ALASKA HOSPITAL AND HEALTHCARE ASSOCIATION

Child and Adolescent Behavioral Healthcare Improvement Project

Report and Recommendations for Positive Change Across the Continuum: **Outcomes Summary**

December 2022

Trust
Alaska Mental Health Trust Authority

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

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Project Overview

Gaps in the behavioral health continuum of care for Alaskans of all ages are significant. These gaps contribute to individuals seeking care in hospital emergency departments. Increasing concerns from Alaska Hospital and Healthcare Association (AHHA) members regarding the number and complexity of children and youth presenting to hospital emergency departments and inpatient settings led AHHA to request funding from the Alaska Mental Health Trust Authority (the Trust) to develop a set of recommendations and actionable workplan to improve acute behavioral health services specific to children and adolescents and address gaps and delays across the continuum of care.

Process

AHHA sought input from a stakeholder workgroup to develop recommendations to support system change so children and adolescents receive proper treatment in the appropriate locations and to reduce the need for acute and intensive services. The stakeholder workgroup convened five times beginning in March 2022, culminating in workplan development and strategy prioritization sessions in September and November 2022. In addition to the five workgroups, this project sought input from representatives from key sectors or service delivery areas in focus groups and ten provider interviews to further explore the strengths, gaps, and barriers in their settings for children and adolescents experiencing a behavioral health crisis.

Incorporating the voices of families with lived experience in accessing behavioral health crisis care in the current system was also identified as a priority for the project. Four individuals with lived experience were interviewed four interviews with lived experience with additional informal conversations with two families with lived experience.

Key Findings

Data from the State of Alaska's Health Facilities Data Reporting (HFDR) program provides a numerical understanding of the volume, characteristics and support needs of children and adolescents ages 0 – 17 presenting to hospitals for behavioral health needs. Data was gathered for calendar years 2019, 2020, and 2021. Results from 2021 are provisional.

- In 2021, there were **2,273 treatment episodes** for children and adolescents with a behavioral health diagnosis at hospital emergency departments (EDs). An additional **613 treatment episodes** occurred in hospital inpatient units.
- Of all 2021 treatment episodes, **25% of ED visits and 24% of hospital inpatient visits had a discharge diagnosis of suicidal ideation**. ED visits with suicidal ideation as a discharge diagnosis increased 6% over prior years, while inpatient visits with this diagnosis decreased 3%.
- Children and adolescents with a behavioral health diagnosis **stay longer** in EDs and inpatient units than their non-behavioral health counterparts and **lengths of stay are increasing**.
- **Most** children and adolescents with a behavioral health diagnosis **discharge to home/self-care** from EDs and hospital inpatient units.

State Context: Concern for the Well-being of Alaska's Children and Adolescents

Behavioral health needs and outcomes are closely intertwined with social determinants of health and Alaska struggles to meet the basic needs of youth within home and community settings. In 2022, Alaska ranked 41st out of 50 states for overall child well-being.[1] The state ranked 44th in Economic Well-being, 49th in Education, 44th in Health, and 22nd in Family and Community domains. [1] Among parents and guardians, 50% or more reported concern about obtaining needed items, health care and paying bills.[2] The COVID-19 pandemic brought a great deal of attention and resources to address these social determinants of health but meeting these needs in a timely manner is challenged by organizational capacities.

Youth with involvement from the Office of Children's Services (OCS) are at increased risk of having unmet needs. Alaska has a high rate of youth maltreatment, with 11.9 per 1000 first-time youth victims- more than twice the national average.[3] Alaska youth identified in an OCS report face an average investigation response of 576 hours, and an average of 78 days from the time of the initial report to receiving some service, whether foster care, counseling, or family preservation. These averages far exceed national averages of only 62 hours for response times and 33 days for service initiation.[3] Even youth with unsubstantiated reports, but perhaps still at increased risk, were five times less likely than peers nationwide to receive some form of post-response service.[3] Once in OCS custody, Alaska youth faced a 21% decrease availability of non-specific foster homes since 2017, with older youth at greater risk of delayed placements in stable environments.[4] These statistics on statewide challenges to social determinants of health and OCS service challenges begin to build an understanding of why 85% of children receiving residential psychiatric treatment or acute services have had one or more allegations of abuse.[5]

Even pre-pandemic, youth demonstrated long-term trends of increasing behavioral health risk factors including increasing feelings of hopelessness, considering suicide, or even attempting suicide.[6] Connection and resilience measures to protect against these risks remain stagnant or even decreasing. Alaska's youth show trends that they don't feel more comfortable seeking help from adults, aren't feeling connected, and don't feel like they matter to their community.[6] Alaska's youth face challenges at all levels of behavioral health risk and resilience factors.

Figure 1: Alaska Youth Risk Behavior Survey hopelessness and suicide measures

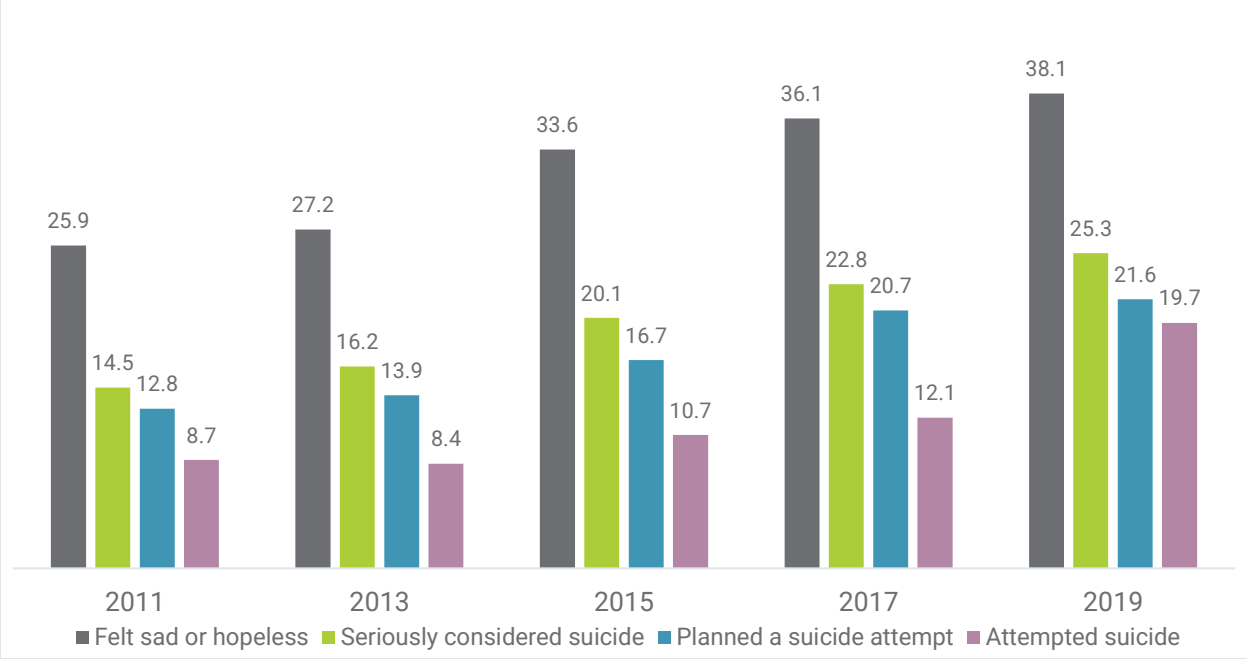
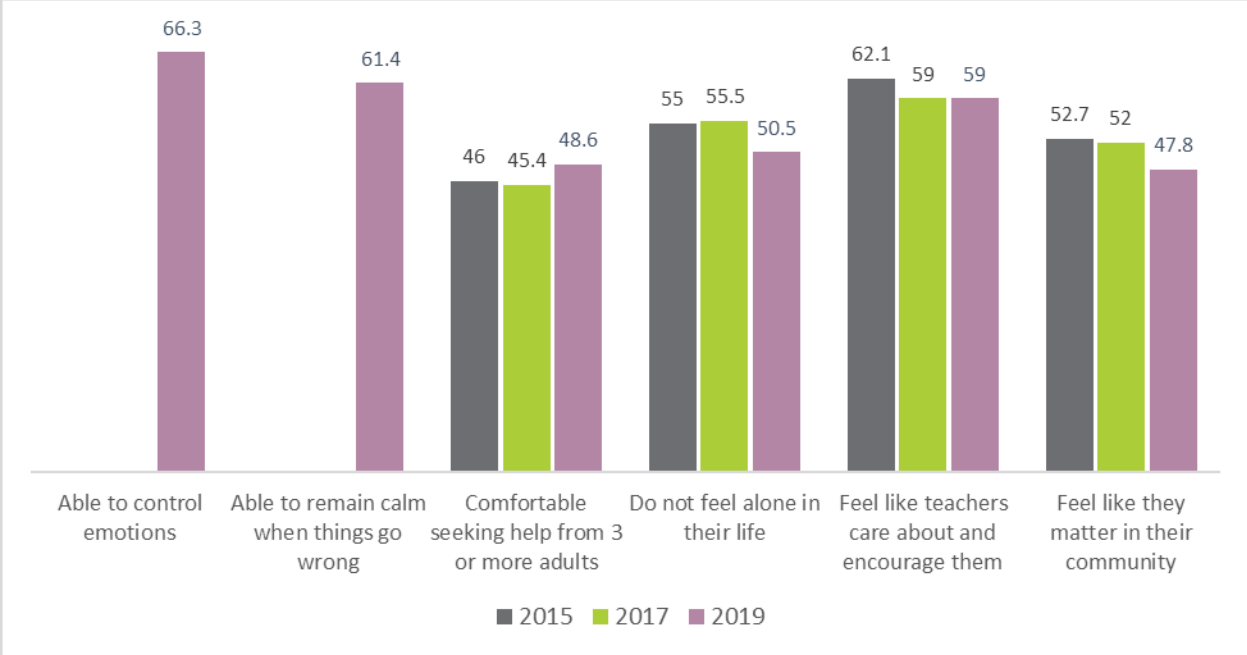


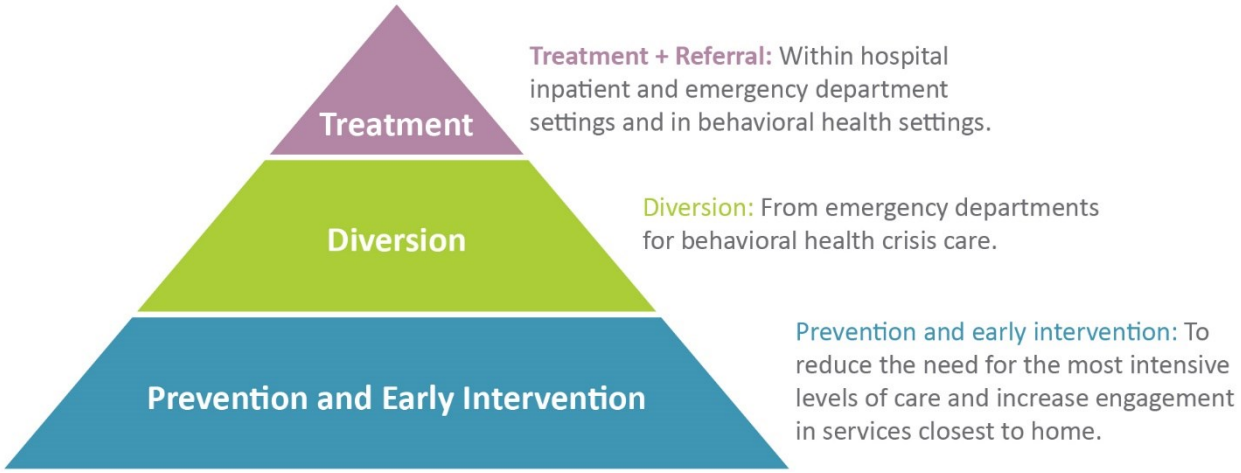
Figure 2: Alaska Youth Risk Behavior Survey connection and resilience-related measures



Finding Solutions

Opportunities for preventing and reducing extended stays in emergency departments for children and adolescents with behavioral health needs were identified across each of the three key system change areas (Figure 3). Bolstering prevention and early intervention will reduce the need for the most intensive levels of care and increase engagement in services closest to home. Diversion from emergency departments for behavioral health crisis care will reduce ED volume for this type of care while meeting the immediate needs of children, adolescents, and their families. Improving the care provided to children and youth in emergency department and inpatient settings and the system of care for ongoing treatment will provide better care and greater connectivity to appropriate treatment options.

Figure 3: System Change Areas



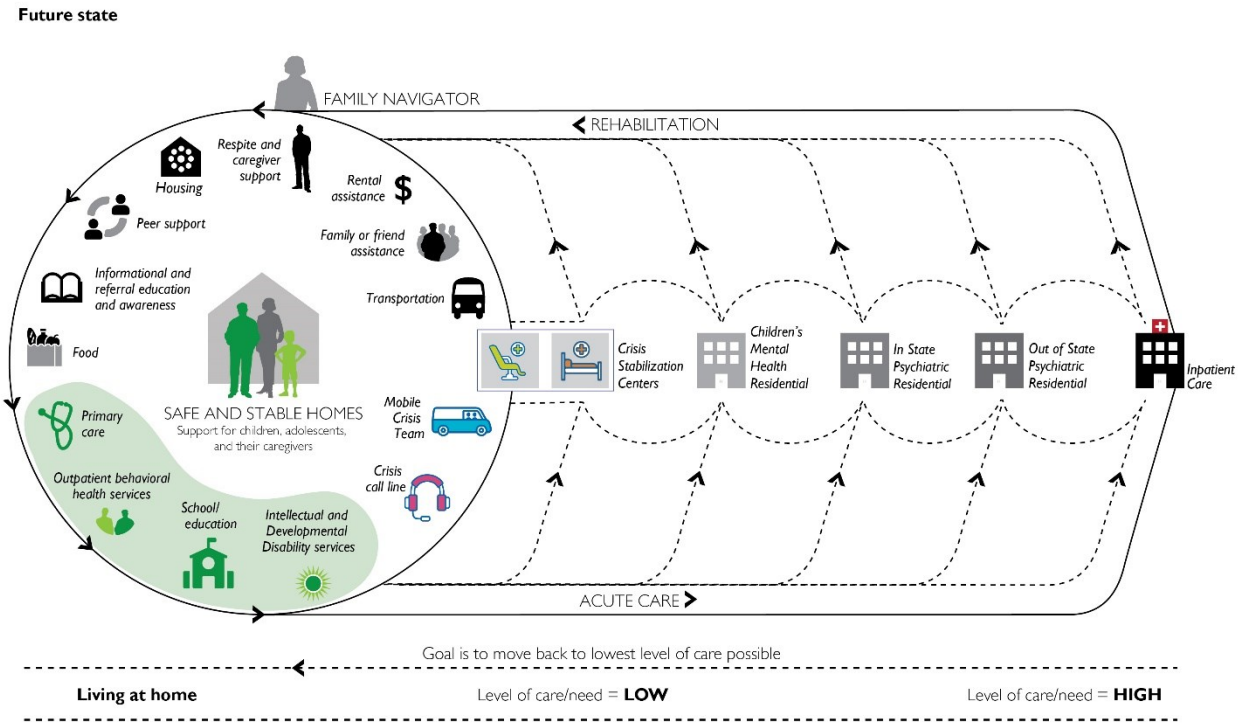
Building the Continuum

Stakeholders envision a continuum of care where children and adolescents can move easily between levels of service intensity and where all levels of care are available. The graphic of the future state of the continuum of care (Figure 4) builds on the current continuum and adds key components:

- Linkages between primary physical health care and behavioral health, schools, and IDD-specific programs
- Family navigators to help find, access and engage in appropriate services, and
- A robust continuum of behavioral health crisis services

Additional priorities identified by stakeholders include to increase access to basic resources, respite care, and specialized residential settings or group homes. These priorities and components are further detailed in the implementation workplan.

Figure 4: Continuum of Care, future state



Implementation Workplan

The workplan is organized by three key strategy areas and considers interventions across the continuum. The final workplan (Figure 5) is organized by strategy area (numbered items) and objectives (lettered items). The top four prioritized objectives are noted in bold. The full workplan (**Error! Reference source not found.**) includes action items under each objective, with the proposed timeline, funding sources and resource needs associated with each. The workplan is intended to be a living document and it is expected that action items and implementation supports will change over time. AHHA, in conjunction with members and partners, will continue to update the workplan and use it to guide implementation.

Figure 5. Adolescent Acute Behavioral Healthcare Improvement Project Workplan

Bolded objectives were identified by the workgroup as the highest priority within each strategy area.

1. Prevention, Early Intervention, and Diversion
A. Make behavioral health crisis care for children and youth widely available.
B. Increase immediate access to outpatient care for Medicaid enrollees.
C. Increase support for families to meet basic needs: housing, food, transportation.
2. Behavioral Health Care in Emergency Departments and Inpatient Settings
A. Increase the number of behavioral health beds in locations around the state; allow billing for BH clinicians in hospitals.
B. Develop designated case conferencing support to fast-track coordination, decision-making, and placement for children and adolescents held in EDs and inpatient units for longer than 24 hours and awaiting a discharge option.
C. Increase access to family navigators and peer supports in hospital and emergency department settings.
D. Implement health information exchange to allow patient record sharing and referrals between hospitals and behavioral health care settings.
3. Treatment and Access Points for Discharge
A. Increase parity between physical and behavioral health services by removing barriers to accessing behavioral health care, reducing administrative burden associated with billing Medicaid for behavioral health services, making it easier for Medicaid enrollees to be assessed for behavioral health care, and making it easier for behavioral health providers to serve clients enrolled in Medicaid.
B. Increase the number of specialized residential facilities or group homes for younger children and children and youth with complex needs, in regions around the state; including locked Level 6 beds.
C. Increase targeted wraparound services and care coordination for children and families with complex care needs.

Prevention, Early Intervention, and Diversion

Strengthening Alaska's continuum of behavioral health services for children, youth, and their families includes reducing the need for the most intensive levels of care by increasing engagement in the least restrictive settings. This involves investment in a range of strategies to prevent, intervene early, and divert youth from the ED and highest-level behavioral health settings. The objectives identified under this strategy area are:

1. Make behavioral health crisis care widely available.
2. Increase immediate access to assessment and outpatient behavioral health care for Medicaid enrollees.
3. Increase support for families to meet basic needs: housing, food, and transportation.

Health Facilities Data Reporting (HFDR) data analysis revealed that 60% of youth with a behavioral health diagnosis have Medicaid identified as their payer source. Stakeholder discussion and internet research indicate very few behavioral health clinicians in private practice accept Medicaid, and

hospital- or community-based programs are at maximum capacity due to staffing shortages. Alaska children without private payer insurance appear to be at greater risk of requiring inpatient or other out-of-home care for behavioral health needs due to limited access to lower levels of care.

> "We had Bring the Kids Home. We now need 'Keep the Kids out of Hospitals' and grant funding to support that."
>
> *~ Residential provider focus group participant*

The stakeholder group identified "**increase immediate access to assessment and outpatient behavioral health care for Medicaid enrollees"** as their top priority for Prevention, Early Intervention, and Diversion. The workplan details 12 action items under this objective to support or develop increased access. The 12 action items fall broadly into the following categories:

- *Expand availability of behavioral health services in schools.* Momentum is building in Alaska to increase access to behavioral health care in schools. Expanding client eligibility for Medicaid School-based Services (allowed under the 2014 CMS free care rule reversal) to include all students, as recommended in the 2021 PCG report, is one way to increase access. Providing clear guidance on the delivery of and billing for behavioral health services in schools to schools and providers will support expansion of services under currently available billing mechanisms. Central to working towards expansion is collecting input from Alaska providers and national experts and developing a network of schools and providers to support shared learning in this area.
    - *Key partners:* State of Alaska Divisions and Departments: Division of Behavioral Health, Division of Public Health, Health Care Services, Department of Education and Early Development, school districts, behavioral health providers.
- *Expand and support integration of behavioral health in primary care settings.* Primary care clinics, Federally Qualified Health Centers, and pediatric medical practices are natural partners in providing primary behavioral health care. Outreach to these providers with training and technical assistance regarding provision of behavioral health care in their settings and connectivity to existing resources such as Help Me Grow-Alaska and PAL-PAK is a critical component of increased access to outpatient behavioral health care.
    - *Key partners:* Alaska Primary Care Association, All Alaska Pediatric Partnership, Alaska Divisions and Departments: Division of Behavioral Health, Health Care Services, Tribal Health Organizations, Alaska Native Tribal Health Consortium CHA-P and BHA programs.
- *Support connectivity to existing resources.* The system to identify and refer individuals to outpatient behavioral health care is fragmented and requires phone calls to multiple agencies. Streamlining the process by using a universally accepted platform that is regularly updated with the availability of assessment and treatment will save providers time and provide a better picture of system capacity. The Department of Health, Division of Public Health released a Request for Information in November 2022 to identify vendors capable of developing and implementing a statewide behavioral health capacity and referral network

platform. Selection of a vendor, and universal use of the identified vendor, is critical to addressing connectivity gaps.

A recent DBH survey showed that hospitals with established relationships with an outpatient behavioral health provider decreased wait times for assessment and follow-on care after a crisis.[7] Identifying and working with hospitals that do not have that established relationship is another actionable step that can be taken to connect individuals in crisis to services as quickly as possible.

    - *Key partners:* Alaska Behavioral Health Association, behavioral health providers, Alaska Divisions and Departments: Division of Behavioral Health, State of Alaska contracted Treatment Referral Network provider
- *Maximize use of available workforce.* Recent changes to expand eligible provider types at FQHCs to include LPCs and LMFTs is one example of how the State of Alaska can and is supporting the expansion of behavioral health services to Medicaid-eligible individuals. At the federal level, CMS has proposed changes to incentivize the integration of psychologists and social workers into primary care settings. Locally, identifying and supporting community behavioral health providers to engage with the independent provider community to increase capacity is another opportunity to ensure our existing workforce is available equitably across payer sources.
    - *Key partners:* Independent provider associations, behavioral health organizations, Alaska Divisions and Departments: Division of Behavioral Health, Health Care Services

Next Steps: Convene identified partners in each of the action item categories described above to share project findings and recommendations, identify alignment with existing initiatives and clarify roles, responsibilities and resources needed to move forward.

Behavioral Health Care in Emergency Departments and Inpatient Settings

Until a robust continuum is built statewide, and perhaps even then, hospital emergency departments and inpatient units around the state are likely to continue to see children and youth experiencing a behavioral health crisis. Thus, strengthening Alaska's continuum of behavioral health services for children, youth, and their families includes increasing the capacity of hospitals to provide treatment and wrap-around supports for behavioral health patients, either internally or in partnership with external organizations. The objectives identified under this strategy area are:

1. Increase the number of behavioral health beds in locations around the state; allow billing for behavioral health clinicians in hospitals.
2. Develop designated case conferencing support to fast-track coordination, decision-making, and placement for children and adolescents held in EDs and inpatient units for longer than 24 hours and awaiting a discharge option.
3. Increase access to family navigators and peer supports in hospital and emergency department settings.
4. Implement health information exchange (HIE) and a referral platform to allow patient record sharing and referrals between hospitals and behavioral health care settings.

Workgroup participants note that it is often the most complex, traumatized youth who are left in EDs and hospital settings because there is nowhere else for them to go. Children and youth in OCS custody are particularly vulnerable to experiencing psychiatric boarding in EDs or prolonged inpatient length of stay due to limited discharge options for treatment or foster placement settings.

The stakeholder group selected **"increase the number of behavioral health inpatient beds in locations around the state; allow billing for BH clinicians in hospitals"** as its number one priority for Behavioral Health Care in Emergency Departments and Inpatient settings. Increasing both bed capacity and the ability for behavioral health clinicians to concurrently bill on inpatient units will improve meeting holistic patient care needs during admissions. Increased behavioral health staff presence could reduce the strain on inpatient medical staff who are currently tasked with supporting the behavioral health needs of children and youth despite limited training and resources. The workplan identifies five action items under this objective that fall broadly into three categories:

- *Assess:* Conduct regional assessments to understand the demand for behavioral health crisis and inpatient services. The assessment should include identification of existing capacity, services, and resources needed to grow capacity to meet regional demand.
- *Plan:* Identify pathways for Tribally-operated hospitals, Critical Access Hospitals and general acute care hospitals to bill for behavioral health services provided, either internally or in partnership with community organizations. Advocate for changes to address barriers to billing.
- *Implement:* Provide hospitals with funding, technical assistance, and training to increase behavioral health service provision within the hospital or in partnership with Community Behavioral Health providers.

Alaska has long sought to increase inpatient treatment options closest to an individual's home community. However, existing Designated Evaluation and Treatment (DET) programs are only available to adults, meaning that all children and adolescents outside of Anchorage must leave their home community or region for this level of care. Stakeholders express desire to reimagine existing resources in communities around the state to better meet the needs of children and adolescents with acute behavioral health needs.

Next Steps: Identify funding to support assessment and planning phases as described above.

Treatment and Access Points for Discharge

Youth and their families with behavioral health needs require treatment options and discharge access points that provide help and do not create or contribute to harm. There are statewide shortages for youth access to behavioral health treatment, community-based, and out-of-home services. Participant consensus is that very few private practice behavioral health providers accept Medicaid, reducing behavioral health access for a significant number of children, youth and their families. Addressing these deficits requires system-level changes to improve Medicaid parity for behavioral health services, reducing administrative burden associated with billing Medicaid, and increasing the availability of services for children and youth with complex care needs. The objectives identified under this strategy area are:

1. Increase parity between physical and behavioral health services by removing barriers to access, reducing administrative burden associated with billing Medicaid for behavioral health services, making it easier for Medicaid enrollees to be assessed for behavioral health care, and making it easier for behavioral health providers to serve clients enrolled in Medicaid.
2. Increase the number of specialized residential facilities or group homes for younger children and children and youth with complex needs in regions around the state, including locked Level 6 beds.
3. Increase targeted wraparound services and care coordination for children and families with complex needs.

Alaska currently has minimal infrastructure for youth with complex needs or co-occurring conditions. Despite the increased need for higher level out-of-home care, overall capacity remains stagnant or has decreased, and many youth with complex needs end up in out-of-state programs or even in correctional facilities. Families must frequently navigate Alaska's fragmented behavioral health system on their own, and often face rigid community or at-home treatment services that are not able to adapt to their unique family needs. Alaska communities are diverse with unique histories, cultures, languages, and community norms. When children and youth must leave their communities to receive care, it is more difficult for their families to participate in care, and other community supports and resources are more difficult to engage.

Stakeholders identified both **"increase the number of specialized residential facilities or group homes for younger children and children and youth with complex needs, in regions around the state; including locked Level 6 beds"** and "**increase targeted wraparound services and care coordination for children and families with complex care needs"** as tied top objectives for this strategy area. However, given that all three priorities were very close, and that the first objective received the most votes in the first round of prioritization, all three are included for further discussion in this report.

Objective 1: Increase parity and reduce administrative burden

The workplan details 20 action items under this objective, more than any other in the plan. The intertwined issues of parity in payment and documentation between physical and behavioral health services and the associated administrative burden underlies and exacerbates challenges across the behavioral health continuum of care. The action items fall broadly into the categories of reducing system complexity and administrative burden, rates, and workforce.

Billing for behavioral health in Alaska is complex and there are many models, each with its own rules regarding settings, services, documentation, facilities, and workforce. The existing complexity is compounded by the lack of tools and forms to help organizations navigate the differences, choose the model that is best for them, and implement programs and services aligned with that model. Parity of rates within Medicaid, between behavioral health and physical health, and between commercial payers and Medicaid, are also issues to be addressed.

- *Key partners:* Alaska Behavioral Health Association, Alaska Mental Health Trust Authority, State of Alaska Division of Behavioral Health and Health Care Services, Department of Labor and Workforce Development, Alaska Hospital and Nursing Home Association, Tribal Health Organizations.

Next Steps: Convene meetings with key partners to identify work already underway in the identified areas, appropriate leads for further efforts, and how to prioritize changes.

Objective 2: Increase specialized residential facilities and group homes

The three action items under this objective will help develop specialized residential facilities and group homes. The first step is to convene key stakeholders to identify the changes needed to develop more specialized residential facilities. Once needed changes are identified and agreed upon, new regulations and payment rates are likely needed. Finally, providers will likely need technical assistance, capital, and start-up operational funds to design and implement new programs.

- *Key partners:* Alaska Behavioral Health Association, Alaska Mental Health Trust Authority, State of Alaska Department of Health, Department of Family and Community Services and Department of Law, Tribal Health Organizations.

Next Steps: Convene providers and State of Alaska stakeholders to identify barriers and solutions related to the design and implementation of specialized and locked residential treatment facilities.

Objective 3: Increase targeted wraparound services and care coordination

There are four identified action items under this objective. Action items include making changes to existing services, adding new billable services, and designing a new Medicaid wavier to support increased wraparound services and care coordination for an identified priority population.

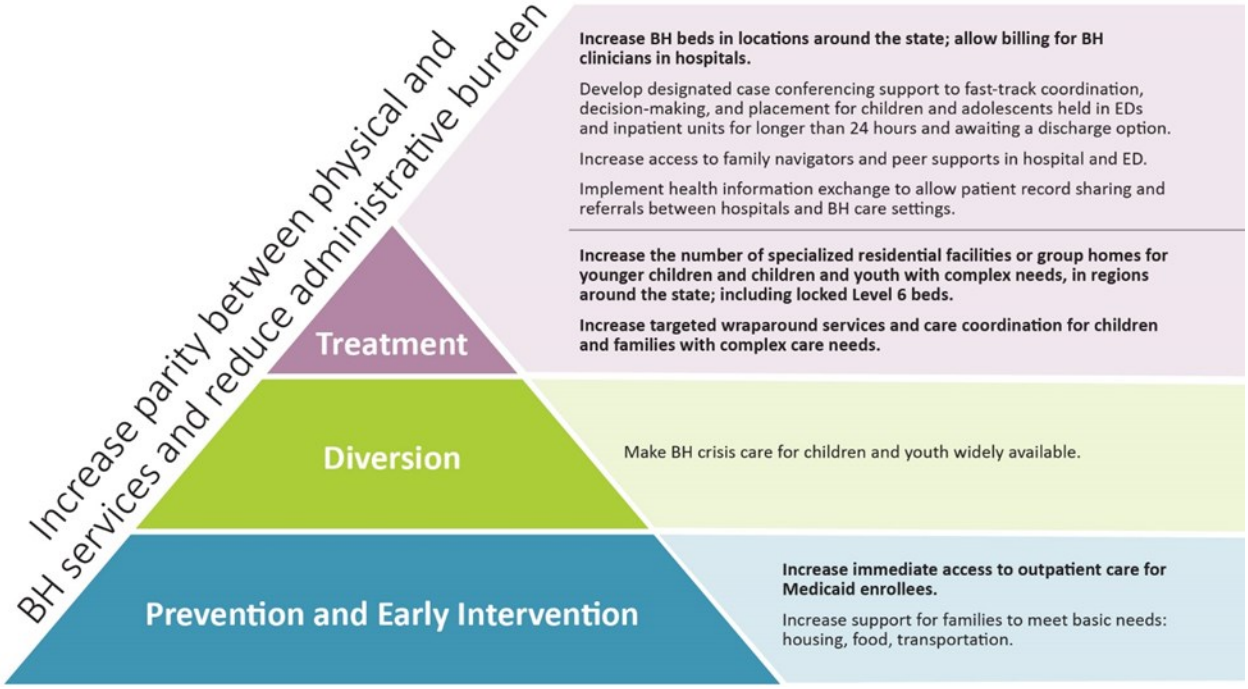
- Providers identified that the existing 1115 Medicaid Waiver services, Therapeutic Treatment Homes and Home-Based Family Treatment Levels 1, 2 and 3, lack the flexibility needed to meet families' needs. Additionally, services billed in 15-minute increments increase the provider documentation burden and don't cover the costs of planning, transportation, and no-shows. As one provider identified, you could spend two hours planning for a meeting, and an hour getting there, only to have the family not open the door. Without contact with the client, the provider cannot bill, which creates a disincentive for providers to develop home-based services.
    - *Key partners:* Alaska Behavioral Health Association, State of Alaska Division of Behavioral Health
- Care coordination is not a billable service line, but one that could be added to compensate providers for the time they spend doing this necessary work. As one interviewee shared "Anytime you have a transition in care, it's an opportunity for things to break down." If properly funded, providers could render this important service.
    - *Key partners:* Alaska Behavioral Health Association, State of Alaska Division of Behavioral Health
- Throughout the course of the project, children and youth with OCS involvement were identified as a top concern. Designing and implementing a 1915c Home and Community-Based Services Medicaid Waiver that identifies families with or at risk of OCS contact is one way to prioritize this population with a set of services and supports that incentivizes whole-family care in the least restrictive setting and supports collaboration between hospitals and community-based providers.
    - *Key partners:* Alaska Behavioral Health Association, Alaska Mental Health Trust Authority, State of Alaska Division of Behavioral Health, Senior and Disabilities Services, Office of Children's Services, and Health Care Services

Next Steps: Convene providers to identify and advocate for changes to Therapeutic Treatment Homes and Home-Based Family Treatment services as part of the 1115 Waiver renewal process. Engage in conversations with key partners regarding the design of a 1915c Waiver.

Priorities for System Change

In summary, to move towards a more robust behavioral health continuum, action is needed across the continuum. Stakeholders have identified the following objectives to better support children, adolescents, and their families (Figure 6).

Figure 6. Prioritized Objectives for Building a Robust Continuum of Care



References

1. Annie E. Casey Foundation. (2022). 2022 Kids Count Data Profile: Alaska. https://static1.squarespace.com/static/61fef737004f564915c6b3cd/t/62f13c03d3903e38f917d61c/1659976707947/2022+Kids+Count+Alaska+Profile.pdf
2. Division of Public Health. (2020, May 27). Impact of COVID-19 on Alaska families: Preliminary survey results. State of Alaska. https://health.alaska.gov/dph/wcfh/Documents/mchepi/COVID_Alaska_Families_survey_results.pdf
3. Williams, S. C. (2022, May 19). State-level data for understanding child welfare in the United States. Child Trends. Retrieved December 2, 2022, from https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states
4. Fernandez, G. (2022, March 7). Alaska sees drop in foster care homes for children as demand persists. KTUU. https://www.alaskasnewssource.com/2022/03/07/alaska-sees-drop-foster-care-homes-children-demand-persists/
5. Division of Behavioral Health. (2019, March 19). Caring for Alaska's children and youth in out-of-home behavioral health care [PowerPoint slides]. State of Alaska. https://alaskamentalhealthtrust.org/wp-content/uploads/2019/03/DBH-Conference-Presentation_FINAL-2019-03-19.pdf
6. Division of Public Health. (2011-2019). Alaska Youth Risk Behavior Survey. Department of Health, State of Alaska. https://health.alaska.gov/dph/Chronic/Pages/yrbs/results.aspx#results
7. Division of Behavioral Health. Email communication: Outpatient transition times. November 2, 2022

Appendix A

Project Workplan

Prevention, Early Intervention, and Diversion			
	Action Items	**Timeline**	**Funding/Resource Needed**
Objective 1	**Make behavioral health crisis care for children and youth widely available.**		
1a.	Where mobile crisis teams exist, increase awareness of team availability in settings that serve children and youth (primary care, schools).	Short-term	TBD, pending discussion with MCT operators
1b.	Adapt rates and regulation to support mobile crisis care in rural and remote communities.	Medium-term	
1c.	Identify communities with high demand for mobile crisis team services; Provide start-up funding, technical assistance, and operating support for first three years of operation.	Medium-term	Start-up and operational funding, technical assistance
1d.	Identify communities with high demand for crisis stabilization and/or short-term crisis residential programs for children and youth; Provide start-up funding, technical assistance, and operating support for the first three years of operation.	Medium-term	Start-up and operational funding, technical assistance
1e.	Provide training and technical assistance to behavioral health providers in best practices for crisis care, including de-escalation techniques, SafeClench, Ukaru, Zero Suicide and other emerging practices that increase safety for staff and clients.	Medium-term	Identification of training models to bring to Alaska, funding to support training of providers
Objective 2	**Increase immediate access to assessment and outpatient behavioral health care for Medicaid enrollees.**		
2a.	Create a clear pathway for behavioral health organizations to contract with independent providers to increase capacity to deliver behavioral health services billable to Medicaid.	Short-term	

2b.	Connect all outpatient behavioral health providers who accept Medicaid to a platform to communicate availability of assessment slots, crisis appointments, and long-term therapy appointments.	Short-term
2c.	As recommended in the 2021 PCG report, expand client eligibility for Medicaid School-Based Services (as allowed under the 2014 CMS free care rule reversal) to include all students. Gather input from Alaska providers and national experts in the design of a State Plan Amendment for this expansion.	Medium-term
2d.	Expand eligible provider types at FQHCs to include LPCs and LMFTs. Ensure FQHCs are aware of changes in regulation and implications for service delivery.	Short-term (in progress)
2e.	Develop clear guidance regarding delivery of and billing for behavioral health services in schools for different Medicaid billing models.	Short-term
2f.	Support non-billable school-based services (tiers 2) with grant-funding.	Short-term
2g.	Develop a statewide network of schools and providers to support shared learning and joint advocacy.	Short-term
2h.	Track CMS proposed changes to incentivize integration of psychologists and social workers into primary care settings by establishing billing codes to encourage integration. Identify and implement changes needed at the state level.	Short-term
2i.	Identify and address gaps in primary care provider knowledge of behavioral health conditions including suicidal ideation and behaviors, and ability to connect patients to needed services.	Medium-term
2j.	Provide technical assistance to primary care clinics, FQHCs and pediatric practices to encourage licensed mental health professionals to deliver behavioral health care in these settings.	Medium-term
2k.	Increase connectivity of primary care providers to Help Me Grow and PAL-PAK.	Medium-term
2l.	Support hospitals in establishing relationships with outpatient behavioral health providers to decrease wait times for assessment and follow-on care after a crisis.	Short-term

Objective 3	**Increase support for families to meet basic needs: housing, food, transportation.**		
3a.	Expand access to programs such as ANMC's Medical-Legal Partnership to support family access to basic needs supports.	Short-term	
3b.	Increase awareness of and connections to Help Me Grow Alaska and Alaska 2-1-1.	Short-term	
3c.	Identify statewide policy changes and funding to increase the supply of affordable housing, affordable childcare, transportation, and access to living wage employment in Alaska communities.	Medium-term	
3d.	Increase availability of and funding for respite care for families and foster families to access in times of need to reduce escalation to a higher level of care.	Medium-term	
3e.	Create an automatic referral to community-based family navigation services at the first report of harm to OCS, substantiated or unsubstantiated. Provide grant funding for family navigation to increase early intervention for at-risk families.	Long term	

Behavioral Health Care in Emergency Department and Inpatient Settings

	Action Items	Timeline	Funding/Resource Needed
Objective 1	**Increase the number of behavioral health beds in locations around the state; allow billing for BH clinicians in hospitals.**		
1a.	Conduct regional assessments to determine the number of crisis chairs and beds needed per region and the number of inpatient beds needed. The assessment should include identification of existing capacity and resources needed to grow capacity.	Short-term	
1b.	Support partnerships between hospitals and community behavioral health providers to explore development of 1115 waiver Crisis Residential and Stabilization programs within hospital campuses (but carved out from hospital cost reporting). Identify barriers and strengths of this approach.	Short-term	
1c.	Identify pathways for Tribally-operated hospitals, Critical Access Hospitals and general acute care hospitals to bill for behavioral health services provided on inpatient units.	Short-term	

1d.	Advocate for changes to address barriers to providing and billing for behavioral health services in hospital inpatient units.	Long-term	
1e.	Support hospitals with funding and technical assistance needed to provide behavioral health services on their inpatient units and/or in partnership with Community Behavioral Health via the 1115 Waiver. Include incorporation of best practices in crisis and suicide care.	Long-term	Funding, technical assistance
Objective 2	**Develop designated case conferencing support to fast-track coordination, decision-making, and placement for children and adolescents held in EDs and inpatient units for longer than 24 hours and awaiting a discharge option.**		
2a.	Develop weekly report of children and adolescents awaiting a higher level of care and share with DOH and DFCS leadership.	Short-term	
2b.	Engage with complex care team in development with the DFCS to determine what, if any, support this team could offer children and youth presenting to hospitals for behavioral health reasons.	Short-term	
2c.	Identify lead to develop case conferencing process, and convene key stakeholders (hospital, residential treatment providers, DBH, DJJ, OCS, etc.). Conduct a pilot of the case conferencing process and determine effectiveness.	Short-term	Position to support convening and coordination
2d.	Establish funding to support enhanced care needs to facilitate and maintain placements in appropriate level of care (e.g. an in-state facility will take a specific child if funding for a one-to-one staff is provided)	Short-term	Funding for enhanced care needs
Objective 3	**Increase access to family navigators and peer supports in hospital and emergency department settings.**		
3a.	Research best practices in family navigation and peer supports in hospital inpatient and emergency department settings.	Short-term	
3b.	Convene existing peer and family navigator organizations to understand current services provided in these and other settings.	Short-term	

3c.	Identify Alaska and national programs providing peer support or family navigation services in hospital settings. Use findings from existing work to support interested hospitals in the development of programs that will work for them. Work with interested hospitals to support development of programs that will work in their community. Develop pilot project to provide peer and/or family navigation in hospital inpatient and ED settings.	Medium-term	Research, connectivity and technical assistance
3d.	Share back lessons learned from pilot program and bring innovations to scale.	Long-term	Funding and technical assistance to expand programs.
3e.	Increase training and competency of workforce in working with families.	Medium-term	Research and bring evidence-based family-focused trainings to Alaska providers

Objective 4	**Implement health information exchange (HIE) and a referral platform to allow patient record sharing and referrals between hospitals and behavioral health care settings.**		
4a.	Support current efforts to increase on-boarding to Alaska's HIE among behavioral health providers.	Short-term	
4b.	Provide training and support to hospital and behavioral health providers to encourage appropriate information sharing using the HIE. Encourage providers to fully utilize the system.	Short-term	
4c.	Onboard hospitals to OpenBeds or similar platform as a referring provider to expedite referral process to behavioral health services.	Short-term	
4d.	Support efforts to onboard receiving providers (outpatient, residential and inpatient) to OpenBeds or similar platform to ensure sufficient volume of receiving providers for hospitals to connect with.	Short-term	
4e.	Integrate OpenBeds or similar platform into ED and inpatient unit workflows for behavioral health patients.	Short-term	

Treatment and Access Points for Discharge			
	Action Items	**Timeline**	**Funding/Resource Needed**
Objective 1	**Increase parity between physical and behavioral health services by removing barriers to accessing behavioral health care, reducing administrative burden associated with billing Medicaid for behavioral health services, making it easier for Medicaid enrollees to be assessed for behavioral health care, and making it easier for behavioral health providers to serve clients enrolled in Medicaid.**		
1a.	Bring all eligible1115 Waiver services into the State Plan.	Medium-term	
1b.	Integrate approval and application processes to create a single application and approval process for all providers of behavioral health services funded by Medicaid.	Medium-term	
1c.	Provide a clear table that identifies the various billing models that can be used for behavioral health services and the differences between them. Be transparent about the different provider types allowed to work in each, services that can and cannot be delivered, documentation and data requirements and reimbursement rates.	Medium-term	
1d.	Publish a FAQ and step-by-step flow diagram to help each provider type navigate the application and approval process.	Medium-term	
1e.	Create a transparent and easily accessible platform for accessing de-identified data required by the state.	Medium-term	
1f.	Decrease administrative burden associated with billing Medicaid for behavioral health services by allowing all documentation and data reporting to be transmitted for a certified Electronic Health Record without requiring additional forms.	Medium-term	
1g.	Decrease administrative burden associated with billing Medicaid for behavioral health services and removing prior authorization requirements where possible.	Medium-term	
1h.	Publish a chart of 1115 and State Plan services that clarifies which can be provided and billed for on the same day and which are contraindicated.	Medium-term	
1i.	Create reimbursement rate parity across behavioral health (CBH/MHPC) and medical Medicaid/Medicare billing models.	Medium-term	
1j.	Identify and address issues with private coverage mental health parity as mandated by federal law.	Long-term	

1k.	Institute tiered reimbursement for some services to enable higher intensity services or higher staffing levels necessary to serve clients with more complex needs.	Medium-term	
1l.	For community-based and mobile services, adjust reimbursement rates to account for transportation time and allow a variety of responses in rural and remote areas.	Medium-term	
1m.	Increase transparency of rate setting methodologies used to set Medicaid rates for behavioral health services.	Medium-term	
1n.	Create more opportunities for bundled care to allow providers to offer a package of services rather than 15-minute units.	Long-term	
1o.	Provide a career ladder for peers and increasing levels of certification with eligibility for higher reimbursement for services based on experience.	Long-term	
1p.	Increase number of independent providers serving Medicaid-enrolled individuals by identifying and addressing barriers to enrollment.	Medium-term	Survey and interviews with providers, workplan/workgroup to remove or decrease barriers
1q.	Support lower-48 recruitment initiatives for behavioral health positions.	Medium-term	
1r.	Support development of psychiatric residency and behavioral health certifications for nursing and allied health professions.	Medium-term	
1s.	Identify and address barriers in licensing and variance processes for behavioral health providers.	Medium-term	Survey and interviews with providers, workplan/workgroup to remove or decrease barriers
1t.	Develop a shared, standardized intake packet for all children and youth residential treatment providers to expedite referral process for hospitals, OCS and other referring entities.	Medium-term	State is currently working toward a universally accepted "SMART" form for psychiatric referrals that could be a good starting place for adolescents.

Objective 2	**Increase the number of specialized residential facilities or group homes for younger children and children and youth with complex needs, in regions around the state; including locked Level 6 beds.**

2a.	Identify and convene key stakeholders to discuss regulation change needed for locked/specialized residential treatment facilities.	Short-term	
2b.	Draft and propose new regulations and payment rates for locked/specialized residential treatment facilities.	Medium-term	New regulation
2c.	Support providers to develop specialized residential facilities by addressing barriers (workforce and wages, capital and start-up operational costs, technical assistance to design and implement programs).	Medium-term	Funding, technical assistance
Objective 3	**Increase targeted wraparound services and care coordination for children and families with complex care needs.**		
3a.	Increase adaptability and flexibility of Therapeutic Treatment Homes (TTH) and Home-Based Family Treatment (HBFT). Includes: Removing limits on the number of days HBFT and TTH services may be billed concurrently, increasing flexibility of TTH and removing participation requirements for HBFT (2-3 times per week required for Level 3)	Short-term	
3b.	Develop care coordination as a billable service line and support its implementation statewide.	Medium-term	
3c.	Support CBHs by reducing administrative burden and implementing tiered rates that support flexible, wraparound care tailored to families' needs.	Medium-term	
3d.	Support design and implementation of a Medicaid waiver to focus on families with or at risk of OCS contact to engage children and families in whole-family programs and services. Support model with appropriate value-based reimbursement that incentivizes whole-family care in the least restrictive setting and supports collaboration between hospitals and community-based providers.	Long-term	