MUNICIPALITY OF ANCHORAGE
Complex Behavioral Health Needs Community Taskforce
Recommendations Final Report

Working Draft August 16, 2023

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Introduction

The charter for the Complex Behavioral Health Needs Task Force (AR-2023-145, As Amended) is to identify and propose solutions to the Anchorage Assembly and Municipal Administration for individuals at risk of experiencing homelessness with complex behavioral health needs. The Task Force is to submit a report with recommendations for immediate solutions by June 1, 2023, and for mid to long term solutions no later than September 5, 2023. Considerations expected as part of the recommendations include needs and capacity mapping, operational and capital needs, workforce development needs, and other items as identified by or referred to the task force by the Chairs of the Assembly's Health Policy and Housing and Homelessness Committees.

Goal of the Taskforce

Identify the optimal solutions to address the complex behavioral health needs of individuals experiencing or at risk of homelessness in the immediate term and considering complex behavioral health needs community-wide for the medium and long-term.

Process

Community members, content experts, and stakeholders were invited to participate in a series of facilitated task force sessions. Publicly noticed weekly meetings were held from May 4th through May 25th. Meeting participants are noted below in the Acknowledgements section. Between each meeting correspondence and feedback were incorporated into the report as it was developed.

In our initial meeting, the group brainstormed known gaps and urgent needs resulting in the identification of four key areas of focus: Health Care, Care Coordination, Housing, and Community Resources & State Support.

In meeting two, the four categories were used to evaluate the "Draft Vision for Comprehensive Behavioral Health Continuum of Care" (Fig.1) and identify gaps and urgent needs along that continuum.

In meeting three, the work from meeting two was further assessed using a World Cafe model so that all present at the meeting were able to contribute and participate in each category. The group began building the action table (included in this report). An initial draft of this report was developed following the meeting and sent out to the participant list from all three meetings.

In meeting four, the group completed a detailed review of the report and recommended action plan. An emphasis was placed on finalizing the recommended "Immediate Needs" identified below. Mid and long-range goals will be addressed at future meetings.

Following the meeting, an updated draft of this report was delivered to the entire participant list. Comments and suggestions were considered and incorporated. *This section will be updated once the process is complete.*

Acknowledgements

Thank you to all the task force members who contributed your time, energy, and talent to this endeavor. Task force members included:

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Theory of Change: Resources, Activities, and Desired Outcomes

Potential Resources	Activities	Outcomes	
		Short and Medium term (0-5 years)	*Long term (5 years +)*
• People experiencing or at risk of homelessness and complex behavioral health conditions • Health care providers: Southcentral Foundation, Anchorage Neighborhood Health Center, Providence Behavioral Health, Providence Family Medicine Center, Mountain View Health Services, Choices, Alaska Behavioral Health, others TBD • Peer Support: Henning, Inc. CITC, True North Recovery, Choices, AK Mental Health Consumers Web, others TBD • 3rd Avenue Navigation Center • Homelessness Prevention and Response System • Anchorage Coalition to End Homelessness • State of Alaska Department of Health, Department of Corrections • MOA: Anchorage Health Department, Anchorage Assembly, Administration, APD, AFD, others TBD • Anchorage hospital providers: Alaska Regional, Providence Alaska, Alaska Native Medical Center • Healthcare payers: Alaska Medicaid Program, Tricare, others TBD • Rasmuson Foundation, others TBD • Alaska Mental Health Trust Authority, Crisis Now, Anchorage Crisis Collaborative	Increase immediate access and navigation to appropriate services to meet physical and behavioral healthcare needs Develop and sustain multiple emergency shelter sites with access to peer supports, physical and behavioral health services Increase mobile and on-site access to behavioral health and addiction treatment, including mobile health care, MAT, and medication management Develop appropriate data sharing to connect patients with providers and track outcomes Build partnerships between health care providers and homelessness response system Train providers to deliver care using a low-barrier, harm reduction, recovery-oriented, trauma-informed approach Work with system leaders and payers to develop payment models to support comprehensive approach to complex care	Increase number of people experiencing or at risk of homelessness and complex behavioral health conditions engaged in comprehensive primary and behavioral healthcare *Measured by*: 1. Decreased use of law enforcement and EMS callouts for behavioral health crisis 2. Increased availability of mobile and same-day medical and behavioral health appointments 3. Increased use of peer support specialists 4. Increased development of core skills among staff: resilience, stress reduction, motivational interviewing, relationship building and others 5. Improved public safety and reduced negative public impacts Decrease in unsheltered homelessness and increase use of shelter, exits to housing and retention of housing. *Measured by*: 1. Decrease in unauthorized camping 2. Decrease in number of days unsheltered 3. Increase in exits to shelter and housing and length of time housing retained Increased cost-effectiveness of healthcare resources through access to lower-cost services *Measured by*: 1. Increased use of community-based physical and behavioral health care and supports 2. Decreased costs associated with emergency department and inpatient hospital care 3. Decreased readmission rates to hospital care	**People experiencing or at risk of homelessness and complex behavioral health conditions achieve whole person health and well-being** *Measured by*: 1. Self-reported reductions in harm and increased sense of wellness and recovery from trauma. 2. Increased length of engagement in health care services with one provider or provider organization. 3. Increased length of time in safe shelter or housing. 4. Increased number of individuals with chronic medical and behavioral health conditions managed without the use of inpatient care. 5. Increased retention of frontline health care workforce.
VALUES Compassion Continuity Holistic Collaborative Accessible Inclusive Relationships Stewardship of resources Health Equity			

Background

What are complex behavioral health needs?

Many experiencing or at risk of homelessness have high rates of chronic and co-occurring health conditions, mental and substance use disorders. Individuals who are homeless also may be dealing with trauma, and children experiencing homelessness are at risk for emotional and behavioral problems (Perlman et al., 2014). Additionally, research has shown that individuals who are homeless have a risk of mortality that is 1.5 to 11.5 times greater than the general population (Gambatese et al., 2013). Preventive services, including mental health, substance use disorder treatment, medical care, and social supports, are needed for people who are homeless, irrespective of whether they present with diagnosable conditions. According to data collected as part of a 2015 national survey, over half of adults living in permanent supportive housing either had a mental disorder or co-occurring mental and substance use disorder (HUD, 2016). Further, people experiencing homelessness are at high risk of overdose from illicit drug use (SAMHSA, 2020).[1]

Which services and supports help people with complex care needs remain housed?

Complex care uses a cross-sector approach to improve outcomes for people with multiple health conditions who also experience social barriers such as homelessness, systemic racism, and poverty. Health conditions can include chronic physical issues, behavioral health conditions, and substance use disorders. This approach is person-centered and team-oriented, meaning that a team works with the individual to holistically assess and coordinate care to meet their needs, and recognizes that stable housing with appropriate supports is ultimately what is needed to address the person's medical and other health and wellness needs.[2]

People with complex care needs need a safe place to stay, meals, access to medical and behavioral health treatment, and connection to permanent housing and benefits such as Medicaid, Social Security, and assessment for specialized services. Complex care includes access to medical and behavioral health care and other supports, such as connecting people to benefits and assistance in securing government identification documents.

Appropriately providing complex care requires a workforce with the skills and abilities to listen to patients to understand their story and properly assess them. This approach is person-centered, meaning it respects individual autonomy of individuals and families and care planning is directed by the person's goals and strengths.

The goal of home- and community-based services is to help people safely maintain functioning outside of a medical facility or other institutional setting. Figure 1 depicts the full spectrum of services that can help a person live independently and the higher levels of care that may be needed periodically.[3] The goal is always to help a person move back towards the lowest level of

[1] Substance Abuse and Mental Health Services Administration. (2021). Behavioral Health Services for People Who Are Homeless. Advisory https://store.samhsa.gov/sites/default/files/pep20-06-04-003.pdf

[2] https://camdenhealth.org/resources/complex-care-startup-toolkit/

[3] This graphic is being developed by Agnew::Beck Consulting under contract to the Alaska Mental Health Trust Authority as part of the stakeholder process related to HB172 and the protection and promotion of patient rights while

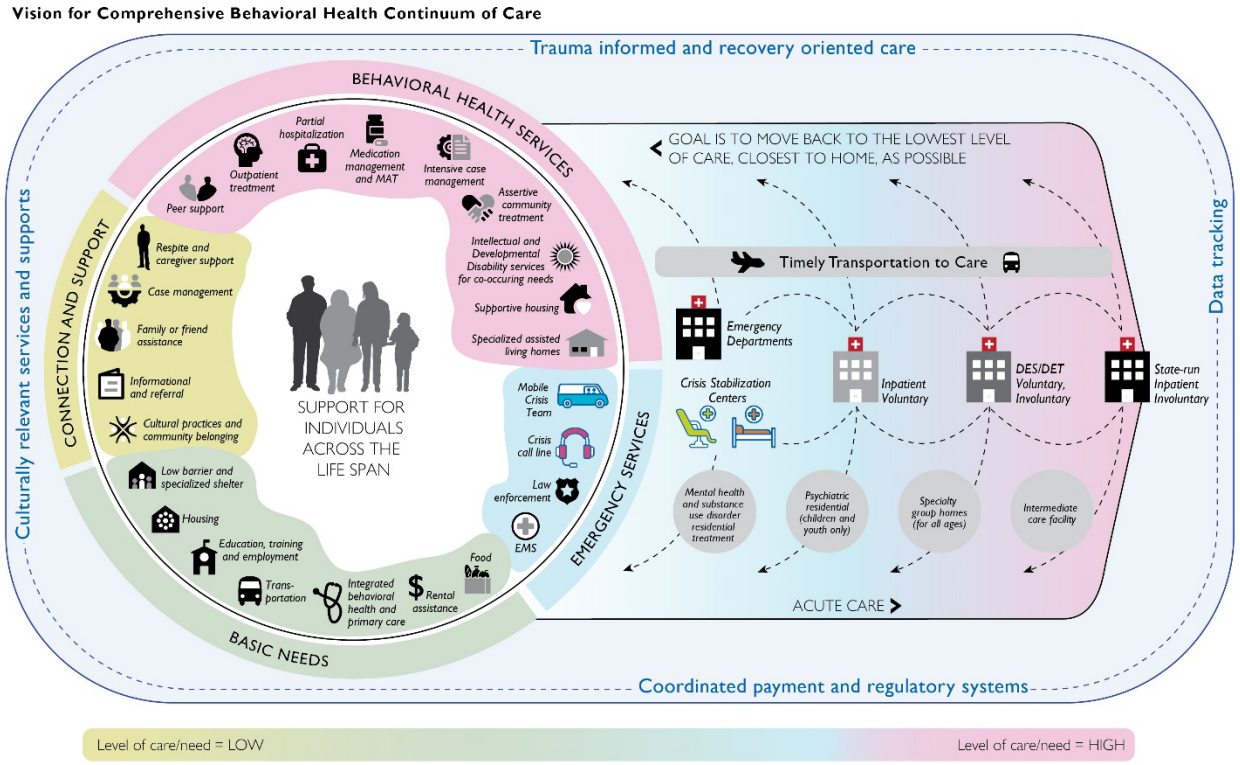
care possible and to access care as close to home as possible. Examples include supportive living environments, access to housing, food security, access to healthcare including medication management and physical healthcare, supportive employment, peer support, and mental and behavioral health treatment and counseling. These are all examples of services that may prevent a person from going into psychiatric crisis and decrease the severity of crisis. For the healthcare system, these home and community-based services reduce the need for inpatient care and involuntary treatment, reduce suicide rates, and improve public safety.[4] Some of these services are available over the phone such as 9-8-8 or Alaska Careline; others, such as a mobile crisis team, should be available in a person's home or community; others might be facility-based, such as the newly created crisis stabilization centers.

Critical for people who are experiencing or at risk of homelessness and have complex behavioral health care needs is immediate access to outreach and mobile resources, engagement with behavioral health and medical care, and safe shelter. Once a trusting relationship starts to develop, assessment and case management are needed to help the person access housing, ongoing healthcare, financial supports, community connections, and employment. Shelter and housing are critical, but by themselves will not lead to success for most people experiencing severe mental illness, addiction, or other complex conditions.

accessing psychiatric care. For more information and updated versions of the graphic see https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/sb124hb172/

[4] See here for more information and resources: https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/

Figure 1. Draft Vision for Comprehensive Behavioral Health Continuum of Care



How many people experience homelessness and complex conditions including behavioral health conditions in Anchorage today?

Anchorage's Homelessness Management Information System (HMIS) system managed by Anchorage Coalition to End Homelessness (ACEH) tracks the total number of people who are actively experiencing homelessness in Anchorage, the proportion that report experiencing a disabling condition, meet critieria as chronically homeless, and those considered beneficiaries of the Alaska Mental Health Trust Authority.[5] By using these criteria and HMIS data, we can estimate the number of people experiencing homelessness and complex conditions including behavioral health conditions in a given period. Figure 2 summarizes the criteria that can be used to identify the group of people who could benefit from the interventions identified in this plan.

Figure 2. HMIS Criteria to Identify those who could benefit from Complex Care

Demographics	Adults (age 18+), including elders; no additional age restrictions; all genders
Housing Status	Experiencing homelessness, or in need of housing assistance
Chronic Status[6]	Identified as chronically experiencing homelessness (HUD definition)

[5] https://aceh.org/data/

[6] Chronic Homelessness is defined by HUD as a person having at least one disabling condition (see following note) and either: 12 months or longer of consecutive homelessness, or 12 months documented homelessness in the last 36 months.

Disability Status[7]	Identified as having one or more disabling conditions, includes physical disabilities, intellectual and developmental disabilities, mental illness and substance use disorders (HUD definition; also included as a component of Chronic Homelessness)
Health Conditions	Identified as having a "Medical Need" (Anchorage HMIS, definition 2): having 3 or more disabilities defined as the Alaska Mental Health Trust beneficiary categories: mental illness, developmental disability, substance use disorder, Alzheimer's disease and related dementia (ADRD) and traumatic brain injury (TBI).[8]

How can we best help and support all Anchorage residents by engaging people who are experiencing or at risk of homelessness and complex behavioral health conditions?

The Proposed Goals and Objectives below identify steps to address the needs that will improve health and well-being for people experiencing or at risk of homelessness and complex behavioral health needs. With the closure of the Sullivan Arena in May 2023, many people have no sanctioned place to shelter and no access to healthcare, housing, or other supports to help them regain stability. This crisis made the work of the taskforce urgent; coordinated resources must be deployed immediately to address the needs of people experiencing homelessness and complex behavioral health needs, and to create a safe and well community for all in Anchorage.

[7] Disability is defined by HUD as one or more of the following conditions: alcohol abuse; both alcohol and drug abuse; chronic health condition; developmental disability; drug abuse; HIV/AIDS diagnosis; mental health problem; physical disability.

[8] Mhtrust.org

Proposed Goals + Objectives

This section will be updated to match the action plan once the process is complete.

1. **GOAL 1: System Coordination: Outreach and Triage**: Identify the most vulnerable individuals experiencing or at risk of homelessness in Anchorage who also have complex behavioral health conditions, many of whom are currently unsheltered, and address care needs.
   OBJECTIVES:
   a. Identify and, if necessary, fund a position and team at the Anchorage Health Department or other municipal entity to manage and coordinate contractors, funding streams, and Municipal, State, and non-Municipal entities to implement this plan.
   b. Partner with State entities to reduce system-level barriers and to increase funding and other resources to rapidly meet the needs of people experiencing or at risk of homelessness and complex behavioral health issues.
   c. Work with Anchorage Chamber of Commerce and local businesses to address community needs, share information, and increase resources.
   d. Coordinate referrals from ACEH and the Coordinated Entry system, shelter providers, outreach, health care providers, mobile crisis team, and hospitals to identify and triage potential clients.
   e. Conduct mobile screening, identify a shared level of care (LOC) assessment and triage process, and implement the use of Z codes in Electronic Health Records (EHR) to facilitate data sharing with HMIS, healthcare organizations, and healtheConnect Alaska.[9]
   f. Facilitate and conduct regular case conferencing to review referrals and develop and manage care plans.
   g. Address lack of Public Guardianship available.
   h. Ensure culturally relevant services and supports are available to all.
   i. Increase and improve public communications to build understanding of people with unmet health and wellness needs that sometimes result in homelessness.
2. **GOAL 2: Shelter**: Provide immediate, very low-barrier, and appropriate safe overnight shelter, and navigation to access health care and supports.
   OBJECTIVES:
   a. **Implement the recommendations of the Sanctioned Camping Taskforce** released May 22, 2023, as finalized by the Sanctioned Camping Taskforce and Anchorage Assembly.
   b. **Add one low-barrier navigation center to provide daytime services, located near to new shelter sites** and not in downtown Anchorage**.**
3. **GOAL 3: Health Care, Care Coordination and Housing**: Rapidly assess and address housing, behavioral health, medical and longer-term care needs.

[9] https://www.healtheconnectak.org/

OBJECTIVES:

a. Identify and treat behavioral, medical, and other care needs.
    i. Support the development of Crisis Now services and facilities:
        1. Promote the connection of APD Dispatch to the Alaska Careline and the expansion of the APD Mobile Intervention Teams
        2. Support the AFD Mobile Crisis Team to operate 24/7
        3. Support Providence and Southcentral Foundation's projects to develop Crisis Stabilization Centers (CSC)
        4. Support the development of the Crisis Care and Connectors group
    ii. Contract with providers to do mobile outreach and provide medical and behavioral health services to people who are experiencing or at risk of homelessness.
    iii. Contract with peer providers to develop trusting relationships to increase client engagement.
    iv. Coordinate and provide transportation to health clinics for primary and behavioral health care and other supports.
b. Assess individuals for benefit eligibility, such as Medicaid and Social Security, and secure all eligible benefits.
c. Identify housing options and help clients secure long-term housing.
d. Add residential treatment beds and outpatient capacity for behavioral health care and conduct collaborative advocacy to decrease barriers and help providers add treatment capacity.
e. Increase behavioral health workforce.
f. Fill funding gaps to add units of supportive housing and other housing options
    i. Quantify units needed, secure funding, develop capacity
        1. Transitional housing
        2. Permanent Supportive Housing, very low barrier
        3. Assisted Living Homes for people with complex behavioral health conditions
        4. Structured group homes for people with combination of Intellectual and Developmental Disabilities (IDD) and behavioral health conditions
        5. Specialized care for Elders with cognitive impairments and behavioral health conditions
        6. Specialized supportive housing options for youth and young adults

Action Plan

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
GOAL 1: SYSTEM COORDINATION: OUTREACH + TRIAGE: Identify the most vulnerable individuals experiencing or at risk of homelessness in Anchorage who also have complex behavioral health conditions, many of whom are currently unsheltered, and address care needs.								
OBJECTIVES								
Identify and, if necessary, fund a position and team at the Anchorage Health Department or other municipal entity to manage and coordinate contractors, funding streams, and Municipal, State, and non-municipal entities to implement this plan	Immediate	MOA AHD or other municipal department	Lack of capacity at AHD Lack of behavioral health workforce in general Funding Unknown alignment between Administration and Taskforce recommendations	Lack of capacity at AHD: 30 open positions, is there salary budget available? Potential to fill need through contracts Is there a different department at MOA that could fill this function?	Identify position and team	If necessary, add resources, defer to AHD		
Partner with State entities to address system-level barriers and to increase funding and other resources	Medium, Long	MOA AHD, Department of Health, Department of Corrections, Department of Family and Community Services	Lack of connection and alignment with the Governor's Office for funding Unclear connections with state-level entities 1115 Medicaid waiver is going through renewal process now; regulations being updated so unclear what changes will be made and when/if rates are changed People who are on electronic monitoring and are homeless, can't charge their ankle monitor, return to jail	Identify point of contact to engage with DOC, API, DOH, DFCS Legislative liaison at the Administration, potentially help with the Governor's office. Connect with Reentry Coalition Work with Department of Corrections to increase pre-release activities to identify and triage needs and supports prior to release AK Council on Homelessness is dormant, could this be used to bring entities together	Follow-up Municipal legislative priorities at state Legislature	Alaska Medicaid State Plan and 1115 waiver services, Alaska Mental Health Trust Authority; Comprehensive Integrated Mental Health Program Plan 2022-24; AHD Opioid Taskforce coordinate with OSMAP		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
				to address issues in Anchorage?				
Work with Anchorage Chamber of Commerce and local businesses to address community needs, share information, and increase resources.	Medium to Long-range	Taskforce,		Need a point of contact and starting a connection with the Chamber, initiate it	TBD	TBD		
Engage other Funders, Leaders, and Community Groups	Immediate	Taskforce	Lack of a coordinating entity to convene and do outreach	Homelessness Leadership Council Anchorage Reentry Coalition				
Coordinate referrals from ACEH and the Coordinated Entry system	Medium	MOA, ACEH or contractor	Lack of connection between healthcare providers and ADRC for people in need of assessments for waiver and assisted living Lack of connection between healthcare and ACEH for connection to the Coordinated Entry process	Could MVHS become an access point for mobile teams to access Coordinated Entry? ACEH has case conferencing for Single Adults, how to connect healthcare providers?				
Identify a shared level of care (LOC) assessment and triage process, and implement the use of Z codes in Electronic Health Records (EHR) to facilitate data sharing with HMIS, healthcare organizations, and healtheConnect Alaska	Long	MOA, ACEH or contractor	Requires a state representative to help identify solutions to implement 1115 services to use them to serve this population because they may not be enrolled in Medicaid, or need support to enroll, and need identification. Medicaid services require enrollment, assessment, formal treatment plan, to deliver services and this will be difficult to do with most of the	Convene a provider workgroup to develop a solution to present to the State and to pilot this process Need a new service for this: could be ICM for people experiencing homelessness, make ICM eligible for people with housing issues, use Z code for this	Funding decisions Data sharing agreements Agreement on Level of Care Assessment tool and triage process Contracts with healthcare, behavioral health, and peer support providers: Mountain View Health Services, Choices, AK	MOA funding Alaska 2-1-1 Medicaid 1115 for eligible providers/clients Requires start-up funding to develop shared data system HUD Continuum of Care funding State of Alaska funding for healtheconnect		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			clients we are focused on.		Behavioral Health, Henning, Inc., Southcentral Foundation, others?			
Facilitate and conduct regular case conferencing to review referrals and develop and manage care plans.	Medium	Anchorage Crisis Continuum	Start-up, need to get this going	Trust has contractors to support start-up of a Case Conferencing group	Data sharing agreements	Support from the Trust via the Crisis Now Implementation Support contract		
Address lack of Guardianship and support navigating the system and process	Medium	Office of Public Advocacy, Department of Health	State-level lack of workforce, not a quick fix because of lengthy certification process Overuse of full guardianship, need to be more strategic about which services a person needs Lack of training and outreach for family and friends to fill the role of limited guardian Lack of early intervention to support people before they need full guardianship	Can ADRC provide more support? Family education Engage Alzheimer's Association and Care Coordinators, Engage Alaska Court System Stacey Maertz Alaska Community Care for access to care coordination				
Ensure culturally relevant services and support	Medium to Long-range	TBD	Define what we mean by 'culturally relevant services and supports': it's not one size fits all, many cultures represented in Anchorage Lack of a robust peer workforce	Expand, use and support of existing peer organizations and Tribal Health and Social Services: Henning, CITC, Mountain View Health Services, others Arc of Anchorage new MH Treatment Homes using peer supports	TBD	Partnership with SCF, CITC and other Tribal entities; partnerships with Peer Leader Navigators, Providence Community Health Workers; partner with diverse community organizations, faith communities, and cultural groups.		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
Build workforce, especially peers, personal care, direct service providers, certified nursing assistants	Medium		Barriers to employment such as criminal history Positions poorly paid, vulnerable Lack of recruitment, competition among employers	Waiver process to reduce barriers to employment Crisis Now services that build up peer workforce and roles CITC have cultural peers and are starting a new apprentice peer program at CITC for those in recovery but many were also homeless at one time.				
Increase and improve public communications to build understanding of people with unmet health and wellness needs that sometimes result in homelessness	Immediate	AHD, Planning and Zoning, Planning Department	Lack of coordinating entity Connected with the education to families and public about how to access needed services for people with behavioral health issues Need for coordinated communication Lack of outreach to community councils Need for alignment between Administration and Assembly lack of agreement on priorities Medical providers who see patients in need but don't know where to direct people for help	Consider Trust communications resources for anti-stigma and for family/consumer outreach Federation of Community Councils Chamber of Commerce outreach with Community Crisis Toolkit	Specific communications with communities near new facilities and programs; consider using the Good Neighbor Policy template when working with communities			

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options

GOAL 2: SHELTER: Provide immediate, very low-barrier, and appropriate safe overnight shelter, and navigation to access health care and supports.								
OBJECTIVES								
Implement the recommendations of the Sanctioned Camping Taskforce	Immediate: 30-60 individuals, temporary structure that can be year-round at 40th and Denali; will include some individual spaces; open campus; may be an expansion in 2024	MOA or contractor	Who will operate the pilot program?	Need to be able to provide mobile healthcare to pilot program Contract with healthcare providers to operate the project	TBD	Funding for contracted providers		Municipal funding
Implement transitional housing for 200 people in no-barrier structures; 4-5 sites, accessible to people with mobility, cognitive, other impairments; include small space for healthcare providers to do exams, assessments meet with clients		MOA or contractor	Funding Locations Community Support Contracts for supports Capital and operational funding	Construct sites in Anchorage, with access to healthcare, EMS located close to where people are currently camping, where providers can get to them. Multiple sites with multiple providers providing services on a regular basis on site				
Add one low-barrier navigation center to provide daytime services, located near to new shelter sites.	Medium, Long-range	MOA or contractor	Long delays, paperwork trails for people needing assistance Difficult to navigate even for healthcare providers and especially clients who have impairments, speak languages other than English Medicaid requires a 28-page application for people to enroll No seats in the waiting room for people waiting for assistance	Need engagement with the State See what is happening at the 3rd Avenue Navigation Center and what else is needed in other parts of Anchorage Special populations, such as people being trafficked, need specific type of assistance and navigation Navigation centers should be able to send out mobile navigators	TBD	TBD		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
GOAL 3: HEALTH CARE, CARE COORDINATION, AND HOUSING: Rapidly assess and address housing, behavioral health, medical and longer-term care needs.								
OBJECTIVES								

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
Identify and treat behavioral, medical, and other care needs.								
Support the development of Crisis Now services and facilities 1. Promote the connection of APD Dispatch to the Alaska Careline and the expansion of the APD Mobile Intervention Teams 2. Support the Mobile Crisis Team to operate 24/7 3. Support Providence and Southcentral Foundation's projects to develop Crisis Stabilization Centers (CSC) 4. Support the development of the Crisis Care and Connectors group.	Immediate	Anchorage Assembly, APD, AFD, Administration Trust	(1) Medicaid funding is not an adequate source for mobile teams to serve this population because they may not be enrolled in Medicaid, or need support to enroll, and need identification. (4) Medicaid services require enrollment, assessment, formal treatment plan to deliver services and this will be difficult to do with most of the clients we are focused on. (3) SCF standing up 23-hour services but not the crisis residential services so there needs to be alignment with regulations being considered now and understanding we don't have enough of the residential beds to manage people within 23 hours (3) Providence will have 12 beds of crisis residential (4-7 days) but this may not be enough and will require appropriate discharge (4) Lack of communication and coordination between facility programs and community providers; not knowing what everyone is doing to be able to work together	(1) Adding teams who are not APD/AFD Building up peer workforce (3) Support for appropriate discharge options from 23-hour program (3) Identify discharge options from crisis residential (4-7 day program) to allow people to return to the least restrictive environment (4) Need more specialized assisted living homes in the community to address people with complex chronic needs Align regulation and payment to support appropriate medications in crisis stabilization programs (e.g. Medicaid Locked-in programs for pharmacy) (3) Capital funding required to complete all phases of construction with Providence CSC (4) Monthly Case Conferencing group supported by Trust and contractor starting up (4) ACEH hosts a weekly highly vulnerable adult case conferencing; ADRC, Catholic Social Services,	Job reclassification for AFD Mobile Crisis Team (MOA HR and Unions) Funding allocations	Continued funding for APD and AFD Additional construction funding for Providence and SCF's CSC projects to complete construction on time and open centers as soon as possible. Trust and contractor, Agnew::Beck, to support development of Crisis Care and Connectors group; additional funding may be needed		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			(4) Shared ROI and system for sharing information appropriately	SCF, VA, Choices, Henning, MVHS, ANHC with shared ROI				
Contract with providers to do mobile outreach and medical and behavioral health services to people who experiencing or at risk of homelessness	Immediate	MOA AHD or contractor to develop subcontractors with healthcare, behavioral health, and peer support providers	Funding for this is not easy to do through Medicaid because it is a fee for service and people are not enrolled 9-1-1 calls you don't get a bill, it's a community service APD/AFD may not have extra funding in their budget Savings from other healthcare expenditures isn't calculated as cost avoidance from providing mobile services Medicaid 1115 ICM regs requires 2 RNs and must be a CBHS to bill	Assembly could add funds to APD/AFD to contract with a mobile team provider to deliver mobile care MVHS and Henning are doing mobile crisis and healthcare Remove barriers and complications associated with Medicaid enrollment and billing Agree that these are essential services and should be paid for all community members e.g. in AZ first 24 hours of a BH emergency are considered an emergency response and people are not billed for these services, covered by braided funding through the regional behavioral health authority Form a funding entity at the MOA to braid funding from multiple sources to cover the first 24 hours of behavioral health care	Funding decisions Contracts with providers	Funding		This may be partly sustainable through Medicaid billing for eligible and enrolled clients; however, unresourced clients and provider transportation costs and time to locate unsheltered clients will require additional payment source
Contract with peer providers to develop trusting relationships to increase client engagement	Immediate	MOA or contractor	API discharging patients with a taxi voucher to Gospel Rescue Mission or Hope Resource Center, many don't have health information and often don't access	Funding for transitions from institutions. Funding for appropriate and adequate no-barrier shelter and access point for coordination of care.	Funding decisions Contracts with providers			Capacity for workforce

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			shelter, nowhere for people to go. Henning is doing camp outreach is unsure what funding is supporting that. No shelter available, people discharged to street, no support.					
Coordinate and provide supportive transportation to health clinics for primary and behavioral health care and other supports	Immediate	MOA or contractor	Need support during transitions in care; taxis aren't always a good option because people need help getting in the door Transportation should be coordinated with the provider that is accepting the discharge; sometimes that provider wants to come and pick the person up Local transportation companies are hesitant to pick up people at locations where they know people are vulnerable, also hesitant to accept vouchers Medicaid Transportation is so time consuming to access that it is almost not worth the time to access it	Funding for contracts Peer supports can accompany people to shelter and ensure that the warm handoff occurs Providers can come and transport the person to start the rapport and support good care coordination API has been doing "soft discharges" where the provider that will accept the person comes into the facility to meet the person, short trips to the new placement to get oriented Home for Good had vehicles to transport clients to support staff in helping a person transition successfully Anchor Rides for people with brain-based disabilities like we do for physical disabilities Phone calls to support discharge also help Centralize transportation with appropriate providers and vehicles like we	Funding decisions Contracts with providers	Bus passes, taxi vouchers, and support for case managers to transport clients, when needed		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
				do with mobile teams but for people returning to home/community Ensure public transportation plans include stops at all major healthcare access points and housing for people				
Assess individuals for benefit eligibility, such as Medicaid and Social Security, and secure all eligible benefits.	Immediate		Lack of mobile case management to meet people where they are and support them getting access to benefits Lack of care coordination and process 45-day wait for Medicaid enrollment Medicaid and other applications are time-consuming to fill out; people lack ID and don't have a place to store documents	Case managers, Peer Supports, 3rd Avenue Navigation Center ACEH mobile teams can help people fill out applications; streamline these to reduce time it takes to fill out applications Bring all providers/agencies together at the same time and bring them to the person e.g. Project Homeless Connect; ACEH hosting these over the next three months Train people in the SOAR process to help people apply for Social Security and SSI Care coordinators communicate with SDS through Harmony, good system to store and share information; could this system expand to serve people with behavioral health issues? MyAlaska system could be used for benefit enrollment and tracking State services	Funding decisions Contracts with providers			

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
Identify housing options and help clients secure long-term housing.	Medium		Lack of available appropriate supportive housing units Lack of adequate rental assistance that is flexible to meet needs: people's needs vary by duration, location, supports; waiting lists are years long Lack of low-barrier housing	ACEH, Providers, MOA ADRC, 3rd Avenue Navigation Center Subsidize the construction of new Permanent Supportive Housing ACEH Gap Analysis: Ways to incentivize healthcare providers to provide housing Coordinated Entry committee (ACEH) is bringing in a new vulnerability assessment to help prioritize people experiencing homelessness for Permanent Supportive Housing Open Beds could be a system for connecting healthcare providers with Assisted Living Homes and other supportive housing to match people to beds	Funding decisions Contracts with providers	TBD		
Add residential treatment beds and outpatient capacity for behavioral health care and conduct collaborative advocacy to decrease barriers and help providers add treatment capacity.	Medium	TBD	Arc's Residential Mental Health Treatment programs (two facilities) is filling up fast and there is a waitlist Getting access to medical records is a challenge Completing assessments is very challenging; psychiatric assessment with a primary diagnosis is needed Lack of standardization of intake and	Support recommendations from Alaska Behavioral Health Association to greatly reduce administrative burdens and barriers to entry to behavioral health care for Medicaid e.g. remove the requirements for full assessment prior to services Implement higher payment rates during transitions to Assisted Living homes for people with complex	TBD	TBD		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			assessment processes Lack of adequate payment to Assisted Living providers to serve people with higher needs Discharge for aftercare is a challenge	conditions to allow for higher staffing Increase payment for Assisted Living to accept and serve people with behavioral health conditions and SMI Decrease barriers to access waivers for people IDD working with Stone Soup Group				
Increase Behavioral Health workforce	Medium to long	TBD	Barrier crimes that disallow people from working in healthcare settings Recruitment is not coordinated State Labor laws prohibit social workers and clinicians, peers and other staff from working 12-hour shifts Payrates are low because billing for behavioral health services is lower than other healthcare services Currently, we are placing people in Assisted Living homes that accept General Relief and are staffed with people who aren't paid a living wage and don't have health insurance; case managers are using their own vehicles; Assisted living home staff need training and support to care for people with high needs to retain housing	Assistance for people to navigate the variance process and gain variances in a timely manner Support Social Work and Licensed Professional Counselors to approve licensure from out of state more quickly; reduce barriers through reciprocal licensing Market Alaska as a wonderful place to live and work; coordinated recruitment for behavioral health workforce Market behavioral health careers to students and young people; engage them in joining the workforce Change State labor laws to allow behavioral health staff other than nurses (who are already allowed to work 12-hour shifts) to work 12-hour shifts Increase number of practicum	TBD	TBD		Support efforts at UAA School of Social Work and College of Health, facilitated by Recover Alaska

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
				placements in Anchorage Increase pay rates and ensure benefits: some agencies still paying $14/hour for direct service positions; no one can live in Anchorage on 40-hour a week for under $21/hour Pay healthcare providers to continue to serve clients when in Assisted Living and to support the staff at the homes Increase access to support, mentoring, and supervision Support staff and reduce burnout				
Fill funding gaps to add units of supportive housing and other housing options	Medium, Long	MOA, AHFC or other State entity, ACEH, Housing Trust, others?	Lack of capital and operating funding	Municipality should apply for any and all funding grants to add units of supportive housing Reduce down payments or provide other support to allow supportive housing providers to purchase homes Municipality should apply for federal funding to support people reentering from Corrections to the community Department of Corrections supports transitional housing in Anchorage Braid funding for developing and supporting new supportive housing units	Quantify units needed, secure funding, develop capacity	Permanent Supportive Housing, low barrier Assisted Living Homes for people with complex behavioral health conditions Structured group homes for people with combination of IDD and behavioral health conditions Specialized supportive housing for youth and young adults such as Therapeutic Treatment Homes and group homes Specialized care for Elders with cognitive impairments and behavioral health conditions		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
				Identify experts who have done this successfully and provide access to their expertise Increase units of transitional housing by removing the barrier at AHFC of requiring a license for accessing support for new units (there is no license for transitional housing as there is for assisted living and foster families) Municipality use tax exemptions, land donations, other deals to support development of new units				