MUNICIPALITY OF ANCHORAGE
Complex Behavioral Health Needs Community Task Force
Recommendations Final Report

Submitted to the Anchorage Assembly, September 5, 2023

Contents

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 with complex behavioral health needs who are at risk of or experiencing homelessness**.

The task force submitted recommendations for immediate solutions on June 1, 2023. This final report provides recommendations for medium to long term solutions submitted on September 5, 2023.

Goal of the Task Force

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

People

First and foremost, this task force focused on the needs of community members who have severe, chronic health conditions and who have inadequate or nonexistent access to appropriate care for their health needs. This is not a large number of people, however, the severity of their health conditions and the lack of access to care can mean each person may have many repeat visits to emergency departments, the Alaska Psychiatric Institute (API), and sometimes jails. When people with severe untreated illness are unable to maintain housing, they often experience additional traumas, become even less able to access care and supports, and can require hours of public safety and emergency health care response.

The task force has developed this plan to address the untreated severe health issues that put community members who experience them at great risk for homelessness and often result in the person experiencing unsheltered homelessness for significant periods.

Process

The task force included 70 community members, content experts, and stakeholders who participated in a series of facilitated sessions. A full list of members is in Appendix A. Publicly noticed weekly meetings were held from May 4th to May 25th, 2023. Between each meeting correspondence and feedback were incorporated into the report as it was developed.

After additional meetings in July, on August 29th, the task force hosted a leadership summit at the Mountain View Library in Anchorage. The participant list is provided in Appendix B. The task force presented the priority objectives and facilitators used the World Café model to identify barriers, what is currently in place, quick fixes, and commitments. Results from the Leadership Summit are included in Appendix C.

Acknowledgements

Thank you to all the task force members who contributed their time and expertise to this process.

Thank you very much to the 60+ community members and leaders who attended the Summit on August 29th, 2023 and the 100+ community members who viewed the video stream. Your leadership, expertise, and input enhanced this process, and we look forward to your commitment to implement this plan.

Thank you to the team that supported and led the task force's work:

Clare Ross, Municipality of Anchorage

Allie Hartman, Municipality of Anchorage

Jennifer Veneklasen, Municipality of Anchorage

Felix Rivera, Anchorage Assembly

Daniel Volland, Anchorage Assembly

Thea Agnew Bemben, Agnew::Beck

John Gregoire, Professional Growth Systems

Recommendations

Outcomes

The task force recommends priority actions to work towards the following short-, medium- and long-term outcomes. The full Theory of Change is included in Appendix D.

Long term outcome: People with complex behavioral health conditions experiencing or at risk of homelessness achieve *whole person health and well-being.*

Measured by:

- Self-reported reductions in harm, increased wellness, and recovery from trauma.
- Increased engagement in health care services with one provider or organization.
- Increased length of time in safe shelter or housing.
- Increased number of individuals with chronic medical and behavioral health conditions managed without the use of inpatient care.
- Increased retention of frontline health care workforce.

Short and medium-term outcomes: People with complex behavioral health conditions experiencing or at risk of homelessness:

Increase engagement in comprehensive primary and behavioral healthcare.

Measured by:

- Decreased use of law enforcement and EMS callouts for behavioral health crisis.
- Increased availability of mobile and same-day medical and behavioral health appointments.
- Increased use of peer supports.
- Increased development of core skills among staff: resilience, stress reduction, motivational interviewing, relationship building and others.
- Improved public safety and reduced negative public impacts.

Decrease experience of unsheltered homelessness and increase use of emergency shelter, exits to housing, and retention of housing.

Measured by:

- Decrease in unauthorized camping.
- Decrease in number of days unsheltered.
- Increase in exits to shelter and housing and length of time housing retained.

Increase cost-effectiveness of community resources through access to lower-cost health care and services.

Measured by:

- Increased use of community physical and behavioral health care and supports.
- Decreased costs associated with emergency department and inpatient care.
- Decreased readmission rates to emergency department and inpatient care.

Goals + Priority Objectives

1. **GOAL 1: System Coordination: Outreach and Triage**: Identify and address care needs of people with complex behavioral health conditions who are experiencing or at risk of homelessness in Anchorage, many of whom are currently unsheltered.
   PRIORITY OBJECTIVE:
   a. By December 31, 2023, identify and, if necessary, fund a coordinator 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.

   RATIONALE:

   To increase participation from other public and private funders, braid funding, manage contracts, and leverage other municipal resources, which are necessary to implement this plan, Anchorage needs a coordinating entity. A municipal department is uniquely situated to provide these functions.

   OTHER OBJECTIVES FOR GOAL 1:
   b. Partner with State entities to reduce system-level barriers and increase funding and resources to rapidly meet the needs of people experiencing or at risk of homelessness and complex behavioral health issues.
   c. Engage funders, leaders, and community groups to implement this plan.
   d. Work with Anchorage Chamber of Commerce and local businesses to address community needs, share information, and increase resources.
   e. 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.
   f. 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.[1]
   g. Facilitate and conduct regular case conferencing to review referrals and develop and manage care plans.
   h. Address lack of Public Guardianship.
   i. Ensure culturally relevant services and supports are available to all.
   j. Build mobile workforce, especially peers, personal care, direct service providers, and certified nursing assistants.
   k. Increase and improve public communications to build understanding of people with unmet health and wellness needs that sometimes result in homelessness.

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

2. **GOAL 2: Shelter**: Provide immediate, no-barrier, appropriate, safe, year-round emergency shelter, and navigation to access health care and supports.

   PRIORITY OBJECTIVE:

   a. By April 30, 2024, create no-barrier shelter options that serve smaller groups of people (approximately 50 at each site), with a mix of individual shelters (such as the Pallet structures) and small-scale congregate shelter (such as a small portable building), portable toilet and shower facilities, and locked storage. All facilities must be safe, secure, and year-round**.** Sites will be managed by contracted health care and/or behavioral health peer providers to provide daily supports with healthcare and basic needs. Case management must be provided to guests at the sites to facilitate transitions to housing and ongoing healthcare. The task force estimates 2-5 of these sites are needed to serve people with complex behavioral health issues in need of emergency shelter.

   RATIONALE:

   Individuals with complex behavioral health issues often have barriers to shelter and housing, require daily visits with health care providers, may not be able to live in larger congregate settings, and may require time to stabilize before moving into housing.

   This approach requires lower capital costs than larger shelters, could be situated on existing municipal lands such as parking lots, and would provide a stable location for health care providers and case managers to work with guests to support transitions. These sites could also be moved, if needed, or de-mobilized if demand decreased.

   OTHER OBJECTIVES FOR GOAL 2:

   b. Implement the recommendations of the Sanctioned Camping Task Force released May 22, 2023, as finalized by the Sanctioned Camping Task Force and Anchorage Assembly.
   c. 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.

   PRIORITY OBJECTIVE:

   a. By January 31, 2023, contract with behavioral health clinical and peer providers to do mobile outreach and provide medical and behavioral health services to people with complex behavioral health needs who are experiencing or at risk of homelessness.

   RATIONALE:

   Individuals with complex behavioral health care needs who are experiencing or at risk of homelessness may not be enrolled in healthcare coverage or other benefits for which they are eligible. Because of housing instability and lack of shelter, individuals may be in camps or other locations in the community. Providing contracts with behavioral health

clinician and peer providers to provide mobile outreach and care to people wherever they are will engage them in ongoing medical, mental health, and Substance Use Disorder (SUD) care, and with shelter, case management, and housing options.

OTHER OBJECTIVES FOR GOAL 3:

b. 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 peer providers to develop trusting relationships to increase client engagement.
    iii. Coordinate and provide transportation to health clinics for primary and behavioral health care and other supports.
c. Assess individuals for benefit eligibility, such as Medicaid and Social Security, and secure all eligible benefits.
d. Identify housing options and help clients secure long-term housing.
e. Add residential treatment beds and outpatient capacity for behavioral health care and conduct collaborative advocacy to decrease barriers and help providers add treatment capacity.
f. Increase behavioral health workforce.
g. 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

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).[2]

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.[3]

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.[4] The goal is always to help a person move back towards the lowest level of

[2] 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

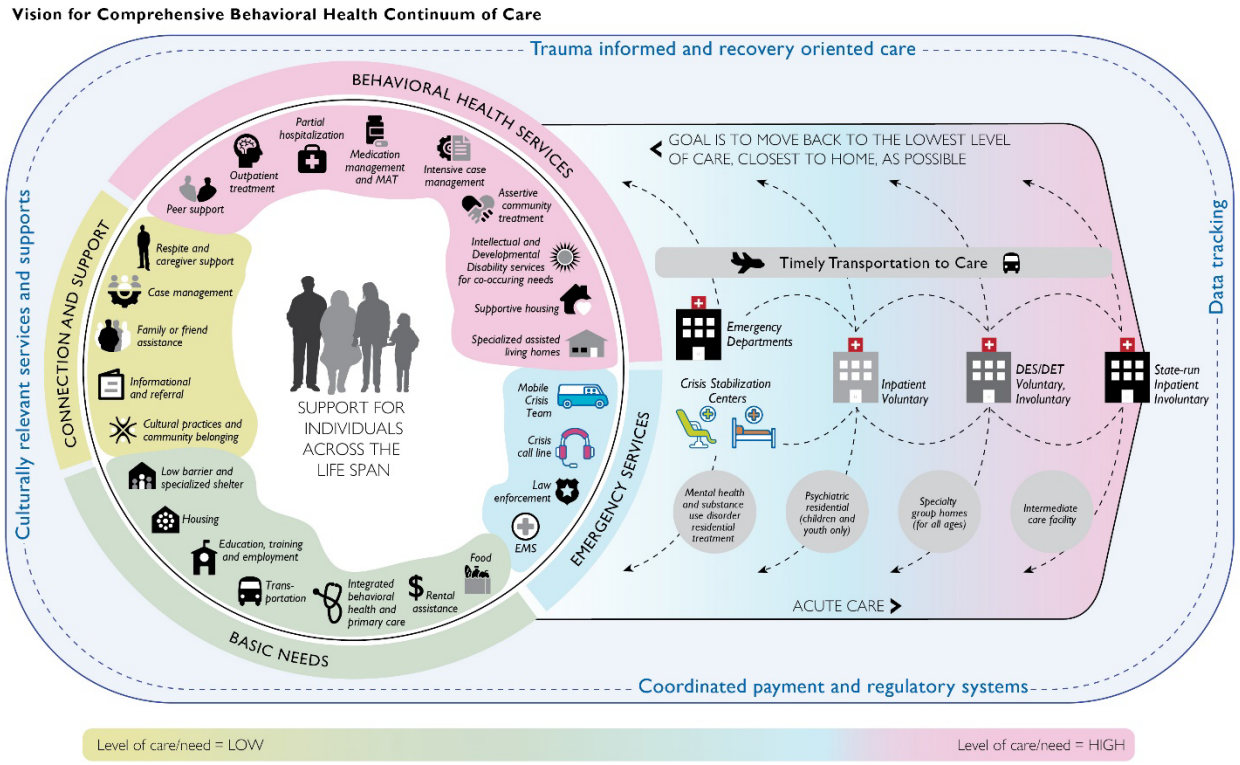
[3] https://camdenhealth.org/resources/complex-care-startup-toolkit/

[4] Developed by Agnew::Beck Consulting under contract to the Alaska Mental Health Trust Authority related to HB172 and the protection of psychiatric patient rights. For more information and updated versions of the graphic see

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 services that may prevent a person from going into psychiatric crisis and decrease the severity of crisis. For the healthcare system, home and community-based services reduce the need for inpatient care and involuntary treatment, reduce suicide rates, and improve public safety.[5] 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.

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



https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/sb124hb172/

[5] See here for more information and resources: https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-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.[6] 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 for those who could benefit from enhanced care for Complex Behavioral Health conditions

Demographics	Adults (age 18+), including elders; no additional age restrictions; all genders
Housing Status	Experiencing homelessness, or in need of housing assistance
Chronic Status[7]	Identified as chronically experiencing homelessness (HUD definition)
Disability Status[8]	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).[9]

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

This plan identifies steps to improve health and well-being for people with complex behavioral health needs who are experiencing or at risk of homelessness. With the closure of the Sullivan Arena in May 2023, many people have no place to shelter and no access to healthcare, housing, or other supports to help them regain stability. This crisis made the work of the task force urgent; coordinated resources must be deployed immediately to address the needs of people with complex behavioral health needs, and to create a safe and well community for all in Anchorage.

---

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

[7] 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.

[8] 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.

[9] Mhtrust.org

Priority 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.								
PRIORITY OBJECTIVE								
By December 31, 2023, 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; by December 31, 2023	MOA AHD or other municipal department	Lack of capacity at AHD Lack of behavioral health workforce in general Funding Unknown alignment between Administration and task force recommendations	Fill the currently vacant *Community Resource Coordinator* and *Assistant Community Resource Coordinator* at AHD; add contract resources to support AHD positions; develop clear workplan and monitor success over the year.	Identify positions and procure contract support	If necessary, add resources, defer to AHD	Fill two currently funded and vacant positions with existing budget; add approximately $150,000 for contract support	Set annual workplan that includes funding plan, identify sustainability targets and incorporate into work plan, monitor completion

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.								
PRIORITY OBJECTIVE								

By April 30, 2024, create no-barrier shelter options that serve smaller groups of people (approximately 50 at each site), with a mix of individual shelters (such as the Pallet options) and small-scale congregate shelter (such as a portable building), portable toilet and shower facilities, and locked storage for belongings. All facilities must be safe, secure, and year-round. Sites managed by contracted health care and/or behavioral health peer providers to provide daily supports with healthcare and basic needs. Case management must also be provided to guests at these	Medium; by April 30, 2024	MOA or contractor	Funding Locations Capital and operational funding Community Support contracts for supports	Construct sites on Municipal-owned 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 providers providing daily services on site.			Approximately $956,000 in capital costs per location (assume Municipal-owned site), 50 people per location; start with two locations for a capital cost of $1,912,000. Contract with a healthcare provider/peer organization to provide staff coverage at site and daily behavioral/medical clinical services. Base contract approximately $500,000 per site per year.	

sites to facilitate transitions to housing and ongoing healthcare. The task force estimates 5 of these sites are needed to serve people with complex behavioral health issues in need of emergency shelter								

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.								
PRIORITY OBJECTIVE								
Identify and treat behavioral, medical, and other care needs.								
By January 31, 2023, contract with providers to do mobile outreach and medical and behavioral health services to people who experiencing or at risk of homelessness	Immediate; by January 31, 2023	MOA AHD to contract with healthcare, behavioral health, and peer support providers to provide mobile care	This may be partly sustainable through Medicaid billing for eligible and enrolled clients; however, unresourced clients and provider transportation costs and time	Assembly could add funds to APD/AFD to contract with a mobile team provider to deliver mobile care Healthcare and peer providers	Funding decisions Contracts with providers	Funding	Approximately $650,000 per year for provider/peer team to provide mobile services.	As individuals are engaged in shelter and care, acuity reduces, Medicaid enrollment increases, contracted services may not be needed at the same level.

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 locate unsheltered clients will require additional payment source 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	interested in doing mobile care if payment is availalbe 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 covered by braided funding through the regional behavioral health authority Form a funding entity to braid funding from multiple sources to cover the first 24 hours of behavioral health crisis care				Consider re-purposing or adding to the current Safety Center contract to expand area and services.

Full 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								
By December 31, 2023, identify and, if necessary, fund a coordinator 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 task force recommendations	Fill the currently vacant Community Resource Coordinator and Assistant Community Resource Coordinator at AHD; add contract resources to support AHD positions; develop clear workplan and monitor success over the year.	Identify positions and procure contract support	If necessary, add resources, defer to AHD	Fill two currently funded and vacant positions with existing budget; add approximately $150,000 for contract support	Set annual workplan that includes funding plan, identify sustainability targets and incorporate into work plan, monitor completion
Partner with State entities to reduce system-level barriers and increase funding and resources	Medium, Long	MOA AHD, Department of Health, Department of Corrections, Department of Family and	Lack of connection and alignment with the Governor's Office for funding Unclear connections with state-level entities	Identify point of contact to engage with DOC, API, DOH, DFCS Legislative liaison at the Administration, potentially help	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		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
		Community Services	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	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 to address issues in Anchorage?		Program Plan 2022-24; AHD Opioid Task Force coordinate with OSMAP		
Work with Anchorage Chamber of Commerce and local businesses to address community needs, share information, and	Medium to Long-range			Need a point of contact and starting a connection with the Chamber, initiate it	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
increase resources.								
Engage Funders, Leaders, and Community Groups to implement this plan	Immediate		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?				
Conduct mobile screening, identify a shared level of care (LOC) assessment and triage process, and implement the use of Z	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	Convene a provider workgroup to develop a solution to present to the State and to pilot this process	Funding decisions Data sharing agreements Agreement on Level of Care Assessment	MOA funding Alaska 2-1-1 Medicaid 1115 for eligible providers/clients		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
codes in Electronic Health Records (EHR) to facilitate data sharing with HMIS, healthcare organizations, and healtheConnect Alaska			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 clients we are focused on.	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	tool and triage process Contracts with healthcare, behavioral health, and peer support providers: Mountain View Health Services, Choices, AK Behavioral Health, Henning, Inc., Southcentral Foundation, others?	Requires start-up funding to develop shared data system HUD Continuum of Care funding State of Alaska funding for healtheconnect		
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 Public Guardianship	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	Can ADRC provide more support? Family education Engage Alzheimer's Association				

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			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	and Care Coordinators, Engage Alaska Court System Stacey Maertz Alaska Community Care for access to care coordination				
Ensure culturally relevant services and supports	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.		
Build mobile workforce, especially	Medium		Barriers to employment such	Waiver process to reduce				

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
peers, personal care, direct service providers, certified nursing assistants			as criminal history Positions poorly paid, vulnerable Lack of recruitment, competition among employers	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	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
			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					

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, no-barrier, appropriate, safe, year-round emergency shelter, and navigation to access health care and supports.								
OBJECTIVES								
Implement the recommendations of the Sanctioned Camping Task Force	Immediate: 30-60 individuals, temporary structure that can be year-round at 40th and Denali; will include some	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	TBD	Funding for contracted providers		Municipal funding

	individual spaces; open campus; may be an expansion in 2024			operate the project				
By April 2024: Create no-barrier shelter options that serve smaller groups of people (approximately 50 at each site), with a mix of individual shelters (such as the Pallet options) and small-scale congregate shelter (such as a portable building), portable toilet and shower facilities, and locked storage for belongings. All facilities must be safe, secure, and year-round. Sites managed by contracted health care and/or behavioral health peer providers to provide daily supports with healthcare and basic needs. Case management must also be provided to guests at these sites to facilitate	Medium; by April 2024	MOA or contractor	Funding Locations Capital and operational funding Community Support contracts for supports	Construct sites on Municipal-owned 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 providers providing services on a daily basis on site.			Approximately $956,000 in capital costs per location (assume Municipal-owned site), 50 people per location; start with two locations for a capital cost of $1,912,000. Contract with a healthcare provider/peer organization to provide staff coverage at site and daily behavioral/medical clinical services. Base contract approximately $680,000 per site per year.	

transitions to housing and ongoing healthcare. The task force estimates 5 of these sites are needed to serve people with complex behavioral health issues in need of emergency shelter								
Add one low-barrier navigation center to provide daytime services, located near to new shelter sites and not in downtown Anchorage.	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	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	TBD	TBD		

			room for people waiting for assistance	able to send out mobile navigators				

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								
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)	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	(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	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		

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. Support the development of the Crisis Care and Connectors group.			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	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, SCF, VA, Choices, Henning, MVHS,		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
			coordination between facility programs and community providers; not knowing what everyone is doing to be able to work together (4) Shared ROI and system for sharing information appropriately	ANHC with shared ROI				
By January 31, 2023, contract with providers to do mobile outreach and medical and behavioral health services to people who experiencing or at risk of homelessness	Immediate; by January 31, 2023	MOA AHD to contract with healthcare, behavioral health, and peer support providers to provide mobile care	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	Assembly could add funds to APD/AFD to contract with a mobile team provider to deliver mobile care Healthcare and peer providers interested in doing mobile care if payment is available. Agree that these are essential services and should be paid for all community members e.g. in	Funding decisions Contracts with providers	Funding	Approximately $650,000 per year for provider/peer team to provide mobile services.	As individuals are engaged in shelter and care, acuity reduces, Medicaid enrollment increases, contracted services may not be needed at the same level. Consider re-purposing or adding to the current Safety Center contract to expand area and services.

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			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	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				
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 shelter, nowhere for people to go.	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
			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	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	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
			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	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 do with mobile teams but for people returning to home/community Ensure public transportation plans include stops at all major healthcare access				

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
				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	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
				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				
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	Funding decisions Contracts with providers	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
				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				
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	Inadequate number of treatment beds and slots for Substance Use Disorder (SUD) treatment, and for those with co-occurring SUD and psychiatric conditions. Arc's Residential Mental Health Treatment programs (two facilities) is filling up fast and there is a waitlist	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
			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 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 Provide capital and start-up funding to increase the number of new treatment beds and slots for Substance Use Disorder (SUD) treatment, and for those with co-occurring SUD and psychiatric conditions.				
Increase Behavioral Health workforce	Medium to long	TBD	Barrier crimes that disallow people from working in	Assistance for people to navigate the variance process and gain	TBD	TBD		Support efforts at UAA School of Social Work and College of Health,

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
			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;	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				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
			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	shifts) to work 12-hour shifts Increase number of practicum 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	Medium, Long	MOA, AHFC or other State entity, ACEH,	Lack of capital and operating funding	Municipality should apply for any and all funding grants to	Quantify units needed, secure funding,	Permanent Supportive Housing, low barrier		

Service or Support	Immediate, Mid or Long Range	Lead Entity	Identified Barriers	Possible Solutions	Policy or Decisions Needed	Resources + Source	Relative Cost	Sustainability Options
housing and other housing options		Housing Trust, others?		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 Identify experts who have done this successfully and provide	develop capacity	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
				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				

Appendices

A: Complex Behavioral Health Task Force Members

B: Leadership Summit Invitees

C: Complex Behavioral Health Task Force Leadership Summit Results

D: Theory of Change: Resources, Activities, and Desired Outcomes

A: Complex Behavioral Health Task Force Members and Process

Members:

Ruth Adolf, Anchorage Police Department
Lauren Anderson, Providence Health and Services
TJ Andrew, Community Member
Josh Arvidson, Alaska Behavioral Health
Delphine Atu-tetuh, Psychiatric Nurse Practitioner
Katie Baldwin-Johnson, Alaska Mental Health Trust
Kelda Barstad, Alaska Mental Health Trust
Kristy Becker, Alaska Psychiatric Institute
Shigone Beighle, Mountain View Health Services
Vincent Botzki, Rural CAP
Jasmine Boyle, Rural CAP
Belinda Breaux, Community Member
Farina Brown, Alaska Division of Behavioral Health
Michelle Brown, Rasmuson Foundation
Jessica Cabrera, Mountain View Health Services
Sean Case, Anchorage Police Department
Ashley Christopherson, Alaska Department of Family and Community Services, DET/DES (Title 47) Coordinator
Sara Clark, Volunteers of America Alaska
Jamie Elkhill, Volunteers of America Alaska
Amy Foraker, Anchorage Police Department
LeeAnn Garrick, Cook Inlet Tribal Council
Monica Gross, Restorative Reentry Services
Samantha Gunes, Southcentral Foundation
Sabrina Gust, The Arc of Anchorage
Tiffany Hall, Recover Alaska
Mary Heiman, Community Member
Gary Hudson, Henning, Inc.
Michael Hughes, Anchorage Health Department
Dar John, Alaska Mental Health Consumer Web
Alexis Johnson, Municipality of Anchorage
Oni Kitsune, Alaska Community Care
Radhika Krishna, Anchorage Downtown Partnership
Carrie Lavallee, Community Member, ER RN
Summer LeFebvre, Southcentral Foundation
Julia Luey, Volunteers of America Alaska
Kathleen McCoy, Community Member
Shanta'i McDermott, Psychiatric Nurse Practitioner
Joshua McHoes, Students for Liberty UAA
Jim Meyers, Alaska Behavioral Health
Angela Michaud, Cook Inlet Tribal Council

Dakota Orm, Anchorage Coalition to End Homelessness
Jessica Parks, Anchorage Coalition to End Homelessness
Jennifer Pierce, Anchorage Fire Department
Jonathan Pistonik, Anchorage Reentry Coalition Partner & Resource Database
Sara Platt, Recover Alaska
Catherine Polinski, Alaska Psychiatric Institute
Renee Rafferty, Providence Health and Services
Mike Riley, Anchorage Fire Department
David Rittenberg, Catholic Social Services
CJ Rook, Southcentral Foundation
Lex Rowland, Community Member
Jen Russell, The Arc of Anchorage
Julie Sanchez, The Arc of Anchorage
Lisa Scharff, Community Member
Erica Steeves, Alaska Psychiatric Institute
Caroline Storm, Sanctioned Camp Task Force
Phillip Toney, Alaska Mental Health Consumer Web
Justin Tsurnos, The Arc of Anchorage
Amy Urbach, Cook Inlet Tribal Council
Tanya Vandenbos, Anchorage Police Department
Jon VanRavenswaay, Mountain View Health Services
Silvia Villamides, Sanctioned Camp Task Force
Makayla Viray, Alaska Department of Family and Community Services, Complex Care Coordinator / Commissioner's Office
Terria Ware, Anchorage Coalition to End Homelessness
Brooke Weaver, Birchwood Behavioral Health
Travis Welch, Alaska Mental Health Trust Authority
Chris Wightman, Southcentral Foundation

Description of Task Force 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 to May 25th, 2023. 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 to finalize the recommended “Immediate Needs”. Following the meeting, an updated draft of the report was shared with the entire participant list. Comments and suggestions were incorporated. On June 1, 2023 the initial recommendations report was submitted to the Anchorage Assembly.

Two task force meetings were held (June 22 & 29) to further develop the action plan and finalize the long-range goals. The task force discussed a priority objective for each of the three goals. to present to statewide and local leadership at a September 29th summit.

A survey was sent to all task force participants requesting feedback on the priority objectives for each goal. Survey respondents overwhelmingly supported the priority objectives and offered minor additions and edits that were incorporated.

On August 29th, the task force hosted a leadership summit at the Mountain View Library in Anchorage. The participant list is provided in Appendix B. The task force presented the priority objectives and facilitators used the world café model to identify barriers, what is currently in place, quick fixes, and commitments. Results from the Leadership Summit are included in Appendix C.

The task force met for a final time on August 30th to review the results from the Summit. The full Action Plan included in this report addresses feedback from Summit participants.

B: Leadership Summit Participants

Commissioner Kim Kovol, SOA Dept. of Family & Community Services
Kim Rash, Anchorage Health Department
Jennifer Osput, Alaska Regional Hospital
Rep. Genevieve Mina, Alaska Legislature
Emily Ricci, Alaska Department of Health
Sarah Skeel, Providence Medical Center
Ray Michaelson, Mat-Su Health Foundation
Hope Allison, Mat-Su Regional Medical Center
Scott York, Alaska Psychiatric Institute
Mayor David Bronson, Municipality of Anchorage
Aesha Pallesen, Alaska Court System
Chief Doug Schrage, Anchorage Fire Department
Deputy Chief Sean Case, Anchorage Police Department
Lieutenant Luis Soto, Anchorage Police Department
Besse Odom, Alaska Legislature - Staff to Sen. Gray-Jackson
Michelle Brown, Rasmuson Foundation
Senator Loki Tobin, Alaska Legislature
Robin Dempsey, Catholic Social Services
Laura Russell, SOA Dept. of Health
Chief Michael Kerle, Anchorage Police Department
Assembly Member Anna Brawley, Municipality of Anchorage
Assembly Member Randy Sulte, Municipality of Anchorage
Assembly Member Felix Rivera, Municipality of Anchorage
Assembly Member Daniel Volland, Municipality of Anchorage
Assembly Member George Martinez, Municipality of Anchorage
Amber Frasure, Anchorage Fire Department
Chelsea Ryan, Southcentral Foundation
Darci Nevzuroff, Southcentral Foundation
Sarah Dewane, Anchorage Neighborhood Health Center
Commissioner Heidi Hedberg, SOA Dept. of Health
Kelda BarstadDave Wallace, Mat-Su Regional Hospital
Alexis Johnston, Anchorage Health Department
CJ Rook, Southcentral Foundation
Michael Riley, Anchorage Fire Department
Jennifer Pierce, Anchorage Fire Department
Ruth Adolf, Anchorage Police Department
Sean Case, Anchorage Police Department
Tanya Vandenbos, Anchorage Police Department
Michael Hughes, Anchorage Health Department

Lauren Anderson, Providence Alaska
Kristy Becker, Alaska Psychiatric Institute
Shigone Beighle, Mountain View Health Services
Ashley Christopherson, AK. Dept. of Family and Community Services
Jamie Elkhill, Volunteers of America Alaska
Sabrina Gust, The Arc of Anchorage
Tiffany Hall, Recover Alaska
Oni Kitsune, Alaska Community Care
Julia Luey, Volunteers of America Alaska
Kathleen McCoy, Community Member
Angela Michaud, Cook Inlet Tribal Council
Dakota Orm, Anchorage Coalition to End Homelessness
Jonathan Pistonik, Anchorage Reentry Coalition Partner & Resource Database
Sara Platt, Recover Alaska
David Rittenberg, Catholic Social Services
Jen Russell, The Arc of Anchorage
Julie Sanchez, The Arc of Anchorage
Erica Steeves, Alaska Psychiatric Institute
Phillip Toney, The Web
Justin Tsurnos, The Arc of Anchorage
Silvia Villamides, Sanctioned Camp Task Force
Terria Ware, Anchorage Coalition to End Homelessness
TJ Andrew, Community Member
Delphine Atu-Tetuh, Mountain View Health Services
Vincent Botzki, RurAL CAP
Sabrina Gust, The Arc of Anchorage

C: Complex Behavioral Health Task Force Leadership Summit

August 29, 2023, 10 am to 1 pm

Meeting Results

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.*

Priority Objective: Identify and, if necessary, fund a position and team at the Anchorage Health Department or other municipal entity to manage contractors, leverage municipal, State, private and public resources, and coordinate Municipal, State, and non-Municipal entities to implement this plan.

Barriers Identified

- Limitations of the 1115 Medicaid waiver, and many people who need assistance are not yet enrolled and some are not eligible for Medicaid
- Lack of Staffing/providers, clinicians
- Grant funding limited
- Length of waiver process for barrier crimes makes it difficult to hire peer workers
- Some MOUs in place/more are needed
- Orgs all use different assessment tools to establish level of care needed
- Construction and start-up costs make it hard to start and sustain needed programs
- Supervision/host availability for practicum work to license new clinicians
- We must address gaps in care within the year
- Lack of dual diagnosis treatment for those with substance use disorders and psychiatric conditions
- Limited access to neuropsychological evaluation to qualify for 1915c waivers - could this requirement change?

Currently in Place

- Working towards 1115 waiver amendments
- Mobile teams
- Outreach pop-ups
- Chanlyut 3.1 Residential SUD treatment step down
- Some outreach groups in place
- 1115 regulations in process of being updated

What is needed?

- Digital fingerprint scanning/sharing
- Review variance requirements for peer support services
- Expand to next levels of care/treatment (Mobile Teams)
- Leverage Alcohol Tax
- Decoupling fee for service for outreach
- Increase funding for docs pharma.
- Outreach with correctional facilities
- Re-entry plan
- Better Medicaid application process
- Capture data of recently relapsed entering homelessness
- Outreach vs. voluntary/involuntary behavioral health facilities

- Way to signal needs for housing in ref. to construction/space increases
- Comprehensive HIE
- Involve OCS/DJJ for youth transition
- Built for zero re-implementation

Goal 2 – Shelter: ***Provide immediate, no-barrier, appropriate safe year-round shelter, and navigation to access health care and supports.***

Priority Objective: Create no-barrier shelter options that serve smaller groups of people (approximately 50 at each site), with a mix of individual shelters (such as the Pallet options) and small-scale congregate shelter (such as a portable building), portable toilet and shower facilities, and locked storage for belongings.

- *All facilities must be safe, secure, and year-round.*
- *Sites managed by contracted health care and/or behavioral health peer providers to provide daily supports with healthcare and basic needs.*
- *Case management must also be provided to guests at these sites to facilitate transitions to housing and ongoing healthcare.*
- *The task force estimates 5 of these sites are needed to serve people with complex behavioral health issues in* need of emergency shelter.

Barriers Identified

- Lack of sustainable funding for case managers and providers
- Lack of workforce
- Lack of community buy-in “NIMBY”
- Use of Alcohol Tax funds
- Use existing facilities Providence, SCF
- Use of technology to coordinate use of beds
- No year-round solution – disrupts progress
- Shelters not integrated into case management

Currently in Place

- Policy solutions
- Talented providers
- Variety of innovative solutions
- APD & AFD response teams
- Coming: Providence & SCF crisis centers
- ARC of Anchorage residential treatment
- Use university for innovative design or facilities

- Outdated inventory of empty spaces
- Tiered residence system

What is needed?

- 300 beds for recovery & treatment

Goal 3 – Health Care Coordination and Housing: ***Rapidly assess and address housing, behavioral health, medical and longer-term care needs.***

Priority Objective: Contract with behavioral health clinical and peer providers to do mobile outreach and provide medical and behavioral health services to people who are experiencing or at risk of homelessness.

Barriers Identified

- Lack of billing and enrollment support from State for behavioral health providers
- No (limited) coordinated care outside of 9-5
- Lack of roundtrip transportation to resources (outside of ER), including back to camp/wherever they are staying
- Not enough guardianship
- Lack of workforce, funding
- Many people don't have a phone, address, license/ID needed to apply for Medicaid or services or healthcare
- Coordination for funding streams - funding is confusing
- Unified correctional system, so no local stakeholders
- Gaps in system & people persistently in the system - need for lifelong care
- Many are not enrolled in Medicaid, some aren't eligible - meeting people where they are at
- General Relief funding/Medicaid 1915c waiver
- Went from immediate placement to waitlist due to finding cuts
- Triage - expedite processes while in care
- HCBS needed for expanded/different eligibility groups
- Setting for billing (camp, shelter, wherever the person is)

Currently in Place

- $5M in AK State looking at rates/how providers are paid
- Engaging in this work now
- AFD mobile crisis team in in place
- Complex care working group statewide
- Looking at waiver modifications

- Outreach to health care providers
- Medical respite at BFS
- Online Medicaid application coming soon!
- New ID law
- Third Ave. Resource Center with access to medical clinic for coordination

What is needed?

- Pharmacy access/roundtrip transportation non-medical
- Expand transitional housing
- OPA needs more capacity for guardianship
- Permanent no or low barrier shelter with navigation center
- Follow through
- Expand to 24/7 operation of AFD mobile crisis team in place
- Block funding for provider groups non-Medicaid and non-billable services
- Strengthen ADRC connection - would require additional $$
- Space near where clients are located
- DOC & Dept. Health need coordination
- More flexibility in use of GR funds & more options for them
- Support in learning how to be housed

For All Goals and Objectives:

Quick Fixes & Low Hanging Fruit

- Find other cities/locations that have had success
- Complex/triage coordination efforts leveraged at higher level with shared end product
- Coordinate with additional providers & outreach pop-ups managed
- Centralized list of resources (website, phone, etc.)
- Alaska Mental Health Trust partnership grants up to $50k
- Research grants that are applicable
- Church volunteers
- Identify those in shelters who can be place in housing
- Use high school & career center volunteers
- Welcome new nonprofit to open a shelter
- Get DOC involved, to include local stakeholders

- Funding for General Relief + reform GR so it can be used for supportive housing and not only assisted living
- Better coordination of what services are available
- Potential to use Alcohol Tax funds on providers and access to care

Commitments

- Continued involvement and resource sharing: Recover Alaska
- Share policies, procedures, operational expertise for emergency shelter: Catholic Social Services
- Assist with implementation of 1115 waiver: Catholic Social Services, Alaska Mental Health Trust Authority technical assistance
- Outsource high school volunteers: Jasmine Sanders
- Advocate for 24/7 MCT: Assembly/AFD
- Advocate for GR behavioral health grants: Representative Genevieve Mina
- Provide education to masters and PhD level providers - mental health training and experiences: AFD MCT
- Convening - goal of coordinating efforts and keeping communication open: Catholic Social Services
- Expand health care and homelessness partnership: ACEH
- Healthcare liaison/homelessness liaison at every hospital: ACEH

D: Theory of Change: Resources, Activities, and Desired Outcomes

Potential Resources	Activities	Outcomes	
		Short and Medium term (0-5 years)	*Long term (5 years +)*
• People with complex behavioral health conditions experiencing or at risk of homelessness • Health care providers: Southcentral Foundation, Anchorage Neighborhood Health Center, Providence Health and Services, Mountain View Health Services, Choices, Alaska Behavioral Health, Arc of Anchorage, 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 Departments of Health; FCS; 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 2-5 no-barrier emergency shelter sites (~50 pp each) with access to peer supports and physical and behavioral health services Increase mobile and on-site physical and behavioral health including addiction treatment, 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 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 number experiencing unsheltered homelessness and increase use of emergency 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 Increase cost-effectiveness of community resources through access to lower-cost health care and 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 with complex behavioral health conditions experiencing or at risk of homelessness 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			