Advisory Board on Alcoholism and Drug Abuse

Alaska Mental Health Board

Quarterly Board Meeting Minutes

Held via Zoom

February 8 – 10, 2022

Dually Appointed Members Present:
Monique Andrews (Day 2-3)
Robert Dorton
Diane Fielden

Dually Appointed Members Absent:

ABADA Members Present:
Renee Schofield, Chair
Lee Breinig
Anthony Cravalho
Philip Licht
Christine Robbins
Katholyn Runnels
Enlow Walker
Kara Nelson
Kathleen Totemoff

ABADA Members Absent:
Blake Burley - unexcused
Chase Griffith - unexcused

AMHB Members Present:
Sharon Clark, Chair
William Cook
Karen Malcom-Smith
Brenda Moore
Tonie Protzman
Charlene Tautfest
James Savage

AMHB Members Absent:

Ex-Officio Members Present:
Tracy Dompeling
Gennifer Moreau-Johnson
Catherine Stone
Duane Mayes (Day 2-3)
Adam Rutherford (Day 1-2)
D.C. Albert Wall (Day 3)
Sharon Fishel – (Day 2)

Staff:
Bev Schoonover, Executive Director
Teri Tibbett, Advocacy Coordinator
Jennifer Weisshaupt, Planner II
Stephanie Hopkins, Health Planner II
Kevin Holian, Administrative Assistant II
Val Cooday, Statistical Technician I

Minutes Prepared by: Paula DiPaolo, Peninsula Reporting

Tuesday, February 8, 2022

CALL TO ORDER – 1:00 p.m.

Chairs Renee Schofield and Sharon Clark welcomed the Board members to the meeting. The mission statement was read, guests were introduced, and Board members introduced themselves and disclosed conflicts of interest as follows:

ETHICS DISCLOSURES

Kathleen Totemoff	Works for Ninilchik Traditional Council clinic, which receives Medicaid. Is also a board member of the Kenai Peninsula Re-Entry Coalition, which receives State funding.
Lee Breinig	Member of the Alaska Commission for Behavioral Health Certification, Peer Support Advisory Board; shareholder in Sealaska and Kavilco; has a family member who is a Trust beneficiary; does training and consulting work for Ionia, which receives funding from the Trust and others.
Philip Licht	CEO of Set Free Alaska, which bills Medicaid and receives State grants; on the board for Recover Alaska, which receives State funds; on the Mat-Su Health Foundation board, which is facilitating some state COVID grants.
Katholyn Runnels	Sits on the Controlled Substances Advisory Board.
Dr. Enlow Walker	Member of the Fairbanks North Star Borough Health and Social Services Commission, which distributes grant funding, some of which is State funds.
Robert Dorton	Works for Fairbanks Native Association, is the co-chair for the Fairbanks Re-Entry Coalition, and is also on the Certification Board for Peer Support.
Brenda Moore	Board president for Christian Health Associates, which receives Medicaid reimbursement and receives State grants.
Charlene Tautfest	On the board of Peninsula Community Health Services, which bills Medicaid and receives State grants.
James Savage	Co-chair for the Mat-Su Opioid Task Force; member of the Mat-Su Re-Entry Coalition; works for an agency that receives State, federal and Indian Health Services funding; owns an assisted living home for older Alaskans who receive Medicaid funding.
Karen Malcom Smith	President of the David Dylan Foundation, which is self-funded.

Tonie Protzman	Executive director of the National Association of Social Workers in Alaska, which receives federal funding; employed by Christian Health Associates, which also receives federal funding.
Kara Nelson	Works with True North Recovery, which receives Medicaid and State grants.

The other members of the Boards had no conflicts to declare.

APPROVAL OF THE AGENDA AND PREVIOUS MEETING MINUTES

Diane Fielden **MOVED** to approve the agenda, **SECONDED** by Enlow Walker. Hearing no objection, the motion **PASSED**.

Diane Fielden **MOVED** to approve the minutes from the October 2021 meeting, **SECONDED** by Enlow Walker. Hearing no objection, the motion **PASSED.**

LEGISLATIVE VISIT DEBRIEF

Diane Fielden:

- Met with Rep. Tuck, who talked to them in two sessions for about 45 minutes total.
- Rep. Tuck was disappointed the Boards weren't coming to the Capitol.
- He is very open to the personal stories and is pushing through legislation.

Brenda Moore:

- Met with Sen. Wilson, who was very engaged and listened intently
- Kathleen Totemoff explained services they offer and assistive technology she feels the State needs to look into for helping more people to be able to receive treatment and support the treatment.
- Kara Nelson spoke about all the services they are providing and linked it back to the need for treatment and the continuum.
- Diane Fielden shared her recent personal experiences, which also tied back to the need for the continuum and support for treatment and prevention services.
- Sen. Wilson asked if the Boards had taken a stance on the Governor's Executive Order (EO) for Department of Health and Social Services.

Bobby Dorton:

- Met with Rep. Zulkosky and discussed the need to increase access to housing for Alaskans with behavioral health concerns, traditional peer support, and behavioral health services in rural communities. He discussed the waitlist for services and people from the villages coming into Fairbanks for assessment and are left walking around with their backpacks in the cold.
- Rep. Zulkosky was receptive to reducing the wait times.
- She was very receptive, and he felt heard.

Lee Breinig:

- Rep. Zulkosky was very tuned into the possibilities of expansion of telehealth and connection to rural tribal health systems.
- Met with Sen. Gray Jackson staffer.
- Karen Malcom Smith did an excellent job of incorporating important facts and figures related to the opioid epidemic and how to deal with that as well as the increased need for withdrawal management and detox facilities.
- Tonie Protzman did an excellent job of communicating the need for decreasing stigma and providing additional services for professionals experiencing a behavioral health challenge.

ALASKA MENTAL HEALTH TRUST AUTHORITY UPDATE

Bev Schoonover welcomed and congratulated newly appointed Trust CEO Steve Williams. Steve introduced himself with some background information and remarked that he has been engaged with the advisory boards for 21 years.

Steve Williams presented to the Boards as follows:

Trust Mission:
It is the duty of the Alaska Mental Health Trust Authority to provide leadership in the advocacy, planning, implementation and funding of services and programs for Trust beneficiaries.

Board of Trustees:

- Chair Anita Halterman
- Vice Chair Rhonda Boyles
- Secretary Brent Fisher
- Verne Boerner
- John Sturgeon
- Chris Cooke
- Kevin Fimon

Organizational Structure:
Steve Williams reviewed the organization chart and explained the structure of the Board of Trustees, the Trust Authority, the Trust Land Office, Long-Term Care Ombudsman, Alaska Permanent Fund Corporation, and the relationship of the statutory advisory boards.

Trust Financial Position
Since inception, there has been sustained growth over time with the exception of the economic downturn between 2008 to 2011. The corpus of the Trust has continued to grow and is currently at approximately $498M, the budget reserves total roughly $270M, real estate equity is currently at $66M.

FY'23 Available Funding

- Investment portfolio payout (4.25 percent) $29M
- Prior year funds carried forward $2.8M
- Land Office spendable income $4.6M
- Interest earnings $600K
- Total: $37M

Over the last five years, the Trust available funding has increased 1 to 2 million dollars each year, which is expected to continue.

Trust Budget Development Process

- Multi-month budget development process
- Trustees approve a budget in late summer
- Approved budget transmitted to the Governor and Legislative Budget and Audit by September 15
- Comprehensive stakeholder engagement:
    - ✓ Advisory boards
    - ✓ Beneficiaries
    - ✓ State, tribal, community, and local partners.
        - Review focus area priority initiative goals and work
        - Comprehensive Integrated Mental Health Program Plan
        - Grant analysis
        - Advocacy priorities
        - Review previous stakeholder recommendations
        - Budget recommendations presented to Trustees.

Steve Williams and Board members engaged in a discussion regarding the process to receive funding from the Trust. He noted that the partnerships line item in the budget is funding that has not been designated to anyone specifically. The Trust receives grant applications on an ongoing basis from organizations applying for funding. He stated they also designate Mental Health Trust Authority Authorized Receipts (MHTAAR) which are Trustee-approved funds that go into the State budget to a department and division for a specific purpose to improve the lives of beneficiaries.

FY'23 Spending

- Authority grants – $17.6M – designated grants to community providers, non-profits, local governments, and tribal organizations. Includes $1.85M in mini grants.
- Agency budgets - $4,349.6M Trust Authority; $4,877.2M Trust Land Office
- MHTAAR - $8,526.3M – designated grants to State agencies. Requires receipt authority.

General Fund/Mental Health (GF/MH) Recommendations

Trustees make recommendations to the administration and the legislature for how the State should spend general fund dollars on services and programs that impact Trust beneficiaries. For FY'23,

there were almost no differences between what the Trustees recommended and what the Governor included in his budget.

Work of the Trust
Established Focus Areas *(FY'23 approved Trust Funding)*

- Disability Justice *($2,674.9)*
- Mental Health and Addiction Intervention *($6,212.5)*
- Beneficiary Employment and Engagement *($2,135.2)*
- Housing and Home and Community-Based Services *($4,076.3)*

Additional priorities:

- Workforce Development *($1,290.6)*
- Early Childhood Intervention and Prevention *(1,772.0)*

Transforming Behavioral Health Crisis Response

- Crisis call center
- Mobile crisis team
- 23-hour crisis stabilization
- Short-term residential beds.

Crisis Efforts:

- Working with stakeholders statewide
- Partnerships for new services in populations centers of Fairbanks, Mat-Su, Anchorage, and Juneau, and they are working with communities in rural Alaska
- SB 124 and HB 172.

Crisis Now – Recent Trust Investments:

- Fairbanks Crisis Now coordinator position - $135,000
- Fairbanks Mobile Crisis Teams – clinical and peer support specialist - $807,000
- Call Center operations expansion - $100,000
- Anchorage crisis stabilization services planning - $885,000
- Mat-Su crisis community development coordinator - $100,000

The Fairbanks Mobile Crisis team went 24/7 in December 2021, and they were dispatched to 40 calls in the community. Those 40 calls represented 23 individuals, and they resolved the crisis situation on scene 29 times with no law enforcement or EMTs. They met the individuals where they were at, de-escalated the situations, made sure people were safe, and connected them to the necessary resources so they could remain where they were. The hope is that type of response will continue and will be achieved in other communities throughout Alaska.

Trust Land Office – Separate unit within the Department of Natural Resources

The sole purpose of the Trust Land Office is to manage a million acres of Trust lands for the sole purpose of generating revenue in the best interest of beneficiaries. The Trust Authority contracts with the Trust Land Office to perform these functions.

Highlights:

- Land sales
- Subdivision platting
- Icy Cape development

FY'22 Anticipated Trust Land Office Revenues:

- Coal $247K
- Oil/Gas $1.158M
- Minerals $1.168M
- Materials $25K
- Timber $2.747M
- Lands $3.2M
- Real Estate $2.068M

In Closing:

- Strong leadership at the Board of Trustees, Trust Authority, and Trust Land Office
- Strong financial position
- Strong partnerships
- Together they can make positive impacts for beneficiaries.

Steve Williams encouraged members of the Boards to go to the Trust website, which contains resources for Crisis Now as well as other information that may be of interest to the members.

Eric Boyer stated that the Trust is working through a group of tribal behavioral health directors to look statewide at their partners in rural Alaska for Crisis Now.

Bev Schoonover informed Steve Williams of the Boards' desire to meet with the Board of Trustees in the near future.

ALASKA BEHAVIORAL HEALTH ASSOCIATION (ABHA) UPDATE

Tom Chard, CEO of the Alaska Behavioral Health Association (ABHA), presented to the Boards as follows:

ABHA:

- State behavioral health treatment provider network
- Over 75 organizational members

- Very diverse group singularly focused on a common goal to improve access to cost-effective, quality behavioral health treatment and recovery services.

Member Challenges:

Funding for behavioral health treatment and recovery services:

- Behavioral health treatment and recovery grants have experienced years of successive flat funding and cuts.
- Grant funding is absolutely critical for capacity development and change.
- Grant funding also pays for:
    - Individuals not eligible for Medicaid
    - Services not eligible for Medicaid or other payer types
    - Service settings not eligible for Medicaid.
- Grant funding is the glue that holds the system together and needs a champion and advocacy to ensure these critical grants remain.

Administrative burden:

- Documenting services – frequency and amount – duplicate data entry
- Billing requirements and risk
- Audits and inspections
- Regulatory requirements
- Accreditation standards
- Administrative Services Organization (ASO)

Symptoms of Underlying Challenges:

- Workforce problems
- Continuity of care
- Inefficiency
- Resistance to change
- System failure.

Member Opportunities:

- Increased awareness of the importance of behavioral health
- Federal COVID relief funds
- Opioid settlement funds
- 1115 Medicaid waiver
- Morris settlement
- Life after COVID – a new start – telehealth.

During discussion, Tom Chard explained that the opioid settlement funds will be coming into the state incrementally in a variety of different ways because of the various litigation.

Tom Chard discussed the historic difficulty in accessing data to be able to move the system forward. He noted that ABHA came up with the Behavioral Health Data Collaborative a few years ago to use a model for the data the State is collecting, analyze it, and use it in a way that helps the system. He stated that they have introduced the idea to their partners such as the university, DHSS, DBH, and Healthcare Services. He stated that the university would like to move forward with the project, but the department doesn't currently have the bandwidth to deal with this right now. He noted that a lot of data is being generated and collected, but it needs to be shared more.

Brenda Moore added that it is frustrating for the Boards to go to the legislature each year and not have data that supports results-based accountability or performance measures. Tom noted that the Boards have a statutory requirement to evaluate the system of care. In order to fulfill that statutory requirement, they need the data to be able to see what's happening. The Boards in particular have some leverage and can ask for the data and hopefully get a quicker response. Brenda Moore suggested discussing this further during Board Business.

Member Legislative Priorities

1. Budget – behavioral health grants
2. Telehealth
3. Budget – Medicaid
4. Workforce
5. Children/youth mental health
6. One percent for behavioral health treatment and recovery services
7. Housing and homelessness
8. Crisis Now legislation
9. Data transparency
10. Mental health education in K-12
11. Title IV – Alcohol Board reform
12. All payer claims database
13. Split DHSS.

Select ABHA Legislative Activities

Budget:

- Explaining the difference between grant funding and Medicaid funding – including the 1115 Medicaid waiver.
- Advocating for increased grant funding
    - 1 percent for behavioral health.

Telehealth:

- Supporting HB 265 / SB 175 and are looking for people interested in providing public testimony.

Crisis Now Legislation:

- Member information/education
- Waiting for committee substitute to evaluate legislation – HB 172.

Other Bills:

- Supporting SB 9
- Supporting HB 60 / SB 80

Lee Breinig noted that Gennifer Moreau-Johnson commented in the chat that the minimal dataset collected by AKAIMS is aggregated and available to providers for free using their report manager. The ASO, Optum, has reported during the spring and fall ABHA meetings, and they offered to run down the analytics for the membership. The division has received no request from ABHA leadership requesting the data. Lee asked if there was some type of miscommunication happening. Tom Chard appreciated hearing that data is available, and he will be sure to follow up on that. Gennifer Moreau-Johnson added that if there is something that was requested and not provided, please follow up with the division to make them aware of it.

RECESS

Hearing no objection, the meeting recessed at 3:46 p.m.

Wednesday, February 9, 2022

CALL TO ORDER – 8:30 a.m.

Chairs Sharon Clark and Renee Schofield welcomed Board members to the meeting.

PUBLIC COMMENT DISCUSSION

Bev Schoonover led a discussion on the process the Boards use to receive public testimony from providers and the public at large. Members of the Boards shared the positive aspects to receiving public testimony such as:

- It spurs initiatives for the Boards and partners to investigate and informs their work.
- Allows the Boards to connect with stakeholders and to connect stakeholders to resources.
- During in-person rural meetings, the Boards would have a community meeting the night before to share a meal and help break down unseen barriers.
- Public comment allows all of them to see they have the same common problems and are in this together.
- In the virtual meeting platform, it's important for Board members to alert their communities to the meetings and the public testimony opportunities.
- Public comment is an opportunity to hear both the good and the bad of what's happening around the state.

- A big part of their role as the Boards is to take public comment and pass it on to policymakers.

WHAT IS SOUTHEAST ALASKA'S CONTINUUM OF CARE FOR SUBSTANCE USE DISORDERS? Community Panel

Panel moderator Philip Licht explained to the Boards the purpose and process of the community panel discussions, and he broadly explained the continuum of care. Philip introduced the following panel members:

- Dr. Joshua Sonkiss – Bartlett Outpatient Psychiatric Services (BRH)
- Claudette Thor – HCH Clinic Manager, Front Street Clinic (FSC)
- Dr. Corey Cox – Clinical Director, Addiction Medicine (SEAHRC)
- Claire Geldof – Public Health Nursing, Southeast Region (PHN)

What levels of care are you providing at your agency for substance misuse?

- BRH – Offers a spectrum of substance use disorder (SUD) treatment services ranging from outpatient substance use counseling up through residential treatment and a medically managed withdrawal unit. Manage patients with co-occurring mental illness and SUD.
- FSC – Provides substance use and co-occurring screening assessment, counseling, and therapy services, which are outpatient services and opioid office-based opioid treatment (OBOT) services. They will be opening an opioid maintenance treatment program soon. They also provide prevention and harm reduction education and supplies. FSC serves primarily adults and older adolescents. SEAHRC in general provides prevention services through intensive outpatient services as well as a residential program. They plan on modeling the intensive outpatient with housing in Juneau as it has been very successful in Sitka.
- SEAHRC – Services same as described above with FSC. Has been focused lately on the expansion of the opening of the opioid treatment program with methadone at FSC.
- PHN – Serve Juneau and many smaller outlying communities. PHN is ingrained in a lot of preventative aspects of healthcare such as STI testing, family planning, and immunizations, and during visits they may discover other issues that might lead to a referral. Hold clinic appointments and do home visits with families and young children. Provide education and teaching in high schools and do systems-level work with community providers to help impact access to treatment and support.

Discuss the role of harm reduction and how it overlaps with the SUD field and treatment services.

- PHN – Harm reduction is a spectrum of ideas, and it's about meeting that individual where they are at and starting a rapport with them that may later lead to getting set up with treatment.

What does your agency or community need to offer a continuum of care to Alaskans with substance misuse disorders? What are some of the gaps you see in the continuum in Southeast?

- FSC – All Southeast communities could benefit from the expansion of peer support services. Determine how to recruit for that workforce and grow them to provide these important services. They also need to expand residential treatment services and detox services.
- SEAHRC – Inpatient beds are scarce, and it's a challenge to get people in. Would also love to see expansion of peer support.
- PHN – Outlying communities need connections with behavioral health support and counseling services.
- BRH – Waitlists have always been a big problem for residential treatment, and it's a multi-layered problem that has been exacerbated by COVID. One challenge is the federal requirement on the number of residential treatment beds that can be in any given facility. It would be beneficial to serve these individuals awaiting residential treatment through group therapy and peer support groups that are organized and have navigators. Ideally, they would also have individual therapy while waiting to get into residential. In theory, Southeast has the whole spectrum of withdrawal management services, but that doesn't mean there is always an availability of beds or personnel to take care of them.

Discuss recovery housing, an important factor in meeting the needs of individuals in Southeast.

- FSC – Housing is an issue across the board, and there isn't an easy answer.
- PHN – This has been a concern for several decades. The opioid epidemic is occurring against a backdrop of social and economic inequalities as well as inequalities in social determinants of health. There is a huge gap in transitional housing, but there is also a gap in helping people after they have gone through a recovery period to help them maintain.
- BRH – Housing is a challenge, and where people go to live after treatment is very important in terms of how successful they are at maintaining some reasonable degree of abstinence. There are waitlists for sober living.

Philip Licht described models in Seward and Mat-Su that are combining recovery-type housing in connection with the intensive outpatient services. The models seem to be sustainable and working well as a step down.

Discuss the role of the behavioral health associates/aides in Southeast and describe how they help support the system.

- FSC – Throughout the remote communities, it has been a huge support to train people with an interest in working in the field so they can expand their employee pool.

- PHN – Not really seeing it, but it may be happening. Communities know what is working well and what isn't, and they often possess the best ideas and solutions for what needs to happen for access to care and treatment models.

How has telehealth impacted service delivery within Juneau and the surrounding communities?

- PHN – The era of COVID has definitely helped advance the areas of practice in telehealth. Has seen a lot of great work happen that has benefitted outlying communities with services that may not have otherwise been there. Profound waitlists continue, even with telehealth. Access to technology in rural and remote Alaska restricts access to telehealth. Need to look at gathering data to see how much access to care has improved or how telehealth has advanced people's capacity to receive services.
- SEAHRC – It has made patient access to office-based opioid treatment (OBOT) services much easier, and there is some de-stigmatizing that came with it too. Patients don't have to come to the clinic and can integrate a visit into their regular workday and not have to take time off. There is lots of room for improvement, particularly around access to outlying communities.
- FSC – Telehealth has expanded services, and it's de-stigmatized receiving mental health and SUD services. It's also allowed people that struggle with transportation or have physical issues and can't get out of their home to access services. The biggest barrier is lack of access to technology. They have provided cell-enabled tablets to people within communities to distribute them.
- BRH – Telehealth has been extremely beneficial across the spectrum of substance use and behavioral health services. No-show rates have dropped significantly. Telehealth doesn't solve the fundamental problem of not having enough personnel to see patients, and telehealth has exacerbated the problem. Telehealth has allowed for a dramatic expansion of OBOT services, but it can only work as long as the DEA remains okay with service providers not having face-to-face exams with patients. It's very important for the DEA to understand that it's important for providers to be able to prescribe controlled substances in general, buprenorphine in particular, to patients without a face-to-face exam. There is also a facilitated exams where a patient is in a remote clinic that has a licensed person with them who assists with the telehealth visit with Bartlett. This would require community health aides be allowed to be the facilitated examiner, but there is proposed legislation that actively excludes community health aides from being able to serve in that role.

What does the 'whole-person care approach to recovery' mean to you? How could the State of Alaska help with the whole-person care approach in your community?

- FSC – Assist the person where they are and provide what they need and build on the relationships. Recognize that successful services look different to everyone, and success should be tailored to the individual. Need to support whatever decisions people make regarding their services. Peer support services are lacking, and that's something that needs to be pushed and advocated for as well as ensuring they have the workforce and developing people's skills to be able to provide peer support services.

- SEAHRC – Whole-person care is hard to define because it would be defined individually for each patient. Ensure medical providers keep an open mind as to what the person wants. Peer support services supplement the work of clinical providers as they can help patients outside of the building and away from the clinic.
- PHN – Whole-person care is supported by a robust model of different service providers, and that's done best when service providers are communicating with each other and breaking down silos to address people's physical, behavioral, emotional, family, and social health. Whole-person care should extend to family and friends to help fortify the network of people and create whole community health.
- BRH – As a medical doctor, has a medically-biased view of what whole-person care means. When managing patients with SUD, pays attention to STI screening, organ health, depression, suicidal ideation, et cetera to address those issues together. The barriers are that they don't all work together in one place, so they have siloing. Ways to overcome that in ambulatory settings are to have co-location of care and coordination of care between specialists. 42 CFR, Part 2 is a big barrier to coordination of care, even for patients willing to sign releases. Fax technology is also an impediment to sharing information. There are federal efforts to align 42 CFR with HIPAA, but most organizations seem to interpret what HIPAA means much more strictly than what it actually says. Most organizational privacy policies far exceed what is required by HIPAA. Sometimes sees that some organizations try to be all things to all people, and while they need to be comprehensive, they should also be humble about what they can accomplish and not try to be all things and get overextended and lose sight of their core mission.

What services/treatment options are available to individuals in your community with co-occurring disorders?

- BRH – Co-occurring disorders almost always refers to SUD that co-occurs with psychiatric disorders. There are a lot of residential programs that are not equipped to manage co-occurring disorders. SUD in the intermediate to late stages of addiction will result in associated physical problems. It's the more difficult patients that have co-occurring psychiatric and physical disorders that really need the services the most, and some organizations tend to cherry pick the easier patients. Those patients with co-occurring disorders are the sickest and should be taken care of, and that takes leadership at a clinical and organizational level.
- FSC – Co-occurring disorders is broad for them. They look at medical/behavioral health issues and anything that will help support the patient. They are able to provide services from basic hygiene items to medical care, behavioral health services, some psychiatric services, and dental services. Barriers are getting people in for those services as well as coordinating the services in the Juneau area. Juneau could improve on warm hand-offs between service providers.
- SEAHRC – The whole consortium is more a more complicated picture than FSC. Lacking certain elements of care will lead to not being as effective because they are missing those other pieces.

- PHN – Seeks and craves more collaboration and education through panels such as this and also provider peer support groups that inform and educate on the areas of practice for treating co-occurring disorders. Public health nurses provide education to a lot of adolescents. The teen health clinic based out of Juneau was established in the late '80s and now incorporates behavioral health.

What SUD services are available for youth in the community? Is this a gap?

- FSC – There seems to be far fewer services for children and adolescents. FSC struggles with being able to keep up with the demand for adolescent and youth services, particularly SUD. They have a few private counselors they reach out to.
- SEAHRC – Sees youth in the OBOT clinic, but the model of care that works for adults doesn't work as well for youth. Making efforts to reach out to youth, and they have the Raven's Way program. But they are missing a piece to deliver that kind of care to youth. Youth clearly benefit from early outreach programs, and identifying youth with risk factors for developing SUDs is an area that very little resources provide the most return. Preventing someone from developing an SUD is the best thing they can do rather than treat one after it happens.
- BRH – There is clearly a lack of formal residential and ambulatory programming in Alaska for youth with SUD. Part of that is due to the lack of population in Alaska and the geographic span of the state. Behavioral health providers on the whole haven't developed the same level of comfort managing SUD in youth that they have in adults, and that's really more cultural than anything else. The treatments, guidelines, and evidence are there, a comfort level just needs to be developed. Also noted that collectively in Alaska, they don't take cannabis use disorder seriously in adults or youth, and it's a devastating thing for youth as it is a gateway drug that permanently impairs frontal lobe development in youth who have habitually used large amounts of cannabis. If they don't address this in youth, Alaska will have bigger problems down the road.

Can someone discuss the Teal Street Center?

- PHN – The Teal Street Center is a ground breaking, Trust-funded effort neighboring the newly built Glory Hall shelter, and the intent is to be a comprehensive place for healthcare, behavioral health, and social support services all under one roof. The Alaskan AIDS Assistance Association will have a room there to provide services, and FSC will have space there as well. It will be a co-op of different service agencies coming in on a rotational basis.
- FSC – Construction is scheduled to be completed by next fall.

Does a mixture of Suboxone or Sublocade with Vivitrol curb methamphetamine cravings?

- BRH – Those medications, because of their pharmacologic activity, are viewed as oil and water. There has been some research on combining Vivitrol with bupropion, which is an

antidepressant, to reduce methamphetamine craving. There are no contraindications, and those medications are safe to combine. Would encourage to try.

- SEAHRC – Heard of trials with Vivitrol being used to help curb meth cravings. Medication assisted treatment (MAT) for stimulant use disorder does not currently exist. They don't have anything that is providing to be effective long term or short term for stimulant use. Heard of naltrexone being used in various formulations with other things, but not with buprenorphine. At a previous clinic worked at, they had a dedicated stimulant use disorder clinic where they tried some of these things in addition to doing a contingency model, and anecdotally nothing really panned out. Maybe patients with a certain genetic pre-disposition might respond to Vivitrol with bupropion. Would also encourage to try.

What is your wish list from a federal level for harm reduction programs in Southeast?

- FSC – More funding for supplies and education.
- PHN – Been on the board of the Alaskan AIDS Assistance Association, which is the number one agency doing the syringe exchange across the state, and the main hub is out of Anchorage. Last year they safely disposed of over 1M needles. They could always benefit from more funding to help provide clean syringes to individuals and to look at ways to keep expanding harm reduction efforts. There is a lot of stigma attached with syringe exchange programs, but people in these programs are five times more likely to eventually get treatment than others who are not. There is a notion that these are enabling programs. The cost to treat hepatitis C is very high, and last year Alaska saw an epic rate of new HIV infections for individuals using IV substances.

HB 172 / SB 124 – MENTAL HEALTH FACILITIES/MEDS

Chair Clark introduced DHSS Deputy Director Heather Carpenter, DHSS Project Coordinator Laura Russel, Trust CEO Steve Williams, and Assistant Attorney General Steve Bookman from the Department of Law who presented to the Boards on this legislation intended to move the crisis model of care forward in Alaska. Steve Williams began the presentation by showing the Boards a three-minute video contained on the Trust's website and led a discussion through his PowerPoint presentation as follows:

HB 172 is a Path Forward:

- Effectuate a no-wrong-door approach to stabilization services
- Enhance options for law enforcement and first responders to efficiently connect Alaskans in crisis to the appropriate level of crisis care
- Support more services designed to stabilize individuals who are experiencing a mental health crisis:
    - 23-hour crisis stabilization centers
    - Short-term crisis residential centers.

Pieces of this legislation are narrowly focused on the current Title 47 civil commitment statutes. They are not opening up and looking at the entire set of statutes at this time, but the Trust will continue to look at that going forward.

Elements of the Behavioral Health Emergency Model:

- Person in crisis
- Crisis call center
- Mobile crisis team
- 23-hour stabilization
- Short-term stabilization

Collaborative Approach - Need input from:

- Individuals who have or might need to use the system
- Community providers, tribal and community non-profits
- Advocacy and support from advisory boards and other partners.

Foundational to this work is a healthy and robust community-based system so people can access services before experiencing a crisis. When a crisis is resolved, the person will hopefully return to their community and access resources so they can maintain the stability that was achieved and maintain their participation and engagement in the community in the least restrictive environment possible. Steve Williams described the graphics in the presentation that demonstrate the components of the model through all the pieces of the behavioral health crisis continuum of care.

Heather Carpenter presented as follows:

Key Takeaways:

HB 172 Does:

- Provide law enforcement with additional tools to protect public safety
- Expand the number of facilities that can conduct a 72-hour evaluation
- Add a new, less restrictive level of care
- Facilitate a faster and more appropriate response to a crisis, expand the types of first responders that can transport an individual in crisis to an appropriate crisis facility
- Create a no-wrong-door approach to providing medical care to a person in psychiatric crisis.

HB 172 Does Not:

- Interfere with an officer's authority or ability to make an arrest
- Change who has the current statutory authority to administer crisis medication
- Change current statutory authority for who can order an involuntary commitment
- Reduce the individual rights of the adult or juvenile in crisis; the parents' rights of care for their child; or existing due process rights of the individual in crisis.

Steve Bookman reported that this supplants but doesn't replace anything they have going on right now. He noted they expect that the involuntary procedures would be used very rarely, and they are trying to make patient's rights match the current system on commitments. He stated that it provides for licensing for the two new kinds of facilities. He noted that they have tried to craft the legislation with provider input that takes into account the perspective of clinicians. He noted that they have crafted language that hearings will be held via teleconference or Zoom, and Heather Carpenter noted that the hearings will happen on site at the crisis residential centers to take the burden off providers.

The floor was opened to questions from members of the Boards.

Bobby Dorton asked what can be done to bring culturally responsive traditional peer support into these efforts to work with the Native Alaskan population. Steve Williams explained that the incorporation of peer support is foundational to the implementation of the framework and transforming the system. He stated that not all of the pieces of the framework are implemented yet, and there are opportunities to integrate peers into the crisis stabilization center as well as the mobile crisis team and ensuring the responses are culturally appropriate. Alaska Behavioral Health is just operating one piece of the model right now, and the piece they are operating doesn't have to stay shaped the way it currently is.

Director Moreau-Johnson stated that the Crisis Now model in this proposed legislation feeds into the no-wrong-door concept. The 1115 is on a parallel track as Crisis Now, and what is useful about the 1115 to the Crisis Now model is that it can be leveraged for those patients who are Medicaid eligible and for those providers who are enrolled in Medicaid. What is parallel and what is separate is that currently authorized right now are mobile crisis response, 23-hour crisis stabilization, short-term crisis residential, and peer crisis services. Peers are currently authorized under the 1115, and the components of the model are authorized under the 1115 with the exception of the call center. What is important about that is that through the 1115, a community can stand up a model that is providing these services but may not be the Crisis Now model, which is a great way for services to be tailored in a community targeted towards needs.

Lee Breinig asked if there is any type of data or outcome tracking being implemented with the expansion of the Crisis Now model either by the Trust or the department on just how effective it is as it's growing and expanding in Alaska. Steve Williams stated that they are starting to get pieces of outcome data from Anchorage and Fairbanks. As components get implemented, tracking the data and evaluating will be an ongoing part of the start up followed by ongoing evaluation of how these services are operating. Director Moreau-Johnson added that the 1115 authorization broke the 1115 into two parts, and SUD services were rolled out first. As a result of that, they now have been into the SUD component long enough to have established baseline data. The behavioral health component was rolled out later, and the are in a bit of a waiting game for the behavioral health portion of the waiver. Under the SUD component, they only had two agencies sign up for crisis stabilization services. Under the behavioral health component of the 1115 waiver, they have 16 providers across the state. She can share data on where they are located and where they are, but they are still waiting for claims data to come in. The Division can also share information on

wait times for designated evaluation treatment (DET) facilities. They have, in fact, seen a reduction in wait times for DET beds. She noted that it's been historically difficult to track diversion, and the goal is ultimately diversion. They are hoping to see an overall effect, and it's going to be a challenge to measure outcomes. Heather Carpenter stated that data is complicated, and it's an area that the department and the Trust are going to be working closely with. She noted that there will be benefits to other departments such as Public Safety as they stand up these services, and they will have to figure out how to show that.

Bev Schoonover asked that if this legislation doesn't pass this session, what will the impacts be to the rollout of the new crisis services and the implementation of the Crisis Now model? Heather Carpenter stated that services can still roll out under the 1115 in a voluntary fashion, but the no-wrong-door access would be hindered. The downside is if there are 23-hour stabilization centers and crisis residential centers that are outside of a hospital setting, they can only accept voluntary patients. Steve Williams stated that this legislation will allow for a facility to accept both voluntary and involuntary patients, which means police offers don't have to figure out where to take someone. Because this is the second year of the two-year session, this could cause a potential delay in standing up the no-wrong-door part of the continuum of care, so they really want to get the legislation through this session. Heather Carpenter added that if the Boards support this, their voice matters, and they should let committee members know.

PUBLIC TESTIMONY

Public testimony was heard, and a full transcript was prepared.

RECESS

Hearing no objection, the meeting recessed at 1:15 p.m.

Thursday, February 10, 2022

CALL TO ORDER – 8:30 a.m.

Chair Schofield welcomed everyone to the meeting and asked that members of the Boards and the Statewide Suicide Prevention Council introduce themselves.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES (DHSS) PRESENTATION ON EXECUTIVE ORDER 121

Commissioner Adam Crum and Heather Carpenter appeared before the Boards to present on Executive Order (EO) 121, the purpose of which is to bifurcate DHSS into two departments, Department of Health (DOH) and Department of Family and Community Services (DFCS).

Commissioner Crum highlighted that DHSS serves and touches Alaskans in all stages of life. Their current budget is almost $3.5B with 3,259 employees. They operate over 100 programs that serve Alaskans directly through 119 different federal funding sources. DHSS's budget is currently more than 12 state agencies, the Office of the Governor, the Judiciary, and the Legislature combined. DHSS is nearly 30 percent of the statewide budget in FY'23.

Because of the massive size of DHSS and the diversity of what the department does, the work they do interacts with and affects every other department. It is their normal course of business to reach out and work with other State departments.

Executive Order Vision – Reorganization of DHSS

Goal: Provide proactive, efficient leadership and management of programs to achieve better outcomes for Alaskans.

Align current functions and programs:

1. Direct care and services to Alaskans in State-administered programs
2. Eligibility for Alaskans and payment to providers.

Focus Management to Improve Outcomes:

1. Innovation
2. Work Processes.

The reorganization would bifurcate the current department as follows:

Department of Health:

- Commissioner's Office
- Finance & Management Services
- Health Care Services
- Behavioral Health
- Senior & Disabilities Services
- Public Assistance
- Public Health

Department of Family & Community Svcs:

- Commissioner's Office
- Finance & Management Services
- Alaska Psychiatric Institute
- Juvenile Justice
- Alaska Pioneer Homes
- Office of Children's Services

The reorganization is designed in such a way as to minimize any disruption in services to any beneficiaries or any payments to providers. This will be accomplished by keeping the public facing divisions intact with no changes to leadership or footprint. Commissioner Crum highlighted that designated evaluation and treatment (DET) centers are being moved from the Division of Behavioral Health (DBH) to DFCS in order to stay closely aligned with API and to help coordinate Title 47 involuntary commitment patient movements between facilities.

He also further explained that Finance and Management Services (FMS) will most likely be impacted the greatest, and they are asking for new and reclassified positions to fill out the FMS staff and Commissioner's Office staff.

Commissioner Crum highlighted that DHSS constantly being reactive to crises has hindered their ability to be collaborative and innovative as a department. With an additional Commissioner's Office and a focused span of control, leadership will be able to more effectively work with stakeholders and employees to address concerns before they turn into issues. He also noted that most of the ideas for reorganization came from division leaders who have had many years in the system. There are many employees of DHSS who care deeply about what they do, but the important work performed by staff is rarely visible, system improvements are slow and cumbersome, and this leads to frustration causing a feedback cycle of negative emotions and concerns. More time to address employee concerns will facilitate improved recruitment and retention. DHSS employees deserve better, and the department should be able to more readily respond to and address their concerns.

Benefits of Reorganization

Improved Services for Alaskans

- Service navigation will be easier for the public with two smaller departments
- Innovation will become more seamless as two departments will be better able to pursue initiatives and efficiencies to serve Alaskans
- Smaller bureaucracy for the public to navigate
- Easier for the legislature to oversee
- Successful department reorganizations have happened in the past
- DHSS is always changing to better serve the public.

Improved Stakeholder Results

- More regular check-ins with stakeholder groups
- More interaction with federal partners to better manage programs and seek flexibilities that benefit Alaska
- Better ability to manage crises and focus effort on long-range, strategic planning.

Commissioner Crum explained that EOs are included in Article 3, Section 23 of the Alaska Constitution saying that the Governor can make changes in the organization of the executive branch necessary for efficient administration. Because EOs are well defined and the process is prescribed, EOs cannot have substantive law change. That means that programs and services won't be changed by the Executive Order. EOs have been used in the past to move Pioneer Homes out of the Department of Administration to DHSS, and to move Department of Corrections out of DHSS.

Governor Dunleavy introduced EO 121 on the first day of session, and the legislature has 60 days to take action by coming together in a joint session to disapprove the EO. If no action is taken in 60 days, then it becomes law with an effective date of July 1st, 2022.

What's Different About This EO than Last Year's?

- Additional time for employees, stakeholders, and constituents who utilize DHSS services to ask questions and be familiar with the change.
- Improved planning for the transition to two departments and continued stakeholder engagement regarding the transition.
- Concerns addressed that were raised by Legislative Legal and prior drafting errors corrected.
- Shorter document.
- Another year into responding to COVID-19 has made it even more apparent that they must move forward with changes.

Stakeholder Engagement, Lessons Learned:

- Meaningful engagement takes time. Leadership needs to spend more time with both internal and external stakeholders
- Stakeholders recommend transition liaison positions in each Commissioner's Office.
- Q and A from stakeholders provide valuable input, which will be utilized in the implementation process.
- Repeated engagement ensures better communication and dispels misinformation.

Commissioner Crum stated that the cost is a strategic investment of $2M in total funds and includes 11 new positions and 10 reclassified positions. This is not a cost cutting or job cutting initiative. This in an initiative for appropriate-size government that can be funded for less than .06 percent of DHSS's total budget.

He reviewed the implementation timeline highlighting that ongoing stakeholder and staff engagement is paramount in the process. He stated that if they do this right, there will be no discernible change for the public when July 1st happens, but over time, systems improvement can be put into action. He shared that some long-term issues that can be addressed after the department division can include:

- Healthcare innovation
- All payers claim database
- Healthcare costs and transparency
- Child well-being and prevention
- Value-based care
- Deferred maintenance
- Staff recruitment and retention
- Medicaid cost containment

Bev Schoonover asked Commissioner Crum if a letter of support from the Boards would be helpful. The Commissioner stated that it would be appreciated and would demonstrate the department's outreach to stakeholder groups.

Commissioner Crum fielded additional questions from members of the Boards and concluded his presentation.

COMMUNITY AND BEHAVIORAL SERVICES IN SOUTHEAST ALASKA

Central Council of the Tlingit and Haida Indian Tribes of Alaska

Dr. Tina Woods, senior director of Community and Behavioral Services (CBS) for Central Council of the Tlingit and Haida Indian Tribes, introduced herself to Board members. She stated that as a result of President Peterson listening to the needs of their tribal citizens, the Community and Behavioral Services department was created. Other departments under CBS include:

- Tribal Family Youth Services
- Family Court Services
- Community Wellness Advocacy
- Re-Entry and Recovery
- Behavioral Services

The Behavioral Services Department has five master's level clinicians, and four of the five are indigenous to the area. They have a psychologist on contract to be able to make referrals and an intern who most recently developed a culturally responsive blended Western and traditionally-based Tlingit values grief and loss group. They have one case manager on staff, and the behavioral health aides can also offer case management. They have been working with a company to develop a customized electronic health record that is HIPAA compliant.

The following services are provided:

- Outpatient mental health and substance use disorder assessments
- Individual therapy
- Group therapy
- Family therapy
- Same-day crisis response
- Tele-behavioral health services
- Community crisis response
- Elder's Program – Elder Virtual Talking Circles
- Youth Program – Native Youth Olympics.

Future programmatic plans include:

- Intensive outpatient program
- Culturally responsive men's healing
- Promoting peer support and adopting a curriculum.

Dr. Woods explained that referrals can be made by going to their website or calling their main number. They do not have a waiting list at this time.

Dr. Woods stated that with the CBS Healing Center, they want to create space for their tribal citizens to be able to share their story, and they believe that individuals have the healing power within themselves. They work with community partners to provide services that individuals are requesting to ensure their needs are met. They promote and encourage the staff to recognize that they are the tools that can lead to helping people heal. Humans have the power within them, and if a space is created that is very trusting, people will open their hearts and begin to talk.

Dr. Woods explained that they have three non-congregate shelters. One was recently damaged by flooding, but the Alaway property that houses 15 women and the Allen Court property housing 12 men are currently operating. These are individuals who are returning citizens after incarceration. They work closely with Lemon Creek and other institutions throughout the state, and they also accept individuals who are in recovery needing a safe, sober place to live. They also accept individuals who are being released from residential treatment. She noted that it is not a clinical environment, and individuals receive the outpatient care they need from other partners. They recently started providing culturally responsive recovery services, and most recently they have been hosting drum making with an artist with the residents.

Dr. Woods stated that they are excited about the Culture Heals Project, which will be coming soon. It's an online addictions education treatment program in partnership with the 5-Actions program in New Mexico. It will be a place where tribal citizens will be able to visit online and start their own self-guided journey to healing. It's also paired with a crisis hotline service with a company called Protocol that will pair the individual to the closest resource in whatever state they live in.

Dr. Woods stated that she is currently working with the State of Alaska to become a Medicaid billable agency as well as CARF to become CARF accredited. She opened the floor to questions from Board members.

Based on a question from Sharon Clark, Dr. Woods stated that since opening their doors November 3rd, their clientele has been only tribal citizens. Once they are able to bill Medicaid, it will open the door to serving others. She noted that they want to serve whole families, and they have accepted non-Native family members in some circumstances. The Re-entry and Recovery program accepts all individuals, and they have a number of Alaska Native/American Indian individuals in the program beyond just their own tribal citizens.

STATEWIDE PANEL ON YOUTH MENTAL HEALTH SERVICES

Stephanie Hopkins facilitated a panel on Youth Mental Health Services with the following attendees:

- Josh Arvidson – Child & Family Services, Alaska Behavioral Health (CFS)
- Maressa Jensen – Juneau School District (JSD)
- Susan Nedza – Bering Strait School District (BSSD)
- Dustin Larna – Residential Youth Care (RYC)

What was the state of youth mental health services in your organization pre-COVID?

- RYC – A year before COVID, they had pulled together an agency-wide plan to implement the 1115 waiver. Engaged in recruitment, training, and developing electronic health records. Looking to provide more community-based services.
- BSSD – Providing services with itinerant counselors was easier pre-COVID. It was easier to get places to provide in-person contact. As a counseling group, they could also get together more easily. Issues prior to COVID were resistance to mental health services in some remote villages. Youth issues were also an issue pre-COVID. The pandemic has caused added stress and the slow down of travel and in-person gatherings.
- CFS – Prior to COVID had analyzed and realized they were dramatically under-scaled to meet the needs in their communities of Anchorage and Fairbanks.
- JSD – Teen Health Center was the only direct service offering mental health service in a handful of high schools. Largely focused on ACEs education and trauma-engaged professional development for staff.

Please describe some of the efforts or innovations that your region made in 2020-21 that were related to COVID-19.

- CFS – The needs of the communities escalated during the pandemic, and they engaged in telehealth access strategies and continue to maintain the growth curve to meet the demand. They embraced the concept that they needed to help people the day they ask for help, and they have cleared their waitlist. Provide short-term crisis intervention walk-in service via Zoom.
- JSD – During the pandemic, the Teen Health Centers expanded to middle schools as a distance-delivered service in response to the need. Put more emphasis on staff well-being in the district. Hydaburg created a virtual calming room as a resource for teachers.

Please describe some of the efforts or innovations that your region made in 2020-21 that were not related to COVID-19.

- JSD – Project AWARE allowed them to add three school-based mental health clinicians.
- CFS – Work with Fairbanks North Star Borough School District on their AWARE grant by providing clinical services. Also partner with the Department of Education in Fairbanks on AK RISES top open mini clinics with clinicians for schools in Fairbanks.

What are some of the current objectives your program is currently working on that could be successful in other areas of the state?

- BSSD – Ensure that school counseling programs are comprehensive, cover all elements of a school counseling program from pre-K through 12th so children have access to that and all elements of a full school counseling program. BSSD has worked with their school board, which has just allowed them to increase the number of school counselors so they have less itinerant and more in-place counselors. There should be a counselor in

every school building, and every grade level should have all elements of the American School Counselor Association School Counseling Program happening vibrantly in their school.

- RYC – Looking at waiver services and the continuum of care to figure out how to broaden that continuum and add more of the different levels of care under the waiver.
- CFS – Look to growing your own to solve workforce challenges that are occurring statewide. They have gotten very strategic about professional development. They developed a clinician intern cohort program in partnership with 30 universities. They are now producing as many clinicians inside of their system as they are hiring into it. They have also developed a life-long workforce development strategy by supporting employees to further their education. They are also working on a retention strategy for clinicians. More information about the internship programs is available on Alaska Behavioral Health website.
- BSSD – Has a grow-their-own teacher program for aides and other school employees. BSSD pays for the classes while the employee works and attends school. When they get within two years of their teaching degree, the employee can go on sabbatical and finish it up while receiving their pay and all benefits. They are considering doing it for counselors.
- JSD – Implemented reflective practice support or reflective supervision for school counselors. Elementary school principals are also participating in reflective supervision.

Please describe some of the gaps or areas of need you have encountered in implementing youth mental health programming. (ex. recruitment, retention, inconsistent funding, etc.)

- JSD – Recruitment. It took a full year to get three mental health positions funded. Other challenges include prevention – ACEs education for staff, supporting a safe environment at school, and social emotional learning so children can develop self-efficacy. Staff development time in the system is continually a challenge.
- RYC – COVID is draining people in ways they haven't seen, which has impacted retention. They have managed to maintain staffing levels needed to operate, but growth has been a challenge with the recruitment difficulties. Capital funding is also a challenge as is administrative burden, which seems to continually grow.
- CFS – The agency is serving three-and-a-half times more children than ever, and they had to bring in federal support in order to grow. The two-to-five-year federal cycles are also a challenge. Capital is also an issue for them as they have tripled their capacity in the same building footprint. They are also getting ready to launch a Partial Hospitalization Program as part of the 1115 waiver, but they have no space to do it. A good portion of Alaska Behavioral Health workforce is military, and a challenge is that they are good employees, but then they leave.
- BSSD – Recruitment and retention is a huge problem off the road system, particularly in counseling where trust has to be built with the students. Housing is also a big issue. Itinerant counselors need to be prepared to sleep on the floor of the school. Recruitment would be easier with in-place counselors versus itinerant. It's been challenging holding interviews and provide site visits for recruits by videoconference. Having private office

space within the schools and places to securely store files is also an issue. Other challenges have been less in-person professional development and conferences.

What are some long-term programming areas you would like to share with the Boards?

- RYC:
    - Crisis response in Ketchikan. Just before COVID they started Ketchikan Cares crisis hotline, which is 24/7 master's level clinicians. This is a local call center that can connect people to local providers. Longer term the goal is to figure out how to add to that and stand up other crisis response services.
    - Push forward home-based services and continuing to increase their community-based programming.
    - Very close to becoming an AmeriCorps volunteer site to recruit more people to come into the community.
    - RYC recruited the first pediatric psychiatrist to ever live in Ketchikan. Moving forward, the plan is to figure out how to expand access to the pediatric psychiatrist to people outside of RYC and outside of Ketchikan.
    - Would like to see a youth center created in Ketchikan, and partners have come forward with capital funding for one.
    - During COVID, they created a youth fishing, harvesting, and life skills program in partnership with a local tour company. They would like to expand this program to include more cultural experiences and harvesting food from the forest.
- JSD:
    - Working to get trauma-engaged practice in all of the schools. If schools are supporting whole child wellness, the flow of adolescents needing mental health services should lessen as they are able to build self-regulation capacity and emotional resilience in kids early on.
    - One of the goals with the Project AWARE grant is to develop sustainable funding to retain positions when the grant ends. Looking to be able to bill Medicaid for behavioral health services.
    - Continuing to grow their own staff to be able to provide mental health services to youth in school, which reduces barriers to service for families. Positions that have been embedded in school are helping not just provide the service, but are also bringing the mental health perspective to staff, behavior planning, and meetings with students and ensuring that interventions are taking into account mental health and not just behavior modification.
- BSSD:
    - Also working on making the AWARE grant sustainable.
    - Working on a comprehensive plan for professional development, suicide prevention plans, SEL plans, et cetera, to support the whole child at school and loop in the community as well.
    - Having counselors in the school building is life saving.
- CFS:

- Changing the lens on service provision. Programs are the structure, but services and someone to talk to are why people call the clinic for help. The agency looks beyond programs and finds a provider that can help the person.
- Transition-aged youth want community, safe relationships with other youth; someone they can talk to and connect with; and vocation and education. Wellness for a lot of youth is a vehicle to achieve their long-term goals, which service providers need to connect to.
- Trying to add the Partial Hospital Program (PHP). Young children shouldn't be in psychiatric hospitals anymore. Children should be kept at home and provided the services they need.
- Partnerships with CFS in the school are reaching many youths, and in Anchorage and Fairbanks, 100 students were served by the behavioral health providers in schools this year. In terms of prevention, it allows them to serve families earlier in the crisis cycle.

What is one area you could use more support from the Boards in advancing your program?

Stephanie Hopkins opened up the discussion to Q and A from members of the Boards. Highlights of the discussion are as follows:

- It seems that there are more and more children with more and more complex needs. Hearing needs at middle schools that used to only be high school issues, and the same is true between elementary and middle school.
- Perhaps the need hasn't increased with younger children, but maybe they are better at recognizing things earlier.
- RYC provides residential care, and by the time youth get to the point of residential placement, they have more challenges. They are seeing younger youth with complex needs.
- In terms of partnership and collaboration to support children involved in the child welfare system for assessment and referral, it was noted that children can be assessed, but it's of no use if there is no service to link them to. The two go hand in hand, and care needs to be improved in the system in which they are doing that integration.

Closing Comments:

- BSSD – This has been a good experience to be a part of, and appreciate the time to respond to the questions and hear everyone else's views. Reiterated that the biggest thing they can do is have a school counselor in every single school with a full, comprehensive school counseling program.
- RYC – Grateful for the work of the Boards, and appreciated being on the panel to learn from others. Grants in Alaska have been under fire and in a lot of cases are shrinking, but grants provide opportunity for innovation and thinking outside the box. It's important to protect grants. There are a lot of conversations that need to happen about how to support

youth involved with OCS beyond just the clinical support. RYC is using the Icelandic Model in their after-school program.

- CFS – It was a pleasure to be here. Alaska has challenges, but everyone is very close knit and works in a spirit of collaboration. Appreciate Board members' service to the state of Alaska, and appreciate colleagues who have also made this their life's work.
- JSD – In the big picture, partnership of mental health with any other system is about helping shift the system to be more supportive of human well-being overall. For youth, developmentally appropriate practice really supports well-being. Sense of self-efficacy is very important for well-being, particularly through adolescence. They have an opportunity in Alaska to ensure they are bringing best practices to serve children and families through their lifespan to support well-being. It's been great to hear what other people are doing in other parts of the state and to be a part of this panel today.

BOARD BUSINESS

Legislative Update

Teri Tibbett stated that the Advocacy Committee has met a few times and has reviewed the budget items and bills that appear to have some relationship with behavioral health. She referred members of the Boards to the folder they received that contain the hard copies of the bills and budget items they are tracking. She encouraged Board members to attend the Advocacy Committee meetings every other Monday at noon.

Teri reviewed the remaining folder contents that included such information as:

- "Who We Are" description sheet of the Boards
- Trust Joint Advocacy:
    - Behavioral Health Services
    - Community-Based Services
    - Medicaid Health Coverage
    - Supportive Housing
    - Employment
    - Workforce

She encouraged members of the Boards to be familiar with these positions to share with their legislators during visits. She also invited members of the Boards to attend the Trust Legislative Teleconferences held every Friday at 12:15.

Legislative Visit Report Out

Teri Tibbett led the Boards through a discussion of their legislative visits as follows:

Brenda Moore:

- Met with legislative aides and legislators.
- Discussed assistive technology, and legislators wanted to know more.
- Discussed the work re-entry coalitions were doing and simulations that were happening.
- Statistics on opioid misuse and suicides was very impactful.
- Personal stories shared were very important.
- Stressed the importance of grant funding for comprehensive treatment grants even with the implementation of the 1115 waiver.
- Sen. Wilson and Sen. von Imhof asked what the Boards' stand was on the DHSS reorganization.

Renee Schofield:

- They spoke about increasing services to the rural communities.
- Discussed extending HB 65, the telehealth bill.
- Met with Conrad Jackson from Micciche's office.
- Discussed re-entry and the gaps as well as the simulation exercises.
- Discussed the waitlist, provider communication, and assistive technology.
- People were receptive and wanted to be more education about the issues.
- Talked about emocha observed remote direct therapies, which was well received.

Anthony Cravalho:

- Met with Rep. Zulkosky, who is a huge supporter of the Boards' issues and is an advocate. The meeting went about 30 minutes. She had follow-up questions about early childhood interventions and peer support programs.
- Met with Rep. Kreiss-Tomkins and thanked him for HB 118. He will look into HB 265 and SB 175. The meeting went about 30 minutes.
- Sen. Micciche's staff gave them about 30 minutes, and he discussed attending a meeting in his region related to re-entry, and that opened his eyes.
- Met with Rep. Patkotak who stated he is not on HSS or Finance. He listened to the issues and seemed willing to be an advocate for anything that supports rural Alaska or expands services. He noted that he's more conservative when it comes to the State budget, but he will advocate for rural Alaska.
- Thanked his teammates for doing such a great job in all the meetings.
- Rep. Merrick gave them 15 minutes.
- Thank you to Teri and Stephanie for all their work.

Lee Breinig:

- Felt all the meetings went really well and had an organic format. Everyone seemed very open to hearing their suggestions, and the personal stories were particularly impactful.
- The need for grandparents' rights is a real problem and needs addressing in Alaska.
- Encouraging that a number of legislators were fairly educated on their issues.

- Thank you to Teri for dealing with the struggle of the juggle.

Diane Fielden:

- Met with Rep. Spohnholz' staff person, who is from the Alaska Primary Care Association.
- Rep Spohnholz is very interested in what the Boards are doing, and she is pushing telehealth through her legislation HB 265.
- Thank you to the staff for all their hard work.

Karen Malcom Smith:

- One of her asks was upstream prevention and a bill for presenting to junior high and high schoolers the signs of addiction and what opiates do to the brain.
- Has an upcoming meeting with Sen. Gray-Jackson and a coalition of mothers who have lost their children.

Tonie Protzman:

- Met with Rep. Tuck and Sen. Gray-Jackson. Rep. Tuck was very engaged and had a lot of follow-up questions.
- Thank you to staff and all the legislative visit teammates. Honored to be on this board.

Bobby Dorton:

- Met with Rep. Zulkosky, who was very engaged with what the Boards had to say. He talked to her about supportive housing and the waitlist as well as the quality of behavioral health services in rural Alaska.
- Rep. LeBon was very interested in what they were saying and asked questions. Talked to him like he was a local person because he's from Fairbanks.
- The big takeaway is that the legislators are people just like them, and they want to hear from their constituents.

Kara Nelson:

- Met with Sen. Wilson, Rep. Kreiss-Tomkins, Rep. LeBon, and Rep. Claman.
- The team worked well together and discussed priorities and lived experience.
- She has worked with Rep. Claman for many years, and he has done a lot of great work for people who have been incarcerated.
- Had met with Sen. Wilson prior during a tour of their facilities.
- Rep. LeBon seemed very engaged and interested to hear more.

Charlene Tautfest:

- All the legislators were very attentive, listened, and took notes.

Narcan Training

Jennifer Weisshaupt presented to the Boards on the Project Hope overdose response kits that everyone had been sent along with their meeting packets. Included in the kit are:

- Two doses of Narcan
- Sanitary gloves
- Fentanyl test strip(s)
- Face shield
- Brochure on how to administer Narcan
- Brochure on how to use the fentanyl test strip.

Recognize Use v. Misuse:

Side Effects of Opioids:

- Increased tolerance
- Physical dependence
- Increased sensitivity to pain
- Sleepiness and dizziness
- Mental confusion
- Nausea and vomiting
- Depression.

Signs of Possible Opioid Overdose

- Face is extremely pale or clammy to touch
- Breathing very slow or stopped
- Fingernails or lips have blue or purple color
- Cannot be awakened from sleep or unable to speak
- Body is limp
- Vomiting or making gurgling noises
- Heartbeat very slow or stopped.

What to do in the event of a suspected overdose:

1. Give Narcan
2. Call 911
3. If trained, provide basic life support per protocol.

- An opioid overdose requires immediate medical attention.
- Tell the 911 operator that someone is unresponsive and not breathing. Give a clear street address and description of location.
- Narcan should reverse the effects of the opioids within 30 to 40 seconds. If not, a dose can be administered every two to three minutes if available.
- If the person is breathing, lay them on their side with their knee bent to keep them from falling forward. This is so they do not choke if they vomit.
- Stay with the person until help arrives.

Opioid Withdrawal:

In some cases, Narcan may cause sudden opioid withdrawal syndrome, so it is important to be ready for symptoms of withdrawal, which may include:

- Vomiting
- Agitation
- Restlessness
- Diarrhea

Jennifer Weisshaupt shared a video on naloxone with Board members and stated that they can get additional kits from Project Hope to hand out in their communities. She stated that they can also go to ANTHC's website: https://www.Iknowmine.org to order supply kits and harm reduction materials that are free and can be distributed.

Jennifer stated that last year the FDA approved KLOXXADO, which is an eight-milligram nasal spray as well, and the Office of Substance Misuse and Prevention (OSMAP) is considering getting it and adding it to the kits. The FDA has also expanded the expiration date from 24 to 36 months.

Board members discussed the release from liability for administering Narcan, additional locations that free kits can be obtained, and a Department of Education model where teachers are taught to recognize the signs in youth and to talk to them about it. Jennifer stated that she would love to encourage youth peer programs.

AMHB/ABADA Goal Setting

Chairs Schofield and Clark sent a letter to members of the Boards asking them to think about goals in their communities they could work on outside of their statutory obligations as Board members.

Chair Schofield stated that she would like to do more research on the Bridge device for opiate withdrawal they learned about at a previous meeting. She plans to make connections with the people that were using it. She doesn't believe there are any providers using it in her community, and she believes they can do some education about it. She will also be following up with letters to her two legislators to share the Boards' priorities and asks.

Chair Clark stated that one of her goals is to see if the Trust is available to help push forward help for people with domestic violence issues, which leads into missing and indigenous people. She believes they should also contact the Council on Domestic Violence and Sexual Assault and invite them to a Board meeting to hear their insight. Charlene Tautfest agreed with Chair Clark and noted that she sent an e-mail about this issue back in October.

Lee Breinig reflected on the presentation from Tom Chard about the amount of data going into the system but the collective lack of ability to pull out meaningful pieces of data. He wondered if they could undertake some type of initiative to pull out data and use it to help inform what they advocate for. Chair Schofield agreed and highlighted that data shared in the legislative meetings had a big impact on legislators. Brenda Moore agreed and feels that it's important for the State to be able to show how the services offered improve lives.

Brenda Moore agreed with Karen Malcom Smith's desire for better withdrawal management and detox services. Karen stated that in Southcentral Alaska, there are less than 30 detox beds. During the peak of the pandemic, there were as little as six beds, and the hospitals were doing quick turnarounds. Rep. Tuck and Sen. Begich are working on a bill right now focusing on this issue. Other groups and coalitions have tried getting detox started, but they have all had funding issues.

Karen Malcom Smith wondered if there is a way to encourage AA or NA through peer support, because they never hear about the eight million people who are in recovery or long-term recovery through this program. Lee Breinig noted that it's against the traditions of the 12-Step Program to promote AA and NA outside of its own community. By encouraging the expansion and development of peer supports, which draws on natural and community supports, these programs will naturally have greater reach.

Lee Breinig stated that addressing stigma is another key issue they could take on, because he has heard that there seem to be some dividing sets of opinions on what recovery should look like. The recovery community shouldn't be exclusive; it should strive to be inclusive. With more of a move towards a public health approach that involves harm reduction and access to medication assisted treatment, that would help in reducing stigma and possibly changing some of the attitudes that perpetuate it.

Philip Licht stated that sober housing or recovery housing has some new and exciting models that have cropped up in Alaska. There are other models around the country, and he recently visited a Community First village that dealt with the chronic homelessness issue in Austin, TX. There is an organization in Anchorage that is talking about a tiny home recovery community with long-term permanent homeless housing. There is a lot of opportunity around that and could be something the Boards can advocate for.

Charlene Tautfest stated that a goal would be to address stigma by normalizing talking about mental health and sharing success stories.

Bobby Dorton suggested looking at utilizing vacant school buildings in the Interior and across Alaska that can be repurposed for other uses such as treatment centers. They should also continue to focus on the quality of behavioral health services in the Interior because the current system isn't working, and people are dying. He suggested incorporating peer support to tackle the long wait lists for service that could be supervised through the hub communities for service to the villages.

Tonie Protzman stated that the workforce shortage is a big issue to her, particularly because telehealth has increased the number of people asking for services. She also wondered what can be done to keep the current provider workforce healthy and strong to be able to provide services.

The chairs thanked Board members for sharing goals and ideas, and Chair Clark suggested that they include the Trust in these conversations, because beneficiaries are being affected by these issues.

Rural Meeting Planning

Bev Schoonover stated that after meeting with the chairs, they decided to propose that the next quarterly meeting be held by videoconference. She noted that the Boards still have travel dollars

to spend by the end of June, and they considered sending Board members out in small groups, maybe two from each board, and only those members who are comfortable traveling. Staff would not be accompanying the Board members, and they would only go to communities that are comfortable having them. Visits would take place in April and May, and Board members would then report out on their visits during a June quarterly meeting.

Charlene Tautfest **MOVED** that the Boards pursue an outreach program, **SECONDED** by Sharon Clark. Hearing no further discussion nor opposition, the motion **PASSED.**

Chair Clark suggested that staff research the rural areas the Boards have gone to and compile a list of places they have been so they can have choices to pick from. She also asked staff to compile a list of rural areas they have been to or they want to go to, and invite one rural village to attend their board meetings. Bev Schoonover stated that they have a list of all the rural board meetings they have done in the past, and she will send that out to Board members.

Other Information for the Good of the Order

Bev Schoonover and Chair Clark discussed putting a message on their public notices of what behavior they will and won't accept during their board meetings. Bev also suggested to the chairs that they might want to look at the bylaws and include some language to that effect. Teri Tibbett stated that prior to the Trust Legislative Teleconferences, they provide a written disclaimer about treating people with respect and not disparaging others. She can share that template language if they would like to use it.

Brenda Moore reminded Board members that legislators were interested in the Boards' position on the DHSS reorganization. Bev Schoonover stated that they are going to discuss this topic at the next Advocacy Committee meeting and have them vote on a letter of support or not. She stated that staff have analyzed the EO, and they don't see any problems with it. Diane Fielden stated she is in favor of a letter of support.

Karen Malcom Smith stated that she receives many requests from people asking where they go to get services. She wondered how they can advertise or get the word out to the general public. Bev Schoonover stated that the Boards are on the statewide advisory panel for Treatment Connections, which is an online platform that lists behavioral health providers that are funded by the State, their bed availability, and the services provided. A person can go to the site, put what their concern is, and it will produce providers in the area or other resources. The program is growing right now, and the goal is to have it heavily populated throughout the state. Bev stated that she can invite the Treatment Connection folks to the next Executive Committee meeting. She also stated that 211 has grown a lot. Chair Schofield challenged Board members to go before each of their Chambers of Commerce to talk to them about where to go to get connections.

FINAL COMMENTS

Board members offered their final comments of the meeting summarized as follows:

- Appreciated having all of the interaction and engagement with DBH and DHSS leadership at this meeting. Would like to see that engagement continue with the bifurcation of the department.
- Thanks to staff for all their hard work.
- Got the sense that people are listening to them and taking note of the different areas of expertise of Board members.
- Missing the personal connection. Wish they could have met in person.
- Diverse board members. There is strength in diversity and power in unity. Feel respected as a Board member, and positive things got done. Honored to be part of this team.
- Good presentations at this meeting and learned new things.
- This was an emotional meeting. Wish I would have had these resources when my family needed them.
- Appreciative for Board members with lived experience sharing their stories. Appreciate how the legislative meetings went. Miss meeting in person, but the pre-meetings and meetings with legislators helped to get to know some of the newer Board members.
- Great legislative visits.
- Presentations were very good. Amazed by the wealth of knowledge and experience of the Boards as well as the positivity and respect shown to each other.
- Suggested that although the next meeting will be via Zoom, perhaps a conference room can be arranged for members that want to appear together at the meeting to be able to support each other during emotional triggers. Looking forward to the rural outreach.

ADJOURNMENT

Diane Fielden **MOVED** to adjourn, **SECONDED** by Sharon Clark. Hearing no objection, the motion **PASSED**, and the meeting adjourned at 4:32 p.m.

MOTIONS

Philip Licht **MOVED** to approve the agenda and the minutes from the July 2021 meeting, **SECONDED** by Charlene Tautfest. Hearing no objection, the motion **PASSED**. Page 2.

Philip Licht **MOVED** that for the ABADA board, Renee Schofield serve a second term as the chair, Lee Breinig as the vice-chair, Anthony Cravalho as the secretary, and Diane Fielden as the at-large position, **SECONDED** by Enlow Walker. Hearing no objection, the motion **PASSED**. Page 3.

Monique Andrews **MOVED** for the AMHB that Sharon Clark serve as chair, Charlene Tautfest as the vice-chair, Brenda Moore as the secretary, and Monique Andrews as member-at-large, **SECONDED** by Diane Fielden. Hearing no objection, the motion **PASSED**. Page 3.

Lee Breinig **MOVED** to have the next board meeting in Juneau at the end February, **SECONDED** by Tonie Protzman. After discussion, Lee Breinig **AMENDED THE MOTION** to meet in Juneau and leave the date open for consideration later, **SECONDED** by Renee Schofield. Hearing no objection, the motion **PASSED AS AMENDED**. Page 18.