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: July 26-27, 2023
Time: 10:45 AM
Location: Trust Authority Building, 3745 Community Park Loop, Anchorage
Teleconference: (844) 740-1264 / Meeting Number: 2634 176 1944 # / Attendee Number: #
https://alaskamentalhealthtrust.org/
Trustees: Agnes Moran (Chair), Rhonda Boyles, Kevin Fimon, Brent Fisher, Anita Halterman, John Morris , John Sturgeon

Wednesday, July 26, 2023

		Page No
10:45	**Call to order (Agnes Moran, Chair)** Roll Call / Announcements / Approve agenda / Ethics Disclosure Approval of Minutes: April 20, 2023	5
10:50	**CEO Report** • Comp Plan • Department of Health Behavioral Health Roadmap • Rural Outreach trip • HB172 Report to Legislature • CEO Quarterly Grant Approvals Report	
11:15	**Trends in Alaska Workforce** • Dan Robinson, Chief of Labor Research & Analysis SOA, Department of Labor & Workforce Development	hand-out
12:15	**Lunch**	
1:00	**Approvals**	
	• Volunteers of America: Supported Employment for Young Alaskans	16
	• UAA Doctoral Occupational Therapy Program	21
	• Bartlett Regional Hospital: Aurora Crisis Services	52
2:30	**Break**	
2:45	**Approvals (continued)**	
	• Juneau Housing First Collaborative: Forget-Me-Not-Manor Phase 3	78
3:30	**Recess**	

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Thursday, July 27, 2023
(continued)

		Page No
8:30	**Call to order (Agnes Moran, Chair)** Announcements	
8:35	**FY25 Trust Budget Recommendations Introduction** • Steve Williams, Chief Executive Officer • Katie Baldwin, Chief Operating Officer	110
9:15	**FY25 Trust Budget Recommendations Presentation** • Mental Health & Addiction Intervention – Eric Boyer, Senior Program Officer	125
10:00	**Break**	
10:15	**FY25 Trust Budget Recommendations Presentation** • Disability Justice – Travis Welch, Program Officer • Beneficiary Employment & Engagement – Jimael Johnson, Program Officer	131 137
11:45	**Lunch**	
12:30	**FY25 Trust Budget Recommendations Presentation** • Housing Home & Community Based Services – Kelda Barstad, Program Officer • Workforce Development – Eric Boyer, Senior Program Officer	143 149
2:00	**Break**	
2:15	**FY25 Trust Budget Recommendations Presentation** • Early Childhood Intervention & Prevention – Jimael Johnson, Program Officer • Non-Focus Area Allocations – Katie Baldwin, Chief Operating Officer	155 161
3:45	**FY25 Trust Budget Recommendations – Next Steps** • Katie Baldwin, Chief Operating Officer • Steve Williams, Chief Executive Officer	167
4:15	**Trustee Comments**	
4:30	**Adjourn**	

Additional Documents
- Link: FY25 Budget Development supporting documents, reports, and resources
- Amended FY24 Signed Budget — hand-out
- FY25 Proposed Budget spreadsheet — hand-out
- FY25 Unallocated Funding Summary — hand-out

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Future Meeting Dates

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

(Updated – June 2023)

• 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
• Audit & Risk Committee	April 24, **2024**	(Wed)
• Finance Committee	April 24, **2024**	(Wed)
• Resource Mgt Committee	April 24, **2024**	(Wed)
• Program & Planning Committee	April 25, **2024**	(Thu)
• Full Board of Trustees	May 22-23, **2024**	(Wed, Thu) – TBD

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Future Meeting Dates

Statutory Advisory Boards

(Updated – June 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: September 18-19, 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: Stephanie Hopkins, 907) 465-4667, stephanie.hopkins@alaska.gov

- Executive Committee – monthly via teleconference (Wednesday / TBD)
- Quarterly Meeting: July 2023 / TBD

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

- Quarterly Meeting: October 9-10, 2023 / Anchorage
- Disability and Aging Summit: October 11-12, 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: <u>A motion to approve the agenda was made by TRUSTEE HALTERMAN; seconded by TRUSTEE FIMON.</u>

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

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:** <u>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.</u>

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

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
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Anchorage, AK 99508
Tel 907.269.7960
www.mhtrust.org

MEMO

To:	Agnes Moran - Program & Planning Committee Chair
Date:	July 26, 2023
Re:	FY24 Beneficiary Employment & Engagement Focus Area Allocation
Amount:	$125,200.00
Grantee:	Volunteers of America Alaska (VOA)
Project Title:	Supported Employment for Young Alaskans

REQUESTED MOTION:

"The Program & Planning Committee approves a $125,200 FY24 Beneficiary Employment & Engagement focus area allocation to Volunteers of America Alaska for the Supported Employment for Young Alaskans project. These funds will come from the IPS Supported Employment line of the FY24 budget."

Assigned Program Staff: Jimael Johnson

STAFF ANALYSIS

VOA is requesting Trust funding to support the piloting of an IPS Supported Employment model within VOA's supportive housing team. Specifically, funding will support costs to staff and implementation of the model. VOA Alaska responded to a recent request from the Trust, in partnership with the Division of Behavioral Health and the Division of Vocational Rehabilitation, to implement the evidence-based supported employment practice of Individual Placement and Supports (IPS) in the Anchorage area. This project will support transition-age youth, 18 to 24 years of age.

Volunteers of America Alaska (VOA Alaska) is an Anchorage-based Trust partner committed to developing a full continuum of care in support of Trust beneficiaries including early intervention, peer support and care coordination, mental health therapy, substance use counseling, family therapy, and supportive housing and residential treatment. VOA Alaska offers services to youth and young adults in schools, in the community, and statewide via telehealth. Agency staff provide services as well as engage in policy and systems development work through advocacy and engagement with the Trust, state, and other community service-providing partners.

Housing and employment are key social determinants of health for improving lives of Trust beneficiaries. The IPS model facilitates integration of employment services within a mental health clinical team which is known to improve both employment and behavioral health outcomes for people experiencing mental illness and/or substance misuse disorders. The Trust and statutory advisory boards support this work, and the IPS model was a key recommendation in the recent "2022 Alaska

Work Matters Task Force" convened by the Division of Vocational Rehabilitation and the Governor's Council on Disabilities and Special Education.

Trust funds allocated for the expansion of the IPS model in Alaska are being requested to fund this initial year of pilot implementation with VOA Alaska. State of Alaska, Division of Behavioral Health funding will likely become available through a competitive process in the next 1-2 years, dependent on state procurement decisions, at which point VOA Alaska will apply for sustainable state funding to continue the pilot should it prove successful. VOA Alaska is also connected with VOA Utah for mentoring in the implementation of IPS in practice. Trust staff will remain engaged throughout the process to support replication and expansion of this work in additional regions and communities throughout Alaska.

Trust staff recommends this project for funding in alignment with ongoing IPS supported employment model strategies of the Beneficiary Employment and Engagement Focus Area. The expansion of this model also provides a pathway for enhanced peer support and workforce priority area opportunities for Trust beneficiaries as well. The work is supported by the "2022 Alaska Work Matters Task Force" and is highlighted in the Comp Plan Goal 3 related to integrated and competitive employment for Trust beneficiaries.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 3 Economic and Social Well-being	3.2 Integrated employment	

PROJECT DESCRIPTION

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

PROJECT DESCRIPTION

VOA's proposed project is piloting an IPS Supported Employment model within our Supportive Housing team. This team provides wrap-around clinical and supportive services to transition-age youth, 18 to 24 years of age, in the Anchorage area experiencing/exiting houselessness and experiencing mental health and/or substance use challenges. Adding the IPS Supported Employment model will enhance the array of services available and provide an evidence-based pathway that leverages individual strengths in a multidisciplinary team approach.

Problem addressed:

VOA Alaska's proposed project aligns with Recommendation 15 of the Alaska Work Matters Task Force's Final Report, which is to: "Expand the use of the Individual Placement and Supports (IPS) model for people with mental health conditions or substance use disorders." If funded, VOA Alaska would be the first and only IPS program in the Anchorage area. According to Trust data, "40% of Alaskans with a disability are currently employed, compared to 80% of those without disabilities." As a behavioral health provider with over 40 years of experience serving young Alaskans and their families, our team understands the importance of providing whole-person care that includes clinical services and the essential wrap-around supportive services that promote recovery and wellness. Integrating the IPS Supported Employment model within VOA's continuum of care will enhance our team's ability to support each individual's goals, often including educational and/or career aspirations.

What we propose to do:
VOA's proposed project is piloting an IPS Supported Employment model within our Supportive Housing team. This team provides wrap-around clinical and supportive services to transition-age youth, 18 to 24 years of age, in the Anchorage area experiencing/exiting houselessness and experiencing mental health and/or substance use challenges. Through a Housing First approach, the team provides a supportive pathway for these young adults to exit houselessness and begin their journey to recovery, wellness, and stability. Adding the IPS Supported Employment model will enhance the array of services available and provide an evidence-based pathway that leverages individual strengths in a multidisciplinary team approach.

Within the first three months of the project: (1) agency and program leadership will work with IPS Supported Employment subject-matter experts, including those at the State, Trust, and VOA Utah, to adopt the IPS model and integrate it within VOA systems, policies, and procedures; (2) program leadership will leverage existing resources to develop and implement a training plan for the dedicated IPS Employment Specialist, who will ultimately work one-on-one with each beneficiary to identify and achieve their education and employment goals; and (3) recruitment of the IPS Employment Specialist will occur.

Within the first six months of the project, (1) Program leadership along with the IPS Employment Specialist will begin to network with employers within the Anchorage area to share information about the model and begin developing key partnerships to support employment opportunities for beneficiaries; and (2) the IPS Employment Specialist will begin to build their caseload of clients, not to exceed the recommended maximum of 15 (per the IPS Fidelity Scale for Young Adults).

Within the first year of the project, VOA expects to implement and integrate the IPS Supported Employment model within our existing continuum of care, with an initial focus on the transition-age youth served in our Supportive Housing program. With 1.0 FTE IPS Employment Specialist providing services, we anticipate helping 15-25 Trust beneficiaries to pursue their employment and education goals in an approach that also promotes recovery and wellness.

EVALUATION CRITERIA

VOA is a data-driven treatment provider with a proven infrastructure. Over 100 employees carry out the organization's mission in Alaska, relying on a customized CareLogic electronic records framework for monthly, quarterly, and annual reports informing continuous quality improvement (CQI) efforts. VOA has established internal organizational processes ensuring accurate and timely collection and input of behavioral health program data.

For the proposed IPS Supported Employment project, VOA's Quality Excellence, Clinical Development, and Impact Data teams will collaborate with Program leadership to ensure appropriate systems, procedures, and training are in place to track and report on the proposed performance measures outlined below:

1) How much did you do?
a. Number of beneficiaries served
b. Number of employers enrolled/participating

2) How well did you do?
a. % of beneficiaries connected to employment within 30 days
b. % of beneficiaries who remained employed for at least 3 months
c. % of beneficiaries enrolled in education program(s)
d. % of beneficiaries who successfully complete/graduate from program

3) Is anyone better off as a result of this project?
a. # and % of beneficiaries who report their overall quality of life has improved
b. # and % of beneficiaries who report they are better able to handle daily life
c. # and % of beneficiaries who report they get along better with other people
d. # and % of beneficiaries who report they are better able to cope when things go wrong

SUSTAINABILITY

The proposed project is a pilot of the IPS Supported Employment model within the State of Alaska. VOA Alaska is collaborating with partners at the State and the Trust to implement this service line with the intent to apply for proposed competitive grants, likely to be deployed in FY2025, as well as pursue earned revenue opportunities, such as Medicaid, to support the costs of service delivery.

WHO WE SERVE

In FY2022, VOA Alaska served 846 Alaska youth and families through our robust continuum of care. Of those served, 491 were youth and young adults who received mental health, substance misuse, and/or supportive housing services and primary beneficiaries of the Trust. Within VOA's treatment programs, approximately 56% of individuals served in FY2022 experienced co-occurring mental health and substance use disorders, 41% experienced mental health only challenges, and 3% experienced substance use disorders only. For the target population of this project, young adults receiving supportive housing services, 76% experienced co-occurring mental health and substance use disorders, 24% experienced mental health only challenges, and 1% experienced substance use disorders only.

Through the proposed project, VOA seeks to provide the young adults receiving treatment services with dedicated support in pursuing and succeeding at their education and employment goals. Similar to our approach to care in treatment programs, IPS at VOA will focus on an individual's strengths and self-defined goals. Through supported employment, individuals will have the opportunity to gain or regain independence, return to work or school, and experience the social and emotional benefits of being a part of the workforce and contributing to the community. Each individual's success will be supported by the dedicated IPS Employment Specialist as well as the appropriate clinical support for their needs, whether that is psychotherapy, peer support, case management, or psychiatric support.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	24
Substance Abuse	19
Number of people to be trained	3

BUDGET

Personnel Services Costs	$106,600.00
Personnel Services Costs (Other Sources)	$0
Personnel Services Narrative:	• IPS Employment Specialist (Direct Service Provider), 1.0 FTE, salary + 27% fringe = $69,900. • Lead Case Manager (Direct Supervisor), .25 FTE, salary + 27% fringe = $19,100 • Program Director (Program Development, Implementation & Oversight), .15 FTE, salary + 27% fringe = $17,600

Travel Costs	$8,000.00
Travel Costs (Other Sources)	$0
Travel Costs Narrative:	• Travel for 2-3 program staff for travel out-of-state (VOA Utah, TBD) and in-state (Homer, Alaska TBD) as site visit and learning community experience opportunities during first year of implementation for IPS evidence based practice and fidelity model standards.

Other Costs	$10,600.00
Other Costs (Other Sources)	$0
Other Costs Narrative:	• 10% for indirect costs of supporting community-based direct-service staff (billing, legal, IT, compliance, etc.)

Total Amount to be Funded by the Trust	$125,200.00
Total Amount Funded by Other Sources	$0

Trust
Alaska Mental Health Trust Authority

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Anchorage, AK 99508
Tel 907.269.7960
www.mhtrust.org

MEMO

To:	Agnes Moran - Program & Planning Committee Chair
Date:	July 26, 2023
Re:	FY24 Partnership Grant Request
Amount:	$84,000.00
Grantee:	The University of Alaska Anchorage
Project Title:	Extension Project for Doctoral Occupational Therapy Trainees in Behavioral Health

REQUESTED MOTION:

"The Program & Planning Committee approves a $84,000 Partnership grant to the University of Alaska Anchorage for the Extension Project for Doctoral Occupational Therapy Trainees in Behavioral Health project."

Assigned Program Staff: Eric Boyer

STAFF ANALYSIS

The University of Alaska Anchorage (UAA) requests these funds to support the Doctoral Occupational Therapy (OTD) trainees within the Alaska Interprofessional Distance Learning Consortium for Expanding Behavioral Workforce in Primary Care (AK-IDLC). If awarded, UAA will use these funds to continue the OTD Extension Project to support OTD students within the AK-IDLC training model and enable stipend payment through non-federal funding sources. The Trust and Mat-Su Health Foundation provided the stipend funding for year 1, and this request will fund years 2-4. Stipend funding supports each OTD student working in community behavioral health care settings in their internships.

The OTD program is one of four core behavioral health disciplines at UAA that are part of the AK-IDLC. The federal Health and Resources Services Administration (HRSA) provided the core funding ($1.9 million) for establishing the AK-IDLC to advance interprofessional, graduate-level education in behavioral health in Alaska. Unlike other behavioral health disciplines, a determination from HRSA precludes Alaska OTD students from enrolling in the federally funded project, so this funding is helping UAA support these OTD students.

Occupational therapy is considered a core mental health profession in Alaska with a distinct scope of practice that supports the recovery process of Trust beneficiaries. Occupational therapists provide integrative neurological assessment, spatial and physical coordination treatment, cognitive development and rehabilitation, and treatment for problem-solving skills.

The OTD students will complete clinical rotations at multiple Alaska health facilities integrating physical and behavioral health care. This continued funding request recognizes the relevance and importance of occupational therapy as an essential behavioral health profession in Alaska and uniquely suited to address the diverse needs of Trust beneficiaries.

This request also meets the intent of the Trust Priority area for Workforce Development by increasing the capacity of the behavioral health workforce. It also supports Goal 9, Objective 9.1 of the Comprehensive Integrated Mental Health Plan for workforce recruitment and retention. The AK-IDLC's work supports the integrated treatment approach at the community level in helping Trust beneficiaries with improved health.

It is recommended by Trust program staff to fund this request fully.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 9 Workforce, Data, & Funding	9.1 Workforce capacity	

PROJECT DESCRIPTION

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

PROJECT DESCRIPTION

In 2021, the University of Alaska Anchorage (UAA) received funding from the Health Resources and Services Administration (HRSA) for $1.9M to advance interprofessional, graduate-level education in behavioral health in Alaska. This funding established the Alaska Interprofessional Distance Learning Consortium for Expanding Behavioral Workforce in Primary Care (AK-IDLC). A determination from HRSA precludes Alaska OTD students from enrolling in the federally funded project. UAA proposes the continuation of the OTD Extension Project to support OTD students within the AK-IDLC training model and enable stipend payment through non-federal funding sources.

In 2021, the University of Alaska Anchorage (UAA) received funding from the Health Resources and Services Administration (HRSA) for $1.9M to advance interprofessional, graduate-level education in behavioral health in Alaska. This funding established the Alaska Interprofessional Distance Learning Consortium for Expanding Behavioral Workforce in Primary Care (AK-IDLC). Over the next four years, this project aims to train 89 graduate students in the tenets of integrated care, diversity and culturally responsive practice, interprofessional collaboration, and technology-driven delivery of care through best practice education in behavioral health. Enrollment data and projections are as follows:

2021-2022: 12 trainees (3 OTD students)
2022-2023: 25 trainees (2 OTD students)
2023-2024: 26 trainees (2 OTD students)
2024-2025: 26 trainees (2 OTD students)

Trainees are recruited from the core graduate professional disciplines of social work (MSW), advanced practice nursing (APN), occupational therapy (OTD through the UAA/Creighton University partnership), clinical psychology (MS and Ph.D.), and counseling psychology (MA and PsyD through Alaska Pacific University). The project will create and sustain a consortium of up to 26 behavioral health providers from across Alaska to learn best practices in behavioral health to high-need populations including principally Alaska Natives, people living in poverty, youth and their families, and those residing in rural and remote areas. A determination from HRSA precludes Alaska OTD students from enrolling in the federally funded project since HRSA. UAA proposes the continuation of the OTD Extension Project to support OTD students within the Alaska training model and enable stipend payment through non-federal funding sources. The inclusion of OTD students in the AK-IDLC strengthens the interprofessional dynamic of behavioral health care in Alaska.

EVALUATION CRITERIA

In alignment with the larger HRSA funded, AK-IDLC project goals, the OTD Extension project goals include the following:

a) Efforts made to increase inter-organizational training capacities of community-based partners in high need areas of Alaska.
b) Efforts made to prepare OTD students in best practices including the use of technology in the care process.
c) Efforts made to increase diversity of behavioral health workforce.
d) Efforts made to increase the employment of behavioral health professionals in Alaska.
e) Efforts made to advance dissemination and knowledge of the project findings regarding workforce development.

As part of the OTD Extension Project, participating OTD students complete didactic and clinical training opportunities focused on the provision of interprofessional behavioral healthcare. Didactic content is offered via an online symposium format and organized into modules with required learning activities of discussion boards and creation of an e-portfolio. The syllabus for the symposium is available for your review in the attachments section. The e-portfolio serves as a showcase of student accomplishments, houses letters of reference and a resume and is utilized in job searches. The e-portfolio also serves to track student progress throughout the training program and was a required component to receive stipends.

Performance measures include:

1. completion of required online discussion boards related to symposium content fall and spring semesters (syllabi attached)
2. creation and submission of an e-portfolio: example can be accessed here: https://alaska.digication.com/hannah-burnett-kinney-ak-idlc/home
3. submission of weekly data assessment forms for clinical practice requirements (form attached)

4. submission of employment data following graduation. Form can be accessed here: https://forms.gle/GrDQfrWh4BmdyUgA8

SUSTAINABILITY

This project is affiliated with a specific, HRSA grant funded training program which will end in 2025. There may be the opportunity to renew this funding but that has yet to be determined. Furthermore, in 2023, HRSA agreed to acknowledge the OTD degree within its legislative mandate. Despite this step, the currently funded project of the AK-IDLC is not eligible to utilize these federal funds to support OTD trainees. If AK-IDLC is renewed in 2025, there is a strong possibility that HRSA will support OTD trainees and further trust funding will not be needed.

WHO WE SERVE

Occupational therapy (OT) is applicable to beneficiaries experiencing the consequences of incarceration, developmental disabilities, serious mental illness, cognitive challenges emanating from physical illness, and substance use. OT is considered a core mental health profession in Alaska with a distinct scope of practice which supports the recovery process of Trust beneficiaries. Occupational therapists provide integrative neurological assessment, spatial and physical coordination treatment, cognitive development and rehabilitation, and treatment for problem-solving skills. Thanks to the generous support of the Alaska Mental Health Trust Authority and the Mat-Su Health Foundation in Academic Year 21 to 22, three OTD students participated in the OTD Extension Project. These students completed clinical rotations at multiple Alaska health facilities that integrate physical and behavioral health care. The AK-IDLC training supported the OTD students in the creation and implementation of a trauma informed life skills curriculum for young children and adolescents. The curriculum also fulfilled the requirements of the students' doctoral capstone projects. This continued funding request recognizes the relevance and importance of occupational therapy as an essential behavioral health profession in Alaska and one that is uniquely suited to address the diverse needs of Trust beneficiaries.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	125
Developmental Disabilities:	100
Substance Abuse	25
Traumatic Brain Injuries:	75
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	500
Number of people to be trained	3

BUDGET

Personnel Services Costs	$75,000.00
Personnel Services Costs (Other Sources)	$0.00

Personnel Services Narrative:	$75,000 ($25,000 for 3 years FY23, FY24, FY25 to fund one OTD student trainee per year)

Other Costs	$9,000.00
Other Costs (Other Sources)	$0.00
Other Costs Narrative:	$ 9,000 in indirect costs for 2023, 2024, 2025 (indirect cost estimate is based on award given in 2022)

Total Amount to be Funded by the Trust	$84,000.00
Total Amount Funded by Other Sources	$156,000.00

OTHER FUNDING SOURCES

Mat Su Health Foundation, SECURED	$100,000.00
Alaska Mental Health Trust Authority 2022, SECURED	$56,000.00
Total Leveraged Funds	**$156,000.00**

AK-IDLC 2021-2022 Weekly Questionnaire

Reference: Project Proposal Section 6.0 Subsection 6.1 Pages 20 to 22

Section 1: Service Delivery at Core Sites (questions 1-11)

Section 2: Service Delivery at Rotational Sites (questions 12-13)

Section 3: Recipient Demographics (questions 14-20)

Section 4: Reflection (questions (21

Section 1: Service Delivery in Core Sites

1. Did you participate in a core site (or your designated clinical practicum) this week?

Yes (Please enter the site)________________________
No

How many hours this week did you participate in a core site or your designated clinical practicum?

_____1 to 3 hours
_____4 to 6 hours
_____More than 6 hours

2. Overall, this week, how many hours did you invest in direct recipient contact?

_____1 to 3 hours
_____4 to 6 hours
_____7 to 9 hours
_____10 or more hours
_____You did not have any direct contact with recipients

3. Did you participate in the provision of behavioral health care through telehealth this week?

Yes
No

If yes, how many hours did you participate in the provision of telehealth this week?

_____1 to 3 hours
_____4 to 6 hours
_____More than 6 hours

4. Did you help recipients use digital tools to address their health or behavioral health this week?

Yes
No

If yes, in your own words, what tools did you help recipients use?

5. Did you receive supervision for your work at the training site this week?

Yes
No

If yes, how satisfied were you with the supervision you received this week?

__Not satisfied

__Sort of satisfied

__Satisfied

__Very satisfied

6. Did you work with other AK-IDLC trainees to address recipient needs?

Yes
No

7. Did you collaborate with other providers in team meetings to address behavioral health needs of recipients?

Yes
No

8. Did you collaborate with providers of physical health to address the behavioral health needs of recipients?

Yes
No

9. Did you use or learn about preventive methods in behavioral health care this week?

Yes
No

10. Did you serve as a liaison with organizations outside of your primary training site to address behavioral health needs of recipients, such as those in schools, incarceration, or other situations?

Yes
No

11. Did you engage in and/or learn about culturally relevant interactions this week?

Yes
No

If yes, in your own words, what culturally relevant interactions stand out for you?

Section 2: Service Delivery at Rotational Sites

12. Did you participate in a rotational site this week?

Yes
No

13. If yes, how many hours did you participate in a rotational site this week?

_____1 to 3 hours
_____4 to 6 hours
_____More than 6 hours

Section 3: Recipient Demographics

14. Did you interact with recipients this week whose behavioral health issue is influenced by or linked to trauma?

Yes
No

15. Overall, during this week, did you engage in trauma focused practice?

Yes

No

If yes, how many hours did you engage in trauma focused practice this week?

_____1 to 3 hours
_____4 to 6 hours
_____More than 6 hours

16. Did you assist or learn about individuals within the following communities during your clinical placement this week?

Alaskan Native

Yes
No

LGBTQ

Yes
No

Immigrant or Refugee

Yes
No

African American

Yes
No

Asian American

Yes
No

Hawaiian or Pacific Islander American

Yes

No

Hispanic or Latino American

Yes
No

Arab American

Yes
No

Veterans

Yes
No

Homeless or housing insecurity

Yes
No

Food insecurity

Yes
No

17. Did you learn about or assist people who have been exposed to or experienced violence of any kind?

Yes
No

18. If yes, how many hours did you participate in addressing the needs of people exposed to or experienced violence this week?

_____1 to 3 hours

_____4 to 6 hours
_____More than 6 hours

19. Did you work with youth (from ages 5-18) this week?

Yes
No

20. If yes, how many hours did you participate in addressing the needs of youth this week?

_____1 to 3 hours
_____4 to 6 hours
_____More than 6 hours

Section 4: Reflection Questions

21. Overall, considering your work as a trainee this week, how satisfied are you with the training you experienced this week?

__Not satisfied

__Sort of satisfied

__Satisfied

__Very satisfied

22. Based on your experiences this week, do you feel more effective in addressing the needs of people from diverse backgrounds?

Yes
No

23. Did you spend at least one hour this week working on your job search in Alaska behavioral health care?

Yes
No

24. Considering your training experiences this week, what new or additional experiences would you like to advance your knowledge, skill, and competence in addressing behavioral health needs of Alaskans?

University of Alaska Anchorage
College of Health
Alaska Interprofessional Distance Learning Consortium (AK-IDLC)
Fall 2022 E-symposium

Instructors: Yvonne Chase, PhD, MSW
Cary Moore, PhD, OTR/L (ccmoore2@alaska.edu)
David Moxley, PhD, MSW (dmoxley@alaska.edu)
Amanda Biggs, MSW
Office hours: By appointment; please email to schedule a meeting
Credit: 1 semester hour
Prerequisites: Acceptance into AK-IDLC

Course Description: This interdisciplinary, online, asynchronous seminar style course offers training in behavioral health with an emphasis on substance use treatment, adults with persistent mental illness, violence exposed youth, and LGBTQ recipients. Through a 4 year, $1.9M grant from the Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET) Program for Professionals, AK-IDLC aims to advance interprofessional graduate-level education in behavioral health across Alaska's urban, ex-urban, rural, frontier and remote areas. The project will prepare 23 trainees annually from graduate programs in: psychology, occupational therapy, social work and nursing

Mission of the UAA College of Health: The mission of the UAA College of Health is to advance the health and well-being of people and communities. This course supports this mission by supporting the development of the behavioral health workforce and introducing students to interdisciplinary behavioral healthcare.

Learning Objectives and Student Outcomes

1. Link interprofessional training in behavioral health with the students' (trainees') disciplinary training.
2. Emphasize integration of care, particularly between physical and behavioral health and behavioral health and substance use recovery.
3. Prepare or augment trainees' readiness for distance delivery of behavioral health care in Alaska.
4. Expand trainees' awareness of and competencies in diversity focused behavioral health care.
5. Advance trainees' understanding of best practices in integrating behavioral health using interprofessional framework..
6. Supplement trainees' disciplinary training with additional interprofessional content.

7. Build trainees' relationships with organizations providing behavioral health in Alaska.
8. Facilitate students' progression in career development in Alaska behavioral health careers.
9. Support trainees' job search in Alaska for long term careers in behavioral health

Teaching Philosophy and Learning Strategies:
As your instructors…

- We want you to challenge you to grow and develop different perspectives.
- We are not here to give you the answers, but instead to guide you in how to find them.
- We will do whatever we can to make you feel safe and welcome in our virtual classroom. If there are ways we can improve, please let us know. We're constantly learning, too.
- We believe that an environment of respect fosters learning. Therefore, we promise to be respectful of you, as well as your time, learning, and questions. We ask that you also be respectful of us, your classmates, guests, and our virtual learning community.
- We want you to be curious & ask questions, both inside and outside the course. You may approach us if you are confused and need clarification, or if you need to discuss a personal matter related to the class, or for any other reason. We are happy to discuss the situation with you, help you problem solve, and provide other resources that may help you.
- Finally, we believe that learning should be fun and engaging so we'll do our best to create an atmosphere that fosters this!

Course Materials and Supplemental Reference/Resource Materials: These will be posted on the Blackboard course site.

Bi-Weekly Learning Units:
Weekly learning units will be posted twice monthly on Tuesdays at 12 Noon. The class week will end at 11:00PM the Monday evening before the next module is released. The posted material will include the topic for the two weeks, objectives and readings and the Discussion Board forum. Any additional course materials for the week will be included in the posting.

Evaluation/Grading Scale: As a seminar course, grades are not provided. Successful engagement in the online discussion board and in monthly zoom meetings ensures satisfactory progression in the training and stipend disbursement.

Required Monthly Zoom Meetings: Monthly Zoom meetings will be held on the first Friday of the month from 12:00-1:00 AKST. Orientation will be held on September 2 from 11:30-1:00. The agenda for these meetings will include announcements, updates and the opportunity to meet with your assigned interdisciplinary team. Please make every effort to join these meetings. If you are unable to do so, please notify your assigned faculty mentor and view the meeting recording when available. Meeting dates for Fall 2022 will be:

Friday, September 2, 11:30-1:00 AKST

Friday, October 7, 12:00-1:00 AKST

Friday, November 4, 12:00-1:00 AKST

Friday, December 2, 12:00-1:00 AKST

All meetings will use this link: Zoom link: https://creighton.zoom.us/j/2476260321

Bi-weekly Online Discussion Boards: Students are expected to participate in online course discussions. By 12 noon on selected Tuesdays, a discussion topic will be posted on the discussion board. The discussion weeks will end Monday at 11PM before the next module is released. During the discussion week, active involvement is expected by posting responses to the topic based on reading materials, posing questions, presenting solutions and responding to other student's postings. The instructor or designated student lead will monitor the discussions during the week, but may or may not comment.

This activity is designed to be practical and fun and will be useful to the extent of active, engaged, and informed participation. Unprofessional behavior in the discussion will not be tolerated and will result in being removed from the discussion.

Guidelines for discussion postings:

- Postings must be substantive to the discussion.
- Follow assignment guidelines for weekly discussion posts.
- Plan to post on different days throughout the week.
- Incorporate ideas shared by others and the instructor to create a "fuller picture" of the concepts under review. Be sure to incorporate content from that week's readings –demonstrate that you read and understood the readings for the week
- Respond to the forum individually with a minimum of one new thread
- Use subject headings that are topic specific; avoid using general terms such as 'my posting'

- Postings are not permitted to be removed or edited. Think about preparing your posting in a WORD document and then cut and paste it to the discussion board
- Include citations if references are used to prepare your posting

Tips on writing effective discussion board messages:

- Keep them concise – no one wants to read lengthy, poorly composed messages.
- Write clearly and pay attention to spelling – this is academic work.
- Criticize the idea, not the person! Be constructive and offer your alternative ideas in a respectful and professional manner.

Overview - Weekly Course Topics and Learning Objectives

	Topic	Learning Objectives	Learning Activities
Module 1 9/6-9/12	Interprofessional and team-based practice	Define interprofessional education (IPE) and interprofessional collaborative practice (IPCP) Identify the 4 core competencies of the Interprofessional Education Collaborative Reflect on your experience to date of IPCP	Discussion Board Complete IPEC Self Assessment
Module 2 9/13-9/19	E-Portfolio Development	Begin development of e-portfolio based on established template	Discussion Board E-portfolio shell created using template
Module 3 9/20-10/3	Job search, career development strategies, and self care	Define the career concept of "Pracademic" Identify 4 areas of career development	Discussion Board and activities as assigned

		Reflect on your profile of assets	
Module 4 10/4-10/17	Diversity and culturally responsive behavioral healthcare	To identify the competencies of culturally responsive practice To reflect on your current competencies to deliver services to underrepresented populations	Discussion Board and activities as assigned
Module 5 10/18-10/31	Trauma and compounded trauma	Recognize key terms in trauma terminology Identify various types of trauma Identify principles of trauma informed care and approaches Identify trauma-informed interventions that recognize patient resilience and are strength based and collaborative in nature	Discussion Board and activities as assigned

Module 6 11/1-11/14	Violence exposure	Understand the various types of violence. Review effects of violence differentiated by types. Understand risk and protective factors associated with various types of violence. Learn about ACES. Review the social-ecological model for violence prevention. Review reporting agencies and resources.	Discussion Board and activities as assigned
Module 7 11/15-11/28	Adolescent focused behavioral healthcare	Review best practices in adolescent focused care Discuss unique developmental needs of adolescents and how this impacts service delivery	Discussion Board and activities as assigned
Module 8 11/29-12/12	Child and family focused behavioral healthcare	Review best practices in child and family focused care Discuss the dyad of children and families and how this impacts service delivery	Discussion Board and activities as assigned

Course Approach
This graduate level course requires independent thinking, critical analysis of the course topics and written communication skills. Course content, activities and all interaction will be conducted on Blackboard. Students are expected to synthesize content from the reading into discussions and assignments. The assigned readings and class activities will be the basis of the online discussions. Engaged participation in discussions is expected and is likely to produce lively, informative and stimulating exchanges. Students will be required to navigate and work in a web-based setting and have the ability to use search engines and online databases.

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Technology Information

- Log into **Blackboard** (https://classes.alaska.edu) and **Zoom** (https://alaska.zoom.us/) using your UAA username and password (https://me.uaa.alaska.edu).
- Required technology tools: Blackboard, Zoom, Microsoft Office or Google Apps, Google Chrome browser, Mozilla Firefox browser, Adobe or Firefox PDF reader *[add your own here]*
- Computer and information literacy skills expectations: Ability to use Blackboard, email, word processing and presentation software, online search tools, online databases *[add your own here]*

Technology Resources

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- We honor diverse experiences and perspectives—including differences in ideas, religion, gender, gender identity, sexual orientation, ethnicity, race, culture, nationality, age, disability, veteran and socioeconomic status—and strive to create welcoming and inclusive learning environments where all are treated with respect.
- At UAA, valuing diversity is integral to excellence. Diversity maximizes our potential for creativity, innovation, educational excellence, and outstanding service to our communities.

Non-discrimination
The University of Alaska is an affirmative action/equal opportunity employer and educational institution. The University of Alaska does not discriminate on the basis of race, religion, color, national origin, citizenship, age, sex, physical or mental disability, status as a protected veteran, marital status, changes in marital status, pregnancy, childbirth or related medical conditions, parenthood, sexual orientation, gender identity, political affiliation or belief, genetic information, or other legally protected status. The University's commitment to nondiscrimination, including against sex discrimination, applies to students, employees, and applicants for admission and employment. Contact information, applicable laws, and complaint procedures are included on UA's statement of nondiscrimination available at www.alaska.edu/nondiscrimination.

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University of Alaska Anchorage
College of Health
Alaska Interprofessional Distance Learning Consortium (AK-IDLC)
Spring 2023 E-symposium

Instructors: Yvonne Chase, PhD, MSW (ymchase@alaska.edu)
Cary Moore, PhD, OTR/L (ccmoore2@alaska.edu)
David Moxley, PhD, MSW (dmoxley@alaska.edu)
Amanda Biggs, MSW (abiggs@alaska.edu)
Office hours: By appointment; please email to schedule a meeting
Credit: 1 semester hour
Prerequisites: Acceptance into AK-IDLC

Course Description: This interdisciplinary, online, asynchronous seminar style course offers training in behavioral health with an emphasis on substance use treatment, adults with persistent mental illness, violence exposed youth, and LGBTQ recipients. Through a 4 year, $1.9M grant from the Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET) Program for Professionals, AK-IDLC aims to advance interprofessional graduate-level education in behavioral health across Alaska's urban, ex-urban, rural, frontier and remote areas. The project will prepare 23 trainees annually from graduate programs in: psychology, occupational therapy, social work and nursing

Mission of the UAA College of Health: The mission of the UAA College of Health is to advance the health and well-being of people and communities. This course supports this mission by supporting the development of the behavioral health workforce and introducing students to interdisciplinary behavioral healthcare.

Learning Objectives and Student Outcomes

1. Link interprofessional training in behavioral health with the students' (trainees') disciplinary training.
2. Emphasize integration of care, particularly between physical and behavioral health and behavioral health and substance use recovery.
3. Prepare or augment trainees' readiness for distance delivery of behavioral health care in Alaska.
4. Expand trainees' awareness of and competencies in diversity focused behavioral health care.
5. Advance trainees' understanding of best practices in integrating behavioral health using interprofessional framework..
6. Supplement trainees' disciplinary training with additional interprofessional content.

7. Build trainees' relationships with organizations providing behavioral health in Alaska.
8. Facilitate students' progression in career development in Alaska behavioral health careers.
9. Support trainees' job search in Alaska for long term careers in behavioral health

Teaching Philosophy and Learning Strategies:
As your instructors…
- We want you to challenge you to grow and develop different perspectives.
- We are not here to give you the answers, but instead to guide you in how to find them.
- We will do whatever we can to make you feel safe and welcome in our virtual classroom. If there are ways we can improve, please let us know. We're constantly learning, too.
- We believe that an environment of respect fosters learning. Therefore, we promise to be respectful of you, as well as your time, learning, and questions. We ask that you also be respectful of us, your classmates, guests, and our virtual learning community.
- We want you to be curious & ask questions, both inside and outside the course. You may approach us if you are confused and need clarification, or if you need to discuss a personal matter related to the class, or for any other reason. We are happy to discuss the situation with you, help you problem solve, and provide other resources that may help you.
- Finally, we believe that learning should be fun and engaging so we'll do our best to create an atmosphere that fosters this!

Course Materials and Supplemental Reference/Resource Materials: These will be posted on the Blackboard course site.

Bi-Weekly Learning Units:
Weekly learning units will be posted twice monthly on Tuesdays at 12 Noon. The class week will end at 11:00PM the Monday evening before the next module is released. The posted material will include the topic for the two weeks, objectives and readings and the Discussion Board forum. Any additional course materials for the week will be included in the posting.

Evaluation/Grading Scale: As a seminar course, grades are not provided. Successful engagement in the online discussion board and in monthly zoom meetings ensures satisfactory progression in the training and stipend disbursement.

Required Monthly Zoom Meetings: Monthly Zoom meetings will be held on the first Friday of the month from 12:00-1:00 AKST. The agenda for these meetings will include announcements, updates and the opportunity to meet with your assigned interdisciplinary team. Please make every effort to join these meetings. If you are unable to do so, please notify your assigned faculty mentor and view the meeting recording when available. Meeting dates for Fall 2022 will be:

Friday, February 3, 12:00-1:00 AKST

Friday, March 3, 12:00-1:00 AKST

Friday, April 7, 12:00-1:00 AKST

Friday, April 28, 12:00-1:00 AKST (wrap up)

All meetings will use this link: Zoom link: https://creighton.zoom.us/j/2476260321

Bi-weekly Online Discussion Boards: Students are expected to participate in online course discussions. By 12 noon on selected Tuesdays, a discussion topic will be posted on the discussion board. The discussion weeks will end Monday at 11PM before the next module is released. During the discussion week, active involvement is expected by posting responses to the topic based on reading materials, posing questions, presenting solutions and responding to other student's postings. The instructor or designated student lead will monitor the discussions during the week, but may or may not comment.

This activity is designed to be practical and fun and will be useful to the extent of active, engaged, and informed participation. Unprofessional behavior in the discussion will not be tolerated and will result in being removed from the discussion.

Guidelines for discussion postings:

- Postings must be substantive to the discussion.
- Follow assignment guidelines for weekly discussion posts.
- Plan to post on different days throughout the week.
- Incorporate ideas shared by others and the instructor to create a "fuller picture" of the concepts under review. Be sure to incorporate content from that week's readings –demonstrate that you read and understood the readings for the week
- Respond to the forum individually with a minimum of one new thread
- Use subject headings that are topic specific; avoid using general terms such as 'my posting'

- Postings are not permitted to be removed or edited. Think about preparing your posting in a WORD document and then cut and paste it to the discussion board
- Include citations if references are used to prepare your posting

Tips on writing effective discussion board messages:

- Keep them concise – no one wants to read lengthy, poorly composed messages.
- Write clearly and pay attention to spelling – this is academic work.
- Criticize the idea, not the person! Be constructive and offer your alternative ideas in a respectful and professional manner.

Overview - Weekly Course Topics and Learning Objectives with release date

	Topic	Learning Objectives	Learning Activities
SUITE AK Modules 1 and 2 1/30/23	1: Introduction to Alcohol & Substance Abuse Disorders 2: Opioids	1. Familiarity substance addiction in the United States and Alaska - its statistical trends, social and financial implications, definition, symptoms, and correlations. 2. An understanding of the origin, history, legislative responses, and use of narcotics.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board
SUITE AK Modules 3 and 4 2/6/23	3: Intoxication, Detoxification, & Withdrawal 4: Screening and Assessment	3. Understand symptoms associated with intoxication, detox, and withdrawal from various substances,continuity of care, and the biopsychosocial model of treatment. 4. Understand SBIRT & motivational interviewing techniques used with it, ASAM treatment criteria, and standard substance use treatment tools.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board

SUITE AK Module 5 2/13/23	Motivational Interviewing & the Stages of Change	Understand MI and how it relates to engaging clients in treatment, interaction skills associated with MI, stigmas surrounding addiction, importance of fostering empathy, compassion, and building a treatment alliance, readiness to change and the stages of change.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board
SUITE AK Module 6 2/20/23	Relapse Prevention	Recognize factors contributing to relapse and strategies to prevent it, client relapse triggers and skills useful in managing them, functions of using behavior and healthy alternatives.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board
SUITE AK Module 7 2/27/23	Recovery Ethics in Substance Use Treatment	Understand the parts of the recovery sphere. Identify recovery ethics, their purpose and relevance.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board
SUITE AK Module 8 3/6/23	Culturally Responsive Treatment	Understand culture, factors that impact it, and how it shapes personal beliefs and health, and social considerations of culture and substance use. Examine strategies behind culturally competent treatment practices and examples of culturally integrated approaches to substance use treatment.	Complete online SUITE AK module(s) and post completion certificate to the weekly discussion board
Module 9 3/20/23	Boundary Issues in Rural Practice		Discussion Board

Module 10 4/3/23	Recovery Paradigms in Integrated Care	Explore concepts related to the context of recovery 2. Introduce models related to recovery 3. Examine implications of recovery paradigms on behavioral health practice	Discussion Board

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Trust
Alaska Mental Health
Trust Authority

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

MEMO

To:	Agnes Moran - Program & Planning Committee Chair
Date:	July 26, 2023
Re:	FY24 Mental Health & Addiction Intervention Focus Area Allocation
Amount:	$476,200.00
Grantee:	Bartlett Regional Hospital
Project Title:	Aurora Crisis Services – Commencement of Operations Assistance

REQUESTED MOTION:

"The Program & Planning Committee approves a $476,200 FY24 Mental Health and Addiction Intervention focus area allocation to Volunteers of Bartlett Regional Hospital for the Aurora Crisis Services – Commencement of Operations Assistance project. These funds will come from the Crisis Continuum of Care line of the FY24 budget."

Assigned Program Staff: Travis Welch

STAFF ANALYSIS

Trust funds are requested to support Bartlett Regional Hospital (BRH) as they stand up new crisis stabilization services in the community and manage unplanned operation delays. BRH is an enterprise of the City and Borough of Juneau (CBJ). For decades, it has operated various forms of behavioral health and mental health services, including crisis services on the Juneau hospital campus. As a leader in providing behavioral health services in Southeast Alaska, BRH has been engaged with the Trust and various local and state partners in identifying gaps in our state's crisis care in Juneau and throughout Alaska. These gaps result in beneficiaries not receiving timely mental health interventions, unnecessary suffering and despair, and frequent engagement with law enforcement. Neither a traditional emergency room department nor a law enforcement response is designed to meet the unique needs of individuals and behavioral health crises. Gaps in the availability of community-based crisis response and behavioral health care can result in individuals waiting in hospitals for hours to days and, on occasion, jails for an appropriate treatment setting, often because other options do not exist.

In FY19, Bartlett Regional Hospital (BRH) was awarded a State of Alaska Department of Behavioral Health (DBH) crisis stabilization grant of 2 million dollars to provide crisis stabilization services. The grant allowed BRH to utilize $500,000 of the award for a capital project to expand BRH's crisis services. In addition to the $500,000 from the original DBH grant award, BRH was successful in acquiring additional funds from the Trust ($200,000), Rasmuson Foundation ($350,000), Premera ($1M), CBJ Revenue Bonds (secured $8M), and BRH Foundation ($8M). The Trust was instrumental in engaging other funders in the project, including Rasmuson and Premera. The capital project has resulted in the new

Aurora Behavioral Health Center (ABHC) on the BRH campus. The ABHC will offer services to adolescents and adults from the Juneau area and throughout the state, many of whom are trust beneficiaries.

In addition to the Trust's grant towards the capital project, the Trust also provided BRH with a grant of $100,000 for technical support. With this support of Trust funding, BRH made significant progress in developing the clinical model of care, policies, workflows, staffing patterns, financial modeling, legal consultation, metrics, and workforce recruitment plans. BRH leadership and staff have also joined the Trust team and state partners to visit and engage with programs in Arizona that are exemplary operators of crisis response and stabilization services to help solidify partnerships, learn from Arizona's successes, and conceptualize application in Juneau.

While making substantial progress during the first phase and through careful consideration taken by the planning team to complete comprehensive planning and service design, BRH is now ready to enter the second phase of service ramp-up and launch by September 2023. Extensive financial modeling has informed this proposal and reflects what is needed to start up services within the identified timeframes.

Once operational, BHR will be the only provider of juvenile stabilization services in Alaska. Once implemented, ABHC will help meet the needs of Trust beneficiaries in crisis and begin diverting them from emergency rooms and the criminal justice system. Data has shown that the 23-hour crisis stabilization centers can resolve crises for a high percentage (90%) of individuals receiving care. Without access to stabilization services, most individuals would otherwise be served in higher levels of care, emergency room departments, jails, or community without support. This new approach and philosophy of care has the potential to be transformative for how we respond to and serve individuals experiencing a behavioral health emergency. BRH, with the support of the State, the CBJ, local law enforcement, and community health providers, is taking the lead to implement Alaska's first low-barrier access to crisis stabilization services and, currently, the only provider for adolescent crisis stabilization services.

The Trust program staff have collaborated with BRH to bring this proposal forward for funding consideration leading to the launch of services. The funding for this request will be designated from the Trustee approved FY24 Mental Health and Addiction (MHAI) focus area, Crisis Now Continuum of Care implementation strategy line. There is $4,000,000 budgeted in this strategy (reference: FY24 budget, MHAI Focus Area, page 4, line 19).

Trust staff recommends this proposal be fully funded.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 5 Suicide Prevention	5.2 Crisis system improvement	Crisis stabilization is a key component of effective crisis response. Additional goals supported include: Goal 5 Suicide Prevention, Objective 5.2 Improve system to assist individuals in crisis; Goal 7, Services in the least restrictive environment, Objectives 7.2 (avoiding institutional placements)

		and 7.3 (reducing the number of beneficiaries entering the criminal justice or juvenile justice settings).

PROJECT DESCRIPTION

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

PROJECT DESCRIPTION

Bartlett Regional Hospital (BRH) will commence operating Crisis Now services (Crisis Observation and Stabilization and Crisis Residential and Stabilization) beginning in September 2023. The new Aurora Behavioral Health Center (ABHC) on the BRH campus will offer services to adolescents and adults from the Juneau area and throughout the state, many of whom are trust beneficiaries. Professional staff will provide essential services such as assessments, diagnosis, individual/group therapy, medication prescribing and monitoring, treatment planning, and referral and linkage to community-based services. Under the Crisis Now model, these services and interventions will enable patients to receive appropriate care within this community. They will facilitate low-barrier access, diverting patients from inappropriate incarceration and unnecessary use of Emergency Departments for behavioral health crises. The grant will provide bridge funding for startup services to provide adequate staffing, continued training opportunities, Crisis Now model consultation, and recommended cameras for the facility.

These services for adolescents and adults will be provided within the new Aurora Behavioral Health Center (ABHC) on the BRH campus. Each unit will offer behavioral health crisis services to Juneau, Southeast, and Alaska residents, who are trust beneficiaries. The programs will employ professionals to provide essential services such as assessments, diagnosis, individual/group therapy, medication prescribing and monitoring, treatment planning, and referral and linkage to community-based services. These services will improve mental health and provide community-based interventions for beneficiaries to prevent adolescents and adults from leaving the community for higher levels of care, including institutionalization. Another goal under the Crisis Now model is to create a "no wrong door" environment that allows law enforcement a diversion from jails when appropriate and reduces the use of Emergency Departments for behavioral health crises.

Bartlett Regional Hospital is committed to building a comprehensive program of mental health crisis services for residents of Juneau, Southeast Alaska, and throughout Alaska. To provide a robust suite of crisis services based on the Crisis Now model, BRH initiated the construction of a large building on the BRH campus, recruitment of psychiatrists, nurses, and other behavioral health professionals, engaged subject matter consultants for strategic guidance, and has collaborated with community partners across the state to determine needs and establish referral pathways. This suite of crisis services has been planned and designed over several years, involving community dialogue with partner agencies, statewide healthcare providers, state agencies, law enforcement officials, public comment, and hospital board approval.

As of this writing, the Aurora Behavioral Health Center is experiencing construction delays, and occupancy and operations are delayed. In addition, our crisis services are further delayed due to the unexpected loss of our contracted psychiatrist due to a catastrophic personal situation.

Recruitment for a temporary psychiatrist and a permanent replacement has been initiated, and the credentialing process is underway. However, these challenges have forced us to postpone our expected commencement of the full suite of crisis services to September 2023. In addition, we have experienced significant difficulties in recruiting mental health staff at all levels. Those new employees that we have hired are now being cross-trained in our hospital so that we can retain them until our crisis services are fully operational.

We are requesting assistance during the startup period of this critical crisis services program to help bridge the gaps created by delays in construction, recruiting, credentialing, and operationalization of services. We are asking for funds to cover three months of wages for our crisis staff as we spool up services, become operational, begin seeing patients, and bill for services. This funding will help us retain and train the team we have recruited or transferred to the new crisis program while we continue to recruit and hire for open positions. This request also covers costs for an appropriate community-based behavioral health training program (CPI) and additional recommended cameras for the crisis services program space. Our proposal also includes further training and program review/guidance for 12 months from Pugsley Consulting (Amy Pugsley, previously with RI International) to ensure that we roll out our suite of services in a manner that provides the highest quality appropriate patient care, is fiscally responsible, regulation compliant adheres to industry best practices, and that best serves our community, patients, and staff.

EVALUATION CRITERIA

Bartlett Regional Hospital's Aurora Crisis Services plans to start with a staggered opening of services, beginning with 23-hour crisis observation stabilization and crisis stabilization residential for adolescents. If all goes well, the next step will be to add 23-hour crisis observation/stabilization and crisis stabilization residential for adults. Data metrics will be further developed before the program is operational. The program intends to track but is not limited to the following patient data in each type of care: the number of patients, length of stay, average age, cost per patient, payment source, risk level, gender, race, admits by day, and admit type. Staff will also collect the reason someone came to the center for care. At the end of care, the program will ask patients to complete a "Guest Feedback Survey" to receive feedback regarding the quality of care received and the effectiveness of care. The data will be collected and stored in a dashboard to be evaluated regularly and over time for trending and improvement purposes. With the understanding that these are new services, staff will use the data to improve care and workflows to meet patient needs in a more specialized setting.

SUSTAINABILITY

Bartlett Regional Hospital is an enterprise of the City and Borough of Juneau and benefits from public funding and collaborative administration. BRH has operated behavioral health and mental health services, including crisis services, in various forms on the Juneau hospital campus for decades. Upon completion, the new Aurora Behavioral Health Center facility will be the hub of crisis healthcare in the region for the foreseeable future. BRH has well-established relationships with community partners and other healthcare facilities throughout the state and is committed to providing comprehensive crisis services for Southeast Alaska and those in need across the state of Alaska. These services are sustainable through public funding, general hospital funding and revenues, and reimbursement for patient care services through Medicaid and private insurance. Comprehensive operational modeling has been completed and indicates a path forward for sustainable operation of services.

WHO WE SERVE

Bartlett Regional Hospital's Aurora Crisis Services will lead the state in providing a crisis facility under the Crisis Now Model to meet the needs of Alaska Mental Health Trust beneficiaries with the City and Borough of Juneau. The Aurora Crisis Services intends to provide adult and adolescent 23-hour crisis observation/stabilization and adult and residential crisis stabilization residential services. The intent is to strengthen the care to allow a no-wrong-door approach that will quickly meet their level of care needs. This will be a cultural shift and how individuals experiencing a behavioral health crisis are cared for by diverting from an inappropriate care setting such as a medical emergency department and jail to a space allowing for time and grace with a staff trained to intervene with someone in crisis. The center will offer a safe, supportive, and appropriate behavioral health crisis placement for those who cannot be stabilized in their current setting. We aim to reduce the number of individuals housed in detention facilities (jails) and those placed on involuntary holds in a locked mental health unit. In addition, there is currently no place for immediate crisis care for adolescents in Juneau. If an adolescent needs emergent crisis care, they are either stabilized on the med surge floor of the hospital or transported to API or North Star. The goal is to keep the adolescent in their home community by stabilizing their crisis in a safe, therapeutic environment.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	1,300
Developmental Disabilities:	620
Substance Abuse	845
Traumatic Brain Injuries:	30
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	700
Number of people to be trained	39

BUDGET

Personnel Services Costs	$284,600.00
Personnel Services Costs (Other Sources)	
Personnel Services Narrative:	We request funds to bridge the startup period costs of retaining our crisis services staff during unforeseen delays. At the same time, we complete our new building, make the program operational, and begin to see patients and bill services. While training our staff in Crisis Now model best practices and other hospital cross-training and

	commencing operations, we request funds to support wages and benefits for salaries (partial and full FTE, as appropriate) of 10 BRH crisis staff for three months. Staff/FTE/Total cost for three mos. salary & benefits TOTAL $284,600 Behavioral Health Clinical Supervisor (.75FTE) - $29,555 Behavioral Health Clinician (1FTE) - $31,101 Behavioral Health Program Manager (1FTE) - $34,317 Navigators (3FTE) (25,209x3) - $75,627 Nurse Manager I (.50FTE) - $21,851 RNII (1FTE) - $33,616 RNIII (1FTE) - $40,236 RNIV (.40FTE) - $18,252

Space or Facilities Costs	$0.00
Space or Facilities Costs (Other Sources)	$10,009,000.00
Space or Facilities Narrative:	OTHER ORGANIZATION FUNDING Other organization(s) and funding sources have contributed to the multi-year construction of the Aurora Behavioral Health Center for crisis services. The facility planning and construction has been a complex project that is still underway and is nearing completion. Facility funding is multifaceted and explained in this application's "Other Costs" section.

Equipment Costs	$43,000.00
Equipment Costs (Other Sources)	$49,000.00
Equipment Costs Narrative:	We request funds to purchase additional necessary safety cameras and data storage. TOTAL $42,996 BRH received technical assistance from Amy Pugsley, previously with RI International, through its contract with Agnew::Beck, who recommended several additional cameras than what was initially planned in the BRH project. Because the project was so close to budget, conduit and cabling were run to the additional camera locations with a plan to install later if funding was found to support the additional cameras, many of which must be anti-ligature in the Level IV risk space. These cameras will improve patient care and resident and staff safety. Cost will cover the cameras, additional server storage needs, and licensing. BRH staff will install the cameras. BRH has already invested $49,000 in cameras, but their coverage

	needs to be improved for this facility's security and observation needs.

Other Costs	$148,600.00
Other Costs (Other Sources)	$100,000.00
Other Costs Narrative:	CPI Training Cost Breakdown and Narrative $28,630 total includes: **$7,200** training certification and membership for three trainers (two initial - $2500 and one renewal $1600 for the two years and a $200 membership fee for each trainer for two years) **$7,930** Estimated travel for three staff to attend two-day certification and two travel days ($1500 pp for airfare, $1,000 pp 3 nights hotel, $100 total for incidental Uber/transportation, and $110 pp for State per diem rate.) **$13,500** ($45 per employee attendee cost x 150 employees x 2 -once a year for two years). The hospital's current physical and verbal de-escalation program must meet community-based behavioral health programs' needs. We plan to train all BH employees who work in the building where Crisis Services are located and who may be responding to assist in the service lines. All Trust recipients who participate in other BRH Behavioral Health Services will benefit from the improved de-escalation training provided through CPI. Pugsley Consulting Breakdown and Narrative Total $120,000 includes: $96,000 - 40hrs/mo x 12mos x $200/hr $24,000 - Travel time @ $100/hr + actual travel costs Consultant Amy Pugsley will provide 12 months of training, program review, and implementation during the first year of establishment and operation of the full suite of crisis services. The consultant will provide 40 hours/month of service for 12 months at $200/hour, plus actual travel costs and $100/hour travel time, with a forecasted total of $120,000. Throughout the implementation process, BRH has consulted with Amy Pugsley, who has extensive knowledge of Crisis Now services. Ms. Pugsley will continue to provide leadership and team training, develop and revise workflow, assist with hiring protocols, develop departmental training content, provide ongoing in-person training, facilitate change management with attention to quality, safety, implementation of the model of care, ensure adherence to the Crisis Now model, and strategize with the

	administration on problems and questions that arise throughout the first year of establishment of services and operationalization. NOTE - Other Costs of $100,000 for previous consulting work by Agnew::Beck for the inception of this project were funded by an earlier AMHTA grant.

Total Amount to be Funded by the Trust	$476,200.00
Total Amount Funded by Other Sources	$10,158,000.00

OTHER FUNDING SOURCES

Department of Health and Social Services secured	$500,000.00
Rasmuson Foundation secured	$350,000.00
Premera secured	$1,000,000.00
CBJ Revenue Bonds secured	$8,000,000.00
Bartlett Regional Hospital Foundation secured	$8,000.00
Alaska Mental Health Trust Authority (previous grant funds for ABHC and Agnew::Beck) secured	$300,000.00
Total Leveraged Funds	**$10,158,000.00**

“Helping people live their own best lives”

June 13, 2023

To Whom It May Concern,

It is my pleasure to write in support of the new Crisis Stabilization and Residential Services starting by Bartlett Regional Hospital’s Behavioral Health Department. Crisis Observation and Crisis Residential Stabilization Services are intended to decrease the dependence on emergency room care while increasing places for youth and adults to go when in a crisis. Individuals in crisis can be evaluated in a more comfortable space (less noise and crowding) by providers who have specialized training in behavioral health and substance use disorders; unlike a traditional emergency department which can have long wait times and can be crowded.

Bartlett Regional Hospital’s Behavioral Health Department has embraced working with other community and statewide stakeholders to develop a crisis response continuum of care which promotes developing a coordinated system that offers a no wrong door approach to crisis care which the community currently lacks. Bartlett Regional Hospital will operate a Crisis Observation and Stabilization Services program and Crisis Residential Stabilization Services program in a new building designed specifically for these services with the intent of increasing the availability of outpatient support for someone experiencing a crisis at a lower cost than inpatient or emergency department services.

In conclusion, we have been involved in the planning for a Crisis Now model in Juneau for many years and support the efforts of Bartlett Regional Hospital’s Behavioral Health Department as they seek external funding to support the much-needed Crisis Observation and Stabilization Services and Crisis Residential Stabilization services. We look forward to the assurance that these resources will be available in our community when people need them.

If you have any questions please do not hesitate to contact me anytime at dave@jamhi.org .

Sincerely,

David G. Branding, PhD

David G. Branding, PhD

3406 Glacier Hwy
Juneau, Alaska 99801

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BARTLETT REGIONAL HOSPITAL
BEHAVIORAL HEALTH CRISIS SERVICES
TIMELINE

Initiation of Services and Implementation of Activities

June 22, 2022 – Fully executed contract signed between Bartlett Regional Hospital (BRH) and Agnew :: Beck to provide crisis services consultation to include planning for the center and financial modeling for the BRH crisis services.

August 22, 2022, Agnew :: Beck onsite at BRH to tour the Aurora Behavioral Health Building (which will house the crisis services), introduce key staff in the project, meet with finance and billing, senior leadership, and have an initial work plan development meeting.

October 3-4, 2022 - Bartlett Regional Hospital (BRH) staff, along with other agencies (Juneau Police Department, JAMHI Health and Wellness, SEARHC, City and Borough of Juneau Mobile Integrated Health) took part in an extensive 2-day tour of RI International located in Phoenix Arizona. Joining the team on this trip were members of our consulting team, Agnew :: Beck, and staff from the Alaska Mental Health, and the Alaska Department of Health. This was a great beginning to build the foundation of the Crisis Now Model. The trip provided firsthand experience to operation of a 23-hour observation and short-term residential stabilization units. Key components while in Arizona were understanding timely access to vital psychiatric care is often unavailable for individuals experiencing significant behavioral health crisis. A majority of these individuals going through a crisis experience have needs that align better with services delivered within a crisis facility. Additionally, fully understanding the key elements of a comprehensive behavioral health crisis system are: 1) Regional or statewide Crisis Call Centers 2) Centrally deployed mobile crisis teams on a 24/7 basis and 3) Crisis Observation and Stabilization Facilities. These new facility-based programs will provide law enforcement, first responders, and community members with a place to go for behavioral health crisis stabilization that is not a hospital emergency department or, by default, a secure correctional facility.. Through this experience in Arizona we left with confidence knowing community members will have someone to call, someone to come to, and some place to go 24/7 to receive appropriate services. Using the “No Wrong” door approach and saying “Yes” 100% of the time to those who experience a crisis.

November 2022 – Policies and Procedures previously developed for the services were collected for review, necessary updates, and identify other areas of policy needing development. Workflow development begins along with continued internal discussions about processes, continuum of services at BRH Behavioral Health and where crisis services fits.

November 4, 2022 - Regulation and licensing initial discussion of BRH timeline and needs with the Division of Behavioral Health.

December 16, 2022 – Chief Behavioral Health Officer participates in the Crisis Now Model Implementation Updates, Discussion, and Next Steps meeting in Anchorage.

December 21, 2022 – Crisis Now Juneau Community workgroup begins, facilitated by Agnew :: Beck.

December 22, 2022 – BRH staff and Tlingit & Haida leadership meeting for introductions, describe crisis services, develop next steps to collaborative partnership with shared patients and referral for ongoing services.

December 23, 2022 – BRH leadership meets with the Juneau legislative delegation to discuss the crisis services and progress of the ABHC.

January 4, 2023 – BRH BH leadership meets to review existing organizational chart and propose reorganization of staff, including identification of which staff will transfer to crisis services; Behavioral Health Assistants, Crisis Navigators, Mental Health Clinician, Psychiatric Emergency Services Clinicians.

January 6, 2023 – Meet and greet with BRH and the Department of Family and Community Services Commissioner's Office staff and Directors/Deputy Directors of Division of Juvenile Justice, Office of Children's Services, Alaska Psychiatric Institute, and Alaska Pioneers Home. Toured the ABHC to include the crisis services units under construction, discussed services, answered questions, attendees provided feedback.

January 24, 2023 – Alaska Mental Health Trust staff and trustees tour the ABHC to include the crisis services units under construction, discussed services, answered questions, attendees provided feedback.

February 2023 – Staff recruitment begins for Registered Nurses, Behavioral Health Assistants, and Mental Health Clinician. Recruitment and hiring process will be ongoing.

February 9, 2023 – Internal BRH meeting to discuss what is needed for setting up the crisis services structures in the EHR system within the hospital. These meetings are continuing monthly until project implementation.

February 15 – 16, 2023 – Technical Assistance providers from RI in Phoenix meet for two days to tour the crisis services space, provide input on workflow, processes, paperwork, staff recruitment, training needs, etc.

February 16, 2016 – Staff from Tlingit & Haida Behavioral Health services tour the ABHC to include the crisis services units under construction, discussed services, answered questions, attendees provided feedback.

March 2023 – Peer Support Specialist position description discussion, legal concerns, etc. Next steps identified.

March 2, 2023 – Lead staff at Providence Behavioral Health and Southcentral Foundation Behavioral Health tour the crisis services units under construction, discussing services, providing collaboration with the next two providers who will be opening COS and CSS programs.

March 6, 2023 – Walk through of crisis services units with Lt. Weske, Juneau Police Department, to collaborate on intake process, location to receive guests, etc.

April 2023 – Meeting requested with BRH legal advisor to discuss HR concerns with Peer Support Specialist interview criteria (lived experience). Reached out to Renee Rafferty at Providence Hospital to determine if they had a similar issue, which they had, and was currently sitting with their legal advisor.

April 11, 2023 – Continued consultation with Amy Pugsley discussing flow of patients from COS to CSS when needed, training plan and potential assistance to provide training.

May 14, 2023, new crisis staff (new to BRH) start and participate in New Employee Orientation.

May 22, 2023, crisis staff (currently working within Bartlett) participate in crisis services training with new crisis staff. All staff will participate in a 3-4 week extensive training (timeline below).

May 22 – May 26, 2023 – Delivery of furniture for the ABHC, staff move into the space.

Early June 2023 – Deliver personal open house invitations to community providers and stakeholders as well as crisis service brochures.

June 13, 2023 – Open House for community and community partners/stakeholders.

SERVICES DELAYED

~~June 19, 2023~~ – Service implementation for Adult COS and CSS, and Adolescent COS and CSS begins.

Proposed Timeline After Services Commence:

Daily

- Ongoing feedback for staff, identify areas for training needs, after action meetings when needed.
- Shift huddles to discuss guest needs, discharge planning, and

Monthly

- Internal meeting with BRH service lines to discuss successes and challenges, modify workflow, practice and policies as needed.
- Internal meetings with Patient Finance Services to ensure there are no billing complications, review process, and make adjustments where needed.
- Meeting with Juneau Police Department to discuss successes and challenges, modify workflow, practice, and policies as needed. Will also work to address issues as they arise with law enforcement to instill confidence in the services.
- Review prior month data to evaluate program outcomes and achievements.
- Evaluate programming and daily schedule within the CSS milieu for effectiveness.
- Evaluate need for increased frequency of meetings with providers/stakeholders.

Quarterly

- Meet with community stakeholders to discuss successes and challenges, modify workflow, practice and policies as needed.
- Provide quarterly data as required by the grant

Week 1

Topic	Hours
Orientation	**0.5**
Client/Family Centered Crisis Response Network *An overview of core training of the local crisis system of care, foundational learning to handle crises, and how to implement into care.*	**3**
Recovery Model *Introduction to recovery model of care and the importance of lived experience; EQ.*	**4.5**
Adolescent Development *What is adolescent Development?* *Provide case examples of crisis care.* *Overview of interworking of system and how to provide warm hand-offs of care.*	**8**
Wellness *Building resiliency as a crisis services provider, building stress reduction models and tools, and knowledge of resources in community.*	**8**
Community Relations ***Ethics*** *Summarize ethical standards and expectations of profession* *Understanding the brain and human behavior* *Risk factors for unethical behavior* *Recognizing and reporting unethical behavior*	**8**
Community Relations ***Diversity & Cultural Competency*** *Improving cultural awareness and reducing biases* *CLAS Standards*	**8**

Week 2

Topic	Hours
Community Relations ***Customer Service, Workplace Communication,*** *Recognize impact of professionalism* *Recognize interpersonal conflict and apply adaptive approaches toward resolutions.* *Enhance problem solving skills*	**4**
Client Rights/Grievances/Appeals *Handling client rights with care, timely processing of grievances, etc.* *Identify need for confidentiality and implications when used improperly*	**4**
Resource Utilization & Aftercare Planning *Enhance ability to identify and utilize resources available to community* *Collaboration with LEO* *How to manage individualized needs of clients, and connect to proper aftercare*	**3**
Power of Support *How/When to involve support system; collaborating with support system when available*	**2**
Documentation *How to document effectively, and recognize risk of ineffective and inaccurate documentation* *Managing clients with difficulty navigating services outside of crisis system of care*	**3**
Behavioral Health *Recognize actions and behaviors that indicate a person may be experiencing a behavioral health crisis. Incorporate peers in this module.* *De-escalation strategies to effectively work with an individual in crisis*	**8**

Week #2 Continued

How to identify individuals who use crisis services often and how to effectively engage them in furthering recovery	
Motivational Interviewing *How to guide communication with person in distress in a way that is empowering and moves toward recovery*	**8**
Trauma-Informed Care *How to serve persons in distress with awareness of potential trauma and triggers*	**8**

Week 3

Topic	Hours
EHR and Documentation	**8**
Comprehensive Assessment & Case Planning	**8**
CPI, ASIST, (or similar) & Critical Incidents	**8**
CPI, ASIST (or similar) & Critical Incidents	**8**
Final and/or Presentations and/or Vignettes	**8**

Memorandum of Agreement between

Bartlett Regional Hospital Behavioral Health

and Juneau Police Department

The purpose of this Memorandum of Agreement is to delineate the collaborative working and referral relationship between Bartlett Regional Hospital Behavioral Health, Aurora Crisis Services, and the Juneau Police Department, to provide an alternative to emergency department and/or secure correctional confinement (when appropriate), for individuals experiencing a behavioral health or substance use disorder crisis.

Both parties agree to:

1. Work collaboratively upon the opening of Aurora Crisis Services to review processes and procedures for improvement and efficiency.

2. Designate specific personnel to participate in monthly meetings to review processes and procedures for improvement and efficiency. This may include training/education for law enforcement about mental illness.

3. Ensure guests arriving at Aurora Crisis Services for crisis stabilization are treated with dignity and respect.

4. Work to ensure a safe referral and admission process for guests needing crisis stabilization services, BRH staff, and law enforcement personnel.

Bartlett Regional Hospital Behavioral Health, Aurora Crisis Services, agrees to:

1. Accept all guests referred to Aurora Crisis Services by law enforcement or other emergency personnel utilizing the "No Wrong Door" philosophy.

2. Designated parking space for emergency personnel in the parking garage under the Aurora Behavioral Health Center.

3. Promptly provide law enforcement personnel with required documentation or develop an electronic document for completion and electronic transmittal, to ensure law enforcement staff are able to return to service in a timely manner. The anticipated goal for the first year of services is to have law enforcement able to return to service within five minutes of arrival at crisis services.

4. Use a handheld wand to search for weapons or other contraband of arriving guests before law enforcement return to service.

5. Engage in ongoing dialog with Juneau Police Department to support continuous quality improvement and collaborative problem-solving.

6. Recognize the role of Juneau Police Department in addressing emergent public safety risk is essential and important.

Juneau Police Department agrees to:

1. When possible, notify Aurora Crisis Services prior to arrival with an individual needing crisis care.

2. Utilize designated parking in the parking garage under the building to provide a more safe and confidential transition from custody to crisis services.

3. Complete and sign required documentation needed by Aurora Crisis Services prior to leaving BRH campus.

4. Ensure that any guest being transported to Aurora Crisis Services has been thoroughly searched for weapons or contraband.

5. Remain on premises while BRH Aurora Crisis Services staff use a handheld wand to perform an additional search for weapons or other contraband that could cause harm to the guest, BRH staff, or other crisis services guests.

6. For adolescent patients, provide Aurora Crisis Services staff with the name of the parent/guardian as well as contact information, if available.

7. For adolescent patients, ensure that the parent/guardian of the patient has been notified of their child's transport to Aurora Crisis Services for continuing crisis stabilization care.

This agreement shall remain in effect from the date of signing, until either party notifies the other of a desire to modify or terminate, with a 30-day written notice.

E. Mercer	4-10-2023
Juneau Police Department	Date
Chief of Police

Tracy A. Dompeling	4/10/2023
Bartlett Regional Hospital Behavioral Health	Date
Chief Behavioral Health Officer

Bartlett Regional Hospital
Aurora Crisis Services
Community Partners and Relationships

- **Department of Health** – ongoing discussions regarding licensure type, proposed regulations

- **Department of Family and Community Services** – discussions with Office of Children's Services regarding the need for collaboration/memorandum of agreement for youth in DFCS custody receiving crisis custody

- **Alaska Mental Health Trust Authority** – provided support for consultants, on-site observation of established Crisis Now Model in Arizona, on-site technical assistance at ABHC with RI International, continued support and guidance to support program implementation.

- **Agnew :: Beck** - Business model development, consultation, multi-media service description development

- **Juneau Police Department** – development of MOA, on-site discussion of best use of space for law enforcement for drop off of crisis guests

- **JAHMI** – ongoing collaboration when guests are receiving community services from JAHMI and referral to services.

- **SEARHC** - ongoing collaboration when guests are receiving community services from SEARHC and referral to services.

- **Tlingit & Haida** – ongoing collaboration when guests tribal members and receiving community services from Tlingit & Haida, and referral to services.

- **Providence Health Corporation** – Ongoing collaboration as we both develop similar services under the Crisis Now Model, brainstorming, touring of ABHC facility, discussion of service delivery.

- **Southcentral Foundation** – Ongoing collaboration as we both develop similar services under the Crisis Now Model, brainstorming, touring of ABHC facility, discussion of service delivery.

- **Crisis Call Center (Statewide & Local) -** Initially have reached out to connect with local call center agencies and 988 oversight to discuss services, implementation date, and connection of guests to services.

- **Crisis Now Model Meetings with Agnew :: Beck and Alaska Mental Health Trust Authority** – participation in community meetings to discuss the full Crisis Now model implementation in Juneau, call center and mobile crisis response existing services and what, if anything, is needed in the community to enhance these two service types within the model.

Memorandum of Agreement for Juneau Behavioral Health Providers for FY22

The Behavioral Healthcare provider signatories to this memorandum of agreement commit their agencies to the following:

All parties wish to develop and maintain behavioral health services in Juneau of the highest quality. The parties acknowledge that this can only be accomplished by a renewed commitment to respect, openness, cooperation, and coordination between service providers. The purpose of this MOA is to facilitate a working relationship at the highest level between behavioral health providers and other related providers in Juneau so that our community can move forward with a fully integrated system of care. This MOA remains open to additional agencies which may in the future constitute a part of the system of care for our service area.

I. All parties that sign on to this memorandum agree to the following principles regarding integrated behavioral health services:

1. Assign appropriately empowered and authorized staff to participate in integrated system planning and program development activities.

2. Adopt the goal of achieving co-occurring disorders proficiency as part of the agency's short and long range strategic planning and quality improvement processes.

3. Participate in system wide efforts to improve identification and reporting of individuals with co-occurring disorders by incorporating agency specific improvements in screening and data capture in the action planning process.

4. Participate in system wide efforts to improve welcoming access for individuals with co-occurring disorders by adopting agency specific welcoming policies, materials, and expected staff competencies.

5. Participate in system wide efforts to enhance utilization of existing funding streams for integrated treatment by adopting specific policies, procedures, and training activities. This will involve implementation of regulatory clarifications and interpretive guidelines regarding reimbursement and documentation of integrated treatment, such that new procedures will be reflected in existing treatment plans, progress notes, and billing documentation.

6. Develop specific procedures to provide access to reimbursable on site (co-located) mental health and substance abuse assessments for service recipients who require specialized assessment for both disorders, in addition to the program's routine integrated screening and assessment protocol.

7. Assign appropriate clinical leadership to participate in interagency care coordination meetings as they are developed and organized.

8. Identify appropriate clinical and administrative staff, as well as service recipients and families where appropriate, to participate as trainers in the implementation of the agency's integrated services.

II. Each organization or individual who signs on to the memorandum agrees to:

1. Work to create an integrated system of care in which consumers receive the best possible services.

2. Establish a contact person within each agency that is responsible for tracking client information, sharing activities and complying with the rules and regulations regarding information sharing.

3. Be solution-focused rather than barrier-driven.

4. Work to create a welcoming system in which there is no wrong door.

5. Promote clinical integration, effectiveness, and efficiency.

6. Reduce redundancy for consumers i.e. multiple intake/assessments.

7. Recognize that each agency is a steward of public money.

8. Focus on positive outcomes and consumer satisfaction.

9. Utilize evidence based best practices and established state best practices.

10. Develop and review written policies and procedures to ensure that confidential information is shared in an appropriate and legal way.

11. Work toward the goal of achieving administrative efficiencies, and operate in an administratively efficient manner.

12. Solicit participation of additional community resources to enhance collaboration and the continuum of care.

III. With regard to the delivery of services to consumers by the signatory agencies, each agrees as follows:

1. Member agencies will enhance consumer linkage to services:

    - Individuals seeking services will be provided with connectivity services regardless of point of entry and lasting until consumer has an established point of contact with an appropriate service provider.
    - Participating entities will be familiar with services provided by other agencies in Juneau and provide information regarding these services to consumers.
    - Staff will make best effort to directly and actively link consumers to the most appropriate agency. The agency that is the initial point of contact will request

permission to share consumer information to ease transition to appropriate services.

- At the receiving agency, staff will meet with consumers to evaluate the appropriateness of the referral. The receiving agency also agrees to provide feedback to the agency from which the consumer was sent.

2. Become familiar with partner agency services, share information and evaluate system-wide gaps.

   - Member agencies agree to commit to have resource and referral staff meet regularly to increase connection and ease referral by familiarizing staff with partner agency processes as well as with one another.

   - Document individuals for whom there is no known service agency currently providing appropriate services.

3. Accept substance abuse assessments that adhere to state and federal Behavioral Health standards.

4. Accept mental health assessments that adhere to state and federal Behavioral Health standards.

5. Accept co-occurring disorder assessments that adhere to state and federal Behavioral Health standards.

6. Share information about and access to staff training opportunities.

7. Participate in interdisciplinary teams to facilitate case management and services for consumers who have co-occurring disorders and other shared clients.

8. Exchange consumer information for shared clients within the standards established under current laws, rules and regulations.

IV. Regular Coordination Meetings

Parties to this agreement agree to the following framework regarding regular coordination meetings:

1. The parties will meet in person at minimum on a quarterly basis, and more often as needed.

2. The purpose of the meetings will be to:

   a. Review progress in accomplishing activities in the community action plan.

   b. Periodically reviewing and updating this memorandum of agreement, the Juneau Behavioral Health Continuum of Care, and the Affiliation Agreement Creating Integrated Primary Care and Behavioral Health Services.

c. Sharing other coalition and agency based information that will enhance the coordination and integration of behavioral health prevention and intervention services.

3. The meetings will be facilitated by the Juneau Youth Services Executive Director or designeee, who will also develop the meeting agendas.

4. Minutes will be taken at each meeting summarizing discussion and actions. The responsibility for minutes will be rotated among the parties to this agreement.

This MOA is open for any agency that agrees to with the philosophies outlined above.

All communication between programs will be in adherence to the client confidentiality requirements of 42 CFR Pt II and the Health Insurance Portability Accountability Act (HIPAA)/HITECH and any other applicable state and federal laws, rules and regulations.

Administrative Terms of Agreement

This agreement shall be in effect as of the date of the agreement is signed by all of the initiating parties.

MODIFICATION OF AGREEMENT:
Modification of this agreement shall be made only by consent of the majority of the initiating parties. Such shall be made with the same formalities as were followed in this agreement and shall include a written document setting forth the modifications, signed by all the consenting parties.

OTHER INTERAGENCY AGREEMENTS:
All parties to this agreement acknowledge that this agreement does not preclude or preempt each of the agencies individually entering into an agreement with one or more parties to this agreement. Such agreements shall not nullify the force and effect of this agreement.

<u>SIGNATURES OF PARTIES TO THIS AGREEMENT:</u>
Upon signing this agreement, this original agreement and signatures will remain on file at the Division of Behavioral Health. A copy of the agreement and signatures shall be provided to each signatory to the agreement in time to include in the grant applications.

<u>ADDITION OF NEW COLLABORATIVE MEMBERS:</u>
The parties not only welcome but agree to solicit and welcome the addition of new collaborative members who provide Behavioral Health services. New agencies and providers can become collaborative participants in this MOA by agreeing to the terms and adding their signature to the document.

DocuSigned by:
Amy Simonds-Taylor
6955A2B72DCB45C...
Amy Simonds, ED, Juneau Youth Services

8/12/2021
Date

DocuSigned by:
Samantha Abernathy
8E463C8CA63E439...
Samantha Abernathy, Executive Director, Gastineau Human Services

8/30/2021
Date

DocuSigned by:
Charles Clement
C66E14E288864E4...
Charles Clement, CEO-President, SEARHC

8/8/2021
Date

DocuSigned by:
Bruce Van Dusen
17CA27EB0A74422...
Bruce Van Dusen, Executive Director, Polaris House

8/6/2021
Date

DocuSigned by:
Dave Branding
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Dave Branding, CEO, JAMHI Health and Wellness

8/8/2021
Date

DocuSigned by:
Bradley Grigg
8DC1F0D550C5466...
Bradley Grigg, Chief Behavioral Health Officer, Bartlett Regional Hospital

8/6/2021
Date

DocuSigned by:
Mandy Cole
83F4A0DD92944BA...
Mandy Cole, Executive Director, AWARE

8/6/2021
Date

DocuSigned by:
Aaron Surma
DCEEB4BD4B9045B...
Aaron Surma, Executive Director, NAMI-Juneau

8/10/2021
Date

Memorandum of Agreement between

Bartlett Regional Hospital Behavioral Health

and SouthEast Alaska Regional Health Consortium

FY24 DHSS CBHTR (July 1, 2023 – June 30, 2024)

The purpose of this Memorandum of Agreement is to delineate the collaborative working and referral relationship between Bartlett Regional Hospital – Behavioral Health and SouthEast Alaska Regional Health Consortium (SEARHC) to improve the access and quality of Behavioral Health Services to Alaskans.

Both Parties agree to:

1. Build our interagency relationships and seek to improve the efficacy of services that both agencies provide for our patients.
2. Protect anonymity for our patient and confidentiality of all information related to patient and adhere to all state and federal laws/ regulations regarding patient confidentiality, especially 42 CFR (part 2) and 45 CFR (Parts 160 and 164). It is agreed that information will be exchanged on an as needed basis to effectively deliver the programs and services outlined in this agreement.
3. Agree designate a staff person(s) who functions as a liaison for purposes of coordinating and facilitating referrals and discharges.
4. Work together to identify common training needs and collaborate in providing staff training and in sharing training resources.
5. Work collaboratively to make optimum use of each agency's expertise and resources to best service our target populations.

<u>SEARHC agrees to:</u>

1. Evaluate/ assess patients in a psychiatric emergency.
2. Provide pertinent demographic and clinical assessment information by phone, secure email, and/or fax.
3. Jointly work with BRH staff to develop appropriate discharge plans for patients transitioning to
SEARHC for continuing care.
4. Forward appropriate records, including assessments and discharge summaries in a timely manner, in accordance with law and regulations.
5. Accept as sufficient the conclusions and recommendations of a diagnostic assessment to determine treatment needs accomplished by BRH staff.

BRH agrees to:

1. Coordinate discharge planning with SEARHC for those patients who wish to follow-up with services with SEARHC.
2. Maintain contact with SEARHC BH staff to ensure communications of final discharge plans,

whenever possible contact will be made within a minimum of 48 hours prior to discharge.

3. Forward appropriate medical records, including assessments and discharge summaries in a timely manner, in accordance with law and regulations.

4. Accept as sufficient the conclusions and recommendations of a diagnostic assessment to determine treatment needs accomplished by SEARHC Clinical Staff.

This agreement shall remain effective from the date of signing, until either party notifies the other of
a desire to modify or terminate, with a 30-day written notice.

X Daniel Keith

X 3/10/2023
Eric Gettis
Vice President, Behavioral Health Services

Society of St. Vincent de Paul – St. Therese Conference

Juneau, Alaska

svdpjuneau.org

We provide material and spiritual charity and work for social justice for all people.

Society of St. Vincent de Paul

St. Therese Conference

8617 Teal St., Juneau, Alaska 99801

(907) 789-5535 phone
(907) 789-2557 fax

June 13, 2023

Re: Bartlett Regional Hospital Crisis Stabilization and Residential Services

To Whom it may Concern:

As Executive Director of the Society of St. Vincent de Paul, it is my pleasure to write a letter in support of the new Crisis Stabilization and Residential Services starting by Bartlett Regional Hospital's Behavioral Health Department. Crisis Observation and Crisis Residential Stabilization Services are intended to decrease the dependence on emergency room care while increasing places for youth and adults to go when in a crisis. Individuals in crisis can be evaluated in a more comfortable space (less noise and crowding) by providers who have specialized training in behavioral health and substance use disorders; unlike a traditional emergency department which can have long wait times and can be crowded.

Bartlett Regional Hospital's Behavioral Health Department has embraced working with other community and statewide stakeholders to develop a crisis response continuum of care which promotes developing a coordinated system that offers a no wrong door approach to crisis care which the community currently lacks. Bartlett Regional Hospital will operate a Crisis Observation and Stabilization Services program and Crisis Residential Stabilization Services program in a new building designed specifically for these services with the intent of increasing the availability of outpatient support for someone experiencing a crisis at a lower cost than inpatient or emergency department services.

As an agency on the front line serving the neediest of the community, I witness every day the increased stresses on individuals and especially families that has been caused by the challenges of COVID and its aftermath. Mental health crisis services are needed now more than ever, and having a local program that allows immediate services and keeps patients within our community will be a huge asset.

In conclusion, I fully support the efforts of Bartlett Regional Hospital's Behavioral Health Department as they seek external funding to support the much-needed Crisis Observation and Stabilization Services and Crisis Residential Stabilization services to assure the resources are available for our community members when they need them. If you have any questions regarding our support for this program, please do not hesitate to contact me at 907-321-7026.

Sincerely,

Dave Ringle

Dave Ringle
Executive Director
Society of St.Vincent de Paul - Juneau

EQUAL HOUSING OPPORTUNITY

Society of St. Vincent de Paul
St. Therese Conference
8617 Teal St., Juneau, Alaska 99801
(907) 789-5535 phone
(907) 789-2557 fax

We provide material and spiritual charity and work for social justice for all people.

EQUAL HOUSING OPPORTUNITY

Trust
Alaska Mental Health
Trust Authority

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

MEMO

To:	Agnes Moran - Program & Planning Committee Chair
Date:	July 26, 2023
Re:	FY24 Housing & Long Term Services & Supports Focus Area Allocation
Amount:	$375,000.00
Grantee:	Juneau Housing First Collaborative
Project Title:	Forget-Me-Not-Manor Phase 3

REQUESTED MOTION:

"The Program & Planning Committee approves a $375,000 FY24 Housing & Long Term Services & Supports focus area allocation to the Juneau Housing First Collaborative for the Forget-Me-Not-Manor Phase 3 project. These funds will come from the Supportive Housing Projects line of the FY24 budget."

Assigned Program Staff: Kelda Barstad

STAFF ANALYSIS

The Juneau Housing First Collaborative's Forget-Me-Not-Manor Phase 3 project will develop 28 units of permanent supportive housing using the Housing First method for chronically homeless adults in Juneau. This Trust funding will support construction of the new, Phase 3 units. Forget-Me-Not Manor serves people who are chronically homeless, meaning they have been homeless for a year or more and have at least one disability or chronic condition, with the most prevalent being chronic medical and behavioral health conditions. As with Phase 1 and 2, Phase 3 will serve 100% Trust beneficiaries and all categories of Trust beneficiaries are eligible, with the most common categories served expected to be beneficiaries experiencing a mental illness or addiction.

The building will be located on the same property as Phase 1 and 2 projects, which have been operating successfully since 2017 and 2022 respectively. In addition to housing, supportive services will be offered. On the property is a health clinic that offers outpatient medical care, behavioral health care, and prescription services. Forget-Me-Not Manor shares housing support staff across Phases for staffing efficiency. This project is a collaboration between many community partners and is a priority for Juneau's comprehensive continuum of care plan.

Homeless beneficiaries are at significant risk of institutionalization. Permanent supportive housing is a proven intervention that disrupts the hospital, corrections, and homelessness cycle to allow people to remain stably housed and have the opportunity to engage in supportive services to meet their goals.

People who were housed through Phase 1 of this project showed that after 6 months of being housed: emergency room visits decreased by 65%, sleep-off center usage decreased by 99%, and police contact decreased by 72%. This is significant for any population and incredibly impactful considering the median number of months homeless for this group was 180 months - approximately 15 years. Five years of data have been collected from the Phase 1 and Phase 2 projects through studies conducted by the University of Alaska Anchorage, School of Social Work. The “Forget Me Not Final Outcomes Report and Five-Year Data Summary” is attached. Statistically significant decreases in police interaction and emergency room usage were shown across projects and time frames. The number of days of drinking alcohol and binge drinking reduced after being housed and both self-reported physical and mental health and wellbeing improved. The outcomes support additional investment in this type of intervention. This project is recommended for funding as it aligns with the focus areas of Housing & Home and Community Based Services and prevents the institutionalization of Trust beneficiaries.

COMP PLAN IDENTIFICATION

Goal	Objective	Comments
Goal 3 Economic and Social Well-being	3.1 Housing	

PROJECT DESCRIPTION

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

PROJECT DESCRIPTION

Forget-Me-Not-Manor, Phase 3 will add 28 units of permanent supportive housing to the existing building. The units will be identical to Phases 1 and 2 units and robust supportive services will be provided to the additional 28 residents. This phase will complete the Forget-Me-Not-Manor project by maxing out the site. This project will improve the lives of AMHTA by offering quality resident-centered permanent supportive housing, helping to reduce Juneau's housing crisis and further limit emergency service utilization.

Phase 3 of the Forget-Me-Not-Manor project will create 28 additional permanent supportive housing units for individuals who currently do not have other options. Existing permanent supportive housing units in Phases 1 and 2 are always full and there is a long list of Trust beneficiaries on a waitlist who will significantly benefit from permanent supportive housing. Due to a high rate of trauma, substance use, and co-occurring disorders, these individuals have been unable to maintain housing, and emergency shelter is not a good long-term option. Most have been evicted and have terrible references due to an inability to comply with program and lease conditions. Many are prevented from accessing housing due to an inability to present well at interviews. Juneau, Alaska, and the rest of the nation are in the midst of a housing crisis with severe shortages of all types of housing available but there is a particular lack of permanent supportive housing. There is simply not enough housing with supportive services on site available. Continuum of care providers report that most chronically homeless adults in Juneau have completed short-term substance use treatment programs multiple times. However, they cannot remain stable due to experiencing homelessness immediately upon exiting treatment or jail/prison. Providing permanent supportive housing increases the possibility of housing stability. This project fills a crucial gap. The result of this expanded housing opportunity will benefit the entire continuum of care, allowing more availability and choice in the community for persons experiencing homelessness, in Juneau and throughout Southeast Alaska. Most importantly this project will ensure that those experiencing chronic homelessness in Juneau will have a chance to not die on the streets.

Phase 3 will build 28 more units of housing that will be attached to the existing Forget-Me-Not-Manor building. The units will contain bathrooms and kitchens and be accessible by an elevator and by stairs. Access to the new units will still be through the secure front door. The same tenant selection process, a referral from the Coordinated Entry Case Conference, will apply to these new units. The units will feature the same durable and easy-to-clean materials and high energy rating as the existing units. The Juneau Housing First Collaborative anticipates starting construction in the Spring of 2024 and finishing in the Spring of 2025 with a construction period of 10-11 months from groundbreaking to occupancy. Phase 1 and 2 have demonstrated reductions to emergency service utilization and improved quality of life among existing residents through the 5-year study completed by the University of Alaska. The study also demonstrates the extreme vulnerability of the residents and that the need for permanent supportive housing is acute.

The additional units target adults who are experiencing chronic homelessness, are AMHTA beneficiaries, are suffering from cooccurring disorders, and are high utilizers of emergency services such as the hospital emergency room, police department, Capital City Fire and Rescue, are vulnerable, likely to die on the street. The project will serve people who are homeless in Juneau and Southeast Alaska.

Outcomes include the creation of 28 new units of permanent supportive housing. Homes for 28 AMHTA beneficiaries, the homes will be furnished and all residents will have access to an array of robust supportive services, including primary and behavioral health care, addiction treatment services, assistance with basic life skills, wellness activities, and other services. Reduction in emergency services utilization is expected. Improvement in quality of life and an increase in housing and personal stability are expected.

The project has broad community support. The City and Borough of Juneau Assembly unanimously approved a 1.4-million-dollar appropriation for the project in May 2023. The Juneau Coalition on Housing and Homelessness has made the project a priority for the upcoming years, citing the housing crisis and the specific need for permanent supportive housing to address Juneau's homelessness challenges. The Juneau Non-Profit Developer's Council has prioritized the project. No opposition to the project has been raised. Senator Murkowski has submitted a congressionally designated appropriation request on behalf of the project after visiting Juneau and speaking with social service providers and community members. The project has received a letter of support from all of the members of the Juneau Delegation.

EVALUATION CRITERIA

The purpose of the project is to end the cycle of chronic homelessness by adding permanent supportive housing units to the Juneau housing stock. This will improve the quality of life and safety of AMHTA beneficiaries who are chronically homeless, and reduce emergency service utilization. The factors below will be used to evaluate the success of this project.

Project Completeness:

- Was the project completed within the planned timeline? ____Yes ____No
  If no, what was/were the reason/s for the delay, and what can be done to avoid such delays in the future?

- Was the project completed under/on budget? ____Yes ____No
  If not what was/were the reason/s and what can be done to avoid overage in the future?

Housing Outcomes:

- What is the vacancy rate? Is it below 5%?
- Are individuals in the apartments able to maintain stable housing?
- Are there still barriers to housing that need to be eliminated? Is the rent truly affordable?
- Are appropriate supportive services, such as mental health services being utilized?
- How many residents returned to homelessness?
- How many residents remain stably housed in the building or have moved onto other stable housing after 1 year, 2 years, 3 years, 4 years, or 5 years?

Resident Outcomes:

- Is there a reduction in emergency service utilization among residents?
- How many residents gained employment after moving into the building?

SUSTAINABILITY

Phase III will rely on the same funding mechanisms as Phases 1 and 2. Specifically, sponsor-based vouchers for every unit. The project will utilize existing Special Needs Housing grant funds and will also utilize rental income due from the residents to ensure that appropriate staffing levels are maintained. The program is sustainable due to robust clinical services provided by partner agencies that can bill Medicaid and other payer sources. Furthermore, additional Phase 3 units will improve the economy of scale for staffing, contributing to further sustainability.

WHO WE SERVE

Every person who will live in the new Phase 3 units and the people who are living in the existing 64 Forget-Me-Not-Manor units is an Alaska Mental Health Trust beneficiary. Residents are referred to the program by the Juneau Continuum of Care Case Conference which consists of representatives from the hospital, emergency services, and continuum of care providers. Adults experiencing chronic homelessness and suffering from symptoms of mental illness and substance abuse are the project's target population. Residents are prioritized based on the acuity of needs and the length of time they have spent experiencing homelessness.

A 5-year study completed by the University of Alaska clearly shows that Trust beneficiaries who were homeless benefit from living in permanent supportive housing with access to robust support services. The study is attached to this application and shows an increase in stability, perceived

sense of safety, reported improvement in quality of life, and a dramatic decline, across the board in the hospital emergency room and other emergency service interactions.
Permanent supportive housing changes the lives of everyone in the community for the better. This includes Trust beneficiaries who are no longer homeless and their family members and neighbors who get relief knowing that their friends and loved ones will not die on the street and receive concrete help.

ESTIMATED NUMBERS OF BENEFICIARIES SERVED EXPERIENCING:

Mental Illness:	28
Substance Abuse	28
Secondary Beneficiaries(family members or caregivers providing support to primary beneficiaries):	100
Number of people to be trained	15

BUDGET

Space or Facilities Costs	$375,000.00
Space or Facilities Costs (Other Sources)	$5,225,000.00
Space or Facilities Narrative:	All AMHTA funds will be used for the construction of the new units.

Total Amount to be Funded by the Trust	$375,000.00
Total Amount Funded by Other Sources	$5,225,000.00

OTHER FUNDING SOURCES

City and Borough of Juneau	$1,400,000.00
Rasmuson Foundation	$500,000.00
US HUD Congressionally Designated appropriation	$2,000,000.00
AHFC GOAL round	$1,200,000.00
Community Fundraising and private foundations	$125,000.00
Total Leveraged Funds	**$5,225,000.00**

Juneau
Coalition on
Housing &
Homelessness

City and Borough of Juneau
Mr. Rorie Watt, CBJ Manager
RE: Juneau Housing First Collaborative Phase III

Dear CBJ Assembly Members and Mr. Manager:

This letter supports a funding request for the development and construction of Phase III of the Juneau Housing First Collaborative Project. Phase 3 would add 28 units of housing to the existing building. Three of the units will be used for the Juneau Medical Respite Program.

The Juneau Coalition of Housing and Homelessness (JHCC) is a partnership of local agencies and organizations who serve Juneau's most vulnerable residents, the homeless, and those most affected by limited housing and the high cost of living. These organizations participate in the Juneau Continuum of Care by providing emergency, transitional, permanent supportive, and supportive services to clients and are working together to develop solutions.

Phases I and II of the Juneau Housing First Collaborative Project have been in operation since 2017 and 2022 respectively. Both projects clearly demonstrate a dramatic reduction in the usage of emergency services such as BRH's Emergency Department and Capital City Fire and Rescue among the residents. In addition to reduction in emergency services utilization, a five-year study conducted by the University of Alaska using data from Bartlett Regional Hospital, CCRF, and program tenants demonstrates an improvement in the quality of life of residents as well. Social service agencies report improvements in service delivery as a result of the project coming online.

It is clear that Juneau has a housing crisis for all types of housing. People who need permanent supportive housing are highly vulnerable and are likely to die on the street. They are high utilizers of CBJ's emergency services. Juneau Housing First Collaborative has a great track record in developing and operating permanent supportive housing. Municipal support will help the development and construction of this project.

JCHH understands that the request is significant and the timeline tight. Phase 3 of housing first will reduce the housing crisis by adding to the stock of permanent supportive housing, will dramatically reduce emergency service use, improve the quality of life, and will bring millions of dollars in construction and operating funding to Juneau. Housing First Phase 1 and 2 have had a tremendous impact on our community.

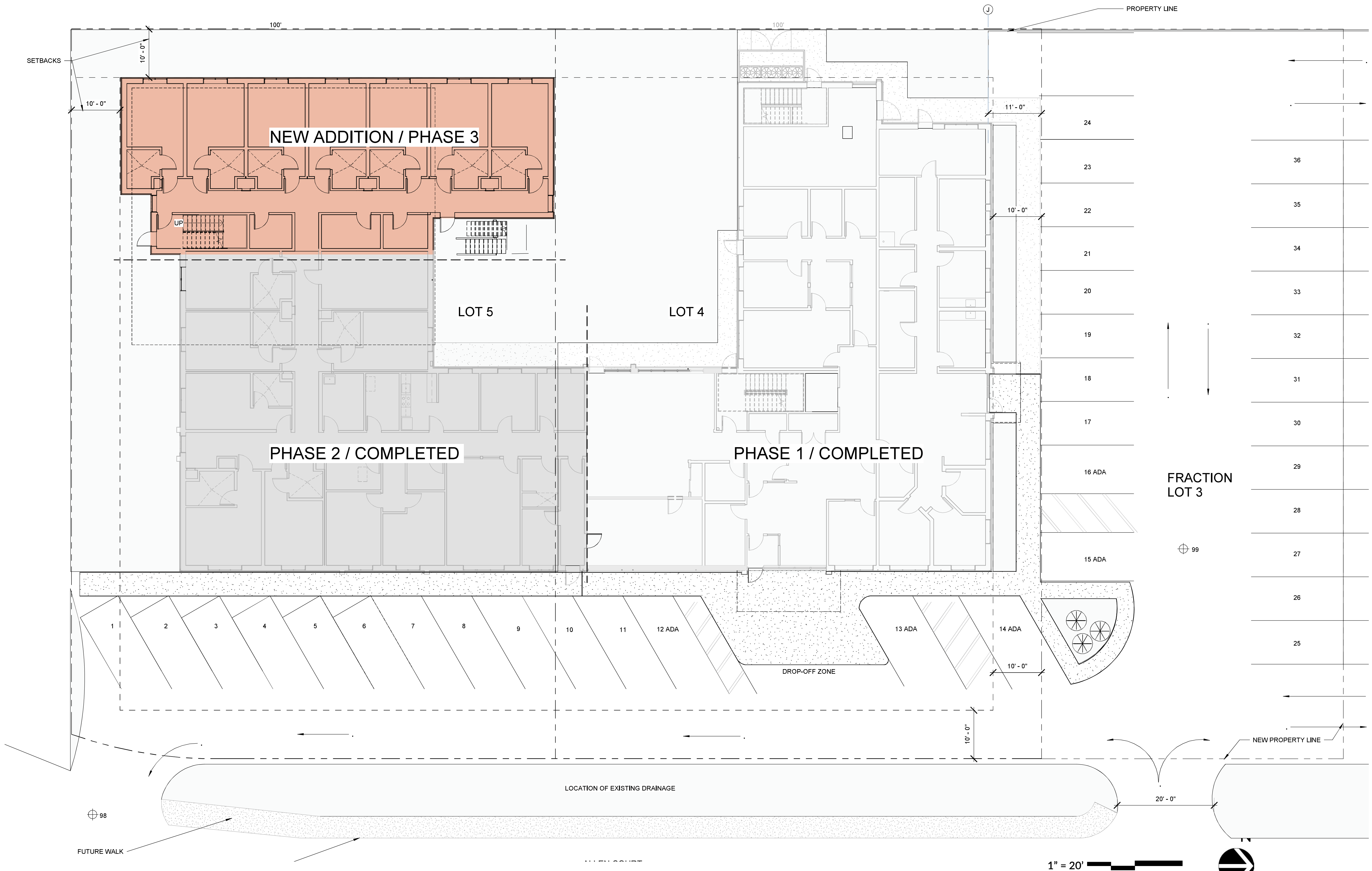
Sincerely,

Dave Ringle

Dave Ringle
Co-chair of JCHH
Executive Director
Society of St. Vincent de Paul St. Therese Conference

Hazel LeCount

Hazel Lecount
Co-chair of JCHH
Executive Director
Polaris House



JUNEAU HOUSING FIRST
PHASE 3

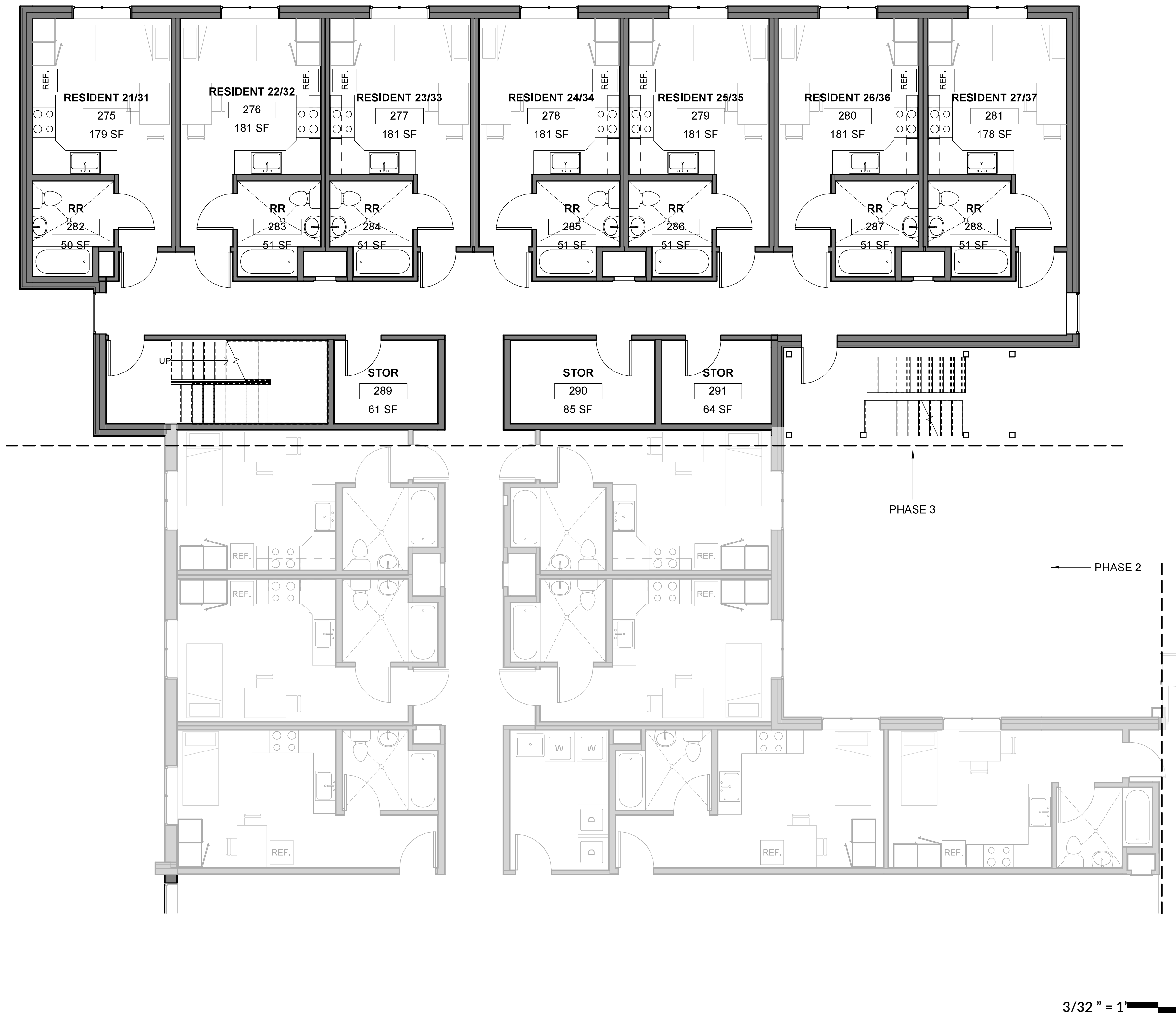
15 FEBRUARY 2023

OVERALL SITE PLAN

MRV ARCHITECTS
ARCHITECTURE · PLANNING · INTERIORS

FLOOR 1 PLAN

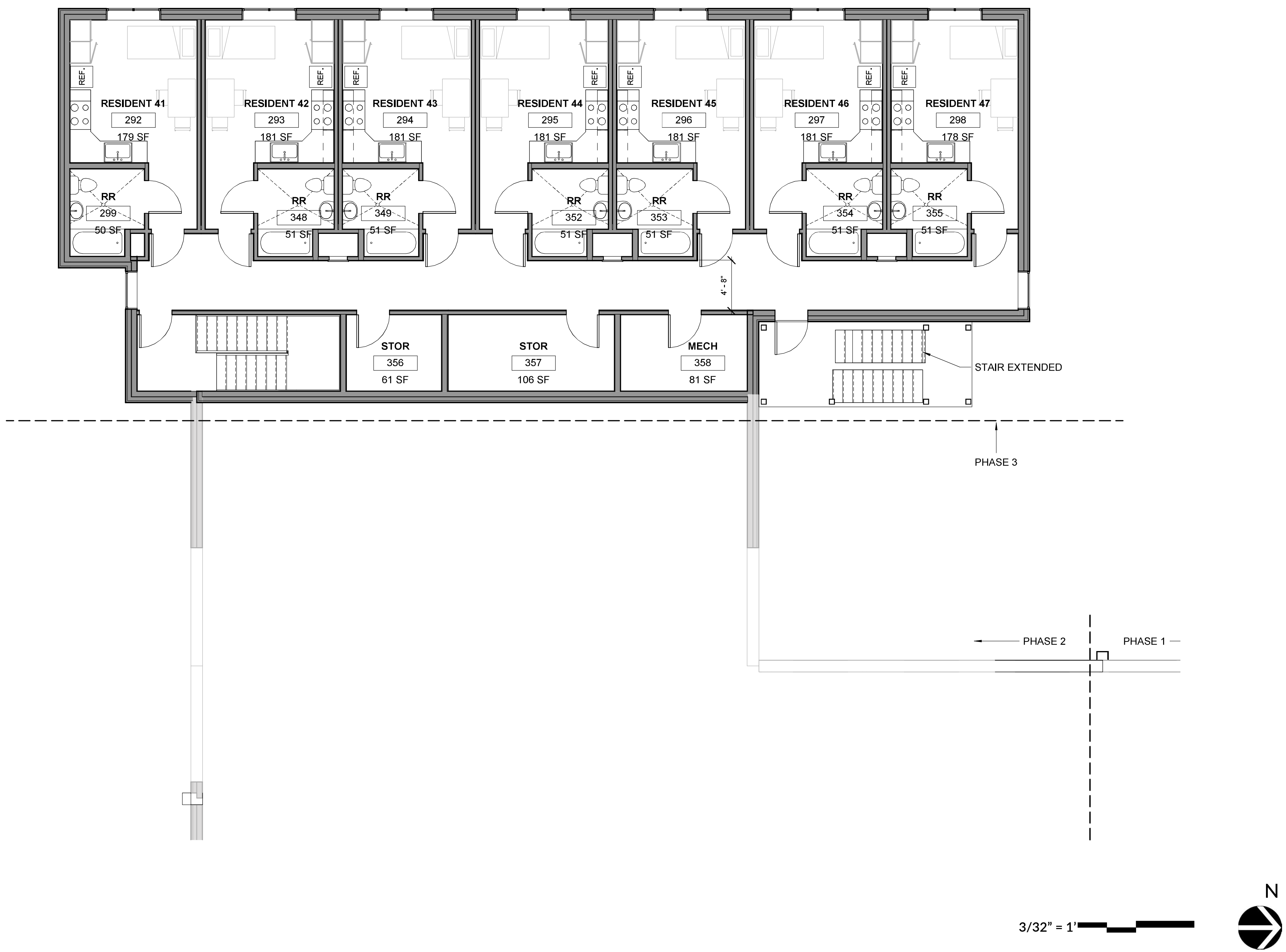
MRV ARCHITECTS
ARCHITECTURE · PLANNING · INTERIORS



JUNEAU HOUSING FIRST
PHASE 3
15 FEBRUARY 2023

FLOOR 2/3 PLAN

MRV ARCHITECTS
ARCHITECTURE · PLANNING · INTERIORS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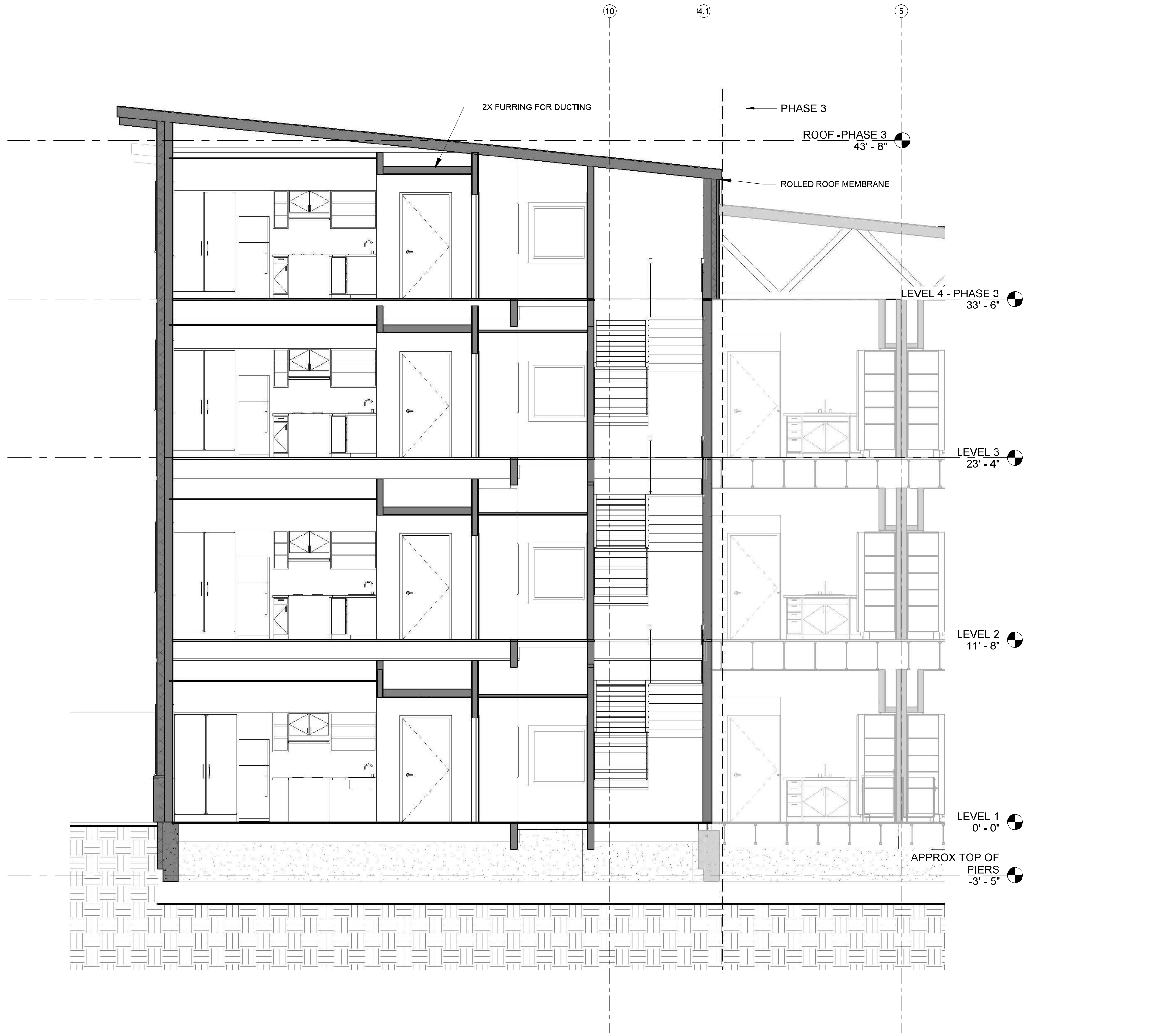
FLOOR 4 PLAN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ROOF -PHASE 3
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ROLLED ROOF MEMBRANE
LEVEL 4 - PHASE 3
33' - 6"
LEVEL 3
23' - 4"
LEVEL 2
11' - 8"
LEVEL 1
0' - 0"
APPROX TOP OF
PIERS
-3' - 5"
1/8" = 1'

SECTION

COMPLETED PHASE III - FROM EXTG. PARKING

COMPLETED PHASE - SIDE/REAR

August, 2022

Forget-Me-Not Manor

Final Outcomes Report & Five Year Data Summary

AUTHORED BY:

UAA School of Social Work
University of Alaska Anchorage

Heidi Brocious, MSW, Ph.D.
Professor of Social Work, University of Alaska Anchorage

Morgan Erisman, MSW, MPH *Adjunct Professor at UAA School of Social Work & Director of Forget-Me-Not Manor*

LaVerne Xilegg Demientieff, LSMW, Ph.D.
Professor of Social Work, University of Alaska Fairbanks

INTRODUCTION

This report summarizes five years of data collection on two distinct phases of tenants at Juneau's Forget-Me-Not Manor (FMNM), a housing first facility in Juneau, Alaska.

In this study, pre and post-data were collected on Phase One, which included tenants who moved into FMNM in the fall and winter of 2017. Initially, 35 individuals in Phase One agreed to participate and provide time one data, however, due to death and other transitions, only 27 were available to provide 6-month post data, and 25 were available to provide 1-year post data.

Phase Two reflects the expansion of FMNM in the summer of 2020, which allowed for the addition of 32 beds to the FMNM facility. Of this second group, 32 individuals participated in initial data collection (From the time period 9/10/20-2/23/21), with 23 available to provide 6-month post data, and 18 available to provide 1-year post data.

Data collected for each phase included general demographics, the use of services such as ambulance transports, contacts with the police department, and emergency room visits, along with self-reported alcohol consumption data, and health and safety data. These are the data points that will be summarized in detail in this report across individual phases and for the total across both phases.

General descriptive statistics were used for analysis. Additionally, all pre-post data were analyzed using the Wilcoxon signed-rank test, a non-parametric statistical test for related samples. This test was chosen over a parametric version because of the relatively small sample sizes in this study, and the abnormal data distribution that often comes with smaller samples.

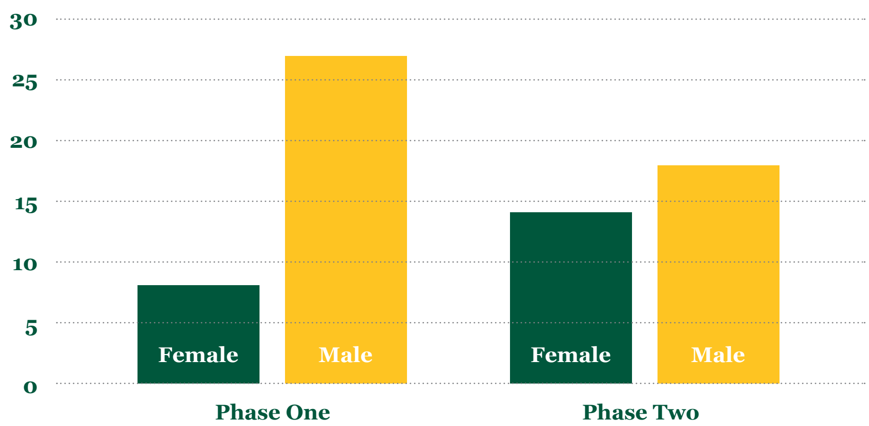
DEMOGRAPHICS

All demographics are reported based on the number of participants first enrolled in the study (n=67). Later comparative data points represent slightly different sample sizes due to study attrition.

Gender

Sixty-seven total individuals agreed to participate between Phase One and Phase Two. Twenty-two females, 45 males, and 0 other gender categories were reported. In Phase One (n=35), 8 participants reported as female (22.9%), and 27 reported as male (77.1%). In Phase Two (n=32), 14 participants reported as female (43.8%), and 18 reported as male (56.3%).

Table 1. Tenant Gender



Race

Of the 67 original participants, 49 reported that they are Alaska Native (73.1%), three self-reported to be Native American (4.5%), and 15 reported being white (22.4%). In Phase One (n=35), 29 (82.9%) participants reported to be Alaska Native, 3 (8.6%) reported as Native American, and 3 (8.6%) reported as white. In Phase Two (n=32), 20 (62.5%) reported as Alaska Native and 12 (37.5%) self-reported as white.

Table 2. Phase One by Race

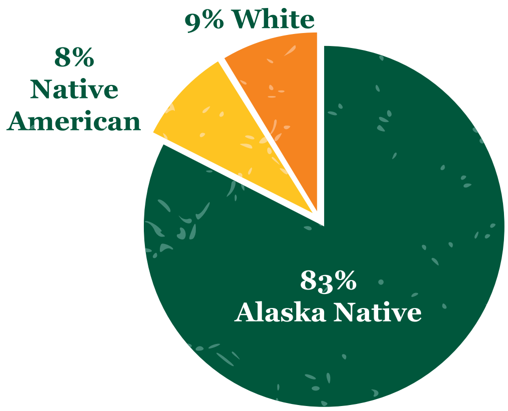
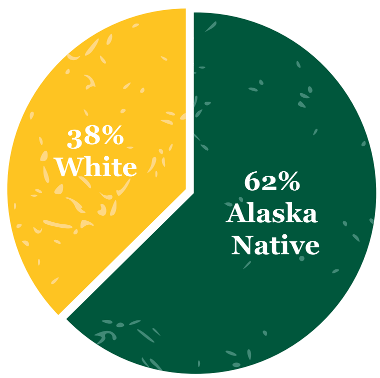


Table 3. Phase Two by Race



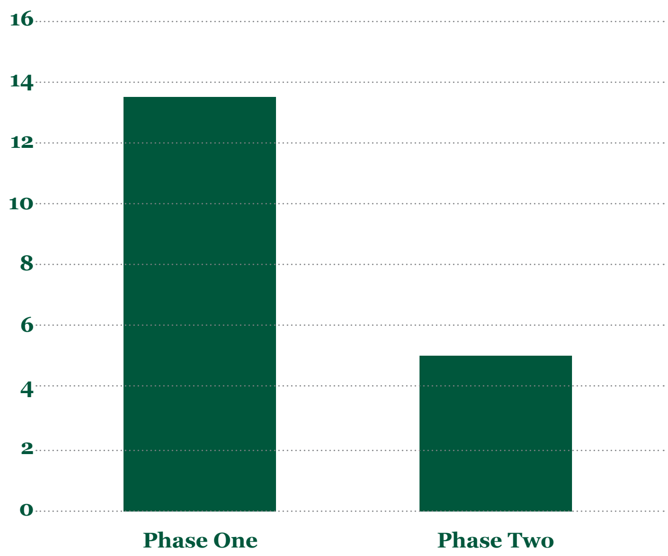
Age

The mean age of the 67 total initial participants was 52.54 years old, and the median was 55 years old. In Phase One (n=35) the mean age was 54.54 and the median was 58. In Phase Two (n=32) the mean age was 50.34 and the median was 52.

Length of Time Spent Homeless

On average, the total group (n=67) spent 9.84 years (118.08 months) homeless prior to moving into FMNM (median = 7.8 years). In Phase One (n=35) the average was 13.5 years (162.69 months), with a median of 11 years (132 months) homeless prior to moving into FMNM. In Phase Two (n=32) the average was 5 years (60.26 months) with a median of 5.3 years (64 months) homeless prior to moving into FMNM.

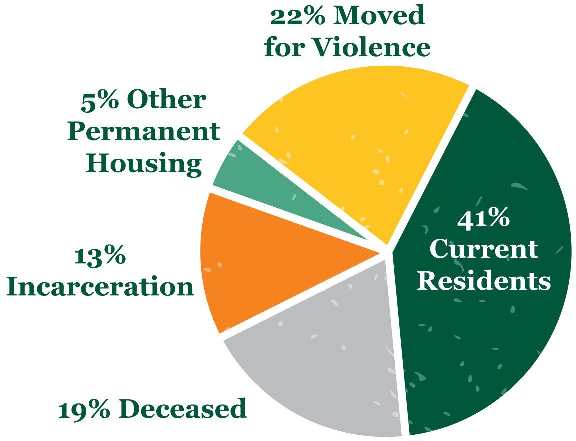
Table 4. Years Homeless before Forget Me Not Manor



Disposition

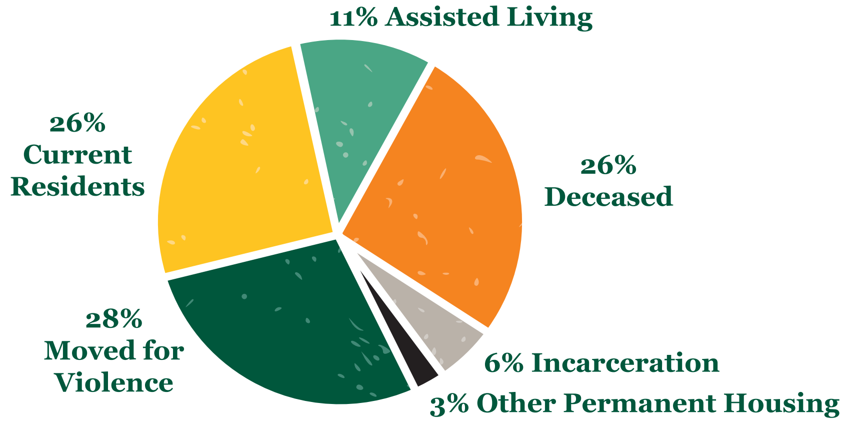
In an effort to understand tenant longevity and the issues that led people to leave FMNM over the last five years, reasons for departure were considered and then compared across groups. In the combined Phase One and Phase Two group, 26 (38.8%) are current residents. Across the two Phases, 12 (17.9%) of the original 67 study participants died while residing at FMNM. Four (6%) moved to assisted living, 14 (20.9%) were asked to leave or evicted for violent behavior, 8 (11.9%) were incarcerated, and 3 (4.5%) moved to alternate housing (i.e. their own apartment or permanently with family).

Table 5. Disposition of All Study Participants Across both Phase One and Phase Two



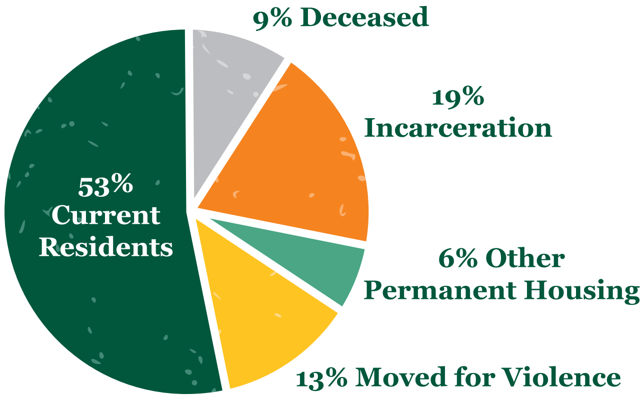
In Phase One, of the initial 35 residents participating in the study, 9 (25.7%) were deceased as of July 15, 2022. Four participants (11.4%) had moved to assisted living homes to better support their medical needs. Ten (28.6%) either voluntarily moved or were evicted by the program due to their violent behavior. Two (5.7%) residents were incarcerated and one (2.9%) had moved to other permanent housing like an apartment or with family. Nine (25.7%) continue to reside at the FMNM as of July 15, 2022, almost five years after their initial move-in in the fall/winter of 2017.

Table 6. Disposition of Phase One Participants



In Phase Two, of the initial 32 residents participating in the study, three, or 9.4% were deceased as of July 15, 2022. Four (12.5%) either voluntarily moved or were evicted by the program due to their violent behavior. Six (18.8%) residents were incarcerated and two (6.3%) had moved to other permanent housing (i.e. their own apartment or with family). Seventeen (53.1%) continue to reside at the FMNM as of July 15, 2022, almost 2 years since their initial move-in in the fall/winter of 2020.

Table 7. Disposition of Phase Two Participants



Time in Housing

One of the indicators of a successful permanent supportive housing (PSH) program is the longevity of residents, as one of the main goals of PSH is stable long-term housing. As noted in earlier data, residents moved on from FMNM for various reasons, including unavoidable reasons such as death, the need for assisted living, or even for positive reasons such as establishing more independent permanent housing or reconnecting and moving in with family. Tenants also moved on for more negative reasons, including eviction, being asked to leave due to violent behavior, or incarceration.

Among the original 67 participants from both Phase One and Phase Two, the average length of tenancy was 1.82 years (663.27 days) and the median length of tenancy was 1.46 years (535 days). Keep in mind this includes the 41% of participants who are still living at FMNM and does not represent an average "end date" to housing. It is expected these averages will continue to grow.

In Phase One (n=35), the average length of tenancy was 2.4 years (874.74 days) and the median length of tenancy was 2.62 years (957 days). This is out of the approximately 4.5 years of possible tenancy.

In Phase Two (n=32), the average length of tenancy was 1.2 years (431.97 days) and the median length of tenancy was 1.33 years (485.50 days). This is out of the approximately 1.8 years of possible tenancy.

VI-SPDAT Scores (n=50)

As a part of the intake process, most participants were assessed using a measure called the VI-SPDAT, a tool that has been historically used to identify the level of vulnerability & housing need the tenant may have, and to assist in prioritizing placement into PSH programs. For reference, a score of 0-3 typically leads to a recommendation for no housing intervention, a score of 4-7 supports a recommendation for Rapid Rehousing. People who score 8+ (for individuals) and 9+ (for families) are typically recommended to PSH programs.

Among the total 67 participants, the average VI score was 12.75 with a median score of 14. In Phase One (n=35) the average VI score was 13.17 with a median score of 14. In Phase Two (n=30), and the average VI score was 12.27 with a median score of 12 (two participants' VI score is missing/not recorded).

These findings indicate that while Phase One was assessed to be slightly more vulnerable than Phase Two, both groups were well over the score of 8 which typically indicates appropriateness for PSH.

PRE & POST EMERGENCY SERVICE USE

As occurred in the first phase of this study, data was collected from the local emergency room (Bartlett Regional), the local ambulance service (Capital City Fire & Rescue/CCFR), and the police (Juneau Police Department). Each participant gave permission for these entities to report the following: 1) Number of ER visits for any reason during the requested time frame; 2) Number of ambulance transports; and 3) Number of police officer contacts for any reason. The findings of this data are reported by Phase One, Phase Two, or combined groups, and compared in two time frames. First, each group's use of these services was compared at 6 months pre-move to 6 months post-move in. Second, emergency service use for each group was compared one year before moving to one year after moving in.

Statistically Significant Decreases in Police Contacts Across All Groups and Time Frames

Findings from this study show a statistically significant decrease in the number of police contacts from tenants in both Phase One, Phase Two, and the two groups combined. These decreases occur both at six months post housing as well as one-year post housing.

Data were collected (with participant consent) directly from the Juneau Police Department (JPD) about the number of times participants had contact with an officer for any reason. Table Eight displays actual contact numbers at 6 months and Table 9 documents pre/post contacts at one year for each Phase individually and combined.

Phase One participants (n= 27) had 667 total contacts with JPD in the six months before moving into FMNM. This number dropped to 231 contacts in the six months after gaining housing. On average, Phase One residents had 26.3 contacts per person before and eight contacts after, a statistically significant decrease (p=.017).

Phase Two participants had 268 police contacts in the six months prior to moving in and 195 contacts after gaining housing. On average, Phase Two residents had 11.7 contacts with the police in the 6 months prior to move in, and only 8.5 contacts in the 6th months after moving in, a statistically significant decrease.

Table 8a. Six Month Police Data

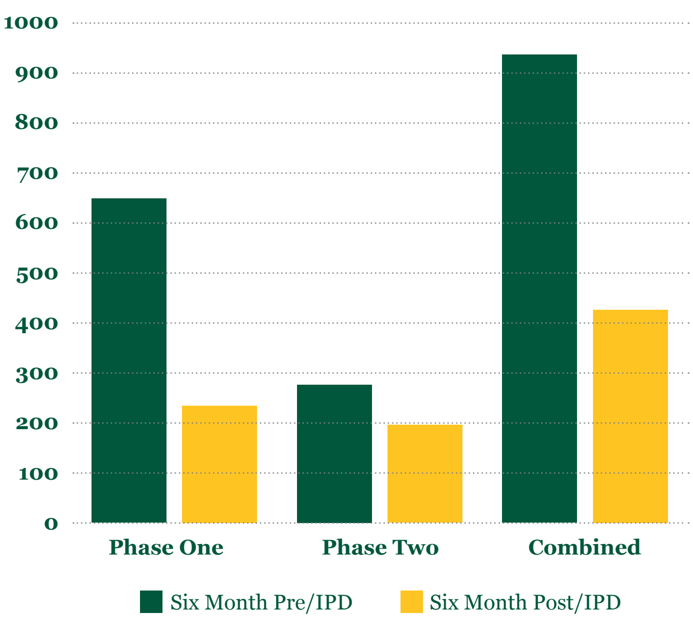


Table 8b. One Year Police Data

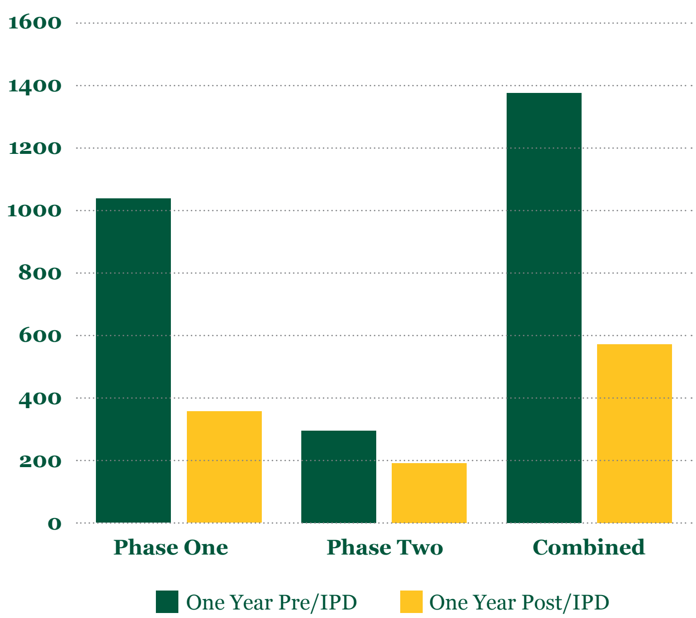


Table 9. Changes in Mean Police Department Contacts Across all Groups

	Mean Contacts Six months Pre	Mean Contacts Six Months Post	p value	Mean Contacts One Year Pre	Contacts One Year Post	p value
Phase 1 JPD	26.3	8	p = .017*	42	14.5	p=.039*
Phase 2 JPD	11.7	8.5	p = .011*	18	10.2	p = .023*
Phase 1 & 2 JPD	19.6	8.2	p < .001*	31.9	12.7	p < .001*

** indicates a statistically significant difference in pre/post data*

Statistically Significant Decreases in Emergency Room Visits Across All Groups and Time Frames

Participants who agreed to be in the study gave permission for researchers to collect use data from the one local emergency department at Bartlett Regional Hospital in Juneau, Alaska. Data was collected on the number of visits to the ER, however, private medical data was not collected.

When considering the impact of FMNM on the emergency service use system, it is important to think both in averages and in total numbers. Tables 9 & 10 represent the actual numbers of visits to the emergency room. Table 9 highlights the changes in use in the six months prior to moving into FMNM for each Phase, and combined. In the study Phase One residents (n=26) visited the ER a total of 383 times in the six months leading up to housing. That number dropped to only 153 ER visits in the 6 months after moving into FMNM.

Phase Two residents (n=18) began with smaller use numbers, with a total of 72 ER visits before moving in. This number still dropped significantly to 37 visits to the ER in the first six months after moving in. While statistical significance is important to the community of Juneau, decreasing actual ER visits by 265 over a six-month period has real implications for resource savings for the emergency room.

Table 9. ER Visits Pre/Post Six Months All Groups

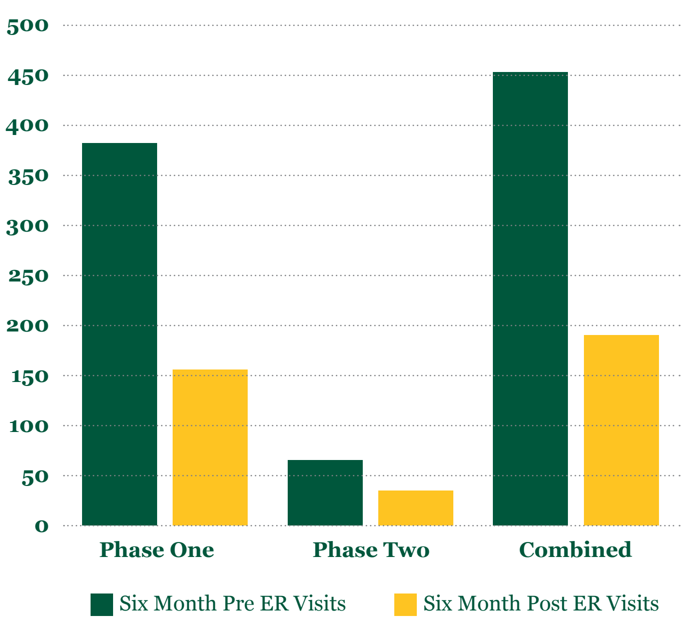


Table 10. ER Visits Pre/Post One Year All Groups

When ER data were analyzed using a Wilcoxon Signed Rank Test, decreases across all groups and all time frames were found to be statistically significant. In other words, both Phase One and Phase Two participants decreased their use of the ER in a significant way at both six months and one year.

Table 11. Changes in Mean ER Visits Across All Phases & Times.

	Mean ER Visits Six Months Pre	Mean ER Visits Six Months Post	p value	Mean ER Visits One Year Pre	Mean ER Visits One Year Post	p value
Phase 1 ER Visits	14.2	5.7	p=.017*	20.1	11.1	p=.039*
Phase 2 ER Visits	3.1	1.6*	p=.029*	5.2	2.9	p=.046*
Phase 1 & 2 ER Visits	9.1	3.8*	p=.002*	13.9	7.7	p=.05*

** indicates a statistically significant difference in pre/post data*

Statistically Significant Decreases in Ambulance Transports in Some but Not all Groups

Transport data was collected from Capital City Fire and Rescue (CCFR) the only entity in Juneau, Alaska that provides ambulance transports. As with other data points, a drop in use data can be seen across all groups in all time periods. Comparing the six months before moving into FMNM to the six months after moving in, Phase One participants reduced the number of ambulance transports from 224 to 103. Phase Two participants also saw a decrease in use, but their numbers were much lower to begin with, with 33 ambulance transports in the six months prior to FMNM move-in, and 22 transports in the six months post.

Similarly, change is seen at one year, with Phase One participants requiring 224 ambulance rides in the year prior to moving in and 103 in the one-year following move-in. Phase Two residents went from 44 ambulance transports to 36 in one-year pre and post. Not all of these represent statistically significant decreases (see table 13). Again, given the amount of resources that go into just one ambulance transport, the decrease in the absolute number of transports translates to resource savings for the City of Juneau (See table 12 & 13).

Table 12. Ambulance Transports Pre/Post Six Months

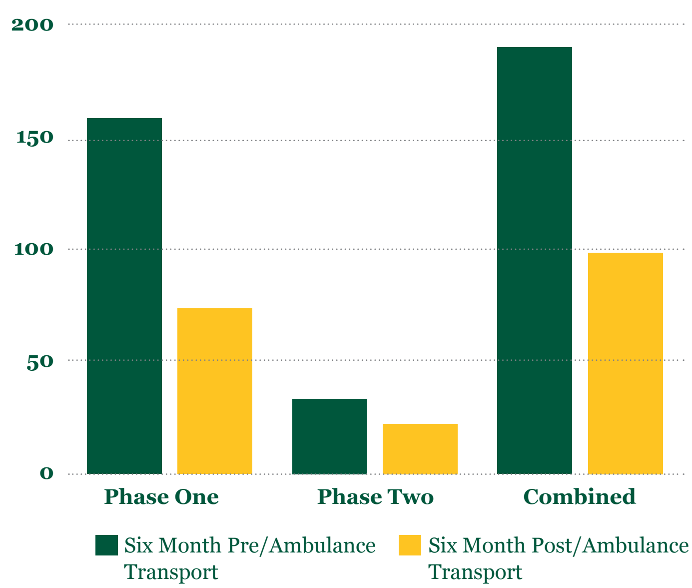


Table 13. Ambulance Transports Pre/Post One Year

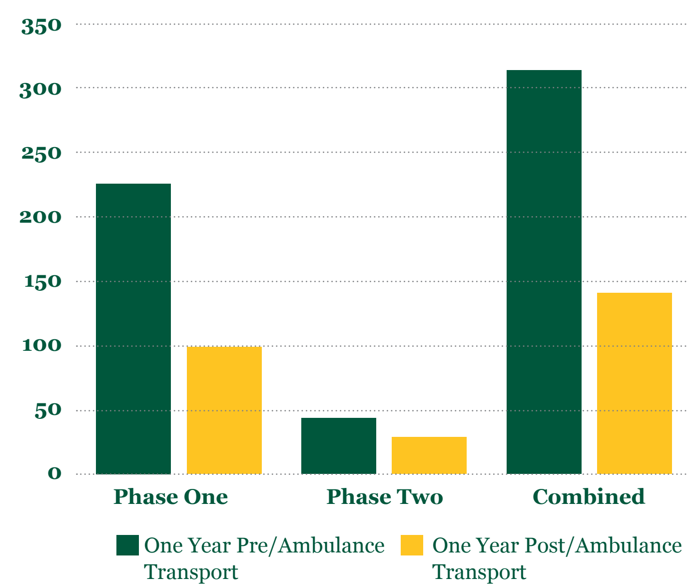


Table 14 highlights the mean number of transports by each phase at 6 months and 1 year and reports the statistical significance of these changes. Phase One participants had statistically significant decreases both at 6 months and one year. Phase Two participants did not demonstrate statistically significant changes in Ambulance use. When the two groups were combined the data was again statistically significant at both 6 months and one year.

Table 14. Changes in Mean Ambulance Transports Across All Phases & Time Frames

	Mean Ambulance Transports Six Months Pre	Mean Ambulance Visits Six Months Post	p value	Mean Ambulance Transports One Year Pre	Mean Ambulance Transports One Year Post	p value2
Phase 1 Ambulance Transports	5.8	2.8	p=.021*	9	4.1	p=.01*
Phase 2 Ambulance Transports	1.4	1	p=.363	2.4	2	p=.776
Phase 1 & 2 Ambulance Transports	3.8	2	p=.015*	6.2	3.2	p=.017*

** indicates a statistically significant difference in pre/post data*

CHANGES IN ALCOHOL, DRUG & TOBACCO USE

Self-reported alcohol use data was collected at moving in and two years for participants in Phase One. Similar data was collected on Phase Two participants at six months and one year. While a reduction in alcohol consumption is not the primary goal of Housing First or other harm reduction programs, it is interesting to look at the impact that housing plays in the overall wellness of the tenants, and this was explored through several data points including self-reported daily drinking and self-reported binge drinking.

When asked “In the last 30 days, how many days did you consume alcohol?” participants self-reported perceived changes in their alcohol consumption. For tenants in Phase One, the number of days alcohol was consumed dropped from an average of 22.9 days per month to 17.4 days per month (see table 14). While this was not a statistically significant difference (p= .108) it is what some would argue as “approaching significance” particularly since this is a very small sample (n=18). Phase Two residents reported consuming at least one drink an average of 7.3 days at the time of move-in. At one year this number dropped to 4.6 days of alcohol consumption, although again, this was not statistically significant (p=.233) (See table 16).

Table 15. Changes to Daily Drinking in Phase One Participants after 2 Years at FMNM.

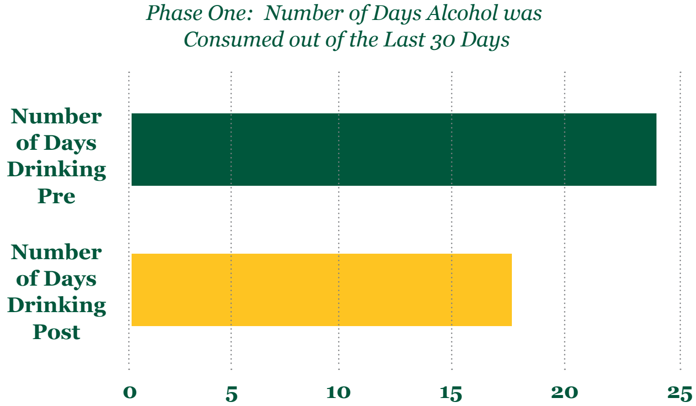
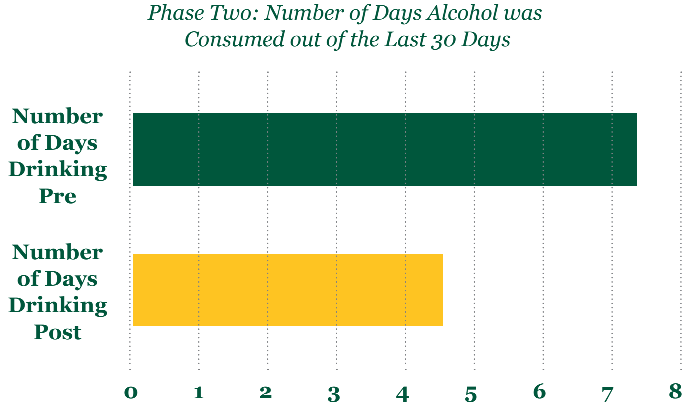


Table 16. Changes to Daily Drinking in Phase Two after 1 Year at FMNM.



Binge Drinking

Similarly, participants were asked about their binge drinking. Specifically, they were asked to self-report the number of days in the last 30 where they consumed 4 or more alcoholic drinks. As in the daily alcohol consumption numbers, binge drinking is self-reported and data was collected from Phase One and Two when moving in, and collected again at two years for Phase One participants and at year one for Phase Two participants. Phase One members reported that on average, they drank 4 or more alcoholic beverages in one day on 18.5 days per month. Two years following move-in, participants reported binge drinking only 14.7 days per month. Again, this data was not statistically significant (p=.325) but it is an observation of interest. Participants in Phase Two reported an average of 5.5 days of binge drinking prior to moving into FMNM, and at one-year post-move-in reported an average of 3.7 days of binge drinking. This is another finding that is "approaching significance" with a p-value =.058 and a small sample size.

Drug Use

Participants were asked about the frequency of daily drug use. In this survey, drug data was collected in general and included cannabis, methamphetamines, heroin, opioids, cocaine, etc. Anecdotally, participants who reported drug use were predominantly reporting cannabis use but not exclusively.

Participants of Phase One reported on average using drugs 8 days out of the last 30 at the point of move-in. This number increased slightly to 9.3 days two years after move-in, however, it is important to contextualize. First, this is not a statistically significant change (p=.813) so it could be a reflection of no change. Another explanation, that many participants reported anecdotally, is that they have worked to replace their alcohol consumption with cannabis use, which many viewed as a harm reduction strategy, reporting that they felt their pain and anxiety were better when they replaced some alcohol use with cannabis use.

Similarly, participants in Phase Two reported a slight increase in average drug use at year one post-move-in. This group reported a mean number of days where they used drugs as 16.5 days prior to moving in, and 17.1 days one year after move-in. Again, this is not a statistically significant change (p=.893) but may also highlight the transition from alcohol or "hard" drugs to cannabis use, as was frequently reported in the qualitative interviews.

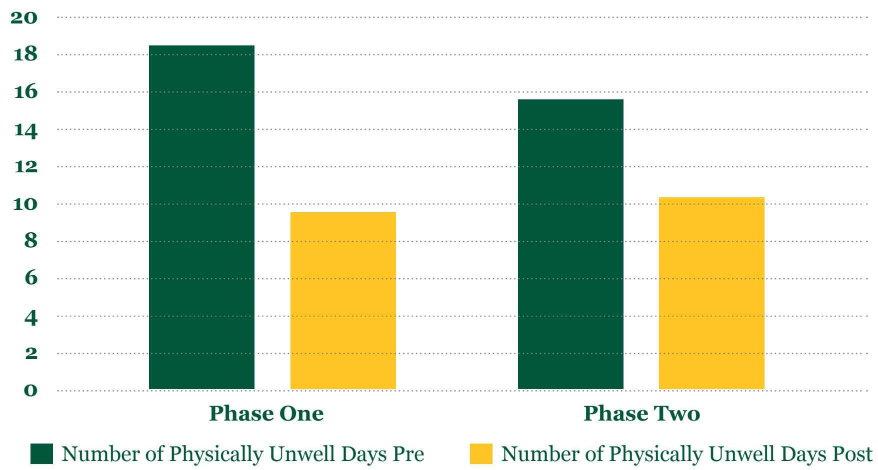
Tobacco Use
No substantial changes were noted in tobacco use in either group in their pre/post-self-reports. Phase One tenants reported smoking an average of 18.7 days prior to moving in, and 17.9 days two years after moving in. Phase Two reported smoking 16.2 days prior to moving in, and 16.1 days after a year of tenancy.

TENANT WELL-BEING

Experiencing homelessness, especially long-term homelessness, is known to have a profound impact on individuals' physical and mental health (Henwood, et al., 2018). To examine the impact that FMNM may have had on tenant well-being, participants were asked a series of questions about their physical & mental health, their sense of connection, safety, and isolation. Changes in these self-reported indicators are highlighted in this section.

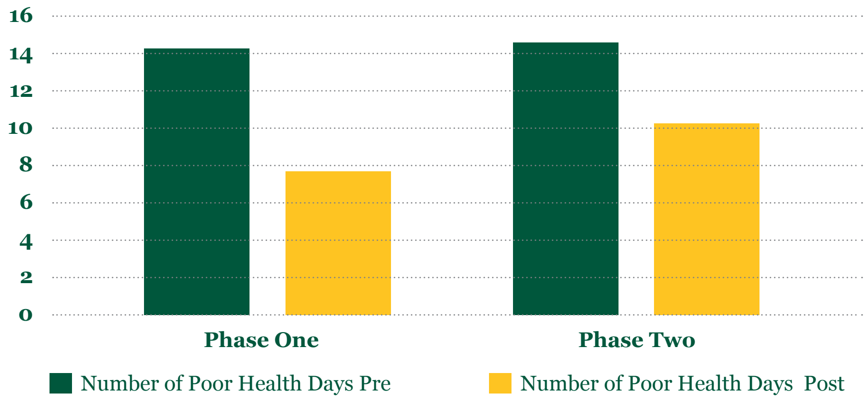
Self-Reported Physical Health
Participants in both groups were asked to assess their physical health both before moving in and after (2 years for Phase One participants, 1 year for Phase Two participants). In Phase One, statistically significant differences were reported. At the time they moved in, when asked "of the last 30 days, how many would you say your physical health was poor?" Phase One tenants reported an average of 18.4 days where they didn't feel physically well prior to moving in. This number dropped in a statistically significant way (p=.006) to 9.6 days per month two years post-move-in. Phase Two participants also reported a substantial drop in unwell days, with an average of 15.5 unwell days prior to moving in, and 10.4 days one year after move-in. This finding was not statistically significant (p=.098) but could be considered "approaching significance".

Table 17. Changes in Days Tenants Felt Physically Unwell Pre/Post



Self Reported Mental Health
Similar to physical health, participants in both groups were asked to assess their mental health both before moving in and after (2 years for Phase One participants, 1 year for Phase Two participants). In both phases, there was a drop in the number of reported poor mental health days, however, the findings were only significant among Phase One participants. At move-in, Phase One tenants reported an average of 14.2 days where they felt their mental health was poor, compared to only 7.8 days of poor mental health reported after 2 years (p=.011). In Phase Two, participants reported an average similar to Phase One participants -- 14.6 days but saw a decrease to an average of 10.2 days at one-year post move-in. This difference was not statistically significant (p=.22), but it is important to note the data was assessed at only one year in Phase Two, while it was two years in Phase One, which could account for the difference along with the small sample size challenge discussed earlier in this report.

Table 18. Changes in Poor Mental Health Days Pre/Post



CHANGES IN SAFETY, COMMUNITY & FAMILY CONNECTEDNESS, & GENERAL WELL-BEING

In general indicators of a sense of safety, community and family connectedness & general well-being improved, although not all changes were statistically significant. Specifically, participants were asked a series of questions on a 7-point Likert Scale, with higher numbers reflecting a more positive outlook in each respective category. Some of the most significant changes occurred across both groups in their sense of satisfaction with their housing, their sense of safety in their housing, and their lives in general. Tenants in Phase One demonstrated statistically significant increases in satisfaction with their friendships and their sense of spirituality. Phase Two participants also demonstrated modest increases in these domains, however, they were not statistically significant.

Table 19. Changes in Pre/Post Wellbeing Across Phase One and Two.

	Phase One Pre-Move In	Phase One Post-Move In	p value	Phase Two Pre-Move In	Phase Two Post-Move In	p value
Satisfaction with Life in General	3.5	5.7	p<.001*	3.9	4.6	p=.046*
Satisfaction with Housing	2.7	5.8	p<.001*	3.1	5.4	p=.005*
Satisfaction with Friendships	4.8	5.7	p=.02*	4.6	5.2	p=.098
Satisfaction with Family Situation	4	4.9	p=.112	4.5	4.9	p=.293
Sense of Spirituality	4.8	5.8	p=.003*	5.1	5.5	p=.301
Safety in Current Housing	3.1	5.8	p=.001*	3.6	5.3	p=.010*

**indicates statistical significance*

Note: Phase One post data was collected two years post-move-in. Phase Two Data was collected at one-year post move-in.

QUALITATIVE FINDINGS

In addition to the pre/post tenancy data, a series of interviews were conducted with residents who had lived at FMNM for more than one year to find out how they felt housing had impacted their wellness. Fifteen participants, 10 males and 5 females (8 Phase One participants and 7 Phase Two participants) were interviewed individually for approximately 1.25 hours. The longest length of tenancy in the sample is almost 5 years, while the shortest was 1.5 years. The average length of time resided at FMNM of the 15 individuals is 3.2 years. These interviews were recorded, transcribed, and analyzed for common themes. Five themes were identified in the data including: 1) Residents think more about their future now, and have glimmers of hope; 2) Resident substance use has changed in both significant and in subtle ways; 3) Tenant's are using preventative and routine health care now and their physical health has improved; 4) COVID has been hard on FMNM Residents; and 5) Residents continue to feel judgment by friends, family, providers, and the community in general. Each theme is described below with supporting quotes from participants.

Theme One: Residents think more about their future now and have glimmers of hope.

One interesting finding from the transcripts is that FMNM residents talk more about their future. When participants were interviewed after moving in, there was very little future thinking or planning. This was a population whose energy was focused on meeting their basic needs for the day, sometimes even for the hour. There was no discussion of the future because survival in the present took all of their energy and resources - and they were exhausted from the chronic lack of sleep that came with being homeless. Now, a year or more after moving in, most of the interviewed participants describe excitement or pleasure along with future plans. For most, these plans were not tremendously long-term, but it appears clear that residents are much more future-facing than they were at move-in. Most of the interviewees expressed a cautious sense of hope such as this participant who stated:

> *Knowing you're facing something that's challenging, it's like climbing a mountain. You look up. I can do it, but I can't do it all at once, and I have to catch my breath first. - FMNM Tenant*

Hope was expressed in many different arenas, including: a) Hope to restore passions or interests they once had; b) Hope to get and stay well; c) Hope to quit, cut back, or stay sober; d) Hope to gain employment; e) And hope for healing in their personal relationships.

Hope to restore the passions or interests they once had.

Tenants discussed establishing new hobbies or getting back into things they used to enjoy. Many described going for hikes, sitting on the beach, doing art, or growing things in the garden as activities that have brought them pleasure since moving in. One resident excitedly described an adventure she had always wanted to experience, stating:

> *I actually got a Christmas present where we - it was a whale watching tour coming up this spring for a friend and I. - FMNM Tenant*

Hope to get and stay well.

Participants described the greatest degree of hope about their health. For many, they had been unable to adequately manage their health conditions while living on the street. Most are on long-term medications, and most reported not taking, or irregularly taking their daily medication while experiencing homelessness. Since FMNM, and especially with the support of staff who assist with medication management and reminders, participants report a much higher degree of hope for a healthier future. For example, one stated:

> *When I first moved into this building, I had found out that I had congestive heart failure and my heart was only working [with an ejection fraction] in the teens. Now, it's a couple of years ago I found out I'm at 55 percent and that makes me feel empowered. Like very proud and happy that I did that. I mean I had to make the step of taking those meds every day, but the building had helped me get to those appointments and keep up with them and keep*

> *going from a day to day basis. But for me, I felt very empowered because I was able to – I was on my way out. - FMNM Tenant*

Hope to quit, cut back, or stay sober.

Some long-term residents have completely quit substance use, however, all discussed cutting back, or attempts to quit with increased hopefulness about the possibility of success. When asked if he had any future goals around alcohol use, one participant stated:

> *Well, eventually, I'm gonna stop. I just don't know when it's gonna happen. I know that I have – I do have the power to do it; it's just one of those things that are easier said than done. - FMNM Tenant*

When another tenant was asked how he felt about his alcohol use he shared the following:

> *I think it's a hell of a lot better than what it used to be. Because it used to be vodka, whiskey, and beer. Now I'm just down to beer. And I'm also cautioning that off. I'm feeling good about it. - FMNM Tenant*

Still another tenant, talking about his desire to change his alcohol use, stated:

> *Alcohol is still part of my life, but the dramatic part has been – it's nowhere near as bad as it used to be, that's the only way I could put it. Before, the law was always involved. Now, it's like I can actually say hi to those guys and not bat an eye. - FMNM Tenant*

Hope to gain employment.

An increasing number of long-term tenants talked about seeking employment as a major goal they are working on. This is frequently complicated by the health challenges many tenants have, but the desire to work, to do something productive, and to improve their income, is foremost on many minds. One tenant described plans to get back to work as a welder in the following way:

> *I actually am – I got a – I think I got a scholarship to go back to welding school. I'm hoping that doesn't – so on the 10th, the school opens. On the 19th is the first class. So they're going to assess my welding skills and decide whether I start on the 19th or on the 8th. Six-week course and I either take the intermediate or the advanced class. - FMNM Tenant*

Hope for healing in their personal relationships.

Many participants discussed their reconnection, or attempts at reconnection with family since moving into FMNM. For some, this reconnection has been unequivocally joyful, with adult children, siblings, aunties and uncles visiting them at their new residence, or residents finally having the stability to reach out and re-establish lines of communication that had been broken. For others, it has also meant working to heal relationships that had become broken due to their substance use. The three tenant quotes below highlight this newfound sense of hope for connection and reconnection:

> *[I used to think] like if I'm not hurting anybody and I'm just drinking, sitting here drinking, if I'm not going to jail, and I'm not physically hurting somebody, I'm all right. But no, I was hurting my kids, their eyes and their ears, they were watching me give up. I showed my children how to give up. Now I gotta show them how to get back up and I think that's the only way I can fix it. - FMNM Tenant*

> *I don't know, for the longest time I thought that getting back and starting to deal with family and everything was my number one thing. But the only thing that I really want to do right now is work on myself and fix the relationship I hope that I can have with my children. I hope that I can fix what I did, I don't know. - FMNM Tenant*

All I know is I just want my children to fucking see me as a better person. I want them to understand. My oldest son, my mother and my oldest son went out drinking, they died drinking. They left this earth drinking. I want my – the rest of my boys to understand this does not overpower you, this does not make you and this, this is not a curse just because your grandma passed away from it or your brother has passed away from it. This does not claim you, that's it. That's the only thing that I'm here to – it's the only way I want to be heard right now, that's all. - FMNM Tenant

In summary, in the year or more since move in, many tenants continue to recover in a variety of ways; recovery in the sense of substance use reduction or abstinence, recovering parts of their health, their relationships, their ability to plan and think about what is next, and to in general have some hope for the future.

Theme Two: Resident substance use change has changed in both significant and in subtle ways.

When tenants were first interviewed at move in, they were skeptical of the HF model that allowed them to have their own housing without first having to become sober. Those early interviews reflected a sense of mistrust, and participants were sometimes defensive and challenging to those who asked questions about their substance use. Now, after an average of 3 years at FMNM, participants have confidence that they are not going to lose their housing because of their substance use. These current interviews reflected a great deal of internal motivation to change their substance use patterns. Several described reasons why they personally wanted to quit or cut back. For many this was tied to fears about their health, but for some it was also about now having hope about their future, which gives them a reason to quit or cut back. Participants describe many paths to reducing their substance use; some quit cold turkey, others scaled back on the amount or type of substances used, while still others cut back naturally because of they didn't need it for warmth (alcohol) or for safety (meth, often taken to stay awake all night when homeless) or as a means to get admitted to the sleep off center for the night. The following quotes illustrate this changing relationship with substances:

I still drink every now and then. I think the longest I've ever stayed sober was around nine months. But compared to five years ago when I first stepped into this building, I was drinking every day around the clock, so.... - FMNM Tenant

Everyone says I'm doing great. They say I look great, look much healthier, I'm more clear-headed. - FMNM Tenant

How do I feel about drinking these days? I feel like it's part of my life that is over now. - FMNM Tenant

Well, like I said, I gave up the vodka and the whiskey, so that was recovery enough for me right there. I know I need to – well, I'm probably never gonna be completely nonalcoholic, but I think that I did a damn good job... cutting myself back to a couple beers. I think that I did a damn good job on that. - FMNM Tenant

One tenant described the cycle he had been living in prior to Housing First, where he kept up his alcohol intake in part to have a place to rest at the Sleep Off Center. He stated:

And so, you got one homeless shelter you can't be drinking and you got one where you have to be drunk enough [sleep off]. Well, guess what the drunks are going to do? So we would do that – we were totally abusing the system. They knew it; we knew it. And so, now all three of us live at Housing First. And actually, all three of us stopped drinking. - FMNM Tenant

Still another describes how he has managed his use with his own system. He states:

> *And alcohol, it does provide a huge level of comfort. Like, tell you the truth, I have two beers sitting up in my fridge. And they would provide me with physical release, but I know that if I went up and drank those beers that I would just fall right back off the wagon and it would be over. So I'm not going to. I just keep them up there for if I have friends that want some. And I've been doing good with that. They've just been sitting up there. - FMNM Tenant*

One final point tenants discussed was that it can be both supportive and difficult to live in recovery at FMNM; some describe feeling more isolated because they don't "party" with other residents like they have in the past. Others describe the frustration and sometimes temptation with being offered substances. However they describe creative coping strategies to deal with this. One tenant talked about having a small group that he got sober with, and notes that the three of them try to just hang out with each other. Another resident, who states she used to use substances regularly with many of the tenants, describes her response now to people who offer her substances is to say "I don't use any more, remember dumbass!?", and after enough times her fellow tenants came to respect that and don't offer. Tenants noted that this challenge is mostly outweighed by the support and assistance they get from FMNM staff, but it can be a struggle.

Theme Three: Tenant's are using preventative and routine health care now and their physical health has improved.

Tenant's overall report that their physical health is better now than before moving into FMNM. In general drinking has decreased, eating more regularly has gotten better, health care needs are being met, medications are taken more regularly, and even though health and wellness progress is relative tenant's are slowly starting to see and feel the benefits. Many tenant's expressed gratitude to have regular appointments with physicians, as well as gratitude for the support from FMNM staff to help remember appointments and for transportation to and from appointments. Even though their physical health has improved and continues to improve, it is significant to note that almost all participants shared that they still live with physical pain in their bodies, as well as emotional pain, highlighting the complexity of their overall health status and needs. They discussed dealing with back pain, foot pain, joint pain, teeth pain, stomach pain, pain of grief from seeing friends die regularly, grief of loss of family and being disconnected from family, the pain of trauma, the pain of falling, which has been frequent for many participants, causing trips to the ER for head injuries, etc. Pain is in the forefront of what participants are managing daily and often takes precedence over things like eating, relationships, housing upkeep, and other basic daily living practices. Even though they deal with pain and that inhibits them in certain ways they are still striving toward healing and getting well. One participant shares their experience with pain and loss, stating:

> *I mean I was very close to death when I first moved in this building. So working on that made me feel empowered. But I had lost my son two years ago to alcoholism and he has the same heart problem I have. And that – so I'm dealing with grief and sadness and loss and feeling like I wasn't a good mother. So stuff like that, but still I'm able to talk to someone here about it. - FMNM Tenant*

One tenant shared the impact of illness on their physical and mental abilities:

> *Right now it's been a physical thing, mostly my health. I figure once I get my health back in line, it felt like this infection really clouded a lot of the things that – I guess when they say you're sick, you're sick. It affected a lot of my mental stuff, too, I guess. That was where I felt like I was clouded quite a bit, and once that infection started disappearing, so did the cloud. - FMNM Tenant*

Part of Permanent Supportive Housing, is the supportive piece. Tenants expressed that FMNM is meeting those needs in regard to their physical health and follow-up care. When individuals feel physically healthier they are able to do more things and continue to grow in other areas of their lives. Tenants expressed feeling stronger, going to physical therapy, and switching from using a walker to a cane, and below are other examples of what keep them going:

Probably the healthiest I've been in probably ten years.

> *I don't know, yeah. I watched my mom give up with her drinking because my dad had passed away. And then I started falling, not realizing it. And I remember looking back at praying and wanting to believe that he's there and that there's some sort of reason why all these things are happening. So, yeah. I think I lost what I was trying to say. - FMNM Tenant*

> *I'm having a hard time, my – I was using a walker last year and every once in a while, I use a cane now. It's not good, my mobility isn't any good. I'm falling apart and I feel helpless to it. So I think I got two different kinds of arthritis, so. Got to say though, without this building I wouldn't have been doing any of that. - FMNM Tenant*

> *Philosophy it could always be worse. I mean I'm pretty happy with the Housing First and I'm not homeless. So like right now even though with the blood infection and stuff and all the medical shit, I'm still pretty happy that I have a place to live and I'm not out there in the cold. So that's what's kind of keeping me going and plus I don't want to lose my place. So yeah. - FMNM Tenant*

> *I feel like – yeah, it's probably the best in a while, I feel that my depression it needs to be addressed and anxiety and anger needs to be addressed. I'm going to be working on that, that's for sure. - FMNM Tenant*

> *Yeah. I mean, I do feel physically good today. Mostly wired on coffee. The most positive thing that I can think of, here, is the staff members, you know, and they're very good at, you know, keeping me on top of my medicine. Every single one of the staff members here, they're all awesome. - FMNM Tenant*

They do everything for me.

> *You know, there's not anything that I don't do for myself, except for wipe my own ass. They do all my meds. They put them in bubble packs. My mail. My, they set up my appointments. They take me to my appointments. They go with me in my appointments, to sit down with my doctor, because I don't understand what the fuck he's saying all the time. So I always have staff go in with me. That there, and taking me to the store and helping me with my PFD and helping me with my mom's death certificate and all her stuff. I mean, they don't do, they do so much. - FMNM Tenant*

> *Interviewee: It's so much. And I can't thank them enough. On Christmas, they got me a huge ass wagon, because I wanted my own wagon to bring up to the third floor with my groceries and stuff. They got me my own wagon, and they got me pillows. I was just teasing with the underwear, but they got me underwear. They're great. I can't let anybody sit there and say anything bad about them. No way. - FMNM Tenant*

> *Everything. I love this whole idea, it's like you've gotta go through a front desk to get to the room. It felt like everybody was rummaging through my bunk down there at the Glory Hole, and now I'm behind a locked door. I feel a lot safer, to be honest. The staff is always, they do the best they can, they do a really good job, considering some of the things we have to go through, they do the best they can. I'm very grateful they're here. They've been a big help, too. - FMNM Tenant*

Many tenants see a reason to get well and when asked what they would want if things could be different, tenant's often expressed a wish to have family, raise children, be a better parent, have a spouse, and many feel they are right where they want to be even though things are not perfect.

Theme Four: COVID has negatively impacted us too.
COVID affected everyone, tenants included. While globally the COVID pandemic affected people in various ways, tenants expressed their COVID impacts:

> *Well, before the COVID, I used to go to – we used to have drumming every Friday. But since the COVID restrictions came, we haven't been doing that for quite a while now. But I did enjoy it. - FMNM Tenant*

Building activities, community dinners, games, and other activities were no longer available for tenants to restrict the spread of COVID. This left tenants with no activities in the building as well as in the community.

> *No, I don't do that no more after the COVID came and hit. Seemed like we lost all the culture ever since the COVID hit. There's no more 40-day parties or pay-out parties no more. It would cause a pandemic, and people get sick. It's just not worth it to have a pay-out party and a 40-day party. I don't want anybody else getting killed from it, dying from it. - FMNM Tenant*

The loss of activities and things to do leaves more down time for drinking, using, and/or isolation which has been expressed previously. Tenants also experience a loss in connection to staff, activities, and things they would do before and could no longer. Along with the restrictions on activities there was also fear of catching COVID. After years of feeling unsafe while being homeless, tenants now expressed feeling unsafe because of COVID.

> *"I don't know, I feel like as much as I've been fighting to survive to like live again to whatever you call is normal, I don't know what the fuck normal is anymore after all I've been through. With this COVID thing going on, I'm sitting here fighting with my health and then COVID on top of it, last year October I had COVID, November I had pneumonia. Then I'm sitting there and I'm fighting to stay on top of my health. And then COVID comes along and I'm sitting here thinking God dang it, that's what's going to take me down." - FMNM Tenant*

Luckily, no tenants passed away due to COVID. Safety is one of the core principles of housing first, being able to have tenants feel safe in their individual homes and in the building was fully possible with COVID.

Lastly, was the wish for the end of the pandemic. Tenants were asked if a magic wand could be waived, what is one thing they would like to see and two tenants answered they would wish to see COVID end. Tenants at Forget-Me-Not Manor go through many struggles after moving in and several years after residing. While COVID could have been much worse in the sense of mortality, it still left a lasting impact on the tenants that other individuals may not have faced. Tenants at FMNM faced the loss of activities and culture, lack of safety, and during a time when things in their life should be coming together they only wished for the pandemic to end.

Theme Five: Residents continue to feel judgment by friends, family, providers, and the community in general.
Many tenant's expressed pride in how far they have come, even if they are still drinking or have health issues or feel alone. All participants have overcome numerous obstacles and work towards managing their trauma, and grief, and overall they feel good about where they are now versus prior to entering FMNM. Tenant's also are very aware of and honest about their circumstances, health conditions, mental health challenges, and they are also very aware of how they are often perceived by others in their family and community. Tenant's shared that being judged for their lifestyle is a frequent occurrence and how they might avoid participating in family, cultural, and community events because of that perceived judgment. One tenant shares how it made her feel to be acknowledged by a physician for something positive:

> *Interviewee: So that was good too when I went in sober , because it was an emergency room doctor that has seen me regularly high. And he was just so happy for me. I think I was like six months clean last time I went to the emergency room, it was like. And I needed a diabetic machine. Mine had gotten stolen. And he made it work. He*

came in with all these supplies and dumped them on my lap and said, is that going to work for you? Are you going to be okay? Are you going to check your sugars now? Now you don't have an excuse. But he was really happy for me, and that made me happy that you know, because I've never lied to this doctor, ever. Not once. Even when I was high. - FMNM Tenant

When asked, 'If life was the way you would want it to be, what would that look like?', one tenant shared they just would like to be part of the community:

It would look like I was a part of the community, I had my family with me, and it'd be – that'd be it, probably. Just a part of the cultural community, spiritual community. - FMNM Tenant

Many of the tenant's appreciate being listened to and supported by FMNM staff and attribute their increased health and wellness today to living at FMNM.

DISCUSSION

The data shows that across all phases and time periods there are both large and small decreases in the use of ambulance transports, police, and the ER among those who reside at FMNM. In general, residents report feeling improved health, and increased engagement with primary care. They feel safer and more hopeful. They are also in pain and many things remain a struggle. Substance use has changed in some dramatic and some subtle ways for many long-term residents. Finally, it is clear in the qualitative data that residents attribute this success both to their own fortitude, but also to the staff and structure of the program. At FMNM, they are able to see the therapist and case manager in the building, and they feel supported and connected to these individuals. They can have regular follow up care in the health clinic located on the first floor of the building. Finally, they have a deep and abiding trust in FMNM staff to support them but also allow autonomy to live as tenants and not as clients, and to lead their own decision making. In closing, we offer the following quote, which is a response to the question, "what would you change if you had a magic wand?" In this instance, after some reflection, the participant responded:

"Actually, to tell you the truth, it'd be exactly the way that I woke up this morning--I felt great. I woke up and I was in a nice comfortable bed with a nice big fat comforter over the top of me. I was nice and warm. And then I went and got some breakfast. And to me, it couldn't have been any better." - Long Term FMNM Tenant

Trust
Alaska Mental Health Trust Authority

Trust FY25 Budget & Focus/Priority Area Overview

Program & Planning Committee, July 2023

Trust Budget Process

- Informed and collaborative development process
- Two-year budget cycle (FY24/25)
  - The first year of the budget cycle is the state's fiscal year ending in an even-numbered year
  - The annual budget is always revisited in the second year of the cycle
- Budgets typically approved by trustees the August before the start of the fiscal year (FY25 begins July 1, 2024)
- The board of trustees submits its budget to the Governor and Legislature no later than September 15 each year
  - Includes recommended expenditures (budget increments) of state general funds (GF/MH) and approved use of Trust funds (MHTAAR)

The Feedback Loop

Advisory Boards

Beneficiaries

Community, Tribal, Local, State Partners

Trust Staff

- Reaffirmation of Focus Areas / Other Concentrated Work
- Review Focus Area Goals & Allocations
- COMP Plan
- Evaluation of Impacts
- Advocacy Priorities
- Previous Stakeholder Recommendations
- Budget Recommendations

FY25 Budget Development Timeline

August 2022	Trustees approve the FY24/25 budgets
Ongoing	Trust staff engage with stakeholders to discuss priorities and the Trust budget
April – July 2023	FY25 budget recommendations are finalized
July 2023	Program & Planning Committee meeting: presentation of proposed changes to the FY25 budget
August 2023	Board meeting: Trustees approve FY25 budget

Core Budget Development Materials

Stakeholder Engagement

- Stakeholder meetings (Summary Notes)
- Stakeholder Budget Survey
- Meetings with advisory boards and key department leads

Grant reporting

- FY22 MHTAAR Performance Summary
- FY23 Grant Analysis Report

Data

- Alaska Scorecard

Stakeholder Engagement – Common Themes

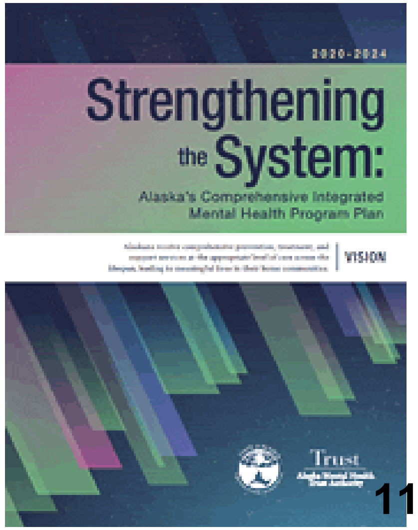
- Workforce shortages
- Serving beneficiaries with complex needs (co-occurring disorders)
- Importance of early intervention/upstream supports
- Need for housing
- Behavioral health continuum, crisis response system
- Medicaid rates/administrative challenges
- Insufficient community-based services

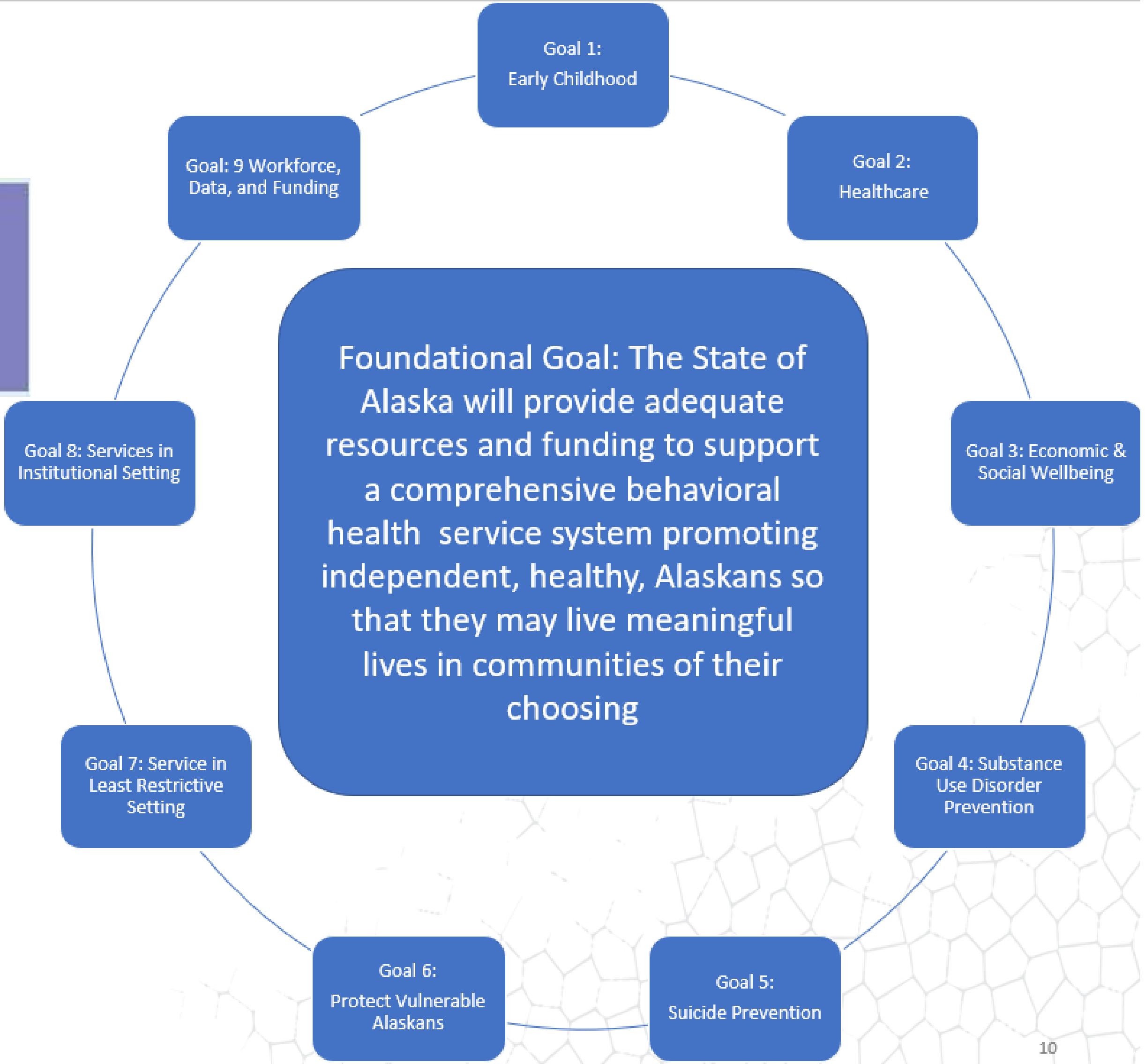
Comp Plan & the Trust Budget

Comp Plan Development:

- DHSS Staff (DOH/DCFS)
- Trust Staff
- Advisory Board ED's & Planners
- Targeted Stakeholder Input
  - Advisory Boards
  - DOC, DOLWD, DEED, Tribal Health Partners
- Public Comment

LIFESPAN: from the prenatal period through end of life

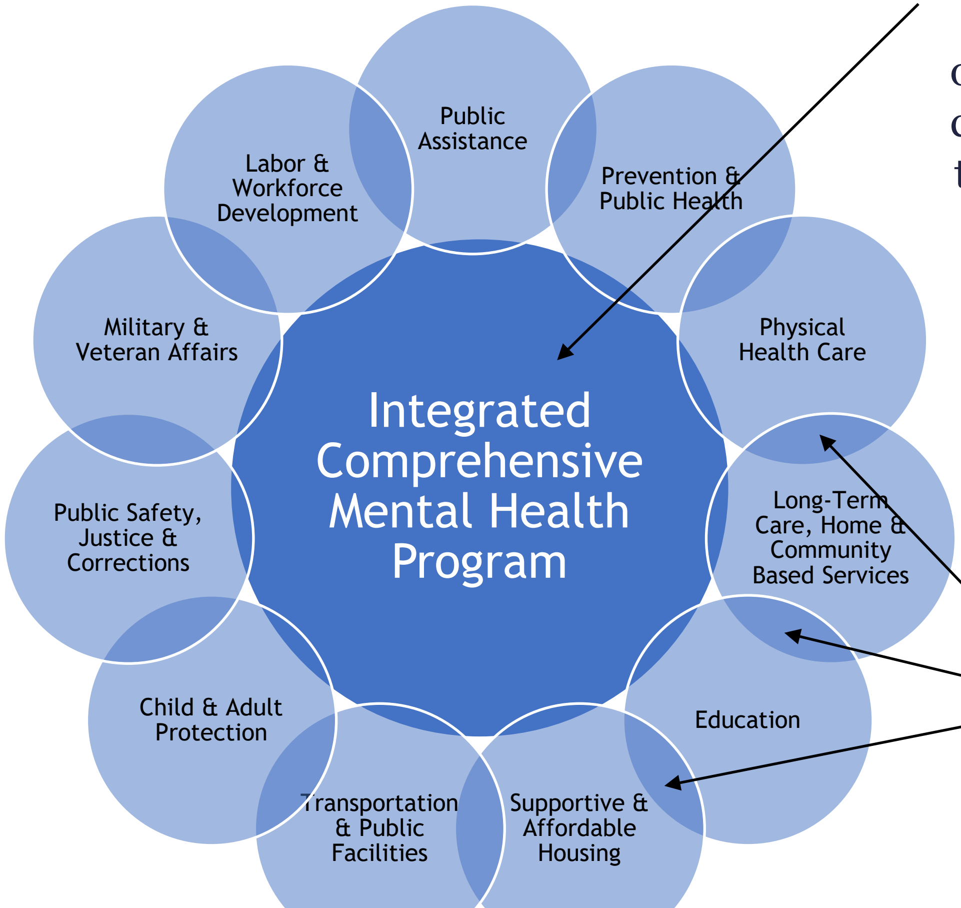




Integrated Comprehensive Mental Health Program

State and Tribal plans inform and are informed by the Comprehensive Program Plan

COMPREHENSIVE MENTAL HEALTH PROGRAM PLAN



"Core":
Programs supported with funds from the Mental Health Budget or State operating and capital funds clearly allocated to advance the Comprehensive Mental Health Program

Integrated:
Areas of Mission Overlap & Shared Responsibility

Scorecard

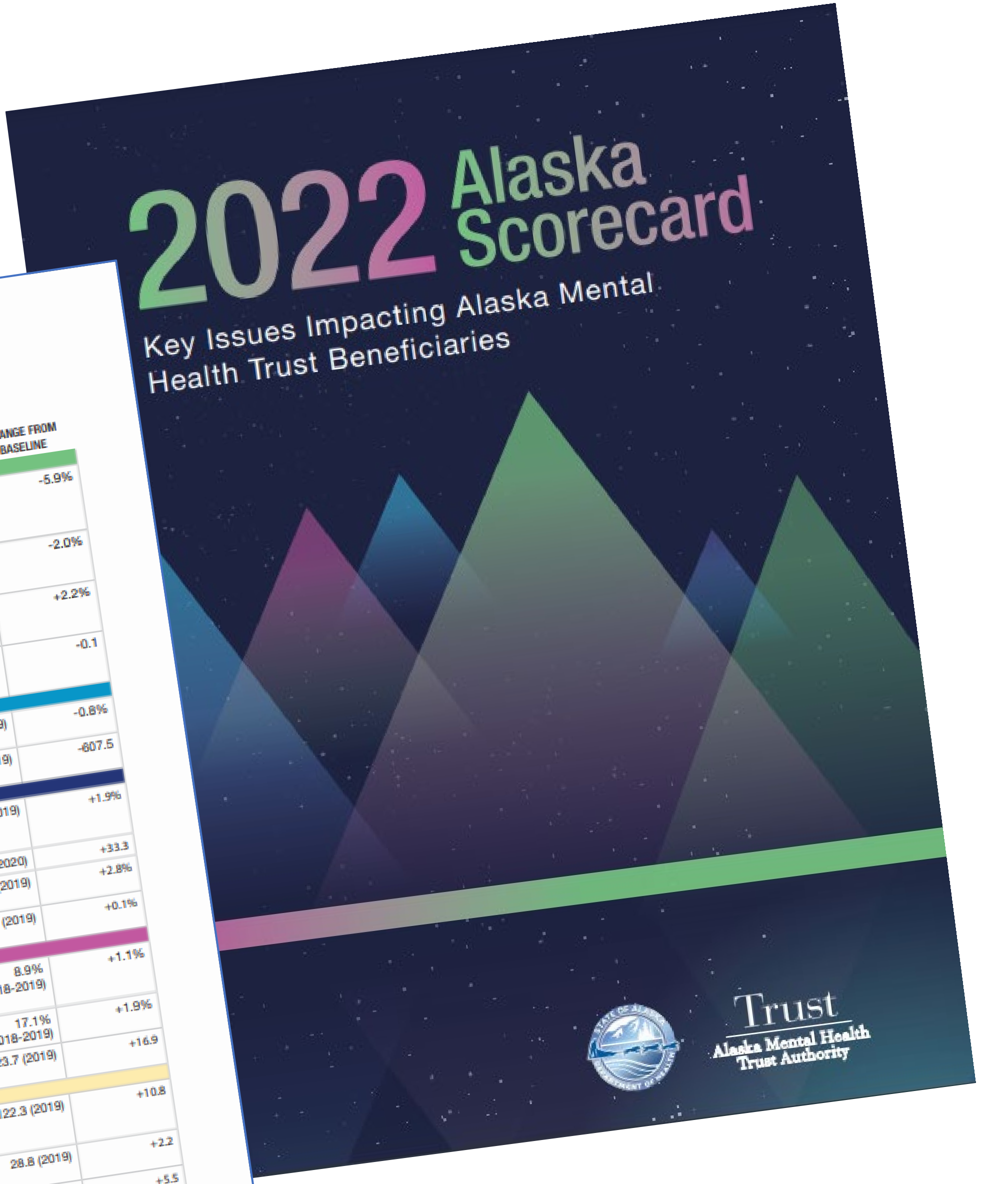
ALASKA SCORECARD 2022

Key Issues Impacting Alaska Mental Health Trust Beneficiaries

INDICATOR	LATEST U.S. DATA	LATEST ALASKA DATA	BASELINE ALASKA DATA	CHANGE FROM BASELINE
EARLY CHILDHOOD				
1. Percentage of children who received a developmental screening using a parent-completed screening tool in the past year (ages 9 months to 35 months)	34.8% (2020-2021)	42.0% (2020-2021)	47.9% (2018-2019)	-5.9%
2. Percentage of incoming students who regulate their feelings and impulses 80% of the time or more (grades K-1)	*	47.1% (2021-2022)	49.1% (2019-2020)	-2.0%
3. Percentage of women who recently delivered a live birth who have a strong social support system during the postpartum period	*	75.2% (2020)	73.0% (2018)	+2.2%
4. Mean index score of (12) indicators associated with child health and well-being that are present at birth	*	9.5 (2021)	9.6 (2019)	-0.1
HEALTHCARE				
5. Percentage of population without health insurance	8.6% (2021)	11.4% (2021)	12.2% (2019)	-0.8%
6. Rate of non-fatal fall injuries (rate per 100,000; ages 65+)	3,263.3 (2020)	3,951.3 (2021)	4,558.8 (2019)	-607.5
ECONOMIC AND SOCIAL WELL-BEING				
7. Percentage of rental occupied households that exceed 50 percent of household income dedicated to housing	24.2% (2021)	20.5% (2021)	18.6% (2019)	+1.9%
8. Rate of chronic homelessness (rate per 100,000)	38.3 (2022)	78.2 (2022)	44.9 (2020)	+33.3
9. Percentage of Alaskans who experience a disability that are employed	40.8% (2021)	46.8% (2021)	44.0% (2019)	+2.8%
10. Percentage of Alaskans living above 125% of the federal poverty level	84.6% (2021)	85.7% (2021)	85.6% (2019)	+0.1%
SUBSTANCE USE DISORDER PREVENTION				
11. Percentage of Alaskans needing but not receiving treatment at a specialty facility for substance use in the past year (ages 12+)	6.8% (2021)	10.0% (2021)	8.9% (2018-2019)	+1.1%
12. Percentage of Alaskans who received mental health services in the past year (ages 18+)	16.9% (2021)	19.0% (2021)	17.1% (2018-2019)	+1.9%
13. Rate of alcohol-induced mortality (rate per 100,000; age-adjusted)	14.4 (2021)	40.6 (2021)	23.7 (2019)	+16.9
SUICIDE PREVENTION				
14. Rate of intentional self-harm/suicide attempt emergency department visits (rate per 100,000; age-adjusted)	40.5 (2020)	133.1 (2021)	122.3 (2019)	+10.8
15. Rate of intentional self-harm/suicide deaths (rate per 100,000; age adjusted)	14.1 (2021)	31.0 (2021)	28.8 (2019)	+2.2
16. Rate of intentional self-harm/suicide deaths (rate per 100,000; ages 15-24)	14.5 (2021)	63.3 (2021)	57.8 (2019)	+5.5

KEY:
- Asterisk (*): No U.S. data available at time of publication
- Calendar year (yyyy): data represents calendar year
- Fiscal year (FYyyyy): data represents fiscal year (July-June)
- Combined year (yyyy-yyyy): data represents year range

04 ALASKA SCORECARD 2022



Budget Orientation

FY25 Approved (8.25.22) | FY25 Changes | FY25 Proposed

	A	B	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
1		Alaska Mental Health Trust Authority																	
2		Program & Planning Committee Meeting																	
3		July 26&27, 2023																	
4		*(amounts in thousands)*																	
5																			
6			FY25 Approved(8/25/2022)						FY25 Funding Amount Change						FY25 Proposed				
7			Sum of MHTAAR/MHT Admin & AG	MHTAAR/MHT Admin	Authority Grant	GF/MH	Other		Sum of MHTAAR/MHT Admin & AG	MHTAAR/MHT Admin	Authority Grant	GF/MH	Other		Sum of MHTAAR/MHT Admin & AG	MHTAAR/MHT Admin	Authority Grant	GF/MH	Other
8																			
9		Non-Focus Area Allocations																	
10		Trust / TLO Operating Budgets	9,643.5	9,643.5	-	-	-		333.0	333.0	-	-	-		9,976.5	9,976.5	-	-	-
11		Other Non-Focus Area Allocations	7,291.0	1,591.0	5,700.0	470.0	-		210.0	210.0	-	1,088.5	-		7,501.0	1,801.0	5,700.0	1,558.5	-
12																			
13																			
14		Focus Areas:																	
15		Mental Health & Addiction Intervention	6,857.5	919.5	5,938.0	2,100.0	-		(100.0)	-	(100.0)	-	-		6,757.5	919.5	5,838.0	2,100.0	-
16		Disability Justice	3,546.1	1,859.6	1,686.5	416.1	-		(45.2)	154.8	(200.0)	(187.2)	-		3,500.9	2,014.4	1,486.5	228.9	-
17		Beneficiary Employment and Engagement	2,799.0	325.0	2,474.0	-	-		(50.0)	-	(50.0)	100.0	-		2,749.0	325.0	2,424.0	100.0	-
18		Housing and Home & Community Based Services	3,926.3	1,936.3	1,990.0	6,063.0	8,100.0		16.0	-	16.0	(63.0)	-		3,942.3	1,936.3	2,006.0	6,000.0	8,100.0
19																			
20		Other Priority Areas	4,937.5	2,972.5	1,965.0	450.0	-		250.0	250.0	-	300.0	-		5,187.5	3,222.5	1,965.0	750.0	-
21																			
22		Totals	39,000.9	19,247.4	19,753.5	9,499.1	8,100.0		613.8	947.8	(334.0)	1,238.3	-		39,614.7	20,195.2	19,419.5	10,737.4	8,100.0
23																			

Trust Budget Terminology

Trust funding allocations approved by Trustees:

- **MHTAAR** = Mental Health Trust Authorized Receipts (*grants to SOA agencies*)
- **AG** = Authority Grants (*funds awarded directly from the Trust*)
- **MHT Admin** = Mental Health Trust Admin. (*Trust agency spending*)

Trustee-approved recommendations to the Governor and Legislature for the state budget:

- **GF/MH** = General Fund/Mental Health *(Recommendations for the use of state general funds as required by AS47.30.046)*
- **Other** = Other funds such as AHFC Receipts

Notes: MHTAAR funds require legislative receipt authority to the state agency. Authority grant funding goes directly from the Trust to a partner grantee.

Budget Orientation Cont’d

Trust Budget Strategies (*in yellow*)

Specific project/initiative, or name of bucket

Named grantee (*buckets are blue fields*)

Fund type:
O: Operating MHTAAR
C: Capital MHTAAR
AG: Authority Grant

Subtotal of all allocations

Allocation type

	A / B	C	G	T	U	V	W	X
5	Disability Justice		Type	FY25 Proposed Approved(8/25/2022)				
6	(amounts in thousands)	Dept/RDU | Component (or recipient)		Sum of MHTAAR/MHT Admin & AG	MHTAAR/MHT Admin	Authority Grant	GF/MH	Other
7	*Systems and Policy development*							
8	Alaska Justice Information Center	UAA/Anchorage Campus	O	225.0	225.0	-	-	-
9	Subtotal			225.0	225.0	-	-	-
10	*Increased Capacity, Training, & Competencies*							
11	Public Guardian Position	DOA/OPA/Public Guardian	O	91.5	91.5	-	-	-
12	Public Guardian Position - OCS Transition	DOA/OPA/Public Guardian	O	138.0	138.0	-	-	-
13	Crisis Intervention Team/Behavioral Health training and Programs for First Responders		AG	50.0	-	50.0	-	-
14	Crisis Intervention Team/Behavioral Health training and Programs for First Responders	DPS - AK State Troopers	O	80.0	80.0	-	-	-

Named Grantees vs. “Buckets”

- Buckets are budget lines, for specific purposes, that are unallocated to a named entity
- Trustees are considering approval of that amount for that specific purpose
- In these lines, there is no named grantee and the recipient field is **blue**
- Throughout the year, projects will be funded from these buckets when identified and developed (approvals follow Trust Charters)
- Buckets will fund one or more projects during the fiscal year

Early Childhood Intervention & Prevention							
Promote practice-informed, universal screening efforts and early intervention services							
Keep the Kids Home: Pediatric BH Services & Supports		AG	50.0	-	50.0	-	-
Children's Mental Health Conferences		AG	50.0	-	50.0	-	-
Help Me Grow Alaska: Community Outreach, Care Coordination & Dev Screening	All Alaska Pediatric Partnership	AG	150.0	-	150.0	-	-
Ages & Stages Questionnaire - 4th Edition (FY24 only)	All Alaska Pediatric Partnership	AG	-	-	-	-	-
Intensive At-Risk Early Intervention Services (Foster/Child Welfare Involved Families)	DOH/SDS/EIILP	O	460.0	460.0	-	-	-
Subtotal			710.0	460.0	250.0	-	-

We Will Cover Funding Recommendations for:

1) Focus Areas:
    a) Mental Health & Addiction Intervention
    b) Disability Justice
    c) Beneficiary Employment & Engagement
    d) Housing & Home and Community Based Services

2) Other Priority Areas:
    a) Workforce Development
    b) Early Childhood Intervention & Prevention

3) Non-Focus Area Allocations

Budget Presentation Approach

The budget is sectioned per focus/priority area, as well as non-focus Area allocations.

For each we will offer:

- Purpose and history
- Comp Plan goals addressed
- Why the work is critical for Trust beneficiaries
- Systems changes sought
- How its going: examples of project/initiative outcomes
- Where we’re going: FY25 budget strategies
- A walk-through of the budget section - including revisions

Mental Health & Addiction Intervention

Mental Health & Addiction Intervention Focus Area

- Focus area since 2013
- Mental Health and Addiction Intervention is focused on the entire continuum of care, ensuring beneficiaries have access to prevention, early intervention, ongoing community-based care, the treatment for mental health and substance use disorders, and recovery support across the various care settings.
- This area also focuses on improving the crisis system of care for individuals in acute behavioral health crises.

Key Comp Plan Strategies Addressed:

Goal 4.3: Improve treatment and recovery support services to reduce the impact of mental health and substance use disorders.

Goal 5.2: Support and improve the system to assist individuals in crisis.

Mental Health & Addiction Intervention

Why is this work critical?

- Access to comprehensive services and treatment is a critical part of the clinical engagement and recovery process
- Changing the crisis system so that a behavioral health crisis is met with a behavioral health response

What are the systems changes sought?

- Beneficiaries have improved health
- Beneficiaries and Alaskans live with increased awareness, knowledge, and reduced stigma to prevent substance and alcohol abuse and have improved help-seeking behaviors
- Beneficiaries are free of the burdens created by alcohol and substance abuse
- Beneficiaries have timely access to a comprehensive continuum of care in the community of their choice and the least-restrictive care setting possible.

How its Going?

Withdrawal Management Beds - Day One Center:

- 95 beneficiaries served
- 70% completed care and moved to long-term care
- Beds are currently full and intakes occurring daily

Crisis Continuum of Care - Crisis Now:

- 94 unique individuals seen by mobile crisis team
- 85% were supported in community, 15% LE or EMS

Mat-Su Post Crisis Network - five weeks of data:

- 15 beneficiaries served by the network (12 providers)
- 14 beneficiaries connected to services

Where we're Going

Mental Health & Addiction Intervention FY25 Budget Strategies:

- Increase awareness, and improve knowledge to prevent drug/alcohol misuse
- Improve treatment and recovery support services
- Ensure Alaskans have access to comprehensive crisis services and supports

Mental Health & Addiction Intervention FY25 Budget

Proposed Focus Area FY25 Budget: $6,757.5

- MHTAAR: $919.5
- Authority Grant: $5,838.0
- GF/MH: $2,100.0

Buckets

- Treatment Access and Recovery Supports: $1,000.0
- Crisis Continuum of Care: $3,875.5
- Child & Youth Crisis Response System of Care and Technical Assistance: $200.0
- Focus Area Administration: $50.0

FY24 Changes

- Behavioral & Physical Health Care Integration: ($100.0 AG)
- Crisis Continuum of Care: ($124.5 AG)
- Ketchikan Crisis Now Coordinator: $124.5 AG

Disability Justice

Disability Justice

- Focus area since 2005
- The Disability Focus area works through partnerships to ensure the criminal justice system effectively accommodates the needs of victims and offenders who are Trust Beneficiaries.

Key Comp Plan Strategies Addressed:

Objective 7.3 Reduce the number of Trust beneficiaries entering or becoming involved with Alaska's criminal justice system

Objective 8.3 Enhance and expand access to clinical and case management resources for incarcerated Alaskans.

Focus Area Name

- Why is this work critical?
  - Beneficiaries are at increased risk of involvement with the criminal justice system
  - Beneficiaries involved with the justice system have an average recidivism rate of nearly double that of other offenders

- What are the systems changes sought?
  - The criminal justice system effectively accommodates the needs of victims and offenders who are Trust beneficiaries
  - When appropriate, divert Trust beneficiaries away from the criminal justice system and connect them to community behavioral health providers and supports

How its Going?

- Crisis Intervention Team/Behavioral Health training and Programs for First Responders
  - Trust supported since 2003
  - Hundreds of law enforcement officers trained
  - 40-hour academies in Anchorage, Mat-Su, and Fairbanks

- Centralized Competency Calendar
  - 196 beneficiaries served in Anchorage
  - 232 where a competency evaluation was ordered
  - 137 orders in cases with felony charges

- Assess Plan Identify Coordinate (APIC)
  - 769 unduplicated participants
  - 346 received assistance with DPA and Medicaid benefits
  - 11 worked at least part-time

Where we're Going

Disability Justice FY25 Budget Strategies:

- System and Policy Development
- Increased Capacity, Training, and Competencies
- Community Prevention
- Community Intervention/Diversion
- In-facility Practices
- Re-entry

Disability Justice - FY25 Budget

Proposed Focus Area FY25 Budget: $3,500.9

- MHTAAR: $2,014.4
- Authority Grant: $1,486.5
- GF/MH: $228.9

Buckets

- Crisis Intervention Team/Behavioral Health training and Programs for First Responders - $50.0
- Re-entry Transition Supports - $200.0
- Focus Area Administration: $50.0

Changes to FY25 budget

- Crisis Intervention Team/Behavioral Health training and Programs for First Responders: Remove APD
- Crisis Intervention Team/Behavioral Health training and Programs for First Responders: Reduction to AST ($30.0 MHTAAR), GF/MH $50.0
- DVSA Victim Transition Support – ANDVSA: $200.0 AG
- Justice Diversion Support Funding: ($100.0 AG)
- Centralized Competency Calendar Paralegal, ACS: $52.8 MH/GF
- DJJ Behavioral Health Program Supports: ($105.2 MHTAAR)
- Disability Justice Support Funding: ($200.0 AG)
- APIC Discharge Planning Model in DOC: ($290.0 GH/MH), $290.0 MHTAAR

Beneficiary Employment & Engagement

Beneficiary Employment & Engagement Focus Area

- Focus area since 2004 (revised 2014)
- Improve outcomes and promote recovery for beneficiaries through integrated, competitive employment, and meaningful engagement opportunities.

Key Comp Plan Strategies Addressed:

- Objective 3.2: Ensure that competitive and integrated employment at part-time or full-time jobs pays minimum wage or above in integrated, typical work settings.
- Objective 4.4: Utilize ongoing recovery support services to end the cycle of substance misuse.

Beneficiary Employment & Engagement Focus Area

- Why is this work critical?
  - Beneficiaries are underemployed (disparity higher with cognitive impairment)
  - Work and/or meaningful engagement is essential to quality of life and recovery

- What are the systems changes sought?
  - Beneficiaries are employed or meaningfully engaged in their communities

How its Going?

- Microenterprise
  - 15-25 annual Microenterprise grants to beneficiaries starting or expanding small businesses

- Beneficiary Project Initiative
  - BPI grantees provide peer support and recovery-oriented services to nearly 4,000 beneficiaries each year

Where we're Going

Beneficiary Employment & Engagement FY25 Budget Strategies:

- Expand resources that promote successful, long-term employment for Trust Beneficiaries
- Utilize ongoing recovery (including peer and family) support services to reduce the impact of mental health and substance use disorder
- Beneficiaries increase self-sufficiency

Beneficiary Employment & Engagement FY25 Budget

Proposed Focus Area FY25 Budget: $2,749.0

- MHTAAR: $325.0
- Authority Grant: $2,424.0
- GF/MH: $100.0

Buckets

- FY25 Beneficiary Employment Conference: $50.0
- Work Matters Task Force: $50.0
- IPS Supported Employment Implementation: $250.0
- Evidence Based & Promising Employment & Engagement Practices: $200.0
- Focus Area Administration: $50.0

Changes to FY25 budget

- Centralized Accommodation Fund, DOA: $100.0 GF/MH
- IPS Supported Employment Implementation: ($50.0 AG)

Housing & Home and Community-Based Services

Housing & Home and Community Based Services Focus Area

- Focus area since 2006

- This focus area concentrates on ensuring beneficiaries have access to housing and a continuum of services and supports that maximize independence in their home and community.

Key Comp Plan Strategies Addressed:

Objective 3.1 Alaskans have stable, safe housing with appropriate, community-based social supports to maintain tenancy.

Objective 7.2 Increase access to effective and flexible, person-centered, long-term services and supports in urban and rural areas to avoid institutional placement.

Housing & Home and Community Based Services Focus Area

- Why is this work critical?
  - Preventing and ending homelessness saves lives.
  - Housing First provides the stability needed for recovery.
  - Support services help people meet goals for self-efficacy.

- What are the systems changes sought?
  - Beneficiaries maintain stable, safe housing.
  - Beneficiaries access effective and flexible person-centered home and community based services.

How its Going?

- Care Coordination Support project has improved system navigation and is starting to turn the curve on increasing access to care coordinators.
  - 10 additional care coordinators in 2022
  - Estimated 2,870 beneficiaries with IDD served

- Supportive housing projects using Housing First methods are under construction in three rural areas and Anchorage. Two more projects are in the design phase.
  - 36 new units supported last year

Where we're Going

Housing & Home and Community Based Services FY25 Budget Strategies:

- Housing and Home & Community-Based Services policy coordination and capacity development
- Beneficiaries have safe, stable housing with tenancy supports
- Beneficiaries access effective and flexible person-centered HCBS
- Optimize information technology and data analytics

Housing & Home and Community-Based Services FY25 Budget

Proposed Focus Area FY25 Budget: $3,942.3

- MHTAAR: $1,936.0
- Authority Grant: $2,006.0
- GF/MH: $6,000.0
- Other amount (AHFC): $8,100.0

Buckets

- ADRD and TABI Capacity Building: $100.0
- Supportive Housing: $650.0
- Services and Supports identified as priorities in TABI and ADRD state plans: $500.0
- Focus Area Administration: $50.0

Changes to FY25 Budget

- Supportive Housing Projects: ($100.0 AG)
- Youth Brain Injury Program Coordinator: $116,000 AG
- IT Application/Telehealth Service System Improvements: ($63,000 GF/MH)

Priority Area:

Workforce Development

Workforce Development Priority Area

- Priority Area since 2008
- The Trust utilizes workforce development strategies to support recruiting and retaining healthcare employees across Alaska who provide residential and community-based care to Trust beneficiaries.

Key Comp Plan Strategies Addressed:

Objective 9.1 Strengthen workforce capacity with improved recruitment and retention

Objective 9.2 Advance the competencies of healthcare, behavioral health, and public health workforce

Workforce Development Priority Area

Why is this work critical?

- Supporting a skilled, employed healthcare workforce promotes beneficiaries leading improved lives.
- Meet changing needs of the beneficiary population.

What are the systems changes sought?

- Address the challenge of assuring a well-prepared and sufficient workforce to meet beneficiary healthcare needs by engaging, training, recruiting, and retaining.
- Increased access and approval for supervising practitioners through online platforms.
- Increased access and use of digital platforms for supporting treatment and care at the community level.

How its Going?

Alaska Training Cooperative at UAA, Post/Pre data results:

- Over 60% of participants fill out evaluations
- 95% were either highly satisfied or satisfied
- Likelihood for change, 4.29 was the average score on a scale of 0- 5, indicating the willingness to utilize the learned knowledge and skills in a community-based setting

Peer Support Certification:

- 146 Peers certified since January 2021
- True North Recovery employs 35 Peers, and their Day 1 Center has served 84 beneficiaries since January 2023.
  - 70% of those served have successfully stepped down to lower levels of care

Where we're Going

Workforce Development FY25 Budget Strategies:

- Increased Capacity,
- Training, and
- Competencies

Workforce Development FY25 Budget

Proposed Priority Area FY25 Budget: $2,007.5

- MHTAAR: $1,857.5
- Authority Grant: $100.0
- GF/MH: $600.0

Buckets

- Priority Area Admin: $50.0

Changes to FY25 Budget

- UAA School Psychology Program: New, $200.0 MHTAAR
- SHARP Support: New, $200.0 GF/MH
- Direct Support Professional Training/Professional Development: ($100.0 AG), $100.0 MHTAAR

Priority Area:

Early Childhood Intervention & Prevention

Early Childhood Intervention & Prevention Priority Area

- Priority area since “Bring the Kids Home” focus area (2004-2012) – formalized in Trust budget 2020
- Programs serving infants and young children promote resiliency, prevent and address trauma, and provide access to early intervention services to improve outcomes for Trust beneficiaries.

Key Comp Plan Strategies Addressed:

- Objective 1.3: Reduce the instances and impact of Adverse Childhood Experiences (ACEs) through community engagement and by improving social determinants of health
- Objective 6.1: Prevent child maltreatment by ensuring resilient families.

Early Childhood Intervention & Prevention Priority Area

- Why is this work critical?
  - Early interventions for beneficiaries with delays or disabilities improve educational and health outcomes
  - Trauma early in life is highly correlated with beneficiary group status
  - Highest return on investment from earliest investments in infants and young children
- What are the systems changes sought?
  - Improve the support system for beneficiary families with young children through adolescence for improved health and life outcomes
  - Increase access to community-based supports for children and families through early identification of developmental and behavioral health issues, and enhancement of “upstream” services

How its Going?

- Help Me Grow Alaska (All Alaska Pediatric Partnership)
    - Sharp increase in children's mental health service needs since March 2020
    - Nearly 200% annual increase in family and provider contacts
    - Over 90% of families expressed high levels of satisfaction with services
- Family Services Training Center (Div. of Behavioral Health)
    - 853 unique training participants
    - 223 agencies with staff that participated in training
    - Monthly multidisciplinary advisory group meetings

Where we're Going

Early Childhood Intervention & Prevention FY25 Budget Strategies:

- Promote practice-informed universal screening efforts and early intervention services
- Ensure accurate identification of social-emotional needs for children and their caregivers
- Reduce instances and impact of Adverse Childhood Experiences (ACEs)

Early Childhood Intervention & Prevention Priority Area FY25 Budget

Proposed Priority Area FY25 Budget: $3,180

- MHTAAR: $1,365.0
- Authority Grant: $1,815.0
- GF/MH: $150.0

Buckets

- Keep the Kids Home: Pediatric BH Services & Supports: $50.0
- Children's Mental Health Conferences: $50.0
- Infant & Early Childhood Mental Health Capacity Building: $400.0
- Improve Social Determinants of Health for Families & Young Children: $265.0
- Foster Care & Child Welfare Systems Improvements: $500.0
- Early Childhood Governance: Public-Private Partnership: $50.0
- Priority Area Admin: $50.0

Changes to FY25 Budget

- Pediatric Mental Health Care Access Program: New, $140.0 MHTAAR
- Trauma Engaged Schools PBIS Coaching: $10.0 MHTAAR

Non-Focus Area Allocations

Non-Focus Area Allocations

- Non-Focus Area Allocations support Trust partners, policy improvements and reduced stigma, a strengthened continuum of care for beneficiaries, and addressing health care, basic needs, and quality of life support for beneficiaries.

Key Comp Plan Strategies Addressed:

- Objective 2.1: Alaskans have access to and receive quality healthcare services.
- Objective 3.4: Enhance timely access to basic needs.
- Objective 9.5: Encourage a culture of data-driven decision-making that includes data sharing, data analysis, and management to link support services across divisions and departments.

Non-Focus Area Allocations

Why is this work critical?

- Improve the lives of Trust beneficiaries across the lifespan
- Support Trust partners with value-adding resources
- Comprehensive planning and evaluation support systems change

What are the systems changes sought?

- Trust beneficiaries have access to needed services and supports in the least restrictive environments and as close to home as possible
- Trust partners have resources that ensure their ability to meet their mission and improve beneficiary outcomes
- The public and policymakers are aware of beneficiary conditions and needs

How its Going?

- Trust Mini-Grants support a broad road range of equipment, supplies and services to improve their quality of life. In FY22:
  - IDD Mini-Grants: 246 grants approved
  - BH Mini-Grants: 509 grants approved
  - ADRD Mini-Grants: 242 grants approved

- In FY23, 21 contracts were awarded through the Trust's Technical Assistance Contract. This program provides beneficiary-serving organizations expertise for projects in the following areas:
  - Non-Profit Governance and Operations,
  - Fund Development and Financial Management,
  - Information Technology,
  - Capital Pre-Development,
  - Incorporating Beneficiary Lived Experience,
  - Supportive Housing, or
  - Crisis Continuum of Care.

Where we’re Going

Non-Focus Area FY25 Budget Strategies:

- Grant Making Programs
- Mini-Grants
- Trust Statutory Advisory Boards
- Consultative & Technical Assistance Services
- Comp Plan / Data Evaluation
- Capital Requests
- Other

Non-Focus Area Allocations FY25 Budget

Proposed FY25 Budget: $7,501.0

- MHTAAR: $1,801.0
- Authority Grant: $5,700.0
- GF/MH: $1,558.5

Buckets

- Partnerships/Designated Grants $2,150.0
- Comprehensive Program Planning & Consultative Services $350.0

Changes to FY25 Budget

- Beneficiary Mental Health Status Data Collection: (-$40.0 MHTAAR) & (-$45.0 GFMH)
- Coordinated Transportation: $4,250.0 MHTAAAR, $1,000.0 GF/MH
- Long Term Care Ombudsman: $133.5 GF/MH

FY25 Budget - Next Steps

- Following trustee feedback, the draft FY25 budget will be prepared for final consideration at the Trust’s August board meeting.
- Once approved, the FY25 budget will be transmitted to the Governor and Legislature by Sept. 15, 2023.
- All MHTAAR increments and GF/MH recommendations will go through the state budget process (Jan – May 2024).
- The approved FY25 budget will be enacted starting July 1, 2024.

Thank you

Questions?

Trust

Alaska Mental Health Trust Authority