# MUNICIPALITY OF ANCHORAGE

## Assembly Information Memorandum

No. AIM 120-2023

Meeting Date: June 6, 2023

Municipal Clerk's Office
Accepted
Date: June 6, 2023

**From:** **ASSEMBLY MEMBERS RIVERA AND VOLLAND**

**Subject:** **COMPLEX BEHAVIORAL HEALTH NEEDS COMMUNITY TASK FORCE IMMEDIATE SOLUTIONS RECOMMENDATIONS**

Per AR 2023-145, As Amended, which created the Complex Behavioral Health Needs Community Task Force, please find their report on Immediate Solutions Recommendations attached.

Reviewed by: Assembly Counsel's Office

Respectfully submitted: Felix Rivera, Assembly Member
District 4, Midtown

Daniel Volland, Assembly Member
District 1, North Anchorage

# MUNICIPALITY OF ANCHORAGE
# Complex Behavioral Health Needs Community Taskforce
## Immediate Solutions Recommendations

Final Draft June 1, 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 at risk of experiencing homelessness with complex behavioral health needs. The Task Force is to submit a report with recommendations for immediate solutions by June 1, 2023, and for mid to long term solutions no later than September 5, 2023. Considerations expected as part of the recommendations include needs and capacity mapping, operational and capital needs, workforce development needs, and other items as identified by or referred to the task force by the Chairs of the Assembly's Health Policy and Housing and Homelessness Committees.

## Goal of the Taskforce

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

## Process

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

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

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

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

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

Following the meeting, an updated draft of this report was delivered to the entire participant list. Comments and suggestions were considered and incorporated.

# Acknowledgements

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

Alexis Johnson, Anchorage Health Department

Angela Michaud, Cook Inlet Tribal Council

Ashely Christopherson, State Department of Family and Community Services

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Jon Van Ravenswaay, Mountain View Health Services

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Kathleen McCoy, Brother Francis Shelter Volunteer and Adult Homeless Advisory Council

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Kristy Becker, Alaska Psychiatric Institute

Lauren Anderson, Providence Health and Services

Lisa Scharff, Mountain View Health Services

Makayla Viray, Complex Care Coordinator, Commissioner's Office, State Department of Family and Community Services

Michael Hughes, Anchorage Health Department

Michael Riley, Anchorage Fire Department

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Monica Gross, Restorative Reentry Services

Radhika Krishna, Anchorage Downtown Partnership

Renee Rafferty, Providence Alaska

Sara Platt, Recover Alaska

Shanta'i McDermott, Psychiatric Prescribing Provider

Shigone Beighle, Mountain View Health Services

Summer LeFebvre, Southcentral Foundation

Thea Agnew Bemben, Agnew::Beck, Task Force Convener

Tiffany Hall, Recover Alaska

Tony Andrew, Community Member

Travis Welch, Alaska Mental Health Trust

Vincent Botzki, RurAL CAP

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

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

# Background

***What are complex behavioral health needs?***

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

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

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

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

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

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

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

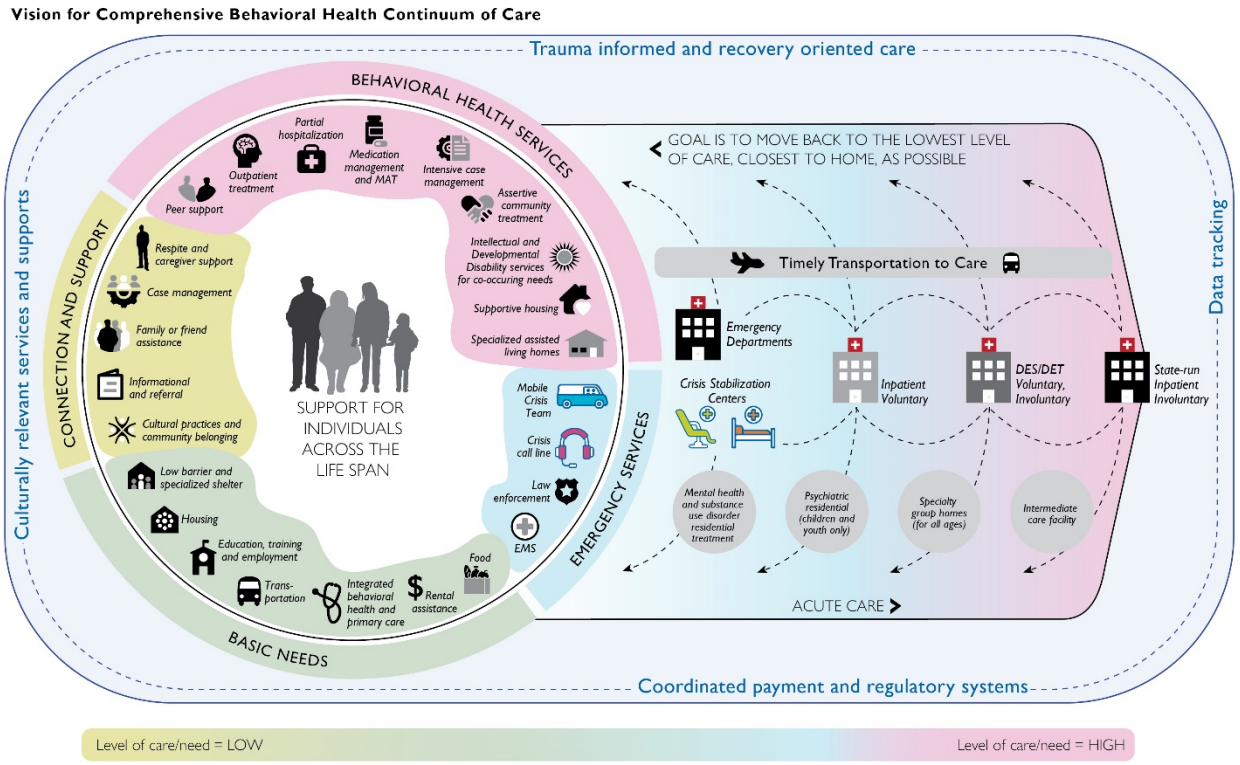
[2] https://camdenhealth.org/resources/complex-care-startup-toolkit/

[3] This graphic is being developed by Agnew::Beck Consulting under contract to the Alaska Mental Health Trust Authority as part of the stakeholder process related to HB172 and the protection and promotion of patient rights while accessing psychiatric care. 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 examples of services that may prevent a person from going into psychiatric crisis and decrease the severity of crisis. For the healthcare system, these home and community-based services reduce the need for inpatient care and involuntary treatment, reduce suicide rates, and improve public safety.[4] Some of these services are available over the phone such as 9-8-8 or Alaska Careline; others, such as a mobile crisis team, should be available in a person's home or community; others might be facility-based, such as the newly created crisis stabilization centers.

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

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/

[4] 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.[5] By using these criteria and HMIS data, we can estimate the number of people experiencing homelessness and complex conditions including behavioral health conditions. Figure 2 summarizes the criteria that can be used to identify the group of people who could benefit from the interventions identified in this plan.

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

| | |
|---|---|
| Demographics | Adults (age 18+), including elders; no additional age restrictions; all genders |
| Housing Status | Experiencing homelessness, or in need of housing assistance |
| Chronic Status[6] | Identified as chronically experiencing homelessness (HUD definition) |
| Disability Status[7] | Identified as having one or more disabling conditions, includes physical disabilities, intellectual and developmental disabilities, mental illness and substance use disorders<br>(HUD definition; also included as a component of Chronic Homelessness) |
| Health Conditions | Identified as having a "Medical Need" (Anchorage HMIS, definition 2): having 3 or more disabilities defined as the Alaska Mental Health Trust beneficiary categories: mental illness, developmental disability, substance use disorder, Alzheimer's disease and related dementia (ADRD) and traumatic brain injury (TBI).[8] |

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

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

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

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

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

[8] Mhtrust.org

# Proposed Goals + Objectives

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

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

1. Promote the connection of APD Dispatch to the Alaska Careline and the expansion of the APD Mobile Intervention Teams
2. Support the AFD Mobile Crisis Team to operate 24/7
3. Support Providence and Southcentral Foundation's projects to develop Crisis Stabilization Centers (CSC)
4. Support the development of the Crisis Care and Connectors group

ii. Contract with providers to do mobile outreach and provide medical and behavioral health services to people who are experiencing or at risk of homelessness.
iii. Contract with peer providers to develop trusting relationships to increase client engagement.
iv. Coordinate and provide transportation to health clinics for primary and behavioral health care and other supports.

b. Assess individuals for benefit eligibility, such as Medicaid and Social Security, and secure all eligible benefits.
c. Identify housing options and help clients secure long-term housing.
d. Add residential treatment beds and outpatient capacity for behavioral health care and conduct collaborative advocacy to decrease barriers and help providers add treatment capacity.
e. Increase behavioral health workforce.
f. Fill funding gaps to add units of supportive housing and other housing options
    i. Quantify units needed, secure funding, develop capacity
        1. Transitional housing
        2. Permanent Supportive Housing, very low barrier
        3. Assisted Living Homes for people with complex behavioral health conditions
        4. Structured group homes for people with combination of Intellectual and Developmental Disabilities (IDD) and behavioral health conditions
        5. Specialized care for Elders with cognitive impairments and behavioral health conditions
        6. Specialized supportive housing options for youth and young adults

# Action Plan

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| **GOAL 1: SYSTEM COORDINATION: OUTREACH + TRIAGE:** Identify the most vulnerable individuals experiencing or at risk of homelessness in Anchorage who also have complex behavioral health conditions, many of whom are currently unsheltered, and address care needs. | | | | | | |
| **OBJECTIVES** | | | | | | |
| **Identify and, if necessary, fund a position and team at the Anchorage Health Department or other municipal entity to manage and coordinate contractors, funding streams, and Municipal, State, and non-municipal entities to implement this plan** | Immediate | MOA AHD or other municipal department | Identify position and team | If necessary, add resources, defer to AHD | | |
| **Partner with State entities to address system-level barriers and to increase funding and other resources** | Medium, Long | MOA AHD, Department of Health | Follow-up Municipal legislative priorities at state Legislature | Alaska Medicaid State Plan and 1115 waiver services, Alaska Mental Health Trust Authority; Comprehensive Integrated Mental Health Program Plan 2022-24; AHD Opioid Taskforce coordinate with OSMAP | | |
| **Work with Anchorage Chamber of Commerce and local businesses to address community needs,** | Medium to Long-range | TBD | TBD | TBD | | |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| **share information, and increase resources.** | | | | | | |
| **Coordinate referrals from ACEH and the Coordinated Entry system**<br><br>**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** | Medium | MOA, ACEH or contractor | Funding decisions<br><br>Data sharing agreements<br><br>Agreement on Level of Care Assessment tool and triage process<br><br>Contracts with healthcare, behavioral health, and peer support providers: Mountain View Health Services, Choices, AK Behavioral Health, Henning, Inc., Southcentral Foundation, others? | MOA funding<br><br>Alaska 2-1-1<br><br>Medicaid 1115 for eligible providers/clients<br><br>Requires start-up funding to develop shared data system<br><br>HUD Continuum of Care funding<br><br>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 | Data sharing agreements | Support from the Trust via the Crisis Now Implementation Support contract | | |
| **Address lack of Guardianship** | Immediate | Office of Public Advocacy, Department of Health | | | | |
| **Ensure culturally relevant services and support** | Medium to Long-range | TBD | TBD | Partnership with SCF, CITC and other Tribal entities; partnerships with | | |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| | | | | Peer Leader Navigators, Providence Community Health Workers; partner with diverse community organizations, faith communities, and cultural groups. | | |
| **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 | Specific communications with communities near new facilities and programs; consider using the Good Neighbor Policy template when working with communities | Consider Trust communications resources for anti-stigma | | |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| **GOAL 2: SHELTER: P**rovide immediate, very low-barrier, and appropriate safe overnight shelter, and navigation to access health care and supports. | | | | | | |
| **OBJECTIVES** | | | | | | |
| **Implement the recommendations of the Sanctioned Camping Taskforce** | Immediate | MOA or contractor | TBD | Funding for contracted providers | | Municipal funding |
| **Add one low-barrier navigation center to provide daytime services, located near to new shelter sites.** | Medium, Long-range | TBD | TBD | TBD | | |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | 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**<br>1. Promote the connection of APD Dispatch to the Alaska Careline and the expansion of the APD Mobile Intervention Teams<br>2. Support the Mobile Crisis Team to operate 24/7<br>3. Support Providence and Southcentral Foundation's projects to develop Crisis Stabilization Centers (CSC)<br>4. Support the development of the Crisis Care and Connectors group. | Immediate | Anchorage Assembly, APD, AFD, Administration | Job reclassification for AFD Mobile Crisis Team (MOA HR and Unions)<br><br>Funding allocations | Continued funding for APD and AFD<br><br>Additional construction funding for Providence and SCF's CSC projects to complete construction on time and open centers as soon as possible.<br><br>Trust and contractor, Agnew::Beck, to support development of Crisis Care and Connectors group; additional funding may be needed | | |
| **Contract with providers to do mobile outreach and medical and behavioral health services to people who experiencing or at risk of homelessness** | Immediate | MOA AHD or contractor to develop subcontractors with healthcare, behavioral health, and peer support providers | Funding decisions<br><br>Contracts with providers | Funding | | This may be partly sustainable through Medicaid billing for eligible and enrolled clients; however, unresourced clients and provider transportation |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| | | | | | | costs and time to locate unsheltered clients will require additional payment source |
| **Contract with peer providers to develop trusting relationships to increase client engagement** | Immediate | MOA or contractor | Funding decisions<br><br>Contracts with providers | | | Capacity for workforce |
| **Coordinate and provide transportation to health clinics for primary and behavioral health care and other supports** | Immediate | MOA or contractor | Funding decisions<br><br>Contracts with providers | Bus passes, taxi vouchers, and support for case managers to transport clients, when needed | | |
| **Assess individuals for benefit eligibility, such as Medicaid and Social Security, and secure all eligible benefits.** | Immediate | Case managers, Peer Supports, 3rd Avenue Navigation Center | Funding decisions<br><br>Contracts with providers | | | |
| **Identify housing options and help clients secure long-term housing.** | Medium | ACEH, Providers, MOA ADRC, 3rd Avenue Navigation Center | Funding decisions<br><br>Contracts with providers | TBD | | |
| **Add residential treatment beds and outpatient capacity for behavioral health care and conduct collaborative advocacy to decrease barriers and help providers add treatment capacity.** | Medium | TBD | TBD | TBD | | |
| **Increase Behavioral Health workforce** | Medium to long | TBD | TBD | TBD | | Support efforts at UAA School of |

| Service or Support | Immediate, Mid or Long Range | Lead Entity | Policy or Decisions Needed | Resources + Source | Relative Cost | Sustainability Options |
|---|---|---|---|---|---|---|
| | | | | | | Social Work and College of Health, facilitated by Recover Alaska |
| **Fill funding gaps to add units of supportive housing and other housing options** | Medium, Long | MOA, AHFC or other State entity, ACEH, Housing Trust, others? | Quantify units needed, secure funding, develop capacity | Permanent Supportive Housing, low barrier<br><br>Assisted Living Homes for people with complex behavioral health conditions<br><br>Structured group homes for people with combination of IDD and behavioral health conditions<br><br>Specialized supportive housing for youth and young adults such as Therapeutic Treatment Homes and group homes<br><br>Specialized care for Elders with cognitive impairments and behavioral health conditions | | |