

Prince of Wales Behavioral Health Planning Project

Strategic Planning Meeting Minutes

January 26, 2011 10 am – 4:30 pm

January 27, 2011 9 am – 2 pm

Shelter Cove Lodge

JANUARY 26

Participants: Shelly Wade (Agnew::Beck), Beth McLaughlin (Agnew::Beck), Peter Rice (PeaceHealth, on phone), Colleen Watson (Craig Public Health, POW Health Network, HOPE), Keturah Sadler (POW Health Network, POW EMS Coordinator), Joe Burke (PeaceHealth), Kara McCoy (Craig Public Health), Audrey Escoffon (City of Kasaan), Mark Walker (Alaska Island Community Services), Diane Casto (State of Alaska Division of Behavioral Health Prevention & Early Intervention), Genevieve Casey (State of Alaska Division of Behavioral Health Prevention & Early Intervention), Ralph Mackie (Craig community member), Beverlee Tyner (Southeast Senior Services), Richard Nault (State of Alaska Division of Behavioral Health Treatment & Recovery), John Borbridge (Island Community Screening Services), Tia Holley (BSW student), Jacinda Broussard (BSW student), Julie McDonald (Whale Tail Pharmacy), Don Filmore (HOPE), Carolyn Lemmon (SEARHC), Bess Clark (Community Connections), Craig Ward (Gateway Center for Human Services), Frances Natkong (Hydaburg Cooperative Association), Jerri Fowler (Hydaburg Cooperative Association), Esther Hammerschlag (POW Health Network), Melody Price-Yonts (SEARHC, on phone)

PURPOSE OF MEETING

The overall goal of this meeting was to create a strategic plan to address the full continuum of behavioral health services – from prevention to intervention, treatment and aftercare – on Prince of Wales Island. The intent was for island residents and stakeholders, providers, and state representatives to work together to develop a clear set of strategies and actions that can be implemented and evaluated locally to work towards an improved behavioral health system on POW.

REVIEW OF POW BEHAVIORAL HEALTH PLANNING PROJECT TO DATE

- This project was funded through a grant from the State of Alaska Division of Behavioral Health, Prevention and Early Intervention.
- The grant required the project to follow the first three steps of the Strategic Prevention Framework (SPF). These steps are 1) Assessment; 2) Capacity Building; and 3) Planning.
- The needs assessment was completed in May, 2010. The results were distributed at a community meeting in May, 2010, and through a series of e-newsletters sent to stakeholders over the summer of 2010.
- In September, 2010, a Capacity Building Workshop was held in Craig. Attendees were asked to prioritize a substance abuse related consequence for POW, based on data collected through the needs assessment. Domestic violence and sexual assault was identified as a priority issue.

- This January meeting completes Step 3 in the SPF process, and marks the end of the Behavioral Health Planning Project as funded by this grant. The project going forward will be funded through other mechanisms.
- All Steps of the SPF are interconnected. As the POW community begins to work on strategies developed, additional assessment, capacity building, and planning may be warranted.
- This process was facilitated by Agnew::Beck Consulting, who was contracted by the Prince of Wales Health Network. Although Agnew Beck's role is essentially done after this meeting, they have a contract with the Alaska Mental Health Trust to provide technical assistance to rural communities and providers of Trust beneficiaries. They can continue to be a resource to POW and the organizations serving the Island.
- As the grantee and convener of this project, the POW Health Network will continue the process begun under this grant project to organize and help convene a formal community coalition that has its foundation in this Strategic Planning meeting. Esther Hammerschlag, Network Director will be the point person for the organization of that coalition.
- Participants were encouraged to consider strategies and actions that can be taken on the local level to create change. Rather than just looking at the treatment system and service providers for solutions, they should also look to community resources.

SUMMARY OF SEPTEMBER CAPACITY BUILDING MEETING AND FEEDBACK RECEIVED

- Notes from the September Capacity Building meeting were provided as a reference.
- The SPF process requires a focus on prevention of substance abuse related consequences. Meeting participants at the Capacity Building workshop were asked to prioritize a consequence based on data and criteria established during the meeting. The group prioritized Domestic Violence and Sexual Assault, and then talked about contributing factors.
- Following the September meeting, feedback was received that the planning process needs an expanded discussion to include the entire behavioral health system on POW.
- This feedback was taken into account. The agenda for this meeting provides time for discussion of current services and expands the focus to include a discussion of the entire system.

PARTICIPANTS' EXPECTATIONS AND HOPES FOR STRATEGIC PLANNING MEETING

- That the group continues to meet with providers as a coalition focused on behavioral health.
- That a firm plan is in place, with commitment to continue meeting and track progress on goals of the strategic plan.
- That there are well defined goals, focus, and emphasis.
- That steps and action will take place for the whole island.
- That new people will sign up to be HOPE members.
- That the means and energy will exist to create a POW behavioral health system coalition. That we give ourselves an identity.
- That there is a way to address gaps in the treatment system – is it the creation of a new entity to provide behavioral health and substance abuse treatment services on the island?

- That there are ideas for improving the referral system – how to identify what happens now for all providers, how to make the system more user friendly, and how to get people into services that are already here.

DISCUSSION OF BEHAVIORAL HEALTH LEVELS OF CARE

- The State has defined Levels of Community (Levels I – V) and corresponding levels of baseline services to be expected in those communities. A summary handout was provided and discussed. Levels of community are defined by characteristics such as government, size of the population, economy, types of health and social services generally available, and access to the community.
- Craig is defined as a Level II community. Smaller communities such as Kasaan or Coffman Cove would be defined as Level I.
- State representatives noted this is the minimum amount of services expected on the community level. Communities/organizations may provide higher levels of care than this establishes.
- It was noted that Level II communities such as Craig or Klawock can function as hubs, with more services centered in those communities, and lower levels of services in the smaller communities.
- The question was raised that if we looked at POW as a whole, wouldn't that make us a Level III community? Should we look at POW as one community rather than each community separately?
- The base level of services represented in the matrix includes tribal resources.

DESCRIPTION OF SERVICES CURRENTLY AVAILABLE ON POW

- Community Connections
 - Community Connections provides a broad array of services in Ketchikan and on POW. They receive grant funding to serve youth on southern POW but have responded to requests for services from communities such as Naukati and Edna Bay.
 - Community Connections currently has two clinicians on POW.
 - Community Connections provides children's mental health services, assessment, individual therapy, group therapy, and therapeutic foster homes for children that need that type of setting.
 - One clinician is now licensed as a substance abuse counselor and can provide these services for children and adults.
 - Services at Community Connections stop at age 18.
 - Community Connections must complete the State's credentialing process before they can offer substance abuse services for youth. It has been difficult to navigate this process and assistance is needed.
 - Staff capacity depends on the youth being served and their needs.
 - Community Connections has the capacity to expand. Clinicians have some limited capacity now with their current caseloads. Community Connections is currently advertising for a lead clinician to supervise clinicians on POW and in Ketchikan, which could also give POW some more capacity.

- Community Connections contracts with Children's Hospital in Seattle for psychiatric services via telemedicine. Every other week they are connected to a psychiatrist. They have ½ day dedicated every other week, which is shared between Ketchikan and POW.
- Community Connections provides emergency services for their own patients, with their therapist responding immediately in emergencies. The therapist physically travels to the patient for enrolled families. If a patient is not already enrolled in services through Community Connections, they would need to go to ARMC for emergencies.
- SEARHC
 - SEARHC offers a full array of mental health and substance abuse services to their beneficiaries as well as non-Native adults on the southern portion of POW.
 - Telebehavioral health service includes psychiatric service as well as continuing care.
 - SEARHC is currently trying to put some groups together for after care and higher levels of substance abuse service.
 - SEARHC does not currently provide psychiatric emergency service. This was formerly provided by COHO, but current grant funding does not provide adequate funding for SEARHC or other organizations to provide this service to the southern portion of POW.
 - SEARHC offers an emergency services crisis line, through a company in the lower 48. Crisis Line staff have local providers' contact information and can call them in an imminent situation. They also have a log that goes back to SEARHC with the permission of the client. SEARHC staff report usage has been good, with support primarily provided for suicide intervention. Phone lines are manned by master's level clinicians who go through an assessment on the phone. In emergencies with limited options, Crisis Line staff would contact the VPSO or police in the smaller communities. The next line of defense in the villages would be the medical staff. The type of response varies by location. Carolyn can get numbers about how often it's being used, and the number of calls from POW. Outreach about the Crisis Line is provided through PSA's, flyers, ads, etc. SEARHC representatives were not able to specify whether outreach was specific to each POW community.
 - Community members shared that they see potential for improvement in marketing and outreach of SEARHC's services available island-wide.
 - There is a misconception that services aren't available. Services have to be accessed on a voluntary basis by the people that need it. This is a catch 22 because providers need permission to outreach to the people that need services. Every job description in SEARHC programs has an element of outreach.
 - SEARHC currently has a prevention program related to substance abuse on POW, facilitated by Brenda Leask. That program also addresses suicide prevention.
 - SEARHC currently has 5 behavioral health focused positions on POW (2 master's level clinicians, 3 Community Family Service Workers); with an additional master's level clinician being recruited for Craig.
 - SEARHC is the primary provider of substance abuse treatment on southern POW.
 - SEARHC has several things in the works for telebehavioral groups, and is hoping there will be a good response, and that this will help with the fear of confidentiality.

- Residential treatment is available off-island.
- SEARHC currently has 3 people who are waiting to be assigned to providers. Once a client is assigned to a provider, there is currently not a waiting list for appointments. The standing waiting list evaporates every week. Typically people can get in within a week when they need an appointment.
- SEARHC and Sitka Counseling and Prevention Services have each approved a conceptual program and will further review the possibility of a joint venture to establish a Behavioral Health Crisis Stabilization Facility in Sitka. The facility would be capable of providing medical detoxification and mental health emergency respite services in a free-standing, specialized facility.
- Alaska Island Community Services
 - Alaska Island Community Services (AICS) provides the same ranges of services listed by other providers to the north end of POW. (Coffman Cove, Whale Pass, Naukati, Edna Bay, Port Protection, Point Baker)
 - There is some limitation in services based on the fact that they provide services itinerantly. They do not have a FT or designated position on-island. They try to visit all their communities every 2 months.
 - AICS provides services to those who formally register as clients through the AKAIMS system. They also provide informal counseling to those who don't want to formally register.
 - AICS provides behavioral health services concurrently with primary care and counseling sessions often remain informal. They are able to see a lot more people that way. Stats on AKAIMS may show AICS is serving 15-20, but the total may be twice as many when informal visits are included.
 - The itinerant clinician has regular clients and is also able to use a telemedicine connection to do counseling in between. Telemedicine is not worked out yet in Coffman Cove, but is planned for a new health clinic that is currently in the planning phase.
 - One challenge with telemedicine has been with equipment in that it is expensive, someone is needed to operate and understand it, and a secure location is needed from which to offer confidential services.
 - The facilities AICS uses are challenging in the different communities.
 - For outreach, AICS sends out a mailing to every resident before clinics are held, and starts a phone tree to let people know of upcoming services. They have also used signs and posters but that hasn't worked as well.
 - AICS handles emergencies by phone if they can. They will travel to the community if there is a need to and weather permits, though there has not been an instance where they've had to yet. Telemedicine will help. For substance abuse treatment, AICS has not been seeing a demand, but knows there is a problem. They have the capacity to provide Level I substance abuse services.
 - AICS has not been able to work out substance abuse services by telemedicine yet.
 - Education (Alcohol Drug Information School and Prime for Life) mostly goes to SEARHC. There are generally not enough people in the smaller communities to warrant a class.

- AICS is working on integrating primary care and behavioral health.
- AICS opened a pharmacy in Wrangell last year and will be making 340B discounted drugs available to patients. This means people on psychiatric meds will be able to get them at a discount. (they must be under the federal poverty level able to qualify)
- AICS will soon be enrolling their behavioral health clients in Wrangell and Petersburg in a wellness program that will track health indicators and encourage healthy lifestyles. They plan to look at how to roll this out on POW in the future.
- Gateway Center for Human Services
 - Gateway currently operates the KAR House in Ketchikan. It is a residential treatment facility. KAR House is a Level 3.5 facility. Patients receive intensive therapy, but medical services are not provided. There is a 90 day minimum requirement for the program, but patients may stay up to 180 days.
 - KAR House uses a therapeutic community model. Program participants are in charge of helping each other with their treatment and behavior, as opposed to the counselor being the one to point things out. This model encourages personal responsibility.
 - If a patient has been in contact with the justice system, sentence requirements must be completed before clients can access the KAR House program.
 - KAR House currently has 12 beds. There are currently vacant beds.
 - Clients are charged \$30/day, or \$2700 for 90 days. The collection rate is less than 40%.
 - Gateway has not had people from POW access KAR House services. They have had some people from POW seek counseling – this has mostly been those seeking couples therapy.
 - Gateway also offers Ambulatory Detox services – this is a walk in and walk out model. Vitals are taken by an LPN, the client gets meds they might need for the day, has a checkup with a substance abuse counselor, motivational interviews, and receives education on what to expect going into treatment. The client must not have medical complications and must not need residential services. Ambulatory detox is not appropriate if medical monitoring is needed. (Ketchikan General Hospital will take people who have medical conditions associated with withdrawal from drugs & alcohol)
 - Clients need to be assessed before they are admitted to the ambulatory detox program. They also need medical clearance. As long as the person has an assessment with ASAM 6 dimensions, they don't have to go to Gateway to get the assessment.
 - If a client is stable and in Ketchikan, Gateway can do the assessment. However, Gateway does not have a sobering center.
- Island Community Screening Services
 - Island Community Screening Services provides drug screening, including a 5 panel employee panel and comprehensive 10 panel screening. 25 panel screening is also available, as well as mouth swabs for those refusing UA.
 - John Borbridge is also a Prime for Life instructor; adult ADIS (Alcohol Drug Information School) provider, and is working on credentialing as a substance abuse professional.
 - Island Community Screening hopes to eventually partner with a non-profit to provide a broader spectrum of treatment services.

- Helping Ourselves Prevent Emergencies (HOPE)
 - HOPE provides Domestic Violence advocacy and some prevention education.
 - HOPE representatives participate in health fairs and other community activities.
 - HOPE is currently recruiting for a paid coordinator of volunteers and advocates.
 - HOPE has 2 places where they can place people who need safe housing on an as available basis. They will sometimes pay for a B&B if no free place is available.
 - The City of Craig provides office space for HOPE.
 - HOPE is currently preparing to apply for grants. They have non-profit status and an 8 member board that meets on a monthly basis.
 - HOPE is staffed with one ½ time paid on call person.
 - HOPE also refers clients to WISH in Ketchikan if the client wants to get off island.
 - HOPE offers referral to legal services.
 - HOPE has a severe need for volunteers.
- Hydaburg Cooperative Association (HCA)
 - HCA is the Tribal organization serving Hydaburg.
 - HCA provides housing, human services, and general assistance to their members. They also provide referral services for kids involved in domestic violence, healthy activities for kids and a culture camp every July.
 - HCA maintains a primary focus on kids. They hold game night, gym night, craft night, and a dance group.
 - HCA also helps their tribal members with housing, etc.
 - HCA also has a roads program and environmental programming and planning.
 - Through the ANTHC meals program, HCA provides a food bank.
 - For many kids in the community, if there is trouble in the home and OCS hasn't stepped in, HCA offers a safe place and healthy activities through a community network that includes family members and natural supports.
 - Hydaburg does not have a safe house in the community for victims of domestic violence. They would like to have a designated safe house and foster care. But no one has wanted to go through the process of setting that up.
 - If something happens to kids, they most likely go to a family member.
 - The community knows which homes are the safe places.
- Southeast Senior Services (SESS)
 - SESS has a gatekeeper program. There is a coordinator in Ketchikan, but the program isn't very well publicized.
- Whale Tail Pharmacy
 - Pharmacists at Whale Tail work closely with the home health nurse.
 - They are working on developing a formal drug disposal program.
 - Julie is working with the home health nurse to spot people who are not on top of refills, and where there may be compliance issues.
 - They are now providing medi-sets, where pills are filled out by the day for morning, afternoon, evening, etc. The Home Health Nurse has notice dramatic improvements with

this program. This is a time intensive program, but a tremendous help for elders and others who have to rely on relatives to help track their medications. Medi-sets can be filled by a pharmacist or a licensed medical professional.

- City of Kasaan
 - The tribe has funding from the Denali Commission for a new clinic, which includes space for a dentist, and room for behavioral health. Construction is slated to start this spring.

DISCUSSION POINTS AROUND SERVICES CURRENTLY AVAILABLE ON POW

- Demand v. need: The demand for services is not as strong as the need. The demand is voluntary. But the need is tremendous. The gap is that we don't have the net to pull them in.
- Community mindset: There is need to change the mindset of the community: What is a healthy way of life and how do you instill that in the individual?
- Location of service choices: It was mentioned that some people in need of services do not use those on-island and chose to go to other locations (such as lower 48) instead.
- Tele behavioral health: Specifically to the communities that AICS serves, the schools have a great system in place already, but the subsidy that allows it is for education. AICS's subsidy is for healthcare. Bureaucratic requirements to meld the two are extremely complex and it doesn't necessarily work. For example, using a school facility to see an adult has conflict, but the system could support providing care to a youth if it works with IEP and education plan. There are 2 federal systems operating in parallel. Do we have to build a 2nd system in a small community of 50 people? Community members recommended that AICS connect with SEISD to discuss further (Loren Birch).
- Critical mass: Some services require a critical mass in order to provide. The reality is that in some communities there will never be a critical mass to provide all services.
- Data Collection:
 - Many of AICS's clients are seen informally, but they don't have a way of tracking these informal clients. This is a problem from the state's perspective because they allocate funding for services based on the number of clients being served. The State and service providers need to work together on this. One possible way may be to capture them through emergency stats.
 - SEARCH has struggled with same issue for many years. Information is in AKAIMS but organizations can't fully report the numbers. Clients don't come to providers to fill out large amounts of paperwork, they come to talk. Providers can't say, "I'd like to talk, but first you have to fill out all this paperwork and answer all these intrusive questions."
 - Capturing informal encounters is critical to understanding the number of people being served. The state as a whole has a gap. This is a systems issue the State can take back and work on. Not capturing this information leads to inaccurate numbers about who is being served.
 - The amount of intake paperwork and data collection is a huge barrier in providing services and capturing data on services in rural communities. It also affects whether or not people feel services are approachable, comfortable, and accessible.

- This group as a coalition could make recommendation to the State based on this feedback.
- Integration of behavioral health with primary care:
 - The mountain of paperwork required for behavioral health services as compared to the paperwork required for primary care makes it difficult to integrate the two services. There are issues around accounting and performance based funding. It presents a significant barrier to people accepting services without feeling like they are being put through the wringer.
- Elders
 - When we talk about seniors, we need to look at drug disposal and monitoring of drugs in the community.
 - Elders and adults with disabilities are very underserved populations. The elder generation isn't used to coming forward with their problems and asking for help.
 - This population should be included in any types of programs/services we look at developing.
- Mobile Medical Van
 - A suggestion was made that a mobile medical van model might be an option for increasing accessibility of services, especially in remote locations.
- Veteran community
 - POW has a large number of veterans, and there is a group of veterans that are active in the community. Aaron Isaacs organizes the veterans' events. Paul Dawson is organizing veterans to form a VFW on the island.

REVIEW OF WHAT WORKED WELL: DAY ONE

- Description of services by providers.
- Networking and meeting new people.
- The process went well.
- Hearing about the different issues happening on an interpersonal level with clients – what works and what doesn't for getting people to care.
- Putting the level of services into perspective with the State matrix discussion – whether the levels of services on POW are atypical or not.
- Chocolate was good.
- It was really nice to have the State here – to see that they care enough to come and spend time and money to get here.
- Format and focus on individual programs and successes. Big group discussion is better than breakout groups.
- Good core group of people here with experience on the island.
- Being able to walk away with ideas how the State can play a role in improving service provision on the island.

JANUARY 27

Participants: Shelly Wade (Agnew::Beck), Beth McLaughlin (Agnew::Beck), Peter Rice (PeaceHealth, on phone), Colleen Watson (Craig Public Health, POW Health Network, HOPE), Keturah Sadler (POW Health Network, POW EMS Coordinator), Joe Burke (PeaceHealth), Kara McCoy (Craig Public Health), Mark Walker (Alaska Island Community Services), Diane Casto (State of Alaska Division of Behavioral Health Prevention & Early Intervention), Genevieve Casey (State of Alaska Division of Behavioral Health Prevention & Early Intervention), Ralph Mackie (Craig community member), Richard Nault (State of Alaska Division of Behavioral Health Treatment & Recovery), John Borbridge (Island Community Screening Services), Tia Holley (BSW student), Jacinda Broussard (BSW student), Julie McDonald (Whale Tail Pharmacy), Don Filmore (HOPE), Carolyn Lemmon (SEARHC), Bess Clark (Community Connections), Frances Natkong (Hydaburg Cooperative Association), Jerri Fowler (Hydaburg Cooperative Association), Esther Hammerschlag (POW Health Network), Sheila Beardsley (Craig High School), Father Perry (St. John's Catholic Church), Jon Bolling (City of Craig)

MEMORANDUM OF AGREEMENT (MOA) / STATE TREATMENT GRANTS

- The Memorandum of Agreement (MOA) between SEARHC, AICS and Community Connections was provided to participants for review and discussion.
- The MOA was created as an agreement between the three service providers serving the island at the time COHO closed in 2009, and designates which services each of the providers offers through funding received from the State of Alaska Behavioral Health Treatment grants.
- The MOA was meant to define how services on POW would be provided and which providers would be responsible for which communities on the island.
- The State Treatment grant is divided into priority populations to be served and is prioritized by the following populations/services: severely mentally ill adults, severely emotionally disturbed youth, substance abuse services, and emergency services.
- The MOA compartmentalizes by service, population served, and geographic area served.
- The MOA does not define how the 3 service providers should work together. There is not currently a concrete plan about this.
- The current MOA really came out of an emergency situation. Something had to happen immediately when COHO closed, and it was the starting place.

DISCUSSION OF CURRENT COLLABORATION BETWEEN PROVIDERS / CHALLENGES TO COLLABORATION

- POW had a major event happen with the closure of COHO. The three remaining providers had to come in and try to fill a major gap left in the service continuum. The community is moving through a period of transition, and needs to ask, "How do we answer a need for services with the resources we have?" It is going to take a while before the new system really gels, and we need to remember we are in the process of solidifying a new way of operating.
- Community Connections was already providing children's services on the island, but once COHO closed it was a large change for their organization to expand and respond to increased need.

- Emergency Services to the South end of POW
 - There is a gap in the MOA in that it does not identify who will provide psychiatric emergency services for the south end of the island.
 - SEARHC does not have qualified staff for evaluation of behavioral health emergencies. They collaborate with Craig Police after a patient has been cleared medically. Manpower and funding for emergency services is lacking. To adequately provide this service would require a staff person on call 24 hours/day, and the infrastructure required to manage that is tremendous. Burnout is tremendous.
 - Emergency services are a big issue that can't be resolved by simply saying yes I'd like to do that. On-island, we are doing well with what we have. The cooperation has been tremendous.
 - In emergency situations on the south side of POW, a person in Craig can be picked up by the Craig Police and held in jail under a Title 47 hold. If they are outside Craig, the State Troopers or Klawock Police respond. There is currently no other holding facility other than the Craig jail and sometimes the emergency area at ARMC. It is not in the scope of ARMC's practice, and although they are not equipped to do these sorts of holds, they will hold people. These types of things don't show up in the MOA because they are not in the scope of service.
 - SEARHC also helps with paperwork and referrals for people who need to be transported off-island. There is definitely room for more clarification between providers about paperwork and referrals.
 - The issue around psychiatric emergencies is somewhat related to medical emergencies. When ARMC received Frontier Extended Stay Clinic designation/funding and received a grant to develop a bed for patients to stay overnight, they were equipped with a facility to take on medical emergencies. But how are psychiatric emergencies going to be funded? This gets mixed up in the logistics of ex partes and psychiatric emergencies if you don't have a designated holding facility. Age, transportation, who has the capacity to evaluate, etc. all are affecting factors.
 - If people need to be escorted to Ketchikan or other places around the state, the escort will often be whoever can go or will go. Sometimes a relative or friend can be found. Sometimes this is local police, but then there is the issue of money to pay for overtime/salaries. There is also a state contract with Goldbelt in Ketchikan to provide escorts.
 - PeaceHealth/Ketchikan General Hospital has 2 psychiatrists and hold rooms for psychiatric emergencies. Providers on POW have to determine whether patients are a risk to themselves or others.
 - A big challenge is how to transport people on and off island. The expense is about \$32,000 to Medevac people from POW to Ketchikan. The Klawock airport has gotten lights, but there are still upgrades that could make it better.
 - The group would like to see PeaceHealth more active in the discussion about emergency services on POW.

- There are different interpretations between Craig Police Department and ARMC as far as where ex partes should go. If someone shows indication of needing medical services, Craig Police wants to send them to a medical provider. But the medical provider sees them as needing to be secured. So, there is a conflict on who is responsible. One thing we could work on in the near term is to figure out how to modify Craig's contract with the Department of Corrections so that the protocol is better defined.
- POW Interagency Group: This is a group of providers and other community member that gets together regularly to discuss local events. Each meeting varies depending who is there. The group has been more informational than action oriented in the past, but perhaps can formalize to become more action oriented.
- Much collaboration between providers to date has been informal, but this strategic planning meeting is a good step towards increased collaboration in the future.

STRATEGIC PLANNING

DEFINITIONS TO GUIDE DISCUSSION:

- Goal: What long term improvements and changes do we want to see or achieve?
- Objective: What do we hope to accomplish or impact with our goal? What will be the measurable change? What is our 3 year target?
- Strategy: How will we achieve our objective? What are the ways we can make progress towards our objectives and goals?

PRELIMINARY GOALS:

The following preliminary goals were presented based on the first day's discussion for review, refinement and further discussion:

1. Improve communication and collaboration between and among service providers and stakeholders
 - All other goals hinge on this one.
2. Increase awareness of existing programs, services and resources
 - Agencies need to sit down and talk about what they are really good at and build on existing strengths in communities.
3. Improve data collection and reporting mechanisms (**note that during later discussion, this goal was eliminated as a separate goal, and instead incorporated into goal #5 below: Increase access to services)
 - Issues around data collection and the AKAIMS system do not just exist on POW. The State needs to be a partner to tackle this.
 - AKAIMS is one piece of the treatment world. There are also gaps in data from public safety officials, such as reports of interpersonal violence. We need to perform a broader review of how we can get data for the whole island. YRBS data, Public Health data, and community surveys were all given as examples.

4. Improve response to behavioral health emergencies
5. Increase access to services
6. Prevent interpersonal violence and promote healthy lifestyles
7. Expand Services (Added as an additional goal during group discussion)

CRITERIA FOR GENERATING AND PRIORITIZING STRATEGIES FOR EACH GOAL:

- Can it be implemented on local level?
- Are we already doing this? If so, is it effective and how can we collaborate to enhance efforts?
- Is the strategy specific? Can we measure it?
- Is there a likely person or organization to work on this strategy? Can collaboration occur?
- Does it fit within our 3 year planning timeframe?
- Is there leadership?
- Does it have broad impact?
- What resources are available to do it? Is it an efficient use of dollars/resources?

DEVELOPMENT OF OBJECTIVES & STRATEGIES USED TO ACHIEVE GOALS:

Participants worked together to begin developing objectives, strategies and action steps for each goal. Due to the limited timeframe, not all objectives and strategies were defined. The plan will be further refined when the coalition meets next. (**Note that numbers in superscript reference discussion points summarized at the end of this section)

Goal 1: Improve Communication and Collaboration between and among Service Providers and Stakeholders

Objective: Coalition meets in-person every 4 months ⁽¹⁾

Strategies:

- Form a coalition.
- Establish communication protocol.
- Evaluate and promote cultural and subcultural relevance in BH planning.

Goal 2: Increase Awareness of Existing Programs, Services and Resources

Objective:

Strategies:

- A POW Resource Guide is being developed by the POW Health Network. Keep this updated.
- Market strengths of various providers serving island/Develop marketing strategy for resources on island.
 - Action: Identify appropriate tools – i.e. newsletter. What are the most appropriate ways of getting information out?
 - Action: Survey community members on most effective ways to spread information.
 - Connect with the 211 system.

- Inventory local resources on the island. A lot of resources on the island are un-tapped.

Goal 3: Improve Response to Behavioral Health Emergencies

Objective:

Strategies:

- Define procedure for who takes responsibility for patients in BH emergencies (police v. medical staff)
- Coordinate with state on options for improving BH emergency system.
- Define responsibility for assessment of BH emergency patients (24/7), keeping in mind that that currently no entity on the south end of POW is responsible for emergencies in the MOA. ⁽²⁾

Goal 4: Increase Access and Quality of Services

Objective: Increase number of behavioral health consumers seen by 10%

Strategies:

- Improve referral coordination systems between providers. ⁽³⁾
- Improve information sharing between providers. (specific to clients)
- Use community members as associate mental health clinicians to extend clinical services. (i.e. State's Rural Human Services and Behavioral Health Aid programs)
- Improve data collection and reporting mechanisms by working in partnership with the State to review current intake mechanisms. ⁽⁴⁾

Goal 5: Prevent interpersonal violence and promote healthy lifestyles

Objective:

Strategies:

- Develop provider knowledge of techniques for intervention.
- Offer Green Dot/Strengthening Families programs to POW community.
- Develop organizational capacity of HOPE.
- Utilize traditional methods to maintain healthy lifestyles, including acknowledging intergenerational trauma, addressing cultural loss and how re-engaging the young people. ⁽⁵⁾
- Build Tribal capacity to build on existing cultural practices/programs that build/promote/help to maintain healthy lifestyles. ⁽⁶⁾

Goal 6: Expand Services

Objective:

Strategies:

- Provide intensive outpatient substance abuse services. ⁽⁷⁾
- Provide youth substance abuse services. ⁽⁸⁾
- Evaluate on-island capacity to provide detox services.

- Clarify policies and procedures for the Department of Corrections and medical services for people with behavioral health issues at the Craig jail.
- Identify options related to the establishment of a crisis respite facility. ⁽⁹⁾
- Partner with Gateway in Ketchikan to offer a higher level of detox service.
- Provide telemedicine services to the north end of the island.
- Determine and work with requirements for using school facilities to offer behavioral health services.
- Provide aftercare.

Notes on Discussion Points Specific to Strategies

⁽¹⁾ Coalition meeting frequency: Further discussion needs to occur about how often the coalition will meet (anywhere from every 1-4 months)

⁽²⁾ Responsibility for assessment in behavioral health emergencies: Emergency Services must be addressed. The current situation contributes to burnout, especially when 1 or 2 people are solely responsible. If SEARHC were to provide this service, they would need to hire more staff which creates a cost issue. At the time the MOA was signed, SEARHC did not feel there would be enough funds available to provide emergency services. The State is preparing for the next grant cycle, so the timing to work on this issue is perfect.

⁽³⁾ Referral Coordination: When patients are transferred, there are issues with prescriptions and medical records in general.

⁽⁴⁾ State data collection: The amount of paperwork is a barrier to patients accessing services, and also takes a great deal of time for the providers and administrative staff. This also impacts the ability to integrate behavioral health services with primary care, as there is much more paperwork required for behavioral health than for primary care. The momentum has been towards more data, not less, and the system needs to be more user friendly. However, a lot of the funding for behavioral health is data driven, so we need the numbers. The state wants to have the data to look at, "What did you do, how did you do it, and is anyone better off?"

⁽⁵⁾ Utilizing traditional methods to maintain healthy lifestyles: This gets back at culture camps, etc. Often people say "that's what we do in Alaska" but they don't actually follow through on the desire to be culturally appropriate.

⁽⁶⁾ Building Tribal capacity to build on existing programs: We should build on what's already working, such as Culture Camps. We need to start with the kids. Hydaburg's Culture Camp has been very successful. CCA makes a donation to culture camp, as does Klawock IRA. Kasaan is also stepping up with donations and staff. Culture camp is promoted really well across the island, which has also allowed it to be successful.

⁽⁷⁾ Intensive outpatient substance abuse services: This is one step below residential treatment, and usually consists of 4 days/week, 2 ½ hrs minimum, and a weekly individual meeting. Programs are usually 12 weeks in length, very intensive, and an option as opposed to residential treatment. This works if the patient has the needed support locally and they want to stay in the community. It allows people who are working locally and/or have families to stay in town. An organization needs at least 2 counselors to provide this service. There is an understanding that if the patient relapses they have to go to residential treatment.

⁽⁸⁾ Youth substance abuse services: Pete Ryan is now certified to provide youth SA services, but there is a credentialing issue with the state. Bess Clark will be working on that with Richard Nault. This would be for the south end of POW. AICS could provide this service to the north end on itinerant basis, but needs to work out ADIS to provide telemedicine. In urban areas this service is typically provided as a group service. It is most effective if it can be done that way.

⁽⁹⁾ Establishment of a crisis respite facility: Discussed the possibility of creating a respite/holding facility for people that are in psychiatric emergencies until they can get to Ketchikan that is not in a jail, but somewhere else that can keep them safe. Possible funding opportunities were discussed. The State reported that the fact that the community has gone through this planning process will open up opportunities for funding.

FORMATION OF THE COALITION

- A suggestion was made that there should be the ability to call a quorum for members of coalition.
- The frequency the coalition will meet needs further discussion. A lot of time and resources are needed to bring people together, yet we also need to make sure the coalition meets frequently enough. Every month, and every 4 months were both suggested.
- The coalition may be able to get technical assistance from Agnew Beck through their technical assistance contract with the Mental Health Trust.
- It is difficult to set some of these goals and objectives without having an idea of what the coalition will look like. We need to define who's on it and who needs to travel to help determine frequency. We're relying on the coalition to improve the coalition. We're making an assumption all parties are represented.
- We would like to have people from out of town at all the meetings. But that also shouldn't keep us from having the meetings. Rather than relying on the outside, we also need to look within our own community and rely on community members.
- We need to consider where people are getting their information from.
- There is a lot of work to do. Some of this will be done by the large coalition, and some can be done by smaller groups within the coalition.
- We need to define values we want to bring to the table for all of this. (i.e. native traditions and cultural humility)

- We will see very different communities depending which village we are talking about – i.e. Kasaan v. Edna Bay.
- We need to maintain awareness of sub-cultures. i.e. sub culture in Craig High School. This should also be kept in mind as we discuss who should be a part of the coalition. This helps us develop the right marketing tools and appropriate programs.

NEXT STEPS

- Agnew Beck will put the draft strategic plan together and it will be included with the needs assessment in a final report.
- The draft strategic plan will be shared for feedback.
- Form the coalition/BH Advisory Committee.
- Prioritize strategies.
- Decide who will take the lead on each of the strategies and further define the individual steps.

FINAL THOUGHTS/DISCUSSION

- The role of the coalition and the POW Health Network and how they will interface was discussed. It will be important not to have too many groups and/or meetings to avoid burnout. The coalition needs more island providers and community members.
- There is a lot of serendipity with timing and coordination of efforts.
- Shelly will send a survey monkey to provide meeting feedback.
- The transparency of providers was appreciated.
- It was nice to be corralled and have Agnew Beck's direction.
- Support from the State of Alaska has been appreciated.
- The State appreciates being welcomed into our community, and talks about the good work we are doing all the time.
- The students appreciated being here, and we appreciated their courage to come.
- Thanks for the chocolate.
- DBH prevention has 2 RFP's coming out in next couple weeks. The Comprehensive Prevention and Early Intervention RFP will have 2 categories:
 - Building capacity – requirements are much simpler.
 - Implementation (Diane Casto would like to see the 4 tribes getting together)
 - The State is requiring groups to come together as coalitions, not individual entities. Coalitions can be formal or informal. You cannot just have an MOA.
- The SPF SIG grant: There will be 6 grants awarded for community and systems change. They will be addressing youth alcohol use and adult heavy and binge drinking, and the following 5 consequences – interpersonal violence, suicide, alcohol related crashes, minor consuming, alcohol related deaths.
- The State is really starting to move away from single agency funding streams and looking at if we are going to make change in any community, we must have people not just dividing up services, but actually coordinating services. They are moving towards funding collaborations and

coalitions rather than single agencies. This is a new approach. They have also been trying to work towards making sure the whole continuum of care is being addressed.

- Membership forms for HOPE were available.
- Thank you from Shelly & Beth for everyone's commitment and enthusiasm. It was fun and an honor. Also thanks everyone for your patience as Shelly pushed us.