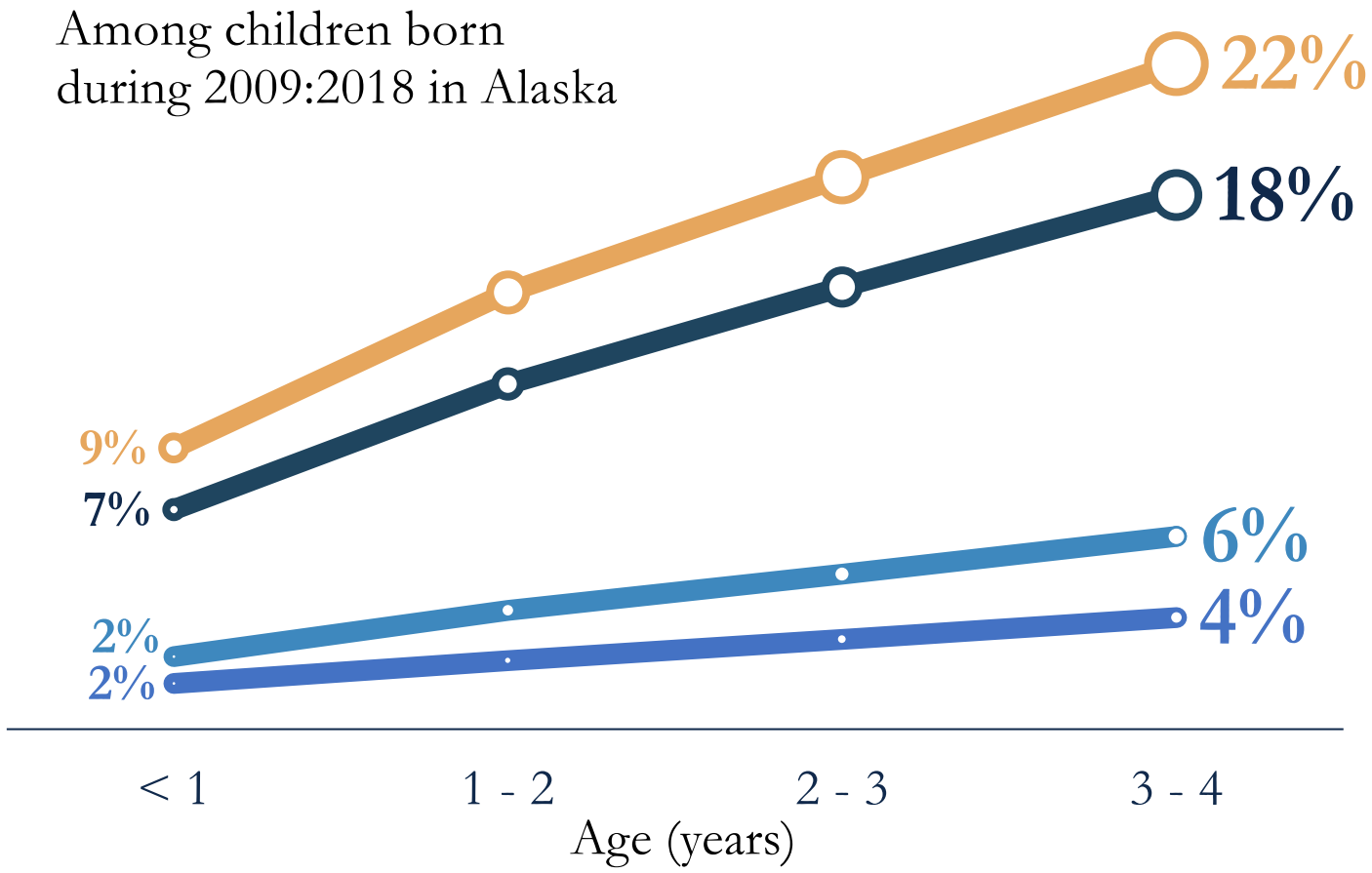
3 – Year
Follow – Up

Annual Linkages

- Permanent Fund Dividend
- Office of Children's Services
- Medicaid
- Dept. of Education & Early Development
- Birth/Death Records

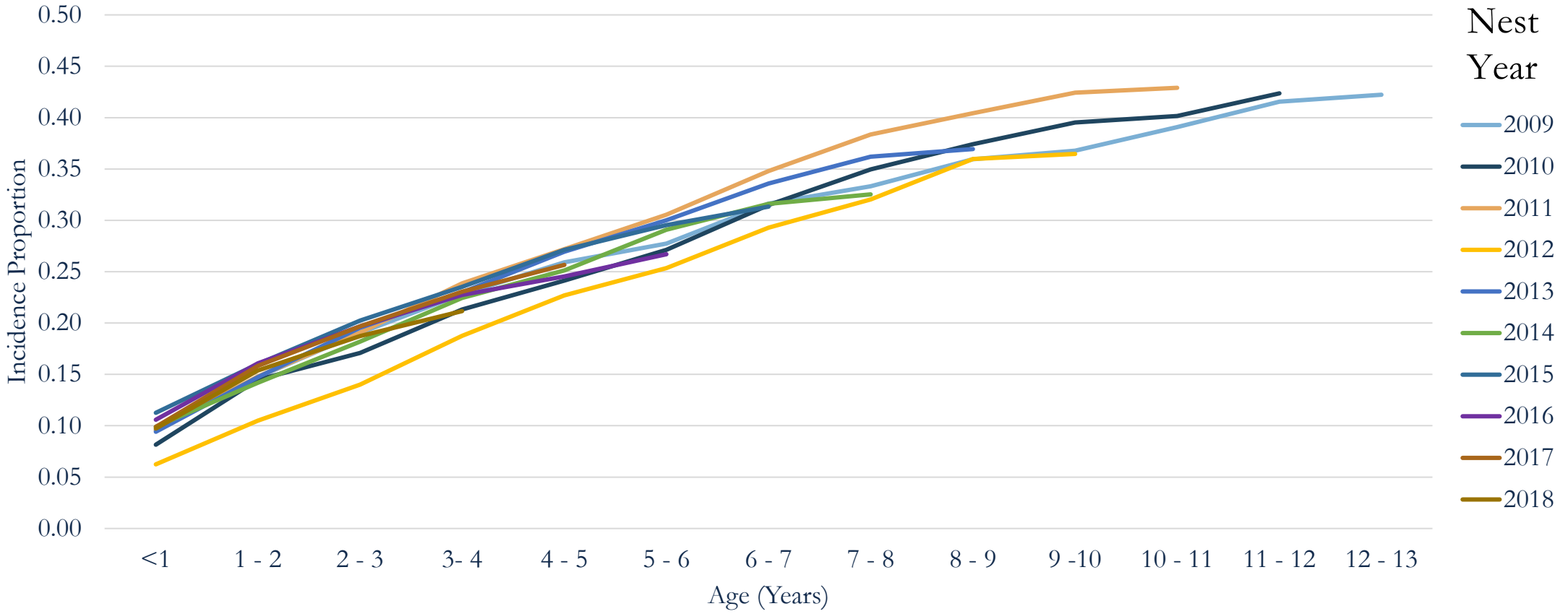
Parent Images Source: storyset.com

Contact with Child Welfare before Age 4

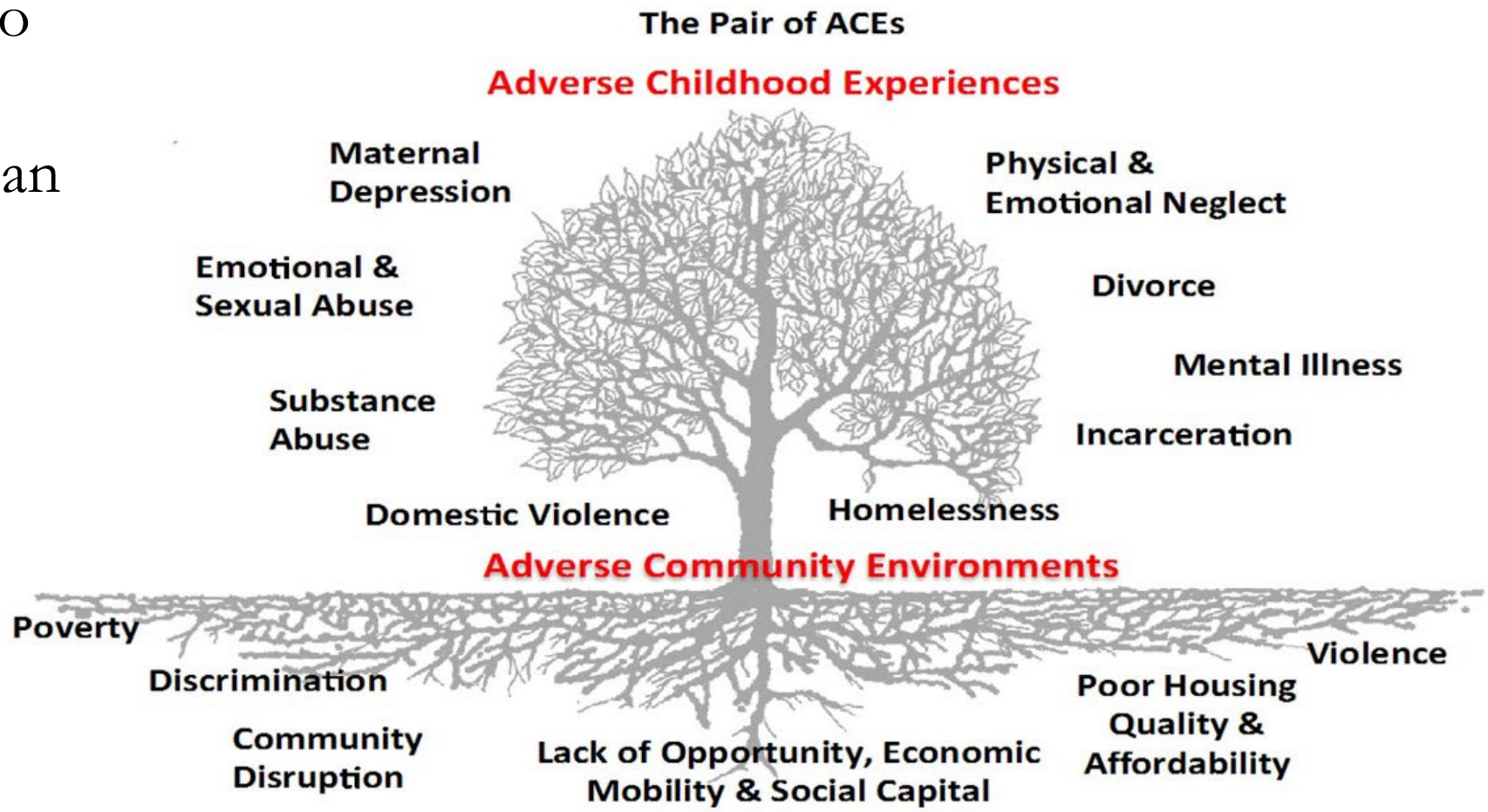


- 1 in every 4.5 births – **reported**
- 1 in every 5 births – **screened in**
- 1 in every 7 births – **substantiated**
- 1 in every 25 births – **removed**

Alaskan Children Born Over a 10-Year Period Have Similar Maltreatment Risk Trajectories as They Age



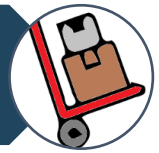
Original ACES have been expanded to include other adversities that can lead to trauma



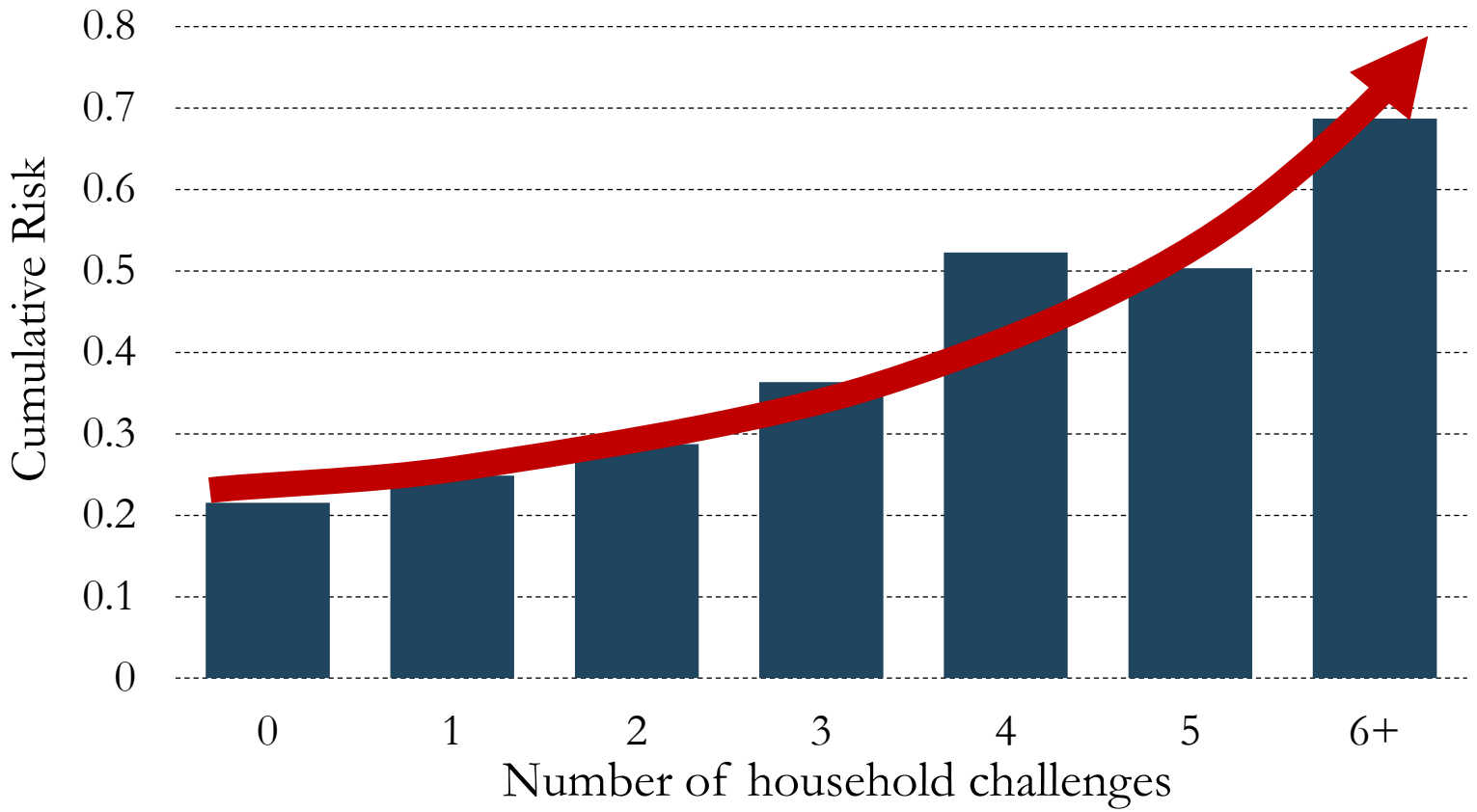
Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Pre-Birth Challenges & Their Impact on Early Childhood Experiences

Pre-Birth Household Challenges on PRAMS

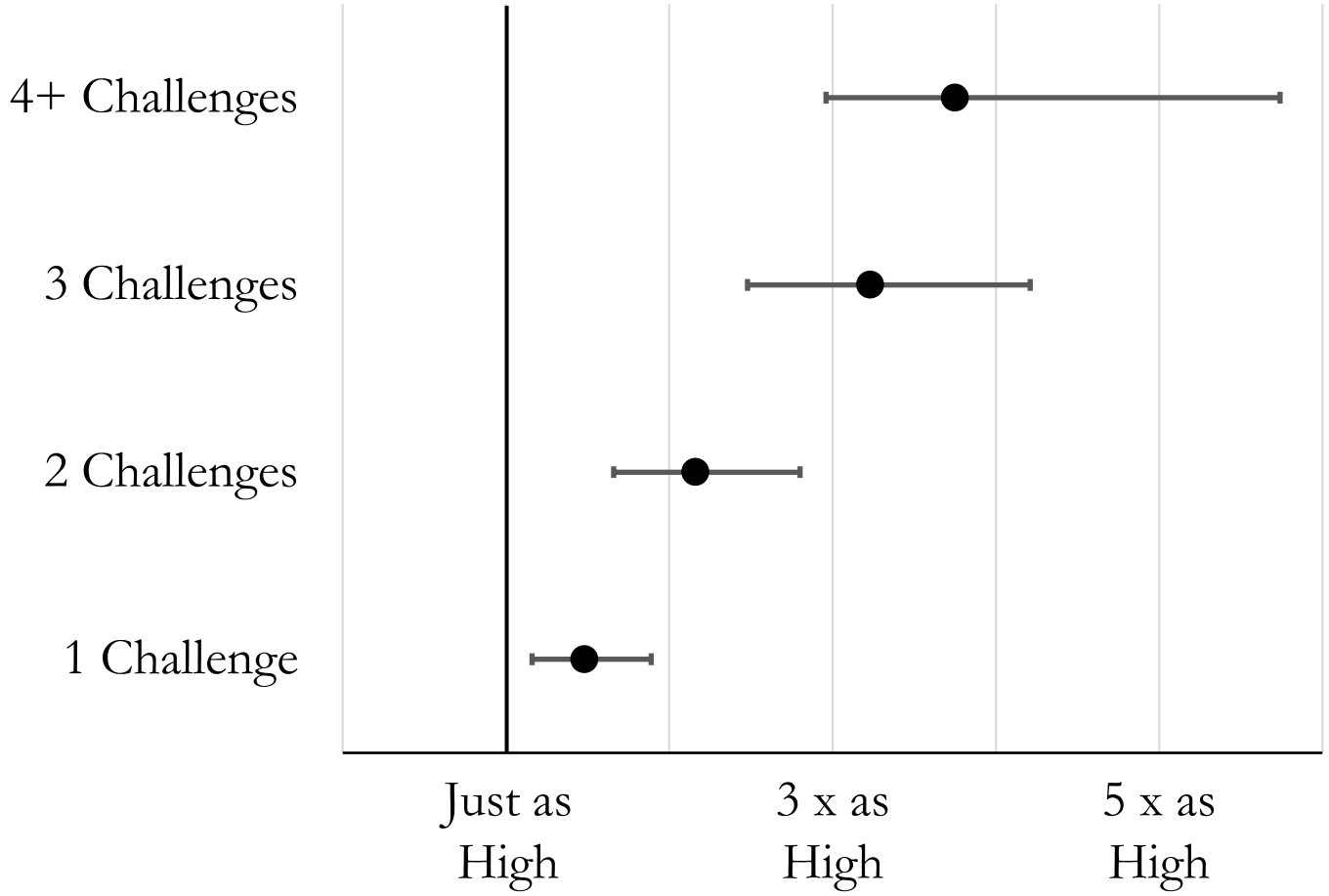
- Illicit Drug Use 
- Mental Illness 
- Divorce/Separation 
- Incarcerated Relative 
- Argued with Partner More Than Usual 
- Mother Treated Violently or Threatened 
- Financial Struggles/Homelessness 
- Family Member in Hospital 
- Moved to New Address 
- Substance Abuse and/or Death in Close Community 
- Job loss or Work Hours Cut 
- Alcohol Abuse/Misuse 

Risk of Child Welfare Contact Increases with the Number of Challenges Reported



16% of children born to mothers who reported experiencing 4+ challenging life events

Pre-Birth Household Challenges Predicting Child ACE Score



Average Expected ACE Score Compared to Zero Pre-Birth Challenges Group

Rittman et al. (2020)

Pre-Birth Household Challenges Predict School Readiness & Academic Achievement

Household Challenges (PRAMS)

Challenges during the 12 months prior to birth/pregnancy

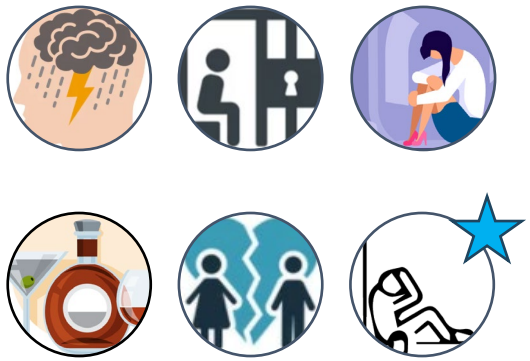
→ Education Records

- Alaska Developmental Profile (ADP)
- 3rd Grade Reading Proficiency
- Average Attendance

Husa et al. (2022)

Pre-Birth Household Challenges Predict School Readiness & Academic Achievement

Household Challenges (PRAMS)



Homelessness

Challenges during the 12 months prior to birth/pregnancy

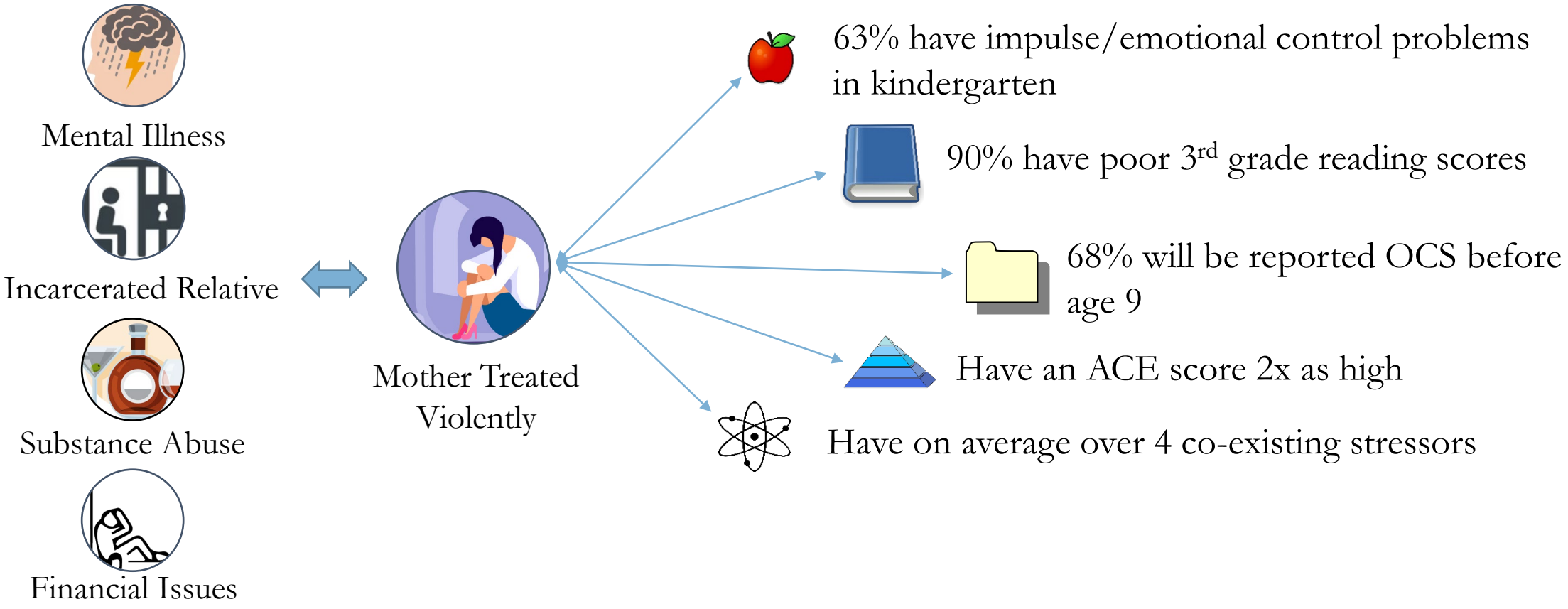
→ Education Records

4+ pre-birth challenges:

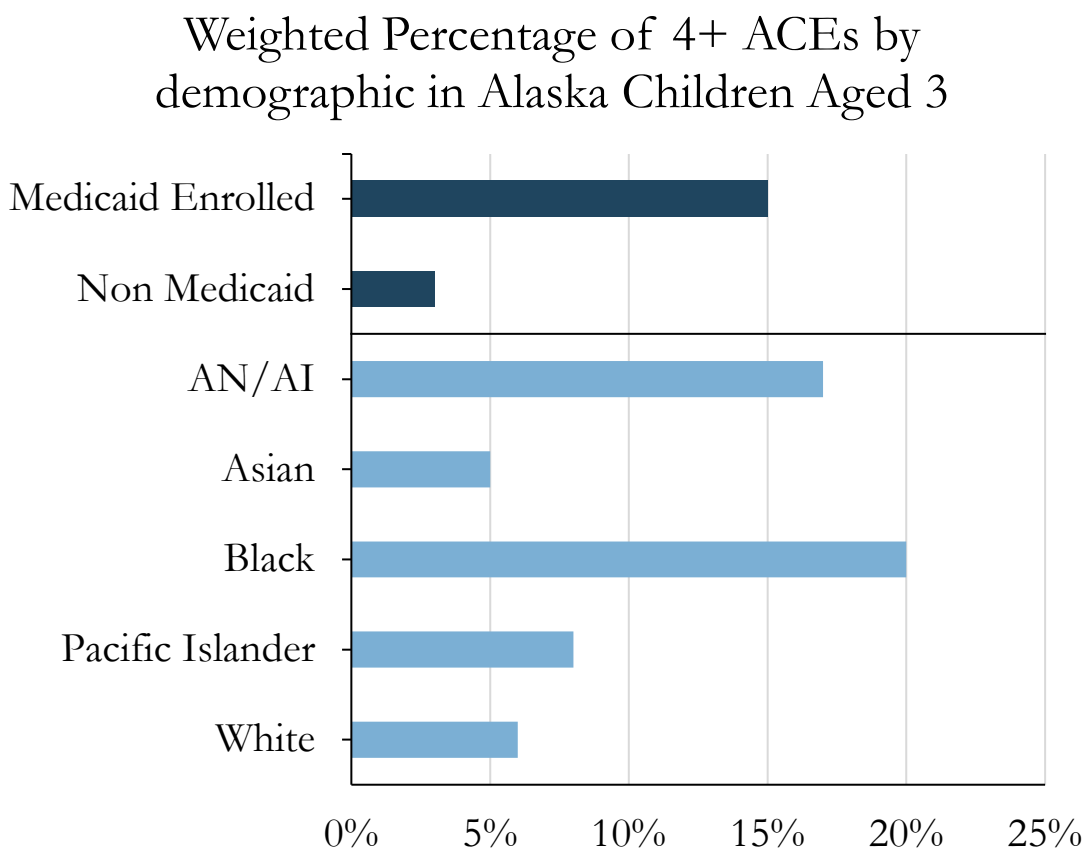
Alaska Developmental Profile (ADP)	16% increased risk
3rd Grade Reading Proficiency	40% increased risk
Average Attendance	29% increased risk

Husa et al. (2022)

Connecting Early Indicators with Child Outcomes



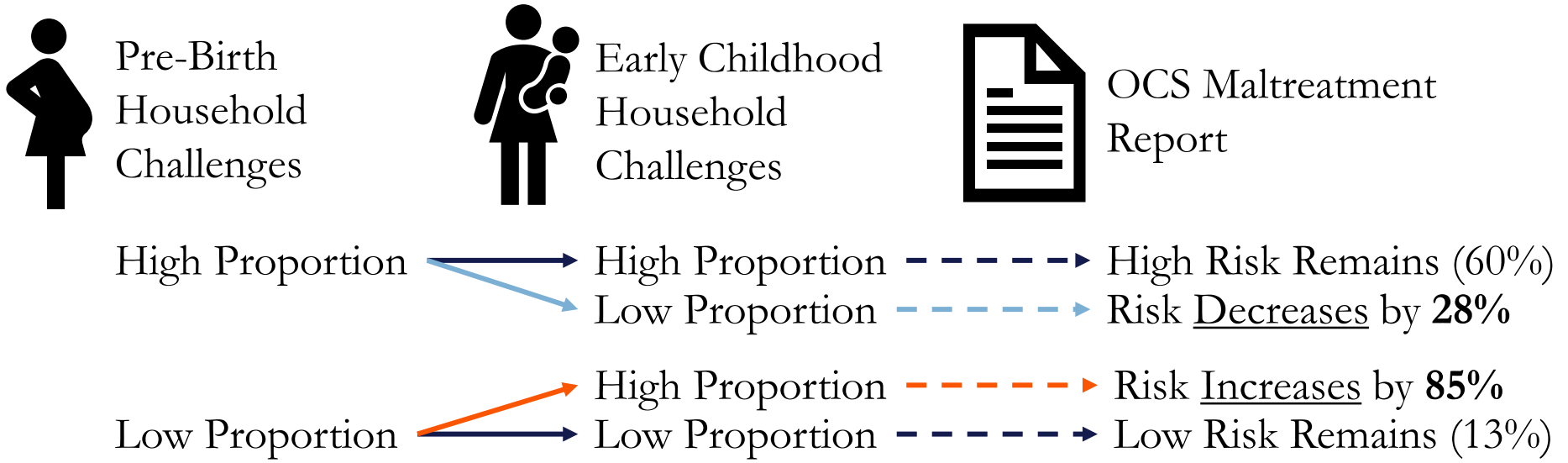
Disparities in ACE Burden



- Disparity = something that should be described and understood between populations to ensure intervention/prevention is appropriate
- Does not define risk, rather the disproportionate load of modifiable risk factors

Households are Dynamic

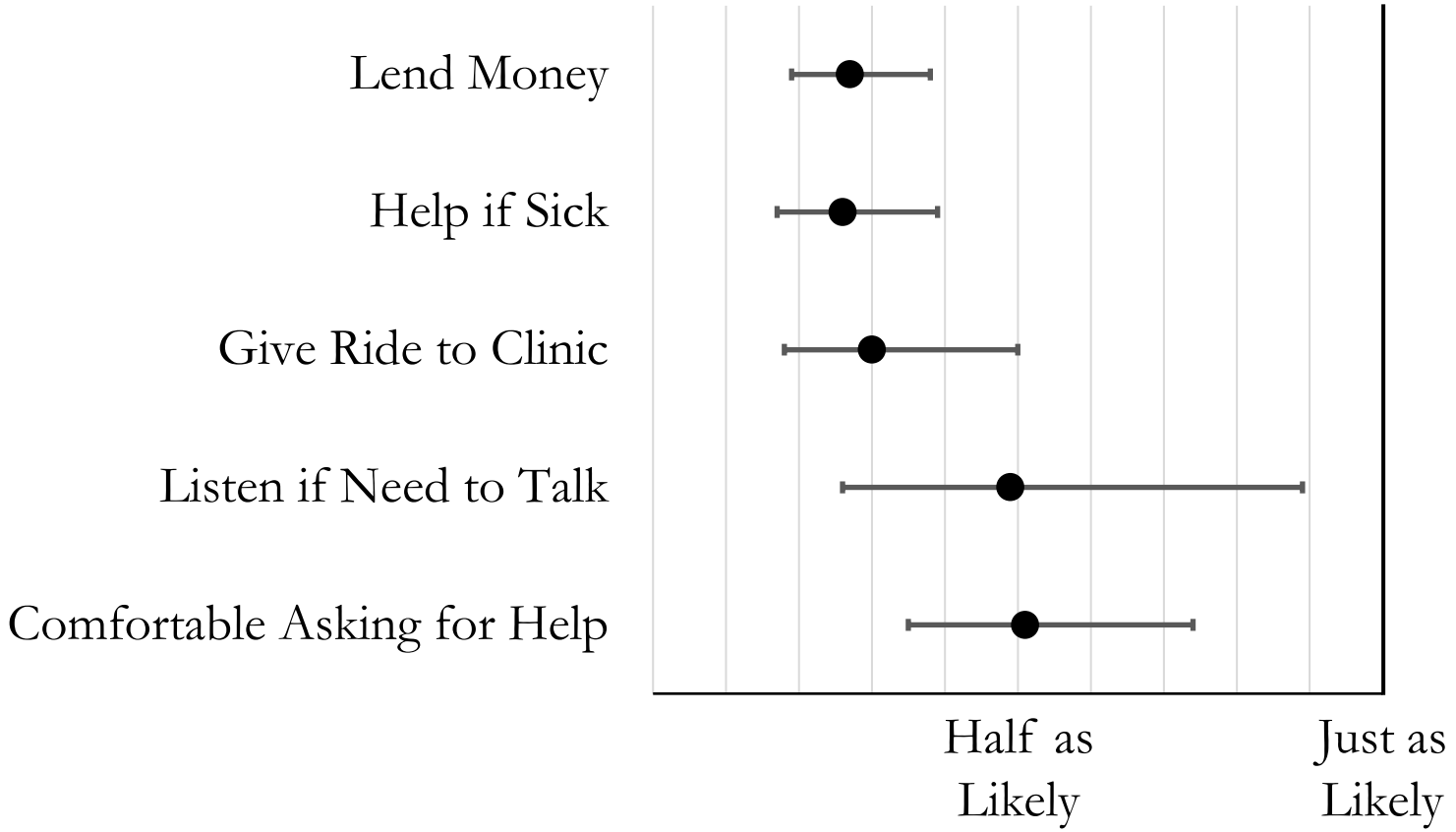
A Change in the Number of Household Challenges is Associated with Change in Risk of OCS Report



OCS: Office of Children's Services

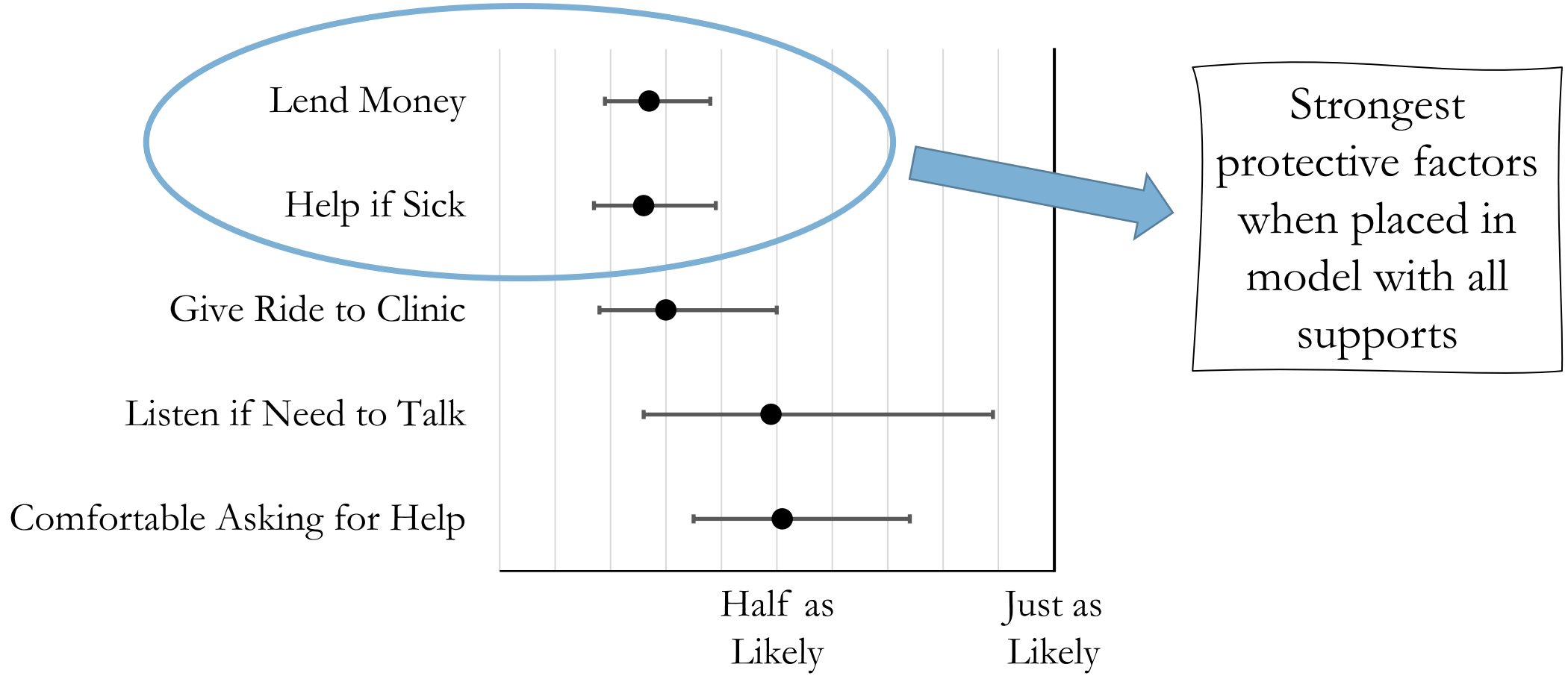
Husa et al. (2023, in press)

Supporting Birthing Parents Reduces the Likelihood of Child Maltreatment



Likelihood of OCS Report Compared to Not Having Support

Supporting Birthing Parents Reduces the Likelihood of Child Maltreatment



Providing care coordination: A guide, a support, and navigator!

- Supporting birthing parents and families early on and throughout childhood can build up and strengthen families
- Team currently developing screening tool to:
  - Identify the most urgent issues for pregnant individuals
  - Connect beneficiaries and navigators (e.g., Help Me Grow)

Thank You

Robyn Husa, PhD
Epidemiology Specialist II
Alaska Division of Public Health,
MCH-Epidemiology Unit
Email: robyn.husa@alaska.gov
Phone: (907) 269-3982

ALCANLink website:
https://health.alaska.gov/dph/wcfh/Pages/mchepi/ALCANlink

Trust

Alaska Mental Health Trust Authority

HB 172 Patient Rights Report to the Legislature

Travis Welch, Program Officer

Project Overview

- The goal of HB 172 is to increase access to behavioral health crisis services in less restrictive settings
- HB 172 also provides an opportunity to address concerns regarding psychiatric patient rights by directing the Trust, the Department of Health, and the Department of Family and Community Services to submit a report to the legislature and the public.
- The report will provide the Alaska Legislature with the information needed to improve psychiatric patient rights in Alaska.

Project Structure

Advisory Team

- Team composition based on statutory requirements.
- Reviews and provides guidance on project direction & recommendations
- Support report and recommendation finalization

Subcommittees

- Vet information learned during stakeholder engagement + make initial recommendations
- Four subcommittees: Data, Legal, Providers, Lived Experience

Stakeholder Engagement

- Facility site visits
- Interviews
- Focus groups

Project management Team

- Logistical support to Advisory Team + Subcommittees
- Drives completion of deliverables
- Team: Trust, DOH, DFCS, Consultant team

Timeline

- Jan-Jun 2023 – Research and stakeholder engagement, report created
- August 2023 – Report posted for public comment
- September 2023 – Public comment input and edits finalized for report
- October 2023 – Final report sent to Alaska Legislature
- Jan-Apr 2024 – Testimony and presentations on findings to legislative committees

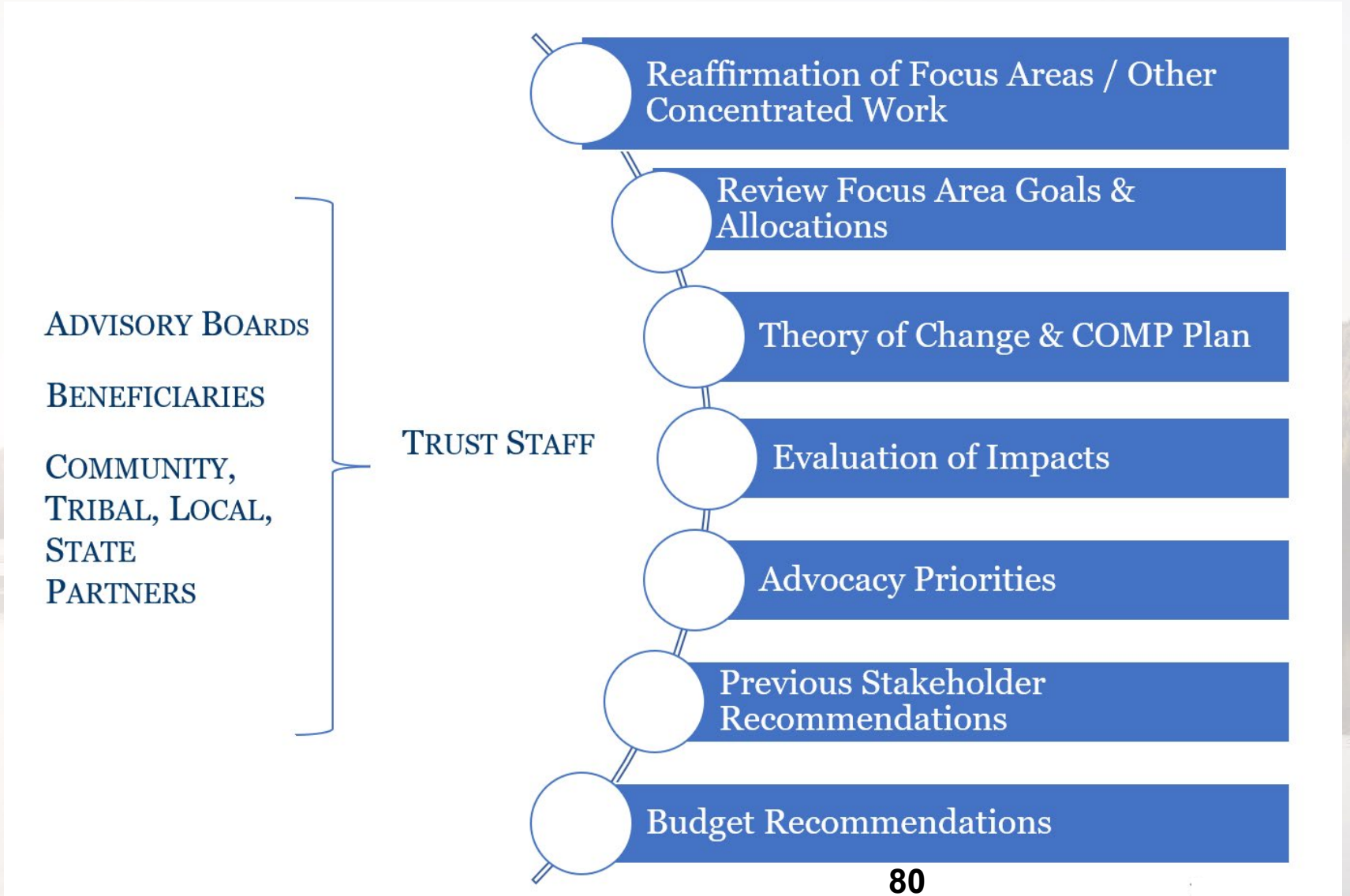
Trust

Alaska Mental Health Trust Authority

Trust FY25 Budget Development Process

Katie Baldwin Johnson, COO

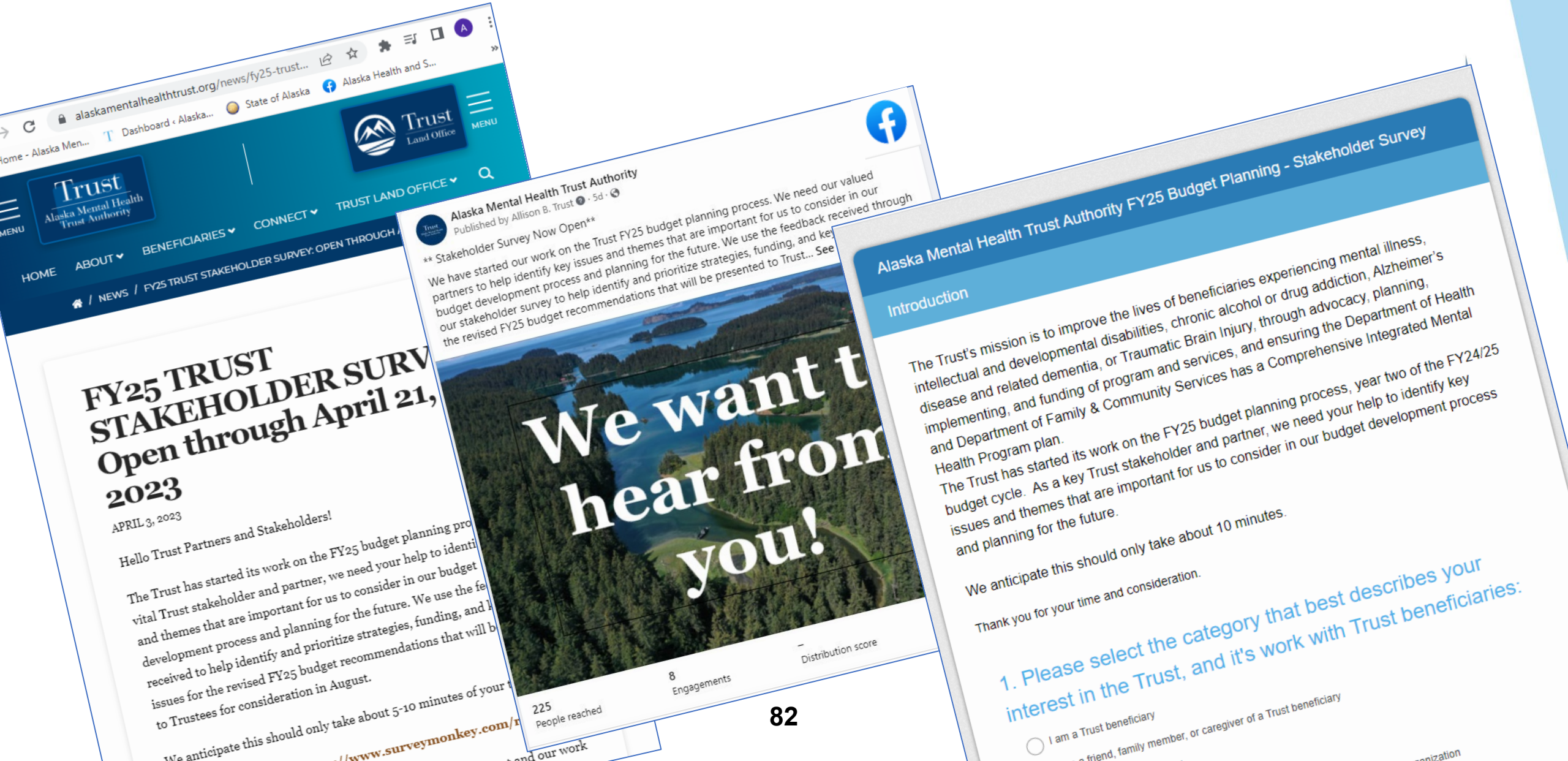
Budget Development Feedback Loop



Timeline: FY25 Budget (CY2023)

February – Early June 2023	Trust staff working with the Advisory Boards & stakeholders to review current/future work to ground FY25 budget strategies/recommendations
Late June – July	Trust staff work with stakeholders to finalize FY25 budget proposal
July 26 -27	Program & Planning Committee meeting: Budget presentation
August 29 – 30	Full Board: FY25 Budget approval
September 15	Budget transmittal to Governor and OMB

Stakeholder Survey



Thank You

Questions?

Trust
Alaska Mental Health Trust Authority

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

MEMO

To: Verné Boerner - Program & Planning Committee Chair
Date: March 31, 2023
Re: Alaska Medicaid rate setting methodology contract
Amount: $475,000
Grantee: Contractual Services
Project Title: Alaska Medicaid Rate Setting Methodologies: Contract Funding

REQUESTED MOTION:

"The Program & Planning Committee recommends approval to the full Board of Trustees of up to $475,000 for a contract for a comprehensive review of Alaska's Medicaid rate reimbursement methodology. These funds will come from previously unobligated FY23 funds and be added as authority grant funds under the Comp Plan/Data Evaluation line of the Non-Focus Area section of the budget."

Assigned Program Staff: Katie Baldwin

STAFF ANALYSIS

The Trust regularly receives feedback from behavioral health organizations, home and community-based service providers, statutory advisory boards, and advocates about inadequate and outdated Medicaid reimbursement rates that are insufficient to operate sustainable services for beneficiaries in Alaska. Increasingly, providers indicate they will not be able to continue providing services without changes to payment methodologies, and in fact, have reported loss in service capacity in both behavioral health and home and community-based serving organizations across the state over the past couple of years.

The Governor's Council on Disabilities and Special Education (GCDSE) with the Alaska Association on Developmental Disabilities (AADD) provided an alarming presentation during the Trust's January 2023 board meeting in Juneau about the dire circumstances facing nonprofits increasingly unable to sustainably operate services. The Alaska Behavioral Health Association (ABHA) has also communicated significant concerns about the fragility of behavioral health services, with notable loss in service capacity across the state. Without correction, these organizations will continue to erode in the near future, resulting in irreparable harm to beneficiaries and an increasing reliance upon higher, more restrictive and costly levels of care.

Proceeding with developing an assessment of Alaska's Medicaid rate reimbursement methodology, and recommendations for updated cost methodologies will provide the state of Alaska, the Trust, and beneficiary serving organizations information that may be used to proceed with addressing these challenges that are impacting so many beneficiary serving partners.

The concept for this proposal was developed in collaboration with the Department of Health (DOH), which supports a rate methodology study facilitated by an external party with whom both providers and the State can partner with to execute a near-term, comprehensive rate methodology analysis. This request seeks approval of funding to support a contract, directed by the Trust in collaboration with the Department of Health, to conduct a meaningful study and analysis of Medicaid rate setting methodologies, to provide recommendations, and to develop necessary tools required to implement identified recommendations.

Utilizing a collaborative approach with the Department, where the Trust procures a contract and jointly manages it with the DOH, will ensure the final information will be available to partners external to the Trust and the information will help benefit and inform all concerned parties, including beneficiary advocates and policy makers. Procurement of this contract will follow state procurement requirements.

Addressing the Medicaid rates is critical to ensure funding is available to support Alaska's Comprehensive Integrated Mental Health Program (Comp Plan) and ties directly to Goal 9: *Alaska has the workforce capacity, data, and technology systems in place to support the resources and funding of Alaska's Comp Plan.*

Staff recommend approval of this request to support long-term sustainability of vital services for beneficiaries.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 9 Workforce, Data, & Funding	9.3 Funding the COMP program	

PROJECT DESCRIPTION

PROJECT DESCRIPTION

Background

Medicaid is relied upon by many Trust beneficiaries to access important services. Medicaid is a joint state/federal program that finances health insurance based on income and family size to some individuals and families, including children, parents, people who are pregnant, elderly people with certain incomes, and people with disabilities. Through a state/federal agreement, the federal government pays a percentage of the cost for services provided. Alaska's Medicaid is a "fee for service" reimbursement model, which pays providers for each specific service provided to a specific recipient. The range of services available depends on provider collaboration to build capacity and coordinate care.

Medicaid coverage for behavioral health and home and community-based services represents one of the most essential tools our state has in meeting the needs of Trust beneficiaries. The Trust recognizes the positive impacts the program has [for]both those served and the providers who are serving them. The Trust has been a longtime advocate, leader, funder, and partner to DHSS, now the Department of Health, on efforts to improve Medicaid in Alaska, including through efforts to expand Medicaid and the development and implementation of the Medicaid 1115 Behavioral Health Waiver.[1]

The State of Alaska administers the Medicaid program as well as six Medicaid waiver programs. The Centers for Medicare & Medicaid Services (CMS) through Medicaid waiver programs gives states the flexibility to redesign and improve Medicaid services and programs by waiving normal Medicaid requirements.

- The Division of Behavioral Health (DBH) manages the 1115 Waiver, an extensive demonstration project which is required to meet federal budget neutrality rules. The waiver expands the array of services available to address substance use disorder and behavioral health needs, with a particular focus on preventive and early intervention. The renewal request for the waiver was submitted on March 1, 2023.
- The Division of Senior and Disabilities Services (SDS) administers five Section 1915(c) waivers, which authorize states to provide home and community-based services as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The services provided in these waivers complement Medicaid state plan services:
    - Individuals with Intellectual and Developmental Disabilities (IDD) waiver serves about 2,100 children and adults who meet the criteria for level of care at an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
    - Alaskans Living Independently (ALI) waiver serves about 2,000 seniors and adults with physical disabilities who meet the criteria for level of care at a nursing facility.
    - Adults with Physical and Developmental Disabilities (APDD) waiver serves about 125 adults who have both intellectual and physical disabilities who meet the criteria for nursing facility level of care.
    - Children with Complex Medical Conditions (CCMC) waiver serves about 250 children with severe, chronic physical conditions who would receive long-term care in a facility for more than 30 days per year and who have prolonged dependency on medical care or technology to maintain well-being.

Individualized Supports Waiver (ISW) is in the last year of its first five-year cycle and expected by 7/1/23 to reach capacity to serve 600 recipients, ages 3 and up, who meet the criteria for level of care at an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Medicaid reimbursement rates for provider services are a critical component of the system of care relied upon by Trust beneficiaries.

[1] Alaska Mental Health Trust Authority 2022 Annual Report

In FY 2022, over 68,000 out of 264,000 Medicaid recipients (approximately 25%) with a paid claim for *any* Medicaid service also had a behavioral health diagnosis code in one of the first 4 diagnosis codes on a claim.

Description of Need

On December 15, 2022, the Department of Justice issued a report finding reasonable cause to believe that the State of Alaska violates Title II of the Americans with Disabilities Act by failing to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs.[2]

The Trust regularly receives feedback and request for support from providers of community behavioral health and home and community-based waiver services, who frequently state that rates of reimbursement are insufficient to cover their costs. Increasingly, providers are indicating that they will not be able to continue providing services to beneficiaries without changes to payment methodologies. In particular, providers are challenged in providing for the needs of complex care individuals—those with, for example, both a developmental disability and a behavioral health diagnosis—and the lack of adequate settings and services for these individuals is particularly acute.

Rates also have a direct impact on workforce recruitment and retention. The Trust's workforce priority focus area is based on the recognition that Alaska lacks the professionals necessary to meet the needs of Trust beneficiaries, negatively impacting health care access.

Within DOH, the Office of Rate Review is the office primarily responsible for establishing Medicaid payment rates for hospitals, nursing facilities, ambulatory surgical centers, rural health clinics, federally qualified health centers, end stage renal dialysis services, free standing birthing centers, community behavioral health centers, and long-term services and supports.

Typically, rate studies are conducted for each individual class of service providers, may not fully account for the interconnectedness between providers and services. Instead of implementing a series of separate, siloed efforts to determine appropriate rates, it is important to consider the continuum of rates needed and how they are interrelated.

The concept for this proposal was developed in collaboration with the Department of Health (DOH), which supports a rate methodology study facilitated by an external agency with whom both providers and the State can partner with to execute a near-term, comprehensive rate methodology analysis. A collaborative approach will also leverage available staff resources across agencies for the project.

Scope of Work

This contract would engage a vendor firm experienced in actuarial and financial modeling for complex health systems, with a particular focus on reimbursement systems within a fee-for-service Medicaid environment and accounting for tribal health components. The vendor would have a demonstrated track record of understanding federal (CMS) requirements, state Medicaid

[2] https://www.justice.gov/opa/pr/justice-department-finds-alaska-unnecessarily-segregates-children-behavioral-health

programs and regulations, audit and compliance risk management, and operationalization of rate reimbursement methodologies in both state plan and waiver settings.

The contract would require evaluation of Alaska's Medicaid payment methodologies, except for skilled nursing facilities and inpatient hospitals. The payment methodology evaluation's intent is to conduct a patient-centric assessment that is focused on ensuring access to care for all Alaskans, including those with complex needs, in a fee-for-service Medicaid environment.

Performance of deliverables may be structured in a tiered timeline, with priority given to the rate setting methodologies for:

- Community behavioral health
- Long term care services and supports
- Professional Services
- Applied Behavior Analysis (Autism)
- Non-Emergency Medical Transportation
    - Ground and Air Ambulance
    - Taxi
    - Paratransit Services
    - Accommodation Services
- Emergency Medical Transportation
    - Ground and Air Ambulance
- Dental Services
- Private Duty Nursing

Other rate setting methodologies to be evaluated include but are not limited to:

- Federally Qualified Heath Centers (FQHC)
- Psychiatric Residential Treatment Centers (PRTC)
- Ambulatory Surgical Centers (ASC)
- Community Health Aid Practitioner (CHAP)
- End Stage Renal Dialysis (ESRD)
- Home Health Agency
- Home Infusion Therapy
- Freestanding Birthing Centers
- Residential Behavioral Rehabilitation
- Tribal Targeted Case Management (TTCM)
- Infant Learning Case Management

The vendor must demonstrate the following minimum qualifications:

- Must have a minimum of (5) years of large scale, complex health care claims processing experience with Medicaid.
- Within the last five (5) years must have worked with at least two (2) state Medicaid agencies on evaluating payment methodologies.

- Must possess at least (2) two-years of experience working with states operating fee-for-service Medicaid programs.
- Must demonstrate at least (2) two-year's experience conveying technically complex Medicaid methodologies to lay audience.
- The vendor must have been the primary contractor for at least one project that approximates the scope of this project.

The vendor will be required to perform the following tasks in collaboration and coordination with the Trust, DOH, partners, and stakeholders, as applicable:

- Identify the process for setting rates in at least three other states for each Alaska Medicaid Payment Methodology focus area. To the extent possible, the states should have characteristics similar to Alaska, keeping in mind Alaska's unique considerations, including:
    - Geography (urban, rural, remote), size, and population
    - Number and type of providers
    - Tribal Health Organizations
    - Workforce
    - Education and training opportunities
    - Utilization of out-of-state providers
- Conduct a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis for each identified Alaska Medicaid Payment Methodology being evaluated.
- Define roles and responsibilities of key players associated with each Alaska Medicaid Payment Methodology, including but not limited to the following: individual/family; providers; workers/workforce; federal government; state government (executive and legislative branches); Tribal government; local government; trade associations; private insurance agencies; public entities.
- Identify financial impact to the State of Alaska as well as the levers available to the state for budgetary purposes for each Alaska Medicaid Payment Methodology focus area. Examples include, but are not limited to, eligibility criteria and services.
- Conduct stakeholder engagement activities including but not limited to online meetings, informational sessions, surveys, work plan email updates, etc. with providers associated with the Alaska Medicaid Payment Methodology under evaluation and/or related provider associations.
- Provide an analysis of the change in payment rates for each facility/provider type and service under each model/methodology chosen and the estimated annual impact on reimbursement to each facility/provider type and service and the aggregate effect on the State's general fund and any changes needed to be in federal reporting compliance such as Upper Payment Limits. For each service determine whether the service is a required or optional service and the pros and cons/impact of discontinuing the service if optional.
- Consider the impact on service delivery method and whether the change will impact access to care or quantity of specific services. For example, when proposing a methodology for a one-on-one service provision, the vendor analysis must consider whether proposed rate changes would dis/incentivize group services.
- Provide specific recommendations and operational steps needed, based on the rate and analysis for each Alaska Medicaid Payment Methodology focus area, for implementation of

models/methodologies that can most reliably and consistently produce rates that can be implemented by Alaska Medicaid.

- Include among the recommendations specific methodologies or proposals to support providers in working with complex needs individuals, including but not limited to targeted acuity rates, adjustments, or add-ons for specific circumstances or needs.
- Development of tools and resources such as: Frequently Asked Questions (FAQs); research of other states payment methodologies; work group, partners and stakeholders contact information and distribution lists; flow chart(s) of processes; decision matrices.
- Development of strategic implementation/action plan and training for Alaska Medicaid Staff on implementation of changes to existing or implementation of new Alaska Medicaid Payment Methodologies.
    - Training will be provided to the State which can be reproduced on implementation. Training must be described in the strategic implementation plan. Strategic implementation/action plan will also need to identify any system changes, regulation changes, policies, and procedures creation and/or updates, any amendments needed to the Alaska Medicaid State Plan, and technology or other purchases that would be helpful for implementation.

- Development of performance measures/outcomes to be measured to track changes and efficiency and effectiveness of policy decisions.

Each recommendation must be supported by delivery of any necessary tools and/or resources and processes to allow timely implementation of recommendations (such as, but not limited to, proposed changes to administrative rules, state plan amendments, system changes, billing manual revisions, provider surveys and reporting forms and proposed timeframes for each step needed). The vendor will develop performance measures/outcomes that the state would track upon implementation of one of the proposed methodologies and would consider what additional resources the state would need to effectively monitor and analyze implementation.

EVALUATION CRITERIA

Evaluation criteria for the contract will be developed/determined in collaboration with DOH once the final scope of work is defined.

BUDGET

Other Costs	$475,000
Other Costs Narrative:	Contract Services

Trust
Alaska Mental Health Trust Authority

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MEMO

To:	Verné Boerner - Program & Planning Committee Chair
Date:	April 20, 2023
Re:	FY23 Mental Health & Addiction Intervention Focus Area Allocation
Fund Source:	FY23 Treatment Access & Recovery Supports
Amount:	$200,000.00
Grantee:	Maniilaq Association
Project Title:	Behavioral Health Crisis and Integrated Care Program

REQUESTED MOTION:

"The Program & Planning Committee approves a $200,000 FY23 Mental Health & Addiction Intervention focus area allocation to the Maniilaq Association for the Behavioral Health Crisis Stabilization Center project. These funds will come from the Treatment Access & Recovery Supports budget line in the FY23 budget."

Assigned Program Staff: Eric Boyer

STAFF ANALYSIS

The Maniilaq Association has been engaged in partnering with the Trust, community stakeholders, and the Division of Behavioral Health in the planning efforts to address gaps in crisis care services in Kotzebue and the surrounding region. The gaps exist in providing an integrated behavioral health (BH) crisis approach, resulting in Trust beneficiaries not receiving timely and therapeutic care when in crisis. This environment leads to individuals not getting their needs met in a timely manner, and potentially returning to unsafe conditions in the community, furthering their potential involvement with police, emergency services, and jail. Recent evaluation and data demonstrate that Trust beneficiaries in the region do not get the treatment and care needed to keep them in the region. Many of them get sent outside of northwest Alaska for behavioral health care, and when they return, the transition to local treatment and care is problematic. In 2021, 70% of the beneficiaries in crisis being seen in the emergency department had alcohol in their system. This demonstrates the need for receiving help in an expedient manner, and follow-up that does not include being housed in a hospital or jail bed.

The Alaska Health Analytics and Vital Records reports that 1,080 people who received care in the Kotzebue hospital in 2021 had one or more behavioral health (BH) diagnoses. There were 100 risk assessments performed in the emergency department, and almost 50% of the people referred to the inpatient unit at Maniilaq Health Center were discharged out of the region for care. Once these

beneficiaries return to the region, the linkage to care and "warm-handoff" can be delayed by waiting for an assessment and space in outpatient treatment within the Maniilaq Counseling and Recovery Center. This wait is further exacerbated by the lack of short-term crisis stabilization beds, which means additional beneficiaries are discharged from the hospital emergency department back home because there are no other options for them to receive care.

Beneficiaries experiencing a behavioral health crisis, but not acute enough to warrant being admitted to the hospital crisis unit, remain home or are returned home by law enforcement (LE), meaning their BH needs go unmet and can increase in acuity over time. It is because of these known challenges that Maniilaq wants to build out crisis services in the region so that Trust beneficiaries can get their BH needs met at the right time and place. Additional crisis services will also result in utilizing more cost-effective measures for treating BH issues, compared to in the hospital, being sent outside of the region, and/or LE/jail. Ultimately, the

In 2022, contractors worked with Maniilaq to evaluate their community-based care and crisis services system of care in in the region, plus evaluate how to adapt the Crisis Now best practice framework for Kotzebue. Kotzebue is the hub-village in northwest Alaska that serves 12 villages in a region comparable in size to the state of Indiana. This fact brings home the need for treating the BH needs of Trust beneficiaries in Kotzebue and helping to stabilize the continuum of care without adding trauma, expense, and loss to families who many have never left their home region. Maniilaq, with the technical support of a contractor, proposes to develop a clinical model of care continuum that will address the gaps in care, and help meet the needs of Trust beneficiaries in the region. This is also the first step in a development process for planning and implementing a Crisis Now adaptation in a rural hub-village.

The model being proposed by Maniilaq would optimize existing programming in the hospital (crisis intervention, inpatient crisis, and brief interventions), while at the same time plan a Crisis Center where Trust beneficiaries can receive services for a few hours up to seven days. A transition program would be implemented for individuals returning to the region, and for those transitioning out of the hospital and/or Crisis Center. Maniilaq is a financial partner in the model, and they have requested funds from other partners including state capital funds, and a federal earmark. Trust funds would be used for phase II of the implementation planning work with contractors, as well as to help fund a Maniilaq staffer to focus on the development of the clinical model, policies and procedures, workflow, staffing patterns, recruitment, and retention.

The funding for this request will be designated from the Trustee approved FY23 Mental Health and Addiction focus area, Treatment Access and Recovery Supports strategy line. Even though this request is rooted in the adapting of the Crisis Now framework to rural Alaska, it is a part of the bigger Maniilaq behavioral health crisis and integrated care program. It is focused on increasing access to crisis BH services at each touchpoint in the system from the hospital to transitioning back home. Trust program staff recommend this proposal for full funding.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments

Goal 5 Suicide Prevention	5.2 Crisis system improvement	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

Maniilaq has been working with Agnew::Beck on the planning of opening the Maniilaq Crisis Stabilization Center, which will provide stabilization to individuals in crisis and offer transitional residential care to individuals needing anything from a couple of hours of care to several days of stabilization. This project has garnered high interest from the Division of Behavioral Health. What we are requesting from the Trust is funding to finish the planning and business plan with Agnew Beck.

Kotzebue is the hub-village in northwest Alaska that serves 12 villages in a region comparable in size to the state of Indiana. This fact brings home the need for treating the BH needs of Trust beneficiaries in Kotzebue and helping to stabilize the continuum of care without adding trauma, expense, and loss to families who many have never left their home region. Maniilaq with the technical support of Agnew::Beck proposes to utilize the funds requested from the Trust to develop a clinical model of care continuum that will address the gaps in care and help meet the needs of Trust beneficiaries in the region. This is also the first development process for planning and implementing a Crisis Now adaptation in a rural hub-village.

Through the renovation of existing infrastructure, startup funding, and a future capital project, we are planning to build a fully operational crisis center staffed 24/7. Maniilaq Behavioral Health can provide stabilization to individuals in crisis and offer transitional residential care to individuals needing anything from a couple of hours of care to several days of stabilization. We believe that this program can be financially sustainable through newly developed 1115 Behavioral Health Medicaid Waiver billable services, all of which the state can claim 100% federal funding through the Federal Tribal Medical Assistance Percentage (FMAP). Maniilaq has been working with Agnew::Beck for the planning of this project and has garnered high interest from the Division of Behavioral Health. Maniilaq has submitted a CAPSIS request for $750,000 in funding for renovation and capital costs for opening Maniilaq Crisis Stabilization Center. What we are requesting from the Trust is funding to finish the planning and business plan with Agnew::Beck.

EVALUATION CRITERIA

We will measure project success using data from our electronic health record (EHR), screening tools, and client feedback. Our EHR allows us to track client demographic information, which we can then use to identify who is receiving services and how many services they are receiving. Similarly, our screening tools provide baselines for our clients, and we use these tools throughout treatment to determine if changes are occurring. Another way to measure change is by tracking client recidivism. Tracking client recidivism and utilizing post-discharge screening tools will help

us understand our service's impact on our community. All of this is possible to measure once services are in place and we will utilize this data to measure beneficiary impact.

- Success for the Behavioral Health Crisis Services buildout will also include a fully developed model of care, financial pro forma, and regulatory and billing path.
- Describe efforts made toward designing the clinical model of crisis care, for the five elements of the Maniilaq Behavioral Health Crisis and Integrated Care Program.
    1. ED Crisis Intervention
    2. Inpatient Crisis
    3. Crisis Center
    4. Integrated Primary Care
    5. Transitions
- Provide a narrative describing the timeline, activities, successes, challenges, and any lessons learned during this phase of planning, development, and implementation.
- Provide a brief narrative describing the workforce plan for the ultimate opening of the integrated care program.
- Describe efforts made to engage external stakeholders in the development process.

SUSTAINABILITY

We believe that this program can be financially sustainable through newly developed 1115 Behavioral Health Medicaid Waiver billable services, all of which the state can claim 100% federal funding through the Federal Tribal Medical Assistance Percentage (FMAP).

WHO WE SERVE

Maniilaq emergency room (ER) providers are often faced with people in crisis, such as extreme alcohol intoxication, behavioral health episodes, or suicide ideation and attempts. Police, fire, and emergency room providers are tasked with stabilizing clients in situations that don't meet therapeutic needs and take up valuable resources. Unfortunately, this can often lead to individuals returning to unsafe conditions or drinking until they are in a medical crisis.

The Alaska Health Analytics and Vital Records reports 1080 people in 2021 received care in the Kotzebue hospital that had one or more BH diagnoses. There were 100 risk assessments performed in the ED, almost 50% of the people referred to the inpatient unit at MHC were discharged out of the region for care. Once these beneficiaries return to the region, the linkage to care and "warm-handoff" can be delayed waiting for an assessment and space in outpatient treatment with the Maniilaq Counseling and Recovery Center. This wait is further exacerbated by the lack of short-term crisis stabilization beds, which means additional beneficiaries are discharged from the hospital emergency department back home because there are no other options for them to receive care.

While psychiatric hospitalization and inpatient withdrawal are necessary for the most severe cases, a standalone crisis stabilization and sobering center would better serve many individuals. In the review of Maniilaq's continuum of care, the most critical need is to address individuals in crisis. New state legislation and Medicaid service lines allow Maniilaq to stand up a service

specifically targeting our individuals in crisis to keep them in the region until they can return home or get into a residential program. Through a phased approach, Maniilaq Behavioral Health will develop a crisis stabilization services to alleviate the burden on the emergency room and reduce costs while providing therapeutic interventions to individuals picked up from EMS, the police, or brought in by family members.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	80
Developmental Disabilities:	20
Substance Abuse	190
Traumatic Brain Injuries:	5
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	600
Number of people to be trained	10

BUDGET

Personnel Services Costs	$92,000.00
Personnel Services Costs (Other Sources)	$0.00
Personnel Services Narrative:	FTE would focus on working with Agnew::Beck and the Trust on the planning and development of the Maniilaq Crisis Now project. This FTE will be the lead person for Maniilaq.

Travel Costs	$8,000.00
Travel Costs (Other Sources)	$0.00
Travel Narrative:	Travel cost for making a site visit to Anchorage and/or Fairbanks to visit the working Crisis program to gain knowledge for how to operate a Crisis program.

Other Costs	$100,000.00
Other Costs (Other Sources)	$21,000.00
Other Costs Narrative:	$100,000 to pay for planning work with Agne::Beck. Maniilaq has spent $21,000 on Agnew Beck BHS Planning.

Total Amount to be Funded by the Trust	$200,000.00
Total Amount Funded by Other Sources	$2,671,000.00

OTHER FUNDING SOURCES

Maniilaq Association, SECURED	$21,000.00
State CAPSIS, Pending	$750,000.00
Federal Earmark Request, Pending	$1,900,000.00
Total Leveraged Funds	**$2,671,000.00**

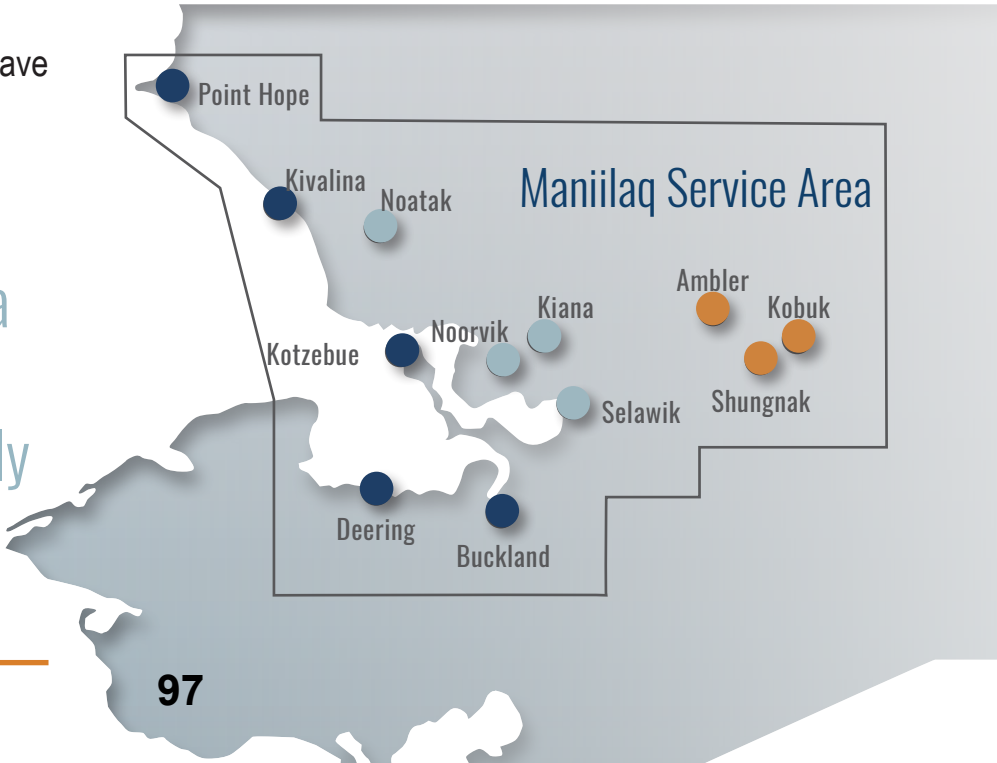
MANIILAQ OVERVIEW

Maniilaq Association is a 501(c)(3) Tribal Non-Profit organization who for over 30 years has been providing health, tribal, and social services to twelve villages in the Maniilaq service area (MSA). Kotzebue is the regional hub with a population of 3,287. The total population in our service area is 8,430 residents, approximately 81% are Alaska Native/American Indian.

The twelve villages in the MSA that are served by Maniilaq Association include Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noorvik, Noatak, Point Hope, Selawik, and Shungnak. These villages are scattered throughout a land area of about 38,000 square miles or the size of the state of Indiana. As there is no road system connecting these communities, travel in the region must be accomplished by air, snow machine in the winter, or by boat during the summer. The lack of a road system makes residents heavily dependent on expensive air travel.

Between 2018-2020, 10 of the 12 villages in the Maniilaq service area were listed on the Denali Commission Distressed Community Report. This classification is due to high unemployment rates, consequently, poverty is a persistent problem. According to the U.S. Census Bureau, 23.7% of Maniilaq service area residents are living below the federal poverty level.
Given that, our villages in the region have small populations, small budgets, and relatively few employees to address hardships without outside assistance.

The Maniilaq service area encompasses 38,000 square miles. It is roughly the size of Indiana.



BEHAVIORAL HEALTH CRISIS STABILIZATION CENTER

OVERVIEW

Maniilaq emergency room (ER) providers are often faced with people in crisis, such as extreme alcohol intoxication, behavioral health episodes, or suicide ideation and attempts. Police, fire, and emergency room providers are tasked with stabilizing clients in situations that don't meet therapeutic needs and take up valuable resources. Unfortunately, this can often lead to individuals returning to unsafe conditions or drinking until they are in a medical crisis.

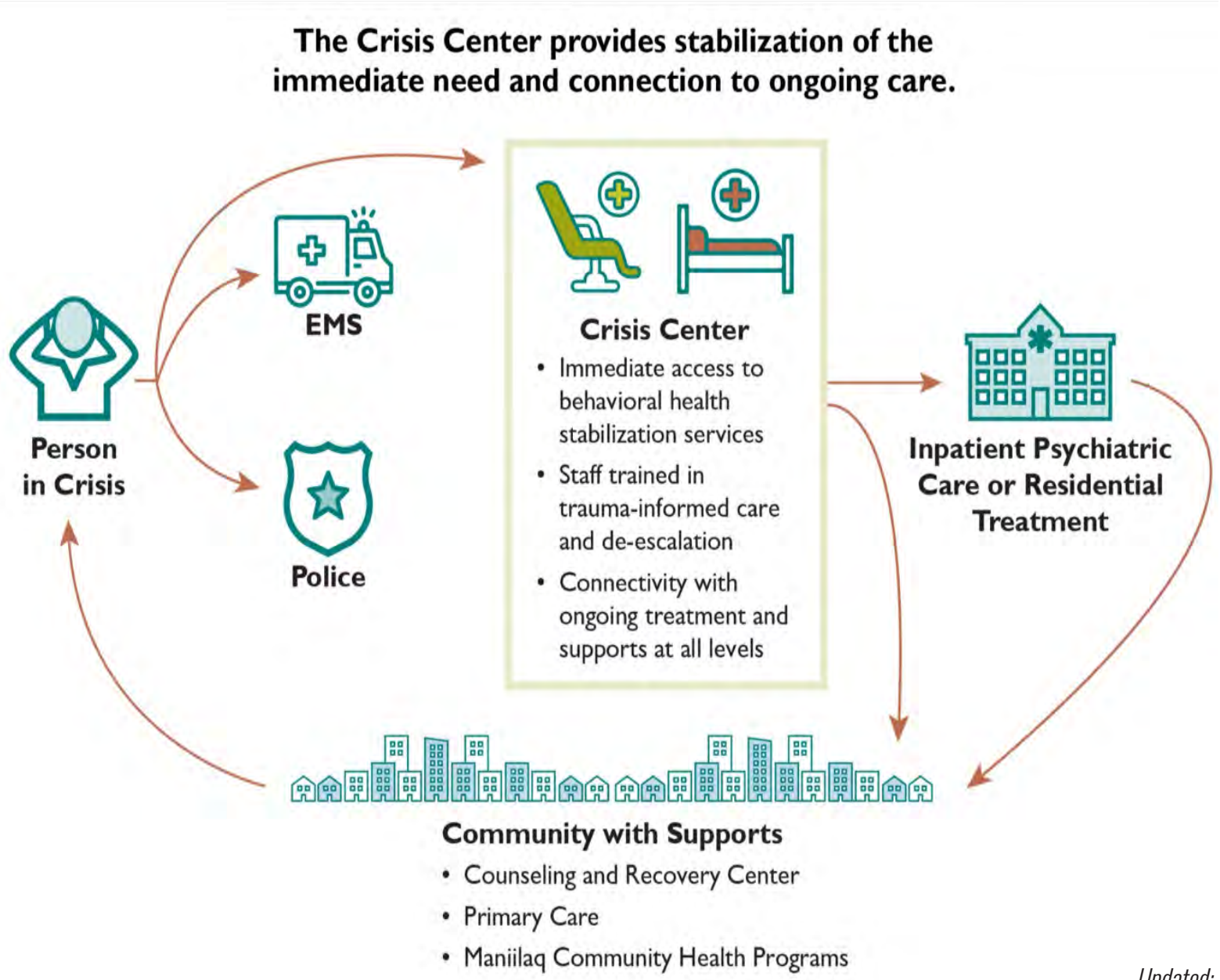
CRISIS STABILIZATION

While psychiatric hospitalization and inpatient withdrawal are necessary for the most severe cases, a standalone crisis stabilization and sobering center would better serve many individuals. In the review of Maniilaq's continuum of care, the most critical need is to address individuals in crisis. New state legislation and Medicaid service lines allow Maniilaq to stand up a service specifically targeting our individuals in crisis to keep them in the region until they can return home or get into a residential program. Through a phased approach, Maniilaq Behavioral Health will develop crisis stabilization services to alleviate the burden on the emergency room and reduce costs while providing therapeutic interventions to individuals picked up from EMS, the police, or brought in by family members.

CRISIS STABILIZATION CENTER

Submitted a CAPSIS request for $750,000 in State CIP funding for renovation and capital cost for opening Maniilaq Crisis Center. Through the renovation of existing infrastructure, startup funding, and a future capital project, we can build a fully operational crisis center staffed 24/7. Maniilaq Behavioral Health can provide stabilization to individuals in crisis and offer transitional residential care to individuals needing anything from a couple of hours of care to several days of stabilization. This program can be financially sustainable through newly developed 1115 Behavioral Health Medicaid Waiver billable services, all of which the state can claim 100% federal funding through Federal Tribal (FMAP). Maniilaq has been working with Agnew Beck for the planning of this project and has garnered high interest from the Division of Behavioral Health, the Alaska Mental Health Trust, and our community partners.

WHAT WE ARE WORKING TO: FUTURE FLOW IN MANIILAQ BEHAVIORAL HEALTH CRISIS SYSTEM



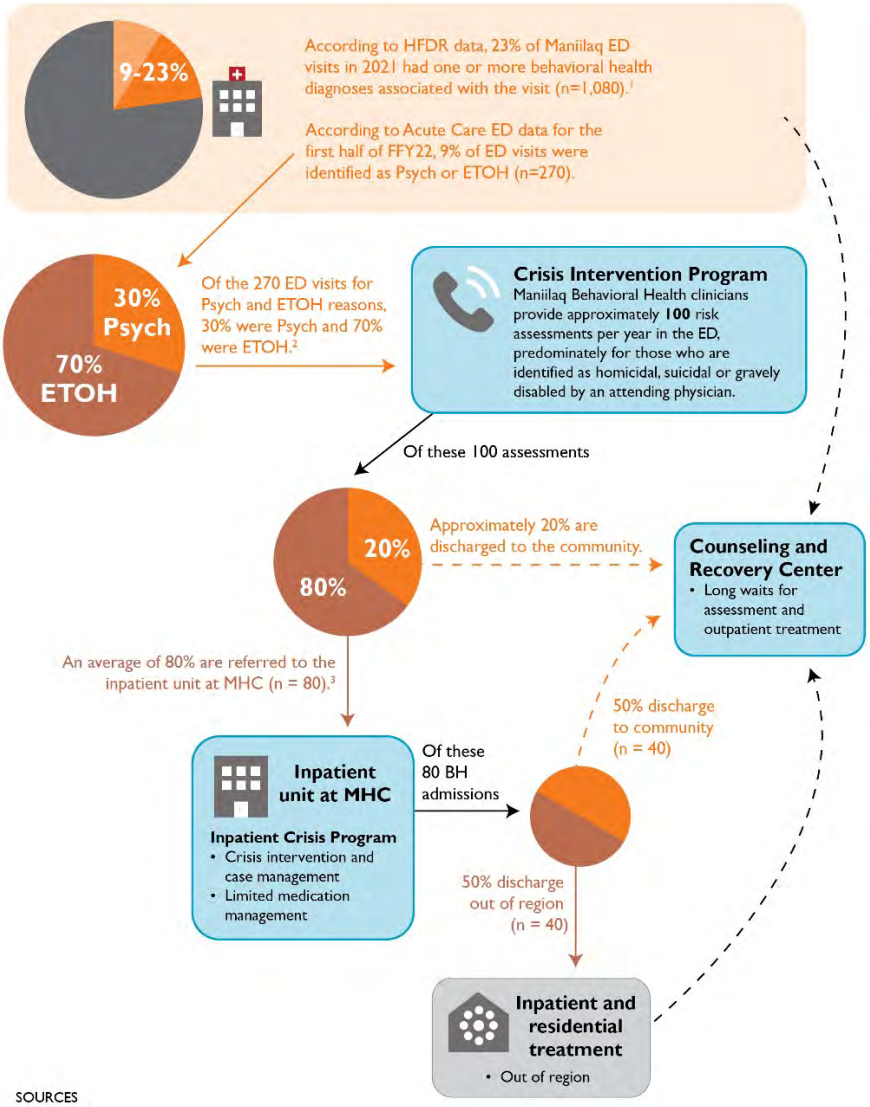
Updated: February 2023

Behavioral Health Crisis Services at Maniilaq Association
Executive Summary

Existing Programs and Gaps

Maniilaq's Behavioral Health Services Department (BHS) currently supports two behavioral health crisis programs within the hospital – a crisis intervention program in the emergency department and an assessment and care coordination program for individuals with behavioral health diagnoses admitted to the hospital's inpatient unit. BHS also oversees the region's community behavioral health center, the Counseling and Recovery Center.

Recognizing challenges with the current flow and with an eye towards improving access to crisis services for the region, BHS seeks to address gaps through a multi-pronged optimization and expansion effort.



SOURCES
1. Alaska Health Analytics and Vital Records, Health Facilities Data Reporting Program, 2019 ver. 5, 2020 ver. 2, and 2021 ver. 1 datasets and Email communication, Maniilaq Health Center March 7, 2022.
2. Workload for Acute Care ED, October 2021-September 2022.
3. Email communication, Maniilaq Health Center March 7, 2022.

Key gaps identified by the behavioral health team related to behavioral health crisis services and connections to ongoing care are as follows:

- Not all individuals who need crisis services present to the emergency department. Because care options are limited, some individuals in need of crisis care for substance use and mental health challenges are transported home by law enforcement or family members.
- Only the most acute individuals (suicidal, homicidal and gravely disabled) are likely to receive a behavioral health risk assessment and referral while in the ER.
- Dual documentation requirements and differing electronic health records impede billing for crisis intervention services provided in the ER as well as hinder coordination of follow-on care.
- For those that do receive a risk assessment in the ER or are stabilized on the inpatient unit, there are limited opportunities for immediate follow-up and on-going care. The limited connection to ongoing care is exacerbated because the assessment required for initiation of outpatient care are not provided to individuals as part of their inpatient stay.
- Psychiatric care is often unavailable for individuals admitted to the inpatient unit for behavioral health reasons.
- For individuals who are discharged to residential or inpatient treatment out of the region, re-connecting those individuals with services following discharge from those settings is a challenge.

Crisis Program Expansion

To address gaps and expand access to care in the region, BHS is considering optimizing existing programming – ED crisis intervention, inpatient crisis and brief interventions – while simultaneously planning for a Crisis Center where individuals can receive services for just a few hours up to seven days and a Transitions program to support transitional care. **The image below summarizes the five components of BHS's proposed Crisis and Integrated Care Program, with existing program components noted in bold**.

Maniilaq Behavioral Health: Crisis and Integrated Care Program

ED Crisis Intervention

- **Risk assessments and referral provided by a clinician for individuals identified as suicidal homicidal or gravely disabled**
- Substance use risk assessment, engagement and connection to care provided by substance use disorder counselors and peers for individuals presenting with a substance use disorder/intoxication
- Engagement and connection to care provided by a peer support specialist for individuals with mild to moderate behavioral health needs

Inpatient Crisis

- **Intervention and case management services provided by a clinician, twice daily contacts with patient**
- **Psychiatric care if available,** moving to 24/7 availability
- Potential to shift from intervention and case management to active treatment model with clinician and psychiatric availability

Crisis Center

- Crisis stabilization recliners and beds with supportive services adjacent to Maniilaq Health Center; stays up to 23-hours 59 minutes or up to 7 days depending on client need

Integrated Primary Care

- **Rapid access to medication assisted treatment and medication management**
- **Brief intervention services for mental health and substance use disorders**
- **Support for tobacco cessation**

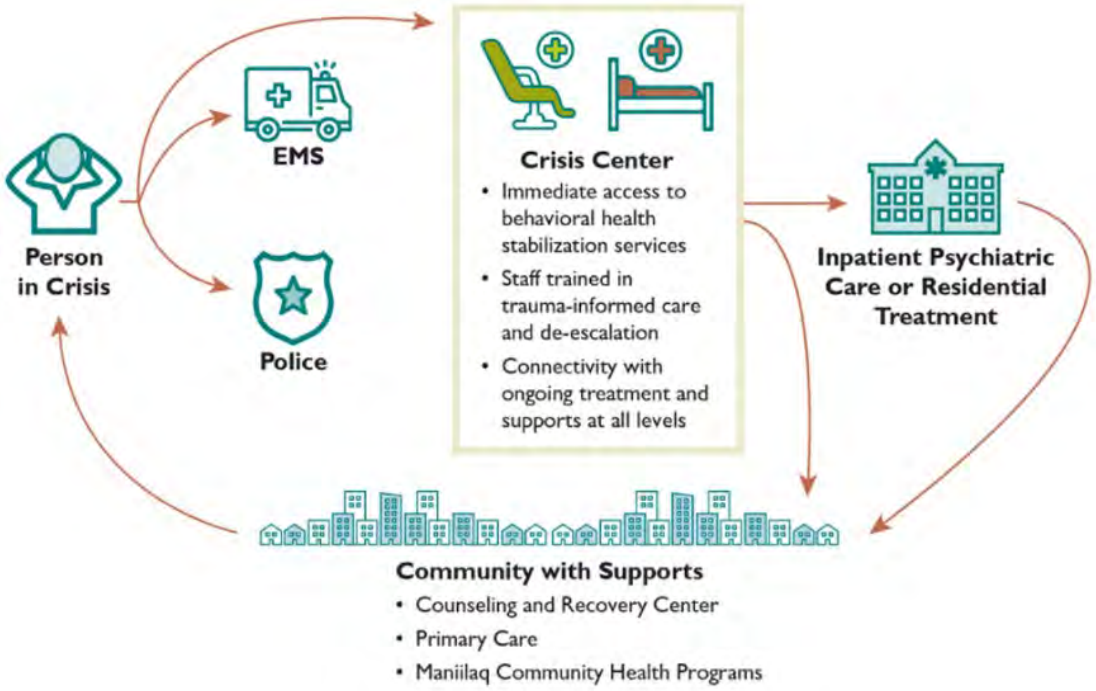
Transitions

- Support for care transitions for individuals returning to the region from an out-of-region behavioral health residential or inpatient stay
- Support for care transitions for individuals following a ED and/or inpatient visit with a behavioral health component (includes, mild, moderate and severe mental illness and substance use)

Crisis Center

The Crisis Center will provide an alternative to the emergency room for individuals in crisis and provide an alternative destination for law enforcement.

Initial financial modeling suggests that billable revenue will cover staffing costs for the program.



Implementation of the Crisis Center is proposed in three phases:

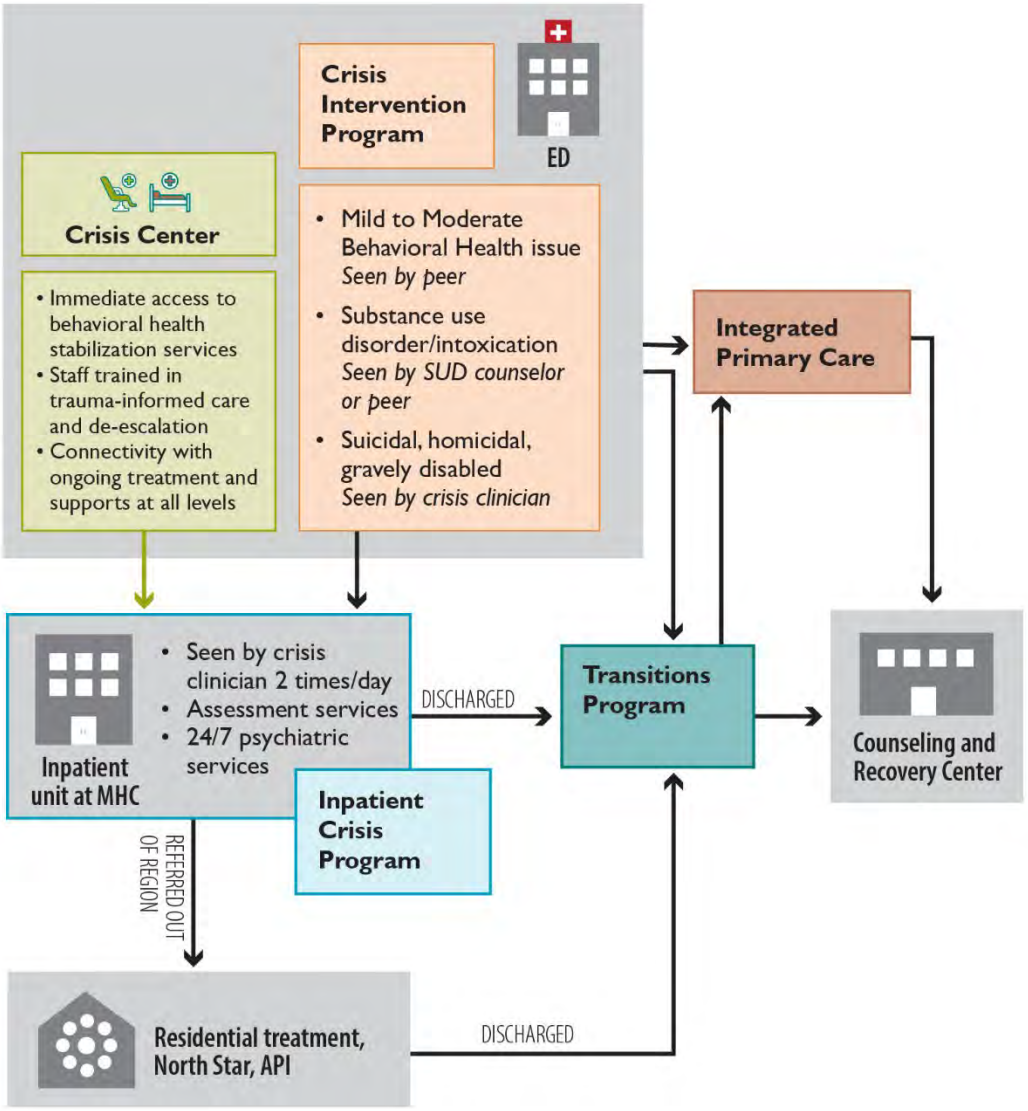
Phase 1: Withdrawal management and case management services for individuals experiencing a substance use disorder crisis.

Phase 2: Crisis stabilization and treatment for individuals in need of short-term crisis care in a safe and secure location, but do not meet criteria for inpatient care and are willing to voluntarily engage in stabilization and treatment services.

Phase 3: "No wrong door" model of crisis care wherein all individuals who present to the center, regardless of the crisis and willingness to engage in services will be triaged, assessed and connected with appropriate resources.

Looking Ahead

When fully implemented, Maniilaq's Crisis and Integrated Care Program will offer robust behavioral health crisis intervention, stabilization and treatment services, regardless of point of entry. Individuals presenting to the ED or Crisis Center will be screened and provided with the most appropriate stabilization services and provided with a warm hand off to the next level of care, whether in the community or outside of the region.



Trust
Alaska Mental Health Trust Authority

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

MEMO

To:	Verné Boerner - Program & Planning Committee Chair
Date:	April 20, 2023
Re:	FY24 Mental Health & Addiction Intervention Focus Area Allocation
Fund Source:	FY24 Crisis Continuum of Care
Amount:	$125,500.00
Grantee:	Ketchikan Wellness Coalition
Project Title:	Ketchikan Crisis Now Community Director

REQUESTED MOTION:

"The Program & Planning Committee approves a $125,500 FY24 Mental Health & Addiction Intervention focus area allocation to the Ketchikan Wellness Coalition for the Ketchikan Crisis Now Community Director project. These funds will come from the Crisis Continuum of Care budget line in the FY24 budget."

Assigned Program Staff: Eric Boyer

STAFF ANALYSIS

The Ketchikan Wellness Coalition (KWC) is requesting this grant from the Trust for the funding of a Crisis Now Community Planning Director position. Locating this impactful, full-time position within the Ketchikan Wellness coalition will position the city and surrounding region to more meaningfully collaborate on setting up a stronger system of crisis response services. This level of community partnership is important in the planning and implementation of a new program like Crisis Now that will require a collaborative effort from the city, emergency services, Trust beneficiaries and community healthcare stakeholders. The KWC has the support from the Ketchikan City Manager, City Assembly, provider organizations, First City Homeless Services, and local Tribal entities in facilitating the planning and implementation efforts needed for standing up the Crisis Now continuum. With the support of the City Assembly, the Ketchikan Fire Department (KFD) has agreed to take the lead on standing up a mobile integrated health response team.

Locating this position within KWC is strategic for leading the Crisis Now effort in Ketchikan, since the coalition's purpose is working collaboratively with community members in solving systemic issues impacting city residents. This level of partnership is also important in the planning and implementation of a comprehensive program like Crisis Now that will require collaboration between the city, emergency services, law enforcement, and community healthcare stakeholders.

Ketchikan lacks triage level crisis related response, which means emergency services (police or EMS) respond to the behavioral health crisis in the community. In 2022, the KFD reported calls to 911 had increased by 500., Approximately 120 of those calls occurred when the primary-duty KFD staff were out on other calls, requiring the use of off-duty staff. KFD reported over 15% of calls to 911 in 2021 as being related to mental health/substance use issues.

Operators of the Ketchikan Crisis Line are also responding to calls related to mental health and drug use, acute or suicidal mental health needs, and fielded 265 calls for a mental health clinician in the emergency department in 2020.

In addition, data collected through the 2020 Behavioral Risk Factor Surveillance System (BRFSS) revealed that 11.8% of Borough residents are diagnosed with depression, 20.5% lack social/emotional support, and premature death associated with suicide is 30%, attributed to alcohol is24.5%, with an additional 12.4 % related to drugs.

The behavioral health crisis needs in Ketchikan are not being met with a timely behavioral health response, so this funding recommendation will help with coordination, planning, and implementation of crisis response models in the region. Trust funding will be necessary to achieve successful implementation of the crisis services in the Ketchikan region, and staff recommends full funding for this request.

The Ketchikan Crisis Now Community Director position supports goal 5/objective 5.2 of the Comprehensive Mental Health Plan by improving the system to assist individuals in crisis. This funding request also supports the Trust's Mental Health and Addiction Intervention Focus Area by working to expand crisis services through improved access and referral. Trust program staff recommend this proposal be fully funded.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 5 Suicide Prevention	5.2 Crisis system improvement	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

The Ketchikan Crisis Now Community Director will be the dedicated coordinator between all facets of a Crisis Now community plan, acting as the liaison between all entities involved. The Community Director, under the Ketchikan Wellness Coalition umbrella, will continue to develop and enhance a local Crisis Now strategic plan in partnership with key stakeholders locally, statewide, and nationally and be the dedicated contact person through the development and implementation stages.

The Crisis Now strategic plan will outline the various model components, stakeholder/provider roles, timelines, budgets, actions and steps, and assets required while also addressing limitations and identifying opportunities unique to the Ketchikan community.

The Crisis Now model has been successful in other communities and demonstrates the strength in having a comprehensive and collaborative response to individuals experiencing mental health/substance use challenges. Implementing this model in a smaller community is especially complicated, with limited resources and services, yet by focusing on the strength of collaboration and integration of multiple stakeholder services it is possible to envision and implement a program in Ketchikan that will meet the needs of the Trust beneficiaries living here. To do this successfully, a director of the program is necessary. This person will function as the local individual who is able to see and manage the big picture and tie in all the sub-components of the model/plan.

EVALUATION CRITERIA

Project success will be measured by updates on work and progress towards developing a strategic plan with community stakeholders with movement towards planning and implementing a mobile integrated health program and other services to help bridge the gaps in behavioral health services.

- Continue to develop and update the activities and outputs for the Ketchikan Crisis Now Strategic Plan.
- Attend, facilitate, and assist local leaders, providers, and community stakeholders in helping to operationalize the crisis now framework and adaptations needed for Ketchikan.
- Collect data that is pertinent to the operationalization of crisis now services in the region and report out to stakeholders.
- Continue to develop a stable and sustainable funding source for standing up the crisis now system of care.

SUSTAINABILITY

This project is projected to continue after the Trust's funding ends. The plan for sustainable funding is to propose an alcohol tax. This plan has gained widespread momentum as seen through the support of the city assembly, mayor's office, fire, and EMS services, when passed, this revenue should be able to fund a mobile health team and a director of community services position. Timing for when to pass a tax like this is critical for community support and buy-in, in the interim, the plan is to braid funding together to get system setup until the alcohol tax is passed and implemented.

The interim plan will require braided funding from the city, Borough, KIC, PeaceHealth, and Public Health. These funds will help plan and implement a mobile integrated team (MIH) based in the fire department. Once the data shows that this program is producing effective results and saving money on all levels, we will advocate for an alcohol tax as a sustainable funding option at that time. The City Manager and two City Council Members have agreed to bring this plan to the Council in April and request partial start-up funding for the MIH team. They will write a letter of

interest/commitment to go along with the LOS that the City Manager already gave us. With that initial funding, the plan that we can get fully funded by braiding additional funding from PeaceHealth, KIC, the Borough, and Public Health. We have applied for a local grant and are waiting to hear if KIC Transportation grant will help us with a MIH vehicle.

WHO WE SERVE

The remote community of Ketchikan has no detox and minimal residential options for trust beneficiaries, as well as limited options for continuum of care services post emergency room release. In 2022, the Ketchikan Fire Department (KFD) reported calls had increased by 500 and about 120 of those occurred when the primary-duty KFD staff were out on other calls, requiring the use of off-duty staff. KFD reported over 15% of calls in 2021 as being related to mental health/substance use issues. The Ketchikan Crisis Line conducted 91 calls (54 individuals) related to mental health and drug use, with 59 calls (29 cases) for non-acute mental health challenges and 32 calls (20 cases) being for acute or suicidal mental health needs. In 2020, PeaceHealth and Akeela Gateway Services for Behavioral Health reported 265 calls for a Mental Health Clinician in the ER, with 67 title 47 requests. The 2020 Behavioral Risk Factor Surveillance System (BRFSS) data revealed that 11.8% of Borough residents are diagnosed with depression, 20.5% lack social/emotional support, and premature death associated with suicide is 30% and 24.5% attributed to alcohol, with an additional 12.4 % related to drugs (please note that the end of 2021 saw 10 overdoses in one week, so this percent may be outdated with our current opioid situation). RI International estimated that the number of crisis episodes in Ketchikan is about 336 a year. The Crisis Now model could alleviate the number of acute hospital bed days and unnecessary incarceration or ER visits, while also connecting beneficiaries to appropriate behavioral health services.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	1,322
Substance Abuse	1,250
Secondary Beneficiaries (family members or caregivers providing support to primary beneficiaries):	257
Number of people to be trained	20

BUDGET

Personnel Services Costs	$93,500.00
Personnel Services Costs (Other Sources)	$37,500.00
Personnel Services Narrative:	Crisis Now - Community Director Salary $68,000 Fringe Benefits/Taxes $12,279.30 Total: $80,279.30 --- KWC – Executive Director @ 15% Salary $75,000

	Fringe Benefits/Taxes $13,024.80 Total: $88,024.80 x 15% = $13,203.72 The .15 FTE ED position supports the CN Director through oversight of the position and collaboration with the Wellness Coalition which is led by the ED. ---------- Total Requested: $93,500 Ketchikan Gateway Borough and City of Ketchikan both provide match for the Executive Director's Salary $20,000 - City of Ketchikan $17,500 - Ketchikan Gateway Borough ---------- Sub Total $37,500 37,000 + 93500 = 131,000

Travel Costs	$18,900.00
Travel Costs (Other Sources)	$0
Travel Narrative:	Local Mileage - $600 represents $50 month X 12 months. Travel for Crisis Now Training – travel for 2 individuals. (Example – Improving Lives Conference) • Flights - $1400 represents 2 people at $700 a ticket (in-state travel) • Per Diem - $600 represents $60 a day X 5 days X 2 people • Lodging - $1800 represents $225 a night X 4 nights X 2 people • Transportation - $224 represents Taxi to and from airport and airport ferry ($12 round trip ferry, $100 round trip taxi, for 2 trips) Travel for Crisis Now Site Visits – 3 trips for 2 individuals. (Example - Arizona, Washington, Anchorage, Fairbanks) • Flights - $6000 represents 2 people at $1000 X 3 trips (out of state) • Per Diem - $1800 represents $60 a day X 5 days X 2 people X 3 trips • Lodging - $5400 represents $225 a night X 4 nights X 2 people X 3 trips • Transportation - $1086 represents the airport ferry ($12 round trip ferry) and a 4-day car rental ($350) X 3 trips. Total Amount $18,910

Space or Facilities Costs	$5,000.00
Space or Facilities Costs (Other Sources)	$0
Space or Facilities Narrative:	Space rental, utilities, & communication at 20%

Supplies Costs	$2,800.00
Supplies Costs (Other Sources)	$0
Supplies Narrative:	Materials, Supplies, & Outreach - $1500 General office supplies/sundries - $250 Food - $1000 Total Amount $2750

Equipment Costs	$300.00
Equipment Costs (Other Sources)	$0
Equipment Costs Narrative:	Additional workspace/storage

Other Costs	$5,000.00
Other Costs (Other Sources)	$0
Other Costs Narrative:	Indirect Costs $5000 - Indirect costs general (insurance, banking, website, technology, general operating expenses)

Total Amount to be Funded by the Trust	$125,500.00
Total Amount Funded by Other Sources	$112,500.00

OTHER FUNDING SOURCES

SOA BH Equipment Grant for MIHP Vehicle - Pending	$25,000.00
Ketchikan Community Foundation Impact Grant for MIHP Training - Pending	$50,000.00
Ketchikan Gateway Borough - Community Grant	$17,500.00
City of Ketchikan - Community Grant	$20,000.00
Total Leveraged Funds	**$112,500.00**

Crisis Now Strategic Plan FY24

Goal: Implement the Crisis Now framework to support Ketchikan's specific community needs.		
Strategy 1: Statewide collaboration on strategies for Crisis Now program		
Create positive working relationships and coordination with other Crisis Now projects. Use lessons learned from other programs to enhance and develop the Ketchikan project.		
Partners	Activities	Outputs
Anchorage **Fairbanks** **Copper River** **Mat-Su** **Juneau** **Agnew::Beck** **AMHT**	Statewide Collaboration • Strategic Plans • Evaluation • Monthly Meetings Identify opportunities to partner/leverage • Schedule one on one conversations with other programs	Bringing valuable information back to the Ketchikan Community of statewide successes Collect data and information from other programs to leverage Ketchikan growth Liaison between location, statewide, and national Crisis Now development and implementation.

Strategy 2: Media and Education		
Undertake education campaigns, general community outreach activities, stakeholder development, strategic planning, and correlation of local resources. ***Someone to Call***		
Partners	Activities	Outputs
PeaceHealth **Community Connections** **KWC** **Public Health** **KIC** **WISH** **RYC** **First City Homeless Services** **City of Ketchikan** **Ketchikan Gateway Borough** **Ketchikan Police Department and Dispatch Center** **Ketchikan, North, and South Fire Departments** **Alaska State Troopers** **Medical and Behavioral Health Clinics**	**Social Media** • Regular posts that have educational messages on mental health and provide resources • sharing partner content • 988 publications and promotion • Program updates local and statewide **Stakeholder Development** • Consistent workgroup gatherings to move forward specific projects within Crisis Now • Share training opportunities • Host trainings **Community Events** • Community Education Event • Individualized presentations for community members to solicit support • Educate and Promote 988 **988** • Program Implementation within Dispatch	Attend and facilitate all necessary meetings with the Crisis Now partners/workgroups Assist local providers with the needed support to adapt the Crisis Now model in the Ketchikan Region Collect data that is pertinent to the operation and development of the Crisis Now program and share with community and stakeholders Research and promote sustainable funding options Function as the central hub during development and implementation

Strategy 3: Mobile Integrated Healthcare Program (MIHP)		
Someone to Respond – Creation and implementation of the MIHP team		
Partners	Activities	Outputs
City of Ketchikan **Ketchikan Fire Department** **Ketchikan Gateway Borough** **Ketchikan Indian Community** **PeaceHealth** **Public Health** **Ketchikan Police Department and Dispatch Center** **Alaska State Troopers** **First City Homeless Services** **Agnew::Beck** **AMHT**	Training • Development of Staff and Staff Structure • Travel to other programs within and outside of the state • Host local trainings Supplies • Purchase and sustainability by City of Ketchikan • Maintenance and Insurance responsibility allocation • MIHP Vehicle Policies/Procedures • Work with Agnew::Beck to promote business plan development • Sustainable Funding research and development Services • Reduce risk factors for vulnerable populations • Resolve reasons for frequent non-emergent 911 calls • Follow-up on referrals received from medical providers (EMS, PeaceHealth, and medical clinics) for patients that do not qualify for home health care, yet require assistance and/or are deemed a high risk for readmission post discharge • Responds to behavioral health crises • Provide stabilization through outreach and service navigation.	Continue to work with other local partners and stakeholders to establish a community Mobile Integrated Healthcare Program plan based off of the national Crisis Now Model. Work in collaboration towards the objective to develop a MIHP that will serve our communities and improve the lives of our community members by delivering exceptional medical and behavioral heather services. Support Crisis Now buildout in Ketchikan through partnership with Trust TA Contractors Assist local providers with the needed support to operate Crisis Now framework within Ketchikan

Strategy 4: Crisis Stabilization		
Somewhere to go – Creation and implementation of a Ketchikan specific response to stabilization needs.		
Partners	Activities	Outputs
City of Ketchikan **Ketchikan Fire Department** **Ketchikan Gateway Borough** **Ketchikan Indian Community** **PeaceHealth** **Public Health** **Ketchikan Police Department and Dispatch Center** **Residential Youth Care** **Community Connections** **Alaska State Troopers** **First City Homeless Services** **Agnew::Beck** **AMHT** **TRN – Day One Center and Dylan's Place**	Training • Development of Staff and Staff Structure • Travel to other programs within and outside of the state • Host local trainings Policies/Procedures • Work with Agnew::Beck to promote business plan development • Sustainable Funding research and development Youth Services • Expand Therapeutic Foster Care with Community Connections and Residential Youth Care • If needed, assist Residential Youth Care with stabilization services Adult Services • Connect Ketchikan with others in the state that have developed and implemented crisis stabilization services and centers • Collaborate with KIC on their Navigation Center and "10 Mile Project" for a Wellness Center	Continue to work with other local partners and stakeholders to establish a community crisis stabilization plan based off of the national Crisis Now Model. Work in collaboration towards the objective to develop a crisis stabilization center that will serve our communities and improve the lives of our community members by delivering exceptional medical and behavioral heather services. Support Crisis Now buildout in Ketchikan through partnership with Trust TA Contractors Assist local providers with the needed support to operate Crisis Now framework within Ketchikan

City Manager/General Manager | 334 Front Street, Ketchikan AK 99901 | (907)228-5603

February 20, 2023
File #: MGR23-077

Lisa DeLaet
Ketchikan Community Crisis Now Director
Ketchikan Wellness Coalition

Via email: lisa@ketchikanwellness.org

RE: Letter of Support for Mobile Integrated Health Program & Team Grant Application

Dear Ms. DeLaet:

On behalf of the City of Ketchikan, this letter conveys the City's support of Ketchikan Wellness Coalition's application for the Ketchikan Community Impact Grant.

The Ketchikan Wellness Coalition is a great asset to our community, engaging multiple community partners and agencies that are working to strengthen and build a healthy community. The organization is able to focus on various community needs through the support of Task Forces, which adapt programming and focus based off the needs of the residents of Ketchikan.

The Crisis Now project, which is the development of a mobile integrated health program and team, will have a direct impact on the community by addressing identified needs at an intervention level prior to escalation of crisis care. As we have discussed in meetings with our first responders, a mobile integrated health team can be dispatched in the place of law enforcement. This would make a significant impact in reducing and preventing a law enforcement solution for a health or behavioral health matter. A mobile integrated health team deployed to meet the long-term health needs of our citizens ensures our EMT services are not overwhelmed, responses are available before a need becomes an emergency, and our local detention center does not become the de facto mental health provider for Ketchikan.

We believe that a Wellness Coalition's pursuit of such a team is invaluable to the community and fully support their application.

Sincerely,

Delilah Walsh
City Manager/General Manager

Letter of Support

Residential Youth Care, Inc.
Dustin Larna, CEO
2506 1st Avenue
Ketchikan, Alaska 99901

Alaska Mental Health Trust

To Whom It May Concern,

The Ketchikan Wellness Coalition has a great community advocating for a behavioral health crisis response plan for the city of Ketchikan and surrounding areas. As a behavioral health youth centered agency, we fully support KWC and their need for a Community Director of Crisis Now. We believe a director for this project is key in developing and implementing the action plan for Ketchikan and ensuring the process runs smoothly. The longevity, stability of services, and overall success for this project will require a full time Community Director; an individual who will be the point of contact between all partners and stakeholders. KWC has our complete and unqualified support.

Sincerely,

Dustin Larna
CEO, Residential Youth Care, Inc.

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To Whom it May Concern:

I am writing to express my full support of Ketchikan Wellness Coalition's application for grant funding.

The Ketchikan Wellness Coalition is a great asset to our community. The Ketchikan Wellness Coalition engages with multiple community partners and agencies to work to strengthen and build a healthy community. They can focus on various community needs through the support of Task Forces, which adapt programming and focus based off the needs of the residents of Ketchikan.

The KTN123 Resource Guide is helpful for many in our community, and their efforts around Mental Health First Aid are making a positive impact on our community. The Ketchikan Wellness Coalition's work towards health equity within the community is making it so healthcare is accessible and relatable for all of the Ketchikan Community.

We believe that a Wellness Coalition is invaluable to the community and support their development and continuation.

Kind Regards,

DocuSigned by:
DBC21D9E6AE443E...

Deborah Asper

EXECUTIVE DIRECTOR & CEO

632 Park Avenue Ketchikan, AK 99901 · (907) 225-0888
deborah@firstcityhomeless.org · firstcityservices.org

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Alaska Mental Health Trust Authority

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MEMO

To: Verné Boerner - Program & Planning Committee Chair
Date: April 20, 2023
Re: FY23 Contract Funds Request
Amount: Not to Exceed $125,000.00
Project Title: Data Development for Traumatic & Acquired Brain Injury and Alzheimer's Disease and Related Dementias

REQUESTED MOTION:

"The Program & Planning Committee approves up to $125,000 for a contract for Data Development for Traumatic & Acquired Brain Injury and Alzheimer's Disease and Related Dementias. These funds will come from the FY23 Comprehensive Program Planning & Consultative Services budget line of the Non-Focus Area section of the budget."

Assigned Program Staff: Michael Baldwin

STAFF ANALYSIS

The Trust has received feedback from stakeholders and partners through several budget development cycles, and stakeholder surveys, that there is an increased need for data related to Trust beneficiaries experiencing Traumatic and Acquired Brain Injuries (TABI) and Alzheimer's Disease and Related Dementias (ADRD). While there are a growing number of TABI and ADRD-related initiatives, stakeholders and key partners have not had the capacity to coordinate and map out a comprehensive resource that addresses the data needed to help support decision-making about funding, policy, intervention, and support. In the last budget development cycle, the Department of Health and Division of Public Health leadership identified this as a need and a way the Trust can provide support for their initiatives.

Funds will be used to secure a contractor through a competitive Request for Proposal (RFP) process, which will be used to conduct a thorough scan of the data needed to assist the Trust, and its partners in planning, to improve the quality of life, and continuum of care for Trust beneficiaries experiencing TABI and ADRD. Specifically, it will identify what data is available, and what data is to be developed, and prioritize recommendations on the data needed to forecast the needs of Trust beneficiaries. It is anticipated that there will be a robust stakeholder engagement process as part of the data development work that will result in a comprehensive resource. This information will be made available to our external facing partners and hosted on the Trust website.

This project is aligned with Comp Plan Goal 9 (Workforce, Data, and Funding), objective 9.5 (Data-driven decision making). The product of this project is aligned with, and will support, additional Comp Plan goals and objectives that include, but are not limited to, Goals 2 (Healthcare), Goal 6 (Protecting Vulnerable Alaskans), Goal 7 (Services in the Least Restrictive Environments), and Goal 8 (Services in Institutional Settings).

When comparing similar past projects that involve reviewing available data sources, stakeholder engagement, and prioritization of recommendations, it is estimated that an allocation of not to exceed $125,000 will be sufficient to complete this project.

Trust staff recommends the approval of this project.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 9 Workforce, Data, & Funding	9.5 Data-driven decision making	While Goal 9, Objective 9.5 is identified, this project is also aligned with additional Comp Plan Goals 2,6,7, and 8.

PROJECT DESCRIPTION

PROJECT DESCRIPTION

We have heard from many stakeholders through several budget development cycles that there is a need for more comprehensive data related to Trust beneficiaries experiencing Traumatic and Acquired Brain Injuries (TABI) and Alzheimer's Disease and Related Dementias (ADRD). A lack of actionable data has hindered the development and implementation of services for Trust beneficiaries. Over the past year, Trustees have had site visits and several presentations from partners, highlighting the need for more data to assist in the programmatic, funding, and policy decision-making to improve the continuum of care for Trust beneficiaries experiencing TABI and ADRD in Alaska.

There are several different partners working on TABI and ADRD-related initiatives, but they don't always have data or know what data they need or how to get it. It's not always clear what data is available, or what sources are available. During the most recent budget development process, leadership from the Department of Health, and Division of Public Health, indicated they are attempting to stand up TABI and ADRD-related initiatives, and on-board staff to support these initiatives, however, they didn't have the staff or funding capacity to coordinate an effort to identify the data needs to support these efforts. They indicated contract support from the Trust to help facilitate the data development agenda would be beneficial and help in the implementation of their program and lay the groundwork for future efforts.

In order to advance and expand TABI and ADRD-related systems initiatives and improvements in the continuum of care, we are using a public health data approach to obtain a baseline

understanding of the needs of Trust beneficiaries. The work to improve the continuum of care for beneficiaries experiencing TABI and ADRD have similar data needs and support.

An example of an ADRD-related initiative is the Trust's support of the Alaska Dementia Action Collaborative, which is supported by a Trust-funded contractor. The Department of Health, Division of Public Health would like assistance in clarifying data sources, and the scope of providers, services, and reimbursement to help lay the groundwork for this effort.

The Department, and Division's implementation of HB308 Dementia Awareness & Healthcare Capacity, which was recently signed into law, requires that the Division develop and implement an evidence-based, data-informed statewide dementia awareness campaign that includes the promotion of screening, early diagnosis, and treatment of dementia, and assess appropriate levels of care and workforce capacity necessary for the population of persons affected by dementia in the state. The law requires that the Department:

- use a public health approach to improve services and awareness of dementia and educate the public on strategies related to risk reduction, early diagnosis, and disease management.
- collect and monitor data to set priorities, develop public health actions, and address the social effects of Alzheimer's disease and other forms of dementia;
- focus on changing systems, environments, and policies to promote risk reduction, improve early diagnosis, prevent and manage comorbidities, and avoid hospitalizations;
- work with systems of care to identify ways to improve early diagnosis, primary care, care coordination, and development of the workforce for delivery of services to persons affected by dementia;
- engage community members and stakeholders in decision-making; and
- develop a statewide strategic plan to improve systems of care infrastructure and awareness of dementia.

While not required by statute, this public health approach and associated data elements are also needed to advance TABI-related efforts.

The scope and methodology of the project will be finalized in collaboration with Trust partners to ensure that desired elements are addressed. Sources of data are anticipated to be identified through stakeholder engagement, a scan of available Alaskan-specific data (Medicaid claims, Behavioral Risk Factor Surveillance System, or the Alaska Trauma Registry), as well as potential federal sources, in order to provide comprehensive cataloging of data needs.

In addition to supporting the Trust and Department's TABI and ADRD-specific initiatives, the product of this work is expected to provide information that can assist the implementation and monitoring of the *Comprehensive Integrated Mental Health Program Plan* and *Alaska Scorecard*. Data from this effort can inform additional statewide efforts such as *Healthy Alaskans 2030*. The Trust will be able to use this resource to guide our future budget development work, programming, funding, and policy decision-making. Additionally, stakeholders and partners will be able to use it in their planning, outcomes monitoring, and funding requests for local, state, and

federal grant opportunities. It is anticipated that the results would be disseminated in a variety of formats to ensure the widest possible use of the information.

EVALUATION CRITERIA

Successful completion of this project will result in a final product that brings together a comprehensive list of available data, needed data, and recommendation and prioritization of data development required to improve the system of care for Trust beneficiaries experiencing Traumatic and Acquired Brain Injuries and Alzheimer's Disease and Related Dementias in Alaska. The results, and sharing of this information with external partners, may result in future funding requests to fund activities to develop or analyze data identified in this project.

BUDGET

Costs	Not To Exceed $125,000.00
Costs Narrative:	This funding will be used to secure a contractor to facilitate and develop the TABI/ADRD-related data resource

Total Amount to be Funded by the Trust	$125,000.00
Total Amount Funded by Other Sources	None currently

Trust
Alaska Mental Health Trust Authority

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

MEMO

To:	Verné Boerner - Program & Planning Committee Chair
Date:	April 20, 2023
Re:	FY24 Other Priority Area – Early Childhood Intervention & Prevention Grant Request
Fund Source:	FY24 Improve Social Determinants of Health for Families and Young Children: Parenting & Family Supports, Home Visiting & Related Programs
Amount:	$265,000.00
Grantee:	Southcentral Foundation
Project Title:	Integrated Parenting & Family Support Services

REQUESTED MOTION:

"The Program & Planning Committee approves a $265,000 FY24 authority grant to Southcentral Foundation for the Integrated Parenting & Family Support Services project. These funds will come from the Improve Social Determinants of Health for Families and Young Children: Parenting & Family Supports, Home Visiting & Related Programs budget line in the FY24 budget."

Assigned Program Staff: Jimael Johnson

STAFF ANALYSIS

Southcentral Foundation (SCF) provides a wide range of health and social services to Alaska Native families and individuals living within Alaska's southcentral region. Through rigorous planning and development processes, SCF has identified the need to build from past successes and provide a more comprehensive array of culturally focused early intervention and home visiting support options to serve customer-owner families with young children. High quality home visiting services have been identified by Trust advisory boards and partners as a key strategy to improve health and developmental outcomes for Trust beneficiary families with young children, particularly for families that have experienced historical and complex trauma. Home visiting programs for beneficiary families with young children are highlighted in the FY24 Trustee approved budget which is identified as the proposed funding source for this project.

Trust funding is requested to blend with SCF agency and potential federal funding to implement the evidence based "Family Spirit" home visiting model for the first time in Alaska. Family Spirit is an evidence-based, culturally tailored home-visiting program of the Johns Hopkins Center for Indigenous Health to promote optimal health and wellbeing for parents and their children. The model combines the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum as a core strategy to support young families. Parents gain knowledge and skills to

promote healthy development and positive lifestyles for themselves and their children. This program has been developed, implemented, and evaluated by the Johns Hopkins Center for Indigenous Health in partnership with the Navajo, White Mountain Apache, and San Carlos Apache Tribes since 1995. SCF has identified the Family Spirit model due to its cultural adaptability and the ability to support Trust beneficiary families that fall outside the eligibility standards of other evidence-based practice models, such as single fathers, foster/kinship, and adoptive families.

The Family Spirit model has been introduced to tribal and community partners statewide through the Alaska Impact Alliance with interest expressed from multiple organizations. SCF is willing to engage in discussions with the Trust and these additional interested partners with the potential to provide mentorship and explore the potential for shared implementation costs. SCF is well poised as the largest tribal health organization in Alaska to initiate cultural adaptations to the Family Spirit model that can be used for replication in smaller and more rural/remote communities throughout the state.

Trust staff recommends this project for funding in alignment with strategies related to the Early Intervention and Prevention priority area, particularly for families involved with or at high risk for child welfare intervention. Evidence-based home visiting and programs that support young beneficiary families are identified in Comp Plan Goals 1 and 6, specifically Objective 1.3 (Reduce the impact of Adverse Childhood Experiences) and 6.1 (Prevent children maltreatment by ensuring resilient families).

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 1 Early Childhood	1.3 Reduce the impact of ACEs	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

The goal of the Integrated Parenting & Family Support Services project is to prevent mental illness in parents of young children and increase early detection of developmental delay through integrated family support service preconception for Alaska Native and American Indian families. This goal will be reached through the development and delivery of Parent Partner services prenatal through the child's 5th birthday in the areas of Infant and Early Childhood Mental Health Services, Social Emotional Development, Nutrition, Growth, and Development as a standard of care.

Southcentral Foundation (SCF) serves 4,670 children ages 0-5. A majority of these children reside in Anchorage or the Matanuska-Susitna Borough. SCF has worked for decades to improve the health outcomes for Alaska Native and American Indian children. Over 20 years ago, SCF started the Nutaqsiivik program to reduce the rate of infant deaths amongst this population. As a result, the infant deaths did reduce, but a great need for parents to receive psychosocial support services during the first 5 years of life was discovered in the data. SCF serves on average 260 families a year through the Nutaqsiivik program. The services provided start prenatally through age 2. SCF

serves families ineligible for these services that require additional support. As part of the New Generations work being done at SCF, it has become clear that families really need a better understanding of Infant & Early Childhood Mental Health and are at risk for postpartum depression. Since the population has extensive intergenerational trauma and experienced disruption in the passing down of traditional parenting practices, home visiting support services are warranted.

SCF would use the requested grant funds for startup costs associated with piloting Family Spirit home visiting services accessible to families through their integrated primary care team. Family Spirit® is an evidence-based, culturally tailored home-visiting program of the Johns Hopkins Center for Indigenous Health to promote optimal health and wellbeing for parents and their children. Family Spirit combines the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum as a core strategy to support young families. Parents gain knowledge and skills to promote healthy development and positive lifestyles for themselves and their children. The decision to implement Family Spirit is based on the work completed under an Indigenous Project LAUNCH grant from the US Department of Health and Human Services. The New Generations team and stakeholder group worked to assess available parenting curriculum and home visiting models as part of that grant and determined that Family Spirit would be the best fit for supporting families with children ages 0-5. The grant required a systems analysis for services provided to support Alaska Native and American Indian Families in five areas, including parenting support services. SCF will be seeking that funding again, but it is not guaranteed and would be insufficient to cover the full costs of Family Spirit implementation.

During the pilot year, SCF aims to support 150 families with these new services using Behavioral Health Consultants to better gauge the acuity of families accepting Parent Partner services. The team will work with Family Spirit and a consultant to bolster the IECMH component of the model and infuse materials with Alaska Native approaches to parenting. The intent is to increase the number served annually and expand services to rural clinics in future years through program expansion staffed with paraprofessionals. As an evidenced-based home visiting program, Family Spirit has tangible outcome measures that prove the model's effectiveness.

EVALUATION CRITERIA

The Integrated Parenting and Family Support Services project goal is for Alaska Native and American Indian families to have access to integrated family support service preconception through a child's 5th birthday in the areas of IECMH, Social Emotional Development, Nutrition, Growth, and Development as a standard of care. This is part of a much larger comprehensive services plan for families and young children preconception through age 8 called New Generations. The process and outcome measures for the Parent Partner Family Spirit component are:

# of parents enrolled in parent partner services
# of parents receiving parenting support services
# of children 0-5 with parents receiving parent partner services
# of children screened for developmental delays
# of children referred to early intervention programs

# of parents receiving evidence-based mental health services
# of parents referred for mental health and related services
# of parents screened for mental health for related services
# of parents receiving training in prevention or mental health promotion

SCF is building off the Nutaqsiivik program's successful outcomes for enrolled families and is working to make similar services available regardless of whether the child's caregiver is their biological mother or not. The Nutaqsiivik program is a prenatal program and therefore only enrolls pregnant women. The Parent Partner program would be open to grandparents raising grandchildren, foster parents, fathers, temporary custodians or guardians and families that relocated to the service area that already have young children. These existing measures will track progress for enrolled families.

SUSTAINABILITY

The funds requested will make it possible for SCF to implement Family Spirit. This initial investment will allow the Family Spirit model to be tailored to better fit the needs and cultural values of Alaska Native and American Indian families in Alaska. Additionally, funds requested to support an IECMH consultant to bolster the model content to infuse it with IECMH principles is an important aspect of this project. These modifications and coverage of the initial training and implementation costs will continue to pay dividends past the end of this grant.

SCF is heavily committed to the integration of services for families and young into primary care and this project is just one component of the New Generation work. Grant funding is being sought to support the expansion of the proposed project and other aspects of Parent Partner and New Generations service plan. As an important foundation piece to the work, efforts supported by this grant will be sustained by SCF potentially through the reallocation of existing resources. Exploring opportunities to bill for Parent Partner services will also be explored by SCF's primary care leadership team.

WHO WE SERVE

As a prevention focused project, the real intent is to prevent mental illness amongst parents and children, and developmental delays that can lead to disabilities to effectively reduce the future beneficiary population. In cases where mental illness or developmental delays or disabilities already exist, early identification, intervention and treatment are paramount to the success of Trust beneficiaries served by SCF and Parent Partner services. The reality is that co-occurring conditions are commonplace with families often facing substance use or misuse; developmental disabilities; and multiple mental illness diagnoses.

During the pilot year, at least two behavioral health consultants serving as Parent Partners will be trained in Family Spirit and begin providing home visiting services. The New Generations team, including the Outpatient Pediatrics Behavioral Health Clinical Supervisor and an IECMH Consultant will also complete Family Spirit Training. The aim is to serve at least 150 families using the Family Spirit Model during the pilot year. As additional funding is secured, services are expected to expand to 240 families a year with further expansion anticipated as resources become

available. Between the Parent Partner program and Nutaqsiivik, SCF would be able to provide home visiting services to 500 families per year. These counts are unique families and would cover more than one person, depending on the household structure and number of children in the home, resulting in a much higher community impact than is estimated above.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	150
Number of people to be trained	25

BUDGET

Personnel Services Costs	$107,100.00
Personnel Services Costs (Other Sources)	$16,800.00
Personnel Services Narrative:	AMTHA Funded Positions: 1. Parent Partners (1.1 FTE for $81,700)-Two Parent Partners will be trained in Family Spirit and provide family support services to families. They will also work with the New Generations team and consultant on modifications to the Family Spirit model based on their experience with providing behavioral health services in the homes of families. The fringe rate is 31.05% for a total of $25,400. SCF Funded Position: 1. Clinical Supervisor (.115 FTE for $13,100)-The Clinical Supervisor oversees the clinical aspects of the Parent Partners' work and provides clinical direction for the New Generations Team. The fringe rate is 30.87% for a total of $3,700.

Other Costs	$157,900.00
Other Costs (Other Sources)	$49,500.00
Other Costs Narrative:	AMHTA Funded Other Costs: Contractual 1. Family Spirit Affiliation Fees: Fees associated with accessing and using the evidence-based model and receiving support from the model developer. The annual cost is $16,000. 2. Family Spirit Site Visit: Each year the model conducts site visits to ensure organizations are sufficiently supported and are delivering home

	visits with fidelity to the model. The annual cost is $11,700. 3. Alaska Native Cultural and IECMH Modification Consultant: A subject matter expert in IECMH and Alaska Native culture will be contracted to support modifications to the Family Spirit materials and services. Costs are estimated at $250 per hour for 75 hours totaling $18,750. Education and Training Fees: 1. Family Visit Home Visitor Training: Training is budgeted at $3,000 per person with 15 being trained for a total of $45,000. Family Spirit will travel to Alaska to conduct the trainings, which will reduce overall costs. Additional employees that will become parent partners will be attending this training. 2. Advance Supervisor Training: Training is budgeted at $4,000 per supervisor with 5 being trained for a total of $20,000. Clinical Supervisors overseeing Parent Partners will receive this training to support SCF in adhering to model delivery requirements. 3. Family Spirit Observer Fees: Training is budgeted at $300 per person with 6 employees to be trained for a total of $1,800. This training is for department managers, administrators, evaluators and other positions that support the work of the parent partners. 4. Family Spirit Training Education Materials: Material costs are budgeted at $400 per employee with 25 employees to be trained. Indirect Costs: 1. Indirect costs of $34,650 are requested, which is 15% of the direct costs requested. SCF Funded Other Costs: 1. Indirect costs of $5,729 are applied to SCF matched personnel at a indirect cost rate of 34.1% 2. Indirect cost shortfall for direct costs request from AMHTA totals $43,771, which SCF will cover as part of its contribution to the project.

Total Amount to be Funded by the Trust	$265,000.00
Total Amount Funded by Other Sources	$243,300.00

OTHER FUNDING SOURCES

Southcentral Foundation	$66,300.00
Project LAUNCH (federal SAMHSA) – PENDING (annual projection of potential 5-year award)	$177,000.00
Total Leveraged Funds	**$243,300.00**

Trust
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MEMO

To:	Verné Boerner - Program & Planning Committee Chair
Date:	April 20, 2023
Re:	FY24 Housing & Home & Community Based Services Focus Area Allocation
Fund Source:	FY24 Services & Supports Identified as Priorities in TABI and ADRD State Plans
Amount:	$500,000.00
Grantee:	Southcentral Foundation
Project Title:	Traumatic and Acquired Brain Injury (TABI) Phasic Implementation Plan for Identification, Intervention, and Continued Assessment of Capacity and Community Infrastructure Building

REQUESTED MOTION:

"The Program & Planning Committee approves a $500,000 FY24 Housing & Home & Community Based Services Focus Area Allocation to Southcentral Foundation for the Traumatic and Acquired Brain Injury (TABI) Phasic Implementation Plan for Identification, Intervention, and Continued Assessment of Capacity and Community Infrastructure Building project. These funds will come from the Services & Supports Identified as Priorities in TABI and ADRD State Plans budget line in the FY24 budget."

Assigned Program Staff: Kelda Barstad

STAFF ANALYSIS

Southcentral Foundation is an Alaska Native-owned, nonprofit health care organization serving nearly 65,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Borough and 55 rural villages in the Anchorage Service Unit (ASU). The ASU is a catchment area determined by the Indian Health Services (IHS) and extends across 107,413 square miles in south central Alaska from the Aleutian Chain and Pribilof Islands on the west coast all the way east to the Canadian border. SCF is a well-established region-wide integrated health system and a holistic vision of a Native Community that enjoys physical, mental, emotional, and spiritual wellness.

Southcentral Foundation (SCF) co-owns and operates the Alaska Native Medical Center (ANMC) with the Alaska Native Tribal Health Consortium (ANTHC). Whereas most Southcentral Foundation programs are offered to residents of Anchorage, the Matanuska-Susitna Valley, ANMC serves the entire Alaska Native and American Indian population of the state – an estimated 108,000 people

(based on U.S. Census data). SCF's primary service role is Primary Care services for the ASU, but also hold state-wide responsibilities for a sub-set of ANMC specialty services. Details regarding the level of service provided by Southcentral by regions and communities is available at https://www.southcentralfoundation.com/about-us/who-we-serve/.

Incorporated in 1982 under the Tribal authority of Cook Inlet Region, Inc., Southcentral Foundation is the largest of the CIRI nonprofits, employing more than 2,500 people in more than 80 programs. Southcentral Foundation's Vision is a Native Community that enjoys physical, mental, emotional, and spiritual wellness. The organization has developed and implemented comprehensive health-related services to meet the changing needs of the Native Community, and support individuals and families on their wellness journey. SCF is now responding to a community need to identify brain injuries and intervene with support services to ensure the best possible outcomes for SCF's customer-owners.

Statewide conversations about the high rates of brain injury in Alaska have been ongoing for many years. With the publication of the Alaska Native Injury Analysis in 2020, SCF knew action needed to be taken. The report revealed that for statewide Alaska Native/American Indian (AN/AI) people:

- The TBI hospitalization rate of AN/AI people was 2.1 times that of non-Native Alaskans (18.1 and 8.5 per 10,000, respectively).
- 18.6% of all injury hospitalizations involved TBI, similar to non-Native patients (19.4%).
- Patients aged 70 years and older had the highest rate of TBI among AN/AI people (29.4 per 10,000), followed by 20 to 29 year olds (26.0 per 10,000), and 40 to 59 year olds (20.9 per 10,000).
- The full report can be accessed here: http://anthctoday.org/epicenter/publications/InjuryAtlas2020/2020_AlaskaNative_InjuryAtlas_FullReport.pdf (page 77 is the beginning of the brain injury data)

While work was necessarily delayed as SCF was responding to the emergent health care needs of COVID, work to address this gap in the system began as soon as it was practical. In 2022 the Trust partnered with SCF to complete the planning necessary for this proposed project. The Traumatic and Acquired Brain Injury (TABI) Early Identification and Intervention Services Planning, Design and Capacity Building identified the best practices selected to move forward with implementing TABI services for SCF's customer owners.

The TABI Phasic Implementation Plan for Identification, Intervention, and Continued Assessment of Capacity and Community Infrastructure Building project will create and implement processes for early identification and intervention services for TABI that require system level changes. There are three identified phases: 1) Adults empaneled to SCF clinics residing in the Municipality of Anchorage and the Matanuska-Susitna Borough; 2) Adults empaneled to SCF's rural Community Health Centers; 3) Children empaneled to Alaska's Tribal Healthcare System. The intent is to ensure individuals with TABIs are identified and provided supportive services at the earliest point in time possible to maximize their quality of life. Links to the clinic specific information for SCF Clinics participating in the proposed TABI work can be found below:

- Physical Therapy, Occupational Therapy, and Exercise: https://www.southcentralfoundation.com/services/physical-therapy-exercise/
- Child and Family Developmental Services: https://www.southcentralfoundation.com/services/cfds/

- Fireweed Clinic and Adult Outpatient Services: https://www.southcentralfoundation.com/services/behavioral-health/fireweed-aos/

The TABI Phasic Implementation Plan for Identification, Intervention, and Continued Assessment of Capacity and Community Infrastructure Building project has a long-term goal of ensuring people served by SCF are routinely screened for TABI and, when indicated, assessed, diagnosed and referred to services as quickly as possible. This project improves access to person-centered health care for the beneficiary population who has a traumatic brain injury with an impact across focus areas. The portion of the project that serves youth offers the opportunity to rehabilitate the brain injury early, avoiding the long-term cognitive effects of going without treatment. TABIs are known to be dramatically underdiagnosed in justice involved and houseless populations and without treatment can create additional barriers for beneficiaries to obtain basic needs, employment, and benefits. There are currently few services available to beneficiaries with a traumatic brain injury. A project of this nature has the potential for replication across providers to create a system change in access to health care services for beneficiaries with a traumatic brain injury. Trust program staff recommend this project for full funding.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 2 Healthcare	2.3 Person-centered healthcare	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

The project will create and implement processes for early identification and intervention services for traumatic and acquired brain injury (TABI) that require system level changes. There are three identified phases: 1) Adults empaneled to SCF clinics residing in the Municipality of Anchorage and the Matanuska-Susitna Borough; 2) Adults empaneled to SCF's rural Community Health Centers; 3) Children empaneled to Alaska's Tribal Healthcare System. The intent is to ensure individuals with TABIs are identified and provided supportive services at the earliest point in time possible to maximize their quality of life.

According to the 2020 Alaska Native Injury Atlas, Alaskans have a high rate of traumatic brain injuries (TBI), which are present in 19.2% of all injuries reported to the Alaska Trauma Registry. Alaska Native people sustained 30% of TBIs, which is disproportionate to the percentage of Alaska Native people in the state with falls, motor vehicle accidents, assault and all-terrain vehicles being the leading causes. Additionally, the rate for Alaska Native people with TBI Hospitalizations was 25.4 per 10,000 people in Anchorage, which is nearly three times the state-wide Non-Native rate and 40% higher than the state-wide Alaska Native and American Indian rate. The rates for Alaskan children ages 0-4 in 2018 reached 110.9 per 10,000; ages 5-9 was 56.1; 10-14 hit 73.5 and 15-19 stood at a staggering 113.7.

Southcentral Foundation (SCF) would use the requested grant funds for the Traumatic and Acquired Brain Injury (TABI) Phasic Implementation Plan for Identification, Intervention, and Continued Assessment of Capacity and Community Infrastructure Building project is designed to help support education and treatment opportunities for those who have experienced a TABI. The implementation plan for improved and expanded best practices is based on the 2022 TABI Early Identification and Intervention Services Planning, Design, and Capacity Building gap analysis project funded by the Alaska Mental Health Trust Authority (AMHTA) performed in 2022. Grant funds will target a phasic approach to creating and implementing processes for early identification and intervention services for TABI that require system level changes. There would be three identified phases: 1) Adults empaneled to SCF clinics residing in the Municipality of Anchorage and the Matanuska-Susitna Borough; 2) Adults empaneled to SCF's rural Community Health Centers; 3) Children empaneled to Alaska's Tribal Healthcare System. The intent is to ensure individuals with traumatic or acquired brain injuries are identified with assessment tools, diagnosed, and interventions and supportive services are provided at the earliest point in time possible to maximize their quality of life in the short and long terms. Requested grant funds are focused on new personnel, training, and equipment needed to initiate enhanced or new services needed based on the gap analysis findings and the implementation plan, currently being developed as part of the planning year.

Site visits to leading adult and pediatric brain injury centers around the nation has made it clear that a comprehensive cross organizational, divisional, departmental and specialist interdisciplinary team is needed. The TABI planning grant conversations have increased coordination with primary and specialty care clinics; behavioral health and inpatient specialties at ANMC.

ANMC and SCF are active participants in the Brain Injury Council of Alaska (BICA). During the planning year, SCF's TABI team has identified system gaps, which have also been identified by BICA, as community/state gaps to provide wrap around care for people who have experienced TABI. In partnership with community groups, like BICA, establishing key team players and education for all is required to reach the aims from the Alaska State Plan for Brain Injury: Prevention, Awareness, Resources, Data, and Infrastructure.

EVALUATION CRITERIA

Project success will be determined by establishing a baseline within the system of customer-owners who have been identified as having a history of head injury. For phase one, the data needed to establish the baseline will come from an additional question being added to the patient history completed when empaneled in primary care and incorporating SCF's Aging Well Initiative that has identified customers at risk of falling. This will be done in process with the STEADI Workflow (already performed as Aging Well processes) and identifying those in need for a Functional Assessment. They are identified by asking: 1) Do you feel unsteady when standing or walking? 2) Are you worried about falling? 3) Have you fallen in the past year? If yes, how many times and were you injured? A Functional Assessment, currently, can be performed by therapists throughout Anchorage and Valley. The following metrics are already created in the electronic health records and are in the process of being captured in SCF's data mall system that uses Tableau to produce reports. By utilizing these measures, initiatives and data systems, the TABI

team will be able to follow customers throughout the healthcare system and assess improvement in reductions of fall risk and increased independence and quality of life. The outcome measures include:

- Timed Up and Go (TUG)
- 30-second Chair Stand
- The Four Stage Balance Test
- Katz Index of Independence of Activities of Daily Living and Instrumental Activities of Daily Living

SUSTAINABILITY

The funds requested will make it possible for SCF, ANTHC, and ANMC to have professionals obtain education and training to specifically support beneficiaries with TABI. The intent is to continue to scale up the efforts, education, training, and infrastructure with local and rural communities to provide a continuum of care. By investing funds in training the workforce and especially developing local Certified Brain Injury Specialist trainers, the access to training and education for the state will be far more accessible. Once established, sustainability comes from increased local resources. The purchase of specific equipment and supplies to support TABI diagnosis and treatment will endure past the grant funding period.

SCF is heavily invested in this project and expanding organizational resources beyond the detailed match for this application. Permanent system changes will be made through this project. In partnership with the community members of BICA, other healthcare entities, State of Alaska, and especially AMTHA support, SCF can improve care for those with a TABI state-wide both in the short and long term.

WHO WE SERVE

SCF's TABI team will be working with customer owner Trust beneficiaries defined as having a traumatic or acquired brain injury (TABI) and an established set of metrics to provide them with treatment and services to improve and protect their quality of life. The caregivers for beneficiaries with TABI that have limited mobility or independence will also be supported and educated by the providers involved with this project. The aim of the TABI work is to improve care coordination between currently siloed specialty services; protect, maximize and improve the quality of life for individuals with TABI; and to reduce or eliminate risks of further TABIs through early identification, prevention services and TABI specific treatments. The Katz Index of Independence of Activities of Daily Living and Instrumental Activities of Daily Living will be an important measure for SCF and ANMC to help gauge the quality and impact of services provided.

It is important to note that other Trust beneficiaries will likely benefit as well, since co-occurring disorders are common amongst individuals with TABI, such as Alzheimer's, dementia, developmental delays and mental illness. By pulling in individuals at risk of falling, the intent is to prevent TABIs from occurring in the first place or to keep further TABIs from occurring.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Traumatic Brain Injuries:	350
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	150
Number of people to be trained	25

BUDGET

Personnel Services Costs	$229,300.00
Personnel Services Costs (Other Sources)	$84,000.00
Personnel Services Narrative:	AMHTA Funded Positions: 1. Speech and Language Pathologist (0.75 FTE grant salary of $75,600)-Oversees assessment and treatment for cognition, communication, stuttering, dysphagia, aphasia, vocal cord dysfunction, swallowing disorders. 2. Case Management Support (0.20 FTE grant salary of $9,427)-Works with the team to develop positive relationships with families served by SCF to assure connection to current programs serving children and families. This positions also connects customers to services, to assists them directly with information and referral sources, and facilitates awareness of services at SCF and within the community for TABI; 3. Program Coordinator (0.50 FTE grant salary of $24,400)-Works closely with the project leads to establish and coordinate outreach with community partners, resources, and customers. They will assist with ordering of supplies and coordination of meetings, meeting agenda's, meeting notes, and training registration; 4. Evaluator (0.20 FTE grant salary of $20,484)-Conducts the local implementation and impact evaluation and will be responsible for all data collection and compilation of data for this project. Evaluator responsibilities include conducting focus groups and surveys, synthesizing project data from multiple sources, conducting qualitative and quantitative analysis, tying results to key evaluative questions, and bringing results to the project team on a regular basis; and

	5. Nurse Case Manager (0.40 FTE grant salary of $48,269)-Provides care coordination of healthcare journey throughout the Alaska Native Medical Center and community re-integration, place referrals and follow up guidance as needed. Requested funding amount for wages is $178,180. Fringe rate averages 28.69% for these positions and the amount requested is $51,120. Southcentral Foundation (SCF) Funded Positions: 1. Clinical Specialist Registered Nurse (0.20 FTE match salary of $27,543)-Advises and guides the implementation of staff receiving Certified Brain Specialist certifications. Participates in workgroups, committees, and advisory groups; and 2. Outpatient Physical Therapists (0.35 FTE match salary of $36,923)-Provide assessment and treatment of customer with TABI including but not limited to vestibular treatment, balance training, conditioning, strengthening, persistent pain management, and gradual return to activity. In addition, they are becoming CBIS Trainers to facilitate project sustainability by training SCF's workforce on TBI, as well as that of other organizations in Alaska serving individuals with a TABI diagnosis. Match Wages total $64,466. Match Fringe: rate averages 30.3% for these positions and the match amount totals $19,534.

Supplies Costs	$14,000.00
Supplies Costs (Other Sources)	$0.00
Supplies Narrative:	Funds are requested to support the purchase of supplies to support the therapists in their work with individuals that have a TABI diagnosis. Two (2) Computerized DVAT at $3,500 each; Three (3) SenMo Cor Cervico-ocular laser trainers at $150 each; Five (5) Airex balance beam at $83 each; Two (2) wobble and rocker board sets at $500 each; a Portable video frenzels at $4,000 each; Optokinetic drum and flag

	supplies totaling $1,019; and Two (2) Mirror balls and motors at $58 dollars each.

Equipment Costs	$199,000.00
Equipment Costs (Other Sources)	$0.00
Equipment Costs Narrative:	Funds are being requested to purchase an Orion comprehensive rotational chair. This chair would live within our Audiology sound testing room that is integrated into the Child and Family Development Services clinic. The rotational chair is the gold standard in diagnosing bilateral vestibular loss and is used to investigate whether dizziness may be due to a disorder of the inner ear or the brain. The amount requested is $199,000. As prices continue to rise on goods, SCF will pay for any additional equipment, shipment or installation costs that exceed the amount requested.

Other Costs	$57,700.00
Other Costs (Other Sources)	$80,000.00
Other Costs Narrative:	AMHTA Funded Other Expenses Training and Education ($18,400): 1. Cognitive Behavioral Therapy for 6 employees at $550 per person for a total of $3,300. 2. Certified Brain Injury Specialist (CBIS) training for 6 people at $330 per person for a total of $1,980. 3. Emory Vestibular First Certificate for 6 people at $88 per person for a total of $528. 4. American Institute of Balance Vestibular Assessment and Management Course for 1 employee for $6,004. 5. Certificate in Competence in Vestibular Rehabilitation for 1 employee for $1,600. 6. American Congress of Rehabilitation Medicine (ACRM) annual conference fee for 1 employee for $150. 7. ACRM full conference and pre-conference fees for 3 employees for a total of $4,838 Indirect Costs: SCF's Indirect Cost Rate for On-site programs is 34.1% but has been capped at 15% for requested AMTHA funds. Equipment does not have indirect applied to it, so the effective indirect rate for this request is 8% totaling $39,300. SCF Matched Other Costs

	1. Indirect Costs for direct dollars matched by SCF at 34.1% totals $28,644. 2. Indirect Costs shortfall on AMHTA requested funds totals $51,356.

Total Amount to be Funded by the Trust	$500,000.00
Total Amount Funded by Other Sources	$164,000.00

OTHER FUNDING SOURCES

Southcentral Foundation-SECURED	$164,000.00
Total Leveraged Funds	**$164,000.00**

Trust
Alaska Mental Health Trust Authority

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MEMO

To: Verné Boerner - Program & Planning Committee Chair
Date: April 20, 2023
Re: FY23 Partnership Grant Request
Amount: $400,000.00
Grantee: Community Connections, Inc.
Project Title: Therapeutic Foster Care: Expansion and Sustainability

REQUESTED MOTION:

"The Program & Planning Committee approves a $400,000 FY23 Partnership grant to Community Connections, Inc. for the Therapeutic Foster Care: Expansion and Sustainability Project."

Assigned Program Staff: Jimael Johnson

STAFF ANALYSIS

Community Connections provides a range of assistance and support services for Trust beneficiaries living in the southeast region of Alaska, including Ketchikan and Prince of Wales Island. Community Connections has successfully provided treatment/therapeutic foster care services to youth in southeast communities for over 23 years and wishes to partner with the Trust and other funders to expand access to this critical service through the purchase of two homes in identified Southeast Alaska communities. High quality therapeutic foster care services have been prioritized by Trust advisory boards and partners as a key strategy to keep young beneficiaries with complex behavioral health care needs out of institutional settings and as close to their home communities as possible.

Trust funding is requested to blend with Community Connections agency and potential Rasmuson funding to purchase two homes for expanded therapeutic foster care services in the Ketchikan and Prince of Wales Island communities. Adequately sized homes for this service (3-5 bedrooms) are currently priced beyond the reach of many highly qualified families who would like to become therapeutic foster care providers in service of young Trust beneficiaries. Community Connections proposes to alleviate this barrier to care by purchasing homes directly and then partnering with qualified families to provide services in the agency owned home setting.

Treatment foster care (TFC), also called therapeutic foster care, is out-of-home care by foster parents with specialized training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social issues or medical needs. Treatment foster care is designed to provide safe and nurturing care to a child or youth in a more structured home environment than

typical foster care, and it can be a cost-effective alternative to residential treatment. Foster parents providing beneficiary services in Ketchikan and Prince of Wales Island receive additional supports and services provided by Community Connections.

This project will result in serving 33% more youth in TFC, growing to 37 youth by March 2024. We expect 85% or higher of the youth in the TFC program to discharge into circumstances consistent with their permanency plan. In other words, youth will predominantly drop down to lower levels of care after being discharged from TFC, such as moving to OCS foster care, being adopted, reunifying with families/kin, or transitioning to independence.

Trust staff recommends this project for funding in alignment with strategies related to the Early Intervention and Prevention priority area and as a continuation of former "Bring the Kids Home" focus area recommendations as a preferred alternative to institutional care on behalf of child welfare involved beneficiaries. Treatment (therapeutic) foster care is an 1115 Medicaid behavioral health waiver service referenced in Comp Plan Goal 6, Objective 6.2 (Promote early intervention in maltreatment and with families at risk for maltreatment).

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 6 Protecting Vulnerable Alaskans	6.2 Early intervention for child maltreatment	

PROJECT DESCRIPTION

The following is excerpted from the prospective grantee's application.

PROJECT DESCRIPTION

The proposed project would contribute towards the expansion and sustainability of the reputable and stable Therapeutic Foster Care program at Community Connections by increasing the number of agency-owned foster homes by 2 homes. Funding is being requested for the purchase of two (2), 3-5 bedroom, homes, one in Ketchikan and one on Prince of Wales Island. Providing Therapeutic Foster Care via more agency owned homes has distinct advantages and will increase the number of youth we can serve right away, as well as contributing to the long term sustainability of the program.

Just like the rest of the state, way too many local Southeast children with significant behavioral health concerns, who are appropriate for community-based services, are forced to endure unnecessary and unnecessarily long admissions to psychiatric hospitals and psychiatric residential treatment facilities outside of their home communities. This problem is so pronounced and widespread throughout the state that more than 800 youth were placed in institutional care in 2020. A recent (2022) Department of Justice finding points out that long-standing gaps in the availability of Therapeutic Foster Care—a critical intervention for children at risk of institutional placement, particularly children in the State's custody—persist in Alaska. The State has capacity to serve about 150 children in therapeutic foster homes, although many more children are appropriate for this service and unable to access it. The DOJ report concludes that 'boosting local community provider capacity and making the necessary infrastructure investments to support

statewide implementation of its Section 1115 waiver, the State could leverage existing resources to fulfill its obligation under the Americans with Disabilities Act". So we are asking the AMHTA boost the capacity of our accredited Therapeutic Foster Care Program, as we believe it's a local antidote to this growing crisis.

Community Connections has successfully provided Therapeutic Foster Care (TFC) services to youth in Ketchikan and on Prince of Wales Island for over 23 years. Throughout the years we have successfully developed the reputation with local partners, personnel capacity, policy and procedural infrastructure, articulated core operating principles, clinical oversight, accreditation, key relationships with DBH and OCS, and the leadership expertise to achieve very positive outcomes for SED youth and their families in the region. TFC services are provided to youth, ages 2-21, who reside in the State of Alaska who experience a behavioral, emotional, or mental health disorder that meet the criteria for Serious Emotional Disturbance (SED) and who cannot be stabilized at a lower level of care. All participating youth are referred after experiencing an out of home placement at a higher level of care or who are imminently at risk of out of home placement. TFC services are centered in private, licensed family foster homes in the communities of Ketchikan, Saxman, and the many small communities located on Prince of Wales Island and are provided by foster providers who are licensed, trained, supervised and supported by our professional staff at Community Connections. We have 3 full-time licensing/management staff who are fully dedicated to the operation of the TFC program along with 6 master's level therapists, 7 case managers, and 20 direct care staff who provide the rehabilitation supports and clinical oversight to the youth placed in TFC homes. Community Connections is a licensed Child Placement Agency with the Office of Children's Services and our TFC program is specifically accredited by CARF through 2024.

If funded, this project will result in serving 33% more youth in TFC, growing to 37 youth by March 2024. We expect 85% or higher of the youth in the TFC program to discharge into circumstances consistent with their permanency plan. In other words, youth will predominantly drop down to lower levels of care after being discharged from TFC, such as moving to OCS foster care, being adopted, reunifying with families/kin, or transitioning to independence.

For evidence of community support for this project, we have attached selected letters of support and MOA's from crucial collaborators. Please see attached infographics, organizational charts, diagrams, for more information about our anticipated outcomes and program characteristics, service values, and philosophical underpinnings. See attached board resolution committing matching funds to this project. Please find the CARF accreditation standards for "specialized treatment foster care" which we met or exceeded during our November 2021 CARF site review. Please find the Family Focused Treatment Association of Alaska (FFTA) program standards for Therapeutic Foster Care which also influence our practices.

Related attachments Question 1:

- TFC infographic AMHTA
- AMHTA board resolution matching
- CMH Diagram TFC 23
- Letters of support – (MOU)
- DOJ report

- CARF TFC standards and accreditation letter
- FFTA Standards
- CAP service matrix

EVALUATION CRITERIA

As part of our CARF required performance improvement plan, Community Connections aggregates and reviews a variety of data on a quarterly basis. Our Performance Management Team meets quarterly to review the performance improvement data and takes steps to improve performance over time. We systematically collect the following data via self-report surveys, normed clinical tools, and records reviews on a quarterly basis.

HOW MUCH DID YOU DO?

Data on the following measures is collected at least every 90 days:

- Percentage of TFC referrals responded to within 3 business days
- Percentage of timely renewal of TFC home licenses (within OCS timeframes)
- Average monthly census of youth being served in Therapeutic Foster Care
- Average number of youth per licensed home
- Average number, if any, of TFC home violations requiring OCS safety incident report

HOW WELL DID YOU DO?

TFC foster Provider Satisfaction: Satisfying and functional relationships between our clinical staff and our TFC foster providers is required to make the biggest possible difference in the lives of youth and their families. Over the last 3 years, approximately 75% of our foster providers report being either satisfied or very satisfied with their relationship with Community Connections clinical and management staff. 75% will continue to be our performance target. We survey our TFC providers every 6 months using our own (attached) 20 question survey that evaluates TFC provider satisfaction, a few of the questions are shared below:

- How satisfied are you with the licensing support you received from your Foster Care Manager?
- How satisfied are you with the clinical support you and your family (parents, children, foster children etc.) have received from your clinical team at Community Connections?
- How satisfied are you with the amount and quality of the communication you have with your clinical treatment team at Community Connections?
- How satisfied are you with how connected you feel to Community Connections Child Placement Agency as a whole?
- How likely are you to recommend a friend or family member interested in becoming a foster parent to Community Connections?
- Please tell us what's working and not working in our relationship?

IS ANYONE BETTER OFF AS A RESULT OF THIS PROJECT?

The Child and Adolescent Service Intensity Instrument (CASII): is a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and his or her family. It is unique in its capacity to determine a service intensity need, guide treatment planning, and monitor treatment outcome in all clinical and community-based settings. The assigned master's level therapist completes a CASII on all youth in our program at least every 90 days. Our performance target is that overall the CASII composite score for youth in TFC homes will decrease by at least 3, which represents about one band of service intensity, over a period of 180 days and sustain that throughout their treatment. See attachments for detailed outcome measures.

The CASII is developmentally informed and developed on the foundation of a System of Care approach -- embracing individualized service planning, supporting the use of intensive care coordination or wraparound planning teams, and providing a broad service array. The CASII is applicable to children living in a variety of settings including those within a community with their parents or extended family, those in foster care, and to children in institutional settings. The CASII assesses the service intensity needs of children and adolescents presenting with psychiatric, substance use, medical and/or developmental concerns. It incorporates holistic information on the child within the context of his/her family and community by assessing service intensity needed across 6 Dimensions including:

- Risk of Harm
- Functional Status
- Co-Occurring Conditions
- Recovery Environment
- Resilience/Response to Services
- Involvement in Services

The CASII links the results of a clinical assessment with a defined level of service intensity using a clinically derived and empirically tested algorithm. It is user-friendly, culturally informed, and supports active participation by child and family. It is designed for use in all child-serving systems, including behavioral health, physical health, education, child welfare, juvenile justice, substance use, and developmental to facilitate integrated attention to the child's needs.

Discharge and Permanency Plan:
All children in TFC have a permanency plan established within the first 90 days of treatment. While individualized, many of the permanency plans fall within one of the following categories:

1. return to family of origin or kinship care,
2. adoption,
3. drop down into typical foster care,
4. or transition to independence.

Every quarter we evaluate the discharges that occur. Our current performance is 85% of TFC youth are discharged to circumstances consistent with their permanency plan. 85% will remain our target.

Youth Services Survey:
Youth Services Survey: We are using a reputable and widely used self-report instrument, the Youth Services Survey (YSS) to determine whether services, including TFC and associated therapeutic services, provided are positively improving or stabilizing the client from the client's perspective. The parent or primary caregiver complete the 22 –item survey if the child is under 14 and the child client responds if they are 14 years old or older. We collect data on the following questions at least every 90 days for all child clients. Our performance target is to have 80% of our TFC clients either agree or strongly agree with 6 key YSS questions below.

1. because of services they received they are better able to handle daily life
2. because of services they received they are better able to get along with other people
3. because of services they received they are better able to cope when things go wrong
4. because of the services they received they are satisfied with life right now
5. the client felt they were treated with respect during services
6. the client felt they reported they were comfortable asking questions about their treatment

Related attachments Question 3:

- Outpatient and TFC outcome indicators
- CASII Scoring System
- TFC survey results
- Youth Services Survey Questions

SUSTAINABILITY

Our TFC program has successfully sustained itself for 23 years and has remained stable in terms of scale and number of clients (+/- 25%) served for the last decade. We had record high enrollment in TFC during the heart of the pandemic, showing our grit and tenacity.

We have relied almost exclusively on Medicaid reimbursement over the years to sustain the program financially. The rate structure for Therapeutic Treatment Home Service increased approximately 20% to $294.65 a day with the adoption of the 1115 Behavioral Health Waiver in 2020. The Therapeutic Treatment Home service is "bundled" meaning it includes not only the interventions provided by contracted foster parent, but also the "case coordination, clinical oversight, linkage to medication services and crisis intervention" provided by Community Connections clinical and management staff. The payment rate has sustained us as long as we keep our TFC census above a certain threshold. We have attached a three year "proforma" financial projection assuming 2 foster homes with 2 kids in each home. Extrapolating from 2 homes with 2 kids scenario shows that these services are clearly sustainable from a financial perspective. There are many very good reasons for us to expand our TFC program that have nothing to do with money but we wouldn't be attempting this without clearly understanding that it will pay for itself.

It is also worth noting that due to various regulatory issues, it's important for us to charge TFC providers a rental charge for the homes. You can see this characterized on the attached revenue projection as "rent revenue" which helps to offset maintenance and insurance. The federal Medicaid regulators need to be sure that Medicaid revenue is not being used for "housing" service

recipients, so charging TFC parents a rental charge is a clean way to show that Medicaid isn't being used for that purpose.

HOW INCREASING AGENCY OWNED HOMES IS CRUCIAL FOR EXPANSION
Throughout our successful history of providing TFC in Ketchikan and on POW, we have owned only one of the homes in our network, with the rest of our homes being owned or rented by our contracted TFC foster providers. We strongly believe adding two large, agency owned, homes to our network will enhance the long-term capacity and sustainability of the TFC program at Community Connections.

- Once we have successfully recruited, trained, and licensed TFC providers, the size of their home often limits the number of TFC placements they can be licensed for, thereby limiting our capacity to intake new referrals into the program. Making larger homes available in our network will increase the program's capacity to serve greater numbers of youth.
- Additionally, the family make-up of the TFC parents to whom we lease the newly purchased homes can be screened so they match with the characteristics of those being referred. Matching client characteristics with new families has been a limiting factor to serving greater numbers of youth.
- Through the contract stipulation process, we can ensure that the newly purchased homes will remain active TFC homes, and will be offered only to those contracted families who are willing to continue providing care to multiple children. Meaning that the permanent purpose of these homes will be to provide TFC to youth in need. Now, when families are ready to terminate their roles as TFC providers, their home goes with them.
- We highly value having a large enough network of homes so that TFC providers can provide respite to each other periodically, so they can have a break from the work. This has prevented us from filling all of our homes to capacity. Respite is crucially important to retain TFC parents for the long haul and having capacity amongst our contracted homes adds much needed stability to the youth in care.
- Community Connections owns and operates many facilities in Ketchikan and on Prince of Wales so our organization has the maintenance staff that can ensure that the purchased homes are maintained and meet or exceed foster care licensing standards. There have been times when contracted providers weren't able to maintain their homes to the licensing standard, which has been a challenge.

Having TFC provided from more agency-owned homes will stabilize the TFC program, reduce challenges we have experienced, and will increase the number of children we impact.

Related attachments Question 4:
- Proforma projected financial sustainability

WHO WE SERVE

TFC services are provided to youth, ages 2-21, who reside in the State of Alaska who experience a behavioral, emotional, or mental health disorder that meet the criteria for Serious Emotional Disturbance (SED) and who cannot be stabilized at a lower level of care. TFC services primarily promote the long term permanency and wellness of children and youth to function effectively in

family settings, at school, and in the community. Other individualized treatment plan goals include: social and emotional skill development, preventing suicide and self-harm, preventing hospitalizations and residential treatment , promoting independence and integration into the community, developing a system of supports to bridge into young adulthood, promoting choices to be substance free, and supporting success in educational and vocational settings, along with others.

To that end the Children's Program is dedicated to working in partnership with families and the community to provide appropriate therapeutic treatment and support services, consistent with their assessed acuity, to help children, adolescents and their parents to reach their highest potential.

If funded, this project will result in serving 33% more youth in TFC, growing to 37 youth (at any given time) by March 2024. So, roughly 50 unduplicated youth with mental illness with be impacted per year. We expect 85% or higher of the youth in the TFC program to discharge into circumstances consistent with their permanency plan. In other words, youth will predominantly drop down to lower levels of care after being discharged from TFC, such as moving to OCS foster care, being adopted, reunifying with families/kin, or transitioning to independence.

Based on historical outcomes, at discharge from TFC, clients and/or their primary caregivers will likely report better coping and life satisfaction. Specifically, they will report being better at handling daily life, better at getting along with other people, better at coping when things go wrong, and will report higher satisfaction with life. Clients will be very likely to have a lower scores on our clinical instrument (CASII) after discharge in terms of risk of harm, functional abilities across environments, and overall resiliency. Specifically, their aggregate score will decrease by 3 within 6 months of entering the program.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	52
Developmental Disabilities:	6
Alzheimer's Disease & Related Dementias:	0
Substance Abuse	5
Traumatic Brain Injuries:	3
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	104
Number of people to be trained	56

BUDGET

Other Costs	$400,000.00
Other Costs (Other Sources)	$850,000.00
Other Costs Narrative:	$400,000 is being requested from AMHTA for the purchase of two, 3-5 bedroom, foster homes, one on Prince of Wales Island and one in Ketchikan. The purchase price is estimated to be $600,000 for each home

	for a total project cost of $1,200,000. Community Connections Board (see attached resolution) is contributing $400,000 and additional project requests (Rasmuson - $400,000, and Ketchikan Community Foundation -$50,000) are pending.

Total Amount to be Funded by the Trust	$400,000.00
Total Amount Funded by Other Sources	$850,000.00

OTHER FUNDING SOURCES

Community Connections - Secured	$400,000.00
Rasmuson Foundation - Pending	$400,000.00
Ketchikan Community Foundation -- Pending	$50,000.00
Total Leveraged Funds	**$850,000.00**

Therapeutic Foster Care Expansion Project

	Year 1	***Year 2***	***Year 3***
Revenue			
Therapeutic Treatment	342,144	351,382	361,923
Total Services	342,144	351,382	361,923
Rent Revenue	43,200	44,496	45,792
Total Revenue	**385,344**	**395,878**	**407,715**
Building Expenses:			
Depreciation on Bldg	13,333	13,333	13,333
Depreciation on F&F	8,571	8,571	8,571
Mortgage	24,000	24,000	24,000
Property Taxes	6,000	6,300	6,600
Insurance	9,000	9,450	9,900
Maintenance	24,000	25,200	26,400
Labor and Administrative Expenses:			
Foster Parents Services	136,800	140,904	145,008
Allocated CMH Professional Services	67,857	69,893	71,929
CARF/Foster Home Accredidation	1,000	1,050	1,100
Admin Assessment	85,536	87,845	90,481
Total Expense	**376,098**	**386,547**	**397,322**
Net Revenue	**9,246**	**9,331**	**10,393**

Assumptions include: 2 foster homes with 2 kids in each home. We had to make some assumptions here so you can exrapolate from there. We can meet to discuss this in more detail at your request. The Medicaid billing service that provides the revenue is a "bundled" service and covers lots of case coordination, therapuetic oversight, licensing, training, support, and other services provided by Community Connections. That is why you see the "allocated CMH professional Serivces" line item. Foster parent services is our TFC contract payments.